County of Ventura
Department of Public Health

Notice of Changes to Policy Manual

Emergency Medical Services
Policies and Procedures

To: ALL VENTURA COUNTY EMS POLICY MANUAL HOLDERS

DATE: January 1, 2026

CHANGES MADE TO PROCEDURES AND/OR TREATMENTS

Policy #	Title/New Title	Notes
402	Patient Diversion / Emergency Department Closures	• Significant changes to circumstances in which a receiving facility may go on ED diversion • Updated diversion requirements for STEMI and TCASC • Removes ICU/CCU diversion category
403	Ambulance Patient Offload Time (APOT) / Ambulance Patient Offload Delay (APOD)	• New Policy • Defines APOT standard for Ventura County as thirty (30) minutes • Establishes guidance for hospitals, transport agencies and VCEMS related to collection of APOT fields
705.16	Neonatal Resuscitation	• Changed age to 28 days. • Added additional language for providing warmth.
705.23	Supraventricular Tachycardia	• Allows Fentanyl administration with SBP less than 90, if there will be no delay in cardioversion. • Changed language from “sedation” to “analgesia.”
705.24	Symptomatic Bradycardia	• Added language that point to Policy 705.18 for consideration of Overdose/Medication related bradycardia.
705.25	Ventricular Tachycardia – Not In Arrest	• Allows Fentanyl administration with SBP less than 90, if there will be no delay in cardioversion. • Changed language from “sedation” to “analgesia.”
705.29	Traumatic Cardiac Arrest	• Removed Epinephrine administration from policy, added guidance in the additional notes section. • Added TXA to pediatric treatment to reflect previous changes to 734 and 705.14.
710	Airway Management	• Added video laryngoscopy requirements.
726	12 Lead ECG	• Added language for focusing on clean tracing • Added Lifepak 35 criteria • Updated algorithm
727	Transcutaneous Cardiac Pacing	• Better defined Patient treatment section. • Added Transfer of Care section to focus on communication.

MINOR CHANGES

Policy #	Title/New Title	Notes
310	Paramedic Scope of Practice	• Updated policy language and authorities to better align with California Code of Regulations • Revised Local Optional Scope of Practice section to match locally approved LOSOP approvals
315	Paramedic Accreditation to Practice	• Adjusted flow of the policy • Added definition and language specific to Field Evaluation • Added reverification section
318	Independent Practice Paramedic	• Revised authorities to match California Code of Regulations • Combined Appendix A and B • Updated new Appendix A to include new policies and only 1 signature area now required • Moved Appendix C to 334
334	Prehospital Personnel Mandatory Training Requirements	• Updated and moved Appendix C from Policy 318 to 334, now 334 Appendix A
335	Out of County Internship Approval Process	• Updated policy language to better align with California Code of Regulations • Updated Attachment A – Out of County Paramedic Internship Authorization
504	ALS/BLS Equipment and Supplies	• Updated authorities to match California Code of Regulations • Re-formatted to clarify required quantities • Updated to include recently added medications and whole blood products
1100	EMT Training Program Approval	• Updated language and authorities to match California Code of Regulations • Added new EMT psychomotor skills manual requirement • Updated application checklist

1102	EMR Training Program Approval	• Updated mandatory reporting requirements
		  • Annual program report
		  • Min. 30-day notification to LEMSA for program changes
		• Updated application checklist

1130	EMS Continuing Education Provider Program Approval	• Updated language and authorities to match California Code of Regulations • Added new EMT psychomotor skills manual requirement • Updated application checklist

1135	Paramedic Training Program Approval	• Updated mandatory reporting requirements
		  • Annual program report
		  • Min. 30-day notification to LEMSA for program changes
		• Updated application checklist

2131	Multi-Casualty Incident (MCI) Response	• *Change to policy number only* • Re-organized policy listing to organize MCI/Disaster/Special Operations policies into a separate category
2132	EMS Coverage for Special Event or Mass Gathering	• *Change to policy number only* • Re-organized policy listing to organize MCI/Disaster/Special Operations policies into a separate category
2141	Hospital EMS Surge Assistance	• *Change to policy number only* • Re-organized policy listing to organize MCI/Disaster/Special Operations policies into a separate category

NO CHANGES

Policy #	Title/New Title	Notes
N/A	VCEMS Psychomotor Skills Verification Packet	• Finalized and published in July 2025 • Standard for all EMT training programs and prehospital CE providers for the purposes of final EMT skills evaluation

CHANGES MADE TO PROCEDURES AND/OR TREATMENTS

BACK

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Patient Diversion / Emergency Department Closures	Policy Number 402
APPROVED: Administration: Steve L. Carroll, Paramedic	Date: October 1, 2025
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: October 1, 2025
Origination Date: January 1990 Date Revised: August 14, 2025 Date Last Reviewed: August 14, 2025 Review Date: August 30, 2026	Effective Date: October 1, 2025

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

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

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

C. Limit situations in which Advanced Life Support (ALS) units are unreasonably removed from their area of primary response when transporting patients to a medical facility

II. INTENT: The intent of this policy is to better define processes and terminology related to hospital diversion and the transportation of patients from the primary hospital / hospital catchment area to another. Diversion is a disruptive process to the EMS system as a whole and must be minimized to limit impacts on the patients we serve. Criteria have been established to better define when a hospital may divert, and requirements have been outlined to ensure hospitals that do divert patients are not doing so inappropriately.

III. AUTHORITY: California Health and Safety Code, Title 22, Sections 1797.220 and 1798; California Code of Regulations (CCR), Title 13, Section 1105(c); CCR Title 22, Sections 100096.02 and 100253

IV. POLICY: Hospitals may divert patients according to the guidelines and procedures described below. This policy shall not negate prearranged interhospital triage and transport agreements approved by VC EMS. Additionally, Basic Life Support (BLS) patients will be transported to the

nearest emergency department unless a patient requests transport to a different facility, or when a facility is closed by internal disaster.

V. DEFINITIONS:

A. **ALS Patient:** A patient who meets the criteria for base hospital contact, in accordance with VCEMS Policy 704 – Guidelines for Base Hospital Contact or VCEMS Policy 0720 – Guidelines for Limited Base Contact.

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

C. **CALDOCs:** A computer-based program that calculates resource saturation in the emergency department using length of stay, lobby waiting, throughput, and other variables. CALDOCs score can range from 1 (normal operations) to 6 (severe over capacity).

D. **Emergency Department Work Index Scale (EDWIN):** a quantitative tool used to measure how busy or crowded an emergency department (ED) is and overall workload of emergency department clinicians. EDWIN is calculated by using a formula that takes into account the number of patients, the number of physicians, and the number of treatment bays. EDWIN score can range from <1.5 (Not Busy / Manageable) to >2 (Overcrowded).

E. **Emergency Severity Index (ESI):** A 5-level triage algorithm used in emergency departments for the purposes of prioritizing patients based on acuity and resource needs. ESI categories range from 1 (most urgent) to 5 (least urgent).

F. **National Emergency Department Overcrowding Scale (NEDOCS):** A scoring system that assesses how crowded an emergency department (ED) is. The NEDOCS score is a standardized way to measure ED crowding, which can be used to help with resource allocation and targeted interventions. NEDOCS score can range from 00 (Not Busy) to 200 (Dangerously overcrowded).

G. **Non- Divertible Patient Conditions:**

1. Unable to adequately ventilate, secure a patent airway, control hemorrhage, or ensure adequate perfusion. Patients who remain unstable will not be diverted from the closest appropriate facility.
2. Specialty Care - Patients meeting STEMI, Stroke, Trauma, Cardiac Arrest / ROSC criteria will not be diverted from the closest appropriate specialty care center unless on diversion for that category.

VI. PROCEDURE

A. DIVERSION REQUEST CATEGORIES

Hospitals will determine the need for diversion in accordance with this policy and based upon established internal standard operating procedures / guidelines that are reviewed by appropriate facility leadership on a regular basis. A hospital may request that ambulances be diverted for the following reasons using the following terminology:

1. **Internal Disaster**

Hospital's emergency department cannot receive any patients (ALS or BLS) because of at least one of the following conditions (as outlined in Reddinet) present:

Power Outage (Generators are Functioning)
Power Outage (Generators not Functioning)
Fire
Bomb Threat
Explosion
Flooding
HAZMAT (with contamination of Patient Care Areas)
Safety and Security Compromised
Phones Down
Water Disruption / Contamination
Active Shooter
Cybersecurity

NOTE: Activation of a hospital's internal policies/plans to handle staffing shortages, diversion and/or throughput (see Section VI.D.3) shall not constitute an internal disaster.

2. Emergency Department Saturation

All Emergency Department treatment beds are full (EDWIN >2, NEDOCS 141 to 200, CALDOCs 5 or 6, or equivalent) and:

a. 30% or greater of the ED has patients who fall into the ESI triage categories 1 or 2, including those ED beds occupied by admitted patients, and
b. hallway expansion/surge beds as well as admitted patients in the waiting room.

c. Additional ED Saturation guidelines are outlined in Section C – Procedure (page 7) and Section D - Considerations (page 8) below.

3. CT Scanner Inoperative

Hospital's CT scanner is not functioning and therefore not the ideal destination for patients with blunt or penetrating head trauma, truncal trauma, or a prehospital Stroke Alert patient.

4. STEMI Receiving Center (SRC) Unavailable

Hospital is unable to accept a "ST segment Elevation Myocardial Infarction (STEMI) Alert" patient due to unavailability of their Cath lab or Cath lab staff. Allowable criteria for SRC diversion shall be limited to the following circumstances:

a. Inpatient Emergent case
b. ED Emergent case
c. Equipment failure with no secondary/backup suite available
d. Inadequate staffing

Criteria will be documented, and diversion times tracked, in Reddinet. Diversion will be activated and de-activated promptly in Reddinet to avoid unnecessary diversion of STEMI patients to other SRCs.

5. Thrombectomy Capable Acute Stroke Center (TCASC) Unavailable

Hospital is unable to accept a "Large Vessel Occlusion (LVO) Alert" patient due to unavailability of their TCASC/Interventional Radiology staff. Allowable criteria for TCASC diversion shall be limited to the following circumstances:

a. Critical equipment unavailable
b. Interventional Radiology unavailable
c. Stroke team encumbered

Criteria will be documented, and diversion times tracked, in Reddinet. Diversion will be activated and de-activated promptly in Reddinet to avoid unnecessary diversion of LVO patients to other TCASCs

B. PATIENT DESTINATION

1. Internal Disaster
    a. A hospital on diversion due to internal disaster shall not receive patients (ALS or BLS).
    b. Base hospitals shall not direct ALS units to transport patients to any medical facility that has requested diversion due to an internal disaster.
2. Diversion requests will be honored provided that:
    a. The involved ALS unit estimates that it can reach an "open" facility without compromising the patient's condition
    b. The patient does not exhibit a non-divertible condition in the field.
3. Destination while adjacent hospitals are on diversion
    a. If multiple adjacent facilities are experiencing ED saturation at the same time, patient may be transported to a further emergency department not experiencing ED saturation. In these situations, the normal transport time shall not be *extended* by more than twenty (20) minutes.
    b. Patient request should be honored, regardless of hospital diversion status at the receiving destination (excluding internal disaster).
        i) This includes situations where patient or authorized representative is requesting transport to a specific facility for the purposes of keeping patients in their "medical home."
4. BLS ambulances will notify receiving hospitals of their impending arrival as early as possible and will provide an accurate estimated time of arrival.
5. Notwithstanding any other provisions of this policy, and in accordance with VCEMS Policy 604 -Transport and Destination Guidelines, final authority for patient destination rests with the Base Hospital.

C. PROCEDURE FOREMERGENCY DEPARTMENT DIVERSION

1. ED Diversion will be implemented in accordance with this policy and with internal hospital standard operating procedures / policies and will be continuously evaluated to determine if the required conditions persist.
2. Once it has been determined that all criteria for ED Diversion is met, the hospital emergency department representative will authorize the appropriate Reddinet user to activate ED diversion, ensuring that all required information is

entered accurately at that time, and that measures are taken internally to mitigate the impacts of ED overcrowding.

3. An impacted facility may place themselves on ED diversion only when it has been determined that the appropriate diversion criteria outlined above exist within the emergency department. All required information will be entered into the appropriate Reddinet fields at the time of diversion.
    a. A facility will not be granted more than 240 minutes of total ED diversion time in a single 24-hour period (measured from 00:00:00 hours to 23:59:59 hours).If at any point a facility is on ED diversion for 120 consecutive minutes, Reddinet will automatically open the hospital to ALS 9-1-1 traffic.
    b. In order for a facility to go back on ED diversion, personnel will need to evaluate and confirm that the appropriate criteria are met within the emergency department and document the required information in Reddinet.
    c. These conditions may be altered by the EMS Agency Duty Officer, in consultation with the EMS Agency Medical Director, if there are extenuating circumstances present.

D. CONSIDERATIONS RELATED TO DIVERSION

1. An effective emergency medical services system is the result of prehospital clinicians, emergency department personnel (including leadership), and hospital administrators working together as a team to care for ill and injured patients.
2. Prolonged periods of ED diversion and ambulance patient offload times (APOT) are not an emergency department problem alone. These issues are the result of dynamics and challenges within the hospital itself, in addition to external stressors and influences that exist as part of the broader EMS system. Regardless, prolonged diversion and extended APOT have a direct impact on the EMS provider agencies tasked with responding to 911 calls and provided high-quality prehospital care.
3. A facility that utilizes ED diversion may be subject to review by the Ventura County EMS Agency and may be required to submit verifiable data affirming conditions necessitating diversion were present in the ED during the applicable diversion window.

a. This data will be submitted to the EMS Agency Duty Officer within five business days of review notification.

4. Each hospital will have an internal policy(ies) or plan(s) that appropriately address hospital surge (e.g. surge plan, diversion procedures, patient throughput plan, etc.). The processes described in this document(s) should outline a multidisciplinary team approach to ensure the ability of the facility to remain open and to flex to surge capacity, thereby preventing or minimizing time of hospital diversion and APOT and downstream impacts on the emergency department team and EMS provider agencies.
   a. This plan(s) and/or standard operating procedure(s) will be submitted to VCEMS for review as part of the facility's approval as a receiving and/or base hospital, in accordance with VCEMS Policy 410 – ALS Base Hospital Standards and Policy 420 – Receiving and Standby Hospital Standards.
5. Per the Emergency Medical Treatment and Labor Act (EMTALA), the responsibility for patient care lies with the receiving facility once the patient being transported via ambulance arrives at the hospital property. Hospital staff shall make every effort to offload patients from ambulance gurneys as soon as possible.
6. Hospitals that have a consistently prolonged APOT will make every effort to offload patients as soon as possible, and will request EMS surge assistance as appropriate, in accordance with VCEMS EMS Policy 141 – Hospital EMS Surge Assistance.
7. Hospital personnel will acknowledge and provide a visual assessment of patients arriving via ambulance within 10 minutes of arrival in the ED to determine whether the patient needs an ED treatment bay or can be sent to other areas of the emergency department.

BACK

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Ambulance Patient Offload Time (APOT) / Ambulance Patient Offload Delay (APOD)		Policy Number 403
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: November 12, 2025
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: November 12. 2025
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 14, 2025 November 12, 2025 November 12, 2025 August 30, 2026	Effective Date: November 12, 2025

I. PURPOSE: This policy will establish systemwide standards related to safe and rapid transfer of patient care from EMS clinicians to hospital emergency department medical personnel. The overall intent is to improve coordination between the Ventura County EMS agency (VCEMS), approved receiving facilities, and EMS clinicians. The official APOT standard for Ventura County is detailed below in Section III.A. While regulatory requirements implemented by the California EMS Authority are effective when that standard is exceeded, hospitals in Ventura County will strive to achieve a patient offload goal of twenty (20) minutes for ninety percent (90%) of ambulance patient offloads. The focus shall remain on the patients we serve, and the goal will be to reduce ambulance patient offload times at receiving facilities with prolonged offload times outside of the established standard.

II. AUTHORITY: California Health and Safety Code - Title 22, Division 2.5, Sections 1797.120, 1797.120.5-1797.120.7, 1797.220 and 1798; California Code of Regulations – Title 22, Division 9, Chapter 1.2 and Section 100253

III. POLICY:

A. The standard for receiving facilities designated by VCEMS shall be within thirty (30) minutes for ninety percent (90%) of ambulance patient offloads.

B. Ambulance Patient Offload Time shall be calculated based on the following criteria:

1. The transporting unit has arrived at the receiving destination, and that documented arrival time is present and logical, and
2. The patient has been physically transferred to the receiving facility stretcher, bed, chair, etc., and

3. A verbal report related to the patient and care received by EMS clinician has been provided to ED medical personnel, and
4. An electronic signature has been received in the patient's electronic patient care report (ePCR) *AND* the date/time of that signature has been documented, AND the transfer of care date/time in ePCR has been documented in the appropriate field.

C. Medical Control and management of the EMS system, including EMS personnel, shall remain the responsibility of the VCEMS Medical Director

D. Per the Emergency Medical Treatment and Labor Act (EMTALA), the responsibility for patient care lies with the receiving facility once the patient being transported via ambulance arrives at the hospital property. Hospital staff shall make every effort to offload patients from ambulance gurneys as soon as possible. Designated receiving hospitals should implement processes for ED medical personnel to immediately triage and provide the appropriate emergency medical care for ill or injured patients upon arrival at the ED by ambulance.

IV. PROCEDURE:

A. Roles and Responsibilities – EMS Transport Provider Agencies
1. Transport provider agency personnel will treat and transport patient in accordance with established VCEMS policies and procedures
2. EMS personnel will present to the customary ambulance receiving area for a triage assessment by assigned ED staff (e.g., charge nurse).
3. Upon arrival at destination, and prior to transfer of care to ED medical personnel, EMS personnel will continue to provide patient care prior to the transfer of patient care to the designated receiving hospital ED medical personnel, in accordance with VCEMS policies and procedures.
4. Provide a verbal patient report to assigned ED medical personnel and transfer patient to hospital equipment as directed.
5. Document incident in accordance with VCEMS Policy 1000 – Documentation of Prehospital Care, including all necessary time fields related to transport and transfer of care to emergency department medical personnel.
    a. This process shall include the collection of an electronic signature from emergency department medical personnel within the VCePCR for that patient *at the time of transfer of care*. The signature field for this transfer of care shall be eOther.18 – Receiving Facility Signature.

   b. Additionally, the date/time of that signature shall be collected at the time of transfer of care. This date/time shall be eOther.19 – Receiving Facility Signature date/time.
6. Ensure that eTimes.12 – Date/Time Pt. Transferred to Hospital Staff is documented *at the time of transfer of care to ED medical personnel.*
   a. The time collected in this field shall be present and logical, and it shall match the date/time documented in eOther.19 – Receiving Facility Signature date/time.
7. Notify appropriate supervisor in situations where extended APOD is anticipated
8. The EMS Transport Agency shall utilize GPS vehicle tracking technology or automatic vehicle locator (AVL) technology to automatically populate or retrospectively verify the eTimes.11 - Patient Arrived at Destination date/time field within the VCePCR. Receiving facility emergency departments may validate GPS data annually in coordination with the EMS transport provider agency.
9. When directed by the California EMS Authority, participate in CalEMSA-hosted bi-weekly calls to update and discuss implementation of the protocol and the outcomes.

B. APOT Roles and Responsibilities – Receiving Facility
1. Hospital personnel will acknowledge and provide a visual assessment of patients arriving via ambulance within 10 minutes of arrival in the ED to determine whether the patient needs an ED treatment bay or can be sent to other areas of the emergency department.
2. At the time the emergency department medical personnel receive the physical transfer of patient care and report from EMS personnel, the emergency department medical personnel shall provide an electronic signature within the VCePCR system that confirms the transfer of care. The date/time for this transfer of patient care from EMS Personnel to ED medical personnel shall be captured in eTimes.12 – Pt. Transferred to Hospital Staff. The date/time for this signature is captured within the VCePCR as eOther.19 – Date/Time of Receiving Facility Signature. For the purposes of this specific transfer of care date/time, both eTimes.12 and eOther.19 shall match.
3. If unable to immediately offload patient, provide a safe area in the ED within direct sight of ED medical personnel where the EMS clinicians can temporarily wait while hospital's patient remains on the ambulance gurney.
4. Inform the ambulance transport crew of the anticipated time for the offload of the patient.
5. In situations of ED crowding / overcrowding, consider ED diversion in accordance with VCEMS Policy 402 - Patient Diversion/Emergency Department Closures

6. Implement internal plans/policies (e.g. ED diversion, throughput, surge plans, etc.) as appropriate to mitigate APOD challenges
7. For periods of excessive patient surge and sustained APODs, implement surge assistance strategies, in accordance with VCEMS Policy 141 – Hospital EMS Surge Assistance
8. Develop and submit an APOT reduction protocol to the California EMS Authority. Submission shall be made electronically via email to apot@emsa.ca.gov with the subject line: "APOT Reduction Protocol – [Hospital Name]" in an electronic format as wither a .PDF or Microsoft Word document. The APOT reduction protocol shall be submitted to CalEMSA annually on or before June 30th and shall include all required data elements and action plans defined in the APOT reduction protocol checklist for General Acute Care Hospitals (GACH) with Emergency Department (Rev. 04/2025).
9. Implement the established APOT reduction protocol within ten (10) business days of receiving email notification and direction from the California EMS Authority to do so.
10. Notify the California EMS Authority no later than twenty-four (24) hours after implementation of the APOT reduction protocol by email at apot@emsa.ca.gov, to confirm compliance.
11. When directed by the California EMS Authority, participate in CalEMSA hosted bi-weekly calls to update and discuss implementation of the protocol and the outcomes.

C. APOT Roles and Responsibilities – VCEMS
1. Establish an APOT standard and ensure designated receiving facilities are aware of standard and maintain a process to track times internally.
2. Maintain a dashboard and report that tracks APOT metrics, in accordance with California Code of Regulations and processes established by the California EMS Authority. This dashboard will be made available to receiving facilities designated by VCEMS.
3. In circumstances where excessive patient surge and/or extended APOD exist at any receiving facility, VCEMS will coordinate with ED medical personnel and ED/hospital leadership and EMS provider agencies to implement appropriate strategies and processes to mitigate impacts on EMS system and provider agencies.
4. Include the established APOT standard and any relevant APOT policies, protocols or procedures in the Response and Transport section of its annual EMS plan submission to the California EMS Authority.

5. Submit any updates or revisions to the local APOT standard occurring independent of the annual EMS plan submission to the California EMS Authority as an amendment to the local EMS plans within thirty (30) days of the effective date of the update or revision.
6. When directed by the California EMS Authority, participate in CalEMSA hosted by-weekly APOT coordination calls.
7. In coordination with receiving facilities, EMS transport provider agencies, and any other relevant local EMS agencies, review and validate APOT/APOD data submitted to CEMSIS by EMS transport provider agencies to resolve any discrepancies in the APOT or APOD data no later than the 15th calendar day of each month for data submitted in the preceding calendar month.

V. DEFINITIONS:

Ambulance Patient Offload Time (APOT): The interval between the arrival of an ambulance patient at an emergency department ambulance bay (NEMSIS element eTimes.11) and the time that patient care is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for care of the patient (NEMSIS element eTimes.12).

Ambulance Patient Offload Delay (APOD): An APOT, measured from the arrival of an ambulance patient at an emergency department ambulance bay (NEMSIS element eTimes.11) to the time that patient care is transferred to an emergency department gurney, bed, chair, or other acceptable location and the emergency department assumes responsibility for the care of the patient (NEMSIS element eTimes.12), which exceeds the thirty (30) minute APOT standard set by VCEMS.

California EMS Information System (CEMSIS): The secure, standardized, and centralized electronic information and data collection system administered by the California EMSA Authority which is used to collect statewide EMS and trauma data

Emergency Department Medical Personnel: For the purposes of APOT/APOD shall be defined as a staff member of a receiving facility emergency department to include a physician, mid-level practitioner (Nurse Practitioner, Physician Assistant) or Registered Nurse (RN) that is authorized by that facility to communicate with EMS personnel and receive transfer of care or EMS patients.

eOther.12 – Type of Person Signing: A NEMSIS value defined as “the individual’s signature associated with eOther.15 (Signature Status).” This value is required for all signatures

obtained in the VCePCR system. With regard to APOT and transfer of care to hospital staff, the value shall be recorded as “Healthcare Provider.”

eOther.13 – Signature Reason: A NEMSIS value defined as “the reason for the individual’s signature.” This value is required for all signatures obtained in the VCePCR system. With regard to APOT and transfer of care to hospital staff, the value shall be recorded as “Transfer of Patient Care.”

eOther.15 – Signature Status: A NEMSIS value defined as “indication that the signature for the Type of Person Signing and Signature Reason has been collected of attempted to be collected.” This value is required for all signatures obtained in the VCePCR system. With regard to APOT and transfer of care to hospital staff, the value shall be recorded as “signed.”

eOther.19 – Date/Time of Signature: A NEMSIS value defined as “the date/time of signature.” This value is required for all signatures obtained in the VCePCR system. With regard to APOT and transfer of care to hospital staff, the value shall be present and logical.

eTimes.11 – Patient Arrived at Destination Date/Time: A NEMSIS value defined as “the date/time the responding unit arrived with the patient at the destination or transfer point.” With regard to APOT and arrival of patient at the destination, the value shall be present and logical.

eTimes.12 – Destination Patient Transfer of Care Date/Time: A NEMSIS value defined as the date/time that patient care was transferred to the destination healthcare staff. With regard to APOT and transfer of patient care to hospital personnel, the date/time value shall be present and logical.

National EMS Information System (NEMSIS): The national repository used to store secure, standardized, and centralized electronic EMS data from every state in the nation

Ventura County Electronic Patient Care Reporting System (VCePCR): The real-time, patient care record that makes information available securely to authorized users in a digital format capable of being shared electronically across more than one agency or health care entity. All agencies operating within the Ventura County EMS system document patient care using the VCePCR system.

Neonatal Resuscitation

BLS Procedures

Newborn or Infant up to 28 days old

Provide Warmth
- Utilize placenta bag/OB Kit Bag, DO NOT cover the Airway

Assess Responsiveness
- Flick soles of feet for infant or
- Assess newborn while drying

Ensure Adequate Ventilation
- Suction if secretions cause airway obstruction
- If Apneic or gasping
    - Positive pressure ventilations (PPV) with BVM and ROOM AIR at 40-60 breaths per minute

Ensure Adequate Circulation
- If HR between 60 and 100 bpm
    - PPV with BVM and ROOM AIR at 40-60 breaths per minute
        - Continue PPV until infant maintains HR > 100 bpm

- If HR < 60 bpm
    - CPR at 3:1 ratio
        - Continue CPR until HR > 60 bpm

Correct Hypoxia
- If no improvement after 90 seconds of ROOM AIR CPR, add supplemental O_2 until HR > 100

ALS Standing Orders

Utilize Handtevy Application

Ensure Adequate Ventilation and Oxygenation
- Monitor waveform capnography
- Consider placement of supraglottic airway device

Obtain IV/IO Access

For asystole/PEA or persistent bradycardia < 60 bpm
Epinephrine 0.1mg/mL
- IV/IO – 0.01mg/kg (0.1mL/kg) q 3-5 min

Normal Saline
- IV/IO – 10mL/kg bolus

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:
- Resuscitation efforts may be withheld for extremely preterm infants (< 21 weeks or < 9 inches long). Sensitivity to the desires of the parent(s) may be considered. If uncertain as to gestational age, begin resuscitation.
- A rising heart rate is the best indicator of adequate PPV.

Effective Date: January 1, 2026
Next Review Date: November 30, 2027

Date Revised: November 4, 2025
Last Reviewed: November 4, 2025

VCEMS Medical Director

Supraventricular Tachycardia

ADULT	PEDIATRIC

BLS Procedures

Administer oxygen as indicated

ALS Standing Orders

ADULT

12 Lead ECG (do not delay synchronized cardioversion for obtaining ECG if unstable)

Valsalva maneuver

IV/IO access

Stable

- **Adenosine**
  - IV/IO – 6 mg rapid push immediately followed by 10-20 mL NS flush

No conversion or rate control

- **Adenosine**
  - IV/IO –12 mg rapid push immediately followed by 10-20 mL NS flush
  - May repeat x 1 if no conversion or rate control

Unstable – hypotension with signs of hypoperfusion

- **Synchronized Cardioversion**
  - **Zoll** 100, 120, 150, 200 joules
  - **Lifepak** 100, 200, 300, 360 joules

- **Fentanyl (Prior to cardioversion)**
  - Consider for analgesia in patients who are awake and alert.
    - Can be given with SBP less than 90, if there will be no delay in cardioversion.
  - 1 mcg/kg IV/IO/IN

PEDIATRIC

12 Lead ECG (do not delay synchronized cardioversion for obtaining ECG if unstable)

Valsalva maneuver

IV/IO access

Stable

- **Adenosine**
  - IV/IO – 0.1 mg/kg (max 6 mg) rapid push immediately followed by 10-20 mL NS flush

No conversion or rate control

- **Adenosine**
  - IV/IO – 0.2 mg/kg (max 12 mg) rapid push immediately followed by 10-20 mL NS flush
  - May repeat x 1 if no conversion or rate control

Unstable – hypotension with signs of hypoperfusion

- **Synchronized Cardioversion**
  - 0.5, 1, 2, 4, 6, 8 joules/kg

- **Fentanyl (Prior to Cardioversion)**
  - Consider for analgesia in patients who are awake and alert.
    - Can be given with SBP less than Handtevy minimum if there will be no delay in cardioversion.
  - 1 mcg/kg IV/IO/IN

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

- Adenosine temporarily blocks AV nodal conduction with the goal of terminating AVNRT.
  - Administration should be reserved for cases with a high suspicion of electrical dysfunction and where heart rate is suspected to be the cause of symptoms. Generally, treatment should be reserved for heart rates greater than 150 bpm.
  - Consider patient potential underlying causes of tachycardia (e.g. sepsis, hypovolemia, heart failure) to aid in identifying cases where transport without Adenosine administration may be appropriate.
- Synchronized cardioversion is indicated for unstable patients with any tachycardic dysrhythmia including rapidly conducting atrial fibrillation and rapidly conducting atrial flutter.
- Document all ECG strips during adenosine administration and/or synchronized cardioversion.

Effective Date: January 2, 2026
Next Review Date: September 30, 2027

Date Revised: September 11, 2025
Last Reviewed: September 11, 2025

VCEMS Medical Director

Symptomatic Bradycardia

ADULT (HR less than 40 bpm)	PEDIATRIC (HR less than 60 bpm)
BLS Procedures	
Administer oxygen as indicated	Administer oxygen as indicated If significant ALOC, initiate CPR
ALS Standing Orders	
12 Lead ECG IV/IO access • **Atropine** ○ IV/IO – 1 mg ○ May repeat q 5 min to a total max dose of 3 mg, if initial Atropine is transiently effective, or patient remains bradycardic without hemodynamic compromise. <u>Hypotension with signs of hypoperfusion</u> Initiate electrical and medical therapy concurrently, tailor additional therapy to patient response. • **Transcutaneous Pacing (TCP)** ○ Should be started immediately for 3º heart blocks and 2º Type 2 (Mobitz II) heart blocks ○ **Pain Control** – per Policy 705.19 ▪ Only needed for analgesia if pain present during TCP • **Epinephrine 10 mcg/mL** ○ 1 mL (10 mcg) q 2 minutes, slow IV/IO push ○ Titrate to SBP ≥ 90 mm/Hg • **Normal Saline** ○ 500 mL IV/IO bolus ○ May repeat x 1 for total of 1,000 mL ○ Withold if signs of heart failure Consider potential underlying causes for bradycardia: <u>For suspected Overdose/Medication related bradycardia</u> • Refer to Policy 705.18 <u>For suspected hyperkalemia</u> • **Calcium Chloride** ○ IV/IO – 1 g ○ Repeat x 1 in 10 min • **Sodium Bicarbonate** ○ IV/IO – 1 mEq/kg ○ Repeat 0.5 mEq/kg x 2 q 5 min	If CPR indicated, initiate CAM and reference appropriate cardiac arrest treatment protocol IV/IO access (only if patient in extremis) • **Atropine** ○ IV/IO – 0.02 mg/kg ○ Minimum single dose 0.1 mg ○ Maximum single dose 1 mg ○ May repeat q 5 min to a max total dose of 0.04 mg/kg • **Epinephrine 10 mcg/mL** ○ 0.1 mL/kg (1 mcg/kg) q 2 minutes, slow IV/IO push ○ Max single dose of 1 mL or 10 mcg ○ Titrate to SBP to greater than Handtevy minimum Consider potential underlying causes for bradycardia: <u>For suspected Overdose/Medication related bradycardia</u> • Refer to Policy 705.18
Base Hospital Orders Only	
Consult with ED Physician for further treatment measures	
Additional Information: ○ Bradycardia does not require treatment unless signs and symptoms are present (chest pain, altered level of consciousness, abnormal skin signs, profound weakness, shortness of breath or low BP)	

Ventricular Tachycardia Sustained – Not in Arrest

Adult

BLS Procedures

Administer oxygen as indicated

ALS Standing Orders

12 Lead ECG (do not delay synchronized cardioversion for obtaining ECG if unstable)

IV/IO Access

Stable

- **Amiodarone**
  - IVPB/IOPB **-** 150 mg in 50mL D_5W infused over 10 minutes

Unstable – hypotension with signs of hypoperfusion

- **Fentanyl (Prior to cardioversion)**
  - Consider for analgesia in patients who are awake and alert.
    - Can be given with SBP less than 90, if there will be no delay in cardioversion.
  - 1 mcg/kg IV/IO/IN

Monomorphic VT

- **Synchronized Cardioversion**
  - **Zoll** 100, 120, 150, 200 joules
  - **Lifepak** 100, 200, 300, 360 joules

Polymorphic (irregular) VT

- **Defibrillate**
  - **Lifepak** 360 joules
  - **Zoll** 200 joules

If recurrent VT, perform synchronized cardioversion or defibrillation at last successful joules setting.

Torsades de Pointes

- **Magnesium Sulfate**
  - IVPB/IOPB – 2 g in 50 mL D_5W infused over 5 min
  - May repeat x 1 if Torsades continues or recurs

Pediatric

12 Lead ECG (do not delay synchronized cardioversion for obtaining ECG if unstable)

IV/IO Access

Stable

- **Amiodarone**
  - IVPB/IOPB **–** 5 mg/kg (max 150 mg) in 50mL D_5W infused over 10 minutes

Unstable – hypotension with signs of hypoperfusion

- **Fentanyl (Prior to Cardioversion)**
  - Consider for analgesia in patients who are awake and alert.
    - Can be given with SBP less than Handtevy minimum if there will be no delay in cardioversion.
  - 1 mcg/kg IV/IO/IN

Monomorphic VT

- **Synchronized Cardioversion**
  - 0.5, 1, 2, 4, 6, 8 joules/kg

Polymorphic (irregular) VT

- **Defibrillate**
  - 2, 4, 6, 8 joules/kg

If recurrent VT, perform synchronized cardioversion or defibrillation at last successful joules setting.

Torsades de Pointes

- **Magnesium Sulfate**
  - IVPB/IOPB – 50 mg/kg (max 2 g) in 50 mL D_5W infused over 5 min
  - May repeat x 1 if Torsades continues or recurs

Base Hospital Orders only

ED Physician Order Only: After synchronized cardioversion or defibrillation, if patient converts to narrow complex rhythm greater than 50 bpm and not in 2nd or 3rd degree heart block, and amiodarone not already given, consider amiodarone - 150 mg IVPB/IOPB in D_5W infused over 10 minutes.

Additional Information:

- Early base hospital contact is recommended in unusual circumstances, e.g. Torsades de Pointes, Tricyclic OD and renal failure.
- Ventricular tachycardia (VT) is a rate greater than 150 bpm.

Effective Date: January 1, 2026
Next Review Date: September 30, 2027

Date Revised: September 11, 2025
Last Reviewed: September 11, 2025

VCEMS Medical Director

Traumatic Cardiac Arrest

BLS Procedures

- **Assess for viability per policy 606**

- **Treat immediate threats to life**
  - **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

- Rapid trauma assessment per Trauma Treatment guidelines to identify potential injuries and prioritize interventions

ALS Standing Orders

Assess patient and mechanism
Prioritize interventions in order of suspected etiology

ADULT

Optimize Oxygenation/Ventilation
- Advanced airway per policy

Correct potential obstructive shock
- Maintain high Index of suspicion for tension pneumothorax
- Bilateral needle thoracostomy per policy 715

Treat potential exsanguination
- Tourniquet for any external hemorrhage
- Obtain bilateral large bore IV or IO access
- **Normal Saline**
  - 1 L normal saline bolus simultaneously via each IV/IO
  - Utilize pressure bag for rapid fluid administration
  - Repeat PRN during arrest
- **Whole Blood -** When arrest is witnessed by EMS and hemorrhage is a likely cause.
  - Warm and rapidly transfuse one unit of low titer O+ whole blood.
  - Repeat x 1 when indications return or persist.

Treat Cardiovascular Collapse
- High quality CPR

If palpable pulse becomes present;
- Re-assess for and control external hemorrhage.
- **Tranexamic Acid** - Administer as indicated in VCEMS Policy 734 and 705.14.
- Titrate normal saline to SBP ≥ 90 mmHg or palpable peripheral pulses.

PEDIATRIC

Optimize Oxygenation/Ventilation
- Clear airway obstruction and suction as indicated

Correct potential obstructive shock
- Maintain high Index of suspicion for tension pneumothorax
- Bilateral needle thoracostomy per policy 715

Treat potential exsanguination
- Tourniquet for any external hemorrhage
- Obtain bilateral large bore IV or IO access
- **Normal Saline**
  - 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

Treat Cardiovascular Collapse
- High quality CPR

If palpable pulse becomes present;
- Re-assess for and control external hemorrhage.
- **Tranexamic Acid** - Administer as indicated in VCEMS Policy 734 and 705.14.
- Titrate normal saline to target SBP 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

- Focus on reversible causes. Utilize **Epinephrine** per 705.07 or 705.08 if suspected medical etiology of arrest. May also discuss with base hospital for additional guidance if unusual circumstances.
- 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 ≤ 10 minutes.

Effective Date: January 1, 2026
Next Review Date: August 31, 2027

Date Revised: August 4, 2025
Last Reviewed: August 4, 2025

VCEMS Medical Director

BACK

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Airway Management		Policy Number 710
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 1, 2026
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: January 1, 2026
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 1986 November 4, 2025 November 4, 2025 November 30, 2027	Effective Date: January 1, 2026

I. PURPOSE: To define the indications, procedure, and documentation for airway management by Ventura County EMS personnel.

II. AUTHORITY: California Health and Safety Code, §1798, §1798.2; §1798.160 and §1798.170 and California Code of Regulations, Title 22, §100091.01 and §100091.02.

III. Policy: Airway management shall be performed on all patients that are unable to maintain their own airway. Paramedics may utilize oral endotracheal intubation on adult patients. Paramedics may utilize oral endotracheal intubation on pediatric patients who are longer than the standard pediatric weight and length tape. Pediatric patients who fit on a pediatric length and weight tape will not be intubated by pre-hospital personnel.

IV. Definitions: Attempt: An interruption of ventilation, with, 1) laryngoscope insertion for the purpose of inserting an endotracheal tube (ETT), or 2) lifting of tongue for the purpose of insertion of a supraglottic airway device.

V. Procedure:

A. Bag-Valve-Mask (BVM) ventilations

1. Indications
    a. Respiratory arrest or severe respiratory compromise
    b. Cardiac arrest – according to VCEMS Policy 705
2. Contraindications
    a. None
3. Equipment
    a. Pediatric, below 15 kg (below white on Broselow or equivalent) infant BVM (240 ml with manometer) and mask with infant ETCO2 adaptor (< 0.5ml sidestream, < 1ml mainstream).

b. Pediatric, above 15 kg and below 36 kg (white through green on Broselow or equivalent) child BVM (500ml with manometer) with pediatric/adult ETCO2 sidestream (6.6 ml) or adult mainstream adaptor (< 5 ml) adaptor.
c. Adult and pediatric above 36 kg, small adult BVM (1,000 ml with manometer) and mask with pediatric/adult ETCO2 sidestream adaptor or adult mainstream adaptor.

B. Supraglottic Airway Device
1. The VCEMSA approved SAD may be used as the primary advanced airway device if utilized in accordance with VCEMS policy 729.
2. The VCEMSA approved SAD may be utilized prior to attempting intubation and/or as a rescue device if attempt(s) at endotracheal intubation are unsuccessful.

C. Endotracheal Intubation (ETI)
1. Indications
a. Cardiac arrest – according to VCEMS Policy 705 – ONLY if unable to adequately ventilate with BVM
b. Respiratory arrest or severe respiratory compromise **AND** unable to adequately ventilate with BVM
c. After Base Hospital (BH) contact has been made, the BH Physician may order endotracheal intubation in other situations.
2. Contraindications
a. Intact gag reflex.
3. Intubation Attempts
a. There shall be no more than two (2) attempts to perform ETI, lasting no longer than 40 seconds each, and prior to BH contact. For patients in cardiac arrest, each ETI attempt shall interrupt chest compressions for no longer than 20 seconds.
b. The patient shall be ventilated with 100% O_2 by BVM for one minute before each attempt.
c. If ETI cannot be accomplished in 2 attempts, the VCEMSA approved supraglottic airway device will be inserted in accordance with policy 729.

d. If attempts at ETI and the supraglottic airway device insertion are unsuccessful, the airway will be managed using BLS techniques.

