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

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
V.	**New Business**	
	A. Do Not Resuscitate – End of Life Option Act	Dr. Salvucci
VI.	**Old Business**	
	A. 605 – Interfacility Transfer of Patients	Dr. Salvucci
VII.	**Informational/Discussion Topics**	
	A. Critical Incident Stress Management Coalition	Julie Frey
	B. Behavioral Health for Children	Chad Panke
	C. Simi Valley Hospital – STEMI Receiving Center Designation	Dr. Salvucci/Karen Beatty
	D. PRESTO Update	Dr. Salvucci
VIII.	**Policies for Review**	
	A. 131 – Multi Casualty Incident Response	
	B. 323 – Mobile Intensive Care Nurse Authorization Challenge	
	C. 332 – EMS Personnel Background Check Requirement	
	D. 1100 - Emergency Medical Technician Training Program Approval	
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	June 09, 2016 8:30 a.m.

	Topic	Discussion	Action	Assigned
II.	**Approve Agenda**		Approved	Approved by Debbie Licht Seconded by Tom O'Connor
III.	**Minutes**	Randy clarified that May 22 is AMR's CPR event. June 2nd is AHA CPR Day.	Approved	Approved by Kathy McShea Seconded by Chad Panke
IV.	**Medical Issues**			
	A. Humeral IO	Adrianne spoke about a case where the patient had 2 Fx. Legs, Full Arrest, and medics could not get an IV. It would have been very helpful to use a Humeral IO. Heather said that the system she came from used Humeral IO's and there were no problems with it. Dr. Salvucci asked Katy to see if this is an isolated incident or a more frequent issue. Dr. Salvucci is not opposed to this, however, he would like to see additional information.	Katy will check will research this issue and report back to the committee in the coming months.	
V.	**New Business**			
	A. Defensive Training for EMS/Fire and Healthcare	Chris asked the committee if there would be interest in a train the trainer course on how to protect yourself and get away from violent patients. The EMS Agency would host a 2 day train the trainer course in the summer. The majority of the committee members felt this would be helpful.	The EMS Agency will schedule the training.	
VI	**Old Business**			
	A. Bariatric Patients	Karen asked the committee if they felt it was necessary to develop a new policy on dealing with the transport of Bariatric Patients. Mark Komins stated that he believes it would be helpful for	Dr. Salvucci offered that Karen will research this issue further and report back to the committee at a future meeting.	

	liability issues. If an ambulance has to pass a closer facility because they do not have Bariatric friendly equipment, and something bad happens to the patient en route, we would have a policy in place allowing a longer transport time. Dr. Salvucci asked if field personnel were having any problems with this issue and they said "no".		
B. CAM Policy	Karen distributed the updated CAM Algorithm for review. Robin stated that policy 606 has Trauma on it, do we need a Traumatic Full Arrest Policy? Should we use AED's in traumatic full arrests? Dr. Chase has had cases where the traumatic full arrest patient is in VF, he sees no down side to placing the AED on the patient. Dr. Salvucci presented supplemental "special considerations" for choking. The committee had no issues with it.	Incorporate "special considerations" for choking into CAM Policy.	
VII. Informational/Discussion Topics			
A. Stroke Interfacility Transfers	Karen distributed a graph of response times to appropriate treatment. She pointed out that the best times are when a nurse escorts the patient from the sending hospital. The Stroke Committee has asked the question "should paramedics be trained in TPA"? Karen and Dr. Salvucci will research and bring back to a future meeting. Dr. Beatty feels that hospitals should be sending a nurse with the patient to the ELVO facility. He stated that nurses are assigned to a specific patient anyway.		

	B. CPAP	Mark Komins stated that 1 out of every 9 patients could benefit from CPAP. Jeff Seabrook expressed a concern about the time and expense of training and felt it was not worth it. Dr. Salvucci does not think it is necessary, however, he is willing to keep looking at any research/information on the issue. Dr. Tilles feels there is very little down side and would support looking at it a bit longer.		
	C. airQ Update	Dr. Salvucci distributed new tube holders for the committee members to look at. Dr. Cook will be coming out in May or June to train personnel.		
	D. Strangulation Assessment Card Presentation	Dr. Duncan spoke to the committee about this program and the importance of knowing the signs and symptoms of strangulation as well as the importance of involving law enforcement.	Dr. Duncan will send Julie information following this meeting, to distribute to the PSC members on this topic.	
VIII.	**Policies for Review**	None		
	A. 605 - Interfacility Transfer of Patients	Tabled	Bring back to next PSC.	
	B. 613 – Do Not Resuscitate (DNR)	Change AVCDS to EPCR. Chad would like something added that address when patients/Family cannot find the DNR.	Approved with change.	Approved by Chad Panke Seconded by Ira Tilles
XI	**TAG Report**	No Tag Meeting		
X.	**Agency Reports**			
	A. Fire departments	**VCFPD** – Jeff Seabrook will be representing Ventura County Fire now. **VCFD** – none **OFD** – Academy will begin in July. The dispatch center is switching over to FCC in July. **Fed. Fire** – none **SPFD** – none **FFD-** Chief Herrera stated that Fillmore has hired Keith Gurrola as their new Chief. Congratulations Keith!		

B.	Transport Providers	**LMT –** James stated that 1 new unit was added to their fleet last week and 1 will be going into service next week. **AMR/GCA** – none	
C.	Base Hospitals	**SVH –** Nicole thanked the committee for their support as she transitioned into the PCC position temporarily. **LRRMC** – Debbie told the committee that they trained 600 kids from Newbury Park High School on Tuesday. Thank you to the tremendous volunteer pool that assisted. **SJRMC** – none **VCMC** – none	
D.	Receiving Hospitals	**PVH** – none **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** – 33 preceptors have been re-trained on line. The college received their Accreditation Renewal.	
G.	EMS Agency	**Dr. Salvucci –** Dr. Salvucci announced he will be leaving Ventura County EMS in June. **Steve** – none **Chris** – New MCI will go live on July 1, 2016. Ventura County Fire starts training on Monday and all other will start training next week. The EPCR pilot will be in October. **Katy** – CARES report is being finalized. **Julie** – CISM Coalition meets each month on PSC days at 1:30 in the EMS Conference Room for anyone interested in attending. **Randy** – World CPR Day is on June 2, 2016. I need the location/site from agencies planning to participate. The EMS Agency will put out a press release. **Karen** – none	
H.	Other		
XI.	**Closing**	**Meeting adjourned at 1145**	

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				AS									
AMR	Carmona	Yoni		YC		YC									
CMH - ER	Canby	Neil		NC		NC									
CMH - ER	Querol	Amy		AQ		AQ									
OVCH - ER	Pulido	Ed		ED		ED									
OVCH - ER	Patterson	Betsy		BP											
CSUCI PD	Drehsen	Charles		CD		CD									
CSUCI PD	DeBoni	Curtis		CD		CD									
FFD	Herrera	Bill				BH									
FFD	Scott	Bob		BS											
GCA	Panke	Chad		CP		CP									
GCA	Reed	Jeff													
Lifeline	Rosolek	James		JR		JR									
Lifeline	Winter	Jeff		JW		JW									
LRRMC - ER	Beatty	Matt		MB		MB									
LRRMC - ER	Licht	Debbie		DL		DL									
OFD	Schroepfer	Kevin		AH		AH									
OFD	Martin	Blair		BM		BM									
SJPVH - ER	Hutchison	Stacy		EH		SH									
SJPVH - ER	Doane	Brian		BD		BD									
SJRMC - ER	Larsen	Todd		TL		TL									
SJRMC - ER	McShea	Kathy		KM		KM									
SPFD	Lazenby	Dustin													
SVH - ER	Tilles	Ira		IT		IT									
SVH - ER	Vorzimer	Nicole		JH		NV									
V/College	O'Connor	Tom		TO		TO									
VCFD	Tapking	Aaron		AT		AT									
VCFD	Ellis	Heather		HE		HE									
VNC	Zeller	Scott		SZ		SZ									
VNC	Dullam	Joe		JD		JS									
VNC - Dispatch	Gregson	Erica		EG		EG									
VCMC - ER	Chase	David		SR		DC									

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		TG									
VCMC-SPH	Gautam	Pai													
VCMC-SPH	Melgoza	Sarah		SM		SM									
VCSO SAR	Hadland	Don		DH		DH									
VCSO SAR	Seabrook	Jeff		JS		JS									
VFF	Santillo	Dave													
VFF	Pena	Greg													
Eligible to Vote	**Date Change/cancelled - not counted against member for attendance**														
Non Voting Members															
EMS	Carroll	Steve		SC		SC									
EMS	Frey	Julie		JF		JF									
EMS	Hadduck	Katy		KH		KH									
EMS	Perez	Randy		RP		RP									
EMS	Rosa	Chris		CR		CR									
EMS	Salvucci	Angelo		AS		AS									
EMS	Hansen	Erik				EH									
EMS	Beatty	Karen		KB		KB									
LMT	Frank	Steve		SF											
VCMC	Duncan	Thomas		TD		TD									
VNC	Shedlosky	Robin		RS		RS									
VNC	Komins	Mark		MK		MK									

TEMPORARY
PARKING PASS
Expires June 9, 2016

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

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

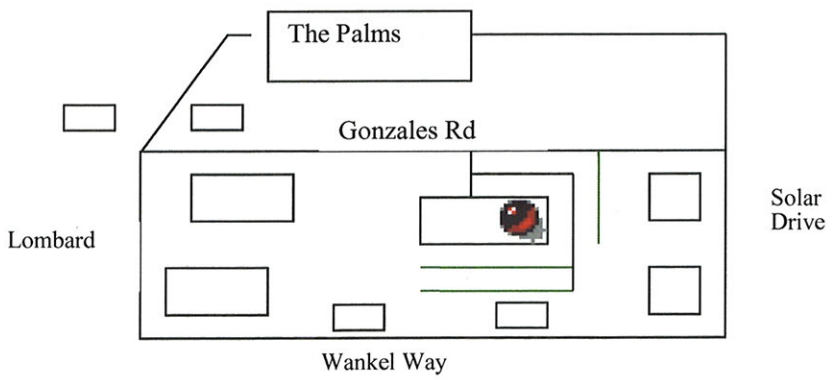
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

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

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

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

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



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Do Not Resuscitate		Policy Number 613
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: June 1, 2016
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: June 1, 2016
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 1, 1993 April 14, 2016 April 14, 2016 April, 2018	Effective Date: June 1, 2016

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 1797.220, 1798 and 7186~~.~~ and Division 1, Part 1.85 (End of Life Option Act).

California Probate Code, Division 4.7 (Health Care Decisions Law).

~~California Code of Regulations, Title 22, Sections~~ 100170.~~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.

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

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;
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. A fully executed FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER, or;
~~7~~8. 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).

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I. "FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER": As defined in the End of Life Option Act, California Health and Safety Code Section 443.11.

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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.
4. If transport has been initiated, continue transporting the patient to the appropriate receiving facility and transfer care to emergency department staff.
   a. If transport has not been initiated, but personnel are still on scene, patient should be left at scene, if not in a sensitive location (place of business, public place, etc.). The situation should be explained to the family or staff at the scene.

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

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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 Ventura County Electronic Patient Care Report (VCePCR):

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

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Declaration, FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER).

