

In-person
2240 E. Gonzales Road #200
Oxnard, CA

Pre-hospital Services Committee
Agenda

February 13, 2025
9:30 a.m.

I. Introductions

II. Approve Agenda

III. Minutes

IV. Medical Director Report

- A. Buprenorphine
- B. Whole Blood
- C. Safety Event Reports
- D. Cardiac Arrest Survival

V. New Business or Policies for Review with Proposed Changes

- A. Hospital Area Command Training Chris Rosa

VI. Old Business

- A. None

VII. Informational/Discussion Topics or Policies Approved at Specialty Care Committees

- A. 0452 - TCASC Standards Adriane Gil-Stefansen
- B. 1401 - Trauma Center Designation Kyle Culkin
- C. 1403 - Trauma Registry and Data Kyle Culkin
- D. 1405 - Field Triage Decision Scheme Kyle Culkin
- E. 1405 – Trauma Triage and Destination Criteria Kyle Culkin
- F. 1406 – Trauma Center Standards Kyle Culkin

VIII. Policies Due for Review (No proposed changes)

- A. 0319 – Paramedic Preceptor
- B. 0321 – MICN Authorization Criteria
- C. 0322 – MICN Reauthorization Requirements
- D. 0322 - _MICN Reauthorization Requirements- CE Log Appendix D
- E. 0324 – MICN Authorization Reactivation
- F. 0613 – Do Not Resuscitate (DNR)
- G. 0625 - POLST
- H. 705.02 – Allergic Reaction and Anaphylaxis
- I. 705.21 – Shortness of Breath – Pulmonary Edema
- J. 705.29 – Traumatic Cardiac Arrest

IX. Agency Reports

- A. Fire Departments
- B. Ambulance Providers
- C. Base Hospitals
- D. Receiving Hospitals
- E. Law Enforcement
- F. ALS Education Program-Ventura College
- G. ALS Education Program-Moorpark College
- H. EMS Agency
- I. Other

X. Closing

In Person
 2240 E. Gonzales rd. #200
 Oxnard

Pre-hospital Services Committee
 Minutes

November 14, 2024
 9:30 a.m.

Topic	Discussion	Action	Approval
I. Introductions	Kristen Shorts – ASVH-Pam Kowalski, new ED RN Supervisor Jaime Villa – OFD-Melissa Corney, new lead EMT Instructor for the EMS Corp Program and functions as administrative paramedic for the agency Michelle Barry- LRH- Dr. Bhatti- new EMS Medical Director	Welcome	
II. Approve Agenda		Approved	Motion: Dr. Tilles Seconded: Tom O'Connor Passed: Unanimous
III. Minutes		Approved	Motion: Tom O'Connor Seconded: Alejandro Villasenor Passed: Unanimous
IV. Recognition Awards	Dr. Daniel Shepherd presented recognition awards to paramedics and EMTs who exemplified in patient care		
V. Medical Director Report			
A. Buprenorphine	Training is on-going with MICNs, finishing online training, same with the medic version, planning on training being complete by end of year. Next step is distribution of the medication. DEA has approved their site. Online portal will be live soon, so Buprenorphine and naloxone kits can be ordered and then delivered directly to the station. Go live date hopefully in January. Still waiting for VCMC to get on-line with Pulsara.		
B. Whole Blood	Working through the logistics with LA County's help who leads the consortium, to help with the monitoring and procurement process.		
C. Safety Event Reports	Recognition awards were given out.		
D. Cardiac Arrest Survival	Weekly reports have been sent out, and Andrew will send a more detailed report later today or tomorrow. Currently 16/45=36% survival with 3 patients pending, for all patients, 39/406=9% with 51 pending		
VI. New Business			
A. 111 – Ambulance Company License Procedure	This policy was reviewed and approved recently; however, it was noted there was not a renewal section and it also contained an incorrect EMS Agency address. Address has been updated and renewal section added.	Approved	Motion: Eric Eckles Seconded: Tom O'Connor Passed: Unanimous

B. 124 – Hospital Emergency Services Reduction Impact Assessment	This policy was due for review, and it was noted SPH was not listed on the last page. SPH was added.	Approved	Motion: Dr. Larson Seconded: Jeff Winter Passed: Unanimous
VII. Old Business			
A. 629 – Hospice Patient Care	This policy is being brought back with suggested updated changes in language referring to phone-call communication between EMS and on-call Hospice nurse. Community Paramedic response language was removed.	Approved	Motion: Jeff Winter Seconded: Joey Williams Passed: Unanimous
VIII. Informational			
A. Transcendental Meditation for First Responders	Representatives from the David Lynch Foundation, Peter and Lynn, presented information on Transcendental Meditation (TM) techniques. They are offering free classes in December for First Responders. For sign-up and more information contact Traci Holt.	N/A	
B. 430 – STEMI (SRC) & (SRH) Standards	This policy was reviewed and approved at the STEMI meeting in October with no recommended changes.	N/A	
IX. Policies for review			
A. 210 – Child Abuse, Dependent Adult Abuse, or Elder Abuse Reporting	This policy is due for review with no proposed changes. Recommendation to add the Child Abuse reporting form link to Image Trend.	Approved	Motion: Dr. Sikes Seconded: Dr. Larsen Passed: Unanimous
B. 604 – Transport and Destination Guidelines	This policy is due for review with no proposed changes. Recommendation to remove “E” form ELVO on last page and insert a few commas.	Approved	Motion: John Everlove Seconded: Dr. Sykes Passed: Unanimous
C. 720 – Guidelines for Limited Base Contact	Recommendation to remove “E” from ELVO on first page. Also to remove the words “call-in” on page 2 under communication so medics will have the option to use Pulsara and not have to “call-in” to the Base hospital.	Approved	Motion: Dr. Larson Seconded: Tom O’Connor Passed: Unanimous
D. 722 – Interfacility Transport of Patients with IV Heparin & Nitroglycerin	Due for review, no changes.	Approved	Motion: Dr. Tilles Seconded: Tom O’Connor Passed: Unanimous
E. 1603 – Nerve Agent Antidote Administration by Public Safety – First Aid Personnel	Due for review, no changes.	Approved	Motion: Alejandro Villasenor Seconded: John Everlove Passed: Unanimous
F. 1604 – O2 Administration and Basic Airway Adjunct Use by Public Safety – First Aid Personnel	Due for review, no changes.	Approved	Motion: Dr. Tilles Seconded: John Everlove Passed: Unanimous
G. 1606 – Epinephrine Administration by PSFA Personnel	Due for review, no changes.	Approved	Motion: John Everlove Seconded: Jeff Winter Passed: Unanimous

X. Agency Reports			
A. Fire departments	<p>VCFD – Finished skills testing for EMTs.</p> <p>VFD – Launched two LIFEPAK 35 monitors on our units for a test run. Image Trend set for an update at the end of the year, so hopefully all new devices will be delivered. More than 10 people are in backgrounds, hoping to start them in new recruit academy in January.</p> <p>OFD – Onboarding Melissa, EMS Corps going well. Finished interviews, taking 27 for in-person secondary interviews in December. Group of TEMS going to TCC in December, approved for canine TCCC, sending two candidates to paramedic school at Ventura College. Easy IO training next week if anyone interested a link can be sent out.</p> <p>Fed. Fire – Not present.</p> <p>FFD – New academy is starting the beginning of the year, about 45-50 interested. Focusing on our paramedic staffing.</p>		
B. Transport Providers	<p>AMR/GCA/LMT – Tom resigned in October looking to fill his vacancy and EMS 48 spot.</p> <p>All Town – Taking a renewed interest in mental health initiative for our employees due to a recent ambulance being stolen at gunpoint. A shipment of 4 new ambulances coming hopefully by December.</p>		
C. Base Hospitals	<p>AHSV – New MICNs starting, Stroke program went through the DNV renewal process with no problems.</p> <p>LRRMC – Continuing construction, youth training completed, MICN test tomorrow for 16 new candidates. EM residents are completed with their rotations, so thank you to everyone for hosting and teaching them.</p> <p>SJRM – Nothing to report.</p> <p>VCMC – Nothing to report.</p>		
D. Receiving Hospitals	<p>SJHC – We will be making a cabinet outside of both hospitals for EMS snacks. Thank you to Karen for helping with the people being dropped off at their ER during the Mountain Fire to get them transported to a shelter.</p> <p>SPH – Nothing to report</p> <p>CMH / OVCH – Been working on both hospitals getting ready to switch over to EPIC system.</p>		
E. Law Enforcement	<p>AIR RESCUE – Very busy, nothing to report.</p> <p>VCSO – Very busy, nothing to report.</p> <p>CSUCI PD – N/A</p> <p>Parks – N/A</p>		

F. ALS Education Programs	<p>Ventura College – Paramedic 28 class graduation is tomorrow; class 29 starts clinic rotation in January and class 30 starts in January.</p> <p>Moorpark College – 11 students doing their internships currently, thank you for supporting them. They had a unique experience during the fire. End of April starting a new program, accepting applications December 1. The Leadership Training EMS held was fantastic, thank you for support and sponsorship.</p>		
G. EMS Agency	<p>Traci Holt – Huge thank you to the Air Unit for hosting VCEMSA and VCMRC last night. There were approximately 50 people in attendance.</p> <p>Adriane Gil-Stefansen – Medical Teams are starting to build out for Baker to Vegas, so we will be sending a recruitment flyer to help assist. It will be April 4-6, 2025.</p> <p>Andrew Casey – EMS Update was assigned to everyone yesterday via email and is live. If there are any issues, email Andrew and he can send direct links.</p> <p>Steve Carroll - Medtrans Ambulance application was approved by the EMS advisory committee, and they should go live in the next month or so. Two BLS ambulances will start out of Simi Valley, but they will be covering county wide. The next Regional Trauma Coordinating Committee's Grand Rounds will be March 5, 2025, 2 Hour CE. RTP still on track for a December 17th Board meeting for approval, and if approved, then to the State for review. EMSAAC conference registration should be going live in December for May 27-29, 2025, at LOWES Coronado in San Diego.</p> <p>Heather Ellis – We have been working with our Hospice and Home Health Facilities to make sure their evac plans have been updated. After Mountain Fire, it was evident these plans need to be looked at and be sure residents are ready to leave if needed.</p> <p>Steve Carroll – During Mountain Fire, one of the Memory Care Facilities thought they needed to evacuate and called 911 to have a Hospice, non-ambulatory, patient transported to CMH. This should not be their plan. It was stopped and they sheltered in place. We are working with our HCC partners to educate these facilities, so hospitals do not become the catch all for their patients.</p>		
H. Other			
XI. Closing	<p>Meeting adjourned at 10:55am</p> <p>Meeting audio recording and transcript available upon request.</p>		<p>Motion: Dr. Larson Seconded: Eric Eckles Passed: Unanimous</p>



HOSPITAL AREA COMMAND

MARCH 5, 2025
1PM - 4PM

Fire Chief Greg Cassell (ret.) from Clark County, NV Fire Department will highlight the concept of Hospital Area Command. This session will discuss critical lessons learned from Route 91 Harvest Festival mass shooting in Las Vegas and how Clark County leverages fire and EMS resources to support hospitals with patient surge in the initial phases of large and dynamic incidents.