4. Special considerations
    a. Video Laryngoscopy (VL)
        1) Providers may utilize a VL device if authorized by VCEMS
        2) The VL device must be equipped with the ability to record the intubation attempt for post-event analysis
        3) A “screenshot” confirming placement will be attached to the PCR for the incident
        4) Optimal technique varies by device and shall be addressed in training prior to use of the device.
    b. Flexible Stylet. A flexible stylet may be used for any ETI attempt that involves an ETT size of at least 6.0 mm.
        1) Two Person Technique (recommended when visualization is less than ideal):
            a) Visualize as well as possible.
            b) Place stylet just behind the epiglottis with the bent tip anterior and midline.
            c) Gently advance the tip through the cords maintaining anterior contact.
            d) Use stylet to feel for tracheal rings.
            e) Advance stylet past the black mark. A change in resistance indicates the stylet is at the carina.
            f) Withdraw the stylet to align the black mark with the teeth.
            g) Have your assistant load and advance the ETT tip to the black mark.
            h) Have your assistant grasp and hold steady the straight end of the stylet.
            i) While maintaining laryngoscope blade position, advance the ETT.
            j) At the glottic opening turn the ETT 90 degrees counterclockwise to assist passage over the arytenoids.

k) Advance the ETT to 22 cm at the teeth.
l) While maintaining ETT position, withdraw the stylet.

1) One Person Technique (recommended when visualization is good but cords are too anterior to pass ET tube).
a) Load the stylet into the ETT with the bent end approximately 4 inches (10 cm) past the distal end of the ETT.
b) Pinch the ETT against the stylet.
c) With the bent tip anterior, while visualizing the cords advance the stylet through the cords.
d) Maintain laryngoscope blade position.
e) When the black mark is at the teeth ease your grip to allow the tube to slide over the stylet. If available have an assistant stabilize the stylet.
f) At the glottic opening turn the ETT 90 degrees counterclockwise to assist passage over the arytenoids.
g) Advance the ETT to 22 cm at the teeth.
h) While maintaining ETT position, withdraw the stylet.

c. Tracheal stoma intubation
1) Select the largest endotracheal tube that will fit through the stoma without force (it should not be necessary to use lubricant).
2) Do not use stylet.
3) Pass ETT until the cuff is just past the stoma.
4) Inflate cuff.
5) Attach the CO_2 measurement device to the ETT and confirm placement (as described below).
6) Secure tube.

5. Confirmation of Placement – It is the responsibility of the paramedic who has inserted the ETT to personally confirm and document proper placement. Responsibility for the position of the ETT shall remain with the intubating paramedic until a formal transfer of care has been made.

a. Prior to intubation, prepare the CO_2 measurement device (capnography).
b. Insert ETT, advance, and hold at the following depth:
    1) Less than 5 ft. tall: balloon 2 cm past the vocal cords.
    2) 5'-6'6" tall: 22 cm at the teeth.
    3) Over 6'6" tall: 24 cm at the teeth or 2 cm past the vocal cords.
c. After inserting the ETT, in the patient requiring CPR, resume chest compressions while confirming ETT placement.
d. Inflate the ETT cuff, attach the CO_2 measurement device, and begin ventilations. During the first 5-6 ventilations, auscultate both lung fields (in the axillae) and the epigastrium.
    1) A regular waveform with each ventilation should be seen with tracheal placement. If the patient has been in cardiac arrest for a prolonged time (more than 5-10 minutes) the waveform may be diminished or, very rarely, absent. In the patient with spontaneous circulation, if a regular waveform with a CO_2 of 25 or higher is not seen, that is a strong indicator of esophageal intubation. If the CO2 measurement device fails, and an alternative is not immediately available, use a colorimetric CO2 detector.
    2) If a colorimetric CO_2 detector device is used for placement confirmation, observe the color at the end of exhalation after six ventilations. Yellow indicates the presence of >5% exhaled CO_2 and tan 2-5% CO_2. Yellow or tan indicates tube placement in the trachea. Purple indicates less than 2% CO_2 and in the patient with spontaneous circulation, is a strong indicator of esophageal intubation.
e. Using information from auscultation and CO_2 measurement, determine the ETT position.
    1) If breath sounds are equal, there are no sounds at the epigastrium, and the CO_2 measurement device indicates tracheal placement, secure the ETT using an ETT holder.

1) If auscultation or the CO_2 measurement device indicates that the ETT may be in the esophagus, immediately reevaluate the patient. The ETT should be removed if there is concern for esophageal intubation. If you are confident that the ETT is in the trachea, you must confirm placement by performing repeat laryngoscopy.
2) If breath sounds are present but unequal, the ETT position may be adjusted as needed.

f. Once ETT position has been confirmed, reassessment using CO_2 measurement, pulse oximetry (if able to obtain), and auscultation of breath sounds should be performed each time patient is moved.
g. Continue to monitor the CO_2 measurement device during treatment and transportation. If a change occurs from positive (yellow/tan) to negative (purple), or the waveform diminishes or disappears, reassess the patient for possible accidental extubation or change in circulation status.
h. The typical normal range of exhaled carbon dioxide is 35-45 mmHg. Patients with underlying pulmonary conditions may have baseline values higher than this. Target 40mmHg if no known such history. Otherwise, higher values may be acceptable (40-50mmHg).
i. After confirmation of proper ETT placement, and prior to movement, all intubated patients shall have their head and neck maintained in a neutral position with head supports. A cervical collar will only be used if a cervical spine injury is suspected.
    1) Reconfirm ETT placement after any manipulation of the head or neck, including positioning of a head support, and after each change in location of the patient.
    2) Report to nurse and/or physician that the head support is for the purpose of securing the ETT and not for trauma (unless otherwise suspected).

6. Documentation
    a. All ETI attempts must be documented in the “ALS Airway” section of the Ventura County Electronic Patient Care Report (VCePCR).

b. If a video laryngoscope is used, a screenshot confirming placement will be attached to the PCR.
c. All validated fields related to an advanced airway attempt shall be completed on the VCePCR. Anything related to the advanced airway attempt that does not have an applicable corresponding field in VCePCR, but needs to be documented, shall be entered into the report narrative. All data related to an advanced airway attempt (successful or not) shall be documented on a VCePCR. In addition, an electronic signature shall be captured on the mobile device used to document the care provided. The treating emergency room physician will sign the 'Advanced Airway Verification' section of the VCePCR, as well as document the supporting information (placement, findings, method, comments, name, and date). In the event the patient was not transported, another on scene paramedic (if available) will sign and complete the verification section.
d. Documentation of the intubation in the approved Ventura County Documentation System must include the following elements. The acronym for the required elements is "SADCASES."
    1) Size of the ETT
    2) Attempts, number
    3) Depth of the ETT at the patient's teeth
    4) Confirmation devices used and results. For capnography, recording of waveform at the following points:
        a) Initial ETT placement confirmation; and
        b) Movement of patient; and
        c) Transfer of care.
    5) Auscultation results
    6) Secured by what means
    7) ETCO2, initial value
    8) Support of the head or immobilization of the cervical spine. An electronic upload of Cardiac Monitor data, including ETCO2 waveform "snapshots" the VCePCR is required. In the event an upload cannot occur, a printed code

summary, mounted and labeled, displaying capnography waveform at the key points noted above is required. This printed code summary shall be scanned and attached to the VCePCR.

7. Supraglottic Airway Device indications, contraindications, placement and documentation in accordance with policy 729.
    a. CQI: For all VL attempts, the ImageTrend intubation CQI module must be completed monthly. Provider agencies are encouraged, though not required, to complete the CQI module for all other intubation attempts
    b. Failure to complete the module may result in loss of authorization to perform VL.
    c. VCEMSA reserves the right to request the complete video file as part of the VCEMS CQI program and medical oversight.
    d. Provider Agency EMS Medical Director commits to meeting with VCEMS Medical Director quarterly to review fall outs and complications.
    e. CQI Metrics
        1) Type of patient: med vs trauma
        2) Suction utilized appropriately?
        3) Grade view?
        4) Number of attempts?
        5) Bougie used?
        6) Blade entry to intubation time? (Defined as when the laryngoscope blade passes the teeth to when the ETT passes through the cords)
        7) Complications? (Hypoxia, bleeding, bradycardia, etc.)

BACK

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title 12 Lead ECG		Policy Number: 726
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 1, 2026
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: January 1, 2026
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 10, 2006 October 22, 2025 October 22, 2025 October 31, 2027	Effective Date: January 1, 2026

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

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

III. Policy: Paramedics will obtain 12-lead ECGs in patients with the indications listed in this policy. EMTs who are specially trained may be authorized to set up the 12-lead.

IV. Procedure:

A. Indications for a 12-lead ECG:

1. History of present illness consistent with an acute coronary syndrome.
    a. Chest, upper back or upper abdominal discomfort
    b. Generalized weakness
    c. Dyspnea
2. Cardiac Dysrhythmia
    a. Symptomatic bradycardia
    b. Inappropriate Tachycardia
    c. After successful cardioversion/defibrillation
3. Post ROSC
4. Paramedic Discretion

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

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

C. ECG Procedure:
    1. Attempt to obtain an ECG during initial patient evaluation. If the patient is not in severe distress, ECG should be completed as soon as possible and prior to medication administration.
    2. The ECG should be done prior to transport.
    3. If the ECG is of poor quality (artifact or wandering baseline), troubleshoot with focus on obtaining a clean tracing.
    4. If patient condition worsens at any time, repeat the ECG. This is not needed if the patient has already been identified as a positive STEMI.

D. Base Hospital Communication/Destination:
    1. If the interpretation from the monitor meets the manufacturer guidelines for a positive STEMI ECG, patients should be transported to the closest and most appropriate STEMI Receiving Center (SRC).
    2. Manufacturer guidelines for a positive STEMI ECG
        a. Lifepak 15: ***Meets ST Elevation MI Criteria***
        b. Lifepak 35: ***ACUTE STEMI***
        c. Zoll: ***STEMI***
    3. Send a STEMI Alert through Pulsara containing a picture of the positive STEMI ECG within 10 minutes of interpretation.
    4. Follow-up the Pulsara STEMI Alert with Base Hospital contact.
    5. Cath lab activation will be at the discretion of the physician reviewing the Pulsara Alert. If no image is available, cath lab activation is not recommended if:
        a. The ECG is poor quality
        b. The patient has a pacemaker
        c. The underlying rhythm is Atrial Flutter
        d. The heart rate is above 140
    6. Paramedics are to ask the patient if they have a cardiologist and report the information to the base hospital.
    7. Positive STEMI ECGs will be handed to the receiving care team.

E. Other ECGs
    1. If an ECG is obtained by a physician and the interpretation on the ECG is positive for STEMI, the patient will be treated as a positive STEMI.
    2. If the ECG is obtained by a physician and the interpretation on the ECG is not positive for STEMI, but the physician is stating ***it is*** a STEMI:

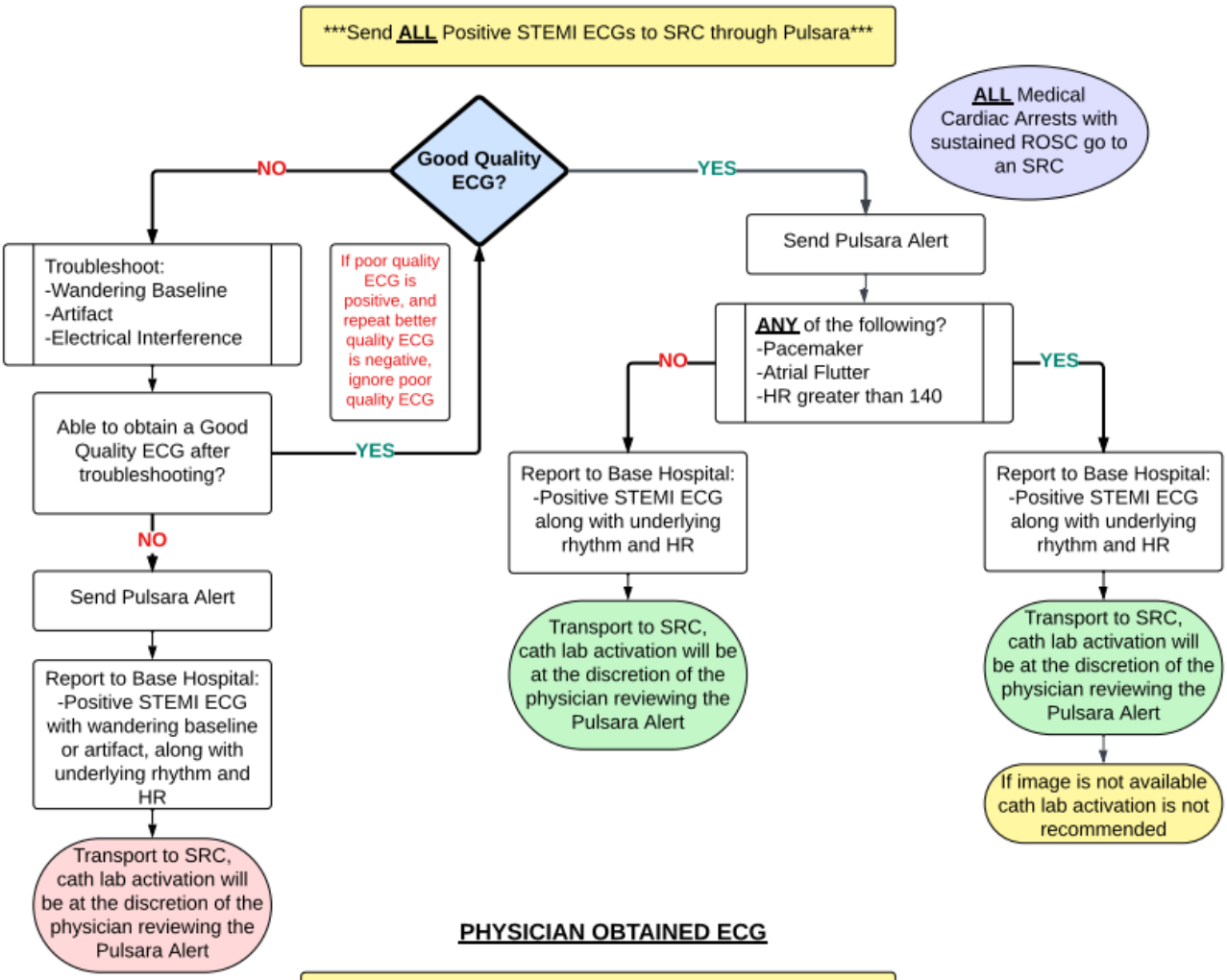
a. Send Pulsara Alert for review and transport to an SRC. Cath lab activation will be at the discretion of the physician reviewing the Pulsara Alert.

3. The original ECG shall be obtained and accompany the patient.
4. The original ECG will be scanned, or a picture will be obtained and added as an attachment to the Ventura County electronic Patient Care Report (VCePCR), in addition to being hand delivered to the receiving care team.

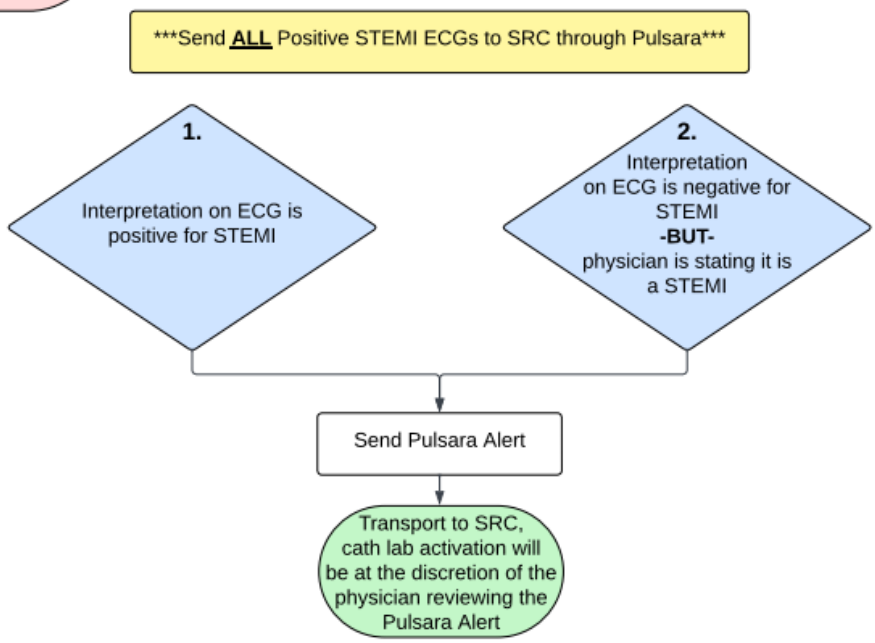
G. Documentation

1. VCePCR and cardiac monitor data transfer will be completed per VCEMS policy 1000.

INTERPRETATION FROM THE MONITOR MEETS THE MANUFACTURER GUIDELINES FOR A POSITIVE STEMI ECG



PHYSICIAN OBTAINED ECG



BACK

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Transcutaneous Cardiac Pacing	Policy Number: 727
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: January 1, 2026
APPROVED: Medical Director Daniel Shepherd, MD	Date: January 1, 2026
Origination Date: December 1, 2008 Date Revised: September 11, 2025 Date Last Reviewed: September 11, 2025 Next Review Date: September 30, 2025	Effective Date: January 1, 2026

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

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

III. POLICY: Paramedics may utilize transcutaneous cardiac pacing (TCP) on adult patients (age 14 or greater) in accordance with Ventura County Policy 705 – Symptomatic Bradycardia, Adult.

IV. PROCEDURE:

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

B. Indications: Symptomatic bradycardia (heart rate less than 40 bpm with one or more of the following signs or symptoms):

1. Altered level of consciousness
2. Chest pain
3. Abnormal skin signs
4. Profound weakness
5. Shortness of breath
6. Hypotensive (Systolic BP less than 90mm Hg)

C. Contraindications:

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

D. Patient Treatment

1. Patient assessment and treatment per 705: Bradycardia treatment protocol.
2. Explain the TCP procedure to the patient.
3. Place pacing electrode pads and attach pacing cable to pacing device per manufacturer's recommendations.
4. Attach 4-Lead to the patient.
5. Set pacing mode to demand mode, pacing rate to 70 BPM, and current at 40 milliamps (mA), or manufacturer recommendation.
    a. Demand mode requires that the 4-Lead be on the patient.
6. Activate pacing device and increase the current in 10 mA increments. This should be done in rapid escalation until electrical capture is achieved (each pacemaker impulse produces a QRS complex). If there is intermittent or doubt about electrical capture, continue to increase the current in 10 mA increments.
7. Assess patient for mechanical capture (pacemaker produces a pulse with each QRS complex) and clinical improvement (BP, pulses, skin signs, LOC).

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

E. Transfer of Care

1. Communicate – this is a key component when transferring care of a patient who has TCP in place. There should be direct communication between the paramedic and hospital provider who will be taking over patient care.
2. Pause – Paramedic should be familiar with the cardiac monitor TCP pausing capabilities.
    a. Utilizing the pause feature allows for the underlying rhythm to be observed without completely shutting off the TCP.
3. Plan – The healthcare team should formulate a plan together for how the patient will be safely transitioned from the EMS gurney to the hospital bed without interrupting pacing.
4. Transfer - Once a plan is in place, transfer the patient.

F. Documentation

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

MINOR CHANGES

COUNTY OF VENTURA HEALTH CARE AGENCY	BACK	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Paramedic Scope of Practice		Policy Number: 310
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: January 1, 2026
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: January 1, 2026
Origination Date: May, 1984 Date Revised: August 14, 2025 Date Last Reviewed: August 14, 2025 Review Date: August 31, 2027		Effective Date: January 1, 2026

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

II. AUTHORITY: Health and Safety Code Section 1797.172 and 1797.185. California Code of Regulations, Division 9, Chapter 3.3, Sections 100091.01, 100091.02 and 100091.03.

III. POLICY:

A. The medical director of the LEMSA may develop policies and procedures or establish standing orders allowing the paramedic to initiate any paramedic activity in the approved scope of practice without voice contact for medical direction from a physician, or mobile intensive care nurse (MICN), provided that an EMSQIP is in place.

B. An accredited/accrediting paramedic may perform any activity identified in Ventura County Policy 300: Emergency Medical Technician Scope of Practice, without requiring a separate certification.

C. A licensed paramedic shall be affiliated with an approved paramedic service provider in order to perform the scope of practice specified in this policy.

D. A paramedic student or a licensed paramedic, as part of an organized EMS system, while caring for patients in a hospital as part of his/her training or continuing education (CE) under the direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, may perform the following procedures or administer the following medications when such are approved by the medical director of the LEMSA and are included in the written policies and procedures of the LEMSA.

E. Basic Scope of Practice:

1. Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms (ECG).
2. Perform defibrillation, synchronized cardioversion, and external cardiac pacing.
3. Visualize the airway by use of the laryngoscope and remove foreign body(ies) with Magill forceps.

4. Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, perilaryngeal airways, stomal intubation, and adult oral endotracheal intubation.
5. Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP)/bi-level positive airway pressure (BPAP) and positive end expiratory pressure (PEEP) in the spontaneously breathing patient.
6. Institute intraosseous (IO) needles or catheters and institute intravenous (IV) catheters, saline locks, needles, or other cannula (IV lines), in peripheral veins.
7. Monitor and administer medications through pre-existing vascular access.
8. Administer IV or IO glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.
9. Obtain venous blood samples.
10. Use laboratory devices, including point of care testing, for pre-hospital screening use to measure lab values including, but not limited to: glucose, capnometry, capnography, and carbon monoxide when appropriate authorization is obtained from State and Federal agencies, including from the Centers for Medicare and Medicaid Services pursuant to the Clinical Laboratory Improvement Amendments (CLIA).
11. Utilize Valsalva maneuver.
12. Perform needle thoracostomy
13. Perform nasogastric and orogastric tube insertion and suction.
14. Monitor thoracostomy tubes.
15. Monitor and adjust IV solutions containing potassium, equal to or less than 40 mEq/L.
16. Administer approved medications by the following routes: IV, IO, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, intranasal, oral or topical
17. Administer, using prepackaged products when available, the following medications:
    a. 5%, 10%, 25% and 50% dextrose
    b. acetaminophen IV
    c. activated charcoal
    d. adenosine
    e. aerosolized or nebulized beta-2 specific bronchodilators
    f. amiodarone

g. aspirin
h. atropine sulfate
i. calcium chloride
j. diazepam
k. diphenhydramine hydrochloride
l. dopamine hydrochloride
m. epinephrine
n. fentanyl
o. glucagon
p. ipratropium bromide
q. lidocaine hydrochloride
r. lorazepam
s. magnesium sulfate
t. midazolam
u. morphine sulfate
v. naloxone hydrochloride
w. nitroglycerin preparations
x. ondansetron
y. pralidoxime chloride
z. sodium bicarbonate
aa. tranexamic acid

D. Local Optional Scope of Practice (LOSOP)

1. Perform or monitor other procedure(s) or administer any other medication(s) determined to be appropriate for paramedic use by the medical director of the LEMSA, that have been approved by the Director of CalEMSA, in consultation with the Emergency Medical Services Medical Directors Association of California's (EMDAC) Scope of Practice Committee. Paramedics shall demonstrate competency in performing these procedures and administering these medications through training and successful testing.
2. Ventura County LOSOP Approvals:
   a. buprenorphine
   b. blood products for 911 response
   c. heparin IV for interfacility transports
   d. hydroxocobalamin
   e. nitroglycerin IV for interfacility transports

COUNTY OF VENTURA HEALTH CARE AGENCY	BACK	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Paramedic Accreditation to Practice		Policy Number 315
APPROVED Administration: Steven L. Carroll, Paramedic		Date: January 1, 2026
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: January 1, 2026
Origination Date: January 1, 1990 Date Revised: September 11, 2025 Date Last Reviewed: September 11, 2025 Review Date: September 30, 2028		Effective Date: January 1, 2026

I. PURPOSE: To establish a mechanism for a paramedic to become accredited to practice in Ventura County. The purpose of accreditation is to ensure that the paramedic has: 1) completed the minimum required education and training, and 2) is oriented to the local EMS system.

II. AUTHORITY: Health and Safety Code Sections 1797.84, 1797.185, 1797.214, 1798 and California Code of Regulations, Title 22, 100094.02.

III. DEFINITIONS:

A. ALS Patient Contact: A patient contact where the paramedic successfully performs an ALS skill listed in VCEMS Policy 310 – Paramedic Scope of Practice, with the exception of central line monitoring, blood glucose testing, 3 or 4-lead cardiac monitoring, and pulse oximetry.

B. Field Training Officer (FTO): An agency designation for those personnel qualified to train/evaluate prehospital personnel on job-related tasks, policies, and procedures.

C. Paramedic Preceptor: A paramedic, as identified VCEMS Policy 319 – Paramedic Preceptor, qualified to train paramedic student interns. A Paramedic Preceptor may also be an FTO, when designated by that individual's agency.

D. Paramedic Accreditation Applicant: A California licensed paramedic who is in the process of applying for local accreditation in Ventura County through the Ventura County EMS Agency.

E. Field Evaluation: Timeframe within the accreditation process where a Paramedic Accreditation Applicant is assigned to a paramedic FTO/Paramedic Preceptor for direct observation of required ALS Patient Contacts.

F. Independent Practice Paramedic: A paramedic accredited in Ventura County to perform the paramedic basic and local optional scope of practice and who is authorized to function independently in accordance with VCEMS Policy 318 – Independent Practice Paramedic.

IV. POLICY: Each paramedic employed by a Ventura County ALS Provider shall be accredited to practice in Ventura County. A paramedic shall apply for accreditation prior to working on an ALS Unit.

V. PROCEDURE:

A. Application: Prior to beginning the Field Evaluation in Ventura County,

1. The paramedic shall,

a. Possess a current California paramedic license.

1) Verification of licensure through the Emergency Medical Services Authority (EMSA) website will be allowed provided a copy of the paramedic license is received within 45 days of the Paramedic Accreditation Application date.

b. Possess a government issued form of identification.

c. Submit a Ventura County EMS Personnel Application.

1) Paramedics must notify VCEMS within 30 days of any contact information change.

d. Submit a signed Eligibility Statement.

1) It is the responsibility of the accredited paramedic to notify VCEMS within 7 days of any change in their eligibility status as outlined in Health and Safety Code, Division 2.5, Section 1798.200.

e. Pay the established fee.

f. Complete a local system orientation. This orientation shall not exceed eight (8) classroom hours and shall consist of the following:

1) Policies and procedures, treatment protocols, radio communications, hospital/facility destination policies, and other unique system features.

2) VCEMS Orientation

3) PCC Orientation (may be done concurrently with the Field Evaluation)

g. Complete local optional scope of practice (LOSOP) training: Submit completion of applicable training as outlined in each LOSOP. The applicant may be exempted from some or all of these requirements if documentation is provided of previous completion of VCEMS LOSOP training.

2. The ALS Service Provider shall,

a. Provide the Paramedic Accreditation Applicant with their schedule for orientation, training, and Paramedic Field Evaluation.

B. Field Evaluation: Upon completion of the requirements of Section V.A.1-2, the applicant is authorized to begin their Field Evaluation in Ventura County.

1. The Field Evaluation will consist of a minimum of five (5) and a maximum of ten (10) ALS Patient Contacts, with continuous supervision by a paramedic FTO/Paramedic Preceptor, from the beginning of assessment to transfer of patient care to hospital staff.

a. A Paramedic Accreditation Applicant who, with the approval of the Paramedic Training Program Director, and having completed their internship in Ventura County within the past 12 months, may use the last five (5) ALS Patient Contacts for accreditation purposes. In order to use these ALS Patient Contacts; an applicant must have received a rating of three (3) in all categories on each of the five (5) ALS Patient Contacts.

2. During the Field Evaluation, the Paramedic Accreditation Applicant shall be the third assigned responder on an ALS unit under the direct supervision of a paramedic FTO/Paramedic Preceptor who is ultimately responsible for patient care rendered by the Paramedic Accreditation Applicant. Paramedic Accreditation Applicants may perform the local optional scope of practice only when under this direct supervision.

a. A Paramedic Accreditation Applicant may also work as the second paramedic of a two (2) paramedic team on an ALS unit, as long as the second paramedic is authorized as an Independent Practice Paramedic. In this circumstance the Paramedic Accreditation Applicant shall be limited to perform in the paramedic basic scope of practice, as defined in VCEMS Policy 310 – Paramedic Scope of Practice. Shifts worked as a second paramedic, and any ALS

Patient Contacts obtained during those shifts, will not be considered part of the Field Evaluation process.

C. Accreditation Application Submission

1. Upon completion of V.A and V.B, the paramedic shall make an appointment with VCEMS to complete the accreditation process.
2. The Paramedic Accreditation Applicant shall successfully complete and provide written verification of completion of the Ventura County accreditation process within 45 days of the date of the Paramedic Accreditation Application date. If the accreditation process is not completed within 45 days, a new accreditation period will automatically begin. If the accreditation process cannot be completed within the two forty-five-day periods, a new Paramedic Accreditation Application and fee to begin a third 45-day period may be required. The applicant may not apply more than three (3) times in one year.

D. Paramedic Accreditation

1. If all requirements are met, a VCEMS Accreditation card will be issued.
2. If requirements are not successfully completed, the application will be submitted to the VCEMS Medical Director for further action. The VCEMS Medical Director shall notify the Paramedic Accreditation Applicant of their findings within 5 working days.

E. Accreditation Period

1. The Accreditation Period shall coincide with the individual's California paramedic license.
2. Paramedic Accreditation shall be continuous as long as the following is maintained:
    a. California Paramedic licensure.
    b. Continuous employment with a VCEMS Approved ALS Service Provider Agency.
        1) The Paramedic Accreditation will end when the paramedic is no longer employed with a VCEMS Approved ALS Service Provider Agency.
    c. The paramedic continues to meet all requirements for updates in VCEMS policy, procedure, protocol and local optional scope of practice, and continues to meet requirements of the system-wide CQI program.

1) This includes any mandatory training, as defined in VCEMS Policy 334 – Mandatory Training Requirements.

F. Paramedic Accreditation Reverification Process: A Ventura County accredited paramedic is required to submit documentation to VCEMS every 2 years verifying that they have maintained the requirements listed in V.E.2

1. Submit an EMS Personnel Application and Eligibility Statement as described in Section V.A.
2. Submit their renewed California paramedic licensure.
3. Submit completed Policy 334 – Mandatory Training Requirements Appendix A.

G. Adverse Paramedic Accreditation Action

1. Denial of Paramedic Accreditation
   a. The VCEMS medical director shall evaluate any Paramedic Accreditation Applicant who fails to successfully complete the Field Evaluation and may recommend further evaluation or training as required to ensure the paramedic is competent. If, after several failed remediation attempts, the medical director has reason to believe that the paramedic's competency to practice is questionable, then the medical director shall notify the California EMS Authority.
   b. Paramedic Accreditation may be denied for failure to complete any requirements listed in Section V.A-C.
      1) The VCEMS Medical Director will inform the applicant of the denial of Paramedic Accreditation by certified mail or hand delivery, with a complimentary copy to the ALS employer, in addition to the EMS Authority as noted above. The notice will include the specific facts and grounds for denial.
2. Suspension of Paramedic Accreditation
   a. Paramedic Accreditation may be suspended for failure to meet the requirements listed in Section V.E.
   b. The VCEMS Medical Director will inform the Paramedic by written notice at least 15 days prior to the intended date of suspension. The notice will include the specific facts and grounds for suspension.

c. Paramedic Accreditation will be suspended until such time as the deficiencies are completed and documented to VCEMS.

3. Due Process

a. This will apply to the decision of the VCEMS Medical Director to either deny or suspend an accreditation.

b. The paramedic may request reconsideration in writing, by certified mail or hand delivery. The VCEMS Medical Director will respond to the request by certified mail or hand delivery within 5 working days.

H. Lapse of Paramedic Accreditation

1. If a paramedic does not maintain Ventura County Paramedic Accreditation requirements, the following requirements must be met to re-establish eligibility:

a. Pay the established fee to reinstate lapsed accreditation.

b. In addition, the following shall be met,

1) If the period of lapse of accreditation is 1-31 days, the paramedic shall complete the requirements for reverification as defined in Section V.F, including mandatory training issued/released during the timeframe the paramedic's accreditation was lapsed.

2) If the period of lapse of accreditation is greater than 31 days and less than one-year, the paramedic shall complete requirements described in Section V.B.1., complete the requirements for reverification as defined in Section V.F, and complete any training issued/released during the timeframe the paramedic's accreditation was lapsed.

3) If the period of lapse of accreditation is greater than one year, the paramedic shall complete all the requirements specified in Section V.A-C.

COUNTY OF VENTURA HEALTH CARE AGENCY	BACK	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Independent Practice Paramedic		Policy Number: 318
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: January 1, 2026
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: January 1, 2026
Origination Date: June 1, 1997 Date Revised: September 11, 2025 Date Last Reviewed: September 11, 2025 Review Date: September 30, 2028		Effective Date: January 1, 2026

I. PURPOSE: To establish medical control standards for initial and ongoing competency of Ventura County Independent Practice Paramedics. This policy is intended to be one of quality improvement and quality assurance. This document defines a minimum set of expectations related to paramedic training and ongoing performance. The LEMSA Medical Director, in coordination with the ALS agency medical director / designee, will maintain and monitor these minimum expectations continuously.

II. AUTHORITY: Health and Safety Code, Sections 1797.214, 1797.220, 1798, and 1798.200 22 CCR Division 9, Chapter 4, Sections 100091.02, 100091.04, 100096.01, 100096.03, 100251, 100253.

III. DEFINITIONS:

A. ALS Patient Contact: A patient contact where the paramedic successfully performs an ALS skill listed in VCEMS Policy 310 – Paramedic Scope of Practice, with the exception of central line monitoring, blood glucose testing, 3 or 4-lead cardiac monitoring, and pulse oximetry.

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

C. Field Training Officer (FTO): An agency designation for those personnel qualified to train/evaluate prehospital personnel on job-related tasks, policies, and procedures.

D. Independent Practice Paramedic: A Paramedic accredited in Ventura County to perform the paramedic basic and local optional scope of practice and who is authorized to function independently in accordance with this policy.

E. Paramedic Preceptor: A paramedic, as identified in VCEMS Policy 319 – Paramedic Preceptor, qualified to train paramedic student interns. A Paramedic Preceptor may also be an FTO, when designated by that individual's agency.

IV. POLICY:

A. ALS response units will be staffed with a minimum of one independent practice paramedic who meets the requirements outlined in this policy.

B. The ALS agency medical director / designee will be responsible for the oversight of training and education programs for that agency and ensuring paramedics working within that agency are proficient in their skills and have an adequate knowledge of VCEMS policies and procedures.

1. ALS agency medical director / designee will be required to attest that the paramedic meets the initial performance standards outlined in this policy. Additionally, the ALS agency medical director / designee will be required to meet with and assess the paramedic's overall competency and readiness and will sign the Independent Practice Paramedic Authorization Form (Appendix A).

V. PROCEDURE:

A. A paramedic will be authorized as an independent practice paramedic upon completion of standards established by the LEMSA Medical Director. At a minimum this training will include, but not be limited to, the following:

1. 240 of direct field observation by an authorized paramedic FTO

a. This will include a minimum of 30 patient contacts, at least half of which will be ALS Patient Contacts.

1) The ALS Patient Contacts obtained during the Paramedic Accreditation Application process may be included as part of the ALS Patient Contact requirement outlined above.

b. For paramedics with a minimum of three (3) years prehospital field experience performing ALS assessment and care may have this requirement reduced at the discretion of the LEMSA Medical Director.

2. Approval by the paramedic FTO who evaluated the majority of the field observation and patient contacts.

3. Successful completion of competency assessments:

a. Scenario based skills assessment conducted by the paramedic FTO/Paramedic preceptor, clinical manager/coordinator, or ALS agency medical director / designee.

b. Demonstrated proficiency in VCEMS policies and procedures through successful passing of the VCEMS cognitive examinations (policy and ECG).

1) The minimum passing score is 80%. Candidates who do not successfully complete either examination with at least an 80% score may complete additional training with the ALS agency medical director / designee prior to re-attempting the examination.

B. In order to maintain independent practice status, the paramedic will remain an active prehospital ALS provider for their particular ALS agency and will demonstrate ongoing proficiency in ALS assessment and care, as well as VCEMS policies and procedures.

1. Demonstration of proficiency may be achieved in a variety of ways including direct observation of ALS assessment and care, case reviews, and ongoing testing of skills and proficiency in VCEMS policies and procedures.

2. As part of the paramedic's ongoing authorization, the ALS agency medical director / designee will attest that paramedic continues to meet minimum performance standards outlined above.

C. Independent practice status will lapse in the following circumstances:

1. The paramedic is no longer employed by an approved ALS provider agency in Ventura County.

2. The paramedic is unable to maintain accreditation requirements outlined in VCEMS Policy 315 – Paramedic Accreditation to Practice.

3. The paramedic has not functioned in a paramedic capacity for at least six months.

4. The paramedic has not met mandatory continuing education and training requirements, as outlined in VCEMS Policy 334 – Prehospital Personnel Mandatory Training Requirements.

D. Maintaining authorization to function as an independent practice paramedic for an ALS agency will require the paramedic to demonstrate competency in skills and assessment, as well as VCEMS policies and procedures. The LEMSA Medical Director will establish requirements for demonstration of competency in coordination with ALS Agencies.

E. The ALS agency will provide quarterly reports to VCEMS. The reports will contain updates on status changes for independent practice paramedics, in addition to training (cognitive and/or psychomotor skills) completed that would be required to maintain independent practice status.

F. VCEMS will maintain an ongoing QA/QI program related to records review, EMS Safety Event reporting, specialty care system(s).

1. VCEMS, under the guidance of the LEMSA Medical Director, will work with ALS Agency representatives and ALS agency medical director / designee if an issue related to patient care and/or overall clinical performance of an independent practice paramedic is observed.

a. Specific issues of concern will be reported and a plan to correct observed issue(s) will be conducted with all parties involved.

Appendix A

INDEPENDENT PRACTICE PARAMEDIC AUTHORIZATION FORM

Independent Practice Paramedic Candidate: Complete the requirements in the order listed. Your employer will submit to VCEMS once all requirements are completed.

_____has been evaluated and has met all criteria for authorization as an Independent Practice Paramedic.

Independent Practice Paramedic Candidate

_____ Completion of 240 hours of direct field observation by an authorized Paramedic FTO

_____ Approval by Paramedic FTO

_____ Submit all appropriate documentation to VCEMS

	Date	**Hours**	**FTO** (Print legibly)		**Date**	**Hours**	**FTO** (Print legibly)
1				11			
2				12			
3				13			
4				14			
5				15			
6				16			
7				17			
8				18			
9				19			
10				20			
						Total Hours Completed	

Ventura County EMS Independent Practice Authorization Procedure	**240 hours or 10 shifts 30 patient contacts (minimum of 15 ALS)**

Policy	Procedure/Policy Title to Review	Date	FTO Signature	Method of Evaluation (see key)
Shift 1: Cardiac				
440	IFT for STEMI			
705.23	SVT			
705.25	VT			
705.24	Symptomatic Bradycardia			
705.09	Acute Coronary Syndrome			
727	Transcutaneous Cardiac Pacing			
726	12 Lead ECG			
Shift 2: Cardiac (continued)				
606	Determination of Death			
613	Do Not Resuscitate			
629	Hospice			
631	Mechanical CPR			
705.07	Cardiac Arrest – Asystole/PEA			
705.08	Cardiac Arrest – VF/VT			
733	Cardiac Arrest Management (CAM) and Post ROSC			
Shift 3: Respiratory / Airway Management				
710	Airway Management			
711	Waveform Capnography			
705.21	Shortness of Breath – Pulmonary Edema			
705.22	Shortness of Breath – Wheezes/other			
729	Supraglottic Airway Devices			
Shift 4: Trauma				
614	Spinal Motion Restriction			
705.01	Trauma Assessment/Treatment Guidelines			
705.11	Crush Injury			
705.19	Pain Control			
734	Tranexamic Acid Administration			
738	Out of Hospital Transfusion of Blood Products			
1404	Guidelines for Inter-facility Transfer of Patients to a Trauma Center			
1405	Trauma Triage and Destination Criteria			
Shift 5: MCI / Air Medical				
131	MCI			
1202	Air Unit Dispatch for Emergency Medical Response			
1203	Criteria for Patient Emergency Transportation			
Shift 6: Medical: Neurological				
451	Stroke System Triage			
460	IFT for Stroke			
705.03	Altered Neurological Function			
705.20	Seizures			
705.26	Suspected Stroke			
705.04	Behavioral Emergencies			
Shift 7: Environmental Emergencies				
607 612	Hazardous Material Incident Response Notification of Exposure to a Communicable Disease			
705.12	Heat Emergencies			
705.13	Cold Emergencies			
705.05	Bites and Stings			
705.17	Nerve Agent / Organophosphate			
705.18	Overdose			
705.02	Allergic/Adverse Reaction and Anaphylaxis			

Ventura County EMS Independent Practice Authorization Procedure	**240 hours or 10 shifts 30 patient contacts (minimum of 15 ALS)**

Policy	Procedure/Policy Title to Review	Date	FTO Signature	Method of Evaluation (see key)
Shift 8: Medical - General				
705 705.00 705.10 705.14 705.15 705.16 705.27 716 717	Treatment Protocol Cover Page General Patient Guidelines Childbirth Hypovolemic Shock Nausea/Vomiting Neonatal Resuscitation Sepsis Alert Pre-existing Vascular Access Device Intraosseous Infusion			
Shift 9: Administrative				
310 334 402 603 618 704 720 1000	Paramedic Scope of Practice Prehospital Personnel Mandatory Training Requirements Patient Diversion/ED Closure Refusal of EMS Services Unaccompanied Minor Guidelines for Base Hospital Contact Guidelines for Limited Base Contact Documentation of Prehospital Care			
Shift 10: Review				
	Review Policies and Procedures ALS Agency Medical Director / designee assessment			
	Complete VCEMS Policy and Arrhythmia Exams			

METHOD OF EVALUATION KEY

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

Please sign and date below for approval.

