To: ALL VENTURA COUNTY EMS POLICY MANUAL HOLDERS Change No.: 2

DATE: November 1, 2010

Policy Status	Policy #	Title/New Title	Notes
Replace	112	Ambulance Rates	
Replace	300	EMT Scope of Practice	
Replace	301	EMT Certification	
Replace	302	EMT Recertification	
Replace	304	EMT Challenge	
Replace	310	Paramedic Scope of Practice	
Replace	315	Paramedic Accreditation to Practice	
Replace	318	ALS Response Unit Staffing	
Replace	333	Accreditation/Certification/Authorization Review Process	
Replace	350	PCC Job Description	
Replace	604	Transport and Destination Guidelines	
Replace	704	Guidelines for Base Hospital Contact	
New	705	General Patient Guidelines	
New	705	Trauma Assessment/Treatment Guidelines	
Delete	705	Airway Obstruction	See General Patient Guidelines
New	705	Allergic/Adverse Reaction and Anaphylaxis	**Combined policy - previous titles:** • Anaphylaxis • Non Traumatic Focal Neuro Changes
Delete	705	Altered Level of Consciousness/Coma	**New Name**: Altered Neurological Function
New	705	Altered Neurological Function	**Combined policy - previous titles:** • ALOC • Non Traumatic Focal Neuro Changes
Delete	705	Anaphylaxis	**New Name**: Allergic/Adverse Reaction and Anaphylaxis
Delete	705	Apnea or Agonal Respirations	
Replace	705	Behavioral Emergencies	

Policy Status	Policy #	Title/New Title	Notes
New	705	Bites and Stings	**Combined policy, previous titles:** • Marine Animals • Insect/Spider Bites • Snake Bites
Delete	705	Bradycardia: Adult, Symptomatic*, Not In Arrest	**New Name**: Symptomatic Bradycardia
Replace	705	Burns	
Delete	705	Cardiac Arrest, Adult	**Combined policy – new titles:** • Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA) • Cardiac Arrest – VF/VT
Delete	705	Cardiac Arrest, Pediatric	**Combined policy – new titles:** • Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA) • Cardiac Arrest – VF/VT
New	705	Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA)	**Combined policy – previous titles** • Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA) • Cardiac Arrest – VF/VT
New	705	Cardiac Arrest – VF/VT	**Combined policy – previous titles** • Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA) • Cardiac Arrest – VF/VT
Delete	705	Chest Pain	**New name:** Chest Pain – Acute Coronary Syndrome
New	705	Chest Pain – Acute Coronary Syndrome	
Replace	705	Childbirth	
Replace	705	Crush Injury/Syndrome	
Deleted	705	Decompression Injuries	
Deleted	705	Heat Exhaustion/Heat Stroke	**New Name:** Heat Emergencies
New	705	Heat Emergencies	**Previous Title**: Heat Exhaustion/Heat Stroke
Replace	705	Hypothermia	
New	705	Hypovolemic Shock	**Combined policy - -previous titles** • Hypovolemic Shock – Trauma • Hypovolemic Shock – Non Trauma
Delete	705	Hypovolemic Shock - Trauma	**New Name**: Hypovolemic Shock

Policy Status	Policy #	Title/New Title	Notes
Delete	705	Hypovolemic Shock Non Trauma	**New Name**: Hypovolemic Shock
Delete	705	Insect and Spider Bites	**New Name**: Bites and Stings:
Delete	705	Marine Animals	**New Name**: Bites and Stings:
New	705	Nausea/Vomiting	
New	705	Neonatal Resuscitation	
Replace	705	Nerve Agent Poisoning	
Delete	705	Newborn Resuscitation	**New Name**: Neonatal Resuscitation
Delete	705	Non-Traumatic Focal Neurological Changes	**New Name**: Altered Neurologic Function
Replace	705	Overdose/Poisoning	
Replace	705	Pain Control	
Replace	705	Seizures	
New	705	Shortness of Breath – Pulmonary Edema	**Previous title:** Shortness of Breath
New	705	Shortness of Breath – Wheezes/Other	**Previous title:** Shortness of Breath
Delete	705	Shortness of Breath	**New Name:** Shortness of Breath –Wheezes/Other Shortness of Breath – Pulmonary Edema
Delete	705	Snake Bite	**New Name:** Bites and Stings
Delete	705	Supraventricular Tachycardia - Rate> 150 (Adult)	**New Name:** Supraventricular Tachycardia
New	705	Supraventricular Tachycardia	
New	705	Symptomatic Bradycardia	**Combined policy, previous titles**: • Bradycardia adult symptomatic - not in arrest • Symptomatic *Bradycardia, Pediatric, Not in Arrest
Delete	705	Symptomatic* Bradycardia, Pediatric, Not In Arrest	**New Name:** Symptomatic Bradycardia
Replace	705	Ventricular Tachycardia Sustained, Not In Arrest	
Replace	710	Airway Management	Title was changed
Replace	715	Needle Thoracostomy	
New	726	12 Lead ECG	Policy effective date was September 1, 2010
New	731	Tourniquet Usage	

Policy Status	Policy #	Title/New Title	Notes
Replace	920	Reddinet	
Replace	1000	Documentation	The policy has been approved with the exception of the abbreviation. The abbreviations will be posted to the EMS Website for 30 days for public commen. The final policy will go into effect on December 1, 2010.
Replace	1203	Criteria For Patient Emergency Transport By Helicopter	Policy effective date was October 14, 2010
New	1400	Trauma Care System – General Provisions	Policy effective date was July 1, 2010
New	1401	Trauma Center Designation	Policy effective date was July 1, 2010
New	1404	Guidelines for IFT of Patients to a Trauma Center	Policy effective date was July 1, 2010
New	1405	Trauma Triage and Destination Criteria	Policy effective date was July 1, 2010
New	1406	Trauma Center Standards	Policy effective date was July 1, 2010
Info.		Excited Delirium FAQ Sheet	

Policy No.	Title	Effect. Date	Origin. Date	Revised Date	Date Last	Review Date
I.	**Administrative Policies**					
100	Emergency Medical Service, Local Agency (9/13/84)	6/15/1998	7/1/1980	10/1/2003	11/12/2009	1/31/2013
105	Prehospital Services Committee Operating Guidelines	6/1/2009	3/1/1999	4/9/2009	4/9/2009	4/30/2012
106	Development of Proposed Policies/Procedures; Amendments to Existing Policies	12/1/2009	3/7/1990	6/11/2009	6/11/2009	6/30/2012
110	County Ord. No. 4099 Ambulance Business License Code	12/1/2007	7/10/1984	9/13/2007	8/13/2009	9/30/2011
111	Ambulance Company Licensing Procedure	12/1/2006	9/26/1986	6/8/2006		8/31/2011
112	Ambulance Rates	7/1/2010	1984	7/1/2010	7/1/2010	7/1/2011
120	Prehospital Emergency Medical Care Quality Assurance Program	6/1/2009	1/1/1996	12/11/2009	12/11/2008	12/31/2012
124	Hospital Emergency Services Reduction Impact Assessment	12/1/2004	6/1/1999	5/13/2004	11/12/2009	4/30/2013
131	Multi-Casualty Incident Response	3/13/2008	9/1/1991	3/13/2008		3/31/2010
150	Unusual Occurrence Reportable Event/Sentinel Event	3/11/2010	6/1/1999	3/10/2010	3/10/2010	6/30/2013
151	Medication Error Reporting	11/1/2003	11/1/2003	4/10/2008		4/30/2010
II.	**Legislation/Regulations**					
210	Child, Dependent Adult, or Elder Abuse Reporting	11/1/2003	6/14/1984	9/11/2003	8/13/2009	11/1/2011
III.	**Personnel Policies**					
300	Scope of Practice Emergency Medical Technician	12/1/2010	8/1/1988	10/14/2010	10/14/2010	10/31/2013
301	Emergency Medical Technician I Certification - Ventura County	12/1/2010	6/1/1984	10/14/2010	10/14/2010	10/31/2013
302	Emergency Medical Technician I Recertification - Ventura County	12/1/2010	6/1/1984	10/14/2010	10/14/2010	10/31/2013
304	Emergency Medical Technician I Completion by Challenge	12/1/2010	6/1/1984	10/14/2010	10/14/2010	10/31/2013
306	EMT-I Requirements to Staff and ALS Unit	12/1/2006	6/1/1997	8/10/2006		10/31/2011
310	Paramedic Scope of Practice	12/1/2010	5/1/1984	10/14/2010	10/14/2010	10/31/2013
315	Emergency Medical Technician-Paramedic Accreditation To Practice	12/1/2010	1/1/1990	10/14/2010	10/14/2010	10/31/2013
318	Paramedic Training and Continuing Education Standards to Staff an ALS Response Unit	12/1/2010	6/1/1997	10/14/2010	10/14/2010	10/31/2013
319	Paramedic Preceptor	12/1/2008	6/1/1997	7/10/2008		7/31/2011
321	Mobile Intensive Care Nurse: Authorization Criteria	12/1/2008	4/1/1983	8/14/2008		8/31/2011
322	Mobile Intensive Care Nurse: Reauthorization Requirements	12/1/2008	4/1/1983	8/14/2008		8/31/2011
323	Mobile Intensive Care Nurse: Authorization Challenge	6/1/2008	4/1/1983	11/8/2007	6/11/2009	11/30/2012
324	Mobile Intensive Care Nurse: Authorization Reactivation	12/1/2008	12/1/1991	8/14/2008		8/31/2011
330	EMT-I/EMT-P/MICN Decertification and Discipline	6/1/2009	4/9/1985	12/12/2008	12/12/2008	12/31/2011
332	EMS Personnel Background Check Requirements	12/1/2004	7/31/1990	5/13/2004	12/11/2008	5/31/2011
333	Denial of Prehospital Care Certification or Accreditation	12/1/2010	4/1/1993	10/14/2010	10/14/2010	10/31/2013
334	Prehospital Personnel Mandatory Training Requirements	6/1/2009	9/14/2000	12/11/2008	12/11/2008	12/31/2012
335	Out of County Paramedic Internship Approval Process	12/1/2008	10/13/2005	10/9/2008		4/30/2011
342	Notification of Personnel Changes - Provider	12/1/2007	5/15/1987	9/13/2007	6/11/2009	9/30/2012
350	Prehospital Care Coordinator Job Duties	12/1/2010	1/0/1900	6/10/2010	6/10/2010	6/30/2013
351	EMS Update Procedure	12/1/2009	2/9/2005	9/10/2009	9/10/2009	9/30/2012
IV.	**Emergency Medical Services - Facilities**					
400	Ventura County Emergency Departments	12/1/2006	10/1/1984	8/10/2006		10/31/2011
402	Patient Diversion/Emergency Department Closures	10/1/2003	12/1/1990	3/31/2003	12/11/2008	11/30/2012
410	ALS Base Hospital Approval Process	6/1/2009	8/22/1986	2/12/2009	2/12/2009	2/28/2012

Policy No.	Title	Effect. Date	Origin. Date	Revised Date	Date Last	Review Date
420	Receiving Hospital Standards	12/1/2007	4/1/1984	9/13/2007		9/30/2009
430	STEMI Receiving Center (SRC) Standards	12/1/2009	7/28/2006	6/11/2009	6/11/2009	6/30/2012
440	Code STEMI Interfacility Transfer	6/11/2009	7/1/2007	6/11/2009	6/11/2009	9/30/2012
V.	**Emergency Medical Services - Field Providers**					
500	Basic/Advanced Life Support Ventura County Ambulance Providers	6/1/2007	7/1/1987	2/8/2007		2/28/2009
501	Advanced Life Support Service Provider Criteria	12/1/2005	4/1/1984	9/8/2005	11/12/2009	4/30/2013
502	Advanced Life Support Service Provider Approval Process	6/1/2008	5/1/1984	1/10/2008	11/12/2009	1/31/2013
504	BLS And ALS Unit Equipment and Supplies	12/1/2009	5/24/1987	6/11/2009	6/11/2009	6/30/2011
506	Advanced Life Support (ALS) Support Vehicles	6/1/2008	10/1/1995	11/8/2007	8/13/2009	11/30/2012
507	Critical Care Transports	11/30/2002	10/31/1995	9/12/2002		11/30/2004
508	First Responder Advanced Life Support Units	12/1/2005	6/1/1997	10/13/2005	11/12/2009	4/30/2013
VI.	**General Emergency Medical Services - Policies**					
600	Control At The Scene of An Emergency	10/31/1999	1/31/1995	9/30/1999		9/30/2001
601	Medical Control At The Scene: EMS Prehospital Personnel	6/1/2000	10/1/1993	10/31/1999		6/1/2002
603	Against Medical Advice/Release From Liability Form	10/31/1995	6/3/1986			10/31/1997
604	Transport and Destination Guidelines	12/1/2010	6/3/1986	6/10/2010	6/10/2010	6/30/2013
605	Interfacility Transfer of Patients	6/1/2006	7/26/1991	4/13/2006		10/31/2011
606	Withholding or Termination of Resuscitation and Determination of Death	6/1/2006	6/1/1984	5/11/2006		10/31/2011
607	Hazardous Material Exposure: Prehospital Protocol	6/10/2010	2/12/1987	3/11/2010	3/11/2010	3/31/2013
612	Notification of Exposure to a Communicable Disease	4/27/1990				4/27/1992
613	Do Not Resuscitate (DNR)	1/12/2009	10/1/1993	1/12/2009	1/12/2009	1/31/2011
614	Spinal Immobilization	6/1/2009	10/31/1992	12/11/2008	12/11/2008	6/30/2011
615	Organ Donor Information Search	6/1/2004	10/1/1993	3/11/2004	11/12/2009	1/31/2013
618	Unaccompanied Minors	10/31/1995	5/1/1995			10/31/1997
619	Safely Surrendered Babies	6/1/2008	2/13/2003	11/8/2007	8/13/2009	11/30/2012
620	EMT-I Administration of Oral Glucose	6/1/2006	11/18/1982	3/9/2006		10/31/2011
622	ICE - In Case of Emergency for Cell Phones	12/1/2008	5/11/2006	7/10/2008		7/31/2011
624	Patient Medications	12/12/2006	12/6/2006			10/31/2011
625	POLST	1/8/2009	1/7/2009			1/31/2011
626	Chempack	6/1/2010	2/2/2010		11/12/2009	6/30/2013
VII.	**Advanced Life Support Medical Control and Treatment Policies**					
701	Medical Control: Base Hospital Medical Director	6/1/2008	8/1/1988	1/10/2008	11/12/2009	1/31/2013
703	Medical Control At Scene, Private Physician	6/1/2008	1/31/1985	3/13/2008	11/12/2009	8/31/2013
704	Guidelines For Base Hospital Contact	12/1/2010	10/1/1984	10/14/2010	10/14/2010	10/31/2013
705	00 - General Patient Guidelines	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011
705	01 - Trauma Treatment Guidelines	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011
705	02 - Allergig/Adverse Reaction and Anaphylaxis	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011
705	03 - Altered Neurologic Function	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	04 - Behavioral Emergencies	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	05 - Bites and Stings	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011

Policy No.	Title	Effect. Date	Origin. Date	Revised Date	Date Last	Review Date
705	06 - Burns	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	07 - Cardiac Arrest - Asystole/Pulseless/PEA	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011
705	08 - Cardiac Arrest - VF/VT	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011
705	09 - Chest Pain - Acute Coronary Syndrome	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011
705	10 - Childbirth	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	11 - Crush Injury/Syndrome	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	12 - Heat Emergencies	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	13 - Hypothermia	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	14 - Hypovolemic Schock	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	15 - Nausea/Vomiting	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011
705	16 - Neonatal Resuscitation	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011
705	17 - Nerve Agent Poisoning	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	18 - Overdose/Poisoning	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	19 - Pain Control	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	20 - Seizures	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	21 - Shortness of Breath - Pulmonary Edema	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011
705	22 - Shortness of Breath - Wheezes/Other	12/1/2010	8/1/2010	8/1/2010	8/1/2010	12/1/2011
705	23 - Supraventricular Tachycardia	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	24 - Symptomatic Bradycardia	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	25 - Ventricular Tachycardia, Sustained Not In Arrest	12/1/2010		8/1/2010	8/1/2010	12/1/2011
708	Patient Transfer From One Prehospital Team To Another	6/1/2009	10/31/1992	12/11/2008	12/11/2008	6/30/2011
710	Airway Management	12/1/2010	6/1/1986	10/14/2010	10/14/2010	10/31/2012
713	Intralingual Injection	6/1/2004	8/30/1990	1/8/2004		7/31/2011
715	Needle Thoracostomy	12/1/2010	11/1/1990	10/14/2010	10-14-10\	10/31/2012
716	Use of Pre-existing Vascular Access Devices	12/1/2007	3/2/1992	9/13/2007	6/11/2009	6/30/2011
717	Pediatric Intraosseous Infusion	6/1/2008	9/10/1992	4/13/2008		3/31/2010
720	Guidelines For Limited Base Hospital Contact	12/11/2008	6/15/1998	12/11/2008	12/11/2008	12/31/2010
722	Interfacility Transport of Patient with Patient with IV Heparin	1/10/2008	6/15/1998	1/10/2008	2/11/2010	1/31/2012
723	Continuous Positive Airway Pressure (CPAP)	12/1/2007	12/1/2004	9/13/2007	6/11/2009	9/30/2011
724	Apparent Life-Threatening Event (ALTE)	6/1/2005	3/1/2005		11/12/2009	4/30/2013
725	Patients After TASER Use	8/29/2006	8/10/2006			10/31/2011
726	12-Lead ECG	9/1/2010	8/10/2006	8/12/2010	8/12/2010	9/30/2012
727	Transcutaneous Cardiac Pacing	12/1/2008	12/1/2008	12/11/2008	12/11/2008	12/31/2010
728	King Airway	8/14/2008	4/10/2008			6/30/2010
729	Trauma Treatment Protocol		6/5/2008			
731	Tourniquet Use	12/1/2010	8/10/2010	8/10/2010		8/31/2012
732	Use of Restraint					
VIII.	**Emergency Medical Technician - Defibrillation Policies**					
802	Emergency Medical Technician-I Defibrillation (EMT-ID) Medical Director	11/30/2002	11/1/1988	6/30/2002		11/30/2004
805	Emergency Medical Technician Defibrillation (EMT-ID) Medical Cardiac Arrest	6/1/2006	10/1/1993	4/24/2006		6/30/2008

Policy No.	Title	Effect. Date	Origin. Date	Revised Date	Date Last	Review Date
808	Emergency Medical Technician Defibrillation Integration with Public AED Operation	11/30/2002	5/9/2002	8/31/2002		11/30/2004
IX.	**Emergency Medical Services Communications**					
905	Ambulance Provider Response Units: Required Frequencies	12/1/2006	7/1/1999	6/8/2006		8/31/2011
910	Emergency Medical Dispatch System Guidelines	12/1/2005	10/31/1994	9/8/2005		5/31/2007
920	ReddiNet Policy	12/1/2010	4/26/2007	10/14/2010	10/14/2010	10/31/2013
X.	**Documentation**					
1000	Documentation of Prehospital Care	12/1/2010	6/15/1998	10/14/2010	10/14/2010	10/31/2013
1001	EMT-P/BH Communication Record	12/1/2007	7/6/2007	7/9/2007	6/11/2009	7/31/2011
XI.	**Education**					
1100	Emergency Medical Technician-1 Program Approval	6/1/2008	2/28/2001	3/13/2008		3/31/2010
1105	MICN Developmental Course and Exam	12/1/2006	7/2/1984	6/8/2006		8/31/2011
1130	Advanced Life Support Continuing Educations Lectures	6/1/2006	2/28/2001	3/10/2006		7/31/2011
1131	Field Care Audit	6/1/2006	8/1/1984	2/9/2006		8/31/2011
1132	Continuing Education: Attendance Roster	6/1/2006	6/1/1993	3/9/2006		8/31/2011
1135	Paramedic Training Program Approval	6/1/2006	10/20/1993	12/8/2005		10/31/2011
1140	Emergency Medical Dispatcher Training Guidelines	5/1/2003	10/1/1991	1/31/2003		1/31/2005
XII.	**Search and Rescue**					
1200	Air Unit Program	6/1/2008	5/1/1999	4/13/2008		6/30/2010
1201	Air Unit Staffing Requirements	12/1/2006	5/30/1988	6/8/2006		10/31/2011
1202	Air Unit Dispatch for Emergency Medical Responses	12/1/2008	10/31/1998	10/9/2008		12/31/2011
1203	Criteria for Patient Emergency Transport	10/14/2010	10/31/1994	10/14/2010	10/14/2010	10/31/2012
1204	EMS Aircraft Classification	12/1/2007	5/31/1999	9/13/2007	6/11/2009	7/31/2011
1205	Air Unit Specifications Equipment and Supplies	12/1/2007	5/1/1999	9/13/2007	6/11/2009	7/31/2011
XIII.	**Public Access Defibrillation**					
1301	Public Access Defibrillation (PAD) Provider Standards	6/1/2008	9/14/2000	3/11/2010	3/11/2010	3/31/2012
XIV.	**Trauma System Protocols**					
1400	Trauma Care System - General Provisions	7/1/2010	7/1/2010			7/1/2011
1401	Trauma Center Designation	7/1/2010	7/1/2010			7/1/2011
1402	Trauma Review Committee					
1403	Trauma Hospital Data Elements					
1404	Guidelines for Interfacility Transfer of Patients to a Trauma Center	7/1/2010	7/1/2010			7/1/2011
1405	Trauma Triage and Destination Criteria	8/2/2010	7/1/2010	8/2/2010	8/2/2010	7/31/2012
1406	Trauma Center Standards	7/1/2010	7/1/2010			7/1/2011
1407	Code Trauma": Emergent Transfer of Patients with Critical Trauma to Trauma Center					

Policy No.	Title	Effect. Date	Origin. Date	Deleted
I.	**Administrative Policies**			
102	Coordination of Ambulance Program (New policy #102)	6/15/1998	10/1/1984	6/1/2004
104	EMCC (old policy #106)	6/1/1984	6/1/1984	2/1/1996
118	Coordination of Ambulance Program (New policy #102)	10/1/1984	10/1/1984	See 102
119	Ambulance Business License (New policy # 110)	7/10/1984	7/10/1984	See 110
122	Trial Study – Additional ALS Procedure (old policy #105)	2/28/1985	2/28/1985	11/1/2003
130	Medical Disaster Response Procedure (old policy #108)	6/1/1984	6/1/1984	?
140	Special Events Medical (0ld policy #109)	6/1/1984	6/1/1984	12/1/2004
II.	**Legislation/Regulations**			
200	Health and Safety Code	2/21/2003		11/1/2003
201	CCR - EMT-I Regulations	1/11/2000	6/17/1994	11/1/2003
202	CCR - Paramedic Regulations	2/20/2003	6/1/1997	11/1/2003
203	CCR - First Aid Standards for Public Safety Personnel	6/30/2000		11/1/2003
204	CCR - EMS Personnel Certification Review Process	3/25/2000		11/1/2003
205	CCR -Prehospital EMS Aircraft Regulations	1/10/1997	3/29/1988	11/1/2003
206	CCR – Process for Applicant Verification	8/4/1998		11/1/2003
207	EMT-I Certification Disciplinary Action Guidelines	3/2/2000		6/1/2001
III.	**Personnel Policies**			
303	Procedure for EMT-NA to become EMT-IA	6/1/1984		6/1/2002
305	EMT-I Ambulance Challenge Exam (New policy # 304)	4/25/1985		See 304
311	EMT-P Certification	4/30/1994	6/16/1980	10/31/1999
312	EMT-P Recertification	4/30/1994	1/6/1986	10/31/1999
313	EMT-P Reactivation of Certification	7/1/1992	6/16/1980	11/1/2003
314	EMT-P Out of State Challenge	1/1/1990	4/25/1985	11/1/2003
316	EMT-P Reactivation of Inactive Accreditation to Practice	10/31/1996	10/1/1990	11/1/2003
317	EMT-P Continuous Accreditation Requirements	5/1/1996	1/1/1990	6/1/2002
331	Certification Review: Base Hospital and Provider Responsibilities	10/1/1987	10/1/1987	4/9/1996
340	Ventura County Ambulance Personnel Listing	6/1/1984		5/1/2003
341	Basic and Advanced Life Support Notification of Personnel Changes – Base Hospital	5/15/1987		5/1/2003
IV.	**Emergency Medical Services - Facilities**			
401	Approved Burn Centers	8/8/1988		6/1/2002
406	Basic and Advanced Life Support Notification of Personnel Changes – EMS Providers (New policy #342)	5/15/1987		See 342
411	Advanced Life Support Base Hospital Approval Process)			12/1/2002
412	ALS New Hospital six month evaluation of provision of ALS service	6/1/2002	4/1/1984	12/1/2002
413	ALS Base Hospital Program Review	5/22/1984		12/1/2002
421	Receiving Hospital Approval Process	6/1/2002	5/22/1984	12/1/2002
422	ALS New Receiving Hospital – six month evaluation of provision of ALS services	7/22/1984		12/1/2002
423	ALS Receiving Hospital Program Review	5/22/1984		12/1/2002
V.	**Emergency Medical Services - Field Providers**			
503	Provider Program Review	5/22/1984		11/1/2003
505	ALS Unit Staffing Exception	7/1/1995	12/12/1988	6/1/2002

Policy No.	Title	Effect. Date	Origin. Date	Deleted
VI.	**General Emergency Medical Services - Policies**			
608	Staffing on Helicopter for Patient Transport (New Policy # 1201)	5/20/1988		See 1201
609	Non-Breather Masks	3/31/1990	1/1/1988	6/1/2002
611	EMT-I Monitoring of IV Fluids	6/1/2004	6/1/1984	6/12/2007
616	Comfort Measures Only	6/1/1990	10/1/1993	5/1/2003
621	EMT-IA-Monitoring IV Fluid Administration (Old policy number 904) (New policy # 611)	6/1/1984		See 611
VII.	**Advanced Life Support Medical Control and Treatment Policies**			
700	Medical Control – Emergency Medical Services Medical Director	8/1/1988		1/1/2004
702	Medical Control- Physician At the Scene	10/31/1995	1/31/1985	12/1/2005
705	Airway Obstruction	12/1/2007		12/1/2010
705	Altered Level of Consciousness/Coma	12/1/2008		12/1/2010
705	Anaphylaxis	6/1/2009		12/1/2010
705	Apnea or Agonal Respirations	12/11/2008		12/1/2010
705	Bradycardia: Adult, Symptomatic*, Not In Arrest	12/1/2008		12/1/2010
705	Cardiac Arrest, Adult	6/1/2010		12/1/2010
705	Cardiac Arrest, Pediatric	6/1/2009		12/1/2010
705	Decompression Injuries	6/1/2008		12/1/2010
705	Hypovolemic Shock, Trauma	12/1/2008		12/1/2010
705	Hypovolemic Shock Non Trauma	12/1/2008		12/1/2010
705	Non-Traumatic Focal Neurological Changes	12/11/2008		12/1/2010
705	Newborn Resuscitation	6/1/2008		12/1/2010
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705	Symptomatic* Bradycardia, Pediatric, Not In Arrest	12/1/2005		12/1/2010
706	Prior to BH Contact -Bradycardia, Adult, Symptomatic, not in arrest	1/5/1993		10/31/1994
706	Prior to BH Contact -Cardiac Arrest	5/13/1993		10/31/1994
706	Prior to BH Contact -Chest Pain	11/12/1992		5/1/1995
706	Prior to BH Contact -Hypovolemic Shock	5/13/1993		4/30/1994
706	Prior to BH Contact -Shortness of Breath	3/31/1994		10/31/1994
706	Prior to BH Contact -Venous Access	12/31/1992	3/30/1983	10/31/1995
707	Communication Failure Protocols	2/24/1993	3/1/1983	10/31/1995
707	Communication Failure Protocols – Airway Obstruction			10/31/1994
707	Communication Failure Protocols – ALOC	9/30/1993	11/1/1990	10/31/1994
707	Communication Failure Protocols - Anaphylaxis	11/1/1990	4/1/1990	10/31/1994
707	Communication Failure Protocols – Apnea	9/30/1993		10/31/1994
707	Communication Failure Protocols - Cardiac Arrest, Asystole, Bradycardic EMD, Non Brady, VF, Tachycardia	5/13/1993		5/1/1995
707	Communication Failure Protocols – Chest Pain	5/13/1993		5/1/1995
707	Communication Failure Protocols – Hypovolemia	3/31/1994		10/1/1994
707	Communication Failure Protocols – Needle Thoracostomy			10/1/1995
707	Communication Failure Protocols – Shortness of Breath	9/30/1993		10/1/1994
707	Communication Failure Protocols – Status Epilepticus	4/22/1992		10/1/1994

