County of Ventura
Department of Public Health

Notice of Changes to Policy Manual

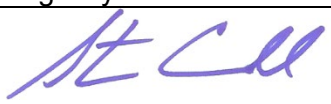
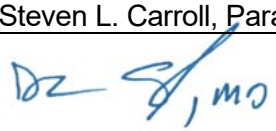
Emergency Medical Services
Policies and Procedures

To: ALL VENTURA COUNTY EMS POLICY MANUAL HOLDERS

DATE: June 1, 2024

Policy Status	Policy #	Title/New Title	Notes
Replace	100	Local Emergency Medical Services Agency	• Reviewed, No changes
NEW	122	EMS Education Committee Operating Guidelines	• New Policy Outlining Committee membership & structure.
Replace	303	EMT Optional Skills	• Updated language allowing for Accredited EMTs to perform the following: **1.** Perilaryngeal airway adjuncts (this will not be allowed until training has been completed, training will be released at a later date). **2.** Administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe. **3.** Auto-injector Atropine and Pralidoxime Chloride for treating exposure to nerve agent.
Replace	342	Notification Of Personnel Changes-Provider	• Reviewed, No changes
Replace	410	ALS Base Hospital Standards	• Added language for BH ED Physicians
Replace	420	Receiving and Stand-By Hospital Standards	• Policy title changed • Removed policy language specific to ED Physician and RN requirements, adding language pointing to requirements in Title 22 instead.
Replace	504	BLS And ALS Unit Equipment and Supplies	• Reviewed, No changes
Replace	601	MEDICAL CONTROL AT THE SCENE: EMS PREHOSPITAL PERSONNEL	• Removed EMT ALS Assist
Replace	603	Refusal of EMS Services	• Reviewed, No changes
Replace	630	Ventura County Pre-Hospital Infectious Disease Policy	• Reviewed, No changes
Replace	701	Medical Control: Paramedic Liaison Physician	• Reviewed, No changes
Replace	705.01	Trauma Treatment Guidelines	• Added language for manufactured binder with pelvic injuries.
Replace	705.04	Behavioral Emergencies	• Removed *Excited Delirium* from the Additional Notes. The use of this term is prohibited in California as a valid medical diagnosis.

Policy Status	Policy #	Title/New Title	Notes
Replace	705.05	Bites and Stings	• Removed BLS/ALS language specific to snake bites.
Replace	705.06	Burns	• Reviewed, No changes
Replace	705.11	Crush Injury/Syndrome	• Reviewed, No changes
Replace	705.14	Hypovolemic Shock	• TXA added for hemorrhagic shock not just trauma related injuries
Replace	705.17	Nerve Agent/Organophosphate Poisoning	• Removed Mark I or Duodote from ALS since it is already listed in BLS Procedures. • Added Atropine dosing to pediatric. • Moved Diazepam dosing from Additional Notes section to ALS Standing Orders section.
Replace	724	Brief Resolved Unexplained Event (BRUE)	• Changed age definition to less than 1 year. • Updated policy wording to better define BRUE. Old policy wording still had definitions and concepts used when describing ALTEs.
Replace	727	Transcutaneous Cardiac Pacing	• Reviewed, No changes
Replace	731	Tourniquet Use	• Added “high and tight” wording for tourniquet placement.
Replace	734	Tranexamic Acid Administration (TXA)	• No longer need base contact for hemorrhage outside of trauma such as GI bleed and postpartum hemorrhage.
Replace	1405	Trauma Triage and Destination Criteria	• Typo correction to one of the footnotes on the last page
Replace	1605	Naloxone Administration by Approved Public Safety First Aid Personnel	• Reviewed, No changes

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

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

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

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

A. Organizational History of the VC EMS Agency:

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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMS Education Committee Operating Guidelines		Policy Number 122
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: February 8, 2024
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: February 8, 2024
Origination Date: Date Revised: Date Last Reviewed: Review Date:	February 8, 2024 February 28, 2025	Effective Date: February 8, 2024

I. Committee Name

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

II. Committee Purpose

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

III. Membership

A. Voting Membership

Voting membership in the committee shall be composed of 1 representative per member organization, as appointed by the organization administrator.

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

B. Non-voting Membership

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

C. Membership Responsibilities

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

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

D. Voting Rights

Designated voting members shall have equal voting rights.

E. Attendance

1. Members shall remain as active voting members by attending 75% of the meetings in a (calendar) year. If attendance falls below 75%, the organization administrator will be notified and the member will lose the right to vote.

(a) Voting Members may have a single alternate attend in their place, no more than two times per calendar year.

2. The member whose attendance falls below 75% may regain voting status by attending two consecutive meetings.
3. If meeting dates are changed or cancelled by VCEMS, members will not be penalized for not attending.

IV. Committee Leadership

A. A chairperson of the EMS Education Committee will be nominated and elected by committee membership. The chairperson of the EMS education committee is the only elected member. The chairperson shall perform the duties prescribed by these guidelines and by the parliamentary authority adopted by the PSC.

B. A nominating committee, composed of 3 members, will be appointed at the regularly scheduled Winter meeting to nominate candidates for EMS Education Committee Chair. The election will take place during the Spring meeting, with duties to begin immediately thereafter.

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

V. Meetings

A. Regular Meetings

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

C. Quorum

The presence of a simple majority (1/2 of committee membership plus 1) of voting members shall constitute a quorum. The presence of a quorum at the beginning of the meeting shall allow the committee to continue to do business until adjournment, regardless of the number of members who leave during the meeting.

VI. Task Forces and Ad-hoc Committees

The EMS Education Committee Chair, VCEMS Administrator, VCEMS Medical Director or VCEMS Deputy Administrator(s) may appoint task forces or ad-hoc committees to make recommendations to the broader EMS Education Committee and/or Prehospital Services Committee (PSC) on particular issues or initiatives. The person appointing the task force or ad-hoc committee will name the chair. A task force or ad-hoc committee shall be composed of at least five (5) members and no more than ten (10) individuals. Persons other than voting members may be appointed to task forces or ad-hoc committees.

VII. Calendar Year

The EMS Education Committee will operate on a calendar year

VIII. Parliamentary Authority

The rules contained in the current edition of Robert's Rules of Order, newly revised, shall govern the organization in all cases to which they are applicable and in which they are not inconsistent with these guidelines, and any special rules of order the EMS Education Committee may adopt.

IX. Submission of Agenda Items

Agenda items shall be received by the Ventura County EMS Office at least 14 days before the meeting it is to be presented. Items may be submitted in person, via US mail, or e-mail and must include the following information:

A. Subject
B. Reason for request
C. Description/Justification
D. Supporting medical information/other research as applicable
E. List of affected VCEMS policies and/or programs as applicable

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMT Optional Skills		Policy Number 303
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: June 1, 2024
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: June 1, 2024
Origination Date: Date Revised: Date Last Reviewed: Review Date:	July 13, 2017 December 14, 2023 December 14, 2023 December 31, 2025	Effective Date: June 1, 2024

I. PURPOSE: To define the process related to authorizing EMT optional skills and EMT trial studies

II. AUTHORITY: Health and Safety Code, Section 1797.107, 1797.109, 1797.160, 1797.170, and California Code of Regulations, Title 22, Division 9, Section 100064

III. POLICY:

A. In addition to the basic and expanded skills outlined in VCEMS Policy 300 – EMT Scope of Practice, the VCEMS Medical Director may establish policies and procedures for local accreditation of an EMT student or certified EMT to perform any or all of the following optional skills specified in this policy. Accreditation for EMTs to practice optional skills shall be granted in accordance with VCEMS Policy 305 – EMT Accreditation, and will be limited to those whose:

1. EMT certification is active,
2. have completed the minimum required education and training outlined in this policy,
3. and are employed by a VCEMS approved optional skills provider.

B. Use of perilaryngeal airway adjuncts

1. Training in the use of perilaryngeal airway adjuncts shall consist of not less than five (5) hours to result in the EMT being competent in the use of the device and airway control. Included in the above training hours shall be the following topics and skills:
   a. Anatomy and physiology of the respiratory system.
   b. Assessment of the respiratory system.

c. Review of basic airway management techniques, which includes manual and mechanical.
d. The role of the perilaryngeal airway adjuncts in the sequence of airway control.
e. Indications and contraindications of the perilaryngeal airway adjuncts.
f. The role of pre-oxygenation in preparation for the perilaryngeal airway adjuncts.
g. Perilaryngeal airway adjuncts insertion and assessment of placement.
h. Methods for prevention of basic skills deterioration.
i. Alternatives to the perilaryngeal airway adjuncts.

2. At the completion of initial training a student shall complete a competency-based written and skills examination for airway management which shall include the use of basic airway equipment and techniques and use of perilaryngeal airway adjuncts.

C. Administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe for suspected anaphylaxis and/or severe asthma.

1. Training in the administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe for suspected anaphylaxis and/or severe asthma shall consist of no less than two (2) hours to result in the EMT being competent in the use and administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe and managing a patient of a suspected anaphylactic reaction and/or experiencing severe asthma symptoms. Included in the training hours listed above shall be the following topics and skills:
   a. Names
   b. Indications and contraindications
   c. Complications
   d. Side/adverse effects and interactions
   e. Routes of administration
   f. Dosage calculation
   g. Mechanisms of drug actions
   h. Medical asepsis
   i. Disposal of contaminated items and sharps
   j. Medical administration

2. At the completion of this training, the student shall complete a competency based written and skills examination for the use and/or administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe, which shall include:
    a. Assessment of when to administer epinephrine,
    b. Managing a patient before and after administering epinephrine,
    c. Using universal precautions and body substance isolation procedures during medication administration,
    d. Demonstrating aseptic technique during medication administration,
    e. Demonstrating preparation and administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe, and
    f. Proper disposal of contaminated items and sharps

D. Administration of the following medications through the use of an auto-injector for the purposes of treating exposure to a nerve agent:
1. Atropine
2. Pralidoxime Chloride
3. In addition to a basic weapons of mass destruction training, the nerve agent antidote training shall consist of no less than two (2) hours of didactic and skills training to result in competency. Training in the profile of the medications contained in the DuoDote/Mark I auto-injector and atropine auto-injector shall include, but not limited to:
    a. Indications and contraindications
    b. Side/adverse effects
    c. Routes of administration
    d. Dosages
    e. Mechanisms of drug action
    f. Disposal of contaminated items and sharps
    g. Medication administration
4. At the completion of this training, the student shall complete a competency based written and skills examination for the administration of the Duo-dote/Mark I and atropine auto-injector.
    a. Assessment of when to administer the auto-injector,
    b. Managing a patient before and after administering the auto-injector

c. Using the universal precautions and body substance isolation precautions during medication administration,
d. Demonstrating aseptic technique during medication administration,
e. Demonstrating the preparation and administration of medications by the intramuscular (IM) route, and
f. Proper disposal of contaminated items and sharps.

E. Competency training in procedures and skills for all EMT optional skills shall be completed at least every two (2) years. At a minimum, ongoing training and demonstration of competency shall be comprised of the following:
1. Review of indications and contraindications
2. Patient assessment and management before and after medication administration
3. Demonstration of appropriate aseptic technique
4. Appropriate preparation and administration of the medication by the intramuscular route utilizing the Ventura County EMS psychomotor skills evaluation form
5. Demonstration of proper disposal of contaminated items sharps.

F. VCEMS shall develop and maintain a plan for each EMT optional skill allowed. This plan will include:
1. A description of the need for use of the optional skill
2. A description of the geographic area within which the optional skills will be utilized
3. A description of the data collection methodology which shall also include an evaluation of the effectiveness of the optional skill
4. The policies and procedures to be instituted by the LEMSA regarding medical control and use of the optional skill

G. For an accredited EMT who fails to demonstrate competency in any of the optional skills outlined in this policy:
1. EMT accreditation shall be immediately suspended pending clinical remediation
2. Employer agency will submit a written plan of action to VCEMS to include: method of remediation, course curriculum, date(s) and location(s) of remediation training.
3. VCEMS will review and approve written plan of action prior to commencement of remediation training

4. Once complete, evidence of satisfactory training and minimum competency in the optional skills will be submitted to VCEMS prior to the reinstatement of the EMT accreditation.

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, Paramedic	Date: June 1, 2024
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: June 1, 2024
Origination Date: Date Revised: Last Review: Review Date:	May 15, 1987 April 8, 2021 April 11,2024 April 30, 2027	Effective Date: June 1, 2024

I. PURPOSE

To define a procedure to assure that the Ventura County Emergency Services Agency is notified of hiring, leave of absence, or termination of employment of an EMT, Paramedic or 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, leave of absence, or termination of employment of an EMT, Paramedic or MICN within 5 working days of taking action.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title ALS Base Hospital Standards		Policy Number: 410
APPROVED Administration:	Steven L. Carroll, Paramedic	Date: June 1, 2024
APPROVED Medical Director:	Daniel Shepherd, MD	Date: June 1, 2024
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 22, 1986 February 8, 2024 February 8, 2024 February 28, 2027	Effective Date: June 1, 2024

I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Base Hospital (BH) designation.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798, 1798.101, 1798.105, 1798.2 and California Code of Regulations, Title 22, Section 100175.

III. POLICY:

A. An Advanced Life Support (ALS) BH, approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:

1. Meet all requirements of an ALS Receiving Hospital (RH) per VCEMS Policy 420.
2. Have an average emergency department (ED) census of 1200 or more visits per month.
3. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics.
    a. If the communications capability of the BH is interrupted, the ALS provider and the nearest BH shall be notified immediately by telephone.
    b. ALS calls shall be routed to the nearest BH until communication capability is restored and telephone notification of the ALS provider and nearest BH is made.
    c. All equipment used for ALS communications shall operate within the frequency requirements of the Ventura County Communications Department. At the time that a countywide communication system is implemented, all ALS providers shall comply with the Ventura County Communications Department ALS communications plan.
4. Assure that communication between the BH and ALS Unit for each ALS call shall be provided only by the BH ED physician or Ventura County authorized Mobile Intensive Care Nurse (MICN) by radio or telephone.

5. Designate a Prehospital Liaison Physician (PLP) who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The PLP shall:
   a. Be regularly assigned to the ED.
   b. Have experience in and knowledge of BH operations.
   c. Be responsible for overall medical control and supervision of the ALS program within the BH's area of responsibility including review of patient care records and critique of personnel involved.
   d. Be responsible for reporting deficiencies in patient care to VCEMS.
   e. Coordinate BH activities with RH, Prehospital Services Committee (PSC) and VCEMS policies and procedures.
   f. Attend PSC meetings.
   g. Provide ED staff education.
   h. Evaluate paramedics for clinical performance and makes recommendation to VCEMS.
   i. Evaluate MICNs for authorization/reauthorization and makes recommendation to VCEMS.
6. All ED Physicians shall be certified by the American Board of Emergency Medicine OR the American Osteopathic Board of Emergency Medicine OR be Board eligible
7. Have on duty, on a 24-hour basis, one (1) MICN who meets the criteria in VCEMS Policy 321.
8. 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.
9. Provide for the CE of prehospital care personnel, paramedics MICNs, EMTs, and first responders, in accordance with VCEMS:
10. Cooperate with and assist the PSC and the VCEMS medical director in the collection of statistics and review of necessary records for program evaluation and compliance.
11. Assure that paramedics perform medical procedures only under medical direction of a physician or Ventura County authorized MICN except for approved standing orders.

12. Agree to maintain all recorded communications and prehospital data in a manner consistent with hospital data requirements. Prehospital data includes, but is not limited to, the recording of the prehospital communication, prehospital care record, paramedic BH communications form and documentation of telephone communication with the RH (if utilized). All prehospital data except the recording will be integrated with the patient chart.

B. There shall be a written agreement between the BH and VCEMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for ALS program participation as specified by State regulations and VCEMS policies and procedures.

C. The VCEMS shall review its agreement with each BH at least every two years.

D. The VCEMS may deny, suspend, or revoke the approval, of a BH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the PSC and Board of Supervisors for appropriate action.

E. A hospital wishing to become an ALS BH in Ventura County must meet Ventura County BH Criteria and agree to comply with Ventura County regulations.

1. Application:
   Eligible hospitals shall submit a written request for BH approval to VCEMS documenting the compliance of the hospital with the Ventura County BH Criteria.
2. Approval:
   a. Program approval or disapproval shall be made in writing by the VCEMS to the requesting BH within a reasonable period of time after receipt of the request for approval and all required documentation. This time period shall not exceed three (3) months.
   b. The VCEMS shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all the program requirements.
3. Withdrawal of Program Approval:
   Non-compliance of any criterion associated with program approval, use of non-certified personnel, or non-compliance with any other Ventura County regulation applicable to a BH, may result in withdrawal, suspension or revocation of program approval by the VCEMS.

F. Advanced Life Support BHs shall be reviewed every two years..

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 ED Physicians shall:		
• Be certified by the American Board of Emergency Medicine OR the American Osteopathic Board of Emergency Medicine OR be Board eligible		
6. All BH MICN's shall:		
• Be authorized in Ventura County by the VCEMS Medical Director.		
• Be assigned only to the ED while functioning as an MICN.		
• Maintain current ACLS certification.		
• Be a BH employee.		

		YES	NO
7.	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.		
8.	Provide for the CE of prehospital care personnel (paramedics MICN's, EMTs, and first responders), in accordance with VCEMS Policy 1131:		
9.	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.		
10.	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.		
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 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.		
12.	Submit a letter to VCEMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for program participation as specified by State regulations and VCEMS policies and procedures.		

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES	HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Receiving and Stand-By Hospital Standards	Policy Number 420
APPROVED Administration: Steven L. Carroll, Paramedic	Date: June 1, 2024
APPROVED Medical Director: Daniel Shepherd, MD	Date: June 1, 2024
Origination Date: April 1, 1984 Date Revised: April 11, 2024 Date Last Reviewed: April 11, 2024 Review Date: April 30, 2027	Effective Date: June 1, 2024

I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Receiving Hospital (RH) designation.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798, 1798.101, 1798.105, 1798.2 and California Code of Regulations, Title 22, Section 100175.

