Virtual	Pre-hospital Services Committee Agenda	February 9, 2023 9:30 a.m.

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	A. Coronavirus/Flu/Respiratory Virus	Dr. Shepherd/Steve Carroll
V.	**New Business or Policies for Review with Proposed Changes**	
	A. 131 – MCI Response	Chris Rosa
	B. 330 – EMT/Paramedic/MICN Decertification and discipline	Steve Carroll
	C. 628 – Rescue Task Force Operations	Chris Rosa
	D. 631 – Mechanical CPR	Dr. Shepherd
	E. 705.20 - Seizures	Andrew Casey
VI.	**Old Business**	
	A. Other	
VII.	**Informational/Discussion Topics or Policies Approved at Specialty Care Committees**	
	A. 430 - STEMI Receiving Standards	Adriane Gil-Stefansen
	B. 733 – CAM Policy Revision	Dr. Shepherd
VIII.	**Policies Due for Review (No proposed changes)**	
	A. 141 – Hospital EMS Surge Assistance	
	B. 705.04 – Behavioral Emergencies	
	C. 705.07 – Cardiac Arrest Asystole and PEA	
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**	

Virtual	Pre-hospital Services Committee Minutes	January 12, 2023 9:30 a.m.

Topic	Discussion	Action	Approval
I. Introductions	**Steve** - All-Towne Ambulance Eric Eckels and Ray Grigoryan (Operations Manager) Gold Coast - Joey Williams introduced Alejandro Villasenor and Jason Averill		
II. Approve Agenda		Approved	Motion: Tom O'Connor Seconded: Dr. Tilles Passed: unanimous
III. Minutes	Tom O'Connor ALS education update information is missing from the minutes.	Approved with changes. Will add: "We successfully graduated the first part-time cohort on 11/4/22. In need of preceptors for March 1-June 15, 2023, and July 1-Oct 31, 2023. PM and EMT advisory committee scheduled for 12/9/22, hosted at Ventura College with virtual access. Moorpark, Oxnard, and Ventura programs reporting".	Motion: Tom O'Connor Seconded: Kyle Blum Passed: unanimous
IV. **Medical Issues**			
A. Coronavirus/Flu/ Respiratory Virus Update	**Carroll –** Looking better overall, much better than expected after the holidays. **Dr. Shepherd –** Comparatively outperforming the rest of the state. **Dr. Larsen -** RSV and flu is down, covid is creeping up. **Andrew** – Hospitalizations are decreasing, total census is decreasing. **Chris** – APOT 11 min median & 19 min percentile		
V. New Business			
A. PSC Meeting February 9th – Virtual or In-Person	Committee voted in-person with hybrid option available		Motion: Dr. Larsen Seconded: Kyle Blum Passed: Unanimous
B. 124 – Hospital Emergency Services Reduction Impact Assessment	Carroll – required to review, changing Pleasant Valley Hospital to St. John's of Camarillo.	Approved	Motion: Dr. Canby Seconded: Dr. Sykes Passed: unanimous

C. 705.18 Overdose/Poisoning	Discussion of keeping IM dosing in ALS orders instead of removing and only have in BLS. Changing from q 1 min to q 3 min, removing max dose and replace with "titrate", keep bullet point in and add clarification instead of removing. Change 0.4mg dose to 0.5 mg dose for easier dosing.	Approve with changes	Motion: Tom O'Connor Seconded: Dr. Sykes Passed: unanimous
VI. Old Business			
A. Just Culture Training Update	Rosa – Previously talked about updating current policy 150 & 151, to a new policy 121"Safety Event Report". Just Culture training to take place on 03/22/23 at 1911 Williams Drive, 1230-1630, reservation link will be sent out soon, figuring out how many can attend, about 50 total. LEMSA attendees and some from SB may attend as well.		
VII. Informational			
A. 107 – Stroke and STEMI Committee	O'Connor- Clarify that 2 representatives can vote from each agency.	Approved at Stroke Committee Will be taken to STEMI Committee for review in February as well.	
B. 452 – TCASC Standards	Adriane – remove e, LVO has replaced the terminology	Approved at STEMI	
C. 705.01 – Trauma Treatment Guidelines	Beatty – recommended to cover the affected eye with eye shield instead of both eyes. O'Connor – minor formatting changes suggested.	Approved with changes	Motion: Tom O'Connor Seconded: Dr. Tilles Passed: unanimous
VIII. Policies for review			
A. 110 – County Ord. No. 4099 Ambulance Business License Code	No changes- due for review	Approved	Motion: Tom O'Connor Seconded: Dr. Sykes Passed: unanimous
B. 626 – CHEMPACK Deployment	Rosa – no changes - due for review Tom O'Connor – additional formatting changes.	Approved with changes: Page 1, III, change large "g" to small "g" for gram. Page 2, III, change "cc" to "ml". Spell out "SNS' on page 5, II.	Motion: Joe Dullam Seconded: Kyle Blum Passed: unanimous
C. 705 – General Patient Guidelines	Beatty – no changes - due for review Tom O'Connor suggested spelling and formatting changes.	Approved with changes: Spelling & formatting	Motion: Tom O'Connor Seconded: Eric Eckels Passed: unanimous
D. 705.15 - Nausea/Vomiting	Beatty – no change - due for review Tom O'Connor changes – add max dosing for Zofran to 4 mg for pediatric patients.	Approved with changes: Add 4mg Zofran as a max dose for pediatrics.	Motion: Tom O'Connor Seconded: Kristin Shorts Passed: unanimous
E. 705.19 – Pain Control	Beatty – no changes - due for review Suggestions of Toradol use, changing 15-minute repeat dose to 10 minutes for IM injections of Fentanyl-add IM directions for Fentanyl like there is for Morphine.	Approved with changes: Toradol will not be added to policy until it is in "Basic Scope of Practice" later this year.	Motion: Eric Eckels Seconded: Dr. Sykes Passed: unanimous

F. 705.28 – Smoke Inhalation	Dr. Larsen brought up discussion about use of Hydroxocobalamin criteria. It was decided to keep policy as is and monitor.		Motion: Jaimie Villa Seconded: Dr. Canby Passed: unanimous
G. 504	Revisit chest seals versus occlusive dressing can we make it an OR instead of both.	Will add to list of changes to 504	Chris Rosa
IX. Agency Reports			
A. Fire departments	**VCFD** – 38 in academy / graduate in July, train on Lucas policy starting Monday. Few out with covid **VFD –** Nothing much to report, 4 in county academy, lateral academy started Monday with 5. Battalion chief Matt Brock retired. Jeremy Henderson been promoted to Battalion Chief. Heather sends thanks for all the coordination efforts during the recent storms. **OFD** – 3 paramedic students starting at UCLA . 1 completed course, waiting to license. **Fed. Fire** – none **FFD** – Thank partners agencies through the storm and FCC. Putting together another academy in March.		
B. Transport Providers	**AMR/GCA/LMT** –.Currently have a scholarship about 30 new students training. Working with mercury medical Q1 to get BiPAP/CPAP combo supplies. If we can assist VCFD with masks, please let us know. **AIR RESCUE –** received new copter last month, Bell 412 to replace copter 9. Training currently and will be put into service soon.		
C. Base Hospitals	**AHSV** – Starting to plan the MICN candidate course this spring. **LRRMC** – Michelle new PCC, continued ED expansion, losing some beds shortly. **SJRMC –** medic students have been nice to have. **VCMC** – continuing helipad construction, hopefully end of February. Thank you to fire department that evaluated a mud slide in the back of Dr. Duncan's home.		
D. Receiving Hospitals	**PVH** – none **SPH** – none **CMH** / **OVCH** – none		
E. Law Enforcement	**VCSO –** none **CSUCI PD –** none **Parks –** none		
F. ALS Education Programs	**Ventura College** – Tom O'Connor, students throughout the sites. We're closing in on students going to the field in March. Program resource survey, low response. Anticipated site visit fall semester.		

G. EMS Agency	Shepherd – Lucas and I-Gel trainings finalized for next month Dr. Larsen – do we have enough Peds heads? Carroll – We're happy to have two new staff, Haley Ebert is working with Andrew doing VCPH data analyst work. Edwardo Herrera joins the warehouse team. Janelle Hahn left to a new position at HSA. Finally got RFP for consultant for ambulance process, closing date first week of February. Rosa – Air show save the date March 18-19, 2023. First Responder appreciate day on the 17th. 100-150K expected in attendance, Blue Angels and Thunderbirds will be performing. More information to be announced.	
H. Other		
X. Closing	**Meeting adjourned at 11:33am**	Motion: Dr. Larsen Seconded: Kyle Passed: unanimous

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Multi Casualty Incident Response		Policy Number 131
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: DRAFT
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: DRAFT
Origination Date: Date Revised: Review Date:	September 1991 February 9, 2023 ~~February 9, 2023~~	Effective Date: DRAFT

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

II. AUTHORITY: California Health and Safety Code, Section 1797.151, 1798, and 1798.220. California Code of Regulations, Sections 100147 and 100169.

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

IV. DEFINITIONS:

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

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

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

V. TRAINING:

The following training will be required:

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

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

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

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

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

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

~~2. Initial advanced MCI training will be offered annually.~~

~~3. Initial Advanced MCI Course: 8 hours~~

~~4. Prerequisite for the Course: Introduction to the Incident Command System (ICS100), ICS for Single Resource and Initial Action Incidents (ICS 200), and National Incident Management System, an Introduction (ICS 700). Intermediate ICS for Expanding Incidents (ICS 300) is a desired prerequisite for the Advanced MCI Training, but it is not required.~~

~~5. Course will be valid for two years~~

~~C.~~B. **~~Basic~~ MCI Refresher Training**

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

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

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

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

~~1. Refresher Course: 4 hours~~

~~2. Advanced MCI refresher course will be offered twice annually.~~

~~3. Course will be valid for two years~~

VI. ACTIVATION OF THE MULTI CASUALTY INCIDENT RESPONSE PLAN:

A. Report of Incident

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

1. Citizen/witness report via 9-1-1 Public Service Answering Point (fire service will

activate the MCI plan).

2. Hospital personnel alert VCEMS.

3. Direct report from law enforcement, or ~~an EMS Provider~~prehospital personnel with capability to contact a PSAP.

B. Prehospital Response

1. The first responder agency or other public safety official will determine that the number and extent of casualties exceeds the capacity of the day-to-day EMS response and/or EMS system (depending on the level of the MCI) and will request ~~their PSAP to contact the EMS Agency and activate the MCI Plan~~that an MCI be activated through the fire communications center (FCC). The Incident Commander (IC) or appropriate public safety official will request activation and/or response of any supporting public safety/service agencies which may be needed, for example:

   a. Transportation resources, such as additional ambulances or buses

   b. Ventura County Chapter American Red Cross

   ~~b.~~c. Ventura County Sheriff's Office of Emergency Services

   ~~c.~~d. Public Health~~/EMS Emergency Preparedness Office~~

   ~~d.~~e. Disaster Medical Support Units (DMSU), Ventura County EMS Agency's Emergency Services Unit, Multi Casualty Unit (MCU) ~~Trailers~~trailers, or other ~~Disaster~~ disaster ~~Caches~~caches

2. The incident commander will establish incident objectives that prioritize not only the safety of personnel at the scene, but also efficient and effective triage, treatment, transport, and tracking (the 4 T's) of victims involved in the MCI.

   ~~e.~~a. Incident roles critical to the success of the incident will be triage unit leader, treatment unit leader, patient transportation unit leader, and MEDCOMM. It is understood that one person may retain more than one of these roles for small-scale incidents within limited victims and complexity.

   b. The role of the Medical Communications Coordinator (MEDCOMM) position is to communicate all relevant victim information to the base hospital, and it should be established as soon as possible, based on available ALS resources at the scene of the incident.

      i. This role may be initially fulfilled by ALS fire personnel and delegated, as appropriate, to transport personnel, an ambulance supervisor or the VC EMS Agency Duty Officer.

ii. The role of MEDCOMM, and the coordination with the base hospital, is crucial to the success of the tracking of patients from the scene to hospitals.

For MCI involving multiple pediatric patients, or an MCI where multiple family members/parents are arriving on scene, consider a role to assist with family reunification at either the triage area or another designated area.

~~f. The IC will appoint a Patient Transportation Unit Leader or Group Supervisor, depending on the size and complexity of the MCI. The Patient Transportation Unit Leader / Group Supervisor will retain or delegate the Medical Communications Coordinator (MEDCOMM) position to communicate all casualty transportation information to the base hospital or designated VCEMS representative.~~

~~Periodically, a request will be made of involved hospitals to update their status in order to accommodate the number of casualties remaining to be evacuated from the scene. (The first responders will provide for the initial triage and treatment of casualties utilizing START and JumpSTART criteria.)~~

C. Base Hospital Responsibilities

1. Upon receiving a declaration of an MCI from the field, the ~~Base~~ base h~~H~~ospital will activate the Reddinet MCI tool and manage patient distribution and determine destination, while maintaining communications with MEDCOMM in the field. The management of the Reddinet MCI module on an MCI may include:

a. Alert all hospitals in the county – including those outside of Ventura County as needed that an MCI has occurred and request that they prepare to receive casualties from the scene. This communication will include:

i. The type, size, and location of the incident.

ii. The estimated number of casualties involved.

iii. Utilizing the Reddinet MCI tool, ~~A~~advise ~~area~~ hospitals to be prepared to confirm their status and make preparations for the possible receipt of patients.

iv. Update all hospitals periodically or when new or routine information is received. ~~Hospitals in unaffected areas may or may not be requested to remain in a stand-by readiness mode.~~

v. Inform MEDCOMM of each hospital's bed availability and determine

destination for all MCI patients.

a. Periodically, a request will be made of involved hospitals to update their status in order to accommodate the number of casualties remaining to be evacuatedtransported from the scene. (The first responders will provide for the initial triage and treatment of casualties utilizing START and JumpSTART criteria.)

b. Patient information relayed from MEDCOMM to the base hospital will consist of the following elements:
- Patient Age
- Patient Gender
- Triage Category
- Triage Tag Number
- Trauma Triage Step (MCI/Level I only)

D. Receiving Hospital Responsibilitiese

1. Utilize all applicable modules of the Reddinet hospital communications application – including the MCI tool.

a. Ambulance arrival time and patient information will be entered into the MCI tool once initial assessment has been conducted and patient registration has occurred.

1.2. Receive/acknowledge incident information and inform hospital administration.

2.3. Activate the hospital's internal disaster/emergency response plan to an appropriate level based upon the MCI's location type and number of casualties.

3.4. Hospitals experiencing difficulty in obtaining needed resources to manage casualties should make needs known to the EMS Agency Duty Officer.

E. Ventura County Trauma System Considerations

1. For any level MCI in which a traumatic mechanism exists, the base hospital shall be the trauma center in whose trauma catchment area the incident occurred. On an MCI/Level I, patients with traumatic injuries shall be triaged utilizing the Ventura County Field Triage Decision Scheme, in addition to START triage. On an MCI/Level I, the applicable VC trauma step shall be relayed to the base hospital by MEDCOMM for all patients with traumatic injuries, in addition to START triage category, age, and gender and triage tag number.

2. Patients shall be transported in accordance with VCEMS 131 Attachment C - MCI Trauma Patient Destination Decision Algorithm.

2.3. For pediatric patients being transported to an out-of-county facility, consider obtaining a name or description along with the triage tag number for quicker reunification with parents.

F. Involved but Not Injured

1. Prehospital personnel may encounter individuals that are involved with an MCI, but not injured. These individuals do not require medical care on the scene or at a hospital but are still impacted by the events that have taken place. Personnel on scene should identify these individuals with the blue ribbon during the triage process and be prepared to provide some level of support for these individuals until such time that law enforcement or some other responsible party can take over and provide support and/or shelter.

G. Ventura County EMS Agency

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

1. Relay all requests/information regarding hospital resource needs or surplus to the Regional Disaster Medical Health Coordinator (RDMHC) representative, when appropriate. Coordinate response of additional medical equipment and personnel.
2. Receive MCI information from PSAP and alert the appropriate VCEMS and Ventura County Health Care Agency (HCA) personnel.
3. Initiate the VCEMS Emergency Response plan to a level appropriate to the information provided.
4. Activate the ~~Health Care Agency~~Public Health Department Operations Center, when appropriate.
5. Inform the Ventura County Sheriff's Office of Emergency Services (OES) and/or the Operational Area EOC of EMS activity, when appropriate.
6. Alert the ~~RDMHC~~ RDMHS/C representative, when appropriate.
7. Request out-of-county medical resources, when necessary, with EMS/HCA management approval. Coordinate requests with OES staff and RDMHC representative.
8. Assist in the coordination of transportation resources.
9. Assist in the coordination of health care facility evacuation.

~~9.~~10. Assist in the coordination of the Family Assistance Center (FAC) as needed.

~~10.~~11. Communicate with hospitals, skilled nursing facilities and appropriate EOCs when warranted.

11. Assist in coordination of incident evaluations and debriefings.
12.

H. Documentation

1. Level 1 MCIMCI/Level I: The care of each patient will be documented using the Ventura County electronic patient care reporting system (VCePCR)
2. Level 2 and 3 MCIMCI/Level II and MCI/Level III: At a minimum, each patient transported to a hospital shall have their care documented on a multi-casualty patient record (Policy 131, Attachment A).
   a. The transporting agency is responsible for completion of the multi-casualty patient record. The record is designed to be completed by the transporting crew enroute to the receiving hospital.
   b. The transporting agency retains the original of the multi-casualty patient record. A copy shall be left with the patient at the receiving hospital. The triage tag shall be attached to this copy and is included as official documentation in the patient's medical record.
   c. The transporting agency shall distribute copies of the multi-casualty patient record to the base hospital and EMS Agency within twenty-four hours of
   de-mobilization of the incident.
   d. Patients not transported from a Level II or Level III MCIMCI Level II or III, may be documented using the multi-casualty non-transport record, (Policy 131, Attachment B).
3. Ventura County EMS Approved MCI Worksheets
   a. Ventura County EMS Providers will utilize the approved MCI worksheets described in the Basic and Advanced MCI courses and attached to this policy as follows:
      1. Form 131-C MCI Trauma Patient Destination Decision Algorithm (Policy 131, Attachment C)
      2. Form 131-1 Level 1 MCI Worksheet (Policy 131, Attachment D)
      3. Triage Count Worksheet
      4. Triage Tag Receipt Holder
      5. Bed Availability Worksheet
      6. Ambulance Staging Resource Status Worksheet
      7. Transportation Receipt Holder

4. Mobile Data Computer (MDC) Equipped Ambulances

   a. In an effort to enhance patient tracking, transport personnel operating ambulances equipped with MDC's, when able, will document the triage tag number, patient name, and destination in the comment section of the dispatch ticket on the MDC.

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

A. Prehospital de-mobilization

1. When advised by the Incident Commander (IC) at the scene, the PSAP handling communications for the incident will notify the VCEMS Duty Officer when all casualties have been ~~removed~~ transported from the MCI scene.

