Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	April 11, 2013 9:30 a.m.

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	B.	CAM Update
	C.	King Airway/ITD Study
	D.	Lasix Discussion
	E.	D50 Shortage Policy 705.03
	F.	Sidewalk CPR
	G.	Morphine Dosing
	H.	Other
V.	**New Business**	
	A.	Policy 124: Hospital Emergency Services Reduction Impact Assessment
	B.	Policy 131: Multi-Casualty Incident Response
	C.	Policy 506: Paramedic Support Vehicle
	D.	Policy 705.01 Trauma Treatment Guidelines
	E.	Policy 705.26 Suspected Stroke
	F.	Policy 710: Airway Management
	G.	Policy 720: LBC
	H.	Policy 724: ALTE
	I.	Policy 728: King Airway
	J.	Other
VI	**Old Business**	
	A.	Policy 318: ALS Response Standards
	B.	Policy 705.14 Hypovolemic Shock
	C.	Policy 705.25 Vtach, Not in Arrest
	D.	Policy 715: Needle Thorocostomy
	E.	Other
VII.	**Informational/Discussion Topics**	
	A.	Rescue Under Force Protection Medical Kits - Tourniquets
	B.	11376.5 Law Enforcement and Drug Use
	C.	Policy 1404 Guidelines for IFT to a Trauma Center
	C.	Policy 1405 Trauma Triage and Destination Criteria
VIII.	**Policies for Review**	
	A.	No policies for review
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 April 11, 2013

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

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

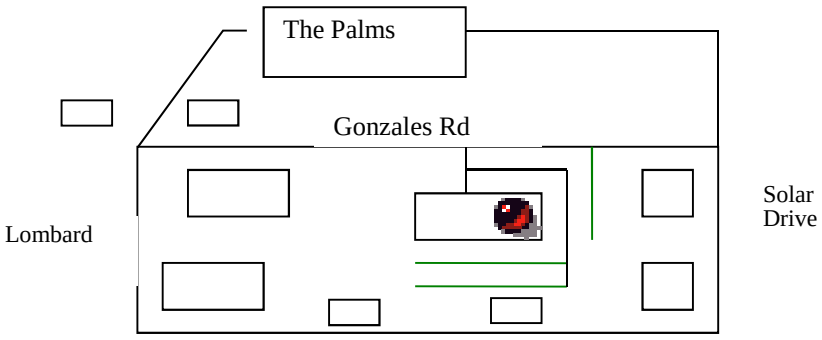
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

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 2013

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/10/2013	2/14/2013	3/14/2013	4/11/2013	5/9/2013	6/13/2013	7/11/2013	8/8/2013	9/12/2013	10/10/2013	11/14/2013	12/12/2013	%
AMR	Stefansen	Adriane		AS											
AMR	Panke	Chad		CP											
CMH - ER	Canby	Neil		NC											
CMH - ER	Cobb	Cheryl		CC											
CSUCI PD	Drehsen	Charles		CD											
CSUCI PD	Rice	Al		AR											
FFD	Herrera	Bill		BH											
FFD	Scott	Bob													
GCA	Norton	Tony		TN											
GCA	Stillwagon	Mike													
Lifeline	Kuroda	Brian		BK											
Lifeline	Winter	Jeff		JW											
LRRMC - ER	Beatty	Matt		MB											
LRRMC - ER	Licht	Debbie		DL											
OFD	Carroll	Scott		SC											
OFD	Huhn	Stephanie		SPH											
OVCH	Boynton	Stephanie													
OVCH	Patterson	Betsy		BP											
SJPVH	Hernandez	Sandi		SH											
SJPVH	Davies	Jeff		JD											
SJRMC	McShea	Kathy		KM											
SJRMC - SJPVH	Larsen	Todd		TL											
SPFD	Dowd	Andrew													
SVH - ER	Tilles	Ira		IT											
SVH - ER	Hoffman	Jennie		JH											
V/College	O'Connor	Tom		TO											
VCFD	Merman	Nancy		NM											
VCFD	Tapking	Aaron		AT											
VNC	Plott	Norm		NP											
VNC	Black	Shannon		SB											
VNC	Shedlosky	Robin		RS											
VCMC - ER	Chase	David		DC											

Agency	LastName	FirstName	1/10/2013	2/14/2013	3/14/2013	4/11/2013	5/9/2013	6/13/2013	7/11/2013	8/8/2013	9/12/2013	10/10/2013	11/14/2013	12/12/2013	%
VCMC - ER	Wilkie	LeeAnn		LW											
VCMC-SPH	Daucett	Michelle													
VCMC-SPH	Beatty	Karen		KB											
VCSO SAR	Hadland	Don		DH											
VCSO SAR	White	Don		DW											
VFF	Rhoden	Crystal													
VFF	Jones	Brad													
Eligible to Vote	**Date Change/cancelled - not counted against member for attendance**														
Non Voting Members															
AMR	Whitmore	Geneva		GW											
AMR	Taigman	Mike		MT											
CSUCI PD	Rice	Lynn													
EMS	Carroll	Steve		SC											
EMS	Buhain	Ruth		RB											
EMS	Frey	Julie													
EMS	Hadduck	Katy		KH											
EMS	Haney	Debora		DH											
EMS	Rosa	Chris		CR											
EMS	Salvucci	Angelo		AS											
LMT	Frank	Steve													
VCMC	Duncan	Thomas		TD											
VCMC	Utley	Dede													
VNC	Gregson	Erica													
VNC	Komins	Mark													

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.

Topic	Discussion	Action	Assigned
I. Introductions	Tom O'Connor new rep for Ventura College Ruth Behain is helping with the STEMI program and will work on other projects.		
II. Approve Agenda	Policy 715 added to the agenda Patterson/Kuroda		
III. Minutes	Corrections noted		
IV. Medical Issues			
A. Stroke System Update	Update on Stroke System provided.		
B. CAM Update	Still gathering data. No big jump in saves. Last month CPR refresher included a CAM review. Loosely polled the crew and seems like cardiac arrests are less chaotic and training helped with this. Need to reach out the VFF and get them trained as well. When are the rest of the providers going to get on board? CAM team needs to be reinstituted and training begun for providers county-wide. Couple things in the training that the crews don't like-- Two thumbs up hold and no check for pulse.		
C. King Airway/ITD Study	Stats distributed to the committee from March of 2008 till August 2012. Make mandatory or make it optional. Clearly need to make a statement that if optional needs to have a statement that as medical director needs to establish standard.	This will be an optional item.	

		IO lines? Mandatory for everyone. Epi some evidence that it may not be making a difference. Witnessed – page 3 – CPC 1-2 survival (neurologically intact) for patients in the vf/vt declined over a 3 month period.		
	D. Lasix Discussion	To be addressed next meeting		
	E. Other			
V.	**New Business**			
	A. Policy 318: ALS Response Standards	Checklist updated 451 (Stroke System) will be added to shift 4	Page number correction Trauma shift taken out of shift 2	Approved for immediate use. Davies/merman
	B. Policy 705.14 Hypovolemic Shock	Trauma - Abdominal, pelvic and thoracic will be added. 705.01 will be edited as well. Low perfusion, do not use automated blood pressure cuff. Use clinical judgment. We need to set a BP or physical finding.	If you don't feel brachial pulse present without automatic BP. This will be addressed with the trauma committees.	Approved with the addition of thoracic trauma Patterson/merman
	C. Policy 705.25 Vtach, Not in Arrest	D5W over 10. add language from bottom to the top.		Approved with change merman/black
	D. Policy 705.26 Suspected Stroke	Delete administer oxygen as indicated Change SAO2 to SPO2 Goal is to get O2 to 94, not high flow. Depending on reading non rebreather or nasal cannula. SPO2 needs to have change in general patient guidelines.		Tabled Training memo will be done
	E. Other	715: Needle Thoracostomy	Change wording in documentation section	Approved with change Licht/mcshea
VI	**Old Business**			
	A. 701: Medical Control: Base Hospital Medical Director		Checking to see if we need a BH medical director	Approved Davies/chase
	B.			

