Virtual	Pre-hospital Services Committee Agenda	October 15, 2020 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. 605 – Interfacility Transfer of Patients	Adriane Gil-Stefansen
	B. 705 – Treatment Protocols	Andrew Casey
	C. 705.04 – Behavioral Emergencies	Andrew Casey
	D. 705.08 – Cardiac Arrest VF/VT	Andrew Casey
	E. 705.15 – Nausea/Vomiting	Andrew Casey
	F. 705.19 – Pain Control	Andrew Casey
	G. 705.20 – Seizures	Andrew Casey
	H. 705.21 – Shortness of Breath – Pulmonary Edema	Andrew Casey
	I. 705.22 – Shortness of Breath – Wheezes/Other	Andrew Casey
	J. 705.24 – Symptomatic Bradycardia	Andrew Casey
	K. 737 – Public Health Emergency Vaccination Administration	Chris Rosa
	L. 738 - Handtevy Policy	Andrew Casey
	M. 1000 – Documentation of Prehospital Care	Andrew Casey
VI.	**Old Business**	
	A. Time certain PRESTO presentation by Dr. Chugh and Dr. Reinier at 10 a.m.	
VII.	**Informational/Discussion Topics**	
	A. Handtevy Presentation	Andrew Casey
VIII.	**Policies for Review**	
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	August 13, 2020 9:30 a.m.

Topic	Discussion	Action	Approval
II. Approve Agenda		Approved	Motion: Heather Ellis Seconded: Tom O'Connor Passed unanimous
III. Minutes		Approved	Motion: Heather Ellis Seconded: Tom O'Connor Passed unanimous
IV. **Medical Issues**			
A. Coronavirus Update	• The county positivity rate is currently at 6.8%. The goal is to have less than 60 new cases per day. • Covid test sites have been expanded. • The EMS Agency has sufficient PPE resources. Please let us know if you need assistance with PPE.		
V. New Business			
A. 2020 Mission Lifeline Awards	Congratulations to all the emergency agencies and hospitals who are receiving the Mission Lifeline Award. The 2020 Mission Lifeline Awards are available to be picked up at the EMS Agency front counter.		
B. IFT Training Bulletin	Karen presented the draft IFT Training Bulletin. Following a lengthy discussion and conflicting opinions, it was agreed that this item will be tabled until next meeting.	Tabled The EMS Agency staff will investigate this issue further and discuss at the next PSC meeting.	
C. Handtevy	Andrew stated that he will have a demonstration at the next PSC meeting. The intention is that Handtevy		

	will eventually replace PALS in this county.		
D. I-gel	Andrew stated that the Igel training is being done and the "go live" date is 12/01/20.		
E. 1404 w/QI Form		Tabled	
F. 504 – BLS and ALS Unit Equipment and Supplies		Approved with changes Add "Securing straps"	Motion: Tom O'Connor Seconded: Ira Tilles Passed unanimous
VI. Old Business			
A. Education Committee Update		This committee was developed to revise educational requirements. Due to Covid, many educational requirements have been waived. The committee will meet on an "as needed" basis until further notice.	
B. 626 - Chempack		Information has been updated by Ventura County Fire. No issues.	
VII. Informational/Discussion Topics			
A. Stroke – 450,451 and 460		These policies were discussed in the Stroke Committee. Changes outlined in these policies were made by the Stroke Committee. Policies went live on August 1, 2020.	
B. Stemi - 440			
C. Trauma – 1400, 1402 and 1406	Karen stated that the Trauma Committee reviewed these policies and agreed on minor changes/updates.	1406 - tabled 1400 – Page 2:E – Removed OPD/OFD communication center.	
VIII. Policies for Review			
A. 605 – Interfacility Transfer of Patients	Following a lengthy discussion and conflicting opinions, it was agreed that this item will be tabled until next meeting.	Tabled The EMS Agency staff will investigate this issue further and discuss at the next PSC meeting.	Motion: Tom O'Connor Seconded: Kathy McShea Passed unanimous
B. 705.00 – VCEMS General Patient Guidelines		Approved	Motion: Tom O'Connor Seconded: Kathy McShea Passed unanimous
C. 705.23 – Supraventricular Tachycardia		Approved	Motion: Tom O'Connor Seconded: Kathy McShea

			Passed unanimous
D. 729 – Supraglottic Airway Devices		Approved	Motion: Tom O'Connor Seconded: Kathy McShea Passed unanimous
X. Agency Reports			
A. Fire departments	**VCFPD** – none **VCFD-** Antibody testing is still being offered at VFD. **OFD** – 2 of their personnel start paramedic school next week. **Fed. Fire** – none **SPFD** – none **FFD** – none		
B. Transport Providers	**LMT –** none **AMR/GCA** – none **AIR RESCUE – none**		
C. Base Hospitals	**SAH** – none **LRRMC** – none **SJRMC –** Phase 2 of construction has begun, and it will not affect the ambulance bay. **VCMC** – none		
D. Receiving Hospitals	**PVH –** none **SPH** – none **CMH** –.none **OVCH** – none		
E. Law Enforcement	**VCSO –**none **CSUCI PD –** none		
F. ALS Education Programs	**Ventura –** The last 3 students have completed their internship. The new class starts Monday morning (23 students). They will have 9 hours of labs weekly. The next advisory committee meeting is in December.		
G. EMS Agency	**Steve –** Karen, Randy and Julie have been working hard on PPE distribution. Andrew has been gathering the data for all the Covid-19 reports. Thank you to my **entire** team for all their hard work. **Dr. Shepherd –** none **Chris** – none **Katy** –none **Karen** – none **Julie** –none **Randy** – none		
H. Other			
XI. Closing	**Meeting adjourned at 11:30**		

Prehospital Services Committee 2020

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/16/2020	2/13/2020	3/12/2020	4/9/2020	5/14/2020	6/11/2020	7/9/2020	8/13/2020	9/10/2020	10/8/2020	11/12/2020	12/10/2020	%
AMR	Goguen	Daniel	AS		AS		x								
AMR	Riggs	Cassie	CR		CR		x								
CMH - ER	Levin	Ross			RL		x								
CMH - ER	Querol	Amy													
OVCH - ER	Pulido	Ed	EP		EP										
OVCH - ER	Ferguson	Catherine	CF		CF		x								
CSUCI PD	Drehsen	Charles	CD		CD										
CSUCI PD	Deboni	Curtis													
FFD	Herrera	Bill	BH				x								
FFD	Panke	Chad													
GCA	TBD														
GCA	Sanders	Mike			MS										
Lifeline	Rosolek	James													
Lifeline	Williams	Joey	JW		JW		x								
LRRMC - ER	Brooks	Kyle			KB		x								
LRRMC - ER	Shaner	Meghan	MS												
OFD	Strong	Adam	AS												
OFD	Villa	Jaime	JV		JV		x								
SJPVH - ER	Hutchison	Stacy					x								
SJPVH - ER	Sikes	Chris	CS		CS										
SJRMC - ER	Larsen	Todd	TL		TL		x								
SJRMC - ER	McShea	Kathy			KM		x								
SVH - ER	Tilles	Ira	IT		IT		x								
SVH - ER	Shorts	Kristen	KS		KS		x								
V/College	O'Connor	Tom	TO		TO		x								
VCFD	Tapking	Aaron	AT												
VCFD	Ellis	Heather	HE		HE		x								
VNC	Williams	Joseph	JW		JW		x								
VNC	Schwab	David	DS		DS		x								
VNC - Dispatch	Gregson	Erica	EG		EG		x								
VCMC - ER	Gillet	John	DC		DC		x								
VCMC - ER	Gallegos	Tom	TG		TG		x								

