Prehospital Care Protocol and Treatment Guidelines

2017 R1
NAVIGATION

If viewing this document as a printed hard copy

The Header color of each section defines the protocol type

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<tr>
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<td>Gray – Reference or Policy</td>
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Side Tabs

The side tabs highlight where you are in each protocol sub-section

The BLUE highlighted text shows which sub-section you are currently viewing

The GREY text shows the sub-sections before and after your current selection

If viewing this document as portable document file

(.pdf / Adobe Acrobat)

This document is hyperlinked for easy navigation in Adobe Acrobat.

The colored boxes in each protocol tree are linked to the respective pages with further information on the specific procedure, medication, or protocol page. There is an active link when hovering over the text within the colored box and the cursor changes from a bar to a pointer finger. Left clicking will jump to the linked page containing further information. Right clicking and selecting “Previous View” will return you to the page you started at.

This document is also bookmarked with respect to the individual sections. Use the book mark feature of Adobe Acrobat to display pre-designated bookmarks and click on each to jump between sections.
KEY TO ALGORITHMS

All algorithms are color coded to denote procedures, which may be performed by each level of certification. To perform procedures color-coded red, Medical Control must be contacted for permission. Higher levels of certification will perform lower level evaluations and procedures when interpreting the algorithms.

The protocol format is for quick reference and does not detail patient assessment, interpretation or interventions. EMS personnel are accountable for all patient care and documentation to their level of training and lower.

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**STOP** – Do NOT perform intervention if listed criteria are present

**Caution** – Reminder about specific intervention. Do NOT perform action unless listed criteria are met and understood. If question(s), contact Medical Control

**Time sensitive** – Requires timely response by providers within timeframe indicated
INTRODUCTION

These protocols and procedures are to be used as guidelines for operation during EMS calls that require medical direction. They are also intended to be guidelines to ensure that personnel are trained in proper pre-hospital patient care.

Procedures are not considered rigid rules, but rather established standards against which EMS practice can be measured.

Treatment protocols are specific orders directing the actions pertaining to techniques and/or medications used by EMS personnel who are required to practice under direct supervision of a physician and under their respective EMS Medical Control authority. Treatment protocols may and should be initiated without prior direct Medical Control contact, especially when the patient’s condition and/or situation is life threatening.

Although not identical, these protocols and procedures are derived from the State of Ohio EMS guidelines. Please note that items in this manual are subject to continuous review for the sake of providing members with the most current emergency medical information. Updates to this material may be frequent to maintain a current standard of care to benefit both the patient and the provider of emergency medical care. Please replace older versions with newly updated material as soon as it is issued. Once updated, older versions are to be considered obsolete and are to be discarded to help eliminate confusion.

ONGOING IMPROVEMENT

In an effort to assure these protocols remain relevant and up-to-date, University Hospitals has created an email specific to the ongoing management of this document. Anyone with ideas for improvement should email uhemsprotocols@uhhospitals.org with their suggestions. If there are specific questions about intent, meaning, or interpretation of the protocols, these should be directed to one’s EMS coordinator or Medical Director.

The above listed email will serve as a singular collection point for all corrections, and suggestions. Please understand that protocol changes are an ongoing, progressive, process requiring involvement of many parties to bring to print. Not all suggestions can or will be used, but all will be reviewed by the protocol committee and the Medical Directors. We look forward to your suggestions and corrections to assure that we field the finest pre-hospital care protocol.
1. The patient history should not be obtained at the expense of the patient. Life-threatening problems detected during the primary assessment must be treated first.

2. Cardiac arrest due to trauma is not treated by medical cardiac arrest protocols. Trauma patients should be transported promptly with CPR, control of hemorrhage, cervical spine immobilization, and other indicated procedures attempted enroute.

3. In patients with non-life-threatening emergencies who require IV’s, only two attempts at IV insertion should be attempted in the field; additional attempts must be made enroute.

4. In patients requiring IV’s, as a courtesy to the patient and emergency department, attempts should be made to obtain a full set of bloods. A patient IV should not be compromised in order to obtain a set of bloods.

5. Patient transport, or other needed treatments, must not be delayed for multiple attempts at endotracheal intubation. Limit to two attempts pre-hospital.

6. Verbally repeat all orders received before their initiation.

7. Any adult medical patient or patients of any age with a cardiac history, irregular pulse, unstable blood pressure, dyspnea, chest pain, medication administration, or venous access must be placed on a cardiac monitor, a 12 lead obtained, and transmitted to the emergency department. The transmission must include the patient’s name.

8. When transferring lower level prehospital care to a higher level of prehospital care, a thorough consult should be performed between caregivers describing initial patient presentation and care rendered to the point of transfer.

9. If the patient’s condition does not seem to fit a protocol or protocols, contact Medical Control for guidance.

10. All trauma patients with a mechanism or history for multiple system trauma should be transported as soon as possible. The scene time should be 10 minutes or less.

11. Medical patients will be transported in the most efficient manner possible considering the medical condition. Advanced life support therapy should be provided at the scene if it would positively impact patient care. Justification for scene times greater than 20 minutes should be documented.
INTRODUCTION

UNIVERSAL PATIENT CARE PROTOCOL

ESTABLISH SCENE SAFETY

PATIENT ASSESSMENT
ADULT PATIENT ASSESSMENT PROCEDURE
PEDIATRIC PATIENT ASSESSMENT PROCEDURE

Cardiac Arrest?

AIRWAY / BREATHING
ADULT AIRWAY PROTOCOL
PEDIATRIC AIRWAY PROTOCOL

CIRCULATION
ADULT SHOCK PROTOCOL
PEDIATRIC SHOCK PROTOCOL

SPINAL MOTION RESTRICTION PROCEDURE
SPINAL IMMOBILIZATION PROCEDURE
Where indicated

VITAL SIGNS
Heart Rate
Respirations
Blood Pressure
Room Air SpO2 – Apply O2 if Needed
4 / 12 Lead EKG

Go to Appropriate Protocol

Patient Does NOT Fit Any Protocol?
CONTACT MEDICAL CONTROL

If ST segment changes are found in Leads II, III and AVF (inferior wall) conduct a right side 12 lead EKG.

Move V4 to right side of chest on the midclavicular line <same location as on the left> and run 12 lead again. Label 12 lead as "right side" look to V4 in the right side 12 lead for ST segment changes and notify ER.

Do Not delay transport while obtaining RV4 12 Lead

EMT Intervention  AEMT Intervention  PARAMEDIC Intervention  MED CONTROL Consult
Universal Patient Care Key Points

- Any patient contact, whether it results in an EMS transport or not, must have a completed PCR.
- Exam: Minimal exam if not noted on the specific protocol is vital signs, mental status, and location of injury or complaint.
- Required vital signs on every patient include BP, pulse, respirations, and pain scale.
- A pediatric patient is defined by the Broselow-Luten tape. If the patient does not fit on the tape, they are considered adult.
- Timing of transport should be based on patient’s clinical condition and the transport policy.

General

- All patient care and documentation MUST be appropriate for your level of training and within the standard of care of the State of Ohio.
- Use the standard AHA guidelines for CPR and rescue breathing.
- Refer to the Post Resuscitation Cardiac Arrest Protocol for all resuscitated cardiac arrest patients.
- One provider can begin resuscitation and treatment while the other performs the assessment.
- It may be necessary to reference several protocols while treating a patient.
- Refer to the appropriate protocol and provide the required interventions as indicated.
- Additional focus may be needed in specific areas as indicated by the patient’s chief complaint.
- Airway management and oxygen administration should be initiated based upon the results of the patient assessment and the protocols.
- IV’s should be initiated in all patients based upon the results of the patient assessment and the Intravenous Access Procedure. Attempt to draw blood samples whenever an IV is initiated. However, do not jeopardize the IV for the blood samples.
- Administer cardiac monitoring and perform a 12-Lead EKG based upon the results of patient assessment or protocols.
- EMTs may apply the cardiac monitor, print a strip, and transfer the strip to the emergency department but may not interpret the rhythm.
- If indicated and possible, perform a 12-Lead EKG before moving to the squad and prior to any medication administration.
- Check the patient’s Blood Glucose Level based upon the patient’s assessment and the protocols.
- When assessing for pain, use a 0-10 pain scale; 0 = no pain; 10 = worst pain ever experienced.
- It is mandatory to document the reason why an intervention was not performed if it was indicated.
- If Medical Control requests that a functioning paramedic perform an intervention outside of the protocol, the functioning paramedic may follow the orders as long as ALL of the following apply:
  - The patient’s condition could be severely affected if the intervention is not performed.
  - The paramedic has documented training in the intervention within the last 3 years.
  - The intervention is in the recognized scope of practice for paramedics in the state of Ohio.
  - The paramedic has received permission to perform the intervention from Medical Control.
  - Medical Control was notified that the intervention is not in the protocol.

Adult

- Patients who are taking beta-blockers may not have an elevated heart rate, but may still be in shock.
- General weakness can be a symptom of a life threatening illness.
- Hip fractures and dislocations in the elderly have a high mortality rate.
- What would be considered a minor or moderate injury in the adult patient can be life threatening in the elderly.
- Diabetic patients may have abnormal presentations of AMI and other conditions due to neuropathy.
- A medical cardiac arrest is not a “load and go” situation. It is in the best interest of the patient to perform all initial interventions (Defib, CPR, ETT, IV) and 1-2 rounds of medications prior to transport.
- An adult patient is considered hypotensive if their systolic BP is 90 mmHg or less.
- Assess the patient after every 250 ml of normal saline, and continue with fluid resuscitation until it is no longer indicated.

Pediatric

- Assess the pediatric patient after every 20 ml/kg fluid bolus of normal saline, and continue with fluid resuscitation until it is no longer indicated.
- Refer to the Pediatric Intraosseous Procedure, if indicated.
- It may be necessary to alter the order of the assessment (except for the Initial Assessment) based upon the developmental stage of the patient.
- A pediatric trauma patient is any trauma patient who is less than 16 years old.
- Refer to the Pediatric Vital Signs Chart, as needed.
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**15. APPENDIX # 3 : MEDICAL CONTROL**

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AIRWAY / BREATHING GUIDELINES

GUIDELINES OF AIRWAY / BREATHING ASSESSMENT

PARTIAL OBSTRUCTION
- May include coughing with some air movement. Give 100% Oxygen and encourage the patient to cough. Monitor for changes. Transport immediately and be prepared for a total obstruction to develop.

FOREIGN BODY AIRWAY OBSTRUCTIONS (FBAO)
- Should be removed immediately if able. Visualize airway and either suction or sweep out liquids and other materials. Solids must be hooked with an instrument. A laryngoscope may be used for direct visualization of the airway. If unable to clear airway by these methods, use Heimlich maneuver and abdominal or chest thrusts as appropriate.

STRIDOR
- High pitched crowing sound caused by obstruction of the upper airway.

WHEEZING
- A whistling or sighing sound, usually lower airway and found upon expiration.

RALES
- Fine to coarse crackles representing fluid in the lower airway.

RHONCHI
- Coarse upper airway sound representing various levels of upper airway obstruction.

COPD
- Pulmonary disease (as emphysema or chronic bronchitis) that is characterized by chronic typically irreversible airway obstruction resulting in prolonged exhalation.

CROUP
- Inflammation, edema, and subsequent obstruction of the larynx, trachea, and bronchi especially of infants and young children that is typically caused by a virus and is marked by episodes of difficulty breathing and hoarse metallic cough.

EPIGLOTTITIS
- Inflammation of the epiglottis usually caused by HIB microbes, now uncommon in children.

KEY POINTS

Airway Assessment:
- If you don’t have an airway – you don’t have anything!
- C-spine precautions must be considered prior to the insertion of airway adjuncts. Provide manual stabilization prior to insertion.
- See PEDIATRIC Section for pediatric airway management.

Breathing Assessment:
- Be sure that the airway is open before assessing breathing.
- When assessing breathing, observe rate, quality, depth, and equality of chest movement.
- COPD patients maintain on low flow oxygen (usually <2 L which keeps their O2 Sat in the 90’s%), and some may stop breathing on high flow. However - if the COPD patient needs high flow oxygen - it should be given. Be prepared to support breathing with BVM if needed.
- Always record vital signs when treating breathing problems.
<table>
<thead>
<tr>
<th>ADJUNCT</th>
<th>INDICATIONS</th>
<th>CONTRAINDICATIONS</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suction</td>
<td>Indispensable for all patients with fluid or particulate debris in airway</td>
<td>NONE</td>
<td>No more than 15 seconds per attempt</td>
</tr>
<tr>
<td>Modified jaw thrust</td>
<td>Initial airway maneuver for all trauma patients</td>
<td>NONE</td>
<td>None of these adjuncts protects against aspiration in patient with depressed consciousness</td>
</tr>
<tr>
<td>Hyperextension of neck</td>
<td>Opening airway of non-trauma patient</td>
<td>Potential cervical spine injury</td>
<td>None of these adjuncts protects against aspiration in patient with depressed consciousness</td>
</tr>
<tr>
<td>Nasal airway</td>
<td>Obstruction by tongue with gag reflex present</td>
<td>Potential mid-face injury</td>
<td>None of these adjuncts protects against aspiration in patient with depressed consciousness</td>
</tr>
<tr>
<td>Oral airway</td>
<td>Obstruction to tongue, etc.</td>
<td>Positive gag reflex</td>
<td>None of these adjuncts protects against aspiration in patient with depressed consciousness</td>
</tr>
<tr>
<td>Orotracheal intubation</td>
<td>Failure of above; provides airway protection</td>
<td>NONE</td>
<td>Difficult in patients with severe maxillofacial injuries</td>
</tr>
<tr>
<td>King Airway (BIAD) Blind Insertion Airway Device</td>
<td>Difficult airway Airway device for BLS providers</td>
<td>NONE</td>
<td>Primary salvage airway Size appropriately</td>
</tr>
<tr>
<td>LMA (BIAD) Blind Insertion Airway Device</td>
<td>Difficult airway Airway device for BLS providers</td>
<td>NONE</td>
<td>Requires special training prior to use</td>
</tr>
<tr>
<td>Needle cricothyrotomy if Trained</td>
<td>High obstructed airway – unable to clear. Unable to establish any other airway.</td>
<td>Must be able to identify cricoid ring. Not best for anterior neck trauma.</td>
<td>Provides route for temporary oxygenation only Requires special training prior to use</td>
</tr>
<tr>
<td>Quicktrach or other cricothyrotomy device if Trained</td>
<td>High obstructed airway – unable to clear. Unable to establish any other airway.</td>
<td>Must be able to identify cricoid ring. Not best for anterior neck trauma.</td>
<td>Cricothyrotomy kits requires special training prior to use</td>
</tr>
</tbody>
</table>
**ADULT PROTOCOL**

**AIRWAY**

**UNIVERSAL PATIENT CARE PROTOCOL**
Assess ABC’s Respiratory Rate, Effort, and Adequacy

Adequate
- Consider Supplemental OXYGEN
- COPD Patients
- Treat per specific protocol

Inadequate
- **BASIC MANEUVERS FIRST**
  - Open airway
  - Nasal / Oral Airway
  - Bag-Valve-Mask

**CAPNOGRAPHY PROCEDURE**

**Consider** Sedation Prior To Advanced Airway Placement
*IF RESPONDS TO PAIN*
LORAZEPAM (ATIVAN) 1 - 2 mg IV / IO / IN

- Head Trauma
- If Lorazepam (Ativan) Unavailable, See Medication Section for Midazolam (Versed)

**INTUBATION PROCEDURE**
Apply nasal cannula 15 LPM during intubation attempts
- Max 2 Intubation Attempts
- AEMT Pulseless Apneic Patient Only
- Document Failed Attempt(s)

**BIAD AIRWAY**
- No Medications Down BIAD Airway
- EMT Pulseless Apneic Patient Only
- Esophageal Disease

**Additional Sedation Required**
*After Advanced Airway Placement*
Consider
LORAZEPAM (ATIVAN) 1 - 2 mg IV / IO / IN

- Head Trauma
- If Lorazepam (Ativan) Unavailable, See Medication Section for Midazolam (Versed)

**TRANSPORT** to appropriate facility **CONTACT** receiving facility **CONSULT** Medical Direction where indicated

**EMT Intervention**

**AEMT Intervention**

**PARAMEDIC Intervention**

**MED CONTROL Consult**
## Adult Protocol

### Airway

<table>
<thead>
<tr>
<th>Indications</th>
<th>Signs and Symptoms</th>
<th>Differential Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apnea</td>
<td>Witnessed aspiration</td>
<td>Cardiac arrest</td>
</tr>
<tr>
<td>Coughing</td>
<td>Sudden episode of choking</td>
<td>Respiratory arrest</td>
</tr>
<tr>
<td>Choking</td>
<td>Gagging</td>
<td>Anaphylaxis</td>
</tr>
<tr>
<td>Inability to speak</td>
<td>Audible stridor</td>
<td>Esophageal obstruction</td>
</tr>
<tr>
<td>Unresponsive</td>
<td>Change in skin color</td>
<td></td>
</tr>
<tr>
<td>Burns</td>
<td>Decreased LOC</td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td>Increased or decreased Respiratory rate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Labored breathing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unproductive cough</td>
<td></td>
</tr>
</tbody>
</table>

**Key Points**

- Advanced EMT's may only intubate pulseless or apneic patients.
- EMT may only place BIAD in pulseless and apneic patients.
- Capnography is mandatory with all methods of intubation. Document results.
- Maintain C-spine immobilization for patients with suspected spinal injury.
- Do not assume hyperventilation is psychogenic - use oxygen, not a paper bag.
- Sellick's maneuver should be used to assist with difficult intubations.
- Paramedics should consider using a BIAD airway (King or LMA) if they are unable to Intubate. Consider c-collar to maintain ETT placement for all intubated patients to maintain tube.
- Consider the use of intubation aids such as a bougie to facilitate intubation.
CONGESTIVE HEART FAILURE (CHF) / PULMONARY EDEMA

UNIVERSAL PATIENT CARE PROTOCOL

12 LEAD EKG PROCEDURE
- 1st Patient Contact to EKG < 10 Min

IV / IO PROCEDURE

Mild
- Adequate BP
- Apply OXYGEN 100%
- NITROGLYCERIN (NITRO-STAT) 0.4 mg SL / Spray
- SBP < 110
  - Erectile Dysfunction / Pulmonary Hypertension
  - Drug Within 48 Hrs

Moderate / Severe
- Adequate BP
- Apply OXYGEN 100%
- NITROGLYCERIN (NITRO-STAT) 0.4 mg SL / Spray
- May repeat up to 3
- SBP < 110
  - Erectile Dysfunction / Pulmonary Hypertension
  - Drug Within 48 Hrs

Cardiogenic Shock Hypotensive
- SBP < 90 / NO RADIAL PULSES
- Pale, cool, clammy, hypotensive, acute MI in progress, severe pulmonary edema
- Do NOT Apply ResQGARD
- Do NOT Apply CPAP
- Do NOT Give Vasodilators
- Minimize IV Fluid Volume

Consider CPAP PROCEDURE
- Hypotension
- Untreated Vomiting
- Monitor and Reassess

CPAP PROCEDURE
- Hypotension
- Untreated Vomiting
- If Wheezing
  - DUONEB (ALBUTEROL / IPRATROPIUM)
  - EMT use only with DIRECT Medical Control

OXYGEN 100%
- Bag – Valve Mask
- Gentle Ventilation
- Refer To Cardiogenic Shock Protocol

DOPAMINE (INTROPIN)
- 5 - 20 mcg / kg / min IV / IO
- Titrate to effect
- Refer to dosing chart
- Follow BP, mental status, capnography
- Monitor and Reassess
- Consider Intubation
- Once BP Corrected

TRANSPORT to appropriate facility CONTACT receiving facility CONSULT Medical Direction where indicated

IRENAVHOShitals EMS Protocol - 6 | 2
### CONGESTIVE HEART FAILURE (CHF) / PULMONARY EDEMA

<table>
<thead>
<tr>
<th>I – MILD</th>
<th>II – MODERATE</th>
<th>III – SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Rate</td>
<td>Normal range</td>
<td>Tachycardia</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Normal or slightly elevated</td>
<td>Elevated</td>
</tr>
<tr>
<td>Breath Sounds</td>
<td>Bilateral rales</td>
<td>Bilateral diffuse rales</td>
</tr>
<tr>
<td></td>
<td>Rhonchi</td>
<td>Wheezing possible</td>
</tr>
<tr>
<td></td>
<td>Wheezing possible</td>
<td>Diminished</td>
</tr>
<tr>
<td></td>
<td>Some difficulty breathing</td>
<td>Working hard to breath</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Frothy sputum may occur</td>
</tr>
</tbody>
</table>

### HISTORY
- Congestive heart failure
- Past medical history
- Medications (digoxin, lasix)
- Erectile dysfunction medication use
- Cardiac history - past myocardial infarction

### SIGNS AND SYMPTOMS
- Respiratory distress, bilateral rales
- Apprehension, orthopnea
- Jugular vein distention
- Pink, frothy sputum
- Peripheral edema, diaphoresis
- Hypotension, shock
- Chest pain
- Positive hepato-jugular reflux (HJR)
- Orthopnea

### DIFFERENTIAL DIAGNOSIS
- Myocardial infarction
- Congestive heart failure
- Asthma
- Anaphylaxis
- Aspiration
- COPD
- Pleural effusion
- Pneumonia
- Pulmonary embolus
- Pericardial tamponade

### DIFFERENTIATE CHF vs. PNEUMONIA

#### Congestive Heart Failure Signs and Symptoms
- Afebrile
- Jugular venous distension (JVD)
- Positive hepato-jugular reflux (HJR)
- Bilateral rales
- Distal edema
- Orthopnea
- History of CHF

#### Pneumonia Signs and Symptoms
- Febrile
- Cough
- History of infectious illness
- Unilateral rales
- No distal edema
- No jugular venous distension (JVD)
- No hepato-jugular reflux (HJR)

### Simple calculation for approx 5 mcg/kg/min (must be 1600 mcg/ml concentration)
- Take the Patient’s weight in lbs and remove the last digit (175lbs = 17)
- Subtract 2 from that figure (17-2=15)
- This gives you the number of drops per min using a 60gtts set. (titrate to desired effect)

Example: 175lbs patient.
175 remove the 5, remainder is 17

17 - 2 = **15 drops per min** (approx 5 mcg/kg/min)

Refer to the Dopamine Dosing Chart in Medication Appendix

### KEY POINTS
- Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro
- Obtain 12-lead EKG to evaluate for M.I.
- Differentiate and document CHF vs.: pneumonia.
- Monitor for hypotension after administration of Nitroglycerin (Nitro-Stat).
- Monitor for hypotension while using CPAP, specifically with Nitroglycerine (Nitro-Stat).
- DO NOT administer Nitroglycerin (Nitro-Stat) to a patient who took an erectile dysfunction (ED) medication (Viagra, Cialas, Levitra, etc.) or pulmonary hypertension medication (PHTN) within the last 48 hours.
FOREIGN BODY AIRWAY OBSTRUCTION (FBAO) - ADULT

UNIVERSAL PATIENT CARE PROTOCOL

Head Tilt / Chin Lift / Jaw Thrust

Airway Maneuvers

Coughing Conscious

Encourage Patient to Cough

OXYGEN 10 – 15 L NRB

Complete Obstruction Conscious

Abdominal Thrusts

Complete Obstruction Unconscious

Visualize

Remove Obvious Obstructions

Open Airway / Rescue Breathing

Chest Thrusts

If unable to ventilate, reposition head and attempt again

If unable to ventilate, continue sequence

Direct Laryngoscopy

Attempt Removal with Magill Forceps

If unable to remove obstruction

NEEDLE CRICOTHYROTOMY

OR

CRICOTHYROTOMY KIT

Must Have Med Command Training / Approval

TRANSPORT to appropriate facility CONTACT receiving facility CONSULT Medical Direction where indicated

EMT Intervention

AEMT Intervention

PARAMEDIC Intervention

MED CONTROL Consult
### FOREIGN BODY AIRWAY OBSTRUCTION (FBAO) - ADULT

<table>
<thead>
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<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coughing</td>
<td>Witnessed aspiration</td>
<td>Cardiac arrest</td>
</tr>
<tr>
<td>Choking</td>
<td>Sudden episode of choking</td>
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<td>Inability to speak</td>
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</tr>
<tr>
<td></td>
<td>Unproductive cough</td>
<td></td>
</tr>
</tbody>
</table>

### KEY POINTS
- With complete obstruction, positive-pressure ventilation may be successful.
- Needle cricothyrotomy will provide short term oxygenation only (not ventilation) and is used to “buy time” until other interventions can assure appropriate ventilation.
- Quicktrach kits have a larger internal diameter and thus will provide some minimal ventilation.
- Needle cricothyrotomy and cricothyrotomy kits are bridge devices to surgical intervention.
**Rapid Sequence Intubation (RSI)**

**Indications**
- SpO₂ < 90% on high flow O₂
- Respiratory rate <10 or >32
- Partial airway obstruction due to blood, secretions, trauma, or GCS less than 8
- Respiratory exhaustion or inevitable loss of the airway

**Basic Maneuvers First**
- Open airway
- Nasal / Oral Airway
- Bag-Valve-Mask

**Ventilating to Maintain Capnography and Pulse Oximetry**

**Universal Patient Care Protocol**

**Intubation Procedure**
- ETomidate (Amidate) 0.2 mg/kg IV / IO – Average Dose 20 mg
- or Ketamine 2 mg/kg IV / IO
- Then Succinylcholine (Anectine) 1 - 2 mg/kg IV / IO – Average Dose 100 mg

**Not Successful Meets Above Criteria**
- Burn or Crush Injury > 24hr old
- HX: Muscular Dystrophy, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS)
- HX: Malignant Hyperthermia (including family)
- Etomidate First
- Hyperkalemia or Renal Failure

**Attempt Intubation**
- Max 2 intubation attempts
- Document Failed Attempt(s)

**Biad Airway Device If Intubation Unsuccessful**
- Post Intubation Sedation
  - Lorazepam (Ativan) 1 - 2 mg IV / IO / IN
  - Head Trauma
  - If Lorazepam (Ativan) Unavailable, See Medication Section for Midazolam (Versed)

**Transport** to appropriate facility **Contact** receiving facility **Consult** Medical Direction where indicated

**E.M.T Intervention**

**A.E.M.T Intervention**

**Paramedic Intervention**

**Medical Control Consult**
RAPID SEQUENCE INTUBATION (RSI)

**INDICATIONS**
- SpO₂ < 90% on high flow O₂
- Respiratory rate <10 or >32
- Partial airway obstruction due to blood, secretions, trauma, or GCS 8 or less
- Respiratory exhaustion or inevitable loss of the airway

**SIGNS AND SYMPTOMS**
- Gagging
- Audible stridor
- Change in skin color
- Decreased LOC
- Increased or decreased Respiratory rate
- Labored breathing

**DIFFERENTIAL DIAGNOSIS**
- Cardiac arrest
- Respiratory arrest
- Respiratory failure
- Anaphylaxis
- Esophageal obstruction

---

**Restrictions and Conditions for Procedure**
- You must be approved and trained by Medical Direction in Rapid Sequence Intubation
- Video laryngoscopy must be available
- Salvage airways must be available
- Capnography must be available
- A minimum of 3 EMS personnel are available to facilitate the procedure, 2 of which are Paramedics

---

**The 7 “P’s” of Rapid Sequence Intubation**
- P = Preparation
- P = Preoxygenation
- P = Pretreatment
- P = Paralysis with Induction
- P = Protection
- P = Placement of the Tube
- P = Post-Induction Management

---

**KEY POINTS**
- Waveform Capnography is required before, during, and after intubation attempts. Ventilate to maintain Capnography and SpO₂.
- Succinylcholine (Anectine) is contraindicated in persons with personal or family history of malignant hyperthermia, skeletal muscle myopathies, known or suspected hyperkalemia, and hypersensitivity to the medication.
- If patient becomes hyperthermic post administration of Succinylcholine (Anectine) advise receiving facility immediately stressing it was post Succinylcholine (Anectine) administration. Begin cooling measures per the HYPERTHERMIA PROTOCOL / HEAT EXPOSURE and the INDUCED HYPOTHERMIA PROCEDURE.
- Succinylcholine (Anectine) is never given alone. It is always preceded by an induction agent (a hypnotic / sedative medication) such as Etomidate (Amidate) or Ketamine.
- Once Etomidate (Amidate) and Succinylcholine (Anectine) the airway must be managed with an airway from that point forward.
- Larger doses of Succinylcholine (Anectine) may be required in myasthenia gravis.
- Attempt intubation prior to induction and paralysis. If unsuccessful, sedate then paralyze patient and attempt intubation. Limit attempts post paralysis to 2 attempts then utilize a BIAD airway such as a King or a LMA.
- Apply a nasal cannula to supply 15 LPM during the intubation attempts to maintain oxygen saturation
- Use Mallampati grade to determine difficulty PRIOR to intubation attempt
- Set up and test all equipment prior to intubation attempt, including suction and back-up airways
- Refer to ADULT AIRWAY protocol if post RSI sedation is required.
ADULT PROTOCOL
RESPIRATORY DISTRESS / ASTHMA / COPD

UNIVERSAL PATIENT CARE PROTOCOL
OXYGEN

12 LEAD EKG PROCEDURE
1ST Contact to EKG and Transmission < 10 Min

IV / IO PROCEDURE

TREATMENT OPTIONS

Mild – Symptoms
Treat with aerosol DUONEB (ALBUTEROL / IPRATROPIUM)
Oxygen as needed

Moderate / Severe Distress
CAPNOGRAPHY PROCEDURE
Tachypnea, wheezing accessory muscle use, difficulty speaking
Treat with aerosol DUONEB (ALBUTEROL / IPRATROPIUM)
Oxygen as needed
Follow up pulse-ox
Repeat aerosols DUONEB (ALBUTEROL / IPRATROPIUM)

Severe Distress with STRIDOR
CAPNOGRAPHY PROCEDURE
Tachypnea, bradypnea, stridor, accessory muscle use, difficulty speaking, CO₂ narcosis
Treat with aerosol RACEMIC EPINEPHRINE
Unit Dose (2.25% 0.5ml)
mixed in 3ml of Normal Saline
Nebulized x1 Dose

BE PREPARED For Emergency Airway
NEEDLE CRICOThYROTOMY OR CRICOThYROTOMY KIT
If Patient Occludes Airway
Must Have Med Command Training / Approval

Evidence of Poor Air Exchange
SEVERE ASTHMA / COPD
EPINEPHRINE 1 mg / ml (1:1000)
0.3 – 0.5 mg IM

METHYLprednisolone (SOLU – MEDROL)
125 mg IV / IO
Fever
Hyperglycemia

If Failed Epinephrine
Consider
MAGNESIUM SULFATE
2 Grams IV / IO SLOW

TRANSPORT to appropriate facility CONTACT receiving facility CONSULT Medical Direction where indicated

EMT Intervention AEMT Intervention PARAMEDIC Intervention MED CONTROL Consult

University Hospitals EMS Protocol - 12 | 2
**ADULT PROTOCOL**

## RESPIRATORY DISTRESS / ASTHMA / COPD

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| • Asthma; COPD -- chronic bronchitis, emphysema, congestive heart failure  
• Home treatment (oxygen, nebulizer)  
• Medications (Theophylline, steroids, inhalers)  
• Toxic exposure, smoke inhalation | • Shortness of breath  
• Pursed lip breathing  
• Decreased ability to speak  
• Increased respiratory rate and effort  
• Wheezing, rhonchi  
• Use of accessory muscles  
• Fever, cough  
• Tachycardia  
• tripod position | • Asthma  
• Anaphylaxis  
• Aspiration  
• COPD (emphysema, bronchitis)  
• Pleural effusion  
• Pneumonia  
• Pulmonary embolus  
• Pneumothorax  
• Cardiac (MI or CHF)  
• Pericardial tamponade  
• Hyperventilation  
• Inhaled toxin (Carbon monoxide, etc.) |

CPAP should be used as a last resort in asthmatic / COPD patents whom are HYPOXEMIC. Prepare to intubate and ventilate.

SEVERE ASTHMA / STATUS ASTHMATICUS patients not moving air or is not moving the mist from an aerosol treatment give Epinephrine (Adrenaline) 1 mg / ml (1:1000) 0.3 - 0.5 mg IM.

<table>
<thead>
<tr>
<th>KEY POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Exam: Mental Status, HEENT, Skin, Neck, Heart, Lungs, Abdomen, Extremities, Neuro</td>
</tr>
</tbody>
</table>
| • Status asthmaticus - severe prolonged asthma attack unresponsive to therapy - life threatening!  
• If the patient is over 50 years of age, has a history of cardiac disease, or if the patient’s heart rate is >120 Epinephrine (Adrenaline) may precipitate cardiac ischemia.  
• Monitor pulse oximetery continuously during treatment and transport.  
• A silent chest in respiratory distress is a pre - respiratory arrest sign.  
• Be alert for respiratory depression in COPD patients on prolonged high flow oxygen administration.  
• DO NOT withhold oxygen from hypoxic patients.  
• If Albuterol (Proventil) and / or Ipratropium (Atrovent) is given, monitor the patient’s cardiac rhythm and initiate IV.  
• Patient with known COPD, asthma and a history of steroid use should receive IV Methylpredisolone (Solu-Medrol). Use with caution in diabetics (hyperglycemia), GI bleeds, and febrile patients (sepsis).  
• Assure sufficient expiration time when ventilating COPD or asthma patients to prevent breath stacking and CO2 elimination.  
• Albuterol (Proventil) and Ipratropium (Atrovent) can be given down an ETT or Tracheotomy during ventilation if there is evidence of bronchoconstriction. |
**KEY POINTS**

- These injuries involve the airway and are life-threatening.
- Do not become distracted by non-life-threatening injuries that appear terrible.
- A **sucking chest wound** is when the thorax is open to the outside. The occlusive dressing may be anything such as petroleum gauze, plastic, or a defibrillator pad. Tape only 3 sides down so that excess intrathoracic pressure can escape, preventing a tension pneumothorax. It may help respirations to place patient on the injured side, allowing unaffected lung to expand easier.
- A **flail chest** is when there are extensive rib fractures present, causing a loose segment of the chest wall resulting in paradoxical and ineffective air movement. This movement must be stopped by applying a bulky pad to inhibit the outward excursion of the segment. Positive pressure breathing via BVM will help push the segment and the normal chest wall out with inhalation and to move inward together with exhalation, getting them working together again. Do not use too much pressure, as to prevent additional damage or pneumothorax.
- A **penetrating object** must be immobilized by any means possible. If it is very large, cutting may be possible, with care taken to not move it while making the cut. Place an occlusive & bulky dressing over the entry wound.
- A **tension pneumothorax** is life threatening, look for HYPOTENSION, unequal breath sounds, JVD, increasing respiratory distress, and decreasing mental status. The pleura must be decompressed with a needle to provide relief. Use the intercostal space between the 2nd and 3rd ribs on the midclavicular line, going in on the top side of the 3rd rib. Once the catheter is placed, watch closely for reocclusion. Be prepared to repeat decompression if signs of tension pneumothorax return. Use a long 3 - 3 ¾” 14 gauge needle based on the patient.

**UNIVERSAL PATIENT CARE PROTOCOL**

**Evidence of Trauma – Blunt or Penetrating**

Abnormal breath sounds, inadequate respiratory rate, unequal symmetry, diminished chest excursion, cyanosis

**Identify Treatable Causes**

- Jaw Thrust Airway Maneuver
  - Give High Flow Oxygen

- **Sucking Chest Wound**
  - Apply 3-sided Occlusive Dressing or Commercial Chest Seal

- **Flail Chest**
  - Splint with Bulky Dressing
  - Assist with Ventilation – Gentle Positive Pressure

- **Penetrating Object**
  - Immobilize Object
  - Apply Sterile Saline Dressing

- **Suspect Tension Pneumothorax**
  - NEEDLE DECOMPRESSION PROCEDURE
    - Decompress when HYPOTENSIVE
    - Be Prepared to Repeat IF S&S Return

**TRANSPORT** to appropriate facility **CONTACT** receiving facility **CONSULT** Medical Direction where indicated
Shock Guidelines .................................................................................................................................................. 2-3
Anaphylactic Shock / Reaction .......................................................................................................................... 4-3
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# SHOCK GUIDELINES

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<th>SIGNS AND SYMPTOMS</th>
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<td>• Hypotension</td>
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<tr>
<td></td>
<td>• Difficulty breathing</td>
</tr>
<tr>
<td></td>
<td>• Cool, clammy skin</td>
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<tr>
<td></td>
<td>• Weakness</td>
</tr>
<tr>
<td><strong>HYPOVOLEMIC SHOCK</strong></td>
<td>• Tachycardia</td>
</tr>
<tr>
<td></td>
<td>• Weak, thready pulse</td>
</tr>
<tr>
<td></td>
<td>• Hypotension with narrow pulse pressure</td>
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<td></td>
<td>• Hypotension or falling systolic BP</td>
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<tr>
<td></td>
<td>• Pale skin</td>
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<td></td>
<td>• Clammy or dry skin</td>
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<tr>
<td></td>
<td>• Dyspnea</td>
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<td></td>
<td>• Altered LOC / coma</td>
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<td></td>
<td>• Decreased urine output</td>
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<td>• Restlessness</td>
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<tr>
<td></td>
<td>• Irritability</td>
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<td></td>
<td>• Decreased urine output</td>
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<tr>
<td><strong>ANAPHYLACTIC SHOCK</strong></td>
<td>• Hypotension</td>
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<tr>
<td>(Distributive Shock)</td>
<td>• Severe respiratory distress</td>
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<tr>
<td></td>
<td>• Shock</td>
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<tr>
<td></td>
<td>• Dyspnea</td>
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<tr>
<td></td>
<td>• Wheezing</td>
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<tr>
<td></td>
<td>• Hoarseness / stridor</td>
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<tr>
<td></td>
<td>• Cyanosis</td>
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<tr>
<td></td>
<td>• Facial / airway edema</td>
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<td></td>
<td>• Urticaria / hives</td>
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<tr>
<td></td>
<td>• Warm burning feeling</td>
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<tr>
<td></td>
<td>• Itching</td>
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<td></td>
<td>• Rhinorrhea</td>
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<td></td>
<td>• Altered LOC / coma</td>
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<tr>
<td></td>
<td>• Pulmonary edema</td>
</tr>
<tr>
<td><strong>NEUROGENIC SHOCK</strong></td>
<td>• Hypotension with a narrow pulse pressure</td>
</tr>
<tr>
<td>(Distributive Shock)</td>
<td>• Evidence of trauma (lacerations, bruising, swelling, deformity)</td>
</tr>
<tr>
<td></td>
<td>• Normal or bradycardic HR</td>
</tr>
<tr>
<td></td>
<td>• Compromise in neurological function</td>
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<tr>
<td></td>
<td>• Normal or flushed skin color</td>
</tr>
<tr>
<td><strong>SEPTIC SHOCK</strong></td>
<td>• Hypotension with a narrow pulse pressure</td>
</tr>
<tr>
<td>(Distributive Shock)</td>
<td>• Dyspnea</td>
</tr>
<tr>
<td></td>
<td>• Febrile</td>
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<tr>
<td></td>
<td>• Tachycardia</td>
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<tr>
<td></td>
<td>• Signs of infection</td>
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<tr>
<td></td>
<td>• Hx of UTI</td>
</tr>
<tr>
<td></td>
<td>• Hypovolemia (Fever, Sweating)</td>
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<tr>
<td></td>
<td>• Dehydration</td>
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<tr>
<td></td>
<td>• Altered LOC / coma</td>
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<tr>
<td></td>
<td>• Pulmonary edema</td>
</tr>
<tr>
<td><strong>OBSTRUCTIVE SHOCK</strong></td>
<td>• Obstruction that interferes with preload / afterload</td>
</tr>
<tr>
<td></td>
<td>• Commonly caused by tension pneumothorax / pulmonary embolism</td>
</tr>
<tr>
<td></td>
<td>• Hypotension</td>
</tr>
<tr>
<td></td>
<td>• Chest pain</td>
</tr>
<tr>
<td></td>
<td>• Hypoxia</td>
</tr>
<tr>
<td></td>
<td>• Absent lung sounds (tension pneumothorax)</td>
</tr>
<tr>
<td></td>
<td>• Present lung sounds (pulmonary embolism)</td>
</tr>
</tbody>
</table>
HISTORY
• Blood loss - vaginal or gastrointestinal bleeding, AAA, ectopic
• Fluid loss - vomiting, diarrhea, fever
• Infection
• Cardiac ischemia (MI, CHF)
• Medications
• Allergic reaction
• Pregnancy

SIGNS AND SYMPTOMS
• Restlessness, confusion
• Weakness, dizziness
• Weak, rapid pulse
• Pale, cool, clammy skin
• Delayed capillary refill
• Hypotension
• Coffee-ground emesis
• Tarry stools

DIFFERENTIAL DIAGNOSIS
• Shock
• Hypovolemic
• Cardiogenic
• Septic
• Neurogenic
• Anaphylactic
• Ectopic pregnancy
• Dysrhythmias
• Pulmonary embolus
• Tension pneumothorax
• Medication effect / overdose
• Vasovagal hypotension
• Physiologic (pregnancy)

KEY POINTS
• Exam: Mental Status, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro
• Hypotension can be defined as a systolic blood pressure of less than 90 systolic
• Consider performing orthostatic vital signs on patients in non-trauma situations if suspected blood or fluid loss
• Consider all possible causes of shock and treat per appropriate protocol

Anaphylactic Shock
• Do not confuse Epinephrine (Adrenaline) 1 mg / ml (1:1000) IM and 0.1 mg / ml (1:10,000) IV
• Treat patients with a history of anaphylaxis aggressively.
• Routine assessment and supportive care of the patient’s respiratory and cardiovascular systems is required.
• Use caution when using Epinephrine (Adrenaline) for patients over fifty years of age.
• Use caution when using Epinephrine (Adrenaline) for patients with a heart rate greater than 120 bpm.
• When possible, remove any stingers.

Cardiogenic Shock
• Circulatory failure is due to inadequate cardiac function.
• Be aware of patients with congenital defects.
• Cardiogenic shock exists in the prehospital setting when an MI is suspected and there is no specific indication of volume related shock.
• Pulmonary edema or CHF may cause cardiogenic shock. (Pediatrics with congenital heart defects may rarely have pulmonary edema)
• Marked, symptomatic tachycardia and bradycardia will also cause cardiogenic shock. Fix rate first.

Hypovolemic Shock
• Patients suffering from hemorrhagic shock secondary to trauma, should be treated under the Trauma Criteria, and should be rapidly transported to the nearest appropriate facility.
• Initiate a second large bore IV for all patients in hypovolemic shock, resuscitate to a MAP of at least 70 or a SBP of 90 (100 SBP if >70 years old) or radial pulses where NIBP is unavailable.

Neurogenic Shock
• Cushings triad is a sign of increased ICP.
• Cushings triad presents as high blood pressure, low pulse rate, and irregular respirations.

Septic Shock
• Hypotensive septic shock patients require aggressive fluid resuscitation and should receive vasopressor support if not responding to fluid challenges.
• Be alert for septic shock in the elderly.
ANAPHYLACTIC REACTION / SHOCK

MILD

- Rash, itching, with no difficulty breathing or throat tightening, B/P – normal limits
- Consider EPINEPHRINE AUTO-INJECTOR
- DIPHENHYDRAMINE (BENADRYL) 25 - 50 mg IV / IO / IM
- If history of severe reaction

MODERATE

- Rash, itching, Wheezing, Throat tightening, Swelling, face lips, B/P – normal limits
- Consider DUONEB (ALBUTEROL / IPRATROPIUM) Aerosol
- DIPHENHYDRAMINE (BENADRYL) 25 - 50 mg IV / IO / IM
- EMT use only with DIRECT Medical Control
- Never Given IV

SEVERE

- Rash, itching, Airway compromise Wheezing Swelling Hypotension
- Consider repeat EPINEPHRINE (ADRENALINE) after 5 min. if no improvement
- METHYLPIREDISOLONE (SOLU – MEDROL) 125 mg IV / IO
- Fever
- Hyperglycemia

IMPENDING ARREST

- Anaphylactic Shock
- Severe Hypotension
- NO Radial Pulses
- Any AGE
- Decreased LOC
- Airway compromise
- Secure Airway and Ventilate
- If only EMT Available
- Epinephrine Auto-Injector
- If only AEMT Available
- Consider repeat EPINEPHRINE (ADRENALINE) 1:1000 0.3 - 0.5 mg IM
- IV NORMAL SALINE BOLUS
- 20 ml / kg
- To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable
- SLOW IV
- 0.1 mg / ml (1:10,000) IV ONLY
- To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable
- DIPHENHYDRAMINE (BENADRYL) 50 mg IV / IO / IM
- Methyldprednisolone (Solu-Medrol) 125 mg IV / IO
- Fever
- Hyperglycemia
- Follow ACLS
- Do not confuse epinephrine 1 mg / ml (1:1000) IM vs 0.1 mg / ml (1:10,000) IV / IO
**ADULT PROTOCOL**

**HYPOVOLEMIC, NEUROGENIC, CARDIOGENIC, AND SEPTIC SHOCK**

- **UNIVERSAL PATIENT CARE PROTOCOL**
  - **AIRWAY PROTOCOL**
    - Monitor Lung Sounds for Fluid Overload
  - **OXYGEN**
  - **IV / IO PROCEDURE**
    - Apply Cardiac Monitor and Assess Vitals
  - **CAPNOGRAPHY PROCEDURE**

**HYPOVOLEMIC SHOCK**
- ResQGARD ITD Procedure
- IV NORMAL SALINE BOLUS
  - Minimum Necessary
  - To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable
- BLOOD GLUCOSE PROCEDURE

**CARDIOWEGENIC SHOCK**
- Cardiogenic Shock
- No ResQGARD
- IV NORMAL SALINE TKO
- 12 Lead Procedure
- BLOOD GLUCOSE PROCEDURE
- DOPAMINE (INTROPIN)
  - 5 – 20 mcg/kg/min IV drip
  - Titrate to effect (If MAP remains < 70 or SBP < 90)

**NEUROGENIC SHOCK**
- Consider
- SPINAL MOTION RESTRICTION PROCEDURE
- ResQGARD ITD Procedure
- IV NORMAL SALINE BOLUS
  - 20 ml / kg
  - To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable
- BLOOD GLUCOSE PROCEDURE

**SEPTIC SHOCK**
- Septic Shock
- ResQGARD ITD Procedure
- IV NORMAL SALINE BOLUS
  - AT LEAST 20 ml / kg
  - To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable
- 12 Lead Procedure
- BLOOD GLUCOSE PROCEDURE
- DOPAMINE (INTROPIN)
  - 5 – 20 mcg/kg/min IV drip
  - Titrate to effect (If MAP remains < 70 or SBP < 90)
- Identify Possible SIRS Patient or Severe Sepsis Patient
- Use Checklist on Following Page
- NOTIFY RECEIVING FACILITY

**TRANSPORT** to appropriate facility
**CONTACT** receiving facility
**CONSULT** Medical Direction where indicated


**ADULT PROTOCOL**

**HYPOVOLEMIC, NEUROGENIC, CARDIOGENIC, AND SEPTIC SHOCK**

### SIRS Checklist

<table>
<thead>
<tr>
<th>Clinical Findings</th>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Temp &gt; 38°C (100.4°F) or &lt; 36°C (96.8°F)</td>
<td>□ Pneumonia</td>
</tr>
<tr>
<td>□ Heart Rate &gt; 90 BPM</td>
<td>□ Urinary Tract Infection</td>
</tr>
<tr>
<td>□ Respiratory Rate &gt; 20 BPM or</td>
<td>□ Cellulitis</td>
</tr>
<tr>
<td>□ Capnography &lt; 32 mmHg</td>
<td>□ Septic Arthritis</td>
</tr>
<tr>
<td>□ Altered Mental Status</td>
<td>□ Diarrhea</td>
</tr>
</tbody>
</table>

### Severe Sepsis Checklist

Clinical Findings (Present and NEW to Patient)

| □ SBP < 90 |
| □ SPo2 < 90 |
| □ No Urine Output last 8 Hours |
| □ Prolonged bleeding from gums |
| □ Lactate > 4 |

### MAP Calculation

2 X Diastolic Blood Pressure + Systolic Blood Pressure / 3 = MAP

### Simple Dopamine Calculation for 5 mcg/kg/min

- Patient Weight in Lbs, remove last digit (ex. 175 lbs = 17)
- Subtract 2 from that number (ex. 17-2=15)
- Result is the drops per minute using 60 gtt set (ex. 15 gtt / min)
- Titrate to MAP / SBP / Capnography / mental status from this number

### DOPAMINE DRIP CHART 1600 mcg/ml

<table>
<thead>
<tr>
<th>WEIGHT(KG)</th>
<th>DOSE (mcg/kg/min)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td>40</td>
<td>8</td>
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<td>50</td>
<td>10</td>
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<td>60</td>
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<td>130</td>
<td>25</td>
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<tr>
<td>140</td>
<td>27</td>
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</table>
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ADULT PROTOCOL

ACUTE CORONARY SYNDROME

UNIVERSAL PATIENT CARE PROTOCOL

OXYGEN to maintain SpO2 >94%

12 LEAD EKG PROCEDURE

Look for ST Elevation - Transmit to ED

EKG INDICATES STEMI - CONSULT PHYSICIAN IF UNSURE

Strongly encourage transport to hospital with interventional cath lab when STEMI is present on 12 lead

If ST Elevation Leads II, III, Avf

12 LEAD EKG PROCEDURE - RIGHT

Right Sided Precordial Lead RV4 - Transmit to ED

DO NOT DELAY TRANSPORT TO ACQUIRE RIGHT SIDE 12 LEAD

WITHOLD NITROGLYCERINE (NITRO-STAT) if elevation in RV4

Use caution with acute septal wall MI (V1, V2) – Watch for AV blocks – Consider placing pacing pads

ASPIRIN

324 mg chew and swallow (81 mg / tab x4)

NITROGLYCERIN (NITRO-STAT)

0.4 mg SL / Spray

(IF SBP > 110 with IV or SBP >120 without IV)

May give up to 3 total if no pain relief, every 5 minutes

If Cocaine Induced STEMI include

LORAZEPAM (ATIVAN) 1 – 2 mg IV / IN / IO / IM

If Lorazepam (Ativan) is unavailable, See Medication Section for Midazolam (Versed)

ONDANSETRON (ZOFRAN) if Nausea / Vomiting

4 mg IV / IM or

ONDANSETRON (ZOFRAN) Oral Disintegrating Tablet (ODT)

if Nausea / Vomiting - 8 mg Oral

Paramedic Treatment if Confirmed STEMI

TICAGRELOR (BRILINTA)

180 mg PO

HEPARIN

60 Units / kg IV / IO

Max Dose 4000 Units

NO STEMI ON EKG - ISCHEMIC CHEST PAIN

ASPIRIN

324 mg chew and swallow (81 mg / tab x4)

NITROGLYCERIN (NITRO-STAT)

0.4 mg SL / Spray

(IF SBP > 110 with IV or SBP >120 without IV)

May give up to 3 total if no pain relief, every 5 minutes

Continued Chest Pain? Adequate BP?

FENTANYL (SUBLIMAZE)

25 – 100 mcg IV / IM / IN / IO – SLOW IV – Max 100 mcg

If Fentanyl (Sublimaze) is unavailable, See Medication Section for Morphine Sulfate

If Cocaine Induced STEMI include

LORAZEPAM (ATIVAN) 1 – 2 mg IV / IN / IO / IM

If Lorazepam (Ativan) is unavailable, See Medication Section for Midazolam (Versed)

ONDANSETRON (ZOFRAN) if Nausea / Vomiting

4 mg IV / IM or

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180 mg PO

HEPARIN

60 Units / kg IV / IO

Max Dose 4000 Units

TRANSPORT to appropriate facility

CONTACT receiving facility

CONSULT Medical Direction where indicated
# A D U L T  P R O T O C O L

## A C U T E  C O R O N A R Y  S Y N D R O M E

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<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
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<tr>
<td>Age</td>
<td>CP (pain, pressure, aching, tightness)</td>
<td>Trauma vs. medical</td>
</tr>
<tr>
<td>Medications</td>
<td>Location (subternal, epigastric, arm, jaw, neck, shoulder)</td>
<td>Angina vs. myocardial infarction</td>
</tr>
<tr>
<td>Past medical history (MI, angina, diabetes)</td>
<td>Radiation of pain</td>
<td>Pericarditis</td>
</tr>
<tr>
<td>Allergies</td>
<td>Pale, diaphoresis</td>
<td>Pulmonary embolism</td>
</tr>
<tr>
<td>Recent physical exertion</td>
<td>Shortness of breath</td>
<td>Asthma / COPD</td>
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<tr>
<td>Onset</td>
<td>Nausea, vomiting, dizziness</td>
<td>Pneumothorax</td>
</tr>
<tr>
<td>Palliation / Provocation</td>
<td>Quality (crampy, constant, sharp, dull, etc.)</td>
<td>Aortic dissection or aneurysm</td>
</tr>
<tr>
<td>Region / Radiation / Referred</td>
<td>Region / Radiation / Referred</td>
<td>GE reflux or hiatal hernia</td>
</tr>
<tr>
<td>Severity (1-10)</td>
<td></td>
<td>Esophageal spasm</td>
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<tr>
<td>Time (duration / repetition)</td>
<td></td>
<td>Chest wall injury or pain</td>
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<td></td>
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<td>Pleural pain</td>
</tr>
</tbody>
</table>

## KEY POINTS
- Make the scene safe: All chest pain patients must have an IV and 12 Lead EKG.
- Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro.
- If patient has taken Nitroglycerin (Nitro-stat) without relief, consider potency of the medication.
- If positive ECG changes, establish a second IV while enroute to the hospital.
- Monitor for hypotension after administration of Nitroglycerin (Nitro-stat) or Fentanyl (Sublimaze).
- Nitroglycerin (Nitro-stat) or Fentanyl (Sublimaze) may be repeated per dosing guidelines in the MEDICATIONS SECTION.
- Diabetics / geriatric patients often have atypical pain, vague, or only generalized complaints. Be suspicious of a “silent MI”.
- Refer to the BRADYCARDIA PROTOCOL (HR < 60 bpm) or NARROW COMPLEX TACHYCARDIA PROTOCOL (HR > 150 bpm) if indicated.
- If the patient becomes hypotensive from Nitroglycerin (Nitro-stat), Fentanyl (Sublimaze) administration, place the patient in the Trendelenburg position and administer a Normal Saline bolus.
- Be prepared to administer Narcan (Naloxone) if the patient experiences respiratory depression due to Fentanyl (Sublimaze) administration.
- If pulmonary edema is present, refer to the CHF / ACUTE PULMONARY EDEMA PROTOCOL.
- Aspirin can be administered to a patient on Coumadin (Warfarin), unless the patient’s physician has advised them otherwise.
- If the patient took a dose of Aspirin that was less than 324 mg in the last (24) hours, then additional Aspirin can be administered to achieve a therapeutic dose of 324 mg.
- DO NOT administer Nitroglycerin (Nitro-stat) to a patient who took an erectile dysfunction medication (Viagra, Cialas, Levitra, etc) within the last 48 hours due to potential severe hypotension.
- Nitroglycerin (Nitro-stat) can be administered to a patient by EMS if the patient has already taken their own prior to your arrival. Document it if the patient had any changes in their symptoms or a headache after taking their own Nitroglycerin.
- Nitroglycerin (Nitro-stat) can be administered without an IV as long as patient has a BP greater than 120 mmHg, without signs of inferior wall MI.
- DO NOT treat the PVC’S with Amiodarone (Cordarone) unless patient develops runs of or sustained V-tach.
- Pulse oximetry is not an indicator of myocardial perfusion.
- Only administer oxygen if the patient is hypoxic with a SpO2 of 94 or less. Do not withhold oxygen from patients that are short of breath regardless of SpO2.
- Once applied to a known or suspected ACS patient do not remove a 12 lead EKG, even if the initial EKG is unremarkable. Some devices continue to look for ST segment changes and will alert if there are changes.

| I – Lateral | aVR | V1 – Septal | V4 – Anterior |
| II – Inferior | aVL – Lateral | V2 – Septal | V5 – Lateral |
| III – Inferior | aVF – Inferior | V3 – Anterior | V6 – Lateral |
ADULT PROTOCOL

BRADYCARDIA

UNIVERSAL PATIENT CARE PROTOCOL

APPLY CARDIAC MONITOR

OXYGEN

CAPNOGRAPHY PROCEDURE

IV / IO PROCEDURE

Hypotensive / Symptomatic?
SBP < 90 / No Radial Pulses / AMS

NO (Stable)

Continual Monitoring and Reassessment

12 LEAD EKG PROCEDURE
Look for ST Elevation - Transmit to ED

Be Prepared for Decompensation
Consider placing pacing pads
Prepare medications

YES (Unstable)

Consider Sedation
LORAZEPAM (ATIVAN)
1 - 2 mg IV / IO / IN / IM

If Lorazepam (Ativan) Unavailable,
See Medication Section for Midazolam (Versed)

EXTERNAL TRANSCUTANEOUS PACING PROCEDURE

OR

ATROPINE 0.5 mg IV / IO
Can repeat every 3 - 5 minutes *if working*
Maximum of 3 mg

OR

Consider DOPAMINE (INTROPIN)
5 - 20 mcg / kg / min IV / IO drip
To Maintain MAP > 70
or SBP 90 / Radial Pulses if NIBP Unavailable

Refer to dosing chart
Follow SBP, Mental status, Capnography

IV NORMAL SALINE BOLUS
To Maintain MAP > 70
or SBP 90 / Radial Pulses if NIBP Unavailable

12 LEAD EKG PROCEDURE
Look for ST Elevation - Transmit to ED

TRANSPORT to appropriate facility CONTACT receiving facility CONSULT Medical Direction where indicated

EMT Intervention

AEMT Intervention

PARAMEDIC Intervention

MED CONTROL Consult
## ADULT PROTOCOL

### BRADYCARDIA

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| • Past medical history  
• Medications  
• Beta-blocker use  
• Calcium channel blocker use  
• Clonidine use  
• Digitalis use  
• Pacemaker | • HR < 60 / min  
• Chest pain  
• Respiratory distress  
• Hypotension or shock  
• Altered mental status  
• Syncope | • Acute myocardial infarction  
• Hypoxia  
• Hypothermia  
• Sinus bradycardia  
• Athletes  
• Head injury (elevated ICP) or stroke  
• Spinal cord lesion  
• Sick sinus syndrome  
• AV blocks (1°, 2°, or 3°) |

### KEY POINTS

- **Exam:** Mental Status, Neck, Heart, Lungs, Neuro
- The use of Amiodarone (Cordarone) in heart block can worsen bradycardia and lead to asystole.
- Treatment of bradycardia is based upon the presence or absence of hypotension.
- If hypotension exists, treat, if blood pressure is adequate, monitor only but have all treatment modalities immediately available if the patient decompensates.
- **DO NOT** administer Atropine, if the patient’s rhythm is a Type II second-degree heart block or a third degree heart block.
- Transcutaneous pacing is the treatment of choice for Type II second-degree heart blocks and third degree heart blocks.
- Transcutaneous pacing in demand mode will shut off if patient’s intrinsic heart rate rises above the set pacer rate.
- If the patient is critical and an IV is not established, initiate pacing use intranasal sedation if required.
- If the patient converts to another rhythm, refer to the appropriate protocol and treat accordingly.
- If bradycardia is a result of calcium channel blocker or beta blocker overdose, follow the Toxic Ingestion / Exposure / Overdose protocol.
ADULT PROTOCOL
NARROW – COMPLEX TACHYCARDIA

UNIVERSAL PATIENT CARE PROTOCOL
APPLY CARDIAC MONITOR
OXYGEN
CAPNOGRAPHY PROCEDURE
IV / IO PROCEDURE

Hypotension / Symptomatic ?
SBP < 90 / No Radial Pulses / AMS

Stable / Regular / (SVT)
12 LEAD EKG PROCEDURE
Attempt Vagal Maneuvers (NO carotid massage)

ADENOSINE (ADENOCARD)
6 mg IV push followed by 20 ml Normal Saline push (Not for rapid Atrial Fibrillation or WPW)

No Response 1 – 2 minutes
ADENOSINE (ADENOCARD)
12 mg IV push followed by 20 ml Normal Saline

METOPROLOL (LOPRESSSOR)
5 mg IV / IO
Discuss Repeat as Required

No Response 1 – 2 minutes
METOPROLOL (LOPRESSSOR)
5 mg IV / IO
Discuss Repeat as Required

RepeaSynchronized CARDIOVERSION
200, 300, 360 J or biphasic equivalent

Irregular Rhythms / Afib

Transport to appropriate facility CONTACT receiving facility CONSULT Medical Direction where indicated

Unstable / Regular or Irregular

Use EXTREME Caution When Cardioverting IRREGULAR Tachycardias.
SIGNIFICANT Potential to Cause CVA, Specifically if Greater Than 48 Hours Duration

Consider Sedation
LORAZEPAM (ATIVAN)
1 - 2 mg IV / IO / IN / IM

If Lorazepam (Ativan) Unavailable, See Medication Section for Midazolam (Versed)

Synchronized CARDIOVERSION
50 – 100 J

Irregular Rhythms / Afib

No Response 1 – 2 minutes

Repeat Synchronized CARDIOVERSION
200, 300, 360 J or biphasic equivalent

Irregular Rhythms / Afib

Stable / Irregular (A-Fib)
12 LEAD EKG PROCEDURE
Attempt Vagal Maneuvers (NO carotid massage)

Supportive Care, Treatment of Symptoms and Close Observation are all that is generally required

Normal Saline
Consider Fluid Bolus to Rule out Hypovolemia / Dehydration as Cause of Tachycardia

If Lorazepam (Ativan) Unavailable, See Medication Section for Midazolam (Versed)

Irregular Rhythms / Afib

Stable / Irregular (A-Fib)
12 LEAD EKG PROCEDURE
Attempt Vagal Maneuvers (NO carotid massage)

NORMAL SALINE
Consider Fluid Bolus to Rule out Hypovolemia / Dehydration as Cause of Tachycardia

If Lorazepam (Ativan) Unavailable, See Medication Section for Midazolam (Versed)

Synchronized CARDIOVERSION
50 – 100 J

Irregular Rhythms / Afib

No Response 1 – 2 minutes

Repeat Synchronized CARDIOVERSION
200, 300, 360 J or biphasic equivalent

Irregular Rhythms / Afib
# A D U L T  P R O T O C O L

## NARROW – COMPLEX TACHYCARDIA

### HISTORY
- Medications (Aminophylline, diet pills, thyroid supplements, decongestants, digoxin)
- Diet (caffeine, chocolate)
- Drugs (nicotine, cocaine)
- Past medical history
- History of palpitations / heart racing
- Syncope / near syncope

### SIGNS AND SYMPTOMS
- HR > 150 bpm
- QRS < .12 Sec
- Dizziness, CP, SOB
- Potential presenting rhythm
- Sinus tachycardia
- Atrial fibrillation / flutter
- Multifocal atrial tachycardia

### DIFFERENTIAL DIAGNOSIS
- Heart disease (WPW, valvular)
- Sick sinus syndrome
- Myocardial infarction
- Electrolyte imbalance
- Exertion, pain, emotional stress
- Fever
- Hypoxia
- Hypovolemia or anemia
- Drug effect / overdose (see HX)
- Hyperthyroidism
- Pulmonary embolus

### KEY POINTS
- Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro
- Continuous pulse oximetry is required for all tachycardic patients.
- Document all rhythm changes with monitor strips and obtain monitor strips with each intervention.
- If the patient converts to another rhythm, refer to the appropriate protocol and treat accordingly.
- Examples of vagal maneuvers include bearing down, coughing, or blowing into a syringe. DO NOT perform a carotid massage.
- If possible, the IV should be initiated in either AC.
- Consider applying the cardioversion / pacing pads prior to Adenosine (Adenocard) administration.
- When administering Adenosine (Adenocard), raise the patient’s arm and immediately follow the bolus with 20 ml rapid bolus of normal saline.
- Record 3-Lead EKG strips during Adenosine (Adenocard) administration.
- Perform a 12-Lead EKG prior to and after Adenosine (Adenocard) conversion or after cardioversion.
- If the patient converts into ventricular fibrillation or pulseless ventricular tachycardia immediately DEFIBRILLATE, the patient and refer to the appropriate protocol and treat accordingly. Be sure to switch the defibrillator out of “Sync” before defibrillating.
- Give a copy of the EKGs and / or code summaries with the receiving facility upon arrival.
- Transient periods of sinus bradycardia and ventricular ectopy are common after termination of SVT.
- It is unlikely that symptoms of instability are caused primarily by the tachycardia when the HR is <150 unless there is impaired ventricular function.
- Metoprolol (Lopressor) is not for physiologic tachycardias (sinus tach) from underlying etiology. Recognize and treat underlying cause.
- Metoprolol (Lopressor) is contraindicated in sympathomimetic drug overdoses such as cocaine.

---

**Known Atrial Fibrillation**
- NO ADENOSINE

**Wolf Parkinson White (WPW)**
- NO ADENOSINE
A D U L T  P R O T O C O L

WIDE – COMPLEX TACHYCARDIA – With Pulse

**UNIVERSAL PATIENT CARE PROTOCOL**

**APPLY CARDIAC MONITOR**

**OXYGEN**

**CAPNOGRAPHY PROCEDURE**

**IV / IO PROCEDURE**

Hypotensive / Symptomatic?
- SBP < 90 / No Radial Pulses / AMS

---

**Stable / Regular**

12 LEAD EKG PROCEDURE

Attempt Vagal Maneuvers (NO carotid massage)

**Stable / Irregular**

12 LEAD EKG PROCEDURE

Attempt Vagal Maneuvers (NO carotid massage)

**Unstable / Regular or Irregular**

Consider Sedation
- LORAZEPAM (ATIVAN) 1 - 2 mg IV / IO / IN / IM

- If Lorazepam (Ativan) Unavailable, See Medication Section for Midazolam (Versed)

Synchronized CARDIOVERSION
- 100, 200, 300, 360 J (or biphasic equivalent)

Irregular Rhythms / Afib
- Defibrillate if Torsades, Do not Synchronize Cardiovert

---

No Response 1 ~2 minutes

Repeat Synchronized CARDIOVERSION
- 200, 300, 360 J or biphasic equivalent

Irregular Rhythms / Afib
- Defibrillate if Torsades, Do not Synchronize Cardiovert

---

Consider Medications if Cardioversion Unsuccessful

AMIODARONE (CORDARONE)
- 150 mg IV / IO mix in 20+ ml NS Over 10 minutes

Slow IV
- Must have USEABLE 12 Lead EKG and Have Transmitted to Hospital

---

If Torsades de pointes
- MAGNESEUM SULFATE 1 - 2 grams IV / IO over 5 to 60 minutes

- Slow IV
- Must have USEABLE 12 Lead EKG and Have Transmitted to Hospital

---

AMIODARONE (CORDARONE)
- 150 mg IV / IO mix in 20+ ml NS Over 10 minutes

Slow IV
- Must have USEABLE 12 Lead EKG and Have Transmitted to Hospital

If Torsades de pointes
- MAGNESEUM SULFATE 1 - 2 grams IV / IO Over 5 minutes

---

**TRANSPORT** to appropriate facility
**CONTACT** receiving facility
**CONSULT** Medical Direction where indicated

---

EMT Intervention

AEMT Intervention

PARAMEDIC Intervention

MED CONTROL Consult

---

University Hospital EMS Protocol - 8 | 4
# Adult Protocol

## Wide-Complex Tachycardia

<table>
<thead>
<tr>
<th><strong>History</strong></th>
<th><strong>Signs and Symptoms</strong></th>
<th><strong>Differential Diagnosis</strong></th>
</tr>
</thead>
</table>
| - Past medical history / medications, diet, drugs.  
- Syncope / near syncope  
- Palpitations  
- Pacemaker  
- Allergies: Amiodarone (Cordarone) | - Ventricular tachycardia on ECG (runs or sustained)  
- Conscious, rapid pulse  
- Chest pain, shortness of breath  
- Dizziness  
- Rate usually 150 + bpm for sustained V-Tach | - Artifact / device failure  
- Cardiac  
- Endocrine / metabolic  
- Drugs  
- Pulmonary |

### Key Points

- Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro
- Polymorphic V-Tach (Torsades de Pointes) may benefit from the administration of Magnesium Sulfate.
- Polymorphic V-Tach (Torsades de Pointes) requires defibrillation rather than synchronized cardioversion.
- If the patient converts to another rhythm, refer to the appropriate protocol and treat accordingly.
- If the patient relapses back into wide complex tachycardia / ventricular tachycardia, initiate synchronized cardioversion with the joules setting that previously cardioverted the patient.
- Record 3 / 4 - Lead EKG strips during medication administration.
- Perform a 12-Lead EKG prior to and after Amiodarone (Cordarone) administration, or synchronized cardioversion of wide complex tachycardia / ventricular tachycardia.
- Perform a code summary and attach it to the patient run report.
- Be sure to treat the patient and not the monitor.
ADULT PROTOCOL

CARDIAC ARREST

REFER TO DOA GUIDELINES CONTACT MEDICAL CONTROL

UNIVERSAL PATIENT CARE PROTOCOL

Criteria for Death
Criteria for DNR

CPR x 5 cycles / 2 minutes

Go to Appropriate Protocol

Review DNR Comfort Care Guidelines CONTACT MEDICAL CONTROL

AT ANY TIME

Return of Spontaneous Circulation (ROSC)

GO TO POST RESUSCITATION CARDIAC CARE

Attach ResQPOD During CPR

Attach Cardiac Monitor Defibrillator / AED

Deliver Shock x 1 if Shockable

CPR x 5 cycles / 2 minutes

IV / IO PROCEDURE

Airway Protocol

Deliver Shock x 1 if Shockable

Maintain CPR / Airway

Follow AED Prompts (if applicable)

Continue CPR

TRANSPORT to appropriate facility CONTACT receiving facility CONSULT Medical Direction where indicated

IF ALS CARE AVAILABLE IN FIELD

Patients in cardiac arrest SHOULD be worked on scene UNLESS special resuscitation circumstances exist that would benefit from hospital treatment unavailable in the field

Field Termination Requirements
1. Advanced Airway in Place
2. Vascular Access in Place
3. Continuous CPR During Resuscitation
4. At Least 2 Rounds of ACLS Medications
5. Asystole Confirmed in 2 leads
6. Non-witnessed arrest
7. 20 Minutes of Resuscitation
8. Medical Direction Approval
9. Capnography <10 Where Available

EMT Intervention AEMT Intervention PARAMEDIC Intervention MED CONTROL Consult
## Adult Protocol

### Cardiac Arrest

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>Signs and Symptoms</th>
<th>Differential Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Events leading to arrest&lt;br&gt;- Estimated downtime&lt;br&gt;- Past medical history&lt;br&gt;- Medications&lt;br&gt;- Existence of terminal illness&lt;br&gt;- Signs of lividity, rigor mortis&lt;br&gt;- DNR</td>
<td>- Unresponsive&lt;br&gt;- Apneic&lt;br&gt;- Pulseless</td>
<td>- Medical vs. trauma&lt;br&gt;- V-fib vs. pulseless V-tach&lt;br&gt;- Asystole&lt;br&gt;- Pulseless electrical activity (PEA)</td>
</tr>
</tbody>
</table>

### Key Points
- Exam: Mental Status
- Always minimize interruptions to chest compressions.
- Attach ResQPOD (ITD) to enhance circulation with chest compressions. Remove if there is a return of spontaneous circulation (ROSC).
- Success is based on proper planning and execution. Procedures require space and patient access, make room to work.
- Reassess airway frequently and with every patient move.
- Maternal arrest - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport.
- If the patient converts to another rhythm, refer to the appropriate protocol and treat accordingly.
- Attempt to obtain patient history from family members or bystanders.
  - Estimated downtime<br>  - Medical history<br>  - Complaints prior to arrest<br>  - Bystander CPR prior to EMS arrival<br>  - AED use prior to EMS arrival
- Administer Dextrose only if the patient has a blood glucose level < 70 mg / dl. Dextrose should be administered as soon as hypoglycemia is determined.
- Reassess the patient if the interventions do not produce any changes.
- If indicated, refer to the TERMINATION OF RESUSCITATION EFFORTS POLICY.
- If patient is pregnant and in cardiac arrest, manually manipulate the uterus to the left during CPR.
ASYSTOLE / PULSELESS ELECTRICAL ACTIVITY (PEA)

Criteria for Death

CPR

Attach ResQPOD during CPR

AIRWAY PROTOCOL

CAPNOGRAPHY PROCEDURE

Apply Cardiac Monitor / AED

Asystole / PEA Persists

Continue CPR

IV / IO PROCEDURE

EPINEPHRINE (ADRENALINE)
1 mg IV / IO of 0.1 mg / ml (1:10,000)
Repeat every 3 - 5 minutes

Continue CPR

Consider Termination – See Field Termination of Resuscitative Efforts Policy

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

Known dialysis patient consider:
Flush IV Line Then CALCIUM CHLORIDE
1 Gram SLOW IV / IO

DO NOT MIX WITH SODIUM BICARBONATE IN SAME LINE

Flush IV Line Then SODIUM BICARBONATE
1 - 2 Amps IV / IO

If CPR or CPR Device yields consciousness despite a non-life sustaining rhythm that interferes with interventions FENTANYL (SUBLIMA) 25mcg IV / IO Repeat as needed to yield patient response permitting resuscitation interventions

IF ALS CARE AVAILABLE IN FIELD
Patients in cardiac arrest SHOULD be worked on scene UNLESS special resuscitation circumstances exist that would benefit from hospital treatment unavailable in the field

Field Termination Requirements
1. Advanced Airway in Place
2. Vascular Access in Place
3. Continuous CPR During Resuscitation
4. At Least 2 Rounds of ACLS Medications
5. Asystole Confirmed in 2 leads
6. Non-witnessed arrest
7. 20 Minutes of Resuscitation
8. Medical Direction Approval
9. Capnography <10 Where Available

Review DNR Comfort Care Guidelines CONTACT MEDICAL CONTROL

AT ANY TIME
Return of Spontaneous Circulation (ROSC)

GO TO POST RESUSCITATION CARDIAC CARE PROTOCOL

REFER TO DOA GUIDELINES CONTACT MEDICAL CONTROL

Criteria for DNR

CONTACT MEDICAL CONTROL

Airway / Breathing

Circulation / Shock

Cardiac

Medical

Trauma
**ADULT PROTOCOL**

**ASYSTOLE / PULSELESS ELECTRICAL ACTIVITY (PEA)**

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| - Past medical history  
- Medications  
- Events leading to arrest  
- End stage renal disease  
- Estimated downtime  
- Suspected hypothermia  
- Suspected overdose  
- DNR  
- Tricyclics  
- Digitalis  
- Beta blockers  
- Calcium channel blockers | - Pulseless  
- Apneic  
- No electrical activity on ECG  
- Cyanosis | - Medical vs. trauma  
- Hypoxia  
- Potassium (hypo / hyper)  
- Acidosis  
- Hypothermia  
- Device (lead) error  
- Death  
- Hypovolemia  
- Cardiac tamponade  
- Drug overdose (Tricyclics, digitalis, beta blockers, calcium channel blockers  
- Massive myocardial infarction  
- Tension pneumothorax  
- Pulmonary embolus |

**CONSIDER TREATABLE CAUSES**

- Hypovolemia  
- Hypo-hyperkalemia  
- Hypoxia  
- Hypoglycemia  
- Hydrogen ion (acidosis)  
- Hypothermia

- Toxins  
- Tamponade (cardiac)  
- Tension pneumothorax  
- Thrombosis (coronary or pulmonary)  
- Trauma

**KEY POINTS**

- Exam: Mental Status
- Always minimize interruptions to chest compressions.
- Attach ResQPOD (ITD) to enhance circulation with chest compressions. Remove if there is a return of spontaneous circulation (ROSC).
- Always confirm asystole in more than one lead.
- Consider each possible cause listed in the differential: Survival is based on identifying and correcting the cause!
- Discussion with Medical Control can be a valuable tool in developing a differential diagnosis and identifying possible treatment options.
- If the patient converts to another rhythm, refer to the appropriate protocol and treat accordingly.
- Early identification and treatment of reversible causes of PEA increases the chance of a successful outcome.
- Consider volume infusion for all patients in PEA. Be alert for fluid overload.
- Treat as ventricular fibrillation if you cannot differentiate between asystole and fine ventricular fibrillation.
- Dextrose should only be administered to a patient with a confirmed blood glucose level less than 70 mg / dl.
- If patient is pregnant and in cardiac arrest, manually manipulate the uterus to the left during CPR.
VENTRICULAR FIBRILLATION (V–FIB)
PULSELESS VENTRICULAR TACHYCARDIA

Universal Patient Care Protocol

Criteria for DNR
Criteria for Death
CPR x 5 cycles / 2 minutes, then check pulse / rhythm

Airway Protocol

Attach ResQPOD during CPR

Capnography Procedure

Apply Cardiac Monitor Defibrillator / AED
Defibrillate 200 J or biphasic equivalent
Immediately resume CPR / 2 minutes, then check pulse & rhythm

Iv / Io Procedure

Epinephrine (Adrenaline)
1 mg IV / IO of 0.1 mg / ml (1:10,000)
Repeat every 3 - 5 minutes
Continue effective CPR / 2 minutes
Then check pulse & rhythm
Defibrillate 300 J or biphasic equivalent
Immediately continue effective CPR / 2 minutes, check pulse & rhythm

Give ONE Antiarrhythmic during CPR
Continue effective CPR / 2 minutes, check pulse & rhythm
Defibrillate 360 J or biphasic equivalent
Immediately continue effective CPR / 2 minutes, Check pulse & rhythm

Transport to appropriate facility
Consult Medical Direction where indicated

Review DNR Comfort Care Guidelines
Contact Medical Control

If CPR or CPR Device yields a LOC despite a non-life sustaining rhythm that interferes with interventions
Fentanyl (Sublimate)
25 mcg IV / IO
Repeat as needed to yield patient response permitting resuscitation interventions

Confirm V-Fib / Pulseless V-Tach

If ALS Care Available in Field
Patients in cardiac arrest SHOULD be worked on scene UNLESS special resuscitation circumstances exist that would benefit from hospital treatment unavailable in the field

Amiodarone (Cordarone)
300 mg IV / IO
May repeat @ 150 mg IV / IO

Magnesium Sulfate
1 – 2 grams slow IV / IO
(Torsades, Alcoholism, Malnutrition ONLY)

Known Dialysis Patient Consider:
Flush IV Line Then Calcium Chloride
1 Gram SLOW IV / IO
Do Not Mix With Sodium Bicarbonate In Same Line
Flush IV Line Then Sodium Bicarbonate
1 - 2 Amps IV / IO

Refractory V-Fib / Tach
After failed 360 J defibrillation and antiarrhythmics
Consider Double Sequential Defibrillation

Consider Field Termination of Resuscitative Efforts

Referral to Doa Guidelines
Contact Medical Control

At Any Time
Return of Spontaneous Circulation (ROSC)
Go to Post Resuscitation Cardiac Care

EMT Intervention
AEMT Intervention
Paramedic Intervention
MED Control Consult

University Hospital EMS Protocol - 14 | 4
# Adult Protocol

## Ventricular Fibrillation (V – FIB)

### Pulseless Ventricular Tachycardia

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Estimated down time</td>
<td>• Unresponsive, apneic, pulseless</td>
<td>• Asystole</td>
</tr>
<tr>
<td>- Past medical history</td>
<td>• Ventricular fibrillation or ventricular tachycardia on ECG</td>
<td>• Artifact / device failure</td>
</tr>
<tr>
<td>- Medications</td>
<td></td>
<td>• Cardiac</td>
</tr>
<tr>
<td>- Events leading to arrest</td>
<td></td>
<td>• Endocrine / metabolic</td>
</tr>
<tr>
<td>- Renal failure / dialysis</td>
<td></td>
<td>• Drugs</td>
</tr>
<tr>
<td>- DNR</td>
<td></td>
<td>• Pulmonary embolus</td>
</tr>
</tbody>
</table>

### Key Points

- Exam: Mental Status
- Always minimize interruptions to chest compressions.
- Attach ResQPOD (ITD) to enhance circulation with chest compressions. Remove if there is a return of spontaneous circulation (ROSC).
- Effective CPR should be as continuous as possible with a minimum of 5 cycles or 2 minutes.
- Reassess and document endotracheal tube placement and Capnography frequently, after every move, and at discharge.
- Polymorphic V-Tach (Torsades de Pointes) may benefit from administration of Magnesium Sulfate.
- If the patient converts to another rhythm, or has a return of circulation, refer to the appropriate protocol and treat accordingly.
- If the patient converts back to ventricular fibrillation or pulseless ventricular tachycardia after being converted to ANY other rhythm, defibrillate at the previous setting used.
- Defibrillation following effective CPR is the definitive therapy for ventricular fibrillation and pulseless ventricular tachycardia. Magnesium Sulfate should be administered early in the arrest if hypomagnesemia (chronic alcoholic or malnourished patients) is suspected.
- If patient is pregnant and in cardiac arrest, manually manipulate the uterus to the left during CPR.
ADULT PROTOCOL

POST – RESUSCITATION CARDIAC CARE

Consider transport of resuscitated patient to facility with hypothermic resuscitation protocol and PCI where available

UNIVERSAL PATIENT CARE PROTOCOL
Continue Ventilatory Support with 100% OXYGEN

CAPNOGRAPHY PROCEDURE

IV / IO PROCEDURE
12 LEAD EKG PROCEDURE
Vital Signs

Bradycardia
Hypotension
Electrical Conversion (NO anti-arrhythmic already given during resuscitation)
Anti-Arrhythmic Conversion with Continued Ventricular Ectopic

Treat per BRADYCARDIA PROTOCOL

IV NORMAL SALINE BOLUS To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable

DOPAMINE (INTROPIN) 5 – 20 mcg / kg / min IV / IO

Refer to dosing chart
Follow BP, Mental status, Capnography

Supportive Care Only No anti-arrhythmic administered

AMIODARONE (CORDARONE) 150 mg IV / IO mix in 20+ ml NS Over 10 minutes IF NOT ALREADY GIVEN (450 mg max during prehospital care)

If MAGNESIUM SULFATE Used No additional magnesium to be given post-resuscitation

If arrest reoccurs, revert to appropriate protocol and / or initial successful treatment

TRANSPORT to appropriate facility CONTACT receiving facility CONSULT Medical Direction where indicated
COMATOSE ADULT PATIENT WITH A RETURN OF SPONTANEOUS CIRCULATION (ROSC)
post V-FIB / V-Tach or WITNESSED Asystolic arrest

Advanced airway in Place?
Intubated, King, or LMA airway
Capnography Procedure
Maintain CO₂ 35 - 45

Do not induce hypothermia in trauma, hypovolemia, preexisting hypothermia, or pregnant.

Apply Cooling Collar or Apply Cold Packs
Neck, Bilateral Axilla, Bilateral Groin

Is patient shivering?

TRANSPORT
Transport to facility with hypothermic resuscitation protocol

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

Do not delay transport to begin hypothermia protocol

Place advanced airway or treat by POST RESUSCITION CARDIAC CARE protocol only if unable to place advanced airway

LORAZEPAM (ATIVAN)
1 - 2 mg
IV / IO / IN / IM

If Lorazepam (Ativan) Unavailable, See Medication Section for Midazolam (Versed)

RECEIVING HOSPITAL MUST BE ABLE TO CONTINUE COOLING!
Use of this protocol is dependent on the ability of the receiving hospital to continue the induced hypothermia protocol. Do not begin induced hypothermia if the receiving hospital is unable to continue cooling.

