
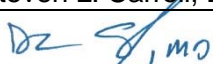


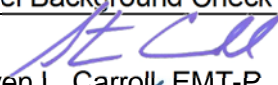

COUNTY OF VENTURA		EMERGENCY MEDICAL SERVICES	
HEALTH CARE AGENCY		POLICIES AND PROCEDURES	
Policy Title: EMT Course Completion by Challenge Examination		Policy Number 304	
APPROVED: Administration:	 Steven L. Carroll, EMT-P	Date: June 1, 2017	
APPROVED: Medical Director:	 Angelo Salvucci, M.D.	Date: June 1, 2017	
Origination Date:	June 1, 1984	Effective Date: June 1, 2017	
Date Revised:	February 9, 2017		
Date Last Reviewed:	February 9, 2017		
Review Date:	February 2020		

- I. **PURPOSE:** To identify the procedure for certification of the Emergency Medical Technician by challenge examination.
- II. **AUTHORITY:** California Code of Regulations (CCR) Title 22, Division 9, Article 1, Sections 100066, 100078 – and Health and Safety Code Sections 1797.107, 1797.170, 1797.208 and 1797.210.
- III. **POLICY:**
 - A. **General Eligibility**
An individual may obtain an EMT course completion record from an approved EMT training program by successfully passing by pre-established standards, developed and/or approved by the Ventura County EMS Agency in accordance with Section 100066 of the California Code of Regulations, a course challenge examination if s/he meets the following eligibility requirements:
 1. Have successfully completed a BLS CPR course, or equivalent, which is consistent with the current American Heart Association Guidelines for CPR and Emergency Cardiovascular Care (ECC), within the previous two (2) years; AND,
 2. Be a currently Licensed Physician, Registered Nurse, Physician Assistant, or Vocational Nurse; OR,
 3. The individual provides documented evidence of having successfully completed an emergency medical service training program of the Armed Forces of the United States within the preceding two (2) years that meets the U.S. DOT National EMS Education Standards (DOT HS 811 077A,

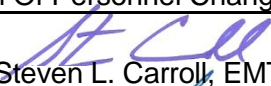

January 2009). Upon review of documentation, the EMT certifying entity may also allow an individual to challenge if the individual was active in the last two (2) years in a prehospital emergency medical classification of the Armed Services of the United States, which does not have formal recertification requirements. These individuals may be required to take a refresher course or complete CE courses as a condition of certification.

B. 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 skills and written examination in conjunction with regularly scheduled testing times.
 2. The course challenge examination shall consist of a competency based written and skills examination (National Registry) to test knowledge of the topics and skills per CCR 100078.
 3. An eligible individual shall be permitted to take the EMT course challenge examination only one (1) time.
 - a. An individual who fails to achieve a passing score on the EMT course challenge examination shall successfully complete an EMT course to receive an EMT course completion record.
 - b. Upon successful completion of the written and skills challenge examination, the challenge applicant will be eligible to take the National Registry written examination.
 4. Proof of successful completion of the National Registry written and skills examination will make the applicant eligible to apply for EMT certification in California, in accordance with VCEMS Policy 301 – EMT Certification.
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COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: EMS Personnel Background Check Requirement		Policy Number 332	
APPROVED: Administrator:	 Steven L. Carroll, EMT-P	Date: June 1, 2011	
APPROVED: Medical Director:	 Daniel Shepherd, MD	Date: Jun 1, 2011	
Origination Date:	July, 1990	Effective Date: June 1, 2011	
Date Revised:	May 13, 2004		
Date Last Reviewed:	December 5, 2016		
Review Date:	December 2019		

- I. PURPOSE: To provide a method to ascertain the criminal background history of persons applying for EMT certification/recertification or Paramedic accreditation as EMS Prehospital care personnel in Ventura County.
- II. AUTHORITY: California Health and Safety Code, Section 1798.200, California Code of Regulations, Section 100206, et seq. Title 13, California Code of Regulations, Section 1101.
- III. POLICY:
 - A. All applicants for Ventura County EMT certification/recertification or paramedic accreditation shall complete a California Bureau of Criminal Identification, Department of Justice background investigation and Federal Bureau of Identification background check via Live Scan Service as a condition of initial EMT certification, initial EMT recertification in Ventura County, or Ventura County Paramedic accreditation.
 - C. Ventura County EMS shall contract with the California Bureau of Criminal Identification for subsequent arrest notification.
 - D. Criteria in Health and Safety Code Section 1798.200 and 13CCR1101 et al shall be used to determine whether certification is given or denied based upon the results of the background check (Refer to Policy 333).
- IV. PROCEDURE:
 - A. All applicants for certification/recertification or accreditation shall contact the Ventura County EMS Office for the fingerprinting procedure.
 - B. This procedure applies to:
 1. All persons applying for initial California EMT certification/ or paramedic accreditation in Ventura County
 2. EMT recertification in Ventura County for the first time
 3. EMT recertification in Ventura County, after lapse in certification, and the Department of Justice has been notified that subsequent notices are no longer required.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Notification Of Personnel Changes-Provider		Policy Number 342	
APPROVED: Administration:	 Steven L. Carroll, EMT-P	Date: June 1, 2017	
APPROVED: Medical Director:	 Daniel Shepherd, MD	Date: June 1, 2017	
Origination Date:	May 15, 1987	Effective Date: June 1, 2017	
Date Revised:	May 11, 2017		
Last Review:	May 11, 2017		
Review Date:	May 2020		

I. PURPOSE



To define a procedure to assure that the Ventura County Emergency Services Agency is notified of hiring or termination of employment of an EMT or paramedic and MICN.

II. AUTHORITY:

Health and Safety Code, Chapter 1, Article 1.

III. POLICY

Each provider of prehospital EMS services shall notify, Emergency Medical Services Administrative Office, in writing or by e-mail, of hiring or termination of employment of an EMT, paramedic or MICN within 5 days of taking action.

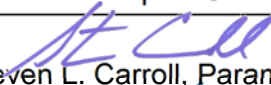

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Prehospital Care Coordinator Job Duties		Policy Number 350	
APPROVED: Administration:	 Steven L. Carroll, Paramedic	Date: June 1, 2017	
APPROVED: Medical Director:	 Daniel Shepherd, MD	Date: June 1, 2017	
Origination Date:	June 15, 1998	Effective Date: June 1, 2017	
Revised Date:	December 5, 2016		
Date Last Reviewed:	December 5, 2016		
Review Date:	December, 2019		

- I. PURPOSE: To provide guidelines for the role of the Prehospital Care Coordinator (PCC) in Ventura County.
- II. POLICY: A PCC will perform his/her role according to the following.
- III. DEFINITION: A PCC is a Registered Nurse designated by each BH (BH) to coordinate all prehospital and Mobile Intensive Care Nurse (MICN) activities sponsored by that BH in compliance with Ventura County Emergency Medical Services (VC EMS) policies, procedure and protocols and in accordance with the Health and Safety Code, Sections 1797-1799 et al, and in accordance with Title 22 of the California Code of Regulations. The PCC evaluates prehospital care, prehospital personnel and MICNs and collaborates with the BH Paramedic Liaison Physician (PLP) in medical direction.
- IV. PROFESSIONAL QUALIFICATIONS:
 - A. Licensed as a Registered Nurse in the State of California.
 - B. Current authorization as a Ventura County Mobile Intensive Care Nurse (MICN).
 - C. One year experience as an MICN in Ventura County. For those nurses with one year work experience as an MICN within the last 18 months, this may be reduced to 6 months.
 - D. Have at least three years emergency department experience.
- V. SPECIFIC RESPONSIBILITIES:
 - A. The PCC is a full-time or full-time equivalency employee whose responsibility is dedicated to the oversight and management of the prehospital / EMS duties of the BH.
 - A. Serve as Liaison by maintaining effective lines of communication with BH personnel, VCEMS, prehospital care providers and local receiving facilities.
 - B. In compliance with VCEMS Policies and Procedures the PCC will:
 1. Ensure a high level of competence and training by developing and instituting prehospital care education programs for MICNs and prehospital

personnel. Programs shall include, but not be limited to, specific issues identified by the VCEMS Continuous Quality Improvement Plan.

