Virtual	Pre-hospital Services Committee Agenda	October 14, 2021 9:30 a.m.

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	A. Coronavirus Update	Dr. Shepherd/Steve Carroll
V.	**New Business**	
	A. Other	
VI.	**Old Business**	
	A. 335 – Out of County Internship	Chris Rosa
	B. 722 – Interfacility IV Heparin and NTG	Adriane Gil-Stefansen
VII.	**Informational/Discussion Topics**	
	A. 420 – Receiving Hospital Criteria	Adriane Gil-Stefansen
	B. 705.03 – Altered Neurologic Function	Andrew Casey
	C. 705.26 – Suspected Stroke	Adriane Gil-Stefansen
	D. 726 – 12 Lead ECG	Adriane Gil-Stefansen
VIII.	**Policies for Review**	
	A. 332 – EMS Personnel Background Check	
	B. 606 – Withholding/Termination of Resuscitation and DOD	
	C. 613 – Do Not Resuscitate	
	D. 704 – Guidelines for Base Hospital Contact	
	E. 705.16 – Neonatal Resuscitation	
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	September 9, 2021 9:30 a.m.

Topic	Discussion	Action	Approval
II. Approve Agenda	Welcome Heather Ellis as our new PSC Chairwoman	Approved	Motion: Ira Tilles Seconded: Todd Larsen Passed unanimous
III. Minutes		Approved	Motion: Ira Tilles Seconded: Todd Larsen Passed unanimous
IV. **Medical Issues**			
A. Coronavirus Update	Steve Carroll– Cases are slightly more stable right now. -Daily case rate 4.7 positivity rate -7-day case rate per 100,000 is 7.6 -Hospitals are still under great stress -Countywide 2 shot vaccination = 69.5%		
V. New Business			
A. Other			
VI. Old Business			
A. 132 – EMS Coverage for Special Events Mass Gathering		Approved	Motion: Jaime Villa Seconded: Tom O’Connor Passed unanimous
B. 335 – Out of County Internship		Tabled Tom O’Connor and Chris Rosa will work on the language for next PSC meeting.	
VII. Informational			
A. 150 – UO Reportable Events/Sentinel Events	No information will change.	Online form will be available next month.	
B. 151 -Medication Error Reporting	No information will change.	Online form will be available next month.	
C. 705.02 – Allergic Reaction and Anaphylaxis	Format: Adult side does not match pediatric side. Andrew Casey corrected.	Approved with changes This will go live immediately.	
VIII. Policies for review			
A. 625 - POLST		Approved	Motion: Todd Larsen

			Seconded: Tom O'Connor Passed unanimous
B. 722 – Interfacility Transport of Patients with IV Heparin & Nitro	Dr. Larsen asked that Chris Rosa develop an Audit Form and send out to the committee to review.	Approved Bring back the Audit Form to the next PSC meeting.	Motion: Chris Sikes Seconded: Todd Larsen Passed unanimous
C. 724 – Brief Resolved Unexplained Event (BRUE)		Approved with formatting changes	Motion: Ira Tilles Seconded: Todd Larsen Passed unanimous
D. 734 – Tranexamic Acid Administration (TXA)		Dr. Shepherd will work on the policy language and bring back to October PSC.	
X. Agency Reports			
A. Fire departments	**VCFPD** – none **VCFD-** Interviews for hiring process **OFD** – Preparing for October Academy, 22 recruits. **Fed. Fire** – none **SPFD** – none **FFD** – none		
B. Transport Providers	**AMR/GCA/LMT** – Sensory Kits donated by the Autism Society will be added to the ambulances soon. **AIR RESCUE – none**		
C. Base Hospitals	**AHSV** – Completed chest pain renewal and we are good for 4 years. **LRRMC** – Still working on helipad. Should be open the end of the month. **SJRMC –** Increasing staff for mid-shift. **VCMC** – Increase in patients and decrease in staff.		
D. Receiving Hospitals	**PVH –** none **SPH** – none **CMH** – none **OVCH** – none		
E. Law Enforcement	**VCSO –**none **CSUCI PD –**.		
F. ALS Education Programs	**Ventura College** – The college has hired a PT and a FT instructor for the 2nd Paramedic Class. There is a need for additional instructors and a skills assistant.		
G. EMS Agency	**Chris –** We have received additional "Leave at Home Naloxone kits".		

	Dr. Shepherd – none **Steve** – none **Katy** –none **Karen** – none **Julie** –none **Randy** – none	
H. Other		
XI. Closing	**Meeting adjourned at 11:30**	Motion: Ira Tilles Seconded: Todd Larsen Passed unanimous

Prehospital Services Committee 2021

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/7/2021	2/11/2021	3/11/2020	4/8/2021	5/13/2021	6/10/2021	7/8/2021	8/12/2021	9/9/2021	10/14/2021	11/11/2021	12/9/2021	%
AMR	Williams	Joey			DG		JW				JW				
AMR	Riggs	Cassie					CR								
CMH - ER	Levin	Ross		RL	RL	RL	RL				RL				
CMH - ER	Querol	Amy			AQ		AQ								
OVCH - ER	Pulido	Ed			EP		EP				EP				
OVCH - ER	Ferguson	Catherine			CF	CF	CF				CF				
CSUCI PD				CD		CD									
CSUCI PD	Deboni	Curtis					CD								
FFD	Herrera	Bill				BH	BH				BH				
FFD															
GCA	Pugliese	Joey													
GCA	Sanders	Mike		MS		MS									
Lifeline	Rosolek	James													
Lifeline	Winter	Jeff				JW	JW								
LRRMC - ER	Brooks	Kyle		KB			KB								
LRRMC - ER	Moore	Bethany		BM	BM	BM	BM				BM				
OFD	Strong	Adam			AS		AS								
OFD	Villa	Jaime		JV	JV	JV	JV				JV				
SJPVH - ER	Hutchison	Stacy													
SJPVH - ER	Sikes	Chris			CS	CS	CS				CS				
SJRMC - ER	Larsen	Todd		TL	TL	TL	TL				TL				
SJRMC - ER	Brock	Jenny		KM	KM	KM	JB								
SVH - ER	Tilles	Ira		IT	IT	IT	IT				IT				
SVH - ER	Shorts	Kristen			KS	KS	KS				KS				
V/College	O'Connor	Tom		TO	TO	TO	TO				TO				
VCFD	Tapking	Aaron		AT	AT	AT	AT				AT				
VCFD	Ellis	Heather		HE	HE	HE	HE				HE				
VNC	Williams	Joseph		JW	JW	JW	JW								
VNC	Miner	Robert				RM	RM								
VNC - Dispatch	Gregson	Erica			EG		EG								
VCMC - ER	Gillett	John		JG	JG	JG	JG								
VCMC - ER	Gallegos	Tom		TG	TG	TG	TG								

Agency	LastName	FirstName	1/7/2021	2/11/2021	3/11/2020	4/8/2021	5/13/2021	6/10/2021	7/8/2021	8/12/2021	9/9/2021	10/14/2021	11/11/2021	12/9/2021	%
VCMC-SPH	Vicencio	Angela													
VCSO SAR	Conahey	Dave		DC	DC	DC	DC								
VCSO SAR	Whitebread	Ryan					RW								
VFF	Lane	Mike													
VFF	Vilaseca	James		JV	JV										
Below names a	**Date Change/cancelled - not counted against member for attendance**														
EMS	Carroll	Steve		SC	SC	SC	SC				SC				
EMS	Frey	Julie		JF		JF	JF				JF				
EMS	Perez	Randy		RP	RP	RP	RP				RP				
EMS	Shepherd	Daniel		DS	DS	DS	DS				DS				
EMS	Rosa	Chris		CR	CR	CR	CR				CR				
EMS	Salvucci	Angelo									AS				
EMS	Hansen	Erik					EH								
EMS	Beatty	Karen			KB	KB	KB				KB				
EMS	Gil-Stefansen	Adriane		AS	AS	AS	AS				AS				
EMS	Garcia	Martha		MG	MG	MG					MG				
EMS	Casey	Andrew		AC	AC	AC	AC				AC				
LMT	Winter	Jeff		JW	JW	JW	JW								
AMR/GCA	Gonzales	Nicole													
State Parks	Futoran	Jack		JF											
VCMC	King	Katie													
VCMC	Duncan	Thomas		TD	TD	TD	TD				TD				
Hospital Assoc.	Strickland	Audra			AS						AS				
CMH	Hall	Elaina													
VNC	Chase	David		DC	DC	DC	DC				DC				
VCSO SAR	Hadland	Don													

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Out of County Paramedic Internship Approval Process	Policy Number 335
APPROVED: Administrator: Steven L. Carroll, ~~EMT-P~~Paramedic	Date: Draft
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: Draft
Origination Date: October 13, 2005 Date Revised: October 14, 2021 Date Last Reviewed: October 14, 2021 Next Review Date: October 31, 2023	Effective Date: Draft

I. PURPOSE: To establish a mechanism for notifying the EMS Agency of out of county paramedic student placement within the local EMS system and ensure appropriate medical control and oversight of Paramedic Interns prior to practicing within the local jurisdiction.

II. AUTHORITY: Health and Safety Code Sections 1797.107, 1797.172, 1797.173, 1798, and California Code of Regulation, Title 22, Sections 100147 and 100153.

