County of Ventura
Department of Public Health

Notice of Changes to Policy Manual

Emergency Medical Services
Policies and Procedures

To: ALL VENTURA COUNTY EMS POLICY MANUAL HOLDERS

DATE: June 1, 2023

Policy Status	Policy #	Title/New Title	Notes
REMOVE	0000	COVID-19 Prehospital Guidelines	Already taken down from website due to end of PH emergency and development of VCEMS Policy 630 – EMS Infectious Disease Policy
REPLACE	107	Stroke and STEMI Committee	Reviewed – No Changes
REPLACE	110	Ambulance Business License Code	Reviewed – No Changes
ADD	121	Safety Event Reporting	New Policy, focused on *Just Culture* framework for reviewing safety events within the VCEMS system.
REPLACE	124	Hospital Emergency Services Reduction Impact Assessment	Changed hospital name to St. John's Camarillo
REPLACE	131	MCI Response	• Removed advanced MCI as mandatory training. Will combine elements of advanced MCI into standard MCI training module. • Updated position cards and organization charts to reflect 2022 FOG standards. • NEW MCI position – Transportation Recorder added to position cards.
REPLACE	141	Hospital EMS Surge Assistance	Reviewed – No Changes
REMOVE	150	Unusual Occurrence and Sentinel Event Reporting	With implementation of Policy 121 – Safety Event Reporting, the unusual occurrence and medication error policies are being archived.
REMOVE	151	Medication Error Reporting	With implementation of Policy 121 – Safety Event Reporting, the unusual occurrence and medication error policies are being archived.
REPLACE	330	EMT/Paramedic/MICN Decertification and Discipline	Update language to reflect current regulations
REPLACE	430	STEMI Receiving Standards	Reviewed - No Changes
REPLACE	452	TCASC Standards	Removed "E" from ELVO.
REPLACE	504	BLS and ALS Unit Equipment and Supplies	Added Eye Shields and Chest Seals
REPLACE	626	CHEMPACK Deployment	Minor corrections to spelling and formatting
REPLACE	628	Rescue Task Force Operations	• Policy updated in several locations to reflect current best practices at these types of scenes. • Added/revised terminology to reflect current FIRESCOPE and NFPA guidelines.

Policy Status	Policy #	Title/New Title	Notes
			• Updated equipment list for BLS and ALS kits
ADD	631	Mechanical CPR	New Policy • Includes indications and procedures for the use of mechanical CPR devices. • Outlines reporting and data transmission requirements when device is used.
REPLACE	705.00	General Patient Guidelines	Minor formatting changes only
REPLACE	705.01	Trauma Treatment Guidelines	Added eye shield for treatment and to cover only the injured eye and not both eyes.
REPLACE	705.04	Behavioral Emergencies	Added BLS Procedures section
REPLACE	705.07	Cardiac Arrest Asystole and PEA	Reviewed - No Changes
REPLACE	705.12	Heat Emergencies	Removed referring to 705.03 for blood glucose less than 60. Removed reference to checking blood glucose in ALS Standing Orders (covered in BLS/Altered Neurologic Function).
REPLACE	705.13	Cold Emergencies	Removed referring to 705.03 for blood glucose less than 60. Removed reference to checking blood glucose in ALS Standing Orders (covered in BLS/Altered Neurologic Function).
REPLACE	705.15	Nausea/Vomiting	Added max dose of 4mg for Ondansetron in pediatrics
REPLACE	705.18	Overdose/Poisoning	• Added IN Narcan dosing to include nasal atomizer for preload. • Removed IM Narcan dosing in adult section adult (covered in BLS). • Removed total dose max, referencing titrate to respirations. • Added pediatric single dose max.
REPLACE	705.19	Pain Control	Separated out IM Fentanyl dosing
REPLACE	705.28	Smoke Inhalation	Reviewed - No Changes
REMOVE	737	PH Emergency Vaccine Administration	Already taken down from website at the end of the PH emergency.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Ventura County Stroke and STEMI Committees	Policy Number 107
APPROVED: Administration: Steve L. Carroll, Paramedic	Date: July 1, 2023
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: July 1, 2023
Origination Date: August 9, 2018 Date Revised: August 9, 2018 Date Last Reviewed: January 12, 2023 Review Date: January 31, 2025	Effective Date: July 1, 2023

I. Committee Names: The names of these committees shall be the Ventura County (VC) Stroke Committee and the VC STEMI Committee.

II. Committee Purpose: The purpose of these committees shall be to provide input to the VC Emergency Medical Services (EMS) Medical Director and VC EMS administration on matters pertaining to the VC Stroke Specialty System and the VC STEMI Specialty System.

III. Membership:

A. Voting Membership

Voting membership in the committee shall be composed of 2 representatives from each facility (see chart below). Alternatives will be considered on a case-by-case basis.

Type of Organization	Member	Member
Acute Stroke Centers (ASC)	Stroke Coordinator	Physician
Non-ASC receiving centers	ED Manager or PCC	Physician
STEMI Receiving Centers	STEMI Coordinator	Physician
STEMI Referral Hospitals	ED Manager or PCC	Physician
Fire	Clinical manager or QI director	Senior Administrator or Medical Director
Ambulance Companies	Clinical manager or QI manager	Senior Administrator or Medical Director
VCEMSA	Administrator	Medical Director

B. Non-voting Membership

Non-voting members of the committee shall be composed of stakeholders from local agencies.

C. Membership Responsibilities

Representatives to the Stroke Committee and STEMI Committee represent the views of their agency. Representatives should ensure that agenda items have been discussed/reviewed by their agency prior to the meeting.

D. Voting Rights

Designated voting members shall have equal voting rights.

E. Attendance

1. Members shall remain as active voting members by attending 75% (Stroke) and 66% (STEMI) of the meetings in a (calendar) year. If attendance falls below these percentages, the organization administrator will be notified, and the member may lose the right to vote.
   (a) Members may have a single designated alternate attend in their place, no more than two times (Stroke) and one time (STEMI) per calendar year.
   (b) Agencies may designate one representative to be able to vote for both representatives, no more than two times (Stroke) and one time (STEMI) per calendar year.
2. The member whose attendance falls below these percentages, may regain voting status by attending two consecutive meetings.
3. If meeting dates are changed or cancelled, members will not be penalized for not attending.

IV. Officers

A. The chairperson of the Stroke Committee and the STEMI Committee is the VCEMSA Medical Director. The chairperson shall perform the duties prescribed by the guidelines outlined in this policy.

V. Meetings

A. Regular Meetings

The Stroke Committee will meet quarterly, and the STEMI Committee will meet once every 4 months. VCEMS will prepare and distribute the meeting agenda no later than one week prior to a scheduled meeting.

B. Special Meetings

Special meetings may be called by the VC EMS Medical Director, VC EMS Administrator or Public Health Director. Except in cases of emergency, seven (7) days' notice shall be given.

C. Quorum

The presence a simple majority (1/2 of committee membership plus 1) of voting members shall constitute a quorum. The presence of a quorum at the beginning of the meeting shall allow the committee to continue to do business until adjournment, regardless of the number of members who leave during the meeting.

VI. Task Forces and Ad-hoc Committees

The VC EMS Medical Director (committee chair), VC EMS Administrator, or Public Health Director may appoint task forces or ad-hoc committees to make recommendations to the Stroke or STEMI Committee on particular issues. The person appointing the task force or ad-hoc committee will name the chair. A task force or ad-hoc committee shall be composed of at least three (3) members and no more than seven (7) individuals. Persons other than voting members may be appointed to task forces or ad-hoc committees.

VII. Calendar Year

The Stroke and STEMI Committee will operate on a calendar year

VIII. Parliamentary Authority

The rules contained in the current edition of Robert's Rules of Order, newly revised, shall govern the organization in all cases to which they are applicable and in which they are not inconsistent with these guidelines, and any special rules of order the Stroke Committee may adopt.

IX. Submission of Agenda Items

Agenda items shall be received by the Ventura County EMS Office 14 days before the meeting it is to be presented. Items may be submitted by US mail, fax or e-mail and must include the following information:

A. Subject
B. Reason for request
C. Description/Justification
D. Supporting medical information/other research as applicable
E. List of affected VC EMS policies, if a requested policy change
F. Agenda Category:
    1. Operational
    2. Medical

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: County Ordinance No. 4099: Ambulance Business License Code		Policy Number 110
APPROVED: Administration	Steven L. Carroll, Paramedic	Date: July 1, 2023
APPROVED: Medical Director	Daniel Shepherd, M.D.	Date: July 1, 2023
Origination Date: Revised Date: Last Reviewed: Review Date:	July 10, 1994 September 13, 2007 January 12, 2023 January 31, 2026	Effective Date: July 1, 2023

See following pages.

ORDINANCE NO. 4099

AN ORDINANCE AMENDING SPECIFIED PROVISIONS OF THE VENTURA COUNTY ORDINANCE CODE RELATING TO REGULATION OF EMERGENCY MEDICAL SERVICES.

The Board of Supervisors of the County of Ventura does ordain as follows:

Section 2421 - DEFINITIONS - Unless otherwise specified, the term:

(a) "AMBULANCE" shall mean any privately or publicly owned motor vehicle that is specifically designed or constructed and equipped to transport persons in need of emergency medical care and is licensed as an ambulance by the California Highway Patrol.

(b) "AMBULANCE COMPANY LICENSE" shall mean a certificate from the County of Ventura which verifies that the company has met the procedural requirements of the Ventura County Emergency Medical Services Agency (VCEMSA) Policies and Procedures Manual for a license and is permitted to establish a base of ambulance operations in a designated ambulance service area.

(c) "AMBULANCE SERVICE AREA" shall mean those geographical areas established for the County of Ventura and shown on the Ambulance Service Map in the VCEMSA P/P Manual, and shall mean the area in which a holder of an ambulance company license may establish a base of operations.

(d) "BOARD" shall mean the Board of Supervisors of the County of Ventura.

(e) "COUNTY" or "VC" shall mean County of Ventura.

(f) "EMCC" shall mean the Ventura County Emergency Medical Care Committee appointed by the Board of Supervisors in accordance with the mandate in the California Health and Safety Code.

(g) "EMERGENCY CALL" shall mean any of the following:

1) A request from an individual who is experiencing or who believes he is experiencing a life threat. Lights and sirens are used.

2) A request from public safety agencies for individuals who are or may be experiencing a life threat; or a sudden and unforeseen need for basic life support or first aid. Lights and sirens are used if needed.

3) A request to transport hospitalized patients to and from another facility for special emergency or urgently needed diagnostic services which the requesting hospital cannot provide. Lights and sirens are used if needed.

(h) "VCEMSA" shall mean the Ventura County Emergency Medical Services Agency.

(i) "VCEMSA Admin" shall mean the Administrator of the VCEMSA.

(j) "VCEMSA MedDir" shall mean the Medical Director of the VCEMSA.

(k) "EMT-IA" shall mean Emergency Medical Technician-IA, who is a person who has successfully completed a basic EMT-IA course which meets State requirements and who has been certified by the VCEMSA MedDir.

(l) "EMT-P". An Emergency Medical Technician-Paramedic is a person who has successfully completed a paramedic training program which meets State requirements and who has been certified by the VCEMSA MedDir.

(m) "EMERGENCY SERVICE" shall mean the service performed in response to an emergency call.

(n) "PATIENT" shall mean a wounded, injured, sick, invalid, dead or incapacitated person who is evaluated or treated by personnel of any provider of emergency medical care Basic Life Support or Advanced Life Support.

(o) "VENTURA COUNTY EMERGENCY MEDICAL SERVICES AGENCY (VCEMSA) POLICIES AND PROCEDURES (P/P) MANUAL" shall include the County Ambulance Ordinance and the policies and operating procedures which are approved by the Ventura County VCEMSA Medical Director and/or Administrator.

Section 2423 - GENERAL PROVISIONS

Section 2423-l - Ambulance Company License Required - No person, either as owner, agent. or otherwise, shall operate an ambulance or conduct, advertise, or otherwise be engaged in or profess to be engaged in the provision of emergency or non-emergency ambulance service upon the streets or any public way or place of the County, unless he holds a current valid license for an ambulance issued pursuant to this ordinance. An ambulance operated by or contracted for by an agency of the United States or the State of California shall not be required to be licensed hereunder.

Section 2423-1.1 - Application for Ambulance Company License -An application for an ambulance company license shall be submitted and processed pursuant to the procedures set forth in the VCEMSA P/P Manual.

Section 2423-1.2 - Insurance - It shall be unlawful for any owner to operate an ambulance or cause or permit the same to be driven or operated, unless there is in full force and effect at all times while such ambulance is being operated, insurance covering the owner of such ambulance against loss by reason of injury or damage that may result to persons or property from negligent operation of such ambulance.
Insurance requirements as specified in the "Agreement for Emergency Ambulance Service and Transport of Indigent Persons" shall be complied with at all times, including but not limited to providing Certificates of Insurance to and naming the County of Ventura as Additional Insured.

Section 2423-1.3 - Exception - Licensing requirements of this article - Licensing requirements of this article shall not apply to an ambulance company or to the EMT-IAs or EMT-Ps who are:

(a) Rendering assistance to licensed ambulances in the case of a major catastrophe or emergency with which the licensed ambulances of County are insufficient or unable to cope.

(b) Operating from a location or headquarters outside of County to transport patients picked up beyond the limits of County to locations within County, or to transport patients picked up at licensed hospitals, nursing homes or extended care facilities within County to locations beyond the limits of County.

(c) Operating from a location or headquarters outside of County and providing emergency ambulance services at the request of and according to the conditions of the County of Ventura, or with the approval of the County of Ventura.

(d) Stationing an ambulance outside the service area for which the company is licensed in order to provide special ambulance service for an activity or event in accordance with a written agreement with the sponsor of the event. If the ambulance company is a prime contractor for emergency service, such an agreement may not cause the usual level of service to be lowered. The VCEMSA Admin shall be notified by ambulance companies when contracts are made for special ambulance service outside the service area of the licensee.

Section 2423-2 - Ambulance Operators and Personnel

Section 2423-2.1 - Ambulance EMT-IA and EMT-P Certification - Ventura County Requirements - Ambulance personnel in Ventura County shall be certified as EMT-IA or EMT-P pursuant to the procedures set forth in the VCEMSA P/P Manual.

Section 2423-2.2 - Ambulance Operations Requirements - No vehicle shall be operated for ambulance purposes and no person shall drive, attend or permit to be operated for such purpose on the streets, or any public way or place of County unless it shall be under the immediate supervision and direction of two (2) people who are at least EMT-IA certified and authorized by the Ventura County, except under conditions cited in Section 2423-1.3. Applications shall be submitted and processed pursuant to the procedures set forth in the VCEMSA P/P Manual.

Section 2423-2.3 - EMT-IA AND EMT-P Certification and California State Ambulance Driving Certificate requirements - No person shall drive an ambulance vehicle unless he or she is holding a currently valid California State Ambulance Driver's Certificate and is also at least EMT-IA certified.

Section 2423-2.4 - Certification Fees - The VCEMSA may charge a certification fee, the rate for which is to be established by the Board of Supervisors.

Section 2423-3 - Rate Schedule - The Board, on its own motion or upon application of a license, may set, establish, change, modify or amend the schedule of rates that may be charged by a licensee.

(a) No rates shall be set, established, changed, modified or amended without a hearing before the Board, except as hereinafter specified.

(b) Notice of such hearing shall be given to each licensee by the VCEMSA Admin.

(c) Maximum fees for "Supplies and Equipment" and "Disposable Items" have been established in the existing approved Rates Schedule (EMS P/P 112). Maximum fees for these, and any added, items may, in the future, be set, established, changed, modified, or amended by the VCEMSA. The VCEMSA may delete items from these categories or may add to these categories additional items which are medically indicated and approved by the VCEMSA.

(1) Prior to making changes as permitted by this subsection (c), the VCEMSA shall notify Ventura County EMS agencies and the public and shall provide an appropriate opportunity for public input at an Emergency Medical Care Committee meeting.

(2) The VCEMSA shall notify the Board of Supervisors via the Informational Agenda of any changes made pursuant to this subsection (c). The Board of Supervisors, after public hearing, may overrule any changes made by the VCEMSA pursuant to this subsection (c).

Section 2424 - SUSPENSION AND REVOCATION - Any license or permit issued pursuant to the provisions of this Article may be suspended or revoked by the Director of the Health Care Agency upon grounds and after following the procedures outlined in the VC EMSD P/P Manual.

Section 2424-1 - Mandatory License Denial, Suspension or Revocation - The DIR-HCA shall deny, suspend or revoke the license of an ambulance company if the operator:

(a) Is required to register as a sex offender under the provisions of Section 290 of the Penal Code; or

(b) Habitually or excessively uses or is addicted to the use of narcotics, dangerous drugs, or alcohol, or has been convicted of any offense relating to the use, sale, possession or transportation of narcotics or habit-forming or dangerous drugs; or

(c) Has falsified or failed to disclose a material fact in his application; or

(d) Has held a license and abandons ambulance operation for a period of seven (7) days. Acts of God and other acts beyond the control of the licensee shall not be abandonment within the meaning of this section; or

(e) Has been convicted of any offense punishable as a felony during the proceeding ten (10) years.

Section 2424-2 - Discretionary License Denial, Suspension or Revocation - The DIR-HCA may deny, revoke or suspend the license of an ambulance company if the operator has violated the standards and regulations set out in the VCEMSA P/P Manual.

Ordinance Code, County of Ventura
Division 2, Chapter 1, Article 1 - General Provisions

Section 2120-1 - Hearing - A license issued pursuant to the provisions of this division may be suspended or revoked only after complying with the following procedures.

Section 2120-1.1 - Statement of Charges - Upon an alleged violation of any of the regulations set forth in the VCEMSA P/P Manual, the VCEMSA Admin/MedDir shall file with the Clerk of the Board a statement of charges.

Section 2120-1.2 - Acts or Omissions Charged - It shall specify the ordinance code sections, policies or regulations allegedly violated.

Section 2120-1.3 - Notice and Request for Hearing - Upon the filing of a statement of charges, the Clerk of the Board shall serve a copy thereof upon the respondent named therein in a manner provided by Ordinance Code Section 14. It shall be accompanied by a statement that respondent may request a hearing by filing a written request with the Clerk of the Board within ten (10) days after service.

Section 2120-1.4 - Waiver of Hearing - If no request for a hearing is received, the hearing is deemed waived and the VC EMSD may proceed with suspension or revocation. Notice shall be sent respondent of suspension or revocation.

Section 2120-1.5 - Hearing Officer - The Tax Collector or his deputy is hereby designated as hearing officer for any hearing conducted pursuant to this article. The hearing officer shall hear all evidence presented and at the conclusion of the hearing, rule on the charges presented.

Section 2120-1.6 - Time, Place and Notice of Hearing - Upon receipt of request for hearing, the Clerk of the Board shall contact the hearing officer and arrange a date, time and place for the hearing. Notice thereof shall be given all parties at least ten (10) days prior to the hearing.

Ordinance Code, County of Ventura
Division 2, Chapter 1, Article 1 - General Provisions
Section 2133 - Appeals

Any person whose application for a license is disapproved or whose license is suspended or revoked after a hearing, may appeal to the Board of Supervisors within thirty (30) days after the date of such denial, suspension or revocation by filing with the Clerk of the Board of Supervisors a request that the Board review denial, suspension or revocation. The appeal shall be in the form of a written notice filed with the Clerk of the Board of Supervisors and signed by the appellant. The notice shall have attached a copy of the written application, suspension or revocation, and shall state clearly and concisely the reasons upon which the appellant relies for his appeal. The Clerk of the Board of Supervisors shall set the matter for hearing within fifteen (15) days after the notice is filed, and shall notify the appellant and VC EMSD of the setting. At the hearing, the appellant shall have the burden of establishing to the satisfaction of the Board that he is entitled to relief, or otherwise the denial of the application, the suspension, or revocation of the license or permit shall stand.

Ord. 4033/215/227.1 April 27, 1993

AN ORDINANCE OF THE COUNTY OF VENTURA
AMENDING VENTURA COUNTY ORDINANCE CODE
SECTION 2423-3 RELATING TO SETTINGS OF AMBULANCE RATES

The Board of Supervisors of the County of Ventura does ordain as follows:

Section 1. Section 2423-3 of the Ventura County Ordinance Code is hereby amended to read as follows:

"Section 2423-3 - Rate Schedule - The Board, on its own motion or upon application of a licensee, may set, establish, change, modify or amend the schedule of rates that may be charged by a licensee.

(a) No rates shall be set, established, changed, modified or amended without a hearing before the Board, except for consumer price index or other changes as provided for in ambulance provider agreements or as hereinafter specified.

(b) Notice of such hearing shall be given to each licensee by the VCEMSA Admin.

(c) Maximum fees for "Supplies and Equipment" and "Disposable Items" have been established in the existing approved Rates Schedule (EMS P/P 112). Maximum fees for these, and any added, items may, in the future, be set, established, changed, modified, or amended by the VCEMSA except that consumer price index or other changes provided for in ambulance provider agreements shall be in accordance with such agreements. The VCEMSA may delete items from these categories or may add to these categories additional items which are medically indicated and approved by the VCEMSA.