Use this protocol in conjunction with standard post resuscitation care. Maintain BP and heart rhythm with treatments in the POST RESUSCITATION CARDIAC CARE protocol. If patient loses pulses / re-arrests discontinue induced hypothermia and treat per appropriate arrest protocol.
**HISTORY**  |  **SIGNS AND SYMPTOMS**  |  **DIFFERENTIAL DIAGNOSIS**
---|---|---
- Respiratory arrest  
- Cardiac arrest | - Return of pulse | - Continue to address specific differentials associated with the original dysrhythmia

**KEY POINTS**
- Exam: Mental Status, Neck, Skin, Lungs, Heart, Abdomen, Extremities, Neuro
- Most patients immediately post resuscitation will require ventilatory assistance.
- The condition of post-resuscitation patients fluctuates rapidly and continuously, and they require close monitoring.
- Appropriate post-resuscitation management can best be planned in consultation with medical control.
- This is the period of time between restoration of spontaneous circulation and the transfer of care at the emergency department. The focus is aimed at optimizing oxygenation and perfusion.
- Post resuscitation SVT should initially be left alone, but routinely monitor the patient. Follow NARROW COMPLEX TACHYCARDIA PROTOCOL or contact Medical Direction.
- If the patient is profoundly bradycardic, refer to the BRADYCARDIA PROTOCOL and treat accordingly.
- Only administer oxygen if the patient is hypoxic with a SpO₂ of 94 or less. Do not withhold oxygen from patients that are short of breath regardless of SpO₂.
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
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<td>Abdominal Pain</td>
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<td>Alcohol Related Emergencies</td>
<td>4-5</td>
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<td>Altered Level of Consciousness</td>
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<td>Anti-Emetic</td>
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<td>Allergic Reaction (see section 4-3 Anaphylactic Shock / Reaction)</td>
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<tr>
<td>Behavioral / Psychiatric Emergencies</td>
<td>10-5</td>
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<td>Diabetic Emergencies</td>
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<td>Dialysis / Renal Patient</td>
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<td>Hypertensive Emergencies</td>
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<tr>
<td>Hypothermia / Frostbite</td>
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<tr>
<td>Seizures</td>
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<td>Severe Pain Management</td>
<td>24-5</td>
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<td>Stroke / CVA</td>
<td>26-5</td>
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<td>Toxic Ingestion / Exposure / Overdose</td>
<td>28-5</td>
</tr>
<tr>
<td>Toxic Inhalation / Ingestion – Cyanide</td>
<td>30-5</td>
</tr>
<tr>
<td>Toxic Inhalation – Carbon Monoxide</td>
<td>32-5</td>
</tr>
</tbody>
</table>
ABDOMINAL PAIN

UNIVERSAL PATIENT CARE PROTOCOL

IV PROCEDURE
NORMAL SALINE BOLUS
To Maintain MAP > 70
or SBP 90 / Radial Pulses if NIBP Unavailable
IF HYPOTENSIVE

Consider ACUTE CORNARY SYNDROME PROTOCOL

12 LEAD EKG PROCEDURE

1ST Contact to EKG and Transmission < 10 Min

Consider ONDANSETRON (ZOFRAZ) as Needed
4 mg IM / IV over 2 - 4 minutes
May repeat to a Max of 8 mg

OR

Consider ONDANSETRON (ZOFRAZ)
Oral Disintegrating Tabs (ODT)
8 mg Oral

FENTANYL (SUBLIMAZE)
25 – 100 mcg IV / IO / IM / IN
Maximum 100 mcg
or
HYDROMORPHONE (DILAUDID)
0.5 - 1 mg IV / IO / IM
May Repeat to a Max 2 mg
HALF DOSE > 65, Liver or Renal Disease

⚠️ If Fentanyl (Sublimaze) or Hydromorphone (Dilaudid) is unavailable, see medication section for Morphine Sulfate

CAPNOGRAPHY PROCEDURE

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

Differentiate Flank Pain from Abdominal Pain and Treat per Pain Management Protocol

EMT Intervention | AEMT Intervention | PARAMEDIC Intervention | MED CONTROL Consult
HISTORY
- Age
- Past medical / surgical history
- Medications
- Onset
- Palliation / provocation
- Quality (crampy, constant, sharp, dull, etc.)
- Region / radiation / referred pain
- Severity (1-10)
- Time (duration / repetition)
- Fever
- Last meal eaten
- Last bowel movement / emesis
- Menstrual history (pregnancy)

SIGNS AND SYMPTOMS
- Pain (location / migration)
- Tenderness
- Nausea
- Vomiting
- Diarrhea
- Dysuria
- Constipation
- Vaginal bleeding / discharge
- Pregnancy

Associated symptoms: (Helpful to localize source)
- Fever, headache, weakness, malaise, myalgias, cough, headache, mental status changes, rash

DIFFERENTIAL DIAGNOSIS
- Pneumonia or pulmonary embolus
- Liver (hepatitis, CHF)
- Peptic ulcer disease / gastritis
- Gallbladder
- Myocardial infarction
- Pancreatitis
- Kidney stone
- Abdominal aneurysm
- Appendicitis
- Bladder / prostate disorder
- Pelvic (PID, ectopic pregnancy, ovarian cyst)
- Spleen enlargement
- Diverticulitis
- Bowel obstruction
- Gastroenteritis (infectious)

KEY POINTS
- Required Exam: Mental Status, Skin, HEENT, Neck, Heart, Lung, Abdomen, Back, Extremities, Neuro
- Abdominal pain in women of childbearing age should be treated as an ectopic pregnancy until proven otherwise.
- The diagnosis of abdominal aneurysm should be considered with abdominal pain in patients over 50.
- Appendicitis may present with vague, peri-umbilical pain, which migrates, to the RLQ over time.
- It is important to remember that abdominal pain can be caused by a large number of different disease processes. The organ systems that may be involved in abdominal pain include esophagus, stomach, intestinal tract, liver, pancreas, spleen, kidneys, male and female genital organs, bladder, as well as referred pain from the chest that can involve the heart, lungs or pleura. Abdominal pain may also be caused by muscular and skeletal problems.
- Abdominal pain emergencies are likely to lead to death due to hypovolemia. There may also be severe electrolyte abnormalities that can cause arrhythmias.
- Myocardial infarction may present as abdominal pain especially in the diabetic and elderly.
- In some patients, cardiac chest pain may manifest as abdominal pain. Consider this in all patients with abdominal pain, especially patients with diabetes and in women.
- Because the abdominal pain may be of cardiac origin, perform cardiac monitoring and a 12-Lead EKG.
- DKA may present with abdominal pain, nausea, and vomiting. Check blood glucose level.
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## Altered Level of Consciousness

### Adult Protocol

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Patient Care Protocol</td>
<td>Consider spinal motion restriction</td>
</tr>
<tr>
<td>Airway Protocol</td>
<td></td>
</tr>
<tr>
<td>12 Lead EKG Procedure</td>
<td>1st Contact to EKG and Transmission &lt; 10 Min</td>
</tr>
<tr>
<td>Oxygen / Pulse Oximetry Procedure</td>
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<tr>
<td>Capnography Procedure</td>
<td></td>
</tr>
<tr>
<td>Blood Glucose Procedure</td>
<td></td>
</tr>
<tr>
<td>IV Procedure</td>
<td>Identify treatable causes, treat per specific protocol</td>
</tr>
</tbody>
</table>

- **Hypoxia** – Treat per Airway / Breathing Protocols
- **Anaphylaxis / Allergic Reaction**
- **Sepsis** – Treat per Septic Shock Protocol
- **Hypotension** – Treat per Specific Shock Protocols
- **Arrhythmia** – Treat per Correct Arrhythmia Protocol
- **Psychiatric** – Treat per Behavioral Emergencies
- **Hypo / Hyperglycemia** – Treat per Diabetic Protocol
- **Hypo / Hyperthermia** – Treat per Specific Protocol
- **Stroke CVA / TIA** – Treat per Stroke Protocol
- **Overdose** – Treat per Toxic Ingestion Protocol
- **Head Trauma** – Treat per Head Trauma Protocol

---

**EMT Intervention** | **AEMT Intervention** | **Paramedic Intervention** | **MED Control Consult**
### ADULT PROTOCOL

#### ALTERED LEVEL OF CONSCIOUSNESS

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| - Known diabetic, medic alert tag  
- Drugs, drug paraphernalia  
- Report of illicit drug use or toxic ingestion  
- Past medical history  
- Medications  
- History of trauma | - Decreased mental status  
- Change in baseline mental status  
- Bizarre behavior  
- Hypoglycemia (cool, diaphoretic skin)  
- Hyperglycemia (warm, dry skin; fruity breath; Kussmaul resps; signs of dehydration) | - Head trauma  
- CNS (stroke, tumor, seizure, infection)  
- Cardiac (MI, CHF)  
- Infection  
- Thyroid (hyper / hypo)  
- Shock (septic, metabolic, traumatic)  
- Diabetes (hyper / hypoglycemia)  
- Toxicological incident  
- Acidosis / alkalosis  
- Environmental exposure  
- Pulmonary (hypoxia)  
- Electrolyte abnormality  
- Psychiatric disorder |

#### KEY POINTS

- Exam: Mental Status, HEENT, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro
- Be aware of AMS as potential sign of an environmental toxin or Haz-Mat exposure and protect personal safety.
- It is safer to assume hypoglycemia than hyperglycemia if doubt exists.
- Do not let alcohol confuse the clinical picture. Alcoholics frequently develop hypoglycemia and need Thiamine before glucose.
- Low glucose (< 70), normal glucose (70 - 120), high glucose (> 250).
- Consider restraints if necessary for patient's and / or personnel's protection per the restraint procedure.
- Protect the patient airway and support ABCs.
- Signs and symptoms of narcotic overdose include respiratory depression and altered mental status.
- Naloxone (Narcan) administration may cause the patient to go into acute opiate withdraw, which includes vomiting, agitation, and / or combative behavior. Always be prepared for combative behavior.
- Naloxone (Narcan) may wear off in as little as 20 minutes causing the patient to become more sedate and possibly hypoventilate. All A&O 4 patients having received Naloxone (Narcan) should be transported. If patient refuses transport, contact Medical Control before release.
**UNIVERSAL PATIENT CARE PROTOCOL**

Administer OXYGEN

**IV PROCEDURE**

Patient has Nausea or Vomiting

**12 LEAD EKG PROCEDURE**

| 1ST Contact to EKG and Transmission < 10 Min |

**ONDANSETRON (ZOFRAN)**

4 mg IM / IV / IO over 2 - 4 minutes

May repeat to a Max of 8 mg

**OR**

**ONDANSETRON (ZOFRAN)**

Oral Disintegrating Tabs

8 mg Oral

**TRANSPORT** to appropriate facility

**CONTACT** receiving facility

**CONSULT** Medical Direction where indicated
# Adult Protocol

## Anti-Emetic Protocol

<table>
<thead>
<tr>
<th>History</th>
<th>Signs and Symptoms</th>
<th>Differential Diagnosis</th>
</tr>
</thead>
</table>
| - Nausea  
- Vomiting  
- Medication(s) administration such as narcotic analgesics | - Complaints of nausea and / or vomiting | - Consider AMI / 12 lead EKG  
- Gastroenteritis  
- Toxic ingestion / food poisoning  
- Bowel obstruction  
- Appendicitis  
- Gastritis  
- Cholecystitis (gallbladder)  
- Hepatitis / cirrhosis  
- Headaches / migraine  
- Pregnancy  
- Hypertensive crisis  
- Electrolyte imbalances  
- DKA  
- Intracranial pressure  
- Sepsis / infections |

### Key Points

- Position patient to protect airway as appropriate. (Recovery position, sitting up, etc.)
- Immediately position entire patient or their head to side if patient begins vomiting then retrieve suction.
- Patients with altered LOC and nausea / vomiting need to have airway maintenance prioritized before medication.
- Prepare and test suction prior to its need.
- Give Ondansetron (Zofran) over at least 2 minutes, slow IV. Follow up with second dose in if symptoms unresolved.
- Treat patients early, no need to wait for patient to begin vomiting to administer Ondansetron (Zofran).
- Patients receiving medications such as narcotic analgesics may require concurrent administration of Ondansetron (Zofran) to reduce nausea associated with such medications.
ADULT PROTOCOL

BEHAVIORAL / PSYCHIATRIC EMERGENCIES

SCENE SAFETY
SUMMON LAW ENFORCEMENT

UNIVERSAL PATIENT CARE PROTOCOL
Remove patient from Stressful environment

Verbal techniques
(Reassurance, calm, establish rapport)

Treat Suspected Problems per Appropriate Protocol
AMS - Overdose - Head Trauma - Hypoglycemia

For Use in ADULT
Psychosis Only
NOT For Medical Emergencies
Such As Hypoxemia, Sepsis,
Seizure, Encephalitis,
Hypoglycemia, or Stroke

Agitation – Not Combative

If Patient Agitated, Consider
LORAZEPAM (ATIVAN)
1 – 2 mg IV / IM / IN

CAUTION If Lorazepam (Ativan) is unavailable, See Medication Section for Midazolam (Versed)

CAPNOGRAPHY PROCEDURE

Combative
Threat to Self or Others

RERAINT PROCEDURE

If Patient Agitated, Consider
LORAZEPAM (ATIVAN)
1 – 2 mg IV / IM / IN

CAUTION If Lorazepam (Ativan) is unavailable, See Medication Section for Midazolam (Versed)

COMBATIVE
Consider Chemical Restraint
if Aggressive, Violent, Severe Agitation
in the Setting of Psychosis
AFTER PHYSICAL RESTRAINT

KETAMINE (KETALAR)
250 mg IM
May Repeat 250 mg IM
in 2 Min if NO RESPONSE

If Signs of Emergence
After KETAMINE Admin
LORAZEPAM (ATIVAN)
1 – 2 mg IV / IM / IN

OR

HALOPERIDOL (HALDOL)
5 mg IM ONLY
Over Age 65 Give 2.5 mg IM ONLY

If Patient Agitated, Consider
LORAZEPAM (ATIVAN)
1 – 2 mg IV / IM / IN

CAUTION If Lorazepam (Ativan) is unavailable, See Medication Section for Midazolam (Versed)

Any time After Injection: If Fasciculations, Extrapyramidal,
Symptoms (EPS) Like Dystonia

DIPHENHYDRAMINE (BENADRYL)
25 - 50 mg IV / IM
May Give Prophylactically

CAUTION Do not mix HALOPERIDOL (HALDOL) and
DIPHENHYDRAMINE (BENADRYL)
in the same syringe - Incompatible

CAPNOGRAPHY PROCEDURE

Constant reassessment of ABC’s, personal, and patient safety

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

EMT Intervention AEMT Intervention PARAMEDIC Intervention MED CONTROL Consult
BEHAVIORAL / PSYCHIATRIC EMERGENCIES

HISTORY
- Situational crisis
- Psychiatric illness / medications
- Injury to self or threats to others
- Medic alert tag
- Substance abuse / overdose
- Diabetes

SIGN AND SYMPTOMS
- Anxiety, agitation, confusion
- Affect change, hallucinations
- Delusional thoughts, bizarre behavior
- Combative violent
- Expression of suicidal / homicidal thoughts

DIFFERENTIAL DIAGNOSIS
- See Altered Mental Status differential diagnosis
- Alcohol Intoxication
- Toxin / substance abuse
- Medication effect / OD
- Withdrawal syndromes
- Depression
- Bipolar (manic-depressive)
- Schizophrenia
- Anxiety disorders

Criteria for Restraint Use:
- Patient out of control and may cause harm to self or others.
- Necessary force required for patient control without causing harm.
- Position of patient must not impede airway or breathing.
- Restraints must not impede circulation.
- Place mask on patient for body secretion protection. May use TB mask, or Non-rebreather if patient needs oxygen.
- Use supine or lateral positioning ONLY.
- MSP checks are required every 15 min.
- DOCUMENT methods used.

Criteria for chemical restraint use:
- Patient out of control and may cause harm to self or others.
- Patient is NOT a medical patient (treat underlying causes).
- Patient is an ADULT patient.
- Ketamine (Ketalar) or Haloperidol (Haldol) can be given safely without harm to patient or EMS.
- Use necessary force required for patient control without causing harm.
- Position of patient must not impede airway or breathing.
- DOCUMENT methods used.

Emergence Symptoms
- Confusion
- Excitement
- Irrational Behavior
- Hallucinations

Extrapyramidal Symptoms (EPS)
- Involuntary Movements
- Purposeless Movements
- Tongue Protrusion - Rapid Eye Blinking
- Facial Grimacing - Lip Smacking / Puckering

Neuroleptic Malignant Syndrome
- Increased Body Temp > 38C (100.4F)
- Muscle Rigidity
- Diaphoresis
- Altered LOC

KEY POINTS
- Exam: Mental Status, Skin, Heart, Lungs, Neuro
- All psychiatric patients must have medical clearance at a hospital ED before transport to a mental health facility.
- Your safety first!!
- Be sure to consider all possible medical / trauma causes for behavior. (Hypoglycemia, overdose, substance abuse, hypoxia, head injury, seizure, etc.)
- Do not irritate the patient with a prolonged exam.
- Do not overlook the possibility of associated domestic violence or child abuse.
- The safety of on scene personnel is the priority. Protect yourself and others by summoning law enforcement to assure everyone’s safety and if necessary, to enable you to render care. Do not approach the patient if he / she is armed with a weapon.
- Consider the medical causes of acute psychosis. Causes may include; head trauma, hypoglycemia, acute intoxication, sepsis, CNS insult and hypoxia.
- Suicide ideation or attempts must be transported for evaluation.
- Be alert for rapidly changing behaviors.
- Limit patient stimulation and use de-escalation techniques.
- If the patient has been placed in handcuffs by a law enforcement agency, then a member from that agency MUST ride with the patient in the ambulance to the hospital.
**ADULT PROTOCOL**

**DIABETIC EMERGENCIES**

- **UNIVERSAL PATIENT CARE PROTOCOL**
- **BLOOD GLUCOSE PROCEDURE**
- **IV PROCEDURE**

**IV PROCEDURE**

- Glucose < 70 or symptomatic
  - ORAL GLUCOSE 1 TUBE
    (If Alert With NO Vascular Access)
  - THIAMINE 100 mg IV or IM
    If Chronic Alcoholism or Malnourished
- Glucose 70 – 250
  - No Diabetic Treatment Required
- Glucose > 250
  - NORMAL SALINE 20 ml / kg if S/S Dehydration and NO Contraindications

**Blood Glucose Procedure**

- Normal Saline 20 ml / kg
  - if S/S Dehydration and NO Contraindications

**EMT Intervention**

- Airway / Breathing
- Circulation / Shock
- Cardiac
- Medical
- Trauma

- **DEXTROSE 10%**
  - Where Available - or -
  - DEXTROSE 50%
    - Glucose < 40 mg/dl
      - 25 Grams IV
    - Glucose 40 – 70 mg/dl
      - 12.5 Grams IV
  - IO Last Resort / Peri-Arrest Patient
- If No Vascular Access
  - GLUCAGON (GLUCAGEN)
    - 1 mg IM / IN Atomized

**Monitor and Reassess**

- Recheck Blood Glucose Level
- May Repeat Medications in 5 - 20 Minutes if Still Hypoglycemic

- **12 LEAD EKG PROCEDURE**
- **TRANSPORT** to appropriate facility
- **CONTACT** receiving facility
- **CONSULT** Medical Direction where indicated

**EMT Intervention**

**AEMT Intervention**

**PARAMEDIC Intervention**

**MED CONTROL Consult**
## Adult Protocol

### Diabetic Emergencies

#### Hypoglycemia

<table>
<thead>
<tr>
<th>History</th>
<th>Signs and Symptoms</th>
<th>Differential Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known diabetic, medic alert tag</td>
<td>Altered level of consciousness</td>
<td>ETOH</td>
</tr>
<tr>
<td>Past medical history</td>
<td></td>
<td>Toxic Overdose</td>
</tr>
<tr>
<td>Medications</td>
<td>Dizziness</td>
<td>Trauma</td>
</tr>
<tr>
<td>Last meal</td>
<td>Irritability</td>
<td>Seizure</td>
</tr>
<tr>
<td>Recent Blood Sugar Analysis</td>
<td>Diaphoresis</td>
<td>Syncope</td>
</tr>
<tr>
<td></td>
<td>Convulsions</td>
<td>CNS disorder</td>
</tr>
<tr>
<td></td>
<td>Hunger</td>
<td>Stroke</td>
</tr>
<tr>
<td></td>
<td>Confusion</td>
<td>Pre-existing condition</td>
</tr>
</tbody>
</table>

#### Hyperglycemia

<table>
<thead>
<tr>
<th>History</th>
<th>Signs and Symptoms</th>
<th>Differential Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known diabetic, medic alert tag</td>
<td>Altered level of consciousness / coma</td>
<td>ETOH</td>
</tr>
<tr>
<td>Past medical history</td>
<td>Abdominal pain</td>
<td>Toxic overdose</td>
</tr>
<tr>
<td>Medications</td>
<td>Nausea / vomiting</td>
<td>Trauma</td>
</tr>
<tr>
<td>Last meal</td>
<td>Dehydration</td>
<td>Seizure</td>
</tr>
<tr>
<td>Recent BGL check</td>
<td>Frequent thirst and urination</td>
<td>Syncope</td>
</tr>
<tr>
<td></td>
<td>General weakness malaise</td>
<td>CNS disorder</td>
</tr>
<tr>
<td></td>
<td>Hypovolemic shock</td>
<td>Stroke</td>
</tr>
<tr>
<td></td>
<td>Hyperventilation</td>
<td>Diabetic ketoacidosis</td>
</tr>
<tr>
<td></td>
<td>Deep / rapid respirations</td>
<td></td>
</tr>
</tbody>
</table>

Hypoglycemic patients who are receiving oral hypoglycemics should be STRONGLY urged to be transported to the hospital. The half-life of such oral medications is long and these patients will need to be closely monitored for recurrent hypoglycemia.

### Key Points

**Hyperglycemia:**
- Diabetic ketoacidosis (DKA) is a complication of diabetes mellitus. It can occur when insulin levels become inadequate to meet the metabolic demands of the body for a prolonged amount of time (onset can be within 12 - 24 hours). Without enough insulin, the blood glucose increases and cellular glucose depletes. The body removes excess blood glucose by dumping it into the urine. Pediatric patients in DKA should be treated as hyperglycemic under the Pediatric Diabetic Emergency Protocol.
- Patients can have hyperglycemia without having DKA.

**Hypoglycemia:**
- Always suspect hypoglycemia in patients with an altered mental status.
- If a blood glucose analysis is not available, a patient with altered mental status and signs and symptoms consistent with hypoglycemia should receive Dextrose or Glucagon (Glucagen).
- Dextrose is used to elevate BGL **but it will not maintain it**. The patient will need to follow up with a meal (carbs), if not transported to a hospital.

**Miscellaneous:**
- If IV access is successful after Glucagon (Glucagen) IM or IN and the patient is still symptomatic, Dextrose IV / IO can be administered.
- For alcoholic or malnourished patients, give 100 mg Thiamine IV or IM before giving glucose to avoid possible Wernicke’s encephalopathy.
- Shut off wearable insulin pumps if patient is hypoglycemic.
- Treat if the patients’ blood glucose is 70 or less, or any level with signs and symptoms.
ADULT PROTOCOL

DIALYSIS / RENAL PATIENT

UNIVERSAL PATIENT CARE PROTOCOL

CAPNOGRAPHY PROCEDURE

AIRWAY PROTOCOL

IV / IO PROCEDURE

12 LEAD EKG PROCEDURE

1ST Contact to EKG and Transmission < 10 Min

Breathing Difficulty

Assess Breath Sounds

See Respiratory Distress Protocol or Congestive Heart Failure Protocol based on Lung Sounds

Chest Pain

Treat with Acute Coronary Symptoms Protocol

Symptomatic HYPERtension

Blurred Vision

Headache

Diaphoresis

DISCUSS each case with Medical Control After STROKE ASSESSMENT

Bleeding Catheter / Shunt

Apply Pressure Over Site / Pressure Points

Apply Tourniquet if risk of Exsanguination Not over Shunt

Hemostatic Agents may be considered in CHEST and GROIN ACCESS ONLY

Missed Dialysis / Cardiac Changes

Wide Complex / Peaked T Waves Suspected Hyerkalemia

ALBUTEROL (PROVENTIL) Serial Aerosols during Entire Transport

Flush IV then
CALCIUM CHLORIDE
1 GRAM IV / IO

Patient on Digoxin (Digitalis)

Symptomatic HYPOtension

Pre Dialysis

Consider

Septic Shock

Cardiogenic Shock

Post Dialysis

Consider

Volume Depletion

ResQGARD ITD PROCEDURE

NO ResQGARD if Cardiogenic Shock

Treat Per Appropriate Shock Protocol

ONLY IF EKG IS SINE WAVE

Flush IV then
CALCIUM CHLORIDE
1 GRAM IV / IO

Patient on Digoxin (Digitalis)

DO NOT MIX IN THE SAME LINE

TRANSPORT to appropriate facility

CONTACT receiving facility

CONSULT Medical Direction where indicated
DIALYSIS / RENAL PATIENT

**HISTORY**
- Renal failure
- Dialysis treatment
- Anemia
- Dialysis treatment schedule
- Previous implications
- Long term catheter access
- Shunt access
- Hyperkalemia

**SIGNS AND SYMPTOMS**
- Hypotension
- Bleeding
- Fever
- Electrolyte imbalances
- Nausea
- Vomiting
- Altered mental status
- Seizure
- Dysrhythmias

**DIFFERENTIAL DIAGNOSIS**
- Congestive heart failure
- Pericarditis
- Diabetic problem

---

**KEY POINTS**

The chronic renal dialysis patient has numerous medical problems. The kidneys help maintain electrolyte balance, acid-base balance and rid the body of metabolic waste. Kidney failure results in a build-up of toxins within the body, which can cause many problems.

Dialysis is a process, which filters out the toxins, excess fluids and restores electrolyte balance. The process may be done in two ways:

1. **Peritoneal Dialysis**
   - Toxins are absorbed by osmosis through a solution infused into the peritoneal cavity; and then drained out. The solution is placed into the abdomen by means of a catheter, which is placed below the navel. This process must be done frequently, as frequently as every 12 hours for a period of 1 - 2 hours.

2. **Hemodialysis**
   - Removes toxins by directly filtering the blood using equipment that functions like an electric kidney, circulating the blood through a Shunt that is connected to a vein and an artery. This process usually needs to be done every 2 - 3 days for a period of 3 - 5 hours. A permanent shunt can be surgically formed as a fistula.

**POSSIBLE COMPLICATIONS OF DIALYSIS TREATMENT**

1. **Hypotension (15-30%)**
   - May result in angina, MI, dysrhythmia, altered mental status, and seizure

2. **Removal of therapeutic medications**
   - Example: Tegretol

3. **Disequilibrium syndrome**
   - Cause: shift of urea and / or electrolytes
   - Signs and symptoms: Nausea and / or vomiting, altered mentation, or seizure

4. **Bleeding**
   - These patients are often treated with heparin and they may have a low platelet count
   - Bleeding may be at the catheter site, retro peritoneal, gastrointestinal, or subdural

5. **Equipment malfunctions**
   - Possible air embolus
   - Possible fever or endotoxin

- Do not take blood pressure in arm that has the shunt.
- T waves must be higher than the QRS to qualify as tall / peaked
ADULT PROTOCOL

HYPERTHERMIA / HEAT EXPOSURE

- Document Patient Temperature
- Remove Patient from Heat Source
- Remove Patient Clothing
- Apply Room Temperature Water to Patient Skin and Increase Air Flow around Patient

CAPNOGRAPHY PROCEDURE

- Apply ICE PACKS to Patient (Groin, Axilla, and Posterior Neck)
- Consider Cooling Collar

IV / IO PROCEDURE

- HEAT EXHAUSTION
  - IV NS Bolus 20 ml / kg

- HEAT STROKE (AMS)
  - IF HYPOTENSIVE - IV NS Bolus 20 ml / kg
  - IF NORMOTENSIVE - IV NS TKO

Cardiac Monitor

- Monitor and Reassess
- Appropriate Protocol Based on Patient Symptoms

- TRANSPORT to appropriate facility
- CONTACT receiving facility
- CONSULT Medical Direction where indicated
# Adult Protocol

## Hypothermia / Heat Exposure

### History
- Age
- Exposure to increased temperatures and humidity
- Past medical history / medications
- Extreme exertion
- Time and length of exposure
- Poor PO intake
- Fatigue and / or muscle cramping

### Signs and Symptoms
- Altered mental status or unconsciousness
- Hot, dry, or sweaty skin
- Hypotension or shock
- Seizures
- Nausea

### Differential Diagnosis
- Fever (infection)
- Dehydration
- Medications
- Hyperthyroidism (storm)
- Delirium tremens (DT's)
- Heat cramps
- Heat exhaustion
- Heat stroke
- CNS lesions or tumors

## Heat Exhaustion: Dehydration
- Muscular / abdominal cramping
- General weakness
- Diaphoresis
- Febrile
- Confusion
- Dry mouth / thirsty
- Tachycardia
- BP normal or orthostatic hypotension

## Heat Stroke: Cerebral Edema
- Confusion
- Bizarre behavior
- Skin hot dry, febrile
- Tachycardia
- Hypotensive
- Seizure
- Coma

## Key Points
- Exam: Mental Status, Skin, HEENT, Heart, Lungs, Neuro
- Extremes of age are more prone to heat emergencies (i.e. young and old).
- Predisposed by use of: tricyclic antidepressants, phenothiazines, anticholinergic medications, and alcohol.
- Cocaine, amphetamines, and salicylates may elevate body temperatures.
- Sweating generally disappears as body temperature rises
- Intense shivering may occur as patient is cooled.
- **Heat Cramps** consists of benign muscle cramping 2° to dehydration and is not associated with an elevated temperature.
- **Heat Exhaustion** consists of dehydration, salt depletion, dizziness, fever, mental status changes, headache, cramping, nausea and vomiting. Vital signs usually consist of tachycardia, hypotension, and an elevated temperature.
- **Heat Stroke** consists of dehydration, tachycardia, hypotension, elevated temperature, and altered mental status.
- Patients at risk for heat emergencies include neonates, infants, geriatric patients, and patients with mental illness. Other contributory factors may include heart medications, diuretics, cold medications and / or psychiatric medications.
- Heat exposure can occur either due to increased environmental temperatures or prolonged exercise or a combination of both. Environments with temperature > 90° F and humidity > 60% present the most risk.
- Heat stroke occurs when the cooling mechanism of the body (sweating) ceases due to temperature overload and / or electrolyte imbalances. Be alert for cardiac dysrhythmias for the patient with heat stroke.
- In patients with significant hyperthermia (temp > 104° F) begin actively cooling with natural or chemical ice packs applied to the patients’ groin, armpits (axilla), and back of neck.
HYPERTENSIVE EMERGENCIES

UNIVERSAL PATIENT CARE PROTOCOL

IV / IO PROTOCOL

Assess Neuro Status – Record and Trend GCS
MEND Stroke Exam

12 LEAD EKG PROCEDURE

1st Contact to EKG and Transmission < 10 Min

BLOOD GLUCOSE PROCEDURE

Consider Potential Causes

Concurrent Chest Pain? - Refer to ACS Protocol
Concurrent Pulmonary Edema? - Treat Per CHF / Pulmonary Edema Protocol

Discontinuation / Non–Compliance with Anti-Hypertensive Medications) – Supportive Care

Head Trauma (Cushing’s Reflex) – See Head Trauma Protocol
Sympathomimetics (Cocaine, Amphetamines, Etc.) – Supportive Care
Aortic Dissection – Supportive Care / Pain Management
Pre-Eclampsia / Eclampsia – See OB Emergencies

Consult Medical Direction
If EMS Needs Consideration of Other Interventions on a Per Case Basis

TRANSPORT
Head Up > 30 Degrees Position

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated
### HYPERTENSIVE EMERGENCIES

#### HISTORY
- Documented hypertension
- Related diseases: diabetes, CVA renal failure, cardiac
- Medications (compliance?)
- Pregnancy

#### SIGNS AND SYMPTOMS
One of these:
- Systolic BP 220 or greater
- Diastolic BP 120 or greater
AND at least one of these:
- Headache
- Nosebleed
- Blurred vision
- Dizziness

#### DIFFERENTIAL DIAGNOSIS
- Hypertensive encephalopathy
- Primary CNS Injury (Cushing's response = bradycardia with hypertension)
- Myocardial infarction
- Aortic dissection
- Pre-eclampsia / Eclampsia
- Sympathomimetic ingestion (cocaine)

#### KEY POINTS
- Prehospital treatment of hypertension is very conservative because a CVA in progress may be made worse by a drop in B/P following aggressive hypertension treatment.
- Consider treatment ONLY if patient has signs and symptoms of CHF or Cardiac Chest Pain!
- Hypertensive emergencies are life threatening emergencies characterized by an acute elevation in blood pressure AND end-organ damage to the cardiac, CNS or renal systems. These crisis situations may occur when patients have poorly controlled chronic hypertension.
- All symptomatic patients with hypertension should be transported with their head elevated.
- Evidence of neurological deficit includes: confusion, slurred speech, facial asymmetry, focal weakness, coma, lethargy and seizure activity.
- Evidence of cardiac impairment includes: angina, jugular vein distention, chest discomfort and pulmonary edema.
- Toxic ingestion such as cocaine may present with a hypertensive emergency.
- Hypertension can be a neuroprotective reflex in patients with increased intracranial pressure.
UNIVERSAL PATIENT CARE PROTOCOL

AIRWAY PROTOCOL

OXYGEN

CAPNOGRAPHY PROCEDURE

Remove wet clothing

Handle Patient Gently

Indirectly Apply Hot Packs and / or Blankets and Turn Up Vehicle Heat

IV / IO PROCEDURE

CARDIAC MONITORING PROCEDURE

Appropriate Protocol(s)
Based on Patient Signs and Symptoms

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated
HYPOTHERMIA / FROSTBITE

### HISTORY
- Past medical history
- Medications
- Exposure to environment even in normal temperatures
- Exposure to extreme cold
- Extremes of age
- Drug use: alcohol, barbiturates
- Infections / sepsis
- Length of exposure / wetness

### SIGNS AND SYMPTOMS
- Cold, clammy
- Shivering
- Mental status changes
- Extremity pain or sensory abnormality
- Bradycardia
- Hypotension or shock

### DIFFERENTIAL DIAGNOSIS
- Sepsis
- Environmental exposure
- Hypoglycemia
- CNS dysfunction
- Stroke
- Head injury
- Spinal cord injury

### KEY POINTS
- Exam: Mental Status, Heart, Lungs, Abdomen, Extremities, Neuro
- Hypothermic / drowning / near drowning patients that appear cold and dead are NOT dead until they are warm and dead, or have other signs of obvious death (putrification, traumatic injury unsustainable to life).
- Defined as core temperature < 93.2° F (34° C).
- Extremes of age are most susceptible (i.e. young and old).
- Patients with low core temperatures will not respond to ALS drug interventions. Maintain warming procedure and supportive care. Warming procedures includes removing wet clothing, limiting exposure, and covering the patient with warm blankets if available.
- Do not allow patients with frozen extremities to ambulate.
- Do not attempt to rewarm deep frostbite unless there is an extreme delay in transport, and there is a no risk that the affected body part will be refrozen. Contact medical direction prior to rewarming a deep frostbite injury.
- With temperature less than 86° F (30° C) ventricular fibrillation is common cause of death. Handling patients gently may prevent this.
- If the temperature is unable to be measured, treat the patient based on the suspected temperature.
- Hypothermia may produce severe bradycardia.
- Shivering stops below 90° F (32° C).
- Hot packs can be activated and placed in the armpit and groin area if available.
- Care should be taken not to place the packs directly against the patient’s skin.
- Consider withholding CPR if patient has organized rhythm. Discuss with medical control.
- Patients with low core temperatures may not respond to ALS drug interventions. Discuss ACLS drug use with medical control in severely hypothermic patients.
- Maintain warming procedure and supportive care. Warming procedures includes removing wet clothing, limiting exposure, and covering the patient with warm blankets if available.
- The most common mechanism of death in hypothermia is ventricular fibrillation. If the hypothermia victim is in ventricular fibrillation, CPR should be initiated. If V-FIB is not present, then all treatment and transport decisions should be tempered by the fact that V-FIB can be caused by rough handling, noxious stimuli or even minor mechanical disturbances, this means that respiratory support with 100% oxygen should be done gently, including intubation, avoiding hyperventilation.
- The heart is most likely to fibrillate between 85 - 88° F (29 - 31° C). Defibrillate VF / VT x1 if no change, perform CPR and defer repeat defibrillation attempts until patient has been rewarmed.
- Do not allow patients with frozen extremities to ambulate.
- Superficial frostbite can be treated by using the patient’s own body heat.
ADULT PROTOCOL

SEIZURES

UNIVERSAL PATIENT CARE PROTOCOL

AIRWAY PROTOCOL
Consider Spinal Motion Restriction

CAPNOGRAPHY PROCEDURE
OXYGEN / VENTILATE DURING SEIZURE BASED ON CAPNOGRAPHY AS REQUIRED
Loosen Patient Clothing / Protect Patient

IV PROCEDURE
Check Blood Glucose Level

BGL < 70 - Treat per Diabetic Protocol

BGL > 70 and Status Epilepticus?

LORAZEPAM (ATIVAN)
1 - 2 mg IV / IO / IN / IM – Where Available
May Repeat if No Effect Max Dose 2 mg
If Lorazepam (Ativan) is unavailable,
See medication section for Midazolam (Versed)

Monitor and Reassess

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

EMT Intervention
AEMT Intervention
PARAMEDIC Intervention
MED CONTROL Consult
# SEIZURES

**HISTORY**
- Reported / witnessed seizure activity
- Previous seizure history
- Medical alert tag information
- Seizure medications
- History of trauma
- History of diabetes
- History of pregnancy

**SIGNS AND SYMPTOMS**
- Decreased mental status
- Sleepiness
- Incontinence
- Observed seizure activity
- Evidence of trauma

**DIFFERENTIAL DIAGNOSIS**
- CNS (head) trauma
- Tumor
- Metabolic, hepatic, or renal failure
- Hypoxia
- Electrolyte abnormality (na, ca, mg)
- Drugs, medications, non-compliance
- Infection / fever
- Alcohol withdrawal
- Eclampsia
- Stroke
- Hyperthermia

## Categories of Seizures

<table>
<thead>
<tr>
<th>Complex = Unconscious</th>
<th>Focal = Partial, Localized</th>
<th>Generalized = All Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple = Conscious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Focal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Generalized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex Focal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex Generalized</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## KEY POINTS

- **Exam:** Mental Status, HEENT, Heart, Lungs, Extremities, Neuro
- **Status epilepticus** is defined as two or more successive seizures without a period of consciousness or recovery. This is a true emergency requiring rapid airway control, treatment, and transport.
- **Grand mal seizures** (generalized) are associated with loss of consciousness, incontinence, and possibly tongue trauma.
- **Focal seizures** (petit mal) effect only a part of the body and are not usually associated with a loss of consciousness.
- For any seizure in a pregnant patient, follow the OB Emergencies Protocol and call Medical Control
- Benzodiazepine administration is reserved for patients who are actively seizing only, not for prophylaxis of seizures.
- Be prepared to manage the airway and breathing of patients who have received benzodiazepines such as Lorazepam (Ativan)
- Jacksonian seizures are seizures that start as a focal seizure and become generalized.
- Be prepared for airway problems and continued seizures.
- Assess possibility of occult trauma and substance abuse.
- The seizure has usually stopped by the time the EMS personnel arrive and the patient will be found in the postictal state.
- There are many causes for seizures including; epilepsy, head trauma, tumor, overdose, infection, hypoglycemia, and withdrawal. Be sure to consider these when doing your assessment.
- Routinely assess the patient’s airway.
- If the patient is combative and postical, DO NOT use the Restraint Procedure before assessing for / treating hypoglycemia and hypoxia.
- If the patient is actively seizing, move any objects that may injure the patient. Protect, but do not try to restrain them.
ADULT PROTOCOL

SEVERE PAIN MANAGEMENT

PATIENT HAS:

- Burns
- Intractable Flank Pain
- Intractable Back Pain
- Musculoskeletal and / or Fracture Pain
- Sickle Cell Pain Crisis (Use Supplemental O₂)
- Unremitting Abdominal Pain (NOT OB)

**FENTANYL (SUBLIMAZE)**

25 – 100 mcg IV / IO / IM / IN – 100 mcg MAX

- Preferred analgesic for trauma / ACS
- Push slow IV / IO
- If Fentanyl (Sublimaze) is unavailable, see medication section for Morphine Sulfate

**HYDROMORPHONE (DILAUDID)**

0.5 - 1 mg IV / IO / IM
May Repeat to a Max 2 mg
HALF DOSE > 65, Liver or Renal Disease

- Preferred analgesic for intractable / unremitting pain
- If Hydromorphone (Dilaudid) is unavailable, see medication section for Morphine Sulfate

**KETOROLAC (TORADOL)**

15 mg IV / IO – 1 DOSE LIMIT
30 mg IM – 1 DOSE LIMIT

- Preferred analgesic for kidney stones, Flank pain
- >65 Years old, Renal disease
- Any recent or suspected bleeding (GI bleeds, CVA)
- Allergy / Hypersensitivity to NSAIDS, Asthma
- Known or obvious pregnancy, Nursing mothers

Consider ONDANSETRON (ZOFRAN) as Needed

4 mg IM / IV over 2 - 4 minutes
May repeat to a Max of 8 mg

**CAPNOGRAPHY PROCEDURE**

Monitor Airway, Breathing, Vitals

**TRANSPORT** to appropriate facility

**CONTACT** receiving facility

**CONSULT** Medical Direction where indicated

Pain Other Than Listed
CONTACT MED CONTROL

NOT FOR
Altered Mentation, Traumatic Abdominal Pain, Head Trauma, Hypovolemia, Multiple System Trauma

**EMT Intervention**
**AEMT Intervention**
**PARAMEDIC Intervention**
**MED CONTROL Consult**
SEVERE PAIN MANAGEMENT

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age / onset</td>
<td>• Severity (pain scale)</td>
<td>• Per the specific protocol</td>
</tr>
<tr>
<td>• Location</td>
<td>• Quality (sharp, dull, etc.)</td>
<td>• Musculoskeletal</td>
</tr>
<tr>
<td>• Duration</td>
<td>• Radiation</td>
<td>• Visceral (abdominal)</td>
</tr>
<tr>
<td>• Severity (0 - 10)</td>
<td>• Relation to movement, respiration</td>
<td>• Cardiac</td>
</tr>
<tr>
<td>• Past medical history</td>
<td>• Increased with palpation of area</td>
<td>• Pleuritic (respiratory)</td>
</tr>
<tr>
<td>• Medications</td>
<td>• Severity (pain scale)</td>
<td>• Neurogenic</td>
</tr>
<tr>
<td>• Drug allergies</td>
<td>• Quality (sharp, dull, etc.)</td>
<td>• Renal (colic)</td>
</tr>
</tbody>
</table>

PAIN SCALE

The Wong-Baker Faces Pain Rating Scale
Designed for children aged 3 years and older, the Wong-Baker Faces Pain Rating Scale is also helpful for elderly patients who may be cognitively impaired. If offers a visual description for those who don’t have the verbal skills to explain how their symptoms make them feel.

To use this scale, your doctor should explain that each face shows how a person in pain is feeling. That is, a person may feel happy because he or she has no pain (hurt), or a person may feel sad because he or she has some or a lot of pain.

A Numerical Pain Scale
A numerical pain scale allows you to describe the intensity of your discomfort in numbers ranging from 0 to 10 (depending on the scale). Rating the intensity of sensation is one way of helping your doctor determine treatment. Numerical pain scales may include words or descriptions to better label your symptoms, from feeling no pain to experiencing excruciating pain. Some researchers believe that this type of combination scale may be most sensitive to gender and ethnic differences in describing pain.

KEY POINTS

• Exam: Mental Status, Area of Pain, Neuro
• Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage.
• Pain is subjective (whatever the patient says it is).
• Pain severity (0-10) is a vital sign to be recorded pre, and post medication delivery and at disposition.
• Use analgesia for suspected cardiac chest pain within the ACS protocol.
• Abdominal pain patients must have a 12 lead EKG to rule out cardiac involvement.
• Vital signs should be obtained pre, 10 minutes post, and at disposition with all pain medications.
• Contraindications to Hydromorphone (Dilaudid), or Fentanyl (Sublimaze) use include hypotension, head injury, respiratory distress or severe COPD.
• All patients should have drug allergies documented prior to administering pain medications.
• All patients who receive pain medications must be observed 15 minutes for drug reaction.
• All patients who receive medication for pain must have continuous ECG monitoring, pulse oximetry, and oxygen administration.
• The patient’s vital signs must be routinely reassessed.
• Routine assessments and reassessments must be documented on the run report.
• Have Naloxone (Narcan) on hand if the patient has respiratory depression or hypotension after Hydromorphone (Dilaudid), or Fentanyl (Sublimaze) administration. Be prepared to ventilate.
• DO NOT administer narcotic analgesics if there is any suspicion of a head injury.
• Capnography is required if patient already has narcotic analgesics on board prior to supplementation.
• Capnography is required if second doses of narcotic analgesics are required to control the patients pain.
## Adult Protocol

### Stroke / CVA

#### Universal Patient Care Protocol

- **Airway Protocol**
- **Oxygen**
- **Capnography Procedure**

#### Blood Glucose Procedure

Cincinnati Prehospital Stroke Screen – On Scene

- **12 Lead EKG Procedure**
  - 1st Contact to EKG and Transmission < 10 Min
- **IV Procedure**
  - Large Bore in AC if possible for TPA

#### EMT Intervention

- **AEMT Intervention**
- **Paramedic Intervention**
- **MED Control Consult**

---

### Cincinnati Prehospital Stroke Assessment

**On Scene**

<table>
<thead>
<tr>
<th>Mental Status</th>
<th>Awake &amp; alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Consciousness</td>
<td>Awake &amp; alert</td>
</tr>
<tr>
<td>Facial Droop</td>
<td>Both sides move equally well on smile/grimace</td>
</tr>
<tr>
<td>Motor—Arm Drift (eyes closed)</td>
<td>Raised arms do not drift down (both together)</td>
</tr>
<tr>
<td>Speech</td>
<td>Repeats You can’t teach an old dog new tricks using correct words and no slurring</td>
</tr>
</tbody>
</table>

### MEND Exam

**Pre-Hospital Stroke Assessment**

**En-Route**

<table>
<thead>
<tr>
<th>Mental Status</th>
<th>Awake &amp; alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Consciousness</td>
<td>Awake &amp; alert</td>
</tr>
<tr>
<td>Speech</td>
<td>Repeats You can’t teach an old dog new tricks using correct words and no slurring</td>
</tr>
<tr>
<td>Questions</td>
<td>Says the month and own age correctly</td>
</tr>
<tr>
<td>Commands</td>
<td>Closes &amp; opens eyes to command</td>
</tr>
<tr>
<td>Cranial Nerves</td>
<td></td>
</tr>
<tr>
<td>Facial Droop</td>
<td>Both sides move equally well on smile/grimace</td>
</tr>
<tr>
<td>Visual Fields</td>
<td>Sees fingers in all 4 quadrants</td>
</tr>
<tr>
<td>Horizontal Gaze</td>
<td>Moves eyes completely side to side</td>
</tr>
<tr>
<td>Limbs</td>
<td></td>
</tr>
<tr>
<td>Motor—Arm Drift (eyes closed)</td>
<td>Raised arms do not drift down (both together)</td>
</tr>
<tr>
<td>Motor—Leg Drift (eyes open)</td>
<td>Each raised leg does not drift down (1 at a time)</td>
</tr>
<tr>
<td>Sensory—Arm (eyes closed)</td>
<td>Feels touch on each arm normally</td>
</tr>
<tr>
<td>Sensory—Leg (eyes closed)</td>
<td>Feels touch on each leg normally</td>
</tr>
<tr>
<td>Coordination—Arm</td>
<td>Finger-to-nose accurate &amp; smooth</td>
</tr>
<tr>
<td>Coordination—Leg</td>
<td>Heel-to-shin accurate &amp; smooth</td>
</tr>
</tbody>
</table>

### Transport to Appropriate Facility

- **Consider Comprehensive Stroke Center**
- **Contact** Receiving facility
- **Consul** Medical Direction where indicated

---

**Identify Last Time Known Normal and Record**

**Identify Point of Contact for Last Known Normal**

**Move to Ambulance Rapid Transport**

**En-Route Conduct MEND Exam**

**Relay MEND Exam to Hospital**
### STROKE / CVA

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| • Previous CVA, TIA’s  
• Previous cardiac / vascular surgery  
• Associated diseases: diabetes, hypertension, CAD  
• Atrial fibrillation  
• Medications (blood thinners)  
• History of trauma | • Altered mental status  
• Weakness / paralysis  
• Blindness or other sensory loss  
• Aphasia  
• Syncpoe  
• Vertigo / dizziness  
• Vomiting  
• Headache  
• Seizures  
• Respiratory pattern change  
• Hyper / hypotension | • See Altered Mental Status  
• TIA (transient ischemic attack)  
• Seizure  
• Hypoglycemia  
• Stroke  
• Thrombotic  
• Embolic  
• Hemorrhagic  
• Tumor  
• Trauma |

Identify Last Time Known Normal and Document

#### KEY POINTS

- Exam: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremities, Neuro
- Onset of symptoms is defined as the last witnessed time the patient was symptom free. (i.e. awakening with stroke symptoms would be defined as an onset time of the previous night when patient was symptom free)
- The differential diagnosis listed on the Altered Mental Status Protocol should also be considered.
- Elevated blood pressure is commonly present with stroke.
- Be alert for airway problems (swallowing difficulty, vomiting, diminished or absent gag reflex).
- Hypoglycemia can present as a localized neurological deficit, especially in the elderly.
- Patients who experience transient ischemic attack (TIA) develop most of the same signs and symptoms as those who are experiencing a stroke. The signs and symptoms of TIA’s can last from minutes up to one day. Thus the patient may initially present with typical signs and symptoms of a stroke, but those findings may progressively resolve. The patient needs to be transported, without delay, to the most appropriate hospital for further evaluation.
- Document the time of onset for the symptoms, or the last time the patient was seen “normal” for them.
- Reassess neurological deficit every 10 minutes and document the findings. Evidence of neurological deficit includes; confusion, slurred speech, facial asymmetry and focal weakness, coma, lethargy, aphasia, dysarthria, and seizure activity.
- Hypertensive emergencies are life threatening emergencies characterized by an acute elevation in blood pressure AND end-organ damage to the cardiac, CNS or renal systems. These crisis situations may occur when patients have poorly controlled chronic hypertension or stroke.
- Blood pressures MUST be taken bilaterally and be similar, contact Medical Control if they vary more than 20 mmHg.
- Verify automated BP readings with manual cuff.
- Document pts GCS score.
- Check patient’s pupils and rule out head trauma.
- All symptomatic patients with hypertension should be transported with their head elevated.
**ADULT PROTOCOL**

**TOXIC INGESTION / EXPOSURE / OVERDOSE**

**UNIVERSAL PATIENT CARE PROTOCOL**

**AIRWAY PROTOCOL**
- Monitor Lung Sounds for Fluid Overload

**OXGEN**

**IV / IO PROCEDURE**
- Apply Cardiac Monitor and Assess Vitals

**CAPNOGRAPHY PROCEDURE**

**Narcotic Overdose**
- AMS / Respiratory Depression

**Tricyclic Anti - Depressants**
- Patient on any TRICYCLIC listed below or otherwise with QRS > 0.12 msec
  - Adapin
  - Anafranil
  - Elavil
  - Endep
  - Ludomil
  - Norpramin
  - Pamelor
  - Pertofrane
  - Sinequin
  - Surmontil
  - Tofranil
  - Vivactil

**Beta Blocker / Calcium Channel Blocker**

**Atropine (NARCAN)**
- 1 - 2 mg IV / IM / IO
- May repeat every 2 min as necessary if obvious or suspected opiate OD until respiratory improvement or 12 mg Max

**SODIUM BICARBONATE**
- 1 mEq / mg IV / IO
- Until QRS narrows / condition improves

**Endoxygen 3 mg IV / IO**
- Repeat every 3 – 5 Minutes or as needed to control secretions
- Given to dry secretions
- No max dose

**Transcutaneous Pacing Procedure**
- IV NORMAL SALINE BOLUS
  - 20 ml / kg
- To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable

**Dopamine (INTROPIN)**
- 5 – 20 mcg/kg/min
- IV / IO DRIP
- Titrated to effect
- (If MAP remains < 70 or SBP < 90)

**ATROPINE**
- 1 mg IV / IO
- Repeat every 3 – 5 Minutes or as needed to control secretions

**Treat with Specific Antidote**
- Calcium Channel Blockers OD
- CALCIUM CHLORIDE
  - 1 Gram IV / IO
- Beta Blocker OD
- GLUCAGON (GLUCAGEN)
  - 3 mg IV / IO

**Transport**
- to appropriate facility

**Contact**
- receiving facility

**Consult**
- Medical Direction where indicated

**EMT Intervention**

**AEMT Intervention**

**PARAMEDIC Intervention**

**MED CONTROL Consult**

---

*If Suspected Carbon Monoxide (CO) or Cyanide Poisoning see Specific Protocol*

*If patient is unresponsive to Naloxone (Narcan), supply is exhausted, or the medication is unavailable, consider Advanced Airway and Support Hemodynamically*

*Assure BLS Ventilation with BVM*

*Support Hemodynamically Utilize Shock Protocol*

*Take PPE Precautions* GLOVES / MASK minimum Contact / aerosol risk with fentanyl based substances
# TOXIC INGESTION / EXPOSURE / OVERDOSE

## HISTORY
- Ingestion or suspected ingestion of a potentially toxic substance
- Substance ingested, route, quantity
- Time of ingestion
- Reason (suicidal, accidental, criminal)
- Available medications in home
- Past medical history, medications

## SIGNS AND SYMPTOMS
- Mental status changes
- Hypo / hypertension
- Decreased respiratory rate
- Tachycardia, dysrhythmias
- Seizures

## DIFFERENTIAL DIAGNOSIS
- Tricyclic antidepressants (TCAs)
- Acetaminophen (Tylenol)
- Depressants
- Stimulants
- Anticholinergic
- Cardiac medications
- Solvents, alcohols, Cleaning agents
- Insecticides (organophosphates)
- Respiratory depression
- Other organophosphates
- Carbamates

### COMMON BETA BLOCKERS
- Acebutolol
- Carvedilol
- Labetolol
- Propranolol
- Atenolol
- Coreg
- Levatol
- Sectral
- Betapace
- Corgard
- Lopressor
- Sotalol
- Bisoprolol
- Inderal
- Nadolol
- Timolol
- Brevibloc
- Innopran XL
- Nebivolol
- Trandate
- Bystolic
- Kerlone
- Pindolol
- Zabeta

### COMMON CALCIUM CHANNEL BLOCKERS
- Acalas
- Cardene
- Lacidipine
- Nitrepin
- Adalat
- Cardif
- Lacipl
- Nivalid
- Amlodipine
- Cardizem
- Landel
- Norvasc
- Aranidipine
- Clnidipine
- Lercanidipine
- Plendil
- Atelec
- Cinalong
- Madipine
- Prandipine
- Azelnidipine
- Clevidipine
- Manidipine
- Procardia
- Barnidipine
- Cleviprex
- Motens
- Procorum
- Baylotensin
- Coniel
- Nicardipine
- Sapresta
- Baymycard
- Diltiazem
- Nifedipine
- Siscard
- Benidipine
- Efondipine
- Nilvadipine
- Sular
- Calan
- Felodipine
- Nimodipine
- Syscor
- Calblock
- Gallopamil
- Nimoto
- Verapamil
- Calslot
- HypoCa
- Nisoldipine
- Zanidip
- Carden SR
- Isoptin
- Nitrendipine

### KEY POINTS
- Exam: Mental Status, Skin, HEENT, Heart, Lungs, Abdomen, Extremities, Neuro
- Do not rely on patient history of ingestion, especially in suicide attempts.
- Bring bottles, contents, and emesis to ED.
- **Tricyclic**: 4 major areas of toxicity: seizures, dysrhythmias, hypotension, decreased mental status or coma; rapid progression from alert mental status to death.
- **Acetaminophen**: initially normal or nausea / vomiting. If not detected and treated, causes irreversible liver failure.
- **Depressants**: decreased HR, decreased BP, decreased temperature, decreased respirations, non-specific pupils.
- **Stimulants**: increased HR, increased BP, increased temperature, dilated pupils, and seizures.
- **Anticholinergics**: increased HR, increased temperature, dilated pupils, and mental status changes.
- **Cardiac Medications**: dysrhythmias and mental status changes.
- **Solvents**: nausea, vomiting, and mental status changes.
- **Insecticides**: increased or decreased HR, increased secretions, nausea, vomiting, diarrhea, pinpoint pupils.
- Consider restraints if necessary for patient’s and / or personnel’s protection per the Restraint Procedure.
- If it can be done safely, take whatever container the substance came from to the hospital along with readily obtainable samples of medication unless this results in an unreasonable delay of transport.
- If applicable, DO NOT transport a patient to the hospital until properly decontaminated.
- Naloxone (Narcan) administration may cause the patient to go into acute opiate withdraw, which includes vomiting, agitation, and / or combative behavior. Always be prepared for combative behavior.
- Naloxone (Narcan) may wear off in as little as 20 minutes causing the patient to become more sedate and possibly hypoventilate. All A&O 4 patients having received Naloxone (Narcan) should be transported. If patient refuses transport, contact Medical Control before release.

**GREATER CLEVELAND POISON CONTROL 1-800-222-1222**

---

**U n i v e r s i t y  H o s p i t a l s  E M S  P r o t o c o l - 2 9 | 5**
POTENTIAL EXPOSURES

Smoke Inhalation

Intentional or unintentional poisoning or ingestion of Laetrile (vitamin B17) or multiple fruit pits.

Industrial exposure such as metal plating and recovery, plastics, industrial uses of hydrogen cyanide or medical complications from the use of sodium nitroprusside.

UNIVERSAL PATIENT CARE PROTOCOL

Cyanide Ingestion or Inhalation

Immediately Remove From Continued Exposure
Avoid Exertion to Limit Tissue Oxygen Demand
Determine Exposure Time

APPLY HIGH FLOW OXYGEN

CAPNOGRAPHY PROCEDURE

Secure Airway If Comatose or Compromised Airway

INTUBATION PROCEDURE
KING AIRWAY or LMA

CARDIAC MONITORING PROCEDURE
PULSE OXIMETRY
PULSE CO-OXIMETRY (If Available)

IV / IO PROCEDURE
To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable
Place 2 IV’s

DOPAMINE (INTROPIN)
5 – 20 mcg / kg / min
If Hypotension Continues

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

Aggressive airway management with delivery of 100% oxygen can be lifesaving. Supportive care with administration of oxygen alone has proven effective in a number of poisonings. It can also treat potential simultaneous CO exposure.
# ADULT PROTOCOL

## TOXIC INHALATION / INGESTION CYANIDE

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhalation or ingestion of cyanides</td>
<td>Malaise, fatigue, drowsiness</td>
<td>Flu / severe cold</td>
</tr>
<tr>
<td>Duration of exposure</td>
<td>Reddened skin</td>
<td>Chronic fatigue</td>
</tr>
<tr>
<td>Reason (suicidal, accidental, criminal)</td>
<td>Dyspnea</td>
<td>Migraine</td>
</tr>
<tr>
<td>Past medical history, medications</td>
<td>Chest pain</td>
<td>Myocardial infarction / ACS</td>
</tr>
<tr>
<td></td>
<td>Nausea / vomiting</td>
<td>Encephalitis</td>
</tr>
<tr>
<td></td>
<td>Abdominal pain</td>
<td>Anaphylaxis</td>
</tr>
<tr>
<td></td>
<td>Dizziness / vertigo</td>
<td>Other ingested toxins</td>
</tr>
<tr>
<td></td>
<td>Memory disturbances</td>
<td>Pulmonary embolism</td>
</tr>
<tr>
<td></td>
<td>Syncope</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seizures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coma</td>
<td></td>
</tr>
</tbody>
</table>

### KEY POINTS

- Exam: Mental Status, Skin, HEENT, Heart, Lungs, Abdomen, Extremities, Neuro
- Cyanide is generally considered to be a rare source of poisoning.
- Cyanide exposure occurs relatively frequently in patients with smoke inhalation from fires.
- Numerous forms of cyanide exist, including gaseous hydrogen cyanide (HCN), water-soluble potassium and sodium cyanide salts, and poorly water-soluble mercury, copper, gold, and silver cyanide salts.
- A number of synthesized (polyacrylonitrile, polyurethane, polyamide, urea-formaldehyde, melamine) and natural (wool, silk) compounds produce HCN when burned.
- Industry widely uses nitriles as solvents and in the manufacturing of plastics. Nitriles may release HCN during burning or when metabolized following absorption by the skin or gastrointestinal tract.
- Cyanide poisoning also may occur in other industries, particularly in the metal trades, mining, electroplating, jewelry manufacturing, and x-ray film recovery.
- Depending on its form, cyanide may cause toxicity through parenteral administration, inhalation, ingestion, or dermal absorption.
- Rapid aggressive therapy, consisting of supportive care and antidote administration, is lifesaving.
- The delay between exposure and onset of symptoms depends on type of cyanide involved, route of entry, and dose. Rapidity of symptom onset, depending on the type of cyanide exposure, occurs in the following order (most rapid to least rapid): gas, soluble salt, insoluble salt, and cyanogens.

GREATER CLEVELAND POISON CONTROL 1-800-222-1222
Known or Suspected Carbon Monoxide Poisoning

Immediately Remove From Continued Exposure
Avoid Exertion to Limit Tissue Oxygen Demand
Determine Exposure Time

APPLY HIGH FLOW OXYGEN

CAPNOGRAPHY PROCEDURE

Secure Airway If Comatose or Compromised Airway

INTUBATION PROCEDURE

KING AIRWAY or LMA

CARDIAC MONITORING PROCEDURE

PULSE OXIMETRY
PULSE CO-OXIMETRY (IF AVAILABLE)

IV / IO PROCEDURE
DRAW LABS FOR CO LEVELS

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

CO Levels
<10% Mild
10% - 20% Moderate
>20% Severe

Special Considerations for Pregnant Females and Children

EMT Intervention
AEMT Intervention
PARAMEDIC Intervention
MED CONTROL Consult
# Toxic Inhalation

## Carbon Monoxide

<table>
<thead>
<tr>
<th>History</th>
<th>Signs and Symptoms</th>
<th>Differential Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhalation of potentially carbon monoxide containing atmosphere</td>
<td>Malaise, fatigue, drowsiness</td>
<td>Flu / severe cold</td>
</tr>
<tr>
<td>Duration of exposure</td>
<td>Flu like symptoms</td>
<td>Chronic fatigue</td>
</tr>
<tr>
<td>Reason (suicidal, accidental, criminal)</td>
<td>Headache</td>
<td>Migraine</td>
</tr>
<tr>
<td>Past medical history, medications</td>
<td>Dyspnea</td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td></td>
<td>Nausea / vomiting</td>
<td>Diabetic emergencies</td>
</tr>
<tr>
<td></td>
<td>Diarrhea</td>
<td>Altitude sickness</td>
</tr>
<tr>
<td></td>
<td>Abdominal pain</td>
<td>Ingested toxins</td>
</tr>
<tr>
<td></td>
<td>Dizziness</td>
<td>Meningitis</td>
</tr>
<tr>
<td></td>
<td>Visual disturbances</td>
<td>Hypothyroidism</td>
</tr>
<tr>
<td></td>
<td>Memory disturbances</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Syncope</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seizures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incontinence</td>
<td></td>
</tr>
</tbody>
</table>

CO Levels

- <10% Mild
- 10% - 20% Moderate
- >20% Severe

Special Considerations for Pregnant Females and Children

<table>
<thead>
<tr>
<th>Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam: Mental Status, Skin, HEENT, Heart, Lungs, Abdomen, Extremities, Neuro</td>
</tr>
<tr>
<td>Consider CO poisoning with any patient exposed to products of combustion.</td>
</tr>
<tr>
<td>Causes and exposure may include malfunctioning gas appliances, vehicle exhaust, improper use of gas burning heaters, animal dung, environmental waste and fires.</td>
</tr>
<tr>
<td>Normal CO levels do not necessarily mean there was not CO poisoning. This is especially true if the patient has already received extensive oxygen therapy.</td>
</tr>
<tr>
<td>Patients that show signs and symptoms at lower CO levels include: pregnant females, infants, children and the elderly.</td>
</tr>
<tr>
<td>Vitals may be normal but could be tachycardic, hypo or hypertensive.</td>
</tr>
<tr>
<td>Cherry red skin is rarely seen.</td>
</tr>
<tr>
<td>PREGNANT patients are special circumstances as the affinity for fetal hemoglobin to carbon monoxide is very high and therapy including hyperbaric care is considered early on.</td>
</tr>
<tr>
<td>Patients that demonstrate altered mental status may NOT sign refusals for treatment or transport.</td>
</tr>
<tr>
<td>Known or suspected CO poisoning patients should receive high flow oxygen despite Spo2 readings.</td>
</tr>
<tr>
<td>The use of a pulse oximeter is not effective in the diagnosis of carbon monoxide poisoning, as patients suffering from carbon monoxide poisoning may have a normal oxygen saturation level on a pulse oximeter.</td>
</tr>
<tr>
<td>Pulse oximetry is still used on all CO poisonings as hypoxia in addition to the CO represents serious compounding respiratory issues possibly from other causes.</td>
</tr>
<tr>
<td>Pulse CO-oximeters estimate carboxyhemoglobin levels with a non-invasive finger clip similar to a pulse oximeter.</td>
</tr>
</tbody>
</table>
TRAUMA PROTOCOLS

Trauma Emergencies ................................................................................................................... 2-6
Trauma Guidelines .................................................................................................................. 3-6
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ADULT PROTOCOL

TRAUMA EMERGENCIES

The Golden Period

GUIDELINES FOR LOAD AND GO TRAUMA TRANSPORTS

INDICATIONS

- Uncorrectable airway obstruction
- Tension pneumothorax
- Pericardial tamponade
- Penetrating chest wounds with signs of shock
- Hemothorax with signs of shock
- Head trauma with unilaterally dilated pupils
- Head trauma with rapidly deteriorating condition
- Unconsciousness

KEY POINTS

- A trauma victim is considered to be a pediatric patient if they are 15 years old or younger.
- Once the patient is determined to be an actual or potential major trauma / multiple system patient, personnel on scene and / or medical control must quickly determine the appropriate course of action including:
  1. Requesting aeromedical evacuation from scene. See AEROMEDICAL TRANSPORT PROCEDURE.
  2. Ground transportation directly to an appropriate facility.
- Major trauma patients are to be transported to the closest Trauma Center.
- Contact the receiving hospital for all major trauma or critical patients.
- Cover open wounds, burns, and eviscerations.
- With the exception of airway control, initiate ALS enroute when transporting major trauma patients.
- If the EMT is unable to access patient airway and ventilate, transport to the closest facility for airway stabilization.
- The on scene time for major trauma patients should not exceed 10 minutes without a documented, acceptable reason for the delay.
- All major trauma patients should receive oxygen administration, an IV(s), and cardiac monitoring.
- Provide a documented reason if an intervention could not be performed.

Mass Casualty Incidents (MCI)

- Upon arrival at a MCI, the first arriving unit should notify their dispatch of the need to implement the mass casualty plan, call for additional resources, establish a safe staging area, and estimate the total number of victims.
- Each EMS service has a pre-defined coordinating hospital based on their county’s mass casualty plan. It is the responsibility of the responding jurisdiction to notify their appropriate coordinating hospital as soon as possible, giving a brief description of the incident and the estimated number of victims. The coordinating hospital will then notify the receiving hospitals of the MCI. The transportation officer should maintain a constant contact with the coordinating hospital until the scene has been cleared of salvageable victims.

THE GOLDEN PERIOD FOR THE PATIENT BEGINS WHEN THE TRAUMA HAPPENS
DO NOT WASTE VALUABLE TIME ON SCENE
Emergency medical service personnel shall use the following criteria, consistent with their certification, to evaluate whether an injured person qualifies as an adult trauma victim or pediatric trauma victim, in conjunction with the definition of trauma per the State of Ohio Trauma Triage Guidelines.

**An Adult Trauma Victim is a person 16 years – 69 years exhibiting one or more of the following physiologic or anatomic conditions:**

<table>
<thead>
<tr>
<th>Physiologic conditions</th>
<th>Anatomic conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Glasgow Coma Scale less than or equal to 13;</td>
<td>• Penetrating trauma to the head, neck, or torso;</td>
</tr>
<tr>
<td>• Loss of consciousness greater than 5 minutes;</td>
<td>• Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;</td>
</tr>
<tr>
<td>• Deterioration in level of consciousness at the scene or during transport;</td>
<td>• Injuries to the head, neck, or torso where the following physical findings are present:</td>
</tr>
<tr>
<td>• Failure to localize to pain;</td>
<td>- Visible crush injury;</td>
</tr>
<tr>
<td>• Respiratory rate &lt; 10 or &gt; 29;</td>
<td>- Abdominal tenderness, distention, or seatbelt sign;</td>
</tr>
<tr>
<td>• Requires ventilator support;</td>
<td>- Pelvic fracture;</td>
</tr>
<tr>
<td>• Requires relief of tension pneumothorax;</td>
<td>- Flail chest;</td>
</tr>
<tr>
<td>• Pulse &gt; 120 in combination with evidence of hemorrhagic shock;</td>
<td>• Injuries to the extremities where the following physical findings are present:</td>
</tr>
<tr>
<td>• Systolic blood pressure &lt; 90, or absent radial pulse with carotid pulse present;</td>
<td>- Amputations proximal to the wrist or ankle;</td>
</tr>
<tr>
<td></td>
<td>- Visible crush injury;</td>
</tr>
<tr>
<td></td>
<td>- Fractures of two or more proximal long bones;</td>
</tr>
<tr>
<td></td>
<td>- Evidence of neurovascular compromise.</td>
</tr>
<tr>
<td></td>
<td>• Signs or symptoms of spinal cord injury;</td>
</tr>
<tr>
<td></td>
<td>• 2nd or 3rd Degree &gt; 10% total BSA, or other significant burns involving the face, feet, hands, genitalia, or airway.</td>
</tr>
<tr>
<td></td>
<td>• Open skull injury</td>
</tr>
<tr>
<td></td>
<td>• Vehicle telemetry data consistent with a high risk for injury</td>
</tr>
</tbody>
</table>

**A Geriatric Trauma Victim is a person greater than 70 years exhibiting one or more of the following physiologic or anatomic conditions:**

<table>
<thead>
<tr>
<th>Physiologic conditions</th>
<th>Anatomic conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Glasgow Coma Scale less than or equal to 14 with a known or suspected traumatic brain injury;</td>
<td>• Penetrating trauma to the head, neck, or torso;</td>
</tr>
<tr>
<td>• Glasgow Coma Scale less than or equal to 13;</td>
<td>• Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;</td>
</tr>
<tr>
<td>• Loss of consciousness greater than 5 minutes;</td>
<td>• Injuries to the head, neck, or torso where the following physical findings are present:</td>
</tr>
<tr>
<td>• Deterioration in level of consciousness at the scene or during transport;</td>
<td>- Visible crush injury;</td>
</tr>
<tr>
<td>• Failure to localize to pain;</td>
<td>- Abdominal tenderness, distention, or seatbelt sign;</td>
</tr>
<tr>
<td>• Respiratory rate &lt; 10 or &gt; 29;</td>
<td>- Pelvic fracture;</td>
</tr>
<tr>
<td>• Requires ventilator support;</td>
<td>- Flail chest;</td>
</tr>
<tr>
<td>• Requires relief of tension pneumothorax;</td>
<td>• Injuries to the extremities where the following physical findings are present:</td>
</tr>
<tr>
<td>• Pulse &gt; 120 in combination with evidence of hemorrhagic shock;</td>
<td>- Amputations proximal to the wrist or ankle;</td>
</tr>
<tr>
<td>• Systolic blood pressure &lt; 100, or absent radial pulse with carotid pulse present;</td>
<td>- Visible crush injury;</td>
</tr>
<tr>
<td></td>
<td>- Fractures of two or more proximal long bones;</td>
</tr>
<tr>
<td></td>
<td>- Evidence of neurovascular compromise.</td>
</tr>
<tr>
<td></td>
<td>• Signs or symptoms of spinal cord injury;</td>
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<tr>
<td></td>
<td>• 2nd or 3rd Degree &gt; 10% total BSA, or other significant burns involving the face, feet, hands, genitalia, or airway.</td>
</tr>
<tr>
<td></td>
<td>• Open skull injury</td>
</tr>
<tr>
<td></td>
<td>• Pedestrian struck by motor vehicle</td>
</tr>
<tr>
<td></td>
<td>• Fall from any height, including standing, with evidence of traumatic brain injury.</td>
</tr>
<tr>
<td></td>
<td>• Vehicle telemetry data consistent with a high risk for injury</td>
</tr>
</tbody>
</table>
**Field Trauma Triage Criteria: Mechanism of Injury (MOI) & Special Considerations**

<table>
<thead>
<tr>
<th>Co-Morbid Diseases and Special Considerations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Age &lt; 5 or &gt; 55</td>
</tr>
<tr>
<td>- Cardiac disease</td>
</tr>
<tr>
<td>- Respiratory disease</td>
</tr>
<tr>
<td>- Diabetes</td>
</tr>
<tr>
<td>- Immunosuppression</td>
</tr>
<tr>
<td>- Morbid obesity</td>
</tr>
<tr>
<td>- Pregnancy</td>
</tr>
<tr>
<td>- Substance abuse / intoxication</td>
</tr>
<tr>
<td>- Liver disease</td>
</tr>
<tr>
<td>- Renal disease</td>
</tr>
<tr>
<td>- Bleeding disorder / anticoagulation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mechanisms of Injury (MOI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- High speed MVC</td>
</tr>
<tr>
<td>- Ejection from vehicle</td>
</tr>
<tr>
<td>- Vehicle rollover</td>
</tr>
<tr>
<td>- Death in same passenger compartment</td>
</tr>
<tr>
<td>- Extrication time &gt; 20 minutes</td>
</tr>
<tr>
<td>- Falls greater than 20 feet</td>
</tr>
<tr>
<td>- Vehicle versus bicycle / pedestrian</td>
</tr>
<tr>
<td>- Pedestrian struck, thrown or run over</td>
</tr>
<tr>
<td>- Motorcycle crash &gt; 20 mph with separation of rider from bike</td>
</tr>
<tr>
<td>- Fall from any height, including standing, with signs of traumatic brain injury</td>
</tr>
</tbody>
</table>

**KEY POINTS**

**Exceptions to Mandatory Transport to a Trauma Center:**

- Emergency Medical Service personnel shall transport a trauma victim directly to an adult or pediatric trauma center that is qualified to provide appropriate adult or pediatric care, unless one or more of the following exceptions apply:

1. It is medically necessary to transport the victim to another hospital for initial assessment and stabilization before transfer to an adult or pediatric trauma center;
2. It is unsafe or medically inappropriate to transport the victim directly to an adult or pediatric trauma center due to adverse weather or ground conditions or excessive transport time;
3. Transporting the victim to an adult or pediatric trauma center would cause a shortage of local emergency medical service resources;
4. No appropriate adult or pediatric trauma center is able to receive and provide adult or pediatric trauma care to the trauma victim without undue delay;
5. Before transport of a patient begins, the patient requests to be taken to a particular hospital that is not a trauma center or, if the patient is less than eighteen years of age or is not able to communicate, such a request is made by an adult member of the patient’s family or a legal representative of the patient.

**Glasgow Coma Scale**

**INFANT**

<table>
<thead>
<tr>
<th>Birth to age 4</th>
<th>ADULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Spontaneously</td>
<td>Age 4 to Adult</td>
</tr>
<tr>
<td>3 To speech</td>
<td>Spontaneously 4</td>
</tr>
<tr>
<td>2 To pain</td>
<td>To command 3</td>
</tr>
<tr>
<td>1 No response</td>
<td>To pain 2</td>
</tr>
<tr>
<td></td>
<td>No Response 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Verbal Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Coos, babbles</td>
</tr>
<tr>
<td>4 Irritable cries</td>
</tr>
<tr>
<td>3 Cries to pain</td>
</tr>
<tr>
<td>2 Moans, grunts</td>
</tr>
<tr>
<td>1 No response</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Best Motor Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Spontaneous</td>
</tr>
<tr>
<td>5 Localizes pain</td>
</tr>
<tr>
<td>4 Withdraws from pain</td>
</tr>
<tr>
<td>3 Flexion (decorticate)</td>
</tr>
<tr>
<td>2 Extension (decerbrate)</td>
</tr>
<tr>
<td>1 No response</td>
</tr>
</tbody>
</table>

___ = TOTAL

**ADULT**

<table>
<thead>
<tr>
<th>Age 4 to Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneously 4</td>
</tr>
<tr>
<td>To command 3</td>
</tr>
<tr>
<td>To pain 2</td>
</tr>
<tr>
<td>No Response 1</td>
</tr>
</tbody>
</table>

| Oriented 5     |
| Confused 4     |
| Inappropriate words 3 |
| Incomprehensible 2 |

| No response 1  |

| Obeys commands 6 |
| Localizes pain 5 |
| Withholds from pain 4 |
| Flexion (decorticlate) 3 |
| Extension (decerbrate) 2 |

| No response 1  |

TOTAL = ___
ABDOMINAL TRAUMA

UNIVERSAL PATIENT CARE PROTOCOL
BLEEDING / HEMORRHAGE CONTROL PROCEDURE
AIRWAY PROTOCOL
SPINAL MOTION RESTRICTION PROCEDURE
OXYGEN
CAPNOGRAPHY PROCEDURE
Determine if Load & Go

Evisceration: Cover, clean saline dressing to loosely stabilize
Penetrating Object: Cover, clean saline dressing – Immobilize object. If too large to transport – attempt to cut with care not to further injure tissue
Penetrating Wounds: Cover, clean saline dressing. Look for exit wound
Blunt Trauma: Assess for change – distention. Note mechanism

IV / IO PROCEDURE
To Maintain MAP > 70 or SBP 90 (100 systolic if >70 years old) / Radial Pulses if NIBP Unavailable
Monitor and Reassess
INITIATE TRAUMA ALERT
TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

Multiple Trauma Protocol if criteria

EMT Intervention | AEMT Intervention | PARAMEDIC Intervention | MED CONTROL Consult
# ADULT PROTOCOL

## ABDOMINAL TRAUMA

<table>
<thead>
<tr>
<th>MECHANISM</th>
<th>SIGNS &amp; SYMPTOMS</th>
</tr>
</thead>
</table>
| • Blunt     | • Altered mental status  
               • Shock  
               • Distention  
               • Swelling  
               • Bulging  
               • Nausea and vomiting  |
| • Penetrating | • Altered mental status  
                           • Bleeding  
                           • Tenderness  
                           • Pain  
                           • Distention  
                           • Evisceration  
                           • Discoloration  
                           • Entrance / exit wounds  
                           • Nausea & vomiting |

### KEY POINTS

Trauma to the abdomen is either Blunt or Penetrating. Blunt injuries are harder to detect and diagnose, and have a death rate twice that of penetrating wounds. Key signs and symptoms of blunt trauma include a patient in shock with no obvious injuries. Distention of the abdomen is an indication of internal hemorrhage. Pain may not be a significant factor. Many abdominal trauma injuries are Load & Go cases.

- Look for both an entrance and exit wound for all penetrating trauma, and treat accordingly.
- For all major trauma patients, the on scene time should be less than ten minutes.
**ADULT PROTOCOL**

**BURNS**

- **UNIVERSAL PATIENT CARE PROTOCOL**
- **CONSIDER SPINAL MOTION RESTRICTION PROCEDURE**
- **AIRWAY PROTOCOL**
- **OXYGEN**
- **CAPNOGRAPHY PROCEDURE**
  - If Chest, Neck, Face, Airway Involvement – Prepare for Invasive Airway Procedures – Perform Early Intubation Needle Cric or Quick Trach (If Approved)
- Remove rings, bracelets, and other constricting items

**Thermal**
- If burn < 10% body surface area (using rule of nines)
  - Cool down wound with NORMAL SALINE
- Cover burn with dry sterile sheet or dressings

**Chemical**
- Eye Injury
  - Continuous flushing with Normal Saline
- Remove clothing and/or expose area
- Flush area with NORMAL SALINE for 10 – 15 minutes

**SEVERE PAIN PROTOCOL**
- IV / IO PROCEDURE
  - Normal Saline bolus 20 mL / kg IV / IO
- Initiate Trauma Alert
  - TRANSPORT to appropriate facility
  - CONTACT receiving facility
  - CONSULT Medical Direction where indicated

**Parkland Burn Formula**

Fluid for first 24 hours (ml) = 4 x Patient's weight in kg x %BSA

The first half of this amount is delivered within 8 hours from the burn incident, and the remaining fluid is delivered in the next 16 hours
# ADULT PROTOCOL

## BURNS

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Type of exposure (heat, gas, chemical)</td>
<td>• Burns, pain, swelling</td>
<td>• Superficial (1°) red and painful</td>
</tr>
<tr>
<td>• Inhalation injury</td>
<td>• Dizziness</td>
<td>• Partial thickness (2°) superficial partial thickness, deep partial thickness, blistering</td>
</tr>
<tr>
<td>• Time of injury</td>
<td>• Loss of consciousness</td>
<td>• Full thickness (3°) painless and charred or leathery skin</td>
</tr>
<tr>
<td>• Past medical history</td>
<td>• Hypotension / shock</td>
<td>• Chemical</td>
</tr>
<tr>
<td>• Medications</td>
<td>• Airway compromise / distress</td>
<td>• Thermal</td>
</tr>
<tr>
<td>• Other trauma</td>
<td>• Singed facial or nasal hair</td>
<td>• Electrical</td>
</tr>
<tr>
<td>• Loss of consciousness</td>
<td>• Hoarseness / wheezing</td>
<td>• Radiation</td>
</tr>
<tr>
<td>• Tetanus / immunization status</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### KEY POINTS

- Exam: Mental Status, HEENT, Neck, Heart, Lungs, Abdomen, Extremities, Back, Neuro
- Early intubation is required in significant inhalation injuries.
- Critical Burns: >25% body surface area (BSA); full thickness burns >10% BSA; partial thickness superficial partial thickness, deep partial thickness and full thickness burns to face, eyes, hand or feet; electrical burns; respiratory burns; deep chemical burns; burns with extremes of age or chronic disease; and burns with associated major traumatic injury. These burns may require hospital admission or transfer to a burn center.
- Potential CO exposure should be treated with 100% oxygen.
- Circumferential burns to extremities are dangerous due to potential vascular compromise partial thickness to soft tissue swelling.
- Burn patients are prone to hypothermia – Never apply ice or cool burns that involve >10% body surface area.
- Do not overlook the possibility of multiple system trauma.
- Do not overlook the possibility of child abuse with children and burn injuries.
- See appendix for rule of nines.

**1. Thermal (dry and moist):**
- Stop burning process: i.e. remove patient from heat source, cool skin, remove clothing
- If patient starts to shiver or skin is cool, stop cooling process.
- Estimate extent (%) and depth of burn (see chart). Determine seriousness (see chart) of burn, contact Medical Control and transport accordingly. Cover burn areas with sterile dressing.

**2. Radiation Burns:**
- Treat as thermal burns except when burn is contaminated with radioactive source, then treat as chemical burn.
- Wear appropriate protective clothing when dealing with contamination.
- Contact HAZ MAT TEAM for assistance in contamination cases.

**3. Chemical Burns:**
- Wear appropriate protective clothing and respirators.
- Remove patient from contaminated area to decontamination site (NOT SQUAD).
- Determine chemicals involved; contact appropriate agency for chemical information.
- Remove patient’s clothing and flush skin.
- Leave contaminated clothes at scene. Cover patient over and under before loading into squad.
- Patient should be transported by personnel not involved in decontamination process.
- Determine severity (see chart), contact Medical Control and transport accordingly.
- Relate type of substance involved to Medical Control.

**4. Electrical Burns:**
- Shut down electrical source; do not attempt to remove patient until electricity is CONFIRMED to be shut off.
- Assess for visible entrance and exit wounds and treat as thermal burns.
- Assess for internal injury, i.e., vascular damage, tissue damage, fractures, and treat accordingly.
- Determine severity of burn, contact Medical Control and transport accordingly.

**5. Inhalation Burns:**
- Always suspect inhalation burns when the patient is found in closed smoky environment and / or exhibits any of the following: burns to face / neck, singed nasal hairs, cough and / or stridor, soot in sputum.
- Provide oxygen therapy, contact Medical Control and transport.

- Handle patients gently to avoid further damage of the patient’s skin.
- If the patient is exposed to a chemical, whenever possible, get the name of the chemical, and document it on the patient run report. DO NOT transport any hazardous materials with the patient.
- Look for signs of dehydration and shock.
- Initiate early intubation for symptomatic patients with inhalation burns.
- Patients with major burns should be transported to the a Regional Burn Center.
- Patients with unstable airway or who are rapidly deteriorating should be transported to the closest appropriate facility.
- Patients with large surface burns lose the ability to regulate their body temperature. Avoid heat loss by covering the patient.
CHEST TRAUMA

UNIVERSAL PATIENT CARE PROTOCOL

BLEEDING / HEMORRHAGE CONTROL PROCEDURE

AIRWAY PROTOCOL

SPINAL MOTION RESTRICTION PROTOCOL

HIGH FLOW OXYGEN

CAPNOGRAPHY PROCEDURE

If S&S of Tension Pneumothorax
(No lung sounds on affected side, Hypotension, JVD)
NEEDLE CHEST DECOMPRESSION PROCEDURE

IV / IO PROCEDURE
Normal Saline Bolus to Maintain MAP > 70
or SBP 90 (100 systolic if >70 years old) / Radial Pulses if NIBP Unavailable

APPLY CARDIAC MONITOR

Cardiac Tamponade: Assess for + Beck’s Triad (Hypotension, +JVD and muffled heart sounds). Paradoxical Pulse (no radial pulse when breathing in) is likely. LOAD AND GO

Massive Hemothorax: Shock, then difficulty breathing. No JVD, decreased breath sounds, dull to percussion. LOAD AND GO

Open Pneumothorax / Sucking Chest Wound: Close wound with occlusive dressing secured on THREE SIDES or commercial device. LOAD AND GO

Flail Chest: Stabilize flail segment with manual pressure then apply bulky dressing and tape. LOAD AND GO

Suspected: Traumatic Aortic Rupture, Tracheal or Bronchial Tree Injury, Myocardial Contusion, Diaphragmatic Tears, Esophageal Injury, And Pulmonary Contusion:
Ensure an Airway, Administer Oxygen, LOAD AND GO

INITIATE TRAUMA ALERT

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated
# CHEST TRAUMA

## SIGNS AND SYMPTOMS

<table>
<thead>
<tr>
<th>SIMPLE PNEUMOTHORAX</th>
<th>OPEN PNEUMOTHORAX</th>
<th>TENSION PNEUMOTHORAX</th>
<th>HEMOTHORAX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shortness of breath</td>
<td>Shortness of breath</td>
<td>Shortness of breath</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>Dyspnea</td>
<td>Dyspnea</td>
<td>Dyspnea</td>
</tr>
<tr>
<td>Tachypnea</td>
<td>Cyanosis</td>
<td>Shock</td>
<td>Cyanosis</td>
</tr>
<tr>
<td>Cyanosis</td>
<td>Sucking chest wound</td>
<td>Absent / diminished</td>
<td>Absent / diminished</td>
</tr>
<tr>
<td>Chest pain</td>
<td>Shock</td>
<td>Lung sounds</td>
<td>Lung sounds</td>
</tr>
<tr>
<td>Absent diminished</td>
<td>Absent / diminished</td>
<td>Tracheal deviation</td>
<td>Tracheal deviation</td>
</tr>
<tr>
<td>Lung sounds on the</td>
<td>Lung sounds on the</td>
<td>Hypotension</td>
<td>Hypotension</td>
</tr>
<tr>
<td>affected side</td>
<td>affected side</td>
<td>JVD</td>
<td>Shock</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tachycardia</td>
<td>Absent / diminished</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dyspnea (late sign)</td>
<td>breath sounds</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Tachycardia</td>
</tr>
</tbody>
</table>

## CARDIAC TAMponade

<table>
<thead>
<tr>
<th>CARDIAC TAMponade</th>
<th>TRAUMATIC ASPHYXIA</th>
<th>FLAIL CHEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypotension</td>
<td>Bloodshot, bulging eyes</td>
<td>Paradoxical chest wall movement</td>
</tr>
<tr>
<td>Decreasing pulse pressure</td>
<td>Blue, bulging tongue</td>
<td>Asymmetric chest movement</td>
</tr>
<tr>
<td>Elevated neck veins</td>
<td>JVD</td>
<td>Upon inspiration</td>
</tr>
<tr>
<td>Muffled heart tones</td>
<td>Cyanotic upper body</td>
<td>Dyspnea</td>
</tr>
<tr>
<td>Bruising over the sternum</td>
<td></td>
<td>Unstable chest segment</td>
</tr>
<tr>
<td>Tachycardia</td>
<td></td>
<td>Significant chest wall pain</td>
</tr>
</tbody>
</table>

## KEY POINTS

Thoracic injuries have been called the deadly dozen. The first six are obvious at the primary assessment.

1. Airway obstruction
2. Flail chest
3. Cardiac tamponade
4. Massive hemothorax
5. Open pneumothorax
6. Tension pneumothorax

The second six injuries may be more subtle and not easily found in the field:

7. Traumatic aortic rupture
8. Esophageal injury
9. Myocardial contusion
10. Diaphragmatic tears
11. Tracheal / bronchial tree injury
12. Pulmonary contusion

- **A sucking chest wound** is when the thorax is open to the outside. The occlusive dressing may be anything such as petroleum gauze, plastic, or a defibrillator pad. Tape only 3 sides down so that excess intrathoracic pressure can escape, preventing a tension pneumothorax. May help respirations to place patient on the injured side, allowing unaffected lung to expand easier.

- **A flail chest** is when there are extensive rib fractures present, causing a loose segment of the chest wall resulting in paradoxical and ineffective air movement. This movement must be stopped by applying a bulky pad to inhibit the outward excursion of the segment. Positive pressure breathing via BVM will help push the segment and the normal chest wall out with inhalation and to move inward together with exhalation, getting them working together again. Do not use too much pressure to prevent additional damage or pneumothorax.

- **A penetrating object** must be immobilized by any means possible. If it is very large, cutting may be possible, with care taken not to move it about when making the cut. Place an occlusive and bulky dressing over the entry wound.

- **A tension pneumothorax** is life threatening, look for HYPOTENSION, unequal breath sounds, JVD, increasing respiratory distress, and decreasing mental status. The pleura must be decompressed with a needle to provide relief. Decompress between the 2nd and 3rd ribs, midclavicular placing the catheter over the 3rd rib. Once the catheter is placed, watch closely for reocclusion. Repeat if needed to prevent reocclusion. Decompress with 3.25” 14 ga catheter or Chest Decompression Needle based on patient’s size.
**UNIVERSAL PATIENT CARE PROTOCOL**

**SPINAL MOTION RESTRICTION PROCEDURE**
Place backboard while still in water if able.

**AIRWAY PROTOCOL**
Initiate ventilation while patient is still in water if not breathing.

**IF DECOMPRESSION SICKNESS**
Give oxygen – no positive pressure ventilation unless NOT breathing.

**OXYGEN ASAP**

**CAPNOGRAPHY PROCEDURE**

Apply Cardiac Monitor

**IF HYPOTHERMIC**
*Treat per HYPOTHERMIA PROTOCOL*

**IV / IO PROCEDURE**
Normal Saline TKO

Monitor and Reassess

**TRANSPORT** to appropriate facility
**CONTACT** receiving facility
**CONSULT** Medical Direction where indicated
### HISTORY
- Submersion in water regardless of depth
- Possible trauma i.e.; fall, diving board
- Duration of immersion
- Temperature of water
- Salt vs. fresh water

### SIGNS AND SYMPTOMS
- Period of unconsciousness
- Unresponsive
- Mental status changes
- Decreased or absent vital signs
- Vomiting
- Coughing

### DIFFERENTIAL DIAGNOSIS
- Trauma
- Pre-existing medical problem
- Barotrauma (diving)
- Decompression sickness

### KEY POINTS
- Exam: Trauma Survey, Head, Neck, Chest, Abdomen, Pelvis, Back, Extremities, Skin, Neuro
- Drowning due to suffocation from submersion in water.
- 2 causes – breath holding which leads to aspiration of water; & laryngospasm which closes the glottis.
- Both causes lead to profound hypoxia and death.
- Fresh water drowning ventricular fibrillation may be likely.
- Salt water drowning may cause pulmonary edema in time.
- Pulmonary edema can develop within 24 - 48 hours after submersion.
- All victims should be transported for evaluation due to potential for worsening over the next several hours.
- Drowning is a leading cause of death among would-be rescuers.
- Allow appropriately trained and certified rescuers to remove victims from areas of danger.
- With pressure injuries (decompression / barotrauma), consider transport for availability of a hyperbaric chamber.
- All hypothermic / hypothermic / near-drowning patients should have resuscitation performed until care is transferred, or if there are other signs of obvious death (putrification, traumatic injury unsustainable to life).
- A drowning patient is in cardiac arrest after the submersion.
- Consider a c-spine injury in all drowning cases. Always immobilize a drowning patient.
- Patients with low core temperatures will not respond to ALS drug interventions. Maintain warming procedures and supportive care.
- DO NOT perform the Heimlich maneuver to remove water from the lungs prior to resuscitation.
EXTREMITY TRAUMA / AMPUTATION

UNIVERSAL PATIENT CARE PROTOCOL

BLEEDING / HEMORRAGE CONTROL PROCEDURE

Risk of Exsanguination?
* Internally or Externally
Upper Extremities Apply Commercial Tourniquet
Lower Extremities 2 Commercial Tourniquets

OXYGEN

IV / IO PROCEDURE

SEVERE PAIN MANAGEMENT PROTOCOL

* Consider Sedation for Complicated Extrication
LORAZEPAM (ATIVAN)
1 – 2 mg IV / IO / IN / IM

If Lorazepam (Ativan) is unavailable,
See Medication Section for Midazolam (Versed)

CAPNOGRAPHY REQUIRED FOR SEDATION / PAIN
MANAGEMENT OF TRAUMA PATIENT

Contact MED CONTROL if
LORAZEPAM (ATIVAN) needed in Head Injury

Amputation?

Clean amputated part with normal saline
irrigation

Wrap part in sterile dressing and place in
plastic bag if able

Place on ice if available – no direct contact to
tissue

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

Consider
Multiple Trauma
Protocol where indicated
# Extremity Trauma / Amputation

## History
- Type of injury
- Mechanism: crush / penetrating / amputation
- Time of injury
- Open vs. closed wound / fracture
- Wound contamination
- Medical history
- Medications

## Signs and Symptoms
- Pain, swelling
- Deformity
- Altered sensation / motor function
- Diminished pulse / capillary refill
- Decreased extremity temperature

## Differential Diagnosis
- Abrasion
- Contusion
- Laceration
- Sprain
- Dislocation
- Fracture
- Amputation

## Key Points
- Exam: Mental Status, Extremity, Neuro
- In amputations, time is critical. Transport and notify medical control immediately, so that the appropriate destination can be determined.
- Hip dislocations and knee and elbow fracture / dislocations have a high incidence of vascular compromise.
- Urgently transport any injury with vascular compromise.
- Blood loss may be concealed or not apparent with extremity injuries.
- Lacerations must be evaluated for repair within 6 hours from the time of injury.

### Extremity Trauma
- In cases of major trauma, the backboard can work as a whole body splint.
- DO NOT take the time to splint injured extremities in major trauma patients unless it does not delay the scene time or prevents you from performing more pertinent patient care.
- Splint the extremity if the patient has signs and symptoms of a fracture or dislocation.
- Treat all suspected sprains or strains as fractures until proven otherwise.
- Splint the joint above and below for all suspected fractures.
- Splint the bone above and below for all suspected joint injuries.
- Check and document the patient’s MSP’s before and after splinting.
- A traction splint with a backboard is the preferred splint to use for femur fractures.

