County of Ventura
Public Health Services

Notice of Changes to Policy Manual

Emergency Medical Services
Policies and Procedures

To: ALL VENTURA COUNTY EMS POLICY MANUAL HOLDERS

Change No.: 1

DATE: June 1, 2012

Policy Status	Policy #	Title/New Title	Notes
Replace		Table of Contents	
Review only	330	EMT/Paramedic/MICN Decertification and Discipline	
Replace	504	BLS/ALS Unit Equipment and Supplies	
Replace	606	Withholding or Termination of Resuscitation and Determination of Death	
Review only	624	Patient Medications	
New	627	Fireline Medic	
Replace	705.09	Chest Pain – Acute Coronary Syndrome	
Replace	705.14	Hypovolemic Shock	
Review only	722	Interfacility Transport of Patients with IV Heparin & Nitroglycerin	
Replace	726	12 Lead ECG	
Replace	1000	Documentation of Prehospital Care	
Replace	1131	Continuing Education – Field Care Audit	
Replace	1201	Air Unit Staffing Requirement	Effective date – December 1, 2011
Replace	1202	Helicopter Dispatch for Emergency Medical Responses	Effective date – December 1, 2011
Replace	1203	Criteria for Patient Emergency Transport by Helicopter	
Review only	1205	Air Unit Specifications, Equipment and Supplies	
Replace	1404	Guidelines for Interfacility Transfer of Patients to a Trauma Center	Effective date – May 1, 2012
Replace	1406	Trauma Center Standards	
Delete	1407	Code Trauma": Emergent Transfer of Patients with Critical Trauma to Trauma Center	

Policy No.	Title	Effect. Date	Origin. Date	Revised Date	ate Last Review	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	6/9/2011	6/30/2014
111	Ambulance Company Licensing Procedure	12/1/2006	9/26/1986	6/8/2006	6/9/2011	6/30/2014
112	Ambulance Rates	7/1/2010	1984	7/1/2010	7/1/2011	7/1/2012
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	6/1/2011	11/1/2003	4/10/2008	12/11/2010	12/31/2013
II.	**Legislation/Regulations**					
210	Child, Dependent Adult, or Elder Abuse Reporting	11/1/2003	6/14/1984	9/11/2003	6/1/2011	6/30/2014
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	6/1/2011	6/1/1997	8/10/2006	2/14/2011	2/28/2014
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	6/9/2011	6/30/2014
321	Mobile Intensive Care Nurse: Authorization Criteria	12/1/2008	4/1/1983	8/14/2008	6/9/2011	6/30/2014
322	Mobile Intensive Care Nurse: Reauthorization Requirements	12/1/2008	4/1/1983	8/14/2008	6/9/2011	6/30/2014
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	6/9/2011	6/30/2014
330	EMT/Paramedic/MICN Decertification and Discipline	6/1/2009	4/9/1985	12/12/2008	4/9/2012	4/30/2014
332	EMS Personnel Background Check Requirements	6/1/2011	7/31/1990	5/13/2004	12/9/2010	12/31/2013
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	6/1/2011	10/13/2005	10/9/2008	12/9/2010	12/31/2013
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	8/11/2011	10/31/2014
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
420	Receiving Hospital Standards	2/10/2011	4/1/1984	2/10/2011	2/10/2011	2/28/2014
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
450	Stroke Center Standards					

Policy No.	Title	Effect. Date	Origin. Date	Revised Date	ate Last Review	Review Date
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	6/1/2012	5/24/1987	4/12/2012	4/12/2012	10/31/2014
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	12/1/2011	10/31/1995	10/13/2011	10/13/2011	11/1/2014
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	12/1/2011	7/26/1991	8/11/2011	8/11/2011	10/31/2014
606	Withholding or Termination of Resuscitation and Determination of Death	6/1/2012	6/1/1984	10/13/2011	10/13/2011	10/31/2014
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	4/27/1990	4/14/2011	4/14/2011	6/30/2014
613	Do Not Resuscitate (DNR)	6/1/2011	10/1/1993	2/10/2011	2/10/2011	2/28/2014
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	6/9/2011	6/30/2014
624	Patient Medications	12/1/2008	12/6/2006		2/9/2012	10/31/2014
625	POLST	1/8/2009	1/7/2009		2/10/2011	1/31/2014
626	Chempack	6/1/2010	2/2/2010		11/12/2009	6/30/2013
627	Fireline Medic	6/1/2012	10/5/2011	11/10/2012	11/10/2011	6/1/2012
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	6/1/2011	8/1/2010	4/14/2011	1/14/2011	6/1/2012
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
705	06 - Burns	12/1/2010		8/1/2010	8/1/2010	12/1/2011
705	07 - Cardiac Arrest - Asystole/Pulseless/PEA	6/1/2011	8/1/2010	4/14/2011	4/14/2011	12/1/2013
705	08 - Cardiac Arrest - VF/VT	12/1/2011	8/1/2010	8/1/2011	8/1/2011	12/1/2013
705	09 - Chest Pain - Acute Coronary Syndrome	6/1/2012	8/1/2010	4/12/2012	4/12/2012	6/30/2014
705	10 - Childbirth	12/1/2011		8/31/2013	8/31/2011	12/31/2013
705	11 - Crush Injury/Syndrome	12/1/2010		8/1/2010	8/1/2010	12/1/2011

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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	6/1/2012		4/12/2012	4/12/2012	4/30/2014
705	15 - Nausea/Vomiting	12/1/2011	8/1/2010	10/13/2011	10/13/2011	12/1/2013
705	16 - Neonatal Resuscitation	6/1/2011	8/1/2010	4/14/2011	4/14/2011	6/1/2012
705	17 - Nerve Agent Poisoning	12/1/2011		11/10/2011	11/10/2011	12/31/2013
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	12/1/2011		10/13/2011	10/13/2011	12/1/2013
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
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	12/1/2011	3/2/1992	8/11/2011	8/11/2011	12/1/2013
717	Pediatric Intraosseous Infusion	6/1/2011	9/10/1992	4/14/2011	4/14/2011	4/30/2013
720	Guidelines For Limited Base Hospital Contact	6/1/2011	6/15/1998	12/11/2008	12/11/2008	2/28/2013
722	Interfacility Transport of Patient with Patient with IV Heparin	1/10/2008	6/15/1998	1/10/2008	2/9/2012	1/31/2014
723	Continuous Positive Airway Pressure (CPAP)	12/1/2011	12/1/2004	8/11/2013	8/11/2013	9/30/2013
724	Apparent Life-Threatening Event (ALTE)	6/1/2005	3/1/2005		11/12/2009	4/30/2013
725	Patients After TASER Use	12/1/2011	8/10/2006	8/13/2011	8/13/2011	12/1/2014
726	12-Lead ECG	6/1/2012	8/10/2006	2/9/2012	2/9/2012	2/28/2014
727	Transcutaneous Cardiac Pacing	12/1/2008	12/1/2008	12/11/2008	12/11/2010	12/31/2013
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	12/1/2011	6/30/2011	6/30/2011	6/30/2011	6/1/2014
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	4/14/2011	4/30/2014
803	EMT Automatic External Defibrillation (AED) Service Provider Program Standards	6/1/2006	11/1/1998	3/1/2006	4/14/2011	4/30/2014
805	Emergency Medical Technician Defibrillation (EMT-ID) Medical Cardiac Arrest	6/1/2006	10/1/1993	4/24/2006	4/14/2011	4/30/2014
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	6/1/2012	6/15/1998	11/10/2011	11/10/2011	11/30/2014
1001	EMT-P/BH Communication Record	12/1/2007	7/6/2007	7/9/2007	6/11/2009	7/31/2011

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XI.	**Education**					
1100	Emergency Medical Technician-1 Program Approval	12/1/2011	2/28/2001	10/14/2011	10/14/2011	10/1/2014
1105	MICN Developmental Course and Exam	12/1/2011	7/2/1984	6/9/2011	6/9/2011	6/30/2014
1130	Advanced Life Support Continuing Educations Lectures	12/1/2011	2/28/2001	10/13/2011	10/13/2011	12/31/2014
1131	Field Care Audit	6/1/2012	8/1/1984	2/9/2012	2/9/2012	2/28/2015
1132	Continuing Education: Attendance Roster	6/9/2011	6/1/1993	6/9/2011	6/9/2011	6/30/2014
1135	Paramedic Training Program Approval	6/9/2011	10/20/1993	12/8/2005	6/9/2011	6/30/2014
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	12/11/2010	12/11/2010	6/30/2013
1201	Air Unit Staffing Requirements	12/1/2011	5/30/1988	11/10/2011	11/10/2011	11/30/2014
1202	Air Unit Dispatch for Emergency Medical Responses	12/1/2011	10/31/1998	11/10/2011	11/10/2011	11/30/2014
1203	Criteria for Patient Emergency Transport	6/1/2011	10/31/1994	4/14/2011	4/14/2011	10/31/2013
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	2/9/2012	2/28/2015
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 Committee s	6/9/2011	6/9/2011		6/9/2011	7/31/2013
1403	Trauma Hospital Data Elements					
1404	Guidelines for Interfacility Transfer of Patients to a Trauma Center	5/1/2012	7/1/2010	4/12/2012	4/12/2012	4/30/2014
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	6/1/2012	7/1/2010	2/9/2012	2/9/2012	2/28/2014