These signatures verify that all supporting documentation has been reviewed. The Independent Practice Paramedic Candidate is recommended for Independent Practice Paramedic Authorization:

Paramedic FTO Signature	Print FTO Name Legibly	Date
Agency Medical Director Signature	Print Agency Medical Director Name Legibly	Date
Employer Representative Signature	Print Employer Representative Name Legibly	Date

COUNTY OF VENTURA HEALTH CARE AGENCY	**BACK**	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Pre-Hospital Personnel Mandatory Training Requirements		Policy Number: 334
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: January 1, 2026
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: January 1, 2026
Origination Date: September 14, 2000 Date Revised: September 11, 2025 Date Last Reviewed: September 11, 2025 Review Date: September 30, 2028		Effective Date: January 1, 2026

I. PURPOSE: To define the requirements for mandatory training sessions for EMTs employed by an approved prehospital provider agency, Paramedics, MICNs and Flight Nurses in Ventura County.

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

III. POLICY: All pre-hospital personnel have requirements for on-going authorization or accreditation to provide pre-hospital care in Ventura County. These requirements are outlined in VCEMS Policies 315 and 318 for Paramedics, 301, 303, 803 for EMTs, and 1201 for Flight Personnel (Nurses and EMTs) and 322 for MICNs.

Unless specifically stated on a course completion or some other correspondence from VCEMS, a mandatory training course is viewed as valid for two years through the end of the month during which the course completion was issued.

IV. PROCEDURE:

A. EMS Updates – Applies to all personnel listed above.

Personnel shall attend mandatory education and/or testing on updates to local policies and procedures (EMS Update), which will be presented by the Ventura County EMS Agency in the Spring and the Fall of each year.

1. Prehospital Services Committee members who attend 75% of the scheduled meetings over the previous 6 months may have this requirement waived.

B. MCI Training – Applies to all personnel listed above.

1. Personnel shall attend MCI training within 6 months of initially starting the certification or accreditation process and complete an MCI Refresher every 2 years as indicated in VCEMS Policy 131.

C. Resuscitation Training

1. Cardiac Arrest Management (CAM) – EMTs, Paramedics and Flight Nurses shall be required to complete the CAM initial training within three months of employment and will be required to complete a CAM refresher every two years.
2. Adult Resuscitation – Paramedic, MICN, and Flight Nurse shall obtain AHA ACLS certification or American Red Cross ALS certification within three months of initially starting the certification or accreditation process (requires both cognitive and skills testing). Adult resuscitation certification must be maintained as current while practicing in Ventura County.
3. Pediatric – Paramedics and Flight Nurses shall obtain a Handtevy Pediatric Provider course completion certification within 3 months of initially starting the accreditation/authorization process. Handtevy may be repeated every two years as a means of maintaining pediatric training requirements. Pediatric Advanced Life Support (AHA or American Red Cross), Pediatric Education for Prehospital Providers (PEPP), or Emergency Nurse Pediatric Course (ENPC) may also be maintained every two years after the initial Handtevy course completion as a means of meeting this pediatric training requirement.

D. Paramedic Skills Verification – Applies to Paramedics only.

1. Paramedics are required to demonstrate competency in skills and assessment, as well as VCEMS policies and procedures.
2. The LEMSA Medical Director will establish requirements for demonstration of competency in coordination with ALS Agencies.

E. Failure to complete mandatory requirements:

1. Independent Practice Paramedics who fail to complete any of these requirements will have their authorization suspended in accordance with VCEMS Policy 318. The Paramedic's accreditation to practice in Ventura County maybe suspended after the State required 15-day notice until the reinstatement criteria has been met.
2. All other required personnel who fail to complete these requirements will have their authorization suspended until the reinstatement criteria has been met.
3. Reinstatement of authorization or accreditation:
    a. Personnel who have not completed or maintained Resuscitation Training (CAM, Adult, or Pediatric requirements), EMS Update, MCI, or Paramedic Skills Verification as outlined above must complete the needed requirements and provide documentation of completion to VCEMS for reinstatement.

Appendix A

PARAMEDIC NAME		AGENCY		LICENSE #	

RESUSCITATION TRAINING		TARGET DATE	DATE ATTENDED	PROVIDER NUMBER
1.	ACLS	EMS Office Use		
2.	Pediatric Course	EMS Office Use		
3.	CAM Course	EMS Office Use		
EMS UPDATE (Held in **Spring** and **Fall** each year)		**TARGET DATE**	**DATE ATTENDED**	
4.	EMS Update #1	EMS Office Use		
	EMS Update #2	EMS Office Use		
	EMS Update #3	EMS Office Use		
	EMS Update #4	EMS Office Use		
MCI COURSE (Refresher course required every 2 years)		**TARGET DATE**	**DATE ATTENDED**	
5.	Ventura County MCI Course	EMS Office Use		
PARAMEDIC SKILLS VERIFICATION		**TARGET DATE**	**DATE VERIFIED**	
6.	Agency Skills Verification	EMS Office Use		

This tracking sheet must be submitted at time of Paramedic Accreditation Reverification as outlined in VCEMS Policy 315.

COUNTY OF VENTURA HEALTH CARE AGENCY	BACK	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Out of County Paramedic Internship Approval Process		Policy Number 335
APPROVED: Administrator: Steven L. Carroll, Paramedic		Date: January 1, 2026
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: January 1, 2026
Origination Date: October 13, 2005 Date Revised: August 14, 2025 Date Last Reviewed: August 14, 2025 Next Review Date: August 30, 2028		Effective Date: January 1, 2026

I. PURPOSE: To establish a mechanism for notifying the EMS Agency of out of county paramedic student placement within the local EMS system and ensure appropriate medical control and oversight of Paramedic Interns prior to practicing within the local jurisdiction.

This policy defines the standards for field interns, whose paramedic training program is located outside the jurisdiction of the Ventura County EMS Agency (VCEMS), and who wish to complete all or a portion of their field internship requirements with an advanced life support provider in Ventura County.

II. AUTHORITY: Health and Safety Code Sections 1797.107, 1797.172, 1797.173, 1798, and California Code of Regulation, Title 22, Sections 100091.02, 100092.02 and 100092.05.

III. POLICY:

A. An out of county paramedic intern is a person trained by an out of county training program that has been reviewed by VCEMS ahead of time to ensure minimum training standards in this policy have been met. The out of county intern, while under the supervision of an approved preceptor, may provide ALS care as directed by local EMS medical control. The intern shall be supervised, trained, counseled and evaluated by the designated preceptor and his/her affiliated training program.

B. All of the following requirements (IV.A.1 – IV.A.3) must be submitted to VCEMS at least 45 days prior to commencement of the internship:

1. Paramedic Training Program Requirements:

a. Letter requesting approval for out of county paramedic student placement within the local EMS system;
b. Copy of Paramedic Training Program's CAAHEP accreditation;
c. Evidence of a contract to provide field training between the ALS training program and the ALS provider agency where the intern will be training;
d. Copies of forms used to document student's progress, continuum of care and the training program's collaboration with the field preceptor;
e. Confirmation that the intern successfully completed didactic and clinical training at the same institution that is requesting internship placement. This requirement may be reduced at the discretion of the VCEMS Medical Director.

2. Paramedic Intern Requirements:
   a. Completed VCEMS application;
   b. Copy of intern's valid government issued photo identification;
   c. Copy of intern's professional rescuer level CPR card;
   d. Letter from training program confirming intern's good standing and current affiliation with a VCEMS approved training program including dates of hospital clinical completion and contact name and phone number for the instructor responsible for the intern;
   e. Letter from training program confirming that the intern has performed five (5) successful live patient endotracheal intubations during primary ALS training;
   f. Upon completion of above requirements, intern shall contact VCEMS to schedule appointment to complete internship process.

3. ALS Provider Agency Requirements:
   a. Notify VCEMS of intention to provide field internship for a specific intern;
   b. Provider agency shall submit a completed Appendix A to VCEMS for each intern who is placed for internship;
   c. Ensure that the student has been oriented to the Ventura County EMS System including local policies, procedures and treatment protocols.

d. Ensure out of county intern has access to the Ventura County Electronic Patient Care Reporting System (VCePCR).

C. Paramedic Intern Photo Identification:
Upon VCEMS verification of all above requirements including background check results, intern will be issued a Paramedic Intern photo identification badge that must be worn visible at all times while providing pre-hospital care in Ventura County. Internship shall not start until the Paramedic Intern photo identification badge is issued.

D. If out of county internship placement coincides with the local paramedic training program's field internship timeframe, prehospital provider agency will coordinate with local program to ensure the out of county placement does not conflict with local field intern placement.

ATTACHMENT A

Out of County Paramedic Internship Authorization
(To be completed by ALS provider agency and submitted to VCEMS)

Out of County Intern Name	
Proposed start Date of Internship	
ALS agency Sponsoring Intern	
Preceptor Name	
Out of County Training Program Name	

****VCEMS Office Use Only****

All Requirements Submitted	☐ Yes ☐ No Date:
Additional Information Requested (Date)	☐ Yes ☐ No Date:
Authorization approved	☐ Yes ☐ No Date:
Reason Authorization Not Approved:	
ALS Provider Notified (Date):	
Training Program Notified (Date):	

Name of VCEMS Representative Reviewing Authorization	
Signature	Date
Phone Number	Email Address

COUNTY OF VENTURA HEALTH CARE AGENCY	**BACK**	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: BLS And ALS Unit Equipment And Supplies		Policy Number: 504
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 1, 2026
APPROVED: Medical Director	Daniel Shepherd, MD	Date: January 1, 2026
Origination Date: Date Revised: Last Reviewed: Review Date:	May 24, 1987 August 14, 2025 August 14, 2025 August 31, 2027	Effective Date: January 1, 2026

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

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

III. AUTHORITY: California Health and Safety Code Section 1797.178, 1797.204, 1797.218, 1797.221 and California Code of Regulations Sections 100066.02, 100091.02, 100091.03, 100091.04, 100096.03

IV. DEFINITIONS:

BLS – Basic Life Support Unit

ALS – Advanced Life Support Unit

PSV – Paramedic Support Vehicle or Paramedic Supervisor Vehicle

CCT – Critical Care Transport Unit

BLS Command – Basic Life Support Staffed Command Vehicle

FR/ALS – First Responder Advanced Life Support Unit

VCAU – Ventura County Aviation Unit

V. PROCEDURE:

1. The following equipment and supplies shall be maintained on each response and/or transport unit in Ventura County.
2. Deviation from the standards outlined in this policy shall only be authorized with written approval (see 504 Waiver Request form) from the VCEMS Medical Director. Mitigation attempts should be documented in the comment section on the waiver request form, such as what vendors were contacted, etc.

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

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

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	VCAU Minimum Amount
OPTIONAL EQUIPMENT (No minimums apply)						
Hemostatic gauze per EMSA guidelines						

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

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

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	VCAU Minimum Amount
D. ALS MEDICATION, MINIMUM AMOUNT						
Acetaminophen, 1 g	N/A	N/A	2 g	Optional	2 g	Optional
Adenosine, 6 mg	N/A	N/A	5	5	5	5
Albuterol 2.5 mg/3ml	N/A	N/A	6	2	2	2
Aspirin, 81 mg	N/A	N/A	4 tablets	4 tablets	4 tablets	4 tablets
Amiodarone, 50 mg/ml (3 ml)	N/A	N/A	6	3	6	3
Atropine sulfate, 1 mg/10 ml	N/A	N/A	3	2	2	2
Buprenorphine, 8 mg	N/A	N/A	6 tablets	Optional	6 tablets	Optional
Diphenhydramine, 50 mg/ml	N/A	N/A	2	1	1	2
Calcium chloride, 1000 mg/10 ml	N/A	N/A	2	1	1	1
Dextrose • 5% 50 ml, AND • 10% 250 ml	N/A	N/A	 2 2	 1 2	 2 2	 1 2
Epinephrine • Epinephrine , 1mg/ml o 1 mL ampule / vial (with syringe and needle), OR o Adult auto-injector (0.3 mg) AND Peds auto-injector (0.15 mg) • Epinephrine 0.1 mg/ml (1 mg/10 ml preparation)	N/A	N/A	 5 Optional 6	 5 Optional 3	 5 Optional 6	 5 Optional 4
Fentanyl, 50 mcg/mL	N/A	N/A	200 mcg	200 mcg	200 mcg	200 mcg
Glucagon, 1 mg/ml	N/A	N/A	2	1	2	1
Intravenous Fluids (in flexible containers) • Normal saline solution, 100 ml • Normal saline solution, 500 ml • Normal saline solution, 1000 ml	N/A	N/A	 2 2 6	 1 1 2	 1 1 4	 1 1 3
Lidocaine, 100 mg/5 ml	N/A	N/A	2	2	2	2
Magnesium sulfate, 1 g per 2 ml	N/A	N/A	4	4	4	4
Midazolam Hydrochloride	N/A	N/A	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials
Morphine sulfate, 10 mg/ml (Only required during a Fentanyl shortage)	N/A	N/A	2	2	2	2
Naloxone Hydrochloride • IN concentration - 4 mg in 0.1 mL (with atomizer) • IM / IV concentration – 2 mg in 2 mL preload	N/A	N/A	 Optional 5	 Optional 5	 Optional 5	 Optional 5
Nitroglycerine preparations, 0.4 mg	N/A	N/A	1 bottle	1 bottle	1 bottle	1 bottle
Normal saline flush, 5 or 10 ml	N/A	N/A	5	5	5	5
Ondansetron • 4 mg IV single use vial • 4 mg oral	 N/A N/A	 N/A N/A	 4 4	 4 4	 4 4	 4 4
Sodium Bicarbonate 8.4%, 1 mEq/mL (50 mL)	N/A	N/A	4	2	2	2
Tranexamic Acid (TXA) 1 g/10 mL	N/A	N/A	2	1	1	1

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

COUNTY OF VENTURA HEALTH CARE AGENCY	BACK	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Emergency Medical Technician Training Program Approval		Policy Number 1100
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: January 1, 2026
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: January 1, 2026
Origination Date: February 2001 Date Revised: August 14, 2025 Date Reviewed: August 14, 2025 Review Date: August 30, 2028		Effective Date: January 1, 2026

I. PURPOSE: To identify the procedure for approval of Emergency Medical Technician programs in Ventura County in accordance with the California Code of Regulations. The purpose of an EMT training program shall be to prepare individuals to render prehospital basic life support at the scene of an emergency, during transport of the sick and injured, or during interfacility transfer within an organized EMS system.

II. AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 3.1, Article 3

III. POLICY: EMT training may be offered only by approved training programs.

A. The approving authority for Emergency Medical Technician (EMT) training programs that will be managed or conducted by a qualified statewide public agency shall be the Director of the California EMS Authority. This shall apply to the California Highway Patrol, California Department of Forestry, etc.

B. The approving authority for Emergency Medical Technician training programs located within the County of Ventura shall be the Ventura County Emergency Medical Services Agency (VCEMS).

C. The purpose of an EMT training program shall be to prepare individuals to render prehospital basic life support at the scene of an emergency, during transport of the sick and injured, or during interfacility transfer within an organized EMS system.

D. EMT training may be offered only by approved training programs. Eligibility for program approval shall be limited to:

1. Accredited universities and colleges including junior and community colleges, school districts, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary and Vocational Education.

2. Medical training units of a branch of the Armed Forces of the United States including the Coast Guard of the United States.
3. Licensed general acute care hospitals which meet the following criteria:
   a. Hold a special permit to operate a Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Title 22, Division 5 of the California Code of Regulations; and
   b. Provide continuing education to other healthcare professionals.
4. Agencies of government, including public safety agencies.
5. Local EMS Agencies

IV. PROCEDURE for EMT Training Program Approval:

A. The Ventura County EMS Agency shall review and approve the following prior to approving an EMT training program:

1. A table of contents listing the required information detailed below, with corresponding page/section numbers
2. A written request for training program approval, signed by the training program director.
3. A statement verifying usage of the US Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009).
4. A statement verifying program meets or exceeds required course hours outlined in Section IV.C.1 of this policy and meets all content requirements outlined in section 100067.11 of the California Code of Regulations
5. Statement signed by training program director that all psychomotor skills outlined in Attachment A of this policy shall be taught, and that all students enrolled in course have been given multiple opportunities to practice required skills in person.
6. A statement verifying CPR training equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the Healthcare Provider level is a prerequisite for admission to an EMT basic course
7. Session guides and lesson plans for course(s) taught by program
8. Samples of cognitive (written) and psychomotor skills examinations used for periodic testing

9. A statement verifying that training program will utilize the Ventura County EMS Psychomotor skills evaluation packet and California EMS Authority's Skills Competency Verification Form (EMSA-SCV) for final skills testing.
10. A final cognitive (written) examination
11. Statement signed by training program director that a comprehensive performance improvement plan will be required when program performance falls below 3-year average of 80% on 1st pass rate for NREMT cognitive (written) examination.
12. The name and qualifications of the EMT training program director, program clinical coordinator, and principal instructor(s)
13. Provisions for clinical experienced, as defined in Section IV.D of this policy
14. Provisions for course completion by challenge, including a challenge examination (if different from the final examination)
15. Provisions for a twenty-four (24) hour refresher course including items 1-6 detailed above, required for recertification
    a. A statement verifying usage of the United States Department of Transportation's EMT-Basic Refresher National Standard Curriculum, DOT HS 808 624, September 1996. The U.S. Department of Transportation's EMT-Basic Refresher National Standard Curriculum can be accessed through the U.S. Department of Transportation's website, http://www.nhtsa.gov/people/injury/ems/pub/basicref.pdf.
16. Statement signed by training program director that an annual report shall be submitted within 45 days of year end. Report shall contain minimum content as outlined in Section IV.L.6 of this policy.
17. The location at which the courses are to be offered and their proposed dates and times for each class

B. The Ventura County EMS Agency shall provide, upon request by the California EMS Authority, any or all materials submitted by an EMT training program pursuant to the requirements of this policy for the purposes of assuring all applicable sections of the California Health and Safety Code and/or California Code of Regulations are being met.

C. Didactic and Psychomotor Skills Laboratory
   1. An approved EMT training program shall assure that no more than ten (10) students are assigned to one (1) principal instructor/teaching assistant during psychomotor skills practice/laboratory sessions.

D. Clinical Experience for EMT

1. Each approved EMT training program shall have written agreement(s) with one or more general acute care hospital(s) and/or operational ambulance provider(s) or rescue vehicle provider(s) for the clinical portion of the EMT training course. The written agreement (s) shall specify the roles and responsibilities of the training program and the clinical provider(s) for supplying the supervised clinical experience for the EMT student(s).
    a. Supervision for the clinical experience shall be provided by an individual who meets the qualifications of a principal instructor or teaching assistant.
    b. No more than three (3) students will be assigned to one (1) qualified supervisor during the supervised clinical experience.

E. Teaching Staff
1. Each EMT training program shall provide for the functions of administrative direction, medical quality coordination, and actual program instruction. Nothing in this policy precludes the same individual from being responsible for more than one of the functions outlined below.
2. Program Director
    a. Each EMT training program shall have an approved program director who shall be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction. Examples of 40 hours of instruction in teaching methodology include, but are not limited to the following:
        1) Four (4) semester units of upper division credit in educational materials, methods, and curriculum development or equivalent; OR,
        2) California State Fire Marshall (CSFM) Instructor I and II; OR,
        3) National Fire Academy's (NFA) Fire Instructional Methodology Course; OR,
        4) National Association of EMS Educators (NAEMSE) Level I Instructor Course.
    b. Duties of the program director, in coordination with the program clinical coordinator, shall include but not be limited to the following:
        1) Administering the training program
        2) Approving course content
        3) Approving all written examinations and the final skills examination
        4) Coordinating all clinical and field activities related to the course
        5) Approving the principal instructor(s) and teaching assistants

6) Signing all course completion records
7) Assuring that all aspects of the EMT training program are in compliance with this chapter and other related laws
8) Serving as the primary point of contact between the training program and the Ventura County EMS Agency

3. Clinical Coordinator
   a. Each training program shall have an approved program clinical coordinator who shall be either a Physician, Registered Nurse, Physician Assistant, or a Paramedic currently licensed in California, and who shall have two (2) years of academic or clinical experience in emergency medicine or prehospital care in the last five (5) years. Duties of the program clinical coordinator shall include, but not be limited to:
      1) Responsibility for the overall quality of medical content of the program
      2) Approval of the qualifications of the principal instructor(s) and teaching assistant(s)
4. Principal Instructor(s)
   a. Each training program shall have a principal instructor(s), who may also be the program clinical coordinator or program director, who shall be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction and shall meet the following qualifications:
      1) Be a Physician, Registered Nurse, Physician Assistant, or Paramedic currently licensed in California; or,
      2) Be an Advanced EMT or EMT who is currently certified in California.
      3) Have at least two (2) years of academic or clinical experience in the practice of emergency medicine or prehospital care in the last five (5) years.
      4) Be approved by the program director in coordination with the program clinical coordinator as qualified to teach the topics to which s/he is assigned. All principal instructors from approved EMT training programs shall meet the minimum qualifications as specific above.
   b. Examples of 40 hours of instruction in teaching methodology include, but are not limited to the following:
      1) Four (4) semester units of upper division credit in educational materials, methods, and curriculum development or equivalent; OR,

2) California State Fire Marshall (CSFM) Instructor I and II; OR,
3) National Fire Academy's (NFA) Fire Instructional Methodology Course; OR,
4) National Association of EMS Educators (NAEMSE) Level I Instructor Course.

5. Teaching Assistant(s)
   a. Each training program may have teaching assistant(s) who shall be qualified by training and experience to assist with teaching of the course and shall be approved by the program director in coordination with the program clinical coordinator as qualified to assist in teaching the topics to which the assistant is to be assigned. A teaching assistant shall be supervised by a principal instructor, the program director and/or the program clinical coordinator.

F. Components of an Approved Program
   1. An approved EMT training program shall consist of the following:
      a. The EMT course, including clinical experience;
      b. Periodic and final written and psychomotor skills competency examinations to include all skills listed in section IV.H.3 of this policy;
      c. A challenge examination;
      d. A refresher course required for renewal or reinstatement.
   2. Ventura County EMS Agency may approve a training program that only offers refresher course(s).

G. EMT Training Program Required Course Hours
   1. The EMT course shall consist of not less than one hundred seventy (170) hours. These training hours shall be divided into:
      a. A minimum of one hundred forty-six (146) hours of didactic instruction and psychomotor skills laboratory; and
      b. A minimum of twenty-four (24) hours of supervised clinical experience. The clinical experience shall include a minimum of ten (10) documented patient contacts wherein a patient assessment and other EMT skills are performed and evaluated.
         1) High fidelity simulation, when available, may replace up to six (6) hours of supervised clinical experience and may replace up to three (3) documented patient contacts
      c. The minimum hours shall not include the required NREMT used examinations for EMT certification.

H. Required Course Content

1. The content of an EMT course shall meet all of the objectives contained in the U.S. current Department of Transportation (DOT) National EMS Education Standards;
2. In addition to National EMS Education Standards, EMT course shall meet all requirements outlined in California Code of Regulations, Title 22, Chapter 2, Section 100067.11.
3. Students shall be given multiple opportunities to practice all skills included in the National EMS education standards, as well as any additional skills outlined in Sections 100066.02 and 100067.11 of the California Code of Regulations. These specific skills requirements can be found at the following web addresses

   Section 100066.02 – Basic Scope of Practice of EMT

   Section 100067.11 – Required Course Content

   a. Simulated or virtual experiences related to psychomotor skills practice will not be permitted, unless specifically granted under special provision or directives issued by the Ventura County EMS Agency and/or the California EMS Authority.

As part of the provision of four (4) hours of tactical casualty care, students shall participate in a hands-on drill or live exercise that allows the practical application of skills and concepts related to the content4. All applicants shall complete Incident Command System (ICS) 100 and 700 training prior to completion of the course.

I. Required Testing

1. EMT training program shall include periodic and final competency-based examinations to test the knowledge and psychomotor skills specified in Section 100067.11 of the California Code of Regulations, and in the National EMS Education Standards.
2. Satisfactory performance in these written and skills examinations shall be demonstrated for successful completion of the course.
3. Satisfactory performance shall be determined by preestablished standards, developed by the training program director and clinical coordinator, and approved by the Ventura County EMS Agency at the time of program approval / re-approval.

4. The final psychomotor skills exam shall include, at a minimum, all skills listed in the Ventura County EMS Agency's psychomotor skills evaluation manual and the current version of the California EMS Authority's Skills Competency Verification form, EMSA-SCV.

J. EMT Training Program Course Completion Record

1. An approved EMT training program shall issue a tamper resistant course completion record to each person who has successfully completed the EMT course, refresher course, or challenge examination.
2. The course completion record shall contain the following information:
   a. The name of the individual.
   b. The date of the course completion.
   c. Type of EMT course completed (i.e. EMT, refresher, or challenge), and the number of hours completed
   d. The signature of the training program director
   e. The name and location of the training program issuing the record
   f. Statement: "This EMT training program has been approved by the Ventura County EMS Agency"
   g. Statement in bold and capitalized print: "THIS IS NOT AN EMT CERTIFICATE"
   h. Statement: This program includes required didactic and psychomotor skills training in Epinephrine, Glucometer, Naloxone, and four hours of Basic Tactical Casualty Care".
3. Within fifteen (15) days of course completion, each program shall submit the VCEMSA EMT Course Completion Roster that is attached to this policy. Students will not be processed for certification until the course completion roster is received by VCEMS.

K. EMT Training Program Course Completion Challenge Process

1. An approved EMT training program shall have a defined process for any EMT challenge request/application, and shall offer the EMT challenge psychomotor skills and cognitive examination in conjunction with regularly scheduled testing periods.

2. EMT course completion eligibility and challenge process shall be carried out in accordance with VCEMS Policy 304 – EMT Course Completion by Challenge Examination

L. EMT Training Program Review and Reporting

1. All program materials specified in this policy and in applicable Sections of the California Code of Regulations shall be subject to periodic review by the Ventura County EMS Agency.
2. All programs shall be subject to periodic on-site (announced and/or unannounced) evaluation by the Ventura County EMS Agency
3. EMT training program shall submit a schedule of psychomotor skills labs for each scheduled course (hybrid and/or traditional programs) that includes dates and list of psychomotor skills that are scheduled to be practiced on each date.
4. In the event that an approved EMT training program wishes to add a course to the schedule, notification shall be submitted in writing to the Ventura County EMS Agency no less than sixty (60) calendar days prior to the proposed start date.
5. The EMT training program shall notify the Ventura County EMS Agency in writing, in advance when possible, and in all cases within thirty (30) calendar days of any change in the following:
    a. Program director
    b. Clinical coordinator
    c. Principal instructor(s)
    d. Change of address, phone number or primary point of contact
    e. Change in course content or course hours of instruction
6. The EMT training program shall submit an annual report to the Ventura County EMS Agency within 45 days of year end. At minimum, this report shall be comprised of the following:
    a. Any changes to course content for the coming year. This does not replace the requirement outlined in Section IV.L.5 of this policy
    b. Changes to any teaching staff and/or program leadership. This does not replace the requirement outlined in Section IV.L.5 of this policy

c. A listing of course dates and locations for the coming year.
d. The number of students that successfully completed the program (broken down by term) versus number of students originally enrolled for the same period of time.

M. Quality Assurance and Improvement
1. At the time of approval and subsequent application for program re-approval, each EMT training program shall submit a comprehensive quality assurance and improvement plan that, at a minimum, addresses the following:
a. Methods of student remediation
b. Methods of student evaluation in demonstrating competency in both cognitive concepts and practical application of psychomotor skills.
c. A plan for continuous review and update of examinations and student materials
d. Identifies the text and resource materials that will be utilized by the program
e. Samples of student course evaluations
2. Any program that fails to maintain a three-year average cumulative pass rate of at least 80% within three attempts on the NREMT cognitive examination shall submit a comprehensive improvement plan to the Ventura County EMS Agency that outlines necessary steps to achieve the desired benchmark.
a. Data from the National Registry of EMTs will be pulled by the Ventura County EMS Agency on a quarterly basis and shared with approved EMT training programs and with members of the Prehospital Services Committee

N. Withdrawal of EMT Training Program Approval
1. Failure to comply with the provisions of this policy may result in the denial, suspension, or revocation of EMT training program approval by the Ventura County EMS Agency
2. The requirements for training program noncompliance notification and actions are as follows:

a. The Ventura County EMS Agency shall provide notification of noncompliance with the requirements of this policy and/or the regulations outlined in applicable sections of the California Code of Regulations. The notification shall be in writing and will be sent by certified mail to the EMT training program director.
b. Within fifteen (15) working days from receipt of the noncompliance notification the approved EMT training program shall submit in writing, by certified mail, to the Ventura County EMS Agency on of the following:
    1) Evidence of compliance with the provisions of this policy and applicable sections of the California Code of Regulations
    2) A plan to comply with the provisions of this policy and applicable sections of the California Code of Regulations within sixty (60) calendar days from the day of receipt of the notification of noncompliance.
c. Within fifteen (15) working days from receipt of the EMT training program's response, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the EMT training program, the Ventura County EMS Agency shall issue a decision letter by certified mail to the California EMS Authority and the EMT training program. The letter shall identify the Ventura County EMS Agency’s decision to take one or more of the following actions:
    1) Accept the evidence of compliance provided.
    2) Accept the plan for meeting compliance.
    3) Place the program on probation.
    4) Suspend or revoke the EMT training program approval.
d. The decision letter shall also include, but not be limited to, the following:
    1) The date of the Ventura County EMS Agency’s decision;
    2) Specific provisions found noncompliant by the training program approving authority, if applicable;
    3) The probation or suspension effective and ending date, if applicable;
    4) The terms and conditions of the probation or suspension, if applicable; and

5) The revocation effective date, if applicable.

e. If the EMT training program found noncompliant with the requirements of this policy, or with applicable sections of the California Code of Regulations does not comply with subsection b outlined above, the Ventura County EMS Agency may uphold the noncompliance finding and initiate a probation, suspension, or revocation action as described above.

f. The Ventura County EMS Agency shall establish the probation, suspension, or revocation effective dates no sooner than sixty (60) days after the date of the decision letter, as described above.

Ventura County Emergency Medical Services Agency
Emergency Medical Technician Training Program

Application Checklist

- Sections 1-4 to be completed by training program
- For additional information on requirements and approval process, please refer to VCEMS Policy 1100 – EMT Training Program Approval

1. General Information		
Training Program Name:		
Program Address	Program City	Program Zip
Program Phone Number	Program Fax Number	Program Email Address

2. Training Program Affiliation	
a. Training program is affiliated with a: ☐ Accredited University or College ☐ Junior or Community College ☐ School District ☐ Private Post-Secondary School *(Submit Post-Secondary School Approval Document)* ☐ Armed Forces Medical Unit ☐ Licensed Acute Care Hospital *(Submit special permit for Basic or Comprehensive Emergency Medical Services and proof of provision of Continuing Education to other Health Care Professionals)* ☐ Agency of Government ☐ Public Safety Agency	Name of Affiliated Agency, Institution, or Business

3. Program Administration and Staff	
a. Program Director ☐ Documentation of education and experience in methods, materials and evaluation of instruction by at least 40 hours in teaching methodology received (see policy section IV.A.2.g.1 for examples of qualifying education)	Name of Program Director
b. Clinical Coordinator ☐ Copy of Current License Received ☐ Documentation of Academic and/or Clinical Experience (2 years in last 5 years) received	Name and Title of Clinical Coordinator (Physician, RN, PA, Paramedic)
c. Principal Instructor(s) ☐ Copy of Current License(s) Received ☐ Documentation of education and experience in methods, materials and evaluation of instruction by at least 40 hours in teaching methodology received (see policy section III.A.2.g.3 for examples of qualifying education) ☐ Documentation of Academic and/or Clinical Experience (2 years in last 5 years) received ☐ Approval by the program director in coordination with the program clinical coordinator as qualified to teach the topics to which s/he is assigned.	Name(s) and Title(s) of Principal Instructor(s) (Physician, RN, PA, Paramedic, Advanced EMT, EMT)
d. Teaching Assistant(s) ☐ Copy of current license(s) received (if applicable) ☐ Qualified by training and experience to assists with teaching ☐ Approval by program director in coordination with the clinical coordinator	Names(s) and Title(s) of Teaching Assistant(s)

4. Program Representative Completing Application	
Name of Program Representative Completing Application	
Signature	Date
Phone Number	Email Address

VCEMS Office Use Only

1. Submission Checklist		
	Required Item	**Date Received**
☐	Written request for program approval, signed by training program director.	
☐	Statement verifying use of the US DOT National EMS Education Standards (DOT HS 811 077A, January 2009) ☐ Statement verifying program meets or exceeds required course hours outlined in Section IV.C.1 of this policy and meets all content requirements outlined in section 100067.11 of the California Code of Regulations	
☐	Statement signed by training program director that all psychomotor skills outlined in CCR Sections 100066.02 and 100067.11 and any others listed in this policy shall be taught, and that all students enrolled in course have been given multiple opportunities to practice required skills in person.	
☐	Statement verifying implementation of current ECC / ILCOR guidelines	
☐	Session guides and/or lesson plans	
☐	Samples of psychomotor skills and cognitive (written) exams used for periodic testing	
☐	A statement verifying that training program will utilize the Ventura County EMS Psychomotor skills evaluation packet and California EMS Authority's Skills Competency Verification Form (EMSA-SCV) for final skills testing.Copies of checklists and/or verification documents used for final psychomotor skills competency exam.	
☐	Final cognitive (written) exam	
☐	Statement signed by training program director that a comprehensive performance improvement plan will be required when program fails to maintain a three-year average cumulative pass rate of at least 80% within three attempts on the NREMT cognitive examination	
☐	Detail of provisions for course completion by challenge, including a challenge examination (if different from final course examination).	
☐	Provisions for refresher course and/or continuing education	
☐	Statement signed by training program director that an annual report shall be submitted within 45 days of year end. Report shall contain minimum content as outlined in Section IV.L.6 of this policy.	
☐	Location and proposed dates at which the course(s) are to be offered	

2. Application Status	
Initial Application Received	Date
Additional Information Requested	Date
All Requirements Submitted	Date
Approval Letter Issued	Date
Approval Expiration	Date
EMS Agency Representative Information	
Name of EMS Agency Representative Reviewing Application	
Signature	Date
Phone Number	Email Address

COUNTY OF VENTURA HEALTH CARE AGENCY	BACK	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Emergency Medical Responder (EMR) Training Program Approval		Policy Number 1102
APPROVED: Administration: Steve L. Carroll, Paramedic		Date: January 1, 2026
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: January 1, 2026
Origination Date: April 13, 2017 Date Revised: September 11, 2025 Date Last Reviewed: September 11, 2025 Review Date: September 30, 2028		Effective Date: January 1, 2026

I. PURPOSE: As the Ventura County EMS Agency has primary responsibility for approving and monitoring the performance of EMR training programs located with the County of Ventura, this policy has been established to outline the process for approval of Emergency Medical Responder training programs to ensure their compliance with local policy, as well as national standards and guidelines.

II. AUTHORITY: California Health and Safety Code, Title 22, Division 2.5, Sections 1797.204, 1797.210, and 1797.212; California Code of Regulations, Title 22, Division 9, Chapter 2.3,

III. POLICY: The approving authority for Emergency Medical Responder (EMR) training programs operating within the County of Ventura will be the Ventura County EMS Agency (VCEMSA). This does not apply to statewide public safety agencies such as California Highway Patrol, California State Parks, etc.

A. Programs eligible for program approval shall be limited to:

1. Accredited universities and colleges including junior and community colleges, school districts, or private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary and Vocational Education
2. Medical training units of a branch of the Armed Forces of the United States including the Coast Guard.
3. Licensed general acute care hospitals which meet the following criteria:
   a. Hold a special permit to operate a Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Division 5; and
   b. Provide continuing education to other healthcare professionals.
4. Agencies of government
5. Public safety agencies

6. Local EMS Agencies

IV. PROCEDURE:

A. Program Approval

1. Eligible training programs shall submit a written request for EMR program approval to VCEMSA.
2. VCEMSA shall review and approve the following prior to approving an EMR training program.
   a. A statement verifying usage of the United States Department of Transportation's (US DOT) National Highway Traffic Safety Administration (NHTSA) National Emergency Medical Services Education Standards: Emergency Medical Responder Instructional Guidelines, DOT HS 811 077B, January 2009, which includes learning objectives, skills protocols, and treatment guidelines. (Available at http://www.ems.gov/pdf/811077b.pdf).
   b. A statement verifying CPR training equivalent to the current Emergency Cardiovascular Care guidelines.
   c. Samples of lesson plans including:
      1) At least two lecture or didactic sessions, and
      2) At least two practical (skills or psychomotor) sessions.
   d. Samples of periodic examinations or assessments including:
      1) At least two written examinations or quizzes.
      2) Statement of utilization of the National Registry EMR Skills Check-Off Sheets
   e. A final psychomotor skills competency examination
   f. A final cognitive (written) examination
   g. Educational Staff:

      Each EMR training program shall provide for the functions of administrative direction, medical quality coordination, and actual program instruction. Nothing in this section precludes the same individual from being responsible for more than one of the following functions if so qualified by the provisions of this section.

      1) Program Director:

         Each EMR training program shall have an approved program director who shall be qualified by education and experience in methods, materials and evaluation of instruction which shall be

documented by at least forty (40) hours in adult teaching methodology or a k-12 teaching credential. Duties of the Program Director shall include but not be limited to:

a) Administering the training program
b) Approving course content
c) Approving all written examinations and the final skills examination.
d) Approving the principal instructor(s) and teaching assistant(s).
e) Signing all course completion records.
f) Assuring that all aspects of the EMR training program are in compliance with applicable California Code of Regulations, local VCEMS policies and procedures and any other applicable regulations, guidelines, or laws.

2) Principal Instructor:

Each training program shall have principal instructor(s), who may also be the program director, who shall be qualified by education and experience with at least forty (40) hours of documented adult teaching methodology instruction or a k-12 teaching credential and shall meet the following qualifications:

a) Be a Physician, Registered Nurse, Physician Assistant or Paramedic licensed in California; or,
b) Be an EMT, Advanced EMT, who is currently certified in California.
c) Have at least two (2) years of academic or clinical experience in the practice of emergency medicine or prehospital care in the last five (5) years.
d) Be approved by the program director as qualified to teach the topics to which s/he is assigned.
e) All principal instructors from an approved EMR training programs shall meet the minimum qualifications outlined in this policy.

3) Teaching Assistants

Each training program may have teaching assistants who shall be qualified by training and experience to assist with teaching of the course and shall be approved by the program director as qualified to assist in teaching the topics to which the assistant is to be assigned. A teaching assistant shall be supervised by a principal instructor and the program director.

k. Course Location, Time, and Instructor Ratios
   1) Each EMR Training Program shall submit an annual listing of course dates and locations.
   2) In the event that an approved EMR Training Program wishes to add a course to the schedule, notification must be received in writing by VCEMSA no less than sixty days prior to the proposed start date.
   3) No greater than ten students shall be assigned to one instructor during the practical portion of course.

l. A table of contents listing the required information detailed in this policy with corresponding page numbers

m. Facilities and Equipment
   1) Facilities must comfortably accommodate all students, including those with disabilities.
   2) Restroom access must be available.
   3) Must permit psychomotor skills testing so that smaller break-out groups are isolated from one another.
   4) Training equipment and supply shall be modern and up to date as accepted by the industry and shall be maintained and/or replaced as necessary.

n. Quality Assurance and Improvement
   1) Each program shall submit a Quality Assurance and Improvement Plan that addresses the following:
      a) Methods of student remediation.
      b) A plan for continuous update of examinations and student materials.
      c) Identify the text and resource materials that will be utilized by the program.

d) Student course evaluations

o. Research Agreement Decree

1) Each approved training program shall provide a statement agreeing to participate in research data accumulation. This information shall be utilized to enhance the emergency medical services systems in Ventura County.

3. Program Approval Time Frames

a. Upon receipt of a complete application packet, VCEMS shall notify the training program submitting its request for training program approval within seven (7) working days of receiving the request that:

1) The request for approval has been received,

2) The request does or does not contain all required information, and

3) What information, if any, is missing from the request.

b. Program approval or disapproval shall be made in writing by VCEMS to the requesting training program, within a reasonable period of time, after receipt of all required documentation, not to exceed three (3) months.

c. VCEMS shall establish an effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.

d. Program approval shall be for four (4) years following the effective date of program approval and may be renewed every four (4) years subject to the procedure for program approval specified by VCEMS in this policy.

