

5090
Public Health Administration
Large Conference Room
2240 E. Gonzales, 2nd Floor
Oxnard, CA 93036

Pre-hospital Services Committee
Agenda

March 8, 2018
9:30 a.m.

I. Introductions

II. Approve Agenda

III. Minutes

IV. Medical Issues

A. Other

V. New Business

A. 430 - STEMI Receiving Center (SRC) Standards Karen Beatty

B. 705.25 - Ventricular Tachycardia Sustained – Not in Arrest Karen Beatty

C. 705.28 – Smoke Inhalation Chris Rosa

D. 726 – 12 Lead ECG Karen Beatty

VI. Old Business

A. 603 - Refusal of EMS Services Dr. Shepherd

B. 705.09 – Chest Pain Karen Beatty and Chris Rosa

C. 724 - Brief Resolved Unexplained Event (BRUE) Dr. Shepherd

VII. Informational/Discussion Topics

A. Other

VIII. Policies for Review

A. 628 - Rescue Task Force Operations

B. 705.04 – Behavioral Emergencies

C. 905 - Ambulance Provider Response Units: Required Frequencies

IX. Agency Reports

A. Fire Departments

B. Ambulance Providers

C. Base Hospitals

D. Receiving Hospitals

E. Law Enforcement

F. ALS Education Program

G. EMS Agency

H. Other

X. Closing

Health Administration
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 Oxnard, CA 93036

Pre-hospital Services Committee
 Minutes

January 11, 2018
 9:30 a.m.

Topic	Discussion	Action	Approval
II. Approve Agenda		Approved	Motion: Tom Gallegos Seconded: Dr. Brooks Passed unanimous
III. Minutes		Approved	Motion: Yoni Carmona Seconded: Tom O'Connor Passed unanimous
SPECIAL PRESENTATION	Steve recognized Debbie Licht and Betsy Patterson for all their contributions to the EMS system in Ventura County. You will both be greatly missed!		
IV. Medical Issues			
V. New Business			
A. 504 – BLS and ALS Unit Equipment and Supplies		Tabled	
B. 705.09 – Chest Pain – Acute Coronary Syndrome	Remove Dopamine. Add repeat dose for Epi. Remove Epi concentration and leave the dosage only.	Approved with changes. *Robin requested that the draft changes be forwarded to her for skills testing in March.	Motion: Kathy McShea Seconded: Dr. Brooks Passed unanimous
C. 705.21 – SOB – Pulmonary Edema	Remove Dopamine. Add repeat dose for Epi. Remove Epi concentration and leave the dosage only.	Tabled for EMS review. *Robin requested that the draft changes be forwarded to her for skills testing in March.	
D. 705.24 – Symptomatic Bradycardia	Remove Dopamine. Add repeat dose for Epi. Remove Epi concentration and leave the dosage only.	Approved with changes. *Robin requested that the draft changes be forwarded to her for skills testing in March.	Motion: Kathy McShea Seconded: Dr. Brooks Passed unanimous
E. 705.28 – Smoke Inhalation		Tabled	
F. 1133 – Continuing Education for EMS Personnel	Chris will correct typos and formatting issues.	Approved with changes	
VI. Old Business			

VII. Informational/Discussion Topics			
A. 603 – Refusal of EMS Services	Chris will meet with Dr. Shepherd to discuss the numerous issues brought up by the committee.	Bring back to next PSC for the committee to review draft changes.	
B. 722 - Approval for Additional Scope of Practice	Chris announced that Dr. Shepherd requested and received approval from the EMS Authority to extend Optional Scope of Practice until 2020.	Fire department paramedics are not required to complete any item on the accreditation list that would only be utilized by transport paramedics. Chris will change the paramedic accreditation form to reflect this.	
VIII. Policies for Review			
A. 500 – Ventura County EMS Provider Agencies		No changes	Motion: James Rosolek Seconded: Tom Gallegos Passed unanimous
B. 501 – ALS Transport Provider Criteria	Committee requested that the policy be updated to reflect current communication modes. Page 2, A:9 – add ENPC as an optional certification. Page 1 – IV:A,1 -Remove “the Base Hospital (BH) and”. Page 3:12 -Remove “only when ALS services are performed”. Page 2 - Add Satellite Phone as #5.	Approved with changes	Motion: Kathy McShea Seconded: Tom O’Connor Passed unanimous
C. 506 – Paramedic Support Vehicle		No changes	Motion: Yoni Carmona Seconded: Dr. Davies Passed unanimous
D. 508 – First Responder ALS Providers	Committee requested that the policy be updated to reflect current communication modes. Page 2, A:7 – add ENPC as an optional certification. Page 1 – IV:A,1 -Remove “the Base Hospital (BH) and”. Page 2 - Add Satellite Phone as #4.	Approved with changes	Motion: Yoni Carmona Seconded: Dr. Davies Passed unanimous
E. 705.27 – Sepsis Alert		No changes	Motion: Nicole Vorzimer Seconded: Dr. Tilles

			Passed unanimous
F. 724 – Apparent Life Threatening Event	Committee had extensive discussion about changing ALTE to BRUE and will discuss further with Dr. Shepherd. (Policy 704 only requires ALTE base contact for AMA patients, Yoni requested we change that to reflect all ALTE patients require base contact.)	Tabled	
X. Agency Reports			
A. Fire departments	VCFPD – Academy was pushed back to March. Barry Parker is the new EMS Chief and Joe Dullam is the new EMS Captain. Welcome to both!! VCFD – none OFD – none. Fed. Fire – none SPFD – none FFD – none		
B. Transport Providers	LMT – An ALS day car has been added in Ventura. AMR/GCA – We continue to have a lot of turn over. Lots of new hires. AIR RESCUE –none		
C. Base Hospitals	SVH – none LRRMC – none SJRMHC – Breaking ground on ER construction. VCMC – none		
D. Receiving Hospitals	PVH – Construction expected to be done by late summer. SPH – SP ER has temporarily lost 4 beds. CMH – Opening new wing in the fall. OVCH – none		
E. Law Enforcement	VCSO – none CSUCI PD – none		
F. ALS Education Programs	Ventura College – Class was evacuated the last two weeks PM program. Moved to Oxnard College to finish hours. Need internships with experienced medics (more than 2 years as a medic).		
G. EMS Agency	Steve – Everyone did a great job working the Thomas Fire. The system “stepped up” and made it work.....ambulances were running calls with no fire support and Dispatch did a fantastic job!! Nice job to all. Dr. Shepherd - none Chris – none Katy – No red top tubes should be used for PRESTO draws. Only PURPLE. Please check that tubes are not expired. Randy – none		