### Traumatic Amputation
- Care of the amputated extremity include:
  - Cleanse an amputated extremity with normal saline or sterile water.
  - DO NOT place any amputated tissue directly on ice or cold pack. Instead, place the amputated limb into a plastic bag. Put the bag into a container of cool water with a few ice cubes (if available).
- Contact the receiving hospital with the patient information, and include the status of the amputated limb.
- Focus on patient care and not on the amputated extremity.
- Tourniquets should be applied early if there is a risk of exsanguination (bleeding out) from extremity injury.
- Remember to calm and reassure the patient. Do not give the patient or their family member’s false hope of re-attachment of the affected limb. A medical team at the receiving hospital makes this decision.
- Delegate someone to do an on scene search for the amputated part when it cannot be readily found and continue with patient care.
UNIVERSAL PATIENT CARE PROTOCOL
Oxygen for all head trauma

SPINAL MOTION RESTRICTION PROCEDURE
BLEEDING / HEMORRHAGE CONTROL PROCEDURE

Determine and Trend GCS

Consider Other Protocols
Multiple Trauma Protocol
(if Not Isolated Head Trauma)
Altered Level of Consciousness Protocol
Seizure Protocol (if Seizure Activity)

Evidence of, or Suspect Traumatic Brain Injury (TBI)?

AIRWAY PROTOCOL

Do NOT HYPERVENTILATE

Isolated Uncomplicated Head Trauma?

Do NOT allow patient to become hypotensive

AIRWAY PROTOCOL

Limit IV fluids due to cerebral edema
To Maintain MAP > 70 or SBP 90
(100 systolic if >70 years old) / Radial Pulses if NIBP Unavailable

Do NOT allow patient to become hypotensive

IV / IO PROCEDURE

Evidence of, or Suspect Traumatic Brain Injury (TBI)?

AIRWAY PROTOCOL

Do NOT Allow Patient to Become Hypoxic During ANY Airway Management
Maintain SpO2 > 94% At All Times!
Apply Capnography If Advanced Airway Used

Herniation = Unilateral or Bilateral Dilation of Pupils, Posturing

If Herniation Ventilate To Maintain CO2 30 - 35 Or 14 - 16 Breaths / Min

If Non - Herniation Ventilate To Maintain CO2 35 - 40 Or 10 - 12 Breaths / Min

IV / IO PROCEDURE

Normal Saline Bolus to Maintain MAP > 90
or SBP 110 / Radial Pulses if NIBP Unavailable

Do NOT allow patient to become hypotensive

Monitor and Reassess

INITIATE TRAUMA ALERT

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

EMT Intervention
AEMT Intervention
PARAMEDIC Intervention
MED CONTROL Consult
### HISTORY
- Time of injury
- Mechanism: blunt / penetrating
- Loss of consciousness
- Bleeding
- Medical history
- Medications
- Evidence of multi-trauma
- Helmet use or damage to helmet

### SIGNS AND SYMPTOMS
- Pain, swelling, bleeding
- Altered mental status
- Unconscious
- Respiratory distress / failure
- Vomiting
- Significant mechanism of injury

### DIFFERENTIAL DIAGNOSIS
- Skull fracture
- Brain injury (concussion, contusion, hemorrhage, or laceration)
- Epidural hematoma
- Subdural hematoma
- Subarachnoid hemorrhage
- Spinal injury
- Abuse

<table>
<thead>
<tr>
<th>INFANT</th>
<th>Eye Opening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to age 4</td>
<td>4 Spontaneously</td>
</tr>
<tr>
<td>3 To speech</td>
<td>2 To pain</td>
</tr>
<tr>
<td>1 No response</td>
<td>5 Coos, babbles</td>
</tr>
<tr>
<td>4 Irritable cries</td>
<td>3 Cries to pain</td>
</tr>
<tr>
<td>2 Moans, grunts</td>
<td>1 No response</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
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<tr>
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</tr>
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<table>
<thead>
<tr>
<th>Best Verbal Response</th>
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</thead>
<tbody>
<tr>
<td>Oriented 5</td>
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<td>Extension (decerebrate) 2</td>
</tr>
<tr>
<td>No response 1</td>
</tr>
</tbody>
</table>

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**KEY POINTS**

- **Exam:** Mental Status, HEENT, Heart, Lungs, Abdomen, Extremities, Back, Neuro
- If GCS < 12 consider air / rapid transport and if GCS < 9 intubation should be anticipated.
- **GCS < 9? Intubate!**
  - Do NOT allow patients to become hypoxic, maintain SpO2 > 94%, abandon intubation attempts if this cannot be maintained. Secure airway by other means.
  - Increased intracranial pressure (ICP) may cause **hypertension** and bradycardia (Cushing's Reflex).
  - **Hypotension** usually indicates injury or shock unrelated to the head injury and should be aggressively treated.
  - Limit IV fluids unless patient is hypotensive (systolic BP < 90) fluid resuscitate if necessary to maintain BP, Do NOT allow patients to become hypotensive.
  - **DO NOT** attempt to lower the blood pressure in hypertensive head injured patients with medications such as Nitroglycerine (Nitro-Stat).
  - Be alert for c-spine injuries with head trauma.
  - Continually reassess the patient, including pupils, LOC, and neurological status.
  - Any decrease in GCS suggests a TBI surgical emergency, transport to trauma center
  - Capnography is critical! Maintain the CO2 ranges indicated in protocol, 1 point of CO2 change = 3% decrease in cerebral perfusion.
  - The most important item to monitor, trend, and document is a change in the level of consciousness / GCS.
  - Herniation may occur. Signs are:
    - Cushing's reflex; Bradycardia, hypertension, widening pulse pressure
    - Decreasing level of consciousness progressing towards coma.
    - Dilation of pupils – may be unilateral or bilateral
    - Decerebrate posturing (extension of arms and legs)
    - Decorticate posturing (flexion arms and legs)
  - Concussions are periods of confusion or LOC associated with trauma, which may have resolved by the time EMS arrives. A physician ASAP should evaluate any prolonged confusion or mental status abnormality, which does not return to normal within 15 minutes or any documented loss of consciousness.
  - Consider **Restraints** if necessary for patient's and / or personnel's protection per the RESTRAINT PROCEDURE.
**MAXILLOFACIAL / EYE TRAUMA**

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| • Trauma of any type that results in injury to one or both eyes. | • Irritation to eye  
• Visual disturbances  
• Obvious penetrating injury  
• Burn (chemical, thermal)  
• Loss of vision  
• Dizziness  
• Loss of consciousness  
• Nausea | • Hypertension  
• Contact lens problem |

**KEY POINTS**

• If unsure if something can be flushed with water, contact Medical Command.
• A garden hose can be used to help flush the patient’s eye(s) if available. **DO NOT** use a high-pressure hose or at a high force. If needed, irrigate the patient’s eyes for approximately 5-15 minutes.
• Begin irrigating immediately, because irreversible damage can occur in a few minutes.

**TRAUMA**

• Do not allow eye injury to distract you from the basics of trauma care.
• Do not remove any foreign body imbedded in the eye or orbit. Stabilize any large protruding foreign bodies.
• With blunt trauma to the eye, if time permits, examine the globe briefly for gross laceration as the lid may be swollen tightly shut later. Sclera rupture may lie beneath an intact conjunctiva.
• Covering both eyes when only one eye is injured may help to minimize trauma to the injured eye, but in some cases the patient is too anxious to tolerate this.
• Transport patient supine unless other life threats prohibit this from being done. (This is based on physics, the goal of not letting the fluid within the eye drain out of the eye)

**CHEMICAL BURNS**

• When possible determine type of chemical involved first. The eye should be irrigated with copious amounts of water or saline, using IV tubing wide open for a minimum of 15 minutes started as soon as possible. Any delay may result in serious damage to the eye.
• Always obtain name and, if possible, a sample of the contaminant or ask that they be brought to the hospital as soon as possible.

**CONTACT LENSES**

• If possible, contact lenses should be removed from the eye; be sure to transport them to the hospital with the patient. If the lenses cannot be removed, notify the ED personnel as soon as possible.
• If the patient is conscious and alert, it is much safer and easier to have the patient remove their lenses.

**ACUTE, UNILATERAL VISION LOSS**

• When a patient suddenly loses vision in one eye with no pain, there may be a central retinal artery occlusion. Urgent transport and treatment is necessary.
• Patient should be transported flat.
Consider Air transport if delay due to extrication

**UNIVERSAL PATIENT CARE PROTOCOL**

**AIRWAY PROTOCOL**

**BLEEDING / HEMORRHAGE CONTROL PROCEDURE**

**SPINAL MOTION RESTRICTION PROCEDURE**

**Rapid Trauma Assessment**

**CAPNOGRAPHY PROCEDURE**

**Attach Cardiac Monitor**

**IV / IO PROCEDURE**

**Assess Vital Signs / Perfusion**

- **Abnormal**
  - **Reassess Airway**
  - **Ventilate Appropriately**
  - **NORMAL SALINE BOLUS**
    To Maintain MAP > 70 or SBP 90 (100 systolic if >70 years old) / Radial Pulses if NIBP Unavailable
  - **Monitor and Reassess**
  - **Continued Hypotension?**
    - **Trauma Arrest?**
    - **Consider NEEDLE DECOMPRESSION**

- **Normal**
  - **Ongoing Assessment**
  - **Monitor and Reassess**
  - **Treat per Appropriate Protocol**

**INITiate TRAUMA ALERT**

**TRANSPORT** to appropriate facility

**CONTACT** receiving facility

**CONSULT** Medical Direction where indicated

---

**EMT Intervention**

**AEMT Intervention**

**PARAMEDIC Intervention**

**MED CONTROL Consult**
## MULTIPLE TRAUMA

**HISTORY**
- Time and mechanism of injury
- Damage to structure or vehicle
- Location in structure or vehicle
- Others injured or dead
- Speed and details of MVC
- Restraints / protective equipment
- Past medical history
- Medications

**SIGNS AND SYMPTOMS**
- Pain, swelling
- Deformity, lesions, bleeding
- Altered mental status or unconscious
- Hypotension or shock
- Arrest

**DIFFERENTIAL DIAGNOSIS**
- Flail chest
- Tension pneumothorax
- Pericardial tamponade
- Open chest wound
- Hemothorax
- Intra-abdominal bleeding
- Pelvis / femur fracture
- Spine fracture / spinal cord injury
- Head injury
- Extremity fracture / dislocation
- HEENT (airway obstruction)
- Hypothermia

### KEY POINTS
- Exam: Mental Status, Skin, HEENT, Heart, Lung, Abdomen, Extremities, Back, Neuro
- Mechanism is the most reliable indicator of serious injury.
- In prolonged extrications or serious trauma, consider air transportation for transport times and the ability to give blood.
- Do not overlook the possibility of associated domestic violence or abuse
# Adult Protocol

## Trauma Arrest

<table>
<thead>
<tr>
<th>History</th>
<th>Signs and Symptoms</th>
<th>Differential Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of injury</td>
<td>Excessive bleeding</td>
<td>Obvious DOA</td>
</tr>
<tr>
<td>Mechanism: blunt / penetrating</td>
<td>Unresponsive; not breathing</td>
<td>Death</td>
</tr>
<tr>
<td>Loss of consciousness</td>
<td>Cardiac arrest</td>
<td></td>
</tr>
<tr>
<td>Bleeding</td>
<td>Significant mechanism of injury</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of multi-trauma</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Key Points
- Immediately transport traumatic cardiac arrest patients.
- With the exception of airway management, traumatic cardiac arrests are “load and go” situations.
- Resuscitation should not be attempted in cardiac arrest patients with spinal transection, decapitation, or total body burns, nor in patients with obvious, severe blunt trauma that are without vital signs, pupillary response, or an organized or shockable cardiac rhythm at the scene. Patients in cardiac arrest with deep penetrating cranial injuries and patients with penetrating cranial or truncal wounds associated with asystole and a transport time of more than 15 minutes to a definitive care facility are unlikely to benefit from resuscitative efforts.
- Extensive, time-consuming care of trauma victims in the field is usually not warranted. Unless the patient is trapped, they should be enroute to a medical facility within 10 minute after arrival of the ambulance on the scene.

### Universal Patient Care Protocol

- **Bleeding / Hemorrhage Control Procedure**
- **Spinal Motion Restriction Protocol**
- **Airway Protocol**
  - Begin Resuscitation
- **Capnography Procedure**
  - Consider Needle Decompression
- **IV / IO Procedure**
  - Apply Cardiac Monitor
  - Appropriate Protocol based on Signs and Symptoms
  - **Initiate Trauma Alert**
  - Transport to appropriate facility
  - Contact receiving facility
  - Consult Medical Direction where indicated
## GLASGOW COMA SCALE

<table>
<thead>
<tr>
<th>EYES</th>
<th>GCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPONTANEously</td>
<td>4</td>
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<td>TO VERBAL COMMAND</td>
<td>3</td>
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<tr>
<td>TO PAIN</td>
<td>2</td>
</tr>
<tr>
<td>NO RESPONSE</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BEST MOTOR RESPONSE</th>
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</thead>
<tbody>
<tr>
<td>OBEYS VERBAL COMMAND</td>
<td>6</td>
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<tr>
<td>PURPOSEFUL MOVEMENT TO PAIN</td>
<td>5</td>
</tr>
<tr>
<td>FLEXION - WITHDRAWAL</td>
<td>4</td>
</tr>
<tr>
<td>FLEXION – ABNORMAL</td>
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<tr>
<td>EXTENSION</td>
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<td>NO RESPONSE</td>
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<table>
<thead>
<tr>
<th>BEST VERBAL RESPONSE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>ORIENTED &amp; CONVERSES</td>
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</tr>
<tr>
<td>DISORIENTED &amp; CONVERSES</td>
<td>4</td>
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<tr>
<td>INAPPROPRIATE WORDS</td>
<td>3</td>
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<tr>
<td>INCOMPREHENSIBLE SOUNDS</td>
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<tr>
<td>NO RESPONSE</td>
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</table>

## REVISED TRAUMA SCORE

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<thead>
<tr>
<th>GLASGOW COMA SCALE</th>
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<tbody>
<tr>
<td>13 – 15</td>
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<tr>
<td>9 – 12</td>
<td>3</td>
</tr>
<tr>
<td>6 – 8</td>
<td>2</td>
</tr>
<tr>
<td>4 – 5</td>
<td>1</td>
</tr>
<tr>
<td>0 – 3</td>
<td>0</td>
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</table>

<table>
<thead>
<tr>
<th>RESPIRATORY RATE</th>
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</tr>
</thead>
<tbody>
<tr>
<td>GREATER THAN 29</td>
<td>4</td>
</tr>
<tr>
<td>10 – 29</td>
<td>3</td>
</tr>
<tr>
<td>6 – 9</td>
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<tr>
<td>1 – 5</td>
<td>1</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
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<table>
<thead>
<tr>
<th>SYSTOLIC BLOOD PRESSURE</th>
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<tbody>
<tr>
<td>GREATER THAN 89</td>
<td>4</td>
</tr>
<tr>
<td>76 – 89</td>
<td>3</td>
</tr>
<tr>
<td>50 – 75</td>
<td>2</td>
</tr>
<tr>
<td>1 – 49</td>
<td>1</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
1% is equal to the surface of the palm of the patient's hand. If unsure of %, describe injured area.

**MAJOR BURN CRITERIA**

- 2° and 3° burns > 10% surface area
- Burns of the face, hands feet genitalia
- Electrical shock with burn injury
- Burn with inhalation injury any burn with potential functional or cosmetic impairment
PEDIATRIC AIRWAY / BREATHING

Pediatric Airway ........................................................................................................................... 2-7
Pediatric Foreign Body Airway Obstruction (FBAO) ................................................................. 4-7
Pediatric Respiratory Distress – Upper Airway (Croup)............................................................ 6-7
Pediatric Respiratory Distress – Lower Airway ....................................................................... 8-7
Pediatric Traumatic Breathing .................................................................................................. 10-7
**KEY POINTS**

- EtCo2 measurement is mandatory with all methods of intubation. Document results of SpO2.
- Limit intubation attempts to 2 per patient max.
- BVM and oral airway is acceptable means of airway control and ventilation during prehospital care.
- If unable to intubate, continue BVM ventilations, transport rapidly, and notify receiving hospital early.
- Provide Spinal Motion Restriction for patients with suspected spinal injury.
- Do not assume hyperventilation is psychogenic - use oxygen, not a paper bag.
- Consider c-collar to help maintain ETT placement for all intubated patients.

---

**Universal Patient Care Protocol**

- Assess ABC’s
  - Respiratory Rate, Effort, and Adequacy

**Adequate**

- Supplemental OXYGEN

**Inadequate**

- Oxygenate
  - Ventilate
  - Position
  - Reassess

- Positive Respirations / Gag Reflex

**Obstruction**

- Pediatric Foreign Body Airway Obstruction Protocol
  - Direct Laryngoscopy
  - Attempt Removal with Magill Forceps

**Capnography Procedure**

**Intubation Procedure**

**Pediatric BIAD**

- continue
  - Apneic / No gag reflex
    - CAPNOGRAPHY PROCEDURE
    - INTUBATION PROCEDURE
    - Pediatric BIAD

- Bag – Valve – Mask Ventilations

- TRANSPORT to appropriate facility
- CONTACT receiving facility
- CONSULT Medical Direction where indicated

---

**Transport**

**To appropriate facility**

**Consult**

**Medical Direction**

---

**Emergency Medical Technician (EMT)**

**Advanced Emergency Medical Technician (AEMT)**

**Paramedic (PARAMEDIC)**

**Medical Control (MED CONTROL)**

---

**University Hospitals EMS Protocol - 2 | 7**
FOREIGN BODY AIRWAY OBSTRUCTION (FBAO)

Infant (0 – 12 months)

- Head Tilt / Chin Lift / Jaw Thrust / Airway Maneuvers

  - Coughing Conscious
    - Encourage patient to cough
    - OXYGEN 10 – 15 L Infant Mask as tolerated
  - Complete Obstruction Conscious
    - 5 Back Blows / 5 Chest thrusts
  - Complete Obstruction Unconscious
    - Visualize Finger Sweep (Only if visualized / attainable)
    - Consider use of Laryngoscope / Magill Forceps
    - Open airway / ventilate (May reposition and repeat)
    - Chest Compressions / CPR
    - If unable to ventilate, repeat / continue sequence

Child (1 – 8 years)

- Head Tilt / Chin Lift / Jaw Thrust / Airway Maneuvers

  - Coughing Conscious
    - Encourage patient to cough
    - OXYGEN 10 – 15 LPM Pediatric Mask as tolerated
  - Complete Obstruction Conscious
    - Abdominal Thrusts
  - Complete Obstruction Unconscious
    - Visualize Finger Sweep (Only if visualized / attainable)
    - Consider use of Laryngoscope / Magill Forceps
    - Open airway / ventilate (May reposition and repeat)
    - Chest Compressions / CPR
    - If unable to ventilate, repeat / continue sequence

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

EMT Intervention AEMT Intervention PARAMEDIC Intervention MED CONTROL Consult
# FOREIGN BODY AIRWAY OBSTRUCTION (FBAO)

## HISTORY
- Coughing
- Choking
- Inability to speak
- Unresponsive

## SIGNS AND SYMPTOMS
- Witnessed aspiration
- Sudden episode of choking
- Audible stridor
- Change in skin color
- Decreased LOC
- Increased / decreased Respiratory rate
- Labored breathing
- Unproductive cough

## DIFFERENTIAL DIAGNOSIS
- Cardiac arrest
- Respiratory arrest
- Anaphylaxis

### KEY POINTS
- Infants 0 -12 months DO NOT receive abdominal thrusts. Use chest thrusts.
- NEVER perform blind finger sweeps in infants or children.
- Attempt to clear the airway should only be made if foreign body aspiration is witnessed or very strongly suspected and there is complete airway obstruction.
- Even with a complete airway obstruction, positive-pressure ventilation is often successful.
RESPIRATORY DISTRESS UPPER AIRWAY - CROUP

UNIVERSAL PATIENT CARE PROTOCOL
IF WHEEZING GO TO RESPIRATORY DISTRESS LOWER AIRWAY PROTOCOL

Calm Patient
Position Patient Sitting Upright
Do not Lay Patient Down
Do Not Perform Digital Airway Exam

PULSE OXIMETRY PROCEDURE
CARDIAC MONITOR

Mild – Moderate Distress
Aerosol
Cool Mist with Normal Saline

Severe Distress - Stridor / Bark at Rest
RACEMIC EPINEPHRINE
Unit Dose (2.25% 0.5ml) mixed in 3ml of Normal Saline
Nebulized x1 Dose

These patient present with “Seal Bark Cough” or Stridor. If Patient is wheezing, it is a lower airway etiology and should be treated by the Respiratory Distress Lower Airway Protocol

TRANSPORT to appropriate facility CONTACT receiving facility CONSULT Medical Direction where indicated
# RESPIRATORY DISTRESS UPPER AIRWAY - CROUP

## HISTORY
- Time of onset
- Possibility of foreign body
- Medical history
- Medications
- Fever or respiratory infection
- Other sick siblings
- History of trauma

## SIGNS AND SYMPTOMS
- Anxious appearance
- Barking cough
- Stridor
- Gagging
- Drooling
- Inability to swallow
- Increased respiratory effort

## DIFFERENTIAL
- Asthma
- Aspiration
- Foreign body
- Infection
- Pneumonia
- Epiglottis
- Congenital heart disease
- Medication or toxin
- Trauma

## KEY POINTS
- **Exam:** Mental Status, HEENT, Skin, Neck, Heart, Lungs, Abdomen, Extremities, Neuro
- **CONSIDER FOREIGN BODY AIRWAY OBSTRUCTION**
- Do not force a child into a position. They will protect their airway by their body position.
- The most important component of respiratory distress is airway control.
- **Croup** typically affects children < 2 years of age. It is viral, possible fever, gradual onset, no drooling is noted.
- **Epiglottitis** typically affects children > 2 years of age. It is bacterial, with fever, rapid onset, possible stridor, patient wants to sit up to keep airway open, and drooling is common. Airway manipulation may worsen the condition. DO NOT attempt invasive procedures on the conscious patient who is suspected to have epiglottitis.
- DO NOT attempt an invasive airway procedure unless the patient is in respiratory arrest.
- **Stridor,** gagging or choking in the breathing patient with respiratory distress may indicate upper airway obstruction.
- **Wheezing** in the breathing patient with respiratory distress indicates lower airway disease, which may come from a variety of causes. The patient with severe lower airway disease may have altered LOC, be unable to talk, may have absent or markedly decreased breath sounds and severe retractions with accessory muscle use.
- If the patient has signs of respiratory failure, begin to assist ventilations with BVM, even when they are breathing.
RESPIRATORY DISTRESS LOWER AIRWAY

UNIVERSAL PATIENT CARE PROTOCOL

PULSE OXIMETRY PROCEDURE

CAPNOGRAPHY PROCEDURE

CARDIAC MONITOR

Respiratory Failure?

Yes

No

Pediatric Airway Protocol

Position to Patient Comfort

MILD / MODERATE

ALBUTEROL (PROVENTIL) Nebulized Unit Dose

EPINEPHRINE (ADRENALINE) 0.01 mg / kg IM of 1 mg / ml (1:1000) Max dose 0.5 mg

May Repeat x1 if Required

EMT use only with DIRECT Medical Control

TRANSPORT to appropriate facility

CONTACT receiving facility

CONSULT Medical Direction where indicated

Severe

DUONEB (ALBUTEROL / IPRATROPIUM) Nebulized Unit Dose

IV PROCEDURE Attempt only if severe respiratory distress

EMT use only with DIRECT Medical Control

If the patient presents with stridor, or a “seal bark cough”, it is a upper airway etiology and should be treated by the Respiratory Distress Upper Airway – Croup Protocol
# Pediatric Protocol

## Respiratory Distress Lower Airway

<table>
<thead>
<tr>
<th>History</th>
<th>Signs and Symptoms</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of onset</td>
<td>Wheezing or stridor</td>
<td>Asthma</td>
</tr>
<tr>
<td>Possibility of foreign body</td>
<td>Respiratory retractions</td>
<td>Aspiration</td>
</tr>
<tr>
<td>Medical history</td>
<td>Increased heart rate</td>
<td>Foreign body</td>
</tr>
<tr>
<td>Medications</td>
<td>Altered level of consciousness</td>
<td>Infection</td>
</tr>
<tr>
<td>Fever or respiratory infection</td>
<td>Anxious appearance</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>Other sick siblings</td>
<td></td>
<td>Epiglottitis</td>
</tr>
<tr>
<td>History of trauma</td>
<td></td>
<td>Congenital heart disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication or toxin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trauma</td>
</tr>
</tbody>
</table>

### Key Points

- **Exam:** Mental Status, HEENT, Skin, Neck, Heart, Lungs, Abdomen, Extremities, Neuro
- Do not force a child into a position. They will protect their airway by their body position.
- The most important component of respiratory distress is airway control.
- **DO NOT** attempt an invasive airway procedures unless the patient is in respiratory arrest.
- For some patients in severe respiratory distress, wheezing may not be heard. Albuterol (Proventil) and Ipratropium (Atrovent) for the known asthmatic in severe respiratory distress.
- Stridor, gagging or choking in the breathing patient with respiratory distress may indicate upper airway obstruction.
- Wheezing in the breathing patient with respiratory distress indicates lower airway disease, which may come from a variety of causes. The patient with severe lower airway disease may have altered LOC, be unable to talk, may have absent or markedly decreased breath sounds and severe retractions with accessory muscle use.
- If the patient has signs of respiratory failure, begin to assist ventilations with BVM, even when they are breathing.
- Contact Medical Direction for patients with a cardiac history.
TRAUMATIC BREATHING

KEY POINTS

- These injuries involve the airway and are life-threatening.
- Do not become distracted by non-life-threatening injuries that appear terrible.
- A sucking chest wound is when the thorax is open to the outside. The occlusive dressing may be anything such as petroleum gauze, plastic, or a defibrillator pad. Tape only 3 sides down so that excess intrathoracic pressure can escape, preventing a tension pneumothorax. It may help respirations to place patient on the injured side, allowing unaffected lung to expand easier.
- A flail chest is when there are extensive rib fractures present, causing a loose segment of the chest wall resulting in paradoxical and ineffective air movement. This movement must be stopped by applying a bulky pad to inhibit the outward excursion of the segment. Positive pressure breathing via BVM will help push the segment and the normal chest wall out with inhalation and to move inward together with exhalation, getting them working together again. Do not use too much pressure, as to prevent additional damage or pneumothorax.
- A penetrating object must be immobilized by any means possible. If it is very large, cutting may be possible, with care taken to not move it while making the cut. Place an occlusive & bulky dressing over the entry wound.
- A tension pneumothorax is life threatening, look for HYPOTENSION, unequal breath sounds, JVD, increasing respiratory distress, and decreasing mental status. The pleura must be decompressed with a needle to provide relief. Use the intercostal space between the 2nd and 3rd ribs on the midclavicular line, going in on the top side of the 3rd rib. Once the catheter is placed, watch closely for reocclusion. Be prepared to repeat decompression if signs of tension pneumothorax return. Use a 18-14 gauge needle, length based on the patient.
Pediatric Shock

2-8
SHOCK

UNIVERSAL PATIENT CARE PROTOCOL
Evidence or history of trauma?

CAPNOGRAPHY PROCEDURE

IV / IO PROCEDURE

Anaphylaxis

Allergic Reaction

Respiratory Distress

Impending Arrest

Anaphylactic Shock

DO NOT CONFUSE

EPI 1 mg / ml (1:1000)
IM ONLY and
0.1 mg / ml (1:10,000)
IV Only

NORMAL SALINE BOLUS
20 ml / kg

Monitor and Reassess

Hypovolemic / Septic / Neurogenic Shock

EPINEPHRINE AUTO-INJECTOR JR

EPINEPHRINE (ADRENALINE)
0.01 mg / kg IM of
1 mg / ml (1:1000)
Max Dose 0.5 mg

DIPHENHYDRAMINE (BENADRYL)
1 mg / kg
slow IV / IM / IO
Max Dose 50 mg

ALBUTEROL (PROVENTIL)
Nebulized Unit Dose

EMT use only with DIRECT Medical Control

EPINEPHRINE (ADRENALINE)
0.01 mg / kg IV / IO of
0.1 mg / ml (1:10,000)
Max Dose 0.5 mg / Dose

DIPHENHYDRAMINE (BENADRYL)
1 mg / kg
slow IV / IM / IO
Max Dose 50 mg

If Glucose < 60

ORAL GLUCOSE
5 - 10 g (1/2 Tube)
(If Alert with no IV Access)
If no airway compromise

or

DEXTROSE 10%
5 ml / kg IV / IO
Where Available - or -
DEXTROSE 25% (D25)
2 ml / kg IV / IO

or

GLUCAGON (GLUCAGEN)
0.1 mg / kg IM / IN
(If no IV Access)
Maximum Dose 1 mg
May repeat if no change

TRANSPORT to appropriate facility

CONTACT receiving facility

CONSULT Medical Direction where indicated

PEDIATRIC PROTOCOL

Pediatric Trauma Protocols

Evidence or history of trauma?

PEDIATRIC PROTOCOL

Evidence or history of trauma?

Circulation / Shock

Airway / Breathing

Cardiac

Medical

Trauma

UNIVERSAL PATIENT CARE PROTOCOL

Evidence or history of trauma?

Circulation / Shock

Airway / Breathing

Cardiac

Medical

Trauma
**SHOCK**

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood loss</td>
<td>Restlessness, confusion, weakness</td>
<td>Trauma</td>
</tr>
<tr>
<td>Fluid loss</td>
<td>Dizziness</td>
<td>Infection</td>
</tr>
<tr>
<td>Vomiting</td>
<td>Increased HR, rapid pulse</td>
<td>Dehydration</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Decreased BP</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Fever</td>
<td>Pale, cool, clammy skin</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Infection</td>
<td>Delayed capillary refill</td>
<td>Fever</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Congenital heart disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medication or toxin</td>
</tr>
</tbody>
</table>

**ALLERGIC REACTION / ANAPHYLAXIS**

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset and location</td>
<td>Warm burning feeling</td>
<td>Urticaria (rash only)</td>
</tr>
<tr>
<td>Insect sting or bite</td>
<td>Itching</td>
<td>Anaphylaxis (systemic effect)</td>
</tr>
<tr>
<td>Food allergy / exposure</td>
<td>Rhinorrhea</td>
<td>Shock (vascular effect)</td>
</tr>
<tr>
<td>Medication allergy / exposure</td>
<td>Hoarseness</td>
<td>Angioedema (drug induced)</td>
</tr>
<tr>
<td>New clothing, soap, detergent</td>
<td>Stridor</td>
<td>Aspiration / airway obstruction</td>
</tr>
<tr>
<td>Past history of reactions</td>
<td>Wheezing</td>
<td>Vasovagal event</td>
</tr>
<tr>
<td>Past medical history</td>
<td>Respiratory distress</td>
<td>Asthma</td>
</tr>
<tr>
<td>Medication history</td>
<td>Altered LOC / coma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cyanosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pulmonary edema</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facial / airway edema</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urticaria / hives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dyspnea</td>
<td></td>
</tr>
</tbody>
</table>

Do Not Confuse Epinephrine 1 mg / ml (1:1000) and 0.1 mg / ml (1:10,000)

If Dextrose 25% Not Available, Waste half an amp of Dextrose 50% and replace with normal saline (25 ml)

Fluid Resuscitate to systolic of 70 + 2 x age

**KEY POINTS**

- Exam: Mental Status, Skin, HEENT, Heart, Lung, Abdomen, Extremities, Back, Neuro
- Consider all possible causes of shock and treat per appropriate protocol.
- Decreasing heart rate is a sign of impending collapse.
- Most maternal medications pass through breast milk to the infant. Examples: Narcotics, Benzodiazepines.
- Be sure to use the appropriate sized BP cuff.
- Findings in the primary assessment should alert you that the patient is in shock. Pay particular attention to the patient’s mental status, tachycardia, skin color, and capillary refill.
- Shock is not only caused by blood loss. The EMT must evaluate for fluid loss from other causes such as excessive vomiting and / or diarrhea, heat exposure and malnutrition.
- Do not use only the patient’s blood pressure in evaluating shock; also look for lower body temperature, poor capillary refill, decreased LOC, increased heart rate and / or poor skin color or turgor
- Routinely reassess the patient and provide supportive care.
- Use caution when using Epinephrine (Adrenaline) for patients with a cardiac history.
- Use caution when using Epinephrine (Adrenaline) for patients with a heart rate greater than 120 bpm.
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Neonatal Resuscitation ................................................................. 2-9
Pediatric Asystole / Pulseless Electrical Activity (PEA) ................................. 4-9
Pediatric Bradycardia ........................................................................ 6-9
Pediatric Narrow Complex Tachycardia (SVT) ............................................. 8-9
Pediatric Post Resuscitation Care .......................................................... 10-9
Pediatric Ventricular Fibrillation (V-FIB) and Pulseless Ventricular Tachycardia ............... 12-9
Pediatric Wide Complex Tachycardia ....................................................... 14-9
**UNIVERSAL PATIENT CARE PROTOCOL (For Mother)**

- Meconium in Amniotic Fluid?
  - Yes: Airway Suction
  - No: Dry Infant and Keep Warm

**Dry Infant and Keep Warm**
- Bulb syringe suction nose and mouth

**Stimulate infant and note APGAR Score at 1 Min**
- Respirations Present?
  - Yes: Assess Heart Rate
  - No: Reassess Heart Rate and APGAR Score at 5 Min

**Assess Heart Rate**
- HR > 100: BVM 30 seconds at 40 – 60 Breaths per minute with ROOM AIR
- HR < 100: Monitor and Reassess

**EFFECTIVE VENTILATIONS PEDIATRIC AIRWAY PROTOCOL**
- Begin CPR 3:1 Ratio

**IV / IO PROCEDURE**
- Appropriate Dysrhythmia Protocol

**CONSIDER**
- NORMAL SALINE BOLUS
- DEXTROSE 10%
  - 2 ml / kg IV / IO
  - If Glucose < 45
- NALOXONE (NARCAN)
  - 0.1 mg / kg IV / IO

**NEWBORN OXYGEN SATURATION**

<table>
<thead>
<tr>
<th>Time</th>
<th>Saturation</th>
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<tbody>
<tr>
<td>1 Min</td>
<td>60-65%</td>
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<tr>
<td>2 Min</td>
<td>65-70%</td>
</tr>
<tr>
<td>3 Min</td>
<td>70-75%</td>
</tr>
<tr>
<td>4 Min</td>
<td>75-80%</td>
</tr>
<tr>
<td>5 Min</td>
<td>80-85%</td>
</tr>
<tr>
<td>10 Min</td>
<td>85-95%</td>
</tr>
</tbody>
</table>

**TRANSPORT to appropriate facility**
- CONTACT receiving facility
- CONSULT Medical Direction where

**OXYGEN**
- Blow - By

**EMT Intervention**
**AEMT Intervention**
**PARAMEDIC Intervention**
**MED CONTROL Consult**
NEONATAL RESUSCITATION

HISTORY
- Due date and gestational age
- Multiple gestation (twins etc.)
- Meconium
- Delivery difficulties
- Congenital disease
- Medications (maternal)
- Maternal risk factors
  - substance abuse
  - smoking

SIGNS AND SYMPTOMS
- Respiratory distress
- Peripheral cyanosis or mottling (normal)
- Central cyanosis (abnormal)
- Altered level of responsiveness
- Bradycardia

DIFFERENTIAL DIAGNOSIS
- Airway failure
- Secretions
- Respiratory drive
- Infection
- Maternal medication effect
- Hypovolemia
- Hypoglycemia
- Congenital heart disease
- Hypothermia

If Dextrose 10% not available, Waste 40 ml of Dextrose 50% and draw up 40 ml of Normal Saline to create Dextrose 10%

KEY POINTS
- Exam: Mental Status, Skin, HEENT, Neck, Chest, Heart, Abdomen, Extremities, Neuro
- Newborn arrest is not a cardiac arrest, it is a respiratory arrest
- Effective ventilation is key to successful resuscitation.
- Effective ventilation can be determined by; Chest rise, Bilateral breath sounds, and Increasing heart rate.
- Term baby resuscitation should begin with room air.
- Preterm baby resuscitate with oxygen but reservoir removed from BVM.
- Hypothermia is a common complication of home and field deliveries. Keep the baby warm and dry.
- Consider hypoglycemia in infant. If the BGL less than 45 mg / dl go to then administer Dextrose 10%.
- Document 1 and 5 minute APGAR scores, but do not use it to guide your resuscitation steps.
- If the patient is in distress, consider causes such as; hypovolemia. Administer a 10 ml / kg fluid bolus of normal saline.
- If drying and suction has not provided enough stimulation, try rubbing the infant’s back or flicking their feet. If the infant still has poor respiratory effort, poor tone, or central cyanosis, consider them to be distressed, Most distressed infants will respond quickly to BVM.
- Use caution not to allow newborns to slip from grasp.

APGAR SCORING

<table>
<thead>
<tr>
<th>SIGN</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLOR</td>
<td>Blue / Pale</td>
<td>Pink Body, Blue Extremities</td>
<td>Completely Pink</td>
</tr>
<tr>
<td>HEART RATE</td>
<td>Absent</td>
<td>Below 100</td>
<td>Above 100</td>
</tr>
<tr>
<td>IRRITABILITY (Response to Stimulation)</td>
<td>No Response</td>
<td>Grimace</td>
<td>Cries</td>
</tr>
<tr>
<td>MUSCLE TONE</td>
<td>Limp</td>
<td>Flexion of Extremities</td>
<td>Active Motion</td>
</tr>
<tr>
<td>RESPIRATORY EFFORT</td>
<td>Absent</td>
<td>Slow and Regular</td>
<td>Strong Cry</td>
</tr>
</tbody>
</table>
ASYSTOLE / PULSELESS ELECTRICAL ACTIVITY (PEA)

UNIVERSAL PATIENT CARE PROTOCOL

Continuous CPR

PEDIATRIC AIRWAY PROTOCOL

Apply Cardiac Monitor

CAPNOGRAPHY PROCEDURE

Confirm Asystole / PEA

IV / IO PROCEDURE

Identify Possible Causes:
- Hypoxemia
- Acidosis
- Hypovolemia
- Tension
- Pneumothorax
- Hypothermia

EPINEPHRINE (ADRENALINE)

0.01 mg / kg IV / IO of 0.1 mg / ml (1:10,000) Solution

Repeat every 3 - 5 minutes

Max 1 mg per dose

Double Check EPI Concentration

NORMAL SALINE IV BOLUS

20 ml / kg

Repeat as needed

BLOOD GLUCOSE PROCEDURE

Glucose < 60

DEXTROSE 10%

5 ml / kg IV / IO

Where Available - or -

DEXTROSE 25% (D25)

2 ml / kg IV / IO

Continuous CPR

TRANSPORT to appropriate facility

CONTACT receiving facility

CONSULT Medical Direction where indicated

AT ANY TIME

Return of Spontaneous Circulation (ROSC)

GO TO PEDIATRIC POST RESUSCITATION CARDIAC CARE PROTOCOL

EMT Intervention

AEMT Intervention

PARAMEDIC Intervention

MED CONTROL Consult
ASYSTOLE / PULSELESS ELECTRICAL ACTIVITY (PEA)

<table>
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<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Time of arrest</td>
<td>• Pulseless</td>
<td>• Ventricular fibrillation</td>
</tr>
<tr>
<td>• Medical history</td>
<td>• Apneic or agonal Respirations</td>
<td>• Pulseless ventricular tachycardia</td>
</tr>
<tr>
<td>• Medications</td>
<td>• Cyanosis</td>
<td></td>
</tr>
<tr>
<td>• Possibility of foreign body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hypothermia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pulseless</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Apneic or agonal Respirations</td>
<td></td>
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</tr>
<tr>
<td>• Cyanosis</td>
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<tr>
<td>• Pulseless ventricular tachycardia</td>
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</table>

<table>
<thead>
<tr>
<th>CONSIDER TREATABLE CAUSES</th>
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</thead>
<tbody>
<tr>
<td>• Hypovolemia</td>
<td>• Cardiac tamponade</td>
<td></td>
</tr>
<tr>
<td>• Tension pneumothorax</td>
<td>• Pulmonary embolism</td>
<td></td>
</tr>
<tr>
<td>• Myocardial infarction</td>
<td>• Tricyclic overdose</td>
<td></td>
</tr>
<tr>
<td>• Drug overdose</td>
<td>• Hypoxia</td>
<td></td>
</tr>
<tr>
<td>• Hypothermia</td>
<td>• Hypoglycemia</td>
<td></td>
</tr>
<tr>
<td>• Acidosis</td>
<td>• Hyperkalemia</td>
<td></td>
</tr>
</tbody>
</table>

Do Not Confuse Epinephrine 1 mg / ml (1:1000) and 0.1 mg / ml (1:10,000)

If Dextrose 25% Not Available, Waste half an amp of Dextrose 50% and replace with normal saline (25 ml)

Fluid Resuscitate to systolic of 70 + 2 x age

KEY POINTS

• Exam: Mental Status
• Always confirm asystole in more than one lead.
• Cardiac arrest in children is primarily due to lack of an adequate airway, resulting in hypoxia.
• If the patient converts to another rhythm or has a return of circulation, refer to the appropriate protocol and treat accordingly.
• When assessing for a pulse palpate the brachial or femoral arteries for infants and the carotid or femoral artery for children.
• Continue BLS procedures throughout the resuscitation.
• If the patient is intubated, be sure to routinely reassess tube placement.
• If the patient has an IO, routinely reassess for patency.
BRADYCARDIA

Poor perfusion? Decreased B/P? Respiratory Insufficiency?

- Yes: Arrest Protocol If Indicated
  - Heart Rate < 60
  - Start CPR
- No: Monitor and Reassess Other Protocols as Indicated

**EPINEPHRINE (ADRENALINE)**
- 0.01 mg / kg IV / IO of 0.1 mg / ml (1:10,000) Solution
- Repeat every 3 - 5 minutes
- Max 1 mg per dose

DOUBLE CHECK EPI CONCENTRATION

**CONSIDER ATROPINE**
- 0.02 mg / kg IV / IO repeat every 3 - 5 minutes
- Min dose 0.1 mg
- Max dose 0.5 mg child
- Max dose 1 mg Adolescent

Consider External Transcutaneous Pacing

Monitor and Reassess Other Protocols as Indicated

**TRANSPORT** to appropriate facility
- **CONTACT** receiving facility
- **CONSULT** Medical Direction where indicated

EMT Intervention | AEMT Intervention | PARAMEDIC Intervention | MED CONTROL Consult
# BRADYCARDIA

## HISTORY
- Past medical history
- Foreign body exposure
- Respiratory distress or arrest
- Apnea
- Possible toxic or poison exposure
- Congenital disease
- Medication (maternal or infant)

## SIGNS AND SYMPTOMS
- Hypoxia
- Decreased heart rate
- Delayed capillary refill or cyanosis
- Mottled, cool skin
- Hypotension or arrest
- Altered level of consciousness
- Poor Perfusion
- Shock
- Short of breath
- Pulmonary fluid

## DIFFERENTIAL DIAGNOSIS
- Respiratory effort
- Respiratory obstruction
- Foreign body / secretions
- Croup / epiglottis
- Hypovolemia
- Hypothermia
- Infection / sepsis
- Medication or toxin
- Hypoglycemia
- Trauma

---

Do Not Confuse Epinephrine 1 mg / ml (1:1000) and 0.1 mg / ml (1:10,000)

---

## KEY POINTS
- Exam: Mental Status, HEENT, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro
- Heart Rate < 100 (Neonates)
- Heart Rate < 80 (Infants)
- Heart Rate <60 (Children > 2 years)
- Infant = < 1 year of age
- Most maternal medications pass through breast milk to the infant.
- The majority of pediatric arrests are due to airway problems.
- Hypoglycemia, severe dehydration and narcotic effects may produce bradycardia.
- Pediatric patients requiring external transcutaneous pacing require the use of pads appropriate for pediatric patients per the manufacturers’ guidelines.
- Identify and treat possible causes for pediatric bradycardia:
  1. Hypoxia
  2. Hypothermia
  3. Head injury
  4. Heart block
  5. Toxic ingestion / exposure
- Refer to pediatric reference material when unsure about patient weight, age and / or drug dosage.
- The minimum dose of Atropine that should be administered to a pediatric patient is 0.1 mg.
- If the rhythm changes, follow the appropriate protocol.
- Be sure of all medication doses, look it up in reference material.
NARROW – COMPLEX TACHYCARDIA

UNIVERSAL PATIENT CARE PROTOCOL

Cardiac Monitor
Attempt to Identify Cause

CAPNOGRAPHY PROCEDURE

IV / IO PROCEDURE

If rhythm changes, Go to Appropriate Protocol

Stable (Signs of Perfusion)
HR > 220 infant / HR >180 child

May attempt Vagal Maneuvers

ADENOSINE (ADENOCARD)
0.1 mg / kg IV / IO Rapid - Followed with flush
Max dose 6 mg

No response
1 –2 minutes

ADENOSINE (ADENOCARD)
0.2 mg / kg IV Rapid - Followed with flush
Max dose 12 mg

IV Normal Saline Bolus 20 ml / kg
If signs dehydration / hypoperfusion

Unstable (Signs of Hypoperfusion)
HR > 220 infant / HR >180 child

May go directly to Cardioversion

Consider Sedation
LORAZEPAM (ATIVAN) 0.05 mg / kg slow IV / IO / IN
Where Available
Max Dose 2 mg

If Lorazepam (Ativan) Unavailable,
See Medication Section for Midazolam (Versed)

SYNCHRONIZED CARDIOVERSION
(0.5 – 2 J / kg)

No response
1 –2 minutes

Repeat SYNCHRONIZED CARDIOVERSION as Needed
(1 – 2 J / kg)

IV Normal Saline Bolus 20 ml / kg
If signs dehydration or hypoperfusion

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

EMT Intervention
AEMT Intervention
PARAMEDIC Intervention
MED CONTROL Consult
# Pediatric Protocol

## Narrow – Complex Tachycardia

### History
- Past medical history
- Medications or toxic ingestion (Aminophylline, diet pills, thyroid supplements, decongestants, digoxin)
- Drugs (nicotine, cocaine)
- Congenital heart disease
- Respiratory distress
- Syncope or near syncope

### Signs and Symptoms
- HR: Child > 180/bpm
  - Infant > 220/bpm
- Pale or cyanosis
- Diaphoresis
- Tachypnea
- Vomiting
- Hypotension
- Altered level of consciousness
- Pulmonary congestion
- Syncope

### Differential Diagnosis
- Heart disease (congenital)
- Hypo / hyperthermia
- Hypovolemia or anemia
- Electrolyte imbalance
- Anxiety / pain / emotional stress
- Fever / infection / sepsis
- Hypoxia
- Hypoglycemia
- Medication / toxin / drugs (see HX)
- Pulmonary embolus
- Trauma
- Tension pneumothorax

### Fluid Resuscitate to systolic of 70 + 2 x age

### Key Points
- **Exam:** Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro
- Carefully evaluate the rhythm to distinguish Sinus Tachycardia, Supraventricular Tachycardia, and Ventricular Tachycardia
- Separating the child from the caregiver may worsen the child’s clinical condition.
- Pediatric pads should be used in children < 10 kg.
- Monitor for respiratory depression and hypotension associated if LORAZEPAM (ATIVAN) or MIDAZOLAM (VERSED) is used.
- Continuous pulse oximetry is required for all SVT Patients if available.
- Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.
- Possible causes of tachycardia; hypoxia, hypovolemia, fear, and pain.
- A complete medical history must be obtained.
- Do not delay cardioversion to gain vascular access for the unstable patient.
- If you are unable to get the monitor to select a low enough joule setting, contact Medical Control.
- If the patient is stable, do not cardiovert.
- Record 3-Lead EKG strips during adenosine administration.
- Perform a 12-Lead EKG prior to and after Adenosine (Adenocard) conversion or cardioversion of SVT.
- If the rhythm changes, follow the appropriate protocol.
DOPAMINE
(INTROPIN)
5 – 20 mcg / kg / min
IV / IO

Electrical Conversion (NO anti-arrhythmic already given during resuscitation)

Treat per BRADYCARDIA PROTOCOL

Hypotension

To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable

Supportive Care Only
No anti-arrhythmic administered

AMIODARONE (CORDARONE)
5 mg / kg IV / IO mix in 20+ ml NS Over 20-60 minutes IF NOT ALREADY GIVEN (450 mg max during prehospital care)

If arrest reoccurs, revert to appropriate protocol and / or initial successful treatment

TRANSPORT to appropriate PEDIATRIC facility
CONTACT receiving facility CONSULT Medical Direction where indicated

EMT Intervention AEMT Intervention PARAMEDIC Intervention MED CONTROL Consult
VENTRICULAR FIBRILLATION (V-FIB)
PULSELESS VENTRICULAR TACHYCARDIA

CPR X 5 cycles / 2 minutes
Apply Cardiac Monitor / AED

CAPNOGRAPHY PROCEDURE

Defibrillate 2 J / kg
CPR X 5 cycles / 2 minutes

PEDIATRIC AIRWAY PROTOCOL

IV / IO PROCEDURE

EPINEPHRINE (ADRENALINE)
0.01 mg / kg IV / IO
0.1 mg / ml (1:10,000) Solution
Repeat every 3 - 5 minutes
Max dose 1 mg per dose

Double Check EPI Concentration

CPR X 5 cycles / 2 minutes
Defibrillate 4 J / kg

AMIODARONE (CORDARONE)
5 mg / kg IV / IO

CPR X 5 cycles / 2 minutes
Defibrillate 4 J / kg

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

Confirm V-Fib / Pulseless V-Tach

Identify Possible Causes:
Hypoxemia
Acidosis
Hypovolemia
Tension
Pneumothorax
Hypothermia

AT ANY TIME
Return of Spontaneous Circulation (ROSC)
GO TO PEDIATRIC POST RESUSCITATION CARDIAC CARE PROTOCOL
# Pediatric Protocol

## VENTRICULAR FIBRILLATION (V-FIB)
### PULSELESS VENTRICULAR TACHYCARDIA

### HISTORY
- Time of arrest
- Medical history
- Medications
- Possibility of foreign body
- Hypothermia

### SIGNS AND SYMPTOMS
- Unresponsive
- Cardiac arrest

### DIFFERENTIAL DIAGNOSIS
- Respiratory failure
- Foreign body
- Secretions
- Infection (croup, epiglotitis)
- Hypovolemia (dehydration)
- Congenital heart disease
- Trauma
- Tension pneumothorax
- Hypothermia
- Toxin or medication
- Hypoglycemia
- Acidosis

---

**Do Not Confuse Epinephrine 1 mg / kg (1:1000) and 0.1 mg / kg (1:10,000)**

---

### KEY POINTS
- **Exam: Mental Status**
- Monophasic and Biphasic waveform defibrillators should use the same energy levels noted.
- In order to be successful in pediatric arrests, a cause must be identified and corrected.
- Airway is the most important intervention. This should be accomplished immediately. Patient survival is often dependent on airway management success.
- If the patient converts to another rhythm, follow the appropriate protocol and treat accordingly.
- If the patient converts back to ventricular fibrillation or pulseless ventricular tachycardia, defibrillate at the previously used setting.
- Defibrillation is the definitive therapy for ventricular fibrillation and pulseless ventricular tachycardia.
- Defibrillate 30 - 60 seconds after each medication administration.
- The proper administration sequence is CPR (continuous), shock, drug, shock, drug.
**WIDE – COMPLEX TACHYCARDIA**

**UNIVERSAL PATIENT CARE PROTOCOL**

- Cardiac Monitor
- Attempt to Identify Cause

**CAPNOGRAPHY PROCEDURE**

**IV / IO PROCEDURE**

If rhythm changes, Go to Appropriate Protocol

Stable (Signs of Perfusion)
- HR > 220 infant / HR > 180 child
- May attempt Vagal Maneuvers

**AMIODARONE (CORDARONE)**
- 5 mg / kg IV / IO
- Mixed in 20+ ml Over 20 – 60 min
- Max dose 300 mg

No response
- 1 – 2 minutes

IV Normal Saline Bolus 20 ml / kg
- If signs dehydration / hypoperfusion

Unstable (Signs of Hypoperfusion)
- HR > 220 infant / HR > 180 child
- May go directly to Synchronized CARDIOVERSION

**SYNCHRONIZED CARDIOVERSION**
- (0.5 – 1 J / kg)
- If Lorazepam (Ativan) Unavailable, See Medication Section for Midazolam (Versed)

No response
- 1 – 2 minutes

Repeat SYNCHRONIZED CARDIOVERSION as Needed
- (1 – 2 J / kg)

IV Normal Saline Bolus 20 ml / kg
- If signs dehydration or hypoperfusion

**TRANSPORT** to appropriate facility
**CONTACT** receiving facility
**CONSULT** Medical Direction where indicated

EMT Intervention AEMT Intervention PARAMEDIC Intervention MED CONTROL Consult
### PEDIATRIC PROTOCOL

**WIDE – COMPLEX TACHYCARDIA**

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| • Past medical history  
• Medications or toxic ingestion (Aminophylline, diet pills, thyroid supplements, decongestants, digoxin)  
• Drugs (nicotine, cocaine)  
• Congenital heart disease  
• Respiratory distress  
• Syncope or near syncope | • HR: Child > 180/bpm  
Infant > 220/bpm  
• Pale or cyanosis  
• Diaphoresis  
• Tachypnea  
• Vomiting  
• Hypotension  
• Altered level of consciousness  
• Pulmonary congestion  
• Syncope | • Heart disease (congenital)  
• Hypo / hyperthermia  
• Hypovolemia or anemia  
• Electrolyte imbalance  
• Anxiety / pain / emotional stress  
• Fever / infection / sepsis  
• Hypoxia  
• Hypoglycemia  
• Medication / toxin / drugs (see HX)  
• Pulmonary embolus  
• Trauma  
• Tension pneumothorax |

**Fluid Resuscitate to systolic of 70 + 2 x age**

**KEY POINTS**

- **Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro**
- Carefully evaluate the rhythm to distinguish Sinus Tachycardia, Supraventricular Tachycardia, and Ventricular Tachycardia
- Separating the child from the caregiver may worsen the child's clinical condition.
- Pediatric paddles should be used in children < 10 kg.
- Monitor for respiratory depression and hypotension associated if LORAZEPAM (ATIVAN) or MIDAZOLAM (VERSED) is used.
- Continuous pulse oximetry is required for all SVT Patients if available.
- Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.
- Possible causes of tachycardia; hypoxia, hypovolemia, fear, and pain.
- A complete medical history must be obtained.
- Do not delay cardioversion to gain vascular access for the unstable patient.
- If you are unable to get the monitor to select a low enough joule setting, contact Medical Control.
- If the patient is stable, do not cardiovert.
- Record 3-Lead EKG strips during adenosine administration.
- Perform a 12-Lead EKG prior to and after Amiodarone (Cordarone) conversion or cardioversion of SVT.
- If the rhythm changes, follow the appropriate protocol.
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PEDIATRIC MEDICAL EMERGENCIES PROTOCOLS

Pediatric Altered Level of Consciousness ................................................................. 2-10
Pediatric Anti-Emetic .................................................................................................. 4-10
Pediatric Diabetic Emergencies ................................................................................ 6-10
Pediatric Hyperthermia / Heat Exposure ................................................................. 8-10
Pediatric Hypothermia / Frostbite ............................................................................. 10-10
Pediatric Seizure ........................................................................................................ 13-10
Pediatric Severe Pain Management ........................................................................... 15-10
Pediatric Toxic Ingestion / Exposure / Overdose ...................................................... 17-10
ALTERED LEVEL OF CONSCIOUSNESS

UNIVERSAL PATIENT CARE PROTOCOL
CONSIDER COMPLETE SPINAL IMOBILIZATION PROCEDURE
AIRWAY PROTOCOL
12 LEAD EKG PROCEDURE
1ST Contact to EKG and Transmission < 10 Min
OXYGEN / PULSE OXIMETRY PROCEDURE
CAPNOGRAPHY PROCEDURE
BLOOD GLUCOSE PROCEDURE
IV / IO PROCEDURE
Identify Treatable Causes
Treat Per Specific Protocol

Hypoxia – Treat per Airway / Breathing Protocols
Anaphylaxis / Allergic Reaction
Sepsis – Treat per Septic Shock Protocol
Hypotension – Treat per Specific Shock Protocols
Arrhythmia – Treat per Correct Arrhythmia Protocol
Psychiatric – Treat per Behavioral Emergencies
Hypo / Hyperglycemia – Treat per Diabetic Protocol
Hypo / Hyperthermia – Treat per Specific Protocol
Stroke CVA / TIA – Treat per Stroke Protocol
Overdose – Treat per Toxic Ingestion Protocol
Head Trauma – Treat per Head Trauma Protocol

EMT Intervention | AEMT Intervention | PARAMEDIC Intervention | MED CONTROL Consult
ALTERED LEVEL OF CONSCIOUSNESS

**HISTORY**
- Known diabetic, medic alert tag
- Drugs, drug paraphernalia
- Report of illicit drug use or toxic ingestion
- Past medical history
- Medications
- History of trauma

**SIGNS AND SYMPTOMS**
- Unresponsive
- Decreased responsiveness
- Inadequate respirations
- Confusion
- Agitation
- Decreased mental status
- Change in baseline mental status
- Hypoglycemia (cool, diaphoretic skin)

**DIFFERENTIAL DIAGNOSIS**
- Head trauma
- CNS (stroke, tumor, seizure, infection)
- Infection
- Shock (septic, metabolic, traumatic)
- Diabetes (hyper / hypoglycemia)
- Toxicologic
- Acidosis / alkalosis
- Environmental exposure
- Pulmonary (Hypoxia)
- Electrolyte abnormality
- Psychiatric disorder

**KEY POINTS**
- Exam: Mental Status, HEENT, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro
- Be aware of AMS as potential sign of an environmental toxin or Haz-Mat exposure and protect personal safety.
- It is safer to assume hypoglycemia than hyperglycemia if doubt exists.
- Do not let alcohol confuse the clinical picture.
- Consider restraints if necessary for patient's and / or personnel's protection per the restraint procedure.
- Protect the patient airway and support ABCs.
- Document the patient’s Glasgow coma score pre and post treatment.
- Signs and symptoms of narcotic overdose include respiratory depression and altered mental status.
- Naloxone (Narcan) administration may cause the patient to go into acute opiate withdraw, which includes vomiting, agitation, and / or combative behavior. Always be prepared for combative behavior.
- Naloxone (Narcan) may wear off in as little as 20 minutes causing the patient to become more sedate and possibly hypoventilate. All A&O 4 patients having received Naloxone (Narcan) should be transported. If patient refuses transport, contact Medical Control before release.

**ONLY A FEW CAUSES CAN BE TREATED IN THE FIELD. CARE SHOULD FOCUS ON MAINTAINING AIRWAY AND RAPID TRANSPORT**
UNIVERSAL PATIENT CARE PROTOCOL

Administer Oxygen

IV PROCEDURE

Patient has Nausea / Vomiting

ONDANSETRON (ZOFRAN)
0.15 mg / kg IM or IV over 2 - 4 minutes
-or- 0.15 mg / kg Injectable Liquid PO > 1 Year
May Repeat X1 if Needed in 15 minutes

ONDANSETRON (ZOFRAN)
Oral Dissolving Tabs
4 mg Oral > 40 kg AND 12 years

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated
## HISTORY
- Nausea
- Vomiting
- Medication(s) administration such as narcotic analgesics

## SIGNS AND SYMPTOMS
- Complaints of nausea and / or vomiting

## DIFFERENTIAL DIAGNOSIS
- Consider AMI / 12 lead EKG
- Gastroenteritis
- Toxic ingestion / food poisoning
- Bowel obstruction
- Appendicitis
- Gastritis
- Cholecystitis (gallbladder)
- Hepatitis / cirrhosis
- Headaches / migraine
- Pregnancy
- Hypertensive crisis
- Electrolyte imbalances
- DKA
- Intracranial pressure
- Sepsis / infections

## KEY POINTS
- Position patient to protect airway as appropriate. (Recovery position, sitting up, etc.)
- Immediately position entire patient or their head to side if patient begins vomiting then retrieve suction.
- Patients with altered LOC and nausea / vomiting need to have airway maintenance prioritized before medication.
- Prepare and test suction prior to its need.
- Give Ondansetron (Zofran) over at least 2 minutes, slow IV. Follow up with second dose in if symptoms unresolved.
- Treat patients early, no need to wait for patient to begin vomiting to administer Ondansetron (Zofran).
- Patients receiving medications such as narcotic analgesics may require concurrent administration of Ondansetron (Zofran) to reduce nausea associated with such medications.
#### DIABETIC EMERGENCIES

**UNIVERSAL PATIENT CARE PROTOCOL**

**IV / IO PROCEDURE**

**BLOOD GLUCOSE PROCEDURE**

**Glucose < 60**
- **ORAL GLUCOSE**
  - 5 - 10 g (1/2 Tube)
  - (If Alert with no IV Access and no airway compromise)

**OR**
- **DEXTROSE 10%**
  - 5 ml / kg IV / IO
  - Where Available - or - **DEXTROSE 25% (D25)**
  - 2 ml / kg IV / IO

**OR**
- **GLUCAGON (GLUCAGEN)**
  - 0.1 mg / kg IM / IN Atomized
  - (If no IV Access)
  - Maximum 1 mg
  - May repeat if no change

**Glucose > 250**
- **Check for Hypotension, Tachycardia, Poor Cap Refill**
- **NORMAL SALINE**
  - 20 ml / kg Bolus
  - IF SIGNS OF DEHYDRATION

**Recheck Blood Glucose**

**TRANSPORT** to appropriate facility

**CONTACT** receiving facility

**CONSULT** Medical Direction where indicated
HYPOGLYCEMIA

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Known diabetic, medic alert tag</td>
<td>• Altered level of consciousness</td>
<td>• ETOH</td>
</tr>
<tr>
<td>• Past medical history</td>
<td>• Dizziness</td>
<td>• Toxic overdose</td>
</tr>
<tr>
<td>• Medications</td>
<td>• Irritability</td>
<td>• Trauma</td>
</tr>
<tr>
<td>• Recent BGL</td>
<td>• Diaphoresis</td>
<td>• Seizure</td>
</tr>
<tr>
<td></td>
<td>• Convulsions</td>
<td>• Syncope</td>
</tr>
<tr>
<td></td>
<td>• Hunger</td>
<td>• CSN disorder</td>
</tr>
<tr>
<td></td>
<td>• Confusion</td>
<td>• Stroke</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tumor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pre-existing condition</td>
</tr>
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</table>

HYPERGLYCEMIA

<table>
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</tr>
<tr>
<td>• Recent BGL</td>
<td>• Dehydration</td>
<td>• Seizure</td>
</tr>
<tr>
<td></td>
<td>• Frequent thirst and urination</td>
<td>• Syncope</td>
</tr>
<tr>
<td></td>
<td>• General weakness malaise</td>
<td>• CSN disorder</td>
</tr>
<tr>
<td></td>
<td>• Hypovolemic shock</td>
<td>• Stroke</td>
</tr>
<tr>
<td></td>
<td>• Hyperventilation</td>
<td>• Diabetic ketoacidosis</td>
</tr>
<tr>
<td></td>
<td>• Deep / rapid respirations</td>
<td></td>
</tr>
</tbody>
</table>

If Dextrose 25% Not Available, Waste half an amp of Dextrose 50% and replace with normal saline (25 ml)

Fluid Resuscitate to systolic of 70 + 2 x age

KEY POINTS

Hyperglycemia:
- Diabetic Ketoacidosis (DKA) is a complication of diabetes mellitus. It can occur when insulin levels become inadequate to meet the metabolic demands of the body for a prolonged amount of time (onset can be within 12 - 24 hours). Without enough insulin the blood glucose increases and cellular glucose depletes. The body removes excess blood glucose by dumping it into the urine. Pediatric patients in DKA should be treated as hyperglycemic under the Pediatric Diabetic Emergencies Protocol.
- Patients can have Hyperglycemia without having DKA.

Hypoglycemia:
- Always suspect Hypoglycemia in patients with an altered mental status.
- If a blood glucose analysis is not available, a patient with altered mental status and signs and symptoms consistent with hypoglycemia should receive Dextrose (D10 or D25), or Glucagon (Glucagen).
  - Dextrose is used to elevate BGL but it will not maintain it. The patient will need to follow up with a meal, if not transported to a hospital.
- If the patient is alert and has the ability to swallow; consider administering oral glucose, have patient drink orange juice with sugar or a sugar containing beverage, or have the patient eat a candy bar or meal.
- Check the patient’s BGL after the administration of Dextrose (D 10 or D25), Glucagon (Glucagen), or after any attempt to raise the patient’s BGL.

Miscellaneous:
- If IV access is successful after Glucagon (Glucagen) IM / IN and the patient is still symptomatic, Dextrose (D10 or D25) should be administered.
HYPERTHERMIA / HEAT EXPOSURE

UNIVERSAL PATIENT CARE PROTOCOL

- Document Patient Temperature
- Remove Patient from Heat Source
- Remove Patient Clothing
- Apply Room Temperature Water to Patient Skin and Increase Air Flow Around Patient

CARDIAC MONITOR

CAPNOGRAPHY PROCEDURE

IV / IO PROCEDURE

- Fever: Normal Saline 20 ml kg Bolus
- Heat Exhaustion: Normal Saline Bolus
- Heat Stroke: Normal Saline TKO

Apply ICE PACKS to Patient (Groin, axilla, and posterior neck)

Monitor and Reassess

Appropriate Protocol Based on Patient Symptoms

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

EMT Intervention
AEMT Intervention
PARAMEDIC Intervention
MED CONTROL Consult
HYPERTHERMIA / HEAT EXPOSURE

**HISTORY**

- Age
- Exposure to increased temperatures and humidity
- Past medical history / medications
- Extreme exertion
- Time and length of exposure
- Poor PO intake
- Fatigue and / or muscle cramping

**SIGNS AND SYMPTOMS**

- Altered mental status or unconsciousness
- Hot, dry or sweaty skin
- Hypotension or shock
- Seizures
- Nausea

**DIFFERENTIAL DIAGNOSIS**

- Fever (infection)
- Dehydration
- Medications
- Hyperthyroidism (storm)
- Delirium tremens (DT’s)
- Heat cramps
- Heat exhaustion
- Heat stroke
- CNS lesions or tumors

---

**Heat Exhaustion: Dehydration**

- Muscular/abdominal cramping
- General weakness
- Diaphoresis
- Fever
- Confusion
- BP normal or orthostatic hypotension

**Heat Stroke: Cerebral Edema**

- Confusion
- Bizarre behavior
- Skin hot, dry, febrile
- Tachycardia
- Hypotensive
- Seizure
- Coma

---

**Fluid Resuscitate to systolic of 70 + 2 x age**

---

**KEY POINTS**

- **Exam: Mental Status, Skin, HEENT, Heart, Lungs, Neuro**
- Extremes of age are more prone to heat emergencies (i.e. young and old).
- Predisposed by use of: tricyclic antidepressants, phenothiazines, anticholinergic medications, and alcohol.
- Cocaine, Amphetamines, and Salicylates may elevate body temperatures.
- Sweating generally disappears as body temperature rises above 104° F (40° C).
- Intensive shivering may occur as patient is cooled.
- **Heat Cramps** consists of benign muscle cramping secondary to dehydration and is not associated with an elevated temperature.
- **Heat Exhaustion** consists of dehydration, salt depletion, dizziness, fever, mental status changes, headache, cramping, nausea and vomiting. Vital signs usually consist of tachycardia, hypotension, and an elevated temperature.
- **Heat Stroke** consists of dehydration, tachycardia, hypotension, temperature > 104° F (40° C), and altered mental status.
- Patients at risk for heat emergencies include neonates, infants, geriatric patients, and patients with mental illness. Other contributory factors may include heart medications, diuretics, cold medications and / or psychiatric medications.
- Heat exposure can occur either due to increased environmental temperatures or prolonged exercise or a combination of both. Environments with temperature > 90° F and humidity > 60% present the most risk.
- Heat stroke occurs when the cooling mechanism of the body (sweating) ceases due to temperature overload and / or electrolyte imbalances. Be alert for cardiac dysrhythmias for the patient with heat stroke.
HYPOTHERMIA / FROSTBITE

UNIVERSAL PATIENT CARE PROTOCOL

- Remove wet clothing
- Evidence or decreased core temperature?
- Handle patient gently
- Apply hot packs indirectly to skin and/or blankets and turn up vehicle heat

CARDIAC MONITOR

CAPNOGRAPHY PROCEDURE

IV / IO PROCEDURE

Appropriate Protocol Based on patient Signs and Symptoms

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated
### HYPOTHERMIA / FROSTBITE

#### HISTORY
- Past medical history
- Medications
- Exposure to environment even in normal temperatures
- Exposure to extreme cold
- Extremes of age
- Drug use: Alcohol, barbituates
- Infections / sepsis
- Length of exposure / wetness

#### SIGNS AND SYMPTOMS
- Cold, clammy
- Shivering
- Mental status changes
- Extremity pain or sensory abnormality
- Bradycardia
- Hypotension or shock

#### DIFFERENTIAL DIAGNOSIS
- Sepsis
- Environmental exposure
- Hypoglycemia
- CNS dysfunction
- Stroke
- Head injury
- Spinal cord injury

#### KEY POINTS
- Exam: Mental Status, Heart, Lungs, Abdomen, Extremities, Neuro
- Hypothermic / drowning / near drowning patients that appear cold and dead are NOT dead until they are warm and dead, or have other signs of obvious death (putrification, traumatic injury unsustainable to life).
- Defined as core temperature < 95° F (35° C).
- Extremes of age are more susceptible (i.e. young and old).
- Patients with low core temperatures will not respond to ALS drug interventions. Maintain warming procedure and supportive care. Warming procedures includes removing wet clothing, limiting exposure, and covering the patient with warm blankets if available.
- Do not allow patients with frozen extremities to ambulate.
- Superficial frostbite can be treated by using the patient’s own body heat.
- Do not attempt to rewarm deep frostbite unless there is an extreme delay in transport, and there is a no risk that the affected body part will be refrozen. Contact Medical Command prior to rewarming a deep frostbite injury.
- With temperature less than 88° F (31° C) ventricular fibrillation is common cause of death. Handling patients gently may prevent this. (rarely responds to defibrillation).
- If the temperature is unable to be measured, treat the patient based on the suspected temperature.
- Hypothermia may produce severe bradycardia.
- Shivering stops below 90° F (32° C).
- Hot packs can be activated and placed in the armpit and groin area if available.
- Care should be taken not to place the packs directly against the patient’s skin.
- Consider withholding CPR if patient has organized rhythm. Discuss with medical control.
- All hypothermic patients should have resuscitation performed until care is transferred, or if there are other signs of obvious death (putrification, traumatic injury unsustainable to life).
- Patients with low core temperatures will not respond to ALS drug interventions. Maintain warming procedure and supportive care. Warming procedures includes removing wet clothing, limiting exposure, and covering the patient with warm blankets if available.
- The most common mechanism of death in hypothermia is ventricular fibrillation. If the hypothermia victim is in ventricular fibrillation, CPR should be initiated. If V fib is not present, then all treatment and transport decisions should be tempered by the fact that V fib can be caused by rough handling, noxious stimuli or even minor mechanical disturbances, this means that respiratory support with 100% oxygen should be done gently, including intubation, avoiding hyperventilation.
- The heart is most likely to fibrillate between 85 - 88° F (29 - 31° C) Defibrillate VF / VT at 2 – 4 j / kg with effective CPR intervals.
- Do not allow patients with frozen extremities to ambulate.
- Superficial frostbite can be treated by using the patient’s own body heat.
- Do not attempt to rewarm deep frostbite unless there is an extreme delay in transport, and there is a no risk that the affected body part will be refrozen. Contact Medical Control prior to rewarming a deep frostbite injury.
Febrile?

**ACETAMINOPHEN (TYLENOL) Oral Liquid**
10 mg / kg PO
If not already given in last 4 hours

**GLUCOSE**
5 - 10 g (1/2 Tube)
(If Alert with no IV Access)
If no airway compromise

**OR**

**DEXTROSE 10%**
5 ml / kg IV / IO
Where Available - or -
**DEXTROSE 25% (D25)**
2 ml / kg IV / IO

**OR**

**GLUCAGON (GLUCAGEN)**
0.1 mg / kg IM / IN
(If no IV Access)
Maximum 1 mg
May repeat if no change

**LORAZEPAM (ATIVAN)**
0.05 mg / kg IV / IO Where Available
Max 2 mg

**COOLING MEASURES**

**TRANSIT** to appropriate facility
**CONTACT** receiving facility
**CONSULT** Medical Direction where indicated

**UNIVERSAL PATIENT CARE PROTOCOL**
**PEDIATRIC AIRWAY PROTOCOL**
**CAPNOGRAPHY PROCEDURE**
Position on side to prevent aspiration

**BLOOD GLUCOSE PROCEDURE**

**IV PROCEDURE**

**Evidence of Shock or Trauma?**

**Active Seizure?**

See Appropriate Protocol

**Glucose < 60**

**OR**

**Glucose < 60**

**If Lorazepam (Ativan) Unavailable,**
See Medication Section for Midazolam (Versed)
**HISTORY**
- Fever
- Prior history of seizures
- Seizure medications
- Reported seizure activity
- History of recent head trauma
- Congenital abnormality

**SIGNS AND SYMPTOMS**
- Observed seizure activity
- Altered mental status
- Hot, dry skin or elevated body temperature

**DIFFERENTIAL**
- Fever
- Infection
- Head trauma
- Medication or toxin
- Hypoxia or respiratory failure
- Hypoglycemia
- Metabolic abnormality / acidosis
- Tumor

**Categories of Seizures**

<table>
<thead>
<tr>
<th>Complex = Unconscious</th>
<th>Focal = Partial, Localized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple = Conscious</td>
<td>Generalized = All Body</td>
</tr>
</tbody>
</table>

- Simple Focal
- Simple Generalized
- Complex Focal
- Complex Generalized

If Dextrose 25% Not Available, Waste half an amp of Dextrose 50% and replace with normal saline (25 ml)

**KEY POINTS**

- **Exam:** Mental Status, HEENT, Heart, Lungs, Extremeties, Neuro
- **Status Epilepticus** is defined as two or more successive seizures without a period of consciousness or recovery. This is a true emergency requiring rapid airway control, treatment, and transport.
- **Grand mal seizures** (generalized) are associated with loss of consciousness, incontinence, and tongue trauma.
- **Focal seizures (petit mal)** effect only a part of the body and are not usually associated with a loss of consciousness.
- **Jacksonian seizures** are seizures, which start as a focal seizure and become generalized.
- Be prepared to assist ventilations especially if a benzodiazepine such as LORAZEPAM (ATIVAN) or MIDAZOLAM (VERSED) is used.
- If evidence or suspicion of trauma, spine should be immobilized.
- If febrile, remove clothing and sponge with room temperature water.
- **In an infant, a seizure may be the only evidence of a closed head injury.**
SEVERE PAIN MANAGEMENT

PATIENT HAS:
- Burns
- Intractable Flank Pain
- Intractable Back Pain
- Musculoskeletal and/or Fracture Pain
- Sickle Cell Pain Crisis (Use Supplemental O2)
- Unremitting Abdominal Pain

CARDIAC MONITOR

CAPNOGRAPHY PROCEDURE

FENTANYL (SUBLIMAZE)
1 mcg / kg IV / IO / IN / IM
REPEAT If no Improvement in 10 – 15 Mins
⚠️ If Fentanyl (Sublimaze) is unavailable, see medication section for Morphine Sulfate

ONDANSETRON (ZOFRAN) if Needed
0.15 mg / kg IM or IV over 2 - 4 minutes
-or- 0.15 mg / kg Injectable Liquid PO > 1 year old
May Repeat X1 if needed in 15 minutes
Up to Max of 8 mg

ONDANSETRON (ZOFRAN)
Oral Dissolving Tabs
4 mg PO > 40 kg AND 12 years
May Repeat X1 if needed in 15 minutes
Up to Max of 8 mg

Monitor Airway, Breathing, Vitals

Pain Other Than Listed
CONTACT MED CONTROL

NOT FOR
Altered Mentation,
Traumatic Abdominal Pain, Head
Trauma, Hypovolemia, Multiple
Trauma

CAPNOGRAPHY REQUIRED
IfAdministering Analgesics to Trauma
Patients Not Listed Above

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

EMT Intervention
AEMT Intervention
PARAMEDIC Intervention
MED CONTROL Consult
# PEDIATRIC PROTOCOL

## SEVERE PAIN MANAGEMENT

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age / onset</td>
<td>• Severity (pain scale)</td>
<td>• Per the specific protocol</td>
</tr>
<tr>
<td>• Location</td>
<td>• Quality (sharp, dull, etc.)</td>
<td>• Musculoskeletal</td>
</tr>
<tr>
<td>• Duration</td>
<td>• Radiation</td>
<td>• Visceral (abdominal)</td>
</tr>
<tr>
<td>• Severity (0 - 10)</td>
<td>• Relation to movement, respiration</td>
<td>• Cardiac</td>
</tr>
<tr>
<td>• Past medical history</td>
<td>• Increased with palpation of area</td>
<td>• Pleuritic (respiratory)</td>
</tr>
<tr>
<td>• Medications</td>
<td></td>
<td>• Neurogenic</td>
</tr>
<tr>
<td>• Drug allergies</td>
<td></td>
<td>• Renal (colic)</td>
</tr>
</tbody>
</table>

## PAIN SCALE

The Wong-Baker Faces Pain Rating Scale

Designed for children aged 3 years and older, the Wong-Baker Faces Pain Rating Scale is also helpful for elderly patients who may be cognitively impaired. It offers a visual description for those who don’t have the verbal skills to explain how their symptoms make them feel.

![Wong-Baker Faces Pain Rating Scale](image)

To use this scale, your doctor should explain that each face shows how a person in pain is feeling. That is, a person may feel happy because he or she has no pain (hurt), or a person may feel sad because he or she has some or a lot of pain.

### A Numerical Pain Scale

A numerical pain scale allows you to describe the intensity of your discomfort in numbers ranging from 0 to 10 (or greater, depending on the scale). Rating the intensity of sensation is one way of helping your doctor determine treatment. Numerical pain scales may include words or descriptions to better label your symptoms, from feeling no pain to experiencing excruciating pain. Some researchers believe that this type of combination scale may be most sensitive to gender and ethnic differences in describing pain.

## KEY POINTS

- Exam: Mental Status, Area of Pain, Neuro
- Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage.
- Pain is subjective (whatever the patient says it is).
- Pain severity (0-10) is a vital sign to be recorded pre and post medication delivery and at disposition.
- Vital signs should be obtained pre, 10 minutes post, and at disposition with all pain medications.
- Contraindications to morphine use include hypotension, head injury, and respiratory distress.
- All patients should have drug allergies documented prior to administering pain medications.
- All patients who receive pain medications must be observed 15 minutes for drug reaction.
- All patients who receive medication for pain must have continuous ECG monitoring, pulse oximetry, and oxygen administration.
- The patient’s vital signs must be routinely reassessed.
- Routine assessments and reassessments must be documented on the run report.
- Have Naloxone (Narcan) on hand if the patient has respiratory depression or hypotension after Morphine administration.
- **NOT FOR** Altered Mentation, Traumatic Abdominal Pain, Head Trauma, Hypovolemia, Multiple Trauma
TOXIC INGESTION / EXPOSURE / OVERDOSE

UNIVERSAL PATIENT CARE PROTOCOL

AIRWAY PROTOCOL
Monitor Lung Sounds for Fluid Overload

OXYGEN

IV / IO PROCEDURE
Apply Cardiac Monitor and Assess Vitals

CAPNOGRAPHY PROCEDURE

Narcotic Overdose
AMS / Respiratory Depression

TAKE PPE PRECAUTIONS
GLOVES / MASK minimum Contact / aerosol risk with fentanyl based substances

ASSURE BLS VENTILATION
WITH BVM
Support Hemodynamically Utilize Shock Protocol

NALOXONE (NARCAN)
1 mg IN Atomized SUMMON ALS IF NO REPSONSE TO IN DOSE

NALOXONE (NARCAN)
0.1 mg / kg
IV / IM / IN / IO

May repeat every 2 min as necessary if obvious or suspected opiate OD until respiratory improvement

If patient is unresponsive to Naloxone (Narcan), supply is exhausted, or the medication is unavailable, consider Advanced Airway and Support Hemodynamically

Tricyclic Anti - Depressants

Patient on any TRICYCLIC listed below or otherwise with QRS > 0.12 mesc

Adapin
Anafranil
Elavil
Endep
Ludiomil
Norpramin
Pamelor
Pertofrane
Sinequan
Surmontil
Tofranil
Vivactil

SODIUM BICARBONATE
1 mEq / kg
Until QRS narrows / condition improves

Beta Blocker / Calcium Channel Blocker

IV NORMAL SALINE BOLUS
20 ml / kg
To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable

DOPAMINE (INTROPIN)
5 – 20 mcg/kg/min IV DRIP
Titrare to effect (if MAP remains < 70 or SBP < 90)

ATROPINE
0.02 mg kg IV / IO
Repeat every 3 – 5 Minutes or as needed to control secretions

Given to dry secretions
No max dose

Treat with specific antidote

Calcium Channel Blockers OD
CALCIUM CHLORIDE
10 mg / kg IV / IO
Max 1 Gram

Beta Blocker OD
GLUCAGON (GLUCAGEN)
0.1 mg / kg IV / IO
Max 3 mg

Organophosphates

ATROPINE
0.02 mg kg IV / IO
Repeat every 3 – 5 Minutes or as needed to control secretions

Given to dry secretions
No max dose

TREAT TO INTRAVENOUS ADMINISTRATION

TRANSPORT to appropriate facility CONTACT receiving facility CONSULT Medical Direction where indicated

EMT Intervention | AEMT Intervention | PARAMEDIC Intervention | MED CONTROL Consult
**TOXIC INGESTION / EXPOSURE / OVERDOSE**

### HISTORY
- Ingestion or suspected ingestion of a potentially toxic substance
- Substance ingested, route, quantity
- Time of ingestion
- Reason (suicidal, accidental, criminal)
- Available medications in home
- Past medical history, medications

### SIGNS AND SYMPTOMS
- Mental status changes
- Hypo / hypertension
- Decreased respiratory rate
- Tachycardia, dysrhythmias
- Seizures

### DIFFERENTIAL DIAGNOSIS
- Tricyclic antidepressants (TCAs)
- Acetaminophen (Tylenol)
- Depressants
- Stimulants
- Anticholinergic
- Cardiac medications
- Solvents, alcohols, Cleaning agents
- Insecticides (organophosphates)
- Respiratory depression
- Carbamates

### COMMON BETA BLOCKERS
- Acebutolol
- Carvedilol
- Labetalol
- Propranolol
- Atenolol
- Coreg
- Levatol
- Sectral
- Betapace
- Corgard
- Lopressor
- Sotalol
- Betaxolol
- Esmolol
- Metoprolol
- Tenormin
- Bisoprolol
- Inderal
- Nadolol
- Timolol
- Brevibloc
- Innopran XL
- Nebivolol
- Trandate
- Bystolic
- Kerlone
- Pindolol
- Zabeta

### COMMON CALCIUM CHANNEL BLOCKERS
- Acalas
- Cardene
- Lacidipine
- Nitrin
- Adalat
- Cardif
- Lacipil
- Norvasc
- Amlodipine
- Cardizem
- Landel
- Plendil
- Aranidipine
- Cildipine
- Lercanidipine
- Atelec
- Cinalong
- Madipine
- Prandipine
- Azelnidipine
- Clevidipine
- Manidipine
- Procardia
- Barnidipine
- Cleviprex
- Motens
- Procorum
- Baylotensin
- Coniel
- Nicardipine
- Sarpenta
- Baymycard
- Diltiazem
- Nifedipine
- Siscard
- Benidipine
- Efondipine
- Nilvadipine
- Solar
- Calan
- Felodipine
- Nimodipine
- Sycor
- Calblock
- Gallopamil
- Nimotop
- Verapamil
- Calslot
- HypoCa
- Nisoldipine
- Zandip
- Carden SR
- Isoptin
- Nifedipine

**KEY POINTS**
- Exam: Mental Status, Skin, HEENT, Heart, Lungs, Abdomen, Extremities, Neuro
- Do not rely on patient history of ingestion, especially in suicide attempts.
- Bring bottles, contents, and emesis to ED.
- **Tricyclic**: 4 major areas of toxicity: seizures, dysrhythmias, hypotension, decreased mental status or coma; rapid progression from alert mental status to death.
- **Acetaminophen**: initially normal or nausea / vomiting. If not detected and treated, causes irreversible liver failure.
- **Depressants**: decreased HR, decreased BP, decreased temperature, decreased respirations, non-specific pupils.
- **Stimulants**: increased HR, increased BP, increased temperature, dilated pupils, and seizures.
- **Anticholinergics**: increased HR, increased temperature, dilated pupils, and mental status changes.
- **Cardiac Medications**: dysrhythmias and mental status changes.
- **Solvents**: nausea, vomiting, and mental status changes.
- **Insecticides**: increased or decreased HR, increased secretions, nausea, vomiting, diarrhea, pinpoint pupils.
- Consider restraints if necessary for patient’s and / or personnel’s protection per the Restrained Procedure.
- If it can be done safely, take whatever container the substance came from along with readily obtainable samples of medication unless this results in an unreasonable delay of transport.
- If applicable, DO NOT transport a patient to the hospital until properly decontaminated.
- Medical Direction may order antidotes for specific ingestions.
- **DO NOT** use syrup of ipecac. Exam: Mental Status, HEENT, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro
- Be aware of AMS as potential sign of an environmental toxin or Haz-Mat exposure and protect personal safety.
- It is safer to assume hypoglycemia than hyperglycemia if doubt exists.
- Do not let alcohol confuse the clinical picture. Alcoholics frequently develop hypoglycemia and need Thiamine before glucose.
- Low glucose (< 60), normal glucose (60 - 120), high glucose (> 250).
- Consider restraints if necessary for patient’s and / or personnel’s protection per the restraint procedure.
- Protect the patient airway and support ABCs.
- Document the patient’s Glasgow coma score pre and post treatment.
- Signs and symptoms of narcotic overdose include respiratory depression and altered mental status.
- Naloxone (Narcan) administration may cause the patient to go into acute opiate withdraw, which includes vomiting, agitation, and / or combative behavior. Always be prepared for combative behavior.
- Naloxone (Narcan) may wear off in as little as 20 minutes causing the patient to become more sedate and possibly hypoventilate. All A&O 4 patients having received Naloxone (Narcan) should be transported. If patient refuses transport, contact Medical Control before release.
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<td>Trauma Emergencies</td>
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<td>Abdominal Trauma</td>
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<td>Burns Trauma</td>
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<td>Chest Trauma</td>
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<td>Drowning/Near Drowning</td>
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<td>Extremity / Amputation Trauma</td>
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<td>Head Trauma</td>
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<td>Maxillofacial Trauma</td>
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<td>Multiple Trauma</td>
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<td>Glasgow Coma Scale</td>
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<td>Revised Trauma Score</td>
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<td>Rule of Nines – Burn Chart</td>
<td>24-11</td>
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</table>
GUIDELINES FOR LOAD AND GO TRAUMA TRANSPORTS

INDICATIONS
- Uncorrectable airway obstruction
- Tension pneumothorax
- Pericardial tamponade
- Penetrating chest wounds with signs of shock
- Hemothorax with signs of shock
- Head trauma with unilaterally dilated pupils
- Head trauma with rapidly deteriorating condition
- Unconsciousness

KEY POINTS
- A trauma victim is considered to be a pediatric patient if they are less than 16 years old.
- Once the patient is determined to be an actual or potential major trauma / multiple system patient, personnel on scene and / or medical control must quickly determine the appropriate course of action including:
  1. Requesting aeromedical evacuation from scene. See AEROMEDICAL TRANSPORT PROCEDURE.
  2. Ground transportation directly to an appropriate facility.
- Major trauma patients are to be transported to the closest Trauma Center.
- Contact the receiving hospital for all major trauma or critical patients.
- Cover open wounds, burns, and eviscerations.
- With the exception of airway control, initiate ALS enroute when transporting major trauma patients.
- If the EMT is unable to access patient airway and ventilate, transport to the closest facility for airway stabilization.
- The on scene time for major trauma patients should not exceed 10 minutes without a documented, acceptable reason for the delay.
- All major trauma patients should receive oxygen administration, an IV(s), and cardiac monitoring.
- Provide a documented reason if an intervention could not be performed.

Mass Casualty Incidents (MCI)
- Upon arrival at a MCI, the first arriving unit should notify their dispatch of the need to implement the mass casualty plan, call for additional resources, establish a safe staging area, and estimate the total number of victims.
- Each EMS service has a pre-defined coordinating hospital based on their county’s mass casualty plan. It is the responsibility of the responding jurisdiction to notify their appropriate coordinating hospital as soon as possible, giving a brief description of the incident and the estimated number of victims. The coordinating hospital will then notify the receiving hospitals of the MCI. The transportation officer should maintain a constant contact with the coordinating hospital until the scene has been cleared of salvageable victims.

THE GOLDEN PERIOD FOR THE PATIENT BEGINS WHEN THE TRAUMA HAPPENS
DO NOT WASTE VALUABLE TIME ON SCENE
Emergency medical service personnel shall use the following criteria, consistent with their certification, to evaluate whether an injured person qualifies as an adult trauma victim or pediatric trauma victim, in conjunction with the definition of trauma according to the State of Ohio Trauma Triage Guidelines.

A Pediatric Trauma Victim is a person < 16 years of age exhibiting one or more of the following physiologic or anatomic conditions:

### Physiologic conditions
- Glasgow Coma Scale < 13;
- Loss of consciousness > 5 minutes;
- Deterioration in level of consciousness at the scene or during transport;
- Failure to localize to pain;
- Evidence of poor perfusion, or evidence of respiratory distress or failure.

