NOTICE OF CHANGES TO POLICY MANUAL

TO: ALL VENTURA COUNTY EMS POLICY MANUAL HOLDERS

Date: May 1, 2009 CHANGE NO. 1

Policy Status	POLICY#	Title
Replace	105	Prehospital Services Committee Operating Guidelines
Replace	120	Continuous Quality Improvement Program
Replace	301	EMT-I Certification
Replace	302	EMT-I Recertification
Replace	310	Paramedic Scope of Practice
Replace	330	EMT/Paramedic/MICN Decertification and Discipline
Review Only/Replace	332	EMS Personnel Background Check Requirements
Replace	334	Prehospital Personnel Mandatory Training
Replace	350	PCC Job Description
Review Only/Replace	402	Patient Diversion/Emergency Department Closures
Replace	410	ALS Base Hospital Standards
Replace	613	Do Not Resuscitate
Replace	614	Spinal Immobilization
Add	625	Physician Orders for Life-Sustaining Treatment (POLST)
Replace	705	Anaphylaxis
Replace	705	Apnea/Agonal Respirations
Replace	705	Behavioral Emergencies
Replace	705	Bradycardia, Adult, Not in Arrest
Review Only/Replace	705	Burns
Replace	705	Cardiac Arrest, Adult
Replace	705	Cardiac Arrest, Pediatric
Replace	705	Crush Injury/Syndrome
Replace	705	Heat Exhaustion/Heat Stroke
Review Only/Replace	705	Insect and Spider Bites
Replace	705	Marine Animals
Review Only/Replace	705	Nerve Agent Poisoning
Review Only/Replace	705	Newborn
Replace	705	Non-Traumatic Focal Neurological Changes
Review Only/Replace	705	Overdose/Poisoning
Review Only/Replace	705	Pain Control
Review Only/Replace	705	Pediatric Bradycardia
Replace	705	Seizures
Replace	705	Ventricular Tachycardia, Sustained, Not in Arrest
Replace	708	Patient Transfer From One Prehospital Team to Another
Replace	720	Guidelines for Limited Base Contact
Replace	726	12 Lead ECG
Add	727	Transcutaneous Cardiac Pacing
Replace		Table of Contents

Policy Status Description

Add	New policy. Please add to your policy manual.
Delete	Policy has been deleted from the VCEMS policy manual. Please delete from you policy manual.
Review Only/Replace	Policy had no changes. Review Date was reached and policy was reviewed for update only. Please replace in your policy manual.
Replace	Policy had changes. Please replace in your policy manual.

EMS website for policies address is http://www.vchca.org/ph/ems/policies/index.htm

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Prehospital Services Committee Operating Guidelines</td><td>Policy Number
105</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steve L. Carroll, EMT-P</td><td>Date: June 1, 2009</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Angelo Salvucci, M.D.</td><td>Date: June 1, 2009</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>March, 1999
April 9, 2009
April 9, 2009
April 30, 2012</td><td>Effective Date: June 1, 2009</td></tr>
</table>

I. Committee Name

The name of this committee shall be the Ventura County (VC) Prehospital Services Committee (PSC).

II. Committee Purpose

The purpose of this committee shall be to provide input to the VC Emergency Medical Services (EMS) Medical Director and VC EMS administration on matters pertaining to emergency medical services, including, but not limited to, dispatch, first responders, ambulance services, communications, medical equipment, training, personnel, facilities, and disaster medical response.

III. Membership

A. Voting Membership

Voting membership in the committee shall be composed of 2 representatives, as appointed by the organization administrator, from each of the following organizations:

<table>
<tr><th>Type of Organization</th><th>Member</th><th>Member</th></tr>
<tr><td>Base Hospitals</td><td>PCC</td><td>PLP</td></tr>
<tr><td>Receiving Hospitals</td><td>ED Manager</td><td>ED Physician</td></tr>
<tr><td>First Responders</td><td>Administrative</td><td>Field (provider of “hands-on” care)</td></tr>
<tr><td>Ambulance Companies</td><td>Administrative</td><td>Field (provider of “hands-on” care)</td></tr>
<tr><td>Emergency Medical Dispatch Agency</td><td colspan="2">Emergency Medical Dispatch Coordinator (1 representative selected by EMD Agency coordinators)</td></tr>
<tr><td>Air Units</td><td>Administrative</td><td>Field (provider of “hands-on” care)</td></tr>
<tr><td>Paramedic Training Programs</td><td colspan="2">Director (1 representative from each program.)</td></tr>
</table>

B. Membership Responsibilities

C. Non-voting Membership

Non-voting members of the committee shall be composed of the following

1. VC EMS Medical Director
2. VC EMS Administrator
3. VC EMS Administrative Support
4. VC County Counsel, as appropriate
5. VC EMS CQI Coordinator
6. VC EMS Emergency Medical Services Specialist

D. Membership Responsibilities

Representatives to PSC represent the views of their agency. Representative should ensure that agenda items have been discussed/reviewed by their agency prior to the meeting.

E. Voting Rights

Designated voting members shall have equal voting rights.

F. Attendance

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

IV. Officers

A. The chairperson of PSC is the only elected member. The chairperson shall perform the duties prescribed by these guidelines and by the parliamentary authority adopted by the PSC.

B. A nominating committee, composed of 3 members, will be appointed at the regularly scheduled March meeting to nominate candidates for PSC Chair. The election will take place in May, with duties to begin at the July meeting.

C. The term of office is one (1) year. A member may serve as Chair for up to three (3) consecutive terms.

V. Meetings

A. Regular Meetings

The PSC will meet on the second Thursday of each month, unless otherwise determined by the PSC membership. VCEMS will prepare and distribute electronic PSC Packet no later that one week prior to a scheduled meeting.

B. Special Meetings

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

C. Quorum

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

VI. Task Forces and Ad-hoc Committees

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

VII. Calendar Year

The Prehospital Services Committee will operate on a calendar year

VIII. Parliamentary Authority

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

IX. Submission of Agenda Items

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

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

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<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Prehospital Emergency Medical Care Quality Improvement Program</td><td>Policy Number
120</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, EMT-P</td><td>Date: June 1, 2009</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Angelo Salvucci, M.D.</td><td>Date: June 1, 2009</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>January 1996
December 11, 2008
December 11, 2008
December 31, 2012</td><td>Effective Date: June 1, 2009</td></tr>
</table>

I. PURPOSE: To define the process to identify areas for improvement in the VC EMS system.

II. AUTHORITY: Reference: H&S Code Section 1798 Medical Control

III. POLICY: The Ventura County EMS Agency shall assess and evaluate all aspects of the EMS System in Ventura County.

IV. Each pre-hospital provider (hospital provider, ambulance provider and first responder agency) will use the Ventura County Continuous Quality Improvement Program (CQI) as a model for their CQI plan with respect to the EMS portion of their activities.

Ventura County Emergency Medical Services Agency

Continuous Quality Improvement Program

Mission Statement

The mission of Ventura County's Emergency Medical Service Agency CQI program is to optimize the health of those requiring emergency medical care in the County of Ventura by promoting timely, highly skilled and effective medical care to those who request our services. We also intend to promote healthy lifestyles, and prevent and control disease, injury and disability though community education programs. Successful performance of this mission demands the development and modeling of strategies that ensure the delivery of cost effective, high quality response and delivery of assessment, treatment and transportation to the residents of, and visitors to, Ventura County who are in need of Emergency Medical Services.

Vision

To foster an ethical[1] work environment, in which all employees see themselves as valued members of a team, working continuously to improve the health of the residents of, and visitors to, Ventura County, who require Emergency Medical Services.

Scope of Services

The Emergency Medical Services Agency provides oversight for all emergency medical care and transportation in the County of Ventura. It assures adherence requirements for personnel education and certification and oversees Advanced Life Support Service providers' compliance with the county contract. Services are provided by a professional and support staff which includes the EMS Medical Director, EMS Administrator, EMS Deputy Administrator, EMS CQI Coordinator, Administrative Assistant, and Student Aide. Programs are coordinated with other providers in the County.

Purpose

The purpose of the EMS Continuous Quality Improvement Program (CQIP) is to improve the quality and effectiveness of emergency medical services through standardization, coordination, and evaluation. The EMS CQI Program coordinates its continuous quality improvement effort with, and reports to, the Ventura County Public Health Department Continuous Quality Improvement Program.

Goals

- ***Coordinate and facilitate implementation*** of a comprehensive, customer-oriented continuous quality improvement program
- ***Maximize utilization*** of both human and material resources within the EMS Program

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[1] See Appendix I, *Ventura County Public Health Code of Ethics*

- ***Assure the greatest benefit*** from services rendered for people who live with or are affected by the Emergency Medical Services Agency in Ventura County
- ***Gauge the ongoing effectiveness*** of EMS CQIP efforts resulting in increased services.

VC EMS Agency

The VC EMS Agency operates according to California Health and Safety Code Division 2.5, Section 1798 and 1798.204.

The VC EMS CQI Program operates under the direction of the VC EMS Medical Director and the VC EMS Administrator. The VC EMS CQI Coordinator acts as facilitator to this meeting.

I. Technical Advisory Group (TAG)

A. Structure

The Technical Advisory Group (TAG) will be multidisciplinary and will include, but not be limited to:

- VC EMS Agency Medical Director
- VC EMS Agency Representative
- ALS Service Provider Medical Director
- Receiving Hospital Medical Director
- EMS Educator(s)
- Base Hospital CQI Representative
- ALS CQI Representative
- EMD CQI Representative
- BLS CQI Representative

B. Interactions

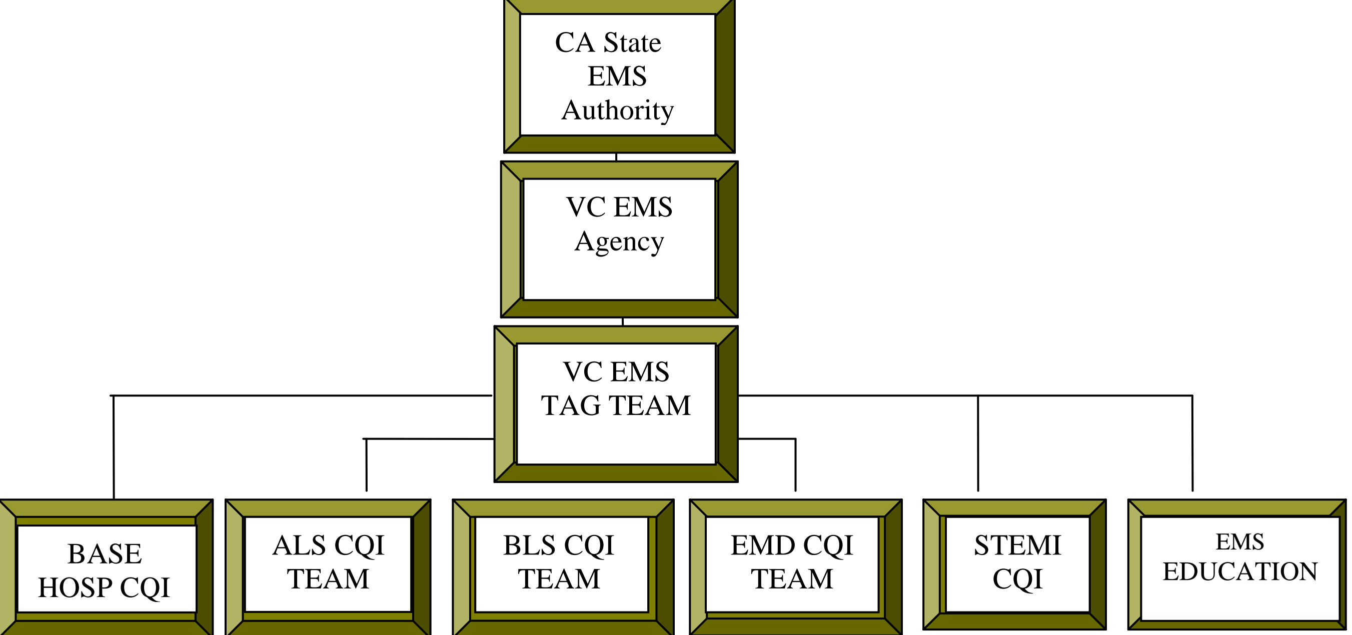
The Technical Advisory Group will seek and maintain relationships with all EMS participants including but not limited to:

- State EMSA
- Other LEMSAs
- EMS Service Provider(s)
- Local Department of Health
- Specialty Care Center(s)
- Law Enforcement
- PSAP(s)
- EMS Dispatch Center(s)
- Constituent Groups

C. Roles and Responsibilities

The VC EMS TAG should be the central repository of local or regional EMS system information as it relates to EMS CQI Program activities. The team should perform the following functions:

- Cooperate with the EMSA in carrying out the responsibilities of statewide EMS QI Program and participate in the EMSA Technical Advisory Group
- Cooperate with the EMSA in the development, approval, and implementation of state required EMS system indicators
- Cooperate with the EMSA in the development, approval, and implementation of state optional EMS system indicators
- Maintain responsibility for monitoring, collecting data on, reporting on, and evaluating state required and optional EMS System indicators from the EMS providers and hospitals within the jurisdiction of the VC EMS.
- Identify and develop VC EMS specific indicators for system evaluation.
- Maintain responsibility for monitoring, collecting data on, and evaluating locally identified indicators
- Re-evaluate, expand upon, and improve state EMS system indicators and locally developed indicators annually or as needed
- Facilitate meetings and presentations on VC EMS indicators and the development of performance improvement plans for review by designated EMS providers
- Establish a mechanism to incorporate input from EMS provider advisory groups for the development of performance improvement plans
- Assure reasonable availability of EMS QI Program training and in-service education for EMS personnel under the statewide EMS CQI Program
- Prepare plans for improving VC EMS CQI Program



II Base Hospital

A. Structure

The Base Hospital EMS QI Program should be a program reviewed by the VC EMSA for compatibility with the VC EMS CQI Program guidelines. The organizational chart should reflect the integration of the VC EMS CQI Program in the organization. There should be:

1. An EMS QI Team under the direction of the Base Hospital medical director. Lead staff should have expertise in management of the base hospital's EMS CQI Program. The following staffing positions are identified (note: organizations with limited resources may combine positions):

   - Base Hospital Medical Director (or designee)
   - EMS CQI Program Coordinator (Prehospital Care Coordinator)

2. An internal EMS QI Program Technical Advisory Group with members, which include but are not limited to:

   - Base Hospital Medical Director

- VC EMS CQI Coordinator
- EMS Service Provider Personnel (Physicians, RNs, Paramedics, EMTs)

B. Interaction

The Base Hospital's CQI Program should involve all EMS system participants including but not limited to the VC EMSA, dispatch agencies, ALS and BLS EMS service providers, receiving hospitals, and specialty care centers

Cooperation and interaction with all EMS system participants should include but not be limited to:

- State EMSA
- VC EMS
- Other Base Hospital(s)
- Receiving Facilities
- Local Department of Health
- Law Enforcement
- PSAP(s)
- Community Group(s)
- Non-EMS Public Representative(s)
- EMS Provider(s)

C. Roles and Responsibilities

The Base Hospital EMS QI Team should be a primary source of EMS activity reporting for statewide and local EMS system indicators. The Base Hospital EMS QI Program will perform the following functions:

- Cooperate with VC EMS in carrying out the responsibilities of the VC EMS CQI Program and participate in the VC MSA Technical Advisory Group
- Cooperate with VC EMS in the implementation of state required EMS system indicators
- Cooperate with VC EMS in the implementation of state optional EMS system indicators
- Cooperate with VC EMS in monitoring, collecting data on, and evaluating state required and optional EMS system indicators
- Cooperate with VC EMS in monitoring, collecting data on, and evaluating local/regional EMS system indicators
- Cooperate with EMSA and VC EMS in the re-evaluation and improvement of state and local EMS system indicators
- Identify and develop base hospital indicators for system evaluation
- Participate in meetings for internal review of base hospital indicators and development of performance improvement plans related to the findings
- Establish a mechanism to incorporate input from VC EMS, service providers, and other hospitals for the development of performance improvement plans
- Assure reasonable availability of EMS CQI Program training and in-service education for base hospital personnel
- Prepare plans for expanding or improving the Base Hospital EMS CQI Program
- Facilitate meetings and presentations of state and local EMS system indicators for peer review to local designated advisory groups and other authorized constituents
- Provide technical assistance to all EMS CQI Programs in the base hospital's jurisdiction
- Participate in annual CQI review conducted by VC EMS

D. Annual Updates

The Base Hospital EMS QI Team will annually publish summary reports of EMS QI Program activity for distribution.

III Emergency Medical Service Provider

A. Structure

The EMS Provider EMS QI Program should be reviewed by VC EMS for compatibility with the VC EMS CQI Program guidelines. The organizational chart should reflect the integration of the EMS CQI Program in the organization. There should be:

1. An EMS QI Team under the direction of the EMS Provider medical director or EMS administrator. Lead staff should have expertise in management of the EMS provider's EMS QI Program. The following staffing positions are identified (organizations with limited resources may combine positions):

   - Provider Medical Director or Designee
   - EMS CQI Program Coordinator

2. An internal EMS CQI Program Technical Advisory Group with members which include but are not limited to:

   - Medical Director or Medical Designee
   - VC EMSA CQI Coordinator
   - EMS QI Program Coordinator
   - Service Personnel (Physicians, RNs, Paramedics, EMTs)
   - Other system participants

B. Interaction:

The EMS Provider's EMS QI Program should involve EMS system participants including but not limited to dispatch agencies, the VC EMSA, EMS personnel training programs, hospitals, specialty care centers, and other EMS service providers. A regional approach, with collaboration between EMS service providers serving neighboring communities, is highly recommended

Cooperation with all EMS participants should include but not limited to:

- State EMSA
- VC EMS
- Other EMS Provider(s)
- Base and Receiving Facilities
- Local Department of Health
- Law Enforcement
- PSAP(s)
- Community Group(s)
- Non-EMS Public representative(s)
- EMS Dispatch Center(s)

C. Roles and Responsibilities

The EMS Provider's EMS CQI Program Technical Advisory Group should be the primary source of EMS QI Program activity reporting for statewide and local EMS System information. The EMS Provider's EMS CQI Program Technical Advisory Group will perform the following functions:

- Cooperate with VC EMS in carrying out the responsibilities of the VC EMS's CQI Program and participate in the VC EMSA Technical Advisory Group
- Cooperate with VC EMS in the implementation of state required EMS system indicators
- Cooperate with VC EMS in the implementation of state optional EMS system indicators
- Cooperate with VC EMSA in monitoring, collecting data on, and evaluating state required and optional EMS system indicators
- Cooperate with VC EMSA in monitoring, collecting data on, and evaluating local/regional EMS system indicators
- Cooperate in the re-evaluation and improvement of state and local EMS system indicators
- Develop, monitor, collect data on, and evaluate indicators specific to the EMS provider
- Conduct meetings for internal review of EMS provider information and development of performance improvement plans related to the findings
- Establish a mechanism to receive input from VC EMS, other service providers and other EMS system participants for the development of performance improvement plans
- Assure reasonable availability of EMS CQI Program training and in-service education for EMS provider personnel
- Prepare plans for expanding or improving the EMS Provider EMS CQI Program
- Participate in meetings and presentations of state EMSA and VC EMS system information for peer review to local designated advisory groups and other authorized constituents
- Participate in annual CQI review conducted by VC EMS
- Develop and conduct a system of Peer Review

D. Annual Updates

The EMS Provider EMS QI Team will annually publish summary reports of EMS QI Program activity for distribution.

IV Emergency Medical Dispatch

A. Structure

The EMD CQI Program should be reviewed by VC EMSA for compatibility with the VC EMS CQI Program guidelines
The organizational chart should reflect the integration of VC EMS CQI Program in the organization. There should be:

1. An EMD CQI Team under the direction of the EMD medical director. Lead staff should have expertise in management of the EMD CQI program. The following staffing positions are identified ()organizations with limited resources may combine positions):

   - Medical Director or Designee
   - VC EMS CQI Coordinator
   - EMD CQI Program Director
   - Other county EMD representatives

B. Interactions

The EMD CQI Program should involve EMS system participants including but not limited to other local dispatch agencies, the VC EMSA, EMS personnel training programs, hospitals, specialty care centers, and other EMS service providers. A regional approach, with collaboration between EMD Program serving neighboring communities, is highly recommended

An internal EMD CQI Program Technical Advisory Group with members which include but are not limited to:

- Medical Director
- Chief/Administrator or designee
- EMD CQI Program Coordinator
- Service Personnel
- Other system participants

C. Roles and Responsibilities

The EMD CQI Program Technical Advisory Group should be the primary source of EMD CQI Program activity reporting for statewide and local EMS System information. The EMD CQI Program Technical Advisory Group will perform the following:

- Cooperate with VC EMS in carrying out the responsibilities of VC EMS's CQI Program and participate in VC EMS Technical Advisory Group
- Cooperate with VC EMS in the implementation of state required EMS system indicators
- Cooperate with VC EMS in the implementation of state optional EMS system indicators
- Cooperate with EMSA and VC EMS in monitoring, collecting data on, and evaluating state required and optional EMS system indicators
- Cooperate with VC EMS in monitoring, collecting data on, and evaluating local/regional EMS system indicators
- Cooperate in the re-evaluation and improvement of state and local EMS system indicators
- Develop, monitor, collect data on, and evaluate indicators specific to the EMD Program
- Conduct meetings for internal review of EMD information and development of performance improvement plans related to the findings
- Establish a mechanism to receive input from VC EMS, other service providers and other EMS system participants for the development of performance improvement plans
- Assure reasonable availability of EMD Program training and in-service education for EMS provider personnel
- Prepare plans for expanding or improving the EMD CQI Program
- Participate in meetings and presentations of state EMSA and VC EMS system information for peer review to local designated advisory groups and other authorized constituents
- Participate in annual CQI review conducted by VC EMS
- Provide monthly CQI reports as determined by VC EMS

D. Annual Updates

The EMD EMS CQI Team will annually publish summary reports of EMS CQI Program activity for distribution

V. Basic Life Support Service Provider

A. Structure

The EMS/BLS Provider CQI Program should be reviewed by VC EMS for compatibility with the VC EMS CQI Program guidelines. The organizational chart should reflect the integration of the EMS CQI Program in the organization. There should be:

1. An EMS/BLS CQI Team under the direction of the BLS Provider medical director or EMS Administrator. Lead staff should have expertise in management of the EMS/BLS provider's CQI Program. The following staffing positions are identified (organizations with limited resources may combine positions):

   - Provider Medical Director or Designee
   - EMS CQI Program Coordinator, or EMS Coordinator

2. An internal EMS/BLS CQI Program Technical Advisory Group with members which include but are not limited to:

   - Medical Director or Medical Designee
   - VC EMSA CQI Coordinator
   - EMS QI Program Coordinator, or EMS Coordinator
   - EMTs
   - Other system participants

B. Interaction:

The EMS/BLS Provider's CQI Program should involve EMS system participants including but not limited to dispatch agencies, the VC EMSA, EMS personnel training programs, hospitals, specialty care centers, and other EMS service providers. A regional approach, with collaboration between EMS service providers serving neighboring communities, is highly recommended

Cooperation with all EMS participants should include but not limited to:

- State EMSA
- VC EMS
- Other EMS/ BLS Provider(s)
- Base and Receiving Facilities
- Local Department of Health
- Law Enforcement
- Community Group(s)
- Non-EMS Public representative(s)
- EMS Dispatch Center(s)

C. Roles and Responsibilities

The EMS/BLS Provider's CQI Program Technical Advisory Group should be the primary source of EMS/BLS CQI Program activity reporting for statewide and local EMS System information. The Provider's CQI Program Technical Advisory Group will perform the following functions:

- Cooperate with VC EMS in carrying out the responsibilities of the VC EMS's CQI Program and participate in the VC EMSA Technical Advisory Group
- Cooperate with VC EMS in the implementation of state required EMS system indicators
- Cooperate with VC EMS in the implementation of state optional EMS system indicators
- Cooperate with VC EMSA in monitoring, collecting data on, and evaluating state required and optional EMS system indicators
- Cooperate with VC EMSA in monitoring, collecting data on, and evaluating local/regional EMS system indicators
- Cooperate in the re-evaluation and improvement of state and local EMS system indicators
- Develop, monitor, collect data on, and evaluate indicators specific to the EMS/BLS provider
- Conduct meetings for internal review of EMS/BLS provider information and development of performance improvement plans related to the findings
- Establish a mechanism to receive input from VC EMS, other service providers and other EMS system participants for the development of performance improvement plans
- Assure reasonable availability of EMS/BLS CQI Program training and in-service education for EMS provider personnel
- Prepare plans for expanding or improving the provider EMS/BLS CQI Program
- Participate in meetings and presentations of state EMSA and VC EMS system information for peer review to local designated advisory groups and other authorized constituents

D. Annual Updates

The EMS/BLS Provider CQI Team will annually publish summary reports of program activity for distribution.