Policy No.	Title	Effect. Date	Origin. Date	Deleted
709	Alternative ALS Airway Management Devices Indications For Use	12/1/2005	9/10/1985	10/1/2008
710	Endotracheal Intubation Indications For Use	6/1/2008	6/1/1986	
711	ALS Verapamil Hydrochloride	6/3/1986		12/1/2005
712	Administration of Nebulized Metaproterenol	2/1/1989	2/1/1989	6/1/2002
714	Glucose Testing	10/1/1990	8/1/1990	11/1/2003
719	Saline Locks		5/15/1993	12/1/2005
721	Pulse Oximetry Monitoring	6/1/2004	6/1/2004	6/12/2007
730	Narcotic Control			
VIII.	**Emergency Medical Technician - Defibrillation Policies**			
800	EMT-I Defibrillation Plan, Equipment Requirements, Program Parameters	6/1/2000	11/1/1988	12/1/2002
801	EMT-I Defibrillation Base Hospital	10/31/1996	11/1/1988	12/1/2002
804	EMT-I Defibrillation Performance Standards	5/1/1996	11/1/1988	12/1/2002
806	EMT-I Defibrillation Initial and Continuing Accreditation Requirements	7/1/1995	11/1/1988	12/1/2002
807	EMT-I Defibrillation Criteria for Hospitals Receiving patients	5/1/1996	11/1/1988	12/1/2002
IX.	**Emergency Medical Services Communications**			
901	Paramedic Communication Plan	10/11/1984	10/11/1984	6/12/2007
902	Frequencies (New policy #905) Contents moved to 905			12/1/2006
906	Verapamil Hydrochloride	1/30/1985 ?		
X.	**Documentation**			
1002	Inability to Make or Maintain Base Hospital Contact Report Form	6/1/2008	10/31/2001	11/30/2009
1004	Paramedic/MICN Lecture Approval Form (form only)			6/12/2007
1005	EMT-P/MICN Attendance Roster (form coversheet)	7/6/2007	7/6/2007	
1009	EMT-P/MICN Continuing Education Record (New policy #1132) Contents moved to 1132	11/9/1984		10/20/1993
1011	ALS MICN Continuing Education Requirements (New policy 322) Contents moved to 322			See 322
XI.	**Education**			
1101	EMT-I Curriculum for IV Monitoring (New policy 611) Contents moved to 611		6/1/1984	1/8/2004
1102	EMT-I Training Programs Approval in California			6/1/2002
1106	ALS Personnel Written Examination Process	1/1/1990		6/1/2002
1107	EMT-ID Training Module	6/1/2000	10/31/1998	6/1/2002
1110	MICN Developmental Course	6/14/1984		11/1/2003
1115	MICN Continuing Education Requirements	12/1/1989	6/14/1984	11/1/2003
1116	MICN Continuing Education Field Observation	11/9/1984	11/9/1984	11/1/2003
1120	Endotracheal Intubation Training, Accreditation and Skills Maintenance	4/30/1994	11/5/1985	1/8/2004
1121	EMT-P Training: Verapamil Hydrochloride	6/3/1986		10/31/1995
1122	Needle Thoracostomy Training	10/31/1996	11/1/1990	12/1/2005
1123	Pre Existing Vascular Access Devices	6/1/2005	7/31/1992	6/1/2002
1124	EMT-P Training: Adenosine			1/8/2004
1125	EMT-P Continuing Education Requirements	1/1/1990	6/16/1980	6/1/2002
1126	EMT-P Clinical Hours			1/8/2004
1127	Esophageal Tracheal Double Lumen Airway Training	10/11/2001	4/30/1994	?
1128	Training for IV Heparin for Use in a Transfer Setting	6/15/1998	4/23/1998	?

Policy No.	Title	Effect. Date	Origin. Date	Deleted
1129	Cervical Spine Immobilization Training	6/1/1999	3/25/1999	?
1133	Continuing Education Record	9/1/1989	11/9/1984	6/1/2002
1134	Training and Testing Criteria		7/21/1989	1/8/2004
XII.	**Search and Rescue**			
1210	Criteria for Patient Transport Via Helicopter	10/31/1994	10/31/1994	11/1/1998
XIII.	**Public Access Defibrillation**			
XIII.	**Trauma System Protcols**			

Policy Title: Ambulance Rates	Policy Number 112
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: July 1, 2010
Origination Date: 1984 Date Revised: July 1, 2010 Last Review: July 1, 2010 Review Date: July 1, 2011	Effective Date: July 1, 2010

I. PURPOSE: To define the allowable ambulance rates for the County of Ventura.

II. AUTHORITY: Ventura County Ambulance Ordinance.

III. POLICY: The rates described in this policy shall be the maximum charged by the ambulance companies in Ventura County.

IV. PROCEDURE: Ambulance rates are approved by the Board of Supervisors and are established based upon the cost to the ambulance operators to provide emergency ambulance service to the citizens of Ventura County. The rates listed are revised annually as needed, and are the maximum to be charged by all licensed ambulance companies to all users of the service. No rates shall be set, established, changed, modified or amended, unless according to the Ventura County Ambulance Ordinance.

COUNTY OF VENTURA

2010/11 Maximum Allowable Ambulance Rates

Pursuant to Ventura County Ordinance Code Section 2423-3, the following constitutes the schedule of maximum rates that may be charged, effective July 1, 2010

BASIC & ADVANCED LIFE SUPPORT (BLS & ALS) RATES

Charge	2010-11	Definition
BLS Base Rate (also known as Non-Emergency Rate)	$728.75	Transport from site of illness or injury to hospital or from hospital to home or other facility. This type of transport is arranged in advance of the transport.
Total BLS Emergency Response	$966.00	Response to 9-1-1 medical request.
Mileage	$29.75	Rate per mile from point of pickup to hospital. This charge is pro rated among the patients if more than one (1) patient is transported.

ADVANCED LIFE SUPPORT (ALS) RATES

Basic ALS Charge	$1,429.75	Charge made to patient for provision of Advanced Life Support measures using VC EMS prior to contact protocols or when ordered by the Base Hospital.

No charge is made for dispatch that is cancelled or that results in no provision of prehospital care.

Policy Title: Emergency Medical Technician Scope of Practice		Policy Number 300
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 1, 2010
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: December 1, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 1988 October 1, 2010 October10, 2010 October 31, 2013	Effective Date: December 1, 2010

I. PURPOSE: To define the scope of practice of an Emergency Medical Technician (EMT) practicing in Ventura County.

II. AUTHORITY: Health and Safety Code, Section 1797.107, 1797.109, 1797.160, 1797.170, and California Code of Regulations, Title 22, Division 9, Section 100063, 10063.1 and10064. Reference: Sections 1797.170 and 1797, Health and Safety Code.

III. POLICY:

A. During training, while at the scene of an emergency and during transport of the sick or injured, or during interfacility transfer, a supervised EMT trainee or certified EMT is authorized to do any of the following:

1. Evaluate the ill and injured
2. Render basic life support, rescue and emergency medical care to patients.
3. Obtain diagnostic signs to include, but not be limited to the assessment of temperature, blood pressure, pulse and respiration rates, level of consciousness, and pupil status.
4. Perform cardiopulmonary resuscitation, including the use of mechanical adjuncts to basic cardiopulmonary resuscitation.
5. Use the following adjunctive airway breathing aids:
   a. oropharyngeal airway
   b. nasopharyngeal airway
   c. suction devices
   d. basic oxygen delivery devices; and
   e. manual and mechanical ventilating devices designed for prehospital use.
6. Use various types of stretchers and body immobilization devices.
7. Provide initial prehospital emergency care of trauma.

8. Administer oral glucose or sugar solutions.
9. Extricate entrapped persons.
10. Perform field triage.
11. Transport patients.
12. Set up for ALS procedures, under the direction of a Paramedic.
13. Perform automated external defibrillation when authorized by an EMT AED service provider.
14. Monitor intravenous lines delivering glucose solutions or isotonic balanced salt solutions including Ringer's lactate for volume replacement;
15. Monitor, maintain, and adjust if necessary in order to maintain, a preset rate of flow and turn off the flow of intravenous fluid; and
16. Transfer a patient, who is deemed appropriate for transfer by the transferring physician, and who has nasogastric (NG) tubes, gastrostomy tubes, heparin locks, Foley catheters, tracheostomy tubes and/or indwelling vascular access lines, excluding arterial lines;
17. Assist patients with the administration of physician-prescribed nitroglycerin, epinephrine devices, inhalers and nebulizers. At the request of the patient the EMT can perform the following:
    a. Nitroglycerin: Remove the medication from the bottle and place under the tongue, or apply spray onto the tongue.
    b. Epinephrine devices: Administer the injection.
    c. Inhalers and nebulizers: Administer one or more puffs.

I. PURPOSE: To identify the procedure for certification of Emergency Medical Technician.

II. AUTHORITY: California Code of Regulations (CCR) Title 22, Division 9, Article 4, Section 100079, Health and Safety Code Section 1797.50 and 1797.175.

III. POLICY:

A. General Eligibility

In order to be eligible for certification, an individual shall:

1. Have a valid EMT course completion record or other documented proof of successful completion of any initial EMT course approved pursuant to Section 100066 of the CCR also see Section III.C.2.c.

   <u>or</u>

   Have documentation of successful completion of an approved out of state initial EMT training course, within the last two years which meets the requirements of CCR 100079,

2. Apply for certification within two years of the date of completion,

3. Pass a competency based written and skills certifying examination approved by the EMS Authority,

4. Be eighteen years of age or older,

5. Complete the Ventura County EMS (VCEMS) Personnel Application,

6. Complete the Ventura County Eligibility Statement (a statement that the individual is not precluded from certification for reasons defined in Section 1798.200 of the Health and Safety Code),

7. Have successfully completed a Professional Rescuer or Healthcare Provider level BLS & CPR course, which is consistent with the American Heart Association 2005 Guidelines for CPR and ECC, within the previous two years,

8. VCEMS will administer a CPR skills evaluation using a recording/reporting manikin and will require a pass rate of 80% prior to issuance of an EMT Certification.
9. Provide a government issued form of identification,
10. Pay the established State and County certification fee
11. Complete a background investigation via “Live Scan” through the California Department of Justice and Federal Bureau of Investigation for VCEMS as the requesting agency and a secondary notification for the State of California Emergency Medical Services Authority. Submit a copy of the “Request for Live Scan Services” form along with your application for certification as proof the service has been completed.
12. The individual will be issued a wallet size certificate after the above steps are completed and the applicant has passed the criminal background clearance. The effective date of certification shall be the date the individual satisfactorily completes all certification requirements. The certification expiration date will be:
    a. Two years from the date of passing the National Registry’s written examination,
       or
    b. Two years from successfully completing the EMT Certification requirements.
13. It is the responsibility of the certified EMT to notify VCEMS within 7 days of any change in their eligibility status as outlined in Health and Safety Code, Division 2.5, Section 1798.200. (For items that this Section applies to, see EMS Personnel Application, Eligibility Statement.)

B. Lapse in EMT Advanced Certification or Paramedic License:
   1. In order for an individual whose California EMT Advanced Certification or Paramedic license has lapsed, to be eligible for certification as an EMT the individual shall:
      a. For a lapse of less than six months, the individual shall comply with the requirements by complying with VCEMS Policy 302, III. A or B.
      b. For a lapse of six months or more, but less than twelve months, the individual shall comply with the requirements of VCEMS Policy 302, III A or B and complete an additional twelve hours of continuing education for a total of 36 hours of training.

c. For a lapse of twelve months or more, but less than 24 months, the individual shall comply with the requirement in VCEMS Policy 302, III, A or B and complete an additional twenty-four hours of continuing education for a total of 48 hours of training and the individual shall pass the EMT written and skills certification exam.

d. For a lapse of greater than twenty four months or more the individual shall complete an entire EMT course and comply with the requirements of Section III A of this policy.

C. Challenge and Reciprocity

1. An individual currently licensed in California as a Paramedic or is certified in California as an EMT Advanced (except when the Paramedic license or EMT Advanced certification is under suspension) is deemed to be certified as an EMT with no further testing upon fulfilling the requirements of III.A.3-11.

   a. For those individuals that possess a current and valid Paramedic License, the expiration date shall be the same date as the expiration date on the Paramedic License.

2. Certification as an EMT shall be valid for a maximum of two (2) years from the date that the individual passes the National Registry EMT-Basic certifying exam, except in the following cases:

   a. A person who possesses a current and valid out-of-state EMT-Intermediate or Paramedic license, the expiration date shall be the same expiration date as stated on the out-of-state certification/license but in no case shall exceed two (2) years from the effective date upon fulfilling the requirements of III.A.3-11.

   b. A person who possesses a valid National Registry issued EMT-Basic, EMT-Intermediate or Paramedic certification, the expiration date shall be two (2) years from the date of passing the National Registry examination, but in no case shall the expiration date of certification exceed two (2) years from the effective date upon fulfilling the requirements of III.A.3-11.

   c. An individual who possesses a current and valid out-of-state EMT certificate shall be eligible for certification upon fulfilling the requirements of III.A.3-11.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Emergency Medication Technician Recertification</td><td colspan="2">Policy Number
302</td></tr>
<tr><td colspan="2">APPROVED:
EMS Administrator: Steven L. Carroll, EMT-P</td><td colspan="2">Date: December 1, 2010</td></tr>
<tr><td colspan="2">APPROVED:
Medical Director: Angelo Salvucci, M.D.</td><td colspan="2">Date: December 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>June 1, 1984
October 1, 2010
October 14, 2010
October 31, 2014</td><td>Effective Date:</td><td>December 1, 2010</td></tr>
</table>

I. PURPOSE: To identify the procedure for recertification of the Emergency Medical Technician.

II. AUTHORITY: Health and Safety Code, Sections 1797.220, 1798. California Code of Regulations (CCR), Title 22 Article 5.

III. POLICY: In order to maintain certification, an EMT shall participate in either continuing education courses or complete a refresher course approved by the Agency. Approved continuing education courses shall be accepted statewide.

A. Continuing Education Method: Continuing education shall be in any of the topics contained in the United States Department of Transportation EMT Basic National Standard Curriculum, DOT HS 808149, August 1994. All approved CE shall contain a written and/or skills competency based evaluation related to course, class or activity objectives.

1. Completion of a minimum of twenty-four hours of education in basic life support knowledge and skills per the following guidelines:

a. Examples of applicable C.E.:

1) Courses offered by the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS). Original course completion record is required.

2) Courses with a California EMS Agency provider number. Original course completion record is required.

3) Courses approved by EMS Offices in other States. Original course completion document is required.

4) Courses in physical, social or behavioral sciences (e.g., anatomy, physiology, sociology, psychology) offered by accredited colleges and universities. Official Transcript must be submitted.

a) Ten continuing education hours will be awarded for each academic quarter unit or fifteen continuing education hours will be awarded for each academic semester unit.

5) Out of State C.E. not approved by an EMS Office in another State must be approved by the California EMS Authority.

b. CE Limitations

1) At least fifty percent of the required C.E. hours must be in a format that is instructor based.

2) An individual may receive credit for taking the same CE course, class or activity no more than two times during a single certification period.

3) Credit as an instructor for an EMT training program, not to exceed 50% of the total required hours and may only be credited one time during any single certification period.

4) C.E. records are valid for no more than two years.

2. Submit a completed EMT Skills Competency Verification form, EMSA-SCV (07/03). Original form must be submitted, copies will not be accepted. (Skills competency is not included in the twenty-four hours of required continuing education). Skills competency shall be verified by an individual who is currently certified or licensed as an EMT, EMTI, Paramedic, RN, PA, or physician and who shall be designated by an EMS approved training program (EMT training program, paramedic training program or continuing education provider) or an EMS service provider; (EMS service providers include, but are not limited to public safety agencies, private ambulance providers and other EMS providers). The skills requiring verification of competency are:

a. Patient examination – Trauma patient

b. Patient examination – Medical patient

c. Airway emergencies

d. Breathing emergencies

e. Cardiopulmonary Resuscitation and Automated External Defibrillation

f. Circulation emergencies

g. Neurological emergencies

h. Soft tissue injuries

i. Musculoskeletal injuries

j. Obstetrical emergencies

3. Successfully complete a Professional Rescuer or Healthcare Provider level BLS & CPR course, which is consistent with the American Heart Association 2005 Guidelines for CPR and ECC, within the previous two years.
4. Unless employed by a VCEMS provider, VCEMS will administer a CPR skills evaluation using a recording/reporting manikin; will require a pass rate of 80% prior to EMT recertification. If employed by a VCEMS Provider, will submit printed documentation of successful completion of CPR Skills using a recording/reporting manikin and will require a pass rate of 80% within the previous 90 days.
5. Applicants for recertification may attain CE at anytime through the valid certification period. If the applicant applies for recertification within the 6 months prior to the end of the current expiration date, the new expiration date shall be two years from the previous expiration date. If the applicant applies for recertification greater than 6 months prior to the end of the current certification period, the expiration date shall be the final day of the month of the 2 year period in which certification requirements are met.
    a. Applicants shall provide original course completion records at time of application. VCEMS will verify continuing education, copy and return originals to the applicant.
    b. Approved Ventura County ALS and BLS Provider Agencies may submit documentation of continuing education for their staff on the attached continuing education roster provided they were the provider of the education. Continuing education not obtained by a Ventura County provider must be documented by submission of course completion records. Continuing education may be audited.
6. Applicants must possess a valid EMT Certificate, which has been expired for no more than two-years to be eligible for recertification.
7. A new applicant to VCEMS, or an applicant whose certification has lapsed, must complete a background investigation via “Live Scan” through the California Department of Justice and Federal Bureau of Investigation for VCEMS as the requesting agency and a secondary notification for the State of California Emergency Medical Services Authority. Submit the second copy of the “Request for Live Scan Services” form along with EMS application for certification as proof the service has been completed.

8. VCEMS will obtain a computer generated photograph of each applicant at time of application for identification purposes. For those applicants with a current photograph in the VCEMS database, this requirement may be waived.
9. It is the responsibility of the certified EMT to notify VCEMS within 7 days of any change in their eligibility status as outlined in Health and Safety Code, Division 2.5, Section 1798.200. (For items that this Section applies to, see EMS Personnel Application, Eligibility Statement.)
10. The individual will be issued a wallet size certificate after certification requirements are completed. The effective date of certification shall be the date the individual satisfactorily completes all certification requirements. The certification expiration date will be:
    a. Two years from the date of passing the National Registry's written examination,
       or
    b. Two years from successfully completing the EMT Certification requirements.

Refresher Course Method

1. Completion of a twenty-four hour refresher EMT course, not including testing.
2. Submit a completed EMT Skills Competency Verification form, EMSA-SCV (07/03). (Skills competency is not included in the twenty-four hours of required continuing education). Skills competency shall be verified by an individual who is currently certified or licensed as an EMT, EMTI, Paramedic, RN, PA, or physician and who shall be designated by an EMS approved training program (EMT training program, paramedic training program or continuing education provider) or an EMS service provider; (EMS service providers include, but are not limited to public safety agencies, private ambulance providers and other EMS providers). The skills requiring verification of competency are:
    a. Patient examination – Trauma patient
    b. Patient examination – Medical patient
    c. Airway emergencies
    d. Breathing Emergencies
    e. Cardiopulmonary Resuscitation and Automated External Defibrillation
    f. Circulation emergencies
    g. Neurological emergencies
    h. Soft tissue injuries
    i. Musculoskeletal injuries

j. Obstetrical emergencies

3. Completion of Agency required updates.
4. Successful completion of a Professional Rescuer or Healthcare Provider level BLS & CPR course, which is consistent with the American Heart Association 2005 Guidelines for CPR and ECC, within the previous two years.
5. VCEMS will administer a CPR skills evaluation using a recording/reporting manikin with a pass rate of 80% prior to issuance of a EMT Certification.
6. Applicants must possess a valid EMT certificate which has been expired for no more than two years to be eligible for recertification.
7. A new applicant to VCEMS, or an applicant whose certification has lapsed, must complete a background investigation via "Live Scan" through the California Department of Justice and Federal Bureau of Investigation for VCEMS as the requesting agency and a secondary notification for the State of California Emergency Medical Services Authority. Submit the second copy of the "Request for Live Scan Services" form along with the application for certification as proof the service has been completed.
8. VCEMS will obtain a computer generated photograph of each applicant at time of application for identification purposes only. For those applicants with a current photograph in the VCEMS database, this requirement may be waived.
9. It is the responsibility of the certified EMT to notify VCEMS within 7 days of any change in their eligibility status as outlined in Health and Safety Code, Division 2.5, Section 1798.200. (For items that this Section applies to, see EMS Personnel Application, Eligibility Statement.)
10. The individual will be issued a wallet size certificate after certification requirements are completed. The effective date of certification shall be the date the individual satisfactorily completes all certification requirements. The certification expiration date will be:
    a. Two years from the date of passing the National Registry's written examination,
       or
    b. Two years from successfully completing the EMT Certification requirements.

C. Recertification after Lapse in Certification:

In order to be eligible for recertification for an individual who's EMT Certification has lapsed to be eligible for recertification, the following requirements shall apply.

1. For a lapse of less than six months, the individual shall comply with the requirements contained in III A or B above.
2. For a lapse of six months or more, but less than twelve months, the individual shall comply with the requirements contained in 3, A or B above and complete an additional twelve hours of continuing education for a total of 36 hours of training.
3. For a lapse of twelve months or more, but less than 24 months, the individual shall comply with the requirements contained in 3 A or B above and complete an additional twenty-four hours of continuing education; for a total of 48 hours of training and the individual shall pass the National Registry written and skills exam.
4. For a lapse of greater than twenty-four months the individual shall complete an entire EMT course and comply with the requirements contained in VCEMS Policy 301.

State of California
EMT Skills Competency Verification Form
EMSA – SCV (07/03)

See back of form for instructions for completion

1a. Name as shown on EMT Certificate	1b. Certificate Number	1c. Signature
1d. Certifying Authority	1e. Date	I certify, under the penalty of perjury, that the information contained on this form is accurate.

Skill	**Verification of Competency**	
1. Patient examination, trauma patient;	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
2. Patient examination, medical patient	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
3. Airway emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
4. Breathing emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
5. Automated external defibrillation	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
6. Circulation emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
7. Neurological emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
8. Soft tissue injury	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
9. Musculoskeletal injury	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number
10. Obstetrical emergencies	Affiliation	Date
Signature of Person Verifying Competency	Print Name	Certification / License Number

INSTRUCTIONS FOR COMPLETION OF EMT SKILLS COMPETENCY VERIFICATION FORM

A completed EMT Skills Verification Form is required to accompany an EMT recertification application for those individuals who are either maintaining EMT certification without a lapse or to renew EMT certification with a lapse in certification less than one year.

1a. Name of Certificate Holder
Provide the complete name, last name first, of the EMT certificate holder who is demonstrating skills competency.

1b. Certificate Number
Provide the EMT certification number from the current or lapsed EMT certificate of the EMT certificate holder who is demonstrating competency.

1c. Signature
Signature of the EMT certificate holder who is demonstrating competency. By signing this section the EMT is verifying that the information contained on this form is accurate and that the EMT certificate holder has demonstrated competency in the skills listed to a qualified individual.

1d. Certifying Authority
Provide the name of the EMT certifying authority for which the individual will be certifying through.

Verification of Competency

1. Affiliation - Provide the name of the training program or EMS service provider that the qualified individual who is verifying competency is affiliated with.
2. Once competency has been demonstrated by direct observation of an actual or simulated patient contact, i.e. skills station, the individual verifying competency shall sign the EMT Skills Competency Verification Form (EMSA-SCV 07/03) for that skill.
3. Qualified individuals who verify skills competency shall be currently licensed or certified as: An EMT, EMTI, Paramedic, Registered Nurse, Physician Assistant, or Physician and shall be either a qualified instructor designated by an EMS approved training program (EMT training program, paramedic training program or continuing education training program) or by a qualified individual designated by an EMS service provider. EMS service providers include, but are not be limited to, public safety agencies, private ambulance providers, and other EMS providers.
4. Certification or License Number – Provide the certification or license number for the individual verifying competency.
5. Date- Enter the date that the individual demonstrates competency in each skill.
6. Print Name: Print the name of the individual verifying competency in the skill.

Ventura County Emergency Medical Services Agency
2220 E. Gonzales Road, Suite 130
Oxnard, CA 93036
805-981-5301

APPLICANTS EMPLOYED BY AN APPROVED VENTURA COUNTY ALS/BLS PROVIDER MAY UTILIZE THIS FORM TO DOCUMENT CONTINUING EDUCATION OBTAINED BY THEIR EMPLOYER

ATTACH ORIGINAL COURSE COMPLETION FOR ANY COURSE NOT COMPLETED BY EMPLOYER AGENCY.

EMT Recertification by Continuing Education

Documentation of Hours

Name: ____ **Date:** _______________________ **EMT Certification #:** ___________________

24 Hours of approved EMS continuing education is required for EMT Recertification (course completion must have an EMS provider number). EMT ALS Assist monthly skills demonstrations do not count towards EMT Refresher hours. Please see policy 302 if certification has lapsed, as extra continuing education hours are required. In addition to continuing education must submit the EMT Skills Competency Verification Form.

Date of Course	Course Title	Provider	Provider #	# of Hours
			TOTAL HOURS	

I certify that I have completed all the hours and courses identified above. I further understand that no less than 10% of submitted C.E will be audited by the Ventura County EMS Agency. I further understand that if audited, I will be required to submit proof of all courses listed above.

Signature: ____ **Date:** ______________________________

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMT Course Completion by Challenge Examination		Policy Number 304
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 1, 2010
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: December 1, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 1, 1984 October 14, 200 October 14, 2010 October 31, 2013	Effective Date: December 1, 2010

I. PURPOSE: To identify the procedure for certification of the Emergency Medical Technician by challenge examination.

II. AUTHORITY: California Code of Regulations (CCR) Title 22, Division 9, Article 1, Section 100078 – Health and Safety Code Section 1797.107, 1797.170, 1797.208 and 1797.210.

