County of Ventura
Public Health Services

Notice of Changes to Policy Manual

Emergency Medical Services
Policies and Procedures

To: ALL VENTURA COUNTY EMS POLICY MANUAL HOLDERS

DATE: May 29, 2015

Policy Status	Policy #	Title/New Title	Notes
Replace	N/A	Policy Listing – Table of Contents	
Replace	351	EMS Update Procedure	
Replace	400	Ventura County Emergency Departments	
Replace	502	Advanced Life Support Service Provider Approval Process	
Replace	614	Spinal Immobilization	
Replace	619	Safely Surrendered Babies	
Replace	705.02	Allergic/Adverse Reaction and Anaphylaxis	
Replace	705.05	Bites and Stings	
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Replace	705.08	Cardiac Arrest – VF/VT	
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Replace	1000	Documentation of Prehospital Care	
Replace	1201	Air Unit Staffing Requirements	
Replace	1202	Helicopter Dispatch for Emergency Medical Responses	
Replace	1404	Guidelines for Interfacility Transfer of Patents to a Trauma Center	
Replace	1405	Trauma Triage and Destination Criteria	

100	Emergency Medical Service, Local Agency (9/13/84)	6/15/1998	7/1/1980	10/1/2003	12/13/2012	11/30/2014
507	Critical Care Transports	12/1/2014	10/31/1995	10/9/2014	10/9/2014	10/1/2017
508	First Responder Advanced Life Support Units	6/1/2013	6/1/1997	4/25/2013	4/11/2013	3/31/2015
VI.	**General Emergency Medical Services - Policies**					
600	Control At The Scene of An Emergency	10/31/1999	1/31/1995	9/30/1999		9/30/2001
601	Medical Control At The Scene: EMS Prehospital Personnel	6/1/2000	10/1/1993	10/31/1999		6/1/2002
603	Against Medical Advice/Release From Liability Form	10/31/1995	6/3/1986			10/31/1997
604	Transport and Destination Guidelines	12/1/2010	6/3/1986	6/10/2010	7/11/2013	7/1/2016
605	Interfacility Transfer of Patients	12/1/2011	7/26/1991	8/11/2011	8/11/2011	10/31/2014
606	Withholding or Termination of Resuscitation and Determination of Death	12/1/2012	6/1/1984	7/12/2012	7/12/2012	7/12/2014
607	Hazardous Materials Incident	6/1/2013	2/12/1987	2/14/2013	2/14/2013	1/31/2015
612	Notification of Exposure to a Communicable Disease	12/1/2014	4/27/1990	9/11/2014	9/11/2014	9/1/2017
613	Do Not Resuscitate (DNR)	6/1/2011	10/1/1993	2/10/2011	2/10/2011	2/28/2014
614	Spinal Immobilization	6/1/2009	10/31/1992	12/11/2008	5/14/2015	5/31/2017
615	Organ Donor Information Search	6/1/2013	10/1/1993	2/14/2013	2/14/2013	1/31/2015
618	Unaccompanied Minors	10/31/1995	5/1/1995			10/31/1997
619	Safely Surrendered Babies	6/1/2008	2/13/2003	11/8/2007	5/14/2015	5/31/2018
620	EMT-I Administration of Oral Glucose	6/1/2006	11/18/1982	3/9/2006		10/31/2011
622	ICE - In Case of Emergency for Cell Phones	12/1/2008	5/11/2006	7/10/2008	9/11/2014	9/1/2017
624	Patient Medications	12/1/2008	12/6/2006		2/9/2012	10/31/2014
625	POLST	12/1/2014	1/7/2009	10/9/2014	10/9/2014	10/1/2016
626	Chempack	6/1/2010	2/2/2010		11/12/2009	6/30/2013
627	Fireline Medic	12/1/2014	10/5/2011	9/11/2014	9/11/2014	9/1/2016
628	Rescue Task Force Operations	12/1/2014	9/3/2014			9/1/2015
VII.	**Advanced Life Support Medical Control and Treatment Policies**					
701	Medical Control: Paramedic Liaison Physician	6/1/2013	8/1/1988	12/13/2012	12/13/2012	1/31/2014
703	Medical Control At Scene, Private Physician	6/1/2008	1/31/1985	3/13/2008	9/12/2013	9/1/2015
704	Guidelines For Base Hospital Contact	12/1/2014	10/1/1984	9/11/2014	9/11/2014	9/1/2016
705	00 - General Patient Guidelines	12/1/2014	8/1/2010	10/9/2014	10/9/2014	10/1/2016
705	01 - Trauma Treatment Guidelines	6/1/2013	8/1/2010	4/11/2013	4/11/2013	3/31/2015
705	02 - Allergig/Adverse Reaction and Anaphylaxis	6/1/2015	8/1/2010	5/14/2015	5/14/2015	5/31/2017
705	03 - Altered Neurologic Function	6/1/2013		4/22/2013	4/11/2013	3/31/2015
705	04 - Behavioral Emergencies	8/1/2013		7/11/2013	7/11/2013	7/1/2015
705	05 - Bites and Stings	12/1/2010	8/1/2010	8/1/2010	3/12/2015	3/12/2017
705	06 - Burns	12/1/2014		10/9/2014	10/9/2014	10/1/2016
705	07 - Cardiac Arrest - Asystole/Pulseless/PEA	6/1/2015	8/1/2010	3/12/2015	3/12/2015	3/31/2017
705	08 - Cardiac Arrest - VF/VT	6/1/2015	8/1/2010	1/8/2015	1/8/2015	1/31/2017
705	09 - Chest Pain - Acute Coronary Syndrome	12/1/2014	8/1/2010	9/11/2014	9/11/2014	9/1/2016
705	10 - Childbirth	12/1/2013		10/30/2013	10/10/2013	10/1/2015
705	11 - Crush Injury/Syndrome	6/1/2015		3/12/2015	3/12/2015	3/31/2017
705	12 - Heat Emergencies	12/1/2014		10/9/2014	10/9/2014	10/1/2016
705	13 - Hypothermia	12/1/2012		8/9/2012	1/8/2015	1/31/2017
705	14 - Hypovolemic Schock	6/1/2013		4/11/2013	4/11/2013	3/31/2015
705	15 - Nausea/Vomiting	12/1/2013	8/1/2010	10/10/2013	10/10/2013	12/1/2015
705	16 - Neonatal Resuscitation	6/1/2011	8/1/2010	4/14/2011	5/14/2015	5/31/2017
705	17 - Nerve Agent Poisoning	6/1/2014		5/8/2014	5/8/2014	4/30/2014
705	18 - Overdose/Poisoning	12/1/2014		10/9/2014	10/9/2014	10/1/2016
705	19 - Pain Control	6/1/2015		5/14/2015	5/14/2015	5/31/2017
705	20 - Seizures	12/1/2013		10/10/2013	10/10/2013	10/1/2015
705	21 - Shortness of Breath - Pulmonary Edema	12/1/2010	8/1/2010	7/1/2013	9/11/2014	9/1/2016
705	22 - Shortness of Breath - Wheezes/Other	12/1/2010	8/1/2010	8/1/2010	1/8/2015	1/31/2017
705	23 - Supraventricular Tachycardia	12/1/2012		8/9/2012	9/11/2014	9/1/2016
705	24 - Symptomatic Bradycardia	6/1/2015		5/14/2015	5/14/2015	5/31/2017
705	25 - Ventricular Tachycardia, Sustained Not In Arrest	6/1/2013		4/11/2013	2/14/2013	1/31/2015
705	26 - Suspected Stroke	12/1/2014	12/1/2012	10/9/2014	10/9/2014	10/1/2016