	C. Other			
VII. Topics	**Informational/Discussion**			
	A. Policy 1404:Guidelines for Interfacility Transfer of Patients to a Trauma Center	Criteria change explained.		
	B. EMS Agency Office Security	Incident last week that brought up some security issues. Front door is locked. Sign on door to have the person call to be let in. Public access will be through the front door entry only. We are trying to move this meeting to another location. Have not found a suitable location. Parking is difficult at this location. FYI, Nikki is on an extended leave.		
	C. Other			
VIII.	**Policies for Review**			
	A. Policy 124:Hospital Emergency Services Reduction Impact Assessment		4 of 4 – make in alphabetical order. Add Santa Paula Hospital. Add PICU and Trauma Look at values	Tabled
	B. Policy 1301: Public Access Defibrillation (PAD) Provider Standards		4.a add not breathing normally Title, fix fonts	Approved
	C. Policy 334:Prehospital Personnel Mandatory Training Requirements			Approved
	D. Policy 342:Notification of Personnel Changes – Provider		EMT-IA correction	Approved with change
	E. Policy 501:Advanced Life Support Service Provider Criteria			Approved
	F. Policy 506:Paramedic		Title change	Tabled

	Support Vehicle			
G.	Policy 508: First Responder Advanced Life Support Units		Page 2, refer to 705 Communication Failure Protocol	Approved with change Merman/Panke (for all approved)
H.	Policy 607: Hazardous Material Exposure: Prehospital Protocol		Consistent fonts. Title Change: Hazardous Material Incident Indent on page 4	Approved with changes
I.	Policy 615: Organ Donor Information Search		Documentation portion to make match with documentation language.	
J.	Policy 720: Guidelines For Limited Base Hospital Contact		Policies to the bottom Page 1, item 6 move into list. Bg < 6 change See Steve and Chris for change.	Tabled
K.	Policy 724: Apparent Life Threatening Event (ALTE)		Refusal of care form. Since agency specific form Chris will investigate the form titles. 3.b. change may to to exam will probably be normal.	Tabled
XI	**TAG Report**			**No meeting**
X.	**Agency Reports**			
A.	ALS Providers	VNC – EMT recert processing. Last year 24317 reports into the system. 12-25 minutes to when CAD is downloaded and first round of procedures 31st CPR save on Dec 30. AMR/GCA – planning world wide CPR challenge day on May 22. All providers can participate. More information to come VEN – promoted Doug Miser to BC, a lot of regular medics are moving to other positions. Nancy retiring April 12. Position is open		
B.	BLS Providers	OFD – announced new Fire Chief James Williams from Oakland. Interim Chief Mike O'Malia will be retiring when new chief starts.		
C.	Base Hospitals	SVH – sidewalk CPR Feb 20. Construction has started for new ER. Helipad is still open but with a fence surrounding it.		

	LR – today doing sidewalk CPR today at Oaks Mall. Ventura Star is going to be present. Apr 19 Dan Davis will conduct a CME lecture from 1230 – 1330, followed by 1400-1600 presentation and discussion of CPR. Zoll Rep present measures the quality of CPR. VCMC – approval for new hospital has been received and construction will begin at future date yet undetermined. New entrance for ambulance will be at front of hospital. Construction will take 4 years. VCMC to get info out to all ER MD and ER Nurse Managers. SJ - 2013 MICN course is ongoing. March is exam.	
D. Receiving Hospitals	CMH: Construction still continuing. If trucks block entrance let Cheryl Cobb know. Record census last month. A lot of flu. PV – stroke accreditation is complete and passed. TPA to a couple who have survived. New manager is working well.	
E. ALS Education Programs	14 paramedic students who are almost through with their clinical. Soon to be out doing the clinical time with the ambulance and fire departments.	
F. EMS Agency	CARES data Sidewalk CPR event on June 4 in combination with several other counties. Similar to what was done last year. Meetings will be planned shortly. We have been challenged by Santa Barbara for numbers. Baxter Larmen called to thank EMS for accepting 3 of their students. Policy does not allow paramedic students while VC college students are in internships. Reddinet flu survey – thanked all that have participated. Wanted to know the % of those who had positive flu test and symptoms for those who were vaccinated and had the flu. Most of the flu tests that were positive were non vaccinated patients. Reddinet Board next month County received a grant 500,000 to put on mass casualty and sheltering exercise. Scheduled for January 13 or 14. Planning will start soon. Master of Disaster skills training on March 14 for anyone involved with EMS. Will be sending out notification.	

	Working on extreme temperature plan. Will have a cold and heat annex. Currently have a heat plan. Hospitals – Julie Frey will be surveying the hospitals as related to active shooter preparedness. ReddiNet Coordinator Meeting after the April PSC Linda Tripoli will be here to discuss any changes and updates. No March PSC Meeting.		
G. Other	VNC hydrostatic body composition testing		
XI. Closing	**11:45**		

Altered Neurologic Function

BLS Procedures

ADULT

If suspected stroke, refer to VC EMS Policy 705.26 – Suspected Stroke
Administer oxygen as indicated
If low blood sugar suspected
• **Oral Glucose**
o PO – 15 gm

PEDIATRIC

If suspected stroke, refer to VC EMS Policy 705.26 – Suspected Stroke
Administer oxygen as indicated
If low blood sugar suspected
• **Oral Glucose**
o PO – 15 gm

ALS Prior to Base Hospital Contact

ADULT

IV Access
Determine Blood Glucose level
If <60
- **D50W**
  - o IV – 25mL (12.5gm)
- **D10W**
  - o IVPB-100mL (10gm)-Rapid Infusion
- **D5W**
  - o IVPB-200mL (10gm)-Rapid Infusion
- **Glucagon** (If no IV access)
  - IM – 1mg

Recheck Blood Glucose level 5 min after D50, D10W, D5W or 10 min after Glucagon administration
If still < 60
- **D50W**
  - o IV – 25mL (12.5gm)
- **D10W**
  - o IVPB-150ml (15gm)-Rapid Infusion
- **D5W**
  - o IVPB-250mL(12.5gm)- Rapid Infusion

PEDIATRIC

Consider IV Access
Determine Blood Glucose Level
If <60
- Less than 2 years old
- **D25W**
  - o IV – 2mL/kg
- 2 years old and greater
- **D50W**
  - o IV – 1mL/kg
- All Pediatric Patients
- **D10W**
  - o IVPB-5ml/kg-Rapid Infusion
  - o Max 100mL
- **D5W**
  - o IVPB-10mL/kg-Rapid Infusion
  - o Max 200mL
- **Glucagon** (If no IV access)
  - o IM – 0.1mL/kg
  - o Max 1 mg

Recheck Blood Glucose level 5 min after D25, D50, D10W, D5W or 10 min after Glucagon administration

If still <60
- Less than 2 years old
- **D25**
  - o IV – 2mL/kg
- 2 years old and greater
- **D50W**
  - o IV – 1mL/kg
- All Pediatric Patients
- **D10W**
  - o IVPB-7.5mL/kg-Rapid Infusion
  - o Max 150mL
- **D5W**
  - o IVPB-15mL/kg-Rapid Infusion
  - o Max 250mL

Base Hospital Orders only

ADULT

Consider IO Access if unable to establish IV access or administer glucagon IM

PEDIATRIC

Consider IO Access if unable to establish IV access or administer glucagon IM

Effective Date: December 15, 2011
Next Review Date: December 15, 2013
Date Revised: October 13, 2011
Last Reviewed: October 13, 2011

VCEMS Medical Director

Additional Information:

• Certain oral hypoglycemic agents (e.g. - sulfonylureas) and long-acting insulin preparations have a long duration of action, sometimes up to 72 hours. Patients on these medications who would like to decline transport MUST be warned about the risk of repeat hypoglycemia for up to 3 days, which can occur during sleep and result in the patient's death. If the patient continues to decline further care, every effort must be made to have the patient speak to the ED Physician prior to leaving the scene.

• If patient has an ALOC and Blood Glucose level is >60 mg/DL, consider alternate causes:

A - Alcohol	**O - Overdose**	**I - Infection**
E - Epilepsy	**U - Uremia**	**P - Psychiatric**
I - Insulin	**T - Trauma**	**S - Stroke**

Am J Emerg Med. 2008 Feb;26(2):148-54. doi: 10.1016/j.ajem.2007.04.020.

Is there an ideal morphine dose for prehospital treatment of severe acute pain? A randomized, double-blind comparison of 2 doses.

Bounes V, Charpentier S, Houze-Cerfon CH, Bellard C, Ducassé JL.

Source

SAMU 31, Pôle de médecine d'urgences, Hôpitaux Universitaires, 31059 Toulouse cedex 9, France. bounes.v@chu-toulouse.fr

Abstract

STUDY OBJECTIVE:
We aimed to determine the best intravenous morphine titration protocol by comparing 2 protocols for prehospital treatment of patients with severe acute pain.

METHODS:
Eligible patients with a numerical rating scale (NRS) score of 60/100 or higher were randomly allocated to receive either 0.05 mg/kg morphine then 0.025 mg/kg every 5 minutes (group A) or 0.1 mg/kg morphine then 0.05 mg/kg every 5 minutes (group B) intravenously. The protocol-defined primary outcome measure was the percentage of patients with pain relief (with a NRS score of 30/100 or lower) 30 minutes after the first injection.

RESULTS:
A total of 106 consecutive patients were randomized. Thirty minutes after the injection, 66% of the patients in group A had an NRS of 30 or lower vs 76% of those in group B (P = .25). Ten minutes after the injection, 17% of the patients in group A had an NRS score of 30 or lower vs 40% of those in group B, (odds ratio, 3.4; 95% confidence interval, 1.3-8.8; P < .01). Patients in group B were significantly more satisfied with their analgesia. In addition, there were no serious complications in either group. However, patients in group B did experience almost twice the incidence of adverse effects overall and in particular 4 times the level of emesis, although neither of these observations were statistically significant. Using univariate and multivariate analysis, only an initial NRS score of 100 was an independent predictive factor for failure of analgesia (odds ratio, 0.125; 95% confidence interval, 0.02-0.68; P < .05).