Target Audience:

- Hospital Staff (ED, Admin, Emergency Managers)
- Fire and EMS Personnel (Leaders/Clinicians)
- Emergency Management Personnel

Location:

VCFD Headquarters
2400 Conejo Spectrum St.
Thousand Oaks, CA 91320

SEATING IS LIMITED

RSVP BY CLICKING THIS LINK



*This course has been approved for three (3) hours of instructor-based prehospital continuing education.
California CE Provider Number 56-0001*

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Thrombectomy Capable Acute Stroke Center (TCASC) Standards		Policy Number 452	
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: July 1, 2023 <u>June 1, 2025</u>	
APPROVED: Medical Director: Daniel Shepherd, MD		Date: July 1, 2023 <u>June 1, 2025</u>	
Origination Date: July 26, 2017			
Date Revised: December 28, 2022			
Last Review: December 28, 2022 <u>January 26, 2025</u>		Effective Date: July 1, 2023 <u>June 1, 2025</u>	
Review Date: December 31, 2024 <u>January 31, 2026</u>			

- I. PURPOSE: To define the criteria for designation as a Thrombectomy Capable Acute Stroke Center (TCASC) in Ventura County.

- II. AUTHORITY: California Health and Safety Code, Sections 1797.114, 1797.220, 1798, 1798.2, 1798.101, and California Code of Regulations, Title 22, Section [100091.03100147](#) and [100096.02100169](#).

- III. DEFINITIONS:

Acute Stroke Center (ASC): Hospital designated as an Acute Stroke Center, as defined in VCEMS Policy 450.

LVO Alert: A pre-arrival notification by pre-hospital personnel to the base hospital that a patient is suffering a possible Large Vessel Occlusion (LVO) ischemic stroke.

Thrombectomy Capable Acute Stroke Center: (TCASC) Acute Stroke Center (ASC) that has the capability to perform neuroendovascular procedures for acute stroke including thrombectomy and intra-arterial thrombolysis.

- IV. POLICY:
 - A. A Thrombectomy Capable Acute Stroke Center (TCASC), approved and designated by Ventura County EMS (VCEMS), shall meet the following requirements:
 1. All the requirements of an Acute Stroke Center (ASC) as defined in Policy 450.
 2. Certified as a Thrombectomy-Capable Stroke Center (TSC) by The Joint Commission or a Primary Plus by Det Norske Veritas, or a

Comprehensive Stroke Center (CSC) by either The Joint Commission or Det Norske Veritas

3. Neurointerventionalist on call 24/7 and available on-site at TCASC within 45 minutes of notification of an LVO alert.
4. Neurosurgeon on call 24/7 and available to provide care as indicated.
5. Neurologist, with hospital privileges to provide ICU level of care for acute stroke patients, on call 24/7 and available to provide care as indicated.
6. An individual Neurointerventionalist or Neurosurgeon may not be simultaneously on call for a separate hospital.
7. Appropriate endovascular catheterization laboratory personnel available on-site within 45 minutes of notification of an LVO alert
8. Will create policies and procedures detailing how the TCASC will notify the appropriate personnel of an LVO alert.
9. Will accept all LVO alert patients, regardless of ICU or ED saturation status, except in the event of internal disaster or no catheterization laboratory availability.
10. Will create policies and procedures detailing how the TCASC will manage the presentation of concurrent LVO alerts.
11. Will create policies and procedures detailing how the TCASC plans to manage competing demands on the procedure suite (staffing, other cardiovascular procedures).
12. Will create policies and procedures that allow the automatic acceptance of any LVO patient from a Ventura County Hospital upon notification by the transferring physician.
13. Ability to perform endovascular procedures as indicated for emergent large vessel occlusions.
14. Have CT or MRI perfusion capabilities.
15. Maintain appropriate staff and facility availability to address complications of emergent endovascular procedures.
16. Will participate in the Ventura County Stroke Registry in accordance with policy 450.

B. Designation Process:

1. Application:

Eligible hospitals shall submit a written request for TCASC designation to VCEMS no later than 30 days prior to the desired date of designation,

documenting the compliance of the hospital with Ventura County TCASC Standards.

2. Approval:
 - a. Upon receiving a written request for TCASC designation, VCEMS will arrange an on-site survey of the requesting hospital to assure compliance with stated requirements.
 - b. TCASC approval or denial shall be made in writing by VCEMS to the requesting hospital within two weeks after receipt of the request for approval and all required documentation and completion of the VCEMS site survey.
 - c. Certification as a TSC or Primary Plus, or a CSC by The Joint Commission or Det Norske Veritas shall occur no later than six months following designation as a TCASC by VCEMS.
3. VCEMS may deny, suspend, or revoke the designation of an TCASC for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.
4. The VCEMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the TCASC that compliance with the regulation would not be in the best interests of the persons served within the affected area.
5. TCASCs shall be reviewed on a biannual basis.
 - a. TCASCs shall receive notification of evaluation from the VCEMS.
 - b. TCASCs shall respond in writing regarding program compliance.
 - c. On-site TCASC visits for evaluative purposes may occur.
 - d. TCASCs shall notify VCEMS by telephone, followed by a letter or email within 48 hours, of changes in program compliance or performance.

C. Provisional Designation Process

VCEMS may grant provisional designation as a TCASC to a requesting hospital that has satisfied the requirements of a TCASC as outlined in section A of this policy but has yet to receive certification by an approving body. Only when the following requirements are satisfied will VCEMS grant a provisional designation:

1. Application:

Eligible hospitals shall submit a written request for provisional TCASC designation to VCEMS no later than 30 days prior to the desired date of

provisional designation, documenting the compliance of the hospital with Ventura County TCASC Standards.

2. Provisional Approval:
 - a. Upon receiving a written request for provisional TCASC designation, VC EMS will arrange an on-site survey of the requesting hospital to assure compliance with stated requirements.
 - b. Provisional TCASC approval or denial shall be made in writing by VCEMS to the requesting hospital within two weeks after receipt of the request for approval and all required documentation, as well as completion of the VC EMS site survey.
 - c. Certification as a Thrombectomy-capable Stroke Center, Primary Plus or Comprehensive Stroke Center by The Joint Commission or Det Norske Veritas shall occur no later than six months following provisional designation as an TCASC by VCEMS.
3. VCEMS may deny, suspend, or revoke the designation of an TCASC for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Trauma Center Designation		Policy Number 1401	
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: June 1, 2025	December 1, 2022
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: June 1, 2025	December 1, 2022
Origination Date:	July 1, 2010		
Date Revised:	December 5, 2024	March _____	Effective Date: June 1, 2025
	14, 2019		December 1, 2022
Date Last Reviewed:	December 5, June 2024		
	30, 2022		
Review Date:	December 31 June 30, 2027		

- I. PURPOSE: To establish a procedure for the designation of trauma centers in Ventura County
- II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798, and California Code of Regulations, Title 22, §~~100136.03~~400255.
- III. POLICY:
 - A. ~~A.~~ Trauma System Assessment
 1. Changes to the trauma system design will be predicated on a needs assessment.
 2. Ventura County Emergency Medical Services Agency (VEMSAVCEMS) will assess the the trauma system biannually (every other year) using the “Needs Based Assessment of Trauma Systems (NBATS)” Tool.
 3. If a need is identified, VCEMSA will provide ~~an application process~~ and a notice of intent to designate an additional trauma center. The notice will include:
 - a. Introduction and background information about Ventura County’s trauma system.
 - b. General information and instructions about trauma center designation including eligibility for application, primary service areas, fees, and EMS’s no guarantee policy of the minimum number of trauma patients

- c. Level of designation desired
 - d. Reference to Title 22 and the American College of Surgeons “Resources for Optimal Care of the Injured Patient” (2022 Standards-Gray book) as the criteria for designation. Applicants will be required to describe their current compliance with these criteria or to indicate plans to achieve compliance within 6 months of the nomination for designation.
 - e. List of the minimal requirements for designation that includes: hospital organization, medical staff support, the trauma program, the trauma medical director, the trauma resuscitation team, the trauma service, the trauma program manager, the trauma registrar and interventional radiology services on site. (Please refer to the “Resources for Optimal Care of the Injured Patient” (2022 Standards-Gray book) for full description of the above).
 - f. A list of trauma center conditions and requirements commensurate with the level of designation desired, which the applicant will be required to accept.
 - g. A contract between the applicant hospital and ~~Ventura County Emergency Medical Services Agency~~ VCEMS to be completed when the hospital’s application has been approved. Applicants will be required to indicate their acceptance of the contract or to submit alternative language for any clause which they are unwilling to accept.
 - h. A schedule of fees for trauma center applications and ongoing designation/contracts.
 - i. ~~How to apply~~ Application process.
4. The County may elect to issue an RFP.
5. An ~~facility~~ acute care hospital in Ventura County seeking trauma center designation prior to, or en lieu of, ~~the~~ VCEMS initiated NBATS assessment, must fund a trauma system assessment. The consultant performing the assessment shall be selected in coordination with ~~VCEMS.MS.~~

6. An facility acute care hospital who seeks/obtains Trauma Center Verification outside of the process outlined above will not be designated by VCEMS as a trauma center.

