

Public Health Administration
Large Conference Room
2240 E. Gonzales, 2nd Floor
Oxnard, CA 93036

Pre-hospital Services Committee
Agenda

March 14, 2019
9:30 a.m.

I. Introductions

II. Approve Agenda

III. Minutes

IV. Medical Issues

A. Other

V. New Business

A. Other

VI. Old Business

A. 210 – Abuse Report Guidelines

Karen Beatty

B. 705.01 – Trauma Treatment Guidelines

Karen Beatty

C. 705.14 – Hypovolemic Shock

Karen Beatty

VII. Informational/Discussion Topics

A. 627 – Fireline Medic

Chris Rosa

VIII. Policies for Review

A. 607 – Hazardous Material Incident

B. 725 – Patients After Taser Use

C. 732 – Use of Restraints

D. 920 – ReddiNet Communication Policy

IX. Agency Reports

A. Fire Departments

B. Ambulance Providers

C. Base Hospitals

D. Receiving Hospitals

E. Law Enforcement

F. ALS Education Program

G. EMS Agency

H. Other

X. Closing

Topic	Discussion	Action	Approval
II. Approve Agenda		Approved	Motion: Ira Tilles Seconded: Tom O'Connor Passed unanimous
III. Minutes		Approved	Motion: Ira Tilles Seconded: Tom O'Connor Passed unanimous
IV. Medical Issues			
A. None			
V. New Business			
A. 705 – Treatment Protocols Cover		Approved	
1. 705.34 – Tranexamic Acid	Adriane asked that the last bullet be deleted. Kathy McShea suggested that this small policy be rolled into 705.14 and delete 705.34.	Approved Add the wording from this policy into Policy 705.14 and delete Policy 705.34. Bring Policy 705.14 with new language to the next PSC meeting for final approval.	Motion: Ira Tilles Seconded: Tom O'Connor Passed unanimous
2. 734 – Tranexamic Acid Administration	Dr. Chase is concerned that the policy is reflecting the guidelines from the recent trial/study in Alameda and San Bernardino. Suggests that we look at changing Spinal Shock to Neurogenic Shock and remove Pregnancy as a Precaution. Dr. Shepherd said he is fine with that and will discuss with EMSA.	Approved with suggested changes. Dr. Shepherd will make changes if approved by CA EMSA.	Motion: Ira Tilles Seconded: Jaime Villa Passed unanimous
B. Push Dose Epinephrine			
1. 705.02 – Allergic Reaction and Anaphylaxis		Approved with changes	Motion: Chris Sikes Seconded: Kathy McShea Passed unanimous
2. 705.09 – Chest Pain -		Approved with changes	Motion: Chris Sikes

			Seconded: Kathy McShea Passed unanimous
3. 705.11 – Crush Injury Syndrome		Approved as presented	Motion: Nicole Vorzimer Seconded: Kathy McShea Passed unanimous
4. 705.21 – SOB – Pulmonary Edema		Approved as presented	Motion: Nicole Vorzimer Seconded: Kathy McShea Passed unanimous
5. 705.22 – SOB – Wheezes/Other		Approved with changes Copy Epi dose, etc. in Moderate to Severe Distress and remove the “x1” in the Severe one. Copy and paste Albuterol dose, etc. under Epi in the Severe Distress section. Change “every” to “q”.	Motion: Chris Sikes Seconded: Kathy McShea Passed unanimous
6. 705.24 – Symptomatic Bradycardia		Approved as presented	Motion: James Rosolek Seconded: Kathy McShea Passed unanimous
7. 735 – Push Dose Epi		Approved	Motion: James Rosolek Seconded: Kathy McShea Passed unanimous
C. 504 – ALS and BLS Equipment and Supplies	Chris Rosa went over changes made to reflect new policy.	Approved as presented	Motion: Aaron Tapping Seconded: Adriane Stefansen Passed unanimous
VI. Old Business			
VII. Informational/Discussion Topics			
VIII. Policies for Review			
A. 622 - ICE	The committee discussed this policy and requested it be deleted.	Delete Policy from VCEMS Policies	
B. 625 - POLST		Approved	
C. 627 - Fireline Medic		Approved Chris will update this policy with all the new/updated Fireline Guidelines.	
X. Agency Reports			
A. Fire departments	VCFPD – Chief Miller and Chief Milkovich are retiring in February and March. EMT expanded scope training will be done in January 2019.		

		VCFD -none OFD –none Fed. Fire – none SPFD – none FFD – none	
B.	Transport Providers	LMT – none AMR/GCA – none AIR RESCUE – none	
C.	Base Hospitals	SVH – none LRRMC – none SJRMC – none VCMC – none	
D.	Receiving Hospitals	PVH – The in-patient unit is open and doing well. SPH – none CMH – Had successful move on December 16 th . Thank you to EMS Agency, MRC and the ambulance companies for assisting. OVCH – The ED is dealing with new law regarding homeless patient discharge.	
E.	Law Enforcement	VCSO –none CSUCI PD – none	
F.	ALS Education Programs	Ventura College – Need preceptors for field training.	
G.	EMS Agency	Steve – We had 9 applicants for Karen’s position. Someone will be chosen by March 2019. The Base and Coastal Trident will host an exercise with an MCI at the end of June. Dr. Shepherd – Extended Scope has been approved by State EMSA Chris – There will be a Rescue Task Force meeting soon to deal with developing a countywide committee to discuss and improve the policy. The committee will have subcommittees to work on multiple issues. Katy –none Karen –none Julie –none Randy – none	
H.	Other		
XI.	Closing	Meeting adjourned at 11:30	