    (1) Prior to making changes as permitted by this subsection (c), the VCEMSA shall notify Ventura County EMS agencies and the public and shall provide an appropriate opportunity for public input at an Emergency Medical Care Committee meeting.

    (2) The VCEMSA shall notify the Board of Supervisors via the informational Agenda of any changes made pursuant to this subsection (c). the Board of Supervisors, after public hearing, may overrule any changes made by the VCEMS pursuant to this subsection (c).

Section 2. This Ordinance shall take effect thirty (30) days following final passage and adoption.
PASSED AND ADOPTED this day of , 1996, by the following vote:

AYES: Supervisors

NOES: Supervisors

ABSENT: Supervisors

CHAIR, BOARD OF SUPERVISORS

ATTEST:
RICHARD D. DEAN, County Clerk
County of Ventura, State of
California, and ex officio
Clerk of the Board of Supervisors
thereof:

By
Deputy Clerk

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Safety Event Review	Policy Number 121
APPROVED Administrator: Steven L. Carroll, Paramedic	Date: July 1, 2023
APPROVED Medical Director: Daniel Shepherd, MD	Date: July 1, 2023
Origination Date: April 13, 2023 Date Revised: Date Last Reviewed: Review Date: October 31, 2023*	Effective Date: July 1, 2023

I. PURPOSE: Identify and address events which may risk the safety of patient(s), provider(s), or communities.

II. AUTHORITY: Health and Safety Code, Division 2.5. California Code of Regulations, Title 22, Division 9. California EMS Authority Model Disciplinary Orders.

III. DEFINITIONS:

Reportable Safety Event: Any circumstance, error, or action, which causes an actual or potential risk to the safety of provider(s), patient(s), or the community. Reportable safety events include, but are not limited to, incorrect medication administration, deviation from policies and/or procedures, vehicle accidents involving EMS personnel, and events which may delay the response to an EMS incident. Reportable safety events are not limited to incidents that have already occurred and may include any observations of potential safety risks or other concerns.

Just Culture: A system of shared accountability in which organizations are accountable for the systems they have designed and for responding to behaviors of individuals in a fair and just manner.

IV. POLICY: Reportable safety events will be submitted and reviewed in accordance with the following procedures. VCEMS will be the coordinating agency for these reviews.

*Review of this policy will take place in 6 months in order to discuss and review this new process and any areas where additional improvement can be made as the EMS system navigates these changes.

V. PROCEDURE:

A. Reporting

1. Reporting safety events is encouraged and is considered an essential component of system development and oversight.
2. Safety events will be reported directly by the provider(s) who identified the risk or were directly engaged in the event. When a safety event is identified after the fact through base hospital or provider agency CQI programs, the safety event may be submitted by a responder agency or base hospital representative.
3. *Reportable Safety Events* will be reported to VCEMS utilizing the online tool provided.
4. *Reportable Safety Events* involving actual/potential harm to patients will be reported immediately. All other events will be reported within 24 hours of event occurrence or subsequent identification.
5. Agencies are encouraged to report any minor unexpected occurrence. This would include minor mechanical issues, equipment failures, misinterpretation of policy, etc. While seemingly innocuous, these events provide important insight into our EMS system.
6. When the incident is severe enough to warrant immediate review or communication, the reporting party should contact the EMS Agency Duty Officer.

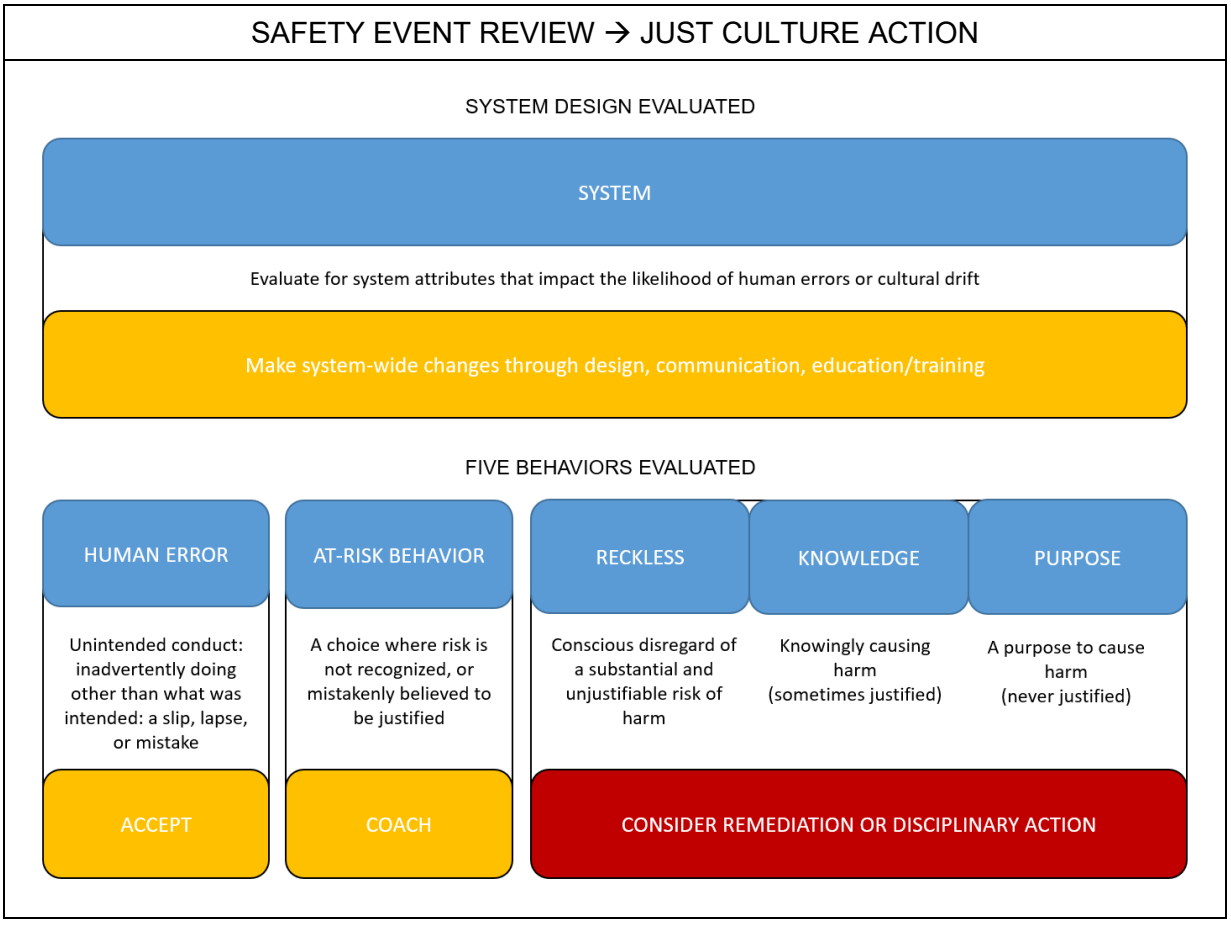
B. Event Review

1. The intent of the review is to evaluate system design and individual behaviors with a focus on learning and improving safety and is not intended to be punitive in nature.
2. When a Reportable Safety Event is submitted VCEMS will receive notification of the submission and the reporting party will receive confirmation that the submission was received.
3. Initial review will determine if additional information is needed.
4. Agencies, Pre-hospital Care Coordinator(s), and personnel involved will be notified that a reportable safety event has been received.

5. When it is determined that additional information is needed, VCEMS will collaborate with providers and clinical management teams for review and follow-up.

C. Just Culture Algorithm

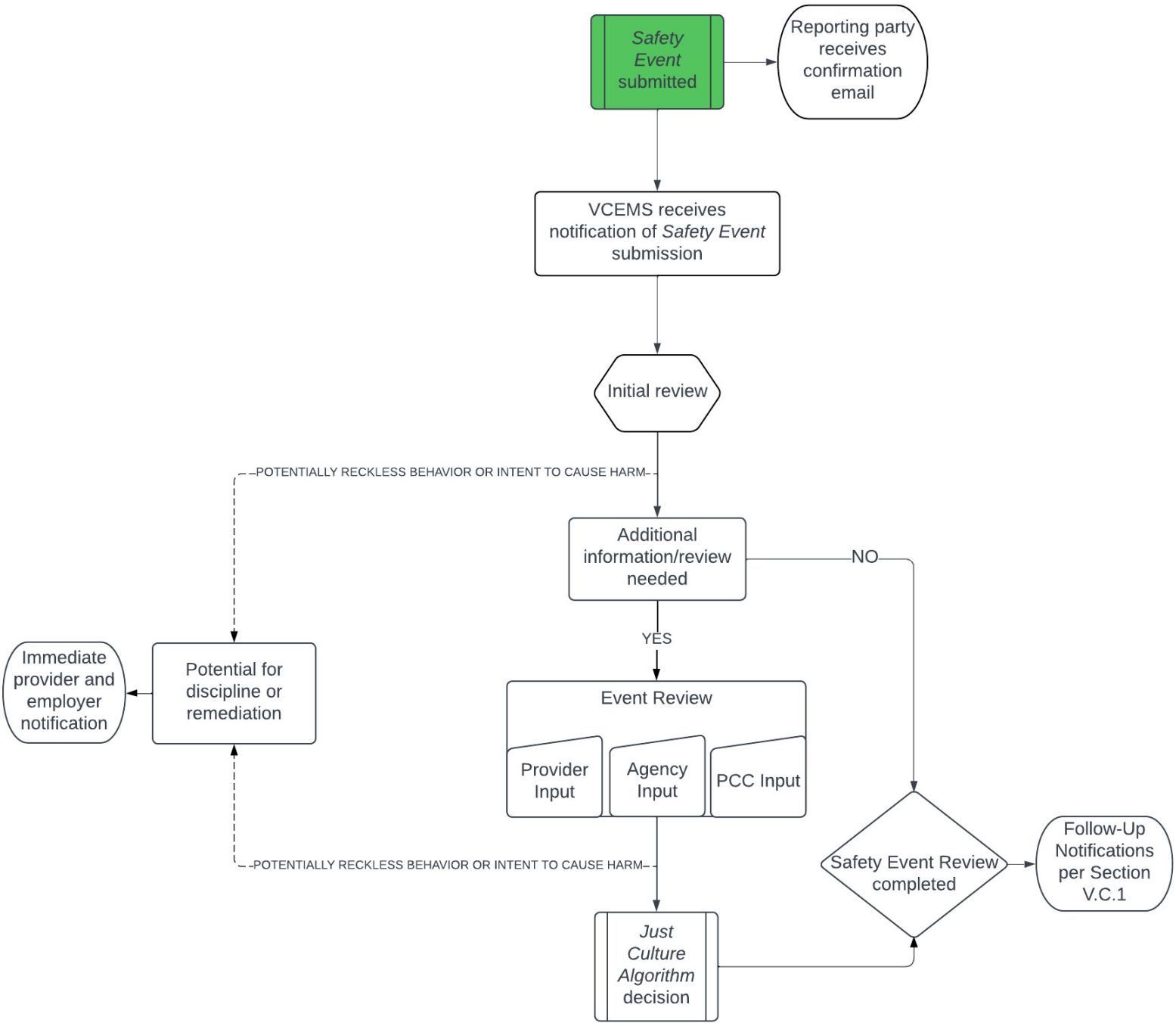
1. *The BETA Healthcare Group Just Culture Algorithm* is the accepted VCEMS framework for identifying the appropriate actions when a *Safety Event Review* is complete.
2. System design will be evaluated when reviewing a safety event for factors that impact the likelihood of the five behaviors.
3. There are 5 behaviors that will be evaluated when reviewing a safety event in order to determine which action is appropriate.



D. Safety Event Review Follow-Up

1. Once a *Safety Event Review* is considered complete the following parties will be notified:
    a. The person who reported the safety event
    b. The agencies involved in the safety event
    c. The personnel involved in the safety event
        i. Notification may be provided directly by VCEMS or via the provider's employer.
    d. The Pre-hospital Care Coordinator(s) involved
    e. EMS System Stakeholders
        i. A CQI report including aggregate safety event information will be provided to the Prehospital Services Committee (PSC) on a quarterly basis.
        ii. All events will be de-identified in order to maintain privacy for everyone involved.

SAFETY EVENT REVIEW PROCESS



Reportable Safety Event Form

To access the electronic form, use this QR Code:

-OR-

Use this link:

REPORTABLE SAFETY EVENT FORM

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Hospital Emergency Services Reduction Impact Assessment	Policy Number 124
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: July 1, 2023
APPROVED: Medical Director Daniel Shepherd, M.D.	Date: July 1, 2023
Origination Date: June 1999 Date Revised: May 13, 2004 Date Last Reviewed: January 12, 2023 Review Date: January 31, 2025	Effective Date: July 1, 2023

I. PURPOSE: To provide a mechanism for Ventura County to evaluate and report on the potential impact on the Emergency Medical Services (EMS) system of the reduction or closure of emergency services in hospitals.

II. AUTHORITY: Health and Safety Code Section 1300 (c).

III. POLICY: Acute care hospitals intending to implement either a reduction or closure of emergency services must advise the EMS agency as soon as possible, but at least 90 days prior to the proposed change.

A. The notification of change proposal must include:

1. Reason for the proposed change(s).
2. Itemization of the services currently provided and the exact nature of the proposed change(s).
3. Description of the local geography, surrounding services, the average volume of calls.
4. Description of potential impact on the EMS community regarding patient volume and type of prehospital and emergency department services available. Include a pre/post comparison.
5. Description of potential impact on the public regarding accessibility of comparable alternative facilities or services. Include a pre/post comparison.

B. Evaluation Process

1. Upon receiving notification of a planned reduction or elimination of emergency medical services by a hospital or the California Department of Health Services, the Department, all local hospitals, fire departments, and ambulance providers, and all local planning and or zoning authorities will be notified.
2. Within thirty-five (35) days of notification, the EMS Agency, in consultation with emergency service providers and planning/zoning authorities, will

complete and distribute a draft EMS Impact Evaluation utilizing the Impact Evaluation Instrument (Attachment A) and set a public hearing date. At a minimum, the Impact Evaluation report shall include:

a. Assessment of community access to emergency medical care.
b. Effect on emergency services provided by other entities.
c. Impact on the local EMS system.
d. System strategies for accommodating the reduction or loss of emergency services.
e. Potential options, if known.
f. Public and emergency services provider comments.
g. Suggested/recommended actions.

3. Within fifty (50) days of notification, the EMS Agency will release the draft impact evaluation report to prehospital and hospital emergency services personnel, with a 10 working day comment period; and conduct at least one (1) public hearing, and incorporate the results of those hearings in the final Impact Evaluation. These public hearings may be incorporated with other public meetings held by the Public Health Department, Board of Supervisors and/or other government agencies, commissions, or committees.
4. Within sixty (60) days of receiving notice, the EMS Agency will prepare the final Impact Evaluation, and submit those findings to the California Department of Health Services, State EMS Authority, Board of Supervisors, all city councils, fire departments, ambulance services, hospitals, planning/zoning authorities, local EMS participants and other interested parties.
5. The hospital will serve notice of the public hearing to the community through standard and reasonable efforts (i.e. local newspapers and notices at hospitals) within the affected county.
6. The Department of Health Services will make the final determination as to the nature of emergency services to be provided by the hospital seeking reduction or closure.
7. The hospital proposing a reduction or closure of service(s) will be charged a $750.00 fee by Ventura County Emergency Medical Services for the impact evaluation.

Time Line (in calendar days) for Development of Report of Impact on the EMS System in the Event of Closure or Reduction of Emergency Department Services in Local Hospitals					
Day 0	By Day 7	By Day 35	By Day 50	By Day 60	By Day 90
VC EMS is notified of pending closure or reduction in emergency services	Hospital has formally received necessary information relating to impact study	1. Draft EMS Impact Evaluation Report completed and distributed. to prehospital and hospital emergency medical services personnel with a 10 working day comment period 2. Public Hearing Date set.	1. At least one public hearing has been conducted 2. Results of comments and hearing(s) are incorporated into the final Impact Evaluation.	VC EMS will prepare Final Impact Evaluation VC EMS will submit the report to agencies listed in Section III.4	The hospital will serve notice of the public hearings regarding closure / reduction of services and hold such hearings.

CLOSURE / REDUCTION IN SERVICES IMPACT EVALUATION
HOSPITAL ASSESSMENT CRITERIA
VENTURA COUNTY EMERGENCY MEDICAL SERVICES AGENCY

This tool provides a quantitative indication of the relative impact potential of an emergency service reduction/elimination by one or more of the listed facilities. The numeric value indicates the magnitude of the impact, not the "value" of the facility to its community or the EMS system. Values are for a 12 month period.

Hospitals (in alphabetical order)	GEOGRAPHIC ISOLATION B (# of Hospitals within 15 mile radius) (Maximum points – 30) < 2 30 2-4 20	911 ALS TRANSPORTS	911 BLS TRANSPORTS	TOTAL ED VOLUME 1 point per 1000	HOSPITAL SERVICES Base Hospital 25 Cardiovascular Surgery 10 Neuro 25 NICU 5 Psych. (5150) 10	ED DIVERSION Hours <50 30 50-99 25 100-199 20 200-299 15 300-399 10 400-499 5 >500 0	TOTAL
Adventist Health Simi Valley							
Los Robles Regional Medical Center							
St. John's Camarillo Hospital							
St. John's Regional Medical Center							
Ojai Valley Community Hospital							
Ventura County Medical Center							
Community Memorial Hospital							

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Multi Casualty Incident Response		Policy Number 131
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: July 1, 2023
Origination Date: Date Revised: Review Date:	September 1991 February 2, 2023 February 28, 2025	Effective Date: July 1, 2023

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

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

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

IV. DEFINITIONS:

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

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

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

V. TRAINING:

The following training will be required:

A. **MCI Training** for prehospital personnel (fire and ambulance), and Mobile Intensive Care Nurses (MICNs).

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

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

B. **MCI Refresher Training**

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

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

VI. ACTIVATION OF THE MULTI CASUALTY INCIDENT RESPONSE PLAN:

A. Report of Incident

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

1. Citizen/witness report via 9-1-1 Public Service Answering Point (fire service will activate the MCI plan).
2. Hospital personnel alert VCEMS.
3. Direct report from law enforcement, or prehospital personnel with capability to contact a PSAP.

B. Prehospital Response

1. The first responder agency or other public safety official will determine that the number and extent of casualties exceeds the capacity of the day-to-day EMS response and/or EMS system (depending on the level of the MCI) and will request that an MCI be activated through the fire communications center (FCC). The Incident Commander (IC) or appropriate public safety official will request activation and/or response of any supporting public safety/service agencies which may be needed, for example:
   a. Transportation resources, such as additional ambulances or buses
   b. Ventura County Chapter American Red Cross
   c. Ventura County Sheriff's Office of Emergency Services
   d. Public Health
   e. Disaster Medical Support Units (DMSU), Ventura County EMS Agency's Emergency Services Unit, Multi Casualty Unit (MCU) trailers, or other disaster caches

2. The incident commander will establish incident objectives that prioritize not only the safety of personnel at the scene, but also efficient and effective triage, treatment, transport, and tracking (the 4 T's) of victims involved in the MCI.
   A. Incident roles critical to the success of the incident will be triage unit leader, treatment unit leader, patient transportation unit leader, and MEDCOMM. It is

understood that one person may retain more than one of these roles for small-scale incidents within limited victims and complexity.

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

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

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

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

C. Base Hospital Responsibilities

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

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

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

      ii. The estimated number of casualties involved.

      iii. Utilizing the Reddinet MCI tool, advise hospitals to be prepared to confirm their status and prepare for the possible receipt of patients.

      iv. Update all hospitals periodically or when new or routine information is received.

      v. Inform MEDCOMM of each hospital's bed availability and determine destination for all MCI patients.

   b. Periodically, a request will be made of involved hospitals to update their status in order to accommodate the number of casualties remaining to be transported from the scene

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

D. Receiving Hospital Responsibilities

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

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

2. Receive/acknowledge incident information and inform hospital administration.
3. Activate the hospital's internal disaster/emergency response plan to an appropriate level based upon the MCI's location type and number of casualties.
4. Hospitals experiencing difficulty in obtaining needed resources to manage casualties should make their needs known to the EMS Agency Duty Officer.

E. Ventura County Trauma System Considerations

1. For any level MCI in which a traumatic mechanism exists, the base hospital shall be the trauma center in whose trauma catchment area the incident occurred. On an MCI/Level I, patients with traumatic injuries shall be triaged utilizing the Ventura County Field Triage Decision Scheme, in addition to START triage. On an MCI/Level I, the applicable VC trauma step shall be relayed to the base hospital by MEDCOMM for all patients with traumatic injuries, in addition to START triage category, age, and gender and triage tag number.
2. Patients shall be transported in accordance with VCEMS 131 Attachment C - MCI Trauma Patient Destination Decision Algorithm.
3. For pediatric victims being transported to an out-of-county facility, consider obtaining a name or description along with the triage tag number for quicker reunification with parents.