2. Hospitals will be notified via Reddinet that the MCI scene has ~~been cleared~~ended, but that victims may still be enroute to various receiving facilities.

~~3. Hospitals will be notified via Reddinet that casualties may still be enroute to various receiving facilities.~~

~~4.~~3. Hospitals will supply EMS with data on ~~casualties~~ victims they have received via ReddiNet, telephone, fax or RACES.

~~5.~~4. If involved in incident operations, VCEMS will maintain communication with all participants until all activity relevant to ~~casualty~~ victim scene disposition and hospital resource needs are appropriately addressed.

~~6.~~ Depending on size of incident, VCEMS will advise all participants when VCEMS has concluded operations related to the MCI.

~~7.~~

~~8.~~5.

VIII. CRITIQUE OF THE MULTI CASUALTY INCIDENT:

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

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

~~C.~~B.

IX. ADDITIONAL CONSIDERATIONS

A. MCI~~ulti Casualty Incidents~~ related to an Active Shooter event, or any other type of

incident involving a heavy law enforcement presence and the need for coordinated Rescue Task Force (RTF) operations will be conducted in accordance with VCEMS Policy 628 – Rescue Task Force Operations.

B. Additional information related to medical health operations on an MCI and/or coordination of medical health assets on an MCI or during a disaster with widespread casualties can be found in the VCEMS Multi/Mass Casualty Medical Response Plan.

~~B.~~C. ~~For MCI involving multiple pediatric patients, refer to the Pediatric and Neonatal Surge Annex found ...???? VCEMS APP page???~~

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

Date:________________**Agency**____________**Unit#:**___________**Location:**________________________**Incident #:**___________________

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

Receiving Hospital to Attach Triage Tag Here

____

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

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

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

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

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

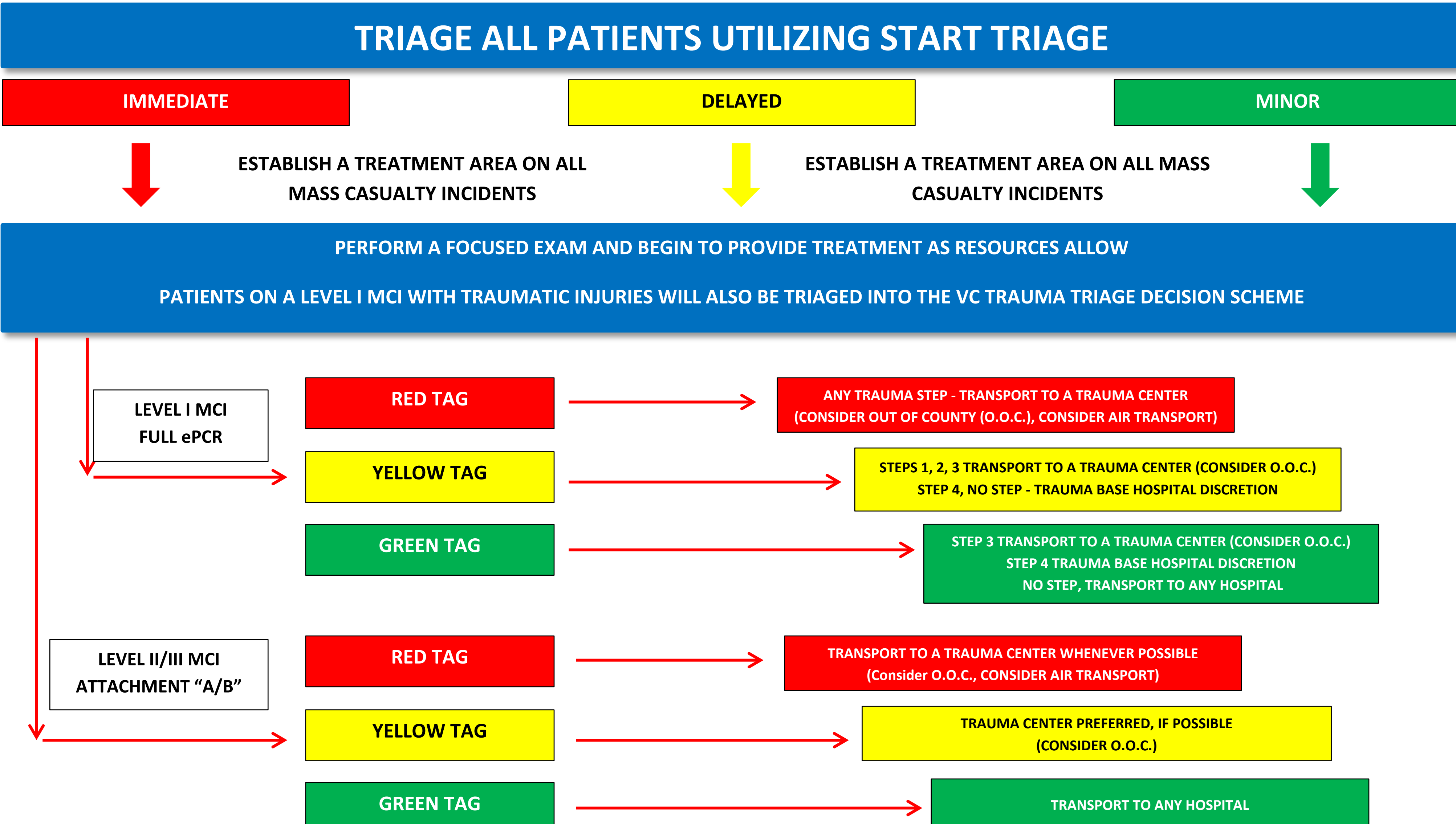
Time: ________________ **Patient Name:** ____________________ **Sex:** ☐ Male ☐ Female **Age:** _________ **Tag #:** ______________	**Airway:** ☐ Patent **Mental Status:** ☐ Awake and Alert ☐ Appropriate for Age	**Skin:** ☐ Normal **Resp:** ________ **Pulse:** ________ **B/P:** ________	**Treatment Provided:**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

________________________ ____________ ________________________
Printed Name **License #** **Signature**

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

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

MCI TRAUMA PATIENT DESTINATION DECISION ALGORITHM



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

LEVEL 1 MCI WORKSHEET

INCIDENT:_______________________________ **DATE:**______________

Person(s) filling out this form:____

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

	TIME						
VCMC		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
LRH		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
Hospital		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
Hospital		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
Hospital		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
		Total		Total		Total	

Revised 2023

VCEMSA Form 131-1: Level 1 MCI Worksheet
Instructions

User: Any First Responder managing patient care in a MCI/Level I, or any incident with 14 or less patients.
Incidents: Any MCI/Level I (3-14 victims)
Follow-up: Dependent on individual agency CQI policy.

The Patient Section

TRIAGE TAG	Enter the last four digits of the patient's triage tag
AGE	Enter the patient's age
SEX	Enter the Patient's sex
PATIENT STATUS	Circle the patient's Triage status
"I"	**Immediate**
"D"	**Delayed**
"M"	**Minor**
VC TRAUMA STEP	For MCI/Level I patients with traumatic injuries, the patient will be triaged using START and according the VC Field Triage Decision Scheme.
INJURIES	List patient's major injuries
DEST	Enter the patient's destination hospital
UNIT ID	Enter the transporting unit's Radio Identification ID
TRANS TIME	Enter the time the transporting unit left the scene enroute to the hospital

The hospital section is to be filled out during base station contact. The beds "available" and "used" sections are to be filled out as snap shots in time. These sections are not cumulative, meaning, you are not adding up the available beds and used beds each time you receive an update.

The Hospital section

TIME	The time you are given/receive hospital bed availability
HOSPITAL	The name of the hospital
AVAIL	Number of hospital beds available
USED	The number of hospital beds you are assigning at that specific time, from the beds available section
IMMEDIATE	Immediate level patients
DELAYED	Delayed level patients
MINOR	Minor level patients
TOTAL	Total number of beds used at that specific time
TOTAL BEDS ASSIGNED	This is the sum of the totals from each USED column. This number should match the number of patient transported.

BED AVAILABILITY WORKSHEET

INCIDENT:______________________________ **DATE:**______________________

Person(s) Filling Out This Form:____

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

OUT-OF-COUNTY BED AVILABILITY WORKSHEET

INCIDENT:_______________________________ **DATE:**________________

PERSON(S) COMPLETING THIS FORM:_________________________________

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

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

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

VCEMSA Form 131-2: Bed Availability Worksheets
Instructions

User: Any First Responder managing patient destination in a MCI, usually Med-Com
Incidents: Any MCI/Level II or MCI/Level III
Follow-up: Dependent on individual agency CQI policy.

This form is to be filled out during base station contact. The beds "available" and "used" sections are to be filled out as snap shots in time. These sections are not cumulative, meaning, you are not adding up the available beds and used beds each time you receive an update.

TIME	The time you are given/receive hospital bed availability
AVAIL	Number of hospital beds available
USED	The number of hospital beds you are assigning at that specific time, from the beds available section
IMMEDIATE	Immediate level patients
DELAYED	Delayed level patients
MINOR	Minor level patients
TOTAL	Total number of beds used at that specific time
TOTAL BEDS ASSIGNED	This is the sum of the totals from each USED column. This number should match the number of patients transported.

Should the need arise to list out-of-county destinations, a blank version of this form has been provided, with the hospital names missing so you can add destinations as needed.

TRANSPORTATION WORKSHEET

INCIDENT: ____ DATE: _______________________

Person(s) filling out this form: __________________________ Agency: _____________________

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

Instructions – Transportation Worksheet

User: Any First Responder managing patient transport (Transportation Group Supervisor), in an MCI.
Incidents: Any level MCI
Follow-up: Dependent on individual agency CQI policy.

Once you have received destinations for patients and you are loading patients into ambulances, you will fill out this form.

AGENCY	Enter the ambulance company name
AMBULANCE ID	Enter the ambulance's radio ID
TRIAGE TAG	Enter the last four digits of the patient's triage tag
AGE	Enter the patient's age
SEX	Enter the patient's sex
PATIENT STATUS	Circle the patient's Triage status
"I"	**Immediate**
"D"	**Delayed**
"M"	**Minor**
DEST	Enter the patient's destination hospital
TRANS TIME	Enter the time the transporting unit left the scene enroute to the hospital

TREATMENT TARP UPDATE WORKSHEET

INCIDENT: ____ **DATE:** ______________________

Person(s) filling out this form: _________________________ **Agency:** ____________________

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

Treatment Tarp Update Instructions

User: Any First Responder managing patient treatment in an MCI.
Incidents: Any Multi patient incident, Level 2 or greater.
Follow-up: Dependent on individual agency CQI policy.

The updates are snap shots in time. As your incident grows, the number of patients on your tarps may increase. As patients are transported and your incident shrinks, the number of patients on your tarps will decrease. You may be able to determine the total number of patients in your incident, by looking at the highest number of patients listed in the total column. This is when you had the most patients accounted for in you incident.

TIME	Enter time of update from treatment tarps
IMMEDIATE	Number of patient triaged as Immediate located on the treatment tarps
DELAYED	Number of patient triaged as Delayed located on the treatment tarps
MINOR	Number of patient triaged as Minor located on the treatment tarps
TOTAL	Enter total number of patients on all 3 tarps.

IMMEDIATE TREATMENT AREA WORKSHEET

INCIDENT: ____ **DATE:** ____________________

Person(s) filling out this form: ________________________ **Agency:** __________________

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

INSTRUCTIONS – IMMEDIATE TREATMENT AREA WORKSHEET

User:	Any First Responder managing patient treatment in the Immediate Treatment Area (Immediate Area Treatment Leader), in a MCI.
Incidents:	Any Level MCI
Follow-up:	Dependent on individual agency CQI policy.

AGE	Enter the patient's age
SEX	Enter the patient's sex
TRIAGE TAG	Enter the last four digits of the patient's triage tag
INJURIES	List the patient's major injuries
TIME OFF	Enter the time the patient is removed from the treatment tarp over a transport team

DELAYED TREATMENT AREA WORKSHEET

INCIDENT: ____ DATE: _____________________

Person(s) filling out this form: ________________________ Agency: ___________________

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

Instructions – Delayed Treatment Area

User:	Any First Responder managing patient treatment in the Delayed Treatment Area (Delayed Area Treatment Leader), in an MCI.
Incidents:	Any Level MCI
Follow-up:	Dependent on individual agency CQI policy.

AGE	Enter the patient's age
SEX	Enter the patient's sex
TRIAGE TAG	Enter the last four digits of the patient's triage tag
INJURIES	List the patient's major injuries
TIME OFF	Enter the time the patient is removed from the treatment tarp over a transport team

MINOR TREATMENT AREA

INCIDENT: ____ **DATE:** _____________________

Person(s) filling out this form: ________________________ **Agency:** ___________________

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

Instructions – Minor Treatment Area

User: Any First Responder managing patient treatment in the Minor Treatment Area (Minor Area Treatment Leader), in an MCI.
Incidents: Any level MCI
Follow-up: Dependent on individual agency CQI policy.

AGE	Enter the patient's age
SEX	Enter the patient's sex
TRIAGE TAG	Enter the last four digits of the patient's triage tag
INJURIES	List the patient's major injuries
TIME OFF	Enter the time the patient is removed from the treatment tarp over a transport team

MORGUE WORKSHEET

INCIDENT: ____ **DATE:** _____________________

Person(s) filling out this form: ________________________ **Agency:** ___________________

AGE	SEX	TRIAGE TAG # (LAST 4)	NOTES

Instructions: Morgue Area Manager

User:	Any First Responder managing patient oversight in the Morgue Area (Morgue Area Leader), in a MCI.
Incidents:	Any MCI where a morgue is established
Follow-up:	Dependent on individual agency CQI policy.

AGE	Enter the patient's age
SEX	Enter the Patient's sex
TRIAGE TAG	Enter the last four digits of the patient's triage tag
NOTES	Enter any identifying information about the patient

INVOLVED/UNINJURED (BLUE RIBBON) WORKSHEET

INCIDENT: ____ **DATE:** _____________________

Person(s) filling out this form: ________________________ **Agency:** ___________________

#	AGE	GENDER	FIRST NAME	LAST NAME	PHONE NUMBER	TIME IN	TIME OUT
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							

Instructions – Involved/Uninjured (Blue Ribbon) Worksheet

User: Any First Responder managing patient treatment in the Immediate Treatment Area (Immediate Area Treatment Leader), in a MCI.
Incidents: Any Level MCI
Follow-up: Dependent on individual agency CQI policy.

#	Pre-determined number assigned to an involved but uninjured individual.
AGE	Enter the individual's age
GENDER	Enter the individual’s gender
First Name	Enter the individual’s first name
Last Name	Enter the individual’s last name
Phone Number	Enter the individual’s best phone number for future contact/follow-up.
Time In	Time individual was contacted, or when tracking began
Time Out	Time individual was released from scene, or when tracking ended.

Air/Ground Ambulance Coordinator Worksheet

INCIDENT: ____ **DATE:** ______________________

Person(s) filling out this form: ________________________ **Agency:** ___________________

AGENCY	UNIT #	ALS/BLS	Time IN	Time OUT

Instructions – Air/Ground Ambulance Coordinator Worksheet

User: Any First Responder managing resources in the staging area (Staging Manager), in an MCI.
Incidents: Any level MCI
Follow-up: Dependent on individual agency CQI policy.

AGENCY	Enter the ambulance company name
UNIT #	Enter the ambulance's radio ID
ALS/BLS	Write ALS for Paramedic staffed units. Write BLS for EMT staffed units
Time IN	Enter the time the ambulance arrives at staging
Time OUT	Enter the time the ambulance leaves staging

Position: Medical Branch Director (FOG – 2022 Edition)

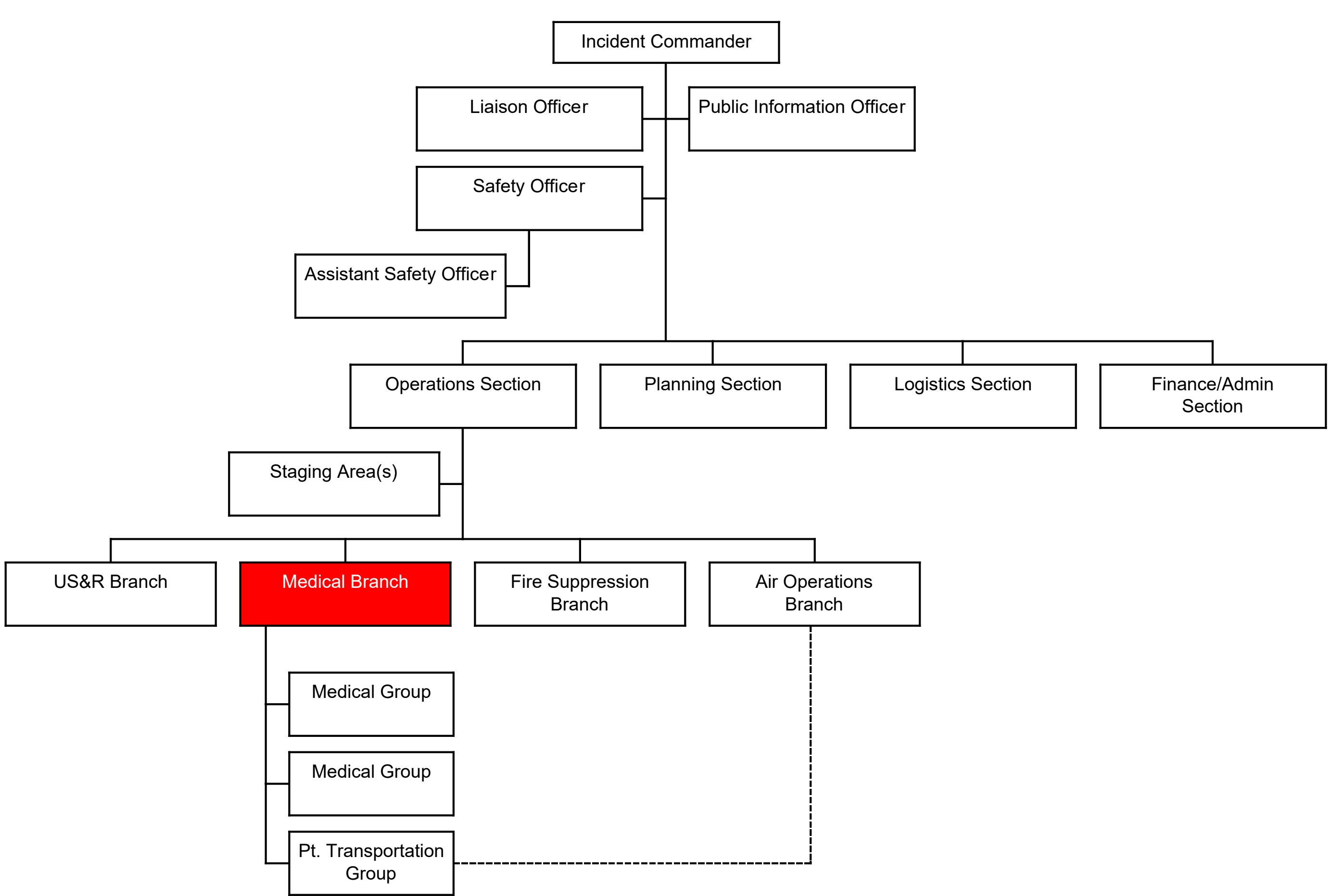
Ideal Staffing: Battalion Chief or EMS Agency Duty Officer

