Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	March 12, 2015 9:30 a.m.

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	A. Other	
V.	**New Business**	
	A. Nomination Committee for PSC Chair	Julie Frey
	B. 705.19 – Pain Control	Chris Rosa
	C. Other	
VI.	**Old Business**	
	A. 1 Liter Resuscitation Bags with Manometer (Update on ordering)	Dr. Salvucci
	B. 705.24 – Symptomatic Bradycardia	Dr. Salvucci
	C. 705.08 – Cardiac Arrest – VF/VT	Dr. Salvucci
	D. Other	
VII.	**Informational/Discussion Topics**	
	A. Update on 440 – Code STEMI Interfacility Transfer	Karen Beatty
	B. CAM/ART Certification Issues	Mark Komins
	C. air-Q Study Trial Update	Dr. Salvucci
	D. PRESTO Trial Update	Dr. Salvucci
	E. 1404 - Guidelines for Interfacility Transfer of Patients to a Trauma Center	Katy Hadduck
	F. 1405 – Trauma Triage and Destination Criteria	Katy Hadduck
	G. Other	
VIII.	**Policies for Review**	
	A. 400 – Ventura County Emergency Departments	
	B. 502 – Advanced Life Support Service provider Approval Process	
	C. 1000 – Documentation of Prehospital Care	
	D. 1201 – Air Unit Staffing Requirements	
	E. 1202 – Air Unit Dispatch for Emergency Medical Responses	
IX.	**Agency Reports**	
	A. Fire Departments	
	B. Ambulance Providers	
	C. Base Hospitals	
	D. Receiving Hospitals	
	E. Law Enforcement	
	F. ALS Education Program	
	G. TAG	
	H. EMS Agency	
	I. Other	
X.	**Closing**	

Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Minutes	January 08, 2015 9:30 a.m.

Topic	Discussion	Action	Assigned
II. Approve Agenda		Approved	Approved by Kathy McShea Seconded by Jennie Hoffman
III. Minutes		Approved	Approved by Kathy McShea Seconded by Jennie **Hoffman**
IV. Medical Issues			
V. New Business			
A. 705.07 – Cardiac Arrest – Asystole/PEA	The Committee approved this policy with the recommended changes. They would like Dr. Salvucci to check the Calcium Chloride dose. Should it be a small "g" or "gm"?	The committee approved whatever small change Dr. Salvucci needs to make to this policy and it does not need to come back to PSC at this time.	Approved by Bob Scott Seconded by Don Hadland
B. 705.08 – Cardiac Arrest – VF/VT	Tom O'Conner asked that Dr. Salvucci look at the Pediatric Dose listed under "ED Physician Order".	Dr. Salvucci will add new information and have the committee look at it one more time.	Approved by Bob Scott Seconded by Don Hadland
VI Old Business			
A. 705.11 – Crush Injury Syndrome		Approved	Approved by James Rosolek Seconded by Kathy McShea
B. CAM/ART Certification Issues	Mark Komins passed out an information sheet outlining the differences between AHA and CAM. He feels that a 7-8 hour class would encompass everything needed for Ventura County and would cover all age groups of patients.	Dr. Salvucci asked that the CAM committee "hash out" the details of what it would take to switch to a CAM certification and bring back to a future meeting.	
C. Other			
VII. Informational/Discussion Topics			
A. 402 – Hospital Diversion	Steve Carroll stated that all 8 hospitals were on diversion last night. Diversion has become an issue lately. Diversion is not a solution or an EMS problem, however, we feel the burden of it. Lynn	Dr. Salvucci will talk to Audra Strickland from Hospital Council and ask her to facilitate a meeting of hospital COO's.	

	Tadlock asked for the EMS Agency to facilitate a meeting with the "decision makers" or COO's at each hospital to make some changes.		
B. air-Q Study Trial Update	34 uses of air-Q 32 were successful 4 had air leaks Paramedics noted that there were problems securing the airway. Dr Cook is developing a new device to secure the air-Q. We should have it in about 3 weeks. Dr. Salvucci added that paramedics should be using the 1000cc ambu-bags for adults and the 240cc bags for children.	Dr. Salvucci will be sending out a new Tip Sheet and check off sheet to address the paramedics concerns. Providers can use up their old stock of ambu-bags before switching to the 240cc and 1000cc bags.	
C. PRESTO Trial Update	Dr. Salvucci introduced Daniel Perez who will be the point person from Cedar Sinai. Daniel is providing red lunch bags for blood to be placed in after it is drawn. The bag will have an ice pack that needs to be activated, pen and labels. The incident number needs to be written on a label and placed on the blood tube. Daniel asked that you try to fill as many lavender tops (up to 4) as possible for testing. The lunch bag will be placed in the designated refrigerator provided at each station.		
VIII. Policies for Review			
A. 430 – STEMI Receiving Center Standards	Approved with changes		Kathy McShea/Debbie Licht
B. 440 – Code STEMI Interfacility Transfer	This policy will go to the STEMI Comm. for updates/changes and will be brought back to PSC.		
C. 705.05 – Bites and Stings	Approved	No Changes	Tom O'Connor/Matt Beatty
D. 705.13-Hypothermia	Approved	No Changes	Kathy McShea/Matt Beatty

E. 705.22 – Shortness of Breath – Wheezes/Other	Approved	No Changes	Matt Beatty/Jennie Hoffman
F. 705.24 – Symptomatic Bradycardia	Dr. Salvucci will look at the language regarding TCP and develop a “footnote”. The draft changes will come back to PSC.		
XI TAG Report	The committee is chartering a new project to increase the survival rate of cardiac arrest victims.		
X. Agency Reports			
A. Fire departments	**VCFPD** – There are 20 people in their new academy. They have 3 new medics on squads and 2 additional will be added soon. They EMS Division will be opening a position for a new EMS Nurse. **VCFD** – Five new PM laterals coming in the next few weeks. They have 2 new FF’s. **OFD** – A new academy is starting and they have 9 FF’s attending. In 2014, they taught over 1000 people Sidewalk CPR. Station 8 is still under construction and expected to be completed/open by Summer or Fall. **Fed. Fire** – none **SPFD** – none **FFD-** none		
B. Transport Providers	**LMT –** They have 1 new promotion**.** One new ambulance will go into service next week. CAM training is completed. **AMR/GCA** – none		
C. Base Hospitals	**SVH –** none **LRRMC** – none **SJRMC –** none **VCMC** – The hospital will no longer be supplying ambulances with linens. They will supply them until a new system is put into place.		
D. Receiving Hospitals	**SPH –** none **CMH** – none **PVH –** none **OVCH** – Dr. Patterson is the new Chief of Staff. CMH doctors group will be taking over the OVCH E.R. contract.		
C. Law Enforcement	**VCSO -** none **CSUCI PD –** none		
F. ALS Education Programs	**Ventura College** – There are 18 students moving to the field in a few weeks.		