Agency	LastName	FirstName	1/16/2020	2/13/2020	3/12/2020	4/9/2020	5/14/2020	6/11/2020	7/9/2020	8/13/2020	9/10/2020	10/8/2020	11/12/2020	12/10/2020	%
VCMC-SPH	Holt	Carrie													
VCSO SAR	Conahey	Dave	DC				x								
VCSO SAR	Tolle	Jonathon	JT												
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		x								
EMS	Frey	Julie	JF		JF		x								
EMS	Perez	Randy			RP		x								
EMS	Shepherd	Daniel	DS		DS		x								
EMS	Rosa	Chris	CR		CR		x								
EMS	Salvucci	Angelo													
EMS	Hansen	Erik	EH												
EMS	Beatty	Karen	KB				x								
EMS	Gil-Stefansen	Adriane					x								
EMS	Garcia	Martha	MG												
EMS	Casey	Andrew	AC		AC		x								
LMT	Winter	Jeff													
LMT	Frank	Steve													
AMR/GCA	Gonzales	Nicole													
State Parks	Futoran	Jack													
VCMC	Hill	Jessica													
VCMC	Duncan	Thomas													
CMH	Hall	Elaina	EH												
VNC	Chase	David													
VNC	James	Lauri			LJ										
VNC	Shedlosky	Robin	RS		RS										
VCSO SAR	Hadland	Don													

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Interfacility Transfer of Patients		Policy Number 605
APPROVED: Administration: Steven L. Carroll		Date: December 1, 2018
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: December 1, 2018
Origination Date: Date Revised: Date Last Reviewed: Next Review Date:	July 26, 1991 August 9, 2018 August 9, 2018 August 31, 2021	Effective Date: December 1, 2018

I. PURPOSE: To define levels of interfacility transfer and to assure that patients requiring interfacility transfer are accompanied by personnel capable and authorized to provide care.

II. AUTHORITY: Health and Safety Code, Sections 1797.218, 1797.220, and 1798.

III. POLICY: A patient shall be transferred according to his/her medical condition and accompanied by EMS personnel whose training meets the medical needs of the patient during interfacility transfer. The transferring physician shall be responsible for determining the medical need for transfer and for arranging the transfer. The patient shall not be transferred to another facility until the receiving hospital and physician consent to accept the patient. The transferring physician retains responsibility for the patient until care is assumed at the receiving hospital.

If a patient requires care during an interfacility transfer which is beyond the scope of practice of an EMT or paramedic or requires specialized equipment for which an EMT or paramedic is untrained or unauthorized to operate, and it is medically necessary to transfer the patient, a registered nurse or physician shall accompany the patient. If a registered nurse accompanies the patient, appropriate orders for care during the transfer shall be written by the transferring physician.

IV. TRANSFER RESPONSIBILITIES

A. All Hospitals shall:

1. Establish their own written transfer policy clearly defining administrative and professional responsibilities.
2. Have written transfer agreements with hospitals with specialty services, and county hospitals.

B. Transferring Hospital

1. Maintains responsibility for patient until patient care is assumed at receiving facility.

2. Assures that an appropriate vehicle, equipment and level of personnel is used in the transfer.

C. Transferring Physician

1. Maintains responsibility for patient until patient care is assumed at receiving facility.
2. Determines level of medical assistance to be provided for the patient during transfer.
3. Receives confirmation from the receiving physician and receiving hospital that appropriate diagnostic and/or treatment services are available to treat the patient's condition and that appropriate space, equipment and personnel are available prior to the transfer.

D. Receiving Physician

1. Makes suitable arrangements for the care of the patient at the receiving hospital.
2. Determines and confirms that appropriate diagnostic and/or treatment services are available to treat the patient's condition and that appropriate space, equipment and personnel are available prior to the transfer, in conjunction with the transferring physician.

E. Transportation Provider

1. The patient being transferred must be provided with appropriate medical care, including qualified personnel and appropriate equipment, throughout the transfer process. The personnel and equipment provided by the transporting agency shall comply with local EMS agency protocols.
2. Interfacility transport within the jurisdiction of VC EMS shall be performed by an ALS or BLS ambulance.
    a. BLS transfers shall be done in accordance with EMT Scope of Practice per Policy 300
    b. ALS transfers shall be done in accordance with Paramedic Scope of Practice per Policy 310

IV. PROCEDURE:

A. Non-Emergency Transfers

Non-emergency transfers shall be transported in a manner which allows the provider to comply with response time requirements.

B. Emergency Transfers

Emergency transfers require documentation by the transferring hospital that the condition of the patient medically necessitates emergency transfer. Provider agency dispatchers shall confirm that this need exists when transferring hospital personnel make the request for the transfer.

C. Transferring process

1. The transferring physician will determine the patient's resource requirements and request an inter-facility ALS, or BLS transfer unit using the following guidelines:

Patient Condition/Treatment	EMT	Paramedic	RN/RT/MD
a. Vital signs stable	x		
b. Oxygen by mask or cannula	x		
c. Peripheral IV glucose or isotonic balanced salt solutions running	x		
d. Continuous respiratory assistance needed (paramedic scope management)		x	
e. Peripheral IV medications running or anticipated (paramedic scope)		x	
f. Paramedic level interventions		x	
g. Central IV line in place		x	
h. Respiratory assistance needed (outside paramedic scope of practice)			x
i. IV Medications (outside paramedic scope of practice)			x
j. PA line in place			x
k. Arterial line in place			x
l. Temporary pacemaker in place			x
m. ICP line in place			x
n. IABP in place			x
o. Chest tube		x	
p. IV Pump		x	
q. Standing Orders Written by Transferring Facility MD			x
r. Medical interventions planned or anticipated (outside paramedic scope of practice)			x

2. The transferring hospital advises the provider of the following:

a. Patient's name

b. Diagnosis/level of acuity

c. Destination

d. Transfer date and time

e. Unit/Department transferring the patient

f. Special equipment with patient

g. Hospital personnel attending patient

h. Patient medications

3. The transferring physician and nurse will complete documentation of the medical record. All test results, X-ray, and other patient data, as well as all pertinent transfer forms, will be copied and sent with the patient at the time of transfer. If data are not available at the time of transfer, such data will be telephoned to the transfer liaison at the receiving facility and then sent by FAX or mail as soon thereafter as possible.
4. Upon departure, the Transferring Facility will call the Receiving Facility and confirm arrangements for receiving the patient and provide an estimated time of arrival (ETA).
5. The Transferring Facility will provide:
   a. A verbal report appropriate for patient condition
   b. Review of written orders, including DNAR status.
   c. A completed transfer form from Transferring Facility.

V. COMMUNICATION

A. For patients with time sensitive conditions requiring transfer for emergency evaluation and/or treatment (ie. STEMI, Stroke, Trauma, etc.) the ambulance personnel will contact the receiving facility advising of ETA and any change in patient condition~~.~~. The intent is to provide the receiving facility with information for appropriate resources to be initiated.

