Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	October 13, 2011 9:30 a.m.

I.	**Introductions**		
II.	**Approve Agenda**		
III.	**Minutes**		
IV.	**Medical Issues**		
	A.	Policy 705.08:	Cardiac Arrest-VF/VT
	B.	Policy 705:09:	Chest Pain
	C.	Policy 705.25:	Ventricular Tachycardia
	D.	Policy 507:	Critical Care Transports
	E.	Other	
V.	**New Business**		
	A.	Policy 606: – K. Hadduck	Withholding or Termination of Resuscitation and Determination of Death
	B.	Policy 627:	Fireline Medic – C. Rosa
	C.	Policy1000:	Documentation of Prehospital Care – C. Rosa
	D. .	Gentle Care Transport application	
	E.	Other	
VI	**Old Business**		
	A.	Other	
VII.	**Informational Topics**		
	A.	Other	
VIII.	**Policies for Review**		
	K.	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.	**A.**	**ReddiNet Annual Advisory Group Meeting – ReddiNet Coordinators only**	
XII	**Closing**		

TEMPORARY
PARKING PASS
Expires October 13, 2011

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.

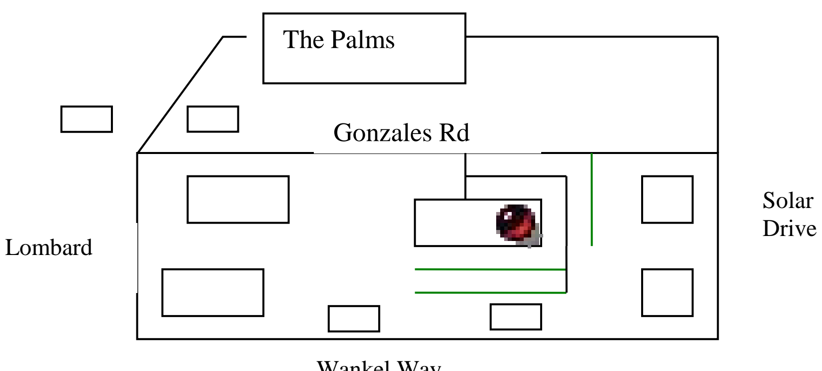
2100 Solar Drive

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	August 11, 2011 9:30 a.m.

Topic	Discussion	Action	Assigned
		Meeting called to order at 10:45 A.M.	
I. Introductions	Davies/UM introduced		
II. Approve Agenda	Policy 717 was added under new business	Policy 507 was tabled The agenda was approved with changes N. Merman/R. Shedlosky	
III. Minutes		It was MSC (M. Mundell/ S. Huhn) to approve the minutes as submitted.	Mark 1 kits are now DuoDote.
IV. Medical Issues			
A. Policy 705.08: Cardiac Arrest- VF/VT B. Policy 705:09: Chest Pain C. Policy 705.25: Ventricular Tachycardia	Discussion included: Lidocaine is no better or worse than Amiodarone. #5 proposed to discuss further with cardiologists for next meeting Do we want to add Amiodarone? If so, need to submit to the State EMSA for approval.	There was a motion to ask State for permission to use Amiodarone instead to Lidocaine. Dr. Salvucci will submit the documentation to state for approval. Policy 705.09 will be brought back next month. Dr. Salvucci asked that representative of PSC speak with their cardiologist about use of Amiodarone in the field.	Approved for addition of Amiodarone. An application to for use will be sent to the State. Agenda
D. Policy 705.10: Childbirth	Discussion included: Putting baby skin to skin?	It was M/S/C (Davies/Larsen) to approve policy as submitted	Approved
E. Policy 507: Critical Care Transports			Tabled
F. Policy 732: Use of Restraints	Discussion included: Law enforcement has approved the policy as written.	Changes to policy include: Patient should never be handcuffed behind their back, should be attached to frame of gurney.	Approved

	Question regarding limiting restraints. Policy does not limit. Anytime the patient is restrained, rider will be sent. This policy only applies when the patient is in restraints. 9.b. Policy of law enforcement to ride with patient. • While it is policy some law enforcement will not allow rider unless in ambulance. • OPD has single officer cars. • More times than not law enforcement will follow • If patient is under control, probably fine to have law enforcement follow • Handcuffs in back of ambulance patients are difficult • If in policy give LE ability to ride • There should not be any wiggle room for no law enforcement. • If patient is handcuffed they are in the custody of law enforcement care. • Patient should be handcuffed to gurney only, single arm only. • Whenever possible should be stricken. • Both arms should be attached to the gurney	Restraints should be attached to frame of gurney. 9.b.: Accompany the patient and strike "whenever possible." It was M/S/C (J. Winter/J. Hall) to approve the policy with changes.	
I. Other			

V. New Business	Policy 717 – discussion included: • Page 3.2.a add "and unresponsive • Page 3.5.f.1 –change to "less than 20-39 kg." • Page 3.b.2.a. strike < 2 years old Add less than 20 kg • 2.b. strike 2 years old add > 20 kg and responsive.	E-mail changes to AS.	Agenda
A. Stroke System	AS/SC have met with the Hospital CEOs and they have agreed to the included proposal. Proposed Fall of next year to begin triaging patients to primary stroke center as certified by Joint Commission. Patients would be transported to certified stroke centers. CMH is no long Joint Commission but is now DNV. Need to explore how they would get approved. Neurologists are not available at all hospitals. Would telemedicine be allowed? This would have to be discussed/allowed in the Joint Commission Standards.		
B. Other			
VI Old Business			
A. Impedance Threshold Device/King Airway Study Report– D. Chase		Study has been completed and is included in this packet. Pig study will be published in AHA in the future.	Item complete
B. Other			

VII. Informational Topics			
A. Pharmacology Manual		Pharmacology manual is completed and AS has approved. Amiodarone will need to be added. Skills manual will continue to be worked on and will be presented at a later date.	Pharmacology manual will be posted to website in next couple days.
B. Other			
VIII. Policies for Review			
A. Policy 210: Child, Dependent Adult, or Elder Abuse Reporting	PH referral form. Do we do both forms? No mandate for PH referral form. EMS will look into it with PH.	It was M/S/C (S. Huhn/N. Merman) to approve the policy. EMS will review PH referral form with Public Health.	Approved
B. Policy 400: Ventura County Emergency Departments			Approved
C. Policy 605: Interfacility Transfer of Patients	Allow medic to monitor a chest tube for an IFT. Chest tube now not approved for medic. It is in national standard. They would not suction.	It was M/S/C (J. Winter/B. Patterson) to approve the policy with the following change. Add paramedic to Page 3.1.0 and remove item s.	Changes approved.
D. Policy 606: Withholding or Termination of Resuscitation and Determination of Death	Blunt or penetrating trauma, do we want to transport to trauma center. Postion paper says .. or trauma center.	Policy tabled for further discussion regarding trauma centers.	Agenda
E. Policy 620: EMT Administration of Oral Glucose	Discussion included: 4.a.b type 'of" Research whether this can be deleted. There was a question on why we have this policy. The policy is for EMT and 705's address paramedic policies	The policy was proposed for possible deletion?	Tabled
F. Policy 624: Patient Medications	Must document "all" medications	Policy was tabled until E-PCR is complete.	Tabled

		New E-PCR documenting medications will be a mandatory entry.		
G.	Policy 716: Use of Pre-Existing Vascular Access Devices			Approved
H.	Policy 713: Intralingual Injection – Possible deletion	This policy is now unnecessary with EZY IO.	It was M/S/C (T. Larsen/D. Chase) to approve the policy for deletion. EMS will issue a training bulletin. This will also need to be deleted from all 705 policies.	Deleted
I.	Policy 723: Continuous Positive Airway Pressure (CPAP)			Approved
J.	Policy 725: Patients after TASER Use		Restraint information Page 1.4.e. add policy 732 referral.	Approved
K.	Other			
IX.	**Reports**			
	TAG Report	ALS CQI completed pharmacology and updating skills. BLS going to torc for All other status quo.		
X.	**Agency Reports**			
A.	ALS Providers	VNC academy finished. Couple of the new medics are now with preceptors VCFD got federal grant 2.3 million to reopen station 4. Will become effective in a couple months. Couple new medics out of the academy. LMT going to start using Stat pads that allow see through CPR and shows on a monitor for correct depth, etc. AMR no report FFD no report		
B.	BLS Providers	Fire Chief Milligan will be retiring on November 18.		
C.	Base Hospitals	VCMC is starting to put together the paramedic skills refresher for November and thanked those who have volunteered to assist.		
D.	Receiving Hospitals	CMH is starting construction for new hospital. Some buildings have been demolished and they are now working on the utilities.		
E.	ALS Education	New paramedic class will be starting in August		

Programs		
F. Trauma System Report	Those of you who have staff that needs to retake exam, please pass out old exams to review. Passed out exams and explanation on why did not pass. Staff has to call and schedule exams with EMS. If they do not retest, EMS will be suspended their authorization or accreditation.. VCMC ACS verification visit next month. They are providing their first ATLS course this year. TORC was cancelled for the month of August.	
G. EMS Agency	• EPCR contract signed. We will be starting development. Devices are being reviewed. ALS will have to go with full software. Request for development committees have gone out to the providers. Pilot program in November for VCFD, LMT. Go live Feb 1. • First watch – monitors several programs. As of last week went live for ambulance monitoring, still fine tuning some items. • ReddiNet drills are being well received. Drill this morning was 100% except for one. • Positive response with hospitals for satellite connection with ReddiNet. • Hospital radios – will contact in next month or so for access to your hospital to look at antenna and radios. • Oct. 4 BOS for trauma system. This will be a 30 min presentation. Hospital will present a case each. Welcome to attend. • EPO has now moved into our suite and are now part of the EMS Agency. • Hosp preparedness program info needs to be relayed to hospitals. The hospital members need to attend. • EMS will be receiving a BLS ambulance application. We have approximately 60 days to review. Application process explained to committee.	
H. Other	No report	
XI. Closing		

Prehospital Services Committee 2011

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/13/2011	2/10/2011	3/10/2011	4/14/2011	5/12/2011	6/9/2011	7/14/2011	8/11/2011	9/8/2011	10/13/2011	11/1 0/2011	12/8/2011	%
AMR	Ober	Brandon		NC											
AMR	Panke	Chad		CP		CP			PLEASE INITIAL JUNE 2011 IF YOU ATTENDED	JH					
CMH - ER	Canby	Neil				NC		NC							
CMH - ER	Cobb	Cheryl		CC		CC		CC		CC					
FFD	Herrera	Bill		BH		BH									
FFD	Hall	Jim		JH		JH				JH					
GCA	Norton	Tony		TN				TN		TN					
GCA	Stillwagon	Mike		MS		MS									
Lifeline	Kuroda	Brian						BK		BK					
Lifeline	Winter	Jeff		JW		JW		JW		JW					
LRRMC - ER	David	Paul		PD											
LRRMC - ER	Licht	Debbie				DL		DL		DL					
OFD	Carroll	Scott				SC		SC		SC					
OFD	Huhn	Stephanie		SPH		SPH		SPH		SPH					
OVCH	Boynton	Stephanie				SB									
OVCH	Patterson	Betsy		BP		BP		LOA		BP					
SJPVH	Hernandez	Sandi		SH		SH		SH		SH					
SJPVH	Davies	Jeff								JD					
SJRMC	McShea	Kathy		KM		KM				UM					
SJRMC - SJPVH	Larsen	Todd		TL						TL					
SPFD	Dowd	Andrew		AD				AD		AD					
SVH - ER	Tilles	Ira		IT		IT		IT		IT					
SVH - ER	Hoffman	Jennie		JH		JH		JH		JH					
V/College	Mundell	Meredith		MM		MM		MM		MM					
VCFD	Merman	Nancy		NM		NM				NM					
VCFD	Dingman	Rodney		RD		RD		RD							
VNC	Plott	Norm		NP		MNP									
VNC	Black	Shannon				SB									
VNC	Shedlosky	Robin		RS				RS		RS					
VCMC - ER	Chase	David		DC		DC		DC		DC					
VCMC - ER	Utley	Dede				DU		DU		DU					
VCMC-SPH	Daucett	Michelle		MD		MD									
VCMC-SPH	Beatty	Karen				CH		KB		KB					
VCSO SAR	Hadland	Don		DH		DH				DH					

Agency	LastName	FirstName	1/13/2011	2/10/2011	3/10/2011	4/14/2011	5/12/2011	6/9/2011	7/14/2011	8/11/2011	9/8/2011	10/13/2011	11/1 0/2011	12/8/2011	%
VCSO SAR	White	Don		DW		DW		DW		DW					
VFF	Rhoden	Crystal		CR						CR					
VFF	Jones	Brad		BJ		BJ		BJ							
Eligible to Vote	**Date Change/cancelled - not c**			SC											
Non Voting Members															
EMS	Carroll	Steve		SC		SC		SC		SC					
AMR	Drehsen	Charles								CD					
VCMC	Duncan	Thomas				TD				TD					
EMS	Fisher	Barry													
LMT	Frank	Steve				SF				SF					
EMS	Hadduck	Katy		KH		KH		KH		KH					
EMS	Haney	Debora		DH		DH									
EMS	Lara-Jenkins	Stephanie		SLJ		SLJ		SLJ		SLJ					
EMS	Rosa	Chris		CR		CR		CR		CR					
EMS	Salvucci	Angelo		AS		AS		AS		AS					

Cardiac Arrest – VF/VT

BLS Procedures

ADULT

If collapse before dispatch, complete 5 cycles (2 minutes) of CPR, then attach AED
If witnessed, immediately attach AED
Airway management per VCEMS policy

PEDIATRIC

If collapse before dispatch, complete 5 cycles (2 minutes) of CPR, then attach AED
If witnessed, immediately attach AED
Airway management per VCEMS policy

ALS Prior to Base Hospital Contact

ADULT

Defibrillate
- Use the biphasic energy settings that have been approved by service provider medical director
- Repeat every 2 minutes as indicated

IV or IO access
Epinephrine
- IV/IO – **1:10,000**: 1 mg (10 mL) q 3-5 min

Amiodarone
- **IV/IO – 300 mg**
- **If rhythm persists, 150 mg IV/IO in 3-5 minutes**

~~**Lidocaine**~~
- ~~IV/IO – 1 mg/kg q 3-5 min~~
  - ~~Max 3 mg/kg~~

ALS Airway Management
- If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures

~~POST-CONVERSION~~
~~If patient converts to narrow complex rhythm greater than 50 bpm and not in 2nd or 3rd degree heart block~~
- ~~**Lidocaine**~~
  - ~~IV/IO – 1 mg/kg~~
    - ~~If Lidocaine has already been administered, then withhold this dose~~

If VF/VT stops, then recurs, perform defibrillation at the last successful biphasic energy setting

PEDIATRIC

Defibrillate – 2 Joules/kg
- If patient still in VF/VT at rhythm check, increase to 4 Joules/kg
- Repeat every 2 minutes as indicated

IV or IO access
Epinephrine 1:10,000
- IV/IO – 0.01mg/kg (0.1 mL/kg) q 3-5 min

Amiodarone
- **IV/IO – 5 mg/kg**
- **If rhythm persists, 2.5 mg/kg IV/IO in 3-5 minutes**

~~**Lidocaine** – Every 3-5 min~~
~~IV/IO – 1 mg/kg~~
~~Max 3 mg/kg~~

ALS Airway Management
- If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures

- ~~POST-CONVERSION~~
- ~~If patient converts to narrow complex rhythm greater than 50 bpm and not in 2nd or 3rd degree heart block~~
- ~~**Lidocaine**~~
- ~~IV/IO – 1 mg/kg~~
- ~~If Lidocaine has already been administered, then withhold this dose~~

If VF/VT stops, then recurs, perform defibrillation at the last successful biphasic energy setting

Base Hospital Orders only

ADULT

Tricyclic Antidepressants
- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg
    - Repeat 0.5 mEq/kg q 5 min

Torsades de Pointes
- **Magnesium Sulfate**
  - IV/IO – 2 gm over 2 min
    - May repeat x 1 in 5 min

Consult with ED Physician for further treatment measures

PEDIATRIC

Tricyclic Antidepressants
- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg
    - Repeat 0.5 mEq/kg q 5 min

Consult with ED Physician for further treatment measures

Additional Information:

- If sustained ROSC (>30 seconds), perform 12-lead EKG. Transport to SRC
- If patient is **hypothermic** – only ONE round of medication administration and limit *defibrillation to 6 times* prior to Base Hospital contact. Field determination of death is discouraged in these patients and they should be transported to the most accessible receiving facility
- Ventricular tachycardia (VT) is a rate > 150 bpm

VCEMS Medical Director

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

~~Ventricular Ectopy – PVC's > 10/min, multifocal PVC's, or unsustained V-Tach~~

- ~~**Lidocaine**~~
  - ~~IV – 1 mg/kg~~
    - ~~May repeat 0.5 mg/kg slow IVP q 5-10 min for continued ectopy~~
    - ~~Max 3 mg/kg~~

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

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

Ventricular Tachycardia Sustained – Not in Arrest

BLS Procedures

Administer oxygen as indicated

ALS Prior to Base Hospital Contact

IV Access

Stable – Mild to moderate chest pain/SOB

- **Amiodarone**
    - IV - 150 mg over 10 minutes
- ~~**Lidocaine**~~
    - ~~IV – 1 mg/kg~~
        - ~~Rate of 50 mg/min~~

Unstable – ALOC, signs of shock or CHF

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

Unstable polymorphic (irregular) VT:

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

~~POST-CONVERSION~~

~~If patient converts to narrow complex rhythm greater than 50 bpm and not in 2nd or 3rd degree heart block~~

- ~~**Lidocaine**~~
    - ~~IV – 1 mg/kg~~
        - ~~If Lidocaine has already been administered, then withhold this dose~~

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

Communication Failure Protocol

~~Stable/Unstable:~~

- ~~*Repeat* **Lidocaine**~~
    - ~~IV – 0.5 mg/kg q 5-10 min~~
        - ~~Max 3 mg/kg~~
        - ~~Hold if decreased cardiac output, significant liver dysfunction, or in patient > 70 years of age~~

Base Hospital Orders only

Torsades de Pointes

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

Consult with ED Physician for further treatment measures

Additional Information:

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

Prehospital Services Committee
Agenda Item Request

Upon completion of this form, submit to the EMS Agency for review.

Submitted by: Susan Franks Date: May 2, 2011

Representing: AMR/GCA CCT Program

A. Description

Title of Agenda Item: Policy 507: Critical Care Transports

Description of Item
Currently this policy requires that CCT vehicle staffing consists of an RN added to an ALS team. We believe the policy ought to allow for various levels of CCT staffing, for example, an RN with a BLS or ALS team. In many cases, an RN and one EMT is sufficient. About 30% of the CCTs done in this county are stable, long term vent-dependant patients going to a sub-acute facility. Another 20% are patients with no IV drips, no ventilator, but an RN is requested by the transferring facility. The RN will receive report from the transferring facility and determine the staffing level needed, according to company policy and procedures. Patients with an unstable airway will not be transferred. If a patient deteriorates enroute, the CCT ambulance can divert to closest emergency facility. If the ETA to that facility is greater than 10 minutes and the RN requires assistance, the ambulance will pull over and request assistance from an ALS unit.

B. Analysis

How will this enhance the Ventura County EMS System?
This procedure allows for a more appropriate utilization of resources. About half of the CCTs done are out of county which removes an ALS unit from service for a significant amount of time.

Advantages
-Less impact on 911 ALS response system
-Utilizes costly resources appropriately
-More options to staff the CCT unit
-Decreased response times for both CCTs and 911

Disadvantages
-Less people to help with patient care. However, this extra help has not proven to be necessary and the RN may always request more staff if he or she foresees a situation that may require it.

-No one ET trained in ambulance. However, most of the patients are intubated or trached already. A good BLS airway can be sufficient and the RN may request help if required.

Financial Impact
Utilizing appropriate resources is more cost effective.

Who has this item been presented to or reviewed by?
Dr. Salvucci.

Attach any proposals or supportive documentation to this form.

C. EMS Agency Review

Received by VC EMS Agency: ________________________

Reviewed by EMS Administrator: ________________________

Assigned to:
____________________________ Purpose: ________________________________
____________________________ Purpose: ________________________________
____________________________ Purpose: ________________________________
____________________________ Purpose: ________________________________

EMS Staff Review Summary
____
____
____
____
____

D. Disposition

- ☐ Add as PSC Agenda item on: _______________________
- ☐ Inadequate or incomplete information - return submission
- ☐ Not to be addressed at this time, resubmit in _____________________.
- ☐ Adopt item
- ☐ Refer to: (for review and comment)
  - ☐ CQI Subcommittee
  - ☐ EMD Subcommittee
  - ☐ Prehospital Educators
  - ☐ MCI Subcommittee
  - ☐ Other: ____

EMS Administrator Signature:_______________________________ Date:__________

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: CRITICAL CARE TRANSPORTS		Policy Number: 507
APPROVED: Administration:	Barry R. Fisher, EMT-P, BS	Date: 10/10/2002
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date: 10/10/2002
Origination Date: October 31, 1995 Date Revised: September 12, 2002 Review Date: November 2004	Effective Date:	November 30, 2002

I. PURPOSE: To establish requirements for nurse-staffed ALS Units

II. AUTHORITY: Health and Safety Code 1798.170.

III. POLICY: An ALS Ambulance Company may be approved to employ or contract with Registered Nurses to staff ALS inter-facility transports providing the company adhere to the outlined conditions. This policy applies to interfacility ground transports only.

IV. PROCEDURE:

A. Vehicle Staffing Requirements

1. One registered nurse, currently licensed to practice in the State of California, shall be added to the ALS Support team, and shall meet the following requirements:

a. RN with a minimum of two (2) years experience in a critical care area within the previous three (3) years, prior to employment with the ambulance provider.

b. Current BLS and ACLS certification from the American Heart Association.

c. Successful completion of an in-house orientation program sponsored by the provider agency.

d. For pediatric CCT's only: Pediatric Advanced Life Support (PALS), Pediatric Education for Prehospital Providers (PEPP) or Emergency Nurses Pediatric Course (ENPC).

e. Optional endotracheal intubation training.
If the nurse is ET trained, the nurse may be added to a BLS team for CCT purposes.

f. Certification in any one of the following: Certified Emergency Nurse (CEN); Critical Care Registered Nurse (CCRN); Mobile Intensive Care Nurse (MICN); Certified Flight Registered Nurse (CFRN), Certified Nurse Anesthetist; Post Anesthesia Recovery Nurse (PAR); may challenge/pass Ventura County MICN certification exam.

2. To maintain authorization as a CCT nurse, s/he will:
    a. Work a minimum of 384 hours in a critical care area (including time worked as a CCT RN) per year, unless employed full time as a critical care transfer nurse.
    b. If the nurse is ET trained, s/he shall obtain a minimum of three (3) successful intubations or demonstration of skills competency to the provider medical director every year.
    c. Maintain current ACLS certification.
    d. For pediatric CCT's only: PALS, PEPP or ENPC.
3. Nurses used to provide ALS in accordance with this policy, may be employed by the ambulance provider or be sub-contracted, at the provider's option.
4. Ambulance providers shall provide an internal orientation to EMT-Is and EMT-Ps participating in nurse-staffed ambulance transports.

B. Equipment:
1. In addition of the items required by California Administrative Code, Title 13, the ambulance provider shall provide, at a minimum, the following equipment for nurse-staffed ALS units:
    a. ALS equipment (EMT-P Standard Drug & Equipment List)
    b. Manual defibrillator with external pacemaker
    c. Infusion pump(s)
    d. Back-up power source
    e. Pulse oximeter

C. Medical Direction: An agency providing CCTs shall have:
1. Medical protocols to be followed by the RN at the ALS level which have been approved and signed by a Physician, and
2. Either a
    a. Physician Director
    Provider shall have either full or part-time Physician Director qualified by training and/or experience and recent practice in emergency or acute critical care medicine. The candidate for Physician Director must be approved by the Medical Director. The Physician Director shall:
        1) Ensure the ongoing training of all medical personnel involved.
        2) Ensure the quality of patient transfers being conducted by the provider by conducting patient care audits.
        3) Be familiar with applicable patient transfer laws, or
    b. Nursing Coordinator

Provider shall have either full or part-time RN employed as Nursing Coordinator qualified by training and/or experience and recent practice in emergency or acute critical care nursing. The Nursing Coordinator shall:

1) Provide ongoing training of all medical personnel involved.
2) Ensure quality of patient transfers being conducted by the provider by conducting patient care audits.
3) Be familiar with applicable patient transfer laws

3. Procedures/Protocols
   a. Each company providing nurse-staffed ALS units shall develop and maintain procedures for the hiring and training of nursing personnel and vehicle staffing.
   b. Each provider must develop a manual clearly displaying:
      1. Malpractice insurance coverage.
      2. Identify and accessibility of the Physician Director and Nursing Coordinator.
      3. Vehicle inventory lists
      4. Copies of all related interfacility transfer paperwork
      5. Statement of responsibility of the sending physician for the patient during transfer and in accordance with COBRA and SB317 laws.
      6. Guidelines for change in patient destination due to patient condition
      7. Protocols (Standing Orders) based on ACLS, PALS/PEPP, or NALS guidelines.
   c. Procedures and protocols shall be subject to review by the VC EMS.
4. CQI
   a. The Physician Director and/or Nursing Coordinator shall be responsible for performing quality assurance outcome audits.
   b. Patient transport record review shall be performed at least quarterly and involve the use of pre-established criteria.
   c. All transports resulting in adverse patient outcome shall be reviewed and reported to the VC EMS Agency per Policy 150.
   d. Periodic staff conferences on audit and outcomes are required in order to improve or revise protocols.
   e. Records of all these activities shall be kept by the provider and be made available for inspection and audit by VC EMS.

f. Report (quarterly) to VC EMS. Reports are to include general statistics (number of runs, types of runs, outcomes, intubation statistics, incidents during which EMT-P assistance at ALS level is required).

5. Program Approval

Requests for approval must be made in writing sixty (60) days prior to anticipated service starting date, to the administrator of VC EMS, and must include:

a. Proposed identification and location of the nurse-staffed unit.
b. Procedures and protocols
c. Documentation of qualifications of the proposed Physician Director (if applicable).
d. Documentation of qualifications for the proposed Nursing Coordinator.
e. Preliminary plan for quality assurance audits.
f. Agreement to comply with all policies and procedures of VC EMS.

VC EMS shall notify the applicant in writing within ten (10) working days of lack of documentation. The applicant shall be notified in writing within thirty (30) days of receipt of complete package of approval or denial of the program.

6 Program Review

a. VCEMS may perform periodic on-site audits of records to ensure compliance with this policy.
b. Non-compliance with this policy may cause VC EMS to suspend or revoke approval to provide nurse-staffed ALS inter-facility transports.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Withholding or Termination of Resuscitation and Determination of Death	Policy Number: 606
APPROVED: Administration: ~~Barry R. Fisher, MPPA~~Steven L. Carroll, EMT-P	Date: ~~December 1, 2008~~
APPROVED: Medical Director Angelo Salvucci, MD	Date: ~~December 1, 2008~~
Origination Date: June 1984 Date Revised: ~~October 9, 2008~~ Date Last Reviewed: ~~October 9, 2008~~ Next Review Date: ~~October, 2011~~	Effective Date: December 1, 2008

DRAFT

I. PURPOSE: To establish criteria for withholding or termination of resuscitation and determination of death by prehospital EMS personnel.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.220,1798 and 7180. Government Code 27491 and 27491.2. California Code of Regulations, Title 22, Division 9, Section 100175.

III. POLICY: Prehospital EMS personnel may withhold or terminate resuscitation and determine that a patient is dead, and leave the body in custody of medical or law enforcement personnel, according to the procedures outlined in this policy.

IV. DEFINITION:

1. Prehospital EMS personnel: Prehospital EMS personnel mean all responding EMT-Is and Paramedics, and flight nurses.
2. Further Assessment: "Further assessment" refers to a methodical evaluation for signs/symptoms of life in the apparently deceased person. This evaluation includes examination of the respiratory, cardiac and neurological systems, and a determination of the presence or absence of rigor mortis and dependent lividity. The patient who displays any signs of life during the course of this assessment may NOT be determined to be dead,
3. Hospital: A licensed health care institution that provides acute medical care.
4. Skilled Nursing Facility: A licensed health care institution that provides non-acute care for elderly or chronically ill patients, and has licensed medical personnel on scene (RN or LVN).
5. Hospice: A care program into which terminally ill patients may be enrolled, to assist with the management of palliative care during the terminal stages of illness.

V. PROCEDURE:

A. General Guidelines:

1. The highest medical authority on scene shall determine death in the field.
   a. If BLS responders have any questions or uncertainty regarding determination of death, BLS measures shall be instituted until arrival of ALS personnel.
   b. If ALS responders have questions or uncertainty regarding determination of death, ALS measures shall be instituted until base hospital contact is made and orders received.
2. Prehospital EMS personnel who have determined death in the field in accordance with the parameters of this policy are not required to make base hospital contact.
3. Prehospital EMS personnel who arrive on scene after the patient is determined to be dead shall not re-evaluate the patient.

PATIENTS WHO ARE OBVIOUSLY DEAD

Upon arrival, prehospital EMS personnel shall rapidly assess the patient. For patients suffering any of the following conditions, no further assessment is required. No treatment shall be started and the patient shall be determined to be dead.

- Decapitation,
- Incineration,
- Hemicorporectomy, or
- Decomposition.

PATIENTS WHO APPEAR TO BE DEAD
(WITH Rigor Mortis and/or Dependent Lividity)

B. Patients who are apneic and pulseless require further assessment as described in table 1.

1. If rigor mortis and/or dependent lividity are present, and if no response for all the assessment procedures indicates signs of life, the patient shall be determined to be dead.
2. Rigor mortis is determined by checking the jaw and other joints for rigidity.

3. Dependent lividity is determined by checking dependent areas of the body for purplish-red discoloration.

Table 1.

CATEGORY	ASSESSMENT PROCEDURES	FINDINGS FOR DETERMINATION OF DEATH
Respiratory	Open the patient's airway. Auscultate lungs or feel for breaths while observing the chest for movement for a minimum of 30 seconds	No spontaneous breathin No breath sounds on auscultation.
Cardiac	Palpate the carotid artery (brachial for infant) for a minimum of 1 minute. Auscultate for heart sounds for minimum 1 minute. OR **ALS ONLY-** Monitor the patient's cardiac rhythm for minimum of 1 minute. Check asystole in 2 leads. Obtain a 6-second strip to be retained with the EMS provider documentation.	No pulse. No heart sounds.
Neurological	Check for pupil response to light. Check for response to painful stimuli.	No pupillary response. No response to painful Stimuli.

1. While in the process of the assessment procedures, if any response indicates signs of life, resuscitation measures shall take place immediately.
2. **If rigor mortis and/or dependent lividity are present**, and if no response for all the assessment procedures indicates signs of life, the patient shall be determined to be dead.

PATIENTS WHO APPEAR TO BE DEAD:
(WITHOUT Rigor Mortis and/or DEPENDENT LIVIDITY)

C. Patients who appear to be dead but display no signs of rigor mortis and/or dependent lividity shall have the cause of apparent death determined to be **MEDICAL** (including drowning, ingestion, asphyxiation, hanging, poisoning, lightning strikes, and electrocution), or **TRAUMATIC** (and injuries are sufficient to cause death).
   1. **MEDICAL ETIOLOGY**: Resuscitation measures shall take place.
   2. **TRAUMATIC ETIOLOGY**: Further assessment as defined in Table 1 shall be performed. If no response for all the assessment

procedures, the patient's age should be determined. (reasonable estimation appropriate if positive determination of age is not possible)

a. For patients younger than 18 years of age, resuscitation measures, including transport to the closest ~~hospital~~ trauma center, shall take place.

b. For patients 18 years or older:

1) BLS RESPONDERS:

a) If the time from **initial determination** of pulselessness and apnea until ~~hospital~~trauma center arrival is estimated to be less than 20 minutes, resuscitation measures, including transport to the ~~hospital~~ closest trauma center, shall take place.

b) If the time from **initial determination** of pulselessness and apnea until ~~hospital~~ trauma center arrival is estimated to be 20 minutes or more, the patient may be determined to be dead.

2) **ALS RESPONDERS:**

a). If the time from **initial determination** of pulselessness and apnea until ~~hospital~~ trauma center arrival is ~~re-~~estimated to be less than twenty minutes, using a cardiac monitor, the patient's rhythm should be assessed.

1. If the rhythm is narrow complex PEA, wide complex PEA greater than 30 beats per minute, ventricular tachycardia or ventricular fibrillation, resuscitation measures, including transport to the ~~hospital~~closest trauma center, shall take place.

2. If the rhythm is asystole or wide complex PEA at a rate of 30 beats per minute or slower, the patient shall be determined to be dead.

b.) If the time from **initial determination** of pulselessness and apnea until ~~hospital~~ trauma center arrival is estimated to be twenty minutes or more, the patient may be determined to be dead, regardless of cardiac rhythm..

D. Termination of Resuscitation

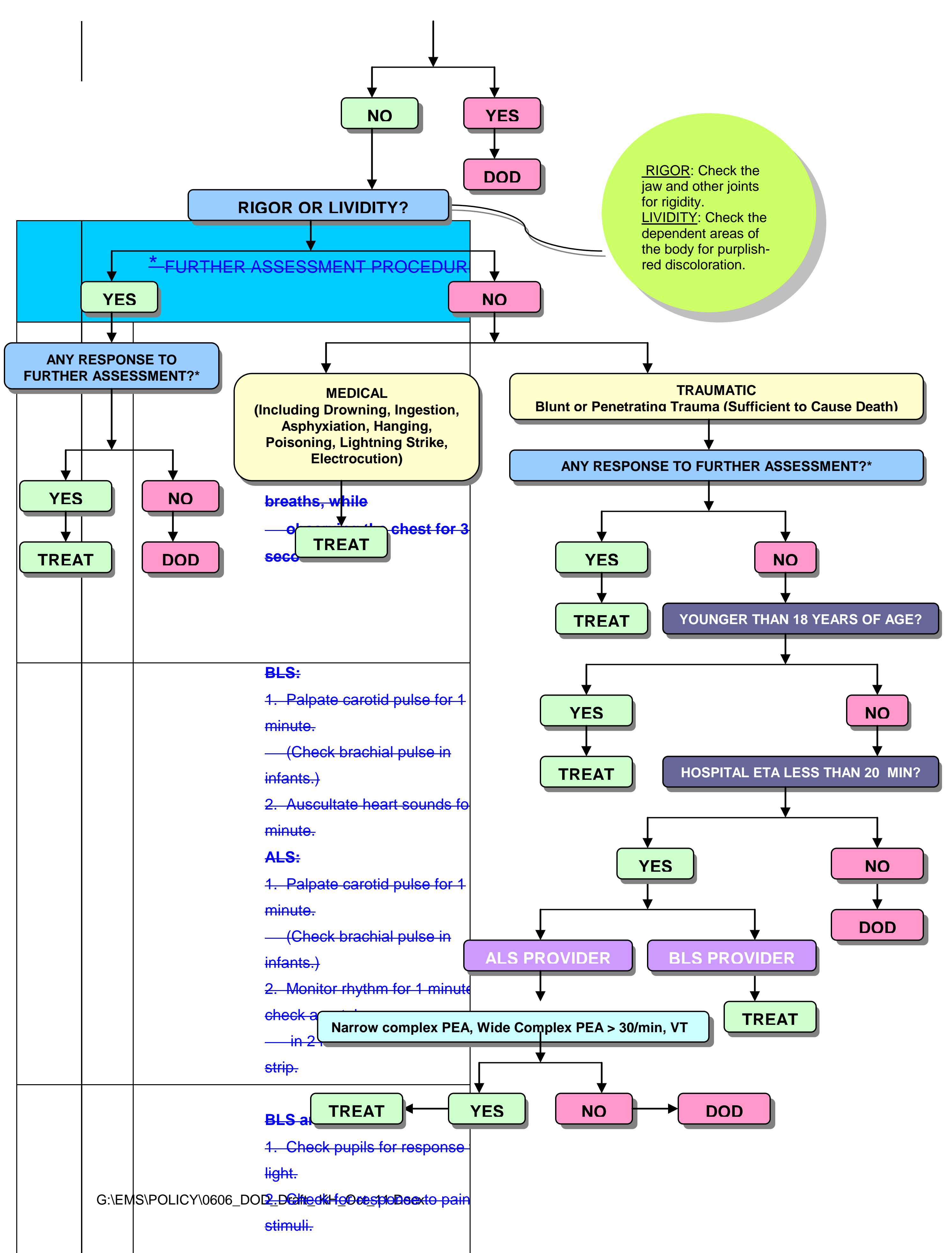
1. Base hospitals and EMS personnel should consider terminating resuscitation measures on adult patients (age 18 and older) who are in cardiopulmonary arrest and fail to respond to treatment under VC EMS Policy 705: Cardiac Arrest, Adult.
2. If resuscitation measures have been initiated, base hospital contact should be attempted before resuscitation is terminated and the patient determined toe dead.
3. If unable to make base hospital contact, resuscitation efforts may be terminated and the patient determined to be dead using the following criteria:
   a. Patients without evidence of trauma who meet termination of resuscitation criteria in VC EMS Policy 705: Cardiac Arrest, Adult.
   b. Patients with blunt or penetrating trauma if the cardiac rhythm is or becomes asystole or wide complex PEA at a rate less than 30 beats per minute.
4. In cases of cardiopulmonary arrest as a result of a lightning strike, electrocution or suspected hypothermia, CPR shall be performed for a minimum of one hour. **BLS responders in these circumstances shall make all reasonable attempts to access ALS care.**

E. Documentation
1. EMS personnel will document determination of death in the approved Ventura County Documentation System (AVCDS).

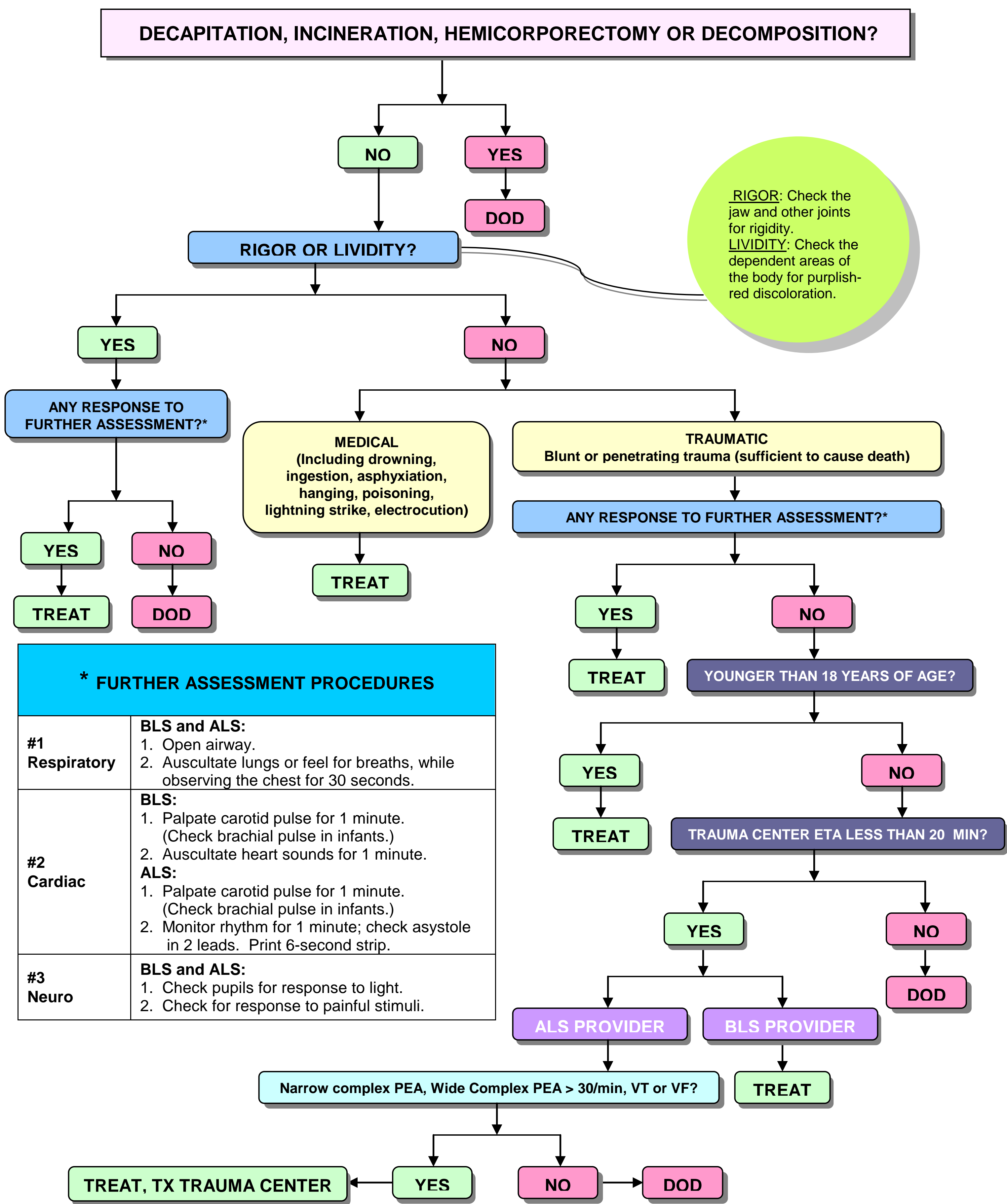
F. Disposition of Decedent's Body
1. Deaths that occur in hospitals or skilled nursing facilities, or to patients enrolled in hospice programs, do not require law enforcement response. Under these circumstances the body may be left at the scene.
2. Deaths that occur anyplace other than a hospital or skilled nursing facility **except to patients enrolled in hospice programs**, must be reported to law

Ventura County EMS Determination of Death

DECAPITATION, INCINERATION, HEMICORPORECTOMY OR DECOMPOSITION?


NO
YES
DOD
RIGOR OR LIVIDITY?
RIGOR: Check the jaw and other joints for rigidity.
LIVIDITY: Check the dependent areas of the body for purplish-red discoloration.
* FURTHER ASSESSMENT PROCEDUR
YES
NO
ANY RESPONSE TO FURTHER ASSESSMENT?*
MEDICAL (Including Drowning, Ingestion, Asphyxiation, Hanging, Poisoning, Lightning Strike, Electrocution)
TRAUMATIC Blunt or Penetrating Trauma (Sufficient to Cause Death)
ANY RESPONSE TO FURTHER ASSESSMENT?*
YES
NO
TREAT
DOD
TREAT
YES
NO
TREAT
YOUNGER THAN 18 YEARS OF AGE?
YES
NO
TREAT
HOSPITAL ETA LESS THAN 20 MIN?
YES
NO
DOD
ALS PROVIDER
BLS PROVIDER
TREAT
Narrow complex PEA, Wide Complex PEA > 30/min, VT
TREAT
YES
NO
DOD
breaths, while
observe the chest for 3
seco
BLS:
1. Palpate carotid pulse for 1 minute.
(Check brachial pulse in infants.)
2. Auscultate heart sounds fo minute.
ALS:
1. Palpate carotid pulse for 1 minute.
(Check brachial pulse in infants.)
2. Monitor rhythm for 1 minute
check a
in 2
strip.
BLS a
1. Check pupils for response light.
2. Check for response to pain stimuli.

Ventura County EMS Determination of Death



* FURTHER ASSESSMENT PROCEDURES	
#1 Respiratory	**BLS and ALS:** 1. Open airway. 2. Auscultate lungs or feel for breaths, while observing the chest for 30 seconds.
#2 Cardiac	**BLS:** 1. Palpate carotid pulse for 1 minute. (Check brachial pulse in infants.) 2. Auscultate heart sounds for 1 minute. **ALS:** 1. Palpate carotid pulse for 1 minute. (Check brachial pulse in infants.) 2. Monitor rhythm for 1 minute; check asystole in 2 leads. Print 6-second strip.
#3 Neuro	**BLS and ALS:** 1. Check pupils for response to light. 2. Check for response to painful stimuli.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Fireline Medic		Policy Number 627
APPROVED: Administration:	Steven Carroll, EMT-P	Date:
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date:
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 5, 2011 October 31, 2013	Effective Date: DRAFT

I. PURPOSE: To establish procedures for responders working for agencies within Ventura County, who are accredited by the Ventura County EMS Agency (VCEMSA), who respond outside of Ventura County to other jurisdictions through the statewide fire and rescue mutual aid system, and who operate as fireline paramedics in those areas.

II. AUTHORITY:: California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220; California Code of Regulations, Title 22, Division 9, Sections 100165 and 100167

III. POLICY:

A. County accredited paramedics shall carry the ALS/BLS inventory consistent with the FIRESCOPE FEMP position description. Reasonable variations may occur; however, any exceptions shall have prior approval of the VCEMSA. The equipment lists are a minimalist, scaled down version of standard inventory in order to meet workable/packable weight limitations (45 lbs including wildland safety gear).

1. It will not be possible to maintain standard ALS minimums on the fireline. The attached ALS inventory essentially prioritizes critical and probable fireline needs.

DRAFT

2. VCEMS accredited paramedics may function within their scope of practice, when serving in an authorized capacity assignment, as an agent of their authorized ALS fire agency.

IV. PROCEDURE:

A. Under the authority of State regulations, a paramedic may render ALS care during emergency operations as long as the following conditions are met:

1. The paramedic is currently licensed by the State of California and is accredited by the Ventura County EMS Agency.

2. The paramedic is currently employed with a Ventura County ALS provider and possesses the requisite wildland fireline skills and equipment.

3. The paramedic practices within the treatment guidelines set forth in VCEMSA policies and procedures manual. Paramedics operating in the capacity of a fireline paramedic (FEMP) shall follow VCEMSA communication failure protocol.

4. The FEMP is expected to check in and obtain a briefing from the Logistics Section Chief, or the Medical Unit Leader (MEDL) if established at the Wildfire Incident.

5. Documentation of patient care will be completed as per VCEMSA policy 1000.

a. Documentation of patient care will be submitted to incident host agencies. A VCePCR will be completed and posted in accordance with VCEMSA policy. The FEMP works shall provide a copy of the report to the incident medical unit leader.

6.. Continuous Quality Improvement activities shall be in accordance with VCEMSA standards.

APPENDIX A

FIRELINE EMERGENCY MEDICAL TECHNICIAN

BASIC LIFE SUPPORT (BLS) PACK INVENTORY

□ Airway, OPA Kit (1)
□ Airway, NPA Kit (1)
□ Biohazard Bag (2)
□ Bag Valve Mask (1)
□ Mylar Thermal Survival Blanket (2)
□ Bandage, Sterile 4 x 4 (6)
□ Bandage, Triangular (2)
□ Cervical Collar, Adjustable (1)
□ Cold Pack (3)
□ Glucose, Oral (1 Tube)
□ Dressing, Multi-Trauma (4)
□ Eye Wash (1 bottle)
□ Pen Light (1)
□ Exam Gloves
□ Coban Wraps/Ace Bandage (2 ea.)
□ Kerlix, Kling, 4.5, Sterile (2)

□ Mask, Face, Disposable w/eye shield (1)
□ Pad, Writing (1)
□ Pen and Pencil (1 ea.)
□ Triangular Dressing with Pin (2)
□ Splinter Kit (1)
□ Shears (1)
□ Burn Sheet (2)
□ Stethoscope (1)
□ Sphygmomanometer (1)
□ Splint, Moldable (1)
□ Suction, Manual Device (1)
□ Tape, 1 inch, Cloth (2 rolls)
□ Petroleum Dressing (2)
□ Thermometer, Digital (1)
□ Triage Tags (6)

APPENDIX B

FIRELINE EMERGENCY MEDICAL TECHNICIAN

PARAMEDIC (ALS) PACK INVENTORY **IN ADDITION TO THE BASIC LIFE SUPPORT INVENTORY, THE FOLLOWING ADDITIONAL ITEMS OR EQUIVALENTS SHALL BE CARRIED BY THE FEMP

ALS AIRWAY EQUIPMENT:

□ Endotracheal Intubation Equipment (6.0, 7.5 ET – Mac 4, Miller 4, stylette and handle)
□ Rescue Airway (1)
□ ETT Restraint
□ End Tidal CO_2 Detector
□ ETT Verification Device
□ Needle Thoracostomy Kit (1)

IV/MEDICATION ADMIN SUPPLIES:

□ IV Administration Set-Macro-Drip (2)
□ IV Site Protector (2)
□ Alcohol Preps (6)
□ Betadine Swabs (4)
□ Tourniquet (2)
□ Razor (1)
□ Tape (1)
□ 14 ga. IV Catheter (2)
□ 16 ga. IV Catheter (2)
□ 18 ga. IV Catheter (2)
□ 20 ga. IV Catheter (2)
□ Adult EZ-IO Kit (1)
□ 25 mm EZ-IO Needle (1)
□ 45 mm EZ-IO Needle (1)
□ EZ Connect tubing (2)
□ 10 cc Syringe (2)
□ 1 cc TB Syringe (2)
□ 18 ga. Needle (4)
□ 25 ga. Needle (2)
□ Glucometer Test Strips (4)
□ Lancet (4) \

MISCELLANEOUS:

□Sharps Container - Small(1)
□ Narcotic Storage (per agency policy)*
□ FEMP Pack Inventory Sheet (1)
□ PCR Paper Forms (6)
□ AMA Paper Forms (3)

DRAFT

BIOMEDICAL EQUIPMENT:

□ Compact AED (waveform display preferred) (1)
□ AED Pads (2)
□ Pulse Oximeter (1 Optional)
□ Glucometer (1)

MEDICATIONS:

□ Albuterol 5 mg/6 ml (6 Vials)
□ Antiarrythmic (quantity and type per local protocol)
□ Aspirin-Chewable (1 Bottle)
□ Atropine Sulfate 1 mg (2)
□ Dextrose 50% 25 G. Pre-Load (1)
□ Diphenhydramine 50 mg (4)
□ Epinephrine 1 10,000 1mg (2)
□ Epinephrine 1 1,000 1 mg (4)
□ Glucagon 1 mg/unit (1)
□ Versed 20 mg
□ Morphine Sulfate 10 mg/ml (6)
□ Nitroglycerin 1/150 gr (1)
□ Saline 0.9% IV 1,000 ML – Can be configured into two 500 cc or four 250 cc

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Documentation of Prehospital Care		Policy Number 1000
APPROVED: Administration:	Steven Carroll, EMT-P	Date: December 1, 2010
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date: December 1, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 15, 1998 October 14, 2010 October 14, 2010 October 31, 2013	Effective Date: December 1, 2010

DRAFT

I. PURPOSE: To define the use of standardized records to be used by Ventura County Emergency Medical Service (VCEMS) providers for documentation of pre-hospital care.

II. AUTHORITY: Title 22 Section 100147.

III. POLICY: Patient care provided by first responders and ambulance personnel will be documented using the appropriate method.

IV. PROCEDURE:

A. Provision of ~~Forms~~Access

VCEMS will provide ~~a supply of First Responder Patient Care Records (FR PCR)~~access to the approved Ventura County Electronic Patient Care Report (VCePCR) system and software~~-~~ to EMS system ~~participants~~ stakeholders required to enter, edit, or analyze data.~~that are not currently on the approved Ventura County documentation system (AVCDS).~~

B. Documentation

1. The VCEMS ~~FR PCR and AVCDS~~ VCePCR ~~report~~ will be used to document the care provided by ~~first responders and ambulance~~ pre-hospital personnel for every ~~patient contact~~patient contact and/or incident to which a particular unit or provider is attached. A~~n~~ ~~patient contact~~incident will be defined as any ~~encounter~~ response involving Ventura County pre-hospital personnel to any event in which there is an actual victim, or the potential for a victim, regardless of whether the responding unit was cancelled enroute or not. A patient contact is defined as any encounter

involving Ventura County pre-hospital personnel with any person consenting, either implied or informed, to assessment and/or treatment. Documentation shall be completed on any person with obvious injury or significant mechanism regardless of consent. The following are exceptions:

a. If a First Responder Advanced Life Support (FR ALS) Paramedic initiates care of the patient, the FR ALS Paramedic will shall document all care provided to the patient on AVCDSePCR.

b. If care is turned over to another ALS agency, an AVCDS VCePCR report will shall be completed by all pre-hospital provider agencies who delivered patient care and/or transport. .

c. The appropriate level VCePCR shall be completed to correspond to the level of care provided to the patient. If an ALS provider determines a patient to only require basic level care, a VCePCR-BLS report can be utilized. If a unit or provider is attached to an incident, but cancelled enroute, a VCePCR-Cancelled Call form shall be completed and posted.

d. A minimum validation score of 95 shall be required for all VCePCRs prior to completion and locking of the document.

e. Patient side reporting is encouraged and should be practiced whenever it would not result in a provider accurately and effectively assessing and/or treating a patient.

f. c. In the event of multiple patients, documentation will be accomplished as follows:

1) Level 1 MCI: The care of each patient shall be documented using an AVCDS VCePCRreport.

2) Level 2 and 3 MCI: Each patient transported to a hospital shall have their care documented on a Ventura County Multi-Casualty Patient Record.

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

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

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

2. Transfer of Care

Transfer of care between two field provider teams and between field provider and hospital shall be documented on appropriate ~~AVCDS~~VCePCR. The first arriving agency will post to the server and perform a coordinated electronic transfer of care whenever possible within the VCePCR system to the next incoming unit. This includes intra-agency units and inter-agency units.

3. A VCePCR~~AVCDS and FR PCR's~~ shall be completed ~~according to instructions~~in accordance with training ~~distributed~~ administered by VCEMS, or designee.

a. ~~First Responder Patient Care Record~~

~~1) Original shall be retained by the provider agency. A copy shall be submitted to the VCEMS Agency.~~

C. In the event the cardiac monitor is attached as required by any of the VCEMS 705 policies, a ~~rhythm strip~~complete ECG data transfer shall be recorded and ~~mounted on an ECG form~~attached to the corresponding VCePCR. ~~Additionally, anytime there are changes in the patient's ECG rhythm, defibrillation occurs, ALS procedures are performed, or after ALS medications are administered, a trace recording of the ECG is required. Distribution of these trace recordings are as follows:~~ ECG data shall be downloaded by each provider agency involved in that incident and attached to the corresponding VCePCR.

1. ~~The original copy shall be placed in the patient's chart.~~
2. ~~Two additional copies of that strip shall be made. The first submitted to the receiving or base hospital (depending on where the patient is transported), and the second to the provider.~~

D. Submission to VCEMS

~~The Emergency Medical Services Agency copy of the FR PCR shall be submitted to the Emergency Medical Services Agency by Provider Agency at least monthly.~~The approved minimum data set shall be electronically posted to the server by transporting agencies prior to the transporting unit returning to service from any incident in which a patient was transported. For all other reports, any and all VCePCRs shall be completed and posted to the server no later than 24 hours from the time the incident was generated.

F. Dry Run/Against Medical Advice

Every patient contact resulting in refusal of medical attention/transport must be documented with the following information, the reason dispatched and/or chief complaint, assessment and vital signs, base hospital contact (when appropriate), patient advised to seek medical attention and completion of AMA. The AMA checklist as well as patient signatures shall be captured whenever possible by each applicable agency at the time of patient contact/refusal. If, at any point, a signature is not obtained for any reason, explanation shall be documented in the narrative section of the VCePCR.

G. ALS Interfacility Transfers (Acute Care Facility to Acute Care Facility)

Documentation shall be completed on all ALS Interfacility transfers only. Documentation will include, but not be limited to, baseline assessment, medications administered, reason for transfer, procedures done to the patient, vital signs and any changes from baseline assessment.

If the transferring facility sends staff to accompany the patient, the staff member(s) name(s) shall be documented on the ~~AVCDS~~VCePCR.

H. Patient Medical Record

The ~~hospital copy of the FR PCR, AVCDS~~ VCePCR and Ventura County Multi-Casualty Patient Record shall be considered a legal document and part of the patient's medical record. The first responder agency, transport agency, and hospital are custodians of record. Printing should only be performed as needed, and an electronic copy of the VCePCR should be utilized and referred to whenever feasible. A print log and reason for printing shall be monitored regularly to help ensure security of protected health information within the system.

Attachment A

These abbreviations have been accumulated from the California approved EMT Curriculum and various other resource material. The abbreviations were collected by the Ventura County ALS CQI Team to assist EMS field, hospital and dispatch personnel in providing consistent medical documentation.

Term	Abbreviation
5% Dextrose in Water	D5W
Abdomen	Abd
Above knee amputation	AKA
Acquired Immunodeficiency Syndrome	AIDS
Ad Libitum (as desired)	Ad lib
Advanced Life Support	ALS
Against medical advise	AMA
Alcohol	ETOH
Alert and oriented	A & O
Also known as	AKA
Altered Level Of Consciousness	ALOC
Amount	Amt
Ampule	Amp
Antecubital	AC
Anterior	Ant
Anterior/Posterior	AP
Appointment	Appt
Arterial Blood Gas	ABG
Arteriosclerotic Heart Disease	ASHD
As necessary	prn
As soon as possible	ASAP
Aspirin	ASA
At	@
Atrial Fibrillation	A fib, AF
Attention Deficit Hyperactivity Disorder	ADHD
Automated external Defibrillator	AED
Automatic Implantable Cardiac Defibrillator	AICD
Bag Valve Mask	BVM
Basic Life Support	BLS
Birth Control Pill	bcp
Bowel Movement	BM
Bundle Branch Block	BBB
By Mouth	p.o.
By Order Of	per
Cancer	CA
Carbon Dioxide	CO_2
Carbon Monoxide	CO

Term	Abbreviation
Cardio Pulmonary Resuscitation	CPR
Central Nervous System	CNS
Cerebrospinal Fluid	CSF
Cerebrovascular Accident	CVA
Cervical Spine	C-Spine
Chief Complaint	CC
Chronic Obstructive Pulmonary Disease	COPD
Circulation, Sensation, Motor	CSM
Clear	Cl
Continuous Positive Airway Pressure	CPAP
Coronary Artery Bypass Graft	CABG
Coronary Artery Disease	CAD
Date of Birth	DOB
Dead on Arrival	DOA
Defibrillated	Defib
Delirium Tremens	DTs
Diabetes Mellitus	DM
Dilation and curettage	D & C
Discontinue*	D/C*
Deformity, Contusion, Abrasion, Penetration, Burn, Tenderness, Laceration, Swelling	DCAPBTLS
Do Not Resuscitate	DNR
Doctor of Osteopathy	DO
Drops	gtts
Dyspnea On Exertion	DOE
Electrocardiogram	ECG
Electroencephalogram	EEG
Emergency Department	ED
Emergency Medical Services	EMS
Emergency Medical Technician	EMT
Endotracheal	ET
Equal	=
Estimated	Est
Estimated Time of Arrival	ETA
Etiology	Etiol.

Term	Abbreviation
Every	q
Every day*	qd*
Evening	pm
Extended Care Facility	ECF
Eye, ear, nose, throat	EENT
Fahrenheit	F
Female	F
Fetal Heart Rate	FHR
Fluid	Fl
Foot	Ft
Foreign body	FB
Four times a day	QID
Fracture	Fx
Gallbladder	GB
Gastrointestinal	GI
Genitourinary	GU
Glasgow Coma Score	GCS
Grain	Gr
Gram	gm
Gravida 1,2,3, etc	G1, G2, G3
Gun Shot Wound	GSW
Gynecological	Gyn
Heart Rate	HR
Hematocrit	Hct
Hemoglobin	Hgb
Hepatitis A Virus	HAV
Hepatitis B Virus	HBV
Hepatitis C Virus	HCV
History	Hx
History and Physical	H & P
Hour of Sleep (bedtime)*	hs*
Human Immunodeficiency Virus	HIV
Hydrochlorothiazide	HCTZ
Hypertension	HTN
Immediately	STAT
Insulin Dependent Diabetes Mellitus	IDDM
Intake and Output	I & O
Intensive Care Unit	ICU
Intercostal Space	ICS
Intracranial Pressure	ICP
Intralingual	IL
Intramuscular	IM
Intraosseous	IO
Intrauterine Device	IUD
Intravenous	IV
Intravenous Push	IVP
Irregular	Irreg
Jugular venous distention	JVD
Kilogram	kg
Kilometer	Km
Labor and Delivery	L & D
Laceration	Lac
Last Menstrual Period	LMP
Lateral	Lat
Left	L
Left Eye*	OD*

Term	Abbreviation
Left Lower Extremity	LLE
Left Lower Lobe	LLL
Left Lower Quadrant	LLQ
Left Upper Extremity	LUE
Left Upper Lobe	LUL
Left Upper Quadrant	LUQ
Less Than	<
Lower Extremity	LE
Lumbar Puncture	LP
Male	M
Medical Doctor	MD
Metered Dose Inhaler	MDI
Microgram	mcg
Milliequivalent	mEq
Milligram	mg
Milliliter	ml
Millimeter	mm
Minute	Min
Morning	am
Morphine Sulphate*	MS*
Motor Vehicle Collision	MVC
Mouth	MO
Moves all Extremities	MAE
Multiple Casualty Incident	MCI
Multiple sclerosis	MS
Myocardial Infarction	MI
Nasal cannula	NC
Nausea/Vomiting	NV
Negative	neg
Night	Noc
Nitroglycerine	NTG
No Acute Distress	NAD
No Known Allergies	NKA
No Known Drug Allergies	NKDA
Non Insulin Dependent Diabetes Mellitus	NIDDM
Non Rebreather Mask	NRBM
Non Steroidal Anti-inflammatory Drugs	NSAID
Normal Saline	NS
Normal Sinus Rhythm	NSR
Not applicable	NA
Nothing by Mouth	NPO
Obstetrics	OB
Occupational Therapy	OT
Oral Dissolving Tablet	ODT
Operating Room	OR
Organic Brain Syndrome	OBS
Ounce	oz
Over the Counter	OTC
Overdose	OD
Oxygen	O2
Palpable	Palp
Para, number of pregnancies	Para 1,2,3, etc
Paramedic	PM

Term	Abbreviation
Paroxysmal Supraventricular Tachycardia	PSVT
Paroxysmal Nocturnal Dyspnea	PND
Past Medical History	PMH
Pediatric Advanced Life Support	PALS
Pelvic Inflammatory Disease	PID
Per Rectum	pr
Percutaneously Inserted Central Catheter	PICC
Phencyclidine	PCP
Physical Exam	PE
Positive	+, pos
Pound	lb
Pregnant	Preg
Premature Ventricular Contraction	PVC
Primary Care Physician	PCP
Private/Primary Medical Doctor	PMD
Privately Owned Vehicle	POV
Pro Re Nata – As Needed	PRN
Pulmonary Embolism	PE
Pulse, Motor, Sensation	PMS
Pulseless Electrical Activity	PEA
Pupils Equal Round and Reactive to Light	PERRL
Range of Motion	ROM
Registered Nurse	RN
Respiration	R
Respiratory Rate	RR
Respiratory Therapist	RT
Right	Rt
Right Eye*	OD*
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ
Right Middle Lobe	RML
Ringer's Lactate	RL
Rule Out	R/O
Sexually Transmitted Disease	STD

Term	Abbreviation
Shortness of Breath	SOB
Sinus Bradycardia	SB
Sinus Tachycardia	ST
Sodium Bicarbonate	NaHCO3
Sodium Chloride	NaCl
Streptococcus	Strep
Subcutaneous*	SQ*
Sublingual	SL
Sudden Acute Respiratory Syndrome	SARS
Sudden Infant Death Syndrome	SIDS
Supraventricular Tachycardia	SVT
Temperature	T
Temperature, Pulse, Respiration	TPR
Three Times a Day	TID
Times	X
To Keep Open	TKO
Tracheostomy	Trach
Traffic Accident	TA
Transient Ischemic Attack	TIA
Transcutaneous Pacing	TCP
Treatment	Tx
Tuberculosis	TB
Twice a day	BID
Upper Respiratory Infection	URI
Urinary Tract Infection	UTI
Ventricular Fibrillation	VF
Ventricular Tachycardia	VT
Vital Signs	VS
Volume	Vol
Water	H20
Weight	Wt
With	w/
Within Normal Limits	WNL
Without	w/o
Wolf-Parkinson-White	WPW
Year	Yr
Years Old	y/o

*JCAHO and ISMP have indicated these abbreviations have a high likelihood of misinterpretation; thereby leading to medical errors, therefore, they are ***not*** to be used in ***handwritten*** documentation.

A Division of the Ventura County Health Care Agency

BARRY R. FISHER, MPPA
Director

EMERGENCY MEDICAL SERVICES

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

STEVEN L. CARROLL, EMT-P
EMS Administrator

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

MEMORANDUM

DATE: October 3, 2011

TO: EMS Advisory Committee and
PreHospital Service Committee Members

FROM: Steve Carroll, EMS Administrator

RE: Gentle Care Transport Inc. Application

The Ventura County EMS Agency (VCEMS) has received an application from Gentle Care Transport Inc. requesting a license to provide Basic Life Support ambulance transportation within the County of Ventura. Gentle Care Transport Inc. is a non-emergency ambulance provider currently based in Los Angeles, Riverside and San Diego Counties.

Per Ventura County Ordinance 4099 and VCEMS Policy 111, an ambulance provider requesting to provide service within the County of Ventura will submit an application to VCEMS. According to the procedure outlined in Policy 111, applications will be reviewed by VCEMS staff, the EMS Advisory Committee and the Pre-Hospital Services Committee (PSC). If PSC issue a recommendation, the application will be submitted to the various City Councils where the applicant wishes to operate, requesting resolution of approval or disapproval. If approval is recommended by PSC, the application along with reports and/or recommendations from the above organizations will be presented to the Board of Supervisors for final action of approval or denial of the application.

The last fully completed application for non-emergency ambulance transportation was received by Schaefer Ambulance Service in 1998. After finding that no significant “need or necessity” existed for additional non-emergency ambulances in Ventura County and that the approval of the application could have a negative impact on the overall viability of the countywide EMS system, the application was denied by the Board of Supervisors. More recently, an incomplete application was received in November of 2009 from ProCare Mobile Response. Recommendation was to deny the application following review of the EMS

Advisory Committee and PSC, based on the continued lack of need and necessity for additional ambulance service and the potential negative impact on the existing providers. ProCare failed to respond to requests for necessary additional documentation and their application was ultimately denied in April 2010.

VCEMS Staff has reviewed the Gentle Care Transport Inc. application and found it deficient in several areas.

- Applications shall include facts demonstrating the necessity for an additional ambulance provider such as written statements indicating either inadequate response times or inadequate care from existing providers. The application from Gentle Care Transport included one statement from Logisticare indicating they would be interested in utilizing the services of a new BLS provider, however, it failed to indicate deficiency with the existing county providers. Additionally, Gentle Care provided a letter indicating that they were invited by Kaiser to provide transportation in Ventura County to improve level of service provided to the Kaiser patients; however, all three existing providers are currently contracted with Kaiser.
- Inquiries to LA County EMS Agency indicated that Gentle Care Transport is a fairly new licensed company in their county. Upon 6 month review of their application, several deficiencies were noted, however they were successfully addressed and no further violations have been found.
- According to Policy 111, applications shall include 3 years of financial statements; however, Gentle Care Transport's application only included 2009 and 2010 statements.

Correspondence has been received from all three current Ventura County ambulance providers expressing serious concerns with their ability to continue providing the high quality and responsive emergency ambulance coverage that is expected on a daily basis if additional competition is allowed to enter the non-emergency ambulance market. They have also expressed concern that additional non-emergency ambulance services would not be subject to the same mandates for system enhancements, dispatch and CQI oversight fees and non-compliance penalties, as outlined in the current performance based ambulance contracts.

Based on the above information, the lack of a verified need and necessity for additional non-emergency ambulances and the potential for significant negative impact on the current Emergency Medical Services system, the EMS Agency recommends denial of the Gentle Care Transport Inc. application.

A Division of the Ventura County Health Care Agency

BARRY R. FISHER, MPPA
Director

EMERGENCY MEDICAL SERVICES

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

STEVEN L. CARROLL, EMT-P
EMS Administrator

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

MEMORANDUM

Date: **October 5, 2011**

To: **Pre-Hospital Services Committee**
Ventura County Emergency Medical Services Agency

From: **Diane Starzak, Chair**
EMS Advisory Committee

Subject: **Gentle Care Transport Inc. Non Emergency Ambulance Application**

Committee Members include: Diane Starzak, Gerry Arcuri, Rodney Smith , Joe Milligan, Ray Blackwell and Bob Taylor. Staff representatives: Steve Carroll, Chris Rosa and Debora Haney

Gentle Care Transport Inc. has submitted an "Application for Ambulance Company License" in Ventura County. Using the guidance of the County of Ventura Health Care Agency, Public Health Department, Emergency Medical Services Policy and Procedures number 110 and 111, the EMS Advisory Committee was requested to review their application. The EMS Agency investigated the application and provided information to the EMS Advisory Committee for review. Information included the application packet, existing ambulance providers' statements, and responses from acute and non acute medical facilities that utilize or interact with ambulance service providers in Ventura County.

Based upon the information reviewed, the EMS Advisory Committee finds there is no demonstrated need for additional non emergency ambulance services in Ventura County at this time. Furthermore, VCEMS Policy 111, Section III.A.7 requires written statement or other evidence of either inadequate response times or inadequate care from existing providers. The EMS Advisory Committee finds no evidence of these issues. Additionally, review of the information provided by the existing providers leads the committee to conclude that the authorization of another ambulance service provider in Ventura County would negatively impact the existing providers' ability to provide emergency services to the citizens of Ventura County.

If you need further information, please contact the EMS Agency at 805-981-5301.