Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	October 11, 2018 9:30 a.m.

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	A. Push dose Epi changes	Dr. Shepherd
V.	**New Business**	
	A. ROSC Policy	Katy Hadduck/Dr. Shepherd
VI.	**Old Business**	
	A. 319 – Paramedic Preceptor	Chris Rosa
	B. 330 – EMT/Paramedic/MICN Decertification and Discipline	Chris Rosa
	C. 504 - ALS/BLS Equipment	Chris Rosa
VII.	**Informational/Discussion Topics**	
	A. 210 – Child, Dependent Adult or Elder Abuse Reporting	Karen Beatty
	B. 705.09 - Nitro Changes	Dr. Shepherd
	C. 726 - STEMI Activation Changes	Karen Beatty
VIII.	**Policies for Review**	
	A. None	
IX.	**Agency Reports**	
	A. Fire Departments	
	B. Ambulance Providers	
	C. Base Hospitals	
	D. Receiving Hospitals	
	E. Law Enforcement	
	F. ALS Education Program	
	G. EMS Agency	
	H. Other	
X.	**Closing**	

Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Minutes	September 13, 2018 9:30 a.m.

Topic	Discussion	Action	Approval
II. Approve Agenda		Approved	Motion: Kathy McShea Seconded: Tom Gallegos Passed unanimous
III. Minutes		Approved	Motion: Heather Ellis Seconded: Tom O'Connor Passed unanimous
IV. **Medical Issues**			
V. New Business			
VI. Old Business			
A. 705.25 – Ventricular Tachycardia, Sustained, Not in arrest	Karen Beatty made requested changes discussed at the last PSC and presented the new draft to the committee. James Rosolek asked for clarification on the use of Versed for cardioversion. Dr. Larsen explained that they wanted to give paramedics the latitude to call base and ask for Versed if needed.	Chris Rosa said he will clarify the use of Versed on cardioversion patients in "Additional Information". Approved with changes.	Motion: Tom Gallegos Seconded: Kathy McShea Passed unanimous
VII. Informational/Discussion Topics			
A.			
VIII. Policies for Review			
A. 105 – Prehospital Services Committee Operations Guideline		No Change	Motion: Kathy McShea Second: Tom O'Connor Unanimous
B. 106 – Development of Proposed Policies/Procedures		Anyone who asks for a PSC item must attend the meeting.	Motion: Kathy McShea Second: Tom O'Connor Unanimous
C. 110 – County Ordinance #4099 Ambulance Business License		No Change Approved	Motion: Kathy McShea Second: Tom O'Connor Unanimous

D. 111 – Ambulance Company Licensing Procedure		No change Approved	Motion: Kathy McShea Second: James Rosolek Unanimous
E. 124 – Hospital Emergency Services Reduction Impact		No change Approved	Motion: Kathy McShea Second: James Rosolek Unanimous
F. 151 – Medication Error Reporting		Add the EMS Duty Officer information/contact number. Re-send hyperlink to the committee. Approved with changes	Motion: Kathy McShea Second: Tom O'Connor Unanimous
G. 210 – Child, Dependent Adult or Elder Abuse Reporting	Barry Parker asked if we could spell out the Penal Codes that are discussed in the policy. Make the language more generic.	Steve Carroll will check state regulations to see if we can take out the Penal Code information and make the headings more generic. Check that Fax number is correct. Tabled – Bring back to next PSC	
H. 319 – Paramedic Preceptor		Change policy name to: Paramedic Preceptor/FTO. Chris will add FTO language and make additional changes to bring up to date. Bring draft back to PSC. Table until next PSC	
I. 321 – MICN Authorization Requirements		No change Approved	Motion: Kathy McShea Second: Tom Gallegos Unanimous
J. 322 – MICN Reauthorization Requirements		No change Approved	Motion: Kathy McShea Second: Nicole Vorzimer Unanimous
K. 324 – MICN Authorization Reactivation		No change Approved	Motion: Kathy McShea Second: Nicole Vorzimer Unanimous
L. 330 – EMT/Paramedic/MICN Decertification and Discipline		Tabled until next PSC. Chris Rosa will work on the changes and prepare draft for PSC to review in October.	
X. Agency Reports			
A. Fire departments	**VCFPD** – Working on upgrading the seasoned personnel to Level 2. **VCFD –** Helping OFD with paramedic upgrades. **OFD** – Working on Level 1 and Level 2 upgrades.		

		Fed. Fire – none **SPFD** – none **FFD** – none	
B.	Transport Providers	**LMT –** none **AMR/GCA** – Chad Panke has stepped down from his position as Regional Director. Mike Sanders will be covering this position until a replacement has been chosen. Two AMR paramedics were deployed to assist with hurricane. **AIR RESCUE –**First Blackhawk helicopter came to Ventura County last Sunday. Still needs to be painted.	
C.	Base Hospitals	**SVH** – none **LRRMC** – none **SJRMC –** none **VCMC** – The new wing at VCMC will be opened any day.	
D.	Receiving Hospitals	**PVH –** The new hospital tower will be populated with patients on October 15, 2018. There will be an open house at PVH on Sept. 27, 2018 from 1100 – 1400. **SPH** – none **CMH** – Conducting life safety training for staff to work in new building. **OVCH** – Conducting life safety training for staff to work in new building.	
E.	Law Enforcement	**VCSO –** The Air Unit received its first Blackhawk last Sunday. **CSUCI PD –** Fall semester has started and it is very busy on campus.	
F.	ALS Education Programs	**Ventura College** – none	
G.	EMS Agency	**Steve –** Katy is retiring and will be missed very much. We will have a going away party on October 11, 2018 immediately following a short PSC meeting. The EMS Agency continues to assist VCPH with setting up TB POD's. **Dr. Shepherd -** none **Chris** – none **Katy** – Katy will be working with Cedars Sanai after she retires. **Karen** – Will send out information on World Stroke Day. **Julie** – Suicide Awareness training in October. Please encourage employees to attend. **Randy** – none	
H.	Other		
XI.	**Closing**	**Meeting adjourned at 12:00**	