- a. Provide continuing education per policy requirements
 - b. Coordinate clinical experience as requested, for purposes of provider plan of action.
 - c. Provide special mandatory programs such as EMS Update classes, Paramedic Skills Labs and Paramedic Orientation.
 - d. Participate in process improvement teams as designated by VC EMS
2. Provide training for probationary MICNs and newly accrediting paramedics by coordinating necessary clinical experience and evaluating performance.
 3. Evaluate the performance of MICNs and submit recommendations for authorization and reauthorization to VC EMS. Such evaluation shall include, but not be limited to:
 - a. Direct observation of BH communications.
 - b. Audit of recorded communications
 - c. Observation of patient assessment and clinical judgment skills (in conjunction with the Emergency Department Nursing Supervisor).
 - d. Review of written documentation.
 - e. Provide written evaluation of the MICNs for hospital performance review.
 4. Provide ongoing evaluation of assessment, reporting, communication and technical skills of assigned paramedics. Such evaluation shall include, but not be limited to:
 - a. Audit of written and recorded communications
 - b. Review of EMS report forms
 - c. Direct field observation during the ride-along, including observation of the transfer of patient care upon arrival at the receiving facility.
 - d. Assess performance during scheduled clinical hours in the Emergency Department.
 - e. Evaluation of paramedic personnel for level advancement, through direct observation, recorded communication and paperwork audit, according to VC EMS Policy 318.

- f. Provide written evaluation of the paramedics, and MICNs
 - g. Facilitate support services for prehospital and hospital EMS Staff, (i.e. Critical Incident Staff Management)
 - h. Participate in Root Cause Analysis as indicated.
5. Report and investigate, and participate in prehospital care unusual occurrences as directed by VC EMS Policy 150.
6. Ensure the operation of the BH communication equipment.
 - a. In conjunction with the BH PLP, ensure that all personnel assigned to communicate with paramedics in the field have attended an MICN developmental course approved by VC EMS.
 - b. Ensure that the radio equipment is operational.
 - c. Ensure that ReddiNet System is operational and up to date.
7. Comply with data collection requirements as directed by VC EMS.
8. Ensure compliance with requirements for retention of recordings, MICN and prehospital care forms, logs and information sheets and maintaining retrieval systems in collaboration with hospital's Medical Records Department.
9. Develop and maintain education records as required by EMS.
 - a. Records must be kept for a period of four years
10. In conjunction with the BH PLP, report to the EMS agency any action of certified/licensed paramedics which results in an apparent deficiency in medical care or constitutes a violation under Section 1798.200 of the Health and Safety Code.
11. Represent the BH at the Prehospital Care Committee, PCC meeting and other associated task forces and special interest committees as directed by the EMS Agency.
12. Actively participate in the development, review and revision of Ventura County Policies and Procedures.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title ALS Base Hospital Standards		Policy Number: 410	
APPROVED Administration:	 Steven L. Carroll, Paramedic	Date: June 1, 2017	
APPROVED Medical Director:	 Daniel Shepherd, MD	Date: June 1, 2017	
Origination Date:	August 22, 1986	Effective Date: June 1, 2017	
Date Revised:	December 5, 2016		
Date Last Reviewed:	December 5, 2016		
Review Date:	December 2019		

- I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Base Hospital (BH) designation.
- II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798, 1798.101, 1798.105, 1798.2 and California Code of Regulations, Title 22, Section 100175.
- III. POLICY:
 - A. An Advanced Life Support (ALS) BH, approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:
 1. Meet all requirements of an ALS Receiving Hospital (RH) per VCEMS Policy 420.
 2. Have an average emergency room census of 1200 or more visits per month.
 3. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics.
 - a. If the communications capability of the BH is interrupted, the ALS provider and the nearest BH shall be notified immediately by telephone.
 - b. ALS calls shall be routed to the nearest BH until communication capability is restored and telephone notification of the ALS provider and nearest BH is made.
 - c. All equipment used for ALS communications shall operate within the frequency requirements of the Ventura County Communications Department. At the time that a countywide communication system is implemented, all ALS providers shall comply with the Ventura County Communications Department ALS communications plan.
 4. Assure that communication between the BH and ALS Unit for each ALS call shall be provided only by the BH Emergency Department (ED) physician or Ventura County authorized Mobile Intensive Care Nurse (MICN) by radio or telephone.
 5. Designate a Prehospital Liaison Physician (PLP) who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The PLP shall:
 - a. Be regularly assigned to the ED.

- b. Have experience in and knowledge of BH operations.
 - c. Be responsible for overall medical control and supervision of the ALS program within the BH's area of responsibility including review of patient care records and critique of personnel involved.
 - d. Be responsible for reporting deficiencies in patient care to VCEMS.
 - e. Coordinate BH activities with RH, Prehospital Services Committee (PSC) and VCEMS policies and procedures.
 - f. Attend PSC meetings.
 - g. Provide ED staff education.
 - h. Evaluate paramedics for clinical performance and makes recommendation to VCEMS.
 - j. Evaluate MICN's for authorization/reauthorization and makes recommendation to VCEMS.
6. Have on duty, on a 24-hour basis, one (1) MICN who meets the criteria in VCEMS Policy 321.
 7. Identify an MICN with experience in, and knowledge of, BH communications operations and VCEMS policies and procedures as a Prehospital Care Coordinator (PCC) to assist the PLP in the medical control, supervision, and continuing education (CE) of prehospital care personnel. The PCC shall be a full-time or full-time equivalency employee whose responsibility is dedicated to the oversight and management of the prehospital / EMS duties of the BH.
 8. Provide for the CE of prehospital care personnel, paramedics MICNs, EMTs, and first responders, in accordance with VCEMS:
 9. Cooperate with and assist the PSC and the VCEMS MD in the collection of statistics and review of necessary records for program evaluation and compliance.
 10. Assure that paramedics perform medical procedures only under medical direction of a physician or Ventura County authorized MICN except for approved standing orders.
 11. Agree to maintain all recorded communications and prehospital data in a manner consistent with hospital data requirements. Prehospital data includes, but is not limited to, the recording of the prehospital communication, prehospital care record, paramedic BH communications form and documentation of telephone communication with the RH (if utilized). All prehospital data except the recording will be integrated with the patient chart.
 12. Resident physicians shall attend BH Physician course.

- B. There shall be a written agreement between the BH and VCEMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for ALS program participation as specified by State regulations and VCEMS policies and procedures.
- C. The VCEMS shall review its agreement with each BH at least every two years.
- D. The VCEMS may deny, suspend, or revoke the approval, of a BH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the PSC and Board of Supervisors for appropriate action.
- E. A hospital wishing to become an ALS BH in Ventura County must meet Ventura County BH Criteria and agree to comply with Ventura County regulations.
 - 1. Application:
Eligible hospitals shall submit a written request for BH approval to VCEMS documenting the compliance of the hospital with the Ventura County BH Criteria.
 - 2. Approval:
 - a. Program approval or disapproval shall be made in writing by the VCEMS to the requesting BH within a reasonable period of time after receipt of the request for approval and all required documentation. This time period shall not exceed three (3) months.
 - b. The VCEMS shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all the program requirements.
 - 3. Withdrawal of Program Approval:
Non-compliance of any criterion associated with program approval, use of non-certified personnel, or non-compliance with any other Ventura County regulation applicable to a BH, may result in withdrawal, suspension or revocation of program approval by the VCEMS.
- F. Advanced Life Support BH s shall be reviewed on an annual basis.
 - 1. All BH's shall receive notification of evaluation from the VCEMS.
 - 2. All BH's shall respond in writing regarding program compliance.
 - 3. On-site visits for evaluative purposes may occur.
 - 4. Any BH shall notify the VCEMS by telephone, followed by a letter within 48 hours of changes in program compliance or performance.