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 DPAHC or AHCD, document the agent's name in the VCePCR narrative.

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CALIFORNIA

Forms for Implementation of the California End of Life Option Act

SHARE THIS

The following forms are part of Assembly Bill 15, California End of Life Option Act.

Written Request for Medications

The End of Life Option Act requires the patient to submit a written request to the attending physician. It is recommended that the written request form be completed and signed only after seeing both the attending and consulting physicians and after both physicians have completed their respective paperwork confirming the patient meets the requirements of the law. We also recommend the patient keep a copy of the written request for their records.

The written request must be witnessed by two individuals, at least one of whom is not related to the patient, or entitled to any portion of his or her estate, or the physician, or an employee of a health care facility caring for the patient.

The written request can be rescinded at any time.

* * * Form begins here * * *

REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, ..., am an adult of sound mind and a resident of the State of California.

I am suffering from ....., which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.
..... I have decided not to inform my family of my decision.
..... I have no family to inform of my decision.

I understand that I have the right to withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the

drug.
I make this request voluntarily, without reservation, and without being coerced.

Signed: .....
Dated: .....

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) is personally known to us or has provided proof of identity;
(b) voluntarily signed this request in our presence;
(c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and
(d) is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

.....Witness 1/Date

.....Witness 2/Date

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident.

* * * Form ends here * * *

Interpreter's Declaration

Under the End of Life Option Act, the written language of the request shall be written in the same translated language as any conversations, consultations, or interpreted conversations or consultations between a patient and his or her

attending or consulting physicians. The written request may be prepared in English even when the conversations or consultations or interpreted conversations or consultations were conducted in a language other than English if the English language form includes an attached interpreter's declaration that is signed under penalty of perjury. The interpreter's declaration shall state words to the effect that:

* * * Form begins here * * *

I, ... (INSERT NAME OF INTERPRETER), am fluent in English and ..... (INSERT TARGET LANGUAGE).

On..... (insert date) at approximately..... (insert time), I read the "Request for an Aid-In-Dying Drug to End My Life" to ..... (insert name of individual/patient) in (insert target language).

Mr./Ms ..... (insert name of patient/qualified individual) affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.

I declare that I am fluent in English and ..... (insert target language) and further declare under penalty of perjury that the foregoing is true and correct.

Executed at ..... (insert city, county, and state) on this ..... (insert day of month) of ..... (insert month), ... (insert year).

X ..... Interpreter signature
X ..... Interpreter printed name
X..... Interpreter address

* * * Form ends here * * *

Final Attestation Form

The attending physician must provide the patient the following form which the patient has to complete within 48 hours prior to taking the medications.

* * * Form begins here * * *

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I, ..., am an adult of sound mind and a resident of the State of California.

I am suffering from ....., which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.
..... I have decided not to inform my family of my decision.
..... I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed: .....
Dated: .....
Time: .....

* * * Form ends here * * *

Death With Dignity
520 SW 6th Avenue, Suite 1220
Portland, OR 97204
Contact Us

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FAQS
SUPPORT US

This is the website of Death with Dignity National Center and Death with Dignity Political Fund

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Privacy Policy

Ventura County
Critical Incident Stress Management (CISM) Coalition
To request CISM Services call: 805-388-4279 (24/7)

INITIAL REACTION TO A CRITICAL INCIDENT OR LOSS

When you have been exposed to a difficult experience such as a loss of a loved one, co-worker, or friend your own response can be troubling. An individual's response can be influence by many factors such as your previous exposure to loss, the availability and continuation of emotional support, as well as other stressors in your life.

For many people, it is natural to experience some "after shock" or a stress reaction. These are normal responses and are the way we process a demanding life experience. A sample of some typical reactions are listed below:

PHYSICAL	EMOTIONAL	COGNITIVE	BEHAVIOR
• Nausea • Grinding teeth • Thirst • Upset stomach • Tremor • Feeling uncoordinated • Sweating • Chills • Diarrhea • Dizziness • Chest pains* • Rapid heat beat* • Increased blood pressure* • Sleep disturbance • Rapid breathing • Headaches • Muscle aches • Lethargic • Fatigue ** Requires immediate medical attention*	• Anxiousness • Fear • Guilt • Grief • Denial • Depression/sadness • Feeling lost or abandoned • Numbness • Feeling isolated • Worry about self and/or others • Wanting to hide • Anger • Irritability • Hopeless • Helpless • Overwhelmed • Reduced feeling of pleasure	• Slowed thinking • Fearful thoughts • Disorientation • Memory problems • Distressing dreams • Blaming • Illogical thinking • Memory flashbacks • Intrusive thoughts • Poor judgment • Change in perceptions • Difficulty: -problem-solving -calculating -naming objects -making decisions -concentrating • Loss of meaning or purpose • Loss of faith • Lost sense of security • Loss of sense of control	• Crying spells • Extreme hyperactivity • Change in activity • Withdrawal • Increased/decreased -intake of food -sleep -sexual activity • Increased: -smoking -drinking -drug use -absenteeism -need for safety -conflicts • Overly vigilant • Avoiding or change in: -social patterns -communication -hygiene -self-care -productivity

The signs and symptoms of a stress reaction may last a few days, a few weeks or a few months and occasionally longer depending on the above noted influences. With understanding and the support the stress reactions usually pass more quickly. Occasionally the circumstances around the loss can be so painful that professional assistance from a counselor may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the person to manage by themselves.

*If you or a loved one need **further** assistance/support following a formal Debriefing or Defusing by the team, please contact the Coalition's Mental Health Clinical Coordinator, Scott Barash at (805) 654-4327. For general questions, contact Julie Frey (805)795-7752 (24/7) – Lead Agency (VCEMS)*

WAYS FOR YOU TO RESPOND TO THE STRESS

- **Within the first 24 – 48 hours**, periods of appropriate physical exercise, alternated with relaxation with alleviate some of the physical symptoms
- Structure your time – keep busy
- Don't label yourself crazy – you are normal and having normal reactions
- Talk to people – talk is the most healing medicine
- Beware of numbing the pain with overuse of alcohol or drugs – you don't need to complicate this with a substance abuse problem
- Reach out – people do care
- Maintain as normal a schedule as possible
- Spend time with others
- Help your co-workers as much as possible by sharing feelings and checking out how they are doing
- Give yourself permission to feel rotten and share your feelings with others
- Keep a journal – write your way through sleepless hours
- Do things that feel good to you
- Realize that those around you are under stress
- Don't make any big life changes
- Do make as many daily decisions as possible which will give you a feeling of control over your life, i.e., if someone asks you what you want to eat – answer them even if you are not sure
- Get plenty of rest
- Don't try to fight reoccurring thoughts, dreams or flashbacks – they are normal and will decrease over time and become less painful
- Eat well-balanced and regular meals, even if you don't feel like it
- **Share the information below with your family and friends so they can help**

HOW YOU CAN HELP YOUR FAMILY MEMBER OR FRIEND

- Listen carefully
- Spend time with traumatized person
- Offer your assistance and a listening ear if they have not asked for help
- Reassure them that they are safe
- Help them with everyday tasks like cleaning, cooking, caring for family, minding children
- Give them some private time
- Don't take their anger or other feelings personally
- Don't tell them that they are "lucky it wasn't worse" – instead, tell them that you are sorry such an event has occurred and you want to understand and assist them

21 Things You Can Do While You're Living Through a Traumatic Experience

Mark Lerner PH.D. *

1. Take immediate action to ensure your physical safety and the safety of others. If it's possible, remove yourself from the event/scene in order to avoid further traumatic exposure.
2. Address your acute medical needs (e.g., If you're having difficulty breathing, experiencing chest pains or palpitations, seek immediate medical attention).
3. Find a safe place that offers shelter, water, food and sanitation.
4. Become aware of how the event is affecting you (i.e., your feelings, thoughts, actions—and your physical and spiritual reactions).
5. Know that your reactions are normal responses to an abnormal event. You are not "losing it" or "going crazy."
6. Speak with your physician or healthcare provider and make him/her aware of what has happened to you.
7. Be aware of how you're holding-up when there are children around you. Children will take their cues from the adults around them.
8. Try to obtain information. Knowing the facts about what has happened will help you to keep functioning.
9. If possible, surround yourself with family and loved ones. Realize that the event is likely affecting them, too.
10. Tell your story. And, allow yourself to feel. It's okay—not to be okay during a traumatic experience.
11. You may experience a desire to withdraw and isolate, causing a strain on significant others. Resist the urge to shut down and retreat into your own world.
12. Traumatic stress may compromise your ability to think clearly. If you find it difficult to concentrate when someone is speaking to you, focus on the specific words they are saying—work to actively listen. Slow down the conversation and try repeating what you have just heard.
13. Don't make important decisions when you're feeling overwhelmed. Allow trusted family members or friends to assist you with necessary decision-making.

14. If stress is causing you to react physically, use controlled breathing techniques to stabilize yourself. Take a slow deep breath by inhaling through your nose, hold your breath for 5 seconds and then exhale through your mouth. Upon exhalation, think the words "relax," "let go," or "I'm handling this." Repeat this process several times.

15. Realize that repetitive thinking and sleep difficulties are normal reactions. Don't fight the sleep difficulty. Try the following: Eliminate caffeine for 4 hours prior to your bedtime, create the best sleep environment you can, consider taking a few moments before turning out the lights to write down your thoughts—thus emptying your mind.

16. Give yourself permission to rest, relax and engage in non-threatening activity. Read, listen to music, consider taking a warm bath, etc.

17. Physical exercise may help to dissipate the stress energy that has been generated by your experience. Take a walk, ride a bike, or swim.

18. Create a journal. Writing about your experience may help to expose yourself to painful thoughts and feelings and, ultimately, enable you to assimilate your experience.

19. If you find that your experience is too powerful, allow yourself the advantage of professional and/or spiritual guidance, support and education.

20. Try to maintain your schedule. Traumatic events will disrupt the sense of normalcy. We are all creatures of habit. By maintaining our routines, we can maintain a sense of control at a time when circumstances may lead us to feel a loss of control.

Crises present opportunities. Cultivate a mission and purpose. Seize the energy from your experience and use it to propel you to set realistic goals, make decisions and take action.

* **Dr. Mark Lerner** is a Clinical Psychologist and Traumatic Stress Consultant He is the President of the American Academy of Experts in Traumatic Stress (www.aaets.org)

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Multi Casualty Incident Response		Policy Number 131
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: June 1, 2014
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: June 1, 2014
Origination Date: Date Revised: Review Date:	September 1991 May 8, 2014 May 2016	Effective Date: June 1, 2014

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

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

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

IV. DEFINITIONS:

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

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

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

V. TRAINING:

The following training will be required:

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

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

1. Initial basic course: 4 hours
2. Prerequisite for the course (for fire companies and EMS providers): Introduction to the Incident Command System (ICS 100), and ICS for Single Resource and Initial Action Incidents (ICS 200). There is no prerequisite for MICNs.
3. Course will be valid for two years

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

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

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

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

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

C. **Basic MCI Refresher Training**

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

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

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

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

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

VI. ACTIVATION OF THE MULTI CASUALTY INCIDENT RESPONSE PLAN:

A. Report of Incident

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

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

B. Prehospital Response

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

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

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

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

C. Ventura County Trauma System Considerations

1. For any level MCI in which a traumatic mechanism exists, the base hospital shall be the trauma center in whose trauma catchment area the incident occurred. On an MCI/Level I, patients with traumatic injuries shall be triaged utilizing the Ventura County Field Triage Decision Scheme, in addition to S.T.A.R.T. triage. On an MCI/Level I, the applicable VC trauma step shall be relayed to the base hospital by MEDCOMM for all patients with traumatic injuries, in addition to S.T.A.R.T triage category, age, and gender.
2. Patients shall be transported in accordance with VCEMS 131 Attachment C ”MCI Trauma Patient Destination Decision Algorithm.”