III. DEFINITIONS: This policy defines the standards for field interns, whose paramedic training program is located outside the jurisdiction of the paramedic training program approving authority, and who wish to complete all or a portion of their field internship requirements with an advanced life support provider in Ventura County.

A paramedic intern is a person trained by a VCEMS approved training program who while under the supervision of an approved preceptor may provide ALS care as directed by local EMS medical control. The intern shall be supervised, trained, counseled and evaluated by the designated preceptor and his/her affiliated training program.

IV. POLICY: ~~The following requirements must be completed prior to internship commencement.~~

A. All of the following requirements (IV.A.1 – IV.A.3) must be submitted to VCEMS at least 45 days prior to commencement of the internship:

1. Paramedic Training Program ~~Responsibilities~~Requirements:

a. Letter requesting approval for out of county paramedic student placement within the local EMS system;

b. Copy of Paramedic Training Program's CAAHEP accreditation;

c. Evidence of a contract to provide field training between the ALS training program and the ALS provider agency where the intern will be training;

d. Copies of forms used to document student's progress, continuum of care and the training program's collaboration with the field preceptor;

~~c.~~e. Confirmation that the intern successfully completed didactic and clinical training at the same institution that is requesting internship placement. This requirement may be reduced at the discretion of the VCEMS Medical Director.

2. Paramedic Intern ~~Responsibilities~~Requirements:

~~a.~~ Completed VCEMS application;

a.

b. Copy of intern's valid government issued photo identification;

c. Copy of intern's professional rescuer level CPR card;

d. Completion of a California Department of Justice (CA DOJ Live Scan) background check through VCEMS. A copy of the Request for Live Scan Services form must be submitted to VCEMS at time of application;

e. Letter from training program confirming intern's good standing and current affiliation with a VCEMS approved training program including dates of hospital clinical completion and contact name and phone number for the instructor responsible for the intern;

f. Letter from training program confirming that the intern has performed five (5) successful live patient endotracheal intubations during primary ALS training;

~~b.~~g. Upon completion of above requirements, intern shall contact VCEMS to schedule appointment to complete internship process.

3. ALS Provider ~~Responsibilities~~Requirements:

a. Notify VCEMS of intention to provide field internship for a specific intern;

b. Provider agency shall submit a completed Appendix A to VCEMS for each intern who is placed for internship prior to the start date;

~~a.~~c. Ensure that the student has been oriented to the Ventura County EMS System including local policies, procedures and treatment protocols.

D. Paramedic Intern Photo Identification:

Upon VCEMS verification of all above requirements including background check results, intern will be issued a Paramedic Intern photo identification badge that must be worn visible at all times while providing pre-hospital care in Ventura County. Internship shall not start until the Paramedic Intern photo identification badge is issued.

E. ~~In order to ensure an adequate number of internship placements for in county paramedic students, no internships involving out of county students will be permitted from February 1st through May 31st of each year. Placement for internships for out of county interns must be initiated prior to November 1st in order to allow adequate time for completion before January 31st.~~

Language Option 1:

If out of county internship placement coincides with the local paramedic training program's field internship timeframe, prehospital provider agency will coordinate with local program to ensure the out of county placement does not conflict with local field intern placement.

Language Option 2:

In order to ensure an adequate number of internship placements for in county paramedic students, out of county students may have limited access during peak preceptor usage windows. Coordination with the local paramedic training program and placement agencies is required prior to placement. Internship placements for out of county interns must conclude prior to the anticipated start date for the local training program's internship period. If adequate numbers of preceptors are available and the preceptor station assignment do not overlap (resulting in multiple paramedic interns responding to the same call), out of county programs would be able to assign internship placements for their students.

Internship placement priority is given in the following order:

1. In county paramedic program student

2. Out of county paramedic program, student is locally employed
3. Out of county paramedic program, student is an in county resident
4. Out of county paramedic program, student is an out of county resident

ATTACHMENT A

Out of County Paramedic Internship Authorization
(To be completed by ALS provider agency and submitted to VCEMS)

Intern Name	
Start date of internship	
Agency sponsoring intern	
Preceptor name	
Training Institute	

Information below is to be completed by the EMS Agency

Authorization approved:	Date
Authorization is not approved because:	
ALS Provider notified on:	Date
Training Program notified on:	Date
EMS Representative	Signature

AVCDS LOGIN

LOGIN	PASSWORD

The password issued is a default password. You must change it upon successful login.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Interfacility Transport of Patients with IV Heparin & Nitroglycerin		Policy Number 722
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: June 1, 2018
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: June 1, 2018
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 15, 1998 January 11, 2018 January 11, 2018 January 31, 2021	Effective Date: June 1, 2018

I. PURPOSE:

To provide a mechanism for paramedics to be permitted to monitor infusions of nitroglycerin and heparin during interfacility transfers.

II. POLICY:

A. Paramedics: Only those Paramedics who have successfully completed a training program approved by the Ventura County EMS Medical Director on nitroglycerin and heparin infusions will be permitted to monitor them during interfacility transports.

B. ALS Ambulance Providers: Only those ALS Ambulance providers approved by the Ventura County EMS Medical Director will be permitted to provide the service of monitoring nitroglycerin and/or heparin infusions during interfacility transports

C. Patients: Patients that are candidates for paramedic transport will have pre-existing intravenous heparin and/or nitroglycerin drips. Pre-hospital personnel will not initiate heparin and nitroglycerin drips.

III. PROCEDURE:

A. Medication Administration

1. The paramedic shall receive a report from the nurse caring for the patient and continue the existing medication drip rate
2. If medication administration is interrupted by infiltration or disconnection, the paramedic may restart or reconnect the IV line.
3. All medication drips will be in the form of an IV piggyback monitored by a mechanical pump familiar to the Paramedic who has received training and is familiar with its use.
4. In cases of pump malfunction that cannot be corrected, the medication drip will be discontinued and the receiving hospital notified.

B. Nitroglycerin Drips: Paramedics are allowed to transport patients on nitroglycerin drips within the following parameters:

1. Infusion fluid will be D5W. Medication concentration will be either 25 mg/250 mL or 50 mg/250mL.
2. Drip rates will remain constant during transport. No regulation of the rate will be performed except to turn off the infusion completely.
3. In cases of severe hypotension, defined as a systolic blood pressure < 90 mmHg, the medication drip will be discontinued and the receiving hospital notified.
4. Drip rates will not exceed 50 mcg/minute.
5. Vital signs will be monitored and documented every 10 minutes.

C. Heparin Drips: Paramedics are allowed to transport patients on heparin drips within the following parameters:

1. Infusion fluid will be D5W or NS. Medication concentration will be 100 units/mL of IV fluid (25,000 units/250 mL, 25,000 units/500 mL or 50,000 units/500 mL).
2. Drip rates will remain constant during transport. No regulation of the rate will be performed except to turn off the infusion completely.
3. The medication drip will be discontinued and the base hospital notified if the patient develops new, rapidly worsening, or uncontrolled bleeding.
4. Drip rates will not exceed 1600 units/hour.
5. Vital signs will be monitored and documented every 10 minutes.

D. All cases of IV Heparin and IV Nitroglycerin administration will be documented in the VCePCR, in accordance with VCEMS Policy 1000 – Documentation of Patient Care.

E. All calls will be audited by the service provider and by the transferring and receiving hospitals. Audits will assess compliance with VCEMS Policy, including base hospital contact in emergency situations. Reports will be sent to the EMS agency as requested.

1. Access to the audit form here (Link or QR code):

VCEMS Policy 722: Audit Form

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES	HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Receiving Hospital Standards	Policy Number 420
APPROVED Administration: Steven L. Carroll, Paramedic	Date: September 1, 2018
APPROVED Medical Director: Daniel Shepherd, MD	Date: September 1, 2018
Origination Date: April 1, 1984 Date Revised: August 9, 2018 Date Last Reviewed: October 14, 2021 ~~August 9, 2018~~ Review Date: October 31, 2024 ~~August 31, 2021~~	Effective Date: December 1, 2021

I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Receiving Hospital (RH) designation.

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.