CONCLUSION:
The high-dose morphine regimen showed a similar analgesic response pattern to the low-dose one in severe acute pain in a prehospital setting. Patients in the high-dose group were more likely to experience pain relief 10 minutes after the injection. In the interests of achieving rapid pain relief, an initial dose of 0.05 mg/kg should no longer be recommended for treating severe acute pain in a prehospital setting. Another important message arising from our study is that a regimented dose of morphine, with an initial dose and strictly administered lower doses at regular intervals, is safe in the prehospital setting.

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:
Origination Date: June 1999 Date Revised: Date Last Reviewed: Review Date:	Effective Date:

Deleted: 06/01/2008

Deleted: May 13, 2004

Deleted: December 1, 2004

Deleted: November 12, 2009

Deleted: April, 2013

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	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 PICU Trauma	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 ~~Hospital~~ and 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							
~~Santa Paula Hospital~~							

Deleted: (in alphabetical order)

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Policy Title: Multi Casualty Incident Response	Policy Number 131
APPROVED: Administration: Steven L. Carroll, EMT-P	Date:
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date:
Origination Date: September 1991 Date Revised: Effective Date: Review Date:	

I. : To develop a standardized protocol for Multi-Casualty Incident (MCI) response and training in Ventura County.

II. AUTHORITY: California Health and Safety Code, Section 1797.151, 1798, and 1798.220. California Code of Regulations, Sections 100147 and 100169.

III. APPLICATION: This policy defines the on-scene medical management, transportation of casualties, and documentation for a multi casualty incident utilizing the principles of the incident command system as outlined in the MCI Plan.

IV. DEFINITIONS:

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

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

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

V. TRAINING:

The following training will be required:

A. **Basic MCI Training** for fire companies and field EMS providers.

Focus: Hands-on functions as described in the Ventura County EMS (VCEMS) basic MCI curriculum

1. Initial basic bourse: 4 hours
2. Prerequisite for the course: Introduction to the Incident Command System (ICS 100), and ICS for Single Resource and Initial Action Incidents (ICS 200).
3. Course will be valid for two years

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

Focus: command and major function integration as described in the VCEMS advanced MCI curriculum.

1. The advanced MCI course is divided into two modules. The morning session (module 1)

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is designed for new supervisory personnel and will cover specific principles of on-scene medical management, transportation of casualties and documentation for multi-casualty incidents. The afternoon session (module 2) will consist of a curriculum review and advanced MCI table top scenarios. Participants attending their initial advanced MCI course are required to attend both module 1 and module 2.

2. Initial advanced MCI training will be offered annually in January.
3. Initial Advanced MCI Course: 8 hours
4. Prerequisite for the Course: Intoroduction to the Incident Command System (ICS100), ICS for Single Resource and Initial Actiion Incidents (ICS 200), and National Incident Management System, an Introduction (ICS 700)
5. Course will be valid for two years

C. **Basic MCI Refresher Training**

Focus: Overview of multi-casualty operations as described in the VCEMS MCI Basic Curriculum

1. Refresher Course: 2 hours
2. Course will be valid for two years

D. **Advanced MCI Refresher Training** (Module 2 of the Advanced MCI Course)

Focus: Overview of Command and Major Function Integration as described in the VCEMS Advanced MCI Curriculum

1. Refresher Course: 4 hours
2. Advanced MCI refresher course will be offered twice annually, in January and July.
3. Course will be valid for two years

VI. ACTIVATION OF THE MULTI CASUALTY INCIDENT RESPONSE PLAN:

A. Report of Incident

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

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

B. Prehospital Response

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

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(IC) or appropriate public safety official will request activation and/or response of any supporting public safety/service agencies which may be needed, for example:

- Transportation resources; such as additional ambulances or buses
- Ventura County Chapter American Red Cross
- Public Health/EMS Emergency Preparedness Office
- Disaster Caches

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

C. Ventura County Trauma System Considerations

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

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

3. On level I MCI incidents, patients with traumatic injuries will be triaged utilizing the Ventura County Field Triage Decision Scheme, in addition to S.T.A.R.T. triage.a. On level I MCI incidents, the VC step will be relayed to the base hospital by MEDCOMM for all patients with traumatic injuries.

D. Ventura County EMS Agency

Upon receiving MCI information and a request from scene public safety personnel to activate the MCI Plan, EMS may contact the Base Hospital that MEDCOMM has communicated with during the initial phases of the MCI, and request an update before relieving the Base Hospital of this duty. The EMS Agency may then act as the medical clearinghouse and perform the following:

1. Alert all hospitals that an MCI has occurred and request that they prepare to receive casualties from the scene. This communication will include:
   - The type, size, and location of the incident.
   - The estimated number of casualties involved.

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- Advise area hospitals to be prepared to confirm their status and make preparations for the possible receipt of patients.

2. Update all hospitals periodically or when new or routine information is received. Hospitals in unaffected areas may or may not be requested to remain in a stand-by readiness mode.
3. Inform MEDCOMM of each hospital's availability.
4. Relay all requests/information regarding hospital resource needs or surplus to the Regional Disaster Medical Health Coordinator (RDMHC) representative, when appropriate. Coordinate response of additional medical equipment and personnel.
5. Inform all hospitals when remaining casualties have been cleared from the MCI scene.

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6. Receive MCI information from PSAP and alert the appropriate VCEMS and Ventura County Health Ccare Agency (HCA) personnel.
7. Initiate the VCEMS Emergency Response plan to a level appropriate to the information provided.
8. Activate the Health Care Agency – Department Operations Center, when appropriate.
9. Inform the Ventura County Sheriff's Office of Emergency Services (OES) and/or the Operational Area EOC of EMS activity, when appropriate.
10. Alert the RDMHC representative, when appropriate.
11. Request out-of-county medical resources, when necessary, with EMS/HCA management approval. Coordinate requests with OES staff and RDMHC representative.
12. Assist in the coordination of transportation resources.
13. Assist in the coordination of health care facility evacuation.
14. Communicate with hospitals, skilled nursing facilities and appropriate EOCs when warranted.
15. Assist in coordination of incident evaluations and debriefings.

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E. Hospital Response
1. Receive/acknowledge incident information and inform hospital administration.
2. Activate the hospital's disaster/emergency response plan to an appropriate level based upon the MCI's location type and number of casualties.
3. Hospitals experiencing difficulty in obtaining needed resources to manage casualties should make needs known to the EMS Agency representative.

F. Documentation
1. Level 1 MCI: The care of each patient shall be documented using an approved Ventura County Documentation System report.
2. Level 2 and 3 MCI: Each patient transported to a hospital shall have their care documented on a multi-casualty patient record (Policy 131, Attachment A).
   a. The transporting agency is responsible for completion of the multi- casualty patient record. The record is designed to be completed by the transporting crew enroute to the receiving hospital.
   b. The transporting agency retains the original of the multi-casualty patient record. A copy shall be left with the patient at the receiving hospital. The triage tag shall be attached to this copy and is included as official documentation in the patient's medical record.
   c. The transporting agency shall distribute copies of the multi-casualty patient

record to the base hospital and EMS Agency within twenty-four hours of demobilization of the incident.

d. Patients not transported from a Level II or Level III MCI, may be documented using the multi-casualty non-transport record, (Policy 131, Attachment B).

3. Ventura County EMS Approved MCI Worksheets

a. Ventura County EMS Providers shall utilize the approved MCI worksheets described in the Basic and Advanced MCI courses and attached to this policy as follows:

1. Form 131-C MCI Trauma Patient Destination Decision Algorithm (Policy 131, Attachment C)
2. Form 131-D Initial Patient Care Capacity – MCI All Levels (Policy 131, Attachment D)
3. Form 131-1 Level 1 MCI Worksheet (Policy 131, Attachment E)
4. Form 131-2 Hospital Worksheet (Policy 131, Attachment F)
5. Form 131-3 Out of County Hospital Worksheet (Policy 131, Attachment G)
6. Form 131-4 Treatment Tarp Updates (Policy 131, Attachment H)
7. Form 131-4A Immediate Treatment Area (Policy 131, Attachment I)
8. Form 131-4B Delayed Treatment Area (Policy 131, Attachment J)
9. Form 131-4C Minor Treatment Area (Policy 131, Attachment K)
10. Form 131-4D Morgue Area (Policy 131, Attachment L)
11. Form 306 Transportation Worksheet (Policy 131, Attachment M)
12. Form 310 Staging Manager (Policy 131, Attachment N)

4. Mobile Data Computer (MDC) Equipped Ambulances

a. In an effort to enhance patient tracking, transport personnel operating ambulances equipped with MDC's, when able, will document the triage tag number patient name, and destination in the comment section of the dispatch ticket on the MDC.

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VII. DE-MOBILIZATION OF THE MULTI CASUALTY INCIDENT RESPONSE PLAN:

A. Prehospital de-mobilization

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1. The Incident Commander (IC) will notify EMS that the MCI has been cleared when all casualties have been removed from the MCI scene.
2. VCEMS will notify all hospitals that the MCI scene has been cleared.
3. VCEMS will advise hospitals that casualties may still be enroute to various receiving facilities.
4. Hospitals will supply EMS with data on casualties they have received via ReddiNet, telephone, fax or RACES.
5. VCEMS will maintain communication with all participants until all activity relevant to

casualty scene disposition and hospital resource needs are appropriately addressed.