G. EMS Agency	**Dr. Salvucci –** none **Steve** – We moved into our new offices. We will have all our meetings, with the exception of PSC, in our conference rooms. Please stop by any time to see the new facility. Also, please be aware of these similar addresses: EMS is located at 2220 and our large conference room is 200 – B. PSC is held at 2240 in conference room 200. **Chris** – We are working to revamp the MCI video and packet for training. I will be ordering large amounts of MCI equipment in the next few months. We will be placing 5 tourniquets on every apparatus in the county. Martha, from our office, will be dealing with more accreditation issues (level 1/level2) and may be contacting you in the future. **Katy –** Please remind personnel to fill out all air-Q data fields so we do not have to track them down. There is a new trauma nurse certification. **Julie** – none **Randy** – none **Karen** – none	
H. Other		
XI. Closing	**Meeting adjourned at 1200**	

Prehospital Services Committee 2015

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/8/2015	2/12/2015	3/12/2015	4/9/2015	5/14/2015	6/11/2015	7/9/2015	8/13/2015	9/10/2015	10/8/2015	11/12/2015	12/10/2015	%
AMR	Stefansen	Adriane	AS												
AMR	Panke	Chad	CP												
CMH - ER	Canby	Neil	NC												
CMH - ER	Cobb	Cheryl													
OVCH - ER	Popescu	Dan	DP												
OVCH - ER	Patterson	Betsy	BP												
CSUCI PD	Drehsen	Charles	CD												
CSUCI PD	Morris	Michael	KM												
FFD	Herrera	Bill													
FFD	Scott	Bob	BS												
GCA	Norton	Tony	TN												
GCA	Shultz	Jeff	JS												
Lifeline	Rosolek	James	JR												
Lifeline	Winter	Jeff	JW												
LRRMC - ER	Beatty	Matt	MB												
LRRMC - ER	Licht	Debbie	DL												
OFD	Carroll	Scott	SC												
OFD	Huhn	Stephanie	SH												
SJPVH - ER	Hall	Elaina													
SJPVH - ER	Davies	Jeff													
SJRMC - ER	Larsen	Todd													
SJRMC - ER	McShea	Kathy	KM												
SPFD	Lazenby	Dustin	DL												
SVH - ER	Tilles	Ira	IT												
SVH - ER	Hoffman	Jennie	JH												
V/College	O'Connor	Tom	TO												
VCFD	Tapking	Aaron	AT												
VCFD	Utley	Dede	DU												
VNC	Zeller	Scott	SZ												
VNC	Dullam	Joe	JD												
VNC - Dispatch	Gregson	Erica	EG												
VCMC - ER	Chase	David	DC												

Agency	LastName	FirstName	1/8/2015	2/12/2015	3/12/2015	4/9/2015	5/14/2015	6/11/2015	7/9/2015	8/13/2015	9/10/2015	10/8/2015	11/12/2015	12/10/2015	%
VCMC - ER	Gallegos	Tom	TG												
VCMC-SPH	Gautam	Pai													
VCMC-SPH	Melgoza	Sarah	SM												
VCSO SAR	Hadland	Don	DH												
VCSO SAR	Seabrook	Jeff	JS												
VFF	Rhoden	Crystal													
VFF	Pena	Greg	GP												
Eligible to Vote	**Date Change/cancelled - not counted against member for attendance**														
Non Voting Members															
AMR	Whitmore	Geneva													
AMR	Taigman	Mike	MT												
EMS	Carroll	Steve	SC												
EMS	Frey	Julie	JF												
EMS	Hadduck	Katy	KH												
EMS	Perez	Randy	RP												
EMS	Rosa	Chris	CR												
EMS	Salvucci	Angelo	AS												
EMS	Beatty	Karen	KB												
LMT	Frank	Steve													
VCMC	Duncan	Thomas													
VNC	Shedlosky	Robin													
VNC	Komins	Mark	MK												

TEMPORARY
PARKING PASS
Expires March 12, 2015

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

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

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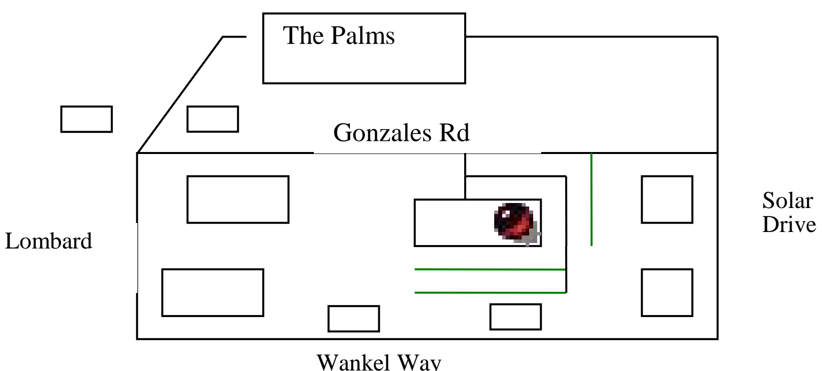
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

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.



<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Prehospital Services Committee Operating Guidelines</td><td>Policy Number
105</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steve L. Carroll, EMT-P</td><td>Date: December 1, 2014</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Angelo Salvucci, M.D.</td><td>Date: December 1, 2014</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>March, 1999
September 11, 2014
September 11, 2014
September, 2017</td><td>Effective Date: December 1, 2014</td></tr>
</table>

I. Committee Name

The name of this committee shall be the Ventura County (VC) Prehospital Services Committee (PSC).

II. Committee Purpose

The purpose of this committee shall be to provide input to the VC Emergency Medical Services (EMS) Medical Director and VC EMS administration on matters pertaining to emergency medical services, including, but not limited to, dispatch, first responders, ambulance services, communications, medical equipment, training, personnel, facilities, and disaster medical response.

III. Membership

A. Voting Membership

Voting membership in the committee shall be composed of 2 representatives, as appointed by the organization administrator, from each of the following organizations:

Type of Organization	**Member**	**Member**
Base Hospitals	PCC	PLP
Receiving Hospitals	ED Manager	ED Physician
First Responders	Administrative	Field (provider of "hands-on" care)
Ambulance Companies	Administrative	Field (provider of "hands-on" care)
Emergency Medical Dispatch Agency	Emergency Medical Dispatch Coordinator (1 representative selected by EMD Agency coordinators)	
Air Units	Administrative	Field (provider of "hands-on" care)
Paramedic Training Programs	Director (1 representative from each program.)	

B. Non-voting Membership

Non-voting members of the committee shall be composed of VC EMS staff to be determined by the VC EMS Administrator and the VC EMS Medical Director.

C. Membership Responsibilities

Representatives to PSC represent the views of their agency. Representative should ensure that agenda items have been discussed/reviewed by their agency prior to the meeting.

D. Voting Rights

Designated voting members shall have equal voting rights.

E. Attendance

1. Members shall remain as active voting members by attending 75% of the meetings in a (calendar) year. If attendance falls below 75%, the organization administrator will be notified and the member will lose the right to vote.
    (a) Physician members may have a single designated alternate attend in their place, no more than two times per calendar year.
    (b) Agencies may designate one representative to be able to vote for both representatives, no more than two times per calendar year.
2. The member whose attendance falls below 75% may regain voting status by attending two consecutive meetings.
3. If meeting dates are changed or cancelled, members will not be penalized for not attending.

IV. Officers

A. The chairperson of PSC is the only elected member. The chairperson shall perform the duties prescribed by these guidelines and by the parliamentary authority adopted by the PSC.

B. A nominating committee, composed of 3 members, will be appointed at the regularly scheduled March meeting to nominate candidates for PSC Chair. The election will take place in May, with duties to begin at the July meeting.

C. The term of office is one (1) year. A member may serve as Chair for up to three (3) consecutive terms.

V. Meetings

A. Regular Meetings

The PSC will meet on the second Thursday of each month, unless otherwise determined by the PSC membership. VCEMS will prepare and distribute electronic PSC Packet no later that one week prior to a scheduled meeting.

B. Special Meetings

Special meetings may be called by the chairman, VC EMS Medical Director, VC EMS Administrator or Public Health Director. Except in cases of emergency, seven (7) days notice shall be given.

C. Quorum

The presence a simple majority (1/2 of committee membership plus 1) of voting members shall constitute a quorum. The presence of a quorum at the beginning of the meeting shall allow the committee to continue to do business until adjournment, regardless of the number of members who leave during the meeting.

VI. Task Forces and Ad-hoc Committees

The PSC Chair, VC EMS Administrator, VC EMS Medical Director or Public Health Director may appoint task forces or ad-hoc committees to make recommendations to the PSC on particular issues. The person appointing the task force or ad-hoc committee will name the chair. A task force or ad-hoc committee shall be composed of at least three (3) members and no more than seven (7) individuals. Persons other than voting members may be appointed to task forces or ad-hoc committees.

VII. Calendar Year

The Prehospital Services Committee will operate on a calendar year

VIII. Parliamentary Authority

The rules contained in the current edition of Robert's Rules of Order, newly revised, shall govern the organization in all cases to which they are applicable and in which they are not inconsistent with these guidelines, and any special rules of order the PSC may adopt.

