Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	April 14, 2016 9:30 a.m.

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	A. Humeral IO	Greg Jelin/Adriane Stefansen
V.	**New Business**	
	A. Transport of Psychiatric Patients to Hillmont	Adriane Stefansen
	B. Defensive Training for EMS/Fire and Healthcare	Chris Rosa
VI.	**Old Business**	
	A. Bariatric Patients	Karen Beatty
	B. CAM Policy	Dr. Salvucci
VII.	**Informational/Discussion Topics**	
	A. Stroke Interfacility Transfers	Karen Beatty/Dr. Salvucci
	B. CPAP (ref: 705.21, 705.22, 723)	Mark Komins
	C. air Q Tube Holders and refresher training	Dr. Salvucci
	D. Strangulation Assessment Card Presentation	Dr. Romero
VIII.	**Policies for Review**	
	A. 605 – Interfacility Transfer of Patients	
	B. 613 – Do Not Resuscitate (DNR)	
	C. 1203 – Criteria for Patient Emergency Transport	
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**	

Topic	Discussion	Action	Assigned
II. Approve Agenda		Approved	Approved by Chad Panke Seconded by Tom O'Connor
III. Minutes		Approved	Approved by Scott Zeller Seconded by Betsy Paterson
IV. Medical Issues	Dr. Salvucci sent out information to all PSC committee members regarding the use of Morphine. He found out that MS is fine to use for IV and IM. Off label use of medications is a common and acceptable practice.	Dr. Salvucci will send out a letter to all providers stating that it is OK to use the IV MS for IM.	
V. New Business			
A. 705.08 – Cardiac Arrest VF/VT	After a brief discussion, the committee requested one change and approved the policy.	Under "Additional Information", line 2, add "sustained/recurrent". Approved with change	Approved by Jeff Winter Seconded by Ira Tilles
B. 720 – Guidelines for Limited Base Contact	Chad Panke requested that **Ondansetron** be added to this policy. These meds are commonly given together for pain/nausea.	Approved with the addition of Ondansetron. Page 1-B/#7 add "and Ondansetron" after Morphine.	Approved by Debbie Licht Seconded by Tom O'Connor
C. 710 – Airway Management	Dr. Salvucci stated that all ITD's (Impedance Threshold Device) will be pulled from the field countywide by June 1, 2016.		
D. 726 – 12 Lead ECG	After a brief discussion on ECG quality, the committee approved the policy with minor changes.	Page 2-IV/D, #1 Add "**immediately along with the rate on ECG**" following "report that to the MICN". Remove "at the beginning of the report".	Approved by Kathy McShea Seconded by Betsy Paterson
VI Old Business			
A. 1130 – Continuing Education Provider Approval	The committee suggested that we change all the specific years mentioned in regard to AHA Guidelines to "Current Guidelines".	Change page 1-IV, #3, page 2-IV, #1-c and page 5, #1 to "Current" and remove 2010.	Approved by Jeff Winter Seconded by Chad Panke

		Page 2-IV/#1-a.: add "1C".	
VII. Informational/Discussion Topics			
A. EMTs- Narcan, Glucose and Epi-pen	The committee discussed the potential benefit of having fire EMTs carry Narcan and Epi-pens. Dr. Salvucci requested that someone research this topic and see if there have been calls in Ventura County where patient outcome may have improved by giving Narcan or Epi prior to ALS arriving.	Mark Komins said that he would investigate this issue and report back to the committee.	
B. Bariatric Patients	Karen Beatty asked the committee if Bariatric patients are an issue for transport and/or CT Scans. The ambulance providers have a few ambulances that can accommodate larger patients. Los Robles has a CT scanner that can handle patients that are 500 pounds and above.	Karen will request Bariatric policies from other EMS Agencies and present to the committee. Should Ventura County have a Bariatric policy? Is it necessary? Bring back to next PSC.	
C. 430 – Stemi Receiving Centers (SRC) Standards	Approved through Stemi Committee. FYI Only.		
D. CPAP	The committee discussed the use of CPAP for BLS personnel. Many members felt that it should be optional and have a fixed setting. Dr. Larsen is a little concerned. Steve Frank questioned the need for this countywide.	Chris Rosa will check Image Trend **to** see if CPAP would have made a difference in patient outcome on any call where BLS arrived to the scene first. Table until next PSC.	
E. Impedance Threshold Device (ITD) Removal	Dr. Salvucci stated that all ITDs should be off the field units by June 1, 2016.		
F. Epinephrine Shortage	Dr. Salvucci told the committee that there is only a shortage of the pre-loaded syringes. The vials of epi are widely available.	Use vials.	
G. Age Specific Treatments	Dr. Salvucci distributed information on age related treatments. After a brief discussion, this item was tabled until a future meeting.	Bring back to PSC in the future.	
VIII. Policies for Review	None		