4. Withdrawal of Program Approval

Noncompliance with any criterion required for EMR training program approval, use of any unqualified personnel, or noncompliance with any other applicable regulation, guidelines or laws may result in suspension or revocation of program approval by VCEMS. Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:

a. VCEMS shall notify the EMR training program director in writing, by registered mail, of the provisions of this policy with which the EMR training program is not in compliance.

b. Within fifteen (15) working days of receipt of the notification of noncompliance, the approved EMR training program shall submit in writing, by registered mail, to VCEMS one of the following:
   1) Evidence of compliance with the provisions outlined in this policy, or
   2) A plan for meeting compliance with the provisions outlined in this policy within sixty (60) calendar days from the day of receipt of the notification of noncompliance.

c. Within fifteen (15) working days of the receipt of the response from the approved EMR training program, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the approved EMR training program, VCEMS shall notify the approved EMR training program in writing, by registered mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the EMR training program approval.

d. If the EMR training program approving authority decides to suspend, revoke, or place an EMR training program on probation the notification specified in this policy shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting the probation or suspension or the effective date of the revocation, which may not be less than sixty (60) days from the date of VCEMS' letter of decision to the EMR training program.

B. Program Review and Reporting

1. All program materials are subject to periodic review by VCEMSA.
2. All programs are subject to periodic on-site (scheduled or unscheduled) evaluation by VCEMSA.
3. VCEMSA shall be advised of any program changes in course content, hours of instruction, or instructional staff.
4. Approved programs shall issue a tamper resistant Course Completion Record to each student who successfully meets all requirements for certification. This Course Completion Record shall include:
   a. The name of the individual
   b. The date the course was completed

c. The name of the course completed "Emergency Medical Responder"

d. Number of hours of instruction completed.

e. The name and signature of the Program Director.

f. The name and location of the training program issuing the course completion.

g. The name of the approving authority (ie; Approved by the Ventura County EMS Agency)

h. The following statements in bold print:

1) "THIS IS NOT AN EMR CERTIFICATE"

2) This course completion record is valid to apply for certification up to a maximum of two years from the course completion date and shall be recognized statewide.

5. The EMR training program shall notify the Ventura County EMS Agency in writing, in advance when possible, and in all cases within thirty (30) calendar days of any change in the following:

a. Program director

b. Clinical coordinator

c. Principal instructor(s)

d. Change of address, phone number or primary point of contact

e. Change in course content, course hours of instruction, additional classes/cohorts, etc.

6. The EMR training program shall submit an annual report to the Ventura County EMS Agency within 45 days of year end. At minimum, this report shall be comprised of the following:

a. Any changes to course content for the coming year.

b. Total cost of attendance (include tuition and fees, books, uniforms, Equipment and supplies, etc.)

c. Changes to any teaching staff and/or program leadership. This does not replace the requirement outlined in item 4 above

d. A listing of course dates and locations for the coming year.

e. The number of students that successfully completed the program (broken down by term) versus number of students originally enrolled for the same period of time.

V. Each program shall submit the Agency provided Course Completion Roster no greater than fifteen (15) days following the completion of the program. This roster shall include the name and address of each person receiving a course completion record and the date of course completion.

Ventura County Emergency Medical Services Agency
Emergency Medical Responder Training Program

Application Checklist

Sections 1-4 to be completed by training program

For additional information on requirements and approval process, please refer to VCEMS Policy 1102 – EMR Training Program Approval

1. General Information		
Training Program Name:		
Program Address	Program City	Program Zip
Program Phone Number	Program Fax Number	Program Email Address

2. Training Program Affiliation	
a. Training program is affiliated with a: ☐ Accredited University or College ☐ Junior or Community College ☐ School District ☐ Private Post-Secondary School *(Submit Post-Secondary School Approval Document)* ☐ Armed Forces Medical Unit ☐ Licensed Acute Care Hospital *(Submit special permit for Basic or Comprehensive Emergency Medical Services and proof of provision of Continuing Education to other Health Care Professionals)* ☐ Agency of Government ☐ Public Safety Agency ☐ Local EMS Agency	Name of Affiliated Agency, Institution, or Business
3. Program Administration and Staff	
a. Program Director ☐ Documentation of education and experience in methods, materials and evaluation of instruction which shall be documented by at least forty (40) hours in adult teaching methodology or a k-12 teaching credential.	Name of Program Director
b. Principal Instructor(s) ☐ Copy of Current License(s) Received ☐ Documentation of education and experience in methods, materials and evaluation of instruction by at least 40 hours in teaching methodology received (see policy section III.A.2.g.3 for examples of qualifying education) ☐ Documentation of Academic and/or Clinical Experience (2 years in last 5 years) received ☐ Approval by the program director in coordination with the program clinical coordinator as qualified to teach the topics to which s/he is assigned.	Name(s) and Title(s) of Principal Instructor(s) (MD, RN, PA, Paramedic, Advanced EMT, EMT)

****Checklist Continued on Next Page****

c. Teaching Assistant(s) ☐ Copy of current license(s) received (if applicable) ☐ Qualified by training and experience to assists with teaching ☐ Approval by program director in coordination with the clinical coordinator	Names(s) and Title(s) of Teaching Assistant(s)

4. Program Representative Completing Application	
Name of Program Representative Completing Application	
Signature	Date
Phone Number	Email Address

VCEMS Office Use Only

1. Submission Checklist	
Required Item	**Date Received**
☐ Written request for program approval	
☐ A statement verifying usage of the US DOT National Highway Traffic Safety Administration (NHTSA) National EMS Education Standards: Emergency Medical Responder Instructional Guidelines, DOT HS 811 077B, January 2009	
☐ Statement verifying implementation of current ECC / ILCOR guidelines	
☐ Session guides and/or lesson plans	
☐ Samples of skills and written exams used for periodic testing	
☐ Final psychomotor skills competency exam	
☐ Final cognitive (written) exam	
☐ Location and proposed dates at which the course(s) are to be offered	
☐ Copy of Course Completion Certificate	
☐ Statement verifying program will comply with all reporting requirements outlined in Section IV.B of this policy	

2. Application Status	
Initial Application Received	Date
Additional Information Requested	Date
All Requirements Submitted	Date
Approval Letter Issued	Date
Approval Expiration	Date

3. EMS Agency Representative Information	
Name of EMS Agency Representative Reviewing Application	
Signature	Date
Phone Number	Email Address

COUNTY OF VENTURA HEALTH CARE AGENCY	BACK	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMS Continuing Education Provider Approval		Policy Number 1130
APPROVED: Administration: Steven L. Carroll, Paramedic		Date January 1, 2026
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date January 1, 2026
Origination Date: February 2001 Date Revised: August 14, 2025 Date Last Reviewed: August 14, 2025 Review Date: August 30, 2028		Effective Date: January 1, 2026

I. PURPOSE: To identify the procedure for approval of Advanced Life Support (ALS) and Basic Life Support (BLS) EMS Continuing Education Providers (CEPs) that are based (headquartered) in Ventura County

II. AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 3.5, Article 4.

III. POLICY:

A. The Ventura County EMS Agency (VCEMS) shall be the agency responsible for approving EMS Continuing Education Providers whose headquarters are located within the geographical boundaries of Ventura County, if not already approved as a statewide public safety agency or for those CE providers who are headquartered out of state. Programs eligible for approval shall be limited to public or private organizations that meet the requirements identified in this policy. All private entities must possess a valid business license and proof of organizational registry (partnership, sole proprietorship, corporation, etc).

B. When a CE provider is approved by either a local EMS agency or the EMS Authority, the CE provider is approved to conduct CE courses statewide

C. Courses and/or CE providers approved by the Commission on Accreditation for Pre-Hospital Continuing Education (CAPCE) or approved by EMS offices of other states are approved for use in California and need no further approval.

D. Courses in physical, social or behavioral sciences offered by accredited colleges and universities are approved for CE and need no further approval.

IV. PROCEDURE:

A. Program Approval

1. Eligible programs shall submit a written request for CEP approval to the EMS Agency and agree to provide at least 12 hours of continuing education per year.
2. Applicant shall agree to participate in the VCEMS Quality Improvement Program and in research data accumulation.
3. Applicant shall agree to implement current American Heart Association ECC and CPR Guidelines.
4. Applicant shall submit resumes for the Program Director and the Clinical Director.
5. Educational Staff Requirements:

   Nothing shall preclude one person from filling more than one position.

   a. Program Director
      1) Shall be qualified by education and experience in methods materials and evaluation of instruction which shall be documented by at least forty hours in teaching methodology. The following are examples of courses that meet the required instruction in teaching methodology:
         a) California State Fire Marshal Fire Instructor 1-A, 1-B and 1-C, or;
         b) National Fire Academy "Fire Service Instructional Methodology" course or equivalent, or;
         c) Training programs that meet the US DOT/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course.
         d) Individuals with equivalent experience may be provisionally approved for up to two years by the Agency pending completion of the above specified requirements.

   b. Clinical Director
      1) Must be either a physician, registered nurse, physician assistant, or paramedic currently licensed in California and shall have two years of academic, administrative or clinical experience in emergency medicine or prehospital care in the last five years.

   c. CE Provider Instructors
      1) Each CE provider instructor shall be approved by the program director and clinical director as qualified to teach the topics assigned, or have evidence of specialized training which may include, but is not limited to, a certificate of training or an

advanced degree in a given subject area, or have at least one year of experience within the last two years in the specialized area in which they are teaching, or be knowledgeable, skillful and current in the subject matter of the course, class or activity.

6. Application Receipt Process

   Upon receipt of a complete application packet, VCEMS will notify the applicant within fourteen business days that;

   a) The request for approval has been received.
   b) The request does or does not contain all required information.
   c) What information, if any, is missing

7. Program Approval Time Frames

   a) Program approval or disapproval shall be made in writing by VCEMS to the requesting program, within sixty calendar days, after receipt of all required documentation.
   b) VCEMS shall establish an effective date for program approval in writing upon the satisfactory documentation of compliance with all program requirements.
   c) Program approval shall be for four years following the effective date of the program and may be reviewed every four years subject to the procedure for program approval specified by VCEMS.

8. Withdrawal of Program Approval

   a) Noncompliance with any criterion required for program approval, use of any unqualified personnel, or noncompliance with any other applicable provision of Title 22 may result in suspension or revocation of program approval by VCEMS.
   b) An approved program shall have no more than sixty days to comply with corrections mandated by this policy.

B. Program Review and Reporting

1. All program materials are subject to periodic review by VCEMS.
2. All programs are subject to periodic on-site evaluation by VCEMS.
3. VCEMS shall be advised of any program changes in course content, hours of instruction, or instructional staff.
4. Records shall be maintained by the CEP for four years and shall contain the following:

a) Complete outlines for each course given, including brief overview, instructional objectives, outline, evaluations, and record of participant performance;
b) Record of time, place, and date each course is given and number of CE hours granted;
c) A curriculum vitae or resume for each instructor.
d) A roster of course participants (instructor-based courses must have course participants sign roster)

5. Approved programs shall issue a tamper resistant Course Completion Certificate to each student who attends a continuing education course within 30 days of completion. This certificate shall include:
   a). Student full legal name.
   b) Certificate or license number
   c) The date the course was completed
   d) The name of the course completed
   e) The name and signature of the Instructor or Program Director.
   f) The name and address of the CE Provider.
   g) Course completion document must contain the following statement with the appropriate information filled in. "This course has been approved for (number) of hours of continuing education by an approved California EMS CE Provider and was (check one) instructor based or non-instructor based." It also must have your approved C.E. provider number on it.
   h) The following statement in bold print:
   "This document must be maintained for no less than four years"
6. For the initial six months of CE program approval, the CE Provider shall submit a lecture approval form to VCEMS prior to offering a course. After the initial six-month period, the CE Provider shall approve and maintain their own records subject to review by VCEMS.
7. A continuing education roster shall be completed for every course offered by the CEP. This roster shall be maintained by the CEP and subject to review by the Agency.
   a) A copy of the Continuing Education roster for all mandatory Ventura County CE programs (EMS Update, Skills testing, etc.) shall be submitted to VCEMS immediately after the completion of the program.

8. Any EMS continuing education program that is responsible for periodic psychomotor skills testing for Emergency Medical Technicians (EMTs) shall utilize the VCEMS Psychomotor Skills Evaluation Manual for final evaluation and reporting.
9. Each CEP shall provide an annual report to VCEMS, within 45 days of year end, detailing the following:
    a. Title of any course taught,
    b. Course times
    c. Number of hours awarded for each course, and
    d. Total number of participants for each course.
10. A template for the CE provider program's required annual report will be provided by VCEMS.

C. Application for Renewal

1. The CEP shall submit an application for renewal at least sixty calendar days before the expiration date of their CE provider approval in order to maintain continuous approval.
2. All CE provider requirements shall be met and maintained for renewal as specified in VCEMS Policy 1130 and CCR, Title 22, Division 9, Chapter 3.5.

Ventura County Emergency Medical Services Agency
EMS Continuing Education Provider Program

Application Checklist for Approval/Renewal

- Sections 1-5 to be completed by training program
- For additional information on requirements and approval process, please refer to VCEMS Policy 1130 – EMS Continuing Education Provider Approval Process

1. General Information		
Applicant (Program) Name:		
Program Primary Point of Contact:		
Program Address	Program City	Program Zip
Program Phone Number	Program Fax Number	Program Email Address
2. Program Eligibility		
☐ Training program is affiliated with a: ☐ Accredited University or College ☐ Junior or Community College ☐ School District ☐ Private Entity *Note: Must possess a valid business license and proof of organizational registry (partnership, sole proprietorship, corporation, etc). Evidence of license and proof of organizational registry shall be provided at time of application.* ☐ Armed Forces Medical Unit ☐ Licensed Acute Care Hospital *(Submit special permit for Basic or Comprehensive Emergency Medical Services and proof of provision of Continuing Education to other Health Care Professionals)* ☐ Agency of Government ☐ Public Safety Agency		Name of Agency, Institution, or Business
☐ Written request for EMS CE program approval		Attach request letter on organization letterhead
☐ Written confirmation that program will adhere to current ECC/ILCOR guidelines ☐ Documentation related to CE program's CPR alignment ☐ AHA ☐ ARC ☐ ASHI		Attach alignment letter or certificate with training center attached
3. Program Administration and Staff		
a. Program Director ☐ Resume / CV of Program Director ☐ Copy of current certification(s)/license(s) ☐ Documentation of education and experience in methods, materials and evaluation of instruction by at least 40 hours in teaching methodology received (see policy section IV.A.2.g.1 for examples of qualifying education)		Name of Program Director
b. Clinical Director ☐ Resume / CV of Clinical Director ☐ Copy of Current Certification(s)/License(s) ☐ Evidence of at least two-years' experience in emergency medicine or prehospital care in the past five (5) years		Name of Clinical Director

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c. Principal Instructor(s) ☐ Resume / CV of All Principal Instructor(s) ☐ Copy of Current License(s) Received ☐ Written confirmation that each CE provider instructor shall be approved by the program director and clinical director as qualified to teach the topics assigned, or have evidence of specialized training which may include, but is not limited to, a certificate of training or an advanced degree in a given subject area, or have at least one year of experience within the last two years in the specialized area in which they are teaching, or be knowledgeable, skillful and current in the subject matter of the course, class or activity.	Name(s) of Principal Instructor(s)
d. Teaching Assistant(s) ☐ Copy of current license(s) received (if applicable) ☐ Qualified by training and experience to assists with teaching ☐ Approval by program director in coordination with the clinical director	Names(s) of Teaching Assistant(s)
4. CE Records and Quality Improvement	
a. Written statement verifying that CE program applicant shall utilize the VCEMS psychomotor skills evaluation manual for any/all psychomotor skills testing performed	Attach Written Statement
b. Written statement that program shall maintain all records for a minimum of four (4) years, in accordance with the standards outlined in this policy	Attach Written Statement
c. Written statement that program agrees to participate in the VCEMS quality improvement program and research data accumulation	Attach Written Statement
d. Written statement agreeing that CE program shall submit an annual report to VCEMS within 45 days of year end, and that the report will meet all requirements outlined in this policy.	Attach Written Statement
e. Copy of the Course Completion Certificate/Record that will be issued upon completion of each session. Course completion shall meet all minimum requirements outlined in this policy.	Attach Copy of Course Completion Certificate

5. Individual Completing Application	
Name of Program Representative Completing Application	
Signature	Date
Phone Number	Email Address

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VCEMS Office Use Only

1. Submission Checklist	
Required Item	**Date Received**
☐ Written request for EMS CE program approval	
☐ For private entities requesting approval: Valid business license and proof of organizational registry (partnership, sole proprietorship, corporation, etc). Evidence of license and proof of organizational registry shall be provided at time of application	
☐ All required documentation submitted for Program Director	
☐ All required documentation submitted for Clinical Director	
☐ All required documentation submitted for Principal Instructor(s)	
☐ All required documentation submitted for Teaching Assistant(s)	
☐ Written confirmation that program will adhere to current ECC/ILCOR guidelines ☐ Documentation related to CE program's CPR alignment ☐ AHA ☐ ARC ☐ ASHI	
☐ Written statement verifying that CE program applicant shall utilize the VCEMS psychomotor skills evaluation manual for any/all psychomotor skills testing performed	
☐ Written statement that program shall maintain all records for a minimum of four (4) years, in accordance with the standards outlined in this policy	
☐ Written statement that program agrees to participate in the VCEMS quality improvement program and research data accumulation	
☐ Written statement agreeing that CE program shall submit an annual report to VCEMS within 45 days of year end, and that the report will meet all requirements outlined in this policy.	
☐ Copy of the Course Completion Certificate/Record that will be issued upon completion of each session. Course completion shall meet all minimum requirements outlined in this policy.	

2. Application Status	
Initial Application Received	Date
Additional Information Requested	Date
All Requirements Submitted	Date
Approval Letter Issued	Date
Approval Expiration	Date
3. EMS Agency Representative Information	
Name of EMS Agency Representative Reviewing Application	
Signature	Date
Phone Number	Email Address

COUNTY OF VENTURA HEALTH CARE AGENCY	**BACK**	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Paramedic Training Program Approval		Policy Number 1135
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: January 1, 2026
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: January 1, 2026
Origination Date: October 20, 1993 Date Revised: September 11, 2025 Date Last Reviewed: September 11, 2025 Next Review Date: September 30, 2028		Effective Date: January 1, 2026

I. PURPOSE: To define the procedure to be followed when applying for approval for a paramedic training program in Ventura County.

II AUTHORITY: Health and Safety Code Sections 1797.172, 1797.178, 1797.200, 1797,202, 1797.204, 1797.208, 1797.220, 1798 and 1798.100. California Code of Regulations, Title 22 Division 9, Sections 100137, 100148 - 100156, 100159, and 100162.

III. POLICY: The purpose of a paramedic training program shall be to prepare individuals to render prehospital advanced life support (ALS) within an organized Emergency Medical Services (EMS) system. The following procedure shall be followed when applying for approval for a paramedic training program approval.

IV. DEFINITION(S): Paramedic training program approving authority means an agency or person authorized by the California Code of Regulations, Title 22, Division 9, Chapter 4, Article 1, Section 100137 to approve a paramedic training program, as follows:

A. The approving authority for a paramedic training program that is conducted by a qualified statewide public safety agency shall be the Director of the California EMS Authority.

B. The approving authority for any paramedic training program(s) based in the County of Ventura shall be the Ventura County Emergency Medical Services Agency (VCEMS).

V. PROCEDURE:

A. Approved Training Programs

1. Eligibility for paramedic training program approval shall be limited to the following institutions:

a. Accredited universities, colleges, including junior and community colleges, and private post-secondary schools as approved by the

Department of Consumer Affairs, Bureau for Private Postsecondary Education

b. Medical training units of the United States Armed Forces or Coast Guard
c. Licensed general acute care hospitals which meet the following criteria:
    1) Hold a special permit to operate a basic or comprehensive emergency medical service pursuant to the provisions of the California Code of Regulations, Title 22, Division 5;
    2) Provide continuing education (CE) to other health care professionals; and
    3) Are accredited by a Centers for Medicare and Medicaid Services (CMS) accreditation organization with deeming authority, such as the Joint Commission or the Healthcare Facilities Accreditation Program of the American Osteopathic Association
d. Agencies of government

2. All approved paramedic training programs shall be accredited and shall maintain current accreditation or be in the process of receiving accreditation approval by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) upon the recommendation of the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) in order to operate as an approved paramedic training program.
3. All approved paramedic training programs shall:
    a. Receive a Letter of Review (LoR) from CoAEMSP prior to starting classes; and
    b. Submit their application, fee, and Initial Self-Study Report (ISSR) to CoAEMSP for accreditation within six (6) months of the first class' graduation; and
    c. Receive and maintain CAAHEP accreditation no later than two (2) years from the date of the ISSR submission to CoAEMSP for accreditation
4. Paramedic training programs approved according to the provisions outlined in this policy shall provide the following information in writing to all their paramedic training program applicants prior to the applicants' enrollment in the paramedic training program:

a. The date the paramedic training program must submit their CAAHEP Request for Accreditation Services (RAS) form and ISSR or the date their application for accreditation renewal was sent to CoAEMSP.
b. The date the paramedic training program must be initially accredited or the date its accreditation must be renewed by CAAHEP.

5. Failure of the paramedic training program to maintain its LoR, submit their RAS form and ISSR to CoAEMSP, or obtain and maintain its accreditation with CAAHEP, as described above, by the date specified shall result in withdrawal of program approval as outlined in Section V.K of this policy.
6. Students graduating from a paramedic training program that fails to apply for, receive, or maintain CAAHEP accreditation by the dates required will not be eligible for state licensure as a paramedic.
7. Paramedic training programs shall submit to VCEMSA all documents submitted to, and received from CoAEMSP and/or CAAHEP, including but not limited to the RAS form, ISSR, and documents required for maintaining accreditation.
8. Paramedic training programs shall submit to the California EMS Authority the date their initial RAS form was submitted to CoAEMSP and copies of documentation received from CoAEMSP and/or CAAHEP verifying accreditation.

B. Student Eligibility

1. To be eligible to enter a paramedic training program an individual shall meet the following requirements:
    a. Possess a high school diploma or general education equivalent; and
    b. possess a current basic cardiac life support (CPR) card equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the healthcare provider level; and
    c. possess a current EMT certificate or NREMT-Basic registration; or
    d. possess a current AEMT certificate in the State of California; or
    e. be currently registered as an Advanced-EMT with the NREMT.

C. Teaching Staff

1. Each paramedic training program shall have a medical director who is a physician currently licensed in the State of California, has experience in

emergency medicine, and has education experience or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to the following:

a. Review and approve educational content of the program curriculum, including training objectives for the clinical and field instruction, to certify its ongoing appropriateness and medical accuracy.
b. Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.
c. Approval of hospital clinical and field internship experience provisions.
d. Approval of principal instructor(s).

2. Each training program shall have a program director who is either a California licensed physician, a registered nurse who has a baccalaureate degree, or a paramedic who has a baccalaureate degree, or an individual who holds a baccalaureate degree in a related health field or in education. The program director shall be qualified by education and experience in methods, materials, and evaluation of instruction, and shall have a minimum of one (1) year experience in an administrative or management level position and have a minimum of three (3) years academic or clinical experience in prehospital care education. Duties of the program director shall include, but not be limited to the following:
   a. Administration, organization, and supervision of the educational program.
   b. In coordination with the training program medical director, approve the principal instructor(s), teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum, including instructional objectives, and approve all methods of evaluation.
   c. Ensure training program compliance with all aspects of this policy, applicable sections of the California Code of Regulations, and other related laws.
   d. Sign all course completion records.
   e. Ensure the preceptors are trained according to VCEMS Policy 319 – Paramedic Preceptor.
3. Each training program shall have a principal instructor(s), who is responsible for areas including, but not limited to, curriculum development, course coordination, and instruction and shall meet the following criteria:

a. Be a physician, registered nurse, physician assistant, or paramedic, currently certified or licensed in the State of California.
b. Be knowledgeable in the course content of the January 2009 United States Department of Transportation (U.S. DOT) National Emergency Medical Services Education Standards DOT HS 811 077 E; and
c. Have six (6) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree.
d. Be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.

4. A principal instructor may also be the training program medical director or training program director.
5. Each training program may have a clinical coordinator(s) who is either a physician, registered nurse, physician assistant or paramedic currently licensed in the State of California, and who shall have two (2) years of academic or clinical experience in emergency medicine or prehospital care. Duties of the clinical coordinator shall include, but not be limited to, the following:
    a. The coordination and scheduling of students with qualified clinical preceptors in approved clinical settings as described in Section V.C.8 of this policy
    b. Ensuring adequate clinical resources exist for student exposure to the minimum number and type of patient contracts established by the paramedic training program as required for continued CAAHEP accreditation.
    c. The tracking of student internship evaluation and terminal competency documents.
6. Each training program may have teaching assistant(s) who has training and experience to assist with teaching the course. The teaching assistant(s) shall be supervised by a principal instructor, the program director and/or the program medical director.
7. Each paramedic training program shall have a field preceptor(s) who meet all criteria outlined in VCEMS Policy 319 – Paramedic Preceptor.
8. Each paramedic training program shall have a hospital clinical preceptor(s) who shall meet the following criteria:

a. Be a physician, registered nurse or physician assistant currently licensed in the State of California.
b. Have worked in emergency medical care services or areas of medical specialization for the last two (2) years.
c. Be under the supervision of a principal instructor, the program director, and/or the program medical director.
d. Receive training in the evaluation of paramedic students in clinical settings. Instructional tools may include, but need not be limited to:
    1) Evaluate a student's ability to safely administer medications and perform assessments.
    2) Document a student's performance.
    3) Review clinical preceptor requirements outlined in this policy
    4) Assess student behaviors using cognitive, psychomotor, and affective domains.
    5) Create a positive and supportive learning environment.
    6) Identify appropriate student progress.
    7) Counsel the student who is not progressing.
    8) Provide guidance and procedures for addressing student injuries or exposure to illness, communicable disease or hazardous materials.

D. Education and Training for Paramedic Students
1. Paramedic training program shall assure that no more than six (6) students are assigned to one instructor/teaching assistant during skills practice/laboratory
2. Hospital Clinical Education and Training
    a. An approved paramedic training program shall provide for and monitor a supervised clinical experience at a hospital(s) that is licensed as a general acute care hospital and holds a permit to operate a basic or comprehensive emergency medical service. The clinical setting may be expanded to include areas commensurate with the skills experience needed. Such settings may include surgicenters, clinics, jails or any other areas deemed appropriate by the VCEMS Medical Director. The maximum number of hours in the expanded clinical setting shall not exceed forty (40) hours of the total clinical hours specified in Section V.E of this policy

b. Paramedic training program shall not enroll any more students than the training program can commit to providing a clinical internship to begin no later than thirty (30) days after a student's completion of the didactic and skills instruction portion of the training program. The paramedic training program course director and a student may mutually agree to a later date for the clinical internship to begin in the event of special circumstances (e.g., student or preceptor illness or injury, student's military duty, etc.).

c. Paramedic training programs in nonhospital institutions shall enter into written agreement(s) with a licensed general acute care hospital(s) that holds a permit to operate a basic or comprehensive emergency medical service for the purpose of providing this supervised clinical experience.

d. Paramedic clinical training hospital(s) and other expanded settings shall provide clinical experience, supervised by a clinical preceptor(s). The clinical preceptor may assign the student to another health professional for selected clinical experience. No more than two (2) students shall be assigned to one preceptor or health professional during the supervised clinical experience at any one time. Clinical experience shall be monitored by the training program staff and shall include direct patient care responsibilities, which may include performance of procedures or administration of medications as specified in VCEMS Policy 310 – Paramedic Scope of Practice. Clinical assignments shall include, but are not to be limited to, emergency, cardiac, surgical, obstetric, and pediatric patients.

3. Field Internship

a. A field internship shall provide emergency medical care training and experience to paramedic students under continuous supervision, instruction, and evaluation by an authorized preceptor and shall promote student competency in medical procedures, techniques, and the administration of medications as specified in VCEMS Policy 310 – Paramedic Scope of Practice, in the prehospital emergency setting within an organized EMS system.

b. An approved paramedic training program shall enter into a written agreement with Advanced Life Support (ALS) service provider(s) that

provide field internship services to students. This agreement shall include provisions to ensure compliance with this policy.

c. The VCEMS Medical Director shall have medical control over the paramedic intern

d. The assignment of a student to a field preceptor shall be a collaborative effort between the paramedic training program and the provider agency
    1) The assignment of a student to a field preceptor shall be limited to duties associated with the student's training or the student training program

e. In the event the ALS service provider is located outside the jurisdiction of the County of Ventura, the paramedic training program shall do the following:
    1) Ensure the student receives orientation in collaboration with the LEMSA where the field internship will occur. The orientation shall include that LEMSA's local policies, procedures, and treatment protocols,
    2) Report to the LEMSA, where the field internship will occur, the name of the paramedic intern, the name of the field internship provider, and the name of the preceptor.
    3) Ensure the field preceptor has the experience and training as required in VCEMS Policy 319 – Paramedic Preceptor.
    4) The LEMSA Medical Director where the internship is located shall have medical control over the paramedic intern

f. The paramedic training program shall enroll only the number of students it is able to place in field internships within ninety (90) days of completion of their hospital clinical education and training phase of the training program. The paramedic training program director and a student may agree to start the field internship at a later date in the event of special circumstances (e.g., student or preceptor illness or injury, student's military duty, etc.). This agreement shall be in writing.

g. The internship, regardless of the location, shall be monitored by the training program staff, in collaboration with the assigned field preceptor.

h. Training program staff shall, upon receiving input from the assigned field preceptor, document the progress of the student. Documentation

shall include the identification of student deficiencies and strengths and any training program obstacles encountered by, or with, the student.

i. Training program staff shall provide documentation reflecting student progress to the student at least twice during the student's internship.

j. No more than one (1) trainee, of any level, shall be assigned to a response vehicle at any one time during the paramedic student's field internship.

E. Required Course Hours

1. The total paramedic training program shall consist of not less than one thousand and ninety-four (1094) hours. These training hours shall be divided into:
   a. A minimum of four-hundred and fifty-four (454) hours of didactic instruction and skills laboratories that shall include not less than four (4) hours of training in tactical casualty care principles as provided in Section V.F of this policy
   b. The hospital clinical training shall consist of no less than one-hundred and sixty (160) hours
   c. The field internship shall consist of no less than four-hundred and eighty (480) hours
2. The student shall have a minimum of forty (40) documented ALS patient contacts during the field internship as specified in V.C.3 of this policy. An ALS patient contact shall be defined as the student performance of one or more ALS skills identified in VCEMS Policy 310 – Paramedic Scope of Practice, with the exception of 3 or 4 lead cardiac monitoring and CPR, on a patient
   a. When available, up to ten (10) of the required ALS patient contacts may be satisfied through the use of high fidelity adult simulation patient contacts.
      1) High Fidelity Simulation means using computerized manikins, monitors, and similar devices or augmented virtual reality environments that are operated by a technologist from another location to produce audible sounds and to alter and manage physiological changes within the manikin to include, but not be

limited to, altering the heart rate, respirations, chest sounds, and saturation of oxygen.

b. Under the supervision of the preceptor, students shall document patient contacts utilizing the Ventura County electronic Patient Care Reporting system (VCePCR) in accordance with VCEMS Policy 1000 – Documentation of Prehospital Care.
   1) The ALS Service provider hosting the paramedic student will provide access to VCePCR through a username and password that is unique to that student.

c. For at least half of the ALS patient contacts the paramedic student shall be required to provide the full continuum of care of the patient beginning with the initial contact with the patient upon arrival at the scene through transfer of care to hospital personnel.

3. The student shall have a minimum of twenty (20) documented experiences performing the role of team lead during the field internship. A team lead shall be defined as a student who, with minimal to no prompting by the preceptor, successfully takes charge of EMS operation in the field including, at least, the following:
   a. Lead coordination of field personnel,
   b. Formulation of field impression,
   c. Comprehensively assessing patent conditions and acuity.
   d. Directing and implementing patient treatment,
   e. Determining patient disposition, and
   f. Leading the packaging and movement of the patient.

4. The minimum hours outlined in this subsection shall not include the following:
   a. Course material designed to teach or test exclusively EMT knowledge or skills including CPR.
   b. Examination for student eligibility.
   c. The teaching of any material not prescribed in Section V.F of this policy.
   d. Examination for paramedic licensure.

F. Required Course Content

1. The content of a paramedic course shall meet the objectives contained in the January 2009 U.S. Department of Transportation (DOT) National

Emergency Medical Services Education Standards, DOT HS 811 077E, and be consistent with the paramedic basic scope of practice specified VCEMS Policy 310 – Paramedic Scope of Practice

2. In addition to the above, the content of the training course shall include a minimum of four (4) hours of tactical casualty care (TCC) principles. The minimum competency-based topics and skills for this TCC requirement are outlined in California Code of Regulations, Title 22, Division 9, Chapter 4, Article 3, Section 100155(b).

G. Required Testing

1. Approved paramedic training programs shall include a minimum of two (2) formative examinations and one (1) final comprehensive competency-based examinations to test the knowledge and skills specified in this policy.
2. Documentation of successful student clinical and field internship performance shall be required prior to course completion

H. Course Completion Record

1. A tamper resistant course completion record shall be issued to each person who has successfully completed the paramedic training program. The course completion record shall be issued no later than ten (10) working days from the date the student successfully completes the paramedic training program.
2. The course completion record shall contain the following:
   a. The name of the individual.
   b. The date of completion.
   c. The following statement:
      1) "The individual named on this record has successfully completed an approved paramedic training program."
   d. The signature of the training program director
   e. The name and location of the training program issuing the card
   f. A list of optional scope of practice procedures and/or medications approved by the VCEMS Medical Director taught in the course.

I. Procedure for Paramedic Training Program Approval

1. Eligible training programs, as outlined in Section V.A of this policy shall pay the established paramedic training program application fee and submit a written request, in addition to the completed application checklist attached to

this policy, to VCEMS for program approval. The following documentation shall be submitted along with written request for approval and application checklist:

a. A statement verifying that the course content meets the requirements contained in the U.S. DOT National Education Standards DOT HS 811 077 E January 2009.
b. An outline of course objectives.
c. Performance objectives for each skill.
d. The names and qualifications of the training program director, program medical director, and principal instructors.
e. Provisions for supervised hospital clinical training including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.
f. Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.
g. The location at which the courses are to be offered and their proposed dates.
h. Written agreements between the paramedic training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.
i. Written contracts or agreements between the paramedic training program and a provider agency (ies) for student placement for field internship training.
j. A copy of a CoAEMSP LoR issued to the training institution applying for approval or documentation of current CAAHEP accreditation.
k. Samples of written and skills examinations administered by the training program.
l. Samples of a final written examination(s) administered by the training program.
m. Evidence of adequate training program facilities, equipment, examination securities, and student record keeping.

J. Program Approval / Disapproval

1. VCEMS shall, within thirty (30) working days of receiving a request for training program approval, notify the applicant that the request has been

received, and shall specify if any additional information is needed to satisfy the requirements outlined in Section V.I

2. The materials submitted will be reviewed and evaluated by VCEMS staff, an educator with a medical/nursing background who is not associated with the applicant, and an MD who is not associated with the submitting applicant
3. Program approval or disapproval shall be made in writing by VCEMS to the requesting training program within a reasonable period of time after receipt of all required documentation. This time period shall not exceed ninety (90) days.
4. VCEMS shall establish the effective date of program approval in writing upon satisfactory documentation of compliance with all program requirements.
5. Paramedic training program approval shall be for four (4) years following the effective date of approval and may be renewed every four (4) years subject to the procedure for program approval outlined in this policy.

K. Withdrawal of Training Program Approval

1. Failure to comply with the requirements of this policy may result in denial, probation, suspension or revocation of program approval by VCEMS.
2. The requirements for training program noncompliance notification and actions are as follows:
   a. VCEMS shall provide written notification of noncompliance with this policy to the paramedic training program provider found in violation. The notification shall be in writing and sent by certified mail to the paramedic training program director.
   b. Within fifteen (15) days from receipt of the noncompliance notification, the approved training program shall submit in writing, by certified mail, to VCEMS one of the following:
      1) Evidence of compliance with the provisions of this policy, or
      2) A plan to comply with the provisions of this policy within sixty (60) days from the day of receipt of the notification of noncompliance.
   c. Within fifteen (15) days from receipt of the approved training program's response, or within thirty (30) days from the mailing date of the noncompliance notification, if no response is received from the approved paramedic training program, VCEMS shall issue a decision letter by certified mail to the California EMS Authority and the

approved paramedic training program. The letter shall identify the VCEMS' decision to take one or more of the following actions:

1) Accept the evidence of compliance provided.
2) Accept the plan for meeting compliance provided.
3) Place the training program on probation.
4) Suspend or revoke the training program approval.

d. The decision letter shall also include, but need not be limited to, the following information:
   1) Date of the program training approval authority's decision;
   2) Specific provisions found noncompliant by the training approval authority, if applicable;
   3) The probation or suspension effective and ending date, if applicable;
   4) The terms and conditions of the probation or suspension, if applicable;
   5) The revocation effective date, if applicable;

e. VCEMS shall establish the probation, suspension, or revocation effective dates no sooner than sixty (60) days after the date of the decision letter.

L. Program Review and Reporting

1. All program materials specified in this policy shall be subject to review by VCEMS and shall also be made available for review upon request by the California EMS Authority.
2. All programs shall be subject to on-site evaluation by VCEMS and may also be evaluated by the California EMS Authority
3. Paramedic training program shall provide VCEMS with written notification of changes to course objectives, hours of instruction, program director, program medical director, principal instructor, provisions for hospital clinical experience, or field internship.
4. Paramedic training program shall provide VCEMS a list of Paramedic Preceptors being utilized for the purposes of field internships no later than thirty (30) days prior to the internship rotations beginning.
5. The Paramedic training program shall notify the Ventura County EMS Agency in writing, in advance when possible, and in all cases within thirty (30) calendar days of any change in the following:

a. Program director

b. Medical Director

c. Principal instructor(s)

d. Change of address, phone number or primary point of contact

e. Change in course content, course hours of instruction, additional classes/cohorts, etc. This shall include voluntary closure of program.

6. The Paramedic training program shall submit an annual report to the Ventura County EMS Agency within 45 days of year end. At minimum, this report shall be comprised of the following:

a. Any changes to course content for the coming year.

b. Total cost of attendance (include tuition and fees, books, uniforms, Equipment and supplies, etc.)

c. Changes to any teaching staff and/or program leadership. This does not replace the requirement outlined in item 4 above

d. A listing of course dates and locations for the coming year.

e. The number of students that successfully completed the program (broken down by term) versus number of students originally enrolled for the same period of time.

M. Training Program Expansion

1. Approved paramedic training programs shall request approval to add additional training classes or to enlarge class size. The training program shall provide written confirmation guaranteeing clinical and internship placement as outlined in Sections V.D.2 and V.D.3 of this policy.

Ventura County Emergency Medical Services Agency
Paramedic Training Program

Application Checklist

Sections 1-10 to be completed by training program

For additional information on requirements and approval process, please refer to VCEMS Policy 1135 – Paramedic Training Program Approval

1. General Information		
Training Program Name:		
Program Address	Program City	Program Zip
Program Phone Number	Program Fax Number	Program Email Address

2. Type of Institution

☐ Accredited University or College ☐ Junior College or Community College ☐ School District ☐ Private Post-Secondary School ***(Submit Post-Secondary School Approval Document)*** ☐ Medical training unit of the United States Armed Forces or Coast Guard ☐ Licensed general acute care hospital, with proof that facility meets the following criteria: ☐ Hold a special permit to operate a basic or comprehensive emergency medical service pursuant to the provisions of the California Code of Regulations, Title 22, Division 5; ☐ Provide continuing education (CE) to other health care professionals; and ☐ Current accreditation by a Centers for Medicare and Medicaid Services (CMS) accreditation organization with deeming authority, such as the Joint Commission or the Healthcare Facilities Accreditation Program of the American Osteopathic Association ☐ Agency of Government	Name of Institution or Agency

3. Program Accreditation

- ☐ Copy of a CoAEMSP LoR issued to the training institution applying for approval or documentation of current CAAHEP accreditation.
- ☐ Sample of letter to training program applicants containing the following:
  - ☐ The date the paramedic training program must submit their CAAHEP Request for Accreditation Services (RAS) form and ISSR or the date their application for accreditation renewal was sent to CoAEMSP.
  - ☐ The date the paramedic training program must be initially accredited or the date its accreditation must be renewed by CAAHEP.
- ☐ Copies of all documents submitted to, and received from CoAEMSP and/or CAAHEP including but not limited to the RAS form, ISSR, and any/all documents required for maintaining accreditation.

4. Teaching Staff

a. Program Medical Director ☐ Copy of current license and certifications received ☐ Evidence of experience in emergency medicine ☐ Evidence of experience in education and/or methods of instruction	Name of Program Medical Director
b. Program Director ☐ Copy of current license and certifications received ☐ Evidence of baccalaureate degree ☐ Evidence of education and experience in methods, materials, and evaluation of instruction ☐ Evidence of one (1) year experience in an administrative or management level position ☐ Evidence of three (3) years academic or clinical experience in prehospital care education	Name of Program Director

c. Principal Instructor(s) ☐ Copy of current license(s) and certifications received ☐ Evidence that individual(s) is knowledgeable in the course content of the January 2009 United States Department of Transportation (U.S. DOT) National Emergency Medical Services Education Standards DOT HS 811 077 E ☐ Evidence of six (6) years of experience in an allied health field and an associate degree or two (2) years of experience in an allied health field and a baccalaureate degree. ☐ Evidence of education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction.	Name(s) and Title(s) of Principal Instructor(s) (MD, RN, PA, Paramedic)
d. Clinical Coordinator(s) (*if applicable*) ☐ Copy of current license and certifications received ☐ Documentation of at least two (2) years of academic and/or clinical experience in emergency medicine or prehospital care	Name(s) and Title(s) of Clinical Coordinator(s) (MD, RN, PA, Paramedic)
e. Teaching Assistant(s) ☐ Copy of current license and certifications received ☐ Evidence of qualification by training and experience to assist with teaching ☐ Approval by program director in coordination with the program medical director	Names(s) and Title(s) of Teaching Assistant(s)

5. Hospital Clinical Education and Training

☐ Provisions for supervised hospital clinical training including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.
☐ Written agreements between the paramedic training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.