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES



BASE HOSPITAL
CRITERIA COMPLIANCE CHECK LIST

Base Hospital: _____

Date: _____

	YES	NO
An Advanced Life Support (ALS) Base Hospital (BH), approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:		
1. Meet all requirements of an ALS Receiving Hospital (RH) per (VCEMS) Policy 420.		
2. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics. If the communications capability of the BH is interrupted, the ALS provider and the nearest BH shall be notified immediately by telephone. All equipment used for ALS communications shall operate within the frequency requirements of the Ventura County Communications Department. At the time that a countywide communication system is implemented, all ALS providers shall comply with the Ventura County Communications Department ALS communications plan.		
3. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics.		
4. Designate a Prehospital Liaison Physician (PLP) who shall be a physician on the hospital staff, licensed in the State of California, and have experience in emergency medical care. The PLP shall:		
• Be regularly assigned to the Emergency Department (ED).		
• Have experience in and knowledge of BH operations.		
• Be responsible for overall medical control and supervision of the ALS program within the BH's area of responsibility including review of patient care records and critique of personnel involved.		
• Be responsible for reporting deficiencies in patient care to VCEMS.		
• Coordinate BH activities with RH, Prehospital Services Committee (PSC) and VCEMS policies and procedures.		
• Attend PSC meetings.		
• Provide ED staff education.		
•		
• Evaluate MICNs for authorization/reauthorization and make recommendation to VCEMS.		
5. All BH MICN's shall:		
• Be authorized in Ventura County by the VCEMS MD		
• Be assigned only to the ED while functioning as an MICN.		
• Maintain current ACLS certification.		
• Be a BH employee.		

	YES	NO
6. Identify an MICN with experience in and knowledge of BH communication operations and VCEMS policies and procedures as a Prehospital Care Coordinator (PCC) to assist the PLP in the medical control, supervision, and continuing education (CE) of prehospital care personnel. The PCC shall be a full-time or full-time equivalency employee whose responsibility is dedicated to the oversight and management of the prehospital / EMS duties of the BH.		
7. Provide for the CE of prehospital care personnel (paramedics MICN's, EMTs, and first responders), in accordance with VCEMS Policy 1131:		
8. Cooperate with and assist the Prehospital Services Subcommittee (PSC) and the VCEMS MD in the collection of statistics and review of necessary records for program evaluation and compliance.		
9. Assure that paramedics perform medical procedures only under medical direction of a physician or Ventura County authorized MICN except for approved standing orders and medical procedures.		
10. Agree to maintain all recorded communications and prehospital data in a manner consistent with hospital data requirements. Prehospital data includes, but is not limited to the tape of the prehospital communication, prehospital care record paramedic BH communications form, documentation of telephone communication with the RH (if utilized). All prehospital data except the tape recording will be integrated with the patient chart.		
11. Submit a letter to VCEMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for program participation as specified by State regulations and VCEMS policies and procedures.		
12. Resident physicians shall attend BH Physician course.		

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: BLS And ALS Unit Equipment And Supplies		Policy Number: 504	
APPROVED: Administration:	 Steven L. Carroll, Paramedic	Date: June 1, 2017	
APPROVED: Medical Director	 Daniel Shepherd, MD	Date: June 1, 2017	
Origination Date:	May 24, 1987	Effective Date:	June 1, 2017
Date Revised:	May 11, 2017		
Last Reviewed:	May 11, 2017		
Review Date:	May, 2020		



- I. PURPOSE: To provide a standardized list of equipment and supplies for response and/or transport units in Ventura County.
- II. POLICY: Each response and/or transport unit in Ventura County shall be equipped and supplied according to the requirements of this policy.
- III. AUTHORITY: California Health and Safety Code Section 1797.178, 1797.204, 1797.218, 1797.221 and California Code of Regulations Sections 100148, 100306, 100404
- IV. PROCEDURE:
The following equipment and supplies shall be maintained on each response and/or transport unit in Ventura County.

	ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS				
Clear masks in the following sizes: Adult Child Infant Neonate	1 each	1 each	1 each	1 adult 1 infant
Bag valve units Adult Child	1 each	1 each	1 each	1 adult
Nasal cannula Adult	3	3	3	3
Nasopharyngeal airway (adult and child or equivalent)	1 each	1 each	1 each	1 each
Oral glucose 15gm unit dose	1	1	1	1
Oropharyngeal Airways Adult Child Infant Newborn	1 each size	1 each size	1 each size	1 each size
Oxygen with appropriate adjuncts (portability required)	10 L/min for 20 minutes	10 L/min for 20 mins.	10 L/min for 20 mins.	10 L/min for 20 mins.
Portable suction equipment	1	1	1	1
Transparent oxygen_masks Adult nonrebreather Child Infant	3 3 2	2 2 2	2 2 2	2 2 2
Bandage scissors	1	1	1	1
Bandages <ul style="list-style-type: none"> • 4"x4" sterile compresses or equivalent • 2",3",4" or 6" roller bandages • 10"x 30" or larger dressing 	12 6	12 2 0	12 6 2	5 4 2
Blood pressure cuffs Thigh Adult Child Infant	1 1 1 1	1 1 1 1	1 1 1 1	1 1 1 1
Emesis basin/bag	1	1	1	1
Flashlight	1	1	1	1
Traction splint or equivalent device	1	1	1	1
Pneumatic or rigid splints (capable of splinting all extremities)	4	4	4	4
Potable water or saline solution	4 liters	4 liters	4 liters	4 liters
Cervical spine immobilization device	2	2	2	2
Spinal immobilization devices KED or equivalent 60" minimum with at least 3 sets of straps	1 1	1 0	1 1	1

	ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
Sterile obstetrical kit	1	1	1	1
Tongue depressor	4	4	4	4
Cold packs	4	4	4	4
Tourniquet	1	1	1	1
OPTIONAL EQUIPMENT				
Nerve agent antidote – (3 kits per person suggested)				
Occlusive dressing or chest seal				
Hemostatic gauze per EMSA guidelines				
B. TRANSPORT UNIT REQUIREMENTS				
Ambulance cot and collapsible stretcher; or two stretchers, one of which is collapsible.	1	0	0	1
Automated External Defibrillator (if not equipped with ALS monitor/defibrillator)	1	1	1	1
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	0	0	1 Set
Soft Ankle and wrist restraints.	1	0	0	0
Sheets, pillow cases, blankets and towels for each stretcher or ambulance cot, and two pillows for each ambulance	1	0	0	0
Bedpan	1	0	0	0
Urinal	1	0	0	0
Personal Protective Equipment per State Guideline #216				
Rescue helmet	2	1	0	0
EMS jacket	2	1	0	0
Work goggles	2	1	0	0
Tyvek suit	2 L / 2 XXL	1 L / 1 XXL	0	0
Tychem hooded suit	2 L / 2 XXL	1 L / 1 XXL	0	0
Nitrile gloves	1 Med / 1 XL	1 Med / 1 XL	0	0
Disposable footwear covers	1 Box	1 Box	0	0
Leather work gloves	3 L Sets	1 L Set	0	0
Field operations guide	1	1	0	0

	ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
C. ALS TRANSPORT UNIT REQUIREMENTS				
Cellular telephone	1	1	1	1
Alternate ALS airway device	2	1	1	1
Arm Boards				
9"	3	0	1	0
18"	3	0	1	0
Blood glucose determination devices	2	1	1	1
Cardiac monitoring equipment	1	1	1	1
CO ₂ monitor	1	1	1	1
Esophageal Detector Device	1	1	1	1
Continuous positive airway pressure (CPAP) device	1	1	1	1
Defibrillator pads or gel	3	3	3	1 adult – No Peds.
Defibrillator w/adult and pediatric paddles/pads	1	1	1	1
EKG Electrodes	10 sets	3 sets	3 sets	6 sets
Endotracheal intubation tubes, sizes 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5 with stylets	1 of each size	1 of each size	1 of each size	4, 5, 6, 6.5, 7, 7.5, 8
EZ-IO intraosseous infusion system	1 Each Size	1 Each Size	1 Each Size	1 Each Size
Intravenous Fluids (in flexible containers)				
• Normal saline solution, 500 ml	2	1	1	1
• Normal saline solution, 1000 ml	6	2	4	3
IV admin set - microdrip	4	1	2	2
IV admin set - macrodrip	4	1	4	3
IV catheter, Sizes I4, I6, I8, 20, 22, 24	6 each 14, 16, 18, 20 3 each 22 3 each 24	2 each	2 each	2 each
Laryngoscope, replacement bulbs and batteries	1 set	1 set	1 set	1 set
Curved blade #2, 3, 4	1 each	1 each	1 each	1 each
Straight blade #1, 2, 3	1 each	1 each	1 each	1 each
Magill forceps				
Adult	1	1	1	1
Pediatric	1	1	1	1
Nebulizer	2	2	2	2
Nebulizer with in-line adapter	1	1	1	1
Needle Thoracostomy kit	2	2	2	2
Pediatric length and weight tape	1	1	1	1
SpO ₂ Monitor (If not attached to cardiac monitor)	1	1	1	1
OPTIONAL ALS EQUIPMENT (No minimums apply)				
Flexible intubation stylet				