F. Involved but Not Injured

1. Prehospital personnel may encounter individuals that are involved with an MCI, but not injured. These individuals do not require medical care on the scene or at a hospital but are still impacted by the events that have taken place. Personnel on scene should identify these individuals with the blue ribbon during the triage

process and be prepared to provide some level of support for these individuals until such time that law enforcement or some other responsible party can take over and provide support and/or shelter.

G. Ventura County EMS Agency

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

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

H. Documentation

1. MCI/Level I: The care of each patient will be documented using the Ventura County electronic patient care reporting system (VCePCR)
2. MCI/Level II and MCI/Level III: At a minimum, each patient transported

to a hospital shall have their care documented on a multi-casualty patient record (Policy 131, Attachment A).

a. The transporting agency is responsible for completion of the multi-casualty patient record. The record is designed to be completed by the transporting crew enroute to the receiving hospital.

b. The transporting agency retains the original multi-casualty patient record. A copy shall be left with the patient at the receiving hospital. The triage tag shall be attached to this copy and is included as official documentation in the patient's medical record.

c. The transporting agency shall distribute copies of the multi-casualty patient record to the base hospital and EMS Agency within twenty-four hours of
de-mobilization of the incident.

d. Patients not transported from a MCI Level II or III, may be documented using the multi-casualty non-transport record, (Policy 131, Attachment B).

3. Ventura County EMS Approved MCI Worksheets

a. Ventura County EMS Providers will utilize the approved MCI worksheets described in the Basic and Advanced MCI courses and attached to this policy as follows:

1. Form 131-C MCI Trauma Patient Destination Decision Algorithm (Policy 131, Attachment C)
2. Form 131-1 Level 1 MCI Worksheet (Policy 131, Attachment D)
3. Triage Count Worksheet
4. Triage Tag Receipt Holder
5. Bed Availability Worksheet
6. Ambulance Staging Resource Status Worksheet
7. Transportation Receipt Holder

4. Mobile Data Computer (MDC) Equipped Ambulances

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

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

A. Prehospital de-mobilization

1. When advised by the Incident Commander (IC) at the scene, the PSAP handling communications for the incident will notify the VCEMS Duty Officer when all casualties have been transported from the MCI scene.
2. Hospitals will be notified via Reddinet that the MCI scene has ended, but that victims may still be enroute to various receiving facilities.
3. Hospitals will supply EMS with data on victims they have received via ReddiNet, telephone, fax or RACES.
4. If involved in incident operations, VCEMS will maintain communication with all participants until all activity relevant to victim scene disposition and hospital resource needs are appropriately addressed.
5. Depending on size of incident, VCEMS will advise all participants when VCEMS has concluded operations related to the MCI.

VIII. CRITIQUE OF THE MULTI CASUALTY INCIDENT:

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

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

IX. ADDITIONAL CONSIDERATIONS

A. MCI related to an Active Shooter event, or any other type of incident involving a heavy law enforcement presence and the need for coordinated Rescue Task Force (RTF) operations will be conducted in accordance with VCEMS Policy 628 – Rescue Task Force Operations.

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

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

Date:_____**Agency**_____**Unit#:**_____**Location:**_____**Incident #:**_____

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

Receiving Hospital to Attach Triage Tag Here

_____

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

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

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

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

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

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

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

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

Printed Name **License #** **Signature**

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

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

MCI TRAUMA PATIENT DESTINATION DECISION ALGORITHM

TRIAGE ALL PATIENTS UTILIZING START TRIAGE

IMMEDIATE | **DELAYED** | **MINOR**

ESTABLISH A TREATMENT AREA ON ALL MASS CASUALTY INCIDENTS

ESTABLISH A TREATMENT AREA ON ALL MASS CASUALTY INCIDENTS

PERFORM A FOCUSED EXAM AND BEGIN TO PROVIDE TREATMENT AS RESOURCES ALLOW

PATIENTS ON A LEVEL I MCI WITH TRAUMATIC INJURIES WILL ALSO BE TRIAGED INTO THE VC TRAUMA TRIAGE DECISION SCHEME

LEVEL I MCI
FULL ePCR

- **RED TAG** → ANY TRAUMA STEP - TRANSPORT TO A TRAUMA CENTER (CONSIDER OUT OF COUNTY (O.O.C.), CONSIDER AIR TRANSPORT)
- **YELLOW TAG** → STEPS 1, 2, 3 TRANSPORT TO A TRAUMA CENTER (CONSIDER O.O.C.) STEP 4, NO STEP - TRAUMA BASE HOSPITAL DISCRETION
- **GREEN TAG** → STEP 3 TRANSPORT TO A TRAUMA CENTER (CONSIDER O.O.C.) STEP 4 TRAUMA BASE HOSPITAL DISCRETION NO STEP, TRANSPORT TO ANY HOSPITAL

LEVEL II/III MCI
ATTACHMENT "A/B"

- **RED TAG** → TRANSPORT TO A TRAUMA CENTER WHENEVER POSSIBLE (Consider O.O.C., CONSIDER AIR TRANSPORT)
- **YELLOW TAG** → TRAUMA CENTER PREFERRED, IF POSSIBLE (CONSIDER O.O.C.)
- **GREEN TAG** → TRANSPORT TO ANY HOSPITAL

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

LEVEL 1 MCI WORKSHEET

INCIDENT:_____ **DATE:**_____

Person(s) filling out this form:_____

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

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

Revised 2023

VCEMSA Form 131-1: Level 1 MCI Worksheet
Instructions

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

The Patient Section

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

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

The Hospital section

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

BED AVAILABILITY WORKSHEET

INCIDENT:_____ **DATE:**_____

Person(s) Filling Out This Form:_____

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

OUT-OF-COUNTY BED AVILABILITY WORKSHEET

INCIDENT:_________________________________ **DATE:**_________________

PERSON(S) COMPLETING THIS FORM:___________________________________

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

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

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

VCEMSA Form 131-2: Bed Availability Worksheets

Instructions

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

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

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

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

TRANSPORTATION WORKSHEET

INCIDENT: _____ **DATE:** _____

Person(s) filling out this form: _____ **Agency:** _____

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

Instructions – Transportation Worksheet

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

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

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

TREATMENT TARP UPDATE WORKSHEET

INCIDENT: ____ **DATE:** ______________________

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

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

Treatment Tarp Update Instructions

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

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

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

IMMEDIATE TREATMENT AREA WORKSHEET

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

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

INSTRUCTIONS – IMMEDIATE TREATMENT AREA WORKSHEET

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

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

DELAYED TREATMENT AREA WORKSHEET

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

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

Instructions – Delayed Treatment Area

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

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

MINOR TREATMENT AREA

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

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

Instructions – Minor Treatment Area

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

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

MORGUE WORKSHEET

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

TRIAGE TAG # (LAST 4)	AGE	GENDER	NOTES

Instructions: Morgue Area Manager

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

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

INVOLVED/UNINJURED (BLUE RIBBON) WORKSHEET

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

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

Instructions – Involved/Uninjured (Blue Ribbon) Worksheet

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

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

Air/Ground Ambulance Coordinator Worksheet

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

AGENCY	UNIT #	ALS/BLS	Time IN	Time OUT

Instructions – Air/Ground Ambulance Coordinator Worksheet

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

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

Position: Medical Branch Director **(FOG – 2022 Edition)**

Ideal Staffing: Battalion Chief or EMS Agency Duty Officer

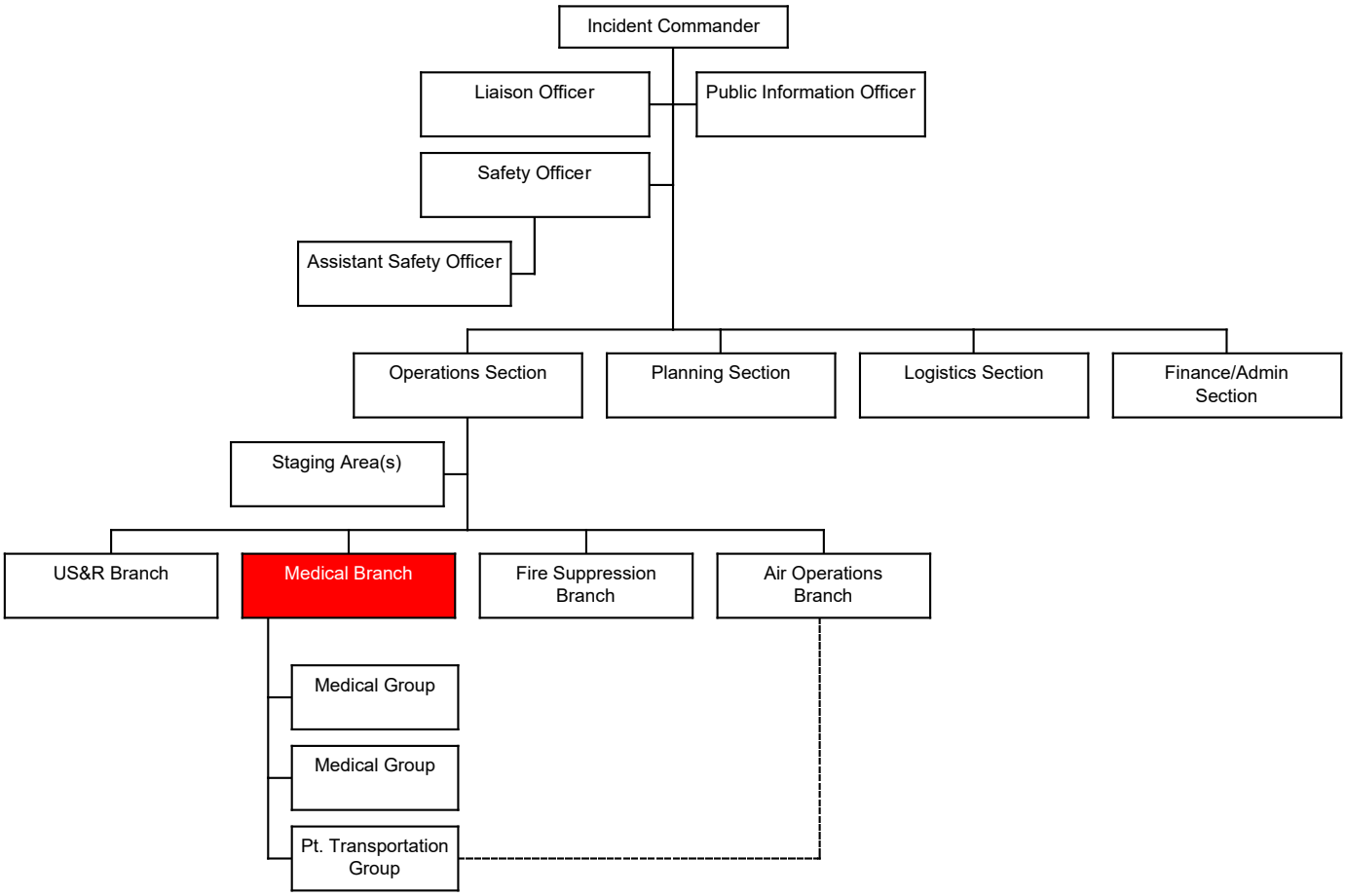
The Medical Branch Director is responsible for the implementation of the Incident Action Plan (IAP) within the Medical Branch. The Branch Director reports to the Operations Section Chief and supervises the Medical Group(s) and the Patient Transportation function (Unit or Group). Patient Transportation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

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

MCI Management Equipment

1. Multi-Casualty Incident Command Worksheet

Multi-Casualty Organization
Multi-Branch Response



Position: Medical Division/Group Supervisor (FOG 2022)

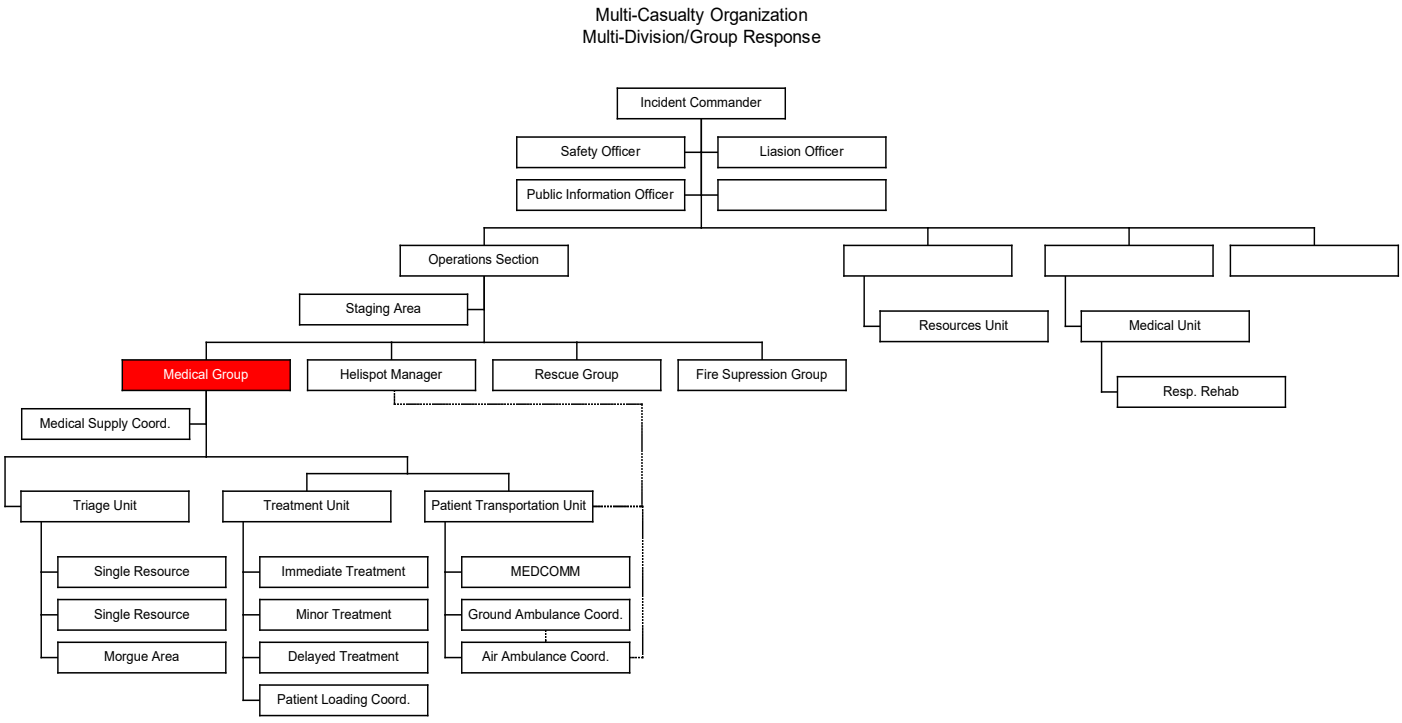
Ideal Staffing: Fire Company Officer or Paramedic Supervisor

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

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

MCI Management Equipment

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



Position: TRIAGE UNIT LEADER **(FOG 2022)**

Ideal Staffing: Fire Company Officer

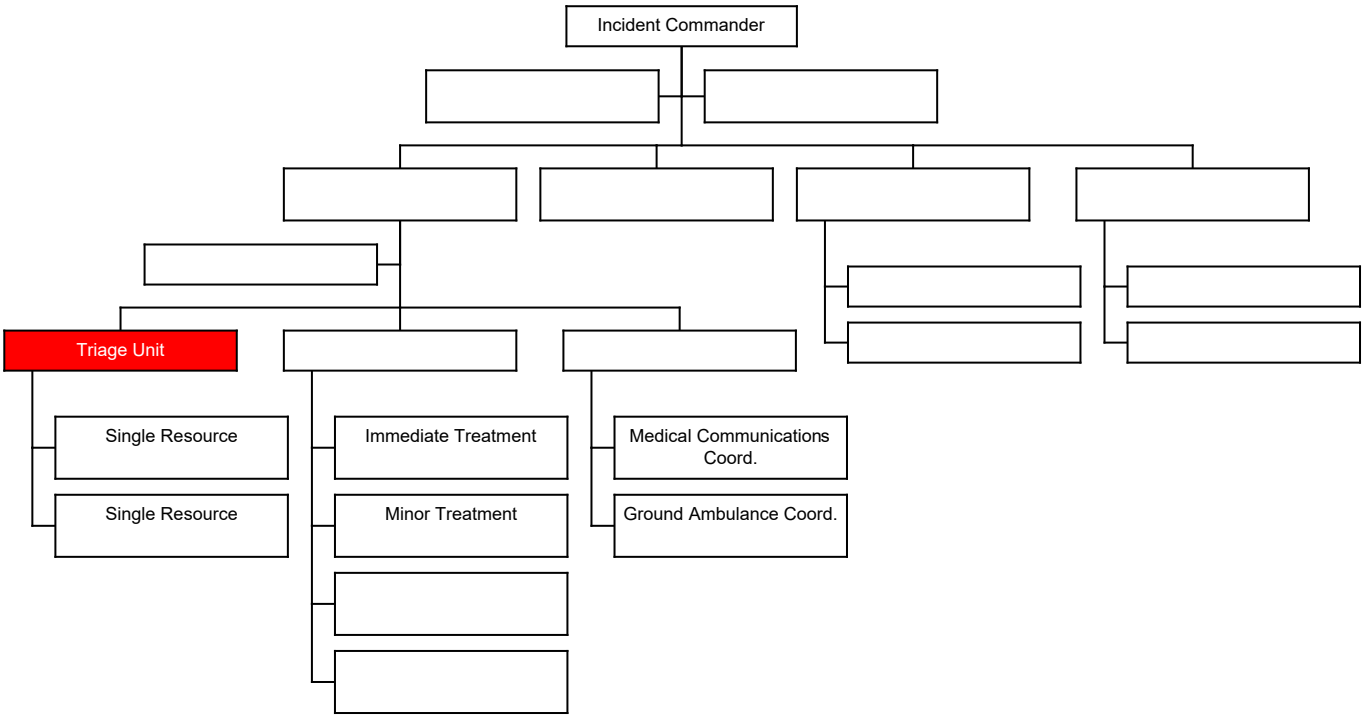
The Triage Unit Leader supervises triage personnel/litter bearers and the Morgue Manager, when applicable. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the Triage Area. When triage has been completed and all the patients have been moved to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

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

MCI Management Equipment

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

Multi-Casualty Organization
Initial Response



Position: Morgue Area Manager **(FOG 2022)**

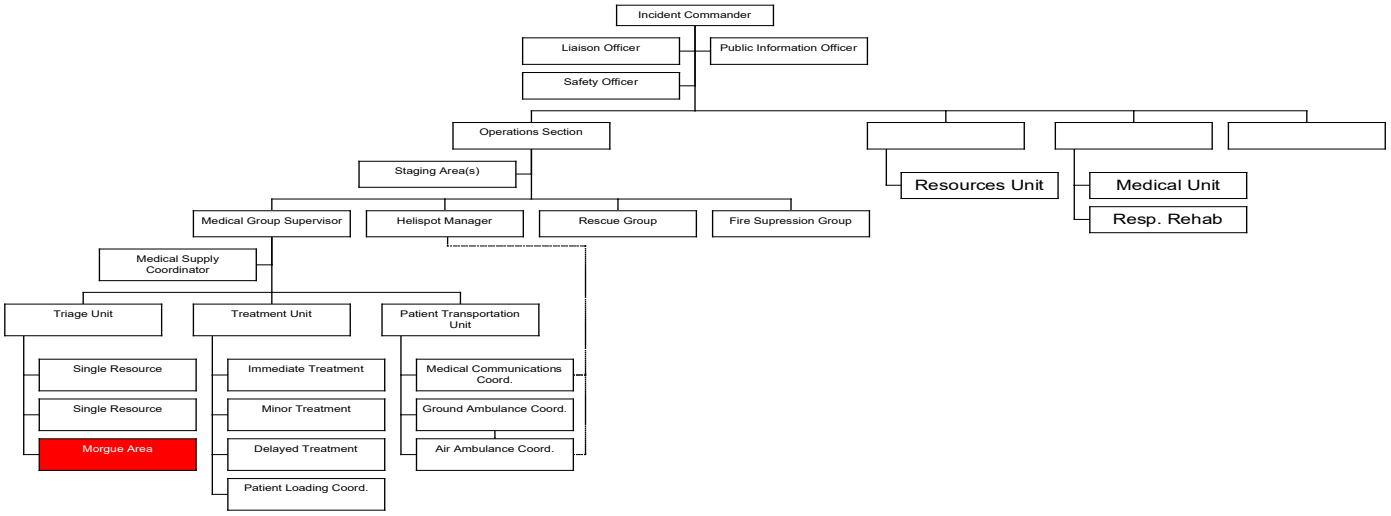
Ideal Staffing: Law Enforcement Personnel or Fire Company Personnel

The Morgue Area Manager reports to the Triage Unit Leader and assumes responsibility for the Morgue Area. Coordinates the handling of decedents and their personal belongings with law enforcement and the Medical Examiner:

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

MCI Management Equipment

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



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

Position: Treatment Unit Leader (FOG 2022)

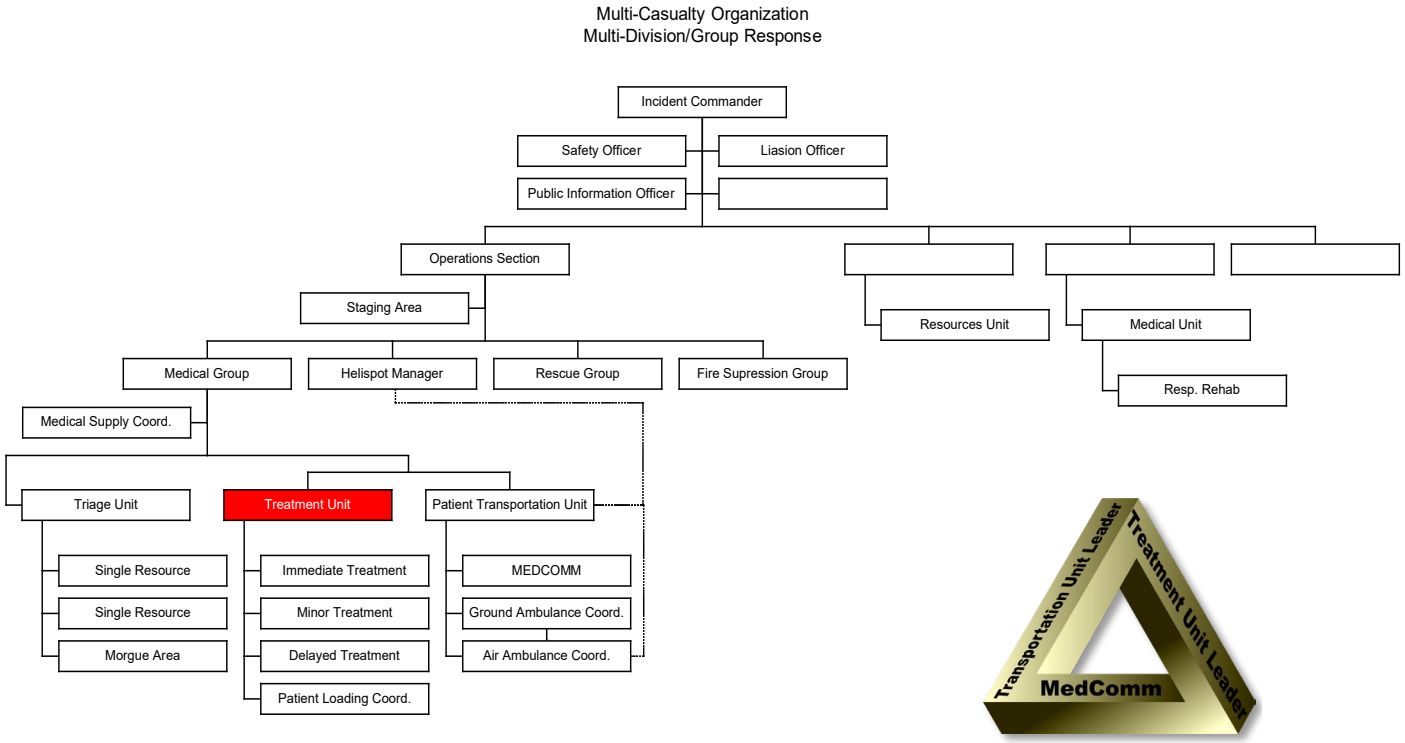
Ideal Staffing: Fire Company Officer

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

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

MCI Management Equipment

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



Position: Patient Loading Coordinator **(FOG 2022)**

Ideal Staffing: Paramedic (Fire Company or Ambulance)

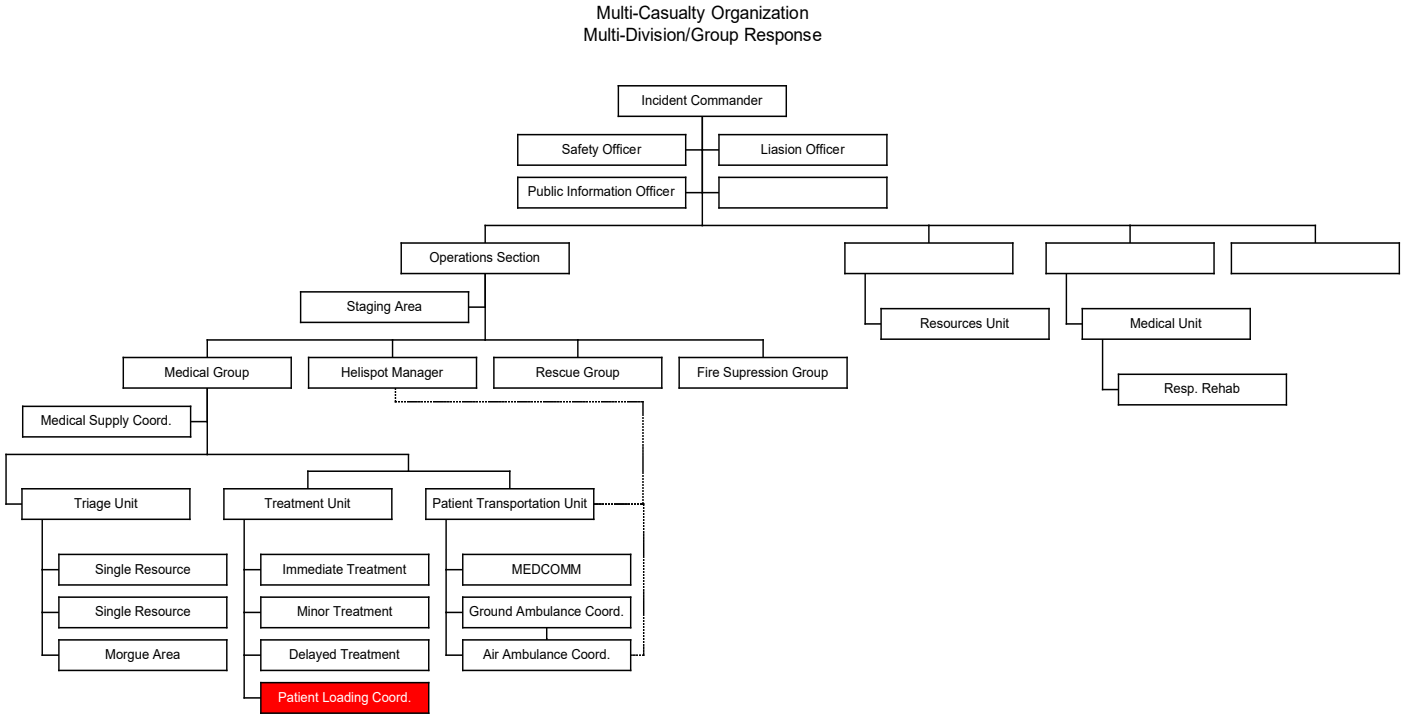
NOTE: On small to medium MCI incidents, the responsibilities of this role may be assumed by the Treatment Unit Leader.

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

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

MCI Management Equipment

1. Patient Loading Coordinator Packet, including vest and clipboard



Position: Treatment Area Manager **(FOG – 2022)**

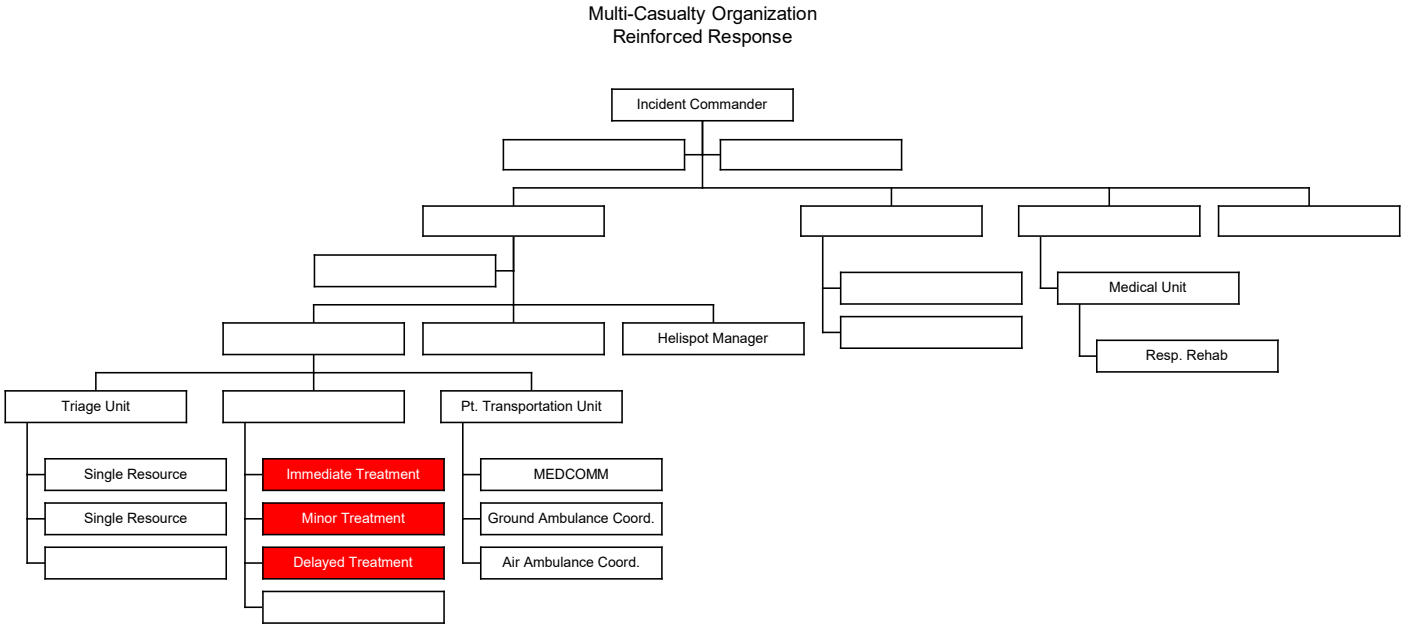
Ideal Staffing – Fire Company Officer

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

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

MCI Management Equipment

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



Position: Patient Transportation Unit Leader **(FOG – 2022)**

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

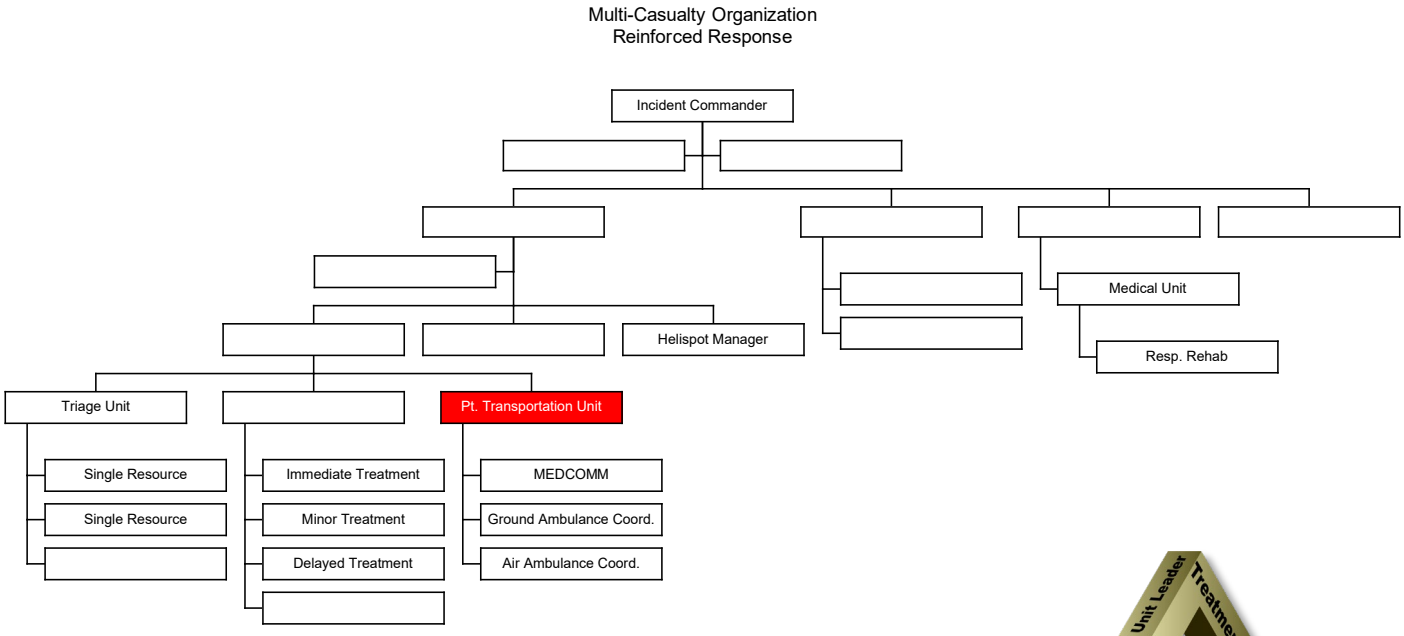
Ideal Staffing: Paramedic Supervisor or EMS Agency Duty Officer

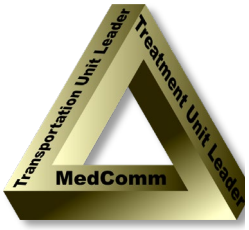
The Patient Transportation Unit Leader reports to the Medical Group Supervisor and supervises the Medical Communications Coordinator, and the Ground/Air Ambulance Coordinators. The Patient Transportation Unit Leader is responsible for the coordination of patient transportation and maintenance of records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

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

MCI Management Equipment

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





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

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

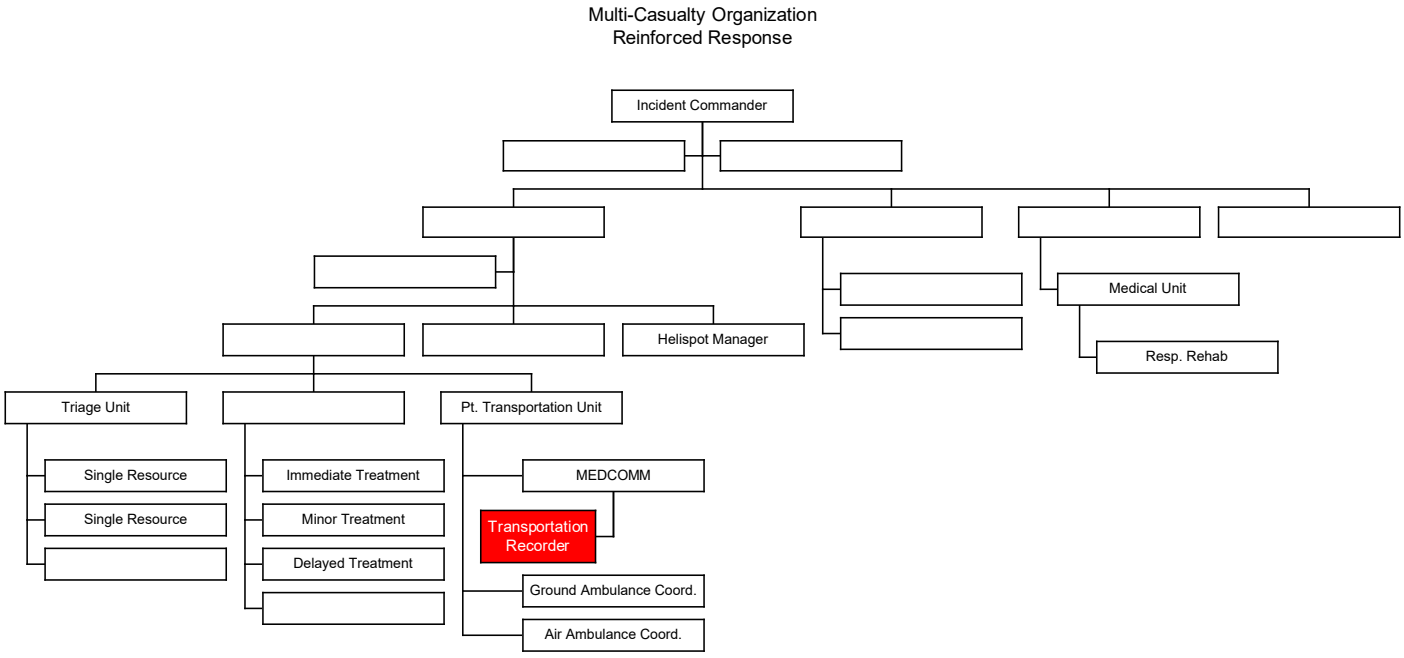
Ideal Staffing: Paramedic, Paramedic Supervisor or VCEMS Personnel

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

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

MCI Management Equipment

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



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

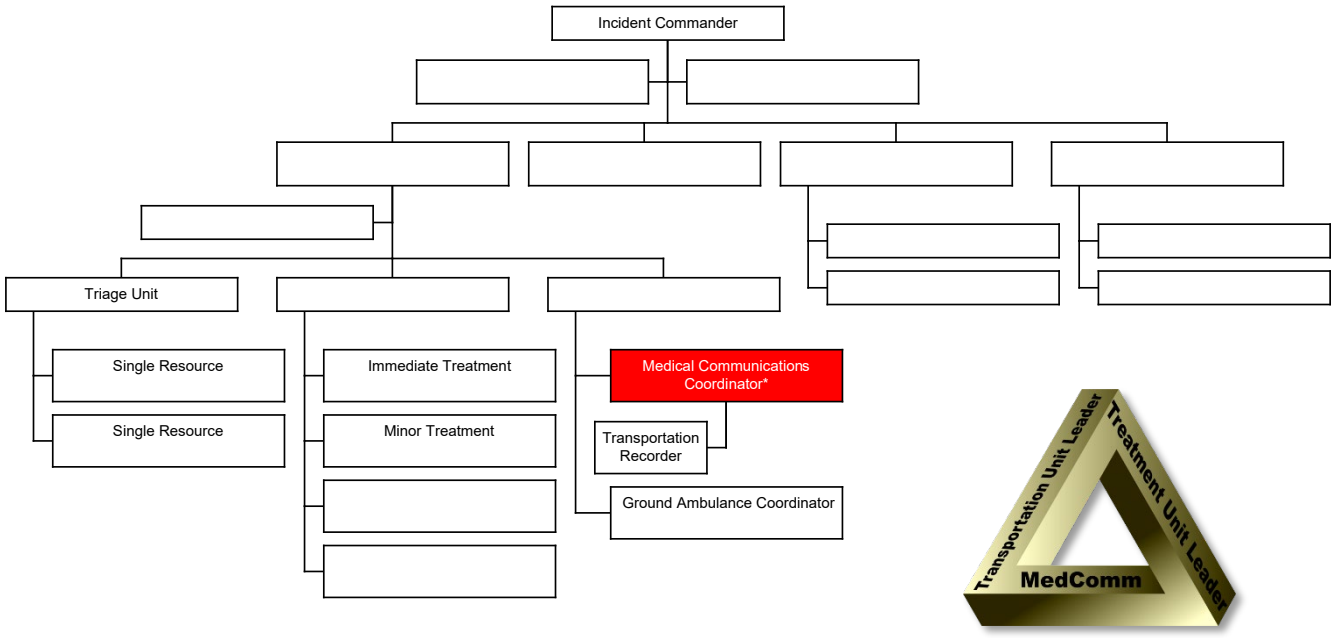
Ideal Staffing: Initial – Paramedic (Fire or Ambulance), Ongoing – Paramedic Supervisor.
The Medical Communications Coordinator (MEDCOMM) reports to the Patient Transportation Unit Leader and establishes communications with the appropriate Base Hospital (BH) to maintain status of available hospital beds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

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

MCI Management Equipment

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

Multi-Casualty Organization
Initial Response



Note: Whenever staffing/resources allow, MEDCOMM should be staffed with two paramedics. First Paramedic will maintain communications with Base Hospital to relay patient information and receive destination assignments. Second Paramedic will act as a runner/scribe, and will serve as the transportation recorder (see MCI position card 9 for specific roles/responsibilities).

