

5090 Public Health Administration Large Conference Room 2240 E. Gonzales, 2 <sup>nd</sup> Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	April 12, 2018 9:30 a.m.
<b>I. Introductions</b>		
<b>II. Approve Agenda</b>		
<b>III. Minutes</b>		
<b>IV. Medical Issues</b>		
A. Other		
<b>V. New Business</b>		
A. 504 - BLS And ALS Unit Equipment and Supplies		Chris Rosa
B. 705 - Treatment Protocols		Chris Rosa
C. 705.02 - Allergic/Adverse Reaction and Anaphylaxis		Chris Rosa
D. 705.03 - Altered Neurologic Function		Chris Rosa
E. 705.17 - Nerve Agent Poisoning		Chris Rosa
F. 705.18 - Overdose/Poisoning		Chris Rosa
G. 705.19 – Pain Control		Adriane Stefansen
H. 705.20 – Seizures		Chris Rosa
I. 705.21 - Shortness of Breath – Pulmonary Edema		Chris Rosa
J. 705.22 - Shortness of Breath – Wheezes/Other		Chris Rosa
K. 705.26 - Suspected Stroke		Chris Rosa
L. 723 - Continuous Positive Airway Pressure (CPAP)		
M. 803 - Emergency Medical Technician (EMT) Automatic External Defibrillation (AED) Service Provider Program Standards		Randy Perez
N. 1601 - Public Safety First Aid (PSFA) and CPR / Tactical Casualty Care Training Program Approval and Checklist		Chris Rosa
<b>VI. Old Business</b>		
A. 603 – Refusal of EMS Services		Dr. Shepherd
<b>VII. Informational/Discussion Topics</b>		
A. 705.07 – Cardiac Arrest, Asystole and PEA		Chris Rosa
B. 705.08 – Cardiac Arrest VF – VT		Chris Rosa
C. 802 - EMT AED Medical Director – Removal		Randy Perez
D. 805 – EMT Medical Cardiac Arrest – Removal		Randy Perez
E. 808 - EMT Defibrillation Integration with Public AED Operation – Removal		Randy Perez
F. 1405 – Policy/Algorithm		Katy Haddock
<b>VIII. Policies for Review</b>		
A. 615 – Organ Donor Information Search		
B. 703 – Medical Control at Scene, Private Physician/Physician on Scene		
<b>IX. Agency Reports</b>		
A. Fire Departments		
B. Ambulance Providers		
C. Base Hospitals		
D. Receiving Hospitals		
E. Law Enforcement		
F. ALS Education Program		
G. EMS Agency		
H. Other		
<b>X. Closing</b>		

Health Administration  
 Large Conference Room  
 2240 E. Gonzales, 2<sup>nd</sup> Floor  
 Oxnard, CA 93036

Pre-hospital Services Committee  
 Minutes

January 11, 2018  
 9:30 a.m.

Topic	Discussion	Action	Approval
<b>II. Approve Agenda</b>		Approved	Motion: Tom O'Conner Seconded: Mike Sanders Passed unanimous
<b>III. Minutes</b>		Approved	Motion: Kathy McShea Seconded: Tom Gallegos Passed unanimous
<b>IV. Medical Issues</b>			
<b>V. New Business</b>			
A. 430 – STEMI Receiving Center (SRC) Standards	Following a lengthy discussion, the committee agreed that a generic statement will replace the Lifepak/Zoll interpretation for "STEMI".	Approved with changes.	Motion: Mike Sanders Seconded: Tom O'Connor Passed unanimous
B. 705.25 – Ventricular Tachycardia Sustained – Not in Arrest		Approved with presented changes.	Motion: Mike Sanders Seconded: Tom O'Connor Passed unanimous
C. 705.28 – Smoke Inhalation	Dr. Chase requested that we change "Administer Oxygen as indicated...." To "Administer high flow oxygen as indicated, or with smoke inhalation and ALOC or if a significant headache is present". He requested it for adult and peds. Correct spelling of Hydroxocobalamin.	Approved with changes.	Motion: Scott Zeller Seconded: Dr. Tilles Passed unanimous
D. 726 – 12 Lead ECG	Replace Lifepak/Zoll with a generic statement referring to policy 430.	Approved with changes.	Motion: Kathy McShea Seconded: Dr. Tilles Passed unanimous
<b>VI. Old Business</b>			
A. 603 – Refusal of EMS Services	Following a lengthy discussion by committee members, the decision was made to have the sub-committee meet again to discuss various concerns with the policy.	Bring back to April PSC with sub-committee recommendations.	

B. 705.09 – Chest Pain		Approved with presented changes.	Motion: Kathy McShea Seconded: Jaime Villa Passed unanimous
C. 724 - Brief Resolved Unexplained Event (BRUE)		Approved with presented changes.	Motion: Scott Zeller Seconded: Dr. Tilles Passed unanimous
<b>VII. Informational/Discussion Topics</b>			
<b>VIII. Policies for Review</b>			
A. 628 – Rescue Task Force Operations	Chris presented the suggested changes to this policy. Most counties have stopped using red ribbons in most counties and designated a new color. We will be changing red to a new color.	Approved with suggested changes.	Motion: Kathy McShea Seconded: Jaime Villa Passed unanimous
B. 705.04 – Behavioral Emergencies	-Minor formatting changes. -Confirm Crisis Team phone number. -Add 5585 for pediatric patients and 5150 for adult patients.	Approved with changes.	Motion: Kathy McShea Seconded: Tom O'Connor Passed unanimous
C. 905 – Ambulance Provider Response Units: Required Frequencies		Tabled	Motion: Scott Zeller Seconded: Dr. Tilles Passed unanimous
<b>X. Agency Reports</b>			
A. Fire departments	<b>VCFPD</b> – Lauri had a baby boy!! Academy starts on Monday with 20 people. Santa Paula will become part of Ventura County Fire on July 1 <sup>st</sup> . <b>VCFD</b> – Currently have 13 open slots. <b>OFD</b> – none <b>Fed. Fire</b> – none <b>SPFD</b> – none <b>FFD</b> – They will get 6 new FF's out of the academy.		
B. Transport Providers	<b>LMT</b> – none <b>AMR/GCA</b> – Starting a new move up plan. They have many new employees and they are hiring 2 new supervisors. <b>AIR RESCUE</b> –none		
C. Base Hospitals	<b>SVH</b> – none <b>LRRMC</b> – none <b>SJRM</b> – 11 nurses participated in the MICN class. <b>VCMC</b> – none		
D. Receiving Hospitals	<b>PVH</b> – none <b>SPH</b> – none		

		<p><b>CMH</b> – They will be given the keys to the new hospital in April.</p> <p><b>OVCH</b> – none</p>	
E.	Law Enforcement	<p><b>VCSO</b> – none</p> <p><b>CSUCI PD</b> – none</p>	
F.	ALS Education Programs	<p><b>Ventura College</b> – 16 new students in June.</p>	
G.	EMS Agency	<p><b>Steve</b> – 3.5 years until new ambulance contracts. Information will be provided as we move forward. Stop the Bleed training has been on going to county personnel, and kits have been mounted in county buildings. EMS Conference will be May 30 and 31<sup>st</sup>. Please go to the EMSAAC website for further information.</p> <p><b>Dr. Shepherd</b> - none</p> <p><b>Chris</b> – Please look at the new EMS App and provide feedback to Chris.</p> <p><b>Katy</b> – Field personnel are doing great with PRESTO. Restock will be given to crews in a kit to make it easier. Katy has extra kits. Katy will send out TORC list to see if anyone needs to be added or deleted.</p> <p><b>Karen</b> – none</p>	
H.	Other		
<b>XI.</b>	<b>Closing</b>	<p><b>Meeting adjourned at 12:00</b></p>	



# TEMPORARY PARKING PASS

Expires April 12, 2018

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.

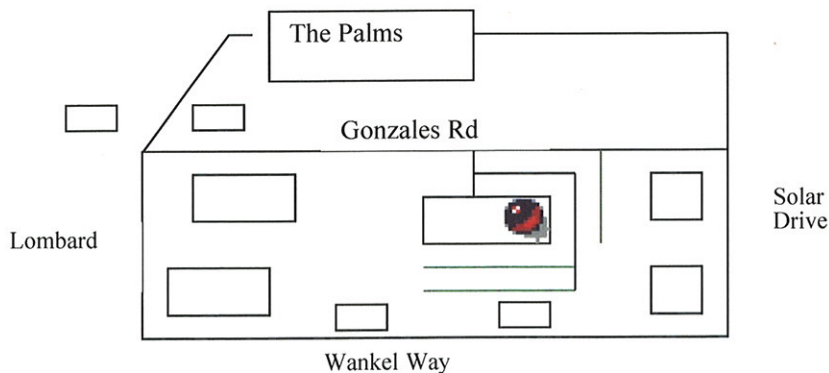
**2100 Solar Drive**

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.**







Policy Title: BLS And ALS Unit Equipment And Supplies		Policy Number: 504
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: <u>DRAFT</u>
APPROVED: Medical Director	Daniel Shepherd, MD	Date: <u>DRAFT</u>
Origination Date:	May 24, 1987	Effective Date: <u>DRAFT</u>
Date Revised:	May 11, 2017	
Last Reviewed:	May 11, 2017	
Review Date:	May, 2020	

- I. PURPOSE: To provide a standardized list of equipment and supplies for response and/or transport units in Ventura County.
- II. POLICY: Each response and/or transport unit in Ventura County shall be equipped and supplied according to the requirements of this policy.
- III. AUTHORITY: California Health and Safety Code Section 1797.178, 1797.204, 1797.218, 1797.221 and California Code of Regulations Sections 100148, 100306, 100404
- IV. PROCEDURE:  
The following equipment and supplies shall be maintained on each response and/or transport unit in Ventura County.

Deviation from the standards outlined in this policy shall only be authorized with written approval from the VCEMS Medical Director.



ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FRALS Minimum Amount	Search and Rescue Minimum Amounts
<b>A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS</b>			
Clear masks in the following sizes:			
1 each	1 each	1 each	1 adult 1 infant
1 each	1 each	1 each	1 adult
3	3	3	3
1 each	1 each	1 each	1 each
1 per size	1 per size	1 per size	1 per size
9	9	9	0
1	1	1	1
1 each size	1 each size	1 each size	1 each size
10 L/min for 20 minutes	10 L/min for 20 mins.	10 L/min for 20 mins.	10 L/min for 20 mins.
1	1	1	1
3	2	2	2
3	2	2	2
2	2	2	2
1	1	1	1
12	12	12	5
6	2	6	4
	0	2	2
1	1	1	1
1	1	1	1
1	1	1	1
1	1	1	1
1	1	1	1
1	1	1	1
1	1	1	1
1	1	1	1
4	4	4	4
4 liters	4 liters	4 liters	4 liters
2	2	2	2
1	1	1	1
1	0	1	1

	ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
Sterile obstetrical kit	1	1	1	1
Tongue depressor	4	4	4	4
Cold packs	4	4	4	4
Tourniquet	1	1	1	1
Nasal Atomizer	2	2	2	2
1ml/3ml syringes with IM needles	4	4	4	4
<b>OPTIONAL EQUIPMENT</b>				
Cyanide Antidote Kit				
Occlusive dressing or chest seal				
Hemostatic gauze per EMSA guidelines				
<b>B. TRANSPORT UNIT REQUIREMENTS</b>				
Ambulance cot and collapsible stretcher, or two stretchers, one of which is collapsible.	1	0	0	1
Automated External Defibrillator (if not equipped with ALS monitor/defibrillator)	1	1	1	1
Straps to secure the patient to the stretcher or ambulance cot, and means of securing the stretcher or ambulance cot in the vehicle.	1 Set	0	0	1 Set
Soft Ankle and wrist restraints.	1	0	0	0
Sheets, pillow cases, blankets and towels for each stretcher or ambulance cot, and two pillows for each ambulance	1	0	0	0
Bedpan	1	0	0	0
Urinal	1	0	0	0
Personal Protective Equipment per State Guideline #216				
Rescue helmet	2	1	0	0
EMS jacket	2	1	0	0
Work goggles	2	1	0	0
Tyvek suit	2 L / 2 XXL	1 L / 1 XXL	0	0
Tychem hooded suit	2 L / 2 XXL	1 L / 1 XXL	0	0
Nitrile gloves	1 Med / 1 XL	1 Med / 1 XL	0	0
Disposable footwear covers	1 Box	1 Box	0	0
Leather work gloves	3 L Sets	1 L Set	0	0
Field operations guide	1	1	0	0

C. ALS TRANSPORT UNIT REQUIREMENTS				
	ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
Cellular telephone	1	1	1	1
Alternate ALS airway device	2	1	1	1
Arm Boards 9" 18"	3 3	0 0	1 1	0 0
Blood glucose determination devices	2	1	1	1
Cardiac monitoring equipment	1	1	1	1
CO <sub>2</sub> monitor	1	1	1	1
Colorimetric CO <sub>2</sub> Detector Device	1	1	1	1
Continuous positive airway pressure (CPAP) device	1	1	1	1
Defibrillator pads or gel	3	3	3	1 adult - No Peds.
Defibrillator w/adult and pediatric paddles/pads	1	1	1	1
EKG Electrodes	10 sets	3 sets	3 sets	6 sets
Endotracheal intubation tubes, sizes 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5 with stylets	1 of each size	1 of each size	1 of each size	4, 5, 6, 6.5, 7, 7.5, 8
EZ-IO intraosseous infusion system	1 Each Size	1 Each Size	1 Each Size	1 Each Size
Intravenous Fluids (in flexible containers)				
• Normal saline solution, 500 ml	2	1	1	1
• Normal saline solution, 1000 ml	6	2	4	3
IV admin set - microdrip	4	1	2	2
IV admin set - macrodrip	4	1	4	3
IV catheter, Sizes 14, 16, 18, 20, 22, 24	6 each 14, 16, 18, 20 3 each 22 3 each 24	2 each	2 each	2 each
Laryngoscope, replacement bulbs and batteries	1 set	1 set	1 set	1 set
Curved blade #2, 3, 4	1 each	1 each	1 each	1 each
Straight blade #1, 2, 3	1 each	1 each	1 each	1 each
Magill forceps Adult Pediatric	1 1	1 1	1 1	1 1
Nebulizer	2	2	2	2
Nebulizer with in-line adapter	1	1	1	1
Needle Thoracostomy kit	2	2	2	2
Pediatric length and weight tape	1	1	1	1
SpO <sub>2</sub> Monitor (if not attached to cardiac monitor)	1	1	1	1
<b>OPTIONAL ALS EQUIPMENT (No minimums apply)</b>				
Flexible intubation stylet				

D. MEDICATION, MINIMUM AMOUNT	BLS Unit Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
Adenosine, 6 mg		3	3	3	3
Albuterol 2.5mg/3ml		6	2	3	1
Aspirin, 81mg		4 ea 81 mg	4 ea 81 mg	4 ea 81 mg	4 ea 81 mg
Amiodarone, 50mg/ml 3ml		6	3	6	3
Atropine sulfate, 1 mg/10 ml		2	2	2	2
Diphenhydramine (Benadryl), 50 mg/ml		2	1	1	2
Calcium chloride, 1000 mg/10 ml		2	1	1	1
Dextrose 5% 50ml		2	1	2	1
Dextrose 10% 250 ml		2	1	2	1
Dextrose 25% 2.5 GM 10ml		1	1	1	1
Dextrose 50%, 25 GM/50		5	2	2	2
<del>Dopamine, 400 mg/250ml-D5W, premixed</del>		2	4	4	2
Epinephrine 1:1-000, 1mg/ml	2	4	2	2	2
Epinephrine 1:10-000, 0.1mg/ml (1 mg/10ml preparation)		6	3	6	4
Epinephrine 1:1-000 1mg/ml, 30 ml multi-dose vial		1	1	1	1
Glucagon, 1 mg/ml		2	1	2	1
Lidocaine, 100 mg/5ml		2	2	2	2
Magnesium sulfate, 1 gm per 2 ml		4	1	2	2
Morphine sulfate, 10 mg/ml		2	2	2	2
Naloxone Hydrochloride (Narcan)	8mg	10 mg	48 mg	48 mg	48mg
Nitroglycerine preparations, 0.4 mg		1 bottle	1 bottle	1 bottle	1 bottle
Normal saline, 10 ml		2	2	2	2
Sodium bicarbonate, 50 mEq/ml		2	1	1	1
Ondansetron 4 mg IV single use vial		4	4	4	4
Ondansetron 4 mg oral		4	4	4	4
Midazolam Hydrochloride (Versed)		5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Treatment Protocols		Policy Number 705	
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: <u>DRAFT</u>	
Origination Date:	January 1988		
Date Revised:	See individual algorithms	Effective Date:	As indicated on individual algorithms
Date Last Revised:	See individual algorithms		
Review Date:	See individual algorithms		

- I. PURPOSE: To provide uniform protocols for prehospital medical control in Ventura County.
- II. AUTHORITY: Health and Safety Code 1797.220 and 1798; California Code of Regulations, Title 22, Division 9, Sections 100063, 100064, and ~~100175~~ 100146.
  - A. DEFINITIONS:
    1. Unless otherwise specified in an individual treatment protocol or policy, the following definitions shall apply:
      - a. Adult: Age 12 or greater (12<sup>th</sup> birthday and older)
      - b. Pediatric: Age less than 12 (up to 12<sup>th</sup> birthday)
  - B. Exceptions to the pediatric definition rule are in the following policies:
    1. Policy 606: Withholding or Termination of Resuscitation and Determination of Death
    2. Policy 710: Airway Management
    3. Policy 717: Intraosseous Infusion
    - ~~4. Policy 805: Emergency Medical Technician (EMT) Medical Cardiac Arrest~~
  - C. Cardiac Monitor/12 Lead EKG
    1. When cardiac monitoring or a 12 Lead ECG is performed, copies of rhythms strips and 12 Lead ECGs shall be submitted to the ALS Provider(s), Base Hospital, and Receiving Hospital.
- IV. POLICY: Treatment protocols shall be used as a basis for medical direction and control for prehospital use. Effective July 1, 2018 BLS personnel are authorized to administer the following medications and/or perform the following procedures for certain conditions as outlined below. BLS personnel shall not administer these medications and/or perform these procedures until all required training has been completed, and all necessary

equipment has been distributed. Training and equipment deployment shall be completed by all agencies no later than July 1, 2019.