The Medical Branch Director is responsible for the implementation of the Incident Action Plan (IAP) within the Medical Branch. The Branch Director reports to the Operations Section Chief and supervises the Medical Group(s) and the Patient Transportation function (Unit or Group). Patient Transportation may be upgraded from a Unit to a Group based on the size and complexity of the incident:

a. Review Group Assignments for effectiveness of current operations and modify as needed.
b. Provide input to Operations Section Chief for the IAP.
c. Supervise Branch activities and confer with the Safety Officer to assure safety of all personnel using effective risk analysis and management techniques.
d. Report to Operations Section Chief on Branch activities.
e. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Multi-Casualty Incident Command Worksheet



Position: Medical Division/Group Supervisor (FOG 2022)

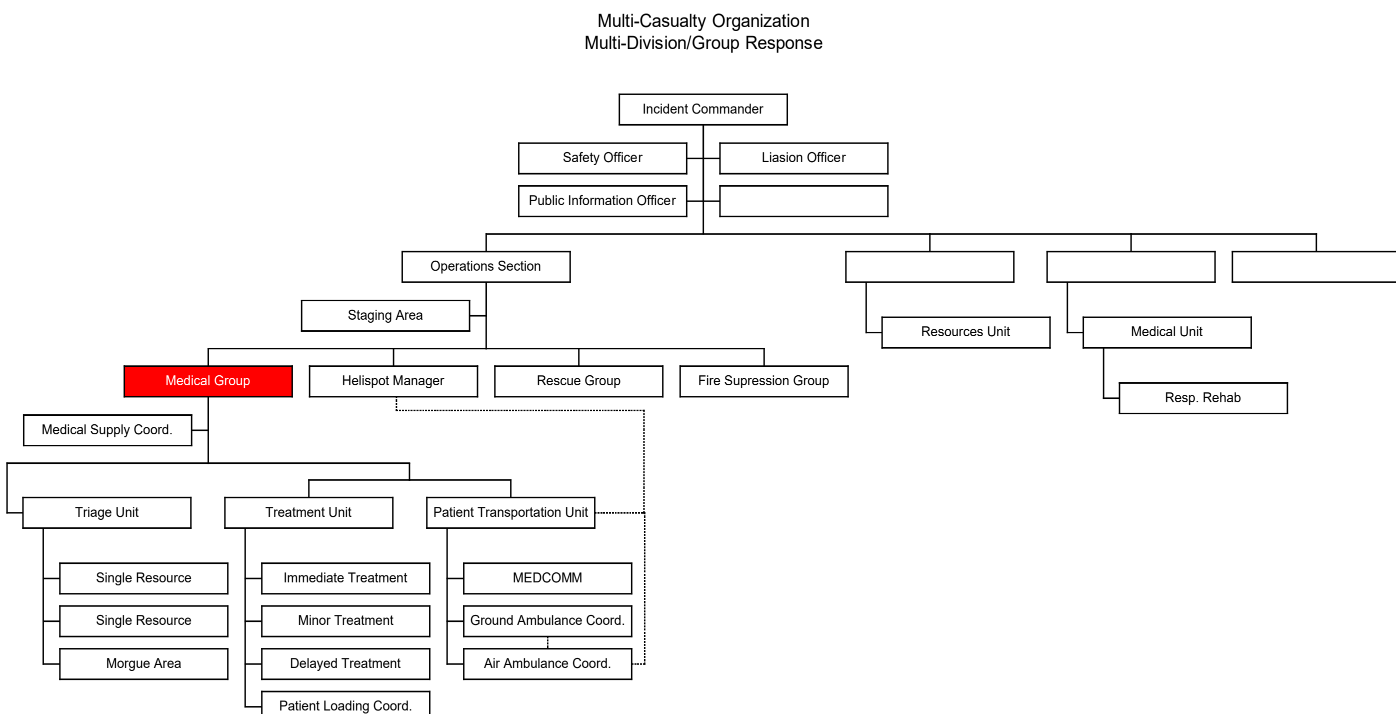
Ideal Staffing: Fire Company Officer or Paramedic Supervisor

The Medical Group Supervisor reports to the Operations Section Chief or Medical Branch Director (depending on level of organization) and supervises the various units within the Medical Group (Triage Unit, Treatment Unit, Patient Transportation Unit, and Medical Supply Coordinator). The Medical Group Supervisor establishes command and control activities within the Medical Group. In large and complex multi-casualty incidents, there may be a need to staff multiple Medical Groups:

a. Participate in the Medical Branch / Operations Section planning activities.
b. Establish Medical Group with assigned personnel and request additional personnel and resources sufficient to handle the magnitude of the incident.
c. Designate Unit Leaders and Treatment Area locations as appropriate.
d. Isolate Morgue and Minor Treatment Area from Immediate and Delayed Treatment Areas.
e. Request law enforcement for security, traffic control, and access for the Medical Group areas.
f. Determine amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (MCI trailers, DMSU, etc.).
g. Ensure communication with appropriate Base Hospital has occurred through the Medical Communications Coordinator, and that an MCI has been declared and initiated in Reddinet.
h. Coordinate with assisting agencies such as law enforcement, Medical Examiner, Public Health, Behavioral Health and transport providers. Law enforcement / medical examiner shall have responsibility for crime scene and decedent management.
i. Coordinate with agencies such as American Red Cross and utilities.
j. Ensure adequate patient decontamination and proper notifications have been made (when applicable)
k. Consider responder rehabilitation
l. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Obtain Medical Group Supervisor packet, including vest and clipboard



Position: TRIAGE UNIT LEADER (FOG 2022)

Ideal Staffing: Fire Company Officer

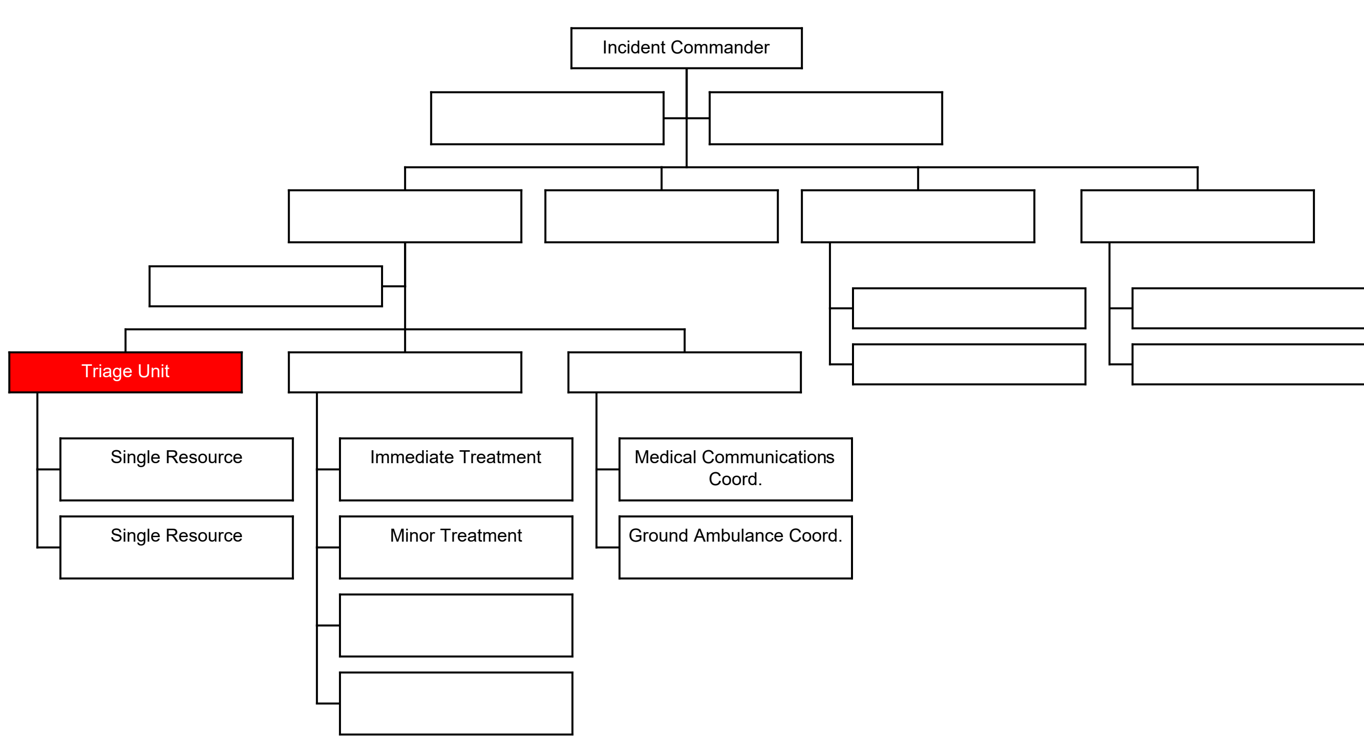
The Triage Unit Leader ~~(MCTL)~~ supervises triage personnel/litter bearers and the Morgue Manager, when applicable. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the Triage Area. When triage has been completed and all the patients have been moved to the treatment areas, the Triage Unit Leader may be reassigned as needed:

a. Develop organization sufficient to handle the assignment.
b. Inform Medical Group Supervisor of resource needs
c. Implement START/Jump START process
d. Coordinate movement of patients from the triage area(s) to the appropriate treatment area(s)
e. Ensure adequate patient decontamination and proper notifications are made, if appropriate
f. Assign resources as triage personnel / litter bearers
g. Give periodic status reports to Medical Group Supervisor
h. Maintain security and control of the triage area(s)
i. Establish a temporary morgue area in coordination with law enforcement and Medical Examiner, if necessary.
j. Maintain Unit Activity Log (ICS 214)

MCI Management Equipment

1. Obtain Triage Unit Leader packet, including vest and clipboards with form(s).
2. Obtain triage patient count cards from triage personnel and total triage numbers on the Triage Count Worksheet found in the Triage Unit Leader packet. Total numbers are reported to Medical Group Supervisor

Multi-Casualty Organization
Initial Response



Position: Morgue Area Manager (FOG 2022~~2017~~)

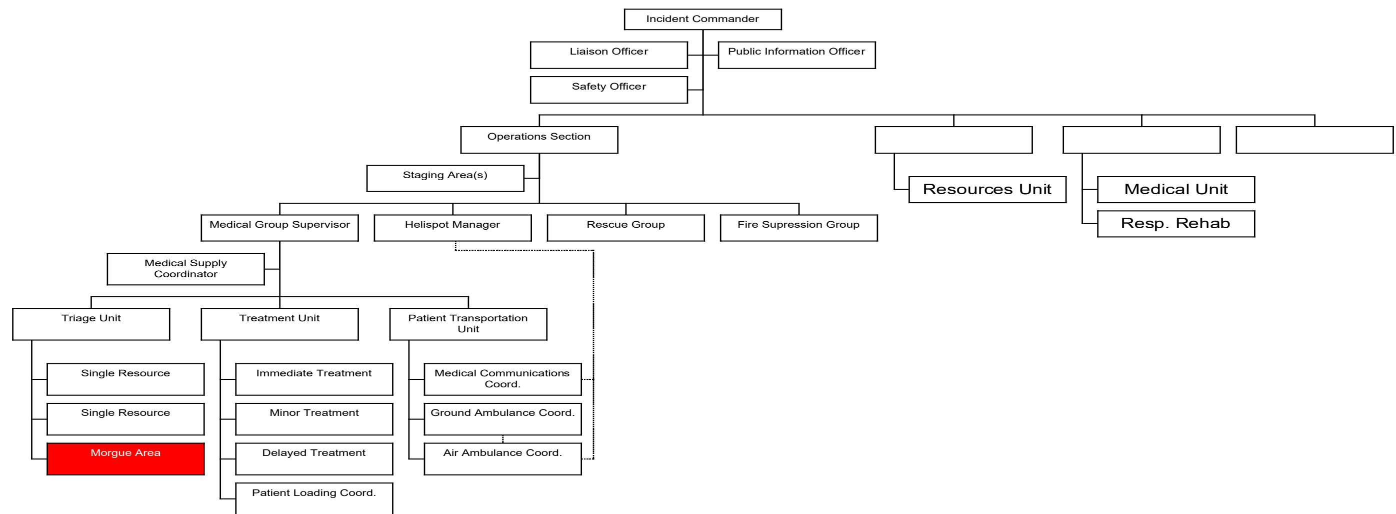
Ideal Staffing: Law Enforcement Personnel or Fire Company Personnel

The Morgue Area Manager~~ (MCMM)~~ reports to the Triage Unit Leader and assumes responsibility for the Morgue Area. ~~MCMM ~~C~~c~~oordinates the handling of decedents and their personal belongings with law enforcement and the Medical Examiner:

a. Assess resource/supply needs and order as needed.
b. Coordinate all morgue area activates with investigative authorities.
c. Keep area separated and off limits to all but authorized personnel.
d. Keep identity of deceased persons confidential.
e. Maintain appropriate records.
f. Maintain Unit/Activity Log (ICS Form 214)

MCI Management Equipment

1. Morgue Packet, including vest and Triage Tag Receipt Holder with Clipboard



**Note: A morgue area manager ~~MCMM m~~may be necessary on smaller multi-casualty events that do not necessarily warrant the staffing of all positions detailed above. Organizational development and positions staffed should be based on incident complexity.*

Position: Treatment Unit Leader (FOG 2022~~17~~)

Ideal Staffing: Fire Company Officer

The Treatment Unit Leader ~~(MCUL)~~ reports to the Medical Group Supervisor and supervises Treatment Area Managers and the Patient Loading Coordinator. The Treatment Unit Leader assumes responsibility for treatment, preparation for transport, and the movement of patients to the loading location(s):

a. Develop organization sufficient to handle assignment
b. Direct and supervise Immediate, Delayed, and Minor Treatment Areas and Patient Loading Coordinator
c. Ensure adequate patient decontamination and that proper notifications have been made (if applicable)
d. Ensure continued assessment of patients and re-assess/re-locate as necessary throughout Treatment Areas
e. Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader
f. Assign incident personnel to be treatment personnel (remember 3-6-9 rule)
g. Request sufficient medical caches and supplies including DMSU or MCI trailers
h. Establish communications and coordination with Patient Transportation Unit Leader and Medical Communications Coordinator (Golden Triangle)
i. Responsible for the movement of patients to ambulance loading areas
j. Give periodic status update to Medical Group Supervisor
k. Request specialized medical resources through the EMS Agency Duty Officer (DMAT, DMORT, MRC, etc.)
l. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Treatment Unit Leader Packet, including Treatment Unit Leader Count Worksheet, vest, and clipboard.
2. Treatment Area Manager vests and clipboards, as needed/staffed.
   a. Provide vests, Triage Tag Receipt Holders and clipboards for all Treatment Area Managers, as needed/staffed.

Multi-Casualty Organization
Multi-Division/Group Response

Position: Patient Loading Coordinator (FOG 2022~~17~~)

Ideal Staffing: Paramedic (Fire Company or Ambulance)

~~FORMER POSITION: Treatment Dispatch Manager~~

NOTE: On small to medium MCI incidents, the responsibilities of this role may be assumed by the Treatment Unit Leader.

The Patient Loading Coordinator reports to the Treatment Unit Leader and is responsible for coordinating with the Patient Transportation Unit Leader (or Group Supervisor if established), the transportation of patients out of the Treatment Areas:

a. Establish communications with the Immediate, Delayed, and Minor Treatment Managers
b. Establish Communications with the Patient Transportation Unit Leader.
c. Verify that patients are prioritized for transportation.
d. Advise Medical Communications Coordinator of patient readiness and priority for transport
e. Coordinate transportation of patients with the Medical Communications Coordinator
f. Ensure that appropriate patient tracking information is recorded
g. Coordinate ambulance loading with the Treatment Managers and ambulance personnel
h. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Patient Loading Coordinator Packet, including vest and clipboard

Multi-Casualty Organization
Multi-Division/Group Response

Incident Commander
Safety Officer
Liasion Officer
Public Information Officer
Operations Section
Staging Area
Resources Unit
Medical Unit
Resp. Rehab
Medical Group
Helispot Manager
Rescue Group
Fire Supression Group
Medical Supply Coord.
Triage Unit
Treatment Unit
Patient Transportation Unit
Single Resource
Single Resource
Morgue Area
Immediate Treatment
Minor Treatment
Delayed Treatment
Patient Loading Coord.
MEDCOMM
Ground Ambulance Coord.
Air Ambulance Coord.

Position: Treatment Area Manager (FOG – 2022~~17~~)

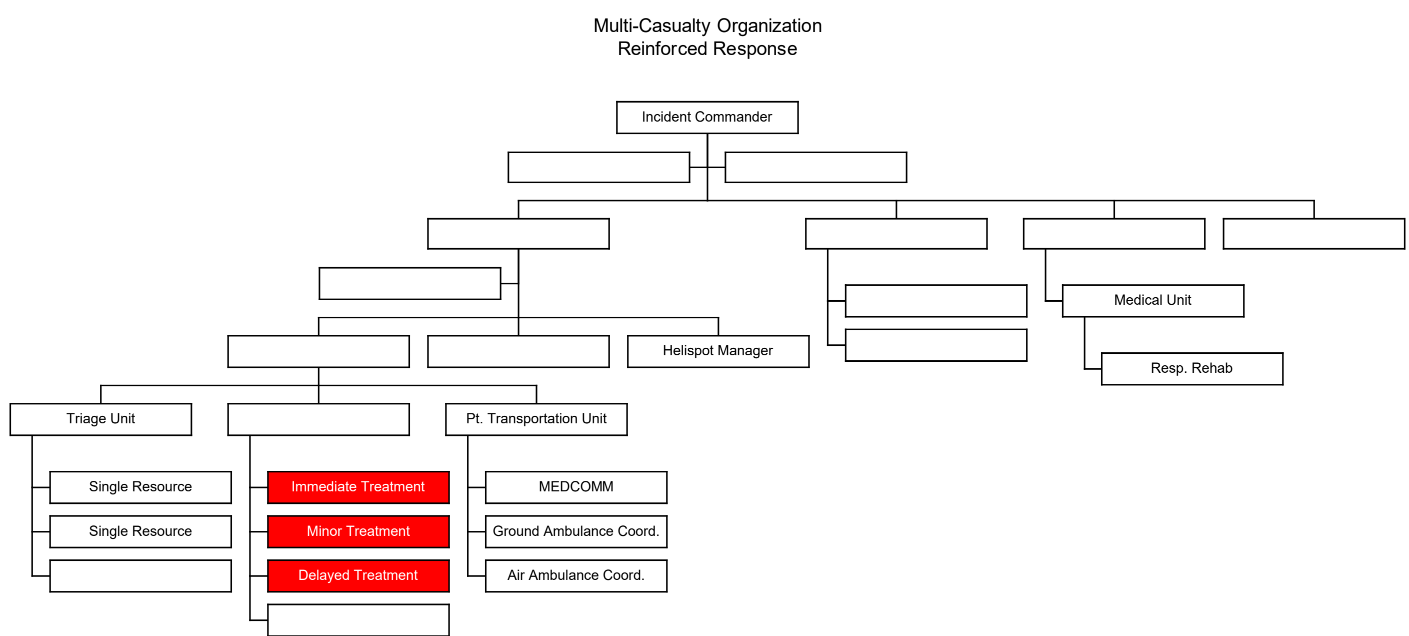
Ideal Staffing – Fire Company Officer

The Immediate, Delayed, and Minor Treatment Area Manager ~~(MCIM, MCDM, MCMT)~~ report to the Treatment Unit Leader and are responsible for treatment and re-triage of patients assigned to a particular treatment area:

a. Assign treatment personnel to patients.
b. Provide assessment of patients and re-triage/re-locate as necessary.
c. Ensure appropriate level of treatment is provided to patients
d. Ensure that patients are prioritized for transportation
e. Coordinate transportation of patients with Patient Loading Coordinator
f. Notify Patient Loading Coordinator of patient readiness and priority for transportation
g. Ensure that appropriate patient information is recorded.
h. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Obtain appropriate Treatment Area Managers packet, including vest and triage tag receipt holder form with clipboard.
2. Treatment area tarps



Position: Patient Transportation Unit Leader (FOG – 2022~~17~~)

NOTE: On medium to large MCIs or those of a dynamic/complex nature, this position may need to be upgraded to a Group Supervisor level assignment to better allow for flexibility within the incident organization. The roles and responsibilities would remain the same.