Goals

The following Dimensions of Performance[2] and additional Aspects of Care[3] form the framework upon which the CQIP process is based. They are:

DOING THE RIGHT THING

- The ***Efficacy*** of service in relation to the client's needs.
- The ***Appropriateness*** of a specific service to meet the client's needs.

DOING THE RIGHT THING WELL

- The ***Availability*** of needed service to the client who needs it
- The ***Timeliness*** with which service is provided to the client
- The ***Effectiveness*** with which services are provided
- The ***Continuity*** of the services provided to the client with respect to other services, practitioners, and providers, over time
- The ***Respect and Caring*** with which services are provided

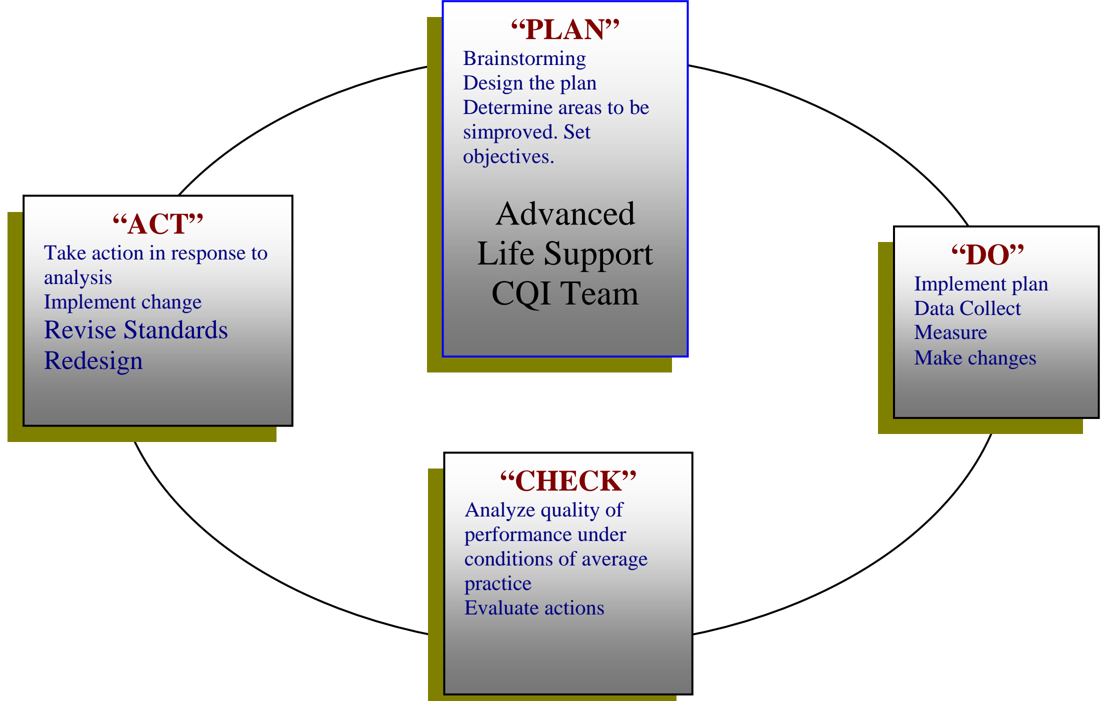
ADDITIONAL ASPECTS OF SERVICE

- Provider Staff Performance
- Support Staff Performance
- Client Record System
- Client Compliance
- Client Satisfaction

[2] Joint Commission On Accreditation of Health Care Organizations
[3] Benson, Dale S., M.S. and Miller, Jane, R.N., *Quality Assessment and Improvement for Primary Care Centers*, Methodist Hospital of Indiana, 1991: Chapter 3, p. 17-24.

CQIP Methodology

We have chosen to use the "PDCA" methodology[4] (Plan, Do, Check, Act). See Appendix VI.



Program-Level Continuous Quality Improvement Implementation Cycle

Plan

Each program will construct (or update) a strategic quality improvement action plan that links to the department's mission, vision, goals, and translates them into the program's specific domains. Programs will develop and implement ways to analyze input from internal and external customers, as well as identify external comparative data sources, and identify and prioritize program assets and needs.

The Nursing Process Model calls for programs to assess diagnosis problems and develop a plan to address them.

Do

Programs select models and methods for measuring objectives. Objectives should be "S-M-A-R-T" (*Specific, Measurable, Achievable, Relevant, Timely). Programs also develop and/or identify internal data sources (formal and/or informal) used in the next phase to establish benchmarks and assess improvement priorities. This includes developing strategies for improvement, identifying sources of relevant information, and identifying external data sources that can provide benchmarks for improvement.

Check

Programs will conduct evaluations to obtain judgments of quality (performance, outcome) about their service delivery or practice. They will also coordinate ongoing data analysis and evaluation and quality improvement efforts with the CQIP Committee. The purpose of this coordination is to improve the overall performance of Public Health.

Information from internal and external sources is collected and used to develop and assess quality improvement priorities. This step also utilizes external data and information sources to compare processes and outcomes with external benchmarks. The American Nurses Association (and other groups) provides general and specific standards for evaluation of processes and outcomes.

Act

Programs will identify next areas of improvement and revise specifications and standards to meet those new needs. They will conduct ongoing internal data analysis and evaluation, and identify areas needing quality improvement efforts. Programs will participate in the consolidation of their individual program CQIP plans to assure coordination and best use of department resources.

Priorities that programs have developed are translated into actual *improvements* and/or innovative actions. These actions then lead to the *redesign* of objectives, which completes the cycle by leading back to the "Plan" phase of designing new procedures.

SECTION I
DATA COLLECTION & REPORTING

Purpose

To improve the EMS system, information must first be collected, reported, and evaluated. The following are guidelines for data collection and reporting of EMS information.

A. Data Collection

Aspects of care which are identified as important should be monitored despite the possible complexity of necessary data or challenges associated with the data collection. All reliable sources of information should be utilized in the evaluation of system performance. EMS organizations should also consider the use of hard copy review, collection check-sheets, customer surveys, direct observation, and skills simulation.

B. Approach to Data System Development

Information systems should be designed to answer EMS system performance questions. It is strongly recommended that EMS organizations establish a practical consensus and clear understanding with all users regarding the purpose for collecting and processing the data. This step is vital to assure validity and reliability.

The following activities are recommended prior to data systems development:

1. Identify the specific mission and purpose of the organization
2. Identify the most important services that support the mission and purpose
3. Identify the resources, activities, and results that comprise the services
4. Identify what information must be reported to others, such as LEMSAs or the state EMSA
5. Identify specific questions (regarding the structures, activities, and outcomes within your organization), which need to be answered in order to better understand the success of the mission and purpose
6. Define how each question will be answered
7. Use the answers as the basis for developing indicators
8. Develop a quality indicator
9. Use the indicators as the basis for identifying what data is needed
10. Develop your technical plan for data collection based upon the elements identified
11. Test the process prior to investing in a data system
12. Recognize that an effective EMS QI Program is dynamic and therefore constantly changing, and incorporate this need for change into your data vendor contract (if applicable) and/or your data management plan

The California State EMS data set (with associated definitions) should be incorporated to allow for statewide data collection. Statewide EMS system indicators provide for comparative analysis between similar EMS providers/LEMSAs as well as statewide system evaluation. Additional data elements and code sets should be collected at a local level to focus on regional issues and concerns. The National EMS Information System (NEMSIS) data set (with associated definitions) may provide consistent data collection with these additional data elements.

Validity and Reliability

Validity - The data have validity if there is sufficient evidence to warrant the collection and use of the information for the purpose of measuring the performance of the EMS system. The information is valid if it is:

- Representative of important aspects of service performance
- Determined to be important for successful service performance
- Predictive of or significantly correlated with important elements of performance

Reliability – The data have reliability if the collection and interpretation methods can be trusted to be consistent and predictable. If the data collection is always performed in the same way, using the same data collection tools and interpreted with the same definitions, the information is likely to be reliable. Standardized definitions or agreement by the users regarding what the data will indicate and how they will be collected is critical to the success of the overall program.

C. Organizational Reporting

Data collection, reporting, and analysis shall occur at each of the four organizational levels. Each level shall submit information to their respective advisory group. Data collection and reporting should be done in the form of summary reports and may be based upon core EMS system indicators as adopted by the State EMSA, LEMSA, hospital, or individual EMS provider. Data collected specific to personnel shall only be exchanged between the personnel and provider levels. EMS information should be consistent in how it is organized, analyzed, presented and evaluated.
See A*ppendix III* for specific diagram showing the flow and exchange of information at all levels.

SECTION II
EVALUATION OF EMS SYSTEM INDICATORS

Organizational Structure
In order to provide a continuous evaluation of EMS services, it is recommended that the organizations establish technical advisory groups at each level (state, local, hospital, and provider). Each technical advisory group should be responsible for decision-making regarding evaluation and improvement and should be composed of stakeholders within the system under evaluation.
Organization of Information
EMS organizations shall develop indicators which address but are not limited to the following (*Appendix E*):
(1) Personnel
(2) Equipment and Supplies
(3) Documentation
(4) Clinical Care and Patient Outcome
(5) Skills Maintenance/Competency
(6) Transportation/Facilities
(7) Public Education and Prevention
(8) Risk Management
The recommended approach to organizing data and other sources of information is through the development and use of standardized indicators.

Indicators Defined
According to the Joint Commission on Accreditation of Healthcare Organizations, an indicator is "a quantitative performance measure…a tool that can be used to monitor performance and direct attention to potential performance issues that may require more intensive review within an organization." In other words, an EMS indicator measures the degree of conformance to a reasonable expectation as defined by the community served. Indicators may be related to structures (people, places, things), processes (activities occurring in a system), and outcomes (the results of the structures and activities within a system). In fact, the three types of indicators (structure, process, and outcome) are all related and dependent upon one another. Hence the following equation:

STRUCTURE + PROCESS = OUTCOME

Changes in structure may affect the process and the outcome. Likewise, changes in the process may affect the structure and outcome. Indicators, in short, are a way to simplify information so that data can be digested more efficiently and in a meaningful way.

Required EMS System Indicators

Statewide EMS system indicators as developed and adopted by the EMSA should be incorporated to allow comparison within the state at all levels. These indicators are developed through a statewide consensus process and supported by the statewide data system.

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Optional EMS System Indicators

Recommended indicators are developed and designed on an as-needed basis and may be used for the long or short term or on an ad hoc basis depending on the goals of the group developing the indicators. While the state may develop some indicators, most development will occur at the local level. All EMS organizations are encouraged to develop their own indicators based upon their specific needs. Ad hoc indicators are not reported outside of the specific user group and level of organization.

Analysis
Prior to presenting or distributing indicators, it is recommended that the results be analyzed to include measurements appropriate for rapid interpretation by evaluators. Measurements may include the following:

- Statistical
    - Measures of Central Tendency
    - Measures of Dispersion
- Process Analysis
    - Trending
    - Causation
    - Benchmarking
    - Best Practices
    - Published References

Presentation
The results and measurements of indicators should be presented to the users of the information in a formal process and on a regularly scheduled basis. Each presentation should include the purpose, objectives, references, benchmarks, measurements, and indicator detail sheet for clarification of data. The indicator information should be displayed to evaluators in a format that is most appropriate for the speed and ease of interpretation. The following are typical ways to display an indicator result:

Flow Chart
Fishbone – Cause and Effect Diagram
Pareto Chart
Histogram
Scatter Diagram
Run Chart
Control Chart

Examples, definitions, and application of these display methods are illustrated in *Appendix L.*

Decision-Making Process
Each organizational level should have a structured process for making decisions. The following is a general outline of the steps in a structured process for evaluation and decision-making by the Technical Advisory Group:

1. Identify the objectives of evaluation
2. Present indicators and related EMS information
3. Compare performance with goals or benchmarks
4. Discuss performance with peers/colleagues
5. Determine whether improvement or further evaluation is required
6. Establish plan based upon decision
7. Assign responsibility for post-decision action plan

SECTION III
ACTION TO IMPROVE

Approach to Performance Improvement
Once valid information has been presented and reliability evaluated, the decision to take action or to solve a problem requires a structured approach that is adaptable and applied to each situation as it is identified. There are many standardized and well-developed quality/performance improvement programs, which may be used during this phase. In all cases, each EMS QI Program Technical Advisory Group should choose an improvement method that is systematic and based upon evidence. The approach to improvement should also be team oriented and be done in a way that does not overwhelm the process due to size and complexity. Small wins are sometimes the basis for the larger wins. It is recommended that initial improvement projects be simple and based upon a strong consensus within the Technical Advisory Group that improvement will benefit all.

Technical Advisory Group
The EMS QI Program at each organizational level should have an oversight body that is responsible for implementing the quality/performance improvement plan. This group may be the same group that collects data from and evaluates the local system. The group should be responsible for delegating action to smaller groups (e.g., the Quality Task Force) and for monitoring the process as it unfolds within the system.

Quality Task Force
It is recommended that the Technical Advisory Group utilize smaller groups within the organizational level to carryout improvement action plans. Quality Task Forces are smaller sub-groups of the larger quality oversight body. Task forces are established to develop and implement action plans. Each task force has one project and is responsible for reporting all activities to the larger oversight group. Once the project is completed, the task force is disbanded. There may be more than one task force working concurrently, with each task force working on a specific action plan.
Note: Availability of resources can vary greatly between urban and rural agencies. It is understood that one task force may handle multiple projects or the Technical Advisory Group may handle the projects without forming any task forces.

Performance Improvement Plan
While there are many approaches to a Performance Improvement Plan within an organization, it is recommended that each Quality Task Force choose a standardized approach and use the same process each time a project is undertaken. The following are traditional components of a standardized improvement process:

- Establish criteria for measurement and evaluation
- Evaluate information
- Make a decision to take action to improve
- Establish criteria for improvement
- Establish an improvement plan
- Measure the results of the improvement plan
- Standardize or integrate change (plan) into the system
- Establish a plan for monitoring future activities

SECTION IV
TRAINING AND EDUCATION

Introduction

Effectiveness of the EMS QI Program and related training is directly proportional to the energy and resources committed. Administrative oversight should be available and directly involved in the process. When clinical issues are addressed, medical oversight is recommended.

Action to improve process is intertwined with training and education

Once the decision to take action or to solve a problem has occurred, training, and education are critical components that need to be addressed. As a Performance Improvement Plan is developed, the Technical Advisory Group will establish criteria for measurement and evaluation. Based on these criteria, delivery methods and content of training will be developed. This integrated process will avoid any misdirection that may occur when training is isolated from the EMS QI Program. Success of the performance improvement plan is dependent upon changing the behavior and knowledge of the staff who deliver care to patients or services to other participants (e.g., EMSA to LEMSA, LEMSA to EMS provider) in the EMS system. To implement change, you must deliver verifiable, ongoing training that is appropriate to the skill level and service goals of the organization.

Medical direction

To successfully implement a Performance Improvement Plan, the organization's EMS QI Program team shall have input into the content and delivery methods of related training and education. This involvement will provide consistency between the current and subsequent Performance Improvement Plans. The structure of the organization shall place the oversight for directing clinical training and education at the highest level of medical knowledge.

Measure the results of the Performance Improvement Plan

Once the Performance Improvement Plan has been implemented, the measurement of a successful outcome will be dependent upon the validity of the plan and the effectiveness of the training and education. If the outcome is not satisfactory, it is necessary to examine both the content of the Plan and delivery method of related training and education.

Integrate change

Once the Performance Improvement Plan has been successfully implemented, the organization needs to standardize the changes within appropriate policies and procedures. When appropriate, assure that staff have successfully completed the training and educational components of the plan. The final steps in integrating change into the system will be to schedule continuing education at appropriate reoccurring intervals and re-evaluate the original EMS system indicators.

SECTION V
Annual Update Guidelines

The Annual Update is a written account of the progress of an organization's activities as stated in the EMS QI Program. In compiling the Annual Update, refer to the previous year's update and work plan.

Description of agency

The description should include an organizational chart showing how the EMS CQI Program is integrated into the organization.

Statement of EMS CQI Program goals and objectives

Describe processes used in conducting quality improvement activities.
Were goals and objectives met?

List and define indicators utilized during the reporting year

- Define state and local indicators
- Define provider specific indicators
- Define methods to retrieve data from receiving hospitals regarding patient diagnoses and disposition
- Audit critical skills
- Identify issues for further system consideration
- Identify trending issues
- Create improvement action plans (what was done and what needs to be done)
- Describe issues that were resolved
- List opportunities for improvement and plans for next review cycle
- Describe continuing education and skill training provided as a result of Performance Improvement Plans
- Describe any revision of in-house policies
- Report to constituent groups
- Describe next year's work plan based on the results of the reporting year's indicator review

Sample Work Plan Template

Indicators Monitored	Key Findings/Priority Issues Identified	Improvement Action Plan Plans for Further Action	Were Goals Met? Is Follow-Up Needed?

SECTION VI
Confidentiality

The activities of the VC EMS CQI Program are legally protected under the California Health & Safety Code Section 1157. The law protects those who participate in quality of care or utilization review. It provides further that "neither the proceedings nor the records of such reviews shall be subject to discovery, nor shall any person in attendance at such reviews be required to testify as to what transpired thereat."

All copies of minutes, reports, worksheets and other data are stored in a manner ensuring strict confidentiality. A written confidentiality policy detailing procedures for maintenance and release of data and other information governs the release of such information. This policy specifies the use of record number or other identifiers in place of client names, and code numbers in place of provider and staff names. This policy also provides methods for restricting all quality improvement documents solely to authorized individuals. In addition, all data shall be considered protected information under the provisions of the California Evidence Code 1157.

EMS Agency CQI Program Coordinator	EMS Agency CQI Medical Director	EMS Agency CQI Committee Member
Signature:	Signature:	Signature:
Date:	Date:	Date:
		Position:

APPENDIX I

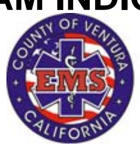
VENTURA COUNTY PUBLIC HEALTH DEPARTMENT CODE OF ETHICS

It is the mission of the Ventura County Public Health Department (VCPH) to optimize the health of the community by promoting healthy lifestyles, and preventing and controlling disease, injury and disability. VCPH will operate according to the following code of ethics to carry out this mission. We will:

- **A**ddress the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes and promote positive health outcomes.
- **D**evelop and evaluate policies, programs, and priorities through processes that foster an opportunity for input from community members.
- **A**dvocate and work for the empowerment of disenfranchised community members, making every effort to ensure that the basic resources and conditions necessary for health are accessible to all people in our communities.
- **S**eek the information needed to implement effective policies and programs that protect and promote health.
- **P**rovide communities with the best available information needed for decisions on policies or programs.
- **A**ct in an appropriate and timely manner on available health information within our resources and mandate.
- **I**ncorporate into our programs and policies a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in our communities, and that also respect and protect the rights of individuals.
- **I**mplement programs and policies in a manner that most enhances our physical and social environment.
- **P**rotect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.
- **E**nsure and continually enhance the professional competence of our employees, and of the department as a whole.
- **E**ngage in collaborations and affiliations with our communities and other health and human services entities in ways that build the public's trust, the effectiveness of our employees, and of our department as a whole.