	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
D. ALS MEDICATION, MINIMUM AMOUNT				
Adenosine, 6 mg	3	3	3	3
Albuterol 2.5mg/3ml	6	2	3	1
Aspirin, 81mg	4 ea 81 mg	4 ea 81 mg	4 ea 81 mg	4 ea 81 mg
Amiodarone, 50mg/ml 3ml	6	3	6	3
Atropine sulfate, 1 mg/10 ml	2	2	2	2
Diphenhydramine (Benadryl), 50 mg/ml	2	1	1	2
Calcium chloride, 1000 mg/10 ml	2	1	1	1
Dextrose 5% 50ml	2	1	2	1
Dextrose 10% 250 ml	2	1	2	1
Dextrose 25% 2.5 GM 10ml	1	1	1	1
Dextrose 50%, 25 GM/50	5	2	2	2
Dopamine, 400 mg/250ml D5W, premixed	2	1	1	2
Epinephrine 1:1,000, 1mg/ml	4	2	2	2
Epinephrine 1:10,000, 1 mg/10ml	6	3	6	4
Epinephrine 1:1,000, 30 ml multi-dose vial	1	1	1	1
Glucagon, 1 mg/ml	2	1	2	1
Lidocaine, 100 mg/5ml	2	2	2	2
Magnesium sulfate, 1 gm per 2 ml	4	1	2	2
Morphine sulfate, 10 mg/ml	2	2	2	2
Naloxone Hydrochloride (Narcan)	10 mg	4 mg	4 mg	4mg
Nitroglycerine preparations, 0.4 mg	1 bottle	1 bottle	1 bottle	1 bottle
Normal saline, 10 ml	2	2	2	2
Sodium bicarbonate, 50 mEq/ml	2	1	1	1
Ondansetron 4 mg IV single use vial	4	4	4	4
Ondansetron 4 mg oral	4	4	4	4
Midazolam Hydrochloride (Versed)	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Medical Control: Paramedic Liaison Physician		Policy Number 701	
APPROVED: Administration:  Steven L. Carroll, EMT-P		Date: June 1, 2014	
APPROVED: Medical Director:  Daniel Shepherd, MD		Date: June 1, 2014	
Origination Date: August 1, 1988		Effective Date: June 1, 2014	
Date Revised: January 9, 2014			
Date Last Reviewed: April 13, 2017			
Review Date: April 2020			

- I. PURPOSE: To define the role and responsibility of the Paramedic Liaison Physician (PLP) with respect to EMS medical control.
- II. AUTHORITY: Health and Safety Code Sections 1707.90, 1798, 1798.2, 1798.102, and 1798.104. California Code of Regulations, Title 22, Sections 100147 and 100162
- III. POLICY: The Base Hospital shall implement the policies and procedures of VCEMS for medical direction of prehospital advanced life support personnel. The PLP shall administer the medical activities of licensed and accredited prehospital care personnel and ensure their compliance with the policies, procedures and protocols of VCEMS. This includes:
 - A. Medical direction and supervision of field care by:
 1. Ensuring the provision of medical direction and supervision of field care for Base Hospital physicians, MICNs, PCCs, and Paramedics.
 2. Ensuring that field medical care adheres to current established medical guidelines, and that ALS activities adhere to current policies, procedures and protocols of VC EMS.
 - B. Education by ensuring the development and institution of prehospital education programs for all EMS prehospital care personnel (MDs, MICNs, Paramedics).
 - C. Audit and evaluation by:
 1. Providing audit and evaluation of Base Hospital Physicians, MICNs, PCCs, and ALS field personnel. This audit and evaluation shall include, but not be limited to:
 - a. Clinical skills and supervisory activities pertaining to providing medical direction to ALS field personnel.
 - b. Compliance with current policies, procedures and protocols of the

- local EMS agency.
 - c. Base Hospital voice communication skills.
 - d. Monthly review of all ALS documentation when the patient is not transported.
- D. Investigations according to VC EMS Policy 150.
- E. Recordkeeping by ensuring that proper accountability and records are maintained regarding:
- 1. The activities of all Base Hospital physicians, MICNs and Paramedics.
 - 2. The education, audit, and evaluation of base hospital personnel
 - 3. Communications by base hospital personnel
- F. Communication equipment operation by ensuring that the base hospital ALS field personnel communication/ telemetry equipment is staffed and operated at all times by personnel who are properly trained and authorized in its use according to the policies, procedures and protocols of VC EMS.
- G. Base Hospital liaison by ensuring:
- 1. Base Hospital physician and PCC representation at Prehospital Services Committee and other appropriate committee meetings
 - 2. Ongoing liaison with EMS provider agencies and the local medical community.
 - 3. On-going liaison with the local EMS agency.
- H. Ensuring compliance with Base Hospital Designation Agreement.

Altered Neurologic Function										
ADULT	PEDIATRIC									
BLS Procedures										
If suspected stroke, refer to VC EMS Policy 705.26 – Suspected Stroke Administer oxygen as indicated If low blood sugar suspected • Oral Glucose o PO – 15 gm	If suspected stroke, refer to VC EMS Policy 705.26 – Suspected Stroke Administer oxygen as indicated If low blood sugar suspected • Oral Glucose o PO – 15 gm									
ALS Prior to Base Hospital Contact										
IV Access Determine Blood Glucose level <u>If <60</u> • D10W - Preferred o IVPB-100mL (10gm)-Rapid Infusion • D5W o IVPB-200mL (10gm)-Rapid Infusion • D50W o IV – 25mL (12.5gm) • Glucagon (If no IV access) o IM – 1mg Recheck Blood Glucose level 5 min after D10W, D5W D50, or 10 min after Glucagon administration <u>If still < 60</u> • D10W - Preferred o IVPB-150ml (15gm)-Rapid Infusion • D5W o IVPB-250mL(12.5gm)- Rapid Infusion • D50W o IV – 25mL (12.5gm) * Treat as above if you have clinical suspicion of hypoglycemia and are unable to obtain glucose level due to glucometer malfunction or error reading.	Consider IV Access Determine Blood Glucose Level <u>If <60</u> • All Pediatric Patients • D10W - Preferred o IVPB-5ml/kg-Rapid Infusion o Max 100mL • D5W o IVPB-10mL/kg-Rapid Infusion o Max 200mL • Less than 2 years old • D25W o IV – 2mL/kg • 2 years old and greater • D50W o IV – 1mL/kg • All Pediatric Patients • Glucagon (If no IV access) o IM – 0.1mL/kg o Max 1 mg Recheck Blood Glucose level 5 min after D25, D50, D10W, D5W or 10 min after Glucagon administration <u>If still <60</u> • All Pediatric Patients • D10W - Preferred o IVPB-7.5mL/kg-Rapid Infusion o Max 150mL • D5W o IVPB-15mL/kg-Rapid Infusion o Max 250mL • Less than 2 years old • D25 o IV – 2mL/kg • 2 years old and greater • D50W o IV – 1mL/kg * Treat as above if you have clinical suspicion of hypoglycemia and are unable to obtain glucose level due to glucometer malfunction or error reading.									
Base Hospital Orders only										
Additional Information: • Certain oral hypoglycemic agents (e.g. - sulfonylureas) and long-acting insulin preparations have a long duration of action, sometimes up to 72 hours. Patients on these medications who would like to decline transport MUST be warned about the risk of repeat hypoglycemia for up to 3 days, which can occur during sleep and result in the patient's death. If the patient continues to decline further care, every effort must be made to have the patient speak to the ED Physician prior to leaving the scene. • If patient has an ALOC and Blood Glucose level is >60 mg/DL, consider alternate causes: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">A - Alcohol</td> <td style="width: 33%;">O - Overdose</td> <td style="width: 33%;">I - Infection</td> </tr> <tr> <td>E - Epilepsy</td> <td>U - Uremia</td> <td>P - Psychiatric</td> </tr> <tr> <td>I - Insulin</td> <td>T - Trauma</td> <td>S – Stroke</td> </tr> </table>		A - Alcohol	O - Overdose	I - Infection	E - Epilepsy	U - Uremia	P - Psychiatric	I - Insulin	T - Trauma	S – Stroke
A - Alcohol	O - Overdose	I - Infection								
E - Epilepsy	U - Uremia	P - Psychiatric								
I - Insulin	T - Trauma	S – Stroke								