D. Ventura County EMS Agency

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

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

preparations for the possible receipt of patients.

2. Update all hospitals periodically or when new or routine information is received. Hospitals in unaffected areas may or may not be requested to remain in a stand-by readiness mode.
3. Inform MEDCOMM of each hospital's availability.
4. Relay all requests/information regarding hospital resource needs or surplus to the Regional Disaster Medical Health Coordinator (RDMHC) representative, when appropriate. Coordinate response of additional medical equipment and personnel.
5. Inform all hospitals when remaining casualties have been cleared from the MCI scene.
6. Receive MCI information from PSAP and alert the appropriate VCEMS and Ventura County Health Care Agency (HCA) personnel.
7. Initiate the VCEMS Emergency Response plan to a level appropriate to the information provided.
8. Activate the Health Care Agency – Department Operations Center, when appropriate.
9. Inform the Ventura County Sheriff's Office of Emergency Services (OES) and/or the Operational Area EOC of EMS activity, when appropriate.
10. Alert the RDMHC representative, when appropriate.
11. Request out-of-county medical resources, when necessary, with EMS/HCA management approval. Coordinate requests with OES staff and RDMHC representative.
12. Assist in the coordination of transportation resources.
13. Assist in the coordination of health care facility evacuation.
14. Communicate with hospitals, skilled nursing facilities and appropriate EOCs when warranted.
15. Assist in coordination of incident evaluations and debriefings.

E. Hospital Response

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

F. Documentation

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

2. Level 2 and 3 MCI: Each patient transported to a hospital shall have their care documented on a multi-casualty patient record (Policy 131, Attachment A).
    a. The transporting agency is responsible for completion of the multi- casualty patient record. The record is designed to be completed by the transporting crew 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 de-mobilization of the incident.
    d. Patients not transported from a Level II or Level III MCI, may be documented using the multi-casualty non-transport record, (Policy 131, Attachment B).
3. Ventura County EMS Approved MCI Worksheets
    a. Ventura County EMS Providers shall utilize the approved MCI worksheets described in the Basic and Advanced MCI courses and attached to this policy as follows:
        1. Form 131-C MCI Trauma Patient Destination Decision Algorithm (Policy 131, Attachment C)
        2. Form 131-1 Level 1 MCI Worksheet (Policy 131, Attachment E)
        3. Form 131-2 Hospital Worksheet (Policy 131, Attachment F)
        4. Form 131-3 Out of County Hospital Worksheet (Policy 131, Attachment G)
        5. Form 131-4 Treatment Tarp Updates (Policy 131, Attachment H)
        6. Form 131-4A Immediate Treatment Area (Policy 131, Attachment I)
        7. Form 131-4B Delayed Treatment Area (Policy 131, Attachment J)
        8. Form 131-4C Minor Treatment Area (Policy 131, Attachment K)
        9. Form 131-4D Morgue Area (Policy 131, Attachment L)
        10. Form 306 Transportation Worksheet (Policy 131, Attachment M)
        11. Form 310 Staging Manager (Policy 131, Attachment N)
4. Mobile Data Computer (MDC) Equipped Ambulances
    a. In an effort to enhance patient tracking, transport personnel operating ambulances equipped with MDC’s, when able, will document the triage tag

number, patient name, and destination in the comment section of the dispatch ticket on the MDC.

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

A. Prehospital de-mobilization

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

VIII. CRITIQUE OF THE MULTI CASUALTY INCIDENT:

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

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

Ventura County Health Care Agency

EMERGENCY MEDICAL SERVICES
A Division of Public Health

MULTI CASUALTY MEDICAL RESPONSE PLAN

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Ventura County EMS Administrator

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Ventura County EMS Medical Director

June 2013

County of Ventura
Emergency Medical Services Agency

MULTI CASUALTY MEDICAL RESPONSE PLAN

SECTION I INTRODUCTION

A. Purpose

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

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

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

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

B. Goal

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

C. Plan Organization

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

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

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

D. Planning for Medical Disasters

1. Levels of Medical Disaster

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

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

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

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

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

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

2. Addressing Medical Disasters

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

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

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

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

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

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

F. SECTION II RESPONSE ORGANIZATIONS

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

1. Ventura County Health Care Agency (HCA)

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

Health Care Agency responsibilities during an MCI include:

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

2. Ventura County/Emergency Medical Services (VCEMS)

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

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

- Coordinating destinations
- Ascertaining hospital availability
- Coordinating medical resources (in and out of county)
- Communicating with the County Health Officer
- Coordinating the dissemination of Public Health information
- Response to the scene, primary dispatch center, HCA Department Operations Center (DOC) or Emergency Operations Center (EOC)
- Obtaining briefing from base hospital for transition
- Establishing communication with OES (consider EOC activation)
- Working within the Incident Command structure, as the medical/health branch of theOperations Section at the County's EOC
- Advising the County Health Officer as to the status of medical resources in Ventura County
- Establishing a liaison with the EMS Authority through the Region I Regional Disaster

Medical/Health Coordinator (RDHMC)

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

3. Municipal Governments

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

Responsibilities of municipal governments during an MCI include:

a. Ventura County Office of Emergency Services

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

b. Law Enforcement

- Providing force protection
- Providing Search and Rescue (SAR)
- Providing Scene Control
- Providing Traffic Control
- Assisting with Incident Command System (ICS) establishment / Unified Command
- Providing Body protection (morgue)
- Conducting Investigations

- Providing a Public Information Officer (PIO)
- Conducting Damage Assessment
- Managing Law Enforcement Air Operations

c. Coroner / Medical Examiner

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

d. Fire Departments

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

Fire agency responsibilities during an MCI include:

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

4. Media

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

- Public awareness (traffic, safety issues, etc.)

- Working with PIOs

5. Transportation Agencies

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

Responsibilities of transportation agencies during an MCI include:

a. Ground

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

b. Air

Air Ambulance

- Providing transport
- Providing documentation
- Conducting transfers
- Providing additional aircraft as needed

Rescue Aircraft

- Providing transport
- Providing documentation
- Conducting transfers
- Providing additional aircraft as needed

6. Hospitals (Acute Care Health Facilities)

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

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

Base Hospital

- Communicating with MEDCOMM at the scene(s) of an MCI
- Determining initial bed availability

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

Receiving Hospital

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

7. American Red Cross - Ventura County Chapter

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

American Red Cross identified duties during an MCI may include:

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

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

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

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

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

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

9. State of California Emergency Medical Services Authority

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

State EMS Authority identified duties during an MCI may include:

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

10. Hospital Association of Southern California (HASC)

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

HASC identified duties during an MCI may include:

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

11. Ventura County Transportation Authority

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

12. Salvation Army

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

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

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

(NDMS – DMAT, DMORT, etc).
- Coast Guard

SECTION III RESPONSE NARRATIVE

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

A. Multi Casualty Incident (MCI) LEVEL I

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

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

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

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

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

B. Multi Casualty Incident (MCI) Level II

The initial phase of an MCI/Level II is similar to that of the MCI/Level I; first responders are dispatched to an incident via the 9-1-1 system. However, upon arrival, rescuers are immediately presented with a scenario which provides a large number of patients too numerous to treat definitively in the field. The stabilization and transportation of prioritized casualties to an appropriate receiving hospital is the

most immediate objective. Management of the MCI/Level II is predicated on the assumption that there are enough prehospital medical responders, adequate transportation resources, sufficient casualty receiving hospitals, and an intact coordinated hospital communication system. VCEMS will coordinate with local dispatch centers to assess current resources and determine adequacy.

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

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

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

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

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

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

C. Multi Casualty Incident (MCI) Level III

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

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

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

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

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

With data gathered from the hospitals, medical aid stations, EMS providers, skilled nursing facilities and

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

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

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

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

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

VCEMS Agency may conduct a post-incident analysis of the MCI at their discretion or at the request of

agencies involved in the incident. All medically involved participants will be invited. VCEMS Agency shall publish a written report following the post-incident analysis. The report will include minutes from the post incident analysis meeting, any summary data available and written reports.

SECTION V INFORMATION MANAGEMENT

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

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

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

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

SECTION VI RESOURCE ACQUISITION

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

GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ventura County
Emergency Medical Services Agency
MULTI-CASUALTY PATIENT RECORD
(For use on declared Level II or Level III MCI's only)

Date:_____**Agency**_____**Unit#:**_____**Location:**_____**Incident #:**_____

Patient Name:	**Injuries**:	**Airway**:	**Cap Refill:**	**Tx Prior to Transport**:	**Base Hospital**:	**Comments:**
_____ **Age**:_____ **Sex**:_____ **Triage Tag #**:_____ ☐ **IMMEDIATE** ☐ **DELAYED** ☐ **MINOR**	_____ _____ _____ _____	☐ Patent ☐ Other (Explain) _____ **Mental Status:** ☐ Follows Simple Commands ☐ Fails to Follow Simple Commands	☐ < 2 Seconds ☐ > 2 Seconds **Skin:** ☐ Normal ☐ Other **Resp Rate**:_____ **Pulse Rate**:_____ **B/P**:_____	☐ C-Spine ☐ Oxygen ☐ IV ☐ Other (Explain) _____ _____ _____ _____	☐ LRHMC ☐ VCMC ☐ SJRMC ☐ SVH **Dest. Hosp**:_____ **Times**: Depart:_____ Destination:_____	_____ _____ _____ _____ _____

Receiving Hospital to Attach Triage Tag Here

_____

PRINTED NAME **LICENSE #** **SIGNATURE**

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

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

Ventura County
Emergency Medical Services Agency
MULTI-CASUALTY NON-TRANSPORT RECORD
(For use on declared Level II or Level III MCI's only)

Date: ___________ **Agency:** ___________ **Unit #:** ___________ **Location:** ______________________ **Fire Incident #:**__________________

Time: ______________ **Patient Name:** ______________ **Sex:** ☐ Male ☐ Female **Age:** ________ **Tag #:** ______________	**Airway:** ☐ Patent **Mental Status:** ☐ Awake and Alert ☐ Appropriate for Age	**Skin:** ☐ Normal **Resp:** ________ **Pulse:** ________ **B/P:** ________	**Treatment Provided:** ______________ ______________ ______________ ______________ ☐ None Indicated	**Comments**: ______________ ______________ ______________ ______________	**Disposition:** ☐ AMA Obtained ☐ No AMA Obtained Other: ________ ______________
Time: ______________ **Patient Name:** ______________ **Sex:** ☐ Male ☐ Female **Age:** ________ **Tag #:** ______________	**Airway:** ☐ Patent **Mental Status:** ☐ Awake and Alert ☐ Appropriate for Age	**Skin:** ☐ Normal **Resp:** ________ **Pulse:** ________ **B/P:** ________	**Treatment Provided:** ______________ ______________ ______________ ______________ ☐ None Indicated	**Comments**: ______________ ______________ ______________ ______________	**Disposition:** ☐ AMA Obtained ☐ No AMA Obtained Other: ________ ______________
Time: ______________ **Patient Name:** ______________ **Sex:** ☐ Male ☐ Female **Age:** ________ **Tag #:** ______________	**Airway:** ☐ Patent **Mental Status:** ☐ Awake and Alert ☐ Appropriate for Age	**Skin:** ☐ Normal **Resp:** ________ **Pulse:** ________ **B/P:** ________	**Treatment Provided:** ______________ ______________ ______________ ______________ ☐ None Indicated	**Comments**: ______________ ______________ ______________ ______________	**Disposition:** ☐ AMA Obtained ☐ No AMA Obtained Other: ________ ______________

______________________________ ______________ ______________________________

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

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

Agency completing form will distribute completed copies to Base Hospital and EMS Agency within 24 hours of the incident.