Position: Ground Ambulance Coordinator (FOG 2022)

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

FORMER POSITION: Ambulance Staging Manager

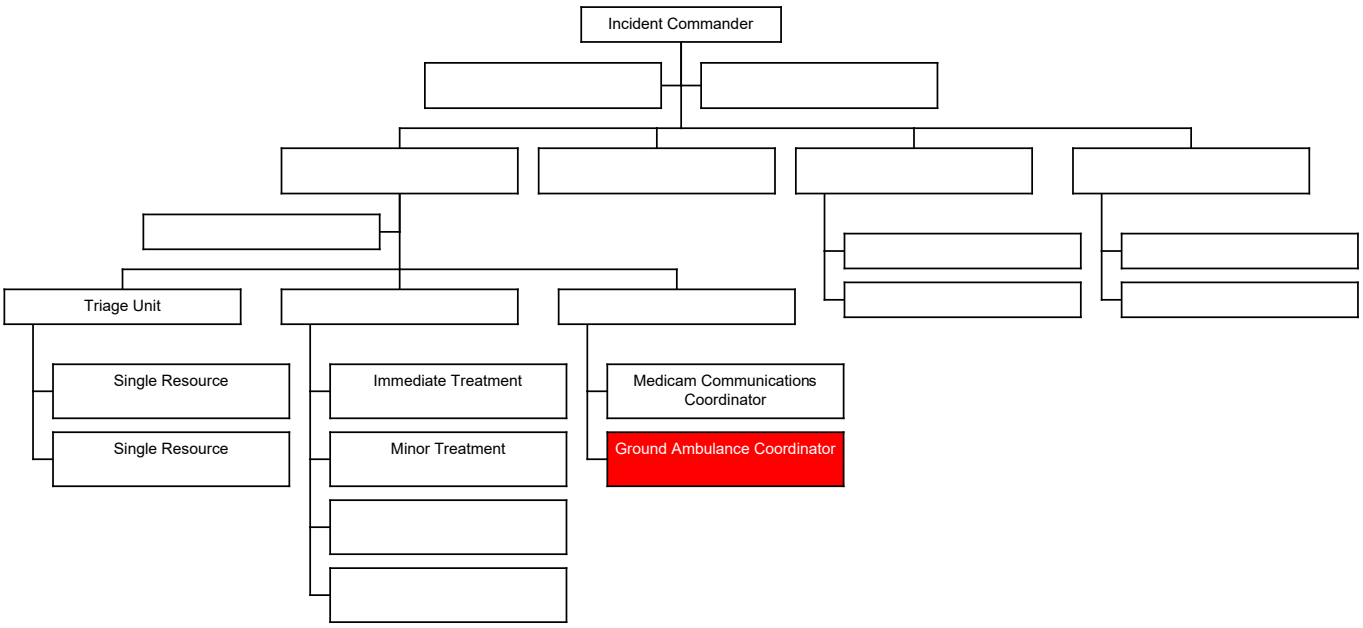
The Ground Ambulance Coordinator reports to the Patient Transportation Unit Leader, manages the Ambulance Staging Area(s), and dispatches ambulances as requested:

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

MCI Management Equipment

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

Multi-Casualty Organization
Initial Response



Position: Air Ambulance Coordinator (FOG 2022)

Ideal Staffing: BLS Fire Company

FORMER POSITION: Ambulance Coordinator

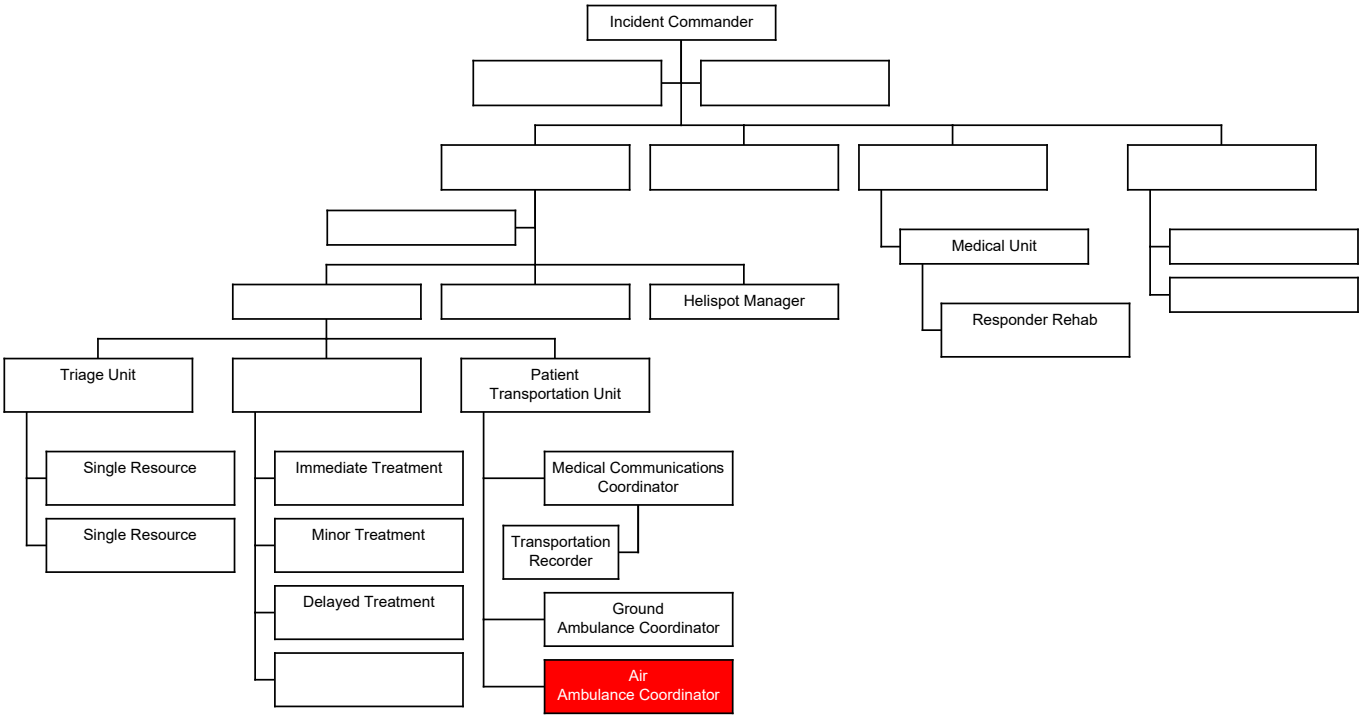
The Air Ambulance Coordinator reports to the Patient Transportation Unit Leader; communicates with MEDCOMM or Transportation Recorder, Patient Loading Coordinator, and Ground Ambulance Coordinator; coordinates patient air transportation needs with the Helispot Manager:

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

MCI Management Equipment

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

Multi-Casualty Organization
Reinforced Response Organization



Position: Medical Supply Coordinator (FOG 2022)

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

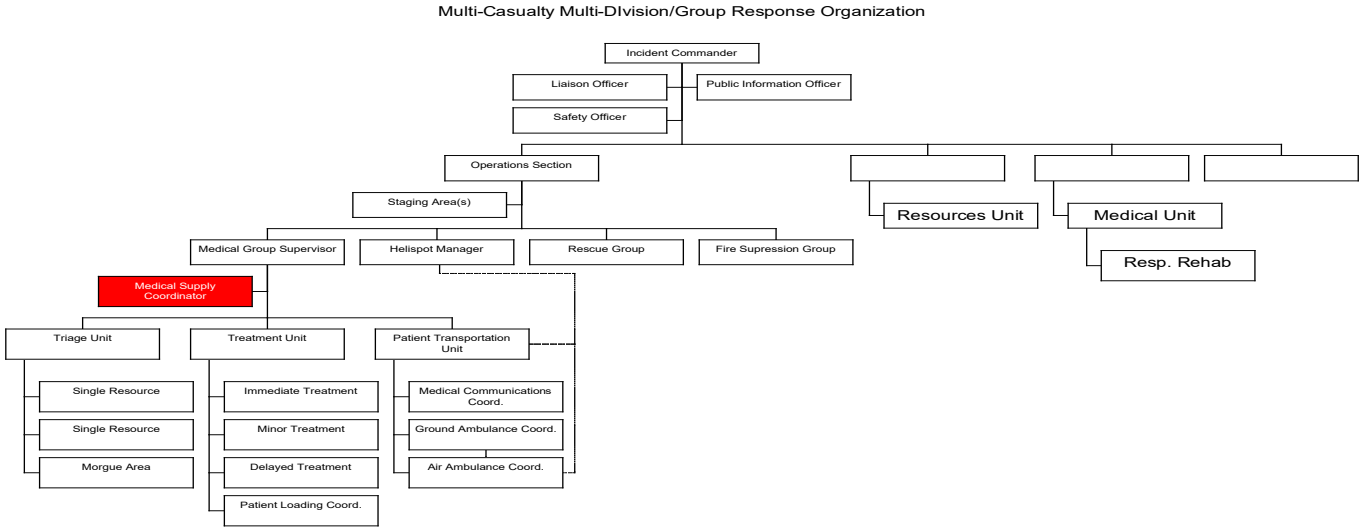
The Medical Supply Coordinator reports to the Medical Group Supervisor and acquires and maintains control of appropriate medical equipment and supplies from units assigned to the Medical Group:

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

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

MCI Management Equipment

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



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

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

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

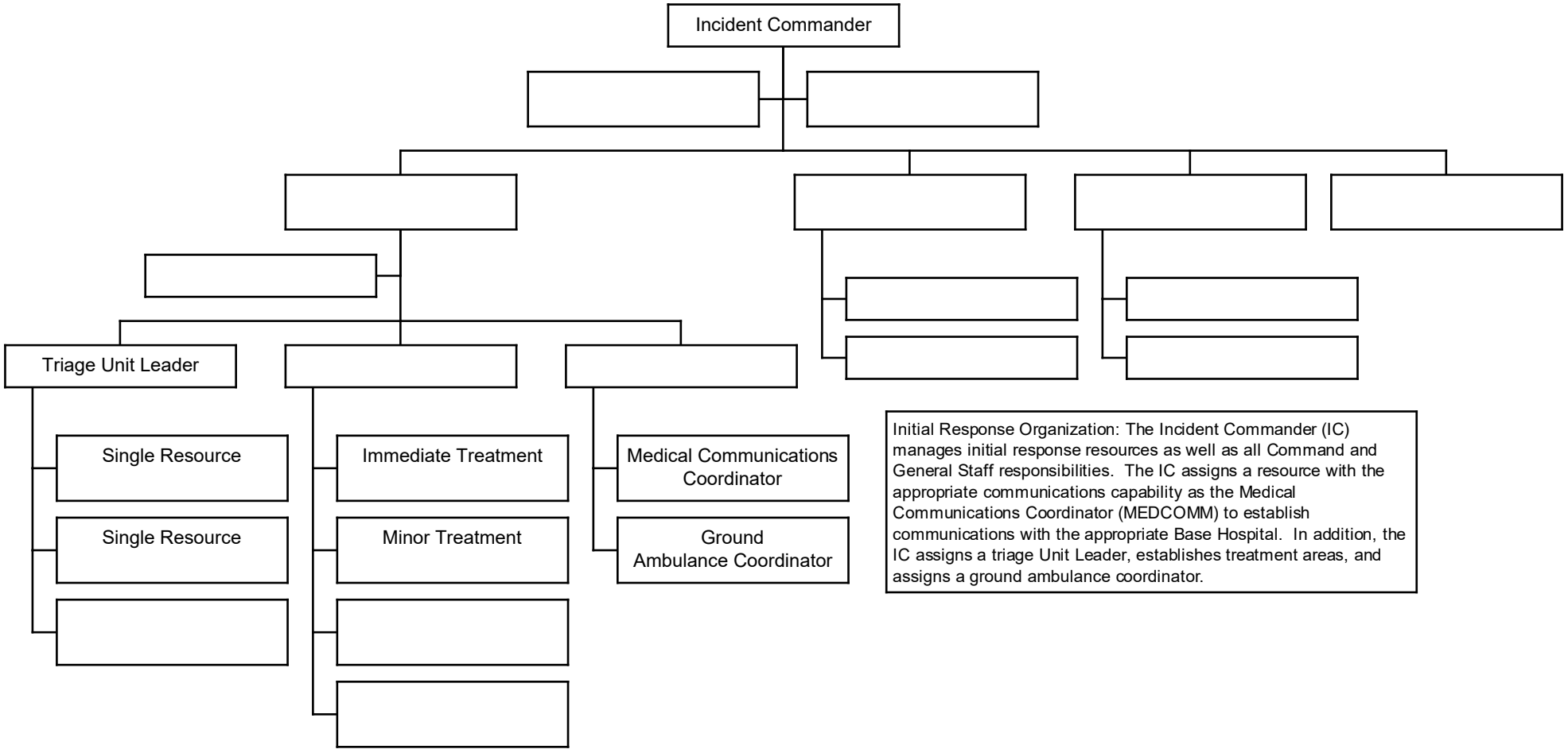
Initial Response Organization: The Incident Commander (IC) manages initial response resources as well as all Command and General Staff responsibilities. The IC assigns a resource with the appropriate communications capability as the Medical Communications Coordinator (MEDCOMM) to establish communications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

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

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

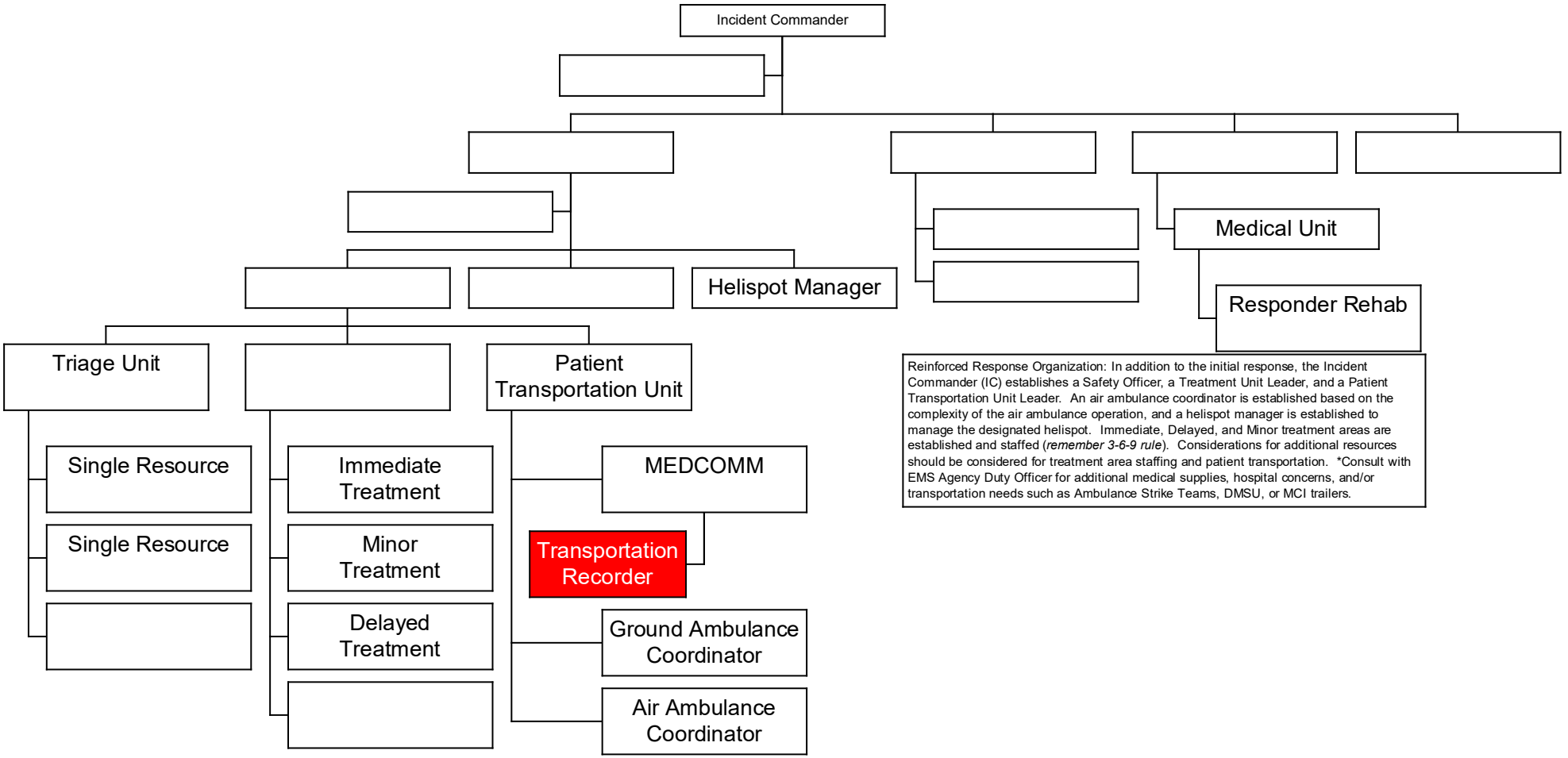
Multi-Branch Response Organization: The complete incident organization shows the Medical Branch and other branches. The Medical branch has multiple Medical Groups due to incident complexity, but only one Patient Transportation Group. This is because all patient transportation must be coordinated through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

Multi-Casualty Incident Response
Initial Response Organization
FOG - 2022



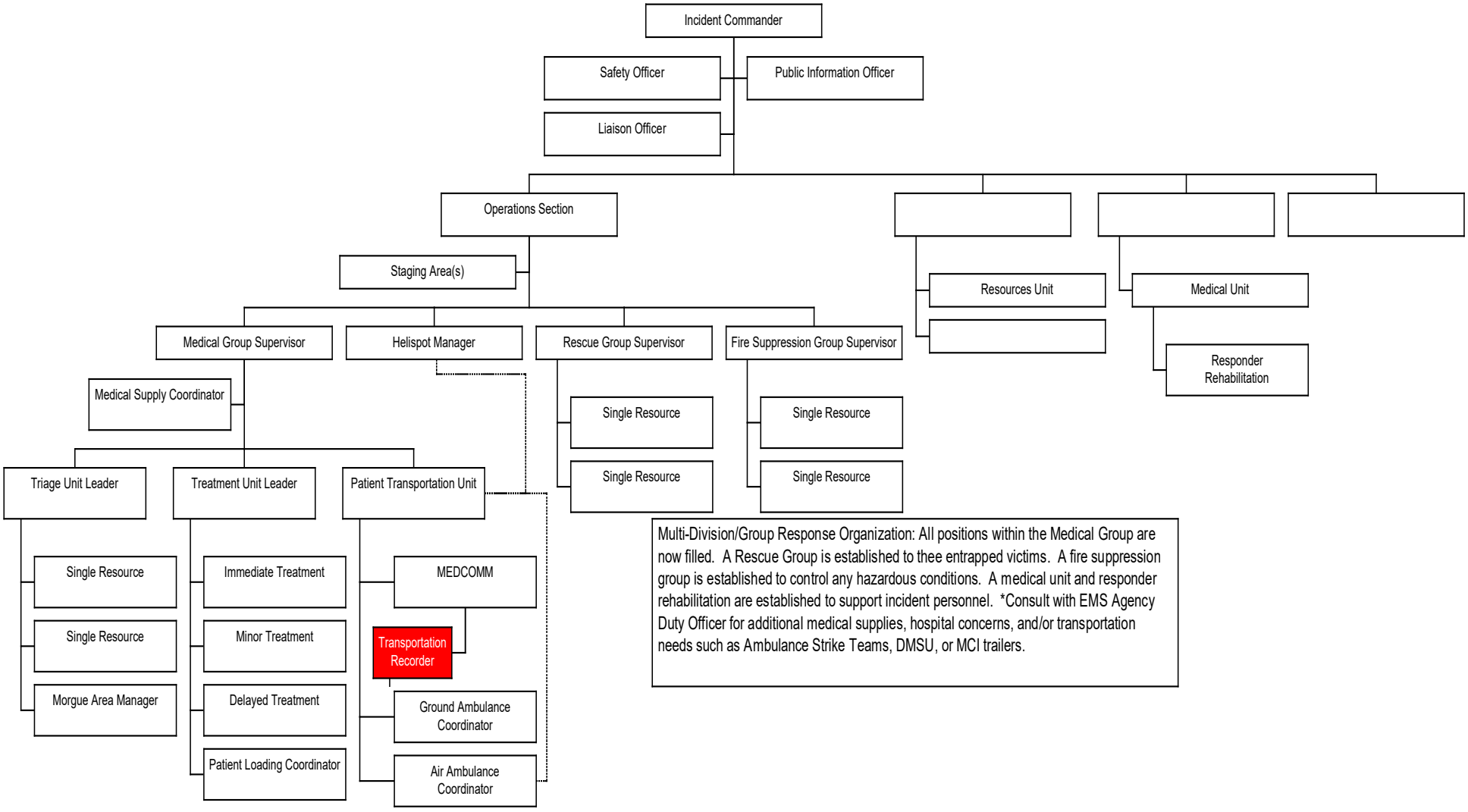
MCI Organization Charts – Reinforced Response Organization **(FOG - 2022)**