Policy No.	Title	Effect. Date	Origin. Date	Revised Date	Date Last Rev	Review 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	1/1/1990		12/1/1991	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 –	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 –	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	2/1/2002		6/30/2004	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	3/14/2002		6/30/2004	12/1/2002
422	ALS New Receiving Hospital – six month evaluation of provision of ALS	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
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	2/1/1990		1/1/1992	6/1/2002
611	EMT-I Monitoring of IV Fluids	6/1/2004	6/1/1984	1/1/2004		1/31/2004	6/12/2007

616	Comfort Measures Only	6/1/1990	10/1/1993	2/1/1999		2/1/2001	5/1/2003
621	EMT-IA-Monitoring IV Fluid Administration (Old policy number 904) (New	6/1/1984					See 611
VII.	**Advanced Life Support Medical Control and Treatment**						
700	Medical Control – Emergency Medical Services Medical Director	8/1/1988				8/1/1990	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		9/13/2007			12/1/2010
705	Altered Level of Consciousness/Coma	12/1/2008		10/9/2008			12/1/2010
705	Anaphylaxis	6/1/2009		1/8/2009		1/8/2009	12/1/2010
705	Apnea or Agonal Respirations	12/11/2008		12/11/2008		5/4/2009	12/1/2010
705	Bradycardia: Adult, Symptomatic*, Not In Arrest	12/1/2008		10/9/2008		5/4/2009	12/1/2010
705	Cardiac Arrest, Adult	6/1/2010		6/1/2010		5/10/2010	12/1/2010
705	Cardiac Arrest, Pediatric	6/1/2009		4/9/2009		5/4/2009	12/1/2010
705	Decompression Injuries	6/1/2008		4/10/2008			12/1/2010
705	Hypovolemic Shock, Trauma	12/1/2008		8/14/2008		8/31/2010	12/1/2010
705	Hypovolemic Shock Non Trauma	12/1/2008		8/14/2008		8/31/2010	12/1/2010
705	Non-Traumatic Focal Neurological Changes	12/11/2008		12/11/2008	12/11/2008	12/31/2010	12/1/2010
705	Newborn Resuscitation	6/1/2008		12/31/2006	1/8/2009	12/31/2010	12/1/2010
705	Snake Bite	12/1/2007		9/13/2007		12/31/2009	12/1/2010
705	Symptomatic* Bradycardia, Pediatric, Not In Arrest	12/1/2005		12/1/2004	12/11/2008	12/31/2010	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	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
709	Alternative ALS Airway Management Devices Indications For Use	12/1/2005	9/10/1985	10/13/2004		12/31/2007	10/1/2008
710	Endotracheal Intubation Indications For Use	6/1/2008	6/1/1986	4/13/2008		4/30/2010	
711	ALS Verapamil Hydrochloride	6/3/1986					12/1/2005
712	Administration of Nebulized Metaproterenol	2/1/1989	2/1/1989				6/1/2002
713	Intraoseous Injection	6/1/2004	8/30/1990	1/8/2004	10/13/2011	7/31/2011	12/1/2011
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	10/31/1999		6/1/2002	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	11/8/2007			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	7/9/2007		7/31/2009	
1009	EMT-P/MICN Continuing Education Record (New policy #1132) Contents	11/9/1984					10/20/1993
1011	ALS MICN Continuing Education Requirements (New policy 322)						See 322
XI.	**Education**						
1101	EMT-I Curriculum for IV Monitoring (New policy 611) Contents moved to		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	3/1/2000			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	12/9/2004		6/30/2007	6/1/2002
1124	EMT-P Training: Adenosine						1/8/2004
1125	EMT-P Continuing Education Requirements	1/1/1990	6/16/1980	1/1/1990		12/1/1991	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				?
1129	Cervical Spine Immobilization Training	6/1/1999	3/25/1999				?
1133	Continuing Education Record	9/1/1989	11/9/1984	9/1/1989		9/1/1990	6/1/2002
1134	Training and Testing Criteria		7/21/1989			7/1/1991	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**						
1407	Code Trauma": Emergent Transfer of Patients with Critical Trauma to Trau	2/10/2011	1/18/2011	2/10/2011	2/10/2011	2/28/2013	5/1/2012

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMT/Paramedic/MICN Decertification and Discipline	Policy Number 330
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2009
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: June 1, 2009
Origination Date: April 9, 1985 Date Revised: December 12, 2008 Date Last Reviewed: April 9, 2012 Review Date: April 30, 2014	Effective Date: June 1, 2009

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

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

III. POLICY: The Ventura County Emergency Medical Services Director (VCEMSD) may provide counseling, place on probation, suspend from practice for a designated time period, deny or revoke certification or deliver reprimands to Ventura County Certified EMT-I, paramedic, or MICN if their actions, while providing prehospital care, constitutes a threat to public health and safety.

GROUNDS FOR DISCIPLINARY ACTION:

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

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

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

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

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

IV. PROCEDURE:

A. Submission of Claim.

When any of the Grounds for Disciplinary Action are exhibited by a certificate holder, any individual observing such grounds may submit a written claim relative to the infraction as well as any other supporting evidence to the VCEMSD. Discovery through medical audit shall be considered as a source of information for action.

B. Notification of Claim against Certificate Holder.

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

When such a claim is submitted to the VCEMSD he/she shall notify the PCC and ED Medical Director at the appropriate Base Hospital, and the ALS provider management (if the certificate holder is an EMT-I or paramedic) of the claim. Notification of such a claim shall be given verbally within twenty-four (24) hours, or as soon as possible, followed by written notification within ten (l0) days. The written notice shall include:

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

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

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

C. Review of Submitted Material.

The VCEMSD shall review the submitted material and determine the appropriate disciplinary action.

1. The nature of the disciplinary action shall be related to the severity of the risk to the public health and safety caused by the actions of the certificate holder or applicant for a prehospital care certificate.

2. The types of action, which may be taken prior to or subsequent to formal investigation, include:

   Immediate suspension: The VCEMSD may immediately suspend a prehospital emergency medical care certificate at any point in the investigative or appeal process if there is evidence which indicates in the expert opinion of the VCEMSD that a continuing threat to the public health and safety will exist if the certificate is not suspended. The certificate holder's relevant employer shall be notified prior to or concurrent with initiation of the suspension. If the certificate is suspended prior to the initiation or completion of a review of the claims by an investigative review panel (IRP), an IRP shall not be required unless the certificate holder requests an IRP review, in writing, within fifteen (15) calendar days of the date that written notification is received. An expedited appeal hearing shall be convened if the certificate holder requests, in writing, such a hearing. Written notification shall be sent by certified mail.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: BLS And ALS Unit Equipment And Supplies		Policy Number: 504
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: June 1, 2012
APPROVED: Medical Director	Angelo Salvucci, MD	Date: June 1, 2012
Origination Date: Date Revised: Last Reviewed: Review Date:	May 24, 1987 April 12, 2012 April 12, 2012 April 30, 2014	Effective Date: June 1, 2012

I. PURPOSE: To provide a standardized list of equipment and supplies for Response and/or Transport units in Ventura County.

II. POLICY: Each Response and/or Transport Unit in Ventura County shall be equipped and supplied according the requirements of this policy.

III. AUTHORITY: California Health and Safety Code Section 1797.178, 1797.204, 1797.218 and California Code of Regulations Section 10017

IV. PROCEDURE:

The following equipment and supplies shall be maintained on each Response and/or Transport Unit in Ventura County.

	ALS / BLS Unit Minimum Amount	ASV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS				
Clear masks in the following sizes: Adult Child Infant Neonate	1 each	1 each	1 each	1 adult 1 infant
Bag valve units Adult Child	1 each	1 each	1 each	1 adult
Nasal cannula Adult	3	3	3	3
Nasopharyngeal airway (adult and child or equivalent)	1 each	1 each	1 each	1 each
Oropharyngeal Airways Adult Child Infant Newborn	1 each size	1 each size	1 each size	1 each size
Oxygen with appropriate adjuncts (portability required)	10 L/min for 20 minutes	10 L/min for 20 mins.	10 L/min for 20 mins.	10 L/min for 20 mins.
Portable suction equipment	1	1	1	1
Transparent oxygen masks Adult nonrebreather Child Infant	 3 3 2	 2 2 2	 2 2 2	 2 2 2
Bandage scissors	1	1	1	1
Bandages • 4"x4" sterile compresses or equivalent • 2",3",4" or 6" roller bandages • 10"x 30" or larger dressing	 12 6	 12 2 0	 12 6 2	 5 4 2
Blood pressure cuffs Thigh Adult Child Infant	 1 1 1 1	 1 1 1 1	 1 1 1 1	 1 1 1 1
Emesis basin/bag	1	1	1	1
Flashlight	1	1	1	1
Half-ring traction splint or equivalent device	1	1	1	1
Pneumatic or rigid splints (capable of splinting all extremities)	4	4	4	4
Potable water or saline solution	1 gallon	1 gallon	1 gallon	1 gallon
Cervical spine immobilization device	2	2	2	2
Spinal immobilization devices KED or equivalent 60" minimum with straps	 1 1	 1	 1 1	 1
Sterile obstetrical kit	1	1	1	1