APPENDIX II

VENTURA COUNTY EMS AGENCY
PROGRAM INDICATORS



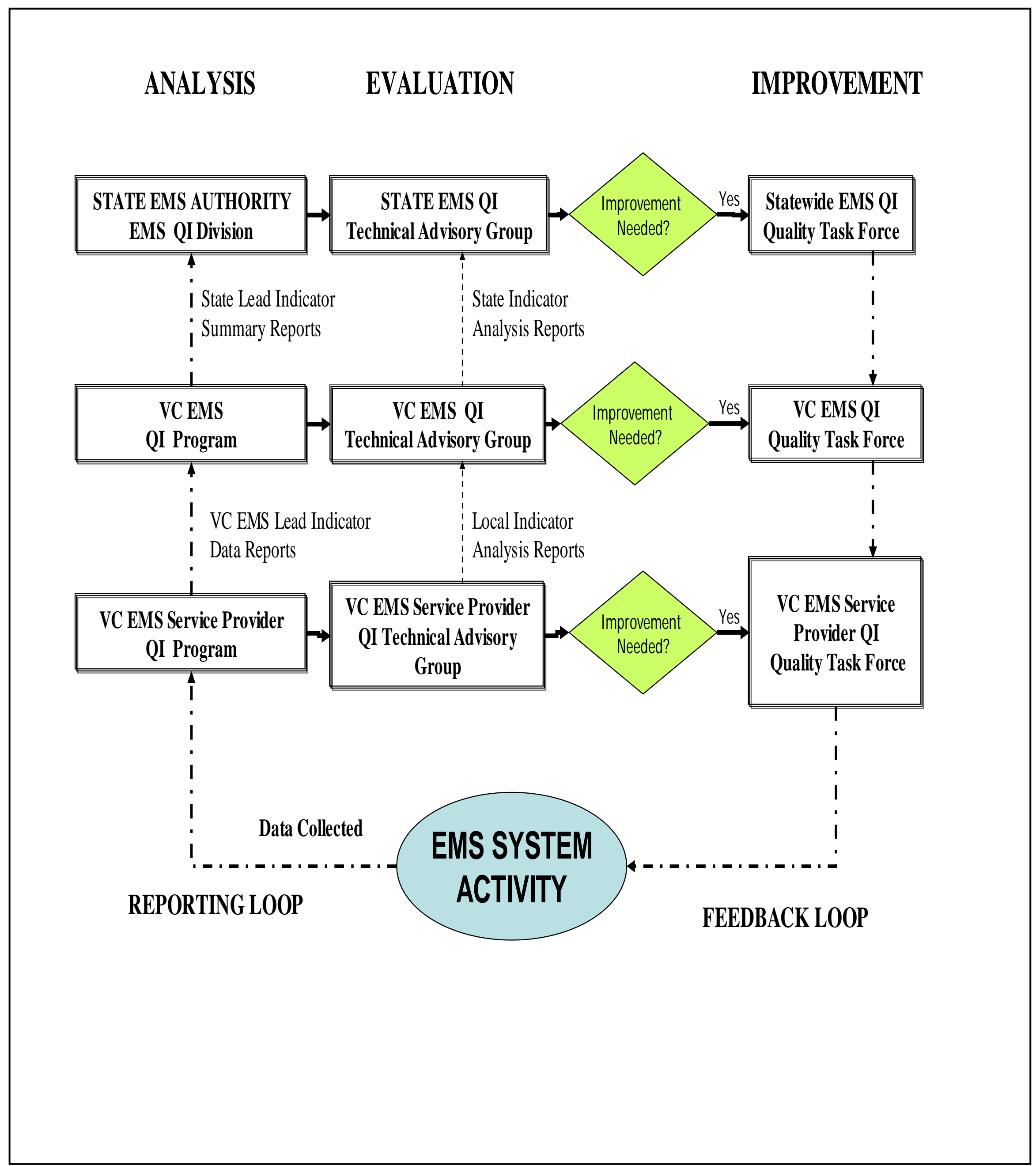
Measure	Definition	Goal
Emergency Medical Dispatch % "Call Entry" correctly followed	Verification of call back #, initial patient conditions to establish Priority Dispatch Determinant	Measured on high risk and random calls 96% C.E. Std, 90% Scoring Std
Emergency Medical Dispatch % correct EMD card selected	Prewritten dispatch card selected based on responses by reporting party	Measured on high risk and random calls 96% C.E. Std, 90% Scoring Std
Emergency Medical Dispatch %Dispatch/Treatment questions asked	Questions asked verbatim related to chief complaint	Measured on high risk and random calls 96% C.E. Std, 90% Scoring Std
Emergency Medical Dispatch %Correct Pre-arrival instructions given	Instructions given correctly to reporting party related to chief complaint	Measured on high risk and random calls 96% C.E. Std, 90% Scoring Std
Emergency Medical Dispatch % Correct final coding	Coding assigned and dispatched correctly	Measured on high risk and random calls 96% C.E. Std, 90% Scoring Std
Advanced Life Support %Rhythm Recognition on 100% patients with AF and SVT	Difference between Rapid Atrial Fibrillation and Supraventricular Tachycardia	Identification of paramedic skill reflective on county education and policy
Advanced Life Support CQI %Correct documentation	Prehospital documentation completed as required on above cases	100% correct documentation using county approved electronic documentation tool
Advanced Life Support CQI % Correctly Intubated Medical Arrests	Number of attempts, Number of successful attempts, reasons for failure. Correct use of policy.	Benchmark not determined Identification of success rate and focus areas for improvement
Advanced Life CQI Team % Correctly Intubated Traumatic Arrests	Number of attempts, Number of successful attempts, reasons for failure. Correct use of policy.	Benchmark not determined Identification of both success rate and focus areas needed for improvement
Advanced Life Support CQI %Correctly Intubated Respiratory Extremis	Number of attempts, Number of successful attempts, reasons for	Benchmark not determined Identification of both success rate and focus

	failure. Correct use of policy.	areas needed for improvement
Advanced Life Support CQI Correct parameters used to determine necessity for intubation on the patient in Respiratory Extremis	Level of Consciousness, Chief Complaint, O2 Saturation, Respiratory Effort, Glascow Coma Scale, Skins will be the evaluation criteria for determining need for intubation on patients presenting with Resp Extremis	Determination of benchmark in progress. Goal is to provide prehospital care providers with parameters to use in determining need for intubation on the patient who is "alive".
Base Hospital CQI % Medication Errors in prehospital venue	Dose, route, patient, drug, calculation, and policy compliance measured	Measurement of skills performance. Determine focus areas for improvement
Base Hospital CQI % Correctly administered Versed in prehospital venue	Dose, route, patient, drug, calculation, and policy compliance measured	Measurement of skills performance. Determine focus areas for improvement
Advisory Team CQI *Trauma Study* Time Study • On Scene • Dispatch to arrival	Compliance with required time to destination (8minutes) Reasonable amount of time spent on scene	100% compliance with dispatch to arrival time of 8 minutes Individual case evaluation of time on scene
Advisory Team CQI *Trauma Study* % Correct Trauma Assessment	Physical assessment and scene assessment done according to VC EMS policy with correct documentation	Comprehensive and appropriate physical and scene assessment performed
Advisory Team CQI *Trauma Study* % Indicated procedures performed	Correct procedures done in response to physical assessment and history	100% of indicated procedures completed based on physical and scene assessment
Advisory Team CQI *Trauma Study* % Correct medications given	Medications given according to physical assessment and history in accordance to VC EMS policy	Medications given according to policy 100% of the time
Advisory Team CQI *Trauma Study* % Vital signs taken	Objective data obtained on a regular basis, and in response to treatment administered	V/S will be monitored and documented according to pt condition and treatments administered 100% of the time
Unusual Occurrences % annual occurrences by categories, providers	Events outside the norm of acceptable patient care, or outside the normal flow of operations surrounding dispatch, response, rescue and disposition of all ALS and BLS Calls	Events trended to identify focal areas for improvement in delivery of EMS care in the County of Ventura.

Appendix III

Ventura County EMS Agency
Flow of Information and Activity

This diagram illustrates the organizational structure for analysis, evaluation, and improvement and demonstrates the fundamental interconnectedness of these critical components. Comprehensive evaluation lays the foundation upon which improvement shall occur.


ANALYSIS
EVALUATION
IMPROVEMENT
STATE EMS AUTHORITY
EMS QI Division
STATE EMS QI
Technical Advisory Group
Improvement Needed?
Yes
Statewide EMS QI
Quality Task Force
State Lead Indicator
Summary Reports
State Indicator
Analysis Reports
VC EMS
QI Program
VC EMS QI
Technical Advisory Group
Improvement Needed?
Yes
VC EMS QI
Quality Task Force
VC EMS Lead Indicator
Data Reports
Local Indicator
Analysis Reports
VC EMS Service Provider
QI Program
VC EMS Service Provider
QI Technical Advisory
Group
Improvement Needed?
Yes
VC EMS Service
Provider QI
Quality Task Force
Data Collected
EMS SYSTEM
ACTIVITY
REPORTING LOOP
FEEDBACK LOOP

I. PURPOSE: To identify the procedure for certification of Emergency Medical Technician – 1.

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

III. POLICY:

A. General Eligibility

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

1. Have a valid EMT-I course completion record or other documented proof of successful completion of an approved EMT-I course or
   Have documentation of successful completion of an approved out of state EMT-I training course, within the last two years which meets the requirements of the California EMT Program Content as identified in Title 22,
2. Apply for certification within two years of the date of completion,
3. Pass a competency based written and skills certifying examination approved by the EMS Authority,
4. Be eighteen years of age or older,
5. Complete the Ventura County EMS Personnel Application,
6. Complete the Ventura County Eligibility Statement (a statement that the individual is not precluded from certification for reasons defined in Section 1798.200 of the Health and Safety Code),
7. Have successfully completed a Professional Rescuer or Healthcare Provider level BLS & CPR course, which is consistent with the American Heart Association 2005 Guidelines for CPR and ECC, within the previous two years,
8. Submit printed documentation of successful completion of a CPR skills evaluation using a recording/reporting manikin within the previous 90 days. Skill proctor must sign the evaluation in order for the verification to be valid.
9. Provide a government issued form of identification,

10. Pay the established fee, and;
11. Complete a background investigation via "Live Scan" through the California Department of Justice with VCEMS as the requesting agency.
12. It is the responsibility of the certified EMT to notify VCEMS within 7 days of any change in their eligibility status as outlined in Health and Safety Code, Division 2.5, Section 1798.200. (For items that this Section applies to, see EMS Personnel Application, Eligibility Statement.)

B. Challenge and Reciprocity
   1. An individual currently licensed in California as a Paramedic or is certified in California as an EMT-II (except when the paramedic license or EMT-II certification is under suspension) is deemed to be certified as an EMT-1 with no further testing. In the case of a paramedic license which is under suspension, the paramedic shall apply for certification.
   2. An individual who possesses a current and valid National Registry EMT Basic, Intermediate or Paramedic certificate or out of state paramedic license shall be eligible for certification upon fulfilling the requirements of III.A.4-10.
   3. An individual who possesses a current and valid out of state EMT-I certificate shall be eligible for certification upon fulfilling the requirements of III.A. 2-10.
      a. An eligible person shall be permitted to take the EMT-I Course Challenge Exam only one time.
      b. An individual who fails to achieve a passing score of 80% on the EMT-I recertification course challenge examination shall successfully complete an EMT-I course to receive an EMT-I course completion record.

C. Lapse in EMT-II Certification or Paramedic License:
   1. In order for an individual whose California EMT-II certification or Paramedic License has lapsed, to be eligible for certification as an EMT-I the individual shall:
      a. For a lapse of less than six months, the individual shall comply with the requirements by complying with VCEMS Policy 302, III. A or B.
      b. For a lapse of six months or more, but less than twelve months, the individual shall comply with the requirements of VCEMS Policy 302, III A or B and complete an additional twelve hours of continuing education for a total of 36 hours of training.
      c. For a lapse of twelve months or more, but less than 24 months, the individual shall comply with the requirement in VCEMS Policy 302, III, A

or B and complete an additional twenty-four hours of continuing education for a total of 48 hours of training and the individual shall pass the EMT-I written and skills certification exam.

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

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

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

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

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

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

a. Examples of applicable C.E.:

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

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

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

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

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

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

b. CE Limitations

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

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

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

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

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

a. Patient examination – Trauma patient
b. Patient examination – Medical patient
c. Airway emergencies
d. Automated external defibrillation
e. Circulation emergencies
f. Neurological emergencies
g. Soft tissue injuries
h. Musculoskeletal injuries
i. Obstetrical emergencies

3. Successfully complete a Professional Rescuer or Healthcare Provider level BLS & CPR course, which is consistent with the American Heart Association 2005 Guidelines for CPR and ECC, within the previous two years.
4. Unless employed by a VC EMS provider, submit printed documentation of successful completion of a CPR skills evaluation using a recording/reporting manikin within the previous 90 days.
5. Applicants for recertification may attain CE at anytime through the valid certification period. If the applicant applies for recertification within the 6 months prior to the end of the current expiration date, the new expiration date shall be two years from the previous expiration date. If the applicant applies for recertification greater than 6 months prior to the end of the current certification period, the expiration date shall be the final day of the month of the 2 year period in which certification requirements are met.
   a. Applicants shall provide original course completion records at time of application. VCEMS will verify continuing education, copy and return originals to the applicant.
   b. Approved Ventura County ALS and BLS Provider Agencies may submit documentation of continuing education for their staff on the attached continuing education roster provided they were the provider of the education. Continuing education not obtained by a Ventura County provider must be documented by submission of course completion records. Continuing education may be audited.
6. Applicants must possess a valid EMT-I Certificate, which has been expired for no more than two-years to be eligible for recertification.
7. Completion of recertification application, background investigation via Live Scan fingerprints with VCEMS as the requesting agency if needed and payment of applicable fees.
8. VCEMS will obtain a computer generated photograph of each applicant at time of application for issuance of photo certification card. For those applicants with a current photograph in the VCEMS database, this requirement may be waived.
9. It is the responsibility of the certified EMT to notify VCEMS within 7 days of any change in their eligibility status as outlined in Health and Safety Code, Division 2.5, Section 1798.200. (For items that this Section applies to, see EMS Personnel Application, Eligibility Statement.)

Refresher Course Method

1. Completion of a twenty-four hour refresher EMT-1 course, not including testing.

2. Submit a completed EMT-I Skills Competency Verification form, EMSA-SCV (07/03). (Skills competency is not included in the twenty-four hours of required continuing education). Skills competency shall be verified by an individual who is currently certified or licensed as an EMT-I, EMT-II, Paramedic, RN, PA, or physician and who shall be designated by an EMS approved training program (EMT-I training program, paramedic training program or continuing education provider) or an EMS service provider; (EMS service providers include, but are not limited to public safety agencies, private ambulance providers and other EMS providers). The skills requiring verification of competency are:
   a. Patient examination – Trauma patient
   b. Patient examination – Medical patient
   c. Airway emergencies
   d. Automated external defibrillation
   e. Circulation emergencies
   f. Neurological emergencies
   g. Soft tissue injuries
   h. Musculoskeletal injuries
   i. Obstetrical emergencies
3. Completion of Agency required updates.
4. Successful completion of a Professional Rescuer or Healthcare Provider level BLS & CPR course, which is consistent with the American Heart Association 2005 Guidelines for CPR and ECC, within the previous two years.
5. Unless employed by a VC EMS provider, submit printed documentation of successful completion of a CPR skills evaluation using a recording/reporting manikin within the previous 30 days.
6. Applicants must possess a valid EMT-I certificate which has been expired for no more than two years to be eligible for recertification.
7. Completion of recertification application, background investigation via Live Scan fingerprints with VCEMS as the requesting agency, if needed and payment of applicable fees.
8. VCEMS will obtain a computer generated photograph of each applicant at time of application for issuance of photo certification card. For those applicants with a current photograph in the VCEMS database, this requirement may be waived.
9. It is the responsibility of the certified EMT to notify VCEMS within 7 days of any change in their eligibility status as outlined in Health and Safety Code, Division

2.5, Section 1798.200. (For items that this Section applies to, see EMS Personnel Application, Eligibility Statement.)

C. Recertification after Lapse in Certification:

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

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

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

See back of form for instructions for completion

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

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

INSTRUCTIONS FOR COMPLETION OF EMT-I SKILLS COMPETENCY VERIFICATION FORM

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

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

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

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

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

Verification of Competency

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

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

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

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

EMT Recertification by Continuing Education

Documentation of Hours

Name: ____ **Date:** _________________________ **EMT Certification #:** ____________________

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

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

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

Signature: ____ **Date:** __________________________________

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

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

III. POLICY:

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

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

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

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

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

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
EMT-I/ /Paramedic/MICN Decertification and Discipline</td><td>Policy Number
330</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, EMT-P</td><td>Date: June 1, 2009</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Angelo Salvucci, M.D.</td><td>Date: June 1, 2009</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>April 9, 1985
December 12, 2008
December 12, 2008
December 31, 2011</td><td>Effective Date: June 1, 2009</td></tr>
</table>

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

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

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

GROUNDS FOR DISCIPLINARY ACTION:

A. Evidence that one or more of the following actions that constitute a threat to public health and safety has/have occurred:
   1. Fraud in the procurement of any certification, license or authorization.
   2. Gross negligence or repeated negligent acts
   3. Incompetence.
   4. Commission of any fraudulent, dishonest, or corrupt act, which is substantially related to the qualifications, functions, and duties of prehospital personnel.
   5. Conviction of any crime, which is substantially related to the qualifications, functions and duties of prehospital personnel. The record of conviction shall be considered conclusive evidence.
   6. Violation of or an attempt to violate or assistance in or abetting the violation of, or conspiring to violate, any provision of Division 2.5 of the Health and Safety Code, or of the regulations promulgated by the California State Emergency Medical Services Authority, or the County of Ventura pertaining to prehospital care personnel.

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

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

IV. PROCEDURE:

A. Submission of Claim.

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

B. Notification of Claim against Certificate Holder.

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

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

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

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

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

C. Review of Submitted Material.

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

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

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

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

I. PURPOSE: To provide a method to ascertain the criminal background history of persons applying for EMT-I certification/authorization or Paramedic accreditation as EMS Prehospital care personnel in Ventura County.

II. AUTHORITY: California Health and Safety Code, Section 1798.200, California Code of Regulations, Section 100206, et seq. Title 13, California Code of Regulations, Section 1101.

III. POLICY:

A. All applicants for Ventura County certification/authorization or accreditation (EMT-I and Paramedic) shall complete a California Bureau of Criminal Identification, Department of Justice background check via Live Scan Service as a condition of initial EMT-I certification, Ventura County EMT-I authorization, first time EMT-I recertification in Ventura County, or Paramedic accreditation by the Ventura County EMS Medical Director. At such time as it is allowed legislatively, a Federal background check shall be done.

B. Exceptions

1. Law Enforcement Agencies

Currently employed County and municipal sworn law enforcement personnel in the County of Ventura may satisfy this requirement by presentation of a photo identification card from his/her agency. Employment status will be verified. (Law Enforcement background checks are defined by GC 1030.)

2. Fire Departments

Currently employed County and municipal sworn fire department personnel in the County of Ventura may satisfy this requirement when a statement, on agency letterhead, from the Chief of his/her employing agency is submitted stating that the employment background investigation process meets the procedure outlined in Section III.A and C and by presentation of a photo identification card from his/her agency. Employment status will be verified. All new employees applying for Ventura County certification/accreditation or authorization will be required to complete the Background Check via Live Scan. If employment of this individual is terminated, VC EMS must be notified immediately, and followed up in writing via e-mail, U.S. Mail or

fax, within 24 hours. The individual will be contacted by VCEMS and required to perform the required background check.

3. Federal Departments

Currently employed Federal personnel working on bases in the County of Ventura may satisfy this requirement when a statement from the Chief of his/ her employing agency is submitted stating that the employment background investigation process meets the procedure outlined in Section III.A and C and by presentation of a photo identification card from his/her agency. Employment status will be verified. . All new employees applying for Ventura County certification/accreditation or authorization will be required to complete the Background Check via Live Scan. If employment of this individual is terminated, VC EMS must be notified immediately and followed up in writing, via e-mail, U.S. Mail or fax, within 24 hours. The individual will be contacted by VCEMS and required to perform the required background check.

4. State of California Departments

Currently employed State of California personnel may satisfy this requirement when a statement on agency letterhead from the Chief of his/her employing agency is submitted stating that the employment background investigation process meets the procedure outlined in Section II.A and C and by presentation of a photo identification card from his/her agency. Employment status will be verified. All new employees applying for Ventura County certification/accreditation or authorization will be required to complete the Background Check via Live Scan. If employment of this individual is terminated, VC EMS must be notified immediately, and followed up in writing, via e-mail, U.S. Mail or fax, within 24 hours. The individual will be contacted by VCEMS and required to perform the required background check.

5. Ventura County Sheriff Search and Rescue

Currently employed VCSO SAR personnel may satisfy this requirement when a statement on agency letterhead from the Chief of his/her employing agency is submitted stating that the employment background investigation process meets the procedure outlined in Section II.A and C and by presentation of a photo identification card from his/her agency. Employment status will be verified. All new employees applying for Ventura County certification/accreditation or authorization will be required to complete the Background Check via Live Scan. If employment of this individual is terminated, VC EMS must be notified immediately, and followed up in writing, via e-mail, U.S. Mail or fax, within 24 hours. The individual will be contacted by VCEMS and required to perform the required background check.

C. Ventura County EMS shall contract with the California Bureau of Criminal Identification for subsequent arrest notification.

D. Criteria in Health and Safety Code Section 1798.200 and 13CCR1101 et al shall be used to determine whether certification is given or denied based upon the results of the background check (Refer to Policy 333).

IV. PROCEDURE:

A. All applicants for certification/authorization or accreditation shall contact the Ventura County EMS Office for the fingerprinting procedure.

B. This procedure applies to:

1. All persons applying for initial California EMT-I certification/authorization in Ventura County
2. EMT-I recertification in Ventura County for the first time
3. EMT-I recertification in Ventura County, after lapse in certification, and the Department of Justice has been notified that subsequent notices are no longer required.

Policy Title: Pre-Hospital Personnel Mandatory Training Requirements		Policy Number: 334
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: June 1, 2009
APPROVED: Medical Director	Angelo Salvucci, MD	Date: June 1, 2009
Origination Date: Date Revised: Date Last Reviewed: Review Date:	September 14, 2000 December 11, 2008 December 11, 2008 December 31, 2012	Effective Date: June 1, 2009

I. PURPOSE: To define the requirements for mandatory training sessions for EMT-1s, Paramedics, EMT-ALS Assist SAR EMT-1s, MICNs and Flight Nurses in Ventura County.

II. AUTHORITY: Title 22, California Code of Regulation, Division 9, Section 100175 and Chapter 6. Health and Safety Code Section 1797.214, 1797.220 and 1798.200.

III. POLICY: All pre-hospital personnel have requirements for on-going authorization or accreditation to provide pre-hospital care in Ventura County. These requirements are outlined in VCEMS Policy 318 for Paramedics, 306 and 803 for EMTs, 1201 for Flight Nurses and SAR EMT-1s and 322 for MICNs.

III. PROCEDURE:

A. EMS Updates – Applies to all personnel listed above except EMT-1's.
Personnel shall attend mandatory education and/or testing on updates to local policies and procedures (EMS Update), which will be presented by the Base Hospitals in May and November each year (minimum of 12 opportunities to attend each session). Prehospital Services Committee members who attend 75% of the scheduled meetings over the previous 6 months may have this requirement waived.

B. MCI Training – Applies to all personnel listed above except MICN's.
Personnel shall attend initial Basic or Advanced MCI training within 6 months of initially starting the certification or accreditation process and complete bi-annual refreshers as indicated in VC EMS Policy 131.