7. An The updated trauma plan must be submitted and approved by the California EMS Authority, in accordance with CCR XXX100136.01 and 100136.04, prior to implementation of the additional trauma center. - Center Designation

— Ventura County Emergency Medical Services (VCEMS) will determine when an added trauma center designation is needed. This will be completed by periodically assessing the needs of the county trauma system by using tools such as the “Needs Based Assessment of Trauma Systems (NBATS) Tool to collect data and/or a Trauma System Evaluation.

1. — If a hospital would like to request a review for a trauma level designation, a letter of request will be sent to the EMS Agency. The hospital may be required to cover the cost of a Trauma System Evaluati

1. — If VCEMS determines the need for additional trauma center(s), VCEMS Ventura County Emergency Medical Services Agency will issue a request for proposal (RFP) for the designation of the trauma center(s). The RFP will include:

a. — Introduction and background information about Ventura County’s trauma system.

b. — General information and instructions about trauma center designation including eligibility for application, primary service areas, fees and EMS’s no guarantee policy of the minimum number of trauma patients

c. — Level of designation desired

d. — Reference to Title 22 and the American College of Surgeons “Resources for Optimal Care of the Injured Patient” (2022 Standards Gray book) “Resource for Optimal Care of the Injured Patient 2006” as the criteria for designation. Applicants will be required to describe their current compliance with these criteria or to indicate plans to achieve compliance within 6 months of the nomination for designation.

e. — List of the minimal requirements for designation that includes: hospital

organization, medical staff support, the trauma program, the trauma medical director, the trauma resuscitation team, the trauma service, the trauma program manager, the trauma registrar and interventional radiology services on site. (Please refer to see page 31–35 of the the “Resource for Optimal Care of the Injured Patient 2006” “Resources for Optimal Care of the Injured Patient” (2022 Standards Gray book) for full description of the above).

f. — A list of trauma center conditions and requirements commensurate with the level of designation desired, which the applicant will be required to accept.

g. — A contract between the applicant hospital and Ventura County Emergency Medical Services Agency to be completed when the hospital's application has been approved. Applicants will be required to indicate their acceptance of the contract or to submit alternative language for any clause which they are unwilling to accept.

h. — A schedule of fees for trauma center applications and ongoing designation/contracts.

~~2. — The RFP will be sent by registered, return receipt requested mail to those hospitals in Ventura County who submitted the required letter of interest. Any hospital wishing to respond to the RFP will be required to complete the RFP as outlined in the RFP and submit the application fee by a specified date and time. Thereafter, all communication regarding the process will be sent only to hospitals that have indicated their interest.~~

~~53. — EMS will host a mandatory pre-proposal conference~~

~~64. — Hospitals will have up to 60 days to submit an original and six copies of the proposal to ACS. Other submission requirements will be outlined in the RFP.~~

~~75. — The independent review panel (IRP) will include experts as appropriate for the level of designation such as a trauma surgeon(s), emergency physician(s), trauma program manager(s), hospital administrator(s), EMS Agency administrator(s) and/or individuals with similar qualifications. The IRP shall be composed of individuals who work outside of the County of Ventura and have no affiliation or allegiance to any hospital within the County, and who are selected and approved by the Trauma Working Group.~~

~~86. — The proposal review process will be contracted to American College of Surgeons which will include a site visit for the purpose of confirming the information submitted as well as an evaluation of the hospital's capability and commitment to serve as a trauma center at the level of designation defined in the RFP. The IRP will evaluate proposals~~

according to but not limited to:

- a. ~~Compliance with minimum standards~~
- b. ~~Quality and scope of service~~
- c. ~~Applicant's demonstrated commitment to the care of major trauma patients~~
- d. ~~Comprehensiveness~~
- e. ~~Cost effectiveness of the proposed service~~
- f. ~~Actuality of the demonstrated ability to provide Level II trauma services at the level of designation requested versus a stated plan to provide the service~~

~~97. The nominated designated hospital must agree to obtain verification by the American College of Surgeons as a trauma center at the level of designation desired within 3 years of designation at cost to the hospital.~~

B. Trauma Center Designation

1. VCEMS may form a review panel to evaluate applications. The format of application review will depend on process determined by VCEMS and will be outlined prior to releasing the applications.

2. A site visit will be required for designation.

3. Following the site visits, the IRP review panel will report to VCEMS on its findings and decision recommendation on designation of trauma hospitals. This will include any recommended corrective action plan that would be required to meet trauma center requirements.

~~42. IRP Review panel recommendations for approval will be forwarded submitted to the Ventura County Board of Supervisors for final designation.~~

~~3. Reports of the IRP will be made available upon request.~~

C. Appeals

1. Notices of findings and copies of reports specific to each applicant will be sent to the appropriate applicant. Applicants will have 10 working days to appeal from the day of receipt of the preliminary recommendations of the review panel IRP. Grounds for appeals are limited to alleged failure to follow the policy, RFP or proposal review process. Expert judgments or analyses of the survey team are not subject to appeal.

2. A County will identify a three-member appeal panel whose members have expertise in proposal ~~reviews, and reviews and~~ have no allegiance or affiliation with any hospital within the County or to any member of the

~~IRP review panel, and who are selected and approved by the Trauma Working Group,~~ The appeal panel will review the appeal and make a decision. All decisions are final and cannot be appealed further.

3. A fee of \$5,000 will be required to request an appeal. These funds shall be used by the County to recover costs of resources used to reply to the appeal.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Trauma Registry and Data		Policy Number 1403	
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: June December 1, 202 5 4	
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: June December 1, 202 5 4	
Origination Date: July 14, 2015		Effective Date: June December 1, 202 5 4	
Date Revised: December 2, 2021			
Date Last Reviewed: December 5 2, 202 4 4			
Review Date: December 31, 202 7 4			

- I. PURPOSE: To standardize data elements collected from trauma care facilities to monitor, review, evaluate, and improve the delivery of prehospital advanced life support and hospital trauma care services.
- II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798, and California Code of Regulations, Title 22, §~~100136.03~~100255.
- III. POLICY: The following information shall be collected by Ventura County designated Trauma Centers and Community Hospitals and reported to the Ventura County EMS Agency.
- IV. INCLUSION CRITERIA
 - A. Patients will be included in the registry when they:
 1. Meet at least ONE of the following criteria :
 - a. Death
 - b. Hospital admission as either observation or inpatient status
 - c. Interfacility transfer to provide a higher level of trauma care (in or out)
 - d. Meets prehospital trauma triage criteria for Step 1-4
 - e. Trauma centers ONLY: full or limited trauma team activation

AND

 - 2. Have a diagnostic code for any injury included in the following range:
ICD-10-CM: S00-S99, T07, T14, T20-T28, T30-T32 and T79.A1-T79.A9

AND

 - 3. Have at least one injury with a diagnostic code outside the following range:
S00, S10, S20, S30, S40, S50, S60, S70, S80, S90

B. Data element description

1. Trauma Centers

- a. Current data components for NTDS® (National Trauma Data Standard)
- b. Ventura County specific data
 - 1. Hospital account number for ED visit
 - 2. If transported to trauma center by ambulance
 - A. ImageTrend incident number
 - B. Trauma Step assigned by EMS

2. Community Hospitals

- a. Date of birth
- b. Date of ED arrival
- c. Date of admission
- d. Hospital account number
- e. ICD-10 codes
- f. Hospital outcome

C. Reporting

1. Trauma Centers

- a. Complete spreadsheets as requested by EMS each quarter
- b. Upload trauma patient data into Ventura County trauma registry by the 15th of each month. Each upload should include patient records from the previous 6 months so that any incomplete records uploaded are overwritten in subsequent uploads.
- c. Complete on-line transfer form (refer to VCEMS Policy 1404) for any transfer of trauma patients for a higher level of care
- d. Comply with data collection as needed by EMS

2. Community Hospitals

- a. Complete on-line transfer form (refer to VCEMS Policy 1404) for any Emergent/Urgent trauma transfer
- b. Comply with data collection as needed by EMS

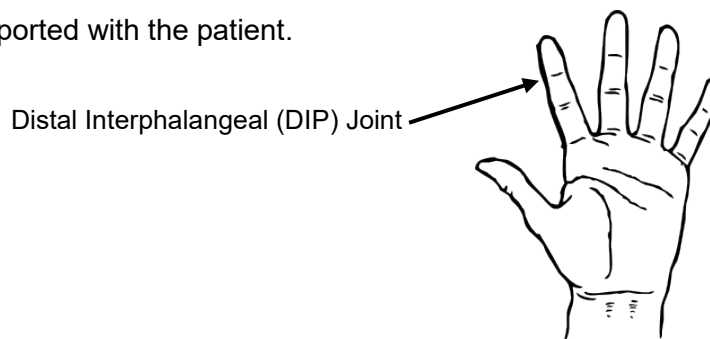
COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Trauma Triage and Destination Criteria		Policy Number: 1405	
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: June 1, 2025 January 3, 2023	
APPROVED: Medical Director: Daniel Shepherd, MD		Date: June 1, 2025 January 3, 2023	
Origination Date: July 1, 2010		Effective Date: June 1, 2025 January 3, 2023	
Date Revised: September 1, 2022			
Date Last Reviewed: December 5, 2024 September 1, 2022			
Review Date: December 31, 2026 September 30, 2024			