	ALS / BLS Unit Minimum Amount	ASV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
Tongue depressor	4	4	4	4
Cold packs	4	4	4	4
OPTIONAL EQUIPMENT				
Nerve agent antidote – (3 kits per person suggested)				
Tourniquet				
Impedance threshold device				
B. TRANSPORT UNIT REQUIREMENTS				
Ambulance cot and collapsible stretcher; or two stretchers, one of which is collapsible.	1	0	0	1
Straps to secure the patient to the stretcher or ambulance cot, and means of securing the stretcher or ambulance cot in the vehicle.	1	0	0	1
Ankle and wrist restraints. Soft ties are acceptable.	1	0	0	0
Sheets, pillow cases, blankets and towels for each stretcher or ambulance cot, and two pillows for each ambulance	1	0	0	0
Bedpan	1	0	0	0
Urinal	1	0	0	0
Personal Protective Equipment per State Guideline #216				
Rescue helmet	2	1	0	0
EMS jacket	2	1	0	0
Work goggles	2	1	0	0
Tyvek suit	2 L / 2 XXL	1 L / 1 XXL	0	0
Tychem hooded suit	2 L / 2 XXL	1 L / 1 XXL	0	0
Nitrile gloves	1 Med / 1 XL	1 Med / 1 XL	0	0
Disposable footwear covers	1 Box	1 Box	0	0
Leather work gloves	3 L Sets	1 L Set	0	0
Field operations guide	1	1	0	0

	ALS / BLS Unit Minimum Amount	ASV/CCT Minimum Amount	FR/ALS Minimum Amount	
Cellular telephone Two-way radio for alternative base hospital contact	1 1	1 1	1 1	1 1
Alternate ALS airway device	2	1	1	1
Arm Boards 9” 18”	 3 3	 0 0	 1 1	 0 0
Blood glucose determination devices	2	1	1	1
Cardiac monitoring equipment	1	1	1	1
CO_2 monitor	1	1	1	1
Continuous positive airway pressure (CPAP) device	1	1	1	1
Defibrillator pads or gel	3	3	3	1 adult – No Peds.
Defibrillator w/adult and pediatric paddles/pads	1	1	1	1
EKG Electrodes	10 sets	3 sets	3 sets	6 sets
Endotracheal intubation tubes, sizes 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5 with stylets	1 of each size	1 of each size	1 of each size	4, 5, 6, 6.5, 7, 7.5, 8
Intraosseous infusion needles	2	1	2	1
Intravenous Fluids (in flexible containers) • 5% Dextrose in water, 50 ml • Normal saline solution, 500 ml • Normal saline solution, 1000 ml	 2 2 6	 1 1 2	 2 1 4	 1 1 3
IV admin set - microdrip	4	1	2	2
IV admin set - macrodrip	4	1	4	3
IV catheter, Sizes l4, l6, l8, 20, 22, 24	6 each 14, 16, 18, 20 3 each 22 3 each 24	2 each	2 each	2 each
Laryngoscope, replacement bulbs and batteries Curved blade #2, 3, 4 Straight blade #1, 2, 3	1 set 1 each 1 each	1 set 1 each 1 each	1 set 1 each 1 each	1 set 1 each 1 each
Magill forceps Child	1 1	1 1	1 1	1 1
Nebulizer	2	2	2	2
Nebulizer with in-line adapter	1	1	1	1
Needle Thoracostomy kit	2	2	2	2
Pediatric length and weight tape	1	1	1	1
SAO_2 monitor	1	1	1	1
OPTIONAL ALS EQUIPMENT (No minimums apply)				
Flexible intubation stylet				
EZ-IO intraosseous infusion system				

	ALS / BLS Unit Minimum Amount	ASV/CCT Minimum Amount	FR/ALS Minimum Amount	
D. ALS MEDICATION, MINIMUM AMOUNT				
Activated charcoal, adult and pediatric	1	1	1	0
Adenosine, 6 mg	3	3	3	3
Aspirin, 162 mg	2 ea. 162 mg or 4 ea 81 mg	2 ea. 162 mg or 4 ea 81 mg	2 ea. 162 mg or 4 ea 81 mg	2 ea. 162 mg or 4 ea 81 mg
Amiodarone, 50mg/ml 3ml	6	3	6	3
Atropine sulfate, 1 mg/10 ml	2	2	2	2
Diphenhydramine (Benadryl), 50 mg/ml	2	1	1	2
Bronchodilators, nebulized beta-2 specific	6	2	3	1
Calcium chloride, 1000 mg/10 ml	2	1	1	1
Dextrose 50%, 25 GM/50	5	2	2	2
Dopamine, 400 mg/250ml D5W, premixed	2	1	1	2
Epinephrine 1:1,000, 1mg/ml	4	2	2	2
Epinephrine 1:10,000, 1 mg/10ml	6	3	6	4
Epinephrine 1:1,000, 30 ml multi-dose vial	1	1	1	1
Glucagon, 1 mg/ml	2	1	2	1
Furosemide (Lasix), 20 mg/2ml	80 mg	40 mg	80 mg	40 mg
Lidocaine, 100 mg/5ml	2	2	2	2
Magnesium sulfate, 1 gm per 2 ml	4	1	2	2
Morphine sulfate, 10 mg/ml	2	2	2	2
Naloxone Hydrochloride (Narcan), adult and pediatric doses	10 mg	4 mg	4 mg	4mg
Nitroglycerine preparations, 0.4 mg	1 bottle	1 bottle	1 bottle	1 bottle
Normal saline, 10 ml	2	2	2	2
Oral glucose 15gm unit dose	1	1	1	1
Sodium bicarbonate, 50 mEq/ml	2	1	1	1
Ondansetron 4 mg IV single use vial	4	4	4	4
Ondansetron 4 mg oral	4	4	4	4
Midazolam Hydrochloride (Versed)	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Patient Medications	Policy Number 624
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: December 1, 2008
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: December 1, 2008
Origination Date: December 6, 2006 Date Revised: Date Last Reviewed: February 9, 2012 Next Review Date: October 31, 2014	Effective Date: December 1, 2008

I. PURPOSE: To establish a procedure for locating, identifying, and transporting medications in order to assist in the prompt and accurate hospital evaluation and treatment of patients.

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

III. POLICY:

A. Reasonable efforts are to be made to determine the essential information for all medications: name, strength, dose, route, frequency, and time of last dose.

B. For patients who do not know this information, either a detailed list or the medications in their original containers will be taken with the patient to the hospital whenever possible.

C. Medications include all prescriptions, nutritional and herbal supplements, over-the-counter preparations, pumps, patches, inhalers, drops, sprays, suppositories, creams or ointments.

IV. PROCEDURE:

A. For patients who do not know all of the essential information on all of their medications, either a list of medications with essential information or the medications in the original containers should be taken to the hospital.

B. If unable to locate the original labeled medication containers, pills in unlabeled containers or pills not in containers will be taken.

C. If the patient or family objects to turning over the medication to EMS personnel, the family must be told of their importance and instructed to take them to the emergency department promptly.

D. Medications taken to the hospital are to be turned over to an identified individual hospital staff person.

E. Hospital staff is responsible for returning the medications to patient or family.

F. EMS personnel must document all actions on VCePCR, including discussing medications, taking them to the hospital, the person to whom they were turned over, and explain if unable to obtain essential information or medications.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Fireline Medic		Policy Number 627
APPROVED: Administration:	Steven Carroll, Paramedic	Date: June 1, 2012
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date: June 1, 2012
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 5, 2011 November 10, 2011 November 10, 2011 October 31, 2014	Effective Date: June 1, 2012

I. PURPOSE: To establish procedures for a fireline paramedic (FEMP) response from and to agencies within or outside local EMS agency (LEMSA) jurisdiction when requested through the statewide Fire and Rescue Mutual Aid System, to respond to and provide advanced life support (ALS) care on the fireline at wildland fires.

II. AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220; California Code of Regulations, Title 22, Division 9, Sections 100165 and 100167

III. POLICY:

A. County accredited paramedics shall carry the ALS/BLS inventory consistent with the FIRESCOPE FEMP position description. Reasonable variations may occur; however, any exceptions shall have prior approval of the VCEMSA. The equipment lists are a minimalist, scaled down version of standard inventory in order to meet workable/packable weight limitations (45 lbs including wildland safety gear).

1. It will not be possible to maintain standard ALS minimums on the fireline. The attached ALS inventory essentially prioritizes critical and probable fireline needs.

2. VCEMS accredited paramedics may function within their scope of practice, when serving in an authorized capacity assignment, as an agent of their authorized ALS fire agency.

IV. PROCEDURE:

A. Under the authority of State regulations, a paramedic may render ALS care during emergency operations as long as the following conditions are met:

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

APPENDIX A

FIRELINE EMERGENCY MEDICAL TECHNICIAN

BASIC LIFE SUPPORT (BLS) PACK INVENTORY

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

APPENDIX B

FIRELINE EMERGENCY MEDICAL TECHNICIAN

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

ALS AIRWAY EQUIPMENT:

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

IV/MEDICATION ADMIN SUPPLIES:

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

MISCELLANEOUS:

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

BIOMEDICAL EQUIPMENT:

	Glucometer (1)		

MEDICATIONS:

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

Chest Pain – Acute Coronary Syndrome

BLS Procedures

Administer oxygen if dyspnea, signs of heart failure or shock, or SAO2 < 94%
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:
- **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

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

ED Physician Order Only: For ventricular ectopy [PVC's > 10/min, multifocal PVC's, or unsustained V-Tach], consider amiodarone 150 mg IVPB.