**TEMPORARY
PARKING PASS
Expires March 14, 2019**

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

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

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

2240 Gonzales Rd. location

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

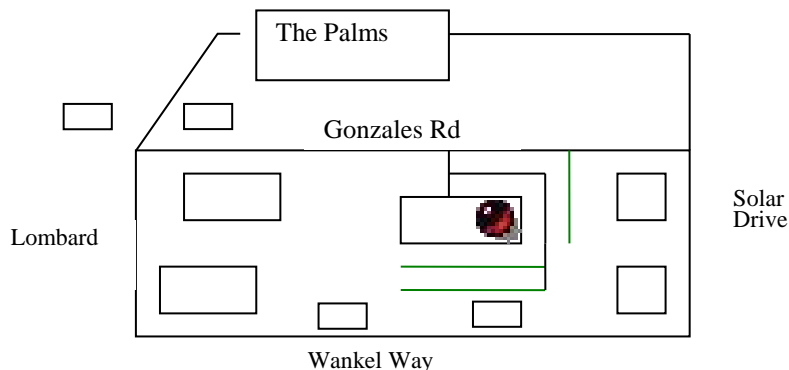
2100 Solar Drive

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

The Palms - shopping mall

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

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



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Child, Dependent Adult, or Elder Abuse Reporting		Policy Number 210	
APPROVED: Administration: Steven L. Carroll, Paramedic		Date:	
APPROVED: Medical Director: Daniel Shepherd M.D.		Date:	
Origination Date: June 14, 1984		Effective Date:	
Date Revised:			
Last Review: September 13, 2018			
Review Date: September 30, 2021			

- I. PURPOSE: To define child, dependent adult and elder abuse and outline the required reporting procedure for prehospital care personnel in all cases of suspected child, dependent adult and elder abuse.
- II. AUTHORITY: Welfare and Institutions code Section 15630-15632
- III. POLICY: EMS Provider will report all suspected cases of abuse.
- IV. DEFINITIONS:
 - A. "Abuse of an elder or a dependent adult" means physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, isolation, or treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods and services which are necessary to avoid physical harm or mental suffering.
 1. "Isolation" means any of the following:
 - a. Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls.
Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor, where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.
False imprisonment, as defined in Section 236 of the Penal Code.
Physical restraint of an elder or dependent adult for the purpose of preventing the elder or dependent adult from meeting with visitors.
 - b. The acts set forth in paragraph a. shall be subject to a rebuttal

presumption that they do not constitute isolation if they are performed pursuant to the instructions of a physician licensed to practice medicine in the State of California, who is caring for the elder or dependent adult at the time the instructions are given, and who gives the instructions as part of his or her medical care.

- c. The acts set forth in paragraph a. shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety.
2. "Child" means any person under the age of 18 years.
3. "Child abuse" means physical injury which is inflicted by other than accidental means on a child by another person....sexual assault of a child....neglect of a child or abuse in out-of-home care.
4. "Dependent Adult" means any person residing in this state between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.
5. "Dependent adult" includes any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.
6. "Elder" means any person residing in this state, 65 years of age or older"
7. "Health practitioner" means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision © of Section 4980.03 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a

coroner.

8. "Physical abuse means all of the following:

- ~~a. Assault, as defined in Section 240 of the Penal Code~~
- ~~ab. Battery or assault, as defined in Section 242 of the Penal Code~~
- ~~b. Assault with a deadly weapon or force likely to produce great bodily injury, as defined by Section 245 of the Penal Code~~
- ~~c. Unreasonable physical constraint or prolonged or continual deprivation of food or water.~~
- ~~d. Sexual Assault, which means any of the following:
 - 1) Sexual battery, ~~rape, incest, sodomy, oral copulation, or penetration of a genital or anal opening by a foreign object, as defined in Section 243.4 of the Penal Code~~
 - 2) ~~Rape, as defined in Section 261 of the Penal Code~~
 - 3) ~~Rape in concert, as described in Section 264.1 of the Penal Code~~
 - 4) ~~Incest, as defined in Section 285 of the Penal Code~~
 - 5) ~~Sodomy, as defined in Section 286 of the Penal Code~~
 - 6) ~~Oral copulation, as defined in Section 288a of the Penal Code~~
 - 7) ~~Penetration of a genital or anal opening by a foreign object, as defined in Section 289 of the Penal Code.~~~~
- ~~e. Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
 - 1) For punishment
 - 2) For a period significantly beyond that for which the restraint or medication was authorized pursuant to the instructions of a physician licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.~~

9. "Reasonable suspicion" means that it is objectively reasonable for a person to entertain such a suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate, on his or her training and experience, to suspect child abuse.

V. PROCEDURE:

1. Report by telephone to a county child or adult protective agency (Ventura County Human Services Agency at (805-654-3200) or to a local law enforcement agency

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immediately or as soon as possible. The telephone report shall include the following:

- a. Name, address, telephone number, and occupation of the person making the report
 - b. Name and address of the victim
 - c. Date, time and place of the incident
 - d. Other details, including the reporter's observations and beliefs concerning the incident
 - e. Any statement relating to the incident made by the victim
 - f. The name of any individuals believed to have knowledge of the incident
 - g. The name of the individuals believed to be responsible for the incident and their connection to the victim.
 - h. Present location of the child
 - i. Nature and extent of the injury
 - j. Information that led such person to suspect child abuse
2. Report in writing and fax to (805-654-5597) within two working days of receiving the information concerning the incident.
 3. When two (2) or more persons who are required to report are present and jointly have knowledge of a suspected instance of child, dependent adult or elder abuse, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by such selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make such report.
 4. The reporting duties are individual, and no supervisor or administrator may impede or inhibit such reporting duties and no person making such report shall be subject to any sanction for making such report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established provided that they are not inconsistent with the provisions of this article.