A. Epinephrine for anaphylaxis or severe respiratory distress as a result of asthma.

B. Naloxone for suspected opioid overdose

C. DuoDote Auto-Injector (Pralidoxime Chloride and Atropine Sulfate) for suspected nerve agent or organophosphate exposure.

D. Determination of blood glucose level for altered neurological function and/or for suspected stroke

A.E. Continuous Positive Airway Pressure (CPAP) for shortness of breath.

V. PROCEDURE: See the following pages for specific conditions.

## Contents

- 00 - General Patient Assessment
- 01 - Trauma Assessment/Treatment Guidelines
- 02 - Allergic/Adverse Reaction and Anaphylaxis
- 03 - Altered Neurological Function
- 04 - Behavioral Emergencies
- 05 - Bites and Stings
- 06 - Burns
- 07 - Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA)
- 08 - Cardiac Arrest – VF/VT
- 09 - Chest Pain – Acute Coronary Syndrome
- 10 - Childbirth
- 11 - Crush Injury/Syndrome
- 12 - Heat Emergencies
- 13 - Hypothermia
- 14 – Hypovolemic/Septic Shock
- 15 - Nausea/Vomiting
- 16 - Neonatal Resuscitation
- 17 - Nerve Agent
- 18 - Overdose/Poisoning
- 19 - Pain Control
- 20 - Seizures
- 21 - Shortness of Breath – Pulmonary Edema
- 22 - Shortness of Breath – Wheezes/Other
- 23 - Supraventricular Tachycardia
- 24 - Symptomatic Bradycardia
- 25 - Ventricular Tachycardia – Not in Arrest
- 26 – Suspected Stroke
- 27 – Sepsis Alert
- 28 – Smoke Inhalation



<b>Allergic/Adverse Reaction and Anaphylaxis</b>	
<b>ADULT</b>	<b>PEDIATRIC</b>
<b>BLS Procedures</b>	
<p><u>Administer oxygen as indicated</u></p> <p><u>Epinephrine 1mg/ml</u></p> <ul style="list-style-type: none"> <li>• IM – 0.3mg via Epi-Pen, pre-filled syringe, or syringe/vial draw               <ul style="list-style-type: none"> <li>○ repeat x 1 as needed</li> </ul> </li> </ul> <p>Assist with prescribed <b>Epi-Pen</b></p> <p><u>Administer oxygen as indicated</u></p>	<p><u>Administer oxygen as indicated</u></p> <p><u>Epinephrine 1mg/ml</u></p> <ul style="list-style-type: none"> <li>• IM – 0.15mg, via Epi-Pen jr., pre-filled syringe, or syringe/vial draw               <ul style="list-style-type: none"> <li>○ Repeat x 1 as needed</li> </ul> </li> </ul> <p>Assist with prescribed <b>Epi-Pen Jr.</b></p> <p><u>Administer oxygen as indicated</u></p>
<b>ALS Prior to Base Hospital Contact</b>	
<p><u>Allergic Reaction, Anaphylaxis, or Dystonic Reaction</u></p> <ul style="list-style-type: none"> <li>• <b>Benadryl</b> <ul style="list-style-type: none"> <li>○ IV/IM – 50 mg</li> </ul> </li> <li>• <b>Albuterol (if wheezing is present)</b> <ul style="list-style-type: none"> <li>○ Nebulizer – 5 mg/6 mL               <ul style="list-style-type: none"> <li>▪ Repeat as needed</li> </ul> </li> </ul> </li> </ul> <p><u>IV/IO Bolus – 1 Liter for hypotension, consider need for second IV</u></p> <p><u>Allergic Reaction or Dystonic Reaction</u></p> <ul style="list-style-type: none"> <li>• <b>Benadryl</b> <ul style="list-style-type: none"> <li>○ IV/IM – 50 mg</li> </ul> </li> </ul> <p><u>If Wheezing is present</u></p> <ul style="list-style-type: none"> <li>• <b>Albuterol</b> <ul style="list-style-type: none"> <li>○ Nebulizer – 5 mg/6 mL               <ul style="list-style-type: none"> <li>▪ Repeat as needed</li> </ul> </li> </ul> </li> </ul> <p><u>Anaphylaxis without Shock, if not already administered by BLS personnel</u></p> <ul style="list-style-type: none"> <li>• <b>Epinephrine 1:1,000</b> <ul style="list-style-type: none"> <li>○ IM –               <ul style="list-style-type: none"> <li>▪ Less than 40 years old – 0.5 mg</li> <li>▪ 40 years old and greater – 0.3 mg                   <ul style="list-style-type: none"> <li>○ Only if severe respiratory distress is present</li> </ul> </li> </ul> </li> <li>• IV/IO access</li> <li>• <b>Benadryl</b> <ul style="list-style-type: none"> <li>○ IV/IO/IM – 50 mg</li> </ul> </li> </ul> <p><u>Anaphylaxis with Shock</u></p> <ul style="list-style-type: none"> <li>• Treatment as above for Anaphylaxis without Shock</li> <li>• Initiate 2<sup>nd</sup> IV/IO</li> <li>• <b>Normal Saline</b> <ul style="list-style-type: none"> <li>○ IV/IO bolus – 1 Liter</li> </ul> </li> </ul> <p><u>For Profound Shock</u></p> <ul style="list-style-type: none"> <li>• <b>Epinephrine 1:10,000 0.1mg/ml</b> <ul style="list-style-type: none"> <li>○ Slow IV/IO P – 0.1 mg (1 mL) increments               <ul style="list-style-type: none"> <li>• Max 0.3 mg (3 mL) over 1-2 min</li> </ul> </li> </ul> </li> </ul> </li></ul>	<p><u>Allergic Reaction, Anaphylaxis, or Dystonic Reaction</u></p> <ul style="list-style-type: none"> <li>• <b>Benadryl</b> <ul style="list-style-type: none"> <li>○ IV/IM – 1 mg/kg               <ul style="list-style-type: none"> <li>• Max 50 mg</li> </ul> </li> </ul> </li> <li>• <b>Albuterol (if wheezing is present)</b> <ul style="list-style-type: none"> <li>○ Less than 2 years old               <ul style="list-style-type: none"> <li>• Nebulizer – 2.5 mg/3 mL                   <ul style="list-style-type: none"> <li>○ Repeat as needed</li> </ul> </li> </ul> </li> <li>○ 2 years old and greater               <ul style="list-style-type: none"> <li>• Nebulizer – 5 mg/6 mL                   <ul style="list-style-type: none"> <li>○ Repeat as needed</li> </ul> </li> </ul> </li> </ul> </li> </ul> <p><u>Anaphylaxis without Shock</u></p> <ul style="list-style-type: none"> <li>• <b>Epinephrine 1:1,000 1mg/ml, if not already administered by BLS personnel</b> <ul style="list-style-type: none"> <li>○ IM – 0.01 mg/kg</li> <li>○ <b>Max 0.3 mg, Max 0.15mg X 2</b> <ul style="list-style-type: none"> <li>• Max 0.3 mg</li> </ul> </li> </ul> </li> <li>• <u>IV access</u></li> <li>• <b>Benadryl</b> <ul style="list-style-type: none"> <li>○ IV/IM – 1 mg/kg               <ul style="list-style-type: none"> <li>• Max 50 mg</li> </ul> </li> </ul> </li> </ul> <p><u>Anaphylaxis with Shock</u></p> <ul style="list-style-type: none"> <li>• Treatment as above for Anaphylaxis without Shock</li> <li>• Initiate 2<sup>nd</sup> IV if possible or establish IO</li> <li>• <b>Normal Saline</b> <ul style="list-style-type: none"> <li>○ IV/IO bolus – 20 mL/kg</li> </ul> </li> </ul> <p><u>For Profound Shock</u></p> <ul style="list-style-type: none"> <li>• <b>Epinephrine 1:10,000 0.1mg/ml</b> <ul style="list-style-type: none"> <li>○ Slow IVP – 0.01 mg/kg (0.1 mL/kg) increments               <ul style="list-style-type: none"> <li>• Max 0.3 mg (3 mL) over 1-2 min</li> </ul> </li> </ul> </li> </ul>
<b>Communication Failure Protocol</b>	
<p><u>Anaphylaxis without Shock</u></p> <ul style="list-style-type: none"> <li>• <b>Repeat Epinephrine 1:1,000 1mg/ml</b> <ul style="list-style-type: none"> <li>○ IM – 0.3 mg q 5 min x 2 as needed</li> </ul> </li> </ul> <p><u>Anaphylaxis with Shock</u></p> <ul style="list-style-type: none"> <li>• For continued shock</li> </ul>	<p><u>Anaphylaxis without Shock</u></p> <ul style="list-style-type: none"> <li>• <b>Repeat Epinephrine 1:1,000 1mg/ml</b> <ul style="list-style-type: none"> <li>○ IM – 0.01 mg/kg q 5 min x 2 as needed</li> </ul> </li> </ul> <p><u>Anaphylaxis with Shock</u></p> <ul style="list-style-type: none"> <li>• For continued shock</li> </ul>

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<ul style="list-style-type: none"> <li>○ Repeat <b>Normal Saline</b> <ul style="list-style-type: none"> <li>● IV bolus – 1 Liter</li> </ul> </li> <li>○ Repeat <b>Epinephrine 1:1,000 1mg/ml</b> <ul style="list-style-type: none"> <li>● IM – 0.3 mg q 5 min x 2 as needed</li> </ul> </li> </ul> <p>For Profound Shock</p> <ul style="list-style-type: none"> <li>● <b>Epinephrine 1:10,000 0.1mg/ml</b> <ul style="list-style-type: none"> <li>○ Slow IVP – 0.1 mg (1 mL) increments</li> <li>● Max 0.3 mg (3 mL) over 1-2 min</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>○ Repeat <b>Normal Saline</b> <ul style="list-style-type: none"> <li>● IV/IO bolus – 20 mL/kg</li> </ul> </li> <li>○ Repeat <b>Epinephrine 1:1,000 1mg/ml</b> <ul style="list-style-type: none"> <li>● IM – 0.01 mg/kg q 5 min x 2 as needed</li> </ul> </li> </ul> <p>For Profound Shock</p> <ul style="list-style-type: none"> <li>● <b>Epinephrine 1:10,000 0.1mg/ml</b> <ul style="list-style-type: none"> <li>○ Slow IVP – 0.01 mg/kg (0.1 mL/kg)</li> <li>● Max 0.3 mg (3 mL) over 1-2 min</li> </ul> </li> </ul>
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures
<p><a href="#">Additional Information</a></p> <ul style="list-style-type: none"> <li>● <a href="#">In the event Epinephrine is administered by BLS personnel, ALS personnel will assume care of the patient as soon as possible and continue care at an ALS level, in accordance with VCEMS Policies and Procedures.</a></li> </ul>	

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<b>Altered Neurologic Function</b>	
<b>ADULT</b>	<b>PEDIATRIC</b>
<b>BLS Procedures</b>	
<p>If suspected stroke, refer to VC EMS Policy 705.26 – Suspected Stroke</p> <p>Administer oxygen as indicated</p> <p><u>Determine Blood Glucose level, if &lt;60 give oral glucose PO – 15gm BLS or as indicated below for ALS</u> <u>If low blood sugar suspected</u></p> <ul style="list-style-type: none"> <li>• <b>Oral Glucose</b></li> <li>○ PO – 15 gm</li> </ul>	<p>If suspected stroke, refer to VC EMS Policy 705.26 – Suspected Stroke</p> <p>Administer oxygen as indicated</p> <p><u>Determine Blood Glucose level, if &lt;60 give oral glucose PO – 15gm BLS or as indicated below for ALS</u> <u>If low blood sugar suspected</u></p> <ul style="list-style-type: none"> <li>• <b>Oral Glucose</b></li> <li>○ PO – 15 gm</li> </ul>
<b>ALS Prior to Base Hospital Contact</b>	
<p>IV/<u>IO</u> Access Determine Blood Glucose level, <u>if not already performed by BLS personnel</u></p> <p><u>If &lt;60</u></p> <ul style="list-style-type: none"> <li>• <b>D10W - Preferred</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u>PB-100mL (10gm)-Rapid Infusion</li> </ul> </li> <li>• <b>D5W</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u>PB-200mL (10gm)-Rapid Infusion</li> </ul> </li> <li>• <b>D50W</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u> – 25mL (12.5gm)</li> </ul> </li> <li>• <b>Glucagon</b> (If no IV access) <ul style="list-style-type: none"> <li>○ IM – 1mg</li> </ul> </li> </ul> <p>Recheck Blood Glucose level 5 min after D10W, D5W D50, or 10 min after Glucagon administration</p> <p><u>If still &lt; 60</u></p> <ul style="list-style-type: none"> <li>• <b>D10W - Preferred</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u>PB-150ml (15gm)-Rapid Infusion</li> </ul> </li> <li>• <b>D5W</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u>PB-250mL(12.5gm)- Rapid Infusion</li> </ul> </li> <li>• <b>D50W</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u> – 25mL (12.5gm)</li> </ul> </li> </ul> <p><i>* Treat as above if you have clinical suspicion of hypoglycemia and are unable to obtain glucose level due to glucometer malfunction or error reading.</i></p>	<p><u>Consider IV/<u>IO</u> Access</u> <u>Determine Blood Glucose Level</u> <u>Determine Blood Glucose level, if not already performed by BLS personnel</u></p> <p><u>If &lt;60</u></p> <ul style="list-style-type: none"> <li>• All Pediatric Patients</li> <li>• <b>D10W - Preferred</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u>PB-5ml/kg-Rapid Infusion</li> <li>○ Max 100mL</li> </ul> </li> <li>• <b>D5W</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u>PB-10mL/kg-Rapid Infusion</li> <li>○ Max 200mL</li> </ul> </li> <li>• Less than 2 years old</li> <li>• <b>D25W</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u> – 2mL/kg</li> </ul> </li> <li>• 2 years old and greater</li> <li>• <b>D50W</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u> – 1mL/kg</li> </ul> </li> <li>• All Pediatric Patients</li> <li>• <b>Glucagon</b> (If no IV/<u>IO</u> access) <ul style="list-style-type: none"> <li>○ IM – 0.1mL/kg</li> <li>○ Max 1 mg</li> </ul> </li> </ul> <p>Recheck Blood Glucose level 5 min after D25, D50, D10W, D5W or 10 min after Glucagon administration</p> <p><u>If still &lt;60</u></p> <p>All Pediatric Patients</p> <ul style="list-style-type: none"> <li>• <b>D10W - Preferred</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u>PB-7.5mL/kg-Rapid Infusion</li> <li>○ Max 150mL</li> </ul> </li> <li>• <b>D5W</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u>PB-15mL/kg-Rapid Infusion</li> <li>○ Max 250mL</li> </ul> </li> </ul> <p>Less than 2 years old</p> <ul style="list-style-type: none"> <li>• <b>D25</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u> – 2mL/kg</li> </ul> </li> </ul> <p>2 years old and greater</p> <ul style="list-style-type: none"> <li>• <b>D50W</b> <ul style="list-style-type: none"> <li>○ IV/<u>IO</u> – 1mL/kg</li> </ul> </li> </ul> <p><i>* Treat as above if you have clinical suspicion of hypoglycemia and are unable to obtain glucose level due to glucometer malfunction or error reading.</i></p>
<b>Base Hospital Orders only</b>	
<p>Additional Information:</p> <ul style="list-style-type: none"> <li>• <u>Certain oral hypoglycemic agents (e.g. - sulfonylureas) and long-acting insulin preparations have a long duration of action, sometimes up to 72 hours. Patients on these medications who would like to decline transport MUST be warned about the risk of repeat hypoglycemia for up to 3 days, which can occur during sleep and result in the patient's death. If the patient continues to decline further care, every effort must be made to have the patient speak to the ED Physician prior to leaving the scene.</u></li> <li>• <u>Hypoglycemic patients with a history of diabetes, who are fully alert and oriented following determination of blood glucose level and a single administration of 15gm Oral Glucose, may be treated as a BLS call.</u></li> </ul>	