Effective Date: June 1, 2017
Next Review Date: April, 2019

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



VCEMS Medical Director

Chest Pain – Acute Coronary Syndrome

BLS Procedures

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

- Hold if SBP < 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
- 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 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 attempt if not successful prior to initial BH contact

- 4 attempts total per patient

If hypotensive and signs of CHF are present or no response to fluid therapy:

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

Base Hospital Orders only

Consult ED Physician for further treatment measures

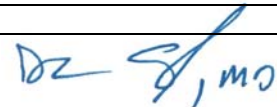
ED Physician Order Only: For ventricular ectopy [PVC's > 10/min, multifocal PVC's, or unsustained V-Tach], consider Amiodarone IVPB - 150 mg in 50mL D5W infused over 10 minutes

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

Effective Date: June 1, 2017
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Date Revised: April 13, 2017
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VCEMS Medical Director

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VCEMS Medical Director

Nerve Agent Poisoning	
The Incident Commander is in charge of the scene and you are to follow his/her direction for entering and exiting the scene. Patients in the hot and warm zones MUST be decontaminated prior to entering the cold zone.	
ADULT	PEDIATRIC
BLS Procedures	
<p><i>Patient's that are exhibiting obvious signs of exposure (SLUDGEM) of Organophosphate exposure and/or Nerve Agents</i></p> <p>Maintain airway and position of comfort</p> <p>Administer oxygen as indicated</p> <p>DuoDote for self or other rescuers</p>	<p><i>Patient's that are exhibiting obvious signs of exposure (SLUDGEM) of Organophosphate exposure and/or Nerve Agents</i></p> <p>Maintain airway and position of comfort</p> <p>Administer oxygen as indicated</p>
ALS Prior to Base Hospital Contact	
<p><i>Patient's that are exhibiting obvious signs of exposure (SLUDGEM) of Organophosphate exposure and/or Nerve Agents</i> <i>If not administered BLS:</i></p> <p>Mild Exposure: Mark 1 or DuoDote Antidote Kit IM X 1</p> <p>Moderate Exposure: Mark 1 or DuoDote Antidote Kit IM X 1</p> <ul style="list-style-type: none"> • May repeat in 10 minutes if symptoms persist <p>Severe Exposure: Mark 1 or DuoDote Antidote Kit IM X 3 in rapid succession, rotating injection sites.</p> <p><u>For seizures:</u></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 – 0.1 mg/kg <ul style="list-style-type: none"> • Max 5 mg 	<p><i>Patient's that are exhibiting obvious signs of exposure (SLUDGEM) of Organophosphate exposure and/or Nerve Agents</i></p> <ul style="list-style-type: none"> • Mark 1 or DuoDote Antidote Kit IM x 1 <ul style="list-style-type: none"> • May repeat x 1 in 10 minutes for patients greater than 40kg if symptoms persist <p><u>For seizures:</u></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
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures
<ul style="list-style-type: none"> • Refer to VCEMS Policy 705.18-Overdose/Poisoning for organophosphate poisoning treatment guidelines. • DuoDote contains 2.1mg Atropine Sulfate and 600mg Pralidoxime Chloride. • EMTs may administer DuoDote to themselves and other responders • Paramedics may administer DuoDote to themselves or other responders and to exposed, symptomatic public. • Diazepam is available in the CHEMPACK and may be deployed in the event of a nerve agent exposure. Paramedics may administer diazepam using the following dosages for the treatment of seizures: <ul style="list-style-type: none"> ○ Adult: 5 mg IM/IV/IO q 10 min titrated to effect (<i>max 30 mg</i>) ○ Pediatric: 0.1 mg/kg IV/IM/IO (max initial dose 5 mg) over 2-3 min q 10 min titrated to effect (<i>max total dose 10 mg</i>) • Mild exposure with symptoms: <ul style="list-style-type: none"> ○ Miosis, rhinorrhea, drooling, sweating, blurred vision, nausea, bradypnea or tachypnea, nervousness, fatigue, minor memory disturbances, irritability, unexplained tearing, wheezing, tachycardia, bradycardia • Moderate exposure with symptoms: <ul style="list-style-type: none"> ○ Miosis, rhinorrhea, SOB, wheezing, secretions, soft muscle weakness and fasciculations, GI effects • Severe exposure with symptoms: <ul style="list-style-type: none"> ○ Strange confused behavior, severe difficulty breathing, twitching, unconsciousness, seizing, flaccid, apnea pinpoint pupils involuntary defecation, urination 	

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



VCEMS Medical Director

Overdose/Poisoning	
ADULT	PEDIATRIC
BLS Procedures	
Decontaminate if indicated and appropriate Administer oxygen as indicated	Decontaminate if indicated and appropriate Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
IV/IO access (IO per Policy 717) Suspected opiate overdose with respirations less than 12/mi and significant ALOC: <ul style="list-style-type: none"> • Narcan <ul style="list-style-type: none"> ○ IM – 2 mg ○ IV – 0.4 mg q 1min <ul style="list-style-type: none"> • Initial max 2 mg ○ May repeat as needed to maintain respirations greater than 12/min Organophosphate Poisoning <ul style="list-style-type: none"> • Mark I or DuoDote Antidote Kit <ul style="list-style-type: none"> ○ Mild Exposure: IM x 1 ○ Moderate Exposure: IM x1 <ul style="list-style-type: none"> • May repeat in 10 minutes if symptoms persist ○ Severe Exposure: IM x 3 in rapid succession, rotating injection sites 	IV/IO access (IO per Policy 717) Suspected opiate overdose with respirations less than 12/min: <ul style="list-style-type: none"> • Narcan <ul style="list-style-type: none"> ○ IV/IM/IO – 0.1 mg/kg <ul style="list-style-type: none"> • Initial max 2 mg ○ May repeat as needed to maintain respirations greater than 12/min Organophosphate Poisoning <ul style="list-style-type: none"> • Mark I or DuoDote Antidote Kit x 1 <ul style="list-style-type: none"> ○ May repeat x 1 in 10 minutes for patients greater than 40kg if symptoms persist
Base Hospital Orders only	
Tricyclic Antidepressant Overdose <ul style="list-style-type: none"> • Sodium Bicarbonate <ul style="list-style-type: none"> ○ IV – 1 mEq/kg Beta Blocker Overdose <ul style="list-style-type: none"> • Glucagon <ul style="list-style-type: none"> ○ IV – 2 mg <ul style="list-style-type: none"> • May give up to 10mg if available Calcium Channel Blocker Overdose <ul style="list-style-type: none"> • Calcium Chloride <ul style="list-style-type: none"> ○ IV – 1 gm over 1 min • Glucagon <ul style="list-style-type: none"> ○ IV – 2 mg <ul style="list-style-type: none"> • May give up to 10 mg if available Stimulant/Hallucinogen Overdose <ul style="list-style-type: none"> • Midazolam <ul style="list-style-type: none"> ○ IV – 2 mg <ul style="list-style-type: none"> • Repeat 1 mg q 2 min as needed • Max 5 mg ○ IM – 0.1 mg/kg <ul style="list-style-type: none"> • Max 5 mg 	Tricyclic Antidepressant Overdose <ul style="list-style-type: none"> • Sodium Bicarbonate <ul style="list-style-type: none"> ○ IV/IO – 1 mEq/kg Beta Blocker Overdose <ul style="list-style-type: none"> • Glucagon <ul style="list-style-type: none"> ○ IV/IO – 0.1 mg/kg <ul style="list-style-type: none"> • May give up to 10 mg if available Calcium Channel Blocker Overdose <ul style="list-style-type: none"> • Calcium Chloride <ul style="list-style-type: none"> ○ IV/IO – 20 mg/kg over 1 min • Glucagon <ul style="list-style-type: none"> ○ IV/IO – 0.1 mg/kg <ul style="list-style-type: none"> • May give up to 10 mg if available Stimulant/Hallucinogen Overdose <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
ED Physician Order Only: Ondansetron Consult with ED Physician for further treatment measures	ED Physician Order Only: Ondansetron Consult with ED Physician for further treatment measure
Additional Information: <ul style="list-style-type: none"> • Refer to VCEMS Policy 705-17-Nerve Agent Poisoning for nerve agent exposure treatment guidelines. • If chest pain present, refer to chest pain policy. DO NOT GIVE ASPIRIN OR NITROGLYCERIN (Consult with ED Physician) • Organophosphate poisoning – SLUDGEM <ul style="list-style-type: none"> ○ S – Salivation ○ L – Lacrimation ○ U – Urination ○ D – Defecation ○ G – Gastrointestinal Distress ○ E – Elimination (vomiting) ○ M - Miosis • Narcan – it is not necessary that the patient be awake and alert. Administer until max dosage is reached <u>or</u> RR greater than 12/min. When given to chronic opioid patients, withdrawal symptoms may present. IM dosing is the preferred route of administration. <ul style="list-style-type: none"> ○ If base hospital contact cannot be made, naloxone should be administered sparingly, in doses no more than 0.1 mg every 2-3 minutes. 	