- I. Purpose: To establish a consistent approach to the care of the trauma patient
 - A. Rapid trauma survey
 1. Airway
 - a. Maintain inline cervical stabilization
 - 1) Follow spinal precautions per VCEMS Policy 614
 - b. Open airway as needed
 - 2) Utilize a trauma jaw thrust to maintain inline cervical stabilization if indicated
 - c. Suction airway if indicated
 2. Breathing
 - a. Assess rate, depth and quality of respirations
 - b. If respiratory effort inadequate, assist ventilations with BVM
 - c. Insert appropriate airway adjunct if indicated
 - d. Assess lung sounds
 - e. Initiate airway management and oxygen therapy as indicated
 - 1) Maintain SpO₂ ≥ 94%
 3. Circulation
 - a. Assess skin color, temperature, and condition
 - b. Check distal/central pulses and capillary refill time
 - c. Control major bleeding
 - d. Initiate shock management as indicated
 4. Disability
 - a. Determine level of consciousness (Glasgow Coma Scale)
 - b. Assess pupils
 5. Exposure
 - a. If indicated, remove clothing for proper assessment/treatment of injury location. Maintain patient dignity
 - b. Maintain patient body temperature
 - B. Detailed physical examination
 1. Head
 - a. Inspect/palpate skull
 - b. Inspect eyes, ears, nose and throat
 2. Neck
 - a. Palpate cervical spine
 - b. Check position of trachea
 - c. Assess for jugular vein distention (JVD)
 3. Chest
 - a. Visualize, palpate, and auscultate chest wall

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

C. Trauma care guidelines

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

- b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
 - 1) Stabilize object manually or with bulky dressings
 - 2) Control bleeding if present
 - 3) In the presence of penetrating injuries, if no neurologic deficit is present upon physical examination, withhold spinal immobilization
- c. Neck injuries
 - 1) Monitor airway
 - 2) Control bleeding if present
- 3. Thoracic Trauma
 - a. General treatments
 - 1) Evaluate chest – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
 - 2) Keep patients sitting high-fowlers
 - a) If in spinal precautions, elevate head of backboard 30° unless contraindicated
 - b) In the presence of isolated penetrating injuries, if no neurologic deficit is present upon physical examination, consider withholding spinal immobilization
 - 3) Goal of fluid resuscitation is to maintain SBP of ≥ 80 mmHg. -If SBP > 80 mmHg, then maintain IV/IO at TKO rate
 - a) Maintain palpable peripheral pulses
 - 4) Tranexamic Acid – For patients 15 years of age and older as indicated in VCEMS Policy 734
 - b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
 - a) Remove object if CPR is interfered
 - b) Stabilize object manually or with bulky dressings
 - c) Control bleeding if present
 - c. Flail Chest/Rib injuries
 - a) Immobilize with padding and bulky dressings to affected area
 - b) Assist ventilations if respiratory status deteriorates
 - d. Pneumothorax/Hemothorax
 - a) Keep patient sitting high-fowlers
 - b) Assist ventilations if respiratory status deteriorates1.
 - 1) Suspected tension pneumothorax should be managed per VCEMS Policy 715

- e. Open (Sucking) Chest Wound
 - a) Place an occlusive dressing to wound site. Secure on 3 sides only
 - b) Assist ventilations if respiratory status deteriorates
- f. Cardiac Tamponade – If suspected, expedite transport
 - a) Beck's Triad
 - 1) Muffled heart tones
 - 2) JVD
 - 3) Hypotension
- g. Traumatic Aortic Disruption
 - a) Assess for quality of radial and femoral pulses
 - b) If suspected, expedite transport
- 4. Abdominal/Pelvic Trauma
 - a. General Treatments
 - 1) Evaluate abdomen and pelvis – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
 - 2) Goal of fluid resuscitation is to maintain SBP of ≥ 80 mmHg. If SBP > 80 mmHg, then maintain IV/IO at TKO rate
 - a) Maintain palpable peripheral pulses
 - 3) Tranexamic Acid – For patients 15 years of age and older as indicated in VCEMS Policy 734
 - b. Blunt injuries
 - 1) Place patient in supine position if hypotension is present
 - c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
 - 1) Stabilize object manually or with bulky dressings
 - 2) Control bleeding if present~~t~~
 - d. Eviscerations
 - 1) DO NOT REPLACE ABDOMINAL CONTENTS
 - a) Cover wound with saline-soaked dressings
 - 2) Control bleeding if present
 - e. Pregnancy
 - 1) Place patient in left-lateral position
 - 2) _____ If in spinal immobilization, place padding under backboard to tilt to the left~~ft~~

- f. Pelvic injuries
 - 1) Consider wrapping a bed sheet tightly around the pelvis and tying it together for use as a binder to help control internal bleeding
 - a) Assessment of pelvis should be only performed **ONCE** to limit additional injury
 - 2) Control bleeding if present
 - 3) If possible avoid log rolling patient.

4. Extremity Trauma

a. General Treatments

- 1) Evaluate CSM distal to injury
 - a) If decrease or absence in CSM is present:
 - (1) Manually reposition extremity into anatomical position
 - (2) Re-evaluate CSM
 - b) If no change in CSM after repositioning, splint in anatomical position and expedite transport
 - c) Cover open wounds with sterile dressings
 - d) Place ice pack on injury area (if closed wound)
 - e) Splint/elevate extremity with appropriate equipment
 - f) Uncontrolled hemorrhage: Tranexamic Acid – For patients 15 years of age and older as indicated in VCEMS Policy 734

b. Dislocations

- 1) Splint in position found with appropriate equipment

c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECTS

- 1) Stabilize object manually or with bulky dressings
- 2) Control bleeding if present

d. Femur fractures

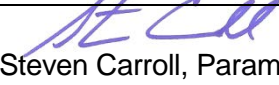

- 1) Utilize traction splint only if isolated mid-shaft femur fracture is suspected
- 2) Assess CSM before and after traction splint application

e. Amputations

- 1) Clean the amputated extremity with NS
- 2) Wrap in moist sterile gauze
- 3) Place in plastic bag