VI. DOCUMENTATION

A. Documentation of Care for Interfacility transfers will be done in accordance to Policy 1000.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Treatment Protocols		Policy Number 705
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: ~~June 1, 2019~~
Origination Date: Date Revised: Date Last Revised: Review Date:	January 1988 See individual algorithms See individual algorithms See individual algorithms	Effective Date: As indicated on individual algorithms

I. PURPOSE: To provide uniform protocols for prehospital medical control in Ventura County.

II. AUTHORITY: Health and Safety Code 1797.220 and 1798; California Code of Regulations, Title 22, Division 9, Sections 100063, 100064, and100146.

A. DEFINITIONS:

1. Unless otherwise specified in an individual treatment protocol or policy, the following definitions shall apply:

a. Adult: Age ~~12~~ 14 or greater (1~~4~~2th birthday and older)

b. Pediatric: Age less than ~~12~~ 14 (up to 1~~4~~2th birthday)

B. Exceptions to the pediatric definition rule are in the following policies:

1. Policy 603: Refusal of EMS Services

~~2~~1. Policy 606: Withholding or Termination of Resuscitation and Determination of Death

~~3~~2. Policy 705.14: Hypovolemic Shock

~~4~~3. Policy 710: Airway Management

~~5~~4. Policy 717: Intraosseous Infusion

~~6~~5. Policy 734: Tranexamic Acid Administration

7. Policy 1405: Trauma Triage and Destination Criteria

C. Cardiac Monitor/12 Lead EKG

1. When cardiac monitoring or a 12 Lead ECG is performed, copies of rhythms strips and 12 Lead ECGs shall be submitted to the ALS Provider(s), Base Hospital, and Receiving Hospital.

IV. POLICY: Treatment protocols shall be used as a basis for medical direction and control for prehospital use.

A. Effective July 1, 2018 BLS personnel are authorized to administer the following medications and/or perform the following procedures for certain conditions as outlined below. BLS personnel shall not administer these medications and/or perform these procedures until all required training has been completed, and all necessary equipment has been distributed. Training and equipment deployment shall be completed by all agencies no later than July 1, 2019.

1. Epinephrine for anaphylaxis or severe respiratory distress as a result of asthma.
2. Naloxone for suspected opioid overdose
3. Nerve Agent Antidote Kit (Pralidoxime Chloride and Atropine Sulfate) for suspected nerve agent or organophosphate exposure.
4. Determination of blood glucose level for altered neurological function and/or for suspected stroke
5. Continuous Positive Airway Pressure (CPAP) for shortness of breath.

B. In the event BLS personnel administer naloxone, epinephrine or a nerve agent antidote kit, ALS personnel will assume care of the patient as soon as possible and continue care at an ALS level, in accordance with all applicable VCEMS policies and procedures.

C. Hypoglycemic patients with a history of diabetes, who are fully alert and oriented following determination of blood glucose level and a single administration of 15g of oral glucose may be transported at a BLS level of care.

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

Contents

Behavioral Emergencies

ADULT	PEDIATRIC
ALS Prior to Base Hospital Contact	
IV/IO Access For Extreme Agitation • **Midazolam** o IM – 5mg or 10 mg (5mg/ml) o IV/IO – 2 mg • Repeat 1 mg q 2 min as needed • Max 5 mg ~~FOR IV USE:~~ ~~Dilute 5 mg (1 mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL~~ When safe to perform, determine blood glucose level	IV/IO Access For Extreme Agitation • **Midazolam** o IM – 0.1 mg/kg • Max 5 mg o 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

Cardiac Arrest – VF/VT

ADULT	PEDIATRIC

BLS Procedures

Initiate Cardiac Arrest Management (CAM) Protocol
Airway management per VCEMS policy

ALS Standing Orders

Defibrillate
- Use the biphasic energy settings that have been approved by service provider medical director
- Repeat every 2 minutes as indicated.
- ~~If VF/VT stops then recurs use last successful Joules setting.~~

IV or IO access
- PRESTO Blood Draw

Epinephrine* 0.1 mg/mL
Administer ASAP goal ≤6 minutes
- IV/IO –1 mg (10 mL) q 6min
- Repeat x 2 for max of 3 doses during initial arrest.
- If ROSC then re-arrest an additional 3 doses may be administered.

Amiodarone
- IV/IO – 300 mg – after second defibrillation
- If VT/VF persists, 150 mg IV/IO in 3-5 minutes

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 Torsades de Pointes is identified:
- **Magnesium Sulfate**
  - IV/IO – 2 g over 2 min
  - Repeat x 1 in 5 min

Treat underlying causes when identified:
Renal Failure / History of Dialysis:
- **Calcium Chloride**
- IV/IO – 1g
- Repeat x 1 in 10 min
- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg
  - Repeat 0.5 mEq/kg x 2 q 5 min

Tricyclic Antidepressant Overdose
- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg
  - Repeat 0.5 mEq/kg x 2 q 5 min

Defibrillate – 2 Joules/kg
- Repeat every 2 minutes as indicated with
- Escalate Joules dosing; 2, 4, 6, 8 Joules/kg
- ~~If patient still in VF/VT at rhythm check, increase to 4 Joules/kg~~
- ~~Repeat every 2 minutes as indicated~~
- ~~If VF/VT stops then recurs use last successful Joules setting.~~

IV or 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 for max of 3 dose during initial arrest.
- If ROSC then re-arrest and additional 3 doses may be administered.

Amiodarone
- IV/IO – 5 mg/kg – after second defibrillation
- If VT/VF-persists, ~~2.5 mg/kg~~repeat x 2, IV/IO ~~in g~~ 3-5 minutes to a total max of 15 mg/kg

Normal Saline
- IV/IO 20 mL/kg bolus

ALS Airway Management
- If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures in accordance with policy 710.

When Torsades de Pointes is identified:
- **Magnesium Sulfate**
  - IV/IO – 40 mg/kg over 2 min
  - Repeat x 1 in 5 min

Treat underlying causes when identified:
Renal failure / History of Dialysis:
- **Calcium Chloride**
- IV/IO – 20 mg/kg
- Repeat x 1 in 10 min
- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg
  - Repeat 0.5 mEq/kg x 2 q 5 min

Tricyclic Antidepressant Overdose
- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg
  - Repeat 0.5 mEq/kg x 2 q 5 min

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

Effective Date: July 1, 2020
Next Review Date: May 31, 2022

Date Revised: May 14, 2020
Last Reviewed: May 14, 2020

VCEMS Medical Director

- If patient is hypothermic–only ONE round of medication administration and limit *defibrillation to 6 times* 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
- Ventricular tachycardia (VT) is a rate > 150 bpm

VCEMS Medical Director

Effective Date: July 1, 2020
Next Review Date: May 31, 2022

Date Revised: May 14, 2020
Last Reviewed: May 14, 2020

VCEMS Medical Director

Nausea/Vomiting

ADULT	PEDIATRIC
BLS Procedures	
Maintain airway and position of comfort Administer oxygen as indicated	Maintain airway and position of comfort Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
Indications for Ondansetron: 1. Moderate to severe nausea or vomiting. 2. Potential for airway compromise secondary to suspected/actual head injury when cervical immobilization is used. 3. Prior to MS administration • IV/IO access • Cardiac Monitor • **Ondansetron** o PO – 4 mg ODT • May repeat x 1 in 10 min o IV/IM/IO – 4 mg • May repeat x 1 in 10 min	Indications for Ondansetron: 1. Moderate to severe nausea or vomiting. 2. Potential for airway compromise secondary to suspected/actual head injury when cervical immobilization is used. 3. Prior to MS administration • IV/IO access • Cardiac Monitor • **Ages 6 months to 4 years** • **Ondansetron** ~~– 4 years old and older~~ o PO – ~~4~~ 2 mg ODT o IV/IM/IO – ~~4 mg~~0.1 mg/kg **Ages ≥ 4 Years** • **Ondansetron** o PO – 4 mg ODT o IV/IM/IO – 0.1 mg/kg ~~o~~
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