	Karen – none	
H. Other		
XI. Closing	Meeting adjourned at 12:00	



**TEMPORARY
PARKING PASS
Expires March 8, 2018**

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

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

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

2240 Gonzales Rd. location

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

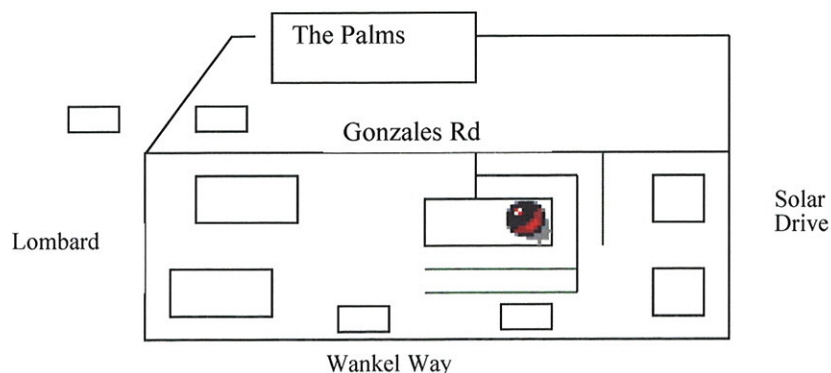
2100 Solar Drive

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

The Palms - shopping mall

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

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



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: STEMI Receiving Center (SRC) Standards		Policy Number 430	
APPROVED: Administration: Steven L. Carroll, EMT-P		Date: June 1, 2016	
APPROVED: Medical Director: Angelo Salvucci, M.D.		Date: June 1, 2016	
Origination Date: July 28, 2006		Effective Date: June 1, 2016	
Date Revised: February 3, 2016			
Last Review: February 3, 2016			
Review Date: February, 2019			

- I. PURPOSE: To define the criteria for designation as a STEMI Receiving Center in Ventura County.
- II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798, 1798.101, 1798.105, 1798.2 and California Code of Regulations, Title 22, Section 100175.
- III. POLICY:
 - A. A STEMI Receiving Center (SRC), approved and designated by Ventura County EMS shall meet the following requirements:
 1. All the requirements of a Receiving Hospital in VCEMS Policy 420.
 2. All the requirements of a SRC in VCEMS Policy 440.
 3. Designate a SRC Coordinator who will have the responsibility for communication with VC EMS.
 4. Operate a cardiac catheterization lab licensed by the Department of Health Services and approved for emergency percutaneous coronary interventions.
 5. Licensed Cardiovascular Surgery.
 6. Maintain a daily roster of on-call cardiologists with privileges in percutaneous coronary interventions.
 7. Have policies for patients to receive emergent angiography or emergent fibrinolysis, based on physician decisions for individual patients.
 8. Maintain a hospital STEMI Quality Improvement Program.
 9. Actively participate in the Ventura County EMS STEMI Quality Improvement Program and comply with data submission and case review standards as established by VCEMS.
 10. Will accept all ambulance-transported patients with ***ACUTE MI SUSPECTED*** or ***MEETS ST SEGMENT ELEVATION MI

CRITERIA*** for Lifepack monitor or ***STEMI*** for Zoll monitor, except on internal disaster or no cardiac catheterization lab is available, regardless of ICU/CCU or ED saturation status.

11. Have policies and procedures that allow the automatic acceptance of any STEMI patient from a Ventura County Hospital upon notification by the transferring physician.
12. Have available continuous Intra-aortic balloon pump and Impella device capability with staffing.
13. Have policies in place for the transfer of STEMI patients.

B. Designation

1. Application:
Eligible hospitals shall submit a written request for SRC approval to the VC EMS, documenting the compliance of the hospital with Ventura County SRC Standards.
2. Approval:
SRC approval or denial shall be made in writing by VCEMS to the requesting Hospital within two weeks after receipt of the request for approval and all required documentation.
3. VC EMS may deny, suspend, or revoke the approval of a SRC for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.
4. The VCEMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the PSC that compliance with the regulation would not be in the best interests of the persons served within the affected area.
5. SRCs shall be reviewed on an annual basis.
 - a. SRCs shall receive notification of evaluation from the VCEMS.
 - b. SRCs shall respond in writing regarding program compliance.
 - c. On-site SRC visits for evaluative purposes may occur.
 - d. SRCs shall notify VCEMS by telephone, followed by a letter or email within 48 hours, of changes in program compliance or performance.

Ventricular Tachycardia Sustained – Not in Arrest

BLS Procedures

Administer oxygen as indicated

ALS Prior to Base Hospital Contact

IV/IO Access

Stable – Mild to moderate chest pain/SOB

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

Unstable – ALOC, signs of shock or CHF

- **Midazolam**
 - IV/IO – 2 mg
 - Should only be given if it does not result in delay of synchronized cardioversion
 - For IV/IO use – Dilute 5 mg (1mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL
- **Synchronized Cardioversion**
 - Use the biphasic energy settings that have been approved by service provider medical director
- If patient needs sedation and there is a delay in obtaining sedation medication:
 - **Amiodarone**
 - IV/IOPB - 150 mg in 50mL D₅W infused over 10 minutes

Unstable polymorphic (irregular) VT:

- **Defibrillation**
 - Use the biphasic energy settings that have been approved by service provider medical director

If recurrent VT, perform synchronized cardioversion at last successful biphasic energy setting

After successful cardioversion, obtain an ECG per Policy 726.

Base Hospital Orders only

Torsades de Pointes

- **Magnesium Sulfate**
 - IV/IOPB – 2 gm in 50 mL D₅W infused over 5 min
 - May repeat x 1 if Torsades continues or recurs

Consult with ED Physician for further treatment measures

ED Physician Order Only: After 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 IV/IOPB in D₅W 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 > 150 bpm