Multi-Casualty Incident Response
Reinforced Response Organization
FOG - 2022

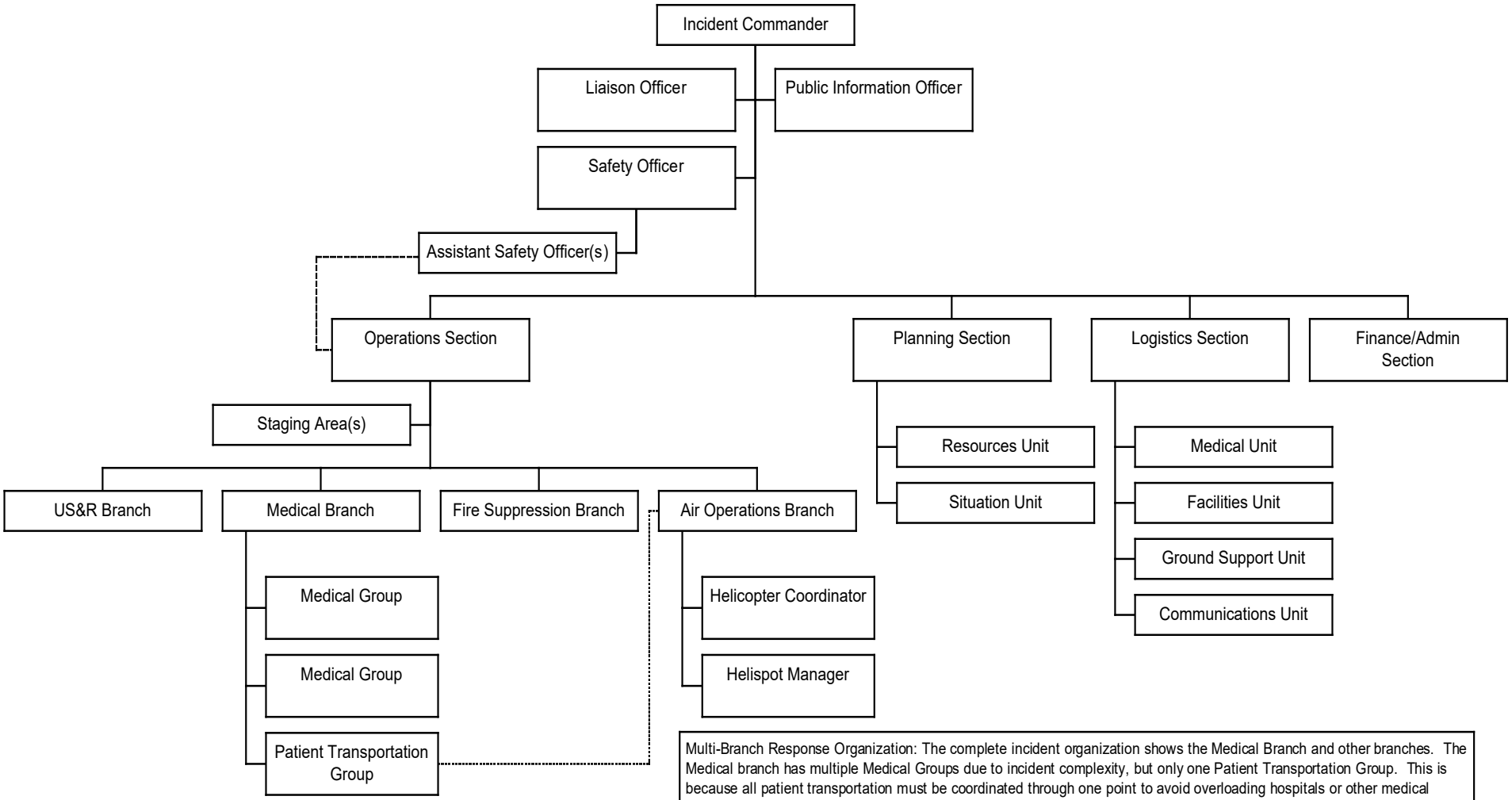


Reinforced Response Organization: In addition to the initial response, the Incident Commander (IC) establishes a Safety Officer, a Treatment Unit Leader, and a Patient Transportation Unit Leader. An air ambulance coordinator is established based on the complexity of the air ambulance operation, and a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

Multi-Casualty Incident Response
Multi-Division/Group Organization
FOG - 2022



Multi-Casualty Incident Response
Multi-Branch Organization
FOG - 2022



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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Hospital EMS Surge Assistance		Policy Number 141
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: July 1, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: July 1, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	February 10, 2022 February 10, 2022 February 9, 2023 February 28, 2026	Effective Date: July 1, 2023

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

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

A. POLICY:

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

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

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

IV. PROCEDURE

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

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

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

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

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

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

1. If possible, this area will be supplied with chairs, stretchers/cots, blankets, oxygen, and other medical equipment/supplies as appropriate.
2. The ambulance offload area will ideally be a tent or similar structure with climate control that can provide adequate shelter from the elements.
3. The hospital will provide appropriate means of communication to ensure that hospital staff and prehospital AREP assigned to the ambulance offload area can maintain effective communications with emergency department personnel at all times.

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

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

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

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

1. To facilitate timely and accurate documentation and tracking/trending of patient vital signs and other pertinent findings, ePCR data should be electronically transferred from the transporting crew to other VCEMS prehospital personnel staffing an ambulance offload area. The transporting crew will still be required to complete and upload a full ePCR, per Policy 1000, and VCEMS prehospital personnel staffing the ambulance offload area will complete an ePCR documenting the ongoing care and assessment until such time that the patient is transferred to a bed in the emergency department and transfer of care has been completed.
    a. Personnel in the ambulance offload area will utilize the time they received the patient from the transporting ambulance and will be required to manually input that time for the following fields:
        i. Dispatch Notified Date/Time
        ii. Unit Notified by Dispatch Date/Time
        iii. Unit En Route Date/Time
        iv. Unit Arrived On Scene Date/Time
        v. Arrived at Patient Date/Time
        vi. Transfer of EMS Patient Care Date/Time
    b. The Destination Patient Transfer of Care Date/Time will be the time when the patient is moved from the ambulance offload area to the emergency department, report is given, and a signature is received from receiving hospital representative.
    c. The Unit Back in Service Date/Time will be when the personnel assigned to the ambulance offload area return and are available to receive an additional patient from a transporting ambulance crew.

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: July 1, 2023
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: July 1, 2023
Origination Date: April 9, 1985 Date Revised: February 9, 2023 Date Last Reviewed: February 9, 2023 Review Date: February 28, 2026	Effective Date: July 1, 2023

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

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

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

GROUNDS FOR DISCIPLINARY ACTION:

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

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

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

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

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

IV. PROCEDURE:

A. Reporting Process

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

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

B. Notification of Claim against Certificate Holder.

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

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

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

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

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

C. Review of Submitted Material

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

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

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: STEMI Receiving Center (SRC) Standards and STEMI Referral Hospital (SRH) Standards	Policy Number 430
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: July 1, 2023
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: July 1, 2023
Origination Date: July 28, 2006 Date Revised: February 5, 2020 Last Review: February 9, 2023 Review Date: February 28, 2025	Effective Date: July 1, 2023

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

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

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

III. POLICY:

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

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

8. SRCs shall comply with the requirements for an annual minimum volume of procedures (25) required for designation by VCEMS.
9. The hospital shall have a STEMI program manager and a STEMI medical director.
10. The hospital shall have job descriptions and organizational structure clarifying the relationship between the STEMI medical director, STEMI program manager, and the STEMI team.
11. Operate a cardiac catheterization lab licensed by the Department of Health Services and approved for emergency percutaneous coronary interventions.
12. A STEMI receiving center without cardiac surgery capability on-site shall have a written transfer plan and agreements for transfer to a facility with cardiovascular surgery capability.
13. The hospital shall maintain daily STEMI team and Cardiac Catheterization team call rosters
14. Have policies for patients to receive emergent angiography or emergent fibrinolysis, based on physician decisions for individual patients.
15. The hospital shall participate in the local EMS agency quality improvement processes related to a STEMI critical care system.
16. The hospital shall submit their data to the STEMI Registry System by the 15th of each month for the previous month patients.
17. Will accept all ambulance-transported patients if the interpretation on the monitor meets the manufacturer guidelines for a POS STEMI ECG, except when on internal disaster or no cardiac catheterization lab is available, regardless of ICU/CCU or ED saturation status.
18. Have policies and procedures that allow the automatic acceptance of any STEMI patient from a Ventura County Hospital upon notification by the transferring physician.
19. The Cardiac Catheterization Team, including appropriate staff, shall be immediately available.
20. Have policies in place for the transfer of STEMI patients.

B. A STEMI Referral Hospital (SRH), approved and designated by Ventura County EMS shall meet the following requirements:
   1. All the requirements of a Receiving Hospital in VCEMS Policy 420.
   2. All the requirements of an SRH in VCEMS Policy 440.

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

B. Designation

1. Application:
   Eligible hospitals shall submit a written request for SRC or SRH approval to the VC EMS, documenting the compliance of the hospital with Ventura County SRC or SRH Standards.
2. Approval:
   SRC or SRH approval or denial shall be made in writing by VCEMS to the requesting Hospital within two weeks after receipt of the request for approval and all required documentation.
3. VC EMS may deny, suspend, or revoke the approval of a SRC or SRH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.
4. The VCEMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the PSC that compliance with the regulation would not be in the best interests of the persons served within the affected area.
5. SRCs and SRHs shall be reviewed every three years.
   a. SRCs or SRHs shall receive notification of evaluation from VCEMS.
   b. SRCs or SRHs shall respond in writing regarding program compliance.

c. On-site SRC or SRH visits for evaluative purposes may occur.

d. SRCs or SRHs shall notify VCEMS by telephone, followed by a letter or email within 48 hours, of changes in program compliance or performance.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Thrombectomy Capable Acute Stroke Center (TCASC) Standards		Policy Number 452
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2023
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: July 1, 2023
Origination Date: Date Revised: Last Review: Review Date:	July 26, 2017 December 28, 2022 December 28, 2022 December 31, 2024	Effective Date: July 1, 2023

I. PURPOSE: To define the criteria for designation as a Thrombectomy Capable Acute Stroke Center (TCASC) in Ventura County.

II. AUTHORITY: California Health and Safety Code, Sections 1797.114, 1797.220, 1798, 1798.2, 1798.101, and California Code of Regulations, Title 22, Section 100147 and 100169.

III. DEFINITIONS:

Acute Stroke Center (ASC): Hospital designated as an Acute Stroke Center, as defined in VCEMS Policy 450.

LVO Alert: A pre-arrival notification by pre-hospital personnel to the base hospital that a patient is suffering a possible Large Vessel Occlusion (LVO) ischemic stroke.

Thrombectomy Capable Acute Stroke Center: (TCASC) Acute Stroke Center (ASC) that has the capability to perform neuroendovascular procedures for acute stroke including thrombectomy and intra-arterial thrombolysis.

IV. POLICY:

A. A Thrombectomy Capable Acute Stroke Center (TCASC), approved and designated by Ventura County EMS (VCEMS), shall meet the following requirements:

1. All the requirements of an Acute Stroke Center (ASC) as defined in Policy 450.
2. Certified as a Thrombectomy-Capable Stroke Center (TSC) by The Joint Commission or a Primary Plus by Det Norske Veritas, or a Comprehensive Stroke Center (CSC) by either The Joint Commission or Det Norske Veritas

3. Neurointerventionalist on call 24/7 and available on-site at TCASC within 45 minutes of notification of an LVO alert.
4. Neurosurgeon on call 24/7 and available to provide care as indicated.
5. Neurologist, with hospital privileges to provide ICU level of care for acute stroke patients, on call 24/7 and available to provide care as indicated.
6. An individual Neurointerventionalist or Neurosurgeon may not be simultaneously on call for a separate hospital.
7. Appropriate endovascular catheterization laboratory personnel available on-site within 45 minutes of notification of an LVO alert
8. Will create policies and procedures detailing how the TCASC will notify the appropriate personnel of an LVO alert.
9. Will accept all LVO alert patients, regardless of ICU or ED saturation status, except in the event of internal disaster or no catheterization laboratory availability.
10. Will create policies and procedures detailing how the TCASC will manage the presentation of concurrent LVO alerts.
11. Will create policies and procedures detailing how the TCASC plans to manage competing demands on the procedure suite (staffing, other cardiovascular procedures).
12. Will create policies and procedures that allow the automatic acceptance of any LVO patient from a Ventura County Hospital upon notification by the transferring physician.
13. Ability to perform endovascular procedures as indicated for emergent large vessel occlusions.
14. Have CT or MRI perfusion capabilities.
15. Maintain appropriate staff and facility availability to address complications of emergent endovascular procedures.
16. Will participate in the Ventura County Stroke Registry in accordance with policy 450.

B. Designation Process:

1. Application:
   Eligible hospitals shall submit a written request for TCASC designation to VCEMS no later than 30 days prior to the desired date of designation, documenting the compliance of the hospital with Ventura County TCASC Standards.
2. Approval:

a. Upon receiving a written request for TCASC designation, VCEMS will arrange an on-site survey of the requesting hospital to assure compliance with stated requirements.
b. TCASC approval or denial shall be made in writing by VCEMS to the requesting hospital within two weeks after receipt of the request for approval and all required documentation and completion of the VCEMS site survey.
c. Certification as a TSC or Primary Plus, or a CSC by The Joint Commission or Det Norske Veritas shall occur no later than six months following designation as a TCASC by VCEMS.

3. VCEMS may deny, suspend, or revoke the designation of an TCASC for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.
4. The VCEMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the TCASC that compliance with the regulation would not be in the best interests of the persons served within the affected area.
5. TCASCs shall be reviewed on a biannual basis.
   a. TCASCs shall receive notification of evaluation from the VCEMS.
   b. TCASCs shall respond in writing regarding program compliance.
   c. On-site TCASC visits for evaluative purposes may occur.
   d. TCASCs shall notify VCEMS by telephone, followed by a letter or email within 48 hours, of changes in program compliance or performance.

C. Provisional Designation Process

VCEMS may grant provisional designation as a TCASC to a requesting hospital that has satisfied the requirements of a TCASC as outlined in section A of this policy but has yet to receive certification by an approving body. Only when the following requirements are satisfied will VCEMS grant a provisional designation:

1. Application:

   Eligible hospitals shall submit a written request for provisional TCASC designation to VCEMS no later than 30 days prior to the desired date of provisional designation, documenting the compliance of the hospital with Ventura County TCASC Standards.
2. Provisional Approval:

a. Upon receiving a written request for provisional TCASC designation, VC EMS will arrange an on-site survey of the requesting hospital to assure compliance with stated requirements.

b. Provisional TCASC approval or denial shall be made in writing by VCEMS to the requesting hospital within two weeks after receipt of the request for approval and all required documentation, as well as completion of the VC EMS site survey.

c. Certification as a Thrombectomy-capable Stroke Center, Primary Plus or Comprehensive Stroke Center by The Joint Commission or Det Norske Veritas shall occur no later than six months following provisional designation as an TCASC by VCEMS.

3. VCEMS may deny, suspend, or revoke the designation of an TCASC for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.

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: July 1, 2023
APPROVED: Medical Director	Daniel Shepherd, MD	Date: July 1, 2023
Origination Date: Date Revised: Last Reviewed: Review Date:	May 24, 1987 January 12, 2023 January 12, 2023 January 31, 2024	Effective Date: July 1, 2023

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 to the requirements of this policy.

III. AUTHORITY: California Health and Safety Code Section 1797.178, 1797.204, 1797.218, 1797.221 and California Code of Regulations Sections 100148, 100306, 100404

IV. DEFINITIONS:

BLS – Basic Life Support Unit

ALS – Advanced Life Support Unit

PSV – Paramedic Support Vehicle or Paramedic Supervisor Vehicle

CCT – Critical Care Transport Unit

BLS Command – Basic Life Support Staffed Command Vehicle

FR/ALS – First Responder Advanced Life Support Unit

Search and Rescue – Sheriff's SAR Helicopter Unit

V. PROCEDURE:

The following equipment and supplies shall be maintained on each response and/or transport unit in Ventura County.

Deviation from the standards outlined in this policy shall only be authorized with written approval (see attached Equipment/Medication Waiver Request form) from the VCEMS Medical Director. Mitigation attempts should be documented in the comment section on the waiver request form, such as what vendors were contacted, etc.

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS						
Bag valve units with appropriate masks Adult (1,000 mL) Child (500 mL) Infant (240 mL)	1 each	1 each	1 each	1 each	1 each	1 adult
Nasal cannula Adult	3	3	3	3	3	3
Nasopharyngeal airway 14 French 18 French 20 French 22 French 24 French 26 French 28 French 32 French 34 French 36 French	1 each	1 each	1 each	1 each	1 each	1 each
Continuous positive airway pressure / Bi-level Positive Airway Pressure (CPAP/BiPap) device	1 Child 1 Small Adult 1 Adult	Optional	1 Child 1 Small Adult 1 Adult	1 Child 1 Small Adult 1 Adult	1 Child 1 Small Adult 1 Adult	1 Child 1 Small Adult 1 Adult
Nerve Agent Antidote DuoDote Auto-Injector	Optional	Optional	3	3	3	Optional
Blood glucose determination devices	1	Optional	2	1	1	1
Occlusive Dressing or Chest Seal	5	5	5	5	5	5
Oral glucose 15gm unit dose	1	1	1	1	1	1
Oropharyngeal Airways 40 mm (Size 00) 50 mm (Size 0) 60mm (Size 1) 70 mm (Size 2) 80 mm (Size 3) 90 mm (Size 4) 100 mm (Size 5) 110 mm (Size 6)	1 each size	1 each size	1 each size	1 each size	1 each size	1 each size
Oxygen with appropriate adjuncts (portability required)	15 L/min for 20 minutes (40 minutes for transport units)	15 L/min for 20 minutes	15 L/min for 20 minutes (40 minutes for transport units)	15 L/min for 20 mins.	15 L/min for 20 mins.	15 L/min for 20 mins.
Portable suction equipment	1	1	1	1	1	1
Nonrebreather oxygen masks Adult Child Infant	 3 3 2	 2 2 2	 3 3 2	 2 2 2	 2 2 2	 2 2 2
Bandage scissors	1	1	1	1	1	1

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
Bandages • 4"x4" sterile compresses or equivalent • 2",3",4" or 6" roller bandages • 10"x 30" or larger dressing	 12 6 2	 12 2 0	 12 6 2	 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	 1 1 1 1	 1 1 1 1
Emesis basin/bag	1	1	1	1	1	1
Flashlight	1	1	1	1	1	1
Traction splint or equivalent device	1	N/A	1	1	1	1
Pneumatic or rigid splints (capable of splinting all extremities)	4	N/A	4	4	4	4
Potable water or saline solution	4 liters	N/A	4 liters	4 liters	4 liters	4 liters
Cervical collar	2	N/A	2	2	2	2
Spinal immobilization backboard 60" minimum with at least 3 sets of straps	 1	 N/A	 1	 N/A	 1	 1
Sterile obstetrical kit	1	1	1	1	1	1
Tongue depressor	4	Optional	4	Optional	Optional	Optional
Cold packs	4	2	4	4	4	4
Eye Shield	2	N/A	2	2	2	2
Tourniquet	2	2	2	2	2	2
1 mL,5 mL, and 10 mL syringes with IM needles	N/A	N/A	4	4	4	4
Automated External Defibrillator	1	1	N/A	N/A	N/A	N/A
Manual Defibrillator	N/A	N/A	1	1	1	1
Defibrillator pads	2 adult 2 peds	2 adult 2 peds	2 adult 2 peds	2 adult 2 peds	2 adult 2 peds	2 adult 2 peds.
Stethoscope	1	1	1	1	1	1
Cellular telephone	1	1	1	1	1	1
CO_2 monitor Infant (<0.5 mL sidestream or <1 mL mainstream adaptor) Pediatric / Adult (6.6 mL sidestream or < 5 mL mainstream adaptor)	Optional	Optional	2 of each	2 of each	2 of each	2 of each
CO_2 Monitor Adult size EtCO2 sampling nasal cannula Pediatric size EtCO2 sampling nasal cannula	Optional	Optional	1 of each	1 of each	1 of each	1 of each
Pediatric length and weight tape	1	1	1	1	1	1
Intranasal mucosal atomization device	Optional	Optional	2	2	2	2
SpO_2 Monitor (If not attached to cardiac monitor)	1	1	1	1	1	1
SpO2 Adhesive Sensor (Adult, Pediatric, Infant)	Optional	Optional	1 of each	1 of each	1 of each	1 of each
Thermometer	1	Optional	1	1	1	Optional
Personal Protective Equipment per State Guideline #216 Rescue helmet EMS jacket Work goggles	 2 2 2	 N/A N/A N/A	 2 2 2	 1 1 1	 N/A N/A N/A	 N/A N/A N/A

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
Tyvek suit	2 L / 2 XXL	N/A	2 L / 2 XXL	1 L / 1 XXL	N/A	N/A
Tychem hooded suit	2 L / 2 XXL	N/A	2 L / 2 XXL	1 L / 1 XXL	N/A	N/A
Nitrile gloves	1 Med / 1 XL	N/A	1 Med / 1 XL	1 Med / 1 XL	N/A	N/A
Disposable footwear covers	1 Box	N/A	1 Box	1 Box	N/A	N/A
Leather work gloves	3 L Sets	N/A	3 L Sets	1 L Set	N/A	N/A
Field operations guide	1	N/A	1	1	N/A	N/A
OPTIONAL EQUIPMENT (No minimums apply)						
Hemostatic gauze per EMSA guidelines						