- The use of ondansetron should be avoided in patients with known congenital long QT syndrome
- Use caution in administration of ondansetron for patients with electrolyte imbalances, CHF, bradyarrhythmias, or patients taking medications known to prolong the QT interval

Pain Control

BLS Procedures

Place patient in position of comfort
Administer oxygen as indicated

ALS Standing Orders

IV/IO access

Cardiac Monitor

Pain 5 out of 10 or greater and SBP > 90 mmHg

Fentanyl
- IV/IO - 1 mcg/kg over 1 minute, OR IN/IM – 1mcg/kg
- Max single dose 100 mcg
- May repeat q 5 minutes for persistent pain to a max total dose 200 mcg
- Repeat doses should be administered IV/IO if vascular access obtained

If Fentanyl unavailable;

Ondansetron ~~- (for patients 4 years old and older)~~Per 705.15 Nausea/Vomiting Policy
- ~~IV/IM/ODT – 4 mg~~

Repeat x 1 in 10 minutes for nausea or > 2 doses of Morphine
-

Morphine
- **IV/IO** - 0.1 mg/kg over 1 minute
- Max single dose 10 mg
- May repeat ½ initial dose x 2 q 5 min

OR

Morphine
- IM - 0.1 mg/kg
- Max single dose 10 mg
- May repeat ½ initial dose x 2 q 15 min
-

Base Hospital Orders only

Consult with ED Physician when orders are needed for interventions within scope but not addressed in policy.

Additional Information

1. **Consider administering ½ normal dose of Opiate pain control;**
   - Patients 65 years of age and older
   - Patients with past adverse reaction to opiates
   - Patients with suspected cardiac ischemia or active TCP
   - Patients with traumatic injuries who are at risk for hemodynamic decompensation

Effective Date: July 1, 2020
Next Review Date: January 31, 2022
Date Revised: January 16, 2020
Last Reviewed: January 16, 2020

VCEMS Medical Director

Seizures

ADULT	PEDIATRIC

BLS Procedures

Protect from injury

Maintain/manage airway as indicated

Administer oxygen as indicated

For suspected febrile seizures, begin passive cooling measures. If seizure activity persists, see below:

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

ALS Prior to Base Hospital Contact

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

Persistent Seizure Activity

- **Midazolam** (Give to ***actively seizing*** pregnant patients prior to magnesium)
  - IM – 0.1 mg/kg
    Max 5 mg
  - IV/IO – 2 mg
    Repeat 1 mg q 2 min as needed
    Max 5 mg

~~FOR IV/IO USE:~~
~~Dilute 5 mg (1 mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL~~

20 weeks gestation to one week postpartum & No Known Seizure History

- **Magnesium Sulfate**
  - ~~o~~ IV/IOPB – ~~2~~ 4 g in 50 mL D_5W infused over ~~5~~10 min
  - ~~o MUST Repeat x 1~~
    - Slow or stop infusion if bradycardia, heart block, or decreased respiratory effort occur

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

Persistent Seizure Activity

- **Midazolam**
  - o IM – 0.1 mg/kg
    Max 5 mg
  - IV/IO – 0.1mg/kg,
    Repeat ~~1 mg~~ q 2 min as needed.
    Max single dose 2 mg
    Max total dose 5 mg

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

- Patients with a known seizure disorder or uncomplicated, apparent pediatric febrile seizures, no longer seizing and with a normal postictal state, may be treated as a BLS call.

Effective Date: June 1, 2018
Next Review Date: April 30, 2020

Date Revised: April 12, 2018
Last Reviewed: April 12, 2018

VCEMS Medical Director

Shortness of Breath – Pulmonary Edema

BLS Procedures

Administer oxygen as indicated

Initiate CPAP for moderate to severe distress

ALS Standing Orders

Nitroglycerin

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

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

Perform 12-lead ECG (Per VCEMS Policy 726)

IV/IO access

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

- **Albuterol**
  - Nebulizer – 5 mg/6 mL
    - Repeat as needed

If patient presents or becomes hypotensive

- Epinephrine 10 mcg/mL
  - 1mL (10 mcg) q 2 minutes, slow IV/IO push
  - Titrate to SBP of greater than or equal to 90 mm/Hg

~~Communication Failure Protocol~~

~~If patient presents or becomes hypotensive~~

- ~~Epinephrine 10 mcg/mL~~
  - ~~1mL (10 mcg) q 2 minutes, slow IV/IO push~~
  - ~~Titrate to SBP of greater than or equal to 90 mm/Hg~~

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

- Refer to VCEMS Policy 735 for additional information on preparing push dose epinephrine solution.
- Nitroglycerin is contraindicated when phosphodiesterase inhibitor medications [Sildenafil (Viagra and Revatio), Vardenafil (Levitra), and Tadalafil (Cialis)] have been recently used (Viagra or Levitra within 24 hours; Cialis within 48 hours). These medications are most commonly used to treat erectile dysfunction or pulmonary hypertension. In this situation, NTG may only be given by ED Physician order.

Effective Date: March 1, 2019
Next Review Date: January 30, 2021

Date Revised: January 10, 2019
Last Reviewed: January 10, 2019

EMS Medical Director

Shortness of Breath – Wheezes/Other

BLS Procedures

Administer oxygen as indicated

Initiate CPAP for both moderate and severe distress – 8 years of age and older

Assist patient with prescribed Metered Dose Inhaler if available

Severe Distress Only
- Epinephrine 1 mg/mL
  - If Under 30 kg
    - IM 0.15 mg
      - May repeat x1 in 5 minutes if patient still in distress
  - If 30 kg and Over
    - IM – 0.3 mg
      - May repeat x 1 in 5 minutes if patient still in distress

ALS Standing Orders

ADULT

Perform Needle Thoracostomy if indicated per VCEMS Policy 715

If not already performed by BLS personnel, consider CPAP for both moderate and severe distress

Moderate Distress
- **Albuterol**
  - Nebulizer – 5 mg/6 mL
    - Repeat as needed

OR
- **Albuterol**
  - Metered dose inhaler – 4 puffs (360 mcg)
    - MDI with spacer is an acceptable alternative to nebulizer treatment
    - Repeat as needed

Severe distress
- **Epinephrine 1 mg/mL**, if not already administered by BLS personnel
  - IM - 0.3mg
    - May repeat q 5 minutes if patient still in distress and ~~unable to establish IV/IO~~unable to obtain vascular access.
- **Albuterol**
  - Nebulizer – 5 mg/6 mL
    - Repeat as needed

- Establish IV/IO ~~and make BHC in anticipation of push dose epi orders~~access

~~If hypotensive, consider alternative etiologies and refer to additional treatment protocols~~

Severe Distress, not improving with prior epinephrine administration
- **Epinephrine 10 mcg/mL**
  - 1 mL (10 mcg) q 2 minutes, slow IV/IO push
  - Titrate to overall improvement in work of breathing

If hypotensive, consider alternative etiologies and refer to additional treatment protocols

PEDIATRIC

Perform Needle Thoracostomy if indicated per VCEMS Policy 715

If not already performed by BLS personnel, consider CPAP if age 8 years old and greater

Moderate Distress
- **Albuterol**
  - **Patients less than 30 kg**
    - Nebulizer – 2.5 mg/3 mL
      - Repeat as needed
  - **Patients ~~greater than 30 kg~~30 kg and greater**
    - Nebulizer – 5 mg/6 mL
      - Repeat as needed

Severe Distress
- **Epinephrine 1 mg/mL,** if not already administered by BLS personnel
  - IM – 0.01 mg/kg up to 0.3mg
    - May repeat q 5 minutes, if patient remains in distress and unable to obtain vascular access.
- **Albuterol**
  - **Patients less than 30 kg**
    - Nebulizer – 2.5 mg/3 mL
      - Repeat as needed
  - **Patients 30 kg and greater ~~greater than 30 kg~~**
    - Nebulizer – 5 mg/6 mL
      - Repeat as needed

Establish IV/IO access

Severe Distress, not improving with prior epinephrine administration
- **Epinephrine 10mcg/mL**
  - 0.1mL/kg (1mcg/kg) every 2 minutes, slow IV/IO push
  - Max single dose of 1mL or 10mcg
  - Titrate to overall improvement in work of breathing.