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

Hypovolemic Shock

ADULT	PEDIATRIC
BLS Procedures	
Place patient in supine position Administer oxygen as indicated	Place patient in supine position Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
IV access **Normal Saline** • IV bolus – 1 Liter o Caution with cardiac and/or renal history o 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	IV/IO access **Normal Saline** • IV/IO bolus – 20 mL/kg o Caution with cardiac and/or renal history o 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
Communication Failure Protocol	
If shock persists: • *Repeat* **Normal Saline** o IV bolus – 1 Liter	If shock persists: • *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

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.

Base Hospital Orders only

ADULT

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

Hot/Warm Zones

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

- **Atropine**
  - IM – 2.1 mg
- **Pralidoxime (2-Pam)**
  - IM – 600 mg

Cold Zone

IV/IO access after complete decontamination

Nerve Agent Kit (single dose):

Give if not administered in Hot/Warm Zone

- **Atropine**
  - IM – 2.1 mg
- **Pralidoxime (2-Pam)**
  - IM – 600 mg

If symptoms persist:

- **Atropine**
  2mg IM/IV/IO q 5 minutes until symptoms relieved.

For seizures:

- **Midazolam**
  - IV/IO – 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

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

Hot/Warm Zones

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

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

Cold Zone

IV/IO access after complete decontamination

- **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
- Duodote may be administered by EMTs to themselves, and other responders
- Duodote may be administered by Paramedics to themselves, other responders, and exposed, symptomatic public.
- **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/IO 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)*
- Mild exposure with symptoms: One dose of Duodote
  - Symptoms: Miosis, rhinorrhea, drooling, sweating, blurred vision, nausea, brady, or tachypnea
  - nervousness, fatigue, minor memory disturbances, irritability, unexplained tearing, wheezing, tachycardia, bradycardia
- Moderate exposure with symptoms: One dose of Duodote followed by a second dose in 10 minutes
  - Symptoms: Miosis, rhinorrhea, SOB, wheezing, secretions, soft muscle weakness and fasciculations, GI effects
- Severe exposure with symptoms: three doses of Duodote in rapid succession
  - Symptoms: Strange confused behavior, severe difficulty breathing, twitching, unconsciousness, seizing, flaccid, apnea pinpoint pupils involuntary defecation, urination

Effective Date: June 1, 2012
Next Review Date: June 30, 2014
Date Revised: November 10, 2011
Last Reviewed: November 10, 2011

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Interfacility Transport Of Patients With IV Heparin & Nitroglycerin	Policy Number 722
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: January, 10, 2008
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: January, 10, 2008
Origination Date: June 15, 1998 Date Revised: January 10, 2008 Date Last Reviewed: February 9, 2012 Review Date: January 31, 2014	Effective Date :January 10, 2008

I. PURPOSE:

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

II. POLICY:

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

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

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

III. PROCEDURE:

A. Medication Administration

1. The paramedic shall receive a report from the nurse caring for the patient and continue the existing medication drip rate
2. If medication administration is interrupted by infiltration or disconnection, the paramedic may restart or reconnect the IV line.
3. All medication drips will be in the form of an IV piggyback monitored by a mechanical pump familiar to the Paramedic who has received training and is familiar with its use.

4. In cases of pump malfunction that cannot be corrected, the medication drip will be discontinued and the receiving hospital notified.

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

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

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

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

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

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, Paramedic	Date: June 1, 2012
APPROVED Medical Director:	Angelo Salvucci, MD	Date: June 1, 2012
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 10, 2006 February 9, 2012 February 9, 2012 February 28, 2014	Effective Date: June 1, 2012

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

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

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

IV. Procedure:

A. Indications for a 12-lead ECG: Medical history and/or presenting complaints consistent with an acute coronary syndrome. Patients will have the acute (within the previous 12 hours) onset 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 if patient is dyspneic, shows signs of heart failure or shock, or has SAO2 < 94% If the ECG can be completed without delay (less than 3 minutes after patient contact), and the patient is not in severe distress, perform ECG prior to medication administration.

2. The ECG should be done prior to transport.
3. If the ECG is of poor quality (artifact or wandering baseline), or the patient's condition worsens, 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**, note underlying rhythm, and verify by history and physical exam that the patient does not have a pacemaker or ICD.

D. Base Hospital Communication/Transportation:

1. If the ECG interpretation is ACUTE MI SUSPECTED; report that to MICN at the beginning of the report. If the ECG is of poor quality, or the underlying rhythm is paced, or atrial flutter, include that information in the initial report. All other information, except that listed in items 2, 4, and 5 below, is optional and can be given at the paramedic and MICN's discretion.
2. Paramedics are to ask the patient if they have a cardiologist and report the information to the base hospital.
3. If 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. Positive ECGs will be handed to the receiving medical practitioner. The receiving practitioner will initial, time and date the ECG to indicate they have received and reviewed the ECG.

E. Patient Treatment:

1. Patient Communication: If the 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 unless the ECG is of poor quality, or the patient's condition worsens.
2. If there is no interpretation of another ECG then repeat the ECG.
3. The original ECG performed by physician shall be obtained and accompany the patient.

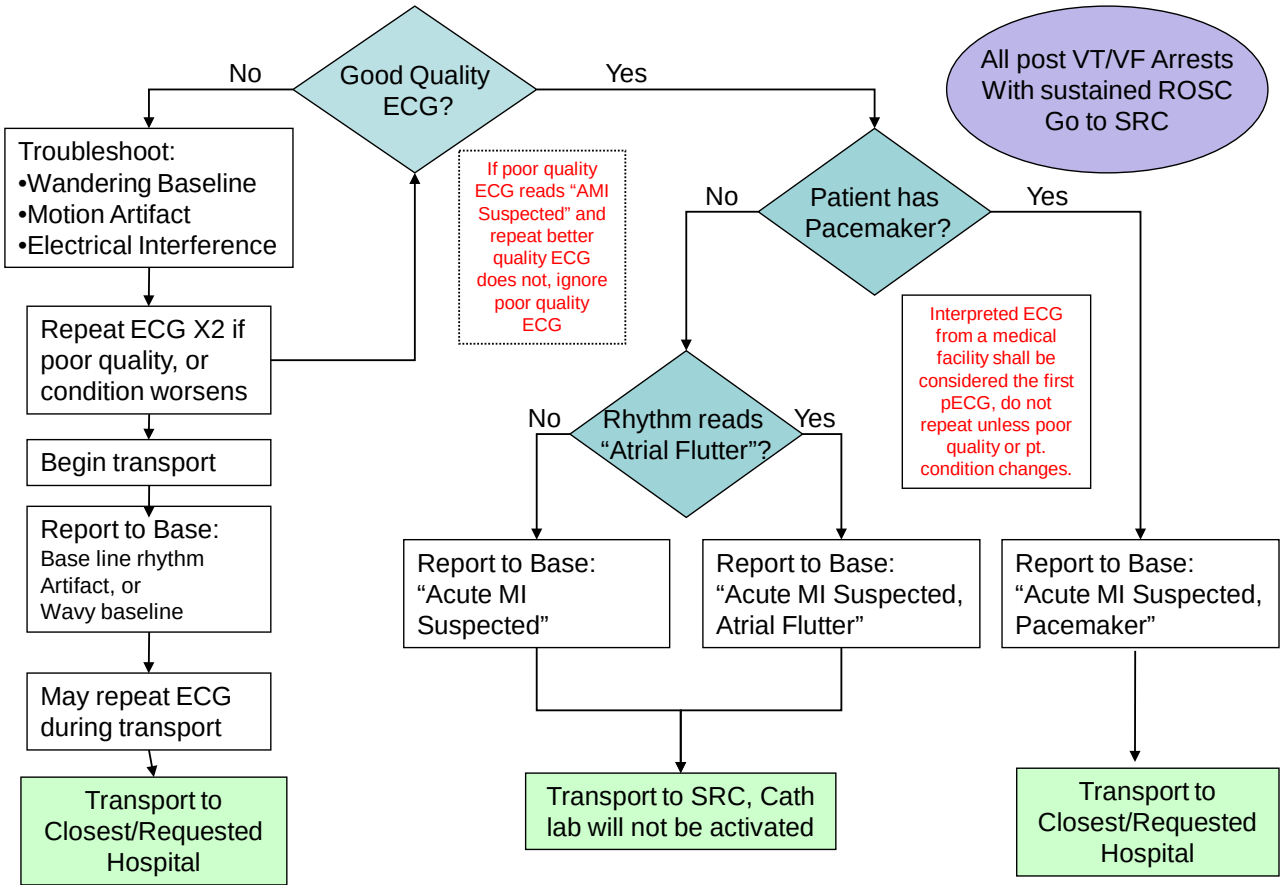
G. Documentation

1. Approved Ventura County Documentation System (AVCDS) documentation will be completed per VCEMS policy. The original ECG will be turned in to the base hospital and ALS Service Provider.

