County of Ventura
Department of Public Health

Notice of Changes to Policy Manual

Emergency Medical Services
Policies and Procedures

To: ALL VENTURA COUNTY EMS POLICY MANUAL HOLDERS

DATE: June 10, 2022

Policy Status	Policy #	Title/New Title	Notes
REPLACE	0105	PSC Guidelines	Change one year to two years for a term
ADD	0141	Hospital EMS Surge Assistance	*New Policy* - People should read to familiarize themselves. Implementing this policy will be done at the EMS Duty Officer and hospital administration level, in coordination with local agency leadership.
REPLACE	0318	ALS Response Unit Staffing	This policy went into effect in April 2022 and is already posted on the EMS website. It is included again here for your information only. Changes made in April: CE Log updated to include only current requirements. No changes to required CE.
REPLACE	0321	MICN Authorization Criteria	Updated Forms
REPLACE	0322	MICN Reauthorization Requirements	Updated Forms
REPLACE	0324	MICN Authorization Reactivation	Forms updated
DELETE	0351	EMS Update Procedure	Policy Retired – guidelines/requirements already exist in other training policies
REPLACE	0410	ALS Base Hospital Standards	Reviewed - *No Changes*
REPLACE	0420	Receiving Hospital Criteria	Updated language related to redundant communications requirements
REPLACE	0504	ALS and BLS Unit Equipment and Supplies	Updated equipment lists and addition of new vehicle type: BLS Command Unit
REPLACE	0603	Refusal of EMS Service	Updated Language and policy structure
REPLACE	0607	Hazmat Incident	Updated terminology and procedures to reflect current best practices and decontamination (patient and/or responder) guidelines.

REPLACE	0614	Spinal Motion Restriction	Changes to formatting applied throughout policy
REPLACE	0615	Organ Donor	Updated formatting. Added guidance to search for donor info on smartphone health app(s).
REPLACE	0618	Unaccompanied Minors	Added "or guardian(s)" to IV.A and IV.C
REPLACE	0619	Safely Surrendered Babies	Reviewed – *No Changes*
REPLACE	0624	Patient Medications	Reviewed – *No Changes*
REPLACE	0627	Fireline Medic	Language changes
ADD	0630	Infectious Disease	*New Policy* - People should read to familiarize themselves. Created with the intent of providing higher-level guidelines for a variety of infectious diseases. Over time, disease specific guidelines will be added as attachments
REPLACE	0705.01	Trauma Treatment Guidelines	Updated fluid administration guidelines.
REPLACE	0705.05	Bites and Stings	Snake Bite - Updated to reflect immobilization in a neutral rather than elevated position.
REPLACE	0705.06	Burns	Removal of not in BLS procedures related to assessment of burn type and appropriate treatment
REPLACE	0705.09	Chest Pain	Reviewed – *No Changes*
REPLACE	0705.11	Crush Injury	Small language updates
REPLACE	0705.14	Hypovolemic Shock	Updated fluid administration guidelines
REPLACE	0705.27	Sepsis	Pediatric criteria added, EtCO2 included as sepsis criteria, push dose Epi added for shock.
REPLACE	0715	Needle Thoracostomy	Handtevy referenced for pediatric BP criteria
REPLACE	0716	Use of Pre-Existing Vascular Devices (PVAD)	Formatting changes
REPLACE	0725	Patients After Conducted Electrical Weapon (TASER) Use	Formatting changes
REPLACE	0729	Airway	Reviewed - *No Changes*
REPLACE	0731	Tourniquet Use	Reviewed - No *Changes*
REPLACE	0732	Use of Restraints	Language Changes related to "Therapeutic Sedation"
REPLACE	1301	Lay Rescuer AED Provider Standards	Language change

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Prehospital Services Committee Operating Guidelines		Policy Number 105
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Review Date:	March, 1999 April 14, 2022 April 14, 2022 April 30, 2025	Effective Date: July 1, 2022

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:

Type of Organization	**Member**	**Member**
Base Hospitals	PCC	PLP
Receiving Hospitals	ED Manager	ED Physician
First Responders	Administrative	Field (provider of "hands-on" care)
Ambulance Companies	Administrative	Field (provider of "hands-on" care)
Emergency Medical Dispatch Agency	Emergency Medical Dispatch Coordinator (1 representative selected by EMD Agency coordinators)	
Air Units	Administrative	Field (provider of "hands-on" care)
Paramedic Training Programs	Director (1 representative from each program.)	

B. Non-voting Membership

Non-voting members of the committee shall be composed of VC EMS staff to be determined by the VC EMS Administrator and the VC EMS Medical Director.

C. 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.

D. Voting Rights

Designated voting members shall have equal voting rights.

E. 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 two (2) years. A member may serve as Chair for up to two (2) 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 than 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

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

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

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

A. POLICY:

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

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

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

IV. PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: ALS Response Unit Staffing		Policy Number: 318
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: April 20, 2022
APPROVED: Medical Director	Daniel Shepherd, MD	Date: April 20, 2022
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 1, 1997 April 14, 2022 April 14, 2022 April 30, 2025	Effective Date: April 20, 2022

I. PURPOSE: To establish medical control standards for ALS response unit paramedic staffing.

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

III. DEFINITIONS:

ALS Response Unit: First Response ALS Unit, Paramedic Support Vehicle, or ALS Ambulance per VCEMS Policies 506 and 508.

ALS Patient Contact: A patient contact where the paramedic successfully performs an ALS skill listed in VCEMS Policy 310, with the exception of glucose testing, cardiac monitoring and pulse oximetry.

Field Training Officer (FTO): An agency designation for those personnel qualified to train others for the purposes of EMT ALS-Assist Authorization, Paramedic Accreditation, Level I or Level II Paramedic Authorization/Re-Authorization.

Paramedic Preceptor: A Paramedic, as identified in California Code of Regulations, qualified to train Paramedic Student Interns. A Paramedic Preceptor may also be a Field Training Officer, when designated by that individual's agency.

IV. POLICY:

A. All ALS Response Units must be staffed with a minimum of one Level II paramedic who meets the requirements in this policy.

B. Additional ALS Response Unit staff may be a Level I or II paramedic meeting the requirements in this policy and/or an EMT meeting requirements in VCEMS Policy 306. An ALS response unit may be staffed with a non-accredited Paramedic only when it is also staffed with an authorized Field Training Officer (FTO) or Paramedic Preceptor, unless the non-accredited Paramedic is functioning in a BLS capacity in accordance with VCEMS Policy 306.

V. PROCEDURE:

A. Level I

1. A paramedic will have Level I status upon completion of the following:
    a. Current Paramedic Licensure by the State of California
    b. Current Accreditation in the County of Ventura per VCEMS Policy 315.
2. To maintain Level I status, the paramedic shall:
    a. Maintain employment with an approved Ventura County ALS service provider.
    b. Complete a minimum of 288 hours of practice as a paramedic or 30 patient contacts (minimum of 15 ALS) every six-month period (January 1 – June 30 and July 1 – December 31);
        1) With the approval of the EMS Medical Director, for those paramedics with a minimum of 1 year of field experience in Ventura County, are employed as a field paramedic in another county or work in an acute care setting (RN or LVN) on a full-time basis, complete a minimum of 144 hours of practice, or 20 patient contacts (minimum 10 ALS), in the previous 6-month period in Ventura County.
    c. Complete VCEMS continuing education requirements, as described in Section V.C.
3. If the paramedic fails to meet these requirements, s/he is no longer authorized as a Level I paramedic.
4. To be reauthorized as a Level I paramedic, the paramedic must complete a minimum of 48 hours as a second or third crewmember of direct field observation by an authorized Paramedic FTO, to include a minimum of 5 ALS contacts.

B. Level II

1. A paramedic will have Level II status upon completion of the following:
    a. Employer approval.
    b. All of the requirements of Level I.
    c. A minimum of 240 hours of direct field observation by an authorized Ventura County Paramedic FTO.
        1) This will include a minimum of 30 patient contacts, (minimum 15 ALS contacts).
        2) If a paramedic has a minimum of 4000 hours of prehospital field experience performing initial ALS assessment and care. Direct field observation with the approval of the Paramedic FTO and PCC may be reduced to 144 hours or 20 patient contacts (minimum 10 ALS).
    d. Approval by the paramedic FTO who evaluated most of the contacts.
    e. Successful completion of competency assessments:

1) Scenario based skills assessment conducted by the candidate's preceptor, Provider's clinical coordinator, PCC and PLP when possible.
2) Written policy competency and arrhythmia recognition and treatment assessment administered by VCEMS. Minimum Passing score will be 80% on each assessment.
3) Candidates who fail to attain 80% on either section V.B.e.2)-3) shall attend a remediation session with the Base Hospital PLP or designee or the provider's Medical Director prior to retaking either assessment. Written documentation of remediation will be forwarded to VCEMS.

f. Obtain favorable recommendations of the PCCs who have evaluated the paramedic during the upgrade process. The PCC's recommendations will be based upon a review of the completed performance evaluation standards, review of patient contacts and direct clinical observation.
1) Delays in arranging or scheduling direct field observation shift(s) should not delay the Level II upgrade process. In the event an observation shift cannot be arranged with the PCC by the end of the 240 hour upgrade process, the observation requirement may be waived with VCEMS approval. Every attempt should be made to schedule this observation in advance, and conduct the shift prior to the completion of the 240 hour upgrade process.

g. Forward Appendix A, Appendix B and copies of the 30 patient contacts to VCEMS.
1) Appendix A shall include all dates and times the upgrading paramedic has spent with the Paramedic FTO to total a minimum of 240 hours.
2) Appendix B shall be completed each shift per the Method of Evaluation Key at the bottom of the form.
3) Submit 30 patient contacts, 15 meeting criteria as defined in Section III, Definitions, ALS Patient Contact.

2. To maintain Level II status, the paramedic shall:
a. Maintain employment with an approved Ventura County ALS service provider.
b. Function as a paramedic for a minimum of 576 hours or have a minimum of 60 patient contacts (minimum 30 ALS), over the previous six-month period (January 1 – June 30 and July 1 – December 31).
1) For those paramedics with a minimum of 3 years field experience, no more than 144 hours of this requirement may be met by documentation of actual instruction at approved PALS, PEPP, ACLS, PHTLS, BTLS, EMT or Paramedic training programs.

2) With the approval of the EMS Medical Director, for those paramedics with a minimum of 3 years of field experience in Ventura County, are employed as a field paramedic in another county or work in an acute care setting (RN or LVN) on a full-time basis, complete a minimum of 288 hours of practice, or 30 patient contacts (minimum 15 ALS), in the previous 6 month period in Ventura County.

3) A paramedic whose primary duties are administering the ALS Program (90% of the time) for his/her agency and with approval of the EMS Medical Director may maintain his/her level II status by performing a minimum of 5 ALS calls per 6 months (January 1 – June 30 and July 1 – December 31).

4) If the paramedic fails to meet this requirement:

   a) His/her paramedic status reverts to Level I.

   b) If Level II authorization has lapsed for less than six months, reauthorization will require completion of a minimum of 96 hours of direct field observation by an authorized Ventura County Paramedic FTO, to include a minimum of 10 ALS patient contacts.

   c) If Level II authorization has lapsed for less than one year and the paramedic has not worked as a paramedic for 6 months or more during the lapse interval OR if Level II authorization has lapsed for greater than one year, reauthorization will require completion of all of the requirements in Section V.B.1. These requirements may be reduced at the discretion of the VCEMS Medical Director.

   d) If the paramedic has been employed as a paramedic outside of Ventura County or has worked in an acute care setting (RN or LVN) during the period of lapse of authorization, these requirements may be reduced at the discretion of the VCEMS Medical Director.

   e) Complete VCEMS continuing education requirements, as described in Section V.C.

C. Continuing Education Requirements

Fifty percent (50%) of all CE hours shall be obtained through Ventura County approved courses and 50% of total CE hours must be instructor based.

1. Advanced Cardiac Life Support (ACLS) certification and Handtevy course completion shall be obtained within three months and remain current (refresher courses every 2 years).
2. Field Care Audits (Field care audit): Twelve (12) hours per two years, at least 6 of which shall be attended in Ventura County. Base Hospitals will offer Field care audit sessions.
3. Periodic training sessions or structured clinical experience (Lecture/ Seminar) as follows:
   a. Attend one skills refresher session in the first year of the license period, one in the second year, and one every year thereafter.
   b. Education and/or testing on updates to local policies and procedures.

c. Completion of Ventura County Multi-Casualty Incident training per VCEMS Policy 131.

d. Successful completion of any additional VCEMS-prescribed training as required. These may include, but not be limited to:

1) Education, and/or testing, in specific clinical conditions identified in the quality improvement program.

2) Education and/or testing for Local Optional Scope of Practice Skills.

3) The remaining hours may be earned by any combination of field care audit, Clinical hours, Self-Study/Video, Lecture, or Instruction at ALS/BLS level. Clinical hours will receive credit as 1-hour credit for each hour spent in the hospital and must include performance of Paramedic Scope of Practice procedures. The paramedic may be required by his/her employer to obtain Clinical Hours. The input of the Base Hospital Prehospital Care Coordinator and/or Paramedic Liaison Physician shall be considered in determining the need for Clinical Hours.

4) Successfully complete a CPR skills evaluation using a recording/reporting manikin once per six (6) month period based on license cycle.

4. Courses shall be listed on the Ventura County Accreditation Continuing Education Log and submitted to VCEMS upon reaccreditation. Continuing education listed on the continuing education log is subject to audit.

D. The VCEMS Medical Director may temporarily suspend or withdraw Level I or Level II authorization pending clinical remediation.

E. Failure to comply with the standards of this policy will be considered to be operating outside of medical control.

F. ALS Service Providers must report any change in Level I/II status to VCEMS within 5 days of taking action.

Appendix A

PARAMEDIC UPGRADE EMPLOYER RECOMMENDATION FORM

Employer: Please instruct the paramedic to complete the requirements in the order listed. Employer shall contact PCC to schedule appointment.

_____, paramedic has been evaluated and has met all criteria for upgrade to Level II status as defined in Ventura County EMS Policy 318.

Level II Paramedic

_____ All the requirement of level I met.
_____ Completion of 240 hrs of direct field observation by an authorized Paramedic FTO
_____ Approval by Paramedic FTO
_____ Submit all appropriate documentation to VCEMS including

	Date	Hours	FTO Print legibly		Date	Hours	FTO Print legibly
1				9			
2				10			
3				11			
4				12			
5				13			
6				14			
7				15			
8				16			
Total Hours Completed							

Please sign and date below for approval.

I have reviewed all supporting documentation and it is attached to this recommendation.

Paramedic FTO Signature	Print FTO name legibly	Date:
Employer Signature	Print Employer name legibly	Date

Per section V.B.1.c.2): PCC signature required if paramedic qualifies for shortened upgrade process.