TEMPORARY
PARKING PASS
Expires October 11, 2018

Health Care Services
2240 E. Gonzales Rd
Oxnard, CA 93036

For use in "Green Permit Parking" Areas only, EXCLUDES Patient parking areas

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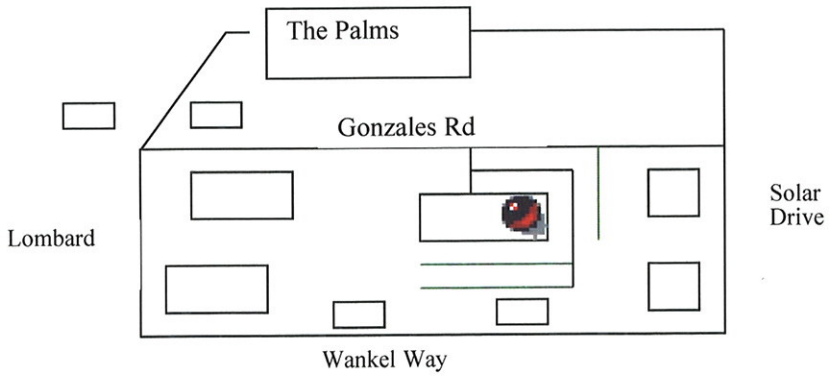
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

2240 Gonzales Rd. location
If you park in a designated "green permit parking" slot, fold this flyer in half and place pass face-up on the dash of your car, to avoid receiving a ticket.

2100 Solar Drive
An additional amount of "Green Permit Parking" spaces (only 30) are available in adjacent parking lot, those that back-up against venue parking area, (Enter this parking lot off of Gonzales[3rd driveway] or Solar Drive). Place this flyer on your dash. If all of those stalls are occupied, overflow parking is available at The Palms shopping area or side streets.

The Palms - shopping mall
Enter The Palms at Lombard and Gonzales. Allow for a ten minute walk to venue location.

Additional parking is available on side streets, Lombard, Solar and Wankel Way.



COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Cardiac Arrest Management: ROSC	Policy Number XXX
APPROVED: Administration: Steven L. Carroll, Paramedic	Date:
APPROVED: Medical Director: Daniel Shepherd, MD	Date:
Origination Date: Date Revised: Date Last Reviewed: Next Review Date:	Effective Date:

I. PURPOSE: To establish a standardized procedure for the treatment of patients who have a return of spontaneous circulation (ROSC) following treatment for cardiac arrest.

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

III. POLICY:

A. For patients who are 18-years-old and older, who achieve ROSC following a cardiac arrest that is non-traumatic in nature, ROSC protocol will be followed.

IV. PROCEDURE:

*****PRIORITIES POST RESUSCITATION*****

- Immediate recognition and treatment of re-arrest
- Preventing re-arrest by effective and continuous management of C – A – B
- Thorough assessment and identification / treatment of correctable causes
- Movement and transport decisions that prioritize ongoing patient care

Rescuer 1

- Palpate femoral pulse continuously for first 10 minutes prior to patient movement
- Immediately begin chest compressions if femoral pulse is lost or in question

Rescuer 2

- Continue rescue breathing
- Deliver 1 ventilation every 6 seconds, no more than 10 breaths per minute
- Deliver ventilations with ONE HAND on bag to avoid hyperventilation

Rescuer 3

- Ensure effective mask seal with continuous “2 thumbs up” technique
- Coach rescuer 2 as needed to assure delivery of ventilations and avoid hyperventilation
- For spontaneously breathing patients apply nasal $EtCO_2$ device, if available

Rescuer 5

- Assist in overseeing triangle of life roles
- Assist rescuer 4 by preparing medications and equipment
- Obtain manual blood pressure
- Obtain 12-lead EKG once directed; assure monitor is returned to pads / paddles mode
- May be delegated a variety of tasks based on scope

Rescuer 4
TEAM LEAD

- Communicate treatment priorities to team -- ensure roles are clear and effective
- Setup cardiac monitor to recognize change in patient status – monitor must remain attached to patient and observed through all phases of incident
- Confirm monitor settings
  - VF alarm activated
  - Pads / paddles mode
  - SpO_2 waveform
  - $EtCO_2$ waveform
- Attach adhesive SpO_2 probe to assure consistent and reliable waveform, if available
- Perform a thorough assessment: history, medications, circumstances
- May delegate interventions as appropriate