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
B. TRANSPORT UNIT REQUIREMENTS						
Ambulance gurney	1	N/A	1	N/A	N/A	N/A
Collapsible stretcher or flat	1	N/A	1	N/A	N/A	2
KED or equivalent (One required for transport units)	1	N/A	1	N/A	N/A	N/A
Straps to secure the patient to the stretcher or ambulance cot and means of securing the stretcher or ambulance cot in the vehicle.	1 set	N/A	1 Set	N/A	N/A	1 Set
Powered portable suction unit	1	N/A	1	N/A	N/A	N/A
Soft ankle and wrist restraints.	1 set of each	N/A	1 set of each	N/A	N/A	0
Sheets, pillowcases, blankets and towels for each stretcher or ambulance cot, and two pillows for each ambulance	1	N/A	1	N/A	N/A	0
Bedpan	1	N/A	1	N/A	N/A	N/A
Urinal	1	N/A	1	N/A	N/A	N/A

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
C. ALS UNIT REQUIREMENTS						
Supraglottic Airway Devices: I-Gel with passive oxygenation port Sizes 1, 1.5, 2, 2.5, 3, 4, 5	N/A	N/A	2 of each	1 of each	1 of each	1 of each
I-Gel Airway Support Straps	N/A	N/A	2	2	2	2
Arm Boards 9” 18”	N/A	N/A	 3 3	 0 0	 1 1	 0 0
Colorimetric CO2 Detector Device	N/A	N/A	1	1	1	1
EKG Electrodes	N/A	N/A	10 sets	3 sets	3 sets	6 sets
Endotracheal tubes, sizes 6.0, 6.5, 7.0, 7.5, 8.0 with stylets	N/A	N/A	1 of each size	1 of each size	1 of each size	1 of each size
EZ-IO intraosseous infusion system	N/A	N/A	1 Each Size	1 Each Size	1 Each Size	1 Each Size
IV admin set - macrodrip	N/A	N/A	8	4	4	4
IV catheter, Sizes 14, 16, 18, 20, 22, 24	N/A	N/A	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	N/A	N/A	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 Adult Pediatric	N/A	N/A	 1 1	 1 1	 1 1	 1 1
Nebulizer	N/A	N/A	2	2	2	2
Nebulizer with in-line adapter	N/A	N/A	1	1	1	1
Needle Thoracostomy kit	N/A	N/A	2	2	2	2
Flexible intubation stylet	N/A	N/A	1	1	1	1
OPTIONAL ALS EQUIPMENT (No minimums apply)						
Cyanide Antidote Kit						
Needle Thoracostomy Anatomical Landmark Guide						

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
D. ALS MEDICATION, MINIMUM AMOUNT						
Adenosine, 6 mg	N/A	N/A	5	5	5	5
Albuterol 2.5mg/3ml	N/A	N/A	6	2	2	2
Aspirin, 81mg	N/A	N/A	4 ea 81 mg	4 ea 81 mg	4 ea 81 mg	4 ea 81 mg
Amiodarone, 50mg/ml 3ml	N/A	N/A	6	3	6	3
Atropine sulfate, 1 mg/10 ml	N/A	N/A	3	2	2	2
Diphenhydramine (Benadryl), 50 mg/ml	N/A	N/A	2	1	1	2
Calcium chloride, 1000 mg/10 ml	N/A	N/A	2	1	1	1
Dextrose						
• 5% 50ml, AND	N/A	N/A	2	1	2	1
• 10% 250 ml	N/A	N/A	2	2	2	2
Epinephrine						
• Epinephrine , 1mg/ml						
• 1 mL ampule / vial, OR	N/A	N/A	5	5	5	5
• Adult auto-injector (0.3 mg),	N/A	N/A	Optional	Optional	Optional	Optional
Peds auto-injector (0.15 mg)	N/A	N/A	Optional	Optional	Optional	Optional
• Epinephrine 0.1mg/ml (1 mg/10ml preparation)	N/A	N/A	6	3	6	4
Fentanyl, 50 mcg/mL	N/A	N/A	200 mcg	200 mcg	200 mcg	200 mcg
Glucagon, 1 mg/ml	N/A	N/A	2	1	2	1
Intravenous Fluids (in flexible containers) • Normal saline solution, 100 ml • Normal saline solution, 500 ml • Normal saline solution, 1000 ml	N/A	N/A	2 2 6	1 1 2	1 1 4	1 1 3
Lidocaine, 100 mg/5ml	N/A	N/A	2	2	2	2
Magnesium sulfate, 1 gm per 2 ml	N/A	N/A	4	4	4	4
Midazolam Hydrochloride (Versed)	N/A	N/A	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials
Morphine sulfate, 10 mg/ml (Only required during a Fentanyl shortage)	N/A	N/A	2	2	2	2
Naloxone Hydrochloride (Narcan)						
• IN concentration - 4 mg in 0.1 mL (with atomizer)	N/A	N/A	Optional	Optional	Optional	Optional
• IM / IV concentration – 2 mg in 2 mL preload	N/A	N/A	5	5	5	5
Nitroglycerine preparations, 0.4 mg	N/A	N/A	1 bottle	1 bottle	1 bottle	1 bottle
Normal saline flush, 5 or 10 ml	N/A	N/A	5	5	5	5
Ondansetron (Zofran) • 4 mg IV single use vial • 4 mg oral	N/A N/A	N/A N/A	4 4	4 4	4 4	4 4
Sodium Bicarbonate 8.4%, 1 mEq/mL (50 mL)	N/A	N/A	4	2	2	2
Tranexamic Acid (TXA) 1 gm/10 mL	N/A	N/A	2	1	1	1

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
E. BLS MEDICATION, MINIMUM AMOUNT						
Epinephrine						
• Epinephrine , 1mg/ml						
• 1 mL ampule / vial (with syringe and needle), OR	2	2	N/A	N/A	N/A	N/A
• Adult auto-injector (0.3 mg), AND	2	2	N/A	N/A	N/A	N/A
Peds auto-injector (0.15 mg)	2	2	N/A	N/A	N/A	N/A
Naloxone Hydrochloride (Narcan)						
• IN concentration - 4 mg in 0.1 mL (with atomizer) OR	2	2	N/A	N/A	N/A	N/A
• IM / IV concentration – 2 mg in 2 mL preload	2	2	N/A	N/A	N/A	N/A

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: CHEMPACK Deployment		Policy Number 626
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2023
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: July 1, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	February 2, 2010 August 13, 2020 January 12, 2023 January 31, 2025	Effective Date: July 1, 2023

I. PURPOSE: This policy establishes guidelines for the deployment and use of the CHEMPACK by pre-hospital care providers in response to incidents involving suspected nerve agent exposure.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.220 & 1798.

III. DEFINITION: The Assistant Secretary for Preparedness and Response (ASPR) has established the “CHEMPACK” project for the forward placement of sustainable repositories of nerve agent antidotes in numerous locations throughout the United States, so that they can be immediately accessible for the treatment of exposed and affected persons.

There are two types of CHEMPACKs available. The “Hospital CHEMPACK” is designed for hospital and healthcare provider use, consisting mostly of single dose vials and a small quantity of auto-injectors. The “EMS CHEMPACK” is designed for field use and contains mostly auto-injectors. Ventura County has elected to only host EMS CHEMPACKs.

Content of CHEMPACKs			
Unit Pack	**Units**	**Cases**	**Quantity**
Pralidoxime 600 mg Auto-Injector	240	5	1200
Atropine Sulfate 0.4 mg/ml 20 ml	100	1	100
Pralidoxime 1 gm inj. 20 ml	276	1	276
Atropen 0.5 mg	144	1	144
Atropen 1.0 mg	144	1	144
Atropen 2 mg	136	5	680

Diazepam 5 mg/ml auto-injector	150	2	300
Midazolam 5mg/mL vial, 10mL	50	1	50
Sterile water for inj (SWFI) 20ml vials	100	2	200
Sensaphone®2050	1	1	1
Satco B DEA Container	1	1	1

IV. POLICY: Actual location of the CHEMPACK will be maintained as confidential. This policy outlines the responsibilities and the operational requirements to pre-position or utilize a cache within the Ventura County Operational Area.

In the case of an accidental or deliberate release of a nerve agent or potent organophosphate compound, time will be of the essence to minimize morbidity and mortality. This is a key consideration in cache placement, notification, transportation and administration.

V. PROCEDURE: CHEMPACK Deployment and Movement

A. Authorization to Open or Forward Deploy a CHEMPACK Container – Emergency Incident Based:

1. The Ventura County EMS Agency shall be contacted for authorization to open or forward deploy any CHEMPACK within the Ventura County Operational Area. The EMS Agency Duty Officer can be accessed on a 24-hour basis by calling the Ventura County Fire Department Fire Communications Center at 805-388-4279.
2. In the event that return contact by the EMS Agency Duty Officer is delayed and the situation clearly warrants immediate action, the CHEMPACK provider may elect to open or forward deploy the CHEMPACK for an emergency incident. Attempts to contact the EMS Agency Duty Officer shall be made in all cases through the Fire Communications Center.
3. The EMS Agency may request deployment of a CHEMPACK to a location within the Ventura County Operational Area or outside the operational area under a medical-health mutual aid request. The CHEMPACK provider shall make CHEMPACK resources immediately available upon request by the EMS Agency.
4. The EMS Agency shall immediately notify the Region 1 Regional Disaster Medical Health Specialist (RDMHS) of any CHEMPACK movement from

fixed locations or opening of a CHEMPACK container. The RDMHS will ensure that California Department of Health Services / Emergency Preparedness Office (DHS/EPO) is notified promptly of any movement or deployment of CHEMPACK material. DHS/EPO will in turn notify ASPR.

5. Qualifying Events – Emergency Deployment: CHEMPACK material may be accessed, deployed or used only when it is determined that an accidental or intentional nerve agent or other organophosphate release has threatened the public health security of a community. A seal will be broken and material used only when it is determined that other means to save human life will not be sufficient. Authorization to deploy, break the seal on, or move a CHEMPACK container from its specified location will be limited to any of the following events:
    a. Release of a nerve agent or potent organophosphate with human effects or immediate threats too great to adequately manage with other pharmaceutical supplies available.
    b. Large or unusual occurrence of patients presenting with signs and/or symptoms consistent with nerve agent or organophosphate exposure or intoxication.
    c. A credible threat of an imminent event of a magnitude likely to require the assets of the CHEMPACK.
    d. An event with potential to create a nerve agent or organophosphate release with human exposure (e.g. a transportation accident with fire or loss of container integrity).
    e. Any mutual aid request from another region or neighboring state in which CHEMPACK assets are being deployed or staged.
    f. Any event which, in the judgment of the County Health Officer, EMS Agency Medical Director, or Medical & Health Operational Area Coordinator (MHOAC), justifies the deployment of CHEMPACK supplies.
    g. A physical threat to the CHEMPACK at the fixed location (i.e. fire, theft, flood).

B. Authorization to Forward Deploy a CHEMPACK Container – Event or Threat Planning:

1. The EMS Agency may authorize movement of a CHEMPACK container and contents to any location within the Ventura County Operational Area, or outside the area under a medical-health mutual aid request. The EMS Agency will notify the Region 1 RDMHS in advance of any pre-planned CHEMPACK container movement for a particular event or threat.
2. Qualifying Events – Pre-Emptive Deployment: Pre-emptive movement is the relocation of a sealed CHEMPACK container and its contents to a site providing for levels of environmental and security controls generally identical to those required for its regular placement site. Breaking the seal, removing any contents, or moving the cache to a location without those controls constitutes deployment, not pre-emptive movement, and must meet deployment conditions.
    a. Pre-emptive movements may be requested to the EMS Agency by any emergency medical, public health, emergency management, hazardous materials or other related agency in preparation for, or response to, a planned or occurring event deemed appropriate for forward CHEMPACK placement.
    b. Any such request must be made to the RDMHS for approval. Unless an imminent or ongoing emergency, each request must be made at least 48 hours before the movement. The RDMHS will refer any request to the RDMHC and to DHS/EPO for consideration. If an RDMHS is unavailable to take timely action on a movement request, that request may be made to DHS/EPO via the State Warning Center.

C. Post Event Actions:

1. Incident documentation should begin as soon as possible following any emergency operation involving CHEMPACK assets by the EMS Agency. The documentation must include the following:
    a. A thorough description of the incident or event involving CHEMPACK resources.
    b. A list of the approving officials.
    c. An inventory of used and unused CHEMPACK contents.
    d. An after-action critique of CHEMPACK deployment effectiveness.

2. The CHEMPACK container and any unused contents will be returned to the CHEMPACK Provider and will be resealed. The EMS Agency will coordinate resupply with the Region 1 RDMHS, DHS/EPO and the ASPR as appropriate. Currently the CHEMPACK Project is not funded to replace CHEMPACK supplies used for an emergency event. However, requests for replenishment of CHEMPACK supplies should be made to the Strategic National Stockpile (SNS) Program as soon as possible after their use. The SNS Program will attempt to secure federal funding to replace and restock supplies used in response to an emergency event.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Rescue Task Force Operations		Policy Number 628
APPROVED: Steven L. Carroll, Paramedic		Date: July 1, 2023
APPROVED: Medical Director: Daniel Shepherd, MD		Date: July 1, 2023
Origination Date: Date Revised: Last Review: Review Date:	September 3, 2014 February 9, 2023 February 9, 2023 February 28, 2025	Effective Date: July 1, 2023

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

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

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

III. POLICY:

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

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

IV. PROCEDURE:

1. Preparatory Phase
   A. Arrive and report to staging or designated location in a secure area.
      i. First arriving command officer (or company officer on single resource incidents) should seek to establish unified command with law enforcement as soon as possible.
      ii. First arriving command officer (or company officer on single resource incidents) should maintain physical contact with law enforcement IC at all times.
   B. Don PPE (fire/ballistic helmet, ballistic vest, wildland jacket, EMS Jacket, etc.), based on departmental requirements and guidelines.
   C. Report to Incident Command / Unified Command that rescue group / team is ready and awaiting an assignment.
   D. Ensure there is clear identification of RTF personnel.

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

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

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

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

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

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

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

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

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

2. Warm Zone Operations

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

   B. Perform rapid assessment and treatment of victims

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

         a. Black/white ribbon will be used for identification of deceased victims.

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

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

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

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

D. Establish RTF medical caches / re-supply points as needed.
E. Re-stock RTF medical bags and prepare for re-entry into the warm zone.
F. Transition RTF personnel to MCI operations in cold zone once rescue of victims from the warm zone is complete.

3. Post Incident Phase
   A. Ensure accountability for all RTF personnel
   B. Collect any/all RTF documents or unit logs
   C. Perform incident de-brief / hot wash with all incident personnel
   D. Assess mental and physical health of RTF personnel and conduct CISD and rehabilitation as needed.
4. Non-RTF Prehospital Personnel
   A. Identify safe ingress, egress, routes of travel, and identify applicable radio communication frequencies prior to entry (eg: mednet)
   B. Utilizing current ICS concepts, establish key roles for the purposes of MCI management that focus on the triage, treatment, and transport of victims.
   C. Identify key locations in the cold zone for equipment staging, treatment area(s), and ambulance loading zone(s).
   D. Ensure Incident Command / Unified Command is aware of the location of this area and of the personnel staffing key MCI management roles.
   E. All MCI operations (where applicable) shall be conducted in accordance with VCEMS Policy 131.
5. Documentation of patient care shall be in accordance with procedure(s) outlined in VCEMS Policy 1000 – Documentation of Prehospital Care, or with VCEMS Policy 131 (if an MCI declaration is applicable).

Common Terms and Definitions Associated with Rescue Task Force Operations

Active Assailant

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

Active Shooter / Hostile Event (ASHE)

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

Barricaded Suspect

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

Casualty Collection Point

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

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

Cold Zone

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

Concealment

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

Contact Team

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

Cover

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

Direct Threat

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

Force Protection

In a tactical environment, the protective actions taken by law enforcement to protect incident personnel or secure a location from hostile threats intended to harm incident personnel or victims.

Force Protection Group

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

Hot Zone

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

Immediately Dangerous to Life or Health (IDLH)

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

Indirect Threat

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

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

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

Multi Casualty Incident (MCI)

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

A. MCI/Level I (3-14 victims)
B. MCI/Level II (15-49 victims)
C. MCI/Level III (50+ victims)

Rapid Deployment

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

Rescue Group

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

Rescue Task Force

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

RTF can/should be deployed for the following reasons:

i. Treatment of victims in a warm zone/IDLH environment

ii. Removal of victims from the warm zone to a Casualty Collection Point (CCP) and/or to the Cold Zone

iii. Movement of equipment/supplies from the cold zone to the warm zone.

iv. Any other activities within the warm zone that are deemed necessary for a successful RTF operation.

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

TEMS FRO

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

TEMS Specialist

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

Tactical Emergency Casualty Care (TECC)

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

Violent Incident Personnel Protective Equipment (PPE)

The required PPE for violent incidents will be a combination of body armor, ballistic element, structure helmet and brush coat or EMS jacket. All personnel will wear the required PPE while on scene regardless of their assignment or work locations. PPE not only protects on scene personnel it is used as an identification method while working on a very dynamic multi-discipline response.

Warm Zone

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

Appendix A – Rescue Task Force Equipment

Minimum Mandatory Requirements

Special Considerations:

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

Personal Protective Equipment

1 – Fire / Ballistic Helmet, Agency and Rank Specific

1 – Ballistic Vest

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

Individual RTF Kit – BLS

1 – Pack or case capable of carrying all required equipment

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

2 – HyFin Vent Chest Seal

1 – 2" Cloth Adhesive Tape

2 – 4" Flat Emergency Trauma Dressing (ETD)

2 – 5x9 Sterile Combine Dressing

2 – 3" Stretch Gauze

6 – Pair, Nitrile Gloves

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

3 – Packets, Sterile Lubricant

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

1 – Roll, 100 yard Red Flagging Tape

1 – Trauma Shears

1 – Safety Goggles

Individual RTF Kit – ALS

1 – Pack or case capable of carrying all required equipment with 'ALS' Markings

1 – Needle Thoracostomy Kit3 – Combat Application Tourniquet (C.A.T.)

2 – HyFin Vent Chest Seal

1 – 2" Cloth Adhesive Tape

2 – 4" Flat Emergency Trauma Dressing (ETD)

2 – 5x9 Sterile Combine Dressing

2 – 3" Stretch Gauze

6 – Pair, Nitrile Gloves

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

3 – Packets, Sterile Lubricant

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

1 – Roll, 100 yard Red Flagging Tape

1 – Trauma Shears

1 – Safety Goggles

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Mechanical CPR	Policy Number 631
APPROVED: Administration: Steve L. Carroll, Paramedic	Date: July 1, 2023
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: July 1, 2023
Origination Date: January 12, 2023 Date Revised: Date Last Reviewed: Review Date: January 30, 2024	Effective Date: July 1, 2023

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

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

III. DEFINITIONS:

A. LUCAS: Lund University Cardiopulmonary Assist System. A device that provides mechanical chest compressions.

B. Staged application: A two stage method where application of the LUCAS device is done during rhythm checks to minimize pauses in chest compressions. Stage 1-the backplate is positioned under the patient and manual compressions are resumed. Stage 2- the LUCAS device is applied over the patient, secured to the backplate, and mechanical compressions initiated.

C. Pause: Interruption in chest compressions greater than or equal to 3 seconds.

D. ROSC: Return of spontaneous circulation.

IV. POLICY:

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

B. Mechanical CPR devices have the potential to improve the quality of CPR, but do not increase the rate of survival, or the percentage of patients who survive with a good neurologic outcome.
C. Successful application of a mechanical CPR device requires a methodical, coordinated approach.
D. The LUCAS device (Stryker) is the only mechanical CPR device approved for use by prehospital personnel in Ventura County.
E. The LUCAS device, if available, MAY be applied to patients if the “triangle of life” has been established, defibrillation has been performed (if indicated), the initial dose of epinephrine has been administered, no immediate airway interventions are indicated, and at least two cycles of CPR have been completed.
    1. The LUCAS device may not be applied to pediatric patients. If utilizing the adult cardiac arrest protocol, LUCAS is authorized. LUCAS is NOT authorized if using a pediatric protocol.
F. The LUCAS device, if immediately available, MAY be applied earlier than outlined above in the following circumstances:
    1. **ROSC:** The device, if available, shall be applied after ROSC, prior to patient movement.
    2. **TRAUMATIC ARREST:** The patient must be ≥ 18 years of age and meet criteria for initiating resuscitation. Consider needle-T insertion prior to device application. The application/operation of LUCAS shall not delay transport or interfere with necessary treatment.
    3. **LOCATION**: the patient is in a location that prohibits quality CPR **AND** immediate movement to a workable space is not possible. Routine movements (e.g. bed to floor, hallway to room) do not apply.
G. Agencies utilizing LUCAS shall evaluate performance prospectively and shall report to VCEMSA the following information, per cardiac arrest, on a quarterly basis:
    1. Whether mechanical compressions were provided.
    2. Whether compressions type was documented correctly in the Patient Care Report
    3. Date and Time of first manual chest compression
    4. Date and Time of first mechanical chest compression.
    5. Duration of CPR pause immediately prior to LUCAS application.

6. Binary (yes/no) for tasks completed prior to LUCAS application: vascular access, defibrillation, and epinephrine administration.
7. Total number of pauses in chest compressions.
8. Longest pause in chest compressions.
9. Total compression fraction.
10. Whether chest compressions were provided during transport.

V. PROCEDURE:

A. The “team leader” or “primary patient caregiver” on scene remains responsible for determining when, and coordinating how, the device should be applied.
B. A staged application process should be used whenever feasible.
C. All LUCAS devices utilized in Ventura County must be programmed to power on in “continuous mode,” not 30:2 or 50:2 modes.
D. Cardiac monitor data (.zol and .PCO files) must be transmitted and attached to the patient care report. LUCAS data files and compatible cardiac monitor data files (.PCO files) will also be transmitted to the VCEMS CODE-STAT database.
E. In the event of a device failure or other malfunction, the device will be removed immediately, and manual CPR resumed.
F. Agencies must notify VCEMS, within 24 hours, of any device failures or other malfunctions using the procedure outlined in VCEMSA Policy 121 Safety Event Review.
G. All providers must receive initial and ongoing training on the device, its application, troubleshooting, reporting, and documentation prior to use on patients.
H. Patients who are transported after application of a mechanical CPR device must be accompanied by at least one provider from the agency who applied the device.

VCEMS General Patient Guidelines 705.00

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

A. Initial response

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

B. Scene arrival and Size-up

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

C. Initial assessment

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

Effective Date: July 1, 2023
Next Review Date: January 31, 2025
Date Revised: August 8, 2019
Last Reviewed: January 12, 2023

VCEMS Medical Director

5. Exposure
    a. If indicated, remove clothing for proper assessment/treatment of injury location, always maintaining patient dignity
    b. Always maintain patient body temperature

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

II. History of Present Illness – including pertinent negatives and additional signs/symptoms
1. Onset of current illness or chief complaint
2. Provoking factors
3. Quality
4. Radiation
5. Severity – 0 to 10 on pain scale
6. Time

III. Vital Signs
1. Blood Pressure and/or Capillary Refill
2. Heart Rate
3. Respirations
4. ALS assessments are primary survey and secondary assessment performed by Paramedic and may include:
    a. Cardiac rhythm
    b. 12-lead ECG as indicated per VCEMS Policy 726
    c. Pulse Oximetry
    d. Capnography

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

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

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

VII. Transport to appropriate facility per VCEMS guidelines
1. Transport and Destination Guidelines – Policy 604
2. STEMI Receiving Center Standards – Policy 430
3. Stroke System Triage and Destination – Policy 451
4. Post cardiac arrest with ROSC – Policy 705 (Cardiac Arrest)
5. Trauma Triage and Destination Criteria – Policy 1405
6. Hospital Diversion – Policy 402

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

IX. Documentation

1. Completion of patient care documentation per VCEMS Policy 1000
2. Document all assessment findings, pertinent negatives, vital signs, interventions/treatments (both initial and ongoing), responses to treatments, and all changes in patient status
3. Submit ECG strips for all ALS patients
4. Always maintain patient confidentiality

Trauma Assessment/Treatment Guidelines 705.01

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

A. Rapid trauma survey

1. Airway

a. Maintain inline cervical stabilization

1) Follow spinal precautions per VCEMS Policy 614

b. Open airway as needed

2) Utilize a trauma jaw thrust to maintain inline cervical stabilization if indicated

c. Suction airway if indicated

d. Insert appropriate airway adjunct if indicated

2. Breathing

a. Assess rate, depth and quality of respirations

b. If respiratory effort inadequate, assist ventilations with BVM

c. Assess lung sounds

d. Initiate airway management and oxygen therapy as indicated

1) Maintain SpO2 ≥ 94%

3. Circulation

a. Assess skin color, temperature, and condition

b. Check distal/central pulses and capillary refill time

c. Control major bleeding

d. Initiate shock management as indicated

4. Disability

a. Determine level of consciousness (Glasgow Coma Scale)

b. Assess pupils

5. Exposure

a. If indicated, remove clothing for proper assessment/treatment of injury location, always maintaining patient dignity

b. Always maintain patient body temperature

B. Detailed physical examination

1. Head

a. Inspect/palpate skull

b. Inspect eyes, ears, nose and throat

2. Neck

a. Palpate cervical spine

b. Check position of trachea

c. Assess for jugular vein distention (JVD)

3. Chest

a. Visualize, palpate, and auscultate chest wall

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

C. Trauma care guidelines

1. Fluid Administration
    a. Maintain SBP of ≥ 80 mmHg
        1) Patients 65 years and older, maintain SBP of ≥ 100 mmHg
        2) Pediatric patients, maintain minimum systolic for respective age in Handtevy
        3) Isolated head injuries, maintain SBP of ≥ 100 mmHg
2. Tranexamic Acid (TXA) Administration
    a. Patients 15 years of age and older as indicated in VCEMS Policy 734
3. Head injuries
    a. General treatments
        1) Evaluate head and face – maintain high index of suspicion for injury if significant mechanism of injury is present or physical examination is remarkable for findings
        2) Elevate head 30° unless contraindicated
        3) Do not attempt to intubate head injured patients unless unable to manage with BLS airway measures
        4) Do not delay transport if significant airway compromise
    b. Penetrating injuries
        1) DO NOT REMOVE IMPALED OBJECT (unless airway obstruction is present)
        2) Stabilize object manually or with bulky dressings
    c. Facial injuries
        1) Assess airway and suction as needed
        2) Remove loose teeth or dentures if present
    d. Eye injuries
        1) Remove contact lenses
        2) Irrigate eye thoroughly with suspected acid/alkali burns
        3) Avoid direct pressure
        4) Place eye shield over injured eye only
        5) Ask patient to keep eyes closed
        6) Stabilize any impaled object manually or with bulky dressing

4. Spinal cord injuries
    a. General treatments
        1) Evaluate spinal column – maintain high index of suspicion for injury if significant mechanism of injury is present or physical examination is remarkable for findings
        2) Place patient in supine position if hypotension is present
    b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
        1) Stabilize object manually or with bulky dressings
        2) Control bleeding if present
        3) In the presence of isolated penetrating injuries, spinal motion restriction is contraindicated
    c. Neck injuries
        1) Monitor airway
        2) Control bleeding if present
5. Thoracic Trauma
    a. General treatments
        1) Evaluate chest – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
        2) Keep patients sitting high-fowlers
            a. In the presence of isolated penetrating injuries, spinal motion restriction is contraindicated
    b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
        a) Remove object if CPR is interfered
        b) Stabilize object manually or with bulky dressings
        c) Control bleeding if present
    c. Flail Chest/Rib injuries
        a) Assist ventilations if respiratory status deteriorates
    d. Pneumothorax/Hemothorax
        a) Keep patient sitting high-fowlers
        b) Assist ventilations if respiratory status deteriorates1.
            1) Suspected tension pneumothorax should be managed per VCEMS Policy 715
    e. Open (Sucking) Chest Wound
        a) Place an occlusive dressing to wound site, secure on 3 sides only or place a vented chest seal.
        b) Assist ventilations if respiratory status deteriorates

f. Cardiac Tamponade – If suspected, expedite transport
    a) Beck's Triad
        1) Muffled heart tones
        2) JVD
        3) Hypotension
g. Traumatic Aortic Disruption
    a) Assess for quality of radial and femoral pulses
    b) If suspected, expedite transport

6. Abdominal/Pelvic Trauma
    a. General Treatments
        1) Evaluate abdomen and pelvis – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
    b. Blunt injuries
        1) Place patient in supine position if hypotension is present
    c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
        1) Stabilize object manually or with bulky dressings
        2) Control bleeding if present
    d. Eviscerations
        1) DO NOT REPLACE ABDOMINAL CONTENTS
            a) Cover wound with saline-soaked dressings
        2) Control bleeding if present
    e. Pregnancy
        1) Place patient in left-lateral position to prevent supine hypotensive syndrome
    f. Pelvic injuries
        1) Consider wrapping a bed sheet tightly around the pelvis and tying it together for use as a binder to help control internal bleeding
            a) Assessment of pelvis should be only performed ***ONCE*** to limit additional injury
        2) Control bleeding if present
        3) If possible, avoid log rolling patient

7. Extremity Trauma
    a. General Treatments
        1) Evaluate CSM distal to injury
            a) If decrease or absence in CSM is present:
                (1) Attempt to reposition extremity into anatomical position

(2) Re-evaluate CSM

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

c) Cover open wounds with sterile dressings

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

e) Splint/elevate extremity with appropriate equipment

f) Uncontrolled hemorrhage: Tranexamic Acid – For patients 15 years of age and older as indicated in VCEMS Policy 734

b. Dislocations

1) Splint in position found with appropriate equipment

c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECTS

1) Stabilize object manually or with bulky dressings

2) Control bleeding if present

d. Femur fractures

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

2) Assess CSM before and after traction splint application

e. Amputations

1) Clean the amputated extremity with NS

2) Wrap in moist sterile gauze

3) Place in plastic bag

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

5) Prevent direct tissue contact with the ice pack

Behavioral Emergencies

ADULT	PEDIATRIC

BLS Procedures

Administer oxygen as indicated

ALS Standing Orders

ADULT	PEDIATRIC
IV/IO Access For Extreme Agitation • **Midazolam** ○ IM – 5mg or 10 mg ○ IV/IO – 2 mg • Repeat 1 mg q 2 min as needed • Max 5 mg	IV/IO Access For Extreme Agitation • **Midazolam** ○ IM – 0.1 mg/kg • Max 5 mg ○ IV/IO – 0.1 mg/kg • Repeat q 2 min as needed • Max single dose 2 mg • Max total dose 5 mg

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

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

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

Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA)

ADULT

BLS Procedures

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

ALS Standing Orders

Assess for and treat underlying cause

IV/IO access
- PRESTO Blood Draw

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

Normal Saline
- IV/IO bolus- 1 Liter

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

When one of the following is a suspected cause of arrest:
History of Renal Failure/Dialysis
- **Calcium Chloride**
  - IV/IO – 1 g
  - Repeat x 1 in 10 min
- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg
  - Repeat x 2 0.5 mEq/kg q 5 min

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

Beta Blocker Overdose
- **Glucagon**
  - IV/IO – 2 mg up to 10 mg when available

Calcium Channel Blocker Overdose
- **Calcium Chloride**
  - IV/IO – 1 g
  - Repeat x 1 in 10 min
- **Glucagon**
  - IV/IO – 2 mg up to 10 mg when available

PEDIATRIC

Assess for and treat underlying cause

IV/IO access
- PRESTO Blood Draw

Epinephrine* 0.1mg/mL
Administer ASAP goal ≤6 minutes
- IV/IO 0.01mg/kg (0.1 mL/kg) q 6 min
- Repeat x 2, max of 3 dose during initial arrest.
- If ROSC then re-arrest an additional 3 doses may be administered.

Normal Saline
- IV/IO bolus- 20 mL/kg

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

When one of the following is a suspected cause of arrest:
History of Renal Failure/Dialysis
- **Calcium Chloride**
  - IV/IO – 20 mg/kg
  - Repeat x 1 in 10 min
- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg
  - Repeat x 2 0.5 mEq/kg q 5 min

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

Beta Blocker Overdose
- **Glucagon**
  - IV/IO – 0.1 mg/kg up to 10 mg when available

Calcium Channel Blocker Overdose
- **Calcium Chloride**
  - IV/IO – 20 mg/kg
  - Repeat x 1 in 10 min
- **Glucagon**
  - IV/IO – 0.1 mg/kg up to 10 mg when available

Base Hospital Orders Only

***Consult with ED Physician for further treatment measures**

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

Effective Date: July 1, 2023
Next Review Date: February 28, 2023

Date Revised: May 14, 2020
Last Reviewed: February 9, 2023

VCEMS Medical Director

Heat Emergencies

ADULT	PEDIATRIC

BLS Procedures

- Place patient in cool, shaded environment
- Initiate active cooling measures
  - Remove clothing
  - Fan the patient, or turn on air conditioner
  - Apply ice packs to axilla, groin, back of neck
  - Other active cooling measures as available
- Administer oxygen as indicated

ALS Standing Orders

ADULT	PEDIATRIC

IV/IO access
 	
Normal Saline
 	
• IV/IO bolus – 1 Liter
  ○ Repeat x 1 for persistent hypotension
	IV/IO access
	
	Normal Saline
	
	• IV/IO bolus – 20 mL/kg
	  ○ Max single dose 1 Liter
	  ○ Repeat x 1 for persistent hypotension

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Cold Emergencies

BLS Procedures

- Gently move patient to warm environment and begin passive warming
- Minimize movement of extremities
- Attempt to maintain supine position
- Increase ambulance cabin heat, if applicable
- *Cut off* wet clothing and cover patient, including head, with dry blankets
- Administer oxygen as indicated
- Monitor vital signs for 1 minute. If vital signs are within the acceptable range for severe hypothermia, do not initiate respiratory assistance or chest compressions
    - Acceptable range for severe hypothermia:
        - Respiratory Rate: at least 4 breaths per minute
        - Heart rate: at least 20 beats per minute
    - Expedite transport if no shivering (indicates core temp below 90°)

ALS Standing Orders

IV/IO access (if needed for medication or fluid administration)

- If administering fluid, avoid administering cold fluids

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Nausea/Vomiting

ADULT	PEDIATRIC
BLS Procedures	
Maintain airway and position of comfort Administer oxygen as indicated	
ALS Standing Orders	

Indications for Ondansetron:
1. Moderate to severe nausea or vomiting.
2. Potential for airway compromise secondary to suspected/actual head injury when cervical immobilization is used.
3. Prior to MS administration
 	
• IV/IO access
• Cardiac Monitor
 	
• **Ondansetron**
  ○ PO – 4 mg ODT
  • May repeat x 1 in 10 min
  ○ IV/IM/IO – 4 mg
  • May repeat x 1 in 10 min
	Indications for Ondansetron:
	1. Moderate to severe nausea or vomiting.
	2. Potential for airway compromise secondary to suspected/actual head injury when cervical immobilization is used.
	3. Prior to MS administration
	
	• IV/IO access
	• Cardiac Monitor
	
	Ages 6 months up to 5 years
	• **Ondansetron**
	  ○ PO – 2 mg ODT
	  • May repeat x 1 in 10 min
	  ○ IV/IM/IO – 0.1 mg/kg
	  • Max single dose 4 mg
	  • May repeat x 1 in 10 min
	
	Ages ≥ 5 Years
	• **Ondansetron**
	  ○ PO – 4 mg ODT
	  • May repeat x 1 in 10 min
	  ○ IV/IM/IO – 0.1 mg/kg
	  • Max single dose 4 mg
	  • May repeat x 1 in 10 min

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

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

Effective Date: July 1, 2023
Next Review Date: January 31, 2025

Date Revised: January 12, 2023
Last Reviewed: January 12, 2023

VCEMS Medical Director

Overdose

BLS Procedures

Decontaminate if indicated and appropriate

Administer oxygen and support ventilations as indicated

Suspected opioid overdose with respirations less than 12/min and significant ALOC:

- **Naloxone**
  - IN – 4 mg via pre-filed nasal spray, may repeat in 3 min x 1 to a total of 8 mg
  - IN – 2 mg (1 mg per nostril) via nasal atomizer, may repeat in 3 min x 1 to a total of 4 mg
  - IM – 2 mg, may repeat in 3 min x 1 to a total of 4 mg

ALS Standing Orders

ADULT

IV/IO access

Suspected opioid overdose with respirations less than 12/min and significant ALOC:

- **Naloxone**
  - IV/IO – 0.5 mg
    - May repeat q 1 min, titrated to maintain respirations greater than 12/min

Dystonic Reaction

- **Benadryl**
  - IV/IO/IM – 50 mg

Stimulant/Hallucinogen Overdose

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

PEDIATRIC

IV/IO access

Suspected opioid overdose with respirations less than 12/min and significant ALOC:

- **Naloxone**
  - IM – 0.1 mg/kg
    - Max single dose 2 mg
    - May repeat in 3 min x 1
  - IV/IO – 0.1 mg/kg
    - Max single dose 0.5 mg
    - May repeat q 1 min, titrated to maintain respirations greater than 12/min

Dystonic Reaction (For patients ≥ 6 months of age)

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

Stimulant/Hallucinogen Overdose

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

Base Hospital Orders Only

ADULT

Tricyclic Antidepressant Overdose

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

Beta Blocker Overdose

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

Calcium Channel Blocker Overdose

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

PEDIATRIC

Tricyclic Antidepressant Overdose

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

Beta Blocker Overdose

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

Calcium Channel Blocker Overdose

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

Additional Information:

- If chest pain present, refer to chest pain policy. DO NOT GIVE ASPIRIN OR NITROGLYCERIN (Consult with ED Physician)
- Narcan
  - It is not necessary that the patient be awake and alert. Titrate to maintain respirations greater than 12/min.
  - If the patient is taking high doses of opioid medication and has decreased respiratory drive, early base hospital contact should be made before administering naloxone. If base hospital contact cannot be made, naloxone should be administered sparingly, in doses no more than 0.1 mg q 1 min titrated to maintain respirations greater than 12/min.

Effective Date: July 1, 2023
Next Review Date: January 31, 2025

Date Revised: January 12, 2023
Last Reviewed: January 12, 2023

VCEMS Medical Director

Pain Control

BLS Procedures

Place patient in position of comfort
Administer oxygen as indicated

ALS Standing Orders

IV/IO access

Cardiac Monitor

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

Fentanyl

- IM/IN – 1mcg/kg, Max 100 mcg
  - Repeat q 10 minutes for persistent pain to a max total dose of 200 mcg.
- IV/IO - 1 mcg/kg over 1 minute, Max 100 mcg
  - Repeat q 5 minutes for persistent pain to a max total dose of 200 mcg.
- Repeat doses should be administered IV / IO if vascular access obtained.

If Fentanyl unavailable;

Ondansetron - Per 705.15 Nausea/Vomiting Policy

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

Morphine

- IM – 0.1 mg/kg, Max 10 mg
  - Repeat ½ initial dose q 10 minutes x 2 for persistent pain.
- IV/IO - 0.1 mg/kg, Max 10 mg, over 1 minute
  - Repeat ½ initial dose q 5 minutes x 2 for persistent pain.

Base Hospital Orders only

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

Additional Information

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

Effective Date: July 1, 2023
Next Review Date: January 31, 2025
Date Revised: January 12, 2023
Last Reviewed: January 12, 2023

VCEMS Medical Director

Smoke Inhalation

ADULT	PEDIATRIC
BLS Procedures	
Remove individual from the environment Consider gross decontamination Assess ABCs Assess for trauma and other acute medical conditions Administer high flow oxygen as indicated, or with evidence of smoke inhalation and ALOC or significant headache	
ALS Standing Orders	

Airway support in accordance with Policy 710 – Airway Management
 	
IV/IO access as indicated
 	
If Wheezes present
• **Albuterol**
  ○ Nebulizer – 5 mg/6 mL
  ▪ Repeat as needed
 	
If smoke inhalation AND unconscious, ALOC, or cardiac arrest:
• **Hydroxocobalamin – If Available**
  ○ IV/IO – 5 g in 200 mL NS over 15 minutes
	Airway support in accordance with Policy 710 – Airway Management
	
	IV/IO access as indicated
	
	If Wheezes present
	• **Albuterol**
	  ○ **Patient ≤ 30 kg**
	  • Nebulizer – 2.5 mg/3 mL
	  ○ Repeat as needed
	  ○ **Patient > 30 kg**
	  • Nebulizer – 5 mg/6 mL
	  ○ Repeat as needed
	
	If smoke inhalation AND unconscious, ALOC, or cardiac arrest:
	• **Hydroxocobalamin – If Available**
	  ○ IV/IO – 70 mg/kg to a max of 5 g in 200 mL NS over 15 minutes

Base Hospital Orders Only	

Continued unconscious/ALOC OR poor response to initial dose
• **Hydroxocobalamin**
  ○ IV/IO – 5 g in 200 mL NS over 15 to 120 minutes, depending on clinical presentation.
	Continued unconscious/ALOC OR poor response to initial dose
	• **Hydroxocobalamin**
	  ○ IV/IO – 70 mg/kg to a max of 5 g in 200 mL NS over 15 to 120 minutes, depending on clinical presentation.

Consult with ED Physician for further treatment measures.	
Additional Information: • If monitoring equipment is available, the patient's carboxyhemoglobin levels should be checked if smoke inhalation is suspected. • Evidence of smoke inhalation includes soot around mouth and/or nares, increased work of breathing, wheezing • If additional IV/IO medications are indicated, establish a second IV or IO. DO NOT administer other medications with hydroxocobalamin through the same IV/IO line. • DO NOT administer hydroxocobalamin if patient has a known allergy to hydroxocobalamin or cyanocobalamin	

Effective Date: July 1, 2023
Next Review Date: January 31, 2025
Date Revised: October 8, 2020
Last Reviewed: January 12, 2023

VCEMS Medical Director