III. POLICY:

A. A RH , approved and designated by the Ventura County, shall:

1. Be licensed by the State of California as an acute care hospital.
2. Meet the requirements of the Health and Safety Code Sections 1250-1262 and Title 22, Sections 70411, 70413, 70415, 70417, 70419, 70649, 70651, 70653, 70655 and 70657 as applicable.
3. Be accredited by a CMS accrediting agency.
4. Operate an emergency department (ED) that is designated by the State Department of Health Services as a “Comprehensive Emergency Department,” “Basic Emergency Department” or a “Standby Emergency Department.”
5. Operate an Intensive Care Unit.
6. Have the following specialty services available at the hospital or appropriate referral hospital (at the discretion of the Emergency Department Physician. and consultant Physician.) within 30 minutes:

Cardiology	Anesthesiology	Neurosurgery
Orthopedic Surgery	General Surgery	General Medicine
Thoracic Surgery	Pediatrics	Obstetrics

7. Have operating room services available within 30 minutes.
8. Have the following services available within 15 minutes.

   X-ray Laboratory Respiratory Therapy

9. Evaluate all ambulance transported patients promptly, either by RH Physician, Private Physician or other qualified medical personnel designated by hospital policy.
10. Have the capability at all times to communicate with the ambulances and the Base Hospital (BH).
11. Designate a ED Medical Director who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The Medical Director shall:
    a. Be regularly assigned to the ED.
    b. Have knowledge of VCEMS policies and procedures.
    c. Coordinate RH activities with BH, Prehospital Services Committee (PSC), and VCEMS policies and procedures.
    d. Attend, or have designee attend, PSC meetings.
    e. Provide ED staff education.
    f. Schedule medical staffing for the ED on a 24-hour basis.
12. Agree to provide, at a minimum, on a 24-hour basis, a physician and a registered nurse (RN) that meets the following criteria:
    a. All Emergency Department physicians shall:
       1) Be immediately available to the Emergency Department at all times.
       2) Be certified by the American Board of Emergency Medicine OR the American Osteopathic Board of Emergency Medicine OR be Board eligible OR have all of the following:
          a) Have and maintain current Advanced Cardiac Life Support (ACLS) certification.
          b. Have and maintain current Advanced Trauma Life Support (ATLS) certification.
          c) Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.
    b. RH EDs shall be staffed by:
       1) Full-time staff: those physicians who practice emergency medicine 120 hours per month or more, and/or

2) Regular part-time staff: those physicians who see 90 patients or more per month in the practice of emergency medicine.
   a) Formula: Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month.
   b) Physicians working in more than one hospital may total their hours.
   c) Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician.
   d) During period of double coverage, the whole shall be met if one of the physicians meets the above standards.

c. All RH RNs shall:
   1) Be regular hospital staff assigned solely to the ED for that shift.
   2) Maintain current ACLS certification.

d. All other nursing and clerical personnel for the Emergency Department shall maintain current Basic Cardiac Life Support certification.

e. Sufficient licensed personnel shall be staffed to support the services offered.

13. Cooperate with and assist the PSC and EMS Medical Director in the collection of statistics for program evaluation.

14. Agree to maintain all prehospital data in a manner consistent with hospital data requirements and provide that the data be integrated with the patient's chart. Prehospital data shall include the Ventura County Electronic Patient Care Report (VCePCR), Paramedic Base Hospital communication form (from the BH), and documentation of a BH telephone communication with the RH.

15. Participate with the BH in evaluation of paramedics for reaccreditation.

16. Permit the use of the hospital helipad as an emergency rendezvous point if a State-approved helipad is maintained on hospital premises.

B. There shall be a written agreement between the RH and EMS indicating the commitment of hospital administration, medical staff, and emergency department staff to meet requirements for ALS program participation as specified by EMS policies and procedures.

C. EMS shall review its agreement with each RH at least every two years.

D. EMS may deny, suspend, or revoke the approval of a RH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Board of Supervisors for appropriate action.

E. The EMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the PSC that, as defined in the regulations, compliance with the regulation would not be in the best interests of the persons served within the affected local area.

F. A hospital that applies to become a RH in Ventura County must meet Ventura County RH Criteria and agree to comply with Ventura County regulation.

  1. Application:
     Eligible hospital shall submit a written request for RH approval to the VCEMS, documenting the compliance of the hospital with the Ventura County RH.
  2. Approval:
     Program approval or denial shall be made in writing by EMS to the requesting RH within a reasonable period of time after receipt of the request for approval and all required documentation. This period shall not exceed three (3) months.

G. ALS RHs shall be reviewed every two years.

  1. All RH shall receive notification of evaluation from the EMS.
  2. All RH shall respond in writing regarding program compliance.
  3. On-site visits for evaluative purposes may occur.
  4. Any RH shall notify the EMS by telephone, followed by a letter within 48 hours, of changes in program compliance or performance.

H. Paramedics providing care for emergency patients with potentially serious medical conditions, and are within the catchment area of a hospital with a standby emergency department, shall make immediate base contact for destination determination. Examples of these patients would include, but are not limited to, patients with:

  1. Patients with seizure of new onset, multiple seizures within a 24-hour period, or sustained alteration in level of consciousness
  2. Chest pain or discomfort of known or suspected cardiac origin
  3. Sustained respiratory distress not responsive to field treatment
  4. Suspected pulmonary edema not responsive to field treatment
  5. Potentially significant cardiac arrhythmias
  6. Orthopedic emergencies having open fractures, or alterations of distal neurovascular status

7. Suspected spinal cord injury of new onset
8. Burns greater than 10% body surface area
9. Drowning or suspected barotrauma with any history of loss of consciousness, unstable vital signs, or respiratory problems
10. Criteria that meet stroke, STEMI, or trauma criteria for transport to a specialty care hospital

I. A RH with a standby emergency department only, offering “standby emergency medical service,” is considered to be an alternative receiving facility. Patients may be transported to a standby emergency department when the use of the facility is in the best interest of patient care.

1. Patients that require emergent stabilization at an emergency department may be transported to a standby emergency department if a basic emergency facility is not within a reasonable distance. These would include patients:
    a. In cardiac arrest with NO return of spontaneous circulation (ROSC) in the field
    b. With bleeding that cannot be controlled
    c. Without an effective airway
2. 3. During hours of peak traffic, the Base Hospital MICN should make destination determinations based on predicted travel time and patient condition. Patients who meet criteria for trauma, stroke, or STEMI in the absence of a condition that meets I.1. above, will be directed to the appropriate destination.
4. A RH with a standby emergency department shall report to Ventura County EMS Agency any change in status regarding its ability to provide care for emergency patients.

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL
CRITERIA COMPLIANCE CHECKLIST

Receiving Hospital: ____________________ Date: _______________

			YES	NO
A.	Receiving Hospital (RH), approved and designated by the Ventura County , shall:			
	1.	Be licensed by the State of California as an acute care hospital.		
	2.	Meet the requirements of the Health and Safety Code Section 1250-1262 and Title 22, Sections 70411, 70413, 70415, 70417, 70419, 70649, 70651, 70653, 70655 and 70657 as applicable.		
	3.	Be accredited by a CMS accrediting agency		
	4.	Operate an Intensive Care Unit.		
	5.	Have the following specialty services available at the hospital or appropriate referral hospital (at the discretion of the Emergency Department (ED) Physician. and consultant Physician.) within 30 minutes:		
		• Cardiology		
		• Anesthesiology		
		• Neurosurgery		
		• Orthopedic Surgery		
		• General Surgery		
		• General Medicine		
		• Thoracic Surgery		
		• Pediatrics		
		• Obstetrics		
	6.	Have operating room services available within 30 minutes.		
	7.	Have the following services available within 15 minutes.		
		• X-Ray		
		• Laboratory		
		• Respiratory Therapy		
	8.	Evaluate all ambulance transported patients promptly, either by RH Physician, Private Physician or other qualified medical personnel designated by hospital policy.		
	9.	Have the capability at all times to communicate with the ambulances and the BH.		
	10.	Designate an Emergency Department Medical Director who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The Medical Director shall:		
		a. Be regularly assigned to the Emergency Department.		
		b. Have knowledge of VC EMS policies and procedures.		

	YES	NO
c. Coordinate RH activities with Base Hospital, Prehospital Services Committee (PSC), and VCEMS policies and procedures.		
d. Attend or have designee attend PSC meetings.		
e. Provide Emergency Department staff education.		
f. Schedule medical staffing for the ED on a 24-hour basis.		
11. Agree to provide, at a minimum, on a 24-hour basis, a physician and a registered nurse that meets the following criteria:		
a. All Emergency Department physicians shall:		
1). Be immediately available to ED at all times.		
2) Be certified by the American Board of Emergency Medicine OR the American Osteopathic Board of Emergency Medicine OR be Board eligible OR have all of the following:		
a). Have and maintain current Advanced Cardiac Life Support (ACLS) certification.		
b) Have and maintain current Advanced Trauma Life Support (ATLS)certification.		
c) Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.		
b. RH EDs shall be staffed by:		
1). Full-time staff: those physicians who practice emergency medicine 120 hours per month or more, and/or		
2) Regular part-time staff: those physicians who see 90 patients or more per month in the practice of emergency medicine.		
a) Formula: Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month		
b) Physicians working in more than one hospital may total their hours		
c) Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician		

	YES	NO
d) During period of double coverage, the whole shall be met if one of the physicians meets the above standards.)		
c. All RH RNs shall:		
1) Be regular hospital staff assigned solely to the ED for that shift.		
2) Maintain current ACLS certification.		
d. All other nursing and clerical personnel for the ED shall maintain current Basic Cardiac Life Support certification.		
e. Sufficient licensed personnel shall be utilized to support the services offered.		
12. Cooperate with and assist the PSC and EMS Medical Director in the collection of statistics for program evaluation.		
13. Agree to maintain all prehospital data in a manner consistent with hospital data requirements and provide that the data be integrated with the patient's chart. Prehospital data shall include the VCePCR, paramedic Base Hospital communication form (from the BH), and documentation of a BH telephone communication with the RH.		
14. Participate with the BH in evaluation of paramedics for reaccreditation.		
15. Permit the use of the hospital helipad as an emergency rendezvous point if a State-approved helipad is maintained on hospital premises.		
B. There shall be a written agreement between the RH and EMS indicating the commitment of hospital administration, medical staff, and emergency department staff to meet requirements for employment as specified by EMS policies and procedures.		