IX. Submission of Agenda Items

Agenda items shall be received by the Ventura County EMS Office 14 days before the meeting it is to be presented. Items may be submitted by US mail, fax or e-mail and must include the following information:

A. Subject
B. Reason for request
C. Description/Justification
D. Supporting medical information/other research as applicable
E. List of affected VC EMS policies, if a requested policy change
F. Agenda Category:
   1. Operational
   2. Medical

Cardiac Arrest – VF/VT

<table>
<tr><th>ADULT</th><th>PEDIATRIC</th></tr>
<tr><th colspan="2">BLS Procedures</th></tr>
<tr><td>If collapse before dispatch, complete 5 cycles
(2 minutes) of CPR, then attach AED
If witnessed, immediately attach AED
Airway management per VCEMS policy</td><td>If collapse before dispatch, complete 5 cycles
(2 minutes) of CPR, then attach AED
If witnessed, immediately attach AED
Airway management per VCEMS policy</td></tr>
<tr><th colspan="2">ALS Prior to Base Hospital Contact</th></tr>
<tr><td>Defibrillate
• Use the biphasic energy settings that have been approved by service provider medical director
• Repeat every 2 minutes as indicated
IV or IO access
Epinephrine
• IV/IO – 1:10,000: 1 mg (10 mL) q 3-5 min
Amiodarone
• IV/IO – 300 mg – after second defibrillation
• If VT/VF persists, 150 mg IV/IO in 3-5 minutes
ALS Airway Management
• Per VCEMS Policies 729 and 710.
•

If VF/VT stops, then recurs, perform defibrillation at the last successful biphasic energy setting</td><td>Defibrillate – 2 Joules/kg
• If patient still in VF/VT at rhythm check, increase to 4 Joules/kg
• Repeat every 2 minutes as indicated
IV or IO access
Epinephrine 1:10,000
• IV/IO – 0.01mg/kg (0.1 mL/kg) q 3-5 min
Amiodarone
• IV/IO – 5 mg/kg – after second defibrillation
• If VT/VF-persists, 2.5 mg/kg IV/IO in 3-5 minutes
ALS Airway Management
• <s>If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures</s>Per VCEMS Policy 710.

If VF/VT stops, then recurs, perform defibrillation at the last successful biphasic energy setting</td></tr>
<tr><th colspan="2">Base Hospital Orders only</th></tr>
<tr><td>Tricyclic Antidepressants
• Sodium Bicarbonate
  ○ IV/IO – 1 mEq/kg
    ▪ Repeat 0.5 mEq/kg q 5 min

Torsades de Pointes
• Magnesium Sulfate
  ○ IV/IO – 2 gm over 2 min
    ▪ May repeat x 1 in 5 min</td><td>Tricyclic Antidepressants
• Sodium Bicarbonate
  ○ IV/IO – 1 mEq/kg
    ▪ Repeat 0.5 mEq/kg q 5 min</td></tr>
<tr><td>Consult with ED Physician for further treatment measures
<u>ED Physician Order Only</u>
1. 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 <s>IVPB</s> IV/IO in 3-5 minutes

2. History of Renal Failure/Dialysis
• Sodium Bicarbonate
  ○ IV/IO – 1 mEq/kg
    ▪ Repeat 0.5 mEq/kg q 5 min
• Calcium Chloride
  ○ IV/IO – 1 gm
    ▪ Repeat x 1 in 10 min</td><td>Consult with ED Physician for further treatment measures
<u>ED Physician Order Only</u>
1. 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 2.5 mg/kg IVPB

2. History of Renal Failure/Dialysis
• Sodium Bicarbonate
  ○ IV/IO – 1 mEq/kg
    ▪ <s>Repeat 0.5 mEq/kg q 5 min</s>
• Calcium Chloride
  ○ IV/IO – 20 mg/kg – maximum 2g
    ○ <s>o</s>Over 1 min
    ▪ <s>Repeat x 1 in 10 min</s></td></tr>
<tr><td colspan="2">Additional Information:
• If sustained ROSC (>30 seconds), perform 12-lead EKG. Transport to SRC
• If patient is <u>hypothermic</u>–only ONE round of medication administration and limit defibrillation to 6 times prior to Base Hospital contact. Field determination of death is discouraged in these patients and they should be transported to the most accessible receiving facility
• Ventricular tachycardia (VT) is a rate > 150 bpm</td></tr>
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Symptomatic Bradycardia

ADULT (HR < 45 bpm)	PEDIATRIC (HR < 60 bpm)
BLS Procedures	
Administer oxygen as indicated Supine position as tolerated	Administer oxygen as indicated Assist ventilations if needed If significant ALOC, initiate CPR
ALS Prior to Base Hospital Contact	
IV access **Atropine** • IV – 0.5 mg (1 mg/10 mL) • For 3º and 2º Type 2 (Mobitz II) heart blocks, TCP preferred. Atropine only if TCP delayed or not effective. **Transcutaneous Pacing (TCP)** • Should be initiated only if patient has signs of hypoperfusion • ~~Should be started immediately for 3º heart blocks and 2º Type 2 (Mobitz II) heart blocks~~ • If pain is present during TCP ○ **Morphine** – per policy 705 - Pain Control	IV access • IO access only if pt in extremis **Epinephrine 1:10,000** • IV/IO – 0.01 mg/kg (0.1 mL/kg) q 3-5 min
Communication Failure Protocol	

If symptoms persist for 3 minutes after first atropine dose and if no capture with TCP
• **Atropine**
  ○ IV – 0.5 mg q 3-5 min
    ▪ Max 0.04 mg/kg
 	
• **Dopamine**
  ○ IVPB – 10 mcg/kg/min
    ▪ Use if patient continues to be unresponsive to atropine and TCP	

Base Hospital Orders only	

For suspected hyperkalemia
• **Calcium Chloride**
  ○ IV – 1 gm over 1 min
    ▪ Withhold if suspected digitalis toxicity
• **Sodium Bicarbonate**
  ○ IV – 1 mEq/kg
	Atropine
	• IV/IO – 0.02 mg/kg
	  ○ Minimum dose – 0.1 mg

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

Additional Information
- Bradycardia does not require treatment unless signs and symptoms are present (chest pain, altered level of consciousness, abnormal skin signs, profound weakness, or low BP)

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, Paramedic	Date:
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date:
Origination Date: July 1, 2010 Date Revised: Date Last Reviewed: Review Date:	Effective Date:

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.

DRAFT

A. For patients who are in the emergency department at a community hospital and have one or more of the following injuries, if the referring physician requests transfer to a trauma center, the trauma center will immediately accept the patient.
   1. Carotid or vertebral arterial injury
   2. Torn thoracic aorta or great vessel
   3. Cardiac rupture
   4. Bilateral pulmonary contusion with PaO2 to FiO2 ratio less than 200
   5. Major abdominal vascular injury
   6. Grade IV, V or VI liver injuries
   7. Grade III, IV or V spleen injuries
   8. Unstable pelvic fracture
   9. Fracture or dislocation with neurovascular compromise
   10. Penetrating injury or open fracture of the skull
   11. Glasgow Coma Scale score <14 or lateralizing neurologic signs
   12. Unstable spinal fracture or spinal cord deficit
   13. >2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion
   14. Open long bone fracture
   15. Significant torso injury with advanced co-morbid disease (such as coronary artery disease, chronic obstructive pulmonary disease, type 1 diabetes mellitus, or immunosuppression)
   16. Amputations or partial amputations of any portion of the hand[1]
   17. Injury to the globe at risk for vision loss[2]

B. Ventura County Level II Trauma Centers:
   1. Agree to immediately accept from Ventura County community hospitals, patients with conditions included in the guidelines above.
   2. Will publish a point-of-contact phone number for an individual authorized to accept the transfer of a patient with a condition included in the guidelines above, or to request consultation with a trauma surgeon.
   3. Will establish a written interfacility transfer agreement with every hospital in Ventura County.
   4. Immediately post on ReddiNet and notify EMS Administrator on-call when there is no capacity to accept trauma patients due to:
      a. Diversion for internal disaster
      b. CT scanner(s) non-operational

c. Primary and back-up trauma surgeons in operating rooms with trauma patients

C. 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.

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

3. For **URGENT** transfers, community hospitals will:

a. Maintain an ambulance arrival to emergency department (ED) departure time of no longer than twenty minutes.