C. Grief Training – Applies to all personnel listed above except MICN's.
All personnel shall be provided the self-study packet titled "Dealing with Grief: A Workbook for Prehospital Personnel." After finishing the self-study packet, personnel shall complete the post-test and evaluation and mail them to VC EMS for a course completion and 2 hours CE credit. This requirement shall be completed within 6 months of initially starting the certification or accreditation process.

D. Emergency Response to Terrorism – Applies to all personnel listed above.

All personnel shall be provided the self-study packet titled "Emergency Response to Terrorism." After finishing the self-study packet, personnel shall complete the post-test and mail it to VC EMS for a course completion and 3 hours CE credit. This requirement shall be completed within 6 months of initially starting the certification or accreditation process.

E. Paramedic Skills Refresher – Applies to Paramedics only

1. Paramedics shall attend one skills refresher session during the first year of licensure and one skills refresher in the second year of licensure.
2. Skills Refreshers will be offered at least 4 times in March and 4 times in September and will be offered over a 3 week period. Dates, times, and locations for the Skills Refreshers will be published one year in advance. Late arrivals will not be admitted into the Skills Refresher.

F. Nerve Agent Training – Applies to Paramedics only

All personnel shall be provided the self study PowerPoint presentation entitled "Ventura County EMS Nerve Agents: Recognition and Treatment". Providers shall forward a copy of the attendance roster to VCEMS to verify completion of the training. New employees shall complete training within 6 months of initially starting the accreditation process.

G. Field Intubation Refresher Training– Applies to Paramedic and SAR Flight Nurses only

One intubation refresher session per six (6) month period based on license cycle as described in Policy 318.

H. Advanced Cardiac Life Support (ACLS)- Applies to all personnel listed above except EMT-1's and SAR-EMT-1's.

ACLS course completion certificate shall be obtained within three months of initially starting the certification or accreditation process and remain current.

I. Pediatric Advanced Life Support (PALS) or Pediatric Education for Prehospital Providers (PEPP)- Applies to Paramedics only.

PALS or PEPP course completion certificate shall be obtained within six months of initially starting the accreditation process and remain current.

J. Failure to complete mandatory requirements:

1. Level II Paramedics who fail to complete any of these requirements will immediately revert to a Level I Paramedic according to VCEMS Policy 318. The Paramedic's accreditation to practice in Ventura County will be suspended after the State required 15 day notice until the following remediation criteria has been

met. All other required personnel who fail to complete these requirements will have their authorization immediately suspended.

2. Reinstatement of authorization or accreditation:
   a. Personnel who have not completed MCI Training, Grief Training or Emergency Response to Terrorism must complete the requirements and provide documentation of completion to VC EMS for determination on reinstatement.
   b. Personnel not attending EMS Update must complete the following remediation criteria.
      1) Personnel will attend a make-up session to be scheduled by VC EMS within 2 weeks of the last regularly scheduled EMS Update session.
      2) Personnel will submit a written statement to VC EMS explaining the circumstances why this requirement could not be met.
      3) Submit a $125.00 fine.
      4) A written post-test will be administered, and must be successfully completed by achieving a minimum passing score of 85%.
      5) If the VC EMS make up session is not attended, the employer may elect to assist the person in completing the requirement.
         a) The employer shall use the materials and test supplied by VC EMS.
         b) The employer will be responsible to forward the written statement and $125.00 fine to VC EMS.
         c) The employer will administer the written test and will forward it to VC EMS for scoring. Minimum passing score will be 85%.
         d) A make up session arranged by an employer will be approved by VC EMS before it is presented.
   c. Paramedics not attending Skills Refresher must complete the following remediation criteria.
      1). Paramedic will submit a written statement to VC EMS explaining the circumstances why this requirement could not be met.
      2) Submit a $125.00 fine.
      3) Paramedic will attend a remediation session on documentation and review of VC EMS Policy 318 to be administered by VC EMS.

4) ALS provider will confirm paramedic has read and reviewed VC EMS Policy and Procedure Sections 6 & 7.

5) ALS provider will be responsible to coordinate a Skills Refresher make-up session conducted by either an ALS Service Provider Medical Director, base hospital physician or their designee. Skills Refresher make-up will include all skills covered at the most recent Skills Refresher.

6) ALS provider will submit a written plan of action to VC EMS to include: course curriculum, date and location of Skills Refresher make-up, equipment to be used and names of instructors.

7) Completed reinstatement checklist, will be submitted to VC EMS for review and determination on reinstatement of paramedic accreditation.

PARAMEDIC SKILLS REFRESHER REINSTATEMENT CHECKLIST

Paramedic Name: ______________________________________ **CA License No.:** ___________

Action	Date	Signature
1. Read and reviewed EMS Policy and Procedure Sections 6 & 7 (signed by provider).		
2. Orientation at EMS Office, Policy 318 review.		
3. Documentation Station: Administered by EMS		
4. Skills refresher verification: The skills must be signed off by a BH physician or Medical Director associated with your employer.		
a.		
b.		
c.		
d.		
e.		
f.		
g.		

After the above is completed, please forward the checklist to the EMS Agency for review and determination on reinstatement of paramedic accreditation.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
Prehospital Care Coordinator Job Duties</td><td>Policy Number
350</td></tr>
<tr><td>APPROVED:
Administration:</td><td colspan="2">Steven L. Carroll, EMT-P</td><td>Date: June 1, 2009</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td colspan="2">Angelo Salvucci, M.D.</td><td>Date: June 1, 2009</td></tr>
<tr><td>Origination Date:
Revised Date:
Date Last Reviewed:
Review Date:</td><td>June 15, 1998
February 12, 2009
February 12, 2009
February 28, 2012</td><td colspan="2">Effective Date: June 1, 2009</td></tr>
</table>

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

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

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

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

IV. PROFESSIONAL QUALIFICATIONS:

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

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

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

D. Have at least three years emergency department experience.

V. SPECIFIC RESPONSIBILITIES:

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

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

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

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

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

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

f. Provide written evaluation of the paramedics.

g. Provide post-incident critiques for hospital and prehospital personnel as identified through the continuous quality improvement process.

5. Investigate prehospital care unusual occurrences as requested by VC EMS. Such review shall include but not be limited to:
   a. Patient assessment
   b.. Appropriateness of care
   c. Patient outcomes
   d. Adherence to Ventura County protocol/policies
   e. Response times
   f. Scene times
   g. Correct documentation

7. Ensure the operation of the base hospital communication equipment.
   a. In conjunction with the Base Hospital PLP, ensure that all personnel assigned to communicate with paramedics in the field have attended an MICN developmental course approved by VC EMS.
   b. Ensure that the radio equipment is operational.
   c. Ensure that ReddiNet System is operational and up to date.

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

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

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

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

12. Represent the Base Hospital at the Prehospital Care Committee, PCC meeting and other associated task forces and special interest committees as directed by the EMS Agency. The PCC will actively participate in the development of Ventura County Policies and Procedures.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
Patient Diversion/Emergency Department Closures</td><td>Policy Number:
402</td></tr>
<tr><td colspan="3">APPROVED:
Administration: Steven L. Carroll, EMT-P</td><td>Date: October 1, 2003</td></tr>
<tr><td colspan="3">APPROVED:
Medical Director Angelo Salvucci, M.D.</td><td>Date: October 1, 2003</td></tr>
<tr><td>Origination Date:
Revised Date:
Date Last Reviewed:
Review Date:</td><td>January 1990
March 2003
December 11, 2008
November 30, 2012</td><td colspan="2">Effective Date:November 1, 2003</td></tr>
</table>

I. PURPOSE: To define the procedures by which Emergency Medical Services (EMS) providers and/or Base Hospitals (BH) may:

A. Transport emergency patients to the most accessible medical facility that is staffed, equipped, and prepared to administer emergency care appropriate to the needs of the patient.

B. Provide a mechanism for a hospital in the Ventura County (VC) EMS system to have patients diverted away from its emergency department when it has been determined that the hospital is not staffed, equipped, and/or prepared to care for additional or specific types of patients.

C. Assure that Advanced Life Support (ALS) units are not unreasonably removed from their area of primary response when transporting patients to a medical facility.

II. AUTHORITY: California Administrative Code, Title 13, Section 1105(c): "In the absence of decisive factors to the contrary, ambulance drivers shall transport emergency patients to the most accessible medical facility equipped, staffed, and prepared to receive emergency cases and administer emergency care appropriate to the needs of the patient".

III. POLICY: Hospitals may divert patients according to the conditions described below. This policy shall not negate prearranged interhospital triage and transport agreements approved by VC EMS Basic Life Support (BLS) patients will be transported to the nearest unless it is closed by internal disaster.

IV. DEFINITIONS:

A. ALS Patient: A patient who meets the criteria for base hospital contact.

B. BLS Patient: A patient whose illness or injury requires BLS care or a patient in a BLS unit, irrespective of the level of care required for the patient's illness or injury.

V. PROCEDURE

A. DIVERSION REQUEST CATEGORIES

A hospital may request that ambulances be diverted for the following reasons using the following terminology:

1. Internal Disaster
   Hospital's emergency department cannot receive any patients because of a physical plant breakdown (e.g. fire, bomb threat, power outage, safety issues in the ED, etc.).
   NOTE: Activation of a hospital's internal plan to handle diversions (see Section IV.D) does NOT constitute an internal disaster.
2. Emergency Department Saturation
   The hospital's emergency department resources are fully committed to critically and/or seriously ill patients and are not available for additional ALS patients.
3. Lack of Neurosurgical coverage
   Hospital is unable to provide appropriate care due to unavailability of a neurosurgeon, and is therefore not an ideal destination for patients likely to require these services.
4. Intensive Care Unit (ICU) / Critical Care Unit (CCU) Saturation
   Hospital's ICUs do not have any available licensed beds to care for additional patients, and is therefore not an ideal destination for patients likely to require these services.
5. CT Scanner Inoperative
   Hospital's CT scanner is not functioning and therefore not the ideal destination for patients with blunt or penetrating head or truncal trauma.

B. PATIENT DESTINATION

1. Internal Disaster
   a. A hospital on diversion due to internal disaster shall not receive patients.
   b. Base hospitals shall not direct ALS units to transport patients to any medical facility that has requested diversion of ALS patients due to an internal disaster.
2. Diversion requests will be honored provided that:
   a. The involved ALS unit estimates that it can reach an "open" facility without compromising the patient's condition by extending the Code 3 en route time from the incident location for hospitals on diversion due to:
      1) ICU/CCU saturation,
      2) Emergency Department saturation, or

3) Neuro/CT scanner limitations for appropriately selected patients.

b. The patient does not exhibit an uncontrollable problem in the field. An "Uncontrollable Problem" is defined as:

1) Unstable vital signs
2) Cardiac Arrest
3) Severe Respiratory Distress
4) Unstable Airway
5) Profound Shock
6) Status Epilepticus
7) OB patient with imminent delivery
8) Life threatening arrythmia
9) Any Patient that the paramedic on scene or the BH MD feels would likely deteriorate due to diversion.

3. Destination while adjacent hospitals are on diversion

a. If adjacent hospitals within an area grouping are on diversion for the same diversion category, patients cannot be diverted for that reason, and the patient will be transported to the closest medical facility.

b. Guidelines for potential diversion destination when a hospital is on diversion based on patient location and estimated transport times are as follows:

Hospital Groupings/Areas

1. **Area 1** (Ojai): Ojai Valley Community Hospital, Community Memorial Hospital, Ventura County Medical Center, Santa Paula Memorial Hospital
2. **Area 2** (Santa Paula/Fillmore): Santa Paula Memorial Hospital, Ventura County Medical Center, Community Memorial Hospital, Ojai Valley Community Hospital
3. **Area 3** (Simi Valley): Simi Valley Hospital, Los Robles Regional Medical Center, St. Johns Pleasant Valley Hospital
4. **Area 4** (Thousand Oaks): Los Robles Regional Medical Center, Simi Valley Hospital, St. Johns Pleasant Valley Hospital
5. **Area 5** (Camarillo): St. Johns Pleasant Valley Hospital, St. Johns Regional Medical Center, Los Robles Regional Medical Center,

Simi Valley Hospital, Ventura County Medical Center, Community Memorial Hospital

6. **Area 6** (Oxnard): St. Johns Regional Medical Center, Ventura County Medical Center, Community Memorial Hospital, St. Johns Pleasant Valley Hospital
7. **Area 7** (Ventura): Ventura County Medical Center, Community Memorial Hospital, St. Johns Regional Medical Center, Ojai Valley Community Hospital, Santa Paula Memorial Hospital.

As needed, an MICN may divert a patient to a hospital outside of Ventura County.
BLS ambulances shall notify receiving hospitals of their impending arrival.

4. Notwithstanding any other provisions of this policy, and in accordance with VCEMS Policy 604, Patient Transport and Destination, final authority for patient destination rests with the Base Hospital.

C. PROCEDURE FOR REQUESTING DIVERSION OF ALS PATIENTS

1. The hospital administrator or his/her designee must authorize the need for diversion.
2. To initiate, update or cancel a diversion, the Administrator or his/her designee shall make the status change via the ReddiNet system.
   a. Hospitals on diversion status shall immediately update their status via the ReddiNet system.
   b. Problems with policy and procedure related to diversion notification will be directed to VC EMS during normal business hours or the on-call VC EMS administrator after normal business hours
   c. Problems arising during a diversion, requiring immediate action should be directed to VC EMS during normal business hours or the on-call VC EMS administrator after normal business hours.
3. VC EMS staff will perform unannounced site visits to hospitals on diversion status to ensure compliance with these guidelines.

D. Hospitals shall develop internal policies and procedures for authorizing diversion of patients in accordance with this policy. These policies shall include internal activation of

backup procedures. These policies and procedures shall be approved according to the hospital policy approval procedure and shall be available to the EMS staff for review.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: ALS Base Hospital Standards		Policy Number: 410
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: June 1, 2009
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date: June 1, 2009
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 22, 1986 February 12, 2009 February 12, 2009 February 28, 2012	Effective Date: June 1, 2009

I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Base Hospital designation.

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

III. POLICY:

A. An Advanced Life Support (ALS) Base Hospital (BH), approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:

1. Meet all requirements of an ALS Receiving Hospital per Ventura County Emergency Medical Services Policy 420.
2. Have an average emergency room census of 1200 or more visits per month.
3. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics.
   a. If the communications capability of the BH is interrupted, the ALS provider and the nearest BH shall be notified immediately by telephone.
   b. ALS calls shall be routed to the nearest BH until communication capability is restored and telephone notification of the ALS provider and nearest BH is made.
   c. All equipment used for ALS communications shall operate within the frequency requirements of the Ventura County Communications Department. At the time that a countywide communication system is implemented, all ALS providers shall comply with the Ventura County Communications Department ALS communications plan.
4. Assure that communication between the BH and ALS Unit for each ALS call shall be provided only by the BH ED physician or Ventura County authorized Mobile Intensive Care Nurse (MICN) by radio or telephone.
6. Designate a BH Medical Director who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The Medical Director shall:

a. Be regularly assigned to the Emergency Department.
b. Have experience in and knowledge of BH operations.
c. Be responsible for overall medical control and supervision of the ALS program within the BH's area of responsibility including review of patient care records and critique of personnel involved.
d. Be responsible for reporting deficiencies in patient care to VC EMS.
e. Coordinate BH activities with Receiving Hospital, PSC and VCEMS policies and procedures.
f. Attend PSC meetings.
g. Provide Emergency Department staff education.
h. Schedule medical staffing for the Emergency Department on a 24-hour basis.
i. Evaluate paramedics for clinical performance and makes recommendation to VCEMS.
j. Evaluate MICN's for authorization/reauthorization and makes recommendation to VCEMS.

7. Have on duty, on a 24-hour basis, one (1) MICN who meets who meets the criteria in VCEMS Policy 321.
8. Identify an MICN with experience in, and knowledge of, BH radio operations and VCEMS policies and procedures as a PCC to assist the BH Medical Director in the medical control, supervision, and continuing education of prehospital care personnel.
9. Provide for the continuing education of prehospital care personnel, 'paramedics MICNs, EMT-I's, and first responders, in accordance with VCEMS:
10. Cooperate with and assist the PSC and the VCEMS Medical Director in the collection of statistics and review of necessary records for program evaluation and compliance.
11. Assure that paramedics perform medical procedures only under medical direction of a physician or Ventura County authorized MICN except for approved standing orders.
12. Agree to maintain all recorded communications and prehospital data in a manner consistent with hospital data requirements. Prehospital data includes, but is not limited to, the recording of the prehospital communication, prehospital care record, paramedic BH communications form and documentation of telephone communication with the RH (if utilized). All prehospital data except the recording will be integrated with the patient chart.
13. Resident physicians shall attend Base Hospital Physician course.

B. There shall be a written agreement between the BH and VCEMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for ALS program participation as specified by State regulations and VCEMS policies and procedures.

C. The VCEMS shall review its agreement with each BH at least every two years.

D. The VCEMS may deny, suspend, or revoke the approval, of a BH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the PSC and Board of Supervisors for appropriate action.

E. A hospital wishing to become an ALS Base Hospital in Ventura County must meet Ventura County Base Hospital Criteria and agree to comply with Ventura County regulations.

1. Application:
   Eligible hospitals shall submit a written request for Base Hospital approval to VCEMS documenting the compliance of the hospital with the Ventura County Base Hospital Criteria.
2. Approval:
   a. Program approval or disapproval shall be made in writing by the VCEMS to the requesting Base Hospital 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.
   b. The VCEMS shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all the program requirements.
3. Withdrawal of Program Approval:
   Non-compliance of any criterion associated with program approval, use of non-certified personnel, or non-compliance with any other Ventura County regulation applicable to a Base Hospital, may result in withdrawal, suspension or revocation of program approval by the VCEMS.

F. Advanced Life Support Base Hospitals shall be reviewed on an annual basis.

1. All Base Hospitals shall receive notification of evaluation from the VCEMS.
2. All Base Hospitals shall respond in writing regarding program compliance.
3. On-site visits for evaluative purposes may occur.
4. Any Base Hospital shall notify the VCEMS by telephone, followed by a letter within 48 hours of changes in program compliance or performance.

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

BASE HOSPITAL
CRITERIA COMPLIANCE CHECK LIST

Base Hospital: ______________________ Date: _______________

	YES	NO
An Advanced Life Support (ALS) Base Hospital (BH), approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:		
1. Meet all requirements of an ALS Receiving Hospital per Ventura County Emergency Medical Services Policy 420.		
2. Have the capability to provide, at all times, operational biomedical and radio communications with the capability to tape record the communications, between the BH and paramedics. All equipment used for ALS communications shall operate within the frequency requirements of the Ventura County Communications Department. At the time that a countywide communication system is implemented, all ALS providers shall comply with the Ventura County Communications Department ALS communications plan.		
3. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics.		
4. Designate a BH Prehospital Care Coordinator (PCC), a paramedic representing each ALS service provider affiliated with the BH, and an ED physician and/or ED Registered Nurse from each Receiving Hospital affiliated with the BH, to function as the BH Paramedic Committee. Additional committee members may be designated according to BH committee policies.		
5. Designate a BH Medical Director who shall be a physician on the hospital staff, licensed in the State of California, and have experience in emergency medical care. The Medical Director shall:		
• Be regularly assigned to the Emergency Department.		
• Have experience in and knowledge of BH operations.		
• Be responsible for overall medical control and supervision of the ALS program within the BH's area of responsibility including review of patient care records and critique of personnel involved.		
• Be responsible for reporting deficiencies in patient care to VC EMS.		
• Coordinate BH activities with Receiving Hospital, PSC and VCEMS policies and procedures.		
• Attend BH Paramedic Committee and PSC meetings.		
• Provide Emergency Department staff education.		
• Schedule medical staffing for the Emergency Department on a 24-hour basis.		
• Evaluate MICNs for authorization/reauthorization and make recommendation to VCEMS.		
6. All Base Hospital MICN's shall:		

		YES	NO
	• Be authorized in Ventura County by the VCEMS Medical Director.		
	• Be assigned only to the Emergency Department while functioning as an MICN.		
	• Maintain current ACLS certification.		
	• Be a Base Hospital employee.		
7.	Identify an MICN with experience in and knowledge of BH radio operations and VCEMS policies and procedures as a PCC to assist the BH medical director in the medical control, supervision, and continuing education of prehospital care personnel.		
8.	Provide for the continuing education of prehospital care personnel ('paramedics MICN's, EMT-I's, and first responders), in accordance with VC EMS Policy 1131:		
9.	Cooperate with and assist the Paramedic Services Subcommittee, the, and the VCEMS Medical Director in the collection of statistics and review of necessary records for program evaluation and compliance.		
10.	Assure that paramedics perform medical procedures only under medical direction of a physician or Ventura County authorized MICN except for approved standing orders and medical procedures.		
11.	Agree to maintain all tape communications and prehospital data in a manner consistent with hospital data requirements. Prehospital data includes, but is not limited to the tape of the prehospital communication, prehospital care record paramedic BH communications form, documentation of telephone communication with the RH (if utilized). All prehospital data except the tape recording will be integrated with the patient chart.		
12.	Submit a letter to VC EMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for program participation as specified by State regulations and VC EMS policies and procedures.		
13.	Resident physicians shall attend Base Hospital Physician course.		

I. PURPOSE: To establish criteria for a Do Not Resuscitate (DNR) Order, and to permit Emergency Medical Services personnel to withhold resuscitative measures from patients in accordance with their wishes.

II. AUTHORITY: California Health and Safety Code, Sections 1798 and 7186. California Probate Code, Division 4.7 (Health Care Decisions Law). California Code of Regulations, Title 22, Sections 70707(6), & 72527(a),(4).

III. DEFINITIONS:

A. "EMS Personnel": All EMT-1s, paramedics and RNs caring for prehospital or interfacility transfer patients as part of the Ventura County EMS system.

B. "Resuscitation": Medical interventions whose purpose is to restore cardiac or respiratory activity, and which are listed below:

1. External cardiac compression (chest compressions).
2. Defibrillation.*
3. Tracheal Intubation or other advanced airway.*
4. Assisted Ventilation for apneic patient.*
5. Administration of cardiotonic medications.*

C. "DNR Medallion": A permanently imprinted insignia, worn by a patient that has been manufactured and distributed by an organization approved by the California Emergency Medical Services Authority.

D. "DNR Order": An order to withhold resuscitation. A DNR Order shall be considered operative under any of the following circumstances. If there is a conflict between two DNR orders the one with the most recent date will be honored.