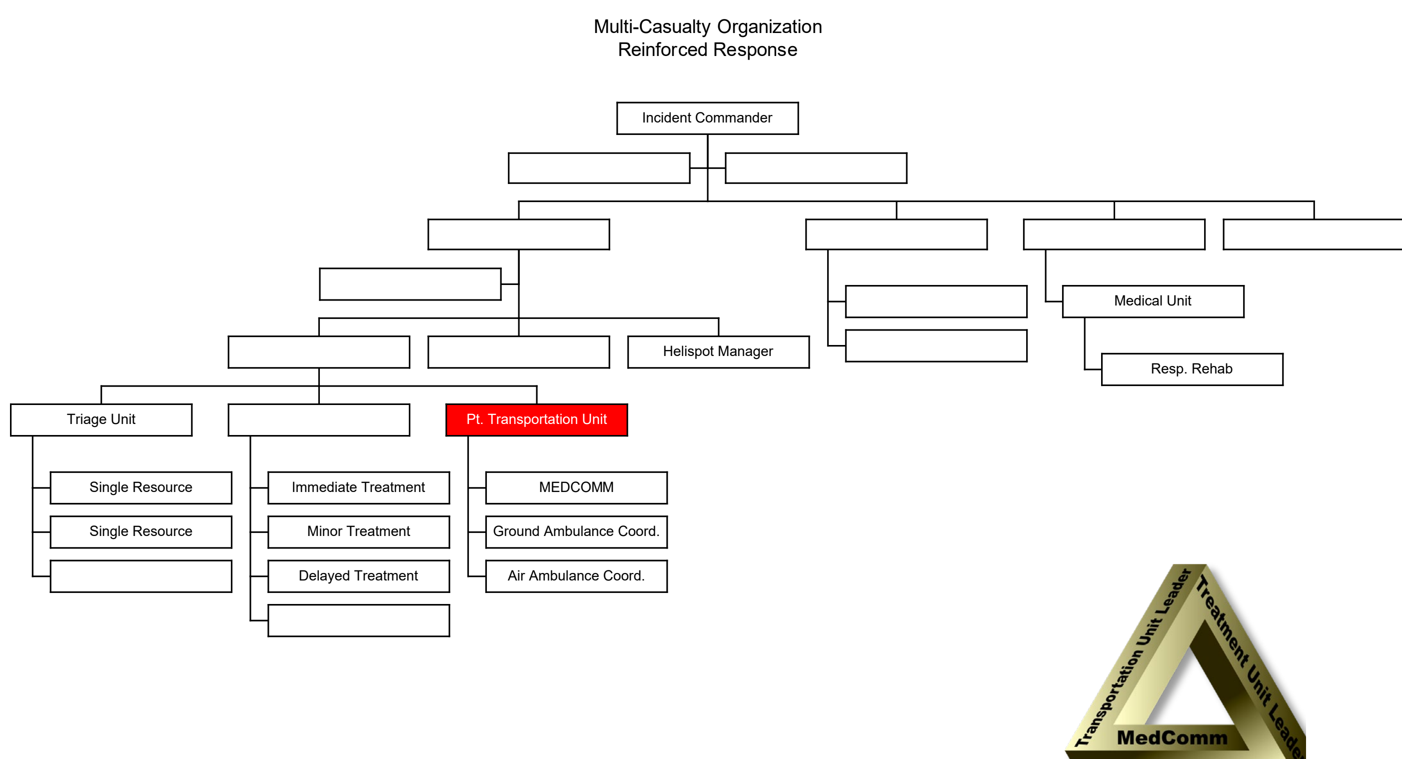
Ideal Staffing: Paramedic Supervisor or EMS Agency Duty Officer

The Patient Transportation Unit Leader reports to the Medical Group Supervisor and supervises the Medical Communications Coordinator, and the Ground/Air Ambulance Coordinators. The Patient Transportation Unit Leader is responsible for the coordination of patient transportation and maintenance of records relating to the patient's identification, condition, and destination. The Patient Transportation function may be initially established as a Unit and upgraded to a Group based on incident size or complexity:

a. Ensure the establishment of communications with the appropriate Base Hospital
b. Designate Ambulance Staging Area(s). **Note, these should be separate from fire/rescue/other staging areas.*
c. Direct the off-incident transportation of patients as determined by the Medical Communications Coordinator.
d. Ensure that patient information and destinations are recorded
e. Establish communications with Ground Ambulance Coordinator, the Air Ambulance Coordinator (if Established), and the Helispot Manager
f. Request additional medical transportation resources (air/ground) as required
g. Notify the Ground/Air Ambulance Coordinators of ambulance requests
h. Coordinate the establishment of Helispot(s) with the Medical Group Supervisor, the Air Ambulance Coordinator, and the Helispot Manager
i. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Patient Transportation Group Supervisor Packet, including vest and clipboard.
2. Maintain required records utilizing the Transportation Receipt Holders
3. Provide Ground/Air Ambulance Coordinators with Ambulance Staging Resource Status form(s)



Position: Transportation Recorder **(FOG – 2022)**

NOTE: The roles and responsibilities of this position have historically been filled by the role of MEDCOMM. On smaller incidents, MEDCOMM will likely retain this function under that position.. On larger incidents, or those with increased complexity, this position may be filled by VCEMS personnel that have access to Reddinet in the field.

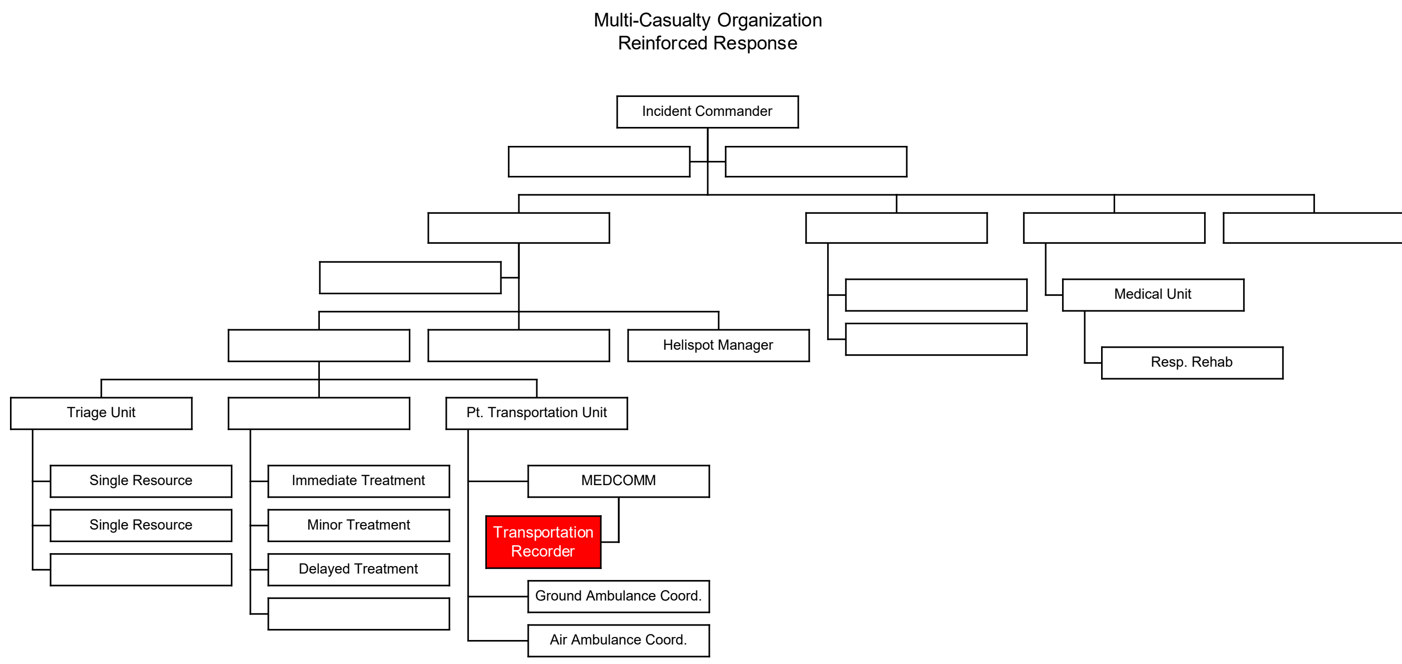
Ideal Staffing: Paramedic, Paramedic Supervisor or VCEMS Personnel

The transportation recorder, if filled, reports to/works in conjunction with MEDCOMM and will track patient destination and transportation information. This information will assist with family reunification and resource tracking:

a. Check-in with transportation Unit Leader / Group Supervisor
b. Utilize appropriate VCEMS MCI worksheets and/or patient tracking resources.
c. Coordinate and communicate with ground ambulance coordinator and MEDCOMM to ensure appropriate tracking of patient destinations, as determined by the appropriate base hospital.
d. Track patient specific information (triage tag number, age, gender, triage color, trauma step) utilizing appropriate worksheets or using the Reddinet application (VCEMS only)
e. Tracking information should be shared with the Family Assistance/Reunification function at the incident (if established)
a.f. Maintain records as required in addition to Unit Activity Log (ICS 214)

MCI Management Equipment

1. VCEMS Level I MCI Worksheet (131-1)
1.2. VCEMS Transportation Worksheet (131-3)



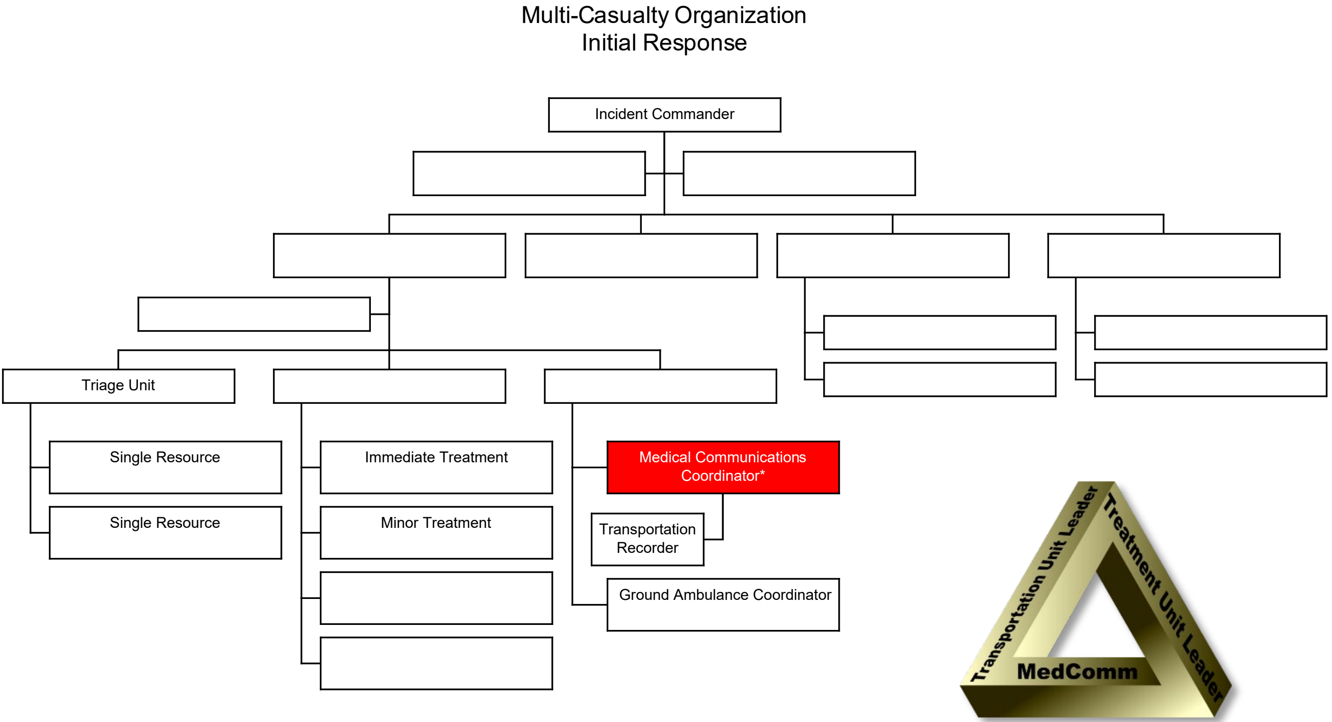
Position: Medical Communications Coordinator (MEDCOMM) (FOG – 2022~~17~~)

Ideal Staffing: Initial – Paramedic (Fire or Ambulance), Ongoing – Paramedic Supervisor.
The Medical Communications Coordinator (~~MCCC or~~ MEDCOMM) reports to the Patient Transportation Unit Leader and establishes communications with the appropriate Base Hospital (BH) to maintain status of available hospital beds to ensure proper patient destination:

a. Establish communications with the appropriate Base Hospital. Provide pertinent incident information and basic patient information, as outlined in VCEMS Policy 131
b. Determine and maintain current status of hospital availability and capability
c. Receive basic patient information and condition from Treatment Area Managers and/or Patient Loading Coordinator
d. Coordinate patient destination with the appropriate base hospital.
e. Communicate patient transportation needs to Ground Ambulance Coordinator based on requests from the Treatment Area Managers and/or Patient Loading Coordinator
f. Communicate patient air transportation needs to the Air Ambulance Coordinator based on requests from the Treatment Area Managers and/or Patient Loading Coordinator
g. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Obtain Medical Communications Coordinator packet, including vest and clipboard with Bed Availability Worksheet.
2. Phone (cellular or satellite) for Base Hospital Communications



Note: Whenever staffing/resources allow, MEDCOMM should be staffed with two paramedics. First Paramedic will maintain communications with Base Hospital to relay patient information and receive destination assignments. Second Paramedic will act as a runner/scribe, ~~gathering key information from other positions in the MCI organization.~~ And will serve as the transportation recorder (see MCI position card 8 for specific roles/responsibilities).

Position: Ground Ambulance Coordinator (FOG ~~– December 2017~~2022)

Ideal Staffing: BLS Fire Company or Ambulance Personnel (*NOT A PARAMEDIC*)

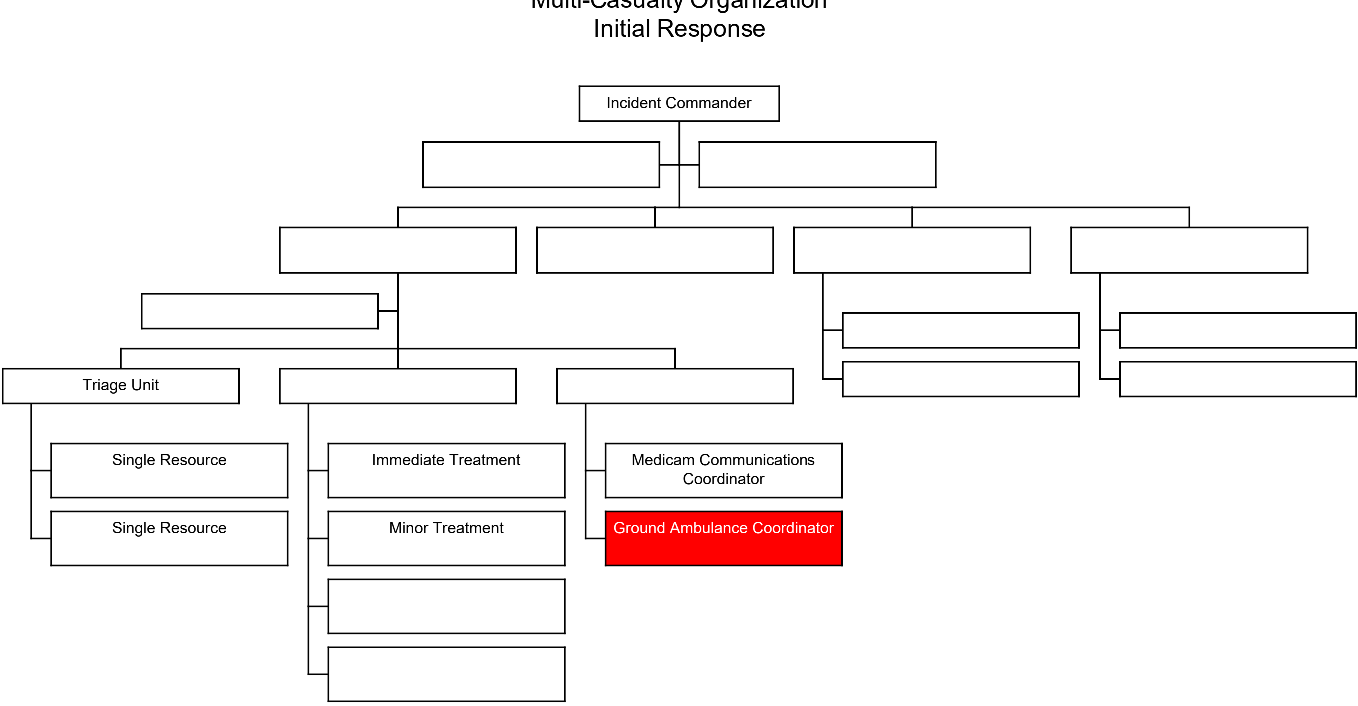
FORMER POSITION: Ambulance Staging Manager

The Ground Ambulance Coordinator reports to the Patient Transportation Unit Leader, manages the Ambulance Staging Area(s), and dispatches ambulances as requested:

a. Establish appropriate Staging Area for ambulances
b. Establish routes of travel for ambulances for incident operations
c. Establish and maintain communications with the air ambulance coordinator and the helispot manager regarding air transportation assignments.
d. Establish and maintain communications with the Medical Communications Coordinator/Transportation Recorder and the Patient Loading Coordinator
e. Provide Ambulances upon request from the Medical Communications Coordinator/Transportation Recorder
f. Ensure the necessary equipment is available in the ambulance for patient needs during transportation
g. Establish contact with ambulance personnel at the staging area
h. Request additional ground transportation resources as appropriate, through the established incident chain of command.
i. Consider the use of alternate transportation resources such as buses or vans, based on VCEMS guidelines.
j. Provide an inventory of medical supplies available at ambulance Staging Area for use at the scene.
k. Maintain adequate staging area records
l. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Obtain Ambulance Coordinator Packet, including vest and clipboard with Ambulance Staging Resource Status form.