- I. PURPOSE: To guide out-of-hospital personnel in determining which patients require the services of a designated trauma center. To serve as the EMS system standard for triage and destination of patients suffering acute injury or suspected acute injury.
- II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798. California Code of Regulations, Title 22, §~~100135.17400252~~ and §~~100136.03400255~~.
- III. POLICY: These criteria apply to any patient who is injured or has a physical complaint related to trauma and is assessed by EMS personnel at the scene.
 - A. Physiologic Criteria, Step 1:
 1. Glasgow Coma Scale
 - Unable to follow commands (GCS motor < 6)
 2. Systolic Blood Pressure
 - Age 10-64 years SBP < 90 mmHg or HR > SBP
 - Age 65 and older SBP < 110 mmHg or HR > SBP
 - Age 0-9 years SBP < 70 mmHg + (2 x age years)
 3. Respiratory
 - RR < 10 or > 29 breaths/min
 - Respiratory Distress or need for respiratory support
 - Room-air pulse oximetry < 90%
 - B. Anatomic Criteria, Step 2:
 1. Penetrating injuries to the head, neck, torso, or extremities proximal to elbow or knee
 2. Chest wall instability, deformity, or suspected flail chest
 3. Suspected two or more proximal long-bone fractures (femur, humerus)
 4. Crushed, degloved, mangled or pulseless extremity
 5. Amputation proximal to wrist or ankle

-
6. Suspected pelvic fracture
 7. Skull deformity, suspected skull fracture
 8. Acute paralysis, extremity weakness, or sensory loss possibly due to spinal cord injury
 9. Seat belt injury: significant bruising to neck, chest, or abdomen
 10. Diffuse abdominal tenderness as a result of blunt trauma
 11. Active bleeding requiring a tourniquet or wound packing with continuous pressure
- C. Mechanism of Injury Criteria, Step 3:
1. Falls
 - Adults: Height > 10 feet
 - < 14 years old: Height > 10 feet or two times the patient height
 2. High-risk auto crash:
 - Intrusion (including roof) > 12" patient site **or** > 18" any occupant site
 - Ejection: partial or complete from automobile
 - Death in same passenger compartment
 - Age 0-9 years unrestrained or in unsecured child safety seat
 3. Auto vs. Pedestrian/Bicycle rider: thrown, run over, with significant impact or > 20 mph
 4. Rider separated from transport vehicle with significant impact or > 20 mph (e.g. motorcycle, ATV, horse, etc.)
- D. Special Patient or System Considerations, Step 4 (these are considerations to be used by the base hospital in determining the appropriate destination hospital):
1. Age 65 years and older
 2. Low level falls with significant head impact in ages < 5 years or 65 years and older
 3. Burns with trauma mechanism
 4. Time sensitive extremity injury (open fracture, neurovascular compromise)
 5. Pregnancy > 20 weeks with known or suspected abdominal trauma
 6. Prehospital care provider or MICN judgment
 7. Amputation or partial amputation of any part of the hand¹
 8. Penetrating injury to the globe of the eye, at risk for vision loss
 9. Anticoagulation use²
- IV. PROCEDURE:
- A. Any patient who is suffering from an acute injury or suspected acute injury shall have the trauma triage criteria applied.
 - B. For patients who meet trauma triage criteria listed in Sections A, B, or C above, the closest trauma center is the base hospital for that patient. Paramedics shall make base hospital contact and provide patient report directly to the trauma center.

- C. Transportation units (both ground and air) shall transport patients who meet at least one of the trauma triage criteria in Sections A or B to the closest appropriate designated trauma center. If the closest trauma center is on internal disaster, these patients shall be transported to the next closest appropriate trauma center. If the closest trauma center is on CT diversion, the paramedic shall make early base contact and the MICN shall determine the most appropriate destination.
- D. For patients who meet trauma triage criteria in Section C, the paramedic shall make base hospital contact with the closest designated trauma center. Based on the paramedic's report of the incident and the patient's assessed injuries, the trauma center MICN or ED physician shall direct destination to either the trauma center or the closest appropriate hospital.
- E. Paramedics providing care for patients who are injured but meet only the trauma triage criteria listed in Section D above will contact the base hospital in whose catchment area the incident occurred. Destination will be determined by the base hospital MICN or ED physician. If the patient is directed other than to the regular catchment base hospital, the MICN will notify the receiving hospital or trauma center of an inbound patient and relay paramedic report.
- F. A trauma patient without an effective airway may be transported to the closest available hospital with an emergency department for airway management prior to transfer to a designated trauma center. In this rare event, the paramedic will contact the base hospital in whose catchment area the incident occurred.
- G. A patient who does not meet trauma triage criteria and who, in the judgment of a base hospital, has a high probability of requiring immediate surgical intervention or other services of a designated trauma center shall be directed to a designated trauma center.

¹For patients with isolated traumatic amputations, partial or complete, of any portion of the hand (at or proximal to the DIP joint of any finger or any part of the thumb) as long as bleeding is controlled, and the amputated part may be transported with the patient.



²For a complete list of anticoagulant and antiplatelet drugs that should be considered for inclusion criteria in Step 4.9, please consult VC EMSA approved list.



Ventura County Field Triage Decision Scheme

For patients with visible or suspected traumatic injuries

STEP 1

Measure vital signs and level of consciousness

- 1.1 Glasgow Coma Scale**
- Unable to follow commands (GCS motor < 6)
- 1.2 Systolic Blood Pressure**
- Age 10-64 years SBP < 90 mmHg or HR > SBP
 - Age 65 years and older SBP < 110 mmHg or HR > SBP
 - Age 0-9 years SBP < 70 mmHg + (2 x age years)
- 1.3 Respiratory**
- RR < 10 or > 29 breaths/min
 - Respiratory distress or need for respiratory support
 - Room-air pulse oximetry < 90%

Yes

Contact base trauma center
Transport to trauma center

STEP 2

Assess anatomy of injury

- 2.1** Penetrating injuries to head, neck, torso, or extremities proximal to elbow or knee
2.2 Chest wall instability, deformity, or suspected flail chest
2.3 Suspected two or more proximal long-bone fractures (femur, humerus)
2.4 Crushed, degloved, mangled or pulseless extremity
2.5 Amputation proximal to wrist or ankle
2.6 Suspected pelvic fracture
2.7 Skull deformity, suspected skull fracture
2.8 Acute paralysis, extremity weakness, or sensory loss possibly due to spinal cord injury
2.9 Seat belt injury: significant bruising to neck, chest, or abdomen
2.10 Diffuse abdominal tenderness because of blunt trauma
2.11 Active bleeding requiring a tourniquet or wound packing with continuous pressure

Yes

Contact base trauma center
Transport to trauma center

STEP 3

Assess mechanism of injury and evidence of high-energy impact

- 3.1 Falls**
- Adults: Height > 10 feet
 - < 14 years old: Height > 10 feet or two times the patient height
- 3.2 High-risk auto crash**
- Intrusion (Including roof) > 12" patient site **or** > 18" any occupant site
 - Ejection: partial or complete from automobile
 - Death in same passenger compartment
 - Age 0-9 years unrestrained or in unsecured child safety seat
- 3.3 Auto vs. Pedestrian/Bicycle** thrown, run over, with significant impact or > 20 mph
3.4 Rider separated from transport vehicle with significant impact or > 20 mph (e.g., motorcycle, ATV, horse, etc.)

Yes

Contact base trauma center for destination decision

STEP 4

Assess special patient or system considerations

- 4.1** Age 65 years and older
4.2 Low level falls with significant head impact in ages < 5 years or 65 years and older
4.3 Burns with trauma mechanism
4.4 Time sensitive extremity injury (open fracture, neurovascular compromise)
4.5 Pregnancy > 20 weeks with known or suspected abdominal trauma
4.6 Prehospital care provider or MICN judgment
4.7 Amputation or partial amputation of any part of the hand¹
4.8 Penetrating injury to the globe of the eye, at risk for vision loss
4.9 Anticoagulation use²

Yes

Contact regular catchment base hospital
Consider transport to trauma center or specific resource hospital

¹See picture
²See list

Transport to closest ED or by patient preference

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Trauma Center Standards		Policy Number 1406	
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: June 1, 2025 <u>December 1, 2024</u>	
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: June 1, 2025 <u>December 1, 2024</u>	
Origination Date: July 1, 2010			
Date Revised: December 2, 2021			
Date Last Reviewed: December 5, 2024 <u>December 2, 2021</u>		Effective Date: June 1, 2025 <u>December 1, 2024</u>	
Review Date: December 31, 2027 <u>2024</u>			

- I. PURPOSE: To establish Ventura County Trauma Center facility and personnel standards for trauma patient care. To obtain and maintain designation as a Trauma Center, the Trauma Center shall maintain compliance with the standards contained in this policy.
- II. AUTHORITY: Health and Safety Code, § 1798, 1798.165 and 1798.170, California Code of Regulations, Title 22, Division 9, Chapter 6.17.
- III. DEFINITIONS:
 - A. "On-site" means being physically present within the patient treatment area at all times.
 - B. "In-house" means being physically present in the trauma center and responding immediately upon trauma team activation. Arrive to the patient treatment area within ten (10) minutes of placement of call with a minimum documented compliance rate of 80% for each calendar month, and in no case greater than fifteen (15) minutes from time call is placed.
 - C. "Immediately available" means: a) dedicated to the trauma center while on duty, b) unencumbered by conflicting duties or responsibilities; c) responding without delay when notified; and d) being physically present within the patient treatment area when the patient arrives or within fifteen (15) minutes of placement of call, whichever is later, and not to exceed fifteen (15) minutes from patient arrival, with a minimum documented compliance rate of 80% for each calendar month, and in no case greater than thirty (30) minutes from time call is placed.
 - D. "Promptly available" means arrival to the patient treatment area within thirty (30) minutes with a minimum documented compliance rate of 80% for each calendar month, and in no case greater than forty-five (45) minutes, from time call is placed.
 - E. "On-call" requires the specified healthcare professional to be available to respond for

trauma care in a defined manner and time period (i.e., immediately available, promptly available).

IV. POLICY:

A. General Provisions

1. California Statutes and Regulations: Trauma Centers will meet all applicable requirements set forth in California Health and Safety Code, Division 2.5, Chapter 6, Article 2.5 and California Code of Regulations, Title 22, Division 9, Chapter [6.17](#).
2. American College of Surgeons Committee on Trauma (ACS-COT) standards:
 - a. Trauma Centers will obtain within three (3) years of designation by VCEMS, and continuously maintain, ACS-COT Trauma Center verification.
 - b. Trauma Centers are required to continuously comply with ACS-COT trauma center verification standards, as determined by VCEMS through the QI program and other oversight activities.
3. VCEMS may establish standards that exceed the requirements above in accordance with established regulations and ACS standards.