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL PHYSICIAN
CRITERIA COMPLIANCE CHECKLIST

Physician Name: ____________________ Date: _______________

All Emergency Department physicians shall:	YES	NO
1. Be immediately available to the RH ED at all times.		
2. Be certified by the American Board of Emergency Medicine OR the American Osteopathic Board of Emergency Medicine OR be Board eligible OR have all of the following:		
a. Have and maintain current ACLS certification.		
b. Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.		
c. Have and maintain current Advanced Trauma Life Support (ATLS) certification.		

The above named physician is:

1) Full-time staff: A physician who practices emergency medicine 120 hours per month or more, and/or		
2) Regular part-time staff: A physician who see 90 patients or more per month in the practice of emergency medicine (Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month, Physicians working in more than one hospital may total their hours, Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician)		

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL
STANDBY EMERGENCY DEPARTMENT
ADDITIONAL CRITERIA COMPLIANCE
CHECKLIST

Receiving Hospital w/Standby ED:_____________ Date: _______________

	EMS REVIEW	
The RH with standby ED has:	YES	NO
A. Medical staff, and the availability of the staff at various times to care for patients requiring emergency medical services.		
B. Ability of staff to care for the degree and severity of patient injuries or condition.		
C. Equipment and services available at the facility necessary to care for patients requiring emergency medical services and the severity of their injuries or condition.		
D. During the current 2-year evaluation period, has reported to Ventura County EMS Agency any change in status regarding its ability to provide care for emergency patients.		
E. Authorization by the Ventura County EMS Agency medical director to receive patients requiring emergency medical services, in order to provide for the best interests of patient care.		
COMMENTS		

Altered Neurologic Function

ADULT | PEDIATRIC

BLS Procedures

If suspected stroke, refer to VC EMS Policy 705.26 – Suspected Stroke
Administer oxygen as indicated
Determine blood glucose level
If less than 60 mg/dl

- **Oral Glucose –** patient must be awake and able to swallow with a gag reflex intact
  - PO 15 g

** Treat as above if you have clinical suspicion of hypoglycemia and are unable to obtain glucose level due to glucometer malfunction or error reading.*

ALS Prior to Base Hospital Contact

ADULT

IV/IO Access
Determine Blood Glucose level, if not already performed by BLS personnel or post oral glucose administration

If less than 60 mg/dl
- **D10W** ~~- Preferred~~
  - IV/IOPB-100 mL (10 g)-Rapid Infusion
- ~~**D50W**~~
  - ~~IV/IO – 25 mL (12.5 g)~~
- **Glucagon** (If no IV access)
  - IM – 1 mg

Recheck Blood Glucose level 5 min after Dextrose, or 10 min after Glucagon administration

If still less than60 mg/dl
- **D10W** ~~- Preferred~~
  - IV/IOPB-150 mL (15 g)-Rapid Infusion
- ~~**D50W**~~
  - ~~IV/IO – 25 mL (12.5 g)~~

** Treat as above if you have clinical suspicion of hypoglycemia and are unable to obtain glucose level due to glucometer malfunction or error reading.*

PEDIATRIC

IV/IO Access
Determine Blood Glucose level, if not already performed by BLS personnel or post oral glucose administration

If less than 60 mg/dl
- **D10W** ~~-~~
  - IV/IOPB-5 mL/kg-Rapid Infusion
  - Max 100 mL
- **Glucagon** (If no IV/IO access)
  - IM – 0.1 mL/kg
  - Max 1 mg

Recheck Blood Glucose level 5 min after Dextrose or 10 min after Glucagon administration

If still less than 60 mg/dl
- **D10W** ~~-~~
  - IV/IOPB-7.5 mL/kg-Rapid Infusion
  - Max 150 mL

** Treat as above if you have clinical suspicion of hypoglycemia and are unable to obtain glucose level due to glucometer malfunction or error reading.*

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:
- Certain oral hypoglycemic agents (e.g. - sulfonylureas) and long-acting insulin preparations have a long duration of action, sometimes up to 72 hours. Patients on these medications who would like to decline transport MUST be warned about the risk of repeat hypoglycemia for up to 3 days, which can occur during sleep and result in the patient's death. If the patient continues to decline further care, every effort must be made to have the patient speak to the ED Physician prior to leaving the scene.
- If patient has an ALOC and Blood Glucose level is greater than 60 mg/dl, consider alternate causes:

A - Alcohol	**O - Overdose**	**I - Infection**
E - Epilepsy	**U - Uremia**	**P - Psychiatric**
I - Insulin	**T - Trauma**	**S – Stroke**

Effective Date:	December 1, 2020	Date Revised:	October 26, 2020
Next Review Date:	October 31, 2022	Last Reviewed:	October 26, 2020

VCEMS Medical Director

Altered Neurologic Function

BLS Procedures

If suspected stroke, refer to VC EMS Policy 705.26 – Suspected Stroke
Administer oxygen as indicated
Determine blood glucose level
If less than 60 mg/dl

- **Oral Glucose –** patient must be awake and able to swallow with a gag reflex intact
  - PO 15 g

** Treat as above if you have clinical suspicion of hypoglycemia and are unable to obtain glucose level due to glucometer malfunction or error reading.*

ALS Prior to Base Hospital Contact

ADULT

IV/IO Access
Determine Blood Glucose level, if not already performed by BLS personnel or post oral glucose administration

If less than 60 mg/dl

- **D10W** ~~- Preferred~~
  - IV/IOPB-100 mL (10 g)-Rapid Infusion
- ~~**D50W**~~
  - ~~IV/IO – 25 mL (12.5 g)~~
- **Glucagon** (If no IV access)
  - IM – 1 mg

Recheck Blood Glucose level 5 min after Dextrose, or 10 min after Glucagon administration

If still less than60 mg/dl

- **D10W** ~~- Preferred~~
  - IV/IOPB-150 mL (15 g)-Rapid Infusion
- ~~**D50W**~~
  - ~~IV/IO – 25 mL (12.5 g)~~

** Treat as above if you have clinical suspicion of hypoglycemia and are unable to obtain glucose level due to glucometer malfunction or error reading.*

PEDIATRIC

IV/IO Access
Determine Blood Glucose level, if not already performed by BLS personnel or post oral glucose administration

If less than 60 mg/dl

- **D10W** -
  - IV/IOPB-5 mL/kg-Rapid Infusion
  - Max 100 mL
- **Glucagon** (If no IV/IO access)
  - IM – 0.1 mL/kg
  - Max 1 mg

Recheck Blood Glucose level 5 min after Dextrose or 10 min after Glucagon administration

If still less than 60 mg/dl

- **D10W** ~~-~~
  - IV/IOPB-7.5 mL/kg-Rapid Infusion
  - Max 150 mL

** Treat as above if you have clinical suspicion of hypoglycemia and are unable to obtain glucose level due to glucometer malfunction or error reading.*

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

- Certain oral hypoglycemic agents (e.g. - sulfonylureas) and long-acting insulin preparations have a long duration of action, sometimes up to 72 hours. Patients on these medications who would like to decline transport MUST be warned about the risk of repeat hypoglycemia for up to 3 days, which can occur during sleep and result in the patient's death. If the patient continues to decline further care, every effort must be made to have the patient speak to the ED Physician prior to leaving the scene.
- If patient has an ALOC and Blood Glucose level is greater than 60 mg/dl, consider alternate causes:

A - Alcohol	**O - Overdose**	**I - Infection**
E - Epilepsy	**U - Uremia**	**P - Psychiatric**
I - Insulin	**T - Trauma**	**S – Stroke**

Suspected Stroke

ADULT

BLS Procedures

Cincinnati Stroke Scale (CSS)

Administer oxygen as indicated

Administer oxygen if SpO2 less than 94% or unknown

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

ALS Standing Orders

IV/IO access

Cardiac monitor – document initial and ongoing rhythm strips

If not already performed by BLS personnel, determine Blood Glucose level, treat according to VC EMS policy 705.03 – Altered Neurologic Function

Patients meeting Stroke Alert criteria as defined in VC EMS Policy 451:

- Notify Base hospital within 10 minutes of identifying a Stroke Alert
- Expedite transport to appropriate Acute Stroke Center (ASC).

Patients meeting ELVO Alert criteria as defined in VC EMS Policy 451:

- Notify TCASC within 10 minutes of identifying an ELVO Alert
- Expedite transport to appropriate Thrombectomy Capable Acute Stroke Center (TCASC).

Base Hospital Orders Only

Consult with ED Physician for further treatment measure

Additional Information

Cincinnati Stroke Scale (CSS)

Facial Droop
- Normal: Both sides of face move equally
- Abnormal: One side of face does not move normally

Arm Drift
- Normal: Both arms move equally or not at all
- Abnormal: One arm does not move, or one arm drifts down compared with the other side

Speech
- Normal: Patient uses correct words with no slurring
- Abnormal: Slurred or inappropriate words or mute

Ventura County ELVO Score (VES)

Forced Eye Deviation

Aphasia

Neglect

Obtundation

Refer to VC EMS Policy 451 for Detailed VES.