Effective Date: June 1, 2017
Next Review Date: April 2019

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



VCEMS Medical Director

Seizures	
ADULT	PEDIATRIC
BLS Procedures	
Protect from injury Maintain/manage airway as indicated Administer oxygen as indicated	Protect from injury Maintain/manage airway as indicated For suspected febrile seizures, begin passive cooling measures. If seizure activity persists, see below Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
IV/IO access Determine Blood Glucose level, and treat according to VC EMS policy 705.03 – Altered Neurologic Function Persistent Seizure Activity <ul style="list-style-type: none"> • Midazolam (Give to <i>actively seizing</i> pregnant patients prior to magnesium) <ul style="list-style-type: none"> • IV/IO – 2 mg Repeat 1 mg q 2 min as needed Max 5 mg • IM – 0.1 mg/kg Max 5 mg <p>FOR IV/IO 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><u>20 weeks gestation to one week postpartum & No Known Seizure History</u></p> <ul style="list-style-type: none"> • Magnesium Sulfate <ul style="list-style-type: none"> ○ IVPB – 2 gm in 50 mL D₅W infused over 5 min <ul style="list-style-type: none"> • MUST Repeat x 1 • Slow or stop infusion if bradycardia, heart block, or decreased respiratory effort occur 	Consider IV/IO access Determine Blood Glucose level, and treat according to VC EMS policy 705.03 – Altered Neurologic Function. Persistent Seizure Activity <ul style="list-style-type: none"> • Midazolam <ul style="list-style-type: none"> ○ IM – 0.1 mg/kg Max 5 mg
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures
Additional Information: <ul style="list-style-type: none"> • Patients with a known seizure disorder or uncomplicated, apparent pediatric febrile seizures, no longer seizing and with a normal postictal state, may be treated as a BLS call 	

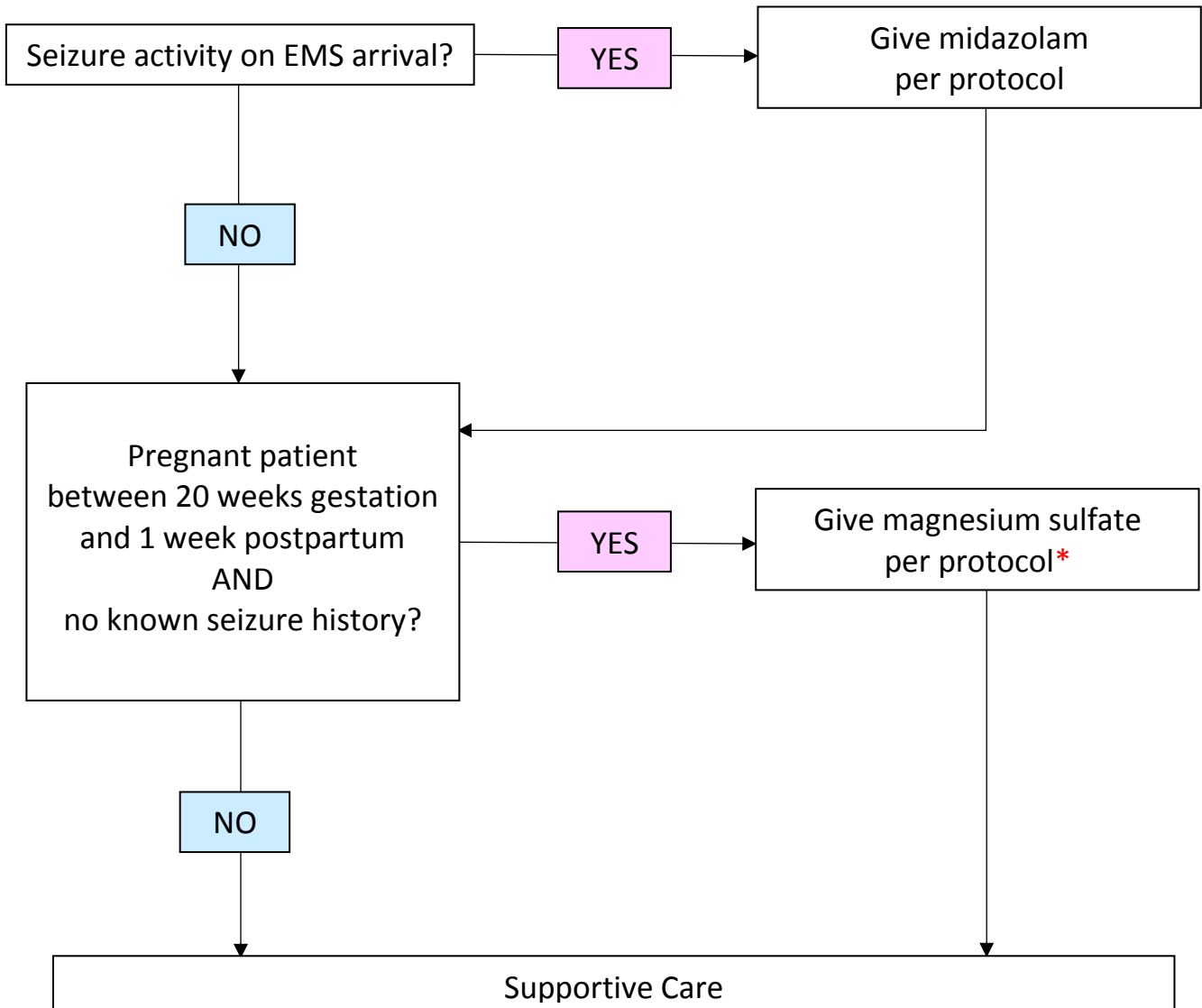
Effective Date: June 1, 2017
Next Review Date: April 2019

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



VCEMS Medical Director

Seizure Flowchart



***HOLD magnesium if
systolic BP less than 140 mm Hg
OR
diastolic BP less than 90 mm Hg**

Shortness of Breath – Pulmonary Edema

BLS Procedures

Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Nitroglycerin

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

Initiate CPAP for moderate to severe distress

Perform 12-lead ECG (Per VCEMS Policy 726)

IV access

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

- **Albuterol**
 - Nebulizer – 5mg/6mL

Communication Failure Protocol

If patient becomes or presents with hypotension

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

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

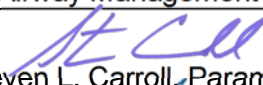

- Nitroglycerin is contraindicated when phosphodiesterase inhibitor medications [Sildenafil (Viagra and Revatio), Vardenafil (Levitra), and Tadalafil (Cialis)] have been recently used (Viagra or Levitra within 24 hours; Cialis within 48 hours). These medications are most commonly used to treat erectile dysfunction or pulmonary hypertension. In this situation, NTG may only be given by ED Physician order.

