Alamance County EMS System

2025

Treatment Protocols, Policies & Procedures

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Revisions:

Alamance County EMS - Introduction and Foundations of Practice

Introduction

The primary goal of Alamance County EMS is to provide high-quality, evidence-based EMS care to all people within Alamance County. This document helps to organize Alamance County's model for patient care delivery. Alamance County's EMS protocols are based on the North Carolina College of Emergency Physicians Protocols. Treatment protocols, policies, and procedures are designed to meet the needs of the vast majority of the patients who are treated. However, no set of protocols can meet the needs of each and every patient. On-line medical direction is available for patient presentations that do not fall within the scope of the document or whenever physician consultation is desired.

Foundations of Practice

Definition of a Patient

A patient is an individual requesting or potentially needing medical evaluation or treatment. The patient-provider relationship is established via telephone, radio, or personal contact. The provider has the responsibility to ensure all potential patients, regardless of the size of the incident, are offered the opportunity for evaluation, treatment, and/or transport. The guidelines for documenting patient encounters are discussed in the EMS Documentation and Data Quality policy.

Rights of a Patient

As soon as the collection of patient information begins, precaution must be taken to protect patient confidentiality as required by ethics and law. These requirements apply to written and verbal information. Speech must be monitored to not inadvertently share patient information in conversation.

Patients with mental capacity retain the right to accept or refuse medical care, even if the consequences of the refusal of care may potentially be harmful for the patient. **In the event a patient refuses medical care, it is important to:**

1. Be courteous
2. Offer transport or treatment without some (or all) of the recommended treatment(s) if the patient will allow (document discussion which lead to the elected course of treatment, obtain refusal documentation including patient signature).
3. Clearly advise the patient of the possible complications of their decision.
4. Advise the patient to call back if they later want treatment and transport.
5. Accurately document all components of the patient encounter.

The following situations regarding **consent** require additional consideration:

1) Minors:

a) In general, patients under the age of 18 may not consent to medical treatment or transport. The following groups may consent for the treatment of a minor:
   i) Parent or a Legal Guardian
   ii) An individual standing in *loco parentis*. A person stands in *loco parentis* when he or she takes on the responsibilities of a parent of the child (e.g., a step-parent or school personnel).

b) In the following circumstances, no consent is required prior to initiating treatment:
   i) The parent, guardian, or person standing in *loco parentis* cannot be reached and the minor needs to receive medical treatment
   ii) The identity of the child is unknown and a delay in giving treatment would endanger the life of the child
   iii) The effort to contact the child's parent, guardian, or a person standing in *loco parentis* would result in a delay which could seriously worsen the condition of the child

c) In North Carolina, under the following circumstances, a minor may consent to treatment without the knowledge of the parent:
   i) Pregnancy, including prevention
   ii) Treatment for sexually transmitted diseases
   iii) Alcohol or drug abuse
   iv) Emotional disturbance

2) Life-threatening situations without ability to communicate

a) A patient of any age who is unable to communicate because of an injury, accident, illness, or unconsciousness – AND- is suffering from what reasonably appears to be a life-threatening injury or illness. This patient is treated on the principle of Implied Consent.

b) The principle of Implied Consent presumes if the individual with the illness or injury were conscious and able to communicate, he or she would consent to emergency treatment.

c) In these situations, patients may be transported without their consent. Law enforcement, physical restraint, and/or chemical restraint may be required.

3) Potentially life-threatening situations

a) Generally patients fall into one of two groups: the alert patient who has a concerning presentation and refuses treatment and/or transport (e.g., the patient with chest pain and EKG changes) or the patient who may be intoxicated but does not have what reasonably appears to be a life-threatening injury (e.g., the patient who has consumed alcohol with a small laceration). In these situations, the following steps should be taken:
   i) Document patient's orientation to person, place, and time.
   ii) Document factors influencing the patient to refuse medical care. Resolve if possible (e.g., patient does not want an IV – offer transport without an IV).
   iii) Considering confidentiality, attempt communication with spouse/significant other/other family members if available.

iv) **Contact on-line medical control physician**.
v) If patient continues to refuse, clearly explain risks of refusal and have the patient repeat these concerns back to you. **Document** your results in the patient care report.
vi) In a courteous manner, tell the patient they can call back for treatment and transport at any time.

On-line Medical Control

On-line medical control is available 24/7/365 via radio or cell phone through the on-duty emergency room physician at Alamance Regional Medical Center. **Document** conversation with medical control physician in patient care report.

Automatic Notification of the Medical Director

Any incident which potentially has an adverse or negative impact on the patient or the System **must be immediately reported to the on-duty EMS supervisor (101)** as soon as possible after the completion of the call. EMS Supervisor is responsible for ensuring Quality Manager is notified of the incident.

Events that require this notification include:

- Cardiac and/or respiratory arrest occurring after administration of midazolam (Versed), morphine, or fentanyl.
- Cardiac arrest after administration of an antiarrhythmic agent in a previously stable patient.
- Any attempt (successful or unsuccessful) at needle and/or surgical airways.
- Incorrect medication administration.
- Any cardiac and/or respiratory arrest or patient injury related to the use of physical restraints.
- System provider operating outside of scope of practice. The scope of practice is defined not only by State Certification but by the provider's level of approved practice within the System.
- Unrecognized misplaced advanced airway device or other complication related to advanced airway management.

Other patient care concerns, potential adverse events, follow-up questions, or clinical issues outside of the above urgent issues may be communicated to the Alamance County EMS Quality Manager.

If an error occurs with adverse clinical outcomes notify the Quality Manager or EMS Training Officer as soon as possible via email or cellphone. The probability of utilization of the EMS Quality and Safety Review procedure is greatly diminished if a provider with a misadventure contacts the Quality Manager or Training Officer directly.

Guidelines for the Use of Protocols

Medical protocols are divided into three sections. The upper sections include **History, Signs and Symptoms, and Differential.** The information in these boxed areas is meant as a guide to assist in obtaining pertinent patient information and to remind each of us to consider multiple potential causes for a patient complaint. From this, providers should choose elements which are pertinent to the particular patient encounter. Every historical element or sign/ symptom may not apply to every patient but pertinent elements should be included in the patient evaluation and documentation.

The center section describes the **Essentials of Patient Care** which are presented in flow chart style. The North Carolina College of Emergency Physicians has extensively reviewed the included elements. Virtually every patient should receive the care suggested in this section, usually in the order described.

The rationale for any deviation from the recommended course must be clearly explained in the narrative of the patient care report. While rare, providers are strongly encouraged to contact the on-line medical control physician prior to any deviations (as long as the patient's condition is stable).

Finally, the **Pearls** section, on the second page or at the bottom of the protocols, provides further guidance for patient care based on experience and common medical knowledge. Emergency Medicine cannot be condensed to a single page flow chart, but the pearls allow for expanded medication advice, dosages, and description of special situations. The Pearls should be studied along with the rest of the protocols and should be followed if applicable. As with the first section, not every patient will require every element under the pearls section. This section should be used as a practical guide for the implementation of the **essentials of patient care** section.

Summary

In summary, these protocols describe the proven practices which are the foundation of our EMS care within Alamance County. I am proud of the professional manner in which Alamance County's EMS Providers carry themselves and treat patients. Do not hesitate to contact the medical director for any questions about any documents, protocols, patient care, cases, or any other matter.

Sincerely,

Mark Quale, MD|MHA
EMS Medical Director
Alamance County, NC

Introduction

The following medical treatment protocols are developed for North Carolina EMS agencies. The process has evolved since 2007 and continues with input from Medical Directors, EMS Administration, North Carolina Chapter of Emergency Physicians Protocol Committee, North Carolina Office of EMS, EMS field personnel and the public at large through on-line surveys, public meetings across North Carolina and direct communication with stakeholders. The 2017 update expands on the 2012 and 2009 version and continues to incorporate evidence-based guidelines, expert opinion and historically proven practices meant to ensure that citizens and visitors of North Carolina will continue to be provided the highest quality pre-hospital patient care available. The North Carolina Chapter of Emergency Physicians develops and provides final approval.

The purpose of the protocol section is to provide treatment protocols outlining permissible and appropriate assessment, delivery of care, reassessment and procedures which may be rendered by pre-hospital providers. The protocols also outline which medical situations require direct voice communication with medical control. In general treatment protocols are specific orders which may and should be initiated prior to contact with Medical Control.

Please note the medical protocols are divided into three (3) to four (4) sections. The upper section includes three (3) boxes (History, Signs and Symptoms and Differential) which serves as a guide to assist in obtaining pertinent patient information and exam findings as well as considering multiple potential causes of the patients complaint. It is not expected that every historical element or sign / symptom be recorded for every patient. It is expected that those elements pertinent to your patient encounter will be included in the patient evaluation.

The algorithm section describes the essentials of patient care. Virtually every patient should receive the care outlined in this section, usually in the order described. However each medical emergency must be dealt with individually and appropriate care determined accordingly. Professional judgment is mandatory in determining treatment modalities within the parameters of these protocols. Circumstances will arise where treatment may move ahead in the algorithm, move outside to another protocol and then re-enter later. While protocols are written based on body systems and primary complaints the patient should be treated as a whole and therefore the protocols should be considered as a whole in providing care.

<u>Professional judgment hierarchy:</u>

The pre-hospital provider may determine that no specific treatment is needed;
Or
The pre-hospital provider may follow the appropriate treatment protocols and then consult Medical Control;
Or
The pre-hospital provider may consult Medical Control before initiating any specific treatment.

Some protocols will encompass two (2) pages. Protocols which exist in a single page format may have page 2 added by the local medical director. The PEARLS section will either be located at the bottom of page 1 (single page protocol) or page 2 (double page protocol). The PEARLS section provides points regarding the main protocol based on evidence to date, common medical knowledge and expert medical opinion.

Information boxes highlighted in purple. These areas are editable at the local level. They will mainly involve specific medications and dosages utilized by the local EMS agency. Page 2 will have a large section highlighted in purple where the local Medical Director may edit as they see fit to provide expanded points and treatment not otherwise specified in the algorithm. If the box is not to be utilized – add "***This Space Left Blank Intentionally***."

Finally these medical treatment protocols are established to ensure safe, efficient and effective interventions to relieve pain and suffering and improve patient outcomes without inflicting harm. They also serve to ensure a structure of accountability for Medical Directors, EMS agencies, pre-hospital providers and facilities to provide continual performance improvement. A recent report of the Institute of Medicine calls for the development of standardized, evidence-based pre-hospital care protocols for the triage, treatment and transport of patients. These protocols establish expectations of pre-hospital care in North Carolina.

Introduction

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Key to Protocol Utilization

History
- Important history items
- Circumstances of event
- SAMPLE
- Time of onset
- Duration

Signs and Symptoms
- Important Signs and Symptoms specific to each protocol

Differential
- A list of other disease or injury which should be considered

Black Box

Hightlights Important Information

Universal Patient Care Protocol
Assumed all protocols utilize and will not appear on individual protocols

Red Box

Highlights Critical Information

May direct to another protocol

Signals protocol within a protocol

Indicates Entry / Exit from / to to another protocol(s)

Information box

Decision Point
Darker outline to highlight

Highlights medication after Contact Medical Control
May be added by Local Medical Director

Purple Shading of Information Box
Indicates items changeable at local agency level, including medications / dosages on NCMB formulary
Local Medical Director may add / change at his / her discretion
Local medical director may add page 2 to any protocol where none exists for additional comments

Algorithm Legend	
	Emergency Medical Responder
B	Emergency Medical Technician
A	Advanced Emergency Medical Technician
P	Paramedic
	Notify Destination or Contact Medical Control

Pearls
- Important information specific to each protocol will appear here.
- Will usually appear on page.
- Important exam items listed here specific to protocol.

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Universal Patient Care

Scene Safe

NO → Call for help/ additional resources
Stage until scene safe

YES →
- Bring all necessary equipment to patient
- Demonstrate professionalism and courtesy
- Consider WMD in mass assemblies

Utilize appropriate PPE

Consider Airborne, Contact, or Droplet Isolation ***if indicated***

Initial assessment
BLS maneuvers
Initiate oxygen ***if indicated***

Adult Assessment Procedure

Pediatric Assessment Procedure

Required VS:
Blood pressure
Palpated pulse rate
Respiratory rate
Pulse ox if available

If Indicated:
Glucose
12 Lead ECG
Temperature
Pain scale
CO Monitoring
EtCO2 Monitoring

Trauma or Medical

Trauma Patient → Evaluate MOI

- Significant MOI → Primary and Secondary trauma assessment
- No Significant MOI → Primary and Secondary trauma assessment
  Focused assessment on specific injury

Medical Patient → Mental Status Exam

- Unresponsive → Primary and secondary assessment
  Obtain history of present illness from available sources / scene survey
- Responsive → Obtain Chief Complaint
  Primary and Secondary assessment
  Focused assessment on specific complaint

Spinal Motion Restriction Procedure / Protocol TB 8 ***as indicated***

Obtain VS

Obtain SAMPLE

Repeat assessment while preparing for transport

Exit to
Age Appropriate Protocol(s)
as indicated

Continue on-going assessment
Repeat initial VS
Evaluate interventions / procedures

Transfer
Patient hand-off includes patient information, personal property and summary of care and response to care

Patient does not fit specific protocol → **Notify Destination or Contact Medical Control**

Universal Protocol Section

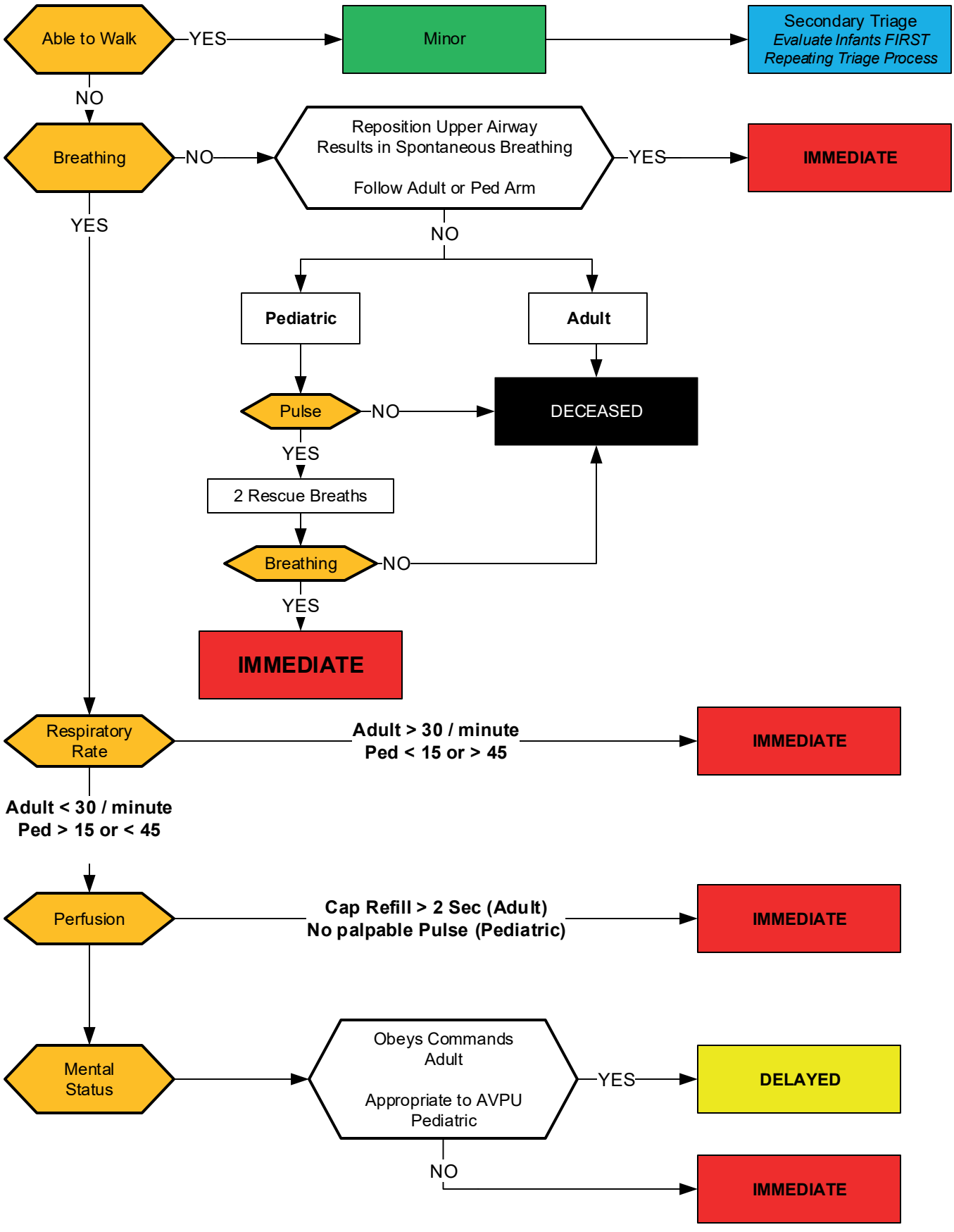
Pearls

- **Recommended Exam: Minimal exam if not noted on the specific protocol is vital signs, mental status with GCS, and location of injury or complaint.**
- **Any patient contact, which does not result in an EMS transport, must have a completed Patient Care Report.**
- **Vital signs should be obtained before, 10 minutes after, and at patient hand off with all pain medications.**
- **Two complete vital sign acquisitions should occur at a minimum with any patient encounter.**
- **For any patient whom cardiac monitor data is obtained, it shall be uploaded into the electronic Patient Care Report.**
- **CAPACITY/REFUSAL CHECKLIST:**
  - **- Is the patient age > 17 and/or emancipated minor?**
  - **- Patient does not have a court appointed guardian?**
  - **- Can the patient retain and comprehend relevant information?**
  - **- Can the patient use information to make a choice?**
  - **- Is the patient NOT DANGEROUS to self or others (i.e. no suicidal or homicidal ideation)?**

  ****If all are "YES" then the patient has capacity to decline further care/transport. If any are "NO" then the patient does not have capacity to make his or her own medical decisions. If patient has a court appointed guardian or is a minor, all available efforts to make contact with the guardian should be made and documented. Document these concepts clearly in your narrative- simply stating "alert and oriented" is not sufficient. Don't hesitate to request and or contact medical control if there are questions about capacity.**

- **Patient Refusal (Declining Treatment and/ or Transport):**
  - Patient refusal is a high risk situation. Encourage patient to accept transport to medical facility.
  - Encourage patient to allow an assessment, including vital signs. Documentation of the event is very important including a mental status assessment describing the patient's capacity to refuse care.
  - **Guide to Assessing capacity:**
  - **C**:***Patient should be able to communicate a clear choice:*** This should remain stable over time. Inability to communicate a choice or an inability to express the choice consistently demonstrates incapacity.
  - **R**: ***Relevant information is understood:*** Patient should be able to voice a factual understanding of the illness/ injury, the options, and the risks and benefits of recommended treatment or transport.
  - **A**: ***Appreciation of the situation:*** Ability to communicate an understanding of the facts of the situation. The patient should be able to recognize the significance of the outcome potentially from their decision.
  - **M**: ***Manipulation of information in a rational manner:*** Demonstrate a rational process to come to a decision. Should be able to describe the logic they are using to come to the decision, though you may not agree with decision.
- **Pediatric Patient General Considerations:**
  - **A pediatric patient is defined by fitting with a Pediatric Medication/ Skill Resuscitation System, Age ≤ 15, weight ≤ 49 kg.**
  - Special needs children may require continued use of Pediatric based protocols regardless of age and weight.
  - Initial assessment should utilize the **Pediatric Assessment Triangle** which encompasses Appearance, Work of Breathing and Circulation to skin.
  - The order of assessment may require alteration dependent on the developmental state of the pediatric patient.
  - Generally the child or infant should not be separated from the caregiver unless absolutely necessary during assessment and treatment.
- Timing of transport should be based on patient's clinical condition and the agency transport policy.
- Consider consultation with Medical Control for patient(s) refusing treatment/ transport.
- Blood Pressure is defined as a Systolic/ Diastolic reading. A palpated Systolic reading may be necessary at times.
- SAMPLE: Signs/ Symptoms; Allergies; Medications; PMH; Last oral intake; Events leading to illness/ injury

Triage


Able to Walk
YES
Minor
Secondary Triage
Evaluate Infants FIRST
Repeating Triage Process
NO
Breathing
NO
Reposition Upper Airway
Results in Spontaneous Breathing
Follow Adult or Ped Arm
YES
IMMEDIATE
YES
NO
Pediatric
Adult
Pulse
NO
DECEASED
YES
2 Rescue Breaths
Breathing
NO
YES
IMMEDIATE
Respiratory Rate
Adult > 30 / minute
Ped < 15 or > 45
IMMEDIATE
Adult < 30 / minute
Ped > 15 or < 45
Perfusion
Cap Refill > 2 Sec (Adult)
No palpable Pulse (Pediatric)
IMMEDIATE
Mental Status
Obeys Commands
Adult
Appropriate to AVPU
Pediatric
YES
DELAYED
NO
IMMEDIATE

Triage

Pearls

- .**When approaching a multiple casualty incident where resources are limited:**
  Triage decisions must be made rapidly with less time to gather information
  Emphasis shifts from ensuring the best possible outcome for an individual patient to ensuring the best possible outcome for the greatest number of patients.
- **Scene Size Up:**
  1. Conduct a scene size up. Assure well being of responders. Determine or ensure scene safety before entering. If there are several patients with the same complaints consider HazMat, WMD or CO poisoning.
  2. Take Triage system kit.
  3. Determine number of patients. Communicate the number of patients and nature of the incident and establish incident command.
  4. **Direct incoming resources. Identify ingress and egress path. Establish a staging area. Assign a medical officer, triage officer, transportation officer, and staging officer as personnel become available.**
- **Triage is a continual process and is a continuous process in each section as resources allow.**
- **Step 1: Global sorting:**
  Call out to those involved in the incident to walk to a designated area and assess group last.
  For those who cannot walk, have them wave/ indicate a purposeful movement and assess them second.
  Those involved who are not moving, or have an obvious life threat, assess first.
- **Step 2: Individual assessments:**
  Control major hemorrhage.
  Open airway and if child, give 2 rescue breaths.
  Perform Needle Chest Decompression Procedure if indicated.
  Administer injector antidotes if indicated.
- **Assess the first patient you encounter using the three objective criteria which can be remembered by RPM.**
  R: Respiratory *(Respiratory rates are difficult to measure quickly, use work of breathing and respiratory distress)*
  P: Perfusion *(Capillary refill can be altered by many factors including skin temperature – use age appropriate heart rates)*
  M: Mental Status *(Motor component of GCS score is important indicator – ability to follow commands)*
- If your patient falls into the RED TAG category, stop, place RED TAG and move on to next patient. Attempt only to correct airway problems, treat uncontrolled bleeding, or administer an antidote before moving to next patient.
- **Treatment:**
  Once casualties are triaged, a focus on treatment can begin. You may need to move patients to treatment areas.
  RED TAGs are moved/ treated first, followed by YELLOW TAGs. BLACK TAGs should remain in place.
  You may also indicate deceased patients by pulling their shirt/ clothing over their head.
  As more help arrives, then the triage/ treatment process may proceed simultaneously.
- **Lightning strike (Reverse Triage):**
  Lightning strike victims are amenable to airway, breathing, cardiac compressions as well as early defibrillation.
  Use concept of reverse triage with multiple casualties. Resuscitate lightning strikes as the priority.
  Lightning strike victims found alive do not often deteriorate quickly.
- **SMART triage tag system is utilized in NC.**

Abdominal Pain Vomiting and Diarrhea

History
- Age
- Time of last meal
- Last bowel movement/emesis
- Improvement or worsening with food or activity
- Duration of problem
- Other sick contacts
- Past medical history
- Past surgical history
- Medications
- Menstrual history (pregnancy)
- Travel history
- Bloody emesis / diarrhea

Signs and Symptoms
- Pain
- Character of pain (constant, intermittent, sharp, dull, etc.)
- Distention
- Constipation
- Diarrhea
- Anorexia
- Radiation

Associated symptoms:
Fever, headache, blurred vision, weakness, malaise, myalgias, cough, headache, dysuria, mental status changes, rash

Differential
- CNS (increased pressure, headache, stroke, CNS lesions, trauma or hemorrhage, vestibular)
- Myocardial infarction
- Drugs (NSAID's, antibiotics, narcotics, chemotherapy)
- GI or Renal disorders
- Diabetic ketoacidosis
- OB-Gyn disease (ovarian cyst, PID, Pregnancy)
- Infections (pneumonia, influenza)
- Electrolyte abnormalities
- Food or toxin induced
- Medication or Substance abuse
- Psychological

	Consider Blood Glucose Analysis Procedure
B	12 Lead ECG Procedure
A	IV or IO Access Protocol UP 6
P	Cardiac Monitor
	Age Appropriate Diabetic Protocol AM 2/ PM 2 ***if indicated***
	Pain Control Protocol UP 11 ***if indicated***
	Age Appropriate Cardiac Protocol(s) ***if indicated***

Age Specific Blood Pressure indicating possible shock

Age 0 – 28 days: SBP < 60
Ages ≥ 1 month: SBP < 70
Age 1 – 9: SBP < 70 + (2*x* Age)

Ages 10 – 64: SBP < 90
Ages ≥ 65: SBP < 110

All ages Shock Index: HR > SBP

Serious Signs/ Symptoms Hypotension, poor perfusion, shock

YES

A	IV or IO Access Protocol UP 6 Consider 2 Large Bore sites
A	**Normal Saline or Lactated Ringer's 500 mL Bolus** Repeat as needed Titrate SPB ≥ 90 mmHg **Maximum 2 L** **Peds: 20 mL/kg IV / IO** Repeat as needed Titrate to Age Appropriate SBP ≥ 70 + (2 x Age) **Maximum 60 mL/kg**
A	**Ondansetron 4 mg** **IV / IO / ODT / IM** **Peds: 0.2 mg/kg** **Peds Maximum 4 mg** May repeat in 15 minutes
	Age Appropriate Hypotension/ Shock Protocol AM 5/ PM 3 ***if indicated***

NO

A	**Normal Saline or Lactated Ringer's IV TKO Or Saline Lock**
A	**Ondansetron 4 mg** **IV / IO / ODT / IM** **Peds: 0.2 mg/kg** **Peds Maximum 4 mg** May repeat in 15 minutes

Monitor and Reassess

Notify Destination or Contact Medical Control

Universal Protocol Section

Abdominal Pain
Vomiting and Diarrhea

Universal Protocol Section

Pearls

- **Recommended Exam: Mental Status, Skin, HEENT, Neck, Heart, Lungs, Abdomen, Back, Extremities, Neuro**
- **Age specific blood pressure 0 – 28 days > 60 mmHg, 1 month - 1 year > 70 mmHg, 1 - 10 years > 70 + (2 x age) mmHg and 11 years and older > 90 mmHg.**
- **Abdominal/ back pain in women of childbearing age should be treated as pregnancy related until proven otherwise.**
- **The diagnosis of abdominal aneurysm should be considered with abdominal pain, with or without back and/ or lower extremity pain or diminished pulses, especially in patients over 50 and/ or patients with shock/ poor perfusion. Notify receiving facility early with suspected abdominal aneurysm.**
- **Consider cardiac etiology in patients > 35, diabetics and/ or women, especially with upper abdominal complaints.**
- **Heart Rate: Tachycardia is one of the first clinical signs of dehydration and volume depletion and typically increases as dehydration becomes more severe.**
- **Nausea without vomiting should be treated like vomiting. Patient will benefit from symptom control with antiemetic even if not actively vomiting.**
- Isolated vomiting in children is common but can be a sign of more serious pathology. Pyloric stenosis, bowel obstruction, and CNS processes (bleeding, tumors, or increased CSF pressures) all often present with vomiting.
- Vomiting and diarrhea are common symptoms, but can be the symptoms of uncommon and serious pathology such as stroke, CO poisoning, acute MI, new onset diabetes, diabetic ketoacidosis (DKA), and organophosphate poisoning. Maintain a high index of suspicion for serious pathology.

