Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	April 12, 2012 9:30 a.m.

I.	**Introductions**		
II.	**Approve Agenda**		
III.	**Minutes**		
IV.	**Medical Issues**		
	A.	Stroke Discussion	
	B.	705.09:	Chest Pain – Acute Coronary Syndrome
	C.	CPR Audit	
	D.	Other	
V.	**New Business**		
	A.	Policy 504:	BLS And ALS Unit Equipment And Supplies
	B.	Policy 705.14:	Hypovolemic Shock
	C.	Policy 1404:	Emergent/Urgent Transfer.
	D.	Policy 1407:	Emergency Trauma Transfer – for deletion
	E.	PSC Chairperson Election	
	F.	Other	
VI	**Old Business**		
	A.	Sidewalk CPR	
	B.	Other	
VII.	**Informational Topics**		
	A.	Other	
VIII.	**Policies for Review**		
	A.	Policy 410:	ALS Base Hospital Approval Process
	B.	Other	
IX.	**Reports**		
	TAG Report		
X.	**Agency Reports**		
	A.	ALS Providers	
	B.	BLS Providers	
	C.	Base Hospitals	
	D.	Receiving Hospitals	
	E.	ALS Education Programs	
	F.	EMS Agency	
	G.	Other	
XI.	**Closing**		

TEMPORARY
PARKING PASS
Expires April 12, 2012

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

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

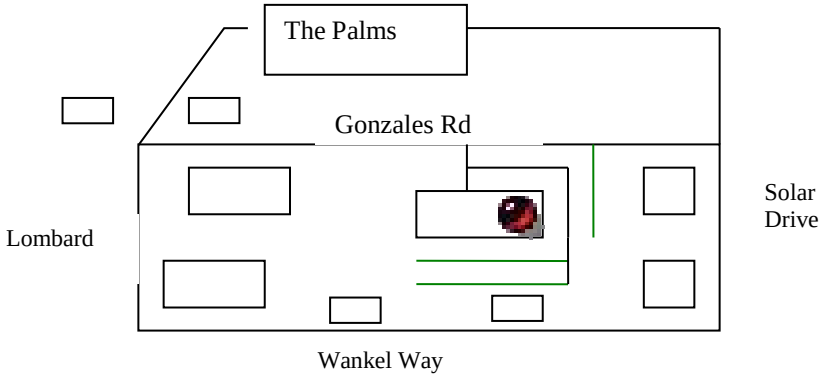
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

2240 Gonzales Rd. location
If you park in a designated "green permit parking" slot, fold this flyer in half and place pass face-up on the dash of your car, to avoid receiving a ticket.

2100 Solar Drive
An additional amount of "Green Permit Parking" spaces (only 30) are available in adjacent parking lot, those that back-up against venue parking area, (Enter this parking lot off of Gonzales[3rd driveway] or Solar Drive). **Place this flyer on your dash.** If all of those stalls are occupied, overflow parking is available at The Palms shopping area or side streets.

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

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



Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Minutes	February 9, 2012 9:30 a.m.

Topic	Discussion	Action	Assigned
I. Introductions			
II. Approve Agenda		Agenda approved as submitted.	
III. Minutes		Minutes approved as submitted March meeting has been cancelled	
IV. Medical Issues			
A. Policy 726: 12-Lead ECG	• Mostly language clean up and making policy in line with current practice. • Oxygen use for specific cases only. • Original, scanned EKGs need to be scanned and sent to EMS • Discussion regarding ROSC. • Positive STEMI EKG will be turned into the SRC • Change in the policy section to allow specially trained EMTs to set up a 12 lead. This is included in the ALS Assist training to set up. • STEMI alone will require a hard copy even when ePCR is completely functional. All others could be electronic. • Currently – download is not being done until the patient has been placed in the hospital bed. • In the future, as soon as an ACUTE MI is suspected, the monitor needs to be uploaded for hospital review prior to the patient being delivered to the hospital.	D.7 – Positive EKG original handed over to the medical practitioner. Change in the policy section to allow specially trained EMTs to set up a 12 lead. "Personnel specially trained…."	Approved with change.
B. Stroke Discussion	EMS is intending to move forward with the	One large meeting will be	

Topic	Discussion	Action	Assigned
	December 1 deadline for hospitals to triage patients using the Cincinnati stroke scale. This will be used to triage patients to a primary stroke center. Need to set up a meeting with the hospitals to see where everyone is in the process. This will be scheduled in the next couple weeks.	scheduled for all hospitals to discuss. Any concerns or questions, please forward to Dr. Salvucci.	
C. Other			
V. New Business			
A. Cardiac Arrest Management/ART/BART Presentation – C. Panke	Presentation by C. Panke regarding ART/BART program. • CPR study looked at seated vs. standing CPR in a moving ambulance • Smartman mannequin was used to measure compliance • Recommendation was to be seated doing CPR and be safe. • 14 participants • Body mechanics needs to be looked at. • Reuters Health interviewed the participants • We all take CPR courses from different instructors and get a different message each time • Propose that we all learn the same thing with the proposal of a new way to do CPR • Technology has improved but survival rates remain steady • Primary directive is continuous quality compressions. Our directive to staff will be compressions continuously from the moment of arrest until the return of spontaneous circulation is assured • Rate, depth and compression recoil will ensure continuous perfusion • We are going to adopt a new method of training • Training method and process was discussed		
B. Sidewalk CPR – S. Carroll	VCEMS will be participating on June 7 in a statewide program along with American Heart Association that which involves a 5 minute hands on presentation to the public on how to do “Hands only CPR”. We would like participation from all of our providers to man the booths and need a contact person. This should take about 5 minutes only with each person. This will involve media attention and are excited to push this out. Packet of information will be sent out shortly.		Contact person to Steve Carroll

Topic	Discussion	Action	Assigned
	CARES outcome data is excellent and we are in the top tier of all areas that review outcome cardiac arrest data. Educating the public will bump the survival of more patients.		
C. Other			
VI Old Business			
A. Other			
VII. Informational Topics			
A. 1406: Trauma Center Standards – K. Hadduck	In February the changes to this policy was approved. Trauma surgeon needs to be available within one hour if the ED physician needs consultation.		Approved
B. Other	ITD trial information research report was presented at the National Association of EMS Physicians earlier this month. 3 abstracts were presented, two by Dr. Chase and one by C Panke. The study is still on-going. The research has been looked at with great interest around the country Summary of information presented: Study 1 • Cardiac arrest outcome with King airway placement and ITD improvement • Outcome • Saw rise in end tidal CO2 • No significant improvement with use • Combination did work in systemic perfusion but at the cost of cerebral perfusion • Looking at period 1 and 3 saw a trend upward with bystander witnessed v-fib Study 2 - Pig study • Study involved 9 pigs • Pig was put into arrest, waited 5 minutes before doing anything before starting CPR • We switched back and forth between different devices, so one device was not always the first epiglottic airway device used • Each time you put in Supraglottic airway device you saw a significant infusion of carotid blood flow • Combi-tube came out consistently the worse • The study revealed that all Supraglottic airway devices had problems • Lower the drop, the worse results		