PCC Signature	Print PCC signature legibly	Date

Appendix B

Ventura County EMS Upgrade Procedure			**240 hours or 10 shifts 30 patient contacts (minimum of 15 ALS)**		
Shift	**Policy**	**Procedure/Policy Title to Review**	**Date**	**Preceptor Signature**	**Method of Evaluation (see key)**
1	310 704 705 726 727 334	Paramedic Scope of Practice Base Hospital Contact General Patient Guidelines SVT VT Cardiac Arrest – Asystole/PEA Cardiac Arrest – VF/VT Symptomatic Bradycardia Acute Coronary Syndrome Transcutaneous Cardiac Pacing 12 Lead ECG Prehospital Personnel Mandatory Training Requirements			
		Notify PCC of Level II upgrade and schedule PCC ride-along.			
2	720 705 614	Limited Base Contact Trauma Assessment/Treatment Guidelines Altered Neurological Function Overdose Seizures Suspected Stroke Spinal Immobilization			
3	705 451	Behavioral Emergencies Burns Childbirth Crush Injury Heat Emergencies Hypothermia Hypovolemic Shock Bites and Stings Nerve Agent Nausea/Vomiting Pain Control Sepsis Alert Stroke System Triage			
4	705 705 1404 1405 1000	Allergic/Adverse Reaction and Anaphylaxis Neonatal Resuscitation Shortness of Breath – Pulmonary Edema Shortness of Breath – Wheezes/other Trauma Assessment/Treatment Guidelines Guidelines for Inter-facility Transfer of Patients to a Trauma Center Trauma Triage and Destination Criteria Documentation of Prehospital Care			
5	710 715 716 717 729 722	Airway Management Needle Thoracostomy Pre-existing Vascular Access Device Intraosseous Infusion air-Q Transport of Pt. with IV Heparin and NTG			

6	600 601 603 606 613 306	Medical Control on Scene Medical Control at the Scene – EMS Personnel Against Medical Advice Determination of Death Do Not Resuscitate EMT-I: Req. to Staff an ALS Unit			
7	402 612 618	Patient Diversion/ED Closure Notification of Exposure to a Communicable Disease Unaccompanied Minor ECG Review Radio Communication			
8	 131 607 1202 1203	Mega Codes MCI Hazardous Material Exposure-Prehospital Protocol Air Unit Dispatch for Emergency Medical Response. Criteria for Patient Emergency Transportation			
9		Multiple System Evaluation Review Head to Toe Assessments			
10		Review Policies and Procedures			
		VCEMS Policy and Arrhythmia Exams			

Paramedic Name: _____ License. #_____Date_____

FTO Signature_____Date_____

PCC Signature_____Date_____

Employer Signature: _____Date: _____

METHOD OF EVALUATION KEY

E = EMEDS Review
S = Simulation/Scenario
D = Demonstration
T = Test/Self Learning Module
DO = Direct Observation in the field or clinical setting
V = Verbalizes Understanding to Preceptor
NA = Performance Skill not applicable to this employee

Appendix C

NAME		Agency		License #	

Lecture Hours

	Required Courses	# of Hours	Date	Location	Provider Number
1.	**ACLS (4 hours)**				
2.	**Handtevy Course**				

EMS Updates are held in May and November each year. **EMS Updates** are completed as new or changed policies become effective. Enter ***ACTUAL*** Date of class attendance below:

	EMS Update	Target Dates	Date	Location	Provider Number
3.	**EMS UPDATE #1** (1 hour)	EMS Office Use			
	EMS UPDATE #2 (1 hour)	EMS Office Use			
	EMS UPDATE #3 (1 hour)	EMS Office Use			
	EMS UPDATE #4 (1 hour)	EMS Office Use			
4.	**Ventura County MCI COURSE** (2 hours)	EMS Office Use			

Skill Refreshers are held in March and September each year. The following requirements must be completed in each year of your license cycle (***for example***: If your re-licensure month is June 2020, you must complete year one requirement between June 2018 and June 2019 and year two requirement between June 2019 and June 2020).

	Paramedic Skills Lab	Target Dates	Enter ***ACTUAL*** Date of class attendance below:		
			Date	Location	Provider Number
5.	**Skills Refresher year 1** (3 hours)	EMS Office Use			
6.	**Skills Refresher year 2** (3 hours)	EMS Office Use			

Field Care Audits **(12 hours)**

	Date	# of Hours	Location	Provider Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Mobile Intensive Care Nurse Authorization Criteria		Policy Number: 321
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: Date Revised: Last Date Reviewed: Next Review Date:	April 1, 1983 February 10, 2022 February 10, 2022 February 28, 2025	Effective Date: July 1, 2022

I. PURPOSE: To define the criteria by which a Registered Nurse (RN) can be authorized to function as a Mobile Intensive Care Nurse (MICN) in the Ventura County Emergency Medical Services (VCEMS) system.

II. AUTHORITY: Health and Safety Code 1797.56 and 1797.58.

III. POLICY: Authorization as a MICN requires professional experience and appropriate training, so that appropriate medical direction can be given to Paramedics at the scene of an emergency.

IV. PROCEDURE: In order to be authorized as a MICN in Ventura County, the candidate shall:

- A. Fulfill the requirements regarding professional experience and prehospital care exposure. (Section V.A and B.)
- B. Successfully completes an approved MICN Developmental Course.
- C. Ride with a Paramedic unit for a minimum of eight (8) maximum of (16) hours and observe at least one (1) emergency response requiring Base Hospital contact.
- D. Be recommended for MICN authorization by his/her employer.
- E. Successfully complete the authorization examination process.
- F. Complete a MICN internship.

V. AUTHORIZATION REQUIREMENTS

- A. Professional Experience:

  The candidate shall hold a valid California RN license and shall have a minimum of 1040 hours (equivalent to six months' full-time employment) critical care experience as an (RN). Critical care areas include, but are not limited to, Intensive Care Unit, Coronary Care Unit, and the Emergency Department.
- B. Prehospital Care Exposure

The candidate shall be employed in a Ventura County Base Hospital. In addition, for a minimum of 520 hours (equivalent to three (3) months full time employment) within the previous six calendar months, the candidate shall have one or more of the following assignments.

1. Be assigned to clinical duties in an Emergency Department responsible for directing prehospital care. (It is strongly recommended that this requirement be in addition to and not concurrent with the candidate's six-(6) months' critical care experience. A Base Hospital may recommend a MICN candidate whose critical care and/or Emergency Department experience are concurrent based on policies and procedures developed by the Base Hospital), or
2. Have responsibility for management, coordination, or training for prehospital care personnel, or
3. Be employed as a staff member of VCEMS.

C. MICN Developmental Course

The candidate shall successfully complete an approved Mobile Intensive Care Nurses Development Course (See Appendix A).

1. The MICN developmental course shall include a four (4) hour Mass Casualty Incident (MCI)-Basic training module to be administered by a VCEMS or authorized representative.

D. Field Observation

Candidates shall ride with an approved Ventura County Paramedic unit for a minimum of eight (8) maximum of (16) hours and observe at least one emergency response patient contact or simulated drill.

1. Candidates shall complete the field experience requirement prior to taking the authorization examination.
2. A completed Field Observation Form shall be submitted to the VC EMS as verification of completion of the field observation requirement (Appendix C).

E. Employer's Recommendation

1. The candidate shall have the recommendation of the Emergency Department Medical Director or Paramedic Liaison Physician (PLP), Prehospital Care Coordinator (PCC) and Emergency Department Clinical Manager.
2. Candidates employed by VCEMS shall have the approval of the Emergency Medical Services Medical Director.

3. All recommendations shall be submitted in writing to VCEMS prior to the authorization examination. (Appendix B.)

   The recommendation shall include:

   a. Each applicant's completed Mobile Intensive Care Nurse Authorization application form (Appendix B).
   b. Verification that the candidate has been an employee of the hospital for a minimum of three (3) months (or has successfully completed the hospital's probationary period) and will, upon certification, will be assigned to the E.D. as set forth in Section B of the MICN Authorization Criteria.
   c. Verification that each candidate has successfully completed an approved MICN Developmental Course.
   d. Verification that each candidate has completed the Field Observation requirement as set forth in Section II.D of the MICN Authorization criteria.

F. Examination Process

1. Written Procedure: Candidates shall successfully complete a comprehensive written examination approved by VCEMS.
   a. The examination's overall minimum passing score shall be 80%.
   b. Employers shall be notified within two (2) weeks of the examination if their candidates passed or failed the examination.
   c. The examination shall be scheduled in conjunction with class completion dates.
2. Examination Failure
   a. A candidate who fails the initial MICN exam shall complete a repeat exam within 30 days. S/he may repeat the authorization exam one (1) time.
   b. A minimum score of 80% must be attained on repeat examination.
   c. If the repeat examination is not successfully completed, the candidate shall repeat the authorization application process, including the developmental course, prior to taking the subsequent examinations.
3. Failure to Appear
   a. If a scheduled candidate fails to appear for the scheduled examination, s/he shall be considered as having failed the examination.

b. Within 24 hours of the scheduled examination, VCEMS shall notify the employer of any candidate failing to appear for testing.

c. Candidates who fail to appear for two scheduled authorization examinations shall not be eligible to take the authorization examination for one (1) calendar year from the last scheduled examination date and must repeat the entire authorization process.

G. Internship

Following notification of successful completion of the authorization examination, the candidate shall satisfactorily direct ten (l0) base hospital runs under the supervision of a MICN, the PCC, and/or an Emergency Department physician.

1. The Communication Equipment Performance Evaluation Form shall be completed for each response handled by the candidate during the internship phase. (Appendix D)
2. Upon successful completion of at least ten (l0) responses, the ten responses shall be evaluated by the Emergency Department Director or PLP, the Emergency Department Clinical Manager, and the PCC. All Communication Equipment Performance Evaluation Forms (Appendix D) and Verification of Internship Completion Form (Appendix E) shall be submitted to Ventura County EMS.
3. The internship requirement shall be completed within six (6) weeks of the successful completion of the authorization examination.
4. If an employer is unable to complete a candidate's internship process within six (6) weeks of the authorization examination, a BH representative shall submit a letter to Ventura County EMS explaining the situation and their intent. If the intent is to continue the authorization process for the individual, the projected date for internship completion shall be stated.
5. If an employer is unable to complete a candidate's internship process within one year of the authorization examination, a BH representative shall resubmit a letter of recommendation and the candidate shall repeat the authorization examination.

VI. AUTHORIZATION

Authorization shall be granted and an authorization card sent to the employer within fifteen (15) working days following receipt of the Communication Equipment Performance Evaluation and Verification of Internship Completion forms. Authorization is valid for a two (2) year period

or during employment at a Ventura County Base Hospital. The nurse must be regularly assigned as a MICN per EMS Policy 322.

Appendix A

LETTER OF RECOMMENDATION
INITIAL AUTHORIZATION

_____ is recommended for Mobile Intensive Care Nurse Authorization in Ventura County.

We have reviewed the attached Mobile Intensive Care Nurse Application and verify that the applicant:

_____ Holds a valid California Registered Nurse License.

_____ Has at least 1040 hours of critical care experience.

_____ Has completed the Field Observation Requirement.

_____ If authorized, will be employed in accordance with guidelines as set for the in Section V.B of the MICN Authorization Criteria.

_____ Has been employed by _____ in the Emergency Department for at least 520 hours gaining prehospital care exposure.

_____ Has completed an approved Mobile Intensive Care Nurse Developmental Course.

_____
Emergency Department Medical Director/
Paramedic Liaison Physician

_____
Emergency Department Clinical Manager

_____
Prehospital Care Coordinator

Date: _____

Policy 321
Appendix B

MICN AUTHORIZATION APPLICATION

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

Application processing requires a minimum of 10 days once all materials are received. Authorization cards will be mailed. Complete application in ink.

Name:		
Street Address:		
City:	State:	Zip code:
Home phone: ( )	Work Phone: ( )	
Base Hospital:		
Current/Prior Authorization Number:	Expiration Date:	

Initial Authorization:

- ☐ Pass the Ventura County EMS MICN Exam with a score of 80% or higher.
- ☐ Provide a copy of a valid and current license as a registered nurse in California
- ☐ Provide a copy of a valid and current ACLS card (front and back of card)
- ☐ Provide a copy of a valid and current PALS, PEPP, or ENPC card (front and back of card)
- ☐. Letter of Recommendation (VCEMS Policy 321, appendix A)
  (to include 1040 hours of Critical Care Experience & 520 hours of Ventura County ED experience)
- ☐. Field Observation Verification (VCEMS Policy 321, appendix C)
- ☐ Communication Equipment Performance Evaluation Form (VCEMS Policy 321, appendix D)
- ☐ Verification of Internship Completion (VCEMS Policy 321, appendix E)

Reauthorization

- ☐ Provide a copy of a valid and current license as a registered nurse in California
- ☐ Provide a copy of a valid and current ACLS card (front and back of card)
- ☐ Provide a copy of a valid and current PALS, PEPP, or ENPC card (front and back of card)
- ☐ Verification of employment as an MICN at a designated base hospital
- ☐ Letter of Recommendation (VCEMS Policy 322, appendix A)
- ☐ Continuing Education Log (VCEMS Policy 322, appendix D)

Applicant Signature: Date

Prehospital Care Coordinator Signature: Date

POLICY 321
APPENDIX C

FIELD OBSERVATION REPORT

MICN NAME: _____ AUTH. NO.:_____

EMPLOYER: _____ RIDE-ALONG DATE: _____

TIME IN: _____ TIME OUT: _____ TOTAL HOURS: _____

BASE CONTACT MADE WITH ALS PROCEDURES PERFORMED:YES: _____# _____ NO_____

ALS PROVIDER: _____

SUMMARY OF FIELD OBSERVATION

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Paramedic Signature EMT/Paramedic Signature

_____ _____
MICN Signature PCC Signature

(Use other side for additional comments)

_____

COMMUNICATION EQUIPMENT PERFORMANCE EVALUATION FORM

Candidate's Name:	MICN Exam Date:	Base Hospital:
MICN Evaluator: Please evaluate this MICN candidate for the following, to include but not be limited to: Proper operation of radio equipment; recommended radio protocols used; correct priorities set; additional info requested as needed; appropriate, complete, specific orders given; able to explain rationale for orders, notification of other agencies involved; and ability to perform alone or with assistance.		

Date	Incident # (and Pt # of Total as needed)	Chief Complaint	Treatment	Evaluator's Comments	Evaluator's Signature	PCC's Comments
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Policy 321
Appendix E

VERIFICATION OF INTERNSHIP COMPLETION

_____, employed at _____, is/is not recommended for Authorization as a Mobile Intensive Care Nurse. S/He has achieved the following rating in the following categories:

Category	Rating	Comments
Understands and operates equipment properly		
Sets correct priorities		
Requests additional information as needed		
Orders are specific, complete and appropriate		
Understands treatment rationale		

NOTE:
In order to qualify for recommendation, a candidate must receive at least a rating of 3 in each category. Ratings are as follows:

1. Poor
2. Fair
3. Average
4. Good
5. Excellent

ATTACH COMMUNICATION EQUIPMENT PERFORMANCE EVALUATION FORM

Signatures:

_____
Base Hospital Medical Director/Paramedic Liaison Physician

_____
Prehospital Care Coordinator

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Mobile Intensive Care Nurse: Reauthorization Requirements		Policy Number: 322
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Next Review Date:	April 1983 February 10, 2022 February 10, 2022 February 28, 2025	Effective Date: July 1, 2022

I. PURPOSE: To define the reauthorization procedures for Ventura County Mobile Intensive Care Nurse (MICNs).

II. AUTHORITY: Health and Safety Code Sections 1797.56 and 1797.58, 1797.213 and 1798.

II. POLICY:

Ventura County (MICNs) shall meet the requirements and apply for reauthorization every two years (Appendix A-C).

III. PROCEDURE:

A. Ventura County MICNs shall:

1. Complete a total of thirty-six hours of Continuing Education, 50% of which, in each category, shall have been obtained at Ventura County Base Hospitals. Document continuing education on Appendix D.
   a. Field Care Audits (Field care audit): Twelve hours per two years.
   b. Periodic training sessions or structured clinical experiences (Lecture/Seminar): Twelve hours per two years. Lecture/Seminar hours may be fulfilled by the following means:
      1) EMS Updates (Mandatory, up to two times per year, as offered).
      2) ACLS recertification - 4 hours credit
      3) PALS, PEPP, or ENPC recertification – 4 hours credit
      3) Self-Study/Video CE - No more than 50% of the total lecture requirement shall be met by combination of self-study and/or video CE.

a) Self-study CE shall be documented by a certificate from the sponsor of the self-study opportunity (e.g., EMS journals mail courses, etc.).

b) Video CE - Video CE shall be presented so that a physician or PCC is available to answer questions at the time of the presentation. A posttest shall be successfully completed at the Base Hospital, signed by the MICN and PCC, and documentation of attendance maintained at the Base Hospital.

c) Ride along with an approved Ventura County Paramedic unit may be required at PCC discretion.

c. Basic MCI Training for the MICN:

1) Two (2) hour refresher training required for MICN re-authorization every two years after the initial training has been completed.

d. Miscellaneous Education: Ten hours per two years.

Examples of miscellaneous education:

1) Ride-along on an ALS Unit for a maximum of 12 hours or at the discretion of the Prehospital Care Coordinator,

2) ALS level teaching, maximum of 8 hours,

3) Additional field care audit and/or lecture/ seminar,

4) Administrative assistance to PCC.

e. Verification of attendance must be retained by the MICN.

1) The Base Hospital Attendance Roster shall be signed individually by each MICN and maintained by the Base Hospital.

2) CE attendance verification for classes taken out of Ventura County shall be documented by completion of the Paramedic/MICN Continuing Education Record or a facsimile of a roll sheet signed by the sponsoring agency PCC with an additional original signature of the sponsoring agency PCC.

3) Credit shall be given only for actual time in attendance at CE.

4) Credit may be received for a class one time only in an authorization cycle.