Suspected Croup
- **Normal Saline**
  - Nebulizer/Aerosolized Mask – 5 mL

Suspected Croup and no improvement with Normal Saline Nebulizer
- **Nebulized 1 mg/mL Epinephrine**
  - **Patients less than 30 kg**
    - Nebulizer/Aerosolized Mask – 2.5 mg/2.5mL
  - **Patients 30 kg and greater**
    Nebulizer/Aerosolized Mask – 5mg/5 mL~~Establish IV/IO and make BHC in anticipation of push dose epi orders~~
- ~~Suspected Croup~~
  - ~~**Normal Saline**~~
    - ~~Nebulizer/Aerosolized Mask – 5 mL~~

~~If hypotensive, consider alternative etiologies and refer to additional treatment protocols~~

Base Hospital Orders Only

Effective Date: July 1, 2020
Next Review Date: May 31, 2022

Date Revised: May 14, 2020
Last Reviewed: May 14, 2020

VCEMS Medical Director

~~Severe Distress, not improving with prior epinephrine administration~~

- ~~**Epinephrine 10 mcg/mL**~~
  - ~~1 mL (10 mcg) q 2 minutes, slow IV/IO push~~
  - ~~Titrate to overall improvement in work of breathing~~

~~Suspected Croup and no improvement with Normal Saline nebulizer~~

- ~~Less than 30 kg~~
  - ~~**Epinephrine 1mg/mL**~~
    - ~~Nebulizer/Aerosolized Mask – 2.5 mg/2.5mL~~
- ~~30 kg and greater~~
  - ~~**Epinephrine 1mg/mL**~~
    - ~~Nebulizer/Aerosolized Mask – 5mg/5 mL~~

~~Severe Distress, not improving with prior epinephrine administration~~

- ~~Epinephrine 10mcg/mL~~
  - ~~0.1mL/kg (1mcg/kg) every 2 minutes, slow IV/IO push~~
  - ~~Max single dose of 1mL or 10mcg~~
  - ~~Titrate to overall improvement in work of breathing.~~

Consult with ED Physician for further treatment measures

Additional Information:

~~Refer to VCEMS Policy 735 for additional information on preparing push dose epinephrine solution~~.

- If hypotensive, consider alternative etiologies and refer to additional treatment protocols.
- Use of a metered dose inhaler (Albuterol 90 mcg/puff) is indicated for fireline paramedics, in accordance with VCEMS Policy 627.
- High flow O_2 is indicated for severe respiratory distress, even with a history of COPD
- COPD patients have a higher susceptibility to spontaneous pneumothorax due to disease process
- If suspected Arterial Gas Embolus/Decompression Sickness secondary to SCUBA emergencies, transport patient in supine position on 15L/min O_2 via mask. Early BH contact is recommended to determine most appropriate transport destination.

Symptomatic Bradycardia

ADULT (HR less than 40~~45~~ bpm)	PEDIATRIC (HR less than 60 bpm)
BLS Procedures	
Administer oxygen as indicated Supine position as tolerated	Administer oxygen as indicated Assist ventilations if needed If significant ALOC, initiate CPR
ALS Standing Orders	
IV/IO access **Obtain 12-lead ECG** **Atropine** • IV/IO – 0.5 mg (1 mg/10 mL) When initial Atropine is transiently effective, or patient remains bradycardic without hemodynamic compromise. • May repeat Atropine 0.5 mg IV/IO q 5 min to a total max dose of 3 mg. **Transcutaneous Pacing (TCP)** • Should be initiated only if patient has signs of hypoperfusion • Should be started immediately for 3º heart blocks and 2º Type 2 (Mobitz II) heart blocks • If pain is present during TCP o **Pain Control**– per policy 705.19 If patient remains hypotensive (SBP less than 90mmHg) • **Epinephrine 10 mcg/mL** o 1 mL (10 mcg) q 2 minutes, slow IV/IO push Titrate to SBP of greater than or equal to 90 mm/Hg For suspected hyperkalemia • **Calcium Chloride** o IV/IO – 1 g • Withhold if suspected digitalis toxicity • **Sodium Bicarbonate** ~~o~~ IV/IO – 1 mEq/k~~g~~ o	**If CPR indicated, initiate CAM and reference appropriate cardiac arrest treatment protocol** **IV/IO access** • IV/IO access only if patient in extremis • **Epinephrine 10 mcg/mL** o 0.1 mL/kg (1 mcg/kg) q 2 minutes, slow IV/IO push o Max single dose of 1 mL or 10 mcg o Titrate to SBP of greater than or equal to 80 mm/Hg
Base Hospital Orders Only	
	Atropine • IV/IO – 0.02 mg/kg o Minimum dose – 0.1 mg
Consult with ED Physician for further treatment measure	
Additional Information • Bradycardia does not require treatment unless signs and symptoms are present (chest pain, altered level of consciousness, abnormal skin signs, profound weakness, shortness of breath or low BP) • Refer to VCEMS Policy 735 for additional information on preparing push dose epinephrine solution.	

Effective Date: July 1, 2020
Next Review Date: May 31, 2022

Date Revised: May 14, 2020
Last Reviewed: May 14, 2020

VCEMS Medical Director

Effective Date: July 1, 2020
Next Review Date: May 31, 2022

Date Revised: May 14, 2020
Last Reviewed: May 14, 2020

VCEMS Medical Director

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Public Health Emergency Vaccine Administration	Policy Number 737
APPROVED: Administration: Steve L. Carroll, Paramedic	Date: DRAFT
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: DRAFT
Origination Date: September 28, 2020 Date Revised: Date Last Reviewed: Review Date: December 31, 2021	Effective Date: DRAFT

I. PURPOSE: To authorize paramedics to administer the intramuscular inactivated influenza and/or COVID-19 vaccine to adult patient populations (14 or older) when authorized by the Ventura County EMS Agency during the COVID-19 disaster declaration.

II. AUTHORITY: California Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Sections 100145 and100169.

III. POLICY: Paramedics accredited by the Ventura County EMS Agency approved for this local optional scope of practice and having had completed training to administer intramuscular influenza and/or COVID-19 (when available) may provide these vaccinations to persons as directed by VCEMSA Medical Director in conjunction with the County Public Health Department. These vaccination policies and procedures shall only be authorized and valid for paramedics accredited in accordance with VCEMS Policy 315 – Paramedic Accreditation to Practice that have been approved to utilize this local optional scope during the California COVID-19 disaster declaration.