Topic	Discussion	Action	Assigned
	The main information that came out of both studies is that the Supraglottic airway may not be the best device for a cardiac arrest patient		
VIII. Policies for Review			
A. Policy 330: EMT/Paramedic/MICN Decertification and Discipline		No changes, review only. M/S/C (T. Norton/C.Panke) to approve the policy as submitted	Approved
B. Policy 410: ALS Base Hospital Approval Process	Bottom first page, BH MD will that be PLP or ED MD? BH meetings, possible deletion	Suggestions to S. Lara-Jenkins	Policy tabled
C. Policy 624: Patient Medication		No changes, review only. M/S/C (T. Norton/C.Panke) to approve the policy as submitted	Approved
D. Policy 722: Interfacility Transport of Patients with IV Heparin	Training – provider is responsible for training	No changes, review only. M/S/C (T. Norton/C.Panke) to approve the policy as submitted	Approved
E. Policy ll31: Field Care Audit		Tape changed to recording in policy Correct typo	Approved
F. Policy 1205: Air Unit Specifications, Equipment and Supplies		No changes, review only. M/S/C (T. Norton/C.Panke) to approve the policy as submitted	Approved
G. Other	Dispatch issue with helicopter timeframe for ground ambulance dispatch. Helicopter will not automatically dispatch until 25 minutes. Follow-up – Heliport understanding and review, process seems to be working. Will ask for review again in a couple months.		SAR review in a couple months. Will report back.
IX. Reports			
A. TAG Report:	Most significant change is the merge of ALS/BLS committees. All other status quo. Additional CQI studies will be discussed at the next meeting.		

Topic	Discussion	Action	Assigned
X. Agency Reports			
A. ALS Providers	VNC – ePCR is ongoing. Pretty successful roll-out. 2000 reports so far. Norm thanked Chris and Dave. Ongoing, but successful so far. VEN – Station 4 has re-opened in November 2011.		
B. BLS Providers	OFD – academy starting on March 19th. 6 firefighter candidates. ePCR started on February 1st.		
C. Base Hospitals	LRHMC – ePCR training is on-going. SVH – please see calendar for educational opportunities SJRMC – 18 candidates completed the MICN course and are proceeding through the authorization process. ePCR training is on-going. VCMC – ACS survey completed and passed. Designated as a Level 2 Trauma Center. Education is being completed for the residents		
D. Receiving Hospitals	CMH – Borchard will be closed and scheduled to reopen mid March, secondary to construction OVCH – new phone system has been installed. If calls sent to CMH, asked to be patient.		
E. ALS Education Programs	Students are now completing their hospital clinical time. Meredith thanked everyone for their help. New rotation added to FCC. Thanks were given to Chief LaPlant and Bob Heaton for setting this up		
F. EMS Agency	ePCR: Hospital training will be conducted. Messages will go out to receiving facilities to determine needs. MCI – accepting membership to restart this committee. Please contact Chris Rosa. Broselow tapes: now available. Will look at these as a system issue. Chris Rosa will chair this committee. Radios: Steve Johnston will redo radios. They will be replacing current radios with disaster radios. Currently working with County IT. Hospitals will be contacted to determine radio hardware. Disaster communication system will be installed. EMS Deputy Administrator – role will be assumed by Chris Rosa		
G. Other			
XI. Closing	**Meeting adjourned at**		

Respectfully submitted,

Debora Haney

Prehospital Services Committee 2012

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/12/2012	2/9/2012	03/08\12	4/12/2012	5/10/2012	6/14/2012	7/12/2012	8/9/2012	9/13/2012	10/11/2012	11/8/2012	12/13/2012	%
AMR															
AMR	Panke	Chad		CP											
CMH - ER	Canby	Neil		NC											
CMH - ER	Cobb	Cheryl		CC											
FFD	Herrera	Bill		BH											
FFD	Scott	Bob		BS											
GCA	Norton	Tony		TN											
GCA	Stillwagon	Mike		MS											
Lifeline	Kuroda	Brian		BK											
Lifeline	Winter	Jeff		JW											
LRRMC - ER	David	Paul													
LRRMC - ER	Licht	Debbie		DL											
OFD	Carroll	Scott		SC											
OFD	Huhn	Stephanie		SH											
OVCH	Boynton	Stephanie		SB											
OVCH	Patterson	Betsy		BP											
SJPVH	Hernandez	Sandi		SH											
SJPVH	Davies	Jeff													
SJRMC	McShea	Kathy		KM											
SJRMC - SJPVH	Larsen	Todd		TL											
SPFD	Dowd	Andrew													
SVH - ER	Tilles	Ira		IT											
SVH - ER	Hoffman	Jennie		JH											
V/College	Mundell	Meredith		MM											
VCFD	Merman	Nancy		NM											
VCFD	Tapking	Aaron		NM											
VNC	Plott	Norm		NP											
VNC	Black	Shannon		SB											
VNC	Shedlosky	Robin		RS											
VCMC - ER	Chase	David		DC											
VCMC - ER	Utley	Dede		DU											
VCMC-SPH	Daucett	Michelle													
VCMC-SPH	Beatty	Karen		KB											
VCSO SAR	Hadland	Don		DH											

Agency	LastName	FirstName	1/12/2012	2/9/2012	03/08\12	4/12/2012	5/10/2012	6/14/2012	7/12/2012	8/9/2012	9/13/2012	10/11/2012	11/8/2012	12/13/2012	%
VCSO SAR	White	Don		DW											
VFF	Rhoden	Crystal		CR											
VFF	Jones	Brad													
Eligible to Vote	**Date Change/cancelled - not counted against member for attendance**														
Non Voting Members															
EMS	Carroll	Steve		SC											
AMR	Drehsen	Charles		CD											
VCMC	Duncan	Thomas		TD											
EMS	Fisher	Barry													
LMT	Frank	Steve		SF											
EMS	Hadduck	Katy		KH											
EMS	Haney	Debora													
EMS	Lara-Jenkins	Stephanie		SLJ											
EMS	Rosa	Chris		CR											
EMS	Salvucci	Angelo													
SAR	Askew	Chris													
CSUDA	Parker	Pilar													
OFD	Donabedian	Chris													
VNC	Komins	Mark		MK											
AMR	Glass	Gil		GG											
VNC	Gregson	Erica		EG											

Chest Pain – Acute Coronary Syndrome

BLS Procedures

Administer oxygen if dyspnea, signs of heart failure or shock, or SAO2 < 94%
Assist patient with prescribed Nitroglycerin as needed for chest pain
- Hold if SBP < 100 mmHg

ALS Prior to Base Hospital Contact

Perform 12-lead ECG
- If "***ACUTE MI SUSPECTED***" is present, expedite transport to closest STEMI Receiving Center
- Document all initial and ongoing rhythm strips and ECG changes

For continuous chest pain consistent with ischemic heart disease:
- **Nitroglycerin**
  - SL or lingual spray – 0.4 mg q 5 min for continued pain
    - No max dosage
    - Maintain SBP > 100 mmHg
      - If normal SBP < 100 mmHg, then maintain SBP > 90 mmHg
- **Aspirin**
  - PO – 324 mg

IV access
- 3 attempts only prior to Base Hospital contact

If pain persists and not relieved by NTG:
- **Morphine** – per policy 705 - Pain Control
  - Maintain SBP > 100 mmHg

If patient presents or becomes hypotensive:
- ~~Elevate legs~~
- **Normal Saline**
  - IV bolus – 250 mL
    - Unless CHF is present

Communication Failure Protocol

One additional IV attempt if not successful prior to initial BH contact
- 4 attempts total per patient

If hypotensive and signs of CHF are present or no response to fluid therapy:
- **Dopamine**
  - IVPB – 10 mcg/kg/min

Base Hospital Orders only

Consult ED Physician for further treatment measures

ED Physician Order Only: For ventricular ectopy [PVC's > 10/min, multifocal PVC's, or unsustained V-Tach], consider amiodarone 150 mg IVPB.