B. Trauma System Activation

Trauma centers will accept all patients that meet trauma triage criteria, as described in VCEMS Policy 1405, except when on diversion per VCEMS Policy 402.

C. Interfacility Transfers

1. As an inclusive trauma system, all hospitals will have a role in providing trauma care to injured patients. All Ventura County trauma centers are required to establish and maintain transfer agreements with each of the Ventura County hospitals.
2. The trauma center is obligated to immediately accept all patients who meet trauma transfer criteria from hospitals in Ventura County per VCEMS Policy 1404.
3. To initiate a transfer, a call shall be placed by the transferring hospital emergency physician or surgeon to the trauma center on-call trauma surgeon or designee. The verbal report for transfer shall be physician to physician.
4. The transferring hospital, in consultation with the trauma center, will be responsible for obtaining the appropriate level of transportation. Consideration of transport modality (e.g., ground vs. air) should be a collaborative decision between transferring hospital and the trauma center.

- D. Response Requirements:
 - 1. Trauma Center staff response times will be in accordance with ACS standards commensurate with the level of designation.
 - 2. Staff response times will be documented in the patient care record and trauma registry for VCEMS review.
- E. Heliport
Trauma Centers are required to operate and maintain a State-permitted heliport, on or immediately adjacent to the hospital, as described in California Code of Regulations Title 21, § 3554.
- F. Prehospital Personnel
 - 1. Trauma centers will have a written agreement with the Ventura College School of Prehospital and Emergency Medicine that allows paramedic students to schedule and experience their clinical rotations at the trauma center, as well as perform clinical procedures (e.g., endotracheal intubation, intravenous access) on patients.
 - 2. Trauma centers will allow EMT and paramedic personnel to perform clinical skills for continuing education and remediation purposes as directed by the VCEMS CQI program.
- G. Base Hospital
 - 1. Trauma Centers must be designated by VCEMS as a Base Hospital and comply with all requirements in VCEMS Policy 410.
 - 2. Trauma Centers must employ a minimum of one FTE Prehospital Care Coordinator.
- H. Maintenance of Designation
 - 1. Trauma Centers will be reviewed every three years.
 - a. Trauma Center shall receive notification of intent to review from VCEMS at least 90 days prior to visit.
 - b. Review may include a site visit.
 - c. Trauma Centers shall notify VCEMS by telephone, followed by a letter or email within 48 hours of changes in program compliance, performance, or verification status.
 - 2. Data
 - a. Continuous compliance with VCEMSA policy 1403 is required.

Appendix One:

- A. VCEMS Level Two Trauma Center Response Time Requirements:

1. Surgical Service:
Availability: an operating suite that is continuously available or being utilized for trauma patients and has operating staff who are on-call and promptly available unless operating on trauma patients, and back-up personnel who are promptly available.
2. General Surgeon:
 - a. Availability: On-call and immediately available for highest level of trauma team activation, and available within one (1) hour of the time of call for other trauma team activations or consultation when requested by the emergency physician.
 - b. Advised of all trauma patient admissions;
 - c. Participate in major therapeutic decisions;
 - d. Present in the emergency department for all major trauma resuscitations; and
 - e. Present in the operating room for all procedures.
3. Emergency Medicine:
Availability: On-Site
4. Respiratory Therapist:
Availability: In House
5. Radiology Technician:
Availability: In House
6. CT Technician:
Availability: On call and immediately available
7. Radiologist:
Availability: On-call and promptly available
8. Interventional Radiology Service and Interventional Radiologist
 - a. Includes diagnostic and therapeutic procedures
 - b. Availability: On-call and promptly available
9. Ultrasound Service
Availability: On-call and promptly available
10. Anesthesiology:
Availability: In-house
11. Clinical Laboratory:

- Availability: On-Site (within the lab)
- 12. Neurosurgery:
Availability: On-call and promptly available
- 13. OB/GYN Service:
Availability: On-call and promptly available
- 14. Orthopedics:
Availability: On-call and promptly available
- 15. Ophthalmologist:
Availability: On-call and promptly available
- 16. Oral or Maxillofacial, or Head and Neck Service:
Availability: On-call and promptly available
- 17. Plastic Surgery:
Availability: On-call and promptly available
- 18. Reimplantation/Microsurgery:
 - a. Availability: On-call and promptly available
 - b. If reimplantation/microsurgery is provided via a transfer agreement, the patient shall be transferred out within one (1) hour of arrival at that trauma center, unless other life-threatening conditions take precedent as determined by the staff trauma surgeon. If transfer is delayed the reason(s) must be documented in the patient's chart.
- 19. Urologist
Availability: On-call and promptly available
- 20. Thoracic Surgery:
Availability: On-call and promptly available
- 21. Critical Care Services:
Availability: On-site within the critical care area
- 22. Critical Care Physician
Availability: On-call and promptly available
- 23. Cardiac Surgery:
 - a. Availability: On-call and promptly available if cardiac surgery is available at the trauma center
 - b. If cardiac surgery is provided via a transfer agreement, the patient shall

be transferred out within one (1) hour of arrival at that trauma center, unless other life-threatening conditions take precedent as determined by the staff trauma surgeon. If transfer is delayed, the reason(s) must be documented in the patient's chart.



24. Additional Specialty Services:

- a. Burn Center. These services may be provided through a written transfer agreement with a burn center.
- b. Acute hemodialysis capability.
- c. Acute spinal cord injury management capability. This service may be provided through a written transfer agreement with a rehabilitation center.
- d. A pediatric intensive care unit approved by the California State Department of Health Services' California Children Services (CCS); or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care

25. Available Consultations:

The following specialist(s) or specialty service(s) will be available for consultation and respond by phone to a call within thirty (30) minutes.

- a. Cardiology
- b. Gastroenterology
- c. Hand Surgery
- d. Hematology
- e. Infectious Diseases
- f. Internal Medicine
- g. Nephrology
- h. Neurology
- i. Pathology
- j. Pulmonary Medicine

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Paramedic Preceptor		Policy Number: 319	
APPROVED: Administration:	 Steven L. Carroll, Paramedic	Date: June December 1, 2025 4	
APPROVED: Medical Director	 Daniel Shepherd, MD	Date: June 1, December 1, 2025 4	
Origination Date:	June 1, 1997	Effective Date: June December 1, 2025 4	
Date Revised:	May 13, 2021		
Last Date Reviewed:	May 13, 2021		
Next Review Date:	May 31, 2024		

- I. PURPOSE: To establish minimum requirements for designation as a Ventura County paramedic preceptor.
- II. AUTHORITY: Health and Safety Code, Sections 1797.214 and 1798. California Code of Regulations, Title 22, Division 9, Section 100092.02150
- III. DEFINITIONS:
 - A. A field training officer (FTO) is an agency designation for those personnel qualified to train other prehospital personnel working for that agency.
 - B. The paramedic preceptor as identified in California Code of Regulations Title 22, Division 9, Chapter 3.34, Article 3, Section 100092.02150, is qualified to train paramedic student Interns. A paramedic preceptor may also be a FTO, when designated by that individual's agency.
- IV. POLICY:
 - A. A Paramedic may be designated a paramedic preceptor upon completion of the following:
 1. Be a licensed paramedic in the state of California, working in the field for at least the last two (2) years
 2. Be under the supervision of the principal instructor, program director and/or program medical director of the applicable paramedic training program.
 3. Have completed a field preceptor training program approved by VCEMS, in accordance with the Commission on Accreditation of Allied Health Education Programs (CAAHEP) standards and guidelines for the accreditation of Educational Programs in the EMS Professions (2015). Training shall include a curriculum that will result in preceptor competency

in the evaluation of paramedic students during the internship phase of the training program and the completion of the following:

- a. Conduct a daily field evaluation of students
 - b. Conduct cumulative and final field evaluations of all students
 - c. Rate students for evaluation using written field criteria
 - d. Identify ALS contacts and requirements for graduation
 - e. Identify the importance of documenting student performance
 - f. Review the field preceptor requirements outlined by the State of California and in local VCEMS Policy
 - g. Assess student behaviors using cognitive, psychomotor, and affective domains.
 - h. Create a positive and supportive learning environment
 - i. Measure students against the standards of entry level paramedics
 - j. Identify appropriate student progress
 - k. Counsel the student who is not progressing
 - l. Identify training program support services available to the student and the preceptor
 - m. Provide guidance and procedures to address student injuries or exposure to illness, communicable disease or hazardous material.
4. 6 months, (minimum 1440 hours) practice in Ventura County as a level II paramedic.
 5. Written approval submitted to VCEMS by employer.
 6. Written approval submitted to VCEMS by the prehospital care coordinator at the base hospital of the area where the paramedic practiced the majority of the time.
 7. Written notification of intent to practice as a paramedic preceptor shall be submitted to VCEMS prior to preceptor working in this capacity.
- B. A preceptor shall not precept or evaluate more than one person at a time.
- C. Paramedic Interns: Preceptors must directly observe the performance of all “Critical Procedures” and must be located in a position to immediately assume control of the procedure. The preceptor may not be functioning in any other capacity during these procedures.
1. Critical Procedures:
 - a. Endotracheal Intubation

- 1) Paramedic Intern shall be limited to one attempt in difficult intubations (e.g., morbidly obese patients, neck or facial trauma, active vomiting, massive oropharyngeal bleeding).
The intern will not make a second attempt.
 - b. Needle Thoracostomy
 - c. Intraosseous needle insertion
 - d. Childbirth
 - e. Medication Administration
 - f. PVAD
 - g. Intravenous Access when patient requires immediate administration of fluids and/or medication(s).
- D. Each preceptor will be evaluated by their intern or candidate at the end of their training period. This evaluation will be forwarded to the preceptor's employer

Recommendation Form

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

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


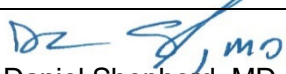
Please initial the appropriate box

<p>Paramedic Preceptor</p> <p>_____ All the requirement of level II met.</p> <p>_____ 6 months (minimum 1440 hrs.) practice in Ventura County as a Level II Paramedic.</p> <p>_____ Successful completion of a preceptor training course approved by VCEMS.</p> <p>_____ Approval by employer</p> <p>_____ Approval by the PCC at the base hospital of the area where the Paramedic practiced the majority of the time during the previous year.</p> <p>_____ Notification of VCEMS</p> <p>_____ Completion of Curriculum Vitae</p>
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Please sign and date below for approval.