6. VCEMS will advise all participants when VCEMS is being de-activated.

VIII. CRITIQUE OF THE MULTI CASUALTY INCIDENT:

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

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

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Ventura County Health Care Agency

EMERGENCY MEDICAL SERVICES
A Division of Public Health

MULTI CASUALTY MEDICAL RESPONSE PLAN

Steven L. Carroll, EMT-P
EMS Administrator

Angelo Salvucci, M.D., FACEP
EMS Medical Director

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June 2013

County of Ventura
Emergency Medical Services Agency

MULTI CASUALTY MEDICAL RESPONSE PLAN

SECTION I INTRODUCTION

A. Purpose

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

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

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

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

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B. Goal

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

C. Plan Organization

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

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

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

D. Planning for Medical Disasters

1. Levels of Medical Disaster

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

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

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

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

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

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

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2. Addressing Medical Disasters

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

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

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

To assess the medical disaster appropriately, two components must be available to responding officials; 1) intelligence regarding the complexity of the incidents, the numbers and types of injuries, and; 2) communications to relay this intelligence to other supporting agencies.

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

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

F. SECTION II RESPONSE ORGANIZATIONS

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

1. Ventura County Health Care Agency (HCA)

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

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Health Care Agency responsibilities during an MCI include:

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

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- Calling for the activation of a Field Treatment Site (FTS).

2. Ventura County/Emergency Medical Services (VCEMS)

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

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VCEMS responsibilities during an MCI may include some or all of the following:

- Coordinating destinations
- Ascertaining hospital availability
- Coordinating medical resources (in and out of county)
- Communicating with the County Health Officer
- Coordinating the dissemination of Public Health information
- Response to the scene, primary dispatch center, HCA Department Operations Center (DOC) or Emergency Operations Center (EOC)
- Obtaining briefing from base hospital for transition
- Establishing communication with OES (consider EOC activation)
- Working within the Incident Command structure, as the medical/health branch of theOperations Section at the County's EOC
- Advising the County Health Officer as to the status of medical resources in Ventura County
- Establishing a liaison with the EMS Authority through the Region I Regional Disaster Medical/Health Coordinator (RDHMC)
- Coordinating resource requests and availability between acute care hospitals, advanced life support providers, basic life support transport providers, skilled nursing facilities and mental health facilities
- Maintain communications with receiving hospitals with Ventura County and throughout the region through the use of the Reddinet hospital communications system.
- Establishing direct communications with the Hospital Disaster Support Communications Radio Amateur Civil Emergency Services (RACES)
- Establishing contact with medical coordinators within city emergency operations centers via the Ventura County EOC to ascertain status and conditions at local Medical Aid Stations (MAS) and any other medically related concerns
- Activate the Ventura County Medical Reserve Corps (MRC) as indicated and coordinate all MRC operations through the County Health Officer and HCA DOC.
- Requesting Disaster Medical Assistance Teams through the RDMHC to implement a Field Treatment Site (FTS) operation at the direction of the Health Officer
- Assisting in the request and coordination of deployment of Critical Incident Stress Management teams
- Gathering information and documentation from Medical Communications (Med Comm)
- Initiating / coordinating an incident review
- Collecting data on casualties

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3. Municipal Governments

Have the responsibility and most likely the best capabilities for assessment of local community damage and injury. Public safety, Neighborhood Watch teams, Disaster Assistance Response

Teams (D.A.R.T.), Community Emergency Response Teams (C.E.R.T.), and RACES operators are some of the data gathering groups which may report on conditions to city/county EOCs. Maintaining effective communications between VCEMS and the EOC managers/coordinators at the city level through the use of a medical/health branch liaison is essential in verifying emergency medical care and available medical resources within the city or county jurisdictions.

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The city/county and VCEMS will coordinate efforts to facilitate medical aid stations and hospitals in the management of casualty care.

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Responsibilities of municipal governments during an MCI include:

a. Ventura County Office of Emergency Services

- Activating the EOC, coordinate large incidents
- Coordinating notifications and non-medical mutual aid requests (regional, state, etc.)
- Obtaining resources for on scene personnel
- Coordinating resource requests

b. Law Enforcement

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

c. Coroner / Medical Examiner

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

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d. Fire Departments

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

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Fire agency responsibilities during an MCI include:

- Providing community assessment of damage and casualties
- Conducting Mitigation of physical hazards
- Performing triage and treatment (including setting up, managing and staffing of treatment areas

with First Responder ALS resources.

- Conducting Scene Assessment
- Determining resource needs
- Assisting with ICS establishment / Unified Command

- Conducting Hazard Control
- Providing Rescue
- Providing a Public Information Officer (PIO)
- Setting Incident Objectives
- Providing scene documentation
- Driving transport vehicles as needed
- Providing communications as needed (Notify EMS and Coroner)
- Providing Dispatch (automatic responses, coordinate with other fire dispatch, communicate with IC)
- Managing fire and medical air operations
- Providing comfort measures

4. Media

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

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

5. Transportation Agencies

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

Responsibilities of transportation agencies during an MCI include:

a. Ground

- Providing Medical Communications
- Providing Medical supplies (initial and ongoing)
- Conducting Triage
- Providing Documentation (collect and forward information to VCEMS and base/receiving hospitals as needed).
- Providing Transport
- Providing Scene Assessment
- Determining resource needs
- Providing Scene documentation (collect documentation and forward to EMS)

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<#>Providing Dispatch (automatic responses, coordinate with other transport agencies)¶
<#>Advising receiving hospital of number of patients they will receive¶

b. Air

Air Ambulance
- Providing Transport
- Providing Documentation
- Conducting Transfers
- Providing additional aircraft as needed

Rescue Aircraft
- Providing Transport
- Providing Rescue
- Providing Documentation
- Providing additional aircraft as needed

6. Hospitals (Acute Care Health Facilities)

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

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

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

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

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7. American Red Cross - Ventura County Chapter

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

American Red Cross identified duties during an MCI may include:

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

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

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

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

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

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

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9. State of California Emergency Medical Services Authority

The Emergency Medical Services Authority ensures quality patient care by administering an effective, statewide system of coordinated emergency medical care, injury prevention, and disaster medical response.

State EMS Authority identified duties during an MCI may include:

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

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10. Hospital Association of Southern California (HASC)

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

HASC identified duties during an MCI may include:

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

11. Ventura County Transportation Authority

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

12. Salvation Army

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

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

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

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SECTION III RESPONSE NARRATIVE

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

1. Multi Casualty Incident (MCI) LEVEL I

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

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

Patient care information transmitted to the paramedic base hospital will be abbreviated and patients will be placed in "immediate", "delayed" and "minor" categories in keeping with the Simple Triage and Rapid

Treatment (S.T.A.R.T.) triage plan. Patients with traumatic injuries will also be triaged into the Ventura County trauma system and will be transported to a trauma center as indicated / directed. Patient care is focused upon life stabilizing treatments and expeditious transport of victims to appropriate receiving hospitals.

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

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

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2. Multi Casualty Incident (MCI) Level II

The initial phase of an MCI/Level II is similar to that of the MCI/Level I; first responders are dispatched to an incident via the 9-1-1 system. However, upon arrival, rescuers are immediately presented with a scenario which provides a large number of patients too numerous to treat definitively in the field. The stabilization and transportation of prioritized casualties to an appropriate receiving hospital is the most immediate objective. Management of the MCI/Level II is predicated on the assumption that there are enough prehospital medical responders, adequate transportation resources, sufficient casualty receiving hospitals and an intact coordinated hospital communication system. VCEMS will coordinate with local dispatch centers to assess current resources and determine adequacy.

Additional prehospital medical and public safety resources are requested through the appropriate communication center. The Incident Command System is utilized in management of the casualty scene, in accordance with principles and practices outlined in the National Incident Management System (NIMS). Because of the greater number of injuries, more branches and positions of the ICS will be activated. All scene responders, fire, law enforcement, ALS, BLS, first aid teams, and others will fall under the direction of the Incident Commander or Unified Command.

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Initial responders will estimate the number of resources needed to triage and transport the casualties. Among the resources requested by the Incident Commander in the very early stages of the MCI/Level II will be the assistance of VCEMS. When VCEMS is activated, a representative will contact the base hospital MICN for an update and may relieve them at that time. VCEMS will also begin filling requests for additional appropriate resources for on scene support. Hospitals may activate disaster plans and prepare to receive casualties. Victims will be transported from the scene as soon as on scene personnel have classified patients according to the S.T.A.R.T. triage system and when transportation resources are available. Considerations for transporting appropriate patients to a trauma center should be made. Because of the number of patients, trauma centers may become quickly inundated at which point patients should be transported to non-trauma hospitals.

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

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The activation of the County's EOC may or may not take place depending upon the complexity and needs of the incident. Activation of municipal EOC(s) may take place, again, depending upon the complexity and needs of the incident. If affected cities do activate EOCs, a limited activation of the County's EOC is required.

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

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

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3. LEVEL III

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

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

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

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Hospitals will be completing assessments of their own capabilities. It is presumed that some hospitals may be able to receive patients, while others may already be overwhelmed with casualties or may have become victims themselves. VCEMS will conduct assessments of all hospitals (as well as other medical care resources) to determine each facility's capabilities and needs following a major incident. RACES and VCEMS personnel at the County EOC or HCA DOC will handle the process of hospital assessment.