100	Emergency Medical Service, Local Agency (9/13/84)	6/15/1998	7/1/1980	10/1/2003	12/13/2012	11/30/2014
705	27- Sepsis Alert	12/1/2012	12/1/2012		10/10/2013	10/1/2015
708	Patient Transfer From One Prehospital Team To Another	6/1/2009	10/31/1992	12/11/2008	12/11/2008	6/30/2011
710	Airway Management	12/1/2014	6/1/1986	10/30/2014	10/14/2014	10/1/2016
715	Needle Thoracostomy	6/1/2013	11/1/1990	4/4/2013	2/14/2013	1/31/2015
716	Use of Pre-existing Vascular Access Devices	12/1/2011	3/2/1992	8/11/2011	8/11/2011	12/1/2013
717	Intraosseous Infusion	12/1/2014	9/10/1992	10/9/2014	10/9/2014	10/1/2016
720	Guidelines For Limited Base Hospital Contact	6/1/2013	6/15/1998	4/9/2013	2/14/2013	1/31/2015
722	Interfacility Transport of Patient with Patient with IV Heparin	6/1/2014	6/15/1998	5/8/2014	5/8/2014	5/31/2017
723	Continuous Positive Airway Pressure (CPAP)	12/1/2011	12/1/2004	9/13/2007	9/12/2013	9/1/2015
724	Apparent Life-Threatening Event (ALTE)	6/1/2013	3/1/2005	4/5/2013	2/14/2013	1/31/2015
725	Patients After TASER Use	12/1/2011	8/10/2006	8/13/2011	10/9/2014	10/1/2016
726	12-Lead ECG	12/1/2014	8/10/2006	10/9/2014	10/9/2014	10/1/2016
727	Transcutaneous Cardiac Pacing	12/1/2008	12/1/2008	12/11/2008	10/10/2013	10/1/2015
728	King Airway	6/1/2013	4/10/2008	4/5/2013	4/11/2013	3/31/2015
729	air-Q	12/1/2014	10/30/2014			10/1/2015
731	Tourniquet Use	12/1/2010	8/10/2010	8/10/2010	8/9/2012	8/31/2014
732	Use of Restraint	12/1/2011	4/1/2011	6/9/2011	9/11/2014	9/1/2016
VIII.	**Emergency Medical Technician - Defibrillation Policies**					
802	Emergency Medical Technician-I Defibrillation (EMT-ID) Medical Director	11/30/2002	11/1/1988	6/30/2002	4/14/2011	4/30/2014
803	EMT Automatic External Defibrillation (AED) Service Provider Program Standards	6/1/2006	11/1/1998	3/1/2006	4/14/2011	4/30/2014
IX.	**Emergency Medical Services Communications**					
905	Ambulance Provider Response Units: Required Frequencies	6/1/2014	7/1/1999	5/8/2014	5/8/2014	6/30/2017
910	Emergency Medical Dispatch System Guidelines	12/1/2005	10/31/1994	9/8/2005		5/31/2007
920	ReddiNet Policy	12/1/2013	4/26/2007	9/12/2013	9/12/2013	9/1/2016
X.	**Documentation**					
1000	Documentation of Prehospital Care	6/1/2015	6/15/1998	3/12/2015	3/12/2015	3/31/2017
1001	EMT-P/BH Communication Record	12/1/2007	7/6/2007	7/9/2007	9/11/2014	9/1/2017
XI.	**Education**					
1100	Emergency Medical Technician-1 Program Approval	6/1/2013	2/28/2001	4/19/2013	4/19/2013	3/31/2013
1105	MICN Developmental Course and Exam	12/1/2014	7/2/1984	9/11/2014	9/11/2014	9/1/2017
1108	National Registry Transition Course Approval					
1130	Advanced Life Support Continuing Educations Lectures	12/1/2011	2/28/2001	10/13/2011	10/13/2011	12/31/2014
1131	Field Care Audit	6/1/2012	8/1/1984	2/9/2012	2/9/2012	2/28/2015
1132	Continuing Education: Attendance Roster	6/9/2011	6/1/1993	6/9/2011	9/11/2014	9/1/2017
1135	Paramedic Training Program Approval	6/1/2013	10/20/1993	4/19/2013	4/19/2013	3/31/2015
1140	Emergency Medical Dispatcher Training Guidelines	5/1/2003	10/1/1991	1/31/2003		1/31/2005
XII.	**Search and Rescue**					

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMS Update Procedure		Policy Number 351
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 12/01/09
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: 12/01/09
Origination Date: Date Revised: Last Reviewed: Review Date:	February 9, 2005 September 10, 2009 May 14, 2015 May 31, 2018	Effective Date: December 1, 2009

I PURPOSE: To establish a standard for the method, design, approval, and delivery of information to EMS personnel on new and amended policies as well as general EMS information.

II AUTHORITY: Ventura County Emergency Medical Services Agency (VC EMS Agency).

III POLICY: VC EMS Agency will develop a method by which all EMS providers will be notified of changes or amendments in County EMS policies as well as general EMS information.

V PROCEDURE:

A. EMS Update will be presented in May and November of each year.

1. Dates, times and locations for EMS Update will be determined by the base hospital PCCs and submitted to VC EMS Agency and providers no later than 30 days prior to the presentation of the first EMS Update.
2. Each base station shall offer a minimum of three EMS Updates in May and in November.

B. EMS Update will consist of the following:

1. All new and revised policies approved by the Prehospital Services Committee since the last EMS Update.
2. Pertinent “information” items discussed at PSC not included in policy updates.
3. Information submitted to the PCCs by the VC EMS Agency

C. EMS Update training materials will be designed by the EMS Update Design Team.

1. Dates and times of the EMS Update design meetings will be determined on an “as needed” basis by the EMS Update Design Team.
2. Membership of the EMS Design Team will include all PCC’s, a representative from the EMS Agency, and a BLS and ALS representative.
3. The training package will include the following materials:
    a. Power Point Presentation
    b. Instructional objectives
    c. Course outline
    d. Lesson plan
    e. Method of evaluation (written and/or skills competency based valuation tool).
    f. Make up exam.
4. The review, editing, and final approval of the EMS Update will be done by the VC EMS Staff.

D. Copies of the final EMS Update will be delivered via email by the VC EMS Agency to the EMS Update training providers prior to the first presentation.

E. BLS provider Agencies will receive a copy by e-mail to adapt materials for EMT-1 providers.

F. Changes to EMS Update following approval of final draft.
1. Errors or omissions discovered following release of the final draft by VC EMS will be reported to VC EMS Agency CQI Coordinator who will be responsible for notifying all EMS training providers of the corrected information.

G. EMS Update Make-Up Session will be held two weeks after the last Update presentation. The Make-Up Session will be held on a date, time and location established by VC EMS Agency.
1. The Power Point training package will used by VC EMS Agency
2. A written post-test, developed by the EMS Update Design Team, will be administered by the VC EMS Agency.
3. A minimum passing score of 85% must be achieved for successful course completion.
4. VC EMS Agency staff will present the Make-Up Session.

H. Course completion records will include the following:
1. Student course evaluation to be retained by training organization.

2. A copy of the continuing education roster shall be submitted to the VC EMS Agency immediately after the completion of each course offered.
3. Documentation of successful course completion for participants.

COUNTY OF VENTURA HEALTH CARE AGENCY	POLICIES AND PROCEDURES EMERGENCY MEDICAL SERVICES
Policy Title: Ventura County Emergency Departments	Policy Number: 400
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: December 1, 2008
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: December 1, 2008
Origination Date: October, 1984 Date Revised: August 10, 2006 Date Last Reviewed: May 14, 2015 Next Review Date: May 31, 2018	Effective Date: December 1, 2008

Base Hospitals

Los Robles Hospital Medical Center
215 W. Janss Road
Thousand Oaks, CA 91360
(805) 370-4435

St. John's Regional Medical Center
1600 N. Rose Ave.
Oxnard, CA 93030
(805) 988-2663

Simi Valley Hospital
2975 N. Sycamore Dr
Simi Valley, CA 93065
(805) 955-6100

Ventura County Medical Center
3291 Loma Vista Road
Ventura, CA 93003
(805) 652-6165

Receiving Hospitals

Community Memorial Hospital
147 No. Brent
Ventura, CA 93003
(805) 652-5018

Ojai Valley Community Hospital
1306 Maricopa Highway
Ojai, CA 93023
(805) 640-2260

St. John’s Pleasant Valley Hospital
2309 Antonio Avenue
Camarillo, CA 93010
(805) 389-5811

VCMC/Santa Paula Hospital
825 N. 10th Street
Santa Paula, CA 93060
(805) 933-8663

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Advanced Life Support Service Provider Approval Process		Policy Number 502
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 06/01/2008
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: 06/01/2008
Origination Date: Date Revised: Date Last Reviewed: Review Date:	May 1984 January 10, 2008 March 12, 2015 March 31, 2018	Effective Date: June 1, 2008

I. PURPOSE: To define criteria by which an agency may be designated as an Advanced Life Support (ALS) Service Provider (SP) in Ventura County.

II. POLICY: An agency wishing to become an ALS SP in Ventura County must meet Ventura County ALS SP Criteria and agree to comply with Ventura County regulations. An initial six-month review of all ALS activity will take place and subsequent program review will occur per Ventura County Emergency Medical Services (VC EMS) policies and procedures.

III. PROCEDURE:

A. Request for ALS SP Program Approval

The agency shall submit a written request for ALS SP approval to Ventura County Emergency Medical Services (VC EMS), documenting the compliance of the company/agency with the Ventura County EMS Policy 501 or 508.

B. Program Approval or Disapproval:

Program approval or disapproval shall be made in writing by VC EMS to the agency requesting ALS SP designation within a reasonable period of time after receipt of the request for approval and all required documentation. This time period shall not exceed three (3) months.