1. A fully executed original or photocopy of the "Emergency Medical Services Prehospital DNR Form" has been read and reviewed on scene;
2. The patient is wearing a DNR Medallion;

* - Defibrillation, advanced airway, assisted ventilation, and cardiotonic medications may be permitted in certain patients using a POLST form. Refer to VCEMS Policy 625.

3. A fully executed California Durable Power of Attorney For Health Care (DPAHC) form is seen, a health care agent designated therein is present, and that agent requests that resuscitation not be done;
4. A fully executed Natural Death Act Declaration has been read and reviewed on scene;
5. A fully executed California Advance Health Care Directive (AHCD) has been read and reviewed on scene and:
   a. a health care agent designated therein is present, and that agent requests that resuscitation not be done, or
   b. there are written instructions in the AHCD stating that the patient does not wish resuscitation to be attempted;
6. A completed and signed Physician Orders for Life-Sustaining Treatment (POLST) form has been read and reviewed on scene, and in Section A, "Do Not Attempt Resuscitation/DNR" is selected, or;
7. For patients who are in a licensed health care facility, or who are being transferred between licensed health care facilities, a written document in the patient's permanent medical record containing the statement "Do Not Resuscitate", No Code", or No CPR," has been seen. A witness from the health care facility must verbally document the authenticity of this document.

E. "California Advance Health Care Directive (AHCD)". As defined in California Probate Code, Sections 4600-4805.

F. "California Durable Power of Attorney for Health Care (DPAHC)": As defined in California Civil Code, Sections 2410-2444.

G. "Natural Death Act Declaration": As defined in the Natural Death Act of California, Health and Safety Code, Sections 7185-7195.

H. "Physician Orders for Life-Sustaining Treatment (POLST)". As defined in California Probate Code, Division 4.7 (Health Care Decisions Law).

IV. PROCEDURE:

A. All patients require an immediate medical evaluation.

B. Correct identification of the patient is crucial in this process. If not wearing a DNR Medallion, the patient must be positively identified as the person named in the

DNR Order. This will normally require either the presence of a witness or an identification band.

C. When a DNR Order is operative:

1. If the patient has no palpable pulse and is apneic, resuscitation shall be withheld or discontinued.
2. The patient is to receive full treatment other than resuscitation (e.g., for airway obstruction, pain, dyspnea, hemorrhage, etc.).
3. If the patient is taking high doses of opioid medication has decreased respiratory drive, early base hospital contact should be made before administering naloxone. If base hospital contact cannot be made, naloxone should be administered sparingly, in doses no more than 0.1 mg every 2-3 minutes.

D. A DNR Order shall be considered null and void under any of the following circumstances:

1. The patient is conscious and states that he or she wishes resuscitation.
2. In unusual cases where the validity of the request has been questioned (e.g., a family member disputes the DNR, the identity of the patient is in question, etc.), EMS prehospital personnel may temporarily disregard the DNR request and institute resuscitative measures while consulting the BH for assistance. Discussion with the family member, with explanation, reassurance, and emotional support may clarify any questions leading to validity of a DNR form.
   The underlying principle is that the patient's wishes should be respected.
3. There is question as to the validity of the DNR Order.
   Should any of these circumstances occur, appropriate treatment should continue or immediately commence, including resuscitation if necessary. Base Hospital contact should be made when appropriate.

E. Other advanced directives, such as informal “living wills” or written instructions without an agent in the California Durable Power of Attorney for Health Care, may be encountered. Should any of these occur, appropriate treatment will continue or immediately commence, including resuscitation if necessary. Base Hospital contact will be made as soon as practical.

F In case of cardiac arrest, if a DNR Order is operative, Base Hospital contact is not required and resuscitation should not be done. Immediate base hospital contact is strongly encouraged should there be any questions regarding any aspect of the care of the patient.

G. If a DPAHC or AHCD agent requests that resuscitation not be done, the EMT shall inform the agent of the consequences of the request.

H. DNR in a Public Place

Persons in cardiac arrest with an operative DNR Order should not be transported. The Medical Examiner's office should be notified by law enforcement or EMS personnel. If possible, an EMS representative should remain on scene until a representative from law enforcement or the Medical Examiner's office arrives.

V. DOCUMENTATION:

For all cases in which a patient has been treated under a DNR Order, the following documentation is required in the AVCDS report:

A. Name of patient's physician signing the DNR Order.

B. Type of DNR Order (DNR Medallion, Prehospital DNR Form, POLST Form, written order in a licensed health care facility, DPAHC, Natural Death Act Declaration).

C. If the decision to withhold or terminate resuscitative measures was made by an EMT-1, his/her name and certificate number.

D. For all cases which occur within a licensed health care facility, in addition to above, if the DNR Order was established by a written order in the patient's medical record, the name of the physician signing and the witness to that order.

E. If resuscitation is not done because of the request of a healthcare agent designated in a DPACH or AHCD, the agent's name.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Spinal Immobilization		Policy Number 614
APPROVED: Administration:	Barry Fisher, MPPA	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 December 11, 2008 December 31, 2011	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: Physician Orders for Life-Sustaining Treatment (POLST)		Policy Number 625
APPROVED: Administration:	Barry R. Fisher, MPPA	Date: January 8, 2009
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: January 8, 2009
Origination Date: Date Revised: Date Last Reviewed: Review Date:	January 7, 2009 January. 2011	Effective Date: January 9, 2009

I. PURPOSE: To permit Ventura County Emergency Medical Services personnel to honor valid POLST forms and provide end-of-life care in accordance with a patient's wishes.

II. AUTHORITY: California Health and Safety Code, Sections 1798 and 7186. California Probate Code, Division 4.7 (Health Care Decisions Law).

III. DEFINITIONS:

A. "EMS Personnel": All EMT-1s, EMT-Ps and RNs caring for prehospital or interfacility transfer patients as part of the Ventura County EMS system.

B. Valid Physician Orders for Life-Sustaining Treatment (POLST). A completed and signed physician order form, according to California Probate Code, Division 4.7 and approved by the California Emergency Medical Services Authority.

IV. POLICY:

A. A POLST form must be signed by the patient or surrogate and physician to be valid.

B. Although an original POLST form is preferred, a copy or FAX is valid.

C. When a valid POLST form is presented, EMS personnel will follow the instructions according to the procedures below.

D. The POLST form is intended to supplement, not replace, an existing Advance Health Care Directive. If the POLST form conflicts with the Advance Health Care Directive, the most recent order or instruction of the patient's wishes governs.

V. PROCEDURE:

A. Confirm that:

1. The patient is the person named in the POLST.
2. The POLST form, Section D, is signed by the patient and physician. The form is not valid if not signed by both.

B. POLST form - Section A:

1. If the patient has no pulse and is not breathing AND “Do Not Attempt Resuscitation/DNR” is selected, refer to VC EMS Policy 613 – Do Not Resuscitate.
2. If the patient has no pulse and is not breathing AND EITHER “Attempt Resuscitation/CPR” is selected OR neither option is selected then begin resuscitation.

C. POLST Form – Section B: This section applies if the patient has a pulse and/or is breathing.

1. If **“Comfort Measures Only”** is selected, the following treatments may be done as indicated to relieve pain and suffering:
   a. Patient positioning
   b. Oxygen
   c. Airway suctioning
   d. Relief of airway obstruction (including Magill Forceps)
   e. Pain control per VC EMS Policy 705
2. If **“Limited Additional Interventions”** is selected, in addition to the above “Comfort Measures Only” items, the following treatments may be done may be done as indicated:
   a. IV fluids
   b bag-mask ventilation
   c. CPAP
   d. DO NOT INTUBATE

   If the “Do Not Transfer to hospital for medical interventions” option is selected, contact the base hospital. Generally the patient will be transported.
3. If “**Full Treatment”** is selected the patient will be treated with all medically indicated medications and/or procedures. If a patient has selected both “Do Not Attempt Resuscitation/DNR” in Section A and “Full Treatment” in Section B, if the patient is witnessed to go into a shockable rhythm and still has agonal respirations, defibrillate once and begin bag-mask ventilations, but do not begin chest compressions.

D. If there is any conflict between the written POLST orders and on-scene individuals, contact the base hospital.

E. Take the POLST form with the patient.

VI. DOCUMENTATION:

For all cases in which a patient has been treated according to a POLST form, the following documentation is required in the narrative section of the AVCDS.:

A. A statement that the orders on a POLST form were followed..

B. The section of the POLST form that was applicable.

HISTORY	PHYSICAL
Respiratory Distress? Syncope? Recent Altered Level of Consciousness?	Vital Signs, Skin Vitals, Breath sounds: Wheezes, stridor Hives, rash, swelling of face or tongue, and/or itching O_2 Sat

TREATMENT PRIOR TO BASE HOSPITAL CONTACT		
ABC's, O2, Monitor, Documentation of Rhythm Strip		
POTENTIAL ANAPHYLAXIS	ANAPHYLAXIS WITHOUT SHOCK	ANAPHYLAXIS WITH SHOCK
Consider IV NS TKO ↓ Begin Transport ↓	EPINEPHRINE 1:1,000 IM Peds: 0.01 ml/kg IM (max 0.3 ml) Adult Age: 12 - 40: 0.3 ml Adult Age: >40: Give only if severe respiratory distress is present[2] ↓ IV NS ↓ BENADRYL Adult: 50 mg IV - IM if no IV access Peds: 1mg/kg IV/IM (max 50 mg), may repeat X1 in 10 minutes ↓ Begin Transport ↓	↓ EPINEPHRINE 1:1,000 IM[1] Peds: 0.01 ml/kg (max. 0.3 ml) Adult Age: 12-40: 0.5 ml Adult Age: > 40 0.3 ml[2] IV NS WO x 2 Adults: 1-2 L Peds: 20 ml/kg For Profound Shock[3] EPI 1:10,000 IV* slow infusion 0.1 mg (1 ml) increments to max of 0.3-0.5 mg (3-5 ml) over 1-2 minutes (adult)[2] ↓ BENADRYL Adult: 50 mg IV - IM if no IV access Peds: 1 mg/kg IV/IM (max 50 mg) ↓ Begin Transport (Expedite if not improving) ↓
BASE HOSPITAL CONTACT, continue treatment as ordered If unable, continue transport, follow COMMUNICATION FAILURE PROTOCOL		
COMMUNICATIONS FAILURE PROTOCOL		
Consider Benadryl Adult: 50 mg IV - IM if no IV access Peds: 1 mg/kg IV/IM (Max 50 mg)	Consider NEBULIZED BRONCHODILATOR ↓ Repeat EPI to effect up to q 5 min X 2	Consider NEBULIZED BRONCHODILATOR ↓ Re-evaluate. If shock persists and no rales, repeat fluid bolus as above Repeat EPI to effect up to q 5 min X 2
BASE HOSPITAL ORDERS ONLY		
Consult with ED MD for further treatment measures		

1. May be initiated simultaneously with IV attempt.
2 Use Epi with caution in older patients. If clearly in anaphylaxis, this is the drug of choice, even in older patients. If doubt exists, initiate early BH Contact, prior to drug therapy. Tachycardia is not a contraindication to epinephrine.
3. BP<=80 and/or signs of severe hypo perfusion, pale, cool, diaphoretic, poor capillary return, altered LOC, etc. Again, if doubt exists, initiate early BH Contact prior to drug therapy.
4. Pediatric dose IV Epinephrine 0.01 mg/kg (0.1ml/kg) 1: 10,000 slow IVP.
5. Pediatric dose IM Epinephrine 0.01 mg/kg (0.01ml/kg) 1:1000

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VC EMS Medical Director

HISTORY	PHYSICAL
IV drug abuse Diabetes Trauma Medications	Apnea or clearly inadequate ventilatory effort O_2 Sat
TREATMENT PRIOR TO BASE HOSPITAL CONTACT	
BLS ventilation techniques ↓ monitor, documentation of rhythm strip	
SUSPECTED OPIOID OD	SUSPECTED HYPOGLYCEMIA OR OTHER MEDICAL CONDITION
IV access ↓ Narcan IVP, ET, IM, IO ↓ Determine Blood Glucose Level ↓ If BG <60 Give 50% Dextrose 50 cc IVP If no IV access, give Glucagon 1 mg IM If patient is awake with intact gag reflex, give Oral Glucose 15 g ↓ Airway Management	IV access ↓ Determine Blood Glucose Level ↓ If BG <60 Give 50% Dextrose 50 cc IVP If no IV access, give Glucagon 1 mg IM If pt is awake with intact gag reflex, give Oral Glucose 15 g ↓ If no response to D50, give Narcan* IVP, ET, IM, IO ↓ Airway Management
BASE HOSPITAL CONTACT, continue treatment as ordered. If unable, initiate transport and follow COMMUNICATION FAILURE PROTOCOLS (Altered Level of Consciousness)	
COMMUNICATION FAILURE PROTOCOLS	
If LOC is still altered after 5 minutes and original BG <60, repeat BG determination ↓ If BG <60, repeat D50, 50 cc IVP (adult)	
BASE HOSPITAL ORDERS ONLY	
Consult with ED MD for further treatment measures	

PEDIATRIC DOSES, DEXTROSE

D50, 1 ml/kg for > 2 years of age D25, 2 ml/kg for age < 2 years of age

If the patient is a known alcoholic and D50 has been given, consider use of Thiamine in the ED.

*Administer Narcan 0.4 mg IV q1 minute to maximum of 2 mg, or until respiratory rate > 12. It is not necessary that patient be awake and alert. Pediatric dose 0.1 mg/kg IV/IM (maximum 2 mg).

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VC EMS Medical Director

BEHAVIORAL EMERGENCIES

Unruly, irrational behavior may be caused by psychiatric illness, or organic illness (such as hypoglycemia, hypoxia, and hypoperfusion states, withdrawal, or intoxicant states).

HISTORY	PHYSICAL
Previous psych history? Medications Medical history	Vital signs (with O2 Sat if available) Skin vitals Mental status exam Evidence of trauma, overdose, ETOH, hypoglycemia, hypoperfusion, hypoxia? Threat to own life or to the life of others? Able to provide food and shelter for self?

PRIOR TO BASE HOSPITAL CONTACT

ABC's
↓
Consider O_2 therapy as indicated
↓
Consider IV and Monitor
↓
Assess and treat injuries or medical condition which might lead to behavioral emergency according to specific treatment guidelines.
↓
For extreme agitation: Adult: Midazolam 1 mg q 2 min IV, max 0.1mg/kg up max 5 mg.
If no IV, Midazolam 0.1 mg/kg IM, max 5 mg.
Peds: Midazolam 0.1 mg/kg IM, max 5 mg.
↓
BASE HOSPITAL CONTACT, continue treatment as ordered
If unable, initiate transport, follow COMMUNICATION FAILURE PROTOCOL

BASE HOSPITAL ORDERS ONLY

Consult with Base Hospital Physician for further treatment measures

Notes:

1. Protect yourself and others. Never try to subdue a patient forcibly without adequate help from law enforcement, other rescuers, etc.
2. If patient refuses care and transport, and that refusal is because of a “mental disorder”, consider having the patient taken into custody according to Welfare and Institutions Code Section 5150. “Mental disorders” do not generally include alcohol or drug intoxication, brain injury, hypoxemia, hypoglycemia, or similar causes.
3. Welfare and Institutions Code Section 5150:
   A patient may be taken into custody if, as a result of a mental disorder, there is a danger to self or others or is gravely disabled. A California peace officer, a California licensed psychiatrist in an approved facility, Ventura County Health Officer or other County-designated individuals, can take the individual into custody, but it must be enforced by the police in the field.
4. Patients should be medically cleared prior to transporting to a psychiatric facility, unless evaluated by Crisis Team or PAT team in the field, and they request direct transport to a psychiatric facility.
5. Refer to Policy 603 if patient attempts to decline treatment or transportation.

Ventura County Mental Health Crisis Team: 805 652 6727

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VC EMS Medical Director

BRADYCARDIA: ADULT, SYMPTOMATIC[1], NOT IN ARREST

HISTORY	PHYSICAL
CP, SOB, Syncope, Dizziness Previous cardiac disease? Previous dysrhythmias? Medications	Airway Breath Sounds Vital Signs O2 sat Level of consciousness Other signs of hypoperfusion

PRIOR TO BASE HOSPITAL CONTACT

Assess Airway

↓

O_2 therapy, airway management as indicated

↓

IV access (If unable, proceed)

↓

Monitor, document rhythm strips

↓

12-Lead ECG

↓

[2]Atropine (if HR < 45):
IV 0.5 mg (1 mg/10 cc), IL 0.5 mg (1 mg/ 1 cc), ET 1.0 mg (1 mg/10 cc)

↓

If unstable VS begin TCP.[3,4]

↓

BASE HOSPITAL CONTACT (If unable, prepare for transport and follow CFP)

COMMUNICATION FAILURE PROTOCOLS

If unable to establish BH Contact And Symptomatic Bradycardia persists X 3 minutes after first atropine administered

↓

[2]Atropine (if HR < 45):
IV 0.5 mg (1 mg/10 cc), IL 0.5 mg (1 mg/ 1 cc), ET 1.0 mg (1 mg/10 cc)

↓

Initiate Transport

↓

Reattempt Base Hospital Contact

↓

If unable to establish BH Contact And Symptomatic Bradycardia persists,
[2]May repeat Atropine in 0.5 mg increments, q 3-5 minutes
To total dose of 0.04 mg/kg (3.0 mg in a 70 kg pt)

↓

If poor perfusion, Mobitz II second degree or third degree AV Block, or persistent bradycardia, begin TCP.[3,4]

↓

If symptomatic bradycardia persists, continue expeditious transport and consider Dopamine 400 mg/250 cc D_5W.
Start at 5-10 mcg/kg/min and titrate to effect, max. 20 mcg/kg/min.[3]

BASE HOSPITAL ORDER ONLY

For suspected hyperkalemia, consider calcium chloride 1 Gm slow IVP (contraindicated if possible digitalis toxicity) and/or sodium bicarbonate 50 - 100 mEq slow IVP

1. Chest Pain, Altered Level of Consciousness, or other signs of hypoperfusion.
2. If patient is in 2° or 3° heart block and takeover rhythm is wide complex, atropine may cause a decrease in the heart rate. If this occurs withhold atropine and use TCP.
3. Transcutaneous cardiac pacing (TCP) is the preferred step after atropine for persistent bradycardia and should be started immediately for unstable VS, particularly if Mobitz II second-degree or third-degree AV block.
4. If required, pain control per Policy 705 Pain Control.

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VC EMS Medical Director

HISTORY	PHYSICAL
Inhalation of smoke or steam? Carbon monoxide produced? Associated trauma? See trauma algorithm. Closed or open space? Type of burn (mechanism), i.e., chemical, flash, explosion, flames, electrical, etc. Other medical problems, i.e., diabetes, liver disease, dysrhythmias.	Vital Signs (If hypotensive, see Hypotension algorithm) Skin vitals % of body burned and degree of burns Breath sounds: wheezes, stridor respiratory distress Singed facial or nasal hair Level of consciousness 0_2 Sat

TREATMENT PRIOR TO BASE HOSPITAL CONTACT

ABC's[1]

↓

O_2 therapy as indicated

↓

Monitor, document rhythm strip[3]

↓

Remove rings, prostheses, shoes, constrictive clothing, garments made from synthetic material

↓

If < 10%, total body surface area (TBSA), cool burned area with saline-soaked dressings, elevate burned extremities[2]

↓

Patient Hypotensive/Major burn? (> 10% TBSA)

YES	NO
Adult: IV WO 1000 cc IV Bolus Peds: 20 cc/Kg Cover patient to maintain body heat Pain control per policy 705 Pain Control	Consider IV TKO Pain control per policy 705 Pain Control

BASE HOSPITAL CONTACT, continue treatment as ordered
If unable, initiate transport, follow COMMUNICATION FAILURE PROTOCOL

COMMUNICATIONS FAILURE PROTOCOL

Morphine according to 705 Pain Control

BASE HOSPITAL ORDERS ONLY

Consult with ED MD for further treatment orders

1. Assume airway/respiratory involvement in inhaled chemical and closed space thermal burns or any signs of respiratory distress, expedite transport.
2. If burning process has stopped, use clean, dry dressings. Covering prevents air currents from causing pain in partial thickness burns.
   For chemical burns, flush agent from body surface with copious amounts of water. Powdered agents should be brushed from the skin prior to flushing.
3. Electric burns may affect cardiac activity.