Position: Air Ambulance Coordinator (FOG ~~– December 2017~~2022)

Ideal Staffing: BLS Fire Company

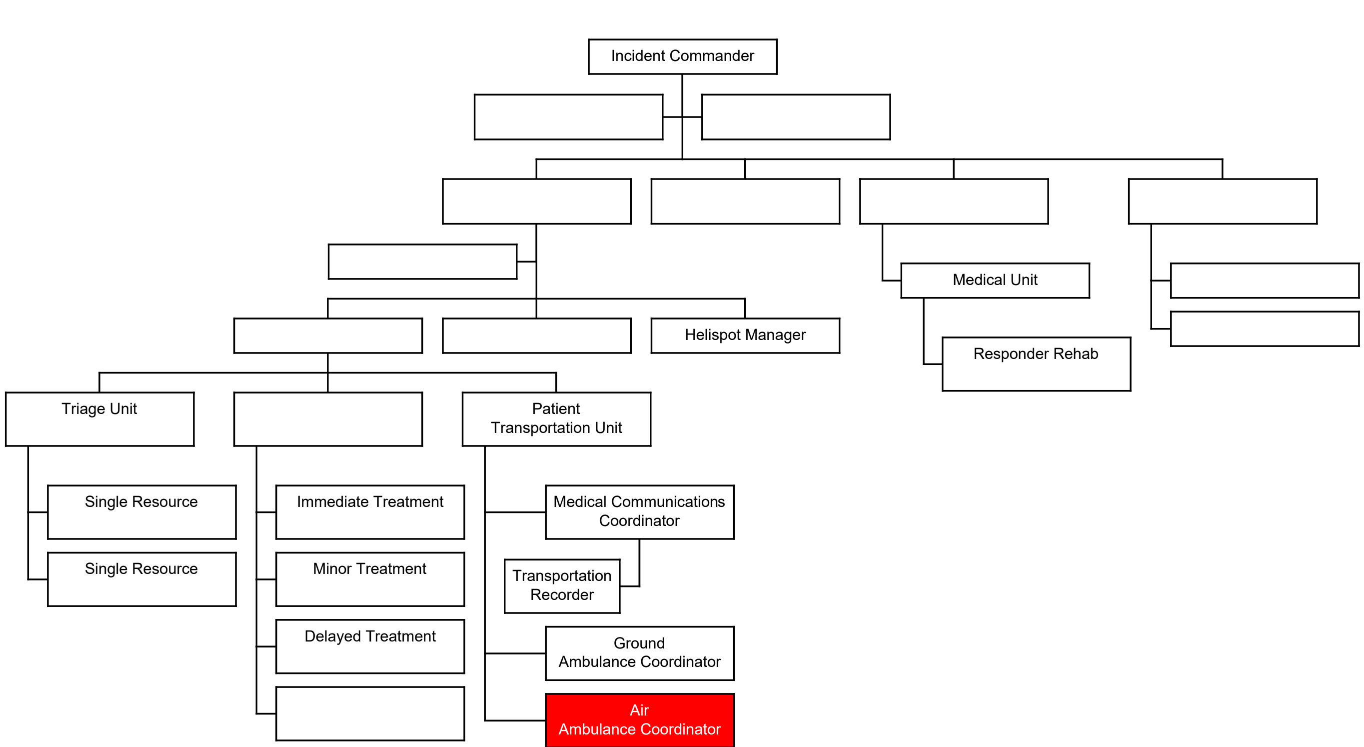
FORMER POSITION: Ambulance Coordinator

The Air Ambulance Coordinator reports to the Patient Transportation Unit Leader; communicates with MEDCOMM or Transportation Recorder, Patient Loading Coordinator, and Ground Ambulance Coordinator; coordinates patient air transportation needs with the Helispot Manager:

a. Coordinate ambulance staging and patient loading procedures at the helispot with the helispot manager
b. Establish and maintain communications with MEDCOMM and Patient Transportation Unit Leader to determine hospital / medical facility destinations.
c. Confirm the type of air resources and patient capacities with the helispot manager, and provide this information to MEDCOMM and patient transportation unit leader
d. Confirm the patient destination with the air ambulance crew, and relay any diversions to MEDCOMM and Patient Transportation Unit Leader
e. Monitor patient care and status at the helispot when patients are waiting for air transportation
f. Maintain adequate records and Activity Log (ICS 214)

MCI Management Equipment

1. Obtain Ambulance Coordinator Packet, including vest and clipboard with Ambulance Staging Resource Status form.



Position: Medical Supply Coordinator (FOG 2022)

Ideal Staffing – Ambulance Company Representative (DMSU Trained), EMS Agency Representative

The Medical Supply Coordinator reports to the Medical Group Supervisor and acquires and maintains control of appropriate medical equipment and supplies from units assigned to the Medical Group:

a. Acquire, distribute, and maintain status of medical equipment and supplies within the Medical Group*
b. Request additional medical supplies*
c. Distribute medical supplies to the Treatment and Triage Units
d. Consider the use of a Disaster Medical Support Unit(s) (DMSU) or MCI trailer.
e. Maintain Activity Log (ICS Form 214)

**If the Logistics Section were established, this position would coordinate with the Logistics Section Chief or Supply Unit Leader. Additional medical resources/supplies can be requested through the EMS Agency Duty Officer, as part of the Medical Health Operational Area program, when all local resources have been exhausted.*

MCI Management Equipment

1. Obtain Medical Supply Coordinator packet, including vest and clipboard.

Multi-Casualty Multi-DIvision/Group Response Organization

Modular Organizational Development (Adapted from 2022 FIRESCOPE Field Operations Guide)

The following organizational structures are intended to provide the Incident Commander with a basic, expandable system to manage any number of patients during incidents of varying complexity. The degree of organizational structure should be driven by incident complexity and need.

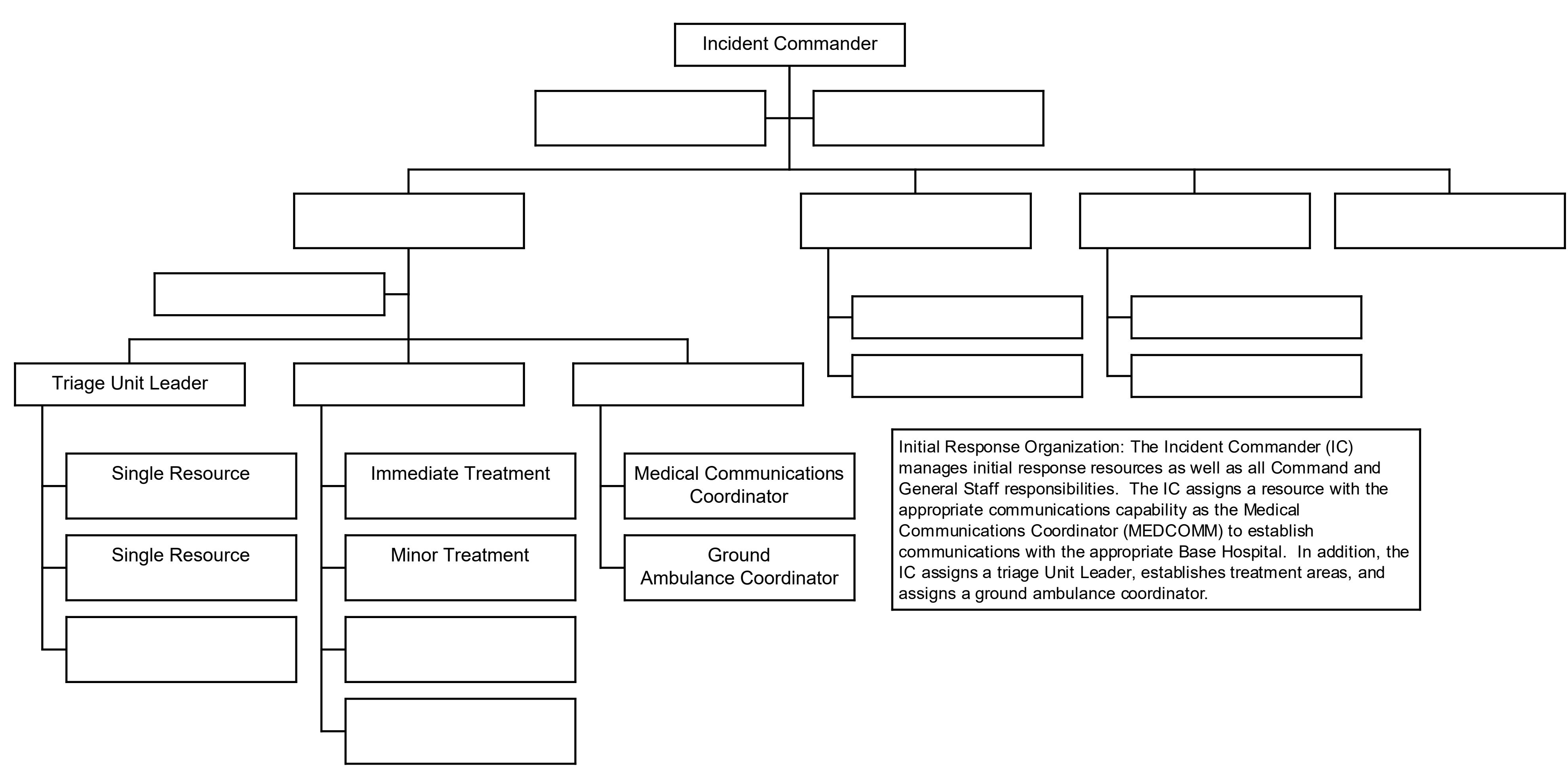
As the complexity of an incident exceeds the capacity of local medical and health resources, additional response capabilities may be provided through provisions of the Public Health and Emergency Operations Manual (EOM) through the EMS Agency Duty Officer and broader Medical Health Operational Area Coordinator (MHOAC). For this reason, the EMS Agency Duty will be notified of any/all MCIs, regardless of size or complexity.

Initial Response Organization: The Incident Commander (IC) manages initial response resources as well as all Command and General Staff responsibilities. The IC assigns a resource with the appropriate communications capability as the Medical Communications Coordinator (MEDCOMM) to establish communications with the appropriate Base Hospital. In addition, the IC assigns a triage Unit Leader, establishes treatment areas, and assigns a ground ambulance coordinator.

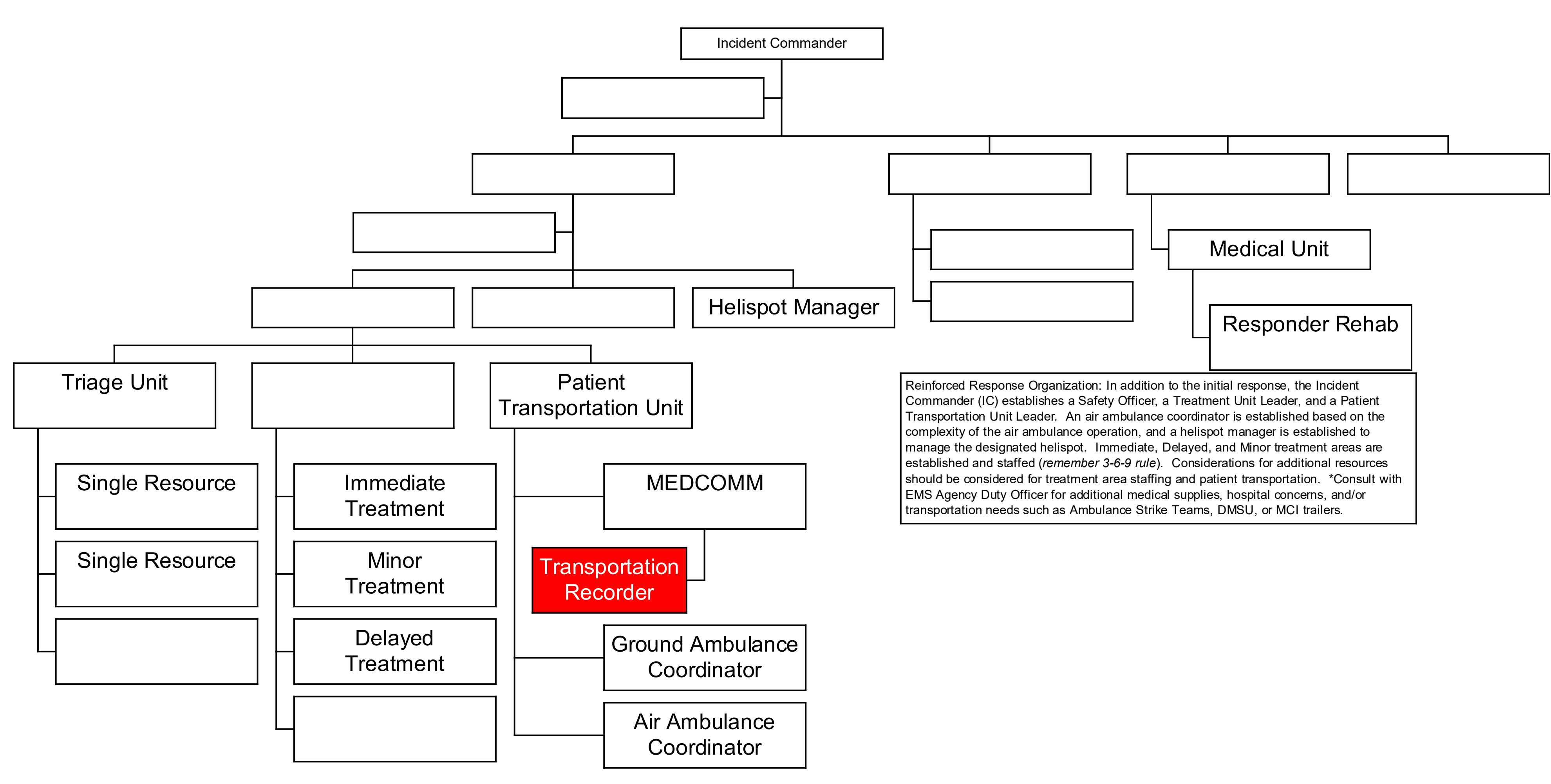
Reinforced Response Organization: In addition to the initial response, the Incident Commander (IC) establishes a Safety Officer, a Treatment Unit Leader, and a Patient Transportation Unit Leader. An air ambulance coordinator is established based on the complexity of the air ambulance operation, and a helispot manager is established to manage the designated helispot. Immediate, Delayed, and Minor treatment areas are established and staffed (*remember 3-6-9 rule*). Considerations for additional resources should be considered for treatment area staffing and patient transportation. *Consult with EMS Agency Duty Officer for additional medical supplies, hospital concerns, and/or transportation needs such as Ambulance Strike Teams, DMSU, or MCI trailers.

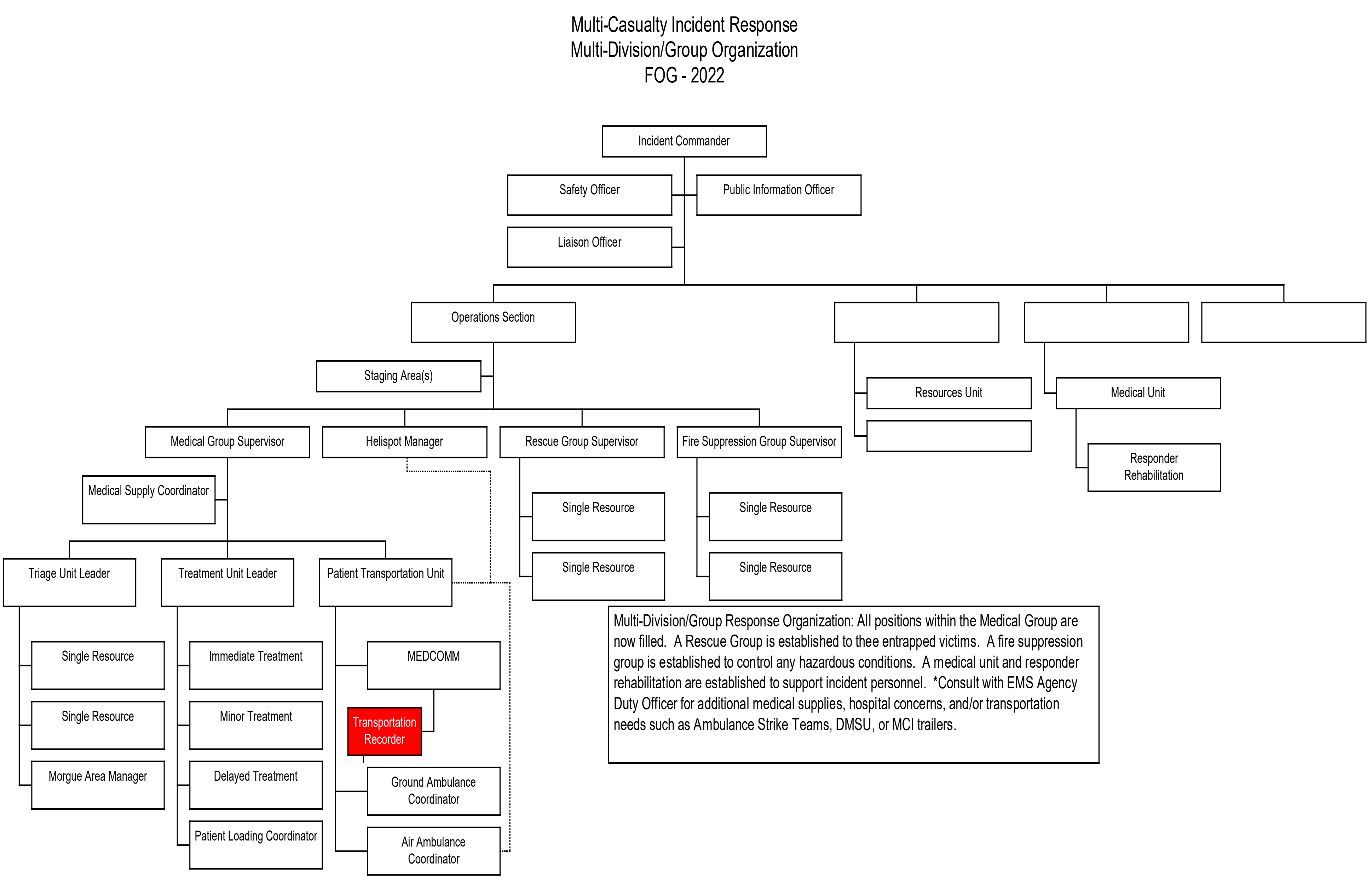
Multi-Division/Group Response Organization: All positions within the Medical Group are now filled. A Rescue Group is established to free entrapped victims. A fire suppression group is established to control any hazardous conditions. A medical unit and responder rehabilitation are established to support incident personnel. *Consult with EMS Agency Duty Officer for additional medical supplies, hospital concerns, and/or transportation needs such as Ambulance Strike Teams, DMSU, or MCI trailers.