MCI TRAUMA PATIENT DESTINATION DECISION ALGORITHM

TRIAGE ALL PATIENTS UTILIZING START TRIAGE

IMMEDIATE | **DELAYED** | **MINOR**

ESTABLISH A TREATMENT AREA ON ALL MASS CASUALTY INCIDENTS

ESTABLISH A TREATMENT AREA ON ALL MASS CASUALTY INCIDENTS

PERFORM A FOCUSED EXAM AND BEGIN TO PROVIDE TREATMENT AS RESOURCES ALLOW

PATIENTS ON A LEVEL I MCI WITH TRAUMATIC INJURIES WILL ALSO BE TRIAGED INTO THE VC TRAUMA TRIAGE DECISION SCHEME

LEVEL I MCI FULL ePCR

- **RED TAG** → ANY TRAUMA STEP - TRANSPORT TO A TRAUMA CENTER (CONSIDER OUT OF COUNTY (O.O.C.), CONSIDER AIR TRANSPORT)
- **YELLOW TAG** → STEPS 1, 2, 3 TRANSPORT TO A TRAUMA CENTER (CONSIDER O.O.C.) STEP 4, NO STEP - TRAUMA BASE HOSPITAL DISCRETION
- **GREEN TAG** → STEP 3 TRANSPORT TO A TRAUMA CENTER (CONSIDER O.O.C.) STEP 4 TRAUMA BASE HOSPITAL DISCRETION NO STEP, TRANSPORT TO ANY HOSPITAL

LEVEL II/III MCI ATTACHMENT "A/B"

- **RED TAG** → TRANSPORT TO A TRAUMA CENTER WHENEVER POSSIBLE (Consider O.O.C., CONSIDER AIR TRANSPORT)
- **YELLOW TAG** → TRAUMA CENTER PREFERRED, IF POSSIBLE (CONSIDER O.O.C.)
- **GREEN TAG** → TRANSPORT TO ANY HOSPITAL

1. When trauma center capacity at local and neighboring county trauma centers has been exhausted, transport to non-trauma hospitals
2. For Level II/III MCI events, red tag patients with traumatic injuries exhibiting the following criteria should be prioritized to trauma centers:
   - Significantly decreased GCS with evidence of neurological trauma
   - Penetrating or blunt injury with signs and symptoms of shock
   - Penetrating wounds to the neck and/or torso

LEVEL 1 MCI WORKSHEET

INCIDENT:_____ **DATE:**_____

Person(s) filling out this form:_____

Pt #	AGE	SEX	PATIENT STATUS	VC TRAUMA STEP	INJURIES	DEST	TRANS UNIT ID	TRANS TIME	TRIAGE TAG # (Last 4)
1			I D M						
2			I D M						
3			I D M						
4			I D M						
5			I D M						
6			I D M						
7			I D M						
8			I D M						
9			I D M						
10			I D M						
11			I D M						
12			I D M						
13			I D M						
14			I D M						

	TIME						
VCMC	PCCI: 3I 4D 5M	AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
LRH	PCCI: 3I 4D 5M	AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
Hospital		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
Hospital		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
Hospital		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
		Total		Total		Total	

HOSPITAL WORKSHEET

INCIDENT:_____ **DATE:**_____

Person(s) Filling Out This Form:_____

TIME											TOTAL BEDS USED
	AVAIL	USED	AVAIL	USED	AVAIL	USED	AVAIL	USED	AVAIL	USED	
LRHMC											
IMMEDIATE											
DELAYED											
MINOR											
VCMC											
IMMEDIATE											
DELAYED											
MINOR											
SJRMC											
IMMEDIATE											
DELAYED											
MINOR											
SVH											
IMMEDIATE											
DELAYED											
MINOR											
CMH											
IMMEDIATE											
DELAYED											
MINOR											
PVH											
IMMEDIATE											
DELAYED											
MINOR											
SPH											
IMMEDIATE											
DELAYED											
MINOR											
OVCH											
IMMEDIATE											
DELAYED											
MINOR											

OUT-OF-COUNTY HOSPITAL WORKSHEET

INCIDENT:_______________________________ **DATE:**________________

PERSON(S) COMPLETING THIS FORM:_________________________________

SANTA BARBARA COUNTY: Santa Barbara Cottage, Goleta Valley Cottage Hospital, Lompoc Valley Medical Center, Marian Medical Center, Santa Ynez Valley Cottage Hospital

LOS ANGELES COUNTY: Henry Mayo, Kaiser Woodland Hills, LAC+USC, Harbor UCLA, Northridge, Holy Cross, St. Joseph, Ronald Regan – UCLA (Westwood), West Hills, Tarzana, Cedars Sinai, Children's Hospital Los Angeles

TIME											TOTAL BEDS USED
	AVAIL	USED	AVAIL	USED	AVAIL	USED	AVAIL	USED	AVAIL	USED	
IMMEDIATE											
DELAYED											
MINOR											
IMMEDIATE											
DELAYED											
MINOR											
IMMEDIATE											
DELAYED											
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IMMEDIATE											
DELAYED											
MINOR											
IMMEDIATE											
DELAYED											
MINOR											

TREATMENT TARP UPDATES

INCIDENT:____ **DATE:**______________________

Person(s) filling out this form:____

TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	TOTAL

IMMEDIATE TREATMENT AREA

INCIDENT:_____ **DATE:**_____

Person(s) filling out this form:_____

AGE	SEX	TRIAGE TAG # (LAST 4)	INJURIES	TIME OFF TARP

DELAYED TREATMENT AREA

INCIDENT:_____ **DATE:**_____

Person(s) filling out this form:_____

AGE	SEX	TRIAGE TAG # (LAST 4)	INJURIES	TIME OFF TARP

MINOR TREATMENT AREA

INCIDENT:_____ **DATE:**_____

Person(s) filling out this form:_____

AGE	SEX	TRIAGE TAG # (LAST 4)	INJURIES	TIME OFF TARP

MORGUE WORKSHEET

INCIDENT:_____ **DATE:**_____

Person(s) filling out this form:_____

AGE	SEX	TRIAGE TAG # (LAST 4)	NOTES

TRANSPORTATION WORKSHEET

INCIDENT:_____ **DATE:** _____

Person(s) filling out this form: _____

	AGENCY	AMBULANCE ID	TRIAGE TAG (Last 4)	AGE	SEX	PATIENT STATUS	DEST	TRANS TIME
1						I D M		
2						I D M		
3						I D M		
4						I D M		
5						I D M		
6						I D M		
7						I D M		
8						I D M		
9						I D M		
10						I D M		
11						I D M		
12						I D M		
13						I D M		
14						I D M		
15						I D M		
16						I D M		
17						I D M		
18						I D M		
19						I D M		
20						I D M		
21						I D M		
22						I D M		
23						I D M		
24						I D M		
25						I D M		

Staging Area Manager Worksheet
Ambulance Resource Status

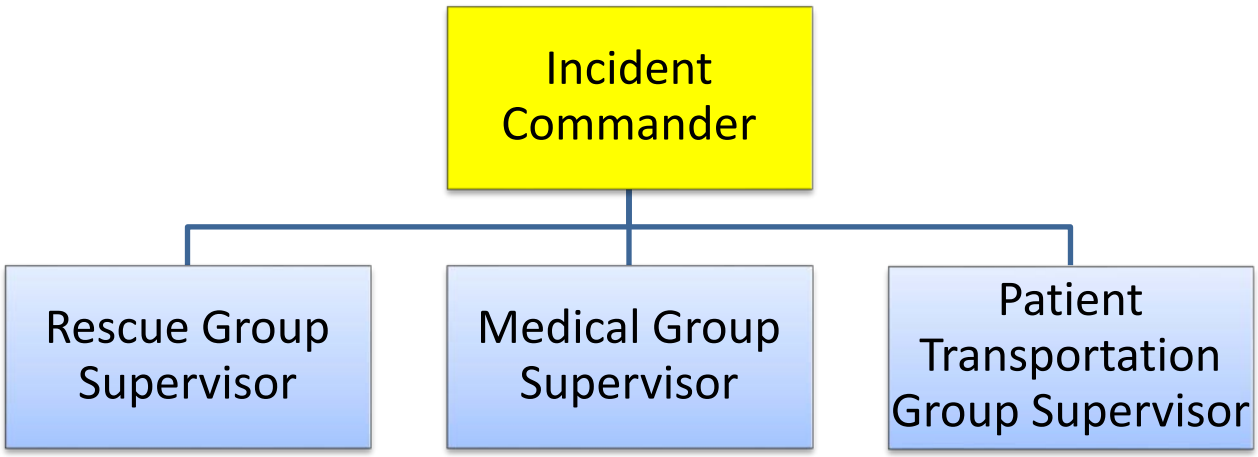
Incident:_____ **Date:**_____

Person(s) Completing Form:_____

AGENCY	UNIT #	ALS/BLS	Time IN	Time OUT

MCI Job Aid

Position: Incident Commander (IC)



Responsibilities:

- The incident commander is the individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources.
- Typically the first engine company captain (red helmet) or the first battalion chief (white helmet) will assume the role of IC
- Once IC has been established, that information needs to be relayed via radio to dispatch as well as other personnel on scene.
- Name the incident (this may be done automatically by dispatch personnel)
- Declare an MCI/Level __ based on the total number of victims involved (transported or not)
    - MCI/Level I 3-14 victims
    - MCI/Level II 14-49 victims
    - MCI/Level III 50+ victims
- The Incident Commander should ensure that the communications center notifies EMSA duty officer of the MCI (automatic for FCC)

Groups will be assigned as needed (e.g. rescue group or HazMat group). Medical group supervisor will be assigned by IC and is typically an early arriving engine company Captain.