H. Reporting

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

ACUTE MI SUSPECTED



COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Documentation of Prehospital Care	Policy Number 1000
APPROVED: Administration: Steven Carroll, Paramedic	Date: June 1, 2012
APPROVED: Medical Director Angelo Salvucci, M.D.	Date: June 1, 2012
Origination Date: June 15, 1998 Date Revised: November 10, 2011 Date Last Reviewed: November 10, 2011 Review Date: November 30, 2014	Effective Date: June 1, 2012

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

II. AUTHORITY: 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 Access

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

B. Documentation

1. The VCEMS VCePCR will be used to document the care provided by pre-hospital personnel for every patient contact and/or incident to which a particular unit or provider is attached. An incident will be defined as any response involving Ventura County pre-hospital personnel to any event in which there is an actual victim, or the potential for a victim, regardless of whether the responding unit was cancelled enroute or not. A patient contact is 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. The following are exceptions:

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

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

c. The appropriate level VCePCR shall be completed to correspond to the level of care provided to the patient. If an ALS provider determines a patient to only require basic level care, a VCePCR-BLS report can be utilized. If a unit or provider is attached to an incident, but cancelled enroute, a VCePCR-Cancelled Call form shall be completed and posted.

d. A minimum validation score of 95 shall be required for all VCePCRs prior to completion and locking of the document.

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

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

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

    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 teams and between field provider and hospital shall be documented on appropriate VCePCR. The first arriving agency will post to the server and perform a coordinated electronic transfer of care whenever possible within the VCePCR system to the next incoming unit. This includes intra-agency units and inter-agency units.

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

C. In the event the cardiac monitor is attached as required by any of the VCEMS 705 policies, a complete ECG data transfer shall be recorded and attached to the corresponding VCePCR. ECG data shall be downloaded by each provider agency involved in that incident and attached to the corresponding VCePCR.

D. Submission to VCEMS

The approved minimum data set shall be electronically posted to the server by transporting agencies prior to the transporting unit returning to service from any incident in which a patient was transported. For all

other reports, any and all VCePCRs shall be completed and posted to the server as soon as possible and no later than the end of shift.

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. The AMA checklist as well as patient signatures shall be captured whenever possible by each applicable agency at the time of patient contact/refusal. If, at any point, a signature is not obtained for any reason, explanation shall be documented in the narrative section of the VCePCR.

G. ALS Inter-facility 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 VCePCR.

H. Patient Medical Record

The VCePCR and Ventura County Multi-Casualty Patient Record shall be considered a legal document and part of the patient's medical record. The first responder agency, transport agency, and hospital are custodians of record. Printing should only be performed as needed, and an electronic copy of the VCePCR should be utilized and referred to whenever feasible. A print log and reason for printing shall be monitored regularly to help ensure security of protected health information within the system.

Attachment A

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

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

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

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

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

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

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

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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Continuing Education - Field Care Audit		Policy Number 1131
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: June 1, 2012
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: June 1, 2012
Origination Date: Date Revised: Date Last Reviewed: Next Review Date:	August 1, 1094 February 9, 2012 February 9, 2012 February 28, 2015	Effective Date: June 1, 2012

I. PURPOSE: The Field Care Audit is an important component of the continuing education of prehospital personnel, and is a vital tool in evaluating the effectiveness of mobile intensive care. These regular reviews allow team members the opportunity to critique their own performance, as well as the performance of others. In addition, the review allows all members of the EMS team the opportunity to exchange ideas and opinions on the management of patient calls, thus improving the interpersonal relationships and promoting appropriate communication patterns.

Implementation of the Field Care Audit guidelines will provide a structured session with the group dynamics important in the recording critique process and will enhance the prehospital education experience.

II. AUTHORITY: California Code of Regulations, Title XXII, Division 9, Chapter II, 100390.

III. POLICY: Each Base Hospital shall provide at least one (1) hour of field care audit per month.

IV. PROCEDURE:

A. All Field Care Audits shall be conducted by a Prehospital Care Coordinator (PCC).

B. Field Care Audits shall be a minimum of one (1) hour and a maximum of four (4) hours.

C. When conducting a field care audit, the following guidelines should be utilized:

1. Field Care Audits shall have a minimum of three (3) persons in attendance, one whom shall be a PCC.

2. Recordings should be reviewed to determine educational value before they are presented at a formal Field Care Audit session. A recording

which is specifically requested by prehospital personnel should be presented at a field care audit as soon as possible.

3. All personnel involved in a response to be discussed at a Field Care Audit should be contacted directly and encouraged to attend the review, If possible. It is appropriate to include didactic instructions as part of a recording critique program when a specific problem needs to be clarified.
4. A continuing education attendance roster shall be made for each Field Care Audit. Each prehospital personnel shall sign and print his/her name. The Ventura County Certification/authorization or paramedic's State license number shall be filled in.
5. An evaluation form shall be completed by each attendee for each hour of Field Care Audit that is provided. The Base Hospital conducting the Field Care Audit shall retain the attendance roster. A CE Certificate will be provided for each hour of Field Care Audit provided, to each attendee.
6. Fifty (50) percent of required Field Care Audit hours shall be attended in Ventura County for Ventura County certified prehospital personnel.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Air Unit Staffing Requirements		Policy Number: 1201
Approved Administration:	Steven L. Carroll, Paramedic	Date: December 1, 2011
Approved Medical Director:	Angelo Salvucci, MD	Date: December 1, 2011
Origination Date: Date Revised: Date Last Reviewed: Review Date:	May 30, 1988 November 10, 2011 November 10, 2011 November 30, 2014	Effective Date: December 1, 2011

I. PURPOSE: To provide guidelines for classification and staffing level for air unit(s) authorized or licensed to operate in Ventura County as a part of the Emergency Medical Services system.

II. AUTHORITY: Health and Safety Code: 1797.103, 1797.206, 1797.218, 1797.220, 1797.252, 1798.2 and 1798.102. CCR, Title XXII, Division 9, Chapter 8: Prehospital EMS Air Regulations.

III POLICY: Ventura County helicopters will be classified and staffed with medical personnel appropriate to the needs of the patient, according to this policy.

IV DEFINITIONS:

A. Air Ambulance Service: An air transportation service, which utilizes air ambulances.

B. EMS Aircraft Classifications:

1. Air Ambulance

Any aircraft specially constructed, modified or equipped, and used for the primary purposes of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum two attendants certified or licensed in advanced life support (ALS).

2. Rescue Aircraft

An aircraft whose usual function is not prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transport when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft and Auxiliary rescue aircraft.

1. “ALS Rescue Aircraft”: a rescue aircraft whose medical flight crew has at least one (1) attendant licensed and/or accredited to provide ALS.
2. “BLS Rescue Aircraft”: a rescue aircraft whose medical flight crew has at least one (1) attendant certified as an EMT

3. Auxiliary Aircraft:

   Auxiliary Aircraft: a rescue aircraft which does not have a medical flight crew, or whose medical flight crew does not meet the minimum requirements established.

C. Medical Flight Crew: The individuals(s), excluding the pilot, specifically assigned to care for the patient during aircraft transport.

D. Classifying EMS Agency: The agency, which categorizes the EMS aircraft into the groups identified in Section 100300(c)(3) of Title 22, California Code of Regulations. This shall be the local EMS agency in the jurisdiction of origin except for aircraft operated by the California Highway Patrol, the California Department of Forestry or the California National Guard which shall be classified by the EMS Authority.

   Note: Military Aircraft are not in the EMS Authority's purview.

E. Authorizing EMS Agency: The local EMS agency which approves utilization of specific EMS aircraft within its jurisdiction.

V. PROCEDURE

A. Aircraft Staffing Requirements

1. Air Ambulance: The medical flight crew has at a minimum two (2) attendants certified or licensed in advanced life support.
2. Advanced Life Support (ALS) Rescue: The medical flight crew has at a minimum one attendant certified or licensed in advanced life support.
3. Basic Life Support (BLS) Rescue Aircraft: The medical flight crew has at a minimum one attendant certified as an EMT-I with at least eight (8) hours of hospital clinical training and whose field/clinical experience specified in Section 100074 (c) of Title 22, California Code of Regulations, is in the air methods transport of patients.
4. Auxiliary Aircraft: An aircraft that does not have a medical flight crew.

B. Criteria for EMS Personnel to Staff Air Unit

1. Emergency Medical Technician-Paramedic (EMT-P)
   a. When staffing a SAR air unit based in Ventura County, a paramedic shall be:
      1) Accredited in Ventura County,
      2) Designated as a level II EMT-P, per VC EMS Policy 318
   b. When accompanying an RN on an air ambulance, a paramedic shall be accredited in Ventura County.
   c. An Paramedic who meets the requirements of IV.B.a.1-2 and is selected to staff an air unit may work with an EMT who meets the requirements for a SAR EMT. The names of all paramedics selected to work with SAR EMT will be submitted to VCEMS.

2. SAR Emergency Medical Technician I
    a. While assigned to work with a paramedic on a Ventura County based air unit, a SAR EMT shall:
        1) Successfully complete the training module described in VCEMS Policy 306. The SAR EMT is not required to complete the arrhythmia/ defibrillation component of the module.
        2) Meet skill maintenance requirements.
        3) Perform duties as described below.
    b. SAR EMT Duties and Responsibilities
        1) Those functions within the EMT Scope of Practice.
        2) May transmit information to a Base Hospital regarding paramedic activity and transport information, but may not ask for, receive, or pass on ALS orders.
3. Registered Nurses
    a. RN with a minimum of two (2) years experience in a critical care area within the previous three (3) years, prior to employment with the provider agency.
    b. Current BLS and ACLS certification from the American Heart Association.
    c. Minimum of 384 hours of critical care area (including time worked as a CCT RN) experience per year, unless employed full time as a critical care transfer nurse.
    d. Successful completion of an in-house orientation program sponsored by the provider agency.
    f. Endotracheal intubation training.
    h. Certification in any of the following: Certified Emergency Nurse (CEN); Critical Care Registered Nurse (CCRN); Mobile Intensive Care Nurse (MICN); Certified Nurse Anesthetist; Post Anesthesia Recovery Nurse (PAR); or Certified Flight Registered Nurse (CFRN) or challenge/pass Ventura County MICN test.