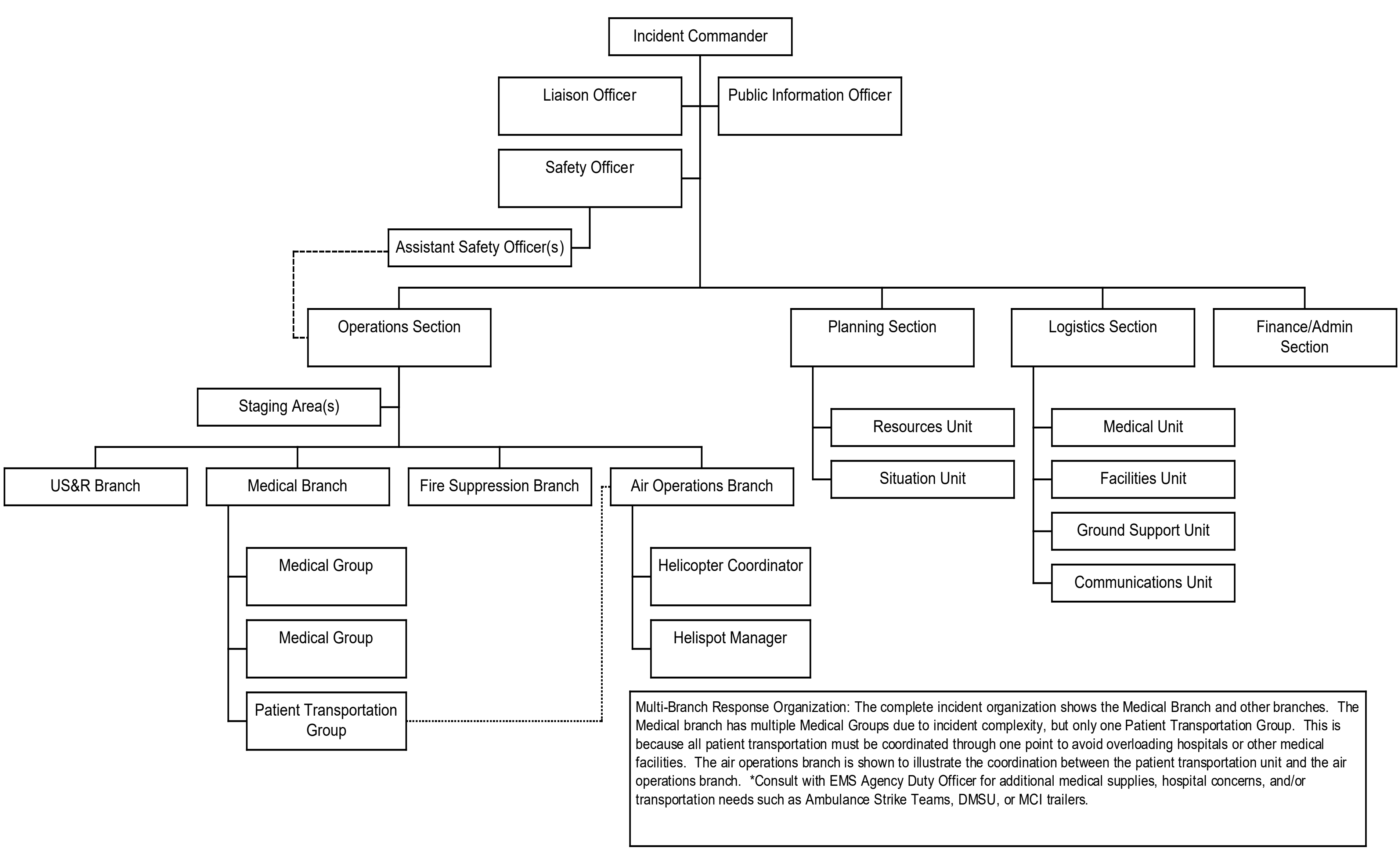
Multi-Branch Response Organization: The complete incident organization shows the Medical Branch and other branches. The Medical branch has multiple Medical Groups due to incident complexity, but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals or other medical facilities. The air operations branch is shown to illustrate the coordination between the patient transportation unit and the air operations branch. *Consult with EMS Agency Duty Officer for additional medical supplies, hospital concerns, and/or transportation needs such as Ambulance Strike Teams, DMSU, or MCI trailers.


Multi-Casualty Incident Response
Initial Response Organization
FOG - 2022
Incident Commander
Triage Unit Leader
Single Resource
Single Resource
Immediate Treatment
Minor Treatment
Medical Communications Coordinator
Ground Ambulance Coordinator
Initial Response Organization: The Incident Commander (IC) manages initial response resources as well as all Command and General Staff responsibilities. The IC assigns a resource with the appropriate communications capability as the Medical Communications Coordinator (MEDCOMM) to establish communications with the appropriate Base Hospital. In addition, the IC assigns a triage Unit Leader, establishes treatment areas, and assigns a ground ambulance coordinator.

MCI Organization Charts – Reinforced Response Organization (FOG - 2022)




Multi-Casualty Incident Response
Multi-Division/Group Organization
FOG - 2022
Incident Commander
Safety Officer
Public Information Officer
Liaison Officer
Operations Section
Staging Area(s)
Resources Unit
Medical Unit
Responder Rehabilitation
Medical Group Supervisor
Helispot Manager
Rescue Group Supervisor
Fire Suppression Group Supervisor
Medical Supply Coordinator
Single Resource
Single Resource
Single Resource
Single Resource
Triage Unit Leader
Treatment Unit Leader
Patient Transportation Unit
Single Resource
Single Resource
Morgue Area Manager
Immediate Treatment
Minor Treatment
Delayed Treatment
Patient Loading Coordinator
MEDCOMM
Transportation Recorder
Ground Ambulance Coordinator
Air Ambulance Coordinator
Multi-Division/Group Response Organization: All positions within the Medical Group are now filled. A Rescue Group is established to thee entrapped victims. A fire suppression group is established to control any hazardous conditions. A medical unit and responder rehabilitation are established to support incident personnel. *Consult with EMS Agency Duty Officer for additional medical supplies, hospital concerns, and/or transportation needs such as Ambulance Strike Teams, DMSU, or MCI trailers.


Multi-Casualty Incident Response
Multi-Branch Organization
FOG - 2022
Incident Commander
Liaison Officer
Public Information Officer
Safety Officer
Assistant Safety Officer(s)
Operations Section
Planning Section
Logistics Section
Finance/Admin Section
Staging Area(s)
Resources Unit
Situation Unit
Medical Unit
Facilities Unit
Ground Support Unit
Communications Unit
US&R Branch
Medical Branch
Fire Suppression Branch
Air Operations Branch
Medical Group
Medical Group
Patient Transportation Group
Helicopter Coordinator
Helispot Manager
Multi-Branch Response Organization: The complete incident organization shows the Medical Branch and other branches. The Medical branch has multiple Medical Groups due to incident complexity, but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals or other medical facilities. The air operations branch is shown to illustrate the coordination between the patient transportation unit and the air operations branch. *Consult with EMS Agency Duty Officer for additional medical supplies, hospital concerns, and/or transportation needs such as Ambulance Strike Teams, DMSU, or MCI trailers.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMT/Paramedic/MICN Decertification and Discipline	Policy Number 330
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: December 1, 2018
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: December 1, 2018
Origination Date: April 9, 1985 Date Revised: October 11, 2018 Date Last Reviewed: October 11, 2018 Review Date: October 31, 2021	Effective Date: December 1, 2018

I. PURPOSE: Defines the disciplinary process regarding prehospital emergency care certificates including provision of counseling, placing certificate holder on probation or suspension, revocation of certificate, denial of renewal of certificate, or denial of certification.

II. AUTHORITY: California Health and Safety Code, Section 1798.200

III. POLICY: The Ventura County Emergency Medical Services Agency (VCEMS) may provide counseling, place on probation, suspend from practice for a designated time period, deny or revoke certification or deliver reprimands to Ventura County Certified EMT, Paramedic, or MICN if their actions, while providing prehospital care, constitutes a threat to public health and safety upon the finding by VCEMS medical director .

GROUNDS FOR DISCIPLINARY ACTION:

A. Evidence that one or more of the following actions that is substantially related to the qualifications and constitute a threat to public health and safety has/have occurred:

1. Fraud in the procurement of any certification, license or authorization.
2. Gross negligence or repeated negligent acts
3. Incompetence
4. Commission of any fraudulent, dishonest, or corrupt act, which is substantially related to the qualifications, functions, and duties of prehospital personnel.
5. Conviction of any crime, which is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction shall be considered conclusive evidence of conviction.
6. Violation of or an attempt to violate directly or indirectly, or assistance in or abetting the violation of, or conspiring to violate, any provision of Division 2.5 of the Health and Safety Code, or of the regulations promulgated by the California

State Emergency Medical Services Authority, or the County of Ventura pertaining to prehospital care personnel.

7. Violation of or an attempt to violate any federal or state statute or regulation, which regulates narcotics, dangerous drugs or controlled substances.
8. Addiction to the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs or controlled substances.
9. Functioning as a Ventura County certified EMT, accredited Paramedic, or authorized MICN while under the influence of alcoholic beverages, narcotics, dangerous drugs or controlled substances.
10. Functioning outside the scope of the held certificate or independent of medical controls in the local prehospital emergency medical care system except as authorized by other license or certification.
11. Unprofessional conduct exhibited by any of the following:
    a. The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT or Paramedic from assisting a peace officer, or a peace offer that is acting in the dual capacity of peace officer and EMT or Paramedic, from using that force that is reasonably necessary to affect a lawful arrest or detention.
    b. The failure to maintain confidentiality of patient medical information, except, as disclosure is otherwise permitted or required by law in Section 56 to 56.6, inclusive, of the California Civil Code.
    c. The commission of any sexually related offense specified under Section 290 of the California Penal Code.
12. Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.

B. Failure to pass a certifying or recertifying examination shall be sufficient grounds for the denial of a certificate or the denial of the renewal of a certificate without a formal appeal process.

IV. PROCEDURE:

A. ~~Submission of Claim~~Reporting Process

When any of the grounds for disciplinary action are exhibited by a certificate holder, any individual observing such grounds may submit a written claim relative to the infraction as

well as any other supporting evidence to the VCEMS. Discovery through medical audit shall be considered as a source of information for action.

B. Notification of Claim against Certificate Holder.

Before any formal investigation is undertaken, VCEMS shall evaluate the claim(s) relative to the potential threat to the public health and safety and determine if further action appears to be warranted.

When such a claim is submitted to VCEMS, the PCC and ED medical director at the appropriate base hospital shall be notified, in addition to the ALS provider management (if the certificate holder is an EMT or paramedic) of the claim. Notification of such a claim shall be given verbally within twenty-four (24) hours, or as soon as possible, followed by written notification within ten (10) days. The written notice shall include:

1. A statement of the claim(s) against the certificate holder.
2. A statement which explains that the claim(s), if found to be true, constitute a threat to the public health and safety and are cause for VCEMS to take disciplinary action pursuant to Section 1798.200 of the Health and Safety Code.
3. An explanation of the possible actions, which may be taken if the claims are found to be true.
4. A brief explanation of the formal investigation process.
5. A request for a written response to the claim(s) from the certificate holder.
6. A statement that the certificate holder may submit in writing any information, which she/he feels in pertinent to the investigation, including statements from other individuals, etc.
7. The date by which the information must be submitted.
8. A statement that if she/he so chooses, the certificate holder may designate another person, including legal counsel or the certificate holder's employer, to represent him/her during the investigation.

   This notification may be combined with notification of disciplinary action if the certificate holder's certificate is being immediately suspended.

   The claim shall be responded to by the appropriate individual(s) and relevant information shall be submitted to VCEMS within fifteen (15) days after receipt of written notification.

C. Review of Submitted Material

VCEMS shall review the submitted material and determine the appropriate disciplinary action.

1. The nature of the disciplinary action shall be related to the severity of the risk to the public health and safety caused by the actions of the certificate holder or applicant for a prehospital care certificate.
2. The types of action, which may be taken prior to or subsequent to formal investigation, include:
   Immediate suspension: VCEMS may immediately suspend a prehospital emergency medical care certificate at any point in the investigative or appeal process if there is evidence which indicates in the expert opinion of the VCEMS Medical Director that a continuing threat to the public health and safety will exist if the certificate is not suspended. The certificate holder's relevant employer shall be notified prior to or concurrent with initiation of the suspension. An expedited appeal hearing shall be convened if the certificate holder requests, in writing, such a hearing. Written notification shall be sent by certified mail.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Rescue Task Force Operations		Policy Number 628
APPROVED: Steven L. Carroll, Paramedic		Date: DRAFT
APPROVED: Medical Director: Daniel Shepherd, MD		Date: DRAFT
Origination Date: September 3, 2014 Date Revised: February 9, 2023 Last Review: February 9, 2023 Review Date: February 28, 2025		Effective Date: DRAFT

I. PURPOSE: To establish procedures for Rescue Task Force operations at the scene of an emergency.

The intent of this policy is to establish a minimum set of guidelines, consistent with standards outlined in NFPA 3000 – Standard for an active shooter / hostile event response (ASHER) program and FIRESCOPE 701 – Emergency response to tactical law enforcement incidents as well as local law enforcement and fire agency operating procedures. Although minimum RTF guidance is outlined in this policy, the document is not intended to dictate specific, tactical on scene operations. It is intended, however, to outline a standard that can be referred to by first responders and prehospital personnel during training or in advance of an incident occurring.

~~I.~~II. AUTHORITY: California Health and Safety Code, Division 2.5, sections 1797.204 and 1797.220; California Code of Regulations, Title 22, Division 9, Sections, 100063, 100146, and 100148

~~II.~~III. POLICY:

1. Rescue task force operations ~~shall~~ will be conducted in accordance with current Incident Command System (ICS) standards, and the primary fire agency conducting RTF operations ~~shall~~ will establish unified command with law enforcement as soon as feasible, ideally prior to the first RTF team making entry with law enforcement.
2. Once rescue operations are complete, all rescued victims ~~shall~~ should be transitioned from the hazard area(s), to a cold zone where they can be treated and prepared for transport ~~in accordance with VCEMS Policy 131~~. In cases of 3 or more patients, medical care and transportation in the cold zone will be conducted in accordance with VCEMS Policy 131 – Multi Casualty Incident Response.

3. Only fire personnel, trained in RTF operations, who are wearing appropriate personal protective equipment, shall make entry into the warm zone as part of an RTF. All others shall remain in the cold zone.
4. Equipment utilized for the purposes of medical care, rescue, and personal protection are outlined in Appendix A of this policy.
5. Treatment (basic or advanced) performed as part of RTF operations will be in line with current VCEMS treatment protocols. Threat based care will be administered as conditions in the hazard zone allow.
   A. Utilize the ~~SCAB-E~~MARCH mnemonic that highlights the principles of RTF medical care within the warm zone: ~~Situation, Circulation, Airway, Breathing, and Evacuation~~Massive hemorrhage, airway, respirations, circulation, head injury / hypothermia.
   B. Medical care should be focused on stabilizing life/limb threatening injuries and should be centered around:
      i. Controlling hemorrhage, including the application of tourniquet(s) and wound packing.
      ii. M~~1) m~~aintaining a patent airway and adequate respirations;
      iii. N~~2) n~~eedle decompression of tension pneumothorax
      iv. Maintaining adequate body heat to prevent hypothermia~~x, and~~;
   C. Evacuation to casualty collection point or treatment area in cold zone should be a priority.
         ~~i. C3) controlling extremity hemorrhage, including the application of tourniquet(s) and wound packing.~~
   ~~B.A. Utilize the SCAB-E mnemonic that highlights the principles of RTF medical care within the warm zone: Situation, Circulation, Airway, Breathing, and Evacuation.~~

~~III.~~IV. PROCEDURE:

1. Preparatory Phase
   A. Arrive and report to staging or designated location in a secure area.
      i. First arriving command officer (or company officer on single resource incidents) should seek to establish unified command with law enforcement as soon as possible.
      ii. First arriving command officer (or company officer on single resource incidents) should maintain physical contact with law enforcement IC at all times.

B. Don PPE (fire/ballistic ~~-~~helmet, ballistic vest, wildland jacket, EMS Jacket, etc.), based on departmental requirements and guidelines.

C. Report to Incident Command / Unified Command that rescue group / team is ready and awaiting an assignment.

D. Ensure there is clear identification of RTF personnel.

~~i.~~ Apparatus ID will be the standard by which RTF personnel are identified. In cases where multiple apparatus share the same ID, personnel will include apparatus type in RTF designator (e.g. RTF Engine 68, RTF Truck 68, RTF Squad 68).

~~D.~~E. Prepare RTF medical bags

~~E.~~F. Perform brief intelligence and threat assessment with law enforcement personnel and Incident Command / Unified Command.

i. Unified Command ~~should~~will be Co-located to simplify LEO and Fire and EMS Overhead Communications

~~i.~~ii. Identify hot, warm, and cold zone(s)

~~ii.~~iii. Identify movement path(s), and entry/exit points, rally points, etc.

~~iii.~~iv. If the size and complexity of the incident, as well as the number of victims warrants it, static and dynamic Casualty Collection Points (CCP)~~(s)~~ should be established.

~~F.~~G. Perform communications check with other RTF personnel and rescue group supervisor.

i. Fire/EMS resources and law enforcement personnel will remain on their assigned frequencies unless specifically directed to a separate channel by incident command / unified command.

~~G.~~H. Develop incident objectives for RTF (fire) personnel that are in line with the objectives outlined by law enforcement personnel.

2. Warm Zone Operations

A. Coordinate movements and maintain cover as directed by law enforcement members of RTF.

B. Perform rapid assessment and treatment of victims

i. Apply ~~red~~ designated ribbon to either arm for treated victims

a. ~~, and B~~black/white ribbon will be used for identification of deceased victims.

C. Move patients to CCP and/or cold zone treatment area.

Establishing a casualty collection point is dependent on a variety of factors including resources (personnel and/or equipment), overall condition of victim(s) and the circumstances of the scene itself. It is understood that casualty collection points may not be feasible at all scenes and in all circumstances.

i. Transfer care to appropriate treatment area manager and ensure medical group supervisor is aware of new patients.

ii. Improvised transport methods may need to be utilized for the purposes of transporting patients from ~~CCPs~~warm zone to treatment area in cold zone.

~~C.~~D. Establish RTF medical caches / re-supply points as needed.

~~D.~~E. Re-stock RTF medical bags and prepare for re-entry into the warm zone.

~~E.~~F. Transition RTF personnel to MCI operations in cold zone once rescue of victims from the warm zone is complete.

3. Post Incident Phase
   A. Ensure accountability for all RTF personnel
   B. Collect any/all RTF documents or unit logs
   C. Perform incident de-brief / hot wash with all incident personnel
   D. Assess mental and physical health of RTF personnel and conduct CISD and rehabilitation as needed.
4. Non-RTF Prehospital Personnel
   A. Identify safe ingress, egress, routes of travel, and identify applicable radio communication frequencies prior to entry (eg: mednet)

   ~~A.~~B. Utilizing current ICS concepts, establish key roles for the purposes of MCI management that focus on the triage, treatment, and transport of victims.

   ~~B.~~C. Identify key locations in the cold zone for equipment staging, treatment area(s), and ambulance loading zone(s).

   ~~C.~~D. Ensure Incident Command / Unified Command is aware of the location of this area and of the personnel staffing key MCI management roles.

   ~~D.~~E. All MCI operations (where applicable) shall be conducted in accordance with VCEMS Policy 131.
5. Documentation of patient care shall be in accordance with procedure(s) outlined in VCEMS Policy 1000 – Documentation of Prehospital Care, or with VCEMS Policy 131 (if an MCI declaration is applicable).

Common Terms and Definitions Associated with Rescue Task Force Operations

Active ShooterAssailant

A suspect who's activity is immediately causing death and serious bodily injury. The activity is not contained and there is immediate risk of death and serious injury to potential victims.

Active Shooter / Hostile Event (ASHE)

An incident involving one or more suspects participating in an ongoing, random or systematic attack using firearms or other weapons and tactics with the intent to harm others and/or commit mass murder

Acts of Violence

Includes but is not limited to large scale complex incidents such as school shootings, workplace violence, active shooter and terrorist activities, as well as smaller scale and/or less complex incidents such as suicide attempts, single patient shootings and stabbings, domestic violence injuries, and assaults.

Barricaded Suspect

A suspect who is in a position of advantage, usually barricaded in a room or building, and is armed and has displayed violence. May or may not be holding hostages and there is no indication that the subject's activity is immediately causing death or serious bodily injury.

Casualty Collection Point

The Casualty Collection Point (CCP) is a forward location where victims can be assembled for movement from areas of high risk to the triage/treatment areas. It is a temporary location to stage patients while awaiting further treatment/evacuation. Based on incident dynamics, multiple CCPs may be required. Law enforcement may evacuate patients out of the Hot Zone to the Warm Zone border for RTF management or, RTFs may evacuate patients to the Warm/Cold zone border for transport to treatment area(s).

- Establishing a casualty collection point is dependent on a variety of factors including resources (personnel and/or equipment), overall condition of victim(s) and the circumstances of the scene itself. It is understood that casualty collection points may not be feasible at all scenes and in all circumstances.

Cold Zone

Area of the incident where victims shall be moved to after rescue. The cold zone is also where transport resources and additional personnel will remain to support triage, treatment, and transport operations in accordance with VCEMS Policy 131 – Multi Casualty Incident Response.

Concealment

A law enforcement term that refers to a location that hides an individual from view but does not provide protection from gunfire.

~~Anything that prevents you from being seen but will not stop a bullet.~~

Contact Team

Contact teams are used by law enforcement to rapidly deploy to the active shooter incident. ~~It is usually~~ C~~c~~omprised of the first few officers on scene. Primary objective is to locate and stop the shooter from inflicting death or injury. Contact Teams will bypass dead, wounded and panicked citizens to neutralize the active threat.

Cover

A law enforcement term that refers to a location or hard barrier that provides protection from gunfire, blast or shrapnel hazard. Cover can be natural or manmade but must be dense enough to provide adequate protection. The higher the caliber of weapon the more substantial the barrier must be.
~~Anything that will stop a bullet.~~

Direct Threat

Immediate threat to life exists. The situation is highly dynamic and varies depending on complexity and circumstances of the incident.

Force Protection

In a tactical environment, the protective actions taken by law enforcement to protect incident personnel or secure a location from hostile threats intended to harm incident personnel or victims
~~Actions taken by law enforcement to prevent or mitigate hostile actions against personnel, resources, facilities and critical infrastructure.~~

Force Protection Group

A law enforcement group with the responsibility to prevent or mitigate hostile actions against personnel, resources, facilities and critical infrastructure. Coordinates with Rescue Group in establishing Rescue Task Forces (RTF).

Hot Zone

Areas wherein a direct and immediate threat exists. A direct and immediate threat is very dynamic and is determined by complexity and circumstances of the incident. Examples of direct and immediate threat are active shooters and unexploded ordinances. These areas are where Law Enforcement has deployed contact teams to isolate or neutralize the threat. TEMS FRO / ambulance personnel ~~Fire personnel~~ will not operate in a Hot Zone. ~~May also be classified as the inner perimeter by law enforcement.~~

Immediately Dangerous to Life or Health (IDLH)

Any atmosphere that poses an immediate threat to life, would cause irreversible adverse health effects, or would impair an individual's ability to escape from the area.

Indirect Threat

Threat that can be mitigated or reduced, but not completely eliminated or secured.

MARCH - Massive Hemorrhage, Airway, Respirations, Circulation, Head Injury / Hypothermia

Mnemonic used to describe medical treatment ~~priorities~~priorities to be used in ~~a~~ the tactical environment~~hazardous area~~. Goal is to rapidly stabilize life threatening injuries where patient lies and evacuate.

Multi Casualty Incident (MCI)

A suddenly occurring event that exceeds the capacity of the routine first response assignment. In Ventura County, MCIs are categorized into three different levels, depending on the number of victims:

A. MCI/Level I (3-14 victims)

B. MCI/Level II (15-49 victims)

C. MCI/Level III (50+ victims)

Rapid Deployment

The swift and immediate deployment of law enforcement resources to on-going, life threatening situations where delayed deployment could otherwise result in death or great bodily injury to innocent persons.

Rescue Group

~~At violent~~ In tactical law enforcement incidents, the Rescue Group is ~~responsible for~~responsible for the medical care and evacuation of patients located in the Warm Zone. This is accomplished through the utilization of public safety personnel~~by assigning firefighters~~, assigned to a Rescue Task Force (s) (RTF). The ~~firefighter~~ members of the RTF report to the Rescue Group Supervisor and operate in conjunction with LEO in the tactical environment. Rescue groups movement within the tactical environment occurs under the lead of force protection. ~~,~~ ~~but work for and at the direction of the lead law enforcement officer of the RTF to which they are assigned.~~ Rescue Group may also be responsible for other operations that will take place within the Warm Zone. This can include objectives such as fire suppression, forcible entry, and fire alarm system activation/deactivation.

Rescue Task Force

The Rescue Task Force (RTF) is a team or teams of trained public saftey~~fire~~ personnel deployed with armed law enforcement personnel (Force Protection) to provide rapid threat-based care and rescue in areas where there is an ongoing indirect threat (ballistic, explosive, etc.). Teams provide this care and rescue only while under force protection ~~the protection of armed law enforcement personnel.~~

RTF can/should be deployed for the following reasons:

i. Treatment of victims in a warm zone/IDLH environment
ii. Removal of victims from the warm zone to a Casualty Collection Point (CCP) and/or to the Cold Zone
iii. Movement of equipment/supplies from the cold zone to the warm zone.
iv. Any other activities within the warm zone that are deemed necessary for a successful RTF operation.

RTFs provide focused, limited, lifesaving interventions (MARCH)~~rapidly stabilize life threating injuries~~ where victims are found, and/or in Casualty Collection Points (CCP). After providing rapid lifesaving medical care, RTFs will evacuate patients to treatment areas and/or Casualty Collection Points. An RTF is comprised of law enforcement personnel providing force protection and fire personnel providing medical care. .

~~**SCAB-E**~~

~~SCAB-E: Situation, Circulation, Airway, Breathing, Evacuation. Mnemonic used to describe medical treatment process that is to be used in a hazardous area. Goal is to rapidly stabilize life threatening injuries where patient lies and evacuate.~~

TEMS FRO

First responders (BLS or ALS level) who have completed a minimum four-hour agency-specific tactical awareness training that enables first responders to operate in a Warm Zone with Force Protection as part of a Rescue Task Force.

TEMS Specialist

TEMS Specialist: First responders who have completed an approved 40-hour tactical medicine course, and who training regularly with SWAT teams. TEMS Specialists have the ability to support SWAT during incident operations and are able to function in the Hot Zone.

~~**TEMS Technician**~~

~~First responders who have completed the same approved 40- hour tactical medicine course as SWAT tactical medics or TEMS Specialists, but have not completed an approved 80-hour SWAT course.~~

Tactical Emergency Casualty Care (TECC)

Forward deployment of stabilizing medical interventions in civilian disaster scenarios. TECC guidelines are based on the military Tactical Casualty Combat Care (TCCC) principles. TECC guidelines take into account the specific needs of civilian EMS providers serving civilian populations. These principles focus on the three most common cause of preventable death in combat (active shooting) situations; 1) extremity hemorrhage, 2) tension pneumothorax, and 3) airway obstructions. All of these are treatable in the field with minimal equipment.

Violent Incident Personnel Protective Equipment (PPE)

The required PPE for violent incidents will be a combination of body armor, ballistic element, structure helmet and brush coat or EMS jacket. All personnel will wear the

required PPE while on scene regardless of their –assignment or work locations. PPE not only protects on scene personnel it is used as an identification method while working on a very dynamic multi-discipline response.

Warm Zone

Areas that have been cleared by Law Enforcement where there is minimal or mitigated threat. These areas can be considered clear but not secure. These areas are where Rescue Task Forces (RTF) deploy. RTFs rapidly stabilize life threating injuries where victims are found, and/or in Casualty Collections Points (CCP), followed by evacuation to treatment areas. Only public safety ~~Fire~~ personnel being provided Force Protection by law enforcement as part of an RTF will enter the Warm Zone. Law Enforcement has sole authority to determine warm zones.

Appendix A – Rescue Task Force Equipment

Minimum Mandatory Requirements

Special Considerations:

1. The equipment below has been identified as the minimum amount of equipment needed to adequately triage/treat victims as part of an RTF response. Agencies may add equipment to their specific build-outs as they deem necessary.
2. An agency may combine the contents of the two kits (ALS and BLS) as space/RTF operations warrant. Any kit stocked with ANY ALS level equipment will be clearly marked as 'ALS' on the outer portion of the pack. Personnel will have a clear understanding that they are only to utilize equipment based on their appropriate scope of practice.

Personal Protective Equipment

1 – Fire / Ballistic Helmet, Agency and Rank Specific

1 – Ballistic Vest

1 – Wildland "Brush" Jacket or EMS Jacket - ~~,~~ Agency Issued.

Individual RTF Kit – BLS

1 – ~~StatPacks Brand "Competitor" Pack – Bla~~Pack or case capable of carrying all required equipment

3 – Combat Application Tourniquet (C.A.T.)

2 – HyFin Vent Chest Seal

~~5 – Petrolatum Gauze 5x9~~

1 – 2" Cloth Adhesive Tape

2 – 4" Flat Emergency Trauma Dressing (ETD)

2 – 5x9 Sterile Combine Dressing

2 – 3" Stretch Gauze

6 – Pair, Nitrile Gloves

1 – Each, Nasopharyngeal Airways Size 28, 30, 32 French

3 – Packets, Sterile Lubricant

1 – Roll, 100 yard White/Black Striped Flagging Tape

1 – Roll, 100 yard Red Flagging Tape

1 – Trauma Shears

1 – Safety Goggles

Individual RTF Kit – ALS

1 – Pack or case capable of carrying all required equipment with 'ALS' Markings ~~StatPacks Brand "Competitor" Pack – Black with 'ALS' Markings~~

1 – ~~Cook Emergency Pneumothorax Set~~Needle Thoracostomy Kit

3 – Combat Application Tourniquet (C.A.T.)

2 – HyFin Vent Chest Seal

~~5 – Petrolatum Gauze 5x9~~

1 – 2" Cloth Adhesive Tape

2 – 4" Flat Emergency Trauma Dressing (ETD)

2 – 5x9 Sterile Combine Dressing

2 – 3" Stretch Gauze

6 – Pair, Nitrile Gloves

1 – Each, Nasopharyngeal Airways Size 28, 30, 32 French

3 – Packets, Sterile Lubricant

1 – Roll, 100 yard White/Black Striped Flagging Tape

1 – Roll, 100 yard Red Flagging Tape

1 – Trauma Shears

1 – Safety Goggles

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Mechanical CPR		Policy Number 631
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date:
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date:
Origination Date: Date Revised: Date Last Reviewed: Review Date:		Effective Date:

I. PURPOSE: To define the indications, procedure, and documentation for use of a mechanical CPR device by Ventura County prehospital personnel.

II. AUTHORITY: California Health and Safety Code, Section 1797.220, and 1798. California Code of Regulations, Title 22, Section 100170.

III. POLICY:

A. The priorities when treating a cardiac arrest patient are high quality CPR, immediate defibrillation if indicated, and expeditious administration of epinephrine.

B. Mechanical CPR devices have the potential to improve the quality of CPR, but do not increase the rate of survival, or the percentage of patients who survive with a good neurologic outcome.

C. Successful application of a mechanical CPR device requires a methodical, coordinated approach.

D. The LUCAS device (Stryker) is the only mechanical CPR device approved for use by prehospital personnel in Ventura County

E. The LUCAS device, if available, MAY be applied to patients > 18 years of age if; the "triangle of life" has been established, defibrillation has been performed (if indicated), the initial dose of epinephrine has been administered, AND no immediate airway interventions are indicated.

F. The LUCAS device, if immediately available, MAY be applied earlier than outlined above in the following circumstances:

1. **ROSC:** The device, if available, shall be applied after ROSC, prior to patient movement.
2. **TRAUMATIC ARREST:** patient must be > 18 years of age and meet criteria for initiating resuscitation. Consider needle T insertion prior to device application. The application/operation of LUCAS shall not delay transport or interfere with necessary treatment.

3. **LOCATION**: the patient is in a location that prohibits quality CPR AND immediate movement to a workable space is not possible. Routine movements (e.g. bed to floor, hallway to room) do not apply.

G. Agencies utilizing LUCAS shall evaluate the devices' performance prospectively and shall report to VCEMSA the following on a biannual basis:
   1. Compression fraction prior to, and after, LUCAS application.
   2. Median duration of pause during device application.
   3. 90th percentile duration for device application.
   4. Number of pauses > 3 seconds/per incident.
   5. Time to critical interventions such as vascular access, defibrillation, and epinephrine administration.

IV. PROCEDURE:

A. The "team leader" or "primary patient caregiver" on scene remains responsible for determining when, and coordinating how, the device should be applied.

B. All LUCAS devices utilized in Ventura County must be programmed to power on in "continuous mode," not 30:2 or 50:2 modes.

C. Cardiac monitor data, including LUCAS data (.PCO) files must be transmitted to the LIFENET/CODE-STAT database.

D. In the event of a device failure or other malfunction, the device will be removed immediately and manual CPR resumed.

E. Agencies must notify VCEMS, within 24 hours, of any device failures or other malfunctions using the procedure outlined in VCEMSA Policy 121 Safety Event Review

F. All providers must receive initial and ongoing training on the device, its application, troubleshooting, reporting, and documentation prior to use on patients.

G. Patients who are transported after application of a mechanical CPR device must be accompanied by at least one provider from the agency who applied the device.

Seizures

ADULT	PEDIATRIC

BLS Procedures

Protect from injury

Maintain patent airway, and administer oxygen as indicated.

For suspected pediatric febrile seizures begin passive cooling measures.

Determine Blood Glucose level, and treat according to VC EMS policy 705.03 – Altered Neurologic Function

ALS ~~Prior to Base Hospital Contact~~Standing Orders

ADULT	PEDIATRIC
Consider IV/IO access	Consider ~~Consider~~ IV/IO access
	~~If not already performed by BLS personnel, determine Blood Glucose level, and treat according to VC EMS policy 705.03 – Altered Neurologic Function~~

Anticonvulsant Treatment - Initial~~If not already performed by BLS personnel, determine Blood Glucose level, and treat according to VC EMS policy 705.03 – Altered Neurologic Function~~
For active and persistent seizure activity
~~Persistent Seizure Activity~~
• **Midazolam** ~~(Give to ***actively seizing*** pregnant patients prior to magnesium)~~
  • IM – 0.2~~1~~ mg/kg, Max ~~5~~ 10 mg
  • IV / IO – ~~2 mg~~ 0.1 mg/kg, Max 4 mg
	Anticonvulsant Treatment - Initial
	For active and persistent seizure activity.
	• **Midazolam**
	  • IM – 0.2 mg/kg, Max 10 mg
	  • IV / IO – 0.1 mg/kg, Max 4 mg

Anticonvulsant Treatment - Repeat
For continued or recurring seizure activity post initial anticonvulsant treatment
• **Midazolam**
  • IM– 0.1 mg/kg, Max 5 mg
  • IV / IO – 0.05 mg/kg, Max 2 mg
  ~~Repeat 1 mg q 2 min as needed~~
  ~~Max 5 mg~~
	Anticonvulsant Treatment - Repeat
	For continued or recurring seizure activity post initial anticonvulsant treatment
	• **Midazolam**
	  • IM – 0.1 mg/kg, Max 5 mg
	  • IV / IO – 0.05 mg/kg, Max 2 mg
	~~Persistent Seizure Activity~~
	• ~~**Midazolam**~~
	  ~~IM – 0.1 mg/kg~~
	  ~~Max 5 mg~~
	  ~~IV/IO – 0.1mg/kg,~~
	  ~~Repeat q 2 min as needed.~~
	  ~~Max single dose 2 mg~~
	  ~~Max total dose 5 mg~~

Eclampsia Treatment *In addition to any indicated anticonvulsant treatment, patients* 20 weeks gestation to one week postpartum *with active or resolved seizure activity.* ~~*& No Known Seizure History*~~ • **Magnesium Sulfate** ○ IV / IO~~PB~~ – 4 g in 50 Ml D_5W ~~infused~~ over 10 min	

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• Slow or stop infusion if bradycardia, heart block, or decreased respiratory effort occur.	
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	

Additional Information:

- Route for anticonvulsant treatment –
  - The initial priority is cessation of seizure activity. When IV/IO access is not available IM is the preferred route to avoid delays in care.
  - When IV or IO access is available this is the preferred route.
  - Repeat doses should be administered IV/IO whenever possible.
- 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 callnot require ALS intervention.