- Patients must meet Stroke Alert criteria in order to continue to VES
- Document name and phone number in ePCR of person who observed patient's Time Last Known Well (TLKW), and report this information to the receiving facility.
- Stroke patients in cardiac arrest with sustained ROSC (greater than30 seconds) shall be transported to the nearest STEMI Receiving Center (SRC).
- For seizure activity, refer to VC EMS Policy 705.20 Seizure.

Policy Title 12 Lead ECG		Policy Number: 726
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: December 1, 2019
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: December 1, 2019
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 10, 2006 July 11, 2019 October 14, 2021~~July 11, 2019~~ October 31, 2023~~July 31, 2021~~	Effective Date: December 1, 2021

I. Purpose: To define the indications, procedure and documentation for obtaining 12-lead ECGs.

II. Authority: California Health and Safety Code, Sections 1797.220 and 1798, California Code of Regulations, Title 22, Section 100175.

III. Policy: Paramedics will obtain 12-lead ECGs in patients demonstrating symptoms of acute coronary syndrome. Treatment of these patients shall be done in accordance with this policy. Only paramedics who have received training in this policy are authorized to obtain a 12-lead ECG on patients. EMTs who are specially trained may be authorized to set up the 12 lead.

IV. Procedure:

A. Indications for a 12-lead ECG: Medical history and/or presenting complaints consistent with an acute coronary syndrome. Patients will have the acute (within the previous 12 hours) onset or acute exacerbation of one or more of the following symptoms that have no other clear identifiable cause:

1. Chest, upper back or upper abdominal discomfort.
2. Generalized weakness.
3. Dyspnea.
4. Symptomatic bradycardia
5. After successful cardioversion/defibrillation of sustained V-Tach (Policy 705.25)
6. Paramedic Discretion

B. Contraindications: Do NOT perform an ECG on these patients:

1. Critical Trauma: There must be no delay in transport.
2. Cardiac Arrest unless return of spontaneous circulation

C. ECG Procedure:

1. Attempt to obtain an ECG during initial patient evaluation. Oxygen should be administered if patient is dyspneic, shows signs of heart failure or shock, or has SpO2 < 94%. If the ECG can be completed without delay (less than 3 minutes after patient contact), and the patient is not in severe distress, perform ECG prior to medication administration.
2. The ECG should be done prior to transport.
3. If the ECG is of poor quality (artifact or wandering baseline), or the patient's condition worsens, repeat to a total of 3.
4. Once an acceptable quality ECG is obtained, switch the monitor to the standard 4-lead function.
5. If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, note underlying rhythm, and verify by history and physical exam that the patient does not have a pacemaker or ICD.

D. Base Hospital Communication/Transportation:

1. If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, notify base hospital within 10 minutes of interpretation. Report POS STEMI ECG to MICN along with the heart rate on ECG. If the ECG is of poor quality, or the underlying rhythm is paced, or atrial flutter, include that information in the initial report. All other information, except that listed in items 2, 4, and 5 below, is optional and can be given at the paramedic and MICN's discretion.
2. Paramedics are to ask the patient if they have a cardiologist and report the information to the base hospital.
3. If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, patients should be transported to the closest and most appropriate STEMI Receiving Center (SRC) depending on patient preference and cardiac catheterization lab availability. MICN may direct ambulance to alternative SRC if cardiac catheterization lab not available.
4. If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, and the underlying rhythm is Atrial Flutter or if the rate is above 140, the Base Hospital shall be notified at the beginning of the report. The Cath Lab will not be activated.

5. If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, and the patient has a pacemaker or the ECG is of poor quality (wandering baseline and/or artifact) report that to the MICN.
6. If a first responder paramedic obtains an ECG that does **not have** an interpretation on monitor that meets your manufacturer guidelines for a POS STEMI ECG, and the patient is stable, patient care may be turned over to the transporting paramedic. The ECG will be turned over to the transporting paramedic.
7. Positive ECGs will be handed to the receiving medical practitioner. The receiving practitioner will initial, time and date the ECG to indicate they have received and reviewed the ECG.

E. Patient Treatment:

1. Patient Communication: If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, the patient should be told that "according to the ECG you may be having a heart attack". If the ECG interpretation is anything else, the patient should NOT be told the ECG is normal or "you are not having a heart attack". If the patient asks what the ECG shows, tell him/her that it will be read by the emergency physician.

F. Other ECGs

1. If an ECG is obtained by a physician and the interpretation on the ECG is positive for STEMI, the patient will be treated as a positive STEMI. If the ECG obtained by a physician does not indicate a STEMI by interpretation, and the physician is stating ***it is*** a STEMI, perform a repeat ECG once patient is in the ambulance. If EMS ECG is positive for STEMI, transport to SRC as a STEMI alert. If EMS ECG is negative for STEMI, transport to SRC, however no STEMI alert will be activated. If physician is ***not stating*** it is a STEMI, and EMS ECG is not positive for STEMI, then transport to nearest facility.
3. The original ECG performed by physician shall be obtained and accompany the patient.
4. 12 Lead ECG will be scanned, or a picture will be obtained and added as an attachment to the Ventura County electronic Patient Care Report (VCePCR), in addition to being hand delivered to the receiving facility.

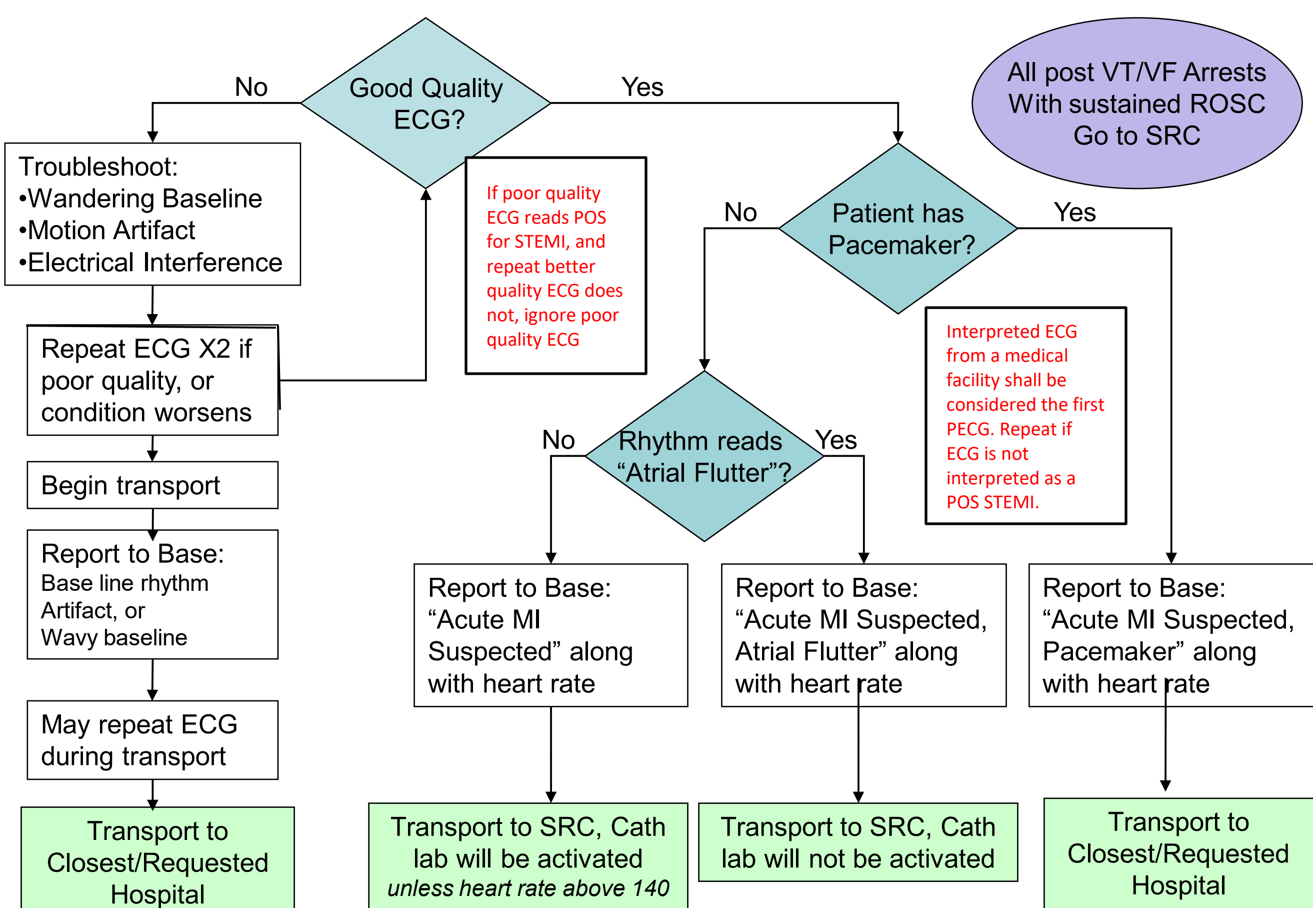
G. Documentation

1. VCePCR will be completed per VCEMS policy 1000. The original ECG will be turned in to the base hospital and ALS Service Provider.

H. Reporting

1. False Positive ECGs not recognized and called in as such to the Base Hospital, will be reported to VC EMS as an Unusual Occurrence in accordance with VC EMS Policy 150.

Interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG:



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMS Personnel Background Check Requirement		Policy Number 332
APPROVED: Administrator:	Steven L. Carroll, Paramedic~~EMT-P~~	Date: December 1, 2021~~June 1, 2011~~
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: December 1, 2021~~Jun 1, 2011~~
Origination Date:	July, 1990	
Date Revised:	October 14, 2021~~May 13, 2004~~	Effective Date: December 1, 2021~~June 1, 2011~~
Date Last Reviewed:	October 14, 2021~~May 11, 2017~~	
Review Date:	October 31, 2024~~May, 2020~~	

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

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

III. POLICY:

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

~~A.~~B. Ventura County EMS shall keep record of criminal background if certification or accreditation is active.

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

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

IV. PROCEDURE:

A. All applicants for certification/recertification or accreditation shall refer to VCEMS website at vchca.org/ems ~~contact the Ventura County EMS Office~~ for the DOJ Live Scan instructions. ~~fingerprinting procedure.~~

B. This procedure applies to:

1. All persons applying for initial California EMT certification/ or paramedic accreditation in Ventura County

2. EMT recertification in Ventura County for the first time

3. EMT recertification in Ventura County, after lapse in certification, and the Department of Justice has been notified that subsequent notices are no longer required.

C. EMTs who are currently certified in Ventura County and are now becoming Paramedics, do not need to repeat their background.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Withholding or Termination of Resuscitation and Determination of Death	Policy Number: 606
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2012
APPROVED: Medical Director ~~Angelo Salvucci, MD~~ Daniel Shepherd, M.D.	Date: June 1, 2012
Origination Date: June 1984 Date Revised: October 13.2011 Date Last Reviewed: October 13, 2011 Next Review Date: October, 2014	Effective Date:June 1, 2012

I. PURPOSE: To establish criteria for withholding or termination of resuscitation and determination of death by prehospital EMS personnel.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.220,1798 and 7180. Government Code 27491 and 27491.2. California Code of Regulations, Title 22, Division 9, Section 100175.

III. POLICY: ~~Prehospital~~ EMS ~~p~~Personnel may withhold or terminate resuscitation and determine that a patient is dead, and leave the body in custody of medical or law enforcement personnel, according to the procedures outlined in this policy.

IV. DEFINITION:

1. ~~Prehospital EMS personnel: Prehospital EMS personnel mean all responding EMT-Is and Paramedics, and flight nurses.~~ EMS Personnel: All EMTs, Paramedics and RNs caring for prehospital or interfacility transfer patients as part of the Ventura County EMS system.
2. Further Assessment: ~~"Further assessment"~~ refers to a methodical evaluation for signs/symptoms of life in the apparently deceased person. This evaluation includes examination of the respiratory, cardiac and neurological systems, and a determination of the presence or absence of rigor mortis and dependent lividity. The patient who displays any signs of life during the course of this assessment may NOT be determined to be dead,
3. Hospital: A licensed health care institution that provides acute medical care.
4. Skilled Nursing Facility: A licensed health care institution that provides non-acute care for elderly or chronically ill patients, and has licensed medical personnel on scene (RN or LVN).

5. Hospice: A care program into which terminally ill patients may be enrolled, to assist with the management of palliative care during the terminal stages of illness.

V. PROCEDURE:

A. General Guidelines:

1. The highest medical authority on scene shall determine death in the field.
   a. If BLS responders have any questions or uncertainty regarding determination of death, BLS measures shall be instituted until arrival of ALS personnel.
   b. If ALS responders have questions or uncertainty regarding determination of death, ALS measures shall be instituted until base hospital contact is made and orders received.
2. ~~Prehospital~~ EMS ~~p~~Personnel who have determined death in the field in accordance with the parameters of this policy are not required to make base hospital contact.
3. ~~Prehospital~~ EMS ~~p~~Personnel who arrive on scene after the patient is determined to be dead shall not re-evaluate the patient.

PATIENTS WHO ARE OBVIOUSLY DEAD

Upon arrival, prehospital EMS ~~p~~Personnel shall rapidly assess the patient. For patients suffering any of the following conditions, no further assessment is required. No treatment shall be started and the patient shall be determined to be dead.

- Decapitation,
- Incineration,
- Hemicorporectomy, or
- Decomposition.

PATIENTS WHO APPEAR TO BE DEAD **(WITH Rigor Mortis and/or Dependent Lividity)**

B. Patients who are apneic and pulseless require further assessment as described in table 1.

1. If rigor mortis and/or dependent lividity are present, and if no response ~~for all the~~ to assessment procedures ~~indicates signs of life~~, the patient shall be determined to be dead.
2. Rigor mortis is determined by checking the jaw and other joints for rigidity.
3. Dependent lividity is determined by checking dependent areas of the body for purplish-red discoloration.

Table 1.

CATEGORY	ASSESSMENT PROCEDURES	FINDINGS FOR DETERMINATION OF DEATH
Respiratory	Open the patient's airway. Auscultate lungs or feel for breaths while observing t chest for movement for a minimum of 30 seconds	No spontaneous breathir No breath sounds on auscultation.
Cardiac	Palpate the carotid artery (brachial for infant) for a minimum of 1 minute. Auscultate for heart sounds for minimum 1 minute. OR **ALS ONLY-** Monitor the patient's cardiac rhythm for minimum of 1 minute. Check asystole in 2 leads. Obtain a 6-second strip to be retained with the EMS provider documentation.	No pulse. No heart sounds.
Neurological	Check for pupil response to light. Check for response to painful stimuli.	No pupillary response. No response to painful Stimuli.

1. While in the process of the assessment procedures, if any response indicates signs of life, resuscitation measures shall take place immediately.
2. **If rigor mortis and/or dependent lividity are present**, and if no response for all the assessment procedures indicates signs of life, the patient shall be determined to be dead.

PATIENTS WHO APPEAR TO BE DEAD:
(WITHOUT Rigor Mortis and/or DEPENDENT LIVIDITY)

C. Patients who appear to be dead but display no signs of rigor mortis and/or dependent lividity shall have the cause of apparent death determined to be **MEDICAL** (including drowning, ingestion, asphyxiation, hanging, poisoning, lightning strikes, and electrocution), or **TRAUMATIC** (and injuries are sufficient to cause death).

1. **MEDICAL ETIOLOGY**: Resuscitation measures shall take place.
2. **TRAUMATIC ETIOLOGY**: Further assessment as defined in Table 1 shall be performed. If no response for all the assessment procedures, the patient's age should be determined. (reasonable estimation appropriate if positive determination of age is not possible)
    a. For patients younger than 18 years of age, resuscitation measures, including transport to the closest trauma center, shall take place.
    b. For patients 18 years or older:
        1) **BLS RESPONDERS**:
            a) If the time from **initial determination** of pulselessness and apnea until trauma center arrival is estimated to be less than 20 minutes, resuscitation measures, including transport to the closest trauma center, shall take place.
            b) If the time from **initial determination** of pulselessness and apnea until trauma center arrival is estimated to be 20 minutes or more, the patient may be determined to be dead.
        2) **ALS RESPONDERS:**
            a) If the time from **initial determination** of pulselessness and apnea until trauma center arrival is estimated to be less than twenty minutes, using a cardiac monitor, the patient's rhythm should be assessed.
                (1) If the rhythm is narrow complex PEA, wide complex PEA greater than 30 beats per minute, ventricular tachycardia or ventricular fibrillation, resuscitation measures, including immediate transport to the closest trauma center, shall take place.
                (2) If the rhythm is asystole or wide complex PEA at a rate of 30 beats per minute or slower, the patient shall be determined to be dead.
            b) If the time from **initial determination** of pulselessness and apnea until trauma center arrival is estimated to be twenty minutes or more, the patient may be determined to be dead, regardless of cardiac rhythm..

D. Termination of Resuscitation

1. Base hospitals and EMS pPersonnel should consider terminating resuscitation measures on adult patients (age 18 and older) who are in cardiopulmonary arrest and fail to respond to treatment under VC EMS Policy 705.07 or 705.08: Cardiac Arrest, Adult.
2. If resuscitation measures have been initiated, base hospital contact should be attempted before resuscitation is terminated and the patient determined toe dead.
3. If unable to make base hospital contact, resuscitation efforts may be terminated and the patient determined to be dead using the following criteria:
   a. Patients without evidence of trauma who meet termination of resuscitation criteria in VC EMS Policy 733: CAM and Post ROSC Care 705: Cardiac Arrest, Adult.
   b. Patients with blunt or penetrating trauma if the cardiac rhythm is or becomes asystole or wide complex PEA at a rate less than 30 beats per minute.
4. In cases of cardiopulmonary arrest as a result of a lightning strike, electrocution or suspected hypothermia, CPR shall be performed for a minimum of one hour. **BLS responders in these circumstances shall make all reasonable attempts to access ALS care.**