Additional Information:
- Nitroglycerin is contraindicated when erectile dysfunction medications (Viagra, Levitra, and Cialis) have been recently used (Viagra or Levitra within 24 hours; Cialis within 48 hours). NTG then may only be given by ED Physician order

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, EMT-P	Date: December 1, 2011
APPROVED: Medical Director Angelo Salvucci, MD	Date: December 1, 2011
Origination Date: May 24, 1987 Date Revised: October 14, 2011 Last Reviewed: October 14, 2011 Review Date: October 31, 2014	Effective Date: December 1, 2011

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 the requirements of this policy.

III. AUTHORITY: California Health and Safety Code Section 1797.178, 1797.204, 1797.218 and California Code of Regulations Section 10017

IV. PROCEDURE:

The following equipment and supplies shall be maintained on each Response and/or Transport Unit in Ventura County.

	ALS / BLS Unit Minimum Amount	ASV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts	~~Air Ambulance~~ ~~Minimum Amounts~~
A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS					
Clear masks in the following sizes: Adult Child Infant Neonate	1 each	1 each	1 each	1 adult 1 ~~Infant~~infant	~~1 each~~
Bag ~~Valve~~ valve ~~Units~~units Adult Child	1 each	1 each	1 each	1 adult	~~1 each~~
Nasal ~~Cannula~~cannula Adult	3	3	3	3	~~1~~
~~Nasopharyngel~~Nasopharyngeal ~~Airway~~airway (A~~a~~dult and ~~Child~~ child or equivalent)	1 each	1 each	1 each	1 each	~~1 each~~
Oropharyngeal Airways Adult Child Infant Newborn	1 each size	1 each size	1 each size	1 each size	~~1 each size~~
Oxygen with appropriate adjuncts (portability required)	10 L/min for 20 minutes	10 L/min for 20 mins.	10 L/min for 20 mins.	10 L/min for 20 mins.	~~10 L/min for 20 mins~~
Portable ~~Suction~~ suction ~~Equipment~~equipment	1	1	1	1	~~1~~
Transparent ~~Oxygen~~ oxygen ~~Masks~~masks Adult ~~Non~~ non~~Rebreather~~rebreather Child Infant	 3 3 2	 2 2 2	 2 2 2	 2 2 2	 ~~2~~ ~~2~~ ~~2~~
Bandage ~~Scissors~~scissors	1	1	1	1	~~1~~
Bandages • 4"x4" sterile compresses or equivalent • 2",3",4" or 6" roller bandages • 10"x 30" or larger dressing	 12 6	 12 2 0	 12 6 2	 5 4 2	 ~~12~~ ~~4~~ ~~2~~
Blood ~~Pressure~~ pressure ~~Cuffs~~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~~
Emesis ~~Basin~~basin/~~Bag~~bag	1	1	1	1	~~1~~
Flashlight	1	1	1	1	~~1~~
Half-ring traction splint or equivalent device	1	1	1	1	~~1~~
Pneumatic or ~~Rigid~~ rigid ~~Splints~~ splints (capable of splinting all extremities)	4	4	4	4	~~4~~
Potable water or saline solution	1 gallon	1 gallon	1 gallon	1 gallon	~~1 gallon~~
Cervical ~~S~~spine ~~Immobilization~~ immobilization ~~Device~~device	2	2	2	2	~~2~~

	ALS / BLS Unit Minimum Amount	ASV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts	Air Ambulance Minimum Amounts
Spinal Immobilization Devices KED or Equivalent 60" minimum with straps	 1 1	 1	 1 1	 1	 1
Sterile Obstetrical Kit	1	1	1	1	1
Tongue Blade	4	4	4	4	4
Cold Packs	4	4	4	4	
OPTIONAL EQUIPMENT					
Nerve Agent Antidote – (3 kits per person suggested)					
Tourniquet					
Impedance Threshold Device					
B. TRANSPORT UNIT REQUIREMENTS					
Ambulance cot and collapsible stretcher; or two stretchers, one of which is collapsible.	1	0	0	1	1
Straps to secure the patient to the stretcher or ambulance cot, and means of securing the stretcher or ambulance cot in the vehicle.	1	0	0	1	1
Ankle and wrist restraints. Soft ties are acceptable.	1	0	0	0	1
Sheets, pillow cases, blankets and towels for each stretcher or ambulance cot, and two pillows for each ambulance	1	0	0	0	1
Bedpan Pan	1	0	0	0	1
Urinal	1	0	0	0	1
Personal Protective Equipment per State Guideline #216 Rescue Helmet EMS Jacket Work Goggles Tyvek Suit Tychem Hooded Suit Nitrile Gloves Disposable Footwear Covers Leather Work Gloves Field Operations Guide	 2 2 2 2 L / 2 XXL 2 L / 2 XXL 1 Med / 1 XL 1 Box 3 L Sets 1	 1 1 1 1 L / 1 XXL 1 L / 1 XXL 1 Med / 1 XL 1 Box 1 L Set 1	 0 0 0 0 0 0 0 0 0 0	 0 0 0 0 0 0 0 0 0 0	 0 0 0 0 0 0 0 0 0 0
C. ALS EQUIPMENT					
Cellular Telephone Two-Way Radio for alternative base hospital contact	1 1	1 1	1 1	1 1	1 1
Alternate ALS Airway Device	2	1	1	1	1
Arm Boards 9” 18”	 3 3	 0 0	 1 1	 0 0	 1 1
Portable Ventilator				0	1
Blood Glucose Determination Devices	2	1	1	1	1
Cardiac Monitoring Equipment	1	1	1	1	1
CO_2 Detector or Monitor	1	1	1	1	1
Continuous Positive aAirway Pressure (CPAP) device	1	1	1	1	1
Defibrillator pads or gel	3	3	3	1 adult – No Peds.	3
Defibrillator w/adult and pediatric paddles/pads	1	1	1	1	1
EKG Electrodes	10 sets	3 sets	3 sets	6 sets	8 sets
Endotracheal Intubation Tubes, sizes 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5 with stylets	1 of each size	1 of each size	1 of each size	4, 5, 6, 6.5, 7, 7.5, 8	1 ea.+ 2.5, 3.0, 3.5, 4.0, 4.5
Intraosseous Infusion Needles	2	1	2	1	2

	ALS Unit Minimum Amount	ASV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts	~~Air Ambulance~~ ~~Minimum Amounts~~
Intravenous Fluids (in flexible containers)					
• 5% ~~Dextrose~~ Dextrose in ~~Water~~water, 50 ml	2	1	2	1	~~1~~
• Normal ~~Saline~~ saline ~~Solution~~solution, 500 ml	2	1	1	1	~~2~~
• Normal ~~Saline~~ saline ~~Solution~~solution, 1000 ml	6	2	4	3	~~4~~
~~IV Admin Set - Blood Set~~	~~2~~	~~1~~	~~1~~	~~2~~	~~1~~
IV ~~Admin~~ admin ~~Set~~ set - ~~Micro~~ micro~~Drip~~drip	4	1	2	2	~~2~~
IV ~~Admin~~ admin ~~Set~~ set - ~~Macro~~ macro~~D~~drip	4	1	4	3	~~4~~
IV ~~Catheter~~catheter, Sizes l4, l6, l8, 20, 22, 24	6 each 14, 16, 18, 20 3 each 22 3 each 24	2 each	2 each	2 each	~~2 each~~
~~IV Pump~~					~~2~~
Laryngoscope, replacement bulbs and batteries	1 set	1 set	1 set	1 set	~~1 set~~
Curved ~~Blade~~blade #2, 3, 4	1 each	1 each	1 each	1 each	~~1 each~~
Straight ~~Blade~~blade #1, 2, 3	1 each	1 each	1 each	1 each	~~1 each~~
Life ~~Vests~~vests					~~5~~
Magill ~~Forceps~~forceps	1	1	1	1	~~1~~
Child	1	1	1	1	~~1~~
Nebulizer	2	2	2	2	~~2~~
Nebulizer with in-line adapter	1	1	1	1	~~1~~
Needle ~~Thoracostomy~~ thoracostomy ~~Kit~~kit	2	2	2	2	~~2~~
Pediatric length and weight tape	1	1	1	1	~~1~~
SAO_2 ~~Monitor~~monitor	1	1	1	1	~~1~~
OPTIONAL ALS EQUIPMENT (No minimums apply)					
Flexible ~~I~~intubation ~~Stylet~~stylet					
EZ-IO intraosseous infusion system					