III. POLICY:

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

1. Be licensed by the State of California as an acute care hospital.
2. Meet the requirements of the Health and Safety Code Sections 1250-1262 and Title 22, Sections 70411, 70413, 70415, 70417, 70419, 70649, 70651, 70653, 70655 and 70657 as applicable.
3. Be accredited by a CMS accrediting agency.
4. Operate an emergency department (ED) that is designated by the State Department of Health Services as a “Comprehensive Emergency Department,” “Basic Emergency Department” or a “Standby Emergency Department.”
5. Have an intensive care service with adequate monitoring and therapeutic equipment
6. Surgical services shall be immediately available for life-threatening situations.
7. Have radiology and laboratory services as defined in Title 22, Section 7041
8. Evaluate all ambulance transported patients promptly, either by RH Physician, Private Physician or other qualified medical personnel designated by hospital policy.

9. Always have the capability to communicate with the ambulances and the Base Hospital (BH).
10. Maintain multiple forms of redundant communication, in the event a widespread disaster disables traditional methods.
    a. Existing amateur radio sites established in each receiving facility will be maintained in coordination with local emergency management agency and amateur radio organizations
11. Designate an ED Medical Director who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The Medical Director shall:
    a. Be regularly assigned to the ED.
    b. Have knowledge of VCEMS policies and procedures.
    c. Coordinate RH activities with BH, Prehospital Services Committee (PSC), and VCEMS policies and procedures.
    d. Attend, or have designee attend, PSC meetings.
    e. Provide ED staff education.
    f. Schedule medical staffing for the ED on a 24-hour basis.
12. Cooperate with and assist the PSC and EMS Medical Director in the collection of statistics for program evaluation.
13. Agree to maintain all prehospital data in a manner consistent with hospital data requirements and provide that the data be integrated with the patient's chart. Prehospital data shall include the Ventura County Electronic Patient Care Report (VCePCR), Paramedic Base Hospital communication form (from the BH), and documentation of a BH telephone communication with the RH.
14. Participate with the BH in evaluation of paramedics for reaccreditation.
15. Permit the use of the hospital helipad as an emergency rendezvous point if a State-approved helipad is maintained on hospital premises.

B. There shall be a written agreement between the RH and EMS indicating the commitment of hospital administration, medical staff, and emergency department staff to meet requirements for ALS program participation as specified by EMS policies and procedures.

C. EMS shall review its agreement with each RH at least every two years.

D. EMS may deny, suspend, or revoke the approval of a RH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Board of Supervisors for appropriate action.

E. The EMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the PSC that, as defined in the regulations, compliance with the regulation would not be in the best interests of the persons served within the affected local area.

F. A hospital that applies to become a RH in Ventura County must meet Ventura County RH Criteria and agree to comply with Ventura County regulation.

1. Application:
   Eligible hospital shall submit a written request for RH approval to the VCEMS, documenting the compliance of the hospital with the Ventura County RH.
2. Approval:
   Program approval or denial shall be made in writing by EMS to the requesting RH within a reasonable period of time after receipt of the request for approval and all required documentation. This period shall not exceed three (3) months.

G. ALS RHs shall be reviewed every two years.

1. All RH shall receive notification of evaluation from the EMS.
2. All RH shall respond in writing regarding program compliance.
3. On-site visits for evaluative purposes may occur.
4. Any RH shall notify the EMS by telephone, followed by a letter within 48 hours of changes in program compliance or performance.

H. Paramedics providing care for emergency patients with potentially serious medical conditions and are within the catchment area of a hospital with a standby emergency department, shall make immediate base contact for destination determination. Examples of these patients would include, but are not limited to, patients with:

1. Patients with seizure of new onset, multiple seizures within a 24-hour period, or sustained alteration in level of consciousness
2. Chest pain or discomfort of known or suspected cardiac origin
3. Sustained respiratory distress not responsive to field treatment
4. Suspected pulmonary edema not responsive to field treatment
5. Potentially significant cardiac arrhythmias
6. Orthopedic emergencies having open fractures, or alterations of distal neurovascular status
7. Suspected spinal cord injury of new onset
8. Burns greater than 10% body surface area

9. Drowning or suspected barotrauma with any history of loss of consciousness, unstable vital signs, or respiratory problems
10. Criteria that meet stroke, LVO, STEMI, or trauma criteria for transport to a specialty care hospital

I. A RH with a standby emergency department only, offering “standby emergency medical service,” is considered to be an alternative receiving facility. Patients may be transported to a standby emergency department when the use of the facility is in the best interest of patient care. Standby Emergency Departments shall be staffed and provide services in accordance with Title 22 section 70653.

1. Patients that require emergent stabilization at an emergency department may be transported to a standby emergency department if a basic emergency facility is not within a reasonable distance. These would include patients:
   a. In cardiac arrest with NO return of spontaneous circulation (ROSC) in the field
   b. With bleeding that cannot be controlled
   c. Without an effective airway
2. During hours of peak traffic, the Base Hospital MICN should make destination determinations based on predicted travel time and patient condition. Patients who meet criteria for trauma, stroke, LVO, or STEMI in the absence of a condition that meets I.1. above, will be directed to the appropriate destination.
3. A RH with a standby emergency department shall report to Ventura County EMS Agency any change in status regarding its ability to provide care for emergency patients.

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL
CRITERIA COMPLIANCE CHECKLIST

Receiving Hospital: _____ Date: _____

			YES	NO
A.	Receiving Hospital (RH), approved and designated by the Ventura County EMS Agency, shall:			
	1.	Be licensed by the State of California as an acute care hospital.		
	2.	Meet the requirements of the Health and Safety Code Section 1250-1262 and Title 22, Sections 70411, 70413, 70415, 70417, 70419, 70649, 70651, 70653, 70655 and 70657 as applicable.		
	3.	Be accredited by a CMS accrediting agency		
	4.	Operate an Intensive Care Unit.		
	5.	Radiology and laboratory services meet the requirements as defined in Title 22, Section 70413		
	6.	Evaluate all ambulance transported patients promptly, either by RH Physician, Private Physician, or other qualified medical personnel designated by hospital policy.		
	7.	Have the capability at all times to communicate with the ambulances and the BH.		
	8.	Designate an Emergency Department Medical Director who shall be a physician on the hospital staff, licensed in the State of California, and have experience in emergency medical care. The Medical Director shall:		
		a. Be regularly assigned to the Emergency Department.		
		b. Have knowledge of VC EMS policies and procedures.		
		c. Coordinate RH activities with Base Hospital, Prehospital Services Committee (PSC), and VCEMS policies and procedures.		
		d. Attend or have designee attend PSC meetings.		
		e. Provide Emergency Department staff education.		
		f. Schedule medical staffing for the ED on a 24-hour basis.		
	9.	Cooperate with and assist the PSC and EMS Medical Director in the collection of statistics for program evaluation.		
	10.	Agree to maintain all prehospital data in a manner consistent with hospital data requirements and provide that the data be integrated with the patient's chart. Prehospital data shall include the VCePCR, paramedic Base Hospital communication form (from the BH), and documentation of a BH telephone communication with the RH.		
	11.	Participate with the BH in evaluation of paramedics for reaccreditation.		
	12.	Permit the use of the hospital helipad as an emergency rendezvous point if a State-approved helipad is maintained on hospital premises.		
B.	There shall be a written agreement between the RH and EMS indicating the commitment of hospital administration, medical staff, and emergency department staff to meet requirements for employment as specified by EMS policies and procedures.			

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

STAND-BY RECEIVING HOSPITAL PHYSICIAN
CRITERIA COMPLIANCE CHECKLIST

Physician Name: _____ Date: _____

All Emergency Department physicians shall:			YES	NO
1.	Be immediately available to the RH ED at all times.			
2.	Be certified by the American Board of Emergency Medicine OR the American Osteopathic Board of Emergency Medicine OR be Board eligible OR have all of the following:			
	a.	Have and maintain current ACLS certification.		
	b.	Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.		
	c.	Have and maintain current Advanced Trauma Life Support (ATLS) certification.		

The above named physician is:

1)	Full-time staff: A physician who practices emergency medicine 120 hours per month or more, and/or		
2)	Regular part-time staff: A physician who see 90 patients or more per month in the practice of emergency medicine (Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month, Physicians working in more than one hospital may total their hours, Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician)		

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

STAND-BY RECEIVING HOSPITAL
EMERGENCY DEPARTMENT
ADDITIONAL CRITERIA COMPLIANCE
CHECKLIST

Receiving Hospital w/Standby ED:_____ Date: _____

	EMS REVIEW	
The RH with standby ED shall:	YES	NO
A. Be staffed and provide services in accordance with Title 22 section 70653.		
B. Report to Ventura County EMS Agency any change in status regarding Its ability to provide care for emergency patients during the current 2-year evaluation period.		
E. Receive authorization by the Ventura County EMS Agency medical director to receive patients requiring emergency medical services, in order to provide for the best interests of patient care.		
COMMENTS		

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

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

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

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

IV. DEFINITIONS:

BLS – Basic Life Support Unit

ALS – Advanced Life Support Unit

PSV – Paramedic Support Vehicle or Paramedic Supervisor Vehicle

CCT – Critical Care Transport Unit

BLS Command – Basic Life Support Staffed Command Vehicle

FR/ALS – First Responder Advanced Life Support Unit

Search and Rescue – Sheriff's SAR Helicopter Unit

V. PROCEDURE:

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

Deviation from the standards outlined in this policy shall only be authorized with written approval (see attached Equipment/Medication Waiver Request form) from the VCEMS

Medical Director. Mitigation attempts should be documented in the comment section on the waiver request form, such as what vendors were contacted, etc.

