

WVEMS BOARD OF DIRECTORS
Thursday, June 21, 2012
Vinton War Memorial - Upstairs Meeting Room
Executive Committee - 5:00 PM
Full Board - 5:30 PM

AGENDA

1. Call to Order
2. Introduction of Guests and New Board Members:

Danielle Lissberger - NSPA Executive Director
Jason Ferguson - Botetourt County
3. Secretary's Report -  [March 2012 Minutes](#)
4. Treasurer's Report
 - a. Periodic Financial Report  [Treasurer's Report June 2012](#)
 - b. FY 2013 Budget  [Budget FY13](#)
5. Standing Committees
 - a. Executive Committee
 - b. Medical Direction
 1. Protocol Project Update - Kathy Cockrell & Bill Duff  [Protocol Work Plan](#)  [Protocol Samples](#) (copies available at meeting)
 - c. Allied Resources
 - d. Communications
 1. Replacement Radios - Alleghany - update
 2. Narrowbanding
 - e. Performance Improvement
 - f. Near Southwest Preparedness Alliance (NSPA)
 1. Hospital Diversion Plan  [Hospital Diversion Plan 2011](#)
 - g. State EMS Advisory Board  [AB Report - June 2012](#)
6. EMS Financial Assistance -  [RSAF Report - July 1, 2012 Awards](#)
7. New Business
 1. MCI Committee - Update
 2. Quarterly Report to OEMS  [OEMS 3rd Qtr Report FY 12](#)  [3rd Q FY12 Deliverables Report](#)
8. President's Report
9. Staff Reports
10. Adjourn to Awards Banquet

**WESTERN VIRGINIA EMERGENCY MEDICAL SERVICES COUNCIL
BOARD OF DIRECTORS**

DRAFT MEETING MINUTES

DATE: June 21, 2012

LOCATION: Vinton War Memorial

Directors Present

Altman, Billy
Cady, Jim Sr.
Coyle, Joe
Eanes, Steven
Ferguson, Jason
Harveycutter, Carey
Jefferson, Mike
Lane, Charles
Lissberger, Danielle
Logan, Robert
Shrader, Kris
Simon, Stephen
Wagoner, Dale
Wirt, Ford

Staff Present

Berger, Charles
Cockrell, Cathy
Dalton, Gene
Garnett, Mike

Guests Present

Billy Duff RCFRD
Mike Berg OEMS

TO ORDER

President Ford Wirt called this regular meeting of the Board of Directors to order at 5:30 PM. He then introduced new directors: Danielle Lissberger, the new NSPA executive director, and Jason Ferguson, representing Botetourt County.

He introduced guests: Bill Duff, battalion chief for Roanoke County Fire & Rescue, and Mike Berg, from the Virginia Office of EMS.

SECRETARY'S REPORT

Ford presented minutes of the last meeting as distributed. He called for any corrections or additions. Motion was made and duly seconded to approve. **Motion CARRIED.**

TREASURER'S REPORT

Treasurer Carey Harveycutter presented the unaudited treasurer's report for FY 12 year-to-date, (May 31). He noted that all accounts were within expectations, and explained variances on some accounts that were over budget.

Motion was made and duly seconded to accept the report,. **Motion CARRIED.**

Treasurer Harveycutter then presented the budget for FY 2013, carried over from the last meeting. The Executive Committee recommended adoption of the budget as originally presented, which included a two percent cost of living increase for full-time staff.

Motion to adopt the budget as presented was made by the Executive Committee. **Motion CARRIED.**

EXECUTIVE COMMITTEE

The Executive Committee met prior to this meeting to review and discuss the agenda items. The budget was reviewed and recommended for adoption,

The Executive Committee received a request from the Executive Director for approval to spend \$5000 to develop android and iPhone apps for the protocols. The Committeemoved to authorize the expenditure of \$5000 in reserve funds to develop smartphone apps for the protocols. **MOTION CARRIED.**

MEDICAL DIRECTION COMMITTEE

Dr. Lane reported for the regional medical direction committee. He introduced and explained the process that was being used to complete the protocol project.

Bill Duff reported on the status and remaining tasks of the protocol workgroup. He presented sample protocols, and gave an overview of the timeline to complete the project and rollout.

ALLIED RESOURCES

Allied Resources has not met since the last board meeting, but will meet soon to discuss and approve changes to restocking necessitated by the new protocols.

COMMUNICATIONS COMMITTEE

Rob Logan reported for the committee concerning the Alleghany radio replacement project. He noted that the license modifications were in review by the Radio Quiet Zone officials, and that funding for replacement repeaters was denied by RSAF due to not being P-25 compliant.

Rob also reported that all other licenses had been modified to allow both narrow and wide band emission. The repeaters on Tinker Mountain have already been modified to operate in narrowband mode.

PERFORMANCE IMPROVEMENT COMMITTEES

Charles Berger reported for the General and Trauma Performance Improvement Committees. Both are scheduled to meet the following week.

NSPA

Danielle Lissberger reported for NSPA.

The regional hospital diversion plan was unchanged since the prior year. It was presented to the board for affirmation. Motion was made and duly seconded to affirm the current Hospital Diversion Plan. **MOTION CARRIED.**

EMS ADVISORY BOARD

Dale Wagoner provided a written report for the Advisory Board. The next meeting is set for August 10, 2012 in Richmond. He noted that the issue of elevating the Office of EMS to department status would likely resurface in the coming fiscal year.

Rob reported on the new testing guidelines that would become effective soon. One change will allow same-day retesting for EMT candidates under some circumstances. Other changes involve the move to National Registry testing at all levels. The CTS sites would then test only the practicals.

EMS FINANCIAL ASSISTANCE

A report of current cycle award recommendations was provided. Board members were reminded that these are recommended awards only, until official notification is received.

The issue of funding only P25 compliant radios was discussed. Billy Altman, who will soon chair FARC, noted that the issue could be revisited. After much discussion, it was moved and seconded to write a letter to the chair of FARC asking for reconsideration of that ruling.

MOTION CARRIED.

NEW BUSINESS

Joy Coyle reported on progress of the bi-regional MCI planning committee. A follow-up meeting is planned for the next week.

Mike Berg thanked the board for allowing him to attend its meeting, and the Awards Banquet.

Rob called the board's attention to the WVEMS quarterly report to OEMS, and to the feedback report. We are 100% compliant with contract deliverables.

PRESIDENT'S REPORT

Ford thanked the board members for their attendance.

STAFF REPORTS

Rob Logan – Nothing additional

Cathy Cockrell – None

Charles Berger - None

Gene Dalton – None

Mike Garnett - None

OTHER BUSINESS

Mike Jefferson noted that Tim Duffer had been promoted to Lieutenant

HEARING OF THE PUBLIC

None

Being no further business, the meeting was adjourned at 6:15 PM.

/s Robert Logan, Executive Director

WESTERN VA EMS COUNCIL
 UNAUDITED TREASURER'S REPORT
 AS OF 5/31/2012

REVENUES	BUDGET	TOTAL	% YTD
STATE GOVERNMENT (OEMS CONTRACT)	416,190	317,843	76.37%
LOCAL GOVERNMENT	104,500	133,332	127.59%
UNITED WAYS	2,000	3,129	156.46%
CONTRIBUTIONS	2,000		0.00%
SPECIAL GRANTS / HOSPITAL FOUNDATIONS	122,000	160,315	131.41%
DIRECT PROGRAM INCOME (Tuitions, grants, VDH/OEMS)	235,000	239,310	101.83%
DIRECT MRC INCOME		47,479	
CISM REVENUE		830	
NSPA OFFSET REVENUE (Contract for services)	7,000	24,369	348.13%
RENT INCOME (NSPA)	18,000	16,500	91.67%
INTEREST	4,000	1,580	39.49%
INVESTMENT / GAINS/LOSSES		(2,746)	
MISCELLANEOUS/SPECIAL FUNDS			
TOTAL REVENUES	910,690	941,941	103.43%
EXPENDITURES	BUDGET	TOTAL	% YTD
SALARIES / WAGES (WVEMS)	342,330	350,902	102.50%
PAYROLL TAXES (FICA)	33,914	26,343	77.68%
VEC	550	1,446	262.86%
403(b) / RETIREMENT	30,810	16,861	54.73%
HOSPITAL / MEDICAL INSURANCE	46,000	41,970	91.24%
LIFE INSURANCE/DISABILITY	10,600	9,175	86.55%
DENTAL INSURANCE	3,400	1,233	36.27%
PROFESSIONAL SERVICES/FEES	12,000	13,355	111.29%
MEDICAL DIRECTION ASSISTANCE	1,000		0.00%
MAINTENANCE / REPAIRS / SERVICE CONTRACTS	2,500	167	6.68%
OCCUPANCY (Utilities, repairs, NRV rent etc.)	16,000	16,970	106.06%
POSTAL / SHIPPING	3,500	1,547	44.20%
TELECOMMUNICATIONS	10,500	9,915	94.43%
SUPPLIES (ADMIN)	6,286	6,593	104.89%
EQUIPMENT	5,200	3,430	65.97%
INSURANCE	7,500	7,091	94.55%
DIRECT NSPA EXPENSE	101,000	149,485	148.01%
DIRECT PROGRAM EXPENSES	220,000	197,538	89.79%
DIRECT MRC EXPENSES		42,841	
PRINTING / PUBLICATIONS	4,000	3,068	76.71%
TRAVEL / LODGING	7,500	4,631	61.75%
FUEL/VEHICLE MAINTENANCE	12,000	9,738	81.15%
MEETING SUPPORT	2,000	1,861	93.04%
DUES / MEMBERSHIP FEES	1,200	1,090	90.83%
STAFF DEVELOPMENT	9,000	6,082	67.58%
CISM PROGRAM COSTS	2,000	1,946	97.30%
COMMUNICATION SITE RENTAL	8,100	7,425	91.67%
COMMUNICATIONS WIRELINES	6,000	7,134	118.91%
COMMUNICATIONS MAINTENANCE	2,000	325	16.25%
COMMUNICATIONS UTILITIES	800	445	55.69%
COMMUNICATIONS INSURANCE	3,000	3,000	100.00%
COMMUNICATIONS EQUIPMENT			
TOTAL EXPENDITURES	910,690	943,610	103.61%

WESTERN VIRGINIA EMS COUNCIL, INC.

Balance Sheet

May 31, 2012

ASSETS

Current Assets		
PETTY CASH	\$	69.59
FSA CASH		1,657.47
MUTUAL BOARD DESIGNATED		5,958.10
SUNTRUST CHECKING		316,487.92
SUNTRUST PAYROLL		200.00
VALLEY BANK MONEY MARKET		65,293.42
PREPAID EXPENSES		804.28
ACCOUNTS RECEIVABLE		41,188.67
		<hr/>
Total Current Assets		431,659.45
Property and Equipment		
		<hr/>
Total Property and Equipment		0.00
Other Assets		
ARC III REIT		25,137.62
FRANKLIN TEMPLETON		96,786.06
COMMUNICATIONS EQUIPMENT		51,757.66
MISCELLANEOUS EQUIPMENT		162,781.70
OFFICE EQUIPMENT		41,879.86
BUILDING		175,223.00
LAND		201,600.00
BLDG. IMPROVEMENTS		64,232.94
GENERATOR BUILDING & EQUIPME		11,402.25
ACCUMULATED DEPRECIATION		(259,010.90)
		<hr/>
Total Other Assets		571,790.19
		<hr/>
Total Assets	\$	<u>1,003,449.64</u>

LIABILITIES AND CAPITAL

Current Liabilities		
ACCOUNTS PAYABLE	\$	102,808.83
CLEARING ACCT (UNCASHED CHEC		290.00
ACCRUED SALARIES		26,153.16
SALES TAX PAYABLE		3.46
FLEX SPENDING ACCOUNT-MEDIC		1,289.39
FLEX SPENDING ACCT-DEPENDENT		235.30
DEFERRED REVENUE		29,361.13
		<hr/>
Total Current Liabilities		160,141.27
Long-Term Liabilities		
		<hr/>
Total Long-Term Liabilities		0.00
		<hr/>
Total Liabilities		160,141.27
Capital		
FUND BAL. UNRESTRICTED		707,162.00
FUND BAL. UNRESTRICTED DES.		55,036.00
RETAINED EARNINGS		111,893.70
FUND BALANCE TEMP. RESTR.		20,374.00
Net Income		(51,157.33)
		<hr/>

Unaudited - For Management Purposes Only

WESTERN VIRGINIA EMS COUNCIL, INC.

Balance Sheet

May 31, 2012

Total Capital	<u>843,308.37</u>
Total Liabilities & Capital	<u><u>\$ 1,003,449.64</u></u>

NSPA

REVENUES (NSPA ACCOUNTS)	TOTAL
SPECIAL GRANTS / HOSPITAL FOUNDATIONS	105,528
TOTAL REVENUES	105,528
EXPENDITURES (NSPA ACCOUNTS)	TOTAL
SALARIES - NSPA	84,211
PAYROLL TAXES (FICA) - NSPA	6,354
BENEFITS - NSPA	6,223
VEC - NSPA	274
TOTAL EXPENDITURES	97,062

REVENUES (VHHA ACCOUNTS)	TOTAL
VHHA FUNDING	54,787
TOTAL REVENUES	54,787
EXPENDITURES (VHHA ACCOUNTS)	TOTAL
SALARIES - VHHA	42,493
PAYROLL TAXES (FICA) - VHHA	3,244
BENEFITS - VHHA	516
MISC. - VHHA	6,171
TOTAL EXPENDITURES	52,424

PROGRAM

REVENUE (PROGRAM ACCOUNTS)	TOTAL
OEMS FUNDS - INTERMEDIATE	7,834
OEMS FUNDS - ENHANCED	1,326
OEMS FUNDS - ADJUNCT	720
OEMS FUNDS - CARDIAC	
OEMS FUNDS - CT TRANSITION	
OEMS FUNDS - SHOCK TRANSITION	
OEMS FUNDS - ALS CE	
PROGRAM SERVICE FEES	2,958
PROTOCOL, ETC. SALES	730
TEXTBOOK SALES	7,562
CONSOLIDATED TESTING	41,330
DRUG BOX ENTRANCE FEES	1,785
GRANTS & SPECIAL PROJECTS	110,727
SALES - CONSUMER GOODS	
WEB DATABASE	
PROCESSING FEES	
PROGRAM TUITION - INTERMEDIATE	2,072
PROGRAM TUITION - ENHANCED	4,125
PROGRAM TUITION - ADJUNCT	8,225
PROGRAM TUITION - CARDIC	
PROGRAM TUITION - OTHER	150
PROGRAM TUITION - NRVTC	17,500
ID CARD SALES	300
TUITION CREDIT REIMBURSEMENT	
OMD PROJECT	
COMMUNITY COLLEGE COURSE REVENUE	31,967
TRAVEL/TOWING CONTRACT REVENUE	
TOTAL REVENUES	239,310

EXPENSES (PROGRAM ACCOUNTS)	TOTAL
CONTRACTS FOR SERVICES (INTERMEDIATE)	8,334
CONTRACTS FOR SERVICES (ENHANCED)	4,125
CONTRACTS FOR SERVICES (ADJUNCT)	1,750
CONTRACTS FOR SERVICES (CARDIAC)	
CONTRACTS FOR SERVICES (SPEC. PROJ.)	
CONTRACTS FOR SERVICES (ALS TEST)	320
CONTRACTS FOR SERVICES (CTS)	20,210
CONTRACTS FOR SERVICES (CE WEEKENDS)	463
CONTRACTS FOR SERVICES (DRUG TESTING)	1,680
PAYROLL TAXES (FICA)	
VEC	
POSTAGE (NRVTC)	38
SUPPLIES (Programs)	638
SUPPLIES (CTS)	573
SUPPLIES (ALS TESTING)	210
SUPPLIES (EDUCATION)	72
SUPPLIES (NRVTC)	2,294
TEXTBOOKS (ALS)	712
TEXTBOOKS (BLS)	
TEXTBOOKS (NRVTC)	6,327
EQUIPMENT (BLS)	
EQUIPMENT(BLS TESTING)	
EQUIPMENT (ALS TESTING)	
EQUIPMENT (EDUCATION)	90
INSURANCE	1,928
PRINTING / PUBLICATIONS (EDUCATION)	398
PRINTING / PUBLICATIONS (NRVTC)	158
GRANTS & SPECIAL PROJECTS	109,543
DRUG BOX EXCHANGE	1,038
CREDIT CARD DISCOUNT	4,644
MERCHANDISE FOR RESALE	
ID CARD PROGRAM	28
RETENTION PROJECT	
COMMUNITY COLLEGE FEES	31,967
TUITION REIMBURSEMENT - ENHANCED	
TUITION REIMBURSEMENT - INTERMEDIATE	
TRAVEL/TOWING CONTRACT EXPENSE	
OMD PROJECT	
SWVEMS CONTRACT	
TOTAL EXPENDITURES	197,538

MRC

REVENUE (MRC ACCOUNTS)	TOTAL
PROGRAM MANAGEMENT - MRC	44,000
COST REIMBURSEMENT - MRC	3,479
TOTAL REVENUES	47,479
EXPENSES (MRC ACCOUNTS)	TOTAL
SALARIES AND WAGES - MRC	32,538
FICA EXPENSE - MRC	2,489
VEC - MRC	274
HOSPITAL MEDICAL - MRC	3,393
DENTAL INSURANCE - MRC	356
POSTAGE - MRC	111
TELECOMMUNICATIONS - MRC	998
SUPPLIES - MRC	49
PROMOTIONAL - MRC	294
TRAINING SUPPLIES - MRC	6
EQUIP-MRC	
TRAVEL/LODGING - MRC	2,056
DUES & MEMBERSHIPS - MRC	106
MEETING SUPPORT - MRC	170
TOTAL EXPENDITURES	42,841

WVEMS ADOPTED BUDGET FY 2012 and PROPOSED FY 2013

	Budget 11-12 Adopted	Budget 12-13 Proposed	Difference 13 vs 12
REVENUES			
State Government (OEMS Contract)	416,190	416,190	0.00%
Local Government	104,500	120,000	14.83%
United Ways	2,000	2,000	0.00%
Contributions	2,000	2,000	0.00%
Special Grants/Hospital Foundations/NSPA/VHHA	122,000	220,000	80.33%
MRC		55,000	new
Direct Program Income (tuitions, grants, VDH/OEMS)	235,000	165,000	-29.79%
NSPA Offset Revenue (Contract for services)	7,000	8,000	14.29%
Rent income (NSPA)	18,000	18,000	0.00%
Interest/Investment	4,000	3,000	-25.00%
TOTAL REVENUES	910,690	1,009,190	10.82%
EXPENDITURES			
Personnel			
Salaries/Wages (WVEMS)	342,330	371,000	8.37%
Payroll Taxes (FICA)	33,915	27,203	-19.79%
VEC	550	450	-18.18%
403(b) Thrift	30,810	20,250	-34.27%
Hospital/Medical Insurance	46,000	47,000	2.17%
Life/ADD/Disability	10,600	10,000	-5.66%
Dental Insurance	3,400	3,400	0.00%
Staff Services Total	467,605	479,303	2.50%
Non-Personnel			
Professional Services/Fees	12,000	8,000	-33.33%
Medical Direction Assistance	1,000	1,000	0.00%
Maintenance/Repairs/Service Contracts	2,500	2,500	0.00%
Occupancy (Utils, cleaning, maint, etc.)	16,000	16,000	0.00%
Postal/Shipping	3,500	2,000	-42.86%
Telecommunications	10,500	10,500	0.00%
Supplies (Admin)	6,286	6,587	4.79%
Equipment	5,200	5,000	-3.85%
Insurance	7,500	7,500	0.00%
Direct Program Expenses	220,000	150,000	-31.82%
NSPA Program Expenses	101,000	195,000	93.07%
MRC Expenses		55,000	new
Printing/Publications	4,000	14,000	250.00%
Travel/Lodging	7,500	7,000	-6.67%
Vehicle Fuel/Maintenance	12,000	10,000	-16.67%
Meeting Support	2,000	1,200	-40.00%
Dues/Membership Fees	1,200	1,200	0.00%
Staff Development	9,000	9,000	0.00%
CISM Program Costs	2,000	2,000	0.00%
Radio Systems			
Site Rental	8,100	8,100	0.00%
Telephone Wirelines	6,000	7,500	25.00%
Maintenance	2,000	2,000	0.00%
Utilities	800	800	0.00%
Insurance	3,000	3,000	0.00%
Equipment		5,000	new
TOTAL EXPENDITURES	910,691	1,009,190	10.82%

Regional Operational Protocols



2012

Protocols

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Protocols

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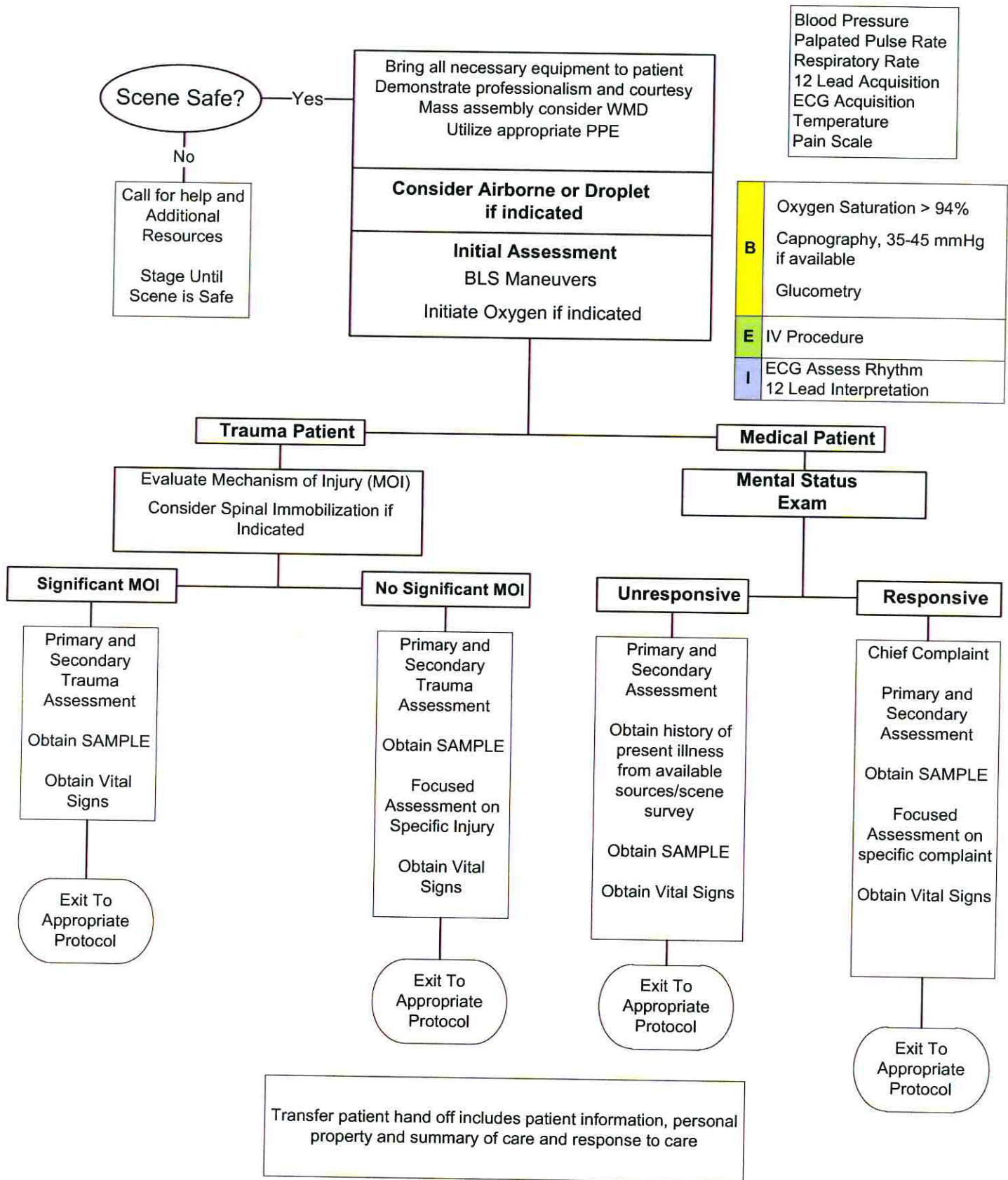
Reminder:

This document provides protocols for common situations faced by EMS. It is not intended to provide complete instructions for all patients in all situations.

Many patients may require the use of more than one protocol, or may require care not addressed at all in these pages.

EMS providers should remember the primary objective is to provide the best possible care to all patients, and should not hesitate to consult with medical control in these situations.

General – Universal Patient Care/Initial Patient Contact



General Protocols

General – Cardiac Arrest (Adult)

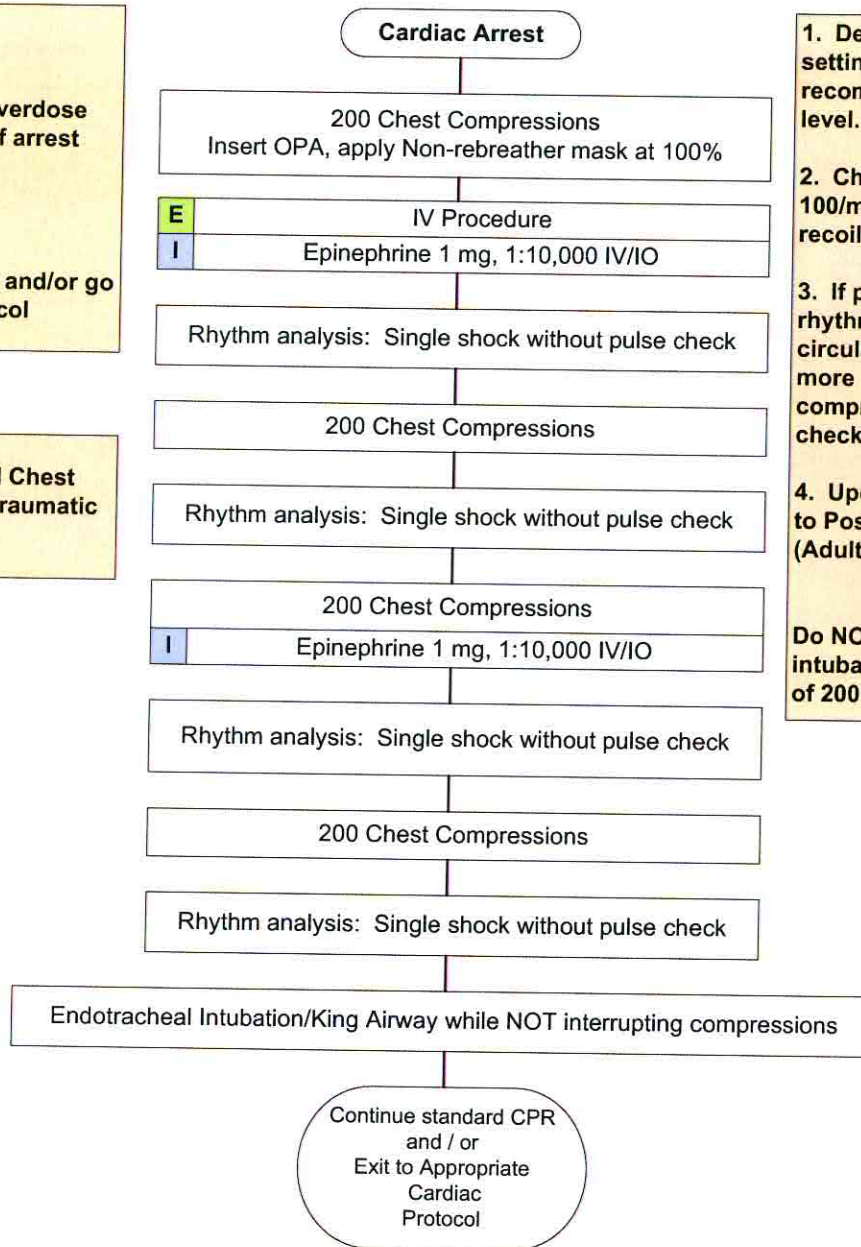
Continuous Compression CPR (CC-CPR)

Contraindications:

Children < 8
 Known/suspected overdose
 Respiratory cause of arrest
 Hypothermia
 Near Drowning
 Traumatic Arrest

Begin standard CPR and/or go to appropriate protocol

Consider bilateral Chest Decompression in traumatic arrests



1. Defibrillate at highest energy setting or the manufacturer's recommendation for energy level.

2. Chest compressions at least 100/min., deep and complete recoil.

3. If potentially perfusing rhythm returns, or signs of circulation, continue with one more round of 200 compressions before pulse check.

4. Upon return of circulation, go to Post Resuscitation Care (Adult) (Protocol 34)

Do NOT attempt ventilation/intubation until after fourth set of 200 compressions

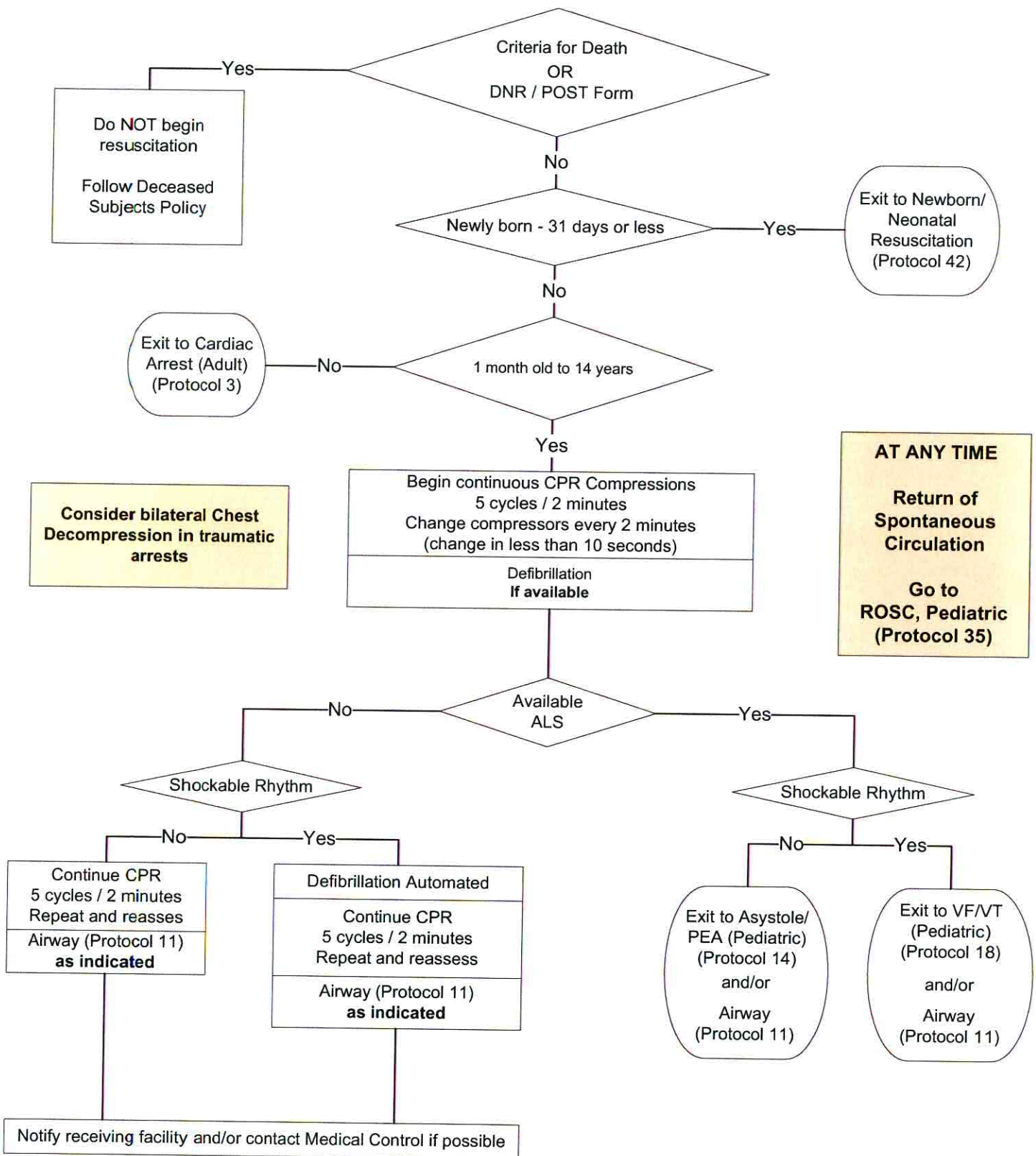
General Protocols

PEARLS

- * Consider early IO placement if available and difficult IV anticipated.
- * DO NOT HYPERVENTILATE: If advanced airway in place, ventilate 8-10 breaths per minute.
- * Use a Team Focused Approach, assigning responders to predetermined tasks.
- * Defibrillation energy should be at manufacturer's recommendation, maximum energy if unknown.

TERMINATION – If after 30 minutes of quality resuscitation effort and no Return of Spontaneous Circulation (ROSC) occurs, the team leader should inform the family of the situation and consider termination of resuscitation on the scene.

General – Cardiac Arrest (Pediatric)



General Protocols

General – Cardiac Arrest (Pediatric)

In contrast to adults, cardiac arrest in infants and children DOES NOT usually result from a primary cardiac event. Typically cardiac arrest is the end result of a progressive process precipitated by respiratory distress or asphyxiation leading to hypoxemia, acidosis and hypotension resulting finally in cardiac arrest.

Compressions:

Compressions should be started immediately with interposed ventilations or ventilations performed by second rescuer when available. High quality, uninterrupted compressions are key to the resuscitative effort. At least 100 compressions per minute should be performed in a 15:2 ratio of compressions:ventilations until an advanced airway is in place then ventilations should be at 8 – 10 breaths per minute. Depth of compressions should be 1.5 inches in the infant and 2 inches in children with complete chest recoil allowed.

Ventilations:

Ventilations are more important in the pediatric patient due to the nature of most cardiac arrests. However DO NOT hyperventilate with volume or by rate of ventilations. Hyperventilation and hyper-oxygenation carry the same dangers in pediatrics as adults. King Airway or BVM is the preferred method of oxygen delivery and ventilation.

Immediately resume compressions / CPR after each defibrillation and check pulses every 2 minutes.

Defibrillation Energy:

First shock is 2 joules / kg with all subsequent shocks at 4 joules / kg.

Scene / Family Members / Public Areas:

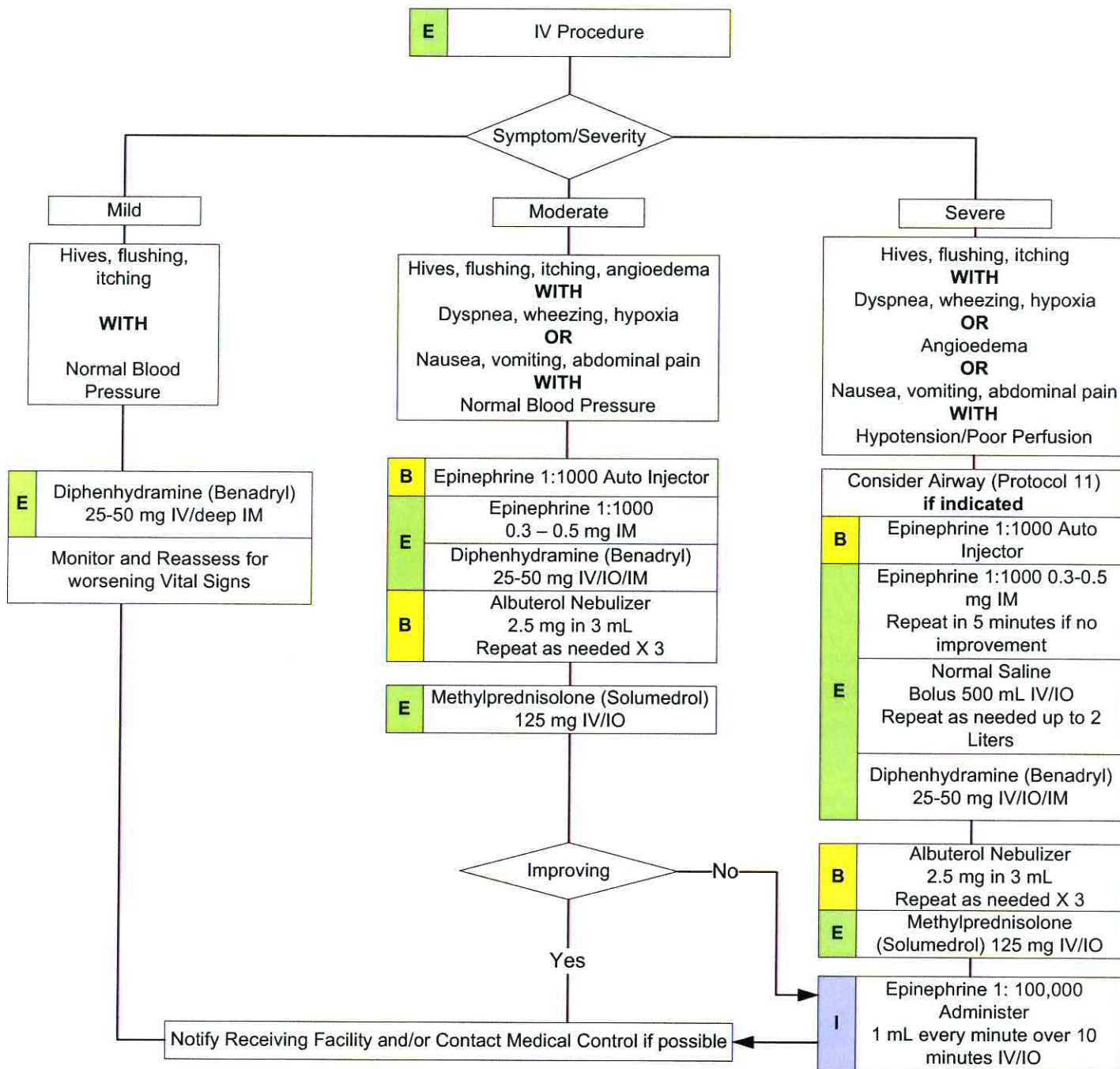
In general high quality compressions cannot be effected during transport. This also represents a hazard to the crew. Cardiac arrests should have resuscitation effort performed where the victim is found unless a hazard exists, physical space does not allow access to patient or until return of spontaneous circulation. In the pediatric patient, after 30 minutes of effort with no response, then transport should be undertaken safely.

Studies show family members who desire to be present during a resuscitation demonstrate better understanding of the event and improved closure. This can be of enormous benefit to the family during the grieving process. The Team Leader should update the family and assign a rescuer to the family to answer questions and be of support during the event. Family members should be allowed access to the resuscitation effort unless they demonstrate a disruption to the effort.

PEARLS

- * Monophasic and Biphasic waveform defibrillators should use the same energy levels of 2 joules/kg and increase to 4 joules/kg on subsequent shocks.
- * In order to be successful in pediatric arrest, a cause must be identified and corrected.
- * Airway is more important intervention in pediatric arrest. This should be accomplished quickly with BVM or supraglottic device. Patient survival is often dependent on proper ventilation and oxygenation airway interventions.
- * Effective CPR is critical
 1. Push hard and fast at appropriate rate
 2. Ensure full chest recoil
 3. Minimize interruptions in CPR. Pause CPR < 10 seconds to verify rhythm

Medical – Allergic Reaction/Anaphylaxis (Adult)



Medical Protocols

PEARLS

* Allergic reactions occur when a patient is exposed to an allergen (pollen, insect, medication, food, etc.) causing the body to respond by releasing specific immunoglobulins such as histamine which causes hives, itching and capillary leaking leading to edema. Most allergic reactions are mild and involve only the skin such as erythema, hives and / or itching and are usually resolved with an anti-histamine like diphenhydramine.

* Anaphylaxis is a severe form of an allergic reaction and recent studies show it is under-recognized and under-treated.

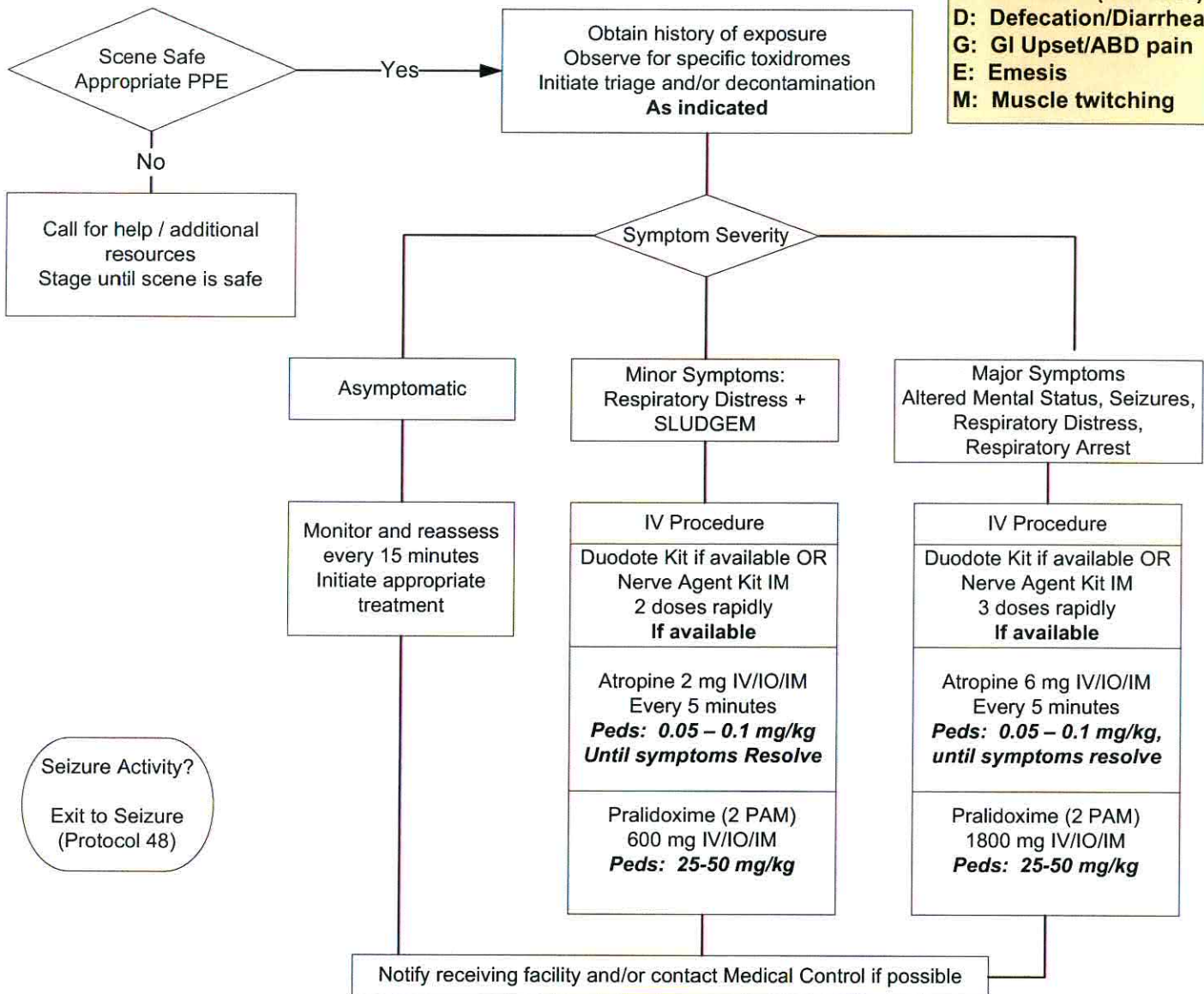
Epinephrine 1:100,000:

In the patient with severe anaphylaxis who is not responding to Epinephrine IM and fluid resuscitation, IV Epinephrine should be administered. Take your Epinephrine 1:10,000 and draw out 1 mL which equals 0.1 mg of epinephrine. Dilute this 1 mL with 10 mL of Normal Saline in a separate syringe to yield a concentration of 1:100,000 (0.1 mg in 10 mL of Normal Saline.) Administer 1 mL each minute over 10 minutes or until symptoms resolve.

WMD – CHEM PACK

This protocol is designed for WMD ONLY. Providers are only to perform skills that they have been trained on.

S: Salivation
L: Lacrimation
U: Urination (increase)
D: Defecation/Diarrhea
G: GI Upset/ABD pain
E: Emesis
M: Muscle twitching



Seizure Activity?

Exit to Seizure
(Protocol 48)

PEARLS

- * In the face of a bona fide attack, begin with 1 Nerve Agent Kit for patients less than 7 years of age; 2 Nerve Agent Kits for children 8-14 years of age, and 3 Nerve Agent Kits for patients 15 years of age and over.
- * Follow local HAZMAT guidelines for decontamination and transportation of patient; use of personal protective equipment.
- * For patients with major symptoms, there is no limit for Atropine dosing.
- * Carefully evaluate patients to ensure they are not symptomatic from exposure to another agent (e.g., narcotics, vesicants, etc.).
- * Each Nerve Agent Kit contains 600mg of Pralidoxime (2 PAM) and 2 mg of Atropine
- * The main symptom that the atropine addresses is excessive secretions, so Atropine should be given until salivation improves.

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Procedures

Procedures may only be performed as trained, authorized by an OMD, and in accordance with the Virginia Scope of Practice Maximums.

The procedures listed here contain general instructions and protocols for their implementation.

If using equipment not listed here, or in the event of conflicting instructions, follow the manufacturer's suggested settings and/or procedures.

12 Lead ECG

Clinical Indications:

- Suspected cardiac patient
- Suspected tricyclic overdose
- Electrical injuries
- Syncope

Procedure:

1. Assess patient and monitor cardiac status.
2. Administer oxygen as patient condition warrants.
3. If patient is unstable, definitive treatment is the priority. If patient is stable or stabilized after treatment, perform a 12 Lead ECG.
4. Prepare ECG monitor and connect patient cable with electrodes.
5. Enter the required patient information (patient name, etc.) into the 12 lead ECG device.
6. Expose chest and prep as necessary. Modesty of the patient should be respected.
7. Apply chest leads and extremity leads using the following landmarks:
 - RA -Right arm
 - LA -Left arm
 - RL -Right leg
 - LL -Left leg
 - V1 -4th intercostal space at right sternal border
 - V2 -4th intercostal space at left sternal border
 - V3 -Directly between V2 and V4
 - V4 -5th intercostal space at midclavicular line
 - V5 -Level with V4 at left anterior axillary line
 - V6 -Level with V5 at left midaxillary line
8. Instruct patient to remain still.
9. Press the appropriate button to acquire the 12 Lead ECG.
10. If the monitor detects signal noise (such as patient motion or a disconnected electrode), the 12 Lead acquisition will be interrupted until the noise is removed.
11. Once acquired, transmit the ECG data to the appropriate hospital if possible. Contact the receiving hospital to confirm that a 12 Lead ECG has been received.
12. Monitor the patient while continuing with the treatment protocol.
13. Document the procedure, time, and results on/with the patient care report (PCR)

Note that while 12 Lead ECG acquisition may be performed by BLS providers, only Intermediates and Paramedics may interpret the 12 lead. Other levels may acquire and transmit to the ED, and may communicate the machine's interpretation to the hospital, but under no circumstances should they attempt to interpret the 12 lead ECG.

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Abuse & Neglect

Recognition and Reporting

Policy:

Domestic violence is physical, sexual, or psychological abuse and/or intimidation, which attempts to control another person in a current or former family, dating, or household relationship. The recognition, appropriate reporting, and referral of abuse is a critical step to improving patient safety, providing quality health care, and preventing further abuse.

Abuse is the physical and/or mental injury, sexual abuse, negligent treatment, or maltreatment of a child, senior citizen, or incapacitated adult by another person. Abuse may be at the hand of a parent, caregiver, spouse, neighbor, or adult child of the patient. The recognition of abuse and the proper reporting is a critical step to improve the health and wellbeing of these at-risk populations.

Purpose:

Ensure compliance with "Mandatory Reporter" status under the Code of Virginia.

Assessment of an abuse case based upon the following principles:

- **Protect** the patient from harm, as well as protecting the EMS team from harm and liability.
- **Suspect** that the patient may be a victim of abuse, especially if the injury/illness is not consistent with the reported history.
- **Respect** the privacy of the patient and family.
- **Collect** as much information and evidence as possible and preserve physical evidence.

Procedure:

1. Assess the/all patient(s) for any psychological characteristics of abuse, including excessive passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, behavioral disorders, substance abuse, medical non-compliance, or repeated EMS requests. This is typically best done in private with the patient.
2. Assess the patient for any physical signs of abuse, especially any injuries that are inconsistent with the reported mechanism of injury. Defensive injuries (e.g. to forearms), and injuries during pregnancy are also suggestive of abuse. Injuries in different stages of healing may indicate repeated episodes of violence.
3. Assess all patients for signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition.
4. Immediately report any suspicious findings to both the receiving hospital (if transported) and social services:
 - If child abuse or neglect is suspected, contact Child Protective Services at (800) 552-7096.
 - If elder abuse or neglect (including incapacitated adults), contact Adult Protective Services at (888) 832-3858.
5. EMS personnel should attempt in private to provide the patient with the phone number of the local domestic violence program, or the **National Hotline, 1-800-799-SAFE**.

Criteria for Death

Policy:

CPR and other EMS interventions are to be withheld only if the patient is obviously dead or a valid Virginia Durable Do Not Resuscitate Order and/or POST form (see separate policy) is present.

Purpose:

The purpose of this policy is to:

- Honor those who have obviously expired prior to EMS arrival.


Procedure:

1. If a patient is in complete cardiopulmonary arrest (clinically dead) and meets one or more of the criteria below, CPR and other EMS interventions need not be initiated:
 - Body decomposition
 - Rigor mortis
 - Dependent lividity
 - Major blunt force trauma
 - Injury not compatible with life (i.e., decapitation, burned beyond recognition, massive open or penetrating trauma to the head or chest with obvious organ destruction)
 - Extended downtime with asystole on the ECG
2. If a bystander or first responder has initiated CPR or automated defibrillation prior to EMS's arrival, and any of the above criteria (signs of obvious death) are present, EMS may discontinue CPR and other interventions.
3. If doubt exists, start resuscitation immediately. Once resuscitation is initiated, continue resuscitation efforts until either:
 - a) Resuscitation efforts meet the criteria for implementing the **Discontinuation of Prehospital Resuscitation Policy** (see separate policy)
 - b) Patient care responsibilities are transferred to the destination hospital staff.

Medication Reference

Medication	Adult Dosage	Pediatric Dosage
<p><u>midazolam</u> (Versed)</p> <p>WVEMS Protocols:</p> <ul style="list-style-type: none"> * 2-Behavioral/Pt. Restraint * 11-Airway * 15-Post Resuscitation Care (Adult) * 16-Post Resuscitation Care (Pediatric) * 24-Crush Syndrome * 48-Seizure * 50-Tachycardia (Adult) * 51-Tachycardia (Pediatric) * 53-Pregnancy Related Emerg. <p>Indication/Contraindications:</p> <ul style="list-style-type: none"> * Benzodiazepine used to control seizures and for sedation * Use with caution if hypotensive 	<p><u>Chemical Restraint</u></p> <ul style="list-style-type: none"> * 2 -5mg IV/IO/IM, repeated every 3-5 minutes as needed <p><u>Sedation</u></p> <ul style="list-style-type: none"> * 2-5 mg IV/IO repeated every 3-5 minutes as needed <p><u>Seizures</u></p> <ul style="list-style-type: none"> * 5mg IV/IO/IM/IN, repeated every 3-5 minutes as needed <p><u>Shivering in Induced Hypothermia</u></p> <ul style="list-style-type: none"> * 3-5 mg IV/IO <ul style="list-style-type: none"> • May repeat once 	<p>* See Color Coded List</p> <p><u>Sedation</u></p> <ul style="list-style-type: none"> * 0.2 mg/kg IV/IO <p><u>Seizures</u></p> <ul style="list-style-type: none"> * 0.1 mg/kg IV/IO/IM/IN, repeated every 3-5 minutes as needed (MAX 10 mg)
<p><u>morphine sulfate</u> (MS Contin)</p> <p>WVEMS Protocols:</p> <ul style="list-style-type: none"> * 7-Pain Control * 34-Cardiac Chest Pain <p>Indication/Contraindications:</p> <ul style="list-style-type: none"> * Narcotic pain relief * Antianxiety * Possible beneficial effect in pulmonary edema * Avoid if hypotensive 	<ul style="list-style-type: none"> * 2-4 mg IV/IO/IM <ul style="list-style-type: none"> • May repeat every 10 minutes as needed (MAX 10 mg) 	<p>* See Color Coded List</p> <ul style="list-style-type: none"> * 0.1 mg IV/IO/IM <ul style="list-style-type: none"> • May repeat every 10 minutes as needed (MAX 10 mg)

Medication Reference

Medication	Adult Dosage	Pediatric Dosage
<p><u>naloxone</u> (Narcan)</p> <p>WVEMS Protocols:</p> <ul style="list-style-type: none"> * 13-Asystole/PEA (Adult) * 14-Asystole/PEA (Pediatric) * 43-OD/Poison/Toxics (Adult) * 44-OD/Poison/Toxics (Pediatric) <p>Indication/Contraindications:</p> <ul style="list-style-type: none"> * Narcotic antagonist 	<p>* Up to 2 mg IV/IO/IM/IN</p> <ul style="list-style-type: none"> • Titrate to respirations/oxygenation, <u>NOT</u> consciousness 	<p>* See Color Coded List</p> <p>* 0.1 mg/kg IV/IO/IM/IN</p> <ul style="list-style-type: none"> • Titrate to respirations/oxygenation, <u>NOT</u> consciousness
<p><u>nitroglycerin</u> (Nitrostat)</p> <p>WVEMS Protocols:</p> <ul style="list-style-type: none"> * 34-Cardiac Chest Pain * 45-Pulmonary Edema/CHF <p>Indication/Contraindications:</p> <ul style="list-style-type: none"> * Vasodilator used in aginal syndromes and CHF * Contraindicated if: <ul style="list-style-type: none"> • SBP <90 mmHg • Use of Viagra or Levitra within previous 24 hours • Use of Cialis within previous 36 hours 	<p style="text-align: center;"><u>Sublingual Tablets</u></p> <p>* 0.4 mg SL</p> <ul style="list-style-type: none"> • Repeat every 5 minutes as needed to MAX of 3 tablets <p style="text-align: center;"><u>Paste</u></p> <p>* Apply 1 inch topically</p>	
<p><u>ondansetron</u> (Zofran)</p> <p>WVEMS Protocols:</p> <ul style="list-style-type: none"> * 28-Abdominal Pain * 41-Nausea/Vomiting <p>Indication/Contraindications:</p> <ul style="list-style-type: none"> * Antiemetic used to control nausea and/or vomiting 	<p>* 4 mg IV/IO</p> <ul style="list-style-type: none"> • May repeat once as needed 	<p>* See Color Coded List</p> <p style="text-align: center;"><u>ONLY if >6 months:</u></p> <p>* 0.15 mg/kg IV/IO</p> <ul style="list-style-type: none"> • May repeat once as needed

Overview of committee's remaining tasks:

1. Dr. Lane will get in touch with Danville to schedule a time to work on the video. Dr. Lane will provide an update on a timeline for the video by **June 28**.
2. The following procedures are still in development and are due to Nathan by **June 21**.
 - a. Refusal of care/transport – Shawn
 - b. DNR/POST – Cathy
 - c. Drug boxes – Charles B.
 - d. Oxygen administration – Matt
 - e. Emergency ECO – Matt
3. Develop and finalize roll-out process

Process and Responsibilities for Protocol Roll-out:

WVEMS:

1. Provides video and test
 - a. Includes skills and lectures
 - b. Available and viewed on-line
 - c. Test to be taken on-line
 - i. Certificate issued on-line upon successful completion of test
2. Trains the trainers
 - a. Provided by agency
 - b. Responsible for doing skills hands on training
 - c. Responsible for provider check off of skill.
3. Notify agency OMD of council's plan
4. Creation of an Opt in/out form
5. Convenes Allied Resources Committee to approve medication list
6. Convenes Pharmacy Committee to develop plan to implement drug box changes
7. Develops smartphone app

Provider:

1. Watches video
2. Take an on-line test
3. Gets certificate of on-Line completion
4. Practical hands on
5. Practical check off

Agency/OMD:

1. Responsible for ensuring personnel successfully complete WVEMS roll out.
2. Provides train the trainer(s) candidates that are endorsed by OMD.
3. Submits provider completion to WVEMS
4. Agency OMD signs to opt in or opt out of the protocols

Western Virginia EMS Council
Report from the State's EMS Advisory Board

The most recent meeting was held May 18, 2012 in Richmond, Virginia.

This past quarter, I made several trips to Richmond. On April 23, I attended the transportation committee meeting and helped score RSAF grant requests for ambulances. On April 27, I attended the executive committee meeting. On May 17, I attended the provider health & safety committee meeting. On May 18, I attended the communications committee and legislative and planning committee meetings.

During the communications committee meeting, I challenged the committee's recommendation requiring all grant requests for radio equipment to be P25 compliant. While this is practical in most applications, there are occasions when P25 is not recommended and a costly option that provides no added value. WVEMS is attempting to replace the MED9/10 repeaters to meet narrow banding requirements; however, it is ridiculous to require these to be P25.

The topic of "*where should EMS be located?*" in State government has surfaced again. One stakeholder group is advocating a campaign to get EMS elevated to the department level with a policy making board.

The executive committee has recognized the importance of completing an EMS needs assessment. It is likely that additional survey questions will be added to the Virginia Dept. of Fire Programs survey to help collect data on EMS-related needs.

Two budget amendments passed the Legislature that impacts EMS. The first one requires that initial National Registry testing fees at the EMR and EMT level be paid from the four-for-life. The other amendment directs \$500,000 from the general fund to fund two poison control centers. The original budget bill called for these funds to be paid from four-for-life. This creates some issues for Poison Control centers as the bill mentions studying two centers, but there is actually three centers in the Commonwealth.

The Board approved a white paper titled, "Patient Non-Transport for Motor Vehicle Collisions." The document is available on the OEMS website.

Thank you for your confidence in me to represent the Council on the Advisory Board. Should you have any questions, comments or concerns, please do not hesitate to contact me.

Respectfully submitted,
Dale Wagoner