4. For **URGENT** transfers, ambulance companies will:
    a. Arrive at the requesting ED no later than thirty minutes from the time the request was received.

V. PROCEDURE:

A. **EMERGENT** Transfers

1. After discussion with the patient, the transferring hospital will:
    a. Call the trauma hotline of the closest trauma center to notify of the transfer.
    b. Call FCC, advise they have an **EMERGENT** transfer, and request an ambulance. If the patient's clinical condition warrants, the transferring hospital will call FCC *before* calling the trauma center's hotline.
    c. Complete transfer consent and treatment summary.
    d. Prepare copies of the ED triage assessment form and demographic information form.
2. Upon request for an **EMERGENT** transfer, the dispatch center will dispatch the closest ALS ambulance and verbalize "MEDxxx E MERGENCY Trauma Transfer from [transferring hospital]". The trauma center will be denoted in the incident comments, which will display on the mobile data computer (MDC). If a unit does not have an operational MDC, the transferring hospital will advise the responding ambulance personnel of the destination trauma center.
3. Upon notification, the ambulance will respond Code (lights and siren).
4. FCC will track ambulance dispatch, enroute, on scene, en-route hospital, at hospital, and available times.
5. The patient shall be emergently transferred without delay. Every effort will be made to limit ambulance on-scene time in the transferring hospital ED to ten minutes.
    a. All forms should be completed prior to ambulance arrival.
    b. Any diagnostic test or radiologic study results may either be relayed to the trauma center at a later time, or if time permits, copied and sent with the patient to the trauma center.
    c. Intravenous drips may be discontinued or remain on the ED pump.
    d. The transporting paramedic will contact the trauma base hospital enroute and provide updated patient information.

B. Trauma Call Continuation

1. Upon determination of a Trauma Call Continuation, and after discussion with the patient, the community hospital will:
    a. Direct the ambulance personnel to prepare to continue the transport to the trauma center.
    b. Notify the designated trauma center ED of the immediate re-triage of a trauma patient, and communicate the patient's apparent injuries or reason for the re-triage, after the call is continued and the patient is enroute to the trauma center.
2. Upon notification of Trauma Call Continuation, the ambulance personnel will notify FCC of their assignment to a Trauma Call Continuation. FCC will link the trauma transfer to the original 911 incident and continue tracking en-route hospital (departure from community hospital), at hospital (arrival at trauma center) and available times.
3. When the transferring physician determines the patient is ready and directs ambulance personnel to continue the transport, the ambulance will emergently transport the patient to the trauma center. The transporting paramedic will contact the trauma base hospital enroute and provide updated patient information.

C. **URGENT** Transfers

1. After discussion with the patient, the transferring hospital will:
    a. Call the trauma hotline for the closest trauma center to 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** transfers, the transferring hospital will submit a completed Emergency Trauma Patient Transfer QI Form to the Ventura County EMS Agency within 72 hours. The transfer will be reviewed for appropriate and timely care and

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

[1]For patients with isolated traumatic amputations or partial amputations of any portion of the hand, a community hospital may elect to transfer the patient to a Ventura County trauma center for potential replantation surgery. In these circumstances, the community hospital shall contact Los Robles Hospital and Medical Center (LRHMC) to determine the availability of a hand surgeon trained in microvascular replantation surgery. If a specialty hand surgeon is available the patient shall be preferentially transferred to LRHMC.

[2]Patients with isolated eye injuries needing transfer to a trauma center for potential ophthalmologic surgery shall be preferentially transferred to Ventura County Medical Center.

EMERGENT Trauma Transfer QI Form
Form: Ventura County EMS Agency Policy 1404

(ALL FIELDS MUST BE COMPLETED)

Date of Incident:______________________

Sending Hospital:
☐ SVH ☐ SJPVH ☐ SJRMC ☐ OVCH ☐ CMH ☐ SPH

Treating Physician:____

Patient arrived at sending ED at ______________(time of ED arrival)
- ☐ Brought by EMS: Fire Incident Number ______________________
- ☐ Brought by POV or Walk-In

Destination Trauma Center:
- ☐ LRHMC
- ☐ VCMC
- ☐ Other: ______________________________

Patient Transfer Process:
- ☐ Ambulance with paramedic ONLY
- ☐ Ambulance with accompanying healthcare personnel
- ☐ Trauma Call Continuation

Which of the following Policy 1404 criteria applies?
- ☐ Indications for an immediate neurosurgical procedure
- ☐ Penetrating gunshot wound to head or torso
- ☐ Penetrating wound by any mechanism and presents with or develops shock.
- ☐ Blunt injury and shock
- ☐ Vascular injury that cannot be stabilized and is at risk of hemorrhagic shock or loss of limb acutely
- ☐ Pregnancy with indications for immediate Cesarean section

Comments:

Within 72 hours of transfer, fax or scan/email to VCEMS: Fax--(805) 981-5300 Email—katy.hadduck@ventura.org

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Trauma Triage and Destination Criteria	Policy Number 1405
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: March 3, 2015
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: March 3, 2015
Origination Date: July 1, 2010 Date Revised: March 3, 2015 Date Last Reviewed: March 3, 2015 Review Date: March 31, 2017	Effective Date:

I. PURPOSE: To guide out-of-hospital personnel in determining which patients require the services of a designated trauma center. To serve as the EMS system standard for triage and destination of patients suffering acute injury or suspected acute injury.

II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798. California Code of Regulations, Title 22, §100252 and §100255.

III. POLICY: These criteria apply to any patient who is injured or has a physical complaint related to trauma, and is assessed by EMS personnel at the scene.

A. Physiologic Criteria, Step 1:

1. Glasgow Coma Scale < 14
2. Systolic blood pressure < 90 mmHg
   (< 110 in patients older than 65 years of age)
3. Respiratory rate < 10 or > 29 breaths per minute
   (< 20 in infant younger than 1 year of age)

B. Anatomic Criteria, Step 2:

1. Penetrating wounds to the head, neck, torso, or extremities proximal to the elbow or knee
2. Flail chest
3. Two or more proximal long bone fractures (femur or humerus)
4. Crushed, degloved, or mangled extremity
5. Amputations proximal to wrist or ankle
6. Pelvic fractures
7. Open or depressed skull fracture
8. Paralysis

C. Mechanism of Injury Criteria, Step 3:

1. Adults: > 20 feet (one story is equal to 10 feet)
   Children < 15 years old: > 10 feet, or two times the height of the child
2. High-risk auto crash:
   a. Intrusion: interior measurement > 12 inches patient site; > 18 inches any occupant site
   b. Ejection: partial or complete from automobile
   c. Death in same passenger compartment
3. Auto-pedestrian / auto-bicyclist thrown, run over, or with > 20 mph impact
4. Unenclosed vehicle (e.g. motorcycle, bicycle, skateboard) crash > 20 mph

D. Other Criteria, Step 4 (these are considerations to be used by the base hospital in determining the appropriate destination hospital):

1. Age > 65 years old
2. Head injury with loss of consciousness AND on an anticoagulant or antiplatelet drug[1]
3. Burns with trauma mechanism
4. Time sensitive extremity injury (open fracture, neurovascular compromise)
5. Pregnancy > 20 weeks with known or suspected abdominal trauma
6. Prehospital care provider or MICN judgment
7. Amputation or partial amputation of any part of the hand[2]
8. Injury to the globe of the eye, at risk for vision loss[3]

V. PROCEDURE:

A. Any patient who is suffering from an acute injury or suspected acute injury shall have the trauma triage criteria applied.

B. For patients who meet trauma triage criteria listed in Sections A, B, or C above, the closest trauma center is considered to be the base hospital for that patient. Paramedics shall make base hospital contact and provide patient report directly to the trauma center.