### Anatomic conditions
- Penetrating trauma to the head, neck, or torso;
- Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;
- Injuries to the head, neck, or torso where the following physical findings are present:
  - Visible crush injury;
  - Abdominal tenderness, distention, or seatbelt sign:
    - Pelvic fracture;
    - Flail chest;
- Injuries to the extremities where the following physical findings are present:
  - Amputations proximal to the wrist or ankle;
  - Visible crush injury:
  - Fractures of two or more proximal long bones;
  - Evidence of neurovascular compromise.
- Signs or symptoms of spinal cord injury;
- 2nd or 3rd Degree burns > 10% total BSA, or other significant burns involving the face, feet, hands, genitalia, or airway.

### Field Trauma Triage Criteria: Mechanism of Injury (MOI) & Special Considerations

#### Co-Morbid Diseases and Special Considerations:
- Age < 5 or > 55
- Cardiac disease
- Respiratory disease
- Diabetes
- Immunosuppression
- Morbid obesity
- Pregnancy
- Substance abuse / intoxication
- Liver disease
- Renal disease
- Bleeding disorder / anticoagulation

#### Mechanisms of Injury (MOI)
- High speed MVC
- Ejection from vehicle
- Vehicle rollover
- Death in same passenger compartment
- Extrication time > 20 minutes
- Falls greater than 20 feet
- Vehicle versus bicycle / pedestrian
- Pedestrian struck, thrown or run over
- Motorcycle crash > 20 mph with separation of rider from bike
- Fall from any height, including standing, with signs of traumatic brain injury
KEY POINTS

Exceptions to Mandatory Transport to a Trauma Center:

- Emergency Medical Service personnel shall transport a trauma victim directly to an adult or pediatric trauma center that is qualified to provide appropriate adult or pediatric care, unless one or more of the following exceptions apply:

  1. It is medically necessary to transport the victim to another hospital for initial assessment and stabilization before transfer to an adult or pediatric trauma center;
  2. It is unsafe or medically inappropriate to transport the victim directly to an adult or pediatric trauma center due to adverse weather or ground conditions or excessive transport time;
  3. Transporting the victim to an adult or pediatric trauma center would cause a shortage of local emergency medical service resources;
  4. No appropriate adult or pediatric trauma center is able to receive and provide adult or pediatric trauma care to the trauma victim without undue delay;
  5. Before transport of a patient begins, the patient requests to be taken to a particular hospital that is not a trauma center or, if the patient is less than eighteen years of age or is not able to communicate, such a request is made by an adult member of the patient’s family or a legal representative of the patient.

Glasgow Coma Scale

<table>
<thead>
<tr>
<th>INFANT</th>
<th>Glasgow Coma Scale</th>
<th>ADULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to age 4</td>
<td><strong>Eye Opening</strong></td>
<td>Age 4 to Adult</td>
</tr>
<tr>
<td>4 Spontaneously</td>
<td>Oriented 5</td>
<td>Spontaneously 4</td>
</tr>
<tr>
<td>3 To speech</td>
<td>Confused 4</td>
<td>To command 3</td>
</tr>
<tr>
<td>2 To pain</td>
<td>Inappropriate words 3</td>
<td>To pain 2</td>
</tr>
<tr>
<td>1 No response</td>
<td>Incomprehensible 2</td>
<td>No Response 1</td>
</tr>
</tbody>
</table>

**Best Verbal Response**

<table>
<thead>
<tr>
<th>INFANT</th>
<th>Glasgow Coma Scale</th>
<th>ADULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to age 4</td>
<td>Best Motor Response</td>
<td>Age 4 to Adult</td>
</tr>
<tr>
<td>6 Spontaneous</td>
<td>Obeys commands 6</td>
<td>Spontaneously 4</td>
</tr>
<tr>
<td>5 Localizes pain</td>
<td>Localizes pain 5</td>
<td>To command 3</td>
</tr>
<tr>
<td>4 Withdraws from pain</td>
<td>Withdraws from pain 4</td>
<td>To pain 2</td>
</tr>
<tr>
<td>3 Flexion (decortic)</td>
<td>Flexion (decortic) 3</td>
<td>No response 1</td>
</tr>
<tr>
<td>2 Extension (decterbrate)</td>
<td>Extension (decterbrate) 2</td>
<td>TOTAL = 1</td>
</tr>
<tr>
<td>1 No response</td>
<td>No response</td>
<td>TOTAL = 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INFANT</th>
<th>Glasgow Coma Scale</th>
<th>ADULT</th>
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<tbody>
<tr>
<td>Birth to age 4</td>
<td>TOTAL = ___</td>
<td></td>
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</table>

___ = TOTAL
ABDOMINAL TRAUMA

Pediatric Multiple Trauma Protocol if criteria

UNIVERSAL PATIENT CARE PROTOCOL

PEDIATRIC AIRWAY PROTOCOL

CONSIDER COMPLETE SPINAL IMOBILIZATION PROCEDURE

Determine if Load & Go

Control Hemorrhage / Dress Wounds

CAPNOGRAPHY PROCEDURE

Evisceration: Cover, clean saline dressing to loosely stabilize

Penetrating Object: Cover, clean saline dressing – Immobilize object. If too large to transport – attempt to cut with care not to further injure tissue

Penetrating Wounds: Cover, clean saline dressing. Look for exit wound

Blunt Trauma: Assess for change – distention. Note mechanism

IV / IO PROCEDURE

Normal Saline Bolus to maintain BP of 90 systolic

Monitor and Reassess

TRANSPORT to appropriate facility

CONTACT receiving facility

CONSULT Medical Direction where indicated

EMT Intervention

AEMT Intervention

PARAMEDIC Intervention

MED CONTROL Consult
ABDOMINAL TRAUMA

<table>
<thead>
<tr>
<th>MECHANISM</th>
<th>SIGNS &amp; SYMPTOMS</th>
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</thead>
<tbody>
<tr>
<td>• Blunt</td>
<td>• Altered mental status</td>
</tr>
<tr>
<td></td>
<td>• Shock</td>
</tr>
<tr>
<td></td>
<td>• Distention</td>
</tr>
<tr>
<td></td>
<td>• Swelling</td>
</tr>
<tr>
<td></td>
<td>• Bulging</td>
</tr>
<tr>
<td></td>
<td>• Nausea and vomiting</td>
</tr>
<tr>
<td>• Penetrating</td>
<td>• Altered mental status</td>
</tr>
<tr>
<td></td>
<td>• Bleeding</td>
</tr>
<tr>
<td></td>
<td>• Tenderness</td>
</tr>
<tr>
<td></td>
<td>• Pain</td>
</tr>
<tr>
<td></td>
<td>• Distention</td>
</tr>
<tr>
<td></td>
<td>• Eviseraton</td>
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<tr>
<td></td>
<td>• Discoloration</td>
</tr>
<tr>
<td></td>
<td>• Entrance / exit wounds</td>
</tr>
<tr>
<td></td>
<td>• Nausea &amp; vomiting</td>
</tr>
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Fluid Resuscitate to systolic of $70 + 2 \times age$

KEY POINTS

Trauma to the abdomen is either Blunt or Penetrating. Blunt injuries are harder to detect and diagnose, and have a death rate twice that of penetrating wounds. Key signs and symptoms of blunt trauma include a patient in shock with no obvious injuries. Distention of the abdomen is an indication of internal hemorrhage. Pain may not be a significant factor. Many abdominal trauma injuries are Load & Go cases.

- Look for both an entrance and exit wound for all penetrating trauma, and treat accordingly.
- For all major trauma patients, the on scene time should be less than ten minutes.
If burn < 10% body surface area (using rule of nines)
Cool down wound with NORMAL SALINE and dressings
Cover burn with dry sterile sheet or dressings

IV / IO PROCEDURE
Normal Saline bolus 20 mL / kg IV / IO

PEDIATRIC SEVERE PAIN PROTOCOL

Parkland Burn Formula
Fluid for first 24 hours (ml) = 4 x Patient's weight in kg x %BSA

The first half of this amount is delivered within 8 hours from the burn incident, and the remaining fluid is delivered in the next 16 hours

Thermal

Chemical

Eye Injury
Continuous flushing with Normal Saline

Remove clothing and / or expose area

Flush area with NORMAL SALINE for 10 – 15 minutes

INITIATE TRAUMA ALERT
TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

EMT Intervention   AEMT Intervention   PARAMEDIC Intervention   MED CONTROL Consult
**HISTORY**
- Type of exposure (heat, gas, chemical)
- Inhalation injury
- Time of injury
- Past medical history
- Medications
- Other trauma
- Loss of consciousness
- Tetanus / immunization status

**SIGNS AND SYMPTOMS**
- Burns, pain, swelling
- Dizziness
- Loss of consciousness
- Hypotension / shock
- Airway compromise / distress
- Singed facial or nasal hair
- Hoarseness / wheezing

**DIFFERENTIAL DIAGNOSIS**
- Superficial (1°) red and painful
- Partial thickness (2°) superficial partial thickness, deep partial thickness, blistering
- Full thickness (3°) painless and charred or leathery skin
- Chemical
- Thermal
- Electrical
- Radiation

**KEY POINTS**
- Exam: Mental Status, HEENT, Neck, Heart, Lungs, Abdomen, Extremities, Back, Neuro
  - Early intubation is required in significant inhalation injuries.
  - Critical Burns: >25% body surface area (BSA); full thickness burns >10% BSA; partial thickness superficial partial thickness, deep partial thickness and full thickness burns to face, eyes, hand or feet; electrical burns; respiratory burns; deep chemical burns; burns with extremes of age or chronic disease; and burns with associated major traumatic injury. These burns may require hospital admission or transfer to a burn center.
  - Potential CO exposure should be treated with 100% oxygen.
  - Circumferential burns to extremities are dangerous due to potential vascular compromise partial thickness to soft tissue swelling.
  - Burn patients are prone to hypothermia – Never apply ice or cool burns that involve >10% body surface area.
  - Do not overlook the possibility of multiple system trauma.
  - Do not overlook the possibility of child abuse with children and burn injuries.
  - See appendix for rule of nines.
  - Administer IV Fluids per the Parkland Burn Formula: Fluid for first 24 hours (ml) = 4 x Patient’s weight in kg x %BSA

1. **Thermal (dry and moist):**
   - Stop burning process: i.e. remove patient from heat source, cool skin, remove clothing
     - a. Stop burning process: i.e. remove patient from heat source, cool skin, remove clothing
     - b. If patient starts to shiver or skin is cool, stop cooling process.
     - c. Estimate extent (%) and depth of burn (see chart). Determine seriousness (see chart) of burn, contact Medical Control and transport accordingly.
       - Cover burn areas with sterile dressing.

2. **Radiation Burns:**
   - Treat as thermal burns except when burn is contaminated with radioactive source, then treat as chemical burn.
     - a. Treat as thermal burns except when burn is contaminated with radioactive source, then treat as chemical burn.
     - b. Wear appropriate protective clothing when dealing with contamination.
     - c. Contact HAZ MAT TEAM for assistance in contamination cases.

3. **Chemical Burns:**
   - Wear appropriate protective clothing and respirators.
     - a. Wear appropriate protective clothing and respirators.
     - b. Remove patient from contaminated area to decontamination site (NOT SQUAD).
     - c. Determine chemicals involved; contact appropriate agency for chemical information.
     - d. Remove patient’s clothing and flush skin.
     - e. Leave contaminated clothes at scene. Cover patient over and under before loading into squad.
     - f. Patient should be transported by personnel not involved in decontamination process.
     - g. Determine severity (see chart), contact Medical Control and transport accordingly.
     - h. Relay type of substance involved to Medical Control.

4. **Electrical Burns:**
   - Shut down electrical source; do not attempt to remove patient until electricity is CONFIRMED to be shut off.
     - a. Shut down electrical source; do not attempt to remove patient until electricity is CONFIRMED to be shut off.
     - b. Assess for visible entrance and exit wounds and treat as thermal burns.
     - c. Assess for internal injury, i.e., vascular damage, tissue damage, fractures, and treat accordingly.
     - d. Determine severity of burn, contact Medical Control and transport accordingly.

5. **Inhalation Burns:**
   - Always suspect inhalation burns when the patient is found in closed smoky environment and / or exhibits any of the following: burns to face / neck, singed nasal hairs, cough and / or stridor, soot in sputum.
     - a. Always suspect inhalation burns when the patient is found in closed smoky environment and / or exhibits any of the following: burns to face / neck, singed nasal hairs, cough and / or stridor, soot in sputum.
     - b. Provide oxygen therapy, contact Medical Control and transport.

- Handle patients gently to avoid further damage of the patient’s skin.
- If the patient is exposed to a chemical, whenever possible, get the name of the chemical, and document it on the patient run report. DO NOT transport any hazardous materials with the patient.
- Look for signs of dehydration and shock.
- Initiate early intubation for symptomatic patients with inhalation burns.
- Patients with major burns should be transported to a Regional Burn Center.
- Patients with unstable airway or who are rapidly deteriorating should be transported to the closest appropriate facility.
- Patients with large surface burns lose the ability to regulate their body temperature. Avoid heat loss by covering the patient.
CHEST TRAUMA

Cardiac Tamponade: Assess for + Beck’s Triad (Hypotension, + JVD and muffled heart sounds). Paradoxical Pulse (no radial pulse when breathing in) is likely. LOAD AND GO

Massive Hemothorax: Shock, then difficulty breathing. No JVD, decreased breath sounds, dull to percussion. LOAD AND GO

Open Pneumothorax / Sucking Chest Wound: Occlusive dressing secured on three sides or Commercial Chest Seal, allowing air escape. Prepare for tension pneumothorax. LOAD AND GO

Flail Chest: Stabilize flail segment with manual pressure then apply bulky dressing and tape. LOAD AND GO

Suspected: Traumatic Aortic Rupture, Tracheal or Bronchial Tree Injury, Myocardial Contusion, Diaphragmatic Tears, Esophageal Injury, Pulmonary Contusion: Ensure an Airway, Administer Oxygen, LOAD AND GO

INITIATE TRAUMA ALERT

TRANSFORM to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated
# CHEST TRAUMA

## SIGNS AND SYMPTOMS

<table>
<thead>
<tr>
<th>SIMPLE PNEUMOTHORAX</th>
<th>OPEN PNEUMOTHORAX</th>
<th>TENSION PNEUMOTHORAX</th>
<th>HEMOTHORAX</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Shortness of breath&lt;br&gt;• Dyspnea&lt;br&gt;• Tachypnea&lt;br&gt;• Cyanosis&lt;br&gt;• Chest pain&lt;br&gt;• Absent diminished Lung sounds on the affected side</td>
<td>• Shortness of breath&lt;br&gt;• Dyspnea&lt;br&gt;• Cyanosis&lt;br&gt;• Sucking chest wound&lt;br&gt;• Shock&lt;br&gt;• Absent / diminished Lung sounds on affected side</td>
<td>• Shortness of breath&lt;br&gt;• Cyanosis&lt;br&gt;• Shock&lt;br&gt;• Absent / diminished Lung sounds&lt;br&gt;• Tracheal deviation&lt;br&gt;• Hypotension&lt;br&gt;• JVD&lt;br&gt;• Tachycardia&lt;br&gt;• Dyspnea (late sign)</td>
<td>• Shortness of breath&lt;br&gt;• Dyspnea&lt;br&gt;• Cyanosis&lt;br&gt;• Dullness to Percussion sounds&lt;br&gt;• Flat neck veins&lt;br&gt;• Hypotension&lt;br&gt;• Shock&lt;br&gt;• Absent / diminished breath sounds&lt;br&gt;• Tachycardia</td>
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## CARDIAC TAMPONADE | TRAUMATIC ASPHYXIA | FLAIL CHEST |
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<tbody>
<tr>
<td>• Hypotension&lt;br&gt;• Decreasing pulse pressure&lt;br&gt;• Elevated neck veins&lt;br&gt;• Muffled heart tones&lt;br&gt;• Bruising over the sternum&lt;br&gt;• Bradycardia</td>
<td>• Bloodshot, bulging eyes&lt;br&gt;• Blue, bulging tongue&lt;br&gt;• JVD&lt;br&gt;• Cyanotic upper body</td>
<td>• Paradoxical chest wall movement&lt;br&gt;• Asymmetric chest movement Upon inspiration&lt;br&gt;• Dyspnea&lt;br&gt;• Unstable chest segment&lt;br&gt;• Significant chest wall pain</td>
</tr>
</tbody>
</table>

### Fluid Resuscitate to systolic of 70 + 2 x age

## KEY POINTS

Thoracic injuries have been called the deadly dozen. The first six are obvious at the primary assessment.

1. Airway obstruction
2. Flail chest
3. Cardiac tamponade
4. Massive hemothorax
5. Open pneumothorax
6. Tension pneumothorax

The second six injuries may be more subtle and not easily found in the field:

7. Traumatic aortic rupture
8. Esophageal injury
9. Myocardial contusion
10. Diaphragmatic tears
11. Tracheal / bronchial tree injury
12. Pulmonary contusion

- A **sucking chest wound** is when the thorax is open to the outside. The occlusive dressing may be anything such as petroleum gauze, plastic, or a defibrillator pad. Tape only 3 sides down so that excess intrathoracic pressure can escape, preventing a tension pneumothorax. May help respirations to place patient on the injured side, allowing unaffected lung to expand easier.

- A **flail chest** is when there are extensive rib fractures present, causing a loose segment of the chest wall resulting in paradoxical and ineffective air movement. This movement must be stopped by applying a bulky pad to inhibit the outward excursion of the segment. Positive pressure breathing via BVM will help push the segment and the normal chest wall out with inhalation and to move inward together with exhalation, getting them working together again. Do not use too much pressure to prevent additional damage or pneumothorax.

- A **penetrating object** must be immobilized by any means possible. If it is very large, cutting may be possible, with care taken not to move it about when making the cut. Place an occlusive and bulky dressing over the entry wound.

- A **tension pneumothorax** is life threatening, look for HYPOTENSION, unequal breath sounds, JVD, increasing respiratory distress, and decreasing mental status. The pleura must be decompressed with a needle to provide relief. Decompress between the 2nd and 3rd ribs, midclavicular placing the catheter over the 3rd rib. Once the catheter is placed, watch closely for reocclusion. Repeat if needed to prevent reocclusion. Use appropriately sized catheter for age.
**DROWNING / NEAR DROWNING**

**UNIVERSAL PATIENT CARE PROTOCOL**

- CONSIDER COMPLETE SPINAL IMOBILIZATION PROCEDURE
  - Place backboard while still in water if able.

**PEDIATRIC AIRWAY PROTOCOL**

- Initiate ventilation while patient is still in water if not breathing.
- Provide high flow oxygen ASAP.

**CAPNOGRAPHY PROCEDURE**

- IF DECOMPRESSION SICKNESS
  - Give oxygen – no positive pressure ventilation unless NOT breathing.

Apply Cardiac Monitor

**IF HYPOThERMIC**

- Treat per Hypothermia Protocol

**IV / IO PROCEDURE**

- Normal Saline TKO

Monitor and Reassess

**TRANSPORT** to appropriate facility
- **CONTACT** receiving facility
- **CONSULT** Medical Direction where indicated
HISTORY

- Submersion in water regardless of depth
- Possible trauma i.e.; fall, diving board
- Duration of immersion
- Temperature of water
- Salt vs. fresh water

SIGNS AND SYMPTOMS

- Period of unconsciousness
- Unresponsive
- Mental status changes
- Decreased or absent vital signs
- Vomiting
- Coughing

DIFFERENTIAL DIAGNOSIS

- Trauma
- Pre-existing medical problem
- Barotrauma (diving)
- Decompression sickness

KEY POINTS

- Exam: Trauma Survey, Head, Neck, Chest, Abdomen, Pelvis, Back, Extremities, Skin, Neuro
- Drowning due to suffocation from submersion in water.
- 2 causes – breath holding which leads to aspiration of water; & laryngospasm which closes the glottis.
- Both causes lead to profound hypoxia and death.
- Fresh water drowning ventricular fibrillation may be likely.
- Salt water drowning may cause pulmonary edema in time.
- Pulmonary edema can develop within 24 - 48 hours after submersion.
- All victims should be transported for evaluation due to potential for worsening over the next several hours.
- Drowning is a leading cause of death among would-be rescuers.
- Allow appropriately trained and certified rescuers to remove victims from areas of danger.
- With pressure injuries (decompression / barotrauma), consider transport for availability of a hyperbaric chamber.
- All hypothermic / hypothermic / near-drowning patients should have resuscitation performed until care is transferred, or if there are other signs of obvious death (putrefaction, traumatic injury unsustainable to life).
- A drowning patient is in cardiac arrest after the submersion.
- Consider SPINAL MOTION RESTRICTIN in all drowning cases. Always immobilize a drowning patient.
- Patients with low core temperatures will not respond to ALS drug interventions. Maintain warming procedures and supportive care.
- DO NOT perform the Heimlich maneuver to remove water from the lungs prior to resuscitation.
Amputation?
- Clean amputated part with normal saline irrigation
- Wrap part in sterile dressing and place in plastic bag if able
- Place on ice if available – no direct contact to tissue

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated
# Extremity Trauma / Amputation

## History
- Type of injury
- Mechanism: crush / penetrating / amputation
- Time of injury
- Open vs. closed wound / fracture
- Wound contamination
- Medical history
- Medications

## Signs and Symptoms
- Pain, swelling
- Deformity
- Altered sensation / motor function
- Diminished pulse / capillary refill
- Decreased extremity temperature

## Differential Diagnosis
- Abrasion
- Contusion
- Laceration
- Sprain
- Dislocation
- Fracture
- Amputation

## Key Points
- **Exam:** Mental Status, Extremity, Neuro
- In amputations, time is critical. Transport and notify medical control immediately, so that the appropriate destination can be determined.
- Hip dislocations and knee and elbow fracture / dislocations have a high incidence of vascular compromise.
- Urgently transport any injury with vascular compromise.
- Blood loss may be concealed or not apparent with extremity injuries.
- Lacerations must be evaluated for repair within 6 hours from the time of injury.

### Extremity Trauma
- In cases of major trauma, the backboard can work as a whole body splint.
- **DO NOT** take the time to splint injured extremities in major trauma patients unless it does not delay the scene time or prevents you from performing more pertinent patient care.
- Splint the extremity if the patient has signs and symptoms of a fracture or dislocation.
- Treat all suspected sprains or strains as fractures until proven otherwise.
- Splint the joint above and below for all suspected fractures.
- Splint the bone above and below for all suspected joint injuries.
- Check and document the patient’s MSP’s before and after splinting.
- A traction splint with a backboard is the preferred splint to use for femur fractures.

### Traumatic Amputation
- Care of the amputated extremity include:
  - Cleanse an amputated extremity with normal saline or sterile water.
  - **DO NOT** place any amputated tissue directly on ice or cold pack. Instead, place the amputated limb into a plastic bag. Put the bag into a container of cool water with a few ice cubes (if available).
- Contact the receiving hospital with the patient information, and include the status of the amputated limb.
- Focus on patient care and not on the amputated extremity.
- Tourniquets should be applied early if there is a risk of exsanguination (bleeding out) from extremity injury.
- Remember to calm and reassure the patient. Do not give the patient or their family member’s false hope of reattachment of the affected limb. A medical team at the receiving hospital makes this decision.
- Delegate someone to do an on scene search for the amputated part when it cannot be readily found and continue with patient care.
- Use only commercially available tourniquets.
**HEAD TRAUMA**

**UNIVERSAL PATIENT CARE PROTOCOL**
- Oxygen for all head trauma
- CONSIDER COMPLETE SPINAL IMOBILIZATION PROCEDURE
- Control Bleeding, Apply Dressing
- Determine and **Trend** GCS
- Consider Other Protocols
  - Multiple Trauma Protocol (if Not Isolated Head Trauma)
  - Altered Mental Status Protocol
  - Seizure Protocol (if Seizure Activity)

**Isolated Uncomplicated Head Trauma?**

**PEDIATRIC AIRWAY PROTOCOL**
- Do Not Hyperventilate
- **IV / IO PROCEDURE**
  - Limit IV fluids due to cerebral edema
  - **Maintain SBP 90**

**Evidence of, or Suspect Traumatic Brain Injury (TBI)?**

**PEDIATRIC AIRWAY PROTOCOL**
- **Do NOT** Allow Patient to Become Hypoxic During ANY Airway Management
- Maintain SpO₂ > 94% At All Times!
- Apply Capnography If Advanced Airway Used
- Herniation = Unilateral or Bilateral Dilation of Pupils, Posturing
- **If Herniation** Ventilate To Maintain CO₂ 30 - 35 or Child 25 Breaths / Min Infant 35 Breaths / Min
- **If Non - Herniation** Ventilate To Maintain CO₂ 35 - 40 Or Age Appropriate Ventilation
- **IV / IO PROCEDURE**
  - Normal Saline Bolus to maintain SBP 90
  - **Do NOT** allow patient to become hypotensive

**Monitor and Reassess**
- **INITIATE TRAUMA ALERT**
- **TRANSPORT** to appropriate facility **CONTACT** receiving facility **CONSULT** Medical Direction where indicated
## HEAD TRAUMA

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| · Time of injury  
· Mechanism (blunt vs. penetrating)  
· Loss of consciousness  
· Bleeding  
· Past medical history  
· Medications  
· Evidence for multi-trauma | · Pain, swelling, bleeding  
· Altered mental status  
· Unconscious  
· Respiratory distress / failure  
· Vomiting  
· Major traumatic mechanism of injury  
· Seizure | · Skull fracture  
· Brain injury (concussion, contusion, hemorrhage or laceration)  
· Epidural hematoma  
· Subdural hematoma  
· Subarachnoid hemorrhage  
· Spinal injury  
· Abuse |

Fluid Resuscitate to systolic of $70 + 2 \times \text{age}$

### KEY POINTS
- **Exam:** Mental Status, HEENT, Heart, Lungs, Abdomen, Extremities, Back, Neuro
- If GCS $< 12$ consider air / rapid transport and if GCS $< 8$ intubation should be anticipated.
- Increased intracranial pressure (ICP) may cause hypertension and bradycardia (Cushing’s Response).
- Hypotension usually indicates injury or shock unrelated to the head injury.
- The most important item to monitor and document is a change in the level of consciousness.
- Concussions are periods of confusion or LOC associated with trauma, which may have resolved by the time EMS arrives. A physician should evaluate any prolonged confusion or mental status abnormality, which does not return to normal within 15 minutes or any documented loss of consciousness.
MAXILLOFACIAL TRAUMA

UNIVERSAL PATIENT CARE PROTOCOL

Determine type of injury

- **Eye**
  - Remove contact lenses (if applicable)
  - If burn or foreign body, determine substance. Flush with copious amounts of normal saline
  - If non-penetrating trauma, consider topical pain control
    - Tetracaine (Pontocaine)
    - 1 drop to affected eye
  - If Tetracaine (Pontocaine) is used, patient must be evaluated at hospital

- **Tongue**
  - Have suction on and immediately available to maintain airway
  - Attempt to control bleeding with direct pressure / gauze if able and will not cause airway obstruction

- **Nose**
  - Have suction on and immediately available to maintain airway
  - Sit patient upright and forward. Pinch nostrils. Consider external applied cold pack to bridge of nose

- **Ear**
  - If foreign body, determine substance
  - Attempt to control bleeding with direct pressure / gauze

- **Tooth**
  - If tooth out attempt preservation as soon as possible in:
    - Commercially available tooth preservation kit (if available) or whole milk (if available).
    - Handle by enamel only, do not touch roots

- **Medical**
  - If Tetracaine (Pontocaine) is used, patient must be evaluated at hospital

- **Airway / Breathing**
  - Attempt to control bleeding with direct pressure / gauze if able and will not cause airway obstruction

- **Cardiac**
  - Sit patient upright and forward.
  - Pinch nostrils.
  - Consider external applied cold pack to bridge of nose

- **Trauma**
  - If Tetracaine (Pontocaine) is used, patient must be evaluated at hospital

TRANSPORT to appropriate facility CONTACT receiving facility CONSULT Medical Direction where indicated

EMT Intervention  AEMT Intervention  PARAMEDIC Intervention  MED CONTROL Consult
MAXILLOFACIAL / EYE TRAUMA

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| • Trauma of any type that results in injury to one or both eyes. | • Irritation to eye  
• Visual disturbances  
• Obvious penetrating injury  
• Burn (chemical, thermal)  
• Loss of vision  
• Dizziness  
• Loss of consciousness  
• Nausea | • Hypertension  
• Contact lens problem |

KEY POINTS

- If unsure if something can be flushed with water, contact Medical Command.
- A garden hose can be used to help flush the patient’s eye(s) if available. DO NOT use a high-pressure hose or at a high force. If needed, irrigate the patient’s eyes for approximately 5-15 minutes.
- Begin irrigating immediately, because irreversible damage can occur in a few minutes.

TRAUMA

- Do not allow eye injury to distract you from the basics of trauma care.
- Do not remove any foreign body imbedded in the eye or orbit. Stabilize any large protruding foreign bodies.
- With blunt trauma to the eye, if time permits, examine the globe briefly for gross laceration as the lid may be swollen tightly shut later. Sclera rupture may lie beneath an intact conjunctiva.
- Covering both eyes when only one eye is injured may help to minimize trauma to the injured eye, but in some cases the patient is too anxious to tolerate this.
- Transport patient supine unless other life threats prohibit this from being done. (This is based on physics, the goal of not letting the fluid within the eye drain out of the eye)

CHEMICAL BURNS

- When possible determine type of chemical involved first. The eye should be irrigated with copious amounts of water or saline, using IV tubing wide open for a minimum of 15 minutes started as soon as possible. Any delay may result in serious damage to the eye.
- Always obtain name and, if possible, a sample of the contaminant or ask that they be brought to the hospital as soon as possible.

CONTACT LENSES

- If possible, contact lenses should be removed from the eye; be sure to transport them to the hospital with the patient. If the lenses cannot be removed, notify the ED personnel as soon as possible.
- If the patient is conscious and alert, it is much safer and easier to have the patient remove their lenses.

ACUTE, UNILATERAL VISION LOSS

- When a patient suddenly loses vision in one eye with no pain, there may be a central retinal artery occlusion. Urgent transport and treatment is necessary.
- Patient should be transported flat.
Consider Air transport if delay due to extrication

**UNIVERSAL PATIENT CARE PROTOCOL**
- Consider complete spinal immobilization procedure
- Pediatric airway protocol
- Rapid trauma assessment
- Capnography procedure
- Attach cardiac monitor

**IV / IO PROCEDURE**
- Assess vital signs / perfusion

**Rapid Trauma Assessment**
- Ongoing assessment
- Reassess airway
- Ventilate appropriately
- Normal saline bolus
  - 20 ml/kg - repeat as needed
- Monitor and reassess
- Continued hypotension?
  - Trauma arrest?
  - Consider needle decompression

**Abnormal**
- Reassess airway
- Ventilate appropriately
- Normal saline bolus
  - 20 ml/kg - repeat as needed
- Monitor and reassess
- Continued hypotension?
  - Trauma arrest?
  - Consider needle decompression

**Normal**
- Ongoing assessment
- Monitor and reassess
- Treat per appropriate protocol

**INITIATE TRAUMA ALERT**
- Transport to appropriate facility
- Contact receiving facility
- Consult medical direction where indicated
MULTIPLE TRAUMA

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Time and mechanism of injury</td>
<td>• Pain, swelling</td>
<td>• Life Threatening:</td>
</tr>
<tr>
<td>• Damage to structure or vehicle</td>
<td>• Deformity, lesions, bleeding</td>
<td>• Chest Tension pneumothorax</td>
</tr>
<tr>
<td>• Location in structure or vehicle</td>
<td>• Altered mental status</td>
<td>• Flail chest</td>
</tr>
<tr>
<td>• Others injured or dead</td>
<td>• Unconscious</td>
<td>• Pericardial tamponade</td>
</tr>
<tr>
<td>• Speed and details of MVC</td>
<td>• Hypotension or shock</td>
<td>• Open chest wound</td>
</tr>
<tr>
<td>• Restraints / protective equipment</td>
<td>• Arrest</td>
<td>• Hemorrhax</td>
</tr>
<tr>
<td>• Car seat</td>
<td></td>
<td>• Intra-abdominal bleeding</td>
</tr>
<tr>
<td>• Helmet</td>
<td></td>
<td>• Pelvis / femur fracture</td>
</tr>
<tr>
<td>• Pads</td>
<td></td>
<td>• Spine fracture / cord injury</td>
</tr>
<tr>
<td>• Ejection</td>
<td></td>
<td>• Head injury (see Head trauma)</td>
</tr>
<tr>
<td>• Past medical history</td>
<td></td>
<td>• Extremity fracture / dislocation</td>
</tr>
<tr>
<td>• Medications</td>
<td></td>
<td>• HEENT (airway obstruction)</td>
</tr>
</tbody>
</table>

A Pediatric Trauma Victim is a person < 16 years of age exhibiting one or more of the following physiologic or anatomic conditions:

**Physiologic conditions**
- Glasgow Coma Scale < 13;
- Loss of consciousness > 5 minutes;
- Deterioration in level of consciousness at the scene or during transport;
- Failure to localize to pain;
- Evidence of poor perfusion, or evidence of respiratory distress or failure.

**Anatomic conditions**
- Penetrating trauma to the head, neck, or torso;
- Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;
- Injuries to the head, neck, or torso where the following physical findings are present;
- Visible crush injury;
- Abdominal tenderness, distention, or seatbelt sign;
  - Pelvic fracture;
  - Flail chest;
- Injuries to the extremities where the following physical findings are present:
  - Amputations proximal to the wrist or ankle;
  - Visible crush injury;
  - Fractures of two or more proximal long bones;
  - Evidence of neurovascular compromise.
- Signs or symptoms of spinal cord injury;
- 2nd or 3rd Degree burns > 10% total BSA, or other significant burns involving the face, feet, hands, genitalia, or airway.

Fluid Resuscitate to systolic of 70 + 2 x age

**KEY POINTS**
- Exam: Mental Status, Skin, HEENT, Heart, Lung, Abdomen, Extremities, Back, Neuro
- Mechanism is the most reliable indicator of serious injury. Examine all restraints / protective equipment for damage.
- In prolonged extrications or serious trauma consider air transportation for transport times and the ability to give blood.
- Do not overlook the possibility for child abuse.
- A trauma victim is considered to be a pediatric patient if they are < 16 years old.
- Major trauma patients are to be transported to the closest pediatric trauma center.
- Contact the receiving hospital for all major trauma or critical patients.
- The Proper size equipment is very important to resuscitation care. Refer to length based drug treatment guide (e.g. BROSELOW PEDIATRIC EMERGENCY TAPE OR SIMILAR GUIDE) when unsure about patient weight, age and / or drug dosage and when choosing equipment size.
- Cover open wounds, burns, eviscerations.
- With the exception of airway control, initiate ALS enroute when transporting major trauma patients.
- If unable to access patient airway and ventilate, then transport to the closest facility for airway stabilization.
- The on scene time for major trauma patients should not exceed 10 minutes without documented, acceptable reason for the delay.
- When initiating an IV and drawing blood, collect a red top blood tube to assist the receiving hospital with determining the patient’s blood type.
- All major trauma patients should receive oxygen administration, an IV(s), and cardiac monitoring.
- Provide a documented reason if an intervention could not be performed.
- Transport to a Pediatric Trauma center when able.
TRAUMA ARREST

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| • Time of injury  
• Mechanism: blunt / penetrating  
• Loss of consciousness  
• Bleeding  
• Medications  
• Evidence of multi-trauma | • Excessive bleeding  
• Unresponsive; not breathing  
• Cardiac arrest  
• Significant mechanism of injury | • Obvious DOA  
• Death |

**KEY POINTS**

- Immediately transport traumatic cardiac arrest patients.
- With the exception of airway management, traumatic cardiac arrests are “load and go” situations.
- Resuscitation should not be attempted in cardiac arrest patients with spinal transection, decapitation, or total body burns, nor in patients with obvious, severe blunt trauma that are without vital signs, pupillary response, or an organized or shockable cardiac rhythm at the scene. Patients in cardiac arrest with deep penetrating cranial injuries and patients with penetrating cranial or truncal wounds associated with asystole and a transport time of more than 15 minutes to a definitive care facility are unlikely to benefit from resuscitative efforts.
- Extensive, time-consuming care of trauma victims in the field is usually not warranted. Unless the patient is trapped, they should be enroute to a medical facility within 10 minute after arrival of the ambulance on the scene.
## GLASGOW COMA SCALE

<table>
<thead>
<tr>
<th>EYE OPENING</th>
<th>Spontaneous</th>
<th>Spontaneous</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>To voice</td>
<td>To voice</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>To pain</td>
<td>To pain</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>None</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VERBAL RESPONSE</th>
<th>Oriented</th>
<th>Coos, babbles</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confused</td>
<td>Irritable cry, inconsolable</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Inappropriate</td>
<td>Cries to pain,</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Garbled speech</td>
<td>Moans to pain</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>None</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOTOR RESPONSE</th>
<th>Obey commands</th>
<th>Normal movements</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Localizes pain</td>
<td>Withdrews to touch</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Withdrews to pain</td>
<td>Withdrews to pain</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Flexion</td>
<td>Flexion</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Extension</td>
<td>Extension</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Flaccid</td>
<td>Flaccid</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

*NOTE: MOTOR RESPONSE IS MOST INDICATIVE OF LEVEL OF INJURY*

## NORMAL VITAL SIGNS

<table>
<thead>
<tr>
<th>AGE</th>
<th>HEART RATE</th>
<th>RESPIRATIONS</th>
<th>SYSTOLIC BLOOD PRESSURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preterm, 1 kg</td>
<td>120-160</td>
<td>30-60</td>
<td>36-58</td>
</tr>
<tr>
<td>Preterm 1 kg</td>
<td>120-160</td>
<td>30-60</td>
<td>42-66</td>
</tr>
<tr>
<td>Preterm 2 kg</td>
<td>120-160</td>
<td>30-60</td>
<td>50-72</td>
</tr>
<tr>
<td>Newborn</td>
<td>126-160</td>
<td>30-60</td>
<td>60-70</td>
</tr>
<tr>
<td>Up to 1 yo</td>
<td>100-140</td>
<td>30-60</td>
<td>70-80</td>
</tr>
<tr>
<td>1-3 yo</td>
<td>100-140</td>
<td>20-40</td>
<td>76-90</td>
</tr>
<tr>
<td>4-6 yo</td>
<td>80-120</td>
<td>20-30</td>
<td>80-100</td>
</tr>
<tr>
<td>7-9 yo</td>
<td>80-120</td>
<td>16-24</td>
<td>84-110</td>
</tr>
<tr>
<td>10-12 yo</td>
<td>60-100</td>
<td>16-20</td>
<td>90-120</td>
</tr>
<tr>
<td>13-14 yo</td>
<td>60-90</td>
<td>16-20</td>
<td>90-120</td>
</tr>
<tr>
<td>15 + yo</td>
<td>60-90</td>
<td>14-20</td>
<td>90-130</td>
</tr>
</tbody>
</table>

Blood pressure is a late and unreliable indicator of shock in children.
1% is equal to the surface of the palm of the patient’s hand. If unsure of %, describe injured area.

**MAJOR BURN CRITERIA**

- 2° and 3° burns > 10% surface area
- Burns of the face, hands feet genitalia
- Electrical shock with burn injury
- Burn with inhalation injury any burn with potential functional or cosmetic impairment
CHILDBIRTH / OBSTETRICAL EMERGENCIES

ABNORMAL BIRTH EMERGENCIES

UNIVERSAL PATIENT CARE PROTOCOL

CORD AROUND NECK
- Loosen cord or clamp and cut if too tight
  - Continue delivery

PROLAPSED CORD
- Transport mother with hips elevated and knees to chest
  - Insert fingers to relieve pressure on cord
  - Cover cord with sterile saline dressing

BREECH BIRTH
- Transport except when delivery is imminent
  - Do not encourage mother to push
  - Support but do not pull presenting parts

SHOULDER DYSTOCIA
- Transport mother with hips elevated and knees to chest
  - Insert fingers to relieve pressure on cord
  - Place pressure above symphysis pubis

If delivery is in process and the head is clamped inside vagina, create air passage by supporting body of infant and placing 2 fingers along sides of nose, and push away from face to facilitate an airway passage.

If unable to deliver, transport mother with hips elevated and knees to chest

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated

EMT Intervention
AEMT Intervention
PARAMEDIC Intervention
MED CONTROL Consult
CHILDBIRTH / OBSTETRICAL EMERGENCIES

ABNORMAL BIRTH EMERGENCIES

CONTACT MEDICAL DIRECTION IMMEDIATELY WHEN ANY ABNORMAL BIRTH PRESENTATION IS DISCOVERED

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| • Past medical history  
• Hypertension meds  
• Prenatal care  
• Prior pregnancies / births  
• Gravida / para  
• Ultrasound findings in prenatal care | • Frank breech (buttocks presents first)  
• Footling breech (one foot or both feet presenting)  
• Transverse lie (fetus is on his / her side with possible arm or leg presenting)  
• Face first presentation  
• Prolapsed cord (umbilical cord presents first) | • Miscarriage  
• Stillbirth |

KEY POINTS

General Information
- DO NOT pull on any presenting body parts.
- These patients will most likely require a c-section, so immediate transport is needed.
- Prolonged, non-progressive labor distresses the fetus and mother. Be sure to reassess mother’s vital signs continuously.
- Transport to an appropriate OB facility if the patient is pregnant.

Cord Around Baby’s Neck:
- As baby’s head passes out the vaginal opening, feel for the cord. Initially try to slip cord over baby’s head; if too tight, clamp cord in two places and cut between clamps.

Breech Delivery:
- Footling breech, which is one or both feet delivered first
- Frank breech, which is the buttocks first presentation
  - When the feet or buttocks first become visible, there is normally time to transport patient to nearest facility.
  - If upper thighs or the buttock have come out of the vagina, delivery is imminent.
  - If the child’s body has delivered and the head appears caught in the vagina, the EMT must support the child’s body and insert two fingers into the vagina along the child’s neck until the chin is located. At this point, the two fingers should be placed between the chin and the vaginal canal and then advanced past the mouth and nose.
  - After achieving this position a passage for air must be created by pushing the vaginal canal away from the child’s face. This air passage must be maintained until the child is completely delivered.

Excessive Bleeding Pre-Delivery:
- If bleeding is excessive during this time and delivery is imminent, in addition to normal delivery procedures, the EMT should use the HYPOVOLEMIC SHOCK PROTOCOL.
- If delivery is not imminent, patient should be transported on her left side and shock protocol followed.

Excessive Bleeding Post-Delivery:
- If bleeding appears to be excessive, start IV of saline.
- If placenta has been delivered, massage uterus and put baby to mother’s breast.
- Follow HYPOVOLEMIC SHOCK PROTOCOL.

Prolapsed Cord:
- When the umbilical cord passes through the vagina and is exposed, the EMT should check cord for a pulse.
- The patient should be transported with hips elevated or in the knee chest position and a moist dressing around cord.
- If umbilical cord is seen or felt in the vagina, insert two fingers to elevate presenting part away from cord, distribute pressure evenly when occiput presents.
- DO NOT attempt to push the cord back. High flow oxygen and transport IMMEDIATELY.

Shoulder Dystocia:
- Following delivery of the head the shoulder(s) become “stuck” behind the symphisis pubis or sacrum of the mother.
- Occurs in approximately 1% of births.
OBSTETRICAL EMERGENCIES

UNIVERSAL PATIENT CARE PROTOCOL

IV / IO PROCEDURE

Vaginal Bleeding / Abdominal Pain?

No

Hypertension

Yes

Mild Pre-eclampsia – (BP >140/90, Peripheral Edema)
Severe Pre-eclampsia – (BP >140/90, Edema, Headache, Visual Disturbances)

Eclampsia = Seizures (other signs absent)

If patient actively seizing, give Magnesium Sulfate 4 - 6 grams in 10 ml NS IV / IO over 2 - 3 minutes

ONLY IF MAGNESIUM FAILS
LORAZEPAM (ATIVAN) 1 – 2 mg IV / IM / IN / IO

If Lorazepam (Ativan) Unavailable, See Medication Section for Midazolam (Versed)

QUIET RAPID TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated
Transport to Hospital with OB Facilities

Yes

Bleeding / Hypotension

Bleeding
1st Trimester – Miscarriage, Ectopic Pregnancy
2nd & 3rd Trimester – Placenta Previa Abruptio Placenta

NORMAL SALINE BOLUS
To Maintain MAP > 70 or SBP 90 / Radial Pulses if NIBP Unavailable

Pad bleeding, save and bring with patient

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated
Transport to Hospital with OB Facilities

EMT Intervention    AEMT Intervention    PARAMEDIC Intervention    MED CONTROL Consult
## Obstetrical Emergencies

### History
- Past medical history
- Hypertension meds
- Prenatal care
- Prior pregnancies / births
- Gravida (preganices) / para (live births)

### Signs and Symptoms
- Vaginal bleeding
- Abdominal pain
- Seizures
- Hypertension
- Severe headache
- Visual changes
- Edema of hands and face

### Differential Diagnosis
- Pre-eclampsia / eclampsia
- Placenta previa
- Placenta abruptio
- Spontaneous abortion

### Key Points
- **Exam:** Mental Status, Abdomen, Heart, Lungs, Neuro
- **General Information**
  - Any woman of child bearing age with syncope should be considered an ectopic pregnancy until proven otherwise.
  - May place patient in a left lateral position to minimize risk of supine hypotensive syndrome.
  - Ask patient to quantify bleeding - number of pads used per hour.
  - Any pregnant patient involved in a MVC should be seen immediately by a physician for evaluation and fetal monitoring.
  - **DO NOT** apply packing into the vagina.
  - Be alert for fluid overload when administering fluids.
  - Consider starting a second IV if the patient is experiencing excessive vaginal bleeding or hypotension maintain BP 90 systolic.
  - Transport to an appropriate OB facility if the patient is pregnant.
- **Abortion / Miscarriage**
  - The patient may be complaining of cramping, nausea, and vomiting.
  - Be sure to gather any expelled tissue and transport it to the receiving facility.
  - Signs of infection may not be present if the abortion/miscarriage was recent.
  - An abortion is any pregnancy that fails to survive over 20 weeks. When it occurs naturally, it is commonly called a “miscarriage”.
- **Abruptio Placenta**
  - Usually occurs after 20 weeks.
  - Dark red vaginal bleeding.
  - May only experience internal bleeding.
  - May complain of a “tearing” abdominal pain.
- **Ectopic Pregnancy**
  - The patient may have missed a menstrual period or had a positive pregnancy test.
  - Acute unilateral lower abdominal pain that may radiate to the shoulder.
  - Any female of childbearing age complaining of abdominal pain is considered to have an ectopic pregnancy until proven otherwise.
- **Pelvic Inflammatory Disease**
  - Be tactful when questioning the patient to prevent embarrassment.
  - Diffuse back pain.
  - Possibly lower abdominal pain.
  - Pain during intercourse.
  - Nausea, vomiting, or fever.
  - Vaginal discharge.
  - May walk with an altered gait do to abdominal pain.
- **Placenta Previa**
  - Usually occurs during the last trimester.
  - Painless.
  - Bright red vaginal bleeding.
- **Post Partum Hemorrhage**
  - Post partum blood loss greater than 300 - 500 ml.
  - Bright red vaginal bleeding.
  - Be alert for shock and hypotension.
- **Uterine Inversion**
  - The uterine tissue presents from the vaginal canal. Cover with sterile saline dressing.
  - Be alert for vaginal bleeding and shock.
- **Pre-Eclampsia / Eclampsia**
  - Severe headache, vision changes, or RUQ pain may indicate pre-eclampsia.
  - In the setting of pregnancy, hypertension is defined as a BP greater than 140 systolic and greater than 90 diastolic, or a relative increase of 30 systolic and 20 diastolic from the patient’s normal (pre-pregnancy) blood pressure.
- **Uterine Rupture**
  - Often caused by prolonged, obstructed, or non-progressive labor.
  - Severe abdominal pain.
- **Vaginal Bleeding**
  - If the patient is experiencing vaginal bleeding, **DO NOT** pack the vagina, pad on outside only.
CHILDBIRTH / OBSTETRICAL EMERGENCIES

UNCOMPLICATED DELIVERY

Contact Medical Control to Notify of Delivery

Observed Head Crowning

UNIVERSAL PATIENT CARE PROTOCOL

Prepare Patient for Delivery
Set-Up Equipment

IV PROCEDURE (if time) Not in AC
Normal Saline at KVO

Delivery of Head
Firm, gentle pressure with flat of hand to slow expulsion
Allow head to rotate normally, check for cord around neck,
wipe face free of debris
Suction mouth and nose with bulb syringe

Delivery of Body
Place one palm over each ear with next contraction gently
move downward until upper shoulder appears
Then lift up gently to ease out lower shoulder
Support the head and neck with one hand and buttocks with other

Newborn and Cord
Keep newborn at level of vaginal opening
Keep warm and dry
After 10 seconds, clamp cord in two places with sterile equipment at least 6 - 8” from newborn
Cut between clamps

Allow placenta to deliver itself but do not delay transport while waiting
Take placenta to hospital with patient
DO NOT PULL ON CORD TO DELIVERY PLACENTA!
Perform APGAR Score 1 min and 5 min post delivery

TRANSPORT to appropriate facility
CONTACT receiving facility
CONSULT Medical Direction where indicated
Transport to Hospital with OB Facilities

EMT Intervention
AEMT Intervention
PARAMEDIC Intervention
MED CONTROL Consult
CHILDBIRTH / OBSTETRICAL EMERGENCIES

UNCOMPLICATED DELIVERY

CONTACT MEDICAL DIRECTION IMMEDIATELY WHEN DELIVERY IS IMMINENT

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>SIGNS AND SYMPTOMS</th>
<th>DIFFERENTIAL DIAGNOSIS</th>
</tr>
</thead>
</table>
| - Due date  
  - Time contractions started / how often  
  - Rupture of membranes  
  - Time / amount of any vaginal bleeding  
  - Sensation of fetal activity  
  - Past medical and delivery history  
  - Medications | - Spasmotic pain  
  - Vaginal discharge or bleeding  
  - Crowning or urge to push  
  - Meconium  
  - Left lateral position  
  - Inspect perineum (No digital vaginal exam) | - Abnormal presentation  
  - Buttock  
  - Foot  
  - Hand  
  - Prolapsed cord  
  - Placenta previa  
  - Abruptio placenta |

APGAR SCORING

<table>
<thead>
<tr>
<th>SIGN</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLOR</td>
<td>Blue / Pale</td>
<td>Pink Body, Blue Extremities</td>
<td>Completely Pink</td>
</tr>
<tr>
<td>HEART RATE</td>
<td>Absent</td>
<td>Below 100</td>
<td>Above 100</td>
</tr>
<tr>
<td>IRRITABILITY (Response to Stimulation)</td>
<td>No Response</td>
<td>Grimace</td>
<td>Cries</td>
</tr>
<tr>
<td>MUSCLE TONE</td>
<td>Limp</td>
<td>Flexion of Extremities</td>
<td>Active Motion</td>
</tr>
<tr>
<td>RESPIRATORY EFFORT</td>
<td>Absent</td>
<td>Slow and Regular</td>
<td>Strong Cry</td>
</tr>
</tbody>
</table>

KEY POINTS

- Exam (of Mother): Mental Status, Heart, Lungs, Abdomen, Neuro
- Document all times (delivery, contraction frequency, and length).
- If maternal seizures occur, refer to the OBSTETRICAL EMERGENCIES PROTOCOL.
- After delivery, massaging the uterus (lower abdomen) will promote uterine contraction and help to control post-partum bleeding.
- Some bleeding is normal with any childbirth. Large quantities of blood or free bleeding are abnormal.
- Prepare to deliver on scene (protecting the patient’s privacy). If delivery becomes imminent while enroute, stop the squad and prepare for delivery.
- Newborns are very slippery, so be careful not to drop the baby.
- There is no need to wait on scene to deliver the placenta.
- If possible, transport between deliveries if the mother is expecting twins.
- Allow the placenta to deliver, but DO NOT delay transport while waiting.
- DO NOT PULL ON THE UMBILICAL CORD WHILE PLACENTA IS DELIVERING.
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<th>Pharmacology Review</th>
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<td>Pregnancy Classes</td>
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### Standard Use Medications

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<tr>
<td>Acetaminophen (Tylenol) ORAL LIQUID</td>
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</tr>
<tr>
<td>Adenosine (Adenocard)</td>
<td>6-13</td>
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<tr>
<td>Albuterol (Proventil / Ventolin)</td>
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</tr>
<tr>
<td>Albuterol and Ipratropium (DuoNeb)</td>
<td>8-13</td>
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<tr>
<td>Amiodarone (Cordarone)</td>
<td>9-13</td>
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<tr>
<td>Aspirin</td>
<td>10-13</td>
</tr>
<tr>
<td>Atropine Sulfate</td>
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</tr>
<tr>
<td>Calcium Chloride</td>
<td>12-13</td>
</tr>
<tr>
<td>Dextrose</td>
<td>13-13</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>14-13</td>
</tr>
<tr>
<td>Dopamine (Intropin)</td>
<td>15-13</td>
</tr>
<tr>
<td>Epinephrine (Adrenalin)</td>
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<tr>
<td>Fentanyl (Sublimaze)</td>
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<tr>
<td>Glucagon (Glucagen)</td>
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<td>Haloperidol (Haldol)</td>
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<td>Heparin</td>
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<td>Hydromorphone (Dilaudid)</td>
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<td>Ipratropium (Atrovent)</td>
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<td>Ketamine (Ketalar)</td>
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<tr>
<td>Ketorolac (Toradol)</td>
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<tr>
<td>Lidocaine (Xylocaine)</td>
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<tr>
<td>Lorazepam (Ativan)</td>
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<tr>
<td>Magnesium Sulfate</td>
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<tr>
<td>Methylprednisolone (Solu-Medrol)</td>
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<tr>
<td>Metoprolol (Lopressor)</td>
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<td>Midazolam (Versed)</td>
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<td>Morphine Sulfate</td>
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<td>Naloxone (Narcan)</td>
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<td>Nitroglycerin (Nitro-Stat)</td>
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<td>Ondansetron (Zofran)</td>
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<tr>
<td>Oral Glucose (Instant Glucose)</td>
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<tr>
<td>Oxygen (O2)</td>
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<tr>
<td>Racemic Epinephrine</td>
<td>37-13</td>
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<tr>
<td>Sodium Bicarbonate</td>
<td>38-13</td>
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<tr>
<td>Tetracaine (Pontocaine)</td>
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<tr>
<td>Thiamine</td>
<td>40-13</td>
</tr>
<tr>
<td>Ticagrelor (Brilinta)</td>
<td>41-13</td>
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<tr>
<td>Blank</td>
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</tbody>
</table>

### Special Use Medications

<table>
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<tr>
<td>Ciprofloxacin (Cipro)</td>
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<tr>
<td>Clopidogril (Plavix)</td>
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<tr>
<td>Doxycycline (Vibramycin)</td>
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<tr>
<td>DuoDote (Atropine and Pralidoxime) and Valium NERVE AGENT KIT</td>
<td>46-13</td>
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<tr>
<td>Etomidate (Amidate)</td>
<td>47-13</td>
</tr>
<tr>
<td>Hydroxocobalamin (Cyanokit)</td>
<td>48-13</td>
</tr>
<tr>
<td>Nitrous Oxide / Oxygen</td>
<td>49-13</td>
</tr>
<tr>
<td>Succinylcholine (Anectine)</td>
<td>50-13</td>
</tr>
<tr>
<td>Tenecteplase (TNKase)</td>
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</table>

### Pediatric Weight Based Dosing

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<tbody>
<tr>
<td>Pediatric Drug Administration Charts</td>
<td>52-13 thru 56-13</td>
</tr>
</tbody>
</table>
I. ACTIONS OF MEDICATIONS
   1. Local effects
   2. Systemic effects

II. EFFECTS DEPENDS UPON
   1. Age of patient
   2. Condition of patient
   3. Dosage
   4. Route of administration

III. ROUTE OF ADMINISTRATION
   1. Intravenous (IV)
      - Most rapidly effective
      - Most dangerous
      - Give SLOWLY through an established IV line (FOR MOST MEDICATIONS)
   2. Intramuscular (IM)
      - Takes longer to act
      - Longer duration of action (Oil vs. water based medications duration varies)
      - Deltoid or gluteus maximus site
      - Absorption VERY dependent on blood flow
   3. Subcutaneous (SQ)
      - Slower and more prolonged absorption
      - Under skin of upper arms, thigh, abdomen
   4. Inhalation
      - Bronchodilators
      - Steroids (Patients may be prescribed)
   5. Endotracheal (Only administer through ET as a last resort with no better options)
      - Epinephrine (Adrenaline), Atropine, Lidocaine (Xylocaine), Naloxone (Narcan)
      - Medication dose must be twice the IV dose
   6. Sublingual (SL)
      - Rapid absorption
      - Patient must be well hydrated for good absorption
   7. Oral
      - Slow rate of absorption
   8. Rectal (PR)
      - Rapid but unpredictable absorption
   9. Intranasal (IN)
      - Must use specific device to aerosolize medication
10. Used with approved medications only
11. Intraossesous (IO)
    - IO is only to be used only if IV is unobtainable in an unconscious patient
    - Nearly as fast as IV route

IV. RATES OF ABSORPTION
   "Directly related to route of administration"
   1. IV (Fastest)
   2. IO (Intraossesous)
   3. Inhalation
   4. ET (Endotracheal)
   5. IM (Intramuscular)
   6. SL (Sublingual)
   7. IN (intranasal)
   8. PR (Rectal)
   9. SQ (Subcutaneous)
   10. Oral (Slowest)

V. ELIMINATION
   1. Many methods
   2. Usually metabolized by the liver
   3. Eliminated by the kidneys, lungs, skin
VI. TERMS
1. Indications – Conditions medications are used for
2. Contraindications – Conditions which make medication use improper
3. Depressants - Lessens / decreases activity
4. Stimulants - Increases activity
5. Physiologic action - Action from therapeutic concentrations of a medication
6. Therapeutic action - Beneficial action expected from a desired concentration of a medication
7. Untoward reaction - Unwanted side effect
8. Irritation - Damage to tissue
9. Antagonism - Opposition between physiologic action
10. Cumulative action - Increased action after repeated administration of medications
11. Tolerance - Decreased effects after repeated doses
12. Synergism - Combined effects greater than sum of individual effects
13. Potentiation - Enhancement of one medication by another
14. Habituation – Becoming abnormally tolerant to and dependent on something that is habit-forming
15. Idiosyncrasy - Abnormal response to a medication
16. Hypersensitivity - Exaggerated response or allergy to a specific agent

VII. AUTONOMIC NERVOUS SYSTEM
1. Parasympathetic - Controls vegetative functions “rest and digest”
2. Sympathetic - "flight or fight"

VIII. PARASYMPATHETIC NERVOUS SYSTEM
1. Mainly mediated by vagus nerve
2. Acetylcholine is transmitter (cholinergic)
3. Atropine is an acetylcholine blocker

IX. SYMPATHETIC NERVOUS SYSTEM
1. Mediated by Nerves from Sympathetic Chain
2. Norepinephrine and Epinephrine are the transmitters

X. SYMPATHETIC RECEPTORS
Alpha (a)
Beta (b)

XI. COMMON SYMPATHETIC AGENTS
Isoproterenol (Isuprel) - pure BETA
Epinephrine (Adrenalin) – ALPHA and BETA
Dobutamine (Dobutrex) - predominately BETA
Norepinephrine (Levophed) - predominately ALPHA
Dopamine (Intropin) - BETA at low dose range, ALPHA at high dose range
Phenylephrine (Neo-Synephrine) - pure ALPHA

XII. SYMPATHETIC BLOCKERS
Propranolol (Inderal) - BETA blocker

XIII. MEDICATION ADMINISTRATION
Appropriate:
1. Medication selection based on protocol
2. Visually examine medication for particulates or discoloration and that the medication has not expired
3. Contraindications are reviewed prior to administration
4. Route is determined by protocol
5. Dose selection based on protocol
6. Dilution is per protocol
7. Rate is per protocol
**Category A**

Controlled studies in women do not demonstrate a risk to the fetus. The possibility of fetal harm appears remote.

**Category B**

Either animal studies have not demonstrated a fetal risk but there are no controlled studies in pregnant women, or animal studies have shown an adverse effect that was not confirmed in controlled studies in women.

**Category C**

Either studies in animals have revealed adverse effects on the fetus and there are no controlled studies in women, or studies in women and animals are not available. Drugs in category C should only be taken if the benefit justifies the fetal risk.

**Category D**

There is positive evidence of human fetal risk (birth defects, etc.), but the benefits from use in pregnant women may be acceptable despite the risk.

**Category X**

Studies in animals or human beings have demonstrated fetal abnormalities or there is evidence of fetal risk based on human experience, and the risk of the use of the drug in pregnant women clearly outweighs any possible benefit. Drugs in category x should not be taken by pregnant women for any reason.

**Category N**

Not classified
### MEDICATIONS

**ACETAMINOPHEN (Tylenol) ORAL LIQUID**

<table>
<thead>
<tr>
<th><strong>PREGNANCY CLASS</strong></th>
<th>C</th>
</tr>
</thead>
</table>
| **ACTIONS**        | 1. Analgesic  
                     | 2. Antipyretic |
| **INDICATIONS**     | Febrile pediatric patient associated with possible febrile seizures |
| **CONTRAINDICATIONS** | Liver failure / insufficiency |
| **PRECAUTIONS**     | Do not give if patient has already taken in any form in last 4 hours |
| **SIDE EFFECTS**    | Allergic reactions |
| **USUALLY SUPPLIED** | 160 mg / 5 ml CUPS  
                        | VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION |

#### PEDIATRIC DOSAGE

**Pediatric Fever:**

10 – 15 mg / kg PO
# MEDICATIONS

## ADENOSINE (Adenocard)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>

### ACTIONS
1. Slows conduction time and can interrupt re-entrant pathways through the AV node
2. Slows the sinus rate

### INDICATIONS
1. Supra ventricular tachycardia (SVT)
2. Monomorphic, regular wide complex arrhythmias

### CONTRAINDICATIONS
1. Atrial fibrillation
2. Atrial flutter
3. Polymorphic, irregular, or unstable ventricular tachycardia
4. Heart blocks
5. Known WPW

### PRECAUTIONS
Inform the patient of likely side effects prior to medication administration

### SIDE EFFECTS
1. Facial flushing
2. Shortness of breath / dyspnea
3. Chest discomfort
4. Brief period of sinus arrest
5. Headache
6. Dizziness
7. Hypotension

### USUALLY SUPPLIED
6 mg / 2ml
VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION

### ADULT DOSAGE

#### SVT Initial Dose:
6 mg rapid IV PUSH (over 1-3 sec.) immediately followed with a 20 ml normal saline flush

#### SVT Repeat Dose: (If no response is observed after 1 minute)
12 mg rapid IV PUSH (over 1-3 sec.) immediately followed with a 20 ml normal saline flush.

#### Wide Complex Regular Initial Dose:
6 mg rapid IV PUSH (over 1-3 sec.) immediately followed with a 20 ml normal saline flush

#### Wide Complex Repeat Dose: (If no response is observed after 1 minute)
12 mg rapid IV PUSH (over 1-3 sec.) immediately followed with a 20 ml normal saline flush.

### PEDIATRIC DOSAGE

#### SVT Initial Dose:
0.1 mg / kg rapid IV PUSH followed with a 10 ml normal saline flush (Max single dose 6 mg)

#### SVT Repeat Dose:
If no response is observed after 1 - 2 min., administer 0.2 mg / kg rapid IV PUSH followed with a 10 ml normal saline flush (Max single dose 12 mg)

See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration

### KEY POINTS
- Adenosine has a short half-life, and should be administered rapidly followed by a rapid IV flush
- Reassess after each medication administration and refer to the appropriate protocol and treat accordingly
- Perform a 12 Lead EKG prior to the administration of adenosine and after the rhythm converts
## ALBUTEROL (Proventil / Ventolin)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Relax bronchial smooth muscles  
2. Reduces airway resistance  
3. Relieves bronchospasm |
| INDICATIONS     | 1. Asthma exacerbation  
2. COPD exacerbation  
3. Pulmonary edema with wheezing  
4. Hyperkalemia |
| CONTRAINDICATIONS | Known hypersensitivity |
| PRECAUTIONS     | 1. Use caution when administering to pregnant women  
2. Patients with cardiac history  
3. Patients with seizure disorders |
| SIDE EFFECTS    | 1. Headache  
2. Drowsiness  
3. Dizziness  
4. Restlessness  
5. Nausea / Vomiting  
6. Tachycardia  
7. Palpitations  
8. Hyper / hypotension  
9. Tremors  
10. PVCs |
| SUPPLIED        | Single unit dose 2.5 mg in 3 ml of nebulizer solution |

### ADULT DOSAGE
- **Respiratory Distress / Asthma / COPD:** (As part of DuoNeb)
  - 2.5 mg in 3 ml unit dose via nebulizer and 6 - 8 lpm oxygen
- **Congestive Heart Failure with wheezing:** (As part of DuoNeb)
  - 2.5 mg in 3 ml unit dose via nebulizer and 6 - 8 lpm oxygen
- **Anaphylaxis:** (As part of DuoNeb)
  - 2.5 mg in 3 ml unit dose via nebulizer and 6 - 8 lpm oxygen
  - EMT MUST CONTACT MEDICAL CONTROL
- **Dialysis Patient / Peaked T waves:**
  - 2.5 mg in 3 ml unit dose via nebulizer and 6 - 8 lpm oxygen
  - Repeat to keep running throughout prehospital care

### PEDIATRIC DOSAGE
- **Respiratory Distress Lower Airway:**
  - Mild/Moderate Distress - 2.5 mg in 3 ml unit dose via nebulizer and 6 – 8 lpm oxygen First Dose – Add Ipratropium (Atrovent) with subsequent doses
  - Severe Distress - 2.5 mg in 3 ml unit dose via nebulizer and 6 – 8 lpm oxygen – Add Ipratropium (Atrovent)
- **Anaphylaxis:**
  - 2.5 mg in 3 ml unit dose via nebulizer and 6 - 8 lpm oxygen
  - EMT MUST CONTACT MEDICAL CONTROL

### KEY POINTS
- May repeat treatment as required
# MEDICATIONS

## ALBUTEROL and IPRATROPIUM (DuoNeb)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Relax bronchial smooth muscles  
                  2. Reduces airway resistance  
                  3. Relieves bronchospasm  
                  4. Dries bronchial secretions |
| INDICATIONS     | 1. Asthma exacerbation  
                  2. COPD exacerbation  
                  3. Pulmonary edema with wheezing |
| CONTRAINDICATIONS | Known hypersensitivity |
| PRECAUTIONS     | 1. Use caution when administering to pregnant women  
                  2. Patients with cardiac history  
                  3. Patients with seizure disorders |
| SIDE EFFECTS    | 1. Headache  
                  2. Drowsiness  
                  3. Dizziness  
                  4. Restlessness  
                  5. Nausea / Vomiting  
                  6. Tachycardia  
                  7. Palpitations  
                  8. Hyper / hypotension  
                  9. Tremors  
                  10. PVCs  
                  11. Dry nose, Mouth |
| SUPPLIED        | 2.5 mg Albuterol and 0.5 mg Ipratropium in single unit dose |

## ADULT DOSAGE

- **Respiratory Distress / Asthma / COPD:** Single unit dose via nebulizer and 6 - 8 lpm oxygen
- **Congestive Heart Failure with wheezing:** Single unit dose via nebulizer and 6 - 8 lpm oxygen
- **Anaphylaxis:** Single unit dose via nebulizer and 6 - 8 lpm oxygen

**EMT MUST CONTACT MEDICAL CONTROL**

## PEDIATRIC DOSAGE

- **Respiratory Distress Lower Airway:**  
  Mild / Moderate distress - Second and third doses use Albuterol/Ipratropium (DuoNeb) Unit dose via nebulizer and 6 – 8 lpm oxygen. First Dose – Use Albuterol Only  
  Severe Distress - Albuterol/Ipratropium (DuoNeb) Unit dose via nebulizer and 6 – 8 lpm oxygen. First Dose – Use Albuterol Only

**EMT MUST CONTACT MEDICAL CONTROL**

## KEY POINTS
- May repeat treatment as required
<table>
<thead>
<tr>
<th>MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AMIODARONE (Cordarone)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolongs the refractory period and action potential duration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ventricular fibrillation</td>
</tr>
<tr>
<td>2. Pulseless ventricular tachycardia</td>
</tr>
<tr>
<td>3. Wide complex tachycardia with a pulse (with consultation)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Known hypersensitivity</td>
</tr>
<tr>
<td>2. If lidocaine was previously used, <strong>Do Not</strong> use amiodarone</td>
</tr>
<tr>
<td>3. Second / third degree AV blocks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIDE EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hypotension</td>
</tr>
<tr>
<td>2. Prolonged QT interval</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPLIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>150 mg / 3 ml vial</td>
</tr>
</tbody>
</table>

VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION

<table>
<thead>
<tr>
<th>ADULT DOSAGE</th>
</tr>
</thead>
</table>

**PULSELESS - Ventricular Fibrillation / Ventricular Tachycardia:**
300 mg IV
(May be repeated one time at 150 mg IV push in 3-5 minutes)

**Post Arrest:**
150 mg mixed in 20 + ml over 10 minutes

**PULSE PRODUCING - Wide Complex Tachycardia:**
150 mg diluted in 20 + ml of saline IV over 10 minutes

<table>
<thead>
<tr>
<th>PEDIATRIC DOSAGE</th>
</tr>
</thead>
</table>

**PULSELESS - Ventricular Fibrillation / Ventricular Tachycardia:**
5 mg / kg IV / IO
If the rhythm converts to a perusing rhythm, then administer 2.5 mg / kg IV / IO mixed in 20 + ml saline over 2 - 3 minutes

**Post Arrest:**
5 mg / kg IV / IO mixed in 20+ ml of saline

**PULSE PRODUCING - Wide Complex Tachycardia:**
2.5 mg / kg diluted in 20 + ml of saline IV over 10 minutes

See **PEDIATRIC DRUG ADMINISTRATION CHART** for weight based administration

<table>
<thead>
<tr>
<th>KEY POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Amiodarone is the preferred antiarrhythmic medication to treat life threatening PULSELESS ventricular arrhythmias</td>
</tr>
<tr>
<td>• Avoid excessive movement and shaking of the medication</td>
</tr>
<tr>
<td>• Do not administer concurrently with other medications that prolong QT interval</td>
</tr>
<tr>
<td>• Ideally mixed in 100 ml bag for administration to patients with perfusing rhythms.</td>
</tr>
<tr>
<td><strong>MEDICATIONS</strong></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td><strong>ASPIRIN</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PREGNANCY CLASS</strong></th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIONS</strong></td>
<td>Blocks platelet aggregation</td>
</tr>
</tbody>
</table>
| **INDICATIONS** | 1. Chest pain suggestive of a MI  
2. 12-Lead EKG indicating a possible MI  
3. Patients with Acute coronary symptoms |
| **CONTRAINDICATIONS** | 1. Known hypersensitivity  
2. Active ulcer disease  
3. Signs of stroke |
| **PRECAUTIONS** | 1. GI bleeds |
| **SIDE EFFECTS** | 1. Heartburn  
2. Nausea and vomiting |
| **SUPPLIED** | 81 mg chewable tablet |

| **ADULT DOSAGE** | **Acute Coronary Symptoms:**  
324 mg (4 tablets) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PEDIATRIC DOSAGE</strong></td>
<td>Not recommended in the pre-hospital setting</td>
</tr>
<tr>
<td><strong>KEY POINTS</strong></td>
<td>• If patient has already taken ASA in the last 24 hours, give ASA to equal 324 mg total</td>
</tr>
</tbody>
</table>
# ATROPINE SULFATE

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Blocks acetylcholine (parasympathetic nervous system)  
2. Increases conduction through the SA node by blocking vagal activity |
| INDICATIONS     | 1. Symptomatic sinus bradycardia  
2. Organophosphate poisoning  
3. Nerve agent exposure |
| CONTRAINDICATIONS | 1. Known hypersensitivity  
2. Second degree AV Blocks (Mobitz type II)  
3. Third degree AV Blocks |
| PRECAUTIONS     | 1. Avoid use in atrial flutter or atrial fibrillation with a rapid ventricular response  
2. May increase myocardial oxygen demand – use caution if possible acute MI  
3. May trigger tachydysrhythmias  
4. Avoid in hypothermic bradycardia |
| SIDE EFFECTS    | 1. Dry mouth  
2. Blurred vision  
3. Flushed skin  
4. Headache  
5. Tachycardia  
6. Pupillary dilation |
| SUPPLIED        | 1 mg / 10 ml |

## ADULT DOSAGE

**Bradycardia:**  
0.5 - 1 mg IV / IO every 3 - 5 minutes  
(max dose 3 mg)  

**Organophosphate Poisoning:**  
1 mg IV repeat every 3 - 5 minutes until resolution of symptoms  
*No max dose. Extremely large doses will likely be required*

## PEDIATRIC DOSAGE

**Bradycardia:**  
0.02 mg / kg IV / IO, repeated in 5 minutes one time  
Minimum dose is 0.1 mg  
(max dose 0.5 mg CHILD / 1 mg ADOLESCENT)  

**Organophosphate Poisoning:**  
0.2 mg / kg IV repeat every 3 - 5 minutes until resolution of symptoms.  
*No max dose. Extremely large doses will likely be required.*

*See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration*
<table>
<thead>
<tr>
<th><strong>PREGNANCY CLASS</strong></th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIONS</strong></td>
<td>Raises serum calcium levels, increases cardiac contractility</td>
</tr>
</tbody>
</table>
| **INDICATIONS**     | 1. Calcium channel blocker OD  
                     | 2. Dialysis patient in cardiac arrest  
                     | 3. Hypocalcemia  
                     | 4. Hyperkalemia  
                     | 5. Hypermagnesemia |
| **CONTRAINDICATIONS** | 1. Patient taking digitalis |
| **PRECAUTIONS**     | 1. Do not infuse with SODIUM BICARBONATE – will cause precipitates – FLUSH LINES BEFORE ADMIN  
                     | 2. PUSH SLOW  
                     | 3. Extravasation may cause tissue necrosis |
| **SIDE EFFECTS**    | 1. Hypotension  
                     | 2. Nausea  
                     | 3. Tissue necrosis at injection site  
                     | 4. Flushing / Hot flashes  
                     | 5. Arrhythmias |
| **SUPPLIED**        | 1 Gram in 10 ml |

### ADULT DOSAGE

- **Dialysis Patients in Cardiac Arrest:**
  - 1 Gram IV / IO Slow
- **Calcium Channel Blocker OD:**
  - 1 Gram IV / IO Slow
- **Hyperkalemia / Peaked T Waves / Sine Wave EKG:**
  - 1 Gram IV / IO Slow

### PEDIATRIC DOSAGE

- **Calcium Channel Blocker OD:**
  - 10 mg / kg IV / IO

See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration
## DEXTROSE

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Restores blood sugar</td>
</tr>
</tbody>
</table>

### INDICATIONS
1. Treatment of altered mental status due to hypoglycemia
2. Adult BGL less than 70 mg / dl or signs and symptoms of hypoglycemia
3. Coma with associated hypoglycemia
4. Delirium tremens with associated hypoglycemia
5. Seizure or status epilepticus with associated hypoglycemia
6. Cardiac arrest with associated hypoglycemia

### CONTRAINDICATIONS
1. Known hyperglycemia
2. Intracranial / intraspinal hemorrhage

### PRECAUTIONS
1. Use with caution with stroke or head injury patients
2. A blood glucose level should be determined prior to and post dextrose administration

### SIDE EFFECTS
1. Extravasation of Dextrose may cause necrosis
2. Hyperglycemia

### SUPPLIED
- 10% IV bags 10 grams / 100 ml (250 ml = 25 g of dextrose)
- 50% Prefilled syringes or vials containing 50 ml of Dextrose 50% (50 ml = 25 g of dextrose)

### ADULT DOSAGE
**Diabetic Emergencies / Hypoglycemia:**
- If glucose < 40 / 25 g (250 ml of 10% or 50 ml of 50%)
  - IV / IO - may repeat as required
- If glucose 40 – 70 / 12.5 g (125 ml of 10% or 25 ml of 50%)
  - IV / IO - may repeat as required

### PEDIATRIC DOSAGE
**Diabetic Emergencies / Hypoglycemia:**
- **PEDIATRICS Dextrose 10 (D10)**
  - 5 ml / kg IV / IO - may repeat as required
- **PEDIATRICS MAKE Dextrose 25 (D25)**
  - Waste ½ amp of D50 and replace with normal saline (25 ml) to create Dextrose 25 (D25)
  - 2 ml / kg IV / IO - may repeat as required
- **NEONATE Dextrose 10% (D10)**
  - Dextrose 10% (D10)
  - 2 ml / kg IV / IO – may repeat as required
- **NEONATE MAKE Dextrose 10% (D10) from 50%**
  - Waste 40 ml of D50 and replace with normal saline (40ml) to make Dextrose 10% (D10)
  - 2 ml / kg IV / IO – may repeat as required

See **PEDIATRIC DRUG ADMINISTRATION CHART** for weight based administration

### KEY POINTS
- Dextrose should not be routinely given through IO, use other methods first.
- Use as a last resort in peri-arrest arrest patients only.
- Extravasation of Dextrose can causes tissue necrosis
- Attempt to use a large vein to administer Dextrose
- Precede Dextrose with Thiamine 100 mg IV / IM if the patient is suspected of chronic alcoholism or malnourishment (Adult patients)
# DIPHENHYDRAMINE (Benadryl)

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIPHENHYDRAMINE (Benadryl)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Antihistamine</td>
</tr>
</tbody>
</table>
| INDICATIONS | 1. Allergic reactions  
2. Adjunctive treatment to epinephrine in anaphylaxis  
3. Medication induced extrapyramidal symptoms (EPS) |
| CONTRAINDICATIONS | 1. Known hypersensitivity  
2. Acute asthma |
| PRECAUTIONS | 1. Carefully monitor patient while awaiting for medication to take effect (effect of medication begins 15 minutes after administration)  
2. May cause CNS depression  
3. Use caution in patients with history of asthma  
4. Use caution in patients with history or cardiovascular disease |
| SIDE EFFECTS | 1. Sedation  
2. Dries secretions  
3. May exacerbate asthma  
4. Blurred vision  
5. Headache  
6. Hypotension  
7. Tachycardia  
8. Thickening of bronchial secretions |
| SUPPLIED | 50mg / 1ml |
| ADULT DOSAGE | Allergic Reaction or Anaphylactic Shock:  
25 mg – 50 mg slow IV / IO or IM  
Extrapyramidal Symptoms:  
25 mg – 50 mg IV / IM  
DO NOT mix in the same syringe as Haloperidol (Haldol) |
| PEDIATRIC DOSAGE | Allergic Reaction or Anaphylactic Shock:  
1 mg/kg slow IV / IO or IM (max dose 50 mg)  
See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration |
| KEY POINTS | Use in anaphylaxis only after Epinephrine (Adrenaline) and stabilization of cardiorespiratory symptoms |
### MEDICATIONS

#### DOPAMINE (Intropin)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>

#### ACTIONS
1. Alpha and beta adrenergic agonist
2. Increased blood pressure
3. Vasoconstriction
4. Increased peripheral arterial resistance
5. Increase cardiac output and heart rate
6. Increase myocardial contractility and stroke volume

#### INDICATIONS
1. Cardiogenic shock
2. Bradycardia
3. Septic shock refractory to volume replacement
4. Neurogenic shock refractory to volume replacement

#### CONTRAINDICATIONS
1. Known hypersensitivity
2. Hypovolemia without fluid replacement therapy
3. Pheochromocytoma (adrenal tumor)

#### PRECAUTIONS
1. Extravasation may cause tissue necrosis
2. Correct hypovolemia with volume replacement prior to starting dopamine
3. May cause tachyarrhythmia’s or excessive vasoconstriction
4. Do not mix with sodium bicarbonate
5. Use caution in patients with cardiovascular disease

#### SIDE EFFECTS
1. Ectopic beats (slow infusion use caution)
2. Nausea / Vomiting
3. Tachycardia
4. Palpitations
5. Dyspnea
6. Headache
7. Angina

#### SUPPLIED
Premixed bag of 400 mg / 250 ml (1600 mcg / ml) for IV drip only
VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION

#### ADULT DOSAGE

<table>
<thead>
<tr>
<th>Post Cardiac Arrest</th>
<th>5 - 20 micrograms / kg / minute IV infusion titrated to effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toxic Inhalation / Ingestion – Cyanide</td>
<td>5 - 20 micrograms / kg / minute IV infusion titrated to effect</td>
</tr>
<tr>
<td>Bradycardia:</td>
<td>5 - 20 micrograms / kg / minute IV infusion titrated to effect</td>
</tr>
</tbody>
</table>

#### PEDIATRIC DOSAGE

| Post Cardiac Arrest: | 5 - 20 micrograms / kg / minute IV infusion titrated to effect |

#### DOPAMINE DRIP CHART 1600 mcg/ml

<table>
<thead>
<tr>
<th>DOSE (mcg/kg/min)</th>
<th>5</th>
<th>10</th>
<th>15</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>WEIGHT (KG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>8</td>
<td>15</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>50</td>
<td>10</td>
<td>19</td>
<td>28</td>
<td>38</td>
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<tr>
<td>60</td>
<td>12</td>
<td>23</td>
<td>34</td>
<td>45</td>
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<tr>
<td>70</td>
<td>14</td>
<td>26</td>
<td>39</td>
<td>56</td>
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<tr>
<td>80</td>
<td>15</td>
<td>30</td>
<td>45</td>
<td>60</td>
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<tr>
<td>90</td>
<td>17</td>
<td>34</td>
<td>51</td>
<td>68</td>
</tr>
<tr>
<td>100</td>
<td>19</td>
<td>38</td>
<td>56</td>
<td>75</td>
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<tr>
<td>110</td>
<td>21</td>
<td>42</td>
<td>62</td>
<td>82</td>
</tr>
<tr>
<td>120</td>
<td>23</td>
<td>46</td>
<td>68</td>
<td>90</td>
</tr>
<tr>
<td>130</td>
<td>25</td>
<td>48</td>
<td>74</td>
<td>98</td>
</tr>
<tr>
<td>140</td>
<td>27</td>
<td>52</td>
<td>78</td>
<td>112</td>
</tr>
</tbody>
</table>

USE 60 GTT SET ONLY - TITRATE TO LEVEL OF CONSCIOUSNESS AND BP
# EPINEPHRINE (Adrenaline)

| PREGNANCY CLASS | C |
| ACTIONS | 1. Alpha and beta adrenergic agonist  
2. Bronchodilation  
3. Increase heart rate and automaticity  
4. Increases cardiac contractility  
5. Increases myocardial conduction velocity  
6. Increases blood pressure |
| INDICATIONS | 1. Cardiac arrest  
2. Anaphylactic reaction  
3. Anaphylactic shock  
4. Respiratory distress |
| CONTRAINDICATIONS | Known hypersensitivity |
| PRECAUTIONS | Blood pressure, pulse, and ECG must be routinely monitored for all patients receiving epinephrine |
| SIDE EFFECTS | 1. Palpitations  
2. Anxiety  
3. Headache  
4. Trembling  
5. Nausea / vomiting |
| SUPPLIED | 1 mg / 10 ml – 0.1 mg / ml (1:10,000)  
1 mg / 1ml (1:1000) |

## ADULT DOSAGE

**Cardiac Arrest:**
1 mg of Epinephrine 0.1 mg / ml (1:10,000) IV / IO every 3 - 5 minutes

**Anaphylactic Reaction / Shock:**
0.3 - 0.5 mg of Epinephrine 1mg / ml (1:1000) IM

**EMT USE EPINEPHRINE AUTO-INJECTOR (0.3 mg)**

**Respiratory Distress – Stridor:**
5 mg of Epinephrine 1 mg / ml (1:1000) Nebulized Undiluted Dose

**Respiratory Distress: (Unresponsive to aerosols)**
0.3 - 0.5 mg of Epinephrine 1mg / ml (1:1000) IM

**Anaphylactic Shock: (Impending Arrest)**
0.1 ml per minute of Epinephrine 0.1 mg / ml (1:10,000) IV / IO until resolution of blood pressure. Max dose 0.5 mg

## PEDIATRIC DOSAGE

**Cardiac Arrest:**
0.01 mg / kg of Epinephrine 0.1 mg / ml (1:10,000) - IV / IO every 3 - 5 minutes. Max 1mg per dose

**Anaphylactic Reaction / Shock:**
0.01 mg / kg of Epinephrine 1mg / ml (1:1000) IM - Max dose 0.5 mg

**EMT USE EPINEPHRINE AUTO-INJECTOR JR (0.15 mg)**

**Croup:**
<10 kg 3 ml of Epinephrine 1 mg / ml (1:1000) nebulized  
>10 kg 5 ml of Epinephrine 1 mg / ml (1:1000) nebulized

**Respiratory Distress: (Unresponsive to aerosols)**
0.01 mg / kg of Epinephrine 1mg / ml (1:1000) IM - Max dose 0.5 mg

**Anaphylactic Shock: (Impending Arrest)**
0.01 mg / kg of 0.1 mg / ml (1:10,000) IV / IO until resolution of blood pressure – Max dose 0.5 mg

See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>3-5 kg</th>
<th>6-7 kg</th>
<th>8-9 kg</th>
<th>10-11 kg</th>
<th>12-14 kg</th>
<th>15-18 kg</th>
<th>19-23 kg</th>
<th>24-29 kg</th>
<th>30-36 kg</th>
</tr>
</thead>
</table>

## KEY POINTS

Do Not Confuse Epi 1 mg / ml (1:1000) IM and 0.1 mg / ml (1:10,000) IV
### MEDICATIONS

### FENTANYL (Sublimaze)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Inhibits pain pathways altering perception and response to pain</td>
</tr>
</tbody>
</table>
| INDICATIONS      | 1. Severe pain management  
                   2. ACS / STEMI  
                   3. Abdominal Pain  
                   4. CPR induced consciousness  
                   5. Isolated trauma |
| CONTRAINDICATIONS| 1. Hypersensitivity  
                   2. Uncontrolled hemorrhage  
                   3. Shock |
| PRECAUTIONS      | |
| SIDE EFFECTS     | 1. Respiratory depression  
                   2. Bradycardia  
                   3. Muscle rigidity |
| SUPPLIED         | 100 mcg / 2 ml  
                   VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION |

#### ADULT DOSAGE

- **Acute Coronary Symptoms:**
  - 25 – 100 mcg IV / IO / IM / IN
- **Severe Pain Management:**
  - 25 – 100 mcg IV / IO / IM / IN
- **Abdominal Pain:**
  - 25 – 100 mcg IV / IO / IM / IN
- **CPR Induced Level of Consciousness:**
  - 25 – mcg IV / IO / IM / IN Repeat to desired effect

#### PEDIATRIC DOSAGE

- **Severe Pain Management:**
  - 1 mcg / kg IV / IO / IM / IN may repeat in 10 – 15 mins

See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration

<table>
<thead>
<tr>
<th>3-5 kg</th>
<th>6-7 kg</th>
<th>8-9 kg</th>
<th>10-11 kg</th>
<th>12-14 kg</th>
<th>15-18 kg</th>
<th>19-23 kg</th>
<th>24-29 kg</th>
<th>30-36 kg</th>
</tr>
</thead>
</table>

#### KEY POINTS

- Likelihood of side effects increases with rapid administration
- Narcotic naive patients may need lower dosing regimen
- Preferred analgesic for trauma / ACS
- Must be given slowly IV
## GLUCAGON (Glucagen)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>B</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Causes breakdown of glycogen to glucose increasing blood glucose level  
2. Antidote to beta blocker overdose |
| INDICATIONS     | 1. Correction of hypoglycemia when an vascular access is not able to be established and oral glucose is contraindicated  
2. Beta blocker overdose |
| CONTRAINDICATIONS | Known hypersensitivity |
| PRECAUTIONS     | 1. Glucagon is only effective in patients with sufficient stores of glycogen (glycogen stored in liver)  
2. Glucagon can be administered on scene, but do not wait for it to take effect |
| SIDE EFFECTS    | 1. Nausea and vomiting  
2. Hyperglycemia |
| SUPPLIED        | Vials of 1mg Glucagon with 1ml of diluting solution |
| ADULT DOSAGE    | **Hypoglycemia without Vascular Access:**  
1 mg IM / IN  
**Beta Blocker Overdose:**  
3 mg IV |
| PEDIATRIC DOSAGE| **Hypoglycemia Without Vascular Access:**  
0.1mg / kg IM / IN  
**Beta Blocker Overdose:**  
0.1 mg / kg IV |
|                 | See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration |

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>3-5 kg</th>
<th>6-7 kg</th>
<th>8-9 kg</th>
<th>10-11 kg</th>
<th>12-14 kg</th>
<th>15-18 kg</th>
<th>19-23 kg</th>
<th>24-29 kg</th>
<th>30-36 kg</th>
</tr>
</thead>
</table>

**KEY POINTS**
- Response is usually noticed in 5 - 20 minutes. If response is delayed, dose may be repeated
- If IV is established after Glucagon (Glucagen) is given and patient is still hypoglycemic, administer Dextrose
# MEDICATIONS

## HALOPERIDOL (Haldol)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Chemical restraint of acute psychosis or agitation patients</td>
</tr>
<tr>
<td>INDICATIONS</td>
<td>Aggressive, violent, or severely agitated patients in the setting of psychosis or alcohol intoxication</td>
</tr>
</tbody>
</table>
| CONTRAINDICATIONS | 1. Not for use in combative or violent reactions resulting from treatable medical emergencies  
2. Dementia related psychosis  
3. Known hypersensitivity  
4. Parkinson’s disease  
5. CNS depression  
6. Severe cardiac disease  
7. Hepatic disease |
| PRECAUTIONS     | 1. Elderly patients  
2. Prolonged QT interval on EKG  
3. Renal patients  
4. Respiratory diseases  
5. Seizure disorders |
| SIDE EFFECTS    | 1. Sedation  
2. Extrapyramidal symptoms (EPS) / dystonic reactions  
3. Orthostatic Hypotension |
| SUPPLIED        | 5 mg / 1 ml |