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

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

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

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

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

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

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

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: MEDICAL CONTROL AT THE SCENE: EMS PREHOSPITAL PERSONNEL	Policy Number: 601
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2024
APPROVED: Medical Director: Daniel Shepherd, MD	Date: June 1, 2024
Origination Date: October 1, 1993 Date Revised: April 11, 2024 Date Last Reviewed: April 11, 2024 Review Date: April 30, 2027	Effective Date: June 1, 2024

I. PURPOSE: To establish guidelines for medical control at the scene of a medical emergency.

II. AUTHORITY: California Health and Safety Code, Sections 1797.220, and 1798.6

III. POLICY: Authority for patient health care management in an emergency shall be vested in that licensed and/or certified health care professional, which may include any paramedic or other prehospital emergency medical personnel, at the scene of an emergency who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency. (Health and Safety Code, Section 1796(a))

IV. PROCEDURE: The following shall be utilized to determine authority for medical control on scene:

A. Prehospital care personnel, certified and/or accredited in Ventura County, have authority for health care management in the following ascending order:

1. EMT
2. Paramedic, operating in accordance with established Ventura County EMS Agency policies and procedures, under medical control from a BH, or who is providing care under the direct order of a physician on scene.
    a. This does not allow the paramedic to receive orders from medical personnel at the scene who are not MD's or DO's. This order is determined by training hours, scope of practice, and available supplies and equipment.

3. The first paramedic on scene assumes initial medical control of the patient. Medical Control of the patient and the best course of patient care will be determined by paramedics on scene, in conjunction with the base hospital MICN/base physician (when indicated). In all cases, transfer of medical control and/or patient care will be done in a coordinated fashion.

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

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

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

III. DEFINITIONS:

Adult – person 18 years of age or older

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

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

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

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

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

Declination of transport and/or assessment – when a patient requests BLS level services but declines transport and/or assessment. These patients meet defined criteria

for declining such services and lack any complaints or exam findings indicative of an emergent medical condition.

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

Emancipated minor – a person under 18 years of age who has been legally separated from their parents and lives independently, minors on military duty, married minors, minors who are pregnant and minors who parents.

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

Incident: Any response involving any Ventura County pre-hospital personnel to any event in which there is an actual victim, or the potential for a victim

Minor – person under 18 years of age.

Patient Contact: Any encounter involving Ventura County pre-hospital personnel with any person consenting, either implied or informed, to assessment and/or treatment.

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

Criteria for Refusal - Adults and emancipated minors may decline services if they meet the criteria for refusal. Persons who refuse care must demonstrate capacity and be free of impairment due to drugs and/or alcohol. Parents of minors and the dedicated decision makers for adults who lack capacity can decline services for others if they themselves meet the criteria for refusal.

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

IV. POLICY:

A. Adults and emancipated minors with decision-making capacity have the right to dictate the scope of their medical care. EMS has an obligation to offer service.
B. For unaccompanied minors, refer to VCEMS Policy 618.
C. All potential patients at the scene of an EMS response shall be offered evaluation, treatment, and transport.
D. Providing care establishes a therapeutic relationship and the expectations therein.
E. Not all EMS patients require ALS care and/or transport.
F. Patients declining care and/or transport should be counseled thoroughly about the pertinent risks of declining such interventions and all discussions should be documented thoroughly.
G. BLS providers with concern for an emergency medical condition shall request an ALS provider for an ALS level assessment.
H. Only adults and emancipated minors may decline services if they meet the criteria for refusal. Persons who refuse care must demonstrate capacity and be free of impairment due to drugs and/or alcohol. Parents of minors and the dedicated decision makers for adults who lack capacity can decline services for others if they themselves meet the criteria for refusal.
I. Provider agencies may require additional documentation over and above the minimum requirements outlined in this policy.

V. PROCEDURE**:**

A. Cancellation
   1. No ePCR is required if:
      a. Cancelled en route prior to arrival
      b. Cancelled by another agency upon arrival at the scene of the incident
      c. Cancelled after arrival and no patient contact as defined in Section III

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

C. Declination of Transport and/or Assessment
   1. Patients with minor injuries or illness, or those in need of strictly BLS interventions, shall be evaluated and treated per protocol.
   2. Adults and emancipated minors may decline any or all assessment, treatment, transport, and be released from EMS care when;
      a. Refusal criteria has been met.
      b. No present indication for ALS assessment, treatment, and/or base hospital contact as defined by VCEMS policy 704.
   3. Minors and those lacking capacity may be released from care if a parent or dedicated decision maker is present and meets criteria listed above.
   4. Documentation per VCEMS Policy 1000 – Documentation of Prehospital Care.
   5. Discuss the risks of declining and document the discussion in your narrative.

D. AMA

1. Patient has evidence of an emergency medical condition, required an ALS intervention, or has a complaint and/or condition as described in VCEMS policy 704.
2. Engage the patient in a discussion detailing the following;
    a. Potential benefits of further treatment, EMS assessment, transport.
    b. Potential benefits to additional assessment by ED physician, observation, and/or diagnostics not available in the EMS environment.
    c. Relevant medical concerns and risks of refusal.
    d. Patient resources and/or plans for obtaining follow up care after refusal of EMS services.
3. Contact base hospital for further assistance and/or to document AMA.
4. Direct communication between the MICN and/or base hospital physician and patient is encouraged.
5. Adults and emancipated minors may be released by ALS providers when;
    a. Base hospital contact has been made.
    b. Refusal criteria has been met
6. These are high-risk contacts for patients, providers, and EMS agencies. Therefore, they must be completed in a thorough and thoughtful manner. This includes detailed documentation of the history, exam, and all pertinent discussions.
7. Have patient and witness complete relevant AMA documentation.
8. If patient does not meet criteria outlined above, or AMA is discouraged by the base hospital, Law enforcement and/or Crisis Team may be requested to the scene and efforts to convince the patient to agree to transport should be continued.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Ventura County Pre-Hospital Infectious Disease Policy	Policy Number 630
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2024
APPROVED: Medical Director Daniel Shepherd, M.D.	Date: June 1, 2024
Origination Date: December 30, 2021 Date Revised: December 30, 2021 Date Last Reviewed: December 14, 2023 Review Date: December 31, 2025	Effective Date: June 1, 2024

I. PURPOSE: To provide direction to prehospital emergency personnel when responding to patients with potential infectious diseases and formalize response to infectious disease threats to implement best practices in an efficient manner. Furthermore, the intent is to provide minimum standards to protect providers/patients and to mitigate infectious disease transmission.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.220,1797.188. California Code of Regulations, Title 22, Division 9 Section 100062, 100063, 100145 and 100146. ASPR TRACIE EMS Infectious Disease Playbook as a reference guide.

III. DEFINITIONS:

A. Transmission Based Precautions: Supplemental infection control measures to be used in addition to Standard Precautions for patients who may be infected or colonized with a communicable disease. Basic infection control to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents.

B. Emergency Medical Dispatcher (EMD): Personnel who receive emergent and non-emergent calls and dispatch responding units to the scene of an incident.

C. Prehospital Responders: Includes any person or agency who responds to the scene of an incident.

D. Screening: A process for evaluating the possible presence of a particular problem.

IV. PROCEDURE

A. Safe response by Emergency Medical Services (EMS) requires a cooperative effort and ongoing assessment to evaluate safety risks by following below:

1. EMDs will identify possible infectious disease patients when taking 911 calls through screening questions and provide potential infectious disease information to responding prehospital emergency personnel prior to arriving on scene.
2. EMD's and prehospital responders should be aware of local disease scenarios, communicable disease surges, clusters, and/or outbreaks. These notifications may be distributed by Ventura County EMS Agency, California Health Alert Network (CAHAN), and/or Public Health "Hot Tips". The screening questions for highly infectious pathogens may be adapted for local area outbreaks.
3. Prehospital responders need to remain vigilant and further evaluate patients when they arrive on-scene to re-assess and determine the appropriate level of precautions. Re-assessment may require the need to change the type of infection control precautions suggested by dispatch when arriving on-scene.
4. Screening for pathogens involves questioning patients about recent travel to high-risk areas and their signs/symptoms. The timeframe for these conditions varies. For example, the screening time frame for Middle East Respiratory Syndrome (MERS) is 14 days but Ebola Virus Disease/Viral Hemorrhagic Fever (EVD/VHF) requires a screening time frame of 21 days. A general timeline of 21 days may be used for suspected infectious disease screening consistency.
5. Fever may be a helpful sign/symptom but should not be used exclusively to determine the type of precaution needed.
6. Avoid direct contact with patients who have a high suspicion of serious communicable disease until the appropriate level of PPE can be determined and safely donned. Strict transmission-based precautions based on the patient's clinical information is essential to avoid contact with infectious bodily fluids, droplets, and airborne particles.
7. If COVID-19 is suspected or novel influenza with potential for pandemic: Refer to Appendix A: Ventura County EMS Agency SARS CoV-2 Prehospital Guidelines.