VC EMS Medical Director

COUNTY WIDE PROTOCOLS: POLICY NO: 705

CARDIAC ARREST, ADULT

Patient pulseless and apneic or with agonal respirations,
CPR, BLS airway management, Monitor, document rhythm strip, Determine Cardiac Rhythm [1, 2]

PRIOR TO BASE HOSPITAL CONTACT

VFIB/V-TACH[3] (Persistent)	**ASYSTOLE**	**BRADYCARDIC PEA**	**NON BRADYCARDIC PEA**
WHILE ON SCENE 1. DEFIBRILLATE*,*** 2. 5 cycles (2 minutes) CPR[5] 3. IV access during CPR 4. Reassess cardiac rhythm. If VFib/Vtach[3] remain: DEFIBRILLATE - 360 J * & resume CPR. 5. EPINEPHRINE: May repeat q 3-5 min IVP: 1:10,000 1.0 mg If NO IV, give IL: 1:1,000 1.0 mg 6. Reassess cardiac rhythm. If VFib/Vtach[3] remain: DEFIBRILLATE * & resume CPR. 7. **Lidocaine IVP: 1.5 mg/kg 8. Defibrillate* 9. ALS airway management.[4] 10. Repeat Epi q 3-5 minutes 11. Defibrillate - 360 J* 12. Repeat Lidocaine 1.5 mg/kg in 3-5 minutes (to total dose of 3 mg/kg) 13. Defibrillate *	1. 5 cycles (2 minutes) CPR 2. IV access 3. EPINEPHRINE May repeat q 3-5 min IVP: 1:10,000 1.0 mg If NO IV, give IL: 1:1,000 1.0 mg 4. Reassess Cardiac Rhythm. If any question in rhythm, confirm in 2 leads. 4. If still ASYSTOLE, give ATROPINE: IVP: 1.0 mg IVP IL: 1.0 mg (1 mg/ml) 5. 5 cycles (2 minutes) CPR 6. ALS Airway management.[4] 7. Repeat Epi q 3-5 minutes 8. Repeat Atropine q 3-5 minutes to a total dose of 0.04 mg/kg (3 mg in a 75 kg patient)	1. 5 cycles (2 minutes) CPR 2. ASSESS/TREAT CAUSE 2. IV access 3. EPINEPHRINE May repeat q 3-5 min IVP: 1:10,000 1.0 mg If no IV, give IL: 1:1,000 1.0 mg 4. Reassess cardiac rhythm. If still BRADYCARDIC PEA, give ATROPINE: IVP: 1.0 mg IL: 1.0 mg (1 mg/ml) 5. 5 cycles (2 minutes) CPR 6. ALS airway management.[4] 7. Repeat Epi q 3-5 minutes 8. Repeat Atropine q 3-5 minutes to a total dose of 0.04 mg/kg (3 mg in a 75 kg patient)	1. 5 cycles (2 minutes) CPR 2. ASSESS/TREAT CAUSE: Medical vs. Trauma. Treat Hypovolemia if present 3. IF TRAUMA OR HYPOVOLEMIA, STAT TRANSPORT AS SOON AS AIRWAY IS SECURED 4. IV access (Wide Open if hypovolemic) 5. EPINEPHRINE May repeat q 3-5 min IVP: 1:10,000 1.0 mg If No IV, IL: 1:1000 1.0 mg 6. 5 cycles (2 minutes) CPR 7. ALS Airway Management.[4] 8. Reassess Cardiac Rhythm. If Non-Bradycardic PEA remains, continue treatment of likely cause. 9. Repeat Epi q 3-5 minutes

* Biphasic waveform defibrillation at energy level approved by service provider medical director, or monophasic waveform at 360J.
** If defibrillation → narrow complex rhythm > 50, not in 2nd or 3rd degree block, and Lidocaine not already given, give Lidocaine 1.5 mg/kg IVP or ET 3 mg/kg (if no IV).
***** If collapse before dispatch, 5 cycles CPR before defibrillation.**

LIKELY CAUSES OF PEA

Acidosis	Pulm Embolism	Drug OD
Hyperkalemia	Massive MI	Tricyclics
Tamponade	Digitalis	Beta Blockers
Hypovolemia	Tension Pneumo	Profound Hypothermia
Hypoxemia		Ca Channel Blockers

Base Hospital Contact (if unable, initiate transport and continue efforts to contact)

BASE HOSPITAL ORDERS ONLY

VFIB/V-TACH	ASYSTOLE	BRADYCARDIC PEA	NON BRADYCARDIC PEA
12. Consider Na Bicarb 1 mEq/kg IVP 13. Defibrillate* 14. Consider $MgSO_4$ 1-2 GM IVP 15. Defibrillate*	8. Consider Na Bicarb 1 mEq/kg IVP	8. Consider Na Bicarb 1 mEq/kg IVP	8. Consider Na Bicarb 1 mEq/kg IVP

NOTES:

1. Early BH contact is recommended in unusual situations, e.g., renal failure, Calcium channel blocker OD, tricyclic OD, Beta blocker OD and Torsade. BH to consider:
   - $CaCl_2$ and Bicarb in renal failure,
   - early Bicarb in Tricyclic OD,
   - early $CaCl_2$ in Ca channel blocker OD,
   - Glucagon in beta blocker OD and calcium channel blocker OD, and
   - $MgSO_4$ in Torsade.
   - Dosages
     - Calcium Chloride: 10 ml of 10% solution, may repeat X1 in 10 minutes
     - Glucagon: 1-5 mg IVP as available
     - Magnesium: 2 g slow IVP over 2 minutes
     - Sodium Bicarbonate: 1 mEq/kg followed by 0.5 mEq/kg q 10 minutes
2. In cases of normothermic adult patients with unmonitored cardiac arrest with adequate ventilation, vascular access, and persistent asystole or PEA despite 20 minutes of standard advanced cardiac life support; the base hospital should consider termination of resuscitation in the field. If transported, the patient may be transported Code II. If unable to contact base hospital, resuscitative efforts may be discontinued and patient determined to be dead.
3. V-Tach = Ventricular Tachycardia with rate > 150/min.
4. If unable to adequately ventilate with BLS measures, insert advanced airway earlier.
5. If organized narrow complex rhythm > 50, not in 2nd or 3rd degree block after 2 minutes post-shock CPR, IV access, lidocaine 1.5 mg/kg IVP.
6. If sustained ROSC, perform 12-Lead ECG. If ROSC after VF/VT, transport to SRC.

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VCEMS Medical Director

COUNTY WIDE PROTOCOLS

POLICY NO: 705

CARDIAC ARREST, PEDIATRIC

Patient pulseless and apneic or with agonal respirations
BLS airway management, establish pulselessness, initiate CPR, monitor, document rhythm strip, determine cardiac rhythm

PRIOR TO BASE HOSPITAL CONTACT[3]		
VFIB/VTACH[4] (persistent) WHILE ON SCENE 1. DEFIBRILLATE : 2 J/kg **** 2. CPR for 2 minutes[5]. 3. Vascular access (NS IV or IO)[2] during CPR4. Reassess, DEFIBRILLATE: 4 J/kg,& resume CPR. 5. EPINEPHRINE q 3-5 minutes IV/IO: 0.01 mg/kg (0.1 ml/kg) 1:10,000 ET: 0.1 mg/kg (0.1 ml/kg) 1:1,000 6. Reassess cardiac rhythm, If VFIB/VTACH[4] remain: **DEFIBRILLATE - 4 J/kg * & resume CPR 7.***LIDOCAINE IV/IO: 1 mg/kg ET: 3 mg/kg 8. Reassess and manage airway[1] (per Policy 710) 9. DEFIBRILLATE – 4J/kg *	**ASYSTOLE** 1. Vascular Access, NS IV/IO[2] 2. EPINEPHRINE IV/IO: 0.01 mg/kg (0.1 ml/kg) 1:10,000 ET: 0.1 mg/kg (0.1 ml/kg) 1:1,000 3. Reassess and manage airway[1] (per Policy 710) 4. If any question in rhythm, confirm in 2 leads.	**PEA** 1. Identify/Treat cause of PEA if able If cardiac tamponade or hemorrhagic hypovolemia, initiate immediate transport 2. Vascular access NS IV/IO[2] Initiate 20 ml/kg infusion unless rales or known CHD & CHF 3. EPINEPHRINE IV/IO: 0.01 mg/kg (0.1 ml/kg) 1:10,000 ET: 0.1 mg/kg (0.1 ml/kg) 1:1,000 4. Reassess and manage airway[1] (per Policy 710) **LIKELY CAUSES OF PEDs PEA** Severe hypoxemia Severe acidosis Severe hypovolemia Tension pneumothorax Cardiac tamponade Profound hypothermia
** If Fibrillation recurs, defibrillate at last successful joules delivered *** If defibrillation into narrow complex rhythm > 50, not in 2nd or 3rd degree block, and Lidocaine not already given, give Lidocaine 1.0 mg/kg IVP or ET 3 mg/kg (if no IV). **** If collapse before dispatch, 2 minutes CPR before defibrillation. BASE HOSPITAL CONTACT (If unable, initiate transport and follow COMMUNICATION FAILURE PROTOCOLS)		
COMMUNICATION FAILURE PROTOCOLS		
9. EPINEPHRINE IV/IO: 0.01 mg/kg (0.1 ml/kg) 1:10,000 ET: 0.1 mg/kg (0.1 ml/kg) 1:1000 q 3-5 minutes 10.DEFIBRILLATE – 4J/kg * 11. LIDOCAINE 1 mg/kg IV/IO 12. DEFIBRILLATE - 4 J/kg * *Or biphasic waveform defibrillation at energy level approved by service provider medical director.	5. EPINEPHRINE q 3-5 minutes IV/IO: 0.01 mg/kg (0.1 ml/kg) 1:10,000 ET: 0.1 mg/kg (0.1 ml/kg) 1:1,000	5. EPINEPHRINE q 3-5 minutes IV/IO: 0.01 mg/kg (0.1 ml/kg) 1:10,000 ET: 0.1 mg/kg (0.1 ml/kg) 1:1,000 6. If hemorrhagic hypovolemia, initiate 2nd bolus infusion NS at 20 ml/kg
BASE HOSPITAL ORDERS ONLY		
13. Consider NA BICARB: 1 mEq/kg IV/IO 14. DEFIBRILLATE - 4 J/kg * 15 Consider LIDOCAINE 1 mg/kg IV/IO 16. DEFIBRILLATE - 4 J/kg * 17. DEFIBRILLATE – 4J/kg * *Or biphasic waveform defibrillation at energy level approved by service provider medical director.	6. Consider NA BICARB: 1 mEq/kg IV/IO	7. Consider NA BICARB: 1 mEq/kg IV/IO 8. Consider repeat bolus (2nd or 3rd) of NS at 20 ml/kg

1. If unable to adequately ventilate with BLS measures, insert advanced airway earlier. If difficulty with airway management, consider immediate transport.
2. If difficulty with vascular access, consider immediate transport. IO route preferred if age < 2 years and may be used up to age 8, per Policy 717.
3. Early BH contact is recommended in unusual situations, e.g., renal failure, Calcium channel blocker OD, tricyclic OD, Beta blocker OD.
   BH to consider:
   - $CaCl_2$ and Bicarb in renal failure,
   - early Bicarb in Tricyclic OD,
   - early $CaCl_2$ in Ca channel blocker OD
   - Glucagon in beta-blocker OD and calcium channel blocker OD.
- Dosages:
  - Calcium Chloride: 0.2 ml/kg IVP (max 10 ml) of 10% solution, may repeat X1 in 10 minutes
  - Glucagon: 0.1 mg/kg IVP (max 5 mg) as available
  - Sodium Bicarbonate: 1 mEq/kg IV, followed by 0.5 mEq/kg q 10 minutes
4. V-Tach = Ventricular Tachycardia with rate > 150/min.
5. If organized rhythm with pulse after 2 minutes post-shock CPR, IV access, Lidocaine and ALS airway.

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COUNTY WIDE PROTOCOL

POLICY NO: 705
CRUSH INJURY/SYNDROME

HISTORY	PHYSICAL
Large muscle, extremity and/or pelvis crush, >1 hour of entrapment Compromised local circulation from debris or body weight Multi system injuries Inhalation of smoke, dust Immobility	Signs of Shock: Delayed Capillary Refill Hypotension, Cool skin ALOC, Diaphoretic Distal pulses could be absent or present Dysrhythmias O2 Sat Capnography (if available)

TREATMENT PRIOR TO BASE HOSPITAL CONTACT

ABCs
O2
IV access
Monitor, document rhythm strips
Advance airway, if indicated
C-spine precaution (per policy 614)
↓
Determine Potential vs. Actual Crush Syndrome

Potential	Actual
↓ IV 500cc NS bolus[4], Ped. 20 mL/kg ↓ Release compression Cover patient to maintain body heat Continuous re-assessment ECG Monitor urine color and output ↓	↓ IV 1-2 liters NS bolus[4], Ped. 20 mL/kg Sodium Bicarb. 1mEq/kg, add to first liter of NS[2] ↓ Albuterol 5mg with Neb./Mask, repeat x1 (Ped. 2.5mg <4 y.o.), repeat x 1 ↓ Pain control per policy 705 Pain Control[1] Release compression Continuous re-assessment of ECG Monitor urine color and output ↓

BASE HOSPITAL CONTACT.
If unable, follow COMMUNICATION FAILURE PROTOCOL

Potential	Actual
Albuterol 5mg with Neb./Mask, repeat x 1 (Ped. 2.5mg <4 y.o.), repeat x 1 ↓	Dysrhythmias[3] Calcium Chloride 1gm [2], slow IVP over 60 sec. Ped. 20mg/kg, Max 500mg ↓ If Shock persists, give 1 liter NS bolus x 1[4] Ped. 20 mL/kg

BASE HOSPITAL ORDERS ONLY
Consider only during ongoing extended entrapment

If signs of CHF or not responding to fluid challenge, initiate Dopamine 400 mg/250 ml D_5W.
Start at 5-10 mcg/kg/min and titrate to effect, max. 20 mcg/kg/min.
Lasix 40-80mg IVP

1. Not recommended in major systems injury.
2. Calcium Chloride and sodium bicarb precipitate when mixed. To prevent precipitation, clamp off IV infusion containing sodium bicarb, flush line with NS, administer CaCl, flush line again with NS, then restart sodium bicarb infusion. A second IV line may be started for the purpose of drug administration if feasible.
3. Suspicion of Hyperkalemia- (Peaked T wave, absent P waves, widened QRS complexes, bradycardia)
4. If elderly or cardiac consider 250-500mL bolus and reassess for CHF or improvement

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VC EMS Medical Director

HISTORY	PHYSICAL
Consider weather, environment, activity Antipsychotic drugs	O_2 sat HEAT EXHAUSTION Normal Temperature Weakness, syncope, vertigo Cool, damp skin Abdominal cramping, nausea Patient is SWEATING HEAT STROKE Elevated temperature, pulse, BP Altered LOC Hot, dry skin Patient is NOT SWEATING

TREATMENT PRIOR TO BASE HOSPITAL CONTACT

ABCs
Oxygen 4-6 L/min
↓
Monitor, document rhythm strip
Cool the environment and patient
↓
Check Blood Glucose
↓
IV NS Fluid Challenge
Adult: 1000 mL
Peds: 20 mL/Kg
Caution if known cardiac history
↓

BASE HOSPITAL CONTACT, continue treatment as ordered
If unable, initiate transport, follow COMMUNICATION FAILURE PROTOCOL

COMMUNICATIONS FAILURE PROTOCOL

If hypotensive, repeat IV bolus x 1 enroute
If patient begins to seize, go to Seizure protocol

BASE HOSPITAL ORDERS ONLY

Consult BH MD for further instructions

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VC EMS Medical Director

HISTORY	PHYSICAL
Identify Spider Black Widow - shiny black body and red/orange hourglass on ventral side	**Black Widow** Sharp pain Muscle cramps Abdominal pain/rigidity (lower extremity bite) Chest pain (upper extremity bite) Ascending motor paralysis **Bee** Local pain and swelling Stinger with sac often present

PRIOR TO BASE HOSPITAL CONTACT

ABC's[1]
↓
0_2 therapy as indicated
↓
If stinger present, remove[2]
↓
Cold pack if recent bite
↓
If patient is stable and in no significant distress, may be treated as BLS call
↓
Consider Monitor
↓
Consider IV NS
↓
Initiate Transport
↓
Pain control per policy 705 Pain Control

BASE HOSPITAL CONTACT, continue treatment as ordered

1. If signs of anaphylaxis, see Anaphylaxis protocol.
2. For honeybee sting, if less than 5 minutes since sting, remove stinger immediately. It is not necessary to use a sharp object. Pinching with fingernails is adequate.

VCEMS Medical Director

HISTORY	PHYSICAL
Identify: Type of animal Time and circumstance of sting Location of sting Transport time	**Jelly Fish** Immediate pain Lesions - small, reddened papular eruptions Erythema Swelling Rash Muscle and abdominal pain Weakness Lacrimation Dyspnea, pain on inspiration **Sting Ray** Intense pain, greatest in 90 min. Redness or swelling around site Wound is either a laceration or puncture Wound edges may have a bluish cast O_2 Sat

PRIOR TO BASE HOSPITAL CONTACT

ABC's
O_2 therapy as indicated[1]
↓
If patient is stable and in no significant distress, may be treated as a BLS call
↓
Monitor, document rhythm strips
↓
Consider IV NS TKO

Scorpion Fish Lion Fish Stone Fish Sting Ray Sculpin Immerse in hot water if available[2]	Jelly Fish Wash with salt water, saline DO NOT Wash with fresh water Rub with wet sand Apply heat

Pain control per policy 705 Pain Control

BASE HOSPITAL CONTACT, continue treatment as ordered
If unable, initiate transport

BASE HOSPITAL ORDERS ONLY

Consult with BH MD for further treatment measures

1. If signs of anaphylaxis, follow Anaphylaxis protocol.
2. Do not delay treatment while locating hot water. Check temperature to avoid scalding patient.

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VCEMS Medical Director

NERVE AGENT POISONING

HISTORY	PHYSICAL
Known nerve agent release Known chemical release with suspicion of nerve agent **Symptoms:** • Blurred or dim vision • Nausea, abdominal cramps, diarrhea • Flushing • Headache • Anxiety • Vertigo • Weakness • Nausea • Tremors	Vital signs Skin vitals LOC 0_2 Saturation **Signs:** • Mild: o SLUDGE (Salivation, Lacrimation, Urination, Gastrointestinal Elimination (vomiting and diarrhea) • Severe: o Decreased LOC o Fasciculations and muscle weakness o Seizures o Apnea from muscle paralysis

PRIOR TO BASE HOSPITAL CONTACT

ABC's
↓

EXCLUSION ZONE (HOT ZONE)[1]	**CONTAMINATION REDUCTION ZONE (WARM ZONE)[2]**
For Severe Exposures Only: ↓ Atropine[3,4] Adult: 2 mg IM ↓ Repeat as needed ↓ Pralidoxime (2-PAM): 600 mg IM[3] (Adult only)	**Mild, Moderate, or Severe Exposure:** ↓ IV access ↓ Atropine[3,4]: Adult 2 mg IV or IM Peds: 0.02 mg/kg (min dose 0.1 mg) IV or IM Repeat as needed ↓ Pralidoxime (2-PAM): 600 mg IM[3] (Adult only) ↓ For seizures[5]: Midazolam Adult: 5mg IM Peds: 0.1 mg/kg IM (Max 5 mg)

BASE HOSPITAL CONTACT, continue treatment as ordered
If unable, initiate transport, follow COMMUNICATION FAILURE PROTOCOL

BASE HOSPITAL ORDERS ONLY

Consult with Base Hospital Physician for further treatment measures

Notes:
1. "Exclusion Zone" or "Hot Zone": The innermost of three circles around a hazardous materials site. Special protection is required for all personnel within.
2. "Contamination Reduction Zone (CRZ)" or "Warm Zone": Site of decontamination and between Exclusion (Hot) and Support (Cold) Zones. Requires a lesser degree of protection equipment.
3. Mark 1 Kits contain two auto-injectors, one containing 2 mg atropine and one containing 600 mg pralidoxime (2PAM).
4. Nerve agent poisoning can be very toxic. Large amounts of atropine may need to be utilized (in the 100's of mg's). If the patient is initially symptomatic and no response is seen to the initial doses of medication, continue giving until a response is achieved.
5. Diazepam is available in the CHEMPACK pharmaceutical stockpile and may be deployed In the event of a nerve agent exposure. Paramedics may administer Diazepam using the following dosages for the treatment of seizures associated with suspected nerve agent toxicity.
   Adult - 5-10 mg IV q 10-20 min, titrated to effect; not to exceed 30 mg
   Pediatric – 0.05-0.3 mg IV over 2-3 min q 15-30 min, titrated to effect; not to exceed 10 mg

Effective Date:	June 1, 2008
Date Revised:	January 8, 2009
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VCEMS Medical Director

COUNTY WIDE PROTOCOLS

POLICY NO: 705

NEWBORN RESUSCITATION

HISTORY		PHYSICAL
NEWLY BORN INFANT[1]: Pregnancy complications? Time of delivery Presence of meconium?[3]	INFANT UP TO 48 HRS OLD[2]: Age of infant? Known complications of the infant following delivery? Known pregnancy or delivery complications?	Vital signs Skin vitals Extreme prematurity (known to be less than 21 weeks gestation, or less than 9 inches long.)[4]

PRIOR TO BASE HOSPITAL CONTACT

NEWLY BORN INFANT	INFANT UP TO 48 HOURS OLD:
Provide warmth, position, clear airway if needed Suction oropharynx if meconium Dry and stimulate (rub gently but briskly with dry towel) Provide dry/warm covering ↓	Provide warmth, position, clear airway if needed Stimulate briefly by gently flicking soles of feet or rubbing infant's back Provide dry/warm covering ↓

Breathing?

YES	NO
Continue to stimulate and maintain open airway If HR < 100 and/or Resp Rate < 30 or weak/gasping, assist respirations with BVM for 15-30 seconds ↓ Check heart rate IF HR < 60, move to NOT BREATHING ARM FOR CPR ↓ Keep warm ↓ Monitor, document rhythm strip ↓ Initiate Transport ↓ Reevaluate every 30 seconds	↓ Positive pressure ventilations with BVM for 15-30 seconds ↓ Assess heart rate IF HR < 60, ADD CHEST COMPRESSIONS Compression Rate = 120/min Respiratory Rate = 40/min[3] (3 compressions for each 1 ventilation) Monitor, document rhythm strip Establish IO line[4] ↓ EPINEPHRINE 0.01 mg/Kg (0.1 ml/Kg 1:10,000) ↓ Initiate transport ↓ Reevaluate every 30 seconds

BASE HOSPITAL CONTACT, continue treatment as ordered

If unable, initiate transport, follow COMMUNICATION FAILURE PROTOCOL

COMMUNICATIONS FAILURE PROTOCOL

	ASYSTOLE	PEA	Persistent Bradycardia <= 60 with palpable pulses
	↓ EPINEPHRINE 0.01 mg/Kg (0.1 ml/Kg 1:10,000) q 3-5 min	↓ Initiate fluid bolus NS 20 mg/Kg ↓ EPINEPHRINE 0.01 mg/Kg (0.1 ml/Kg 1:10,000) q 3-5 min	↓ EPINEPHRINE 0.01 mg/Kg (0.1 ml/Kg 1:10,000) q 3-5 min

BASE HOSPITAL ORDERS ONLY

Consult Base Hospital Physician for further treatment measures

1. Applies to newborns immediately following delivery.
2. Applies to newborns who have already undergone transition from intrauterine to extrauterine life, and are less than 48 hours old.
3. If meconium is present, suction mouth and nose thoroughly prior to drying and stimulating to breathe.
4. Resuscitation efforts may be deferred for obviously extremely preterm infants. Sensitivity to the desires of the parent(s) may be considered. If uncertain as to gestational age, begin resuscitation.
5. If difficulty with airway management, consider immediate transport.
6. If difficulty establishing IO line, consider immediate transport.