XI	**TAG Report**	No Tag Meeting	
X.	**Agency Reports**		
	A. Fire departments	**VCFPD** – Chief Zeller told the committee that engine 21 has been converted to ALS. **VCFD** – none **OFD** – The EMS Coordinators position is open. **Fed. Fire** – none **SPFD** – none **FFD-** Bob Scott thanked everyone involved with Chief Landeros funeral. They have a new Rescue Squad in the field today. They have also hired 5 firefighters and 6 paramedics.	
	B. Transport Providers	**LMT** – Jeff stated that they are adding new ambulances to their fleet. **AMR/GCA** – Mike Taigman is taking a new job at First Watch. Good Luck Mike!! Chad Panke will be the new General Manager and Mike Sanders will be the Operations Manager.	
	C. Base Hospitals	**SVH** – The new E.R. is open next week. **LRRMC** – Debbie thanked the EMS agency for sending the Medical Reserve Corp. to assist with the high school CPR training. The program continues to grow and they are adding more schools. The ELVO Project is seeing good outcomes. **SJRMC** – Kathy reminded everyone that the MICN class starts next week at Ventura College, across from the paramedic class. **VCMC** – February 16th, elevators should be working to the roof. Helicopters can start landing on the hospital roof again.	
	D. Receiving Hospitals	**PVH** – Still having parking issues. **SPH** – none **CMH** – none **OVCH** – none	
	E. Law Enforcement	**VCSO** – The Air Unit has 4 Rescue Platform Helicopters. Copter 7 does not have a satellite phone. They would have to work under the Communication Failure Policy. **CSUCI PD** – none	
	F. ALS Education Programs	**Ventura College** – Looking for internship placements. There is a 4 hour re-training course on line for preceptors.	
	G. EMS Agency	**Dr. Salvucci** – New air-Q holding device will be here shortly. Katy has a friend that will allow paramedics to practice air-Q's at his Surgi-Center. **Steve** – none **Chris** – July 1st is the "go live" date for the new MCI policy and equipment to be in place. There will be more information on this in the next few weeks.	

	Katy – There is grant money available for State Trauma Programs. There will be a state trauma system survey out in March. **Julie** – none **Randy** – World CPR Day is on June 2, 2016. Any suggestions? **Karen** – none	
H. Other		
XI. Closing	**Meeting adjourned at 1130**	

Prehospital Services Committee 2016

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/14/2016	2/11/2016	3/10/2016	4/14/2016	5/12/2016	6/9/2016	7/14/2016	8/11/2016	9/8/2016	10/13/2016	11/10/2016	12/8/2016	%
AMR	Stefansen	Adriane													
AMR	Carmona	Yoni		YC											
CMH - ER	Canby	Neil		NC											
CMH - ER	Querol	Amy		AQ											
OVCH - ER	Pulido	Ed		ED											
OVCH - ER	Patterson	Betsy		BP											
CSUCI PD	Drehsen	Charles		CD											
CSUCI PD	DeBoni	Curtis		CD											
FFD	Herrera	Bill													
FFD	Scott	Bob		BS											
GCA	Panke	Chad		CP											
GCA	Reed	Jeff													
Lifeline	Rosolek	James		JR											
Lifeline	Winter	Jeff		JW											
LRRMC - ER	Beatty	Matt		MB											
LRRMC - ER	Licht	Debbie		DL											
OFD	Schroepfer	Kevin		AH											
OFD	Martin	Blair		BM											
SJPVH - ER	Hall	Elaina		EH											
SJPVH - ER	Doane	Brian		BD											
SJRMC - ER	Larsen	Todd		TL											
SJRMC - ER	McShea	Kathy		KM											
SPFD	Lazenby	Dustin													
SVH - ER	Tilles	Ira		IT											
SVH - ER	Hoffman	Jennie		JH											
V/College	O'Connor	Tom													
VCFD	Tapking	Aaron		AT											
VCFD	Ellis	Heather		HE											
VNC	Zeller	Scott		SZ											
VNC	Dullam	Joe		JD											
VNC - Dispatch	Gregson	Erica		EG											
VCMC - ER	Roslansky	Stephen		SR											

Agency	LastName	FirstName	1/14/2016	2/11/2016	3/10/2016	4/14/2016	5/12/2016	6/9/2016	7/14/2016	8/11/2016	9/8/2016	10/13/2016	11/10/2016	12/8/2016	%
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	Santillo	Dave													
VFF	Pena	Greg													
Eligible to Vote	Date Change/cancelled - not counted against member for attendance														
Non Voting Members															
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	Hansen	Erik													
EMS	Beatty	Karen		KB											
LMT	Frank	Steve		SF											
VCMC	Duncan	Thomas		TD											
VNC	Shedlosky	Robin		RS											
VNC	Komins	Mark		MK											

TEMPORARY
PARKING PASS
Expires April 14, 2016

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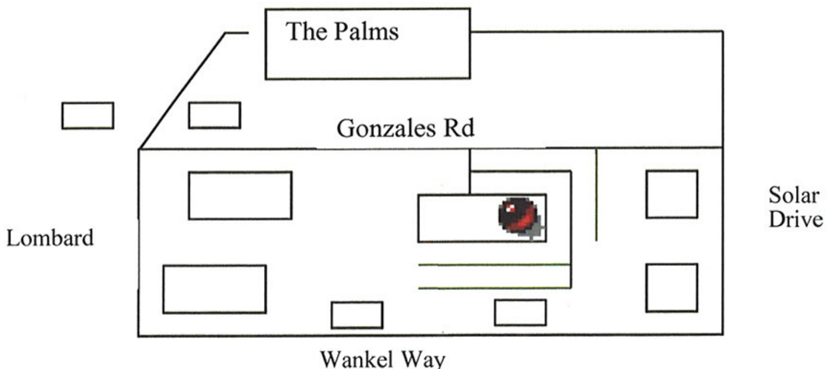
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

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.



BARIATRIC PATIENT TRANSPORTS PROCEDURE

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

To be used when the weight of the patient exceeds the weight limitations of the ambulance equipment.

CRITICAL INFORMATION

- The emergent need to transport a patient shall supersede the application of this policy.
- At all times, the dignity of the patient will be preserved and considered a high priority for all personnel.
- Ambulance cots shall be clearly labeled with weight capacity information.
- Additional personnel shall be utilized when moving bariatric patients to prevent injury to rescue personnel and the patient.
- The additional time to move the patient shall be considered when evaluating the decision to wait for a bariatric transport unit.