8. If EVD/VHF/Ebola is suspected, stage at a safe distance. Notify EMS Duty Officer and request augmented response. Refer to Appendix B: Ventura County EMS Agency Ebola Guidelines.
9. Destination hospital must be notified of potential infectious disease by EMS personnel prior to patient arrival. If base hospital contact is made, the base hospital will notify the destination/receiving hospital of patient status and infectious disease precaution level.
10. Responding agencies in the County of Ventura shall assure that employees are properly instructed on the use of protective equipment in accordance with the manufacturer's instructions per Cal OSHA regulations.

V. INFECTIOUS DISEASE PRECAUTION LEVELS

A. All transmission-based precautions include standard precaution measures. These are recommended minimum standards, and providers are encouraged to error on the side of caution when encountering a potentially infectious patient. Refer to Appendix C: CDC PPE for donning and doffing direction. Refer to Appendix D Guidelines for Isolation Precautions.

1. Standard Precautions: Hand hygiene, gloves, mask, eyewear
2. Contact Precautions: Gown
3. Droplet Precautions: Goggles or face shield, mask on patient if possible
4. Airborne Precautions: NIOSH approved N-95, mask on patient if possible
5. Special Respiratory Precautions: NIOSH approved N-95, gown, mask on patient if possible
6. VCEMSA SARS-CoV-2 Guidelines: Augmented Response (Appendix A) - NIOSH approved N-95, goggles or face shield, gown, mask on patient if possible
7. EVD-VHF/Ebola Precautions: Augmented Response (Appendix B) - Stage, notify EMS Duty Officer, and request augmented response

VI. CONSIDERATIONS

A. Resources not immediately needed may consider staging to limit potential infectious disease exposure to personnel.
B. When possible, a mask should be placed on patients with suspected potential infectious respiratory diseases.

C. When a determination of suspected infectious disease is difficult to determine, assume the highest level of contagious threat and use the appropriate level of protection.

D. Prehospital responders may consider assessing infectious disease potential from six feet away when arriving on-scene as appropriate to determine the level of precautions required.

E. If the medical personnel driving the transporting ambulance is not isolated, they must also wear the appropriate respiratory protection during transport even when not in direct patient contact.

F. American Medical Response houses a High-Risk Ambulance (HRA) in Ventura County for augmented medical transport needs. Refer to Appendix D: High Risk Ambulance Operations

G. Patients and their caregivers may find prehospital responders wearing high levels of personal protective equipment (PPE) alarming. Responders should be mindful of this potential and work to reassure patients while taking reasonable measures to address their distress.

H. Hand hygiene is one of the best ways to remove infectious contaminates, avoid getting sick and prevent the spread of infectious disease.

I. Circulate ambulance cabin air and utilize ambulance ventilation system.

J. Unprotected exposure to a suspected/confirmed communicable disease will be reported in accordance with VCEMSA Policy 612-Notification of Exposure to a Communicable Disease.

VII. APPENDICES

i. Ventura County EMS Agency SARS CoV-2 Prehospital Guidelines
Ventura County EMS Agency Ebola Guidelines

ii. CDC PPE

iii. Guidelines for Isolation Precautions

iv. High Risk Ambulance Operations

vi. VCEMSA Policy 612-Notification of Exposure to a Communicable Disease

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, Paramedic	Date: June 1, 2024
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: June 1, 2024
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 1, 1988 January 9, 2014 April 11, 2024 April 30, 2027	Effective Date: June 1, 2024

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.

Trauma Assessment/Treatment Guidelines 705.01

I. Purpose: To establish a consistent approach to the care of the trauma patient

A. Rapid trauma survey

1. Airway

a. Maintain inline cervical stabilization

1) Follow spinal precautions per VCEMS Policy 614

b. Open airway as needed

2) Utilize a trauma jaw thrust to maintain inline cervical stabilization if indicated

c. Suction airway if indicated

d. Insert appropriate airway adjunct if indicated

2. Breathing

a. Assess rate, depth and quality of respirations

b. If respiratory effort inadequate, assist ventilations with BVM

c. Assess lung sounds

d. Initiate airway management and oxygen therapy as indicated

1) Maintain SpO2 ≥ 94%

3. Circulation

a. Assess skin color, temperature, and condition

b. Check distal/central pulses and capillary refill time

c. Control major bleeding

d. Initiate shock management as indicated

4. Disability

a. Determine level of consciousness (Glasgow Coma Scale)

b. Assess pupils

5. Exposure

a. If indicated, remove clothing for proper assessment/treatment of injury location, always maintaining patient dignity

b. Always maintain patient body temperature

B. Detailed physical examination

1. Head

a. Inspect/palpate skull

b. Inspect eyes, ears, nose and throat

2. Neck

a. Palpate cervical spine

b. Check position of trachea

c. Assess for jugular vein distention (JVD)

3. Chest

a. Visualize, palpate, and auscultate chest wall

4. Abdomen/Pelvis
    a. Inspect/palpate abdomen
    b. Assess pelvis, including genitalia/perineum if pertinent
5. Extremities
    a. Visualize, inspect, and palpate
    b. Assess Circulation, Sensory, Motor (CSM)
6. Back
    a. Visualize, inspect, and palpate thoracic and lumbar spines

C. Trauma care guidelines

1. Fluid Administration
    a. Maintain SBP of ≥ 80 mmHg
        1) Patients 65 years and older, maintain SBP of ≥ 100 mmHg
        2) Pediatric patients, maintain minimum systolic for respective age in Handtevy
        3) Isolated head injuries, maintain SBP of ≥ 100 mmHg
2. Tranexamic Acid (TXA) Administration
    a. Patients 15 years of age and older as indicated in VCEMS Policy 734
3. Head injuries
    a. General treatments
        1) Evaluate head and face – maintain high index of suspicion for injury if significant mechanism of injury is present or physical examination is remarkable for findings
        2) Elevate head 30° unless contraindicated
        3) Do not attempt to intubate head injured patients unless unable to manage with BLS airway measures
        4) Do not delay transport if significant airway compromise
    b. Penetrating injuries
        1) DO NOT REMOVE IMPALED OBJECT (unless airway obstruction is present)
        2) Stabilize object manually or with bulky dressings
    c. Facial injuries
        1) Assess airway and suction as needed
        2) Remove loose teeth or dentures if present
    d. Eye injuries
        1) Remove contact lenses
        2) Irrigate eye thoroughly with suspected acid/alkali burns
        3) Avoid direct pressure
        4) Place eye shield over injured eye only
        5) Ask patient to keep eyes closed
        6) Stabilize any impaled object manually or with bulky dressing

4. Spinal cord injuries
    a. General treatments
        1) Evaluate spinal column – maintain high index of suspicion for injury if significant mechanism of injury is present or physical examination is remarkable for findings
        2) Place patient in supine position if hypotension is present
    b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
        1) Stabilize object manually or with bulky dressings
        2) Control bleeding if present
        3) In the presence of isolated penetrating injuries, spinal motion restriction is contraindicated
    c. Neck injuries
        1) Monitor airway
        2) Control bleeding if present
5. Thoracic Trauma
    a. General treatments
        1) Evaluate chest – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
        2) Keep patients sitting high-fowlers
            a. In the presence of isolated penetrating injuries, spinal motion restriction is contraindicated
    b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
        a) Remove object if CPR is interfered
        b) Stabilize object manually or with bulky dressings
        c) Control bleeding if present
    c. Flail Chest/Rib injuries
        a) Assist ventilations if respiratory status deteriorates
    d. Pneumothorax/Hemothorax
        a) Keep patient sitting high-fowlers
        b) Assist ventilations if respiratory status deteriorates1.
            1) Suspected tension pneumothorax should be managed per VCEMS Policy 715
    e. Open (Sucking) Chest Wound
        a) Place an occlusive dressing to wound site, secure on 3 sides only or place a vented chest seal.
        b) Assist ventilations if respiratory status deteriorates

f. Cardiac Tamponade – If suspected, expedite transport
    a) Beck's Triad
        1) Muffled heart tones
        2) JVD
        3) Hypotension
g. Traumatic Aortic Disruption
    a) Assess for quality of radial and femoral pulses
    b) If suspected, expedite transport

6. Abdominal/Pelvic Trauma
a. General Treatments
    1) Evaluate abdomen and pelvis – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
b. Blunt injuries
    1) Place patient in supine position if hypotension is present
c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
    1) Stabilize object manually or with bulky dressings
    2) Control bleeding if present
d. Eviscerations
    1) DO NOT REPLACE ABDOMINAL CONTENTS
        a) Cover wound with saline-soaked dressings
    2) Control bleeding if present
e. Pregnancy
    1) Place patient in left-lateral position to prevent supine hypotensive syndrome
f. Pelvic injuries
    1) All providers must be knowledgeable in the application of a commercial binder or sheet. Correct application is essential.
    2) Assessment of pelvis should be only performed ***ONCE*** to limit additional injury
    3) Control external bleeding if present
    4) Place a commercial binder or sheet if pelvic injury is suspected and patient is hemodynamically unstable (see step one for parameters).
    5) Empirically place a binder or sheet if patient is in cardiac arrest due to a blunt or blast injury.
    6) **Consider** applying a binder or sheet in patients with suspected pelvic injury **without** hemodynamic instability.