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VC EMS Medical Director

NON-TRAUMATIC FOCAL NEUROLOGICAL CHANGES

HISTORY	PHYSICAL
History of Previous CVA Diabetes Hypertension Trauma Time of symptom onset (last time patient appeared to be normal) Medications	Vital Signs Skin Vitals O_2 sat Symmetry vs. asymmetry of face, movement, etc. Level of Consciousness Depth of Coma Eyes (Pupils) Respirations Movement

TREATMENT PRIOR TO BASE HOSPITAL CONTACT

ABC's

↓

O_2 4-6L/min

↓

Monitor, document rhythm strip

↓

IV NS TKO

↓

If hypertensive, elevate head of bed

↓

Determine Blood Glucose Level

↓

BLOOD GLUCOSE < 60	BLOOD GLUCOSE > 60
50% Dextrose 50 cc IVP (Give Glucagon, 1 mg IM if no IV access)	

BASE HOSPITAL CONTACT, continue treatment as ordered

If unable, initiate transport, follow COMMUNICATION FAILURE PROTOCOL

COMMUNICATIONS FAILURE PROTOCOL

Repeat Blood Glucose determination if neuro symptoms persist ↓ Repeat D50 if BG < 60	

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VC EMS Medical Director

HISTORY	PHYSICAL
Known suicide attempts Depression Psychiatric problems Meds: Phenothiazines Thorazine, Stelazine Compazine, Phenergan, etc Tricyclics Tofranil, Elavil, Triavil, Sinequan, etc Occupational Exposure Hydrocarbons Corrosives or Caustics Recent GI Surgery	Protected Airway Vital signs Skin vitals LOC Environmental clues O_2 sat Cardiac rhythm Pupils Signs of Trauma Anatomically intact GI tract SLUDGE **S**alivation **L**acrimation **U**rination **D**iaphoresis **G**astrointestinal **E**limination (vomiting & diarrhea)

PRIOR TO BASE HOSPITAL CONTACT

ABC's, Decontaminate as needed
For dysrhythmias/hypotension, see appropriate protocol
BRING ALL CONTAINERS TO THE EMERGENCY DEPARTMENT (if practical and safe)
↓
O_2 therapy as indicated
↓
Monitor, document rhythm strip
↓
Consider IV NS TKO
↓
Alert with gag reflex?
↓

YES	NO
Activated Charcoal (If oral OD within 1 hour) Adults/Peds: 1 Gm/kg PO, max 50 Gm ↓ Transport	See Altered Level of Consciousness Protocol

BASE HOSPITAL CONTACT, continue treatment as ordered
If unable, initiate transport, follow COMMUNICATION FAILURE PROTOCOL

BASE HOSPITAL ORDERS ONLY

Consult with Base Hospital Physician for further treatment measures

NOTES:

1. For caustics/petroleum distillates, DO NOT INDUCE VOMITING, DO NOT GIVE CHARCOAL.
2. For Phenothiazines, give Benadryl, 50 mg IV (Peds: 1 mg/kg IV) for extra-pyramidal reaction.
3. For Tricyclics, monitor for dysrhythmias, consider bicarbonate, DO NOT GIVE CHARCOAL.
4. For symptomatic organophosphate exposure (SLUDGE) give Atropine 2 mg IVP q 5 min. until symptom subsides. (Besides "SLUDGE" Bradycardia, miosis, fasciculation, muscle weakness, and ALOC are relatively common in organophosphate poisoning.)
5. For Beta blocker overdoses, consider Glucagon. (Initial dose: Adult 2 mg, IVP may give up to 10 mg as available, Peds. 0.05-0.15 mg/kg IVP up to 2 mg - may give up to 4 mg IVP as available.)
6. For calcium channel blocker overdose, consider IV $CaCl_2$ (initial dose: Adult 5-10-ml, peds. 10-30 mg/kg IVP). If no response, Glucagon (Initial dose: Adult 2 mg, IVP may give up to 10 mg as available, Peds. 0.05-0.15 mg/kg up to 2 mg - may give up to 4 mg as available.)
7. For sympathomimetic excess (e.g., tachycardia, hypertension, excessive motor activity, agitation, and chest pain) consider midazolam 1 mg IV q 2minutes max: 0.1mg/kg up to 5 mg, or, if no IV, 0.1mg.kg IM, max 5 mg.
8. For chest pain, see Chest Pain protocol, but do NOT give aspirin.

VC EMS Medical Direcotr

HISTORY	PHYSICAL
Severe pain associated with: • Isolated fractures or extremity injuries. • Musculoskeletal conditions of the back or neck. • Snake or insect bites, marine animal or insect stings. • Burns.	Assess for signs of shock, head, chest, abdomen injuries. O_2 Sat

PRIOR TO BASE HOSPITAL CONTACT

ABCs
↓
O_2 if indicated
↓
IV Access
↓
Document VS
↓

Adult: Morphine 2-4 mg slow IV (give over 1-2 minutes)
May repeat every 3 minutes to maximum total of 10 mg
Check and document VS between doses
If no IV access, may give Morphine 0.1 mg/kg IM, maximum dose 10 mg

Peds: Morphine 0.1 mg/kg slow IV (give over 1-2 minutes) **(NOT TO EXCEED 10 mg)**
May repeat every 3 minutes to maximum total of 0.2 mg/kg
Check and document VS between doses
If no IV access, may give Morphine 0.2 mg/kg IM, maximum dose 10 mg

BASE HOSPITAL CONTACT, continue treatment as ordered

COMMUNICATIONS FAILURE PROTOCOL

If significant pain persists after initial morphine total dosage and VS stable, may give additional morphine:

Adult: Morphine 2-4 mg slow IV (give over 1-2 minutes)
May repeat every 3 minutes to **MAXIMUM TOTAL DOSE of 20 mg**
Check and document VS between doses

Peds: Morphine 0.1 mg/kg slow IV (give over 1-2 minutes)
May repeat every 3 minutes to **MAXIMUM TOTAL DOSE of 0.4 mg/kg (NOT TO EXCEED 20 mg)**
Check and document VS between doses

BASE HOSPITAL ORDERS ONLY

Consult Base Hospital Physician for further treatment measures

1. No medications if significant abdomen, chest, or head trauma or patient in shock, unless ordered by BH MD
2. Do not delay transport

VC EMS Medical Director

HISTORY	PHYSICAL
SOB, Syncope, Dizziness Previous cardiac disease? Previous dysrhythmias? Medications	0_2 Sat Airway Breath Sounds Vital Signs - with O_2 Sat if available Level of consciousness Other signs of hypoperfusion

TREATMENT PRIOR TO BASE HOSPITAL CONTACT

Assess/Manage Airway/O_2 **

↓

Cardiac Monitor, document rhythm strips
If rate < 60, and significant ALOC, initiate CPR

↓

Vascular Access, NS IV/IO
IO preferred if age < 2, and may be used up to 8 years of age per Policy 717
IO for significant ALOC only

↓

EPINEPHRINE
IV/IO: 0.01 mg/kg (0.1 ml/kg) 1:10,000

BASE HOSPITAL CONTACT

(If unable, initiate transport and follow COMMUNICATION FAILURE PROTOCOLS)

EPINEPHRINE
IV/IO: 0.01 mg/kg (0.1 ml/kg) 1:10,000
(q 3-5 minutes)

BASE HOSPITAL ORDERS ONLY

Atropine 0.02 mg/kg
(Minimum dose = 0.1 mg IV/IO)

* Including, but not limited to, altered LOC, other signs of hypoperfusion, respiratory difficulty.

** **Most bradycardias in children are due to hypoxia. IMMEDIATELY USE HIGH FLOW OXYGEN AND ASSIST VENTILATIONS.**

Effective Date: December 1, 2005
Date Revised: December, 2004
Date Last Reviewed: December 11, 2008
Review Date: December 31, 2010
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VC EMS Medical Director

<table>
<tr><th colspan="3">HISTORY</th><th colspan="3">PHYSICAL</th></tr>
<tr><td colspan="3">Description?
Duration?
Repetition?
Trauma?
Diabetes?
Drugs?
Known seizure disorder</td><td colspan="3">Vital signs
Loss of consciousness
Skin signs
Signs of trauma
02 Sat</td></tr>
<tr><th colspan="6">TREATMENT PRIOR TO BASE HOSPITAL CONTACT</th></tr>
<tr><td colspan="6">ABC'S
↓
0_2 therapy as indicated
↓
Monitor, document rhythm strips
↓
Seizures stopped?</td></tr>
<tr><th colspan="3">YES</th><th colspan="3">NO</th></tr>
<tr><td>Known Seizure Disorder[4]</td><td>No Known Seizure Disorder</td><td>No Known Seizure Disorder
3rd Trim Pregnancy</td><td>Known Seizure Disorder</td><td>No Known Seizure Disorder</td><td>No Known Seizure Disorder
3rd Trim Preg</td></tr>
<tr><td>Left Lateral Position
↓
If Altered LOC persists, determine blood glucose level by finger stick
↓
IV NS TKO only if atypical presentation or BG < 60
↓
If BG < 60
50 ml Dextrose 50%
↓</td><td>Left Lateral Position
↓
IV NS TKO
↓
If Altered LOC persists, determine blood glucose level
↓
Dextrose 50% 50 ml IV if BG < 60
↓
If no response to D50 or BG >60
↓
Repeat BG determination if neuro symptoms persist
↓
D50 if BG < 60
↓</td><td>Left Lateral Position
↓
IV NS TKO
↓
Determine blood glucose level
↓
Dextrose 50% 50 ml if BG < 60

May proceed while Chemstrip developing
↓
MgSO4 2 GM in 50 ml D5W over 5 minutes[1]
↓
Repeat x 1
↓
STAT transport during infusion
↓</td><td>IV NS TKO
↓
Determine blood glucose level
↓
Dextrose 50% 50 ml IV if BG < 60
↓</td><td>IV NS TKO
↓
Determine blood glucose level
↓
Dextrose 50% 50 ml if BG < 60

May proceed while Chemstrip developing
↓</td><td>Left Lateral Position
↓
IV NS TKO
↓
Determine blood glucose level
↓
Dextrose 50% 50 ml if BG < 60

May proceed while Chemstrip developing
↓
MgSO4 2 GM in 50 ml D5W over 5 minutes[1]
↓
Repeat x 1
↓
STAT transport during infusion
↓</td></tr>
<tr><td colspan="3"></td><td colspan="3">SEIZURE PERSISTS[2]
Adult: Midazolam 1 mg q 2 min IV, max 0.1 mg/kg up to 5 mg.[3]
If no IV, Midazolam 0.1 mg/kg IM, max 5 mg.

Peds: Midazolam 0.1 mg/kg IM, max 5 mg.</td></tr>
<tr><th colspan="6">TRANSPORT</th></tr>
<tr><th colspan="6">BASE HOSPITAL ORDERS
Consult with ED MD for further treatment</th></tr>
<tr><td colspan="6">For extreme agitation: Adult: Midazolam 1 mg q 2 min IV, max 0.1mg/kg to max 5 mg if needed for safety of patient or EMS personnel. If no IV, Midazolam 0.1 mg/kg IM, max 5 mg.</td></tr>
</table>

1. Slow or stop infusion rate if bradycardia, heart block, decreased respiratory effort. Slow infusion if seizure stops.
2. Treatment with Midazolam as indicated in the following:
   a. Continuous seizure > 5 minutes (or > 2 minutes in pregnancy).
   b. Repetitive seizures without regaining consciousness.
3. For IV use, dilute Midazolam 5mg (1ml) with 4ml NS for a final volume of 5ml and concentration of 1mg/ml.
4. Patients with known seizure disorder or uncomplicated apparent pediatric febrile seizures, no longer seizing and with a normal postictal state, may be treated as a BLS call.

VC EMS Medical Director

VENTRICULAR TACHYCARDIA, SUSTAINED, NOT IN ARREST

HISTORY	PHYSICAL
Medications	Vital Signs O2 Saturation Breath Sounds Level of Consciousness Pulses

TREATMENT PRIOR TO BASE HOSPITAL CONTACT

ABC'S
↓
O_2
↓
IV access [1]
↓
Monitor, document rhythm strips

Rate > 150/min., Stable	Rate > 150/min., Unstable
↓ Lidocaine [2] 1.5 mg/kg IV[5]	↓ Place on Backboard ↓ Prepare for Cardioversion[3] ↓ Consider sedation with Midazolam 2mg IV[4]: if patient needs sedation and delay in obtaining sedation medication, give Lidocaine 1.5mg/kg IV5. Proceed to Cardioversion as soon as possible unless patient converts. ↓ Synch Cardioversion #1 - 100 J[7] #2 - 200 J[7] #3 - 300 J[7] #4 - 360 J[7] Lidocaine [1,6]

BASE HOSPITAL CONTACT, continue treatment as ordered
If unable, follow COMMUNICATION FAILURE PROTOCOL

COMMUNICATIONS FAILURE PROTOCOL

TRANSPORT	TRANSPORT
↓ Repeat Lidocaine [2] 0.5 mg/kg q 5-10 minutes (up to a total of 3 mg/kg) [Hold if decreased cardiac output, significant liver dysfunction, or in-patient > 70 years of age]	↓ Repeat Lidocaine [2] 0.5 mg/kg q 5-10 minutes (up to a total of 3 mg/kg) ↓ If recurrent, cardiovert again at last successful J

1. Early BH contact is recommended in unusual circumstances, e.g., torsade de pointes, tricyclic OD and renal failure. BH to consider $MgSO_4$ 1 GM in 50 cc D_5W IV over 2-4 minutes for torsade (may repeat X 1 if torsade continues or recurs), Bicarb for tricyclic OD and Ca plus Bicarb for renal failure.
2. Lidocaine administered at no greater than 50mg/min IV.
3. For unstable polymorphic (irregular) VT, immediate unsynchronized countershock (defibrillation) at 360 J, or biphasic energy level approved by service provider medical director.
4. For IV use, dilute Midazolam 5mg (1ml) with 4ml NS for a final volume of 5ml and concentration of 1mg/ml.
5. May be given in conjunction with sequential cardioversion attempts.
6. If cardioversion/defibrillation→ narrow complex rhythm > 50, not in 2nd or 3rd degree block, and Lidocaine not already given, give Lidocaine 1.5 mg/kg IVP or ET 3 mg/kg (if no IV).
7. Or biphasic energy level approved by service provider medical director.

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VC EMS Medical Director

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Patient Transfer From One Prehospital Team To Another		Policy Number: 708
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: June 1, 2009
APPROVED: Medical Director	Angelo Salvucci, MD	Date: June 1, 2009
Origination Date: Date Revised: Date Last Reviewed: Review Date	October 31, 1992 December 11, 2008 December 11, 2008 June 30, 2012	Effective Date: June 1, 2009

I. PURPOSE: To provide guidelines for transfer of patient care from one prehospital team to another prehospital team, if necessary.

II. POLICY: Care of a patient may be transferred from one prehospital team to another according to the following procedures.

III. PROCEDURE:

A. Ground Unit to Ground Unit

1. ALS level response

a. Attempt to inform the Base Hospital (BH) and inform the patient of the necessity of a transfer.

b. Obtain agreement from the receiving team to accept responsibility for the patient.

c. Give a report concerning the patient's condition. This report should include history, physical assessment and all treatment rendered.

d. Document times and units involved on the Approved Ventura County Documentation System (AVCDS).

e. The receiving team is responsible for documentation.

2. BLS level response

a. Inform the patient of the necessity for a transfer.

b. Obtain agreement from the receiving team to accept responsibility for the patient.

c. Give a report concerning the patient's condition. This report should include history, physical assessment and all treatment rendered.

d. Document times and units involved on the Approved Ventura County Documentation System (AVCDS).

e. The receiving team is responsible for documentation.

B. Ground Unit to Air Unit

1. ALS capable personnel, if on scene, shall accompany a critical patient on the air unit.

2. Transfer from ground to air may be to a crew with lesser certificate level. If ALS procedures have been started (other than an IV in a stable patient), ALS personnel shall accompany the patient.

3. If the ground crew is unable to make BH contact, the ALS personnel may operate under Communication Failure Protocols.

C. Multi Casualty Incident (MCI) (Greater than 3 patients)

1. Patients should be identified by START triage number, and this number shall be used during the remainder of the call.

2. Care for a stable patient with a prophylactic IV (no meds) may be transferred to an EMT-I crew.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Guidelines for Limited Base Contact	Policy Number 720
APPROVED: Administration: Barry R. Fisher, MPPA	Date: December 11, 2008
APPROVED: Medical Director Angelo Salvucci, M.D.	Date: December 11, 2008
Origination Date: June 15, 1998 Date Revised: December 11, 2008 Date Last Reviewed: December 11, 2008 Review Date: December 31, 2010	Effective Date: December 11, 2008

I. PURPOSE: To define patient conditions for which EMT-P's shall establish LIMITED BH contact.

II. AUTHORITY: Health and Safety Code 1797.220.

III. POLICY: EMT-P's shall make Limited BH contact for simple, uncomplicated non-traumatic cases, which respond positively to initial treatment and require no further intervention.

A. Patient criteria:

1. Hypoglycemia
2. Narcotic Overdose.
3. Chest pain - no arrhythmia, hypertension or associated shortness of breath.
4. COPD/Asthma
5. Focal Neuro Changes suspected TIA or CVA, Chemstick > 60 (no need for Narcan)
6. Seizure: No drug ingestion, no dysrhythmias, Chemstick > 60 (new onset, no longer seizing, not status epilepticus, not pregnant).
7. Syncope or near-syncope (stable vs. no dysrhythmia, Chemstick > 60.
8. Patients with severe pain who meet requirements of Policy 705 Pain Control

B. Treatment to include:

1. Hypoglycemia: Prior to Contact procedure up to Dextrose
2. Narcotic Overdose: Prior to Contact procedure up to Narcan
3. Chest pain: Prior to Contact procedure up to three sublingual nitroglycerin or nitroglycerin spray (administered by paramedic) and Aspirin 324 mg po.
4. COPD/Asthma: Prior to Contact procedure up to one nebulized breathing treatment only (administered by paramedic).
5. Focal Neuro Changes: Prior to Contact procedure up to administration of Dextrose.
6. Seizure: Prior to contact procedure up to administration of Dextrose and/or Versed.
7. Syncope or near-syncope: Prior to Contact procedure up to IV Chemstick check.
8. Pain: Prior to Contact procedure, including administration of morphine.

C. Communication

1. The limited BH contact call-in shall include the following information:
   a. ALS unit number
   b. "We have a completed Limited Base Contact (LBC) call"
   c. Age/Sex
   d. Brief nature of call
   e. Patient Care Record
   f. ETA and destination

D. Documentation

1. ALS Unit
   a. Complete the PCR with "LBC" noted in the "Base Hospital Contact" box.
   b. PCR delivered to base station within the required time frame.
2. MICN
   a. Complete log entry with "LBC" noted in the treatment section.
   b. EMT-P/BH Communication form is NOT required.
   c. Call will be documented on tape.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES</td><td colspan="2">HEALTH CARE AGENCY
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title
12 Lead ECG</td><td>Policy Number:
726</td></tr>
<tr><td>APPROVED
Administrator</td><td colspan="2">Steven L. Carroll, EMT-P</td><td>Date: June 1, 2009</td></tr>
<tr><td>APPROVED
Medical Director:</td><td colspan="2">Angelo Salvucci, MD</td><td>Date: June 1, 2009</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Las Reviewed:
Review Date:</td><td>August 10, 2006
March, 2009
March 12, 2009
March 31, 2011</td><td>Effective Date:</td><td>June 1, 2009</td></tr>
</table>

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

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

III. Policy: Paramedics will obtain 12-lead ECGs in patients suspected of having acute coronary syndrome and provide treatment in accordance with this policy. Only paramedics who have received training according to Appendix A are authorized to obtain a 12-lead ECG on patients.

IV. Procedure:

A. Indications for 12-lead ECG: Medical history and/or presenting complaints consistent with an acute coronary syndrome. Patients will have one or more of the following:

1. Chest or upper abdominal discomfort suggestive of acute coronary syndrome
2. New onset cardiac dysrhythmias (including adult cardiac arrest if return of spontaneous circulation)
3. Unexplained syncope or near syncope
4. Unexplained acute generalized weakness with or without diaphoresis
5. Acute onset of dyspnea suggestive of congestive heart failure
6. Other signs or symptoms suggestive of acute coronary syndrome

B. Contraindications: Do NOT perform ECG on these patients:

1. Trauma: There must be no delay in transport.
2. Cardiac Arrest (unless return of spontaneous circulation)

C. ECG Procedure:

1. Attempt to obtain ECG during initial patient evaluation. Oxygen should be administered first to all patients. If the ECG can be completed without delay (less than 3 minutes after patient contact), and the patient is not in

severe distress, perform ECG prior to medication administration (other than oxygen).

2. The ECG should be done before moving the patient.
3. If the ECG is of poor quality (artifact or wandering baseline), may repeat to a total of 3.
4. May repeat ECG if interpretation is NOT ** ACUTE MI SUSPECTED**, and patient's condition worsens so paramedic believes that the ECG may have changed to show an acute MI.
5. If interpretation is ***ACUTE MI SUSPECTED**, verify by history and physical exam that the patient does not have a pacemaker or ICD.

D. Base Hospital Communication/Transportation:

1. If ECG interpretation begins with ***ACUTE MI SUSPECTED***, report that to MICN at the beginning of the report. All other information, except that listed in items 2, 4, and 5 below, is optional and can be given at the paramedic and MICN's discretion.
2. Paramedics are to ask the patient if they have a cardiologist and report the information to the base hospital.
3. If ECG Interpretation is "***ACUTE MI SUSPECTED***", patients should be transported to the closest and most appropriate STEMI Receiving Center (SRC) depending on patient preference and cardiac catheterization lab availability. MICN may direct ambulance to alternative SRC if cardiac catheterization lab not available.
4. If the ECG interpretation is "***ACUTE MI SUSPECTED***", and the underlying rhythm reads, "Atrial Flutter" the Base Hospital shall be notified at the beginning of the report. The Cath Lab will not be activated.
5. If the ECG interpretation is ***ACUTE MI SUSPECTED*** and the patient has a pacemaker or the ECG is of poor quality (wandering baseline and/or artifact) report that to the MICN.
6. If a first responder paramedic obtains an ECG that is not ***ACUTE MI SUSPECTED*** and the patient is stable, patient care may be turned over to the transporting paramedic. The ECG will be turned over to the transporting paramedic.
7. Prehospital ECGs will be handed to the receiving medical practitioner for review. The receiving practitioner will be requested to initial, time and date the ECG to indicate they have received and reviewed the ECG.

E. Patient Treatment:

1. Patient Communication: If the ECG interpretation is “Acute MI Suspected”, the patient should be told that “according to the ECG you may be having a heart attack”. If the ECG interpretation is anything else, the patient should NOT be told the ECG is normal or “you are not having a heart attack”. If the patient asks what the ECG shows, tell him/her that it will be read by the emergency department MD.
2. For patients with an ECG interpretation of “***ACUTE MI SUSPECTED***”, consider NTG 0.4 mg every 5 minutes even if no ongoing chest pain (if SBP > 100).

F. Other ECGs

1. If an ECG is obtained by a physician and the physician interpretation is Acute MI, the patient will be treated as an ***ACUTE MI SUSPECTED***. Do not perform an additional ECG.
2. If there is no interpretation of another ECG then repeat the ECG.

G. Documentation

1. Approved Ventura County Documentation System (AVCDS) documentation will be completed per VCEMS policy. A copy of the 12 Lead ECG will be turned in to the base hospital and ALS Service Provider.