### ADULT DOSAGE

- **Combative Psych Patient:**  
  5 mg IM ONLY  
  Over age 65; 2.5 mg IM ONLY  

- **Alcohol Related Emergencies:**  
  5 mg IM ONLY  
  Over age 65; 2.5 mg IM ONLY

### PEDIATRIC DOSAGE

Not Indicated in the pre-hospital setting

### KEY POINTS

- If administration causes extrapyramidal symptoms (EPS) give Diphenhydramine (Benadryl) 25 mg – 50 mg IV / IM  
- EPS symptoms are: Involuntary purposeless movements of body, usually of the face such as grimacing, tongue protrusion, lip smacking, lip puckering, or eye blinking.  
- DO NOT mix Haloperidol (Haldol) and Diphenhydramine (Benadryl) in the same syringe.
# MEDICATIONS

## Heparin

<table>
<thead>
<tr>
<th><strong>PREGNANCY CLASS</strong></th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIONS</strong></td>
<td>Anticoagulant</td>
</tr>
<tr>
<td><strong>INDICATIONS</strong></td>
<td>1. STEMI</td>
</tr>
</tbody>
</table>
| **CONTRAINDICATIONS** | 1. Hypersensitivity  
                        2. Active bleeding  
                        3. Trauma  
                        4. Hypertension  
                        5. Aortic dissection  
                        6. Pregnancy  
                        7. Surgery within last 14 days  
                        8. Symptoms of CVA |
| **PRECAUTIONS**    | |
| **SIDE EFFECTS**   | 1. Bleeding |
| **SUPPLIED**       | 5000 U / 5 ml  
                       VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION |
| **ADULT DOSAGE**   | **Confirmed STEMI:**  
                       60 units / kg IV / IO  
                       Max dose 4000 units |
| **PEDIATRIC DOSAGE** | Not recommended in the pre-hospital setting |
### HYDROMORPHONE (Dilaudid)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>

| ACTIONS | Inhibits pain pathways altering perception and response to pain |

#### INDICATIONS

1. Moderate to severe pain management
2. Burns
3. Intractable flank pain
4. Intractable back pain
5. Musculoskeletal and/or fracture pain
6. Sickle cell pain crisis (USE SUPPLEMENTAL O2)
7. Unremitting abdominal pain (NOT OF OB ORIGIN)
8. Chest Pain

#### CONTRAINDICATIONS

1. Known hypersensitivity
2. Head injury or head trauma
3. Hypotension
4. Respiratory depression
5. Acute or severe asthma or COPD
6. Labor pain
7. Shock

#### PRECAUTIONS

1. Liver failure, renal failure, or patients in excess of 65 years should receive half dose, titrated to their pain tolerance
2. If the patient responds with respiratory depression administer Naloxone (Narcan) to reverse the effects
3. All patients must have supplemental oxygen administration and oxygen saturation monitoring
4. Hydromorphone (Dilaudid) will mask pain, so conduct a complete assessment prior to administration
5. Use caution if patient is hypersensitive to sulfites
6. Use caution if patient is hypersensitive to latex
7. May cause CNS depression
8. Use caution in patients with hypersensitivity to other narcotics

#### SIDE EFFECTS

1. Respiratory depression
2. Altered LOC
3. Bradycardia
4. Nausea and vomiting
5. Constricted pupils

#### SUPPLIED

1 mg / 1 ml
*VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION*

#### ADULT DOSAGE

**Severe Pain Management:**

0.5 mg – 1 mg IV / IM

Over 65 years, liver failure, renal failure or debilitated patients:

Titrated to pain tolerance, up to 0.5 mg IV / IM

May repeat if needed

**Abdominal Pain:**

0.5 mg – 1 mg IV / IM

Over 65 years, liver failure, renal failure or debilitated patients:

Titrated to pain tolerance, up to 0.5 mg IV / IM

May repeat if needed

#### PEDIATRIC DOSAGE

Not recommended in the pre-hospital setting

#### KEYPOINTS

- Likelihood of side effects increases with rapid administration
- Narcotic naive patients may need lower dosing regiment
- Preferred analgesic for intractable/unremitting pain
<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>B</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Blocks action of acetylcholine at receptor sites on bronchial smooth muscle  
                 2. Dries bronchial secretions |
| INDICATIONS     | Treatment of bronchospasm in patients with COPD as an adjunct to albuterol |
| CONTRAINDICATIONS | Known hypersensitivity |
| SIDE EFFECTS    | 1. Dry nose, mouth  
                 2. Paradoxical bronchospasm  
                 3. Nausea  
                 4. Chest pain  
                 5. Palpitations  
                 6. Headache  
                 7. Dizziness |
| SUPPLIED        | Single unit dose 0.5 mg in 2.5 ml of nebulizer solution |
| ADULT DOSAGE    | Respiratory Distress / Asthma / COPD: (As Part of DuoNeb)  
                 Single unit dose via nebulizer and 6 - 8 lpm oxygen  
                 Congestive Heart Failure with wheezing: (As Part of DuoNeb)  
                 Single unit dose via nebulizer and 6 - 8 lpm oxygen  
                 Anaphylaxis: (As Part of DuoNeb)  
                 Single unit dose via nebulizer and 6 - 8 lpm oxygen  
                 [ caut ] EMT MUST CONTACT MEDICAL CONTROL |
| PEDIATRIC DOSAGE| Respiratory Distress Lower Airway:  
                 Mild Moderate Distress - Second and third doses use Albuterol/Ipratropium (DuoNeb) Unit dose via nebulizer and 6 – 8 lpm oxygen, First Dose – Use Albuterol Only  
                 Severe Distress - Albuterol/Ipratropium (DuoNeb) Unit dose via nebulizer and 6 – 8 lpm oxygen  
                 [ caut ] EMT MUST CONTACT MEDICAL CONTROL |
| KEY POINTS      | • Mix with Albuterol (Proventil) for administration |
# MEDICATIONS

## KETAMINE (Ketalar)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Sedation, analgesia, and anesthesia</td>
</tr>
<tr>
<td>INDICATIONS</td>
<td>1. Induction of anesthesia for RSI</td>
</tr>
</tbody>
</table>
| CONTRAINDICATIONS | 1. Hypertension  
                          2. Aneurysm  
                          3. CHF |
| PRECAUTIONS     | 1. Schizophrenia |
| SIDE EFFECTS    | 1. Hallucinations  
                          2. Hypertension  
                          3. Tachycardia  
                          4. Increased ICP  
                          5. Salivation |
| SUPPLIED        | 200 mg / 20 ml or 500 mg / 5 ml  
                           VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION |
| ADULT DOSAGE    | **Induction for RSI:** For Departments Who Provide RSI  
                          2 mg / kg IV / IO  
                          **Combative Psych / Excited Delirium / Acute Psychosis**  
                          250 mg IM of the 500 mg / 5 ml concentration,  
                          May repeat 250 IM in 2 mins if no response |
<p>| KEY POINTS      | If emergence reaction occurs (Confusion, excitement, irrational behavior, hallucinations) after administration of Ketamine (Ketalar), administer a Benzodiazepine such as Lorazepam (Ativan) or Midazolam (Versed) |</p>
<table>
<thead>
<tr>
<th>MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>KETOROLAC (Toradol)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Non-Steroidal Anti Inflammatory Analgesic  
|                 | 2. Antipyretic |
| INDICATIONS     | 1. Kidney stones / Flank pain  
|                 | 2. Moderate pain |
| CONTRAINDICATIONS | 1. Known hypersensitivity to NSAIDS / Aspirin  
|                  | 2. >65 years old  
|                  | 3. Bleeding (GI, Cerebrovascular)  
|                  | 4. Obvious pregnancy / nursing mothers  
|                  | 5. Asthma |
| SIDE EFFECTS    | 1. Edema  
|                 | 2. Hypertension  
|                 | 3. Rash  
|                 | 4. Nausea  
|                 | 5. Dizziness |
| SUPPLIED        | 30 mg / 1 ml |
| ADULT DOSAGE    | Moderate Pain / Kidney Stones:  
|                 | 15 mg IV / IO  
|                 | 30 mg IM |
| PEDIATRIC DOSAGE | Not recommended in the pre-hospital setting |
## MEDICATIONS

### LIDOCAINE (Xylocaine)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIONS</strong></td>
<td>Anesthetizes the intraosseous space during fluid administration to increase pain tolerance</td>
</tr>
<tr>
<td><strong>INDICATIONS</strong></td>
<td>Anesthetization of intraosseous space prior to or during IO administration of fluids</td>
</tr>
</tbody>
</table>
| **CONTRAINDICATIONS** | 1. Known hypersensitivity to Lidocaine (Xylocaine) or caine family  
2. AV blocks  
3. Idioventricular escape rhythms  
4. Accelerated idioventricular rhythm  
5. Sinus bradycardia or arrest or block  
6. Hypotension  
7. Shock |
| **SIDE EFFECTS** | 1. Dizziness  
2. Numbness  
3. Drowsiness  
4. Confusion  
5. Seizure  
6. Respiratory depression |
| **SUPPLIED**    | 100 mg / 5 ml |

### ADULT DOSAGE

**Anesthetization of Intraosseous Space:**
Up to 40 mg IO push

### PEDIATRIC DOSAGE

**Anesthetization of Intraosseous Space:**
0.5 mg / kg up to 40 mg IO Push

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 kg</td>
<td>6-7 kg</td>
</tr>
<tr>
<td>6-7 kg</td>
<td>8-9 kg</td>
</tr>
<tr>
<td>8-9 kg</td>
<td>10-11 kg</td>
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<td>10-14 kg</td>
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<tr>
<td>15-18 kg</td>
<td>15-18 kg</td>
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<tr>
<td>19-23 kg</td>
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<tr>
<td>24-29 kg</td>
<td>24-29 kg</td>
</tr>
<tr>
<td>30-36 kg</td>
<td>30-36 kg</td>
</tr>
</tbody>
</table>
### MEDICATIONS

**LORAZEPAM (Ativan)**

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>D</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Sedative  
2. Anticonvulsant  
3. Amnestic (induces amnesia) |
| INDICATIONS     | 1. Status epilepticus  
2. Sedation prior to transcutaneous pacing, synchronized cardioversion, and painful procedures in the conscious patient  
3. Cocaine induced acute coronary syndromes  
4. Agitated or combative patients |
| CONTRAINDICATIONS | 1. Known hypersensitivity  
2. Altered mental status of unknown origin  
3. Head injury  
4. Respiratory insufficiency |
| PRECAUTIONS     | 1. May cause respiratory depression, respiratory effort must be continuously monitored with Capnography  
2. Should be used with caution with hypotensive patients and patients with altered mental status  
3. Lorazepam (Ativan) potentiates alcohol or other CNS depressants |
| SIDE EFFECTS    | 1. Respiratory depression  
2. Hypotension  
3. Lightheadedness  
4. Confusion  
5. Slurred speech  
6. Amnesia |
| SUPPLIED        | 2 mg / 1 ml |
| ADULT DOSAGE    | Status Epilepticus:  
1 – 2 mg IM / IV / IO / IN (max dose 2 mg)  
Half dose > 65 / Liver disease  
May repeat in 5 - 10 minutes, if seizure persists and patient SBP is > 90 mmHg |
| Procedural Sedation (Transcutaneous Pacing and Cardioversion):  
1 – 2 mg IM / IV / IO / IN (max dose 2 mg) |
| Cocaine Induced ACS:  
1 – 2 mg IM / IV / IO / IN (max dose 2 mg) |
| Airway Management:  
1 – 2 mg IM / IV / IO / IN (max dose 2 mg) |
| Combative Psych Patient:  
1 – 2 mg IM / IV / IO / IN (max dose 2 mg) |
| Extremity Trauma:  
1 – 2 mg IM / IV / IO / IN (max dose 2 mg) |
| Alcohol Related Emergencies – Combative / Withdrawal:  
1 – 2 mg IM / IV / IO / IN (max dose 2 mg) |

| PEDIATRIC DOSAGE | Status Epilepticus:  
0.05 mg / kg slow IV / IO / IN (max dose 2 mg) |
| Procedural Sedation (Transcutaneous Pacing and Cardioversion):  
0.05 mg / kg slow IV / IO / IN (max dose 2 mg) |
| See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration |

| 3-5 kg | 6-7 kg | 8-9 kg | 10-11 kg | 12-14 kg | 15-18 kg | 19-23 kg | 24-29 kg | 30-36 kg |
# Magnesium Sulfate

## Medications

### Actions

1. Central Nervous System Depressant  
2. Anticonvulsant  
3. Antiarrhythmic  
4. Bronchodilation

### Indications

1. Ventricular fibrillation / pulseless ventricular tachycardia in patients who are malnourished or chronic alcoholics  
2. Treatment of seizures in eclampsia patients  
3. Torsades de pointes  
4. Asthma / COPD refractory to sympathomimetic

### Contraindications

1. Known hypersensitivity  
2. Shock  
3. Heart blocks

### Precautions

1. Hypotension  
2. Renal impairment

### Side Effects

1. Respiratory depression  
2. Flushing  
3. Drowsiness

### Supplied

1 gram / 2 ml vial 50% solution or 2 grams / 50 ml

*Verify actual concentration on hand before administration*

### Adult Dosage

**Cardiac Arrest / Torsades or Hypomagnesemia:**  
1 - 2 g IV diluted in 10 ml normal saline

**Torsades with Pulse:**  
1 - 2 g diluted with 50 – 100 ml normal saline over 5 - 60 min

**Eclampsia / Toxemia:**  
4 - 6 g diluted in 10 ml normal saline IV slow

**Respiratory Distress / Bronchoconstriction refractory to Epinephrine**  
2 Grams Slow IV

### Pediatric Dosage

*Not recommended in the pre-hospital setting*

See **Pediatric Drug Administration Chart** for weight based administration

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 kg</td>
<td>6-7 kg</td>
</tr>
</tbody>
</table>

### Key Points

- Check deep tendon reflexes (DTR's) after administration
- Monitor EKG, vial signs and respiratory effort during administration
# MEDICATIONS

## METHYPREDNISOLONE (Solu-Medrol)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>1. Reduces inflammation in lower airways</td>
</tr>
</tbody>
</table>
| INDICATIONS     | 1. Anaphylaxis  
|                 | 2. Asthma  
|                 | 3. COPD |
| CONTRAINDICATIONS | None in the emergency setting |
| PRECAUTIONS     | 1. Use with caution in diabetics, hyperglycemia  
|                 | 2. Use with caution in recent MI |
| SIDE EFFECTS    | 1. Hyperglycemia  
|                 | 2. Increased susceptibility to infection  
|                 | 3. GI bleeding |
| SUPPLIED        | 125 mg / 2 ml Act-o-Vial |

### ADULT DOSAGE

- **Anaphylaxis:** 125 mg IV / IO
- **Respiratory Distress / Asthma / COPD:** 125 mg IV / IO

### PEDIATRIC DOSAGE

- **Anaphylaxis:** 2 mg / kg IV (max dose 125 mg)

  See [PEDIATRIC DRUG ADMINISTRATION CHART](#) for weight based administration

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 kg</td>
<td>6-7 kg</td>
</tr>
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</tr>
<tr>
<td>24-29 kg</td>
<td>24-29 kg</td>
</tr>
<tr>
<td>30-36 kg</td>
<td>30-36 kg</td>
</tr>
</tbody>
</table>

### KEY POINTS

- Solu-medrol will need to be mixed just prior to administration. Fluid will initially be cloudy, but will change quickly to clear.
- Be cautious with pediatric dosing, as the amounts may be very small. Use a 1 ml syringe for accuracy.
<table>
<thead>
<tr>
<th>MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>METOPROLOL (Lopressor)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Reduces heart rate and BP by blocking B1 receptors</td>
</tr>
<tr>
<td>INDICATIONS</td>
<td>Rate control in tachyarrhythmias that will not convert with other medications</td>
</tr>
</tbody>
</table>
| CONTRAINDICATIONS | 1. Asthma  
2. CHF  
3. Heart blocks  
4. Bradycardia  
5. Shock  
6. Cocaine / Sympathomimetic abuse / use |
| PRECAUTIONS     | |
| SIDE EFFECTS    | 1. Bradycardia  
2. Heart blocks  
3. CHF  
4. Bronchospasm  
5. Hypotension |
| SUPPLIED        | 5 mg / 5 ml  
VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION |
| ADULT DOSAGE    | Narrow Complex Tachycardia:  
5 mg IV / IO over 1 min  
Discuss repeat doses |
| PEDIATRIC DOSAGE | Not recommended in the pre-hospital setting |
### MEDICATIONS

**MIDAZOLAM (Versed)**

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Hypnotic and sedative effects</td>
</tr>
</tbody>
</table>
| INDICATIONS      | Premedication before cardioversion or transcutaneous pacing  
Status epilepticus |
| CONTRAINDICATIONS | 1. Known hypersensitivity to the drug  
2. Hypotension  
3. Respiratory Depression  
4. Allergy to Benzodiazepines  
5. Caution with CHF and COPD |
| PRECAUTIONS      | 1. Use lower initial doses in elderly or debilitated patients  
2. Avoid rapid injection |
| SIDE EFFECTS     | 1. Drowsiness  
2. Hypotension  
3. Amnesia  
4. Respiratory Depression  
5. CNS Depression  
6. Nausea  
7. Vomiting |
| SUPPLIED         | 5 mg / 1 ml  
VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION |

#### ADULT DOSAGE

- **Status Epilepticus - With Vascular Access:**  
  2 mg IV - Max 4 mg  
- **Status Epilepticus - Without Vascular Access:**  
  5 mg IN Atomized – (1/2 dose up each nostril – 1 ml total for each nostril) Max 10 mg  
- **Procedural Sedation (Cardioversion, Pacing) With Vascular Access:**  
  2 mg IV (1 minute prior to procedure) Max 4 mg  
- **Procedural Sedation (Cardioversion, Pacing) No Vascular Access:**  
  5 mg IN Atomized – (1/2 dose up each nostril – 1 ml total for each nostril) Max 10 mg  
- **Airway Management – With Vascular Access:**  
  2 mg IV (1 minute prior to procedure) Max 4 mg  
- **Airway Management – No Vascular Access:**  
  5 mg IN Atomized – (1/2 dose up each nostril – 1 ml total for each nostril) Max 10 mg  
- **Extremity Trauma – With Vascular Access:**  
  2 mg IV (1 minute prior to procedure) Max 4 mg  
- **Extremity Trauma – No Vascular Access**  
  5 mg IN Atomized – (1/2 dose up each nostril – 1 ml total for each nostril) Max 10 mg  
- **Alcohol Related Emergencies – Combative / Withdrawal – With Vascular Access**  
  2 mg IV (1 minute prior to procedure) Max 4 mg  
- **Alcohol Related Emergencies – Combative / Withdrawal – No Vascular Access**  
  5 mg IN Atomized – (1/2 dose up each nostril – 1 ml total for each nostril) Max 10 mg  
- **Combative Psych Patient – With Vascular Access**  
  2 mg IV (1 minute prior to procedure) Max 4 mg  
- **Combative Psych Patient – NO Vascular Access**  
  5 mg IN Atomized – (1/2 dose up each nostril – 1 ml total for each nostril) Max 10 mg  
- **Cocaine Induced ACS – With Vascular Access**  
  2 mg IV (1 minute prior to procedure) Max 4 mg  
- **Cocaine Induced ACS – NO Vascular Access**  
  5 mg IN Atomized – (1/2 dose up each nostril – 1 ml total for each nostril) Max 10 mg

#### PEDIATRIC DOSAGE

- **Seizure – With Vascular Access:**  
  0.1 mg / kg IV max dose 2 mg  
- **Seizure – NO Vascular Access:**  
  0.2 mg / kg IN – (1/2 dose up each nostril) Max Dose 5 mg  

See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>3-5 kg</th>
<th>6-7 kg</th>
<th>8-9 kg</th>
<th>10-11 kg</th>
<th>12-14 kg</th>
<th>15-18 kg</th>
<th>19-23 kg</th>
<th>24-29 kg</th>
</tr>
</thead>
</table>

#### KEY POINTS
- Monitor respiratory status continuously
# MEDICATIONS

## MORPHINE SULFATE

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>
| ACTIONS          | 1. Inhibits pain pathways altering perception and response to pain  
2. Mild vasodilatation |
| INDICATIONS      | 1. Cardiac chest discomfort and acute MI  
2. Pain Management |
| CONTRAINDICATIONS| 1. Known hypersensitivity  
2. Respiratory depression  
3. Head injury or head trauma  
4. Hypotension  
5. Multi-system trauma patients |
| PRECAUTIONS      | 1. May cause respiratory depression and / or hypotension  
2. Routinely monitor the patient’s respiratory effort / Spo2  
3. Morphine may mask pain, so conduct a complete assessment prior to administration  
4. Administer slowly and titrate to pain |
| SIDE EFFECTS     | 1. Respiratory depression  
2. Altered LOC  
3. Hypotension  
4. Bradycardia  
5. Nausea and vomiting  
6. Constricted pupils |
| SUPPLIED         | 10 mg / 1 ml  
VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION |
| ADULT DOSAGE     | Cardiac Chest Discomfort and Acute MI:  
2.5 - 5 mg IV Repeated as needed (Max dose 10 mg)  
Severe Pain Management:  
2.5 - 5 mg IV / IM  
May repeat if needed |
| PEDIATRIC DOSAGE | Severe Pain Management:  
0.1 mg / kg IV / IO  
See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration |
| KEY POINTS       | • Rapid administration increases likelihood of side effects  
• Elderly may be more susceptible to respiratory depression effects |
# MEDICATIONS

## NALOXONE (Narcan)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Blocks opiates from acting on opiate receptors</td>
</tr>
<tr>
<td>INDICATIONS</td>
<td>1. Respiratory depression due to opioids</td>
</tr>
<tr>
<td>CONTRAINDICATIONS</td>
<td>1. Known hypersensitivity</td>
</tr>
<tr>
<td>PRECAUTIONS</td>
<td>1. Assist ventilations prior to and while waiting for Naloxone (Narcan) to work</td>
</tr>
<tr>
<td></td>
<td>2. Should be used and titrated to desired respiratory effect, and not intended to restore full consciousness</td>
</tr>
<tr>
<td></td>
<td>3. Naloxone (Narcan) may induce acute withdrawal in patients who are opiate dependent. Be prepared for a potentially combative patient</td>
</tr>
<tr>
<td></td>
<td>4. The effects of Naloxone (Narcan) do not usually last as long as the effects of opiates, therefore subsequent doses may need to be administered</td>
</tr>
<tr>
<td></td>
<td>5. Withdrawal may cause: pain, hypertension, agitation, irritability, and diaphoresis</td>
</tr>
<tr>
<td>SIDE EFFECTS</td>
<td>Narcotic withdrawal</td>
</tr>
<tr>
<td>SUPPLIED</td>
<td>2 mg / 2 ml prefilled syringe</td>
</tr>
</tbody>
</table>

### ADULT DOSAGE

**Opiate Overdose:**
1 - 2 mg IV / IM may be repeated as needed to maintain respiratory effort – Max 12 mg

**Opiate Overdose:**
2 mg IN Atomized – If IN dose ineffective, summon ALS to administer subsequent doses IV / IO

### PEDIATRIC DOSAGE

**Opiate Overdose:**
0.1 mg / kg IV / IM may be repeated as needed to maintain respiratory effort

**Opiate Overdose:**
1 mg IN Atomized – If IN dose ineffective, summon ALS to administer subsequent doses IV / IO

See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration

<table>
<thead>
<tr>
<th>3-5 kg</th>
<th>6-7 kg</th>
<th>8-9 kg</th>
<th>10-11 kg</th>
<th>12-14 kg</th>
<th>15-18 kg</th>
<th>19-23 kg</th>
<th>24-29 kg</th>
<th>30-36 kg</th>
</tr>
</thead>
</table>

### KEY POINTS

- Intra-arrest use of Naloxone (Narcan) is acceptable if indicated
- If sufficient dose is not available to resolve breathing, ventilate and consider advanced airway intervention
# NITROGLYCERIN (Nitro-Stat)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Vasodilatation  
                  2. Coronary artery dilation  
                  3. Decreases myocardial oxygen demand  
                  4. Decreases vascular resistance |
| INDICATIONS     | 1. Suspected ischemic chest pain / AMI  
                  2. Hypertensive emergency with signs and symptoms of ACS  
                  3. Pulmonary edema |
| CONTRAINDICATIONS | 1. Hypotension  
                      2. Known hypersensitivity  
                      3. Use of Viagra or similar erectile dysfunction or pulmonary hypertension medications within 48 hours |
| PRECAUTIONS     | 1. Use caution in patients with inferior wall MI (Elevation in leads II, III, AVF)  
                  2. Avoid use in patients with increased intracranial pressure or glaucoma  
                  3. If the patient becomes hypotensive after nitroglycerine administration, then place the patient in a semi-reclined position with legs elevated and give IV normal saline bolus |
| SIDE EFFECTS    | 1. Hypotension  
                  2. Throbbing headache  
                  3. Lightheadedness / dizziness  
                  4. Syncope |
| SUPPLIED        | 0.4 mg SL tablet / Spray |

## ADULT DOSAGE

**Cardiac Chest Discomfort / AMI:**

0.4 mg SL (may be repeated up to 3 doses total)

**Pulmonary Edema / CHF:**

0.4 mg SL (may be repeated up to 3 doses total)

## PEDIATRIC DOSAGE

Not recommended in prehospital setting

## KEY POINTS

- May repeat up to 3 doses if B/P systolic > 110 with IV or 120 without IV
- Assure that patient does not chew or swallow tablets
# ONDANSETRON (Zofran)

<table>
<thead>
<tr>
<th><strong>PREGNANCY CLASS</strong></th>
<th><strong>B</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIONS</strong></td>
<td>1. Prevents nausea and vomiting by blocking serotonin peripherally and centrally in the small intestines</td>
</tr>
</tbody>
</table>
| **INDICATIONS**     | 1. Nausea and vomiting  
2. Chemotherapy and radiation induced nausea and vomiting |
| **CONTRAINDICATIONS** | 1. Known hypersensitivity  
2. Severe liver disease |
| **PRECAUTIONS**     | 1. Pregnancy  
2. May prolong QT interval when used with other QT prolonging agents |
| **SIDE EFFECTS**    | 1. Constipation, diarrhea  
2. Increased liver enzymes  
3. Headache  
4. Fatigue and malaise |
| **SUPPLIED**        | 4 mg / 2 ml single dose vial and 4 mg oral disintegrating tablets (ODT) |

## ADULT DOSAGE

**Anti-Emetic**
- 4 mg IM or IV  
May repeat in 15 minutes if symptoms unresolved

**Anti-Emetic ODT**
- 8 mg Oral disintegrating tablets (ODT) (x2) 4mg tablets

## PEDIATRIC DOSAGE

**Anti-Emetic**
- 0.15 mg / kg IM or IV -or- 0.15 mg / kg PO (injectable liquid) > 1 year old  
Max 4 mg / per dose  
May repeat in 15 minutes if symptoms unresolved

**Anti-Emetic ODT**
- if > 40 kg / 12 Years, then 4 mg Oral disintegrating tablets (ODT) (x1) 4mg tablet

See **PEDIATRIC DRUG ADMINISTRATION CHART** for weight based administration

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>3-5 kg</th>
<th>6-7 kg</th>
<th>8-9 kg</th>
<th>10-11 kg</th>
<th>12-14 kg</th>
<th>15-18 kg</th>
<th>19-23 kg</th>
<th>24-29 kg</th>
<th>30-36 kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 kg</td>
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<td>6-7 kg</td>
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<td>8-9 kg</td>
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<td>10-11 kg</td>
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<td>12-14 kg</td>
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<td>15-18 kg</td>
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<td>19-23 kg</td>
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<td>24-29 kg</td>
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<tr>
<td>30-36 kg</td>
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</tr>
</tbody>
</table>
### MEDICATIONS

#### ORAL GLUCOSE (Instant Glucose)

<table>
<thead>
<tr>
<th><strong>PREGNANCY CLASS</strong></th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIONS</strong></td>
<td>Raises blood glucose level</td>
</tr>
<tr>
<td><strong>INDICATIONS</strong></td>
<td>Treatment of hypoglycemia</td>
</tr>
</tbody>
</table>
| **CONTRAINDICATIONS** | 1. Known hypersensitivity to corn products  
                          2. Unconscious patients |
| **PRECAUTIONS**     | 1. Patient must be alert and able to sufficiently swallow  
                          2. Monitor patient for difficulty swallowing or choking due to the thick consistency of agent |
| **SUPPLIED**        | Squeeze tube containing 24 grams of flavored oral dextrose gel |

**ADULT DOSAGE**

One complete tube (15 g - 24 g) by mouth

**PEDIATRIC DOSAGE**

Half a tube by mouth

**KEY POINTS**

The patient must be alert and have the ability to swallow!
# MEDICATIONS

## OXYGEN (O₂)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>B</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Increases oxygen content of blood  
2. Improves tissue oxygenation  
3. Decreases energy expended for respirations |
| INDICATIONS     | 1. Cardiac chest discomfort / ACS  
2. Suspected stroke  
3. Hypoxemia  
4. Cardiopulmonary emergencies  
5. Trauma  
6. Shortness of breath / dyspnea  
7. Sedative drug administration  
8. Unknown oxyhemoglobin saturation |
| CONTRAINDICATIONS | None in the prehospital setting |
| PRECAUTIONS     | Be aware for respiratory depression in COPD patients on prolonged high flow oxygen |
| SIDE EFFECTS    | High concentrations of oxygen may reduce the respiratory drive in some COPD patients; these patients should be carefully monitored |
| SUPPLIED        | As a compressed gas in cylinders of varying sizes |
| ADULT DOSAGE    | 12 - 15 lpm via NRB mask or 2 - 6 lpm via nasal cannula, 6 - 10 lpm via small volume nebulizer, unless otherwise indicated |
| PEDIATRIC DOSAGE | 12 - 15 lpm via NRB mask or 2 - 6 lpm via nasal cannula, or 6 - 10 lpm via unit dose nebulizer, unless otherwise indicated |
| KEY POINTS      | • Never withhold oxygen to those who need it  
• All sedative medication administration must have oxygen administration |
<table>
<thead>
<tr>
<th>MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>RACEMIC EPINEPHRINE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Reduces subglottic edema via vasoconstriction  
                  2. Bronchodilation |
| INDICATIONS     | 1. Stridor  
                  2. Croup |
| CONTRAINDICATIONS | Known hypersensitivity |
| PRECAUTIONS     | Patient may have a rebound worsening after effects wear off |
| SIDE EFFECTS    | 1. Tachycardia  
                  2. Hypertension |
| SUPPLIED        | Single unit dose 0.50 ml 2.25%  
                  Must be diluted with 3 ml normal saline |

| ADULT DOSAGE    | Stridor:  
                  Single unit dose (0.50 ml) nebulized, diluted in 3 ml normal saline |
| PEDIATRIC DOSAGE | Croup / Stridor:  
                  Single unit dose (0.50 ml) nebulized, diluted in 3 ml normal saline |
| KEY POINTS      |   |
## MEDICATIONS

### SODIUM BICARBONATE

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
</table>
| ACTIONS         | Alkalinizing agent  
                  Decreases absorption of certain drug in the kidneys |
| INDICATIONS     | 1. Used in cardiac arrest for known dialysis patients  
                  2. Tricyclic overdoses |
| CONTRAINDICATIONS | Known hypersensitivity |
| PRECAUTIONS     | 1. Should be administered after airway is secured  
                  2. Heart failure |
| SIDE EFFECTS    | 1. Hyperosmolarity  
                  2. Alkalosis |
| SUPPLIED        | Prefilled syringes 8.4% 50ml |

### ADULT DOSAGE

- **Cardiac Arrest / Known Dialysis Patient:**  
  1 - 2 Amps IV / IO
- **Tricyclic Overdose:**  
  1 meq / kg IV / IO
- **Hyperkalemia / Sine Wave EKG:**  
  1 meq / kg IV / IO

### PEDIATRIC DOSAGE

- **Tricyclic Overdose:**  
  1 mEq / kg IV / IO

**See PEDIATRIC DRUG ADMINISTRATION CHART for weight based administration**

<table>
<thead>
<tr>
<th>Weight Range</th>
<th>3-5 kg</th>
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<th>19-23 kg</th>
<th>24-29 kg</th>
<th>30-36 kg</th>
</tr>
</thead>
</table>

### KEY POINTS

- Tricyclic anti-depressants include (but not limited to): Amitriptyline, Nortryptiline, Elavil, Amoxapine, Clomipramine, Desipramine, Doxepin, Imipramine, Nortriptyline, Protriptyline, and Trimipramine
- Administer until QRS complex narrows to less than 0.12 m sec and the patient condition improves
- Carefully flush IV lines after administration
- Extravasation may cause tissue resistance
- Will cause transient increase in capnography
## TETRACAINE (PONTOCAINE)

<table>
<thead>
<tr>
<th><strong>PREGNANCY CLASS</strong></th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIONS</strong></td>
<td>Topical local anesthetic</td>
</tr>
<tr>
<td><strong>INDICATIONS</strong></td>
<td>Ocular irritation / pain with NO PENETRATING TRAUMA</td>
</tr>
</tbody>
</table>
| **CONTRAINDICATIONS** | 1. Hypersensitivity  
2. Allergy to caine family (Novacaine, Lidocaine, Etc.)  
3. Penetrating eye injury |
| **PRECAUTIONS**     | 1. Burning sensation  
2. Redness  
3. Tearing |
| **SIDE EFFECTS**    | 1. Burning sensation  
2. Redness  
3. Tearing |
| **SUPPLIED**        | 0.5% 2 ml dropper |
| **ADULT DOSAGE**    | Non-Penetrating Eye Trauma  
1 – 2 drops in affected eye |
| **PEDIATRIC DOSAGE** | Non-Penetrating Eye Trauma  
1 drop in affected eye |
| **KEY POINTS**      | • Keep dropper sterile  
• Single patient use packaging |
## THIAMINE

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>THIAMINE</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Allows the normal breakdown of glucose</td>
</tr>
<tr>
<td>INDICATIONS</td>
<td>Suspected thiamine deficiency in malnourished or alcoholic patients prior to giving dextrose</td>
</tr>
<tr>
<td>CONTRAINDICATIONS</td>
<td>Known hypersensitivity</td>
</tr>
<tr>
<td>PRECAUTIONS</td>
<td>Rare anaphylactic reactions</td>
</tr>
</tbody>
</table>
| SIDE EFFECTS    | 1. Known hypersensitivity  
2. Restlessness  
3. Anaphylactic reaction  
4. Nausea  
5. Weakness |
| SUPPLIED        | 100 mg / 1 ml vial |
| ADULT DOSAGE    | Hypoglycemic Chronic Alcoholic / Malnourished Patient:  
100 mg IV or IM prior to dextrose |
<p>| PEDIATRIC DOSAGE | Not recommended in the pre-hospital setting |</p>
<table>
<thead>
<tr>
<th><strong>MEDICATIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TICAGRELOL (Brilinta)</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PREGNANCY CLASS</strong></th>
<th><strong>C</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIONS</strong></td>
<td>P2Y platelet inhibitor</td>
</tr>
<tr>
<td><strong>INDICATIONS</strong></td>
<td>1. Confirmed STEMI</td>
</tr>
</tbody>
</table>
| **CONTRAINDICATIONS** | 1. Bleeding  
                        | 2. Intracranial hemorrhage  
                        | 3. Hepatic impairment |
| **PRECAUTIONS**     | |
| **SIDE EFFECTS**    | 1. Bleeding  
                        | 2. Dyspnea |
| **SUPPLIED**        | 90 mg tablets |

**ADULT DOSAGE**  
Confirmed STEMI:  
180 mg PO (2 – 90 mg Tablets)  

**PEDIATRIC DOSAGE**  
Not recommended in the pre-hospital setting
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CIPROFLOXACIN (Cipro)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Antimicrobial</td>
</tr>
</tbody>
</table>
| INDICATIONS     | 1. Anthrax exposure  
                  | 2. Other microorganism exposure deemed public health threat |
| CONTRAINDICATIONS | 1. Hypersensitivity  
                   | 2. Allergy |
| PRECAUTIONS     |  |
| SIDE EFFECTS    | 1. Nausea / Vomiting |
| SUPPLIED        | 100, 250, 500 mg tablets or 200 mg in 100 ml / 400 mg in 200 ml IV bags  
                  | VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION |
| ADULT DOSAGE    | Anthrax / Microorganism Exposure:  
                  | 500 mg PO or 400 mg IV / IO |
# SPECIAL USE MEDICATIONS

ONLY FOR USE IF TICAGRELOR (Brilinta) Unavailable

## CLOPIDOGRIL (Plavix)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Platelet aggregate inhibitor</td>
</tr>
<tr>
<td>INDICATIONS</td>
<td>1. Confirmed STEMI where Ticagrelor (Brilinta) is unavailable</td>
</tr>
</tbody>
</table>
| CONTRAINDICATIONS | 1. Bleeding  
2. Intracranial hemorrhage  
3. Hepatic impairment |
| PRECAUTIONS     |  |
| SIDE EFFECTS    | 1. Chest pain  
2. Weakness  
3. Bleeding |
| SUPPLIED        | 600 mg tablet |
| ADULT DOSAGE    | Confirmed STEMI with NO TICAGRELOR (Brilinta) Available:  
600 mg PO |
### DOXYCYCLINE (Vibramycin)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Antibiotic</td>
</tr>
</tbody>
</table>
| INDICATIONS     | 1. Anthrax  
                | 2. Plague   |
| CONTRAINDICATIONS | 1. Allergy  
                    | 2. Pregnancy  
                    | 3. Pediatrics |
| PRECAUTIONS     |              |
| SIDE EFFECTS    | Diarrhea    |
| SUPPLIED        | 100 mg Tablet |
| ADULT DOSAGE    | Anthrax / Plague Exposure:  
                    | 100 mg PO |
### SPECIAL USE MEDICATIONS

**Only for NERVE AGENT EMERGENCY RESPONSE**

---

**Duo-Dote (Atropine and Pralidoxime Chloride)**

**VALIUM Auto Injector**

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>DuoDote</td>
</tr>
<tr>
<td></td>
<td>• Blocks nerve agents effects and relieves airway constriction and secretions in the lungs and gastrointestinal tract.</td>
</tr>
<tr>
<td></td>
<td>• Acts to restore normal functions at the nerve ending by removing the nerve agent and reactivating natural function</td>
</tr>
<tr>
<td>Valium:</td>
<td>• Given to treat seizures caused by exposure to nerve agents (buddy treatment) – SUPPLEMENT TO DUODOTE</td>
</tr>
<tr>
<td>INDICATIONS</td>
<td>Suspected or confirmed nerve agent exposure</td>
</tr>
<tr>
<td>CONTRAINDICATIONS</td>
<td>Both medications in the kit should be used with caution (but not withheld) in patients with preexisting cardiac disease, HTN, or CVA history</td>
</tr>
<tr>
<td>PRECAUTIONS</td>
<td></td>
</tr>
<tr>
<td>SIDE EFFECTS</td>
<td>1. Chest pain</td>
</tr>
<tr>
<td></td>
<td>2. Exacerbation of angina</td>
</tr>
<tr>
<td></td>
<td>3. Myocardial infarction</td>
</tr>
<tr>
<td></td>
<td>4. Blurred vision</td>
</tr>
<tr>
<td></td>
<td>5. Headache</td>
</tr>
<tr>
<td></td>
<td>6. Drowsiness</td>
</tr>
<tr>
<td></td>
<td>7. Nausea</td>
</tr>
<tr>
<td></td>
<td>8. Tachycardia</td>
</tr>
<tr>
<td></td>
<td>9. Hypertension</td>
</tr>
<tr>
<td></td>
<td>10. Hyperventilation</td>
</tr>
<tr>
<td>SUPPLIED</td>
<td>DUODOTE - Each auto injector contains BOTH: Atropine 2.1 mg and Pralidoxime 600 mg</td>
</tr>
<tr>
<td></td>
<td>Valium auto injector contains 10 mg</td>
</tr>
<tr>
<td>ADULT DOSAGE</td>
<td>For Nerve Agent Exposure (SLUDGE symptoms):</td>
</tr>
<tr>
<td></td>
<td>Up to 3 auto injectors may be used for one patient based on signs (1 - 2 kits for self-treatment - up to 3 for buddy treatment with severe symptoms)</td>
</tr>
<tr>
<td></td>
<td>For Seizures Associated with Nerve Agent Exposure:</td>
</tr>
<tr>
<td></td>
<td>1 Valium auto injector (buddy administration)</td>
</tr>
<tr>
<td>PEDIATRIC DOSAGE</td>
<td>DuoDotes are not authorized for the use of children under the age of 9 years</td>
</tr>
<tr>
<td>KEY POINTS</td>
<td>• DuoDotes are reserved for treatment of public service personnel exposed to nerve agents</td>
</tr>
</tbody>
</table>
### ETOMIDATE (Amidate)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Hypnotic sedative</td>
</tr>
<tr>
<td>INDICATIONS</td>
<td>Induction of anesthesia during RSI</td>
</tr>
<tr>
<td>CONTRAINDICATIONS</td>
<td>Hypersensitivity</td>
</tr>
<tr>
<td>PRECAUTIONS</td>
<td></td>
</tr>
<tr>
<td>SIDE EFFECTS</td>
<td>Skeletal muscle movements</td>
</tr>
<tr>
<td>SUPPLIED</td>
<td>20 mg / 10 ml</td>
</tr>
<tr>
<td></td>
<td>VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADULT DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction For RSI:</td>
</tr>
<tr>
<td>0.3 mg / kg IV / IO - Usual dose 20 mg</td>
</tr>
</tbody>
</table>
# SPECIAL USE MEDICATIONS

Only for CYANIDE EXPOSURE RESPONSE – Where available

## HYDROXOCOBALMIN (Cyanokit)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Cyanide antidote – binds to cyanide ions for excretion</td>
</tr>
<tr>
<td>INDICATIONS</td>
<td>Known or suspected cyanide poisoning</td>
</tr>
<tr>
<td>CONTRAINDICATIONS</td>
<td>None in the emergency setting – assure airway, breathing, and circulatory support are in place prior to administration.</td>
</tr>
</tbody>
</table>
| PRECAUTIONS     | 1. Use caution if other cyanide antidotes are used simultaneously with Hydroxocobalmin (Cyanokit), use separate IV lines  
2. Do not use if there is particulate matter in the vial after reconstitution or the solution is not dark red |
| SIDE EFFECTS    | 1. Possible allergic reaction  
2. Eye irritation, redness, swelling  
3. Abdominal pain, nausea, vomiting, diarrhea  
4. Chest discomfort  
5. Dizziness, restlessness  
6. Dyspnea, tight throat  
7. Skin flushing, urticaria |
| SUPPLIED        | (1) 5 g vials for reconstitution – shake for 30 seconds per vial |
| ADULT DOSAGE    | Cyanide Exposure:  
5 g over 15 minutes |
| KEY POINTS      | • A second dose of 5 g may be considered depending on patient response and severity of exposure.  
• Discard unused medication after 6 hours  
• Reconstitute with normal saline (0.9% sodium chloride)  
• May have drug interactions, administer all other medications via a separate IV line |

---

**Complete Starting Dose: 5 g**

1. **Reconstitute:** Place the vial in an upright position. Add 200 mL of 0.9% Sodium Chloride injection* to the vial using the transfer spike. Fill to the line.  
   *0.9% Sodium Chloride injection is the recommended diluent (diluent not included in the kit). Lactated Ringers injection and 5% Dextrose injection have also been found to be compatible with hydroxocobalamin and may be used if 0.9% Sodium Chloride is not readily available.**

2. **Mix:** The vial should be repeatedly inverted or rocked, not shaken, for at least 60 seconds prior to infusion.  
   • CYANOKIT solutions should be visually inspected for particulate matter and color prior to administration – Discard solution if particulate matter is present or solution is not dark red.

3. **Infuse Vial:** Use vented intravenous tubing, hang and infuse over 15 minutes.
# NITROUS OXIDE / OXYGEN (Nitronox)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>N</th>
</tr>
</thead>
</table>
| ACTIONS         | 1. Nitrous oxide / oxygen is a mixture of 50% nitrous oxide and 50% oxygen  
2. When inhaled, nitrous oxide/oxygen depresses the central Nervous system, causing sedation and analgesia  
3. Nitrous Oxide: oxygen is self-administered  
4. Provides rapid, easily reversible relief of pain |
| INDICATIONS     | 1. Burns  
2. Kidney stones  
3. Musculoskeletal trauma  
4. Fractures |
| CONTRAINDICATIONS | 1. Known hypersensitivity  
2. Decreased level of consciousness or unable to follow instructions  
3. History of drug or alcohol ingestion  
4. History of COPD, emphysema, or any condition that may compromise respiratory efforts including: chest trauma, CHF, respiratory tract burns, or other trauma  
5. Bowel obstruction or traumatic abdominal injury  
6. Maxillofacial injuries or head injuries  
7. Obstetric patient not in the process of delivery  
8. Pediatric patient < 12 years or < 75 pounds  
9. Intoxication  
10. Psychiatric problems  
11. Respiratory distress  
12. Increased intracranial pressure  
13. Decompression sickness |
| SUPPLIED        | Supplied as Nitronox, a set containing oxygen and a nitrous oxide cylinder joined by a valve that regulates flow to provide a 50:50 mixture of the two gasses. The mixture is piped to a demand valve apparatus. |
| SIDE EFFECTS    | Dizziness, apnea, cyanosis, nausea, vomiting. Ambulance crew may experience giddiness if the vehicle is not properly vented |
| ADULT DOSAGE    | Extremity Trauma:  
Instruct the patient to inhale deeply though a patient-held demand valve and mask or mouthpiece. Have patient inhale gas until pain relief or patient spontaneously is unable to hold mask. |
| PEDIATRIC DOSAGE | Not indicated in the pre-hospital setting |
| KEY POINTS      | • Self-administered by mask: a good seal around mouth and nose is important; the gas is breathed deeply and may give relief after about two minutes; the patient should stop when relief is obtained  
• The paramedic should not hold the face mask in place for the patient |
<table>
<thead>
<tr>
<th><strong>PREGNANCY CLASS</strong></th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTIONS</strong></td>
<td>Depolarizing neuromuscular blocking agent</td>
</tr>
<tr>
<td><strong>INDICATIONS</strong></td>
<td>Facilitate endotracheal intubation</td>
</tr>
</tbody>
</table>
| **CONTRAINDICATIONS** | 1. History of malignant hyperthermia  
2. Skeletal muscle myopathies  
3. Known or suspected hyperkalemia  
4. Renal failure  
5. Burns >34 hours old |
| **PRECAUTIONS**     |  |
| **SIDE EFFECTS**    | 1. Apnea  
2. Arrhythmias  
3. Increased intraocular pressure  
4. Muscle fasciculations |
| **SUPPLIED**        | 200 mg / 10 ml  
VERIFY ACTUAL CONCENTRATION ON HAND BEFORE ADMINISTRATION |
| **ADULT DOSAGE**    | **Muscle Relaxant for RSI:**  
2 mg / kg - Usual dose 100 mg |
**SPECIAL USE MEDICATIONS**

For CONFIRMED STEMI ONLY where SUPPLIED AND SUPPORTED due to TRANSPORT TIMES TO PCI CENTERS

### TENECTEPLASE (TNKase)

<table>
<thead>
<tr>
<th>PREGNANCY CLASS</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIONS</td>
<td>Thrombolytic agent</td>
</tr>
<tr>
<td>INDICATIONS</td>
<td>1. Confirmed STEMI where transport times to PCI are &gt;60 min</td>
</tr>
</tbody>
</table>
| CONTRAINDICATIONS| 1. Active bleeding  
|                  | 2. CVA History  
|                  | 3. Trauma within 2 months  
|                  | 4. Surgery within 2 months  
|                  | 5. Uncontrolled hypertension |
| PRECAUTIONS      | 1. Cerebrovascular disease  
|                  | 2. Recent gastrointestinal or genitourinary bleeding  
|                  | 3. Recent trauma  
|                  | 4. Hypertension: systolic BP ≥180 mm Hg and/or diastolic BP ≥110 mm Hg  
|                  | 5. High likelihood of left heart thrombus, e.g., mitral stenosis with atrial fibrillation  
|                  | 6. Acute pericarditis  
|                  | 7. Subacute bacterial endocarditis  
|                  | 8. Hemostatic defects, including those secondary to severe hepatic or renal disease  
|                  | 9. Severe hepatic dysfunction  
|                  | 10. Pregnancy  
|                  | 11. Diabetic hemorrhagic retinopathy or other hemorrhagic ophthalmic conditions  
|                  | 12. Septic thrombophlebitis or occluded AV cannula at seriously infected site  
|                  | 13. Advanced age (see PRECAUTIONS: Geriatric Use)  
|                  | 14. Patients currently receiving oral anticoagulants, e.g., warfarin sodium  
|                  | 15. Recent administration of GP IIb/IIIa inhibitors  
|                  | 16. Any other condition in which bleeding constitutes a significant hazard or would be particularly difficult to manage because of its location |
| SIDE EFFECTS     | 1. Bleeding  
|                  | 2. CVA |
| SUPPLIED         | 50 mg vial with 10 ml sterile water for Reconstitution |
| ADULT DOSAGE     | **Confirmed STEMI:**  
|                  | <60 kg | 30 mg IV (6 ml)  
|                  | 60 kg – 70 kg | 35 mg IV (7 ml)  
|                  | 70 kg – 80 kg | 40 mg IV (8 ml)  
|                  | 80 kg – 90 kg | 45 mg IV (9 ml)  
|                  | > 90 kg | 50 mg IV (10 ml)  

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**Image:**

1. **Withdraw:** 10 ml of Sterile Water for Injection, USP, using the 10 ml BD Syringe with BD Twinpak™ Dual Cannula Device included in the kit. See TNKase Package Insert for instructions on use of the dual cannula device.

2. **Inject:** entire contents into the TNKase vial, directing the diluent at the powder. Lightly shake until all the powder is dispersed and the solution is clear. The solution should be colorless or pale yellow and transparent. Use upon RECONSTITUTION. If any precipitate forms, it should be filtered through a 40 μm filter device. If not used immediately, refrigerate solution at 2 to 8°C (36-46°F) and use within 8 hours. DO NOT FREEZE. The recommended total dose should not exceed 50 mg. Any unused solution should be discarded.

3. **Gently Swirl:** until completely dissolved. DO NOT SHAKE. Solution should be colorless or pale yellow and transparent. Use upon RECONSTITUTION. If not used immediately, refrigerate solution at 2 to 8°C (36-46°F) and use within 8 hours. DO NOT FREEZE. The recommended total dose should not exceed 50 mg. Any unused solution should be discarded.

4. **Withdraw:** the appropriate volume of solution based on patient weight. (See Dosing Information) The recommended total dose should not exceed 50 mg. Any unused solution should be discarded.

5. **Flush:** the plastic or metal containing line with a saline-containing solution prior to and following administration (precipitation may occur when TNKase is administered in an intravenous [IV] line containing dextrose).

6. **Administer:** as an IV BOLUS over 5 seconds.
## PEDIATRIC WEIGHT BASED DOSING CHARTS

### GRAY

<table>
<thead>
<tr>
<th>CONCENTRATION</th>
<th>ROUTES</th>
<th>3 KG</th>
<th>4 KG</th>
<th>5 KG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td>160 mg / 5 ml</td>
<td>PO</td>
<td>30 mg (1 ml)</td>
<td>40 mg (1.25 ml)</td>
</tr>
<tr>
<td>Adenosine (1st dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>0.3 mg (0.1 ml)</td>
<td>0.4 mg (0.13 ml)</td>
</tr>
<tr>
<td>Adenosine (2nd dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>0.6 mg (0.2 ml)</td>
<td>0.8 mg (0.27 ml)</td>
</tr>
<tr>
<td>Amiodarone (Cordarone)</td>
<td>150 mg / 3 ml</td>
<td>IV / IO</td>
<td>15 mg (0.5 ml)</td>
<td>20 mg (0.4 ml)</td>
</tr>
<tr>
<td>Atropine</td>
<td>1 mg / 10 ml</td>
<td>IV / IO</td>
<td>0.1 mg (1 ml)</td>
<td>0.1 mg (1 ml)</td>
</tr>
<tr>
<td>Calcium Chloride</td>
<td>1 G / 10 ml</td>
<td>IV / IO</td>
<td>60 mg (0.6 ml)</td>
<td>80 mg (0.8 ml)</td>
</tr>
<tr>
<td>Dextrose 10% (Made from D50)</td>
<td>1 G / 10 ml</td>
<td>IV / IO</td>
<td>0.6 G (6 ml)</td>
<td>0.8 G (8 ml)</td>
</tr>
<tr>
<td>Dextrose 10%</td>
<td>10 grams / 100 ml</td>
<td>IV / IO</td>
<td>0.6 G (6 ml)</td>
<td>0.8 G (8 ml)</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>50 mg / ml</td>
<td>IV / IO / IM</td>
<td>3 mg (0.06 ml)</td>
<td>4 mg (0.08 ml)</td>
</tr>
<tr>
<td>Epinephrine 1 mg / ml (1:1,000)</td>
<td>1 mg / ml</td>
<td>IM</td>
<td>0.03 mg (0.03 ml)</td>
<td>0.04 mg (0.04 ml)</td>
</tr>
<tr>
<td>Epinephrine 0.1 mg / ml (1:10,000)</td>
<td>0.1 mg / ml</td>
<td>IV / IO</td>
<td>0.03 mg (0.3 ml)</td>
<td>0.04 mg (0.4 ml)</td>
</tr>
<tr>
<td>Fentanyl (Sublimaze)</td>
<td>100 mcg / 2 ml</td>
<td>IN / IV / IM</td>
<td>3 mcg (0.06 ml)</td>
<td>4 mcg (0.08 ml)</td>
</tr>
<tr>
<td>Glucagon (Glucagen)</td>
<td>1 mg / ml</td>
<td>IN / IM</td>
<td>0.3 mg (0.3 ml)</td>
<td>0.4 mg (0.4 ml)</td>
</tr>
<tr>
<td>Lidocaine (Xylocaine)</td>
<td>20 mg / ml</td>
<td>IO</td>
<td>1.5 mg (0.075 ml)</td>
<td>2 mg (0.1 ml)</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>2 mg / ml</td>
<td>IV / IO</td>
<td>0.15 mg (0.075 ml)</td>
<td>0.2 mg (0.1 ml)</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>1 g / ml</td>
<td>IV / IO</td>
<td>150 mg (3.75 ml)</td>
<td>200 mg (5 ml)</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>40 mg / ml</td>
<td>IV / IO</td>
<td>150 mg (3.75 ml)</td>
<td>200 mg (5 ml)</td>
</tr>
<tr>
<td>Methylprednisolone (Solu-Medrol)</td>
<td>125 mg / 2 ml</td>
<td>IV / IO</td>
<td>6 mg (0.1 ml)</td>
<td>8 mg (0.125 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IV / IO</td>
<td>0.3 mg (0.06 ml)</td>
<td>0.4 mg (0.08 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>10 mg / ml</td>
<td>IV / IO</td>
<td>0.3 mg (0.03 ml)</td>
<td>0.4 mg (0.04 ml)</td>
</tr>
<tr>
<td>Morphine</td>
<td>2 mg / 2 ml</td>
<td>IV / IO / IN</td>
<td>0.3 mg (0.3 ml)</td>
<td>0.4 mg (0.4 ml)</td>
</tr>
<tr>
<td>Ondansetron (Zofran)</td>
<td>4 mg / 2 ml</td>
<td>IV / IO / PO</td>
<td>0.45 mg (0.23 ml)</td>
<td>0.6 mg (0.3 ml)</td>
</tr>
<tr>
<td>Sodium Bicarbonate 8.4%</td>
<td>1 mEq / ml</td>
<td>IV / IO</td>
<td>6.5 mEq (6.5 ml)</td>
<td></td>
</tr>
</tbody>
</table>

### PINK

<table>
<thead>
<tr>
<th>CONCENTRATION</th>
<th>ROUTES</th>
<th>6 - 7 KG (6.5 kg average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td>160 mg / 5 ml</td>
<td>65 mg (2 ml)</td>
</tr>
<tr>
<td>Adenosine (1st dose)</td>
<td>6 mg / 2 ml</td>
<td>0.65 mg (0.22 ml)</td>
</tr>
<tr>
<td>Adenosine (2nd dose)</td>
<td>6 mg / 2 ml</td>
<td>1.3 mg (0.43 ml)</td>
</tr>
<tr>
<td>Amiodarone (Cordarone)</td>
<td>150 mg / 3 ml</td>
<td>32 mg (0.64 ml)</td>
</tr>
<tr>
<td>Atropine</td>
<td>1 mg / 10 ml</td>
<td>0.13 mg (1.3 ml)</td>
</tr>
<tr>
<td>Calcium Chloride</td>
<td>1 G / 10 ml</td>
<td>130 mg (1.3 ml)</td>
</tr>
<tr>
<td>Dextrose 10% (Made from D50)</td>
<td>1 G / 10 ml</td>
<td>1.3 G (13 ml)</td>
</tr>
<tr>
<td>Dextrose 10%</td>
<td>10 grams / 100 ml</td>
<td>1.3 G (13 ml)</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>50 mg / ml</td>
<td>6.5 mg (0.13 ml)</td>
</tr>
<tr>
<td>Epinephrine 1 mg / ml (1:1,000)</td>
<td>1 mg / ml</td>
<td>0.065 mg (0.065 ml)</td>
</tr>
<tr>
<td>Epinephrine 0.1 mg /ml (1:10,000)</td>
<td>0.1 mg / ml</td>
<td>0.065 mg (0.065 ml)</td>
</tr>
<tr>
<td>Fentanyl (Sublimaze)</td>
<td>100 mcg / 2 ml</td>
<td>6.5 mcg (0.13 ml)</td>
</tr>
<tr>
<td>Glucagon (Glucagen)</td>
<td>1 mg / ml</td>
<td>0.65 mg (0.5 ml)</td>
</tr>
<tr>
<td>Lidocaine (Xylocaine)</td>
<td>20 mg / ml</td>
<td>3.25 mg (0.16 ml)</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>2 mg / ml</td>
<td>0.325 mg (0.1625 ml)</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>1 g / ml</td>
<td>325 mg (0.325 ml)</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>40 mg / ml</td>
<td>325 mg (8.125 ml)</td>
</tr>
<tr>
<td>Methylprednisolone (Solu-Medrol)</td>
<td>125 mg / 2 ml</td>
<td>13 mg (0.21 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>0.65 mg (0.13 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>10 mg / ml</td>
<td>1.3 mg (0.26 ml)</td>
</tr>
<tr>
<td>Morphine</td>
<td>2 mg / 2 ml</td>
<td>0.65 mg (0.065 ml)</td>
</tr>
<tr>
<td>Naloxone (Narcan)</td>
<td>2 mg / 2 ml</td>
<td>0.65 mg (0.65 ml)</td>
</tr>
<tr>
<td>Ondansetron (Zofran)</td>
<td>4 mg / 2 ml</td>
<td>1 mg (0.5 ml)</td>
</tr>
<tr>
<td>Sodium Bicarbonate 8.4%</td>
<td>1 mEq / ml</td>
<td>6.5 mEq (6.5 ml)</td>
</tr>
<tr>
<td>RED</td>
<td>CONCENTRATION</td>
<td>ROUTES</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td>160 mg / 5 ml</td>
<td>PO</td>
</tr>
<tr>
<td>Adenosine (1st dose)</td>
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<td>IV / IO</td>
</tr>
<tr>
<td>Adenosine (2nd dose)</td>
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<td>IV / IO</td>
</tr>
<tr>
<td>Amiodarone (Cordarone)</td>
<td>150 mg / 3 ml</td>
<td>IV / IO</td>
</tr>
<tr>
<td>Atropine</td>
<td>1 mg / 10 ml</td>
<td>IV / IO</td>
</tr>
<tr>
<td>Calcium Chloride</td>
<td>1 G / 10 ml</td>
<td>IV / IO</td>
</tr>
<tr>
<td>Dextrose 25% (Made from D50)</td>
<td>12.5 G / 50 ml</td>
<td>IV / IO</td>
</tr>
<tr>
<td>Dextrose 10%</td>
<td>10 grams / 100 ml</td>
<td>IV / IO</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>50 mg / ml</td>
<td>IV / IO / IM</td>
</tr>
<tr>
<td>Epinephrine 1 mg / ml (1:1,000)</td>
<td>1 mg / ml</td>
<td>IM</td>
</tr>
<tr>
<td>Epinephrine 0.1 mg / ml (1:10,000)</td>
<td>0.1 mg / ml</td>
<td>IV / IO</td>
</tr>
<tr>
<td>Fentanyl (Sublimaze)</td>
<td>100 mcg / 2 ml</td>
<td>IN / IV / IM</td>
</tr>
<tr>
<td>Glucagon (Glucagen)</td>
<td>1 mg / ml</td>
<td>IN / IM</td>
</tr>
<tr>
<td>Lidocaine (Xylocaine)</td>
<td>20 mg / ml</td>
<td>IO</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>2 mg / ml</td>
<td>IV / IO</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>1 g / ml</td>
<td>IV / IO</td>
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<td>IV / IO</td>
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<tr>
<td>Methylprednisolone (Solu-Medrol)</td>
<td>125 mg / 2 ml</td>
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<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IV / IO</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IN</td>
</tr>
<tr>
<td>Morphine</td>
<td>10 mg / ml</td>
<td>IV / IO</td>
</tr>
<tr>
<td>Naloxone (Narcan)</td>
<td>2 mg / 2ml</td>
<td>IV / IO / IN</td>
</tr>
<tr>
<td>Ondansetron (Zofran)</td>
<td>4 mg / 2 ml</td>
<td>IV / IO / PO</td>
</tr>
<tr>
<td>Sodium Bicarbonate 8.4%</td>
<td>1 mEq / ml</td>
<td>IV / IO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PURPLE</th>
<th>CONCENTRATION</th>
<th>ROUTES</th>
<th>10-11 kg (10.5 kg average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td>160 mg / 5 ml</td>
<td>PO</td>
<td>105 mg (3.3 ml)</td>
</tr>
<tr>
<td>Adenosine (1st dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>1 mg (0.33 ml)</td>
</tr>
<tr>
<td>Adenosine (2nd dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>2 mg (0.66 ml)</td>
</tr>
<tr>
<td>Amiodarone (Cordarone)</td>
<td>150 mg / 3 ml</td>
<td>IV / IO</td>
<td>52 mg (1.04 ml)</td>
</tr>
<tr>
<td>Atropine</td>
<td>1 mg / 10 ml</td>
<td>IV / IO</td>
<td>0.21 mg (2.1 ml)</td>
</tr>
<tr>
<td>Calcium Chloride</td>
<td>1 G / 10 ml</td>
<td>IV / IO</td>
<td>210 mg (2.1 ml)</td>
</tr>
<tr>
<td>Dextrose 25% (Made from D50)</td>
<td>12.5 G / 50 ml</td>
<td>IV / IO</td>
<td>5.25 G (21 ml)</td>
</tr>
<tr>
<td>Dextrose 10%</td>
<td>10 grams / 100 ml</td>
<td>IV / IO</td>
<td>3.15 G (31.5 ml)</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>50 mg / ml</td>
<td>IV / IO / IM</td>
<td>10.5 mg (0.21 ml)</td>
</tr>
<tr>
<td>Epinephrine 1 mg / ml (1:1,000)</td>
<td>1 mg / ml</td>
<td>IM</td>
<td>0.10 mg (0.1 ml)</td>
</tr>
<tr>
<td>Epinephrine 0.1 mg / ml (1:10,000)</td>
<td>0.1 mg / ml</td>
<td>IV / IO</td>
<td>0.1 mg (1 ml)</td>
</tr>
<tr>
<td>Fentanyl (Sublimaze)</td>
<td>100 mcg / 2 ml</td>
<td>IN / IV / IM</td>
<td>10.5 mcg (0.21 ml)</td>
</tr>
<tr>
<td>Glucagon (Glucagen)</td>
<td>1 mg / ml</td>
<td>IN / IM</td>
<td>1 mg (1 ml)</td>
</tr>
<tr>
<td>Lidocaine (Xylocaine)</td>
<td>20 mg / ml</td>
<td>IO</td>
<td>5.25 mg (0.26 ml)</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>2 mg / ml</td>
<td>IV / IO</td>
<td>0.525 mg (0.2625 ml)</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>1 g / ml</td>
<td>IV / IO</td>
<td>525 mg (0.525 ml)</td>
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<td>Magnesium Sulfate</td>
<td>40 mg / ml</td>
<td>IV / IO</td>
<td>525 mg (13.125 ml)</td>
</tr>
<tr>
<td>Methylprednisolone (Solu-Medrol)</td>
<td>125 mg / 2 ml</td>
<td>IV / IO</td>
<td>21 mg (0.34 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IV / IO</td>
<td>1.05 mg (0.21 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IN</td>
<td>2.1 mg (0.42 ml)</td>
</tr>
<tr>
<td>Morphine</td>
<td>10 mg / ml</td>
<td>IV / IO</td>
<td>1.05 mg (0.105 ml)</td>
</tr>
<tr>
<td>Naloxone (Narcan)</td>
<td>2 mg / 2ml</td>
<td>IV / IO / IN</td>
<td>1.05 mg (1.05 ml)</td>
</tr>
<tr>
<td>Ondansetron (Zofran)</td>
<td>4 mg / 2 ml</td>
<td>IV / IO / PO</td>
<td>1.58 mg (0.8 ml)</td>
</tr>
<tr>
<td>Sodium Bicarbonate 8.4%</td>
<td>1 mEq / ml</td>
<td>IV / IO</td>
<td>10.5 mEq (10.5 ml)</td>
</tr>
<tr>
<td>YELLOW</td>
<td>CONCENTRATION</td>
<td>ROUTES</td>
<td>12-14 kg (13 kg average)</td>
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<tr>
<td>Acetaminophen (Tylenol)</td>
<td>160 mg / 5 ml</td>
<td>PO</td>
<td>130 mg (4.07 ml)</td>
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<tr>
<td>Adenosine (1st dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>1.3 mg (0.43 ml)</td>
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<tr>
<td>Adenosine (2nd dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>2.6 mg (0.87 ml)</td>
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<tr>
<td>Amiodarone (Cordarone)</td>
<td>150 mg / 3 ml</td>
<td>IV / IO</td>
<td>65 mg (1.3 ml)</td>
</tr>
<tr>
<td>Atropine</td>
<td>1 mg / 10 ml</td>
<td>IV / IO</td>
<td>0.26 mg (2.6 ml)</td>
</tr>
<tr>
<td>Calcium Chloride</td>
<td>1 G / 10 ml</td>
<td>IV / IO</td>
<td>260 mg (2.6 ml)</td>
</tr>
<tr>
<td>Dextrose 25% (Made from D50)</td>
<td>12.5 G / 50 ml</td>
<td>IV / IO</td>
<td>6.5 G (26 ml)</td>
</tr>
<tr>
<td>Dextrose 10%</td>
<td>10 grams / 100 ml</td>
<td>IV / IO</td>
<td>6.5 G (65 ml)</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>50 mg / ml</td>
<td>IV / IO / IM</td>
<td>13 mg (0.21 ml)</td>
</tr>
<tr>
<td>Epinephrine 1 mg / ml (1:1,000)</td>
<td>1 mg / ml</td>
<td>IM</td>
<td>0.13 mg (0.13 ml)</td>
</tr>
<tr>
<td>Epinephrine 0.1 mg / ml (1:10,000)</td>
<td>0.1 mg / ml</td>
<td>IV / IO</td>
<td>0.13 mg (1.3 ml)</td>
</tr>
<tr>
<td>Fentanyl (Sublimaze)</td>
<td>100 mcg / 2 ml</td>
<td>IN / IV / IM</td>
<td>13 mcg (0.26 ml)</td>
</tr>
<tr>
<td>Glucagon (Glucagen)</td>
<td>1 mg / ml</td>
<td>IN / IM</td>
<td>1 mg (1 ml)</td>
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<tr>
<td>Lidocaine (Xylocaine)</td>
<td>20 mg / ml</td>
<td>IO</td>
<td>6.5 mg (0.325 ml)</td>
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<tr>
<td>Lorazepam (Ativan)</td>
<td>2 mg / ml</td>
<td>IV / IO</td>
<td>0.65 mg (0.325 ml)</td>
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<tr>
<td>Magnesium Sulfate</td>
<td>40 mg / ml</td>
<td>IV / IO</td>
<td>650 mg (16.25 ml)</td>
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<td>Magnesium Sulfate</td>
<td>125 mg / 2 ml</td>
<td>IV / IO</td>
<td>26 mg (0.42 ml)</td>
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<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IV / IO</td>
<td>1.3 mg (0.26 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IN</td>
<td>2.6 mg (0.52 ml)</td>
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<tr>
<td>Morphine</td>
<td>10 mg / ml</td>
<td>IV / IO</td>
<td>1.3 mg (0.13 ml)</td>
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<tr>
<td>Naloxone (Narcan)</td>
<td>2 mg / 2ml</td>
<td>IV / IO / IN</td>
<td>1.3 mg (1.3 ml)</td>
</tr>
<tr>
<td>Ondansetron (Zofran)</td>
<td>4 mg / 2 ml</td>
<td>IV / IO / PO</td>
<td>1.95 mg (.975 ml)</td>
</tr>
<tr>
<td>Sodium Bicarbonate 8.4%</td>
<td>1 mEq /ml</td>
<td>IV / IO</td>
<td>13 mEq (13 ml)</td>
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</table>

<table>
<thead>
<tr>
<th>WHITE</th>
<th>CONCENTRATION</th>
<th>ROUTES</th>
<th>15-18 kg (16.5 kg average)</th>
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<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td>160 mg / 5 ml</td>
<td>PO</td>
<td>165 mg (5 ml)</td>
</tr>
<tr>
<td>Adenosine (1st dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>1.65 mg (0.55 ml)</td>
</tr>
<tr>
<td>Adenosine (2nd dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>3.3 mg (1.1 ml)</td>
</tr>
<tr>
<td>Amiodarone (Cordarone)</td>
<td>150 mg / 3 ml</td>
<td>IV / IO</td>
<td>82.5 mg (1.65 ml)</td>
</tr>
<tr>
<td>Atropine</td>
<td>1 mg / 10 ml</td>
<td>IV / IO</td>
<td>0.33 mg (3.3 ml)</td>
</tr>
<tr>
<td>Calcium Chloride</td>
<td>1 G / 10 ml</td>
<td>IV / IO</td>
<td>330 mg (3.3 ml)</td>
</tr>
<tr>
<td>Dextrose 25% (Made from D50)</td>
<td>12.5 G / 50 ml</td>
<td>IV / IO</td>
<td>8.5 G (34 ml)</td>
</tr>
<tr>
<td>Dextrose 10%</td>
<td>10 grams / 100 ml</td>
<td>IV / IO</td>
<td>8.25 G (82.5 ml)</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>50 mg / ml</td>
<td>IV / IO / IM</td>
<td>16.5 mg (0.33 ml)</td>
</tr>
<tr>
<td>Epinephrine 1 mg / ml (1:1,000)</td>
<td>1 mg / ml</td>
<td>IM</td>
<td>0.16 mg (0.16 ml)</td>
</tr>
<tr>
<td>Epinephrine 0.1 mg / ml (1:10,000)</td>
<td>0.1 mg / ml</td>
<td>IV / IO</td>
<td>0.165 mg (1.65 ml)</td>
</tr>
<tr>
<td>Fentanyl (Sublimaze)</td>
<td>100 mcg / 2 ml</td>
<td>IN / IV / IM</td>
<td>16.5 mcg (0.33ml)</td>
</tr>
<tr>
<td>Glucagon (Glucagen)</td>
<td>1 mg / ml</td>
<td>IN / IM</td>
<td>1 mg (1 ml)</td>
</tr>
<tr>
<td>Lidocaine (Xylocaine)</td>
<td>20 mg / ml</td>
<td>IO</td>
<td>8.25 mg (0.41 ml)</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>2 mg / ml</td>
<td>IV / IO</td>
<td>0.825 mg (0.42 ml)</td>
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<tr>
<td>Magnesium Sulfate</td>
<td>1 g / ml</td>
<td>IV / IO</td>
<td>825 mg (0.825 ml)</td>
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<tr>
<td>Magnesium Sulfate</td>
<td>40 mg / ml</td>
<td>IV / IO</td>
<td>825 mg (20.625 ml)</td>
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<tr>
<td>Methylprednisolone (Solu-Medrol)</td>
<td>125 mg / 2 ml</td>
<td>IV / IO</td>
<td>33 mg (0.53 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IV / IO</td>
<td>1.65 mg (0.33 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IN</td>
<td>3.3 mg (0.66 ml)</td>
</tr>
<tr>
<td>Morphine</td>
<td>10 mg / ml</td>
<td>IV / IO</td>
<td>1.65 mg (0.165 ml)</td>
</tr>
<tr>
<td>Naloxone (Narcan)</td>
<td>2 mg / 2ml</td>
<td>IV / IO / IN</td>
<td>1.65 mg (1.65 ml)</td>
</tr>
<tr>
<td>Ondansetron (Zofran)</td>
<td>4 mg / 2 ml</td>
<td>IV / IO / PO</td>
<td>2.48 mg (1.24 ml)</td>
</tr>
<tr>
<td>Sodium Bicarbonate 8.4%</td>
<td>1 mEq/ml</td>
<td>IV / IO</td>
<td>16.5 mEq (16.5 ml)</td>
</tr>
</tbody>
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### BLUE

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Concentration</th>
<th>Routes</th>
<th>19-23 kg (21 kg average)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td>160 mg / 5 ml</td>
<td>PO</td>
<td>210 mg (6.56 ml)</td>
</tr>
<tr>
<td>Adenosine (1st dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>2.1 mg (0.7 ml)</td>
</tr>
<tr>
<td>Adenosine (2nd dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>4.2 mg (1.4 ml)</td>
</tr>
<tr>
<td>Amiodarone (Cordarone)</td>
<td>150 mg / 3 ml</td>
<td>IV / IO</td>
<td>105 mg (2.1 ml)</td>
</tr>
<tr>
<td>Atropine</td>
<td>1 mg / 10 ml</td>
<td>IV / IO</td>
<td>0.42 mg (4.2 ml)</td>
</tr>
<tr>
<td>Calcium Chloride</td>
<td>1 G / 10 ml</td>
<td>IV / IO</td>
<td>420 mg (4.2 ml)</td>
</tr>
<tr>
<td>Dextrose 25% (Made from D50)</td>
<td>12.5 G / 50 ml</td>
<td>IV / IO</td>
<td>10.5 G (42 ml)</td>
</tr>
<tr>
<td>Dextrose 10%</td>
<td>10 grams / 100 ml</td>
<td>IV / IO</td>
<td>10.5 G (105 ml)</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>50 mg / ml</td>
<td>IV / IO / IM</td>
<td>21 mg (0.42 ml)</td>
</tr>
<tr>
<td>Epinephrine 1 mg / ml (1:1,000)</td>
<td>1 mg / ml</td>
<td>IM</td>
<td>0.21 mg (0.21 ml)</td>
</tr>
<tr>
<td>Epinephrine 0.1 mg / ml (1:10,000)</td>
<td>0.1 mg / ml</td>
<td>IV / IO</td>
<td>0.21 mg (2.1 ml)</td>
</tr>
<tr>
<td>Fentanyl (Sublimaze)</td>
<td>100 mcg / 2 ml</td>
<td>IN / IV / IM</td>
<td>21 mcg (0.42 ml)</td>
</tr>
<tr>
<td>Glucagon (Glucagen)</td>
<td>1 mg / ml</td>
<td>IN / IM</td>
<td>1 mg (1 ml)</td>
</tr>
<tr>
<td>Lidocaine (Xylocaine)</td>
<td>20 mg / ml</td>
<td>IO</td>
<td>10.5 mg (0.525 ml)</td>
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<td>Lorazepam (Ativan)</td>
<td>2 mg / ml</td>
<td>IV / IO</td>
<td>1.05 mg (0.525 ml)</td>
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<tr>
<td>Magnesium Sulfate</td>
<td>1 g / ml</td>
<td>IV / IO</td>
<td>1.050 mg (1.05 ml)</td>
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<td>Magnesium Sulfate</td>
<td>40 mg / ml</td>
<td>IV / IO</td>
<td>1.050 mg (26.25 ml)</td>
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<tr>
<td>Methylprednisolone (Solu-Medrol)</td>
<td>125 mg / 2 ml</td>
<td>IV / IO</td>
<td>42 mg (0.675 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IV / IO</td>
<td>2.1 mg (0.42 ml)</td>
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<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IN</td>
<td>4.2 mg (0.84 ml)</td>
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<td>Morphine</td>
<td>10 mg / ml</td>
<td>IV / IO</td>
<td>2.1 mg (0.21 ml)</td>
</tr>
<tr>
<td>Naloxone (Narcan)</td>
<td>2 mg / 2 ml</td>
<td>IV / IO / IN</td>
<td>2 mg (2 ml)</td>
</tr>
<tr>
<td>Ondansetron (Zofran)</td>
<td>4 mg / 2 ml</td>
<td>IV / IO / PO</td>
<td>3.15 mg (1.58 ml)</td>
</tr>
<tr>
<td>Sodium Bicarbonate 8.4%</td>
<td>1 mEq / ml</td>
<td>IV / IO</td>
<td>21 mEq (21 ml)</td>
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### ORANGE

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Concentration</th>
<th>Routes</th>
<th>24 - 29 kg (26.5 kg average)</th>
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</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td>160 mg / 5 ml</td>
<td>PO</td>
<td>265 mg (8.3 ml)</td>
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<tr>
<td>Adenosine (1st dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>2.65 mg (0.9 ml)</td>
</tr>
<tr>
<td>Adenosine (2nd dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>5.3 mg (1.8 ml)</td>
</tr>
<tr>
<td>Amiodarone (Cordarone)</td>
<td>150 mg / 3 ml</td>
<td>IV / IO</td>
<td>132.5 mg (2.65 ml)</td>
</tr>
<tr>
<td>Atropine</td>
<td>1 mg / 10 ml</td>
<td>IV / IO</td>
<td>0.53 mg (5.3 ml)</td>
</tr>
<tr>
<td>Calcium Chloride</td>
<td>1 G / 10 ml</td>
<td>IV / IO</td>
<td>530 mg (5.3 ml)</td>
</tr>
<tr>
<td>Dextrose 25% (Made from D50)</td>
<td>12.5 G / 50 ml</td>
<td>IV / IO</td>
<td>12.5 G (50 ml)</td>
</tr>
<tr>
<td>Dextrose 10%</td>
<td>10 grams / 100 ml</td>
<td>IV / IO</td>
<td>13.25 G (132.5 ml)</td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>50 mg / ml</td>
<td>IV / IO / IM</td>
<td>26.5 mg (0.54 ml)</td>
</tr>
<tr>
<td>Epinephrine 1 mg / ml (1:1,000)</td>
<td>1 mg / ml</td>
<td>IM</td>
<td>0.27 mg (0.27 ml)</td>
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<tr>
<td>Epinephrine 0.1 mg / ml (1:10,000)</td>
<td>0.1 mg / ml</td>
<td>IV / IO</td>
<td>0.27 mg (2.7 ml)</td>
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<tr>
<td>Fentanyl (Sublimaze)</td>
<td>100 mcg / 2 ml</td>
<td>IN / IV / IM</td>
<td>26.5 mcg (0.53 ml)</td>
</tr>
<tr>
<td>Glucagon (Glucagen)</td>
<td>1 mg / ml</td>
<td>IN / IM</td>
<td>1 mg (1 ml)</td>
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<tr>
<td>Lidocaine (Xylocaine)</td>
<td>20 mg / ml</td>
<td>IO</td>
<td>13.25 (0.66 ml)</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>2 mg / ml</td>
<td>IV / IO</td>
<td>1.325 mg (0.66 ml)</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>1 g / ml</td>
<td>IV / IO</td>
<td>1325 mg (1.325 ml)</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>40 mg / ml</td>
<td>IV / IO</td>
<td>1325 mg (33.125 ml)</td>
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<td>Methylprednisolone (Solu-Medrol)</td>
<td>125 mg / 2 ml</td>
<td>IV / IO</td>
<td>53 mg (0.85 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IV / IO</td>
<td>2 mg (0.4 ml)</td>
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<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IN</td>
<td>5 mg (1 ml)</td>
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<td>Morphine</td>
<td>10 mg / ml</td>
<td>IV / IO</td>
<td>2.65 mg (0.265 ml)</td>
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<td>Naloxone (Narcan)</td>
<td>2 mg / 2 ml</td>
<td>IV / IO / IN</td>
<td>2 mg (2 ml)</td>
</tr>
<tr>
<td>Ondansetron (Zofran)</td>
<td>4 mg / 2 ml</td>
<td>IV / IO / PO</td>
<td>4 mg (2 ml)</td>
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<tr>
<td>Sodium Bicarbonate 8.4%</td>
<td>1 mEq / ml</td>
<td>IV / IO</td>
<td>26.5 mEq (26.5 ml)</td>
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<tr>
<td>GREEN</td>
<td>CONCENTRATION</td>
<td>ROUTES</td>
<td>30 - 36 kg (33 kg average)</td>
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<tr>
<td>Acetaminophen (Tylenol)</td>
<td>160 mg / 5 ml</td>
<td>PO</td>
<td>320 mg (10 ml)</td>
</tr>
<tr>
<td>Adenosine (1st dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>3.3 mg (1.1 ml)</td>
</tr>
<tr>
<td>Adenosine (2nd dose)</td>
<td>6 mg / 2 ml</td>
<td>IV / IO</td>
<td>6.6 mg (2.2 ml)</td>
</tr>
<tr>
<td>Amiodarone (Cordarone)</td>
<td>150 mg / 3 ml</td>
<td>IV / IO</td>
<td>165 mg (3.3 ml)</td>
</tr>
<tr>
<td>Atropine</td>
<td>1 mg / 10 ml</td>
<td>IV / IO</td>
<td>0.66 mg (6.6 ml)</td>
</tr>
<tr>
<td>Calcium Chloride</td>
<td>1 G / 10 ml</td>
<td>IV / IO</td>
<td>660 mg (6.6 ml)</td>
</tr>
<tr>
<td>Dextrose 25% (Made from D50)</td>
<td>12.5 G / 50 ml</td>
<td>IV / IO</td>
<td>12.5 G (50 ml)</td>
</tr>
<tr>
<td>Dextrose 10%</td>
<td>10 grams / 100 ml</td>
<td>IV / IO</td>
<td>16.5 G (165 ml)</td>
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<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>50 mg / ml</td>
<td>IV / IO / IM</td>
<td>33 mg (0.66 ml)</td>
</tr>
<tr>
<td>Epinephrine 1 mg / ml (1:1,000)</td>
<td>1 mg / ml</td>
<td>IM</td>
<td>0.33 mg (0.33 ml)</td>
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<tr>
<td>Epinephrine 0.1 mg / ml (1:10,000)</td>
<td>0.1 mg / ml</td>
<td>IV / IO</td>
<td>0.33 mg (3.3 ml)</td>
</tr>
<tr>
<td>Fentanyl (Sublimaze)</td>
<td>100 mcg / 2 ml</td>
<td>IN / IV / IM</td>
<td>33 mcg (0.66 ml)</td>
</tr>
<tr>
<td>Glucagon (Glucagen)</td>
<td>1 mg / ml</td>
<td>IN / IM</td>
<td>1 mg (1 ml)</td>
</tr>
<tr>
<td>Lidocaine (Xylocaine)</td>
<td>20 mg / ml</td>
<td>IO</td>
<td>16.5 mg (0.825 ml)</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>2 mg / ml</td>
<td>IV / IO</td>
<td>1.65 mg (0.825 ml)</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>1 g / ml</td>
<td>IV / IO</td>
<td>1,650 mg (1.65 ml)</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>40 mg / ml</td>
<td>IV / IO</td>
<td>1,650 mg (41.25 ml)</td>
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<tr>
<td>Methylprednisolone (Solu-Medrol)</td>
<td>125 mg / 2 ml</td>
<td>IV / IO</td>
<td>66 mg (1.06 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IV / IO</td>
<td>2 mg (0.4 ml)</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>5 mg / ml</td>
<td>IN</td>
<td>5 mg (1 ml)</td>
</tr>
<tr>
<td>Morphine</td>
<td>10 mg / ml</td>
<td>IV / IO</td>
<td>3.3 mg (0.33 ml)</td>
</tr>
<tr>
<td>Naloxone (Narcan)</td>
<td>2 mg / 2ml</td>
<td>IV / IO / IN</td>
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<tr>
<td>Ondansetron (ZoFran)</td>
<td>4 mg / 2 ml</td>
<td>IV / IO / PO</td>
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</tr>
<tr>
<td>Sodium Bicarbonate 8.4%</td>
<td>1 mEq / ml</td>
<td>IV / IO</td>
<td>33 mEq (33 ml)</td>
</tr>
</tbody>
</table>
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INDICATIONS

- Any MEDICAL patient 18 years or older, any TRAUMA patient 16 years or older.

PROCEDURE

1. Scene size-up, including universal precautions, scene safety, environmental hazards assessment, need for additional resources, by-stander safety, and patient / caregiver interaction.
2. Assess need for additional resources.
3. Initial assessment includes a general impression as well as the status of a patient’s airway, breathing, and circulation.
4. Assess mental status (e.g., AVPU) and disability (e.g., GCS).
5. Control major hemorrhage and assess overall priority of patient.
6. Perform a focused history and physical based on patient’s chief complaint.
7. Assess need for critical interventions.
8. Complete critical interventions and perform a complete secondary exam to include a baseline set of vital signs as directed by protocol.
9. Maintain an on-going assessment throughout transport, to include patient response / possible complications of interventions, need for additional interventions, and assessment of evolving patient complaints / conditions.

KEY POINTS

Dealing with the family:

- REMAIN CALM. Show efficiency and competence, even if you don’t really feel it.
- Show a caring a concerned manner for both the family and the patient. If you have negative feelings about the situation (for example if it is an injury as a result of neglect or abuse), try not to let them show. This will only increase hostility between yourself and the family.
- Honestly inform them of what you are doing and what you think is wrong with the patient.
- Reassurance is important for the family as well. Involve them in the care (for example, holding the oxygen or talking to the patient to calm them). This will help develop some trust between you and the family.
INDICATIONS
- Any MEDICAL patient less than 18 years old, or any TRAUMA patient less than 16 years old

PROCEDURE
1. Scene size-up, including universal precautions, scene safety, environmental hazards assessment, need for additional resources, by-stander safety, and patient / caregiver interaction.
2. Assess patient using the pediatric triangle of ABCs:
   - Airway and appearance: speech / cry, muscle tone, inter-activeness, look / gaze, movement of extremities
   - Work of breathing: absent or abnormal airway sounds, use of accessory muscles, nasal flaring, body positioning
   - Circulation to skin: pallor, mottling, cyanosis
3. Establish spinal immobilization if suspicion of spinal injury.
4. Establish responsiveness appropriate for age. (AVPU, GCS, etc.)
5. Color code using Broselow tape.
6. Assess disability. (pulse, motor function, sensory function, papillary reaction)
7. Perform a focused history and physical exam. Recall that pediatric patients easily experience hypothermia and thus should not be left uncovered any longer than necessary to perform an exam.
8. Record vital signs (BP > 3 years of age, cap refill < 3 years of age)
9. Include immunizations, allergies, medications, past medical history, last meal, and events leading up to injury or illness where appropriate.
10. Treat chief complaint as per protocol.

KEY POINTS
- Illness and injuries in children can cause significant anxiety for prehospital personnel as well as panic in the patient, family, and bystanders. It is important for the EMT to remain calm and take control of the patient and situation.

Dealing with the child:
- Tell them what’s happening. It is important to remember to communicate with the child.
- Relate and speak one their developmental level.
- Be honest with them. Don’t say, “This won’t hurt”, if it will. Explain actions.
- Try to enlist their cooperation, if possible.
- Do not separate child from the parent unless they are ill enough to require significant interventions like airway positioning and ventilation.
- Reassure the child frequently.

Dealing with the family:
- REMAIN CALM. Show efficiency and competence, even if you don’t really feel it.
- Show a caring a concerned manner for both the family and the patient. If you have negative feelings about the situation (for example if it is an injury as a result of neglect or abuse), try not to let them show. This will only increase hostility between yourself and the family.
- Honestly inform them of what you are doing and what you think is wrong with the patient.
- Reassurance is important for the family as well. Involve them in the care (for example, holding the oxygen or talking to the patient to calm them). This will help develop some trust between you and the family.
AEROSOL / INHALER TREATMENTS

AEROSOL TREATMENT

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
</table>
| • Patients experiencing bronchospasm | • Shortness of breath  
• Wheezing  
• History of COPD / asthma  
• Unable to complete full sentences  
• Accessory muscle use  
• Nasal flaring  
• Fatigue | • Allergy to medication  
• Arrhythmias |

PROCEDURE – EMT MUST CONTACT MEDICAL CONTROL
1. Gather the necessary equipment.
2. Assemble the nebulizer kit.
3. Instill the premixed medication into the reservoir well of the nebulizer.
4. Connect the nebulizer device to oxygen at 6 - 8 liters per minute or adequate flow to produce a steady, visible mist.
5. Instruct the patient to inhale normally through the mouthpiece of the nebulizer. The patient needs to have a good lip seal around the mouthpiece if no mask.
6. The treatment should last until the solution is depleted. Tapping the reservoir well near the end of the treatment will assist in utilizing all of the solution.
7. Monitor the patient for medication effects. This should include the patient’s assessment of his / her response to the treatment and reassessment of vital signs, ECG, and breath sounds.

KEY POINTS
• Use mouthpiece if patient is able to hold nebulizer effectively.
• Use nebulizer mask if patient is unable to hold nebulizer effectively.