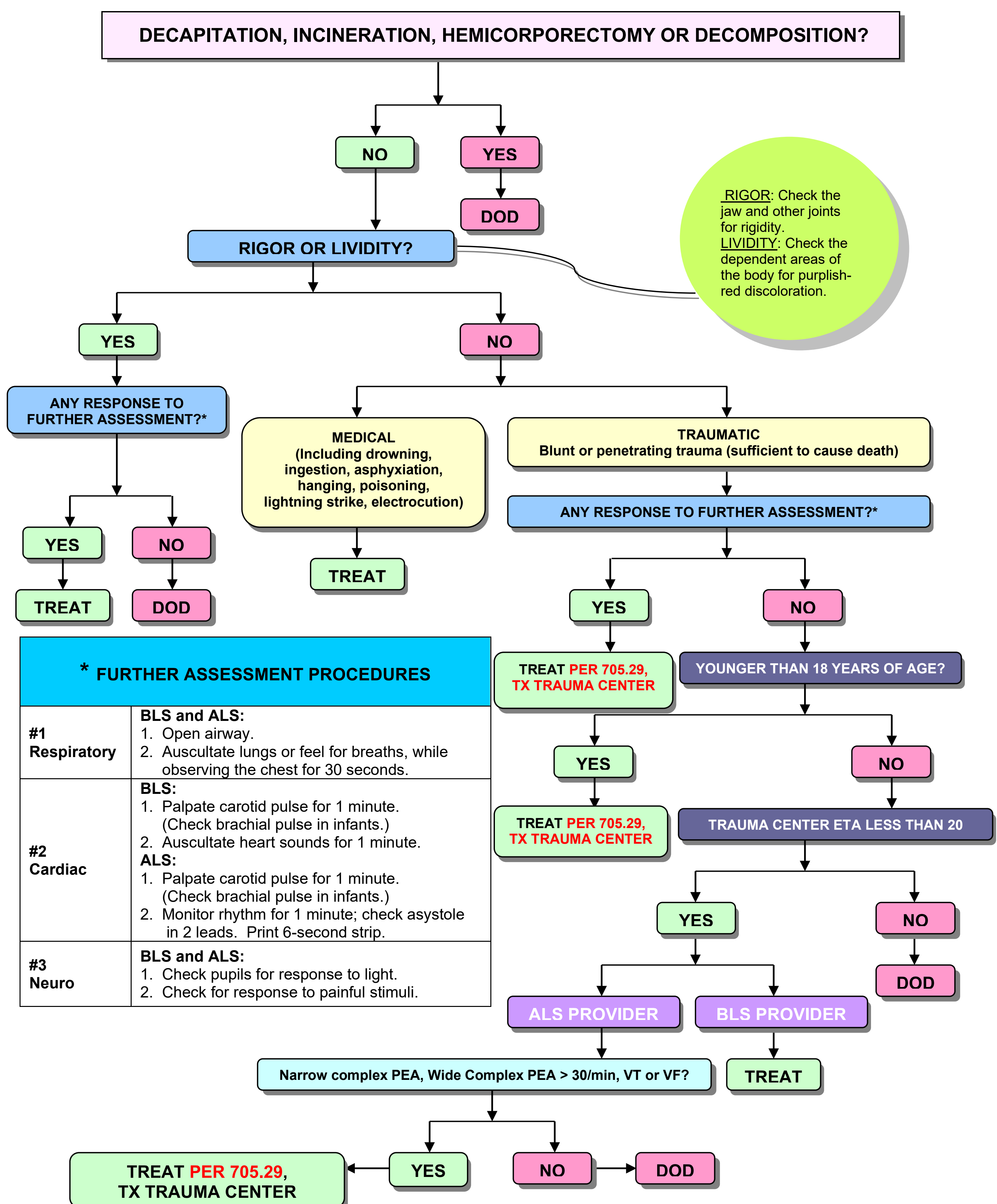
E. Documentation

1. EMS pPersonnel will document determination of death in the approved Ventura County Electronic Patient Care Reporting System (VCePCR). Documentation System (AVCDS).

F. Disposition of Decedent's Body

1. Deaths that occur in hospitals or skilled nursing facilities, or to patients enrolled in hospice programs, do not require law enforcement response. Under these circumstances the body may be left at the scene.
2. Deaths that occur anyplace other than a hospital or skilled nursing facility **except to patients enrolled in hospice programs**, must be reported to law enforcement personnel and the body must be left in their custody.

Ventura County EMS Determination of Death



* FURTHER ASSESSMENT PROCEDURES	
#1 Respiratory	**BLS and ALS:** 1. Open airway. 2. Auscultate lungs or feel for breaths, while observing the chest for 30 seconds.
#2 Cardiac	**BLS:** 1. Palpate carotid pulse for 1 minute. (Check brachial pulse in infants.) 2. Auscultate heart sounds for 1 minute. **ALS:** 1. Palpate carotid pulse for 1 minute. (Check brachial pulse in infants.) 2. Monitor rhythm for 1 minute; check asystole in 2 leads. Print 6-second strip.
#3 Neuro	**BLS and ALS:** 1. Check pupils for response to light. 2. Check for response to painful stimuli.

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

II. AUTHORITY: California Health and Safety Code, Sections 1797.220, 1798 and 7186 and Division 1, Part 1.85 (End of Life Option Act).
California Probate Code, Division 4.7 (Health Care Decisions Law).
California Code of Regulations, Title 22, Section 100170.
Emergency Medical Service Authority California Health and Human Services Agency, EMSA #311, 6th Revision (EMSA Personnel Guidelines Limiting Pre-Hospital Care)

III. DEFINITIONS:

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

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

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

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

D. “DNR Order”: An order to withhold resuscitation. A DNR Order shall be considered operative under any of the following circumstances. If there is a

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

conflict between two DNR orders the one with the most recent date will be honored.

1. A fully executed original or photocopy of the "Emergency Medical Services Prehospital DNR Form" has been read and reviewed on scene;
2. The patient is wearing a DNR Medallion;
3. A fully executed California Durable Power of Attorney For Health Care (DPAHC) form is seen, a health care agent designated therein is present, and that agent requests that resuscitation not be done;
4. A fully executed Natural Death Act Declaration has been read and reviewed on scene;
5. A fully executed California Advance Health Care Directive (AHCD) has been read and reviewed on scene and:
   a. a health care agent designated therein is present, and that agent requests that resuscitation not be done, or
   b. there are written instructions in the AHCD stating that the patient does not wish resuscitation to be attempted;
6. A completed and signed Physician Orders for Life-Sustaining Treatment (POLST) form has been read and reviewed on scene, and in Section A, "Do Not Attempt Resuscitation/DNR" is selected;
7. A fully executed Final Attestation Form, or;
8. For patients who are in a licensed health care facility, or who are being transferred between licensed health care facilities, a written document in the patient's permanent medical record containing the statement "Do Not Resuscitate", "No Code", or "No CPR," has been seen. A witness from the health care facility must verbally document the authenticity of this document.
9. In cases where a verbal DNR request is expressed, EMS Personnel shall directly consult with the base hospital physician. Base hospital physicians retain authority for determining appropriateness of resuscitation.

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

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

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

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

I. "Final Attestation Form": As defined in the End of Life Option Act, California Health and Safety Code Section 443.11.

J. Comfort measures: Medical interventions used to provide and promote patient comfort. Comfort measures applicable to the End of Life Option Act may include airway positioning and suctioning.

IV. PROCEDURE:

A. All patients require an immediate medical evaluation.

B. Correct identification of the patient is crucial in this process. If not wearing a DNR Medallion, the patient must be positively identified as the person named in the DNR Order. This will normally require either the presence of a witness or an identification band.

C. When a DNR Order is operative:

1. If the patient has no palpable pulse and is apneic, resuscitation shall be withheld or discontinued.

2. The patient is to receive full treatment other than resuscitation (e.g., for airway obstruction, pain, dyspnea, hemorrhage, etc.).

3. If the patient is taking high doses of opioid medication and has decreased respiratory drive, early base hospital contact should be made before administering naloxone. If base hospital contact cannot be made, naloxone should be administered sparingly, in doses no more than 0.1 mg every 2-3 minutes.

4. If transport has been initiated, continue transporting the patient to the appropriate receiving facility and transfer care to emergency department staff.

   a. If transport has not been initiated, but personnel are still on scene, patient should be left at scene, if not in a sensitive location (place of business, public place, etc.). The situation should be explained to the family or staff at the scene.

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

1. The patient is conscious and states that he or she wishes resuscitation.
2. In unusual cases where the validity of the request has been questioned (e.g., a family member disputes the DNR, the identity of the patient is in question, etc.), EMS ~~prehospital p~~Personnel may temporarily disregard the DNR request and institute resuscitative measures while consulting the ~~BH~~ base hospital for assistance. Discussion with the family member, with explanation, reassurance, and emotional support may clarify any questions leading to validity of a DNR form.

   The underlying principle is that the patient's wishes should be respected.
3. There is question as to the validity of the DNR Order.

   Should any of these circumstances occur, appropriate treatment should continue or immediately commence, including resuscitation if necessary. Base ~~H~~hospital contact should be made when appropriate.

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

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

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

H. DNR in a Public Place

1. Persons in cardiac arrest with an operative DNR Order should not routinely be transported. The Medical Examiner’s office should be notified by law

enforcement or EMS personnel. If possible, an EMS representative should remain on scene until a representative from law enforcement or the Medical Examiner's office arrives.

2. If in a sensitive location (place of business, public place, etc.), it may be necessary to transport the patient to a hospital even without resuscitative measures, in order to move the body to a location that provides the family with more privacy and where arrangements can be made more expeditiously.