- 4) Place bag with amputated extremity into a separate bag containing ice packs
- 5) Prevent direct tissue contact with the ice packs

Hypovolemic Shock	
ADULT	PEDIATRIC
BLS Procedures	
Place patient in supine position Administer oxygen as indicated	Place patient in supine position Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
IV/IO access Normal Saline <ul style="list-style-type: none"> • IV/IO bolus – 1 Liter • Caution with cardiac and/or renal history • Evaluate lung sounds. If signs of CHF, decrease IV/IO to TKO • If vital signs return to within normal limits, decrease IV/IO to TKO <u>Traumatic Injury</u> <ul style="list-style-type: none"> • Tranexamic Acid – For patients 15 years of age and older as indicated in VCEMS Policy 734 <ul style="list-style-type: none"> ○ IV/IOPB - 1gm TXA in 100mL NS over 10 minutes • Do not delay transport for first IV/IO attempt • Attempt second IV/IO while enroute to ED • Refer to Policy 705.01- Trauma Treatment Guidelines, for fluid therapy in thoracic, abdominal and pelvic trauma. <ul style="list-style-type: none"> ○ Goal is to maintain palpable peripheral pulses 	IV/IO access Normal Saline <ul style="list-style-type: none"> • IV/IO bolus – 20 mL/kg <ul style="list-style-type: none"> ○ Caution with cardiac and/or renal history ○ Evaluate lung sounds. If signs of CHF, decrease IV/IO to TKO ○ If vital signs return to within normal limits, decrease IV/IO to TKO <u>Traumatic Injury</u> <ul style="list-style-type: none"> • Do not delay transport for first IV/IO attempt • Attempt second IV/IO while enroute to ED
Communication Failure Protocol	
If shock persists: <ul style="list-style-type: none"> • Repeat Normal Saline <ul style="list-style-type: none"> ○ IV/IO bolus – 1 Liter 	If shock persists: <ul style="list-style-type: none"> • Repeat Normal Saline <ul style="list-style-type: none"> ○ IV/IO bolus – 20 mL/kg
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures
Additional Information <ul style="list-style-type: none"> • Prepare and administer TXA concentration consistent with standards outlined in VCEMS Policy 734 – Tranexamic Acid (TXA) Administration 	

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Fireline Medic		Policy Number 627	
APPROVED: Administration:	 Steven Carroll, Paramedic	Date: December 1, 2014	
APPROVED: Medical Director	 Angelo Salvucci, M.D.	Date: December 1, 2014	
Origination Date:	October 5, 2011		
Date Revised:	September 11, 2014	Effective Date: December 1, 2014	
Date Last Reviewed:	September 11, 2014		
Review Date:	September, 2016		

- I. PURPOSE: To establish procedures for a fireline paramedic (FEMP) response from and to agencies within or outside local EMS agency (LEMSA) jurisdiction when requested through the statewide Fire and Rescue Mutual Aid System, to respond to and provide advanced life support (ALS) care on the fireline at wildland fires.
- II. AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220; California Code of Regulations, Title 22, Division 9, Sections 100165 and 100167
- III. POLICY:
 - A. County accredited paramedics shall carry the ALS/BLS inventory consistent with the FIRESCOPE FEMP position description. Reasonable variations may occur; however, any exceptions shall have prior approval of the VCEMSA. The equipment lists are a scaled down version of standard inventory in order to meet workable/packable weight limitations (45 lbs including wildland safety gear, divided between a two person team. Weight limit to include the Personal Pack Inventory as outlined in FireScope).
 1. It will not be possible to maintain standard ALS minimums on the fireline. The attached ALS inventory essentially prioritizes critical and probable fireline needs.
 2. VCEMS accredited paramedics may function within their scope of practice, when serving in an authorized capacity assignment, as an agent of their authorized ALS fire agency.

IV. PROCEDURE:

- A. Under the authority of State regulations, a paramedic may render ALS care during emergency operations as long as the following conditions are met:
1. The paramedic is currently licensed by the State of California and is accredited by the Ventura County EMS Agency.
 2. The paramedic is currently employed with a Ventura County ALS provider and possesses the requisite wildland fireline skills and equipment.
 3. The paramedic practices within the treatment guidelines set forth in VCEMSA policies and procedures manual. Paramedics operating in the capacity of a fireline paramedic (FEMP) shall follow VCEMSA communication failure protocol.
 4. The FEMP is expected to check in and obtain a briefing from the Logistics Section Chief, or the Medical Unit Leader (MEDL) if established at the Wildfire Incident.
 5. Documentation of patient care will be completed as per VCEMSA policy 1000.
 - a. Documentation of patient care will be submitted to incident host agencies. A VCePCR shall be completed for all ALS patients contacted, and shall be completed by the FEMP upon return to camp, or as soon as practical.
 6. Continuous Quality Improvement activities shall be in accordance with VCEMSA standards.

APPENDIX A

**FIRELINE EMERGENCY MEDICAL TECHNICIAN
BASIC LIFE SUPPORT (BLS) PACK INVENTORY**

Airway, NPA Kit (1)	Mask, Face, Disposable w/eye shield (1)
Airway, OPA Kit (1)	Mylar Thermal Survival Blanket (2)
Bag Valve Mask (1)	Pad, Writing (1)
Bandage, Sterile 4 x 4 (6)	Pen and Pencil (1 ea.)
Bandage, Triangular (2)	Pen Light (1)
Biohazard Bag (2)	Petroleum Dressing (2)
Burn Sheet (2)	Shears (1)
Cervical Collar, Adjustable (1)	Sphygmomanometer (1)
Coban Wraps/Ace Bandage (2 ea.)	Splint, Moldable (1)
Cold Pack (3)	Splinter Kit (1)
Commercially Available Tourniquet (1)	
Dressing, Multi-Trauma (4)	Stethoscope (1)
Exam Gloves	Suction, Manual Device (1)
Eye Wash (1 bottle)	Tape, 1 inch, Cloth (2 rolls)
Glucose, Oral (1 Tube)	Triage Tags (6)
Kerlix, Kling, 4.5, Sterile (2)	Triangular Dressing with Pin (2)
Digital Thermometer (1)	

