Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	August 12, 2010 9:30 a.m.

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	A.	STEMI Update 1. Indications for ECG and ECG Quality – A. Salvucci
	B.	Cardiac Arrest Improvement 2010 1. CPR Competency Testing – A. Salvucci
	C.	Policy 715: Needle Thoracostomy – A. Salvucci
	D.	Other
V.	**New Business**	
	A.	Ambulance-to-Hospital Transfer of Care – A. Salvucci
	B.	SmartMan testing – A. Salvucci
	C.	Policy 731: Tourniquet Use – A. Salvucci
	D.	Patient Restraint– S. Carroll Policy 705: Behavioral Emergencies Policy 732: Use of Restraints Policy 1000: Documentation of Care
	E.	Other
VI	**Old Business**	
	A.	Trauma System Update – S. Carroll
	B.	Impedance Threshold Device/King Airway Study – D. Chase
	C.	Other
VII.	**Informational Topics**	
	A.	Policy 705 Rollout Discussion – See EMS Website for review: http://portal.countyofventura.org/portal/page/portal/HCA/PUBLICHEALTH/DISEASECONTROL/EMS/COMMITTEES
	B.	Trauma Policy Discussion
	C.	Policy 1405: Trauma Triage and Destination Guidelines
	D.	Epi Shortage
	E.	Other
VIII.	**Policies for Review**	
	A.	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.	Trauma System Report
	G.	EMS Agency
	H.	Other
XI.	**Closing**	

TEMPORARY
PARKING PASS
Expires August 12, 2010

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

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

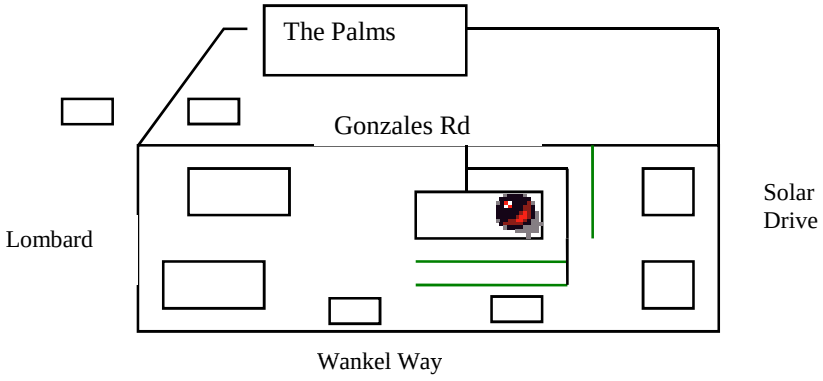
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

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	June 10, 2010 9:30 a.m.

I. Introductions	S. Carroll announced two new employees with EMS and they are: • Chris Rosa, Deputy Administrator who will be taking on MCI, AED as well as other duties not assigned as yet. • Katy Hadduck, Trauma System Manager. She will be tasked with getting the Ventura County trauma system up and running. VNC announced a new PSC representative, Shawn Black. SJRMC – Erica Gregson announced that she will no longer be the PCC for SJRMC and introduced Kathy McShea as their new PCC. GCA – Tony Norton announced a structure change to GCA as they have been purchased by AMR. They will continue to operate as GCA for the time being with the same management structure. Tony congratulated Nick Clay as their new operations chief for AMR Ventura. Tony and Nick will be answering to Brandon Ober, who has taken over Director of Operation for AMR.	
II. Approve Agenda	It was M/S/C (N. Merman/T. Norton) to approve the agenda as submitted.	
III. Minutes	It was M/S/C (R. Shedlosky/M. Mundell) to approve the minutes as submitted.	
IV. Medical Issues		
A. STEMI Update 1. Scan/Email of ECGs – S. Lara-Jenkins 2. False Positive ECGs as Unusual Occurrence – S Lara-Jenkins	1. S. Lara-Jenkins thanked all STEMI participants. We have monthly requests from other LEMSAs for consultation. Part of what we need to do is constantly review our progress. As of late, we have noticed and increase of false positive and false negative ECGs. Up until 5 months ago we were running at about 20% and we are now close to 40%. The implication of this to the SRCs is financial when you call in a team and then you do not have an actual STEMI. We are now looking at each case to try and determine the cause of the false positive. In most cases a false positive is the result of a poor quality ECG, not a machine error. In order to continue to find a cause we need to be able to read the ECG. We absolutely need to have scanned, original ECGs to the EMS Agency. STEMI receiving centers are responsible for ensuring that the EMS Agency has all ECGs but they cannot accomplish this without the prehospital providers' cooperation.	

		What we are going to require that the prehospital providers submit original ECGs to the SRC. Paramedics need to ensure that all STEMIs are called appropriately. We do not want to trigger a STEMI team when there is not actually a STEMI. 2. We are going to ask that all false positive ECG be handled as an unusual occurrence. EMS will be putting together a report form for this process. The discovery party is responsible to reporting the unusual occurrence whether it is an ER or prehospital provider. This will be for all those who have a STEMI called but the physican interpretation of the prehospital ECG is not a STEMI. We need to ensure that those who need to get to a Cath Lab are those patients that the STEMI needs to be triggered, if not, do not call it in. If any questions, call the doctor over for review. GCA sends AS every ECG they do. They are the first who found quality as an issue. They have started using the gel that the cardiologist use and quality has improved tremendously. They have had very few poor quality ECGs since implementation. Prep needs to be done correctly the first time so you do not have to redo the ECG. TAG met this morning and there will be a directive to ALS Providers that we do a focused study on quality ECGs. A tool will be developed and all ECGs will be reviewed for quality at the provider level.	
B.	Cardiac Arrest Improvement 2010 CPR Competency Testing – A. Salvucci	The last testing for rate, depth and compression were at about 72% and would like the range to be 80+%. We previously discussed a timeframe for testing but have not been finalized and will have suggestions for the next meeting. ROSC was discussed and there will be more information at a later date. There was discussion regarding the death of a family member and not transporting to the hospital.		
C.	Other			
V.	**New Business**			
A.	Policy 350: PCC Job Description - S. Lara-Jenkins		B.4.d. will remain as B.4.g will be separated into	Approved

			two lines and make a new h. It was M/S/C (E. Gregson/) to approve the policy with the above changes.	
B.	Ambulance-to-Hospital Transfer of Care – A. Salvucci	For all ALS calls we need to start tracking the time of transfer of care. There was a lengthy discussion and topics included: • Questions regarding wall time in transferring care from ambulance to hospital. • We need to know what the time difference is for this process. There are differences in when/how a provider goes back into service, i.e. when patient is off gurney or when crew is leaving the hospital. This process needs to be consistent across the county. • Every provider is responsible for pushing the button when they transfer care to someone else. • We are looking at the possibility of First Watch to monitor the system. We need to get EMEDS onto First Watch before this can be accomplished. • Concern expressed over this being an approximate time as they have to fill in the box. Start date is July 1. This is a change in data collection. There will be a new datapoint into EMEDS (transfer of care time). We will be able to determine if there is a delay in transfer of care. • The definition of when the transfer of care has completed is "the patient has been physically transferred from the ambulance gurney to the hospital gurney and the hospital report has been given".		Start date for transfer of care will be July 1.
C.	SmartMan testing – A. Salvucci	We had an unintended serendipitous audit. When Nikki was out of the office, testing was being done in a slightly different way. We found there was discordance between the testing results brought in by the applicant and the test administered by EMS. We asked some of those being tested why the difference, and it appears there may be coaching during testing. We need to administer the testing the same across the county. So we are asking that all applicants be tested in our office, and in the medium term, we will develop expectations of those tested outside our office. We need to ensure that there is no coaching during test.		

	D. Tourniquet Use – A. Salvucci	Article distributed and discussed. We should probably allow the use of tourniquets. Use will be extremely rare. EMS will develop a policy.		Tabled
VI	**Old Business**			
	A. Trauma System Update – S. Carroll	EMS is expecting an appeal panel decision as early as today. Depending on the appeal panel decision, will make a decision on how to move forward for the West County. We have decided to go ahead with the designation of LRHMC with a start date of July 1. It will go before the Board of Supervisor's next Tuesday. This will affect the communities of Thousand Oaks, Simi Valley and Moorpark. Katy and Dr. Salvucci are working on the implementation. If approved by BOS the providers will receive training. West county will continue to operate as normal until a decision is made.		
	B. Impedance Threshold Device/King Airway Study – D. Chase	After review of preliminary data, it has been decided to remove King Airway as the preferred airway and replace it with BVM. We will continue to us the ITD.		
	C. Policy 604: Transport and Destination Guidelines		It was M/S/C (/) to approve the policy as submitted.	Approved
	D. Other	Epi 1:10,000 and 1:1000 are in short supply. There is only one sole source in the country for purchase. Dr. Salvucci will research.		
VII.	**Informational Topics**			
	A. Policy 705 Rollout Discussion	Policies 705 are on the website for review. Review period ends on June . There is a problem with the link that was sent out in the memo. If you cannot connect to the policies, please contact Stephanie for assistance.		
	B. Trauma Policy Discussion	We are now part of a region and triage of patients will be standardized. The CDC has a document that was distributed outlining the standard triage criteria. If we find a flaw with the criteria then we would have cause to deviate from the standard. Our region starts with San Luis Obispo and runs through Orange County		
	C. Terrorism Booklet and Emergency Response Guide Discussion	EPO has money to purchase publications. The circulating booklets are suggested publications. If you have needs or desire to publish our own book we can get EPO to purchase. Contact Steve with your interest.		
VIII.	**Policies for Review**			
	A. Other			
IX.	**Reports**			
	TAG Report	BLS is reviewing the C-spine policy for clarification and possible algorithm.		

		All other committees are staus quo.	
X.	**Agency Reports**		
	A. ALS Providers		
	B. BLS Providers		
	C. Base Hospitals		
	D. Receiving Hospitals		
	E. ALS Education Programs		
	F. EMS Agency	• Debbie is out for the next 6 weeks and Dawn has stepped up to cover for both when Nikki was out and now for Debbie. Debbie has no access to her e-mail and if you have items that routinely go to Debbie, please send to Nikki or Dawn. • Advanced MCI schedule sent out last night. Full class is either of the two days, refresher is the afternoon. RSVP to Chris Rosa. • EPCR is moving along. We received the RFI and now putting together the RFP. In the meantime we are trying to get EMEDS fixed, by moving to a new server, the VPN logins need to be switched to CAG. • Homeland security proposal for an exercise was received yesteday. The vendor will run the exercise. All agencies are invited to participate. Spring of next year is the possible time line. Chris will be lead on the MCI project. • EMT 2010 is moving forward. Expect if you have EMTs with expiration the end of the month and do not apply before the end of the month will be delayed. Background checks will change on July 1, if you have personnel with only our agency listed will need to have them redone. • ALS, BLS and Stemi button has been instituted. No report yet but will have before next PSC. • HavBed was completed earlier in the week and we had 100% compliance and the State had 80% compliance. That should put the need for additional drills in the near future. • Last batch of mark 1 kits will expire in early 2011. The DuoDotes will arrive later in the week and when we distribute will require training.	
	G. Other		
XI.	**Closing**	Meeting adjourned at 11:30 a.m.	

Respectfully submitted
Debbie Haney

Prehospital Services Committee 2010

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/14/2010	2/11/2010	3/11/2010	4/8/2010	5/13/2010	6/10/2010	7/8/2010	8/12/2010	9/9/2010	10/14/2010	11/11/2010	12/9/2010	%
AMR	Clay	Nick		NC	NC			NC							
AMR	Stevens	Ambrose		AS	AS			AS							
CMH - ER	Canby	Neil		NC	NC			NC							
CMH - ER	Cobb	Cheryl		CC	CC			CC							
FFD	Herrera	Bill		BH											
FFD	Hall	Jim		JH	JH										
GCA	Norton	Tony		TN	TN			TN							
GCA	Stillwagon	Mike		MS	MS			MS							
Lifeline	Kuroda	Brian		BK	BK			BK							
Lifeline	Winter	Jeff		JW	JW			JW							
LRRMC - ER	David	Paul						PD							
LRRMC - ER	Hoffman	Jennie		JH	JH			LT							
OFD	Carroll	Scott		SC	SC			SC							
OFD	Huhn	Stephanie		SPH	SPH			SPH							
OVCH	Boynton	Stephanie			SB										
OVCH	Patterson	Betsy													
SJPVH	McCulpin	Aaron													
SJRMC	McShea	Kathy		EG	EG			EG							
SJRMC - SJPVH	Larsen	Todd		RH	RH			KM							
SPFD	Dowd	Andrew		AD	AD			AD							
SVH - ER	Yu	Alfred		AY				AY							
SVH - ER	Estrada	Leticia		LE	LE			LE							
V/College	Mundell	Meredith		MM	MM			MM							
VCFD	Merman	Nancy		NM	NM			NM							
VCFD	Hansen	Jack		JH	JH			JH							
VNC				KH	KH			NP							
VNC	Black	Shannon		MP				SB							
VNC	Shedlosky	Robin		RS	RS			RS							
VCMC - ER	Chase	David		DC	DC			DC							
VCMC - ER	Utley	Dede		DU	DU			DU							
VCMC-SPH	Daucett	Michelle		MD				MD							

Prehospital Services Committee 2010

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/14/2010	2/11/2010	3/11/2010	4/8/2010	5/13/2010	6/10/2010	7/8/2010	8/12/2010	9/9/2010	10/14/2010	11/11/2010	12/9/2010	%
VCMC-SPH	Pelkola	Marie		MP	MP			MP							
VCSO SAR	Fuggles	Lisa		LF	LF			LF							
VCSO SAR	White	Don		CP	CP										
VFF	Rhoden	Crystal													
VFF	Dison	Derrick													
Eligible to Vote	**Date Change/cancelled - not counted against member for attendance**														
Non Voting Members															
SAR	Askew	Chris			CA										
EMS	Carroll	Steve		SC	SC			SC							
AMR	Drehsen	Charles		CD	CD			CD							
VCMC	Duncan	Thomas			TD			TD							
EMS	Fisher	Barry													
LMT	Frank	Steve		SF	SF			SF							
REACH	Frick	Robert		RF											
EMS	Hadduck	Katy						KH							
EMS	Haney	Debora		DH	DH										
VNC	Komins	Mark		MK				MK							
EMS	Lara-Jenkins	Stephanie		SLJ	SLJ			SLJ							
VNC	Plott	Norm			NP										
EMS	Rosa	Chris						CR							
EMS	Rose	Dawn		DR	DR										
EMS	Salvucci	Angelo		AS	AS			AS							

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES	HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Needle Thoracostomy	Policy Number: 715
APPROVED: Administration: Steven L. Carroll, EMT-P	Date:
APPROVED: Medical Director Angelo Salvucci, M.D.	Date:
Origination Date: August 2010 Date Revised: Date Last Reviewed: Review Date:	Effective Date: DRAFT

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

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

III. Policy: Paramedics may perform needle thoracostomy on patients with a suspected tension pneumothorax in accordance with this policy.

IV. Procedure:

A. Indications

1. Patients with **ALL** of the following:
   a. Clinical suspicion of pneumothorax (e.g., trauma, dyspnea, chest pain),
   b. Systolic Blood Pressure less than 90, and
   c. Absent or significantly decreased breath sounds on the affected side.

B. Contraindications: None in this setting

C. Equipment

1. Povidone-iodine prep swab
2. 10 ml syringe
3. 5.0 - 6.0 cm, 12-16 gauge over-the-needle catheter
4. Connection tubing
5. Heimlich valve
6. Tape

D. Placement

1. Attach the syringe to the needle/catheter.
2. Identify and prep the site:
   - Locate the second intercostal space in the mid-clavicular line.
   - If unable to place anteriorly, lateral placement is in the fourth intercostal space in the mid-axillary line.
   - Prepare the site with povidone-iodine solution.

3. Insert the needle/catheter perpendicular to the skin over the rib and direct it just over the top of the rib into the intercostal space.
4. After inserting the needle under the skin, maintain negative pressure in the syringe.
5. Advance the needle/catheter through the parietal pleura until a “pop” is felt and/or air or blood enters the syringe, then advance **ONLY** the catheter (not the syringe/needle) until the catheter hub is against the skin.

CAUTION: Do not reinsert needle into cannula due to danger of shearing cannula.

6. Hold the catheter in place and remove and discard the syringe and needle.
7. Attach tubing and Heimlich valve.
8. Secure the catheter hub to the chest wall with dressings and tape.
9. Reevaluate the patient (VS, lung sounds).

E. Documentation

1. All needle thoracostomy attempts must be documented in the Ventura County Approved Documentation System.
2. Documentation will include indication, location and results.

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES	HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Tourniquet Use	Policy Number: 731
APPROVED: Administration: Steven L. Carroll, EMT-P	Date:
APPROVED: Medical Director Angelo Salvucci, M.D.	Date:
Origination Date: August 2010 Date Revised: Date Last Reviewed: Review Date:	Effective Date: DRAFT

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

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

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

IV. Procedure:

A. Indications

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

B. Contraindications

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

C. Equipment

1. Only commercially available tourniquet devices approved by the VCEMS Medical Director or Service Provider Medical Director is approved for use.

D. Tourniquet Placement:

1. Visually inspect injured extremity and avoid placement of tourniquet over joint, angulated or open fracture, stab or gun shot wound sites.
2. Assess and document circulation, motor and sensation distal to injury site.
3. Apply tourniquet proximal to wound (usually 2-4 inches).
4. Tighten tourniquet incrementally to least amount of pressure required to stop bleeding.
5. Cover wound with appropriate sterile dressing and/or bandage.
6. Do not cover tourniquet- the device must be visible.
7. Re-assess and document circulation, motor and sensation distal to tourniquet and time and date the tourniquet was placed

8. Tourniquet placement date and time must be documented on the tourniquet device.
9. Ensure receiving facility staff is aware of tourniquet placement and time tourniquet was placed.

E. Tourniquet Removal (Paramedic only)

1. Releasing the tourniquet should only be considered if applied for 60 minutes or longer.
2. Obtain IV/ IO access.
3. Maintain continuous ECG monitoring.
4. Hold firm direct pressure over wound for at least 5 minutes before releasing tourniquet.
5. Gently release the tourniquet and monitor for reoccurrence of bleeding
6. Document time tourniquet was released.
7. Bandage wound and re-assess and document circulation, motor and sensation distal to the wound site regularly.

F. Documentation

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

Behavioral Emergencies

ADULT	PEDIATRIC
ALS Prior to Base Hospital Contact	
IV Access For Extreme Agitation • **Midazolam** o IV – 2 mg • Repeat 1 mg q 2 min as needed • Max 5 mg o IM – 0.1 mg/kg • Max 5 mg FOR IV USE: Dilute 5 mg (1 mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL When safe to perform, determine blood glucose level	For Extreme Agitation • **Midazolam** o IM – 0.1 mg/kg • Max 5 mg When safe to perform, determine blood glucose level
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

Additional Information:

- If patient refuses care and transport, and that refusal is because of "mental disorder", consider having patient taken into custody according to Welfare and Institutions Code Section 5150. "Mental disorders" do not generally include alcohol or drug intoxication, brain injury, hypoxemia, hypoglycemia, or similar causes.
- Refer to VC EMS pre-hospital provider fact sheet for suspected excited delirium patients. Be sure to consider and rule out other possible causes or behavior (traumatic or medical).
- Physical restraints shall be utilized per VC EMS Policy XXXX
- Welfare and Institutions Code Section 5150:
  - A patient may be taken into custody if, as a result of a mental disorder, there is a danger to self and others or is gravely disabled. A California peace officer, a California licensed psychiatrist in an approved facility, Ventura County Health Officer or other County-designated individuals, can take the individual into custody, but it must be enforced by the police in the field.
- Patients shall be medically cleared prior to transporting to a psychiatric facility if patient is placed on 5150 hold by law enforcement.
- Patient may be transported directly to a psychiatric facility if evaluated by Crisis Team or PAT Team in the field.
- All patients that are deemed medically unstable shall be transported to the most accessible Emergency Department

Ventura County Mental Health Crisis Team: (805) 652-6727

Effective Date:
Date Revised:
Date Last Reviewed:
Next Review Date:

VCEMS Medical Director

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Use of Restraints	Policy Number 732
APPROVED: Administration: Steven L. Carroll, EMT-P	Date:
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date:
Origination Date: Date Revised: Date Last Reviewed: Review Date:	Effective Date: DRAFT

I. PURPOSE: To provide guidelines for the use of physical and chemical restraints during the course of emergency medical treatment or during an inter-facility transport (IFT) for patients who are violent or potentially violent to themselves or others.

II. AUTHORITY: California Health and Safety Code, Sections: 1797.2, 1798; California Code of Regulations, Title 22, Sections: 100075, 100147, 100160; California Administrative Code, Title 13, Section 1103.2.

III. DEFINITIONS:

A. Verbal Restraint: Any verbal communication from a pre-hospital provider to a patient utilized for the sole purpose of limiting or inhibiting the patient's behavior.

B. Physical Restraint: Any method in which a technique or piece of equipment is applied to the patient's body in a manner that reduces the subject's ability to move his arms, legs, head, or body.

C. Chemical Restraint: Any pharmaceutical administered by healthcare providers that is used specifically for the purpose of limiting or controlling a person's behavior or movement.

IV. POLICY:

A. Physical Restraint

1. Prior to use of physical or chemical restraints, every attempt to calm patient should be made using verbal, non physical means.
2. Perform a physical assessment and obtain a medical history as soon as safe and appropriate. Treat any underlying conditions per VCEMS 705 Treatment guidelines
3. If necessary, apply physical restraints while performing assessment and obtaining history.

4. Padded soft restraints shall be the only form of restraints utilized by EMS providers.
5. Restraints shall be applied in a manner that does not compromise vascular, neurological, or respiratory status.
6. Extremities in which restraints are applied shall be continuously monitored for signs of decreased neurologic and vascular function
7. Patients shall not be transported in a prone position. The patient's position shall be in a manner that does not compromise vascular or respiratory status at any point. Additionally, the patient position shall not prohibit the provider from performing any and all assessment and treatment tasks.
8. Restraints shall not be attached to the hand rails of the gurney.
9. Handcuffs applied by law enforcement require that an officer remain with the patient whenever possible to ensure provider and patient safety and to facilitate removal of the restraint device if a change in the patient's condition requires it.
    a. If the patient is restrained with handcuffs and placed on a gurney, two to three pairs of handcuffs shall be utilized to allow the patients arms to remain at his side. This facilitates easy access to the patient's arms for vital sign assessment and medication administration.
    b. In the event that the law enforcement agency is not able to accompany the patient in the ambulance, a unit must follow the ambulance in tandem along a predetermined route to the receiving facility. A plan to address any problems that may arise while transporting the patient should be discussed with the following officer prior to leaving the scene.

B. Chemical Restraint

I. If while in restraints, the patient demonstrates behavior that may result in harm to the patient or providers, chemical restraint should be considered.
    a. Refer to VCEMS Policy 705: Behavioral Emergencies for guidance and administration or appropriate chemical restraint.

b. It is important again to investigate and treat possible underlying causes of erratic behavior (e.g. hypoglycemia, trauma, meningitis).

C. Required Documentation

1. Instances in which physical or chemical restraints are applied shall be documented according to VCEMS Policy 1000. Required documentation shall include:

a. Type of restraint applied (e.g. soft padded restraint, midazolam, handcuffs by law enforcement)

b. Reason restraints were utilized.

c. Location on patient restraints were utilized

d. Personnel and agency applying restraints.

e. Time restraints were applied

~~f.~~ Every 10 minute neurologic and vascular chec~~ks~~

~~l.~~f. Base Hospital shall be notified in all circumstances in which physical and chemical restraints are utilized.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Documentation of Prehospital Care		Policy Number 1000
APPROVED: Administration:	~~Barry R. Fisher, EMT-P~~	Date
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 15, 1998 October 14, 2004 October, 2006	Effective Date: December 1, 2004

I. PURPOSE: To define the use of standardized records to be used by Ventura County Emergency Medical Service (VC EMS) 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

VC EMS will provide a supply of First Responder Patient Care Records (FR PCR) to EMS system participants that are not currently on the approved Ventura County documentation system (AVCDS).

B. Documentation

1. The VCEMS FR PCR and AVCDS report will be used to document the care provided by first responders and ambulance personnel for every patient contact. A patient contact will be 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. Documentation of care given by first responders will not interfere with transport agency assessment or patient care procedures. 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 document all care provided to the patient on AVCDS.

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

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

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

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. AVCDS and FR PCR's shall be completed according to instructions distributed by VC EMS.

A. First Responder Patient Care Record

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

~~a. First Responder Patient Care Record~~

~~1) Original (White) retained by agency, copied or submitted to VC EMS for data processing.~~

~~2) Patient (Yellow) given to the transport agency at scene to become part of patient chart. This copy may be incomplete at the time that it is handed to the transport crew. If the FR PCR does not accompany the patient, it will be delivered to the RH within 12 hours. If the report is~~

~~submitted through AVCDS, it should be sent as soon as possible or prior to the end of their 24 hour shift.~~

~~3) Base Hospital (Pink) - to be completed and delivered to the BH by the FR agency at least weekly.~~

C. In the event the cardiac monitor is attached as required by any of the VC EMS 705 policies, a rhythm strip shall be recorded and mounted on an ECG form. 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:

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 or where the patient is transported), and the second to the provider.

D. Submission to VC EMS

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.

E. Documenting Use of Restraints

I. In accordance with VC EMS Policy xxx, the pre-hospital provider shall document all instances in which physical and/or chemical restraints are applied. Documentation of such procedures shall include:

a. Type of restraint applied (e.g. soft padded restraint, midazolam, handcuffs by law enforcement).
b. Reason restraints were utilized.
c. Location on patient restraints were utilized.
d. Personnel and agency applying restraints.
e. Time restraints were applied.
f. Every 10 minute neurologic and vascular checks.

E. 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.

F. 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.

G. Patient Medical Record

The hospital copy of the FR PCR, AVCDS 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.

Attachment A

These abbreviations have been accumulated from the California approved EMT-1 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
After	p
Against medical advise	AMA
Alcohol	ETOH
Alert and oriented	A & O
Also known as	AKA
~~Altered level of consciousness~~	~~ALOC~~
Altered Level Of Consciousness	ALOC
Amount	Amt
Ampere	Amp
Ampule	Amp
Antecubital	AC~~c~~
Anterior	Ant~~.~~
Anterior/Posterior	AP
Appointment	Appt~~.~~
Arterial Blood Gas	ABG
Arteriosclerotic Heart Disease	ASHD
As necessary	p~~P~~rn
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
Before	a
Birth Control Pill	bcp
Bowel Movement	BM
Bundle Branch Block	BBB
By Mouth	p.o.
By Order Of	p~~P~~er
Cancer	CA
Carbon Dioxide	CO_2

Term	Abbreviation
Carbon Monoxide	CO
Cardio Pulmonary Resuscitation	CPR
Central Nervous System	CNS
Cerebrospinal Fluid	CSF
Cerebrovascular Accident	CVA
Cervical Spine	C-Spine
Change	Δ
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
Decreased	↓
Defibrillated	Defib
Degrees, Hour	°
Delirium Tremens	DTs
Diabetes Mellitus	DM
Dilation and curettage	D & C
Discontinue*	D/C*
~~Distention Deformity Contusion Abrasion Penetration Paradoxical Respiration Burn Laceration Swelling Tenderness Instability Crepitus~~Deformity, Contusion, Abrasion, Penetration, Burn, Tenderness, Laceration, Swelling	~~dDCAPpBLSTICD~~ CAPBTLS
Do Not Resuscitate	DNR
Drops	gtts
Dyspnea On Exertion	DOE
Electrocardiogram	ECG
Electroencephalogram	EEG
Emergency Department	ED
Emergency Medical Services	EMS

Term	Abbreviation
Emergency Medical Technician~~Endotracheal~~	~~ET~~EMT
Endotracheal	ET
Equal	=
Estimated	Est
Estimated Time of Arrival	ETA
Etiology	Etiol.
Every	q
Every day*	qd*
Evening	pm
Extended Care Facility	ECF
Eye, ear, nose, throat	EENT
Fahrenheit	F
Female	Fe
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	G-1, G2, G3
Greater Than	>
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
Increase	↑
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

Term	Abbreviation
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 Ear*	AS*
Left Eye*	OD*
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	♂
Medical Doctor	MD
Meter	M
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
Moving 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
None/No	ø
Normal Saline	NS
Normal Sinus Rhythm	NSR
Not applicable	NA
Nothing by Mouth	NPO
Obstetrics	OB
Occupational Therapy	OT

Term	Abbreviation
Operating Room	OR
Organic Brain Syndrome	OBS
Ounce	oz
Over the Counter	OTC
Overdose	OD
Oxygen	O_2
Palpable	Palp
Para, number of pregnancies	Para 1,2,3, etc
Paramedic	PM
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	+
Pound	~~lb~~ 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 and Reactive to Light	PEARL
Range of Motion	ROM
Registered Nurse	RN
Respiration	R
Respiratory Rate	RR
Respiratory Therapist	RT
Right	Rt
Right Ear*	AD*
Right Eye*	OD*
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ

Term	Abbreviation
Right Middle Lobe	RML
Ringer's Lactate	RL
Rule Out	R/O
Sexually Transmitted Disease	STD
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	H_20
Weight	Wt
With	c
Within Normal Limits	WNL
Without	s
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.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Trauma Triage and Destination Criteria	Policy Number 1405
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: July 1, 2010
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: July 1, 2010
Origination Date: July 1, 2010 Date Revised: August 2, 2010 Date Last Reviewed: Review Date: July 31, 2112	Effective Date: August 2, 2010

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

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

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

A. Physiologic Criteria, Step 1:

1. Glasgow Coma Scale < 14
2. Systolic blood pressure < 90 mmHg
3. Respiratory rate < 10 or > 29 breaths per minute
   (< 20 in infant younger than 1 year of age)

B. Anatomic Criteria, Step 2:

1. Penetrating wounds to the head, neck, torso, or extremities proximal to the elbow or knee
2. Flail chest
3. Two or more proximal long bone fractures (femur or humerus)
4. Crushed, degloved, or mangled extremity
5. Amputations proximal to wrist or ankle
6. Pelvic fractures
7. Open or depressed skull fracture
8. Paralysis

C. Mechanism of Injury Criteria, Step 3:

1. Adults: > 20 feet (one story is equal to 10 feet)
   Children < 15 years old: > 10 feet, or two times the height of the child
2. High-risk auto crash:

a. Intrusion: interior measurement > 12 inches patient site; > 18 inches any occupant site
b. Ejection: partial or complete from automobile
c. Death in same passenger compartment

3. Auto-pedestrian / auto-bicyclist thrown, run over, or with > 20 mph impact
4. Motorcycle crash > 20 mph

D. Other Criteria, Step 4 (these are considerations to be used by the base hospital in determining the appropriate destination hospital):

1. Age > 65 years old
2. Head injury with loss of consciousness AND on warfarin (Coumadin)
3. Burns with trauma mechanism
4. Time sensitive extremity injury (open fracture, neurovascular compromise)
5. Pregnancy > 20 weeks with known or suspected abdominal trauma
6. Prehospital care provider or MICN judgment

V. PROCEDURE:

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

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

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

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

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

F. A trauma patient without an effective airway may be transported to the closest available hospital with an emergency department for airway management prior to

transfer to a designated trauma center. In this rare event, the paramedic will contact the base hospital in whose catchment area the incident occurred.

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

H. If any patient who meets trauma triage criteria listed in Sections A, B, or C above either declines transportation to a designated trauma center, or declines treatment and wishes to be released against medical advice (AMA), the paramedic shall call the closest trauma center, which is considered to be the base hospital for this patient. The trauma center MICN and/or ED physician will guide EMS personnel in arriving at a destination decision and/or disposition.

Ventura County Field Triage Decision Scheme

For patients with visible or suspected traumatic injuries

STEP 1

Measure vital signs and level of consciousness

1.1 Glasgow Coma Scale	< 14
1.2 Systolic Blood Pressure	< 90
1.3 Respiratory Rate	< 10 or > 29 breaths per minute (< 20 in infant age < 1 year)

Yes → **Contact base trauma center**

Transport to trauma center

No

STEP 2

Assess anatomy of injury

- **2.1** All penetrating injuries to head, neck, torso and extremities proximal to elbow and knee
- **2.2** Flail chest
- **2.3** Two or more proximal long-bone fractures (femur, humerus)
- **2.4** Crushed, degloved, or mangled extremity
- **2.5** Amputation proximal to wrist and ankle
- **2.6** Pelvic fractures
- **2.7** Open or depressed skull fracture
- **2.8** Paralysis

Yes → **Transport to trauma center**

No

STEP 3

Assess mechanism of injury and evidence of high-energy impact

Falls
- **3.1.1** Adults: > 20 feet (one story is equal to 10 feet)
- **3.1.2** Children < 15 years old: > 10 feet, or two times the height of the child

High-risk auto crash
- **3.2.1** Intrusion: interior measurement > 12" patient site or > 18" any occupant site
- **3.2.2** Ejection: partial or complete from automobile
- **3.2.3** Death in same passenger compartment

3.3 Auto vs. pedestrian/bicyclist thrown, run over, or with > 20 mph impact

3.4 Motorcycle crash > 20 mph

Yes → **Contact base trauma center for destination decision**

No

STEP 4

Assess special patient or system considerations

- **4.1** Age > 65
- **4.2** Head injury with loss of consciousness AND on warfarin (Coumadin)
- **4.3** Burns with trauma mechanism
- **4.4** Time sensitive extremity injury (open fracture, neurovascular compromise)
- **4.5** Pregnancy > 20 weeks with known or suspected abdominal trauma
- **4.6** Prehospital care provider or MICN judgment

Yes → **Contact regular catchment base hospital**

Consider transport to trauma center or specific resource hospital

No

Transport to closest ED or by patient preference