	ALS Unit Minimum Amount	ASV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts	Air Ambulance Minimum Amounts
D. ALS MEDICATION, MINIMUM AMOUNT					
Activated ~~Charcoal~~charcoal, ~~Adult~~ adult and ~~Pediatric~~pediatric	1	1	1	0	1
Adenosine, 6 mg ~~vials~~	3	3	3	3	6
Aspirin, 162 mg	2 ea. 162 mg or 4 ea 81 mg	2 ea. 162 mg or 4 ea 81 mg	2 ea. 162 mg or 4 ea 81 mg	2 ea. 162 mg or 4 ea 81 mg	2 ea. 162 mg or 4 ea 81 mg
Amiodarone, 50mg/ml 3ml ~~Ampul or Vial~~	6	3	6	3	6
Atropine sulfate, 1 mg/10 ml ~~Pre-load/Amp~~	2	2	2	2	2
Benadryl, 50 mg/ml~~, Pre-load/Amp~~	2	1	1	2	2
Bronchodilators, ~~Nebulized~~ nebulized ~~Beta~~beta-2 specific	6	2	3	1	3
Calcium chloride, 1000 mg/10 ml ~~Pre-load/Amp~~	2	1	1	1	1
Dextrose 50%, 25 GM/50 ~~ml~~~~Pre-load/Amp~~	5	2	2	2	2
Dopamine, 400 mg/250ml D5W, premixed	2	1	1	2	1
Epinephrine 1:1,000, 1mg/ml ~~Pre-load/Amp~~	4	2	2	2	2
Epinephrine 1:10,000, 1 mg/10ml ~~Pre-load/Amp~~	6	3	6	4	6
Epinephrine 1:1,000, 30 ml multi-dose vial	1	1	1	1	1
Glucagon, 1 mg/ml ~~Amp~~	2	1	2	1	1
Lasix, 20 mg/2ml	80 mg	40 mg	80 mg	40 mg	80 mg
Lidocaine, 100 mg/5ml ~~Pre-load~~	2	2	2	2	2
Magnesium ~~Sulfate~~sulfate, 1 gm per 2 ml	4	1	2	2	4
Morphine sulfate, 10 mg/ml ~~Ampule~~	2	2	2	2	2
Narcan, ~~Adult~~ adult and ~~Pediatric~~ pediatric doses	10 mg	4 mg	4 mg	4mg	4mg
Nitroglycerine preparations, 0.4 mg	1 bottle	1 bottle	1 bottle	1 bottle	1 bottle
Normal ~~Saline~~saline, 10 ml multi-dose vial	2	2	2	2	2
Oral ~~Glucose~~ glucose 15gm unit dose	1	1	1	1	1
Sodium bicarbonate, 50 mEq/ml ~~Pre-load~~	2	1	1	1	2
Ondansetron 4 mg IV single use vial	4	4	4	4	4
Ondansetron 4 mg oral don't-blow tablet (ODT)	4	4	4	4	4
Versed	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials

~~E. PARALYTIC AGENTS APPROVED BY AIR AMBULANCE MEDICAL DIRECTOR~~					
~~*Succinylcholine, 200 mg*~~					~~2~~
~~Vecuronium, 10 mg.~~					~~2~~

Hypovolemic Shock

ADULT	PEDIATRIC
BLS Procedures	
Evaluate patient lung sounds, if lungs clear place patient in shock position Administer oxygen as indicated	Evaluate patient lung sounds, if lungs clear place patient in shock position Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
IV access **Normal Saline** • IV bolus – 1 Liter o Caution with cardiac and/or renal history o Continue to evaluate lung sounds. If signs of CHF, decrease IV to TKO o If vital signs return to within normal limits, decrease IV to TKO <u>Traumatic Injury</u> • Do not delay transport for first IV attempt • Attempt second IV while enroute to ED • ~~Consider Blood Tubing~~	IV/IO access **Normal Saline** • IV/IO bolus – 20 mL/kg o Caution with cardiac and/or renal history o Continue to evaluate lung sounds. If signs of CHF, decrease IV to TKO o If vital signs return to within normal limits, decrease IV to TKO <u>Traumatic Injury</u> • Do not delay transport for first IV attempt • Attempt second IV while enroute to ED • ~~Consider Blood Tubing~~
Communication Failure Protocol	
If shock persists: • *Repeat* **Normal Saline** o IV bolus – 1 Liter	If shock persists: • *Repeat* **Normal Saline** o IV/IO bolus – 20 mL/kg
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Guidelines for Interfacility Transfer of Patients to a Trauma Center	Policy Number 1404
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: July 1, 2011
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: July 1, 2011
Origination Date: July 1, 2010 Date Revised: June 2, 2011 Date Last Reviewed: June 2, 2011 Review Date: July, 2013	Effective Date: July 1, 2011

I. PURPOSE: To establish guidelines for the transfer of a trauma patient from a hospital in Ventura County to a Level II trauma center.

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

III. DEFINITIONS:

A. **EMERGENT** Transfer: A process by which a patient with potential life-or-limb threatening traumatic injuries is transferred to a trauma center. The patient requires an immediate procedure at a trauma center, and a delay in transfer will result in deterioration of the patient's condition, and the treating physician requests immediate transport to a trauma center.

1. Trauma Call Continuation: A process by which a patient with potential life-or-limb threatening traumatic injuries who has been taken to the emergency department by ALS ambulance is transferred to a trauma center. The patient requires an immediate procedure at a trauma center, the ALS ambulance is still on the premises, and the treating physician requests immediate transport to a designated trauma center.

B. URGENT Transfer: A process by which a patient with time-critical traumatic injuries is transferred to a trauma center. The patient requires a timely procedure at a trauma center, and a lengthy delay will result in deterioration of the patient's condition, and the treating physician requests prompt transport to a trauma center.

IV~~II.~~ POLICY: The following criteria will be used as a guideline for the transfer of a trauma patient to a trauma center.

A. For ~~Life-threatening i~~patients who are in the emergency department at a community hospital and have one or more of the following injuries, if the referring physician requests transfer to a trauma center, the trauma center will immediately accept the patient~~njuries to trauma center~~

1. Carotid or vertebral arterial injury
2. ~~1.~~ Torn thoracic aorta or great vessel
3. ~~1.~~ Cardiac rupture
4. ~~1.~~ Bilateral pulmonary contusion with PaO2 to FiO2 ratio less than 200
5. ~~1.~~ Major abdominal vascular injury
6. ~~1.~~ Grade IV, V or VI liver injuries
7. ~~1.~~ Grade III, IV or V spleen injuries
8. ~~1.~~ Unstable pelvic fracture
9. ~~1.~~ Fracture or dislocation with neurovascular compromise
10. ~~1.~~ Penetrating injury or open fracture of the skull
11. ~~1.~~ Glasgow Coma Scale score <14 or lateralizing neurologic signs
12. ~~1.~~ Unstable spinal fracture or spinal cord deficit
13. ~~1.~~ >2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion
14. ~~1.~~ Open long bone fracture
15. ~~1.~~ Significant torso injury with advanced co-morbid disease (such as coronary artery disease, chronic obstructive pulmonary disease, type 1 diabetes mellitus, or immunosuppression)

~~1.Any traumatic injury that meets criteria as a life-or-limb threatening injury as listed in VCEMSA Policy 1407, "Emergency Trauma Transfers"~~

B. Ventura County Level II Trauma Centers:

1. Agree to immediately accept from Ventura County community hospitals, patients with conditions included in the guidelines above.
2. Will publish a point-of-contact phone number for an individual authorized to accept the transfer of a patient with a condition included in the guidelines above, or to request consultation with a trauma surgeon.
3. Will establish a written interfacility transfer agreement with every hospital in Ventura County.

C. Community Hospitals:

1. Are not required to transfer patients with conditions included in the guidelines above to a trauma center when resources and capabilities for providing care exist at their facility.
2. Will enter into a written interfacility transfer agreement with every trauma center in Ventura County.

D. **EMERGENT** Transfers

1. **EMERGENT** transfers are indicated for patients with life-or-limb threatening injuries in need of emergency procedures at a trauma center. Criteria **MUST** includes at least one of the following:
   a. Indications for an immediate neurosurgical procedure.
   b. Penetrating gunshot wounds to head or torso.
   c. Penetrating or blunt injury with shock.
   d. Vascular injuries that cannot be stabilized and are at risk of hemorrhagic shock or loss of limb acutely (excluding fingers/toes).
   e. Pregnancy with indications for an immediate Cesarean section.
2. For **EMERGENT** transfers, trauma centers will:
   a. Publish a single phone number ("hotline"), that is answered 24/7, for an individual authorized to accept the transfer of patients who have a condition as described in Section D.1 of this policy.
   b. Immediately upon initial notification by a transferring physician, accept in transfer all patients who have a condition as described in Section D.1 of this policy.
   c. Immediately post on ReddiNet when there is no capacity to accept trauma patients.
3. For **EMERGENT** transfers, community hospitals will:
   a Assemble and maintain a "Emergency Transfer Pack" in the emergency department to contain all of the following:
      1. Checklist with phone numbers of Ventura County trauma centers.
      2. Patient consent/transfer forms.
      3. Treatment summary sheet.
      4. Ventura County EMS "Emergency Trauma Patient Transfer QI Form."

b. Have policies, procedures, and a quality improvement system in place to track and review all EMERGENT transfers and Trauma Call Continuations.

c. Maintain an ambulance arrival to emergency department (ED) departure time of no longer than ten minutes.

d. Establish policies and procedures to make personnel available, when needed, to accompany the patient during the transfer to the trauma center.

4. For **EMERGENT** transfers, Ventura County Fire Communications Center (FCC) will:

a. Respond to an **EMERGENT** transfer request by immediately dispatching the closest available ALS ambulance to the requesting hospital.

b. Consider Trauma Call Continuation transfers to be a follow-up to the original incident, and will link the trauma transfer fire incident number to the original 911 fire incident number.

5. For **EMERGENT** transfers, ambulance companies will:

a. Respond immediately upon request.

b. For "Trauma Call Continuation" requests, immediately transport the patient to a trauma center with the same ALS personnel and vehicle that originally transported the patient to the community hospital.

c. Not be required to consider EMERGENT transports as an "interfacility transport" as it pertains to ambulance contract compliance.

E. **URGENT** Transfers

1. Urgent transfers are indicated for patients with time-critical injuries in need of timely procedures at a trauma center.

2. For Urgent transfers, trauma centers will:

a. Publish a single phone number, that is answered 24/7, for a community hospital physician to consult with a trauma surgeon.

3. For Urgent transfers, community hospitals will:

a. Maintain an ambulance arrival to emergency department (ED) departure time of no longer than twenty minutes.

4. For Urgent transfers, ambulance companies will:

a. Arrive at the requesting ED no later than thirty minutes from the time the request was received.

V. PROCEDURE:

A. **EMERGENT** Transfers

1. After discussion with the patient, the transferring hospital will:
   a. Call the trauma hotline for the closest trauma center to notify of the transfer.
   b. Call FCC, advise they have an EMERGENT transfer, and request an ambulance. If the patient's clinical condition warrants, the transferring hospital will call FCC *before* calling the trauma center's hotline.
   c. Complete transfer consent and treatment summary.
   d. Prepare copies of the ED triage assessment form and demographic information form.
2. Upon request for an **EMERGENT** transfer, the dispatch center will dispatch the closest ALS ambulance and verbalize "MEDxxx EMERGENCY Trauma Transfer from [transferring hospital]". The trauma center will be denoted in the incident comments, which will display on the mobile data computer (MDC). If a unit does not have an operational MDC, the transferring hospital will advise the responding ambulance personnel of the destination trauma center.
3. Upon notification, the ambulance will respond Code (lights and siren).
4. FCC will track ambulance dispatch, enroute, on scene, en-route hospital, at hospital, and available times.
5. The patient shall be emergently transferred without delay. Every effort will be made to limit ambulance on-scene time in the transferring hospital ED to ten minutes.
   a. All forms should be completed prior to ambulance arrival.
   b. Any diagnostic test or radiologic study results may either be relayed to the trauma center at a later time, or if time permits, copied and sent with the patient to the trauma center.
   c. Intravenous drips may be discontinued or remain on the ED pump.

B. Trauma Call Continuation

1. Upon determination of a Trauma Call Continuation, and after discussion with the patient, the community hospital will:
   a. Direct the ambulance personnel to prepare to continue the transport to the trauma center.
   b. Notify the designated trauma center ED of the immediate re-triage of a trauma patient, and communicate the patient's apparent injuries or reason for the re-triage, after the call is continued and the patient is enroute to the trauma center.
2. Upon notification of Trauma Call Continuation, the ambulance personnel will notify FCC of their assignment to a Trauma Call Continuation. FCC will link the trauma transfer to the original 911 incident and continue tracking en-route hospital (departure from community hospital), at hospital (arrival at trauma center) and available times.
3. When the transferring physician determines the patient is ready and directs ambulance personnel to continue the transport, the ambulance will emergently transport the patient to the trauma center. The transporting paramedic will contact the trauma base hospital enroute and provide updated patient information.

C. Urgent Transfers
   1. After discussion with the patient, the transferring hospital will:
      a. Call the trauma hotline for the closest trauma center to consult with the trauma surgeon.
      b. Call the transport provider to request an ambulance.
      c. Complete transfer consent and treatment summary.
      d. Prepare copies of the ED triage assessment form.
      e. Limit ambulance on-scene time in the transferring hospital ED to twenty minutes.
   2. Upon request for an Urgent transfer, the transport provider will dispatch an ambulance to arrive no later than thirty minutes after the request.

D. For all **EMERGENT** and Urgent transfers, the transferring hospital will submit a completed Emergency Trauma Patient Transfer QI Form to the Ventura County EMS Agency within 72 hours. The transfer will be reviewed for appropriate and timely care and to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS Trauma Operational Review Committee.

~~D. A transfer from a community hospital to a trauma center for a patient with a condition NOT included in the guidelines above shall be arranged per VCEMS Policy 605: "Interfacility Transfer of Patients."~~

~~E. An emergent transfer will be arranged as a Code Trauma, per VCEMS Policy 1407: "Emergency Trauma Transfers."~~

EMERGENT and Urgent Trauma Transfer QI Form
Form: Ventura County EMS Agency Policy 1404

(ALL FIELDS MUST BE COMPLETED)

Date:_____

Sending Hospital:

☐ SVH ☐ SJPVH ☐ SJRMC ☐ OVCH ☐ CMH ☐ SPH

Treating Physician:_____

Patient Arrived at Sending ED:

☐ Brought by EMS: Fire Incident Number _____

☐ Brought by POV or Walk-In

Destination Trauma Center:

☐ LRHMC

☐ VCMC

☐ Other: _____

Patient Transfer Process:

☐ EMERGENT

- ☐ Ambulance with paramedic ONLY
- ☐ Ambulance with accompanying healthcare personnel
- ☐ Trauma Call Continuation

☐ Urgent

If the transfer was EMERGENT, which of the following Policy 1404 criteria applies?

☐ Indications for an immediate neurosurgical procedure.

☐ Penetrating gunshot wound to head or torso.

☐ Penetrating wound by any mechanism and presents with or develops shock.

☐ Blunt injury and shock.

☐ Vascular injury that cannot be stabilized and is at risk of hemorrhagic shock or loss of limb acutely (excluding fingers/toes).

☐ Pregnancy with indications for immediate Cesarean section.

Comments:

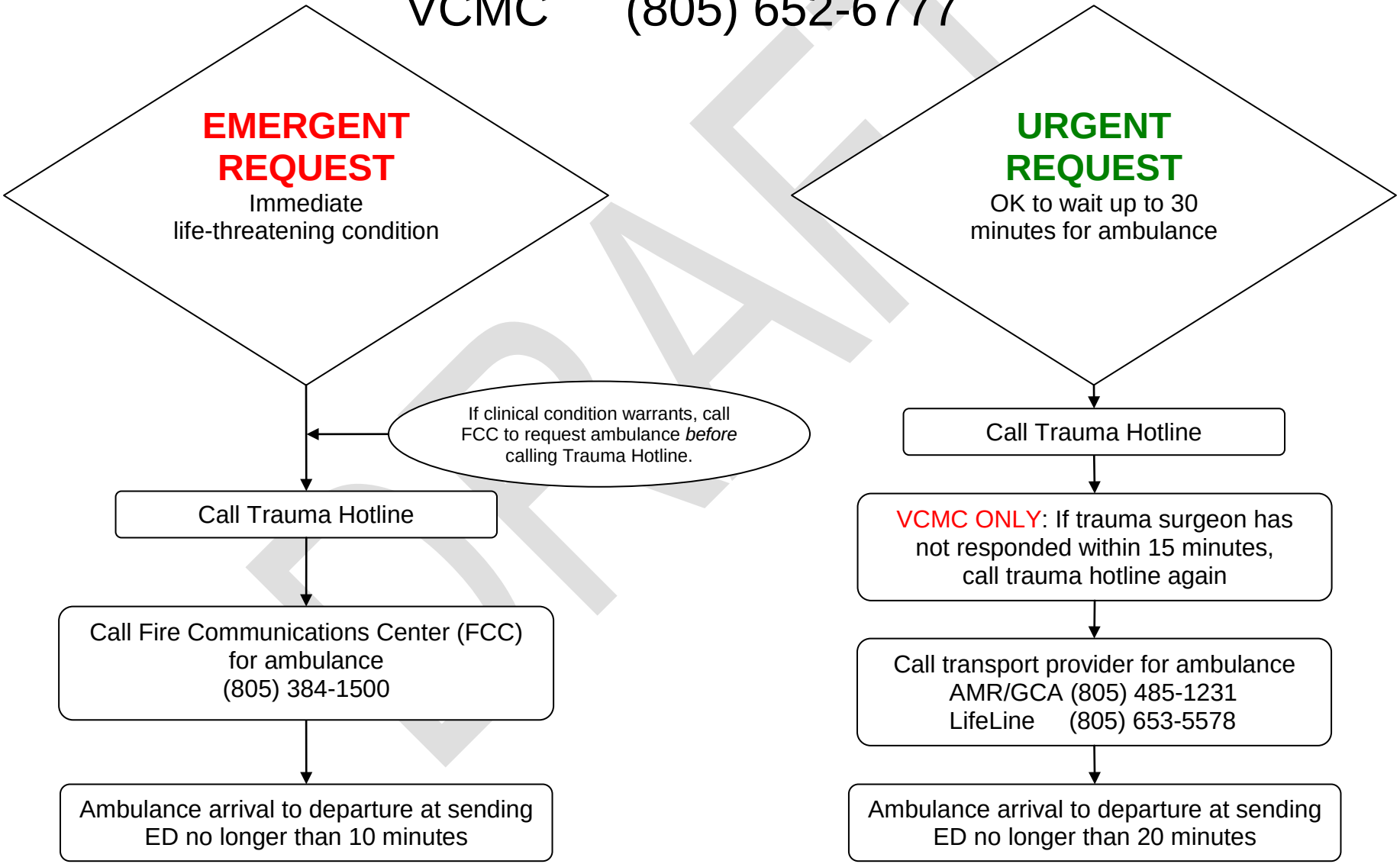
Within 72 hours of transfer, fax or scan/email to VCEMS: Fax--(805) 981-5300 Email—katy.hadduck@ventura.org

Ventura County Trauma Centers

Trauma Hotlines

LRHMC (805) 370-5901

VCMC (805) 652-6777



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title Emergency Trauma Transfers		Policy Number 1407
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: July 1, 2011
APPROVED: Medical Director:	Angelo Salvucci, MD	Date: July 1, 2011
Origination Date: Date Revised: Last Reviewed: Review Date:	January 18, 2011 June 2, 2011 June 2, 2011 July 1, 2013	Effective Date: July 1, 2011

I. PURPOSE: To define the "Code Trauma" and "Trauma Call Continuation" process by which patients at a community hospital that emergently require the specialty services of a designated trauma center are transferred.

II. AUTHORITY: Health and Safety Code, §1797.220 and §1798, and California Code of Regulations, Title 22, §100255.

III. DEFINITIONS:

A. Code Trauma: A process by which a patient with potential life-or-limb threatening traumatic injuries who require an immediate procedure at a designated trauma center and a delay in transfer will result in deterioration of the patient's condition, and the treating physician requests immediate transport to a designated trauma center.

B. Trauma Call Continuation: A process by which a patient with potential life-or-limb threatening traumatic injuries who has been taken to the emergency department by ALS ambulance requires an immediate procedure at a designated trauma center, the ALS ambulance is still on the premises, and the treating physician requests immediate transport to a designated trauma center.

C. Life-or-limb threatening injuries in need of emergency procedures are patients with at least one of the following:

1. Indications for an immediate neurosurgical procedure.
2. Penetrating gunshot wounds to head or torso.
3. Penetrating or blunt injury with shock.
4. Vascular injuries that cannot be stabilized and are at risk of hemorrhagic shock or loss of limb acutely (excluding fingers/toes).
5. Pregnancy with indications for an immediate Cesarean section secondary to trauma.

IV. POLICY: Responsibilities of each of the trauma system participants are listed below.

A. Community hospitals will:

1. Assemble and maintain a “Code Trauma Pack” in the emergency department to contain all of the following:
    a. Checklist with phone numbers of Ventura County trauma centers.
    b. Patient consent/transfer forms.
    c. Treatment summary sheet.
    d. Ventura County EMS “Emergency Trauma Patient Transfer QI Form.”
2. Have policies, procedures, and a quality improvement system in place to track and review all Code Trauma activations, Trauma Call Continuations, and minimize emergency department (ED)-arrival-to-departure time.
3. Establish policies and procedures to make personnel available, when needed, to accompany the patient during the transfer to the trauma center. These policies will include patient criteria for requiring healthcare personnel beyond the paramedic scope of practice to accompany a trauma patient in transport.

B. Ventura County Fire Communications Center (FCC) will:
1. Respond to a “Code Trauma” transfer request by immediately dispatching the closest available ALS ambulance to the requesting hospital.
2. Consider “Trauma Call Continuation” transfers to be a follow-up to the original incident, and will link the trauma transfer fire incident number to the original 911 fire incident number.

C. Ambulance Companies
1. Ambulance companies will respond immediately upon request for “Code Trauma” transfer.
2. For patients who are re-triaged on arrival at a community hospital and are determined by the referring physician to require “Trauma Call Continuation,” ambulance companies will immediately transport the patient to a designated trauma center, with the same ALS personnel and vehicle that originally transported the patient to the community hospital.
3. Transports performed according to this policy are not to be considered an interfacility transport as it pertains to ambulance contract compliance.

D. Trauma Centers will:
1. Publish a single phone number, that is answered 24/7, for an individual authorized to accept the transfer of patients who have a condition as described in Section III.B of this policy.
2. Immediately upon initial notification by a transferring physician, accept in transfer all patients who have a condition as described in Section III.C of this policy.
3. Immediately post on ReddiNet when there is no capacity to accept trauma patients.

V. PROCEDURE:

A. Code Trauma:

1. Upon determination of Code Trauma, and after discussion with the patient, the transferring hospital will:

a. Determine the most appropriate means for the patient transfer, either paramedic ambulance, critical care transport (CCT), or paramedic ambulance accompanied by healthcare staff from the transferring hospital.

(1) For patients appropriate for paramedic ambulance transport:

(a) Immediately call the Ventura County Fire Communication Center at 805-384-1500 for an ambulance.

(b) Identify their facility to the dispatcher and advise they have a “Code Trauma” transfer and the destination trauma center.

(2) For patients appropriate for CCT transport (the patient requires accompaniment of healthcare staff beyond paramedic scope of practice):

(a) Immediately contact the appropriate CCT provider agency, advise they have a “Code Trauma” and are requesting emergency CCT response.

(3) For patients appropriate for CCT transport and CCT response is delayed:

(a) Arrange for one or more healthcare staff, as determined by the clinical status of the patient, to accompany the patient to the trauma center.

(b) Immediately call Ventura County Fire Communications Center to request an ambulance as described in paragraph A.1.a.1. above.

b. After requesting the transport vehicle, the transferring physician will notify the trauma center emergency physician of the transfer.

c. Complete transfer consent and treatment summary.

d. Prepare copies of the ED triage assessment form and demographic information form.

e. Contact the trauma center for nurse report at the time of, or immediately after, the ambulance departs.

2. Upon request for “Code Trauma” transfer, the dispatch center will dispatch the closest ALS ambulance and verbalize “MEDxxx Code Trauma from [transferring hospital]”. The trauma center will be denoted in the incident comments, which will display on the mobile data computer (MDC). If a unit does not have an operational MDC, the transferring hospital will advise the responding ambulance personnel of the destination trauma center.

3. Upon notification, the ambulance will respond Code (lights and siren) and the ambulance personnel will notify their ambulance company supervisor of the “Code Trauma” transfer.
4. Ambulance units will remain attached to the incident and FCC will track their dispatch, enroute, on scene, en-route hospital, at hospital, and available times.
5. The patient shall be emergently transferred without delay. Every effort will be made to minimize ambulance on-scene time in the transferring hospital ED.
    a. All forms should be completed prior to ambulance arrival.
    b. Any diagnostic test or radiologic study results may either be relayed to the trauma center at a later time, or if time permits, copied and sent with the patient to the trauma center.
    c. Intravenous drips may be discontinued or remain on the ED pump.

B. Trauma Call Continuation

1. Upon determination of a Trauma Call Continuation, and after discussion with the patient, the community hospital will:
    a. Direct the ambulance personnel to prepare to continue the transport to the trauma center.
    b. Notify the designated trauma center ED of the immediate re-triage of a trauma patient, and communicate the patient’s apparent injuries or reason for the re-triage, after the call is continued and the patient is enroute to the trauma center.
2. Upon notification of Trauma Call Continuation, the ambulance personnel will notify FCC of their assignment to a Trauma Call Continuation. FCC will link the trauma transfer to the original 911 incident and continue tracking en-route hospital (departure from community hospital), at hospital (arrival at trauma center) and available times.
3. When the transferring physician determines the patient is ready and directs ambulance personnel to continue the transport, the ambulance will emergently transport the patient to the trauma center. The transporting paramedic will contact the trauma base hospital enroute and provide updated patient information.

C. For all Code Trauma and Trauma Call Continuation transfers, the transferring hospital will submit a completed Emergency Trauma Patient Transfer QI Form to the Ventura County EMS Agency within 72 hours. The transfer will be reviewed for appropriate and timely care and to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS Trauma Operational Review Committee.

Emergency Trauma Transfer QI Form
Form: Ventura County EMS Agency Policy 1407

Date:_____

Sending Hospital:
☐ SVH ☐ SJPVH ☐ SJRMC ☐ OVCH ☐ CMH ☐ SPH

Treating Physician:_____

Patient Arrived ED:
☐ Brought by EMS: Fire Incident Number _____
☐ Brought by POV or Walk-In

Destination Trauma Center:
☐ LRHMC
☐ VCMC
☐ Other: _____

Patient Transfer Process:
☐ Code Trauma
  ☐ Ambulance with paramedic ONLY
  ☐ CCT
  ☐ Ambulance with accompanying healthcare personnel
☐ Trauma Call Continuation

Describe the condition that required an immediate procedure at a trauma center:
☐ Indications for an immediate neurosurgical procedure.
☐ Penetrating gunshot wounds to head or torso.
☐ Penetrating or blunt injury with shock.
☐ Vascular injuries that cannot be stabilized and are at risk of hemorrhagic shock or loss of limb acutely (excluding fingers/toes).
☐ Pregnancy with indications for an immediate Cesarean section secondary to trauma.

Comments:

Within 72 hours of transfer, fax or scan/email to VCEMS: Fax--(805) 981-5300
Email—katy.hadduck@ventura.org

VCPH Ventura County Public Health

A Division of the Ventura County Health Care Agency

BARRY R. FISHER, MPPA
Director

EMERGENCY MEDICAL SERVICES

STEVEN L. CARROLL, EMT-P
EMS Administrator

ANGELO SALVUCCI, M.D., F.A.C.E.P
Medical Director

2220 E. Gonzales Rd., Suite 130, Oxnard, CA 93036-0619
www.vchca.org/ph/ems
Phone: 805-981-5301
Fax: 805-981-5300

TO: Ventura County Fire Departments
Ventura County Hospitals
Ventura County Transport Providers

FROM: Stephanie Lara-Jenkins, RN
Ventura County EMS Agency

RE: Sidewalk CPR, June 7, 2012

DATE: March 26, 2012

Ventura County Emergency Medical Services Agency is partnering with the American Heart Association and Southern California LEMSAs to coordinate a county-wide CPR program.

We are asking emergency healthcare providers, such as fire departments, ambulance companies, hospitals and education programs to go out into the community to teach residents how to save a life with “Hands Only CPR.” This service will be free to the public and will be held in various locations across Southern California, including Ventura County with the goal of increasing the number of lifesavers in the community.

Instructors will be teaching shoppers the proper techniques of “Hands Only CPR” which takes about 5-6 minutes. Instructional information as well as public information will be provided by American Heart Association.

Last year, Ventura County EMS responded to 440 cardiac arrests. Only 30% of those had bystander CPR in progress when the ALS responders arrived. Because bystander CPR increases chances of survivability by 30-40%, we believe we can save more lives with this public training.

The VCEMS Agency is organizing this effort and contacting approximately 20 locations to get permission to stage a teaching crew at their place of business from 9:00 am to 12:00pm on June 7, 2012. We hope that you will participate!

Please contact Stephanie Lara-Jenkins, RN at the VCEMS office (805) 981-5306, or at Stephanie.lara-jenkins@ventura.org for more information.

SideWalk CPR
Instructor Curriculum

Why Learn Hands-Only CPR:

- 80% of Sudden Cardiac Arrests occur at home – so the life you are most likely to help save is a family member or friend.
- Sudden Cardiac Arrest is an electrical problem with the heart where it stops beating and pumping blood. That causes the brain to shut down, so the person suddenly collapses and is unconscious.
- EMS can restart the heart using a defibrillator (AED) and/or medications – but take 5 or more minutes to arrive.
- Hands-Only CPR can keep the heart and brain alive until EMS takes over.
- Mouth-to-mouth breathing is not necessary – there is oxygen in the blood.

How to Perform CPR:

1. **Check** for responsiveness:
   - Shake the person and shout, "Are you all right?"
   - If still no response, move to step 2.
2. **Call** 9-1-1 or tell someone to do so:
   - If the person is unresponsive and breathing slowly or not at all.
3. **Compress**:
   - Position the person on the floor, face up.
   - Kneel right next to the person – so your knees touch his/her arm.
   - Place the heel of one hand on the center of the chest (between the nipples) and the other hand on top of the first.
   - Lock your elbows, put your shoulders over the center of the chest, and push **HARD** straight downward - at least **two inches**.
   - Lift your hands off the chest slightly after each compression to allow the chest to fully re-expand.
   - Compress **FAST** - at a rate of **100 per minute**.
4. **Continue** until EMS arrives:
   - Don't stop if the person gasps. Gasping is not a sign of recovery – it's because you are doing a good job with CPR.
   - When you tire, switch off with others

That's It!

- For additional questions, refer to FAQ sheet.
- Trainees should get a wallet card and instruction sheet.

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, EMT-P	Date: June 1, 2009
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date: June 1, 2009
Origination Date: Date Revised: Date Last Reviewed: Review Date:	August 22, 1986 February 12, 2009 February 12, 2009 February 28, 2012	Effective Date: June 1, 2009

I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Base Hospital 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) Base Hospital (BH), approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:

1. Meet all requirements of an ALS Receiving Hospital per Ventura County Emergency Medical Services Policy 420.
2. Have an average emergency room census of 1200 or more visits per month.
3. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics.
    a. If the communications capability of the BH is interrupted, the ALS provider and the nearest BH shall be notified immediately by telephone.
    b. ALS calls shall be routed to the nearest BH until communication capability is restored and telephone notification of the ALS provider and nearest BH is made.
    c. All equipment used for ALS communications shall operate within the frequency requirements of the Ventura County Communications Department. At the time that a countywide communication system is implemented, all ALS providers shall comply with the Ventura County Communications Department ALS communications plan.
4. Assure that communication between the BH and ALS Unit for each ALS call shall be provided only by the BH ED physician or Ventura County authorized Mobile Intensive Care Nurse (MICN) by radio or telephone.
6. Designate a BH 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 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 VC EMS.
e. Coordinate BH activities with Receiving Hospital, PSC and VCEMS policies and procedures.
f. Attend PSC meetings.
g. Provide Emergency Department staff education.
h. Schedule medical staffing for the Emergency Department on a 24-hour basis.
i. Evaluate paramedics for clinical performance and makes recommendation to VCEMS.
j. Evaluate MICN's for authorization/reauthorization and makes recommendation to VCEMS.

7. Have on duty, on a 24-hour basis, one (1) MICN who meets who meets the criteria in VCEMS Policy 321.
8. Identify an MICN with experience in, and knowledge of, BH radio operations and VCEMS policies and procedures as a PCC to assist the BH Medical Director in the medical control, supervision, and continuing education of prehospital care personnel.
9. Provide for the continuing education of prehospital care personnel, 'paramedics MICNs, EMT-I's, 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.
13. Resident physicians shall attend Base Hospital Physician course.

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

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

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

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

1. Application:

   Eligible hospitals shall submit a written request for Base Hospital approval to VCEMS documenting the compliance of the hospital with the Ventura County Base Hospital Criteria.

2. Approval:

   a. Program approval or disapproval shall be made in writing by the VCEMS to the requesting Base Hospital 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 Base Hospital, may result in withdrawal, suspension or revocation of program approval by the VCEMS.

F. Advanced Life Support Base Hospitals shall be reviewed on an annual basis.

1. All Base Hospitals shall receive notification of evaluation from the VCEMS.
2. All Base Hospitals shall respond in writing regarding program compliance.
3. On-site visits for evaluative purposes may occur.
4. Any Base Hospital 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 per Ventura County Emergency Medical Services Policy 420.		
2. Have the capability to provide, at all times, operational biomedical and radio communications with the capability to tape record the communications, between the BH and paramedics. 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 BH Prehospital Care Coordinator (PCC), a paramedic representing each ALS service provider affiliated with the BH, and an ED physician and/or ED Registered Nurse from each Receiving Hospital affiliated with the BH, to function as the BH Paramedic Committee. Additional committee members may be designated according to BH committee policies.		
5. Designate a BH 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:		
• Be regularly assigned to the Emergency Department.		
• 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 VC EMS.		
• Coordinate BH activities with Receiving Hospital, PSC and VCEMS policies and procedures.		
• Attend BH Paramedic Committee and PSC meetings.		
• Provide Emergency Department staff education.		
• Schedule medical staffing for the Emergency Department on a 24-hour basis.		
• Evaluate MICNs for authorization/reauthorization and make recommendation to VCEMS.		
6. All Base Hospital MICN's shall:		

		YES	NO
	• Be authorized in Ventura County by the VCEMS Medical Director.		
	• Be assigned only to the Emergency Department while functioning as an MICN.		
	• Maintain current ACLS certification.		
	• Be a Base Hospital employee.		
7.	Identify an MICN with experience in and knowledge of BH radio operations and VCEMS policies and procedures as a PCC to assist the BH medical director in the medical control, supervision, and continuing education of prehospital care personnel.		
8.	Provide for the continuing education of prehospital care personnel ('paramedics MICN's, EMT-I's, and first responders), in accordance with VC EMS Policy 1131:		
9.	Cooperate with and assist the Paramedic Services Subcommittee, the, and the VCEMS Medical Director 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 tape 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 VC EMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for program participation as specified by State regulations and VC EMS policies and procedures.		
13.	Resident physicians shall attend Base Hospital Physician course.		