APPENDIX B

**FIRELINE EMERGENCY MEDICAL TECHNICIAN
PARAMEDIC (ALS) PACK INVENTORY **IN ADDITION TO THE BASIC LIFE SUPPORT
INVENTORY, THE FOLLOWING ADDITIONAL ITEMS OR EQUIVALENTS SHALL BE
CARRIED BY THE FEMP**

ALS AIRWAY EQUIPMENT:

Endotracheal Intubation Equipment (6.0, 7.5 ET – Mac 4, Miller 4, stylette and handle)	ETT Verification Device
End Tidal CO2 Detector	Needle Thoracostomy Kit (1)
	Pulse Oximeter (Optional)
ETT Restraint	Rescue Airway (1)

IV/MEDICATION ADMIN SUPPLIES:

1 ml TB Syringe (2)	20 ga. IV Catheter (2)
10 ml Syringe (2)	IV Site Protector (2)
18 ga. Needle (4)	IV Administration Set-Macro-Drip (2)
25 ga. Needle (2)	Alcohol Preps (6)
Adult EZ-IO Kit (1)	Betadine Swabs (4)
	E-Z IO Stabilizer
EZ Connect tubing (2)	Glucometer Test Strips (4)
25 mm EZ-IO Needle (1)	Lancet (4)
45 mm EZ-IO Needle (1)	Razor (1)
14 ga. IV Catheter (2)	Tape (1)
16 ga. IV Catheter (2)	Tourniquet (2)
18 ga. IV Catheter (2)	

MISCELLANEOUS:



AMA Paper Forms (3)	PCR Paper Forms (6)
FEMP Pack Inventory Sheet (1)	Sharps Container – Small(1)
Narcotic Storage (per agency policy)	

BIOMEDICAL EQUIPMENT:

Defibrillator Electrodes (2)	Glucometer (1)
Defibrillator with ECG waveform display (1)	

MEDICATIONS:

Amiodarone 50 mg/ml 3 ml (2)	Epinephrine 1:1,000 1 mg (4)
Albuterol – 90mcg/puff (1 MDI) with Spacer Device	Glucagon 1 mg/unit (1)
Aspirin-Chewable (1 Bottle)	Midazolam 20 mg
Atropine Sulfate 1mg (2)	Morphine Sulfate 10 mg/ml (6)
	Naloxone – 2mg (2)
Dextrose 50% 25 G. Pre-Load (1)	Nitroglycerin 1/150 gr (1)
Diphenhydramine 50 mg (4)	Saline 0.9% IV 1,000 ml – Can be configured into two 500 ml or four 250 ml
Epinephrine 1:10,000 1mg (2)	5% Dextrose in Water, 50 ml (1)

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Hazardous Material Incident		Policy Number: 607	
APPROVED: Administration:	 Steven L. Carroll, EMT-P	Date: June 1, 2013	
APPROVED: Medical Director	 Angelo Salvucci, MD	Date: June 1, 2013	
Origination Date:	February 12, 1987	Effective Date: June 1, 2013	
Date Revised:	February 14, 2013		
Date Last Reviewed:	February 14, 2013		
Review Date:	January 31, 2015		

- I. PURPOSE: This policy establishes guidelines for the response of pre-hospital care providers to incidents involving hazardous materials.
- II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.220 & 1798. California Code of Regulations, Title 22, Division 9, Section 100175.
- III. POLICY: The Ventura County Regional Response Team (VCRRT), under direction of the Incident Commander, assumes responsibility for control of the hazardous materials incident.

The responding Emergency Medical Services personnel assume responsibility for patient care and transportation after release and/or decontamination by VCRRT. The EMS personnel and/or treatment team shall coordinate treatment/transport efforts with VCRRT so as not to jeopardize scene integrity, causing unnecessary spread of contamination to ambulance, equipment, EMS personnel and hospital personnel or citizens.
- IV. PROCEDURE:
 - A. INITIAL NOTIFICATION
 1. The responding EMS unit shall be notified by the Fire Department as soon as possible on all hazardous material incidents in order to facilitate their entry into the scene. Necessary information should include:
 - a. Radio channel/frequency for the incident
 - b. Estimated number of victims or potential victims
 - c. Urgency of the incident
 - d. Approach to the incident

- e. Location of the staging area
 - f. Identification (radio designation) of the Incident Commander
 - g. Hazardous substance involved
 - h. Request for specialized equipment needed
2. While enroute, the EMS unit shall make radio contact with the Incident Commander or FCC and verify location, approach and staging information prior to their arrival on-scene.
 3. Upon arrival at the scene, the ambulance unit shall notify the base hospital or receiving hospital affected as to the number of patients, description of hazard, and any other pertinent information relative to hospital needs. (Note: the IC or VCRRT should provide this information upon request).

B. ARRIVAL ON-SCENE

1. If the scene has not been secured and a staging area has not been established, the ambulance unit should make radio contact with the Incident Commander or FCC for staging instructions.
2. In the absence of an Incident Commander and/or a staging area, EMS personnel should stay upwind and avoid entering the contaminated area.
3. If the scene has been secured, the first-in ambulance unit should enter the staging area and report to the Incident Commander for direction.

C. VICTIM DECONTAMINATION

1. Victims contaminated by a hazardous substance or radiation shall be appropriately decontaminated by VCRRT, despite the urgency of their medical condition, prior to being moved to the triage area for transportation.
2. VCRRT shall determine the disposition of all contaminated clothing and personal articles.
3. The transfer of the victim from the contaminated zone to the safe zone must be accomplished by trained personnel in an appropriate level of protective clothing and carefully coordinated so as not to permit the spread of contamination.