7. Extremity Trauma
a. General Treatments

1) Evaluate CSM distal to injury
   a) If decrease or absence in CSM is present:
      (1) Attempt to reposition extremity into anatomical position
      (2) Re-evaluate CSM
   b) If no change in CSM after repositioning, splint and expedite transport
   c) Cover open wounds with sterile dressings
   d) Place ice pack on injury area (if closed wound)
   e) Splint/elevate extremity with appropriate equipment
   f) Uncontrolled hemorrhage: Tranexamic Acid – For patients 15 years of age and older as indicated in VCEMS Policy 734

b. Dislocations
   1) Splint in position found with appropriate equipment

c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECTS
   1) Stabilize object manually or with bulky dressings
   2) Control bleeding if present

d. Femur fractures
   1) Utilize traction splint only if isolated mid-shaft femur fracture is suspected
   2) Assess CSM before and after traction splint application

e. Amputations
   1) Clean the amputated extremity with NS
   2) Wrap in moist sterile gauze
   3) Place in plastic bag
   4) Place bag with amputated extremity into a separate bag containing ice packs
   5) Prevent direct tissue contact with the ice pack

Behavioral Emergencies

ADULT	PEDIATRIC

BLS Procedures

Administer oxygen as indicated

ALS Standing Orders

ADULT	PEDIATRIC
IV/IO Access For Extreme Agitation • **Midazolam** ○ IM – 0.2 mg/kg, Max 10 mg ○ IV / IO – 0.1 mg/kg, Max 4 mg	IV/IO Access For Extreme Agitation • **Midazolam** ○ IM – 0.1 mg/kg, Max 5 mg ○ IV / IO – 0.1 mg/kg, Max 4 mg

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

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

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

Bites and Stings

BLS Procedures

Animal/insect bites:

- Flush site with sterile water
- Control bleeding
- Apply bandage

Snake bites/envenomation:

- Mark the edge of the inflammatory process ASAP and then every 10-15 minutes
- Remove rings and constrictions
- Immobilize the affected part in a ***neutral*** position
- Avoid excessive activity

Bee stings:

- If present, quickly remove stinger
- Apply ice pack

Jellyfish stings:

- Rinse thoroughly with normal saline
  - ***DO NOT***:
    - Rinse with fresh water
    - Rub with wet sand
    - Apply heat

All other marine animal stings:

- If present, remove barb
- Immerse in hot water if available

Administer oxygen as indicated

ALS Standing Orders

IV/IO Access

Monitor for allergic reaction or anaphylaxis

Pain Control– per Policy 705.19

Base Hospital Orders Only

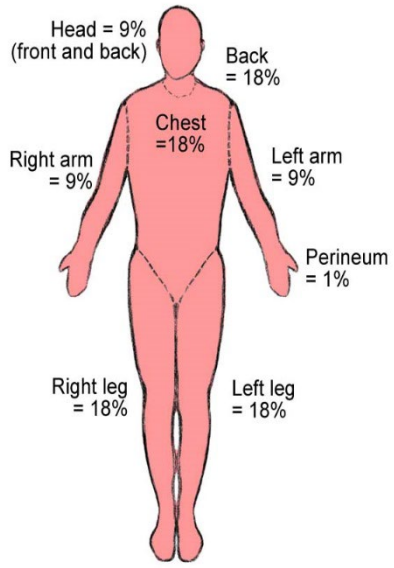
Consult with ED Physician for further treatment measures

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

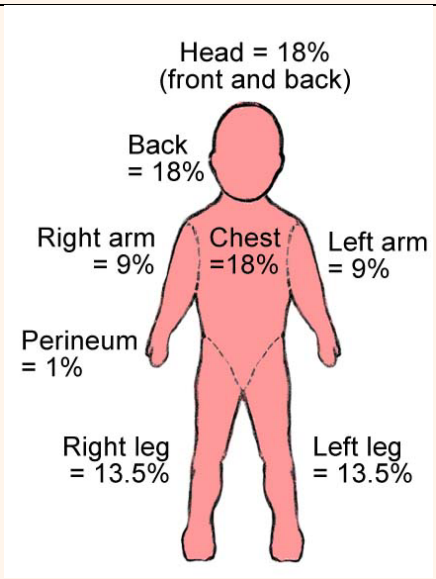
VCEMS Medical Director

Burns

ADULT



PEDIATRIC



BLS Procedures

- Stop the burning process
  - Thermal
    - Put out fire using water or some other non-hazardous, non-flammable liquid. Fire extinguisher may be used.
  - Liquid Chemical
    - Flush area with water.
  - Powdered Chemical
    - Brush off as much as possible prior to flushing area with copious amounts of water.
  - Electrical
    - Turn off power source and safely remove victim from hazard area.
- Remove rings, constrictive clothing and garments made of synthetic material
- If less than 10% Total Body Surface Area (TBSA) is burned, cool with saline dressings.
- For TBSA greater than 10%, cover burned area with dry sterile dressings first, followed by a clean dry sheet.
- Once area is cooled, remove saline dressings and cover with dry, sterile burn sheets
- Elevate burned extremities if possible
- Maintain body heat at all times
- Administer oxygen as indicated

ALS Standing Orders

ADULT	PEDIATRIC

IV/IO access
Pain Control – per Policy 705.19
 	
If TBSA greater than 10% or hypotension is present:
• **Normal Saline**
  ○ IV/IO bolus – 1 Liter
	IV/IO access
	Pain Control – per Policy 705.19
	
	If TBSA greater than 10% or hypotension is present:
	• **Normal Saline**
	  ○ IV/IO bolus – 20 mL/kg

Base Hospital Orders Only

Consult with ED Physician for further treatment measures

Additional Information

- Hypothermia is a concern in patients with large body surface area burns. As moist dressings increase the risk of hypothermia, medication is the preferred method of pain control in these patients.

Crush Injury/Syndrome

ADULT	PEDIATRIC

BLS Procedures

Perform spinal precautions as indicated
Determine Potential vs. Actual Crush Syndrome
Administer oxygen as indicated
Maintain body heat

ALS Standing Orders

Potential for Crush Syndrome
- IV/IO access
- Release compression
- Monitor for cardiac dysrhythmias

Crush Syndrome
- Initiate 2nd IV/IO access
- **Normal Saline**
  - IV/IO bolus – 1 Liter
- **Sodium Bicarbonate**
  - IV/IO mix – 1 mEq/kg
    - Added to 1st Liter of Normal Saline
- **Albuterol**
  - Nebulizer – 5 mg/6 mL
    - Repeat as needed
- **Pain Control**– Per Policy 705.19
- Release compression
- Monitor for cardiac dysrhythmias
- For cardiac dysrhythmias:
  - **Calcium Chloride**
    - IV/IO slow push – 1 g over 1 min

For continued shock
- *Repeat* **Normal Saline**
  - IV/IO bolus – 1 Liter

For persistent hypotension after fluid bolus:
- **Epinephrine 10 mcg/mL**
  - IV/IO slow push - 1 mL (10 mcg) every 2 minutes
  - Titrate to SBP of greater than or equal to 90 mm/Hg

Crush Syndrome
- Initiate 2nd IV/IO access if possible or establish IO
- **Normal Saline**
  - IV/IO bolus – 20 mL/kg
- **Sodium Bicarbonate**
  - IV/IO mix– 1 mEq/kg
    - Added to 1st Normal Saline bolus
- **Albuterol**
  - **Patient ≤ 30 kg**
    - Nebulizer – 2.5 mg/3 mL
      - Repeat as needed
  - **Patient > 30 kg**
    - Nebulizer – 5 mg/6 mL
      - Repeat as needed
- **Pain Control**– Per Policy 705.19
- Release compression
- Monitor for cardiac dysrhythmias
- For cardiac dysrhythmias:
  - **Calcium Chloride**
    - IV/IO slow push – 20 mg/kg over 1 min

For continued shock
- *Repeat* **Normal Saline**
  - IV/IO bolus – 20 mL/kg

For persistent hypotension after fluid bolus:
- **Epinephrine 10 mcg/mL**
  - IV/IO slow push - 0.1 mL/kg (1 mcg/kg) every 2 minutes
  - Max single dose of 1 mL or 10 mcg
  - Titrate to SBP of greater than or equal to 80 mm/Hg

Base Hospital Orders Only

Consult with ED Physician when orders are needed for interventions within scope but not addressed in policy