C. Initial Education for Medical Flight Crews
1. All Medical Flight Crew personnel shall receive training in air methods transportation, including but not limited to the following:
    a. General patient care in-flight.
    b. Changes in barometric pressure, and pressure related maladies.
    c. Changes in partial pressure of oxygen.

d. Other environmental factors affecting patient care.
e. Aircraft operational systems.
f. Aircraft emergencies and safety.
g. Care of patients requiring special consideration in the airborne environment.
h. EMS system and communications procedures.
i. The prehospital care system(s) within which they operate, including local medical and procedural protocols.
j. Use of onboard medical equipment.

2. Air Unit service providers will provide documentation of training to VC EMS.

D. Continuing Education Requirements

1. All medical flight crews shall participate in such continuing education requirements as required by their licensure or certification and as defined in VC EMS Policy 334.
   a. All registered nurses, regardless of the certification which qualifies them to serve as flight nurses within Ventura County, must attend EMS updates twice yearly.
   b. Flight Nurses who challenge and pass the MICN examination to comply with this policy must meet the continuing education requirements of thirty-six (36) hours per recert cycle, 50% of which, in each category, shall have been obtained at Ventura County Base Hospitals.
      (1) Field Care Audits (Field care audit): Twelve hours per two years.
      (2) Periodic training sessions (Lecture/Seminar): Twelve hours per two years.
         (a) EMS Updates (Mandatory, two times per year)
         (b) ACLS recertification – 2 hours credit
         (c) Self-Study/Video CE
      (3) Miscellaneous Education: Twelve hours per two years.
   c. SAR EMT-I Requirements (In addition to EMT-I recertification requirements)
      (1) Skills Update - 2 hours per certification period
      (2) EMS Updates – Mandatory, two times per year
2. Air Unit service providers will provide documentation of continuing education to VC EMS.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Helicopter Dispatch for Emergency Medical Responses	Policy Number: 1202
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: December 1, 2011
APPROVED: Medical Director: Angelo Salvucci, MD	Date: December 1, 2011
Origination Date: May 30, 1988 Date Revised: November 10, 2011 Date Last Reviewed: November 10, 2011 Next Review Date: November 30, 2014	Effective Date: December 1, 2011

I. PURPOSE: To define dispatch procedures for helicopter emergency medical responses.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.220, and 1798. California Code of Regulations, Title 22, Division 9, Section 100276.

III. DEFINITIONS:

A. EMS Aircraft: any aircraft utilized for the purpose of pre-hospital emergency patient response and transport. This includes “Air Ambulances” and all categories of “Rescue Aircraft.”

B. Air Ambulance: Any aircraft specially constructed, modified or equipped, and used for the primary purposes of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum two attendants certified or licensed in advanced life support (ALS).

C. Rescue Aircraft: An aircraft whose usual function is not prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transport when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft and Auxiliary rescue aircraft.

1. ALS Rescue Aircraft: a rescue aircraft whose medical flight crew has at least one (1) attendant licensed and/or accredited to provide ALS.
2. BLS Rescue Aircraft: a rescue aircraft whose medical flight crew has at least one (1) attendant certified as an EMT

3. Auxiliary Aircraft: a rescue aircraft which does not have a medical flight crew, or whose medical flight crew does not meet the minimum requirements established.

D. Helicopter Dispatch Center: The helicopter dispatch center is the Ventura County Fire Protection District Fire Communications Center (FCC).

E. Automatic Response Area(s): Any remote area where the response time for ground ambulance personnel exceeds 25 minutes as determined by the FCC CAD system.

IV. POLICY: Helicopters will be dispatched when an incident is located in an Automatic Response Area or when requested by on-scene VCEMS personnel.

V. PROCEDURE

A. Helicopters, staffed and equipped according to VCEMS policies and procedures, will be dispatched by the designated dispatch center in the following manner:

1. All requests for and cancellations of EMS helicopters shall be made through FCC. The authority for requesting the dispatch of a helicopter for patient transport shall be vested with the on-scene public agency or Ventura County EMS personnel. This policy does not preclude the Ventura County Sheriff's Aviation Unit from responding to incidents requiring law enforcement response.
2. FCC will determine the appropriate aviation resources using information from on-scene public safety/EMS personnel or from the reporting party if the patient is located in an Automatic Response Area.
3. No EMS helicopter shall respond to an incident without the request of or notifying of FCC. All responding public safety/EMS personnel shall be notified of the dispatch of a helicopter
4. An air ambulance will be dispatched to incidents when a suitable landing site is available and the victim is accessible from the landing site. If the designated air ambulance is unavailable, the Ventura County Sheriff’s Department Search and Rescue (VCSD SAR) helicopter will be dispatched.
5. The VCSD SAR helicopter will be dispatched to incidents that describe the need for the specialized skills and capabilities of a rescue aircraft. If the VCSD SAR helicopter is unavailable, mutual aid resources will be contacted. Incidents that require a rescue helicopter involve the need for:

a. Hoist operations: use of a mechanical device (“hoist”; attached to the helicopter) to lift a patient from a location inaccessible to ground personnel, and transfer him/her into the cabin of the helicopter.

b. Short haul operations: use of a long line (attached to the helicopter) to lift a patient from a location inaccessible to ground personnel, and transport him/her to a location on the ground a short distance away where care may be provided.

c. The need for search capabilities, including the utilization of Night Vision Goggles (NVG).

B. Helicopter transportation should be considered for all cases that meet criteria per VCEMS Policy 1203 (Criteria For Patient Emergency Transport by Helicopter)

1. Helicopter transportation will not be used for diversion purposes unless the closest hospital is on internal disaster.

C. A helicopter response may be terminated:

1. By FCC if on-scene VCEMS personnel determine that the helicopter is not needed.

2. If the helicopter pilot and/or flight crew determine the call should be terminated for safety considerations.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Criteria For Patient Emergency Transport by Helicopter	Policy Number 1203
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: December 1, 2011
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: December 1, 2011
Origination Date: October 31, 1994 Date Revised: November 10, 2011 Date Last Reviewed: November 10, 2011 Review Date: December 31, 2014	Effective Date: December 1, 2011

I. PURPOSE: To define criteria for patient transport via helicopter

II. POLICY: Patients shall be transported to hospitals via ground ambulance unless such transport is unavailable or if ground transport is significantly longer than air transport (and this difference in time may negatively impact the patient's condition

III. PROCEDURE:

A. If a helicopter is being considered for patient transport, early recognition (including request for a helicopter while enroute to the call) will help decrease delay in patient transport

B. Helicopter transportation of patients should be considered for cases that meet **ALL** of the following criteria. Transport decisions will be determined jointly by the Base Hospital (BH), if BH contact is established, and on-scene personnel.

1. A minimum of 15 minutes ground travel time to the *appropriate* hospital,
2. The helicopter can deliver the patient to the hospital in a shorter time than the ground unit based on the time that the patient is ready for transport. This decision should be based on the following formula:

___ minutes for ETA of the helicopter to the scene
+ ___ minutes for air transport time to the hospital
+ 10 minutes for loading/unloading/transfer of patient to ED
= ___ ETA to hospital for the helicopter

3. Any one or more of the following patient conditions:
    a. Medical-related complaints:
        1) Hypotension/shock (non-traumatic)
        2) Snake bite with signs of significant envenomation
        3) Unstable near drowning
        4) Status epilepticus refractory to medications
        5) Cardiovascular instability (chest pain with dysrhythmias or post-resuscitation)
        6) Critical burns or electrical burns
        7) Critical respiratory patients (use caution with altitude)
        8) SCUBA-related emergencies or barotrauma (use caution with altitude)
        9) Any other medical problems in areas inaccessible to, or with prolonged ETA times, for responding ground units
        10) Other conditions subject to the approval of the BH physician or the highest medical authority on-scene
    b. Traumatic injuries – Patients with traumatic injuries who are to be transported by helicopter shall be triaged prior to transport according to VCEMS Policy 1405 (Trauma Triage and Destination Criteria)
        1) Trauma Step 1-3 criteria:
            a) All trauma patients to be transported by helicopter that meet Step 1-3 criteria **SHALL** be transported to a designated trauma center
            b) Helicopter personnel may determine on a case-by-case basis which trauma center is the closest and most appropriate destination
            c) BH contact with the destination trauma center shall be initiated by the caregiver(s) staffing the helicopter and coordination with the ground units.
            d) On rare occasion, the most appropriate destination hospital may be outside the county. However, it is preferred that trauma patients involved in incidents

within Ventura County are transported to a designated Ventura County trauma center

2). Trauma Step 4 criteria:

a) An on-scene paramedic shall contact the base hospital in whose catchment area the incident occurred

b) A BH order is ***required*** for all patients meeting Step 4 criteria, unless the patient is located within an inaccessible area or if patient transport will be prolonged

c) 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

c. Mass Casualty Incidents (MCI) or multi-patient incidents

1) Helicopter transport may be utilized during MCI responses

2) Patient transport should be coordinated by the BH and on-scene personnel

3) Patients transported by helicopter should be taken to a farther facility, allowing for ground providers to transport patients to the closer facilities

C. Contraindications to transport

1. Patients contaminated with hazardous materials regardless of decontamination status.
2. Violent or potentially violent patients who have not been chemically restrained.
3. Stable patients (except in backcountry areas inaccessible to ground units or it patient transport will be prolonged)
4. When ground transport time is equal to or shorter than air transport time

D. Relative contraindications to transport

1. Asystole, not responding to appropriate therapy and not meeting any criteria of an exceptional situation (e.g., cold water drowning, lightning strike or electrocution)
2. Transports from heavily populated areas

3. Transports for which, prior to departing the scene, conditions exist such that helicopter arrival at the intended destination is uncertain
4. Other safety conditions as determined by pilot and/or flight crew

E. Information about the patient(s) condition, level of medical personnel staffing the helicopter, and ambulance staffing is reviewed by medical and public safety personnel.