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- [Oral Glucose – patient must be awake and able to swallow with a gag reflex intact.](#)
- If patient has an ALOC and Blood Glucose level is >60 mg/DL, consider alternate causes:

**A - Alcohol**

**O - Overdose**

**I - Infection**

**E - Epilepsy**

**U - Uremia**

**P - Psychiatric**

**I - Insulin**

**T - Trauma**

**S – Stroke**

<b>Nerve Agent Poisoning</b>	
The Incident Commander is in charge of the scene and you are to follow his/her direction for entering and exiting the scene. Patients in the hot and warm zones MUST be decontaminated prior to entering the cold zone.	
ADULT	PEDIATRIC
BLS Procedures	
<p><i>Patient's that are exhibiting obvious signs of exposure (SLUDGEM) of Organophosphate exposure and/or Nerve Agents</i></p> <p>Maintain airway and position of comfort</p> <p>Administer oxygen as indicated</p> <ul style="list-style-type: none"> <li>• <b>Mark I or DuoDote Antidote Kit</b> <ul style="list-style-type: none"> <li>○ Mild Exposure: IM x 1</li> <li>○ Moderate Exposure: IM x1                             <ul style="list-style-type: none"> <li>• May repeat in 10 minutes if symptoms persist</li> </ul> </li> <li>○ Severe Exposure: IM x 3 in rapid succession, rotating injection sites</li> </ul> </li> </ul> <p><u>DuoDote for self or other rescuers</u></p>	<p><i>Patient's that are exhibiting obvious signs of exposure (SLUDGEM) of Organophosphate exposure and/or Nerve Agents</i></p> <p>Maintain airway and position of comfort</p> <p>Administer oxygen as indicated</p> <ul style="list-style-type: none"> <li>• <b>Mark I or DuoDote Antidote Kit</b> <ul style="list-style-type: none"> <li>○ Mild Exposure: IM x 1</li> <li>○ Moderate Exposure: IM x1                             <ul style="list-style-type: none"> <li>• May repeat in 10 minutes if symptoms persist</li> </ul> </li> <li>○ Severe Exposure: IM x 3 in rapid succession, rotating injection sites</li> </ul> </li> </ul>
ALS Prior to Base Hospital Contact	
<p><i>Patient's that are exhibiting obvious signs of exposure (SLUDGEM) of Organophosphate exposure and/or Nerve Agents</i> <i>If not <u>already administered by BLS personnel:</u></i></p> <ul style="list-style-type: none"> <li>• <b>Mark I or DuoDote Antidote Kit</b> <ul style="list-style-type: none"> <li>○ Mild Exposure: IM x 1</li> <li>○ Moderate Exposure: IM x1                             <ul style="list-style-type: none"> <li>• May repeat in 10 minutes if symptoms persist</li> </ul> </li> <li>○ Severe Exposure: IM x 3 in rapid succession, rotating injection sites</li> </ul> </li> </ul> <p>Mild Exposure: <del>Mark I or DuoDote Antidote Kit IM X-1</del></p> <p>Moderate Exposure: <del>Mark I or DuoDote Antidote Kit IM X-1</del> • May repeat in 10 minutes if symptoms persist</p> <p>Severe Exposure: <del>Mark I or DuoDote Antidote Kit IM X-3</del> in rapid succession, rotating injection sites.</p> <p><u>For seizures:</u></p> <ul style="list-style-type: none"> <li>• Midazolam             <ul style="list-style-type: none"> <li>○ IV/IO – 2 mg                 <ul style="list-style-type: none"> <li>• Repeat 1 mg q 2 min as needed</li> <li>• Max 5 mg</li> </ul> </li> <li>○ IM – 0.1 mg/kg                 <ul style="list-style-type: none"> <li>• Max 5 mg</li> </ul> </li> </ul> </li> </ul>	<p><i>Patient's that are exhibiting obvious signs of exposure (SLUDGEM) of Organophosphate exposure and/or Nerve Agents</i> <i>If not <u>already administered by BLS personnel:</u></i></p> <ul style="list-style-type: none"> <li>• <b>Mark I or DuoDote Antidote Kit</b> <ul style="list-style-type: none"> <li>○ Mild Exposure: IM x 1</li> <li>○ Moderate Exposure: IM x1                             <ul style="list-style-type: none"> <li>• May repeat in 10 minutes if symptoms persist</li> </ul> </li> <li>○ Severe Exposure: IM x 3 in rapid succession, rotating injection sites</li> </ul> </li> </ul> <p><del>Mark I or DuoDote Antidote Kit IM x-1</del> ○ May repeat x 1 in 10 minutes for patients greater than 40kg if symptoms persist</p> <p><u>For seizures:</u></p> <ul style="list-style-type: none"> <li>• Midazolam             <ul style="list-style-type: none"> <li>○ IM – 0.1 mg/kg                 <ul style="list-style-type: none"> <li>• Max 5 mg</li> </ul> </li> </ul> </li> </ul>
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures
<ul style="list-style-type: none"> <li>• Refer to VCEMS Policy 705.18-Overdose/Poisoning for organophosphate poisoning treatment guidelines.</li> <li>• DuoDote contains 2.1mg Atropine Sulfate and 600mg Pralidoxime Chloride.</li> <li>• <del>EMTs may administer DuoDote to themselves and other responders</del></li> <li>• Paramedics may administer DuoDote to themselves or other responders and to exposed, symptomatic public.</li> <li>• <b>Diazepam</b> is available in the CHEMPACK and may be deployed in the event of a nerve agent exposure. Paramedics may administer diazepam using the following dosages for the treatment of seizures:</li> </ul>	

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Effective Date: **DRAFT**  
Next Review Date: April 2019

Date Revised: April 13, 2017  
Last Reviewed: April 13, 2017

VCEMS Medical Director

- **Adult:** 5 mg IM/IV/IO q 10 min titrated to effect (*max 30 mg*)
- **Pediatric:** 0.1 mg/kg IV/IM/IO (max initial dose 5 mg) over 2-3 min q 10 min titrated to effect (*max total dose 10 mg*)
- Mild exposure with symptoms:
  - Miosis, rhinorrhea, drooling, sweating, blurred vision, nausea, bradypnea or tachypnea, nervousness, fatigue, minor memory disturbances, irritability, unexplained tearing, wheezing, tachycardia, bradycardia
- Moderate exposure with symptoms:
  - Miosis, rhinorrhea, SOB, wheezing, secretions, soft muscle weakness and fasciculations, GI effects
- Severe exposure with symptoms:
  - Strange confused behavior, severe difficulty breathing, twitching, unconsciousness, seizing, flaccid, apnea, pinpoint pupils, involuntary defecation, urination

<b>Overdose/Poisoning</b>	
<b>ADULT</b>	<b>PEDIATRIC</b>
<b>BLS Procedures</b>	
<p>Decontaminate if indicated and appropriate Administer oxygen as indicated</p> <p><u>Suspected opiate overdose with respirations less than 12/min and significant ALOC:</u></p> <ul style="list-style-type: none"> <li>• <b>Narcan</b> <ul style="list-style-type: none"> <li>○ IM – 2 mg, may repeat X 2, Max of 6mg</li> <li>○ IN – 4mg, may repeat X 2, Max of 12mg</li> <li>○ Maintain respirations greater than 12/min</li> </ul> </li> </ul> <p><u>Organophosphate Poisoning</u></p> <ul style="list-style-type: none"> <li>• <b>Mark I or DuoDote Antidote Kit</b> <ul style="list-style-type: none"> <li>○ Mild Exposure: IM x 1</li> <li>○ Moderate Exposure: IM x1                             <ul style="list-style-type: none"> <li>• May repeat in 10 minutes if symptoms persist</li> </ul> </li> <li>○ Severe Exposure: IM x 3 in rapid succession, rotating injection sites</li> </ul> </li> </ul>	<p>Decontaminate if indicated and appropriate Administer oxygen as indicated</p> <p><u>Organophosphate Poisoning</u></p> <ul style="list-style-type: none"> <li>• <u>Less than 41kg</u> <ul style="list-style-type: none"> <li>○ <b>Mark I or DuoDote Antidote Kit x1</b> <ul style="list-style-type: none"> <li>• May repeat x1 in 10 minutes if symptoms persist</li> </ul> </li> </ul> </li> <li>• <u>Greater than or equal to 41kg</u> <ul style="list-style-type: none"> <li>○ Mild Exposure: IM x 1</li> <li>○ Moderate Exposure: IM x1                             <ul style="list-style-type: none"> <li>• May repeat in 10 minutes if symptoms persist</li> </ul> </li> <li>○ Severe Exposure: IM x 3 in rapid succession, rotating injection sites</li> </ul> </li> </ul>
<b>ALS Prior to Base Hospital Contact</b>	
<p>IV/IO access (IO per Policy 717)</p> <p><u>May repeat/continue Narcan as needed to maintain respirations greater than 12/min</u></p> <p>Suspected opiate overdose with respirations less than 12/min and significant ALOC:</p> <ul style="list-style-type: none"> <li>• <b>Narcan</b> <ul style="list-style-type: none"> <li>○ IM – 2 mg, may repeat x2, Max of 6mg</li> <li>○ IV/IO – 0.4 mg q 1min                             <ul style="list-style-type: none"> <li>• Initial max 2 mg</li> <li>• IN – 4mg, may repeat x2, Max of 12mg</li> </ul> </li> <li>○ May repeat as needed to maintain respirations greater than 12/min</li> </ul> </li> </ul> <p>Organophosphate Poisoning</p> <ul style="list-style-type: none"> <li>• <b>Mark I or DuoDote Antidote Kit, if not already administered by BLS personnel</b> <ul style="list-style-type: none"> <li>○ Mild Exposure: IM x 1</li> <li>○ Moderate Exposure: IM x1                             <ul style="list-style-type: none"> <li>• May repeat in 10 minutes if symptoms persist</li> </ul> </li> <li>○ Severe Exposure: IM x 3 in rapid succession, rotating injection sites</li> </ul> </li> </ul>	<p>IV/IO access (IO per Policy 717)</p> <p>Suspected opiate overdose with respirations less than 12/min:</p> <ul style="list-style-type: none"> <li>• <b>Narcan, if not already administered by BLS personnel</b> <ul style="list-style-type: none"> <li>○ IV/IM/IO/IN – 0.1 mg/kg                             <ul style="list-style-type: none"> <li>• Initial max 2 mg</li> </ul> </li> <li>○ May repeat as needed to maintain respirations greater than 12/min</li> </ul> </li> </ul> <p>Organophosphate Poisoning</p> <ul style="list-style-type: none"> <li>• <b>Mark I or DuoDote Antidote Kit x 1, if not already administered by BLS personnel</b> <ul style="list-style-type: none"> <li>○ May repeat x 1 in 10 minutes for patients greater than 40kg if symptoms persist</li> </ul> </li> </ul>
<b>Base Hospital Orders only</b>	
<p>Tricyclic Antidepressant Overdose</p> <ul style="list-style-type: none"> <li>• <b>Sodium Bicarbonate</b> <ul style="list-style-type: none"> <li>○ IV/IO – 1 mEq/kg</li> </ul> </li> </ul> <p>Beta Blocker Overdose</p> <ul style="list-style-type: none"> <li>• <b>Glucagon</b> <ul style="list-style-type: none"> <li>○ IV/IO – 2 mg                             <ul style="list-style-type: none"> <li>• May give up to 10mg if available</li> </ul> </li> </ul> </li> </ul> <p>Calcium Channel Blocker Overdose</p> <ul style="list-style-type: none"> <li>• <b>Calcium Chloride</b> <ul style="list-style-type: none"> <li>○ IV/IO – 1 gm over 1 min</li> </ul> </li> <li>• <b>Glucagon</b> <ul style="list-style-type: none"> <li>○ IV/IO – 2 mg                             <ul style="list-style-type: none"> <li>• May give up to 10 mg if available</li> </ul> </li> </ul> </li> </ul> <p>Stimulant/Hallucinogen Overdose</p> <ul style="list-style-type: none"> <li>• <b>Midazolam</b> <ul style="list-style-type: none"> <li>○ IV/IO – 2 mg                             <ul style="list-style-type: none"> <li>• Repeat 1 mg q 2 min as needed</li> <li>• Max 5 mg</li> </ul> </li> <li>○ IM – 0.1 mg/kg</li> </ul> </li> </ul>	<p>Tricyclic Antidepressant Overdose</p> <ul style="list-style-type: none"> <li>• <b>Sodium Bicarbonate</b> <ul style="list-style-type: none"> <li>○ IV/IO – 1 mEq/kg</li> </ul> </li> </ul> <p>Beta Blocker Overdose</p> <ul style="list-style-type: none"> <li>• <b>Glucagon</b> <ul style="list-style-type: none"> <li>○ IV/IO – 0.1 mg/kg                             <ul style="list-style-type: none"> <li>• May give up to 10 mg if available</li> </ul> </li> </ul> </li> </ul> <p>Calcium Channel Blocker Overdose</p> <ul style="list-style-type: none"> <li>• <b>Calcium Chloride</b> <ul style="list-style-type: none"> <li>○ IV/IO – 20 mg/kg over 1 min</li> </ul> </li> <li>• <b>Glucagon</b> <ul style="list-style-type: none"> <li>○ IV/IO – 0.1 mg/kg                             <ul style="list-style-type: none"> <li>• May give up to 10 mg if available</li> </ul> </li> </ul> </li> </ul> <p>Stimulant/Hallucinogen Overdose</p> <ul style="list-style-type: none"> <li>• <b>Midazolam</b> <ul style="list-style-type: none"> <li>○ IM – 0.1 mg/kg                             <ul style="list-style-type: none"> <li>• Max 5 mg</li> </ul> </li> </ul> </li> </ul>

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Effective Date: DRAFT  
Next Review Date: April 2019

Date Revised: April 13, 2017  
Last Reviewed: April 13, 2017

VCEMS Medical Director


• Max 5 mg	
<b>ED Physician Order Only: Ondansetron</b>	<b>ED Physician Order Only: Ondansetron</b>
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measure
<p>Additional Information:</p> <ul style="list-style-type: none"> <li>• <a href="#">In the event Narcan is administered by BLS personnel, ALS personnel will assume care of the patient as soon as possible and continue care at an ALS level, in accordance with VCEMS Policies and Procedures.</a></li> <li>• Refer to VCEMS Policy 705-17-Nerve Agent Poisoning for nerve agent exposure treatment guidelines.</li> <li>• If chest pain present, refer to chest pain policy. DO NOT GIVE ASPIRIN OR NITROGLYCERIN (Consult with ED Physician)</li> <li>• Organophosphate poisoning – SLUDGE             <ul style="list-style-type: none"> <li>○ S – Salivation</li> <li>○ L – Lacrimation</li> <li>○ U – Urination</li> <li>○ D – Defecation</li> <li>○ G – Gastrointestinal Distress</li> <li>○ E – Elimination (vomiting)</li> <li>○ M - Miosis</li> </ul> </li> <li>• Narcan – it is not necessary that the patient be awake and alert. Administer until max dosage is reached <u>or</u> RR greater than 12/min. When given to chronic opioid patients, withdrawal symptoms may present. IM dosing is the preferred route of administration.             <ul style="list-style-type: none"> <li>○ If base hospital contact cannot be made, naloxone should be administered sparingly, in doses no more than 0.1 mg every 2-3 minutes.</li> </ul> </li> </ul>	