C. Transportation units (both ground and air) shall transport patients who meet at least one of the trauma triage criteria in Sections A or B to the closest appropriate designated trauma center. If the closest trauma center is on internal disaster, these patients shall be transported to the next closest appropriate trauma center. If the closest trauma center is on CT diversion, the paramedic shall make early base contact and the MICN shall determine the most appropriate destination.

D. For patients who meet trauma triage criteria in Section C, the paramedic shall make base hospital contact with the closest designated trauma center. Based on the paramedic's report of the incident and the patient's assessed injuries, the trauma center MICN or ED physician shall direct destination to either the trauma center or the closest appropriate hospital.

E. Paramedics providing care for patients who are injured but meet only the trauma triage criteria listed in Section D above will contact the base hospital in whose catchment area the incident occurred. Destination will be determined by the base hospital MICN or ED physician. If the patient is directed other than to the regular catchment base hospital, the MICN will notify the receiving hospital or trauma center of an inbound patient and relay paramedic report.

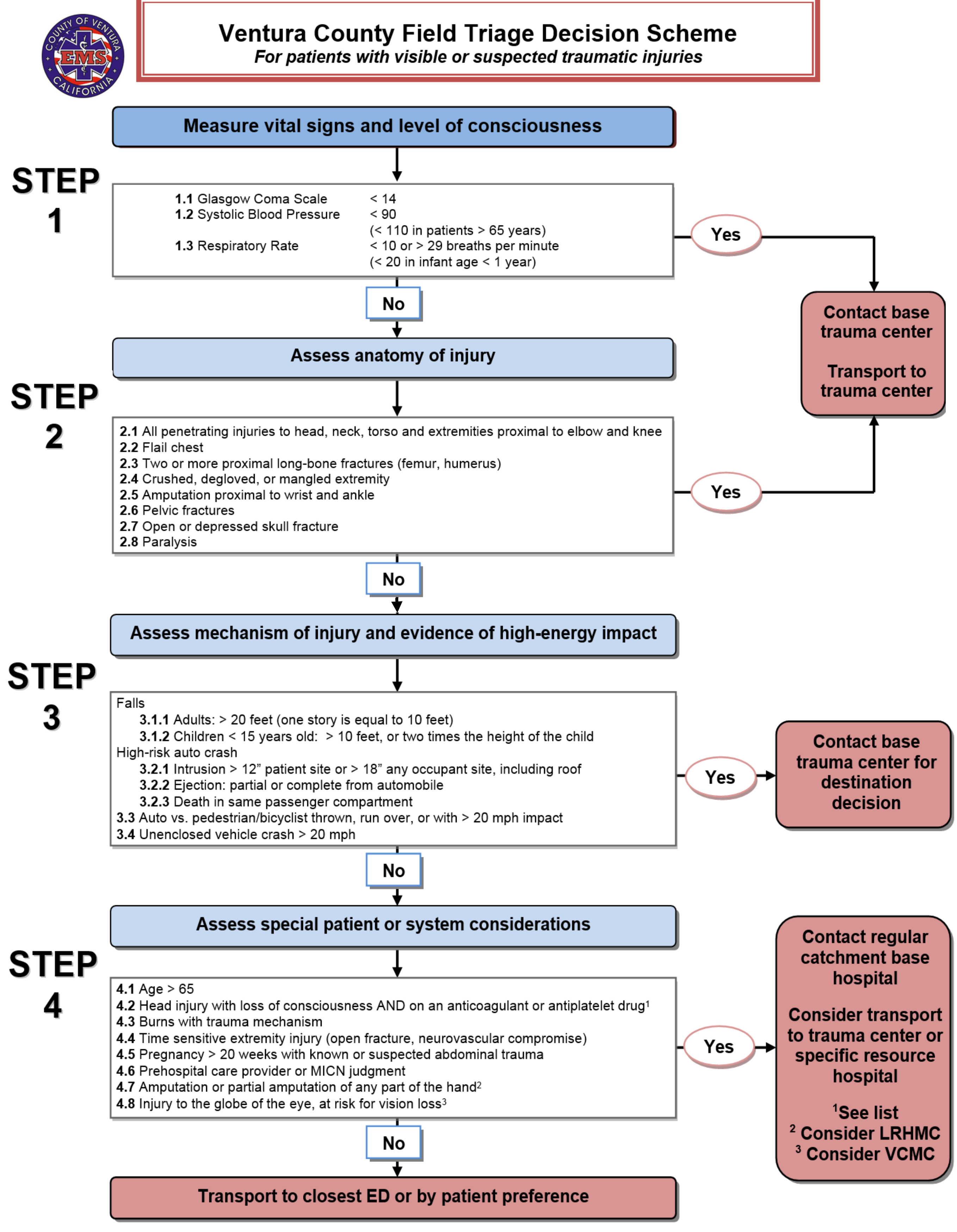
F. A trauma patient without an effective airway may be transported to the closest available hospital with an emergency department for airway management prior to transfer to a designated trauma center. In this rare event, the paramedic will contact the base hospital in whose catchment area the incident occurred.

G. A patient who does not meet trauma triage criteria and who, in the judgment of a base hospital, has a high probability of requiring immediate surgical intervention or other services of a designated trauma center shall be directed to a designated trauma center.

[1]For a complete list of anticoagulant and antiplatelet drugs that should be considered for inclusion criteria in Step 4.2, please consult VC EMSA approved list.

[2]For patients with isolated traumatic amputations, partial or complete, of any portion of the hand (at or proximal to the DIP joint of any finger or any part of the thumb), as long as bleeding is controlled and the amputated part may be transported with the patient, the regular catchment base hospital MICN may contact Los Robles Hospital and Medical Center (LRHMC) to determine the availability of a hand surgeon trained in microvascular replantation surgery. If a specialty hand surgeon is available at LRHMC and not at the regular catchment hospital, the MICN shall direct the patient to LRHMC.

[3]For patients with isolated blunt or penetrating injury to the globe of the eye, at risk for vision loss, the regular catchment base hospital MICN may direct the patient to Ventura County Medical Center (VCMC) for specialized ophthalmologic care and possible surgical intervention.


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
No
Contact base trauma center
Transport to trauma center
Assess anatomy of injury
STEP 2
2.1 All penetrating injuries to head, neck, torso and extremities proximal to elbow and knee
2.2 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
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 an anticoagulant or antiplatelet drug[1]
4.3 Burns with trauma mechanism
4.4 Time sensitive extremity injury (open fracture, neurovascular compromise)
4.5 Pregnancy > 20 weeks with known or suspected abdominal trauma
4.6 Prehospital care provider or MICN judgment
4.7 Amputation or partial amputation of any part of the hand[2]
4.8 Injury to the globe of the eye, at risk for vision loss[3]
Yes
Contact regular catchment base hospital
Consider transport to trauma center or specific resource hospital
[1]See list
[2] Consider LRHMC
[3] Consider VCMC
No
Transport to closest ED or by patient preference
Version 4 Revised 3-3-2015

COUNTY OF VENTURA HEALTH CARE AGENCY	POLICIES AND PROCEDURES EMERGENCY MEDICAL SERVICES
Policy Title: Ventura County Emergency Departments	Policy Number: 400
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: December 1, 2008
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: December 1, 2008
Origination Date: October, 1984 Date Revised: August 10, 2006 Date Last Reviewed: August 11, 2011 Next Review Date: October 31, 2014	Effective Date: December 1, 2008

Base Hospitals

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

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

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

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

Receiving Hospitals

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

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

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

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

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

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

III. PROCEDURE:

A. Request for ALS SP Program Approval

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

B. Program Approval or Disapproval:

Program approval or disapproval shall be made in writing by VC EMS to the agency requesting ALS SP designation within a reasonable period of time after receipt of the request for approval and all required documentation. This time period shall not exceed three (3) months.