ASSESS

CIRCULATION

- Evaluate for palpable femoral pulse
- Evaluate MANUAL blood pressure
  - repeat every 5 minutes
  - manual for patient changes or SBP < 90 mmHg
- Monitor for falling $EtCO_2$ as sign of re-arrest
- Obtain and evaluate 12-lead only after assessment and interventions

AIRWAY – VENTILATION - OXYGENATION

- Confirm $EtCO_2$ waveform present with every ventilation; normal 35 – 45 mmHg
- Confirm presence of bilateral lung sounds
- Evaluate SpO_2; goal is 94% – 98%
- Consider likelihood of respiratory cause; e.g. choking

SUPPORT

CIRCULATION

- Obtain peripheral IV – preferred 18g, minimum 20g
- Initiate 1 L fluid bolus, use pressure bag for IO or rapid infusion via peripheral IV
- Administer pressor epinephrine* IV 10 µg (1 mL of prepared solution*) every 5 minutes PRN for SBP < 90mmHg
- Circulation treatment goals
  - Peripheral pulses present
  - Systolic BP > 90 mmHg
  - Ongoing fluid therapy**
- Consider etiology and treat if possible
  - Hypovolemia, sepsis, GI bleeding
  - MI, heart failure, idiopathic electrical anomaly
  - Hyperkalemia, opiate overdose

AIRWAY – VENTILATION - OXYGENATION

- Place advanced airway as needed to
  - Improve ventilation or oxygenation
  - Protect against aspiration
  - Effectively ventilate while moving
- SpO_2 goal 94%-99% - titrate supplemental oxygen down if SpO_2 is 100%
- Ventilation treatment goals
  - $EtCO_2$ waveform present with each breath
  - Bilateral breath sounds
- Consider etiology and treat if possible
  - Tension pneumothorax
  - Bronchoconstriction
  - Pulmonary embolus
  - Upper airway obstruction

*To prepare pressor epinephrine for treatment of hypotension, discard 1 mL from 10 mL saline flush syringe and draw 1 mL from epinephrine preload into flush syringe. This creates a solution of 10 mL / 100 µg – AND -- 1 mL / 10 µg.
**Fluid bolus is given whether or not patient is hypotensive.

Triangle of Life: ROSC

Rescuer 3

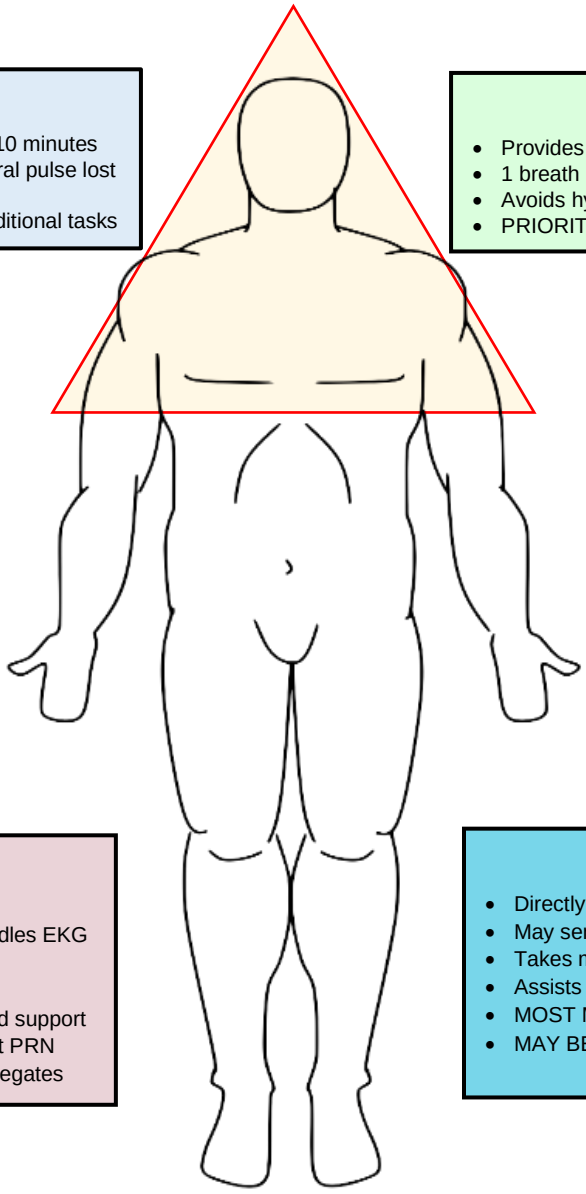
- Maintains 2 hand, thumbs up mask seal
- Coaches to ensure adequate ventilation and avoid hyperventilation

Rescuer 1

- Palpates femoral pulse continuously for 10 minutes
- Immediately starts compressions if femoral pulse lost or in question
- PRIORITY position; does not take on additional tasks

Rescuer 2

- Provides 1 hand BVM ventilations
- 1 breath every 6 seconds
- Avoids hyperventilation
- PRIORITY position; does not take on additional tasks



Rescuer 4
TEAM LEAD

- Visually monitors $EtCO_2$, SpO_2 pads/paddles EKG
- Obtains / delegates peripheral IV
- Initiates NS bolus
- Provides ALS circulatory assessment and support
- Provides airway assessment and support PRN
- Determines all ALS care – performs / delegates