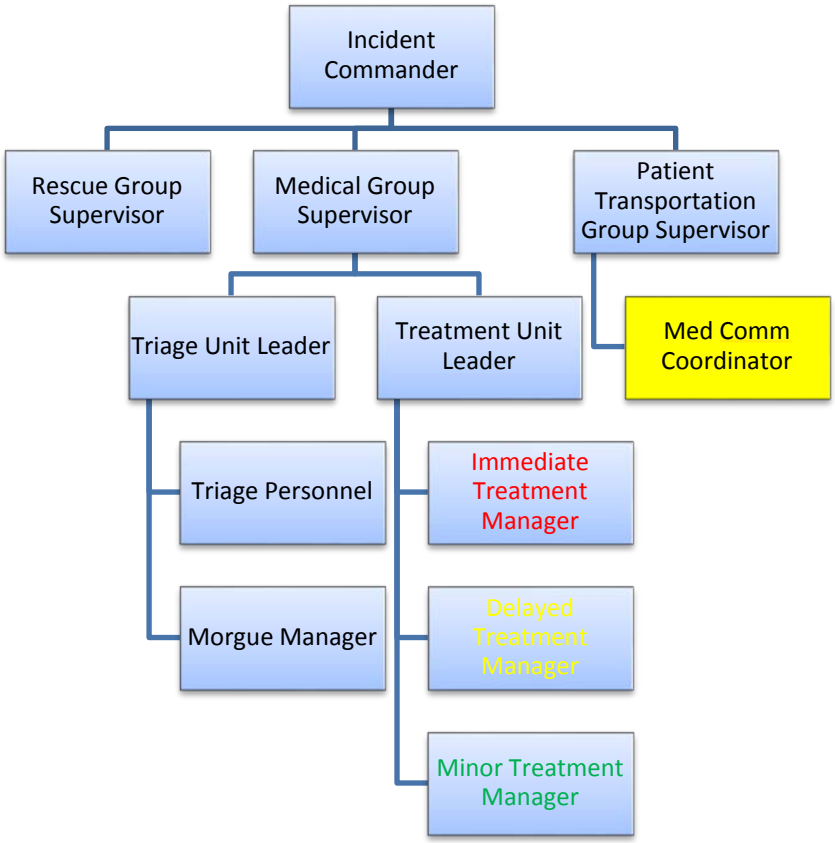
Depending on the level of the MCI, other groups and positions will be assigned. These positions will be assigned by the IC as the incident progresses. The assignment of these groups will be based on need. For MCI, there will always be a need for a medical group and a patient transportation group.

The role of the IC can be passed on as the incident progresses (Captain to Battalion Chief, Battalion Chief to Division/Assistant Chief, etc).

Medical group supervisor may be established on smaller incidents, but the role will likely be under the Operations Section on larger-scale incidents.

MCI JOB AID

MEDICAL COMMUNICATIONS COORDINATOR (MEDCOMM)

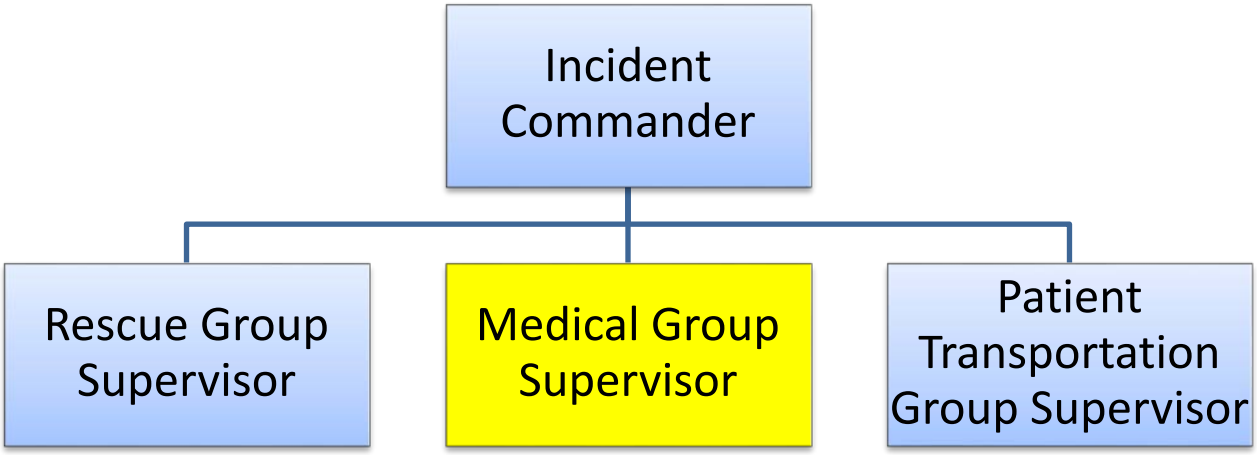


Responsibilities:

- Coordinate method of transport (ground/air) as well as destination for patients being transported. Communicates directly with the Patient Transportation Group Supervisor as well as the Base Hospital to ensure that patients are transported to the most appropriate destination as efficiently as possible.
- Determine and maintain communications with the Base Hospital to ensure that bed availability and destination information remains accurate.
- Receive patient information from Treatment Unit Leader and/or Patient Loading Manager (in larger-scale incidents)
- Maintain accurate records (include triage and transport receipts).
- This position may be held in conjunction with Patient Transportation Group Supervisor, or may be delegated by the Patient Transportation Group Supervisor, depending on scope and scale of the incident.

MCI Job Aid

Position: Medical Group Supervisor

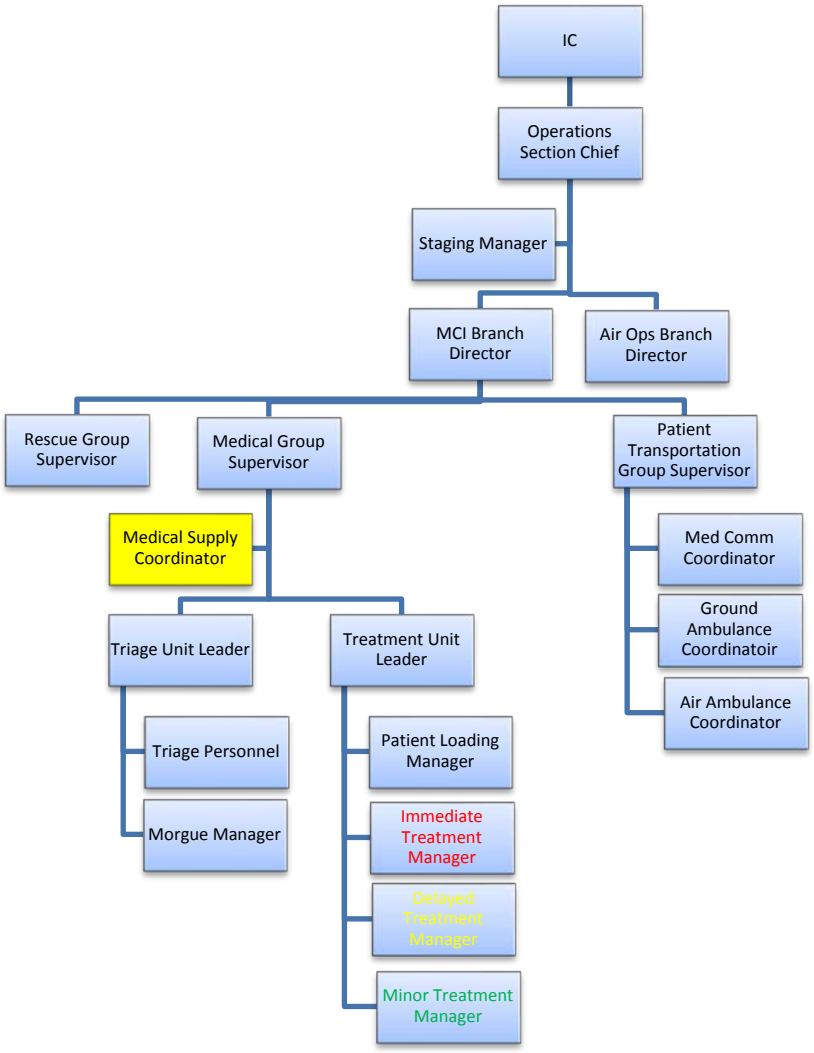


Responsibilities:

- The Medical Group Supervisor reports to the Incident Commander (on smaller incidents) or the Operations Section or Medical Branch Director (on larger incidents) and supervises the Triage Unit Leader, Treatment Unit Leader, and the Medical Supply Coordinator
- Designate treatment and triage unit leaders as well as treatment areas (including morgue)
- Determine amount and type of additional resources and supplies necessary to complete objectives
- Establish face to face communication and coordinate with Patient Transportation Group Supervisor
- Responsible for ensuring adequate medical care to patients is being delivered.
- Maintain a unit log (ICS 214)

MCI JOB AID

POSITION: MEDICAL SUPPLY COORDINATOR

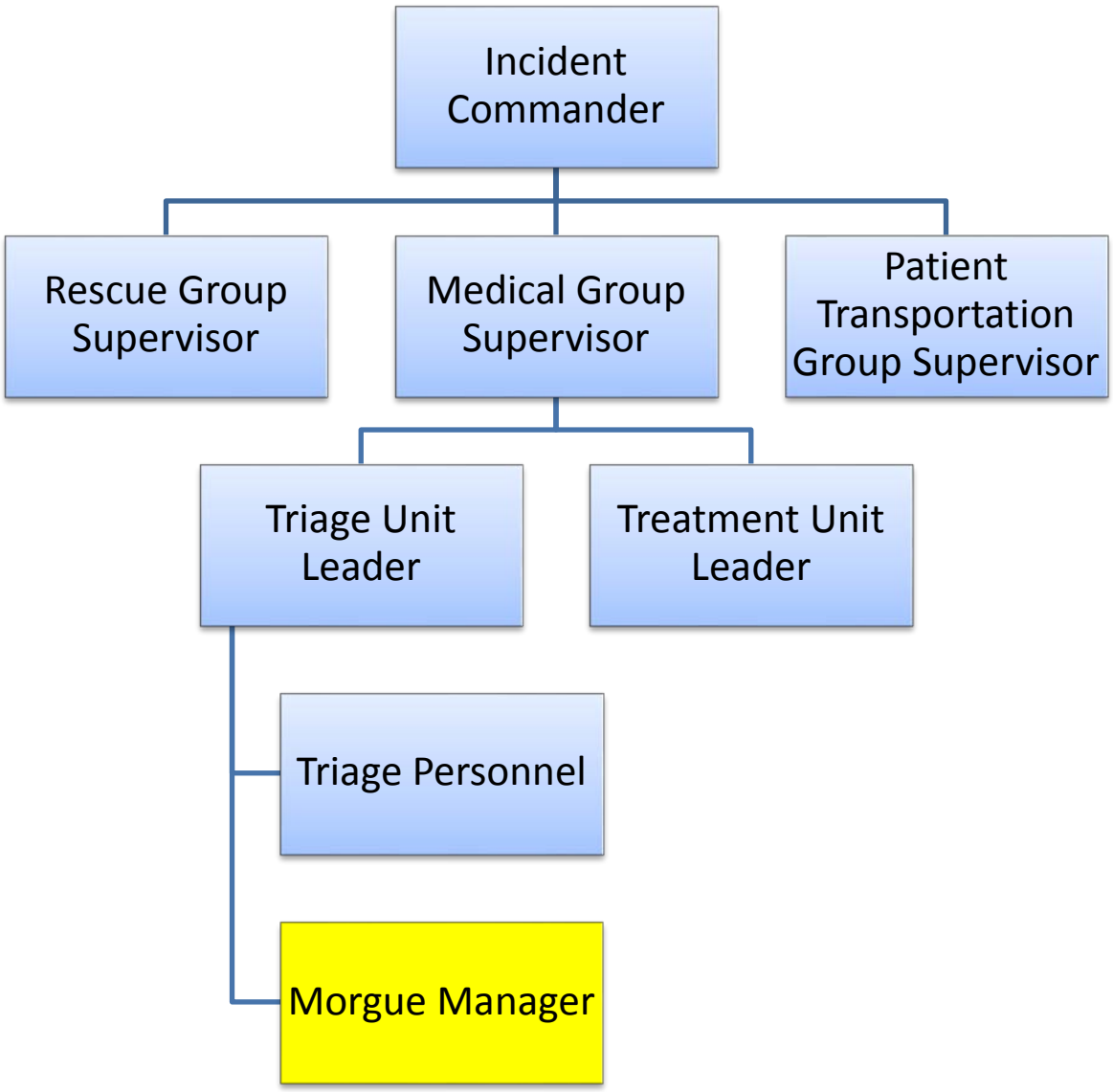


Responsibilities:

- Reports to the Medical Group Supervisor. Acquires, distributes, and maintains the status of medical supplies and equipment within the Medical Group / Division.
- Request additional supplies (MCI caches/trailers, DMSU)
- Distribute medical supplies to Triage and Treatment Units
- Maintain documentation (ICS 214 – Unit Activity Log).