VC EMS shall establish the effective date of program approval upon the satisfactory documentation of compliance with all the program requirements. All contracts or memorandum of understanding must be approved by the County Board of Supervisors prior to implementation.

C. Initial Program Evaluation

Review of all ALS activity for the initial 6 months of operation as an Advanced Life Support Ambulance Provider shall be done in accordance with VC EMS policies and procedures.

D. Program Review

Program review will take place at least every two years according to policies and procedures established by VC EMS.

E. ALS SP Program Changes

An approved ALS Service Provider shall notify VC EMS by telephone, followed by letter within 48 hours, of program or performance level changes.

F. Withdrawal, Suspension or Revocation of Program Approval

Non-compliance with any criterion associated with program approval, use of non-licensed or accredited personnel, or non-compliance with any other Ventura County regulation or policy applicable to an ALS SP may result in withdrawal, suspension or revocation of program approval by VC EMS.

G. Appeal of Withdrawal, Suspension or Revocation of Program Approval

An ALS SP whose program approval has been withdrawn, suspended, or revoked may appeal that decision in accordance with the process outlined in the Ventura County Ordinance Code,

ADVANCED LIFE SUPPORT SERVICE PROVIDER APPROVAL PROCESS
CRITERIA COMPLIANCE STATEMENT

APPLICANT:	DATE:

The above named agency agrees to observe the following criteria as a condition of approval as an Advanced Life Support Provider in the Ventura County EMS system.

	YES	NO
1. Provide ALS service on a continuous 24-hour per day basis.		
2. Provide appropriate transportation for ALS patients.		
3. Provide for electronic communication between the EMT-Ps and the BH, complying with VC Communications Department requirements.		
4. Provide and maintain ALS drugs, solutions and supplies per VC EMS policies and procedures.		
5. Assure that all personnel meet certification/accreditation and or training standards in VCEMS policies.		
6. Cooperate with data collection, QA and CQI programs.		
7. Provide BLS service when ALS in not indicated.		
8. Charge for ALS services only when rendered.		
9. Submit patient care and other documentation per VC EMS policies and procedures.		
10. Comply with all VC EMS policies and procedures.		

If any statements are checked as “NO”, supply information stating the rationale for each “NO” answer. The information will be considered, but submission does not assure approval of the program.

Signature: _____

Title: _____

Date: _____

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Spinal Immobilization		Policy Number 614
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 11, 2008
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: December 11, 2008
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 1992 December 11, 2008 May 14, 2015 May 31, 2017	Effective Date: December 11, 2008

I. PURPOSE: To define the use of spinal immobilization by field personnel in Ventura County.

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

II. POLICY: Field personnel in Ventura County may apply spinal immobilization devices under the following circumstances.

III. PROCEDURE: Patients who meet any of the criteria listed in Section A will be carefully evaluated according to criteria in Section B. Spinal immobilization will only be done on patients who meet the criteria of *both* Section A *and* Section B.

A. Patients who meet at least one of the following criteria will require further evaluation as listed in Section B to determine whether spinal immobilization is required. Patients who do *not* meet any of these criteria do *not* require spinal immobilization:

1. Any patient with head or neck trauma who complains of neck or back pain, or weakness, numbness or radiating pain in a trauma setting.
2. Any patient with altered level of consciousness, neurological deficit, or alcohol or drug intoxication to the extent that appreciation of pain is altered, or suffering from severe distracting painful injuries for whom the mechanism of injury is unknown or suspicious for spinal injury.

B. Spinal immobilization will be done on patients who meet criteria listed in Section A above if they have at least one of the following:

1. Neck or spinal pain,
2. Spinal tenderness,
3. A painful distracting injury (e.g., long bone fracture),
4. Neurological deficit, OR
5. Inability to communicate effectively.

The awake, alert patient, not under the influence of alcohol or drugs to the extent that appreciation of pain is altered, with whom you can communicate effectively, who

denies spine pain or tenderness, is neurologically intact, does not have a distracting injury, does NOT require spinal immobilization.

C. Cervical immobilization is not necessary in the awake, alert patient, not under the influence of alcohol or drugs to the extent that appreciation of pain is altered, with whom you can communicate effectively who complains of isolated lumbar pain or tenderness but denies cervical pain or tenderness and does not have weakness or numbness in a trauma setting. Long board immobilization without cervical immobilization is adequate for this type of patient.

D. In patients with penetrating torso or neck injury and unstable vital signs, transportation must be expedited. For potential spinal injury, the patient should be placed on a backboard. The head should be taped if a cervical spine injury is suspected.

VI. Special Procedure for Care of Potentially Spine-Injured Football Athlete

A. The facemask should always be removed prior to transportation, regardless of current respiratory status.

1. Tools for facemask removal include screwdriver, FM Extractor, Anvil Pruners, or ratcheting PVC pipe cutter should be readily accessible.
2. All loop straps of the facemask should be cut and the facemask removed from the helmet, rather than being retracted.

B. The helmet should not be removed during the prehospital care of the football athlete with a potential spinal injury, unless:

1. After a reasonable period of time, the face mask cannot be removed to gain access to the airway,
2. The design of the helmet and chin strap is such that even after removal of the face mask, the airway cannot be controlled or ventilation provided,
3. The helmet and chin straps do not hold the head securely such that immobilization of the helmet does not also immobilize the head, or
4. The helmet prevents immobilization for transport in an appropriate position.

C. If the helmet must be removed, spinal immobilization must be maintained while removing.

1. In most circumstances, it may be helpful to remove cheek padding and/or deflate the air padding prior to helmet removal.
2. If the helmet is removed, the shoulder pads must be removed at the same time.

D. If needed, the front of the shoulder pads can be opened to allow access for CPR and defibrillation. They should only be removed if the helmet is removed at the same time.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Safely Surrendered Babies		Policy Number: 619
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 06/01/2008
APPROVED: Medical Director:	Angelo Salvucci, MD	Date: 06/01/2008
Origination Date: Revised Date: Last Reviewed: Review Date:	February 2003 November 8, 2007 May 14, 2015 May 31, 2018	Effective Date: June 1, 2008

I. PURPOSE: This policy outlines the procedures whereby prehospital care providers accept a newborn under the California Safe Haven Law. This law as amended allows a person to surrender a minor child, less than 72 hours old to a person at any *designated* fire station, or emergency room without fear of arrest or prosecution, provided that the infant has not been abused or neglected. According to the law, "no person or entity that accepts a surrendered child shall be subject to civil, criminal, or administrative liability for accepting the child and caring for the child in the good faith belief that action is required or authorized by the bill, including but not limited to instances where the child is older than 72 hours or the person surrendering the child did not have lawful physical custody of the child".

II. AUTHORITY: 1797.220, 1798 Health & Safety Code; CCR Division 9 Chapter 4, 100175; Senate Bill 1368, Chapter 824, and Statutes of 2000; and Ventura County Board of Supervisor Resolution dated May 6, 2003.

III. POLICY: Emergency Medical Services (EMS) personnel shall follow the procedures outlined in this document to ensure the surrendered infant is protected and medically cared for until delivered to the closest hospital emergency department.

IV. PROCEDURE:

A. When an infant is surrendered to a fire station, the personnel shall notify their dispatch center of the situation.

B. The dispatch center will dispatch the closest paramedic transport unit.

C. Fire station personnel will assess the newborn and treat as needed.

D. Initiate first responder form.

E. Open the Newborn Safe Surrender Kit, (available at the fire station).

F. Place a confidential coded bracelet on the infant's ankle and wrist. (Record this number on the first responder form)

G. Provide the surrendering party the inner business reply mail envelope. This contains the Safe Haven medical questionnaire (English and Spanish version), an information sheet and a matching coded, confidential bracelet. Advise the surrendering party that provided that there has been no abuse or neglect, the parent may reclaim the infant within **14 days**, by taking the bracelet back to the hospital. Hospital personnel will provide information about the baby.

H. Upon arrival of the transport paramedic unit, the fire station personnel will provide a copy of the written report and a verbal report of the infants' care and status.

I. If the infant appears to be greater than 72 hours old, abused or neglected, accept the infant and provide medical treatment as necessary.

J. The paramedic transport unit will initiate base station contact and begin transport to the closest appropriate hospital emergency department.

K. The paramedic transport unit will initiate care and treat the infant as needed.

L. The paramedic transport unit will complete a PCR via approved Ventura County Documentation System and will record the confidential coded ankle bracelet number.

M. Upon arrival at the receiving emergency department, the transporting paramedic will provide a verbal and written report.

N. Receiving hospital personnel will make verbal and written notification to the Ventura County HSA Department of Children and Family Services (DCFS).