Rescuer 5

- Directly assists team lead
- May serve as timekeeper
- Takes manual blood pressure
- Assists in obtaining 12-lead
- MOST MOBILE POSITION
- MAY BE DELEGATED OTHER TASKS

CARDIAC ARREST ROSC MANAGEMENT CHECKLIST	
☑	**Initial Actions**
☐	Initiate 10 minute continuous femoral pulse check
☐	Continue rescue breathing as needed
☐	Paddles attached and EKG waveform visible
☐	VF alarm set, SpO_2 and $EtCO_2$ waveforms visible
	Circulation
☐	Obtain peripheral IV access (18 g preferred, 20 g minimum)
☐	Initiate NS fluid bolus
☐	Assess for peripheral pulses
☐	Obtain manual blood pressure
☐	Epinephrine IN ADDITION TO fluids for systolic BP < 90 mmHg
	Airway / Ventilation
☐	Assess for responsiveness and spontaneous ventilations
☐	Assess $EtCO_2$, lung sounds, SpO_2
☐	Maintain BLS airway or place advanced airway as indicated
☐	Place advanced airway if needed to ventilate while moving patient
☐	Oxygenate to SpO_2 94% to 99%
☐	Oxygen flow rate titrated to prevent SpO_2 100%
☐	Obtain 12-lead EKG only after managing C-A-B and prior to movement
	Prior to Moving Patient, Confirm
☐	Patient has sustained ROSC > 10 minutes
☐	Stabilization of hemodynamics has been addressed
☐	Team has planned how to effectively ventilate during move
☐	Team is prepared to recognize re-arrest: • STOP MOVING • RESUME CAM ON SCENE

Post Resuscitation Transport
• Transport is indicated after a patient has sustained ROSC > 10 minutes and effective efforts have been made to stabilize airway, breathing, and circulation • Continuous patient assessment and treatment must remain the priority during transport. Recognizing hypotension, inadequate ventilation, or re-arrest, will have a large impact on patient outcome.

Re-Arrest Guidelines (Loss of ROSC)	

• Re-arrests require the same high quality CAM and ALS care as the initial arrest:
  ○ Remain on scene or stop transport
  ○ Ensure adequate workspace
  ○ Begin CAM Procedure
  ○ Defibrillate VF / VT ASAP
• Provide an additional 20 minutes of high quality CAM prior to any further movement or transport.
• If ROSC is obtained again, reassess, stabilize C – A – B as indicated, then continue with previous transport plan.
• If no ROSC, or multiple re-arrests, through 20 minutes from initial re-arrest consider underlying cause, circumstances, and presentation, then contact base for consultation.	

Prioritizing Care in Re-Arrest	
Re-Arrest On Scene	**Re-Arrest During Transport**
• If re-arrest occurs during movement to gurney or ambulance, resume CAM on scene outside of ambulance • If re-arrest occurs after loading but prior to transport, unload patient from ambulance, resume CAM, and move to workable space	• Do not continue transport • Move to ambulance to safe location to provide CAM without movement • IF DOD is indicated after re-arrest in ambulance, transport Code 2 to SRC
NOTE: Most re-arrests occur in the first 10 minutes after ROSC is achieved. Most delayed identification of re-arrest occurs during movement of the patient and during transport.	

NO ROSC - NO ROSC AFTER RE-ARREST - FREQUENT RE-ARREST Base Consultation		
• Base consultation is indicated when considering DOD vs continuing resuscitation. • Assessment findings, observations, and circumstances should be clearly communicated to base. • Strongly consider base consultation with ED physician for cases of prolonged resuscitation and predictors of increased chance of survival. In such cases high quality CAM should continue on scene unless transport is ordered by base hospital.		
Patient Factors	**Base Consult Takes Place**	**DOD**
• Asystole / PEA • Never defibrillated, no shockable rhythm observed	After 20 minutes of resuscitation efforts	Consider after 20 minutes; base consult
• VF / VT • Defibrillated at least once during arrest	After 40 minutes of resuscitation efforts without ROSC	Consider after 40 minutes; base consult
• Witnessed collapse • Any arrest in which EMS witnessed loss of pulses	After 40 minutes of resuscitation efforts without ROSC	Consider after 40 minutes; base consult
• Signs of survivability ○ EtCO2 > 30 ○ Spontaneous breathing attempts ○ Spontaneous movement ○ Frequent / persistent VF / VT	After 40 minutes of resuscitation efforts without ROSC	Consider DOD after 40 minutes; base consult Physician consult preferred
• Re-arrest without ROSC • Frequent re-arrest	After 20 minutes of re-arrest, or 20 minutes of intermittent ROSC	Consider after base consult Consider rhythm and signs of survivability If DOD is appropriate after re-arrest in transport, continue resuscitation efforts and transport Code 2

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Paramedic Preceptor / FTO	Policy Number: 319
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: DRAFT
APPROVED: Medical Director Daniel Shepherd, MD	Date: DRAFT
Origination Date: June 1, 1997 Date Revised: September 13, 2018 Last Date Reviewed: September 13, 2018 Next Review Date: September 30, 2021	Effective Date: DRAFT

I. PURPOSE: To establish minimum requirements for designation as a Ventura County pParamedic pPreceptor.

II. AUTHORITY: Health and Safety Code, Sections 1797.214 and 1798. California Code of Regulations, Title 22, Division 9, Section 100150

III. DEFINITIONS:

A. A fField tTraining oOfficer (FTO) is an agency designation for those personnel qualified to train others for the purposes of EMT ALS-Assist authorization, PparamedicaAccreditation, lLevel I or lLevel II Paramedic authorization/re-authorization.