Effective Date: June 1, 2017
Next Review Date: May 2019

Date Revised: May 11, 2017
Last Reviewed: May 11, 2017



EMS Medical Director

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: June 1, 2017	
APPROVED: Medical Director:	 Daniel Shepherd, MD	Date: June 1, 2017	
Origination Date:	June 1986		
Date Revised:	April 13, 2017		
Date Last Reviewed:	April 13, 2017	Effective Date: June 1, 2017	
Review Date:	April, 2019		

- 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, §100145 and §100146.
- 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 patients eight (8) years of age or older, in accordance with Ventura County Policy 705.
- 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 the air-Q.
- 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
 - B. Endotracheal Intubation (ETI)
 3. 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.
- 4. Contraindications
 - a. Traumatic brain injury – unless unable to maintain adequate airway (e.g. – persistent vomiting).
 - b. Intact gag reflex.
- 5. 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% O₂ by BVM for one minute before each attempt.
 - c. If ETI cannot be accomplished in 2 attempts, the airway shall be managed by BLS techniques.
 - d. If ETI and BLS techniques are unsuccessful, the approved alternate ALS airway device may be inserted.
- 6. Special considerations
 - a. 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.

5. Attach the CO₂ measurement device to the ETT and confirm placement (as described below).
6. Secure tube.
7. Confirmation of Placement – It is the responsibility of the paramedic who has inserted the ETT to personally confirm (using air aspiration, auscultation, and CO₂ detection/measurement) 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 both the air aspiration and the CO₂ measurement devices.
 - 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. Before inflating ETT balloon, perform the air aspiration technique.
 1. Deflate the bulb, connect to the ETT, and observe for refilling.
 2. Refilling of the bulb in less than 5 seconds indicates tube placement in trachea.
 3. If the bulb does not completely refill within 5 seconds, unless able to definitively confirm placement on repeat direct laryngoscopy, remove the ETT. Suspect delayed filling with the ETT in the trachea if the patient is morbidly obese, has fluid in the airway (pulmonary edema, aspiration, pneumonia, drowning), or the ETT is against the carina.
 - d. Inflate the ETT cuff, attach the CO₂ measurement device, and begin ventilations. During the first 5-6 ventilations, auscultate both lung fields (in the axillae) and the epigastrium.
 - e. After 6 ventilations, observe the CO₂ measurement device:

1. If a colorimetric CO₂ detector device is used for initial placement confirmation prior to capnography, observe the color at the end of exhalation. Yellow indicates the presence of >5% exhaled CO₂ and tan 2-5% CO₂. Yellow or tan indicates tube placement in the trachea. Purple indicates less than 2% CO₂ and in the patient with spontaneous circulation is a strong indicator of esophageal intubation.
 2. When capnography is applied, 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, rarely, absent. In the patient with spontaneous circulation, if a regular waveform with a CO₂ of 25 or higher is not seen, that is a strong indicator of esophageal intubation.
- f. Using information from auscultation and CO₂ measurement, determine the ETT position.
1. If breath sounds are equal, there are no sounds at the epigastrium, and the CO₂ measurement device indicates tracheal placement, secure the ETT using an ETT holder.
 2. If auscultation or the CO₂ measurement device, indicates that the ETT may be in the esophagus, immediately reevaluate the patient. If you are not CERTAIN that the ETT is in the trachea, the decision to remove the ETT should be based upon the patients overall clinical status (e.g., skin color, respirations, pulse oximetry)
 3. If breath sounds are present but unequal, the ETT position may be adjusted as needed.
- g. Once ETT position has been confirmed, reassessment, using CO₂ measurement, pulse oximetry (if able to obtain), and auscultation of breath sounds should be performed each time patient is moved.
- h. Continue to monitor the CO₂ measurement device during treatment and transportation. If a change occurs from positive

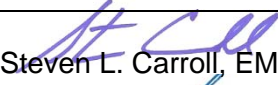

(yellow/tan) to negative (purple), or the waveform diminishes or disappears, reassess the patient for possible accidental extubation or change in circulation status.

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

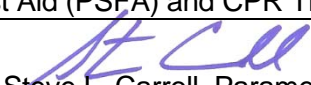

C. air-Q[®]

1. Indications, contraindications, placement and documentation in accordance with Policy 729.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: air-Q®		Policy Number: 729	
APPROVED: Administration:	 Steven L. Carroll, EMT-P	Date: June 1, 2017	
APPROVED: Medical Director:	 Daniel Shepherd, MD	Date: June 1, 2017	
Origination Date:	November 13, 2014	Effective Date: June 1, 2017	
Date Revised:	May 11, 2017		
Date Last Reviewed:	May 11, 2017		
Review Date:	May 2019		

- I. Purpose: To define the indications and use of the air-Q.
- II. Authority: California Health and Safety Code, §1798, §1798.2; §1798.160 and §1798.170, and California Code of Regulations, Title 22, §100145 and §100146.
- III. Policy: Paramedics may utilize the air-Q according to this policy and Policies 705 and 710. The air-Q may be used as the primary advanced airway device by paramedics who opt to use it during the care of a patient for whom they believe it would be the most appropriate airway management device. Alternately, the air-Q shall be used if BVM ventilation is inadequate and attempts at endotracheal intubation have failed.
- IV. Procedure:
 - A. Indications:
 1. Cardiac arrest.
 2. Respiratory arrest or severe respiratory compromise AND absent gag reflex.
 - B. Contraindications:
 1. Intact gag reflex.
 2. Weight less than 45 kg (100 pounds).
 3. Age less than 18 years.
 - C. Preparation:
 1. Sizing:
 - a. Size 3.5 (red top) for women less than 6', men less than 5'6" tall, and any patient whose mouth is too small to accept a size 4.5.
 - b. Size 4.5 (purple top) for women at least 6' and men at least 5'6" tall.
 2. There will be no more than 2 attempts, each no longer than 40 seconds.
 3. For patients in cardiac arrest, chest compressions will not be interrupted.
 4. Verify the red or purple top is securely seated on the tube.
 5. Generously lubricate the entire surface, including the mask cavity ridges.

- D. Placement:
1. Tilt the patient's head back - unless there is a suspected cervical spine injury.
 2. Open the patient's mouth and insert the air-Q so the tube is between the teeth, then elevate the tongue with thumb. The air-Q will serve as a bite block and protect fingers. A laryngoscope may be used if laryngoscopy is performed to inspect for foreign body.
 3. Direct the air-Q between the base of the tongue and the soft palate at a slight forward angle.
 4. Gently advance the air-Q into position in the pharynx by applying forward pressure on the tip of the tube while lifting up on the jaw. Stop when first resistance is felt. Inserting too deeply will worsen the seal. A rocking or wiggling motion works best.
 5. The patient's teeth should be between the tube markings.
 6. Return head to neutral position.
 7. Attach capnography airway adapter and bag-valve device and verify placement by capnography waveform.
 8. If there is any question about the proper placement (e.g., large air leak, airway resistance):
 - a. In and Out Technique: Pull the air-Q back until the bowl is visible under the tongue. Gently wiggle and advance just until a "soft stop" is reached.
 - b. Finger Flick Technique: If large air leak continues, the problem may be that the air-Q tip is still bent backward. With your right hand, pull the air-Q back until the bottom of the bowl is at the level of the teeth. Insert your left index finger, with the back of the finger against the back of the air-Q bowl, to be sure the bowl is straight.
 9. If 2 attempts at air-Q placement are unsuccessful, attempt again to ventilate the patient with BVM.
 10. Secure the air-Q with cloth strap from air-Q package.
 11. If patient vomits, do not remove tube. May turn patient on side, suction both air-Q and oropharynx.
- E. Documentation:
1. Documentation per Policy 1000.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Public Safety First Aid (PSFA) and CPR Training Program Approval		Policy Number 1101	
APPROVED: Administration:	 Steve L. Carroll, Paramedic	Date: June 1, 2017	
APPROVED: Medical Director:	 Daniel Shepherd, M.D.	Date: June 1, 2017	
Origination Date:	April 13, 2017	Effective Date: June 1, 2017	
Date Revised:	April 13, 2017		
Date Last Reviewed:	April 13, 2017		
Review Date:	April, 2020		