Altered Mental Status

History
- Known diabetic, medic alert tag
- Drugs, drug paraphernalia
- Report of illicit drug use or toxic ingestion
- Past medical history
- Medications
- History of trauma
- Change in condition
- Changes in feeding or sleep habits

Signs and Symptoms
- Decreased mental status or lethargy
- Change in baseline mental status
- Bizarre behavior
- Hypoglycemia (cool, diaphoretic skin)
- Hyperglycemia (warm, dry skin; fruity breath; Kussmaul respirations; signs of dehydration)
- Irritability

Differential
- Head trauma
- CNS (stroke, tumor, seizure, infection)
- Cardiac (MI, CHF)
- Hypothermia
- Infection (CNS and other)
- Thyroid (hyper / hypo)
- Shock (septic, metabolic, traumatic)
- Diabetes (hyper / hypoglycemia)
- Toxicological or Ingestion
- Acidosis / Alkalosis
- Environmental exposure
- Pulmonary (Hypoxia)
- Electrolyte abnormality
- Psychiatric disorder

	Age Appropriate Airway Protocol(s) AR 1, 2, 3, 5, 6 ***if indicated***
	Blood Glucose Analysis Procedure
B	12 Lead ECG Procedure
A	IV or IO Access Protocol UP 6
	Age Appropriate Diabetic Protocol(s) AM 2/ PM 2 ***if indicated***

Signs of shock/ Poor perfusion Traumatic Injury — YES → Exit to Age Appropriate Hypotension/ Shock Protocol AM 5/ PM 3, Multiple Trauma Protocol TB 6, Head Injury Protocol TB 5

NO

Signs of OD/ Toxicology — YES → Exit to Overdose/ Toxic Exposure Protocol TE 7

NO

Signs of CVA Or Seizure — YES → Exit to Suspected Stroke Protocol UP 14, Seizure Protocol UP 13

NO

Signs of Hypo/ Hyperthermia — YES → Exit to Hypothermia Protocol TE 5, Hyperthermia Protocol TE 4

NO

Arrhythmia/ STEMI/ CP — YES → Exit to Age Appopriate Appropriate Cardiac Protocol(s)

NO

Fever/ Sepsis — YES → Exit to Fever Protocol UP 10, Suspected Sepsis Protocol UP 15

NO → **Notify Destination or Contact Medical Control**

Universal Protocol Section

Altered Mental Status

Pearls

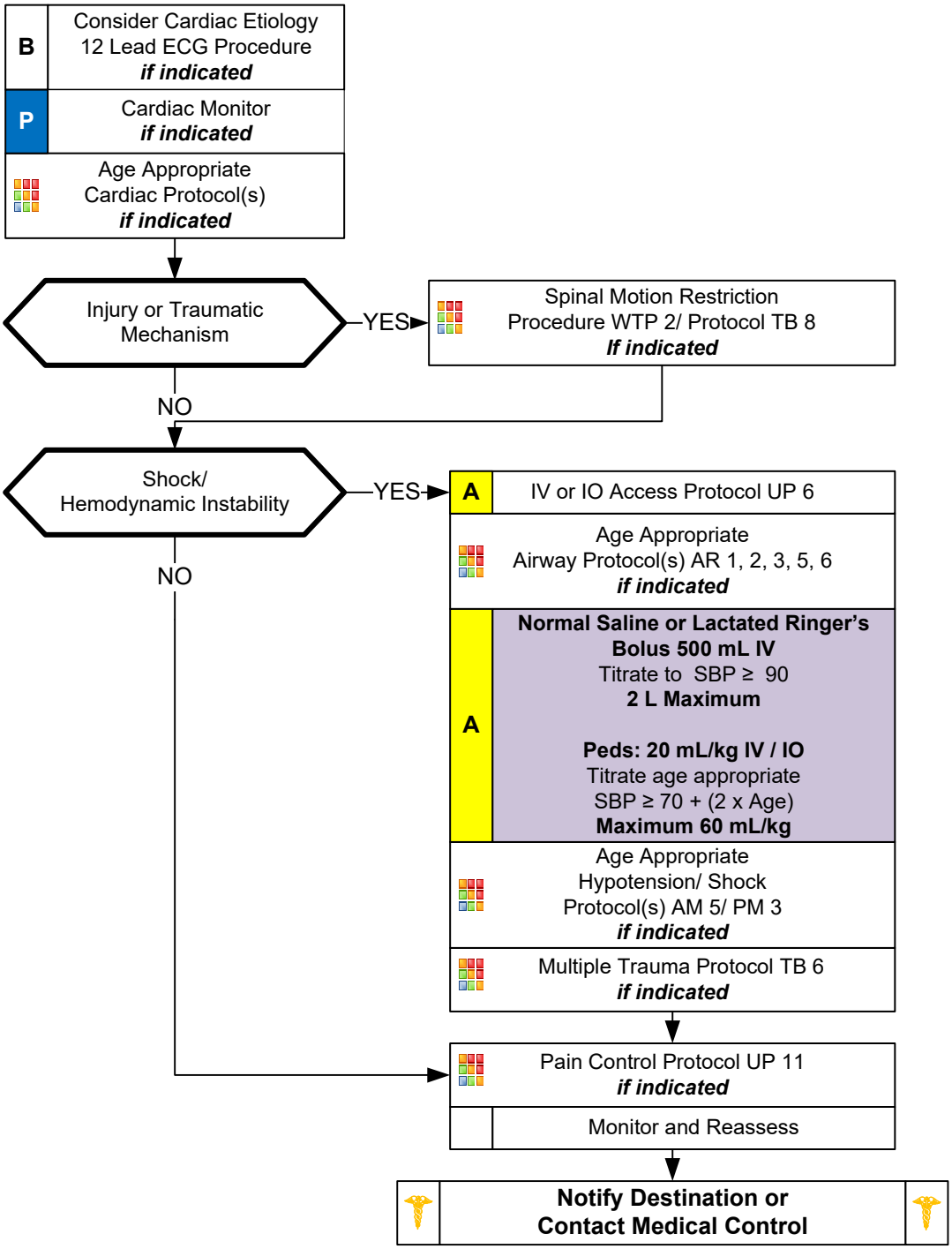
- **Recommended Exam: Mental Status, HEENT, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro.**
- **AMS may present as a sign of an environmental toxin or Haz-Mat exposure, protect personal safety.**
- **General:**
  - **The patient with AMS poses one of the most significant challenges.**
  - **A careful assessment of the patient, the scene, and the circumstances should be undertaken.**
  - **Assume the patient has a life threatening cause of their AMS until proven otherwise.**
  - **Pay careful attention to the head exam for signs of bruising or other injury.**
  - **Information found at the scene must be communicated to the receiving facility.**
  - **Patients not able to communicate with you coherently require a complete secondary survey (head-to-toe) exam to assess for trauma, infection, or signs of maltreatment/ abuse, or neglect.**
  - **Acute Stroke should be considered in all patients with acute AMS when < 24 hours from onset.**
- **Substance misuse:**
  - Patients ingesting substances can pose a great challenge.
  - DO NOT assume recreational drug use and/ or alcohol are the sole reasons for AMS.
  - Misuse of alcohol/ recreational drugs may lead to hypoglycemia or occult trauma.
  - More serious underlying medical and trauma conditions may be the cause.
- **Behavioral health:**
  - The behavioral health patient may present a great challenge in forming a differential.
  - DO NOT assume AMS is the result solely of an underlying psychiatric etiology.
  - Often an underlying medical or trauma condition precipitates a deterioration of a patients underlying disease.
- **Spinal Motion Restriction/ Trauma:**
  - Only utilize spinal immobilization if the situation warrants.
  - The patient with AMS may worsen with increased agitation when immobilized.
- **It is safer to assume hypoglycemia than hyperglycemia if doubt exists. Recheck blood glucose after Dextrose or Glucagon**
- Consider Restraints if necessary for patient's and/ or personnel's protection per USP 5 Restraints: Physical procedure.

Back Pain

History
- Age
- Past medical history
- Past surgical history
- Medications
- Onset of pain / injury
- Previous back injury
- Traumatic mechanism
- Location of pain
- Fever
- Improvement or worsening with activity

Signs and Symptoms
- Pain (paraspinous, spinous process)
- Swelling
- Pain with range of motion
- Extremity weakness
- Extremity numbness
- Shooting pain into an extremity
- Bowel / bladder dysfunction

Differential
- Muscle spasm / strain
- Herniated disc with nerve compression
- Sciatica
- Spine fracture
- Kidney stone
- Pyelonephritis
- Aneurysm
- Pneumonia
- Spinal Epidural Abscess
- Metastatic Cancer
- AAA



Universal Protocol Section

Back Pain

Universal Protocol Section

Pearls

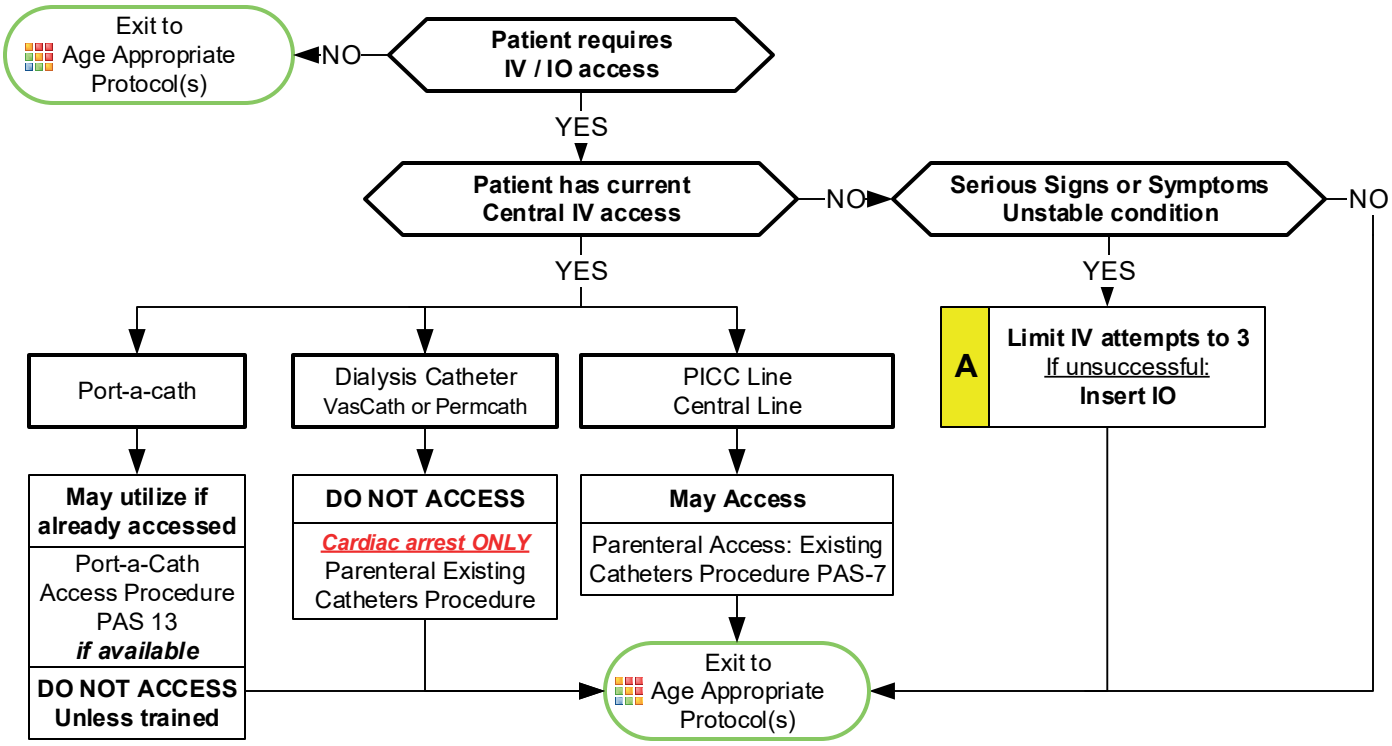
- **Recommended Exam: Mental Status, Heart, Lungs, Abdomen, Neuro, Lower extremity perfusion, Back**
- **Back pain is one of the most common complaints in medicine and affects more than 90% of adults at some point in their life. Back pain is also common in the pediatric population. Most often it is a benign process but in some circumstances can be life or limb threatening.**
- **Consider pregnancy or ectopic pregnancy with abdominal or back pain in women of childbearing age.**
- **Consider abdominal aortic aneurysm with abdominal pain especially in patients over 50 and/ or patients with shock/ poor perfusion. Patients may have abdominal pain and/ or lower extremity pain with diminished pulses. Notify receiving facility early with suspected abdominal aneurysm.**
- **Consider cardiac etiology in patients > 35, diabetics and/ or women especially with upper abdominal complaints.**
- **Red Flags which may signal a more serious process associated with back pain:**
  - Age > 50 or < 18
  - Neurological deficit (leg weakness, urinary retention, or bowel incontinence)
  - IV Drug use
  - Fever
  - History of cancer, either current or remote
  - Night time pain in pediatric patients
- **Cauda equina syndrome is where the terminal nerves of spinal cord are being compressed (Symptoms include):.**
  - Saddle anesthesia (numbness between the genitalia and rectum)
  - Recent onset of bladder and bowel dysfunction. (Urine retention and bowel incontinence)
  - Severe or progressive neurological deficit in the lower extremity.
  - Motor weakness of thigh muscles or foot drop
- **Back pain associated with infection:**
  - Fever/ chills.
  - IV Drug user (consider spinal infection)
  - Recent bacterial infection like pneumonia.
  - Immune suppression such as HIV or patients on chronic steroids like prednisone.
  - Meningitis.
- **Spinal motion restriction in patients with underlying spinal deformity should be maintained in their functional position.**
- Kidney stones typically present with an acute onset of flank pain which radiates around to the groin area.

IV or IO Access

History
- Chronic medical conditions requiring recurrent need for IV access for medication, hydration, or blood sampling.
- Medical condition requiring administration of IV medications at home.
- End-stage renal disease requiring hemodialysis.
- Chronic medical condition requiring IV nutrition.

Signs and Symptoms
- Fever
- Bleeding
- Hypotension
- Redness, swelling, and/or pain at IV catheter site
- Shortness of breath
- Chest pain
- IV catheter patency

Differential
- Infection or sepsis
- Infection of catheter
- Clotted IV catheter
- Air embolism
- Pneumothorax
- Overdose of home medication
- Shock



Universal Protocol Section

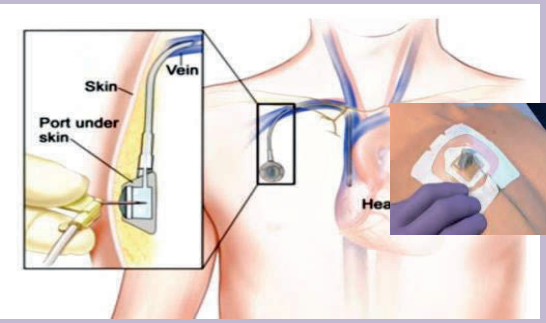
Pearls
- **Frequent encounter of patients with IV access devices and confusion as to which device can be accessed and used by EMS providers are common.**
- **If unclear about device use, always ask "Is this device used for dialysis?"**
- **When accessing central catheter, always ensure sterility of catheter connection point by cleaning port with alcohol, or similar disinfectant, 2 – 3 times prior to access.**
- **Central line catheters placed for administration of chemotherapy, medications, electrolytes, antibiotics, and blood are available to EMS providers for access and administration of fluids, medications, antibiotics, and blood products.**
- **Central line catheters placed for hemodialysis are NOT available for access by EMS providers unless the patient is in cardiac arrest.**
- Long term IV access is frequently needed for a variety of indications:
  - Medication administration such as antibiotics, pain relief, or chemotherapy.
  - Administration of IV nutrition or feeding.
  - Need for multiple IV line access or recurrent blood sampling.
  - Poor vasculature requiring repeated attempts at IV access.
  - End-stage renal disease requiring hemodialysis.
- Common complications of central access devices:
  - Infection
  - Damage to vasculature
  - Air embolism
  - Loss of patency due to clogging or clotting
  - Pneumothorax

IV or IO Access

Types of IV catheters:

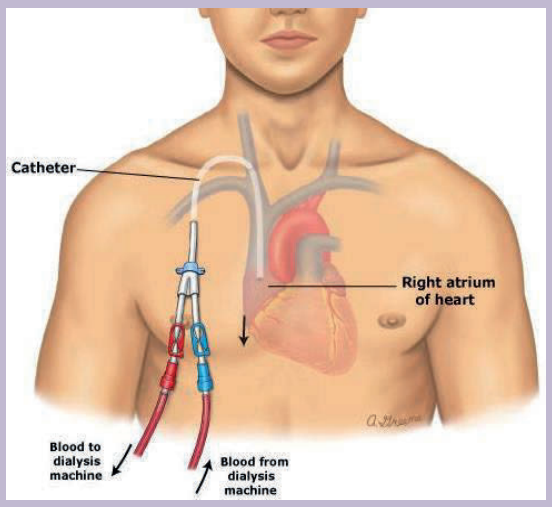
Port-a-Cath® :

Surgically implanted device allowing easy access to venous system.
The port and the catheter are all placed beneath the skin.
Requires a special kit and a specific needle to access.
Paramedic does NOT routinely access this device.
Paramedic may utilize if already accessed with needle/ extension.
Paramedic may access if trained on procedure with access to proper equipment.



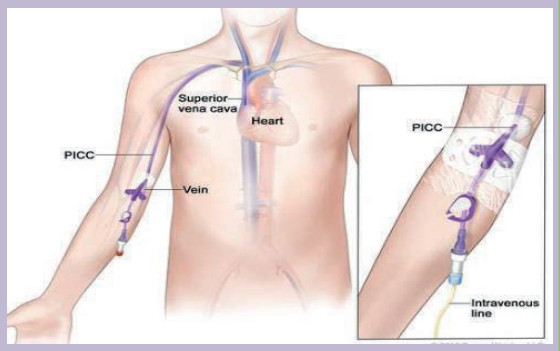
Dialysis Catheter:

Surgically implanted device used to access the vasculature for hemodialysis.
May be tunneled under the skin with access on outside of skin surface or may be non-tunneled with greater portion of catheter on outside of skin surface.
Catheter has a RED port indicating use for dialysis:
Most catheters have a RED port and a BLUE port.
Some catheters have a RED port and a WHITE port.
Dialysis catheters may be used for both short and long-term dialysis and should not accessed or used for delivery of fluids, medications, antibiotics, or blood products as it increases risk of infection, which then requires removal and subsequent loss of dialysis access.
Paramedic and AEMT do NOT routinely access this device.
Paramedic and AEMT MAY access during cardiac arrest only (Only if IV or IO access cannot be established.)



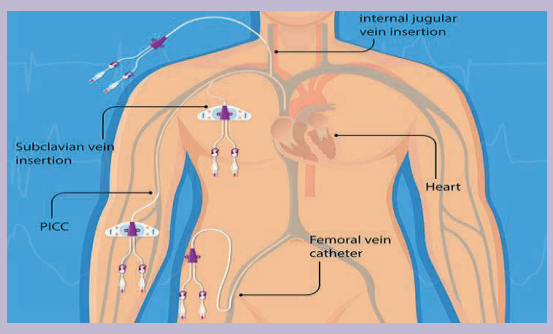
PICC (Peripherally Inserted Central Catheters):

Long catheter inserted into a vein in arm or leg (less common) with the tip of the catheter positioned into the central circulation.
Used for long-term IV fluids, medication administration, blood administration or blood draws.
May have 1 or 2 ports (possibly more, but less common.)
Port ends usually white, blue, or purple. (May be red, less common and is not used for dialysis.)
Paramedic and AEMT may access and utilize following clean technique.



Central Lines:

Catheter placed in large vein in the neck, under the clavicle, or in the groin.
Used for long-term IV fluids, medication administration, blood administration or blood draws.
May have 1 - 4 ports (possibly more, but less common.)
Port ends usually white, blue, or purple. (May be red, less common and is not used for dialysis.)
Paramedic and AEMT may access and utilize following sterile technique.

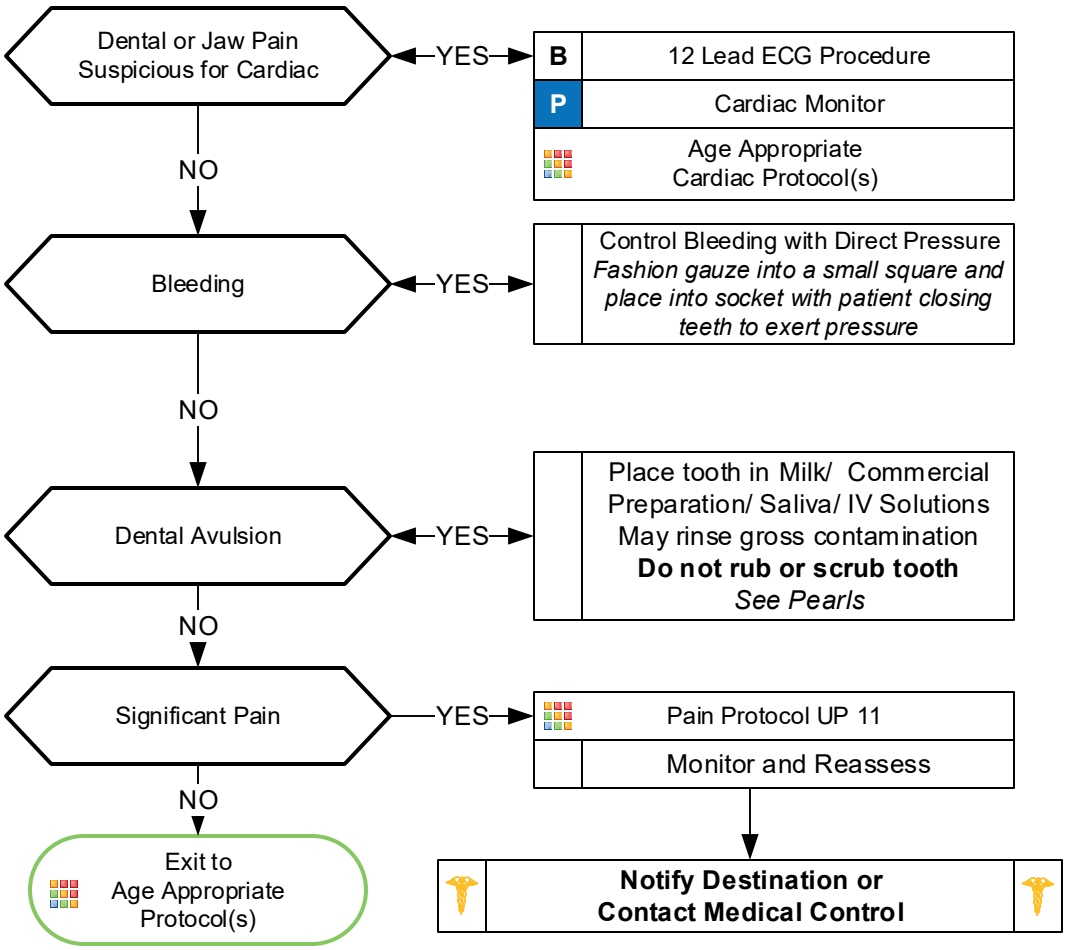


Dental Problems

History
- Age
- Past medical history
- Medications
- Onset of pain / injury
- Trauma with "knocked out" tooth
- Location of tooth
- Whole vs. partial tooth injury

Signs and Symptoms
- Bleeding
- Pain
- Fever
- Swelling
- Tooth missing or fractured

Differential
- Decay
- Infection
- Fracture
- Avulsion
- Abscess
- Facial cellulitis
- Impacted tooth (wisdom)
- TMJ syndrome
- Myocardial infarction



Universal Protocol Section

Pearls
- **Recommended Exam: Mental Status, HEENT, Neck, Chest, Lungs, Neuro**
- Significant soft tissue swelling to the face or oral cavity can represent a cellulitis or abscess.
- Scene and transport times should be minimized in complete tooth avulsions. Reimplantation is possible within 4 hours if the tooth is properly cared for, but unlikely when > 1 hour from time of injury.
- Cardiac chest pain may radiate to the jaw and teeth mimicking dental pain.
- **Avulsed tooth:**
  Handle tooth by the crown, do not touch the root.
  Rinse tooth if soiled but do not scrub, as this can damage the ligaments vital for possible reimplantation.
  Rinse with mild, commercial tooth solution, normal saline or lactated ringers, or the patient's own saliva if dry.
  Transport tooth in milk, commercial solution, patient's own saliva, or IV solution in a container to protect.

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Emergencies Involving Indwelling Central Lines

History

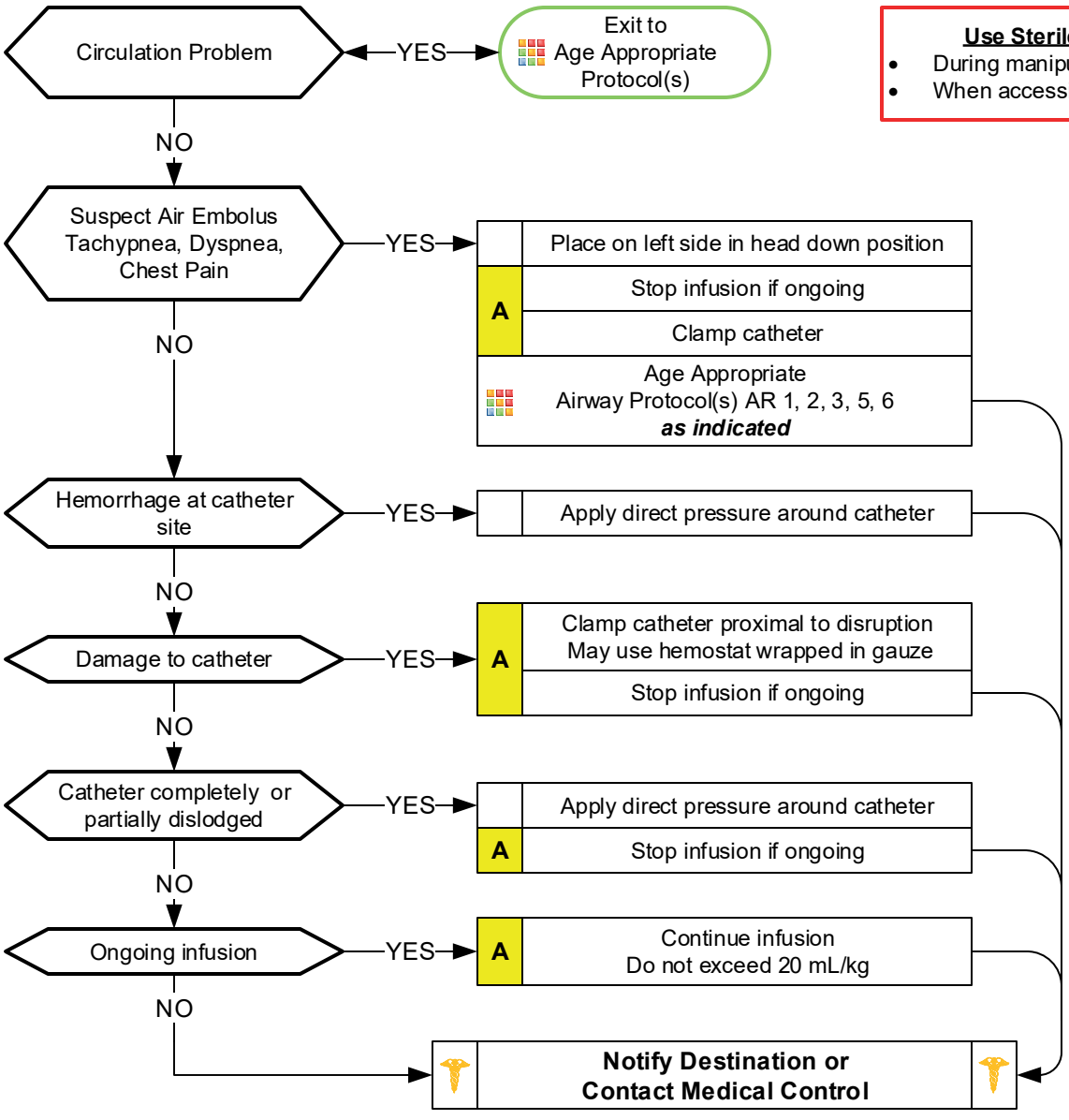
- Central Venous Catheter Type
  - Tunneled Catheter (Broviac/ Hickman)
  - PICC (peripherally inserted central catheter
  - Implanted catheter (Mediport/ Hickman)
- Occlusion of line
- Complete or partial dislodge
- Complete or partial disruption

Signs and Symptoms

- External catheter dislodgement
- Complete catheter dislodgement
- Damaged catheter
- Bleeding at catheter site
- Internal bleeding
- Blood clot
- Air embolus
- Erythema, warmth or drainage about catheter site indicating infection

Differential

- Fever
- Hemorrhage
- Reactions from home nutrient or medication
- Respiratory distress
- Shock



Use Sterile Technique:

- During manipulation of central line
- When accessing central line

Universal Protocol Section

Pearls

- **Always involve family/ caregivers as they may have specific knowledge and skills related to catheter device.**
- **Use strict sterile technique when accessing/ manipulating an indwelling catheter.**
- **Cardiac arrest: May access central catheter and utilize if functioning properly.**
- Do not attempt to force catheter open if occlusion evident.
- Some infusions may be detrimental to stop. Ask family or caregiver if it is appropriate to stop or change infusion.
- Hyperalimentation infusions (IV nutrition): If stopped for any reason, monitor for hypoglycemia.

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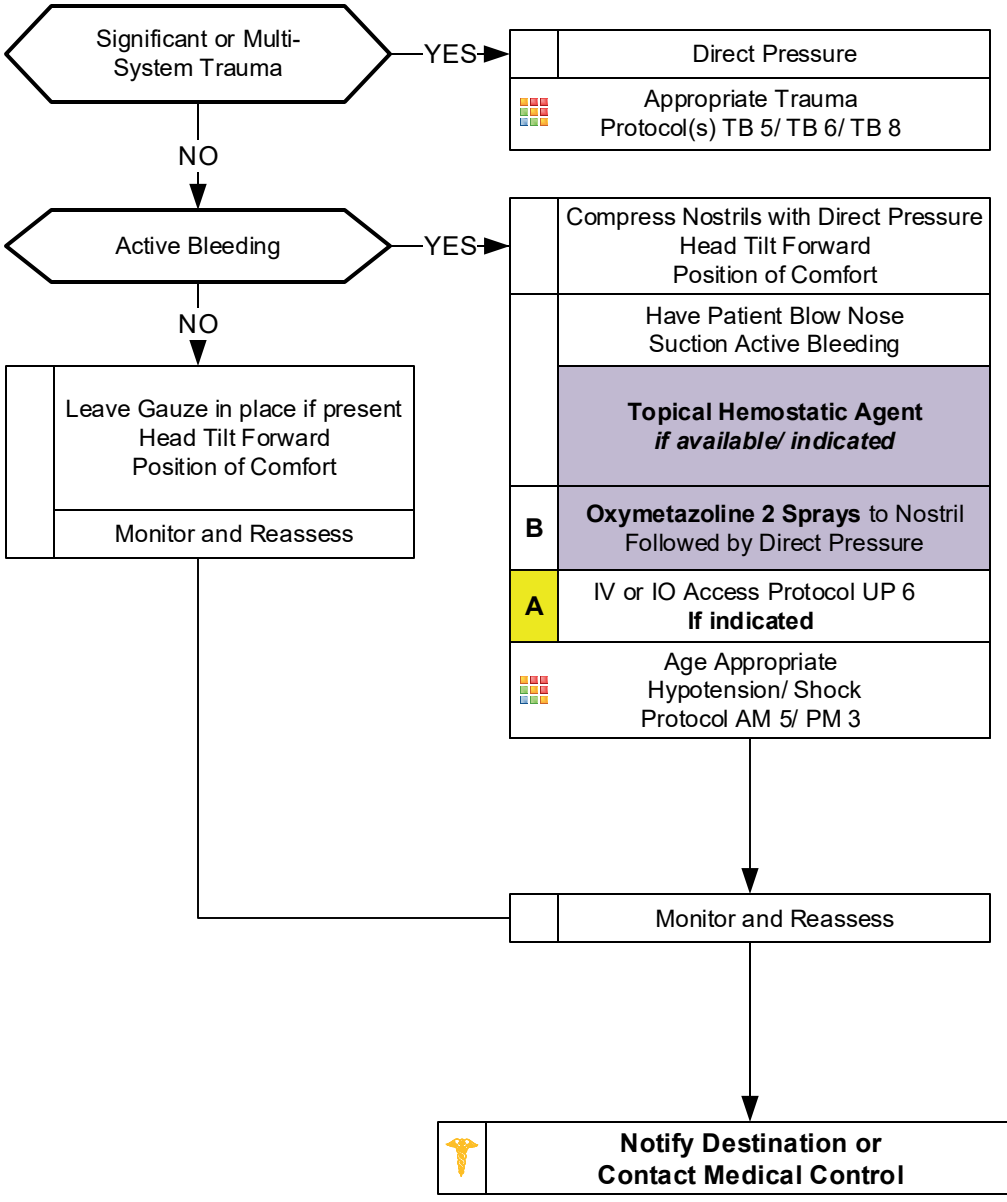
Epistaxis

History
- Age
- Past medical history
- Medications (HTN, anticoagulants, aspirin, NSAIDs)
- Previous episodes of epistaxis
- Trauma
- Duration of bleeding
- Quantity of bleeding

Signs and Symptoms
- Bleeding from nasal passage
- Pain
- Nausea
- Vomiting

Differential
- Trauma
- Infection (viral URI or Sinusitis)
- Allergic rhinitis
- Lesions (polyps, ulcers)
- Hypertension



Age Specific Blood Pressure indicating possible shock

Age 0 – 28 days: SBP < 60
Ages ≥ 1 month: SBP < 70
Age 1 – 9: SBP < 70 + (2*x* Age)

Ages 10 – 64: SBP < 90
Ages ≥ 65: SBP < 110

All ages Shock Index: HR > SBP

Universal Protocol Section

Pearls
- **Recommended Exam: Mental Status, HEENT, Heart, Lungs, Neuro**
- It is very difficult to quantify the amount of blood loss with epistaxis.
- Bleeding may also be occurring posteriorly. Evaluate for posterior blood loss by examining the posterior pharnyx.
- Anticoagulants include warfarin (Coumadin), Apixaban (Eliquis), heparin, enoxaparin (Lovenox), dabigatran (Pradaxa), rivaroxaban (Xarelto), and many over the counter headache relief powders.
- Anti-platelet agents like aspirin, clopidogrel (Plavix), aspirin/ dipyridamole (Aggrenox), and ticlopidine (Ticlid) can contribute to bleeding.