<b>Pain Control</b>	
<b>ADULT</b>	<b>PEDIATRIC</b>
<b>BLS Procedures</b>	
Place patient in position of comfort Administer oxygen as indicated	
<b>ALS Prior to Base Hospital Contact</b>	
<p>IV/IO access</p> <p>Cardiac Monitor</p> <p><b>Ondansetron</b></p> <ul style="list-style-type: none"> <li>IV/IM/ODT – 4 mg</li> </ul> <p><b>Morphine – Pain 5 out of 10 or greater</b></p> <p><b>Initial IV Dose</b></p> <ul style="list-style-type: none"> <li>Slow IVP - 0.1 mg/kg over 2 minutes<sup>1</sup></li> <li>Maximum for <b>ANY</b> IV dose is 10 mg</li> </ul> <p><b>Initial IM Dose</b></p> <ul style="list-style-type: none"> <li>IM - 0.1 mg/kg<sup>1</sup></li> <li>Maximum for <b>ANY</b> IM dose is 10 mg</li> </ul> <p><b>Second IV/IM Dose, if pain persists</b> 5 minutes after IV morphine, or 15 minutes after IM morphine</p> <ul style="list-style-type: none"> <li>Administer half of the initial morphine dose</li> </ul> <p><b>Third IV/IM Dose, if pain persists</b> 5 minutes after 2<sup>nd</sup> IV morphine, or 15 minutes after 2<sup>nd</sup> IM morphine</p> <ul style="list-style-type: none"> <li><b>Ondansetron</b> (only if third dose of morphine needed)</li> <li>IV/IM/ODT – 4 mg</li> <li>Administer half of the initial morphine dose</li> </ul> <p>Check and document vital signs before and after each administration</p> <ul style="list-style-type: none"> <li>Hold if SBP &lt; 100 mmHg</li> </ul> <p><i>If patient has significant injury to head, chest, abdomen or is hypotensive, <b>DO NOT</b> administer pain control unless ordered by ED Physician</i></p>	<p>IV/IO access</p> <p>Cardiac Monitor</p> <p><b>Ondansetron:</b> Patient 4 years of age or older</p> <ul style="list-style-type: none"> <li>IV/IM/ODT – 4 mg</li> </ul> <p><b>Morphine – Pain 5 out of 10 or greater</b></p> <p><b>Morphine</b> – given for burns and isolated extremity injuries only. Consider early base contact for other pediatric complaints of pain (e.g. dog bite, cancer)</p> <p><b>Initial IV Dose</b></p> <ul style="list-style-type: none"> <li>Slow IVP - 0.1 mg/kg over 2 minutes<sup>1</sup></li> <li>Maximum for <b>ANY</b> IV dose is 10 mg</li> </ul> <p><b>Initial IM Dose</b></p> <ul style="list-style-type: none"> <li>IM - 0.1 mg/kg<sup>1</sup></li> <li>Maximum for <b>ANY</b> IM dose is 10 mg</li> </ul> <p><b>Second IV/IM Dose, if pain persists</b> 5 minutes after IV morphine, or 15 minutes after IM morphine</p> <ul style="list-style-type: none"> <li>Administer half of the initial morphine dose</li> </ul> <p><b>Third IV/IM Dose, if pain persists</b> 5 minutes after 2<sup>nd</sup> IV morphine, or 15 minutes after 2<sup>nd</sup> IM morphine</p> <ul style="list-style-type: none"> <li><b>Ondansetron</b> (only if third dose of morphine needed)</li> <li>IV/IM/ODT – 4 mg</li> <li>Administer half of the initial morphine dose</li> </ul> <p>Check and document vital signs before and after each administration</p> <ul style="list-style-type: none"> <li>Hold if SBP &lt; 100 mmHg</li> </ul> <p><i>If patient has significant injury to head, chest, abdomen or is hypotensive, <b>DO NOT</b> administer pain control unless ordered by ED Physician</i></p>
<b>Base Hospital Orders only</b>	
Consult with ED Physician for further treatment measures	
<p><b>Additional Information</b></p> <p>1. <b>Special considerations, administer 0.05 mg/kg</b></p> <ul style="list-style-type: none"> <li>Consider lower dose for patients 65 years of age and older.</li> <li>Chest pain not resolved by nitroglycerine (NTG)</li> <li>Patient with history of adverse reaction to morphine</li> <li>Symptomatic bradycardia for patients receiving transcutaneous pacing.</li> </ul>	

Effective Date: September 1, 2015  
Next Review Date: August, 2017

Date Revised: August 13, 2015  
Last Reviewed: August 13, 2015

  
VCEMS Medical Director

<b>Seizures</b>	
<b>ADULT</b>	<b>PEDIATRIC</b>
<b>BLS Procedures</b>	
Protect from injury  Maintain/manage airway as indicated  Administer oxygen as indicated  <a href="#">Determine Blood Glucose level, and treat according to VC EMS policy 705.03 – Altered Neurologic Function</a>	Protect from injury  Maintain/manage airway as indicated  For suspected febrile seizures, begin passive cooling measures. If seizure activity persists, see below  Administer oxygen as indicated  <a href="#">Determine Blood Glucose level, and treat according to VC EMS policy 705.03 – Altered Neurologic Function</a>
<b>ALS Prior to Base Hospital Contact</b>	
IV/IO access  <del>If not already performed by BLS personnel, determine</del> <b>Determine</b> Blood Glucose level, and treat according to VC EMS policy 705.03 – Altered Neurologic Function  Persistent Seizure Activity <ul style="list-style-type: none"> <li>• <b>Midazolam</b> (Give to <b>actively seizing</b> pregnant patients prior to magnesium)                             <ul style="list-style-type: none"> <li>• IV/IO – 2 mg Repeat 1 mg q 2 min as needed Max 5 mg</li> <li>• IM – 0.1 mg/kg Max 5 mg</li> </ul> </li> </ul> FOR IV/IO USE: Dilute 5 mg (1 mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL  <u>20 weeks gestation to one week postpartum &amp; No Known Seizure History</u> <ul style="list-style-type: none"> <li>• <b>Magnesium Sulfate</b> <ul style="list-style-type: none"> <li>○ IV/IO PB – 2 gm in 50 mL D<sub>5</sub>W infused over 5 min                                     <ul style="list-style-type: none"> <li>• MUST Repeat x 1</li> <li>• Slow or stop infusion if bradycardia, heart block, or decreased respiratory effort occur</li> </ul> </li> </ul> </li> </ul>	Consider IV/IO access  <del>If not already performed by BLS personnel, determine</del> <b>determine</b> Blood Glucose level, and treat according to VC EMS policy 705.03 – Altered Neurologic Function <del>Determine Blood Glucose level, and treat according to VC EMS policy 705.03 – Altered Neurologic Function.</del>  Persistent Seizure Activity <ul style="list-style-type: none"> <li>• <b>Midazolam</b> <ul style="list-style-type: none"> <li>○ IM – 0.1 mg/kg Max 5 mg</li> </ul> </li> </ul>
<b>Base Hospital Orders only</b>	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures
Additional Information: <ul style="list-style-type: none"> <li>• Patients with a known seizure disorder or uncomplicated, apparent pediatric febrile seizures, no longer seizing and with a normal postictal state, may be treated as a BLS call</li> </ul>	

Effective Date: DRAFT  
Next Review Date: April 2019

Date Revised: April 13, 2017  
Last Reviewed: April 13, 2017

VCEMS Medical Director

## Shortness of Breath – Pulmonary Edema

### BLS Procedures

Administer oxygen as indicated

Initiate CPAP for moderate to severe distress

### ALS Prior to Base Hospital Contact

#### Nitroglycerin

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

If not already performed by BLS personnel, Initiate CPAP for moderate to severe distress

Perform 12-lead ECG (Per VCEMS Policy 726)

IV/IO access

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

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

### Communication Failure Protocol

If patient becomes or presents with hypotension

- **Epinephrine 0.1 mg/mL**
  - Slow IVP – 0.1 mg (1 mL) increments
  - Repeat q 3-5 min
  - Max 0.3 mg (3 mL) over 1-2 min
- **Dopamine**
  - IVPB—10 mcg/kg/min

### Base Hospital Orders only

Consult with ED Physician for further treatment measures

#### Additional Information:

- Nitroglycerin is contraindicated when phosphodiesterase inhibitor medications [Sildenafil (Viagra and Revatio), Vardenafil (Levitra), and Tadalafil (Cialis)] have been recently used (Viagra or Levitra within 24 hours; Cialis within 48 hours). These medications are most commonly used to treat erectile dysfunction or pulmonary hypertension. In this situation, NTG may only be given by ED Physician order.

Effective Date: **DRAFT**  
Next Review Date: May 2019

Date Revised: May 11, 2017  
Last Reviewed: May 11, 2017

EMS Medical Director

<b>Shortness of Breath – Wheezes/Other</b>	
<b>ADULT</b>	<b>PEDIATRIC</b>
<b>BLS Procedures</b>	
<p><u>Administer oxygen as indicated</u></p> <p><u>Initiate CPAP for both moderate and severe distress</u></p> <p>Assist patient with prescribed Metered Dose Inhaler if available</p> <p><u>Severe Distress Only</u></p> <ul style="list-style-type: none"> <li>• <b>Epinephrine 1mg/ml</b> <ul style="list-style-type: none"> <li>○ IM – 0.3 mg</li> <li>○ <u>May repeat x 1</u></li> </ul> </li> </ul> <p><u>Administer oxygen as indicated</u></p>	<p><u>Administer oxygen as indicated</u></p> <p><u>Initiate CPAP if age 8 years old and greater</u></p> <p>Assist patient with prescribed Metered Dose Inhaler if available</p> <p><u>Severe Distress Only</u></p> <ul style="list-style-type: none"> <li>• <b>Epinephrine 1mg/ml</b> <ul style="list-style-type: none"> <li>○ IM – 0.15 mg</li> <li>○ <u>May repeat x 1</u></li> </ul> </li> </ul> <p><u>Administer oxygen as indicated</u></p>
<b>ALS Prior to Base Hospital Contact</b>	
<p>Perform Needle Thoracostomy if indicated per <a href="#">VCEMS</a> Policy 715</p> <p>Moderate Distress</p> <ul style="list-style-type: none"> <li>• <b>Albuterol</b> <ul style="list-style-type: none"> <li>○ Nebulizer – 5 mg/6 mL</li> <li>• Repeat as needed</li> </ul> </li> </ul> <p><u>For Moderate to Severe Distress</u></p> <ul style="list-style-type: none"> <li>• <u>Epinephrine 0.1 mg/ml – 0.3mg IM</u></li> </ul> <p>Severe Distress, <u>if not already performed by BLS personnel</u> Treatment for moderate distress Less than 40 years old</p> <ul style="list-style-type: none"> <li>○ <b>Epinephrine 1:1,000</b> <ul style="list-style-type: none"> <li>• IM – 0.3 mg</li> </ul> </li> </ul> <p><u>If not already performed by BLS personnel, c</u>Consider CPAP for both moderate and severe distress</p> <p><u>IV/IO</u> access</p>	<p>Perform Needle Thoracostomy if indicated per <a href="#">VCEMS</a> Policy 715</p> <p>Moderate Distress</p> <ul style="list-style-type: none"> <li>• <u>Less than 2 years old</u> <ul style="list-style-type: none"> <li>○ <u>Epinephrine 0.1mg/ml – 0.01 mg/kg</u> <ul style="list-style-type: none"> <li>• <u>May repeat X 1</u></li> </ul> </li> <li>○ <b>Albuterol</b> <ul style="list-style-type: none"> <li>• Nebulizer – 2.5 mg/3 mL</li> <li>○ Repeat as needed</li> </ul> </li> </ul> </li> <li>• <u>2 years old and greater</u> <ul style="list-style-type: none"> <li>○ <u>Epinephrine 0.1mg/ml – 0.01 mg/kg</u> <ul style="list-style-type: none"> <li>• <u>May repeat X 1</u></li> </ul> </li> <li>○ <b>Albuterol</b> <ul style="list-style-type: none"> <li>• Nebulizer – 5 mg/6 mL</li> <li>○ Repeat as needed</li> </ul> </li> </ul> </li> </ul> <p>Severe Distress</p> <ul style="list-style-type: none"> <li>• Treatment for moderate distress</li> <li>• <b>Epinephrine 1:1,000</b> <ul style="list-style-type: none"> <li>○ IM – 0.01 mg/kg                             <ul style="list-style-type: none"> <li>▪ Max 0.3 mg</li> </ul> </li> </ul> </li> </ul> <p>Suspected Croup</p> <ul style="list-style-type: none"> <li>• <b>Normal Saline</b> <ul style="list-style-type: none"> <li>○ Nebulizer/Aerosolized Mask – 5 mL</li> </ul> </li> </ul> <p><u>If not already performed by BLS personnel, c</u>Consider CPAP if age 8 years old and greater</p> <p><u>IV/IO</u> -access</p>
<b>Communication Failure Protocol</b>	
<p>Severe Distress</p> <ul style="list-style-type: none"> <li>• Less than 40 years old                             <ul style="list-style-type: none"> <li>○ If no change is apparent 10 minutes after first Epinephrine administration:                                     <ul style="list-style-type: none"> <li>• <u>Repeat Epinephrine 1:1,000</u> <ul style="list-style-type: none"> <li>○ IM – 0.3 mg</li> </ul> </li> </ul> </li> </ul> </li> <li>• 40 years old and greater                             <ul style="list-style-type: none"> <li>○ <b>Epinephrine 1:1,000</b> <ul style="list-style-type: none"> <li>• IM – 0.3 mg                                     <ul style="list-style-type: none"> <li>○ Only if apparent asthma</li> <li>○ Only if age less than 60 years old</li> <li>○ Only if no improvement with initial therapies</li> </ul> </li> </ul> </li> </ul> </li> </ul>	<p>Severe Distress</p> <ul style="list-style-type: none"> <li>• If no change is apparent 10 minutes after first Epinephrine administration                             <ul style="list-style-type: none"> <li>○ <u>Repeat Epinephrine 1:1,000- 1mg/ml</u> <ul style="list-style-type: none"> <li>• IM – 0.01 mg/kg                                     <ul style="list-style-type: none"> <li>○ Max 0.3 mg</li> </ul> </li> </ul> </li> </ul> </li> </ul>
<b>Base Hospital Orders only</b>	

Effective Date:  
Next Review Date: Jan 31, 2017

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

VCEMS Medical Director

	<p>Suspected Croup and no improvement with Normal Saline nebulizer</p> <ul style="list-style-type: none"> <li>• Less than 2 years old             <ul style="list-style-type: none"> <li>○ <b>Epinephrine 1:1,000 1mg/ml</b> <ul style="list-style-type: none"> <li>• Nebulizer/Aerosolized Mask – 2.5 mL</li> </ul> </li> </ul> </li> <li>• 2 years old and greater             <ul style="list-style-type: none"> <li>○ <b>Epinephrine 1:1,000 1mg/ml</b> <ul style="list-style-type: none"> <li>• Nebulizer/Aerosolized Mask – 5 mL</li> </ul> </li> </ul> </li> </ul>
<p>Consult with ED Physician for further treatment measures</p>	<p>Consult with ED Physician for further treatment measures</p>
<p>Additional Information:</p> <ul style="list-style-type: none"> <li>• <a href="#">In the event Epinephrine is administered by BLS personnel, ALS personnel will assume care of the patient as soon as possible and continue care at an ALS level, in accordance with VCEMS Policies and Procedures.</a></li> <li>• High flow O<sub>2</sub> is indicated for severe respiratory distress, even with a history of COPD</li> <li>• COPD patients have a higher susceptibility to spontaneous pneumothorax due to disease process</li> <li>• If suspected Arterial Gas Embolus/Decompression Sickness secondary to SCUBA emergencies, transport patient in supine position on 15L/min O<sub>2</sub> via mask. Early BH contact is recommended to determine most appropriate transport destination.</li> </ul>	