F. BH contact should be attempted to establish standard medical control. If ALS personnel are unable to establish BH contact, Communication Failure Protocols should be followed per VCEMS Policy 705.

G. Provider agencies which utilize medical flight crew members who have an expanded scope of practice beyond the Paramedic scope of practice (MD or RN) may utilize specific treatments/procedures only upon prior written approval by the VCEMS Agency. In such cases, notification to the receiving hospital shall be made and BH medical direction is not required.

H. Staffing decision for transport will be determined jointly by the BH (if BH contact is established) and on-scene personnel
1. A minimum of a paramedic (Level II) must accompany the patient if ALS procedures are initiated and no physician is present.
   a. Exception - In a MCI situation, a patient who has had an IV started that does not contain any additives may be transported by an EMT.
2. Destination will be determined by the pilot and flight crew, taking into consideration the patient(s) condition, flight conditions, and any other factors necessary

I. Complications during patient transport via helicopter:
1. If a helicopter is transporting a patient to the hospital and is unable to complete the transport due to weather, mechanical/safety issues, or any other factor that was impossible to predict prior to the helicopter lifting from the scene, the helicopter will notify FCC as soon as possible to arrange an alternate LZ and for a ground ambulance to rendezvous with the helicopter
2. Medical personnel staffing the helicopter shall retain responsibility for patient care until transfer of care to ground ambulance personnel is accomplished. If the final destination for the helicopter was to be a

trauma center, ground personnel shall complete the transport to the designated trauma center within that catchment area.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Air Unit Specifications, Equipment and Supplies		Policy Number 1205
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 1, 2007
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: December 1, 2007
Origination Date: Date Revised: Last Reviewed: Review Date:	May 1999 July 9, 2007 February 9, 2012 February 28, 2015	Effective Date: December 1, 2007

I. PURPOSE: To define air unit specifications, equipment and supplies.

II. POLICY: All air units transporting patients in Ventura County shall meet the requirements of this policy.

III. PROCEDURE:

A. EMS Aircraft Configuration

1. Air ambulances shall be accredited by the Commission on Accreditation of Medical Transport Systems
2. All EMS aircraft shall be configured so that: There is sufficient space in the patient compartment to accommodate one (1) patient on the stretcher and one (1) patient attendant.
3. There is sufficient space for medical personnel to have adequate access to the patient in order to carry out necessary procedures including CPR on the ground and in the air.
4. There is sufficient space for medical equipment and supplies required.
5. Additional VC EMS requirements are met.

B. Safety Equipment.

1. Each EMS aircraft shall have adequate safety belts and tie-downs for all personnel, patient(s), stretcher(s) and equipment to prevent inadvertent movement.
2. Providers shall assure that adequate safety equipment is available for the flight and medical crews to meet any Federal, State or local statutes, regulations or policies.

C. Each EMS aircraft shall have on-board equipment and supplies commensurate with the scope of practice of the medical flight crew as specified in VC EMS Policy 504. This requirement may be fulfilled through the utilization of appropriate medical kits (cases/packs) which can be carried on a given flight to meet the needs of a specific type of patient and/or additional medical personnel not usually staffing the aircraft.

D. Communications

1. In accordance with VC EMS policies, all EMS aircraft shall have the capability of communicating with:
   a. Designated dispatch center(s).
   b. EMS ground units at the scene of an emergency.
   c. Designated base hospitals.
   d. Receiving hospitals.
   e. Other appropriate facilities or agencies.
2. All EMS aircraft shall utilize radio frequencies, in accordance with the Ventura County EMS Communications Plan, for dispatch, routing and coordination of flights.
3. Radio equipment may be inspected to assure compliance with the requirements of VC EMS.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Guidelines for Interfacility Transfer of Patients to a Trauma Center	Policy Number 1404
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: May 1, 2012
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: May 1, 2012
Origination Date: July 1, 2010 Date Revised: April 12, 2012 Date Last Reviewed: April 12, 2012 Review Date: April 30, 2014	Effective Date: May 1, 2012

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. DEFINITIONS:

A. **EMERGENT** Transfer: A process by which a patient with potential life-or-limb threatening traumatic injuries is transferred to a trauma center. The patient requires an immediate procedure at a trauma center, and a delay in transfer will result in deterioration of the patient's condition, and the treating physician requests immediate transport to a trauma center.

1. Trauma Call Continuation: A process by which a patient with potential life-or-limb threatening traumatic injuries who has been taken to the emergency department by ALS ambulance is transferred to a trauma center. The patient requires an immediate procedure at a trauma center, the ALS ambulance is still on the premises, and the treating physician requests immediate transport to a designated trauma center.

B. **URGENT** Transfer: A process by which a patient with time-critical traumatic injuries is transferred to a trauma center. The patient requires a timely procedure at a trauma center, and a lengthy delay will result in deterioration of the patient's condition, and the treating physician requests prompt transport to a trauma center.

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

A. For patients who are in the emergency department at a community hospital and have one or more of the following injuries, if the referring physician requests transfer to a trauma center, the trauma center will immediately accept the patient

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, V or VI liver injuries
7. Grade III, IV or V spleen injuries
8. Unstable pelvic fracture
9. Fracture or dislocation with neurovascular compromise
10. Penetrating injury or open fracture of the skull
11. Glasgow Coma Scale score <14 or lateralizing neurologic signs
12. Unstable spinal fracture or spinal cord deficit
13. >2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion
14. Open long bone fracture
15. Significant torso injury with advanced co-morbid disease (such as coronary artery disease, chronic obstructive pulmonary disease, type 1 diabetes mellitus, or immunosuppression)

B. Ventura County Level II Trauma Centers:

1. Agree to immediately accept from Ventura County community hospitals, patients with conditions included in the guidelines above.
2. Will publish a point-of-contact phone number for an individual authorized to accept the transfer of a patient with a condition included in the guidelines above, or to request consultation with a trauma surgeon.
3. Will establish a written interfacility transfer agreement with every hospital in Ventura County.

C. Community Hospitals:

1. Are not required to transfer patients with conditions included in the guidelines above to a trauma center when resources and capabilities for providing care exist at their facility.
2. Will enter into a written interfacility transfer agreement with every trauma center in Ventura County.

D. **EMERGENT** Transfers

1. **EMERGENT** transfers are indicated for patients with life-or-limb threatening injuries in need of emergency procedures at a trauma center. Criteria **MUST** includes at least one of the following:
   a. Indications for an immediate neurosurgical procedure.
   b. Penetrating gunshot wounds to head or torso.
   c. Penetrating or blunt injury with shock.
   d. Vascular injuries that cannot be stabilized and are at risk of hemorrhagic shock or loss of limb acutely (excluding fingers/toes).
   e. Pregnancy with indications for an immediate Cesarean section.
2. For **EMERGENT** transfers, trauma centers will:
   a. Publish a single phone number ("hotline"), that is answered 24/7, for an individual authorized to accept the transfer of patients who have a condition as described in Section D.1 of this policy.
   b. Immediately upon initial notification by a transferring physician, accept in transfer all patients who have a condition as described in Section D.1 of this policy.
   c. Immediately post on ReddiNet when there is no capacity to accept trauma patients.
3. For **EMERGENT** transfers, community hospitals will:
   a Assemble and maintain a "Emergency Transfer Pack" in the emergency department to contain all of the following:
      1. Checklist with phone numbers of Ventura County trauma centers.
      2. Patient consent/transfer forms.
      3. Treatment summary sheet.
      4. Ventura County EMS "Emergency Trauma Patient Transfer QI Form."
   b. Have policies, procedures, and a quality improvement system in place to track and review all **EMERGENT** transfers and Trauma Call Continuations.
   c. Maintain an ambulance arrival to emergency department (ED) departure time of no longer than ten minutes.

d. Establish policies and procedures to make personnel available, when needed, to accompany the patient during the transfer to the trauma center.

4. For **EMERGENT** transfers, Ventura County Fire Communications Center (FCC) will:

a. Respond to an **EMERGENT** transfer request by immediately dispatching the closest available ALS ambulance to the requesting hospital.

b. Consider Trauma Call Continuation transfers to be a follow-up to the original incident, and will link the trauma transfer fire incident number to the original 911 fire incident number.

5. For **EMERGENT** transfers, ambulance companies will:

a. Respond immediately upon request.

b. For "Trauma Call Continuation" requests, immediately transport the patient to a trauma center with the same ALS personnel and vehicle that originally transported the patient to the community hospital.

c. Not be required to consider **EMERGENT** transports as an "interfacility transport" as it pertains to ambulance contract compliance.

E. **URGENT** Transfers

1. **URGENT** transfers are indicated for patients with time-critical injuries in need of timely procedures at a trauma center.