4. Contaminated clothing and personal articles shall be properly prepared for disposal by the VCRRT.
5. Every effort shall be made to preserve, protect and return personal articles.

D. TRANSPORTATION

1. Any equipment, including transportation units, found to have been exposed and contaminated by a hazardous substance shall be taken out of service pending decontamination and a second ambulance unit responded to transport patients to the hospital when available.
2. At no time shall ambulance personnel transport contaminated patients. If during transport a victim off-gasses a strong odor or vomits what is believed to be toxic emesis, personnel/victim shall vacate ambulance and request assistance from fire.
3. Prior to transportation of patients to the hospital, the ambulance unit shall notify the hospital of the following:
 - a. number of victims
 - b. confirmation that patients being transported have been field decontaminated
 - b. extent each patient was contaminated
 - c. materials causing contamination
 - d. extent of injuries
 - e. patient assessment
 - f. ETA
 - g. any other pertinent information

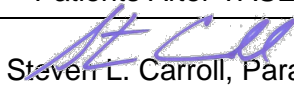

E. ARRIVAL AT EMERGENCY ROOM

1. Upon arrival at the hospital, emergency room personnel shall meet the patient at the ambulance in order to determine if further decontamination is needed prior to delivery of patient(s) into the emergency room.
2. All hospitals should develop a plan for receiving patients who have been decontaminated and those patients who may need additional decontamination and a contingency plan for mass decontamination.

3. If additional decontamination resources are needed, the VCCRRT decontamination equipment and personnel may be requested through dispatch.


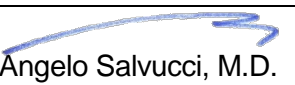
F. EMERGENCY PERSONNEL DECONTAMINATION

1. All treatment team members coming in contact with contaminated patients or contaminated materials shall take immediate measures to insure proper decontamination. Secondary decontamination is recommended which includes taking a shower and changing clothes.
2. Clothing, bedding, instruments, body fluids, etc. may be considered extremely hazardous and must be handled with care, contained and disposed of properly.
3. Follow-up monitoring of all personnel shall be conducted as deemed necessary by the Medical Director.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Patients After TASER Use		Policy Number: 725	
APPROVED: Administration:	 Steven L. Carroll, Paramedic	Date: December 1, 2011	
APPROVED: Medical Director	 Angelo Salvucci, MD, FACEP	Date: December 1, 2011	
Origination Date:	August 10, 2006	Effective Date: December 1, 2011	
Date Revised:	August 11, 2011		
Date Last Reviewed:	October 9, 2014		
Next Review Date:	October, 2016		

- I. PURPOSE: To define the treatment and transportation of the patient on whom a TASER has been used.
- II. AUTHORITY: Health and Safety Code, Sections 1797.214, 1797.220, 1798, and 1798.200, California Code of Regulations, Title 22, Section 100169.
- III. POLICY: It is the policy of the Ventura County Sheriff's Department that all persons on whom a TASER is used be medically cleared prior to incarceration. Law enforcement officers may remove the TASER probes and may transport individuals in custody to an emergency department. On occasion, EMS personnel may be called to evaluate and transport patients with or without the probes in place.
 - A. TASER probes should not be removed by EMS personnel unless they interfere with the safe transportation of the patient.
 - B. Patients should be transported to the closest available hospital or the hospital requested by the law enforcement officer.
- IV. PROCEDURE:
 - A. When safe to do so, patients should be immediately evaluated, with particular attention to signs and symptoms of excited delirium.
 - B. Any injuries or medical conditions will be treated according to the appropriate treatment protocol.
 - C. These patients will be in the custody of law enforcement and will require transportation to an emergency department for medical clearance.
 - D. If the transporting paramedic determines that the patient is a risk to him/herself and/or the ambulance personnel, law enforcement officer(s) may be requested to accompany the patient.
 - E. Unless otherwise contraindicated, the patient should be adequately and safely restrained in an upright position prior to transport. Please see VCEMS Policy 732.
 - F. If one or both of the TASER probes requires removal for safe transportation:

1. Verify the wires to the probes have been severed.
 2. Use routine biohazard precautions.
 3. Place one hand on the patient in the area where the probe is embedded and stabilize the skin surrounding the puncture site between two fingers. Keep your hand several inches away from the probe. With your other hand, in one fluid motion pull the probe straight out from the puncture site.
 4. Reinsert TASER probes, point down, into the discharged air cartridge and hand it to the law enforcement officer.
 5. Apply direct pressure for bleeding, and apply a sterile dressing to the wound site.
- G. If the TASER may be in a dangerous area (e.g., face, neck, hand, bone, groin or spinal column), where it may injure bone, nerves, blood vessels, or an eye, do NOT remove the probe. Transport the patient to the ED in an appropriate position.
- H. Refer to Policy 705: Behavioral Emergencies if patient requires sedation.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Use of Restraints		Policy Number 732	
APPROVED: Administration:	 Steven L. Carroll, EMT-P	Date: December 1, 2011	
APPROVED: Medical Director:	 Angelo Salvucci, M.D.	Date: December 1, 2011	
Origination Date:	April 1, 2011		
Date Revised:	June 9, 2011	Effective Date: December 1, 2011	
Date Last Reviewed:	September 11, 2014		
Review Date:	September, 2016		

- I. PURPOSE: To provide guidelines for the use of physical and chemical restraints during the course of emergency medical treatment or during an inter-facility transport (IFT) for patients who are violent or potentially violent to themselves or others.
- II. AUTHORITY: California Health and Safety Code, Sections: 1797.2, 1798; California Code of Regulations, Title 22, Sections: 100075, 100147, 100160; California Administrative Code, Title 13, Section 1103.2.
- III. DEFINITIONS:
 - A. Verbal Restraint: Any verbal communication from a pre-hospital provider to a patient utilized for the sole purpose of limiting or inhibiting the patient's behavior.
 - B. Physical Restraint: Any method in which a technique or piece of equipment is applied to the patient's body in a manner that reduces the subject's ability to move his arms, legs, head, or body.
 - C. Chemical Restraint: Any pharmaceutical administered by healthcare providers that is used specifically for the purpose of limiting or controlling a person's behavior or movement.
- IV. POLICY:
 - A. Physical Restraint
 1. Prior to use of physical or chemical restraints, every attempt to calm patient should be made using verbal, non physical means.
 2. Perform a physical assessment and obtain a medical history as soon as safe and appropriate. Treat any underlying conditions per VCEMS 705 Treatment guidelines.
 3. If necessary, apply soft physical restraints while performing assessment and obtaining history.