EQUIPMENT

- Bariatric Ambulance

PROCEDURE

- When ambulance crews are faced with a patient that exceeds the weight limitations of the standard ambulance equipment, personnel shall request a 'bariatric ambulance' from their dispatcher. Crews will provide the estimated weight of the patient.
- The dispatcher shall contact the local private ambulance providers to determine if they have a bariatric unit available. The private ambulance provider will provide an ETA to the incident scene.
- Dispatchers will relay this information to the personnel at the incident who will then confirm their need for the specialized equipment.
- If the patient's condition is such that a delay in transport (caused by the use of a bariatric equipped ambulance) will potentially cause additional harm to the patient, ambulance personnel should consider transporting the patient on the floor of the standard ambulance. In those cases, floor and wall cot hardware shall be removed (if possible) so as not to compromise patient safety.
- Bariatric patients shall only be transported in an ambulance.
- As early as possible, field personnel will relay to the destination hospital that they are inbound with a bariatric patient. The communication will include the approximate weight of the patient.
- Field personnel shall notify their agency CQI coordinator and immediate supervisor of any incident involving the management and transport of a bariatric patient. Management personnel will review all cases for appropriate care.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4072
Effective Date: 10/1/11
Review Date: 1/1/14
Supersedes: New

BARIATRIC PATIENT TRANSPORTS

I. PURPOSE

A. To establish standards for the transport of bariatric patients that assures their comfort, safety and dignity.

B. To authorize the temporary use of non-permitted bariatric ambulances to operate in the San Francisco EMS system for the transport of bariatric patients.

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.222, 1798.170, and 1798.172

B. California Code of Regulations, Title 22, Sections 100063, 100145, 100147, 100172, 100175, and 100266

III. DEFINITIONS

A. Bariatric Patient: A patient weighing > 350 pounds and/or has a body habitus that exceeds the capacity standards for a normal ambulance gurney in either height, width or both.

B. Bariatric Ambulance: Specially equipped ambulances specifically designed for the transport of bariatric patients.

IV. POLICY

A. Bariatric ambulances not permitted by the City and County of San Francisco, which are operated by a company possessing an ALS or BLS permit from the San Francisco EMS Agency, are authorized to temporarily operate within the San Francisco EMS system for the purposes of transporting bariatric patients when it is determined by either an ambulance provider, hospital or other health institution provider to be in the best interest of patient safety.

B. zNon-San Francisco permitted bariatric ambulances must be permitted by the California Highway Patrol, and if applicable, by the local EMS agency from which the ambulance originates.

C. Ambulance personnel must be knowledgeable about the extrication and transport needs for bariatric patients that assures for their comfort, safety and dignity.

D. Bariatric patients meeting the critical patient triage criteria as defined in Policies 5000 Destination or 5001 Critical Trauma Criteria should be transported to an appropriate receiving hospital as rapidly as possible whether or not a bariatric ambulance is available. Ambulance crews may request assistance from SFFD.

E. Medically stable bariatric patients may be held at the scene until a bariatric transport ambulance becomes available. Required transport times from the scene to a hospital as identified in EMS Agency Policy 4000 Pre-hospital Provider Standards are waived as long as the bariatric patient remains medically stable. At no time should the patient be unattended by medical personnel. If necessary, additional staff should be arranged to attend to the patient. At a minimum, this shall be an EMT with a defibrillator and an 800 MHz radio.

IV. PROCEDURES

A. Any field crew may request a bariatric ambulance through the Division of Emergency Communications (DEC). DEC will contact the private ambulance providers for an available bariatric ambulance.

B. If necessary during 9-1-1 calls, the transporting unit may request additional assistance from the SFFD in order to safely extricate and load a patient.

C. Private ambulance company crews for inter-facility transports will request a bariatric-equipped ambulance through their respective dispatch centers. Proper equipment and the proper number of personnel necessary to handle the patient safely must be assured. If an extraordinary situation arises with little or no advance notice, and with the approval of a Paramedic Captain, the SFFD may be asked to assist.

V. QUALITY IMPROVEMENT

A. Ambulance provider companies shall report scene transports of bariatric patients to the EMS Agency within 24 hours by completing and submitting a "Confidential Exception Report Form." This includes transports without a bariatric-equipped ambulance for critical calls by either the SFFD or a private provider. The EMS Agency shall cumulate and analyze this data annually.

B. Continuing education of all EMS personnel shall address new findings on providing emergency medical care to the bariatric patient in both emergency and non-emergency situations.

San Joaquin County
Emergency Medical Services Agency

http://www.sjgov.org/ems

Mailing Address
PO Box 220
French Camp, CA 95231

Health Care Services Complex
Benton Hall
500 W. Hospital Rd.
French Camp, CA 95231

Phone Number
(209) 468-6818

Fax Number
(209) 468-6725

Policy Memorandum No. 2010-04

DATE: December 17, 2010

TO: Advance Life Support (ALS) Providers
Lifecom
San Joaquin County Base Hospital

FROM: Richard N. Buys, M.D., Medical Director
Dan Burch, EMS Administrator

SUBJ.: Bariatric Patient Transports

Recently several EMS providers have contacted the EMS Agency seeking advice on the care and transport of prehospital bariatric patients. This Policy Memorandum is intended to provide clarification and direction to prehospital care providers and personnel in treating and transporting bariatric patients until such time that appropriate policies or policy modifications are implemented.