III. POLICY:

A. General Eligibility

In order to be eligible to challenge EMT exam, an individual shall:

1. Be a currently Licensed Physician, Registered Nurse, Physician Assistant, or Vocational Nurse, , OR

2. The person provides documented evidence of having successfully completed an emergency medical service training program of the Armed Forces within the preceding two (2) years which meets the United States Department of Transportation EMT-Basic National Standard Curriculum, DOT HS 808 149, August 1994, which can be accessed through the U.S. Department of Transportation's website, http://www.nhtsa.gov/people/injury/ems/pub/emtbnsc.pdf. Upon review of documentation, the EMT certifying entity may also allow an individual to challenge if the individual was active in the last two (2) years in a prehospital emergency medical classification of the Armed Services, which does not have formal recertification requirements. These

individuals may be required to take a refresher course or complete CE courses as a condition of certification.

B. Examination

1. The course challenge examination shall consist of a competency based written and skills examination (National Registry) to test knowledge of the topics and skills per CCR 100078.
2. An approved EMT training program shall offer an EMT challenge examination (skills) on an as needed basis
3. The EMT certifying authority will administer the written test (National Registry) and designate such test as the certifying examination.
4. An eligible person shall be permitted to take the EMT course challenge examination only one time.
5 An individual who fails to achieve a passing score on the EMT course challenge examination shall successfully complete an EMT course to receive an EMT course completion record.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
Paramedic Scope of Practice</td><td>Policy Number:
310</td></tr>
<tr><td>APPROVED:
Administration:</td><td colspan="2">Steven L. Carroll, EMT-P</td><td>Date: December 1, 2010</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td colspan="2">Angelo Salvucci, M.D.</td><td>Date: December 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>May, 1984
October 14, 2010
October 14, 2010
October 31, 2013</td><td colspan="2">Effective Date: December 1, 2010</td></tr>
</table>

I. PURPOSE: To define the scope of practice of a Paramedic accredited and practicing in Ventura County.

II. AUTHORITY: Health and Safety Code Section 1797.172 and 1797.185. California Code of Regulations, Division 9, Chapter 4, Section 100145.

III. POLICY:

A. A paramedic may perform any activity identified in the Scope of Practice of an EMT or EMT Advanced as defined in regulations governing those certification levels.

B. A paramedic trainee or paramedic accredited in Ventura County, while caring for patients in a hospital as part of their training or continuing education, under the direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency, during transport, or during inter-facility transfer when medical direction is maintained by a physician or an MICN according to the policies and procedures approved by the Ventura County Emergency Medical Services Medical Director, may:

1. Perform pulmonary ventilation by use of oral endotracheal intubation or a Ventura County EMS approved alternative ALS airway management device.
2. Institute intravenous (IV) catheters, saline locks, needles or other cannulae (IV) lines, in peripheral veins.
3. Monitor and access pre-existing peripheral and central vascular access lines.
4. Administer intravenous D_5W and Normal Saline solutions.
5. Obtain venous blood samples.
6. Administer the following drugs:
    a. Activated charcoal
    b. Adenosine
    c. Aspirin
    d. Atropine sulfate

- e. Bronchodilators, Nebulized beta-2 specific
- f. Calcium chloride
- g. Dextrose, 50% and 25%
- h. Diazepam
- i. Diphenhydramine hydrochloride
- j. Dopamine hydrochloride
- k. Epinephrine
- l. Furosemide
- m. Heparin (Interfacility transfers)
- n. Glucagon hydrochloride
- o. Lidocaine hydrochloride
- p. Magnesium sulfate
- q. Midazolam
- r. Morphine sulfate
- s. Naloxone hydrochloride
- t. Nitroglycerine preparations, (oral only)
- u. Nitroglycerine preparations, IV (Interfacility transfers)
- v. Ondansetron
- w. Pralidoxime
- x. Sodium bicarbonate

7. Perform defibrillation.
8. Perform synchronized cardioversion.
9. Perform transcutaneous pacing
10. Visualize the airway by use of the laryngoscope and remove foreign body(ies) with forceps.
11. Perform Valsalva maneuver.
12. Monitor thoracostomy tubes.
13. Monitor and adjust IV solutions containing potassium <= 20 mEq/L.
14. Perform needle thoracostomy.
15. Perform blood glucose level determination.
16. Insertion of intraosseous needle and intraosseous infusion.

I. PURPOSE: To establish a mechanism for a Paramedic to become accredited to practice in Ventura County. The purpose of accreditation is to ensure that the Paramedic has: 1) completed the minimum required education and training, and 2) is oriented to the local EMS system.

II. AUTHORITY: Health and Safety Code Sections 1797.84, 1797.185, 1797.214, 1798 and California Code of Regulations, Title 22, Section 100166.

III. POLICY: Each Paramedic employed by a Ventura County ALS Provider shall be accredited to practice in Ventura County. A Paramedic shall apply for accreditation prior to working on an ALS Unit.

IV. PROCEDURE:

A. Application. Prior to beginning an Accreditation Internship and/or assignment to function as an Paramedic in the Basic Scope of Practice on an ALS Unit in Ventura County,

1. The Paramedic shall

a. Possess a current California Paramedic license. Verification of licensure through Emergency Medical Services Authority website will be allowed provided a copy of the wallet size paramedic license is received by EMS within 30 day of application date.

b. Possess a valid California driver's license.

c. Complete the Ventura County accreditation application process. (Note: Falsification of information on the application will result in immediate suspension of accreditation to practice as a Paramedic in Ventura County.)

1) Fill out a Ventura County Accreditation application. (Attachment A). Paramedic must notify VCEMS within 30 days of any contact information change.

2) Sign a statement that the individual is not precluded from accreditation to practice as a Paramedic for reasons defined in Section 1798.200 of the Health and Safety Code. (Attachment A).

3) Pay the established fee.

4) Complete a California Department of Justice (CA DOJ Live Scan) background check. Results of a CA DOJ background check include Notification of Subsequent Arrests. Background checks will not be repeated as long as accreditation remains active.

5) It is the responsibility of the accredited paramedic to notify VCEMS within 7 days of any change in their eligibility status as outlined in Health and Safety Code, Division 2.5, Section 1798.200. (For items that this Section applies to, see EMS Personnel Application, Eligibility Statement.)

2. The ALS Service Provider shall:

   a. Provide the applicant with his/her schedule for orientation, training and testing in skills and field evaluation.

B. Accreditation Internship:

1. Upon completion of the requirements of Section II.A.1-2 of this policy, the applicant is authorized to begin practice as a Paramedic Accreditation Intern in Ventura County.

2. During evaluation for accreditation, the Accreditation Intern shall be the third assigned VCEMS responder at the call and shall be under the direct supervision of a VC preceptor or FTO who is ultimately responsible for the patient care rendered by the Accreditation Intern.

3. An Accreditation Intern may work as the second Paramedic of a two Paramedic team on an ALS unit, but is limited to performance of the Basic Paramedic Scope of Practice, as defined in the California Code of Regulations, Title 22, Division 9, Chapter 4, and Section 100145(c) (1)(A-N). Shifts worked as a second Paramedic and any ALS skills performed

during those shifts will not be considered part of the accreditation evaluation process.

4. The applicant shall successfully complete, and provide written verification of satisfactory completion of a Ventura County Accreditation Process within 45 days of the date of the applicant's hire/start date. If the accreditation process is not completed within 45 days, a new accreditation application and fee to begin a new 45-day period will be required. The applicant may not apply more than three (3) times in one year. (Attachment B).
    a. An orientation of the local EMS system. This orientation shall not exceed eight (8) classroom hours and shall consist of the following:
        1) Orientation of ALS Service Provider responsibilities and practices.
        2) PCC Orientation
        3) VCEMS Orientation
    b. Complete a supervised pre-accreditation field evaluation consisting of a minimum of five (5) and maximum of ten (10) ALS patient contacts as the third assigned VCEMS responder with continuous supervision by an FTO from the beginning of assessment to transfer of patient care to hospital staff. An FTO/Clinical Coordinator/Operations Manager will sign off documentation of ALS patient contacts. The FTO will determine that the response included ALS assessment and treatment skills for all ALS patient contacts submitted for accreditation.
    c. Definition of an ALS Patient Contact: A patient contact where the paramedic successfully performs an ALS skill listed in VCEMS Policy 310, with the exception of glucose testing, cardiac monitoring and pulse oximetry.
    d. An applicant who, with the approval of the instructor, and having completed their internship in Ventura County (40 contacts), may use the last five (5) ALS patient contacts for accreditation purposes. In order to use these ALS patient contacts, an

applicant must have received a rating of three (3) in all categories on each of the five (5) ALS patient contacts.

e. Successful completion of training and testing of the applicant's knowledge of VCEMS optional scope of practice skills, procedures and medications. The applicant may be exempted from some or all of these requirements if s/he provides documentation of previous successful completion of a training program in any other jurisdiction.

f. Successful completion of testing in Ventura County policies and procedures.

C. Accreditation. Upon completion of the above requirements, the Paramedic shall call the EMS office for an appointment to complete the accreditation process or may submit the required documentation by mail.

1. If all requirements are met, a VCEMS Accreditation Card will be issued.

2. If requirements are not successfully completed, the application will be submitted to the EMS Medical Director for further action. The EMS Medical Director shall notify the applicant of his/her findings within 5 working days.

D. Adverse Accreditation Action.

1. Denial of Accreditation

a. Accreditation may be denied for failure to complete application requirements listed in Section IV.A or for failure to successfully complete the Accreditation requirements listed in Section IV.B.

b. The EMS Medical director will evaluate an applicant who fails to successfully complete the application and internship process and may recommend further education and evaluation as required.

c. Upon failure to successfully complete the requirements of Section IV.A or IV.B, the EMS MD will inform the applicant of the denial of accreditation by certified mail or hand delivery, with a complimentary copy to the ALS employer. The notice will include the specific facts and grounds for denial.

2. Suspension of Accreditation

   a. Accreditation may be suspended for failure to meet the requirements listed in Section IV.E.

   b. The EMS Medical Director will inform the Paramedic by written notice at least 15 days prior to the intended date of suspension. The notice will include the specific facts and grounds for suspension.

   c. Accreditation will be suspended until such time as the deficiencies are completed and documented to VCEMS.

3. Due Process. This will apply to the decision of the EMS MD to either deny or suspend an accreditation.

   a. The Paramedic may request reconsideration in writing, by certified mail or hand delivery. The EMS MD will respond to the request by certified mail or hand delivery within 5 working days.

   b. If the matter is not resolved after reconsideration, the Paramedic may request that an Investigative Review Panel (IRP) be convened.

   c. The IRP will be conducted according to VCEMS Policy 330.

   d. The IRP will report its findings to the MD who will make a final determination of action.

   e. The MD will notify the Paramedic of the final determination of action by certified mail within 5 working days of receipt of the IRP report.

E. Accreditation Period

The accreditation to practice period shall coincide with the individual's Paramedic license. Accreditation to practice shall be continuous as long as the following is maintained:

1, California State Paramedic Licensure

2. The Paramedic continues to meet requirements for updates in VCEMS policy, procedure, protocol and local optional scope of practice, and continues to meet requirements of the system-wide CQI program.

F. Lapse of Accreditation. If a Paramedic does not maintain Ventura County accreditation requirements, the following requirements must be met to re-establish eligibility:

1. Completion of application as described in Section IV.A.
2. In addition, the following shall be met:
   a. If the period of lapse of accreditation is 1-31 days, the Paramedic shall complete the requirements for continuing accreditation as defined in Section IV.E.
   b. If the period of lapse of accreditation is greater than 31 days and less than one year, complete requirement described in Section IV.B.4.b and complete any items which are new since the Paramedic was last accredited.
   c. If the period of lapse of accreditation is greater than one year, the applicant must complete all the requirements specified in Section IV.B.

Print Form

Ventura County Emergency Medical Services
2220 East Gonzales Road, Suite 130
Oxnard, CA 93036
Telephone: 805-981-5301
Fax: 805-981-5300
www.vchca.org/ph/ems

EMS PERSONNEL APPLICATION

This application is for: ☐ EMT Certification ☐ EMT Recertification ☐ Paramedic Accreditation ☐ Paramedic Internship

Last Name ______ **First Name** ______ **MI** ___ **Birth Date** ______

Address ______ **City** ______ **State** ______ **Zip** ______

Phone# ______ **E-Mail** ______

SS# ______ **CDL #** ______ ☐ **Male** ☐ **Female**

Primary EMS Employer Name & Address ______ Hire Date ______

Additional EMS Employer Name & Address ______ Hire Date ______

Previous Certification/License/Accreditation

◯ EMT Certification ◯ Paramedic Accreditation ◯ Other ______

Previous Certification/Accreditation/ License # ______ Previous Expiration Date ______ State/ County ______

Training Facility: EMT Program ☐ Paramedic School ☐ CE (Submit Original Course Completions) ☐

Facility Name: ______ Completion Date: ______

All Applicants Must Complete the Following Questions or the Application Will Be Returned

Have you ever applied for an EMT-I, II, or Paramedic certificate/license or accreditation in another County or State ☐ Yes ☐ No

If YES, was the certificate/accreditation/license issued? ☐ Yes ☐ No

If certificate/accreditation/license was not issued attach a detailed statement of explanation.

Have you ever been convicted of any felony or misdemeanor offense in California or in any other state or place, including entering a plea of Nolo Contendere (No Contest), or any conviction which has been expunged (set aside) or record(s) sealed under Penal Code 1203.4 ? ☐ Yes ☐ No

If YES, attach a detailed statement that describes the incident, charge(s), date, location, court, sentence served, and probation or parole (if any). Also attach any applicable court documents and police reports.

Are there any criminal charges currently pending against you? ☐ Yes ☐ No

If YES, attach a detailed statement that describes the incident, charge(s) pending and date and location of occurrence. Also attach any applicable court documents and police reports.

Have you ever had a certification, accreditation, or professional healing arts license denied, suspended, revoked or placed on probation, or are you under investigation at this time? ☐ Yes ☐ No

If YES, attach a detailed statement that describes the action, any corrective action, and/or remediation as a result of the action.

I hereby certify **under penalty of perjury** that all the information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT Certification or Paramedic Accreditation in the State of California. I understand all information on this application is subject to verification, and I hereby give my express permission for the Ventura County EMS Agency to contact any person or agency for information related to my role and function as an EMT or Paramedic in California.

Signature of Applicant ______ **Date** ______

Ventura County Emergency Medical Services
2220 East Gonzales Road, Suite 130
Oxnard, CA 93036
Telephone: 805-981-5301
Fax: 805-981-5300
www.vchca.org/ph/ems

ELIGIBILITY STATEMENT

Submit with EMS Application

Health and Safety Code Section 1798.200, Division 2.5 states that the Medical Director may place a certificate holder on probation, suspend, or revoke any certificate issued under the following provisions and in accordance with the California Emergency Medical Services Authority, upon the finding of the Medical Director of an imminent threat to the public health and safety as evidenced by the occurrence of any of the following:

- Fraud in the procurement of a professional certificate
- Gross negligence
- Repeated workplace negligent acts.
- Incompetence in workplace performance.
- The commission of any fraudulent, dishonest, or corrupt acts, which is substantially related to the qualifications, functions and/or duties of a prehospital care provider.
- Conviction of any crime, which is substantially related to the qualifications, functions and/or duties of a prehospital care provider.
- Violating or attempting to violate directly or indirectly, or assisting in, or abetting the violation of, or conspiring to violate, any provision promulgated by the California EMS Authority pertaining to prehospital care.
- Violating or attempting to violate any federal, state, or local statute, or regulation, which regulates narcotics, dangerous drugs, or controlled substances.
- Addiction to the excessive use of, or misuse of, alcoholic beverages, narcotics, dangers drugs, or controlled substances.
- Functioning outside the scope of practice of a prehospital care provider as determined by certification, accreditation, or licensure
- Demonstration of irrational behavior or occurrence of physical disability reasonable cause to believe that the ability to perform the duties normally expected may be impaired.
- Unprofessional conduct exhibited by any of the following: The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT-I or EMT-P from assisting a peace officer, or a peace officer that is acting in the dual capacity of peace officer and EMT-I or EMT-P from using that force that is reasonably necessary to affect a lawful arrest or detention.
- The failure to maintain confidentiality of patient medical information, except, as disclosure is otherwise permitted or required by law in Section 56 to 56.6, inclusive, of the Civil Code.

It is the responsibility of the Certified EMT or Accredited Paramedic to notify the Ventura County EMS Agency within 7 days of any arrest or change in their eligibility status as listed above.

I hereby certify under penalty of perjury that I have read and understand the Eligibility Statement. I have truthfully answered all of the information I provided on this application and it is true and correct to the best of my knowledge and belief. I further understand that if I violate any of the items listed in this eligibility statement I must report that to Ventura County EMS Ageny within 7 days of the event or my certification/accreditation may be revoked, suspended, or placed on probation. I hereby state that I am not precluded from certification for any of the reasons identified above.

Printed Name ______________________ Date ______________

Signature ______________________

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
ALS Response Unit Staffing</td><td>Policy Number:
318</td></tr>
<tr><td>APPROVED:
Administration:</td><td colspan="2">Steven L. Carroll, EMT-P</td><td>Date: December 1, 2010</td></tr>
<tr><td>APPROVED:
Medical Director</td><td colspan="2">Angelo Salvucci, MD</td><td>Date: December 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>June 1, 1997
October 14, 2010
October 14, 2010
October 31, 2014</td><td>Effective Date:</td><td>December 1, 2010</td></tr>
</table>

I. PURPOSE: To establish medical control standards for ALS response unit paramedic staffing.

II. AUTHORITY: Health and Safety Code, Sections 1797.214, 1797.220, 1798, and 1798.200 22 CCR Division 9, Chapter 4, Sections 100175, 100179

III. DEFINITIONS:

A. ALS Response Unit: First Response ALS Unit, Ambulance Support Vehicle, or ALS Ambulance per VCEMS Policies 506 and 508.

B. Definition of an ALS Patient Contact: A patient contact where the paramedic successfully performs an ALS skill listed in VCEMS Policy 310, with the exception of glucose testing, cardiac monitoring and pulse oximetry.

IV. POLICY:

A. All ALS Response Units must be staffed with a minimum of one Level II paramedic who meets the requirements in this policy.

B. Additional ALS Response Unit staff may be a Level I or II paramedic meeting the requirements in this policy and/or an EMT-1 meeting requirements in VCEMS Policy 306.

C. An ALS Response Unit may be staffed with a paramedic who is not authorized as a Level I or II only if is also staffed by an authorized Ventura County Paramedic Preceptor.

V. PROCEDURE:

A. Level I

1. A paramedic will have Level I status upon completion of the following:

a. Current Paramedic Licensure by the State of California

b. Current Accreditation in the County of Ventura per VCEMS Policy 315.

2. To maintain Level I status, the paramedic shall:

a. Maintain employment with an approved Ventura County ALS service provider.

b. Complete a minimum of 288 hours of practice as a paramedic or 30 patient contacts (minimum of 15 ALS) every six month period (January 1 – June 30 and July 1 – December 31);

c. Complete VCEMS continuing education requirements, as described in Section V.C.

3. If the paramedic fails to meet these requirements, s/he is no longer authorized as a Level I paramedic.

4. To be reauthorized as a Level I paramedic, the paramedic must complete a minimum of 48 hours as a second or third crewmember of direct field observation by an authorized Ventura County Paramedic Preceptor, to include a minimum of 5 ALS contacts.

B. Level II

1. A paramedic will have Level II status upon completion of the following:

a. Employer approval.

b. All of the requirements of Level I.

c. A minimum of 288 hours of direct field observation by an authorized Ventura County Paramedic Preceptor.

1) This will include a minimum of 30 patient contacts, (minimum 15 ALS contacts).

2) If a paramedic has a minimum of 4000 hours of prehospital field experience performing initial ALS assessment and care, Ventura County Preceptor observation with the approval of the Paramedic Preceptor and PCC may be reduced to 144 hours or 20 patient contacts (minimum 10 ALS).

d. Approval by the paramedic preceptor who evaluated the majority of contacts.

e. Successful completion of competency assessments:

1) Scenario based skills assessment conducted by the candidate's preceptor, provider's clinical coordinator, PCC and PLP when possible.

2) Written policy competency assessment administered by VCEMS. Passing score will be 80%.

3) Arrhythmia recognition and treatment assessment administered by VCEMS. Passing score will be 80%.

4) Candidates who fail to attain 80% on either section V.B.e.2)-3) shall attend a remediation session with the Base Hospital PLP or designee or the provider's Medical Director prior to retaking either assessment. Written documentation of remediation will be forwarded to VCEMS.

f. Obtain favorable recommendations of the PCCs who have evaluated the paramedic during the upgrade process. The PCC's recommendations will be based upon a review of the completed performance evaluation standards, review of patient contacts and direct clinical observation. Appeals may be made to the VCEMS Medical Director.

g. Forward Appendix A, Appendix B and copies of the 30 patient contacts to VCEMS.

1) Appendix A shall include all dates and times the upgrading paramedic has spent with the preceptor to total a minimum of 288 hours.

2) Appendix B shall be completed each shift per the Method of Evaluation Key at the bottom of the form.

3) Submit 30 patient contacts, 15 meeting criteria as defined in Section III, Definitions, ALS Patient Contact.

2. To maintain Level II status, the paramedic shall:

a. Maintain employment with an approved Ventura County ALS service provider.

b. Function as a paramedic for a minimum of 576 hours, or have a minimum of 60 patient contacts (minimum 30 ALS), over the previous six-month period (January 1 – June 30 and July 1 – December 31).

1) For those paramedics with a minimum of 3 years field experience, no more than 144 hours of this requirement may be met by documentation of actual instruction at approved PALS, PEPP, ACLS, PHTLS, BTLS, EMT-1 or Paramedic training programs.

2) With the approval of the EMS Medical Director, for those paramedics with a minimum of 3 years of field experience in Ventura County, are employed as a field paramedic in another county or work in an acute care setting (RN or LVN) on a full time basis, complete a minimum of 288 hours of practice, or 30

patient contacts (minimum 15 ALS), in the previous 6 month period in Ventura County.

3) A paramedic whose primary duties are administering the ALS Program (90% of the time) for his/her agency and with approval of the EMS Medical Director may maintain his/her level II status by performing a minimum of 5 ALS calls per 6 months (January 1 – June 30 and July 1 – December 31).

4) If the paramedic fails to meet this requirement:

a) His/her paramedic status reverts to Level I.

b) If Level II authorization has lapsed for less than six months, reauthorization will require completion of a minimum of 96 hours of direct field observation by an authorized Ventura County Paramedic Preceptor, to include a minimum of 10 ALS patient contacts.

c) If Level II authorization has lapsed for less than one year and the paramedic has not worked as a paramedic for 6 months or more during the lapse interval OR if Level II authorization has lapsed for greater than one year, reauthorization will require completion of all of the requirements in Section V.B.1. These requirements may be reduced at the discretion of the VCEMS Medical Director.

d) If the paramedic has been employed as a paramedic outside of Ventura County or has worked in an acute care setting (RN or LVN) during the period of lapse of authorization, these requirements may be reduced at the discretion of the VCEMS Medical Director.

e) Complete VCEMS continuing education requirements, as described in Section V.C.

C. Continuing Education Requirements

Fifty percent (50%) of all CE hours shall be obtained through Ventura County approved courses and 50% of total CE hours must be instructor based.

1. Advanced Cardiac Life Support (ACLS) certification shall be obtained within three months and either Pediatric Advanced Life Support (PALS) certification or Pediatric Education for Prehospital Providers (PEPP) shall be obtained within six months, and remain current.

2. Field Care Audits (Field care audit): Twelve (12) hours per two years, at least 6 of which shall be attended in Ventura County. Base Hospitals will offer Field care audit sessions.
3. Periodic training sessions or structured clinical experience (Lecture/ Seminar) as follows:
    a. Attend one skills refresher session in the first year of the license period, one in the second year, and one every year thereafter.
    b. Education and/or testing on updates to local policies and procedures.
    c. Completion of Ventura County Multi-Casualty Incident training per VCEMS Policy 131.
    d. Successful completion of any additional VCEMS-prescribed training as required. These may include, but not be limited to:
        1) Education, and/or testing, in specific clinical conditions identified in the quality improvement program.
        2) Education and/or testing for Local Optional Scope of Practice Skills.
        3) The remaining hours may be earned by any combination of field care audit, Clinical hours, Self-Study/Video, Lecture, or Instruction at ALS/BLS level. Clinical hours will receive credit as 1-hour credit for each hour spent in the hospital and must include performance of Paramedic Scope of Practice procedures. The paramedic may be required by his/her employer to obtain Clinical Hours. The input of the Base Hospital Prehospital Care Coordinator and/or Paramedic Liaison Physician shall be considered in determining the need for Clinical Hours.
        4) One endotracheal intubation refresher session per six (6) month period based on license cycle, to be held by a Base Hospital, ALS Provider Medical Director approved by the VCEMS Medical Director, or the VCEMS Medical Director.
        5) Successfully complete a CPR skills evaluation using a recording/reporting manikin once per six (6) month period based on license cycle.

4. Courses shall be listed on the Ventura County Accreditation Continuing Education Log and submitted to VCEMS upon reaccreditation. Continuing education listed on the continuing education log is subject to audit.

D. The VCEMS Medical Director may temporarily suspend or withdraw Level I or Level II authorization pending clinical remediation.

E. Failure to comply with the standards of this policy will be considered to be operating outside of medical control.

F. ALS Service Providers must report any change in Level I/II status to VCEMS within 5 days of taking action.

Appendix A

PARAMEDIC UPGRADE EMPLOYER RECOMMENDATION FORM

Employer: Please instruct the paramedic to complete the requirements in the order listed. Employer shall contact PCC to schedule appointment.

____, paramedic has been evaluated and has met all criteria for upgrade to Level II status as defined in Ventura County EMS Policy 318.

Level II Paramedic

______ All the requirement of level I met.
______ Completion of 288 hrs of direct field observation by an authorized VC Paramedic Preceptor
______ Approval by Paramedic preceptor
______ Submit all appropriate documentation to VCEMS including

	Date	Hours	Preceptor Print legibly		Date	Hours	Preceptor Print legibly
1				9			
2				10			
3				11			
4				12			
5				13			
6				14			
7				15			
8				16			
Total Hours Completed							

Please sign and date below for approval.

I have reviewed all supporting documentation and it is attached to this recommendation.

Paramedic Preceptor Signature	Print preceptor name legibly	Date:
Employer Signature	Print Employer name legibly	Date

Per section V.B.1.c.2): PCC signature required if paramedic qualifies for shortened upgrade process.