B. The pParamedic pPreceptor as identified in California Code of Regulations, is qualified to train paramedic student Interns. A paramedic preceptor may also be a FTO, when designated by that individual's agency.

IV. POLICY:

A. A Paramedic may be designated a pParamedic preceptor upon completion of the following:

1. Be a licensed paramedic in the state of California, working in the field for at least the last two (2) years
2. Be under the supervision of the principal instructor, program director and/or program medical director of the applicable paramedic training program.
3. 6 months, (minimum 1440 hours) practice in Ventura County as a lLevel II pParamedic.
4. Written approval submitted to VC-EMSA by employer.

5. Written approval submitted to VC-EMSA by the pPrehospital cCare cCoordinator at the base hospital of the area where the pParamedic practiced the majority of the time.
6. Successful completion of aThe Ventura County Emergency Medical Services Agency (VC-EMSA) pParamedic pPreceptor tTraining course.
7. Written notification of intent to practice as a pParamedic pPreceptor shall be submitted to VC-EMSA prior to preceptor working in this capacity.

B. . will be responsible for the training, supervision and evaluation of personnel in Ventura County who are preparing for accreditation or completion of requirements for Level I, Level II or EMT-ALS Assist authorizations, and Paramedic Interns.

C. A preceptor shall not precept or evaluate more than one person at a time.

D. Paramedic Interns: Preceptors must directly observe the performance of all "Critical Procedures" and must be located in a position to immediately assume control of the procedure. The preceptor may not be functioning in any other capacity during these procedures.

1. Critical Procedures:

a. Endotracheal Intubation

1) Paramedic Intern shall be limited to one attempt in difficult intubations (e.g., morbidly obese patients, neck or facial trauma, active vomiting, massive oropharyngeal bleeding). The intern will not make a second attempt.

b. Needle Thoracostomy
c. Intraosseous needle insertion
d. Childbirth
e. Drug Medication Administration
f. PVAD
g. Intravenous Access when patient requires immediate administration of fluids and/or medication(s).

F. Paramedics acting as preceptors for paramedic interns need to meet State of California, Title XXII requirements and successfully complete the Ventura County Preceptor Training course.

G. Each preceptor will be evaluated by their intern or candidate at the end of their training period. This evaluation will be forwarded to the preceptor's employer

Recommendation Form

Employer: Please instruct the Paramedic to complete the requirements in the order listed. Upon employer approval the employer will contact the PCC prior to Paramedic contacting PCC for approval.

_____, Paramedic has been evaluated and is approved to provide EMS Prehospital Care in the following instances. S/he has met all criteria as defined in Ventura County EMS policies. I have reviewed documentation of such and it is attached to this recommendation.

Please initial the appropriate box

Paramedic Preceptor

_____ All the requirement of level II met.
_____ 6 months (minimum 1440 hrs.) practice in Ventura County as a Level II Paramedic.
_____ Successful completion of the VC EMS Preceptor Training course.
_____ Approval by employer
_____ Approval by the PCC at the base hospital of the area where the Paramedic practiced the majority of the time during the previous year.
_____ Notification of VC EMS
_____ Completion of Curriculum Vitae

Please sign and date below for approval.

Employer Date:

PCC, BH Date:

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMT/Paramedic/MICN Decertification and Discipline	Policy Number 330
APPROVED: Administration: Steven L. Carroll, Paramedic	Date:
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date:
Origination Date: April 9, 1985 Date Revised: Date Last Reviewed: September 13, 2018 Review Date: September 30, 2021	Effective Date: DRAFT

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

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

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

GROUNDS FOR DISCIPLINARY ACTION:

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

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

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

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

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

IV. PROCEDURE:

A. Submission of Claim.

When any of the ~~G~~grounds for d~~D~~isciplinary a~~A~~ction are exhibited by a certificate holder, any individual observing such grounds may submit a written claim relative to the infraction as well as any other supporting evidence to the VCEMS~~D~~. 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~~ VCEMS~~D~~ 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~~ VCEMS~~,D~~ ~~he/she shall notify~~ the PCC and ED m~~M~~edical d~~D~~irector at the appropriate b~~B~~ase h~~H~~ospital shall be notified, ~~and~~ in addition to the ALS provider management (if the certificate holder is an EMT or p~~P~~aramedic) of the claim. Notification of such a claim shall be given verbally within twenty-four (24) hours, or as soon as possible, followed by written notification within ten (10~~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~~ VCEMS~~D~~ 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~~ VCEMS~~D~~ within fifteen (15) days after receipt of written notification.

C. Review of Submitted Material~~.~~

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

1. The nature of the disciplinary action shall be related to the severity of the risk to the public health and safety caused by the actions of the certificate holder or applicant for a prehospital care certificate.
2. The types of action, which may be taken prior to or subsequent to formal investigation, include:

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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: BLS And ALS Unit Equipment And Supplies		Policy Number: 504
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date:
APPROVED: Medical Director	Daniel Shepherd, MD	Date:
Origination Date: Date Revised: Last Reviewed: Review Date:	May 24, 1987 April 12, 2018 April 12, 2018 April 30, 2021	Effective Date: DRAFT

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

II. POLICY: Each response and/or transport unit in Ventura County shall be equipped and supplied according to the requirements of this policy.