IV. PROCEDURE:

A. Vaccine Administration

1. Assess the need for the vaccine in question utilizing the current guidance on that vaccination, which will be provided by the Ventura County Public Health Department. (also see CDC information regarding the seasonal flu vaccine https://www.cdc.gov/flu/prevent/keyfacts.htm)
2. Screen for contraindications and precautions of inactivated vaccine (listed below).
3. Collect and review Vaccine Consent/Record of Administration sheet.

a. Confirm that the consent has been signed.

4. To prevent syncope, vaccinate patients while they are seated or lying down and consider observing them for 15 minutes after receipt of the vaccine.
5. Paramedics must maintain aseptic technique when administering the influenza or COVID vaccines.
6. The screening questionnaire must be completed prior to administration of the influenza or COVID vaccine.
7. Equipment Required:
   a. Vaccine
   b. 23-25 g, 1-inch needle
      i. For larger patients, 1.5-inch needle length may be more appropriate.
      ii. See “Needle Gauge/Length and Injection Site Guidance” below for additional information.
      iii. COVID-19 vaccine may come as prefilled/ready to administer or require other injection supplies or sizes.

Needle Gauge/Length and Injection Site Guidance

Gender, Age, Weight of Pt.	Needle Gauge	Needle Length (inches)	Injection Site
11-18 years	22-25	5/8* – 1 1 – 1 ½	Deltoid muscle of arm Anterolateral thigh muscle
Female or male less than 130 lbs	22–25	5⁄8*–1"	Deltoid muscle of arm
Female or male 130–152 lbs	22–25	1"	Deltoid muscle of arm
Female 153–200 lbs	22–25	1–1½"	Deltoid muscle of arm
Male 153–260 lbs	22–25	1–1½"	Deltoid muscle of arm
Female 200+ lbs	22–25	1½"	Deltoid muscle of arm
Male 260+ lbs	22–25	1½"	Deltoid muscle of arm

** A 5⁄8" needle may be used in patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle with the skin is stretched tight, the subcutaneous tissue not bunched, and at a 90-degree angle to the skin, although specific differences may be required by various COVID-19 manufacturers.*

8. Wash hands and don gloves
9. Check expiration date of vaccine
10. Cleanse the area of the deltoid muscle with the alcohol prep.
    a. Deltoid landmarks: 2-3 finger widths down from the acromion process; bottom edge is imaginary line drawn from axilla.
11. Insert the needle at a 90-degree angle into the muscle.
    a. Pulling back on the plunger prior to injection is <u>not</u> necessary.

12. Inject the vaccine into the muscle.
13. Withdraw the needle, and using the alcohol prep, apply slight pressure to the injection site.
14. Do not recap or detach needle from syringe. All used syringes/needles should be placed in puncture-proof containers.
15. Monitor the patient for any symptoms of allergic reaction.
16. Document the following information:
    a. Date of vaccination
    b. Name of patient
    c. Injection site
    d. Vaccine lot number
    e. Vaccine manufacturer
17. Complete Appropriate Documentation:
    a. **Vaccine Consent/Record of Administration form:** ensure this is completed, retained and appropriately submitted after administration.
        i. Note that medical records/charts should be documented and retained in accordance with applicable state laws and regulations. If vaccine was not administered, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal). Discuss the need for vaccine with the patient (or, in the case of a minor, their parent or legal representative) at the next visit.
    b. **Vaccine Information Statement:** document the publication date and the date it was given to the patient.
    c. **Patient's medical record:** if accessible, record vaccine information (above) in the patient's medical record.
    d. **Personal immunization record card:** record the date of vaccination and name/location of administering clinic.
    e. **Immunization Information System (IIS), or "registry":** Report the vaccination to the appropriate state/local IIS, if available.
    f. **VAERS:** report all adverse events following the administration of a vaccine to the federal Vaccine Adverse Event Reporting System (VAERS).
        i. To submit a VAERS report online (preferred) or to download a writable PDF

form, go to https://vaers.hhs.gov/reportevent.html. Further assistance is available at (800) 822-7967.

18. Give patient vaccine information sheet, using the appropriately translated sheet for non-English speaking client; these can be found at www.immunize.org/vis.
19. Advise patient when to return for subsequent vaccination, if appropriate.

B. Contraindications, Relative Contraindications, and Considerations for Vaccine Administration
   1. Contraindications for Use of Vaccines
      a. Do not administer vaccines to a person who has an allergic reaction or a serious systemic or anaphylactic reaction to a prior dose of that vaccine or to any of its components. For a list of vaccine components, refer to guidance specific to this vaccine provided by the manufacturer and the LEMSA.
      b. The manufacturer's package insert contains a list of ingredients (www.immunize.org/fda) and these are also listed at www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf
      c. Contraindications for Live Attenuated Vaccines are not pertinent as these are not being administered under this local optional scope of practice
   2. Relative Contraindications for Use of Vaccines
      a. Moderate or severe acute illness with or without fever
      b. History of Guillain-Barré syndrome within 6 weeks of a previous vaccination
      c. People with egg allergies can receive any licensed, recommended age-appropriate influenza vaccine (IIV, RIV4, or LAIV4) that is otherwise appropriate. People who have a history of severe egg allergy (those who have had any symptom other than hives after exposure to egg) should be vaccinated in a medical setting, supervised by a health care provider who is able to recognize and manage severe allergic reactions. Two completely egg-free (ovalbumin-free) flu vaccine options are available: quadrivalent recombinant vaccine and quadrivalent cell-based vaccine.
   3. Considerations for Vaccine Administration
      a. Treatment of medical emergencies related to the administration of vaccine will be in accordance with VCEMSA Policies and Procedures.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Documentation of Prehospital Care		Policy Number 1000
APPROVED: Administration:	Steven Carroll, Paramedic	Date: December 1, 2019
APPROVED: Medical Director	Daniel Shepherd, M.D.	Date: December 1, 2019
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 15, 1998 October 10, 2019 October 10, 2019 October 31, 2021	Effective Date: December 1, 2019

I. PURPOSE: To define the use of standardized records to be used by Ventura County Emergency Medical Service (VCEMS) providers for documentation of pre-hospital care.

II. AUTHORITY: California Health and Safety Code, Sections 1797.225, and 1798; California Code of Regulations, Title 22, Division 9, Section 100147.

III. Definitions:

Incident: For the purposes of this policy, will be defined as any response involving any Ventura County pre-hospital personnel to any event in which there is an actual victim, or the potential for a victim

Patient Contact: Any encounter involving Ventura County pre-hospital personnel with any person consenting, either implied or informed, to assessment and/or treatment.

National EMS Information System (NEMSIS): The national data standard for emergency medical services as defined by the National Highway Traffic and Safety Administration (NHTSA) and the NEMSIS Technical Assistance Center (TAC)

California EMS Information System (CEMSIS): The California data standard for emergency medical services, as defined by the California EMS Authority (CalEMSA). This data standard includes the NEMSIS standards and state defined data elements.

VCEMS Data Standard: The local data standard, as defined by VCEMS. This data standard includes the NEMSIS and CEMSIS standards, in addition to locally defined data elements.

Ventura County Electronic Patient Care Report (VCePCR): The electronic software platform that allows for real time collection of prehospital patient care information at the time of service.

IV. POLICY: Patient care provided by first responders and transport personnel shall be documented using the appropriate method.