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

C. Initial Program Evaluation

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

D. Program Review

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

E. ALS SP Program Changes

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

F. Withdrawal, Suspension or Revocation of Program Approval

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

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

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

ADVANCED LIFE SUPPORT SERVICE PROVIDER APPROVAL PROCESS
CRITERIA COMPLIANCE STATEMENT

APPLICANT:	DATE:

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

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

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

Signature: ______________________________

Title: ______________________________

Date: ______________________________

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Documentation of Prehospital Care</td><td>Policy Number
1000</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven Carroll, Paramedic</td><td>Date: June 1, 2012</td></tr>
<tr><td>APPROVED:
Medical Director</td><td>Angelo Salvucci, M.D.</td><td>Date: June 1, 2012</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>June 15, 1998
August 9, 2012
August 9, 2012
September 4, 2014</td><td>Effective Date: September 4, 2012</td></tr>
</table>

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

II. AUTHORITY: Title 22 Section 100147.

III. POLICY: Patient care provided by first responders and ambulance personnel will be documented using the appropriate method.

IV. PROCEDURE:

A. Provision of Access

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

B. Documentation

1. The VCEMS VCePCR will be used to document the care provided by pre-hospital personnel for every patient contact and/or incident to which a particular unit or provider is attached. An incident will be defined as any response involving Ventura County pre-hospital personnel to any event in which there is an actual victim, or the potential for a victim, regardless of whether the responding unit was cancelled enroute or not. A patient contact is defined as any encounter involving Ventura County pre-hospital personnel with any person consenting, either implied or informed, to assessment and/or treatment. Documentation shall be completed on any

person with obvious injury or significant mechanism regardless of consent. The following are exceptions:

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

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

c. The appropriate level VCePCR shall be completed to correspond to the level of care provided to the patient. If an ALS provider determines a patient to only require basic level care, a VCePCR-BLS report can be utilized. If a unit or provider is attached to an incident, but cancelled enroute, a VCePCR-Cancelled Call form shall be completed and posted.

d. A minimum validation score of 95 shall be required for all VCePCRs prior to completion and locking of the document.

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

f. In the event of multiple patients, documentation will be accomplished as follows:

    1) Level 1 MCI: The care of each patient shall be documented using an VCePCR.

    2) Level 2 and 3 MCI: Each patient transported to a hospital shall have their care documented on a Ventura County Multi-Casualty Patient Record.

        a) The transporting agency is responsible for completion of the multi-casualty patient record. The record is designed to be completed by the transporting crew enroute to the receiving hospital.

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

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

C. Transfer of Care

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

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

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

D. In the event the cardiac monitor is attached as required by any of the VCEMS 705 policies, a complete ECG data transfer shall be recorded and attached to the corresponding VCePCR. ECG data shall be downloaded by each provider agency involved in that incident and attached to the corresponding VCePCR. An original 12 lead ECG shall be printed and submitted upon transfer of care to hospital staff for any patient where a 12 lead ECG was performed.

E. Submission to VCEMS

1. In the following circumstances, a complete VCePCR shall be completed and posted by any transporting unit, and by FR ALS personnel retaining care, within thirty (30) minutes of arrival at destination:
   a. Any patient that falls into Step 1 or Step 2 (1.1 – 2.8) of the Ventura County Field Triage Decision Scheme
   b. Any patient that is in cardiac arrest, or had a cardiac arrest with ROSC.
   c. Any patient with a STEMI positive 12 lead ECG.
   d. Any patient with a positive Cincinnati Stroke Screening (CSS +).
   e. Any patient that is unable to effectively communicate information regarding present or past medical history.
   f. An exception to this circumstance would be during times of EMS system overload where a delay in a unit returning to service could pose significant delays in response times.
2. For circumstances not listed above, in which the patient was transported to a hospital, the entire data set found on the VCePCR ‘REPORT’ tab shall be completed and electronically posted to the server by transporting agencies, and by FR ALS personnel retaining care, within thirty (30) minutes of arrival at destination.
   a. An exception to this circumstance would be during times of EMS system overload where a delay in a unit returning to service could pose significant delays in response times.
3. All other reports not falling into the above criteria shall be completed and posted to the server as soon as possible and no later than the end of shift.

F. Dry Run/Against Medical Advice

Every patient contact resulting in refusal of medical attention/transport must be documented with the following information, the reason dispatched and/or chief complaint, assessment and vital signs, base

hospital contact (when appropriate), patient advised to seek medical attention and completion of AMA. The AMA checklist as well as patient signatures shall be captured whenever possible by each applicable agency at the time of patient contact/refusal. If, at any point, a signature is not obtained for any reason, explanation shall be documented in the narrative section of the VCePCR.

G. ALS Inter-facility Transfers (Acute Care Facility to Acute Care Facility)
Documentation shall be completed on all ALS Interfacility transfers only. Documentation will include, but not be limited to, baseline assessment, medications administered, reason for transfer, procedures done to the patient, vital signs and any changes from baseline assessment.
If the transferring facility sends staff to accompany the patient, the staff member(s) name(s) shall be documented on the VCePCR.

H. The completion of any VCePCR should not delay patient transport to the hospital.

I. Patient Medical Record
The VCePCR and Ventura County Multi-Casualty Patient Record shall be considered a legal document and part of the patient's medical record. The first responder agency, transport agency, and hospital are custodians of record. Printing should only be performed as needed, and an electronic copy of the VCePCR should be utilized and referred to whenever feasible. A print log and reason for printing shall be monitored regularly to help ensure security of protected health information within the system.

Attachment A

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

Term	Abbreviation
5% Dextrose in Water	D5W
Abdomen	Abd
Above knee amputation	AKA
Acquired Immunodeficiency Syndrome	AIDS
Ad Libitum (as desired)	Ad lib
Advanced Life Support	ALS
Against medical advise	AMA
Alcohol	ETOH
Alert and oriented	A & O
Also known as	AKA
Altered Level Of Consciousness	ALOC
Amount	Amt
Ampule	Amp
Antecubital	AC
Anterior	Ant
Anterior/Posterior	AP
Appointment	Appt
Arterial Blood Gas	ABG
Arteriosclerotic Heart Disease	ASHD
As necessary	prn
As soon as possible	ASAP
Aspirin	ASA
At	@
Atrial Fibrillation	A fib, AF
Attention Deficit Hyperactivity Disorder	ADHD
Automated external Defibrillator	AED
Automatic Implantable Cardiac Defibrillator	AICD
Bag Valve Mask	BVM
Basic Life Support	BLS
Birth Control Pill	bcp
Bowel Movement	BM
Bundle Branch Block	BBB
By Mouth	p.o.
By Order Of	per
Cancer	CA
Carbon Dioxide	CO_2
Carbon Monoxide	CO
Cardio Pulmonary Resuscitation	CPR

Term	Abbreviation
Central Nervous System	CNS
Cerebrospinal Fluid	CSF
Cerebrovascular Accident	CVA
Cervical Spine	C-Spine
Chief Complaint	CC
Chronic Obstructive Pulmonary Disease	COPD
Circulation, Sensation, Motor	CSM
Clear	Cl
Continuous Positive Airway Pressure	CPAP
Coronary Artery Bypass Graft	CABG
Coronary Artery Disease	CAD
Date of Birth	DOB
Dead on Arrival	DOA
Defibrillated	Defib
Delirium Tremens	DTs
Diabetes Mellitus	DM
Dilation and curettage	D & C
Discontinue*	D/C*
Deformity, Contusion, Abrasion, Penetration, Burn, Tenderness, Laceration, Swelling	DCAPBTLS
Do Not Resuscitate	DNR
Doctor of Osteopathy	DO
Drops	gtts
Dyspnea On Exertion	DOE
Electrocardiogram	ECG
Electroencephalogram	EEG
Emergency Department	ED
Emergency Medical Services	EMS
Emergency Medical Technician	EMT
Endotracheal	ET
Equal	=
Estimated	Est
Estimated Time of Arrival	ETA
Etiology	Etiol.
Every	q
Every day*	qd*
Evening	pm