6. Field Internship

☐ Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.
☐ Written contracts or agreements between the paramedic training program and ALS provider agencies for student placement for field internship training.

7. Required Course Hours and Content

☐ Statement verifying that the course content meets the requirements contained in the U.S. DOT National Education Standards DOT HS 811 077 E January 2009.
☐ Statement verifying program meets or exceeds required course hours outlined in Section V.E of this policy.
☐ Outline of course objectives.
☐ Performance objectives for each skill.
☐ Samples of written and skills examinations administered by the training program.
☐ Samples of a final written examination(s) administered by the training program.

8. Training Program Facilities

☐ The location at which the courses are to be offered and their proposed dates.
☐ Evidence of adequate training program facilities, equipment, examination securities, and student record keeping.

9. Administrative Requirements

☐ Statement verifying program will comply with any/all reporting requirements outlined in Section V.L of this policy
☐ Provide copy of course completion record
☐ Provide copy of fee schedule
☐ Provide copy of liability insurance for students

10. Program Representative Completing Application

Name of Program Representative Completing Application	
Signature	Date
Phone Number	Email Address

****VCEMS Office Use Only****

1. Submission Checklist	
Required Item	**Date Received**
☐ Written request for program approval	
☐ Training program application checklist	
☐ Payment of established fee	
☐ Statement verifying that the course content meets the requirements contained in the U.S. DOT National Education Standards DOT HS 811 077 E January 2009.	
☐ Statement verifying program meets or exceeds required course hours outlined in Section V.E of this policy.	
☐ An outline of course objectives.	
☐ Performance objectives for each skill.	
☐ Names, CV/Resume, and copies of license(s)/cert(s) for each of the following: ☐ Training program director ☐ Program medical director ☐ Principal instructor(s) ☐ Clinical Coordinator(s) ☐ Teaching Assistant(s)	
☐ Provisions for supervised hospital clinical training including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.	
☐ Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating paramedic students; and monitoring of preceptors by the training program.	
☐ The location at which the courses are to be offered and their proposed dates.	
☐ Written agreements between the paramedic training program and a hospital(s) and other clinical setting(s), if applicable, for student placement for clinical education and training.	
☐ Written contracts or agreements between the paramedic training program and ALS provider agencies for student placement for field internship training.	
☐ A copy of a CoAEMSP LoR issued to the training institution applying for approval or documentation of current CAAHEP accreditation.	
☐ Samples of written and skills examinations administered by the training program.	
☐ Samples of a final written examination(s) administered by the training program.	
☐ Evidence of adequate training program facilities, equipment, examination securities, and student record keeping.	
☐ Statement verifying program will comply with any/all reporting requirements outlined in Section V.L	
☐ Copy of Course Completion Record	
☐ Copy of Liability Insurance for Students	
☐ Copy of Fee Schedule	

2. Application Status	
Initial Application Received	Date
Additional Information Requested	Date
All Requirements Submitted	Date
Approval Letter Issued	Date
Approval Expiration	Date
3. EMS Agency Representative Information	
Name of EMS Agency Representative Reviewing Application	
Signature	Date

Phone Number	Email Address

COUNTY OF VENTURA HEALTH CARE AGENCY	BACK	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Multi Casualty Incident Response		Policy Number 2131
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: July 1, 2023
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: July 1, 2023
Origination Date: September 1991 Date Revised: February 2, 2023 Review Date: February 28, 2025		Effective Date: July 1, 2023

I. PURPOSE: To develop a standardized protocol for Multi-Casualty Incident (MCI) response and training in Ventura County.

II. AUTHORITY: California Health and Safety Code, Section 1797.151, 1798, and 1798.220. California Code of Regulations, Sections 100147 and 100169.

III. APPLICATION: This policy defines the on-scene medical management, transportation of casualties, and documentation for a multi casualty incident utilizing the principles of the incident command system as outlined in the MCI Plan.

IV. DEFINITIONS:

A. **MCI/Level I -** a suddenly occurring event that exceeds the capacity of the routine first response assignment. (3 - 14 victims)

B. **MCI/Level II –** a suddenly occurring event that exceeds the capacity of the routine first response assignment. (15 - 49 victims)

C. **MCI/Level III -** a suddenly occurring event that exceeds the capacity of the routine first response assignment. (50+ victims)

V. TRAINING:

The following training will be required:

A. **MCI Training** for prehospital personnel (fire and ambulance), and Mobile Intensive Care Nurses (MICNs).

Focus: Hands-on functions as described in the Ventura County EMS (VCEMS) MCI curriculum

1. Course Length: 4 hours
2. Prerequisite for the course: Introduction to the Incident Command System (ICS 100), and ICS for Single Resource and Initial Action Incidents (ICS 200). There is no prerequisite for MICNs.
3. Mobile Intensive Care Nurses will utilize the MCI for MICN training module.
4. Course will be valid for two years.

B. **MCI Refresher Training**

Focus: Overview of multi-casualty operations as described in the VCEMS MCI Curriculum

1. Refresher Course Length: 2 hours
2. Course will be valid for two years.

VI. ACTIVATION OF THE MULTI CASUALTY INCIDENT RESPONSE PLAN:

A. Report of Incident

The report of a multi casualty incident (MCI) will ordinarily be made to a Ventura County Public Safety Answering Point (PSAP) in the following manner:

1. Citizen/witness report via 9-1-1 Public Service Answering Point (fire service will activate the MCI plan).
2. Hospital personnel alert VCEMS.
3. Direct report from law enforcement, or prehospital personnel with capability to contact a PSAP.

B. Prehospital Response

1. The first responder agency or other public safety official will determine that the number and extent of casualties exceeds the capacity of the day-to-day EMS response and/or EMS system (depending on the level of the MCI) and will request that an MCI be activated through the fire communications center (FCC). The Incident Commander (IC) or appropriate public safety official will request activation and/or response of any supporting public safety/service agencies which may be needed, for example:
   a. Transportation resources, such as additional ambulances or buses
   b. Ventura County Chapter American Red Cross
   c. Ventura County Sheriff's Office of Emergency Services
   d. Public Health
   e. Disaster Medical Support Units (DMSU), Ventura County EMS Agency's Emergency Services Unit, Multi Casualty Unit (MCU) trailers, or other disaster caches

2. The incident commander will establish incident objectives that prioritize not only the safety of personnel at the scene, but also efficient and effective triage, treatment, transport, and tracking (the 4 T's) of victims involved in the MCI.
   A. Incident roles critical to the success of the incident will be triage unit leader, treatment unit leader, patient transportation unit leader, and MEDCOMM. It is

understood that one person may retain more than one of these roles for small-scale incidents within limited victims and complexity.

B. The role of the Medical Communications Coordinator (MEDCOMM) position is to communicate all relevant victim information to the base hospital, and it should be established as soon as possible, based on available ALS resources at the scene of the incident.

   a. This role may be initially fulfilled by ALS fire personnel and delegated, as appropriate, to transport personnel, an ambulance supervisor or the VC EMS Agency Duty Officer.

   b. The role of MEDCOMM, and the coordination with the base hospital, is crucial to the success of the tracking of patients from the scene to hospitals.

For MCI involving multiple pediatric victims, or an MCI where multiple family members/parents are arriving on scene, consider a role to assist with family reunification at either the triage area or another designated area.

C. Base Hospital Responsibilities

1. Upon receiving a declaration of an MCI from the field, the base hospital will activate the Reddinet MCI tool and manage patient distribution and determine destination, while maintaining communications with MEDCOMM in the field. The management of the Reddinet MCI module on an MCI may include:

   a. Alert all hospitals in the county – including those outside of Ventura County as needed that an MCI has occurred and request that they prepare to receive casualties from the scene. This communication will include:

      i. The type, size, and location of the incident.

      ii. The estimated number of casualties involved.

      iii. Utilizing the Reddinet MCI tool, advise hospitals to be prepared to confirm their status and prepare for the possible receipt of patients.

      iv. Update all hospitals periodically or when new or routine information is received.

      v. Inform MEDCOMM of each hospital's bed availability and determine destination for all MCI patients.

   b. Periodically, a request will be made of involved hospitals to update their status in order to accommodate the number of casualties remaining to be transported from the scene

c. Patient information relayed from MEDCOMM to the base hospital will consist of the following elements:
   - Patient Age
   - Patient Gender
   - Triage Category
   - Triage Tag Number
   - Trauma Triage Step (MCI/Level I only)

D. Receiving Hospital Responsibilities

1. Utilize all applicable modules of the Reddinet hospital communications application – including the MCI tool.

   A. Ambulance arrival time and patient information will be entered into the MCI tool once initial assessment has been conducted and patient registration has occurred.

2. Receive/acknowledge incident information and inform hospital administration.
3. Activate the hospital's internal disaster/emergency response plan to an appropriate level based upon the MCI's location type and number of casualties.
4. Hospitals experiencing difficulty in obtaining needed resources to manage casualties should make their needs known to the EMS Agency Duty Officer.

E. Ventura County Trauma System Considerations

1. For any level MCI in which a traumatic mechanism exists, the base hospital shall be the trauma center in whose trauma catchment area the incident occurred. On an MCI/Level I, patients with traumatic injuries shall be triaged utilizing the Ventura County Field Triage Decision Scheme, in addition to START triage. On an MCI/Level I, the applicable VC trauma step shall be relayed to the base hospital by MEDCOMM for all patients with traumatic injuries, in addition to START triage category, age, and gender and triage tag number.
2. Patients shall be transported in accordance with VCEMS 131 Attachment C - MCI Trauma Patient Destination Decision Algorithm.
3. For pediatric victims being transported to an out-of-county facility, consider obtaining a name or description along with the triage tag number for quicker reunification with parents.

F. Involved but Not Injured

1. Prehospital personnel may encounter individuals that are involved with an MCI, but not injured. These individuals do not require medical care on the scene or at a hospital but are still impacted by the events that have taken place. Personnel on scene should identify these individuals with the blue ribbon during the triage

process and be prepared to provide some level of support for these individuals until such time that law enforcement or some other responsible party can take over and provide support and/or shelter.

G. Ventura County EMS Agency

Upon receiving MCI information and a request from scene public safety personnel to activate the MCI Plan, EMS may contact the base hospital that MEDCOMM has communicated with during the initial phases of the MCI and request an update before relieving the Base Hospital of this duty. The EMS Agency may then act as the medical clearinghouse and perform the following:

1. Relay all requests/information regarding hospital resource needs or surplus to the Regional Disaster Medical Health Coordinator (RDMHC) representative, when appropriate. Coordinate response of additional medical equipment and personnel.
2. Receive MCI information from PSAP and alert the appropriate VCEMS and Ventura County Health Care Agency (HCA) personnel.
3. Initiate the VCEMS Emergency Response plan to a level appropriate to the information provided.
4. Activate the Public Health Department Operations Center, when appropriate.
5. Inform the Ventura County Sheriff's Office of Emergency Services (OES) and/or the Operational Area EOC of EMS activity, when appropriate.
6. Alert the RDMHS/C representative, when appropriate.
7. Request out-of-county medical resources, when necessary, with EMS/HCA management approval. Coordinate requests with OES staff and RDMHC representative.
8. Assist in the coordination of transportation resources.
9. Assist in the coordination of health care facility evacuation.
10. Assist in the coordination of the Family Assistance Center (FAC) as needed.
11. Communicate with hospitals, skilled nursing facilities and appropriate EOCs when warranted.
12. Assist in coordination of incident evaluations and debriefings.

H. Documentation

1. MCI/Level I: The care of each patient will be documented using the Ventura County electronic patient care reporting system (VCePCR)
2. MCI/Level II and MCI/Level III: At a minimum, each patient transported

to a hospital shall have their care documented on a multi-casualty patient record (Policy 131, Attachment A).

a. The transporting agency is responsible for completion of the multi-casualty patient record. The record is designed to be completed by the transporting crew enroute to the receiving hospital.

b. The transporting agency retains the original multi-casualty patient record. A copy shall be left with the patient at the receiving hospital. The triage tag shall be attached to this copy and is included as official documentation in the patient's medical record.

c. The transporting agency shall distribute copies of the multi-casualty patient record to the base hospital and EMS Agency within twenty-four hours of
de-mobilization of the incident.

d. Patients not transported from a MCI Level II or III, may be documented using the multi-casualty non-transport record, (Policy 131, Attachment B).

3. Ventura County EMS Approved MCI Worksheets

a. Ventura County EMS Providers will utilize the approved MCI worksheets described in the Basic and Advanced MCI courses and attached to this policy as follows:

1. Form 131-C MCI Trauma Patient Destination Decision Algorithm (Policy 131, Attachment C)
2. Form 131-1 Level 1 MCI Worksheet (Policy 131, Attachment D)
3. Triage Count Worksheet
4. Triage Tag Receipt Holder
5. Bed Availability Worksheet
6. Ambulance Staging Resource Status Worksheet
7. Transportation Receipt Holder

4. Mobile Data Computer (MDC) Equipped Ambulances

a. In an effort to enhance patient tracking, transport personnel operating ambulances equipped with MDC’s, when able, will document the triage tag number, patient name, and destination in the comment section of the dispatch ticket on the MDC.

VII. DE-MOBILIZATION OF THE MULTI CASUALTY INCIDENT RESPONSE PLAN:

A. Prehospital de-mobilization

1. When advised by the Incident Commander (IC) at the scene, the PSAP handling communications for the incident will notify the VCEMS Duty Officer when all casualties have been transported from the MCI scene.
2. Hospitals will be notified via Reddinet that the MCI scene has ended, but that victims may still be enroute to various receiving facilities.
3. Hospitals will supply EMS with data on victims they have received via ReddiNet, telephone, fax or RACES.
4. If involved in incident operations, VCEMS will maintain communication with all participants until all activity relevant to victim scene disposition and hospital resource needs are appropriately addressed.
5. Depending on size of incident, VCEMS will advise all participants when VCEMS has concluded operations related to the MCI.

VIII. CRITIQUE OF THE MULTI CASUALTY INCIDENT:

A. VCEMS Agency may conduct a post-incident analysis of the MCI at their discretion or at the request of agencies involved in the incident. All medically involved participants will be invited.

B. VCEMS Agency may publish a written report following the post-incident analysis. The report will include minutes from the post incident analysis meeting, any summary data available, and written reports.

IX. ADDITIONAL CONSIDERATIONS

A. MCI related to an Active Shooter event, or any other type of incident involving a heavy law enforcement presence and the need for coordinated Rescue Task Force (RTF) operations will be conducted in accordance with VCEMS Policy 628 – Rescue Task Force Operations.

B. Additional information related to medical health operations on an MCI and/or coordination of medical health assets on an MCI or during a disaster with widespread casualties can be found in the VCEMS Multi/Mass Casualty Medical Response Plan.

Ventura County
Emergency Medical Services Agency
MULTI-CASUALTY PATIENT RECORD
(For use on declared Level II or Level III MCI's only)

Date:_____**Agency**_____**Unit#:**_____**Location:**_____**Incident #:**_____

Patient Name:	**Injuries**:	**Airway**:	**Cap Refill:**	**Tx Prior to Transport**:	**Base Hospital**:	**Comments:**
_____ **Age**:_____ **Sex**:_____ **Triage Tag #**:_____ ☐ **IMMEDIATE** ☐ **DELAYED** ☐ **MINOR**	_____ _____ _____ _____	☐ Patent ☐ Other (Explain) _____ **Mental Status:** ☐ Follows Simple Commands ☐ Fails to Follow Simple Commands	☐ < 2 Seconds ☐ > 2 Seconds **Skin:** ☐ Normal ☐ Other **Resp Rate**:_____ **Pulse Rate**:_____ **B/P**:_____	☐ C-Spine ☐ Oxygen ☐ IV ☐ Other (Explain) _____ _____ _____ _____	☐ LRHMC ☐ VCMC ☐ SJRMC ☐ SVH **Dest. Hosp**:_____ **Times**: Depart:_____ Destination:_____	_____ _____ _____ _____ _____

Receiving Hospital to Attach Triage Tag Here

_____

PRINTED NAME **LICENSE #** **SIGNATURE**

Distribution: Original – Provider, Copies – Base Hospital, Receiving Hospital & EMS Agency

Copy shall be left with Receiving Hospital at time of arrival and become part of the patient's medical record.
Transport provider to distribute completed copies to Base Hospital and EMS Agency within 24 hours of the incident.

Ventura County
Emergency Medical Services Agency
MULTI-CASUALTY NON-TRANSPORT RECORD
(For use on declared Level II or Level III MCI's only)

Date: ___________ **Agency:** ___________ **Unit #:** ___________ **Location:** ______________________ **Fire Incident #:**_________________

Time: ________________ **Patient Name:** ____________________ **Sex:** ☐ Male ☐ Female **Age:** _______ **Tag #:** _______________	**Airway:** ☐ Patent **Mental Status:** ☐ Awake and Alert ☐ Appropriate for Age	**Skin:** ☐ Normal **Resp:** ________ **Pulse:** ________ **B/P:** ________	**Treatment Provided:** ________________ ________________ ________________ ________________ ☐ None Indicated	**Comments**: ________________ ________________ ________________ ________________	**Disposition:** ☐ AMA Obtained ☐ No AMA Obtained Other: __________ ________________
Time: ________________ **Patient Name:** ____________________ **Sex:** ☐ Male ☐ Female **Age:** _______ **Tag #:** _______________	**Airway:** ☐ Patent **Mental Status:** ☐ Awake and Alert ☐ Appropriate for Age	**Skin:** ☐ Normal **Resp:** ________ **Pulse:** ________ **B/P:** ________	**Treatment Provided:** ________________ ________________ ________________ ________________ ☐ None Indicated	**Comments**: ________________ ________________ ________________ ________________	**Disposition:** ☐ AMA Obtained ☐ No AMA Obtained Other: __________ ________________
Time: ________________ **Patient Name:** ____________________ **Sex:** ☐ Male ☐ Female **Age:** _______ **Tag #:** _______________	**Airway:** ☐ Patent **Mental Status:** ☐ Awake and Alert ☐ Appropriate for Age	**Skin:** ☐ Normal **Resp:** ________ **Pulse:** ________ **B/P:** ________	**Treatment Provided:** ________________ ________________ ________________ ________________ ☐ None Indicated	**Comments**: ________________ ________________ ________________ ________________	**Disposition:** ☐ AMA Obtained ☐ No AMA Obtained Other: __________ ________________

________________________________ ____________ ________________________________
Printed Name **License #** **Signature**

Distribution: Original – Provider, Copies – Base Hospital & EMS Agency

Agency completing form will distribute completed copies to Base Hospital and EMS Agency within 24 hours of the incident.

MCI TRAUMA PATIENT DESTINATION DECISION ALGORITHM

TRIAGE ALL PATIENTS UTILIZING START TRIAGE

IMMEDIATE | **DELAYED** | **MINOR**

ESTABLISH A TREATMENT AREA ON ALL MASS CASUALTY INCIDENTS

ESTABLISH A TREATMENT AREA ON ALL MASS CASUALTY INCIDENTS

PERFORM A FOCUSED EXAM AND BEGIN TO PROVIDE TREATMENT AS RESOURCES ALLOW

PATIENTS ON A LEVEL I MCI WITH TRAUMATIC INJURIES WILL ALSO BE TRIAGED INTO THE VC TRAUMA TRIAGE DECISION SCHEME

LEVEL I MCI
FULL ePCR

- **RED TAG** → ANY TRAUMA STEP - TRANSPORT TO A TRAUMA CENTER (CONSIDER OUT OF COUNTY (O.O.C.), CONSIDER AIR TRANSPORT)
- **YELLOW TAG** → STEPS 1, 2, 3 TRANSPORT TO A TRAUMA CENTER (CONSIDER O.O.C.) STEP 4, NO STEP - TRAUMA BASE HOSPITAL DISCRETION
- **GREEN TAG** → STEP 3 TRANSPORT TO A TRAUMA CENTER (CONSIDER O.O.C.) STEP 4 TRAUMA BASE HOSPITAL DISCRETION NO STEP, TRANSPORT TO ANY HOSPITAL

LEVEL II/III MCI
ATTACHMENT "A/B"

- **RED TAG** → TRANSPORT TO A TRAUMA CENTER WHENEVER POSSIBLE (Consider O.O.C., CONSIDER AIR TRANSPORT)
- **YELLOW TAG** → TRAUMA CENTER PREFERRED, IF POSSIBLE (CONSIDER O.O.C.)
- **GREEN TAG** → TRANSPORT TO ANY HOSPITAL

1. When trauma center capacity at local and neighboring county trauma centers has been exhausted, transport to non-trauma hospitals
2. For Level II/III MCI events, red tag patients with traumatic injuries exhibiting the following criteria should be prioritized to trauma centers:
   - Significantly decreased GCS with evidence of neurological trauma
   - Penetrating or blunt injury with signs and symptoms of shock
   - Penetrating wounds to the neck and/or torso

LEVEL 1 MCI WORKSHEET

INCIDENT:_____ **DATE:**_____

Person(s) filling out this form:_____

Pt #	TRIAGE TAG # (Last 4)	AGE	GENDER	PATIENT STATUS	VC TRAUMA STEP	INJURIES	DEST	TRANS UNIT ID	TRANS TIME
1				I D M					
2				I D M					
3				I D M					
4				I D M					
5				I D M					
6				I D M					
7				I D M					
8				I D M					
9				I D M					
10				I D M					
11				I D M					
12				I D M					
13				I D M					
14				I D M					

	TIME						
VCMC		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
LRH		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
Hospital		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
Hospital		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
Hospital		AVAIL	USED	AVAIL	USED	AVAIL	USED
	IMMEDIATE						
	DELAYED						
	MINOR						
		Total		Total		Total	

Revised 2023

VCEMSA Form 131-1: Level 1 MCI Worksheet
Instructions

User: Any First Responder managing patient care in a MCI/Level I, or any incident with 14 or less patients.
Incidents: Any MCI/Level I (3-14 victims)
Follow-up: Dependent on individual agency CQI policy.

The Patient Section

TRIAGE TAG	Enter the last four digits of the patient's triage tag
AGE	Enter the patient's age
GENDER	Enter the Patient's gender
PATIENT STATUS	Circle the patient's Triage status
"I"	**Immediate**
"D"	**Delayed**
"M"	**Minor**
VC TRAUMA STEP	For MCI/Level I patients with traumatic injuries, the patient will be triaged using START and according the VC Field Triage Decision Scheme.
INJURIES	List patient's major injuries
DEST	Enter the patient's destination hospital
UNIT ID	Enter the transporting unit's Radio Identification ID
TRANS TIME	Enter the time the transporting unit left the scene enroute to the hospital

The hospital section is to be filled out during base station contact. The beds "available" and "used" sections are to be filled out as snap shots in time. These sections are not cumulative, meaning, you are not adding up the available beds and used beds each time you receive an update.

The Hospital section

TIME	The time you are given/receive hospital bed availability
HOSPITAL	The name of the hospital
AVAIL	Number of hospital beds available
USED	The number of hospital beds you are assigning at that specific time, from the beds available section
IMMEDIATE	Immediate level patients
DELAYED	Delayed level patients
MINOR	Minor level patients
TOTAL	Total number of beds used at that specific time
TOTAL BEDS ASSIGNED	This is the sum of the totals from each USED column. This number should match the number of patient transported.

BED AVAILABILITY WORKSHEET

INCIDENT:_____ **DATE:**_____

Person(s) Filling Out This Form:_____

TIME											TOTAL BEDS USED
	AVAIL	USED	AVAIL	USED	AVAIL	USED	AVAIL	USED	AVAIL	USED	
LRHMC											
IMMEDIATE											
DELAYED											
MINOR											
VCMC											
IMMEDIATE											
DELAYED											
MINOR											
SJRMC											
IMMEDIATE											
DELAYED											
MINOR											
SVH											
IMMEDIATE											
DELAYED											
MINOR											
CMH											
IMMEDIATE											
DELAYED											
MINOR											
PVH											
IMMEDIATE											
DELAYED											
MINOR											
SPH											
IMMEDIATE											
DELAYED											
MINOR											
OVCH											
IMMEDIATE											
DELAYED											
MINOR											

OUT-OF-COUNTY BED AVILABILITY WORKSHEET

INCIDENT:________________________________ **DATE:**________________

PERSON(S) COMPLETING THIS FORM:__________________________________

SANTA BARBARA COUNTY: Santa Barbara Cottage, Goleta Valley Cottage Hospital, Lompoc Valley Medical Center, Marian Medical Center, Santa Ynez Valley Cottage Hospital

LOS ANGELES COUNTY: Henry Mayo, Kaiser Woodland Hills, LAC+USC, Harbor UCLA, Northridge, Holy Cross, St. Joseph, Ronald Regan – UCLA (Westwood), West Hills, Tarzana, Cedars Sinai, Children's Hospital Los Angeles

TIME											TOTAL BEDS USED
	AVAIL	USED	AVAIL	USED	AVAIL	USED	AVAIL	USED	AVAIL	USED	
IMMEDIATE											
DELAYED											
MINOR											
IMMEDIATE											
DELAYED											
MINOR											
IMMEDIATE											
DELAYED											
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MINOR											
IMMEDIATE											
DELAYED											
MINOR											
IMMEDIATE											
DELAYED											
MINOR											

VCEMSA Form 131-2: Bed Availability Worksheets

Instructions

User: Any First Responder managing patient destination in a MCI, usually Med-Com
Incidents: Any MCI/Level II or MCI/Level III
Follow-up: Dependent on individual agency CQI policy.

This form is to be filled out during base station contact. The beds "available" and "used" sections are to be filled out as snap shots in time. These sections are not cumulative, meaning, you are not adding up the available beds and used beds each time you receive an update.

TIME	The time you are given/receive hospital bed availability
AVAIL	Number of hospital beds available
USED	The number of hospital beds you are assigning at that specific time, from the beds available section
IMMEDIATE	Immediate level patients
DELAYED	Delayed level patients
MINOR	Minor level patients
TOTAL	Total number of beds used at that specific time
TOTAL BEDS ASSIGNED	This is the sum of the totals from each USED column. This number should match the number of patients transported.

Should the need arise to list out-of-county destinations, a blank version of this form has been provided, with the hospital names missing so you can add destinations as needed.

TRANSPORTATION WORKSHEET

INCIDENT: _____ **DATE:** _____

Person(s) filling out this form: _____ **Agency:** _____

	TRIAGE TAG # (Last 4)	AGE	GENDER	AGENCY	AMBULANCE ID	PATIENT STATUS	DEST	TRANS TIME
1						I D M		
2						I D M		
3						I D M		
4						I D M		
5						I D M		
6						I D M		
7						I D M		
8						I D M		
9						I D M		
10						I D M		
11						I D M		
12						I D M		
13						I D M		
14						I D M		
15						I D M		
16						I D M		
17						I D M		
18						I D M		
19						I D M		
20						I D M		
21						I D M		
22						I D M		
23						I D M		
24						I D M		
25						I D M		

Instructions – Transportation Worksheet

User: Any First Responder managing patient transport (Transportation Group Supervisor), in an MCI.
Incidents: Any level MCI
Follow-up: Dependent on individual agency CQI policy.

Once you have received destinations for patients and you are loading patients into ambulances, you will fill out this form.

TRIAGE TAG	Enter the last four digits of the patient's triage tag
AGE	Enter the patient's age
GENDER	Enter the patient's gender
AGENCY	Enter the ambulance company name
AMBULANCE ID	Enter the ambulance's radio ID
PATIENT STATUS	Circle the patient's Triage status
"I"	**Immediate**
"D"	**Delayed**
"M"	**Minor**
DEST	Enter the patient's destination hospital
TRANS TIME	Enter the time the transporting unit left the scene enroute to the hospital

TREATMENT TARP UPDATE WORKSHEET

INCIDENT: ____ **DATE:** _______________________

Person(s) filling out this form: __________________________ **Agency:** ____________________

TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL
TIME	IMMEDIATE	DELAYED	MINOR	MORGUE	TOTAL

Treatment Tarp Update Instructions

User: Any First Responder managing patient treatment in an MCI.
Incidents: Any Multi patient incident, Level 2 or greater.
Follow-up: Dependent on individual agency CQI policy.

The updates are snap shots in time. As your incident grows, the number of patients on your tarps may increase. As patients are transported and your incident shrinks, the number of patients on your tarps will decrease. You may be able to determine the total number of patients in your incident, by looking at the highest number of patients listed in the total column. This is when you had the most patients accounted for in you incident.

TIME	Enter time of update from treatment tarps
IMMEDIATE	Number of patient triaged as Immediate located on the treatment tarps
DELAYED	Number of patient triaged as Delayed located on the treatment tarps
MINOR	Number of patient triaged as Minor located on the treatment tarps
TOTAL	Enter total number of patients on all 3 tarps.

IMMEDIATE TREATMENT AREA WORKSHEET

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

TRIAGE TAG # (LAST 4)	AGE	GENDER	INJURIES	TIME OFF TARP

INSTRUCTIONS – IMMEDIATE TREATMENT AREA WORKSHEET

User: Any First Responder managing patient treatment in the Immediate Treatment Area (Immediate Area Treatment Leader), in a MCI.
Incidents: Any Level MCI
Follow-up: Dependent on individual agency CQI policy.

TRIAGE TAG #	Enter the last four digits of the patient's triage tag
AGE	Enter the patient's age
GENDER	Enter the patient's gender
INJURIES	List the patient's major injuries
TIME OFF	Enter the time the patient is removed from the treatment tarp over a transport team

DELAYED TREATMENT AREA WORKSHEET

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

TRIAGE TAG # (LAST 4)	AGE	GENDER	INJURIES	TIME OFF TARP

Instructions – Delayed Treatment Area

User: Any First Responder managing patient treatment in the Delayed Treatment Area (Delayed Area Treatment Leader), in an MCI.
Incidents: Any Level MCI
Follow-up: Dependent on individual agency CQI policy.

TRIAGE TAG #	Enter the last four digits of the patient's triage tag
AGE	Enter the patient's age
GENDER	Enter the patient's gender
INJURIES	List the patient's major injuries
TIME OFF	Enter the time the patient is removed from the treatment tarp over a transport team

MINOR TREATMENT AREA

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

TRIAGE TAG # (LAST 4)	AGE	GENDER	INJURIES	TIME OFF TARP

Instructions – Minor Treatment Area

User: Any First Responder managing patient treatment in the Minor Treatment Area (Minor Area Treatment Leader), in an MCI.
Incidents: Any level MCI
Follow-up: Dependent on individual agency CQI policy.

TRIAGE TAG #	Enter the last four digits of the patient's triage tag
AGE	Enter the patient's age
GENDER	Enter the patient's gender
INJURIES	List the patient's major injuries
TIME OFF	Enter the time the patient is removed from the treatment tarp over a transport team

MORGUE WORKSHEET

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

TRIAGE TAG # (LAST 4)	AGE	GENDER	NOTES

Instructions: Morgue Area Manager

User: Any First Responder managing patient oversight in the Morgue Area (Morgue Area Leader), in a MCI.
Incidents: Any MCI where a morgue is established
Follow-up: Dependent on individual agency CQI policy.

TRIAGE TAG #	Enter the last four digits of the patient's triage tag
AGE	Enter the patient's age
GENDER	Enter the Patient's gender
TRIAGE TAG	Enter the last four digits of the patient's triage tag
NOTES	Enter any identifying information about the patient

INVOLVED/UNINJURED (BLUE RIBBON) WORKSHEET

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

#	AGE	GENDER	FIRST NAME	LAST NAME	PHONE NUMBER	TIME IN	TIME OUT
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							

Instructions – Involved/Uninjured (Blue Ribbon) Worksheet

User: Any First Responder managing patient treatment in the Immediate Treatment Area (Immediate Area Treatment Leader), in a MCI.
Incidents: Any Level MCI
Follow-up: Dependent on individual agency CQI policy.

#	Pre-determined number assigned to an involved but uninjured individual.
AGE	Enter the individual's age
GENDER	Enter the individual's gender
First Name	Enter the individual's first name
Last Name	Enter the individual's last name
Phone Number	Enter the individual's best phone number for future contact/follow-up.
Time In	Time individual was contacted, or when tracking began
Time Out	Time individual was released from scene, or when tracking ended.

Air/Ground Ambulance Coordinator Worksheet

INCIDENT: _____ DATE: _____

Person(s) filling out this form: _____ Agency: _____

AGENCY	UNIT #	ALS/BLS	Time IN	Time OUT

Instructions – Air/Ground Ambulance Coordinator Worksheet

User: Any First Responder managing resources in the staging area (Staging Manager), in an MCI.
Incidents: Any level MCI
Follow-up: Dependent on individual agency CQI policy.

AGENCY	Enter the ambulance company name
UNIT #	Enter the ambulance's radio ID
ALS/BLS	Write ALS for Paramedic staffed units. Write BLS for EMT staffed units
Time IN	Enter the time the ambulance arrives at staging
Time OUT	Enter the time the ambulance leaves staging

Position: Medical Branch Director **(FOG – 2022 Edition)**

Ideal Staffing: Battalion Chief or EMS Agency Duty Officer

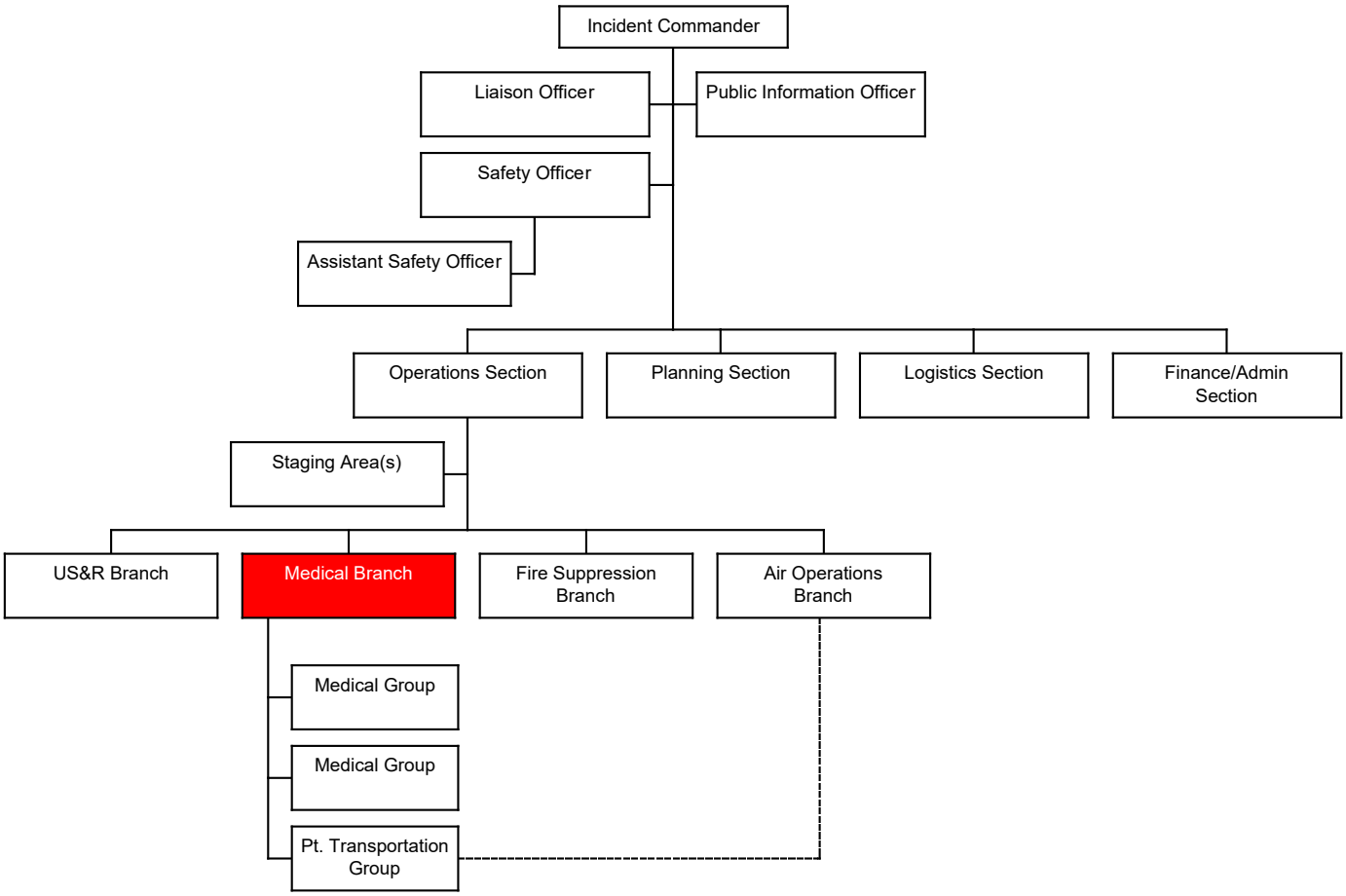
The Medical Branch Director is responsible for the implementation of the Incident Action Plan (IAP) within the Medical Branch. The Branch Director reports to the Operations Section Chief and supervises the Medical Group(s) and the Patient Transportation function (Unit or Group). Patient Transportation may be upgraded from a Unit to a Group based on the size and complexity of the incident:

a. Review Group Assignments for effectiveness of current operations and modify as needed.
b. Provide input to Operations Section Chief for the IAP.
c. Supervise Branch activities and confer with the Safety Officer to assure safety of all personnel using effective risk analysis and management techniques.
d. Report to Operations Section Chief on Branch activities.
e. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Multi-Casualty Incident Command Worksheet

Multi-Casualty Organization
Multi-Branch Response



Position: Medical Division/Group Supervisor (FOG 2022)

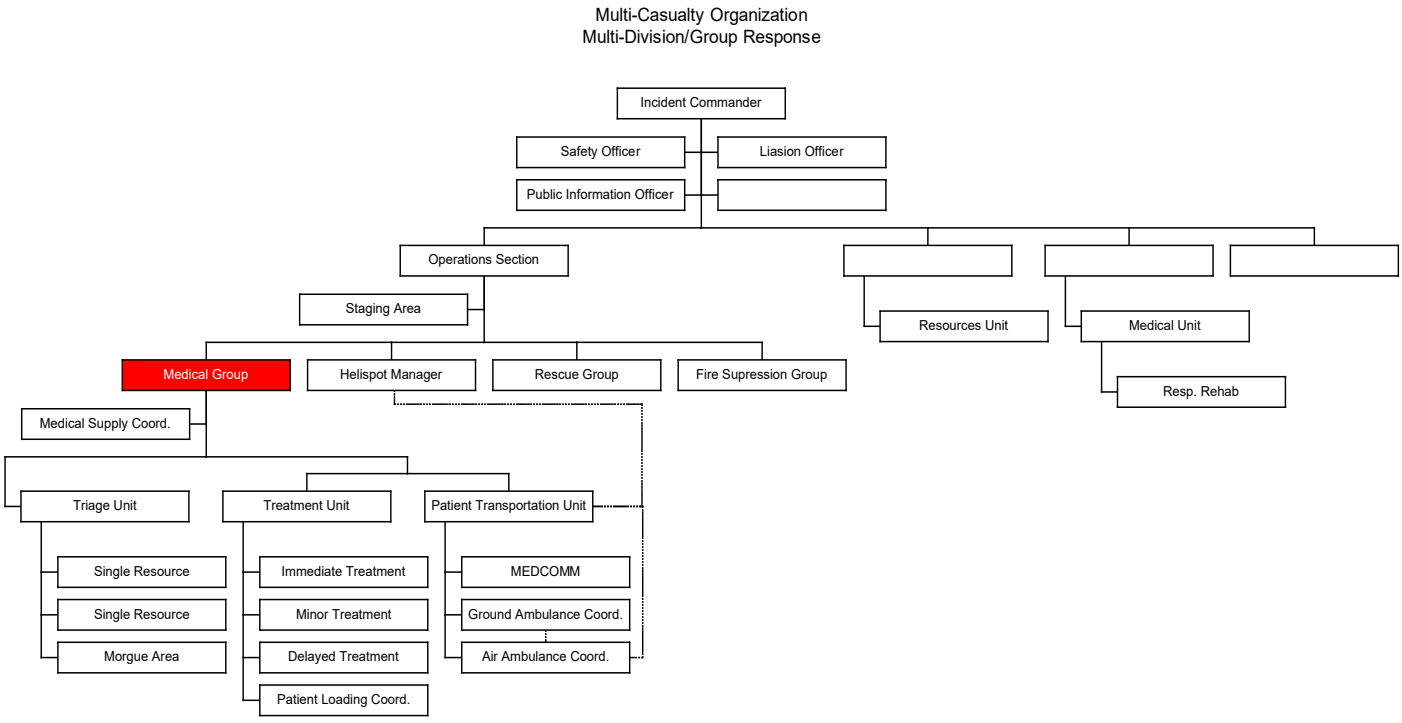
Ideal Staffing: Fire Company Officer or Paramedic Supervisor