V. PROCEDURE:

A. Provision of Access

VCEMS will provide access to the approved Ventura County Electronic Patient Care Report (VCePCR) system and software to EMS system stakeholders required to enter, edit, or analyze data.

B. Documentation

1. The VCEMS VCePCR will be used to document the care provided by pre-hospital personnel for every incident in which there is a patient contact. Documentation shall be completed on any person with obvious injury or significant mechanism regardless of consent. The following are exceptions:

a. If a First Responder Advanced Life Support (FR ALS) Paramedic initiates care of the patient, the FR ALS Paramedic shall document all care provided to the patient on VCePCR.

b. If care is turned over to another ALS agency, a VCePCR shall be completed by all pre-hospital provider agencies who delivered patient care and/or transport.

c. All relevant fields pertaining to the EMS event will be appropriately documented on the VCePCR.

d. Patient side documentation is encouraged and should be practiced whenever patient care would not be negatively affected.

e. In the event of an incident with three or more victims, documentation will be accomplished as follows:

1) MCI/Level I (3-14 victims): The care of each patient shall be documented using a VCePCR.

2) MCI/Level II or III (15+ victims): Each patient transported to a hospital shall have their care documented on a Ventura County Multi-Casualty Patient Record.

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 demobilization of the incident.

C. Transfer of Care

1. Transfer of care between two field provider teams and between field provider and hospital will be documented on the VCePCR. The first arriving agency will post to the server and perform a coordinated electronic transfer of care whenever possible within the VCePCR system to the next incoming unit. The unit receiving the electronic transfer will download the correct corresponding report prior to completion of the VCePCR. This includes intra-agency units and inter-agency units.

a. Any / all agencies involved in the transferring of electronic medical records shall ensure they are uploading and downloading the correct record for the correct patient.

2. A VCePCR shall be completed in accordance with training administered by VCEMS, or designee.

3. The time that patient care is transferred to hospital staff shall be documented by the primary provider handling patient care in all circumstances where a patient is transported to a hospital.

a. Transfer of care to the receiving facility is complete when:

1) The patient is moved off of the EMS gurney, and;

2) Verbal patient report is given by transporting EMS personnel and acknowledged by Emergency Department medical personnel and a signature of patient receipt is obtained in the VCePCR.

a) The signature time shall be the official transfer of care time, and will be documented in eTimes.12 – Destination Patient Transfer of Care Date/Time Destination.

D. Cardiac Monitor

In the event the cardiac monitor is attached as required by any of the VCEMS 705 policies, a complete ECG data transfer shall be recorded and attached to the corresponding VCePCR. ECG data shall be downloaded by each provider agency involved in that incident and attached to the corresponding VCePCR. An original 12 lead ECG shall be printed and submitted upon transfer of care to hospital staff for any patient where a 12 lead ECG was performed.

1. If a 12 lead ECG is performed by medical staff at a clinic or urgent care the original document shall be scanned or photographed and attached to the VCePCR, at the time of posting to the server, as part of the patient's prehospital medical record and the original or a copy of the 12-lead ECG shall be submitted to SRC staff upon transfer of care to hospital personnel.

E. Handtevy

In the event the patient is treated, within the pediatric definition of VCEMS Policies, a complete Handtevy data transfer will be recorded and attached to the corresponding VCePCR.

~~1.~~

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F~~E~~. Submission to VCEMS

1. In the following circumstances, a complete VCePCR shall be completed and posted by any transporting unit, and by FR ALS personnel retaining care, within thirty (30) minutes of arrival at destination:
   a. Any patient that falls into Step 1 or Step 2 (1.1 – 2.8) of the Ventura County Field Triage Decision Scheme
   b. Any patient that is in cardiac arrest, or had a cardiac arrest with ROSC.
   c. Any patient with a STEMI positive 12 lead ECG.
   d. Any patient with a positive Cincinnati Stroke Screening (CSS +). This includes all prehospital Stroke Alerts and all prehospital ELVO alerts.
   e. Any patient that is unable to effectively communicate information regarding present or past medical history.
   f. An exception to this circumstance would be during times of EMS system overload where a delay in a unit returning to service could pose significant delays in response times.
2. For circumstances not listed above, in which the patient was transported to a hospital, the entire data set found within the VCePCR 'REPORT' tab shall be completed and electronically posted to the server by transporting agencies, and by FR ALS personnel retaining care, within thirty (30) minutes of arrival at destination. This includes all assessments, vital signs, procedures, and medications performed as part of the response.

a. An exception to this circumstance would be during times of EMS system overload where a delay in a unit returning to service could pose significant delays in response times.

3. All other reports not falling into the above criteria shall be completed and posted to the server as soon as possible and no later than the end of shift.

4. In all circumstances in which a person is transported to a receiving hospital from the scene of an emergency, or as part of any emergent/urgent specialty care transfer (STEMI, Stroke, Trauma), the transporting personnel shall obtain and document the eOutcome.04 – Hospital Encounter Number.

~~F~~G. For Refusal of EMS Services, Refer to Policy 603 for documentation requirements. Every patient contact resulting in refusal of any medical treatment and/or transport must be documented with the following information, the reason dispatched and/or chief complaint, assessment and vital signs, base hospital contact (when appropriate), patient advised to seek medical attention and completion of all applicable fields. Signatures will be captured whenever possible by each agency at the time of patient contact/refusal. If, at any point, a signature is not obtained for any reason, explanation shall be documented in the narrative section of the VCePCR.

~~G~~H. ALS Inter-facility Transfers (Acute Care Facility to Acute Care Facility) Documentation shall be completed on all ALS Inter-facility transfers only. Documentation will include, but not be limited to, baseline assessment, medications administered, reason for transfer, procedures done to the patient, vital signs and any changes from baseline assessment.
If the transferring facility sends staff to accompany the patient, the staff member(s) name(s) shall be documented on the VCePCR.

~~H~~I. The completion of any VCePCR will not delay patient transport to hospital receiving facility.

~~I~~J. Patient Medical Record
The VCePCR and Ventura County Multi-Casualty Patient Record shall be considered a legal document and part of the patient's medical record.

The first responder agency, transport agency, and hospital are custodians of record. Printing should only be performed as needed, and an electronic copy of the VCePCR should be utilized and referred to whenever feasible. A print log and reason for printing shall be monitored regularly to help ensure security of protected health information within the system.

Attachment A

These abbreviations have been accumulated from the California approved EMT Curriculum and various other resource material. The abbreviations were collected by the Ventura County ALS CQI Team to assist EMS field, hospital and dispatch personnel in providing consistent medical documentation.