Allergic/Adverse Reaction and Anaphylaxis

BLS Procedures

ADULT

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

PEDIATRIC

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

ALS Prior to Base Hospital Contact

ADULT

Allergic Reaction or Dystonic Reaction
- **Benadryl**
  - IV/IM – 50 mg

If Wheezing is present
- **Albuterol**
  - Nebulizer – 5 mg/6 mL
    - Repeat as needed

Anaphylaxis without Shock
- **Epinephrine 1:1,000**
  - IM –
    - Less than 40 years old – 0.5 mg
    - 40 years old and greater – 0.3 mg
      - Only if severe respiratory distress is present
- IV access
- **Benadryl**
  - IV/IM – 50 mg

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

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

PEDIATRIC

Allergic Reaction or Dystonic Reaction
- **Benadryl**
  - IV/IM – 1 mg/kg
    - Max 50 mg

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

Anaphylaxis without Shock
- **Epinephrine 1:1,000**
  - IM – 0.01 mg/kg
    - Max 0.3 mg
- IV access
- **Benadryl**
  - IV/IM – 1 mg/kg
    - Max 50 mg

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

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

Communication Failure Protocol

ADULT

Anaphylaxis without Shock
- *Repeat* **Epinephrine 1:1,000**
  - IM – 0.3 mg q 5 min x 2 as needed

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

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

PEDIATRIC

Anaphylaxis without Shock
- *Repeat* **Epinephrine 1:1,000**
  - IM – 0.01 mg/kg q 5 min x 2 as needed

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

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

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Consult with ED Physician for further treatment measures

Effective Date: June 1, 2015
Next Review Date: May 31, 2017
Date Revised: May 14, 2015
Last Reviewed: May 14, 2015

VCEMS Medical Director

Bites and Stings

BLS Procedures

Animal/insect bites:

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

Snake bites/envenomations:

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

Bee stings:

- If present, remove stinger
- Apply ice pack

Jellyfish stings:

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

All other marine animal stings:

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

Administer oxygen as indicated

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

ALS Prior to Base Hospital Contact

IV access for snake bites

Monitor for allergic reaction or anaphylaxis

Morphine – per Policy 705 - Pain Control

Base Hospital Orders only

Consult with ED Physician for further treatment measure

Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA)

ADULT	PEDIATRIC
BLS Procedures	
Initiate Cardiac Arrest Management (CAM) Protocol Airway management per VCEMS policy	
ALS Prior to Base Hospital Contact	
Assess/treat causes IV/IO access • PRESTO Blood Draw **Epinephrine** • IV/IO – **1:10,000**: 1 mg (10 mL) q 3-5 min If suspected hypovolemia: • **Normal Saline** o IV/IO bolus – 1 Liter ALS Airway Management • If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures	Assess/treat causes IV/IO access • PRESTO Blood Draw **Epinephrine 1:10,000** • IV/IO – 0.01mg/kg (0.1 mL/kg) q 3-5 min If suspected hypovolemia: • **Normal Saline** o IV/IO bolus – 20 mL/kg • Repeat x 2 ALS Airway Management • If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures Make early Base Hospital contact for all pediatric cardiac arrests
Base Hospital Orders only	
Tricyclic Antidepressant Overdose • **Sodium Bicarbonate** • IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min Beta Blocker Overdose • **Glucagon** o IV/IO – 2 mg • May give up to 10mg if available Calcium Channel Blocker Overdose • **Calcium Chloride** o IV/IO – 1 g • Repeat x 1 in 10 min • **Glucagon** o IV/IO – 2 mg • May give up to 10mg if available 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 0.5 mEq/kg q 5 min x2	Tricyclic Antidepressant Overdose • **Sodium Bicarbonate** • IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min Beta Blocker Overdose • **Glucagon** • IV/IO – 0.1 mg/kg • May give up to 10mg if available Calcium Channel Blocker Overdose • **Calcium Chloride** • IV/IO – 20 mg/kg • Repeat x 1 in 10 min • **Glucagon** • IV/IO – 0.1 mg/kg • May give up to 10mg if available History of Renal Failure/Dialysis • **Calcium Chloride** • IV/IO – 20 mg/kg • Repeat x 1 in 10 min • **Sodium Bicarbonate** • IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min x2
Consult with ED Physician for further treatment measures	**Consult with ED Physician for further treatment measures**

Additional Information :

- If sustained ROSC (> 30 seconds), perform 12-lead EKG. Transport to SRC.
- If suspected hypovolemia, initiate immediate transport
- In cases of normothermic cardiac arrest patients 18 years and older with unwitnessed cardiac arrest, adequate ventilations, vascular access, and persistent asystole or PEA despite 20 minutes of standard advanced cardiac life support, the base hospital should consider termination of resuscitation in the field. If transported, the patient may be transported Code 2. If unable to contact the base hospital, resuscitative efforts may be discontinued and patient determined to be dead.
- If patient is **hypothermic** – only ONE round of medication administration prior to Base Hospital contact. Field determination of death is discouraged in these patients and they should be transported to the most accessible receiving facility.

Cardiac Arrest – VF/VT

ADULT	PEDIATRIC
BLS Procedures	
Initiate Cardiac Arrest Management (CAM) Protocol Airway management per VCEMS policy	
ALS Prior to Base Hospital Contact	
Defibrillate • Use the biphasic energy settings that have been approved by service provider medical director • Repeat every 2 minutes as indicated **IV or IO access** • PRESTO Blood Draw **Epinephrine** • IV/IO – 1:10,000: 1 mg (10 mL) q 3-5 min **Amiodarone** • IV/IO – 300 mg – after second defibrillation • If VT/VF persists, 150 mg IV/IO in 3-5 minutes **ALS Airway Management** • If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures If VF/VT stops, then recurs, perform defibrillation at the last successful biphasic energy setting	**Defibrillate** – 2 Joules/kg • If patient still in VF/VT at rhythm check, increase to 4 Joules/kg • Repeat every 2 minutes as indicated **IV or IO access** • PRESTO Blood Draw **Epinephrine** 1:10,000 • IV/IO – 0.01mg/kg (0.1 mL/kg) q 3-5 min **Amiodarone** • IV/IO – 5 mg/kg – after second defibrillation • If VT/VF-persists, 2.5 mg/kg IV/IO in 3-5 minutes **ALS Airway Management** • If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures If VF/VT stops, then recurs, perform defibrillation at the last successful biphasic energy setting
Base Hospital Orders only	
Tricyclic Antidepressants • Sodium Bicarbonate o IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min Torsades de Pointes • Magnesium Sulfate o IV/IO – 2 gm over 2 min • May repeat x 1 in 5 min	Tricyclic Antidepressants • Sodium Bicarbonate o IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min
Consult with ED Physician for further treatment measures <u>ED Physician Order Only</u> 1. If patient converts to narrow complex rhythm greater than 50 bpm and not in 2nd or 3rd degree heart block, and amiodarone not already given, consider amiodarone 150 mg IVPB 2. History of Renal Failure/Dialysis • **Calcium Chloride** o IV/IO – 1g o Repeat x 1 in 10 min • **Sodium Bicarbonate** o IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min	Consult with ED Physician for further treatment measures <u>ED Physician Order Only</u> 1. If patient converts to narrow complex rhythm greater than 50 bpm and not in 2nd or 3rd degree heart block, and amiodarone not already given, consider amiodarone 2.5 mg/kg IVPB 2. History of Renal Failure/Dialysis • **Calcium Chloride** o IV/IO – 20 mg/kg over 1 min • Repeat x 1 in 10 min • **Sodium Bicarbonate** • IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min
Additional Information: • If sustained ROSC (>30 seconds), perform 12-lead EKG. Transport to SRC • If patient is <u>hypothermic</u>–only ONE round of medication administration and limit *defibrillation to 6 times* prior to Base Hospital contact. Field determination of death is discouraged in these patients and they should be transported to the most accessible receiving facility • Ventricular tachycardia (VT) is a rate > 150 bpm	

Effective Date: June 1, 2015
Next Review Date: Jan 31, 2017

Date Revised: Jan 8, 2015
Last Reviewed: Jan 8, 2015

VCEMS Medical Director

Crush Injury/Syndrome

BLS Procedures

Perform spinal precautions as indicated
Determine Potential vs. Actual Crush Syndrome
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Potential for Crush Syndrome

- IV access
- Maintain body heat
- Release compression
- Monitor for cardiac dysrhythmias