Employer Date:

PCC, BH Date:

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: 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:	April 1, 1983		
Date Revised:	February 10, 2022		
Last Date Reviewed:	February 10, 2022	Effective Date: July 1, 2022	
Next Review Date:	February 28, 2025		

- 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 (10) 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 (10) 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.

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: _____

MICN AUTHORIZATION APPLICATION

	County of Ventura Emergency Medical Services Agency 2220 E. Gonzales Road, Suite 130 Oxnard, CA 93036 805-981-5301	
<i>Application processing requires a minimum of 10 days once all materials are received. Authorization cards will be mailed. Complete application in ink.</i>		
Name:		
Street Address:		
City:	State:	Zip code:
Home phone: ()	Work Phone: ()	
Base Hospital:		
Current/Prior Authorization Number:	Expiration Date:	
Initial Authorization: <ul style="list-style-type: none"> <input type="checkbox"/> Pass the Ventura County EMS MICN Exam with a score of 80% or higher. <input type="checkbox"/> Provide a copy of a valid and current license as a registered nurse in California <input type="checkbox"/> Provide a copy of a valid and current ACLS card (front and back of card) <input type="checkbox"/> Provide a copy of a valid and current PALS, PEPP, or ENPC card (front and back of card) <input type="checkbox"/> Letter of Recommendation (VCEMS Policy 321, appendix A) (to include 1040 hours of Critical Care Experience & 520 hours of Ventura County ED experience) <input type="checkbox"/> Field Observation Verification (VCEMS Policy 321, appendix C) <input type="checkbox"/> Communication Equipment Performance Evaluation Form (VCEMS Policy 321, appendix D) <input type="checkbox"/> Verification of Internship Completion (VCEMS Policy 321, appendix E) 		
Reauthorization <ul style="list-style-type: none"> <input type="checkbox"/> Provide a copy of a valid and current license as a registered nurse in California <input type="checkbox"/> Provide a copy of a valid and current ACLS card (front and back of card) <input type="checkbox"/> Provide a copy of a valid and current PALS, PEPP, or ENPC card (front and back of card) <input type="checkbox"/> Verification of employment as an MICN at a designated base hospital <input type="checkbox"/> Letter of Recommendation (VCEMS Policy 322, appendix A) <input type="checkbox"/> Continuing Education Log (VCEMS Policy 322, appendix D) 		
Applicant Signature:		Date
Prehospital Care Coordinator Signature:		Date



COMMUNICATION EQUIPMENT PERFORMANCE EVALUATION FORM

Candidate's Name:	MICN Exam Date:	Base Hospital:
<p>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.</p>		

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.						

VERIFICATION OF INTERNSHIP COMPLETION

<p>_____, 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:</p>								
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								
<p>NOTE: In order to qualify for recommendation, a candidate must receive at least a rating of 3 in each category. Ratings are as follows:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. Poor</td> <td style="width: 50%;">4. Good</td> </tr> <tr> <td>2. Fair</td> <td>5. Excellent</td> </tr> <tr> <td>3. Average</td> <td></td> </tr> </table>			1. Poor	4. Good	2. Fair	5. Excellent	3. Average	
1. Poor	4. Good							
2. Fair	5. Excellent							
3. Average								
ATTACH COMMUNICATION EQUIPMENT PERFORMANCE EVALUATION FORM								
Signatures:	<p>_____</p> <p>Base Hospital Medical Director/Paramedic Liaison Physician</p>							
	<p>_____</p> <p>Prehospital Care Coordinator</p>							

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:	April 1983		
Date Revised:	February 10, 2022		
Date Last Reviewed:	February 10, 2022	Effective Date: July 1, 2022	
Next Review Date:	February 28, 2025		

- 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.
-

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: _____

MICN AUTHORIZATION APPLICATION

	County of Ventura Emergency Medical Services Agency 2220 E. Gonzales Road, Suite 130 Oxnard, CA 93036 805-981-5301	
<i>Application processing requires a minimum of 10 days once all materials are received. Authorization cards will be mailed. Complete application in ink.</i>		
Name:		
Street Address:		
City:	State:	Zip code:
Home phone: ()	Work Phone: ()	
Base Hospital:		
Current/Prior Authorization Number:	Expiration Date:	
Initial Authorization: <ul style="list-style-type: none"> <input type="checkbox"/> Pass the Ventura County EMS MICN Exam with a score of 80% or higher. <input type="checkbox"/> Provide a copy of a valid and current license as a registered nurse in California <input type="checkbox"/> Provide a copy of a valid and current ACLS card (front and back of card) <input type="checkbox"/> Provide a copy of a valid and current PALS, PEPP, or ENPC card (front and back of card) <input type="checkbox"/> Letter of Recommendation (VCEMS Policy 321, appendix A) (to include 1040 hours of Critical Care Experience & 520 hours of Ventura County ED experience) <input type="checkbox"/> Field Observation Verification (VCEMS Policy 321, appendix C) <input type="checkbox"/> Communication Equipment Performance Evaluation Form (VCEMS Policy 321, appendix D) <input type="checkbox"/> Verification of Internship Completion (VCEMS Policy 321, appendix E) Reauthorization <ul style="list-style-type: none"> <input type="checkbox"/> Provide a copy of a valid and current license as a registered nurse in California <input type="checkbox"/> Provide a copy of a valid and current ACLS card (front and back of card) <input type="checkbox"/> Provide a copy of a valid and current PALS, PEPP, or ENPC card (front and back of card) <input type="checkbox"/> Verification of employment as an MICN at a designated base hospital <input type="checkbox"/> Letter of Recommendation (VCEMS Policy 322, appendix A) <input type="checkbox"/> Continuing Education Log (VCEMS Policy 322, appendix D) 		
Applicant Signature:		Date
Prehospital Care Coordinator Signature:		Date

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.				

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.

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	Date	Location	# Of Hours	Provider Number
1.				
2.				
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12.				

Lecture Hours					
	Required Courses	# of Hours	Date	Location	Provider Number
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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.					
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7.	Basic MCI for the MICN-Refresher (2 Hours)				

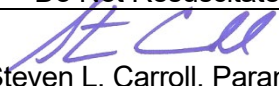

Miscellaneous Hours (10 hours are required) (These hours can be earned with any combination of additional field care audit, lecture, etc.)				
	Date	# of Hours	Location	Provider Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Mobile Intensive Care Nurse Authorization 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:	December 1991		
Revised:	February 10, 2022	Effective Date: July 1, 2022	
Date Last Reviewed:	February 10, 2022		
Next Review Date:	February 28, 2025		

- 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: Do Not Resuscitate		Policy Number 613	
APPROVED: Administration:	 Steven L. Carroll, Paramedic	Date: December 1, 2021	
APPROVED: Medical Director:	 Daniel Shepherd, M.D.	Date: December 1, 2021	
Origination Date:	October 1, 1993	Effective Date: December 1, 2021	
Date Revised:	October 14, 2021		
Date Last Reviewed:	October 14, 2021		
Review Date:	October 31, 2023		

- I. **PURPOSE:** To establish criteria for a Do Not Resuscitate (DNR) Order, and to permit Emergency Medical Services personnel to withhold resuscitative measures from patients in accordance with their wishes.
- II. **AUTHORITY:** California Health and Safety Code, Sections 1797.220, 1798 and 7186 and Division 1, Part 1.85 (End of Life Option Act).
California Probate Code, Division 4.7 (Health Care Decisions Law).
California Code of Regulations, Title 22, Section ~~100096.03400470~~.
Emergency Medical Service Authority California Health and Human Services Agency, EMSA #311, 6th Revision (EMSA Personnel Guidelines Limiting Pre-Hospital Care)
- III. **DEFINITIONS:**
- A. “EMS Personnel”: All EMTs, paramedics and RNs caring for prehospital or interfacility transfer patients as part of the Ventura County EMS system.
- B. “Resuscitation”: Medical interventions whose purpose is to restore cardiac or respiratory activity, and which are listed below:
1. External cardiac compression (chest compressions).
 2. Defibrillation.*
 3. Tracheal Intubation or other advanced airway.*
 4. Assisted Ventilation for apneic patient.*
 5. Administration of cardiotoxic medications.*
- C. “DNR Medallion”: A permanently imprinted insignia, worn by a patient that has been manufactured and distributed by an organization approved by the California Emergency Medical Services Authority.
- D. “DNR Order”: An order to withhold resuscitation. A DNR Order shall be considered operative under any of the following circumstances. If there is a

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

conflict between two DNR orders the one with the most recent date will be honored.

1. A fully executed original or photocopy of the “Emergency Medical Services Prehospital DNR Form” has been read and reviewed on scene;
 2. The patient is wearing a DNR Medallion;
 3. A fully executed California Durable Power of Attorney For Health Care (DPAHC) form is seen, a health care agent designated therein is present, and that agent requests that resuscitation not be done;
 4. A fully executed Natural Death Act Declaration has been read and reviewed on scene;
 5. A fully executed California Advance Health Care Directive (AHCD) has been read and reviewed on scene and:
 - a. a health care agent designated therein is present, and that agent requests that resuscitation not be done, or
 - b. there are written instructions in the AHCD stating that the patient does not wish resuscitation to be attempted;
 6. A completed and signed Physician Orders for Life-Sustaining Treatment (POLST) form has been read and reviewed on scene, and in Section A, “Do Not Attempt Resuscitation/DNR” is selected;
 7. A fully executed Final Attestation Form, or;
 8. For patients who are in a licensed health care facility, or who are being transferred between licensed health care facilities, a written document in the patient’s permanent medical record containing the statement “Do Not Resuscitate”, “No Code”, or “No CPR,” has been seen. A witness from the health care facility must verbally document the authenticity of this document.
 9. In cases where a verbal DNR request is expressed, EMS Personnel shall directly consult with the base hospital physician. Base hospital physicians retain authority for determining appropriateness of resuscitation.
- E. “California Advance Health Care Directive (AHCD)”. As defined in California Probate Code, Sections 4600-4805.
- F. “California Durable Power of Attorney for Health Care (DPAHC)”: As defined in California Civil Code, Sections 2410-2444.