Smoke Inhalation	
ADULT	PEDIATRIC
BLS Procedures	
<p><u>Remove individual from the environment</u></p> <p><u>Consider gross decontamination</u></p> <p><u>Assess ABCs</u></p> <p><u>Assess for trauma and other acute medical conditions</u></p> <p><u>Administer oxygen as indicated, or with evidence of smoke inhalation</u></p> <ul style="list-style-type: none"> • <u>Maintain SpO₂ greater than 93%</u> 	<p><u>Remove individual from the environment</u></p> <p><u>Consider gross decontamination</u></p> <p><u>Assess ABCs</u></p> <p><u>Assess for trauma and other acute medical conditions</u></p> <p><u>Administer oxygen as indicated, or with evidence of smoke inhalation</u></p> <ul style="list-style-type: none"> • <u>Maintain SpO₂ greater than 93%</u>
ALS Prior to Base Hospital Contact	
<p><u>Airway support in accordance with Policy 710 – Airway Management</u></p> <p><u>IV/IO access as indicated</u></p> <p><u>If Wheezes present</u></p> <ul style="list-style-type: none"> • <u>Albuterol</u> <ul style="list-style-type: none"> ○ <u>Nebulizer – 5mg/6mL</u> ▪ <u>Repeat as needed</u> <p><u>If smoke inhalation AND unconscious or ALOC</u></p> <ul style="list-style-type: none"> • <u>Hydroxycobalamin</u> <ul style="list-style-type: none"> ○ <u>IV/IO – 5gm in 200mL NS over 15 minutes</u> 	<p><u>Airway support in accordance with Policy 710 – Airway Management</u></p> <p><u>IV/IO access as indicated</u></p> <p><u>If Wheezes present</u></p> <ul style="list-style-type: none"> • <u>Albuterol</u> <ul style="list-style-type: none"> ○ <u>Nebulizer – 5mg/6mL</u> ▪ <u>Repeat as needed</u> <p><u>If smoke inhalation AND unconscious or ALOC</u></p> <ul style="list-style-type: none"> • <u>Hydroxycobalamin</u> <ul style="list-style-type: none"> ○ <u>IV/IO – 70mg/kg to a max of 5gm in 200mL NS over 15 minutes</u>
Base Hospital Orders only	
<p><u>Continued unconscious/ALOC OR poor response to initial dose</u></p> <ul style="list-style-type: none"> • <u>Hydroxycobalamin</u> <ul style="list-style-type: none"> ○ <u>IV/IO – 5gm in 200mL NS over 15 to 120 minutes, depending on clinical presentation.</u> 	<p><u>Continued unconscious/ALOC OR poor response to initial dose</u></p> <ul style="list-style-type: none"> • <u>Hydroxycobalamin</u> <ul style="list-style-type: none"> ○ <u>IV/IO – 70mg/kg to a max of 5gm in 200mL NS over 15 to 120 minutes, depending on clinical presentation.</u>
<p><u>Consult with ED Physician for further treatment measures.</u></p>	<p><u>Consult with ED Physician for further treatment measures.</u></p>
<p><u>Additional Information:</u></p> <ul style="list-style-type: none"> • <u>Evidence of smoke inhalation includes soot around mouth and/or nares, increased work of breathing, wheezing</u> • <u>If additional IV/IO medications are indicated, establish a second IV or IO. DO NOT administer other medications with hydroxycobalamin through the same IV/IO line.</u> • <u>DO NOT administer hydroxycobalamin if patient has a known allergy to hydroxycobalamin or cyanocobalamin</u> 	

Effective Date: DRAFT
Next Review Date:

Date Revised:
Last Reviewed:

VCEMS Medical Director

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		DRAFT		HEALTH CARE AGENCY POLICIES AND PROCEDURES	
Policy Title 12 Lead ECG			Policy Number: 726		
APPROVED: Administration: Steven L. Carroll, Paramedic			Date: December 1, 2017		
APPROVED: Medical Director: Daniel Shepherd, MD			Date: December 1, 2017		
Origination Date: August 10, 2006		Date Revised: October 12, 2017		Effective Date: December 1, 2017	
Date Last Reviewed: October 12, 2017		Review Date: October 31, 2019			

- I. Purpose: To define the indications, procedure and documentation for obtaining 12-lead ECGs.
- II. Authority: California Health and Safety Code, Sections 1797.220 and 1798, California Code of Regulations, Title 22, Section 100175.
- III. Policy: Paramedics will obtain 12-lead ECGs in patients demonstrating symptoms of acute coronary syndrome. Treatment of these patients shall be done in accordance with this policy. Only paramedics who have received training in this policy are authorized to obtain a 12-lead ECG on patients. EMTs who are specially trained may be authorized to set up the 12 lead.
- IV. Procedure:
 - A. Indications for a 12-lead ECG: Medical history and/or presenting complaints consistent with an acute coronary syndrome. Patients will have the acute (within the previous 12 hours) onset or acute exacerbation of one or more of the following symptoms that have no other clear identifiable cause:
 1. Chest, upper back or upper abdominal discomfort.
 2. Generalized weakness.
 3. Dyspnea.
 4. Symptomatic bradycardia
 5. **After successful cardioversion of sustained V-Tach (Policy 705.25)**
 6. Paramedic Discretion
 - B. Contraindications: Do NOT perform an ECG on these patients:
 1. Critical Trauma: There must be no delay in transport.
 2. Cardiac Arrest unless return of spontaneous circulation
 - C. ECG Procedure:
 1. Attempt to obtain an ECG during initial patient evaluation. Oxygen should be administered if patient is dyspneic, shows signs of heart failure or shock, or has SAO2 < 94% If the ECG can be completed

without delay (less than 3 minutes after patient contact), and the patient is not in severe distress, perform ECG prior to medication administration.

2. The ECG should be done prior to transport.
3. If the ECG is of poor quality (artifact or wandering baseline), or the patient's condition worsens, **may** repeat to a total of 3.
4. Once an acceptable quality ECG is obtained
 - a. Switch the monitor to the standard 4-lead function
 - b. ~~Repeat the 12-lead ECG only if the original ECG interpretation is **NOT ***ACUTE MI SUSPECTED***, ***MEETS ST SEGMENT ELEVATION MI CRITERIA*** for Lifepack monitor or ***STEMI*** for Zoll monitor and patient's condition worsens.**~~
5. If interpretation is *****ACUTE MI SUSPECTED****, *****MEETS ST SEGMENT ELEVATION MI CRITERIA*** for Lifepack monitor** or *****STEMI*** for Zoll monitor**, note underlying rhythm, and verify by history and physical exam that the patient does not have a pacemaker or ICD.