Communication Failure Protocol

ADULT

Crush Syndrome

- Initiate 2nd IV access
- **Normal Saline**
  - IV bolus – 1 Liter
    - Caution with cardiac and/or renal history
- **Sodium Bicarbonate**
  - IV mix – 1 mEq/kg
    - Added to 1st Liter of Normal Saline
- **Albuterol**
  - Nebulizer – 5 mg/6 mL
    - Repeat x 2
- **Morphine** – Per Policy 705 - Pain Control
- Maintain body heat
- Release compression
- Monitor for cardiac dysrhythmias
- For cardiac dysrhythmias:
  - **Calcium Chloride**
    - IV – 1 g over 1 min

For continued shock

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

PEDIATRIC

Crush Syndrome

- Initiate 2nd IV access if possible or establish IO
- **Normal Saline**
  - IV/IO bolus – 20 mL/kg
    - Caution with cardiac and/or renal history
- **Sodium Bicarbonate**
  - IV mix– 1 mEq/kg
    - Added to 1st Liter of Normal Saline
- **Albuterol**
  - Less than 2 years old
    - Nebulizer – 2.5 mg/3 mL
      - Repeat x 2
  - 2 years old and greater
    - Nebulizer – 5 mg/6 mL
      - Repeat x 2
- Maintain body heat
- Release compression
- Monitor for cardiac dysrhythmias
- For cardiac dysrhythmias:
  - **Calcium Chloride**
    - IV/IO – 20 mg/kg over 1 min

For continued shock

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

Base Hospital Orders only

ADULT

For persistent hypotension after fluid bolus:

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

Consult with ED Physician for further treatment measures

PEDIATRIC

For persistent hypotension after fluid bolus:

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

Consult with ED Physician for further treatment measures

Additional Information:

- Potential Crush Syndrome – Continuous crush injury to torso or extremity above wrist or ankle for 2 hours or less.
- Crush Syndrome – Continuous crush injury to torso or extremity above wrist or ankle for greater than 2 hours.
- If elderly or cardiac history is present, use caution with fluid administration. Reassess and treat accordingly.
- Dysrhythmias are usually secondary to Hyperkalemia. ECG monitor may show: Peaked T-waves, Absent P-waves, widened QRS complexes, bradycardia
- Calcium Chloride and Sodium Bicarbonate precipitate when mixed. Strongly consider starting a second IV (if feasible) for administration of Calcium Chloride

Effective Date: June 1, 2015
Next Review Date: March 31, 2017
Date Revised: March 12, 2015
Last Reviewed: March 12, 2015

VCEMS Medical Director

Hypothermia

BLS Procedures

Gently move patient to warm environment and begin passive warming

Increase ambulance cabin heat, if applicable

Remove 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 Prior to Base Hospital Contact

IV access (if needed for medication or fluid administration)

- If administering fluid, avoid administering cold fluids.

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Neonatal Resuscitation

BLS Procedures

Newly Born Infant

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

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

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

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

Infant up to 48 hours old

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

Provide warm/dry covering
Continue to assess

Assess Breathing
- If crying or breathing, assess circulation
- If apneic or gasping
  - Positive pressure ventilations (PPV) with BVM and ROOM AIR at 40-60 breaths per minute for 30 seconds
    - Continue PPV, reassessing every 30 seconds, until infant is breathing adequately
  - Reassess breathing, assess circulation

Assess Circulation
- If HR between 60 and 100 bpm
  - PPV with BVM and ROOM AIR at 40-60 breaths per minute for 30 seconds
    - Continue PPV, reassessing every 30 seconds, until infant maintains HR >100 bpm
- If HR < 60 bpm
  - CPR at 3:1 ratio for 30 seconds
    - 90/min compressions
    - 30/min ventilations
    - Continue CPR, reassessing every 30 seconds, until HR > 60 bpm
  - If no improvement after 90 seconds of ROOM AIR CPR, add supplemental O_2 until HR > 100

ALS Prior to Base Hospital Contact

Establish IO line only in presence of CPR

Asystole OR Persistent Bradycardia < 60 bpm

- **Epinephrine 1:10,000**
  - IO – 0.01mg/kg (0.1mL/kg) q 3-5 min

PEA

- **Epinephrine 1:10,000**
  - IO – 0.01mg/kg (0.1mL/kg) q 3-5 min
- **Normal Saline**
  - IO bolus – 10mL/kg

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:
- Resuscitation efforts may be withheld for extremely preterm infants (< 21 weeks or < 9 inches long). Sensitivity to the desires of the parent(s) may be considered. If uncertain as to gestational age, begin resuscitation.

Effective Date: June 1, 2011
Next Review Date: May 31, 2017
Date Revised: April 14, 2011
Last Reviewed: May 14, 2015

VCEMS Medical Director

Pain Control

ADULT	PEDIATRIC
BLS Procedures	
Place patient in position of comfort Administer oxygen as indicated	
ALS Prior to Base Hospital Contact	
IV/IO access Cardiac Monitor **Ondansetron** • IV/IM/ODT – 4 mg **Morphine – Pain 5 out of 10 or greater** **Initial IV Dose** • Slow IVP - 0.1 mg/kg over 2 minutes[1] • Maximum for **ANY** IV dose is 10 mg • **65 years of age or older** o **IV 0.05 mg/kg MAX dose 5 mg** **Initial IM Dose** • IM - 0.1 mg/kg[1] • Maximum for **ANY** IM dose is 10 mg • **65 years of age or older** o **IM 0.05 mg/kg MAX dose 5 mg** **Second IV/IM Dose, if pain persists** 5 minutes after IV morphine, or 15 minutes after IM morphine • Administer half of the initial morphine dose **Third IV/IM Dose, if pain persists** 5 minutes after 2nd IV morphine, or 15 minutes after 2nd IM morphine • **Ondansetron** (only if third dose of morphine needed) • IV/IM/ODT – 4 mg • Administer half of the initial morphine dose Check and document vital signs before and after each administration • Hold if SBP < 100 mmHg *If patient has significant injury to head, chest, abdomen or is hypotensive, **DO NOT** administer pain control unless ordered by ED Physician*	IV/IO access Cardiac Monitor **Ondansetron:** Patient 4 years of age or older • IV/IM/ODT – 4 mg **Morphine – Pain 5 out of 10 or greater** **Morphine** – given for burns and isolated extremity injuries only. Consider early base contact for other pediatric complaints of pain (e.g. dog bite, cancer) **Initial IV Dose** • Slow IVP - 0.1 mg/kg over 2 minutes[1] • Maximum for **ANY** IV dose is 10 mg **Initial IM Dose** • IM - 0.1 mg/kg[1] • Maximum for **ANY** IM dose is 10 mg **Second IV/IM Dose, if pain persists** 5 minutes after IV morphine, or 15 minutes after IM morphine • Administer half of the initial morphine dose **Third IV/IM Dose, if pain persists** 5 minutes after 2nd IV morphine, or 15 minutes after 2nd IM morphine • **Ondansetron** (only if third dose of morphine needed) • IV/IM/ODT – 4 mg • Administer half of the initial morphine dose Check and document vital signs before and after each administration • Hold if SBP < 100 mmHg *If patient has significant injury to head, chest, abdomen or is hypotensive, **DO NOT** administer pain control unless ordered by ED Physician*
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	

Additional Information

1. **Special considerations, administer 0.05 mg/kg**
   - Chest pain not resolved by nitroglycerine (NTG)
   - Patient with history of adverse reaction to morphine
   - Symptomatic bradycardia for patients receiving transcutaneous pacing.

Effective Date: June 1, 2015
Next Review Date: May 31, 2017

Date Revised: May 14, 2015
Last Reviewed: May 14, 2015

VCEMS Medical Director

Shortness of Breath – Wheezes/Other

ADULT

BLS Procedures

Assist patient with prescribed Metered Dose Inhaler if available
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Perform Needle Thoracostomy if indicated per Policy 715

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

Severe Distress
- Treatment for moderate distress
- Less than 40 years old
  - **Epinephrine 1:1,000**
    - IM – 0.3 mg

Consider CPAP for both moderate and severe distress

IV access

Communication Failure Protocol

Severe Distress
- Less than 40 years old
  - If no change is apparent 10 minutes after first Epinephrine administration:
    - *Repeat* **Epinephrine 1:1,000**
      - IM – 0.3 mg
- 40 years old and greater
  - **Epinephrine 1:1,000**
    - IM – 0.3 mg
      - Only if apparent asthma
      - Only if age less than 60 years old
      - Only if no improvement with initial therapies

Base Hospital Orders only

Consult with ED Physician for further treatment measures

PEDIATRIC

BLS Procedures

Assist patient with prescribed Metered Dose Inhaler if available
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Perform Needle Thoracostomy if indicated per Policy 715

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

Severe Distress
- Treatment for moderate distress
- **Epinephrine 1:1,000**
  - IM – 0.01 mg//kg
    - Max 0.3 mg

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

Consider CPAP if age 8 years old and greater

IV access

Communication Failure Protocol

Severe Distress
- If no change is apparent 10 minutes after first Epinephrine administration
  - *Repeat* **Epinephrine 1:1,000**
    - IM – 0.01 mg/kg
      - Max 0.3 mg

Base Hospital Orders only

Suspected Croup and no improvement with Normal Saline nebulizer
- Less than 2 years old
  - **Epinephrine 1:1,000**
    - Nebulizer/Aerosolized Mask – 2.5 mL
- 2 years old and greater
  - **Epinephrine 1:1,000**
    - Nebulizer/Aerosolized Mask – 5 mL

Consult with ED Physician for further treatment measures

Additional Information:
- High flow O_2 is indicated for severe respiratory distress, even with a history of COPD
- COPD patients have a higher susceptibility to spontaneous pneumothorax due to disease process
- If suspected Arterial Gas Embolus/Decompression Sickness secondary to SCUBA emergencies, transport patient in supine position on 15L/min O_2 via mask. Early BH contact is recommended to determine most appropriate transport destination.