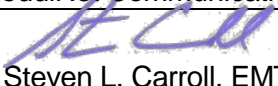

4. Padded soft restraints shall be the only form of restraints utilized by EMS providers.
5. Restraints shall be applied in a manner that does not compromise vascular, neurological, or respiratory status.
6. Extremities in which restraints are applied shall be continuously monitored for signs of decreased neurologic and vascular function
7. Patients shall not be transported in a prone position. The patient's position shall be in a manner that does not compromise vascular or respiratory status at any point. Additionally, the patient position shall not prohibit the provider from performing any and all assessment and treatment tasks.
8. Restraints shall be attached to the frame of the gurney.
9. Handcuffs applied by law enforcement require that an officer accompany the patient to ensure provider and patient safety and to facilitate removal of the restraint device if a change in the patient's condition requires it.
 - a. If the patient is restrained with handcuffs and placed on a gurney, both arms shall be restrained to the frame of the gurney in a manner that in no way limits the ability to care for the patient. The patient should not be placed on gurney with hands or arms restrained behind patient's back.
 - b. In the event that the law enforcement agency is not able to accompany the patient in the ambulance, a law enforcement unit must follow the ambulance in tandem along a predetermined route to the receiving facility.

B. Chemical Restraint

1. If while in restraints, the patient demonstrates behavior that may result in harm to the patient or providers, chemical restraint should be considered.
 - a. Refer to VCEMS Policy 705: Behavioral Emergencies for guidance and administration of appropriate chemical restraint.
 - b. It is important again to investigate and treat possible underlying causes of erratic behavior (e.g. hypoglycemia, trauma, meningitis).

C. Required Documentation

1. Instances in which physical or chemical restraints are applied shall be documented according to VCEMS Policy 1000. Required documentation shall include:
 - a. Type of restraint applied (e.g. soft padded restraint, midazolam, handcuffs by law enforcement)
 - b. Reason restraints were utilized.
 - c. Location on patient restraints were utilized
 - d. Personnel and agency applying restraints.
 - e. Time restraints were applied
 - f. Every 10 minute neurologic and vascular checks
2. Base Hospital shall be notified in all circumstances in which physical and chemical restraints are utilized.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: ReddiNet Communications Policy		Policy Number 920	
APPROVED: Administration:	 Steven L. Carroll, EMT-P	Date: December 1, 2013	
APPROVED: Medical Director:	 Angelo Salvucci, M.D.	Date: December 1, 2013	
Origination Date:	April 26, 2007		
Date Revised:	September 12, 2013	Effective Date: December 1, 2013	
Date Last Reviewed:	September 12, 2013		
Review Date:	September, 2016		

- I. **PURPOSE:** The Rapid Emergency Digital Data Network (REDDINET) is the computerized system that links hospitals, the EMS Agency, and Public Health for a variety of purposes; including but not limited to **daily** (Q24 hr) reports of diversion status, multiple casualty incidents (MCI), assessment communication, disease surveillance, and current HAvBED status. This policy defines the expectation for the use and maintenance of ReddiNet by all facilities.
- II. **AUTHORITY:** Health and Safety Code, Division 2.5, Chapter 1, Section 1797.204 and Chapter 6, Section 1798.100.
- III. **POLICY:**
 - A. The ReddiNet System is to be maintained by each individual facility. This includes, but is not limited to, maintenance and upgrade of all associated hardware, software, and licensing.
 - B. It is the responsibility of each facility to ensure that any staff expected to use the ReddiNet System be properly trained and refreshed on a routine basis (at least twice per year). At least one staff member who is knowledgeable on the use of the ReddiNet System is to be on duty at all times.
 - C. The ReddiNet System is to remain online at all times unless there is a hardware or software problem that disables the system, in which case every effort shall be made to correct the problem as quickly as possible.
 - D. The sound volume on the ReddiNet System is to be maintained at an adequate level to alert staff within a facility at all times, and is never to be placed on mute.
 - E. The ReddiNet System shall be placed in an easily accessible location within each facility.
 - F. The use of the ReddiNet computer is limited to operation of the ReddiNet System and access to EMS educational materials only. Accessing the Internet or other applications on the system is prohibited.
 - G. VCEMS may send an Assessment Poll as needed. Each facility is to acknowledge and respond to this poll as directed by the system.
 - H. The ReddiNet System is not to be used to disseminate non-system information such as conference flyers, educational opportunities, and other like materials.