Effective Date:  
Next Review Date: Jan 31, 2017

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

VCEMS Medical Director

<b>Suspected Stroke</b>	
<b>ADULT</b>	
<b>BLS Procedures</b>	
Cincinnati Stroke Scale (CSS)	
Administer oxygen as indicated	
Administer oxygen if SpO2 less than 94% or unknown	
<a href="#">Determine Blood Glucose level, treat according to VC EMS policy 705.03 – Altered Neurologic Function</a> <ul style="list-style-type: none"> <li><del>If low blood sugar suspected, refer to VC EMS Policy 705.03 – Altered Neurologic Function</del></li> </ul>	
<b>ALS Prior to Base Hospital Contact</b>	
IV/IO access	
Cardiac monitor – document initial and ongoing rhythm strips	
<del>If not already performed by BLS personnel, d</del> Determine Blood Glucose level, treat according to VC EMS policy 705.03 – Altered Neurologic Function	
Patients meeting Stroke Alert criteria as defined in VC EMS Policy 451, expedite transport to appropriate Acute Stroke Center (ASC).	
Patients meeting ELVO Alert criteria as defined in VC EMS Policy 451, expedite transport to appropriate Thrombectomy Capable Acute Stroke Center (TCASC).	
<b>Base Hospital Orders only</b>	
Consult with ED Physician for further treatment measure	
<b>Additional Information</b>	
<u>Cincinnati Stroke Scale (CSS)</u>	<u>Ventura County ELVO Score (VES)</u>
Facial Droop Normal: Both sides of face move equally Abnormal: One side of face does not move normally  Arm Drift Normal: Both arms move equally or not at all Abnormal: One arm does not move, or one arm drifts down compared with the other side  Speech Normal: Patient uses correct words with no slurring Abnormal: Slurred or inappropriate words or mute	Forced Eye Deviation  Aphasia  Neglect  Obtundation  Refer to VC EMS Policy 451 for Detailed VES.
<ul style="list-style-type: none"> <li>Patients must meet Stroke Alert criteria in order to continue to VES</li> <li>Document name and phone number in ePCR of person who observed patient's Time Last Known Well (TLKW), and report this information to the receiving facility.</li> <li>Stroke patients in cardiac arrest with sustained ROSC (&gt;30 seconds) shall be transported to the nearest STEMI Receiving Center (SRC).</li> <li>For seizure activity, refer to VC EMS Policy 705.20 Seizure.</li> </ul>	

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Continuous Positive Airway Pressure (CPAP)		Policy Number: 723	
APPROVED: Administration: Steven L. Carroll, <u>Paramedic</u>		Date: <u>DRAFT</u>	
APPROVED: Medical Director <u>Daniel Shepherd, MD</u>		Date: <u>DRAFT</u>	
Origination Date: December 2004		Effective Date: <u>DRAFT</u>	
Date Revised: September 13, 2007			
Last Reviewed: September 12, 2013			
Review Date: September, 2015			

- I. PURPOSE: To define the indications, procedure and documentation for the use of Continuous Positive Airway Pressure (CPAP) by EMS Personnel paramedics
- II. AUTHORITY: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Division 9, Section 100063.
- III. POLICY: EMS Personnel Paramedics may utilize CPAP on patients in accordance with Ventura County Policy 705.
- IV. PROCEDURE:
  - A. Training: Prior to using CPAP EMS Personnel the paramedic must successfully complete a training program approved by the VC EMS Medical Director, which includes operation of the device to be used.
  - B. Indications: Patients age 8 and above with one or more of the following:
    1. Congestive Heart Failure with acute pulmonary edema
    2. Near drowning
    3. Any cause of respiratory failure.
  - C. Contraindications:
    1. Absolute
      - a. Respiratory or cardiac arrest
      - b. Agonal respirations
      - c. Unconsciousness
      - e. Pneumothorax
      - f. Inability to maintain airway patency
      - g. Head injury with increased ICP
    2. Relative:
      - a. Decreased LOC
      - b. Unable to tolerate mask

- c. Systolic blood pressure < 90
- d. Vomiting

E. Patient Treatment

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

D. DOCUMENTATION

- 1. The use of CPAP must be documented.
  - 2. Vital signs and SpO2 must be documented every 5 minutes.
  - 3. Narrative documentation should include a description of the patient's response to CPAP.
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CITY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Emergency Medical Technician (EMT) Automatic External Defibrillation (AED) Service Provider Program Standards		Policy Number: 803	
APPROVED: Administration: Steven L. Carroll, EMT-P		Date: 04-24-06	
APPROVED: Medical Director: Angelo Salvucci, M.D.		Date: 04-24-06	
Origination Date: November 1988		Effective Date: June 1, 2006	
Date Revised: March 2006			
Date Last Reviewed: April 14, 2011			
Review Date: April 30, 2014			

- I. PURPOSE: To establish criteria [and procedure](#) for approval and oversight of EMT AED Service Provider programs.
- II. AUTHORITY: Health and Safety Code 1797.107, 1797.170, 1798 and California Code of Regulations, Title 22, 100063.1.
- III. DEFINITION: An EMT AED service provider is an agency or organization that employs individuals as defined in [Title 22, Division 9](#), Section 100060, and who obtain AEDs for the purpose of providing AED services to the general public.
- IV. POLICY:
  - A. An AED Service Provider shall be approved by Ventura County Emergency Medical Services (VC EMS) prior to beginning service. In order to receive and maintain EMT AED Service Provider approval, an EMT AED Services Provider shall comply with the requirements of this policy.
  - B. An EMT AED Service Provider shall:
    - ~~1. Have a written agreement with a physician who meets requirements in VCEMS Policy 802 to serve as Medical Director.~~
    - 12. Provide orientation of AED authorized personnel to the AED
    - 23. Ensure maintenance of AED equipment.
    - 34. Ensure [initial training and](#) continued competency of AED authorized personnel
      - a. Demonstration of skills competence at least every six months to the EMT [Medical Program](#) Director or his/her designee as identified to the EMS office.
      - b. ~~Skills competency records shall be maintained at least four years. Use of AEDs shall be incorporated into each fire station's quarterly drills.~~
      - ~~e. Attendance records shall be maintained.~~
      - ~~d. Continuing Education Lecture: The EMT (AED) shall attend one (1) hour lecture per six months to total four (4) per two year certification period with content in cardiac arrest management.~~
    - 45. Ensure that EMT personnel complete first responder BLS Prehospital Care

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- Record (PCR) or electronic PCR (ePCR) for all patient contacts, ~~and submit to VC EMS.~~
56. Authorize personnel and maintain a current listing of all EMT AED Service Provider authorized personnel and provide a listing upon request by the VC EMS Agency. Authorized personnel means EMT personnel trained to operate an AED and authorized by an approved EMT AED Service Provider.
67. Train all EMTs who have not already been trained in use of AED. Training shall include the following:
- a. Perform emergency cardiac care in accordance with protocols developed and/or approved by the EMS Agency Medical Director.
  - b. Recognize that a patient is in cardiac arrest and that CPR and immediate application of the automated external defibrillator ~~or manual defibrillator~~ is required.
  - ~~e. If collapse before call to 9-1-1, 2 minutes of CPR before first analysis.~~
  - cd. Set up the automated defibrillator correctly.
  - de. Correctly apply the defibrillator pads.
  - ef. Ensure that rescuers or bystanders are not in contact with the patient while the AED is analyzing or delivering a shock.
  - fg. ~~If collapse after call to 9-1-1, d~~ Deliver shocks for ventricular fibrillation in the shortest time possible following their arrival at the patient side, ideally within 90 seconds.
  - gh. Recognize that a shock was delivered to the patient.
  - hi. Provide supportive care to a patient who has been successfully defibrillated.
  - ij. Immediately recognize and respond to patients when an arrest recurs ~~who redefibrillate~~ either at the scene or during transport, in accordance with protocols.
  - ~~k. Deliver no more than the number of shocks allowed in the standing orders.~~
  - jl. Record the pertinent events of the emergency response on a PCR.
  - km. Maintain the AED monitor/defibrillator and voice/ECG recorder or other documentation device in accordance with manufacturer's recommendations.
78. Develop and maintain a quality improvement program, approved by the VC EMS Medical Director that contains the following:
- a. Assure timely and competent review of EMT managed cardiac arrest

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cases, accurate logging of required data, and timely, accurate and informative statistical summaries of system performance over time, as well as recommendations, as indicated, for modifications of system design, performance protocols, or training standards designed to improve patient outcome.

- b. Collect, store and analyze, at a minimum, the following data related to EMT management of cardiac arrest patients:
  - (1) Patient Data:
    - a) Age,
    - b) Sex,
    - c) Whether arrest was witnessed or unwitnessed,
    - d) Distance of collapse from EMT responding unit, and
    - e) Initial cardiac rhythm.
  - (2) EMS System Data:
    - a) Estimated time from collapse to call for help,
    - b) Estimated time from collapse to initiation of CPR,
    - c) EMT responding unit response time, and
    - d) Scene to hospital transport time.
  - (3) EMT Performance:
    - ~~a) Accuracy of rhythm interpretation,~~
    - ~~ab) Time from arrival to actual defibrillation,~~
    - ~~be) Time between defibrillation attempts,~~
    - ~~d) Appropriateness of management for each rhythm encountered, and~~
    - ~~ce) General adherence to established protocol.~~
  - (4) Patient Outcome:
    - a) Rhythm after each shock.
    - b) Return of pulse and/or spontaneous respirations in the field.

~~87.~~ EMT AED documentation submission

- a. If EMT AED Service Provider has Ventura County Electronic Patient Care Record (ePCR) capabilities, documentation shall be consistent with VCEMS Policy 1000.
- b. If EMT AED Service Provider does not have ePCR capabilities, documentation submission shall be as follows:

~~a-(1)~~ EMT documentation (incident printout and prehospital care record (PCR))

shall be submitted to the receiving hospital as soon as possible (not more than two hours after patient arrival).

b-(2) EMT documentation for all arrests (incident printout and PCR including times) shall be submitted by the provider to the involved base hospital within 30 days of the end of the calendar month of the occurrence.

e-(3) EMT documentation (incident printout, PCR including times, and audio tape) shall be submitted to the EMT medical director or designee within 10 working days of the occurrence.

9e. The EMT AED Service Provider, ~~in conjunction with its medical director,~~ shall submit an annual written report to the EMS Agency to include as a minimum the following information.

- a. The total number of cases in which the AED was activated. The number of those cases where return of spontaneous circulation (ROSC) was achieved.
- b. The number of cases that presented in Ventricular Fibrillation (VF). The number of those cases where ROSC was achieved.
- c. The number of cases that presented in witnessed VF. The number of those cases where ROSC was achieved.
- d. The 90% fractile times from first notification to on-scene, to with patient and to first analysis, in case of secondary PSAP, time received.
- e. The number of cases of cardiac arrest responded to where the AED was not activated and the 90% fractile time from first notification to on-scene for those cases, in case of secondary PSAP, time received.

#### IV. PROCEDURE:

##### A. Program Approval

1. Eligible programs shall submit a written request for EMT AED Service Provider approval to the EMS Agency and agree to comply with the provisions of this policy.

##### 2. Application Receipt Process

Upon receipt of a complete application packet, the Agency will notify the applicant within fourteen business days that:

- a. The request for approval has been received.
- b. The request does or does not contain all required information.
- c. What information, if any, is missing

##### 5. Program Approval Time Frames

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- a. Program approval or disapproval shall be made in writing by the Agency to the requesting program, within sixty calendar days, after receipt of all required documentation.
- b. The Agency shall establish an effective date for program approval in writing upon the satisfactory documentation of compliance with all program requirements.
- c. Program approval shall be for four years following the effective date of the program and may be reviewed every four years subject to the procedure for program approval specified by the Agency.

6. Withdrawal of Program Approval

- a. Noncompliance with any criterion required for program approval, use of any unqualified personnel, or noncompliance with any other applicable provision of Title 22 may result in suspension or revocation of program approval by the Agency.
- b. An approved program shall have no more than sixty days to comply with corrections mandated by this policy.

B. Program Review and Reporting

1. All program materials are subject to periodic review by the Agency.
2. All programs are subject to periodic on-site evaluation by the Agency.
3. The Agency shall be advised of any change in Program staff.
4. Records shall be maintained by the EMT AED SERVICE PROVIDER for four years and shall contain the following:
  - a. Roster of Authorized Personnel
  - b. Documentation of skills competency

C. Application for Renewal

1. The EMT AED SERVICE PROVIDER shall submit an application for renewal at least sixty calendar days before the expiration date of their Program approval in order to maintain continuous approval.

**Ventura County Emergency Medical Services Agency**  
**Emergency Medical Technician AED Service Provider**

**APPROVAL REQUEST**

**General Information**

Program/Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Date Submitted: \_\_\_\_\_

**Requirements**

(All items below refer to Ventura County EMS Policy 803 and Title 22 Regulations)

**1. Program Eligibility**

<u>Eligible Programs</u>	<u>Name of Program</u>
<ul style="list-style-type: none"> <li>Programs eligible for approval shall be limited to public or private organizations that meet the requirements identified in this policy. All private entities must possess a valid business license and proof of organizational registry (partnership, sole proprietorship, corporation, etc.)</li> </ul>	
Written request for EMT AED Service Provider Approval	<input type="checkbox"/> Attached

**2. Records and Quality Improvement**

<u>Agree to maintain all records for a minimum of four years.</u>	Signature: _____
<u>Agree to participate in the VCEMS Quality Improvement Program and in research data accumulation.</u>	Signature: _____

**VCEMS Office Use Only**

<u>All Requirements Submitted:</u>	<u>Date:</u>
<u>EMT AED SERVICE PROVIDER Application Approved:</u>	<u>Date:</u>
<u>Approval Letter Sent:</u>	<u>Date:</u>
<u>Re-Approval Due:</u>	<u>Date:</u>
<u>Signature of person approving EMT AED SERVICE PROVIDER</u>	<u>Date</u>

Typed or printed name

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**PSFA CPR (PSFA) and Tactical Casualty Care (TCC) TRAINING PROGRAM APPROVAL CHECKLIST**

<b>PROGRAM APPROVAL APPLICATION PROCEDURE</b>	
<b>TRAINING PROGRAM AFFILIATION:</b>	
<p><b>The Training Program is affiliated with a:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Statewide PSFA/TCC course approved by CalEMSA</li> <li><input type="checkbox"/> ARC equivalent first aid class of at least 21 hours AND an AHA equivalent CPR AED healthcare provider course</li> <li><input type="checkbox"/> <u>Tactical training program course that meets or exceeds all mandatory minimum guidelines outlined in CalEMSA #370 – California Tactical Casualty Care Training Guidelines.</u></li> <li><input type="checkbox"/> VCEMS approved EMT or Paramedic training program</li> <li><input type="checkbox"/> EMR course approved by CalEMSA and developed and authorized by CalFire POST DPR CHP or other statewide public safety agency as determined by CalEMSA</li> </ul>	<b>Name of Agency of Affiliation</b>
<b>EDUCATIONAL STAFF</b>	
<ul style="list-style-type: none"> <li><input type="checkbox"/> Primary Teaching Staff CV/Resume(s)</li> <li><input type="checkbox"/> Statement verifying each instructor is proficient in skills taught and qualified to teach by education and/or experience.</li> <li><input type="checkbox"/> <u>Applicable licenses and/or certifications</u></li> </ul>	
<b>Submission of the following:</b>	<b>Date Received</b>
<input type="checkbox"/> Table of contents listing required information and corresponding page numbers	
<input type="checkbox"/> Written request for program approval <b>IF PSFA:</b> <input type="checkbox"/> <u>Statement verifying AHA equivalent CPR and AED Healthcare Provider, and</u> <input type="checkbox"/> <u>Statement verifying 21 hours of ARC equivalent initial training, and</u> <input type="checkbox"/> <u>Statement verifying a minimum 8-hour retraining course, and</u> <b>IF TCC:</b> <input type="checkbox"/> <u>Statement verifying training course meets the appropriate minimum requirements outlined in CalEMSA #370</u> <b>IF BOTH PSFA and TCC:</b> <input type="checkbox"/> <u>All requirements outlined above</u>	
<input checked="" type="checkbox"/> <del>Statement verifying minimum of 21 hours of ARC equivalent training course</del>	
<input checked="" type="checkbox"/> <del>A statement verifying AHA equivalent CPR and AED healthcare )</del>	
<input type="checkbox"/> A detailed course outline	
<input type="checkbox"/> Samples of skills and written exams used for periodic testing	
<input type="checkbox"/> Final psychomotor skills competency testing criteria with pre-established scoring standards	
<input type="checkbox"/> Final cognitive exam with pre-established scoring standards <input type="checkbox"/> Provisions for retraining of public safety first aid personnel in accordance with CCR Section 100022	
<input type="checkbox"/> Location and proposed dates at which the course(s) are to be offered.	
<input type="checkbox"/> <u>Sample attendance record and training roster</u>	
<input type="checkbox"/> Sample of course completion certificate	
<p><u>As program director for the applicant training program or curriculum, I certify that I will adhere to the State of California EMS Regulations, Guidelines and all applicable VCEMS policies and procedures. Furthermore, I certify that all information submitted with this application is true and correct.</u></p>	
<p>Signature of PSFA/TCC program representative completing checklist (above) _____ Date (above) _____</p>	
<p>Typed or printed name (above) _____</p>	