The Medical Group Supervisor reports to the Operations Section Chief or Medical Branch Director (depending on level of organization) and supervises the various units within the Medical Group (Triage Unit, Treatment Unit, Patient Transportation Unit, and Medical Supply Coordinator). The Medical Group Supervisor establishes command and control activities within the Medical Group. In large and complex multi-casualty incidents, there may be a need to staff multiple Medical Groups:

a. Participate in the Medical Branch / Operations Section planning activities.
b. Establish Medical Group with assigned personnel and request additional personnel and resources sufficient to handle the magnitude of the incident.
c. Designate Unit Leaders and Treatment Area locations as appropriate.
d. Isolate Morgue and Minor Treatment Area from Immediate and Delayed Treatment Areas.
e. Request law enforcement for security, traffic control, and access for the Medical Group areas.
f. Determine amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (MCI trailers, DMSU, etc.).
g. Ensure communication with appropriate Base Hospital has occurred through the Medical Communications Coordinator, and that an MCI has been declared and initiated in Reddinet.
h. Coordinate with assisting agencies such as law enforcement, Medical Examiner, Public Health, Behavioral Health and transport providers. Law enforcement / medical examiner shall have responsibility for crime scene and decedent management.
i. Coordinate with agencies such as American Red Cross and utilities.
j. Ensure adequate patient decontamination and proper notifications have been made (when applicable)
k. Consider responder rehabilitation
l. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Obtain Medical Group Supervisor packet, including vest and clipboard



Position: TRIAGE UNIT LEADER **(FOG 2022)**

Ideal Staffing: Fire Company Officer

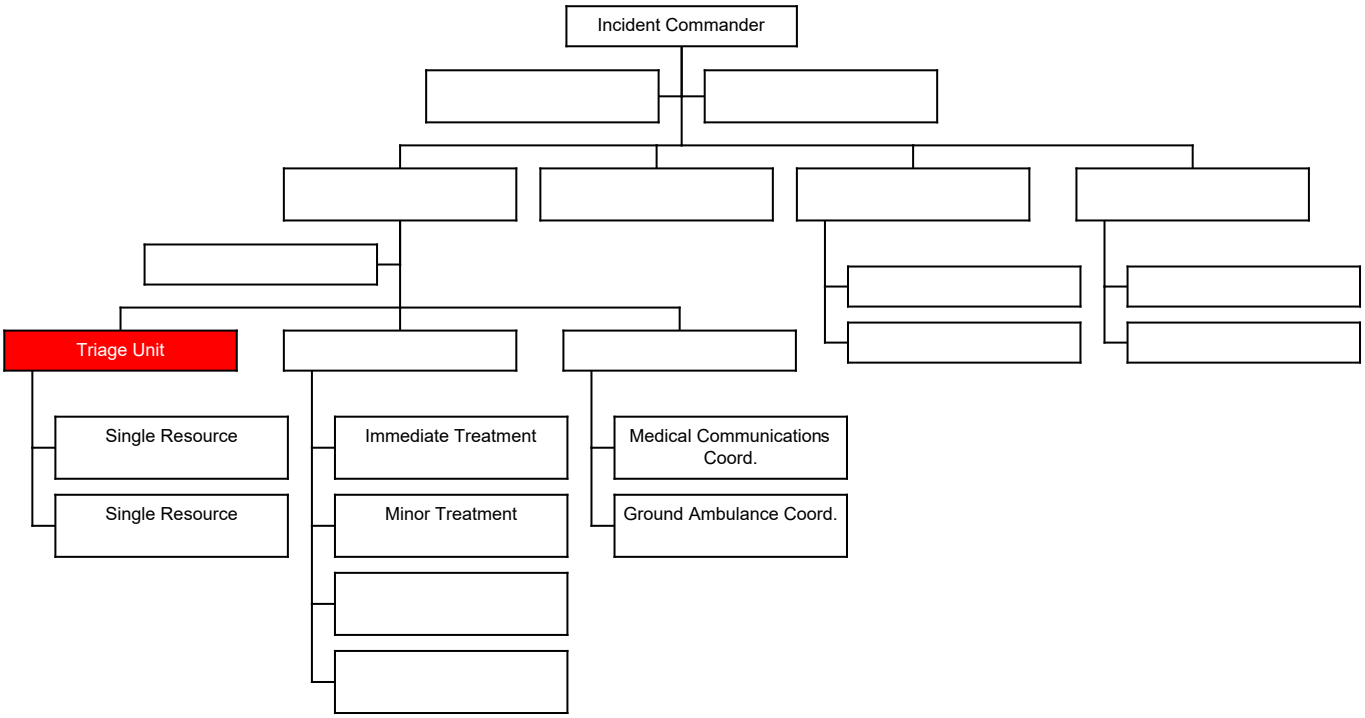
The Triage Unit Leader supervises triage personnel/litter bearers and the Morgue Manager, when applicable. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the Triage Area. When triage has been completed and all the patients have been moved to the treatment areas, the Triage Unit Leader may be reassigned as needed:

a. Develop organization sufficient to handle the assignment.
b. Inform Medical Group Supervisor of resource needs
c. Implement START/Jump START process
d. Coordinate movement of patients from the triage area(s) to the appropriate treatment area(s)
e. Ensure adequate patient decontamination and proper notifications are made, if appropriate
f. Assign resources as triage personnel / litter bearers
g. Give periodic status reports to Medical Group Supervisor
h. Maintain security and control of the triage area(s)
i. Establish a temporary morgue area in coordination with law enforcement and Medical Examiner, if necessary.
j. Maintain Unit Activity Log (ICS 214)

MCI Management Equipment

1. Obtain Triage Unit Leader packet, including vest and clipboards with form(s).
2. Obtain triage patient count cards from triage personnel and total triage numbers on the Triage Count Worksheet found in the Triage Unit Leader packet. Total numbers are reported to Medical Group Supervisor

Multi-Casualty Organization
Initial Response



Position: Morgue Area Manager **(FOG 2022)**

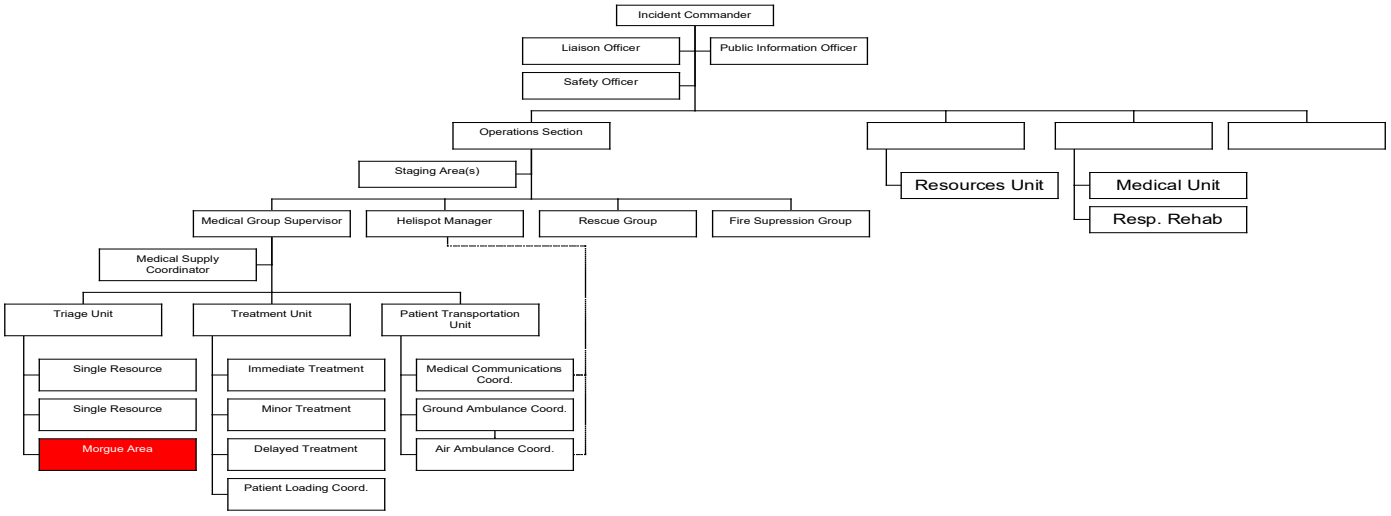
Ideal Staffing: Law Enforcement Personnel or Fire Company Personnel

The Morgue Area Manager reports to the Triage Unit Leader and assumes responsibility for the Morgue Area. Coordinates the handling of decedents and their personal belongings with law enforcement and the Medical Examiner:

a. Assess resource/supply needs and order as needed.
b. Coordinate all morgue area activates with investigative authorities.
c. Keep area separated and off limits to all but authorized personnel.
d. Keep identity of deceased persons confidential.
e. Maintain appropriate records.
f. Maintain Unit/Activity Log (ICS Form 214)

MCI Management Equipment

1. Morgue Packet, including vest and Triage Tag Receipt Holder with Clipboard



**Note: A morgue area manager may be necessary on smaller multi-casualty events that do not necessarily warrant the staffing of all positions detailed above. Organizational development and positions staffed should be based on incident complexity.*

Position: Treatment Unit Leader (FOG 2022)

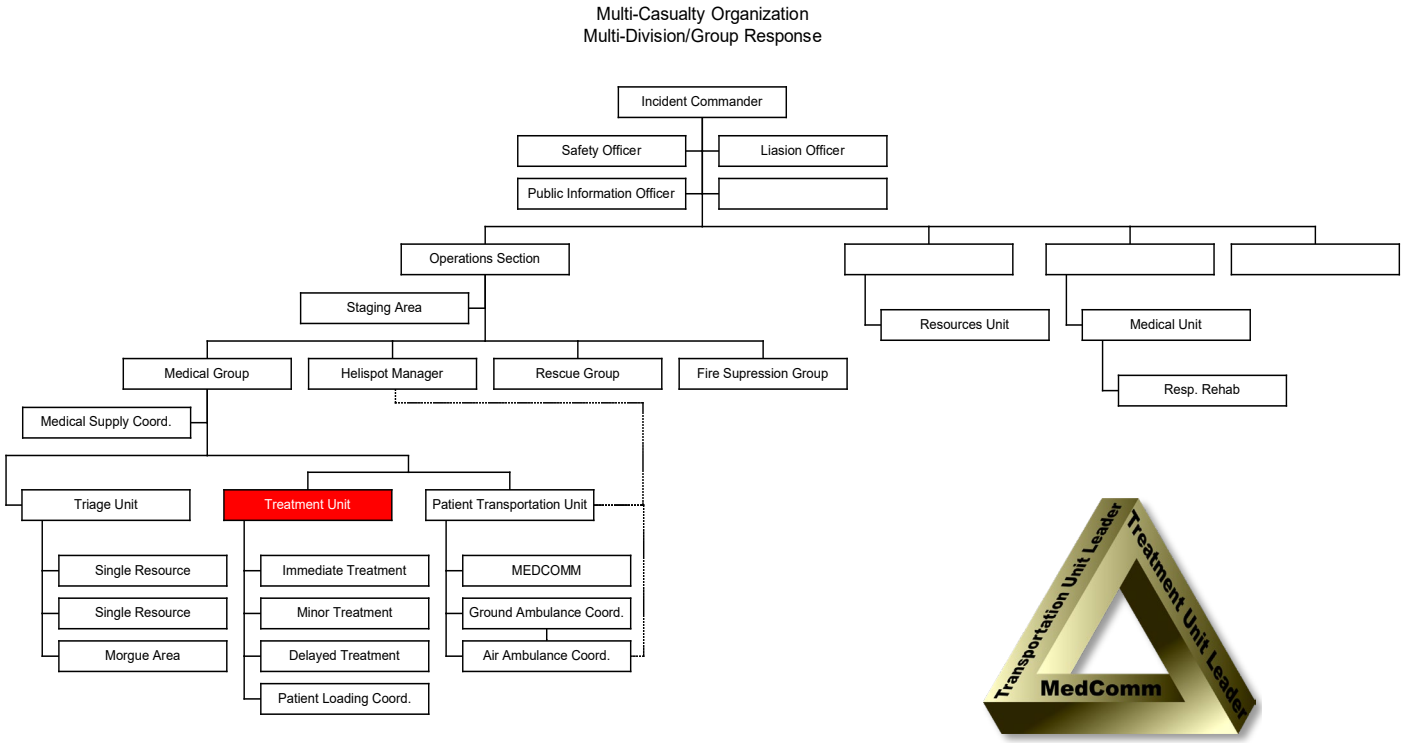
Ideal Staffing: Fire Company Officer

The Treatment Unit Leader reports to the Medical Group Supervisor and supervises Treatment Area Managers and the Patient Loading Coordinator. The Treatment Unit Leader assumes responsibility for treatment, preparation for transport, and the movement of patients to the loading location(s):

a. Develop organization sufficient to handle assignment
b. Direct and supervise Immediate, Delayed, and Minor Treatment Areas and Patient Loading Coordinator
c. Ensure adequate patient decontamination and that proper notifications have been made (if applicable)
d. Ensure continued assessment of patients and re-assess/re-locate as necessary throughout Treatment Areas
e. Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader
f. Assign incident personnel to be treatment personnel (remember 3-6-9 rule)
g. Request sufficient medical caches and supplies including DMSU or MCI trailers
h. Establish communications and coordination with Patient Transportation Unit Leader and Medical Communications Coordinator (Golden Triangle)
i. Responsible for the movement of patients to ambulance loading areas
j. Give periodic status update to Medical Group Supervisor
k. Request specialized medical resources through the EMS Agency Duty Officer (DMAT, DMORT, MRC, etc.)
l. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Treatment Unit Leader Packet, including Treatment Unit Leader Count Worksheet, vest, and clipboard.
2. Treatment Area Manager vests and clipboards, as needed/staffed.
   a. Provide vests, Triage Tag Receipt Holders and clipboards for all Treatment Area Managers, as needed/staffed.



Position: Patient Loading Coordinator **(FOG 2022)**

Ideal Staffing: Paramedic (Fire Company or Ambulance)

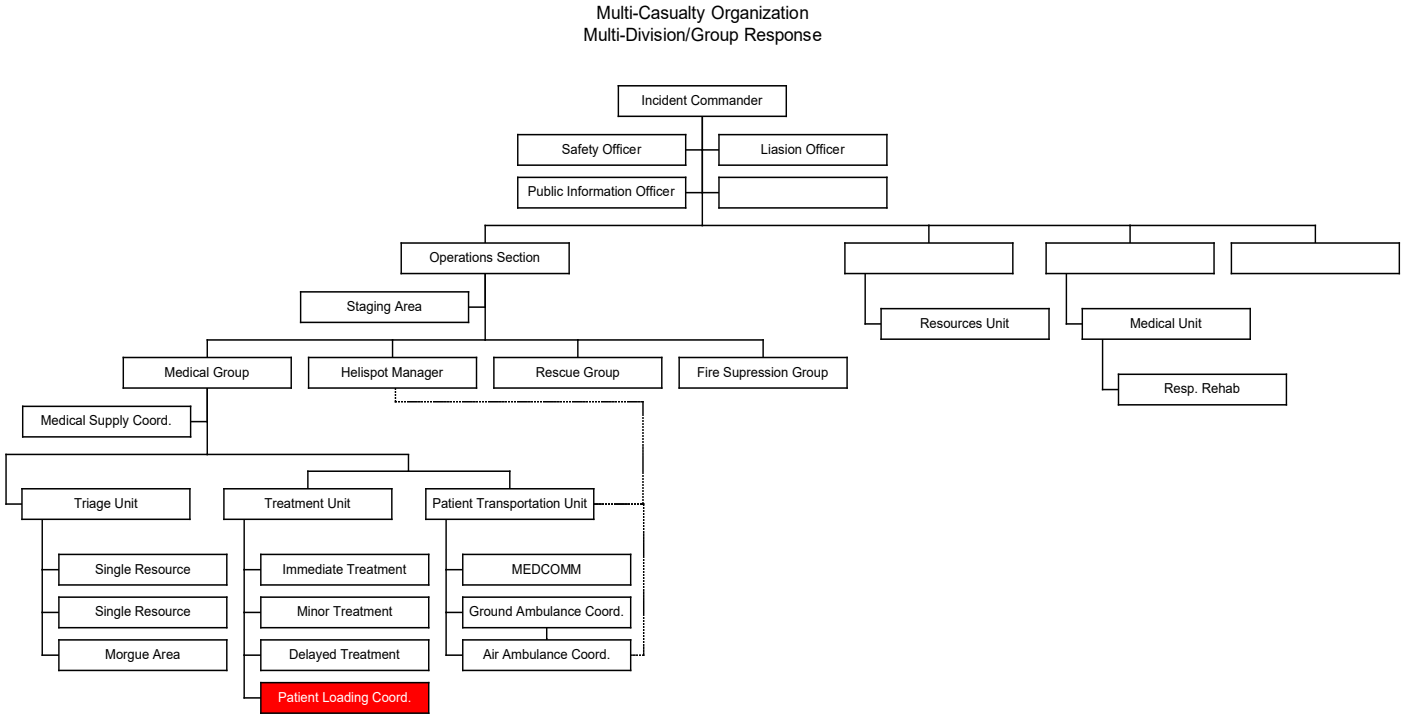
NOTE: On small to medium MCI incidents, the responsibilities of this role may be assumed by the Treatment Unit Leader.

The Patient Loading Coordinator reports to the Treatment Unit Leader and is responsible for coordinating with the Patient Transportation Unit Leader (or Group Supervisor if established), the transportation of patients out of the Treatment Areas:

a. Establish communications with the Immediate, Delayed, and Minor Treatment Managers
b. Establish Communications with the Patient Transportation Unit Leader.
c. Verify that patients are prioritized for transportation.
d. Advise Medical Communications Coordinator of patient readiness and priority for transport
e. Coordinate transportation of patients with the Medical Communications Coordinator
f. Ensure that appropriate patient tracking information is recorded
g. Coordinate ambulance loading with the Treatment Managers and ambulance personnel
h. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Patient Loading Coordinator Packet, including vest and clipboard



Position: Treatment Area Manager **(FOG – 2022)**

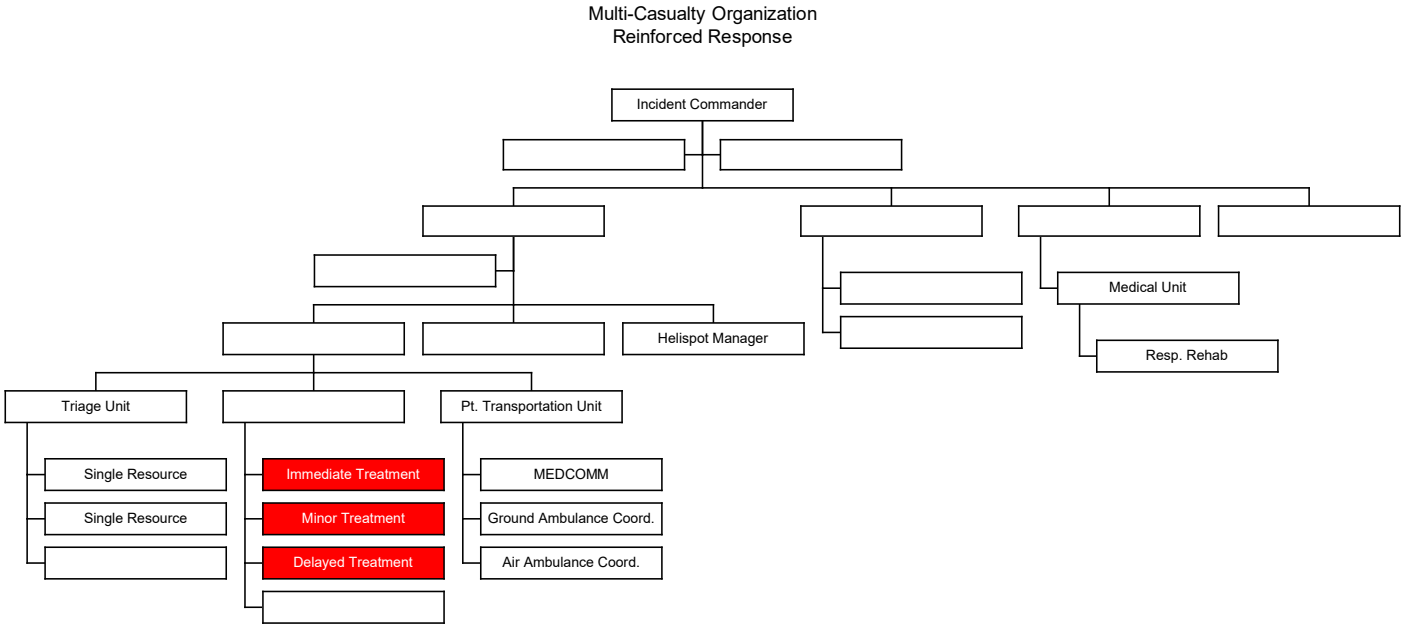
Ideal Staffing – Fire Company Officer

The Immediate, Delayed, and Minor Treatment Area Manager report to the Treatment Unit Leader and are responsible for treatment and re-triage of patients assigned to a particular treatment area:

a. Assign treatment personnel to patients.
b. Provide assessment of patients and re-triage/re-locate as necessary.
c. Ensure appropriate level of treatment is provided to patients
d. Ensure that patients are prioritized for transportation
e. Coordinate transportation of patients with Patient Loading Coordinator
f. Notify Patient Loading Coordinator of patient readiness and priority for transportation
g. Ensure that appropriate patient information is recorded.
h. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Obtain appropriate Treatment Area Managers packet, including vest and triage tag receipt holder form with clipboard.
2. Treatment area tarps



Position: Patient Transportation Unit Leader **(FOG – 2022)**

NOTE: On medium to large MCIs or those of a dynamic/complex nature, this position may need to be upgraded to a Group Supervisor level assignment to better allow for flexibility within the incident organization. The roles and responsibilities would remain the same.

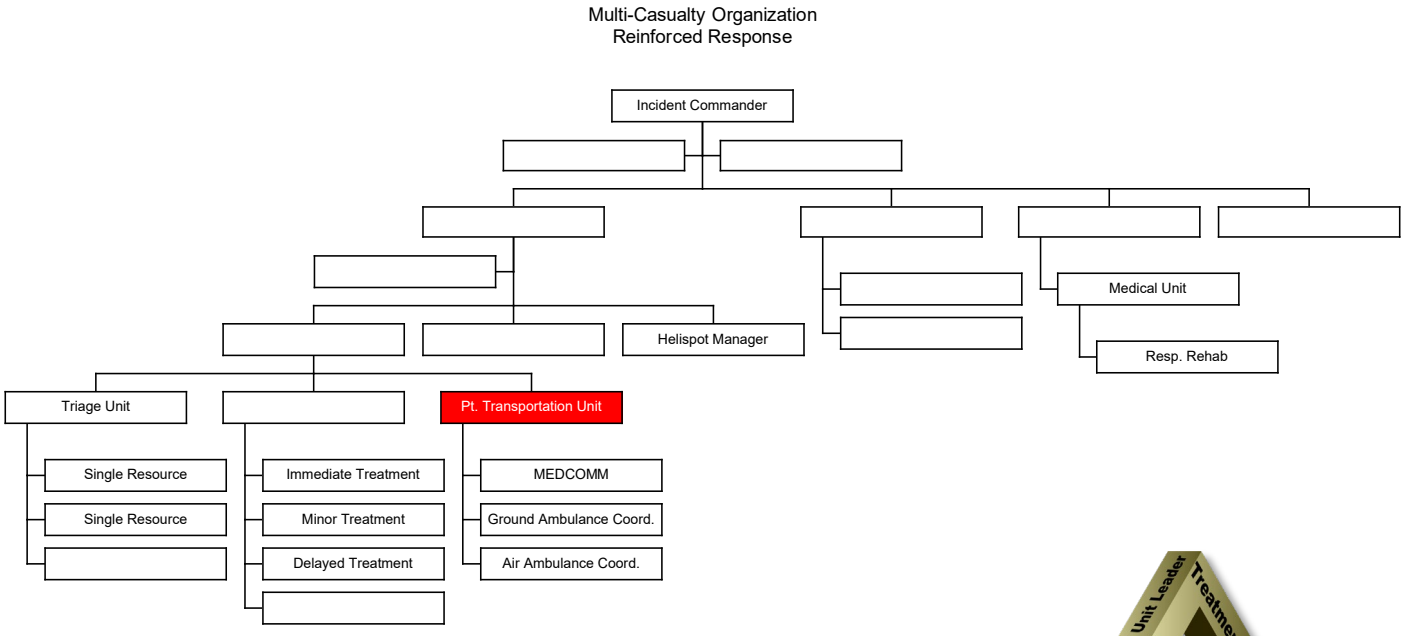
Ideal Staffing: Paramedic Supervisor or EMS Agency Duty Officer

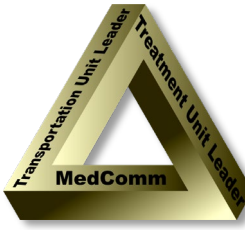
The Patient Transportation Unit Leader reports to the Medical Group Supervisor and supervises the Medical Communications Coordinator, and the Ground/Air Ambulance Coordinators. The Patient Transportation Unit Leader is responsible for the coordination of patient transportation and maintenance of records relating to the patient's identification, condition, and destination. The Patient Transportation function may be initially established as a Unit and upgraded to a Group based on incident size or complexity:

a. Ensure the establishment of communications with the appropriate Base Hospital
b. Designate Ambulance Staging Area(s). **Note, these should be separate from fire/rescue/other staging areas.*
c. Direct the off-incident transportation of patients as determined by the Medical Communications Coordinator.
d. Ensure that patient information and destinations are recorded
e. Establish communications with Ground Ambulance Coordinator, the Air Ambulance Coordinator (if Established), and the Helispot Manager
f. Request additional medical transportation resources (air/ground) as required
g. Notify the Ground/Air Ambulance Coordinators of ambulance requests
h. Coordinate the establishment of Helispot(s) with the Medical Group Supervisor, the Air Ambulance Coordinator, and the Helispot Manager
i. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Patient Transportation Group Supervisor Packet, including vest and clipboard.
2. Maintain required records utilizing the Transportation Receipt Holders
3. Provide Ground/Air Ambulance Coordinators with Ambulance Staging Resource Status form(s)





Position: Transportation Recorder **(FOG – 2022)**

NOTE: The roles and responsibilities of this position have historically been filled by the role of MEDCOMM. On smaller incidents, MEDCOMM will likely retain this function under that position. On larger incidents, or those with increased complexity, this position may be filled by VCEMS personnel that have access to Reddinet in the field.

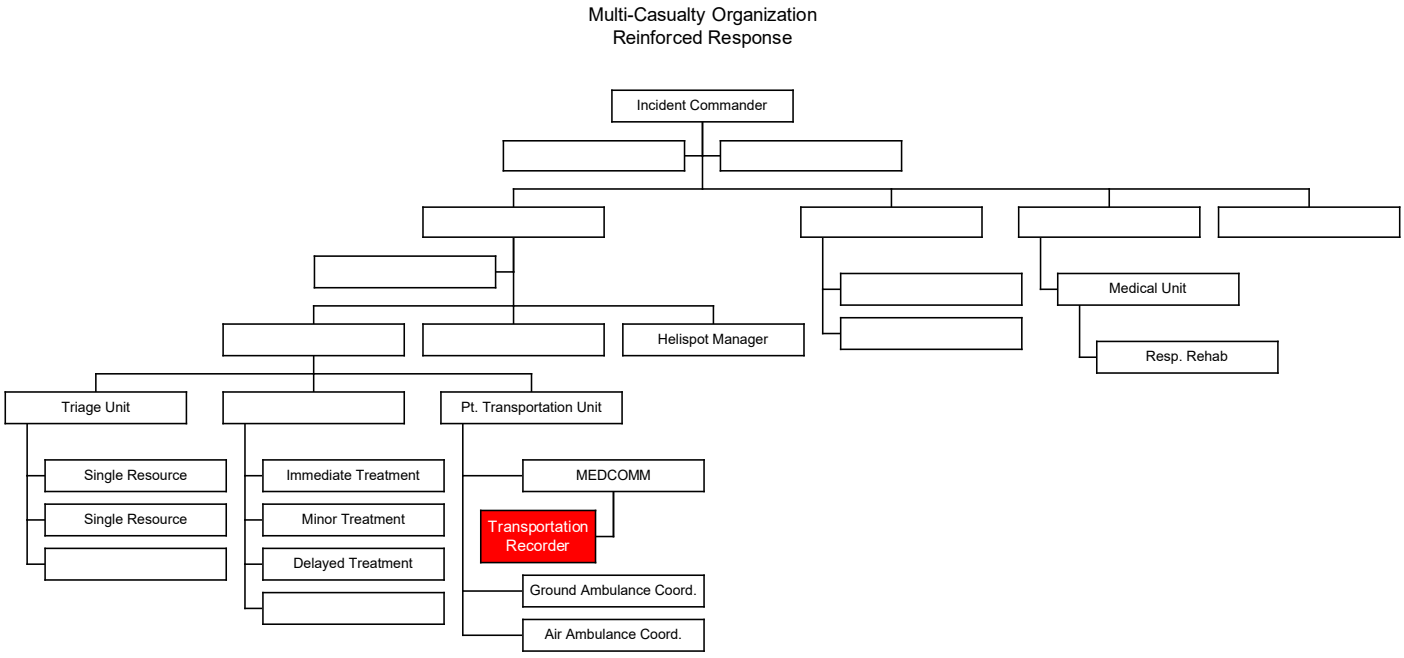
Ideal Staffing: Paramedic, Paramedic Supervisor or VCEMS Personnel

The transportation recorder, if filled, reports to/works in conjunction with MEDCOMM and will track patient destination and transportation information. This information will assist with family reunification and resource tracking:

a. Check-in with transportation Unit Leader / Group Supervisor
b. Utilize appropriate VCEMS MCI worksheets and/or patient tracking resources.
c. Coordinate and communicate with ground ambulance coordinator and MEDCOMM to ensure appropriate tracking of patient destinations, as determined by the appropriate base hospital.
d. Track patient specific information (triage tag number, age, gender, triage color, trauma step) utilizing appropriate worksheets or using the Reddinet application (VCEMS only)
e. Tracking information should be shared with the Family Assistance/Reunification function at the incident (if established)
f. Maintain records as required in addition to Unit Activity Log (ICS 214)

MCI Management Equipment

1. VCEMS Level I MCI Worksheet (131-1)
2. VCEMS Transportation Worksheet (131-3)



Position: Medical Communications Coordinator (MEDCOMM) (FOG – 2022)

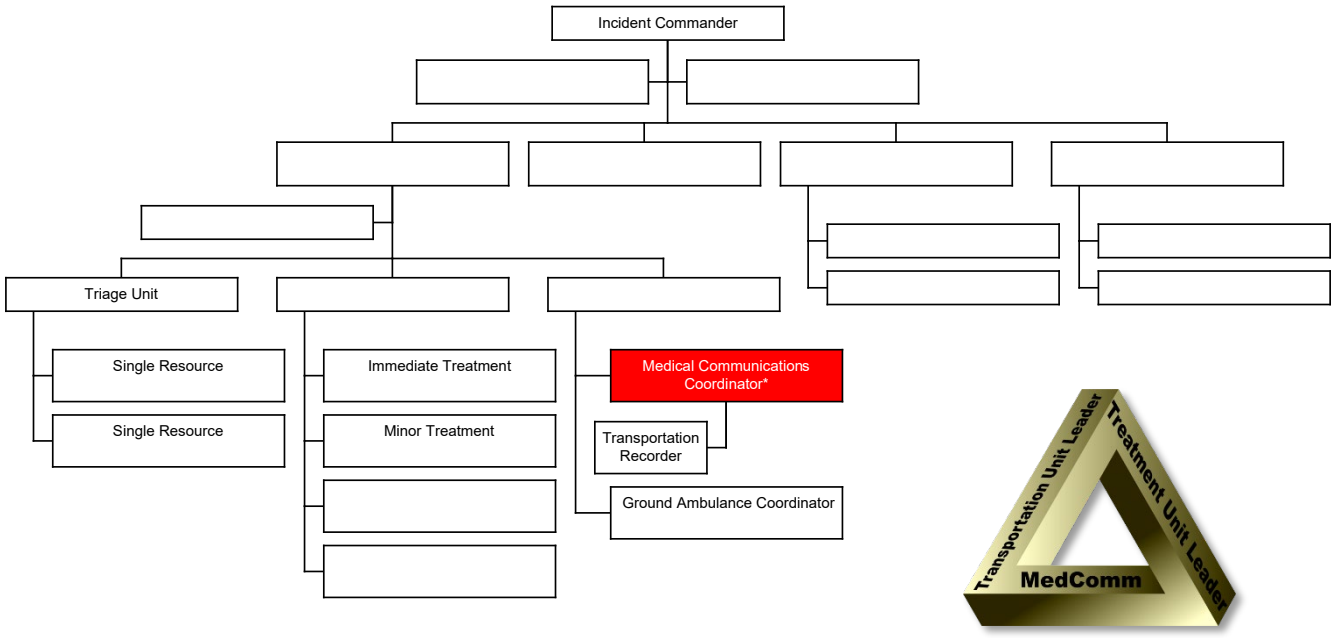
Ideal Staffing: Initial – Paramedic (Fire or Ambulance), Ongoing – Paramedic Supervisor.
The Medical Communications Coordinator (MEDCOMM) reports to the Patient Transportation Unit Leader and establishes communications with the appropriate Base Hospital (BH) to maintain status of available hospital beds to ensure proper patient destination:

a. Establish communications with the appropriate Base Hospital. Provide pertinent incident information and basic patient information, as outlined in VCEMS Policy 131
b. Determine and maintain current status of hospital availability and capability
c. Receive basic patient information and condition from Treatment Area Managers and/or Patient Loading Coordinator
d. Coordinate patient destination with the appropriate base hospital.
e. Communicate patient transportation needs to Ground Ambulance Coordinator based on requests from the Treatment Area Managers and/or Patient Loading Coordinator
f. Communicate patient air transportation needs to the Air Ambulance Coordinator based on requests from the Treatment Area Managers and/or Patient Loading Coordinator
g. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Obtain Medical Communications Coordinator packet, including vest and clipboard with Bed Availability Worksheet.
2. Phone (cellular or satellite) for Base Hospital Communications

Multi-Casualty Organization
Initial Response



Note: Whenever staffing/resources allow, MEDCOMM should be staffed with two paramedics. First Paramedic will maintain communications with Base Hospital to relay patient information and receive destination assignments. Second Paramedic will act as a runner/scribe, and will serve as the transportation recorder (see MCI position card 9 for specific roles/responsibilities).

Position: Ground Ambulance Coordinator (FOG 2022)

Ideal Staffing: BLS Fire Company or Ambulance Personnel (*NOT A PARAMEDIC*)

FORMER POSITION: Ambulance Staging Manager

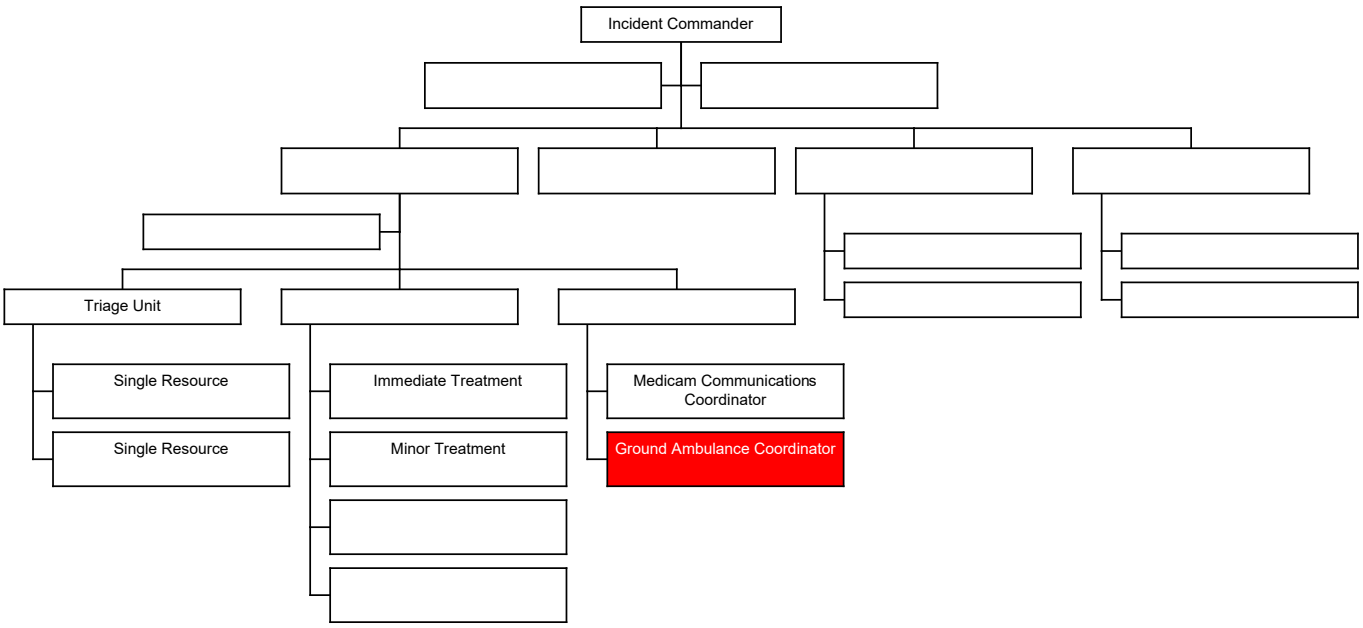
The Ground Ambulance Coordinator reports to the Patient Transportation Unit Leader, manages the Ambulance Staging Area(s), and dispatches ambulances as requested:

a. Establish appropriate Staging Area for ambulances
b. Establish routes of travel for ambulances for incident operations
c. Establish and maintain communications with the air ambulance coordinator and the helispot manager regarding air transportation assignments.
d. Establish and maintain communications with the Medical Communications Coordinator/Transportation Recorder and the Patient Loading Coordinator
e. Provide Ambulances upon request from the Medical Communications Coordinator/Transportation Recorder
f. Ensure the necessary equipment is available in the ambulance for patient needs during transportation
g. Establish contact with ambulance personnel at the staging area
h. Request additional ground transportation resources as appropriate, through the established incident chain of command.
i. Consider the use of alternate transportation resources such as buses or vans, based on VCEMS guidelines.
j. Provide an inventory of medical supplies available at ambulance Staging Area for use at the scene.
k. Maintain adequate staging area records
l. Maintain Activity Log (ICS Form 214)

MCI Management Equipment

1. Obtain Ambulance Coordinator Packet, including vest and clipboard with Ambulance Staging Resource Status form.

Multi-Casualty Organization
Initial Response



Position: Air Ambulance Coordinator (FOG 2022)

Ideal Staffing: BLS Fire Company

FORMER POSITION: Ambulance Coordinator

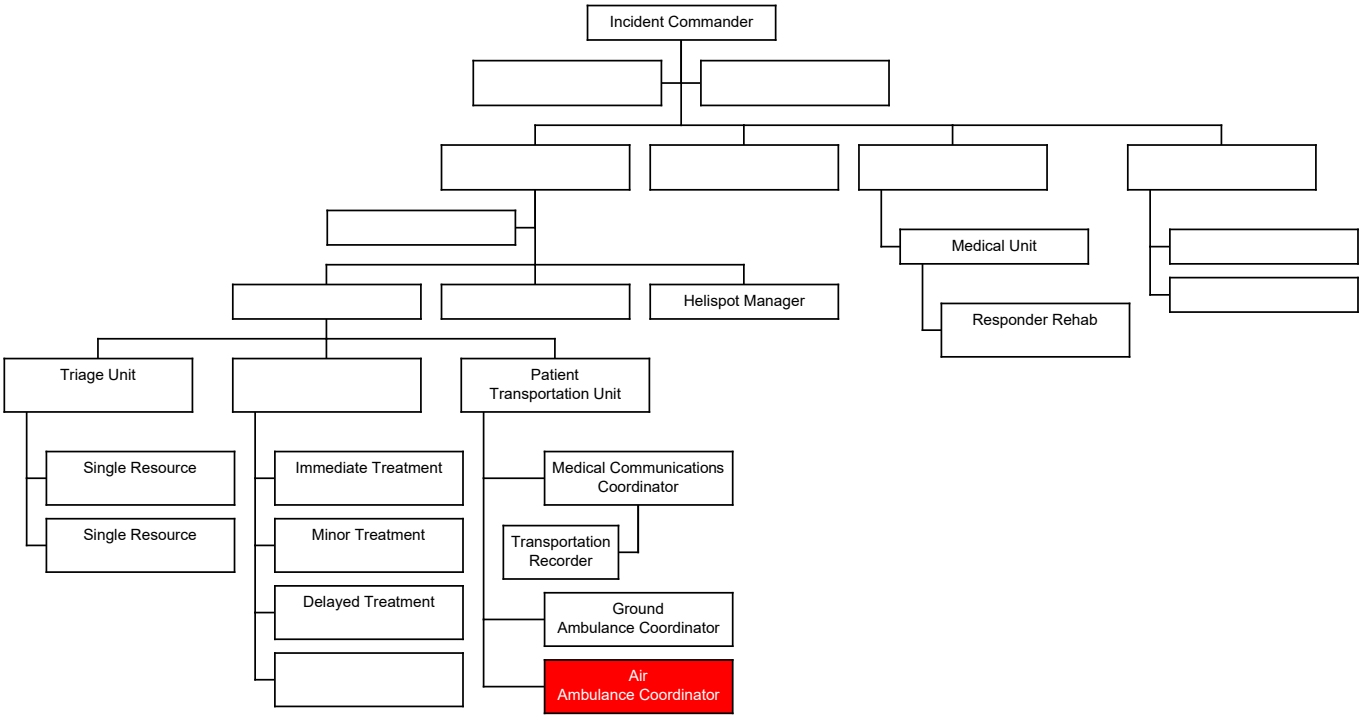
The Air Ambulance Coordinator reports to the Patient Transportation Unit Leader; communicates with MEDCOMM or Transportation Recorder, Patient Loading Coordinator, and Ground Ambulance Coordinator; coordinates patient air transportation needs with the Helispot Manager:

a. Coordinate ambulance staging and patient loading procedures at the helispot with the helispot manager
b. Establish and maintain communications with MEDCOMM and Patient Transportation Unit Leader to determine hospital / medical facility destinations.
c. Confirm the type of air resources and patient capacities with the helispot manager, and provide this information to MEDCOMM and patient transportation unit leader
d. Confirm the patient destination with the air ambulance crew, and relay any diversions to MEDCOMM and Patient Transportation Unit Leader
e. Monitor patient care and status at the helispot when patients are waiting for air transportation
f. Maintain adequate records and Activity Log (ICS 214)

MCI Management Equipment

1. Obtain Ambulance Coordinator Packet, including vest and clipboard with Ambulance Staging Resource Status form.

Multi-Casualty Organization
Reinforced Response Organization



Position: Medical Supply Coordinator (FOG 2022)

Ideal Staffing – Ambulance Company Representative (DMSU Trained), EMS Agency Representative

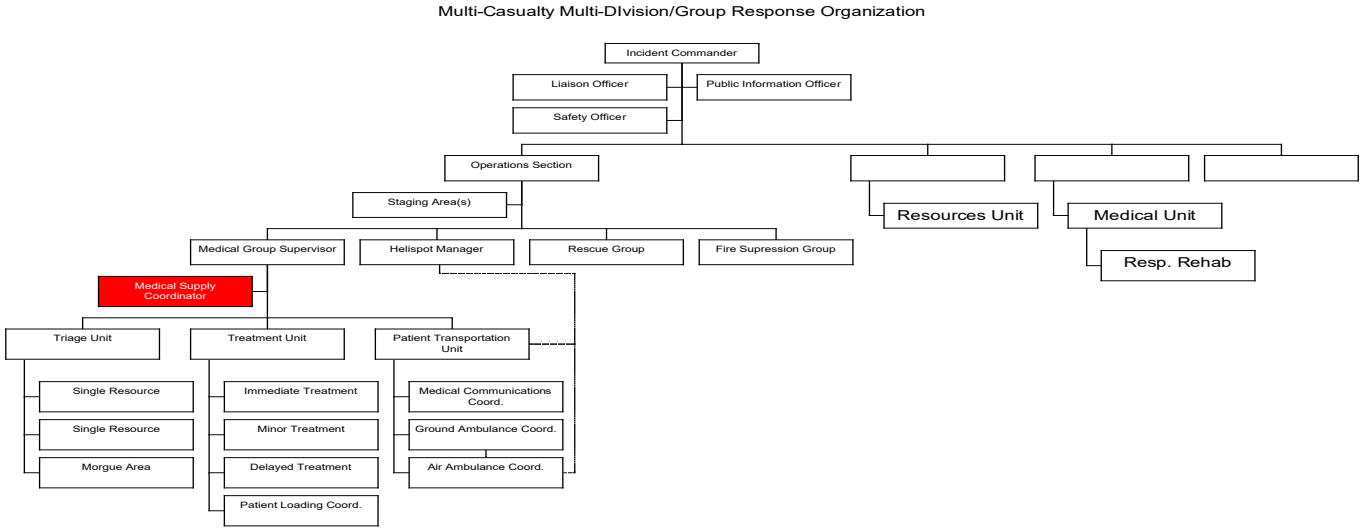
The Medical Supply Coordinator reports to the Medical Group Supervisor and acquires and maintains control of appropriate medical equipment and supplies from units assigned to the Medical Group:

a. Acquire, distribute, and maintain status of medical equipment and supplies within the Medical Group*
b. Request additional medical supplies*
c. Distribute medical supplies to the Treatment and Triage Units
d. Consider the use of a Disaster Medical Support Unit(s) (DMSU) or MCI trailer.
e. Maintain Activity Log (ICS Form 214)

**If the Logistics Section were established, this position would coordinate with the Logistics Section Chief or Supply Unit Leader. Additional medical resources/supplies can be requested through the EMS Agency Duty Officer, as part of the Medical Health Operational Area program, when all local resources have been exhausted.*

MCI Management Equipment

1. Obtain Medical Supply Coordinator packet, including vest and clipboard.



Modular Organizational Development (Adapted from 2022 FIRESCOPE Field Operations Guide)

The following organizational structures are intended to provide the Incident Commander with a basic, expandable system to manage any number of patients during incidents of varying complexity. The degree of organizational structure should be driven by incident complexity and need.