Term	Abbreviation
Extended Care Facility	ECF
Eye, ear, nose, throat	EENT
Fahrenheit	F
Female	F
Fetal Heart Rate	FHR
Fluid	Fl
Foot	Ft
Foreign body	FB
Four times a day	QID
Fracture	Fx
Gallbladder	GB
Gastrointestinal	GI
Genitourinary	GU
Glasgow Coma Score	GCS
Grain	Gr
Gram	gm
Gravida 1,2,3, etc	G1, G2, G3
Gun Shot Wound	GSW
Gynecological	Gyn
Heart Rate	HR
Hematocrit	Hct
Hemoglobin	Hgb
Hepatitis A Virus	HAV
Hepatitis B Virus	HBV
Hepatitis C Virus	HCV
History	Hx
History and Physical	H & P
Hour of Sleep (bedtime)*	hs*
Human Immunodeficiency Virus	HIV
Hydrochlorothiazide	HCTZ
Hypertension	HTN
Immediately	STAT
Insulin Dependent Diabetes Mellitus	IDDM
Intake and Output	I & O
Intensive Care Unit	ICU
Intercostal Space	ICS
Intracranial Pressure	ICP
Intralingual	IL
Intramuscular	IM
Intraosseous	IO
Intrauterine Device	IUD
Intravenous	IV
Intravenous Push	IVP
Irregular	Irreg
Jugular venous distention	JVD
Kilogram	kg
Kilometer	Km
Labor and Delivery	L & D
Laceration	Lac
Last Menstrual Period	LMP
Lateral	Lat
Left	L
Left Eye*	OD*
Left Lower Extremity	LLE
Left Lower Lobe	LLL

Term	Abbreviation
Left Lower Quadrant	LLQ
Left Upper Extremity	LUE
Left Upper Lobe	LUL
Left Upper Quadrant	LUQ
Less Than	<
Lower Extremity	LE
Lumbar Puncture	LP
Male	M
Medical Doctor	MD
Metered Dose Inhaler	MDI
Microgram	mcg
Milliequivalent	mEq
Milligram	mg
Milliliter	ml
Millimeter	mm
Minute	Min
Morning	am
Morphine Sulphate*	MS*
Motor Vehicle Collision	MVC
Mouth	MO
Moves all Extremities	MAE
Multiple Casualty Incident	MCI
Multiple sclerosis	MS
Myocardial Infarction	MI
Nasal cannula	NC
Nausea/Vomiting	NV
Negative	neg
Night	Noc
Nitroglycerine	NTG
No Acute Distress	NAD
No Known Allergies	NKA
No Known Drug Allergies	NKDA
Non Insulin Dependent Diabetes Mellitus	NIDDM
Non Rebreather Mask	NRBM
Non Steroidal Anti-inflammatory Drugs	NSAID
Normal Saline	NS
Normal Sinus Rhythm	NSR
Not applicable	NA
Nothing by Mouth	NPO
Obstetrics	OB
Occupational Therapy	OT
Oral Dissolving Tablet	ODT
Operating Room	OR
Organic Brain Syndrome	OBS
Ounce	oz
Over the Counter	OTC
Overdose	OD
Oxygen	O2
Palpable	Palp
Para, number of pregnancies	Para 1,2,3, etc
Paramedic	PM
Paroxysmal Supraventricular Tachycardia	PSVT

Term	Abbreviation
Paroxysmal Nocturnal Dyspnea	PND
Past Medical History	PMH
Pediatric Advanced Life Support	PALS
Pelvic Inflammatory Disease	PID
Per Rectum	pr
Percutaneously Inserted Central Catheter	PICC
Phencyclidine	PCP
Physical Exam	PE
Positive	+, pos
Pound	lb
Pregnant	Preg
Premature Ventricular Contraction	PVC
Primary Care Physician	PCP
Private/Primary Medical Doctor	PMD
Privately Owned Vehicle	POV
Pro Re Nata – As Needed	PRN
Pulmonary Embolism	PE
Pulse, Motor, Sensation	PMS
Pulseless Electrical Activity	PEA
Pupils Equal Round and Reactive to Light	PERRL
Range of Motion	ROM
Registered Nurse	RN
Respiration	R
Respiratory Rate	RR
Respiratory Therapist	RT
Right	Rt
Right Eye*	OD*
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ
Right Middle Lobe	RML
Ringer's Lactate	RL
Rule Out	R/O
Sexually Transmitted Disease	STD

Term	Abbreviation
Shortness of Breath	SOB
Sinus Bradycardia	SB
Sinus Tachycardia	ST
Sodium Bicarbonate	NaHCO3
Sodium Chloride	NaCl
Streptococcus	Strep
Subcutaneous*	SQ*
Sublingual	SL
Sudden Acute Respiratory Syndrome	SARS
Sudden Infant Death Syndrome	SIDS
Supraventricular Tachycardia	SVT
Temperature	T
Temperature, Pulse, Respiration	TPR
Three Times a Day	TID
Times	X
To Keep Open	TKO
Tracheostomy	Trach
Traffic Collision	TC
Transient Ischemic Attack	TIA
Transcutaneous Pacing	TCP
Treatment	Tx
Tuberculosis	TB
Twice a day	BID
Upper Respiratory Infection	URI
Urinary Tract Infection	UTI
Ventricular Fibrillation	VF
Ventricular Tachycardia	VT
Vital Signs	VS
Volume	Vol
Water	H20
Weight	Wt
With	w/
Within Normal Limits	WNL
Without	w/o
Wolf-Parkinson-White	WPW
Year	Yr
Years Old	y/o

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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Air Unit Staffing Requirements		Policy Number: 1201
Approved Administration:	Steven L. Carroll, Paramedic	Date: December 1, 2011
Approved Medical Director:	Angelo Salvucci, MD	Date: December 1, 2011
Origination Date: Date Revised: Date Last Reviewed: Review Date:	May 30, 1988 November 10, 2011 November 10, 2011 November 30, 2014	Effective Date: December 1, 2011

I. PURPOSE: To provide guidelines for classification and staffing level for air unit(s) authorized or licensed to operate in Ventura County as a part of the Emergency Medical Services system.

II. AUTHORITY: Health and Safety Code: 1797.103, 1797.206, 1797.218, 1797.220, 1797.252, 1798.2 and 1798.102. CCR, Title XXII, Division 9, Chapter 8: Prehospital EMS Air Regulations.

III POLICY: Ventura County helicopters will be classified and staffed with medical personnel appropriate to the needs of the patient, according to this policy.

IV DEFINITIONS:

A. Air Ambulance Service: An air transportation service, which utilizes air ambulances.

B. EMS Aircraft Classifications:

1. Air Ambulance

Any aircraft specially constructed, modified or equipped, and used for the primary purposes of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum two attendants certified or licensed in advanced life support (ALS).

2. Rescue Aircraft

An aircraft whose usual function is not prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transport when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft and Auxiliary rescue aircraft.

1. “ALS Rescue Aircraft”: a rescue aircraft whose medical flight crew has at least one (1) attendant licensed and/or accredited to provide ALS.

2. “BLS Rescue Aircraft”: a rescue aircraft whose medical flight crew has at least one (1) attendant certified as an EMT

3. Auxiliary Aircraft:

Auxiliary Aircraft: a rescue aircraft which does not have a medical flight crew, or whose medical flight crew does not meet the minimum requirements established.

C. Medical Flight Crew: The individuals(s), excluding the pilot, specifically assigned to care for the patient during aircraft transport.

D. Classifying EMS Agency: The agency, which categorizes the EMS aircraft into the groups identified in Section 100300(c)(3) of Title 22, California Code of Regulations. This shall be the local EMS agency in the jurisdiction of origin except for aircraft operated by the California Highway Patrol, the California Department of Forestry or the California National Guard which shall be classified by the EMS Authority.

Note: Military Aircraft are not in the EMS Authority's purview.

E. Authorizing EMS Agency: The local EMS agency which approves utilization of specific EMS aircraft within its jurisdiction.

V. PROCEDURE

A. Aircraft Staffing Requirements

1. Air Ambulance: The medical flight crew has at a minimum two (2) attendants certified or licensed in advanced life support.
2. Advanced Life Support (ALS) Rescue: The medical flight crew has at a minimum one attendant certified or licensed in advanced life support.
3. Basic Life Support (BLS) Rescue Aircraft: The medical flight crew has at a minimum one attendant certified as an EMT-I with at least eight (8) hours of hospital clinical training and whose field/clinical experience specified in Section 100074 (c) of Title 22, California Code of Regulations, is in the air methods transport of patients.
4. Auxiliary Aircraft: An aircraft that does not have a medical flight crew.