A bariatric patient is any morbidly obese patient that cannot be safely transported using a standard ambulance cot due to the weight of the patient or the inability to properly secure the patient to the cot due to the patient's size. The Striker Pro XT ambulance cot has a maximum weight capacity of 700 lbs.

American Medical Response (AMR) San Joaquin Operations has one ambulance specially designed to provide safe, dignified transport of the bariatric or morbidly obese patient. AMR's bariatric ambulance has the capacity to accommodate a patient weighing up to 1,500 lbs, and is equipped with an extra wide gurney, a movable ramp, and bed winch.

Emergency ambulance personnel (AMR, Manteca, Escalon, and Ripon) should consider requesting, through Lifecom, the response of the AMR bariatric ambulance anytime they encounter a bariatric patient that cannot be safely transported using a standard ambulance cot due to the size or weight of the patient. If the AMR San Joaquin bariatric ambulance is unavailable, Lifecom may make a mutual aid request for a bariatric ambulance from AMR operations in Alameda County or Sacramento County.

If no bariatric ambulance is immediately available, consideration should be given to transporting the bariatric patient on the floor of a standard ambulance. In such instances, ambulance personnel shall ensure that all floor/wall mounts have been removed and all other patient safety risks have been mitigated prior to loading the patient into the ambulance. In no circumstance should a patient be transported by prehospital care personnel by any vehicle other than an ambulance.

For known bariatric patient responses Lifecom should dispatch the AMR bariatric ambulance to augment the response of the closest ALS ambulance.

In accordance with EMS Policy No. 5103 Determination of Death in the Field when presented with a bariatric patient in cardiac arrest, prehospital personnel should initiate appropriate treatment and remain on scene unless a life sustaining cardiac rhythm is reestablished.

Questions regarding EMS Policy Memo 2010-04 should be directed to Kevin O'Loughlin, Sr., MICP, EMS Specialist at (209) 468-6818 or by email at koloughlin@sjgov.org

Ventura County EMS DRAFT

Cardiac Arrest Management (CAM) Protocol

For patients who are in cardiac arrest and greater than 48 hours old.

*******PRIORITIES DURING RESUSCITATION*******

1: High Quality Continuous Chest Compressions with minimal interruptions
2: Low-volume interposed ventilations.
2: Early defibrillation
3: Switch Compressors every 2 Minutes

Rescuer 1

- Verify Cardiac Arrest (<10 seconds)
  (Assess responsiveness, Shake and Shout, Open airway with "Shark Hook" maneuver)

If not breathing:

- Move patient to place that will allow optimal CPR
- Immediately Start High Quality Continuous Compressions Over Shirt

Rescuer 2

- Turn on metronome (112/minute)*
- Remove clothing over chest.
- Apply AED or Cardiac monitor/Defibrillator pads onto the patient*

Basic Life Support (AED)	Advanced Life Support (Manual Defib)
• Turn on AED • Attach Pads to patient's chest • Press Analyze (Do not touch patient)	• Turn on Cardiac Monitor • Attach Pads to patient's chest • Pre-charge monitor to appropriate Joules setting*

"Shock Advised"	"No Shock Advised"	VF/VT	Non-Shockable rhythm
Clear patient and press "Shock"		Clear patient and Deliver Shock	Disarm defibrillator pre-charge

RESUME CHEST COMPRESSIONS IMMEDIATELY!

Rescuer 3

- Insert OPA/NPA
- Assist ventilation with BVM along with 15L/min high flow O2
- Ensure proper seal with BVM mask to the patient with "2 Thumbs Up" technique (When extra manpower arrives, one rescuer shall be dedicated to provide a proper seal with two hands on the mask. Please refer to "Triangle Of Life" Chart
- Deliver 1 brief low-volume ventilation on the recoil phase of every 10th compression (Ventilation delivered with ONE HAND on bag to ensure low volume)
- Attach waveform capnography sensor, if equipped

When 4th Rescuer ALS arrives
• Attach waveform capnography sensor to BVM if not already completed by BLS • ALS: Establish IV/IO Access • Draw blood for PRESTO • Follow 705 ALS protocol for appropriate IV/IO Medication delivery • Advanced Airway PRN • Follow VC EMS Policy 705.07 Cardiac Arrest Asystole/PEA • Follow VC EMS Policy 705.08 Cardiac Arrest VF/VT

When 5th Rescuer ALS arrives
• Assist Rescuer 4 with IV/IO, PRESTO draw, medications • Gather patient information/medications • Communicate with family members if needed

- Pre-Charge monitor to appropriate Joules setting*
- Perform pulse/rhythm check every 2 min (< 3 seconds)
- Perform pulse/rhythm check if $EtCO_2$ > 20

VF/VT	Non-Shockable rhythm
Clear patient and Deliver Shock	Disarm defibrillator pre-charge

RESUME CHEST COMPRESSIONS IMMEDIATELY!