- G. “Natural Death Act Declaration”: As defined in the Natural Death Act of California, Health and Safety Code, Sections 7185-7195.
 - H. “Physician Orders for Life-Sustaining Treatment (POLST)”. As defined in California Probate Code, Division 4.7 (Health Care Decisions Law).
 - I. “Final Attestation Form”: As defined in the End of Life Option Act, California Health and Safety Code Section 443.11.
 - J. Comfort measures: Medical interventions used to provide and promote patient comfort. Comfort measures applicable to the End of Life Option Act may include airway positioning and suctioning.
- IV. PROCEDURE:
- A. All patients require an immediate medical evaluation.
 - B. Correct identification of the patient is crucial in this process. If not wearing a DNR Medallion, the patient must be positively identified as the person named in the DNR Order. This will normally require either the presence of a witness or an identification band.
 - C. When a DNR Order is operative:
 - 1. If the patient has no palpable pulse and is apneic, resuscitation shall be withheld or discontinued.
 - 2. The patient is to receive full treatment other than resuscitation (e.g., for airway obstruction, pain, dyspnea, hemorrhage, etc.).
 - 3. If the patient is taking high doses of opioid medication and has decreased respiratory drive, early base hospital contact should be made before administering naloxone. If base hospital contact cannot be made, naloxone should be administered sparingly, in doses no more than 0.1 mg every 2-3 minutes.
 - 4. If transport has been initiated, continue transporting the patient to the appropriate receiving facility and transfer care to emergency department staff.
 - a. If transport has not been initiated, but personnel are still on scene, patient should be left at scene, if not in a sensitive location (place of business, public place, etc.). The situation should be explained to the family or staff at the scene.

- D. A DNR Order shall be considered null and void under any of the following circumstances:
1. The patient is conscious and states that he or she wishes resuscitation.
 2. In unusual cases where the validity of the request has been questioned (e.g., a family member disputes the DNR, the identity of the patient is in question, etc.), EMS Personnel may temporarily disregard the DNR request and institute resuscitative measures while consulting the base hospital for assistance. Discussion with the family member, with explanation, reassurance, and emotional support may clarify any questions leading to validity of a DNR form.
The underlying principle is that the patient's wishes should be respected.
 3. There is question as to the validity of the DNR Order.
Should any of these circumstances occur, appropriate treatment should continue or immediately commence, including resuscitation if necessary. Base hospital contact should be made when appropriate.
- E. Other advanced directives, such as informal "living wills" or written instructions without an agent in the California Durable Power of Attorney for Health Care, may be encountered. Should any of these occur, appropriate treatment will continue or immediately commence, including resuscitation if necessary. Base hospital contact will be made as soon as practical.
- F. In case of cardiac arrest, if a DNR Order is operative, base hospital contact is not required and resuscitation should not be done. Immediate base hospital contact is strongly encouraged should there be any questions regarding any aspect of the care of the patient.
- G. If a DPAHC or AHCD agent requests that resuscitation not be done, EMS Personnel shall inform the agent of the consequences of the request.
- H. DNR in a Public Place
1. Persons in cardiac arrest with an operative DNR Order should not routinely be transported. The Medical Examiner's office should be notified by law enforcement or EMS personnel. If possible, an EMS representative should remain on scene until a representative from law enforcement or the Medical Examiner's office arrives.

2. If in a sensitive location (place of business, public place, etc.), it may be necessary to transport the patient to a hospital even without resuscitative measures, in order to move the body to a location that provides the family with more privacy and where arrangements can be made more expeditiously.
- I. For End-of-Life Option Act:
 1. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient's mental state. In this instance, EMS personnel will provide medical care as per standard protocols and contact the base hospital.
 2. Family member(s) or significant other(s) may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act:
 - a. BLS personnel will provide BLS airway management and bag-mask ventilation as needed until ALS arrives.
 - b. ALS personnel will provide BLS airway management and bag-mask ventilation as needed, or instruct BLS personnel to continue, and consult the base hospital physician.
- V. DOCUMENTATION:
- For all cases in which a patient has been treated under a DNR Order, the following documentation is required in the Ventura County Electronic Patient Care Report (VCePCR):
- A. Name of patient's physician signing the DNR Order.
 - B. Type of DNR Order (DNR Medallion, Prehospital DNR Form, POLST Form, written order in a licensed health care facility, DPAHC, Natural Death Act Declaration, Final Attestation Form).
 - D. For all cases which occur within a licensed health care facility, in addition to above, if the DNR Order was established by a written order in the patient's medical record, the name of the physician signing and the witness to that order.
 - E. If resuscitation is not done because of the request of a healthcare agent designated in a DPAHC or AHCD, document the agent's name in the VCePCR narrative.

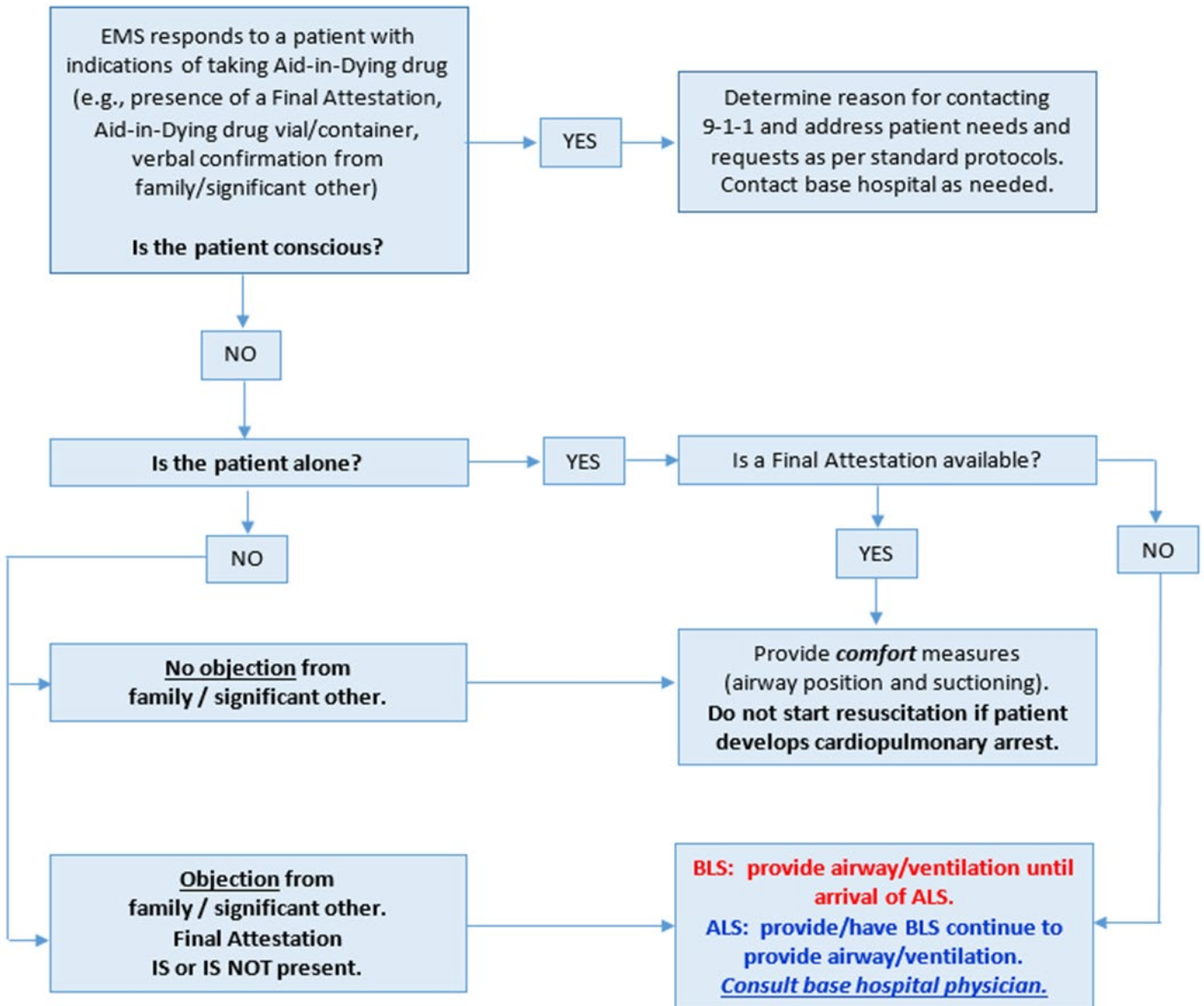
Appendix 1: Algorithm, Aid-in-Dying

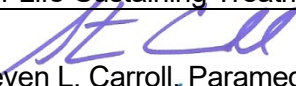



Appendix 1
Ventura County EMS Policy 613, "Do Not Resuscitate (DNR)"

For End of Life Options Act only:

Patient has taken Aid-in-Dying drug, is NOT in cardiopulmonary arrest



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Physician Orders for Life-Sustaining Treatment (POLST)		Policy Number 625	
APPROVED Administrator:	 Steven L. Carroll, Paramedic	Date: December 1, 2021	
APPROVED: Medical Director:	 Daniel Shepherd, MD	Date: December 1, 2021	
Origination Date:	January 7, 2009	Effective Date: December 1, 2021	
Date Revised:	January 10, 2019		
Date Last Reviewed:	September 9, 2021		
Review Date:	September 30, 2023		

- I. **PURPOSE:** To permit Ventura County Emergency Medical Services personnel to honor valid POLST forms and provide end-of-life care in accordance with a patient's wishes.
- II. **AUTHORITY:** California Health and Safety Code, Sections 1798 and 7186.
California Probate Code, Division 4.7 (Health Care Decisions Law).
- III. **DEFINITIONS:**
 - A. "EMS Personnel": All EMTs, Paramedics and RNs caring for prehospital or interfacility transfer patients as part of the Ventura County EMS system.
 - B. Valid Physician Orders for Life-Sustaining Treatment (POLST). A completed and signed physician order form, according to California Probate Code, Division 4.7 and approved by the California Emergency Medical Services Authority.
- IV. **POLICY:**
 - A. A POLST form must be signed by the patient or surrogate and physician to be valid.
 - B. Although an original POLST form is preferred, a copy or FAX is valid.
 - C. When a valid POLST form is presented, EMS personnel will follow the instructions according to the procedures below.
 - D. The POLST form is intended to supplement, not replace, an existing Advance Health Care Directive. If the POLST form conflicts with the Advance Health Care Directive, the most recent order or instruction of the patient's wishes governs.
- V. **PROCEDURE:**
 - A. Confirm that:
 1. The patient is the person named in the POLST.
 2. The POLST form, Section D, is signed by the patient or surrogate and physician. The form is not valid if not signed by both.