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Fever/ Infection Control

History
- Age
- Duration of fever
- Severity of fever
- Past medical history
- Medications
- Immunocompromised (transplant, HIV, diabetes, cancer)
- Environmental exposure
- Last acetaminophen or ibuprofen

Signs and Symptoms
- Warm
- Flushed
- Sweaty
- Chills/Rigors

Associated Symptoms (Helpful to localize source)
- Myalgias, cough, chest pain, headache, dysuria, abdominal pain, mental status changes, rash

Differential
- Infections / Sepsis
- Cancer / Tumors / Lymphomas
- Medication or drug reaction
- Connective tissue disease
  - Arthritis
  - Vasculitis
- Hyperthyroidism
- Heat Stroke
- Meningitis

	Contact, Droplet, and Airborne Precautions See Pearls
B	Temperature Measurement Procedure ***if available***
A	IV or IO Access Protocol UP 6 ***If indicated***

Temperature ≥ 100.4° F (38° C)

NO → Exit to Age Appropriate Protocol(s) ***as indicated***

YES →

Acetaminophen IV should only be administered to patients unable to take Acetaminophen PO

B	**Ibuprofen 10 mg / kg PO** (if age > 6 months) **Adult Ibuprofen 400 – 600 mg PO** And / Or **Acetaminophen 15 mg / kg PO** **Adult Acetaminophen 325 – 1000 mg PO**
A	**Adult Patients Only** **Acetaminophen 1,000 mg IV/IO** **Administer over 10 minutes** **Contraindicated in Hypotensive Patient**

Exit to Age Appropriate Protocol(s) ***as indicated***

Universal Protocol Section

Pearls
- **Recommended Exam: Mental Status, Skin, HEENT, Neck, Heart, Lungs, Abdomen, Back, Extremities, Neuro**
- Febrile seizures are more likely in children with a history of febrile seizures and with a rapid elevation in temperature.
- Patients with a history of liver failure should not receive acetaminophen.
- **Droplet precautions** include standard PPE plus a standard surgical mask for providers who accompany patients in the back of the ambulance and a surgical mask or NRB O2 mask for the patient. This level of precaution should be utilized when influenza, meningitis, mumps, streptococcal pharyngitis, and other illnesses spread via large particle droplets are suspected. A patient with a potentially infectious rash should be treated with droplet precautions.
- **Airborne precautions** include standard PPE plus utilization of a gown, change of gloves after every patient contact, and strict hand washing precautions. This level of precaution is utilized when multi-drug resistant organisms (e.g. MRSA), scabies, or zoster (shingles), or other illnesses spread by contact are suspected.
- **All-hazards precautions** include standard PPE plus airborne precautions plus contact precautions. This level of precaution is utilized during the initial phases of an outbreak when the etiology of the infection is unknown or when the causative agent is found to be highly contagious (e.g. **SARS, SARS-CoV-2, COVID-19, MERS, Monkeypox**).
- Rehydration with fluids increases the patient's ability to sweat and improves heat loss.
- Allergies to NSAIDs (non-steroidal anti-inflammatory medications) are a contraindication to Ibuprofen. Do not give to patients who have renal disease or renal transplant.
- NSAIDs should not be used in the setting of environmental heat emergencies.
- **Do not** give aspirin to a child, age ≤ 15 years.
- Agency Medical Director may require contact of medical control prior to EMT/ EMR administering any medication.

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Pain Control

History
- Age
- Location
- Duration
- Severity (1 - 10)
- If child use Wong-Baker faces scale
- Past medical history
- Medications
- Drug allergies

Signs and Symptoms
- Severity (pain scale)
- Quality (sharp, dull, etc.)
- Radiation
- Relation to movement, respiration
- Increased with palpation of area

Differential
- Per the specific protocol
- Musculoskeletal
- Visceral (abdominal)
- Cardiac
- Pleural/ Respiratory
- Neurogenic
- Renal (colic)

Specific Complaint Protocol

Assess Pain Severity

Combination of Pain Scale, MOI, circumstances, Injury or Illness severity

Mild

B

Ibuprofen 10 mg/kg PO
(400 – 600 mg typical adult)
Maximum 800 mg
Or
Acetaminophen 15 mg/kg PO
(325 – 1000 mg typical adult)
Maximum 1000 mg
Or
Aspirin 324 mg PO
(≥ 16 years only)

A

<u>If no improvement</u>
Consider
IV or IO Access Protocol UP 6
if indicated

Monitor and Reassess

ADULT ONLY
Patients administered up to 75 mcg of Fentanyl for a non-cardiac complaint may be released to EMT for transport unless otherwise indicated for Paramedic monitoring during transport.

Patients that have been administered IV Acetaminophen may be released to EMT for transport unless otherwise indicated for ALS monitoring during transport.

Moderate to Severe

IV or IO Access Protocol UP 6

P

Cardiac Monitor

A

<u>Adult Patients Only</u>
Acetaminophen 1,000 mg IV/IO
Administer over 10 minutes
Contraindicated in Hypotensive Patient

P

Adult
Fentanyl 25 – 75 mcg IV / IO / IM / IN
Repeat **25 mcg** every 10 minutes as needed
Maximum 200 mcg

AGE ≥ 65 years
25-50 mcg IV / IO / IM / IN
May repeat **25 mcg** every 10 minutes as needed
Maximum 200 mcg

Peds: 1 mcg/kg IV / IO / IM / IN
May repeat 0.5 mcg/kg every 5 minutes as needed
Maximum 2 mcg/kg

-Or-

Adult: Morphine 2 - 4 mg IV / IO / IM
Repeat **2 mg** every 5 minutes as needed
Peds: 0.1 mg/kg IV / IO / IM
May repeat every 5 minutes
Maximum 10 mg

Continuous EtCO2 monitoring

Monitor and Reassess
Every 10 minutes following sedative

P

Adult Burn Patient Pain Control
(Transporting to Burn Center)

Fentanyl 25 – 100 mcg IV / IO / IM / IN
Repeat **25 – 100 mcg** every 10 minutes as needed
Maximum 300 mcg

-Or-

Adult: Morphine 2 – 4 mg IV / IO / IM
Repeat **2 – 4 mg** every 5 minutes as needed
Maximum 20 mg

Notify Destination or Contact Medical Control

Universal Protocol Section

Pain Control

Any patient administered IV, IO, IN or IM pain medication by Alamance County EMS must be cared for and monitored by an appropriate ALS provider throughout transport **EXCEPT** (see below).

When Paramedic is not available due to system constraints/ call volume, **ADULT** patients administered up to 75 mcg of Fentanyl for a non-cardiac complaint may be released to EMT for transport unless otherwise indicated for Paramedic monitoring during transport. Patients that have been administered IV Acetaminophen may be released to EMT for transport unless otherwise indicated for ALS monitoring during transport.

IV Fentanyl and Morphine should be administered **slowly** over 2 – 3 minutes.

Pearls

- **Recommended Exam: Mental Status, Area of Pain, Neuro**
- **Pain severity (0-10) is a vital sign to be recorded before and after PO, IV, IO, IN or IM medication delivery and at patient hand off. Monitor BP closely as sedative and pain control agents may cause hypotension and/or respiratory depression.**
- **USE EXTREME CAUTION in administering opioids to patients less than 10 kg.**
- **Both arms of the treatment protocol may be used in concert. For patients in Moderate pain for instance, you may use the combination of an oral medication and parenteral if no contraindications are present.**

- **Patients may display a wide variation of response to opioid pain medication (Morphine and Fentanyl, aka "narcotics"). Consider the patient's age, weight, clinical condition, other recent drugs or alcohol, and prior exposure to opiates when determining initial opioid dosing. Weight-based dosing may provide a standard means for dose calculation, but does NOT predict patient response. For example, minimal doses of opioids may be effective for pain management and/or cause respiratory depression in the elderly, opiate naïve, and possibly intoxicated patients. It is often appropriate to start with LESS THAN the weight-based dose, consider:**
  - **A "typical" initial dose of fentanyl for an adult may be 25 – 75 mcg, depending on condition**
  - **A "typical" initial dose of morphine for an adult may be 2 – 4 mg, depending on condition**

- **Consider attempts at non-opiate based pain control (acetaminophen, NSAIDS including ketorolac) for chronic and or non-acute, non-traumatic sources of pain. Always consider whether a patient may have a care plan if there is evidence of recurrent high utilization of opioid medications.**

- **Pediatrics:**
  For children use Wong-Baker faces scale or the FLACC score (see Assessment Pain Procedure ASP 2)
  Use Numeric (> 9 yrs), Wong-Baker faces (4-16yrs) or FLACC scale (0-7 yrs) as needed to assess pain.

- **Vital signs should be obtained before, 10 minutes after, and at patient hand off with all pain medications.**
- All patients who receive IM, IV, IO or IN medications must be observed 15 minutes for drug reaction in the event no transport occurs.
- **Ibuprofen should not be used in patients with known renal disease or renal transplant, in patients who have known drug allergies to NSAID's (non-steroidal anti-inflammatory medications), with active bleeding, headaches, abdominal pain, stomach ulcers or in patients who may need surgical intervention such as open fractures or fracture deformities.**
- Do not administer **Acetaminophen** to patients with a history of liver disease.

- Burn patients may require higher than usual opioid doses to effect adequate pain control. IF AN ADULT PATIENT HAS SUFFERED BURNS THAT REQUIRE TRANSPORT TO THE BURN CENTER, **THE MAXIMUM TOTAL DOSE OF FENTANYL is 300 mcg AND THE MAXIMUM TOTAL DOSE OF MORPHINE IS 20 mg**. Do not hesitate to contact medical control regarding the pain management strategy for patients in severe pain despite medications or with significant burns.

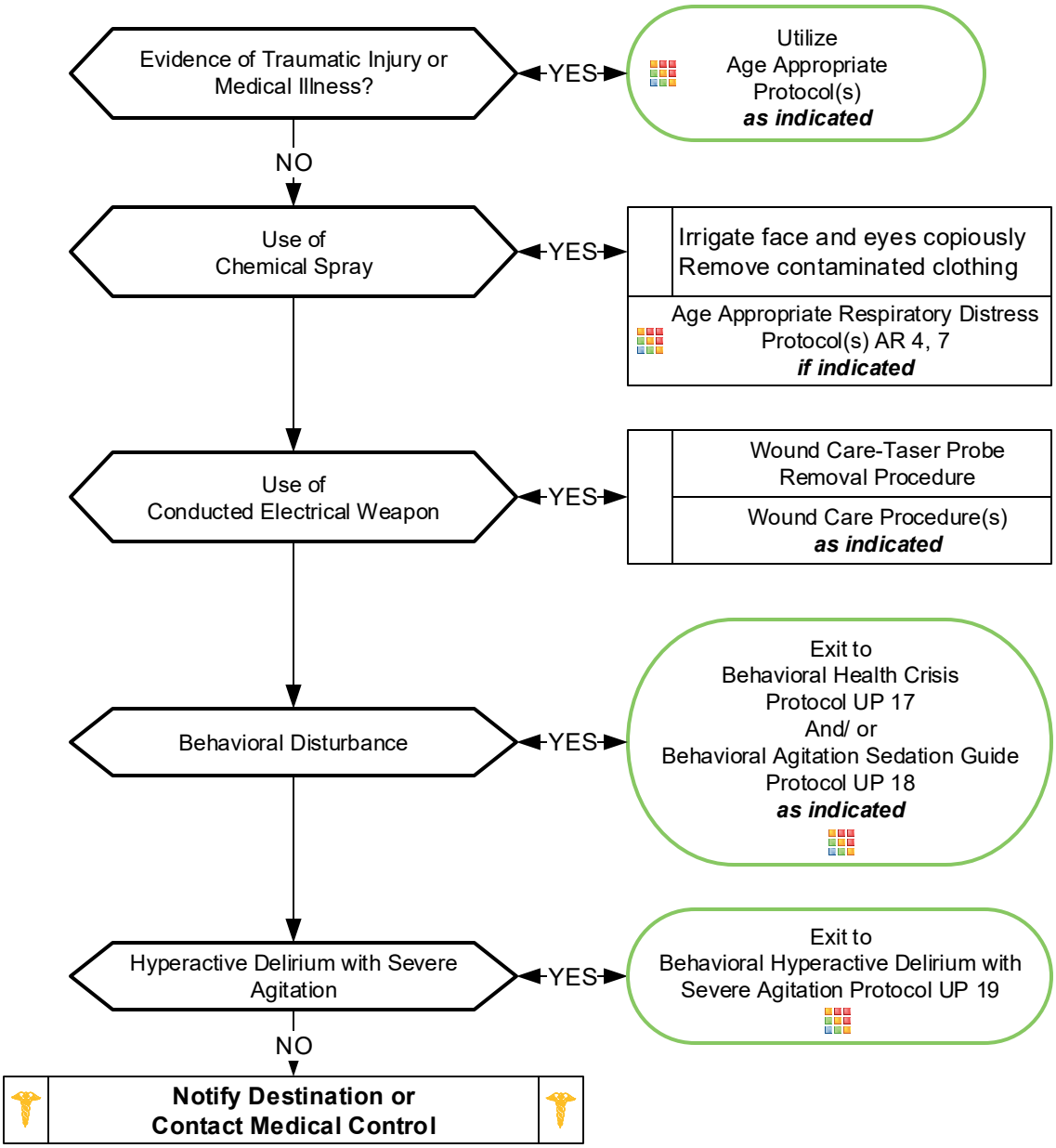
- Consider Ondansetron for nausea and/ or vomiting.

Police Custody

History
- Traumatic Injury
- Drug Abuse
- Cardiac History
- History of Asthma
- Psychiatric History

Signs and Symptoms
- External signs of trauma
- Palpitations
- Shortness of breath
- Wheezing
- Altered Mental Status
- Intoxication/Substance Abuse

Differential
- Agitated Delirium Secondary to Psychiatric Illness
- Agitated Delirium Secondary to Substance Abuse
- Traumatic Injury
- Closed Head Injury
- Asthma Exacerbation
- Cardiac Dysrhythmia



Universal Protocol Section

Police Custody

Pearls

- **Recommended Exam: Mental Status, Skin, Heart, Lungs, Neurologic status**
- **Patient does not have to be in police custody or under arrest to utilize this protocol.**
- **Local EMS agencies should formulate a policy with local law enforcement agencies concerning patients requiring EMS and Law Enforcement services simultaneously.**
- **Agencies should work together to formulate a disposition in the best interest of the patient.**
- **Patients restrained by law enforcement devices must be transported and accompanied by a law enforcement officer in the patient compartment who is capable of removing the devices. However, when rescuers have utilized restraints in accordance with Restraint Procedure, the law enforcement agent may follow the ambulance during transport.**
- **All patients who receive either physical or chemical restraint must be continuously observed by ALS personnel on scene or immediately upon their arrival.**
- The responsibility for patient care rests with the highest authorized medical provider on scene per North Carolina law.
- If an asthmatic patient is exposed to irritant/ pepper spray and released to law enforcement, all parties should be advised to immediately contact EMS if wheezing/ difficulty breathing occurs.
- All patients with decision-making capacity in police custody retain the right to participate in decision-making regarding their care and may request care or refuse care of EMS.
- If extremity/ chemical/ law enforcement restraints are applied, follow USP 5 Restraints: Physical.
- **Consider Haldol for patients with history of psychosis or a benzodiazepine for patients with presumed substance misuse.**
- **Haldol is acceptable treatment in pediatric patients ≥ 12 years old. Safety and efficacy is not established in younger ages. Contact Medical Control for advice as needed.**
- **<u>Hyperactive Delirium with Severe Agitation:</u>**
  - Medical emergency: Combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent/ bizarre behavior, insensitivity to pain, hyperthermia and increased strength.
  - Potentially life-threatening and associated with use of physical control measures, including physical restraints and Tasers.
  - Most commonly seen in male subjects with a history of serious mental illness and/or acute or chronic drug abuse, particularly stimulant drugs such as cocaine, crack cocaine, methamphetamine, amphetamines or similar agents. Alcohol withdrawal or head trauma may also contribute to the condition.
  - **If patient suspected of Hyperactive Delirium with Severe Agitation suffers cardiac arrest, consider a fluid bolus, administration of calcium gluconate (or chloride), and sodium bicarbonate early.**
- Do not position or transport any restrained patient is such a way that could impact the patients respiratory or circulatory status.
- Patients exposed to chemical spray, with or without history of respiratory disease, may develop respiratory complaints up to 20 minutes post exposure.

Seizure

History
- Reported / witnessed seizure activity
- Previous seizure history
- Medical alert tag information
- Seizure medications
- History of trauma
- History of diabetes
- History of pregnancy
- Time of seizure onset
- Document number of seizures
- Alcohol use, abuse or abrupt cessation
- Fever

Signs and Symptoms
- Decreased mental status
- Sleepiness
- Incontinence
- Observed seizure activity
- Evidence of trauma
- Unconscious

Differential
- 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
- Hypoglycemia

Age Appropriate Airway Protocol(s) AR 1, 2, 3, 5, 6 ***as indicated***

Altered Mental Status Protocol UP 4 ***if indicated***

Childbirth/Labor Protocol AO 1
Obstetrical Emergency Protocol AO 3 ***if indicated***

Behavioral Protocol UP 17, 18, 19 ***if indicated***

Loosen any constrictive clothing
Protect patient

Active Seizure Activity → YES → IV / IO Access → YES

P — **Midazolam 2 – 2.5 mg IV / IO**
May repeat every 3 to 5 minutes as needed
Maximum 10 mg

Peds: Midazolam 0.2 mg/kg IV / IO
Maximum single dose 2.5 mg
May repeat every 3 to 5 minutes as needed
Maximum 10 mg

NO

P — **≥ 49 kg**
Midazolam 5 mg IM
May repeat in 3 minutes if needed
Maximum 10 mg

< 49 kg
Midazolam 0.2 mg/kg IM
Maximum single dose 5 mg

May repeat in 5 minutes if needed
Maximum 10 mg

Blood Glucose Analysis Procedure

A — IV or IO Access Protocol UP 6 ***if indicated***

P — Cardiac Monitor ***if indicated***

Monitor and Reassess

Notify Destination or Contact Medical Control

Universal Protocol Section

Seizure

Wt. in kg	3	4	5	6	7	8	9	10	11	12	13	14	15
mg	0.6	0.8	1	1.2	1.4	1.6	1.8	2	2.2	2.4	2.6	2.8	3
Pediatric Midazolam Drug Dosage based on 5 mg in 5 ml vial													
ml	0.6	0.8	1	1.2	1.4	1.6	1.8	2	2.2	2.4	2.6	2.8	3

Wt. in kg	16	17	18	19	20	22	24	26	28	30	32	34	36
mg	3.2	3.4	3.6	3.8	4	4.4	4.8	5	5	5	5	5	5
Pediatric Midazolam Drug Dosage based on 5 mg in 5 ml vial													
ml	3.2	3.4	3.6	3.8	4	4.4	4.8	5	5	5	5	5	5

When administering a Pediatric Midazolam dose IV / IO, max single dose is 2.5 mg. May repeat every 3 to 5 minutes as needed. Max total dose IV / IO is 10 mg.

When administering a Pediatric Midazolam dose IM, max single dose is 5 mg. May repeat in 5 minutes if needed. Max total dose IM is 10 mg.

Universal Protocol Section

Pearls

- **Recommended Exam: Mental Status, HEENT, Heart, Lungs, Extremities, Neuro**
- **Items in Red Text are key performance measures used to evaluate protocol compliance and care.**
- **Brief seizure-like activity can be seen following ventricular fibrillation or ventricular tachycardia associated cardiac arrest.**
- **Status epilepticus is defined by seizure activity lasting > 5 minutes or multiple seizures without return to baseline.**
- **Most seizure activity is brief, lasting only 1 – 2 minutes, and is associated with transient hypoventilation.**
- **Be prepared for airway problems and continued seizures.**
- **Seizure activity may be a marker of closed head injury, especially in the very young, examine for trauma.**
- **IN Midazolam is not recommended for seizure termination.**
- **Adult:**
  Midazolam IM is effective in termination of seizures.
  Do not delay IM administration with difficult IV or IO access. IM Preferred over IO.
- **Pediatrics:**
  Midazolam 0.2 mg/kg (Maximum 5 mg) IM is effective in termination of seizures.
  Do not delay IM administration with difficult IV or IO access. IM Preferred over IO.
- **Do not delay administration of anti-epileptic drugs to check for blood glucose.**
- **Grand mal seizures (generalized)** are associated with loss of consciousness, incontinence, and tongue trauma.
- **Focal seizures** affect only a part of the body and are not usually associated with a loss of consciousness, but can propagate to generalized seizures with loss of consciousness.
- Be prepared to assist ventilations especially if diazepam or midazolam is used.
- For any seizure in a pregnant patient, follow the AO 3 Obstetrical Emergencies Protocol.
- Midazolam (Versed) is shown to be as effective with IM route as Lorazepam (Ativan) is via the IV or IO route.
- Lorazepam (Ativan) is not as effective when administered IM. IV or IO route is preferred.
- Diazepam (Valium) is not effective when administered IM. Give IV or Rectally.
- **Optimal conditions for patients refusing transport following a seizure:**

Known history of seizures/epilepsy	Seizure not associated with drugs or alcohol
Full recovery to baseline mental status	Only 1 seizure episode in the past hour
No injuries requiring treatment or evaluation	Seizure not associated with pregnancy
Adequate supervision	No Benzodiazepine administered

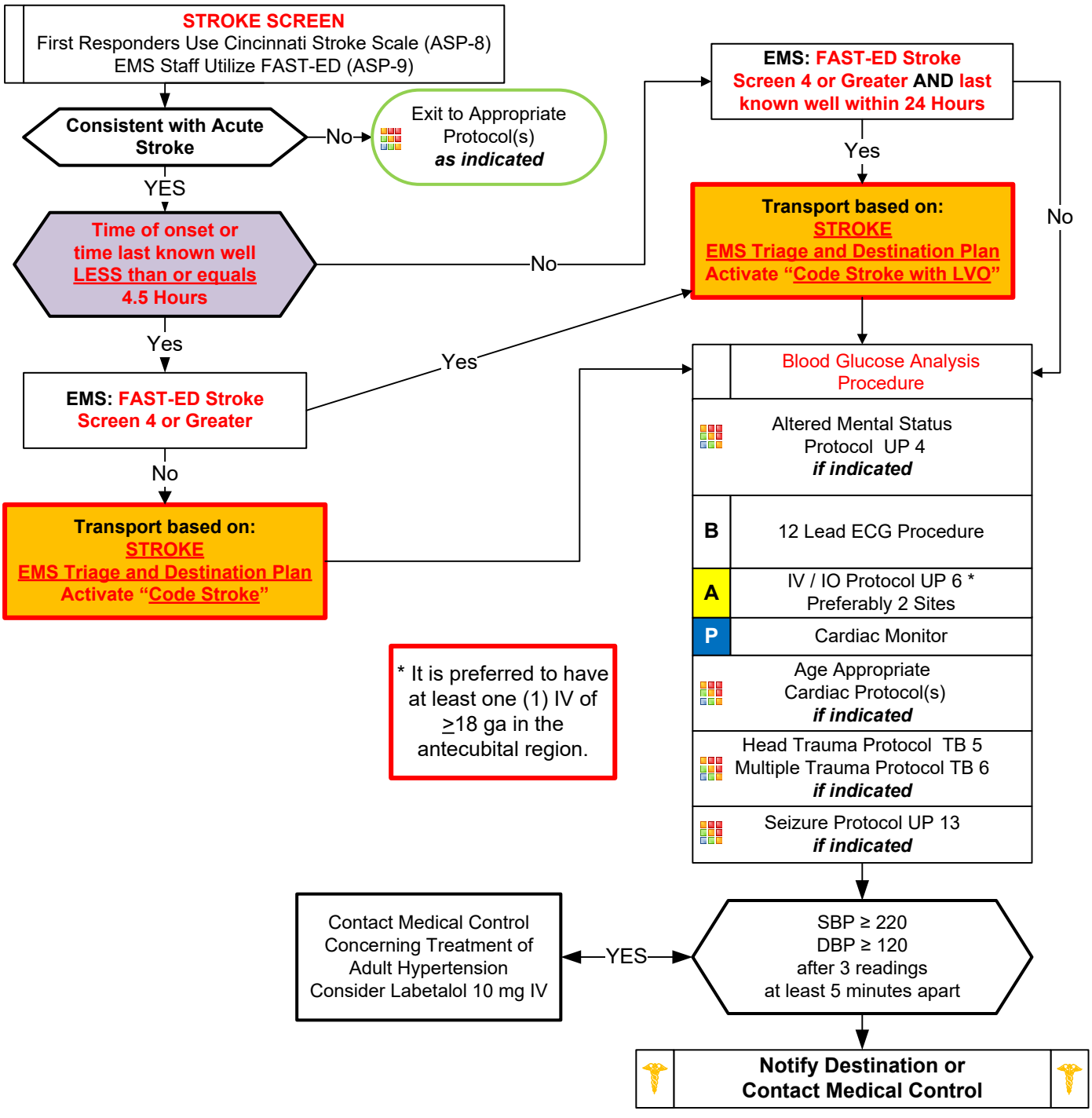
Contact Medical Control for patient refusal after Benzodiazepine administration.

Suspected Stroke

History
- Previous CVA, TIA's
- Previous cardiac / vascular surgery
- Associated diseases: diabetes, hypertension, CAD
- Atrial fibrillation
- Medications (blood thinners)
- History of trauma
- Sickle Cell Disease
- Immune disorders
- Congenital heart defects
- Maternal infection / hypertension

Signs and Symptoms
- Altered mental status
- Weakness / Paralysis
- Blindness or other sensory loss
- Aphasia / Dysarthria
- Syncope
- Vertigo / Dizziness
- Vomiting
- Headache
- Seizures
- Respiratory pattern change
- Hypertension / hypotension

Differential
- See Altered Mental Status
- TIA (Transient ischemic attack)
- Seizure
- Todd's Paralysis
- Hypoglycemia
- Stroke
  - Thrombotic or Embolic (~85%)
  - Hemorrhagic (~15%)
- Tumor
- Trauma
- Dialysis / Renal Failure



Universal Protocol Section

Suspected Stroke

Cincinnati Pre-hospital Stroke Scale

1. FACIAL DROOP: *Have patient show teeth or smile.*

Normal: both sides of the face move equally

Abnormal: one side of face does not move as well as the other side

2. ARM DRIFT: *Patient closes eyes & holds both arms out for 10 sec.*

Normal: both arms move the same or both arms do not move at all

Abnormal: one arm does not move or drifts down compared to the other

3. ABNORMAL SPEECH: *Have the patient say "you can't teach an old dog new tricks."*

Normal: patient uses correct words with no slurring **Abnormal:** patient slurs words, uses the wrong words, or is unable to speak

INTERPRETATION: If any 1 of these 3 signs is abnormal, the probability of a stroke is 72%.

Pearls

- **Recommended Exam: Mental Status, HEENT, Heart, Lungs, Extremities, Neuro**
- **Items in Red Text are key performance measures used in the EMS Acute Stroke Care Toolkit.**
- **Acute Stroke care is evolving rapidly. Time of onset / last seen normal may be changed at any time depending on the capabilities and resources of your hospital based on Stroke: EMS Triage and Destination Plan.**
- **Time of Onset or Last Seen Normal:**
  - **One of the most important items the pre-hospital provider can obtain, of which all treatment decisions are based.**
  - **Be very precise in gathering data to establish the time of onset and report as an actual time (i.e. 13:47 NOT "about 45 minutes ago.")**
  - **Without this information patient may not be able to receive thrombolytics at facility.**
  - **Wake up stroke: Time starts when patient last awake or symptom free.**
- **Time of Symptom Discovery:**
  - **Time when symptoms of stroke are first noticed by patient, bystanders, witnesses, or family/ caregivers.**
- **Sources of information pertaining to Last Known Well Time or Symptoms Onset:**
  - **You are often in the best position to determine the actual Time of Onset while you have family, friends or caretakers available.**
  - **Often these sources of information may arrive well after you have delivered the patient to the hospital.**
  - **Delays in decisions due to lack of information may prevent an eligible patient from receiving thrombolytics.**
- **Obtain contact information (phone number and name) of best witnesses and give to hospital providers.**
- **For any suspected stroke, scene times should be limited to less than 10 minutes, early notification / activation of receiving facility should be performed and transport times should be minimized.**
- **If possible place 2 IV sites, preferably above the wrists, and if possible both in the left upper extremity.**
- The differential listed in the UP 4 Altered Mental Status Protocol should also be considered.
- Be alert for airway problems (swallowing difficulty, vomiting/aspiration).
- Hypoglycemia can present as a localized neurologic deficit, especially in the elderly.
- Document the FAST-ED (LVO) Screen results in ESO within the forms section.
- Agencies may use validated pre-hospital stroke screen of choice.
- **Pediatrics:**

  Strokes do occur in children, they are slightly more common in ages less than 2, in boys, and in African-Americans.

  Newborn and infant symptoms consist of seizures, extreme sleepiness, and using only one side of the body.

  Children and teenagers symptoms may consist of severe headaches, vomiting, sleepiness, dizziness, and/or loss of balance or coordination.