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With data gathered from the hospitals, medical aid stations, EMS providers, skilled nursing facilities and other information sources, VCEMS will be able to proceed with a number of actions which include the following; 1) Advise the Health Officer to designate Field Treatment Sites (FTS). FTS's will be strategically located around the county, ideally near hospitals. 2) Provide the MHOAC and County Health Officer with a list of medical resources needed and suggest that mutual aid be requested through the Region I RDMHsystem. The Health Officer and MHOAC will direct medical resources to appropriate locations.

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

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radio with the assistance of a County designated communicator will handle communication between these two entities, if available.

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

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

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

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

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SECTION V INFORMATION MANAGEMENT

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

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

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

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

SECTION VI RESOURCE ACQUISITION

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

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GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

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

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

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

HEICS **Hospital Emergency Incident Command System**
A generic medical response template developed by Ventura County EMS to provide health care facilities with an incident command based, standardized emergency response plan.

Hospital Inventory
The number of "Immediate" and "Delayed" patients which a hospital has identified that it may care for at any given time as a result of an MCI.

Immediate (patient)
First level of patient priority according to the S.T.A.R.T. triage system. A patient who requires rapid assessment and medical intervention in order to increase chances of survival.

MAS **Medical Aid Station**
A neighborhood disaster medical resource center; which may be organized under a three-way partnership; 1) a sponsoring city,
2) host medical site, and 3) community volunteers.

MCI **Multi Casualty Incident**
A suddenly occurring incident, which injures more than one individual, and presents conditions which may require fire and ambulance service mutual aid resources and the assistance of VCEMS.

Minor (patient)
Third priority of patient in the S.T.A.R.T. triage system. A patient requiring only simple, rudimentary first-aid. These patients are considered ambulatory.

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

RACES **Radio Amateur Civil Emergency Services**
RACES provides for amateur radio operation for emergency communications purposes only during periods of local, regional, or national emergencies. Members of RACES organizations make their volunteer services available to municipal, county and state governments; additionally, RACES will provide communication services wherever there is a need for life saving and property preserving assistance.

Receiving Hospital
A hospital that has been approved by the EMS Agency to receive patients requiring emergency medical services.

ReddiNet **Rapid Emergency Digital Data Information Network**
Web based computer system to coordinate hospital and paramedic services in the event of a major emergency. In non-emergency situations, ReddiNet provides hospitals with daily diversion status updates to determine which hospitals can provide appropriate patient care.

S.T.A.R.T. **Simple Triage and Rapid Treatment**

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A prehospital patient prioritizing system developed by Hoag Hospital and Newport Beach Fire Department for use during an MCI/LEVEL I, II or III. The S.T.A.R.T. system is based on four levels of prioritization: Deceased, Minor, Delayed, or Immediate.

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

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(For use on declared Level II or Level III MCI's only)¶
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The Authority shall coordinate, through local EMS agencies, medical and hospital disaster preparedness with other local, state, and federal agencies and departments having a responsibility relating to disaster response, and shall assist the Office of Emergency Services in the preparation of the emergency medical services component of the State Emergency Plan as defined in Section 8560 of the Government Code.

Date:_____ Agency:____ Unit #:_____ Location:_____ Incident Name / #:_____

Patient Name: **Age:** _____ D **Immediate** D **Delayed** D **Minor**	**Injuries**: _____ _____	**Airway:** D Patent D Other **Mental Status:** D	**Cap Refill:** D < 2 seconds D > 2 seconds **Skin:** D Normal D Other **Resp:** _____	**Treatment Prior to** D C-Spine D	**Base Hospital**: D D SVH D SJRMC D VCMC **Receiving**	**Comments:** _____

Receiving Hospital to Attach Triage Tag Here

Printed Name **License #** **Signature**

Distribution: Original – Provider, Copies – Base Hospital, Receiving Hospital & EMS Agency

Copy shall be left with Receiving Hospital at time of arrival and become part of the patient's medical record. Transport provider to distribute completed copies to Base Hospital and EMS Agency within 24 hours of the incident.

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MULTI-CASUALTY NON-TRANSPORT RECORD

(For use on declared Level II or Level III MCI's only)

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Date:____Agency:_____Unit #:_______Location:______Fire Incident #:_

Time: ____________ **Sex:** ☐ Male ☐ Female	**Airway:** Patent **Mental Status:** Awake and Alert Appropriate for Age	**Skin:** Normal **Resp:** ________	**Treatment Provided:**	**Comments**: ____________ ____________	**Disposition:** AMA Obtained No AMA Obtained Other: ________
Time: ____________ **Sex:** ☐ Male ☐ Female	**Airway:** Patent **Mental Status:** Awake and Alert Appropriate for Age	**Skin:** Normal **Resp:** ________	**Treatment Provided:**	**Comments**: ____________ ____________	**Disposition:** AMA Obtained No AMA Obtained Other: ________
Time: ____________ **Sex:** ☐ Male ☐ Female	**Airway:** Patent **Mental Status:** Awake and Alert Appropriate for Age	**Skin:** Normal **Resp:** ________	**Treatment Provided:**	**Comments**: ____________ ____________	**Disposition:** AMA Obtained No AMA Obtained Other: ________

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LEVEL 1 MCI WORKSHEET

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SANTA BARBARA: YNEZ VALLEY

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TREATMENT TARP UPDATES

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COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Paramedic Support Vehicles	Policy Number 506
APPROVED: Administration: Steven L. Carroll, EMT-P	Date:
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date:
Origination Date: October 1995 Revised Date: Last Reviewed: Review Date:	Effective Date:

Deleted: Advanced Life Support (ALS)
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Deleted: November 8, 2007
Deleted: June 1, 2008
Deleted: August 13, 2009
Deleted: November 30, 2012

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

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

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Deleted: an ALS Support Vehicle

III. PROCEDURE:

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

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1. The PSV is the closest unit to a call.

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

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3. During multi-patient incidents

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B. Personnel Requirements

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

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C. Equipment Requirements

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

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D. Documentation

PSV care shall be documented per Policy 1000.

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Trauma Assessment/Treatment Guidelines

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

A. Rapid trauma survey

1. Airway

a. Maintain inline cervical stabilization

1) Follow spinal precautions per VCEMS Policy 614

b. Open airway as needed

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

c. Suction airway if indicated

2. Breathing

a. Assess rate, depth and quality of respirations

b. If respiratory effort inadequate, assist ventilations with BVM

c. Insert appropriate airway adjunct if indicated

d. Assess lung sounds

e. Initiate airway management and oxygen therapy as indicated

1) Maintain SpO2 ≥ 95%

3. Circulation

a. Assess skin color, temperature, and condition

b. Check distal/central pulses and capillary refill time

c. Control major bleeding

d. Initiate shock management as indicated

4. Disability

a. Determine level of consciousness (Glasgow Coma Scale)

b. Assess pupils

5. Exposure

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

b. Maintain patient body temperature

B. Detailed physical examination

1. Head

a. Inspect/palpate skull

b. Inspect eyes, ears, nose and throat

2. Neck

a. Palpate cervical spine

b. Check position of trachea

c. Assess for jugular vein distention (JVD)

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

C. Trauma care guidelines
1. Head injuries
   a. General treatments
      1) Evaluate head and face – maintain high index of suspicion for injury if significant mechanism of injury is present or physical examination is remarkable for findings
      2) If in spinal precautions, elevate head of backboard 30° unless contraindicated
      3) Do not attempt to intubate head injured patients unless unable to manage with BLS airway measures
      4) Do not delay transport if significant airway compromise
   b. Penetrating injuries
      1) DO NOT REMOVE IMPALED OBJECT (unless airway obstruction is present)
      2) Stabilize object manually or with bulky dressings
   c. Facial injuries
      1) Assess airway and suction as needed
      2) Remove loose teeth or dentures if present
   d. Eye injuries
      1) Remove contact lenses
      2) Irrigate eye thoroughly with suspected acid/alkali burns
      3) Avoid direct pressure
      4) Cover both eyes
      5) Stabilize any impaled object manually or with bulky dressings
2. Spinal cord injuries
   a. General treatments

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1) Evaluate spinal column – maintain high index of suspicion for injury if significant mechanism of injury is present or physical examination is remarkable for findings
2) Place patient in supine position if hypotension is present

b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
1) Stabilize object manually or with bulky dressings
2) Control bleeding if present
3) In the presence of penetrating injuries, if no neurologic deficit is present upon physical examination, withhold spinal immobilization

c. Neck injuries
1) Monitor airway
2) Control bleeding if present

3. Thoracic Trauma
a. General treatments
1) Evaluate chest – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
2) Keep patients sitting high-fowlers
a) If in spinal precautions, elevate head of backboard 30° unless contraindicated
b) In the presence of isolated penetrating injuries, if no neurologic deficit is present upon physical examination, consider withholding spinal immobilization
3) Goal of fluid resuscitation is to maintain SBP of > 80 mmHg. If SBP > 80 mmHg, then maintain IV at TKO rate

b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
a) Remove object if CPR is interfered
b) Stabilize object manually or with bulky dressings
c) Control bleeding if present

c. Flail Chest/Rib injuries
a) Immobilize with padding and bulky dressings to affected area
b) Assist ventilations if respiratory status deteriorates

d. Pneumothorax/Hemothorax
a) Keep patient sitting high-fowlers
b) Assist ventilations if respiratory status deteriorates
1) Suspected tension pneumothorax should be managed per VCEMS Policy 715