MCI Job Aid

Position: Morgue Manager

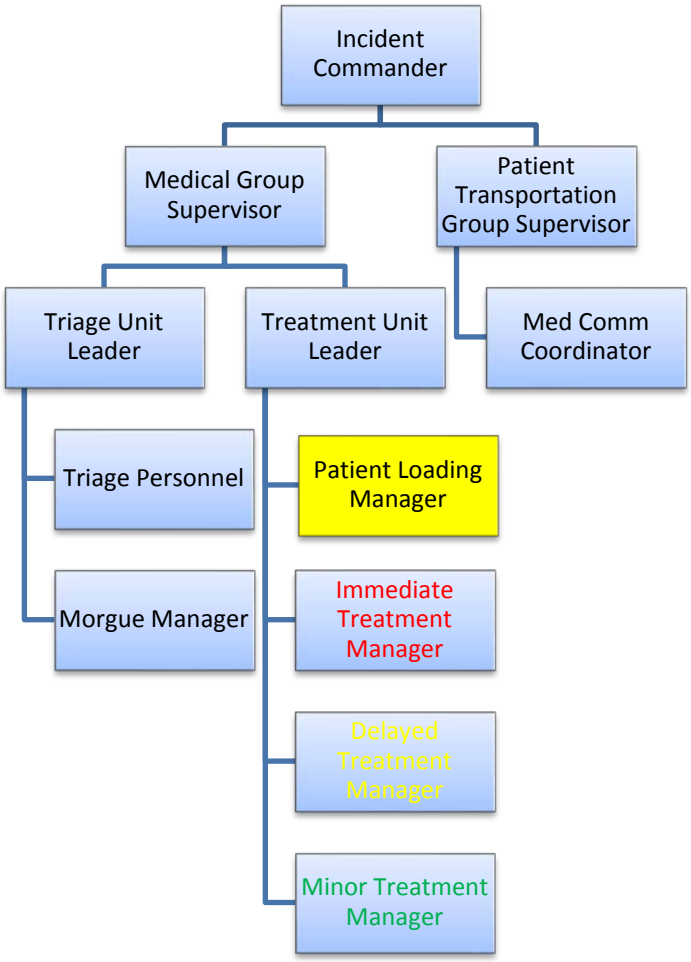


Responsibilities:

- Coordinate and manage all morgue area activities
- Keep area secure and separate from patient treatment areas
- Coordinate with law enforcement and the Medical Examiner's office. Ideally, transition management of the morgue area to one of those entities.
- Maintain accurate records and maintain integrity/privacy of all victim identification/information.

MCI Job Aid

Position: Patient Loading Manager

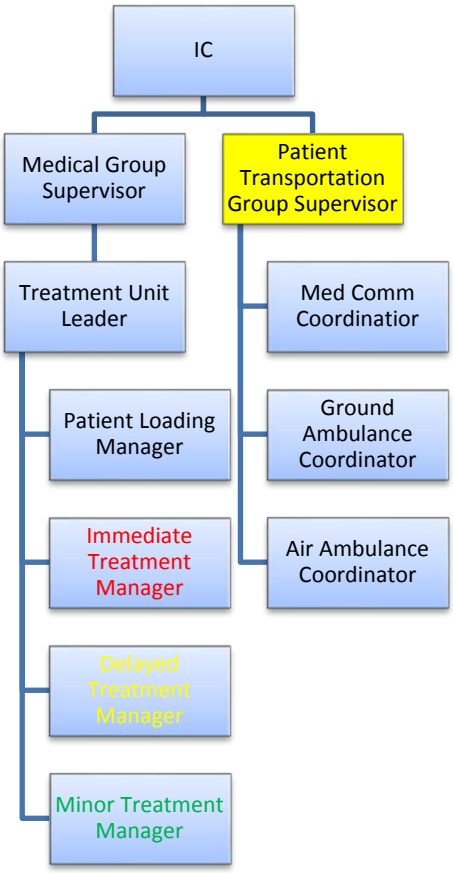


Responsibilities:

- The Patient Loading Manager reports to the Treatment Unit Leader and is responsible for coordinating the transportation of patients out of the treatment area with the Patient Transportation Group Supervisor
- Communicate and coordinate with Immediate, Delayed, and Minor Treatment Area Managers
- Establish communications and coordinate with the Patient Transportation Group Supervisor
- Verify that patients are prioritized for transport
- Coordinate the transport of patients with Medical Communication Coordinator (MEDCOMM) by relaying patient readiness and priority
- Assure appropriate patient tracking
- Coordinate ambulance loading with the Treatment Area Manager(s) and ambulance personnel

MCI Job Aid

Position: Patient Transportation Group Supervisor



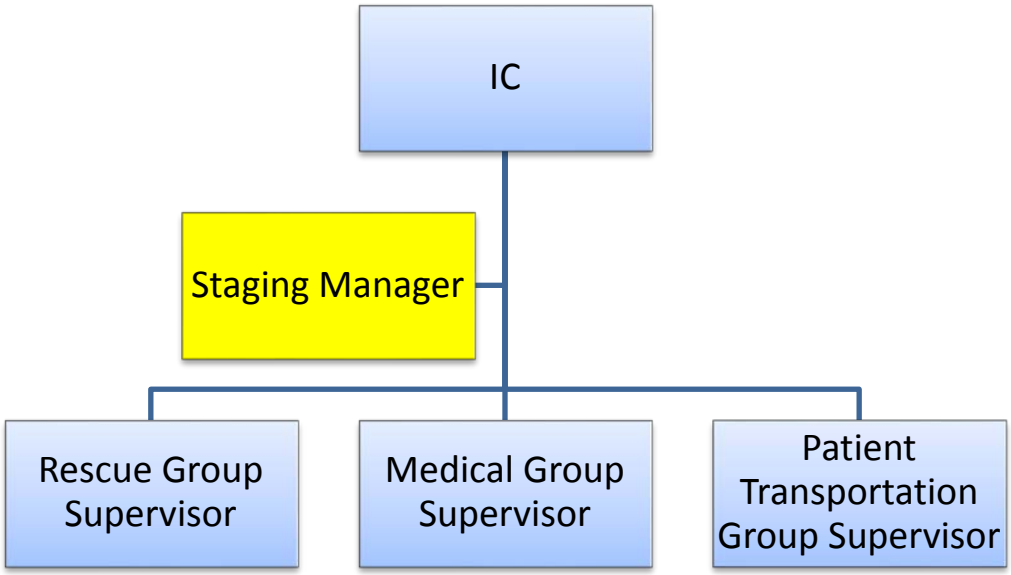
Responsibilities:

Reports to the IC or Operations Section Chief and supervises MEDCOMM as well as the Ground and Air Ambulance Coordinator positions. This is often the first transport paramedic on scene. Responsible for maintaining a wide focus on the incident, as it relates to transporting patients from the incident, to hospitals.

- Ensures MEDCOMM (retain or delegate) has been established and that communications with the base hospital remains efficient and effective.
- Maintain effective communication with IC or Operations Section, as well as the Medical Group Supervisor.
- Ensures that safe and appropriate patient loading area(s) have been established.
- Ensure that ground and air ambulance staging areas/helispots are established.
- Maintain records related to patient transportation and destinations.
- Assign Ground and Air Ambulance Coordinators.
- Utilize Policy 131 Attachments to track patient destinations and unit log.
- Ensures resource and staging needs are communicated effectively through the appropriate chain of command.

MCI Job Aid

Position: Staging Manager

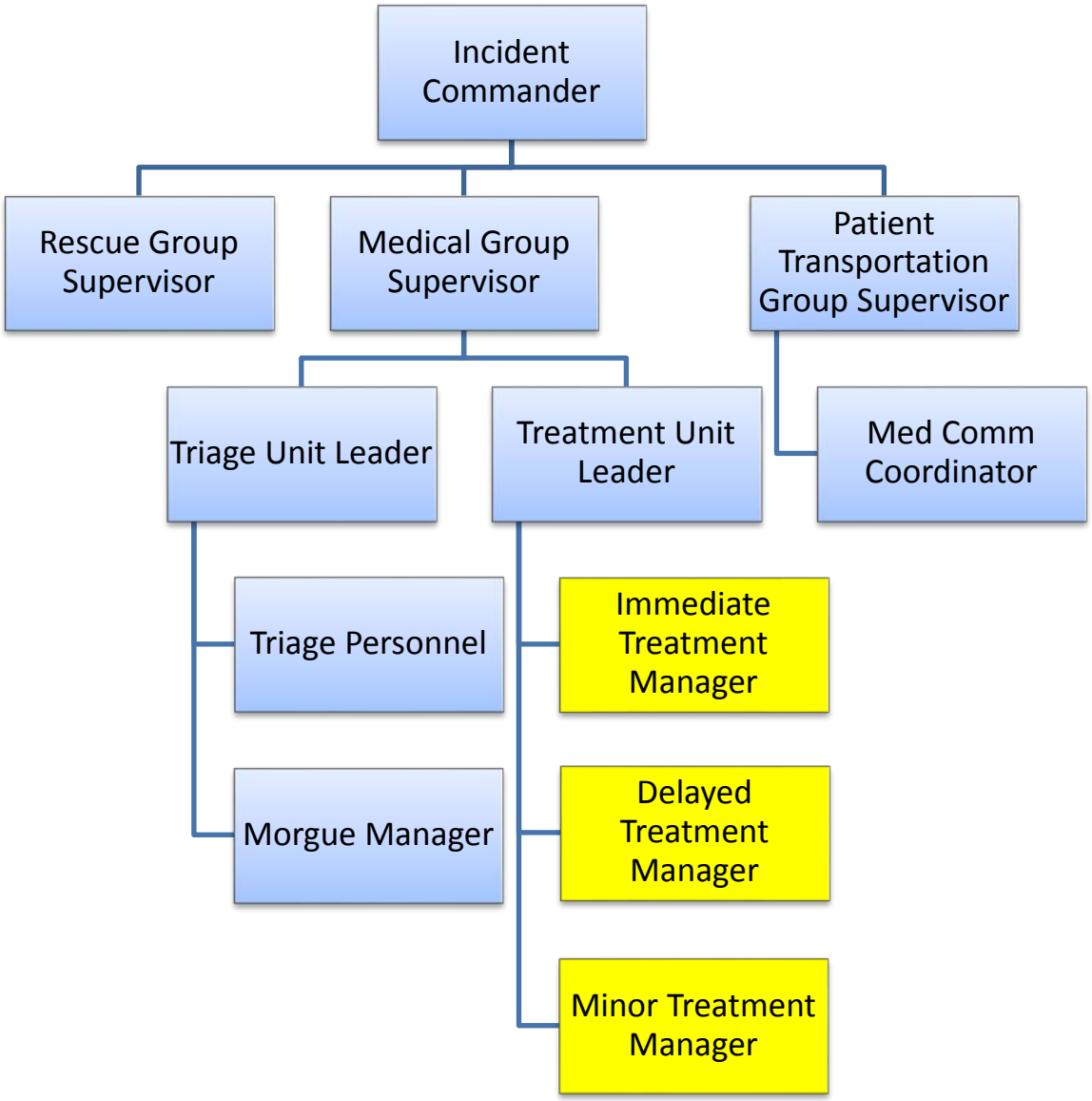


Responsibilities:

- Typically filled on larger incidents (MCI/Level II-III)
- Manages the staging area.
- Communicates with ground ambulance coordinator.
- All personnel should report to staging when arriving at the incident.
- If they are re-assigned to the MCI after transporting a patient, ambulances will return to staging when patient transportation is completed (remain in staging until re-assigned or released).