PERSONAL INHALER TREATMENT – EMT DOES NOT NEED MEDICAL CONTROL

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
</table>
| • Patients experiencing bronchospasm | • Shortness of breath  
• Wheezing  
• Patient has own prescribed inhaler | • Medication is not prescribed to patient  
• Medication has expired  
• Patient has received maximum dose |

PROCEDURE
1. Make sure that personal inhaler is at room temperature or warmer.
2. Follow the instructions for either gentle or vigorous shaking.
3. Instruct patient to seal lips around opening of inhaler, using spacer if present.
4. Instruct patient to inhale deeply while depressing the inhaler.
5. Instruct patient to hold breathe as long as possible.
6. Follow the Respiratory Distress protocol.
CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE

**INDICATIONS**
- Breathing patient whose condition is not improving with oxygen therapy
- Respiratory distress or failure, due to pulmonary edema, CHF, or COPD
- Patients 16 years of age or older

**SIGN AND SYMPTOMS**
- Dyspnea and tachypnea > 25
- Chest pain
- Hypertension
- Tachycardia
- Anxiety
- Altered LOC
- Rales and wheezes
- Frothy sputum (severe cases)
- Accessory muscle use
- Retractions
- SPO2 < 94%

**CONTRAINDICATIONS**
- Respiratory arrest / compromise
- Agonal respirations
- Unconscious
- Shock (cardiac insufficiency)
- Pneumothorax - (with no chest tube)
- Penetrating chest trauma
- Persistent nausea and vomiting
- Facial anomalies, facial trauma
- Known blebs
- Unable to follow commands
- Hypercarbia
- B/P < 90 systolic

**PROCEDURE**
1. Assure there is a patent airway and patient breathing is life sustaining.
2. Administer 100% oxygen via appropriate delivery system.
3. Perform appropriate patient assessment, including obtaining vital signs, SPO2 reading and cardiac rhythm.
4. Verbally instruct the CPAP procedure to the patient.
5. Apply CPAP device, starting at 5 cm H2O.
6. Slowly titrate the pressure up to patient response. 10 cm H2O maximum.
7. Continuously reassess the patient, obtaining vital signs every 5 minutes.

**KEY POINTS**
- The use of CPAP has long been recognized as an effective treatment for patients suffering from exacerbation of congestive heart failure.
- Utilize aerosol treatments in-line as defined in protocol.
- The use of CPAP for the treatment of patients who might otherwise receive endotracheal intubation holds several benefits:
  1. CPAP is a less invasive procedure with lesser risk of infection. This eliminates the possibility for adverse reactions following the administration of any antibiotics given for infection.
  2. CPAP eliminates the necessity of weaning the patient off an ET tube and ventilator.
  3. CPAP used prehospitaly reduces the need to intubate patients in the hospital.
  4. CPAP allows the alert patient to have a continued dialogue with his / her caregivers. This allows for the exchange of additional medical history. It also allows for the patient to be involved in the decision-making process for his / her care.
  5. CPAP should be used as a last resort only in asthmatic patients. Prepare to intubate and ventilate.

For circumstances in which the patient does not improve or continues to deteriorate despite CPAP and / or medication therapy, terminate CPAP administration and perform BVM ventilation and endotracheal intubation if necessary.
**KEY POINTS**

- **CPAP Indications**: Hypoxemia and SOB secondary to CHF or other causes not responding to O2 therapy
- **CPAP Contraindications**: BP <90 systolic, respiratory arrest, agonal respirations, unconscious, shock, pneumothorax, penetrating chest trauma, persistent nausea and vomiting, facial anomalies, facial trauma, known blebs, unable to follow commands, apnea, hypercarbia, and airway compromise.
- **Patient must be adequately and spontaneous breathing**

---

**CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE**

**Patient must have adequate respiratory effort**

If Insufficient, go directly to BVM ventilation

Patient is experiencing acute respiratory distress AND is **NOT** hypotensive

Suspected Cause?

**Congestive Heart Failure (CHF)**
- Afbrile
- **Bilateral** rales
- JVD / HJR
- Distal edema
- Orthopnea
- CHF history
- Hypoxia

**Other respiratory etiology (such as pneumonia or COPD)**
- Fever (Pneumonia)
- Wheezing
- Hypoxia / dyspnea

Treat per Respiratory Distress protocol **first**

If patient remains hypoxic despite traditional oxygenation therapies (nasal cannula, non-rebreather, nebulized)

**Administer CPAP**

Start at 5 cm H2O
May titrate up to 10 cm H2O to maintain SpO2

Monitor SpO2, HR, LOC, and **Blood Pressure**. Remove or reduce CPAP if patient becomes **hypotensive**

Patient Improving?

YES

Continue CPAP
Reassess every 5 minutes

NO

Remove from CPAP
Apply BVM Ventilation

**TRANSPORT** to appropriate facility
**CONTACT** receiving facility
**CONSULT** Medical Direction where indicated

---

**ASTHMA CAUTION**

Use extreme caution when using CPAP on ASTHMA patients.

Use only if patient is hypoxic and not responding to any other treatment including aerosols and IM Epinephrine (Adrenaline).

Be prepared to intubate and ventilate these patients.

---

**University Hospitals EMS Protocol Page 7 | 14**
END TIDAL CO2 / CAPOGRAPHY PROCEDURE

**INDICATIONS**
- The End-Tidal CO2 shall be measured on all intubated patients, or with placements of King Airway / LMA
- Cardiac Arrest / Shock
- Intubated Patients
- Respiratory Failure
- COPD
- Hyper / Hypoventilation / Seizures
- Sedated Patients

**CONTRAINDICATIONS**
- This device is not to be used for:
  - Detection of mainstem bronchial intubation

**PROCEDURE – Capnography (Intubated Patient)**
Capnography is required for all patients requiring ventilation through an ET tube, King Airway / LMA.

1. Turn on recording instrumentation (usually part of a cardiac monitor in the pre-hospital setting)
2. Place CO2 Sampling device in between ventilation device (BVM / Ventilator) and the ET / BIAD
3. Attach sampling device to recording instrumentation and ventilate to a CO2 of 35 – 45
4. If ResQPOD is used, place ResQPOD directly on tube, followed by intubated CO2 sampling device, then BVM.

**PROCEDURE – Capnography (Non-Intubated, Spontaneously breathing patient)**

1. Turn on recording instrumentation (usually part of a cardiac monitor in the pre-hospital setting)
2. Place the sampling cannula on the patient
3. Attach sampling device to recording instrumentation record results and treat per results

Capnography vs. Capnometry

Capnography comprises the continuous analysis and recording of carbon dioxide concentrations (CO2) in respiratory gases. Although the terms capnography and capnometry are sometimes considered synonymous, capnometry suggests measurement (ie, analysis alone) without a continuous waveform.

RESPIRATORY CYCLE

The primary components of the respiratory cycle are oxygenation and ventilation.

- **Oxygenation**: Oxygen is inhaled into the lungs and carried into the blood.
- **Ventilation**: CO2 is exhaled from the lungs.
## Colorimetric End Tidal CO₂ Procedure

<table>
<thead>
<tr>
<th>Indications</th>
<th>Signs and Symptoms</th>
<th>Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Backup to Capnography</td>
<td>• Intubated Patients</td>
<td>This device is not to be used for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Detection of hypercarbia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Detect mainstem bronchial intubation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not for continuous monitoring, use capnography</td>
</tr>
</tbody>
</table>

### Procedure – Colorimetric Co₂ monitoring

1. Remove the CO₂ detector from package or activate detector.
2. Attach the CO₂ detector to a King or endotracheal tube.
3. Ventilate patient and note color change on the CO₂ detector.
4. Compare color of indicator on full end-expiration to color chart on product dome. SEE ALGORITHM BELOW.
5. The CO₂ detector shall remain in place with the airway and monitored throughout the prehospital care and transport. Any loss of CO₂ detection or color change is to be documented and monitored as procedures are done to verify or correct the airway problem.
6. Tube placement should be verified frequently and with each patient move or change in the CO₂ detector.
7. If initial intubation attempts fail, the CO₂ detector can be used for re-intubation on the same patient provided the indicator color still matches the "CHECK" color standard on product dome.

### Indicated Color

- **ET tube in esophagus / BIAD not ventilating lungs**
  - and / or –
  - no pulmonary perfusion

Determine if evidence of no pulmonary perfusion

- Cardiac Arrest
- Hypoxia / Cyanosis despite oxygenation

- Re-visualize ET tube placement
  - Only leave in place if placement can be visualized and confirmed by at least one other method

Verify placement of BIAD is creating bilateral chest rise

- Assure BIAD seal
  - Remove only if no chest rise

- **Questionable device placement or inadequate pulmonary perfusion**

Deliver 6 additional breaths

- If color unchanged treat as purple

- **ET tube in trachea or BIAD successfully ventilating lungs**
AIRWAY / BREATHING

INTUBATION - ENDOTRACHEAL

INDICATIONS
- A patient without a gag reflex, is apneic, or is demonstrating inadequate respiratory effort
- Any patient medicated for rapid sequence intubation

SIGNS AND SYMPTOMS
- Unstable airway
- Respiratory arrest
- Cardiac arrest
- GCS less than 8 without a treatable cause (for example, hypoglycemia)

PRECAUTIONS
- Patient intolerance is only a relative contraindication to this procedure

PROCEDURE
1. Cervical immobilization should be applied to the patient when indicated by mechanism of injury or when it is deemed necessary.
2. Prepare all equipment and have suction ready.
3. Hyperoxygenate the patient (one breath every three seconds) for at least one minute before attempting endotracheal intubation, if possible.
4. Suction the pharynx as needed.
5. Open the patient's airway and holding the laryngoscope in the left hand, insert the blade into the right side of the mouth and sweep the tongue to the left.
6. Use the blade to lift the tongue and epiglottis (either directly with the straight blade or indirectly with the curved blade).
7. Once the glottic opening is visualized, slip the tube through the cords and continue to visualize until the cuff is past the cords.
8. No more than 30 seconds may be used per attempt.
   a. Re-ventilation for at least 30 seconds after each attempt.
   b. Some situations such as copious vomiting or bleeding may require suction attempts longer than 30 seconds. These are the exception; not the norm.
9. Remove the stylet.
10. Inflate the cuff of the endotracheal tube with 10 ml of air.
11. Attach the bag-valve device to the ET tube and ventilate the patient.
12. Assess for tube placement:
   a. Watched tube pass through cords.
   b. Waveform Capnography
   c. Confirmation of lung sounds in the apices and bases bilaterally.
   d. Absence of epigastric sounds.
   e. Chest rise with ventilation.
   f. Good compliance with bag-valve ventilation
   g. Patent color improves.
   h. SpO2 improves. (If distal perfusion is present to create a reading)
If at any time placement cannot be confirmed or obtained, the ETT shall be removed, an alternate airway placed, and the patient shall be ventilated. If there is any doubt about proper placement, the tube shall be removed.
13. If proper placement is confirmed, the cm markings on the tube at the level of the teeth shall be noted and secure the tube with a commercial tube holder.
14. Document ETT size, time, result, and placement location by the centimeter marks either at the patient’s teeth or lips on the patient care report (PCR). Document all devices used to confirm initial tube placement. Also document breath sounds before and after each movement of the patient.
15. Routinely reassess for proper tube placement. The initial tube placement and all reassessments must be documented.

KEY POINTS
- It is essential to have complete and detailed documentation concerning the placement of the endotracheal tube. The documentation MUST include: Methods used, success / failure, pre-oxygenation, suction, SpO2, CO2, medications used, visualization, tube size, lip line, all confirmation techniques, securement of tube, and repeat assessments of placement.
- Placement - direct visualization of the tube passing through the vocal cords.
- Applying c-collar may assist in minimizing ETT movement after placement.
- It is the responsibility of the practitioner to be familiar with the proper technique of using the different laryngoscope blades.
- Tube placement must be confirmed; after it was initially placed, after every movement, any significant change in patient status, and prior to entering the emergency department.
- Continually monitor the patient’s SpO2, EtCO2, ease of ventilation, heart rate, and presence of JVD.
- A complication of endotracheal intubation and / or manual ventilation is a pneumothorax and tension pneumothorax. Refer to the chest decompression procedure if this occurs.
- Only functioning paramedics and AEMT may intubate. AEMT’S may only intubate patients who are apneic.
- Intubation does NOT have to be attempted if their airway can be effectively managed with BVM ventilations.
- Have tube placement confirmed immediately upon entering the ER by a Physician prior to moving patient to ER bed.
BOUGIE ASSISTED INTUBATION

1. Prepare patient as described above for standard orotracheal intubation.
2. Use laryngoscope to lift mandible and displace tongue as normal.
3. Use the gum rubber bougie with the bent end up in place of an ETT.
4. Pass the bougie through the cords, this works as a place keeper to an ETT can be slide over the Bougie and into the trachea.
5. Pass a generously lubricated tube over the Bougie and into the trachea. Do not use force to advance the tube past the vocal cords.
6. Pull the Bougie out once the tube has been passed to the desired depth, inflate the ETT cuff, and verify tube placement using all standard methods.

VIDEO LARYNGOSCOPY - OTHER DEVICES

Video laryngoscopes are permitted to be substituted for standard laryngoscopes during intubation procedures. The user must have previous training specific to the make and model of laryngoscope being used and have and must have a standard laryngoscope set available in the event of device failure. Manufacturer’s recommendations must be followed on use, sizing, disposal or cleaning, indications and contraindications for the device. A BIAD device must still be available if unable to pass an endotracheal tube with either video or standard laryngoscopy.

PEDIATRIC TUBE SIZING

The size of tube that can be passed easily into most adults is 8.0 mm (id). Therefore this tube should be tried first on the average adult. The size of tube is judged by the size of the adult, not by age.

For children, the proper tube is usually equal to the size of the child’s little finger. The following guide will also help in determining the proper size tube:

<table>
<thead>
<tr>
<th>Premature.........3mm (id)</th>
<th>18-24 months.....5-6mm (id)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-24 weeks....4mm (id)</td>
<td>2-4 years........6mm (id)</td>
</tr>
<tr>
<td>6-12 months.....4-5mm (id)</td>
<td>4-7 years........6-7mm (id)</td>
</tr>
<tr>
<td>12-18 months....5mm (id)</td>
<td>7-10 years.......7mm (id)</td>
</tr>
</tbody>
</table>

KEY POINTS

- All the above tube sizes are still dependent on the child’s size rather than consideration of age.
- Children before puberty should have a cuffless tube, or if the tube has a cuff it should not be inflated after insertion.

TUBE REMOVAL

If the patient begins to breathe spontaneously and effectively and is resisting the presence of the tube, removal of the tube may be necessary. The following procedures will be followed:

1. Explain procedure to victim.
2. Prepare suction equipment with large-bore catheter and suction secretions from endotracheal tube, mouth and pharynx.
3. The lungs should be completely inflated so that the patient will initially cough or exhale as the tube is taken from the larynx. This is accomplished in 2 ways:
   a. The patient is asked to take the deepest breath they possibly can and, at the very peak of the inspiratory effort, the cuff is deflated and the tube removed rapidly; or
   b. Positive pressure is administered with a hand-held ventilator and, at the end of deep inspiration, the cuff is deflated and the tube rapidly removed.
4. Prepare to suction secretions and gastric content if vomiting occurs.
5. Appropriate oxygen is then administered.
6. The patient’s airway is immediately evaluated for signs of obstruction, stridor or difficulty breathing. The patient should be encouraged to take deep breaths and to cough.
AIRWAY / BREATHING PROCEDURES

KING AIRWAY DEVICE (BIAD)

INDICATIONS

- Emergent airway management of pulseless and apneic patients (EMT Provider)
- Emergent salvage airway management of apneic patients (AEMT and PARAMEDIC Provider)

CONTRAINDICATIONS

- Responsive patients with an intact gag reflex.
- Patients with known esophageal disease. (varices)
- Patients who have ingested caustic substances.

PROCEDURE

1. Hold the King Airway at the connector, using the dominant hand.
2. With non-dominant hand, hold mouth open and apply chin lift.
3. Using a lateral approach, introduce device into corner of mouth.
4. Advance tip behind the base of the tongue, while rotating tube back to midline so that the blue orientation line faces the chin of the patient.
5. Without exerting excessive force, advance tube until base of connector is aligned with teeth or gums.
6. Attach the syringe and inflate the cuffs to the appropriate volume:
   - SIZE 2 = 25-35 ml (LT or LTS-D)
   - SIZE 2.5 = 30-40 ml (LT or LTS-D)
   - SIZE 3 = 40-55 ml (LT or LTS-D)
   - SIZE 4 = 50-70 ml (LT or LTS-D)
   - SIZE 5 = 60-80 ml (LT or LTS-D)
7. Attach a bag-valve device to the connector. While gently bagging the patient to assess ventilation, gently withdraw the tube until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).
8. Adjust cuff inflation, if necessary, to obtain a seal of the airway.
9. After placement, perform standard checks for breath sounds and utilize an appropriate carbon dioxide detection device, as required by protocol.

REMOVAL OF DEVICE (if indicated):

1. Confirm need for removal of the device.
2. Suction above cuffs in the oral cavity.
3. FULLY deflate both cuffs before removal of the device. (may require multiple attempts of air removal with syringe to fully evacuate air)
4. Remove the device when protective reflexes have returned.
**KEY POINTS**

1. The key to insertion is to get the distal tip of KING around the corner in the posterior pharynx, under the base of the tongue. Experience has indicated that a lateral approach, in conjunction with a chin lift, facilitates placement of the KING. Alternatively, a laryngoscope or tongue depressor can be used to lift the tongue anteriorly to allow easy advancement of the KING into position.

2. Insertion can also be accomplished via a midline approach by applying a chin lift and sliding the distal tip along the palate and into position in the hypopharynx. In this instance, head extension may also be helpful.

3. As the KING is advanced around the corner in the posterior pharynx, it is important that the tip of the device is maintained at the midline. If the tip is placed or deflected laterally, it may enter the piriform fossa and the tube will appear to bounce back upon full insertion and release. Keeping the tip at the midline assures that the distal tip is placed properly in the hypopharynx / upper esophagus.

4. Depth of insertion is key to providing a patent airway. Ventilatory openings of the KING must align with the laryngeal inlet for adequate oxygenation / ventilation to occur. Accordingly, the insertion depth should be adjusted to maximize ventilation. Experience has indicated that initially placing the KING deeper (proximal opening of gastric access lumen aligned with teeth or gums), inflating the cuffs and withdrawing until ventilation is optimized results in the best depth of insertion for the following reasons:
   - It ensures that the distal tip has not been placed laterally in the piriform fossa (see item #3 above).
   - With a deeper initial insertion, only withdrawal of the tube is required to realize a patent airway. A shallow insertion will require deflation of the cuffs to advance the tube deeper.
   - As the KING is withdrawn, the initial ventilation opening exposed to or aligned with the laryngeal inlet is the proximal opening. Since the proximal opening is closest to and is partially surrounded by the proximal cuff, airway obstruction is less likely, especially when spontaneous ventilation is employed.
   - Withdrawal of the KING with the balloons inflated results in a retraction of tissue away from the laryngeal inlet, thereby encouraging a patent airway.

5. Ensure that the cuffs are not over-inflated. If a cuff pressure gauge is not available, inflate cuffs with the minimum volume necessary to seal the airway at the peak ventilatory pressure employed. (just seal volume)

6. Removal of the KING is well tolerated until the return of protective reflexes. For later removal, it may be helpful to remove some air from the cuffs to reduce the stimulus during wake-up.

7. King Airway Kit Includes:
   - King Airway
   - 60-80 cc Syringe
   - Lubricant
   - Instructions for use

---

**DO NOT GIVE MEDICATIONS DOWN THE KING AIRWAY**

<table>
<thead>
<tr>
<th>Color</th>
<th>Size</th>
<th>Size</th>
<th>Weight</th>
<th>Cuff Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>2</td>
<td>35-40 Inches</td>
<td>12-25 kg</td>
<td>25-35 Verify On Tube</td>
</tr>
<tr>
<td>Orange</td>
<td>2.5</td>
<td>41-51 Inches</td>
<td>25-35 kg</td>
<td>30-40 Verify On Tube</td>
</tr>
<tr>
<td>Yellow</td>
<td>3</td>
<td>4-5 Feet</td>
<td>NA</td>
<td>40-55 Verify On Tube</td>
</tr>
<tr>
<td>Red</td>
<td>4</td>
<td>5-6 Feet</td>
<td>NA</td>
<td>50-80 Verify On Tube</td>
</tr>
<tr>
<td>Purple</td>
<td>5</td>
<td>&gt;6 Feet</td>
<td>NA</td>
<td>60-90 Verify On Tube</td>
</tr>
</tbody>
</table>

---
STEP 1 – Preparing the King Vision Video Laryngoscope (the Display and Blade combination) for use

Choose the style of Blade (Standard or Channeled) to be used.

Install the Display into the Blade (only goes together one way). Listen for a “click” to signify that the Display is fully engaged with the Blade. Note that the front and back of the parts are color-coded to facilitate proper orientation.

<table>
<thead>
<tr>
<th>Using The King Vision Channeled Blade</th>
<th>Using The King Vision Standard Blade</th>
</tr>
</thead>
<tbody>
<tr>
<td>The size #3 Channeled blade is designed to be used with standard ETT sizes 6.0 to 8.0. No stylet is needed.</td>
<td>The size #3 Standard blade is used when integral guidance of the ETT is not indicated. In this case, a stylet will likely be necessary.</td>
</tr>
<tr>
<td>Lubricate the ETT, the guiding channel of the Channeled Blade and the distal tip of the Blade using a water soluble lubricant. Take care to avoid covering the imaging element of the blade with lubricant. The ETT may be preloaded into the guiding channel with its distal tip aligned with the end of the channel. Note that the ETT tip should not be evident on the screen when loaded properly. Alternatively, the ETT can be inserted into the channel after the blade has been inserted into the mouth and the vocal cords have been visualized.</td>
<td>Lubricate the distal tip of the Standard Blade using a water soluble lubricant. Take care to avoid covering the imaging element of the blade with lubricant. The ETT and stylet should be lubricated and the stylet pre-loaded into the ETT in the same manner as with other intubations where a stylet is used. User tip: Shaping the ETT with a pre-loaded stylet to match the blade curvature may be helpful.</td>
</tr>
</tbody>
</table>

Step 2 – Powering On

Press the POWER button (Fig. 1, #4) on the back of the King Vision Display. The King Vision Display should turn “ON” immediately AND Display shows a moving image. Confirm the imaging of the King Vision is working properly. If not, stop and refer to the “Acquiring an Image” section. IMPORTANT: If the LED Battery indicator light (Fig. 1, #5) in the upper left hand corner of the King Vision Display is FLASHING RED, the battery life remaining is limited and the batteries should be replaced as soon as possible.

Step 3 – Insertion of King Vision Blade into the Mouth

Open the patient’s mouth using standard technique.

In the presence of excessive secretions/blood, suction the patient’s airway prior to introducing the Blade into the mouth. Insert the Blade into the mouth following the midline. Take care to avoid pushing the tongue towards the larynx. As the Blade is advanced into the oropharynx, use an anterior approach toward the base of the tongue. Watch for the epiglottis and direct the Blade tip towards the vallecula to facilitate visualization of the glottis on the Display’s video screen. The King Vision Blade tip can be placed in the vallecula like a Macintosh blade or can be used to lift the epiglottis like a Miller blade. For best results, center the vocal cords in the middle of the Display’s video screen.

If the lens becomes obstructed (e.g., blood/secretions), remove the Blade from the patient’s mouth and clear the lens. Avoid putting pressure on the teeth with the King Vision Video Laryngoscope.

Step 4 – ETT Insertion

<table>
<thead>
<tr>
<th>Advance the ETT (Channeled Blade)</th>
<th>Insert the ETT/Stylet (Standard Blade)</th>
</tr>
</thead>
<tbody>
<tr>
<td>After you can see the vocal cords in the center of the King Vision Display, advance the ETT slowly and watch for the cuff to pass through the vocal cords. Note that minor manipulation of the blade may be needed to align the ETT tip with the vocal cords.</td>
<td>After you can see the vocal cords on the King Vision Display, insert the ETT with pre-loaded stylet into the mouth using a lateral approach. Once the ETT tip has reached the posterior pharynx, manipulate the ETT to direct its tip toward the vocal cords. Advance ETT tip just through the cords then retract the stylet prior to advancing the ETT into position in the trachea with the cuff below the cords. Fully remove the stylet.</td>
</tr>
</tbody>
</table>
# Needle Cricothyrotomy (Only if Trained)

## Indications
- Management of an obstructed airway when standard airway procedures cannot be accomplished or have failed.
- Unable to intubate by another route.
- Cervical spine injuries
- Maxillofacial trauma
- Laryngeal trauma / edema

## Signs and Symptoms
- Airway obstruction from:
  - Edema from infection, caustic ingestion, allergic reaction, and / or inhalation injuries
  - Foreign body
  - Mass lesion

## Complications
- Post procedure bleeding
- Cellulitis of neck
- Subcutaneous emphysema
- Voice change
- Feeling of lump in throat
- Persistent stoma
- Obstructive problems
- Misplacement of the airway

---

**PROCEDURE**

1. If time permits, prep with appropriate antiseptic solution.
2. Have suction supplies available and ready.
3. Locate the cricothyroid membrane utilizing anatomical landmarks (in the midline between thyroid cartilage and cricoid cartilage).
4. Secure larynx laterally between thumb and forefinger.
5. Relocates the cricothyroid membrane.
6. Using the a syringe attached to a short 10 to 14 gauge catheter-over-needle device if needed, insert the needle through the cricothyroid membrane at a 45 to 60 degree angle caudally (towards feet).
7. Confirm entry of needle in trachea by aspirating air through the syringe.
8. If air is present, change the angle of insertion to 60 degrees.
9. Advance the catheter to the level of the hub.
10. Carefully remove the needle and syringe.
11. Secure the cannula to patient.
12. Attach the cannula to a 15 mm adapter. (3.0 – 3.5 pediatric ET tube adapter)
13. Attach a BVM to the airway adapter and begin oxygenation.
14. Make certain ample time is used not only for inspiration but expiration as well.
15. If unable to obtain an adequate airway, resume basic airway management and transport the patient as soon as possible.
16. **Regardless of success or failure of needle cricothyrotomy, notify the receiving hospital at the earliest possible time of a surgical airway emergency.**

---

**KEY POINTS**

- Use needle cricothyrotomy as a bridge to more invasive surgical airways. (Tracheotomy, surgical cricothyrotomy)
- If placement is required due to foreign body obstruction, removal attempts should continue after performing needle cric procedure.
- Use procedure early to prevent ongoing hypoxia if foreign body is not easily removed.
- QuickTrach device provides a better airway and ventilation if device is available and provider has undergone specific training for that device. See Cricothyrotomy / QuickTrach Procedure.

---

This procedure buys TIME only. It is not a definitive airway. It will provide OXYGENATION only, not appropriate VENTILATION.
**AIRWAY / BREATHING**

**CRICOTHYROTOMY – QUICKTRACH (Only if trained)**

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>COMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Management of an obstructed airway when standard airway procedures cannot be accomplished or have failed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Unable to intubate by another route</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cervical spine injuries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maxillo facial trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Laryngeal trauma / edema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Airway obstruction from:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Edema from infection, caustic ingestion, allergic reaction, and / or inhalation injuries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Foreign body</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mass lesion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Post procedure bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cellulitis of neck</td>
<td></td>
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<td>• Voice change</td>
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<td>• Feeling of lump in throat</td>
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<td></td>
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<tr>
<td>• Persistent stoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Obstructive problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Misplacement of the airway</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This procedure will provide OXYGENATION and life sustaining VENTILATION in an emergency.

**PROCEDURE**
1. If time permits, prep with appropriate antiseptic solution.
2. Have suction supplies available and ready.
3. Locate the cricothyroid membrane utilizing anatomical landmarks.
4. Secure larynx laterally between thumb and forefinger.
5. Relocate the cricothyroid membrane (in the midline between thyroid cartilage and cricoid cartilage).
6. Using the syringe and the finder needle supplied in the QuickTrach kit, insert the needle through the cricothyroid membrane at a 45 to 60 degree angle caudally (toward the feet).
7. Confirm entry of needle in trachea by aspirating air through the syringe.
8. If air is present, change the angle of insertion to 60 degrees.
9. Advance the device to the level of the stop guide.
10. Remove the stop guide and slide the plastic cannula along the needle into the trachea until the flange rest against the neck.
11. Carefully remove the needle and syringe.
12. Secure the cannula with the provided anchoring device.
13. Attach the connecting tube to the 15mm connection.
14. Attach a BVM to the connecting tube.
15. Confirm placement by auscultation and observing patient for adequate chest rise. Make certain ample time is used not only for inspiration but expiration as well.
16. If unable to obtain an adequate airway, resume basic airway management and transport the patient as soon as possible.
17. Regardless of success or failure of the placement of QuickTrach, notify the receiving hospital at the earliest possible time of a surgical airway emergency.

**KEY POINTS**

**Guidelines for Sizing**
• Adult (4.0 mm) QuickTrach: Any patient greater than 100 pounds (45kg) and greater than 8 years in age.
• Use a scalpel to make a VERTICAL MIDLINE incision over the cricothyroid membrane if the landmarks are difficult to identify. Once identified, use the QuickTrach as noted above.
NEEDLE CHEST DECOMPRESSION

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>PRECAUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tension pneumothorax with significant</td>
<td>Tachypnea / tachycardia</td>
<td>Insufficient training</td>
</tr>
<tr>
<td>dyspnea</td>
<td>Hyperresonance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Absent breath sounds on the affected side</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Possibly diminished breath sounds on the unaffected side</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cyanosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypotension</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Distended neck veins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chest pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extreme anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Altered LOC/coma</td>
<td></td>
</tr>
</tbody>
</table>

PROCEDURE

1. Confirm presence of a tension pneumothorax or identify strong clinical evidence in a rapid deteriorating patient in the setting of major trauma. Consider in the setting of refractory PEA / traumatic arrest.
2. Locate the insertion site at the second intercostal space at the midclavicular line on the affected side of the chest.
3. Prep the insertion site. Use sterile gloves and utilize aseptic procedure to the fullest extent possible under the circumstances.
4. Remove rear cap of IV catheter.
5. Insert the 3 – 3.25 inch, 12 - 14 gauge IV catheter (1 inch, 18 gauge IV catheter in patients less than 8 years) by directing the needle just over the top of the third rib (2nd intercostal space) to avoid intercostal nerves and vessels which are located on the inferior rib borders.
6. Advance the catheter 1 - 2 inches (3/4 - 1 inch in patients less than 8 years) through the chest wall. Tension should be felt until the needle enters the pleural space. A pop or give may also be felt. Do not advance the needle any further.
7. In a tension pneumothorax, air under pressure should be released when the needle enters the pleural cavity. This will be heard as a rush of air through an open catheter-over-the-needle. If you are using a syringe attached to the catheter-over-the-needle you should be able to withdraw air by pulling out on the barrel of the syringe.
8. Withdraw the needle and advance the catheter until flush with the skin. Listen for a gush or hiss of air which confirms placement and diagnosis. This is frequently missed due to ambient noise.
9. Dispose of the needle properly and **never reinsert into the catheter**.
10. Once the presence of a tension pneumothorax has been confirmed:
    a. Remove the needle, leaving the catheter in place.
    b. Tape the catheter in place.
11. Secure the catheter and rapidly transport the patient providing appropriate airway assistance.
12. Be prepared to re-needle the chest next to original site if catheter kinks or becomes occluded.

KEY POINTS

- A tension pneumothorax can occur in any situation in which a simple pneumothorax occurs.
- Some patients who are at risk of developing a tension pneumothorax; include those receiving positive pressure ventilation, or any patient with blunt or penetrating trauma, and those with pre-existing lung diseases such as COPD.
- Cover all penetrating chest trauma with an occlusive dressing taped on three sides.
- In some cases of penetrating chest trauma, placing an occlusive dressing on the wound will convert an open pneumothorax to a closed tension pneumothorax. In these cases, treatment consists of removing the dressing and converting the wound back to an open pneumothorax. This may be the only treatment needed.
- **DO NOT** perform a chest decompression, if the patient is not in significant respiratory distress and is otherwise stable.
- **Major trauma victims should have catheter-over-the-needles placed on both sides of the chest, if all of the following are present:**
  1. Obvious chest trauma
  2. Difficulty bagging, and absent breath sounds on one / both sides
  3. Hypotensive or pulseless
- Needle decompression is a temporary lifesaving procedure only. Patients requiring decompression will require chest tube placement for long term maintenance.
- Catheters may kink or become occluded, always be prepared to re-needle the chest next to the original site. **BE ALERT FOR SIGNS OF CONTINUEING OR RECURRING TENSION PNEUMOTHORAX.**
## PULSE OXIMETRY

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>PRECAUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with suspected hypoxemia.</td>
<td>Dyspnea</td>
<td>Poor perfusion; must be applied with good perfusion</td>
</tr>
<tr>
<td>All cases of respiratory distress</td>
<td>Tachypnea</td>
<td>Patients with history of anemia</td>
</tr>
<tr>
<td>For the treatment of primary respiratory</td>
<td>Tachycardia</td>
<td>Patients with suspected high carboxyhemoglobin / methemoglobin</td>
</tr>
<tr>
<td>or cardiac disease</td>
<td>Bradycardia (late sign in adults)</td>
<td>(CO poisoning, smoke inhalation, heavy cigarette smokers)</td>
</tr>
<tr>
<td>All cases of altered or depressed level</td>
<td>Altered mental status</td>
<td></td>
</tr>
<tr>
<td>of consciousness</td>
<td>Pallor, cyanosis</td>
<td></td>
</tr>
<tr>
<td>Drug overdoses</td>
<td>Diaphoresis</td>
<td></td>
</tr>
<tr>
<td>Any patient requiring intubation or BVM</td>
<td>Prolonged capillary refill</td>
<td></td>
</tr>
<tr>
<td>support</td>
<td>Accessory muscle use</td>
<td></td>
</tr>
<tr>
<td>Major trauma</td>
<td>Abnormal breath sounds</td>
<td></td>
</tr>
<tr>
<td>Smoke Inhalation (may not be accurate due</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to CO)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any patient on home oxygen, home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ventilator, or BiPAP</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PROCEDURE

1. Turn the machine on and allow for self-tests.
2. Apply probe to patient’s finger or any other digit as recommended by the device manufacturer.
3. Allow machine to register saturation level.
4. Record time and initial saturation percent on room air if possible on the patient care report (PCR).
5. Verify pulse rate on machine with actual pulse of the patient.
6. Monitor critical patients continuously until arrival at the hospital. If recording a one-time reading, monitor patients for a few minutes as oxygen saturation can vary.
7. Document percent of oxygen saturation every time vital signs are recorded and in response to therapy to correct hypoxemia.
8. In general, normal saturation is 97 - 99%. Below 94%, suspect a respiratory compromise.
9. Use the pulse oximetry as an added tool for patient evaluation. Treat the patient, not the data provided by the device.
10. The pulse oximeter reading should never be used to withhold oxygen from a patient in respiratory distress or when it is the standard of care to apply oxygen despite good pulse oximetry readings, such as chest pain.
11. Factors which may reduce the reliability of the pulse oximetry reading include:
   - Poor peripheral circulation. (blood volume, hypotension, hypothermia)
   - Excessive pulse oximeter sensor motion.
   - Fingernail polish. (may be removed with acetone pad or sensor turned 90 degrees)
   - Carbon monoxide bound to hemoglobin.
   - Irregular heart rhythms. (atrial fibrillation, SVT, etc.)
   - Jaundice.
   - High ambient light. (washes out the sensors light)

All patients who require vital signs to be taken should have oxygen saturation measured and recorded as part of the vital signs.

Measure oxygen saturation before applying oxygen and repeat the measurement after oxygen has been applied. Do not delay oxygen administration in patients experiencing severe respiratory distress.
### TREATMENT GUIDELINES

<table>
<thead>
<tr>
<th>SPO2 READING</th>
<th>INTERPRETATION</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;94%</td>
<td>Ideal Range</td>
<td>No supplemental oxygen is needed if no distress noted</td>
</tr>
<tr>
<td>93% TO 90%</td>
<td>Mild to Moderate Hypoxemia</td>
<td>Check airway, start oxygen therapy via nasal cannula @ 2 - 6 lpm</td>
</tr>
<tr>
<td>90% TO 85%</td>
<td>Severe Hypoxemia</td>
<td>Check airway, start aggressive oxygen therapy, high flow oxygen via nonrebreather mask @ 15 lpm. Consider bag valve mask ventilation with 100% oxygen if the patient does not have adequate ventilations. Consider CPAP if indicated.</td>
</tr>
<tr>
<td>85% OR LESS</td>
<td>Respiratory Failure</td>
<td>Prepare to intubate or assist ventilations with 100% oxygen and bag valve mask</td>
</tr>
</tbody>
</table>

### KEY POINTS

- 100% oxygen should be administered to all patients despite a good SpO2 if they are hypoxic.
- Make sure that all dirt and nail polish or any obstructive covering is removed to prevent the unit from giving a false reading.
- Attempt to obtain a room air reading and a reading with supplemental oxygen.
- DO NOT read while BP being taken. May give false readings.
- Oxygen saturation measurements must routinely be recorded as part of the run report. Include those measurements taken as part of routine vital signs and those measurements taken before and after oxygen administration.
- Although the pulse oximeter displays the heart rate, the unit should not be used in place of a physical assessment of the heart rate.
- Oxygen saturation readings may be inaccurate in any situation where the flow of blood through the finger is impaired, such as:
  - Hypotension or shock with poor peripheral perfusion
  - Peripheral vascular disease
  - Extremity injury with restriction of peripheral perfusion
  - Cold extremities
- Oxygen saturation readings may be incorrectly high in situations such as carbon monoxide poisoning.
- Many patients with COPD have chronic low oxygen readings and may lose their respiratory drive if administered prolonged high oxygen therapy. Routinely assess pulse oximetry as well as respiratory drive when administering oxygen to these patients. Do not withhold oxygen from any patient that requires it.
- The room air pulse oximetry reading is NOT required if the patient has been placed on supplemental oxygen prior to EMS arrival.
- Pulse oximetry is NOT and indicator of myocardial or cerebral perfusion.
AIRWAY / BREATHING

SUCTIONING

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>PRECAUTIONS</th>
</tr>
</thead>
</table>
| • Any patient who is having trouble maintaining an airway and fluid is noted in the oropharynx, endotracheal tube, or tracheotomy.  
• Tracheal suctioning should also be performed when rhonchi is heard in the intubated patient or tracheotomy patients. | • Obstruction of the airway (secondary to secretions, blood, or any other substance) in a patient currently being assisted by an airway adjunct such as a nasotracheal tube, endotracheal tube, tracheostomy tube, or a cricothyrotomy tube. | • The patient must be well oxygenated before attempting this procedure. |

PROCEDURES

ORAL SUCTIONING

1. Body substance isolation procedures must be used.
2. Assess the need for suctioning.
3. Oxygenate the patient for 30 seconds prior to suctioning.
4. Select an appropriate size suction catheter.
   a. A soft flexible suction catheter or a “whistle tip” can be used if only fluids need to be removed.
   b. A yankauer or “tonsil tip” should be used for thick fluids, small particles, or large volumes.
5. Prepare a cup of sterile water or saline to flush the catheter after suctioning and in between attempts.
6. Quickly insert the catheter into the patient’s mouth until it is at the desired depth.
7. Apply suction and withdraw the catheter. Suction no more than 15 seconds per attempt.
8. Immediately after each suction attempt, oxygenate the patient for thirty seconds with 100% oxygen.
9. Repeat this procedure as needed until the airway is clear.

TRACHEAL SUCTIONING (Trach tube or endotracheal tube)

1. Body substance isolation procedures must be used.
2. Assess the need for suctioning.
3. Oxygenate the patient prior to suctioning.
4. Select an appropriate size suction catheter.
   a. A soft flexible suction catheter or a “whistle tip” should be used.
   b. A yankauer or “tonsil tip” should NOT be used.
5. Prepare a cup of sterile water or saline to flush the catheter after suctioning and in between attempts.
6. While maintaining aseptic technique, quickly insert the catheter into the endotracheal or tracheal tube until it is at the desired depth.
7. Apply suction and withdraw the catheter using a gentle rotating motion. Suction no more than 15 seconds per attempt.
8. Immediately after each suction attempt, oxygenate the patient for thirty seconds with 100% oxygen.
9. Repeat this procedure as needed until the airway is clear.
KEY POINTS

- **General**
  - In order to maintain aseptic technique, keep the distal end of the catheter in the wrapper when not being used.
  - If the suction catheter needs to be set down between suction attempts, place it back inside its wrapper.
  - Patients who require assisted ventilations should be hyperventilated before and after every suction attempt.
  - DO NOT suction for more than 15 seconds per attempt.
  - DO NOT insert farther than the desired depth.
  - If a backboarded patient vomits, turn the board on its side and then suction.

- **Oral Suctioning**
  - If using a soft flexible suction catheter, determine the length by holding it against the patient’s face. Measure from the edge of the patient’s mouth to the tip of the ear lobe.
  - Patients with clenched teeth may need to be suctioned via the naso-tracheal route. Use a soft suction catheter only.

- **Tracheal Suctioning**
  - Even though endotracheal tubes isolate the trachea, if there is fluid present in the lower airway, oxygenation will be reduced.
  - There are many patients at home with tracheotomy tubes. These tubes have a tendency to become obstructed because the patient cannot cough normally. EMS is often called when these tubes become obstructed.
  - This procedure should be performed with aseptic technique. Use an unopened sterile catheter for every patient.
  - Use the largest sized suction catheter that will fit down the endotracheal tube.
  - Estimate the length by looking at the distance between the end of the tube and the sternal notch. This approximates the level of the carina.
  - If tracheal secretions are extremely thick and unable to be removed, administer 2 - 3 ml of sterile saline followed by 2 BVM ventilations and then perform succioning.
TRANSPORT VENTILATION DEVICES

Inclusion: This procedure applies to CONTROL only resuscitative ventilators for use during cardiac arrest

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Transport of an intubated or tracheostomy patient</td>
<td>• Pt. currently breathing with ventilation device</td>
<td>• Insufficient training</td>
</tr>
</tbody>
</table>

PROCEDURE
1. Confirm the placement of tube as per airway protocol.
2. Ensure adequate oxygen delivery to the ventilator device.
3. Pre-oxygenate the patient as much as possible with BVM.
4. Remove BVM and attach ventilation device.
5. Per instructions of device, set initial respiration values; respiratory rate and volume.
7. If any worsening of patient condition, decrease in oxygen saturation, or any question regarding the function of the ventilator, remove and resume bag-valve ventilations.

IF THERE IS EVER ANY QUESTION ABOUT WHETHER OR NOT THE DEVICES IS VENTILATING CORRECTLY, REMOVE IT AND VENTILATE MANUALLY

USERS MUST RECEIVE TRAINING REGARDING THEIR SPECIFIC VENT DEVICE

KEY POINTS
• Transportation ventilators may be used on patients according to the manufacturer’s directions.
• It must be noted that this is a short term adjunct, which must be monitored at all times to prevent tube displacement. If the patient begins to show any signs of further deterioration, the entire airway must be re-evaluated and a bag-valve-mask should be used until the airway can be successfully stabilized.
CIRCULATION / SHOCK

Automatic CPR Device (LUCAS)

PURPOSE
This procedure describes the appropriate methods to apply, operate, and discontinue the LUCAS CPR device in patients > 12 years of age requiring mechanical chest compression related to cardiac arrest.

INDICATIONS
1. The LUCAS may be used in patients 12 years of age and older who have suffered non-traumatic cardiac arrest, where manual CPR would otherwise be used.

CONTRAINDICATIONS
1. Patients < 12 years of age.
2. Patients suffering traumatic cardiac arrest or patients with obvious signs of traumatic injury.
3. Patients who do not fit within the device.
   a. Patients who are too large and with whom you cannot press the pressure pad down 2 inches.
   b. Patients who are too small and with whom you cannot pull the pressure pad down to touch the sternum.

PLACEMENT
1. All therapies related to the management of cardiac arrest should be continued as currently defined in protocol
2. Initiate typical resuscitative measures
   a. Early defibrillation should be considered and provided as indicated based on clinical presentation.
   b. Manual chest compressions should be initiated immediately while the LUCAS device is being placed on the patient.
   c. Limit interruptions in chest compressions to 10 seconds or less.
   d. Do not delay manual CPR for the LUCAS. Continue manual CPR until the device can be placed.
3. While resuscitative measures are initiated, the LUCAS device should be removed from its carrying device and placed on the patient in the following manner;

   **Backplate Placement**
   - The backplate should be centered on the nipple line and the top of the backplate should be located just below the patient’s armpits. Placement should occur during a scheduled discontinuation of compressions [e.g., after five cycles of 30:2 or two minutes of uninterrupted compressions]].

   **Position the Compressor**
   - Turn the LUCAS Device on (the device will perform a 3 second self-test).

   **ON/OFF Switch**

   - Remove the LUCAS device from its carrying case using the handles provided on each side.
• With the index finger of each hand, pull the trigger to ensure the device is set to engage the backplate. Once this is complete, you may remove your index finger from the trigger loop.

• **Approach the patient from the side opposite the person performing manual chest compressions.**

• Attach the claw hook to the backplate on the side of the patient opposite that where compressions are being provided.

• Place the LUCAS device across the patient, between the staff member’s arms who is performing manual CPR.

• At this point the staff member performing manual CPR stops and assists attaching the claw hook to the backplate on their side.

• Pull up once to make sure that the parts are securely attached.

**Adjust the Height of the Compression Arm**

• Use two fingers (V pattern) to make sure that the lower edge of the Suction Cup is immediately above the end of the sternum. If necessary, move the device by pulling the support legs to adjust the position.

• Press the Adjust Mode Button on the control pad labeled #1 (This will allow you to easily adjust the height of the compression arm).

• To adjust the start position of the compression arm, manually push down the SUCTION CUP with two fingers onto the chest (without compressing the patient’s chest).

• Once the position of the compression arm is satisfactory, push the green PAUSE button labeled #2 (This will lock the arm in this position), then remove your fingers from the SUCTION CUP.

• If the position is incorrect, press the ADJUST MODE BUTTON and repeat the steps.

**Start Compressions**

• If the patient is not intubated and you will be providing compression to ventilation ratio of 30:2 push ACTIVE (30:2) button to start.

• If the patient is intubated and you will be providing continuous compressions push ACTIVE (continuous) button.
Patient Adjuncts

- Place the neck roll behind the patient’s head and attach the straps to the LUCAS device.
  - This will prevent the LUCAS from migrating toward the patient’s feet.
- Place the patient’s arms in the straps provided.

USING THE LUCAS DURING RESUSCITATION

Defibrillation

- Defibrillation can and should be performed with the LUCAS device in place and in operation.
- One may apply the defibrillation electrodes either before or after the LUCAS device has been put in position.
  - The defibrillation pads and wires should not be underneath the suction cup.
  - If the electrodes are already in an incorrect position when the LUCAS is placed, you must apply new electrodes.
- Defibrillation should be performed according to the joint EMS protocols and following the instructions of the defibrillator manufacturer.
- If the rhythm strip cannot be assessed during compressions, one may stop the compressions for analysis by pushing the PAUSE BUTTON (The duration of interruption of compressions should be kept as short as possible and should not be > 10 seconds. There is no need to interrupt chest compressions other than to analyze the rhythm).
- Once the rhythm is determined to require defibrillation, the appropriate ACTIVE BUTTON should be pushed to resume compressions while the defibrillator is charging and then the defibrillator should be discharged.

Pulse Checks / Return of Spontaneous Circulation (ROSC)

- Pulse checks should occur intermittently while compressions are occurring.
- If the patient moves or is obviously responsive, the LUCAS Device should be paused and the patient evaluated.
- If there is a change in rhythm, but no obvious indication of responsiveness or ROSC, a pulse check while compressions are occurring should be undertaken. If the palpated pulse is asynchronous, one may consider pausing the LUCAS Device. If the pulse remains, reassess the patient. If the pulse disappears, one should immediately restart the LUCAS Device.

Disruption or Malfunction of Lucas Device

- If disruption or malfunction of the LUCAS device occurs, immediately revert to Manual CPR.

Care of the LUCAS Device after use

- Remove the Suction cup and the Stabilization Strap (if used, remove the Patient Straps).
- Clean all surfaces and straps with a cloth and warm water with an appropriate disinfectant agent.
- Replace the used Battery with a fully-charged Battery.
- Remount (or replace) the Suction Cup and straps.
- Repack the device into the carrying bag.
- Make sure that the Charging Cord is plugged into the LUCAS Device.
## CIRCULATION / SHOCK

### PERIPHERAL INTRAVASCULAR ACCESS (IV)

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
</table>
| • Any patient where intravenous access is indicated (significant trauma or mechanism, emergent or potentially emergent medical condition) | • Dehydration  
• Hypovolemia  
• Need for drug therapy | • Hypersensitivity to IV catheter |

### PROCEDURES

2. Prepare equipment.
3. Inspect the IV solution for expiration date, cloudiness, discoloration, leaks, or the presence of particles.
4. Connect IV tubing to the solution in a sterile manner. Fill the drip chamber half full and then flush the tubing bleeding all air bubbles from the line.
5. Place a tourniquet around the patient’s extremity to restrict venous flow only.
6. Select a vein and an appropriate gauge catheter for the vein and the patient’s condition.
7. Prep the skin with an antiseptic solution.
8. Insert the needle with the bevel up into the skin in a steady, deliberate motion until the blood flashback is visualized in the catheter.
9. Advance the catheter into the vein. **Never** reinsert the needle through the catheter.
10. Dispose of the needle into the proper container without recapping.
11. Draw blood samples when appropriate.
12. Remove the tourniquet and connect the IV tubing or saline lock.
13. Open the IV to assure free flow of the fluid and then adjust the flow rate as per protocol or as clinically indicated.
14. Secure IV using appropriate measures to insure stability of the line.
15. Check for signs of infiltration.
17. Document the procedure, time and result on the patient care report (PCR).

### KEY POINTS

- IVs will be started by the Advanced EMT and / or the Paramedic as allowed by each patient care protocol.
- IV placement must not delay transport of any critical patient involved in trauma.
- Generally, no more than two (2) attempts or more than two minutes should be spent attempting an IV. If unable to initiate IV line, transport patient and notify hospital IV was not able to be started.
- IVs may be started on patients of any age providing there are adequate veins and patient’s condition warrants an IV.
- Use 1000 ml bags of normal saline for trauma patients and 500 - 1000 ml bags of normal saline for medical patients.
- Any prehospital fluids or medications approved for IV use may be given through intraosseous access.
- All IV rates should be at KVO (minimal rate to keep vein open) unless administering fluid bolus.
- Extreme care should be made to discard of all IV sharps in the appropriate sharps container immediately after cannulation. No sharps should be found on patient / sheets after transport to the hospital.
- Any venous catheter which has already been accessed prior to EMS arrival may be used.
- Upper extremity IV sites are preferable to lower extremity sites.
- Lower extremity IV sites are relatively contraindicated in patients with vascular disease or diabetes.
- In post-mastectomy patients, avoid IV, blood draw, injection, or blood pressure in arm on affected side.
- Use IV catheters appropriately sized for the patient and their condition.

Attempt to draw labwork on all patients when the IV is started, unless the draw will compromise the access site or the patient is in extremis. Label all blood draws with patient name and DOB.
PROCEDURE FOR STARTING SALINE LOCK

1. Prepare equipment: Flush saline lock with saline (approx. 1 ml) leave saline syringe attached device.
2. The initial attempt should be the dorsum of hand. Further attempts should proceed to the forearm; the antecubital fossa should not be used for saline locks.
3. Apply tourniquet.
4. Cleanse site with alcohol.
5. Use appropriately sized catheter for all saline locks. Perform venipuncture.
6. Attach IV tubing and push remaining saline through tubing and catheter. Remove syringe.
7. Secure IV using appropriate measures to insure stability of the line.
8. Check for signs of infiltration.

KEY POINTS

- Saline lock is preferred for patients who do not need immediate IV medication or fluids.
- Saline locks can be used whenever a patient requires an IV primarily for medication administration, or for any patient where the IV would be run at a TKO rate.
- A saline lock should not be used with a 14 -16 gauge IV unless attached to IV tubing and a bag or normal saline.
- Extreme care should be made to discard of all IV sharps in the appropriate sharps container immediately after cannulation. No sharps should be found on patient or in sheets after transport to the hospital.
- External jugular. (> 12 years of age).

Blood Draws

- Blood specimen drawing should be performed whenever the patient has a medical condition requiring an IV.
- Blood draws are not required if the IV site may become compromised, trauma, or the patient’s condition dictates otherwise.
- Blood tubes should be labeled with the patient’s name and initialized by the drawer of the specimen, and placed in a biohazard bag.
- If the tube does not draw a vacuum, discard tube and try another of the same color.
- Tube should be rotated upright, not shaken, when mixing additives and blood.
## EXTERNAL JUGULAR INTRAVASCULAR (IV)

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• External jugular vein cannulation is indicated in a critically ill patient &gt; 8 years of age who requires intravenous access for fluid or medication administration and in whom an extremity vein is not obtainable</td>
<td>• Dehydration</td>
<td>• Only (1) attempt per pt.</td>
</tr>
<tr>
<td>• External jugular cannulation can be attempted initially in life threatening events where no obvious other peripheral site is noted</td>
<td>• Hypovolemia</td>
<td>• Start IV Away from head, towards feet</td>
</tr>
<tr>
<td></td>
<td>• Need for drug therapy</td>
<td></td>
</tr>
</tbody>
</table>

### PROCEDURE
1. Place the patient in a supine head down position. This helps distend the vein and prevents air embolism.
2. Turn the patient’s head toward the opposite side if no risk of cervical injury exists.
3. Position yourself at patient’s head.
4. Locate external jugular vein.
5. Select IV catheter.
6. Prep the site as per peripheral IV site.
7. Align the catheter with the vein and aim toward the same side shoulder.
8. “Tourniqueting” the vein lightly with one finger above the clavicle, puncture the vein midway between the angle of the jaw and the clavicle and cannulate the vein in the usual method.
9. Attach the IV and secure the catheter avoiding circumferential dressing or taping.
10. Secure IV using appropriate measures to insure stability of the line.
11. Check for signs of infiltration.
12. Adjust flow rate.

### KEY POINTS
• Hypotensive patients may not produce a good “flash” from their EJ vein.
• May use a syringe to aspirate blood on the back of the IV catheter to help establish patency.
• Flow a bolus of saline through EJ IV catheter to assure solid patency prior to administering medications through the line, especially dextrose or vasopressors.
ADULT INTRAOSSEOUS INFUSION:

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Unable to access peripheral IV</td>
<td>• Altered level of consciousness</td>
<td>• Fracture of the tibia or humerus</td>
</tr>
<tr>
<td></td>
<td>• Arrhythmias</td>
<td>• Previous orthopedic procedures</td>
</tr>
<tr>
<td></td>
<td>• Burns</td>
<td>• Pre-existing medical condition</td>
</tr>
<tr>
<td></td>
<td>• Cardiac / respiratory arrest</td>
<td>• Infection at the insertion</td>
</tr>
<tr>
<td></td>
<td>• Dehydration</td>
<td>• Inability to locate landmarks</td>
</tr>
<tr>
<td></td>
<td>• Head Injury</td>
<td>• Excessive tissue over the insertion site</td>
</tr>
<tr>
<td></td>
<td>• Hypotension</td>
<td>• Seizures</td>
</tr>
<tr>
<td></td>
<td>• Seizures</td>
<td>• Traumatic Injuries / shock</td>
</tr>
<tr>
<td></td>
<td>• Traumatic Injuries / shock</td>
<td>• Other medical conditions when immediate vascular access is required</td>
</tr>
</tbody>
</table>

PROCEDURE: EZ IO Adult Device: (For providers trained in technique)
1. Select site:
2. Humoral head, outer aspect (use the 45 mm yellow needle) OR Tibia medial to the tibial tuberosity on flat plane of tibia (use 25mm blue or 45 mm yellow).
3. Locate the anatomical site and prep with betadine and / or alcohol.
4. Load the needle onto the driver.
5. Firmly stabilize the leg near (not under) the insertion site.
6. Firmly press the needle against the site at a 90°angle and operate the driver. Use firm, gentle pressure.
7. As the needle reaches the bone, stop and be sure that the 5 mm marking on the needle is visible; if it is, continue to operate the driver.
8. When a sudden decrease in resistance is felt and the flange of the needle rests against the skin, remove the driver and remove the stylet from the catheter.
9. Do not attempt to aspirate bone marrow. (may clog needle and tubing)
10. Use a syringe to infuse 0.9% normal saline.
11. If no S/S of infiltration are found, attach the IV line and infuse fluids and medications as normal. (IV bag will need to be under pressure)
12. Secure the needle and dress the site.
13. Manage IO pain with LIDOCAINE (XYLOCAINE) through the IO 20 – 40 mg. Allow to dwell in IO space. Approved for AEMT

Consider use of 45 mm length IO needle for patients with excessive tissue over the insertion site. Use the 45 mm needle for all humeral head insertions.

PROCEDURE: Adult IO Manual Placement:
1. Expose the lower leg.
2. Identify the tibial tubercle (bony prominence below the knee cap) on the proximal tibia.
3. The insertion location will be 1 - 2 cm (2 finger widths) below this and medially.
4. Prep the site as per peripheral IV site.
5. Insert needle at 90 degree angle to the skin surface, approximately one to two finger breadths distal to the tibial tuberosity. With a straight steady push and / or rotary motion, push needle through subcutaneous tissue and bone until a drop or pop is felt.
6. Remove the trocar and attach the IV.
7. Once the needle has reached the bone marrow, saline should be injected via syringe to clear needle.
8. Observe for signs of subcutaneous infiltration.
9. The needle should feel firm in position and stand upright without support.
10. Stabilize and secure the needle.
11. Infusion via this route is the same as venous access without limit to rate of administration, drugs pushed or fluid type infused, pressure infuser may be necessary to facilitate flow.
13. Manage IO pain with LIDOCAINE (XYLOCAINE) through the IO 20 – 40 mg. Allow to dwell in IO space. Approved for AEMT
PEDIATRIC INTRAOSSEOUS INFUSION:

**PROCEDURE: May use manual IO Device or EZ IO Pediatric Device**

1. Select site.
2. Identify the tibial tubercle (bony prominence below the knee cap) on the proximal tibia or the humeral head. The insertion location will be 1-2 cm (2 finger widths) below this and medially.
3. Prep the site as per peripheral IV site.
4. Stabilize leg / shoulder as needed.
5. Needle insertion varies between 70 and 90 degree angle to the skin surface, approximately one to two finger breadths distal to the tibial tuberosity. With a straight steady push and/or rotary motion, push needle through subcutaneous tissue and bone until a drop or pop is felt.
6. Remove the trocar and attach the IV.
7. Once the needle has reached the bone marrow, saline should be injected via syringe to clear needle.
8. Observe for signs of subcutaneous infiltration.
9. The needle should feel firm in position and stand upright without support.
10. Stabilize and secure the needle.
11. Infusion via this route is the same as venous access without limit to rate of administration, drugs pushed or fluid type infused, pressure infuser may be necessary to facilitate flow.
12. Document the procedure, time, and result on the patient care report (PCR).
13. Manage IO pain with LIDOCAINE (XYLOCAINE) through the IO 0.5 mg / kg, not to exceed 40 mg. Allow to dwell in IO space. Approved for AEMT

**KEY POINTS**

- An IO can administer any medication or fluid that can be administered by an IV.
- Consider using a three-way stopcock, and a syringe with the IV tubing. Use the “pull-push” method to infuse fluid for small bolus in infants / children.
- A blood pressure cuff or pressure infuser may have to be used to apply pressure to the IV bag to maintain an adequate flow rate.
- An IO may be attempted prior to attempting an IV if the patient is in cardiac arrest or is in decompensated shock and requires immediate access.
- If attempt unsuccessful remove needle and apply pressure to site for 5 minutes.
- Intravenous infusions of fluids may cause subcutaneous infiltration, osteomyelitis, or subcutaneous infections if not placed properly.
**INTRAOSSEOUS INFUSION – Humeral Head**

<table>
<thead>
<tr>
<th>Adult or Pediatric</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Place the patient’s hand over the abdomen (elbow adducted and humerus internally rotated)</td>
<td></td>
</tr>
</tbody>
</table>
| Place your palm on the patient’s shoulder anteriorly  
  - The area that feels like a “ball” under your palm is the general target area  
  - You should be able to feel this ball, even on obese patients, by pushing deeply |  |
| Place the ulnar aspect of one hand vertically over the axilla  
Place the ulnar aspect of the opposite hand along the midline of the upper arm laterally. |  |
| Place your thumbs together over the arm.  
  - This identifies the vertical line of insertion on the proximal humerus |  |
| Palpate deeply as you climb up the humerus to the surgical neck.  
  - It will feel like a golf ball on a tee – the spot where the “ball” meets the “tee” is the surgical neck  
  - The insertion site is on the most prominent aspect of the greater tubercle, 1 to 2 cm above the surgical neck |  |
| **Insertion:** |  |
| - Prepare the site by using antiseptic solution of your choice  
- Use a clean, “no touch” technique  
- Remove the needle cap  
- Point the needle set tip at a 45-degree angle to the anterior plane and posteromedial  
- Push the needle tip through the skin until the tip rests against the bone  
- The 5mm mark must be visible above the skin for confirmation of adequate needle length  
- Gently drill into the humerus 2cm or until the hub reaches the skin in an adult.  
  - The hub of the needle set should be perpendicular to the skin  
- Hold the hub in place and pull the driver straight off  
- Continue to hold the hub while twisting the stylet off the hub with counter clockwise rotations  
  - The needle should feel firmly seated in the bone (1st confirmation of placement)  
- Place the stylet in a sharps container  
- Place the EZ-Stabilizer™ dressing over the hub  
- Attach a primed EZ-Connect® extension set to the hub, firmly secure by twisting clockwise  
- Pull the tabs off the EZ-Stabilizer dressing to expose the adhesive, apply to the skin  
- Aspirate for blood/bone marrow (2nd confirmation of placement)  
- Secure the arm in place across the abdomen |  |
ResQPOD Impedance Threshold Device

ResQPOD Circulatory Enhancer:
Conventional CPR provides 15% of normal blood flow to the heart and blood flow to the brain is 25% of normal.
The ResQPOD is an impedance threshold device that prevents unnecessary air from entering the chest during the decompression phase of CPR. When air is prevented from rushing into the lungs as the chest wall recoils, the vacuum (negative pressure) in the thorax pulls more blood back to the heart, resulting in:
1. Doubling of blood flow to the heart.
2. 50% increase in blood flow to the brain.
3. Doubling of systolic blood pressure.

Indications:
Cardiopulmonary arrest 12 years and older (medical etiology)

Contraindications:
Patients under 12 years of age
Cardiopulmonary arrest related to trauma

Procedure:
Confirm absence of pulse and begin CPR immediately. Assure that chest wall recoils completely after each compression.

Using the ResQPOD on a facemask:
Connect ResQPOD to the facemask.
Connect ventilation source (BVM) to top of ResQPOD. If utilizing a mask without a bag, connect a mouthpiece.
Establish and maintain a tight face seal with mask throughout chest compressions. Use a two-handed technique or head strap.
Do not use the ResQPODs timing lights during CPR utilizing a facemask for ventilation.
Perform ACLS interventions as appropriate.
Prepare for endotracheal intubation.

Using the ResQPOD on an endotracheal tube, LMA or King Airway:
1. Place airway and confirm placement.
2. Move the ResQPOD from the facemask to the advanced airway and turn on timing assist lights (remove clear tab).
3. Continue CPR with minimal interruptions:
   a. Provide continuous (no pauses) chest compressions (approximately 10 per light flash) and ventilate asynchronously over 1 second when light flashes (10 / min).
4. Perform ACLS interventions as appropriate.
5. If a pulse is obtained, remove the ResQPOD and assist ventilations as needed.

Special Notes:
A. Always place EtCo2 device between the ResQPOD and ventilation source.
B. Do not interrupt CPR unless absolutely necessary.
C. If a pulse returns, discontinue CPR and the ResQPOD. If the patient re-arrests, resume CPR with the ResQPOD.
D. Do not delay compressions if the ResQPOD is not readily available.
**ResQPump / ACD-CPR**

For Trained and Supplied Departments

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**ResQPump® ACD-CPR Device**

The ResQPump® further enhances the effect of the ResQPOD by allowing the user to actively re-expand the chest, rather than relying on it to passively recoil. It also promotes proper compression rates (80/min), and helps guide compression and lifting forces.

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**Rescuer and ResQPump Positioning**

Kneel close to the patient’s side with shoulders directly over the patient’s chest. Place the ResQPump® in the middle of the chest (between the nipples) and above the xiphoid process. Shaving is rarely needed to achieve good suction.

**Compress**

Compress to recommended depth (e.g., 2” or 5 cm). Observe the force required to achieve that depth, as it will vary according to how compliant the chest is. The tip of the red arrow indicates the force being applied. The approximate amount of force required to compress the chest 2 inches is as follows:
- 30 kg: soft/supple chest
- 40 kg: chest of average compliance
- 50 kg: stiff/rigid chest

Once the amount of force required is known, use that target as a guide for continued compressions.

Arms should be straight with shoulders directly over the sternum. Bend at the waist and compress, using the entire upper body and large thigh muscles. Compress at a rate of 80/min using the metronome (push button) as a guide. This slightly slower rate allows for more filling time. Compress on one tone, lift on the other tone.

**Lift**

To fully achieve the benefits of ACD-CPR, actively pull up until the tip of the red arrow on the force gauge registers ~10 kg. Lift using the upper body and large thigh muscles, and bending at the waist. If the suction cup dislodges, then pull up slightly less. It is not necessary to lift with more than 10 kg of force. The ResQPump® is the only device that allows rescuers to deliver true ACD-CPR.

---

**Performing High Quality ResQCPR**

1. Confirm absence of pulse and send for AED.
3. Attach the ResQPOD to a facemask, using a 2-handed technique to maintain a tight facemask seal and airway position. Move it to the advanced airway once intubated, and turn on lights to guide ventilations.
4. Begin using both devices as soon as possible so that the patient receives the benefit of ResQCP at the earliest opportunity.
5. Perform chest compressions at the recommended compression-to-ventilation ratio. Use a 50% duty cycle, spending equal time compressing and lifting. Avoid interruptions.
6. Use the force gauge to monitor forces and rescuer fatigue. Rotate ACD-CPR duties every two minutes (or more often) to avoid fatigue.
7. If the patient has a return of spontaneous circulation (ROSC) use of both devices should be discontinued. If the patient re-arrests, resume ResQCP immediately.
8. NOTE: Signs and symptoms of improved cerebral blood flow (e.g., eye opening, gagging, spontaneous breathing, limb or body movement) have been reported in patients without a pulse who are undergoing ResQCP. If these occur, check quickly to see if a pulse has returned. If the patient remains in cardiac arrest, continue ResQCP and contact your medical control authority for guidance on managing these signs and symptoms in an arrested patient. If ROSC occurs, discontinue ResQCP and support ventilations as indicated.
The ResQGARD is an impedance threshold device (ITD) that provides therapeutic resistance to inspiration in spontaneously breathing patients. During inspiration, a negative pressure (created from expansion of the thorax) draws air into the lungs. When inspiratory impedance is added to the ventilation circuit, it enhances the negative pressure (vacuum) in the chest, which pulls more blood back to the heart, resulting in increased preload and thus, enhanced cardiac output on the subsequent cardiac contraction.

**Indications for Use:**
Spontaneously breathing patients who are experiencing symptoms of low blood circulation (e.g. diaphoresis, tachycardia, weak radial pulses, cold, clammy skin, tachypnea) or hypotension (e.g. < 90 mm Hg [adults]; per age & weight and as directed by a physician [children]), which can be secondary to a variety of causes such as; Anaphylaxis, Blood loss (traumatic or medical etiology) or blood donation, Burns, Dehydration, Dialysis, Drug overdose, Heat shock, Orthostatic intolerance, Pregnancy, Sepsis / toxins, and Spinal shock.

2. Permissive Hypotension: in cases (e.g. hemorrhage due to a trauma-related injury) in which a lower than normal blood pressure (BP) is desired to assist in the blood-clotting process, the ResQGARD may still be a reasonable therapy to help maintain “permissive hypotension.”

**Contraindications:**
1. Flail chest
2. Shortness of breath or respiratory insufficiency
3. Chest pain
4. Dilated cardiomyopathy
5. Congestive heart failure (Cardiogenic Shock)
6. Pulmonary hypertension
7. Aortic stenosis
8. Penetrating chest trauma

**Precautions:**
1. Children under 25 lbs may not be cooperative enough to tolerate use of the ResQGARD.
2. The safety and effectiveness in persons suffering from arterial stenosis or asthma has not been established.
3. If respiratory distress develops during use of the ResQGARD, immediately discontinue use.
4. Do not leave the ResQGARD in the hands of untrained healthcare providers.
5. Nausea / Vomiting

**Procedure for Use:**
1. Identify the need for ResQGARD application (assess indication for use).
2. Reassure patient and position as appropriate.
3. Obtain baseline vital signs (pulse, respirations, blood pressure and oxygen saturation) and monitor cardiac rhythm.
4. Explain to the patient that the device will make it slightly more difficult to breathe, but that the resistance is what may make them feel better.
   i. Gently (but firmly) hold the ResQGARD over the nose and mouth (or have the patient hold), establishing and maintaining a tight face seal with facemask. The head strap (e.g. ResQStrap) may be used if the patient does not want to hold the ResQGARD in place.
6. Have patient breathe in slowly (over 2 - 3 seconds) and deeply; exhale normally. Breathe at a rate of 10 – 16/minute.
7. If supplemental oxygen is used, attach the tubing to the oxygen port on the ResQGARD and deliver up to 15 lpm, but do not exceed 15 lpm.
8. If end tidal carbon dioxide (ETCO2) monitoring is desired, attach the sensor to the exhalation port of the ResQGARD.
9. Reassess vital signs often (every 3 - 5 minutes).
10. Once the patient’s blood pressure has stabilized and risen to an acceptable level it is recommended that you continue ResQGARD treatment for approximately 5 minutes before discontinuing its use. Reapply if necessary if the blood pressure drops again.
11. Document ResQGARD therapy on patient care report (e.g. time initiated and discontinued, vital sign response).

**Special Patient Considerations:**
1. In a patient without intravenous (IV) access, applying the ResQGARD may make it easier to establish an IV because of the improvement in blood pressure.
2. The ResQGARD may be used in conjunction with other indicated treatments for hypotension (e.g. fluids, vasopressors, patient positioning).
3. In cases where the rate of blood loss is unclear, the recommendation is to use the ResQGARD as you would a fluid challenge in the field (i.e. if a fluid challenge is indicated, then the ResQGARD may be too).
Ventricular assist device patients (VAD) are special care situations. Unless these patients are in cardiac arrest they need to be transported to their VAD implantation center. Local or regional hospitals are not equipped to handle these patients.

**UNIVERSAL PATIENT CARE PROTOCOL**

**Determine if VAD is functioning**
Auscultate chest and upper abdominal quadrants – Continuous Humming sound = pump is working

⚠️ Many pumps are non-pulsatile; patient may not have palpable pulses, measurable BP, or Pulse Oximetry.

⚠️ Use other indicators of perfusion such as skin signs, mental status, and Capnography.

**Functioning**
Do not ever shut off

**Not Functioning / Alarming**

**Find Accompanying Instructions for Device**
1. Page / call VAD team
2. Check that all Wires / Leads Connected to Controller / Power
3. Check Power Sources
4. Change Power Sources (Only change 1 battery at a time)
5. Attempt Re-start or Start in Backup Mode

**IF unable to Maintain Pump Operation**
Follow VAD team instructions
Treat for Cardiogenic Shock

**Contact Appropriate VAD Team**
University Hospital
216-207-7244 Pager 32343

Cleveland Clinic
216-444-2200 Pager 23400

The Patient should have a companion (Family member, friend, caretaker, etc) who is knowledgeable in the function of the VAD. Utilize this resource regarding specifics of each type of VAD system. Keep the companion with the patient Keep all equipment with the patient

**Patient Unstable**
Treat Per Standard ACLS Protocols
Pacing OK
Defibrillation OK
ACLS drugs OK
Chest Compressions only as ABSOLUTE last resort
Manual chest compressions only, do not use automated chest compression devices

**Patient Stable**
Treat Per Standard Medical Protocols

**TRANSPORT** to appropriate facility (Air Transport OK for VAD Patients)

**CONTACT** receiving facility

**CONSULT** Medical Direction where indicated
CARDIAC / ACLS

AUTOMATED EXTERNAL DEFIBRILATOR (AED)

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Non-traumatic cardiac arrest in patients &gt; 8 years of age</td>
<td>The patient must meet ALL of the following criteria:</td>
<td>• If patient is found in water, remove from water and dry patient thoroughly. Do not use an AED in an explosive atmosphere, extremely wet atmosphere, or on a metal surface</td>
</tr>
<tr>
<td></td>
<td>• Unresponsive</td>
<td>• If a medication patch is found, remove patch and wipe clean before applying defibrillation pads</td>
</tr>
<tr>
<td></td>
<td>• Apneic</td>
<td>• Do not place defibrillation pads directly over patient’s implanted defibrillator</td>
</tr>
<tr>
<td></td>
<td>• Pulseless</td>
<td>• Patients &lt; 8 years of age require specific pediatric defibrillation equipment</td>
</tr>
<tr>
<td></td>
<td>• Weighs greater than 55 lbs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pediatric patients &gt; 8 years</td>
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</tbody>
</table>

PROCEDURE

Establish that the patient is pulseless and apneic.
1. Perform CPR for (2) minutes.
2. Attach the defibrillation pads to the patient’s chest and connect the cables to the AED.
3. The sternum pad is to be attached to the patient’s upper right chest, to the right of the sternum on the mid-clavicular line.
4. The apex pad is to be attached to the patient’s lower left rib cage, laterally and beneath the left nipple.
5. Turn the unit ON and follow the voice prompts.
6. Rhythm analysis:
   - Do not have any patient contact while the AED analyzes.
   - Rhythm analysis should take approximately 9 - 13 seconds.
7. If the AED unit’s voice prompts advise that “no shock advised”:
   - Check for a pulse, if no pulse, continue CPR.
8. Visually check that no one is in contact with the patient and announce CLEAR.
9. Press the SHOCK button when advised to by the unit’s voice prompts:
10. Continue CPR for 2 minutes.
11. If the patient’s pulse has returned:
    - Insure that the patient has a patent airway and treat accordingly.
12. If the patient remains pulseless, continue use of CPR and AED.

KEY POINTS

• Do not use the AED in cases of traumatic or hypovolemic cardiac arrest (unless driver involved in MVA is in cardiac arrest and is suspected of having an acute MI while driving).
• Resuscitation should be withheld in all cases where such efforts would be futile. Patients should be considered DOA and resuscitation should not be attempted in the following situations:
  - Refer to the Dead on Arrival (DOA) Policy.
  - A valid (within the last 2 years) Do Not Resuscitate (DNR). Refer to the Advanced Directives – Do Not Resuscitate (DNR) Policy.
• Defibrillation cables should be inspected for damage and / or wear.
• Defibrillation pads should be routinely inspected to assure that they are within their expiration and are not opened.
• Assure that batteries are charged and spares are available.
CARDIAC / ACLS

CARDIAC DEFIBRILLATION (MANUAL)

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
</table>
| • Cardiac arrest with ventricular fibrillation or pulseless ventricular tachycardia | The patient must meet ALL of the following criteria
  • Unresponsive
  • Apneic
  • Pulseless | • If patient is found in water, remove from water and dry patient thoroughly. Do not use an AED in an explosive atmosphere, extremely wet atmosphere, or on a metal surface
  • If medication patch found, remove patch and wipe clean before applying defibrillation pads
  • Do not place defibrillation pads directly over patient’s implanted defibrillator
  • Pediatric patients < 8 years of age require specific pediatric monitoring equipment |

PROCEDURES
1. Establish that the patient is pulseless and apneic.
2. Provide (2) minutes of CPR.
3. Attach defibrillation pads and cables. Plug cable into EKG monitor.
4. Recognize EKG findings as ventricular fibrillation or pulseless ventricular tachycardia.
5. Charge the device to 360 J or recommended biphasic charge.
6. Visually check that no one is in contact with the patient and announce CLEAR.
7. Press the SHOCK button and deliver the shock.
8. Resume CPR for (2) minutes.
9. Check monitor for changes in rhythm. Check pulse.
10. If no change in rhythm repeat steps 5 - 8.
11. If EKG reveals change in findings, treat with the appropriate ACLS Protocol.

Double Sequential Defibrillation
1. Apply 2 defibrillators per typical measures.
2. One set of pads standard apex / sternum placement
3. One set of pads anterior / posterior placement
4. Charge BOTH defibrillators to 360 joules
5. ONE PERSON clears patient and SIMULTANEOUSLY presses shock buttons on BOTH defibrillators
# CARDIAC / ACLS

## 12 - LEAD CARDIAC MONITORING

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Suspected cardiac patient</td>
<td>• Any complaint of pain or discomfort between the nose and the navel</td>
<td>• Insufficient training</td>
</tr>
<tr>
<td>• Suspected tricyclic overdose</td>
<td>• Chest pain / tightness</td>
<td></td>
</tr>
<tr>
<td>• Electrical injuries</td>
<td>• Chest discomfort</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Chest discomfort relieved prior to arrival</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pulmonary edema</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Palpitations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Irregular heartbeat</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Syncope</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dizziness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unexplained diaphoresis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Dyspnea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Weakness / numbness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HR&lt; 50 or &gt; 120</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hypotension / hypertension</td>
<td></td>
</tr>
</tbody>
</table>

## Placement of the “V” Leads

### LEFT SIDE EKG
- **V1**: 4th ICS – right of the sternum
- **V2**: 4th ICS – left of the sternum
- **V3**: Between V2 and V4
- **V4**: 5th ICS midclavicular LEFT
- **V5**: Between V4 and V6
- **V6**: Even with V4 midaxillary

### RIGHT SIDE EKG
- **V1**: 4th ICS – right of the sternum
- **V2**: 4th ICS – left of the sternum
- **V3**: Between V2 and V4
- **RV4**: 5th ICS midclavicular RIGHT
- **V5**: Between V4 and V6
- **V6**: Even with V4 midaxillary

## KEY POINTS
- A 12-Lead EKG should be performed on any patient with a complaint that may be cardiac in origin.
- Protect the patient’s modesty.
- The 12-Lead ECG should be acquired prior to medication administration (except oxygen) and extrication of the patient.
- If the patient is having an acute MI, contact the receiving hospital as soon as possible.
- The paramedic should give one copy of the 12-Lead EKG to the ED physician / nurse immediately upon your arrival, and attach a second copy to the run report.
- EKG adhesive patches should remain on the patient for consistent lead placement with follow up EKGs, but should be removed before defibrillation patches are applied if necessary.
- The monitor should remain on the patient for continuous cardiac monitoring enroute.

## TREATMENT DECISIONS ARE NOT TO BE BASED ON COMPUTERIZED EKG INTERPRETATIONS

Any adult medical patient or patients of any age with a cardiac history, irregular pulse, unstable blood pressure, dyspnea, chest pain, medication administration, or venous access must be placed on a cardiac monitor, a 12 lead obtained, and transmitted to the emergency department. The transmission must include the patient’s last name.

**EMTS AND AEMTS ARE EXPECTED TO PLACE LEADS ON THE PATIENT TO OBTAIN AND TRANSMIT A 12-LEAD EKG TO THE HOSPITAL IN THE ABSENCE OF A PARAMEDIC.**

**EMT AND AEMTS ARE NOT PERMITTED TO INTERPRET THE EKG.**
### INDUCED HYPOTHERMIA (IH)

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
</table>
| • Patents who have experienced ROSC after Vfib, Vtach, or witnessed asystole | • Post cardiac arrest | • Pregnancy  
• Traumatic Arrest  
• Preexisting Hypothermia  
• Known Hypovolemia |

**Patient is to be cooled by direct application of cooling devices to the patient.**  
**Active cooling with cold saline is not permitted.**

**CHEMICAL COLD PACKS OR ICE PACKS**  
Place cold packs on the groin are on top of bilateral femoral circulation  
Place cold packs in the axilla bilaterally  
Place cold packs on neck bilaterally or cooling collar

**CRYOCOLLAR**  
The Cryo Cooling System is a single use device to induce mild cerebral therapeutic hypothermia. This system is composed of a unique collar with a specialized door that works in conjunction with the Excel Cryo Cooling Elements, properly aligning the Excel Cryo Cooling Element with the patient's carotid triangle. Heat is extracted from the blood as it passes through the arteries inducing mild hypothermia.

**PROCEDURE**  
1. Place the collar on the person neck as you would any other C-Collar  
2. Once the collar is properly placed on the patient, the Excel Cryo Cooling Element must be activated. (Manufacture supplied cold pack)  
3. Once activated, open the collar door and insert the Excel Cryo Cooling Element  
4. The Excel Cryo Cooling Element should be replaced every 20 minutes.  
5. Cooling should be maintained throughout transport of the ROSC patient

Apply  
Activate  
Insert
SYNCHRONIZED CARDIOVERSION (MANUAL)

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
</table>
| • Unstable patient with a tachydysrhythmia  
• Patient is not pulseless | • Symptomatic narrow complex tachycardia  
• Symptomatic wide complex tachycardia  
• Grossly symptomatic atrial fibrillation  
• Grossly symptomatic atrial flutter | • A pulseless patient |

PROCEDURE

1. Apply limb leads  
2. Consider sedation with versed or valium prior to administering synchronized cardioversion.  
3. Attach defibrillation pads to the patient and monitor.  
4. Push the SYNC button.  
5. Observe the EKG rhythm. Confirm that the triangle sense marker appears near the middle of each QRS complex.  
6. If the sense markers do not appear or they are displayed in the wrong location adjust the EKG size or select another lead.  
7. The location of the sense marker may vary slightly with each QRS complex.  
8. Rotate the ENERGY SELECT dial and select the proper setting as required by protocol.  
9. Push the CHARGE button.  
10. Make sure that everyone is clear of the patient.  
11. After confirming that the monitor is still in SYNC mode, push and hold the SHOCK button until it discharges.  
12. Reassess the patient and the cardiac rhythm. Repeat steps 4 - 9 as indicated by the protocol.

KEY POINTS

• When attempting to cardiovert, double check to make sure that the SYNC button is ON.  
• Monitor the patient for ventricular fibrillation.  
• If the patient converts into ventricular fibrillation or pulseless ventricular tachycardia, reassess the patient. Immediately defibrillate the patient at and refer to the Ventricular Fibrillation / Pulseless Ventricular Tachycardia Protocol and treat accordingly.  
• If the SHOCK button is not pushed, the energy will be internally removed. It will be necessary to recharge to the indicated energy setting.  
• When synchronized cardioverting a patient, there may be a delay from when the button is depressed to when the shock is delivered.  
• Use EXTREME caution in patients with rapid atrial fibrillation or atrial flutter. Cardioversion of these patients is associated with high risk of embolus. Prehospital cardioversion of these patients is reserved for life-threatening situations only.
INDICATIONS | SIGNS AND SYMPTOMS | CONTRAINDICATIONS
---|---|---
- Patients with symptomatic bradycardia after no response to atropine or primary treatment if unable to start an IV  
- Pediatric patients requiring external transcutaneous pacing require the use of pads appropriate for pediatric patients per the manufacturer’s guidelines | - Adult bradycardia with severe hemodynamic compromise.  
- Symptomatic bradycardia that is refractory to pharmacological intervention.  
- Symptomatic 2nd or 3rd degree heart block | - Hypothermia  
- Pediatric bradycardia

PROCEDURE
1. Apply limb leads
2. Consider sedation with Midazolam (Versed) or Lorazepam (Ativan) prior to administering transcutaneous pacing.
3. Attach defibrillation / pacing pads to the patient and monitor.
4. Place the defibrillation / pacing pads anterior-posterior or anterior-lateral.
5. Do not place the pacing patches over the sternum, spine or nipple.
6. Push the PACER button.
7. Push the RATE button.
8. Push the CURRENT button and increase the milliamps until you reach electrical and mechanical capture (assess the carotid or femoral pulses to confirm mechanical capture).
9. Hold the PAUSE button to stop the pacing so you can assess the patient’s underlying rhythm.
10. Push the EVENT button to quick log CPR, medication administration, ETT placement etc.

Start at pacing rate of 60 beats per min (PPM on device).
Increase milliamps until electrical capture, verify mechanical capture with femoral or radial pulses, blood pressure, and capnography.
Increase milliamps a minimum of 10 to maintain capture during transport.

KEY POINTS
- The pacing will begin immediately once the pacer is turned on.
- Monitor the patient for ventricular fibrillation.
**BLOOD GLUCOSE ANALYSIS**

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patients with suspected hypoglycemia</td>
<td>• Decreased mental status</td>
<td>• Insufficient training</td>
</tr>
<tr>
<td>(diabetic emergencies, change in mental</td>
<td>• Change in baseline mental status</td>
<td></td>
</tr>
<tr>
<td>status, bizarre behavior, etc.)</td>
<td>• Bizarre behavior</td>
<td></td>
</tr>
<tr>
<td>• Medical alert tags</td>
<td>• Hypoglycemia (cool, diaphoretic skin)</td>
<td></td>
</tr>
<tr>
<td>• Drug / toxic ingestion</td>
<td>• Hyperglycemia (warm, dry skin; fruity breath;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kussmal breathing; signs of dehydration)</td>
<td></td>
</tr>
</tbody>
</table>

**PROCEDURE**

1. Gather and prepare equipment.
2. Blood samples for performing glucose analysis shall be obtained from finger stick.
3. Place correct volume of blood in / on the glucometer per the manufacturer's instructions.
4. Time the analysis as instructed by the manufacturer.
5. Document the glucometer reading and treat the patient as indicated by the analysis and protocol.
6. Repeat glucose analysis as indicated for reassessment after treatment and as per protocol.

**KEY POINTS**

- Exam: Mental Status, HEENT, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro
- Be aware of AMS as presenting sign of an environmental toxin or Haz-Mat exposure and protect personal safety.
- It is safer to assume hypoglycemia than hyperglycemia if doubt exists.
- Do not let alcohol confuse the clinical picture. Alcoholics frequently develop hypoglycemia.
- Low glucose (< 70), normal glucose (70 - 120), high glucose (> 250)
- Consider restraints if necessary for patient's and / or personnel's protection per the restraint procedure.
- Glucometers must be calibrated and coded for the appropriate glucose strips following manufacturer and department recommendations or policies.
- Know the read range of the device you are using. “LO” and “HI” values vary between manufactures.
**MEDICAL**

**MEDICATION INJECTIONS**

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• When medication administration is necessary and the medication must be given via the SQ or IM route or as an alternative route in selected medications</td>
<td>• Determined per protocol</td>
<td>• Allergy to medication per protocol • Aspiration of blood</td>
</tr>
</tbody>
</table>

**INTRAMUSCULAR – EMT MAY PROVIDE IM INJECTION BY APPROVED AUTOINJECTOR ONLY**

**PROCEDURE**

1. Receive and confirm medication order or perform according to standing orders.
2. Prepare equipment and medication expelling air from the syringe.
3. Explain the procedure to the patient and reconfirm patient allergies.
4. The possible injection sites for intramuscular injection include the arm, buttock and thigh. Injection volume should not exceed 1 ml for the arm and not more than 2 ml in the thigh or buttock.
5. The thigh should be used for injections in pediatric patients and injection volume should not exceed 1 ml.
6. Expose the selected area and cleanse the injection site with alcohol.
7. Hold intramuscular syringe at 90 degree angle, with skin pinched and flattened.
8. Insert the needle into the skin with a smooth, steady motion.
10. Inject the medication.
11. Withdraw the needle quickly and dispose of properly without recapping.
12. Apply pressure to the site.
13. Monitor the patient for the desired therapeutic effects as well as any possible side effects.

**SUBCUTANEOUS**

**PROCEDURE**

1. Receive and confirm medication order or perform according to standing orders.
2. Prepare equipment and medication expelling air from the syringe.
3. Explain the procedure to the patient and reconfirm patient allergies.
4. The most common site for subcutaneous injection is the arm. Injection volume should not exceed 1 ml.
5. The thigh should be used for injections in pediatric patients and injection volume should not exceed 1 ml.
6. Expose the selected area and cleanse the injection site with alcohol.
7. Hold subcutaneous syringe at 45 degree angle.
8. Insert the needle into the skin with a smooth, steady motion.
10. Inject the medication.
11. Withdraw the needle quickly and dispose of properly without recapping.
12. Apply pressure to the site.
13. Monitor the patient for the desired therapeutic effects as well as any possible side effects.
MUCOSAL ATOMIZATION DEVICE (MAD)

INDICATIONS

- Used for atomizing topical solutions across the nasopharyngeal and oropharyngeal mucous membranes.
- For use when administering the following medications:
  - Lorazepam (Ativan) for seizures / sedation – AEMT / PARAMEDIC USE ONLY
  - Midazolam (Versed) for seizures / sedation - AEMT / PARAMEDIC USE ONLY
  - Naloxone (Narcan) for opiate overdoses – APPROVED FOR EMT USE
  - Glucagon (Glucagen) for hypoglycemia - AEMT / PARAMEDIC USE ONLY
  - Fentanyl (Sublimaze) for analgesia - AEMT / PARAMEDIC USE ONLY

PROCEDURE

1. Disconnect MAD from the included syringe and/or retrieve a needless syringe.
2. Attach needle to syringe.
3. Fill syringe with the desired volume of solution and eliminate remaining air.
4. Remove needle and dispose of appropriately.
5. Connect the MAD to the syringe.
6. Place the MAD tip in the nostril or oropharyngeal cavity.
7. Compress the syringe plunger to spray atomized solution into the nasal or oropharyngeal cavity.
8. Re-use the MAD on the same patient as needed, then discard.

KEY POINTS

The following are some of the benefits of IN (Atomized) drug delivery for the patient and provider:

- Eliminated the risk of a contaminated needlestick to the EMS provider.
- Simple and convenient for the EMS provider.
- Less frightening for children.
- Disposable.
- Discomfort is minimized for the patient.
- Serum levels of many IN administered medications are comparable to injected medications and much improved over rectal and oral routes.