PCC Signature	Print PCC signature legibly	Date

Appendix B

Ventura County EMS Upgrade Procedure			**288 hours or 12 shifts 30 patient contacts (minimum of 15 ALS)**		
Shift	**Policy**	**Procedure/Policy Title to Review**	**Date**	**Preceptor Signature**	**Method of Evaluation (see key)**
1	310 704 705* 726 727 334 1005	Paramedic Scope of Practice Base Hospital Contact General Patient Guidelines SVT VT Cardiac Arrest – Asystole/PEA Cardiac Arrest – VF/VT Symptomatic Bradycardia Acute Coronary Syndrome Transcutaneous Cardiac Pacing 12 Lead ECG Prehospital Personnel Mandatory Training Requirements Communication Failure			
2	720 705 614	Limited Base Contact Trauma Assessment/Treatment Guidelines Altered Neurological Function Overdose Seizures Spinal Immobilization			
3	705*	Behavioral Emergencies Burns Childbirth Crush Injury Heat Emergencies Hypothermia Hypovolemic Shock Bites and Stings Nerve Agent Nausea/Vomiting Pain Control			
4	705* 705 1404 1405 1000	Allergic/Adverse Reaction and Anaphylaxis Neonatal Resuscitation Shortness of Breath – Pulmonary Edema Shortness of Breath – Wheezes/other Trauma Assessment/Treatment Guidelines Guidelines for Inter-facility Transfer of Patients to a Trauma Center Trauma Triage and Destination Criteria Documentation of Prehospital Care			
5	710 713 715 716 717 728 722	Airway Management Intralingual Injection Needle Thoracostomy Pre-existing Vascular Access Device Intraosseous Infusion King Airway Transport of Pt. with IV Heparin and NTG			

6	600 601 603 606 613 306	Medical Control on Scene Medical Control at the Scene – EMS Personnel Against Medical Advice Determination of Death Do Not Resuscitate EMT-I: Req. to Staff an ALS Unit			
**		Notify PCC of progress and set dates for tests and ride-a-long.			
7	402 612 618	Patient Diversion/ED Closure Notification of Exposure to a Communicable Disease Unaccompanied Minor ECG Review Radio Communication			
8	 131 607 1202 1203	Mega Codes MCI Hazardous Material Exposure-Prehospital Protocol Air Unit Dispatch for Emergency Medical Response. Criteria for Patient Emergency Transportation			
9		Multiple System Evaluation Review Head to Toe Assessments			
10		Practice Tests			
11		Review Policies and Procedures			
12		Review Policies and Procedures			
	*	Review Drugs, rates and routes that are present in that policy			
	**	PCC ride-a-long			
	**	PCC, Clinical Coordinator, Preceptor and Base Hospital Medical Director interview and scenario			
		Written Test			

Paramedic Name: ____________________________ **License. #**________________**Date**_________________

Preceptor Signature____ **Date**____________________

PCC Signature____ **Date**_____________________

Employer Signature: _______________________________________ **Date:** ___________________

METHOD OF EVALUATION KEY

E = EMEDS Review
S = Simulation/Scenario
D = Demonstration

T = Test/Self Learning Module

DO = Direct Observation in the field or clinical setting
V = Verbalizes Understanding to Preceptor
NA = Performance Skill not applicable to this employee

Appendix C

NAME: ____

EMPLOYER: ________________LICENSE #: P____________

Ventura County Accreditation Requirements
Continuing Education Log

This form should be used to track your continuing education requirements. This form must be turned in when it is time for your reaccredidation. When attending a continuing education course, remember to get a course completion, as EMS will audit 10% of all paramedics reaccrediting and if you are randomly selected you must provide a course completion for each course attended in order to receive credit for that course. Course completions must have the name of the course, number of hours, date, provider agency and provider number.

When you complete the Ventura County continuing education standards per Policy 318 you will automatically meet the State of California requirements for re-licensure.

Remember that the Skills Refresher and intubation requirements are to be completed yearly based on license cycle.

The Skills Refresher, Intubation refresher session and the EMS Update requirements are mandatory and they must be completed in the stated time frames or negative action will be taken against your paramedic training level.

Field care audit hours (12 hours are required, 6 hours must be completed in Ventura County)				
	Date	Location	# Of Hours	Provider Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Lecture Hours					
Required Courses		**Date**	**Location**	**# Of Hours**	**Provider Number**
1.	**ACLS** (4 hours)				
2.	**PALS** (4 hours)				
EMS Updates are held in May and November each year. EMS Updates are completed as new or changed policies become effective.					
3.	**EMS UPDATE #1** (1 hour)				
	EMS UPDATE #2 (1 hour)				
	EMS UPDATE #3 (1 hour)				
	EMS UPDATE #4 (1 hour)				
4.	**Ventura County MCI COURSE** (2 hours)				
Any hours that are in addition to the noted amounts in the above categories, should be noted in the additional hours section of this log.					
Skill Refreshers are held in March and September each year. The following requirements must be completed in each year of your license cycle (for example: If your re-licensure month is June 2006, you must complete year one requirement between June 2004 and June 2005 and year two requirement between June 2005 and June 2006).					
5.	**Skills Refresher year 1** (3 hours)				
	Skills Refresher year 2 (3 hours)				
6.	**Endotracheal intubations refresher session (1 session every 6 months based on your license expiration date.)**				
	#1				
	#2				
	#3				
	#4				
Additional Hours (12 hours) These hours can be earned with any combination of additional field care audit, lecture, etc.)					
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Accreditation/Authorization/Certification Review Process</td><td colspan="2">Policy Number:
333</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steve L. Carroll, EMT-P</td><td colspan="2">Date: December 1. 2010</td></tr>
<tr><td>APPROVED:
Medical Director</td><td>Angelo Salvucci, M.D.</td><td colspan="2">Date: December 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>April 1993
October 14, 2010
October 14, 2010
October 31, 2013</td><td>Effective Date:</td><td>December 1, 2010</td></tr>
</table>

I. PURPOSE: This policy defines the Ventura County Emergency Medical Services (VCEMS) accreditation/authorization/certification review process. This policy shall apply to holders of an EMT Certification, Mobile Intensive Care Nurse Authorization, and Paramedic Accreditation governing reportable situations and the evaluation and determination regarding whether or not Disciplinary Cause exists.

II. AUTHORITY: California Health and Safety Code Sections 1797.56, 1798, 1798.200-1798.208. CCR, Title 22, Division 9, Chapter 6.

III. DEFINITIONS:

Certificate - means a valid Emergency Medical Technician (EMT) certificate issued pursuant to Division 2.5 of the California Health and Safety Code.

Certifying Entity - as used in this policy means VCEMS.

Certification Action - means those actions that may be taken by the VCEMS Medical Director that include denial, suspension, revocation of a Certificate, or placing a Certificate Holder on probation.

Certificate Holder – for the purpose of this policy, shall mean the holder of a certificate, as that term is defined above.

CCR – means the California Code of Regulations, Title 22, Division 9.

Crime - means any act in violation of the penal laws of California, any other state, or federal laws.

Conviction – means the final judgment on a verdict or finding of guilt, a plea of guilty or a plea of Nolo Contendere.

Discipline - means either a Disciplinary Plan taken by a Relevant Employer pursuant to Section 100206.2 of the CCR or Certification Action taken by the VCEMS Medical Director pursuant to Section 100204 of the CCR, or both a Disciplinary Plan and Certification Action.

Disciplinary Cause - means an act that is substantially related to the qualifications, functions, and duties of an EMT and is evidence of a threat to the public health and safety, per Health

and Safety Code Section 1798.200.

Disciplinary Plan - means a written plan of action that can be taken by a Relevant Employer as a consequence of any action listed in Section 1798.200 (c). The Disciplinary Plan shall be submitted to the VCEMS Medical Director and may include recommended Certification Action consistent with the Recommended Guidelines for Disciplinary Orders and Conditions of Model Disciplinary Orders.

Functioning outside of medical control - means any provision of prehospital emergency medical care which is not authorized by, or is in conflict with, any policies, procedures, or protocols established by VCEMS, or any treatment instructions issued by the base hospital providing immediate medical direction.

***Model Disciplinary Orders* (MDO)** - means the Recommended Guidelines for Disciplinary Orders and Conditions of Probation (State EMS Authority Document #134) which were developed to provide consistent and equitable discipline in cases dealing with Disciplinary Cause.

Relevant Employer(s) - means those ambulance services permitted by the Department of the California Highway Patrol or a public safety agency that the Certificate Holder works for or was working for at the time of the incident under review, as an EMT either as a paid employee or a volunteer.

IV. POLICY: Any information received from any source, including discovery through medical audit or routine follow-up on complaints, which purports a violation of, or deviation from, state or local EMS laws, regulations, policies, procedures or protocols will be evaluated pursuant to this policy and consistent with the CCR, Chapter 6. For the purposes of a Crime, the record of Conviction or a certified copy of the record shall be conclusive evidence of such Conviction.

V. PROCEDURE:

A. An individual who indicates a criminal history on their certification, authorization or accreditation application or whose background check results in a criminal history will be subject to an investigation. Criminal history does not include an arrest only. The investigation shall consist of one or more of the following:

1. Documentation review
2. Interview by staff
3. An Interview by the VCEMS Medical Director and/or Administrator or designee

B. VCEMS will use the most current version of the MDO's as a reference.

C. Responsibilities of Relevant Employer

1. Under the provisions of the CCR and this policy, Relevant Employers:

a. Shall notify VCEMS within three (3) working days after an allegation has been validated as potential for Disciplinary Cause.

b. Shall notify VCEMS within three (3) working days of the occurrence of any of following:

1) The employee is terminated or suspended for a Disciplinary Cause,

2) The employee resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a Disciplinary Cause,

or

3) The employee is removed from employment-related duties for a Disciplinary Cause after the completion of the employer's investigation.

c. May conduct investigations to determine Disciplinary Cause.

d. Upon determination of Disciplinary Cause, the Relevant Employer may develop and implement a Disciplinary Plan in accordance with the MDOs.

1) The Relevant Employer shall submit that Disciplinary Plan to VCEMS along with the relevant findings of the investigation related to Disciplinary Cause, within three (3) working days of adoption of the Disciplinary Plan.

2) The employer's Disciplinary Plan may include a recommendation that the VCEMS Medical Director consider taking action against the holder's certificate to include denial of certification, suspension of certification, revocation of certification, or placing a certificate on probation.

D. Jurisdiction of VCEMS

1. VCEMS shall conduct investigations to validate allegations for Disciplinary Cause when the EMT is not an employee of a Relevant Employer or the Relevant Employer does not conduct an investigation. Upon determination of Disciplinary Cause, the VCEMS Medical Director may take certification action as necessary against a Certificate Holder.

2. VCEMS may, upon determination of Disciplinary Cause and according to the provisions of this policy, take certification action against an EMT to deny, suspend, or revoke, or place a Certificate Holder on probation, upon the findings by the VCEMS of the occurrence of any of the actions listed in Health

and Safety Code, Section 1798.200 (c) and for which any of the following conditions are true:

a. The Relevant Employer, after conducting an investigation, failed to impose discipline for the conduct under investigation, or the VCEMS Medical Director makes a determination that discipline imposed by the Relevant Employer was not in accordance with the MDOs and the conduct of the Certificate Holder constitutes grounds for Certification Action.

b. The VCEMS Medical Director determines, following an investigation conducted in accordance with this policy, that the conduct requires Certification Action.

3. The VCEMS Medical Director, after consultation with the Relevant Employer or without consultation when no Relevant Employer exists, may temporarily suspend, prior to a hearing, a Certificate Holder upon a determination of the following:

a. The EMT has engaged in acts or omissions that constitute grounds for revocation of the certificate; and

b. Permitting the EMT to continue to engage in certified activity without restriction poses an imminent threat to the public health and safety.

4. If the VCEMS Medical Director takes any certification action the VCEMS Medical Director shall notify the State EMS Authority of the findings of the investigation and the certification action taken and shall enter said information into the State Central Registry.

E. Evaluation of Information

1. A Relevant Employer who receives an allegation of conduct listed in Section 1798.200 (c) of the Health and Safety Code against a Certificate Holder and once the allegation is validated, shall notify the VCEMS, within three (3) working days, of the Certificate Holder’s name, certification number, and the allegation(s).

2. When VCEMS receives a complaint against a Certificate Holder, VCEMS shall forward the original complaint and any supporting documentation not otherwise protected by the law to the Relevant Employer for investigation, if there is a Relevant Employer, within three (3) working days of receipt of the information. If there is no Relevant Employer or the Relevant Employer does not wish to investigate the complaint, VCEMS shall evaluate the information received from

a credible source, including but not limited to, CORI information, information obtained from an application, medical audit, or public complaint, alleging or indicating the possibility of a threat to the public health and safety by the action of an applicant for, or holder of, a certificate issued by VCEMS or pursuant to Division 2.5, of the Health and Safety Code.

3. The Relevant Employer or VCEMS shall conduct an investigation of the allegations in accordance with the provisions of this policy, if warranted.

F. Investigations Involving Firefighters

1. The rights and protections described in Chapter 9.6 of the Government Code shall only apply to a firefighter during events and circumstances involving the performance of official duties.
2. All investigations involving Certificate Holders who are employed by a public safety agency as a firefighter shall be conducted in accordance with Chapter 9.6 of the Government Code, Section 3250 et. seq.

G. Due Process

The Certification Action process shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

H. Determination of Action

1. Upon determining the Disciplinary Plan or Certification Action to be taken, the Relevant Employer or VCEMS shall complete and place in the personnel file or any other file used for any personnel purposes by the Relevant Employer or VCEMS, a statement certifying the decision made and the date the decision was made. The decision must contain findings of fact and a determination of issues, together with the Disciplinary Plan and the date the Disciplinary Plan shall take effect.
2. A temporary suspension order pursuant to Section 100209 (c) of the CCR shall take effect upon the date the notice required by Section 100213 of the CCR, is mailed to the Certificate Holder.
3. For all other Certification Actions, the effective date shall be thirty days from the date the notice is mailed to the applicant for, or holder of, a Certificate unless another time is specified or an appeal is made.

I. Temporary Suspension Order

1. The VCEMS Medical Director may temporarily suspend a certificate prior to hearing if the Certificate Holder has engaged in acts or omissions that constitute grounds for denial or revocation according to Section 100216(c) of

the CCR and if in the opinion of the VCEMS Medical Director permitting the Certificate Holder to continue to engage in certified activity would pose an imminent threat to the public health and safety.

2. Prior to, or concurrent with, initiation of a temporary suspension order of a Certificate pending hearing, the VCEMS Medical Director shall consult with the Relevant Employer of the Certificate Holder.
3. The notice of temporary suspension pending hearing shall be served by registered mail or by personal service to the Certificate Holder immediately, but no longer than three (3) working days from making the decision to issue the temporary suspension. The notice shall include the allegations that allowing the Certificate Holder to continue to engage in certified activities would pose an imminent threat to the public health and safety.
4. Within three (3) working days of the initiation of the temporary suspension, by VCEMS, Relevant Employer and VCEMS shall jointly investigate the allegation in order for the VCEMS Medical Director to make a determination of the continuation of the temporary suspension.
    a. All investigatory information, not otherwise protected by the law, held by the VCEMS and the Relevant Employer shall be shared between the parties via facsimile transmission or overnight mail relative to the decision to temporarily suspend.
    b. VCEMS shall serve within fifteen (15) calendar days, an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (Administrative Procedures Act).
    c. If the Certificate Holder files a Notice of Defense, the administrative hearing shall be held as soon as possible based on .Administrative Law Judge's (ALJ) availability.
    d. The temporary suspension order shall be deemed vacated if VCEMS fails to serve an accusation within fifteen (15) calendar days or fails to make a final determination on the merits within fifteen (15) calendar days after the ALJ renders a proposed decision.

J. Final Determination of Certification Action by the VCEMS Medical Director

1. Upon determination of certification action following an investigation, and appeal of certification action pursuant to Section 100211.1 of the CCR, if the

respondent so chooses, the VCEMS Medical Director may take the following final actions on a Certificate:

a. Place the Certificate Holder on probation
b. Suspension
c. Denial

K. Placement of a Certificate Holder on Probation

The VCEMS Medical Director may place a Certificate Holder on probation any time an infraction or performance deficiency occurs which indicates a need to monitor the Certificate Holder's conduct in the EMS system, in order to protect the public health and safety. The term of the probation and any conditions shall be in accordance with the MDOs. VCEMS may revoke the Certificate if the Certificate Holder fails to successfully complete the terms of probation.

L. Suspension of a Certificate

1. The VCEMS Medical Director may suspend an individual's Certificate for a specified period of time for Disciplinary Cause in order to protect the public health and safety.
2. The term of the suspension and any conditions for reinstatement shall be in accordance with the MDOs.
3. Upon the expiration of the term of suspension, the individual's certificate shall be reinstated only when all conditions for reinstatement have been met. The VCEMS Medical Director shall continue the suspension until all conditions for reinstatement have been met.
4. If the suspension period will run past the expiration date of the certificate, the EMT shall meet the recertification requirements for certificate renewal prior to the expiration date of the certificate.

M. Denial or Revocation of a Certificate

1. The VCEMS Medical Director may deny or revoke any Certificate for Disciplinary Cause that has been investigated and verified by application of this policy.
2. The VCEMS Medical Director shall deny or revoke an Certificate if any of the following apply to the applicant:
    a. Has committed any sexually related offense specified under Section 290 of the Penal Code.
    b. Has been convicted of murder, attempted murder, or murder for hire.
    c. Has been convicted of two (2) or more felonies.

d. Is on parole or probation for any felony.

e. Has been convicted and released from incarceration for said offense during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter.

f. Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.

g. Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.

h. Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offence relating to force, threat, violence, or intimidation.

i. Has been convicted within the preceding five (5) years of any theft related misdemeanor.

j. Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven (7) years.

k. Is required to register pursuant to Section 11590 of the Health and Safety Code.

4. Subsection V.M.1 and 2 shall not apply to convictions that have been pardoned by the Governor, and shall only apply to convictions where the applicant/Certificate Holder was prosecuted as an adult. Equivalent convictions from other states shall apply to the type of offenses listed in V.M.1 and 2. As used in Section M, “felony” or “offense punishable as a felony” refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.

5. This Section shall not apply to EMTs who obtain their California Certificate prior to July 1, 2010; unless:

a. The Certificate Holder is convicted of any misdemeanor or felony after July 1, 2010.

b. The Certificate Holder committed any sexually related offense specified under Section 290 of the Penal Code.

c. The Certificate Holder failed to disclose to the certifying entity any prior convictions when completing the application for initial EMT certification or certification renewal.

6. Nothing in this Section shall negate an individual's right to appeal a denial of a Certificate pursuant to this policy.

7. Certification action by the VCEMS Medical Director shall be valid statewide and honored by all certifying entities for a period of at least twelve (12) months from the effective date of the certification action. An EMT whose application was denied or an EMT whose certification was revoked by the VCEMS Medical Director shall not be eligible for EMT Certification by any other certifying entity for a period of at least twelve (12) months from the effective date of the certification action. EMT's whose certification is placed on probation must complete their probationary requirements with the Certifying Entity that imposed the probation.

N. Notification of Final Decision of Certification Action

1. For the final decision of Certification Action, the VCEMS Medical Director shall notify the applicant/Certificate Holder and Relevant Employer(s) of the Certification Action within ten (10) working days after making the final determination.

2. The notification of final decision shall be served by registered mail or personal service and shall include the following information:

   a. The specific allegations or evidence which resulted in the Certification Action;

   b. The Certification Action(s) to be taken, and the effective date(s) of the Certification Action(s), including the duration of the action(s);

   c. Which certificate(s) the Certification Action applies to in cases of holders of multiple certificates;

   d. A statement that the Certificate Holder must report the Certification Action within ten (10) working days to any other EMS Agency and Relevant Employer in whose jurisdiction s/he uses the certificate.

O. Certification/authorization or accreditation applicants who fail to reveal a criminal history, but for whom a criminal history of conviction is discovered, or for an applicant who fraudulently answered any question on their application or eligibility statement may have their certification/authorization or accreditation placed on probation, suspended or revoked.

Ventura County Emergency Medical Services
2220 E. Gonzales Road, Suite 130
Oxnard, CA 93036
Phone: 805-981-5301
Fax: 805-981-5300

APPENDIX A

Arrest Status Report Form

Today's Date: ____________________________

After initial report, the form is due on the first of each month until the case has been settled

****

Personal Information

Name: ____

____
Street Address

____
City State Zip

Certification/License # (if applicable) ______________________

****

This report form is being submitted for the following reason: (Please check all that apply)

☐ Initial report (Please attach all court documents and arrest reports)

☐ Monthly report form

☐ Final Report (attach all court documentation)

****

Court Information

Case Number #: ________________________

Court Address: ____

____

When is your next court appearance scheduled? _______________________________

If you are completed with your court hearings, please forward a copy of your court documents to the VCEMS Office immediately.

Signature: ____

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Prehospital Care Coordinator Job Duties</td><td>Policy Number
350</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, EMT-P</td><td>Date: December 1, 2010</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Angelo Salvucci, M.D.</td><td>Date: December 1, 2010</td></tr>
<tr><td>Origination Date:
Revised Date:
Date Last Reviewed:
Review Date:</td><td>June 15, 1998
June 10, 2010
June 10, 2010
June 30 2013</td><td>Effective Date: December 1, 2010</td></tr>
</table>

I. PURPOSE: To provide guidelines for the role of the Prehospital Care Coordinator (PCC) in Ventura County.

II. POLICY: A PCC will perform his/her role according to the following.

III. DEFINITION: A PCC is a Registered Nurse designated by each Base Hospital to coordinate all prehospital and Mobile Intensive Care Nurse (MICN) activities sponsored by that Base Hospital in compliance with Ventura County Emergency Medical Services (VC EMS) policies, procedure and protocols and in accordance with the Health and Safety Code, Sections 1797-1799 et al, and in accordance with Title 22 of the California Code of Regulations.

The PCC evaluates prehospital care, prehospital personnel and MICNs and collaborates with the Base Hospital Paramedic Liaison Physician (PLP) in medical direction.

IV. PROFESSIONAL QUALIFICATIONS:

A. Licensed as a Registered Nurse in the State of California.

B. Current authorization as a Ventura County Mobile Intensive Care Nurse (MICN).

C. One year experience as an MICN in Ventura County. For those nurses with one year work experience as an MICN within the last 18 months, this may be reduced to 6 months.

D. Have at least three years emergency department experience.

V. SPECIFIC RESPONSIBILITIES:

A. Serve as Liaison by maintaining effective lines of communication with base hospital personnel, VCEMS, prehospital care providers and local receiving facilities.

B. In compliance with VCEMS Policies and Procedures the PCC will:

1. Ensure a high level of competence and training by developing and instituting prehospital care education programs for MICNs and prehospital

personnel. Programs shall include, but not be limited to, specific issues identified by the VCEMS Continuous Quality Improvement Plan.

a. Provide continuing education per policy requirements
b. Coordinate clinical experience as requested
c. Provide special mandatory programs such as EMS Update classes, Paramedic Skills Labs and Paramedic Orientation.
d. Participate in process improvement teams as designated by VC EMS

2. Provide training for probationary MICNs and newly accrediting paramedics by coordinating necessary clinical experience and evaluating performance.
3. Evaluate the performance of MICNs and submit recommendations for authorization and reauthorization to VC EMS. Such evaluation shall include, but not be limited to:
   a. Direct observation of radio performance.
   b. Audit of recorded communications
   c. Observation of patient assessment and clinical judgment skills (in conjunction with the Emergency Department Nursing Supervisor).
   d. Review of written documentation.
   e. Provide written evaluation of the MICNs for hospital performance review.
4. Provide ongoing evaluation of assessment, reporting, communication and technical skills of assigned paramedics. Such evaluation shall include, but not be limited to:
   a. Audit of written and recorded communications
   b. Review of EMS report forms
   c. Direct field observation during the ride-along, including observation of the transfer of patient care upon arrival at the receiving facility.
   d. Assess performance during scheduled clinical hours in the Emergency Department.
   e. Evaluation of paramedic personnel for level advancement, through direct observation, recorded communication and paperwork audit, according to VC EMS Policy 318.
   f. Provide written evaluation of the paramedics, and MICNs

g. Facilitate support services for prehospital and hospital EMS Staff, (i.e. Critical Incident Staff Management)

h. Participate in Root Cause Analysis as indicated.

5. Report and investigate, and participate in prehospital care unusual occurrences as directed by VC EMS Policy 150.

6. Ensure the operation of the base hospital communication equipment.

   a. In conjunction with the Base Hospital PLP, ensure that all personnel assigned to communicate with paramedics in the field have attended an MICN developmental course approved by VC EMS.

   b. Ensure that the radio equipment is operational.

   c. Ensure that ReddiNet System is operational and up to date.

7. Comply with data collection requirements as directed by VC EMS.

8. Ensure compliance with requirements for retention of recordings, MICN and prehospital care forms, logs and information sheets and maintaining retrieval systems in collaboration with hospital's Medical Records Department.

9. Develop and maintain education records as required by EMS.

   a. Records must be kept for a period of four years

10. In conjunction with the Base Hospital PLP, report to the EMS agency any action of certified/licensed paramedics which results in an apparent deficiency in medical care or constitutes a violation under Section 1798.200 of the Health and Safety Code.

11. Represent the Base Hospital at the Prehospital Care Committee, PCC meeting and other associated task forces and special interest committees as directed by the EMS Agency.

12. Actively participate in the development, review and revision of Ventura County Policies and Procedures.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Transport and Destination Guidelines</td><td>Policy Number
604</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, EMT-P</td><td>Date: December 1, 2010</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Angelo Salvucci, M.D.</td><td>Date: December 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>June 3, 1986
June 10, 2010
June 10, 2010
June 30, 2013</td><td>Effective Date: December 1, 2010</td></tr>
</table>

I. PURPOSE: To establish guidelines for determining appropriate patient destination, so that to the fullest extent possible, individual patients receive appropriate medical care while protecting the interests of the community at large by optimizing use and availability of emergency medical care resources.

II. AUTHORITY: Health and Safety Code, Section 1317, 1797.106(b), 1797.220, and 1798 California Code of Regulations, Title 13, Section 1105(c) and Title 22, Section 100147.

III. POLICY: In the absence of decisive factors to the contrary, patients shall be transported to the most accessible medical facility equipped, staffed, and prepared to receive emergency cases and administer emergency medical care appropriate to the needs of the patients.

IV. PROCEDURE:

A. Hospitals unable to accept patients due to an internal disaster shall be considered NOT "prepared to receive emergency cases".

B. In determining the most accessible facility, transport personnel shall take into consideration traffic obstruction, weather conditions or other factors which might affect transport time.

C. Most Accessible Facility

The most accessible facility shall ordinarily be the nearest hospital emergency department, except for:

1. Base Hospital Direction for ALS patients

a. Upon establishment of voice communication, the Base Hospital is responsible for patient management until the patient reaches a hospital and medical care is assumed by the receiving hospital.

b. The Base Hospital may direct that the patient be transported to a more distant hospital which in the judgment of the BH physician or MICN is more appropriate to the medical needs of the patient.

c. Patients may be diverted in accordance with Policy 402.

2. Patients transported in BLS ambulances demonstrating conditions requiring urgent ALS care (e.g., unstable vital signs, chest pain, shortness of breath, airway obstruction, acute unconsciousness, OB patient with contractions), shall be transported to the nearest hospital emergency department prepared to receive emergency cases.

D. "Decisive Factors to the Contrary"

Decisive factors to the contrary include, but are not limited to, the following:

1. Prepaid Health Plans

a. EMS personnel shall not request information on insurance or delay transport or treatment while determining insurance status.

b. A member of a group practice prepayment health care service who volunteers such information and requests a specific facility may be transported according to that plan when the ambulance personnel or the ALS Base Hospital determines that the condition of the member permits such transport.. Therefore when ALS Base Hospital contact is made the ALS Base Hospital must always be notified of the patient’s request.

c. However, when it is determined that such transport would unreasonably remove the ambulance unit from the service area, the member may be transported to the nearest hospital capable of treating the member.