2. For **URGENT** transfers, trauma centers will:

a. Publish a single phone number, that is answered 24/7, for a community hospital physician to consult with a trauma surgeon.

3. For **URGENT** transfers, community hospitals will:

a. Maintain an ambulance arrival to emergency department (ED) departure time of no longer than twenty minutes.

4. For **URGENT** transfers, ambulance companies will:

a. Arrive at the requesting ED no later than thirty minutes from the time the request was received.

V. PROCEDURE:

A. **EMERGENT** Transfers

1. After discussion with the patient, the transferring hospital will:

a. Call the trauma hotline of the closest trauma center to notify of the transfer.
b. Call FCC, advise they have an **EMERGENT** transfer, and request an ambulance. If the patient's clinical condition warrants, the transferring hospital will call FCC *before* calling the trauma center's hotline.
c. Complete transfer consent and treatment summary.
d. Prepare copies of the ED triage assessment form and demographic information form.

2. Upon request for an **EMERGENT** transfer, the dispatch center will dispatch the closest ALS ambulance and verbalize "MEDxxx EMERGENCY Trauma Transfer from [transferring hospital]". The trauma center will be denoted in the incident comments, which will display on the mobile data computer (MDC). If a unit does not have an operational MDC, the transferring hospital will advise the responding ambulance personnel of the destination trauma center.
3. Upon notification, the ambulance will respond Code (lights and siren).
4. FCC will track ambulance dispatch, enroute, on scene, en-route hospital, at hospital, and available times.
5. The patient shall be emergently transferred without delay. Every effort will be made to limit ambulance on-scene time in the transferring hospital ED to ten minutes.
   a. All forms should be completed prior to ambulance arrival.
   b. Any diagnostic test or radiologic study results may either be relayed to the trauma center at a later time, or if time permits, copied and sent with the patient to the trauma center.
   c. Intravenous drips may be discontinued or remain on the ED pump.

B. Trauma Call Continuation

1. Upon determination of a Trauma Call Continuation, and after discussion with the patient, the community hospital will:
   a. Direct the ambulance personnel to prepare to continue the transport to the trauma center.
   b. Notify the designated trauma center ED of the immediate re-triage of a trauma patient, and communicate the patient's apparent injuries or

reason for the re-triage, after the call is continued and the patient is enroute to the trauma center.

2. Upon notification of Trauma Call Continuation, the ambulance personnel will notify FCC of their assignment to a Trauma Call Continuation. FCC will link the trauma transfer to the original 911 incident and continue tracking en-route hospital (departure from community hospital), at hospital (arrival at trauma center) and available times.
3. When the transferring physician determines the patient is ready and directs ambulance personnel to continue the transport, the ambulance will emergently transport the patient to the trauma center. The transporting paramedic will contact the trauma base hospital enroute and provide updated patient information.

C. **URGENT** Transfers

1. After discussion with the patient, the transferring hospital will:
   a. Call the trauma hotline for the closest trauma center to consult with the trauma surgeon.
   b. Call the transport provider to request an ambulance.
   c. Complete transfer consent and treatment summary.
   d. Prepare copies of the ED triage assessment form.
   e. Limit ambulance on-scene time in the transferring hospital ED to twenty minutes.
2. Upon request for an Urgent transfer, the transport provider will dispatch an ambulance to arrive no later than thirty minutes after the request.

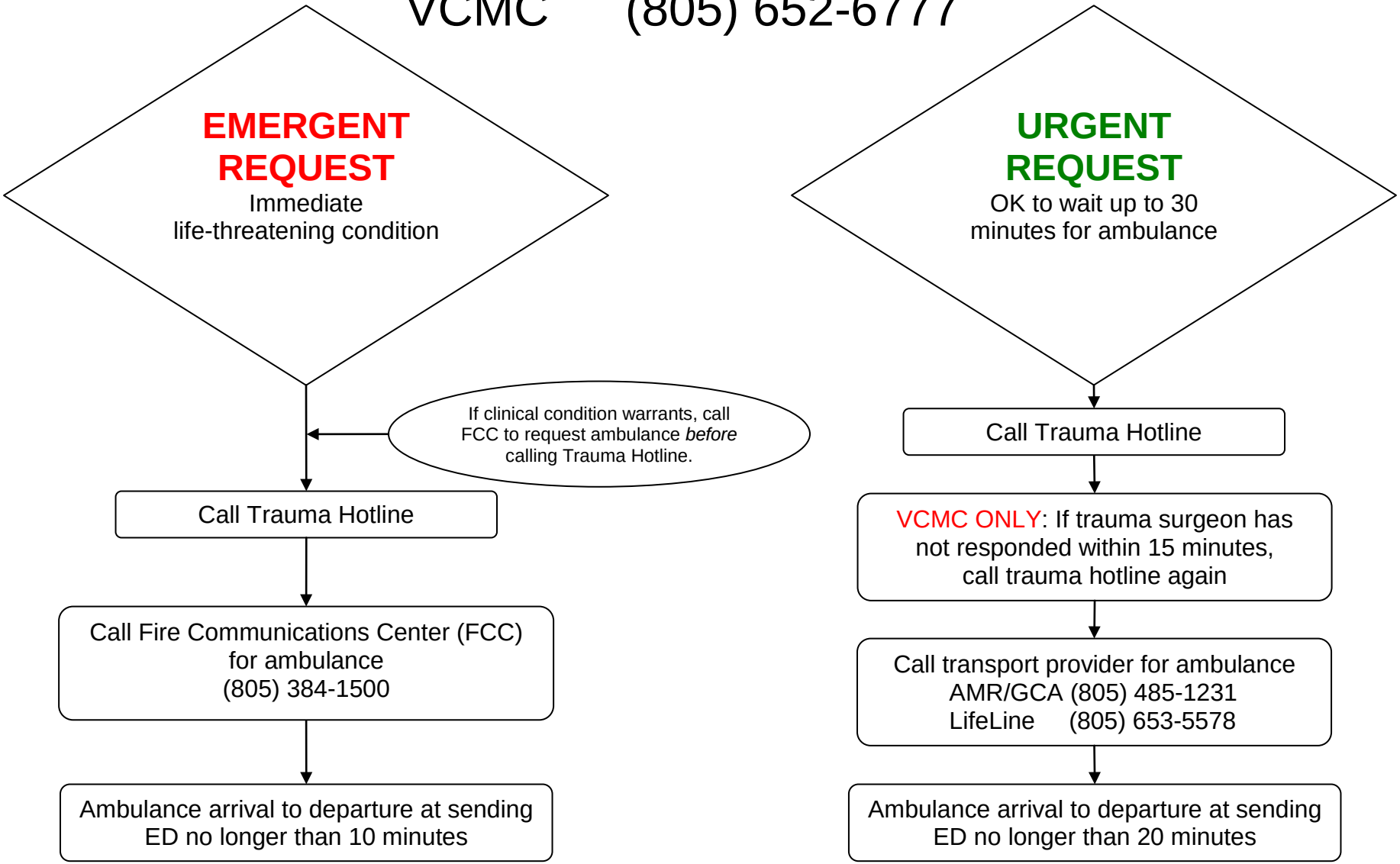
D. For all **EMERGENT** and **URGENT** transfers, the transferring hospital will submit a completed Emergency Trauma Patient Transfer QI Form to the Ventura County EMS Agency within 72 hours. The transfer will be reviewed for appropriate and timely care and to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS Trauma Operational Review Committee.

Ventura County Trauma Centers

Trauma Hotlines

LRHMC (805) 370-5901

VCMC (805) 652-6777



EMERGENT and URGENT Trauma Transfer QI Form
Form: Ventura County EMS Agency Policy 1404

(ALL FIELDS MUST BE COMPLETED)

Date:_____

Sending Hospital:

☐ SVH ☐ SJPVH ☐ SJRMC ☐ OVCH ☐ CMH ☐ SPH

Treating Physician:_____

Patient Arrived at Sending ED:

☐ Brought by EMS: Fire Incident Number _____

☐ Brought by POV or Walk-In

Destination Trauma Center:

☐ LRHMC

☐ VCMC

☐ Other: _____

Patient Transfer Process:

☐ EMERGENT

- ☐ Ambulance with paramedic ONLY
- ☐ Ambulance with accompanying healthcare personnel
- ☐ Trauma Call Continuation

☐ **URGENT**

If the transfer was EMERGENT, which of the following Policy 1404 criteria applies?

☐ Indications for an immediate neurosurgical procedure.

☐ Penetrating gunshot wound to head or torso.

☐ Penetrating wound by any mechanism and presents with or develops shock.

☐ Blunt injury and shock.

☐ Vascular injury that cannot be stabilized and is at risk of hemorrhagic shock or loss of limb acutely (excluding fingers/toes).

☐ Pregnancy with indications for immediate Cesarean section.

Comments:

Within 72 hours of transfer, fax or scan/email to VCEMS: Fax--(805) 981-5300 Email—katy.hadduck@ventura.org

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Trauma Center Standards		Policy Number 1406
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: June 1, 2012
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: June 1, 2012
Origination Date: Date Revised: Date Last Reviewed: Review Date:	July 1, 2010 February 9, 2012 February 9, 2012 February 28, 2014	Effective Date: June 1, 2012

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 hospital, in consultation with the trauma center, will be responsible 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, and available within one (1) hour of the time of call for other trauma team activations or consultation when requested by the emergency physician.
   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.