Studies have shown that the most effective method to deliver a medication through the IN route is to atomize it across the nasal mucosa. Atomized particles (10 to 50 microns) adhere to the nasal mucosa over a large surface area, preventing waste and improving absorption of the medication. Administer half the dose in each nostril to increase the surface area, and further improve absorption.
MEDICAL
ORTHOSTATIC BLOOD PRESSURE MEASUREMENT

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Patient situations with suspected blood / fluid loss / dehydration</td>
<td>- Abdominal Pain</td>
<td>- Prepare for patient being unsteady on feet</td>
</tr>
<tr>
<td>- Patients &gt; 8 years of age, or patients larger than the Broselow tape</td>
<td>- Dizziness</td>
<td></td>
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<tr>
<td></td>
<td>- Pregnancy</td>
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</tr>
<tr>
<td></td>
<td>- Syncope</td>
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</tr>
</tbody>
</table>

PROCEDURE
1. Assess the need for orthostatic blood pressure measurement.
2. Obtain patient’s pulse and blood pressure while supine.
3. Have patient stand for one minute.
4. Obtain patient’s pulse and blood pressure while standing.
5. If pulse has increased by 20 BPM or systolic blood pressure decreased by 20 mmHg, the orthostatic measurements are considered positive.
6. If patient is unable to stand, orthostatic measurements may be taken while the patient is sitting with feet dangling.
7. If positive orthostatic changes occur while sitting, DO NOT continue to the standing position.
8. Document the time and vital signs for supine and standing positions on the patient care report.
9. Determine appropriate treatment based on protocol.
MEDICAL

PAIN ASSESSMENT

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Injury or illness requiring pain management.</td>
<td>• Abdominal pain</td>
<td>• Altered level of consciousness</td>
</tr>
<tr>
<td></td>
<td>• Chest pain secondary to infarction or angina</td>
<td>• Head injuries</td>
</tr>
<tr>
<td></td>
<td>• Acute urinary retention</td>
<td>• Chest injuries (blunt or penetrating)</td>
</tr>
<tr>
<td></td>
<td>• Fractures</td>
<td>• Intoxication</td>
</tr>
<tr>
<td></td>
<td>• Severe burns</td>
<td>• Maxillofacial injuries</td>
</tr>
<tr>
<td></td>
<td>• Kidney stones</td>
<td>• Psychiatric problems</td>
</tr>
<tr>
<td></td>
<td>• Musculoskeletal trauma</td>
<td>• Pediatric patients under 12 years of age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pregnancy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Respiratory distress / failure</td>
</tr>
</tbody>
</table>

PROCEDURE

1. Initial and ongoing assessment of pain intensity and character is accomplished through the patient’s self-report.
2. Pain should be assessed and documented during initial assessment, before starting pain control treatment, and with each set of vitals.
3. Pain should be assessed using the appropriate approved scale.
4. Two pain scales are available: the 0 - 10 and the Wong - Baker "faces" scale.
5. 0 - 10 Scale: the most familiar scale used by EMS for rating pain with patients. It is primarily for adults and is based on the patient being able to express their perception of the pain as related to numbers. Avoid coaching the patient; simply ask them to rate their pain on a scale from 0 to 10, where 0 is no pain at all and 10 is the worst pain ever.
6. Wong - Baker Faces scale: this scale is primarily for use with pediatrics but may also be used with geriatrics or any patient with a language barrier. The faces correspond to numeric values from 0-10. This scale can be documented with the numeric value or the textual pain description.

SEVERE PAIN MANAGEMENT

KEY POINTS

• Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage.
• Pain is subjective (whatever the patient says it is).

The Wong-Baker Faces Pain Rating Scale

Designed for children aged 3 years and older, the Wong-Baker Faces pain rating scale is also helpful for elderly patients who may be cognitively impaired. If offers a visual description for those who don’t have the verbal skills to explain how their symptoms make them feel.

To use this scale, you should explain that each face shows how a person in pain is feeling. That is, a person may feel happy because he or she has no pain (hurt), or a person may feel sad because he or she has some or a lot of pain.

A Numerical Pain Scale

A numerical pain scale allows you to describe the intensity of your discomfort in numbers ranging from 0 to 10 (or greater, depending on the scale). Rating the intensity of sensation is one way of helping your doctor determine treatment. Numerical pain scales may include words or descriptions to better label your symptoms, from feeling no pain to experiencing excruciating pain. Some researchers believe that this type of combination scale may be most sensitive to gender and ethnic differences in describing pain.
# PATIENT RESTRAINT

## INDICATIONS
- Patient out of control and may cause harm to self or others.
- Necessary force required for patient control without causing harm
- Immobilization of an extremity for transport to secure medically necessary devices such as intravenous catheters

## SIGNS AND SYMPTOMS
- Head Trauma
- Alcohol / drug related problems
- Metabolic disorders (i.e., hypoglycemia, hypoxia, etc.)
- Psychiatric/stress related disorders

## CONTRAINDICATIONS
- None if warranted

## KEY POINTS
- Soft restraints are to be used only when necessary in situations where the patient is potentially violent and may be of danger to themselves or others. EMS providers must remember that aggressive violent behavior may be a symptom of medical conditions.
- Patient health care management remains the responsibility of the EMS provider. The method of restraint shall not restrict the adequate monitoring of vital signs, ability to protect the patient’s airway, compromise peripheral neurovascular status or otherwise prevent appropriate and necessary therapeutic measures. It is recognized that evaluation of many patient parameters requires patient cooperation and thus may be difficult or impossible.
- All restraints should have the ability to be quickly released, if necessary.
- Restraints applied by law enforcement (i.e., handcuffs) require a law enforcement officer to remain available to adjust restraints as necessary for the patient’s safety. This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment to establish scene control.
- Patients shall not be transported in a face down prone position to endure adequate respiratory and circulatory monitoring and management.
- Restrained extremities should be monitored for color, nerve and motor function, pulse quality and place mask on patient for body secretion protection. May use TB mask, or non-rebreather if patient needs oxygen.
- Use supine or lateral positioning ONLY.
- Neurovascular checks are required every 15 minutes.
- DOCUMENT all methods used.

![Supine pt. in 4-point restraints on stretcher](image-url)
## NORMAL CHILDBIRTH

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Imminent delivery with crowning</td>
<td>• Urge to push</td>
<td>• See Gynecological Emergencies Protocol</td>
</tr>
<tr>
<td></td>
<td>• Visible crowning</td>
<td></td>
</tr>
</tbody>
</table>

### PROCEDURE

1. Delivery should be controlled so as to allow a slow controlled delivery of the infant. This will prevent injury to the mother and infant.
2. Support the infant’s head as needed.
3. Check the umbilical cord surrounding the neck. If it is present, slip it over the head. If unable to free the cord from the neck, double clamp the cord and cut between the clamps.
4. Suction the airway with a bulb syringe. Mouth then nose.
5. Grasping the head with hands over the ears, gently pull down to allow delivery of the anterior shoulder.
6. Gently pull up on the head to allow delivery of the posterior shoulder.
7. Slowly deliver the remainder of the infant.
8. Clamp the cord 2 inches from the abdomen with 2 clamps and cut the cord between the clamps.
9. Record APGAR scores at 1 and 5 minutes.
11. The placenta will deliver spontaneously, within 5-15 minutes of the infant. Do not force the placenta to deliver. Contain all tissue in plastic bag and transport.
12. Massaging the uterus may facilitate delivery of the placenta and decrease bleeding by facilitating uterine contractions.
13. Continue rapid transport to the hospital.
STROKE TELEMEDICINE
FOR DEPARTMENTS EQUIPPED TO PROVIDE TELEMEDICINE

SUSPECTED STROKE BASED ON INITIAL ASSESSMENT

BLOOD GLUCOSE PROCEDURE

COMPLETE STROKE ASSESSMENT PER STROKE / CVA PROTOCOL

Consider Alternate Diagnosis

Positive INITIAL Stroke Screen

Treat Per STROKE / CVA

Have Information Available
- Blood Glucose Level
- Vital Signs
- Last Known Normal
- Patient Name, Age, DOB
- Any Known TPA Exclusions

Negative INITIAL Stroke Screen

Have Information Available
- Blood Glucose Level
- Vital Signs
- Last Known Normal
- Patient Name, Age, DOB
- Any Known TPA Exclusions

INITIATE VIDEO CALL WITH RECEIVING HOSPITAL
This Will Be Your Patient Report

Demonstrate Findings
MEND EXAM

ACTIVATE STROKE ALERT IF POSITIVE MEND EXAM

Continue Treatment Per Protocol or Medical Direction

Transport to Primary Stroke Center or Comprehensive Stroke Center

DEVICE USEAGE

Cincinnati Pre-Hospital Stroke Assessment Conducted on Scene
Move Patient to Ambulance

Initiate Video Call
Select CISCO JABBER App from Home Screen

Select receiving hospital from contacts

Hold Tablet Vertical and with Screen Toward Patient, Camera UP

When Call is Answered, A Small Box Appears in the Lower Corner. This is the View the Hospital Sees. Direct Tablet and Viewer(s) to Area

Being Assessed. When Completed with Assessment and ETA, End Video Call

If video call dropped or unavailable, make hospital contact by standard radio or telephone methods

EMT Intervention
AEMT Intervention
PARAMEDIC Intervention
MED CONTROL Consult
**KEY POINTS**

- Vacuum mattresses may be used for major findings patients, but backboards alone may be harmful. Neutral placement on a cot mattress with a cervical collar is sufficient if a vacuum mattress unavailable.

- Backboards and KED’s should still be used for extrication, but removed if the patient does not meet criteria for a backboard

- If a backboard is used for extrication but the patient does not meet criteria for its use, the patient may be left on the board during transport as situationally required

- If a vacuum mattress is used, place a sheet over the mattress prior to placement of the patient on the device

- If a vacuum mattress is used, a backboard may be used underneath to provide additional support as required

- Never leave patients alone if they are back boarded. Be prepared to turn the long board while maintaining manual in line stabilization of the spine if the patient begins to vomit to maintain their airway

- Penetrating trauma does not require cervical motion restriction unless there is evidence of focal neurological deficits

- Document thoroughly the decision process and the assessment findings for treatment decision(s)

- Patients shall not be aided to stand then sit on a backboard during extrication. Non-ambulatory patients shall be properly extricated to a backboard or with the use of a KED

- Mental Status (AVPU), Glasgow Coma Scale (GCS), and thorough documentation of Motor, Sensory, and Pulses (MSP’S) are required to support treatment decisions.
**COMPLETE CERVICAL SPINE IMMOBILIZATION - PEDS**

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Need for spinal immobilization as determined by protocol</td>
<td>• Suspected traumatic injury</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unresponsive / altered LOC of unknown mechanism</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mechanism of Injury</td>
<td></td>
</tr>
</tbody>
</table>

**PROEDURE**

1. Gather a backboard, straps, C-collar appropriate for patient’s size, tape, and head blocks or similar device(s) to secure the head.
2. Explain the procedure to the patient.
3. Place the patient in an appropriately sized C-collar while maintaining manual in-line stabilization of the spine. This stabilization, to be provided by a second rescuer, should not involve traction or tension but rather simply maintaining the head in a neutral, midline position while the first rescuer applied the collar.
4. Once the collar is secure, the second rescuer should still maintain their position to ensure stabilization.
5. Place the patient on a long spine board with the log-roll technique if the patient is supine or prone. For the patient in a vehicle or otherwise unable to be placed prone or supine, place them on a backboard by the safest method available that allows maintenance of inline spinal stability.
6. Stabilize the patient with straps and head rolls / tape or other similar device. Once the head is secured to the backboard, the second rescuer may release manual in-line stabilization.
7. NOTE: Some patients, due to size or age, will not be able to be immobilized through inline stabilization with standard backboards and C-collars. Never force a patient into a non-neutral position to immobilize them. Such situations may require a second rescuer to maintain manual stabilization throughout the transport to the hospital.

**KEY POINTS**

- Use of a backboard for stabilization injuries other than the neck or to move the patient, does not automatically require cervical immobilization.
- Use of cervical immobilization in adult trauma patients, should always be followed with long board immobilization, including straps.
- Never leave patients alone if they are fully immobilized. Be prepared to turn the long board while maintaining c-spine stabilization if the patient begins to vomit to maintain their airway.
- A c-collar by itself does NOT adequately immobilize the patient.
- PROPERLY DOCUMENT THE DECISION TO NOT PROVIDE CERVICAL SPINE IMMOBILIZATION!!

**Trauma:**

In trauma cases the neck should be immobilized under any of the following circumstances:

- The patient complains of neck pain, pain on palpation, or pain with range of motion.
- The patient complains of numbness, tingling, or motor weakness in any extremity.
- Mechanism of injury with other distracting injuries.
- The patient has a head injury, altered mental status, or language barrier, which limits the patient’s ability to describe pain, numbness or weakness.
- The patient has a head injury or altered mental status that limits their ability to describe pain, numbness or weakness.
- Mechanism of injury with patient intoxication.
  1. If the history suggests a mechanism of injury, which could result in cervical injury in a patient who is intoxicated, cervical immobilization must be provided whether or not the patient is alert and oriented.
  2. This does not mean that every grossly intoxicated patient who is unable to provide reliable responses should have cervical immobilization.
     A. If the mechanism of injury is such that a neck injury is not a reasonable possibility, cervical immobilization is not indicated. (For example, if a call involves a grossly intoxicated person who has an isolated ankle injury after a simple fall.)
- Any time the paramedic or EMT judges that cervical immobilization is necessary.

**Pediatric Considerations:**

Small children (less than 8 years of age) have relatively large heads. Use of standard cervical immobilization and backboards will result in cervical flexion. Use a immobilization method that avoids flexion of the neck. Current approved methods include, but are not limited to;

- Devices which have a recess for the child’s occiput (Pedipak with padding applied).
- Placing the patient into the sniffing position by placing padding under the shoulders and lower back.
- Cervical collars should be used along with any of these modifications, unless there is not an appropriate size c-collar. If a circumstance prevents the use of a c-collar, other approved methods of immobilization include;
  1. Manual immobilization
  2. Blanket or towel roll immobilization
  3. Tape immobilization
# TRAUMA

## HELMET REMOVAL

<table>
<thead>
<tr>
<th>REMOVAL OF HELMET</th>
<th>LEAVE HELMET IN PLACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inability to access, assess and maintain airway and breathing</td>
<td>• Helmet fits well with little or no movement of head in helmet</td>
</tr>
<tr>
<td>• Improperly fitted helmet allowing for excessive head movement within helmet</td>
<td>• No impending airway or breathing problems</td>
</tr>
<tr>
<td>• Proper C-spine alignment and immobilization cannot be achieved</td>
<td>• Removal may cause further injury</td>
</tr>
<tr>
<td>• Cardiac arrest</td>
<td>• Proper C-spine alignment and immobilization can be achieved with helmet in place</td>
</tr>
<tr>
<td>• EMTs are trained in technique</td>
<td>• There is no interference with the ability to assess and reassess airway and breathing</td>
</tr>
</tbody>
</table>

## KEY POINTS

### Helmet Types:

1. **Sport (Football, Ice Hockey, Field Hockey, Fencing, Baseball)**
   - Typically open anteriorly
   - Easier to access airway
   - If shoulder pads are used in conjunction with helmet and helmet is removed then shoulder pads need to be removed simultaneously for proper C-spine alignment.

2. **Motorcycle / Bike / Skateboarding**
   - When full-faced, airway is harder to access and maintain.
   - Face shield may be removed for airway access.

### SPORTS HELMETS PROCEDURE:

1. Most fit athlete tightly, especially football. They should be left in place.
2. All are equipped to have face piece removed separate from helmet. In most cases, removal of facemask is all that is needed, as the alignment of c-spine can be done with shoulder pads and helmet in place.
3. Removal of facemask may be done by cutting snubber straps that hold it in place to access airway.

**Removal:**

- If helmet must be removed due to unusual circumstances, at least 4 people are needed.
- Shoulder pads need to simultaneously be removed. (When shoulder pads are involved is to use forearms to stabilize helmet and place hands at base of neck grasping the shoulder area).
- **While maintaining manual c-spine,** Helmet’s inside face pads may be loosened by use of a tongue blade to unsnap them with a twisting motion. Then cut the shoulder pads laces and straps and all shirts and jerseys from end of sleeve to center to allow for quick removal.
- Lift patient flat up for removal of equipment. Helmet should be grasped and tilted slightly to remove – **DO NOT SPREAD SIDES OR BACK EDGE OF HELMET, WILL IMPINGE UPON NECK.**
- At same lift, pull off shoulder pads and clothing.
- Lower patient down and apply c-collar.

### MOTORCYCLE / BIKE / SKATEBOARDING HELMETS PROCEDURE:

1. Usually do not fit tightly and may allow movement of head inside helmet.
2. If head can move, no c-spine immobilization is possible.
3. Some have separate face piece that can be moved for airway access.
4. Some have full face design that is not moveable where chin section is a rigid continuation of the helmet.
5. C-spine alignment difficult due to no shoulder padding. Must create pad to form straight alignment.
6. If unable to secure c-spine of airway, the helmet should be removed at the scene.
Removal:

- Take eyeglasses off before removal of the helmet.
- One EMT stabilizes the helmet by placing hands on each side of the helmet with fingers on mandible to prevent movement.
- Second EMT removes any straps by cutting them.
- Second EMT places one hand on the mandible at the angle of the jaw and the other hand posteriorly at the occipital region.
- The EMT holding the helmet pulls the sides of the helmet outwards away from the head and gently slips the helmet halfway off and stops.
- The EMT maintaining stabilization of the neck repositions hold by sliding the posterior hand superiorly to secure to head from falling back after complete helmet removal.
- Helmet is then completely removed.
TOURNAQUET

INDICATIONS

- The tourniquet is a device which is used for life threatening appendage hemorrhage that cannot be controlled with direct pressure and conventional bandaging techniques.

PROCEDURE

1. Place the device around the injured appendage above the level of bleeding. Place two tourniquets around lower extremities, one above the other.
2. Pull strap tight.
3. Turn windlass rod or knob to tighten to control bleeding.
4. Monitor the site, distal pulses should be absent if properly tightened.

KEY POINTS

- Apply directly to the skin 2-3 inches above wound.
- A distal pulse check should be accomplished. If a distal pulse is still present, consider additional tightening of the tourniquet or the use of a second tourniquet side by side and proximal to the first, to eliminate the distal pulse.
- Apply two tourniquets to lower extremity wounds. Tighten both.
- Expose and clearly mark all tourniquet sites with the time of tourniquet application.
- Use tourniquets to control life-threatening external hemorrhage that is possible to apply a tourniquet to for any traumatic amputation.
**iT CLAMP**

**INDICATIONS**

- The iTClamp50 device is indicated for use as an acute skin closure device for short-term soft tissue approximation to inhibit severe bleeding in trauma wounds, lacerations, junctional bleeds, or surgical incisions.

**PROCEDURE**

1. Open the package by pulling forward on the outer tabs.
2. Remove the device from the package by lifting up, taking care not to close the device until it has been applied to the wound.
3. If the device has inadvertently closed, push the side buttons inward with one hand, and pull the device open with the other hand.
4. Locate the wound edges (fig 1).
5. Align the device parallel to the length of wound edge. Position the needles about 1-2 cm (0.5-1 in.) from the wound edge on either side (fig 2).
6. Press the arms of device together to close the device. Device seal will break with pressure (fig 3).
7. Ensure the entire wound is sealed and bleeding stops (fig 4).
8. A gauze or compression wrap can be placed around the device on the wound to protect the device and increase pressure on the wound to limit hematoma expansion.

**NOTE:** More than one device may be required.

---

**REMOVAL**

(Two-handed operation):

1. Holding the device by the arms, press the device closed (fig 5).

2. While maintaining pressure on the arms, press the release buttons with your other hand (fig 6).

3. While pressing the release buttons, pull the arms to open the device and rotate the needles out of the wound (fig 7 and 8).
HEMOSTATIC GAUZE

INDICATIONS

- Hemostatic gauze is indicated for supplemental bleeding control in addition to direct pressure where other methods of hemorrhage control are unable to be utilized due to location and direct pressure with standard gauze product has, or is likely to fail.

PROCEDURE

1. Open hemostatic gauze package
2. Pack wound with contents
3. Apply pressure for at least 3 minutes
4. Apply standard bandaging over hemostatic gauze to maintain pressure
5. Take hemostatic gauze package with instructions for removal to ER

PRODUCT REMOVAL: 1. Gently remove gauze from wound. 2. Thoroughly irrigate wound.
Direct pressure / Gauze

Placing pressure on the wound will constrict the blood vessels manually, helping to stem any blood flow. When applying pressure, the type and direction of the wound may have an effect, for instance, a cut lengthways on the hand would be opened up by closing the hand into a fist, whilst a cut across the hand would be sealed by making a fist. A patient can apply pressure directly to their own wound, if their consciousness level allows. Direct pressure can be used with some foreign objects protruding from a wound; padding is applied from each side of the object to push in and seal the wound - objects are never removed. Use available gauze products to cover wounds and roll gauze products and / or tape to provide continued pressure to wounds.

Pressure points

The arterial pressure points

In situations where direct pressure and elevation are either not possible or proving ineffective the use of pressure points to constrict the major artery which feeds the point of the bleed is indicated. This is usually performed at a place where a pulse can be found, such as in the femoral artery. There is particularly high danger if constricting the carotid artery in the neck, as the brain is sensitive to hypoxia and brain damage can result within minutes of application of pressure. Pressure on the carotid artery can also cause vagal tone induced bradycardia, which can eventually stop the heart. Other dangers in use of a constricting method include rhabdomyolysis, which is a buildup of toxins below the pressure point, which if released back into the main bloodstream may cause renal failure.
PELVIC STABILIZATION DEVICE

INDICATIONS

- Suspected adult pelvic fractures and dislocations.

PROCEDURE

1. Unfold Pelvic Sling with white surface facing up.
2. Place white side of Pelvic Sling beneath patient at level of buttocks.
3. Firmly close Pelvic Sling by placing black Velcro side of flap down on the black Velcro strip (fold material and center at midline).
4. Grab orange handle on outer surface of flap and release from flap by pulling upward.
5. Firmly pull both orange handles in opposite directions to tighten the Pelvic Sling.
6. Keep pulling free handle until you feel or hear the buckle click.
7. As soon as the buckle clicks, maintain tension and firmly press orange handle onto the black Velcro strip.

TO REMOVE PELVIC SLING

1. Lift orange free handle away from flap by pulling upward. Maintain tension and slowly allow Pelvic Sling to loosen.

KEY POINTS

1. Of 120,000 pelvic fractures reported in the U.S. in a typical year, 21,000 were pelvic ring fractures.
2. The mortality rate of pelvic fractures is reported to be more than 25%.
3. The combination of pelvic ring fractures with other injuries increases the mortality rate.
4. Stabilizing pelvic fractures reduces blood loss.
5. Victims are often confused or unconscious making it difficult to diagnose pelvic fractures without X-rays or CT scans. Physical examination is inaccurate approximately 90% of the time.
6. Trauma surgeons and emergency department physicians have recognized the benefits of circumferential pelvic compression.
7. At the time of initial evaluation, the exact type of fracture is usually unknown. In some cases, too little force will not close or stabilize the fracture, in others, too much force can collapse the pelvic ring.
8. Because of the potentially devastating hemorrhage associated with pelvic fractures, standard first aid protocol has included applying some type of circumferential binder around the victim’s hips.
9. Cannot be over-tightened. The force applied is safe and correct.
10. Standard size fits 95% of the population without cutting or trimming.

NOT RECOMMENDED FOR USE ON CHILDREN
# PHARMACOLOGY

## NITROUS OXIDE ADMINISTRATION

<table>
<thead>
<tr>
<th>INDICATIONS</th>
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<tbody>
<tr>
<td>• Injury requiring pain management&lt;br&gt;• Patient able to self-administer</td>
<td>• Chest pain secondary to infarction or angina&lt;br&gt;• Acute urinary retention&lt;br&gt;• Fractures&lt;br&gt;• Severe burns&lt;br&gt;• Kidney stones&lt;br&gt;• Musculoskeletal trauma</td>
<td>• Altered level of consciousness&lt;br&gt;• Head injuries&lt;br&gt;• Chest injuries (blunt or penetrating)&lt;br&gt;• Intoxication&lt;br&gt;• Maxillofacial injuries&lt;br&gt;• Psychiatric problems&lt;br&gt;• COPD (because of the 50% oxygen mixture)&lt;br&gt;• Pediatric patients under 12 years of age&lt;br&gt;• Pregnancy&lt;br&gt;• Respiratory distress&lt;br&gt;• Abdominal pain</td>
</tr>
</tbody>
</table>

### PROCEDURE

1. Instruct patients to administer nitrous oxide to themselves by placing the mask tightly against their face and breathing deeply and slowly
2. Allow mask to fall away from face spontaneously when effects are felt
3. Check blood pressure, as nitrous oxide may cause BP to drop in some cases

### KEY POINTS

- Nitrous oxide is a self-administered analgesic gas containing a mixture of 50% oxygen and 50% nitrous oxide.
- Nitrous oxide is supplied in a carrying case containing two cylinders, one of nitrous oxide and one containing oxygen, with a mixing valve and supply tubing. These agents are mixed on administration to deliver a 50% concentration of each to the patient.
- Nitrous oxide should be given to any patient who is alert and complaining of severe pain.
- Only self-administration by the patient is to be used.
- Upon administration of nitrous oxide, constantly monitor patient to see he does not fall asleep with mask in place.
- The side effects of nitrous oxide, in addition to analgesia, include light-headedness, drowsiness, and very occasionally nausea and vomiting. Changes in heart rate and respiratory rate are minimal.
- Nitrous oxide and oxygen are both non-flammable gases, but both support combustion. For this reason do not use nitrous oxide in areas where there is a combustion hazard.

There is an increased risk of liver cancer and birth defects to individuals who are exposed repeated applications of nitrous oxide. For this reason nitrous oxide should be used in a well-ventilated environment.
SPECIAL PROCEDURES

TASERED PATIENT

ALL PATIENTS SUBJECTED TO TASER USE MUST BE TRANSPORTED TO THE HOSPITAL FOR MEDICAL EVALUATION.

INDICATIONS

- Any patient that was subjected to taser use.

PROCEDURE

1. Follow Universal Patient Care Protocol.
2. Confer with law enforcement officer regarding the patient’s behavior prior to EMS arrival.
3. Refer to the appropriate medical protocol if the patient has a life-threatening injury or medical illness or continues to be combative.
4. Determine the location of the Taser probes. Do not remove probes unless they interfere with patient care.
5. Perform a 12-Lead EKG and continuously monitor the patient’s EKG. If the patient has a dysrhythmia, refer to the appropriate protocol.

KEY POINTS

- With the increased use and deployment of TASERs by our area’s local law enforcement agencies, EMS providers must be aware of the appropriate medical assessment of the tasered patient. The TASER is designed to transmit electrical impulses that temporarily disrupt the body’s central nervous system. Its Electro-Muscular Disruption (EMD) Technology causes an uncontrollable contraction of the muscle tissue, allowing the TASER to physically debilitate a target regardless of pain tolerance or mental focus.
- All patients subjected to taser use must be assessed for trauma and medical causes for the combative behavior.
- Always apply the cardiac monitor and obtain a strip for patients with irregular / abnormal pulse, elderly, pacer, AICD, known CAD, and excited delirium.
- The patient’s vital signs must be reassessed every 5 minutes.
- Determine if the patient used any mind altering drugs, has a cardiac history, and the date of their last tetanus shot.
- The cord or wire may be cut, but leave the probes embedded in the patient.
- Removal of the probe. (Remove one at a time).
- Stabilize the skin surrounding the puncture site by placing one hand by where the probe is embedded.
- Pull the probe straight out from the puncture site in one fluid motion.
- TASER bars that do penetrate the skin and are removed in the field are to be treated as “contaminated sharps” and are to be placed in an appropriate sharps container. Use small single use containers as law enforcement may wish to hold custody of the bars after removal.
SPECIAL OPERATIONS

ACTIVE SHOOTER / DIRECT THREAT PROTOCOL

KEY POINTS

- To be used in direct threat when scene has been cleared but not secured (Warm Zone).
- Priority is to intervene on immediate life threatening conditions.
- Direct Threat Care is the care rendered by the medical provider while the provider and the patient are still within an effective hostile environment. These protocols are intended to be a guideline to medical intervention and cannot replace sound judgment and situational awareness. Providers are also cautioned not to rely on these protocols as a sole source of information about patient care, but rather to tailor their therapy to the clinical situation.
- Expedite removal to indirect threat environment.
- There is no need to immobilize the cervical spine with only penetrating trauma to the extremities or trunk. Consider cervical immobilization for penetrating neck trauma.
- Once scene secured, return to standard protocols.
- Warm / Hot Zone terminology should be considered the same as Inner Ring terminology for the purpose of this protocol.
# SPECIAL OPERATIONS

## PATIENT DECONTAMINATION

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>PRECAUTIONS</th>
</tr>
</thead>
</table>
| • Any patient who may have been exposed to significant hazardous materials, including chemical, biological, or radiological weapons. | • Ambulatory / Non-Ambulatory  
  • Exposure to toxic substances (dry, liquids, fumes)  
  • Irritants  
  • Emergent / Non-Emergent | • Dry chemicals must be wiped off prior to wet decontamination  
  • Clothing must be removed  
  • Maintain patient privacy as needed.  
  • Gross Decon (Primary)  
  • Fine Decon (Secondary) |

## PROCEDURE

1. In coordination with Hazardous Materials and other Emergency Management personnel, establish hot, warm and cold zones of operation.
2. Ensure that personnel assigned to operate within each zone have proper personal protective equipment.
3. In coordination with other public safety personnel, assure each patient from the hot zone undergoes appropriate initial decontamination. This is specific to each incident; such decontamination may include:
   - Removal of patients from Hot Zone
   - Simple removal of clothing
   - Irrigation of eyes
   - Passage through high-volume water bath (e.g., between two fire apparatus) for patients contaminated with liquids or certain solids. Patients exposed to gases, vapors, and powders often will not require this step as it may unnecessarily delay treatment and/or increase dermal absorption of the agent(s).
4. Initial triage of patients should occur after step #3. Immediate life threats should be addressed prior to technical decontamination.
5. Assist patients with technical decontamination (unless contraindicated based on #3 above). This may include removal of all clothing and gentle cleansing with soap and water. All body areas should be thoroughly cleansed, although overly harsh scrubbing which could break the skin should be avoided.
6. Place triage identification on each patient. Match triage information with each patient’s personal belongings, which were removed during technical decontamination. Preserve these personnel affects for law enforcement.
7. Monitor all patients for environmental illness.
8. Transport patients per local protocol.

Notify Hospital EARLY of contaminated patients; assure time for mobilization of Hospital Emergency Response Team (H.E.R.T) or other resources.
ENSURE SCENE SAFETY AND PROPER PPE

UNIVERSAL PATIENT CARE PROTOCOL

Obtain history of exposure
Observe for specific toxidromes
Initiate triage and / or decontamination as indicated

Assess for presence of major or minor symptoms

If Continued Seizures:
LORAZEPAM (ATIVAN)
1 - 2 mg IV / IO / IN / IM
Or
MIDAZOLAM (VERSED)
2 mg IV / IO or 5 mg IN / IM

If Continued SLUDGEM Symptoms:
ATROPINE
2 mg IV / IM
q 5 minutes until symptoms resolved

TRANSPORT to appropriate facility
CONTACT receiving facility
CONTACT Medical Direction where indicated

MINOR SYMPTOMS
(Self Treatment)
Salivation
Lacrimation
Visual Disturbances

DuoDote x 1 – 2 sets
IM Rapidly

Monitor for appearance of major symptoms

SLUDGEM
SALIVATION
LACRIMATION
URINATION
DEFICATION
GASTROINTESTINAL DISTRESS
EMESIS
MUSCLE TWITCHING

MAJOR SYMPTOMS
(Buddy Treatment)
Altered LOC
Seizures
SOB
Respiratory Arrest

DuoDote x 3 sets
IM Rapidly

If Seizures:
DIAZEPAM (VALIUM)
Auto-Injector IM

UNIVERSAL PATIENT CARE PROTOCOL
## SPECIAL OPERATIONS

### NERVE AGENT EXPOSURE KIT

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>SIGNS AND SYMPTOMS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nerve agent exposure (e.g., VX, Sarin, Soman, etc.)&lt;br&gt;• For use of Fire, EMS, and Police personnel only</td>
<td>• Visual disturbances&lt;br&gt;• Headache&lt;br&gt;• Nausea / vomiting&lt;br&gt;• Salivation&lt;br&gt;• Lacrimation&lt;br&gt;• Respiratory distress&lt;br&gt;• Diaphoresis&lt;br&gt;• Seizure activity&lt;br&gt;• Respiratory arrest</td>
<td>• Vesicant exposure (e.g., Mustard Gas, etc.)&lt;br&gt;• Respiratory irritant exposure (e.g., hydrogen sulfide, ammonia, chlorine, etc.)</td>
</tr>
</tbody>
</table>

### KEY POINTS

- If Triage / MCI issues exhaust supply of Mark 1 kits or DuoDotes, use Atropine. Give 2 mg IM dose for patients greater than 90 pounds (>40kg).
- Follow local HAZMAT protocols for decontamination and use of personal protective equipment.
- For patients with major symptoms, there is no limit for atropine dosing.
- Carefully evaluate patients to ensure they not from exposure to another agent. (e.g., narcotics, vesicants, etc.)
- Each DuoDote auto injector contains both 600 mg of pralidoxime (2-PAM) and 2.1 mg of atropine
- Each valium auto injector contains 10 mg of valium
- If the presence of a nerve agent is suspected by presentation of symptoms of large numbers of patients, personnel should immediately contact dispatch to notify other responding units and command staff.
- The patient and / or crew must be decontaminated prior to transport. DO NOT transport a contaminated patient to a treatment facility.
- SLUDGEM: Salivation, Lacrimation, Urination, Gastrointestinal upset, Emesis, Muscle twitching.
- When the nerve agent has been ingested, exposure may continue for some time due to slow absorption from the lower bowel, and fatal relapses have been reported after initial improvement.
- If dermal exposure has occurred, decontamination is critical and should be done with standard decontamination procedures. Patient monitoring should be directed to the same signs and symptoms as with all nerve or organophosphate exposures.
- Continued medical monitoring and transport is mandatory.
Ohio Senate Bill 58 became Law in September 2010.

The Law includes provisions for EMS providers to withdraw blood for the purpose of evidence collection in cases involving allegations of operating watercraft or vehicles under the influence.

The language of the bill states that drawing blood “may” not “shall” be done for evidence collection “in the course of” providing emergency medical treatment.

- You CANNOT be dispatched or called by the police for the sole purpose of performing phlebotomy when the person does not require emergency medical treatment.

- The Medic/AEMT in charge can refuse law enforcements request to draw the blood if doing so would interfere with lifesaving patient care or outcome.

- The patient must consent to the collection of blood for evidence purposes. (If unconscious, Implied Consent applies)

- The Police Officer making the request must be present at all times during the draw and must provide the Medic/AEMT with the evidence collection kit.

- EMS Providers MUST use the evidence kit provided by law enforcement to obtain the blood samples for evidence.
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# APPENDIX #3: MEDICAL CONTROL

## OVERVIEW

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<td>EMS Recertification Requirements</td>
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## OPERATIONS

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<td>EMS Documentation</td>
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<td>Emergency Department Restrictions</td>
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## GUIDELINES / PROCEDURES

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<td>Aeromedical Transport</td>
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<td>Children with Special Healthcare Needs</td>
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<td>Concealed Weapons Guidelines</td>
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<td>Consent and Refusal of Care Guidelines</td>
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<td>Crime Scene Guidelines</td>
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<tr>
<td>Dead on Arrival (DOA)</td>
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<tr>
<td>Domestic Violence / Sexual Assault / Rape / Elder Abuse</td>
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<tr>
<td>Health Insurance Portability and Accountability Act (HIPAA)</td>
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<tr>
<td>Newborn Abandonment</td>
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<td>Obese Patients</td>
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<td>On - Scene EMT / Nurse / Physician Intervener</td>
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<tr>
<td>School Bus Accidents</td>
<td>23-15</td>
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<td>Termination of Resuscitation Efforts</td>
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</tbody>
</table>

## INFECTION CONTROL

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>EMS Bloodborne Pathogen Exposure Guidelines</td>
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## ADMINISTRATION

<table>
<thead>
<tr>
<th>Topic</th>
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<tbody>
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<td>Blood Collection for Evidence</td>
<td>26-15</td>
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<tr>
<td>Department Supplied Medical Equipment</td>
<td>27-15</td>
</tr>
<tr>
<td>Drug Box Exchange</td>
<td>28-15</td>
</tr>
<tr>
<td>Transports, Interfacility, and Non-Hospital Patients</td>
<td>29-15</td>
</tr>
</tbody>
</table>
These protocols recognize that there is a role for all levels of Emergency Medical Technician Certification. Not every function defined by the State of Ohio is approved under specific hospital Medical Directors. Patient care should always be delivered at the highest level of EMS available. All Provider levels must function within the State Of Ohio EMS Scope Of Practice for their particular Provider level. Every EMS Provider must be aware of the State of Ohio requirements for recertification, and each individual is responsible for personally fulfilling these requirements. Those seeking to fulfill National Registry of Emergency Medical Technician (NREMT) requirements may do so under their own individual responsibility.

Continuing Education certifications must be received through an approved Continuing Education site with a valid accreditation # noted, and must be filed properly. Each EMS Provider must maintain his / her own personal records, and be responsible for his / her own Continuing Education status.
**MEDICAL CONTROL / OVERVIEW**

**EMS RECERTIFICATION REQUIREMENTS**

Refer to the State EMS website for current requirements.

<table>
<thead>
<tr>
<th>EMT</th>
<th>ADVANCED EMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>40 hours of CE which includes:</strong></td>
<td><strong>60 hours of CE which includes:</strong></td>
<td><strong>86 hours of CE which includes:</strong></td>
</tr>
<tr>
<td>• 6 hours of pediatric education</td>
<td>• 8 hours of pediatric education</td>
<td>• 12 hours of pediatric education</td>
</tr>
<tr>
<td>• 2 hours of geriatric education</td>
<td>• 4 hours of geriatric education</td>
<td>• 4 hours of geriatric education</td>
</tr>
<tr>
<td>• 8 hours of trauma training</td>
<td>• 8 hours of trauma training</td>
<td>• 8 hours of trauma training</td>
</tr>
<tr>
<td>• 2 hours of trauma triage protocol / issues training (2 of the 8 hrs must be dedicated to local / issues training)</td>
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</tr>
<tr>
<td><strong>OR</strong></td>
<td><strong>OR</strong></td>
<td><strong>PLUS</strong></td>
</tr>
<tr>
<td>State approved Refresher Course (including pediatric, geriatric and trauma requirements)</td>
<td>State approved Refresher Course which satisfies 40 of the required 60 hours PLUS 20 additional hours of CE.</td>
<td>6 hours on emergency cardiac care; which may be satisfied by ACLS certification or equivalent course approved by EMS Board</td>
</tr>
<tr>
<td><strong>Current NREMT Renewal Requirements</strong></td>
<td><strong>Current NREMT Renewal Requirements</strong></td>
<td><strong>Forty-eight (48) hours Paramedic Refresher Course</strong></td>
</tr>
<tr>
<td>• Current registration as an EMT with the NREMT on the expiration date of your Ohio certification will be recognized as having met the CE requirements for renewal.</td>
<td>• Current registration as an Advanced EMT with the NREMT on the expiration date of your Ohio certification will be recognized as having met the CE requirements for renewal.</td>
<td><strong>PLUS</strong></td>
</tr>
<tr>
<td>If opting for National Registry Renewal, all that is required is:</td>
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<td>Forty-four (38) additional hours of CE</td>
</tr>
<tr>
<td>• 2 hours of trauma / triage / issues training</td>
<td>• 2 hours of trauma / triage issues training</td>
<td><strong>OR</strong></td>
</tr>
<tr>
<td><strong>Exam in Lieu of CE</strong> (for all levels)</td>
<td><strong>Exam in Lieu of CE</strong> (for all levels)</td>
<td><strong>Current National Registry Paramedic Renewal Requirements</strong></td>
</tr>
<tr>
<td>This exam is similar to the exam for initial certification and can be taken during the last six months of your certification cycle. Contact the Division of EMS to obtain information on registering for this exam.</td>
<td>This exam is similar to the exam for initial certification and can be taken during the last six months of your certification cycle. Contact the Division of EMS to obtain information on registering for this exam.</td>
<td>• Current registration as a Paramedic with the NREMT on the expiration date of your Ohio certification will be recognized as having met the CE requirements for renewal.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If opting for National Registry Renewal, all that is required is:</td>
</tr>
<tr>
<td></td>
<td></td>
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MEDICAL CONTROL / OVERVIEW

EMS COMMUNICATIONS

Direct communication by EMS with the receiving hospital is required to insure continuity of care and the accurate reporting of the incoming patient’s condition, history, and treatment. A member of the prehospital care team must contact the receiving hospital at the earliest time that is conducive to good patient care.

If patient treatment advice is needed or if Medical Command orders are required per the protocol, Medical Command should be contacted. Medical Command will provide advice and any protocol orders deemed necessary in the care of the patient. If transporting the patient to a Non-UH facility, EMS will then contact the receiving hospital as stated above.

PURPOSE

- To provide the receiving hospital and accurate, updated report of the patient’s presentation and condition throughout prehospital care and transport.
- To allow the receiving hospital the opportunity to prepare for receiving the patient and continue necessary medical treatment.

PROCEDURE

1. Contact the receiving facility and provide the following information:
   - Type of Squad: EMT, Advanced EMT, Paramedic
   - Age and Sex of Patient
   - Type of Situation: Injury and/or Illness
   - Specific Complaint: Short and to the point (i.e., chest pain, skull fracture)
   - Mechanism: MVA / MCA / Fall
   - Vital Signs: B/P / Pulse / Resp. / LOC / EKG
   - Patient Care: Airway Management, Circulatory Support, Drug Therapy
   - General Impression: Stable / Unstable
   - Destination ETA

KEY POINTS

- When calling in a report it should begin by identification of the squad calling, and the level of care that can be provided to the patient (EMT, AEMT, Paramedic) and the nature of the call (who you need to talk with, physician or nurse).
- Whenever possible, the EMS provider responsible for the highest level of direct patient care should call in the report.
- Although all EMS Providers have been trained to give a full, complete report, this is often not necessary and may interfere with the physician’s duties in the Emergency Department. Reports should be as complete but concise as possible to allow the physician to understand the patient’s condition.
- It is not an insult for the physician to ask questions after the report is given. This is often more efficient than giving a thorough report consisting mostly of irrelevant information.
- If multiple victims are present on the scene, it is advisable to contact Medical Control with a preliminary report. This should be an overview of the scene, including the number of victims; seriousness of the injuries, estimated on-scene and transport times to the control hospital or possible other nearby facilities. This allows preparation for receiving the victims and facilitates good patient care.
EMS DOCUMENTATION

- An EMS patient care report form (PCR) will be completed accurately and legibly to reflect the patient assessment, patient care and interactions between EMS and the patient, for each patient contact which results some assessment component.
- Every patient encounter by EMS will be documented. Vital signs are a key component in the evaluation of any patient and a complete set of vital signs is to be documented for any patient who receives some assessment component.

PURPOSE
To document total patient care provided including:
- Care provided prior to EMS arrival.
- Exam of the patient as required by each specific complaint based protocol.
- Past medical history, medications, allergies, living will / DNR, and personal MD.
- All times related to the event.
- All procedures / medications administered and their associated time and patient response.
- Notation of treatment authorization if any deviation from protocol / narcotic use.
- Reason for inability to complete or document any above item.
- A complete set of vital signs.

PROCEDURE
1. The patient care report should be completed as soon as possible after the time of the patient encounter.
2. All patient interactions are to be recorded on the patient care report form or the disposition form (if refusing care).
3. The patient care report form must be completed with the above information.
4. A copy of the patient care report form should be provided to the receiving medical facility.
5. A copy of the patient care report form is to be maintained by the EMS entity.
6. A copy of the patient care report shall be given to the Medical Director per his or her order.

KEY POINTS
- Document the contact and any on-line medical direction that is given. If you are not able to reach Medical Control, document attempts and cause for failure. Always describe the circumstances of the call. It is very important to document the mental status of the patient who refuses transport. Any refusal call should also note the contact of Medical Control.
- The times vitals are taken must be noted. Vitals should be repeated every five minutes, or following any medical treatments. Vitals should be completely recorded. If a part of the set of vitals is omitted, the reason should be clearly given.
- Use accepted medical abbreviations and terminology. Do not make them up.
- Make an effort to spell correctly. Become familiar with the correct spelling of commonly used words.
- The name, dose, route, time and effect should be documented for all medications.
- When standards are followed such as in a full arrest; every step should be documented. To write "ACLS protocols followed" is NOT SATISFACTORY.
- When providing copies of the run report for the Emergency Department and the Medical Director, be sure to include the EKG strips and second sheets.
- A complete set of times must be recorded on every report.

Documentation of Vital Signs:
1. An initial complete set of vital signs includes:
   - Pulse rate
   - Systolic AND diastolic blood pressure
   - Respiratory rate
   - Pain / severity (when appropriate to patient complaint)
   - Pulse Oximetry
2. Every attempt should be made to auscultate blood pressures, however if unable to auscultate, a palpated pressure will suffice.
3. If the patient refuses this evaluation, the patient’s mental status and the reason for refusal of evaluation must be documented, along with an offer to return and transport. Medical Control contact should be noted.
4. Document situations that preclude the evaluation of a complete set of vital signs.
5. Record the time vital signs were obtained.
6. Any abnormal vital sign should be repeated and monitored closely.
This procedure provides for hospitals to notify the EMS departments of restrictions in their patient care capabilities. EMS departments should honor hospital restrictions unless doing so would endanger the patient.

RESTRICTION EXCEPTIONS
Regardless of what status a hospital has imposed on its facility, there are situations when EMS personnel should be able to transport a patient to the facility. These exceptions apply only to general hospitals having a full service Emergency Department, and do not apply to specialty facilities. The type of cases that should always be accepted are as follows:

1. Patients in cardiac arrest due to either medical or traumatic causes.
2. Patients whose airways cannot be controlled by the EMS Personnel.
3. Patients felt to be in extremis to the point that diversion to another facility would dangerously delay needed immediate stabilization. This is based on the judgment of the EMS provider in charge.
4. Patients who typically receive their care at the hospital on diversion, and any diversion from that hospital would potentially jeopardize the expedient care of their emergency condition.
5. Pediatric patients
6. Obstetric patients
7. If the EMS provider in charge states that they are not comfortable diverting and states that transport must be made to the facility (due to family or physician situation / request).
MEDICAL CONTROL / PROCEDURES
ADVANCED DIRECTIVES - DO NOT RESUSCITATE (DNR) ORDERS

PURPOSE
• Ideally, any patient presenting to the EMS system with a valid DNR form shall have the form honored and CPR and ALS therapy withheld in the event of cardiac arrest.
• To honor the end of life wishes of the patient
• To prevent the initiation of unwanted resuscitation

PROCEDURE
Ohio’s DNR Comfort Care is the only law encompassing EMS. For any other type of DNR documents, you must contact Medical Control and describe your circumstances to a Physician. The Physician will then decide if EMS should honor the DNR document, or begin resuscitation of the patient. This includes the Ohio Living Will or any other document to this effect.

A DNR order for a patient of a healthcare facility shall be considered current in accordance with the facility’s policy. A DNR order for a patient outside a healthcare facility shall be considered current unless discontinued by the patient’s attending physician / CNP / CNS, or revoked by the patient. EMS personnel are not required to research whether a DNR order that appears to be current has been discontinued.

STATE OF OHIO DNR COMFORT CARE GUIDELINES
Under its DNR Comfort Care Protocol, the Ohio Department of Health has established two standardized DNR order forms.

  DNR Comfort Care – Terminally ill condition and in effect at all times.
  DNR Comfort Care – Arrest – In effect in the event of a cardiac or respiratory arrest.

When completed by a doctor (or certified nurse practitioner or clinical nurse specialist, as appropriate), these standardized DNR orders allow patients to choose the extent of the treatment they wish to receive at the end of life. Ohio DNR Comfort Care can be identified by the original / copy of the State of Ohio DNR Comfort Care Form with official DNR logo, a DNR Comfort Care necklace, bracelet, or card with official DNR Comfort Care logo, the form must be completed with effective date and signed by the patient’s physician. To enact the DNR Comfort Care, the patient must be experiencing a terminal event. EMS is not required to search for a DNR identification but should make a reasonable attempt to identify that the patient is the person named in the DNR Comfort Care form. Only the patient may request reversal of the DNR – Comfort Care.

CARE to be provided by EMS:
• Suction the airway
• Administer oxygen
• Position for comfort
• Splint of immobilize
• Control bleeding
• Provide pain medication
• Provide emotional support
• Contact other appropriate health care providers (hospice, home health, attending physician or certified nurse)

Care NOT to be provided by EMS:
• Administer chest compressions
• Insert artificial airway
• Administer resuscitative drugs
• Defibrillate or cardiovert
• Provide respiratory assistance (other than described above)
• Initiate resuscitative IV
• Initiate cardiac monitoring
KEY POINTS

- The DNR order addresses your current state of health and the kind of medical treatment you and your physician decide is appropriate under current circumstances.
- A DNR order for a patient of a health care facility shall be considered current in accordance with the facility’s policy. A DNR order for a patient outside a health care facility shall be considered current unless discontinued by the patient’s attending physician / CNP / CNS, or revoked by the patient. EMS personnel are not required to research whether a DNR order that appears to be current has been discontinued.
- It is imperative that a copy of or the original DNR / Comfort Care orders and identification accompany the patient wherever the patient goes. This will help to alleviate any confusion between health care givers at multiple sites.
- Be careful to check the patient’s DNR order or DNR identification to determine if DNR - CC or DNR - CC Arrest.
- EMS is not required to search a person to see if they have DNR identification. If any of the DNR identifiers are in the possession of the patient, EMS must make a reasonable attempt to identify the patient by patient’s name given by patient, family, caregiver or friend, health care worker who knows the patient, ID band from health care institution, driver’s license or other picture I.D. If identification cannot be verified, the protocol should be followed.
- The patient may request resuscitation even if he / she is a DNR Comfort Care or DNR Comfort Care-Arrest Patient and / or the DNR Comfort Care Protocol has already been activated. The patient’s request for resuscitation amounts to a revocation of any or all DNR Comfort Care Status and resuscitative efforts must be activated.
- If EMS has responded to an emergency situation by initiating any of the “will not perform actions” prior to confirming that the DNR Comfort Care Protocol must be activated, discontinue them when you activate the protocol. You may continue respiratory assistance, IV medications, etc, that have been part of the patient’s ongoing course of treatment for their underlying condition or disease.
- If the patient’s family or bystanders request or demand resuscitation for a patient for whom the DNR Comfort Care Protocol has been activated, do not proceed with resuscitation. Provide “will perform actions” as outlined above and try to help them understand the dying process the patient’s initial choice not to be resuscitated.
- For EMS - The Ohio DNR Comfort Care law is the only one you (EMS) can honor on your own. For any other types of DNR documents, you must contact Medical Control and describe your circumstances to a Physician. The Physician will decide if you should honor the DNR document, or begin resuscitation of the patient.
- Your living will document specifies in advance the kind of medical treatment you would want if and when you have a terminal illness or are in a permanently unconscious state and are no longer able to state your own wishes. It may not protect you from receiving CPR or other heroics. It only takes effect if you are in a certifiably terminal or permanently unconscious state, and emergency squad personnel cannot determine if you meet these conditions.
- A Health Care Power of Attorney is a document that names another person (usually a spouse, child, or other relative, and preferably someone who can understand your health status and make hard decisions on your behalf, if necessary) to make health care decisions for you whenever you are unable to do so yourself. It is not a DNR order, though it ordinarily would permit the person you appoint to agree to a DNR order for you, if you are unable to express your wishes at the time.
- The General Power of Attorney usually does not address health care issues and ends if you become disabled. You may have given your general power of attorney to someone to manage your financial affairs while you were on vacation or in the hospital. If you want a general power of attorney to continue, even if you become disabled, the document must state that it is a durable, or continuing, power of attorney. A health care power of attorney is a durable power; it continues even after you become disabled and appoints someone to carry out your health care wishes.
MEDICAL CONTROL / PROCEDURES

AEROMEDICAL TRANSPORT

Helicopter / Hospital Intercepts
If the patient requires specialized care, i.e. level 1 trauma center, and conditions allow for rapid transport to the nearest facility, a helicopter/hospital intercept can be initiated. When a helicopter / hospital intercept is initiated, the receiving hospital medical control will be contacted, advised of request for helicopter intercept and minimum patient information of nature of call / chief complaint, and then medical control will direct the appropriate personnel to call for the helicopter.

Scene Flights
Scene flights will be organized with the cooperation of the responding EMS, fire, and law enforcement agencies. The following defines how the on-scene Incident Command (IC) should request an Air Ambulance to the scene of an emergency incident due to the mixture of public fire, EMS and private EMS systems.

- Recognize that it is safer to transport a patient from a well-lit, specially designed helipad than it is from an accident scene. EMS must be aware of the potential danger presented by poor lighting and potential scene hazards such as electrical wires or fire. Limit helicopter scene loading to the few cases where it is essential.
- Patient transportation via ground ambulance will not be delayed to wait for helicopter transportation. If the patient is packaged and ready for transport and the helicopter is not on the ground, or within a reasonable distance, the transportation will be initiated by ground ambulance.
- Time estimation should be made from the time the patient is ready for transport to arrival at the medical facility / the most appropriate trauma center. This should include aircraft response to the scene.
- The helicopter crew shall use their best judgment, at the suggestion of On-Line Medical Direction, and / or prior guidelines agreed to with Off-Line Medical Direction to determine the destination hospital.
- EMS should request aeromedical transport of the patient to the closest most appropriate hospital, based upon location, patient or family request, and the capabilities of the hospitals (i.e.: Trauma Center, OB Unit, etc.).

AEROMEDICAL LANDING ZONE (LZ) SET UP PROCEDURE

1. LZ area should be free of obstructions. Eliminate these hazards:
   - Wires (surrounding the landing area and High Tension power lines within 1/2 mile)
   - Towers (TV, Radio, Cellular within 1/2 mile)
   - Trees
   - Signs and Poles
   - Buildings
   - Vehicles
   - People

2. LZ area should be 100' X 100' if possible.
3. LZ should have as little of a slope as possible (less than 5 degrees).
4. LZ area should be a hard surface (concrete, asphalt, gravel, lawns, etc.).
5. LZ corners should be marked with highly visible devices (cones, flairs, strobes).
6. No debris on landing surface and within 100' of landing area.
7. Land the helicopter(s) a safe distance from the scene / patient.
8. Never point bright lights directly at the aircraft!
9. Maintain security of LZ while helicopter is present.
10. Landing Zone Briefing.
11. Type of LZ surface and size
12. How LZ is marked (cones, flairs, strobes, etc.).
13. All noted obstructions (see list above).

NEVER ASSUME A FLIGHT CREW WILL SEE A HAZARD
NEVER APPROACH A HELICOPTER UNLESS DIRECTED BY FLIGHT CREW

University Medevac 1-877-842-3822
MEDICAL CONTROL / PROCEDURES

BED BUGS

PURPOSE:
To provide personal protection recommendations to EMS providers who are presented with a patient in a known or suspected bed bug infestation.

PROCEDURE:
- Take universal precautions.
- Take only needed equipment into the area of infestation to minimize exposure.
- Seal equipment in plastic bags when necessary to prevent exposure.
- Avoid sitting on beds or furniture. If you have to sit, do so on a hard surface.
- If you feel you have been infested, shower and seal clothes in a plastic bag.
- Place potentially exposed clothing in a hot dryer for 10 minutes to kill the bugs.
- Footies, caps, and gloves should be worn if available during care.
- Remove these items before entering the vehicle and place in a plastic bag.
- Dispose of trash bags containing used PPE equipment in sealed containers.
- Keep patients wrapped during transport as much as possible to prevent transfer of bed bugs to the ambulance, or locations other than the hospital room the patient is put into.
- Clean and disinfect the vehicle as soon as possible.
- Notify the receiving facility as soon as possible regarding potential for bed bug exposure.

![Life Cycle of the Bed Bug](image.png)
GENERAL CONSIDERATIONS

1. Treat the ABC’s first. Treat the child, not the equipment. If the emergency is due to an equipment malfunction, manage the child appropriately using your own equipment.

2. Children formerly cared for in hospitals or chronic care facilities are often cared for in homes by parents or other caretakers. These children may have self-limiting or chronic diseases. There are multitudes of underlying medical conditions that may categorize children as having special needs. Many are often unstable and may frequently involve the EMS system for evaluation, stabilization, and transport. Special needs children include technology-assisted children such as those with tracheostomy tubes with or without assisted ventilation, children with gastrostomy tubes, and children with indwelling central lines. The most serious complications are related to tracheostomy problems.

3. Children with Special Healthcare Needs (CSHCN) have many allergies. Children with spina bifida are often allergic to latex. Before treating a patient, ask the caregivers if the children are allergic to latex or have any other allergies. Stock latex-free equipment. (Some regularly used equipment that contains latex includes gloves, oxygen masks, IV tubing BVM, blood pressure cuff, IV catheters, etc.)

4. Knowing which children in a given area have special needs and keeping a logbook is encouraged.

5. Parents and caretakers are usually trained in emergency management and can be of assistance to EMS personnel. Listen carefully to the caregiver and follow his/her guidance regarding the child’s treatment.

6. Children with chronic illnesses often have different physical development from well children. Therefore, their baseline vital signs may differ from normal standards. The size and developmental level may be different from age-based norms and length based tapes used to calculate drug dosages. Ask the caregiver if the child normally has abnormal vital signs. (i.e. a fast heart rate or a low pulse oximeter reading)

7. Some CSHCN may have sensory deficits (i.e. they may be hearing impaired or blind) yet may have age-appropriate cognitive abilities. Follow the caregivers’ lead in talking to and comforting a child during treatment and transport. Do not assume that a CSHCN is developmentally delayed.

8. When moving a special needs child, a slow careful transfer with two or more people is preferable. Do not try to straighten or unnecessarily manipulate contracted extremities as it may cause injury or pain to the child. Certain medical conditions will require special care. Again, consult the child’s caregiver.

9. Caregivers of CSHCN often carry “go bags” or diaper bags that contain supplies to use with the child’s medical technologies and additional equipment such as extra tracheostomy tubes, adapters for feeding tubes, suction catheters, etc. Before leaving the scene, ask the caregivers if they have a “go bag” and carry it with you.

10. Caregivers may also carry a brief medical information form or card. The child may be enrolled in a medical alert program whereby emergency personnel can get quick access to the child’s medical history. Ask the caregivers if they have an emergency information form or some other form of medical information for their child.

11. Caregivers of CSHCN often prefer that their child be transported to the hospital where the child is regularly followed or the “home” hospital. When making the decision as to where to transport a CSHCN, take into account: local protocols, the child’s condition, capabilities of the local hospital, caregivers’ request, ability to transport to certain locations.
• Child abuse is the physical and mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child’s welfare. The recognition of abuse and the proper reporting is a critical step to improving the safety of children and preventing child abuse.

PURPOSE
Assessment of a child abuse case based upon the following principles:
• Protect the life of the child from harm, as well as that of the EMS team from liability.
• Suspect that the child may be a victim of abuse, especially if the injury / illness is not consistent with the reported history.
• Respect the privacy of the child and family.
• Collect as much evidence as possible, especially information.

PROCEDURE
1. With all children, assess for and document psychological characteristics of abuse, including excessively passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, fussy behavior, hyperactivity, or other behavioral disorders.
2. With all children, assess for and document physical signs of abuse, including especially any injuries that are inconsistent with the reported mechanism of injury. The back, buttocks, genitals, and face are common sites for abusive injuries.
3. With all children, assess for and document 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). Law Enforcement must also be notified.
5. EMS should not accuse or challenge the suspected abuser. This is a legal requirement to report, not an accusation. In the event of a child fatality, law enforcement must also be notified.

KEY POINTS
• Child abuse / neglect are widespread enough that nearly all EMS providers will see these problems at some time. The first step in recognizing abuse or neglect is to accept that they exist and to learn the signs and symptoms.
• Initiate treatment as necessary for situation using established protocols.
• If possible remove child from scene, transporting to hospital even if there is no medical reason for transport.
• If parents refuse permission to transport, notify law enforcement for appropriate disposition. If patient is in immediate danger, let law enforcement handle scene.
• Advise parents to go to hospital. AVOID ACCUSATIONS as this may delay transport. Adult with child may not be the abuser.

RED FLAGS TO CHILD ABUSE:
The presence of a red flag does not necessarily mean maltreatment. The suspicion of maltreatment is also based upon the EMS provider’s observations and assessment.

Signs that parents may display may include (not all inclusive):
• Parent apathy
• Parent over reaction
• A story that changes or that is different when told by two different “witnesses”
• Story does not match the injury
• Injuries not appropriate for child’s age
• Unexplained injuries

Signs that the child may display may include (not all inclusive):
• Pattern burns (donuts, stocking, glove, etc.)
• Multiple bruises in various stages of healing
• Not age appropriate when approached by strangers
• Not age appropriate when approached by parent
• Blood in undergarments
While the possibility of finding a dangerous weapon on a scene has always existed, EMS personnel must be aware of current issues, which impose unique hazards upon them while performing their duties. These dangers present in many different ways, regardless of jurisdiction or call volume. Though not all accidents can be prevented, awareness must be made regarding the State of Ohio Concealed - Carry Laws.

Ohio's Concealed - Carry Law permits individuals to obtain a license to carry a concealed handgun in Ohio, including into private businesses if the licensee also carries a valid license and valid identification when carrying the concealed handgun. This law has been in effect since April 8th, 2004. Be aware that all patients may be carrying a dangerous weapon at all times, regardless of whether a permit has or has not been issued.

GUIDELINES

- Upon arrival at the scene, EMS personnel should directly ask patients if they are carrying a weapon prior to performing a physical assessment. If the patient is unable to answer, please proceed with caution.
- If a weapon is present on scene or with a patient, it is recommended that a Law Enforcement official be present to secure the weapon.
- The training of EMS personnel in the safe handling and use of firearms lock boxes in squads is a departmental and municipal decision.
- Caution is advised due to the many types of weapons and the handler’s ability to modify them.
- When transporting a patient to the hospital, please inform the receiving facility that a weapon has been found on the patient. This will allow enough time for Security to safely secure the weapon and maintain possession of it until Law Enforcement arrives.
MEDICAL CONTROL / PROCEDURES
CONSENT AND REFUSAL OF CARE GUIDELINES

PURPOSE
To provide:
- Rapid emergency EMS transport when needed.
- Protection of patients, EMS personnel, and citizens from undue risk when possible.
- Method to document patient refusal of care.

PROCEDURES - ADULT Consent:

Two types apply;
Express Consent, where a conscious, oriented (to person, place and time) competent adult (over 18 year old) gives the EMS provider permission to care for him. This may be in the form of a nod, verbal consent or gesture after the intended treatment has been explained.
Implied Consent occurs when a person is incapable of giving their permission for treatment due to being unconscious or incompetent. It is assumed that their permission would be given for any life saving treatments.

Refusal of Treatment:

Competent: A competent adult may refuse treatment even after calling for help. The person must be informed that they may suffer loss of life, limb or severe disability if they refuse care and transport, and sign a Release indicating that they understand this. If the patient refuses to sign, a witness at the scene, preferably a relative should sign. Documentation of the events must be clearly made. It also must be documented on the run sheet that the person is oriented to person place and time, and a set of vital signs should be obtained if at all possible. An offer to return and transport them at a later time should be made by EMS. Contact with Medical Control should be made if there is any question about the person’s competency. If the need for treatment is obvious, speaking directly to the Nurse or Physician may assist in convincing the patient to be transported.

For the purposes of this Protocol, Competent will be defined as – Lucid and capable of making an informed decision, alert to Person, Place, Time, and Event.

Incompetent: While an adult may refuse treatment, in some situations, their refusal may not be competent. In the following situations, the refusal of treatment may be incompetent:

- Patients showing altered mental status due to head trauma, drugs, alcohol, psychiatric illness, hypotension, hypoxia, or severe metabolic disturbances.
- Violent patients.
- Uncooperative minors.

PROCEDURES – MINORS consent

Consent to treat Minors:

Consent to treat Minors (under the age of 18 years in Ohio), must be obtained from the parent or guardian with two exceptions; there is need for life saving immediate treatment which should be given to the point of it being considered elective; or the Minor is emancipated; ie: married, living on their own, or in the armed forces and may give permission themselves.
Refusal of Treatment:

A minor might refuse to cooperate with the EMS crew, or the minor’s parent or guardian may refuse to consent to necessary treatment of the minor. A minor under the age of 18 years may not refuse treatment in Ohio. Transport should be initiated unless the parent or legal guardian refuse treatment on behalf of the minor. A circumstance may occasionally arise where the patient is a minor and there is no illness or injury, yet EMS has been called to the scene. If the responsible person is not able to be at the scene, it is acceptable for contact to be made by telephone. If care and transport is refused by the parent or guardian, TWO witnesses should verify this, and this shall be documented and signed by both witnesses on the run sheet. A request may be made that the person come to the fire station as soon as possible, to sign the release. A second circumstance may occur when the minor patient really needs to be transported and the parent or guardian is refusing transport. In this case, action must be taken in the minor’s best interest. This is described in the following section, incompetent refusal.

Incompetent Refusal:

- Parent / guardian refuses to give consent for treating their child when the child’s life or limb appears to be at risk.
- Parent / guardian refuses to give consent where child abuse is suspected.
- Suicidal patients – any age.

In all such cases, contact with Medical Control and a Physician is mandatory, as the patient may have a life-threatening problem and is in need of medical care. The involvement of the Police in these situations is often necessary and crucial. They may assist the EMS crew with transport as ordered by the On-line Physician. This is described in the Ohio Revised Code, Section 5122.10.

TRANSPORTATION

Destination Refusal:

There may be EMS calls where the EMS unit is unable to transport patient to their destination of choice. If the competent patient refuses this, and is in stable condition, a private ambulance may be called to take the patient. The responding EMS unit must stand by until the private EMS providers arrive and assume care of the patient.
This guideline shall be used when law enforcement personnel advise EMS that they have responded to a crime scene, or EMS determines that a crime scene may exist. The purpose is to ensure the protection of the patient welfare as well as to ensure the ability to conduct an effective and thorough investigation of the crime.

If a provider finds themselves on a known or suspected crime scene;

- Assure safety of all EMS providers
- Summon Law Enforcement if not already present
- Lead EMS provider may request entry of safe area to determine viability of patient
- Additional personnel must be with visual contact
- Summon additional resources to the patient side only as absolutely necessary
- Minimize scene disturbances
- Enter and exit on same path
- Do not go anywhere else on the scene except as necessary for patient care
- Wear gloves at all times
- Avoid pools of blood
- Minimize personnel to only those required for patient care
- Do not cut through knife/bullet holes in clothing
- Do not go through patients effects
- If patient is believed to be DOA, one provider to approach and attach cardiac monitor to confirm death
- If patient is believed to be viable, follow appropriate treatment protocol for situation, remove from crime scene as soon as possible and relay any information discovered to Police as soon as possible.

If refused access to patient, contact Medical Control
PURPOSE
EMS should not begin to resuscitate if any of the following criteria for death in the field are met for a patient who presents pulseless, apneic and with any one of the following:

- Injury incompatible with life (i.e. decapitated, gross innervation)
- Signs of decomposition, rigor mortis, extreme dependent lividity
- Cardiac arrest, secondary to massive blunt trauma without signs of exsanguination
- Adult: Unwitnessed cardiac arrest >20 minutes, history of absence of vital signs >20 minutes with asystole on the EKG, not secondary to hypothermia or cold water drowning.
- Ohio DNR Comfort Care order
- Other DNR as validated by on-line physician

PROCEDURE
In all cases, contact with Medical Control should be immediate and well documented. Obtaining an EKG of asystole in two leads may be possible in some cases. When the on-line physician states to do nothing, it should be documented as the pronouncement of death. Once this is done, the police should assume control of the scene, and EMS may go back into service.

 KEY POINTS

- If a bystander or first responder has initiated CPR or automated defibrillation prior to an EMS Paramedic’s arrival and any of the above criteria (signs of obvious death) are present, the Paramedic may discontinue CPR and ALS therapy. All other EMS personnel levels must communicate with medical control prior to discontinuation of the resuscitative efforts.
- If doubt exists, start resuscitation immediately. Once resuscitation is initiated, continue resuscitation efforts until either:
  - Resuscitation efforts meet the criteria for implementing the Termination of Resuscitative Efforts Protocol, if valid in the EMS jurisdiction.
  - Patient care responsibilities are transferred to the destination hospital staff.
  - When a Dead on Arrival (DOA) patient is encountered, the squad members should avoid disturbing the scene or the body as much as possible, unless it is necessary to do so in order to care for and assist other victims. Once it is determined that the victim is, in fact, dead the squad members should move as rapidly as possible to transfer responsibility or management of the scene to the Police Department of EMS should not pronounce enroute.
  - Pregnant patients estimated to be 20 weeks or later in gestation should have standard resuscitation initiated and rapid transport to a facility capable of providing an emergent c-section. Paramedics CANNOT perform a c-section even with Medical Control permission.
  - Victims of lightning strike, drowning, or a mechanism of injury that suggested non-traumatic cause for cardiac arrest should have standard resuscitation initiated.
  - If the patient is pronounced on scene, leave the ETT, IV, and other interventions in place.
• 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.
• Elder abuse is the physical and / or mental injury, sexual abuse, negligent treatment, or maltreatment of a senior citizen by another person. Abuse may be at the hand of a 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 well-being of senior citizens.

PURPOSE
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. The back, chest, abdomen, genitals, arms, legs, face, and scalp are common sites for abusive injuries. 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. Assess all patients for signs of sexual abuse, including torn, stained, or bloody underclothing, unexplained injuries, pregnancy, or sexually transmitted diseases.
5. Immediately report any suspicious findings to the receiving hospital (if transported). If an elder or disabled adult is involved, also contact the Department of Social Services (DSS). After office hours, the adult social services worker on call can be contacted by the 911 communications center.

KEY POINTS
SEXUAL ASSAULT:
• A victim of a sexual assault has experience an emotionally traumatic event. It is imperative to be compassionate and non-judgmental. Be sensitive to the victim. Expect a wide range of response to such an assault, depending upon social, cultural, and religious background.
• An abbreviated assessment may be indicated based on the patient’s mental state.
• Your responsibility is patient care and not detective work. Questioning of the patient should be limited, because there is no need for the EMS provider to attempt to get a detailed description of the assault. That type of questioning by EMS can harm the investigation, and should be left up to professional investigators. However, carefully document verbatim anything the patient says about the attack. DO NOT paraphrase. Based upon the patient’s mental state, the following questions may be asked and documented: (Do not persist with questions.)
  ➢ What happened? (A brief description is acceptable)
  ➢ When did the attack occur?
  ➢ Did the patient bathe or clean up after the attack?
• If the patient changed his / her clothes, attempt to bring the clothes in a brown paper bag. DO NOT use a plastic bag.
• If the patient did not change his / her clothes, have the patient bring a change of clothes to the hospital (if possible).
• Transport the patient to an appropriate medical facility. Some hospitals are capable of providing additional sexual assault care (SANE Program).
What does HIPAA stand for?
- The Health Insurance Portability and Accountability Act. Enacted in 1996, this federal law regulates health insurance and insurance benefit programs.

What is HIPAA’s privacy rule?
- The privacy rule is a set of laws created to protect the privacy of a patient’s health information, including medical records.

Why was HIPAA created?
- Before this rule was created, it was possible for patient information to be easily accessible without the patient’s authorization and for reasons that had nothing to do with medical treatment. For example, a patient’s medical information might be passed to a bank or lender, who might deny or approve a loan requested by the patient.

Who has to follow the rule?
- The privacy rule directly relates to healthcare providers (such as ambulance services, hospitals, physicians, and home health agencies), health plans and insurance companies, and healthcare clearing houses (such as companies that bill for healthcare services).

What if you don’t comply?
- The penalty for one violation is $100, with a limit of $25,000 per year for any single organization that fails to comply with multiple requirements. The authority to impose penalties is carried out by the Department of Health and Human Services. In cases involving grossly flagrant and intentional misuse of patient information, violators may be socked with criminal penalties up to $250,000, ten years in jail, or both - depending on the circumstances.

What should I do at the scene?
- Exercise confidentiality on the scene by:
  - Not sharing information with bystanders.
  - Limiting radio transmissions that identify patients.
  - Avoid disclosure of unnecessary information to police (appropriate info includes patient’s name, DOB, and destination hospital.)
  - Protecting patient’s privacy whenever possible.
  - Don’t volunteer patient medical information with people at the scene.

Hospital Contact and EMS
The relationship of the hospital and EMS are not really affected by HIPAA. The process of Performance Improvement is an important element of patient care that is worked on at each department under Medical Control and then the issues are addressed by the Medical Director during Run Reviews at each station. Information about the patient may be given to the Emergency Department by radio, phone, fax, or electronically. The information is needed for treatment of the patient and becomes part of the medical record.

Following the privacy policy along with common sense regarding your patient’s right will assure that no HIPAA rules are violated.
MEDICAL CONTROL / PROCEDURES

NEWBORN ABANDONMENT

Ohio law provides that a parent may drop off a newborn baby within the first 30 Days after birth at any law enforcement agency, hospital, or emergency medical service. Should this occur, the first priority is to care for the infant’s health and safety. Notification should then be made to the Public Children’s Services agency for that county. If possible, obtain any medical information that may be available. If it appears that the infant has suffered any type of physical harm, attempts should be made to detain the person who delivered the child.

PURPOSE

To provide:

- Protection to infants that are placed into the custody of EMS under this law
- Protection to EMS systems and personnel when confronted with this issue

PROCEDURE

1. Initiate the Pediatric Assessment Procedure.
2. Initiate other treatment protocols as appropriate.
4. Contact Medical Control as soon as infant is stabilized.
5. Transport infant to medical facility as per local protocol.
6. Assure infant is secured in appropriate child restraint device for transport.
7. Document protocols, procedures, and agency notifications.
MEDICAL CONTROL / PROCEDURES

OBESE PATIENTS

All individuals served by the EMS system will be evaluated, furnished transportation (if indicated) in the most timely and appropriate manner for each individual situation.

PURPOSE
To provide:

- Rapid emergency EMS transport when needed.
- Appropriate medical stabilization and treatment at the scene when necessary.
- Protection of patients, EMS personnel, and citizens from undue risk when possible.

PROCEDURE
1. Each situation may dictate its own procedure for the transport of morbidly obese patients.
2. It is the responsibility of EMS personnel at the scene to provide the most appropriate medical care, including the protection of the patient, EMS personnel, and bystanders, while transporting morbidly obese patients.
3. Utilization of additional resources may be required, at the discretion of the on-scene EMS personnel.

KEY POINTS
In any community there may be one or more individuals who fall into this extreme. As patients, these individuals are frequently classed as high risk because of the increased medical complications associated with their excess weight. In the EMS system they present the additional problem of movement and transportation. These individuals have the right to expect prompt and expert emergency medical care. Therefore, in order to facilitate the care of these individuals without risking the health of EMS workers, the following protocol is established.

- In managing a patient with weight over 300 lbs., at no time should the patient be moved without at least sufficient manpower to assist.
- At the scene, as many EMS personnel as can be mobilized may be supplemented by police or other safety personnel as appropriate. If sufficient manpower is not available, mutual aid may be required.
- It may be necessary to remove doors, walls or windows. The situation is no different than extrication from a vehicle, although property damage may be higher. At all times the patient's life must be the first priority.
- The patient is to be placed on at least 2 (double) backboards or other adequate transfer device for support.
- The patient is to be loaded on a cot that is in the down position, and the cot is to be kept in the down position at all times. Be aware of the cot weight limitations.
- It is necessary to notify the hospital well in advance of arrival so that preparations can be completed in a timely fashion.
- If individuals in the community are known to fall within this special category it is appropriate to inform them in advance of the type of assistance they can expect from the EMS system, and help them make plans well in advance to assist you.
- When calling for the squad, and if they identify themselves and their special needs, it will promote the timeliness of your efforts.
The medical direction of prehospital care at the scene of an emergency is the responsibility of those most appropriately trained in providing such care.

**PURPOSE**
- To identify a chain of command to allow field personnel to adequately care for the patient
- To assure the patient receives the maximum benefit from prehospital care
- To minimize the liability of the EMS system as well as the on-scene Physician

**PROCEDURE**
1. When a non-Medical Control Physician offers assistance to EMS or the patient is being attended by a Physician with whom they do not have an ongoing patient relationship, EMS personnel must review the On-Scene Physician form with the Physician. All requisite documentation must be verified and the Physician must be approved by on-line Medical Control.

2. When the patient is being attended by a Physician with whom they have an ongoing patient relationship, EMS personnel may follow orders given by the Physician if the orders conform to current EMS guidelines, and if the Physician signs the PCR. Notify Medical Control at the earliest opportunity. Any deviation from local EMS protocols requires the Physician to accompany the patient to the hospital.

3. EMS personnel may accept orders from the patient’s Physician over the phone with the approval of Medical Control. The Paramedic should obtain the specific order and the Physician’s phone number for relay to Medical Control so that Medical Control can discuss any concerns with the Physician directly.

**EMT / Nurse / Healthcare - Intervener:**
On an EMS run where an unknown EMT / Nurse / Healthcare - Intervener from outside the responding EMS agency wishes to intervene in the care of patients, the following steps should be initiated:

- Ideally, if no further assistance is needed, the offer should be declined.
- If the intervenor’s assistance is needed or may contribute to the care of the patient:
  - An attempt should be made to obtain proper identification of a valid license / certification. Notation of intervenor name, address and certification numbers must be documented on the run report.
  - Medical Control should be contacted and permission given.

**On - Scene Physician:**
This is a Physician with no previous relationship to the patient, who is not the patient’s private Physician, but is offering assistance in caring for the patient. The following criteria must be met for this Physician to assume any responsibility for the care of the patient:

- Ideally, if no further assistance is needed, offer should be declined.
- Medical Control must be informed and give approval. Encourage Physician to Physician contact.
- The physician must have proof they are a Physician. They should be able to show you their medical license. Notation of Physician name, address and licence numbers must be documented on the run report.
- The Physician should have expertise in the medical field for which the patient is being treated.
- The Physician must be willing to assume responsibility for the patient until relieved by another Physician, usually at the Emergency Department.
- The Physician must not require the EMT to perform any procedures or institute any treatment that would vary from protocol and / or procedure.
- If the Physician is not willing or able to comply with all the above requirements, his / her assistance must be declined.

**On - Scene Personal Care Physician:**
This is a Physician with a current relationship to the patient, who is offering assistance in caring for the patient. The following criteria must be met for this Physician to assume further responsibility for the care of the patient:

- EMS should perform its duties as usual under the supervision of Medical Control or by protocol.
- Physician to ED Physician contact is optimal.
- The Physician may elect to treat the patient in his office.
- EMS should not provide any treatment under the Physician’s direction that varies from protocol. If asked, EMS should decline until contact is made with Medical Control.
- Once the patient has been transferred into the squad, the patient’s care comes under Medical Control.
PURPOSE:

Provide treatment / transport guidelines for on scene providers when faced with incidents involving school buses

PROCEDURE:

- Check with the school district regarding their specific school bus response polices
- School administrators are responsible for the students; a school administrator should be requested to the scene as soon as possible.
- Administrators may take the children back to the school in another bus or school vehicle; they may arrange for transportation back to the home or have the student parents pick them up at school.
- Children should be cleared from the scene as safely and as quickly as possible.
- ANY injury should be transported to the nearest most appropriate emergency department and the parents notified.
- EMS responders must be prepared to enact mass casualty protocols in the event of any serious school bus accident.
- If school administrators accept responsibility for the non-injured children as per their bus accident protocols / policies, then individual releases are not required.
- If for whatever reason there is no school administrator on scene, EMS providers must take responsibility for all children until school administrators arrive.
- If there will be a significant delay in the arrival of school administrators, and the accident is minor, the bus should be directed to return to the school or to a safe area out of traffic.
- Notification of the number and types of injuries should be communicated with the receiving facilities in the event of transportation of injured students to the receiving facilities as early as possible.
MEDICAL CONTROL / PROCEDURES

TERMINATION OF RESUSCITATIVE EFFORTS

PURPOSE
The purpose of this policy is to:

- Allow for discontinuation of prehospital resuscitation after delivery of adequate and appropriate ALS therapy.

EACH PATIENT SHOULD BE EVALUATED ON A CASE-BY-CASE BASIS

INDICATIONS

When a patient that is in cardiac arrest has failed to respond to Advanced Life Support, it may be decided to terminate the effort and not transport the patient to the hospital. When the paramedic determines that this option is appropriate, the following criteria must be met:

1. The victim is 18 years or older.
2. Must be an unwitnessed arrest.
3. The victim must be in asystole in two leads and have the absence of a pulse confirmed.
4. The victim must not be in arrest due to hypothermia, or apparent drug overdose.
5. The victim must have a properly placed advanced airway.
6. The patient must have a patent IV / IO access.
7. At least two rounds of ACLS drugs have been administered.
8. At least 20 minutes of resuscitation has been performed.
9. Capnography must be below 10 where available.
10. Medical control must be contacted - the physician must speak directly with the paramedic. Then the physician and paramedic must agree on the termination of efforts. The physician must give consent for the resuscitation effort to cease.

Do not remove endotracheal tubes, IV’S, etc.
Ohio law provides for the welfare and protection of EMS and other Emergency Care Workers (ECW) in two separate sections of the Ohio Revised Code:

- If there has been either an Airborne or Bloodborne exposure to the ECW, every hospital must have a policy to follow-up appropriately. This may include testing of the patient source and the ECW. **It is important to report the exposure so the patient source can be tested at the facility where the patient has been transported.**

- The second section establishes the obligation of the hospital, once a patient has been diagnosed with a communicable disease, to find out if there was any exposure during transport of the patient.

All possible exposures must be documented both at the hospital and at the place of employment. Various forms must be completed.

**STANDARD PRECAUTIONS**

Emergency Care Workers are to consider **ALL** patients as potentially infected with a communicable disease and are to adhere **RIGOROUSLY** to Infection Control precautions for minimizing the risk of exposure to blood and body fluids of **ALL** patients.

**Guidelines:**
1. Wear gloves **ALWAYS.**
2. **ALWAYS** Wear gloves, mask, and goggles when performing Airway Maneuvers such as Bagging, King Insertion, Intubation, and Suctioning.
3. Wear apron, jumpsuit or other coverall when exposed to large amounts of blood or body fluids.
4. For **Airborne Communicable Diseases,** care must be taken to wear the proper mask, ventilate the squad, and limit exposure of EMS personnel as much as possible. If a patient has fever, cough or rash, a mask is a good idea.
5. Maintain good handwashing practices after removing gloves.
6. Obtain Hepatitis B Vaccination and other testing and vaccines as recommended.
7. Handle "Sharps" carefully - dispose of properly.
8. Wear personal protective gear when **CLEANING** contaminated equipment.
9. Dispose of contaminated waste, equipment and clothing carefully and properly

**Report EXPOSURES immediately and at location of patient transport.**
**Document and follow up properly.**

**Download Exposure control Policy and Exposure forms at UHEMS.org**
Ohio Senate Bill 58 became Law in September 2010.

The Law includes provisions for EMS providers to withdraw blood for the purpose of evidence collection in cases involving allegations of operating watercraft or vehicles under the influence.

The language of the bill states that drawing blood “may” not “shall” be done for evidence collection “in the course of” providing emergency medical treatment.

- You CANNOT be dispatched or called by the police for the sole purpose of performing phlebotomy when the person does not require emergency medical treatment.
- The Medic/AEMT in charge can refuse law enforcement’s request to draw the blood if doing so would interfere with lifesaving patient care or outcome.
- The patient must consent to the collection of blood for evidence purposes. (If unconscious, Implied Consent applies)
- The Police Officer making the request must be present at all times during the draw and must provide the Medic/AEMT with the evidence collection kit.
- EMS Providers MUST use the evidence kit provided by law enforcement to obtain the blood samples for evidence.
MEDICAL CONTROL / ADMINISTRATION

DEPARTMENT SUPPLIED PATIENT CARE EQUIPMENT

PURPOSE

- To allow equipment supplied by individual EMS departments, but not specifically referenced in EMS protocol to be used for the benefit of patient care.
- Define the process of Medical Director review and approval of EMS Department supplied patient care equipment
- Define where and who is responsible for the Operating Procedures for EMS department supplied patient care devices.

POLICY

It is understood that EMS departments may have particular equipment that is not necessarily referenced in this EMS protocol. For these items to be used within the scope of University Hospitals EMS Medical Direction and as an adjunct to these EMS protocols the following must occur;

1. The device must be approved by the Medical Director in writing.
2. The Department must develop, implement, and periodically review operating procedures for the device. These will become the protocol for the use of the particular referenced device. The operating procedure must include indications, contra-indications, instructions for use, approved levels of EMS certification, signs and symptoms, key points, outline training requirements, and define maintenance (if applicable). The operating procedures must be approved and signed by the Medical Director.
3. The Department must be willing to incur all costs associated with operating said device, including disposable items.
4. The Department must provide training on the device to all department members expected to use the device under the direction and approval of the Medical Director
5. The Department must be willing to share performance data on the device with the University Hospitals EMS Medical Direction, including Patient Care Reports, within the scope of HIPAA.
6. The Department must report adverse patient outcomes that may be attributed to the patient care device as soon as identified.
7. The Department must agree to discontinue use of the device on the instruction of the Medical Director.
The exchange of drugs use by the EMS services under the Medical Control is done using a drug box system. These drug boxes are stocked and inventoried by the Pharmacy Departments at each of the Health Systems Medical Centers. An explanation and Procedure for the exchange of drugs / drug boxes is as follows:

- The Pharmacy will stock, inventory and seal the drug box with the appropriate drugs and amounts needed as per the Pre-Hospital Protocol.
  
  Note: All drug boxes are numbered and have a sticker on them indicating the date filled and the earliest expiration date of the drugs in the box.

- The Box is sealed by the Pharmacy Department with a numbered Green zip tie tag. This Green zip tie tag indicates that the box is fully stocked and ready for use.

- Once the Green tag is broken and drugs are used in the treatment of a patient, the EMS Provider that is responsible for the care of the patient must follow the following procedure:

  - Fill out an account of the drugs used on the drug inventory sheet that can be found inside the box. This sheet should be filled out completely.
  
  - For Controlled substances a separate inventory form found inside the box must be filled out completely. The amounts of the drugs used and wasted must be signed for and witnessed as per the information found on the sheet.
  
  - The EMS Services official Patient Care Report (if using ePCR, your ePCR is the official PCR) Will be completed, and signed (in wet ink) by all Providers that were present on the run and placed inside the box with the completed inventory sheets.
  
  - If controlled substances were used the box is to be sealed with a numbered Red zip line tag found inside the drug box and exchanged for a new drug box immediately as the box is out of service.

  - If no controlled substances were used and the box still has an adequate supply of drugs (enough of a supply to properly treat another patient per the protocol). The EMS Provider has the option to seal the drug box with a numbered Yellow zip tie tag found inside the box.

- The Yellow zip tag indicates that non controlled drugs were used from the box. The box is still in service and ready to treat any patient to the fullest extent of the protocol.

- All signed run sheets and inventory sheets from the previous patient must be in the Yellow zip tie tag sealed box.

- Any box that is being turned into pharmacy for exchange must be sealed and have all appropriate paperwork inside.

- All drug boxes should be exchanges at the University Hospital Medical Center Pharmacy from which it was originally stocked, inventoried, and sealed.

- If a drug box is missing, or suspected stolen from your EMS Service you must immediately notify the Director of the EMS Training and Disaster Preparedness Institute. This should be done via email to establish a time line for your services reporting of the situation. The email that should be used is Daniel.Ellenberger@uhhospitals.org, and carbon copied to Dominic.Silvestro@uhhospitals.org and Donald.Barnes@uhhospitals.org.

- If any drug is found to be missing from any drug box you must immediately notify the Director of the EMS Training and Disaster Preparedness Institute. This should be done via email to establish a time line for your services reporting of the situation. The email that should be used is Daniel.Ellenberger@uhhospitals.org and carbon copied to EMS Coordinators Dominic.Silvestro@uhhospitals.org and Donald.Barnes@uhhospitals.org.
EMS Providers might be called upon to transport patients from one healthcare facility to another healthcare facility or a non-healthcare facility to another non-healthcare facility or a combination thereof.

Procedure
- The provider(s) will follow the written or pre-existing orders of the transferring physician unless acting as the agent of the receiving facility with superseding medical control, or if a physician accompanies the patient. Regardless of origin or destination, patients remain the responsibility of the transferring physician until received by the accepting physician or his/her agent.
- The decision regarding the level and scope of practice of the transporting agency and the individual providers should be made in consultation with the receiving physician and must be appropriate to the stability of the patient and their medical and equipment needs.
- The transfer papers and accompanying record must document the reason for the transfer as well as the time of contact and name of the receiving facility, physician, and/or accepting agent in accordance with nationally recognized standards and federal regulations.
- If unanticipated problems arise during transport, direct, on line medical control will be obtained. If for technical or logistical reasons this is not possible, the transporting agent should follow written protocols or standing orders until the transferring, receiving, or nearest diversionary facility can be contacted on-line.
- Any questions or concerns regarding orders, including but not limited to Do Not Resuscitate orders, medication, or treatments must be answered or clarified prior to departure.
## APPENDIX #4: ODPS EMS SCOPE OF PRACTICE

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Scope of Practice
Approved by
State Board of Emergency Medical, Fire and Transportation Services
Division of EMS, Ohio Department of Public Safety

This document offers an “at-a-glance” view of the Scope of Practice for Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics as approved by the State Board of Emergency Medical, Fire and Transportation Services (EMFTS Board). The authorized services can be found in sections 4765.35 (FR/EMR), 4765.37 (EMT-B/EMT), 4765.38 (EMT-I/AEMT), and 4765.39 (EMT-P/Paramedic) of the Revised Code. The scopes of practice can be found in rules 4765-12-04 (EMR), 4765-15-04 (EMT), 4765-16-04 (AEMT), and 4765-17-03 (Paramedic) of the Administrative Code.