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e. Open (Sucking) Chest Wound
   a) Place an occlusive dressing to wound site. Secure on 3 sides only
   b) Assist ventilations if respiratory status deteriorates
f. Cardiac Tamponade – If suspected, expedite transport
   a) Beck's Triad
      1) Muffled heart tones
      2) JVD
      3) Hypotension
g. Traumatic Aortic Disruption
   a) Assess for quality of radial and femoral pulses
   b) If suspected, expedite transport

4. Abdominal/Pelvic Trauma
   a. General Treatments
      1) Evaluate abdomen and pelvis – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
      2) Goal of fluid resuscitation is to maintain SBP of > 80 mmHg. If SBP > 80 mmHg, then maintain IV at TKO rate
   b. Blunt injuries
      1) Place patient in supine position if hypotension is present
   c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
      1) Stabilize object manually or with bulky dressings
      2) Control bleeding if present
   d. Eviscerations
      1) DO NOT REPLACE ABDOMINAL CONTENTS
         a) Cover wound with saline-soaked dressings
      2) Control bleeding if present
   e. Pregnancy
      1) Place patient in left-lateral position
      2) If in spinal immobilization, place padding under backboard to tilt to the left
   f. Pelvic injuries
      1) DO NOT LOG ROLL PATIENT
         a) Assessment of pelvis should be only performed once to limit additional injury
      2) Control bleeding if present

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3) Consider wrapping a bed sheet tightly around the pelvis and tying it together for use as a sling

4. Extremity Trauma

a. General Treatments

1) Evaluate CSM distal to injury

a) If decrease or absence in CSM is present:

(1) Manually reposition extremity into anatomical position

(2) Re-evaluate CSMb) If no change in CSM after repositioning, splint in anatomical position and expedite transport

c) Cover open wounds with sterile dressings

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

e) Splint/elevate extremity with appropriate equipment

b. Dislocations

1) Splint in position found with appropriate equipment

c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECTS

1) Stabilize object manually or with bulky dressings

2) Control bleeding if present

d. Femur fractures

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

2) Assess CSM before and after traction splint application

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e. Amputations

1) Clean the amputated extremity with NS

2) Wrap in moist sterile gauze

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3) Place in plastic bag

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

5) Prevent direct tissue contact with the ice packs

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Suspected Stroke

ADULT

BLS Procedures

Cincinnati Stroke Scale (CSS)

Administer oxygen if SpO2 < 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.

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COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Airway Management	Policy Number 710
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: December 1, 2012
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: December 1, 2012
Origination Date: June 1986 Date Revised: October 11, 2012 Date Last Reviewed: October 11, 2012 Review Date: October 31, 2014	Effective Date: December 1, 2012

I. PURPOSE: To define the indications, procedure and documentation for airway management by Ventura County EMS personnel.

II. AUTHORITY: Health and Safety Code, §1798 and §1798.2; §1798.160, and §1798.170 and California Code of Regulations, Title 22, §100218 and §100254.

III. Policy: Airway management shall be performed on all patients that are unable to maintain their own airway. Paramedics may utilize oral endotracheal intubation on patients eight (8) years of age or older, in accordance with Ventura County Policy 705.

IV. Definitions: Intubation Attempt – an interruption of ventilation, with laryngoscope insertion, for the purpose of endotracheal tube (ETT) placement.

V. Procedure:

A. Bag-Valve-Mask (BVM) ventilations

1. Indications

a. Respiratory arrest or severe respiratory compromise

b. Cardiac arrest – according to VCEMS Policy 705

2. Contraindications

a. None

3. [OPTIONAL] Impedance Threshold Device (ITD, ResQPOD) – CARDIAC ARREST ONLY

a. MUST UTILIZE 2-RESCUER VENTILATION TECHNIQUE

b. For all rhythms, in patients 18 y/o and above, start continuous compressions at 100/min. Attach ResQPOD to BVM. As soon as BVM/ResQPOD is ready, insert oral airway and perform CPR at

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30:2 compression to ventilation ratio, utilizing the BVM/ResQPOD to deliver the 2 breaths.

c. Maintain a 2-handed face mask seal throughout compressions.

d. If the patient has return of spontaneous circulation (ROSC), immediately remove ResQPOD.

e. Continue to assist ventilations at 1 breath every 5-6 seconds.

B. Endotracheal Intubation (ETI)

1. Indications

a. Cardiac arrest – according to VCEMS Policy 705 – ONLY if unable to adequately ventilate with BVM.

b. Respiratory arrest or severe respiratory compromise **AND** unable to adequately ventilate with BVM.

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c. After Base Hospital (BH) contact has been made, the BH Physician may order endotracheal intubation in other situations.

2. Contraindications

a. Traumatic brain injury – unless unable to maintain adequate airway (e.g. – persistent vomiting).

b. Intact gag reflex.

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3. Intubation Attempts

a. There shall be no more than two (2) attempts to perform ETI, lasting no longer than 40 seconds each, and prior to BH contact. For patients in cardiac arrest, each ETI attempt shall interrupt chest compressions for no longer than 20 seconds.

b. The patient shall be ventilated with 100% O_2 by BVM for one minute before each attempt.

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c. If ETI cannot be accomplished in 2 attempts, the airway shall be managed by BLS techniques.

d. If ETI and BLS techniques are unsuccessful, the approved alternate ALS airway device may be inserted.

4. [OPTIONAL] - ITD (ResQPOD) – CARDIAC ARREST ONLY

a. If/when advanced airway is established, transfer the ResQPOD to the advanced airway and start continuous compressions at 100/min with one breath each 6 seconds (timing light) or every 10th compression

b. If patient has ROSC, immediately remove ResQPOD from advanced airway and continue to assist ventilations at 1 breath every 5-6 seconds as needed.

5. Special considerations

a. Flexible Stylet. A flexible stylet may be used for any ETI attempt that involves an ETT size of at least 6.0 mm.

1) Two Person Technique (recommended when visualization is less than ideal):

a) Visualize as well as possible.

b) Place stylet just behind the epiglottis with the bent tip anterior and midline.

c) Gently advance the tip through the cords maintaining anterior contact.

d) Use stylet to feel for tracheal rings.

e) Advance stylet past the black mark. A change in resistance indicates the stylet is at the carina.

f) Withdraw the stylet to align the black mark with the teeth.

g) Have your assistant load and advance the ETT tip to the black mark.

h) Have your assistant grasp and hold steady the straight end of the stylet.

i) While maintaining laryngoscope blade position, advance the ETT.

j) At the glottic opening turn the ETT 90 degrees counter-clockwise to assist passage over the arytenoids.

k) Advance the ETT to 22 cm at the teeth.

l) While maintaining ETT position, withdraw the stylet.

2) One Person Technique (recommended when visualization is good but cords are too anterior to pass ET tube).

a) Load the stylet into the ETT with the bent end approximately 4 inches (10 cm) past the distal end of the ETT.

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b) Pinch the ETT against the stylet.

c) With the bent tip anterior, while visualizing the cords advance the stylet through the cords.

d) Maintain laryngoscope blade position.

e) When the black mark is at the teeth ease your grip to allow the tube to slide over the stylet. If available have an assistant stabilize the stylet.

f) At the glottic opening turn the ETT 90 degrees counter-clockwise to assist passage over the arytenoids.

g) Advance the ETT to 22 cm at the teeth.

h) While maintaining ETT position, withdraw the stylet.

b. Tracheal stoma intubation

1) Select the largest endotracheal tube that will fit through the stoma without force (it should not be necessary to use lubricant).

2) Do not use stylet.

3) Pass ETT until the cuff is just past the stoma.

4) Inflate cuff.

5) Attach the CO_2 measurement device to the ETT and confirm placement (as described below).

6) Secure tube.

6. Confirmation of Placement – It is the responsibility of the paramedic who has inserted the ETT to personally confirm (using air aspiration, auscultation, and CO_2 detection/measurement) and document proper placement. Responsibility for the position of the ETT shall remain with the intubating paramedic until a formal transfer of care has been made.

a. Prior to intubation, prepare both the air aspiration and the CO_2 measurement devices.

b. Insert ETT, advance, and hold at the following depth:

1) Less than 5 ft. tall: balloon 2 cm past the vocal cords.

2) 5'-6'6" tall: 22 cm at the teeth.

3) Over 6'6" tall:24 cm at the teeth or 2 cm past the vocal cords.

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c. After inserting the ETT, in the patient requiring CPR, resume chest compressions while confirming ETT placement.

d. Before inflating ETT balloon, perform the air aspiration technique.

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1) Deflate the bulb, connect to the ETT, and observe for refilling.

2) Refilling of the bulb in less than 5 seconds indicates tube placement in trachea.