2. To Maintain MICN Authorization
    a. Function as a MICN for an average of 32 hours per month over a six-month period or
    b. A MICN whose duties for his/her primary employer are administering a VC ALS Program may, with approval of the EMS Medical Director, maintain his/her MICN status by performing MICN clinical functions at a VC Base Hospital for 8 hours per month, averaged over a six month period.
3. Complete all reauthorization requirements (Appendix A-D) by the first day of the month that the Authorization card expires. In the event the MICN takes a leave of absence from their employer, he/she will have 60 days from the date of return to work to complete any outstanding CE prior to reauthorization, if an EMS Update was offered during leave of absence, it must be made up prior to radio assignment.
4. Maintain current ACLS and PALS, PEPP or ENPC certification.

B. Upon successful completion of the above requirements, a MICN shall be authorized for a period of two years from the last day of the month in which all requirements were met.

Policy 322
Appendix A

LETTER OF RECOMMENDATION
REAUTHORIZATION

_____ is recommended for Mobile Intensive Care Nurse Reauthorization in Ventura County.

We have reviewed the attached Mobile Intensive Care Nurse Application and verify that the applicant:

_____ Holds a valid California Registered Nurse License.

_____ Holds a valid and current ACLS card (front and back of card)

_____ Holds a valid and current PALS, PEPP, or ENPC card (front and back of card)

_____ Currently employed at _____ as an MICN
(Name of Base Hospital or Agency)

_____
Emergency Department Medical Director/
Paramedic Liaison Physician

_____
Emergency Department Clinical Manager

_____
Prehospital Care Coordinator

Date: _____

Policy 322
Appendix B

MICN AUTHORIZATION APPLICATION

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

Application processing requires a minimum of 10 days once all materials are received.
Authorization cards will be mailed. Complete application in ink.

Name:		
Street Address:		
City:	State:	Zip code:
Home phone: ( )	Work Phone: ( )	
Base Hospital:		
Current/Prior Authorization Number:	Expiration Date:	

Initial Authorization:

- ☐ Pass the Ventura County EMS MICN Exam with a score of 80% or higher.
- ☐ Provide a copy of a valid and current license as a registered nurse in California
- ☐ Provide a copy of a valid and current ACLS card (front and back of card)
- ☐ Provide a copy of a valid and current PALS, PEPP, or ENPC card (front and back of card)
- ☐. Letter of Recommendation (VCEMS Policy 321, appendix A)
  (to include 1040 hours of Critical Care Experience & 520 hours of Ventura County ED experience)
- ☐. Field Observation Verification (VCEMS Policy 321, appendix C)
- ☐ Communication Equipment Performance Evaluation Form (VCEMS Policy 321, appendix D)
- ☐ Verification of Internship Completion (VCEMS Policy 321, appendix E)

Reauthorization

- ☐ Provide a copy of a valid and current license as a registered nurse in California
- ☐ Provide a copy of a valid and current ACLS card (front and back of card)
- ☐ Provide a copy of a valid and current PALS, PEPP, or ENPC card (front and back of card)
- ☐ Verification of employment as an MICN at a designated base hospital
- ☐ Letter of Recommendation (VCEMS Policy 322, appendix A)
- ☐ Continuing Education Log (VCEMS Policy 322, appendix D)

Applicant Signature: Date

Prehospital Care Coordinator Signature: Date

POLICY 322
APPENDIX C

FIELD OBSERVATION REPORT
(PCC discretion for reauthorization)

MICN NAME: _____ AUTH. NO.:_____

EMPLOYER: _____ RIDE-ALONG DATE: _____

TIME IN: _____ TIME OUT: _____ TOTAL HOURS: _____

BASE CONTACT MADE WITH ALS PROCEDURES PERFORMED:YES: _____# _____ NO_____

ALS PROVIDER: _____

SUMMARY OF FIELD OBSERVATION

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____
Paramedic Signature EMT/Paramedic Signature

_____ _____
MICN Signature PCC Signature

(Use other side for additional comments)

_____

Policy 322
Appendix D

NAME:
_____

EMPLOYER: _____ Authorization #: M_____

Ventura County Authorization Requirements
Continuing Education Log

This form should be used to track your continuing education requirements. This form must be turned in when it is time for your reauthorization. When attending a continuing education course, remember to get a course completion, as EMS will audit 10% of all MICN's reauthorizing and if you are randomly selected you must provide a course completion for each course attended in order to receive credit for that course. Course completions must have the name of the course, number of hours, date, provider agency and provider number.

The EMS Update requirements are mandatory, and they must be completed in the stated time frames or negative action will be taken against your MICN authorization.

Field Care Audit Hours (12 Hours)				
	Date	Name of Topic Discussed	# Of Hours	Provider Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Policy 322
Appendix D Continued

Lecture Hours					
	Required Courses	# of Hours	Date	Location	Provider Number
1.	EMS UPDATE #1 (1 hour)				
2.	EMS UPDATE #2 (1 hour)				
3.	EMS UPDATE #3 (1 hour)				
4.	EMS UPDATE #4 (1 hour)				
	EMS Updates are completed as the new or changed policies are put into place. This is usually done every 6 months in May and November.				
5.	ACLS Course **(4 hours – additional hours please record in miscellaneous hours section)**				
6.	PALS, PEPP or ENPC **(4 hours – additional hours please record in miscellaneous hours section)**				
7.	Basic MCI for the MICN-Refresher (2 Hours)				

Miscellaneous Hours (10 hours are required) (These hours can be earned with any combination of additional field care audit, lecture, etc.)				
	Date	# of Hours	Name of Topic Discussed	Provider Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Mobile Intensive Care Nurse Authorization Reactivation		Policy Number 324
APPROVED: Administration	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: Revised: Date Last Reviewed: Next Review Date:	December 1991 February 10, 2022 February 10, 2022 February 28, 2025	Effective Date: July 1, 2022

I. Purpose: To define the procedure for reactivating a lapsed or inactive authorization.

II. Authority: Health and Safety Code 1797.56 and 1797.58, 1797.213 and 1798.

III. Policy: An individual may reactivate his/her authorization upon completion of the following requirements.

V. Procedure: An individual whose Mobile Intensive Care Nurse (MICN) authorization has become inactive or lapsed shall be eligible for reauthorization when the following have been met:

A. MICN Authorization has lapsed due to failure to meet continuous service requirements and date on authorization has not expired.

1. Notify VCEMS of intent to reactivate authorization.
2. Within six (6) months of notification of intent to reactivate, complete a minimum of six - (6) hours of lecture/seminar and six (6) hours field care audit. These hours will be applied to continuing education requirements for reauthorization.
3. Demonstrate competence to practice as an MICN by satisfactorily providing medical direction to a field unit under the direction of an authorized MICN or MD during minimum of five (5) ALS call-ins requiring ALS care.
4. Submit recommendations for reactivation of authorization from Base Hospital.

B. MICN authorization expired for 1-31 days:

1. Notify VCEMS of intent to reactivate.
2. Meet the requirements for authorization reactivation as defined in Policy 322.

C. MICN authorization expired less than one (1) year.

1. Notify VCEMS of intent to reactivate. Complete the following in order and within six (6) months.
2. Prior to assignment on a radio:
    a Meet the requirements for reauthorization as defined in Policy 322.
    b Complete additional continuing education consisting of six (6) hours lecture/seminar and six (6) hours field care audit.
    c Complete eight (8) hours of Field Observation on a Ventura County ALS unit.
3. Demonstrate competence to practice as a MICN by satisfactorily rendering the medical direction, while under the supervision of the PCC, MICN or MD, during a minimum of five (5) ALS responses. An ALS response is defined as the performance, by the Paramedic one or more of the skills listed in the VC EMS Scope of Practice.
4. Submit recommendations for reactivation of MICN authorization from the Base Hospital to VC EMS.

D. MICN authorization expired between one (1) and two (2) years.
1. Notify VC EMS of intent to reactivate. In the following order, and within six (6) months:
2. Prior to assignment on a radio:
    a. Meet the requirements for reauthorization as defined in Policy 322.
    b. Complete additional continuing education consisting of nine (9) hours lecture/seminar and nine (9) hours field care audit.
    c. Complete twelve (12) hours of field observation on a Ventura County ALS unit.
3. Demonstrate competence to practice as a MICN by satisfactorily rendering medical direction, while under the supervision of the PCC, MICN or MD, during minimum of ten ALS responses. An ALS response is defined as the performance, by the Paramedic one or more of the skills listed in the VC EMS Scope of Practice.
4. Submit recommendations for reactivation of MICN authorization from ALS employer and Base Hospital to VC EMS.

E. Authorization expired for two (2) years or more
1. Notify VC EMS of intent to reactivate. Criteria must be met in the following order and within six (6) months.

2. Prior to assignment on a radio:
   a. Meet the requirements for reauthorization as defined in Policy 322
   b. Complete additional continuing education consisting of an additional twelve (12) hours field care audit and twelve (12) hours lecture/seminar.
   c. Complete twelve (12) hours of field observation on a Ventura County ALS unit.
3. Demonstrate competence to practice as a MICN by satisfactorily rendering medical direction, while under the supervision of the PCC, MICN or MD, during a minimum of ten (10) ALS responses. An ALS response is defined as the performance, by the Paramedic one or more of the skills listed in the VC EMS Scope of Practice.
4. Submit recommendations for reactivation of MICN authorization from ALS employer and Base Hospital to VC EMS.

F. EMS Agency Responsibilities

VC EMS shall issue an authorization card upon successful completion of the requirements for reactivation.

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, Paramedic	Date: July 1, 2022
APPROVED Medical Director:	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 22, 1986 August 9, 2018 February 10, 2022 February 28, 2025	Effective Date: July 1, 2022

I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Base Hospital (BH) 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) BH, approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:

1. Meet all requirements of an ALS Receiving Hospital (RH) per VCEMS Policy 420.
2. Have an average emergency department (ED) 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.
5. Designate a Prehospital Liaison Physician (PLP) who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The PLP shall:

a. Be regularly assigned to the ED.
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 VCEMS.
e. Coordinate BH activities with RH, Prehospital Services Committee (PSC) and VCEMS policies and procedures.
f. Attend PSC meetings.
g. Provide ED staff education.
h. Evaluate paramedics for clinical performance and makes recommendation to VCEMS.
i. Evaluate MICNs for authorization/reauthorization and makes recommendation to VCEMS.

6. Have on duty, on a 24-hour basis, one (1) MICN who meets the criteria in VCEMS Policy 321.
7. Identify an MICN with experience in, and knowledge of, BH communications operations and VCEMS policies and procedures as a Prehospital Care Coordinator (PCC) to assist the PLP in the medical control, supervision, and continuing education (CE) of prehospital care personnel. The PCC shall be a full-time or full-time equivalency employee whose responsibility is dedicated to the oversight and management of the prehospital / EMS duties of the BH.
8. Provide for the CE of prehospital care personnel, paramedics MICNs, EMTs, and first responders, in accordance with VCEMS:
9. 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.
10. Assure that paramedics perform medical procedures only under medical direction of a physician or Ventura County authorized MICN except for approved standing orders.
11. 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.

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 BH in Ventura County must meet Ventura County BH Criteria and agree to comply with Ventura County regulations.

1. Application:
   Eligible hospitals shall submit a written request for BH approval to VCEMS documenting the compliance of the hospital with the Ventura County BH Criteria.
2. Approval:
   a. Program approval or disapproval shall be made in writing by the VCEMS to the requesting BH 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 BH, may result in withdrawal, suspension or revocation of program approval by the VCEMS.

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

1. All BH's shall receive notification of evaluation from the VCEMS.
2. All BH's shall respond in writing regarding program compliance.
3. On-site visits for evaluative purposes may occur.
4. Any BH 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 (RH) per (VCEMS) Policy 420.		
2. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics. If the communications capability of the BH is interrupted, the ALS provider and the nearest BH shall be notified immediately by telephone. 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 Prehospital Liaison Physician (PLP) who shall be a physician on the hospital staff, licensed in the State of California, and have experience in emergency medical care. The PLP shall:		
• Be regularly assigned to the Emergency Department (ED).		
• 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 VCEMS.		
• Coordinate BH activities with RH, Prehospital Services Committee (PSC) and VCEMS policies and procedures.		
• Attend PSC meetings.		
• Provide ED staff education.		
• Evaluate MICNs for authorization/reauthorization and make recommendation to VCEMS.		
5. All BH MICN's shall:		
• Be authorized in Ventura County by the VCEMS Medical Director.		
• Be assigned only to the ED while functioning as an MICN.		
• Maintain current ACLS certification.		
• Be a BH employee.		

		YES	NO
6.	Identify an MICN with experience in and knowledge of BH communication operations and VCEMS policies and procedures as a Prehospital Care Coordinator (PCC) to assist the PLP in the medical control, supervision, and continuing education (CE) of prehospital care personnel. The PCC shall be a full-time or full-time equivalency employee whose responsibility is dedicated to the oversight and management of the prehospital / EMS duties of the BH.		
7.	Provide for the CE of prehospital care personnel (paramedics MICN's, EMTs, and first responders), in accordance with VCEMS Policy 1131:		
8.	Cooperate with and assist the Prehospital Services Subcommittee (PSC) and the VCEMS MD in the collection of statistics and review of necessary records for program evaluation and compliance.		
9.	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.		
10.	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 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.		
11	Submit a letter to VCEMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for program participation as specified by State regulations and VCEMS policies and procedures.		

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Receiving Hospital Standards		Policy Number 420
APPROVED Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED Medical Director:	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: April 1, 1984 Date Revised: February 10, 2022 Date Last Reviewed: February 10, 2022 Review Date: February 28, 2025		Effective Date: July 1, 2022

I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Receiving Hospital (RH) 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. A RH, approved and designated by the Ventura County EMS Agency, shall:

1. Be licensed by the State of California as an acute care hospital.
2. Meet the requirements of the Health and Safety Code Sections 1250-1262 and Title 22, Sections 70411, 70413, 70415, 70417, 70419, 70649, 70651, 70653, 70655 and 70657 as applicable.
3. Be accredited by a CMS accrediting agency.
4. Operate an emergency department (ED) that is designated by the State Department of Health Services as a “Comprehensive Emergency Department,” “Basic Emergency Department” or a “Standby Emergency Department.”
5. Operate an Intensive Care Unit.
6. Have the following specialty services available at the hospital or appropriate referral hospital (at the discretion of the Emergency Department Physician. and consultant Physician.) within 30 minutes:

Cardiology	Anesthesiology	Neurosurgery
Orthopedic Surgery	General Surgery	General Medicine
Thoracic Surgery	Pediatrics	Obstetrics

7. Have operating room services available within 30 minutes.
8. Have the following services available within 15 minutes.

   X-ray Laboratory Respiratory Therapy
9. Evaluate all ambulance transported patients promptly, either by RH Physician, Private Physician or other qualified medical personnel designated by hospital policy.
10. Always have the capability to communicate with the ambulances and the Base Hospital (BH).
11. Maintain multiple forms of redundant communication, in the event a widespread disaster disables traditional methods.
    a. Existing amateur radio sites established in each receiving facility will be maintained in coordination with local emergency management agency and amateur radio organizations
12. Designate an ED 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 ED.
    b. Have knowledge of VCEMS policies and procedures.
    c. Coordinate RH activities with BH, Prehospital Services Committee (PSC), and VCEMS policies and procedures.
    d. Attend, or have designee attend, PSC meetings.
    e. Provide ED staff education.
    f. Schedule medical staffing for the ED on a 24-hour basis.
13. Agree to provide, at a minimum, on a 24-hour basis, a physician and a registered nurse (RN) that meets the following criteria:
    a. All Emergency Department physicians shall:
        1) Be immediately available to the Emergency Department at all times.
        2) Be certified by the American Board of Emergency Medicine OR the American Osteopathic Board of Emergency Medicine OR be Board eligible OR have all of the following:
            a) Have and maintain current Advanced Cardiac Life Support (ACLS) certification.
            b) Have and maintain current Advanced Trauma Life Support (ATLS) certification.

c) Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.

b. RH EDs shall be staffed by:

1) Full-time staff: those physicians who practice emergency medicine 120 hours per month or more, and/or

2) Regular part-time staff: those physicians who see 90 patients or more per month in the practice of emergency medicine.

a) Formula: Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month.

b) Physicians working in more than one hospital may total their hours.

c) Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician.

d) During period of double coverage, the whole shall be met if one of the physicians meets the above standards.

c. All RH RNs shall:

1) Be regular hospital staff assigned solely to the ED for that shift.

2) Maintain current ACLS certification.

d. All other nursing and clerical personnel for the Emergency Department shall maintain current Basic Cardiac Life Support certification.

e. Sufficient licensed personnel shall be staffed to support the services offered.

13. Cooperate with and assist the PSC and EMS Medical Director in the collection of statistics for program evaluation.

14. Agree to maintain all prehospital data in a manner consistent with hospital data requirements and provide that the data be integrated with the patient's chart. Prehospital data shall include the Ventura County Electronic Patient Care Report (VCePCR), Paramedic Base Hospital communication form (from the BH), and documentation of a BH telephone communication with the RH.

15. Participate with the BH in evaluation of paramedics for reaccreditation.

16. Permit the use of the hospital helipad as an emergency rendezvous point if a State-approved helipad is maintained on hospital premises.

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

C. EMS shall review its agreement with each RH at least every two years.

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

E. The EMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the PSC that, as defined in the regulations, compliance with the regulation would not be in the best interests of the persons served within the affected local area.

F. A hospital that applies to become a RH in Ventura County must meet Ventura County RH Criteria and agree to comply with Ventura County regulation.

1. Application:
   Eligible hospital shall submit a written request for RH approval to the VCEMS, documenting the compliance of the hospital with the Ventura County RH.
2. Approval:
   Program approval or denial shall be made in writing by EMS to the requesting RH within a reasonable period of time after receipt of the request for approval and all required documentation. This period shall not exceed three (3) months.

G. ALS RHs shall be reviewed every two years.

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

H. Paramedics providing care for emergency patients with potentially serious medical conditions and are within the catchment area of a hospital with a standby emergency department, shall make immediate base contact for destination determination. Examples of these patients would include, but are not limited to, patients with:

1. Patients with seizure of new onset, multiple seizures within a 24-hour period, or sustained alteration in level of consciousness

2. Chest pain or discomfort of known or suspected cardiac origin
3. Sustained respiratory distress not responsive to field treatment
4. Suspected pulmonary edema not responsive to field treatment
5. Potentially significant cardiac arrhythmias
6. Orthopedic emergencies having open fractures, or alterations of distal neurovascular status
7. Suspected spinal cord injury of new onset
8. Burns greater than 10% body surface area
9. Drowning or suspected barotrauma with any history of loss of consciousness, unstable vital signs, or respiratory problems
10. Criteria that meet stroke, STEMI, or trauma criteria for transport to a specialty care hospital

I. A RH with a standby emergency department only, offering "standby emergency medical service," is considered to be an alternative receiving facility. Patients may be transported to a standby emergency department when the use of the facility is in the best interest of patient care.

1. Patients that require emergent stabilization at an emergency department may be transported to a standby emergency department if a basic emergency facility is not within a reasonable distance. These would include patients:
    a. In cardiac arrest with NO return of spontaneous circulation (ROSC) in the field
    b. With bleeding that cannot be controlled
    c. Without an effective airway
2. During hours of peak traffic, the Base Hospital MICN should make destination determinations based on predicted travel time and patient condition. Patients who meet criteria for trauma, stroke, or STEMI in the absence of a condition that meets I.1. above, will be directed to the appropriate destination.
3. A RH with a standby emergency department shall report to Ventura County EMS Agency any change in status regarding its ability to provide care for emergency patients.

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL
CRITERIA COMPLIANCE CHECKLIST

Receiving Hospital: _____ Date: _____

		YES	NO
A.	Receiving Hospital (RH), approved and designated by the Ventura County EMS Agency, shall:		
1.	Be licensed by the State of California as an acute care hospital.		
2.	Meet the requirements of the Health and Safety Code Section 1250-1262 and Title 22, Sections 70411, 70413, 70415, 70417, 70419, 70649, 70651, 70653, 70655 and 70657 as applicable.		
3.	Be accredited by a CMS accrediting agency		
4.	Operate an Intensive Care Unit.		
5.	Have the following specialty services available at the hospital or appropriate referral hospital (at the discretion of the Emergency Department (ED) Physician. and consultant Physician.) within 30 minutes:		
	• Cardiology		
	• Anesthesiology		
	• Neurosurgery		
	• Orthopedic Surgery		
	• General Surgery		
	• General Medicine		
	• Thoracic Surgery		
	• Pediatrics		
	• Obstetrics		
6.	Have operating room services available within 30 minutes.		
7.	Have the following services available within 15 minutes.		
	• X-Ray		
	• Laboratory		
	• Respiratory Therapy		
8.	Evaluate all ambulance transported patients promptly, either by RH Physician, Private Physician, or other qualified medical personnel designated by hospital policy.		
9.	Have the capability at all times to communicate with the ambulances and the BH.		
10.	Designate an Emergency Department 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 knowledge of VC EMS policies and procedures.		

				YES	NO
	c.		Coordinate RH activities with Base Hospital, Prehospital Services Committee (PSC), and VCEMS policies and procedures.		
	d.		Attend or have designee attend PSC meetings.		
	e.		Provide Emergency Department staff education.		
	f.		Schedule medical staffing for the ED on a 24-hour basis.		
11.	Agree to provide, at a minimum, on a 24-hour basis, a physician and a registered nurse that meets the following criteria:				
	a.		All Emergency Department physicians shall:		
		1)	Be immediately available to ED at all times.		
		2)	Be certified by the American Board of Emergency Medicine OR the American Osteopathic Board of Emergency Medicine OR be Board eligible OR have all of the following:		
			a) Have and maintain current Advanced Cardiac Life Support (ACLS) certification.		
			b) Have and maintain current Advanced Trauma Life Support (ATLS)certification.		
			c) Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.		
	b.		RH EDs shall be staffed by:		
		1)	Full-time staff: those physicians who practice emergency medicine 120 hours per month or more, and/or		
		2)	Regular part-time staff: those physicians who see 90 patients or more per month in the practice of emergency medicine.		
			a) Formula: Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month		
			b) Physicians working in more than one hospital may total their hours		
			c) Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician		

	YES	NO
d) During period of double coverage, the whole shall be met if one of the physicians meets the above standards.		
c. All RH RNs shall:		
1) Be regular hospital staff assigned solely to the ED for that shift.		
2) Maintain current ACLS certification.		
d. All other nursing and clerical personnel for the ED shall maintain current Basic Cardiac Life Support certification.		
e. Sufficient licensed personnel shall be utilized to support the services offered.		
12. Cooperate with and assist the PSC and EMS Medical Director in the collection of statistics for program evaluation.		
13. Agree to maintain all prehospital data in a manner consistent with hospital data requirements and provide that the data be integrated with the patient's chart. Prehospital data shall include the VCePCR, paramedic Base Hospital communication form (from the BH), and documentation of a BH telephone communication with the RH.		
14. Participate with the BH in evaluation of paramedics for reaccreditation.		
15. Permit the use of the hospital helipad as an emergency rendezvous point if a State-approved helipad is maintained on hospital premises.		
B. There shall be a written agreement between the RH and EMS indicating the commitment of hospital administration, medical staff, and emergency department staff to meet requirements for employment as specified by EMS policies and procedures.		

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL PHYSICIAN
CRITERIA COMPLIANCE CHECKLIST

Physician Name: _____ Date: _____

All Emergency Department physicians shall:		YES	NO
1.	Be immediately available to the RH ED at all times.		
2.	Be certified by the American Board of Emergency Medicine OR the American Osteopathic Board of Emergency Medicine OR be Board eligible OR have all of the following:		
a.	Have and maintain current ACLS certification.		
b.	Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.		
c.	Have and maintain current Advanced Trauma Life Support (ATLS) certification.		

The above named physician is:

1)	Full-time staff: A physician who practices emergency medicine 120 hours per month or more, and/or		
2)	Regular part-time staff: A physician who see 90 patients or more per month in the practice of emergency medicine (Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month, Physicians working in more than one hospital may total their hours, Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician)		

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL STANDBY EMERGENCY DEPARTMENT ADDITIONAL CRITERIA COMPLIANCE CHECKLIST

Receiving Hospital w/Standby ED:_____ Date: _____

	EMS REVIEW	
The RH with standby ED has:	YES	NO
A. Medical staff, and the availability of the staff at various times to care for patients requiring emergency medical services.		
B. Ability of staff to care for the degree and severity of patient injuries or condition.		
C. Equipment and services available at the facility necessary to care for patients requiring emergency medical services and the severity of their injuries or condition.		
D. During the current 2-year evaluation period, has reported to Ventura County EMS Agency any change in status regarding its ability to provide care for emergency patients.		
E. Authorization by the Ventura County EMS Agency medical director to receive patients requiring emergency medical services, in order to provide for the best interests of patient care.		
COMMENTS		

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: BLS And ALS Unit Equipment And Supplies		Policy Number: 504
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: Date Revised: Last Reviewed: Review Date:	May 24, 1987 June 9, 2022 June 9, 2022 June 30, 2023	Effective Date: July 1, 2022

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

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

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

IV. DEFINITIONS:

BLS – Basic Life Support Unit

ALS – Advanced Life Support Unit

PSV – Paramedic Support Vehicle or Paramedic Supervisor Vehicle

CCT – Critical Care Transport Unit

BLS Command – Basic Life Support Staffed Command Vehicle

FR/ALS – First Responder Advanced Life Support Unit

Search and Rescue – Sheriff's SAR Helicopter Unit

V. PROCEDURE:

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

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

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS						
Bag valve units with appropriate masks Adult (1,000 mL) Child (500 mL) Infant (240 mL)	1 each	1 eacn	1 each	1 each	1 each	1 adult
Nasal cannula Adult	3	3	3	3	3	3
Nasopharyngeal airway 14 French 18 French 20 French 22 French 24 French 26 French 28 French 32 French 34 French 36 French	1 each	1 each	1 each	1 each	1 each	1 each
Continuous positive airway pressure (CPAP) device	1 per size	Optional	1 per size	1 per size	1 per size	1 per size
Nerve Agent Antidote Kit	Optional	Optional	9	9	9	Optional
Blood glucose determination devices	1	Optional	2	1	1	1
Occlusive Dressing	5	5	5	5	5	5
Oral glucose 15gm unit dose	1	1	1	1	1	1
Oropharyngeal Airways 40 mm (Size 00) 50 mm (Size 0) 60mm (Size 1) 70 mm (Size 2) 80 mm (Size 3) 90 mm (Size 4) 100 mm (Size 5) 110 mm (Size 6)	1 each size	1 each size	1 each size	1 each size	1 each size	1 each size
Oxygen with appropriate adjuncts (portability required)	15 L/min for 20 minutes (40 minutes for transport units)	15 L/min for 20 minutes	15 L/min for 20 minutes (40 minutes for transport units)	15 L/min for 20 mins.	15 L/min for 20 mins.	15 L/min for 20 mins.
Portable suction equipment	1	1	1	1	1	1
Nonrebreather oxygen masks Adult Child Infant	3 3 2	2 2 2	3 3 2	2 2 2	2 2 2	2 2 2
Bandage scissors	1	1	1	1	1	1

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

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

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

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

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

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

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Refusal of EMS Services	Policy: 603
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: July 1, 2022
Origination Date: October 31, 1995 Date Revised: February 10, 2022 Last Review: February 10, 2022 Review Date: February 28, 2024	Effective Date: July 1, 2022

I. PURPOSE: To define the policy and operating procedures for the approach to patients, or potential patients, at the scene of an EMS response who decline services

II. AUTHORITY: California Health and Safety Code, Division 2.5, sections 1797.204, 1797.206, 1798, and 1798.2, California Code of Regulations Title 22, Division 9, sections 100170(5) and 100128(4), California Welfare and Institution Code, sections 305,625, 5150 and 5170

III. DEFINITIONS:

Adult – person 18 years of age or older

ALS – advanced level EMS services as defined in the policies and procedures of the Ventura County Emergency Medical Services Agency (VCEMS) and the California Health and Safety Code, section 1797.52

AMA – when a patient with evidence of an emergency or acute medical condition, or who has required an ALS intervention, refuses transport or other indicated interventions. Patient must be an adult or emancipated minor, and have capacity as defined below, to decline service against medical advice.

BLS – basic level EMS services as defined in the policies and procedures of VCEMS and the California Health and Safety Code, section 1797.60

Capacity – a person's ability to make an informed decision after consideration of the risks and benefits of such a decision. Capacity differs from competence, which is a legal definition that extends beyond the act of making specific medical decisions.

Declination of EMS Service – a contact at the scene of an EMS response who does not demonstrate any evidence of an injury or acute medical condition and is declining any and all EMS services. Example: ambulatory individuals at a minor traffic accident, bystanders at a structure fire.

Declination of transport and/or assessment – when a patient requests BLS level services but declines transport and/or assessment. These patients meet defined criteria for declining such services and lack any complaints or exam findings indicative of an emergent medical condition.

Dedicated decision maker – an individual who has been selected by or legally appointed to make medical decisions on behalf of the patient, including individuals with a power of attorney.

Emancipated minor – a person under 18 years of age who has been legally separated from their parents and lives independently, minors on military duty, married minors, minors who are pregnant and minors who parents.

Emergency Medical Condition – a medical condition that is acute or subacute in nature and requires immediate assessment. Emergency medical conditions typically carry the risk of sudden deterioration and possibly death. These conditions may be readily apparent or suspected based on the reported signs and symptoms, mechanism of injury, or medical history.

Incident: Any response involving any Ventura County pre-hospital personnel to any event in which there is an actual victim, or the potential for a victim

Minor – person under 18 years of age.

Patient Contact: Any encounter involving Ventura County pre-hospital personnel with any person consenting, either implied or informed, to assessment and/or treatment.

Power of attorney – the authority to act for another person in specified legal, medical or financial matters.

Criteria for Refusal - Adults and emancipated minors may decline services if they meet the criteria for refusal. Persons who refuse care must demonstrate capacity and be free of impairment due to drugs and/or alcohol. Parents of minors and the dedicated decision makers for adults who lack capacity can decline services for others if they themselves meet the criteria for refusal.

1. Alert, oriented (x4) person, place, time, and purpose/situation.
2. Able to demonstrate capacity by participating in a discussion of the risks of refusal.
3. Must adequately acknowledge risks of declining the relevant services.
4. Free of impairment due to drugs or alcohol.
5. No evidence of suicidality, homicidality, grave disability, or other acute psychiatric condition that may require a 5150.

IV. POLICY:

A. Adults and emancipated minors with decision-making capacity have the right to dictate the scope of their medical care. EMS has an obligation to offer service.
B. For unaccompanied minors, refer to VCEMS Policy 618.
C. All potential patients at the scene of an EMS response shall be offered evaluation, treatment, and transport.
D. Providing care establishes a therapeutic relationship and the expectations therein.
E. Not all EMS patients require ALS care and/or transport.
F. Patients declining care and/or transport should be counseled thoroughly about the pertinent risks of declining such interventions and all discussions should be documented thoroughly.
G. BLS providers with concern for an emergency medical condition shall request an ALS provider for an ALS level assessment.
H. Only adults and emancipated minors may decline services if they meet the criteria for refusal. Persons who refuse care must demonstrate capacity and be free of impairment due to drugs and/or alcohol. Parents of minors and the dedicated decision makers for adults who lack capacity can decline services for others if they themselves meet the criteria for refusal.
I. Provider agencies may require additional documentation over and above the minimum requirements outlined in this policy.

V. PROCEDURE**:**

A. Cancellation
    1. No ePCR is required if:
        a. Cancelled en route prior to arrival
        b. Cancelled by another agency upon arrival at the scene of the incident
        c. Cancelled after arrival and no patient contact as defined in Section III

B. Declination of EMS Services
    1. Those individuals contacted at an EMS response who have no medical complaints or evidence of an emergency medical condition may decline service. An ePCR with a no treatment disposition shall be completed.

C. Declination of Transport and/or Assessment
    1. Patients with minor injuries or illness, or those in need of strictly BLS interventions, shall be evaluated and treated per protocol.
    2. Adults and emancipated minors may decline any or all assessment, treatment, transport, and be released from EMS care when;
        a. Refusal criteria has been met.
        b. No present indication for ALS assessment, treatment, and/or base hospital contact as defined by VCEMS policy 704.
    3. Minors and those lacking capacity may be released from care if a parent or dedicated decision maker is present and meets criteria listed above.
    4. Documentation per VCEMS Policy 1000 – Documentation of Prehospital Care.
    5. Discuss the risks of declining and document the discussion in your narrative.

D. AMA
   1. Patient has evidence of an emergency medical condition, required an ALS intervention, or has a complaint and/or condition as described in VCEMS policy 704.
   2. Engage the patient in a discussion detailing the following;
      a. Potential benefits of further treatment, EMS assessment, transport.
      b. Potential benefits to additional assessment by ED physician, observation, and/or diagnostics not available in the EMS environment.
      c. Relevant medical concerns and risks of refusal.
      d. Patient resources and/or plans for obtaining follow up care after refusal of EMS services.
   3. Contact base hospital for further assistance and/or to document AMA.
   4. Direct communication between the MICN and/or base hospital physician and patient is encouraged.
   5. Adults and emancipated minors may be released by ALS providers when;
      a. Base hospital contact has been made.
      b. Refusal criteria has been met
   6. These are high-risk contacts for patients, providers, and EMS agencies. Therefore, they must be completed in a thorough and thoughtful manner. This includes detailed documentation of the history, exam, and all pertinent discussions.
   7. Have patient and witness complete relevant AMA documentation.
   8. If patient does not meet criteria outlined above, or AMA is discouraged by the base hospital, Law enforcement and/or Crisis Team may be requested to the scene and efforts to convince the patient to agree to transport should be continued.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Hazardous Material Incident	Policy Number: 607
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: February 12, 1987 Date Revised: June 9, 2022 Date Last Reviewed: June 9, 2022 Review Date: June 30, 2024	Effective Date: July 1, 2022

I. PURPOSE: This policy establishes guidelines for the response of pre-hospital care providers to incidents involving hazardous materials.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.220 & 1798. California Code of Regulations, Title 22, Division 9, Section 100175.

III. POLICY: The Incident Commander assumes responsibility for "functional" control within a hazardous materials incident. Functional control includes all operations within all zones and control of any contamination.

The responding Emergency Medical Services personnel assume responsibility for patient care and transportation after release and/or decontamination by the Hazard Incident Response Team (HIRT). The EMS personnel and/or treatment team shall coordinate treatment/transport efforts with HIRT so as not to jeopardize scene integrity, causing unnecessary spread of contamination to ambulance, equipment, EMS personnel and hospital personnel or citizens.

IV. PROCEDURE:

A. INITIAL NOTIFICATION

1. The responding EMS unit shall be notified by the Fire Department as soon as possible on all hazardous material incidents in order to facilitate their entry into the scene. Necessary information should include:

   a. Radio channel/frequency for the incident

   b. Estimated number of patients or potential patients

   c. Approach to the incident

   d. Location of the staging area

e. Identification (radio designation) of the Incident Commander

f. Request for specialized equipment needed

2. While enroute, the EMS unit shall make radio contact with the Incident Commander or FCC and verify location, best access and staging information prior to their arrival on-scene.

3.

B. ARRIVAL ON-SCENE

1. Upon arrival at the scene, the ambulance unit shall notify the base hospital or receiving hospital affected as to the number of patients, description of hazard, actions performed related to victim decontamination, and any other pertinent information relative to hospital needs. (Note: the IC or HIRT should provide this information upon request).

2. If the scene has been secured, the first-in ambulance unit should enter the staging area and report to the Incident Commander, or designee, for direction.

C. PATIENT DECONTAMINATION

1. Patients contaminated by a hazardous substance or radiation shall be appropriately decontaminated by HIRT or fire resources, despite the urgency of their medical condition, prior to being moved to the triage area for transportation.

2. The HIRT shall determine the disposition of all contaminated clothing and personal articles.

3. The transfer of the patient from the contaminated zone to the support zone must be accomplished by trained personnel in an appropriate level of protective clothing and carefully coordinated so as not to permit the spread of contamination.

4. Contaminated clothing and personal articles shall be properly prepared for disposal by the HIRT.

5. Every effort shall be made to preserve, protect and return personal articles.

D. TRANSPORTATION

1. Any equipment, including transportation units, found to have been exposed and contaminated by a hazardous substance shall be taken

out of service pending decontamination and a second ambulance unit responded to transport patients to the hospital when available.

2. At no time shall ambulance personnel transport contaminated patients. If during transport a patient off-gasses a strong odor or vomits what is believed to be toxic emesis, personnel/patient shall vacate ambulance and request assistance from the Incident Commander.
3. Prior to transportation of patients to the hospital, the ambulance unit shall notify the hospital of the following:
   a. number of patients
   b. materials causing contamination (if known)
   c. extent of patient contamination
   d. decontamination actions taken
   e. patient assessment, including injuries
   f. pertinent information related to scene or incident
   g. ETA
4. Deceased victims shall be left undisturbed at the scene

E. ARRIVAL AT EMERGENCY ROOM

1. Transport of patients that have not been at least grossly decontaminated is prohibited. Ideally, patients will be thoroughly decontaminated at the scene. Patients who have been transported should be considered exposed and treated accordingly.
2. All hospitals should develop a plan for receiving patients who have been decontaminated and those patients who may need additional decontamination and a contingency plan for mass decontamination.
3. If additional decontamination resources are needed, the HIRT decontamination equipment and personnel may be requested through the Ventura County Regional Dispatch Center.

F. EMERGENCY PERSONNEL DECONTAMINATION

1. All treatment team members coming in contact with contaminated patients or contaminated materials shall take appropriate measures to insure proper decontamination and elimination of cross contamination.

Secondary decontamination is recommended which includes taking a shower and changing clothes whenever necessary.

2. Clothing, bedding, instruments, body fluids, etc. may be considered extremely hazardous and must be handled with care, contained and disposed of properly.
3. Emergency medical responders who are accidentally contaminated at the hazmat incident scene shall not board the ambulance until they have been at least grossly decontaminated at the scene. Ideally, responders will be thoroughly decontaminated at the scene. Responders presenting with symptoms secondary to exposure to a contaminant should be considered patients.
4. If medical responders identify that they are contaminated during any transport, they shall immediately stop at the closest safe location, notify FCC that they are contaminated and request a hazardous materials response. Responders presenting with symptoms secondary to exposure to a contaminant should be considered patients.
5. Follow-up monitoring of all personnel shall be conducted as deemed necessary by the Medical Director.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Spinal Motion Restriction	Policy Number 614
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: July 1, 2022
Origination Date: October 1992 Date Revised: April 14, 2022 Date Last Reviewed: April 14, 2022 Review Date: April 30, 2024	Effective Date: July 1, 2022

I. PURPOSE: To define the use of spinal motion restriction 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

III. DEFINITION:

A. Spinal motion restriction: the use of cervical collars, gurneys, and other commercial devices to limit the movement of patients with potential spine injuries. Spinal motion restriction refers to the same concept as "spinal immobilization," which traditionally incorporates the use of rigid backboards. This technique often limits movement but rarely provides true "immobilization." The goal of spinal motion restriction is to maintain spinal alignment and limit unwanted movement. "This can be accomplished by placing the patient on a long backboard, a scoop stretcher, a vacuum mattress, or an ambulance cot."[1]

IV. POLICY:

A. Spinal motion restriction is a procedure that should be performed judiciously.

B. Backboards are a tool that may be utilized for patient movement and CPR. They should not be used for transport unless necessary to continue patient care (e.g. unconscious patient)

C. Patients should be secured to the gurney with gurney straps whenever possible. A slide board should be used to transfer the patient to the hospital gurney.

D. Cervical collars should be used in the appropriate patients as defined below. Patients with or without a cervical collar should then be secured to the gurney with gurney straps. Patient should then be instructed to remain as still as possible.

Awake and alert, potentially ambulatory patients, not intoxicated, without neurologic symptoms and/or deficits, can self-extricate (after application of cervical collar if indicated).[2]

E. In the event of simultaneous transport of more than one patient requiring spinal motion restriction, the second patient should be secured supine to the bench seat. A backboard can be used if necessary.

V. PROCEDURE:

A. Patients who meet any of the following criteria require spinal motion restriction:

1. Any trauma patient who complains of neck pain and/or back pain and has spinal tenderness.
2. Any patient with known or suspected trauma with altered level of consciousness to the extent that their appreciation of pain or ability to communicate is impaired.
3. Any trauma patient with a neurological deficit (e.g. numbness, weakness)
4. Any patient under the influence of drugs or alcohol alcohol to the extent that appreciation of pain or ability to communicate is impaired.
5. Patients suffering from severe distracting painful injuries for whom the mechanism of injury is unknown or suspicious for spinal injury.

B. 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, and does not have a distracting injury, should not be placed in spinal motion restriction.

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, numbness, or a distracting injury.

D. Spinal motion restriction is contraindicated in patients with isolated penetrating torso or neck injury. Transportation must be expedited. DO NOT place these patients in spinal motion restriction. A backboard may be utilized for patient movement and/or CPR. A cervical collar is not necessary.

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, a neutral head position must be maintained during removal.
   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 or the head padded to maintain neutral position.

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.

VII. Pediatric patients

A. The approach to pediatric patients is similar to that for adults. There is no need to employ spinal motion restriction based on age criteria alone.

B. The index of suspicion for spine injury should be higher given the increased difficulty communication with younger patients. Indications for spinal motion restriction include:
   1. Complaint of neck pain
   2. Torticollis
   3. Neurologic deficit
   4. Altered mental status including GCS <15, intoxication, and other signs (agitation, apnea, hypopnea, somnolence, etc.)
   5. Involvement in a high-risk motor vehicle, high impact diving injury, or has substantial torso injury

C. Appropriate patients can be secured to gurney in their car seat. An appropriately sized c-collar should be applied if indicated.

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[1] Spinal Motion Restriction in the Trauma Patient – A Joint Position Statement
Fischer PE, Perina DG, Delbridge TR, Fallat ME, Salomone JP, Dodd J, Bulger EM, Gestring ML.
Prehosp Emerg Care. 2018 Nov-Dec;22(6):659-661. doi: 10.1080/10903127.2018.1481476. Epub 2018 Aug 9.

[2] Dixon M, O'Halloran J, Cummins NM
Biomechanical analysis of spinal immobilisation during prehospital extrication: a proof of concept study
Emerg Med J 2014;31:745-749.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Organ Donor Information Search		Policy Number 615
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 1, 1993 June 9, 2022 June 9, 2022 June 30, 2024	Effective Date: July 1, 2022

I. PURPOSE: To establish guidelines for Emergency Medical Services (EMS) field personnel to meet requirements that they search for organ donor information on adult patients for whom death appears to be imminent.

II. AUTHORITY: Health and Safety Code Section 7152.5(b)

III. POLICY: EMS field personnel shall make a brief reasonable search to determine the presence or absence of an organ donor card on adult patients for whom death appears to be imminent. This brief search shall not interfere with patient care and must be done in the presence of a witness, preferably a public safety officer, unless extenuating circumstances make having a witness clearly infeasible.

IV. DEFINITIONS:

Reasonable Search: A brief attempt by EMS field personnel to locate documentation that may identify a patient as a potential organ donor, or one who has refused to make an anatomical gift. This search shall be limited to an electronic health application located on the patient's smartphone. Other locations may include patient's wallet, purse or other personal belongings on or near the individual likely to contain a driver's license or other identification card with this information. A REASONABLE SEARCH SHALL NOT TAKE PRECEDENCE OVER PATIENT CARE/TREATMENT.

Imminent Death: A condition wherein illness or injuries are of such severity that in the opinion of EMS field personnel, death is likely to occur before the patient arrives at a hospital. For purposes of this policy, this definition does not include any conscious patient regardless of the severity of illness or injury.

Receiving Hospital: The hospital to which the patient is being transported

V. PROCEDURE:

A. When EMS field personnel encounter an unconscious adult patient for whom it

appears that death is imminent (that is, death prior to arrival at a hospital), they shall attempt a "reasonable search" as defined in Section IV. This search must be done in the presence of a witness, preferably a public safety officer, unless extenuating circumstances make having a witness clearly infeasible. If a family member or patient representative is the only witness available, EMS field personnel should clearly and carefully explain the intent of the brief search. The identity of the witness to the brief search will be documented on the Ventura County Electronic Patient Care Reporting System (VCePCR).

B. Treatment and transport of the patient remains the highest priority for EMS field personnel. This search shall not interfere with patient care or transport.

C. EMS field personnel shall notify the receiving hospital if organ donor information is discovered. Advanced Life Support (ALS) units shall notify the base hospital in addition to the receiving hospital.

D. Any organ donor document that is discovered should be transported to the receiving hospital with the patient unless it is requested by the investigating law enforcement officer. If the investigating law enforcement officer retains the organ donor card, the presence of the card will be documented in the VCePCR. In the event that the patient is not transported, any document will remain with the patient.

E. Field personnel should briefly note the results of the search, notification of hospital, and witness name(s) in the narrative section of the VCePCR.

F. No search is to be made by EMS field personnel after patient death occurs.

G. If a member of the patient's immediate family or other patient representative objects to the search for an organ donor document at the scene, no search shall be made, and their response to a question about the patient's organ donor wishes may be considered to satisfy the requirement of this policy. This information shall be documented in the VCePCR.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Unaccompanied Minors		Policy Number 618
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Review Date:	May 1, 1995 June 9, 2022 June 9, 2022 June 30, 2024	Effective Date: July 1, 2022

I. PURPOSE: To describe the process to be followed when EMS personnel determine that an unaccompanied minor does not need ambulance transport.

II. AUTHORITY: Sections 1797.200 and 1798, California Health & Safety Code; Section 100148, Title 22, Division 9 California Code of Regulations.

III. POLICY: The following procedure will be followed when field personnel assess a minor patient who is unaccompanied by a responsible adult and who is determined not to have an illness or injury requiring ambulance transport.

IV. PROCEDURE:

A. The patient is assessed according to Policy 603. Field personnel should attempt to contact the parent(s)/guardian(s) of the patient.

B. Documentation of care provided and overall situation/circumstances in VCePCR in accordance with VCEMS Policies 1000 and 603.

C. The field personnel will document the name/badge# of an officer who will assume responsibility for the child until his/her parent(s)/guardian(s) arrive.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Safely Surrendered Babies		Policy Number: 619
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: Revised Date: Last Reviewed: Review Date:	February 2003 May 9, 2019 June 9, 2022 June 30, 2024	Effective Date: July 1, 2022

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

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

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

IV. PROCEDURE:

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

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

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

D. Initiate first responder form.

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

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

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

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

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

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

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

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

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

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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Patient Medications		Policy Number 624
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Next Review Date:	December 6, 2006 October 10, 2019 June 9, 2022 June 30, 2024	Effective Date: July 1, 2022

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

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

III. POLICY:

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

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

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

IV. PROCEDURE:

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

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

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

D. For cases involving a deceased individual with no resuscitation attempted, leave medication bottles or other drugs where they are so that the medical examiner's

investigator and/or law enforcement personnel can effectively assess and document the scene.

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

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

G. EMS personnel must document all actions in the Ventura County Electronic Patient Care Reporting (VCePCR) system, including discussing medications, taking them to the hospital, the person to whom they were turned over, and explain if unable to obtain essential information or medications.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Fireline Medic		Policy Number 627
APPROVED: Administration:	Steven Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 5, 2011 April 14, 2022 April 14, 2022 April 30, 2024	Effective Date: July 1, 2022

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

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

III. POLICY:

A. County accredited paramedics shall carry the ALS/BLS inventory consistent with the FIRESCOPE FEMP position description. Reasonable variations may occur; however, any exceptions shall have prior approval of the VCEMSA. The equipment lists are a scaled down version of standard inventory in order to meet workable/packable weight limitations (45 lbs including wildland safety gear, divided between a two person team. Weight limit to include the Personal Pack Inventory as outlined in FireScope).

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

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

IV. PROCEDURE:

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

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

APPENDIX A

FIRELINE EMERGENCY MEDICAL TECHNICIAN

BASIC LIFE SUPPORT (BLS) PACK INVENTORY

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

APPENDIX B

FIRELINE EMERGENCY MEDICAL TECHNICIAN

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

ALS AIRWAY EQUIPMENT:

	Endotracheal Intubation Equipment (6.0, 7.5 ET – Mac 4, Miller 4, stylette and handle)		Needle Thoracostomy Kit (1)
	End Tidal CO2 Detector		Pulse Oximeter (Optional)
	ETT Restraint		iGel Airway (1 – Size 3 and 1 – Size 4)

IV/MEDICATION ADMIN SUPPLIES:

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

MISCELLANEOUS:

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

BIOMEDICAL EQUIPMENT:

	Defibrillator Electrodes (2)		Glucometer (1)
	Defibrillator with ECG Waveform Display (1)		

MEDICATIONS:

	Amiodarone 50 mg/ml 3 ml (3)		Epinephrine 1mg/10ml (3)
	Albuterol – 90mcg/puff (1 MDI) with Spacer Device		Glucagon 1 mg/unit (1)
	Aspirin-Chewable (1 Bottle)		Midazolam 10 mg
	Atropine Sulfate 1mg (2)		Fentanyl 50 mcg/ml (4)
			Naloxone – 2mg (2)
	Dextrose 10% 10 G, 250ml. (1)		Nitroglycerin 1/150 gr (1)
	Diphenhydramine 50 mg (4)		Saline 0.9% IV 1,000 ml – Can be configured into two 500 ml or four 250 ml
	Epinephrine 1mg/mL (2)		5% Dextrose in Water, 50 ml (1)

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Ventura County Pre-Hospital Infectious Disease Policy	Policy Number 630
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director Daniel Shepherd, M.D.	Date: July 1, 2022
Origination Date: December 30, 2021 Date Revised: Date Last Reviewed: Review Date: July 31, 2023	Effective Date: July 1, 2022

I. PURPOSE: To provide direction to prehospital emergency personnel when responding to patients with potential infectious diseases and formalize response to infectious disease threats to implement best practices in an efficient manner. Furthermore, the intent is to provide minimum standards to protect providers/patients and to mitigate infectious disease transmission.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.220,1797.188. California Code of Regulations, Title 22, Division 9 Section 100062, 100063, 100145 and 100146. ASPR TRACIE EMS Infectious Disease Playbook as a reference guide.

III. DEFINITIONS:

A. Transmission Based Precautions: Supplemental infection control measures to be used in addition to Standard Precautions for patients who may be infected or colonized with a communicable disease. Basic infection control to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents.

B. Emergency Medical Dispatcher (EMD): Personnel who receive emergent and non-emergent calls and dispatch responding units to the scene of an incident.

C. Prehospital Responders: Includes any person or agency who responds to the scene of an incident.

D. Screening: A process for evaluating the possible presence of a particular problem.

IV. PROCEDURE

A. Safe response by Emergency Medical Services (EMS) requires a cooperative effort and ongoing assessment to evaluate safety risks by following below:

1. EMDs will identify possible infectious disease patients when taking 911 calls through screening questions and provide potential infectious disease information to responding prehospital emergency personnel prior to arriving on scene.
2. EMD's and prehospital responders should be aware of local disease scenarios, communicable disease surges, clusters, and/or outbreaks. These notifications may be distributed by Ventura County EMS Agency, California Health Alert Network (CAHAN), and/or Public Health "Hot Tips". The screening questions for highly infectious pathogens may be adapted for local area outbreaks.
3. Prehospital responders need to remain vigilant and further evaluate patients when they arrive on-scene to re-assess and determine the appropriate level of precautions. Re-assessment may require the need to change the type of infection control precautions suggested by dispatch when arriving on-scene.
4. Screening for pathogens involves questioning patients about recent travel to high-risk areas and their signs/symptoms. The timeframe for these conditions varies. For example, the screening time frame for Middle East Respiratory Syndrome (MERS) is 14 days but Ebola Virus Disease/Viral Hemorrhagic Fever (EVD/VHF) requires a screening time frame of 21 days. A general timeline of 21 days may be used for suspected infectious disease screening consistency.
5. Fever may be a helpful sign/symptom but should not be used exclusively to determine the type of precaution needed.
6. Avoid direct contact with patients who have a high suspicion of serious communicable disease until the appropriate level of PPE can be determined and safely donned. Strict transmission-based precautions based on the patient's clinical information is essential to avoid contact with infectious bodily fluids, droplets, and airborne particles.
7. If COVID-19 is suspected or novel influenza with potential for pandemic: Refer to Appendix A: Ventura County EMS Agency SARS CoV-2 Prehospital Guidelines.

8. If EVD/VHF/Ebola is suspected, stage at a safe distance. Notify EMS Duty Officer and request augmented response. Refer to Appendix B: Ventura County EMS Agency Ebola Guidelines.
9. Destination hospital must be notified of potential infectious disease by EMS personnel prior to patient arrival. If base hospital contact is made, the base hospital will notify the destination/receiving hospital of patient status and infectious disease precaution level.
10. Responding agencies in the County of Ventura shall assure that employees are properly instructed on the use of protective equipment in accordance with the manufacturer's instructions per Cal OSHA regulations.

V. INFECTIOUS DISEASE PRECAUTION LEVELS

A. All transmission-based precautions include standard precaution measures. These are recommended minimum standards, and providers are encouraged to error on the side of caution when encountering a potentially infectious patient. Refer to Appendix C: CDC PPE for donning and doffing direction. Refer to Appendix D Guidelines for Isolation Precautions.

1. Standard Precautions: Hand hygiene, gloves, mask, eyewear
2. Contact Precautions: Gown
3. Droplet Precautions: Goggles or face shield, mask on patient if possible
4. Airborne Precautions: NIOSH approved N-95, mask on patient if possible
5. Special Respiratory Precautions: NIOSH approved N-95, gown, mask on patient if possible
6. VCEMSA SARS-CoV-2 Guidelines: Augmented Response (Appendix A) - NIOSH approved N-95, goggles or face shield, gown, mask on patient if possible
7. EVD-VHF/Ebola Precautions: Augmented Response (Appendix B) - Stage, notify EMS Duty Officer, and request augmented response

VI. CONSIDERATIONS

A. Resources not immediately needed may consider staging to limit potential infectious disease exposure to personnel.
B. When possible, a mask should be placed on patients with suspected potential infectious respiratory diseases.

C. When a determination of suspected infectious disease is difficult to determine, assume the highest level of contagious threat and use the appropriate level of protection.

D. Prehospital responders may consider assessing infectious disease potential from six feet away when arriving on-scene as appropriate to determine the level of precautions required.

E. If the medical personnel driving the transporting ambulance is not isolated, they must also wear the appropriate respiratory protection during transport even when not in direct patient contact.

F. American Medical Response houses a High-Risk Ambulance (HRA) in Ventura County for augmented medical transport needs. Refer to Appendix D: High Risk Ambulance Operations

G. Patients and their caregivers may find prehospital responders wearing high levels of personal protective equipment (PPE) alarming. Responders should be mindful of this potential and work to reassure patients while taking reasonable measures to address their distress.

H. Hand hygiene is one of the best ways to remove infectious contaminates, avoid getting sick and prevent the spread of infectious disease.

I. Circulate ambulance cabin air and utilize ambulance ventilation system.

J. Unprotected exposure to a suspected/confirmed communicable disease will be reported in accordance with VCEMSA Policy 612-Notification of Exposure to a Communicable Disease.

VII. APPENDICES

i. Ventura County EMS Agency SARS CoV-2 Prehospital Guidelines
Ventura County EMS Agency Ebola Guidelines

ii. CDC PPE

iii. Guidelines for Isolation Precautions

iv. High Risk Ambulance Operations

vi. VCEMSA Policy 612-Notification of Exposure to a Communicable Disease

Trauma Assessment/Treatment Guidelines 705.01

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

A. Rapid trauma survey

1. Airway

a. Maintain inline cervical stabilization

1) Follow spinal precautions per VCEMS Policy 614

b. Open airway as needed

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

c. Suction airway if indicated

2. Breathing

a. Assess rate, depth and quality of respirations

b. If respiratory effort inadequate, assist ventilations with BVM

c. Insert appropriate airway adjunct if indicated

d. Assess lung sounds

e. Initiate airway management and oxygen therapy as indicated

1) Maintain SpO2 ≥ 94%

3. Circulation

a. Assess skin color, temperature, and condition

b. Check distal/central pulses and capillary refill time

c. Control major bleeding

d. Initiate shock management as indicated

4. Disability

a. Determine level of consciousness (Glasgow Coma Scale)

b. Assess pupils

5. Exposure

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

b. Maintain patient body temperature

B. Detailed physical examination

1. Head

a. Inspect/palpate skull

b. Inspect eyes, ears, nose and throat

2. Neck

a. Palpate cervical spine

b. Check position of trachea

c. Assess for jugular vein distention (JVD)

3. Chest

a. Visualize, palpate, and auscultate chest wall

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

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

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

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

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

7. Extremity Trauma
    a. General Treatments
        1) Evaluate CSM distal to injury
            a) If decrease or absence in CSM is present:

(1) Manually reposition extremity into anatomical position

(2) Re-evaluate CSM

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

c) Cover open wounds with sterile dressings

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

e) Splint/elevate extremity with appropriate equipment

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

b. Dislocations

1) Splint in position found with appropriate equipment

c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECTS

1) Stabilize object manually or with bulky dressings

2) Control bleeding if present

d. Femur fractures

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

2) Assess CSM before and after traction splint application

e. Amputations

1) Clean the amputated extremity with NS

2) Wrap in moist sterile gauze

3) Place in plastic bag

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

5) Prevent direct tissue contact with the ice pack

Bites and Stings

BLS Procedures

Animal/insect bites:

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

Snake bites/envenomation:

- Mark the edge of the inflammatory process ASAP and then every 10-15 minutes
- Remove rings and constrictions
- Immobilize the affected part in a ***neutral*** position
- Avoid excessive activity

Bee stings:

- If present, quickly remove stinger
- Apply ice pack

Jellyfish stings:

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

All other marine animal stings:

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

Administer oxygen as indicated

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

ALS Standing Orders

IV access for snake bites

Monitor for allergic reaction or anaphylaxis

Pain Control– per Policy 705.19

Base Hospital Orders Only

Consult with ED Physician for further treatment measures

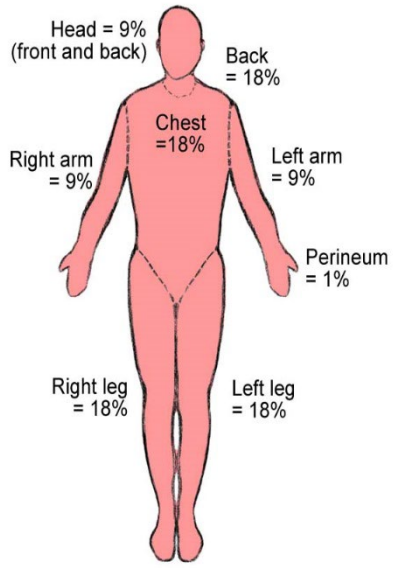
Effective Date: July 1, 2022
Next Review Date: February 28, 2024
Date Revised: February 10, 2022
Last Reviewed: February 10, 2022

DZ S, MD

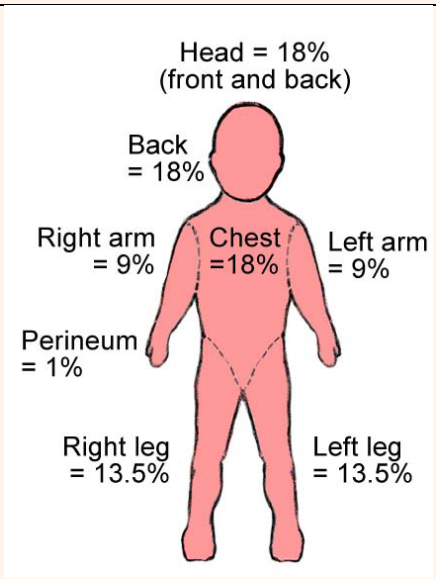
VCEMS Medical Director

Burns

ADULT



PEDIATRIC



BLS Procedures

- Stop the burning process
  - Thermal
    - Put out fire using water or some other non-hazardous, non-flammable liquid. Fire extinguisher may be used.
  - Liquid Chemical
    - Flush area with water.
  - Powdered Chemical
    - Brush off as much as possible prior to flushing area with copious amounts of water.
  - Electrical
    - Turn off power source and safely remove victim from hazard area.
- Remove rings, constrictive clothing and garments made of synthetic material
- If less than 10% Total Body Surface Area (TBSA) is burned, cool with saline dressings.
- For TBSA greater than 10%, cover burned area with dry sterile dressings first, followed by a clean dry sheet.
- Once area is cooled, remove saline dressings and cover with dry, sterile burn sheets
- Elevate burned extremities if possible
- Maintain body heat at all times
- Administer oxygen as indicated

ALS Standing Orders

IV/IO access
Pain Control – per Policy 705.19

If TBSA greater than 10% or hypotension is present:

- **Normal Saline**
  - IV/IO bolus – 1 Liter

IV/IO access
Pain Control – per Policy 705.19

If TBSA greater than 10% or hypotension is present:

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

Base Hospital Orders Only

Consult with ED Physician for further treatment measures

Additional Information

- Hypothermia is a concern in patients with large body surface area burns. As moist dressings increase the risk of hypothermia, medication is the preferred method of pain control in these patients.

Effective Date: July 1, 2022
Next Review Date: February 28, 2024

Date Revised: February 10, 2022
Last Reviewed: February 10, 2022

VCEMS Medical Director

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 Standing Orders

Perform 12-lead ECG

- Expedite transport to closest STEMI Receiving Center if monitor interpretation meets the manufacturer guidelines for a positive STEMI ECG and/or physician states ECG is positive for STEMI.
- Notify Base hospital within 10 minutes of monitor interpretation of a positive STEMI ECG
- Document all initial and ongoing rhythm strips and ECG changes

For 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

IV/IO access

If pain persists and not relieved by NTG:

- **Pain Control**– per policy 705.19
  - Maintain SBP greater than 90 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

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

- **Epinephrine 10mcg/mL**
  - IV/IO slow push 1mL (10mcg) every 2 minutes
  - Titrate to SBP of greater than or equal to 90mm/Hg

For ventricular irritability resulting in runs of ventricular tachycardia (>3 consecutive ventricular complexes):

- **Amiodarone IV/IOPB - 150 mg in 50 mL D5W infused over 10 minutes**

Base Hospital Orders Only

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

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.

Effective Date: July 1, 2022
Next Review Date: February 28, 2024
Date Revised: January 16, 2020
Last Reviewed: February 10, 2022

VCEMS Medical Director

Crush Injury/Syndrome

BLS Procedures

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

ALS Standing Orders

Potential for Crush Syndrome
- IV/IO access
- Release compression
- Monitor for cardiac dysrhythmias

ADULT

Crush Syndrome
- Initiate 2nd IV/IO access
- **Normal Saline**
  - IV/IO bolus – 1 Liter
- **Sodium Bicarbonate**
  - IV/IO mix – 1 mEq/kg
    - Added to 1st Liter of Normal Saline
- **Albuterol**
  - Nebulizer – 5 mg/6 mL
    - Repeat as needed
- **Pain Control**– Per Policy 705.19
- Release compression
- Monitor for cardiac dysrhythmias
- For cardiac dysrhythmias:
  - **Calcium Chloride**
    - IV/IO slow push – 1 g over 1 min

For continued shock
- *Repeat* **Normal Saline**
  - IV/IO bolus – 1 Liter

For persistent hypotension after fluid bolus:
- **Epinephrine 10 mcg/mL**
  - IV/IO slow push - 1 mL (10 mcg) every 2 minutes
  - Titrate to SBP of greater than or equal to 90 mm/Hg

PEDIATRIC

Crush Syndrome
- Initiate 2nd IV/IO access if possible or establish IO
- **Normal Saline**
  - IV/IO bolus – 20 mL/kg
- **Sodium Bicarbonate**
  - IV/IO mix– 1 mEq/kg
    - Added to 1st Normal Saline bolus
- **Albuterol**
  - **Patient ≤ 30 kg**
    - Nebulizer – 2.5 mg/3 mL
      - Repeat as needed
  - **Patient > 30 kg**
    - Nebulizer – 5 mg/6 mL
      - Repeat as needed
- **Pain Control**– Per Policy 705.19
- Release compression
- Monitor for cardiac dysrhythmias
- For cardiac dysrhythmias:
  - **Calcium Chloride**
    - IV/IO slow push – 20 mg/kg over 1 min

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

For persistent hypotension after fluid bolus:
- **Epinephrine 10 mcg/mL**
  - IV/IO slow push - 0.1 mL/kg (1 mcg/kg) every 2 minutes
  - Max single dose of 1 mL or 10 mcg
  - Titrate to SBP of greater than or equal to 80 mm/Hg

Base Hospital Orders Only

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

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

Effective Date: July 1, 2022
Next Review Date: February 28, 2024

Date Revised: February 10, 2022
Last Reviewed: February 10, 2022

VCEMS Medical Director

Hypovolemic Shock

ADULT	PEDIATRIC
BLS Procedures	
Place patient in supine position Administer oxygen as indicated	
ALS Standing Orders	

IV/IO access
 	
Normal Saline
• IV/IO bolus – 1 Liter
  ○ Repeat x 1 for persistent signs of shock
 	
<u>Traumatic Injury</u>
• Do not delay transport for IV/IO attempts
• Tranexamic Acid – For patients 15 years of age and older as indicated in VCEMS Policy 734
  ○ IV/IOPB - 1g TXA in 100mL NS over 10 minutes
• Refer to Policy 705.01- Trauma Treatment Guidelines, for fluid administration
  ○ Goal is to maintain SBP of ≥ 80 mmHg
  ○ Patients 65 years and older, maintain SBP of ≥ 100 mmHg
	IV/IO access
	
	Normal Saline
	• IV/IO bolus – 20 mL/kg
	  ○ Repeat x 1 for persistent signs of shock
	
	<u>Traumatic Injury</u>
	• Do not delay transport for IV/IO attempts
	• Refer to Policy 705.01- Trauma Treatment Guidelines, for fluid administration.
	  ○ Goal is to maintain minimum systolic blood pressure for respective age in Handtevy.
	  ○

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

Effective Date: July 1, 2022
Next Review Date: April 30, 2024

Date Revised: April 14, 2022
Last Reviewed: April 14, 2022

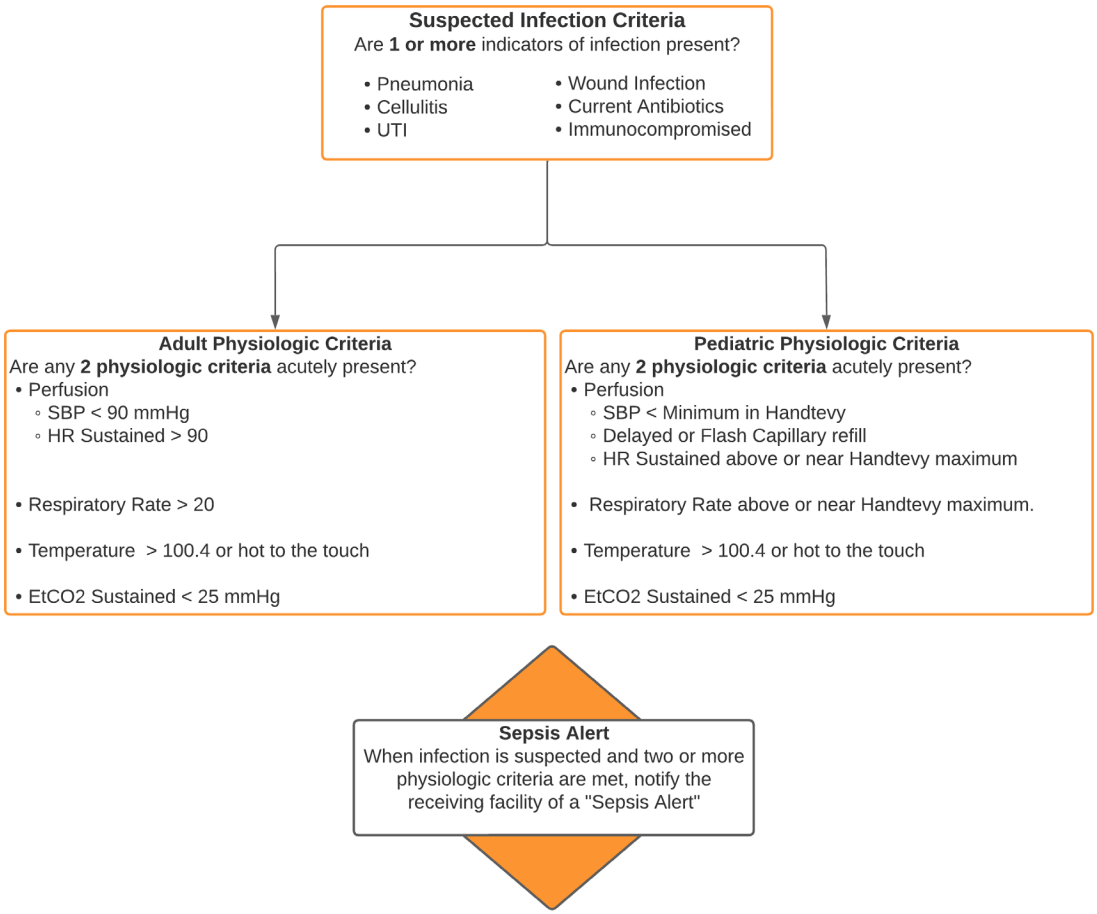
VCEMS Medical Director

Sepsis Alert

ADULT | PEDIATRIC

BLS Procedures

- Administer oxygen as indicated



ALS Standing Orders

Sepsis Suspected
IV/IO Access
- Normal Saline
  - IV/IO Bolus - 1 Liter

Suspected Shock
- Epinephrine 10 mcg/mL
  - 1 mL (10 mcg) q 2 minutes, slow IV/IO push
  - Titrate to SBP of greater than or equal to 90 mm/Hg

Sepsis Suspected
IV/IO Access
- Normal Saline
  - IV/IO Bolus - 20 mL/kg

Suspected Shock
- Epinephrine 10 mcg/mL
  - 0.1 mL/kg (1 mcg/kg) q 2 minutes, slow IV/IO push
  - Max single dose of 1 mL or 10 mcg
  - Titrate to SBP of greater than or equal to 80 mm/Hg

Base Hospital Orders Only

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

Effective Date: July 1, 2022
Next Review Date: June 30, 2024

Date Revised: June 9, 2022
Last Reviewed: June 9, 2022

VCEMS Medical Director

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Needle Thoracostomy		Policy Number: 715
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director	Daniel Shepherd, M.D.	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 2010 February 10, 2022 February 10, 2022 February 28, 2024	Effective Date: July 1, 2022

I. Purpose: To define the indications, procedure and documentation for needle thoracostomy use by paramedics.

II. Authority: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Sections 100145 and100169.

III. Policy: Paramedics may perform needle thoracostomy on patients with a suspected tension pneumothorax in accordance with this policy.

IV. Procedure:

A. Indications

1. Patients with **ALL** of the following:
   a. Clinical suspicion of pneumothorax (e.g., trauma, dyspnea, chest pain),
   b. Signs of hypoperfusion and systolic blood pressure less than 90 mmHg (adults) or below minimum systolic for respective age in Handtevy (pediatrics).
   c. Absent or significantly decreased breath sounds on the affected side.
2. Patients in traumatic cardiac arrest:
   a. Bilateral needle thoracostomy should be performed when patients meet criteria for resuscitation per policy 606 and have known or suspected torso trauma.

B. Contraindications: None in this setting

C. Equipment

1. Antiseptic solution
2. 10 ml syringe
3. Adults and pediatric patients over 40kg: 3-3.5 inch (8.0-8.5 cm), 10 to 14 gauge over-the-needle catheter
   Peds under 40kg: 1.25-inch (3cm), 14 to 16 gauge over-the-needle catheter
4. Connection tubing
5. Heimlich valve
6. Tape

D. Placement

1. Attach the syringe to the needle/catheter.
2. Identify and prep the site with antiseptic solution:

Preferred Adult Site:

- The lateral placement is the preferred method which is the fourth intercostal space in the anterior-axillary line (lateral to nipple).

Preferred Adult *Alternative* Site and Preferred Pediatric Site:

- If unable to access lateral placement due to patient size, position, or failed attempt, locate the second intercostal space in the mid-clavicular line.

3. Insert the needle/catheter perpendicular to the skin over the rib and direct it just over the top of the rib into the intercostal space.
4. After inserting the needle under the skin, maintain negative pressure in the syringe.
5. Advance the needle/catheter through the parietal pleura until a “pop” is felt and/or air or blood enters the syringe, then advance **ONLY** the catheter (not the syringe/needle) until the catheter hub is against the skin.

CAUTION: Do not reinsert needle into cannula due to danger of shearing cannula.

6. Hold the catheter in place and remove and discard the syringe and needle.
7. Attach tubing and Heimlich valve.
8. Secure the catheter hub to the chest wall with dressings and tape.
9. Reevaluate the patient (VS, lung sounds).

E. Documentation

1. All needle thoracostomy attempts must be documented in the Ventura County Electronic Patient Care Reporting System (VCePCR).
2. Documentation will include location, size of equipment, number of attempts, success, complications, patient response and any applicable comments.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Use of Pre-existing Vascular Device (PVAD)		Policy Number: 716
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: Date Revised: Last Reviewed: Review Date:	March 2, 1992 June 9, 2022 June 9, 2022 June 30, 2022	Effective Date: July 1, 2022

I. PURPOSE: To define the use of pre-existing vascular access devices (PVAD) by Paramedics in the prehospital setting.

II. AUTHORITY: Authority: California Health and Safety Code, §1798, §1798.2; §1798.160 and §1798.170, and California Code of Regulations, Title 22, §100145 and §100146.

III. POLICY: PVADs may be used in the prehospital setting as set forth by this document.

IV. Definition: A PVAD is a heparin/saline lock or an indwelling catheter/device placed into a vein, to provide vascular access for those patients requiring long term intravenous therapy or hemodialysis. Internal subcutaneous indwelling devices are not to be accessed by prehospital field personnel.

V. Procedure: After successful completion of an approved Ventura County training module, a Paramedic may access a PVAD and administer normal saline and medications, for a patient with the following conditions:

A. Peripheral Vein Heparin/Saline Lock

1. Any conditions requiring intravenous fluids and/or medications

B. Central line devices with externally visible access ports – PICC, tunneled catheters, or temporary dialysis catheters

1. Urgent need to administer fluids and/or medications which can only be given by the IV route and a peripheral IV site is not readily/immediately available.

C. Hemodialysis Fistula (to be used only in the absence of IO, peripheral, or central IV access):

1. Urgent need to administer fluids and/or medications which can only be given by the IV route and an alternate IV site is not readily/immediately available. Attempt to aspirate at least 5 ml of blood prior to administering any medications.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Patients After Conducted Electrical Weapon (TASER) Use	Policy Number: 725
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director Daniel Shepherd, M.D.	Date: July 1, 2022
Origination Date: August 10, 2006 Date Revised: June 9, 2022 Date Last Reviewed: June 9, 2022 Next Review Date: June 30, 2024	Effective Date: July 1, 2022

I. PURPOSE: To provide a framework for the pre-hospital treatment and transport of patients after TASER deployment.

II. AUTHORITY: Health and Safety Code, Sections 1797.214, 1797.220, 1798, and 1798.200, California Code of Regulations, Title 22, Section 100169.

III. POLICY: Law enforcement officers may remove the TASER probes and may choose to transport individuals in custody to an emergency department. On occasion, EMS personnel may be called to evaluate, treat and/or transport patients with or without the TASER probes in place.

A. When requested by law enforcement and absent any contraindications as outlined in policy, TASER probes may be removed by EMS personnel.

B. If EMS transport is indicated or requested by law enforcement EMS personnel should transport to the closest receiving facility, appropriate specialty care facility, or the hospital requested by law enforcement.

IV. PROCEDURE:

A. Be sure the scene has been deemed safe and secured by law enforcement before evaluating and treating the patient.

B. Before touching any patient where the Taser has been deployed, ensure law enforcement has disconnected cartridge from the handheld unit.

C. Any injuries or medical conditions will be treated according to the appropriate treatment protocol.

D. If the transporting paramedic determines that the patient is a risk to him/herself and/or the ambulance personnel, law enforcement officer(s) may be requested to accompany the patient.

E. TASER Probe Removal:

If one or both of the TASER probes requires removal for safe transportation or if removal requested by law enforcement:

1. Procedure must be witnessed by the arresting law enforcement officer. Identify the appropriate officer and confirm they are ready to witness the procedure.
2. Verify the cartridge has been removed from the handle or has been cut.
3. Used taser probes shall be considered a sharp biohazard, similar to used hypodermic needle. Standard safety precautions should be taken.
4. Place one hand on the patient in the area where the probe is embedded and stabilize the skin surrounding the puncture site between two fingers. With your other hand, in one fluid motion pull the probe straight out from the puncture site.
5. Reinsert TASER probes, point down, into the discharged air cartridge and hand it to the law enforcement officer.
6. Use appropriate antiseptic wipe to cleanse the skin surrounding the puncture site.
7. Apply direct pressure for bleeding and apply a sterile dressing to the wound site.
8. Assess for any injuries that may need medical attention and seek appropriate level of care.

F. Contraindications:

1. If the Taser has penetrated a sensitive area (e.g. head, face, neck, hand bone, axilla, groin, female breast), Do NOT remove the probe as injury may occur to bone, nerves, blood vessels, or an eye. Transport the patient to the ED in an appropriate position.

G. Documentation:

1. Any EMS incidents resulting from TASER deployment or probe removal will be documented in the Ventura County Electronic Patient Care Reporting System Refer to policy 1000: Documentation of Prehospital Care.
2. Incidents that do not result in EMS transport will be documented as outlined in VCEMS policy 603: Refusal of EMS Services.
3. If TASER probes are removed by EMS personnel documentation will include that procedure as well as the requesting law enforcement officer and/or agency.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Supraglottic Airway Devices	Policy Number: 729
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director: Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: November 13, 2014 Date Revised: January 16, 2020 Date Last Reviewed: February 10, 2022 Review Date: February 28, 2024	Effective Date: July 1, 2022

I. Purpose: To define the indications and use of supraglottic airway devices.

II. Authority: California Health and Safety Code, §1798, §1798.2; §1798.160 and §1798.170, and California Code of Regulations, Title 22, §100145 and §100146.

III. Policy: Paramedics may utilize the VCEMSA approved supraglottic airway device (SAD) for adult and pediatric patients according to this policy and Policies 705 and 710. The VCEMSA approved SAD may be used as the primary advanced airway device by paramedics who opt to use it during the care of patients for whom they believe it would be the most appropriate airway management device. Alternately, the VCEMSA approved SAD shall be used if BVM ventilation is inadequate and attempts at endotracheal intubation have failed.

IV. Procedure:

A. Indications:

1. Cardiac arrest.
2. Respiratory arrest or severe respiratory compromise AND absent gag reflex.

B. Contraindications:

1. Intact gag reflex.
2. Caustic ingestion
3. Unresolved complete airway obstruction
4. Trismus or limited ability to open the mouth such that the device cannot be Inserted
5. Oral trauma
6. Distorted anatomy that prohibits proper placement (e.g. oropharyngeal mass or abscess)

C. Preparation:

1. Sizing:

A. Choose correct size based on patient's weight and manufacturer's recommendations.

2. There will be no more than 2 attempts, each no longer than 40 seconds.

3. For patients in cardiac arrest, chest compressions will not be interrupted.

5. Generously lubricate the cuff with a water-based lubricant.

D. Placement:

1. Remove dentures if present

2. Tilt the patient's head back - unless there is a suspected cervical spine injury.

3. Open the patient's mouth and insert the SAD per the manufacturer's recommendations. A laryngoscope may be used if laryngoscopy is performed to inspect for foreign body.

4. Gently advance the SAD into position in the pharynx by applying forward pressure on the tip of the tube while lifting up on the jaw

5. Return head to neutral position.

6. Attach capnography airway adapter and bag-valve device and verify placement by capnography waveform.

9. If 2 attempts at SAD placement are unsuccessful, attempt again to ventilate the patient with BVM.

10. Secure the SAD with appropriate strap.

11. If patient vomits, do not remove SAD. May turn patient on side, suction both SAD and oropharynx.

E. Documentation:

1. Documentation per Policy 1000.

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Tourniquet Use		Policy Number: 731
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Review Date:	July 2010 July 10, 2018 April 14, 2022 April 30, 2024	Effective Date: July 1, 2022

I. Purpose: To define the indications, procedure and documentation for tourniquet use by EMTs and paramedics.

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

III. Policy: EMTs and Paramedics may utilize tourniquets on patients in accordance with this policy.

IV. Procedure:

A. Indications

1. Life threatening extremity hemorrhage that cannot be controlled by other means.

B. Contraindications

1. Non-extremity hemorrhage.
2. Proximal extremity location where tourniquet application is not practical.

C. Relative Contraindications

1. AV fistulas: Bleeding fistulas are best managed with firm direct pressure. Applying a tourniquet can ruin a fistula and should be a last resort. Base contact prior to applying a tourniquet is encouraged but not required.

D. Tourniquet Placement:

1. Visually inspect injured extremity and avoid placement of tourniquet over joint, angulated or open fracture, stab or gunshot wound sites.
2. Assess and document circulation, motor and sensation distal to injury site.
3. Apply tourniquet proximal to wound (usually 2-4 inches).
4. Tighten tourniquet rapidly to least amount of pressure required to stop bleeding.
5. Cover wound with appropriate sterile dressing and/or bandage.
6. Do not cover tourniquet- the device must be visible.
7. Re-assess and document absence of bleeding distal to tourniquet.

8. Remove any improvised tourniquet that may have been previously applied.
9. Tourniquet placement time must be documented on the tourniquet device.
10. Ensure receiving facility staff is aware of tourniquet placement and time tourniquet was placed.

D. Tourniquet removal, replacement, or repositioning

1. BLS providers may reposition an improperly placed tourniquet or replace malfunctioning device. Only ALS personnel may formally remove a tourniquet to assess if it is still necessary.
2. Indications
   a. Improperly placed tourniquet
   b. Poorly functioning device
   c. Absence of bleeding distal to the tourniquet should be confirmed after manipulation, adjustment, or removal.
3. Procedure
   a. Obtain IV/IO access
   b. Maintain continuous ECG monitoring.
   c. If repositioning or replacing a tourniquet, place a second tourniquet proximal to the first device in the appropriate location.
   d. Hold firm direct pressure over wound for at least 5 minutes before releasing a tourniquet.
   e. Gently release the initial tourniquet and monitor for reoccurrence of bleeding.
   f. If appropriate, document the time the tourniquet was released.
   g. Bandage wound and re-assess and document circulation, motor and sensation distal to the wound site regularly.
   h. If bleeding resumes, requiring a tourniquet, re-application will be in accordance with application procedures outlined in Section IV of this policy.

E. Documentation

1. All tourniquet uses must be documented in the Ventura County Electronic Patient Care Reporting System.
2. Documentation will include location of tourniquet, time of application, and person at the receiving hospital to whom the tourniquet is reported.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Use of Restraints		Policy Number 732
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Review Date:	April 1, 2011 April 14, 2022 April 14, 2022 April 30, 2024	Effective Date: July 1, 2022

I. PURPOSE: To provide guidelines for the use of physical restraints and therapeutic sedation during the course of emergency medical treatment or during an inter-facility transport (IFT) for patients who are violent or potentially violent to themselves or others.

II. AUTHORITY: California Health and Safety Code, Sections: 1797.2, 1798; California Code of Regulations, Title 22, Sections: 100075, 100147, 100160; California Administrative Code, Title 13, Section 1103.2.

III. DEFINITIONS:

A. Verbal De-escalation : Any verbal communication from a pre-hospital provider to a patient utilized for the sole purpose of limiting or inhibiting the patient's behavior.

B. Physical Restraint: Any method in which a technique or piece of equipment is applied to the patient's body in a manner that reduces the subject's ability to move his arms, legs, head, or body.

C. Therapeutic Sedation: Any pharmaceutical administered by healthcare providers that is used specifically for the purpose of limiting or controlling a person's behavior or movement.

IV. POLICY:

A. Physical Restraint

1. Prior to use of physical or therapeutic sedation, every attempt to calm a patient should be made using verbal de-escalation and/or nonphysical means.

2. Perform a physical assessment and obtain a medical history as soon as safe and appropriate. Treat any underlying conditions per VCEMS 705 Treatment guidelines.

3. If necessary, apply soft physical restraints while performing assessment and obtaining history.
4. Padded soft restraints shall be the only form of restraints utilized by EMS providers.
5. Restraints shall be applied in a manner that does not compromise vascular, neurological, or respiratory status.
6. Extremities in which restraints are applied shall be continuously monitored for signs of decreased neurologic and vascular function
7. Patients shall not be transported in a prone position. The patient's position shall be in a manner that does not compromise vascular or respiratory status at any point. Additionally, the patient position shall not prohibit the provider from performing any and all assessment and treatment tasks.
8. Restraints shall be attached to the frame of the gurney.
9. Handcuffs applied by law enforcement require that an officer accompany the patient to ensure provider and patient safety and to facilitate removal of the restraint device if a change in the patient's condition requires it.
    a. If the patient is restrained with handcuffs and placed on a gurney, both arms shall be restrained to the frame of the gurney in a manner that in no way limits the ability to care for the patient. The patient should not be placed on gurney with hands or arms restrained behind patient's back.
    b. In the event that the law enforcement agency is not able to accompany the patient in the ambulance, a law enforcement unit must follow the ambulance in tandem along a predetermined route to the receiving facility.

B. Therapeutic Sedation

1. If while in restraints, the patient demonstrates behavior that may result in harm to the patient or providers, therapeutic sedation should be considered.
    a. Refer to VCEMS Policy 705: Behavioral Emergencies for guidance and administration of appropriate therapeutic sedation.
    b. It is important again to investigate and treat possible underlying causes of erratic behavior (e.g. hypoglycemia, trauma, meningitis).

C. Required Documentation

1. Instances in which physical or therapeutic sedation are applied shall be documented according to VCEMS Policy 1000. Required documentation shall include:
    a. Type of restraint applied (e.g. soft padded restraint, medication, handcuffs by law enforcement)
    b. Reason physical restraints or therapeutic sedation were utilized
    c. Location on patient physical restraints were utilized
    d. Personnel and agency applying physical restraints or administering therapeutic sedation
    e. Time restraints were applied, or therapeutic sedation was administered
    f. Every 10-minute neurologic and vascular checks
2. Base Hospital shall be notified in all circumstances in which physical restraints and/or therapeutic sedation is utilized.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Automated External Defibrillation (AED) Service Provider Standards		Policy Number 1301
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: July 1, 2022
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: July 1, 2022
Origination Date: Date Revised: Date Last Reviewed: Review Date:	September 14, 2000 April 14, 2022 April 14, 2022 April 30, 2025	Effective Date: July 1, 2022

I. PURPOSE

A. To provide for system wide lay rescuer automated external defibrillation standards, review and oversight by Ventura County Emergency Medical Services.

B. To provide structure to programs implementing automated external defibrillators for use by lay persons treating victims of cardiac arrest.

C. To provide for integration of public access defibrillation (PAD) programs in the established emergency medical services system.

D. To provide a mechanism for AED quality improvement throughout the Ventura County EMS System.

II. AUTHORITY

A. California Health and Safety Code Sections 1797.5, 1797.107, 1797.190, 1797.196 and 104113.

III. SERVICES PROVIDED AND APPLICABILITY

AED programs shall be operated consistent with VCEMS policy and California state statutes and regulations.

IV. DEFINITIONS

A. “AED Service Provider” means any agency, business, organization or individual who purchases an AED for use in a medical emergency involving an unconscious person who is not breathing normally. This definition does not apply to individuals who have been prescribed an AED by a physician for use on a specifically identified individual.

B. “Automated External Defibrillator” or “AED” means an external defibrillator that, after user activation, is capable of cardiac rhythm analysis and will charge and deliver a shock, either automatically or by user interaction, after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.

C. "Lay Rescuer" means any person, not otherwise licensed or certified to use the automated external defibrillator, who has met the training standards of this policy.

D. "Cardiopulmonary resuscitation" or "CPR" means a basic emergency procedure for life support, consisting of artificial respiration, manual external cardiac massage, and maneuvers for relief of foreign body airway obstruction.

E. "Internal Emergency Response Plan" means a written Internal Emergency Response Plan of action which utilizes responders within a facility to activate the "9-1-1" emergency system, and which provides for the access, coordination, and management of immediate medical care to seriously ill or injured individuals.

F. "Health studio" means a facility permitting the use of its facilities and equipment or access to its facilities and equipment, to individuals or groups for physical exercise, body building, reducing, figure development, fitness training, or any other similar purpose, on a membership basis. "Health studio" does not include a hotel or similar business that offers fitness facilities to its registered guests for a fee or as part of the hotel charges.

V. AED VENDOR REQUIREMENTS:

Any AED vendor who sells an AED to an AED Service Provider shall:

A. Notify the AED Service Provider, at the time of purchase, in writing of the AED Service Provider's responsibility to comply with this policy.

B. Provide to the acquirer of the AED all information governing the use, installation, operation, training, and maintenance of the AED.

VI. GENERAL TRAINING PROVISIONS: APPLICATION AND SCOPE

A. In an emergency situation, always call 9-1-1 first. A 9-1-1 operator can provide directions on how you can help someone experiencing sudden cardiac arrest. AEDs are not difficult to use, but **training in the use of AEDs is highly recommended**. This training, in connection with CPR training, is offered by major health organizations such as the American Heart Association and Red Cross as well as a number of private companies.

B. The training standards prescribed by this policy shall apply to employees of the AED service provider and not to licensed, certified or other prehospital emergency medical care personnel as defined by Section 1797.189 of the California Health and Safety Code.

VII. AED TRAINING PROGRAM REQUIREMENTS:

CPR and AED training shall comply with the American Heart Association or American Red Cross CPR and AED Guidelines. The training shall include the following topics and skills:

A. Basic CPR skills;

B. Proper use, maintenance and periodic inspection of the AED;

C. The importance of;

1. Early activation of an Internal Emergency Response Plan,
2. Early CPR,
3. Early defibrillation, and
4. Early advanced life support

D. Overview of the local EMS system, including 9-1-1 access, and interaction with EMS personnel.

E. Assessment of an unconscious patient, to include evaluation of airway and breathing, to determine appropriateness of applying and activating an AED.

F. Information relating to defibrillator safety precautions to enable the individual to administer a shock without jeopardizing the safety of the patient or the Lay Rescuer or other nearby persons to include, but not limited to;

1. Age and weight restrictions for use of the AED,
2. Presence of water of liquid on or around the victim,
3. Presence of transdermal medications, and
4. Implantable pacemakers or automatic implantable cardioverter-defibrillators;

G. Recognition that an electrical shock has been delivered to the patient and that the defibrillator is no longer charged.

H. Rapid, accurate assessment of the patient's post-shock status to determine if further activation of the AED is necessary; and,

I. The responsibility for continuation of care, such as continued CPR and repeated shocks, as indicated, until the arrival of more medically qualified personnel.

The training standards prescribed by this section shall not apply to licensed, certified or other prehospital emergency medical care personnel as defined by Section 1797.189 of the California Health and Safety Code.

VIII. AED SERVICE PROVIDER OPERATIONAL REQUIREMENTS

A. An AED Service Provider shall do all of the following:

1. Comply with all regulations governing the placement of an AED.
2. Notify an agent of the local EMS agency of the existence, location, and type of AED acquired. (See attachment A)
3. Ensure that the AED is maintained and tested according to the operation and maintenance guidelines set forth by the manufacturer.

4. Ensure that the AED is tested at least biannually and after each use.
5. Ensure that an inspection is made of all AEDs on the premises at least every 90 - days for potential issues related to operability of the device, including a blinking light or other obvious defect that may suggest tampering or that another problem has arisen with the functionality of the AED.
6. Ensure that records of the maintenance and testing required pursuant to this paragraph are maintained.
7. Notify an agent of the local EMS agency of any application and activation of the AED. (see Attachment B)

B. When an AED is placed in a building, the building owner shall do all of the following:
   1. At least once a year, notify the tenants as to the location of the AED units and provide information to tenants about who they can contact if they want to voluntarily take AED or CPR training.
   2. At least once a year, offer a demonstration to at least one person associated with the building so that the person can be walked through how to use an AED properly in an emergency. The building owner may arrange for the demonstration or partner with a nonprofit organization to do so.
   3. Next to the AED, post instructions, in no less than 14-point type, on how to use the AED.

C. A medical director or other physician and surgeon is not required to be involved in the acquisition or placement of an AED.

D. When an AED is placed in a public or private K–12 school, the principal shall ensure that the school administrators and staff annually receive information that describes sudden cardiac arrest, the school's emergency response plan, and the proper use of an AED. The principal shall also ensure that instructions, in no less than 14-point type, on how to use the AED are posted next to every AED. The principal shall, at least annually, notify school employees as to the location of all AED units on the campus.

VIIII. HEALTH STUDIO AED SERVICE PROVIDER OPERATIONAL REQUIREMENTS

A. A Health Studio AED Service Provider shall do all of the following:
   1. Every health studio, as defined, shall acquire, maintain, and train personnel in the use of, an automatic external defibrillator pursuant to this section.
   2. Comply with all regulations governing the placement of an automatic external defibrillator.

3. Ensure all of the following:
   a. The automatic external defibrillator is maintained and regularly tested according to the operation and maintenance guidelines set forth by the manufacturer, the American Heart Association, or the American Red Cross, and according to any applicable rules and regulations set forth by the governmental authority under the federal Food and Drug Administration and any other applicable state and federal authority.
   b. The automatic external defibrillator is checked for readiness after each use and at least once every 30 days if the automatic external defibrillator has not been used in the preceding 30 days. The health studio shall maintain records of these checks.
   c. A person who renders emergency care or treatment to a person in cardiac arrest by using an automatic external defibrillator activates the emergency medical services system as soon as possible and reports the use of the automatic external defibrillator to the licensed physician and to the local EMS agency.
   d. For every automatic external defibrillator unit acquired, up to five units, no less than one employee per automatic external defibrillator unit shall complete a training course in cardiopulmonary resuscitation and automatic external defibrillator use that complies with the regulations adopted by the Emergency Medical Services Authority and the standards of the American Heart Association or the American Red Cross. After the first five automatic external defibrillator units are acquired, for each additional five automatic external defibrillator units acquired, a minimum of one employee shall be trained beginning with the first additional automatic external defibrillator unit acquired. Acquirers of automatic external defibrillator units shall have trained employees who should be available to respond to an emergency that may involve the use of an automatic external defibrillator unit during staffed operating hours. Acquirers of automatic external defibrillator units may need to train additional employees to ensure that a trained employee is available at all times.
   e. There is a written plan that exists that describes the procedures to be followed in the event of an emergency that may involve the use of an automatic external defibrillator, to ensure compliance with the requirements of this section. The written plan shall include, but not be limited to, immediate notification of 911.

and trained office personnel at the start of automatic external defibrillator procedures.

Attachment A

Ventura County EMS Agency
Notice of New Public Access Defibrillation Program

Location of AED	
Name of Building / Business	
Address of Building City, State, Zip	
Floor and/or AED Location Description	
Is AED in public view (yes/no)	
Can public access the AED (yes/no)	
Make/Model of AED	
AED Serial Number	

On-Site Contact Information	
Name of On-Site Contact	
Email Address of On Site Contact	
Phone Number of On-Site Contact	
Mailing Address of On-Site Contact (if different from Business)	

☐ Please check if you wish to be excluded from our Pulse Point Database.
For more information on the Pulse Point Program, please visit:
http://www.pulsepoint.org/

Please complete a separate form for each AED Site. Additional locations on the same site can be listed on page 2

Return this completed form to:
AED Program, Ventura County EMS Agency,
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036-0619.
Fax: 805-981-5300
email to: EMSAgency@ventura.org

Please call 805-981-5301 with any questions.

For Internal Use Only	Received	Date:	By:
PSAP Notified		Date	By

Requirements for acquiring and placing a public access AED are located in Sections 1797.196 and 104113 of the California Health and Safety Code and 1714.21 of the Civil Code.

Additional Locations on the Same Site

Location of AED	
Building, Floor and/or Room AED Location Description	
Is AED in public view (yes/no)	
Can public access the AED (yes/no)	
Make/Model of AED	
AED Serial Number	

Location of AED	
Building, Floor and/or Room AED Location Description	
Is AED in public view (yes/no)	
Can public access the AED (yes/no)	
Make/Model of AED	
AED Serial Number	

Location of AED	
Building, Floor and/or Room AED Location Description	
Is AED in public view (yes/no)	
Can public access the AED (yes/no)	
Make/Model of AED	
AED Serial Number	

Location of AED	
Building, Floor and/or Room AED Location Description	
Is AED in public view (yes/no)	
Can public access the AED (yes/no)	

[illegible]of AED	
[illegible]umber	

Attachment B

Ventura County EMS Agency
REPORT OF CPR OR AED USE

AED Program (location name)	
AED Provider (defibrillator user)	
Place of Occurrence (address and specific site)	
Date Incident Occurred	
Time of Incident	
Patient's Name (if able to determine)	
Patient's Age (Estimate if unable to determine)	
Patient's Sex (Male or Female)	
Time (Indicate best known or approximated time lapse between events):	
• Witnessed arrest to CPR	min(s)
• Witnessed arrest to 9-1-1 Called	min(s)
• Witnessed arrest to first shock	min(s)
• Patient contact to first shock	min(s)
• 9-1-1 to arrival on scene	min(s)
• 9-1-1 to first shock	min(s)
Total number of defibrillation shocks	

Was the cause of the arrest determined?	Yes	No
Was the cause of the arrest cardiac?	Yes	No
Was the arrest witnessed?	Yes	No
Was bystander CPR implemented?	Yes	No
Was there any return of spontaneous circulation?	Yes	No

Please attach any additional information that you think would be helpful.

This form must be completed and sent to Ventura County EMS within 96 hours of a cardiac arrest incident at an AED site. Send this completed form to:

Ventura County EMS - AED Program
2220 E. Gonzales Road, Suite 200
Oxnard, CA 93036-0619

Phone: 805-981-5301 **FAX: 805-981-5300** **email: EMSAgency@ventura.org**

Office Use Only

• Date Received by EMS Agency	

• Patient prehospital outcome	
• Patient discharged from hospital?	