I. For End-of-Life Option Act:

1. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient's mental state. In this instance, EMS personnel will provide medical care as per standard protocols and contact the base hospital.
2. Family member(s) or significant other(s) may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act:
   a. BLS personnel will provide BLS airway management and bag-mask ventilation as needed until ALS arrives.
   b. ALS personnel will provide BLS airway management and bag-mask ventilation as needed, or instruct BLS personnel to continue, and consult the base hospital physician.

V. DOCUMENTATION:

For all cases in which a patient has been treated under a DNR Order, the following documentation is required in the Ventura County Electronic Patient Care Report (VCePCR):

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

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

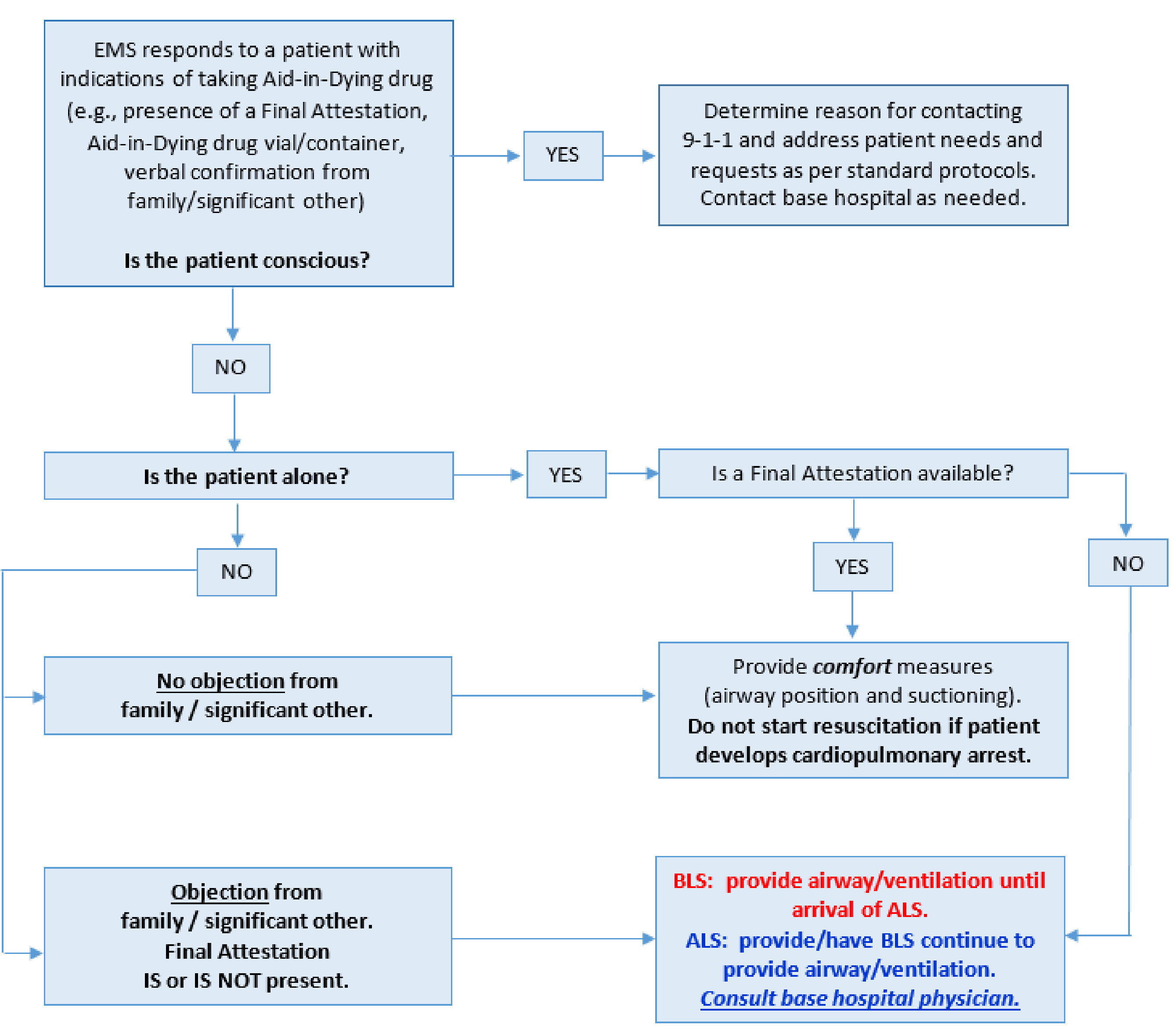
D. For all cases which occur within a licensed health care facility, in addition to above, if the DNR Order was established by a written order in the patient's medical record, the name of the physician signing and the witness to that order.

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

Appendix 1
Ventura County EMS Policy 613, "Do Not Resuscitate (DNR)

For <u>End of Life Options Act</u> only:

Patient has taken Aid-in-Dying drug, is NOT in cardiopulmonary arrest



COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Guidelines For Base Hospital Contact	Policy Number: 704
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2018
APPROVED: Medical Director: Daniel Shepherd, MD	Date: June 1, 2018
Origination Date: October 1984 Date Revised: March 8, 2018 Date Last Reviewed: October 14, 2021~~March 8, 2018~~ Review Date: October 31, 2023~~March 31, 2021~~	Effective Date: December 1, 2021~~June 1, 2018~~

I. PURPOSE: To define patient conditions for which Paramedics shall establish BH contact.

II. AUTHORITY: Health and Safety Code Sections 1798, 1798.102 and 1798.2

III. POLICY: A paramedic shall contact a Base Hospital in the appropriate catchment area, based on the location of the incident in the following circumstances:

A. Any patient to which ALS care is rendered under VCEMS Policy 705: County Wide Protocols.

B. Patients with traumatic injuries who triage into steps 1-4 of VCEMS Policy 1405: Field Triage Decision Scheme.

C. General Cases

1. Significant vaginal bleeding (OB or non-OB related).
2. Pregnant female in significant distress (e.g., symptoms of placenta previa, placenta abruptio, toxemia, retained placenta, etc.).
3. Syncope / Near Syncope
4. Any safely surrendered baby.
5. AMA involving any of the conditions listed in this policy.
6. AMA including suspected altered level of consciousness
7. AMA involving an actual/suspected BRUE patient.
8. AMA involving any pediatric patient under 2 years old
9. Any patient who, in paramedic's opinion, would benefit from base hospital consultation.

Neonatal Resuscitation

BLS Procedures

Newborn or Infant up to 48 hours old

Provide Warmth

Assess Responsiveness
- Flick soles of feet for infant or
- Assess newborn while drying

Newly Born Infant

Provide warmth, dry briskly and discard wet linen
- Suction ONLY if secretions, including meconium, cause airway obstruction

Assess while drying infant
1. Full term?
2. Crying or breathing?
3. Good muscle tone?

If "YES" to all three
- Place skin-to-skin with mother
- Cover both with dry linen
- Observe breathing, activity, color

If "NO" to any of three
- Stimulate briefly (<15 seconds)
  - Flick soles of infant's feet
  - Briskly rub infant's back
- Provide warm/dry covering

Continue to assess

Infant up to 48 hours old

Provide warmth
- Suction ONLY if secretions cause airway obstruction
- Stimulate briefly (<15 seconds)
  - Flick soles of infant's feet
  - Rub infant's back with towel

Provide warm/dry covering
Continue to assess

Assess BreathingEnsure Adequate Ventilation
- If crying or breathing, assess circulation
- If apneic or gaspingSuction if secretions cause airway obstruction.
- If Apneic or gasping
  - Positive pressure ventilations (PPV) with BVM and ROOM AIR at 40-60 breaths per minute for 30 seconds

Continue PPV, reassessing every 30 seconds, until infant is breathing adequately

  - Reassess breathing, assess circulation

Assess CirculationEnsure Adequate Circulation
- If HR between 60 and 100 bpm
  - PPV with BVM and ROOM AIR at 40-60 breaths per minute for 30 seconds
    - Continue PPV, reassessing every 30 seconds, until infant maintains HR >100 bpm
- If HR < 60 bpm
  - CPR at 3:1 ratio for 30 seconds
    - 90/min compressions
    - 30/min ventilations

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- Continue CPR , reassessing every 60 seconds, until HR > 60 bpm

Correct Hypoxia

- If no improvement after 90 seconds of ROOM AIR CPR, add supplemental O_2 until HR > 100

ALS Prior to Base Hospital ContactStanding Orders

Utilize Handtevy Application

Establish IO line only in presence of CPREnsure Adequate Ventilation and Oxygenation

- Monitor waveform capnography
- Consider placement of supraglottic airway device

Obtain IV/IO Access

For aAsystole/PEA OR or pPersistent bBradycardia < 60 bpm

- **Epinephrine 0.1mg/mL**
  - IV/IO – 0.01mg/kg (0.1mL/kg) q 3-5 min
- **Normal Saline**
  - IV/IO bolus – 10mL/kg

PEA

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- **Normal Saline**

IO bolus – 10mL/kg

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

- Resuscitation efforts may be withheld for extremely preterm infants (< 21 weeks or < 9 inches long). Sensitivity to the desires of the parent(s) may be considered. If uncertain as to gestational age, begin resuscitation.
- A rising heart rate is the best indicator of adequate PPV.

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VCEMS Medical Director