- I. PURPOSE: The Ventura County EMS Agency shall establish minimum requirements for Public Safety First Aid and CPR training programs.
- II. AUTHORITY: California Health and Safety Code, Title 22, Division 2.5, Sections 1797.204, 1997.210 and 1797.212; California Code of Regulations, Title 22, Division 9 Chapter 1.5
- III. POLICY: The approving authority for Public Safety First Aid (PSFA) and CPR training programs, not meeting the definition of a statewide public safety agency operating within the County of Ventura shall be the Ventura County EMS Agency (VCEMS). This does not apply to PSFA CPR programs authorized by statewide public safety agencies such as the California Highway Patrol, California State Parks, etc. and approved by the California EMS Authority This also does not apply to PSFA CPR programs authorized by the Commission on Peace Officer Standards and Training (POST) and approved by the California EMS Authority.
 - A. Programs eligible for program approval shall be limited to:
 1. A course in public safety first aid, including CPR and AED, developed and/or authorized by the California Department of Forestry and Fire Protection (Cal Fire); or
 2. A course in public safety and first aid, including CPR and AED, authorized by the Commission on Peace Officer Standards and Training (POST) and approved by the California EMS Authority. No later than 24-months from the adoption of these regulations, POST, in consultation with the California EMS Authority, shall develop the course curriculum and testing competency standards for these regulations as they apply to peace officers; or
 3. A course in public safety first aid, including CPR and AED, developed and authorized by the California Department of Parks and Recreation (DPR) and approved by the California EMS Authority; or

4. A course in public safety first aid, including CPR and AED, developed and authorized by the Department of the California Highway Patrol (CHP) and approved by the California EMS Authority; or
5. The U.S. Department of Transportation's emergency medical responder (EMR) course which includes first aid practices and CPR and AED, approved by the VCEMS; or
6. A course of at least 21 hours in first aid equivalent to the standards of the American Red Cross and healthcare provider level CPR and AED equivalent to the standards of the American Heart Association in accordance with the course content contained in Section 100017 of the California Code of Regulations, and approved by the VCEMS; or
7. An EMT or Paramedic training program approved pursuant to established VCEMS policies and procedures; or
8. An EMR course approved by the California EMS Authority, and developed and authorized by CAL FIRE, POST, DPR, CHP or other Statewide public safety agency, as determined by the California EMS Authority.

B. Approved training program course content shall meet or exceed all requirements outlined in Chapter 1.5, Section 100017 of the California Code of Regulations.

IV. PROCEDURE:

A. Program Approval

1. Eligible training programs shall submit a written request for Public Safety First Aid and CPR training program approval to VCEMS
2. VCEMS shall review and approve the following prior to approving a PSFA CPR training program:
 - a. Name of the sponsoring institution, organization, or agency.
 - b. A statement verifying the initial course of instruction shall at a minimum consist of not less than twenty-one (21) hours of first aid and CPR training.
 - c. A statement verifying CPR training equivalent to the current Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.
 - d. A detailed course outline
 - 1) Any and all optional skills, as outlined in Section 100019 of the California Code of Regulations, the program chooses to apply to

its curriculum shall have prior written authorization by VCEMS Medical Director.

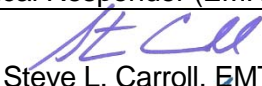

- e. Final written examination with pre-established scoring standards; and
 - f. Skill competency testing criteria, with pre-established scoring standards.
 - g. Provisions for the retraining of public safety first aid personnel in accordance with Section 100022 of the California Code of Regulations.
 - h. Educational Staff
Validation of the instructor's qualifications shall be the responsibility of the agency or organization whose training program has been approved by VCEMS. Training in public safety first aid and CPR program shall be conducted by an instructor who is:
 - 1) Proficient in the skills taught; and
 - 2) Qualified to teach by education and/or experience
 - i. Testing Requirements
 - 1) The initial and retraining course of instruction shall include a written and skills examination which tests the ability to assess and manage all of the conditions, content and skills listed in sections 100017 and 100018 of Chapter 1.5 of the California Code of Regulations
 - 2) A passing standard shall be established by the training program before administration of the examination and shall be in compliance with the standard submitted to and approved by VCEMS
 - 3) PSFA CPR training programs shall test the knowledge and skills specific in chapter 1.5 of the California Code of Regulations and have a passing standard for successful completion of the course and shall ensure competency of each skill.
 - j. Course Completion Records
PSFA CPR training programs shall outline a process for validation of course completion, in accordance with Section 100029 of the California Code of Regulations.
 - 1) A sample of the course completion certificate shall be submitted to VCEMS as part of the program approval application.
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- 2) The PSFA CPR training program shall maintain a record of the names of trainees and the date(s) on which training courses have been completed for at least four (4) years.
 - 3) All training records shall be made available for inspection by VCEMS upon request.
 - k. A table of contents listing the required information detailed in this policy with corresponding page numbers.
 - l. Facilities and Equipment
 - 1) Facilities must comfortably accommodate all students, including those with disabilities
 - 2) Restroom access must be available
 - 3) 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.
 3. Course approval is valid for four (4) years from the date of approval.
 - a. Requests for re-approval shall be submitted in the form of a formal training program approval packet and shall include all items outlined in Section IV.A.1-2
 - b. Requests for re-approval shall be submitted to VCEMS no later than sixty (60) days prior to the date of program approval expiration.
 - c. VCEMS may request additional materials or documentation as a condition of course approval and/or re-approval.
 4. Training Program Notification
 - a. VCEMS shall notify the training program submitting its request for PSFA CPR training program approval within twenty-one (21) working days of receiving the request that:
 - 1) The request for approval has been received,
 - 2) The request for approval contains or does not contain the information outlined in this policy 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 as specified in this policy.
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- c. VCEMS shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.
 - d. VCEMS shall notify the California EMS Authority concurrently with the training program of approval, renewal of approval, or disapproval of the training program, and include the effective date. This notification is in addition to the name and address of training program, name of the program director, phone number of the contact person, and program approval/ expiration date of program approval.
5. Withdrawal of Program Approval
- a. Noncompliance with any criterion required for training program approval, use of any unqualified teaching personnel, non-compliance with any provision of this policy, non-compliance with any applicable regulation outlined in the California Code of Regulations or non-compliance with any other applicable guidelines regulations or laws may result in the denial, probation, suspension or revocation of program approval by VCEMS.
 - b. Notification of non-compliance and action to place on probation, suspend, or revoke shall be done as follows:
 - 1) VCEMS shall notify the approved training program course director in writing, by registered mail, of the provisions of this Policy with which the training program is not in compliance.
 - 2) Within fifteen (15) working days of receipt of the notification of noncompliance, the approved training program shall submit in writing, by registered mail, to VCEMS one of the following:
 - a) Evidence of compliance with the provisions of this policy, or
 - b) A plan for meeting compliance with the provisions of this Chapter within sixty (60) calendar days from the day of receipt of the notification of noncompliance.
 - 3) Within fifteen (15) working days of receipt of the response from the approved training program, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the approved training program,
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VCEMS shall notify the approved 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 training program approval.

- 4) If VCEMS decides to suspend, revoke, or place an training program on probation the notification shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting of the probation or suspension or the effective date of the revocation, which may not be less than sixty (60) calendar days from the date of VCEMS's letter of decision to the training program.
6. Program Review and Reporting
 - a. All course outlines, written exams, and competency testing criteria used in an approved PSFA CPR training program shall be subject to periodic oversight and review as determined by VCEMS.
 - b. Program approval and renewal is contingent upon continued compliance with all required criteria and provisions outlined in this policy and in Chapter 1.5 of the California Code of Regulations, and may be revoked by VCEMS in accordance with section IV.4 of this policy.
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COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Emergency Medical Responder (EMR) Training Program Approval		Policy Number 1102	
APPROVED: Administration:	 Steve L. Carroll, EMT-P	Date: June 1, 2017	
APPROVED: Medical Director:	 Daniel Shepherd, M.D.	Date: June 1, 2017	
Origination Date:	April 13, 2017		
Date Revised:	May 11, 2017	Effective Date: June 1, 2017	
Date Last Reviewed:	May 11, 2017		
Review Date:	May 2020		

- 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 1.5, Section 100026
- 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, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary and Vocational Education., and approved Continuing Education Providers (CEP).
 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.
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- 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 California EMS Authority and 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.

- 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.
-