MCI Job Aid

Position: Treatment Area Managers



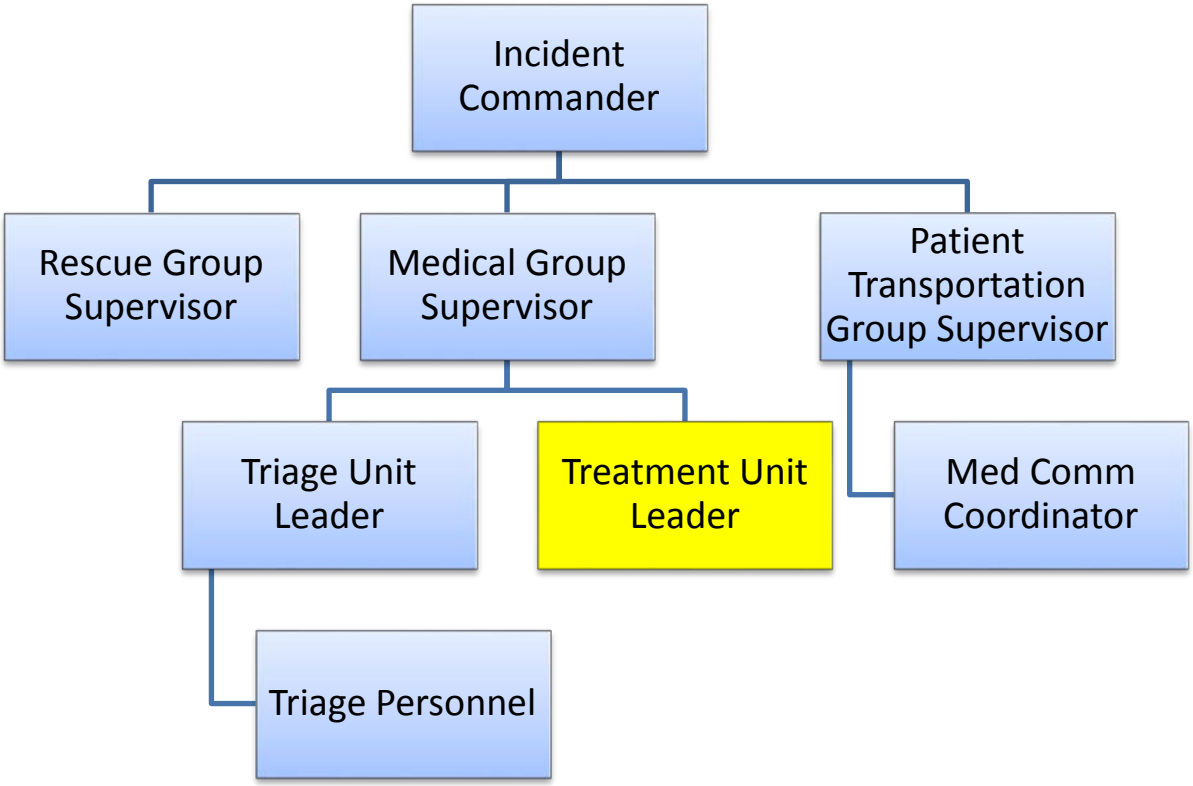
Responsibilities:

- The Treatment Area Managers report to the Treatment Unit Leader and are responsible for the oversight of patient treatment and prioritization of patients assigned to their areas – Immediate, Delayed, and Minor.
- Responsible for requesting and tasking personnel within their given treatment areas.
- Ensure adequate treatment and prioritization of patients in a given treatment area.
- Ensure that personnel within the treatment areas gather and record accurate and detailed patient information and record on the triage tags.
- Minor Treatment Area Manager is responsible for identifying those walking wounded who were initially removed from the triage/hazard area, but who may have potential injuries (sometimes significant).
- **For MCI/Level I – Ensure that patients with traumatic injuries are re-assessed and triaged into the Ventura County Trauma System.**

Note: Minor Treatment Area Manager should coordinate volunteer personnel through Agency reps and the Treatment Unit Leader to assist with care and supervision of the minor category patients.

MCI Job Aid

Position: Treatment Unit Leader

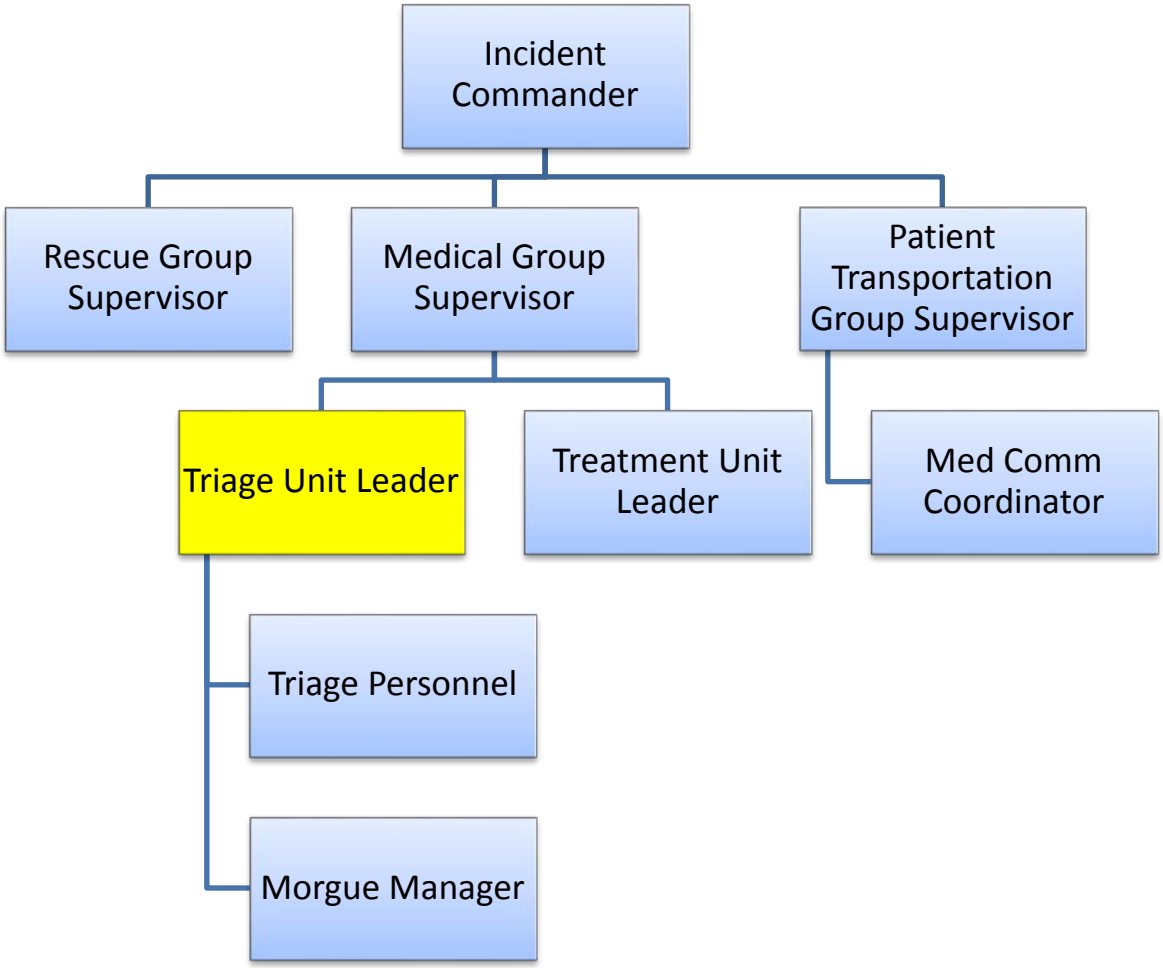


Responsibilities:

- The Treatment Unit Leader assumes responsibility for treatment, preparation for transport, and coordination of patient treatment in the treatment areas and directs movement of patients to loading areas.
- Direct and supervise the Patient Loading Manager as well as the Immediate, Delayed, and Minor Treatment Area Managers.
- Identify a suitable (and safe) area for treatment operations
- Communicate and coordinate the movement of patients from triage to the treatment areas with Triage Unit Leader
- Request additional medical supplies and resources utilizing the proper chain of command
- Establish communication and coordination with the Patient Transportation Group Supervisor
- Direct the movement of patients to the ambulance loading areas
- Retain destination portion of the triage tag (this may be done by the Patient Loading Manager)
- This position can be staffed by fire personnel, and can be an EMT. Ideally, this position will be filled by a fire Captain.