*Additional Information:

- All of the above procedures can be performed simultaneously if sufficient amount of resources are available and ONLY when PRIORITIES DURING RESUSCITATION is achieved.
- Chest compressions should achieve:
    - 2-2.4 inches in depth for an adult
    - 1/3 the anterior-posterior chest dimension in depth for a child or infant
    - Full chest recoil after each compression
- Biphasic recommended defibrillation settings from manufacturer or provider medical director
- If BLS resource was the first to arrive on scene and shock(s) has/have been delivered by an AED that BLS resource MUST advise the arriving ALS resource the number of AED shocks.
    - If 1 AED shock was delivered, ALS defibrillation at next sequential Joules setting
    - If 2 or more AED shocks delivered, ALS defibrillation at next sequential Joules setting
- Life Pak 12/15 must be in paddles mode for to capture compression data
- Please refer to "Triangle Of Life" Diagrams for team member duties and on scene placements
- Patients less than 48 hours old will follow VC EMS Neonatal resuscitation Policy

Shortness of Breath – Pulmonary Edema

BLS Procedures

Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Nitroglycerin

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

Initiate CPAP for moderate to severe distress

Perform 12-lead ECG

IV access

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

- **Albuterol**
    - Nebulizer – 5mg/6mL

Communication Failure Protocol

If patient becomes or presents with hypotension

- **Dopamine**
    - IVPB – 10 mcg/kg/min

Base Hospital Orders only

Consult with ED Physician for further treatment measures

VCEMS Medical Director

Shortness of Breath – Wheezes/Other

BLS Procedures

ADULT

Assist patient with prescribed Metered Dose Inhaler if available
Administer oxygen as indicated

PEDIATRIC

Assist patient with prescribed Metered Dose Inhaler if available
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

ADULT

Perform Needle Thoracostomy if indicated per Policy 715

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

Severe Distress
- Treatment for moderate distress
- Less than 40 years old
  - **Epinephrine 1:1,000**
    - IM – 0.3 mg

Consider CPAP for both moderate and severe distress

IV access

PEDIATRIC

Perform Needle Thoracostomy if indicated per Policy 715

Moderate Distress
- Less than 2 years old
  - **Albuterol**
    - Nebulizer – 2.5 mg/3 mL
      - Repeat as needed
- 2 years old and greater
  - **Albuterol**
    - Nebulizer – 5 mg/6 mL
      - Repeat as needed

Severe Distress
- Treatment for moderate distress
- **Epinephrine 1:1,000**
  - IM – 0.01 mg//kg
    - Max 0.3 mg

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

Consider CPAP if age 8 years old and greater

IV access

Communication Failure Protocol

ADULT

Severe Distress
- Less than 40 years old
  - If no change is apparent 10 minutes after first Epinephrine administration:
    - *Repeat* **Epinephrine 1:1,000**
      - IM – 0.3 mg
- 40 years old and greater
  - **Epinephrine 1:1,000**
    - IM – 0.3 mg
      - Only if apparent asthma
      - Only if age less than 60 years old
      - Only if no improvement with initial therapies

PEDIATRIC

Severe Distress
- If no change is apparent 10 minutes after first Epinephrine administration
  - *Repeat* **Epinephrine 1:1,000**
    - IM – 0.01 mg/kg
      - Max 0.3 mg

Base Hospital Orders only

ADULT

Consult with ED Physician for further treatment measures

PEDIATRIC

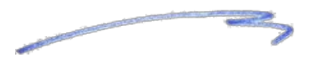
Suspected Croup and no improvement with Normal Saline nebulizer
- Less than 2 years old
  - **Epinephrine 1:1,000**
    - Nebulizer/Aerosolized Mask – 2.5 mL
- 2 years old and greater
  - **Epinephrine 1:1,000**
    - Nebulizer/Aerosolized Mask – 5 mL

Consult with ED Physician for further treatment measures

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

Effective Date: December 1, 2010
Next Review Date: Jan 31, 2017

Date Revised: August, 2010
Last Reviewed: Jan 8, 2015



VCEMS Medical Director

<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:
Continuous Positive Airway Pressure (CPAP)</td><td>Policy Number:
723</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, EMT-P</td><td>Date: December 1, 2011</td></tr>
<tr><td>APPROVED:
Medical Director</td><td>Angelo Salvucci, MD</td><td>Date: December 1, 2011</td></tr>
<tr><td>Origination Date:
Date Revised:
Last Reviewed:
Review Date:</td><td>December 2004
September 13, 2007
September 12, 2013
September, 2015</td><td>Effective Date: December 1, 2011</td></tr>
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I. PURPOSE: To define the indications, procedure and documentation for the use of Continuous Positive Airway Pressure (CPAP) by paramedics

II. AUTHORITY: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Division 9, Section 10063.

III. POLICY: Paramedics may utilize CPAP on patients in accordance with Ventura County Policy 705.

IV. PROCEDURE:

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

B. Indications: Patients age 8 and above with one or more of the following:

1. Congestive Heart Failure with acute pulmonary edema
2. Near drowning
3. Any cause of respiratory failure.

C. Contraindications:

1. Absolute
   a. Respiratory or cardiac arrest
   b. Agonal respirations
   c. Unconsciousness
   e. Pneumothorax
   f. Inability to maintain airway patency
   g. Head injury with increased ICP
2. Relative:
   a. Decreased LOC
   b. Unable to tolerate mask

c. Systolic blood pressure < 90

d. Vomiting

E. Patient Treatment

1. Place patient in a seated position with legs dependant
2. Monitor ECG, Vital signs, SpO2
3. Set up CPAP system
4. Explain procedure to patient.
5. Apply mask while reassuring patient.
6. Frequently reevaluate patient. Normally, the patient should improve in the first 5 minutes with CPAP, as evidenced by a decreased heart rate, respiratory rate and/or blood pressure and an increased SpO2. Should the patient become worse with CPAP, remove the CPAP device and assist ventilations with BVM as needed.