Term	Abbreviation
5% Dextrose in Water	D5W
Abdomen	Abd
Above knee amputation	AKA
Acquired Immunodeficiency Syndrome	AIDS
Ad Libitum (as desired)	Ad lib
Advanced Life Support	ALS
Against medical advise	AMA
Alcohol	ETOH
Alert and oriented	A & O
Also known as	AKA
Altered Level Of Consciousness	ALOC
Amount	Amt
Ampule	Amp
Antecubital	AC
Anterior	Ant
Anterior/Posterior	AP
Appointment	Appt
Arterial Blood Gas	ABG
Arteriosclerotic Heart Disease	ASHD
As necessary	prn
As soon as possible	ASAP
Aspirin	ASA
At	@
Atrial Fibrillation	A fib, AF
Attention Deficit Hyperactivity Disorder	ADHD
Automated external Defibrillator	AED
Automatic Implantable Cardiac Defibrillator	AICD
Bag Valve Mask	BVM
Basic Life Support	BLS
Birth Control Pill	bcp
Bowel Movement	BM
Bundle Branch Block	BBB
By Mouth	p.o.
By Order Of	per
Cancer	CA
Carbon Dioxide	CO_2
Carbon Monoxide	CO
Cardio Pulmonary Resuscitation	CPR

Term	Abbreviation
Central Nervous System	CNS
Cerebrospinal Fluid	CSF
Cerebrovascular Accident	CVA
Cervical Spine	C-Spine
Chief Complaint	CC
Chronic Obstructive Pulmonary Disease	COPD
Circulation, Sensation, Motor	CSM
Clear	Cl
Continuous Positive Airway Pressure	CPAP
Coronary Artery Bypass Graft	CABG
Coronary Artery Disease	CAD
Date of Birth	DOB
Dead on Arrival	DOA
Defibrillated	Defib
Delirium Tremens	DTs
Diabetes Mellitus	DM
Dilation and curettage	D & C
Discontinue*	D/C*
Distal Interphalangeal Joint	DIP
Deformity, Contusion, Abrasion, Penetration, Burn, Tenderness, Laceration, Swelling	DCAPBTLS
Do Not Resuscitate	DNR
Doctor of Osteopathy	DO
Drops	gtts
Dyspnea On Exertion	DOE
Electrocardiogram	ECG
Electroencephalogram	EEG
Emergency Department	ED
Emergency Medical Services	EMS
Emergency Medical Technician	EMT
Endotracheal	ET
End-Tidal CO_2	$EtCO_2$
Equal	=
Estimated	Est
Estimated Time of Arrival	ETA
Etiology	Etiol.
Every	q

Term	Abbreviation
Every day*	qd*
Evening	pm
Extended Care Facility	ECF
Eye, ear, nose, throat	EENT
Fahrenheit	F
Female	F
Fetal Heart Rate	FHR
Fluid	Fl
Foot	Ft
Foreign body	FB
Four times a day	QID
Fracture	Fx
Gallbladder	GB
Gastrointestinal	GI
Genitourinary	GU
Glasgow Coma Score	GCS
Grain	Gr
Gram	g
Gravida 1,2,3, etc	G1, G2, G3
Gun Shot Wound	GSW
Gynecological	Gyn
Heart Rate	HR
Hematocrit	Hct
Hemoglobin	Hgb
Hepatitis A Virus	HAV
Hepatitis B Virus	HBV
Hepatitis C Virus	HCV
History	Hx
History and Physical	H & P
Hour of Sleep (bedtime)*	hs*
Human Immunodeficiency Virus	HIV
Hydrochlorothiazide	HCTZ
Hypertension	HTN
Immediately	STAT
Insulin Dependent Diabetes Mellitus	IDDM
Intake and Output	I & O
Intensive Care Unit	ICU
Intercostal Space	ICS
Intracranial Pressure	ICP
Intralingual	IL
Intramuscular	IM
Intraosseous	IO
Intrauterine Device	IUD
Intravenous	IV
Intravenous Push	IVP
Irregular	Irreg
Jugular venous distention	JVD
Kilogram	kg
Kilometer	Km
Labor and Delivery	L & D
Laceration	Lac
Last Menstrual Period	LMP
Lateral	Lat
Left	L
Left Eye*	OD*

Term	Abbreviation
Left Lower Extremity	LLE
Left Lower Lobe	LLL
Left Lower Quadrant	LLQ
Left Upper Extremity	LUE
Left Upper Lobe	LUL
Left Upper Quadrant	LUQ
Less Than	<
Lower Extremity	LE
Lumbar Puncture	LP
Male	M
Medical Doctor	MD
Metered Dose Inhaler	MDI
Microgram	mcg
Milliequivalent	mEq
Milligram	mg
Milliliter	ml
Millimeter	mm
Minute	Min
Morning	am
Morphine Sulphate*	MS*
Motor Vehicle Collision	MVC
Mouth	MO
Moves all Extremities	MAE
Multiple Casualty Incident	MCI
Multiple sclerosis	MS
Myocardial Infarction	MI
Nasal cannula	NC
Nausea/Vomiting	NV
Negative	neg
Night	Noc
Nitroglycerin	NTG
No Acute Distress	NAD
No Known Allergies	NKA
No Known Drug Allergies	NKDA
Non Insulin Dependent Diabetes Mellitus	NIDDM
Non Rebreather Mask	NRBM
Non Steroidal Anti-inflammatory Drugs	NSAID
Normal Saline	NS
Normal Sinus Rhythm	NSR
Not applicable	NA
Nothing by Mouth	NPO
Obstetrics	OB
Occupational Therapy	OT
Oral Dissolving Tablet	ODT
Operating Room	OR
Organic Brain Syndrome	OBS
Ounce	oz
Over the Counter	OTC
Overdose	OD
Oxygen	O2
Oxygen Saturation	SpO_2
Palpable	Palp
Para, number of pregnancies	Para 1,2,3, etc
Paramedic	PM

Term	Abbreviation
Paroxysmal Supraventricular Tachycardia	PSVT
Paroxysmal Nocturnal Dyspnea	PND
Past Medical History	PMH
Pediatric Advanced Life Support	PALS
Pelvic Inflammatory Disease	PID
Per Rectum	pr
Percutaneously Inserted Central Catheter	PICC
Phencyclidine	PCP
Physical Exam	PE
Positive	+, pos
Pound	lb
Pregnant	Preg
Premature Ventricular Contraction	PVC
Primary Care Physician	PCP
Private/Primary Medical Doctor	PMD
Privately Owned Vehicle	POV
Pro Re Nata – As Needed	PRN
Pulmonary Embolism	PE
Pulse, Motor, Sensation	PMS
Pulseless Electrical Activity	PEA
Pupils Equal Round and Reactive to Light	PERRL
Range of Motion	ROM
Registered Nurse	RN
Respiration	R
Respiratory Rate	RR
Respiratory Therapist	RT
Right	Rt
Right Eye*	OD*
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ
Right Middle Lobe	RML
Ringer's Lactate	RL
Rule Out	R/O
Sexually Transmitted Disease	STD

Term	Abbreviation
Shortness of Breath	SOB
Sinus Bradycardia	SB
Sinus Tachycardia	ST
Sodium Bicarbonate	NaHCO3
Sodium Chloride	NaCl
Streptococcus	Strep
Subcutaneous*	SQ*
Sublingual	SL
Sudden Acute Respiratory Syndrome	SARS
Sudden Infant Death Syndrome	SIDS
Supraventricular Tachycardia	SVT
Temperature	T
Temperature, Pulse, Respiration	TPR
Three Times a Day	TID
Times	X
To Keep Open	TKO
Tracheostomy	Trach
Traffic Collision	TC
Transient Ischemic Attack	TIA
Transcutaneous Pacing	TCP
Treatment	Tx
Tuberculosis	TB
Twice a day	BID
Upper Respiratory Infection	URI
Urinary Tract Infection	UTI
Ventricular Fibrillation	VF
Ventricular Tachycardia	VT
Vital Signs	VS
Volume	Vol
Water	H20
Weight	Wt
With	w/
Within Normal Limits	WNL
Without	w/o
Wolf-Parkinson-White	WPW
Year	Yr
Years Old	y/o

*THE JOINT COMMISSION and ISMP have indicated these abbreviations have a high likelihood of misinterpretation; thereby leading to medical errors, therefore, they are ***not*** to be used in ***handwritten*** documentation.