*VCEMS Use Only*

All Requirements submitted	Date:
Approval letter sent	Date:
Re-approval date	Date:

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COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Public Safety First Aid (PSFA) and CPR / <u>Tactical Casualty Care</u> Training Program Approval		Policy Number 1601	
APPROVED: Administration: Steve L. Carroll, Paramedic		Date: <u>DRAFT</u>	
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: <u>DRAFT</u>	
Origination Date: April 13, 2017		Effective Date: <u>DRAFT</u>	
Date Revised: April 13, 2017			
Date Last Reviewed: April 13, 2017			
Review Date: April, 2018			

- I. PURPOSE: The Ventura County EMS Agency shall establish minimum requirements for Public Safety First Aid and CPR and/or Tactical Casualty Care training programs.
- II. AUTHORITY: California Health and Safety Code, Title 22, Division 2.5, Sections 1797.204, 1997.210 and 1797.212; California Code of Regulations, Title 22, Division 9 Chapter 1.5; California EMS Authority #370 – California Tactical Casualty Care Training Guidelines
- III. POLICY: The approving authority for Public Safety First Aid and CPR (PSFA) ~~and CPR~~ and/or Tactical Casualty Care (TCC) training programs, not meeting the definition of a statewide public safety agency operating within the County of Ventura shall be the Ventura County EMS Agency (VCEMS). This does not apply to PSFA-~~CPR~~ or TCC programs authorized by statewide public safety agencies such as the California Highway Patrol, California State Parks, etc. and approved by the California EMS Authority This also does not apply to PSFA ~~CPR~~ or TCC programs authorized by the Commission on Peace Officer Standards and Training (POST) and approved by the California EMS Authority.
  - A. Programs eligible for program approval shall be limited to:
    - 1. A course in public safety first aid, including CPR and AED, developed and/or authorized by the California Department of Forestry and Fire Protection (Cal Fire); or
    - 2. A course in public safety and first aid, including CPR and AED, authorized by the Commission on Peace Officer Standards and Training (POST) and approved by the California EMS Authority. No later than 24-months from the adoption of these regulations, POST, in consultation with the California EMS Authority, shall develop the course curriculum and testing competency standards for these regulations as they apply to peace officers; or

3. A course in public safety first aid, including CPR and AED, developed and authorized by the California Department of Parks and Recreation (DPR) and approved by the California EMS Authority; or
4. A course in public safety first aid, including CPR and AED, developed and authorized by the Department of the California Highway Patrol (CHP) and approved by the California EMS Authority; or
5. The U.S. Department of Transportation's emergency medical responder (EMR) course which includes first aid practices and CPR and AED, approved by the VCEMS; or
6. A course of at least 21 hours in first aid equivalent to the standards of the American Red Cross and healthcare provider level CPR and AED equivalent to the standards of the American Heart Association in accordance with the course content contained in Section 100017 of the California Code of Regulations, and approved by the VCEMS; or
- 6.7. A tactical training program course that meets or exceeds all mandatory minimum guidelines outlined in CalEMSA #370
- 7.8. An EMT or Paramedic training program approved pursuant to established VCEMS policies and procedures; or
- 8.9. An EMR course approved by the California EMS Authority, and developed and authorized by CAL FIRE, POST, DPR, CHP or other Statewide public safety agency, as determined by the California EMS Authority.

- B. Approved training program course content shall meet or exceed all requirements outlined in Chapter 1.5, Section 100017 of the California Code of Regulations. If a Tactical Casualty Care Training program, all minimum requirements of CalEMSA #370 shall be met or exceeded.

IV. PROCEDURE:

A. Program Approval

1. Eligible training programs shall submit a written request for ~~Public Safety First Aid and CPR-PSFA and/or TCC~~ training program approval to VCEMS
2. VCEMS shall review ~~and approve~~ the following prior to approving a PSFA-~~CPR~~ /~~TCC~~ training program:
  - a. Name of the sponsoring institution, organization, or agency.

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- b. A statement verifying the initial course of instruction shall at a minimum consist of not less than twenty-one (21) hours of first aid and CPR training (If PSFA).
- b-c. A statement verifying that the training course meets the appropriate minimum requirements outlined in CalEMSA #370 (If TCC)
- e-d. A statement verifying CPR training equivalent to the current Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care (If PSFA).
- e-e. A detailed course outline
- 1) If PSFA - Any and all optional skills, as outlined in Section 100019 of the California Code of Regulations, the program chooses to apply to its curriculum shall have prior written authorization by VCEMS Medical Director.
- e-f. Final written examination with pre-established scoring standards; and
- f-g. Skill competency testing criteria, with pre-established scoring standards.
- g-h. Provisions for the retraining of public safety first aid personnel in accordance with Section 100022 of the California Code of Regulations (If PSFA).
- h-i. Educational Staff  
Validation of the instructor's qualifications shall be the responsibility of the agency or organization whose training program has been approved by VCEMS. Training in PSFA and/or TCC ~~public safety first aid and CPR program~~ shall be conducted by an instructor who is:
- 1) Proficient in the skills taught; and
  - 2) Qualified to teach by education and/or experience
- h-j. Testing Requirements
- 1) The initial and retraining course of instruction shall include a written and skills examination which tests the ability to assess and manage all of the conditions, content and skills listed in sections 100017 and 100018 of Chapter 1.5 of the California Code of Regulations (If PSFA)
  - 2) A passing standard shall be established by the training program before administration of the examination and shall be in

compliance with the standard submitted to and approved by  
VCEMS

- 3) ~~PSFA-CPR-t~~ training programs shall test the knowledge and skills ~~specific in chapter 1.5 of the specified in~~ California Code of Regulations ~~or CalEMSA #370~~ and have a passing standard for successful completion of the course and shall ensure competency of each skill.

j.k. Course Completion Records

~~PSFA-CPR-t~~ training programs shall outline a process for validation of course completion, in accordance with Section 100029 of the California Code of Regulations ~~or CalEMSA #370~~.

- 1) A sample of the course completion certificate shall be submitted to VCEMS as part of the program approval application.
- 2) The ~~PSFA-CPR~~ training program shall maintain a record of the names of trainees and the date(s) on which training courses have been completed for at least four (4) years.
- 3) All training records shall be made available for inspection by VCEMS upon request.

k.l. A table of contents listing the required information detailed in this policy with corresponding page numbers.

l.m. Facilities and Equipment

- 1) Facilities must comfortably accommodate all students, including those with disabilities
- 2) Restroom access must be available
- 3) Training equipment and supply shall be modern and up to date as accepted by the industry and shall be maintained and/or replaced as necessary.

3. Course approval is valid for four (4) years from the date of approval.
    - a. Requests for re-approval shall be submitted in the form of a formal training program approval packet and shall include all items outlined in Section IV.A.1-2
    - b. Requests for re-approval shall be submitted to VCEMS no later than sixty (60) days prior to the date of program approval expiration.
-

- c. VCEMS may request additional materials or documentation as a condition of course approval and/or re-approval.
4. Training Program Notification
- a. VCEMS shall notify the training program submitting its request for ~~PSFA~~ ~~CPR~~-training program approval within twenty-one (21) working days of receiving the request that:
    - 1) The request for approval has been received,
    - 2) The request for approval contains or does not contain the information outlined in this policy and,
    - 3) What information, if any, is missing from the request.
  - b. Program approval or disapproval shall be made in writing by VCEMS to the requesting training program within a reasonable period of time after receipt of all required documentation as specified in this policy.
  - c. VCEMS shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.
  - d. VCEMS shall notify the California EMS Authority concurrently with the training program of approval, renewal of approval, or disapproval of the training program, and include the effective date. This notification is in addition to the name and address of training program, name of the program director, phone number of the contact person, and program approval/ expiration date of program approval.
5. Withdrawal of Program Approval
- a. Noncompliance with any criterion required for training program approval, use of any unqualified teaching personnel, non-compliance with any provision of this policy, non-compliance with any applicable regulation outlined in the California Code of Regulations and/or CalEMSA #370 or non-compliance with any other applicable guidelines regulations or laws may result in the denial, probation, suspension or revocation of program approval by VCEMS.
  - b. Notification of non-compliance and action to place on probation, suspend, or revoke shall be done as follows:
-

- 1) VCEMS shall notify the approved training program course director in writing, by registered mail, of the provisions of this Policy with which the training program is not in compliance.
  - 2) Within fifteen (15) working days of receipt of the notification of noncompliance, the approved training program shall submit in writing, by registered mail, to VCEMS one of the following:
    - a) Evidence of compliance with the provisions of this policy, or
    - b) A plan for meeting compliance with the provisions of this Chapter within sixty (60) calendar days from the day of receipt of the notification of noncompliance.
  - 3) Within fifteen (15) working days of receipt of the response from the approved training program, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the approved training program, VCEMS shall notify the approved training program in writing, by registered mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the training program approval.
  - 4) If VCEMS decides to suspend, revoke, or place an training program on probation the notification shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting of the probation or suspension or the effective date of the revocation, which may not be less than sixty (60) calendar days from the date of VCEMS's letter of decision to the training program.
6. Program Review and Reporting
- a. All course outlines, written exams, and competency testing criteria used in an approved ~~PSFA-CPR~~-training program shall be subject to periodic oversight and review as determined by VCEMS.
  - b. Program approval and renewal is contingent upon continued compliance with all required criteria and provisions outlined in this policy, ~~the and in Chapter 1.5 of the~~ California Code of Regulations, ~~and/or in CalEMSA #370~~ and may be revoked by VCEMS in accordance with section IV.4.5 of this policy.

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COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Refusal of EMS Services	Policy: 603
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: <u>DRAFT</u>
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: <u>DRAFT</u>
Origination Date October 31, 1995 Date Revised: May 11, 2017 Last Review: May 11, 2017 Review Date May, 2020	Effective Date: <u>DRAFT</u>

I. PURPOSE: To define the policy and operating procedures for the approach to patients, or potential patients, at the scene of an EMS response who decline services

II. AUTHORITY: California Health and Safety Code, Division 2.5, sections 1797.204, 1797.206, 1798, and 1798.2, California Code of Regulations Title 22, Division 9, sections 100170(5) and 100128(4), California Welfare and Institution Code, sections 305,625, 5150 and 5170

III. DEFINITIONS:

**Adult** – person over 18 years of age

**ALS** – advanced level EMS services as defined in the policies and procedures of the Ventura County Emergency Medical Services Agency (VCEMS) and the California Health and Safety Code, section 1797.52

**AMA** – when a patient with evidence of an emergency or acute medical condition, or who has required an ALS intervention, refuses transport or other indicated interventions. Patient must be an adult or emancipated minor, and have capacity as defined below, to decline service against medical advice.

**BLS** – basic level EMS services as defined in the policies and procedures of VCEMS and the California Health and Safety Code, section 1797.60

**Capacity** – a person’s ability to make an informed decision after consideration of the risks and benefits of such a decision. Capacity differs from competence, which is a legal definition that extends beyond the act of making specific medical decisions.

**Dedicated decision maker** – an individual who has been selected by or legally appointed to make medical decisions on behalf of the patient, including individuals with a power of attorney.

**Emancipated minor** – a person under 18 years of age who has been legally separated from their parents and lives independently.

**Emergency Medical Condition** – a medical condition that is acute or subacute in nature and requires immediate assessment. Emergency medical conditions typically carry the risk of sudden deterioration and possibly death. These conditions may be readily apparent or suspected based on the reported signs and symptoms, mechanism of injury, or medical history.

**Minor** – person under 18 years of age.

**Power of attorney** – the authority to act for another person in specified legal, medical or financial matters.

**Declination of EMS Service** – a contact at the scene of an EMS response who does not demonstrate any evidence of an injury or acute medical condition and is declining any and all EMS services. Example: ambulatory individuals at a minor traffic accident, bystanders at a structure fire.

**Declination of transport and/or assessment** – when a patient requests BLS level services but declines transport and/or assessment. These patients meet defined criteria for declining such services and lack any complaints or exam findings indicative of an emergent medical condition.

[Define Patient Contact from Policy 1000](#)

[Define Incident from Policy 1000](#)

IV. POLICY:

- A. Adults and a select group of minors with decision-making capacity have the right to dictate the scope of their medical care. EMS has an obligation to offer service.
  - B. All potential patients at the scene of an EMS response shall be offered evaluation and treatment. Transportation is an essential component of EMS care and should be encouraged.
  - C. Providing care establishes a therapeutic relationship and the expectations therein.
  - D. Not all EMS patients require ALS care and/or transport.
  - E. Patients declining care and/or transport should be counseled thoroughly about the pertinent risks of declining such interventions and all discussions should be documented thoroughly.
  - F. If there is any concern, the BLS providers shall request an ALS provider.
  - G. BLS providers with concern for an emergency medical condition shall request an ALS provider for an ALS level assessment.
  - H. Only adults and a select group of minors can refuse care. Persons who refuse care must demonstrate capacity and be free of impairment due to drugs and/or alcohol. Emancipated minors, minors on military duty, and married minors may decline services if they meet the criteria for refusal. Parents of minors and the dedicated decision makers for adults who lack capacity can decline services for others if they themselves meet the criteria for refusal.
  - I. Criteria for refusal:
    1. Alert, oriented (x4) person, place, time, and purpose/situation.
-



2. Able to demonstrate capacity by participating in a discussion of the risks of refusal. Must adequately acknowledge risks of declining the relevant services.
3. Free of impairment due to drugs or alcohol.
4. No evidence of suicidality, homicidality, grave disability, or other acute psychiatric condition that may require a 5150.

4-B. Provider agencies may require additional documentation over and above the minimum requirements outlined in this policy.