2. Patient Requests

a. When a person or his/her legally authorized representative requests emergency transportation to a hospital other than the most accessible emergency department, the request should be honored when ambulance personnel, BH MD or MICN determines that the condition of the patient permits such transport. Therefore when ALS Base Hospital contact is made the ALS Base Hospital must always be notified of the patient’s request.

b. When it is determined that such transport would unreasonably remove the ambulance unit from the service area, the patient may be transported to the nearest hospital capable of treating him/her.

3. Private Physician's Requests

When a treating physician requests emergency transportation to a hospital other than the most accessible acute care hospital, the request should be honored unless it is determined that such transport would unreasonably remove the ambulance from the service area. In such cases:

a. If the treating physician is immediately available, ambulance personnel shall confer with the physician regarding a mutually agreed upon destination.

b. If the treating physician is not immediately available, the patient should be transported to the nearest hospital capable of treating him/her.

c. If Base Hospital contact has been made due to the condition of the patient and the immediate unavailability of the treating physician, and the BH MD or MICN determines that the condition of the patient **permits or** does not permit such transport, BH directions shall be followed. If communication with the treating physician is possible, the BH should consult with the physician.

4. Physician on Scene per VC EMS Policy 702

5. Direct Admits

When a patient's physician has arranged direct admission to a hospital, the patient should be transported to that hospital regardless of Emergency Department diversion status unless the Base Hospital determines that the patient's condition requires that s/he be transported to a more appropriate facility.

E. “Medical facilities equipped, staffed and prepared to administer care appropriate to needs of the patients.”

1. Patients that meet trauma criteria in VCEMS Policy 1405 will be transported to a designated Trauma Center.

2. Patients who meet STEMI criteria in VCEMS Policy 440 will be transported to a STEMI Receiving Center.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Guidelines For Base Hospital Contact</td><td>Policy Number:
704</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, EMT-P</td><td>Date: December 1, 2010</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Angelo Salvucci, MD</td><td>Date: December 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>October 1984
October 14, 2010
October 14, 2010
October 31, 2013</td><td>Effective Date: December 1, 2010</td></tr>
</table>

I. PURPOSE: To define patient conditions for which EMT-Ps 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 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. AMA involving any of the conditions listed in this policy.
5. AMA including suspected altered level of consciousness
6. Any patient who, in paramedic's opinion, would benefit from base hospital consultation.

<table>
<tr><td>COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Treatment Protocols</td><td>Policy Number
705</td></tr>
<tr><td colspan="2">APPROVED:
Medical Director: Angelo Salvucci, M.D.</td><td>Date: December 1, 2010</td></tr>
<tr><td>Origination Date: January 1988
Date Revised: See individual algorithms
Date Last Revised: See individual algorithms
Review Date: See individual algorithms</td><td colspan="2">Effective Date: As indicated on individual algorithms</td></tr>
</table>

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, Section 100175.

A. DEFINITIONS:

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

a. Adult: Age 12 or greater (12th birthday and older)

b. Pediatric: Age less than 12 (up to 12th birthday)

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

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

2. Policy 710: Endotracheal Intubation

3. Policy 717: Intraosseous Infusion

4. Policy 805: EMT-D Medical Cardiac Arrest Protocols – SAED

C. Cardiac Monitor/12 Lead EKG

1. When cardiac monitoring or a 12 Lead EKG is performed, copies of rhythms strips and 12 Lead EKGs 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.

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

Contents

00 - General Patient Assessment

01 - Trauma Assessment/Treatment Guidelines

02 - Allergic/Adverse Reaction and Anaphylaxis

03 - Altered Neurological Function

04 - Behavioral Emergencies

05 - Bites and Stings

06 - Burns

07 - Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA)

08 - Cardiac Arrest – VF/VT

09 - Chest Pain – Acute Coronary Syndrome

10 - Childbirth

11 - Crush Injury/Syndrome

12 - Heat Emergencies

13 - Hypothermia

14 - Hypovolemic Shock

15 - Nausea/Vomiting

16 - Neonatal Resuscitation

17 - Nerve Agent

18 - Overdose/Poisoning

19 - Pain Control

20 - Seizures

21 - Shortness of Breath – Pulmonary Edema

22 - Shortness of Breath – Wheezes/Other

23 - Supraventricular Tachycardia

24 - Symptomatic Bradycardia

25 - Ventricular Tachycardia – Not in Arrest

VCEMS General Patient Guidelines

I. Purpose: To establish a consistent approach to patient care

A. Initial response

1. Review dispatch information with crew members and dispatch center as needed
2 Consider other potential issues (location, time of day, weather, etc.)

B. Scene arrival and Size-up

1. Address Body Substance Isolation/Personal Protection Equipment (BSI/PPE)
2. Evaluate scene safety
3. Determine the mechanism of injury (if applicable) or nature of illness
4. Determine the number of patients
5. Request additional help if necessary (refer to VCEMS Policy 131)
6. Consider spinal precautions (refer to VCEMS Policy 614)

C. Initial assessment

1. Airway
    a. Open airway as needed, maintaining inline cervical stabilization if trauma is suspected
    b. Insert appropriate airway adjunct if indicated
    c. Suction airway if indicated
    d. If a partial or complete Foreign Body Airway Obstruction (FBAO) is present, utilize appropriate interventions
2. Breathing
    a. Assess rate, depth, and quality of respirations
    b. Assess lung sounds
    c. If respiratory effort inadequate, assist ventilations with BVM
    d. Initiate airway management and oxygen therapy as indicated
3. Circulation
    a. Assess skin color, temperature, and condition
    b. Check distal/central pulses, including capillary refill time
    c. Control major bleeding
    d. Initiate shock management as indicated
4. Disability
    a. Determine level of consciousness
    b. Assess pupils
    c. Assess Circulation, Sensory, Motor (CSM)
5. Exposure
    a. If indicated, remove clothing for proper assessment/treatment of injury location. Attempt to maintain patient dignity

b. Maintain patient body temperature at all times

D. Determine chief complaint. Initiate treatment per VCEMS policies/protocols

II. History of Present Illness – including pertinent negatives and additional signs/symptoms

1. Onset of current illness or chief complaint
2. Provoking factors
3. Quality
4. Radiation
5. Severity – 1 to 10 on pain scale
6. Time

III. Vital Signs

1. Blood Pressure and/or Capillary Refill
2. Heart Rate
3. Respirations
4. ALS assessments shall include:
    a. Cardiac rhythm
    b. 12-lead ECG as indicated per VCEMS Policy 726
    c. Pulse Oximetry
    d. Capnography (after advanced airway placement)

IV. Obtain history, including pertinent negatives

1. Signs/Symptoms leading up to the event
2. Allergies
3. Medications taken
4. Past medical history
5. Last oral intake (as indicated)
6. Events leading up to present illness

V. Perform Detailed Physical Examination per Trauma Assessment/Treatment Guidelines

VI. Base Hospital contact shall be made for all ALS patients in accordance with VCEMS Policy 704

VII. Transport to appropriate facility per VCEMS guidelines

1. Transport and Destination Guidelines – Policy 604
2. STEMI Receiving Center Standards – Policy 430
3. Post VF/VT with ROSC – Policy 705 (Cardiac Arrest VF/VT)
4. Trauma Triage and Destination Criteria – Policy 1405
5. Hospital Diversion – Policy 402

VII. Continuously monitor vital signs and document all findings. Continue appropriate treatments and reassess throughout transport to assess for changes in patient status

IX. Documentation

1. Completion of patient care documentation per VCEMS Policy 1000

2. Document all assessment findings, pertinent negatives, vital signs, interventions/treatments (both initial and ongoing), responses to treatments, and all changes in patient status
3. Submit ECG strips for all ALS patients
4. Maintain patient confidentiality at all times

Trauma Assessment/Treatment Guidelines

I. Purpose: To establish a consistent approach to the care of the trauma patient

A. Rapid trauma survey

1. Airway
   a. Maintain inline cervical stabilization
      1) Follow spinal precautions per VCEMS Policy 614
   b. Open airway as needed
      2) Utilize a trauma jaw thrust to maintain inline cervical stabilization if indicated
   c. Suction airway if indicated
2. Breathing
   a. Assess rate, depth and quality of respirations
   b. If respiratory effort inadequate, assist ventilations with BVM
   c. Insert appropriate airway adjunct if indicated
   d. Assess lung sounds
   e. Initiate airway management and oxygen therapy as indicated
      1) Maintain SpO2 ≥ 95%
3. Circulation
   a. Assess skin color, temperature, and condition
   b. Check distal/central pulses and capillary refill time
   c. Control major bleeding
   d. Initiate shock management as indicated
4. Disability
   a. Determine level of consciousness (Glasgow Coma Scale)
   b. Assess pupils
5. Exposure
   a. If indicated, remove clothing for proper assessment/treatment of injury location. Maintain patient dignity
   b. Maintain patient body temperature

B. Detailed physical examination

1. Head
   a. Inspect/palpate skull
   b. Inspect eyes, ears, nose and throat
2. Neck
   a. Palpate cervical spine
   b. Check position of trachea
   c. Assess for jugular vein distention (JVD)
3. Chest
   a. Visualize, palpate, and auscultate chest wall

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

C. Trauma care guidelines

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

1) Stabilize object manually or with bulky dressings
2) Control bleeding if present
3) Even in the presence of penetrating injuries, if no neurologic deficit is present upon physical examination, consider withholding spinal immobilization

c. Neck injuries
1) Monitor airway
2) Control bleeding if present

3. Thoracic Trauma
a. General treatments
1) Evaluate chest – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
2) Keep patients sitting high-fowlers
a) If in spinal precautions, elevate head of backboard 30° unless contraindicated
b) Even in the presence of penetrating injuries, if no neurologic deficit is present upon physical examination, consider withholding spinal immobilization

b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
a) Remove object if CPR is interfered
b) Stabilize object manually or with bulky dressings
c) Control bleeding if present

c. Flail Chest/Rib injuries
a) Immobilize with padding and bulky dressings to affected area
b) Assist ventilations if respiratory status deteriorates

d. Pneumothorax/Hemothorax
a) Keep patient sitting high-fowlers
b) Assist ventilations if respiratory status deteriorates
1) Suspected tension pneumothorax should be managed per VCEMS Policy 715

e. Open (Sucking) Chest Wound
a) Place an occlusive dressing to wound site. Secure on 3 sides only
b) Assist ventilations if respiratory status deteriorates

f. Cardiac Tamponade – If suspected, expedite transport
a) Beck's Triad
1) Muffled heart tones
2) JVD

3) Hypotension

g. Traumatic Aortic Disruption

a) Assess for quality of radial and femoral pulses

b) If suspected, expedite transport

4. Abdominal/Pelvic Trauma

a. General Treatments

1) Evaluate abdomen and pelvis – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings

2) Goal of fluid resuscitation is to maintain SBP of > 80 mmHg. If SBP > 80 mmHg, then maintain IV at TKO rate

b. Blunt injuries

1) Place patient in shock position if hypotension is present

c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT

1) Stabilize object manually or with bulky dressings

2) Control bleeding if present

d. Eviscerations

1) DO NOT REPLACE ABDOMINAL CONTENTS

a) Cover wound with saline-soaked dressings

2) Control bleeding if present

e. Pregnancy

1) Place patient in left-lateral position

2) If in spinal immobilization, place padding under backboard to tilt to the left

f. Pelvic injuries

1) DO NOT LOG ROLL PATIENT

a) Assessment of pelvis should be only performed once to limit additional injury

2) Control bleeding if present

3) Consider wrapping a bed sheet tightly around the pelvis and tying it together for use as a sling

4. Extremity Trauma

a. General Treatments

1) Evaluate CSM distal to injury

a) If decrease or absence in CSM is present:

(1) Manually reposition extremity into anatomical position

(2) Re-evaluate CSM

b) If no change in CSM after repositioning, splint in anatomical position and expedite transport

c) Cover open wounds with sterile dressings

d) Place ice pack on injury area (if closed wound)

e) Splint/elevate extremity with appropriate equipment

b. Dislocations

1) Splint in position found with appropriate equipment

c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECTS

1) Stabilize object manually or with bulky dressings

2) Control bleeding if present

d. Femur fractures

1) Utilize traction splint only if isolated mid-shaft femur fracture is suspected

2) Assess CSM before and after traction splint application

e. Amputations

1) Clean the amputated extremity with NS

2) Wrap in moist sterile gauze

3) Place in plastic bag

4) Place bag with amputated extremity into a separate bag containing ice packs

5) Prevent direct tissue contact with the ice packs

Allergic/Adverse Reaction and Anaphylaxis

BLS Procedures

ADULT

Assist with prescribed **Epi-Pen**
Administer oxygen as indicated

PEDIATRIC

Assist with prescribed **Epi-Pen Jr.**
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

ADULT

Allergic Reaction or Dystonic Reaction

- **Benadryl**
  - IV/IM – 50 mg

If Wheezing is present

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

Anaphylaxis without Shock

- **Epinephrine 1:1,000**
  - IM –
    - Less than 40 years old – 0.5 mg
    - 40 years old and greater – 0.3 mg
      - Only if severe respiratory distress is present
- IV access
- **Benadryl**
  - IV/IM – 50 mg
    - May repeat x 1 in 10 min

Anaphylaxis with Shock

- Treatment as above for Anaphylaxis without Shock
- Initiate 2nd IV
- **Normal Saline**
  - IV bolus – 1 Liter

For Profound Shock

- **Epinephrine 1:10,000**
  - Slow IVP – 0.1 mg (1 mL) increments
    - Max 0.3-0.5 mg (3-5 mL) over 1-2 min

PEDIATRIC

Allergic Reaction or Dystonic Reaction

- **Benadryl**
  - IV/IM – 1 mg/kg
    - Max 50 mg

If Wheezing is present

- **Albuterol**
  - Less than 2 years old
    - Nebulizer – 2.5 mg/3 mL
      - Repeat as needed
  - 2 years old and greater
    - Nebulizer – 5 mg/6 mL
      - Repeat as needed

Anaphylaxis without Shock

- **Epinephrine 1:1,000**
  - IM – 0.01 mg/kg
    - Max 0.3 mg
- IV access
- **Benadryl**
  - IV/IM – 1 mg/kg
    - May repeat x 1 in 10 min
    - Max 50 mg

Anaphylaxis with Shock

- Treatment as above for Anaphylaxis without Shock
- Initiate 2nd IV if possible or establish IO
- **Normal Saline**
  - IV/IO bolus – 20 mL/kg

For Profound Shock

- **Epinephrine 1:10,000**
  - Slow IVP – 0.01 mg/kg (0.1 mL/kg) increments
    - Max 0.3 mg (3 mL) over 1-2 min

Communication Failure Protocol

ADULT

Anaphylaxis without Shock

- *Repeat* **Epinephrine 1:1,000**
  - IM – 0.3 mg q 5 min x 2 as needed

Anaphylaxis with Shock

- For continued shock
  - *Repeat* **Normal Saline**
    - IV bolus – 1 Liter
  - *Repeat* **Epinephrine 1:1,000**
    - IM – 0.3 mg q 5 min x 2 as needed

PEDIATRIC

Anaphylaxis without Shock

- *Repeat* **Epinephrine 1:1,000**
  - IM – 0.01 mg/kg q 5 min x 2 as needed

Anaphylaxis with Shock

- For continued shock
  - *Repeat* **Normal Saline**
    - IV/IO bolus – 20 mL/kg
  - *Repeat* **Epinephrine 1:1,000**
    - IM – 0.01 mg/kg q 5 min x 2 as needed

Base Hospital Orders only

ADULT

Consult with ED Physician for further treatment measures

PEDIATRIC

Consult with ED Physician for further treatment measures

VCEMS Medical Director

Altered Neurologic Function

BLS Procedures

ADULT

If suspected stroke, perform Cincinnati Stroke Scale
Administer oxygen as indicated
If low blood sugar suspected

- **Oral Glucose**
  - PO – 15 gm

PEDIATRIC

If suspected stroke, perform Cincinnati Stroke Scale
Administer oxygen as indicated
If low blood sugar suspected

- **Oral Glucose**
  - PO – 15 gm

ALS Prior to Base Hospital Contact

ADULT

IV access

Determine Blood Glucose level

<u>If < 60</u>

- **D_{50}**
  - IV – 25 mL
- **Glucagon** (if no IV access)
  - IM – 1 mg

Recheck Blood Glucose level 5 min after D_{50} or 10 min after Glucagon administration

<u>If still < 60</u>

- **D_{50}**
  - IV – 25 mL

PEDIATRIC

Consider IV/IO access

Determine Blood Glucose level

<u>If < 60</u>

- Less than 2 years old
  - **D_{25}**
    - IV – 2 mL/kg
  - **Glucagon** (if no IV access)
    - IM – 0.1 mg/kg
      - Max 1 mg
- 2 years old and greater
  - **D_{50}**
    - IV – 1 mL/kg
  - **Glucagon** (if no IV access)
    - IM – 0.1 mg/kg
      - Max 1 mg

Recheck Blood Glucose level 5 min after D_{50} or 10 min after Glucagon administration

<u>If still < 60</u>

- Less than 2 years old
  - **D_{25}**
    - IV – 2 mL/kg
- 2 years old and greater
  - **D_{50}**
    - IV – 1 mL/kg

Base Hospital Orders only

ADULT

Consult with ED Physician for further treatment measures

PEDIATRIC

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 stroke is suspected and the last time known to be without signs/symptoms was < 3 hours prior to EMS arrival, expedite treatment and transport

VCEMS Medical Director

Behavioral Emergencies

ADULT	PEDIATRIC
ALS Prior to Base Hospital Contact	

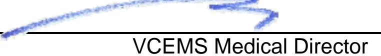
IV Access
 	
For Extreme Agitation
• **Midazolam**
  ○ IV – 2 mg
    • Repeat 1 mg q 2 min as needed
    • Max 5 mg
  ○ IM – 0.1 mg/kg
    • Max 5 mg
 	
FOR IV USE:
Dilute 5 mg (1 mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL
 	
When safe to perform, determine blood glucose level
	For Extreme Agitation
	• **Midazolam**
	  ○ IM – 0.1 mg/kg
	    • Max 5 mg
	
	When safe to perform, determine blood glucose level

Base Hospital Orders only	
Consult with ED Physician for further treatment measures	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. "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 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.
- Patients shall be medically cleared prior to transporting to a psychiatric facility if patient is placed on 5150 hold by law enforcement.
- Patient may be transported directly to a psychiatric facility if evaluated by Crisis Team or PAT Team in the field.
- All patients that are deemed medically unstable shall be transported to the most accessible Emergency Department.

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



Bites and Stings

BLS Procedures

Animal/insect bites:

- Flush site with sterile water
- Control bleeding
- Apply bandage

Snake bites/envenomations:

- Remove rings and constrictions
- Immobilize the affected part in dependent position
- Avoid excessive activity

Bee stings:

- If present, remove stinger
- Apply ice pack

Jellyfish stings:

- Rinse thoroughly with normal saline
  - DO NOT:
    - Rinse with fresh water
    - Rub with wet sand
    - Apply heat

All other marine animal stings:

- If present, remove barb
- Immerse in hot water if available

Administer oxygen as indicated

All bites other than snake bites may be treated as a BLS call

ALS Prior to Base Hospital Contact

IV access for snake bites

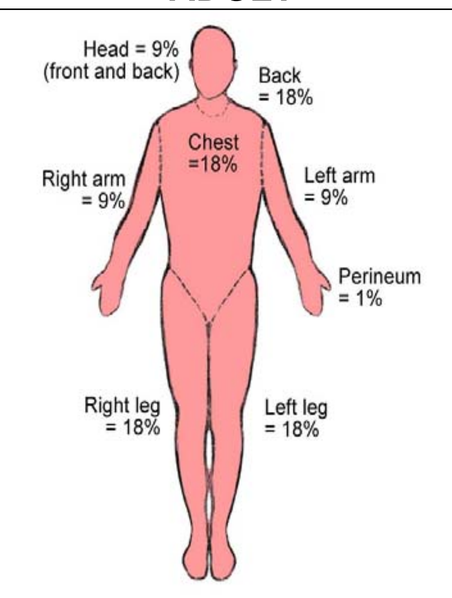
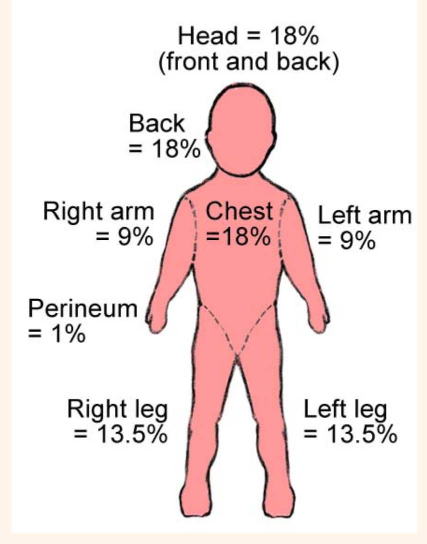
Monitor for allergic reaction or anaphylaxis

Morphine – per Policy 705 - Pain Control

Base Hospital Orders only

Consult with ED Physician for further treatment measure

Burns

<table>
<tr><th>ADULT</th><th>PEDIATRIC</th></tr>
<tr><td></td><td></td></tr>
<tr><th colspan="2">BLS Procedures</th></tr>
<tr><td>
• Remove rings, constrictive clothing and garments made of synthetic material
• Assess for chemical, thermal, electrical, or radiation burns and treat accordingly
• If < 10% Total Body Surface Area (TBSA) is burned, cool with saline dressings and elevate burned extremities if possible
• Once area is cooled, remove saline dressings and cover with dry, sterile burn sheets
• Maintain body heat at all times
• Administer oxygen as indicated
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<tr><th colspan="2">ALS Prior to Base Hospital Contact</th></tr>
<tr><td>
IV access
Morphine – per Policy 705 - Pain Control

If TBSA > 10% or hypotension is present:
• Normal Saline
  o IV bolus – 1 Liter
</td><td>
IV/IO access
Morphine – per Policy 705 - Pain Control

If TBSA > 10% or hypotension is present:
• Normal Saline
  o IV/IO bolus – 20 mL/kg
</td></tr>
<tr><th colspan="2">Base Hospital Orders only</th></tr>
<tr><td>Consult with ED Physician for further treatment measures</td><td>Consult with ED Physician for further treatment measures</td></tr>
</table>

Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA)

BLS Procedures

ADULT

If collapse before dispatch, complete 5 cycles (2 minutes) of CPR, then attach AED
If witnessed, immediately attach AED
Airway management per VCEMS policy

PEDIATRIC

If collapse before dispatch, complete 5 cycles (2 minutes) of CPR, then attach AED
If witnessed, immediately attach AED
Airway management per VCEMS policy

ALS Prior to Base Hospital Contact

ADULT

Assess/treat causes
IV access
Epinephrine

- IV – **1:10,000**: 1 mg (10 mL) q 3-5 min
- IL – **1:1,000**: 1 mg (1 mL) q 3-5 min

If patient is in asystole or PEA is < 60:

- **Atropine**
  - IV – 1 mg (10 mL) q 3-5 min
    - Max 0.04 mg/kg
  - IL – 1 mg (1 mL)

If suspected hypovolemia:

- **Normal Saline**
  - IV bolus – 1 Liter

ALS Airway Management

- If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures

PEDIATRIC

Assess/treat causes
IV/IO access
Epinephrine 1:10,000

- IV/IO – 0.01mg/kg (0.1 mL/kg) q 3-5 min

If suspected hypovolemia:

- **Normal Saline**
  - IV/IO bolus – 20 mL/kg
    - Repeat x 2

ALS Airway Management

- If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures

Make early Base Hospital contact for all pediatric cardiac arrests

Base Hospital Orders only

ADULT

Tricyclic Antidepressant Overdose

- **Sodium Bicarbonate**
  - IV – 1 mEq/kg
    - Repeat 0.5 mEq/kg q 5 min

Beta Blocker Overdose

- **Glucagon**
  - IV – 2 mg
    - May give up to 10mg if available

Calcium Channel Blocker Overdose

- **Calcium Chloride**
  - IV – 1 gm
    - Repeat x 1 in 10 min
- **Glucagon**
  - IV – 2 mg
    - May give up to 10mg if available

History of Renal Failure/Dialysis

- **Sodium Bicarbonate**
  - IV – 1 mEq/kg
    - Repeat 0.5 mEq/kg q 5 min
- **Calcium Chloride**
  - IV – 1 gm
    - Repeat x 1 in 10 min

Consult with ED Physician for further treatment measures

PEDIATRIC

Tricyclic Antidepressant Overdose

- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg
    - Repeat 0.5 mEq/kg q 5 min

Beta Blocker Overdose

- **Glucagon**
  - IV/IO – 0.1 mg/kg
    - May give up to 10mg if available

Calcium Channel Blocker Overdose

- **Calcium Chloride**
  - IV/IO – 20 mg/kg
    - Repeat x 1 in 10 min
- **Glucagon**
  - IV/IO – 0.1 mg/kg
    - May give up to 10mg if available

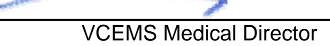
History of Renal Failure/Dialysis

- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg
    - Repeat 0.5 mEq/kg q 5 min
- **Calcium Chloride**
  - IV/IO – 20 mg/kg
    - Repeat x 1 in 10 min

Consult with ED Physician for further treatment measures

Additional Information :

- If sustained ROSC, perform 12-lead EKG. Consult base hospital for destination determination.
- If suspected hypovolemia, initiate immediate transport
- In cases of normothermic cardiac arrest patients 18 years and older with unwitnessed cardiac arrest, adequate ventilations, vascular access, and persistent asystole or PEA despite 20 minutes of standard advanced cardiac life support, the base hospital should consider termination of resuscitation in the field. If transported, the patient may be transported Code II. If unable to contact the base hospital, resuscitative efforts may be discontinued and patient determined to be dead.
- If patient is **hypothermic** – only ONE round of medication administration prior to Base Hospital contact. Field determination of death is discouraged in these patients and they should be transported to the most accessible receiving facility.