Additional Information:
- Potential Crush Syndrome – Continuous crush injury to torso or extremity above wrist or ankle for 2 hours or less.
- Crush Syndrome – Continuous crush injury to torso or extremity above wrist or ankle for greater than 2 hours.
- Dysrhythmias are usually secondary to Hyperkalemia. ECG monitor may show: Peaked T-waves, Absent P-waves, widened QRS complexes, bradycardia
- Calcium Chloride and Sodium Bicarbonate precipitate when mixed. Strongly consider starting a second IV (if feasible) for administration of Calcium Chloride

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

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

VCEMS Medical Director

Nerve Agent / Organophosphate 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

Patients that are exhibiting obvious signs (SLUDGEM) of organophosphate exposure and/or nerve agents

Maintain airway and position of comfort

Administer oxygen as indicated

- **Mark I or DuoDote Antidote Kit (If Available)**
  - Mild Exposure: IM x 1
    - May repeat in 10 minutes if symptoms persist
  - Severe Exposure: IM x 3 in rapid succession, rotating injection sites

ALS Standing Orders

When Mark I or DuoDote Antidote kit is not available:

- **Atropine**
  - Mild or Severe Exposure:
  - IV/IO – 2 mg
  - May repeat q 5 minutes for persistent symptoms

If CHEMPAK deployed:

- **Diazepam**
  - IM/IV/IO – 5 mg
  - q 10 minutes titrated to effect
  - Max 30 mg

When Mark I or DuoDote Antidote kit is not available:

- **Atropine**
  - Mild or Severe Exposure:
  - IV/IO – 0.05 mg/kg mg
  - May repeat q 5 minutes for persistent symptoms

If CHEMPAK deployed:

- **Diazepam**
  - IM/IV/IO - 0.1 mg/kg
  - q 10 min titrated to effect
  - Max single dose 5 mg
  - Max total dose 10 mg

Base Hospital Orders Only

Consult with ED Physician for further treatment measures

Additional Information:

- DuoDote contains 2.1 mg Atropine Sulfate and 600 mg Pralidoxime Chloride.
- **Diazepam** is available in the CHEMPACK and may be deployed in the event of a nerve agent exposure.
- Mild Exposure symptoms:
  - Miosis, rhinorrhea, drooling, sweating, blurred vision, nausea, bradypnea or tachypnea, nervousness, fatigue, minor memory disturbances, irritability, unexplained tearing, wheezing, tachycardia, bradycardia, SOB, muscle weakness and fasciculations, GI effects.
- Severe Exposure:
  - Abnormal behavior, severe difficulty breathing, twitching, unconsciousness, seizing, flaccid, apnea, involuntary defecation, urination.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Brief Resolved Unexplained Event (BRUE)		Policy Number: 724
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: June 1, 2024
APPROVED: Medical Director	Daniel Shepherd, MD	Date: June 1, 2024
Origination Date: Date Revised: Date Last Reviewed: Review Date:	March, 2005 April 11, 2024 April 11, 2024 April 30, 2026	Effective Date: June 1, 2024

I. PURPOSE: To define and provide guidelines for the recognition, assessment and treatment of infants with a Brief Resolved Unexplained Event (BRUE).

II. AUTHORITY: Health and Safety Code, Sections 1797.220 and 1798.

III. POLICY: All EMS personnel should be knowledgeable with BRUE and follow the guidelines listed below.

IV. PROCEDURE:

A. Recognition:

1. BRUE is used to describe an event occurring in an infant less than 1 year of age when the observer reports a sudden, brief, and now resolved episode of 1 or more of the following:
    a. Cyanosis or pallor
    b. Absent, decreased, or irregular breathing
    c. Marked change in tone (hyper- or hypotonia)
    d. Altered level of responsiveness
2. These events are characterized as “brief” (less than 1 minute and usually less than 20 – 30 seconds) and “resolved” (meaning the patient returned to baseline state of health after the event).
3. BRUEs are also “unexplained,” meaning that a clinician is unable to explain the cause of the event after an appropriate history and physical examination.
4. High and Low-risk Infants
    a. High-risk infants
        i. Infants less than 2 months of age
        ii. History of prematurity (higher in infants born at less than 32 weeks)
        iii. More than one event
    b. Low-risk infants

i. Age greater than 60 days
ii. Born greater than or equal to 32 weeks gestation
iii. Corrected gestational age is greater than or equal to 45 weeks
iv. First event (no previous BRUE ever and not occurring in clusters)
v. Event lasted less than 1 minute
vi. No CPR by trained medical provider
vii. No concerning historical features
viii. No concerning physical examination findings

c. Infants who have experienced a BRUE who do not qualify as lower-risk patients are, by definition, at higher risk.

B. Assessment and Treatment

1. Perform a physical exam that includes general appearance, skin color, extent of interaction with the environment, and evidence of current or past trauma.
   Note: Exam May Be Normal.
2. Obtain medical history, family history, and history of the event.
3. Treat any identifiable causes as indicated.
4. Base Hospital contact required.

C. Precautions

1. In most cases, the infant will have a normal physical exam when assessed by healthcare providers. The parent/caregiver's perception that "something is or was wrong" must be taken seriously. **Assume the history given is accurate**.
2. Keep in mind, especially if the parent/guardian declines transport to the hospital, that child abuse may be a cause of the BRUE symptoms listed above.
   a. If child abuse is suspected, refer to the reporting guidelines in VCEMS Policy 210.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Transcutaneous Cardiac Pacing	Policy Number: 727
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2024
APPROVED: Medical Director Daniel Shepherd, MD	Date: June 1, 2024
Origination Date: December 1, 2008 Date Revised: January 27, 2022 Date Last Reviewed: February 28, 2024 Next Review Date: February 28, 2026	Effective Date: June 1, 2024

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

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

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

IV. PROCEDURE:

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

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

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

C. Contraindications:

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

D. **Patient Treatment**

1. Patient assessment and treatment per 705: Bradycardia treatment protocol. If IV/IO access not promptly available, proceed to pacing.
2. Explain procedure to the patient.
3. Place pacing electrodes and attach pacing cable to pacing device per manufacturer's recommendations.
4. Set pacing mode to demand mode, pacing rate to 70 BPM, and current at 40 milliamps (mA), or manufacturer recommendation.
5. If required, provide patient pain relief. Patients with profound shock and markedly altered level of consciousness may not require pain relief
6. Activate pacing device and increase the current in 10 mA increments until capture is achieved (i.e., pacemaker produces pulse with each paced QRS complex).
7. Assess patient for mechanical capture and clinical improvement (BP, pulses, skin signs, LOC).

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

E. **Documentation**

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

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES	HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Tourniquet Use	Policy Number: 731
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2024
APPROVED: Medical Director: Daniel Shepherd, MD	Date: June 1, 2024
Origination Date: July 2010 Date Revised: April 11, 2024 Date Last Reviewed: April 11, 2024 Review Date: April 30, 2026	Effective Date: June 1, 2024

I. Purpose: To define the indications, procedure and documentation for tourniquet use by EMTs and paramedics.

II. Authority: Health and Safety Code, Sections 1797.220 and 1798.

III. Policy: EMTs and Paramedics may utilize tourniquets on patients in accordance with this policy.

IV. Procedure:

A. Indications

1. Life threatening extremity hemorrhage that cannot be controlled by other means.

B. Contraindications

1. Non-extremity hemorrhage.
2. Proximal extremity location where tourniquet application is not practical.

C. Relative Contraindications

1. AV fistulas: Bleeding fistulas are best managed with firm direct pressure. Applying a tourniquet can ruin a fistula and should be a last resort. Base contact prior to applying a tourniquet is encouraged but not required.

D. Tourniquet Placement:

1. Visually inspect injured extremity and avoid placement of tourniquet over joint, angulated or open fracture, stab or gunshot wound sites.
2. Assess and document circulation, motor and sensation distal to injury site.
3. Apply tourniquet proximal to wound (usually 2-4 inches). Tourniquet may be applied “high and tight” (as proximal as possible) in the following situations:
   a. There is an active threat that warrants the need for rapid application and extraction (direct threat / hot or warm zone operations).

b. The injury site is not readily apparent, or there are multiple injuries to the same extremity.

4. Tighten tourniquet rapidly to least amount of pressure required to stop bleeding.
5. Cover wound with appropriate sterile dressing and/or bandage.
6. Do not cover tourniquet- the device must be visible.
7. Re-assess and document absence of bleeding distal to tourniquet.
8. Remove any improvised tourniquet that may have been previously applied.
9. Tourniquet placement time must be documented on the tourniquet device.
10. Ensure receiving facility staff is aware of tourniquet placement and time tourniquet was placed.

D. Tourniquet removal, replacement, or repositioning

1. BLS providers may reposition an improperly placed tourniquet or replace malfunctioning device. Only ALS personnel may formally remove a tourniquet to assess if it is still necessary.
2. Indications
   a. Improperly placed tourniquet
   b. Poorly functioning device
   c. Absence of bleeding distal to the tourniquet should be confirmed after manipulation, adjustment, or removal.
3. Procedure
   a. Obtain IV/IO access
   b. Maintain continuous ECG monitoring.
   c. If repositioning or replacing a tourniquet, place a second tourniquet proximal to the first device in the appropriate location.
   d. Hold firm direct pressure over wound for at least 5 minutes before releasing a tourniquet.
   e. Gently release the initial tourniquet and monitor for reoccurrence of bleeding.
   f. If appropriate, document the time the tourniquet was released.
   g. Bandage wound and re-assess and document circulation, motor and sensation distal to the wound site regularly.
   h. If bleeding resumes, requiring a tourniquet, re-application will be in accordance with application procedures outlined in Section IV of this policy.