D. DOCUMENTATION

1. The use of CPAP must be documented.
2. Vital signs and SpO2 must be documented every 5 minutes.
3. Narrative documentation should include a description of the patient's response to CPAP.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Interfacility Transfer of Patients		Policy Number 605
APPROVED: Administration:	Steven L. Carroll	Date: December 1, 2011
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: December 1, 2011
Origination Date: July 26, 1991 Date Revised: April 13, 2006 Date Last Reviewed: August 11, 2011 Next Review Date: October 31, 2014		Effective Date: December 1, 2011

I. PURPOSE: To define levels of interfacility transfer and to assure that patients requiring interfacility transfer are accompanied by personnel capable and authorized to provide care.

II. AUTHORITY: Health and Safety Code, Sections 1797.218, 1797.220, and 1798.

III. POLICY: A patient shall be transferred according to his/her medical condition and accompanied by EMS personnel whose training meets the medical needs of the patient during interfacility transfer. The transferring physician shall be responsible for determining the medical need for transfer and for arranging the transfer. The patient shall not be transferred to another facility until the receiving hospital and physician consent to accept the patient. The transferring physician retains responsibility for the patient until care is assumed at the receiving hospital.

If a patient requires care during an interfacility transfer which is beyond the scope of practice of an EMT or paramedic or requires specialized equipment for which an EMT or paramedic is untrained or unauthorized to operate, and it is medically necessary to transfer the patient, a registered nurse or physician shall accompany the patient. If a registered nurse accompanies the patient, appropriate orders for care during the transfer shall be written by the transferring physician.

IV. TRANSFER RESPONSIBILITIES

A. All Hospitals shall:

1. Establish their own written transfer policy clearly defining administrative and professional responsibilities.
2. Have written transfer agreements with hospitals with specialty services, and county hospitals.

B. Transferring Hospital

1. Maintains responsibility for patient until patient care is assumed at receiving facility.

2. Assures that an appropriate vehicle, equipment and level of personnel is used in the transfer.

C. Transferring Physician

1. Maintains responsibility for patient until patient care is assumed at receiving facility.
2. Determines level of medical assistance to be provided for the patient during transfer.
3. Receives confirmation from the receiving physician and receiving hospital that appropriate diagnostic and/or treatment services are available to treat the patient's condition and that appropriate space, equipment and personnel are available prior to the transfer.

D. Receiving Physician

1. Makes suitable arrangements for the care of the patient at the receiving hospital.
2. Determines and confirms that appropriate diagnostic and/or treatment services are available to treat the patient's condition and that appropriate space, equipment and personnel are available prior to the transfer, in conjunction with the transferring physician.

E. Transportation Provider

1. The patient being transferred must be provided with appropriate medical care, including qualified personnel and appropriate equipment, throughout the transfer process. The personnel and equipment provided by the transporting agency shall comply with local EMS agency protocols.
2. Interfacility transport within the jurisdiction of VC EMS shall be performed by an ALS or BLS ambulance.
   a. BLS transfers shall be done in accordance with EMT Scope of Practice per Policy 300
   b. ALS transfers shall be done in accordance with Paramedic Scope of Practice per Policy 310

IV. PROCEDURE:

A. Non-Emergency Transfers

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

B. Emergency Transfers

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

C. Transferring process

1. The transferring physician will determine the patient's resource requirements and request an inter-facility ALS, or BLS transfer unit using the following guidelines:

Patient Condition/Treatment	EMT	Paramedic	RN/RT/MD
a. Vital signs stable	x		
b. Oxygen by mask or cannula	x		
c. Peripheral IV glucose or isotonic balanced salt solutions running	x		
d. Continuous respiratory assistance needed (paramedic scope management)		x	
e. Peripheral IV medications running or anticipated (paramedic scope)		x	
f. Paramedic level interventions		x	
g. Central IV line in place		x	
h. Respiratory assistance needed (outside paramedic scope of practice)			x
i. IV Medications (outside paramedic scope of practice)			x
j. PA line in place			x
k. Arterial line in place			x
l. Temporary pacemaker in place			x
m. ICP line in place			x
n. IABP in place			x
o. Chest tube		x	x
p. IV Pump		x	
q. Standing Orders Written by Transferring Facility MD			x
r. Medical interventions planned or anticipated (outside paramedic scope of practice)			x

2. The transferring hospital advises the provider of the following:
   a. Patient's name
   b. Diagnosis/level of acuity
   c. Destination
   d. Transfer date and time
   e. Unit/Department transferring the patient
   f. Special equipment with patient

g. Hospital personnel attending patient

h. Patient medications

3. The transferring physician and nurse will complete documentation of the medical record. All test results, X-ray, and other patient data, as well as all pertinent transfer forms, will be copied and sent with the patient at the time of transfer. If data are not available at the time of transfer, such data will be telephoned to the transfer liaison at the receiving facility and then sent by FAX or mail as soon thereafter as possible.

4. Upon departure, the Transferring Facility will call the Receiving Facility and confirm arrangements for receiving the patient and provide an estimated time of arrival (ETA).

5. The Transferring Facility will provide:

a. A verbal report appropriate for patient condition

b. Review of written orders, including DNAR status.

c. A completed transfer form from Transferring Facility.

V. DOCUMENTATION

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

I. PURPOSE: To establish criteria for a Do Not Resuscitate (DNR) Order, and to permit Emergency Medical Services personnel to withhold resuscitative measures from patients in accordance with their wishes.

II. AUTHORITY: California Health and Safety Code, Sections 1798 and 7186. California Probate Code, Division 4.7 (Health Care Decisions Law). California Code of Regulations, Title 22, Sections 70707(6), & 72527(a),(4).

III. DEFINITIONS:

A. "EMS Personnel": All EMTs, paramedics and RNs caring for prehospital or interfacility transfer patients as part of the Ventura County EMS system.