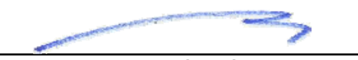
VCEMS Medical Director

Cardiac Arrest – VF/VT

ADULT	PEDIATRIC
BLS Procedures	
If collapse before dispatch, complete 5 cycles (2 minutes) of CPR, then attach AED If witnessed, immediately attach AED Airway management per VCEMS policy	If collapse before dispatch, complete 5 cycles (2 minutes) of CPR, then attach AED If witnessed, immediately attach AED Airway management per VCEMS policy
ALS Prior to Base Hospital Contact	
Defibrillate • Use the biphasic energy settings that have been approved by service provider medical director • Repeat every 2 minutes as indicated IV access **Epinephrine** • IV – **1:10,000**: 1 mg (10 mL) q 3-5 min • IL – **1:1,000**: 1 mg (1 mL) q 3-5 min **Lidocaine** • IV – 1 mg/kg q 3-5 min o Max 3 mg/kg ALS Airway Management • If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures POST-CONVERSION If patient converts to narrow complex rhythm greater than 50 bpm and not in 2nd or 3rd degree heart block • **Lidocaine** o IV – 1 mg/kg • If Lidocaine has already been administered, then withhold this dose If VF/VT stops, then recurs, perform defibrillation at the last successful biphasic energy setting	**Defibrillate** – 2 Joules/kg • If patient still in VF/VT at rhythm check, increase to 4 Joules/kg • Repeat every 2 minutes as indicated IV or IO access **Epinephrine 1:10,000** • IV/IO – 0.01mg/kg (0.1 mL/kg) q 3-5 min **Lidocaine** – Every 3-5 min • IV/IO – 1 mg/kg o Max 3 mg/kg ALS Airway Management • If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures POST-CONVERSION If patient converts to narrow complex rhythm greater than 50 bpm and not in 2nd or 3rd degree heart block • **Lidocaine** o IV – 1 mg/kg • If Lidocaine has already been administered, then withhold this dose If VF/VT stops, then recurs, perform defibrillation at the last successful biphasic energy setting
Base Hospital Orders only	
Tricyclic Antidepressants • **Sodium Bicarbonate** o IV – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min Torsades de Pointes • **Magnesium Sulfate** o IV – 2 gm over 2 min • May repeat x 1 in 5 min	Tricyclic Antidepressants • **Sodium Bicarbonate** o IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

Additional Information:

- If sustained ROSC, perform 12-lead EKG. Transport to SRC
- 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

Chest Pain – Acute Coronary Syndrome

BLS Procedures

Administer oxygen as indicated
Assist patient with prescribed Nitroglycerin as needed for chest pain

- Hold if SBP < 100 mmHg

ALS Prior to Base Hospital Contact

Perform 12-lead ECG

- If "***ACUTE MI SUSPECTED***" is present, expedite transport to closest STEMI Receiving Center
- Document all initial and ongoing rhythm strips and ECG changes

For continuous chest pain consistent with ischemic heart disease:

- **Nitroglycerin**
    - SL or lingual spray – 0.4 mg q 5 min for continued pain
        - No max dosage
        - Maintain SBP > 100 mmHg
            - If normal SBP < 100 mmHg, then maintain SBP > 90 mmHg
- **Aspirin**
    - PO – 324 mg

IV access

- 3 attempts only prior to Base Hospital contact

If pain persists and not relieved by NTG:

- **Morphine** – per policy 705 - Pain Control
    - Maintain SBP > 100 mmHg

If patient presents or becomes hypotensive:

- Elevate legs
- **Normal Saline**
    - IV bolus – 250 mL
        - Unless CHF is present

Communication Failure Protocol

One additional IV attempt if not successful prior to initial BH contact

- 4 attempts total per patient

Ventricular Ectopy – PVC's > 10/min, multifocal PVC's, or unsustained V-Tach

- **Lidocaine**
    - IV – 1 mg/kg
        - May repeat 0.5 mg/kg slow IVP q 5-10 min for continued ectopy
        - Max 3 mg/kg

If hypotensive and signs of CHF are present or no response to fluid therapy:

- **Dopamine**
    - IVPB – 10 mcg/kg/min

Base Hospital Orders only

Consult ED Physician for further treatment measures

Additional Information:

- Nitroglycerin is contraindicated when erectile dysfunction medications (Viagra, Levitra, and Cialis) have been recently used (Viagra or Levitra within 24 hours; Cialis within 48 hours). NTG then may only be given by ED Physician order

Childbirth

BLS Procedures

Determine
- number of pregnancies (gravida)
- number of deliveries (para)
- due date (weeks of gestation)
- onset/duration/frequency/intensity of contractions
- if a rupture of membranes has occurred (including color)
- if any expected complications during pregnancy are present
- Visualize to determine if there is crowning or any abnormal presenting part

PROLAPSED CORD	OTHER PRESENTING PART	
	DELIVERING	**NOT DELIVERING**
Cover cord with wet saline dressing Place mother in left-lateral Trendelenberg position Provide constant manual pressure on presenting part to avoid cord compression	Elevate hips Assist delivery while initiating Code-3 transport Assist with breech delivery while supporting the infant's body (covering to maintain body warmth)	Place mother in left-lateral Trendelenberg position Initiate Code-3 transport

Initiate Code-3 transport if there is partial delivery of the infant and no further progress after 1-2 minutes

If the HEAD is crowning, prepare to assist mother with delivery –
- Guide baby out
- Suction mouth, then nose
  - If meconium is present, suction mouth and nose thoroughly prior to drying and stimulating to breathe
- Dry and stimulate (rub gently, but briskly with warm towel)
- Note time of birth
- Double clamp cord and cut with sterile scissors between clamps
- Begin transport
  - *Do not* wait for placenta to delivery
- If placenta delivery is present, assist and package, then gently massage fundus
  - *Do not* massage fundus until the placenta has delivered

Fetal assessment – at 1 minute and 5 minutes post-delivery

APGAR score	0	1	2
A - Appearance	Blue/Pale	Pink w/ blue extremities	Pink
P – Pulse	Absent	< 100 bpm	> 100 bpm
G – Grimace (reflexes)	Absent	Grimace	Cough/Cry/Sneeze
A – Activity (muscle tone)	Limp	Some flexion	Active
R – Respirations	Absent	Slow	Good cry

ALS Prior to Base Hospital Contact

IV Access

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information
- If a patient is in an area where the most accessible hospital does not have obstetric services, consult with the Base Hospital for destination determination.

Crush Injury/Syndrome

ADULT	PEDIATRIC
BLS Procedures	
Perform spinal precautions as indicated Determine Potential vs. Actual Crush Syndrome Administer oxygen as indicated	Perform spinal precautions as indicated Determine Potential vs. Actual Crush Syndrome Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
Potential crush injury • IV access • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias	Potential crush injury • IV access • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias
Communication Failure Protocol	
Actual crush syndrome • Initiate 2nd IV access • **Normal Saline** o IV bolus – 1 Liter • Caution with cardiac and/or renal history • **Sodium Bicarbonate** o IV mix – 1 mEq/kg • Added to 1st Liter of Normal Saline • **Albuterol** o Nebulizer – 5 mg/6 mL • Repeat x 2 • **Morphine** – Per Policy 705 - Pain Control • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias • For cardiac dysrhythmias: o **Calcium Chloride** • IV – 1 gm over 1 min For continued shock • *Repeat* **Normal Saline** o IV bolus – 1 Liter	Actual crush syndrome • Initiate 2nd IV access if possible or establish IO • **Normal Saline** o IV/IO bolus – 20 mL/kg • Caution with cardiac and/or renal history • **Sodium Bicarbonate** o IV mix– 1 mEq/kg • Added to 1st Liter of Normal Saline • **Albuterol** o Less than 2 years old • Nebulizer – 2.5 mg/3 mL o Repeat x 2 o 2 years old and greater • Nebulizer – 5 mg/6 mL o Repeat x 2 • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias • For cardiac dysrhythmias: o **Calcium Chloride** • IV/IO – 20 mg/kg over 1 min For continued shock • *Repeat* **Normal Saline** o IV/IO bolus – 20 mL/kg
Base Hospital Orders only	
For ongoing extended entrapment and no response to fluid therapy: • **Dopamine** o IVPB – 10 mcg/kg/min Consult with ED Physician for further treatment measures	For ongoing extended entrapment and no response to fluid therapy: • **Dopamine** o IVPB – 10 mcg/kg/min Consult with ED Physician for further treatment measures

Additional Information:
- If elderly or cardiac history is present, use caution with fluid administration. Reassess and treat accordingly.
- Dysrhythmias are usually secondary to Hyperkalemia. ECG monitor may show: Peaked T-waves, Absent P-waves, widened QRS complexes, bradycardia
- Calcium Chloride and Sodium Bicarbonate precipitate when mixed. Strongly consider starting a second IV (if feasible) for administration of Calcium Chloride

Heat Emergencies

ADULT	PEDIATRIC
BLS Procedures	
Place patient in cool environment Initiate active cooling measures Administer oxygen as indicated	Place patient in cool environment Initiate active cooling measures Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
Determine Blood Glucose IV access **Normal Saline** • IV bolus – 1 Liter o Caution with cardiac and/or renal history	Determine Blood Glucose IV/IO access **Normal Saline** • IV/IO bolus – 20 mL/kg o Caution with cardiac and/or renal history
Communication Failure Protocol	
If hypotensive after initial IV fluid bolus: • *Repeat* **Normal Saline** o IV bolus – 1 Liter	If hypotensive after initial IV fluid bolus: • *Repeat* **Normal Saline** o IV/IO bolus – 20 mL/kg
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

Hypothermia

BLS Procedures

Monitor vital signs for 1 minute
- *Acceptable ranges for severe hypothermia*
  - Respiratory Rate: 4-6/minute
  - Heart rate: 20-30/minute

Gently move patient to warm environment
Remove wet clothing and replace with dry blankets
Insulate head
Begin passive rewarming
STAT transport if no shivering (indicates core temp below 90º)
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

IV access (if needed for medication or fluid administration)
- If administering fluid, avoid administering cold fluids.

Base Hospital Orders only

Consult with ED Physician for further treatment measures

VCEMS Medical Director

Hypovolemic Shock

<table>
<tr><th>ADULT</th><th>PEDIATRIC</th></tr>
<tr><td colspan="2">BLS Procedures</td></tr>
<tr><td>Evaluate patient lung sounds, if lungs clear place patient in shock position
Administer oxygen as indicated</td><td>Evaluate patient lung sounds, if lungs clear place patient in shock position
Administer oxygen as indicated</td></tr>
<tr><td colspan="2">ALS Prior to Base Hospital Contact</td></tr>
<tr><td>IV access
Normal Saline
• IV bolus – 1 Liter
o Caution with cardiac and/or renal history
o Continue to evaluate lung sounds. If signs of CHF, decrease IV to TKO
o If vital signs return to within normal limits, decrease IV to TKO
<u>Traumatic Injury</u>
• Do not delay transport for first IV attempt
• Attempt second IV while enroute to ED
• Consider Blood Tubing</td><td>IV/IO access
Normal Saline
• IV/IO bolus – 20 mL/kg
o Caution with cardiac and/or renal history
o Continue to evaluate lung sounds. If signs of CHF, decrease IV to TKO
o If vital signs return to within normal limits, decrease IV to TKO
<u>Traumatic Injury</u>
• Do not delay transport for first IV attempt
• Attempt second IV while enroute to ED
• Consider Blood Tubing</td></tr>
<tr><td colspan="2">Communication Failure Protocol</td></tr>
<tr><td>If shock persists:
• Repeat Normal Saline
o IV bolus – 1 Liter</td><td>If shock persists:
• Repeat Normal Saline
o IV/IO bolus – 20 mL/kg</td></tr>
<tr><td colspan="2">Base Hospital Orders only</td></tr>
<tr><td>Consult with ED Physician for further treatment measures</td><td>Consult with ED Physician for further treatment measures</td></tr>
</table>

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	
If moderate to severe nausea or vomiting is present or there is a potential for airway compromise (secondary to suspected/actual head injury) • IV access • **Ondansetron** o PO – 4 mg ODT • May repeat x 1 in 10 min o IV/IM – 4 mg • May repeat x 1 in 10 min	If moderate to severe nausea or vomiting is present or there is a potential for airway compromise (secondary to suspected/actual head injury) • IV access • **Ondansetron** – 4 years old and greater o PO – 4 mg ODT o IV/IM – 4 mg
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

VCEMS Medical Director

Neonatal Resuscitation

BLS Procedures

Newborn Infant	Infant up to 48 hours old
Provide warmth, position, and suction as needed • Suction if meconium is present Dry and stimulate • Rub gently, but briskly with warm towel Provide warm/dry covering	Provide warmth, position, and suction as needed Stimulate briefly by flicking soles of infant's feet or rubbing infant's back Provide warm/dry covering

Assess Breathing

- If breathing is present and adequate
  - Continue to stimulate and maintain open airway
  - Administer blow-by oxygen as indicated
- For respiratory rate < 30 or is inadequate (weak/gasping)
  - Assist ventilations with BVM for 15-30 seconds, then reassess
  - Continue to assist ventilations as needed until patient is able to maintain own respirations

Assess Circulation

- If HR < 100 bpm
  - Assist ventilations with BVM for 15-30 seconds, then reassess
  - Continue to assist ventilations as needed until patient is able to maintain own HR > 100 bpm
- If HR < 60 bpm
  - Begin CPR – 3:1 ratio
    - 120/min compressions
    - 40/min ventilations

ALS Prior to Base Hospital Contact

Establish IO line

- In presence of CPR or persistent bradycardia only

Persistent Bradycardia < 60 bpm	PEA	Asystole
• **Epinephrine 1:10,000** o IO – 0.01mg/kg (0.1mL/kg) q 3-5 min	• **Epinephrine 1:10,000** o IO – 0.01mg/kg (0.1mL/kg) q 3-5 min • **Normal Saline** o IO bolus – 20mL/kg	• **Epinephrine 1:10,000** o IO – 0.01mg/kg (0.1mL/kg) q 3-5 min

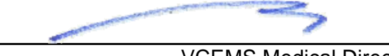
Continue CPR until patient is able to maintain own HR > 100

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.



VCEMS Medical Director

Nerve Agent Poisoning

The Incident Commander is in charge of the scene and you are to follow his/her direction for entering and exiting the scene. Patients in the hot and warm zones MUST be decontaminated prior to entering the cold zone.

ADULT

Base Hospital Orders only

Patient's that are exhibiting obvious signs of exposure (SLUDGE)

Hot/Warm Zones

- **Atropine**
  - IM – 2 mg q 5 min
    - Repeat until symptoms are relieved
- **Pralidoxime (2-Pam)**
  - IM – 600 mg
    - If available
    - Single dose only

IV access should only be performed in the cold zone after complete decontamination

Cold Zone

- IV access
- **Atropine**
  - IV – 2 mg q 1 min
    - Repeat until symptoms are relieved
  - IM – 2 mg q 5 min
    - Repeat until symptoms are relieved
- **Pralidoxime (2-Pam)**
  - IM – 600 mg
    - If available
    - Single dose only (give if not administered within the hot/warm zones)

For seizures:

- **Midazolam**
  - IV – 2 mg
    - Repeat 1 mg q 2 min as needed
    - Max 5 mg
  - IM – 0.1 mg/kg
    - Max 5 mg

Consult with ED Physician for further treatment measures

PEDIATRIC

Base Hospital Orders only

Patient's that are exhibiting obvious signs of exposure (SLUDGE)

Hot/Warm Zones

- **Atropine**
  - IM – 0.05 mg/kg q 5 min
    - Minimum dose – 0.1 mg
    - Repeat until symptoms are relieved

IV/IO access should only be performed in the cold zone after complete decontamination

Cold Zone

- IV/IO access
- **Atropine**
  - IV/IO – 0.05 mg/kg q 1 min
    - Minimum dose – 0.1 mg
    - Repeat until symptoms are relieved
  - IM – 0.05 mg/kg q 5 min
    - Minimum dose – 0.1 mg
    - Repeat until symptoms are relieved

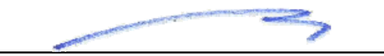
For seizures:

- **Midazolam**
  - IM – 0.1 mg/kg
    - Max 5 mg

Consult with ED Physician for further treatment measures

Additional Information

- **Diazepam** is available in the CHEMPACK and may be deployed in the event of a nerve agent exposure. Paramedics may administer diazepam using the following dosages for the treatment of seizures:
  - **Adult**: 5 mg IM/IV q 10 min titrated to effect *(max 30 mg)*
  - **Pediatric**: 0.1 mg/kg IV/IM/IO (max initial dose 5 mg) over 2-3 min q 10 min titrated to effect *(max total dose 10 mg)*



Overdose/Poisoning

BLS Procedures

ADULT

Decontaminate if indicated and appropriate
Administer oxygen as indicated

PEDIATRIC

Decontaminate if indicated and appropriate
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

ADULT

IV access

Oral ingestion within 1 hour and gag reflex present:

- **Activated Charcoal**
  - PO – 1 gm/kg
    - Max 50 gm

Suspected opiate overdose with respirations less than 12/min:

- **Narcan**
  - IM – 2 mg
  - IV – 0.4 mg q 1 min
    - Initial max 2 mg
  - May repeat as needed to maintain respirations greater than 12/min

PEDIATRIC

IV/IO access

- IO access only if pt in extremis

Oral ingestion within 1 hour and gag reflex present:

- **Activated Charcoal**
  - PO – 1 gm/kg
    - Max 25 gm

Suspected opiate overdose with respirations less than 12/min:

- **Narcan**
  - IV/IM/IO – 0.1 mg/kg
    - Initial max 2 mg
  - May repeat as needed to maintain respirations greater than 12/min

Base Hospital Orders only

ADULT

Tricyclic Antidepressant Overdose

- **Sodium Bicarbonate**
  - IV – 1 mEq/kg

Beta Blocker Overdose

- **Glucagon**
  - IV – 2 mg
    - May give up to 10 mg if available

Calcium Channel Blocker Overdose

- **Calcium Chloride**
  - IV – 1 gm over 1 min
- **Glucagon**
  - IV – 2 mg
    - May give up to 10 mg if available

Stimulant/Hallucinogen Overdose

- **Midazolam**
  - IV – 2 mg
    - Repeat 1 mg q 2 min as needed
    - Max 5 mg
  - IM – 0.1 mg/kg
    - Max 5 mg

Organophosphate Poisoning

- **Atropine**
  - IV – 2 mg q 1 min
    - Repeat until symptoms are relieved

Consult with ED Physician for further treatment measures

PEDIATRIC

Tricyclic Antidepressant Overdose

- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg

Beta Blocker Overdose

- **Glucagon**
  - IV/IO – 0.1 mg/kg
    - May give up to 10 mg if available

Calcium Channel Blocker Overdose

- **Calcium Chloride**
  - IV/IO – 20 mg/kg over 1 min
- **Glucagon**
  - IV/IO – 0.1 mg/kg
    - May give up to 10 mg if available

Stimulant/Hallucinogen Overdose

- **Midazolam**
  - IM – 0.1 mg/kg
    - Max 5 mg

Organophosphate Poisoning

- **Atropine**
  - IV/IO – 0.02 mg/kg q 1 min
    - Minimum dose – 0.1mg
    - Repeat until symptoms are relieved

Consult with ED Physician for further treatment measures

Additional Information:

- For Caustic/Corrosive or petroleum distillate ingestions, DO NOT GIVE CHARCOAL OR INDUCE VOMITING
- For Tricyclic Antidepressant Overdose, DO NOT GIVE CHARCOAL
- If chest pain present, refer to chest pain policy. DO NOT GIVE ASPIRIN
- Organophosphate poisoning – SLUDGE
  - S – Salivation
  - L – Lacrimation
  - U – Urination
  - D – Defecation
  - G – Gastrointestinal Distress
  - E – Elimination (vomiting)
- Narcan – it is not necessary that the patient be awake and alert. Administer until max dosage is reached **or** RR greater than 12/min. When given to chronic opioid patients, withdrawal symptoms may present. IM dosing is the preferred route of administration.

VCEMS Medical Director

Pain Control

ADULT	PEDIATRIC
BLS Procedures	
Place patient in position of comfort Administer oxygen as indicated	Place patient in position of comfort Administer oxygen as indicated
ALS Prior to Base Hospital Contact	

IV access
 	
Morphine
• IV – 2-4 mg over 1-2 min
  o Repeat q 3 min as needed for pain relief
  o Max 10 mg
• IM – 0.1 mg/kg
  o Max 10 mg
 	
Recheck vital signs before and after each administration
• Hold if SBP < 100 mmHg
 	
If patient has significant injury to head, chest, abdomen or is hypotensive, ***DO NOT*** *administer pain control unless ordered by ED Physician*
	IV access
	
	Morphine – given for burns and isolated extremity injuries only
	• IV – 0.1 mg/kg over 1-2 min
	  o May repeat x 1 after 3 min as needed for pain relief
	  o Max 0.2 mg/kg or 10 mg
	• IM – 0.2 mg/kg
	  o Max 10 mg
	
	Recheck vital signs before and after each administration
	
	If patient has significant injury to head, chest, abdomen or is hypotensive, ***DO NOT*** *administer pain control unless ordered by ED Physician*

Communication Failure Protocol	

If significant pain continues:
• **Morphine**
  o IV – 2-4 mg over 1-2 min
    • Max repeat dose of 10 mg
    • Max total dosage of 20 mg
  o IM – 0.1 mg/kg
    • Max repeat dose of 10 mg
	If significant pain continues:
	• **Morphine**
	  o IV – 0.1 mg/kg over 1-2 min
	    • May repeat x 1 after 3 min as needed for pain relief
	    • Max repeat dose of 10 mg
	    • Max total dosage of 0.4 mg/kg or 20 mg
	  o IM – 0.2 mg/kg
	    • Max repeat dose of 10 mg

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

Seizures

BLS Procedures

ADULT

Protect from injury
Maintain/manage airway as indicated
Administer oxygen as indicated

PEDIATRIC

Protect from injury
Maintain/manage airway as indicated
For suspected febrile seizures, begin passive cooling measures. If seizure activity persists, see below
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

ADULT

IV access

Determine Blood Glucose level

If < 60

- **D_{50}**
  - IV – 25 mL
- **Glucagon** (if no IV access)
  - IM – 1 mg

Persistent Seizure Activity

- **Midazolam**
  - IV – 2 mg
    - Repeat 1 mg q 2 min as needed
    - Max 5 mg
  - IM – 0.1 mg/kg
    - 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

3rd Trimester Pregnancy & No Known Seizure History

- **Magnesium Sulfate**
  - IVPB – 2 gm in 50 mL D_5W infused over 5 min
    - MUST Repeat x 1
    - Slow or stop infusion if bradycardia, heart block, or decreased respiratory effort occur

Recheck Blood Glucose level 5 min after D_{50} or 10 min after Glucagon administration

If still < 60

- *Repeat* **D_{50}**
  - IV – 25 mL

PEDIATRIC

Consider IV/IO access

Determine Blood Glucose level

If < 60

- Less than 2 years old
  - **D_{25}**
    - IV – 2 mL/kg
  - **Glucagon** (if no IV access)
    - IM – 0.1 mg/kg
      - Max 1 mg
- 2 years old and greater
  - **D_{50}**
    - IV – 1 mL/kg
  - **Glucagon**
    - IM – 0.1 mg/kg
      - Max 1 mg

Persistent Seizure Activity

- **Midazolam**
  - IM – 0.1 mg/kg
    - Max 5 mg

Recheck Blood Glucose level 5 min after D_{50} or 10 min after Glucagon administration

If still < 60

- Less than 2 years old
  - **D_{25}**
    - IV – 2 mL/kg
- 2 years old and greater
  - **D_{50}**
    - IV – 1 mL/kg

Base Hospital Orders only

ADULT

Consult with ED Physician for further treatment measures

PEDIATRIC

Consult with ED Physician for further treatment measures

Additional Information:

- Treatment with Midazolam as indicated in the following:
  - Continuous seizures > 5 min (or > 2 min in pregnancy)
  - Repetitive seizures without regaining consciousness
- 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

Shortness of Breath – Pulmonary Edema

BLS Procedures

Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Nitroglycerin

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

Initiate CPAP for moderate to severe distress

Perform 12-lead ECG

IV access

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

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

Communication Failure Protocol

Lasix

- IV – 40 mg
    - Only if patient prescribed Lasix or Bumex

If patient becomes or presents with hypotension

- **Dopamine**
    - IVPB – 10 mcg/kg/min

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Shortness of Breath – Wheezes/Other

ADULT	PEDIATRIC
BLS Procedures	
Assist patient with prescribed Metered Dose Inhaler if available Administer oxygen as indicated	Assist patient with prescribed Metered Dose Inhaler if available Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
Perform Needle Thoracostomy if indicated per Policy 715 Moderate Distress • **Albuterol** o Nebulizer – 5 mg/6 mL • Repeat as needed Severe Distress • Treatment for moderate distress • Less than 40 years old o **Epinephrine 1:1,000** • IM – 0.3 mg Consider CPAP for both moderate and severe distress IV access	Perform Needle Thoracostomy if indicated per Policy 715 Moderate Distress • Less than 2 years old o **Albuterol** • Nebulizer – 2.5 mg/3 mL o Repeat as needed • 2 years old and greater o **Albuterol** • Nebulizer – 5 mg/6 mL o Repeat as needed Severe Distress • Treatment for moderate distress • **Epinephrine 1:1,000** o IM – 0.01 mg//kg • Max 0.3 mg Suspected Croup • **Normal Saline** o Nebulizer/Aerosolized Mask – 5 mL Consider CPAP if age 8 years old and greater IV access
Communication Failure Protocol	
Severe Distress • Less than 40 years old o If no change is apparent 10 minutes after first Epinephrine administration: • *Repeat* **Epinephrine 1:1,000** o IM – 0.3 mg • 40 years old and greater o **Epinephrine 1:1,000** • IM – 0.3 mg o Only if apparent asthma o Only if age less than 60 years old o Only if no improvement with initial therapies	Severe Distress • If no change is apparent 10 minutes after first Epinephrine administration o *Repeat* **Epinephrine 1:1,000** • IM – 0.01 mg/kg o Max 0.3 mg
Base Hospital Orders only	
	Suspected Croup and no improvement with Normal Saline nebulizer • Less than 2 years old o **Epinephrine 1:1,000** • Nebulizer/Aerosolized Mask – 2.5 mL • 2 years old and greater o **Epinephrine 1:1,000** • Nebulizer/Aerosolized Mask – 5 mL
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

Additional Information:

- 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.