E. Documentation

1. All tourniquet uses must be documented in the Ventura County Electronic Patient Care Reporting System.
2. Documentation will include location of tourniquet, time of application, and person at the receiving hospital to whom the tourniquet is reported.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Tranexamic Acid (TXA) Administration	Policy Number 734
APPROVED: Administration: Steve L. Carroll, Paramedic	Date: June 1, 2024
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: June 1, 2024
Origination Date: January 10, 2019 Date Revised: March 7, 2024 Date Last Reviewed: March 7, 2024 Review Date: March 31, 2026	Effective Date: June 1, 2024

I. PURPOSE: To define the indications, contraindications, and procedure related to administration of Tranexamic Acid (TXA) by paramedics.

II. AUTHORITY: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Sections 100145 and100169.

III. POLICY: Paramedics may administer TXA to patients presenting with hypovolemic shock secondary to trauma in accordance with this policy. Base hospital physician may order TXA to be administered for indications other than those listed below.

IV. PROCEDURE:

A. Indications

1. Blunt or penetrating traumatic injury with SBP less than or equal to 90mmHg
2. Significant hemorrhage not controlled by direct pressure, hemostatic agents, or tourniquet application **AND** SBP less than or equal to 90 mmHg
3. Consider for other severe hemorrhage with SBP less than or equal to 90 mmHg (e.g., GI Bleed, postpartum hemorrhage)

B. Contraindications

1. Greater than 3 hours post injury
2. Isolated neurogenic shock
3. Isolated extremity injury when bleeding has been controlled
4. Patient less than 15 years of age
5. Active thromboembolic event (within the last 24 hours); i.e., stroke, myocardial infarction, pulmonary embolism or DVT
6. History of hypersensitivity or anaphylactic reaction to TXA
7. Traumatic arrest without ROSC
8. Drowning or hanging victims

C. Precautions
    1. Severe kidney disease
    2. Pregnancy
D. Adverse Effects
    1. Chest Tightness
    2. Difficulty Breathing
    3. Facial flushing
    4. Swelling in hands and feet
    5. Blurred vision
    6. Hypotension with rapid IV infusion
E. Preparation
    1. Supplies Needed:
        i. 1g Tranexamic Acid (TXA) (1)
        ii. 100mL bag of 0.9% normal saline (1)
        iii. 10mL syringe (1)
    2. Maintain sterile technique
    3. Mixing Instructions
        i. Inject 1g (10mL) of TXA into 100 mL NS bag
    4. Label bag with the drug name and final concentration
        i. Example: (TXA 1g in 100mL NS)
F. Dosing
    1. IV/IO - 1g in 100mL Normal Saline over 10 minutes
G. Communication and Documentation
    1. Communicate the use of TXA to the base hospital
    2. Administration of TXA and any/all associated fields will be documented in the Ventura County electronic Patient Care Report (VCePCR)

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

I. PURPOSE: To guide out-of-hospital personnel in determining which patients require the services of a designated trauma center. To serve as the EMS system standard for triage and destination of patients suffering acute injury or suspected acute injury.

II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798. California Code of Regulations, Title 22, §100252 and §100255.

III. POLICY: These criteria apply to any patient who is injured or has a physical complaint related to trauma and is assessed by EMS personnel at the scene.

A. Physiologic Criteria, Step 1:

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

B. Anatomic Criteria, Step 2:

1. Penetrating injuries to the head, neck, torso, or extremities proximal to elbow or knee
2. Chest wall instability, deformity, or suspected flail chest
3. Suspected two or more proximal long-bone fractures (femur, humerus)
4. Crushed, degloved, mangled or pulseless extremity
5. Amputation proximal to wrist or ankle
6. Suspected pelvic fracture
7. Skull deformity, suspected skull fracture

8. Acute paralysis, extremity weakness, or sensory loss possibly due to spinal cord injury
9. Seat belt injury: significant bruising to neck, chest, or abdomen
10. Diffuse abdominal tenderness as a result of blunt trauma
11. Active bleeding requiring a tourniquet or wound packing with continuous pressure

C. Mechanism of Injury Criteria, Step 3:

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

D. Special Patient or System Considerations, Step 4 (these are considerations to be used by the base hospital in determining the appropriate destination hospital):

1. Age 65 years and older
2. Low level falls with significant head impact in ages < 5 years or 65 years and older
3. Burns with trauma mechanism
4. Time sensitive extremity injury (open fracture, neurovascular compromise)
5. Pregnancy > 20 weeks with known or suspected abdominal trauma
6. Prehospital care provider or MICN judgment
7. Amputation or partial amputation of any part of the hand[1]
8. Penetrating injury to the globe of the eye, at risk for vision loss
9. Anticoagulation use[2]

IV. PROCEDURE:

A. Any patient who is suffering from an acute injury or suspected acute injury shall have the trauma triage criteria applied.

B. For patients who meet trauma triage criteria listed in Sections A, B, or C above, the closest trauma center is the base hospital for that patient. Paramedics shall make base hospital contact and provide patient report directly to the trauma center.

C. Transportation units (both ground and air) shall transport patients who meet at least one of the trauma triage criteria in Sections A or B to the closest appropriate designated trauma

center. If the closest trauma center is on internal disaster, these patients shall be transported to the next closest appropriate trauma center. If the closest trauma center is on CT diversion, the paramedic shall make early base contact and the MICN shall determine the most appropriate destination.

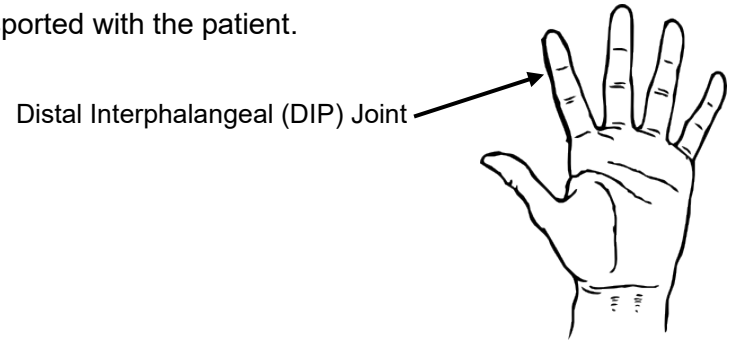
D. For patients who meet trauma triage criteria in Section C, the paramedic shall make base hospital contact with the closest designated trauma center. Based on the paramedic's report of the incident and the patient's assessed injuries, the trauma center MICN or ED physician shall direct destination to either the trauma center or the closest appropriate hospital.

E. Paramedics providing care for patients who are injured but meet only the trauma triage criteria listed in Section D above will contact the base hospital in whose catchment area the incident occurred. Destination will be determined by the base hospital MICN or ED physician. If the patient is directed other than to the regular catchment base hospital, the MICN will notify the receiving hospital or trauma center of an inbound patient and relay paramedic report.

F. A trauma patient without an effective airway may be transported to the closest available hospital with an emergency department for airway management prior to transfer to a designated trauma center. In this rare event, the paramedic will contact the base hospital in whose catchment area the incident occurred.

G. A patient who does not meet trauma triage criteria and who, in the judgment of a base hospital, has a high probability of requiring immediate surgical intervention or other services of a designated trauma center shall be directed to a designated trauma center.

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



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

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

I. PURPOSE:

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

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

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

III. POLICY:

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

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

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

IV. PROCEDURE:

A. Indications

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

B. Contraindications

1. Known allergy to naloxone hydrochloride

C. Relative Contraindications

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

D. Intranasal (IN) Naloxone Administration

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

4. Open airway using established Basic Life Support techniques, Provide supplemental oxygen and assist ventilations, if authorized, per VCEMS Policy 1604 – Oxygen Administration and Basic Airway Adjunct Use by PSFA Personnel
5. Perform CPR as indicated.
6. Administer intranasal naloxone
    a. Naloxone 4mg IN
    b. May repeat dose, if no improvement in patient condition, x 1 (total of 2 doses)
7. If response to naloxone and patient is a suspected chronic opiate user, prepare for possible narcotic reversal behavior or withdrawal symptoms (agitation and vomiting)
8. Report administration of nasal naloxone to prehospital personnel for additional assessment and follow-up care, as needed.
9. Document administration of naloxone as indicated per PSFA agency policies and procedures.
    a. On a monthly basis, law enforcement agencies that administer naloxone shall report all cases to the Ventura County EMS Agency using the established reporting form (Attachment A)

Ventura County EMS Agency

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

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

PSFA Agency Name: _____

Review Month: _____

Current Program Coordinator: _____

☐ No Utilizations
(*check here if applicable)*

OR

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

Program Coordinator Signature:_____ Date:_____

Program Notes/Comments:

For VCEMS Use Only

Received Date	Reviewed Date	Reviewed By
/ /	/ /	