B. "Resuscitation": Medical interventions whose purpose is to restore cardiac or respiratory activity, and which are listed below:

1. External cardiac compression (chest compressions).
2. Defibrillation.*
3. Tracheal Intubation or other advanced airway.*
4. Assisted Ventilation for apneic patient.*
5. Administration of cardiotonic medications.*

C. "DNR Medallion": A permanently imprinted insignia, worn by a patient that has been manufactured and distributed by an organization approved by the California Emergency Medical Services Authority.

D. "DNR Order": An order to withhold resuscitation. A DNR Order shall be considered operative under any of the following circumstances. If there is a conflict between two DNR orders the one with the most recent date will be honored.

1. A fully executed original or photocopy of the "Emergency Medical Services Prehospital DNR Form" has been read and reviewed on scene;
2. The patient is wearing a DNR Medallion;

* - Defibrillation, advanced airway, assisted ventilation, and cardiotonic medications may be permitted in certain patients using a POLST form. Refer to VCEMS Policy 625.

3. A fully executed California Durable Power of Attorney For Health Care (DPAHC) form is seen, a health care agent designated therein is present, and that agent requests that resuscitation not be done;
4. A fully executed Natural Death Act Declaration has been read and reviewed on scene;
5. A fully executed California Advance Health Care Directive (AHCD) has been read and reviewed on scene and:
   a. a health care agent designated therein is present, and that agent requests that resuscitation not be done, or
   b. there are written instructions in the AHCD stating that the patient does not wish resuscitation to be attempted;
6. A completed and signed Physician Orders for Life-Sustaining Treatment (POLST) form has been read and reviewed on scene, and in Section A, “Do Not Attempt Resuscitation/DNR” is selected, or;
7. For patients who are in a licensed health care facility, or who are being transferred between licensed health care facilities, a written document in the patient’s permanent medical record containing the statement “Do Not Resuscitate”, No Code”, or No CPR,” has been seen. A witness from the health care facility must verbally document the authenticity of this document.

E. “California Advance Health Care Directive (AHCD)”. As defined in California Probate Code, Sections 4600-4805.

F. “California Durable Power of Attorney for Health Care (DPAHC)”: As defined in California Civil Code, Sections 2410-2444.

G. “Natural Death Act Declaration”: As defined in the Natural Death Act of California, Health and Safety Code, Sections 7185-7195.

H. “Physician Orders for Life-Sustaining Treatment (POLST)”. As defined in California Probate Code, Division 4.7 (Health Care Decisions Law).

IV. PROCEDURE:

A. All patients require an immediate medical evaluation.

B. Correct identification of the patient is crucial in this process. If not wearing a DNR Medallion, the patient must be positively identified as the person named in the

DNR Order. This will normally require either the presence of a witness or an identification band.

C. When a DNR Order is operative:

1. If the patient has no palpable pulse and is apneic, resuscitation shall be withheld or discontinued.
2. The patient is to receive full treatment other than resuscitation (e.g., for airway obstruction, pain, dyspnea, hemorrhage, etc.).
3. If the patient is taking high doses of opioid medication and has decreased respiratory drive, early base hospital contact should be made before administering naloxone. If base hospital contact cannot be made, naloxone should be administered sparingly, in doses no more than 0.1 mg every 2-3 minutes.

D. A DNR Order shall be considered null and void under any of the following circumstances:

1. The patient is conscious and states that he or she wishes resuscitation.
2. In unusual cases where the validity of the request has been questioned (e.g., a family member disputes the DNR, the identity of the patient is in question, etc.), EMS prehospital personnel may temporarily disregard the DNR request and institute resuscitative measures while consulting the BH for assistance. Discussion with the family member, with explanation, reassurance, and emotional support may clarify any questions leading to validity of a DNR form.
   The underlying principle is that the patient's wishes should be respected.
3. There is question as to the validity of the DNR Order.
   Should any of these circumstances occur, appropriate treatment should continue or immediately commence, including resuscitation if necessary. Base Hospital contact should be made when appropriate.

E. Other advanced directives, such as informal “living wills” or written instructions without an agent in the California Durable Power of Attorney for Health Care, may be encountered. Should any of these occur, appropriate treatment will continue or immediately commence, including resuscitation if necessary. Base Hospital contact will be made as soon as practical.

F In case of cardiac arrest, if a DNR Order is operative, Base Hospital contact is not required and resuscitation should not be done. Immediate base hospital contact is strongly encouraged should there be any questions regarding any aspect of the care of the patient.

G. If a DPAHC or AHCD agent requests that resuscitation not be done, the EMT shall inform the agent of the consequences of the request.

H. DNR in a Public Place

Persons in cardiac arrest with an operative DNR Order should not be transported. The Medical Examiner's office should be notified by law enforcement or EMS personnel. If possible, an EMS representative should remain on scene until a representative from law enforcement or the Medical Examiner's office arrives.

V. DOCUMENTATION:

For all cases in which a patient has been treated under a DNR Order, the following documentation is required in the AVCDS report:

A. Name of patient's physician signing the DNR Order.

B. Type of DNR Order (DNR Medallion, Prehospital DNR Form, POLST Form, written order in a licensed health care facility, DPAHC, Natural Death Act Declaration).

C. If the decision to withhold or terminate resuscitative measures was made by an EMT, his/her name and certificate number.

D. For all cases which occur within a licensed health care facility, in addition to above, if the DNR Order was established by a written order in the patient's medical record, the name of the physician signing and the witness to that order.