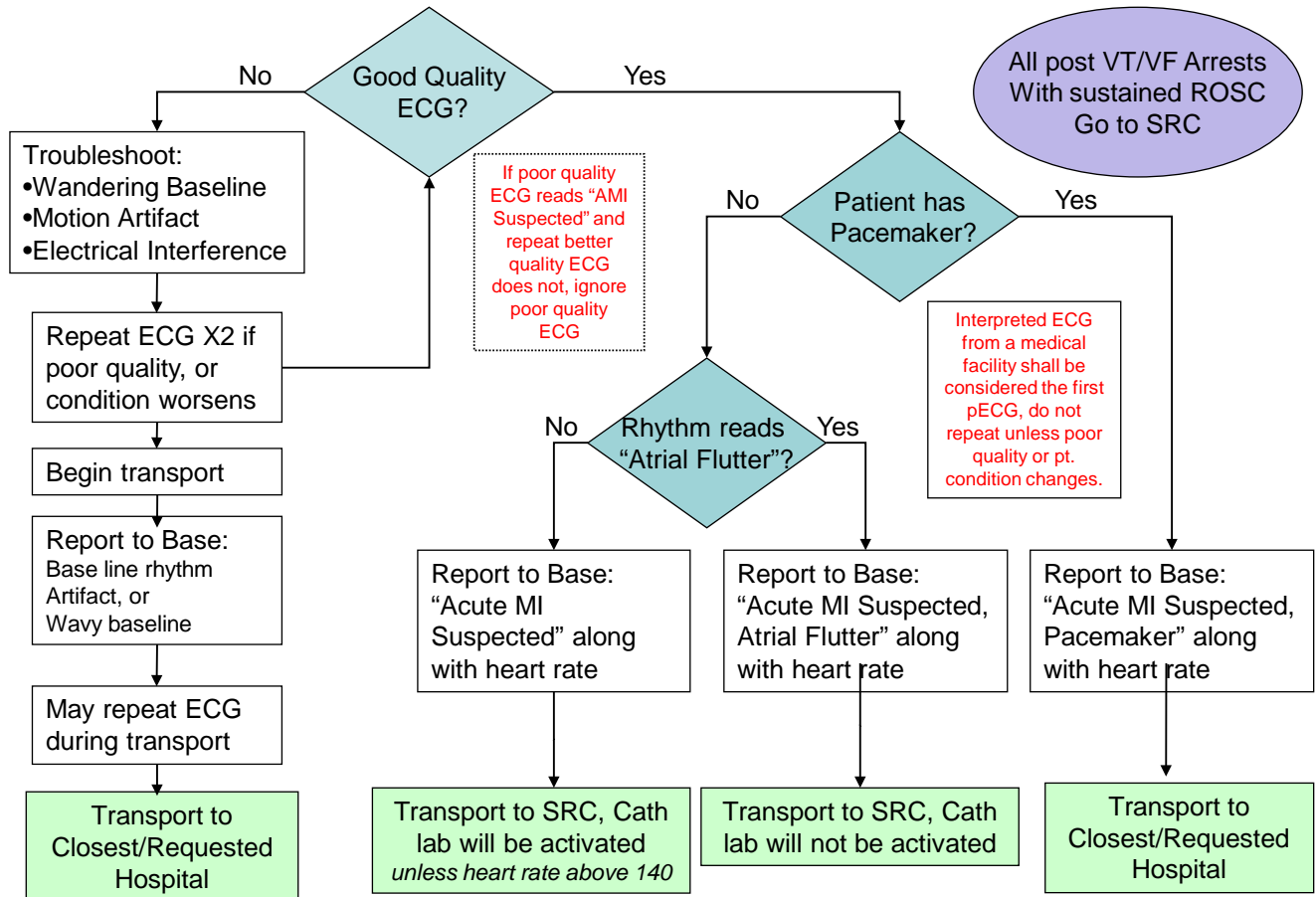
D. Base Hospital Communication/Transportation:

1. If the ECG interpretation is *****ACUTE MI SUSPECTED*****, *****MEETS ST SEGMENT ELEVATION MI CRITERIA*** for Lifepack monitor** or *****STEMI*** for Zoll monitor**; report that to MICN immediately, along with the heart rate on ECG. If the ECG is of poor quality, or the underlying rhythm is paced, or atrial flutter, include that information in the initial report. All other information, except that listed in items 2, 4, and 5 below, is optional and can be given at the paramedic and MICN's discretion.
2. Paramedics are to ask the patient if they have a cardiologist and report the information to the base hospital.
3. If ECG Interpretation is *****ACUTE MI SUSPECTED*****, *****MEETS ST SEGMENT ELEVATION MI CRITERIA*** for Lifepack monitor** or *****STEMI*** for Zoll monitor**, patients should be transported to the closest and most appropriate STEMI Receiving Center (SRC) depending on patient preference and cardiac catheterization lab availability. MICN may direct ambulance to alternative SRC if cardiac catheterization lab not available.
4. If the ECG interpretation is *****ACUTE MI SUSPECTED*****, *****MEETS ST SEGMENT ELEVATION MI CRITERIA*** for Lifepack monitor** or

- ***STEMI*** for Zoll monitor and the underlying rhythm is Atrial Flutter or if the rate is above 140, the Base Hospital shall be notified at the beginning of the report. The Cath Lab will not be activated.
5. If the ECG interpretation is ***ACUTE MI SUSPECTED***, ***MEETS ST SEGMENT ELEVATION MI CRITERIA*** for Lifepack monitor or ***STEMI*** for Zoll monitor and the patient has a pacemaker or the ECG is of poor quality (wandering baseline and/or artifact) report that to the MICN.
 6. If a first responder paramedic obtains an ECG that is **not** ***ACUTE MI SUSPECTED***, ***MEETS ST SEGMENT ELEVATION MI CRITERIA*** for Lifepack monitor or ***STEMI*** for Zoll monitor and the patient is stable, patient care may be turned over to the transporting paramedic. The ECG will be turned over to the transporting paramedic.
 7. Positive ECGs will be handed to the receiving medical practitioner. The receiving practitioner will initial, time and date the ECG to indicate they have received and reviewed the ECG.
- E. Patient Treatment:
1. Patient Communication: If the ECG interpretation is ***ACUTE MI SUSPECTED***, ***MEETS ST SEGMENT ELEVATION MI CRITERIA*** for Lifepack monitor or ***STEMI*** for Zoll monitor, the patient should be told that “according to the ECG you may be having a heart attack”. If the ECG interpretation is anything else, the patient should NOT be told the ECG is normal or “you are not having a heart attack”. If the patient asks what the ECG shows, tell him/her that it will be read by the emergency physician.
- F. Other ECGs
1. If an ECG is obtained by a physician and the physician interpretation is Acute MI, the patient will be treated as an ***ACUTE MI SUSPECTED***, ***MEETS ST SEGMENT ELEVATION MI CRITERIA*** for Lifepack monitor or ***STEMI*** for Zoll monitor. Do not perform an additional ECG unless the ECG is of poor quality, or the patient’s condition worsens.
 2. If there is no interpretation of another ECG then repeat the ECG.
 3. The original ECG performed by physician shall be obtained and accompany the patient.

4. 12 Lead ECG will be scanned and added as an attachment to the Ventura County electronic Patient Care Report (VCePCR), in addition to being hand delivered to the receiving facility.
- G. Documentation
1. VCePCR will be completed per VCEMS policy 1000. The original ECG will be turned in to the base hospital and ALS Service Provider.
- H. Reporting
1. False Positive ECGs not recognized and called in as such to the Base Hospital, will be reported to VC EMS as an Unusual Occurrence in accordance with VC EMS Policy 150.

*****ACUTE MI SUSPECTED*** or
*****MEETS ST SEGMENT ELEVATION MI CRITERIA*******



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Refusal of EMS Services		Policy: 603	
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: <u>DRAFT</u>	
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: <u>DRAFT</u>	
Origination Date October 31, 1995 Date Revised: May 11, 2017 Last Review: May 11, 2017 Review Date May, 2020		Effective Date: <u>DRAFT</u>	

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

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

III. DEFINITIONS:

Adult – person over 18 years of age

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

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

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

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

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

Emancipated minor – a person under 18 years of age who has been legally separated from their parents and lives independently.

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

Minor – person under 18 years of age.