VCEMS Medical Director

Supraventricular Tachycardia

BLS Procedures

Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Valsalva maneuver

IV Access

Stable – Mild to moderate chest pain/SOB

Unstable – ALOC, signs of shock or CHF

- Place on backboard and prepare for synchronized cardioversion

Communication Failure Protocol

Stable

- **Adenosine**
  - IV – 6 mg rapid push immediately followed by 10-20 mL NS flush

No conversion or rate control

- **Adenosine**
  - IV – 12 mg rapid push immediately followed by 10-20 mL NS flush
    - May repeat x 1 if no conversion or rate control

Unstable

- **Midazolam**
  - IV – 2 mg
    - Should only be given if it does not result in delay of synchronized cardioversion
    - 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
- **Synchronized Cardioversion**
  - Use the biphasic energy settings that have been approved by service provider medical director

Base Hospital Orders only

Consult with ED Physician for further treatment measure

Additional Information:

- Adenosine is contraindicated in pt with 2° or 3rd° AV Block, Sick Sinus Syndrome (except in pt with functioning pacemaker), or known hypersensitivity to adenosine
- Unless the patient is in moderate or severe distress, consider IV access and transport only. Consider withholding adenosine administration if patient is stable until ED Physician evaluation
- Document all ECG strips during adenosine administration and/or synchronized cardioversion

VCEMS Medical Director

Symptomatic Bradycardia

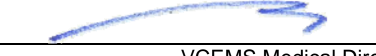
<table>
<tr><th>ADULT (HR < 45 bpm)</th><th>PEDIATRIC (HR < 60 bpm)</th></tr>
<tr><th colspan="2">BLS Procedures</th></tr>
<tr><td>Administer oxygen as indicated
Shock position as tolerated</td><td>Administer oxygen as indicated
Assist ventilations if needed
If significant ALOC, initiate CPR</td></tr>
<tr><th colspan="2">ALS Prior to Base Hospital Contact</th></tr>
<tr><td>IV access

Atropine
• IV – 0.5 mg (1 mg/10 mL)

Transcutaneous Pacing (TCP)
• Should be initiated only if patient has signs of hypoperfusion
• Should be started immediately for 3° heart blocks and 2° Type 2 (Mobitz II) heart blocks
• If pain is present during TCP
  o Morphine – per policy 705 - Pain Control</td><td>IV access
• IO access only if pt in extremis

Epinephrine 1:10,000
• IV/IO – 0.01 mg/kg (0.1 mL/kg) q 3-5 min</td></tr>
<tr><th colspan="2">Communication Failure Protocol</th></tr>
<tr><td>If symptoms persist for 3 minutes after first atropine dose and if no capture with TCP
• Atropine
  o IV – 0.5 mg q 3-5 min
    • Max 0.04 mg/kg

• Dopamine
  o IVPB – 10 mcg/kg/min
    • Use if patient continues to be unresponsive to atropine and TCP</td><td></td></tr>
<tr><th colspan="2">Base Hospital Orders only</th></tr>
<tr><td>For suspected hyperkalemia
• Calcium Chloride
  o IV – 1 gm over 1 min
    • Withhold if suspected digitalis toxicity
• Sodium Bicarbonate
  o IV – 1 mEq/kg</td><td>Atropine
• IV/IO – 0.02 mg/kg
  o Minimum dose – 0.1 mg</td></tr>
<tr><td>Consult with ED Physician for further treatment measures</td><td>Consult with ED Physician for further treatment measures</td></tr>
<tr><td colspan="2">Additional Information
• Bradycardia does not require treatment unless signs and symptoms are present (chest pain, altered level of consciousness, abnormal skin signs, profound weakness, or low BP)</td></tr>
</table>



VCEMS Medical Director

Ventricular Tachycardia Sustained – Not in Arrest

BLS Procedures

Administer oxygen as indicated

ALS Prior to Base Hospital Contact

IV Access

Stable – Mild to moderate chest pain/SOB

- **Lidocaine**
  - IV – 1 mg/kg
    - Rate of 50 mg/min

Unstable – ALOC, signs of shock or CHF

- **Midazolam**
  - IV – 2 mg
    - Should only be given if it does not result in delay of synchronized cardioversion
    - For IV use – Dilute 5 mg (1mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL
- **Synchronized Cardioversion**
  - Use the biphasic energy settings that have been approved by service provider medical director
- If patient needs sedation and there is a delay in obtaining sedation medication
  - **Lidocaine**
    - IV – 1 mg/kg
      - Rate of 50 mg/min

Unstable polymorphic (irregular) VT:

- **Defibrillation**
  - Use the biphasic energy settings that have been approved by service provider medical director

POST-CONVERSION

If patient converts to narrow complex rhythm greater than 50 bpm and not in 2nd or 3rd degree heart block

- **Lidocaine**
  - IV – 1 mg/kg
    - If Lidocaine has already been administered, then withhold this dose

If recurrent VT, perform synchronized cardioversion at last successful biphasic energy setting

Communication Failure Protocol

Stable/Unstable:

- *Repeat* **Lidocaine**
  - IV – 0.5 mg/kg q 5-10 min
    - Max 3 mg/kg
    - Hold if decreased cardiac output, significant liver dysfunction, or in patient > 70 years of age

Base Hospital Orders only

Torsades de Pointes

- **Magnesium Sulfate**
  - IVPB – 2 gm in 50 mL D_5W infused over 5 min
    - May repeat x 1 if Torsades continues or recurs

Consult with ED Physician for further treatment measures

Additional Information:

- Early base hospital contact is recommended in unusual circumstances, e.g. Torsades de Pointes, Tricyclic OD and renal failure.
- Ventricular tachycardia (VT) is a rate > 150 bpm

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Airway Management		Policy Number 710
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 1, 2010
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: December 1, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 1986 October 14, 2010 October 14, 2010 October 31, 2012	Effective Date: December 1, 2010

I. PURPOSE: To define the indications, procedure and documentation for airway management by prehospital emergency medical personnel within Ventura County

II. AUTHORITY: Health and Safety Code, §1798 and §1798.2; §1798.160, and §1798.170 and California Code of Regulations, Title 22, §100218 and §100254.

III. Policy: Airway management shall be performed on all patients that are unable to maintain or protect their own airway. Paramedics may utilize oral endotracheal intubation on patients eight (8) years of age or older, in accordance with Ventura County Policy 705.

IV. Definitions: Intubation Attempt – an interruption of ventilation, with laryngoscope insertion, for the purpose of endotracheal tube (ETT) placement.

V. Procedure:

A. Bag-Valve-Mask (BVM) ventilations

1. Indications
   a. Respiratory arrest or severe respiratory compromise
   b. Cardiac arrest – according to VCEMS Policy 705
2. Contraindications
   a. None
3. Impedance Threshold Device (ITD, ResQPOD) – CARDIAC ARREST ONLY
   a. MUST UTILIZE 2-RESCUER VENTILATION TECHNIQUE
   b. For all rhythms, in patients 18 y/o and above, start continuous compressions at 100/min. Attach ResQPOD to BVM. As soon as BVM/ResQPOD is ready, insert oral airway and perform CPR at

30:2 compression to ventilation ratio, utilizing the BVM/ResQPOD to deliver the 2 breaths.

c. Maintain a 2-handed face mask seal throughout compressions.

d. If the patient has return of spontaneous circulation (ROSC), immediately remove ResQPOD.

e. Continue to assist ventilations at 1 breath every 5-6 seconds.

B. Endotracheal intubation (ETI)

1. Indications

a. Cardiac arrest – according to VCEMS Policy 705

b. Respiratory arrest or severe respiratory compromise **AND** unable to maintain an adequate airway and adequately ventilate with BVM.

c. After Base Hospital (BH) contact has been made, the BH Physician may order endotracheal intubation in other situations.

2. Contraindications

a. Traumatic brain injury – unless unable to maintain adequate airway (e.g. – persistent vomiting).

b. Intact gag reflex.

3. Intubation Attempts

a. There shall be no more than two (2) attempts to perform ETI, lasting no longer than 40 seconds each, and prior to BH contact. For patients in cardiac arrest, each ETI attempt shall interrupt chest compressions for no longer than 20 seconds.

b. The patient shall be ventilated with 100% O_2 by BVM for one minute before each attempt.

c. If ETI cannot be accomplished in 2 attempts, the airway shall be managed by BLS techniques.

d. If ETI and BLS techniques are unsuccessful, the approved alternate ALS airway device may be inserted.

4. ITD (ResQPOD) – CARDIAC ARREST ONLY

a. If/when advanced airway is established, transfer the ResQPOD to the advanced airway and start continuous compressions at 100/min with one breath each 6 seconds (timing light) or every 10th compression

b. If patient has ROSC, immediately remove ResQPOD from advanced airway and continue to assist ventilations at 1 breath every 5-6 seconds as needed.

5. Special considerations

a. Flexible Stylet. A flexible stylet may be used for any ETI attempt that involves an ETT size of at least 6.0 mm.

1) Two Person Technique (recommended when visualization is less than ideal):

a) Visualize as well as possible.

b) Place stylet just behind the epiglottis with the bent tip anterior and midline.

c) Gently advance the tip through the cords maintaining anterior contact.

d) Use stylet to feel for tracheal rings.

e) Advance stylet past the black mark. A change in resistance indicates the stylet is at the carina.

f) Withdraw the stylet to align the black mark with the teeth.

g) Have your assistant load and advance the ETT tip to the black mark.

h) Have your assistant grasp and hold steady the straight end of the stylet.

i) While maintaining laryngoscope blade position, advance the ETT.

j) At the glottic opening turn the ETT 90 degrees counter-clockwise to assist passage over the arytenoids.

k) Advance the ETT to 22 cm at the teeth.

l) While maintaining ETT position, withdraw the stylet.

2) One Person Technique (recommended when visualization is good but cords are too anterior to pass ET tube).

a) Load the stylet into the ETT with the bent end approximately 4 inches (10 cm) past the distal end of the ETT.

b) Pinch the ETT against the stylet.

c) With the bent tip anterior, while visualizing the cords advance the stylet through the cords.

d) Maintain laryngoscope blade position.

e) When the black mark is at the teeth ease your grip to allow the tube to slide over the stylet. If available have an assistant stabilize the stylet.

f) At the glottic opening turn the ETT 90 degrees counter-clockwise to assist passage over the arytenoids.

g) Advance the ETT to 22 cm at the teeth.

h) While maintaining ETT position, withdraw the stylet.

b. Tracheal stoma intubation

1) Select the largest endotracheal tube that will fit through the stoma without force (it should not be necessary to use lubricant).

2) Do not use stylet.

3) Pass ETT until the cuff is just past the stoma.

4) Inflate cuff.

5) Attach the CO_2 measurement device to the ETT and confirm placement (as described below).

6) Secure tube.

6. Confirmation of Placement – It is the responsibility of the paramedic who has inserted the ETT to personally confirm (using air aspiration, auscultation, and CO_2 detection/measurement) and document proper placement. Responsibility for the position of the ETT shall remain with the intubating paramedic until a formal transfer of care has been made.

a. Prior to intubation, prepare both the air aspiration and the CO_2 measurement devices.

b. Insert ETT, advance, and hold at the following depth:

1) Less than 5 ft. tall: balloon 2 cm past the vocal cords.

2) 5’-6’6” tall: 22 cm at the teeth.

3) Over 6’6” tall: 24 cm at the teeth or 2 cm past the vocal cords.

c. After inserting the ETT, in the patient requiring CPR, resume chest compressions while confirming ETT placement.

d. Before inflating ETT balloon, perform the air aspiration technique.

1) Deflate the bulb, connect to the ETT, and observe for refilling.

2) Refilling of the bulb in less than 5 seconds indicates tube placement in trachea.

3) If the bulb does not completely refill within 5 seconds, unless able to definitively confirm placement on repeat direct laryngoscopy, remove the ETT. Suspect delayed filling with the ETT in the trachea if the patient is morbidly obese, has fluid in the airway (pulmonary edema, aspiration, pneumonia, drowning), or the ETT is against the carina.

e. Inflate the ETT cuff, attach the CO_2 measurement device, and begin ventilations. During the first 5-6 ventilations, auscultate both lung fields (in the axillae) and the epigastrium.

f. After 6 ventilations, observe the CO_2 measurement device:

1) If a colorimetric CO_2 detector device is used for initial placement confirmation prior to capnography, observe the color at the end of exhalation. Yellow indicates the presence of >5% exhaled CO_2 and tan 2-5% CO_2. Yellow or tan indicates tube placement in the trachea. Purple indicates less than 2% CO_2 and in the patient with spontaneous circulation is a strong indicator of esophageal intubation.

2) When capnography is applied, a regular waveform with each ventilation should be seen with tracheal placement. If the patient has been in cardiac arrest for a prolonged time (more than 5-10 minutes) the waveform may be diminished or, rarely, absent. In the patient with spontaneous circulation, if a regular waveform with a CO_2 of 25 or higher is not seen, that is a strong indicator of esophageal intubation.

g. Using information from auscultation and CO_2 measurement, determine the ETT position.
   1) If breath sounds are equal, there are no sounds at the epigastrium, and the CO_2 measurement device indicates tracheal placement, secure the ETT using an ETT holder.
   2) If auscultation or the CO_2 measurement device, indicates that the ETT may be in the esophagus, immediately reevaluate the patient. If you are not CERTAIN that the ETT is in the trachea, the decision to remove the ETT should be based upon the patients overall clinical status (e.g., skin color, respirations, pulse oximetry)
   3) If breath sounds are present but unequal, the ETT position may be adjusted as needed.

h. Once ETT position has been confirmed, reassessment, using CO_2 measurement, pulse oximetry (if able to obtain), and auscultation of breath sounds should be performed each time patient is moved.

i. Continue to monitor the CO_2 measurement device during treatment and transportation. If a change occurs from positive (yellow/tan) to negative (purple), or the waveform diminishes or disappears, reassess the patient for possible accidental extubation or change in circulation status.

j. After confirmation of proper ETT placement and prior to movement, all intubated patients shall have their head and neck maintained in a neutral position with head supports. A cervical collar will only be used if a cervical spine injury is suspected.
   1) Reconfirm ETT placement after any manipulation of the head or neck, including positioning of a head support, and after each change in location of the patient.
   2) Report to nurse and/or physician that the head support is for the purpose of securing the ETT and not for trauma (unless otherwise suspected).

7. Documentation

a. All ETI attempts must be documented in the “ALS Airway” section of the approved Ventura County Documentation System and the

Ventura County "Advanced Airway Quality Improvement Data Collection" form.

b. Information not obvious from the "ALS Airway" section (e.g., vomitus in airway, suctioning, extubation and reintubation) will be documented in the narrative.

c. An "Advanced Airway Quality Improvement Data Collection" form must be completed after **any** attempt at intubation. The form must be completed by the intubating paramedic, signed by the treating emergency physician or, if the patient is not transported, another on-scene paramedic if one is on-scene., , and delivered to the intubating paramedic's agency representative before the end of the paramedic's shift,. If all ETI attempts are unsuccessful, no physician signature is needed.

d. Documentation of the intubation in the approved Ventura County Documentation System must include the following elements. The acronym for the required elements is "SADCASES."

1) Size of the ETT
2) Attempts, number
3) Depth of the ETT at the patient's teeth
4) Confirmation devices used and results. For capnography, recording of waveform at the following points:
    a. Initial ETT placement confirmation;
    b. Movement of patient; and
    c. Transfer of care.
5) Auscultation results
6) Secured by what means
7) ETCO2, initial value
8) Support of the head or immobilization of the cervical spine.

e. A printed code summary mounted and labeled displaying capnography waveform at the key points noted above. This printed code summary shall be maintained by the provider as part of the patient record.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES</td><td>HEALTH CARE AGENCY
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Needle Thoracostomy</td><td>Policy Number:
715</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, EMT-P</td><td>Date: December 1, 2010</td></tr>
<tr><td>APPROVED:
Medical Director</td><td>Angelo Salvucci, M.D.</td><td>Date: December 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>August 2010
October 14, 2010
October 14, 2010
October 31, 2012</td><td>Effective Date: December 1, 2010</td></tr>
</table>

I. Purpose: To define the indications, procedure and documentation for needle thoracostomy use by paramedics.

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

III. Policy: Paramedics may perform needle thoracostomy on patients with a suspected tension pneumothorax in accordance with this policy.

IV. Procedure:

A. Indications

1. Patients with **ALL** of the following:
   a. Clinical suspicion of pneumothorax (e.g., trauma, dyspnea, chest pain),
   b. Systolic Blood Pressure less than 90, and
   c. Absent or significantly decreased breath sounds on the affected side.

B. Contraindications: None in this setting

C. Equipment

1. Povidone-iodine prep swab
2. 10 ml syringe
3. 5.0 - 6.0 cm, 12-16 gauge over-the-needle catheter
4. Connection tubing
5. Heimlich valve
6. Tape

D. Placement

1. Attach the syringe to the needle/catheter.
2. Identify and prep the site:
   - Locate the second intercostal space in the mid-clavicular line.
   - If unable to place anteriorly, lateral placement is in the fourth intercostal space in the mid-axillary line.

- Prepare the site with povidone-iodine solution.

3. Insert the needle/catheter perpendicular to the skin over the rib and direct it just over the top of the rib into the intercostal space.
4. After inserting the needle under the skin, maintain negative pressure in the syringe.
5. Advance the needle/catheter through the parietal pleura until a “pop” is felt and/or air or blood enters the syringe, then advance **ONLY** the catheter (not the syringe/needle) until the catheter hub is against the skin.

CAUTION: Do not reinsert needle into cannula due to danger of shearing cannula.

6. Hold the catheter in place and remove and discard the syringe and needle.
7. Attach tubing and Heimlich valve.
8. Secure the catheter hub to the chest wall with dressings and tape.
9. Reevaluate the patient (VS, lung sounds).

E. Documentation

1. All needle thoracostomy attempts must be documented in the Ventura County Approved Documentation System.
2. Documentation will include indication, location and results.

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title 12 Lead ECG		Policy Number: 726
APPROVED Administrator	Steven L. Carroll, EMT-P	Date: September 1, 2010
APPROVED Medical Director:	Angelo Salvucci, MD	Date: September 1, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 10, 2006 August, 2010 August 12, 2010 September 1, 2012	Effective Date: September 1, 2010

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 suspected of having an acute myocardial infarction and provide treatment in accordance with this policy. Only paramedics who have received training in this policy are authorized to obtain a 12-lead ECG on patients.

IV. Procedure:

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

1. Chest, upper back or upper abdominal discomfort.
2. Generalized weakness.
3. Dyspnea.

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 first to all patients. 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 (other than oxygen).
2. The ECG should be done prior to transport.

3. If the ECG is of poor quality (artifact or wandering baseline), may repeat to a total of 3.
4. Once an acceptable quality ECG is obtained, switch the monitor to the standard 3-lead function. Repeat the 12-lead ECG only if the original ECG interpretation is NOT ***ACUTE MI SUSPECTED***, and patient's condition worsens.
5. If interpretation is ***ACUTE MI SUSPECTED**, verify by history and physical exam that the patient does not have a pacemaker or ICD.

D. Base Hospital Communication/Transportation:

1. The ECG interpretation begins with ACUTE MI SUSPECTED, report that to MICN at the beginning of the 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 ECG Interpretation is ACUTE MI SUSPECTED, 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 ECG interpretation is "***ACUTE MI SUSPECTED***", and the underlying rhythm is Atrial Flutter the Base Hospital shall be notified at the beginning of the report. The Cath Lab will not be activated.
5. If the ECG interpretation is ***ACUTE MI SUSPECTED*** 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 is **not** ***ACUTE MI SUSPECTED*** 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. Original prehospital 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 ECG interpretation is ***ACUTE MI SUSPECTED***, 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 physician interpretation is Acute MI, the patient will be treated as an ***ACUTE MI SUSPECTED***. Do not perform an additional ECG.
2. If there is no interpretation of another ECG then repeat the ECG.

G. Documentation

1. Approved Ventura County Documentation System (AVCDS) documentation will be completed per VCEMS policy. A copy of the 12 Lead 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.

Policy Title: Tourniquet Use		Policy Number: 731
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 1, 2010
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date: December 1, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	July 2010 August, 2010 August, 2010 August 31, 2012	Effective Date: December 1, 2010

I. Purpose: To define the indications, procedure and documentation for tourniquet use by EMTs and paramedics.

II. Authority: Health and Safety Code, Sections 1797.220 and 1798.

III. Policy: EMTs and Paramedics may utilize tourniquets on patients in accordance with this policy.

IV. Procedure:

A. Indications

1. Life threatening extremity hemorrhage that can not be controlled by other means.

B. Contraindications

1. Non-extremity hemorrhage.
2. Proximal extremity location where tourniquet application is not practical.

C. Tourniquet Placement:

1. Visually inspect injured extremity and avoid placement of tourniquet over joint, angulated or open fracture, stab or gun shot wound sites.
2. Assess and document circulation, motor and sensation distal to injury site.
3. Apply tourniquet proximal to wound (usually 2-4 inches).
4. Tighten tourniquet rapidly to least amount of pressure required to stop bleeding.
5. Cover wound with appropriate sterile dressing and/or bandage.
6. Do not cover tourniquet- the device must be visible.
7. Re-assess and document absence of bleeding distal to tourniquet.
8. Remove any improvised tourniquet that may have been previously applied.
9. Tourniquet placement time must be documented on the tourniquet device.
10. Ensure receiving facility staff is aware of tourniquet placement and time tourniquet was placed.

D. Tourniquet Removal (Paramedic only)

1. Indications

    a. Releasing the tourniquet should only be considered if applied for 60 minutes or longer.

    b. Absence of bleeding distal to the tourniquet should be confirmed.

2. Procedure

    a. Obtain IV/ IO access.

    b. Maintain continuous ECG monitoring.

    c. Hold firm direct pressure over wound for at least 5 minutes before releasing tourniquet.

    c. Gently release the tourniquet and monitor for reoccurrence of bleeding

    d. Document time tourniquet was released.

    e. Bandage wound and re-assess and document circulation, motor and sensation distal to the wound site regularly.

E. Documentation

1. All tourniquet uses must be documented in the Ventura County Approved Documentation System.

2. Documentation will include location of tourniquet, time of application, and person at the receiving hospital to whom the tourniquet is reported.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
ReddiNet Communications Policy</td><td>Policy Number
920</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, EMT-P</td><td>Date: December 1, 2010</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Angelo Salvucci, M.D.</td><td>Date: December 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>April 26, 2007
October 14, 2010
October 14, 2010
October 31, 2013</td><td>Effective Date: December 1, 2010</td></tr>
</table>

I. PURPOSE: The Rapid Emergency Digital Data Network (REDDINET) is the computerized system that links hospitals, the EMS Agency, and Public Health for a variety of purposes; including but not limited to **daily** (Q24 hr) reports of diversion status, multiple casualty incidents (MCI), assessment communication, disease surveillance, and current HAvBED status. This policy defines the expectation for the use and maintenance of ReddiNet by all facilities.

II. AUTHORITY: Health and Safety Code, Division 2.5, Chapter 1, Section 1797.204 and Chapter 6, Section 1798.100.

III. POLICY:

A. The ReddiNet System is to be maintained by each individual facility. This includes, but is not limited to, maintenance and upgrade of all associated hardware, software, and licensing.

B. It is the responsibility of each facility to ensure that any staff expected to use the ReddiNet System be properly trained and refreshed on a routine basis (at least twice per year). At least one staff member who is knowledgeable on the use of the ReddiNet System is to be on duty at all times.

C. The ReddiNet System is to remain online at all times unless there is a hardware or software problem that disables the system, in which case every effort shall be made to correct the problem as quickly as possible.

D. The sound volume on the ReddiNet System is to be maintained at an adequate level to alert staff within a facility at all times, and is never to be placed on mute.

E. The ReddiNet System shall be placed in an easily accessible location within each facility.

F. The use of the ReddiNet computer is limited to operation of the ReddiNet System and access to EMS educational materials only. Accessing the Internet or other applications on the system is prohibited.

G. VCEMS may send an Assessment Poll as needed. Each facility is to acknowledge and respond to this poll as directed by the system.

H. The ReddiNet System is not to be used to disseminate non-system information such as conference flyers, educational opportunities, and other like materials.

IV. PROCEDURE:

A. Emergency Department and other appropriate hospital staff will use ReddiNet for the following information:

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

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

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

B. ReddiNet System Failure or Disruption

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

2. If the ReddiNet System is not functioning due to a systemwide issue, (ie: ReddiNet server or internet service provider failure), facilities are to utilize the following procedure:
   a. Notify the EMS Agency of the ReddiNet System failure.
   b. FAX Appendix A to the EMS Agency and all facilities in your hospital grouping to notify of your current diversion status. Updates should be provided every 8 hours until the system is functional. For Internal Disaster category only, fax should also be sent to Fire Communications Center (FCC).
   c. ReddiNet and/or the EMS Agency will notify all facilities and FCC when service is restored.

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

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

County of Ventura
Emergency Medical Services Agency

Diversion Notification

(For use during ReddiNet failure only)

Date: ________________________ **ReddiNet Failure Reason:** _________

Time: ________________________ ________________________________

Name: ________________________ ________________________________

Hospital:

- ☐ CMH
- ☐ LRRMC
- ☐ OVCH
- ☐ SPH
- ☐ SJPVH
- ☐ SJRMC
- ☐ SVH
- ☐ VCMC

Diversion Category:

- ☐ ICU / CCU Saturation
- ☐ ED Saturation
- ☐ Neuro / CT Scanner
- ☐ Internal Disaster

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

Hospital	*Fax Number*	*Hospital Grouping*
Community Memorial Hospital	**(805) 648-6170**	(OVCH, SJRMC, SPH, VCMC)
Los Robles Hospital and Medical Center	**(805) 370-4579**	(SVH, SJRMC, SJPVH)
Ojai Valley Community Hospital	**(805) 640-2360**	(CMH, SPH, VCMC)
Santa Paula Hospital	**(805) 525-6778**	(CMH, OVCH, SJRMC, VCMC)
Simi Valley Hospital	**(805) 527-9374**	(LRHMC, SJPVH, SJRMC, VCMC)
St. Johns Regional Medical Center	**(805) 981-4436**	(CMH, SJPVH, VCMC)
St. Johns Pleasant Valley Hospital	**(805) 383-7465**	(SJRMC, LRHMC, SVH, VCMC)
Ventura County Medical Center	**(805) 652-3299**	(CMH, SPH, OVCH, SJRMC)

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

Ventura County Fire Communications Center (805) 383-7631

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Documentation of Prehospital Care</td><td colspan="2">Policy Number
1000</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven Carroll, EMT-P</td><td colspan="2">Date: December 1, 2010</td></tr>
<tr><td>APPROVED:
Medical Director</td><td>Angelo Salvucci, M.D.</td><td colspan="2">Date: December 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>June 15, 1998
October 14, 2010
Octoer 14, 2010
October 31, 2013</td><td>Effective Date:</td><td>December 1, 2010</td></tr>
</table>

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

II. AUTHORITY: Title 22 Section 100147.

III. POLICY: Patient care provided by first responders and ambulance personnel will be documented using the appropriate method.

IV. PROCEDURE:

A. Provision of Forms

VC EMS will provide a supply of First Responder Patient Care Records (FR PCR) to EMS system participants that are not currently on the approved Ventura County documentation system (AVCDS).

B. Documentation

1. The VCEMS FR PCR and AVCDS report will be used to document the care provided by first responders and ambulance personnel for every patient contact. A patient contact will be defined as any encounter involving Ventura County pre-hospital personnel with any person consenting, either implied or informed, to assessment and/or treatment. Documentation shall be completed on any person with obvious injury or significant mechanism regardless of consent. Documentation of care given by first responders will not interfere with transport agency assessment or patient care procedures. The following are exceptions:

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

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

c. In the event of multiple patients, documentation will be as follows:

1) Level 1 MCI: The care of each patient shall be documented using an AVCDS report.

2) Level 2 and 3 MCI: 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.

2. Transfer of Care

Transfer of care between two field provider temas and between field provider and hospital shall be documented on appropriate AVCDS.

3. AVCDS and FR PCR’s shall be completed according to instructions distributed by VC EMS.

A. First Responder Patient Care Record

1) Original shall be retained by the provider agency. A copy shall be submitted to the VC EMS Agency.

C. In the event the cardiac monitor is attached as required by any of the VC EMS 705 policies, a rhythm strip shall be recorded and mounted on an ECG form. Additionally, anytime there are changes in the patient's ECG rhythm, defibrillation occurs, ALS procedures are performed, or after ALS medications are administered, a trace recording of the ECG is required. Distribution of these trace recordings are as follows:

1. The original copy shall be placed in the patient's chart.
2. Two additional copies of that strip shall be made. The first submitted to the receiving or base hospital (depending on where the patient is transported), and the second to the provider.

D. Submission to VC EMS

The Emergency Medical Services Agency copy of the FR PCR shall be submitted to the Emergency Medical Services Agency by Provider Agency at least monthly.

F. Dry Run/Against Medical Advice

Every patient contact resulting in refusal of medical attention/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 AMA.

G. ALS Interfacility Transfers (Acute Care Facility to Acute Care Facility)

Documentation shall be completed on all ALS Interfacility 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 AVCDS.

H. Patient Medical Record

The hospital copy of the FR PCR, AVCDS 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.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Trauma Care System – General Provisions		Policy Number 1400
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: July 1, 2010
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: July 1, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	July 1, 2010 July 1, 2011	Effective Date: July 1, 2010

I. PURPOSE: To provide standards and guidelines for the Ventura County Trauma Care System. To provide all injured patients the accessibility to an organized, multi-disciplinary and inclusive system of trauma care. To ensure that all injured patients are taken to the time-closest and most appropriate medical facility.