E. If resuscitation is not done because of the request of a healthcare agent designated in a DPACH or AHCD, the agent's name.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Criteria For Patient Emergency Transport by Helicopter		Policy Number 1203
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: December 1, 2011
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: December 1, 2011
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 31, 1994 November 10, 2011 November 10, 2011 December 31, 2014	Effective Date: December 1, 2011

I. PURPOSE: To define criteria for patient transport via helicopter

II. POLICY: Patients shall be transported to hospitals via ground ambulance unless such transport is unavailable or if ground transport is significantly longer than air transport (and this difference in time may negatively impact the patient's condition

III. PROCEDURE:

A. If a helicopter is being considered for patient transport, early recognition (including request for a helicopter while enroute to the call) will help decrease delay in patient transport

B. Helicopter transportation of patients should be considered for cases that meet **ALL** of the following criteria. Transport decisions will be determined jointly by the Base Hospital (BH), if BH contact is established, and on-scene personnel.

1. A minimum of 15 minutes ground travel time to the *appropriate* hospital,
2. The helicopter can deliver the patient to the hospital in a shorter time than the ground unit based on the time that the patient is ready for transport. This decision should be based on the following formula:

	___ minutes for ETA of the helicopter to the scene
+	___ minutes for air transport time to the hospital
+	10 minutes for loading/unloading/transfer of patient to ED
=	___ ETA to hospital for the helicopter

3. Any one or more of the following patient conditions:
   a. Medical-related complaints:
      1) Hypotension/shock (non-traumatic)
      2) Snake bite with signs of significant envenomation
      3) Unstable near drowning
      4) Status epilepticus refractory to medications
      5) Cardiovascular instability (chest pain with dysrhythmias or post-resuscitation)
      6) Critical burns or electrical burns
      7) Critical respiratory patients (use caution with altitude)
      8) SCUBA-related emergencies or barotrauma (use caution with altitude)
      9) Any other medical problems in areas inaccessible to, or with prolonged ETA times, for responding ground units
      10) Other conditions subject to the approval of the BH physician or the highest medical authority on-scene
   b. Traumatic injuries – Patients with traumatic injuries who are to be transported by helicopter shall be triaged prior to transport according to VCEMS Policy 1405 (Trauma Triage and Destination Criteria)
      1) Trauma Step 1-3 criteria:
         a) All trauma patients to be transported by helicopter that meet Step 1-3 criteria **SHALL** be transported to a designated trauma center
         b) Helicopter personnel may determine on a case-by-case basis which trauma center is the closest and most appropriate destination
         c) BH contact with the destination trauma center shall be initiated by the caregiver(s) staffing the helicopter and coordination with the ground units.
         d) On rare occasion, the most appropriate destination hospital may be outside the county. However, it is preferred that trauma patients involved in incidents

within Ventura County are transported to a designated Ventura County trauma center

2). Trauma Step 4 criteria:

a) An on-scene paramedic shall contact the base hospital in whose catchment area the incident occurred

b) A BH order is ***required*** for all patients meeting Step 4 criteria, unless the patient is located within an inaccessible area or if patient transport will be prolonged

c) 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

c. Mass Casualty Incidents (MCI) or multi-patient incidents

1) Helicopter transport may be utilized during MCI responses

2) Patient transport should be coordinated by the BH and on-scene personnel

3) Patients transported by helicopter should be taken to a farther facility, allowing for ground providers to transport patients to the closer facilities

C. Contraindications to transport

1. Patients contaminated with hazardous materials regardless of decontamination status.

2. Violent or potentially violent patients who have not been chemically restrained.

3. Stable patients (except in backcountry areas inaccessible to ground units or it patient transport will be prolonged)

4. When ground transport time is equal to or shorter than air transport time

D. Relative contraindications to transport

1. Asystole, not responding to appropriate therapy and not meeting any criteria of an exceptional situation (e.g., cold water drowning, lightning strike or electrocution)

2. Transports from heavily populated areas

3. Transports for which, prior to departing the scene, conditions exist such that helicopter arrival at the intended destination is uncertain
4. Other safety conditions as determined by pilot and/or flight crew

E. Information about the patient(s) condition, level of medical personnel staffing the helicopter, and ambulance staffing is reviewed by medical and public safety personnel.

F. BH contact should be attempted to establish standard medical control. If ALS personnel are unable to establish BH contact, Communication Failure Protocols should be followed per VCEMS Policy 705.

G. Provider agencies which utilize medical flight crew members who have an expanded scope of practice beyond the Paramedic scope of practice (MD or RN) may utilize specific treatments/procedures only upon prior written approval by the VCEMS Agency. In such cases, notification to the receiving hospital shall be made and BH medical direction is not required.

H. Staffing decision for transport will be determined jointly by the BH (if BH contact is established) and on-scene personnel
1. A minimum of a paramedic (Level II) must accompany the patient if ALS procedures are initiated and no physician is present.
    a. Exception - In a MCI situation, a patient who has had an IV started that does not contain any additives may be transported by an EMT.
2. Destination will be determined by the pilot and flight crew, taking into consideration the patient(s) condition, flight conditions, and any other factors necessary

I. Complications during patient transport via helicopter:
1. If a helicopter is transporting a patient to the hospital and is unable to complete the transport due to weather, mechanical/safety issues, or any other factor that was impossible to predict prior to the helicopter lifting from the scene, the helicopter will notify FCC as soon as possible to arrange an alternate LZ and for a ground ambulance to rendezvous with the helicopter
2. Medical personnel staffing the helicopter shall retain responsibility for patient care until transfer of care to ground ambulance personnel is accomplished. If the final destination for the helicopter was to be a

trauma center, ground personnel shall complete the transport to the designated trauma center within that catchment area.