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

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

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

IV. POLICY:

- A. Adults and a select group of minors with decision-making capacity have the right to dictate the scope of their medical care. EMS has an obligation to offer service.
 - B. All potential patients at the scene of an EMS response shall be offered evaluation and treatment. Transportation is an essential component of EMS care and should be encouraged.
 - C. Providing care establishes a therapeutic relationship and the expectations therein.
 - D. Not all EMS patients require ALS care and/or transport.
 - E. Patients declining care and/or transport should be counseled thoroughly about the pertinent risks of declining such interventions and all discussions should be documented thoroughly.
 - F. If there is any concern, the BLS providers shall request an ALS provider.
 - G. BLS providers with concern for an emergency medical condition shall request an ALS provider for an ALS level assessment.
 - H. Only adults and a select group of minors can refuse care. Persons who refuse care must demonstrate capacity and be free of impairment due to drugs and/or alcohol. Emancipated minors, minors on military duty, and married minors may decline services if they meet the criteria for refusal. Parents of minors and the dedicated decision makers for adults who lack capacity can decline services for others if they themselves meet the criteria for refusal.
-

I. Criteria for refusal:

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

V. PROCEDURE:

A. Cancellation ~~and Declination of Service~~

1. No ePCR is required for an incident in which your unit was canceled en route or by another agency within two minutes of arrival to the scene and there was no patient contact.

B. Declination of Service

- ~~1. Those individuals at an EMS response who have no medical complaints or evidence of an emergency medical condition may decline service. Service will still be offered, and encouraged. An ePCR with no treatment disposition shall be completed.~~

~~1.2.~~ No ePCR is required for ~~patients~~ individuals involved in any incident who are without complaint and no trauma triage criteria are present.

~~2.3.~~ No ePCR is required for the occupants of a vehicle involved in a minor traffic collision in which all occupants in the vehicle are without complaint and no trauma triage criteria are present.

~~3.4.~~ Advise contact of the potential risks of declining service.

~~4.5.~~ Document encounter as required by VCEMS policy 1000.

~~5.6.~~ Use of the narrative to describe the scene is strongly encouraged.

~~2. An ePCR is required for all occupants of a vehicle in a minor traffic collision if any individual within the vehicle requires assessment, care, and/or transport or trauma triage criteria are present.~~

C. Declination of Transport and/or Assessment

1. Patients with minor injuries or illness, or those in need of strictly BLS interventions, shall be evaluated and treated per protocol.
2. Transport must be offered and encouraged.
3. Adults and appropriate minors may decline transport and/or assessment if all of the following criteria are met:
 - a. Alert, oriented (x4) person, place, time, and purpose/situation.
 - b. Able to demonstrate capacity by participating in a discussion of the risks and benefits of declining additional service. Must adequately acknowledge risks of declining.

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- c. Free of impairment due to drugs or alcohol.
 - d. No evidence of suicidality, homicidality, grave disability, or other acute psychiatric condition that may require a 5150.
 - e. No need for ALS level intervention.
 - f. No criteria for ALS assessment and base hospital contact as defined by VCEMS policy 704.
4. Adults and appropriate minors may be released by ALS providers after base hospital contact if ALL of the following criteria are met:
 - a. Alert, oriented (x4) person, place, time, and purpose/situation.
 - b. Able to demonstrate capacity by participating in a discussion of the risks and benefits of declining additional service. Must adequately acknowledge risks of declining.
 - c. Free of impairment due to drugs or alcohol.
 - d. No evidence of suicidality, homicidality, grave disability, or other acute psychiatric condition that may require a 5150.
 5. Minors and those lacking capacity may be released from care if a parent or dedicated decision maker is present and meets criteria listed above.
 6. Documentation is essential. You MUST document the mechanism of injury or medical complaint, past medical history with medications, a physical exam with vital signs, a general impression or assessment, and a follow-up plan.
 7. Discuss the risks of declining and document the discussion in your narrative.
 8. Obtain relevant signatures.
 9. The relevant documentation shall be completed expeditiously.

D. AMA

1. Patient has evidence of an emergency medical condition, required an ALS intervention, or has a complaint and/or condition as described in VCEMS policy 704.
 2. Attempt to convince the patient to consent to care and/or transport.
 3. Engage patient in a discussion detailing the risks of declining additional services.
 4. Contact base hospital for further assistance and/or to document AMA.
 5. Direct communication between the MICN and/or base hospital physician and patient is encouraged.
 6. Adults and appropriate minors may be released if the appropriate criteria are met:
 - a. Alert, oriented (x4) person, place, time, and purpose/situation.
 - b. Able to demonstrate capacity by participating in a discussion of the risks and benefits of refusal. Must adequately acknowledge risks of refusal.
-

- c. Free of impairment due to drugs or alcohol.
 - d. No evidence of suicidality, homicidality, grave disability, or other acute psychiatric condition that may require a 5150.
7. These are high-risk contacts for patients, providers, and EMS agencies. Therefore, they must be completed in a thorough and thoughtful manner. This includes detailed documentation of the history, exam, and all pertinent discussions.
8. Have patient and witness complete relevant AMA documentation.
9. If patient does not meet criteria outlined above, or AMA is discouraged by the base hospital, Law enforcement and/or Crisis Team may be requested to the scene and efforts to convince the patient to agree to transport should be continued.
-

Chest Pain – Acute Coronary Syndrome

BLS Procedures

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

- Hold if SBP < 100 mmHg

ALS Prior to Base Hospital Contact

Perform 12-lead ECG

- ~~If **ACUTE MI SUSPECTED** or **MEETS ST SEGMENT ELEVATION MI CRITERIA** are present, expedite transport to closest STEMI Receiving Center~~ Expedite transport to closest STEMI Receiving Center if monitor interpretation reads:
- ~~Lifepack Monitor: **Acute MI Suspected** or **MEETS ST SEGMENT ELEVATION MI CRITERIA**~~
- ~~Zoll Monitor: **STEMI** (Note: **Acute MI** is not a STEMI activation)~~
- Document all initial and ongoing rhythm strips and ECG changes

For continuous chest pain consistent with ischemic heart disease:

- **Nitroglycerin**
 - SL or lingual spray – 0.4 mg q 5 min for continued pain
 - No max dosage
 - Maintain SBP > 100 mmHg
 - ~~If normal SBP < 100 mmHg, then maintain SBP > 90 mmHg~~
- **Aspirin**
 - PO – 324 mg

IV/IO access

- 3 attempts only prior to Base Hospital contact

If pain persists and not relieved by NTG:

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

If patient presents or becomes hypotensive:

- Lay Supine
- **Normal Saline**
 - IV bolus – 250 mL
 - Unless CHF is present

Communication Failure Protocol

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

- 4 attempts total per patient

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

- ~~Epinephrine 0.1 mg/mL~~
 - ~~Slow IVP – 0.1 mg (1 mL) increments~~
 - ~~Repeat q 3-5 min~~
 - ~~Max 0.3 mg (3 mL) over 1-2 min~~

- ~~Dopamine~~
 - ~~IVPB – 10 mcg/kg/min~~

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Base Hospital Orders only

Consult ED Physician for further treatment measures

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

Effective Date: **DRAFT**
Next Review Date: April 2019

Date Revised: April 13, 2017
Last Reviewed: April 13, 2017

VCEMS Medical Director

Additional Information:

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

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Effective Date: **DRAFT**
Next Review Date: April 2019