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COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: STEMI Receiving Center (SRC) Standards and STEMI Referral Hospital (SRH) Standards	Policy Number 430
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June~~ly~~ 1, 2023~~0~~
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: June~~ly~~ 1, 2023~~0~~
Origination Date: July 28, 2006 Date Revised: February 5, 2020 Last Review: February 9, 2023~~5, 2020~~ Review Date: February 28, 2026~~3~~	Effective Date: June~~ly~~ 1, 2023~~0~~

I. PURPOSE: To define the criteria for designation as a STEMI Receiving Center in Ventura County.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798, 1798.101, 1798.105, 1798.2 and California Code of Regulations, Title 22, Section 100175, 100270.124 and 100270.125.

III. DEFINITIONS: Refer to California Code of Regulations, Title 22, Chapter 7.1, Article 1.

III. POLICY:

A. A STEMI Receiving Center (SRC), approved and designated by Ventura County EMS shall meet the following requirements:

1. All the requirements of a Receiving Hospital in VCEMS Policy 420.
2. All the requirements of an SRC in VCEMS Policy 440.
3. The hospital shall have established protocols for triage, diagnosis, and Cath lab activation following field notification.
4. The hospital shall have a single call activation system to activate the Cardiac Catheterization Team directly.
5. Written protocols shall be in place for the identification of STEMI patients.
   a. At a minimum, these written protocols shall be applicable in the ICU/Coronary Unit, Cath lab, and the Emergency Department.
6. The hospital shall be available for treatment of STEMI patients 24 hours per day, 7 days a week, 365 days per year.
7. The hospital shall have a process in place for the treatment and triage of simultaneous arriving STEMI patients.

8. SRCs shall comply with the requirements for an annual minimum volume of procedures (25) required for designation by VCEMS.

9. The hospital shall have a STEMI program manager and a STEMI medical director.
10. The hospital shall have job descriptions and organizational structure clarifying the relationship between the STEMI medical director, STEMI program manager, and the STEMI team.
11. Operate a cardiac catheterization lab licensed by the Department of Health Services and approved for emergency percutaneous coronary interventions.
12. A STEMI receiving center without cardiac surgery capability on-site shall have a written transfer plan and agreements for transfer to a facility with cardiovascular surgery capability.
13. The hospital shall maintain daily STEMI team and Cardiac Catheterization team call rosters
14. Have policies for patients to receive emergent angiography or emergent fibrinolysis, based on physician decisions for individual patients.
15. The hospital shall participate in the local EMS agency quality improvement processes related to a STEMI critical care system.
16. The hospital shall submit their data to the STEMI Registry System by the 15th of each month for the previous month patients.
17. Will accept all ambulance-transported patients if the interpretation on the monitor meets the manufacturer guidelines for a POS STEMI ECG, except when on internal disaster or no cardiac catheterization lab is available, regardless of ICU/CCU or ED saturation status.
18. Have policies and procedures that allow the automatic acceptance of any STEMI patient from a Ventura County Hospital upon notification by the transferring physician.
19. The Cardiac Catheterization Team, including appropriate staff, shall be immediately available.
20. Have policies in place for the transfer of STEMI patients.

B. A STEMI Referral Hospital (SRH), approved and designated by Ventura County EMS shall meet the following requirements:

1. All the requirements of a Receiving Hospital in VCEMS Policy 420.
2. All the requirements of an SRH in VCEMS Policy 440.
3. The hospital shall be available for treatment of STEMI patients 24 hours per day, 7 days a week, 365 days per year.
4. Written protocols shall be in place to identify STEMI patients and provide an optimal reperfusion strategy using fibrinolytic therapy.
5. The Emergency Department shall maintain a standardized procedure for the treatment of STEMI patients.
6. The hospital shall have a transfer process through interfacility transfer agreements and have pre-arranged agreements with EMS ambulance providers for rapid transport of STEMI patients to an SRC.
7. The hospital shall have a program to track and improve treatment of STEMI patients.
8. The hospital must have a plan to work with an SRC and VCEMS on quality improvement processes.

B. Designation

1. Application:
   Eligible hospitals shall submit a written request for SRC or SRH approval to the VC EMS, documenting the compliance of the hospital with Ventura County SRC or SRH Standards.
2. Approval:
   SRC or SRH approval or denial shall be made in writing by VCEMS to the requesting Hospital within two weeks after receipt of the request for approval and all required documentation.
3. VC EMS may deny, suspend, or revoke the approval of a SRC or SRH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.
4. The VCEMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the PSC that compliance with the

regulation would not be in the best interests of the persons served within the affected area.

5. SRCs and SRHs shall be reviewed every three years.
    a. SRCs or SRHs shall receive notification of evaluation from VCEMS.
    b. SRCs or SRHs shall respond in writing regarding program compliance.
    c. On-site SRC or SRH visits for evaluative purposes may occur.
    d. SRCs or SRHs shall notify VCEMS by telephone, followed by a letter or email within 48 hours, of changes in program compliance or performance.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Hospital EMS Surge Assistance		Policy Number 141
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: Junely 1, 20232
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: Junely 1, 20232
Origination Date: Date Revised: Date Last Reviewed: Review Date:	February 10, 2022 February 9, 2023 February 28, 20263	Effective Date: Junely 1, 20232

I. PURPOSE: To manage 911 ambulance resources during periods of prolonged ambulance patient offload times (APOT) at hospital emergency departments (EDs). This will be accomplished through coordination with local ambulance and fire resources, in addition to emergency department personnel and hospital administration.

II. AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.220 and 1798; California Code of Regulations, Title 22, Sections 100062 and 100170

A. POLICY:

1. This policy will be implemented in coordination with the Ventura County EMS Agency (VCEMS), the impacted hospital(s), and prehospital provider agencies.
2. The goal of this policy is to allow for transporting ambulances to offload patients and return to service as soon as possible.
3. The hospital is not relieved of its responsibilities outlined in the Emergency Medical Treatment and Active Labor Act. Patient care in the ambulance offload area is ultimately the responsibility of the hospital.
4. While prehospital personnel may assist with monitoring patients in the ambulance offload area, patient care is ultimately the responsibility of the hospital and hospital personnel.
5. Hospital administration shall be notified by emergency department personnel any time this policy is implemented at a receiving hospital.
6. A designated agency representative (AREP) or EMS Agency personnel will coordinate all prehospital resources utilized in the ambulance offload area and will determine when prehospital resources are no longer needed for monitoring of ambulance patients.

7. Each EMT and Paramedic may observe up to four (4) patients in the ambulance offload area, and will provide care to patients, if/when needed, per their scope of practice and VCEMS Policies and Procedures.
8. Paramedics staffing the ambulance offload area may monitor patients requiring ALS or BLS level care. EMTs may monitor patients requiring BLS level of care.
   a. During extenuating circumstances or extended periods of heavy surge and delays, EMTs may be authorized by the VCEMS Medical Director to monitor ALS level patients. This authorization will be made at the time of need and will be done in coordination with the impacted facility and prehospital provider agencies.
9. Paramedics and EMTs staffing the ambulance offload area will maintain effective, and ongoing, communication with ED staff regarding the condition of patient(s) in the ED holding area. The intent is to ensure that hospital staff have the information necessary to prioritize triage and transfer of care, initiate treatment, or direct treatment when clinically indicated. Communication will encompass, but not be limited to;
   a. Acute change(s) in patient condition which may indicate a potential life threat or need for time sensitive intervention.
   b. Change(s) in condition or need for treatment which are not consistent with prior field impression(s).
   c. Patient condition(s) currently requiring ongoing or repeat interventions such as continuous infusion of or repeat doses of medication.

B. Criteria For Implementation of this Policy:
1. All available treatment areas, including hallway beds, within the emergency department are fully occupied and ambulance patients are being managed on ambulance gurneys (inside or outside of the emergency department), and;
2. Three (3) or more ambulances are waiting to offload patients for greater than one (1) hour; or
3. Three or more ALS level patients are being managed by prehospital personnel waiting to be triaged/accepted by emergency department personnel.

IV. PROCEDURE

A. Hospital emergency department leadership or prehospital provider agency will contact the EMS Agency Duty Officer when criteria outlined in Section III.B are met.

B. EMS Agency will work with emergency department personnel and prehospital provider agency to determine the need for implementation, and appropriate prehospital resources that may be necessary.

C. If it is determined that additional prehospital resources will respond to the impacted emergency department to facilitate staffing of an ambulance offload area, an agency representative will be requested to consult with EMS Agency Duty Officer and emergency department personnel. The AREP will be the primary coordinator of prehospital resources at an impacted emergency department. The AREP may employ different strategies to manage these resources and achieve desired outcomes:

   1. An ambulance crew or paramedic supervisor may be assigned to the ambulance offload area with the intent of observing several patients at the same time. Under this construct, transporting ambulances would offload their patients into the ambulance offload area and give report to the assigned crew, transfer care, and return to service.

   2. An ALS fire resource (squad, engine or overhead) may be assigned to the ambulance offload area with the intent of observing several patients at the same time. Transporting ambulances would offload their patients into the ambulance offload area and give report to the assigned fire personnel, transfer care, and return to service.

D. The impacted hospital may designate and assign an individual to the ambulance offload area if/when one is activated. This individual would coordinate with the assigned AREP and would coordinate patient assessment and care from a hospital perspective and would coordinate resources and beds as they become available.

E. If not utilizing interior emergency department space, the impacted hospital may pre-identify a space to be utilized as an ambulance offload area if/when needed.

   1. If possible, this area will be supplied with chairs, stretchers/cots, blankets, oxygen, and other medical equipment/supplies as appropriate.

   2. The ambulance offload area will ideally be a tent or similar structure with climate control that can provide adequate shelter from the elements.

   3. The hospital will provide appropriate means of communication to ensure that hospital staff and prehospital AREP assigned to the ambulance offload area can maintain effective communications with emergency department personnel at all times.

F. Patients arriving to an impacted emergency department with an active ambulance offload area will be categorized according to the following criteria:

1. Black (Morgue) – Patients arriving at the hospital will be immediately assessed by emergency department physician for prognosis and futility of effort. If futility is determined, resuscitation shall be terminated. Patient will be received by the hospital and an account/visit will be generated in this hospital EHR system. The decedent will be transported directly to the hospital morgue, and the decedent remains will be transferred to morgue personnel expeditiously so that the ambulance crew can return to service.
2. Red (Immediate) – Patients that exhibit severe respiratory, circulatory or neurological symptoms that would likely result in significant morbidity or mortality if not addressed immediately. These patients require rapid assessment and intervention by emergency department personnel. These patients should be offloaded into the emergency department immediately, or they should be assigned top priority for offload if assigned to the ambulance offload area. If assigned to the ambulance offload area, these patients will be closely monitored by the designated hospital personnel and/or prehospital crew(s). Transfer of care to emergency department personnel will remain a top priority for this category of patient, and all efforts will be made within the ED to create an available bed. A single Paramedic may observe up to two (2) red/immediate category patients.
3. Yellow (Delayed) – Patients that require some degree of advanced care and/or assessment, but who are stable to wait in the ambulance offload area until appropriate resources are available inside the emergency department. The designated hospital staff will ensure the patient's information is captured in the hospital's EHR and the AREP will ensure that appropriate prehospital personnel have been assigned to monitor the patient's status. A single Paramedic may observe up to four (4) yellow/delayed category patients.
4. Green (Minor) – Patients that don't require advanced care and/or assessment and are medically stable with minimal observation. If space in the emergency department waiting room is available and appropriate, the patient may be transported there directly and report given to appropriate ED personnel so that the transporting ambulance crew can return to service. If no space is available in the emergency department waiting room, the patient may be transitioned to

personnel in the ambulance offload area, and transfer of care will be initiated. The hospital personnel will ensure that the patient has been entered into the hospital's EHR.

G. For prehospital personnel employed by a Ventura County – based provider, documentation of patient care shall be in accordance with VCEMS Policy 1000 – Documentation of patient care.

1. To facilitate timely and accurate documentation and tracking/trending of patient vital signs and other pertinent findings, ePCR data should be electronically transferred from the transporting crew to other VCEMS prehospital personnel staffing an ambulance offload area. The transporting crew will still be required to complete and upload a full ePCR, per Policy 1000, and VCEMS prehospital personnel staffing the ambulance offload area will complete an ePCR documenting the ongoing care and assessment until such time that the patient is transferred to a bed in the emergency department and transfer of care has been completed.

   a. Personnel in the ambulance offload area will utilize the time they received the patient from the transporting ambulance and will be required to manually input that time for the following fields:

      i. Dispatch Notified Date/Time
      ii. Unit Notified by Dispatch Date/Time
      iii. Unit En Route Date/Time
      iv. Unit Arrived On Scene Date/Time
      v. Arrived at Patient Date/Time
      vi. Transfer of EMS Patient Care Date/Time

   b. The Destination Patient Transfer of Care Date/Time will be the time when the patient is moved from the ambulance offload area to the emergency department, report is given, and a signature is received from receiving hospital representative.

   c. The Unit Back in Service Date/Time will be when the personnel assigned to the ambulance offload area return and are available to receive an additional patient from a transporting ambulance crew.

Behavioral Emergencies

ADULT	PEDIATRIC
ALS Prior to Base Hospital Contact	

IV/IO Access
 	
For Extreme Agitation
• **Midazolam**
  ○ IM – 5mg or 10 mg (5mg/ml)
  ○ IV/IO – 2 mg
    • Repeat 1 mg q 2 min as needed
    • Max 5 mg
 	
When safe to perform, determine blood glucose level
	IV/IO Access
	
	For Extreme Agitation
	• **Midazolam**
	  ○ IM – 0.1 mg/kg
	    • Max 5 mg
	  ○ IV/IO – 0.1 mg/kg
	    • Repeat q 2 min as needed
	    • Max single dose 2 mg
	    • Max total dose 5 mg
	
	When safe to perform, determine blood glucose level

Base Hospital Orders only	
Consult with ED Physician for further treatment measures	

Additional Information:

- If patient refuses care and transport, and that refusal is because of "mental disorder", consider having patient taken into custody according to Welfare and Institutions Code Section 5150 or 5585 "Mental disorders" do not generally include alcohol or drug intoxication, brain injury, hypoxemia, hypoglycemia, or similar causes.
- Refer to VC EMS pre-hospital provider fact sheet for suspected excited delirium patients. Be sure to consider and rule out other possible causes or behavior (traumatic or medical).
- Use of restraints (physical or chemical) shall be documented and monitored in accordance with VCEMS policy 732
- Welfare and Institutions Code Section 5585:
  - Known as the Children's Civil Commitment and Mental Health Treatment Act of 1988, a minor patient may be taken into custody if, as a result of a mental disorder, there is a danger to self and others or is gravely disabled. A California peace officer, a California licensed psychiatrist in an approved facility, Ventura County Health Officer or other County-designated individuals, can take the individual into custody, but it must be enforced by the police in the field.
- Welfare and Institutions Code Section 5150:
  - A patient may be taken into custody if, as a result of a mental disorder, there is a danger to self and others or is gravely disabled. A California peace officer, a California licensed psychiatrist in an approved facility, Ventura County Health Officer or other County-designated individuals, can take the individual into custody, but it must be enforced by the police in the field.
- All patients shall be transported to the most accessible Emergency Department for medical clearance prior to admission to a psychiatric facility

Ventura County Mental Health Crisis Team: (866) 998-2243

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Effective Date: June 1, 2023December 1, 2020
Next Review Date: February 28, 2025October 31, 2022

Date Revised: October 8, 2020
Last Reviewed: February 9, 2023October 8, 2020

VCEMS Medical Director

Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA)

ADULT	PEDIATRIC
BLS Procedures	
Initiate Cardiac Arrest Management (CAM) Protocol Airway management per VCEMS policy	
ALS Standing Orders	
Assess for and treat underlying cause **IV/IO access** • PRESTO Blood Draw **Epinephrine* 0.1 mg/mL** **Administer ASAP goal ≤6 minutes** • IV/IO 1 mg (10 mL) q 6 min • Repeat x 2, max of 3 doses during initial arrest. • If ROSC then re-arrest an additional 3 doses may be administered. **Normal Saline** • IV/IO bolus- 1 Liter **ALS Airway Management** • If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures in accordance with policy 710. **When one of the following is a suspected cause of arrest:** History of Renal Failure/Dialysis • **Calcium Chloride** ○ IV/IO – 1 g ○ Repeat x 1 in 10 min • **Sodium Bicarbonate** ○ IV/IO – 1 mEq/kg ○ Repeat x 2 0.5 mEq/kg q 5 min Tricyclic Antidepressant Overdose • **Sodium Bicarbonate** ○ IV/IO – 1 mEq/kg ○ Repeat x 2 0.5 mEq/kg q 5 min Beta Blocker Overdose • **Glucagon** ○ IV/IO – 2 mg up to 10 mg when available Calcium Channel Blocker Overdose • **Calcium Chloride** ○ IV/IO – 1 g ○ Repeat x 1 in 10 min • **Glucagon** ○ IV/IO – 2 mg up to 10 mg when available	**Assess for and treat underlying cause** **IV/IO access** • PRESTO Blood Draw **Epinephrine* 0.1mg/mL** **Administer ASAP goal ≤6 minutes** • IV/IO 0.01mg/kg (0.1 mL/kg) q 6 min • Repeat x 2, max of 3 dose during initial arrest. • If ROSC then re-arrest an additional 3 doses may be administered. **Normal Saline** • IV/IO bolus- 20 mL/kg **ALS Airway Management** • If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures in accordance with policy 710. **When one of the following is a suspected cause of arrest:** History of Renal Failure/Dialysis • **Calcium Chloride** ○ IV/IO – 20 mg/kg ○ Repeat x 1 in 10 min • **Sodium Bicarbonate** ○ IV/IO – 1 mEq/kg ○ Repeat x 2 0.5 mEq/kg q 5 min Tricyclic Antidepressant Overdose • **Sodium Bicarbonate** ○ IV/IO – 1 mEq/kg ○ Repeat x 2 0.5 mEq/kg q 5 min Beta Blocker Overdose • **Glucagon** ○ IV/IO – 0.1 mg/kg up to 10 mg when available Calcium Channel Blocker Overdose • **Calcium Chloride** ○ IV/IO – 20 mg/kg ○ Repeat x 1 in 10 min • **Glucagon** ○ IV/IO – 0.1 mg/kg up to 10 mg when available
Base Hospital Orders Only	
***Consult with ED Physician for further treatment measures**	

Additional Information:

- If sustained ROSC (> 30 seconds), activate VF/VT alarm and initiate post arrest resuscitation as outlined in Policy 733: Cardiac Arrest management and Post Arrest Resuscitation.
- For termination of resuscitation, transport decisions, and use of base hospital consult reference Policy 733: Cardiac Arrest Management and Post Arrest Resuscitation.
- If patient is **hypothermic** – only ONE round of medication administration prior to Base Hospital contact. Field determination of death is discouraged in these patients and they should be transported to the most accessible receiving facility.