Performance of services outlined in this document and in the aforementioned code sections, shall only be performed if the EMR, EMT, AEMT, and Paramedic have received training as part of an initial certification course or through subsequent training approved by the EMFTS Board. If specific training has not been specified by the EMFTS Board, the EMR, EMT, AEMT, and Paramedic must have received training regarding such services approved by the local medical director before performing those services.

In accordance with rule 4765-10-06 of the Administrative Code, the individual medical director of each EMS agency may limit or ask that providers obtain medical control approval for certain treatments. Each community may need to tailor and revise the protocol to fit their region and individual practice, but must ensure that they remain within the approved scope of practice. EMS medical directors are reminded that they are not permitted to expand the scope of practice for EMS providers, but may provide clarifications or limitations on services that are permitted.

EMS medical directors and EMS providers are strongly encouraged to review the EMFTS Board’s policy statement “Regarding EMS Provider Pre-Hospital transport of Patients with Pre-Existing Medical Devices or Drug Administrations” dated October 2013 (attached to this document, page 6). This statement clarifies how EMS providers, in the prehospital setting, should deal with medical devices and medicine administrations that are outside their scope of practice.

Pursuant to rule 4765-6-04 of the Administrative Code, the EMFTS Board may allow EMRs, EMTs, AEMTs, and Paramedics to perform services beyond their respective scopes of practices as part of a board-approved research study. An entity must submit a research proposal to the EMFTS Board in accordance with the requirements of rule 4765-6-04 of the Administrative Code. The EMFTS Board is not obligated to approve the proposed research study nor accept any recommendation to permanently amend the scope of practice.

Updated 11/19/03; 5/17/05; 10/26/05; 10/17/07; 3/8/12; 8/22/13, 10/16/13, 12/18/13, 4/16/2014, 10/19/16
## Airway Management

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### Cardiac Management

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<td>Administration of cardiac medication</td>
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<td>13</td>
<td>12-lead EKG set up and application for electronic transmission §</td>
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§ An EMT or AEMT may set up and apply a 12-lead electrocardiogram when assisting a Paramedic or for the purposes of electronic transmission if all of the following conditions are met: 1) performed in accordance with written protocol; 2) EMT or AEMT shall not interpret the electrocardiogram; 3) delay in patient transport is minimized; and 4) EKG is used in conjunction with destination protocols approved by the local medical director.

### Medical Management

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<td>7</td>
<td>Sublingual nitroglycerin administration (non-patient assisted)</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>8</td>
<td>Aerosolized or nebulized medications administration (patient assisted) §</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td>Administration of aerosolized or nebulized medications (non-patient assisted)</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>Naloxone administration via auto-injector</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>11</td>
<td>Naloxone administration via ETT, IM, IV, IO, or SQ routes</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>12</td>
<td>Naloxone administration via intranasal route</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>13</td>
<td>Medication administration (protocol-approved) §</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

§ An EMT or AEMT may set up and apply a 12-lead electrocardiogram when assisting a Paramedic or for the purposes of electronic transmission if all of the following conditions are met: 1) performed in accordance with written protocol; 2) EMT or AEMT shall not interpret the electrocardiogram; 3) delay in patient transport is minimized; and 4) EKG is used in conjunction with destination protocols approved by the local medical director.
<table>
<thead>
<tr>
<th></th>
<th>Administration of intranasal medications (in addition to naloxone)</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>16</td>
<td>Immunizations for influenza to firefighters or EMS providers (ORC 4765.391)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Set up of IV administration kit in the presence of an AEMT or Paramedic</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>18</td>
<td>Transport of central/peripheral IV without an infusion to sub-acute care facilities, scheduled events, or home</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>19</td>
<td>IV access and peripheral initiation (including saline locks)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>IV maintenance and fluid administration</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Maintenance of medicated IV fluids</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>22</td>
<td>Central line monitoring</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>23</td>
<td>IV infusion pump</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>24</td>
<td>Intranasosseous needle insertion</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Peripheral IV blood specimens</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Maintenance of blood administration</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>27</td>
<td>Thrombolytic therapy initiation and monitoring</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient Assisted Definition:** May assist with 1) patient’s prescription upon patient request and with written protocol - OR – 2) EMS-provided medications with verbal medical direction.

**See “AEMT Medications Approved by the EMFTS Board.”**

### Trauma Management

<table>
<thead>
<tr>
<th></th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PASG</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>Long spine board</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>Short spine board</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>Splinting devices</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5</td>
<td>Traction splint</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>6</td>
<td>Cervical immobilization device (CID)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>Helmet removal</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>8</td>
<td>Rapid extrication procedures</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>9</td>
<td>Needle decompression of the chest</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>Soft tissue management</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>11</td>
<td>Management of suspected fractures</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>12</td>
<td>Controlling of hemorrhage</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

### Basic Performances

<table>
<thead>
<tr>
<th></th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Body substance isolation precaution/administration</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>Taking and recording of vital signs</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>Patient Care Report (PCR) documentation</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td>Trauma triage determination per OAC 4765-14-02</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

### Additional Services

<table>
<thead>
<tr>
<th></th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Emergency childbirth management</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>Glucose monitoring system use (with Clinical Laboratory Improvement Amendments (CLIA) waiver in place)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>Blood chemistry analysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4</td>
<td>Eye irrigation</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5</td>
<td>Eye irrigation with Morgan lens</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Maintenance of blood administration</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>Thrombolytic therapy initiation and monitoring</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\[\text{An EMR may only assist with emergency childbirth management.}\]

<table>
<thead>
<tr>
<th>Emergency Medical Services in Hospital</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>An EMS provider may perform emergency medical services in the hospital emergency department (ED) or while moving a patient between the ED and another part of the hospital. The EMS provider shall be under physician medical direction and has received appropriate training. (ORC 4765.36)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Services in a Declared Emergency</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the event of an emergency declared by the governor that affects the public’s health, an EMS provider may perform immunizations and administer drugs or dangerous drugs, in relation to the emergency, provided the EMS provider is under physician medical direction and has received appropriate training regarding the administration of such immunizations and/or drugs. (OAC 4765-6-03)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nerve Agent or Organophosphate Release</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>An EMS provider may administer drugs or dangerous drugs contained within a nerve agent antidote auto-injector kit, including a MARK I® kit, in response to suspected or known exposure to a nerve or organophosphate agent provided the EMS provider is under physician medical direction and has received appropriate training regarding the administration of such drugs within the nerve agent antidote auto-injector kit. (OAC 4765-6-05)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**AEMT Medication Administration Approved by the EMFTS Board**

*A certified AEMT may administer medications from the following list, provided the AEMT is under physician medical direction and has received appropriate training regarding the administration of such medications. A medication that does not appear on the following list SHALL NOT be added to the department’s AEMT protocol.*

<table>
<thead>
<tr>
<th>Medication Category</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td>Nalbuphine</td>
</tr>
<tr>
<td>Bronchodilators</td>
<td>Naloxone</td>
</tr>
<tr>
<td>Dextrose in water</td>
<td>Narcotics or other analgesics for pain relief</td>
</tr>
<tr>
<td>Diphenhydramine</td>
<td>Nitrous oxide</td>
</tr>
<tr>
<td>Epinephrine 1:1,000 (subcutaneous or intramuscular)</td>
<td>Oral ondansetron(^{\text{a}})</td>
</tr>
<tr>
<td>Glucagon</td>
<td>Sublingual nitroglycerin</td>
</tr>
<tr>
<td>Lidocaine for pain relief after intraosseous needle insertions</td>
<td></td>
</tr>
</tbody>
</table>

\(^{\text{a}}\)A certified AEMT may administer oral ondansetron to patients are the age of 18 years and older. For patients from the age of 12 years to 17 years who weigh greater than or equal to 40 kg, the maximum dose of ondansetron that can be administered is 4 mg. The administration of ondansetron is not permitted for patients of the age of 12 years to 17 years who weigh less than 40 kg nor is its administration permitted for all patients under the age of 12 years.

*The approved route of administration of any specific medication is stated in the respective EMT, AEMT, and Paramedic curriculum. The EMS provider shall administer medications only via the route addressed in each respective curriculum and consistent with their level of training.*
The Ohio Board of Emergency Medical, Fire, and Transportation Services (“EMFTS Board”) issues the following statement:

Regarding EMS Provider Pre-Hospital Transport of Patients with Pre-Existing Medical Devices or Drug Administrations
October 2013

This statement is an attempt to provide general information about the above issue facing EMS providers. It should not be treated as legal advice or medical direction. For direct advice regarding a particular scenario, please consult with your medical director and legal counsel. Although the following statement represents the EMS Board’s general position on the above issue, this statement in no way precludes the EMFTS Board from taking disciplinary action in a particular case if necessary. Any potential complaints brought before the EMFTS Board will be decided on a case-by-case basis.

Introduction:
The EMFTS Board and the Ohio Department of Public Safety, Division of Emergency Medical Services, has developed a defined scope of practice for EMS providers. It is maintained in matrix form and available online as a reference for public access. This scope of practice addresses all levels of EMS providers and has been approved by the EMFTS Board. Updates to the scope of practice are made as necessary and after approval by the EMFTS Board.

From time to time, EMS providers are confronted on-scene with patients with preexisting medical situations not included or addressed in their respective EMFTS Board approved scope of practice. Specifically, patients with pre-existing medical devices and drug administrations requiring prehospital EMS service are becoming more commonplace. The intent of this position paper is to address the EMS provider’s approach to that prehospital patient with a pre-existing physician-ordered medical device or drug administration (“MDDA”) not covered in the provider’s scope of practice.

Discussion:
In general, the EMS provider should maintain the pre-existing MDDA and transport the patient to the appropriate facility. There is no expectation that the EMS provider will initiate, adjust, or discontinue the pre-existing MDDA. This implies that the EMS provider will maintain and continue care so that the patient can be transported.

The EMS provider is expected to follow local protocols regarding the overall evaluation, treatment, and transportation of this type of prehospital patient requiring EMS service. It applies to EMS provider situations where alternative transportation and care is not available or practical (prehospital or “911 scene response”). It implies that the most appropriate and available level of EMS provider will respond to the request for prehospital EMS service. It also implies that the patient requires the pre-existing MDDA and it is not feasible or appropriate to transport the patient without the pre-existing MDDA.

The number and type of pre-existing MDDAs currently or potentially encountered by the EMS provider in the community setting is extensive and may change frequently. The intent of this position paper is not to provide an inclusive list of pre-existing MDDAs. However, as a guideline for the EMS provider, current pre-existing MDDAs may include ventilatory adjuncts (CPAP, BiPAP), continuous or intermittent IV medication infusions (analgesics, antibiotics, chemotherapeutic agents, vasopressors, cardiac drugs), and nontraditional out-of-hospital drug infusion routes (subcutaneous infusaports, central venous access lines, direct subcutaneous infusions, self-contained implanted pumps).

Conclusion:
In conclusion, the EMS provider confronted with a prehospital patient with a pre-existing physician-ordered medical device or drug administration not covered in the EMS provider’s respective scope of practice should provide usual care and transportation while maintaining the pre-existing MDDA, if applicable. Concerns or questions regarding real-time events associated with a pre-existing MDDA should be directed to the relevant
Medical Control Physician. Concerns or questions regarding previous, recurrent, or future pre-hospital transportations with a pre-existing MDDA should be directed to the appropriate EMS Medical Director and legal counsel.

Approved by the EMFTS Board February 2014
The Ohio Board of Emergency Medical, Fire, and Transportation Services ("EMFTS Board") issues the following statement:

Regarding Interfacility Transport of Patients by EMS Providers and the Scope of Practice
October 2013

This statement is an attempt to provide general information about the above issue facing EMS providers. It should not be treated as legal advice or medical direction. For direct advice regarding a particular scenario, please consult with your medical director and legal counsel. Although the following statement represents the EMFTS Board’s general position on the above issue, this statement in no way precludes the EMFTS Board from taking disciplinary action in a particular case if necessary. Any potential complaints brought before the EMFTS Board will be decided on a case-by-case basis.

Introduction:
The Ohio Board of Emergency Medical, Fire, and Transportation Services and the Ohio Department of Public Safety, Division of Emergency Medical Services, have developed a defined scope of practice for all EMS providers. The scope of practice for emergency medical technicians (EMTs), advanced emergency medical technicians (AEMTs), and Paramedics is established respectively in Ohio Administrative Code Chapters 4765-15, 4765-16, and 4765-17. An outline of the Ohio EMS scope of practice is available in a matrix form and is posted on the Ohio Department of Public Safety, Division of EMS’ website as a reference for public access. This scope of practice addresses all levels of EMS providers and has been approved by the EMFTS Board. Updates to the scope of practice are made as necessary and must be approved by the EMFTS Board.

From time to time, during interfacility transport, EMS providers are confronted with medications and therapies that are out of their usual scope of practice and training. The intent of this position paper is to address the approach of the EMS providers and their medical directors to these situations which are not explicitly covered in the Ohio EMS scope of practice.

Discussion:
The number and type of medications and therapies in the medical field currently or potentially encountered by the EMS provider in the interfacility transport setting is extensive and may change frequently. The intent of this position paper is not to provide an inclusive or exclusive list of therapies and medications that should be included or excluded from the EMS provider’s scope of practice. Rather, the intention of this document is to frame the discussion around maintenance of patient safety during interfacility transport and provision of patient care that is appropriate to the EMS provider’s level of training.

Additionally, the success of any EMS service requires robust medical direction from an actively involved physician who meets the requirements set forth in Ohio Administrative Code Rule 4765-3-05. This includes, but is not limited to, the initial and ongoing training of EMS providers, as well as an active performance improvement process in which all transports are subject to review for quality assurance.

The scope of this document includes all transports in which the highest level of training of the personnel in the transport vehicle is a Paramedic. The addition of the registered nurse to the crew creates a mobile intensive care unit which is qualified to transport critical patients as legislated in Section 4766.01 of the Ohio Revised Code and Rule 4766-4-12 of the Ohio Administrative Code.

Conclusion:
The EMT, AEMT, and Paramedic certification is limited to the scope of practice that is set forth respectively in Ohio Administrative Code Chapters 4765-15, 4765-16, and 4765-17. Furthermore, this position paper does not
provide an inclusive or exclusive list of therapies and medications that should be included or excluded from the EMS provider’s scope of practice.

In addition, during the interfacility transportation of patients, the EMS provider:

- Shall not initiate the infusion of blood or blood products including the initiation of infusion of additional units. Under the current scope of practice, the Paramedic may only maintain the infusion of blood or blood products.
- Shall not initiate the infusion of intravenous parenteral nutrition including the initiation of infusion of additional units. Under the current scope of practice, the Paramedic may only maintain the infusion of intravenous parenteral nutrition.
- Shall not initiate or continue the infusion of chemotherapeutic agents.
- Shall follow written protocols, which have been developed and signed by the EMS provider’s medical director, for the infusion of medications that are not specifically outlined within the EMS scope of practice as outlined by the State of Ohio.
  - The training for the infusion of these specific medications shall not be done at the time of the interfacility transfer of the patient.
  - This training must be completed well in advance of the transfer.
  - The completion of the training must be documented and approved by the medical director of the EMS agency.
  - Continuing education and recurrent training on the indications, contraindications, pharmacology, and side effects of these medications is also required.
- Should refuse to initiate a transport if the EMS provider feels that adequate training on a specific intervention has not been provided well in advance of the transfer as outlined above or if the EMS provider feels uncomfortable with the transport for any reason, including but not exclusive to safety reasons, patient scenario, or any requested parameter of patient care delivery ordered during patient transport.

Concerns or questions regarding specific interfacility transports should be directed to the Ohio Department of Public Safety, Division of Emergency Medical Services.
To: Ohio EMS providers and Ohio EMS medical directors  
From: Carol A. Cunningham, M.D., FAAEM, FACEP  
State Medical Director, Ohio Department of Public Safety, Division of EMS  
Date: August 18, 2015  
RE: Electronic transmission of 12-lead EKGs and the Ohio EMS scope of practice  

On August 18, 2015, the Emergency Medical Services, Fire, and Transportation Services (EMFTS) Board approved a position statement regarding electronic technologies and the impact on EMS. For EMS agencies who wish to implement policies and procedures for the use of electronic technology for the transmission of data and images, this will provide additional options for the modes of transmission of prehospital 12-lead electrocardiograms (EKGs), and in some cases, cardiac monitor strips, by Ohio EMS providers.  

At the time when the rules addressing the performance and transmission of prehospital 12-lead EKGs were promulgated, the majority of cellular phones lacked camera and internet capabilities, and the primary mode for transmission of a 12-lead EKG to a receiving facility was by telemetry. With the expanded modalities that are cited in the EMFTS Board position paper as inclusive in the definition of electronic transmission, it is important to reinforce the fact that the primary goal of the acquisition of a prehospital 12-lead EKG is to rapidly activate a cardiac catheterization laboratory when a patient experiencing an acute ST-segment myocardial infarction is identified.  

The ability to transmit the image of an EKG or a cardiac monitor strip as a digital image via telemedicine avenues or via a cellular phone does not alter the Ohio EMS scope of practice. Regardless of an EMS agency’s policies and procedures to utilize electronic technologies or the protocols provided by the EMS medical director, Ohio EMS providers may not exceed the Ohio EMS scope of practice for their respective level of Ohio EMS certification.  

As a review, please note the following key information regarding cardiac monitoring and 12-lead EKG acquisition:  

1. The Ohio EMS scope of practice permits Emergency Medical Technicians (EMTs) and Advanced Emergency Medical Technicians (AEMTs) to set up and apply a 12-lead EKG when assisting a Paramedic or for the purposes of electronic transmission if all of the following conditions are met:  
   A. The EKG is performed in accordance with a written protocol  
   B. The EMT and the AEMT shall not interpret the EKG  
   C. Delay in patient transport is minimized  
   D. The EKG is used in conjunction with destination protocols approved by the local medical director  

Mission Statement  
“to save lives, reduce injuries and economic loss, to administer Ohio’s motor vehicle laws and to preserve the safety and well being of all citizens with the most cost-effective and service-oriented methods available.”
2. The Ohio EMS scope of practice does not permit EMTs to set up a cardiac monitor unless an AEMT or a Paramedic is present. The EMT shall not perform cardiac monitor interpretation.

Due to the Ohio EMS scope of practice for EMTs and AEMTs, the EMFTS Board continues to strongly recommend the inactivation of the automated interpretation function that is installed in many 12-lead EKG machines and/or the blockade of the printing of the interpretation when the EKG is acquired by an EMT or by an AEMT in the absence of a Paramedic. This action has three benefits:

A. The lack of an automated 12-lead EKG interpretation prevents the EMT and the AEMT from exceeding the Ohio EMS scope of practice.
B. The EMT and the AEMT will avoid the scenario where a patient experiencing chest pain refuses prehospital care and/or transport due to a “normal” automated 12-lead EKG interpretation.
C. Automated interpretations should not be used and are not intended to serve as a substitute for the primary interpretation of a 12-lead EKG by a Paramedic or other medical professional whose training and scope of practice includes 12-lead EKG interpretation.
Emergency Medical Responder Treatment Guidelines 2017
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INTRODUCTION

MEDICAL CONTROL PROTOCOLS AND PROCEDURES GUIDELINES

These protocols and procedures are to be used as Emergency Medical Responder guidelines for operation during the medical and or trauma care of a person that require medical direction. They are also intended to be guidelines to ensure that personnel are trained in proper pre-hospital patient care.

Procedures are not considered rigid rules, but rather established standards against which Emergency Medical Responder care practice can be measured.

Treatment protocols are specific orders directing the actions pertaining to techniques and/or medications used by Emergency Medical Responder personnel who are required to practice under direct supervision of a physician and under their respective EMS Medical Control authority.

Treatment protocols may and should be initiated without prior direct Medical Control contact, especially when the patient’s condition and/or situation is life threatening. As soon as the condition and/or situation permits, the patient should be transported to the emergency department via company policy or local 911 emergency service.

These protocols assume that the Emergency Medical Responder has a thorough working knowledge and current completion card in Basic Life Support (BLS) by the American Heart Association or American Red Cross. Accordingly, BLS procedures are not discussed at length in these protocols.

The Protocols may be used as an educational device before, during and after a run, as a general education tool for squads and responders.

Although not identical, these protocols and procedures are derived from the State of Ohio EMS guidelines. Please note that items in this manual are subject to continuous review for the sake of providing members with the most current emergency medical information. Updates to this material may be frequent to maintain a current standard of care to benefit both the patient and the provider of emergency medical care. The cover page of this manual indicates when the most current version was printed. Please replace older versions with newly updated material as soon as it is issued. Once updated, older versions are to be considered obsolete and are to be discarded to help eliminate confusion.
1. The patient history should not be obtained at the expense of the patient. Life-threatening problems detected during the primary assessment *must* be treated first.

2. Cardiac arrest due to trauma is not treated by medical cardiac arrest protocols. Trauma patients should be transported promptly with CPR, control of hemorrhage, cervical spine immobilization, and other indicated procedures attempted en route.

3. When transferring lower level pre-hospital care to a higher level of prehospital care, a thorough consult should be performed between caregivers describing initial patient presentation and care rendered to the point of transfer.

4. If the patient’s condition does not seem to fit a protocol or protocols, contact Medical Control for guidance.

5. All trauma patients with a mechanism or history for multiple system trauma should be transported as soon as possible. The scene time should be 10 minutes or less.

6. Medical patients will be transported in the most efficient manner possible considering the medical condition. Justification for scene times greater than 20 minutes should be documented.

7. The state of Ohio, Division of EMS, specifies minimum Emergency Medical Responder equipment. The Medical Director may also make specific recommendations for equipment choices.

8. These protocols are the written Medical Direction and Standing Orders of the Medical Director and authorize the activities of the Emergency Medical Responder until such time as these Standing Orders are overridden / supplemented by:
   
   a. Radio / telephone contact with the Emergency Department for direct “on-line” medical direction / orders.
   b. The arrival on the scene of a person with a higher level of EMS certification. This person must provide proof and state / accept responsibility for the care delivered to that patient.
   c. The arrival of local EMS to take over care and transport of the patient.

9. Vital signs should be obtained and recorded every 5 minutes for unstable or critical patients, if possible.
1. When a non-medical-control physician offers assistance to EMS or the patient is being attended by a physician with whom they do not have an ongoing patient relationship, EMS personnel must contact On-line Medical Control and the physician must be approved by On-line Medical Control.

2. When the patient is being attended by a physician with whom they have an ongoing patient relationship, EMS personnel may follow orders given by the physician if the orders conform to current EMS guidelines, and if the physician signs the PCR. Notify Medical Control at the earliest opportunity. Any deviation from local EMS protocols requires the physician to accompany the patient to the hospital.

3. EMS personnel may accept orders from the patient’s physician over the phone with the approval of Medical Control. The paramedic should obtain the specific order and the physician’s phone number for relay to Medical Control so that Medical Control can discuss any concerns with the physician directly.
INTRODUCTION
MEDICAL CONTROL GENERAL GUIDELINES

All algorithms are color coded to denote procedures, which may be performed by the Emergency Medical Responder. To perform procedure color-coded red, Medical Control must be contacted for permission. Higher levels of certification will perform lower level evaluations and procedures when interpreting the algorithms.

The protocol format is for quick reference and does not detail patient assessment, interpretation or interventions. EMS personnel are accountable for all patient care and documentation to their level of training.

<table>
<thead>
<tr>
<th>COLOR CODES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WHITE</strong></td>
<td>Universal Patient Care Protocol / Patient Care Notes</td>
</tr>
<tr>
<td><strong>GRAY</strong></td>
<td>Emergency Medical Responder Skill and Assessment Level Interventions</td>
</tr>
<tr>
<td><strong>GREEN</strong></td>
<td>Medication Administration / Assist</td>
</tr>
<tr>
<td><strong>RED</strong></td>
<td>Medical Direction Contact / Authorization Required</td>
</tr>
</tbody>
</table>
INTRODUCTION

UNIVERSAL PATIENT CARE PROTOCOL

ASSURE TRANSPORT CAPABLE EMS RESOURCES HAVE BEEN SUMMONED

PATIENT ASSESSMENT
Assess the patient’s level of consciousness
If unresponsive – assess for a pulse

HAS PULSE - CHECK AIRWAY
Is the airway open and patient?

HAS AIRWAY – CHECK BREATHING
Is the Patient Breathing?

DETERMINE CHIEF COMPLAINT
OBTAIN VITAL SIGNS
Respirations, Heart Rate, Blood Pressure

OBTAIN “SAMPLE” HISTORY
S – Signs and Symptoms
A – Allergies
M – Medications patient is currently taking
P – Past Medical History
L – Last Oral Intake (time and what)
E – Events leading to the Problem

REFER TO AND TREAT PER APPROPRIATE PROTOCOL AS REQUIRED

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS

NO PULSE - BEGIN CPR

Open Airway with a head tilt chin lift
Insert and Oropharyngeal Airway if available

Provide rescue breathing with a BVM or pocket mask at 10 – 12 bpm

Administer Supplemental Oxygen via NRB or NC

O – Onset
P – Provocation
Q – Quality
R – Radiation / Region
S – Severity (1 to 10 scale)
RESPIRATORY EMERGENCIES

MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

Place Patient in a Position of Comfort

Assess ABC’s
Respiratory Rate, Effort, Adequacy

If Foreign Body Airway Obstruction
Follow AHA BLS Guidelines

Administer Supplemental Oxygen via 10 – 15 lpm via NRB or BVM
Never withhold O2 from patients in respiratory distress
If respiratory rate <8 or >40 assist with BVM

ASTHMA / COPD
Allow patient to use their metered dose inhaler or breathing treatments
IF AVAILABLE

ALLERGIC REACTION / ANAPHYLAXIS

IF SEVERE REACTION
Facial swelling
Difficulty Breathing
Stridor
Low BP
ADMINISTER EPINEPHRINE AUTO INJECTOR (EPI-PEN)

Remove patient from allergen if possible
Remove stinger with a rigid card
Apply ice to swollen areas

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
CHEST PAIN
MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

Place Patient in a position of comfort
If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible

**DO NOT ALLOW**
Patient to take Nitroglycerin if they have a systolic Blood Pressure <120

Administer Supplemental Oxygen
via NC or NRB
Never withhold O2 from patients in respiratory distress

Reassess Vital every 5 minutes

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
STROKE
MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
If Patient is having trouble speaking, pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

Administer Supplemental Oxygen via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

DETERMINE THE TIME THE PATIENT WAS LAST SEEN NORMAL
This will be time zero
Report time last seen normal to EMS

DETERMINE IF THE PATIENT HAS ANY NEUROLOGIC DEFICITS
(Paralysis, Speech Problems, Headache, etc.)

Reassess Vital every 5 minutes

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS

Did Patient Fall during this episode?
Are they Injured?
Consider Spinal Immobilization
ALTERED MENTAL STATUS
MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible IF NO AIRWAY OR BREATHING COMPROMISE

Administer Supplemental Oxygen via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

DIABETIC PATIENT
If patient has their own glucose meter allow them to check their glucose levels

If patient is conscious and able to swallow
Allow patient to have food or beverages containing sugar

Consider Causes
Head Injury
Overdose
Stroke
Hypoxia
(Report Findings to EMS)

IF OPIATE OVERDOSE SUSPECTED
Administer NALOXONE (NARCAN)
One whole syringe, half of dose up each nostril using atomizer tip

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
ABDOMINAL PAIN
MEDICAL EMERGENCIES

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to
control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible IF NO AIRWAY
COMPROMISE

Administer Supplemental Oxygen
via NC or NRB
Never withhold O2 from patients in
respiratory distress
If Respiratory Rate <8 or >24 Assist with
BVM

Focused Exam of the Abdomen
Assess all 4 quadrants for pain on palpation,
distension, or rigidity
Last Oral Intake?
Any Vomiting or Diarrhea?
Is the pain sharp or dull?

Reassess Vital every 5 minutes

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
POISONING / OVERDOSE

MEDICAL EMERGENCIES

FOLLOW UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible
IF NO AIRWAY OR BREATHING COMPROMISE

Administer Supplemental Oxygen via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

POISONING

ATTEMPT TO DETERMINE
What was the exposure?
How much was the exposure?
How long ago was the exposure?
Reassess Vital every 5 minutes

OVERDOSE

ATTEMPT TO DETERMINE
Was the overdose intentional?
What was taken?
How much was taken?
How long ago was it taken?

IF OPIATE OVERDOSE SUSPECTED
Administer NALOXONE (NARCAN)
One whole syringe, half of dose up each nostril using atomizer tip
Reassess Vital every 5 minutes

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
ENVIROMENTAL EMERGENCIES
MEDICAL EMERGENCIES

FOLLOW UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible
IF NO AIRWAY OR BREATHING COMPROMISE

Administer Supplemental Oxygen via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

HYPOTHERMIA
Move Patient to a warm environment
Remove wet clothing
Begin to warm the patient slowly
Reassess Vital every 5 minutes
Be alert to bradycardia (slow heartrate)

HYPERTHERMIA
Remove patient from the warm environment
Begin cooling with tepid water
If the patient is hot to touch and has an altered mental status
Begin rapid cooling with ice in the groin and axilla

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
IS THE SCENE SAFE?
Your safety is the top priority
CALL LAW ENFORCEMENT TO THE SCENE IF NEEDED

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

Avoid upsetting the patient any further
Do not make judgments about the patient’s situation
Assess if patient is competent to make his own decisions as they pertain to medical care and transport

CONSIDER CAUSES
Behavioral emergency could have a medical cause.
Hypoxia, Hypoglycemia, Head Trauma, Overdose, Stroke

IF COOPERITIVE
Administer Supplemental Oxygen via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

CONTACT MEDICAL CONTROL AS NECESSARY
TRANSPORT VIA EMS
Determine if there is time for transport or whether delivery is imminent. Signs of imminent delivery include contractions 1-2 minutes apart, lasting 30-45 seconds, bulging membranes, or the presence of crowning.

- Activate the EMS system to expedite transport.
- If delivery **IS NOT** imminent, prepare patient for incoming ambulance.
- If delivery **IS** imminent, prepare to assist with the delivery.

### FOLLOW UNIVERSAL PATIENT CARE PROTOCOL

1. **Administer Supplemental Oxygen NRB 10-15 LPM**
2. Protect Mothers Privacy and close off area from onlookers
   - Observe Head Crowning
   - Prepare Patient for Delivery
   - Set-Up Equipment
3. **Delivery of Head**
   - Apply firm, gentle pressure with flat of hand to slow expulsion.
   - Allow head to rotate normally, check for cord around neck, and wipe face free of debris.
   - Suction mouth and nose with bulb syringe.
4. **Delivery of Body**
   - Place one palm over each ear with next contraction gently move downward until upper shoulder appears.
   - Then lift up gently to ease out lower shoulder Support the head and neck with one hand and buttocks with other.
   - **REMEMBER THE NEWBORN IS SLIPPERY**
5. **Newborn and Cord**
   - Keep newborn at level of vaginal opening. Keep warm and dry. After 10 seconds, clamp cord in two places with sterile equipment at least 6-8” from newborn. Cut between clamps.
   - Allow placenta to deliver itself but do not delay transport waiting. **DO NOT PULL ON CORD TO DELIVER PLACENTA.** Take placenta to hospital with patient.

### CONTACT MEDICAL CONTROL AS NECESSARY

### TRANSPORT VIA EMS
CARDIAC ARREST / AED
MEDICAL EMERGENCIES

UNRESPONSIVE PATIENT
Feel for a carotid pulse
IF no Pulse BEGIN CPR at 30:2 Compression to Ventilation ratio
Send someone to get the AED

When AED arrives:
Turn on the AED and follow the prompts
Attach the pads to patient’s bare chest
(Continue chest compression while pads are being attached to the patient)
Plug in the pads connector
Clear patient so AED can analyze

If a shock is indicated:
Allow AED to charge
Clear everyone from touching the patient
Press the SHOCK button to deliver the shock
Immediately continue CPR

After 2 minutes the AED will prompt you to clear the patient so the AED can analyze the rhythm

If a shock is indicated:
Allow AED to charge
Clear everyone from touching the patient
Press the SHOCK button to deliver the shock
Immediately continue CPR and follow AED prompts

If NO shock is advised
Immediately continue 2 minutes of CPR
Continue to follow AED prompts
If patient begins to breath or starts to move stop CPR and assess vitals

FOLLOW UNIVERSAL PATIENT CARE PROTOCOL

RESPONSIVE PATIENT
FOLLOW APPROPRIATE PROTOCOL

CONTACT MEDICAL CONTROL AS NECESSARY
TRANSPORT VIA EMS
Emergency medical service personnel shall use the following criteria, consistent with their certification, to evaluate whether an injured person qualifies as an adult trauma victim or pediatric trauma victim, in conjunction with the definition of trauma according to the State of Ohio Trauma Triage Guidelines.

**An Adult Trauma Victim** is a person 16 years of age or older exhibiting one or more of the following physiologic or anatomic conditions:

**Physiologic conditions**
- Glasgow Coma Scale < 13
- Loss of consciousness > 5 greater minutes
- Deterioration in level of consciousness at the scene or during transport
- Failure to localize to pain
- Respiratory rate < 10 or > 29
- Requires endotracheal intubation
- Requires relief of tension pneumothorax
- Pulse > 120 in combination with evidence of hemorrhagic shock
- Systolic blood pressure < 90, or absent radial pulse with carotid pulse present

**Anatomic conditions**
- Penetrating trauma to the head, neck, or torso
- Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise
- Injuries to the head, neck, or torso where the following physical findings are present:
  - Visible crush injury
  - Abdominal tenderness, distention, or seatbelt sign
  - Pelvic fracture
  - Flail chest
- Injuries to the extremities where the following physical findings are present:
  - Amputations proximal to the wrist or ankle
  - Visible crush injury
  - Fractures of two or more proximal long bones
  - Evidence of neurovascular compromise
- Signs or symptoms of spinal cord injury
- 2nd or 3rd Degree > 10% total BSA or other significant burns involving the face, feet, hands, genitalia, or airway

**Field Trauma Triage Criteria: Mechanism of Injury (MOI) & Special Considerations**

<table>
<thead>
<tr>
<th>Co-Morbid Diseases and Special Considerations:</th>
<th>Mechanisms of Injury (MOI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &lt; 5 or &gt; 55</td>
<td>High speed MVC</td>
</tr>
<tr>
<td>Cardiac disease</td>
<td>Ejection from vehicle</td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>Vehicle rollover</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Death in same passenger compartment</td>
</tr>
<tr>
<td>Immunosuppression</td>
<td>Extrication time &gt; 20 minutes</td>
</tr>
<tr>
<td>Morbid obesity</td>
<td>Falls greater than 20 feet</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Vehicle versus bicycle / pedestrian</td>
</tr>
<tr>
<td>Substance abuse/intoxication</td>
<td>Pedestrian thrown or run over</td>
</tr>
<tr>
<td>Liver disease</td>
<td>Motorcycle crash &gt; 20 mph with separation of rider from bike</td>
</tr>
<tr>
<td>Renal disease</td>
<td></td>
</tr>
<tr>
<td>Bleeding disorder/anticoagulation</td>
<td></td>
</tr>
</tbody>
</table>
**KEY POINTS**

**Exceptions to Mandatory Transport to a Trauma Center:**

Emergency medical service personnel shall transport a trauma victim directly to an adult or pediatric trauma center that is qualified to provide appropriate adult or pediatric care, unless one or more of the following exceptions apply:

- It is medically necessary to transport the victim to another hospital for initial assessment and stabilization before transfer to an adult or pediatric trauma center
- It is unsafe or medically inappropriate to transport the victim directly to an adult or pediatric trauma center due to adverse weather or ground conditions or excessive transport time
- Transporting the victim to an adult or pediatric trauma center would cause a shortage of local emergency medical service resources
- No appropriate adult or pediatric trauma center is able to receive and provide adult or pediatric trauma care to the trauma victim without undue delay
- Before transport of a patient begins, the patient requests to be taken to a particular hospital that is not a trauma center or, if the patient is less than eighteen years of age or is not able to communicate, such a request is made by an adult member of the patient's family or a legal representative of the patient

---

**Glasgow Coma Scale**

<table>
<thead>
<tr>
<th>INFANT</th>
<th>Glasgow Coma Scale</th>
<th>ADULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to age 4</td>
<td><strong>Eye Opening</strong></td>
<td><strong>Age 4 to Adult</strong></td>
</tr>
<tr>
<td>4</td>
<td>Spontaneously</td>
<td>Spontaneously 4</td>
</tr>
<tr>
<td>3</td>
<td>To speech</td>
<td>To command 3</td>
</tr>
<tr>
<td>2</td>
<td>To pain</td>
<td>To pain 2</td>
</tr>
<tr>
<td>___1</td>
<td>No response</td>
<td>No Response 1___</td>
</tr>
<tr>
<td>5</td>
<td>Coos, babbles</td>
<td>Oriented 5</td>
</tr>
<tr>
<td>4</td>
<td>Irritable cries</td>
<td>Confused 4</td>
</tr>
<tr>
<td>3</td>
<td>Cries to pain</td>
<td>Inappropriate words 3</td>
</tr>
<tr>
<td>2</td>
<td>Moans, grunts</td>
<td>Incomprehensible 2</td>
</tr>
<tr>
<td>___1</td>
<td>No response</td>
<td>No response 1___</td>
</tr>
<tr>
<td><strong>Best Verbal Response</strong></td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>Spontaneous</td>
<td>Obeys commands 6</td>
</tr>
<tr>
<td>5</td>
<td>Localizes pain</td>
<td>Localizes pain 5</td>
</tr>
<tr>
<td>4</td>
<td>Withdraws from pain</td>
<td>Withdraws from pain 4</td>
</tr>
<tr>
<td>3</td>
<td>Flexion (decorticate)</td>
<td>Flexion (decorticate) 3</td>
</tr>
<tr>
<td>2</td>
<td>Extension (decerebrate)</td>
<td>Extension (decerebrate) 2</td>
</tr>
<tr>
<td>___1</td>
<td>No response</td>
<td>No response 1___</td>
</tr>
<tr>
<td>___</td>
<td>= TOTAL</td>
<td>TOTAL = ___</td>
</tr>
</tbody>
</table>

GCS < 8? Intubate!
TRAUMA GUIDELINES

TRAUMA

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway

HAVE SUCTION AVAILABLE
Consider positioning patient on their side

Control Bleeding, Apply Dressing

Consider Spinal Immobilization

Administer Supplemental Oxygen via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

ONLY IF there are signs of cerebral herniation:
Blown pupils, bradycardia, posturing
High Flow O2 via BVM
14-16 Breath Per Min

Obtain Glasgow Score
Repeat every 5 minutes
Consider altered LOC protocol

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS

Be alert for Seizure activity
Protect Airway
Be Prepared to Suction
EYE INJURY

TRAUMA

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

Remove Contact Lens
(If Applicable)

Do NOT remove penetrating objects,
stabilize in place

Flush debris from the eye with normal saline or sterile water

Cover soft tissue injuries with moist sterile dressings

Eye out; cover with moist sterile dressing

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
CHEST TRAUMA

TRAUMA

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway
HAVE SUCTION AVAILABLE

C-Spine Immobilization
Evidence of Trauma, Blunt or Penetrating
Abnormal breath sounds, inadequate respiratory rate, unequal symmetry, diminished chest excursion, cyanosis, flail segment, bruising
Use Jaw Thrust Airway Maneuver

Control bleeding cover wounds
If impaled object LEAVE OBJECT IN PLACE
Secure with bulky dressings

Administer Supplemental Oxygen
via NC or NRB
Never withhold O2 from patients in respiratory distress
If Respiratory Rate <8 or >24 Assist with BVM

Constantly reassess for adequate breathing

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
EXTREMITY / AMPUTATION TRAUMA

FOLLOW UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC's
Pay close attention to their ability to control their own airway
HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible
IF NO AIRWAY COMPROMISE

POSSIBLE EXTREMITY FRACTURE
Remove rings, bracelets, and other constricting items on injured extremity if possible

Check for MSP's (motor, sensory, pulse) distal to the fracture
Apply Ice to the extremity
Immobilize the extremity with a splint
Reassess for MSP's (motor, sensory, pulse) distal to the fracture

CONTROL BLEEDING with gauze products
Severe spurting / spraying bleeding
APPLY TOURNAQUET

Amputation?
Clean amputated part with NS or sterile water
Wrap part in Sterile Dressing and place in plastic bag if able
Place that bag on Ice if available
No direct ice contact to tissue

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
BURNS
TRAUMA

FOLLOW
UNIVERSAL PATIENT CARE PROTOCOL

ASSESS ABC’s
Pay close attention to their ability to control their own airway
HAVE SUCTION AVAILABLE
Consider positioning patient on their side

If Hypotensive (Low Blood Pressure)
Lay patient as flat as possible
IF NO AIRWAY COMPROMISE

Remove rings, bracelets, and other constricting items

THERMAL BURNS
Remove clothing and / or expose area
If burn < 10% body surface area (using Rule of Nines)
Cool down wound with Water or Normal Saline
Cover burn with dry sterile sheet or dressings

CHEMICAL BURNS
Remove clothing and / or expose area
Flush area with Water or Normal Saline for 15 - 20 minutes

CONTACT MEDICAL CONTROL AS NECESSARY

TRANSPORT VIA EMS
Specialty Care and Interfacility Transport Guidelines / Protocols

2017
INTRODUCTION

These Specialty care and interfacility transport guidelines / protocols are designed to be used in situations where patients are being transported from one healthcare facility to another, for continued or upgraded care. This document is an adjunct document to the current Prehospital Care Protocol and Treatment Guidelines, and that document outlines core scope of practice as well as current standard of care for out of hospital providers. Where indicated, treatment modalities described in either document may apply to a given patient situation, and knowledge of both documents contents is required.

Definitions
Prehospital Care Protocols and Treatment Guidelines are referenced as “PCP” (Prehospital Care Protocols) throughout this document. This document will be referenced as “IFTP” (Interfacility Transport Protocols) throughout this document.

Hyperlinks
This document is hyperlinked as a .PDF for rapid retrieval of information. The cover is linked to the Table of Contents and each entry is linked to the corresponding page. The header of each page is linked back to the Table of Contents.
INTRODUCTION

TRANSPORT CARE GENERAL GUIDELINES

1. Patient safety first! Do NOT transport patients who cannot be appropriately managed in an ambulance or with the level of care available. Summon appropriate resources as necessary. Much scrutiny will come from decisions made regarding these situations. Be sure decisions are truly made because you do not have capability to manage the patient.

2. Receive a report on patient condition from their healthcare provider before transporting the patient. Assure patient report if from a direct healthcare provider engaged in the patient’s care. Consult Physician in charge of patient if the patient is critical.

3. Plan for patient decompensation enroute. Put appropriate interventions or monitoring in play before transport.

4. Assure knowledge of and assure function of all patient treatment devices and therapies before transport.

5. Develop a plan with sending Physician if patient has potential for decompensation enroute before departure of the sending facility.

6. Paramedics may manage up to three (3) patient care devices per patient per call. A patient care device is defined as any externally managed device that would cause detriment to the patient if not in place or discontinued. Each medication infusion line counts as a device when running anything other than crystalloids. If additional patient care devices are required, additional help is required to manage the patient and devices. A cardiac monitor / defibrillator is not counted as a patient care device unless electrical therapy is or could be required for the patient during transport. Example; a bradycardic patient may require pacing if decompensation occurs, a monitor would be counted against the 3 patient care devices rule. If defibrillation (cardioversion) or pacing pads are on the patient for any reason at time of pickup, the monitor / defibrillator will count as a managed device.

7. Cardiac monitors and continuous pulse oximetry are required on all patients with advanced airways in place.

8. Cardiac monitors and continuous pulse oximetry are required on all patients with medications running or attached patient care devices as defined above.

9. EMS is required to leave a PCR at receiving facility during all intrafacility transports.

10. Communicate any changes in patient condition during transport with receiving facility to assure proper patient care is available at the receiving.

11. Vital signs at time of pickup and drop off must be recorded and notated as such.

12. Waveform capnography is required on all patients with advanced airways in place.

13. Waveform capnography is required on all patients with NPPV in place.

14. Reports must be called to the receiving facility if the destination is the ED.

15. Glucose values should be reevaluated prior to or during transport if patients have not eaten, have been made NPO, received large volumes of fluids, has an insulin pump, has received steroids throughout their course of treatment, is post OP, or has had their blood glucose managed as part of their course of treatment.

16. A complete assessment shall be conducted of the patient prior to transport.

17. Assure double the anticipated amount of medications including oxygen, are available for expected transport time.

18. Document interventions and medications given before transport by the receiving facility as such on the PCR.

19. Contact Medical Control as necessary during intrafacility transports as defined in this document.

20. Multiple protocols are likely to apply to every patient encounter.
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Purpose:
Describes requirements and recommendations for transporting patients with advanced artificial airways.

Overview:
Patients with advanced airways are generally managed by positive pressure ventilation. Patients who are on mechanical ventilation at the sending facility should remain on mechanical ventilation during transport unless there is a CRISIS situation.

Associated Protocols / Guidelines:
Ventilator Management
If Patient is Tracheostomy patient, see Tracheostomy Patient Protocol / Guidelines in this document

Permissions:

| PARAMEDICS may transport patients with advanced artificial advanced airways in place |
| ADVANCED EMT’s may NOT transport patients with advanced artificial airways in the IFT setting |
| EMT’s may NOT transport patients with advanced artificial airways in the IFT setting except uncomplicated, non-ventilated tracheostomy patients |

General Requirements:
- Determine type of airway, and its location. Ex. Intratracheal, supraglottic, transtracheal.
- Assure device is properly positioned by auscultation, examination, and capnography.
- Wave form capnography is required for every advanced airway transport.
- Pulse oximetery is required for every advanced airway transport.
- Assure proper cuff seal on device by tactile inspection of the pilot balloon.
- Assure adequate tube restraint for transport, replace as necessary. Tape and twill are not appropriate for the rigors of out-of-hospital transport. Use commercial tube securing devices with a bite block.
- Document tube type, depth, size placement indicators prior to departure. Document with capnography strip attached to PCR.
- Document tube type, depth, size placement indicators during transport. Document with capnography strip attached to PCR.
- Document tube type, depth, size placement indicators once patient left in receiving facilities care. Document with capnography strip attached to PCR.
- Determine last sedation / analgesia regiment (if applicable) and understand how long given agents are expected to last and correlate with anticipated transport time. Be prepared to continue sedation / analgesia.
- Determine the need for sedation / analgesia during transport. Treat per Sedation / Analgesia IFTP.
- Calculate oxygen requirements for transports and assure adequate supply.
- If an established airway fails, treat per appropriate PCP.
• Suction must be available during transport and the movement of the patient to the receiving location.
• Continuous cardiac monitoring is required during intrafacility transport of patients.

Recommendations:
• C-Collars placement may be considered on patients with advanced artificial airways to prevent migration during transport.

Key points:
• Pulse oximetry is an indicator of oxygenation, not ventilation. Do not rely on pulse oximetry to verify proper airway placement.
• Capnography is an indicator of ventilation. A waveform indicates proper airway placement. The capnography number is the sum of metabolism, perfusion, and ventilation. Abnormalities in the number should be addressed by correcting metabolic, perfusion, or ventilation dysfunction. Identify and correct metabolic dysfunction (temperature, glucose, and oxygenation) first, perfusion second, ventilation concerns last.
ARTERIAL CATHETERS

Purpose:
To describe when it is appropriate to transport patients with arterial lines.

Overview:
Arterial access is sometimes utilized for pressure monitoring and interventional access for specialty procedures in hospital. Patients requiring arterial pressure monitoring shall go via a Critical Care Transport Team. Patients with arterial access, not requiring pressure monitoring may be transported with the arterial access in place. Maintenance beyond a saline or heparin infusion is not permitted. Pressure infusers are generally required to provide pressure greater than the SBP.

Permissions:
- PARAMEDICS may transport patients with arterial catheters in place NOT requiring pressure transduction or maintenance other than a saline infusion
- ADVANCED EMT may NOT transport patients with arterial catheters in place
- EMT may NOT transport patients with arterial catheters in place

General Requirements:
- Determine type and location of arterial line(s), document accordingly.
- Assure catheter is anchored to the patient securely to prevent migration or dislodgement.
- Mark catheter / patient along somewhere along its length as a reference in case of migration.
- Assure all attached tubing is securely connected to the catheter.
- Provide pressure infusion of saline as required to maintain patency of the line per sending facilities setup.
- Assure IV set spike is seated, up to the flange, into the saline bag to prevent dislodgement under pressure infusion.
- Inflate pressure infusers to the green line, 300 mmHg, or as required for specific setups per sending facility instruction.
- If migration occurs, without evidence of bleeding (internal or external), additionally secure catheter and notify receiving facility. Monitor vital signs.
- If migration or dislodgement occurs with bleeding, immediately divert to acute care ED while holding direct pressure over the insertion point. Have a tourniquet available if direct pressure is unsuccessful.
- Patients with femoral access shall have pedal pulses documented and reassessed every 10 minutes throughout transport.

Recommendations:
- Verify catheter patency after every movement and document.
- Assure catheter entry sites are viable during transport.
Purpose:
To describe when it is appropriate to continue blood products established by the sending facility.

Overview:
There is no substitute for blood. Patient care often requires blood or blood products to yield optimal outcomes.

Permissions:
- Paramedics are permitted to transport already established blood or blood products. Special training and competency required.
- Paramedics transporting blood products must have undergone testing consistent with a medical director approved competency and refreshed yearly.
- Paramedics transporting blood products must have undergone hands on training with the device consistent with manufacturers manual and established competency.
- Paramedics may change blood or blood product bags / containers en-route as directed by sending Physician to meet patient treatment goals.
- Verify that RBC’s provided are same type as previously established.
- If being infused with an IV pump at the sending facility and the tubing is incompatible with transport IV pumps, the sending IV pump must be taken, or the infusion must be run in via gravity after consultation with the sending Physician.
- Special tubing must sometimes be utilized for administration. Use only administration devices provided by the sending facility or approved tubing.
- If a transfusion reaction occurs during transport, discontinue the infusion and contact medical control. See IFTP Medical Control. Do not discard the blood product, it must be turned into the receiving facility.
- Type of blood product, route, volume, and completion, must be documented on the PCR.
- If blood products must be changed during transport, the products must be prepared by the sending facility and sent with EMS.
- Use separate IV site for other medication administrations or infusions.

Key points:
- Transfusion reactions include fever, hypotension, pulmonary edema, and typical anaphylactic type reactions.
Purpose:
Describe the requirements for transportation of burn patients

Overview:
Burn patients require evaluation and treatment at specialized burn centers for optimal outcomes. These patients will have large IV fluid requirements and frequently require aggressive analgesia.

Permissions:
- PARAMEDICS are permitted to transport burn patients including those with airway involvement
- ADVANCED EMT’s are permitted to transport burn patients who DO NOT have airway or near-airway burns as indicated by singed nasal hairs, soot, redness, or swelling
- EMT’s are ONLY permitted to transport adult burn patients with extremity burns less than 15% BSA of partial depth or less grade

General Requirements:
- Establish body surface area affected.
- Determine type of burn, and understand treatment provided prior to arrival.
- Establish depth of burns. Document on PCR along with dressings.
- Calculate or obtain fluid resuscitation requirements per the Parkland Burn Formula.
- Complete a detailed assessment of the airway, oropharynx, neck, and chest to determine potential for deterioration enroute.
- Secure or have secured any potentially involved airway PRIOR to transport.
- Feel and consider marking the cricothyroid membrane on all patients with head, neck, and chest involvement in case of outright upper airway failure.
- Capnography is required on all burn transports.
- Assure multiple vascular access points are established for the administration of fluid and/or analgesia.
- If a patient becomes hypotensive despite continued fluid administration, consider augmenting care with ResQGARD assuming patient does not have an advanced airway.
- Administer / continue pain management as required per the PCP Burn Protocol.
- Sleepy, obtunded, respiratory distress, hypotensive patients, or stridorous patients require Paramedic ALS transport.
- Treat stridor aggressively per PCP and be prepared to perform cricothyrotomy.
CHEST TUBE MANAGEMENT

Purpose:
To describe the process for management of chest tubes in transport.

Overview:
Many patients require chest tubes for relief of pressure or fluids from the thorax.

Permissions:
PARAMEDICS are permitted to transport patients with chest tubes
ADVANCED EMT’s are NOT permitted to transport patients with chest tubes
EMT’s are NOT permitted to transport patients with chest tubes

General Requirements:
• Determine reason for chest tube; to relieve air, fluid, or both from the thorax.
• Determine location of chest tube(s).
• Assure that the tube(s) are securely affixed to the patient prior to transport. Secure additionally as required.
• Mark catheter / patient along somewhere along its length as a reference in case of migration.
• Determine what type of collection or venting process is in place (ex. one way valve, or collection set).
• If collection set being utilized, verify water seal chamber is full to indicated line.
• Collections sets must be transported upright, and lower than the patients’ thorax.
• Determine if collection set is on suction, and continue suction as necessary.
• Record volumes of collected fluids in collection chamber prior to transport and at destination.
• The Paramedic must have booted hemostats available to clamp a chest tube if the collection set or valve becomes disconnected.
• Listen to and document lung sounds before moving the patient and after each move.
• Assure adequate vascular access prior to transport.
• If migration of a chest tube occurs, secure in place and assess for signs of hemo/pneumothorax. Be prepared to perform needle chest decompression. Contact medical control, refer to the IFTP Medical Control.
• If complete dislodgement occurs, cover the ostomy with gauze. Monitor for signs for hemo/pneumothorax. Be prepared to perform needle chest decompression. Contact medical control, refer to the IFTP Medical Control.
• Paramedics transporting chest tubes must have undergone testing consistent with a medical director approved competency and refreshed yearly.
• Paramedics transporting chest tubes must have undergone hands on training with the device consistent with manufacturers manual and established competency.
• If the patient has a drop in blood pressure and / shortness of breath, evaluate for tension pneumothorax and perform needle chest decompression per the PCP.
DIALYSIS PATIENT

Purpose:
To describe the requirements and recommendations during the transport of dialysis patients.

Overview:
Dialysis patients are chronically ill patients, usually with multiple co-morbidities. These patients are high risk patients for numerous life threatening issues and require detailed assessment with every encounter.

Permissions:
- PARAMEDICS are permitted to transport dialysis patients
- ADVANCED EMT’s are permitted to transport dialysis patients
- EMT’s are permitted to transport dialysis patients to SNF’s, dialysis centers, and scheduled non-acute patients.

General Requirements:
- A minimum of 2 set of vital signs are required on EVERY transport, including Spo2.
- A glucose is required to be assessed during transport if the patient has any alteration in normal mental status, (or unknown mental status), fever, refusing or unable to eat meals, describes malaise, or appears diaphoretic.
- Lung sounds must be obtained and results recorded.
- Actively bleeding patients cannot be returned to SNF’s.
- IV access is not permitted in extremities where active AV fistulas are present below the active fistula.
- IV access in extremities with old / inactive fistulas should be avoided.
- AV fistulas access established by dialysis center may be left in place during transport for use by EMS if the patient is, or has potential to become unstable enroute. The extremity must be kept straight if fistula access is left in place.
- Patients must have their access site visible during transport for ongoing assessment of bleeding.
- Cardiac monitoring, continuous pulse oximetry and 12 lead EKG’s are required on all dialysis patients being transported to the ED or for hospital admission.
- Attempt to ascertain the potassium level on hospital to hospital transfers prior to departure from sending and be prepared to treat hyperkalemia per the Dialysis / Renal Patient PCP if complications arise
- No food or drink shall be provided during EMS care to a dialysis patient.

Recommendations:
- Have a high index of suspicion for decompensation with all dialysis patients.
- Glucose evaluation on most dialysis patients, especially post dialysis, may be warranted.

Key points:
- These patients have complex medical problems, and they are seen with frequency. They are not “routine”.
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Patients come into dialysis hypervolemic and leave hypovolemic.
All electrolytes are elevated pre‐dialysis, and reduced post dialysis.
Many therapeutic medications are removed during dialysis.
Patients with indwelling catheters are incredibly high risk for introduction of infectious
pathogens. They should be considered at least bacteremic, and assessed for sepsis
during beach encounter.
AV grafts or shunts my bleed after removal of dialysis needles post dialysis. Do not
package patient such as bleeding would not be identified during transport.
If AV graft is ripped or torn, a tourniquet may be necessary to stop bleeding. Divert
immediately to the closest ED.
Generally bleeding from an AV graft from removal of dialysis needles can be controlled
with direct pressure. Divert to and ED if bleeding does not subside with direct pressure.
Have all access needles removed from dialysis patients before departing dialysis centers.

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DRAIN SYSTEM / TUBE MANAGEMENT

Purpose:
Describe general management of various types drain tubes a patient may have.

Overview:
A patient may have various type of drain tubes inserted for any number of reasons.

Permissions:
- PARAMEDICS may transport all drain tubes
- ADVANCED EMT’s may transport drain tubes that do not drain the chest
- EMT’s may transport drain tubes that do not drain the chest

General Requirements:
- Ascertain what the tube is draining, and why it was placed.
- Determine how the fluid is collected.
- Assure that the collection tube or system is secured to the patient prior to transport.
- Determine if there is any special orientation or power requirements for the collection device.
- Have a clamp available to occlude the drain tubing in the event the drain gets separated from the collection device. Clamp the patient side of any tube.
- If a drain tube gets pulled out inadvertently, cover the entry hole with sterile occlusive dressing and notify receiving facility.
FOLEY CATHETER MANAGEMENT

Purpose:
To describe the management of foley catheters.

Overview:
Many patients have foley catheters and drain bags.

Permissions:
- PARAMEDICS may transport patients with foley catheters and drain bags
- ADVANCED EMT’s may transport patients with foley catheters and drain bags
- EMT’s may transport patients with foley catheters and drain bags

General Requirements:
- Empty foley drain bags before transport and advise facility of volume.
- Record volume of output during transport.
- Keep the collection bag at a level lower than the patients’ bladder.
- If a foley is inadvertently pulled out, treat any bleeding and advise receiving facility. Do not attempt reinsertion.
- Document color and clarity of urine collected
INVASIVE PRESSURE MONITORING

Purpose:
This describes that non-arterial invasive line monitoring is a critical care function but defines transportation with hardware in place, without monitoring would be acceptable.

Overview:
Patients may have various invasive pressure monitors in place for numerous conditions. These could include, but are not limited to CVP or ICP.

Permissions:
- PARAMEDICS are NOT permitted to monitor invasive lines, but may transport the patient with invasive lines in place assuming they do NOT need monitored
- ADVANCED EMT’s are NOT permitted to monitor invasive lines
- EMT’s are NOT permitted to monitor invasive lines

General Requirements:
- Determine the placement of the catheter, if venous, arterial, or otherwise.
- If placement is arterial, refer to IFTP Arterial Catheters.
- Determine if the patient can be transported without that particular pressure being transduced.
- If pressure transduction is required and patient care decisions made based on that information, a Critical Care Team must be summoned.
MEDICATION MANAGEMENT

Purpose:
To define the continuation of hospital established medications during transport.

Overview:
Medications are required for numerous reasons for patients. Proper maintenance of these medications during transport are necessary for optimal patient outcomes.

Permissions:
- PARAMEDICS are permitted to manage any medication on a fixed rate for transport.
- ADVANCED EMT’s are NOT permitted to manage medications other than normal saline, lactated ringers, or dextrose preparations without a pump.
- EMT’s are NOT permitted to manage medications during transport.

General Requirements:
- Paramedics may continue any medication on a fixed rate established by the sending hospital.
- A Paramedic may establish titration criteria with the sending Physician on a per case basis.
- A Paramedic may communicate with Medical Control (Reference IFTP, Medical Control) regarding medication changes enroute.
- Establish that the patient is stable on a selected medication before transport. If patient is not stable, consult sending Physician to stabilize prior to transport.
- If a patient becomes unstable due to a medication during transport, discontinue the medication, treat by appropriate PCP Protocol and contact Medical Control (refer to IFTP Medical Control protocol).
- All drip medications must be on an IV pump except normal saline, lactated ringers, or dextrose products less than or equal to a 10% concentration.
- Glass bottles require vented IV tubing.
- Nitro requires special IV tubing.
- UNDERSTAND THE DIFFERENCE BETWEEN TPA AND TPN.
- TPN may NOT be changed by Paramedics during transport. If it completes during transport it is to stay connected.
- TPA is bolused by the sending facility prior to departure, never by EMS.
- TPA is NOT titrated enroute and is discontinued after 60 mins. Document total volume delivered, and total delivered during transport.
- If TPA is going to finish during transport, attach saline to the IV line to assure all volume in line is delivered, it is within the timeframe. Administration rate must remain the same.
- Confirm delivery rate with sending providers prior to transport.
- Paramedics transporting medications must have undergone testing consistent with a medical director approved competency and refreshed yearly.
- Paramedics transporting medications must have undergone hands on training with the device consistent with manufacturers manual and established competency.
- Document rate, concentration, route, and whom initiated.
- If patient is on a PCA pump and requires augmentation of sedation or analgesia provided by the PCA, contact Medical Control.
- Chemotherapeutic agents cannot be transported including but not limited to irradiated platelets.
- EMT’s and Advanced EMT’s may take patients with PCA pumps under the auspices of the Pre-existing medical device guideline statement by the Ohio Department of public safety.
MEDICATION PORT ACCESS

Purpose:
To define the use and access of subcutaneous medication ports.

Overview:
Medications ports are placed for numerous reasons in patients with poor vascular access or requiring frequent vascular access.

Permissions:
- PARAMEDICS are permitted to manage already accessed med ports. Paramedics with special training may access med ports.
- ADVANCED EMT’s are NOT permitted to access / manage medications ports
- EMT’s are NOT permitted to access / manage medications ports

General Requirements:
- Paramedics accessing med ports must have undergone testing consistent with a medical director approved competency.
- Paramedics accessing med ports must have undergone hands on training with the device consistent with manufacturers manual and established competency.
- Paramedics accessing med ports must have special Huber needles for accessing med ports.
- Paramedics may utilize prior accessed med ports consistent with requirement outlined in the indwelling venous lines IFTP.
**MEDICAL CONTROL**

**Purpose:**
To define Medical Control for interfacility transport patients.

**Overview:**
Multiple Physicians may be involved in the care of a patient, whom to call in which order and when is important.

**Permissions:**
- PARAMEDICS may contact Medical Direction as required
- ADVANCED EMT’s may contact Medical Direction as required
- EMT’s may contact Medical Direction as required

**General Requirements:**
- The sending Physician is responsible for the patient during transport.
- As required, get contact information for the sending Physician prior to transport.
- A provider should consult the sending Physician for orders specific to the transport as long as the orders are within the providers’ scope of practice and the provider has appropriate resources to carry the orders out safely. Orders from any Physician must be within the scope of practice of transporting EMS providers.
- If the patient condition changes during transport, the sending Physician should attempt to be contacted first,
- If the sending Physician is unavailable, and the accepting Physician is known and available, patient specific orders should be obtained from them.
- In the event the sending or receiving Physician is not available, Prehospital Medical Control may be contacted.
- Document all Medical Control contact and name of Doctor.
OB PATIENT

Purpose:
Define the parameters for successful OB patient transport.

Overview:
OB patient transports require careful assessment and planning for optimal outcome.

Permissions:
- PARAMEDICS can transport OB patients including OB emergencies.
- ADVANCED EMT’s can transport OB patients EXCLUDING OB emergencies.
- EMT’s can transport OB patients EXCLUDING OB emergencies.

General Requirements:
- Patients experiencing contractions less than 5 min apart and / or 6 cm dilation should be delivered before transport unless sending facility wishes to send trained staff.
- Patients experiencing OB emergencies should have benefit of transport carefully weighed with ability to treat and manage said emergency in an ambulance. Discuss situation with sending Physician and / or medical control as necessary.
- Patients receiving magnesium IV should have deep tendon reflexes (DTR’s) monitored every 10 minutes throughout transport. Calcium must be available as an antidote.
- Collect and understand patient OB history before transport. Obtain and record Para / Gravida status, prenatal care, pre‐eclampsia, and previous OB history / complications.
- C‐Sections may not be performed by EMS.
- Fetal monitoring is not performed by EMS. Other healthcare providers with fetal monitoring equipment and training may be transported with the patient as the situation dictates.
- If patient is pre‐eclamptic and progresses to eclampsia enroute, reference PCP for OB emergencies.
- Specialty Health Care provides may be transported with the patient in crisis situations to assist with in transport emergencies.

Key points:
- DTR’s are checked by using impulses from a reflex hammer to stretch the muscle and tendon. The limbs should be in a relaxed and symmetric position, since these factors can influence reflex amplitude. It is important to compare each reflex immediately with its contralateral counterpart so that any asymmetries can be detected.
**PEDIATRIC / INFANT PATIENT**

**Purpose:**
Describe the needs and safe treatment and transport of the pediatric / neonatal patient

**Overview:**
Child and Infant transports require specialized equipment and training. Good history, assessment, and planning yield optimal outcomes

**Permissions:**
- **PARAMEDICS** may transport Pediatric / Infant patients requiring ALS care enroute
- **ADVANCED EMT’s** may transport Pediatric / Infant patients requiring non medicated IV fluids enroute
- **EMT’s** may transport stable Pediatric / Infant patients requiring BLS care

**General Requirements:**
- Pediatric / Infant patients require weight appropriate restraint devices. Refer to and follow the manufacturers recommendations for patient weight.
- Cot mounted restraint devices are NOT to be utilized anywhere but on ambulance cots.
- Caregiver supplied car seats may be utilized if instructions for proper securement are available and legible for that device and is otherwise in good working order.
- Weight based reference material for resuscitation must be available.
- Parents / caregivers are never permitted to hold the patient while sitting on the cot.
- Paramedics may NOT transport patients under the age of 16 years old on ventilators.
- EMS may transport patients under 16 years of age if the patient is chronically ventilated and is on their native vent and there is a family or caregiver trained to manage said device.

**Recommendations:**
- Patients with airway / breathing issues should be placed in flexible cot mounted restraint devices rather than traditional car seats for ease of positioning and intervention if required during transport.
- Assure venous access if needed is in place and functional prior to transport

**Key points:**
- Additional non-patient children or family members are not to be transported in the ambulance.
- One caregiver, translator, or family member may accompany the patient in the ambulance at the discretion of the treating crew.
Purpose:
Describe the situations and care of patients who are pink slipped.

Overview:
Safety of the crew is priority. Summon law enforcement as necessary to assure crew safety.

Permissions:
- PARAMEDICS may transport pink slipped patients
- ADVANCED EMT’s may transport pink slipped patients
- EMT’s may transport pink slipped patients

General Requirements:
- Summon appropriate help to assure crew and patient safety.
- If patient is restrained follow procedure for restraint in the PCP if applicable.
- The transporting crew must have a copy of the pink slip (application for emergency admission) prior to transport.
- Patient must be searched by EMS prior to transport for crew and patient safety.
- Consider elopement risk and plan accordingly. Consider sedation and restraint options.
- Eloped patients from EMS care are to be followed at a safe distance and police summoned for recovery.
- Belongings must be kept separate from the patient.
- Secure any items in the truck that may be used as a weapon against the crew.
- The treating crew must have a copy of the Pink Slip order.

Recommendations:
- Lights and sirens are not to be used unless the patient experiences a medical emergency aside from the reason for restraint or crew safety is in immediate jeopardy.
- Remove shoes, pants, and transport in hospital gown to discourage elopement.

Key points:
- Same sex providers should be utilized whenever possible.
Purpose:
Describe the care of patients transported in restraints

Overview:
Safety of the crew is priority. Summon law enforcement as necessary to assure crew safety.

Permissions:

- PARAMEDICS may transport restrained patients
- ADVANCED EMT’s may transport restrained patients
- EMT’s may transport restrained patients

General Requirements:
- Patients may NOT be transported in KEY locked leather restraints unless special critical circumstances exist. Keyless leather restraints require all 4 restraints to be applied to function correctly.
- Tie on soft restraints are permitted in any quantity.
- Restrain patient per PCP restraint procedure.
- MSP’s must be checked after application and every 10 mins thereafter and documented on the PCR.
- Patients may not be transported face down.
- Place a HEPA mask or oxygen mask with oxygen supplied over patient if they are spitting. Hospital or law enforcement supplied spit hoods are permitted as long as they are purpose made for that application, do not obstruct the airway, and can be removed quickly in the event of an emergency.
- Use verbal de-escalation techniques during restraint and transport.
- Establish last sedation and chemical restraint from sending facility (if given) and document. Be prepared to supplement or redose as necessary per PCP.
- Eloped patients from EMS care are to be followed at a safe distance and police summoned for recovery.
- Restrained or handcuffed prisoners require law enforcement to accompany the patient in the ambulance.
- If fever, tachycardia, muscle rigidity and AMS accompany a patient who has received any tranquilizer or antipsychotic drugs is indicative of Neuroleptic Malignant Syndrome and is an emergency. Begin cooling and divert to an ED immediately.
- No restraint may be made across the patient’s chest. This excludes seat belts required for safe transport in a moving vehicle. Cot seat belts shall not be so tight as to provide impairment to breathing.
- Nothing is to be placed over the patient head.

Recommendations:
- Lights and sirens are not to be used unless the patient experiences a medical emergency aside from the reason for restraint or crew safety is in immediate jeopardy.
SALINE / “HEP” LOCK

Purpose:
Describe whom can transport Saline Locks

Overview:
Saline locks may be present in many patients requiring transport.

Permissions:
- **PARAMEDICS** are permitted to take patients with Saline Locks
- **ADVANCED EMT’s** are permitted to transport patients with saline locks
- **EMT’s** are permitted to transport patients with saline locks assuming no other ALS intervention are required enroute and there are no fluids attached or flowing through the lock and the patient is being transported to a sub-acute care destination or a scheduled appointment. Ex. Hospital discharge, scheduled appointment, dialysis, discharge to home.

General Requirements:
- If able by scope of practice, locks should be flushed prior to transport to assure patency.
- EMTs are permitted to transport saline locks with nothing attached given patient destination is a non-acute care destination. See above permissions.
- Advanced EMT’s are permitted to transport saline locks with saline, ringers, or dextrose preparations attached.
- IV access with a lock attached must be documented as such on the PCR.
- Document location and gauge of IV on PCR.
- If the lock gets pulled out, apply direct pressure to the site. Inspect catheter to assure all has come out. Transport catheter with patient if unsure.
Purpose:
Describe the situations where additional sedation or analgesia are applicable during transport

Overview:
Many patients requiring transport need or have undergone sedation or analgesia for various reasons.

Permissions:
- **PARAMEDICS** may provide additional analgesia or sedation as required
- **ADVANCED EMT’s** may provide additional analgesia as required
- **EMT’s** may NOT provide additional analgesia or sedation

General Requirements:
- Capnography must be utilized when redosing any patient with analgesics or sedatives.
- Use like agents as given by the sending facility wherever possible, unless not indicated.
- Confer with sending Physician or medical control prior to transport for their preferred agents.
- Begin with analgesics first for patient comfort and graduate to sedation unless otherwise indicated or instructed.
- Patients on drip analgesics or sedatives should be augmented with small incremental doses of EMS supplied medications as needed unless there is a pre-approved titration order on a per case basis.
- Patients on drip analgesics and sedatives shall have documented the beginning volume, ending volume, total amount given, and what was left at receiving facility. Document nurse names at both sending and receiving.
- Patients on any type of sedation or analgesic regimen who suffer respiratory or hemodynamic compromise as a result of said regimen shall have the treatment stopped (if able) and resuscitated per PCP.
- Rule out other medical issues and treat underlying cause before adding additional analgesia or sedation.
- Advanced EMT’s and Paramedics may provide supplemental pain management for patients experiencing symptoms of pain. Dosing is per PCP pain management protocol.
- If patient is on a PCA pump and requires augmentation of sedation or analgesia provided by the PCA, contact Medical Control.

Recommendations:
- Understand what agents were used and know when to expect them to begin wearing off. Establish last administration and dose.
SPECIALTY CARDIAC SUPPORT DEVICES - MECHANICAL

Purpose:
Describe the handling and permissions associated with the transport of patients requiring specialty cardiac support devices.

Overview:
Many types of devices are attached to patients for cardiac support depending on need and disease pattern.

Permissions:
- PARAMEDICS may transport patients with cardiac support devices as required
- ADVANCED EMT’s may transport patients with implanted cardiac support devices not requiring intervention ex. Hospital discharge or doctor’s appointment.
- EMT’s may transport patients with implanted cardiac support devices not requiring intervention ex. Hospital discharge or doctor’s appointment.

General Requirements:
- Surgically implanted devices contained within the patient body and run by external controllers may be transported by EMS.
- Capnography and heart rhythm must be monitored in addition to continuous basic vital signs for all patients experiencing difficulty as a result of / concurrent with use of the device.
- Care givers and patients are generally extensively trained in the operation and emergency procedures associated with implanted devices that the patient lives with. Keep persons knowledgeable in the operation of the device with the patient and use as a resource for management of the patient.
- Make sure destination is equipped and ready to receive patients with specialty cardiac devices.
- Patients requiring temporary catheter based intervention for cardiac support must be transported by a Critical Care Transport team. Ex. ECMO, Impella, Balloon Pump (IABP).
- Take instructions, extra batteries, chargers, cords, and trained caregivers with the patient.
- Most patients sent home with cardiac support devices have are followed by specialty teams. These teams usually have an on-call number. Determine this number and contact the on call team if there are complications from the device.
- Patients should be transported to specialty care services, determine where the patient had said support device placed and arrange transport to that facility.
- Be prepared for decompensation and have a diversion / treatment plan if the patient becomes hypotensive or arrests.
SPECIALTY CARDIAC SUPPORT DEVICES – ELECTRICAL

Purpose:
Describe the handling and permissions associated with the transport of patients requiring specialty cardiac support devices.

Overview:
Many types of devices are attached to patients for cardiac support depending on need and disease pattern.

Permissions:
- PARAMEDICS May transport electrical cardiac support devices such as internal pacer, lifevests, and external pacers.
- ADVANCED EMT’s may NOT transport patients with electrical cardiac support devices
- EMT’s may NOT transport patients with electrical cardiac support devices

General Requirements:
- Identify type of device and underlying disease process requiring its use.
- Assure all documentation, batteries, charger cords are transported with the patient.
- Continuous pulse oximetry is required during transport of patients with electrical cardiac support devices.
- Cardiac monitoring is required during transport of patients with electrical cardiac support devices.
- Be prepared for decompensation and have a diversion / treatment plan if the patient becomes hypotensive or arrests.
- Sedation analgesia may be necessary during transport, dosing per the PCP.
**Purpose:**
Define procedure and requirements for the transport of MI patients

**Overview:**
MI patients may be transported to hospitals for admission or interventional needs

**Permissions:**
- PARAMEDICS may transport STEMI / cardiac patients
- ADVANCED EMT’s may NOT transport STEMI / cardiac patients
- EMT’s may NOT transport STEMI / cardiac patients

**General Requirements:**
- Differentiate patients being transported for intervention from those going for higher care, assessment for intervention, or admission.
- Patients being transported for emergent intervention should be treated as an emergency. Lights and sirens are appropriate per agency emergency vehicle operation policy.
- Patients being transported for assessment for intervention or admission are treated as urgent, but not emergent.
- Cardiac monitors are required bedside to bedside
- Assure patient has vascular access prior to transporting
- Cardiac monitoring, automated blood pressure, and capnography are required during transport.
- Vital signs must be evaluated at a minimum every 10 minutes.
- Notify receiving facility of ETA enroute with acute MI patients going for intervention.
- Prepare for and expect decompensation enroute, have potentially needed items readily available.
- Precautionary placement of pacing / defib pads should be considered for transport.
STROKE TRANSFER

Purpose:
Define procedure and requirements for the transport of acute stroke patients

Overview:
Stroke patients may be transported to hospitals for admission or interventional needs

Permissions:
- **PARAMEDICS** may transport acute stroke patients
- **ADVANCED EMT’s** transport acute stroke patients NOT requiring medication administration during transport.
- **EMT’s** may transport non-acute stroke patients to rehab and SNF’s

General Requirements:
- Determine type of stroke prior to transport (ex. Hemorrhagic, or occlusive)
- Obtain onset time from the sending facility
- Assure patient has vascular access prior to transporting
- If patient is having blood pressure controlled, understand and document target BP / MAP as discussed with the sending Physician.
- Determine if patient is being transported for intervention or just admission. Lights and siren use is permitted if there will be measurable time savings and the patient is going for urgent / emergent intervention. Patients being transported to be assessed for interventions shall be treated as non-emergent.
- Conduct a stroke assessment at patient contact and every 10 minutes during transport and document
- Maintain medications enroute per the medication management IFTP
- TPA is bolused by the sending facility prior to departure.
- TPA is NOT titrated enroute and is discontinued after 60 mins. Document total volume delivered, and total delivered during transport.
- If TPA is going to finish during transport, attach saline to the IV line to assure all volume in line is delivered, it is within the timeframe. Administration rate must remain the same.
TRAUMA TRANSFER

Purpose:
Define procedure and requirements for the transport of acute trauma patients

Overview:
Trauma patient may need transport from non-traumas facilities to trauma facilities

Permissions:
| PARAMEDICS may transport trauma patients |
| ADVANCED EMT’s may transport trauma patients |
| EMT’s may NOT transport acute trauma patient that may require ALS intervention (Ex. Fluid bolus, needle decompression, etc.) |

General Requirements:
- Determine type of trauma prior to transport
- Obtain onset time from the sending facility
- Assure patient has vascular access prior to sending
- If patient is being fluid resuscitated, understand and document target BP / MAP as discussed with the sending Physician.
- Determine if patient is being transported for intervention or just admission. Lights and siren use is permitted if there will be measurable time savings and the patient is going for emergent intervention. Patients being transported to be assessed for interventions shall be treated as non-emergent.
- Prepare for and expect decompensation enroute, have potentially needed items readily available.
- Notify receiving facility of ETA enroute with acute stroke going for intervention.
- Patients who have had their c-spine cleared do not require re-immobilization prior to transport unless there is specific case specific reason to do so. C-collars should be left in place if present.
- Vital signs must be evaluated at a minimum every 10 minutes.
- Cardiac monitoring, automated blood pressure, and capnography are required during transport.
- Patients being transported to the Trauma Center ED or OR should be treated like a scene run.
- Patients being transported for trauma rehab or admission to the floor shall be non-emergent unless decompensation occurs enroute.
TRACHEOSTOMY PATIENT

Purpose:
Describe the care and treatment of patients who have existing tracheostomies.

Overview:
Patients may have existing tracheostomies in place for a variety of reasons.

Permissions:
- PARAMEDICS may transport, suction and replace tracheostomies
- ADVANCED EMT’s may transport and suction tracheostomies
- EMT’s may transport and suction tracheostomies

General Requirements:
- Identify reason patient has the tracheostomy and length of time patient has had it.
- Determine how frequently patient requires suction.
- Determine type and size of tracheostomy and document.
- Cuffed tracheotomies must be used with mechanical ventilation. Assure proper cuff fill by assessing pilot balloon. If patient does not have cuffed tracheostomy and requires ventilation, replace with a cuffed tracheostomy or insert an endotracheal tube in the stoma.
- Take a spare inner cannula or spare tracheostomy for transport where available.
- Some pediatric tracheostomies may not have an inner cannula and require strict attention to suction need.
- Suction devices and catheters must be immediately available.
- A BVM must be immediately available bedside to bedside.
- Many different configurations of tracheostomies and stoma covers exists. Understand how each device functions prior to transport.
- If unseen bleeding is occurring from within the stoma, hyper-inflate the cuff and transport immediately. Obvious external bleeding should be controlled by traditional means.

Key points:
- Uncuffed tracheotomies are used in patients who are spontaneously breathing.
UNSTABLE AT TIME OF TRANSFER

Purpose:
Define when a patient who is unstable at time of transfer is to be taken by EMS.

Overview:
Patients who are unstable at time of transfer may continue to deteriorate in transport. Every effort should be made to make the patient stable prior to transport. In only select situations should patients be knowingly transported in an unstable condition.

Permissions:

| PARAMEDICS may take patients who are unstable at time of transfer |
| ADVANCED EMT’s may NOT take patients who are unstable at time of transfer |
| EMT’s may NOT take patients who are unstable at time of transfer |

General Requirements:

- Instability is defined as BP <80 with symptoms, Heart Rate <50 or greater than 130 with symptoms, EtCo2 <20, Reparatory rate < 8 or > 30 with uncorrected Spo2, Capnography, Blood gases or otherwise not perfusing.
- EMS should interface with the Physician if any instability exists and discuss further stabilization prior to departure.
- EMS should NOT begin transport until the patient has been made stable for the transport unless special transport circumstances exist.
- Special circumstances exist when a sending facilities has limited capabilities and is unable to make the patient any more stable for transport. These could include, but are not limited to, the absence of specialty interventions, interventional specialists, blood or blood products.
UNSTABLE PATIENT DIVERSION

Purpose:
Define when a patient requires diversion to another facility from the originally defined destination.

Overview:
Patients who are stable at time of transfer may deteriorate in transport.

Permissions:
- PARAMEDICS may divert patients who are unstable
- ADVANCED EMT’s may divert patients who are unstable
- EMT’s may divert patients who are unstable

General Requirements:
- Patients shall not be diverted for crew / EMS convenience.
- EMS should attempt to divert to in system hospitals if reasonable for continuity of record access unless a specialty service is required.
- Patient must be symptomatic to the event and not responding to treatment / resuscitation efforts.
- Carefully weigh need for additional stabilization and interruption of transport with the treatment goals for the patient at the initial destination. Ex. It may be prudent to continue on despite ongoing deterioration to the original destination if treatments for said condition are only available at the original destination.
USE OF LIGHTS AND SIRENS

Purpose:
Define when it is appropriate to use lights and sirens during intrahospital transports.

Overview:
The use of lights and sirens may be prudent in some patients who require time sensitive interventions at the receiving facility.

Permissions:
- PARAMEDICS may use lights and sirens
- ADVANCED EMT’s use lights and sirens
- EMT’s may use lights and sirens

General Requirements:
- The use of lights and sirens must not be a solution to having the proper level of care available for the transport. Ex. A BLS crew shall not attempt to take a patient “quickly” because that are present at the sending when ALS resources are truly needed.
- Life threatening changes to the patient can prompt a change in response mode.
- Any potential time benefit must be in favor of the patient.
- The patient must be going to the receiving for a known intervention not available at the sending, not an evaluation for intervention, or admission for evaluation.
- This document does not override established organizational emergency vehicle operation policies.
- Use of lights and sirens should be used in situations where the patient is being diverted due to instability, trauma transfers to the ED or OR, and for patient going for immediate lifesaving intervention. Ex. Stroke intervention, surgical intervention.
- Crew and patient must be restrained during transport.
- Sending Physicians may request the use of lights and sirens for critical patients and assume liability for such request.

Key points:
- The use of lights and sirens rarely saves appreciable time and creates a remarkable amount of risk.
- Priority one calls are a lights and siren response.
VENTILATOR MANAGEMENT – Assist /Control Only Device

Purpose:
Define use of simple transport ventilators in transport

Overview:
Most patients requiring artificial ventilation during transport use assist / control settings.

Permissions:

<table>
<thead>
<tr>
<th>PARAMEDICS may use AC ventilators</th>
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</thead>
<tbody>
<tr>
<td>ADVANCED EMT’s may NOT use AC ventilators</td>
</tr>
<tr>
<td>EMT’s may NOT use AC ventilators</td>
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</tbody>
</table>

General Requirements:

- If at any time the ventilator or patient responds poorly, the ventilator must be stripped and the patient bagged. Troubleshooting of ventilators shall not be undertaken while attached to a patient.
- Paramedics utilizing AC vents must have undergone testing consistent with a medical director approved competency and refreshed yearly.
- Paramedics utilizing AC vents must have undergone hands on training with the device consistent with manufacturers manual and established competency.
- Slight changes may be made for patient comfort.
- Waveform capnography is required.
- The patient must be placed on the transport vent for a minimum of 5 mins prior to transfer to cot to assure they will acclimate properly.
- Take backup oxygen sources when away from the ambulance.
- Suction must be available.
- Spare ventilator tubing must be available if there are issues with the original tubing.
- Medical control must be contacted for authorization for major ventilator changes.
- Verify last sedation / analgesia, and understand their duration of action. Treat per Sedation / Analgesia IFTP
- Set PEEP as designated by sending facility. If patient must be bagged for any reason, a PEEP valve must be used to assure continued PEEP.
- If patient becomes hypotensive, increase FiO2 and remove PEEP.
- A BVM must be immediately available bedside to bedside.
VENTILATOR MANAGEMENT - Multi Mode Device

Purpose:
Define use of multi-mode ventilators in transport

Overview:
Most patients requiring artificial ventilation during transport use Assist / Control settings. Some patients may require special modes requiring advanced ventilation. Such as intubated CPAP, BiPAP, SIMV, or Patients requiring Pressure Support or Pressure Control.

Permissions:
| PARAMEDICS may use multi-mode ventilators with appropriate training |
| ADVANCED EMT’s may NOT use multi-mode ventilators |
| EMT’s may NOT use multi-mode ventilators |

General Requirements:
- If at any time the ventilator or patient responds poorly, the ventilator must be stripped and the patient bagged. Troubleshooting of ventilators shall not be undertaken while attached to a patient.
- Employees utilizing multi-mode vents must have undergone testing consistent with a medical director approved competency and at least refreshed yearly.
- Employees utilizing multi-mode vents must have undergone hands on training with the device consistent with manufacturers manual and established competency.
- Employees utilizing multi-mode vents must have undergone a minimum of 6 documented hours of ventilation physiology training.
- Slight changes may be made for patient comfort.
- Waveform capnography is required.
- The patient must be placed on the transport vent for a minimum of 5 mins prior to transfer to cot to assure they will acclimate properly.
- Take backup oxygen sources when away from the ambulance.
- Suction must be available.
- Spare ventilator tubing must be available if there are issues with the original tubing.
- Medical control must be contacted for authorization for major ventilator changes.
- Verify last sedation / analgesia, and understand their duration of action. Treat per Sedation / Analgesia IFTP
- Set PEEP as designated by sending facility. If patient must be bagged for any reason, a PEEP valve must be used to assure continued PEEP.
- If patient becomes hypotensive, increase FiO2 and remove PEEP.
- A BVM must be immediately available bedside to bedside.
INDWELLING VENOUS LINES

Purpose:
Define use of indwelling venous lines in transport

Overview:
Indwelling venous lines of multiple configurations are frequently used in patient care.

Permissions:
- PARAMEDICS may use indwelling venous lines
- ADVANCED EMT’s may NOT use indwelling venous lines
- EMT’s may NOT use indwelling venous lines, but may transport patients with indwelling venous line to sub-acute destinations such as nursing homes, dialysis centers, scheduled appointments, etc.

General Requirements:
- The Paramedic must establish type and location of indwelling access before beginning the transport.
- Blue capped ports are venous ports red capped port are arterial
- Flush lines prior to transport to assure patency.
- If access is required during transport, the port must be cleaned thoroughly with alcohol prior to attaching any device.
- The paramedic must assure that the lines are securely affixed to the patient during transport to withstand the rigors of transport.
- If a venous line comes out, apply direct pressure to the site and notify receiving facility. Save the catheter.
- If a venous line becomes partially dislodged, secure in place and notify the receiving facility.
- Indwelling venous catheters may be used in patients requiring medication administration enroute and may be accessed if no medications are being infused for interventions on patients whose condition changes during transport.
- Multi-lumen lines may have different internal diameters. Understand what lumens are available and their diameter.
- Reference markings on catheter ends for size and use.
- Venous dialysis catheters are to be utilized for crisis situations / resuscitation only.
**Purpose:**
Define the management of IV pumps in transport

**Overview:**
IV pumps are necessary during transport to assure that medication and fluid deliver is at a safe and therapeutic rate.

**Permissions:**
- **PARAMEDICS** may manage IV pumps
- **ADVANCED EMT’s** may NOT manage IV pumps
- **EMT’s** may NOT manage IV pumps

**General Requirements:**
- Paramedics utilizing IV pumps must have undergone testing consistent with a medical director approved competency and refreshed yearly.
- Employees utilizing IV pumps must have undergone hands on training with the device consistent with manufacturers manual and established competency.
- Paramedics may not titrate medications without established orders. Orders may be established with sending or receiving medical control on a per case basis.
- Blood and blood products may be taken on an IV pump if the Paramedic has undergone established training in such products.
- Medications may not be gravity dripped when on a IV pump at the sending facility. Normal saline, lactated ringers and dextrose preparations up to 10% concentration may be gravity dripped.
- If a patient becomes undesired effect as a result of an infusion, the infusion must be discontinued, patient resuscitated per PCP protocols, and medical control contacted.
- Manufacturers specific IV tubing must be used with like IV pumps.
- Keep pumps plugged in whenever possible to assure they continue to operate.
- Note all drips and document any discontinuations prior to departure.
- Verify all drip rates / doses with sending facility before departure.
- Each medication infusion line equals 1 intervention against the 3 devices per provider limit.
- Document patient weight for weight based medications.
- Verify dose / rate against pharmacy labels.
Purpose:
Define the use of Paramedics and Advanced EMT’s as IV Technicians

Overview:
Other healthcare specialties may call upon EMS to assist in starting IVs where no providers are able or have the experience with such initiations.

Permissions:
- PARAMEDICS may function as an IV tech
- ADVANCED EMT’s may function as an IV tech
- EMT’s may NOT function as an IV tech

General Requirements:
- Standard sterile technique shall be used
- Technician must understand the need for the IV and treatment. Tailor catheter size and insertion location to the treatment modality.
- Establish if there are healthcare specialty restrictions on location or management of the IV.
- Verbal physicians’ orders are required for lower extremity, scalp, and external jugular insertions.
- Technicians may establish access only. It is up to the healthcare specialty to hang medications / fluids.