Suspected Sepsis

History
- Duration and severity of fever
- Past medical history
- Medications / Recent antibiotics
- Immunocompromised (transplant, HIV, diabetes, cancer)
- Indwelling medical device
- Last acetaminophen or ibuprofen
- Recent Hospital / healthcare facility
- Bedridden or immobile
- Elderly and very young – at risk
- Prosthetic device / indwelling device

Signs and Symptoms
- Warm
- Flushed
- Sweaty
- Chills / Rigors
- Delayed cap refill
- Mental status changes

Associated Symptoms (Helpful to localize source)
- myalgias, cough, chest pain, headache, dysuria, abdominal pain, rash

Differential
- Infections: UTI, Pneumonia, skin/ wound
- Cancer / Tumors / Lymphomas
- Medication or drug reaction
- Connective tissue disease: Arthritis, Vasculitis
- Hyperthyroidism
- Heat Stroke
- Meningitis
- Hypoglycemia/hypothermia
- MI / CVA

	Consider: Contact, Droplet, and Airborne Precautions
	Temperature Measurement Procedure ***if available***
	Fever / Infection Control Protocol UP 10 ***if needed***
	Altered Mental Status Protocol UP 4 ***if needed***
B	12 Lead ECG Procedure
A	IV or IO Access Protocol UP 6 ***If indicated***
P	Cardiac Monitor

Sepsis Screen Positive

YES → **A**

NO → Exit to Age Appropriate Condition Appropriate Protocol(s)

Sepsis Screen
1. Suspected Infection

- AND -

2. Two or more of the following:
- Temperature > 38° C (100.4° F) OR < 36° C (96.8° F)
- Respiratory Rate > 20 breaths / min
- Heart Rate > 90 beats / min

Pediatrics Criteria
Temperature
Same as adult

AND

Heart Rate
1 month – 1 year > 180
2 – 5 years > 140
6 – 12 years > 130
13 – 18 years > 120

A

Normal Saline or Lactated Ringer's 500 mL Bolus
Repeat as needed
Titrate SBP ≥ 90 mmHg or MAP ≥ 65 mmHg
Maximum 2 L

Peds: 20 mL/kg IV / IO
Repeat to titrate to age appropriate
SBP ≥ 70 + 2 x Age
Maximum 60 mL/kg

SEPSIS ALERT
If ETCO2 < 25 mmHg or SBP < 90 or MAP < 65
Notify Receiving Hospital

P

Norepinephrine (Levophed)
Adult 1 – 10 mcg/min IV/IO
Peds: 0.1 – 2 mcg/kg/min IV/IO (Max 10 mcg/min
Adult: Titrate to effect SBP ≥ 90 or Map ≥ 65
Peds: Titrate to Age Appropriate SBP (See PEARLS)

MAP
(Mean Arterial Pressure)

$$\frac{SBP + 2(DBP)}{3}$$

Monitor usually calculates this value on screen

Age Appropriate Hypotension / Shock Protocol AM 5 / PM 3

Notify Destination or Contact Medical Control

Universal Protocol Section

Suspected Sepsis

Universal Protocol

SEPSIS ALERT Notes:
If a patient has a positive sepsis screen PLUS EtCo2 < 25 or SBP < 90 mmHg or MAP < 65 mmHg notifiy the accepting emergency room/hospital early with a Sepsis Alert. **Sepsis Alert patients, as identified by this protocol, have elevated risk for severe sepsis and septic shock.**

Age specific blood pressure 0 – days > 60 mmHg, 1 month - 1 year > 70 mmHg, 1 - 10 years > 70 + (2 x age) mmHg and 11 years and older > 90 mmHg.

Important Documentation Note:
For fluis bolus documentation: START TIME, STOP TIME and Amount of IV fluid administered needs to be recorded in the PCR Flowchart.

Pearls

- **Recommended Exam: Mental Status, Skin, HEENT, Neck, Heart, Lungs, Abdomen, Back, Extremities, Neuro**
- **Recommended Exam Pediatrics: In childhood, physical assessment reveals important clues for sepsis. Look for mental status abnormalities such as anxiety, restlessness, agitation, irritability, confusion, or lethargy. Cardiovascular findings to look for include cool extremities, capillary refill >3 seconds, or mottled skin.**
- **Sepsis is a life threatening condition where the body's immune response to infection injures its own tissues and organs.**
- **Severe sepsis is a suspected infection and 2 or more SIRS criteria with organ dysfunction such as AMS or hypotension.**
- **Septic shock is severe sepsis and poor perfusion unimproved after fluid bolus.**

- Quantitative waveform capnography can be a reliable surrogate for lactate monitoring in detecting metabolic distress in sepsis patients. $EtCO_2$ < 25 mm Hg are associated with serum lactate levels > 4 mmol/L.

- **Vasopressor Utilization:**
  Correct hypovolemia early (often 1 to 2 liters of Normal Saline or Lactated Ringer's administration in adults) when suspected prior to initiation of vasopressors unless severe shock or peri-arrest, in which case it is likely both intravenous fluid resuscitation and vasopressors may be indicated.
  Norepinephrine (Levophed) is generally preferable over dopamine for treatment of septic shock. Unless contraindicated (ie. Allergy), preference Norepinephrine if both medications are available. Titrate vasopressor to lowest dose necessary to achieve SBP > 90mmHg or MAP > 65 mmHg.

- **Following each fluid bolus, assess for pulmonary edema. Consider administration of a vasopressor.**
- **Supplemental oxygen should be given and titrated to oxygenation saturation ≥ 94%.**
- **EKG should be obtained with suspected sepsis, but should not delay care in order to obtain.**
- **Abnormally low temperatures increase mortality and found often in geriatric patients.**

- **Contact precautions:**
  Include standard PPE and utilization of a gown, change of gloves after every patient contact, and strict hand washing precautions. *Recall that hand washing is paramount (alcohol based hand sanitizer is not effective against C. Diff). This level of precaution should be utilized when gastrointestinal infections (including diarrhea of unknown origin), clostridium difficile, scabies, wound and skin infections (e.g. impetigo), or colonization with multi-drug resistant bacteria (e.g. methicillin-resistant Staphylococcus aureus (MRSA) are suspected.
- **Droplet precautions:**
  Include standard PPE plus a standard surgical mask for providers who accompany patients in the back of the ambulance and a surgical mask or NRB O2 mask for the patient.
  This level of precaution should be utilized when influenza, meningitis, mumps, streptococcal pharyngitis, and other illnesses spread via large particle droplets are suspected.
  A patient with a potentially infectious rash should be treated with droplet precautions.
- **Airborne precautions:**
  Include standard PPE plus utilization of a gown, change of gloves after every patient contact, and strict hand washing precautions.
  This level of precaution is utilized when multi-drug resistant organisms (e.g. MRSA), scabies, or zoster (shingles), or other illnesses spread by contact are suspected.
- **All-hazards precautions:**
  Include standard PPE plus airborne precautions plus contact precautions.
  This level of precaution is utilized during the initial phases of an outbreak when the etiology of the infection is unknown or when the causative agent is found to be highly contagious (e.g. SARS).

- All patients should have drug allergies documented prior to administering pain medications.
- Allergies to NSAIDs (non-steroidal anti-inflammatory medications) are a contraindication to Ibuprofen.
- Patients with a history of liver failure should not receive acetaminophen.

Syncope

History
- Cardiac history, stroke, seizure
- Occult blood loss (GI, ectopic)
- Females: LMP, vaginal bleeding
- Fluid loss: nausea, vomiting, diarrhea
- Past medical history
- Medications

Signs and Symptoms
- Loss of consciousness with recovery
- Lightheadedness, dizziness
- Palpitations, slow or rapid pulse
- Pulse irregularity
- Decreased blood pressure

Differential
- Vasovagal
- Orthostatic hypotension
- Cardiac syncope
- Micturition / Defecation syncope
- Psychiatric
- Stroke
- Hypoglycemia
- Seizure
- Shock (see Shock Protocol)
- Toxicological (Alcohol)
- Medication effect (hypertension)
- PE
- AAA

	Age Appropriate Airway Protocol(s) AR 1, 2, 3, 5, 6 ***if indicated***
	Blood Glucose Analysis Procedure
B	12 Lead ECG Procedure
A	IV or IO Access Protocol UP 6
P	Cardiac Monitor
	Altered Mental Status Protocol UP 4 ***if indicated***
	Age Appropriate Cardiac Protocol(s) ***if indicated***
	Age Appropriate Hypotension/ Shock Protocol AM 5/ PM 3 ***if indicated***
	Multiple Trauma Protocol TB 6 Spinal Motion Restriction Procedure/ Protocol TB 8 ***if indicated***

Age Specific Blood Pressure indicating possible shock

Age 0 – 28 days: SBP < 60
Ages ≥ 1 month: SBP < 70
Age 1 – 9: SBP < 70 + (2*x* Age)

Ages 10 – 64: SBP < 90
Ages ≥ 65: SBP < 110

All ages Shock Index: HR > SBP

Serious Signs/ Symptoms Hypotension, poor perfusion, shock

YES →

A	IV or IO Access Protocol UP 6 Consider 2 Large Bore sites
	Normal Saline or Lactated Ringer's 500 mL Bolus Repeat as needed Titrate SPB ≥ 90 mmHg **Maximum 2 L** **Peds: 20 mL/kg IV / IO** Repeat as needed Titrate to Age Appropriate SBP ≥ 70 + 2 x Age **Maximum 60 mL/kg**

Exit to Age Appropriate Condition Appropriate Protocol(s)

NO

Notify Destination or Contact Medical Control

Universal Protocol Section

Syncope

Universal Protocol Section

Pearls

- **Recommended Exam: Mental Status, Skin, HEENT, Heart, Lungs, Abdomen, Back, Extremities, Neuro**
- **Syncope is both loss of consciousness and loss of postural/ muscle tone with collapse. Symptoms preceding the event are important in determining etiology.**
- **Syncope often is due to a benign process but can be an indication of serious underlying disease in both the adult and pediatric patient.**
- **Often patients with syncope are found normal on EMS evaluation. In general patients experiencing syncope require cardiac monitoring and emergency department evaluation.**
- **Differential should remain wide and include:**

Cardiac arrhythmia	Neurological problem	Choking	Pulmonary embolism
Hemorrhage	Stroke	Respiratory	Hypo or Hyperglycemia
GI Hemorrhage	Seizure	Sepsis	

- **High-risk patients:**

Age ≥ 60	Syncope with exertion
History of CHF	Syncope with chest pain
Abnormal ECG	Syncope with dyspnea

- **Abdominal/ back pain in women of childbearing age should be treated as pregnancy related until proven otherwise.**
- **The diagnosis of abdominal aneurysm should be considered with abdominal pain, with or without back and/ or lower extremity pain or diminished pulses, especially in patients over 50 and/ or patients with shock/ poor perfusion. Notify receiving facility early with suspected abdominal aneurysm.**
- **Consider cardiac etiology in patients > 35, diabetics, and/ or women especially with upper abdominal complaints.**
- **Heart Rate: Tachycardia is one of the first clinical signs of dehydration, typically increases as dehydration becomes more severe.**
- Syncope with no preceding symptoms or event may be associated with an arrhythmia.
- Assess for signs and symptoms of trauma if associated or questionable fall with syncope.
- Consider dysrhythmias, GI bleed, ectopic pregnancy, and seizure as possible causes of syncope.
- In general these patients should be transported: Patients who experience syncope associated with headache, neck pain, chest pain, abdominal pain, back pain, dyspnea, or dyspnea on exertion need prompt medical evaluation.
- More than 25% of geriatric syncope is cardiac dysrhythmia based.

Behavioral Health Crisis

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

Signs and Symptoms
- Anxiety, agitation, confusion
- Affect change, hallucinations
- Delusional thoughts, bizarre behavior
- Combative violent
- Expression of suicidal / homicidal thoughts

Differential
- Altered Mental Status
- Alcohol Intoxication
- Toxin / Substance abuse
- Medication effect / overdose / withdrawal
- Depression
- Bipolar (manic-depressive)
- Schizophrenia
- Anxiety disorders

Call for help
Call for additional resources
Stage prior to arrival
or
Withdraw from scene until safe

Screen patient for weapons
Screen for scene safety

Assess for underlying medical or traumatic condition causing behavioral disturbance

Age Appropriate Protocol(s)

Establish rapport
- Genuine respect for feelings/ circumstances
- Active listening
- Eye contact and meet at eye level

Create a quiet and safe environment
- Only 1 provider talks to patient to limit stimuli
- Decrease unnecessary stimuli

Identify major problem or crisis
- "What happened to upset you?"
- "How are you feeling right now?"

Assess for suicidal and/or homicidal thoughts

If Suicidal or Homicidal
Contact Law Enforcement if patient refuses care or does not complete transport

Exit to
Behavioral
Agitation/ Sedation Guide
UP 18
Hyperactive Delirium with Severe Agitation
UP 19
Age Appropriate Protocol(s)

Assess and score: BARS
Behavioral Activity Rating Scale

BARS
1 – Difficult or unable to wake

2 – Asleep, but responds normally to verbal or physical stimuli

3 – Drowsy, appears sedated

4 – Quiet and awake (normal activity)

5 – Overt activity (physical or verbal) Agitated but not disruptive

6 – Extremely or continuously active, Agitated, disruptive, but not violent

7 – Violent, requires restraint Agitated and violent

P
Evaluation and Screening
Mental Health and Substance Use Protocol
CIT Paramedic Preferred
if available
Page 3

Triage and Alternative Destination
Mental Health / Substance Abuse
if available
Page 3

Notify Destination or Contact Medical Control

Universal Protocol Section

Behavioral Health Crisis

Universal Protocol Section

Pearls

- **Recommended Exam: Mental Status, Skin, Heart, Lungs, Neurologic status**
- **Crew/ responders safety is the main priority. Call for assistance, stage, or withdraw from scene if necessary.**
- **Law Enforcement:**
  - **Any patient who is handcuffed or restrained by Law Enforcement and transported by EMS, must be accompanied by law enforcement during transport.**
  - **Patient should not be transported with upper extremities hand-cuffed behind back as this prevents proper assessment and could lead to injury.**
  - **Consider multidisciplinary coordination with law enforcement to approach verbal de-escalation, restraint, and/ or USP 6 Restraints: Therapeutic Take-down Procedure.**
- **Maintain high-index of suspicion for underlying medical or traumatic disorder causing or contributing to behavioral disturbance. Medical causes more likely in ages < 12 or > 40.**
- **General communications techniques**
  - **Ask Open-ended questions (questions that cannot be answered with a yes/no)**
    "Tell me how we can help you?" "What caused you to call 911 today?"
  - **Active listening (stay engaged, be able to summarize patient's story, use your body language to convey listening)**
    Eye contact, nodding your head, periodically repeating back part of patient's story
  - **Encouraging (remain positive, convey interest in patient's crisis)**
    "Tell me more about that…"
  - **Clarifying questions (ask patient to rephrase or repeat if you don't understand)**
    "I'm not sure I understand, can you…?"
  - **Emotional labeling (naming emotions patient is demonstrating, validating emotions)**
    "You look upset." "You seem angry."
  - **Conversational pause (okay to allow a period of silence for patient to process information)**
- **Behavioral health disturbance incidents are increasing and commonly involve the following:**
  - **Substance misuse**
  - **Depression/ Anxiety/ Stress Reactions / Bipolar**
  - **Psychosis**
  - **Schizophrenia or schizophrenia-like illness**
- **Restraints:**
  - **All patients who receive either physical or chemical restraint must be continuously observed by highest certification level ALS personnel on scene or immediately upon their arrival.**
  - **Do not position or transport any restrained patient is such a way that could impact the patients respiratory or circulatory status (i.e. prone position).**
- **Maintain high-index of suspicion for medical, trauma, abuse, or neglect causes:**
  Hypoglycemia, hyperglycemia, overdose, substance abuse, hypoxia, head injury, shock, sepsis, stroke, etc. Domestic violence, child or geriatric abuse/ neglect.
- **Extrapyramidal reactions:**
  Condition causing involuntary muscle movements or spasms typically of the face, neck and upper extremities. May present with contorted neck and trunk with difficult motor movements. Typically an adverse reaction to antipsychotic drugs like Haloperidol and may occur with your administration. When recognized, give **Diphenhydramine 50 mg IV / IO / IM / PO** in adults or **1 mg/kg IV / IO / IM / PO** in pediatrics, **Maximum 50 mg**.

Behavioral CIT Paramedic

P Alamance County EMS
CIT Paramedic Preferred
if available

Contact Medical Control at ARMC if any questions regarding appropriate triage to ER or Alternative Destination

- ☐ Any Acute Medical Illness Suspected
- ☐ Blood/Vomit/Difficulty Breathing/Headache/Chest Pain
- ☐ Blood Glucose <70 or >300
- ☐ Head Trauma in past 7 days
- ☐ In and out of consciousness
- ☐ Seizure activity in past 24 hours
- ☐ Unable to speak or walk (unless wheelchair bound)
- ☐ Overdose reported or suspected
- ☐ Acute Withdrawal with confusion
- ☐ Hospital transport requested by patient
- ☐ Oxygen Dependent
- ☐ Patient requiring EMS administration of IM or IV medication
- ☐ Any abnormal vital sign such as:
  HR <35 or >150
  SpO2 <94%
  RR <6
  SBP <90 or >220
  Temp ≥ 100.4 F or ≤ 96.8 F
- ☐ BARS Score of 1, 2, or 7
  BARS
  1 – Difficult or unable to wake
  2 – Asleep, but responds normally to verbal or physical stimuli
  7 – Violent, requires restraint; Agitated and violent

YES TO ANY → **Transport to Emergency Department**

Notify Destination or Contact Medical Control

NO

- ☐ Suicidal
- ☐ Homicidal Ideation
- ☐ Psychosis (auditory/visual hallucinations or delusions)
- ☐ Request for Detox
- ☐ Psychiatric Med Request
- ☐ Request for Mental Health Evaluation

→ **Triage and Alternative Destination Mental Health / Substance Abuse**

If Overdose patient refuses transport to the Emergency Department, offer transport to the Alternative Destination → **Triage and Alternative Destination Mental Health / Substance Abuse**

Alternative Destinations / Crisis Providers For Alamance County

Alamance Behavioral Health Center
963 Kirkpatrick Rd.
Burlington, NC 27215
RN Contact Phone (336)421-2471

Hours of Operation
24/7

Universal Protocol Section

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Behavioral Agitation/ Sedation Guide

Behavioral Activity Rating Scale (BARS)

Behavioral Activity Rating Scale
BARS scoring: 1 - 4

YES → No sedation required → Exit to Age Appropriate Protocol(s)

NO

Behavioral Activity Rating Scale
BARS scoring: 5
Agitated but not disruptive
Able to calm and redirect

YES →
Verbal De-escalation Procedure ASP 11
P: **PO / ODT Medication**
Future Use

NO

Condition Improving?
YES → Exit to Age Appropriate Protocol(s)
NO

Behavioral Activity Rating Scale
BARS scoring: 6

Agitated and disruptive
Not violent

Verbal De-escalation Procedure ASP 11
A: IV or IO Access Protocol UP 6 ***if indicated***
P:
Age ≥ 12
Haloperidol 2 - 5 mg
IM
Age ≥ 65
2.5 mg IM
May repeat every 5 minutes as needed
Maximum 10 mg

And/Or
Midazolam 2.5 mg IV / IO / IN
5 mg IM
Maximum 10 mg
Age ≥ 65
1 – 2.5 mg IV / IO / IN
2.5 mg IM
Peds: 0.1 – 0.2 mg/kg
IV / IO / IM / IN
Maximum 2 mg
Repeat every 2-3 minutes as needed

Consider
Restraint Physical Procedure USP 5
Monitor per restraint procedure
if indicated

NO

Condition Improving?
YES → Exit to Age Appropriate Protocol(s)
NO

Behavioral Activity Rating Scale
BARS scoring: 7

Agitated and violent

→ Exit to Hyperactive Delirium with Severe Agitation Protocol UP 19

Universal Protocol Section

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Behavioral
Hyperactive Delirium With Severe Agitation

Scene Safe

YES

NO

Call for help
Call for additional resources
Stage prior to arrival
or
Withdraw from scene until safe

Behavioral Activity Rating Scale (BARS)

Behavioral Activity Rating Scale

BARS scoring: 7

P

Adult 18 – 64 years
Midazolam 10 mg IM

Age ≥ 65
Midazolam 5 mg IM

Maximum Dose 20 mg

Pediatrics:
Midazolam 0.1 – 0.2 mg/kg IM
Repeat every 5 minutes as needed

Maximum Dose 10 mg

A

IV or IO Access Protocol UP 6
Preferably 2 large bore

Normal Saline or Lactated Ringer's 1 L Bolus
May repeat **500 mL** Bolus
as needed
Maximum 2 L

Peds: 20 – 60 mL/kg IV / IO
Maximum 60 mL/kg

Restraint Physical Procedure USP 5
Monitor per restraint procedure
if indicated

Restraint Therapeutic Take Down Procedure USP 6
if indicated

Hyperthermia Protocol

P Cardiac Monitor

Notify Destination or
Contact Medical Control

General Guidance

- **Use of protocol is indicated when a medical emergency requires a combination of both physical restraint and chemical restraint in order to prevent imminent injury to a patient and/ or providers.**
- **Use of this protocol requires medical judgement and consultation with Medical Control where indicated.**
- **Non-medical personnel requests or opinions should not be used as a factor when implementing this protocol.**

Universal Protocol Section

Behavioral
Hyperactive Delirium With Severe Agitation

Universal Protocol Section

Pearls

- **Hyperactive Delirium with Severe Agitation:**
  - Medical emergency: Combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent/ bizarre behavior, insensitivity to pain, hyperthermia and increased strength.
  - Potentially life-threatening and associated with use of physical control measures, including physical restraints.
  - Most commonly seen in male subjects with a history of serious mental illness and/or acute or chronic drug abuse, particularly stimulant drugs such as cocaine, crack cocaine, methamphetamine, amphetamines or similar agents.
  - Alcohol or substance withdrawal as well as head trauma may also contribute to the condition.
- **Restraint use:**
  - Physical restraints are not contraindicated in agitated or excited delirium, but you must use caution.
  - Once sedated, prevent patient from continued struggle, which can worsen metabolic condition.
  - Prevent patient from assuming a prone position for prolonged period, move to supine position as quickly as possible.
  - Team approach for sedation and Restraint Therapeutic Take Down Procedure USP-6:
    - 1 provider for each limb.
    - 1 provider to lead restraint, maintain airway and control head.
    - 1 Provider to administer medication.
  - Do not position prone or prone with restraints, as this can impede respiration and ventilation.
- Hyperthermia: Assess for and treat hyperthermia.

Sickle Cell Crisis

History
- Past medical history
- Medications
- Recent illness
- Prior pain crisis location
- Pain regimen at home

Signs and Symptoms
- Pain
- One sided paralysis / weakness
- Difficulty walking / speaking
- Sudden vision changes
- Unexplained numbness
- Severe headache
- Fever
- SOB
- Chest Pain
- Abdominal Pain
- Pallor

Differential
- Sickle Celle Pain Crisis
- Aplastic Crisis
- Acute Chest Syndrome
- Alcohol / drug use
- Toxic ingestion
- Seizure
- Stroke
- Altered baseline mental status
- Sepsis
- Pneumonia

Apply Hot Packs to affected areas: especially joints and areas of increased pain

Provide emotional support Calm and continual reassurance

- **B** Blood Glucose Analysis as needed
  Assess Pain Severity
  12 Lead ECG Procedure
- IV or IO Access Protocol UP 6
- **P** Cardiac Monitor
- Altered Mental Status Protocol UP 4 ***if indicated***
- Manage Airway as appropriate Protocol AR 1 & AR 5 ***if indicated***
- Suspected Stroke Protocol UP 14 ***if indicated***
- Suspected Seizure Protocol UP 13 ***if indicated***
- Hypotension/ Shock Protocol AM 5 & PM 3 ***if indicated***

Fluids indicated if signs of shock or hypotensive

Sickle Cell Crisis
- Acute Chest Syndrome
- Abdominal Crisis
- Joint Crisis

YES

Pain Control Protocol UP 11

Notify Destination or Contact Medical Control

Universal Protocol Section

Sickle Cell Crisis

PEARLS

Patterns of an acute sickle cell crisis are now recognizable. They are based on the part of the body where the crisis occurs.
Is this their typical pain crisis? If not, what is different about it?
Any fever, SOB, pleuritic chest pain?

Acute chest syndrome:

Sudden acute chest pain with coughing up of blood can occur. Low-grade fevers can be present. The person is usually short of breath. If a cough is present, it often is nonproductive. Acute chest syndrome is common in a young person with sickle cell disease.
Chronic (long-term) sickle cell lung disease develops over time because the acute and subacute lung crisis leads to scarred lungs as well as other problems.

Abdominal crisis:

The pain associated with the abdominal crisis of sickle cell disease is constant and sudden. It becomes unrelenting. The pain may or may not be localized to any one area of the abdomen. Nausea, vomiting, and diarrhea may or may not occur.

Joint crisis:

Acute and painful joint crisis may develop without a significant traumatic history. Its focus is either in a single joint or in multiple joints. Often the connecting bony parts of the joint are painful. Range of motion is often restricted because of the pain. Avascular necrosis of the hips can occur, causing permanent damage.

Stroke:

Many sickle cell patients can present with strokes at a younger age than average. Ensure hospital pre-notification indicating it is a sickle cell patient as the standard of care for a Sickle Cell Stroke can involve exchange therapy as opposed to other treatments such as tPA.

Well Person Check / Public Assist

History
- Patient presents requesting a “blood pressure check”
- EMS responds to “assist patient”
- Someone else called 9-1-1; patient did not request EMS
- Other situation in which patient does not have a medical complaint or obvious injury.

Signs and Symptoms
- Assess for medical complaint
- For patients with hypertension, check for chest pain, shortness of breath, and/or neurologic changes
- For “patient assist calls”, check for syncope, trauma from a fall, and or inability to ambulate

Differential
- Hypertensive urgency
- Syncope
- Cardiac ischemia
- Cardiac dysrhythmia
- Fracture
- Head trauma

Universal Patient Care Protocol UP1

Patient has medical complaint or obvious trauma

Yes → Recommend Transport
Exit to appropriate protocol

NO

ADULT PATIENT with CAPACITY to make medical decisions

Patients **will not be refused transport** regardless of injury or illness.

Assess Vital Signs:
HR, BP, RR, SpO2, Temp

If indicated - Blood Glucose

Pulse <50 or >110 or
RR <6 or >24 or
SBP <85 or >200 or
Temp ≥ 100.4 or
SpO2 < 94%, or
CBG <60 or >300

Yes → **Recommend Transport for Evaluation**. If transport is declined, explain refusal form and have patient sign. Provide patient with vital sign results and have them contact their doctor to report results.

No

Re-confirm patient has no medical complaint. If transport is declined, explain refusal form and have patient sign. Provide patient with vital sign results and have them contact their doctor to report results.

Advise patient to call 9-1-1 if they develop any symptoms. Complete PCR and document the elements of this protocol.

Universal Protocol Section

Well Person Check / Public Assist

CAPACITY/REFUSAL CHECKLIST:
- Is the patient age > 17 and/or emancipated minor?
- Patient does not have a court appointed guardian?
- Can the patient retain and comprehend relevant information?
- Can the patient use information to make a choice?
- Is the patient NOT DANGEROUS to self or others (i.e. no suicidal or homicidal ideation)?

****If all are "YES" then the patient has capacity to decline further care/transport. If any are "NO" then the patient does not have capacity to make his or her own medical decisions. If patient has a court appointed guardian or is a minor, all available efforts to make contact with the guardian should be made and documented. Document these concepts clearly in your narrative- simply stating "alert and oriented" is not sufficient. Don't hesitate to request and or contact medical control if there are questions about capacity.**

Pearls

- This protocol applies to all responders.
- Patients who are denying more severe symptoms may initially present for a "routine check". Confirm with the patient at least twice that they have no medical complaints.
- All persons who request services are considered patients and have a PCR completed.
- For a patient in this category, the PCR may be brief but must include vital signs and documentation of the lack of a medical complaint. Additionally, patients with a potential mechanism for trauma should have a trauma exam completed and documented.
- Should a patient refuse evaluation and / or decline further evaluation once begun, document as much as you can. Even patients who refuse vital signs can be observed and respirations measured. The PCR narrative is key in these and all cases and must thoroughly and accurately describe the patient encounter.

Guide to Assessing capacity:

C:***Patient should be able to communicate a clear choice:*** This should remain stable over time. Inability to communicate a choice or an inability to express the choice consistently demonstrates incapacity.

R: ***Relevant information is understood:*** Patient should be able to voice a factual understanding of the illness/ injury, the options, and the risks and benefits of recommended treatment or transport.

A: ***Appreciation of the situation:*** Ability to communicate an understanding of the facts of the situation. The patient should be able to recognize the significance of the outcome potentially from their decision.

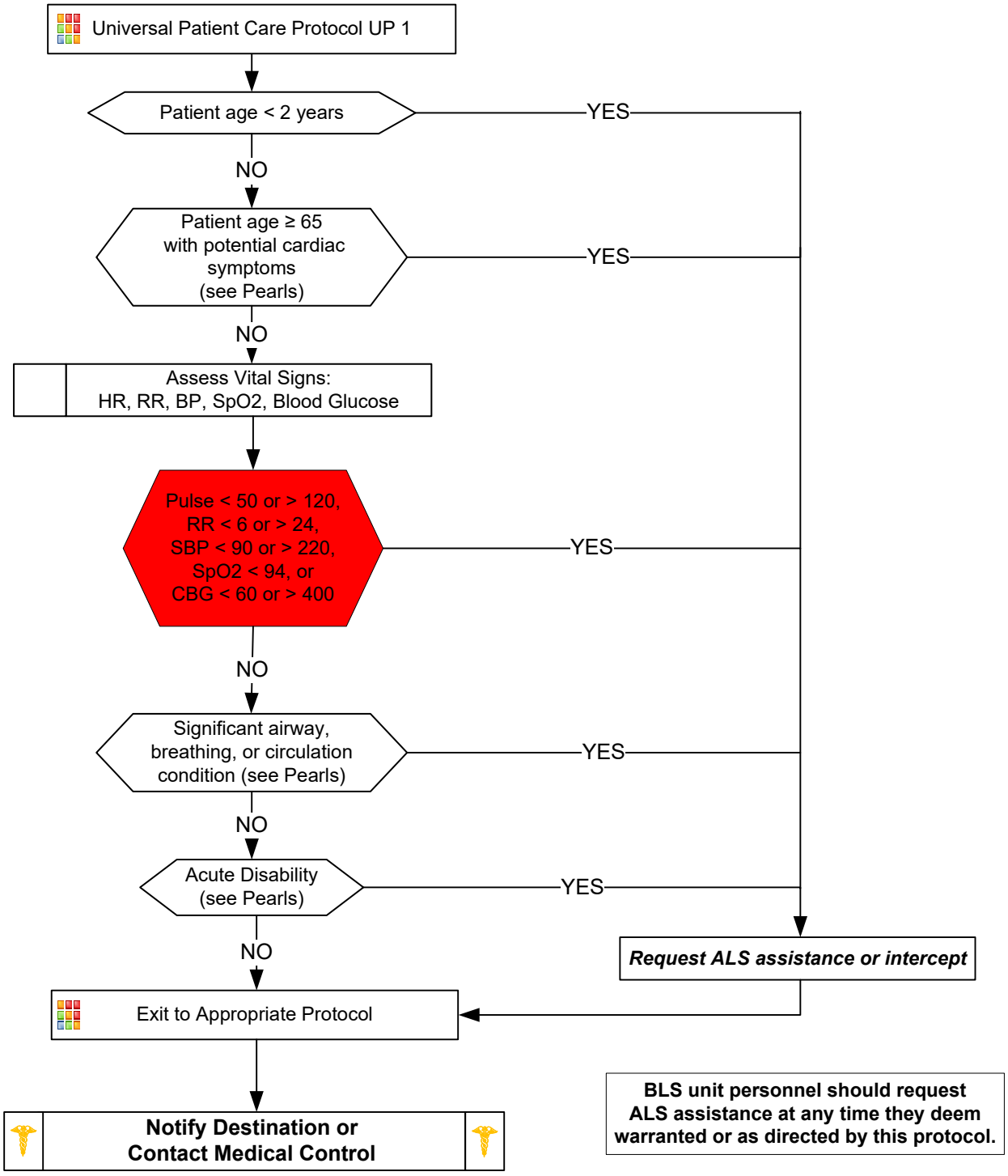
M: ***Manipulation of information in a rational manner:*** Demonstrate a rational process to come to a decision. Should be able to describe the logic they are using to come to the decision, though you may not agree with decision.

BLS Transport

History
- Patient with low priority health complaint, received through 911
- Patient age greater than 2 years

Signs and Symptoms
- Assess for current complaint
- Evaluate if BLS care and transport are sufficient and appropriate

Differential
- Altered mental status (Diabetic, Overdose, Stroke)
- Breathing difficulty (Asthma, COPD, CHF)
- Cardiac event (Chest Pain, Syncope)
- Seizure, Neurologic deficit
- Trauma for which pain management is warranted



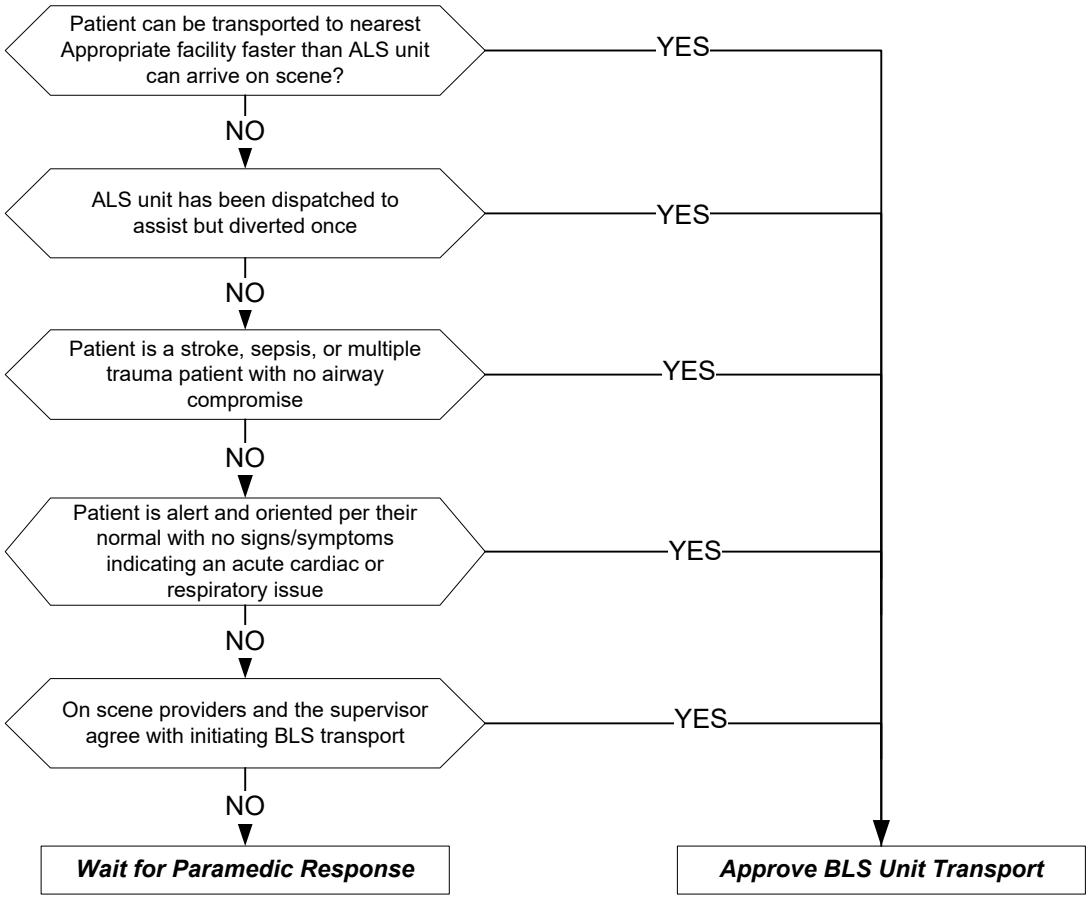
BLS unit personnel should request ALS assistance at any time they deem warranted or as directed by this protocol.

Universal Protocol Section

BLS Transport

Pearls:

- This protocol applies to ALL responders.
- **Elderly patients with a potential cardiac complaint:** weakness, unexplained diaphoresis, pale skin condition, jaw pain (without trauma), shoulder pain (without trauma), nausea, subjective shortness of breath; should be considered potential cardiac patients and evaluated by an ALS provider, when possible.
- **Significant Airway Conditions** include, but are not limited to, the following:
  - Advanced Airway Procedures (iGel airway placement)
  - Unrelieved airway obstruction
  - Uncontrollable blood loss
  - Uncontrollable emesis
- **Significant Breathing Conditions** include, but are not limited to, the following:
  - Angioedema
  - Asthma, COPD, CHF
  - Inability to maintain SpO2 > 94%
- **Significant Circulation Conditions** include, but are not limited to, the following:
  - Uncontrollable blood loss
- **Acute Disability** may include, but is not limited to, the following:
  - Pain in need of medication management other than acetaminophen
  - Glasgow Coma Score less than 13
  - New onset altered mental status or active seizure activity
  - Neurologic deficit (numbness, tingling, weakness, paralysis, vision changes, speech changes)
  - Suspected or obvious fracture or deformity for which pain control is warranted
  - Chest Pain complaints (nausea, diaphoresis, arm/ jaw pain without trauma)
  - Syncope symptoms
- An ALS unit may always be requested for additional assessment and treatment.
- When ALS assistance is requested, and an ALS provider makes patient contact, their ALS level assessment must be documented and included in the PCR.
- EMS Supervisor(s) may override this protocol if system status demands it using the flow chart below.



Adult Airway

Assess Respiratory Rate, Effort, Oxygenation
Is Airway/ Breathing Adequate?

YES → Supplemental oxygen
Goal oxygen saturation ≥ 92%
Exit to
Appropriate Protocol(s)

NO

Basic Maneuvers First
-open airway chin lift/ jaw thrust
-nasal and/ or oral airway(s)
-Bag-valve mask (BVM) +/- PEEP

Spinal Motion Restriction Procedure/ Protocol TB 8 ***if indicated***

Altered Mental Status Protocol UP 4 ***if indicated***

Respiratory Distress with a Tracheostomy Tube Protocol AR 10 ***if indicated***

Capnography Monitoring

- **End-tidal (EtCO2) monitoring is mandatory following placement of an endotracheal tube.**
- **EtCO2 monitoring is mandatory following placement of a BIAD once available on scene.**

Protocols AR 1, 2, and 3 should be utilized together (even if agency is not using Drug Assisted Airway Protocol) as they contain useful information for airway management.

Airway Obstructed

YES →
- Airway Foreign Body Obstruction Procedure
- A: Direct Laryngoscopy ***Optional***
- P: Airway Cricothyrotomy Surgical Procedure ***if indicated***

NO

Breathing/ Oxygenation Support needed?

YES →
- Supplemental Oxygen BVM Maintain Oxygen Saturation ≥ 92 %
- B: Consider Airway NIPPV (CPAP) Procedure
- B: Airway BIAD Procedure ***if indicated***
- A: Oral/ Nasotracheal Intubation Procedure ***Optional***
- P: Chest Decompression Procedure ***if indicated***
- P: Consider Airway Drug Assisted Protocol AR 3 ***if available***
- P: Post-intubation/ BIAD Management Protocol AR 8 ***if indicated***

NO → Monitor / Reassess Supplemental Oxygen ***if indicated***

Exit to appropriate protocol(s)

Failed Airway:

Unable to Ventilate and Oxygenate ≥ 90% during or after one (1) or more unsuccessful intubation attempts

and/ or
Anatomy inconsistent with continued attempts

and/ or
Three (3) unsuccessful attempts by most experienced Paramedic/ AEMT.

Exit to Adult Failed Airway Protocol AR 2

Notify Destination or Contact Medical Control

Airway Respiratory Protocol Section

Adult Airway

Pearls

- **See Pearls section of protocols AR 2 and 3.**
- **For the purposes of this protocol a secure airway is when the patient is receiving appropriate oxygenation and ventilation.**
- **If an effective airway is being maintained by BVM with continuous pulse oximetry values of ≥ 90%, it is acceptable to continue with basic airway measures.**
- **Ventilation rate should be 10 - 12 per minute to maintain a EtCO2 of 35 – 45 and avoid hyperventilation.**
- **Anticipating the Difficult Airway and Airway Assessment**
  - **Difficult BVM Ventilation (ROMAN): R**adiation treatment/ **R**estriction; **O**bese/ **O**bstruction/ **O**B – 2d and 3d trimesters/ **O**bstructive sleep apnea; **M**ask seal difficulty (hair, secretions, trauma); **A**ge ≥ 55; **N**o teeth.
  - **Difficult Laryngoscopy (LEON): L**ook externally for anatomical problems; **E**valuate 3-3-2 (Mouth opening should equal 3 of patients finger's width, mental area to neck should equal 3 of patient's finger's width, base of chin to thyroid prominence should equal 2 of patients finger's width); **O**bese, obstruction, OB – 2d and 3d trimesters; **N**eck mobility limited.
  - **Difficulty BIAD (RODS): R**adiation treatment/ **R**estriction; **O**bese/ **O**bstruction/ **O**B – 2d and 3d trimesters/ **O**bstructive sleep apnea; **D**istorted or disrupted airway; **S**hort thyromental distance/ **S**mall mandible.
  - **Difficulty Cricothyrotomy / Surgical Airway (SMART): S**urgery scars**; M**ass or hematoma**, A**ccess or anatomical problems**; R**adiation treatment to face, neck, or chest; **T**umor.
- **Complete an Airway Evaluation Form with any BIAD or Intubation procedure where medications are used to facilitate.**
- **Intubation attempt defined as laryngoscope blade passing the teeth.**
- **If first intubation attempt fails, make an adjustment and then consider:**
  - **Consider change of provider in addition to equipment**
  - Different laryngoscope blade / Video or other optical laryngoscopy devices
  - Gum Elastic Bougie
  - Different ETT size
  - Change head positioning
- AEMT and Paramedics should consider using a BIAD if oral-tracheal intubation is unsuccessful.
- During intubation attempts use External Laryngeal Manipulation to improve view of glottis.
- Gastric tube placement should be considered in all intubated patients if available or time allows.
- It is important to secure the endotracheal tube well to better maintain ETT placement. Manual stabilization of endotracheal tube should be used during all patient moves / transfers.
- **DOPE: D**isplaced tracheostomy tube / ETT, **O**bstructed tracheostomy tube / ETT, **P**neumothorax and **E**quipment failure.

Adult, Failed Airway

Definition of Failed Airway:
Unable to Ventilate and Oxygenate ≥ 90% during
or after one (1) or more unsuccessful intubation attempts

and/ or
Anatomy inconsistent with continued attempts

and/ or
Three (3) unsuccessful attempts by most experienced Paramedic/AEMT.
Each attempt should include change in approach or equipment

NO MORE THAN THREE (3) ATTEMPTS TOTAL

Capnography Monitoring

- **End-tidal (EtCO2) monitoring is mandatory following placement of an endotracheal tube.**
- **EtCO2 monitoring is mandatory following placement of a BIAD once available on scene.**

Protocols AR 1, 2, and 3 should be utilized together (even if agency is not using Drug Assisted Airway as they contain useful information for airway management.

Failed Airway ↔ Call for additional resources if available

BVM
Adjunctive Airway NPA/ OPA
Maintains
Oxygen Saturation ≥ 92 %

YES → Continue BVM
Supplemental Oxygen
Exit to
Appropriate Protocol(s)

NO

B	Attempt Airway Blind Insertion Airway Device Procedure
A	Airway Video Laryngoscopy Device Procedure ***if available*** ***Optional***
P	Airway Cricothyrotomy Surgical Procedure
	Supplemental oxygen BVM with Airway Adjuncts Maintain Oxygen Saturation ≥ 92 %
	Post-intubation BIAD Management Protocol AR 8

Notify Destination or Contact Medical Control

Adult, Failed Airway

Pearls

- **For the purposes of this protocol a secure airway is when the patient is receiving appropriate oxygenation and ventilation.**
- **If an effective airway is being maintained by BVM with continuous pulse oximetry values of ≥ 90%, it is acceptable to continue with basic airway measures.**
- **Ventilation rate should be 10 - 12 per minute to maintain a EtCO2 of 35-45 and avoid hyperventilation.**
- **Anticipating the Difficult Airway and Airway Assessment**
  - **Difficult BVM Ventilation (ROMAN): R**adiation treatment/ **R**estriction; **O**bese/ **O**bstruction/ **O**B – 2d and 3d trimesters/ **O**bstructive sleep apnea; **M**ask seal difficulty (hair, secretions, trauma); **A**ge ≥ 55; **N**o teeth.
  - **Difficult Laryngoscopy (LEON): L**ook externally for anatomical problems; **E**valuate 3-3-2 (Mouth opening should equal 3 of patients finger's width, mental area to neck should equal 3 of patient's finger's width, base of chin to thyroid prominence should equal 2 of patients finger's width); **O**bese, obstruction, OB – 2d and 3d trimesters; **N**eck mobility limited.
  - **Difficulty BIAD (RODS): R**adiation treatment/ **R**estriction; **O**bese/ **O**bstruction/ **O**B – 2d and 3d trimesters/ **O**bstructive sleep apnea; **D**istorted or disrupted airway; **S**hort thyromental distance/ **S**mall mandible.
  - **Difficulty Cricothyrotomy / Surgical Airway (SMART): S**urgery scars**; M**ass or hematoma**, A**ccess or anatomical problems**; R**adiation treatment to face, neck, or chest; **T**umor
- **Complete an Airway Evaluation Form with any BIAD or Intubation procedure where medications are used to facilitate.**
- **Intubation attempt defined as laryngoscope blade passing the teeth.**
- **If first intubation attempt fails, make an adjustment and then consider:**
  - **Consider change of provider in addition to equipment**
  - Different laryngoscope blade / Video or other optical laryngoscopy devices
  - Gum Elastic Bougie
  - Different ETT size
  - Change head positioning
- AEMT and Paramedics should consider using a BIAD if oral-tracheal intubation is unsuccessful.
- During intubation attempts use External Laryngeal Manipulation to improve view of glottis.
- Gastric tube placement should be considered in all intubated patients if available or time allows.
- It is important to secure the endotracheal tube well to better maintain ETT placement. Manual stabilization of endotracheal tube should be used during all patient moves/ transfers.
- **Notify Medical Control AS EARLY AS POSSIBLE concerning the patient's difficult / failed airway.**
- **DOPE: D**isplaced tracheostomy tube/ ETT, **O**bstructed tracheostomy tube/ ETT, **P**neumothorax and **E**quipment failure.

Airway, Drug Assisted
(Is Not Utilized By Alamance County)

Indications for Drug Assisted Airway
Failure to protect the airway
and/or
Unable to oxygenate
and/or
Unable to ventilate
and/or
Impending airway compromise

Capnography Monitoring
- **End-tidal (EtCO2) monitoring is mandatory following placement of an endotracheal tube.**
- **EtCO2 monitoring is mandatory following placement of a BIAD once available on scene.**

Protocols AR 1, 2, 3, 5, and 6 should be utilized together (even if agency is not using Drug Assisted Airway Protocol) as they contain useful information for airway management.

Preoxygenate 100% O2

IV or IO Access Protocol UP 6
2 points of access

P — Assemble Airway Equipment
Suction equipment
Alternative Airway Device

Hypoxic Or
Hypotensive Or
Dangerously Combative?

YES →

P — **Ketamine 2 mg/kg IV / IO**

No IV or IO Access:
Ketamine 4 mg/kg IM
Maximum 400 mg

Pediatric: *See Pearls*
2 mg/kg IM
Maximum 400 mg

Correct Hypoxia and/ or Hypotension

Age Appropriate Airway Protocol(s) AR 1, 2, 5, 6, ***as indicated***

Hypotension/ Shock Protocol AM 5/ PM 3 ***as indicated***

Hypoxia corrected
Hypotension corrected
Dangerously Combative condition corrected

Patient still requires intubation

YES → (back to Hypoxic Or Hypotensive Or Dangerously Combative?)

NO

NO ↓

P — **Etomidate 0.3 mg/kg IV / IO**
Or
Ketamine 2 mg/kg IV / IO
May repeat x 1

P — **Succinylcholine 2 mg/kg IV / IO**
Or
Rocuronium 1 mg/kg IV / IO
(if Succinylcholine contraindicated)
May repeat x 1

Intubate trachea

Placement Verified
Continuous Waveform Capnography

Consider Restraints Physical Procedure

P — Consider Gastric Tube Insertion Procedure

Awakening or Moving after intubation

NO → Exit to Appropriate Protocol(s)

YES ↓

Exit to Post-intubation/ BIAD Management Protocol AR 8

Procedure will remove patient's protective airway reflexes and ability to breath.

You must be sure of your ability to intubate before beginning this procedure.

Must have two (2) Paramedics on scene

Red Text
Key performance indicators used to evaluate protocol compliance.

A NCOEMS Airway Evaluation Form must be completed for every patient who receives Drug Assisted Airway.

Is Not Utilized In Alamance County

Airway, Drug Assisted
(Is Not Utilized By Alamance County)

Is Not Utilized In Alamance County

Pearls

- Agencies must maintain a separate Performance Improvement Program specific to Drug Assisted Airway.
- This procedure requires at least 2 Paramedics. See Pearls section of protocols AR 1 and 2.
- For the purposes of this protocol, a secure airway is when the patient is receiving appropriate oxygenation and ventilation.
- If an effective airway is being maintained by BVM with continuous pulse oximetry values of ≥ 90%, it is acceptable to continue with basic airway measures.
- Ventilation rate:
  - 30 for Neonates, 25 for Toddlers, 20 for School Age, and for Adolescents the normal Adult rate of 10 - 12 per minute.
  - Maintain $EtCO_2$ between 35 - 45 and avoid hyperventilation.
- Hypoxia and/ or Hypotension:
  - Increased risk of cardiac arrest when a sedative with paralytic medications are administered while hypoxic and/ or hypotensive.
  - Resuscitation and correction of hypoxia and/ or hypotension are paramount prior to use of these combined agents.
  - Ketamine administration allows time for appropriate resuscitation of hypoxia and/or hypotension while managing the airway.
- Ketamine for airway intervention and/ or sedation purposes:
  - Ketamine may be used in pediatric patients (fit within a Pediatric Medication/ Skill Resuscitation System product, ≤ 15 years of age, or ≤ 49 kg) with DIRECT ONLINE MEDICAL ORDER by the system MEDICAL DIRECTOR or ASSISTANT MEDICAL DIRECTOR only.
  - Agencies using Ketamine in the pediatric population must also be using in their adult population.
- KETAMINE:
  - Ketamine may be used with or without a paralytic agent in conjunction with either an OPA, NPA, BIAD or endotracheal tube. (BIAD is preferred over endotracheal tube until hypoxia and/ or hypotension are corrected).
  - Ketamine may be used during the resuscitation of hypoxia or hypotension in conjunction with airway management. Once hypoxia and hypotension are corrected, use of a sedative and paralytic can proceed if indicated.
  - Ketamine may be used in the dangerously combative patient requiring airway management IM. IV/ IO should be established as soon as possible.
  - Ketamine may be used for sedation once a BIAD or endotracheal tube are established and confirmed.
  - Agencies using Ketamine must follow Standards Policy: Medial Policy Section Ketamine Program Requirements. Medical Policy 2.
- Intubation attempt defined as laryngoscope blade passing the teeth or endotracheal tube passed into the nostril.
- If First intubation attempt fails, make an adjustment and try again: (Consider change of provider in addition to equipment)
- NC EMS Airway Evaluation Form:
  - Fully complete and have receiving healthcare provider sign confirming BIAD or endotracheal tube placement.
  - Complete online in region specific *ReadyOp* and upload completed form.
  - Complete when Ketamine, Etomidate, Succinylcholine and/ or Rocuronium or used to facilitate use of a BIAD and/ or endotracheal intubation.
- Paramedics/ AEMT should consider using a BIAD if endotracheal intubation is unsuccessful.
- Drug Assisted Airway is not recommended in an urban setting (short transport) when able to maintain oxygen saturation ≥ 90 %.
- **DOPE: D**isplaced tracheostomy tube/ ETT, **O**bstructed tracheostomy tube/ ETT, **P**neumothorax and **E**quipment failure.

Adult COPD/ Asthma Respiratory Distress

History
- Asthma; COPD -- chronic bronchitis, emphysema, congestive heart failure
- Home treatment (oxygen, nebulizer)
- Medications (theophylline, steroids, inhalers)
- Toxic exposure, smoke inhalation

Signs and Symptoms
- Shortness of breath
- Pursed lip breathing
- Decreased ability to speak
- Increased respiratory rate and effort
- Wheezing, rhonchi
- Use of accessory muscles
- Fever, cough
- Tachycardia

Differential
- Asthma
- Anaphylaxis
- Aspiration
- COPD (Emphysema, Bronchitis)
- Pleural effusion
- Pneumonia
- Pulmonary embolus
- Pneumothorax
- Cardiac (MI or CHF)
- Pericardial tamponade
- Hyperventilation
- Inhaled toxin (Carbon monoxide, etc.)

	Adult Airway Protocol(s) ***as indicated***
	Adult Allergic Reaction/ Anaphylaxis Protocol AM 1 ***as indicated***
B	12 Lead ECG Procedure
A	IV or IO Access Protocol UP 6
P	Cardiac Monitor

Following Assessment

WHEEZING

B	**Albuterol Nebulizer 2.5 – 5 mg** Repeat as needed x 3 Or **Levalbuterol (Xopenex) 1.25 mg** Repeat as needed x 3

B	**May Use Patient's Levalbuterol (Xopenex)**

STRIDOR

B	**Albuterol Nebulizer 2.5 – 5 mg** Repeat as needed x 3 Or **Levalbuterol (Xopenex) 1.25 mg** Repeat as needed x 3
A	**Epinephrine Nebulizer 1 mg (1:1000) in 2 mL NS** May repeat x 1

	Adult Airway Protocol(s) ***as indicated***	
B	Airway NIPPV (CPAP) Procedure	
A	**Albuterol Nebulizer 2.5 – 5 mg +/- Ipratropium 0.5 mg (DuoNeb)** Repeat as needed x 3 ***if indicated***	Or **Levalbuterol (Xopenex) 1.25 mg +/- Ipratropium 0.5 mg (DuoNeb)** Repeat as needed x 3 ***if indicated***
A	Consider **Epinephrine 1:1000 0.3 – 0.5 mg IM**	
A	**Methylprednisolone 125 mg IV / IO / IM**	
A	**Magnesium Sulfate 2g in 100 ml of D5W IV / IO** Infuse over 10 – 20 minutes	

Notify Destination or Contact Medical Control

Airway Respiratory Protocol Section

Adult COPD/ Asthma Respiratory Distress

Pearls

- **Recommended Exam: Mental Status, HEENT, Skin, Neck, Heart, Lungs, Abdomen, Extremities, Neuro**
- **Items in Red Text are key performance measures used to evaluate protocol compliance and care.**
- **This protocol includes all patients with respiratory distress, COPD, Asthma, Reactive Airway Disease, or bronchospasm.**
- **Patients may also have wheezing and respiratory distress with viral upper respiratory tract infections and pneumonia.**
- **Pulse oximetry should be monitored continuously and consider End-tidal CO_2 monitoring if available.**
- **<u>Combination nebulizers containing albuterol and ipratropium (DuoNeb) or levalbuterol (Xopenex) and ipratropium (Duoneb):</u>**
  - **Patients may require more than 3 nebulizer treatments, treatments should continue until improvement.**
  - **Following 3 combination nebulizers (DuoNeb), it is preferable to continue albuterol or levalbuterol (Xopenex) solely with subsequent treatments as there is no proven benefit to continual use of ipratropium.**
- **<u>Epinephrine:</u>**
  - **If allergic reaction or anaphylaxis is suspected, give immediately and repeat until improvement.**
  - **If allergic reaction is not suspected, administer with failure to improve and/ or impending respiratory failure.**
- **Consider Magnesium Sulfate with no improvement and/ or impending respiratory failure. Likely more effective with asthmatic exacerbation and less so with COPD exacerbation.**
- **<u>Non-Invasive Positive Pressure Ventilation (NIPPV: CPAP or Bi-Level/ BiPap):</u>**
  - **May be used with COPD, Asthma, Allergic reactions, and/ or CHF.**
  - **Consider early in treatment course.**
  - **Consider removal if SBP remains < 100 mmHg and not responding to other treatments.**
- In patients using levalbuterol (Xopenex) you may use Albuterol for the first treatment then use the patient's supply for repeat nebulizers or agency's supply.
- A silent chest in respiratory distress is a pre-respiratory arrest sign.
- **<u>EMR/ EMT:</u>**
  - **The use of Epinephrine IM is limited to the treatment of anaphylaxis and may be given only by autoinjector,** unless manual draw-up is approved by the Agency Medical Director and the NC office of EMS.
  - **Administration of diphenhydramine is limited to the oral route only**.
- **EMT administration of beta-agonist is limited to only patients currently prescribed the medication,** unless approved by the Agency Medical Director and the NC office of EMS.
- Agency Medical Director may require contact of medical control prior to EMT/ EMR administering any medication(s).

Pediatric Airway

Assess Respiratory Rate, Effort, Oxygenation
Is Airway / Breathing Adequate?

YES → Supplemental oxygen
Goal oxygen saturation ≥ 92%

Exit to
Appropriate Protocol(s)

NO

Basic Maneuvers First
-open airway chin lift/ jaw thrust
-nasal and/ or oral airway
-Bag-valve mask (BVM) +/- PEEP

Spinal Motion Restriction
Procedure / Protocol TB 8
if indicated

Consider AMS Protocol UP 4

Respiratory Distress with a
Tracheostomy Tube
Protocol AR 10
if indicated

Capnography Monitoring

- **End-tidal (EtCO2) monitoring is mandatory following placement of an endotracheal tube.**
- **EtCO2 monitoring is mandatory following placement of a BIAD once available on scene.**

Protocols AR 3, 5, and 6 should be utilized together (even if agency is not using Drug Assisted Airway Protocol) as they contain useful information for airway management.

Airway Obstructed → YES

- Airway Foreign Body Obstruction Procedure
- A: Direct Laryngoscopy ***Optional***

NO

Breathing / Oxygenation Support needed → YES

- Supplemental Oxygen
  BVM
  Maintain
  Oxygen Saturation ≥ 92 %
- B: Airway BIAD Device Procedure ***if indicated***
- A: Oral / Tracheal Intubation Procedure ***Optional***
- P: Chest Decompression Procedure ***if indicated***
- P: Consider Airway, Drug Assisted Protocol AR 3 ***if available***
- P: Post-intubation / BIAD Management Protocol AR 8 ***if indicated***

NO

Monitor /Reassess
Supplemental Oxygen
if indicated

Exit to
Appropriate Protocol(s)

Failed Airway:

Unable to Ventilate and Oxygenate ≥ 90% during or after one (1) or more unsuccessful intubation attempts

and/ or
Anatomy inconsistent with continued attempts

and/ or
Three (3) unsuccessful attempts by most experienced Paramedic/ AEMT.

Exit to
Pediatric Failed Airway
Protocol AR 6

Notify Destination or Contact Medical Control

Airway Respiratory Protocol Section

Pediatric Airway

Pearls

This protocol is for use in patients who FIT within a Pediatric Medication/ Skill Resuscitation System Product.

- For the purposes of this protocol, a secure airway is when the patient is receiving appropriate oxygenation and ventilation.
- If an effective airway is being maintained by BVM with continuous pulse oximetry values of ≥ 90%, it is acceptable to continue with basic airway measures.
- Ventilation rate:
  30 for Neonates, 25 for Toddlers, 20 for School Age, and for Adolescents the normal Adult rate of 10 - 12 per minute. Maintain EtCO2 between 35 - 45 and avoid hyperventilation.
- Intubation:
  Attempt defined as laryngoscope blade passing the teeth.
  Use of a stylet is recommended in all pediatric intubations.
  Endotracheal tube: Depth = 3 x the diameter of the ETT. Estimated Size = 16 + age (years) / 4. Term newborn = 3. 5 mm.
  If First intubation attempt fails, make an adjustment and try again:
  - **Consider change of provider in addition to equipment**
  - **Different laryngoscope blade**
  - **Gum Elastic Bougie**
  - **Different ETT size**
  - **Apply BURP(Backward, Upward, Rightward and Posterior pressure on the larynx)**
  - **Change head positioning**
- Capnography Monitoring (EtCO2):
  Continuous Waveform or Quantitative Capnography and Pulse Oximetry are required for intubation verification and ongoing patient monitoring (Not validated and may prove impossible in the neonatal population - verification by two (2) other means is recommended in this population.)
  Capnography verification and monitoring is required for BIAD verification and monitoring once available on scene.
- NC EMS Airway Evaluation Form:
  Fully complete and have receiving healthcare provider sign confirming BIAD or endotracheal tube placement.
  Complete online in region specific *ReadyOp* and upload completed form.
- Paramedics/ AEMT should consider using a BIAD if endotracheal intubation is unsuccessful.
- During intubation attempts use External Laryngeal Manipulation to improve view of glottis.
- Secure the endotracheal tube well and consider c-collar in pediatric patients (even in absence of trauma) to better maintain ETT placement. Manual stabilization of endotracheal tube should be used during all patient moves / transfers.
- Airway Surgical Cricothyrotomy Procedure:
  Indicated as a lifesaving / last resort procedure in pediatric patients ≥ 10 years of age.
- **DOPE: D**isplaced tracheostomy tube/ ETT, **O**bstructed tracheostomy tube/ ETT, **P**neumothorax and **E**quipment failure.

Pediatric Failed Airway

Definition of Failed Airway:

- Unable to Ventilate and Oxygenate ≥ 90% during or after one (1) or more unsuccessful intubation attempts.

and/ or

- Anatomy inconsistent with continued attempts.

and/ or

- Three (3) unsuccessful attempts by most experienced Paramedic/ AEMT.

Each attempt should include change in approach or equipment

NO MORE THAN THREE (3) ATTEMPTS TOTAL

Call for additional resources if available ↔ Failed Aiway

BVM
Adjunctive Airway NPA/ OPA
Maintains
Oxygen Saturation ≥ 92%

YES → Continue BVM
Supplemental Oxygen

Exit to
Appropriate
Protocol(s)

NO

A Airway Video Laryngoscopy Device Procedure ***if available*** ***Optional***

B Attempt
Airway Blind Insertion Airway Device Procedure

P Airway Cricothyrotomy Surgical Procedure
If ≥ 10 years of age

BIAD / Cricothyrotomy Successful
Or
Oxygenation / Ventilation Adequate

YES → Exit to Post-intubation/ BIAD Management Protocol AR 8

NO

Capnography Monitoring

- **End-tidal (EtCO2) monitoring is mandatory following placement of an endotracheal tube.**
- **EtCO2 monitoring is mandatory following placement of a BIAD once available on scene.**

Protocols AR 3, 5, and 6 should be utilized together (even if agency is not using Drug Assisted Airway Protocol) as they contain useful information for airway management.

Supplemental oxygen
BVM with Airway Adjuncts
Maintain Oxygen Saturation ≥ 92%

Notify Destination or Contact Medical Control

Airway Respiratory Protocol Section

Pediatric Failed Airway

Pearls

This protocol is for use in patients who FIT within a Pediatric Medication/ Skill Resuscitation System Product.

- For the purposes of this protocol, a secure airway is when the patient is receiving appropriate oxygenation and ventilation.
- If an effective airway is being maintained by BVM with continuous pulse oximetry values of ≥ 90%, it is acceptable to continue with basic airway measures.
- Ventilation rate:
  30 for Neonates, 25 for Toddlers, 20 for School Age, and for Adolescents the normal Adult rate of 10 - 12 per minute. Maintain EtCO2 between 35 - 45 and avoid hyperventilation.
- **Intubation:**
  Attempt defined as laryngoscope blade passing the teeth.
  Use of a stylet is recommended in all pediatric intubations.
  Endotracheal tube: Depth = 3 x the diameter of the ETT. Estimated Size = 16 + age (years) / 4. Term newborn = 3. 5 mm.
  If First intubation attempt fails, make an adjustment and try again:
  - **Consider change of provider in addition to equipment**
  - **Different laryngoscope blade**
  - **Gum Elastic Bougie**
  - **Different ETT size**
  - **Apply BURP(Backward, Upward, Rightward and Posterior pressure on the larynx)**
  - **Change head positioning**
- **Capnography Monitoring (EtCO2):**
  Continuous Waveform or Quantitative Capnography and Pulse Oximetry are required for intubation verification and ongoing patient monitoring (Not validated and may prove impossible in the neonatal population - verification by two (2) other means is recommended in this population.)
  Capnography verification and monitoring is required for BIAD verification and monitoring once available on scene.
- **NC EMS Airway Evaluation Form:**
  Fully complete and have receiving healthcare provider sign confirming BIAD or endotracheal tube placement.
  Complete online in region specific *ReadyOp* and upload completed form.
- Paramedics/ AEMT should consider using a BIAD if endotracheal intubation is unsuccessful.
- During intubation attempts use External Laryngeal Manipulation to improve view of glottis.
- Secure the endotracheal tube well and consider c-collar in pediatric patients (even in absence of trauma) to better maintain ETT placement. Manual stabilization of endotracheal tube should be used during all patient moves / transfers.
- **Airway Surgical Cricothyrotomy Procedure:**
  Indicated as a lifesaving / last resort procedure in pediatric patients ≥ 10 years of age.
- **DOPE: D**isplaced tracheostomy tube/ ETT, **O**bstructed tracheostomy tube/ ETT, **P**neumothorax and **E**quipment failure.

Pediatric Asthma
Respiratory Distress

History
- Time of onset
- Possibility of foreign body
- Past Medical History
- Medications
- Fever / Illness
- Sick Contacts
- History of trauma
- History / possibility of choking
- Ingestion / OD
- Congenital heart disease

Signs and Symptoms
- Wheezing / Stridor / Crackles / Rales
- Nasal Flaring / Retractions / Grunting
- Increased Heart Rate
- AMS
- Anxiety
- Attentiveness / Distractability
- Cyanosis
- Poor feeding
- JVD / Frothy Sputum
- Hypotension

Differential
- Asthma / Reactive Airway Disease
- Aspiration
- Foreign body
- Upper or lower airway infection
- Congenital heart disease
- OD / Toxic ingestion / CHF
- Anaphylaxis
- Trauma

Pediatric Airway Protocol(s) 3, 5 - 7
as indicated

Pediatric
Allergic Reaction/ Anaphylaxis
Protocol PM 1
as indicated

B 12 Lead ECG Procedure

A IV or IO Access Protocol UP 6
if indicated

P Cardiac Monitor

Following Assessment

WHEEZING / Asthma

B **Albuterol Nebulizer 1.25 – 2.5 mg**
Repeat as needed x 3
Or
Levalbuterol (Xopenex) 1.25 mg
Repeat as needed x 3

B **May Use Patient's Levalbuterol (Xopenex)**

STRIDOR / Croup

B **Albuterol Nebulizer 1.25 – 2.5 mg**
Repeat as needed x 3
Or
Levalbuterol (Xopenex) 1.25 mg
Repeat as needed x 3

A **Epinephrine Nebulizer**
1 mg (1:1000) in 2 mL NS
May repeat x 1

Pediatric Airway Protocol(s) 3, 5 - 7
as indicated

A

Albuterol Nebulizer
1.25 - 2.5 mg
+/- Ipratropium 0.5 mg (DuoNeb)
Repeat as needed x 3
if indicated

Or
Levalbuterol (Xopenex) 1.25 mg
+/- Ipratropium 0.5 mg (DuoNeb)
Repeat as needed x 3
if indicated

Consider
Epinephrine 1:1000
0.01 mg / kg IM
Maximum 0.3 mg

Methylprednisolone 2 mg / kg
IV / IO / IM
Maximum 125 mg

Magnesium Sulfate 40 mg/kg IV / IO
in 100 ml D5W
Infuse over 10 – 20 minutes
Maximum 2 gm

Indicated for
Asthma / Wheezing
Not indicated in
upper airway
Stridor / Croup

Notify Destination or
Contact Medical Control

Airway Respiratory Protocol Section

Pediatric Asthma
Respiratory Distress

Pearls

- **Recommended Exam: Mental Status, HEENT, Skin, Neck, Heart, Lungs, Abdomen, Extremities, Neuro**
- **Items in Red Text are key performance measures used to evaluate protocol compliance and care.**
- **This protocol includes all patients with respiratory distress, Asthma, Reactive Airway Disease, croup, or bronchospasm.**
- **Patients may also have wheezing and respiratory distress with viral upper respiratory tract infections and pneumonia.**
- **Pulse oximetry should be monitored continuously and consider End-tidal CO2 monitoring if available.**
- **Combination nebulizers containing albuterol and ipratropium (DuoNeb) or levalbuterol (Xopenex) and ipratropium (Duoneb):**
  Patients may require more than 3 nebulizer treatments, treatments should continue until improvement.
  Following 3 combination nebulizers (DuoNeb), it is preferable to continue albuterol or levalbuterol (Xopenex) solely with subsequent treatments as there is no proven benefit to continual use of ipratropium.
- **Epinephrine:**
  If allergic reaction or anaphylaxis is suspected, give immediately and repeat until improvement.
  If allergic reaction is not suspected, administer with no improvement and/ or impending respiratory failure.
- **Consider Magnesium Sulfate with impending respiratory failure and/ or no improvement.**
- **Consider IV access when Pulse oximetry remains ≤ 92 % after first beta-agonist nebulizer treatment.**
- **Do not force a child into a position, allow them to assume position of comfort, typically the tripod position.**
- **Albuterol dosing: ≤ 1 year of age 1.25 mg; 1 – 6 years 1.25 – 2.5 mg; 6 – 14 years 2.5 mg; ≥ 15 years 2.5 – 5 mg.**
- Bronchiolitis is a viral infection typically affecting infants which results in wheezing which may not respond to beta-agonists. Consider Epinephrine nebulizer if patient < 18 months and not responding to initial beta-agonist treatment.
- 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, drooling is common. Airway manipulation may worsen the condition.
- In patients using levalbuterol (Xopenex) you may use Albuterol for the first treatment then use the patient's supply for repeat nebulizers or agency's supply.
- A silent chest in respiratory distress is a pre-respiratory arrest sign.
- **EMR/ EMT:**
  The use of Epinephrine IM is limited to the treatment of anaphylaxis and may be given only by autoinjector, unless manual draw-up is approved by the Agency Medical Director and the NC office of EMS.
  Administration of diphenhydramine is limited to the oral route only.
- **EMT administration of beta-agonist is limited to only patients currently prescribed the medication,** unless approved by the Agency Medical Director and the NC office of EMS.
- Agency Medical Director may require contact of medical control prior to EMT/ EMR administering any medication(s).

Post-intubation/ BIAD Management

Capnography Monitoring

- **End-tidal (EtCO2) monitoring is mandatory following placement of an endotracheal tube.**
- **EtCO2 monitoring is mandatory following placement of a BIAD once available on scene.**

Protocols AR 1, 2, 3, 5, and 6 should be utilized together (even if agency is not using Drug Assisted Airway Protocol) as they contain useful information for airway management.

ETT or Blind Insertion Airway Device Successful

NO → Exit to Appropriate Adult or Pediatric Airway Protocol(s) 1 – 7

YES

Continue Airway Adjuncts
Maintain SpO2 ≥ 92%
Ventilate Age Appropriate breaths/ minute
May require faster rate
See Pearls

B	Maintain EtCO2 35 – 45
	12 Lead ECG Procedure ***as indicated***
A	IV or IO Access Protocol UP 6 (preferably 2 sites)
P	Cardiac Monitor
	Transport Ventilator Procedure ***If available***

Is Sedation Needed?
(Awakening or Moving after Intubation / BIAD Placement Evidence of Anxiety / Agitation)

P

Fentanyl 50 - 75 mcg IV / IO
Repeat every 5 minutes as needed
Maximum 300 mcg

Pediatric: 1 mcg / kg IV / IO / IN
May repeat **0.5 mcg / kg** every 5 minutes as needed
Maximum 2 mcg / kg

Or

Morphine 4 mg IV / IO
Repeat **2 mg** every 5 minutes as needed
Maximum 10 mg

Pediatric: 0.1 mg / kg IV / IO
May repeat **0.1 mg / kg** every 5 minutes as needed
Maximum single dose 5 mg
Maximum 10 mg

Midazolam 2 - 2.5 mg IV / IO
Repeat every 3 – 5 minutes as needed
Maximum 10 mg

Pediatric: 0.1 – 0.2 mg / kg IV / IO / IN
Repeat every 3 – 5 minutes as needed
Maximum 5 mg

Notify Destination or Contact Medical Control

Post-intubation/ BIAD Management

Pearls

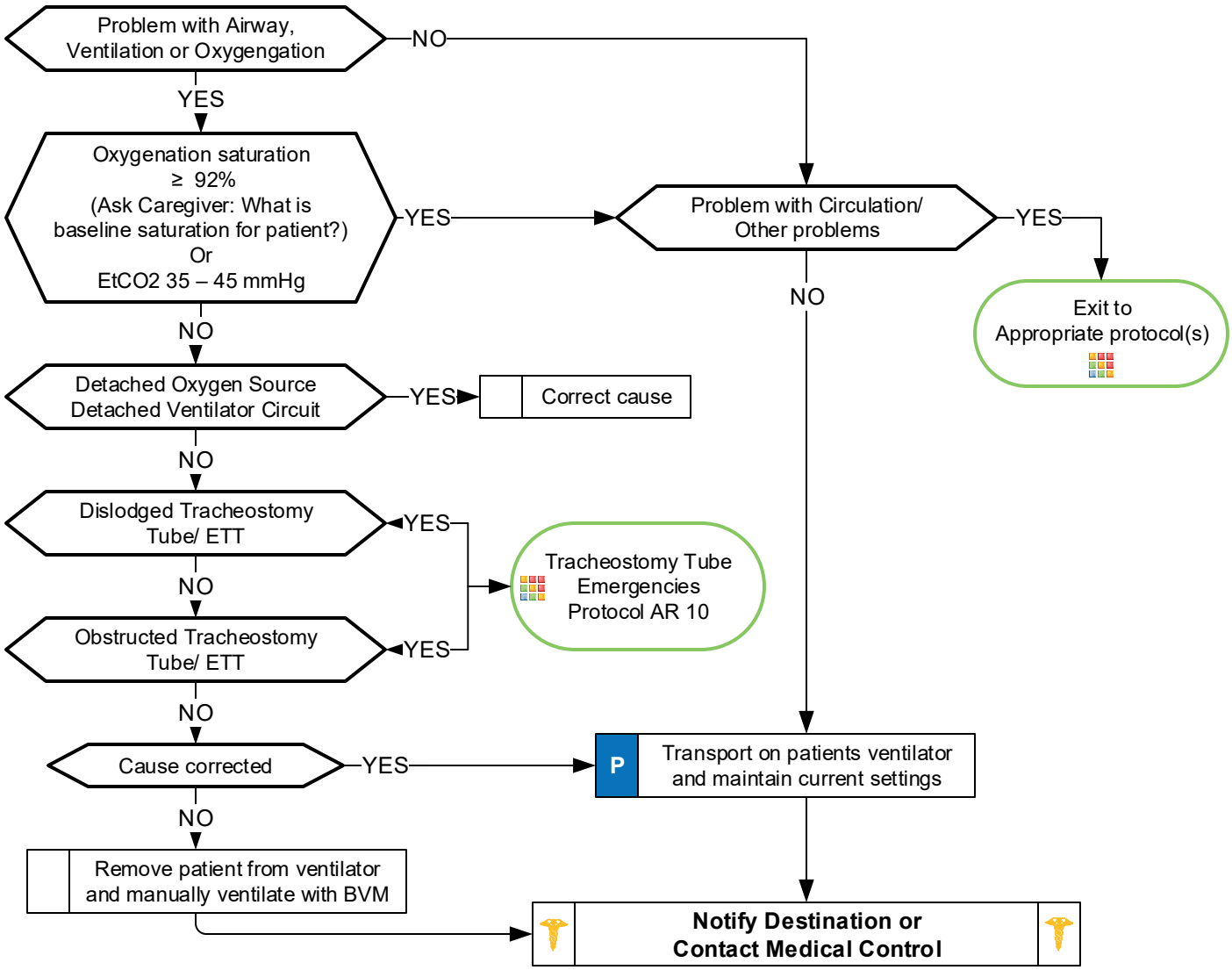
- **Recommended Exam: Mental Status, HEENT, Heart, Lungs, Neuro**
- **Patients requiring advanced airways and ventilation commonly experience pain and anxiety.**
- **Unrelieved pain can lead to increased catecholamine release, ischemia, immunosuppression, and prolonged hospitalization.**
- **Ventilated patients cannot communicate pain/ anxiety and providers are poor at recognizing pain/ anxiety.**
- **Vital signs such as tachycardia and/ or hypertension can provide clues to inadequate sedation, however they are not always reliable indicators of a patient's lack of adequate sedation.**
- **Sedation strategy:**
  Pain is the primary reason patients experience agitation and must be addressed first.
  Opioids are the first line agents.
  Benzodiazepines may be utilized if patient is not responding to adequate opioid doses.
  Ventilation rate:
  Guidelines: 30 for Neonates, 25 for Toddlers, 20 for School Age, and for Adolescents the normal Adult rate of 10 – 12 per minute.
  Maintain EtCO2 between 35 - 45 and avoid hyperventilation.
- **Ventilation strategies will need to be tailored to individual patient presentations. Medical director can indicate different strategies above.**
- In general, ventilation with BVM should cause chest rise. With mechanical ventilation a reasonable tidal volume should be about 6 - 8 mL/kg and peak pressures should be < 30 cmH_20. Plateau Pressures should be < 30 cmH_20.
- Head of bed should be maintained at least 10 – 20 degrees of elevation when possible, to decrease aspiration risk.
- With abrupt clinical deterioration, if mechanically ventilated, disconnect from ventilator to assess lung compliance.
- Search for dislodged ETT or BIAD, obstruction in tubing or airway, pneumothorax, or ETT balloon leak.
- **DOPE: D**isplaced tracheostomy tube/ ETT, **O**bstructed tracheostomy tube/ ETT, **P**neumothorax and **E**quipment failure.

Ventilator Emergencies

History
- Birth defect (tracheal atresia, tracheomalacia, craniofacial abnormalities)
- Surgical complications (damage to phrenic nerve)
- Trauma (post-traumatic brain or spinal cord injury)
- Medical condition (bronchopulmonary dysplasia, muscular dystrophy)

Signs and Symptoms
- Transport requiring maintenance of a mechanical ventilator
- Power or equipment failure at residence

Differential
- Disruption of oxygen source
- Dislodged or obstructed tracheostomy tube
- Detached or disrupted ventilator circuit
- Cardiac arrest
- Increased oxygen requirement / demand
- Ventilator failure



Airway Respiratory Protocol Section

Pearls
- **Always talk to family/ caregivers as they have specific knowledge and skills.**
- **If using the patient's ventilator bring caregiver knowledgeable in ventilator operation during transport.**
- **Take patient's ventilator to hospital even if not functioning properly.**
- **Always use patient's equipment if available and functioning properly.**
- Continuous pulse oximetry and End Tidal CO_2 monitoring must be utilized during assessment and transport.
- Unable to correct ventilator problem: Remove patient from ventilator and manually ventilate using BVM.
- Typical alarms: Low Pressure/ Apnea: Loose or disconnected circuit, leak in circuit or around tracheostomy site.
  Low Power: Internal battery depleted.
  High Pressure: Plugged/ obstructed airway or circuit.
- **DOPE: D**isplaced tracheostomy tube/ ETT, **O**bstructed tracheostomy tube/ ETT, **P**neumothorax and **E**quipment failure.

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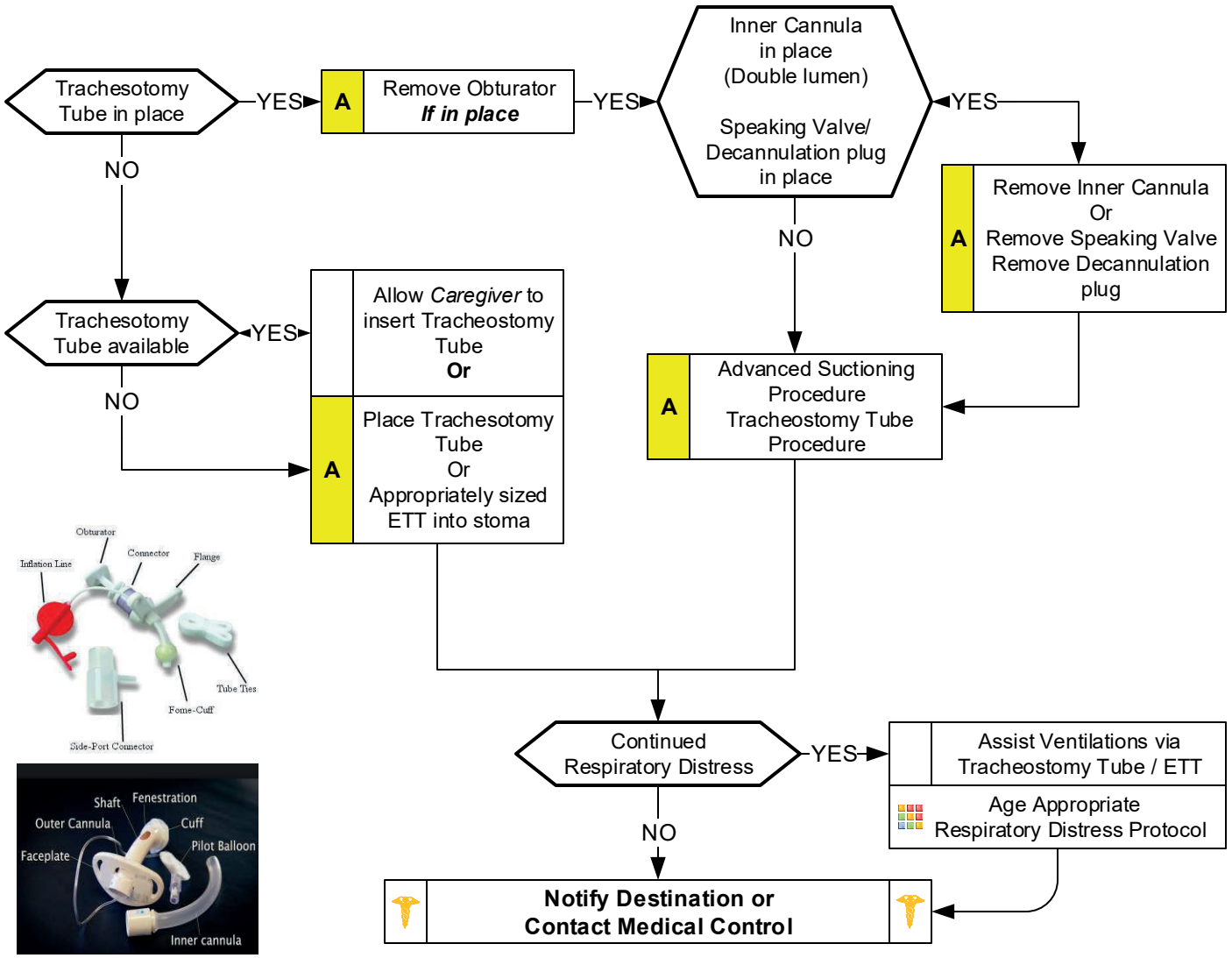
Tracheostomy Tube Emergencies

History
- Birth defect (tracheal atresia, tracheomalacia, craniofacial abnormalities)
- Surgical complications (accidental damage to phrenic nerve)
- Trauma (post-traumatic brain or spinal cord injury)
- Medical condition (bronchial or pulmonary dysplasia, muscular dystrophy)

Signs and Symptoms
- Nasal flaring
- Chest wall retractions (with or without abnormal breath sounds)
- Attempts to cough
- Copious secretions noted coming out of the tube
- Faint breath sounds on both sides of chest despite significant respiratory effort
- AMS
- Cyanosis

Differential
- Allergic reaction
- Asthma
- Aspiration
- Septicemia
- Foreign body
- Infection
- Congenital heart disease
- Medication or toxin
- Trauma



Airway Respiratory Protocol Section

Pearls
- **Always talk to family/ caregivers as they have specific knowledge and skills.**
- **Important to ask if patient has undergone laryngectomy. This does not allow mouth/ nasal ventilation by covering stoma.**
- **Use patient's equipment if available and functioning properly.**
- Estimate suction catheter size by doubling the inner tracheostomy tube diameter and rounding down.
- Suction depth: Ask family/ caregiver. No more than 3 to 6 cm typically. Instill 2 – 3 mL of NS before suctioning.
- Do not suction more than 10 seconds each attempt and pre-oxygenate before and between attempts.
- DO NOT force suction catheter. If unable to pass, then tracheostomy tube should be changed.
- Always deflate tracheal tube cuff before removal. Continual pulse oximetry and EtCO2 monitoring if available.
- **DOPE: D**isplaced tracheostomy tube/ ETT, **O**bstructed tracheostomy tube/ ETT, **P**neumothorax and **E**quipment failure.

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Adult Asystole / Pulseless Electrical Activity

History
- SAMPLE
- Estimated downtime
- See Reversible Causes below
- DNR, MOST, or Living Will

Signs and Symptoms
- Pulseless
- Apneic
- No electrical activity on ECG
- No heart tones on auscultation

Differential
- See Reversible Causes below

Cardiac Arrest Protocol AC 3

Criteria for Death / No Resuscitation
Review DNR / MOST Form

YES →
Decomposition
Rigor mortis
Dependent lividity
Blunt force trauma
Injury incompatible with life
Extended downtime with asystole

Do not begin resuscitation

Follow
Deceased Subjects
Policy

NO ↓

Begin Continuous Chest Compressions
Push Hard (≥ 2 inches)
Push Fast (100 - 120 / min)
Change Compressors every 2 minutes (sooner if fatigued)
(Limit changes / pulse checks ≤ 5 seconds)
Apply Non-Rebreather Mask at 15 lpm for first 3 compression cycles if cardiac etiology suspected.

After 3rd compression cycle, Ventilate 1 breath every 6 – 8 seconds with Bag Mask connected to supplemental Oxygen without pausing compressions.

AED Procedure
if available

A

Cardiac Monitor

IV or IO Access Protocol UP 6

Epinephrine (1:10,000) 1 mg IV / IO
Repeat every 4 minutes Max of 3 mg
Resets if ROSC occurs

Normal Saline or Lactated Ringer's Bolus
500 mL IV / IO
May repeat as needed
Maximum 2 L

Search for Reversible Causes

Blood Glucose Analysis Procedure
if applicable

On Scene Resuscitation / Discontinuation of Prehospital Resuscitation Policy DP 3
as indicated

↓

Notify Destination or Contact Medical Control

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Resuscitation Protocol AC 10

AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.

Consider Early for PEA

1. Repeated Normal Saline or Lactated Ringer's Boluses for possible hypovolemia
2. Dextrose IV/IO
3. Naloxone 2mg IV/IO
4. Glucagon 4mg IV/IO/IM for suspected beta blocker or calcium channel blocker overdose.
5. Calcium Chloride 1 g IV/IO for suspected hyperkalemia, hypocalcemia
6. Sodium Bicarbonate 50meq IV/ IO for possible overdose, hyperkalemia, renal failure
7. Chest Decompression

Reversible Causes
Hypovolemia
Hypoxia
Hydrogen ion (acidosis)
Hypothermia
Hypo / Hyperkalemia

Tension pneumothorax
Tamponade; cardiac
Toxins
Thrombosis; pulmonary (PE)
Thrombosis; coronary (MI)

Suspected Opioid Overdose
Administer Naloxone per Overdose / Toxic Ingestion Protocol TE 7

Adult Cardiac Protocol Section

Adult Asystole / Pulseless Electrical Activity

Pearls

- **SURVIVAL FROM PEA OR ASYSTOLE is based on identifying and correcting the CAUSE: consider a broad differential diagnosis, with early and aggressive treatment of possible causes.**
- **Team Focused Approach / Pit-Crew Approach recommended; assigning responders to predetermined tasks. Refer to optional Team Focused CPR Protocol AC 11 or development of local agency protocol.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated.**
- **DO NOT HYPERVENTILATE: If no advanced airway (BIAD, ETT), compression to ventilation ratio is 30:2. If advanced airway in place, ventilate 10 breaths per minute with continuous, uninterrupted compressions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **Passive oxygenation optional in agencies practicing Team Focused Approach / Pit-Crew Approach.**
- **Reassess and document BIAD and / or endotracheal tube placement and EtCO2 frequently, after every move, and at transfer of care.**
- **IV / IO access and drug delivery are secondary to high-quality chest compressions and early defibrillation**.
- **Follow IV or IO Access Protocol UP 6.**
- **Cardiac Monitor:** AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.
- **Defibrillation:** Follow manufacture's recommendations concerning defibrillation / cardioversion energy when specified.
- **End Tidal CO2 (EtCO2)**
  If EtCO2 is < 10 mmHg, improve chest compressions. Goal is ≥ 20 mmHg.
  If EtCO2 spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **Special Considerations**
  Maternal Arrest - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm. Defibrillation is safe at all energy levels.
  Renal Dialysis / Renal Failure - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.
  Opioid Overdose - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol TE 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.
  Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- **Transcutaneous Pacing:**
  Pacing is NOT effective in cardiac arrest and pacing in cardiac arrest does NOT increase chance of survival
- Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.
- Discussion with Medical Control can be a valuable tool in developing a differential diagnosis and identifying possible treatment options.

Bradycardia; Pulse Present

History
- Past medical history
- Medications
  - Beta-Blockers
  - Calcium channel blockers
  - Clonidine
  - Digoxin
- Pacemaker

Signs and Symptoms
- HR < 60/min with hypotension, acute altered mental status, chest pain, acute CHF, seizures, syncope, or shock secondary to bradycardia
- Chest pain
- Respiratory distress
- Hypotension or Shock
- Altered mental status
- Syncope

Differential
- Acute myocardial infarction
- Hypoxia / Hypothermia
- Pacemaker failure
- Sinus bradycardia
- Head injury (elevated ICP) or Stroke
- Spinal cord lesion
- Sick sinus syndrome
- AV blocks (1°, 2°, or 3°)
- Overdose

Heart Rate < 60 / min and Symptomatic:
Hypotension, Acute AMS, Ischemic Chest Pain, Acute CHF, Seizures, Syncope, or Shock secondary to bradycardia
Typically HR < 50 / min

NO → Exit to Appropriate Protocol(s)

YES

Airway Protocol(s) AR 1, 2, 3 ***if indicated***

Respiratory Distress Protocol AR 4 ***if indicated***

Chest Pain: Cardiac and STEMI Protocol AC 4 ***if indicated***

B Search for Reversible Causes

B 12 Lead ECG Procedure

A IV / IO Protocol UP 6

P Cardiac Monitor

A **Normal Saline or Lactated Ringer's Fluid Bolus**
500 mL – 2 L NS IV / IO
(Unless Acute CHF)
Maximum 2 L

P **Atropine 1 mg IV / IO**
May repeat every 3 – 5 minutes
Maximum 3 mg

P **Epinephrine 1 - 10 mcg/min IV / IO**
(Add 1 mg Epinephrine 1:1,000 to 250 ml D5W or NS to make concentration of 4 mcg/ml)
Titrate to SBP ≥ 90 mmHg
MAP ≥ 65 mmHg

P **If No Improvement**
Transcutaneous Pacing Procedure
(Consider earlier in 2nd or 3rd AVB)
Pacing should be considered first-line therapy for symptomatic bradycardia due to cardiac ischemia (e.g. STEMI, 3rd degree heart block)

P Consider Sedation
Midazolam 2 – 2.5 mg
IV / IO / IM / IN
May repeat as needed
Maximum 5 mg

Notify Destination or Contact Medical Control

Reversible Causes

Hypovolemia
Hypoxia
Hydrogen ion (acidosis)
Hypothermia
Hypo / Hyperkalemia

Tension pneumothorax
Tamponade; cardiac
Toxins
Thrombosis; pulmonary (PE)
Thrombosis; coronary (MI)

Suspected Beta-Blocker or Calcium Channel Blocker

Follow Overdose/ Toxic Ingestion Protocol TE 7

Transcutaneous Pacing
Adjust Heart Rate to 70 BPM for an Adult

Adult Cardiac Protocol Section

Bradycardia; Pulse Present

Epinephrine 1 – 10 mcg/min IV/IO
Add 1 mg Epinephrine 1:1,000 to 250 ml D5W or NS to make concentration of 4 mcg/ml

1 – 4 mcg/min rate utilizing 60 drop set for administration.
15 gtt/min = 1 mcg/min (one drop every 4 seconds)
30 gtt/min = 2 mcg/min (one drop every 2 seconds)
45 gtt/min = 3 mcg/min (one drop every 1.3 seconds)
60 gtt/min = 4 mcg/min (one drop every second)

4 – 10 mcg/min rate utilizing 10 drop set for administration.
10 gtt/min = 4 mcg/min (one drop every 6 seconds)
15 gtt/min = 6 mcg/min (one drop every 4 seconds)
20 gtt/min = 8 mcg/min (one drop every 3 seconds)
25 gtt/min = 10 mcg/min (one drop every 2.4 seconds)

4 – 10 mcg/min rate utilizing 15 drop set for administration.
15 gtt/min = 4 mcg/min (one drop every 4 seconds)
22.5 gtt/min = 6 mcg/min (one drop every 2.7 seconds)
30 gtt/min = 8 mcg/min (one drop every 2 seconds)
37.5 gtt/min = 10 mcg/min (one drop every 1.6 seconds)

4 – 10 mcg/min rate utilizing 20 drop set for administration.
20 gtt/min = 4 mcg/min (one drop every 3 seconds)
30 gtt/min = 6 mcg/min (one drop every 2 seconds)
40 gtt/min = 8 mcg/min (one drop every 1.5 seconds)
50 gtt/min = 10 mcg/min (one drop every 1.2 seconds)

Pearls

- **Recommended Exam: Mental Status, HEENT, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro**
- **Identifying signs and symptoms of poor perfusion caused by bradycardia are paramount.**
- **Rhythm should be interpreted in the context of symptoms and pharmacological treatment given only when symptomatic, otherwise monitor and reassess.**
- **Consider hyperkalemia with wide complex, bizarre appearance of QRS complex, and bradycardia. Give Calcium Chloride or Gluconate in addition to Sodium Bicarbonate if hyperkalemia suspected.**
- **12-Lead ECG:**
  12 Lead ECG not necessary to diagnose and treat
  Obtain when patient is stable and/or following rhythm conversion.
- **Unstable condition**
  Condition which acutely impairs vital organ function and cardiac arrest may be imminent.
  If at any point patient becomes unstable move to unstable arm in algorithm.
- **Hypoxemia is a common cause of bradycardia. Ensure oxygenation and support respiratory effort.**
- **Atropine:**
  Atropine is considered a first line agent in symptomatic bradycardia.
  Ineffective and potentially harmful in cardiac transplantation. May cause paradoxical bradycardia.
- **Symptomatic bradycardia causing shock or peri-arrest condition:**
  If no IV or IO access immediately available start Transcutaneous Pacing, establish IV / IO access, and then administer atropine and/or epinephrine.
  Epinephrine or Levophed may be considered if no response to Atropine.
- **Symptomatic condition**
  Arrhythmia is causing symptoms such as palpitations, lightheadedness, or dyspnea, but cardiac arrest is not imminent.
  Symptomatic bradycardia usually occurs at rates < 50 beats per minute.
  Search for underlying causes such as hypoxia or impending respiratory failure.
- **Serious Signs / Symptoms:**
  Hypotension. Acutely altered mental status. Signs of shock / poor perfusion. Chest pain with evidence of ischemia (STEMI, T wave inversions or depressions.) Acute CHF.
- **Transcutaneous Pacing Procedure (TCP)**
  Indicated with unstable bradycardia unresponsive to medical therapy.
  If time allows transport to specialty center because transcutaneous pacing is a temporizing measure.
  Transvenous / permanent pacemaker will probably be needed.
  Immediate TCP with high-degree AV block (2d or 3d degree) with no IV / IO access.
- Consider treatable causes for bradycardia (Beta Blocker OD, Calcium Channel Blocker OD, etc.)

Cardiac Arrest; Adult

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Resuscitation Protocol AC 10

Criteria for Death / No Resuscitation
Review DNR / MOST Form

YES

- Decomposition
- Rigor mortis
- Dependent lividity
- Blunt force trauma
- Injury incompatible with life
- Extended downtime with asystole

Do not begin resuscitation

Follow Deceased Subjects Policy

NO

Begin Continuous Chest Compressions
Push Hard (≥ 2 inches)
Push Fast (100 - 120 / min)
Change Compressors every 2 minutes
(sooner if fatigued)
(Limit changes / pulse checks ≤ 5 seconds)
Apply Non-Rebreather Mask at 15 lpm for first 3 compression cycles if cardiac etiology suspected.

After 3rd compression cycle, Ventilate 1 breath every 6 – 8 seconds with Bag Mask connected to supplemental Oxygen without pausing compressions.

ALS Available

NO → AED Procedure ***if available***

YES → **A** Cardiac Monitor

Shockable Rhythm

NO → Continue CPR 2 Minutes
Repeat and reassess
Airway Protocol(s) AR 1, 2, 3

YES → AED Procedure → Continue CPR 2 Minutes / Repeat and reassess / Airway Protocol(s) AR 1, 2, 3

Shockable Rhythm

NO → Asystole / PEA Protocol AC 1 ***as indicated***
Airway Protocol(s) AR 1, 2, 3

YES → VF / VT Protocol AC 9
Tachycardia Protocol(s) AC 6, 7 ***as indicated***
Airway Protocol(s) AR 1, 2, 3

AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.

Arrest secondary to Opioid OD?

YES →
Naloxone 0.4 – 2 mg IN / IM
Peds: 0.1 mg/kg IN
Maximum 4 mg

A
Naloxone 0.4 – 2 mg
Peds: 0.1 mg/kg
IV / IO / IM / IN
Maximum 4 mg

NO →

Discontinuation of Prehospital Resuscitation Policy DP 3 ***as indicated***

Notify Destination or Contact Medical Control

Adult Cardiac Protocol Section

Cardiac Arrest; Adult

Pearls

- **Team Focused Approach / Pit-Crew Approach recommended; assign responders to pit crew positions in order. Refer to protocol AC 11.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated.**
- **Utilize Passive Oxygenation (Non-rebreather and Airway Adjunct) as resources arrive. Breathing / Airway management should occur after 3 cycles of compressions (2 minutes each cycle).**
- **DO NOT HYPERVENTILATE: If no advanced airway (BIAD, ETT) compression to ventilation ratio is 30:2. If advanced airway in place, ventilate 10 breaths per minute, ventilating once every 6 – 8 seconds with continuous, uninterrupted compressions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **Reassess and document BIAD and / or endotracheal tube placement and EtCO2 frequently, after every move, and at transfer of care.**
- **IV / IO access and drug delivery is secondary to high-quality chest compressions and early defibrillation**.
- **Follow IV or IO Access Protocol UP 6.**
- **Cardiac Monitor:** AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.
- **Defibrillation:**
  Follow manufacture's recommendations concerning defibrillation / cardioversion energy when specified.
  Charge defibrillator during chest compressions, near the end of 2-minute cycle, to decrease peri-shock pause.
  Following defibrillation, provider should immediately restart chest compressions with no pulse check until end of next cycle.
  Manual Defibrillation at the AEMT level is permissible only during pulseless cardiac arrest with VF or VT.
- **End Tidal CO2 (EtCO2)**
  If EtCO2 is < 10 mmHg, improve chest compressions. Goal is ≥ 20 mmHg.
  If EtCO2 spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **Special Considerations**
  Maternal Arrest - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm. Defibrillation is safe at all energy levels.
  Renal Dialysis / Renal Failure - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.
  Opioid Overdose - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol TE 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.
  Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- **Transcutaneous Pacing:**
  Pacing is NOT effective in cardiac arrest and pacing in cardiac arrest does NOT increase chance of survival
- Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.
- Discussion with Medical Control can be a valuable tool in developing a differential diagnosis and identifying possible treatment options.

Chest Pain: Cardiac and STEMI

History
- Age
- Medications (Viagra / sildenafil, Levitra / vardenafil, Cialis / tadalafil)
- Past medical history (MI, Angina, Diabetes, post menopausal)
- Allergies
- Recent physical exertion
- **O**nset / **P**alliation / **P**rovocation
- **Q**uality (crampy, constant, sharp, dull, etc.)
- **R**egion / **R**adiation / **R**eferred
- **S**everity (1-10)
- **T**ime (onset /duration / repetition)

Signs and Symptoms
- CP (pain, pressure, aching, vice-like tightness)
- Location (substernal, epigastric, arm, jaw, neck, shoulder)
- Radiation of pain
- Pale, diaphoresis
- Shortness of breath
- Nausea, vomiting, dizziness
- **Time of Onset**
- Women:
  - More likely to have dyspnea,
  - N/V, weakness, back or jaw pain

Differential
- Trauma vs. Medical
- Angina vs. Myocardial infarction
- Pericarditis
- Pulmonary embolism
- Asthma / COPD
- Pneumothorax
- Aortic dissection or aneurysm
- GE reflux or Hiatal hernia
- Esophageal spasm
- Chest wall injury or pain
- Pleural pain
- Overdose: Cocaine or Methamphetamine

B	**12 Lead ECG Procedure**
	Aspirin 81 mg x 4 PO (chewed) Or **325 mg PO**
	Nitroglycerin 0.3 / 0.4 mg Sublingual Repeat every 5 minutes x 3 ***if prescribed to patient and (BP ≥ 100)***
P	Cardiac Monitor

Acute MI / STEMI
See box to right

YES →

EMT and AEMT providers are NOT permitted to interpret 12 Lead ECG.

12 Lead ECG performed by EMT or AEMT should be interpreted by Paramedic or utilize ECG software interpretation AND transmitted to Medical Control for interpretation.

Transport based on:
STEMI
EMS Triage and Destination Plan
Immediate Notification of Facility
Immediate Transmission of ECG
if capable
Keep Scene Time to ≤ 10 Minutes

STEMI Hotline

ARMC / Cone – 336-271-4956
Duke – 866–642-3853
UNC – 984–974-2024

Acute MI / STEMI

STEMI Definition:
- **≥ 1 mm ST Segment elevation in ≥ 2 contiguous leads**
- **≥ 2 mm ST/J point elevation in V2-V3 for men**
- **≥ 1.5 mm ST/J point elevation in V2-V3 for women**
- **ECG software diagnoses Acute MI (symptomatic)**

NO ↓

A	IV / IO Protocol UP 6
	Nitroglycerin 0.3 / 0.4 mg SL Repeat every 5 minutes as needed
	Nitroglycerin Paste SBP Greater Than: 100 = 1 inch 150 = 1.5 inches 200 = 2 inches
P	**Fentanyl 50 – 75 mcg IV / IO** Repeat 25 mcg every 20 minutes as needed **Maximum 200 mcg** **- OR -** **Morphine 2 – 4 mg IV / IO** Repeat every 5 minutes as needed **Maximum 10 mg**
	Hypotension / Shock Protocol AM 5 ***if indicated***
	CHF / Pulmonary Edema Protocol AC 5 ***if indicated***

Notify Destination or Contact Medical Control

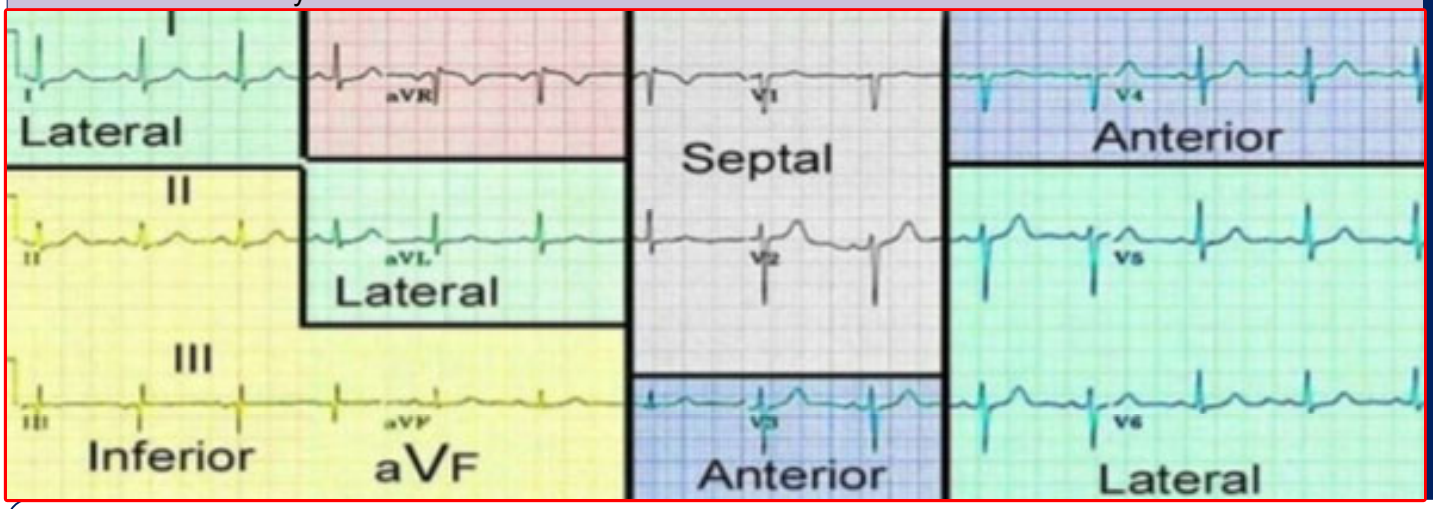
Adult Cardiac Protocol Section

Chest Pain: Cardiac and STEMI

DO NOT administer nitroglycerin to patients with a SBP < 90 mmHg or who have taken a PDE-5 inhibitor (such as Viagra (sildenafil), Cialis (tadalafil), etc.) within 48 hours.

*** SEE 12-LEAD/CODE STEMI CATH LAB ACTIVATION PROCEDURE FOR CRITERIA TO CALL "CODE STEMI" AND ACTIVATE CATH LAB VS. SEND EKG FOR CONSULT.**

ST Elevation in 2 or more leads: II, III, aVF = Inferior wall MI (vessel likely RCA or LCx)
ST Elevation in 2 or more leads: I, aVL, V5, V6 = Lateral wall MI (vessel likely LCx or LAD branch)
ST Elevation in 2 or more leads: V1, V2, V3, V4 = Septal/Anterior wall MI (vessel likely LAD)
**Look for ST DEPRESSION in reciprocal leads (opposite wall) to confirm diagnosis.
** Isolated ST elevation in aVR, with ST depression EVERYWHERE ELSE is concerning for a possible proximal LAD or Left Main lesion. Not STEMI criteria, but EKG should be sent for consult and ED notified early.



Pearls

- **Recommended Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro**
- **Items in Red Text are the key performance indicators for the EMS Acute Cardiac (STEMI) Care Toolkit**
- **Nitroglycerin:**
  - **Avoid Nitroglycerin in any patient who has used Viagra (sildenafil) or Levitra (vardenafil) in the past 24 hours or Cialis (tadalafil) in the past 36 hours due to potential severe hypotension.**
  - **Nitroglycerin may cause hypotension during any type myocardial infarction. It is NOT more likely to cause hypotension in an inferior MI and should NOT be avoided unless already hypotensive.**
- **STEMI (ST-Elevation Myocardial Infarction)**
  - **Positive Reperfusion Checklist should be transported to the appropriate facility based on STEMI EMS Triage and Destination Plan.**
  - **Consider placing 2 IV sites in the left arm: Many PCI centers use the right radial artery for intervention.**
  - **Consider placing defibrillator pads on patient as a precaution.**
  - **Consider Normal Saline or Lactated Ringers bolus of 250 – 500 mL as pre-cath hydration.**
  - **Scene time goal is < 10 minutes.**
  - **Document and time-stamp facility STEMI notification and make notification as soon as possible.**
  - **Document the time of the 12-Lead ECG in the PCR as a Procedure along with the interpretation (Paramedic).**
- **Cardiac related symptoms in men and women:**
  - Pressure, squeezing, fullness, or pain in the chest.
  - Pain or discomfort in one or both arms, the back, neck, jaw, or stomach.
  - Shortness of breath with or without chest pain.
  - Sweating, nausea, weakness, and/or lightheadedness.
  - **Women, diabetic patients, and the elderly often experience only weakness, shortness of breath, nausea/ vomiting, and back or jaw pain.**
- If patient has taken nitroglycerin without relief, consider potency of the medication.
- Monitor for hypotension after administration of nitroglycerin and opioids.
- **EMT may administer Nitroglycerin to patients already prescribed medication. May give from EMS supply.**
- Agency medical director may require Contact of Medical Control prior to administration.

CHF / Pulmonary Edema

History
- Congestive heart failure
- Past medical history
- Medications (digoxin, Lasix, Viagra / sildenafil, Levitra / vardenafil, Cialis / tadalafil)
- 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

Differential
- Myocardial infarction
- Congestive heart failure
- Asthma
- Anaphylaxis
- Aspiration
- COPD
- Pleural effusion
- Pneumonia
- Pulmonary embolus
- Pericardial tamponade
- Toxic Exposure

Airway
Protocol(s) AR 1, 2, 3
as indicated

Chest Pain and STEMI
Protocol AC 4
if indicated

B: 12 Lead ECG Procedure

B: **Nitroglycerin 0.3 / 0.4 mg Sublingual**
Repeat every 5 minutes x 3
if prescribed to patient and (BP >100)

P: Cardiac Monitor

A: IV / IO Protocol UP 6

Assess Symptom Severity

MILD
Normal Heart Rate
Elevated or Normal BP

A: **Nitroglycerin 0.3 / 0.4 mg SL**
Repeat every 5 minutes

A: **Nitroglycerin Paste**
SBP >100 = 1"
>150 = 1.5"
> 200 = 2"

Improving
NO → B: **Airway NIPPV(CPAP) Procedure**
YES

MODERATE / SEVERE
Elevated Heart Rate
Elevated BP

B: **Airway NIPPV(CPAP) Procedure**

A: **Nitroglycerin 0.3 / 0.4 mg SL**
Repeat every 5 minutes

A: **Nitroglycerin Paste**
SBP >100 = 1"
>150 = 1.5"
> 200 = 2"

P: **ACE-Inhibitor - Enalaprilat 1.25 mg IV/IO if SBP > 200 mmHg**

CARDIOGENIC SHOCK
Tachycardia followed by bradycardia
Hypertension followed by hypotension

B: Remove NIPPV(CPAP)
if in place

Adult Hypotension / Shock
Protocol AM 5
if indicated

Notify Destination or Contact Medical Control

Adult Cardiac Protocol Section

CHF / Pulmonary Edema

Pearls

- **Recommended Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro**
- **Items in Red Text are key performance measures used to evaluate protocol compliance and care**
- **Diuretics (furosemide) and opioids have NOT been shown to improve the outcomes of EMS patients with pulmonary edema. Even though this historically has been a mainstay of EMS treatment, it is no longer routinely recommended.**
- **Nitroglycerin:**
  - **Avoid Nitroglycerin in any patient who has used Viagra (sildenafil) or Levitra (vardenafil) in the past 24 hours or Cialis (tadalafil) in the past 36 hours due to potential severe hypotension.**
  - **Nitroglycerin may cause hypotension during any type myocardial infarction. It is NOT more likely to cause hypotension in an inferior MI and should NOT be avoided unless already hypotensive.**
- **Carefully monitor the level of consciousness, BP, and respiratory status with the above interventions.**
- **Document the time of the 12-Lead ECG in the PCR as a Procedure along with the interpretation (Paramedic).**
- **Consider myocardial infarction in all these patients. Diabetics, geriatric and female patients often have atypical pain, or only generalized complaints.**
- **Cardiac related symptoms in men and women:**
  - Pressure, squeezing, fullness, or pain in the chest.
  - Pain or discomfort in one or both arms, the back, neck, jaw, or stomach.
  - Shortness of breath with or without chest pain.
  - Sweating, nausea, weakness, and/or lightheadedness.
  - **Women, diabetic patients, and the elderly often experience only weakness, shortness of breath, nausea/ vomiting, and back or jaw pain.**
- If patient has taken nitroglycerin without relief, consider potency of the medication.
- Contraindications to opioids include severe COPD and respiratory distress. Monitor the patient closely.
- Monitor for hypotension after administration of nitroglycerin and opioids.
- Allow the patient to be in their position of comfort to maximize their breathing effort.
- **EMT may administer Nitroglycerin to patients already prescribed medication. May give from EMS supply**.
- Agency medical director may require Contact of Medical Control.

Adult Tachycardia
NARROW (≤ 0.11 sec)

History
- Age
- Past medical history (MI, Angina, Diabetes, post menopausal)
- Recent physical exertion
- Palpitations, irregular heart beat
- Time (onset /duration / repetition)

Signs and Symptoms
- Chest pain, heart failure, dyspnea
- AMS
- Shock, poor perfusion, hypotension
- Pale, diaphoresis
- Shortness of breath
- Nausea, vomiting, dizziness

Differential
- Trauma vs. Medical
- Sinus Tachycardia vs. dysrhythmia
- Fever, sepsis, infection
- Pericarditis, pulmonary embolism
- Aortic dissection or aneurysm
- Overdose: Stimulants

Assess tachycardia in context of clinical condition
Identify and treat underlying cause of tachycardia

Unstable / Serious Signs and Symptoms
HR Typically ≥ 150
Hypotension, Acute AMS, Ischemic Chest Pain, Acute CHF, Seizures, Syncope, or Shock secondary to tachycardia

YES →

P

***Consider* Only if regular/narrow complex (E.g. SVT)**
Adenosine 6 mg IV / IO
Rapid push with flush
May repeat **12 mg IV / IO once**

Cardioversion Procedure

Consider Sedation Prior to Cardioversion

Midazolam 2 – 2.5 mg IV / IO
May repeat as needed
Maximum 5 mg

Synchronized
Narrow and Regular: 360J
Narrow and Irregular: 360J
May repeat dose with subsequent cardioversion attempts

NO

B	12 Lead ECG Procedure
P	Cardiac Monitor
A	IV or IO Access Protocol UP 6

Regular Rhythm?

YES →

P

Attempt Vagal Maneuvers Procedure

Adenosine 6 mg IV / IO
Rapid push with flush

May repeat **12 mg IV / IO once**

NO

P

(E.g. A-Fib w/ RVR)

Metoprolol (Lopressor)
2.5 – 5 mg over 1-2 minutes
Max Dose – 5 mg

Or

Diltiazem 0.25 mg/kg IV / IO
Over 2 – 3 minutes
Maximum 10 mg

Monitor and Reassess

Notify Destination or Contact Medical Control

Adult Cardiac Protocol Section

Adult Tachycardia
NARROW (≤ 0.11 sec)

Pearls

- Recommended Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro
- Most important goal is to differentiate the type of tachycardia and if STABLE or UNSTABLE and SYMPTOMATIC.
- 12-Lead ECG:
  - 12 Lead ECG not necessary to diagnose and treat
  - Obtain when patient is stable and/or following rhythm conversion.
- Unstable condition
  - Condition which acutely impairs vital organ function and cardiac arrest may be imminent.
  - If at any point patient becomes unstable move to unstable arm in algorithm.
- **Search for underlying cause of tachycardia such as fever, sepsis, dyspnea, etc.**
- **Typical sinus tachycardia is in the range of 100 to (200 - patient's age) beats per minute.**
- **Symptomatic condition**
  - **Arrhythmia is causing symptoms such as palpitations, lightheadedness, or dyspnea, but cardiac arrest is not imminent.**
  - **Symptomatic tachycardia usually occurs at rates ≥ 150 beats per minute.**
  - **Patients symptomatic with heart rates < 150 likely have impaired cardiac function such as CHF.**
- **Serious Signs / Symptoms:**
  - **Hypotension. Acutely altered mental status. Signs of shock / poor perfusion. Chest pain with evidence of ischemia (STEMI, T wave inversions or depressions.) Acute CHF.**
- **If patient has history or 12 Lead ECG reveals Wolfe Parkinson White (WPW):**
  - **DO NOT administer a Calcium Channel Blocker (e.g. Diltiazem) or Beta Blockers.**
  - **Use caution with Adenosine and give only with defibrillator available.**
- **Regular Narrow-Complex Tachycardia:**
  - Vagal maneuvers and adenosine are preferred. Vagal maneuvers may convert 19% to 54 % of SVT.
  - Using passive leg raise with Valsalva is more effective.
  - Adenosine should be pushed rapidly via proximal IV site followed by 20 mL Normal Saline rapid flush.
  - Adenosine should not be used in the post-cardiac transplant patient without **Contact of Medical Control.**
  - Agencies using both calcium channel blockers and beta blockers should choose one primarily. Giving the agents sequentially requires **Contact of Medical Control**. This may lead to profound bradycardia / hypotension.
- **Irregular Narrow-Complex Tachycardia:**
  - Rate control is more important in pre-hospital setting rather than focus on rhythm conversion.
- **Synchronized Cardioversion:**
  - Recommended to treat UNSTABLE Atrial Fibrillation, Atrial Flutter and SVT.
- Monitor for hypotension after administration of Calcium Channel Blockers or Beta Blockers.
- Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.

Adult Monomorphic Tachycardia

Wide Complex (≥0.12 sec)

History
- Age
- Past medical history (MI, Angina, Diabetes, post menopausal)
- Recent physical exertion
- Palpitations, irregular heart beat
- Time (onset /duration / repetition)

Signs and Symptoms
- Chest pain, heart failure, dyspnea
- AMS
- Shock, poor perfusion, hypotension
- Pale, diaphoresis
- Shortness of breath
- Nausea, vomiting, dizziness

Differential
- Trauma vs. Medical
- Sinus Tachycardia vs. dysrrhythmia
- Fever, sepsis, infection
- Pericarditis, pulmonary embolism
- Aortic dissection or aneurysm
- Overdose: Stimulants

Assess tachycardia in context of clinical condition
Identify and treat underlying cause of tachycardia

Unstable/ Serious Signs and Symptoms
HR Typically > 150
Hypotension, Acute AMS, Ischemic Chest Pain, Acute CHF, Seizures, Syncope, or Shock secondary to tachycardia

YES

P	Cardiac Monitor
	Cardioversion Procedure
	Consider Sedation Prior to Cardioversion **Midazolam 2 – 2.5 mg IV / IO** May repeat as needed **Maximum 5 mg**
	Wide: Regular and Irregular: 360J • **Monomorphic QRS (Synchronized)** • **Polymorphic QRS (Not-Synchronized)** **(If Synchronization does Not discharge when attempting to cardiovert a Wide and Irregular rhythm, switch to Un-Synchronized)** *May repeat dose with subsequent cardioversion attempts*

NO

B	12 Lead ECG Procedure
P	Cardiac Monitor
A	IV or IO Access Protocol UP 6
P	**Consider consultation with medical control**

REGULAR MONOMORPHIC RHYTHM
Is QRS Complex Less Than (<) .20ms

NO

P	**Consider Metabolic or Toxicity Causes**
	Sodium Bicarbonate 50 - 100 mEq IV / IO
	Calcium Chloride 1 gm IV / IO
	Consider consultation with Medical Control

Rhythm Converts

NO

YES

P	Attempt Vagal Maneuvers Procedure ***Only if regular monomorphic complex***
	Consider **Only if regular monomorphic complex** **Adenosine 6 mg IV / IO** Rapid push with flush May repeat **12 mg IV / IO once**
	Amiodarone 150 mg in 100 mL of D5W IV / IO **Infuse over 10 minutes** May repeat if wide complex tachycardia recurs
	Monitor and Reassess
	Notify Destination or Contact Medical Control

B	12 Lead ECG Procedure

Single lead ECG able to diagnose and treat arrhythmia

12 Lead ECG not necessary to diagnose and treat, but preferred when patient is stable.

Monomorphic QRS:
- **All QRS complexes in a single lead are similar in shape.**

Adult Cardiac Protocol Section

Adult Monomorphic Tachycardia

Wide Complex (≥0.12 sec)

'Synchronized' cardioversion should be utilized for Wide and Regular. Wide and IRREGULAR, Synchronized cardioversion 360J if QRS is distinguishable. If the monitor is unable to synchronize then the paramedic may perform unsynchronized cardioversion.

Single lead ECG able to diagnose and treat arrhythmia

- 12 Lead ECG not necessary to diagnose and treat, but preferred when patient is stable.

Pearls

- **Recommended Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Extremities, Neuro**
- **Most important goal is to differentiate the type of tachycardia and if STABLE or UNSTABLE and if SYMPTOMATIC.**
- **12-Lead ECG:**
  12-Lead ECG is not necessary to diagnose and treat arrhythmia. A single lead ECG is often all that is needed. Obtain 12-Lead when patient is stable and/ or following a rhythm conversion.
- **Monomorphic QRS:**
  All QRS complexes in a single lead are similar in shape.
- **Polymorphic QRS:**
  QRS complexes in a single lead will change shape from complex to complex.
- **Rhythm should be interpreted in the context of symptoms and pharmacological or electrical treatment given only when symptomatic, otherwise monitor and reassess.**
- **Unstable condition**
  Condition which acutely impairs vital organ function and cardiac arrest may be impending.
  If at any point patient becomes unstable move to unstable arm in algorithm.
- **Symptomatic condition**
  Arrhythmia is causing symptoms such as palpitations, lightheadedness, or dyspnea but cardiac arrest is not impending.
  Symptomatic tachycardia usually occurs at rates ≥ 150 beats per minute. Patients symptomatic with heart rates < 150 likely have impaired cardiac function such as CHF.
- **Serious Signs/ Symptoms:**
  Hypotension. Acutely altered mental status. Signs of shock/ poor perfusion. Chest pain with evidence of ischemia (STEMI, T wave inversions or depressions.) Acute congestive heart failure.
- **Search for underlying cause of tachycardia such as fever, sepsis, dyspnea, etc.**
- **Typical sinus tachycardia is in the range of 100 to (220 – patients age) beats per minute.**
- **If patient has history or 12-Lead ECG reveals Wolfe Parkinson White (WPW), DO NOT administer a Calcium Channel Blocker (e.g., Diltiazem) or Beta Blockers. Use caution with Adenosine and give only with defibrillator available.**
- **Regular Wide-Complex Tachycardia:**
  Unstable condition: Immediate defibrillation if pulseless and begin CPR.
  Stable condition: Typically VT or SVT with aberrancy. Adenosine may be given if regular and monomorphic and if defibrillator available. Verapamil contraindicated in wide-complex tachycardias.
  Agencies using Amiodarone, Procainamide, and Lidocaine need to choose one agent primarily. Giving multiple anti-arrhythmics requires contact of Medical Control.
  Atrial arrhythmias with WPW should be treated with Amiodarone.
- **Irregular Tachycardia:**
  Wide-complex, irregular tachycardia: Do not administer calcium channel, beta blockers, or adenosine as this may cause paradoxical increase in ventricular rate. This will usually require cardioversion. Contact Medical Control.
- **Polymorphic / Irregular Tachycardia:**
  This situation is usually unstable and immediate defibrillation is warranted.
  When associated with prolonged QT this is likely Torsades de pointes: Give 2 gm of Magnesium Sulfate slow IV / IO.
  Without prolonged QT likely related to ischemia, Magnesium may not be helpful.
- Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.

Adult Polymorphic Tachycardia
WIDE (≥ 0.12 sec) Torsades de pointes

History
- Age
- Past medical history (MI, Angina, Diabetes, post menopausal)
- Recent physical exertion
- Palpitations, irregular heart beat
- Time (onset /duration / repetition)

Signs and Symptoms
- Chest pain, heart failure, dyspnea
- AMS
- Shock, poor perfusion, hypotension
- Pale, diaphoresis
- Shortness of breath
- Nausea, vomiting, dizziness

Differential
- Cardiac arrest
- Sinus Tachycardia vs. dysrhythmia
- Fever, sepsis, infection
- Pericarditis, pulmonary embolism
- Aortic dissection or aneurysm
- Overdose

Assess tachycardia in context of clinical condition
Identify and treat underlying cause of tachycardia

Unstable / Serious Signs and Symptoms
HR Typically ≥ 150
Hypotension, Acute AMS, Ischemic Chest Pain, Acute CHF, Seizures, Syncope, or Shock secondary to tachycardia

YES →

P	Synchronized Cardioversion Procedure
	Consider Sedation Prior to Defibrillation **Midazolam 2 – 2.5 mg IV / IO** May repeat as needed **Maximum 5 mg**
	Wide and Irregular: 360J **Polymorphic QRS (If Synchronization does not discharge, switch to Un-Synchronized)** *May repeat dose with subsequent cardioversion attempts*

NO ↓

B	12 Lead ECG Procedure
P	Cardiac Monitor
A	IV or IO Access Protocol UP 6

Pulse Present?