As the complexity of an incident exceeds the capacity of local medical and health resources, additional response capabilities may be provided through provisions of the Public Health and Emergency Operations Manual (EOM) through the EMS Agency Duty Officer and broader Medical Health Operational Area Coordinator (MHOAC). For this reason, the EMS Agency Duty will be notified of any/all MCIs, regardless of size or complexity.

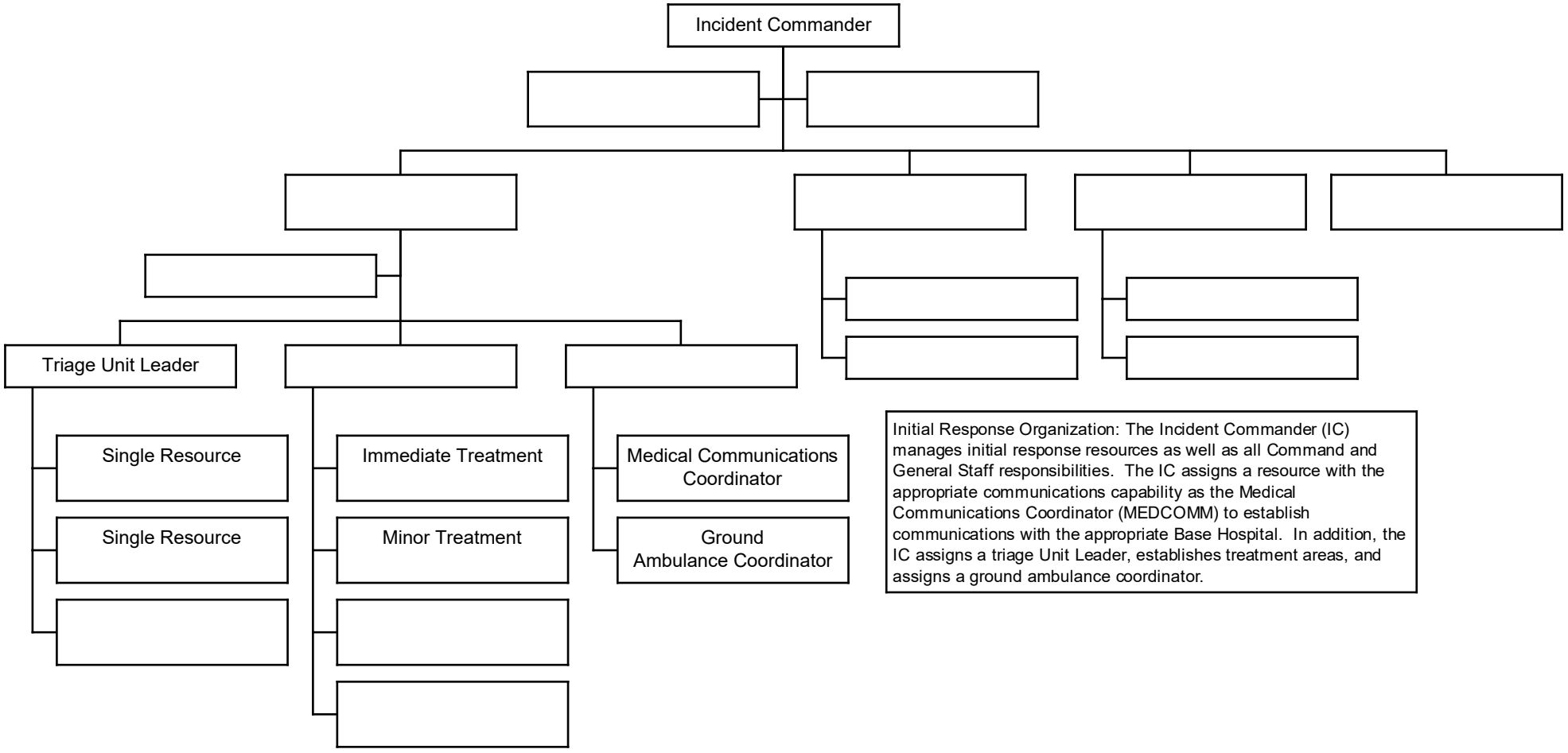
Initial Response Organization: The Incident Commander (IC) manages initial response resources as well as all Command and General Staff responsibilities. The IC assigns a resource with the appropriate communications capability as the Medical Communications Coordinator (MEDCOMM) to establish communications with the appropriate Base Hospital. In addition, the IC assigns a triage Unit Leader, establishes treatment areas, and assigns a ground ambulance coordinator.

Reinforced Response Organization: In addition to the initial response, the Incident Commander (IC) establishes a Safety Officer, a Treatment Unit Leader, and a Patient Transportation Unit Leader. An air ambulance coordinator is established based on the complexity of the air ambulance operation, and a helispot manager is established to manage the designated helispot. Immediate, Delayed, and Minor treatment areas are established and staffed (*remember 3-6-9 rule*). Considerations for additional resources should be considered for treatment area staffing and patient transportation. *Consult with EMS Agency Duty Officer for additional medical supplies, hospital concerns, and/or transportation needs such as Ambulance Strike Teams, DMSU, or MCI trailers.

Multi-Division/Group Response Organization: All positions within the Medical Group are now filled. A Rescue Group is established to free entrapped victims. A fire suppression group is established to control any hazardous conditions. A medical unit and responder rehabilitation are established to support incident personnel. *Consult with EMS Agency Duty Officer for additional medical supplies, hospital concerns, and/or transportation needs such as Ambulance Strike Teams, DMSU, or MCI trailers.

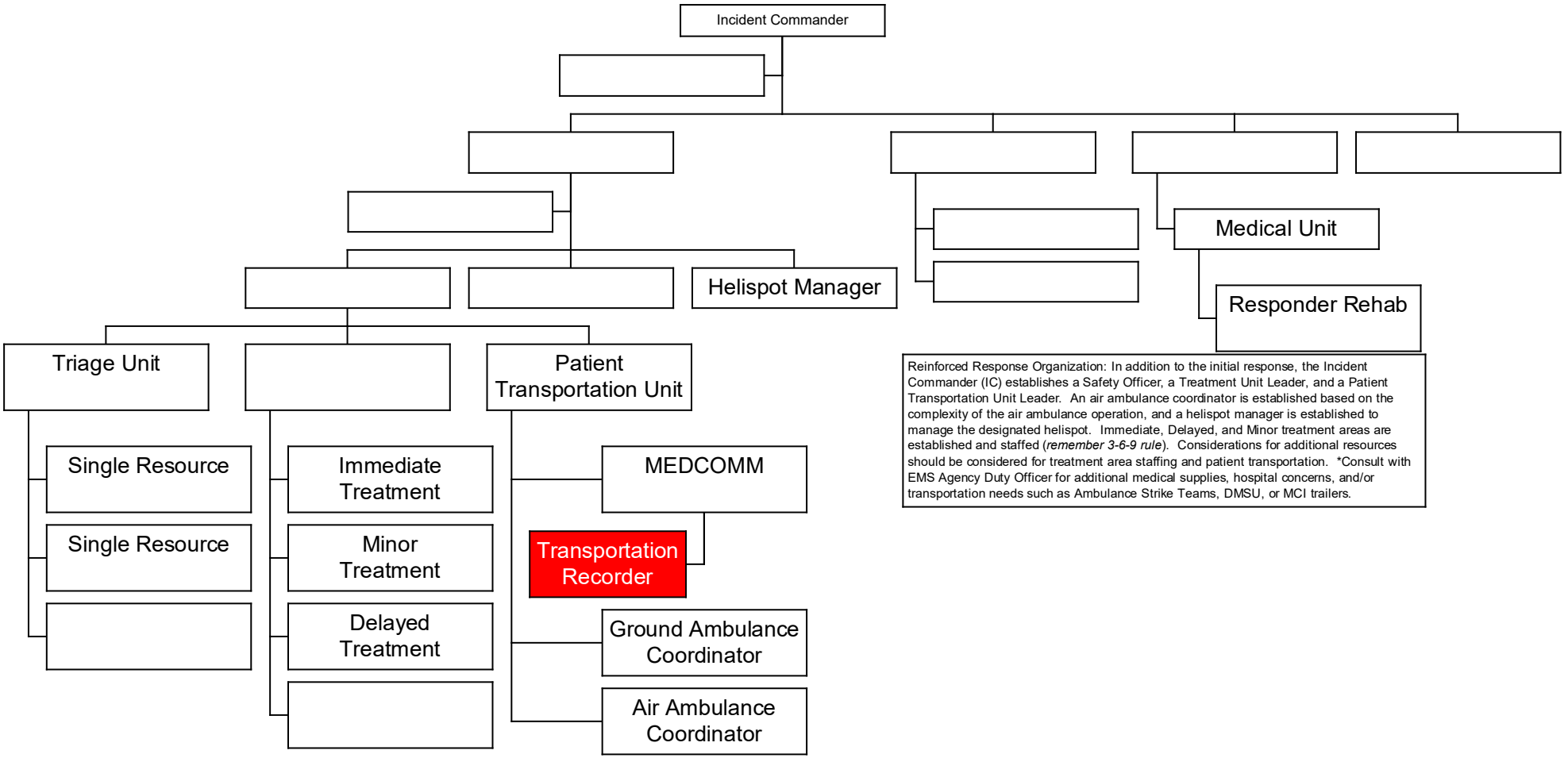
Multi-Branch Response Organization: The complete incident organization shows the Medical Branch and other branches. The Medical branch has multiple Medical Groups due to incident complexity, but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals or other medical facilities. The air operations branch is shown to illustrate the coordination between the patient transportation unit and the air operations branch. *Consult with EMS Agency Duty Officer for additional medical supplies, hospital concerns, and/or transportation needs such as Ambulance Strike Teams, DMSU, or MCI trailers.

Multi-Casualty Incident Response
Initial Response Organization
FOG - 2022



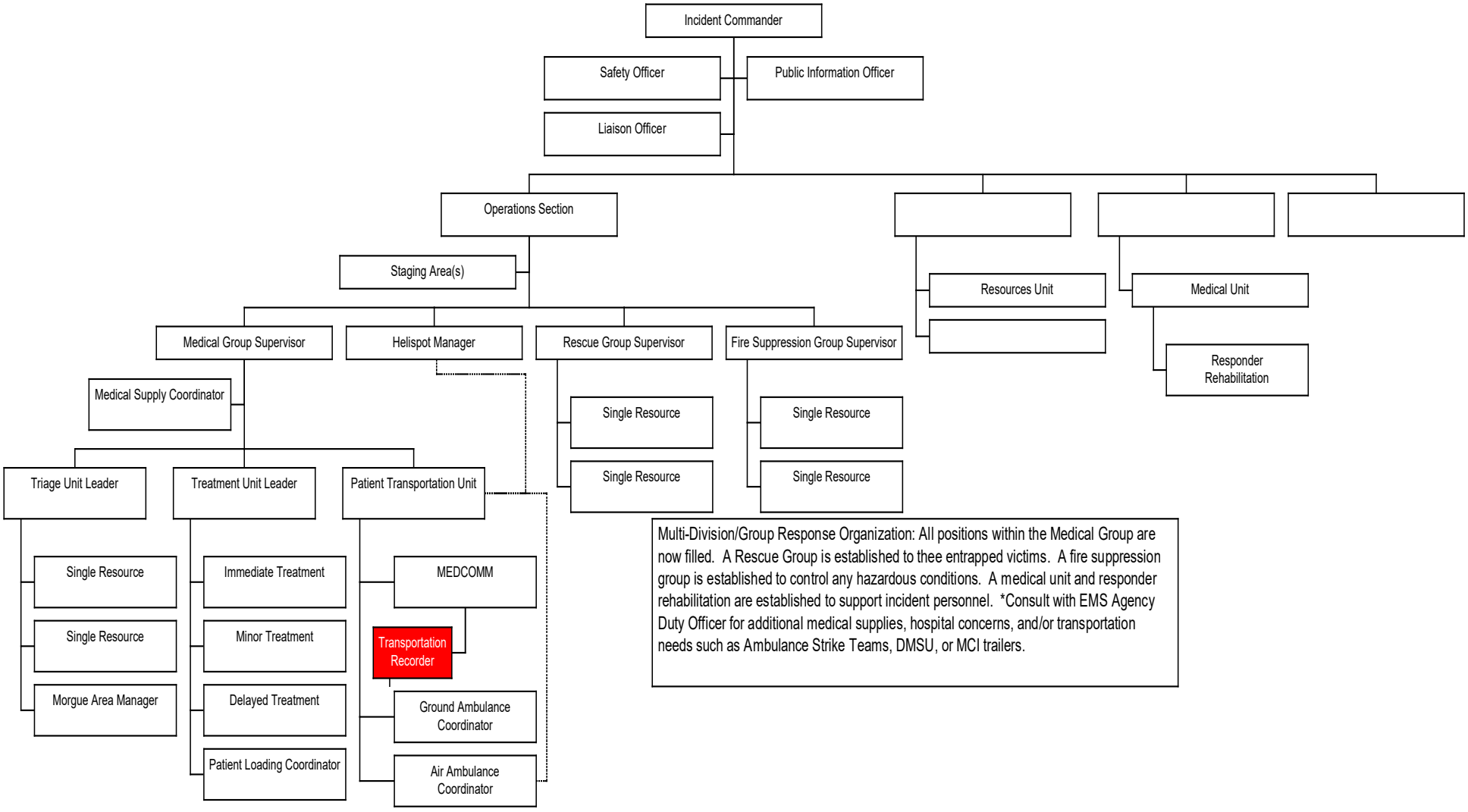
MCI Organization Charts – Reinforced Response Organization **(FOG - 2022)**

Multi-Casualty Incident Response
Reinforced Response Organization
FOG - 2022

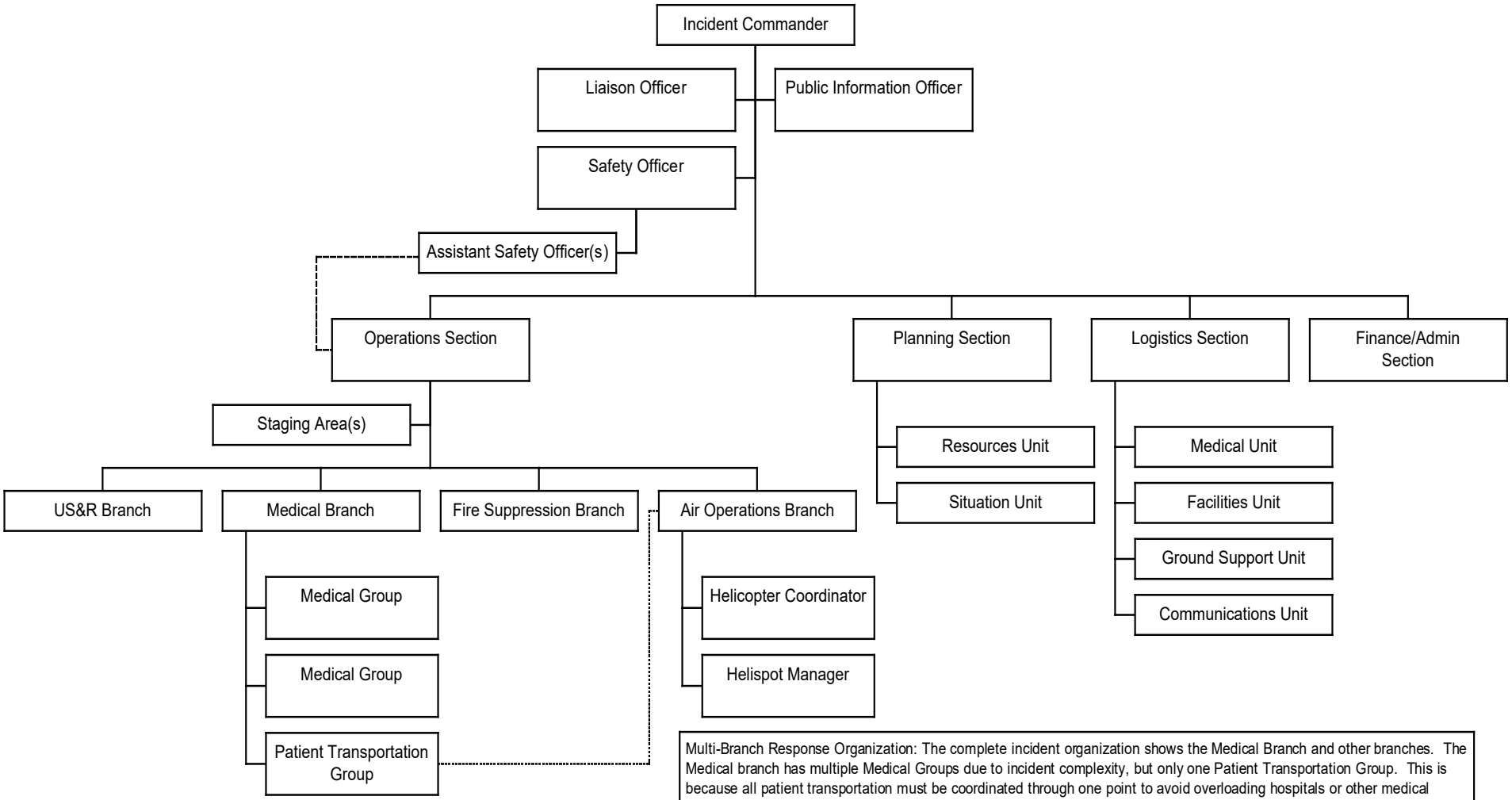


Reinforced Response Organization: In addition to the initial response, the Incident Commander (IC) establishes a Safety Officer, a Treatment Unit Leader, and a Patient Transportation Unit Leader. An air ambulance coordinator is established based on the complexity of the air ambulance operation, and a helispot manager is established to manage the designated helispot. Immediate, Delayed, and Minor treatment areas are established and staffed (*remember 3-6-9 rule*). Considerations for additional resources should be considered for treatment area staffing and patient transportation. *Consult with EMS Agency Duty Officer for additional medical supplies, hospital concerns, and/or transportation needs such as Ambulance Strike Teams, DMSU, or MCI trailers.

Multi-Casualty Incident Response
Multi-Division/Group Organization
FOG - 2022



Multi-Casualty Incident Response
Multi-Branch Organization
FOG - 2022



Multi-Branch Response Organization: The complete incident organization shows the Medical Branch and other branches. The Medical branch has multiple Medical Groups due to incident complexity, but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals or other medical facilities. The air operations branch is shown to illustrate the coordination between the patient transportation unit and the air operations branch. *Consult with EMS Agency Duty Officer for additional medical supplies, hospital concerns, and/or transportation needs such as Ambulance Strike Teams, DMSU, or MCI trailers.

COUNTY OF VENTURA HEALTH CARE AGENCY	BACK	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMS Coverage for Special Events or Mass Gatherings		Policy Number 2132
APPROVED: Administration: Steve L. Carroll, Paramedic		Date: December 1, 2023
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: December 1, 2023
Origination Date: September 9, 2021 Date Revised: September 9, 2021 Date Last Reviewed: June 8, 2023 Review Date: June 30, 2025		Effective Date: December 1, 2023

I. PURPOSE: To establish recommendations for adequate EMS coverage at special events and/or mass gatherings occurring within the County of Ventura.

II. AUTHORITY: California Health and Safety Code, Sections 1797.202, 1797.204, 1797.220, and 1798; California Code of Regulations, Title 22, Sections 100063, 100146, 100253

III. DEFINITIONS:

Special Event: Any event associated with some level of planning leading up to the actual event taking place. For the purposes of this policy, EMS coverage for a special event will be recommended when daily attendance is expected to exceed 2,500 people. This threshold may be reduced in the event that planned activities include a greater potential for illness or injury.

Mass Gathering: An event, whether spontaneous or planned, that is associated with an increased risk of strain on the EMS resources and/or the EMS system within the County of Ventura. Examples of mass gatherings may include public demonstrations, protests, and/or civil unrest.

IV. POLICY:

A. A special event requiring review prior to the issuance of a permit by a local jurisdiction and/or fire district or department should be reviewed for medical coverage and should meet the minimum coverage recommendations for the size and type of event, as outlined in this policy. These minimum coverage recommendations are included in Attachment A of this policy.

B. For special events or mass gatherings where daily attendance is expected to exceed 10,000 people or in any event where there is a significantly heightened risk for the health and well-being of special event/mass gathering participants and/or the surrounding community(ies), the Ventura County EMS Agency Medical Director, or his designee, should review and approve the proposed medical coverage plan.

V. PROCEDURE:

A. Special event and/or mass gathering medical plans should include the following:

1. Event description, including the event name, location and expected attendance;
2. Participant safety (the safety plan for the event participants and spectators);
3. Non-participant safety (the safety plan for individuals not participating in, but affected by the event such as neighboring local residents and onlookers);
4. Description of the following medical resources:
    a. Personnel trained in CPR and in the use of an Automated External Defibrillator (AED), and in how to activate the 911 system;
    b. Aid Station(s), as indicated in Attachment A;
    c. Ambulances (ALS and/or BLS), as indicated in Attachment A;
    d. Advanced licensed medical practitioners, as indicated in Attachment A
5. A communications plan, including the names and contact information for the event organizers and lead personnel, as well as an on-site primary point of contact for the duration of the event. This plan will include method of communications (e.g. cell phone, two-way radios, etc.);
    a. If the special event / mass gathering is being coordinated through a government entity, or a public safety agency, the communications plan should be completed on an Incident Radio Communications Plan (ICS 205) form.
6. A multi-casualty contingency plan describing the ability to care for multiple casualties, and activate additional medical resources, should the need arise.

B. Minimum Requirements for Medical Personnel

1. Basic Life Support (BLS)
    a. On-site medical personnel will be minimally certified as an Emergency Medical Technician in the State of California.
    b. If a Paramedic is equipped and utilized only to provide care at a BLS level, that Paramedic will be currently licensed in the State of California.
2. Advanced Life Support (ALS)
    a. Any Paramedic utilized for the purposes of ALS medical coverage at a special event or mass gathering shall be employed by a VCEMS approved ALS service provider, and shall meet all requirements outlined in VCEMS Policies and Procedures.

1) ALS Ambulance Services utilized for the purposes of special event or mass gathering coverage shall be licensed to operate within the County of Ventura, and shall be authorized by VCEMS, in accordance with VCEMS Policies and Procedures.
2) ALS Ambulance(s) should be co-located with an aid station, when applicable

b. Medical plans outlining the use of advanced level practitioners (RN, PA, DO, MD) will be reviewed and approved by the VCEMS Medical Director or his designee.

C. Submitting Special Event Medical Plans

1. Medical plans for special events where daily attendance is greater than or equal to 2,500 but less than 15,000:
   a. Permitting fire district / department should review medical coverage plan to ensure it meets minimum recommendations outlined in this policy.
2. Medical plans for special events where daily attendance equals or exceeds 15,000:
   a. Medical coverage plan should be submitted to VCEMS for review and approval.
      1) Upon receipt, VCEMS will review and return approval form (Attachment B) or request for additional information within five (5) working days.

D. Unplanned Mass Gatherings

1. Spontaneously occurring mass gatherings that present an increased risk of strain on the EMS system and/or public safety personnel should be met with an increased index of suspicion, as it relates to medical standby coverage, regardless of incident size.
   a. VCEMS Duty Officer will be notified in all instances of unplanned mass gatherings that present an increased risk of strain on the EMS system and/or public safety personnel.
   b. Personnel on scene will coordinate with law enforcement agencies to ensure that plans are in place and contingencies have been discussed in terms of tactical operations and forward-deployment of tactical medical personnel (TEMS-Specialist and/or TEMS-FRO), if applicable.

E. Documentation of Patient Care

1. Agencies operating within the formal VCEMS system will document patient care in accordance with VCEMS Policies and Procedures.
    a. Depending on the type of event, and number of event participants, these requirements may be altered or reduced at the discretion of VCEMS.
2. Organizations not operating within the formal VCEMS system will document patient care in a manner that is appropriate for the level of care provided to the patient.
    a. For the purposes of QA/QI and medical system oversight, this documentation of patient care may be requested by VCEMS for further review and/or after-action reporting.

F. VCEMS Duty Officer Notification

1. VCEMS Duty Officer should be notified of any special event or mass gathering that has an expected attendance greater than or equal to ten thousand (10,000).
    a. Request for duty officer notification may be made over the air or by contacting FCC.
    b. Duty officer notification may also be made by emailing relevant incident information to emsagencydutyofficer@ventura.org. *Please note that this email address is only monitored during regular business hours, and it should not be used for emergent/urgent issues.*
2. VCEMS Duty Officer will be on site for any event or mass gathering that has an attendance greater than or equal to fifty thousand (50,000).

COUNTY OF VENTURA HEALTH CARE AGENCY	BACK	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Hospital EMS Surge Assistance		Policy Number 2141
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: July 1, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: July 1, 2023
Origination Date: February 10, 2022 Date Revised: February 10, 2022 Date Last Reviewed: February 9, 2023 Review Date: February 28, 2026		Effective Date: July 1, 2023

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

II. AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.220 and 1798; California Code of Regulations, Title 22, Sections 100066.01 and 100079.03

A. POLICY:

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

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

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

IV. PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

NO CHANGES

BACK

Ventura County Emergency Medical Services Agency

Psychomotor Skills Evaluation Manual

Emergency Medical Technician

V1 – FINAL (Summer 2025)

Acknowledgement

This project would not have been possible without the collective thoughts, discussions, and significant contributions of the representatives from several agencies and training programs that are active in EMS education and prehospital care. Their commitment to this process, and their ongoing commitment to improving the overall level of quality in training and prehospital emergency medicine is very much appreciated. Members of this workgroup include:

Andrew Casey, Ventura County EMS Agency

Melissa Corney, Oxnard Fire Department

Adriane Gil-Stefansen, Ventura County EMS Agency

Mark Komins, Safety Unlimited, Inc (Workgroup Co-Chair)

Jules Griggs, Safety Unlimited, Inc

Ryan McNerny, Ventura Fire Department

Tom O'Connor, Ventura College (Workgroup Co-Chair)

Chris Rosa, Ventura County EMS Agency

Jaime Villa, Oxnard Fire Department

Alejandro Villasenor, Oxnard Fire Department

Authorities: California Health and Safety Code, Title 22, Division 2.5, Sections 1797.208 and 1797.220

California Code of Regulations, Title 22. Division 9, Chapter 3.1, Sections 100069.01,100069.02, 100067.02, and 100067.12

Ventura County EMS Agency policies 301, 302 and 1100

Project: The EMT psychomotor skills working group was tasked by the VCEMSA Education committee to revise the current EMT Skills verification plan while staying within current regulations. The goal was to make realistic skills sheets, valid scenarios, educational, fair grading rubric, and ensuring all EMT's are minimally competent.

Introduction: This manual provides guidance to students, educators, and evaluators to ensure objective and fair assessment of EMT psychomotor skills contained on the California EMT Verification form. EMT practice requires that professionals use a combination of technical skills and judgment in decision making. Judgment is necessary to allow decision to account for individualized patient situations to provide high quality patient care. It is expected when making significant or impactful deviations from the technical information from these guidance materials, that reasonable consultations with experts, technical committees, and/or policy setting bodies occur prior to actions with the timeframes allowed.

This manual is intended to be a tool for all levels of EMT psychomotor skills evaluation – from initial training at the introductory level, to a tool that can be used for periodic psychomotor skills evaluation, and finally as a tool that will be used for the ongoing psychomotor skills testing that is required for renewal of an EMT certificate or the reinstatement of an expired one.

Principles: The skills competency checklists are pass/fail. All items listed were deemed required and if missed would fail the evaluation. The skills competency checklist was designed to minimize cognitive assessment and permit the candidate to demonstrate the skill involved.

Rationale: Field demonstration of a skill would not come with prompts for the evolution of the skill. For example, the candidate demonstrated bleeding control in a patient and effectively managed the bleeding with direct pressure. The evaluator would not tell the candidate that the patient continues to bleed in this setting to get them to demonstrate the remaining skills performance items.

Medication administration by itself is a demonstratable skill. Knowing the specifics about the medication is a required item that was included with the skill's performance.

The equipment made available for skills competency verification must not create barriers for the programs or providers. Options for various equipment are included in the skills verification forms to avoid the need to have items not customary for the entity.

Skills verification can be purely evaluation or may be a hybrid of evaluation and education. The end goal is to correct and update skills performance.

Evaluation: Candidate passes skill station and progresses to the next station

Candidate does not pass the skill and is made aware of the errors that need correction. Permit time for skills practice.

Second attempt at the skill following remediation.

Failure a second time requires a second remediation with a different skills evaluator followed by a third attempt

Failure a third time – requires the candidate to return another day for that skill

Code of Ethics: Professional status as an Emergency Medical Services (EMS) Clinician is maintained and enriched by the willingness of the individual clinician to accept and fulfill obligations to society, other medical professionals, and the EMS profession. This manual aligns with the following principles from the Code of Ethics for EMS Practitioners, as adopted and maintained by the National Association of Emergency Medical Technicians

To maintain professional competence, striving always for clinical excellence in the delivery of patient care.
To assume responsibility in upholding standards of professional practice and education.

This manual is intended to be a repository of best practices. A "best practice" is a method or technique that, through experience, research or evaluation has shown to achieve reliable and superior results. A "best practice" is expected to evolve over time and is used as a guide rather than a prescribed practice.

References

National Association of Emergency Medical Technicians (NAEMT) EMS Code of Ethics

National Association of Emergency Medical Technicians (NAMET) Prehospital Trauma Life Support (PHTLS), 10th Edition

National Association of Emergency Medical Technicians (NAMET) Advanced Medical Life Support (AMLS), 4th Edition

National Highway Traffic Safety Administration, National EMS Education Standards, 2009
https://www.ems.gov/assets/National-EMS-Education-Standards-FINAL-Jan-2009.pdf

State of California
EMT Skills Competency Verification Form
EMSA – SCV (01/17)

See attached for instructions for completion

This section is to be filled out by the EMT whose skills are being verified:
I certify that I have performed the below listed skills before an approved verifier and have been found competent to perform these skills in the field.

Name as shown on California EMT Certificate	EMT Certificate Number	Signature

This section is to be filled out by an approved Verifier (see instructions for information on approved Verifiers).
By filling out this section the Verifier certifies that they have, through direct observation, verified that the above EMT is competent in the skills below.

Skill Verified	**Verifiers Information**	
1. Trauma Assessment (Signature of Verification)	Name of Verifier:	Date of Verification:
	Approval to Verify from:	Cert./License Info. of Verifier:
2. Medical Assessment (Signature of Verification)	Name of Verifier:	Date of Verification:
	Approval to Verify from:	Cert./License Info. of Verifier:
3. Bag-Valve-Mask Ventilation (Signature of Verification)	Name of Verifier:	Date of Verification:
	Approval to Verify from:	Cert./License Info. of Verifier:
4. Oxygen Administration (Signature of Verification)	Name of Verifier:	Date of Verification:
	Approval to Verify from:	Cert./License Info. of Verifier:
5. Cardiac Arrest Management w/ AED (Signature of Verification)	Name of Verifier:	Date of Verification:
	Approval to Verify from:	Cert./License Info. of Verifier:
6. Hemorrhage Control & Shock Management (Signature of Verification)	Name of Verifier:	Date of Verification:
	Approval to Verify from:	Cert./License Info. of Verifier:
7. Spinal Motion Restriction- Supine & Seated (Signature of Verification)	Name of Verifier:	Date of Verification:
	Approval to Verify from:	Cert./License Info. of Verifier:
8. Penetrating Chest Injury (Signature of Verification)	Name of Verifier:	Date of Verification:
	Approval to Verify from:	Cert./License Info. of Verifier:
9. Epinephrine & Naloxone Administration (Signature of Verification)	Name of Verifier:	Date of Verification:
	Approval to Verify from:	Cert./License Info. of Verifier:
10. Childbirth & Neonatal Resuscitation (Signature of Verification)	Name of Verifier:	Date of Verification:
	Approval to Verify from:	Cert./License Info. of Verifier:

INSTRUCTIONS FOR COMPLETION OF EMT SKILLS COMPETENCY VERIFICATION FORM

1. A completed EMT Skills Verification Form (EMSA-SCV 01/17) is required for those individuals who are either renewing or reinstating their EMT certification. This verification form must accompany the application.

2. Verification of skills competency shall be accepted as valid to apply for EMT renewal or reinstatement for a maximum of two (2) years from the date of skill verification.

3. The EMT that is being skills tested shall provide their complete name as shown on their California EMT certification, the EMT certificate number and signature in the spaces provided.

4. **Verification of Competency**

   Once skills competency has been demonstrated by direct observation of an actual or simulated patient contact, i.e. skills station, the individual verifying competency shall:

   a. Sign the EMT Skills Competency Verification Form for that skill.
   b. Print their name on the EMT Skills Competency Verification Form for that skill.
   c. Enter the date that the individual demonstrated the competency of the skill.
   d. Provide the name of the organization that has approved them to verify skills.
   e. Provide their certification or license type and number.

5. In order to be an **approved skills verifier** you must meet the following qualifications:

   a. Be currently licensed or certified as an EMT, AEMT, Paramedic, Registered Nurse, Physician Assistant, or Physician, and
   b. Be approved to verify by:
      - EMT training program, or
      - AEMT training program, or
      - Paramedic training program, or
      - Continuing education providers, or
      - EMS service provider (including but limited to public safety agencies, private ambulance providers, and other EMS providers).

Emergency Medical Technician Psychomotor Examination

Trauma Assessment

Attempt:
#1_____
#2_____
#3_____

Candidate:_____ Examiner:_____

Date:_____ Signature:_____

	PASS / FAIL
Initial Observations / General Impression	
SCENE / SITUATION	
Takes appropriate PPE precautions and determines if the scene/situation is safe	
Introduce yourself to the patient	
Determines and obtains consent to treat the patient	
Determines the mechanism of injury	
Requests additional EMS assistance if necessary	
Considers stabilization of the spine	
PATIENT	
Determines the general impression of the patient	
Determines level of consciousness (person, place, time, and event) or responsiveness (AVPU)	
Identifies any immediate life-threats (X A B C) • **Exsanguinating Hemorrhage** Verbalizes need to initiate bleeding control procedures (direct pressure/pressure dressing, tourniquet, wound packing, etc.) • **Airway** Assesses airway and inserts adjunct as indicated • **Breathing** Assess breathing rate, rhythm, and quality Initiates ventilation if needed Initiates appropriate oxygen therapy if needed Manages any injury which may compromise breathing/ventilation • **Circulation** Checks pulse rate, rhythm, and quality Assess skin [either skin color, temperature, or condition] Assesses for and controls major bleeding if present Initiates shock management [positions patient properly, conserves body heat]	
Determines chief complaint	
Verbalizes need for immediate transport if life threats present	
RAPID HEAD-TO-TOE ASSESSMENT	
Head: Inspects and palpates scalp and ears — Assesses eyes Inspects mouth, nose and assesses facial area	
Neck: Checks position of trachea — Palpates cervical spine Checks jugular veins	
Chest Inspects Chest — Auscultates Chest Palpates Chest	
Abdomen/Pelvis Inspects and Palpates Abdomen — Assesses Pelvis Verbalizes assessment of genitalia/perineum as needed	
Upper Extremities Inspects, palpates and assesses motor, sensory and distal circulatory functions	
Lower Extremities Inspects, palpates and assesses motor, sensory and distal circulatory functions	
Posterior Thorax, Lumbar and Buttocks Inspects and palpates posterior thorax — Inspects and palpates lumbar and buttocks areas	
DETAILED ASSESSMENT	
Directs partner to obtain vital signs (BP, P, R, Temperature)	
Attempts to obtain SAMPLE history	
ONGOING PATIENT MANAGEMENT	
Identifies patient priority and makes treatment/transport decision	
Manages secondary injuries and wounds appropriately	
Demonstrates how and when to reassess the patient	
Provides accurate verbal report to arriving EMS unit / hospital transfer of care	

Elements of this checklist based on NAEMT Prehospital Trauma Life Support 10th Edition assessment algorithm.

CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS IN ORDER TO PASS SKILL STATION

Performance Objectives

Perform an accurate trauma assessment
Identify and effectively manage immediate life-threatening conditions
Works effectively in a team environment and manages/directs key aspects of patient assessment and care
Prevent hypothermia and determine most appropriate transport method and priority

Equipment

- Simulation manikin or live patient with trauma moulage
- Gloves, eye protection, mask
- OPA, NPA, BVM, Suction device
- NRB, Nasal Cannula, portable oxygen tank
- Tourniquets, hemostatic dressings, chest seals, trauma dressings, splints
- Long board, scoop stretcher or flat
- Stethoscope, BP cuff, pulse oximeter, cardiac monitor (as available)
- Blankets and/or other patient warming devices
- Scenario sheets for proctors that outline mechanism of injury, situation, vital signs, patient presentation and condition, etc.
- Documentation tools (iPad, pen, paper, patient care report forms)

Key Concepts

- **Initial Observations / General Impression**
  - Prioritize safety of self and crew and identify appropriate PPE, based on conditions present
  - Identiy and manage any/all immediate life threats – Prioritize the XABC penemonic
    - X – Exsanguinating Hemorrhage
    - A – Airway
    - B – Breathing
    - C – Circulation
  - Identify need for immediate transport as appropriate
- **Rapid Head-To-Toe Assessment**
  - Appropriate assess body systems and documents as needed
- **Detailed Assessment**
  - Obtains Vital Signs
  - Collects patient history as appropriate
- **Ongoing Patient Management**
  - Makes appropriate decision related to patient acuity and transport mode/method
  - Demonstrates ability to re-assess
  - Provides appropriate verbal report, including any/all critical elements of assessment, injuries and treatment

Emergency Medical Technician Psychomotor Examination

Medical Assessment

Attempt:
#1____
#2____
#3____

Candidate:_____ Examiner:_____

Date:_____ Signature:_____

	PASS / FAIL
INITIAL OBSERVATIONS / GENERAL IMPRESSION	
SCENE/SITUATION	
Takes appropriate PPE precautions	
Determines if the scene/situation is safe and/or appropriately addresses safety threats	
Introduces yourself to the patient	
Determines and obtains consent to treat the patient	
Appropriately Acknowledges/Recognizes Situational Clues	
PATIENT	
Determines Cardinal Presentation / Chief Complaint	
Determines level of consciousness (person, place, time and event) or responsiveness (AVPU)	
Airway Assesses airway and inserts adjunct as necessary	
Breathing Assess breathing rate, rhythm, and quality Initiates oxygen therapy and/or ventilation if needed	
Circulation Checks pulse rate, rhythm, and quality Assesses for and controls major bleeding if present Assess skin [either skin color, temperature, or condition] Initiates shock management [positions patient properly, conserves body heat]	
FIRST IMPRESSION	
Identifies any immediate life-threats	
Identifies patient priority and makes treatment/transport decision	
Creates initial/working differential diagnosis	
DETAILED ASSESSMENT	
History of the Present Illness **O**nset **P**rovoke **Q**uality **R**adiation **S**everity **T**ime	
Directs partner to obtain vital signs (BP, P, R, Temperature)	
Past Medical History Signs and Symptoms Medications Last Oral Intake Allergies Past Pertinent History Events Leading to Present Illness	
Assesses Relevant Body System(s) Cardiovascular Neurological Integumentary Reproductive Pulmonary Musculoskeletal GI/GU Psychological/Social	
ONGOING PATIENT MANAGEMENT	
Confirm/modify differential diagnosis and treatment of patient	
Interventions [verbalizes proper interventions/treatment]	
Demonstrates how and when to continually reassess the patient to determine changes in condition	
Provides accurate verbal report to arriving EMS unit / hospital transfer of care	

Elements of this checklist based on NAEMT Advanced Medical Life Support 4th Edition assessment pathway.

CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS IN ORDER TO PASS SKILL STATION

VCEMSA EMT Education Sub Committee – Rev 03/13/2025 Ver 4

Performance Objectives

- Perform an accurate medical assessment, including determination of a differential diagnosis
- Identify and effectively manage immediate life-threatening conditions
- Work effectively in a team environment and manages/directs key aspects of patient assessment and care
- Determine most appropriate transport method and priority

Equipment

• Simulation manikin or live patient with trauma moulage	• Scenario sheets for proctors that outline mechanism of injury, situation, vital signs, patient presentation and condition, etc.
• Gloves, eye protection, mask	• Documentation tools (iPad, pen, paper, patient care report forms)
• OPA, NPA, BVM, Suction device	
• NRB, Nasal Cannula, portable oxygen tank	
• Stethoscope, BP cuff, pulse oximeter, ECG monitor (if available)	
• Trauma shears, penlight, thermometer, glucometer	
• Long board, scoop stretcher or flat	

Key Concepts

- **Initial Observations**
  - Prioritize safety of self and crew and identify appropriate PPE, based on conditions present
  - Determine cardinal presentation / chief complain and level of consciousness
  - Conduct primary assessment
- **First Impression**
  - Identify/treat any immediate life threats
  - Identify patient acuity and make treatment and transport decision
  - Create an initial/working differential diagnosis
- **Detailed Assessment**
  - Determine history of present illness utilizing appropriate methods
  - Collect or direct partner to collect vital signs
  - Determine past medical history and perform assessment on relevant body systems
- **Ongoing Patient Management**
  - Monitor for patient changes and modify differential diagnosis as needed
  - Perform (verbalize) appropriate treatment/interventions
  - Demonstrate ability to re-assess as needed
  - Provides appropriate verbal report, including any/all critical elements of assessment and treatment

Attempt:
#1____
#2____
#3____

Emergency Medical Technician Psychomotor Examination

BAG-VALVE MASK VENTILATION

Candidate: _____ Examiner: _____

Date: _____ Signature: _____

	PASS / FAIL
AIRWAY	
Demonstrate head tilt chin lift	
Demonstrate modified jaw thrust	
SUCTION (Candidate chooses appropriate powered or manual suction device)	
POWERED:	
Prepares rigid suction catheter	
Turns on power to suction catheter and sets appropriate suction pressure	
Appropriately measures oropharynx depth for suction catheter	
Inserts rigid suction catheter to appropriate depth without applying suction	
Suctions the mouth and oropharynx for no more than 10 seconds	
MANUAL:	
Prepares suction device	
Appropriately measures oropharynx depth for suction catheter	
Inserts suction catheter to appropriate depth without applying suction	
Suctions the mouth and oropharynx for no more than 10 seconds	
Demonstrate removal and replacement of manual suction container	
ADJUNCTS	
Demonstrates proper sizing and insertion of Oropharyngeal Airway	
Demonstrates proper sizing and insertion of Nasopharyngeal Airway	
BAG-VALVE MASK VENTILATION – Adult	
Attaches the BVM assembly [mask, bag, reservoir] to oxygen at 15 lpm	
Ventilates the patient adequately for 1 minute -Proper volume to cause visible chest rise -Proper rate (1 ventilation every 6 seconds)	
BAG-VALVE MASK VENTILATION – Pediatric	
Attaches the BVM assembly [mask, bag, reservoir] to oxygen at 15 lpm	
Ventilates the patient adequately for 1 minute -Proper volume to cause visible chest rise -Proper rate (1 ventilation every 3 seconds)	
BAG-VALVE MASK VENTILATION – Adult Tracheostomy	
Attaches the BVM assembly [bag and reservoir] to oxygen at 15 lpm	
Ventilates the patient adequately for 1 minute -Proper volume to cause visible chest rise -Proper rate (1 ventilation every 6 seconds)	
BAG-VALVE MASK VENTILATION – Pediatric Tracheostomy	
Attaches the BVM assembly [bag and reservoir] to oxygen at 15 lpm	
Ventilates the patient adequately for 1 minute -Proper volume to cause visible chest rise -Proper rate (1 ventilation every 3 seconds)	

You must factually document your rationale for checking any of the above critical items on this form.

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CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS IN ORDER TO PASS SKILL STATION

Performance Objectives

Demonstrate competency in performing oropharyngeal suctioning using a rigid, flexible suction catheter and bulb syringe.
Demonstrate competency in suctioning a patient with a tracheostomy tube while maintaining an aseptic technique.
Demonstrate competency in sizing, inserting, and removing a nasopharyngeal airway.
Demonstrate competency in sizing, inserting, and removing an oropharyngeal airway.
Demonstrate proficiency in ventilating a simulated patient utilizing a BVM device

Equipment

- Adult, pediatric, infant, neonate, and tracheostomy airway manikins
- Suction devices (powered and manual with adapter)
- Hard and flexible suction catheters
- Bulb syringe
- Normal saline irrigation solution
- Container
- Tracheostomy tube with inner cannula
- Various sizes of nasopharyngeal and oropharyngeal airways
- Silicone spray or water-soluble lubricant
- Bag-Valve-Mask (various sizes of bag and masks)
- $EtCO_2$ measuring device
- PPE (eye protection, masks, gown, gloves) Can use an image of PPE in place of actual items
- Pediatric resuscitation tape
- Airway bag (agency items with above contents)
- Sharps/Biohazard/Trash containers

Key Concepts

- ### Personal protective equipment
  - Gloves, goggles, N-95 mask (aerosolizing procedures like suctioning and PPV require N-95 masks)
- ### Suction
  - Indications: vomit, blood, or sputum present
  - Contraindications: Infants less than 1 year of age – use bulb syringe
  - Complications:
    - Excess suctioning may cause hypoxia, damage to tracheal mucosa, or lung collapse
    - Insertion past the base of the tongue may stimulate the gag reflex and cause vomiting. Vagal stimulation may cause bradycardia, especially in pediatric patients.
  - Saline or sterile water is used to flush the suction catheter. All secretions and irrigation fluids are to be treated as contaminated waste
  - Allow the patient to regain adequate oxygen levels between suction attempts
- ### NPA
  - Indications: Semiconscious or unresponsive patient with an intact gag reflex
  - Contraindications: basilar skull fracture
  - Size the NPA by measuring from the tip of the nose to the tragus (pointed prominence of the external ear that is situated in front of the ear canal)
  - Lubricate with water-soluble lubricant.
  - The right nostril should be attempted first unless the left nostril is larger than the right.
  - Insert bevel towards the septum.
  - Should have none to minimal resistance when inserting the NPA
- ### OPA
  - Indications: unresponsive patient without a gag reflex
  - Contraindications: conscious or semi-conscious patient, the presence of a gag reflex; gently brush the eyelashes to see if that reflex is present – similar level of consciousness for both reflexes to be present or absent. Eyelash brushing does not induce vomiting.
  - Complications: vomiting, laryngospasm, injury to the hard or soft palate, airway obstruction
  - Size the OPA by measuring from the maxillary incisors to the angle of the mandible (ACLS.com, n.d.)
    - If OPA is too small – can push the tongue to block the airway
    - If OPA is too large – can press the epiglottis against the opening of the trachea
- ### Positive pressure ventilation
  - select an appropriately sized bag and mask for the patient. Only inflate to the point of chest rise.
  - Do not delay ventilation to connect the BVM to an oxygen source
  - For Tracheostomy patients, connect bag device without mask directly to trach tube.

Attempt:
#1____
#2____
#3____

Emergency Medical Technician Psychomotor Examination

OXYGEN ADMINISTRATION

Candidate: _____ Examiner: _____

Date: _____ Signature: _____

	PASS / FAIL
OXYGEN EQUIPMENT	
Cracks valve on the oxygen tank	
Check regulator for intact gasket	
Assembles the regulator to the oxygen tank	
Opens the oxygen tank valve	
Checks for minimum oxygen tank pressure	
Checks for leaks	
Secures the tank to keep from falling or rolling	
NASAL CANNULA	
Attaches nasal cannula to correct port of regulator	
Properly places and adjusts nasal cannula to patient	
Adjusts regulator flow rate between 2-6 lpm	
NON-REBREATHER MASK	
Attaches non-rebreather mask to correct port of regulator	
Adjusts regulator flow rate between 10-15 lpm	
Prefills non-rebreather mask reservoir bag before applying to patient	
Attaches mask to patient's face and adjusts to fit snugly	

You must factually document your rationale for checking any of the above critical items on this form.

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CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS IN ORDER TO PASS SKILL STATION

Performance Objectives

Demonstrate competency in setting up and attaching an oxygen delivery device to a patient.

Equipment needed

- PPE (eye protection, masks, gown, gloves, etc.) Can use an image of PPE in place of actual items
- Adult and pediatric airway manikins
- Nasal cannula and Non-rebreather masks (adult and pediatric sizes)
- Oxygen tank or wall-mounted compressed air device
- Regulator and gasket
- Airway bag (agency items with above contents)
- Sharps/Biohazard/Trash containers

Key Concepts

- ### Personal protective equipment
  - Gloves and goggles
- ### Oxygen Equipment
  - Ensure the tank is medical grade oxygen (green, green/white, unpainted aluminum with green). The pin index should easily align with the oxygen regulator.
  - To clear dust or debris from the opening, open the main valve slowly until gas flow is heard, and then immediately close the valve.
  - O-rings
    - Crush-type (plastic) is manufactured for single-use only and must be replaced each time a regulator is attached.
    - Brass and rubber-type O-rings are reusable multiple times
  - Attach the regulator by aligning the pin index and tightening the screw bolt with firm hand pressure. Do not use a wrench or other device as it may cause a break in the seal and/or damage the regulator.
  - Open the valve and check for leaks and the minimum oxygen tank pressure.
    - Full tanks read approximately 2000 psi
    - Portable tanks should be changed out when between 500 and 1000 psi (per agency policy) [bring a second tank and run it down]
    - House tanks should be replaced at 500 psi to ensure
  - Secure the tank to prevent falling or rolling. If the valve stem is damaged during a drop/roll, the tank will become a projectile that can easily go through a concrete wall.
- ### Nasal Cannula
  - The nasal cannula is a low-flow, low-oxygen concentration delivery device that delivers 24-44% oxygen with flow rates of 2-6 L/min
  - Do not exceed a flow rate of 6 L/min with a standard nasal cannula. This will dry out the mucosal lining.
  - The curvature of the prongs should be oriented so the tips will curve down and are slightly posterior once inserted
  - Slip the tubing around the patient's ears and under the chin. Tighten the tubing enough to maintain placement and not cause patient discomfort.
    - Placing the tubing behind the head may decrease the flow of oxygen.
- ### Non-Rebreather Mask
  - A non-rebreather mask is a low-flow, high-oxygen concentration delivery device that delivers 90-95% oxygen with a flow rate of 15L/min
  - The reservoir bag must be inflated completely before placing the mask on a patient
  - Never apply an oxygen mask to a patient without supplemental oxygen flowing; this may result in the patient rebreathing their CO_2, acidosis, hypoxia, and death.

Emergency Medical Technician Psychomotor Examination

CARDIAC ARREST MANAGEMENT with AED

Attempt:
#1____
#2____
#3____

Candidate:_____ Examiner: _____

Date:_____ Signature: _____

	PASS / FAIL
Checks patient responsiveness	
Checks breathing and pulse simultaneously, no greater than 10 seconds	
Direct assistant to retrieve AED	
Requests additional EMS assistance	
Immediately begins chest compressions [adequate depth and rate; allows the chest to recoil completely]	
Performs 2 minutes of high-quality, 1-rescuer adult CPR -At least 2″ (5cm) compression depth and 100-120 compressions per minute -30:2 compression-to-ventilation ratio with BVM -Allows the chest to recoil completely -Adequate volumes for each breath -Minimal interruptions of no more than 10 seconds throughout	
Candidate receives AED from assistant	
Candidate directs second rescuer to immediately resume CPR	
Turns on power to AED	
Follows prompts and correctly attaches AED to patient	
Stops CPR and ensures all individuals are clear of the patient during rhythm analysis	
Restarts CPR compressions while AED is charging	
Ensures that all individuals are clear of the patient and delivers shock from AED	
Immediately directs rescuer to resume chest compressions	

You must factually document your rationale for checking any of the above critical items on this form.

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CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS IN ORDER TO PASS SKILL STATION

Performance Objectives

Demonstrate competency in performing cardiopulmonary resuscitation and managing a full arrest.
Demonstrate competency in assessing signs of cardiopulmonary arrest and performing defibrillation using a semi-automated external defibrillator in compliance with the 2025 Emergency Cardiac Care (ECC) standards.

Equipment

- PPE (eye protection, masks, gown, gloves, etc.) Can use an image of PPE in place of actual items.
- Adult or pediatric manikin; full-sized
- AED trainer with pads for the size of the manikin
- BVM with mask sized for manikin
- Oxygen source
- Suction
- NPA/OPA

Key Concepts

- ***Personal protective equipment***
  - Gloves and goggles
- ***Cardiac Arrest Management***
  - Indications: Unresponsive, pulseless, apneic patient
  - Contraindications: Patients with a pulse; Unresponsive patients with a DNR or POLST
  - Complications: Gastric distention, Rib fractures, Separation of ribs from sternum, Pneumothorax, Hemothorax, Lung and heart contusion
  - Minimally interrupted high-quality chest compression before defibrillation results in improved survival rates.
  - Chest compressions must be performed on a hard surface. If on a soft surface, place a board under the patient or move the patient to the floor.
  - Immediately resume compression post shock.
  - DO NOT hyperventilate the patient; this increases intrathoracic pressure, decreases venous return to the heart, and diminishes cardiac output and survival.
  - Refer to Airway Management – Bag Valve Mask Ventilation.
- ***AED***
  - **Indications**: Unresponsive, pulseless, apneic patient
  - Contraindications: Patients with a pulse; Unresponsive patients with a DNR or POLST (No CPR)
  - Complications: Burns to the chest, inappropriate shocks, or failure to shock
  - The initial priority in cardiac arrest is to use the AED as soon as it is available because the “pump” is still primed.
  - The AED should be placed near the operator to prevent reaching across the patient to press the “analyze” and “shock” buttons.
  - The time it takes to analyze the cardiac rhythm results in a delay of CPR resulting in ineffective circulation. Therefore, chest compressions should be initiated and resumed within 10 seconds after a shock has been delivered.
  - The AED operator is responsible for ensuring that no one touches the patient when the AED is analyzing or when shocks are given.
  - Careful consideration should be made when determining the appropriate time to transport. Chest compressions in the back of a moving ambulance are generally ineffective and unsafe for the provider.
  - Some manufacturers recommend that pads be placed in specific locations on the patient. Follow the manufacturer’s guidelines.
  - Avoid placing pads over existing medical devices.
  - Remove medication patches and clean the area before applying the pads.

Emergency Medical Technician Psychomotor Examination

HEMORRHAGE CONTROL / SHOCK MANAGEMENT

Attempt:
#1____
#2____
#3____

Candidate: _____ Examiner: _____

Date: _____ Signature: _____

	PASS / FAIL
DIRECT PRESSURE	
Demonstrates applying appropriate direct pressure to bleeding wound	
Apply appropriate pressure dressing	
TOURNIQUET (SELF)	
Demonstrates applying California approved tourniquet (2"-4" above wound or High and Tight)	
Demonstrates applying second California approved tourniquet	
TOURNIQUET (PATIENT)	
Demonstrates applying California approved tourniquet (2"-4" above wound or High and Tight)	
Demonstrates applying second California approved tourniquet	
WOUND PACKING	
Demonstrates appropriate wound packing (California approved Hemostatic gauze or traditional gauze)	
Demonstrates holding pressure for at least 3 minutes and applies appropriate pressure dressing	
SHOCK MANAGEMENT	
Properly positions the patient	
Administers high-flow oxygen, if appropriate	
Initiates steps to prevent heat loss from the patient	
Initiates Transport / Evacuation of patient	

You must factually document your rationale for checking any of the above critical items on this form.

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VCEMSA EMT Education Sub Committee – Rev 01/02/2025 FINAL

CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS IN ORDER TO PASS SKILL STATION

Performance Objectives

Demonstrate competency in controlling external venous and/or arterial bleeding.

Equipment

- PPE (eye protection, masks, gown, gloves, etc.) Can use an image of PPE in place of actual items
- Adult or pediatric manikin; full-sized
- Moulage – bleeding wound
- Tourniquet
- Bandaging materials
- Bulky dressing
- Tape
- Trauma shears
- Marker/Pen

Key Concepts

- Personal protective equipment
  - Gloves, goggles, gown
- Direct Pressure – Extremities, Junctional, Core – superficial & deep wounds
  - Use the fingertips to apply firm, steady pressure at the site of the bleeding; may use the palm of your hand for larger bleeding sites
  - Most bleeding can be controlled with 5-10 minutes of firm pressure
  - Do not remove blood-soaked dressings. This may cause the clot to break resulting in further bleeding.
  - Once bleeding has stopped, bandage a dressing firmly in place to form a pressure dressing
  - If direct pressure does not effectively stop the bleeding, place a tourniquet
  - If direct pressure is not appropriate (multiple lacerations, penetrations, and anatomic destruction that may lead to bleeding from more than one area, protruding bones, or crush-type amputations), place a tourniquet
- Wound Packing – Junctional or Extremities; Do not use for chest or abdominal wounds
  - Begin with direct pressure
  - If a deep wound creates a cavity, pack it with gauze (California approved hemostatic or traditional gauze)
  - Place the end of the gauze against the site of the bleeding and begin feeding gauze into the wound cavity, all the way to the bottom of the cavity, until the cavity is full.
  - Wound packing can cause severe pain which can be treated with pain management.
  - Resume direct pressure.
- Tourniquet – Extremities only
  - If direct pressure does not effectively stop the bleeding, place a tourniquet 2-3 inches proximal to the wound without placing it over a joint
  - Document the time of application on the tourniquet.
  - If bleeding is not controlled, a second tourniquet should be placed proximal to the first. Do not remove the first tourniquet
  - Proper tourniquet application can cause severe pain which can be treated with pain management
  - Reassess the bleeding site every 5 minutes to ensure bleeding is controlled
- Pressure Dressing
  - A bulky dressing held in position with a tightly wrapped bandage, which applies pressure to help control bleeding
  - Should control most non-massive external bleeding and may be useful to maintain direct pressure once a wound has been packed
  - The pressure dressing should be snug enough to accomplish its goal of applying pressure to the wound without cutting off circulation and becoming a tourniquet.
- Shock Management
  - Hypothermia interferes with the clotting process; remove wet clothing and cover with blankets.
  - Turn on the heat in the patient compartment (if you are not sweating, it is not warm enough for the patient)
  - Place the patient in a supine position

Emergency Medical Technician Psychomotor Examination

Spinal Motion Restriction (SMR)

Attempt:
#1____
#2____
#3____

Candidate:_____ Examiner:_____

Date:_____ Signature:_____

PRESENTATION:	PASS / FAIL
Patient #1: Adult patient involved in minor TC, c/o midline neck pain	
Directs the patient to remain seated and not move or turn head	
Demonstrating placing the patient's head in neutral position and maintains axial stabilization	
Assesses all four extremities for circulation, motor movement, and sensation (CMS)	
Sizes and applies a cervical collar using appropriate technique	
Verbalizes to direct patient to stand and move to gurney, sitting in comfortable position	

Patient #2: Adult patient found lying supine involved in high speed TC with ALOC and ETOH	
Directs assistant to place/maintain head in the neutral position and maintains axial stabilization	
Assesses all four extremities for circulation, motor movement, and sensation (CMS)	
Sizes and applies a cervical collar using appropriate technique	
Positions the long board device appropriately	
Directs movement of the patient onto the device without compromising the integrity of the spine	
Applies padding to void between the torso and the device as necessary	
Secure the patient's torso to the device	
Evaluates and pads behind the patient's head as necessary	
Secure the patient's extremities to the device	
Secure the patient's head to the device	
Reassesses all four extremities for circulation, motor movement, and sensation (CMS)	

You must factually document your rationale for checking any of the above critical items on this form.

_____
_____
_____
_____
_____
_____
_____

CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS IN ORDER TO PASS SKILL STATION

Performance Objectives

Demonstrate competency in applying a cervical collar
Demonstrate competency in securing a patient to a rigid spine board

Equipment

- PPE (eye protection, masks, gown, gloves, etc.) Can use an image of PPE in place of actual items
- Adult or pediatric manikin; full-sized
- Cervical Collar
- Vest-type extrication device
- Rigid spine board or scoop stretcher
- Head bed securing device

Key Concepts

- Personal protective equipment
  - Gloves, goggles
- Spinal Motion Restriction - General
  - **Indications:** Patients with suspected injuries to the spinal column
  - **Contraindications**: Patients with isolated penetrating torso or neck injury. Transportation must be expedited. DO NOT place these patients in spinal motion restriction.
- Spinal Motion Restriction – Seated (Cervical Collar + Seated on Gurney)
  - **Indications:** Responsive patient with midline tenderness, pain, and/or deformity of the spine.
  - **Complications:** Respiratory compromise (hypoventilation, aspiration, asphyxia)
- Spinal Motion Restriction – Seated (Vest-type Extrication Device)
  - **Indications:** Responsive patient with midline tenderness, pain, and/or deformity of the spine.
  - **Complications:** Respiratory compromise (hypoventilation, aspiration, asphyxia)
- Spinal Motion Restriction – Supine (Backboard)
  - **Indications:** Altered or intoxicated patient with MOI, any patient with midline neck or back pain/tenderness, focal neurological signs and symptoms, anatomic traumatic deformity of the spine, distracting injury or circumstances
  - **Contraindications**: Patients with isolated penetrating torso or neck injury. Transportation must be expedited. DO NOT place these patients in spinal motion restriction.
  - **Complications:** pain, discomfort, respiratory compromise, and pressure ulcer sores.
- Spinal Motion Restriction – Helmet/ Sports Equipment
  - Full-face motorcycle helmets must be removed (to maintain airway access capabilities)
  - Football helmet facemasks should be removed regardless of the current respiratory status
  - Football shoulder pads should remain in place when the helmet (without facemask) is still in place
  - If football shoulder pads have been removed, the helmet must be removed.
  - It takes two people to safely remove the helmet from a patient

Emergency Medical Technician Psychomotor Examination

Penetrating Chest Injury

Attempt:
#1____
#2____
#3____

Candidate:_____ Examiner:_____

Date:_____ Signature:_____

	PASS / FAIL
Demonstrates covering chest wound with gloved hand	
Candidate chooses occlusive dressing or commercial chest seal	
OCCLUSIVE DRESSING	
Prepares appropriate petroleum gel-impregnated gauze occlusive dressing	
Ensures occlusive dressing covers entirety of wound	
Places dressing on sucking chest wound	
Demonstrate securing dressing on three sides	
HYFIN VENTED CHEST SEAL	
Demonstrate placing seal centered with vent over wound	
Firmly press onto the skin to ensure a smooth seal	
Ensures all venting channels are patent	

You must factually document your rationale for checking any of the above critical items on this form.

_____
_____
_____
_____
_____
_____
_____

CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS IN ORDER TO PASS SKILL STATION

Performance Objectives

Demonstrate competency in applying a dressing to an open chest wall injury.
Demonstrate competency in managing an impaled object.

Equipment

- PPE (eye protection, masks, gown, gloves, etc.) Can use an image of PPE in place of actual items
- Adult or pediatric manikin; full-sized or torso
- Moulage – open wound and impaled object
- Occlusive dressings and vented chest seals
- Bandaging materials
- Bulky dressing
- 2-inch tape
- Trauma shears

Key Concepts

- ### Personal protective equipment
  - Gloves, goggles, gown
- ### Occlusive dressing
  - Tape on 3 sides
- ### Vented chest seal
  - Wipe dirt/ fluids from the skin with gauze
  - Place dressing on the patient, adhesive side down, and centered over the wound
- ### Pneumothorax
  - A hole larger than the size of the patient's pinky fingernail is large enough to allow air to flow through the chest wall and into the pleural space.
  - As air accumulates, the lung begins to collapse decreasing ventilation and gas exchange
- ### Tension Pneumothorax - Critical
  - A tension pneumothorax with additional air entering through the chest wall that exerts pressure on the heart and vena cava decreasing cardiac output
  - Signs and symptoms:
    - Clinical suspicion of pneumothorax (trauma, dyspnea, chest pain)
    - Signs of hypoperfusion and/or systolic blood pressure of less than 90mmHg (adults) be below the minimum systolic blood pressure for respective age in Handtevy (pediatrics)
    - Absent or significantly decreased breath sounds on the affected side
    - Jugular vein distension is a late sign (may not be present if blood volume is low)
    - Tracheal deviation is a very late sign

Attempt:
#1____
#2____
#3____

Emergency Medical Technician Psychomotor Examination

Naloxone Administration

Candidate: _____ Examiner: _____

Date: _____ Signature: _____

Pt. Presentation: You have a non-responsive, suspected opioid overdose patient with a respiratory rate of 6 breaths per minute.	PASS / FAIL
GENERAL DISCUSSION	
What are your initial interventions?	
Position Airway / Suction, as needed / BVM Ventilation at 1 breath every 6 seconds	
What are the indications for use of Naloxone?	
States all appropriate indications for medication use	
Are there any absolute contraindications for the use of Naloxone?	
States "No"	
States the actions of Naloxone	
☐Displaces narcotics from opiate receptor sites	
☐Reverses respiratory depression, sedation, and pupillary effects of narcotics	
State at least 3 possible adverse effects of Epinephrine	
(Check actions stated by candidate) ☐ Tachycardia ☐ Hypertension ☐ Anxiety ☐ Seizures ☐ Pupillary dilation ☐ Behavioral changes ☐ Nausea / Vomiting	

HIGH CONCENTRATION NASAL SPRAY:	
What are the 6-rights for medication administration?	
States 6-Rights (Patient, Medication, Time, Route, Dosage (4.0mg), Documentation)	
What is DICCE?	
States DICCE (Drug, Integrity, Clarity, Concentration (4.0mg / 0.1ml), Expiration Date)	
Which nostril do you administer the device?	
Choose most appropriate nostril (largest and least deviated or obstructed)	
Inserts device into nostril and briskly depresses the plunger	
What is the appropriate waste container for this device?	
Standard trash can or sharps container	
What is the desired effect to the patient?	
Reversal of Opioid induced respiratory depression	
What is the repeat dose and time interval, if any?	
4.0 mg 1 time in 3 minutes	

NASAL PRELOAD WITH ATOMIZER	
Assembles medication preload and atomizer	
What are the 6-rights for medication administration?	
States 6-Rights (Patient, Medication, Time, Route, Dosage(2.0mg), Documentation)	
What is DICCE?	
States DICCE (Drug, Integrity, Clarity, Concentration(2.0mg / 2.0ml), Expiration Date)	
Inserts device into nostril and briskly depresses the plunger, administering no more than 1ml per nostril	
Disposes of device in sharps container	
What is the desired effect to the patient?	
Reversal of Opioid induced respiratory depression	
What is the repeat dose and time interval, if any?	
2.0 mg 1 time in 3 minutes	

INTRAMUSCULAR INJECTION	
What is the appropriate device and needle for administration	
Naloxone Preload with 25g needle	
Assembles preload device and needle	
What are the 6-rights for medication administration?	
States 6-Rights (Patient, Medication, Time, Route, Dosage(2.0 mg), Documentation)	
What is DICCE?	
States DICCE (Drug, Integrity, Clarity, Concentration (2.0mg / 2.0ml), Expiration Date)	
Demonstrate appropriate IM injection	
Identifies and cleanses appropriate injection site	
Stretches skin, warns patient, and inserts needle at 90°angle while maintaining asepsis	
Removes needle from patient and disposes of syringe, needle, and vial in sharps container	
Applies direct pressure to site	
Covers puncture site with an adhesive bandage	
What is the desired effect to the patient?	
Reversal of Opioid induced respiratory depression	
What is the repeat dose and time interval, if any?	
2.0 mg 1 time in 3 minutes	

You must factually document your rationale for checking any of the above critical items on this form.

CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS OF SELECTED METHOD OF DELIVERY IN ORDER TO PASS SKILL STATION

Performance Objectives

Demonstrate competency in recognizing the indications, contraindications, and criteria for administering Naloxone to a patient with inadequate ventilations secondary to a suspected opiate overdose.

Equipment

- PPE (eye protection, masks, gown, gloves, etc.) Can use an image of PPE in place of actual items
- Adult or pediatric manikin and an IM injection pad
- Suction device
- Oxygen delivery devices / BVM
- Oxygen cylinder with regulator
- High concentration nasal spray
- Nasal preload with atomizer
- Multiple size syringes (1mL, 3mL, 5mL, 10mL)
- Multiple size needles (21g, 23g, 25g, 27g)
- Simulated Naloxone vial
- Alcohol prep
- Sharps container

Key Concepts

- ### Personal protective equipment
  - Gloves, goggles
- ### Situational Awareness
  - Use caution when approaching patient and interacting with the scene to avoid the possibility of needle sticks
  - Continue to monitor patient post administration; may need additional ventilatory support as the duration of some opioids exceed that of Naloxone.
- ### 6 rights of medication administration
  - All medication administration follows the 6 rights at all levels of medical care.
- ### DICCE
  - Only administer if the solution is clear and not expired.
  - Discolored solutions or the presence of particulates may indicate vial compromise or contamination
- ### Airway & Ventilation
  - Maintain adequate airway and ventilatory support at all times.
  - Resume ventilations following medication administration.
  - Suction airway as needed.
  - Ventilate one (1) breath every six (6) seconds until patient is breathing on their own.
- ### High Concentration Nasal Spray
  - 4mg / 0.1 ml concentration
  - Insert into larger nostril until base of stem touches nostril
  - Depress plunger to administer medication
- ### Nasal Preload with Medication Atomization Device (MAD)
  - Make sure preload is secured to the atomizer
  - Place the head in a neutral position
  - Push firmly and gently in the nostril
  - Briskly administer 1ml per nostril to minimize medication flowing into the mouth
- ### Vial Draw Intramuscular injection
  - Only draw up the amount needed for the patient dosing. DO NOT draw up multiple doses at one time.
  - Draw up slightly more than a single dose. Expel any air and excess medication from the syringe/needle while advancing the plunger to the desired volume marker.
  - Dispose of needle used to draw up medication in sharps container, avoiding needle stick
  - Appropriate Injection Site: Deltoid
  - Pull back the plunger slightly to check for blood. If you see blood, you're in a vein—do not inject. If no blood appears, it's safe to proceed with the injection.

Attempt:
#1____
#2____
#3____

Emergency Medical Technician Psychomotor Examination

Epinephrine Administration

Candidate: _____ Examiner: _____

Date: _____ Signature: _____

	PASS / FAIL
GENERAL DISCUSSION	
What are the indications for use of Epinephrine?	
☐Severe Asthma Attack ☐Anaphylaxis	
Are there any contraindications for the use of Epinephrine?	
States "No"	
State all possible actions of Epinephrine	
(Check actions stated by candidate) ☐ Increased cardiac output ☐ Relaxes smooth muscles of respiratory tract ☐ Increases systolic BP ☐ Causes vasoconstriction	
State at least 3 possible adverse effects of Epinephrine	
(Check actions stated by candidate) ☐ Tachycardia ☐ Hypertension ☐ Chest Pain ☐ Palpitations ☐ Anxiety ☐ Dizziness ☐ Headache ☐ Tremors ☐ Seizures ☐ Nausea / Vomiting ☐ Ventricular Fibrillation	

AUTOINJECTOR:	
Selects appropriate autoinjector (Pediatric = 15-30 kg; Adult = >30 kg)	
What are the 6-rights for medication administration?	
Identifies 6-Rights (Patient, Medication, Time, Route, Dosage, Documentation)	
Explain DICCE	
Identifies DICCE (Drug, Integrity, Clarity, Concentration, Expiration Date)	
Identifies appropriate injection site	
Explains procedure to patient	
Holds autoinjector at 90° to injection site and in a dart like form, not touching either end	
Inserts autoinjector at injection site and holds for 2-10 seconds as per manufacturer recommendations	
Remove autoinjector and places in appropriate sharps container or otherwise makes needle safe	
Covers puncture site with an adhesive bandage, if possible	
Massages injection site for 1-2 minutes	
What is the desired effect to the patient?	
Increased blood pressure and decreased breathing difficulty	
What is the repeat dose and time interval, if any?	
Appropriate auto-injector 1 time in 5 minutes	

VIAL DRAW	
What is the appropriate size syringe and needle for administration?	
1 ml syringe with 25g needle	
What is the correct dose to administer?	
0.15 mg <30 kg or 0.30 mg =/> 30kg	
What is the correct concentration to administer?	
1.0mg/ml	
Assembles syringe and needle	
Draws appropriate volume of medication into syringe and dispels air (0.15 ml <30kg or 0.30 ml =/> 30kg)	
What are the 6-rights for medication administration?	
Identifies 6-Rights (Patient, Medication, Time, Route, Dosage, Documentation)	
Explain DICCE	
Identifies DICCE (Drug, Integrity, Clarity, Concentration, Expiration Date)	
Demonstrate appropriate IM injection	
Identifies and cleanses appropriate injection site	
Stretches skin, warns patient, and inserts needle at 90°angle while maintaining asepsis	
Removes needle from patient and disposes of syringe, needle, and vial in sharps container	
Applies direct pressure to site	
Covers puncture site with an adhesive bandage	
What is the desired effect to the patient?	
Increased blood pressure and decreased breathing difficulty	
What is the repeat dose and time interval, if any?	
0.15 mg <30 kg or 0.30 mg =/> 30kg 1 time in 5 minutes	

You must factually document your rationale for checking any of the above critical items on this form.

CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS OF SELECTED METHOD OF DELIVERY IN ORDER TO PASS SKILL STATION

Performance Objectives

Demonstrate competency in recognizing the indications, contraindications, and criteria for administering epinephrine to a patient with anaphylaxis or severe asthma.

Equipment

- PPE (eye protection, masks, gown, gloves, etc.) Can use an image of PPE in place of actual items
- Adult or pediatric manikin and an IM injection pad
- Auto-injector (pediatric and adult)
- Multiple size syringes (1mL, 3mL, 5mL, 10mL)
- Multiple size needles (21g, 23g, 25g, 27g)
- Simulated Epinephrine vial
- Alcohol prep
- Sharps container

Key Concepts

- Personal protective equipment
  - Gloves, goggles
- 6 rights of medication administration
  - All medication administration follows the 6 rights at all levels of medical care.
- DICCE
  - Only administer if the solution is clear and not expired.
  - Discolored solutions or the presence of particulates may indicate vial compromise or contamination
- Appropriate Injection Sites
  - Middle of the outer thigh
- Auto-Injector
  - May be administered through clothing
- Vial Draw
  - Only draw up the amount needed for the patient dosing. DO NOT draw up multiple doses at one time.
  - Draw up slightly more than a single dose. Expel any air and excess medication from the syringe/needle while advancing the plunger to the desired volume marker.
  - Pull back the plunger slightly to check for blood. If you see blood, you're in a vein—do not inject. If no blood appears, it's safe to proceed with the injection.

Attempt:
#1____
#2____
#3____

Emergency Medical Technician Psychomotor Examination

CHILDBIRTH & NEONATAL RESUSCITATION

Candidate: _____ Examiner: _____

Date: _____ Signature: _____

Skills Discussion:	PASS / FAIL
Obtains a history relevant to the pregnancy	
Expected due date and how many children is the patient expecting	
Frequency of contractions	
Duration of contractions	
Rupture of amniotic sac (time and presence of meconium)	
Previous pregnancies and deliveries (Gravida/Para, complications, vaginal delivery, C-section)	
Pre-existing medical conditions (HTN, DM, seizure, cardiac)	
Medications taken prior to labor	
Prenatal care (identified abnormalities with pregnancy)	
Vaginal bleeding	
Abdominal pain	
Evidence of imminent delivery (crowning, contractions – 2 to 3 minutes apart, 30-60 seconds in length, the urge to push, or the urge to defecate)	

Skills Demonstration:

Prepares the mother for delivery	
Prepares appropriate delivery area (privacy for the mother)	
Removes patient's clothing	
Opens and prepares obstetric kit	
Places clean pad under patient	
Prepares bulb syringe, cord clamps, towels, newborn blanket	
Describes all the special PPE (sterile gloves, gown, cap, facemask, and eye protection) that is required to be donned by the EMT prior to delivery	
Assisting the delivery of the newborn	
During contractions, urges the mother to push	
Supports the infant's head with gentle pressure to prevent uncontrolled expulsion of the newborn	
Checks to see if the amniotic sac is broken, if not - puncture by twisting the membrane	
Checks for the presence of meconium; if present, suctions the mouth first, then each nostril	
Checks for nuchal cord, if present, tell mother not to push, loosen cord with 2 fingers and slip over newborn's head, or if needed, clamps in 2 places approximately 2" apart and cut the cord	
Help deliver the shoulders	
Support the baby throughout the entire birth process	
Notes the time of birth	
Controls hemorrhage as necessary; uterine massage following intact placenta delivery	

Newborn care (Birth – 30 seconds postpartum):	
Keeps newborn at the level of the mother's perineum with the head slightly down	
Assesses baby's airway, suctions if needed with mouth first, then nostrils	
Warms and dries newborn	
Wraps newborn in blanket or towels to prevent hypothermia	
Newborn care (30 – 60 seconds postpartum):	
Once umbilical cord stops pulsating, clamps the cord at 10" from baby, then 7" from baby then cuts between the clamps with sterile scissors or sterile scalpel	
Places on mother's chest to retain warmth	
Determines 1 minute APGAR score	
Neonatal Resuscitation:	
If heart rate is less than 100, gasping or apneic – Provide PPV at 40-60/min with room air	
If heart rate is less than 100 after 30 seconds of PPV, add O2 and continue PPV	
If heart rate is less than 60 – begin chest compressions at 3:1 ratio	
Determines 5-minute APGAR score	
Describes all APGAR scale components	

CANDIDATE MUST BE SUCCESSFUL IN ALL STEPS IN ORDER TO PASS SKILL STATION

Performance Objectives

- Assess for imminent delivery by evaluating crowning, contraction frequency, and urge to push.
- Recognize complications such as nuchal cord, breech presentation, shoulder dystocia, and postpartum hemorrhage.
- Assess and manage the neonate using the Neonatal Resuscitation Program (NRP)-based sequence: warm, position, clear airway, dry, stimulate.
- Initiate neonatal resuscitation interventions: positive pressure ventilation (PPV), chest compressions, oxygen administration.

Necessary Equipment

• Simulation manikin (OB and neonate) with features to simulate delivery and resuscitation	• Weight-based measuring tape
• Obstetric Delivery Kit	
• Oxygen delivery system and bag valve masks with appropriately sized masks	
• Bulb aspirator and other suction equipment for airway management	
• Stethoscope, thermometer	
• Blankets, cap, and other appropriate warming equipment	

Key Concepts

- Ability to recognize stages of labor
- Effectively perform emergency delivery procedure
- Demonstrate APGAR scoring protocol
- Perform skills necessary to assess and treat neonate immediately following birth
- Demonstrate resuscitative skills for neonate