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

IV. PROCEDURE:

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

Deviation from the standards outlined in this policy shall only be authorized with written approval from the VCEMS Medical Director.

	ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS				
Clear masks in the following sizes: Adult Child Infant Neonate	1 each	1 each	1 each	1 adult 1 infant
Bag valve units Adult Child	1 each	1 each	1 each	1 adult
Nasal cannula Adult	3	3	3	3
Nasopharyngeal airway (adult and child or equivalent)	1 each	1 each	1 each	1 each
Continuous positive airway pressure (CPAP) device	1 per size	1 per size	1 per size	1 per size
Nerve Agent Antidote Kit	9	9	9	0
Blood glucose determination devices *(optional for non-911 BLS units)*	2	1	1	1
Oral glucose 15gm unit dose	1	1	1	1
Oropharyngeal Airways Adult Child Infant Newborn	1 each size	1 each size	1 each size	1 each size
Oxygen with appropriate adjuncts (portability required)	10 L/min for 20 minutes	10 L/min for 20 mins.	10 L/min for 20 mins.	10 L/min for 20 mins.
Portable suction equipment	1	1	1	1
Transparent oxygen masks Adult nonrebreather Child Infant	 3 3 2	 2 2 2	 2 2 2	 2 2 2
Bandage scissors	1	1	1	1
Bandages • 4"x4" sterile compresses or equivalent • 2",3",4" or 6" roller bandages • 10"x 30" or larger dressing	 12 6	 12 2 0	 12 6 2	 5 4 2
Blood pressure cuffs Thigh Adult Child Infant	 1 1 1 1	 1 1 1 1	 1 1 1 1	 1 1 1 1
Emesis basin/bag	1	1	1	1
Flashlight	1	1	1	1
Traction splint or equivalent device	1	1	1	1
Pneumatic or rigid splints (capable of splinting all extremities)	4	4	4	4
Potable water or saline solution	4 liters	4 liters	4 liters	4 liters
Cervical spine immobilization device	2	2	2	2
Spinal immobilization devices KED or equivalent	1	1	1	1

	ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
60" minimum with at least 3 sets of straps	1	0	1	
Sterile obstetrical kit	1	1	1	1
Tongue depressor	4	4	4	4
Cold packs	4	4	4	4
Tourniquet	1	1	1	1
1 mL/3 mL syringes with IM needles	4	4	4	4
Automated External Defibrillator (if not equipped with ALS monitor/defibrillator)	1	1	1	1
Personal Protective Equipment per State Guideline #216				
Rescue helmet	2	1	0	0
EMS jacket	2	1	0	0
Work goggles	2	1	0	0
Tyvek suit	2 L / 2 XXL	1 L / 1 XXL	0	0
Tychem hooded suit	2 L / 2 XXL	1 L / 1 XXL	0	0
Nitrile gloves	1 Med / 1 XL	1 Med / 1 XL	0	0
Disposable footwear covers	1 Box	1 Box	0	0
Leather work gloves	3 L Sets	1 L Set	0	0
Field operations guide	1	1	0	0
OPTIONAL EQUIPMENT				
Occlusive dressing or chest seal				
Hemostatic gauze per EMSA guidelines				
B. TRANSPORT UNIT REQUIREMENTS				
Ambulance cot and collapsible stretcher; or two stretchers, one of which is collapsible.	1	0	0	1
~~Automated External Defibrillator (if not equipped with ALS monitor/defibrillator)~~	~~1~~	~~1~~	~~1~~	~~1~~
Straps to secure the patient to the stretcher or ambulance cot, and means of securing the stretcher or ambulance cot in the vehicle.	1 Set	0	0	1 Set
Soft Ankle and wrist restraints.	1	0	0	0
Sheets, pillow cases, blankets and towels for each stretcher or ambulance cot, and two pillows for each ambulance	1	0	0	0
Bedpan	1	0	0	0
Urinal	1	0	0	0
~~Personal Protective Equipment per State Guideline #216~~				
~~Rescue helmet~~	~~2~~	~~1~~	~~0~~	~~0~~
~~EMS jacket~~	~~2~~	~~1~~	~~0~~	~~0~~
~~Work goggles~~	~~2~~	~~1~~	~~0~~	~~0~~
~~Tyvek suit~~	~~2 L / 2 XXL~~	~~1 L / 1 XXL~~	~~0~~	~~0~~
~~Tychem hooded suit~~	~~2 L / 2 XXL~~	~~1 L / 1 XXL~~	~~0~~	~~0~~
~~Nitrile gloves~~	~~1 Med / 1 XL~~	~~1 Med / 1 XL~~	~~0~~	~~0~~
~~Disposable footwear covers~~	~~1 Box~~	~~1 Box~~	~~0~~	~~0~~
~~Leather work gloves~~	~~3 L Sets~~	~~1 L Set~~	~~0~~	~~0~~
~~Field operations guide~~	~~1~~	~~1~~	~~0~~	~~0~~

	ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
C. ALS TRANSPORT UNIT REQUIREMENTS				
Cellular telephone	1	1	1	1
Alternate ALS airway device	2	1	1	1
Arm Boards 9" 18"	 3 3	 0 0	 1 1	 0 0
Cardiac monitoring equipment	1	1	1	1
CO_2 monitor	1	1	1	1
Colorimetric CO2 Detector Device	1	1	1	1
Defibrillator pads or gel	3	3	3	1 adult – No Peds.
Defibrillator w/adult and pediatric paddles/pads	1	1	1	1
EKG Electrodes	10 sets	3 sets	3 sets	6 sets
Endotracheal intubation tubes, sizes 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5 with stylets	1 of each size	1 of each size	1 of each size	4, 5, 6, 6.5, 7, 7.5, 8
EZ-IO intraosseous infusion system	1 Each Size	1 Each Size	1 Each Size	1 Each Size
Intravenous Fluids (in flexible containers) • Normal saline solution, 500 ml • Normal saline solution, 1000 ml	 2 6	 1 2	 1 4	 1 3
IV admin set - microdrip	4	1	2	2
IV admin set - macrodrip	4	1	4	3
IV catheter, Sizes I4, I6, I8, 20, 22, 24	6 each 14, 16, 18, 20 3 each 22 3 each 24	2 each	2 each	2 each
Laryngoscope, replacement bulbs and batteries Curved blade #2, 3, 4 Straight blade #1, 2, 3	1 set 1 each 1 each	1 set 1 each 1 each	1 set 1 each 1 each	1 set 1 each 1 each
Magill forceps Adult Pediatric	 1 1	 1 1	 1 1	 1 1
Nebulizer	2	2	2	2
Nebulizer with in-line adapter	1	1	1	1
Needle Thoracostomy kit	2	2	2	2
Pediatric length and weight tape	1	1	1	1
SpO_2 Monitor (If not attached to cardiac monitor)	1	1	1	1
OPTIONAL ALS EQUIPMENT (No minimums apply)				
Flexible intubation stylet				
Cyanide Antidote Kit				

	BLS Unit Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
D. MEDICATION, MINIMUM AMOUNT					
Adenosine, 6 mg		3	3	3	3
Albuterol 2.5mg/3ml		6	2	3	1
Aspirin, 81mg		4 ea 81 mg	4 ea 81 mg	4 ea 81 mg	4 ea 81 mg
Amiodarone, 50mg/ml 3ml		6	3	6	3
Atropine sulfate, 1 mg/10 ml		2	2	2	2
Diphenhydramine (Benadryl), 50 mg/ml		2	1	1	2
Calcium chloride, 1000 mg/10 ml		2	1	1	1
Dextrose 5% 50ml		2	1	2	1
Dextrose 10% 250 ml		2	1	2	1
Dextrose 25% 2.5 GM 10ml		1	1	1	1
Dextrose 50%, 25 GM/50		5	2	2	2
Epinephrine					
• Epinephrine , 1mg/ml	2	4	2	2	2
• 1 mL ampule / vial, OR	2	4	2	2	2
• Adult auto-injector (0.3 mg), AND Peds auto-injector (0.15 mg)	2	4	2	2	2
• Epinephrine 0.1mg/ml (1 mg/10ml preparation)		6	3	6	4
• Epinephrine 1mg/ml, 30 ml multi-dose vial		1	1	1	1
Glucagon, 1 mg/ml		2	1	2	1
Lidocaine, 100 mg/5ml		2	2	2	2
Magnesium sulfate, 1 gm per 2 ml		4	1	2	2
Morphine sulfate, 10 mg/ml		2	2	2	2
Naloxone Hydrochloride (Narcan)					
• IN concentration - 4 mg in 0.1 mL (optional for ALS and non-911 BLS units), OR	2	5	5	5	5
• IM / IV concentration – 2 mg in 2 mL preload (optional for non-911 BLS units)	42	5	5	5	5
Nitroglycerine preparations, 0.4 mg		1 bottle	1 bottle	1 bottle	1 bottle
Normal saline, 10 ml		2	2	2	2
Sodium bicarbonate, 50 mEq/ml		2	1	1	1
Ondansetron 4 mg IV single use vial		4	4	4	4
Ondansetron 4 mg oral		4	4	4	4
Midazolam Hydrochloride (Versed)		5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials

Chest Pain – Acute Coronary Syndrome

BLS Procedures

Administer oxygen if dyspnea, signs of heart failure or shock, or SpO2 < 94%
Assist patient with prescribed Nitroglycerin as needed for chest pain

- Hold if SBP less than 100 mmHg

ALS Prior to Base Hospital Contact

Perform 12-lead ECG

- Expedite transport to closest STEMI Receiving Center if monitor interpretation meets the manufacturer guidelines for a positive STEMI ECG.
- Document all initial and ongoing rhythm strips and ECG changes

For continuous chest pain consistent with ischemic heart disease:

- **Aspirin**
  - PO – 324 mg
- **Nitroglycerin** (DO NOT administer if ECG states inferior infarct)
  - SL or lingual spray – 0.4 mg q 5 min for continued pain
    - No max dosage
    - Maintain SBP greater than 100 mmHg
    - ~~**Aspirin**~~
    - ~~PO – 324 mg~~

IV/IO access

- 3 attempts only prior to Base Hospital contact

If pain persists and not relieved by NTG:

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

If patient presents or becomes hypotensive:

- Lay Supine
- **Normal Saline**
  - IV/IO bolus – 500 mL -may repeat x1 for total 1000 mL.
    - Unless CHF is present

Communication Failure Protocol

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

- 4 attempts total per patient

If hypotensive (SBP less than 90 mmHg) and signs of CHF are present or no response to fluid therapy:

- **Epinephrine 0.1 mg/mL**
  - Slow IV/IOP – 0.1 mg (1 mL) increments over 1-2 minutes
    - Repeat every 3-5 min
      - Max 0.3 mg (3 mL)

Base Hospital Orders only

Consult ED Physician for further treatment measures

ED Physician Order Only: For ventricular ectopy [PVC's > 10/min, multifocal PVC's, or unsustained V-Tach], consider Amiodarone IV/IOPB - 150 mg in 50 mL D5W infused over 10 minutes

Additional Information:

- Nitroglycerin is contraindicated in inferior infarct or when phosphodiesterase inhibitor medications [Sildenafil (Viagra and Revatio), Vardenafil (Levitra), and Tadalafil (Cialis)] have been recently used (Viagra or Levitra within 24 hours; Cialis within 48 hours). These medications are most commonly used to treat erectile dysfunction or pulmonary hypertension. NTG then may only be given by ED Physician order
- Appropriate dose of Aspirin is 324mg. Aspirin may be withheld if able to confirm that patient has received appropriate dose prior to arrival. If unable to confirm appropriate dose, administer Aspirin, up to 324mg.

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title 12 Lead ECG		Policy Number: 726
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: June 1, 2018
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: June 1, 2018
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 10, 2006 March 8, 2018 March 8, 2018 March 8, 2021	Effective Date: June 1, 2018

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

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

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

IV. Procedure:

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

1. Chest, upper back or upper abdominal discomfort.
2. Generalized weakness.
3. Dyspnea.
4. Symptomatic bradycardia
5. After successful cardioversion/defibrillation of sustained V-Tach (Policy 705.25)
6. Paramedic Discretion

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

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

C. ECG Procedure:

1. Attempt to obtain an ECG during initial patient evaluation. Oxygen should be administered if patient is dyspneic, shows signs of heart

failure or shock, or has SpO2 < 94%. If the ECG can be completed without delay (less than 3 minutes after patient contact), and the patient is not in severe distress, perform ECG prior to medication administration.

2. The ECG should be done prior to transport.
3. If the ECG is of poor quality (artifact or wandering baseline), or the patient's condition worsens, repeat to a total of 3.
4. Once an acceptable quality ECG is obtained, switch the monitor to the standard 4-lead function.
5. If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, note underlying rhythm, and verify by history and physical exam that the patient does not have a pacemaker or ICD.

D. Base Hospital Communication/Transportation:

1. If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, report that to MICN immediately, along with the heart rate on ECG. If the ECG is of poor quality, or the underlying rhythm is paced, or atrial flutter, include that information in the initial report. All other information, except that listed in items 2, 4, and 5 below, is optional and can be given at the paramedic and MICN's discretion.
2. Paramedics are to ask the patient if they have a cardiologist and report the information to the base hospital.
3. If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, 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 interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, and the underlying rhythm is Atrial Flutter or if the rate is above 140, the Base Hospital shall be notified at the beginning of the report. The Cath Lab will not be activated.
5. If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, 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 does **not have** an interpretation on monitor that meets your manufacturer guidelines for a

POS STEMI ECG, and the patient is stable, patient care may be turned over to the transporting paramedic. The ECG will be turned over to the transporting paramedic.

7. Positive ECGs will be handed to the receiving medical practitioner. The receiving practitioner will initial, time and date the ECG to indicate they have received and reviewed the ECG.

E. Patient Treatment:

1. Patient Communication: If the interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG, the patient should be told that "according to the ECG you may be having a heart attack". If the ECG interpretation is anything else, the patient should NOT be told the ECG is normal or "you are not having a heart attack". If the patient asks what the ECG shows, tell him/her that it will be read by the emergency physician.

F. Other ECGs

1. If an ECG is obtained by a physician and the interpretation of ECG is positive for STEMI,~~physician interpretation is Acute MI,~~ the patient will be treated as a positive ~~POS~~ STEMI. If the ECG obtained by a physician does not indicate a STEMI by interpretation, and the physician is stating it is a STEMI, perform another ECG once patient is in the ambulance. A STEMI alert will be initiated or not, based on this repeat ECG interpretation. Regardless if PECG is a STEMI alert or not, all patients from a medical facility will be transported to an SRC. ~~Do not perform an additional ECG unless the ECG is of poor quality, or the patient's condition worsens.~~

~~2. If there is no interpretation of another ECG then repeat the ECG.~~

3. The original ECG performed by physician shall be obtained and accompany the patient.

4. 12 Lead ECG will be ~~scanned~~scanned, or a picture will be obtained and added as an attachment to the Ventura County electronic Patient Care Report (VCePCR), in addition to being hand delivered to the receiving facility.

G. Documentation

1. VCePCR will be completed per VCEMS policy 1000. The original ECG will be turned in to the base hospital and ALS Service Provider.

H. Reporting

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

Interpretation on monitor meets your manufacturer guidelines for a POS STEMI ECG: