In-person **2240 E. Gonzales Road #200** **Oxnard, CA**	Pre-hospital Services Committee Agenda	February 8, 2024 9:30 a.m.

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	A. Other	
V.	**New Business or Policies for Review *with Proposed Changes***	
	A. 01XX – EMS Education Committee Operating Guidelines	Chris Rosa
	B. 410 – ALS Base Hospital Standards	Steve Carroll
	C. 420 – Receiving Hospital	Steve Carroll
	D. 705.04 – Behavioral Emergencies	Adriane Gil-Stefansen
	E. 705.05 – Bites and Stings	Andrew Casey
	F. 732 – Use of Restraints	Adriane Gil-Stefansen
VI.	**Old Business**	
	A. N/A	
VII.	**Informational/Discussion Topics or Policies Approved at Specialty Care Committees**	
	A. NREMT Pass rates	Chris Rosa
VIII.	**Policies Due for Review (*No proposed changes*)**	
	A. 100 – Emergency Medical Services, Local Agency	
	B. 504 – BLS and ALS Unit Equipment and Supplies	
	C. 603 – Refusal of EMS Services	
	D. 705.06 - Burns	
	E. 705.11 – Crush Injury/Syndrome	
	F. 736 – Leave at Home Naloxone	
	G. 1605 – Naloxone Administration by PSFA Personnel	
IX.	**Agency Reports**	
	A. Fire Departments	
	B. Ambulance Providers	
	C. Base Hospitals	
	D. Receiving Hospitals	
	E. Law Enforcement	
	F. ALS Education Program	
	G. EMS Agency	
	H. Other	
X.	**Closing**	

In Person 2240 E. Gonzales rd. #200 Oxnard	Pre-hospital Services Committee Minutes	December 14, 2023 9:30 a.m.

Topic	Discussion	Action	Approval
I. Introductions	GCA introduction – Sophie Elliot new field representative.		
II. Approve Agenda		Approved	Motion: Ira Tilles Seconded: Todd Larsen Passed: unanimous
III. Minutes	No changes	Approved	Motion: Chris Sikes Seconded: Todd Larsen Passed: unanimous
IV. **Medical Issues**	None		
A. Other	None		
V. New Business			
A. 303 – EMT Optional Skills	**Chris Rosa** – Added language on page 3 about what should be reviewed and where the emphasis should be. Clarifying language to line up with regs. Tie in 303 accreditation policy. Add peri-laryngeal airway adjunct training requirements to policy.	Approved	Motion: Kyle Blum Seconded: Joey Williams Passed: Unanimous
B. 705.17 Nerve Agent/Organophosphate Poisoning	**Adriane Gil-Stefansen** – Proposed change is to remove the midazolam and use seizure policy. Pull CHEMPAK diazepam into ALS standing orders in event that it is deployed. Mark I and DuoDote dosing removed from ALS, stays as BLS procedure. Cleaned up the language under severe exposure. Removing pinpoint pupils.	Approved	Motion: Ira Tilles Seconded: Todd Larson Passed: Unanimous
VI. Old Business			
A. None			Motion: Seconded: Passed: Unanimous
VII. Informational			
A. Destination of Burn Patients	**Danny Shepherd** – Will keep the same destinations for now. Will look into ABLS training.		
B. Quality Improvement Plan	**Chris Rosa** – Been in place for several years, last revision was in 2009. Requirement that gets submitted to EMSA. EMSA said overdue this year. First significant revision since 2009. Get a good cross section of our group to work on the updated plan for 2024, with an ongoing process for the future. The QIP should be a representation of the good work we do as a whole. EMS education		

	committee to regularly meet, first meeting in January. Education data collection is represented. Some agency expectations – moving forward yearly report will be submitted. Safety event was added. Please read through it and ask any questions. **Todd Larson** – documentation and data section – do we need to be that detailed about the platforms? What if we change platforms? **Chris Chris Rosa** – Can discuss that moving forward. **Steve Carroll** – Every year we have to send an update, every five years we have to send a new plan. **Thomas Duncan** – Under #B2C that should be trauma program manager, similar under TAC.		
C. 451 – Stroke Triage and Destination (Stroke Committee)	**Adriane Gil-Stefansen** – for 451 and 705.26, changes to policies prior to EMS update. Removed the E from ELVO, removed ED sat as a reason to divert stroke alerts. They were approved in Stroke Committee and went out with the EMS update. **Kristen Shorts** – Confirmed stroke alerts can be diverted with CT scan diversion and patient request less than 20 minutes.		
D. 705.26 Suspected Stroke (Stroke Committee)	See above.		
VIII. Policies for review			
A. 724 – Brief Resolved Unexplained Event (BRUE)	**Karen Beatty** - No suggested changes, due for review in September 2023. **Neil Canby** – Add paragraph to policy of what to do if suspected child absue. **Steve Carroll** - Directed to reporting policy.		Motion: Chris Sikes Seconded: Kristen Shorts Passed: Unanimous
B. 630 - Ventura County Pre-Hospital Infections Disease Policy	**Karen Beatty** - New policy a year ago, up for review. No proposed changes.		Motion: Joey Williams Seconded: Ira Tilles Passed: Unanimous
IX. Agency Reports			
A. Fire departments	**VCFD** – Closed escrow on new building, hoping to move after the first of the year. Received four new ambulances to replace old ambulances, two current ambulances will go into reserve. **VFD –** Busy, 10 grads between lateral and new. Prepared to launch two squads in January. **OFD –** Five paramedic students starting at UCLA in January.		

	Fed. Fire – Captain Shoumake promoted to Battalion Chief. **FFD** – none		
B. Transport Providers	**AMR/GCA/LMT** – Fully staffed by the end of January with extra paramedics. New ambulances coming in. **All Town** – none **AIR RESCUE –** none		
C. Base Hospitals	**AHSV** – none **LRRMC** – MICN course, 18 new MICNs total came out of that. ED residents completed EMS rotations. Continuing construction. **SJRMC –** none **VCMC** – Five new MICN's.		
D. Receiving Hospitals	**SJHC** – none **SPH** – none **CMH** / **OVCH** – none		
E. Law Enforcement	**VCSO –** none **CSUCI PD –** none **Parks –** none		
F. ALS Education Programs	**Ventura College** – Dr. Larsen for Tom O'Connor – ALS program report Thank you to those that attended the graduation event in November. There are 5 students from that cohort working on their final shifts of internship. Anticipated completion by Jan 2024. Thank you to AMR/GCA for providing ambulances in support of the paramedic simulation event last week. Real ambulances mixed with the simulation add to the realism and are greatly appreciated by the students and the program. Thank you to those that were able to participate in the EMT & Paramedic advisory committee meeting this week. There were robust conversations with recommendations for both county-based paramedic programs to have the same prerequisites for entry. A&P would be a recommended preparation item instead of required. 1000 hours of EMT experience would be required for both programs. Types of EMT experience were a long discussion with program director discretion being the recommendation. A follow-up survey was sent to the advisory committee members. Please complete the survey as soon as possible so we can close out the resource assessment. VC PM class 27 enters clinical rotations in January and the first wave of students will be ready for field internship in late February. Need preceptor information by mid-January in order to schedule and submit list of preceptors to EMS. This helps keep the internship process efficient in startup. Field Preceptor Agencies - due to decreased local preceptor availability, would it be possible for preceptors to take interns back-to-back? We are sending		

	students out of the area to other internship locations around the state and in Utah. We are in the process of hiring a full-time educator and have interviews scheduled for January for additional part time faculty. We hope to get to full staffing soon. Lastly, thank you to the clinical sites for trialing 12-hour ED shifts for the paramedic students starting in January. We hope this will result in improved efficiency for student learning. **Moorpark College** – Appreciate the support for our program. Great success for students that may have been excluded from other programs due to prerequisites. Recognize this is a lot of work, continue to have an off-calendar program to eliminate conflict with other paramedic programs. **All Town Ambulance**– none	
G. EMS Agency	**Chris Rosa** – Rescue task force exercise on base in January. Working with other agencies, January 30th is the date. Don't anticipate full scale transport. May 14th medical response and surge exercise, organophosphate component. May do live patients through decontamination process. **Adriane Gil-Stefansen** – We welcome back Martha from her LOA **Steve Carroll** – EMSAAC is back at Loews in Coronad end of May this year. Conference agenda already set up on a new website. In addition to Martha coming back, Diane is retiring after 21 years. Adriane stepped up to take over for Martha in her absence. Adriane received promotion to Deputy EMS Administrator. Ambulance RFP has been submitted to CAL-EMSA.	
H. Other		
X. Closing	**Meeting adjourned at 10:22a**	Motion: Todd Larsen Seconded: Eric Eccles Passed: Unanimous
	Meeting audio recording and transcript available upon request.	

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMS Education Committee Operating Guidelines		Policy Number 105
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: DRAFT
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: DRAFT
Origination Date: Date Revised: Date Last Reviewed: Review Date:	February 8, 2024 February 28, 2025	Effective Date: DRAFT

I. Committee Name

The name of this committee shall be the Ventura County EMS Education Committee

II. Committee Purpose

To promote high quality EMS education and training amongst Advanced Life Support (ALS), Basic Life Support (BLS) and prehospital continuing education (CE) training programs approved by the Ventura County EMS Agency. To collectively support the ongoing training of existing prehospital personnel and to support the success of students as they undertake their initial training and pathways into the EMS profession.

~~II.~~ III. Membership

A. Voting Membership

Voting membership in the committee shall be composed of 2 representatives per member organization, as appointed by the organization administrator.

1. Member organizations will be comprised of prehospital CE programs, Emergency Medical Technician (EMT) training programs and Paramedic training programs approved by the Ventura County EMS Agency.
2. Organization types will include fire agencies, ambulance providers, base hospitals, community colleges, public schools and private education providers that fall under one of the approved education categories outlined above.
3. Examples of voting membership include program directors, clinical coordinators, and/or program medical directors (paramedic training programs)

B. Non-voting Membership

Non-voting members of the committee shall be composed of VC EMS staff that participate in committee activities, policy development, etc. Representatives from other non-voting organizations may attend the meeting as observers and provide comments/feedback but will not be authorized to make motions and/or vote on initiatives that arise.

C. Membership Responsibilities

Members of the EMS Education Committee represent the views of their agency/organization. Representative should ensure that agenda items have been discussed/reviewed by their respective organizations prior to the committee meetings. Additional responsibilities of committee members will include, but not be limited to the following:

1. Review, analyze, and propose corrective actions for issues occurring with the broader prehospital education framework that impact local training initiatives and goals.
2. Recommend development and/or revisions of policies that impact prehospital education and training.
3. Evaluate system needs and recommend education or certification courses for prehospital personnel.
4. Recommend and collaborate with other Ventura County agencies and organizations on various projects or initiatives.
5. Recommend and collaborate on system-wide research efforts.

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) Voting Members may have a single alternate attend in their place, 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 by VCEMS, members will not be penalized for not attending.

IV. Committee Leadership

A. A chairperson of the EMS Education Committee will be nominated and elected by committee membership. The chairperson of the EMS education committee 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 Winter meeting to nominate candidates for EMS Education Committee Chair. The election will take place during the Spring meeting, with duties to begin immediately thereafter.

C. The term of office is two (2) years. A member may serve as committee Chair for up to two (2) consecutive terms.

V. Meetings

A. Regular Meetings

The EMS Education Committee will meet quarterly on the first Thursday of the month, unless otherwise determined by the PSC membership. VCEMS will prepare and distribute an agenda and any meeting-specific materials electronically no later than one week prior to a scheduled meeting.

C. Quorum

The presence of 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 EMS Education Committee Chair, VCEMS Administrator, VCEMS Medical Director or VCEMS Deputy Administrator(s) may appoint task forces or ad-hoc

committees to make recommendations to the broader EMS Education Committee and/or Prehospital Services Committee (PSC) on particular issues or initiatives. 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 five (5) members and no more than ten (10) individuals. Persons other than voting members may be appointed to task forces or ad-hoc committees.

VII. Calendar Year

The EMS Education 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 EMS Education Committee may adopt.

IX. Submission of Agenda Items

Agenda items shall be received by the Ventura County EMS Office at least 14 days before the meeting it is to be presented. Items may be submitted in person, via US mail, 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 VCEMS policies and/or programs as applicable

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: June 1, 2024~~July 1, 2022~~
APPROVED Medical Director: Daniel Shepherd, MD	Date: June 1, 2024~~July 1, 2022~~
Origination Date: August 22, 1986 Date Revised: February 8, 2024~~August 9, 2018~~ Date Last Reviewed: February 8, 2024~~10, 2022~~ Review Date: February 28, 2027~~5~~	Effective Date: June 1, 2024~~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 every two years.~~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: June 1, 2024~~July 1, 2022~~
APPROVED Medical Director: Daniel Shepherd, MD	Date: June 1, 2024~~July 1, 2022~~
Origination Date: April 1, 1984 Date Revised: February 8, 2024~~10, 2022~~ Date Last Reviewed: February 8, 2024~~10, 2022~~ Review Date: February 28, 2027~~5~~	Effective Date: June 1, 2024~~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 100243~~100175~~.

III. POLICY:

A. A RH, approved and designated by the Ventura County EMS Agency, shall:

1. Be licensed by the State of California a general~~s 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, LVO, 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, LVO, 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 a general ~~n~~ acute care hospital.		
2.	Meet the requirements of the Health and Safety Code Section 1250-1262 and Title 22, Sections 100243, ~~-~~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		

Behavioral Emergencies

ADULT	PEDIATRIC
BLS Procedures	
Administer oxygen as indicated	
ALS Standing Orders	
IV/IO Access For Extreme Agitation • **Midazolam** ○ IM – 0.2 mg/kg, Max 10 mg ○ IV / IO – 0.1 mg/kg, Max 4 mg	IV/IO Access For Extreme Agitation • **Midazolam** ○ IM – 0.1 mg/kg, Max 5 mg ○ IV / IO – 0.1 mg/kg, Max 4 mg
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	

Additional Information:

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

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

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~~IV/IO Access

Monitor for allergic reaction or anaphylaxis

Pain Control– per Policy 705.19

Base Hospital Orders Only

Consult with ED Physician for further treatment measures

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Effective Date:	June 1, 2024~~July 1, 2022~~	Date Revised:	February 10~~10~~, 2022
Next Review Date:	February 28, 2026~~4~~	Last Reviewed:	February ~~8~~10, 2024~~2~~

VCEMS Medical Director

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: June 1, 2024~~July 1, 2022~~
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: June 1, 2024~~July 1, 2022~~
Origination Date: Date Revised: Date Last Reviewed: Review Date:	April 1, 2011 February 8, 2024~~April 14, 2022~~ February 8, 2024~~April 14, 2022~~ February 28, 2026~~April 30, 2024~~	Effective Date: June 1, 2024~~July 1, 2022~~

I. PURPOSE: To provide guidelines for the use of verbal de-escalation, 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 d~~D~~e-escalation~~:~~ : Use of calm language and non-threatening body language intended to reduce a patient's agitation and/or aggression.~~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 r~~R~~estraint: 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 s~~S~~edation: Any pharmaceutical administered by healthcare providers that is used specifically for the purpose of mitigating injury to self or others. ~~limiting or controlling a person's behavior or movemen~~t.

IV. POLICY:

A. Assessment

1. Perform a physical assessment and obtain a medical history as soon as safe and appropriate.

2. Be sure to consider and treat other possible causes (traumatic or medical).

~~A.~~B. ~~Physical Restraint~~Verbal de-escalation

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

~~B.~~C. Physical restraint

~~1. Perform a physical assessment and obtain a medical history as soon as safe and appropriate. Treat any underlying conditions per VCEMS 705 Treatment guidelines.~~

~~2.~~1. ~~-~~If necessary, apply soft physical restraints while performing assessment and obtaining history.

~~1.~~2. Padded soft restraints shall be the only form of physical restraints utilized by EMS providers.

~~2.~~3. Physical ~~R~~restraints shall be applied in a manner that does not compromise vascular, neurological, or respiratory status.

~~3.~~4. Extremities in which physical restraints are applied shall be continuously monitored for signs of decreased neurologic and vascular function.

~~4.~~1. Physical ~~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.~~

5. r~~R~~estraints shall be attached to the frame of the gurney.

6. If h~~H~~andcuffs are applied by law enforcement and utilized as the means of physical restraint, it is required that ~~require that an officer~~law enforcement accompany the patient to ensure provider and patient safety and to facilitate removal of the handcuffs~~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,~~ ~~b~~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.

~~a.~~b. The patient shall~~ould~~ not be placed on gurney with hands or arms restrained behind their~~patient's~~ back.

~~b.~~c. 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.

~~C.~~D. 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 per VCEMS 705 Treatment Guidelines~~of erratic behavior~~ (~~e.g.~~e.g., hypoglycemia, trauma, meningitis).
   b. Monitor if patient is sedated (when patient condition permits: cardiac monitor, SpO2, and EtCO2)

E. Transport

1. Patients shall not be transported in a prone position.
2. The patient's position shall be in a manner that does not compromise vascular or respiratory status at any point.
3. ~~Additionally, t~~The patient position shall not prohibit the provider from performing any and all assessment and treatment tasks.

~~D.~~ Base hospital contact

F.

1. Base Hospital shall be notified in all circumstances in which physical restraints and/or therapeutic sedation is utilized.

~~E.~~G. 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. Reason physical restraints or therapeutic sedation were utilized
   ~~a.~~b. Type of restraint applied (~~e.g.~~e.g., soft padded restraint, handcuffs by law enforcement, pharmaceutical~~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.

~~g.~~f. ~~Base Hospital shall be notified in all circumstances in which physical restraints and/or therapeutic sedation is utilized.~~

	2021				2022				2023				3 Year Avg - 3 Attempts*
	1st Attempt		3 Attempts		1st Attempt		3 Attempts		1st Attempt		3 Attempts		
CVAS	8 of 14	57%	11 of 14	79%	12 of 15	80%	13 of 15	87%	10 of 15	67%	12 of 15	80%	82%
Moorpark	47 of 52	90%	51 of 52	98%	42 of 58	72%	52 of 58	90%	34 of 44	77%	37 of 44	84%	91%
Oxnard	88 of 150	59%	107 of 150	71%	68 of 134	51%	87 of 134	65%	80 of 142	56%	92 of 142	65%	67%
SVAS	13 of 20	65%	17 of 20	85%	15 of 32	47%	18 of 32	56%	46 of 55	84%	49 of 55	89%	77%
Ventura	55 of 75	73%	63 of 75	84%	47 of 63	75%	54 of 63%	86%	35 of 46	76%	35 of 46	76%	82%

** 3 Year Avg Calculated from 2021, 2022, 2023*

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Local Emergency Medical Services Agency	Policy Number 100
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2024~~December 1, 2017~~
APPROVED: Medical Director: Daniel Shepherd, MD	Date: June 1, 2024~~December 1, 2017~~
Origination Date: July 1, 1980 Date Revised: October, 2003 Last Reviewed: February 8, 2024~~11, 2021~~ Review Date: February 28, 2027~~28, 2024~~	Effective Date: June 1, 2024~~December 1, 2017~~

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I. PURPOSE: To establish a local EMS agency as required for the development of an emergency medical services program in Ventura County.

II. AUTHORITY: Health and Safety Code, Sections 1797.94 and 1797.200. Ventura County Board of Supervisors Board Letter dated July 1, 1980.

III. POLICY: The Ventura County Health Care Agency is designated as the Local Emergency Medical Services Agency for Ventura County. The Ventura County Emergency Medical Services Agency (VCEMS) has primary responsibility for administration of emergency medical services in Ventura County.

A. Organizational History of the VC EMS Agency:

- 1980 EMS Coordinator reports directly to the County Health Officer
- 1987 VCEMS is made a department of Public Health
- 1989 VCEMS is made a department of the Health Care Agency
- 1996 VCEMS is made a department of Public Health

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: June~~July~~ 1, 2024~~3~~
APPROVED: Medical Director	Daniel Shepherd, MD	Date: June~~July~~ 1, 2024~~3~~
Origination Date: Date Revised: Last Reviewed: Review Date:	May 24, 1987 January 12, 2023 February 8~~January 12~~, 2024~~3~~ February 28~~January 31~~, 2025~~4~~	Effective Date: June~~July~~ 1, 2024~~3~~

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

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

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

IV. DEFINITIONS:

BLS – Basic Life Support Unit

ALS – Advanced Life Support Unit

PSV – Paramedic Support Vehicle or Paramedic Supervisor Vehicle

CCT – Critical Care Transport Unit

BLS Command – Basic Life Support Staffed Command Vehicle

FR/ALS – First Responder Advanced Life Support Unit

Search and Rescue – Sheriff's SAR Helicopter Unit

V. PROCEDURE:

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

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

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

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

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

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

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

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

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

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Refusal of EMS Services	Policy: 603
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2024
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: June 1, 2024
Origination Date: October 31, 1995 Date Revised: February 10, 2022 Last Review: February 8, 2024 Review Date: February 28, 2026	Effective Date: June 1, 2024

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

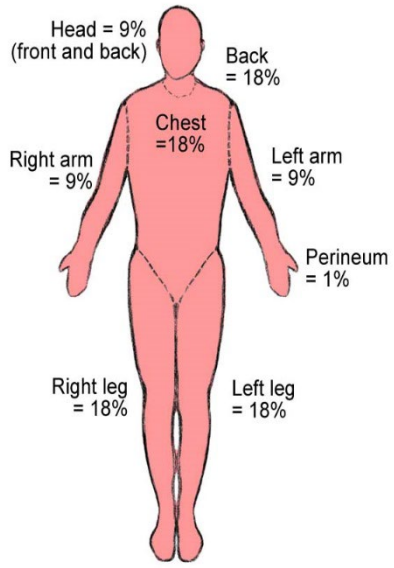
B. Declination of EMS Services
    1. Those individuals contacted at an EMS response who have no medical complaints or evidence of an emergency medical condition may decline service. An ePCR with a no treatment disposition shall be completed.

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.

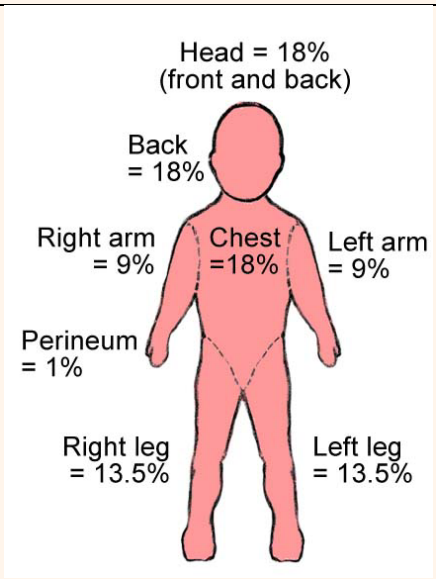
D. AMA
   1. Patient has evidence of an emergency medical condition, required an ALS intervention, or has a complaint and/or condition as described in VCEMS policy 704.
   2. Engage the patient in a discussion detailing the following;
      a. Potential benefits of further treatment, EMS assessment, 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.

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

ADULT	PEDIATRIC

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.

Crush Injury/Syndrome

ADULT	PEDIATRIC

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

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

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: June 1, 2024
Next Review Date: February 28, 2026

Date Revised: February 10, 2022
Last Reviewed: February 8, 2024

VCEMS Medical Director

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Leave at Home Naloxone Program		Policy Number 736
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: June 1, 2024~~December 1, 2021~~
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: June 1, 2024~~December 1, 2021~~
Origination Date: Date Revised: Date Last Reviewed: Review Date:	March 12, 2020 May 13, 2021 February 8, 2024~~May 13, 2021~~ February 28, 2026~~May 31, 2023~~	Effective Date: June 1, 2024~~December 1, 2021~~

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I. PURPOSE: To authorize ALS prehospital personnel to distribute naloxone kits to patients with suspected opioid misuse, or family/friends of these patients, and to delineate the process for distribution of naloxone to Ventura County ALS provider agencies.

II. AUTHORITY: California Health and Safety Code, Sections 1797.220 and 1798; California Code of Regulations, Title 22, Sections 100146, 100169, 100170

III. POLICY: The opioid crisis has had a profound impact on communities across the United States. This policy is part of a broader harm reduction strategy that attempts to mitigate the impact of the crisis by increasing the availability of Naloxone. ALS prehospital personnel may distribute naloxone kits to patients with suspected opiate misuse, or the friends/family of these patients. All appropriate training will be offered to the recipient at the time of distribution.

A. Indications
   1. Suspected opioid use misuse or self-reported dependence
   2. Patient is not transported

B. Contraindications
   1. Patient is transported

IV. PROCEDURE:

A. Treat Patient in accordance with VCEMS policies and procedures

B. Once it has been determined that patient will refuse transport, AMA shall be processed and documented in accordance with VCEMS Policy 603 – Refusal of EMS Services.

C. Once AMA process has been completed, the patient, or the patient's family/friends (must be present on scene) will be offered a leave-at-home naloxone kit, with clearly identified kit number and medication expiration date, and the relevant training

D. Friends/family can be offered a kit if the patient is determined to be dead. Kits and training should be offered if the individuals at the scene appear to be at risk for opioid misuse. For example, they were using drugs with the patient or there is paraphernalia on scene. Document as outlined below.

E. In limited circumstances where patient is treated with naloxone for a suspected overdose and transported to hospital, but patient and/or family/friends express concern that they will not be able to afford a prescription or demonstrate an inability to access naloxone, a leave at home kit may be left at the scene.
   1. In these limited circumstances, efforts should be made to ensure patient and/or family/friends understand resources that are available to them related to overdose prevention. Resources include, but are not limited to:
      a. OD rescue kit and training on how to administer nasal naloxone (Ventura County Behavioral Health) 805-667-6663
      b. Treatment Services Access Line (Ventura County Behavioral Health) 844-385-9200

F. Recipient Training and Education
   1. If the naloxone kit is accepted, the patient and/or family and friends will be trained on the recognition of opioid overdose and on the administration of nasal naloxone.
   2. At a minimum, the training will consist of the following:
      a. Signs and symptoms of an opioid overdose
      b. Administration of nasal naloxone
      c. Activating the 911 system
      d. Hands Only CPR. Instruct the recipient how to perform chest compressions: "place your hands between the nipples and push hard and fast."
   3. Printed training materials and resources related to ongoing drug treatment services, including the Behavioral Health Department's 24/7 Access line will be left with patient or patient's family/friends at the scene.

G. Documentation
   1. Information will be completed for both the patient contact, as well as the refusal of EMS services, in accordance with VCEMS Policy 1000 – Documentation of Patient Care.
   2. In addition to the standard ePCR documentation, additional fields related to the leave at home naloxone kit will also be documented via supplemental ePCR fields. At a minimum, these fields will include:
      a. Name of Naloxone Kit Recipient
      b. Recipient relationship to patient
      c. Recipient phone number
      d. Kit number on Naloxone kit provided - Should begin with a letter, followed by three or four numbers (e.g. E123)
      e. Confirmation that training was provided to recipient and family/friends on scene
      f. Confirmation that addiction resources were left with recipient

H. Inventory
   1. Distribution of leave at home naloxone will be tracked through the ePCR system, which means accurate documentation is very important.
   2. Nasal naloxone should not be distributed through standard inventory that is part of the day-to-day equipment (i.e. jump bags, supply cabinets, etc). These kits will be specially marked and tracked outside of the standard inventory process.
   3. As nasal naloxone inventory is depleted through the leave at home program, replacement kits will be supplied by VCEMS to agencies on a one-for-one basis.

Ventura County EMS Agency

VCEMS Policy 1605 Attachment A
Monthly PSFA Optional Skills UTILIZATION & UPDATE FORM

Due the 15th of the following month
(ex: Jan. 1-31, due Feb. 15)

PSFA Agency Name: _____

Review Month: _____

Current Program Coordinator: _____

☐ No Utilizations
(*check here if applicable)*

OR

Date of Incident	Patient Initials	Provider Name	PCR Attached
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

Program Coordinator Signature:_____ Date:_____

Program Notes/Comments:

For VCEMS Use Only

Received Date	Reviewed Date	Reviewed By
/ /	/ /	

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Naloxone Administration by Approved Public Safety First Aid Personnel	Policy Number 1605
APPROVED: Administration: Steve L. Carroll, Paramedic	Date: June 1, 2024~~December 1, 2021~~
APPROVED: Medical Director: Daniel Shepherd, MD	Date: June 1, 2024~~December 1, 2021~~
Origination Date: July 13, 2017 Date Revised: May 13, 2021 Date Last Reviewed: February 8, 2024~~May 13, 2021~~ Review Date: February 28, 2026~~May 31, 2023~~	Effective Date: June 1, 2024~~December 1, 2021~~

I. PURPOSE:

A. To outline criteria for approved Public Safety First Aid (PSFA) administration of naloxone hydrochloride in cases of suspected acute opioid overdose.

B. To provide medical direction and naloxone administration parameters for approved PSFA optional skills provider agencies and personnel in the County of Ventura.

II. AUTHORITY: California Health and Safety Code, Division 2.5; California Code of Regulations, Title 22, Division 9, Section 100019.

III. POLICY:

A. Training shall be completed as outlined in California Code of Regulations, section 100019 and VCEMS Policy 1602 – PSFA Optional Skills Approval and Training

B. The PSFA agency training program director shall be responsible for the following:

1. Ensuring the agency's supply of nasal naloxone remains current and not expired at all times.
2. Ensuring proper and efficient deployment of nasal naloxone for use within the agency.
3. Prompt replacement of any nasal naloxone that is used in the course of care, expired, damaged, or otherwise deemed unusable.
4. Ensuring all personnel that will be using nasal naloxone has received appropriate training.
5. Maintain records of all documented use, restocking, damaged, expired or otherwise unusable naloxone.

IV. PROCEDURE:

A. Indications

1. Suspected or confirmed opiate overdose
    a. Environment indicates illegal or prescription use of opiate medication, AND
    b. Victim is unconscious or poorly responsive and respiratory rate appears to slow (less than 8 per minute) or shallow/inadequate; or victim is unconscious and not breathing.
2. Need for complete or partial reversal of central nervous system and respiratory depression induced by opioids.
3. Decreased level of consciousness of unknown origin and opioid induced respiratory depression
4. Law enforcement or First Responders with known or suspected opiate exposure AND signs and symptoms of opiate overdose.

B. Contraindications

1. Known allergy to naloxone hydrochloride

C. Relative Contraindications

1. Use with caution in opiate-dependent patients and in neonates of opiate addicted mothers; opiate-dependent patients who receive naloxone may experience acute withdrawal reaction syndrome. Opiate withdrawal symptoms in the opiate-dependent patient include:
    a. Agitation
    b. Tachycardia
    c. Hypertension
    d. Seizures
    e. Cardiac Rhythm Disturbances
    f. Nausea, vomiting, and/or diarrhea
    g. Profuse sweating

D. Intranasal (IN) Naloxone Administration

1. Ensure EMS personnel (fire and transport) have been responded to the scene through established communications channels.
2. Maintain standard body substance isolation precautions utilizing appropriate personal protective equipment.
3. Check patient/victim for responsiveness

4. Open airway using established Basic Life Support techniques, Provide supplemental oxygen and assist ventilations, if authorized, per VCEMS Policy 1604 – Oxygen Administration and Basic Airway Adjunct Use by PSFA Personnel

~~5.~~ Perform CPR as indicated.

~~6.~~5.

~~7.~~6. Administer intranasal naloxone

   a. Naloxone 4mg IN

   b. May repeat dose, if no improvement in patient condition, x 1 (total of 2 doses)

~~8.~~7. If response to naloxone and patient is a suspected chronic opiate user, prepare for possible narcotic reversal behavior or withdrawal symptoms (agitation and vomiting)

~~9.~~8. Report administration of nasal naloxone to prehospital personnel for additional assessment and follow-up care, as needed.

~~10.~~9. Document administration of naloxone as indicated per PSFA agency policies and procedures.

   a. On a monthly basis, law enforcement agencies that administer naloxone shall report all cases to the Ventura County EMS Agency using the established reporting form (Attachment A)