Effective Date: December 1, 2010
Next Review Date: Jan 31, 2017

Date Revised: August, 2010
Last Reviewed: Jan 8, 2015

VCEMS Medical Director

Symptomatic Bradycardia

ADULT (HR < 45 bpm)	PEDIATRIC (HR < 60 bpm)
BLS Procedures	
Administer oxygen as indicated Supine position as tolerated	Administer oxygen as indicated Assist ventilations if needed If significant ALOC, initiate CPR
ALS Prior to Base Hospital Contact	
IV access **Atropine** • IV – 0.5 mg (1 mg/10 mL) **Transcutaneous Pacing (TCP)** • Should be initiated only if patient has signs of hypoperfusion • Should be started immediately for 3º heart blocks and 2º Type 2 (Mobitz II) heart blocks • If pain is present during TCP o **Morphine** – per policy 705.19 - Pain Control	IV access • IO access only if pt in extremis **Epinephrine 1:10,000** • IV/IO – 0.01 mg/kg (0.1 mL/kg) q 3-5 min
Communication Failure Protocol	
If symptoms persist for 3 minutes after first atropine dose and if no capture with TCP • **Atropine** o IV – 0.5 mg q 3-5 min • Max 0.04 mg/kg • **Dopamine** o IVPB – 10 mcg/kg/min • Use if patient continues to be unresponsive to atropine and TCP	
Base Hospital Orders only	
For suspected hyperkalemia • **Calcium Chloride** o IV – 1 g over 1 min • Withhold if suspected digitalis toxicity • **Sodium Bicarbonate** o IV – 1 mEq/kg	**Atropine** • IV/IO – 0.02 mg/kg o Minimum dose – 0.1 mg
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

Additional Information
- Bradycardia does not require treatment unless signs and symptoms are present (chest pain, altered level of consciousness, abnormal skin signs, profound weakness, or low BP)

Effective Date: June 1, 2015
Next Review Date: May 31, 2017

Date Revised: May 14, 2015
Last Reviewed: May 14, 2015

VCEMS Medical Director

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Documentation of Prehospital Care		Policy Number 1000
APPROVED: Administration:	Steven Carroll, Paramedic	Date: June 1, 2015
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date: June 1, 2015
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 15, 1998 March 12, 2015 March 12, 2015 March 31, 2017	Effective Date: June 1, 2015

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

II. AUTHORITY: Title 22 Section 100147.

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

IV. PROCEDURE:

A. Provision of Access

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

B. Documentation

1. The VCEMS VCePCR will be used to document the care provided by pre-hospital personnel for every patient contact and/or incident to which a particular unit or provider is attached. An incident will be defined as any response involving Ventura County pre-hospital personnel to any event in which there is an actual victim, or the potential for a victim, regardless of whether the responding unit was cancelled enroute or not. A patient contact is defined as any encounter involving Ventura County pre-hospital personnel with any person consenting, either implied or informed, to assessment and/or treatment. Documentation shall be completed on any

person with obvious injury or significant mechanism regardless of consent. The following are exceptions:

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

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

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

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

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

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

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

    2) Level 2 and 3 MCI: Each patient transported to a hospital shall have their care documented on a Ventura County Multi-Casualty Patient Record.

        a) The transporting agency is responsible for completion of the multi-casualty patient record. The record is designed to be

completed by the transporting crew enroute to the receiving hospital.

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

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

C. Transfer of Care

1. Transfer of care between two field provider teams and between field provider and hospital shall be documented on appropriate VCePCR. The first arriving agency will post to the server and perform a coordinated electronic transfer of care whenever possible within the VCePCR system to the next incoming unit. The unit receiving the electronic transfer will download the correct corresponding report prior to completion of the ePCR. This includes intra-agency units and inter-agency units.
2. A VCePCR shall be completed in accordance with training administered by VCEMS, or designee.
3. The time that patient care is transferred to hospital staff shall be documented by the primary provider handling patient care in all circumstances where a patient is transported to a hospital.

D. In the event the cardiac monitor is attached as required by any of the VCEMS 705 policies, a complete ECG data transfer shall be recorded and attached to the corresponding VCePCR. ECG data shall be downloaded by each provider agency involved in that incident and attached to the corresponding VCePCR. An original 12 lead ECG shall

be printed and submitted upon transfer of care to hospital staff for any patient where a 12 lead ECG was performed.

E. Submission to VCEMS

1. In the following circumstances, a complete VCePCR shall be completed and posted by any transporting unit, and by FR ALS personnel retaining care, within thirty (30) minutes of arrival at destination:
    a. Any patient that falls into Step 1 or Step 2 (1.1 – 2.8) of the Ventura County Field Triage Decision Scheme
    b. Any patient that is in cardiac arrest, or had a cardiac arrest with ROSC.
    c. Any patient with a STEMI positive 12 lead ECG.
    d. Any patient with a positive Cincinnati Stroke Screening (CSS +).
    e. Any patient that is unable to effectively communicate information regarding present or past medical history.
    f. An exception to this circumstance would be during times of EMS system overload where a delay in a unit returning to service could pose significant delays in response times.
2. For circumstances not listed above, in which the patient was transported to a hospital, the entire data set found on the VCePCR 'REPORT' tab shall be completed and electronically posted to the server by transporting agencies, and by FR ALS personnel retaining care, within thirty (30) minutes of arrival at destination.
    a. An exception to this circumstance would be during times of EMS system overload where a delay in a unit returning to service could pose significant delays in response times.
3. All other reports not falling into the above criteria shall be completed and posted to the server as soon as possible and no later than the end of shift.

F. Dry Run/Against Medical Advice

Every patient contact resulting in refusal of medical attention/transport must be documented with the following information, the reason dispatched and/or chief complaint, assessment and vital signs, base hospital contact (when appropriate), patient advised to seek medical attention and completion of AMA. The AMA checklist as well as patient signatures shall be captured whenever possible by each applicable agency at the time of patient contact/refusal. If, at any point, a signature is not obtained for any reason, explanation shall be documented in the narrative section of the VCePCR.

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

H. The completion of any VCePCR should not delay patient transport to the hospital.

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

Attachment A

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

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

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

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

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

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

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

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

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Air Unit Staffing Requirements	Policy Number: 1201
Approved Administration: Steven L. Carroll, Paramedic	Date: June 1, 2015
Approved Medical Director: Angelo Salvucci, MD	Date: June 1, 2015
Origination Date: May 30, 1988 Date Revised: March 12, 2015 Date Last Reviewed: March 12, 2015 Review Date: March 31, 2018	Effective Date: June 1, 2015

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

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

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

IV DEFINITIONS:

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

B. EMS Aircraft Classifications:

1. Air Ambulance

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

2. Rescue Aircraft

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

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

3. Auxiliary Aircraft:

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

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

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

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

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

V. PROCEDURE

A. Aircraft Staffing Requirements

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

B. Criteria for EMS Personnel to Staff Air Unit

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

a. While assigned to work with a paramedic on a Ventura County based air unit, a SAR EMT shall:
   1) Successfully complete the training module described in VCEMS Policy 306. The SAR EMT is not required to complete the arrhythmia/ defibrillation component of the module.
   2) Meet skill maintenance requirements.
   3) Perform duties as described below.

b. SAR EMT Duties and Responsibilities
   1) Those functions within the EMT Scope of Practice.
   2) May transmit information to a Base Hospital regarding paramedic activity and transport information, but may not ask for, receive, or pass on ALS orders.

3. Registered Nurses
   a. RN with a minimum of two (2) years experience in a critical care area within the previous three (3) years, prior to employment with the provider agency.
   b. Current BLS and ACLS certification from the American Heart Association.
   c. Minimum of 384 hours of critical care area (including time worked as a CCT RN) experience per year, unless employed full time as a critical care transfer nurse.
   d. Successful completion of an in-house orientation program sponsored by the provider agency.
   f. Endotracheal intubation training.
   h. Certification in any of the following: Certified Emergency Nurse (CEN); Critical Care Registered Nurse (CCRN); Mobile Intensive Care Nurse (MICN); Certified Nurse Anesthetist; Post Anesthesia Recovery Nurse (PAR); or Certified Flight Registered Nurse (CFRN) or challenge/pass Ventura County MICN test.

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

f. Aircraft emergencies and safety.

g. Care of patients requiring special consideration in the airborne environment.

h. EMS system and communications procedures.

i. The prehospital care system(s) within which they operate, including local medical and procedural protocols.

j. Use of onboard medical equipment.

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

D. Continuing Education Requirements

1. All medical flight crews shall participate in such continuing education requirements as required by their licensure or certification and as defined in VC EMS Policy 334.

a. All registered nurses, regardless of the certification which qualifies them to serve as flight nurses within Ventura County, must attend EMS updates twice yearly.

b. Flight Nurses who challenge and pass the MICN examination to comply with this policy must meet the continuing education requirements of thirty-six (36) hours per recertification cycle, 50% of which, in each category, shall have been obtained at Ventura County Base Hospitals.

(1) Field Care Audits (Field care audit): Twelve hours per two years.

(2) Periodic training sessions (Lecture/Seminar): Twelve hours per two years.

(a) EMS Updates (Mandatory, two times per year)

(b) ACLS recertification – 2 hours credit

(c) Self-Study/Video CE

(3) Miscellaneous Education: Twelve hours per two years.

c. SAR EMT Requirements (In addition to EMT recertification requirements)

(1) Skills Update - 2 hours per certification period

(2) EMS Updates – Mandatory, two times per year

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

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Helicopter Dispatch for Emergency Medical Responses	Policy Number: 1202
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: December 1, 2011
APPROVED: Medical Director: Angelo Salvucci, MD	Date: December 1, 2011
Origination Date: May 30, 1988 Date Revised: November 10, 2011 Date Last Reviewed: March 12, 2015 Next Review Date: March 31, 2018	Effective Date: December 1, 2011

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

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

III. DEFINITIONS:

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

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

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

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

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

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

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

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

V. PROCEDURE

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

1. All requests for and cancellations of EMS helicopters shall be made through FCC. The authority for requesting the dispatch of a helicopter for patient transport shall be vested with the on-scene public agency or Ventura County EMS personnel. This policy does not preclude the Ventura County Sheriff's Aviation Unit from responding to incidents requiring law enforcement response.

2. FCC will determine the appropriate aviation resources using information from on-scene public safety/EMS personnel or from the reporting party if the patient is located in an Automatic Response Area.

3. No EMS helicopter shall respond to an incident without the request of or notifying of FCC. All responding public safety/EMS personnel shall be notified of the dispatch of a helicopter

4. An air ambulance will be dispatched to incidents when a suitable landing site is available and the victim is accessible from the landing site. If the designated air ambulance is unavailable, the Ventura County Sheriff’s Department Search and Rescue (VCSD SAR) helicopter will be dispatched.

5. The VCSD SAR helicopter will be dispatched to incidents that describe the need for the specialized skills and capabilities of a rescue aircraft. If the VCSD SAR helicopter is unavailable, mutual aid resources will be contacted. Incidents that require a rescue helicopter involve the need for:

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

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

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

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

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

C. A helicopter response may be terminated:

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

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

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Guidelines for Interfacility Transfer of Patients to a Trauma Center	Policy Number 1404
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2015
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: June 1, 2015
Origination Date: July 1, 2010 Date Revised: March 3, 2015 Date Last Reviewed: March 3, 2015 Review Date: March 31, 2017	Effective Date: June 1, 2015

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

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

III. DEFINITIONS:

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

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

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

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

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

1. Carotid or vertebral arterial injury
2. Torn thoracic aorta or great vessel
3. Cardiac rupture
4. Bilateral pulmonary contusion with PaO2 to FiO2 ratio less than 200
5. Major abdominal vascular injury
6. Grade IV, V or VI liver injuries
7. Grade III, IV or V spleen injuries
8. Unstable pelvic fracture
9. Fracture or dislocation with neurovascular compromise
10. Penetrating injury or open fracture of the skull
11. Glasgow Coma Scale score <14 or lateralizing neurologic signs
12. Unstable spinal fracture or spinal cord deficit
13. >2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion
14. Open long bone fracture
15. Significant torso injury with advanced co-morbid disease (such as coronary artery disease, chronic obstructive pulmonary disease, type 1 diabetes mellitus, or immunosuppression)
16. Amputations or partial amputations of any portion of the hand[1]
17. Injury to the globe at risk for vision loss[2]

B. Ventura County Level II Trauma Centers:

1. Agree to immediately accept from Ventura County community hospitals, patients with conditions included in the guidelines above.
2. Will publish a point-of-contact phone number for an individual authorized to accept the transfer of a patient with a condition included in the guidelines above, or to request consultation with a trauma surgeon.
3. Will establish a written interfacility transfer agreement with every hospital in Ventura County.
4. Immediately post on ReddiNet and notify EMS Administrator on-call when there is no capacity to accept trauma patients due to:
    a. Diversion for internal disaster
    b. CT scanner(s) non-operational

c. Primary and back-up trauma surgeons in operating rooms with trauma patients

C. Community Hospitals:

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

D. **EMERGENT** Transfers

1. **EMERGENT** transfers are indicated for patients with life-or-limb threatening injuries in need of emergency procedures at a trauma center. Criteria **MUST** include at least one of the following:
   a. Indications for an immediate neurosurgical procedure.
   b. Penetrating gunshot wounds to head or torso.
   c. Penetrating or blunt injury with shock.
   d. Vascular injuries that cannot be stabilized and are at risk of hemorrhagic shock or loss of limb acutely (excluding fingers/toes).
   e. Pregnancy with indications for an immediate Cesarean section.
2. For **EMERGENT** transfers, trauma centers will:

a. Publish a single phone number ("hotline"), that is answered 24/7, for an individual authorized to accept the transfer of patients who have a condition as described in Section D.1 of this policy.

b. Immediately upon initial notification by a transferring physician, accept in transfer all patients who have a condition as described in Section D.1 of this policy.

3. For **EMERGENT** transfers, community hospitals will:
   a Assemble and maintain a "Emergency Transfer Pack" in the emergency department to contain all of the following:
      1. Checklist with phone numbers of Ventura County trauma centers.
      2. Patient consent/transfer forms.
      3. Treatment summary sheet.
      4. Ventura County EMS "Emergency Trauma Patient Transfer QI Form."

b. Have policies, procedures, and a quality improvement system in place to track and review all **EMERGENT** transfers and Trauma Call Continuations.

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

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

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

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

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

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

a. Respond immediately upon request.

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

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

E. **URGENT** Transfers

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

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

a. Publish a single phone number, that is answered 24/7, for a community hospital to request an urgent trauma transfer. Additionally, this line may be used to request additional consultation with a trauma surgeon if needed

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

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

4. For **URGENT** transfers, ambulance companies will:
    a. Arrive at the requesting ED no later than thirty minutes from the time the request was received.

V. PROCEDURE:

A. **EMERGENT** Transfers

1. After discussion with the patient, the transferring hospital will:
    a. Call the trauma hotline of the closest trauma center to notify of the transfer.
    b. Call FCC, advise they have an **EMERGENT** transfer, and request an ambulance. If the patient's clinical condition warrants, the transferring hospital will call FCC *before* calling the trauma center's hotline.
    c. Complete transfer consent and treatment summary.
    d. Prepare copies of the ED triage assessment form and demographic information form.
2. Upon request for an **EMERGENT** transfer, the dispatch center will dispatch the closest ALS ambulance and verbalize "MEDxxx E MERGENCY Trauma Transfer from [transferring hospital]". The trauma center will be denoted in the incident comments, which will display on the mobile data computer (MDC). If a unit does not have an operational MDC, the transferring hospital will advise the responding ambulance personnel of the destination trauma center.
3. Upon notification, the ambulance will respond Code (lights and siren).
4. FCC will track ambulance dispatch, enroute, on scene, en-route hospital, at hospital, and available times.
5. The patient shall be emergently transferred without delay. Every effort will be made to limit ambulance on-scene time in the transferring hospital ED to ten minutes.
    a. All forms should be completed prior to ambulance arrival.
    b. Any diagnostic test or radiologic study results may either be relayed to the trauma center at a later time, or if time permits, copied and sent with the patient to the trauma center.
    c. Intravenous drips may be discontinued or remain on the ED pump.
    d. The transporting paramedic will contact the trauma base hospital enroute and provide updated patient information.

B. Trauma Call Continuation

1. Upon determination of a Trauma Call Continuation, and after discussion with the patient, the community hospital will:
    a. Direct the ambulance personnel to prepare to continue the transport to the trauma center.
    b. Notify the designated trauma center ED of the immediate re-triage of a trauma patient, and communicate the patient's apparent injuries or reason for the re-triage, after the call is continued and the patient is enroute to the trauma center.
2. Upon notification of Trauma Call Continuation, the ambulance personnel will notify FCC of their assignment to a Trauma Call Continuation. FCC will link the trauma transfer to the original 911 incident and continue tracking en-route hospital (departure from community hospital), at hospital (arrival at trauma center) and available times.
3. When the transferring physician determines the patient is ready and directs ambulance personnel to continue the transport, the ambulance will emergently transport the patient to the trauma center. The transporting paramedic will contact the trauma base hospital enroute and provide updated patient information.

C. **URGENT** Transfers

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

D. For all **EMERGENT** transfers, the transferring hospital will submit a completed Emergency Trauma Patient Transfer QI Form to the Ventura County EMS Agency within 72 hours. The transfer will be reviewed for appropriate and timely care and

to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS Trauma Operational Review Committee.

[1]For patients with isolated traumatic amputations or partial amputations of any portion of the hand, a community hospital may elect to transfer the patient to a Ventura County trauma center for potential replantation surgery. In these circumstances, the community hospital shall contact Los Robles Hospital and Medical Center (LRHMC) to determine the availability of a hand surgeon trained in microvascular replantation surgery. If a specialty hand surgeon is available the patient shall be preferentially transferred to LRHMC.

[2]Patients with isolated eye injuries needing transfer to a trauma center for potential ophthalmologic surgery shall be preferentially transferred to Ventura County Medical Center.

EMERGENT Trauma Transfer QI Form

Form: Ventura County EMS Agency Policy 1404

(ALL FIELDS MUST BE COMPLETED)

Date of Incident:_____

Sending Hospital:

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

Treating Physician:_____

Patient arrived at sending ED at _____(time of ED arrival)

☐ Brought by EMS: Fire Incident Number _____

☐ Brought by POV or Walk-In

Destination Trauma Center:

☐ LRHMC

☐ VCMC

☐ Other: _____

Patient Transfer Process:

☐ Ambulance with paramedic ONLY

☐ Ambulance with accompanying healthcare personnel

☐ Trauma Call Continuation

Which of the following Policy 1404 criteria applies?

☐ Indications for an immediate neurosurgical procedure

☐ Penetrating gunshot wound to head or torso

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

☐ Blunt injury and shock

☐ Vascular injury that cannot be stabilized and is at risk of hemorrhagic shock or loss of limb acutely

☐ Pregnancy with indications for immediate Cesarean section

Comments:

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

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Trauma Triage and Destination Criteria	Policy Number: 1405
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: June 1, 2015
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: June 1, 2015
Origination Date: July 1, 2010 Date Revised: March 3, 2015 Date Last Reviewed: March 3, 2015 Review Date: March 31, 2017	Effective Date: June 1, 2015

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

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

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

A. Physiologic Criteria, Step 1:

1. Glasgow Coma Scale < 14
2. Systolic blood pressure < 90 mmHg
   (< 110 in patients older than 65 years of age)
3. Respiratory rate < 10 or > 29 breaths per minute
   (< 20 in infant younger than 1 year of age)

B. Anatomic Criteria, Step 2:

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

C. Mechanism of Injury Criteria, Step 3:

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

a. Intrusion: interior measurement > 12 inches patient site; > 18 inches any occupant site
b. Ejection: partial or complete from automobile
c. Death in same passenger compartment

3. Auto-pedestrian / auto-bicyclist thrown, run over, or with > 20 mph impact
4. Unenclosed vehicle (e.g. motorcycle, bicycle, skateboard) crash > 20 mph

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

1. Age > 65 years old
2. Head injury with loss of consciousness AND on an anticoagulant or antiplatelet drug[1]
3. Burns with trauma mechanism
4. Time sensitive extremity injury (open fracture, neurovascular compromise)
5. Pregnancy > 20 weeks with known or suspected abdominal trauma
6. Prehospital care provider or MICN judgment
7. Amputation or partial amputation of any part of the hand[2]
8. Penetrating injury to the globe of the eye, at risk for vision loss[3]

V. PROCEDURE:

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

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

C. Transportation units (both ground and air) shall transport patients who meet at least one of the trauma triage criteria in Sections A or B to the closest appropriate designated trauma center. If the closest trauma center is on internal disaster, these patients shall be transported to the next closest appropriate trauma center. If the closest trauma center is on CT diversion, the paramedic shall make early base contact and the MICN shall determine the most appropriate destination.

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

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

the MICN will notify the receiving hospital or trauma center of an inbound patient and relay paramedic report.

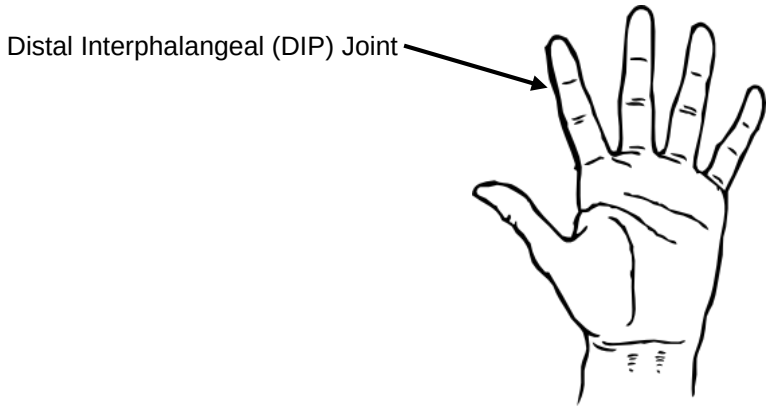
F. A trauma patient without an effective airway may be transported to the closest available hospital with an emergency department for airway management prior to transfer to a designated trauma center. In this rare event, the paramedic will contact the base hospital in whose catchment area the incident occurred.

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

[1]For a complete list of anticoagulant and antiplatelet drugs that should be considered for inclusion criteria in Step 4.2, please consult VC EMSA approved list.

[2]For patients with isolated traumatic amputations, partial or complete, of any portion of the hand (at or proximal to the DIP joint of any finger or any part of the thumb) [see illustration], as long as bleeding is controlled and the amputated part may be transported with the patient, the regular catchment base hospital MICN may contact Los Robles Hospital and Medical Center (LRHMC) to determine the availability of a hand surgeon trained in microvascular replantation surgery. If a specialty hand surgeon is available at LRHMC and not at the regular catchment hospital, the MICN shall direct the patient to LRHMC.

[3]For patients with isolated penetrating injury to the globe of the eye, at risk for vision loss, the regular catchment base hospital MICN may direct the patient to Ventura County Medical Center (VCMC) for specialized ophthalmologic care and possible surgical intervention.



Ventura County Field Triage Decision Scheme

For patients with visible or suspected traumatic injuries

Measure vital signs and level of consciousness

STEP 1

1.1 Glasgow Coma Scale	< 14
1.2 Systolic Blood Pressure	< 90 (< 110 in patients > 65 years)
1.3 Respiratory Rate	< 10 or > 29 breaths per minute (< 20 in infant age < 1 year)

Yes → **Contact base trauma center**

Transport to trauma center

No

Assess anatomy of injury

STEP 2

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

Yes → **Contact base trauma center**

Transport to trauma center

No

Assess mechanism of injury and evidence of high-energy impact

STEP 3

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

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

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

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

No

Assess special patient or system considerations

STEP 4

4.1 Age > 65
4.2 Head injury with loss of consciousness AND on an anticoagulant or antiplatelet drug[1]
4.3 Burns with trauma mechanism
4.4 Time sensitive extremity injury (open fracture, neurovascular compromise)
4.5 Pregnancy > 20 weeks with known or suspected abdominal trauma
4.6 Prehospital care provider or MICN judgment
4.7 Amputation or partial amputation of any part of the hand[2]
4.8 Penetrating injury to the globe of the eye, at risk for vision loss[3]

Yes → **Contact regular catchment base hospital**

Consider transport to trauma center or specific resource hospital

[1]See list
[2] Consider LRHMC
[3] Consider VCMC

No

Transport to closest ED or by patient preference

Version 4 Revised 3-3-2015