- B. POLST form - Section A:
1. If the patient has no pulse and is not breathing AND “Do Not Attempt Resuscitation/DNR” is selected, refer to VC EMS Policy 613 – Do Not Resuscitate.
 2. If the patient has no pulse and is not breathing AND EITHER “Attempt Resuscitation/CPR” is selected OR neither option is selected then begin resuscitation. (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- C. POLST Form – Section B: This section applies if the patient has a pulse and/or is breathing.
1. If “**Full Treatment**” is selected, the following treatments may be done as indicated:
 - a. All items included in Selective and Comfort-Focused Treatment
 - b. Intubation and other advanced airway interventions
 - c. Mechanical Ventilation
 - d. Cardioversion / Defibrillation
 2. If “**Selective Treatment**” is selected, the following treatments may be done as indicated:
 - a. All items included in Comfort-Focused Treatment
 - b. General Medical Treatment
 - c. IV Antibiotics
 - d. IV Fluids
 - e. Non-Invasive positive airway pressure
 3. If “**Comfort-Focused Treatment**” is selected, the following treatments may be done as indicated:
 - a. Relieve pain and suffering with medication by any route as needed
 - b. Oxygen
 - c. Suctioning
 - d. Manual treatment of airway obstruction

Do not use treatments listed in Full and/or Selective Treatment unless consistent with comfort goal. Request transfer to hospital **only** if comfort needs cannot be met in current location.

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

VI. DOCUMENTATION:

For all cases in which a patient has been treated according to a POLST form, the following documentation is required in the narrative section of the Ventura County Electronic Patient Care Report (VCePCR):

- A. A statement that the orders on a POLST form were followed.
- B. The section of the POLST form that was applicable.

Allergic Reaction and Anaphylaxis

ADULT

PEDIATRIC

BLS Procedures

Administer oxygen as indicated

Anaphylaxis: Assist patient with prescribed epinephrine auto-injector, or

- If under 30 kg – Epinephrine 1 mg/mL
 - IM - 0.15 mg via auto-injector, pre-filled syringe, or syringe/vial draw
 - May repeat x 1 in 5 minutes if patient remains in distress
- If 30 kg and over – Epinephrine 1mg/mL
 - IM - 0.3mg via auto-injector, pre-filled syringe, or syringe/vial draw
 - May Repeat x 1 in 5 minutes if patient remains in distress

ALS Standing Orders

IV/IO access

Allergic Reaction:

Benadryl

- IV/IO/IM – 50 mg

IV/IO Access

Allergic Reaction:

For patients ≥ 6 months of age

Benadryl

- IV/IO/IM – 1 mg/kg
- Max 50 mg

Anaphylaxis without shock:

Epinephrine 1 mg/mL, if not already administered by BLS personnel

- IM - 0.3 mg
- May repeat q ~~in~~ 5 minutes if patient remains in distress

Albuterol (if wheezing is present)

- Nebulizer – 5 mg/6 mL
- May repeat as needed

Anaphylaxis without Shock:

Epinephrine 1 mg/mL, if not already administered by BLS personnel

- IM – 0.01 mg/kg up to 0.3mg
- May repeat q 5 minutes, if patient remains in distress

Albuterol (if wheezing is present)

- Patient ≤ 30 kg
 - Nebulizer – 2.5 mg/3 mL
 - Repeat as needed
- Patient > 30kg
 - Nebulizer – 5 mg/6 MI
 - Repeat as needed

Anaphylaxis with Shock:

Epinephrine 10mcg/mL

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

- Initiate 2nd IV/IO

Normal Saline

- IV/IO bolus – 1 Liter
- May repeat x 1 as indicated

Anaphylaxis with Shock:

Epinephrine 10mcg/mL

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

- Initiate 2nd IV if possible or establish IO

Normal Saline

- IV/IO bolus – 20 mL/kg
- May repeat x 1 as indicated

Base Hospital Orders Only

Consult with ED Physician for further treatment measures

Additional Information

- In cases of anaphylaxis or anaphylactic shock do not delay epinephrine administration. Utilize IM Epinephrine prior to other medications or prior to IV/IO epinephrine. Epinephrine is the priority in patients with anaphylaxis.
- Refer to VCEMS Policy 735 for additional information on preparing push dose epinephrine solution.

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Date Revised: October 26, 2020
Last Reviewed: October 26, 2020



VCEMS Medical Director

Shortness of Breath – Pulmonary Edema

BLS Procedures

Administer oxygen as indicated

Initiate CPAP/BiPAP for moderate to severe distress

ALS Standing Orders

Nitroglycerin

- SL or lingual spray – 0.4 mg q 1 min x 3
 - Repeat 0.4 mg q 2 min
 - No max dosage
 - Hold for SBP < 100 mmHg

If not already performed by BLS personnel, Initiate CPAP/BiPAP for moderate to severe distress

Perform 12-lead ECG (Per VCEMS Policy 726)

IV/IO access

If wheezes are present and suspect COPD/Asthma, consider:

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

If patient presents or becomes hypotensive

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

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

- Refer to VCEMS Policy 735 for additional information on preparing push dose epinephrine solution.
- Nitroglycerin is contraindicated 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. In this situation, NTG may only be given by ED Physician order.

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EMS Medical Director

Traumatic Cardiac Arrest	
ADULT	PEDIATRIC
BLS Procedures	
<ul style="list-style-type: none"> • Assess for viability per policy 606 • Treat immediate threats to life <ul style="list-style-type: none"> External hemorrhage: Tourniquet as indicated Airway and Breathing: Clear airway when indicated, place OPA, BVM ventilations Chest Compressions: Chest compressions should be performed when possible without delaying transport or other treatments <p>Rapid trauma assessment per Trauma Treatment guidelines to identify potential injuries and prioritize interventions</p>	
ALS Standing Orders	
Assess patient and mechanism Prioritize interventions in order of suspected etiology	
<p>Optimize Oxygenation/Ventilation</p> <ul style="list-style-type: none"> • Advanced airway per policy <p>Correct potential obstructive shock</p> <ul style="list-style-type: none"> • Maintain high Index of suspicion for tension pneumothorax • Bilateral needle thoracostomy per policy 715 <p>Treat potential exsanguination</p> <ul style="list-style-type: none"> • Obtain bilateral large bore IV or IO access • Tourniquet for any external hemorrhage • 1 L normal saline bolus simultaneously via each IV/IO • Utilize pressure bag for rapid fluid administration • Repeat PRN during arrest <p>Treat Cardiovascular Collapse</p> <ul style="list-style-type: none"> • High quality CPR • Epinephrine per policy <p>If palpable pulse becomes present;</p> <ul style="list-style-type: none"> • Re-assess for and control external hemorrhage. • Administer TXA as indicated in VCEMS Policy 734 • Titrate normal saline to SBP \geq 80 mmHg or palpable peripheral pulses 	<p>Optimize Oxygenation/Ventilation</p> <ul style="list-style-type: none"> • Clear airway obstruction and suction as indicated <p>Correct potential obstructive shock</p> <ul style="list-style-type: none"> • Maintain high Index of suspicion for tension pneumothorax • Bilateral needle thoracostomy per policy 715 <p>Treat potential exsanguination</p> <ul style="list-style-type: none"> • Obtain bilateral large bore IV or IO access • Tourniquet for any external hemorrhage • 20 mL/kg normal saline bolus simultaneously via each IV/IO • Utilize pressure bag or push pull technique for rapid fluid administration • Repeat PRN during arrest <p>Treat Cardiovascular Collapse</p> <ul style="list-style-type: none"> • High quality CPR • Epinephrine per policy <p>If palpable pulse becomes present;</p> <ul style="list-style-type: none"> • Re-assess for and control external hemorrhage. • Titrate normal saline to SBP \geq 80 mmHg or palpable peripheral pulses
Base Hospital Orders only	
Consult with ED Physician when orders are needed for interventions within scope but not addressed in policy.	
Additional Information	
<ul style="list-style-type: none"> • Lung sounds are subjective and when pneumothorax is present will worsen over time with BVM ventilations. Diminished or absent lung sounds should make needle thoracostomy the priority. Any other findings are inconclusive and do not contraindicate needle thoracostomy. • IO access is preferred for initial access unless circumstances are such that IO is less likely to be successful than IV. • Basic interventions should be initiated immediately and can be terminated if indicated after initial 606 assessment. • Intubation of immobilized patient in cardiac arrest is inherently difficult. Strongly consider use of supraglottic device as primary advanced airway adjunct. • Minimize Scene time to \leq 10 minutes. 	

Effective Date: December 1, 2019
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VCEMS Medical Director