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V. PROCEDURE:

A. Cancellation ~~and Declination of Service~~

1. No ePCR is required if:
  - a. Cancelled enroute prior to arrival
  - b. Cancelled by another agency upon arrival at the scene of the incident
  - ~~4-c. Cancelled after arrival and no patient contact as defined in Section III for an incident in which your unit was canceled en route or by another agency within two minutes of arrival to the scene.~~

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B. Declination of EMS Services

1. Those individuals contacted at an EMS response who have no medical complaints or evidence of an emergency medical condition may decline service. Service will still be offered, and encouraged. An ePCR with no treatment disposition shall be completed.
- ~~2. No ePCR is required for patients involved in any incident who are without complaint and no trauma triage criteria are present.~~
- ~~3. No ePCR is required for the occupants of a vehicle involved in a minor traffic collision in which all occupants in the vehicle are without complaint and no trauma triage criteria are present.~~
- ~~4. Advise contact of the potential risks of declining service.~~
- ~~5. Document encounter as required by VCEMS policy 1000.~~
- ~~6. Use of the narrative to describe the scene is strongly encouraged.~~
  
- ~~2. An ePCR is required for all occupants of a vehicle in a minor traffic collision if any individual within the vehicle requires assessment, care, and/or transport or trauma triage criteria are present.~~

C. Declination of Transport and/or Assessment

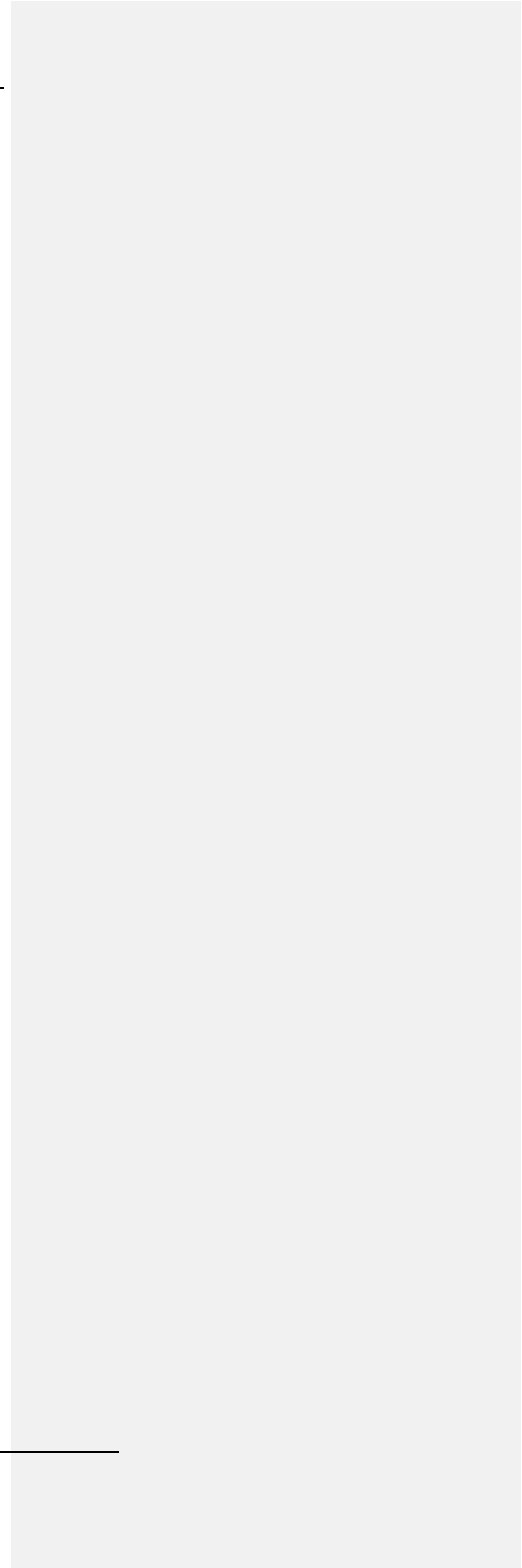
1. Patients with minor injuries or illness, or those in need of strictly BLS interventions, shall be evaluated and treated per protocol.
2. Transport must be offered and encouraged.
3. Adults and appropriate minors may decline transport and/or assessment if all of the following criteria are met:
  - a. Alert, oriented (x4) person, place, time, and purpose/situation.
  - b. Able to demonstrate capacity by participating in a discussion of the risks and benefits of declining additional service. Must adequately acknowledge risks of declining.
  - c. Free of impairment due to drugs or alcohol.

- d. No evidence of suicidality, homicidality, grave disability, or other acute psychiatric condition that may require a 5150.
  - e. No need for ALS level intervention.
  - f. No criteria for ALS assessment and base hospital contact as defined by VCEMS policy 704.
4. Adults and appropriate minors may be released ~~by ALS providers after base hospital contact~~ if ALL of the following criteria are met:
- a. Alert, oriented (x4) person, place, time, and purpose/situation.
  - b. Able to demonstrate capacity by participating in a discussion of the risks and benefits of declining additional service. Must adequately acknowledge risks of declining.
  - c. Free of impairment due to drugs or alcohol.
  - d. No evidence of suicidality, homicidality, grave disability, or other acute psychiatric condition that may require a 5150.
5. Minors and those lacking capacity may be released from care if a parent or dedicated decision maker is present and meets criteria listed above.
6. Documentation ~~is essential. You MUST document the mechanism of injury or medical complaint, past medical history with medications, a physical exam with vital signs, a general impression or assessment, and a follow-up plan per VCEMS Policy 1000 – Documentation of Prehospital Care.~~
7. Discuss the risks of declining and document the discussion in your narrative.
- ~~8. Obtain relevant signatures.~~
- ~~9. The relevant documentation shall be completed expeditiously.~~

**D. AMA**

1. Patient has evidence of an emergency medical condition, required an ALS intervention, or has a complaint and/or condition as described in VCEMS policy 704.
2. Attempt to convince the patient to consent to care and/or transport.
3. Engage patient in a discussion detailing the risks of declining additional services.
4. Contact base hospital for further assistance and/or to document AMA.
5. Direct communication between the MICN and/or base hospital physician and patient is encouraged.
6. Adults and appropriate minors may be released by ALS providers after base hospital contact if the appropriate criteria are met:
  - a. Alert, oriented (x4) person, place, time, and purpose/situation.
  - b. Able to demonstrate capacity by participating in a discussion of the risks and benefits of refusal. Must adequately acknowledge risks of refusal.
  - c. Free of impairment due to drugs or alcohol.
  - d. No evidence of suicidality, homicidality, grave disability, or other acute psychiatric condition that may require a 5150.
7. These are high-risk contacts for patients, providers, and EMS agencies. Therefore, they must be completed in a thorough and thoughtful manner. This includes detailed documentation of the history, exam, and all pertinent discussions.
8. Have patient and witness complete relevant AMA documentation.

9. If patient does not meet criteria outlined above, or AMA is discouraged by the base hospital, Law enforcement and/or Crisis Team may be requested to the scene and efforts to convince the patient to agree to transport should be continued.



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

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- I. PURPOSE: To guide out-of-hospital personnel in determining which patients require the services of a designated trauma center. To serve as the EMS system standard for triage and destination of patients suffering acute injury or suspected acute injury.
- II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798. California Code of Regulations, Title 22, §100252 and §100255.
- III. POLICY: These criteria apply to any patient who is injured or has a physical complaint related to trauma, and is assessed by EMS personnel at the scene.
  - A. Physiologic Criteria, Step 1:
    1. Glasgow Coma Scale < 14
    2. Systolic blood pressure < 90 mmHg (< 110 in patients older than 65 years of age)
    3. Respiratory rate < 10 or > 29 breaths per minute (< 20 in infant younger than 1 year of age)
  - B. Anatomic Criteria, Step 2:
    1. Penetrating wounds to the head, neck, torso, or extremities proximal to the elbow or knee
    2. Flail chest
    3. Two or more proximal long bone fractures (femur or humerus)
    4. Crushed, degloved, or mangled extremity
    5. Amputations proximal to wrist or ankle
    6. Pelvic fractures
    7. Open or depressed skull fracture
    8. Paralysis
    9. Seat belt injury: significant bruising to neck, chest, or abdomen
    10. Diffuse abdominal tenderness as a result of blunt trauma

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- C. Mechanism of Injury Criteria, Step 3:
1. Adults: > 20 feet (one story is equal to 10 feet)  
Children < 15 years old: > 10 feet, or two times the height of the child
  2. High-risk auto crash:
    - a. Intrusion: interior measurement > 12 inches patient site; > 18 inches any occupant site
    - b. Ejection: partial or complete from automobile
    - c. Death in same passenger compartment
  3. Auto-pedestrian / auto-bicyclist thrown, run over, or with > 20 mph impact
  4. Unenclosed vehicle (e.g. motorcycle, bicycle, skateboard) crash > 20 mph
- D. Other Criteria, Step 4 (these are considerations to be used by the base hospital in determining the appropriate destination hospital):
1. Age > 65 years old
  2. Head injury with loss of consciousness AND on an anticoagulant or antiplatelet drug<sup>1</sup>
  3. Burns with trauma mechanism
  4. Time sensitive extremity injury (open fracture, neurovascular compromise)
  5. Pregnancy > 20 weeks with known or suspected abdominal trauma
  6. Prehospital care provider or MICN judgment
  7. Amputation or partial amputation of any part of the hand<sup>2</sup>
  8. Penetrating injury to the globe of the eye, at risk for vision loss<sup>3</sup>
- V. PROCEDURE:
- A. Any patient who is suffering from an acute injury or suspected acute injury shall have the trauma triage criteria applied.
  - B. For patients who meet trauma triage criteria listed in Sections A, B, or C above, the closest trauma center is considered to be the base hospital for that patient. Paramedics shall make base hospital contact and provide patient report directly to the trauma center.
  - C. Transportation units (both ground and air) shall transport patients who meet at least one of the trauma triage criteria in Sections A or B to the closest appropriate designated trauma center. If the closest trauma center is on internal disaster, these patients shall be transported to the next closest appropriate trauma center. If the closest trauma center is on CT diversion, the paramedic shall make early base contact and the MICN shall determine the most appropriate destination.
  - D. For patients who meet trauma triage criteria in Section C, the paramedic shall make base hospital contact with the closest designated trauma center. Based on the paramedic's report of the incident and the patient's assessed injuries, the trauma center MICN or ED

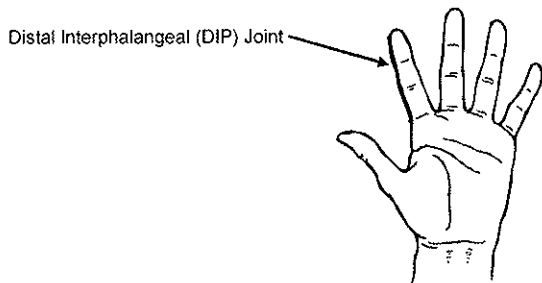
physician shall direct destination to either the trauma center or the closest appropriate hospital.

- E. Paramedics providing care for patients who are injured but meet only the trauma triage criteria listed in Section D above will contact the base hospital in whose catchment area the incident occurred. Destination will be determined by the base hospital MICN or ED physician. If the patient is directed other than to the regular catchment base hospital, the MICN will notify the receiving hospital or trauma center of an inbound patient and relay paramedic report.
- F. A trauma patient without an effective airway may be transported to the closest available hospital with an emergency department for airway management prior to transfer to a designated trauma center. In this rare event, the paramedic will contact the base hospital in whose catchment area the incident occurred.
- G. A patient who does not meet trauma triage criteria and who, in the judgment of a base hospital, has a high probability of requiring immediate surgical intervention or other services of a designated trauma center shall be directed to a designated trauma center.

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

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

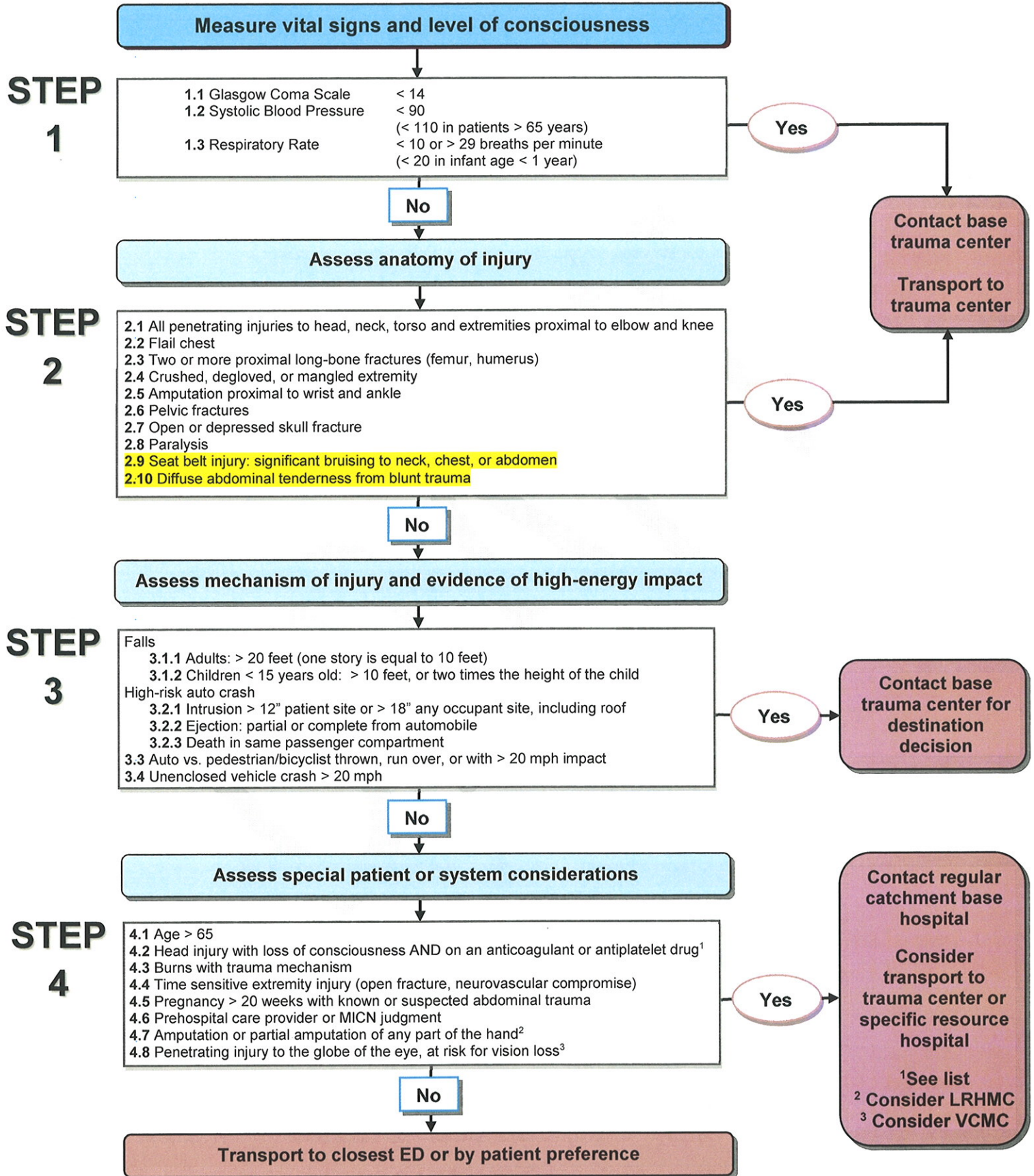
<sup>3</sup>For patients with isolated penetrating injury to the globe of the eye, at risk for vision loss, the regular catchment base hospital MICN may direct the patient to Ventura County Medical Center (VCMC) for specialized ophthalmologic care and possible surgical intervention.





# Ventura County Field Triage Decision Scheme

*For patients with visible or suspected traumatic injuries*





COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Emergency Medical Technician-I Automatic External Defibrillation (AED) Service Provider Medical Director		Policy Number: 802	
APPROVED: Administration: Steven L. Carroll, EMT-I-P		Date: 10/10/2002	
APPROVED: Medical Director: Angelo Salvucci, M.D.		Date: 10/10/2002	
Origination Date: November 1988 Date Revised: June, 2002 Date Last Reviewed: April 14, 2011 Review Date: April 2014		Effective Date: November 30, 2002	

- I. PURPOSE: To define the qualifications and responsibilities of the EMT AED Medical Director.
- II. AUTHORITY: Health and Safety Code 1797.107, 1707.170, 1797.220, 1798 and California Code of Regulations, Title 22, Division 9, Sections 10063 and 100063.1.
- III. DEFINITION: "Defibrillation Medical Director" means a physician and surgeon licensed in the State of California who is certified by the American Board of Emergency Medicine and is designated by the local EMS medical director to be responsible for the EMT-I defibrillation program, including medical control, under his/her jurisdiction. Waiver of the board certified requirement may be granted by the local EMS medical director if such physicians are not available for designation. (22CCR100059.1)
- IV. POLICY: An EMT AED Service Provider Medical Director in Ventura County shall meet the qualifications and perform the functions defined in this policy.
- V. PROCEDURE: The EMT AED Medical Director shall:
  - A. Either:
    1. Be certified by the American Board of Emergency Medicine or
    2. Maintain current ACLS certification
  - B. Have skills in cardiac rhythm interpretation
  - C. Possess a working knowledge of the prehospital EMS system and EMT AED systems.
  - D. Make sufficient time commitment to actively participate in the review of individual cases and in the development and approval of all periodic reports.
  - E. Approve and monitor training programs, including refresher training



- F. Establish policies and procedures for demonstration of continued competency in defibrillation
- G. Require documented demonstration of skills proficiency
  - 1. Monthly for manual defibrillation
  - 2. At least every 6 months for automatic or semi-automatic defibrillation
- H. Rescind accreditation if an EMT fails to show continued competency
- I. Establish policies and procedures for temporary suspension, as needed, by EMS Medical Director, EMT AED medical director or Base Hospital medical director and submit these policies to the EMS Medical Director for approval.
- J. Submit reports to the EMS Medical Director according to policies and procedures established by the local EMS agency.

The EMT AED medical director may delegate specific field care audits, training and clinical experience/demonstration of competency to the medical director of a Base Hospital, physician, registered nurse, physician assistant or EMT-P licensed or certified in the State of California. An EMT may assist an instructor in demonstration of competency and training.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Emergency Medical Technician (EMT) Medical Cardiac Arrest		Policy Number 805	
APPROVED Administrator	 Steven L. Carroll, EMT-P	Date: 04/24/2006	
APPROVED Medical Director:	 Angelo Salvucci, MD	Date: 04/24/2006	
Origination Date:	October 1, 1993	Effective Date: June 1, 2006	
Revised:	April 24, 2006		
Date Last Reviewed:	April 14, 2011		
Review Date:	April, 2014		

- I. PURPOSE: To define the protocol to be followed by non-transport unit EMT-Is during a response to a medical cardiac arrest.
- II. AUTHORITY: Health and Safety Code 1797.107, 1797.170, 1797.220, 1798 and California Code of Regulations, Title 22, Division 9, Section 100063 and 100063.1.
- III. POLICY: The following protocol shall be used by EMT-Is in a medical cardiac arrest.
- IV. PROCEDURE: EMT-Is shall:
  - A. CONFIRM: Patient is unconscious, non-breathing or has agonal respiration and pulseless.
    1. Arrest not secondary to trauma (if trauma, follow trauma protocol)
    2. If AED has demonstrated a high specificity for pediatric shockable rhythms, as determined by the service provider medical director, patient is 1 year of age or older. If the AED has not demonstrated a high specificity for pediatric shockable rhythms, as determined by the service provider medical director, patient is 8 years of age or older.
  - B. Initiate CPR/set up defibrillator.
    1. If collapse before call to 9-1-1, 2 minutes of CPR (1 or 2+ rescuers) before first analysis.
    2. If collapse after call to 9-1-1:
      - a. If alone, do not start CPR. Start defibrillator immediately and analyze.
      - b. For 2 or more rescuers, CPR while setting up defibrillator, then analyze immediately.
  - C. Clear personnel prior to analyzing rhythm. Re-clear and visually clear prior to administering shock.
  - D. Have machine analyze rhythm
    1. If the AED is not in compliance with the 2005 AHA Guidelines
      - a. If machine determines that a shock is necessary, press button to shock patient (360 J monophasic)\*.
      - b. Analyze rhythm: If machine determines that a shock is necessary, press button to shock patient (360J monophasic)\*.

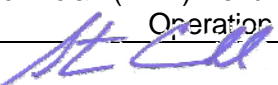

\* Or monophasic or biphasic energy level approved by service provider medical director.

- c. Analyze rhythm: If machine determines that a shock is necessary, press button to shock patient (360 J monophasic)\*. Check carotid pulse.
  - d. If the patient remains unconscious and pulseless after the third shock, perform CPR for 1 minute and repeat the series of up to three shocks.
  - e. Continue cycles of CPR and assessment until turning over care to ALS responders or to the hospital.
  - f. If after any of the shocks, the rhythm has changed and there is a pulse, maintain the airway and breathing, monitor pulse, and check blood pressure. If pulse is less than 30 and patient remains unconscious, do CPR for 1 minute and reevaluate patient.
2. If the AED is compliant with the 2005 AHA Guidelines:
    - a. If machine determines that a shock is necessary, press button to shock patient (360 J)\*, then immediately begin CPR.
    - b. Perform CPR for 2 minutes, reassess, and shock if necessary.
    - c. Continue cycles of CPR and assessment until turning over care to ALS responders or to the hospital.
- E. Patient Transportation
1. If the transport unit is an Advanced Life Support unit, the care of the patient will be turned over to the EMT-Ps. The EMT-I may accompany the patient to the hospital.
  2. If the transport unit is a Basic Life Support unit, CPR shall be continued and the patient transported to the nearest (in terms of time) hospital.
    - a. The EMT-I shall accompany the patient in the BLS unit.
    - b. If the patient transiently regains pulses as a result of previous defibrillation, and then patient loses pulses, the unit may pull over for machine evaluation of the patient's rhythm and deliver further shocks.
- F. If the initial rhythm is not shockable or any time that the machine indicates a non-shockable rhythm and patient remains pulseless:
1. Do CPR for two minutes
  2. Have machine analyze rhythm
  3. If unshockable rhythm remains, check pulse. If pulseless, do CPR for 2 minutes. If pulse is absent, reanalyze. Repeat cycle until transport unit arrives, patient resumes pulse, or a shockable rhythm presents.

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\* Or monophasic or biphasic energy level approved by service provider medical director.

4. If a shockable rhythm presents, follow shock series as above.
  5. If pulse returns, maintain airway and breathing, monitor pulse, and check blood pressure. Except in cases of hypothermia, if pulse is less than 30 and patient remains unconscious, do CPR for 2 minutes and reevaluate patient.
- F. When repeating shocks on a patient who has converted and then refribrillates, administer shocks at the level that conversion occurred (e.g., if the patient converted at 360 J, begin new series of shocks at 360 J) \*1.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Emergency Medical Technician (EMT) Defibrillation Integration With Public AED Operation		Policy Number 808	
APPROVED Administrator	 Steven L. Carroll, EMT-P	Date: 0/10/2002	
APPROVED Medical Director:	 Angelo Salvucci, MD	Date: 10/10/2002	
Origination Date:	May 9, 2002	Effective Date: November 30, 2002	
Date Revised:	August 2002		
Date Last Reviewed:	April 14, 2011		
Review Date:	April 2014		

- I. PURPOSE: To define criteria for EMS providers to integrate with public AED operations.
- II. AUTHORITY: Health and Safety Code 1797.107, 1797.170, 1798 and California Code of Regulation, Title 22 10063.1.
- III. POLICY: Ventura County EMS Agency will notify local EMS providers of known AED programs in their area, including type of AED device. EMS providers will attempt to integrate pre-arrival AED care with current Ventura County Policy.
- IV. PROCEDURE:
  - A. Obtain brief report from public AED operation, which shall include:
    1. Situation (patient age, sex, history, events occurring prior to arrival)
    2. Initial analysis – Shock or no shock? If shock - # of shocks delivered
    3. Time of last analysis or shock
  - B. Confirm patient is unconscious, non-breathing or agonal respirations and pulseless UNLESS public AED is in the process of analyzing or in the middle of a shocking sequence.
  - C. Determine need to switch to first responder's AED.
    1. Criteria for switching units to include:
      - a. Pads incorrectly positioned
      - b. Questionable or unsafe operation of public AED
    2. Criteria for continuing with public AED
      - a. Appropriate operation of AED
      - b. Pads correctly positioned
    3. If decision is made to switch to first responder AED, be sure to deactivate or turn off the public AED prior to removing pads.
  - D. Assume or take over ventilations and compressions from bystanders.
  - E. Follow EMT Protocol outlined in Policy 805.

1. In continuing with public AED, supervise and advise public AED operator for compliance with Policy 805.
  2. If switching to first responder AED, begin with initial analysis or rhythm and follow EMT protocol in Policy 805.
- F. If a pulse is obtained, stop CPR and continuously monitor the pulse. Immediately analyze if pulse is lost. (Not all public AEDs will sound an alert if the patient's rhythm changes to a shockable rhythm.)
- G. Switch to ALS agency (manual) defibrillator during CPR, not during analysis or shocking sequence.
- H. Obtain and document information for a complete cardiac arrest report to include:
1. Information listed in IV.A.1, 2, 3 and C.1, 2, 3.
  2. Time down
  3. Witnessed or non-witnessed arrest
  4. Presence of bystander CPR
  5. Type of public AED
  6. Contact person and phone number for the public AED program
- I. Acknowledge the public AED operator's and bystander's efforts in the resuscitation attempt.



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Organ Donor Information Search		Policy Number 615	
APPROVED: Administration:  Steven L. Carroll, EMT-P		Date: June 1, 2013	
APPROVED: Medical Director:  Angelo Salvucci, M.D.		Date: June 1, 2013	
Origination Date: October 1, 1993		Effective Date: June 1, 2013	
Date Revised: February 14, 2013			
Date Last Reviewed: February 14, 2013			
Review Date: January 31, 2015			

- I. **PURPOSE:** To establish guidelines for Emergency Medical Services (EMS) field personnel to meet requirements that they search for organ donor information on adult patients for whom death appears to be imminent.
- II. **AUTHORITY:** Health and Safety Code Section 7152.5(b)
- III. **POLICY:** EMS field personnel shall make a brief reasonable search to determine the presence or absence of an organ donor card on adult patients for whom death appears to be imminent. This brief search shall not interfere with patient care, and must be done in the presence of a witness, preferably a public safety officer, unless extenuating circumstances make having a witness clearly infeasible.
- IV. **DEFINITIONS:**
  - A. "Reasonable Search": A brief attempt by EMS field personnel to locate documentation that may identify a patient as a potential organ donor, or one who has refused to make an anatomical gift. This search shall be limited to a wallet, purse or other personal belongings on or near the individual likely to contain a driver's license or other identification card with this information. **A REASONABLE SEARCH SHALL NOT TAKE PRECEDENCE OVER PATIENT CARE/TREATMENT.**
  - B. "Imminent Death": A condition wherein illness or injuries are of such severity that in the opinion of EMS field personnel, death is likely to occur before the patient arrives at a hospital. For purposes of this policy, this definition does not include any conscious patient regardless of the severity of illness or injury.
  - C. "Receiving Hospital": The hospital to which the patient is being transported.

IV. PROCEDURE:

- A. When EMS field personnel encounter an unconscious adult patient for whom it appears that death is imminent (that is, death prior to arrival at a hospital), they shall attempt a "reasonable search" as defined in Section III. A. This search must be done in the presence of a witness, preferably a public safety officer, unless extenuating circumstances make having a witness clearly infeasible. If a family member or patient representative is the only witness available, EMS field personnel should clearly and carefully explain the intent of the brief search. The identity of the witness to the brief search will be documented on the approved Ventura County Documentation System.
- B. Treatment and transport of the patient remains the highest priority for EMS field personnel. This search shall not interfere with patient care or transport.
- C. EMS field personnel shall notify the receiving hospital if organ donor information is discovered. Advanced Life Support (ALS) units shall notify the base hospital in addition to the receiving hospital.
- D. Any organ donor document that is discovered should be transported to the receiving hospital with the patient unless it is requested by the investigating law enforcement officer. If the investigating law enforcement officer retains the organ donor card, the presence of the card will be documented on the approved Ventura County documentation system. In the event that the patient is not transported, any document will remain with the patient.
- E. Field personnel should briefly note the results of the search, notification of hospital, and witness name(s) in the narrative section of the VCePCR.
- F. No search is to be made by EMS field personnel after patient death occurs.
- G. If a member of the patient's immediate family or other patient representative objects to the search for an organ donor document at the scene, no search shall be made, and their response to a question about the patient's organ donor wishes may be considered to satisfy the requirement of this policy. This information shall be documented on the approved Ventura County Documentation System.



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Medical Control At Scene, Private Physician/Physician On Scene		Policy Number: 703	
APPROVED: Administration:	 Steven L. Carroll, EMT-P	Date: June 1, 2008	
APPROVED: Medical Director:	 Angelo Salvucci, M.D.	Date: June 1, 2008	
Origination Date:	January, 1985	Effective Date: June 1, 2008	
Revised Date:	March 13, 2008		
Date Last Reviewed:	September 12, 2013		
Review Date:	September, 2015		

- I. Purpose: To establish guidelines for medical control of patient care at the scene of a medical emergency. To assist the paramedic who, arrives on the scene of a patient who is being attended by a California licensed physician.
- II. Authority: Health and Safety Code, Division 2.5, Sections 1798 & 1798.6. California Code of Regulations, Title 22, Division 9, Section 100175.
- III. Policy: paramedics shall use the following procedure to determine on-scene authority for patient care.
- IV. Procedure:
  - A. When a bystander at the scene of a medical emergency identifies himself/herself as a physician, the paramedic shall:
    - 1. Obtain proper identification from the individual (preferably California licensure as M.D., or D.O.) and document name on the PCR.
    - 2. Present the CMA card "Note to Physician on Involvement with EMT-II and Paramedic" to him/her to read and choose level of involvement.



STATE OF CALIFORNIA



CALIFORNIA  
MEDICAL ASSOCIATION

**NOTE TO PHYSICIAN ON INVOLVEMENT WITH EMT-II's and EMT-Ps (PARAMEDIC)**

A life support team (EMT-II or EMT-P (Paramedic) operates under standard policies and procedures developed by the local EMS agency and approved by their Medical Director under the Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy.

If you want to assist, this can only be done through one of the alternatives listed on the back of this card. These alternatives have been endorsed by CMA, State EMS Authority, CCLHO, and BMQA.

Assistance rendered in the endorsed fashion, **without compensation**, is covered by the protection of the "Good Samaritan Code" (see Business and Professions Code, Sections 2144, 2395-2398 and Health and Safety Code, Section 1799.104).

(over)

**ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT**

After identifying yourself by name as a physician licensed in the State of California, and, if requested, showing proof of identity, you may choose to do one of the following:

1. Offer your assistance with another pair of eyes, hands, or suggestions, but let the life support team remain under base hospital control; or,
2. Request to talk to the base station physician and directly offer your medical advice and assistance; or,
3. Take **total responsibility** for the care given by the life support team and physically accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedure. (Whenever possible, remain in contact with the base station physician.)

(REV. 7/88) 88 48638 Provided by the Emergency Medical Services Authority

- 3. Contact the Base Hospital and advise them that there is a physician on scene.
- 4. Determine the level of involvement the physician wishes to have and inform the Base Hospital.
- B. If the physician chooses not to assume patient care, the Base Hospital shall retain medical control and the paramedic's will utilize the physician as an "assistant" in patient care activities.

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- C. If the physician chooses to take medical control, the paramedic's will instruct the physician in radio operation procedures and have the physician at the scene communicate with the Base Hospital physician. The Base Hospital physician may do either of the following:
1. Retain medical control, but consider and/or utilize suggestions offered by the physician at the scene.
  2. Request that the physician at the scene function in an observer capacity only.
  3. Delegate medical control to the physician at the scene.
  4. If the physician at the scene has been given medical control by the Base Hospital physician, the paramedic shall:
    - a. Make ALS equipment and supplies available to the physician and offer assistance.
    - b. Ensure that the physician accompany the patient in the ambulance to the hospital, and signs for all instructions and medical care given.
    - c. Keep the Base Hospital advised.
- D. The paramedic, while under the direction of a physician at the scene, shall perform only those procedures and administer only those drugs for which he/she is accredited for in Ventura County. Paramedics shall be held accountable and possibly liable for performing a procedure or treatment outside the paramedic scope of practice. If a physician at the scene wishes such a procedure or treatment performed, he/she may perform that procedure. The paramedic should attempt to have the on-site physician call the Base Hospital physician regarding the treatment.
- E. The Base Hospital shall:
1. Speak to the physician on scene, unless a delay would be detrimental to patient care, or the physician is the patient's personal physician, to determine qualification regarding emergency treatment and level of involvement chosen by the physician.
  2. Document the physician's intent to assume patient care responsibility.
  3. Relinquish patient care to the patient's personal physician, if he/she has arrived after Base Contact has been made and wishes to assume control.
  4. In cases where a dispute arises regarding medical care, the ultimate decision as to patient care shall be made by the Base Hospital, except when the personal physician is present.

F. Private Physician On Scene

1. If the private physician is present and assumes responsibility for the patient care, the paramedic shall advise the Base Hospital that the patient is under the care of his/her private medical doctor (PMD) and inform the Base Hospital of the PMD's instructions.
2. The paramedic, while under the direction of a physician at the scene, shall perform only those procedures and administer only those drugs for which he/she is accredited for in Ventura County. Paramedics shall be held accountable and possibly liable for performing a procedure or treatment outside the paramedic scope of practice. If a physician at the scene wishes such a procedure or treatment performed, he/she may perform that procedure. The paramedic should attempt to have the on-site physician call the Base Hospital physician regarding the treatment.