Date Revised: April 13, 2017
Last Reviewed: April 13, 2017

VCEMS Medical Director

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Brief Resolved Unexplained Event ig (BRUEALTE)		Policy Number: 724	
APPROVED: Administration: Steven L. Carroll, EMT-P		Date: 06/01/2008	
APPROVED: Medical Director Angele Salvucci Daniel Shepherd, MD		Date: 06/01/2008	
Origination Date: March, 2005		Effective Date: June 1, 2005	
Date Revised:			
Date Last Reviewed: November 12, 2009			
Review Date: April, 2013			

- I. PURPOSE: To define and provide guidelines for the identification and management of pediatric patients with a Brief Resolved Unexplained Event (BRUE) ~~an Apparent Life-Threatening Event (ALTE)~~.
- II. AUTHORITY: Health and Safety Code, Sections 1797.220 and 1798.
- III. POLICY: All EMS personnel should be knowledgeable with BRUEALTE and follow the guidelines listed below.
- IV. PROCEDURE:
- A. Recognition:**
1. Chief Complaint.
 - a. BRUEs (or "ALTEs" as previously termed) usually occur in infants under 12 months old, however; any child less than 2 years of age who exhibits any of the symptoms listed below should be considered an BRUE.
 - b. A Brief Resolved Unexplained~~An Apparent Life-Threatening~~ Event (BRU~~ALTE~~) is any episode that is frightening to the observer (may even think infant or child has died) and usually involves any combination of the following symptoms:
 - 1) **Marked change or loss in muscle tone**
 - 2) **Color change** (cyanosis, pallor, erythrim, plethora)
 - 3) Apnea ~~(central or obstructive)~~ Absent, decreased, or irregular breathing
 - 4) ~~Loss of consciousness or altered level responsiveness~~
 - 5) Choking or gagging
 2. History:
 - a. Hx of any of the following:
 - 1) Absent, decreased, or irregular breathing ~~Apnea~~
 - 2) Loss of consciousness or other altered level of responsiveness

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- 3) Color change
 - 4) Loss in muscle tone
 - 5) Episode of choking or gagging
 - b. Determine the severity, nature and duration of the episode.
 - 1) Was child awake or sleeping at time of episode?
 - 2) What resuscitative measures were taken?
 - c. Obtain a complete medical history to include:
 - 1) Known chronic diseases?
 - 2) Evidence of seizure activity?
 - 3) Current or recent infections?
 - 4) Recent trauma?
 - 5) Medication history?
 - 6) Known gastro esophageal reflux or feeding difficulties?
 - 7) Unusual sleeping or feeding patterns?
3. Treatment:
 - a. **Assume the history given is accurate.**
 - b. Perform a comprehensive physical assessment that includes general appearance, skin color, extent of interaction with the environment, and evidence of current or past trauma. **Note: Exam May Be Normal**
 - c. Treat any identifiable causes as indicated.
 - d. Transport. **Note:** [Base Hospital contact required. If parent/guardian refuses medical care/and or transport, a consult with Base Hospital is required prior to completing a Refusal of Care form.](#)
4. Precautions and Comments
 - a. In most cases, the infant/child will have a normal physical exam when assessed by prehospital personnel. The parent/caregiver's perception that "something is or was wrong" must be taken seriously.
 - b. Approximately 40-50% of [BRUE](#)ALTE cases can be attributed to an identifiable cause(s) such as child abuse, SIDS, swallowing dysfunction, gastro esophageal reflux, infection, bronchiolitis, seizures, CNS anomalies, cardiac disease, chronic respiratory disease, upper airway obstruction, metabolic disorders, or anemia. The remaining causes have no known etiology.
 - c. Keep in mind, especially if the parent/guardian declines transportation, that child abuse is one cause of [BRUE](#)ALTE.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Rescue Task Force Operations		Policy Number 628	
APPROVED: Steven L. Carroll, Paramedic		Date: DRAFT	
APPROVED: Medical Director: Angelo Salvucci, M.D.		Date:	
Origination Date: September 3, 2014		Effective Date:	
Review Date: September, 2015			

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- I. PURPOSE: To establish procedures for Rescue Task Force operations at the scene of an emergency.
- II. AUTHORITY: California Health and Safety Code, Division 2.5, sections 1797.204 and 1797.220; California Code of Regulations, Title 22, Division 9, Sections, 100063, 100146, and 100148
- III. POLICY:
 1. Rescue task force operations shall be conducted in accordance with current Incident Command System (ICS) standards, and the primary fire agency conducting RTF operations shall establish unified command with law enforcement as soon as feasible, ideally prior to the first RTF team making entry with law enforcement.
 2. Once rescue operations are complete, all rescued victims shall be transitioned from the hazard area(s), to a cold zone where they can be treated and prepared for transport ~~in~~ [accordance with VCEMS Policy 131. In cases of 3 or more patients, medical care and transportation in the cold zone will be conducted in accordance with VCEMS Policy 131 – Multi Casualty Incident Response.](#)
 3. Only fire personnel, trained in RTF operations, who are wearing appropriate personal protective equipment, shall make entry into the warm zone as part of an RTF. All others shall remain in the cold zone.
 4. Equipment utilized for the purposes of medical care, rescue, and personal protection are outlined in Appendix A of this policy.
 5. Treatment (basic or advanced) performed as part of RTF operations will be in line with current VCEMS treatment protocols.
 - A. Medical care should be focused on stabilizing life/limb threatening injuries and should be centered around: 1) maintaining a patent airway and adequate respirations; 2) needle decompression of tension pneumothorax, and; 3) controlling extremity hemorrhage, including the application of tourniquet(s).

- B. Utilize SCAB-E mnemonic that highlights the principles of RTF medical care within the warm zone: Situation, Circulation, Airway, Breathing, and Evacuation.

IV. PROCEDURE:

1. Preparatory Phase

- A. Arrive and report to staging or designated location in a secure area.
 - i. First arriving command officer (or company officer on single resource incidents) should seek to establish unified command with law enforcement as soon as possible.
 - ii. First arriving command officer (or company officer on single resource incidents) should maintain physical contact with law enforcement IC at all times.
- B. Don PPE (fire helmet, ballistic vest, wildland jacket, EMS Jacket, etc.), based on departmental requirements and guidelines.
- C. Report to Incident Command / Unified Command that rescue group / team is ready and awaiting an assignment.
- D. Ensure there is clear identification of RTF personnel.
- E. Prepare RTF medical bags
- F. Perform brief intelligence and threat assessment with law enforcement personnel and Incident Command / Unified Command.
 - i. Identify hot, warm, and cold zone(s)
 - ii. Identify movement path(s), and entry/exit points, rally points, etc.
 - iii. If the size and complexity of the incident, as well as the number of victims warrants it, static and dynamic CCP(s) should be pre-determined.
- G. Perform communications check with other RTF personnel and rescue group.
 - i. Fire/EMS resources and law enforcement personnel will remain on their assigned frequencies unless specifically directed to a separate channel by incident command / unified command.
- H. Develop incident objectives for RTF (fire) personnel that are in line with the objectives outlined by law enforcement personnel.