MCI Job Aid

Position: Triage Unit Leader

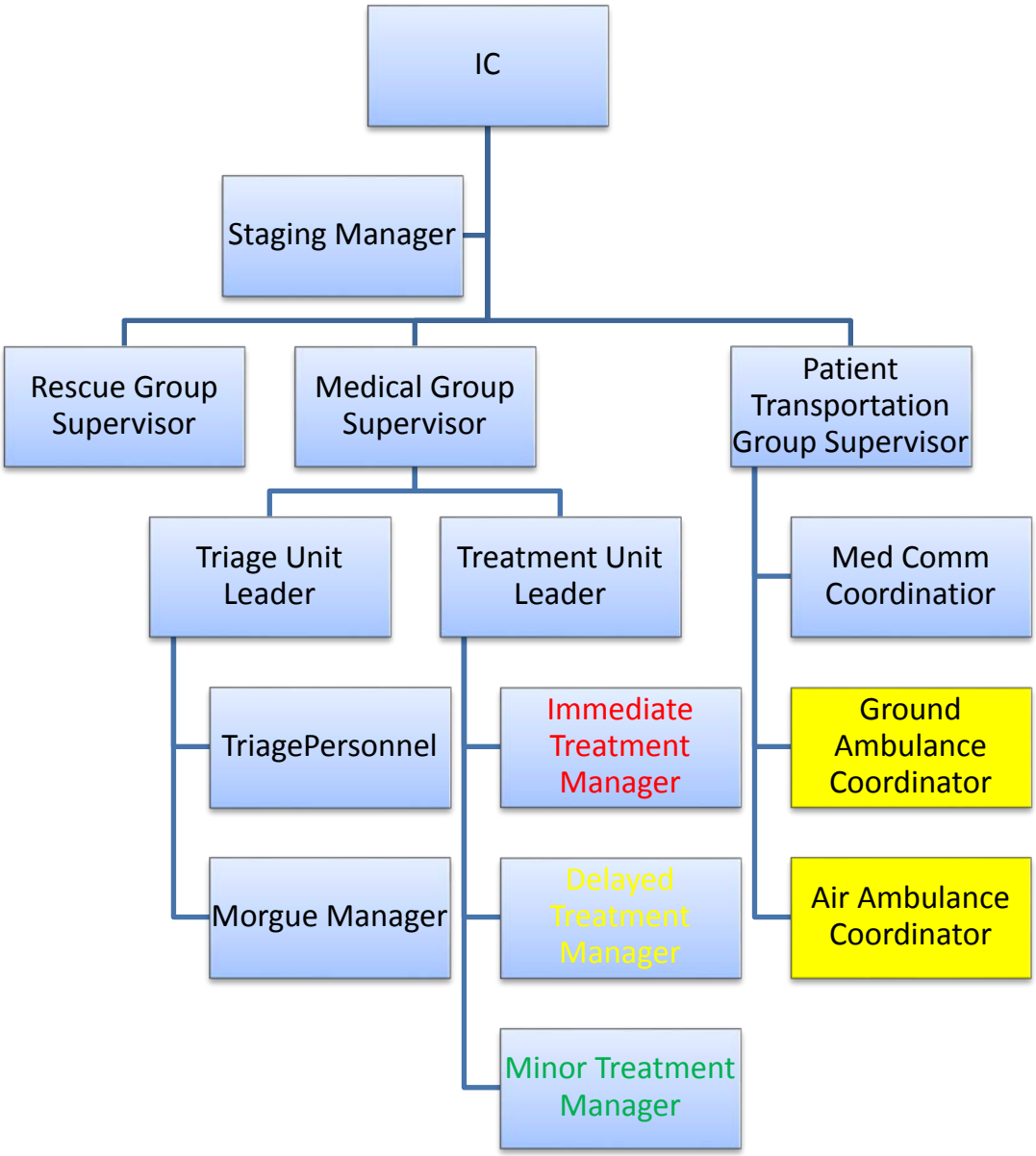


Responsibilities:

- Determine resources required to conduct triage operations
- Communicate resource needs and status reports to the Medical Group Supervisor
- Implement the triage process
- Coordinate movement of patients to appropriate treatment area
- Maintain security and control of the triage area
- Establish a morgue (as needed), an assign a morgue manager

MCI JOB AID

POSITION: AIR/GROUND AMBULANCE COORDINATOR



Responsibilities:

- Maintains effective communications with the Patient Transportation Group Supervisor, MEDCOMM, and Patient Loading Manager. Should also maintain effective communications with the Air Ops Branch (if one is assigned).
- Establish appropriate staging area(s) for ground ambulances and safe helispots for air resources
- Establish safe routes of travel for ambulances to or through the incident
- Request additional transportation resources through the proper chain of command.
- Document resources through VCEMS 310 – Ambulance Staging Area Manager Worksheet.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Mobile Intensive Care Nurse Authorization Challenge	Policy Number 323
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: 06/01/2008
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: 06/01/2008
Origination Date: April 1983 Date Revised: November 8, 2007 Last Reviewed: December 13, 2012 Review Date: November 30, 2014	Effective Date: June 1, 2008

I. PURPOSE: To define the procedure by which a Registered Nurse who is currently authorized as a Mobile Intensive Care Nurse (MICN) in another California County or state may challenge for Ventura County authorization.

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

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

IV. PROCEDURE:

A. VC EMS shall be notified by the Base Hospital of an MICN wishing to challenge Ventura County MICN Authorization procedures. The employer shall submit the following to Ventura County EMS prior to starting challenge procedure:

1. Evidence of the candidate's current out-of-county authorization as an MICN
2. Application (Appendix B)
3. Record of Continuing Education from the previous authorizing agency, and
4. BH recommendation (Appendix A)

B. A currently certified MICN in another California county shall meet the following requirements for Ventura County authorization:

1. Professional experience

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

2. Prehospital care exposure

   The candidate shall be employed in a Ventura County Base Hospital Emergency Department for a minimum of 520 hours (equivalent to three (3) months full time employment) within the previous six calendar months, and have one or more of the following assignments:

   a. Be assigned to clinical duties in an Emergency Department responsible for directing prehospital care. (It is strongly recommended that this requirement be in addition to and not con current with the candidate's six- (6) months' critical care experience. Base Hospital may recommend an MICN candidate whose critical care and/or Emergency Department experience are concurrent based on policies and procedures developed by the Base Hospital), or
   b. Have responsibility for management, coordination, or training for prehospital care personnel, or
   c. Be employed as a staff member of Ventura County Emergency Medical Services.
   d. The internship requirement shall be completed within six (6) months of the initiation of the challenge process.

3. Field observation

   Candidates shall ride with an approved Ventura County EMT-P unit for a minimum of eight (8) hours. A completed Field Observation Form shall be submitted to the VC EMS as verification of completion of the field observation requirement (See Appendix C).

4. Internship

   The candidate shall satisfactorily direct ten (l0) base hospital runs under the supervision of a Mobile Intensive Care Nurse, the Paramedic Care Coordinator, and/or an Emergency Department physician.

   a. The Radio Communication Performance Evaluation Form shall be completed for each response handled by the candidate during the internship phase. (Appendix D.)
   b. Upon successful completion of at least ten (l0) responses, the responses shall be evaluated by the Emergency Department Director or Paramedic Liaison Physician, the Emergency

Department Nursing Supervisor, and the Paramedic Care Coordinator. All Radio Communication Performance Evaluation Forms (Appendix D) and Verification of Internship Completion Form (Appendix E) shall be submitted to Ventura County EMS.

5. Employer recommendation
   a. Mobile Intensive Care Nurse candidates shall have the recommendation of the Emergency Department Medical Director or Paramedic Liaison Physician, Paramedic Care Coordinator and Emergency Department Nurse Supervisor.
   b. Candidates employed by Ventura County Emergency Medical Services shall be recommended by the Emergency Medical Services Medical Director.
6. All recommendations shall be submitted in writing to Ventura County Emergency Medical Services
7. Examination Process
   1. Written Procedure: Candidates shall successfully complete a comprehensive written examination approved by VCEMS.
      a. The examination's overall minimum passing score shall be 80%.
      b. Employers shall be notified within two (2) weeks of the examination if their candidates passed or failed the examination.
      c. Candidate will have only one opportunity to pass the examination

C. After receipt and review of all challenge documents for satisfactory compliance with Ventura County requirements, authorization shall be granted.

D. The expiration date of the authorization card shall be the same date of the out-of-county authorization card.

Policy 323
Appendix A

LETTER OF RECOMMENDATION
AUTHORIZATION CHALLENGE

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

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

_____ Holds a valid California Registered Nurse License.

_____ Is currently authorized as an MICN in another California County or State in the United States.

_____ Has at least 1040 hours of critical care experience.

_____ Has completed the Field Observation Requirement.

_____ Has been employed by _____ in the Emergency Department for at least 520 hours gaining prehospital care exposure.

_____
Emergency Department Medical Director/
Paramedic Liaison Physician

_____
Emergency Department Nursing Supervisor

_____
Prehospital Care Coordinator

Date: _____

Policy 323
Appendix B

AUTHORIZATION APPLICATION, OUT OF COUNTY CHALLENGE

Attach the following:

1. Facsimile of California RN License
2. Facsimile of ACLS Certification
3. Field Observation Verification
4. Letter of Recommendation
5. Facsimile of out of county MICN Authorization
6. Documentation of completion of Internship
7. Record of Continuing Education during current authorization period from currently authorizing county.

_____
MICN Candidate Signature

_____
Prehospital Care Coordinator

Date: _____

POLICY 323
APPENDIX C

FIELD OBSERVATION REPORT

MICN NAME: _____ AUTH. NO.:_____

EMPLOYER: _____ RIDE-ALONG DATE: _____

TIME IN: _____ TIME OUT: _____ TOTAL HOURS: _____

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

ALS PROVIDER: _____

SUMMARY OF FIELD OBSERVATION

_____

_____

_____

_____

_____

_____

_____

_____

EMT-P Signature

EMT-P Signature

MICN Signature

PCC Signature

(Use other side for additional comments)

POLICY 323
APPENDIX D

RADIO COMMUNICATION PERFORMANCE EVALUATION FORM

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

Date	Incident # (and Pt # of Total as needed)	Chief Complaint	Treatment	Evaluator's Comments	Evaluator's Signature	PCC's Comments
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Policy 323
Appendix E

VERIFICATION OF INTERNSHIP COMPLETION

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

Category	Rating	Comments
Understands and operates equipment properly		
Sets correct priorities		
Requests additional information as needed		
Orders are specific, complete and appropriate		
Understands treatment rationale		

NOTE:
In order to qualify for recommendation, a candidate must receive at least a rating of 3 in each category. Ratings are as follows:

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

ATTACH RADIO COMMUNICATION PERFORMANCE EVALUATION FORM

Signatures:

_____
BH Medical Director/Paramedic Liaison Physician

_____
Prehospital Care Coordinator

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMS Personnel Background Check Requirement		Policy Number 332
APPROVED: Administrator:	Steven L. Carroll, EMT-P	Date: June 1, 2011
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: Jun 1, 2011
Origination Date: Date Revised: Date Last Reviewed: Review Date:	July, 1990 May 13, 2004 December 9, 2010 December, 2013	Effective Date: June 1, 2011

I. PURPOSE: To provide a method to ascertain the criminal background history of persons applying for EMT certification/recertification or Paramedic accreditation as EMS Prehospital care personnel in Ventura County.

II. AUTHORITY: California Health and Safety Code, Section 1798.200, California Code of Regulations, Section 100206, et seq. Title 13, California Code of Regulations, Section 1101.

III. POLICY:

A. All applicants for Ventura County EMT certification/recertification or paramedic accreditation shall complete a California Bureau of Criminal Identification, Department of Justice background investigation and Federal Bureau of Identification background check via Live Scan Service as a condition of initial EMT certification, initial EMT recertification in Ventura County, or Ventura County Paramedic accreditation.

C. Ventura County EMS shall contract with the California Bureau of Criminal Identification for subsequent arrest notification.

D. Criteria in Health and Safety Code Section 1798.200 and 13CCR1101 et al shall be used to determine whether certification is given or denied based upon the results of the background check (Refer to Policy 333).

IV. PROCEDURE:

A. All applicants for certification/recertification or accreditation shall contact the Ventura County EMS Office for the fingerprinting procedure.

B. This procedure applies to:

1. All persons applying for initial California EMT certification/ or paramedic accreditation in Ventura County
2. EMT recertification in Ventura County for the first time
3. EMT recertification in Ventura County, after lapse in certification, and the Department of Justice has been notified that subsequent notices are no longer required.