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3) If the bulb does not completely refill within 5 seconds, unless able to definitively confirm placement on repeat direct laryngoscopy, remove the ETT. Suspect delayed filling with the ETT in the trachea if the patient is morbidly obese, has fluid in the airway (pulmonary edema, aspiration, pneumonia, drowning), or the ETT is against the carina.

e. Inflate the ETT cuff, attach the CO_2 measurement device, and begin ventilations.During the first 5-6 ventilations, auscultate both lung fields (in the axillae) and the epigastrium.

f. After 6 ventilations, observe the CO_2 measurement device:

1) If a colorimetric CO_2 detector device is used for initial placement confirmationprior to capnography, observe the color at the end of exhalation. Yellow indicates the presence of >5% exhaled CO_2 and tan 2-5% CO_2. Yellow or tan indicates tube placement in the trachea. Purple indicates less than 2% CO_2 and in the patient with spontaneous circulation is a strong indicator of esophageal intubation.

2) When capnography is applied, a regular waveform with each ventilation should be seen with tracheal placement. If the patient has been in cardiac arrest for a prolonged time (more than 5-10 minutes) the waveform may be diminished or, rarely, absent. In the patient with spontaneous circulation, if a regular waveform with a CO_2 of 25 or higher is not seen, that is a strong indicator of esophageal intubation.

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g. Using information from auscultation and CO_2 measurement, determine the ETT position.

1) If breath sounds are equal, there are no sounds at the epigastrium, and the CO_2 measurement device indicates tracheal placement, secure the ETT using an ETT holder.

2) If auscultation or the CO_2 measurement device, indicates that the ETT may be in the esophagus, immediately reevaluate the patient. If you are not CERTAIN that the ETT is in the trachea,the decision to remove the ETT should be based upon the patients overall clinical status (e.g., skin color, respirations, pulse oximetry)

3) If breath sounds are present but unequal, the ETT position may be adjusted as needed.

h. Once ETT position has been confirmed, reassessment, using CO_2 measurement, pulse oximetry (if able to obtain), and auscultation of breath sounds should be performed each time patient is moved.

i. Continue to monitor the CO_2 measurement device during treatment and transportation. If a change occurs from positive (yellow/tan) to negative (purple), or the waveform diminishes or disappears, reassess the patient for possible accidental extubation or change in circulation status.

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j. After confirmation of proper ETT placement and prior to movement, all intubated patients shall have their head and neck maintained in a neutral position with head supports. A cervical collar will only be used if a cervical spine injury is suspected.

1) Reconfirm ETT placement after any manipulation of the head or neck, including positioning of a head support, and after each change in location of the patient.

2) Report to nurse and/or physician that the head support is for thepurpose of securing the ETT and not for trauma (unless otherwise suspected).

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7. Documentation

a. All ETI attempts must be documented in the “ALS Airway” section of the Ventura County Electronic Patient Care Report (VCePCR).

b. All validated fields related to an advanced airway attempt shall be completed on the VCePCR. Anything related to the advanced airway attempt that does not have an applicable corresponding field in VCePCR, but needs to be documented, shall be entered into the report narrative.All data related to an advan**ced** airway attempt (successful or not) shall be documented on a VCePCR. In addition, an electronic signature shall be captured on the mobile device used to document the care provided. The treating emergency room physician will sign the 'Advanced Airway Verification' section of the VCePCR, as well as document the supporting information (placement, findings, method, comments, name, and date). In the event the patient was not transported, another on scene paramedic (if available) will sign and complete the verification section.

c. Documentation of the intubation in the approved Ventura County Documentation System must include the following elements. The acronym for the required elements is "SADCASES."

1) Size of the ETT
2) Attempts, number
3) Depth of the ETT at the patient's teeth
4) Confirmation devices used and results. For capnography, recording of waveform at the following points:
   a. Initial ETT placement confirmation;
   b. Movement of patient; and
   c. Transfer of care.
5) Auscultation results
6) Secured by what means
7) ETCO2, initial value
8) Support of the head or immobilization of the cervical spine.

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d. An electronic upload of Cardiac Monitor data, including ETCO2 waveform "snapshots" the the VCePCR is required. In the event an upload cannot occur, a printed code summary, mounted and labeled, displaying capnography waveform at the key points noted above is

required. This printed code summary shall be scanned and attached to the VCePCR.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: King Airway	Policy Number: 728
APPROVED: Administration: Steven L. Carroll, EMT-P	Date:
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date:
Origination Date: April 10, 2008 Date Revised: Date Last Reviewed: Next Review Date:	Effective Date:

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I. Purpose: To define the indications and use of the King Airway in the pre-hospital setting by paramedic personnel.

II. Authority: Health and Safety Code 1797.220 and 1798; California Code of Regulations, Title 22, Division 9, Section 100175.

III. Policy: Paramedic personnel may use the King Airway in accordance with Policy 705 as an option for ALS Airway Management.

IV. Procedure:

A. Indications: Patients who require assisted ventilation, meet criteria for an advanced airway as listed in VC EMS Policy 710, and an endotracheal tube cannot be inserted.

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B. The following contraindications shall be observed:

1. Its use will be restricted only to unconscious patients without a gag reflex.
2. It is not to be used on patients under four (4) feet tall.
3. It is not to be used on suspected cases of esophageal diseases or of ingestion of caustic substances.

C. Placement

1, Select appropriately sized King Airway:

a. Size 3 – Patient between 4 and 5 feet tall (

b. Size 4 – Patient between 5 and 6 feet tall

c. Size 5 – Patient over 6 feet tall

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2. Check King Airway cuffs to ensure patency. Deflate tube cuffs. Leave syringe attached. Lubricate the tip of the tube.

3. Oxygenate with 100% oxygen.

4. Position the head. The ideal position is the “sniffing position”. A neutral position can also be used if trauma is suspected.

5. Without exerting excessive force, advance tube until base of connector is aligned with teeth or gums.

6. Inflate cuffs with the minimum volume necessary to seal the airway at the peak ventilatory pressure employed. Typical inflation volumes are as follows: Size #3; 45-60 ml, Size #4; 60-80 ml, Size #5; 70-90 ml

7. Attach bag-valve to King Airway. While gently bagging the patient to assess ventilation, withdraw the airway until ventilation is easy and free flowing.

8. Attach bag valve device and verify placement by **ALL** of the following:
   a. Rise and fall of the chest
   b. Bilateral breath sounds
   c. Absent epigastric sounds
   d. CO2 measurement

9. If there is any question about the proper placement of the King Airway, deflate the cuffs and remove device, ventilate the patient with BVM for 30 seconds and repeat.

10. Secure the tube with tape or commercial tube holder. Note depth marking on tube.

11. Continue to monitor the patient for proper tube placement throughout prehospital treatment and transport.

D. Troubleshooting:
- If placement is unsuccessful, remove tube, ventilate via BVM and repeat sequence of steps.
- If unsuccessful on second attempt, BLS airway management should be resumed.
- Most unsuccessful placements relate to failure to keep tube in midline during placement.

E. Additional Information:
- Cuffs can be lacerated by broken teeth or dentures. Remove dentures before placing tube.
- Do not force tube, as airway trauma may occur.

F. Documentation:

a. Document time of placement and results of tube placement checks performed throughout the resuscitation and transport.

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<sp>**Ventura County**¶
Emergency Medical Services¶
¶
¶
King Airway Documentation Form¶
Date: _____ Paramedic: _____
Agency_____ ¶
FI #_____
_____ Pt Age: _____ Gender: _____
Height: _____ ¶
¶
King Airway Size: . (Circle One) . . 3 . 4 . 5 . ¶
Type: . . Medical Arrest . . Traumatic Arrest . Submersion Arrest¶
(Circle One) . . Respiratory Arrest . Other: _____¶
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Criteria ... [1]

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Ventura County
Emergency Medical Services

King Airway Documentation Form

Date: _____ Paramedic: _____

Agency_____

FI #_____ _____ Pt Age: _____ Gender: _____ Height: _____

King Airway Size: (Circle One) 3 4 5

Type: (Circle One) Medical Arrest Traumatic Arrest Submersion Arrest Respiratory Arrest Other: _____

Criteria	Yes	No	Other
1. # of ETI attempts? (Circle One) 0 1 2			
2. # of King Airway attempts? (Circle One) 1 2			
3. King Airway Successful?			
4. Physical Exam Confirms Successful Placement?			
4a. Chest Rise?			
4b. Lung Sounds Present?			
4c. Abdominal Sounds Absent?			
4d. Colorimetric CO2 Detector Used?			(Circle One) Purple Gray Tan Yellow
4e. Capnography Used?			Reading_____
5. Complications? (i.e. Unable to Ventilate, Inadequate Seal, Failed Placement, Ruptured Balloon, Etc.)			Describe Complications:

6. Patient Transported?			Hospital_____
7. Patient Outcome?			☐ Resuscitated ☐ Expired ☐ Unknown

For VC EMS use only:

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:
APPROVED: Medical Director Angelo Salvucci, MD	Date:
Origination Date: June 1, 1997 Date Revised: Date Last Reviewed: Review Date:	Effective Date:

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

II. AUTHORITY: California Health and Safety Code, Sections 1797.214, 1797.220, and 1798, California Code of Regulations, Title 22, Sections 100147 and 100169.

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.