2. Warm Zone Operations

- A. Coordinate movements and maintain cover as directed by law enforcement members of RTF.
- B. Perform rapid assessment and treatment of victims
 - i. Apply red ribbon for treated victims, and black/white for deceased.
- C. Move patients to CCP and/or cold zone treatment area.

- i. Transfer care to appropriate treatment area manager and ensure medical group supervisor is aware of new patients.
 - D. Establish RTF medical caches / re-supply points as needed.
 - E. Re-stock RTF medical bags and prepare for re-entry into the warm zone.
 - F. Transition RTF personnel to MCI operations in cold zone once rescue of victims from the warm zone is complete.
- 3. Post Incident Phase
 - A. Ensure accountability for all RTF personnel
 - B. Collect any/all RTF documents or unit logs
 - C. Perform incident de-brief / hot wash with all incident personnel
 - D. Assess mental and physical health of RTF personnel and conduct CISD and rehabilitation as needed.
- 4. Non-RTF Prehospital Personnel
 - A. Utilizing current ICS concepts, establish key roles for the purposes of MCI management that focus on the triage, treatment, and transport of victims.
 - B. Identify key locations in the cold zone for equipment staging, treatment area(s), and ambulance loading zone(s).
 - C. Ensure Incident Command / Unified Command is aware of the location of this area and of the personnel staffing key MCI management roles.
 - D. All MCI operations (where applicable) shall be conducted in accordance with VCEMS Policy 131.
- 5. Documentation of patient care shall be in accordance with procedure(s) outlined in VCEMS Policy 1000 – Documentation of Prehospital Care, or with VCEMS Policy 131 (if an MCI declaration is applicable).

Common Terms and Definitions Associated with Rescue Task Force Operations

Active Shooter

A suspect who's activity is immediately causing death and serious bodily injury. The activity is not contained and there is immediate risk of death and serious injury to potential victims.

Acts of Violence

Includes but is not limited to large scale complex incidents such as school shootings, workplace violence, active shooter and terrorist activities, as well as smaller scale and/or less complex incidents such as suicide attempts, single patient shootings and stabbings, domestic violence injuries, and assaults.

Barricaded Suspect

A suspect who is in a position of advantage, usually barricaded in a room or building, and is armed and has displayed violence. May or may not be holding hostages and there is no indication that the subject's activity is immediately causing death or serious bodily injury.

Casualty Collection Point

The Casualty Collection Point (CCP) is a forward location where victims can be assembled for movement from areas of high risk to the triage/treatment areas. It is a temporary location to stage patients while awaiting further treatment. Based on incident dynamics, multiple CCPs may be required. Law enforcement may evacuate patients out of the Hot Zone to the Warm Zone border for RTF management or, RTFs may evacuate patients to the Warm/Cold zone border for transport to treatment area(s).

Cold Zone

Area of the incident where victims shall be moved to after rescue. The cold zone is also where transport resources and additional personnel will remain to support triage, treatment, and transport operations in accordance with VCEMS Policy 131 – Multi Casualty Incident Response.

Concealment

Anything that prevents you from being seen but will not stop a bullet.

Contact Team

Contact teams are used by law enforcement to rapidly deploy to the active shooter incident. It is usually comprised of the first few officers on scene. Primary objective is to stop the shooter from inflicting death or injury. Contact Teams will bypass dead, wounded and panicked citizens to neutralize the active threat.

Cover

Anything that will stop a bullet.

Direct Threat

Immediate threat to life exists. The situation is highly dynamic and varies depending on complexity and circumstances of the incident.

Force Protection

Actions taken by law enforcement to prevent or mitigate hostile actions against personnel, resources, facilities and critical infrastructure.

Force Protection Group

A law enforcement group with the responsibility to prevent or mitigate hostile actions against personnel, resources, facilities and critical infrastructure. Coordinates with Rescue Group in establishing Rescue Task Forces (RTF).

Hot Zone

Areas wherein a direct and immediate threat exists. A direct and immediate threat is very dynamic and is determined by complexity and circumstances of the incident. Examples of direct and immediate threat are active shooters and unexploded ordinances. These areas are where Law Enforcement has deployed contact teams to isolate or neutralize the threat. Fire personnel will not operate in a Hot Zone. May also be classified as the inner perimeter by law enforcement.

Indirect Threat

Threat that can be mitigated or reduced, but not completely eliminated or secured.

Multi Casualty Incident (MCI)

A suddenly occurring event that exceeds the capacity of the routine first response assignment. In Ventura County, MCIs are categorized into three different levels, depending on the number of victims:

A. MCI/Level I (3-14 victims)

B. MCI/Level II (15-49 victims)

C. MCI/Level III (50+ victims)

Rapid Deployment

The swift and immediate deployment of law enforcement resources to on-going, life threatening situations where delayed deployment could otherwise result in death or great bodily injury to innocent persons.

Rescue Group

At violent incidents Rescue Group is responsible for the medical care and evacuation of patients located in the Warm Zone. This is accomplished by assigning firefighters to a Rescue Task Force (s) (RTF). The firefighter members of the RTF report to the Rescue Group Supervisor, but work for and at the direction of the lead law enforcement officer of the RTF to which they are assigned. Rescue Group may also be responsible for other operations that will take place within the Warm Zone. This can include objectives such as fire suppression, forcible entry, and fire alarm system activation/deactivation.

Rescue Task Force

The Rescue Task Force (RTF) is a team or teams of trained fire personnel deployed with armed law enforcement personnel to provide rapid care and rescue in areas where there is an ongoing indirect threat (ballistic, explosive, etc.). Teams provide this care and rescue only while under the protection of armed law enforcement personnel.

RTF can/should be deployed for the following reasons:

- i. Treatment of victims in a warm zone
- ii. Removal of victims from the warm zone to a Casualty Collection Point (CCP) and/or to the Cold Zone
- iii. Movement of equipment/supplies from the cold zone to the warm zone.
- iv. Any other activities within the warm zone that are deemed necessary for a successful RTF operation.

RTFs rapidly stabilize life threatening injuries where victims are found, and/or in Casualty Collection Points (CCP). After providing rapid lifesaving medical care, RTFs will evacuate patients to treatment areas and/or Casualty Collection Points. An RTF is comprised of law enforcement personnel providing force protection and fire personnel providing medical care. Comprised of a minimum of one law enforcement officer (LEO) and two firefighters. The Task Force Leader (TFLD) will be a LEO. The firefighter RTF members report to the Rescue Group Supervisor but are assigned to the RTF TFLD.

SCAB-E

SCAB-E: Situation, Circulation, Airway, Breathing, Evacuation. Mnemonic used to describe medical treatment process that is to be used in a hazardous area. Goal is to rapidly stabilize life threatening injuries where patient lies and evacuate.