I. PURPOSE: To define the indications, procedure and documentation for the use of transcutaneous cardiac pacing by paramedics

II. AUTHORITY: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Sections 100145 and 100169.

III. POLICY: Paramedics may utilize transcutaneous cardiac pacing (TCP) on adult patients (age > 12) in accordance with Ventura County Policy 705 – Symptomatic Bradycardia, Adult.

IV. PROCEDURE:

A. Training: Prior to using TCP the paramedic must successfully complete a training program approved by the VC EMS Medical Director, which includes operation of the device to be used.

B. Indications: Symptomatic bradycardia (heart rate <45 with one or more of the following signs or symptoms):

1. Signs of poor perfusion, evidenced by: Decreased level of consciousness, prolonged capillary refill, cool extremities or cyanosis;
2. Chest pain;
3. CHF.

C. Contraindications:

1. Absolute
   a. Asystole
2. Relative:
   a. Hypothermia – patient warming measures have precedence. (Base Hospital contact required.

D. Patient Treatment

1. Patient assessment and treatment per 705: Bradycardia treatment protocol. If IV/IO access not promptly available, proceed to pacing.
2. Explain procedure to the patient.
3. Place pacing electrodes and attach pacing cable to pacing device per manufacturer's recommendations.
4. Set pacing mode to demand mode, pacing rate to 70 BPM, and current at 40 milliamps (mA).
5. If required, provide patient pain relief. Patients with profound shock and markedly altered level of consciousness may not require pain relief
6. Activate pacing device and increase the current in 10 mA increments until capture is achieved (i.e., pacemaker produces pulse with each paced QRS complex).
7. Assess patient for mechanical capture and clinical improvement (BP, pulses, skin signs, LOC).
8. Continue monitoring. Contact base for further orders if patient symptoms are not resolving (consideration for dopamine, further alteration of pacer settings) or if further pain control needed, orders are required.

NOTE: Patients with high grade AV block (second degree type II or third degree block) who do not have symptoms do not require pacing. However, equipment should be immediately available if symptoms arise. Patients with symptoms who respond initially to atropine should have pacing equipment immediately available.

E. Documentation

1. The use of TCP must be documented.
2. Vital signs must be documented every 5 minutes.

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

Policy No.	Title	Effect. Date	Origin. Date	Revised Date	Last Reviewed	Review Date
501	Advanced Life Support Service Provider Criteria	12/1/2005	4/1/1984	9/8/2005		4/30/2010
502	Advanced Life Support Service Provider Approval Process	6/1/2008	5/1/1984	1/10/2008		1/31/2010
504	BLS And ALS Unit Equipment and Supplies	12/1/2007	5/24/1987	6/12/2007		6/30/2009
506	Advanced Life Support (ALS) Support Vehicles	6/1/2008	10/1/1995	11/8/2007		11/30/2009
507	Critical Care Transports	11/30/2002	10/31/1995	9/12/2002		11/30/2004
508	First Responder Advanced Life Support Units	12/1/2005	6/1/1997	10/13/2005		4/30/2010
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	6/1/2008	6/3/1986	1/9/2008		1/31/2010
605	Interfacility Transfer of Patients	6/1/2006	7/26/1991	4/13/2006		10/31/2011
606	Withholding or Termination of Resuscitation and Determination of Death	6/1/2006	6/1/1984	5/11/2006		10/31/2011
607	Hazardous Material Exposure: Prehospital Protocol	6/1/2008	2/12/1987	3/13/2008		3/31/2010
612	Notification of Exposure to a Communicable Disease	4/27/1990				4/27/1992
613	Do Not Resuscitate (DNR)	1/12/2009	10/1/1993	1/12/2009	1/12/2009	1/31/2011
614	Spinal Immobilization	6/1/2009	10/31/1992	12/11/2008	12/11/2008	6/30/2011
615	Organ Donor Information Search	6/1/2004	10/1/1993	3/11/2004		1/31/2010
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		11/30/2009
620	EMT-I Administration of Oral Glucose	6/1/2006	11/18/1982	3/9/2006		10/31/2011
622	ICE - In Case of Emergency for Cell Phones	12/1/2008	5/11/2006	7/10/2008		7/31/2011
624	Patient Medications	12/12/2006	12/6/2006			10/31/2011
625	POLST	1/8/2009	1/7/2009			1/31/2011
VII.	**Advanced Life Support Medical Control and Treatment Policies**					
701	Medical Control: Base Hospital Medical Director	6/1/2008	8/1/1988	1/10/2008		1/31/2010
703	Medical Control At Scene, Private Physician	6/1/2008	1/31/1985	3/13/2008		3/31/2010
704	Guidelines For Base Hospital Contact	6/1/2008	10/1/1984	3/13/2008		3/31/2010
705	Airway Obstruction	12/1/2007		9/13/2007		12/31/2009
705	Altered Level of Consciousness/Coma	12/1/2008		10/9/2008		12/31/2010
705	Anaphylaxis	6/1/2009		1/8/2009	1/8/2009	6/30/2011
705	Apnea or Agonal Respirations	12/11/2008		12/11/2008	12/11/2008	12/31/2010
705	Behavioral Emergencies	12/1/2007		5/1/2007	1/8/2009	6/30/2011
705	Bradycardia: Adult, Symptomatic*, Not In Arrest	12/1/2008		10/9/2008	1/8/2009	12/31/2010
705	Burns	6/1/2008		4/1/2008	1/8/2009	6/30/2011
705	Cardiac Arrest, Adult	6/1/2009		4/8/2009	4/9/2009	6/30/2011
705	Cardiac Arrest, Pediatric	6/1/2009		4/9/2009	4/9/2009	6/30/2011
705	Chest Pain	12/1/2008		10/9/2008		12/31/2010
705	Childbirth	0601-09		4/9/2009	4/9/2009	6/30/2011
705	Crush Injury/Syndrome	6/1/2009		4/9/2009		6/30/2011
705	Decompression Injuries	6/1/2008		4/10/2008		4/30/2009
705	Heat Exhaustion/Heat Stroke	6/1/2009		1/8/2009	1/8/2009	6/30/2011
705	Hypothermia	6/1/2008		4/10/2008		6/30/2011
705	Hypovolemic Schock - Trauma	12/1/2008		8/14/2008		12/31/2010
705	Hypovolemic Shock Non Trauma	12/1/2008		8/14/2008		8/31/2010

Policy No.	Title	Effect. Date	Origin. Date	Revised Date	Last Reviewed	Review Date
705	Insect and Spider Bites	6/1/2008		4/1/2008	1/8/2009	6/30/2011
705	Marine Animals	6/1/2009		1/8/2009	1/8/2009	6/30/2011
705	Nerve Agent Poisoning	6/1/2009		1/8/2009	1/8/2009	6/30/2011
705	Newborn Resuscitation	6/1/2008		12/31/2006	1/8/2009	12/31/2010
705	Non-Traumatic Focal Neurological Changes	12/11/2008		12/11/2008	12/11/2008	12/31/2010
705	Overdose/Poisoning	6/1/2009		1/8/2009	1/8/2009	6/30/2011
705	Pain Control	1/10/2008		1/1/2008	12/12/2008	1/31/2011
705	Seizures	12/11/2008		12/11/2008	12/11/2008	12/31/2010
705	Shortness of Breath	12/1/2007		10/15/2007		12/1/2009
705	Snake Bite	12/1/2007		9/13/2007		12/31/2009
705	Supraventricular Tachycardia - Rate> 150 (Adult)	12/1/2008		8/14/2008		8/31/2010
705	Symptomatic* Bradycardia, Pediatric, Not In Arrest	12/1/2005		12/1/2004	12-11-008	12/31/2010
705	Ventricular Tachycardia, Sustained Not In Arrest	6/1/2009		1/8/2009	1/8/2009	6/30/2011
708	Patient Transfer From One Prehospital Team To Another	6/1/2009	10/31/1992	12/11/2008	12/11/2008	6/30/2011
710	Endotracheal Intubation Indications For Use	6/1/2008	6/1/1986	4/13/2008		4/30/2010
713	Intralingual Injection	6/1/2004	8/30/1990	1/8/2004		7/31/2011
715	Needle Thoracostomy	12/1/2007	11/1/1990	9/13/2007		9/30/2009
716	Use of Pre-existing Vascular Access Devices	12/1/2007	3/2/1992	9/13/2007		9/30/2009
717	Pediatric Intraosseous Infusion	6/1/2008	9/10/1992	4/13/2008		3/31/2010
720	Guidelines For Limited Base Hospital Contact	12/11/2008	6/15/1998	12/11/2008	12/11/2008	12/31/2010
722	Interfacility Transport of Patient with Patient with IV Heparin	1/10/2008	6/15/1998	1/10/2008		1/31/2010
723	Continuous Positive Airway Pressure (CPAP)	12/1/2007	12/1/2004	9/13/2007		9/30/2009
724	Apparent Life-Threatening Event (ALTE)	6/1/2005	3/1/2005			4/30/2010
725	Patients After TASER Use	8/29/2006	8/10/2006			10/31/2011
726	12-Lead ECG	6/1/2009	8/10/2006	3/31/2009	3/12/2009	3/31/2011
727	Transcutaneous Cardiac Pacing	12/1/2008	12/1/2008	12/11/2008	12/11/2008	12/31/2010
728	King Airway	8/14/2008	4/10/2008			6/30/2010
729	Trauma Treatment Protocol		6/5/2008			
730	Narcotic Control					
VIII.	**Emergency Medical Technician - Defibrillation Policies**					
802	Emergency Medical Technician-I Defibrillation (EMT-ID) Medical Director	11/30/2002	11/1/1988	6/30/2002		11/30/2004
805	Emergency Medical Technician Defibrillation (EMT-ID) Medical Cardiac Arrest	6/1/2006	10/1/1993	4/24/2006		6/30/2008
808	Emergency Medical Technician Defibrillation Integration with Public AED Operation	11/30/2002	5/9/2002	8/31/2002		11/30/2004
IX.	**Emergency Medical Services Communications**					
905	Ambulance Provider Response Units: Required Frequencies	12/1/2006	7/1/1999	6/8/2006		8/31/2011
910	Emergency Medical Dispatch System Guidelines	12/1/2005	10/31/1994	9/8/2005		5/31/2007
920	ReddiNet Policy	3/13/2008	4/26/2007	3/13/2008		3/31/2010
X.	**Documentation**					
1000	Documentation of Prehospital Care	12/1/2004	6/15/1998	10/14/2004		10/31/2006
1001	EMT-P/BH Communication Record			7/12/2007		7/31/2009
1002	Inability to Make or Maintain Base Hospital Contact Report Form	6/1/2008	10/31/2001	11/8/2007		11/30/2009
XI.	**Education**					
1100	Emergency Medical Technician-1 Program Approval	6/1/2008	2/28/2001	3/13/2008		3/31/2010

Policy No.	Title	Effect. Date	Origin. Date	Revised Date	Last Reviewed	Review Date
1105	MICN Developmental Course and Exam	12/1/2006	7/2/1984	6/8/2006		8/31/2011
1130	Advanced Life Support Continuing Educations Lectures	6/1/2006	2/28/2001	3/10/2006		7/31/2011
1131	Field Care Audit	6/1/2006	8/1/1984	2/9/2006		8/31/2011
1132	Continuing Education: Attendance Roster	6/1/2006	6/1/1993	3/9/2006		8/31/2011
1135	Paramedic Training Program Approval	6/1/2006	10/20/1993	12/8/2005		10/31/2011
1140	Emergency Medical Dispatcher Training Guidelines	5/1/2003	10/1/1991	1/31/2003		1/31/2005
XII.	**Search and Rescue**					
1200	Air Unit Program	6/1/2008	5/1/1999	4/13/2008		6/30/2010
1201	Air Unit Staffing Requirements	12/1/2006	5/30/1988	6/8/2006		10/31/2011
1202	Air Unit Dispatch for Emergency Medical Responses	12/1/2008	10/31/1998	10/9/2008		12/31/2011
1203	Criteria for Patient Emergency Transport	12/1/2007	10/31/1994	7/9/2007		7/31/2009
1204	EMS Aircraft Classification	12/1/2007	5/31/1999	9/13/2007		9/30/2009
1205	Air Unit Specifications Equipment and Supplies	12/1/2007	5/1/1999	9/13/2007		9/30/2009
XIII.	**Public Access Defibrillation**					
1301	Public Access Defibrillation (PAD) Provider Standards	6/1/2008	9/14/2000	3/13/2008		3/31/2010
XIV.	**Trauma System Protocols**					
1400	Trauma Care System - General Provisions		6/5/2008			
1401	Trauma Center Designation		6/5/2008			
1402	Trauma Review Committee		6/5/2008			
1403	Trauma Hospital Data Elements		6/5/2008			
1404	Trauma Triage Criteria		6/5/2008			
1405	Trauma Patient Destination		6/5/2008			

Policy No.	Title	Effect. Date	Origin. Date	Deleted
I.	**Administrative Policies**			
102	Coordination of Ambulance Program (New policy #102)	6/15/1998	10/1/1984	6/1/2004
104	EMCC (old policy #106)	6/1/1984	6/1/1984	2/1/1996
118	Coordination of Ambulance Program (New policy #102)	10/1/1984	10/1/1984	See 102
119	Ambulance Business License (New policy # 110)	7/10/1984	7/10/1984	See 110
122	Trial Study – Additional ALS Procedure (old policy #105)	2/28/1985	2/28/1985	11/1/2003
130	Medical Disaster Response Procedure (old policy #108)	6/1/1984	6/1/1984	?
140	Special Events Medical (0ld policy #109)	6/1/1984	6/1/1984	12/1/2004
II.	**Legislation/Regulations**			
200	Health and Safety Code	2/21/2003		11/1/2003
201	CCR - EMT-I Regulations	1/11/2000	6/17/1994	11/1/2003
202	CCR - Paramedic Regulations	2/20/2003	6/1/1997	11/1/2003
203	CCR - First Aid Standards for Public Safety Personnel	6/30/2000		11/1/2003
204	CCR - EMS Personnel Certification Review Process	3/25/2000		11/1/2003
205	CCR -Prehospital EMS Aircraft Regulations	1/10/1997	3/29/1988	11/1/2003
206	CCR – Process for Applicant Verification	8/4/1998		11/1/2003
207	EMT-I Certification Disciplinary Action Guidelines	3/2/2000		6/1/2001
III.	**Personnel Policies**			
303	Procedure for EMT-NA to become EMT-IA	6/1/1984		6/1/2002
305	EMT-I Ambulance Challenge Exam (New policy # 304)	4/25/1985		See 304
311	EMT-P Certification	4/30/1994	6/16/1980	10/31/1999
312	EMT-P Recertification	4/30/1994	1/6/1986	10/31/1999
313	EMT-P Reactivation of Certification	7/1/1992	6/16/1980	11/1/2003
314	EMT-P Out of State Challenge	1/1/1990	4/25/1985	11/1/2003
316	EMT-P Reactivation of Inactive Accreditation to Practice	10/31/1996	10/1/1990	11/1/2003
317	EMT-P Continuous Accreditation Requirements	5/1/1996	1/1/1990	6/1/2002
331	Certification Review: Base Hospital and Provider Responsibilities	10/1/1987	10/1/1987	4/9/1996
340	Ventura County Ambulance Personnel Listing	6/1/1984		5/1/2003
341	Basic and Advanced Life Support Notification of Personnel Changes – Base Hospital	5/15/1987		5/1/2003
IV.	**Emergency Medical Services - Facilities**			
401	Approved Burn Centers	8/8/1988		6/1/2002
406	Basic and Advanced Life Support Notification of Personnel Changes – EMS Providers (New policy #342)	5/15/1987		See 342
411	Advanced Life Support Base Hospital Approval Process)			12/1/2002
412	ALS New Hospital six month evaluation of provision of ALS service	6/1/2002	4/1/1984	12/1/2002
413	ALS Base Hospital Program Review	5/22/1984		12/1/2002
421	Receiving Hospital Approval Process	6/1/2002	5/22/1984	12/1/2002
422	ALS New Receiving Hospital – six month evaluation of provision of ALS services	7/22/1984		12/1/2002
423	ALS Receiving Hospital Program Review	5/22/1984		12/1/2002
V.	**Emergency Medical Services - Field Providers**			
503	Provider Program Review	5/22/1984		11/1/2003
505	ALS Unit Staffing Exception	7/1/1995	12/12/1988	6/1/2002
VI.	**General Emergency Medical Services - Policies**			
608	Staffing on Helicopter for Patient Transport (New Policy # 1201)	5/20/1988		See 1201
609	Non-Breather Masks	3/31/1990	1/1/1988	6/1/2002
611	EMT-I Monitoring of IV Fluids	6/1/2004	6/1/1984	6/12/2007

616	Comfort Measures Only	6/1/1990	10/1/1993	5/1/2003
621	EMT-IA-Monitoring IV Fluid Administration (Old policy number 904) (New policy # 611)	6/1/1984		See 611
VII.	**Advanced Life Support Medical Control and Treatment Policies**			
700	Medical Control – Emergency Medical Services Medical Director	8/1/1988		1/1/2004
702	Medical Control- Physician At the Scene	10/31/1995	1/31/1985	12/1/2005
706	Prior to BH Contact - Airway Obstruction	5/16/1991		10/31/1994
706	Prior to BH Contact -Anaphylaxis	11/12/1995		10/31/1994
706	Prior to BH Contact -Apnea or Agonal Respiration	9/30/1993		10/31/1994
706	Prior to BH Contact -Bradycardia, Adult, Symptomatic, not in arrest	1/5/1993		10/31/1994
706	Prior to BH Contact -Cardiac Arrest	5/13/1993		10/31/1994
706	Prior to BH Contact -Chest Pain	11/12/1992		5/1/1995
706	Prior to BH Contact -Hypovolemic Shock	5/13/1993		4/30/1994
706	Prior to BH Contact -Shortness of Breath	3/31/1994		10/31/1994
706	Prior to BH Contact -Venous Access	12/31/1992	3/30/1983	10/31/1995
707	Communication Failure Protocols	2/24/1993	3/1/1983	10/31/1995
707	Communication Failure Protocols – Airway Obstruction			10/31/1994
707	Communication Failure Protocols – ALOC	9/30/1993	11/1/1990	10/31/1994
707	Communication Failure Protocols - Anaphylaxis	11/1/1990	4/1/1990	10/31/1994
707	Communication Failure Protocols – Apnea	9/30/1993		10/31/1994
707	Communication Failure Protocols - Cardiac Arrest, Asystole, Bradycardic EMD, Non Brady, VF, Tachycardia	5/13/1993		5/1/1995
707	Communication Failure Protocols – Chest Pain	5/13/1993		5/1/1995
707	Communication Failure Protocols – Hypovolemia	3/31/1994		10/1/1994
707	Communication Failure Protocols – Needle Thoracostomy			10/1/1995
707	Communication Failure Protocols – Shortness of Breath	9/30/1993		10/1/1994
707	Communication Failure Protocols – Status Epilepticus	4/22/1992		10/1/1994
709	Alternative ALS Airway Management Devices Indications For Use	12/1/2005	9/10/1985	10/1/2008
711	ALS Verapamil Hydrochloride	6/3/1986		12/1/2005
712	Administration of Nebulized Metaproterenol	2/1/1989	2/1/1989	6/1/2002
714	Glucose Testing	10/1/1990	8/1/1990	11/1/2003
719	Saline Locks		5/15/1993	12/1/2005
721	Pulse Oximetry Monitoring	6/1/2004	6/1/2004	6/12/2007
VIII.	**Emergency Medical Technician - Defibrillation Policies**			
800	EMT-I Defibrillation Plan, Equipment Requirements, Program Parameters	6/1/2000	11/1/1988	12/1/2002
801	EMT-I Defibrillation Base Hospital	10/31/1996	11/1/1988	12/1/2002
804	EMT-I Defibrillation Performance Standards	5/1/1996	11/1/1988	12/1/2002
806	EMT-I Defibrillation Initial and Continuing Accreditation Requirements	7/1/1995	11/1/1988	12/1/2002
807	EMT-I Defibrillation Criteria for Hospitals Receiving patients	5/1/1996	11/1/1988	12/1/2002
IX.	**Emergency Medical Services Communications**			
901	Paramedic Communication Plan	10/11/1984	10/11/1984	6/12/2007
902	Frequencies (New policy #905) Contents moved to 905			12/1/2006
906	Verapamil Hydrochloride	1/30/1985	?	?
X.	**Documentation**			
1004	Paramedic/MICN Lecture Approval Form (form only)			6/12/2007
1005	EMT-P/MICN Attendance Roster (form coversheet)	7/6/2007	7/6/2007	
1009	EMT-P/MICN Continuing Education Record (New policy #1132) Contents moved to 1132	11/9/1984		10/20/1993
1011	ALS MICN Continuing Education Requirements (New policy 322) Contents moved to 322			See 322

XI.	**Education**			
1101	EMT-I Curriculum for IV Monitoring (New policy 611) Contents moved to 611		6/1/1984	1/8/2004
1102	EMT-I Training Programs Approval in California			6/1/2002
1106	ALS Personnel Written Examination Process	1/1/1990		6/1/2002
1107	EMT-ID Training Module	6/1/2000	10/31/1998	6/1/2002
1110	MICN Developmental Course	6/14/1984		11/1/2003
1115	MICN Continuing Education Requirements	12/1/1989	6/14/1984	11/1/2003
1116	MICN Continuing Education Field Observation	11/9/1984	11/9/1984	11/1/2003
1120	Endotracheal Intubation Training, Accreditation and Skills Maintenance	4/30/1994	11/5/1985	1/8/2004
1121	EMT-P Training: Verapamil Hydrochloride	6/3/1986		10/31/1995
1122	Needle Thoracostomy Training	10/31/1996	11/1/1990	12/1/2005
1123	Pre Existing Vascular Access Devices	6/1/2005	7/31/1992	6/1/2002
1124	EMT-P Training: Adenosine			1/8/2004
1125	EMT-P Continuing Education Requirements	1/1/1990	6/16/1980	6/1/2002
1126	EMT-P Clinical Hours			1/8/2004
1127	Esophageal Tracheal Double Lumen Airway Training	10/11/2001	4/30/1994	?
1128	Training for IV Heparin for Use in a Transfer Setting	6/15/1998	4/23/1998	?
1129	Cervical Spine Immobilization Training	6/1/1999	3/25/1999	?
1133	Continuing Education Record	9/1/1989	11/9/1984	6/1/2002
1134	Training and Testing Criteria		7/21/1989	1/8/2004
XII.	**Search and Rescue**			
1210	Criteria for Patient Transport Via Helicopter	10/31/1994	10/31/1994	11/1/1998
XIII.	**Public Access Defibrillation**			