B. Criteria for EMS Personnel to Staff Air Unit

1. Emergency Medical Technician-Paramedic (EMT-P)
   a. When staffing a SAR air unit based in Ventura County, a paramedic shall be:
      1) Accredited in Ventura County,
      2) Designated as a level II EMT-P, per VC EMS Policy 318
   b. When accompanying an RN on an air ambulance, a paramedic shall be accredited in Ventura County.
   c. An Paramedic who meets the requirements of IV.B.a.1-2 and is selected to staff an air unit may work with an EMT who meets the requirements for a SAR EMT. The names of all paramedics selected to work with SAR EMT will be submitted to VCEMS.
2. SAR Emergency Medical Technician I

a. While assigned to work with a paramedic on a Ventura County based air unit, a SAR EMT shall:
   1) Successfully complete the training module described in VCEMS Policy 306. The SAR EMT is not required to complete the arrhythmia/ defibrillation component of the module.
   2) Meet skill maintenance requirements.
   3) Perform duties as described below.
b. SAR EMT Duties and Responsibilities
   1) Those functions within the EMT Scope of Practice.
   2) May transmit information to a Base Hospital regarding paramedic activity and transport information, but may not ask for, receive, or pass on ALS orders.

3. Registered Nurses
   a. RN with a minimum of two (2) years experience in a critical care area within the previous three (3) years, prior to employment with the provider agency.
   b. Current BLS and ACLS certification from the American Heart Association.
   c. Minimum of 384 hours of critical care area (including time worked as a CCT RN) experience per year, unless employed full time as a critical care transfer nurse.
   d. Successful completion of an in-house orientation program sponsored by the provider agency.
   f. Endotracheal intubation training.
   h. Certification in any of the following: Certified Emergency Nurse (CEN); Critical Care Registered Nurse (CCRN); Mobile Intensive Care Nurse (MICN); Certified Nurse Anesthetist; Post Anesthesia Recovery Nurse (PAR); or Certified Flight Registered Nurse (CFRN) or challenge/pass Ventura County MICN test.

C. Initial Education for Medical Flight Crews
   1. All Medical Flight Crew personnel shall receive training in air methods transportation, including but not limited to the following:
      a. General patient care in-flight.
      b. Changes in barometric pressure, and pressure related maladies.
      c. Changes in partial pressure of oxygen.
      d. Other environmental factors affecting patient care.
      e. Aircraft operational systems.
      f. Aircraft emergencies and safety.

g. Care of patients requiring special consideration in the airborne environment.

h. EMS system and communications procedures.

i. The prehospital care system(s) within which they operate, including local medical and procedural protocols.

j. Use of onboard medical equipment.

2. Air Unit service providers will provide documentation of training to VC EMS.

D. Continuing Education Requirements

1. All medical flight crews shall participate in such continuing education requirements as required by their licensure or certification and as defined in VC EMS Policy 334.

a. All registered nurses, regardless of the certification which qualifies them to serve as flight nurses within Ventura County, must attend EMS updates twice yearly.

b. Flight Nurses who challenge and pass the MICN examination to comply with this policy must meet the continuing education requirements of thirty-six (36) hours per recert cycle, 50% of which, in each category, shall have been obtained at Ventura County Base Hospitals.

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

(2) Periodic training sessions (Lecture/Seminar): Twelve hours per two years.

(a) EMS Updates (Mandatory, two times per year)

(b) ACLS recertification – 2 hours credit

(c) Self-Study/Video CE

(3) Miscellaneous Education: Twelve hours per two years.

c. SAR EMT-I Requirements (In addition to EMT-I recertification requirements)

(1) Skills Update - 2 hours per certification period

(2) EMS Updates – Mandatory, two times per year

2. Air Unit service providers will provide documentation of continuing education to VC EMS.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Helicopter Dispatch for Emergency Medical Responses		Policy Number: 1202
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: December 1, 2011
APPROVED: Medical Director:	Angelo Salvucci, MD	Date: December 1, 2011
Origination Date: Date Revised: Date Last Reviewed: Next Review Date:	May 30, 1988 November 10, 2011 November 10, 2011 November 30, 2014	Effective Date: December 1, 2011

I. PURPOSE: To define dispatch procedures for helicopter emergency medical responses.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.220, and 1798. California Code of Regulations, Title 22, Division 9, Section 100276.

III. DEFINITIONS:

A. EMS Aircraft: any aircraft utilized for the purpose of pre-hospital emergency patient response and transport. This includes “Air Ambulances” and all categories of “Rescue Aircraft.”

B. Air Ambulance: Any aircraft specially constructed, modified or equipped, and used for the primary purposes of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum two attendants certified or licensed in advanced life support (ALS).

C. Rescue Aircraft: An aircraft whose usual function is not prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transport when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft and Auxiliary rescue aircraft.

1. ALS Rescue Aircraft: a rescue aircraft whose medical flight crew has at least one (1) attendant licensed and/or accredited to provide ALS.

2. BLS Rescue Aircraft: a rescue aircraft whose medical flight crew has at least one (1) attendant certified as an EMT

3. Auxiliary Aircraft: a rescue aircraft which does not have a medical flight crew, or whose medical flight crew does not meet the minimum requirements established.

D. Helicopter Dispatch Center: The helicopter dispatch center is the Ventura County Fire Protection District Fire Communications Center (FCC).

E. Automatic Response Area(s): Any remote area where the response time for ground ambulance personnel exceeds 25 minutes as determined by the FCC CAD system.

IV. POLICY: Helicopters will be dispatched when an incident is located in an Automatic Response Area or when requested by on-scene VCEMS personnel.

V. PROCEDURE

A. Helicopters, staffed and equipped according to VCEMS policies and procedures, will be dispatched by the designated dispatch center in the following manner:

1. All requests for and cancellations of EMS helicopters shall be made through FCC. The authority for requesting the dispatch of a helicopter for patient transport shall be vested with the on-scene public agency or Ventura County EMS personnel. This policy does not preclude the Ventura County Sheriff's Aviation Unit from responding to incidents requiring law enforcement response.
2. FCC will determine the appropriate aviation resources using information from on-scene public safety/EMS personnel or from the reporting party if the patient is located in an Automatic Response Area.
3. No EMS helicopter shall respond to an incident without the request of or notifying of FCC. All responding public safety/EMS personnel shall be notified of the dispatch of a helicopter
4. An air ambulance will be dispatched to incidents when a suitable landing site is available and the victim is accessible from the landing site. If the designated air ambulance is unavailable, the Ventura County Sheriff’s Department Search and Rescue (VCSD SAR) helicopter will be dispatched.
5. The VCSD SAR helicopter will be dispatched to incidents that describe the need for the specialized skills and capabilities of a rescue aircraft. If the VCSD SAR helicopter is unavailable, mutual aid resources will be contacted. Incidents that require a rescue helicopter involve the need for:

a. Hoist operations: use of a mechanical device (“hoist”; attached to the helicopter) to lift a patient from a location inaccessible to ground personnel, and transfer him/her into the cabin of the helicopter.

b. Short haul operations: use of a long line (attached to the helicopter) to lift a patient from a location inaccessible to ground personnel, and transport him/her to a location on the ground a short distance away where care may be provided.

c. The need for search capabilities, including the utilization of Night Vision Goggles (NVG).

B. Helicopter transportation should be considered for all cases that meet criteria per VCEMS Policy 1203 (Criteria For Patient Emergency Transport by Helicopter)

1. Helicopter transportation will not be used for diversion purposes unless the closest hospital is on internal disaster.

C. A helicopter response may be terminated:

1. By FCC if on-scene VCEMS personnel determine that the helicopter is not needed.

2. If the helicopter pilot and/or flight crew determine the call should be terminated for safety considerations.