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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			
2	720	Limited Base Contact			
	705	Altered Neurological Function			
		Overdose			
		Seizures			
		Suspected Stroke			
	451	Stroke System Triage			
	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			
4	705*	Allergic/Adverse Reaction and Anaphylaxis			
		Neonatal Resuscitation			
		Shortness of Breath – Pulmonary Edema			
		Shortness of Breath – Wheezes/other			
	705	Trauma Assessment/Treatment Guidelines			
	1404	Guidelines for Inter-facility Transfer of Patients to a Trauma Center			
	1405	Trauma Triage and Destination Criteria			
	1000	Documentation of Prehospital Care			
5	710	Airway Management			
	715	Needle Thoracostomy			
	716	Pre-existing Vascular Access Device			
	717	Intraosseous Infusion			
	728	King Airway			
	722	Transport of Pt. with IV Heparin and NTG			

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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, and Preceptor interview and scenario			
		Written Test			

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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.					
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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 Traumatic Injury • 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 thoracic, 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 Traumatic Injury • 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

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VCEMS Medical Director

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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 in 50 mL D_5W infused 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 in 50 mL D_5W infused over 10 minutes

Unstable polymorphic (irregular) VT:

- **Defibrillation**
  - Use the biphasic energy settings that have been approved by service provider medical director

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

Base Hospital Orders only

Torsades de Pointes

- **Magnesium Sulfate**
  - IVPB – 2 gm in 50 mL 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

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COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES	HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Needle Thoracostomy	Policy Number: 715
APPROVED: Administration: Steven L. Carroll, EMT-P	Date:
APPROVED: Medical Director Angelo Salvucci, M.D.	Date:
Origination Date: August 2010 Date Revised: Date Last Reviewed: Review Date:	Effective Date:

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I. Purpose: To define the indications, procedure and documentation for needle thoracostomy use by paramedics.

II. Authority: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Sections 100145 and100169.

III. Policy: Paramedics may perform needle thoracostomy on patients with a suspected tension pneumothorax in accordance with this policy.

IV. Procedure:

A. Indications

1. Patients with **ALL** of the following:
   a. Clinical suspicion of pneumothorax (e.g., trauma, dyspnea, chest pain),
   b. Systolic Blood Pressure less than 90, and
   c. Absent or significantly decreased breath sounds on the affected side.

B. Contraindications: None in this setting

C. Equipment

1. Povidone-iodine prep swab
2. 10 ml syringe
3. 5.0 - 6.0 cm, 12-16 gauge over-the-needle catheter
4. Connection tubing
5. Heimlich valve
6. Tape

D. Placement

1. Attach the syringe to the needle/catheter.
2. Identify and prep the site:
   - Locate the second intercostal space in the mid-clavicular line.
   - If unable to place anteriorly, lateral placement is in the fourth intercostal space in the mid-axillary line.

- Prepare the site with antiseptic solution.

3. Insert the needle/catheter perpendicular to the skin over the rib and direct it just over the top of the rib into the intercostal space.
4. After inserting the needle under the skin, maintain negative pressure in the syringe.
5. Advance the needle/catheter through the parietal pleura until a “pop” is felt and/or air or blood enters the syringe, then advance **ONLY** the catheter (not the syringe/needle) until the catheter hub is against the skin.

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

6. Hold the catheter in place and remove and discard the syringe and needle.
7. Attach tubing and Heimlich valve.
8. Secure the catheter hub to the chest wall with dressings and tape.
9. Reevaluate the patient (VS, lung sounds).

E. Documentation

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

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COUNTY OF VENTURA 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 Blood Glucose < 60 mg/DL
2. Narcotic Overdose.
3. Chest pain – Acute Coronary Syndrome no arrhythmia, or associated shortness of breath.
4. Shortness of Breath - Wheezes/Other
5. 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

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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.
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.

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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.

(2) 2-amino-1-phenyl-1-propanone (cathinone) or variation in any of the following ways:

(A) By substitution in the phenyl ring to any extent with alkyl, alkoxy, alkylenedioxy, haloalkyl, or halide substituents, whether or not further substituted in the phenyl ring by one or more other univalent substituents.

(B) By substitution at the 3-position with an alkyl substituent.

(C) By substitution at the nitrogen atom with alkyl, dialkyl, or benzyl groups, or by inclusion of the nitrogen atom in a cyclic structure.

(c) This section shall not prohibit prosecution under any other provision of law.

11376. Upon the diversion or conviction of a person for any offense involving substance abuse, the court may require, in addition to any or all other terms of diversion or imprisonment, fine, or other reasonable conditions of sentencing or probation imposed by the court, that the defendant participate in and complete counseling or education programs, or both, including, but not limited to, parent education or parenting programs operated by community colleges, school districts, other public agencies, or private agencies.

11376.5. (a) Notwithstanding any other law, it shall not be a crime for a person to be under the influence of, or to possess for personal use, a controlled substance, controlled substance analog, or drug paraphernalia, if that person, in good faith, seeks medical assistance for another person experiencing a drug-related overdose that is related to the possession of a controlled substance, controlled substance analog, or drug paraphernalia of the person seeking medical assistance, and that person does not obstruct medical or law enforcement personnel. No other immunities or protections from arrest or prosecution for violations of the law are intended or may be inferred.

(b) Notwithstanding any other law, it shall not be a crime for a person who experiences a drug-related overdose and who is in need of medical assistance to be under the influence of, or to possess for personal use, a controlled substance, controlled substance analog, or drug paraphernalia, if the person or one or more other persons at the scene of the overdose, in good faith, seek medical assistance for the person experiencing the overdose. No other immunities or protections from arrest or prosecution for violations of the law are intended or may be inferred.

(c) This section shall not affect laws prohibiting the selling, providing, giving, or exchanging of drugs, or laws prohibiting the forcible administration of drugs against a person's will.

(d) Nothing in this section shall affect liability for any offense that involves activities made dangerous by the consumption of a controlled substance or controlled substance analog, including, but not limited to, violations of Section 23103 of the Vehicle Code as specified in Section 23103.5 of the Vehicle Code, or violations of Section 23152 or 23153 of the Vehicle Code.

(e) For the purposes of this section, "drug-related overdose" means an acute medical condition that is the result of the ingestion or use by an individual of one or more controlled substances or one or more controlled substances in combination with alcohol, in quantities that are excessive for that individual that may result in

death, disability, or serious injury. An individual's condition shall be deemed to be a "drug-related overdose" if a reasonable person of ordinary knowledge would believe the condition to be a drug-related overdose that may result in death, disability, or serious injury.

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: February 7, 2013 Date Last Reviewed: February 7, 2013 Review Date: February, 2015	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.
4. Immediately post on ReddiNet when there is no capacity to accept trauma patients due to diversion for internal disaster or if CT Scanner is down.

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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.

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.

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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 to request an urgent trauma transfer. Additionally, this line may be used to request additional consultation with a trauma surgeon if needed.

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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.

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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 request an urgent trauma transfer. This call may be used to request additional consultation with the trauma surgeon if needed.
   b. Call the transport provider 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

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timely care and to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS Trauma Operational Review Committee.

Ventura County Field Triage Decision Scheme

For patients with visible or suspected traumatic injuries

Measure vital signs and level of consciousness

STEP 1

1.1 Glasgow Coma Scale	< 14
1.2 Systolic Blood Pressure	< 90 (< 110 in patients > 65 years)
1.3 Respiratory Rate	< 10 or > 29 breaths per minute (< 20 in infant age < 1 year)

Yes → **Contact base trauma center**

Transport to trauma center

No

Assess anatomy of injury

STEP 2

2.1 All penetrating injuries to head, neck, torso and extremities proximal to elbow and knee
2.2 Flail chest
2.3 Two or more proximal long-bone fractures (femur, humerus)
2.4 Crushed, degloved, or mangled extremity
2.5 Amputation proximal to wrist and ankle
2.6 Pelvic fractures
2.7 Open or depressed skull fracture
2.8 Paralysis

Yes → **Contact base trauma center**

Transport to trauma center

No

Assess mechanism of injury and evidence of high-energy impact

STEP 3

Falls
- **3.1.1** Adults: > 20 feet (one story is equal to 10 feet)
- **3.1.2** Children < 15 years old: > 10 feet, or two times the height of the child

High-risk auto crash
- **3.2.1** Intrusion > 12" patient site or > 18" any occupant site, including roof
- **3.2.2** Ejection: partial or complete from automobile
- **3.2.3** Death in same passenger compartment

3.3 Auto vs. pedestrian/bicyclist thrown, run over, or with > 20 mph impact
3.4 Unenclosed vehicle crash > 20 mph

Yes → **Contact base trauma center for destination decision**

No

Assess special patient or system considerations

STEP 4

4.1 Age > 65
4.2 Head injury with loss of consciousness AND on warfarin (Coumadin)
4.3 Burns with trauma mechanism
4.4 Time sensitive extremity injury (open fracture, neurovascular compromise)
4.5 Pregnancy > 20 weeks with known or suspected abdominal trauma
4.6 Prehospital care provider or MICN judgment

Yes → **Contact regular catchment base hospital**

Consider transport to trauma center or specific resource hospital

No

Transport to closest ED or by patient preference

Version 3 Revised 4-7-2013