IV. PROCEDURE:

- A. Emergency Department and other appropriate hospital staff will use ReddiNet for the following information:
1. Status – Hospitals will utilize the Reddinet System to update all diversion status pursuant to VCEMS Policy 402. Hospitals should note that the ReddiNet System also displays diversion status for other facilities within the region.
 2. Multi Casualty Incidents (MCI) – During an MCI, the designated Base Hospital will coordinate response activities with other hospitals using ReddiNet unless relieved by EMS Agency personnel. The Base Hospitals will initiate an MCI using the ReddiNet MCI function. All patients received by hospitals during an MCI are to be recorded in ReddiNet, within the MCI function. The System will send an alert tone when a facility is being included in an MCI response.
 3. Assessment – This function within the ReddiNet System allows a facility or the EMS Agency to assess the status of other facilities and other resources (such as staffing, equipment, etc). Assessments are polls that ask specific questions and require a response. All facilities are to respond as quickly as possible to active polls. Assessments contain one or more questions whose answers are formatted (I.e., Yes/No, numeric, multiple choice, text, etc) The System will send an alert tone when Assessments are received.
 4. Public Health Surveillance – The Public Health Department may initiate disease surveillance programs utilizing Reddi-Net. These will be in the form of assessment polls that ask for specific information on a routine basis. Each facility is to ensure that these assessments are answered in a timely manner. This will likely require involvement of Infectious/Communicable Disease staff at each facility. This does not replace the obligation of health care providers to report certain diseases on a Confidential Morbidity Report (CMR) pursuant to Title 17, California Code of Regulations, §2500 (rev. 1996)
 5. Messages – All facilities are expected to utilize the ReddiNet messaging function to communicate appropriate information within their facility, with other hospitals, the EMS Agency and the Public Health Department. The system is similar to email. All messages that are appropriate for dissemination to other staff are to be printed or otherwise shared with affected staff. The System will send an alert tone when messages are received.
 6. HAvBED Status – Hospitals are expected to update their current HAvBED status by 9:00 AM on a daily basis. Updates ideally should be done twice per day, morning and

evening shift. Hospitals should update their bed availability after their normally scheduled daily discharge time. HAvBED shall be the only function utilized on Reddinet for the purposes of assessing bed capacity.

7. Daily HAvBED status updates allow facilities to meet Federal bed availability guidelines. The HAvBED status board carries over all fields from the previous bed availability menu as well as adding two additional fields: ventilators (owned, stockpiled or committed by vendor to the facility), and whether or not a mass decontamination system is available at the facility during the specified time frame.

B. ReddiNet System Failure or Disruption

1. If the ReddiNet System is not functioning due to an internal hospital issue (ie: computer or internet failure), facilities are to utilize the following procedure:
 - a. Attempt to resolve the problem at the computer. Check for correct power and internet connections as well as correct log-in and password.
 - b. Notify the facility ReddiNet coordinator or IT department according to facility policy.
 - c. Notify the EMS Agency of the status of the ReddiNet System and the anticipated return to service.
 - d. Fax Appendix A to the EMS Agency and all facilities in your hospital grouping to notify of your current diversion status. Updates should be provided every 8 hours until the system is functional. If available, the EMS Agency will update facility status on the Reddinet System. For Internal Disaster category only, fax should also be sent to Fire Communications Center (FCC).
 - e. Notify other hospitals, EMS Agency and FCC via ReddiNet when connection is restored.
2. If the ReddiNet System is not functioning due to a systemwide issue, (ie: ReddiNet server or internet service provider failure), facilities are to utilize the following procedure:
 - a. Notify the EMS Agency of the ReddiNet System failure.
 - b. FAX Appendix A to the EMS Agency and all facilities in your hospital grouping to notify of your current diversion status. Updates should be provided every 8 hours until the system is functional. For Internal Disaster category only, fax should also be sent to Fire Communications Center (FCC).
 - c. ReddiNet and/or the EMS Agency will notify all facilities and FCC when service is restored.

- C. Hospital Groupings: The following hospital groupings are to be used for faxed diversion status notifications during a ReddiNet failure. The hospital with a diversion status change will send a fax to the EMS Agency and to each of the hospitals in their group.

<u>Hospital</u>	<u>Hospital Grouping</u>
Community Memorial Hospital	(OVCH, SJRMC, SPH, VCMC)
Los Robles Hospital and Medical Center	(SVH, SJRMC, SJPVH, VCMC)
Ojai Valley Community Hospital	(CMH, SPH, VCMC)
Santa Paula Hospital	(CMH, OVCH, SJRMC, VCMC)
Simi Valley Hospital	(LRHMC, SJPVH, SJRMC, VCMC)
St. Johns Regional Medical Center	(CMH, SJPVH, VCMC)
St. Johns Pleasant Valley Hospital	(SJRMC, LRHMC, SVH, VCMC)
Ventura County Medical Center	(CMH, SPH, OVCH, SJRMC, LRHMC)



County of Ventura Emergency Medical Services Agency

Diversion Notification

(For use during ReddiNet failure only)

Date: _____

ReddiNet Failure Reason: _____

Time: _____

Name: _____

Hospital:

Diversion Category:

CMH

SJPVH

ICU / CCU Saturation

LRRMC

SJRMC

ED Saturation

OVCH

SVH

Neuro / CT Scanner

SPH

VCMC

Internal Disaster

**All Diversion Categories, send FAX to VCEMS at (805) 981-5300
and to each location in your hospital grouping:**

Hospital

Fax Number

Hospital Grouping

Community Memorial Hospital

(805) 648-6170

(OVCH, SJRMC, SPH, VCMC)

Los Robles Hospital and Medical Center

(805) 370-4579

(SVH, SJRMC, SJPVH, VCMC)

Ojai Valley Community Hospital

(805) 640-2360

(CMH, SPH, VCMC)

Santa Paula Hospital

(805) 525-6778

(CMH, OVCH, SJRMC, VCMC)

Simi Valley Hospital

(805) 527-9374

(LRHMC, SJPVH, SJRMC, VCMC)

St. Johns Regional Medical Center

(805) 981-4436

(CMH, SJPVH, VCMC)

St. Johns Pleasant Valley Hospital

(805) 383-7465

(SJRMC, LRHMC, SVH, VCMC)

Ventura County Medical Center

(805) 652-3299

(CMH, SPH, OVCH, SJRMC, LRHMC)

For diversion due to Internal Disaster, also send FAX to:

Ventura County Fire Communications Center

(805) 383-7631