Tactical Emergency Casualty Care (TECC)

Forward deployment of stabilizing medical interventions in civilian disaster scenarios. TECC guidelines are based on the military Tactical Casualty Combat Care (TCCC)

principles. TECC guidelines take into account the specific needs of civilian EMS providers serving civilian populations. These principles focus on the three most common cause of preventable death in combat (active shooting) situations; 1) extremity hemorrhage, 2) tension pneumothorax, and 3) airway obstructions. All of these are treatable in the field with minimal equipment.

Violent Incident Personnel Protective Equipment (PPE)

The required PPE for violent incidents will be body armor, structure helmet and brush coat or EMS jacket. All personnel will wear the required PPE while on scene regardless of their assignment or work locations. PPE not only protects on scene personnel it is used as an identification method while working on a very dynamic multi-discipline response.

Warm Zone

Areas that have been cleared by Law Enforcement where there is minimal or mitigated threat. These areas can be considered clear but not secure. These areas are where Rescue Task Forces (RTF) deploy. RTFs rapidly stabilize life threatening injuries where victims are found, and/or in Casualty Collections Points (CCP), followed by evacuation to treatment areas. Only Fire personnel being provided Force Protection by law enforcement as part of an RTF will enter the Warm Zone. Law Enforcement has sole authority to determine warm zones.

Appendix A – Rescue Task Force Equipment
Mandatory Minimum Requirements

Personal Protective Equipment

- 1 – Fire Helmet, Agency and Rank Specific
- 1 – Ballistic Vest
- 1 – Wildland “Brush” Jacket or EMS Jacket, Agency Issued.



Individual RTF Kit – BLS

- 1 – StatPacks Brand “Competitor” Pack - Black
- 3 – Combat Application Tourniquet (C.A.T.)
- 2 – HyFin Vent Chest Seal
- 5 – Petrolatum Gauze 5x9
- 1 – 2” Cloth Adhesive Tape
- 2 – 4” Flat Emergency Trauma Dressing (ETD)
- 2 – 5x9 Sterile Combine Dressing
- 2 – 3” Stretch Gauze
- 6 – Pair, Nitrile Gloves
- 1 – Each, Nasopharyngeal Airways Size 28, 30, 32 French
- 3 – Packets, Sterile Lubricant
- 1 – Roll, 100 yard White/Black Striped Flagging Tape
- 1 – Roll, 100 yard Red Flagging Tape
- 1 – Trauma Shears
- 1 – Safety Goggles

Individual RTF Kit – ALS

- 1 – StatPacks Brand “Competitor” Pack – Black with ‘ALS’ Markings
- 1 – Cook Emergency Pneumothorax Set
- 3 – Combat Application Tourniquet (C.A.T.)
- 2 – HyFin Vent Chest Seal
- 5 – Petrolatum Gauze 5x9
- 1 – 2” Cloth Adhesive Tape
- 2 – 4” Flat Emergency Trauma Dressing (ETD)
- 2 – 5x9 Sterile Combine Dressing
- 2 – 3” Stretch Gauze
- 6 – Pair, Nitrile Gloves
- 1 – Each, Nasopharyngeal Airways Size 28, 30, 32 French
- 3 – Packets, Sterile Lubricant
- 1 – Roll, 100 yard White/Black Striped Flagging Tape
- 1 – Roll, 100 yard Red Flagging Tape
- 1 – Trauma Shears
- 1 – Safety Goggles

Behavioral Emergencies	
ADULT	PEDIATRIC
ALS Prior to Base Hospital Contact	
<p>IV Access</p> <p>For Extreme Agitation</p> <ul style="list-style-type: none"> • Midazolam <ul style="list-style-type: none"> ○ IV/IO – 2 mg <ul style="list-style-type: none"> • Repeat 1 mg q 2 min as needed • Max 5 mg ○ IM – 5 – 10 mg <p>FOR IV USE: Dilute 5 mg (1 mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL</p> <p>When safe to perform, determine blood glucose level</p>	<p>For Extreme Agitation</p> <ul style="list-style-type: none"> • Midazolam <ul style="list-style-type: none"> ○ IM – 0.1 mg/kg <ul style="list-style-type: none"> • Max 5 mg <p>When safe to perform, determine blood glucose level</p>
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures
<p>Additional Information:</p> <ul style="list-style-type: none"> • If patient refuses care and transport, and that refusal is because of “mental disorder”, consider having patient taken into custody according to Welfare and Institutions Code Section 5150. “Mental disorders” do not generally include alcohol or drug intoxication, brain injury, hypoxemia, hypoglycemia, or similar causes. • Refer to VC EMS pre-hospital provider fact sheet for suspected excited delirium patients. Be sure to consider and rule out other possible causes or behavior (traumatic or medical). • Use of restraints (physical or chemical) shall be documented and monitored in accordance with VCEMS policy 732 • Welfare and Institutions Code Section 5150: <ul style="list-style-type: none"> ○ A patient may be taken into custody if, as a result of a mental disorder, there is a danger to self and others or is gravely disabled. A California peace officer, a California licensed psychiatrist in an approved facility, Ventura County Health Officer or other County-designated individuals, can take the individual into custody, but it must be enforced by the police in the field. • Patients shall be medically cleared prior to transporting to a psychiatric facility if patient is placed on 5150 hold by law enforcement. • Patient may be transported directly to a psychiatric facility if evaluated by Crisis Team or PAT Team in the field. • All patients that are deemed medically unstable shall be transported to the most accessible Emergency Department. <p>Ventura County Mental Health Crisis Team: (866) 998-2243</p>	

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Ambulance Provider Response Units: Required Frequencies		Policy Number 905	
APPROVED: Administration:  Steven L. Carroll, EMT-P		Date: June 1, 2014	
APPROVED: Medical Director:  Angelo Salvucci, M.D.		Date: June 1, 2014	
Origination Date: July 1, 1999		Effective Date: June 1, 2014	
Date Revised: May 8, 2014			
Date Last Reviewed: May 8, 2014			
Next Review Date: June 2017			

- I. PURPOSE: To define the communications frequencies required on VCEMS licensed ambulance provider response units.
- II. AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.204
- III. POLICY: Ambulance provider response units shall be equipped as listed in this policy.
- IV. PROCEDURE:
 - A. Ambulance provider response unit mobile radios shall be programmed with the first 64 channels of the current Ventura County Fire Protection District radio plan. To reduce confusion, assignments for channels 1-64 will be programmed exactly as listed in the radio plan on all vehicle mounted mobile radios. It is recommended that all portable radios also utilize the same program list; however, providers may adjust the portable lists to accommodate agency specific issues.
 - B. Specific channels in the Ventura County Fire Protection District radio plan are available for the ambulance provider to program agency specific frequencies, if desired. Frequencies on channels 65 and above may be programmed at provider's discretion.
 - C. Any VCEMS licensed ambulance provider units shall have a minimum of one mobile radio and one portable radio compliant with this policy.
 - D. Ambulance providers will post a list of frequency channel assignments in each response unit.
 - E. A list of frequency channel assignments will be submitted to VCEMS by each ambulance provider.