II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798, and California Code of Regulations, Title 22, §100255.

III. POLICY:

A. Multi-disciplinary Nature of Systematized Trauma Care

The Ventura County EMS Agency (VCEMS) recognizes the multi-disciplinary nature of a systemized approach to trauma care. VCEMS has adopted policies, guidelines and triage criteria that provide for the coordination of all resources and ensure the accessibility to the time-closest and most appropriate medical facility for all injured patients.

B. Public Information and Education

1. VCEMS is committed to the establishment of trauma system support and the promotion of injury prevention and safety education.
2. VCEMS facilitates speakers to address public groups, and serves as a resource for trauma information/education.
3. VCEMS assists community and professional groups in the development and dissemination of education to the public on such topics as injury prevention, safety education programs and access to the Trauma Care System.

4. Each designated facility must participate in the development of public awareness and education campaigns for their service area.

C. Marketing and Advertising

1. In accordance with the Health and Safety Code, Division 2.5, no healthcare provider shall use the term "trauma facility," "trauma hospital," "trauma center," "trauma care provider," "trauma care vehicle," or similar terminology in its signs or advertisements or in printed materials and information it furnishes to the general public unless its use has been authorized by VCEMS.
2. All marketing and promotional plans, with respect to trauma center designation shall be submitted to VCEMS for review and approval, prior to implementation. Such plans will be reviewed by VCEMS, with approval or denial issued within 10 days, based on the following guidelines:
   a. Shall provide accurate information
   b. Shall not include false claims
   c. Shall not be critical of other providers
   d. Shall not include financial inducements to any providers or third parties

D. Service Areas for Hospitals

Service areas for local trauma hospitals are determined by the VCEMS policy of transporting patients to the time-closest and appropriate facility.

E. EMS Dispatching

EMS dispatching for Ventura County is provided for and coordinated through the Ventura County Fire/EMS Communications Center, and, for Oxnard Fire, through the Oxnard PD center. The closest ALS transporting unit to an incident is dispatched, as well as BLS, and in some cases ALS, first responders.

F. Training of EMS Personnel

1. Designated facilities will provide training to hospital staff on trauma system policies and procedures.
2. Base Hospitals conduct periodic classes to orient prehospital providers to the local EMS system. Representatives from a designated trauma center may present the orientation to the Ventura County trauma system.

G. Coordination and Mutual Aid between neighboring jurisdictions

1. VCEMS will establish and maintain reciprocity agreements with neighboring EMS jurisdictions that provide for the coordination of mutual aid within those jurisdictions.
2. VCEMS works cooperatively and executes agreements, as necessary, in order to ensure that patients are transported to the time-closest and appropriate facility.
3. VCEMS maintains contact with neighboring EMS agencies in order to monitor the status of trauma care systems in surrounding jurisdictions.

H. Interfacility Transfers

1. As an inclusive trauma system, all hospitals have a role in providing trauma care to injured patients.
2. Designated trauma centers are required to establish and maintain a transfer agreement with other trauma center(s) of higher designation for the transfer of patients that require a higher level of care.
3. Transferring facilities, in conjunction with the higher-level facility, shall be responsible for obtaining the appropriate level of transportation when transferring trauma patients.

I. Pediatric Trauma Care.

Integration of pediatric hospital (s), when applicable, into the overall trauma care system to ensure that all trauma patients receive appropriate trauma care in the most expeditious manner possible

1. Designated trauma centers are required to maintain a transfer agreement with a pediatric trauma center.
2. As with all specialties, pediatric consultation should be promptly available
3. The transferring facility, in conjunction with the higher-level facility, shall be responsible for obtaining the appropriate level of care during transport.

J. Coordinating and Integration of Trauma Care with Non-Medical Emergency Services

1. VCEMS ensures that all non-medical emergency service providers are apprised of trauma system activities, as it relates to their agency/organization.
2. Non-medical emergency service providers are included in the VCEMS committee memberships, as appropriate.

3. VCEMS disseminates information to non-medical emergency service agencies through written communication, as necessary.

K. Trauma Center Fees

VCEMS has developed a fee structure that covers the direct cost of the designation process and to effectively monitor and evaluate the trauma care system. Fees are based on the direct VCEMS cost of administering the trauma care system.

L. Medical Control and Accountability

1. Each designated trauma center shall:
   a. Provide base hospital medical control for field prehospital care providers.
   b. Provide base hospital service in accordance with California Code of Regulations, Title 22, as outlined in the VCEMS Base Hospital Agreements.
   c. Participate in the VCEMS data collection system as defined by VCEMS, CEMSIS-Trauma and the National Trauma Database.
   d. Participate in the VCEMS continuous quality improvement program.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
Trauma Center Designation</td><td>Policy Number
1401</td></tr>
<tr><td>APPROVED:
Administration:</td><td colspan="2">Steven L. Carroll, EMT-P</td><td>Date: July 1, 2010</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td colspan="2">Angelo Salvucci, M.D.</td><td>Date: July 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>July 1, 2010

July 1, 2011</td><td colspan="2">Effective Date: July 1, 2010</td></tr>
</table>

I. PURPOSE: To establish a procedure for the designation of Level II trauma centers in Ventura County

II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798, and California Code of Regulations, Title 22, §100255.

III. POLICY:

A. Trauma Center Designation

1. Ventura County Emergency Medical Services Agency will issue a request for proposal (RFP) for the designation of the Level II trauma center(s). The RFP will include:

a. Introduction and background information about Ventura County's trauma system.

b. General information and instructions about trauma center designation including eligibility for application, primary service areas, fees and EMS's no guarantee policy of the minimum number of trauma patients

c. Reference to Title 22 and the American College of Surgeons "Resource for Optimal Care of the Injured Patient 2006" as the criteria for designation. Applicants will be required to describe their current compliance with these criteria or to indicate plans to achieve compliance within 6 months of the nomination for designation.

d. List of the minimal requirements for designation that includes: hospital organization, medical staff support, the

trauma program, the trauma medical director, the trauma resuscitation team, the trauma service, the trauma program manager, the trauma registrar and interventional radiology services on site. (Please see page 31- 35 of the “Resource for Optimal Care of the Injured Patient 2006” for full description of the above).

e. A list of Level II trauma center conditions and requirements, which the applicant will be required to accept.

f. A contract between the applicant hospital and Ventura County Emergency Medical Services Agency to be completed when the hospital’s application has been approved. Applicants will be required to indicate their acceptance of the contract or to submit alternative language for any clause which they are unwilling to accept.

g A schedule of fees for Level II trauma center applications and ongoing designation/contracts.

2. The RFP will be sent by registered, return-receipt-requested mail to those hospitals in Ventura County who submitted the required letter of interest. Any hospital wishing to respond to the RFP will be required to complete the RFP as outlined in the RFP and submit the application fee by a specified date and time. Thereafter, all communication regarding the process will be sent only to hospitals that have indicated their interest.
3. EMS will host a mandatory pre-proposal conference
4. Hospitals will have up to 60 days to submit an original and six copies of the proposal to ACS. Other submission requirements will be outlined in the RFP.
5. The independent review panel (IRP) will include experts as appropriate for the level of designation such as a trauma surgeon(s), emergency physician(s), trauma program manager(s), hospital administrator(s), EMS Agency administrator(s) and/or individuals with similar qualifications. The IRP shall be composed of individuals who work outside of the County of Ventura and have no affiliation or allegiance to any hospital within the County, and who are selected and approved by the Trauma Working

Group.

6. The proposal review process will be contracted to American College of Surgeons which will include a site visit for the purpose of confirming the information submitted as well as an evaluation of the hospital's capability and commitment to serve as a Level II trauma center. The IRP will evaluate proposals according to but not limited to:
   a. Compliance with minimum standards
   b. Quality and scope of service
   c. Applicant's demonstrated commitment to the care of major trauma patients
   d. Comprehensiveness
   e. Cost effectiveness of the proposed service
   f. Actuality of the demonstrated ability to provide Level II trauma services versus a stated plan to provide the service
7. The nominated designated hospital must agree to obtain verification by the American College of Surgeons as a Level II trauma center within 3 years of designation at cost to the hospital.

B. Designation
1. Following the site visits, the IRP will report on its findings and decision on designation of trauma hospitals. This will include any recommended corrective action plan that would be required to meet trauma center requirements.
2. IRP recommendations will be forwarded to the Ventura County Board of Supervisors for final designation.
3. Reports of the IRP will be made available upon request.

C. Appeals
1. Notices of findings and copies of reports specific to each applicant will be sent to the appropriate applicant. Applicants will have 10 working days to appeal from the day of receipt of the preliminary recommendations of IRP. Grounds for appeals are limited to alleged failure to follow the RFP or proposal review process. Expert judgments or analyses of the survey team are not subject to appeal.
2. A three-member appeal panel whose members have expertise in proposal reviews, and have no allegiance or affiliation with any hospital

within the County or to any member of the IRP, and who are selected and approved by the Trauma Working Group, will review the appeal and make a decision. All decisions are final and cannot be appealed further.

3. A fee of $5,000 will be required to request an appeal. These funds shall be used by the County to recover costs of resources used to reply to the appeal.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Guidelines for Interfacility Transfer of Patients to a Trauma Center</td><td>Policy Number
1404</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, EMT-P</td><td>Date: 07-01-2010</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Angelo Salvucci, M.D.</td><td>Date: 07-01-2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>July 1, 2010

July 1, 2012</td><td>Effective Date: July 1, 2010</td></tr>
</table>

I. PURPOSE: To establish guidelines for the transfer of a trauma patient from a hospital in Ventura County to a Level II trauma center.

II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798, and California Code of Regulations, Title 22, §100255.

III. POLICY: The following criteria will be used as a guideline for the transfer of a trauma patient to a trauma center.

A. Life-threatening injuries to trauma center

1. Carotid or vertebral arterial injury
2. Torn thoracic aorta or great vessel
3. Cardiac rupture
4. Bilateral pulmonary contusion with PaO2 to FiO2 ratio less than 200
5. Major abdominal vascular injury
6. Grade IV or V liver injuries requiring >6 U RBC transfusion in 6 hours
7. Unstable pelvic fracture requiring >6 U RBC transfusion in 6 hours
8. Fracture or dislocation with loss of distal pulses
9. Penetrating injury or open fracture of the skull
10. Glasgow Coma Scale score <14 or lateralizing neurologic signs
11. Spinal fracture or spinal cord deficit
12. >2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion
13. Open long bone fracture
14. Significant torso injury with advanced co-morbid disease (such as coronary artery disease, chronic obstructive pulmonary disease, type 1 diabetes mellitus, or immunosuppression)

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Trauma Triage and Destination Criteria		Policy Number 1405
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: July 1, 2010
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: July 1, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	July 1, 2010 August 2, 2010 July 31, 2112	Effective Date: August 2, 2010

I. PURPOSE: To guide out-of-hospital personnel in determining which patients require the services of a designated trauma center. To serve as the EMS system standard for triage and destination of patients suffering acute injury or suspected acute injury.

II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798. California Code of Regulations, Title 22, §100252 and §100255.

III. POLICY: These criteria apply to any patient who is injured or has a physical complaint related to trauma, and is assessed by EMS personnel at the scene.

A. Physiologic Criteria, Step 1:

1. Glasgow Coma Scale < 14
2. Systolic blood pressure < 90 mmHg
3. Respiratory rate < 10 or > 29 breaths per minute
   (< 20 in infant younger than 1 year of age)

B. Anatomic Criteria, Step 2:

1. Penetrating wounds to the head, neck, torso, or extremities proximal to the elbow or knee
2. Flail chest
3. Two or more proximal long bone fractures (femur or humerus)
4. Crushed, degloved, or mangled extremity
5. Amputations proximal to wrist or ankle
6. Pelvic fractures
7. Open or depressed skull fracture
8. Paralysis

C. Mechanism of Injury Criteria, Step 3:

1. Adults: > 20 feet (one story is equal to 10 feet)
   Children < 15 years old: > 10 feet, or two times the height of the child
2. High-risk auto crash:

a. Intrusion: interior measurement > 12 inches patient site; > 18 inches any occupant site

b. Ejection: partial or complete from automobile

c. Death in same passenger compartment

3. Auto-pedestrian / auto-bicyclist thrown, run over, or with > 20 mph impact

4. Motorcycle crash > 20 mph

D. Other Criteria, Step 4 (these are considerations to be used by the base hospital in determining the appropriate destination hospital):

1. Age > 65 years old
2. Head injury with loss of consciousness AND on warfarin (Coumadin)
3. Burns with trauma mechanism
4. Time sensitive extremity injury (open fracture, neurovascular compromise)
5. Pregnancy > 20 weeks with known or suspected abdominal trauma
6. Prehospital care provider or MICN judgment

V. PROCEDURE:

A. Any patient who is suffering from an acute injury or suspected acute injury shall have the trauma triage criteria applied.

B. For patients who meet trauma triage criteria listed in Sections A, B, or C above, the closest trauma center is considered to be the base hospital for that patient. Paramedics shall make base hospital contact and provide patient report directly to the trauma center.

C. Transportation units (both ground and air) shall transport patients who meet at least one of the trauma triage criteria in Sections A or B to the closest appropriate designated trauma center.

D. For patients who meet trauma triage criteria in Section C, the paramedic shall make base hospital contact with the closest designated trauma center. Based on the paramedic's report of the incident and the patient's assessed injuries, the trauma center MICN or ED physician shall direct destination to either the trauma center or the closest appropriate hospital.

E. Paramedics providing care for patients who are injured but meet only the trauma triage criteria listed in Section D above will contact the base hospital in whose catchment area the incident occurred. Destination will be determined by the base hospital MICN or ED physician. If the patient is directed other than to the regular catchment base hospital, the MICN will notify the receiving hospital or trauma center of an inbound patient and relay paramedic report.

F. A trauma patient without an effective airway may be transported to the closest available hospital with an emergency department for airway management prior to

transfer to a designated trauma center. In this rare event, the paramedic will contact the base hospital in whose catchment area the incident occurred.

G. A patient who does not meet trauma triage criteria and who, in the judgment of a base hospital, has a high probability of requiring immediate surgical intervention or other services of a designated trauma center shall be directed to a designated trauma center.

H. If any patient who meets trauma triage criteria listed in Sections A, B, or C above either declines transportation to a designated trauma center, or declines treatment and wishes to be released against medical advice (AMA), the paramedic shall call the closest trauma center, which is considered to be the base hospital for this patient. The trauma center MICN and/or ED physician will guide EMS personnel in arriving at a destination decision and/or disposition.

Ventura County Field Triage Decision Scheme

For patients with visible or suspected traumatic injuries

STEP 1

Measure vital signs and level of consciousness

1.1 Glasgow Coma Scale	< 14
1.2 Systolic Blood Pressure	< 90
1.3 Respiratory Rate	< 10 or > 29 breaths per minute (< 20 in infant age < 1 year)

Yes → **Contact base trauma center**

Transport to trauma center

No ↓

STEP 2

Assess anatomy of injury

2.1 All penetrating injuries to head, neck, torso and extremities proximal to elbow and knee
2.2 Flail chest
2.3 Two or more proximal long-bone fractures (femur, humerus)
2.4 Crushed, degloved, or mangled extremity
2.5 Amputation proximal to wrist and ankle
2.6 Pelvic fractures
2.7 Open or depressed skull fracture
2.8 Paralysis

Yes → **Contact base trauma center** / **Transport to trauma center**

No ↓

STEP 3

Assess mechanism of injury and evidence of high-energy impact

Falls
- **3.1.1** Adults: > 20 feet (one story is equal to 10 feet)
- **3.1.2** Children < 15 years old: > 10 feet, or two times the height of the child

High-risk auto crash
- **3.2.1** Intrusion: interior measurement > 12" patient site or > 18" any occupant site
- **3.2.2** Ejection: partial or complete from automobile
- **3.2.3** Death in same passenger compartment

3.3 Auto vs. pedestrian/bicyclist thrown, run over, or with > 20 mph impact
3.4 Motorcycle crash > 20 mph

Yes → **Contact base trauma center for destination decision**

No ↓

STEP 4

Assess special patient or system considerations

4.1 Age > 65
4.2 Head injury with loss of consciousness AND on warfarin (Coumadin)
4.3 Burns with trauma mechanism
4.4 Time sensitive extremity injury (open fracture, neurovascular compromise)
4.5 Pregnancy > 20 weeks with known or suspected abdominal trauma
4.6 Prehospital care provider or MICN judgment

Yes → **Contact regular catchment base hospital**

Consider transport to trauma center or specific resource hospital

No ↓

Transport to closest ED or by patient preference

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
Trauma Center Standards</td><td>Policy Number
1406</td></tr>
<tr><td>APPROVED:
Administration:</td><td colspan="2">Steven L. Carroll, EMT-P</td><td>Date: July 1, 2010</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td colspan="2">Angelo Salvucci, M.D.</td><td>Date: July 1, 2010</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>July 1, 2010

July 1, 2011</td><td colspan="2">Effective Date: July 1, 2010</td></tr>
</table>

I. PURPOSE: To establish Ventura County Trauma Center facility and personnel standards for trauma patient care. To obtain and maintain designation as a Level II Trauma Center, the Trauma Center shall be in compliance with the standards contained in this policy.

II. AUTHORITY: Health and Safety Code, § 1798, 1798.165 and 1798.170, California Code of Regulations, Title 22, Division 9, Chapter 7.

III. DEFINITIONS:

A. "On-site" means being physically present within the patient treatment area at all times.

B. "In-house" means being physically present in the trauma center and responding immediately upon trauma team activation. Arrive to the patient treatment area within ten (10) minutes of placement of call with a minimum documented compliance rate of 80% for each calendar month, and in no case greater than fifteen (15) minutes from time call is placed.

C. "Immediately available" means: a) dedicated to the trauma center while on duty, b) unencumbered by conflicting duties or responsibilities; c) responding without delay when notified; and d) being physically present within the patient treatment area when the patient arrives or within fifteen (15) minutes of placement of call, whichever is later, and not to exceed fifteen (15) minutes from patient arrival, with a minimum documented compliance rate of 80% for each calendar month, and in no case greater than thirty (30) minutes from time call is placed.

D. "Promptly available" means arrival to the patient treatment area within thirty (30) minutes with a minimum documented compliance rate of 80% for each calendar month, and in no case greater than forty-five (45) minutes, from time call is placed.

E. "On-call" requires the specified healthcare professional to be available to respond for trauma care in a defined manner and time period (i.e., immediately available, promptly available).

IV. POLICY:

A. General Provisions

1. California Statutes and Regulations: Trauma Centers will meet all applicable requirements set forth in California Health and Safety Code, Division 2.5, Chapter 6, Article 2.5 and California Code of Regulations, Title 22, Division 9, Chapter 7.
2. American College of Surgeons Committee on Trauma (ACS-COT) standards:
   a. Trauma Centers will obtain within three (3) years of designation by VCEMS, and continuously maintain, ACS-COT Level II Trauma Center verification.
   b. Trauma Centers are required to continuously comply with ACS-COT trauma center verification standards, as determined by VCEMS through the QI program and other oversight activities.
3. VCEMS may establish standards that exceed the requirements above.

B. Trauma System Activation

Trauma centers will accept all patients that meet trauma triage criteria, as described in VCEMS Policy 1405, except when on diversion per VCEMS Policy 402.

C Interfacility Transfers

1. As an inclusive trauma system, all hospitals will have a role in providing trauma care to injured patients. All Ventura County trauma centers are required to establish and maintain transfer agreements with each of the Ventura County hospitals.
2. The trauma center is obligated to immediately accept all patients who meet trauma transfer criteria from hospitals in Ventura County per VCEMS Policy 1404.
3. To initiate a transfer, a call shall be placed by the transferring hospital emergency physician or surgeon to the trauma center on-call trauma surgeon or designee. The verbal report for transfer shall be physician to physician.

4. The transferring hospitalin consultation with the trauma center will beresponsible for obtaining the appropriate level of transportation. Consideration of transport modality (e.g., ground vs. air) should be a collaborative decision between transferring hospital and the trauma center.

D. Response Requirements:

Staff response times will be documented in the patient care record and trauma registry for VCEMS review.

1. Surgical Service:
   Availability: an operating suite is continuously available or being utilized for trauma patients and has operating staff who are on-call and promptly available unless operating on trauma patients.
2. General Surgeon:
   a. Availability: On-call and immediately available for highest level of trauma team activation, promptly available for other trauma team activations, and available within one (1) hour of the time of call for consultation and admission when requested by the emergency physician and prior to admission.
   b. Advised of all trauma patient admissions;
   c. Participate in major therapeutic decisions;
   d. Present in the emergency department for all major trauma resuscitations; and
   e. Present in the operating room for all procedures.
3. Emergency Medicine:
   Availability: On-Site
4. Respiratory Therapist:
   Availability: In House
5. Radiology Technician:
   Availability: In House
6. CT Technician:
   Availability: On call and immediately available
7. Radiologist:
   Availability: On-call and promptly available
8. Interventional Radiology Service and Interventional Radiologist

a. Includes diagnostic and therapeutic procedures
b. Availability: On-call and promptly available

9. Ultrasound Service
   Availability: On-call and promptly available
10. Anesthesiology:
   Availability: On call and promptly available
11. Clinical Laboratory:
   Availability: On-Site (within the lab)
12. Neurosurgery:
   Availability: On-call and promptly available
13. OB/GYN Service:
   Availability: On-call and promptly available
14. Orthopedics:
   Availability: On-call and promptly available
15. Ophthalmologist:
   Availability: On-call and promptly available
16. Oral or Maxillofacial, **or** Head and Neck Service:
   Availability: On-call and promptly available
17. Plastic Surgery:
   Availability: On-call and promptly available
18. Reimplantation/Microsurgery:
   a. Availability: On-call and promptly available
   b. If reimplantation/microsurgery is provided via a transfer agreement, the patient shall be transferred out within one (1) hour of arrival at that trauma center, unless other life threatening conditions take precedent as determined by the staff trauma surgeon. If transfer is delayed the reason(s) must be documented in the patient's chart.
19. Urologist
   Availability: On-call and promptly available
20. Thoracic Surgery:
   Availability: On-call and promptly available
21. Critical Care Services:
   Availability: On-site within the critical care area

22. Critical Care Physician
    Availability: On-call and promptly available
23. Cardiac Surgery:
    a. Availability: On-call and promptly available if cardiac surgery is available at the trauma center
    b. If cardiac surgery is provided via a transfer agreement, the patient shall be transferred out within one (1) hour of arrival at that trauma center, unless other life threatening conditions take precedent as determined by the staff trauma surgeon. If transfer is delayed, the reason(s) must be documented in the patient's chart.
24. Additional Specialty Services:
    a. Burn Center. These services may be provided through a written transfer agreement with a burn center.
    b. Acute hemodialysis capability.
    c. Acute spinal cord injury management capability. This service may be provided through a written transfer agreement with a rehabilitation center.
    d. A pediatric intensive care unit approved by the California State Department of Health Services' California Children Services (CCS); or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care
25. Available Consultations:
    The following specialist(s) or specialty service(s) will be available for consultation and respond by phone to a call within thirty (30) minutes.
    a. Cardiology
    b. Gastroenterology
    c. Hand Surgery
    d. Hematology
    e. Infectious Diseases
    f. Internal Medicine
    g. Nephrology
    h. Neurology

i. Pathology

j. Pulmonary Medicine

E. Heliport

Trauma Centers are required to operate and maintain a State-permitted heliport, on or immediately adjacent to the hospital, as described in California Code of Regulations Title 21, § 3554.

F. Prehospital Personnel

1. Trauma centers will have a written agreement with the Ventura College School of Prehospital and Emergency Medicine that allows paramedic students to schedule and experience their clinical rotations at the trauma center, as well as perform clinical procedures (e.g., endotracheal intubation, intravenous access) on patients.
2. Trauma centers will allow EMT and paramedic personnel to perform clinical skills for continuing education and remediation purposes as directed by the VCEMS CQI program.

G. Base Hospital

1. Trauma Centers must be designated by VCEMS as a Base Hospital and comply with all requirements in VCEMS Policy 410.
2. Trauma Centers must employ a minimum of one FTE Prehospital Care Coordinator.

Excited / Agitated Delirium Fact Sheet
For Ventura County EMS Field Providers

Excited Delirium (ED) • Agitated Delirium (AD)

Excited Delirium / Agitated Delirium

A condition first diagnosed in 1849 (Bell's Mania) and popularized in the 1980's when describing a category of symptoms seen in some people after ingesting stimulants such as cocaine. The symptoms of this condition include delirium, bizarre behavior, and violent struggle, often followed by death. Causes for ED/AD can be metabolic, pharmacologic, infectious, and psychological. Excited delirium is often followed by sudden death and is a common cause of in-custody deaths with law enforcement.

Excited Delirium Presents in Four Phases

- Hyperthermia (>102 F)
- Acute delirium with agitation
- Respiratory distress or arrest (during or after a struggle)
- Cardiac arrest (during or after restraint – up to 24 hours post)

Excited Delirium Contributing Factors

- Hyperthermia
- Delirium Tremens
- Hypoglycemia
- Head Injury
- Thyroid storm
- Meningitis

Who Is At Risk For Excited Delirium Death?

- 91% - 99% Male
- 31-45 years of age
- Persons generally involved in a struggle
- Death usually follows an episode of bizarre behavior, and/or use of illegal or prescription drugs.

Pre-Disposing Factors for Sudden Death

- U.I. alcohol or withdrawal
- Past use or U.I. illegal drugs (cocaine, methamphetamine, PCP, LSD)
- Failure to take Rx meds (or took too much)
- Dehydration
- Hypoglycemia
- Epilepsy
- Head Injury (past or present)
- Underlying psych disorder
- Cardiomegaly
- Small vessel wall thickening
- Coronary atherosclerosis
- Fibrotic scar tissue

Preventing or Limiting Excited Delirium

- Avoid pressure on chest and/or torso (compressional asphyxia) or prone positioning for an extended duration (positional asphyxia). Never transport patient prone.

On Scene Responsibilities

- Scene safety – L.E. will request fire/EMS early and to stage nearby for rapid response. Be prepared for extended stage times.
- Early rule-out of possible non-psych, non-drug related causes. S/S of CNS disorder, trauma, hypoglycemia, meningitis, post-ictal state.
- If able to rule out hypoglycemia as a cause, prepare for chemical restraint with midazolam.
- Rapid vital sign assessment as soon as possible.
- S/S of hyperthermia? Active cooling measures with inguinal and axial cooling. Remove clothing if not done so already.
- Be prepared for rapid deterioration of patient.
  - ***Will decline from an agitated state to respiratory arrest quickly and without warning.***

A Medical Crisis ™ Mnemonic

Developed and © By John G. Peters Jr, Ph.D.

A	Acute onset
M	Mental health issues
E	Excited, Extreme agitation, Emotional changes
D	Delusional, Disoriented, Distracted
I	Insensitive to pain; Invisible people
C	Call for back-up
A	Aggression towards objects
L	Large belly; Loud incoherent speech; Screaming
C	Confused, disoriented
R	Resists violently before during and after restraint
I	I can't breathe
S	Strips off clothing
I	Intense paranoia
S	Superhuman strength; Seemingly unstoppable; Struggles