YES → P **Consider consultation with medical control**

NO → Exit to Cardiac Arrest Protocol AC 3

QT Interval < 500 msec

P	**Amiodarone 150 mg in 100 mL of D5W IV / IO** Infuse over 10 minutes May repeat if tachycardia recurs or persists
	Monitor and Reassess

QT Interval > 500 msec

P	*Consider* **Magnesium Sulfate 2 g in 100 ml of D5W IV / IO** Infuse over 10 minutes May repeat **Maximum 4 g**
	Monitor and Reassess

Notify Destination or Contact Medical Control

Polymorphic QRS:
- **QRS complexes in a single lead will change shape from complex to complex.**

Adult Cardiac Protocol Section

Adult Polymorphic Tachycardia
WIDE (≥ 0.12 sec) Torsades de pointes

Pearls

- Recommended Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro
- Most important goal is to differentiate the type of tachycardia and if STABLE or UNSTABLE and SYMPTOMATIC.
- 12-Lead ECG:
  - 12 Lead ECG not necessary to diagnose and treat
  - Obtain when patient is stable and/or following rhythm conversion.
- Monomorphic QRS:
  - All QRS complexes in a single lead are similar in shape.
- Polymorphic QRS:
  - QRS complexes in a single lead will change shape from complex to complex.
- Rhythm should be interpreted in the context of symptoms and pharmacological or electrical treatment given only when symptomatic, otherwise monitor and reassess.
- Unstable condition
  - Condition which acutely impairs vital organ function and cardiac arrest may be imminent.
  - If at any point patient becomes unstable move to unstable arm in algorithm.
- Symptomatic condition
  - Arrhythmia is causing symptoms such as palpitations, lightheadedness, or dyspnea, but cardiac arrest is not imminent.
  - Symptomatic tachycardia usually occurs at rates ≥ 150 beats per minute. Patients symptomatic with heart rates <150 likely have impaired cardiac function such as CHF.
- Serious Signs / Symptoms:
  - Hypotension. Acutely altered mental status. Signs of shock / poor perfusion. Chest pain with evidence of ischemia (STEMI, T wave inversions or depressions.) Acute congestive heart failure.
- Search for underlying cause of tachycardia such as fever, sepsis, dyspnea, etc.
- Typical sinus tachycardia is in the range of 100 to (220 – patients age) beats per minute.
- If patient has history or 12 Lead ECG reveals Wolfe Parkinson White (WPW), DO NOT administer a Calcium Channel Blocker (e.g., Diltiazem) or Beta Blockers. Use caution with Adenosine and give only with defibrillator available.
- Polymorphic / Irregular Tachycardia:
  - This situation is usually unstable and immediate defibrillation is warranted.
  - If QT length is known, use for decision-making. Prolonged QT length defined as > 500 msec.
  - QT length < 500 msec:
    - Arrhythmia more likely related to ischemia or infarction and Magnesium Sulfate not likely helpful.
    - May quickly deteriorate into Ventricular Fibrillation.
    - Even when terminated by defibrillation, may recur, so follow with medication therapy.
  - QT prolongation > 500 msec:
    - Magnesium Sulfate more likely to be helpful.
- Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.

Ventricular Fibrillation
Pulseless Ventricular Tachycardia

Cardiac Arrest Protocol AC 3

AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.

A — **Defibrillate 360 Joules without delay (Shock #1)**

Begin Continuous Chest Compressions
Push Hard (≥ 2 inches)
Push Fast (100 - 120 / min)
Change Compressors every 2 minutes (sooner if fatigued)
(Limit changes / pulse checks ≤ 5 seconds)
Apply Non-Rebreather Mask at 15 lpm for first 3 compression cycles if cardiac etiology suspected.

After 3rd compression cycle, Ventilate 1 breath every 6 – 8 seconds with Bag Mask connected to supplemental Oxygen without pausing compressions.

Search for Reversible Causes continuously

IV / IO Protocol UP 6

A — **Epinephrine (1:10,000) 1 mg IV / IO**
Repeat every 4 minutes Max of 3 mg
Resets if ROSC occurs

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Resuscitation Protocol AC 10

Reversible Causes

Hypovolemia
Hypoxia
Hydrogen ion (acidosis)
Hypothermia
Hypo / Hyperkalemia

Tension pneumothorax
Tamponade; cardiac
Toxins
Thrombosis; pulmonary (PE)
Thrombosis; coronary (MI)

Consider Early

1. Repeated Normal Saline or Lactated Ringer's Boluses for possible hypovolemia
2. Dextrose IV/IO
3. Naloxone 2mg IV/IO
4. Glucagon 4mg IV/IO/IM for suspected beta blocker or calcium channel blocker overdose.
5. Calcium Chloride 1 g IV/IO for suspected hyperkalemia, hypocalcemia
6. Sodium Bicarbonate 50meq IV/ IO for possible overdose, hyperkalemia, renal failure

A — **Continue CPR, Fill Pit Crew Positions, pre-charge monitor, pause for rhythm check at 2 minutes and Defibrillate 360 Joules if indicated. (Shock #2)**

After second shock, resume compressions: Continue CPR, give meds during compressions.

P — **Amiodarone 300 mg IV / IO**
May repeat if refractory
Amiodarone 150 mg IV / IO
Refractory

A — **Magnesium Sulfate 2 g slow IV / IO push**
Torsades de Pointes, Low Magnesium States (Malnourished / Alcoholic) Suspected Digitalis Toxicity

Pre-Charge Monitor. After 2 minutes of CPR, rhythm check. **If VF/VT, Defibrillate 360 Joules.** (Shock #3)
Place a second set of Defib Pads at a new location.

A — **Continue CPR, Pre-charge monitor, Pause for rhythm check at 2 minutes and Defibrillate 360 Joules with new pads at new vector. (Shock #4)**

A — **Continue high-quality 2 minute CPR cycles. Pause for rhythm check at 2 minutes with PRE-CHARGED MONITOR and Defibrillate 360 Joules. DO NOT consider field termination while the patient has recurrent or refractory VF/VT.**

Notify Destination or Contact Medical Control

Adult Cardiac Protocol Section

Ventricular Fibrillation
Pulseless Ventricular Tachycardia

- **Pearls**
- **Utilize Team Focused / Pit-Crew Approach; assigning responders to tasks as available.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated.**
- **Consider early IO placement if available and / or difficult IV access anticipated.**
- **DO NOT HYPERVENTILATE: Ventilate 10 breaths per minute with continuous, uninterrupted compressions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **Passive oxygenation optional in agencies practicing Team Focused Approach / Pit-Crew Approach.**
- Reassess and document BIAD and / or endotracheal tube placement and EtCO2 frequently, after every move, and at transfer of care.
- **IV / IO access and drug delivery is secondary to high-quality chest compressions and early defibrillation.**
- **Follow IV or IO Access Protocol UP 6.**
- **Cardiac Monitor:** AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.
- **Defibrillation:** **Manual Defibrillation at the AEMT level is permissible only during pulseless cardiac arrest with VF or VT.**
- **End Tidal CO2 (EtCO2)**
- If EtCO2 is < 10 mmHg, improve chest compressions.
- If EtCO2 spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **Special Considerations**
- **Maternal Arrest** - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm. Defibrillation is safe at all energy levels.
- **Renal Dialysis / Renal Failure** - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.
- **Opioid Overdose** - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol TE 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.
- **Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike** – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- **Magnesium Sulfate is not routinely recommended during cardiac arrest, but may help with Torsades de points, Low Magnesium States (Malnourished / alcoholic), and Suspected Digitalis Toxicity**
- Return of spontaneous circulation: Heart rate should be greater than (>) 60 when initiating anti-arrhythmic infusions.
- **Recurrent ventricular fibrillation/tachycardia** is defined as SUCCESSFULLY CONVERTED to another rhythm at next rhythm check by standard defibrillation techniques (i.e. 360 J), but subsequently returns at a subsequent rhythm check. It should not be treated by double sequential external defibrillation. It is managed by treatment of correctable causes and use of anti-arrhythmic medications in addition to standard defibrillation.
- **Refractory ventricular fibrillation/tachycardia** is defined as NOT CONVERTED by standard defibrillation (i.e. **VF/VT remains present after at least 3 rhythm checks/defibrillations in a row during a code (including a defib with new pads/vector).** It is also managed by treating correctable causes and with antiarrhythmic medications.
- Prolonged cardiac arrests may lead to tired providers and decreased compression quality. Ensure compressor rotation, summon additional resources as needed, and ensure provider rest and rehab during and post-event.

Post Resuscitation

Return of Spontaneous Circulation

Reversible Causes

Hypovolemia
Hypoxia
Hydrogen ion (acidosis)
Hypothermia
Hypo / Hyperkalemia

Tension pneumothorax
Tamponade; cardiac
Toxins
Thrombosis; pulmonary (PE)
Thrombosis; coronary (MI)

Repeat Primary Assessment

B — **Optimize Ventilation and Oxygenation**
- Respiratory Rate 8 -10 / minute
- Maintain SpO2 94%-99%
- DO NOT HYPERVENTILATE
- ETCO2 ideally 35 – 45 mmHg, Do Not Hyperventilate to correct.

Airway Protocol(s) AR 1, 2, 3, 4 ***as indicated***

B — 12 Lead ECG Procedure

A — IV / IO Protocol UP 6

P — Cardiac Monitor

Monitor Vital Signs / Reassess

A — PREPARE for possible re-arrest; Prepare to take care of a critically ill patient:
1. One provider should maintain a finger on the pulse at all times.
2. Wait ~10 minutes after ROSC to initiate transport, with the exception of STEMI and Trauma patients.

P — 3. Prepare Pressor drips and have them ready to treat potential hypotension and bradycardia.

Chest Pain and STEMI Protocol AC 4 ***if indicated*** → **STEMI EMS Triage and Destination Plan**

Hypotension / Shock Protocol AM 5 ***as indicated***

A — **Optimize Systolic BP/Mean Arterial BP**
P
- Systolic BP > 90 mmHg
- Mean Arterial BP > 65 mmHg

Appropriate Arrhythmia Protocol(s) AC 2, 6, 7, 8, 9 ***as indicated***

Post Intubation BIAD Management Protocol AR 8

A — **Normal Saline or Lactated Ringer's Bolus 500 mL IV / IO**
May repeat as needed
Maximum 2 L

P — **If SBP <90 mmHg**
Norepinephrine (Levophed) 1 – 10 mcg / min
Titrate to SBP ≥ 90 mmHg or MAP ≥ 65mmHg

P — **If Bradycardic and unable to obtain capture when pacing**
Epinephrine 1 - 10 mcg/min IV / IO (Add 1 mg Epinephrine 1:1,000 to 250 ml D5W or NS to make concentration of 4 mcg/ml)
Titrate to SBP ≥ 90 mmHg
MAP ≥ 65 mmHg

Arrhythmias are common and usually self limiting after ROSC and may not need further treatment, especially atrial dysrhythmias. Providers Should treat worsening bradycardia, as it may precede re-arrest.

If Arrhythmia Persists follow Rhythm Appropriate Protocol

Notify Destination or Contact Medical Control

Adult Cardiac Protocol Section

Post Resuscitation

Post-Arrest Checklist

- ☐ Vitals Signs with continuous **ALS MONITORING** at all times
- ☐ Verify **AIRWAY**
- ☐ Note changes in **EtCO2 (Goal 35-40 mmHg)**
  - EtCO2 with good waveform present
  - DO NOT HYPERVENTILATE!!
- ☐ Maintain **Sp02: 94% -99%**
- ☐ Stay **ON-SCENE first 10 minutes** to stabilize
  - Exceptions STEMI, trauma
- ☐ Obtain **12 lead EKG** (STEMI ALERT if indicated)
  - If STEMI, expedite transport with well controlled movements
- ☐ Obtain blood glucose
- ☐ Appropriate personnel and number for transport in event of re-arrest
  - **Continuous monitoring** and frequent pulse checks
- ☐ Consider Levophed if SBP < 90 mmHg
- ☐ Consider Epinephrine Drip in Bradycardia if unable to obtain capture when pacing

Epinephrine 1 – 10 mcg/min IV/IO
Add 1 mg Epinephrine 1:1,000 to 250 ml D5W or NS to make concentration of 4 mcg/ml

1 – 4 mcg/min rate utilizing 60 drop set for administration.
15 gtt/min = 1 mcg/min (one drop every 4 seconds)
30 gtt/min = 2 mcg/min (one drop every 2 seconds)
45 gtt/min = 3 mcg/min (one drop every 1.3 seconds)
60 gtt/min = 4 mcg/min (one drop every second)

4 – 10 mcg/min rate utilizing 10 drop set for administration.
10 gtt/min = 4 mcg/min (one drop every 6 seconds)
15 gtt/min = 6 mcg/min (one drop every 4 seconds)
20 gtt/min = 8 mcg/min (one drop every 3 seconds)
25 gtt/min = 10 mcg/min (one drop every 2.4 seconds)

4 – 10 mcg/min rate utilizing 15 drop set for administration.
15 gtt/min = 4 mcg/min (one drop every 4 seconds)
22.5 gtt/min = 6 mcg/min (one drop every 2.7 seconds)
30 gtt/min = 8 mcg/min (one drop every 2 seconds)
37.5 gtt/min = 10 mcg/min (one drop every 1.6 seconds)

4 – 10 mcg/min rate utilizing 20 drop set for administration.
20 gtt/min = 4 mcg/min (one drop every 3 seconds)
30 gtt/min = 6 mcg/min (one drop every 2 seconds)
40 gtt/min = 8 mcg/min (one drop every 1.5 seconds)
50 gtt/min = 10 mcg/min (one drop every 1.2 seconds)

- **Pearls**
- **Recommended Exam: Mental Status, Neck, Skin, Lungs, Heart, Abdomen, Extremities, Neuro**
- **Continue to search for potential cause of cardiac arrest during post-resuscitation care.**
- **Hyperventilation is a significant cause of hypotension and recurrence of cardiac arrest in the post resuscitation phase and must be avoided at all costs. Titrate FiO2 to maintain SpO2 of ≥ 94%.**
- **Initial End tidal CO2 may be elevated immediately post-resuscitation, but will usually normalize. While goal is 35 – 45 mmHg avoid hyperventilation to achieve.**
- Most patients immediately post resuscitation will require ventilatory assistance.
- **Titrate fluid resuscitation and vasopressor administration to maintain SBP of 90 – 100 mmHg or Mean Arterial Pressure (MAP) of 65 – 80 mmHg.**
- **<u>STEMI:</u>**
- **Transport to a primary cardiac catheter facility with evidence of STEMI on 12 Lead ECG.**
- **<u>Targeted Temperature Management:</u>**
- **Maintain core temperature between 32 - 36°C.**
- **Infusion of cold saline is NOT recommended in the prehospital setting.**
- **Consider transport to facility capable of managing the post-arrest patient including hypothermia therapy, cardiology / cardiac catheterization, intensive care service, and neurology services.**
- The condition of post-resuscitation patients fluctuates rapidly and continuously, and they require close monitoring. Appropriate post-resuscitation management may best be planned in consultation with medical control.

Team Focused CPR

Criteria for Death / No Resuscitation
Review DNR / MOST Form

YES

- Decomposition
- Rigor mortis
- Dependent lividity
- Blunt force trauma
- Injury incompatible with life
- Extended downtime with asystole

Do not begin resuscitation

Follow Deceased Subjects Policy

NO

Begin Continuous Chest Compressions
Push Hard (≥ 2 inches)
Push Fast (100 - 120 / min)
Change Compressors every 2 minutes (sooner if fatigued)
(Limit changes / pulse checks ≤ 5 seconds)
Apply Non-Rebreather Mask at 15 lpm for first 3 compression cycles if cardiac etiology suspected. After 3rd compression cycle, Ventilate 1 breath every 6 – 8 seconds with Bag Mask connected to supplemental Oxygen without pausing compressions.

First Arriving First Responders
Initiate Compressions Only CPR, CPR Triangle
Automated Defibrillation Procedure, NRB Mask O2
Call for additional resources
Fills Pit Crew Positions 1 & 2

First Arriving EMS Crew / Responder
Assure Pit Crew Positions 1 and 2 are filled
1. Cardiac monitor analysis, defibrillation
2. CPR Triangle Team Leader, focus on CPR quality, airway is secondary

Second Arriving EMS Crew / Responder
Fill Pit Crew Positions 3 and 4
3. IV/IO Access, meds, fluids
4. Checklist, History, Family

Third Arriving EMS Crew / Responder
Ensure Pit Crew positions 1-4 have been filled and that CPR triangle is working effectively/has enough people for good ongoing CPR quality.
Fill in position 5 as "helper" with meds, fluids, setups, checklist, rotate positions as necessary.

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Resuscitation Protocol AC 10

AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.

Arriving Responder Duties
BLS or ALS

BLS

Establish Team Leader
(Hierarchy)
Fire Department or Squad Officer
EMT or First Arriving Responder

Fourth / Subsequent Arriving Responders
Take direction from Team Leader

Rotate with Compressor
To prevent Fatigue and effect high quality compressions
Take direction from Team Leader

Continue Cardiac Arrest Protocol AC 3

ALS

Establish Team Leader
(Hierarchy)
EMS ALS Personnel
Fire Department or Squad Officer
EMT or First Arriving Responder

A Initiate Defibrillation Automated Procedure
Establish Airway with BIAD if not in place

A Establish IV / IO
Administer Appropriate Medications

A / **P** Initiate Defibrillation Manual Procedure
Continuous Cardiac Monitoring
Establish IV / IO
Administer Appropriate Medications
Establish Airway with BIAD if not in place

Continue Cardiac Arrest Protocol AC 3

Patient Care Leader / Pit Crew Leader / "Code Commander"
Responsible for patient care with CPR team Leader, Ensures high-quality resuscitation, responsible for overall patient care effort

Scene Leader / Incident Commander
Fire Department / First Responder Officer
Team Leader until ALS arrival, Manages Scene / Bystanders
Responsible for briefing family prior to ALS arrival

Adult Cardiac Protocol Section

Team Focused CPR

ACEMS Cardiac Arrest Checklist:

- ☐ TEAM LEADER identified, team-focused of CPR
- ☐ Continuous chest compressions
  - Rate of 100-110/min
  - Depth of at least 2 inches (adult) with full recoil
- ☐ LifePak connected with D-Fib pads in place
  - Paddles mode with rhythm visible
  - Metronome on
  - Defibrillate every 2 minutes for shockable rhythms
- ☐ Airway management:
  - Non-rebreather with passive oxygenation first 3 cycles CPR
    - Exceptions if unwitnessed arrest or non-cardiac cause: (i.e. asthma, COPD, choking, drowning, trauma, primary respiratory)
  - Verified airway placement (BIAD/King/ETT)
  - EtCO2 Waveform present and monitored
  - Goal EtCO2 35-40 mmHg (8-10 ventilations/minute)
- ☐ Assess for reversible causes and treat early

Common Causes of Cardiac Arrest:

Hypoxia	Tension Pneumothorax
Hypovolemia	Toxins
Hyper- /hypokalemia	Thrombosis (Cardiac)
Hypothermia	Thrombosis (Pulmonary)
Hydrogen ion/ Acidosis	Tamponade

- ☐ Check that BVM/advanced airway is connected to oxygen
- ☐ IV/IO access obtained
- ☐ Appropriate protocol(s) utilized

VFib / V-Tach
Defib
CPR 2 min
Defib
EPI 1 mg
CPR 2 min
Defib
Amiodarone 300mg/150 mg

PEA / Asystole
CPR 2 min
Epi 1 mg
CPR 2 min

- ☐ Appropriate cardiac medications administered
- ☐ LUCAS placed in ≤ 10 sec. only after 3rd round of CPR after EMS arrives
- ☐ Family receiving care/updates

Post-Arrest Checklist

- ☐ Vitals Signs with continuous **ALS MONITORING** at all times
- ☐ Verify **AIRWAY**
- ☐ Note changes in **EtCO2 (Goal 35-40 mmHg)**
  - EtCO2 with good waveform present
  - DO NOT HYPERVENTILATE!!
- ☐ Maintain **Sp02: 94% -99%**
- ☐ Stay **ON-SCENE first 10 minutes** to stabilize
  - Exceptions STEMI, trauma
- ☐ Obtain **12 lead EKG** (STEMI ALERT if indicated)
  - If STEMI, expedite transport with well controlled movements
- ☐ Obtain blood glucose
- ☐ Appropriate personnel and number for transport in event of re-arrest
  - **Continuous monitoring** and frequent pulse checks
- ☐ Consider Levophed if SBP < 90 mmHg
- ☐ Consider Epinephrine Drip in Bradycardia if unable to obtain capture when pacing

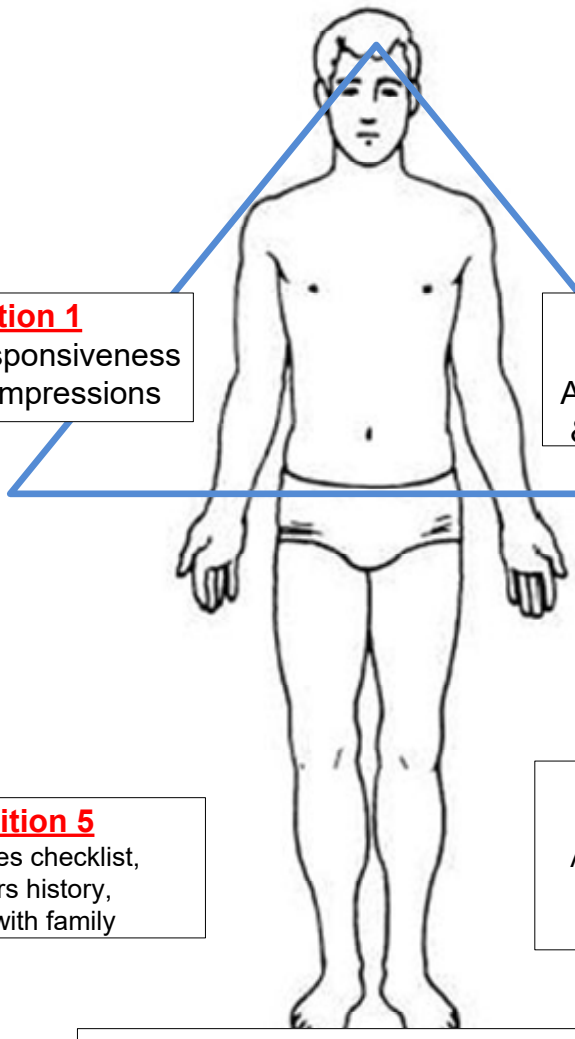
Adult Cardiac Protocol Section

Pearls

- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated.**
- **DO NOT HYPERVENTILATE: Ventilate 10 breaths per minute with continuous, uninterrupted compressions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **Passive oxygenation should be utilized for first 2 – 3 compressions cycles (4-6 minutes) or until resources arrive for BVM use, and may continue during the code.**
- Reassess and document BIAD and / or endotracheal tube placement and EtCO2 frequently, after every move, and at transfer of care.
- **IV / IO access and drug delivery are secondary to high-quality chest compressions and early defibrillation**.
- **Follow IV or IO Access Protocol UP 6.**
- **Cardiac Monitor:** AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.
- **Defibrillation:** **Manual Defibrillation at the AEMT level is permissible only during pulseless cardiac arrest with VF or VT.** Charge defibrillator during chest compressions, near the end of 2-minute cycle, to decrease peri-shock pause. Following defibrillation, provider should immediately restart chest compressions with no pulse check until end of next cycle.
- Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.
- Discussion with Medical Control can be a valuable tool in developing a differential diagnosis and identifying possible treatment options.
- Consider possible CAUSE of arrest early: For example, resuscitated V-fib may be STEMI and more rapid transport is indicated. Consider traditional ACLS "H's and T's" for PEA: Hypovolemia, Hypoxia, Hydrogen ions (acidosis), Hyperkalemia, Hypothermia, Hypo/Hyperglycemia, Tablets/Toxins/Tricyclics, Tamponade, Tension pneumothorax, Thrombosis (MI), Thromboembolism (Pulmonary Embolism), Trauma.

Team Focused CPR

Position 4
Ventilates every 8 – 10 seconds, Inserts advanced airway if needed.



Position 1
Checks Responsiveness
Begins Compressions

Position 2 *
Attaches / Operates AED, Inserts OPA, NPA & passive oxygenation

If ALS Provider is in the 'resting position', may establish IV/IO and administer Medications

Position 3
Establishes IV/IO
Administers Medications / Immediately Correctable Interventions

Position 5
Completes checklist,
Gathers history,
Talks with family

Code Commander
Responsible for ensuring all aspects of the code run efficiently. Should remain out of the action area unless needed for IO or Airway. If solo medic, may have to fill ALS rolls as well.

Position 4 takes priority over Postion 3 if arrest is unwitnessed or non-cardiac cause suspected

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Mechanical Circulatory Support
LVAD, RVAD, and Bi-VAD

History
- SAMPLE
- Bridge to transplant
- Destination therapy
- Estimated downtime
- LVAD, RVAD, Bi-Vad, TAH
- DNR, MOST, or Living Will
- Contact with LVAD coordinator

Signs and Symptoms
- Unconsciousness
- Pulseless
- Apneic
- Poor capillary refill / skin color
- AMS or decreased mental status
- No electrical activity on ECG
- No heart tones on auscultation

Differential
- See Reversible Causes below
- Infection/Sepsis
- Hypovolemia
- Cardiac arrest
- Hemorrhage

Contact VAD coordinator:
- As quickly as possible for troubleshooting and treatment advice, but do not delay emergency treatment
- Follow patient specific emergency plan if present

Rapid assessment
Check for signs of life
Assess for adequate perfusion

Criteria for Death / No Resuscitation
Review DNR / MOST Form

YES ▶
Decomposition
Rigor mortis
Dependent lividity
Blunt force trauma
Injury incompatible with life
Extended downtime with asystole

Do not begin resuscitation

Follow Deceased Subjects Policy

NO

Unresponsive and Not breathing normally

Responsive or Unresponsive and Breathing normally

Airway Protocol(s) AR 1, 2, 3 ***if indicated***

Respiratory Distress Protocol AR 4 ***if indicated***

Assess LVAD function
Look and listen for alarms
LVAD Alarming?

YES ▶ **Go to Page 2** ◀ YES

NO

Place stethoscope over heart

Humming sound present?

YES ▶ **Go to Page 3** ◀ YES

NO

Airway Protocol(s) AR 1, 2, 3 ***if indicated***

Respiratory Distress Protocol AR 4 ***if indicated***

Assume VAD failure
Initiate age appropriate ventilation rate

Go to Page 2

On-Call VAD Coordinators
Cone – 336-319-0137 (Pager)
Duke – 919-970-5823 (Pager)
UNC – 919-216-2095 (Pager)

Adult Cardiac Protocol Section

Mechanical Circulatory Support
LVAD, RVAD, and Bi-VAD

History
- SAMPLE
- Bridge to transplant
- Destination therapy
- Estimated downtime
- LVAD, RVAD, Bi-Vad, TAH
- DNR, MOST, or Living Will
- Contact with LVAD coordinator

Signs and Symptoms
- Unconsciousness
- Pulseless
- Apneic
- Poor capillary refill / skin color
- AMS or decreased mental status
- No electrical activity on ECG
- No heart tones on auscultation

Differential
- See Reversible Causes below
- Infection/Sepsis
- Hypovolemia
- Cardiac arrest
- Hemorrhage

Entering from Page 1
No VAD humming heard and/or
VAD is alarming

Attempt to restart LVAD

Expose VAD control module
Expose VAD power source
Expose VAD driveline

Driveline:
- **Ensure driveline is connected firmly to control module**

Power source (batteries or main power source):
- **Ensure all power connections are firmly connected to control module**

Battery charge:
- **Check by pressing charge indicator**
- **Replace battery(s) if indicated**

LVAD restarted?
Humming sound over heart?

YES → **Go to Page 3**

NO

Spare control module:
- **Attach batteries or main power source to spare control module**
- **Detach driveline and attach to spare control module**

LVAD restarted?
Humming sound over heart?

YES → **Go to Page 3**

NO

Possible driveline cable fracture:
- **Quickly, but gently manipulate cable trying to restore break**
- **If successful, tape driveline in place where functioning restored**

Mechanical Circulatory Support
LVAD, RVAD, and Bi-VAD

Reassess
Patient responsive?

YES → **Rhythm analysis**
Ventricular Tachycardia?
Ventricular Fibrillation?

YES → **Do Not Defibrillate**

Assess Circulation
- **Cap refill < 2 – 3 sec?**
- **EtCO2 > 20 mmHg?**
- **MAP > 50 mmHg?**

YES → (to Contact VAD Coordinator)

NO → IV / IO Access Protocol UP 6

A — **Normal Saline or Lactated Ringer's Bolus 500 mL IV / IO**
May repeat as needed
Maximum 2 L

AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.

NO → **Rhythm analysis**
Ventricular Tachycardia?
Ventricular Fibrillation?

YES → AED Procedure ***if available***
A — Defibrillation Procedure

NO → **Assess Circulation**
- **Cap refill < 2 – 3 sec?**
- **EtCO2 > 20 mmHg?**
- **MAP > 50 mmHg?**

YES → (to Contact VAD Coordinator)

NO →
Cardiac Arrest Protocol AC 3 ***as indicated***
Team Focused CPR Protocol AC 11 ***as indicated***
A — IV / IO Access Protocol UP 6
A — **Normal Saline or Lactated Ringer's Bolus 500 mL IV / IO**
May repeat as needed
Maximum 2 L
Contact VAD Coordinator
On Scene Resuscitation ***as indicated***
Notify Destination or Contact Medical Control

- **Contact VAD Coordinator**
- **Transport to VAD Center**
- **Take all spare VAD equipment**

Notify Destination or Contact Medical Control

Reversible Causes
Hypovolemia
Hypoxia
Hydrogen ion (acidosis)
Hypothermia
Hypo / Hyperkalemia

Tension pneumothorax
Tamponade; cardiac
Toxins
Thrombosis; pulmonary (PE)
Thrombosis; coronary (MI)

Suspected Opioid Overdose
Administer Naloxone per Overdose / Toxic Ingestion Protocol TE 7

Adult Cardiac Protocol Section

Left Ventricular Assist Device LVAD Unresponsive or AMS

Pearls

- **Recommended exam: Mental status, skin color, capillary refill, peripheral pulses, blood pressure.**
- **Assessment of blood flow and perfusion status:**
  - **Optimal BP attained by manual BP and Doppler.**
  - **Automated BP devices can measure a BP in about 50% of attempts and is not reliable to assess perfusion**
  - **A MAP of ≥ 60 mmHg is adequate for most LVAD patients.**
  - **Skin color, skin temperature, capillary refill**
- **Mechanical Circulatory Support devices:**
  - **LVAD – Left Ventricular Assist Device**
  - **RVAD – Right Ventricular Assist Device**
  - **BiVAD – Biventricular Ventricular Assist Device**
  - **TAH – Total Artificial Heart**
- **Reasons for use:**
  - **Bridge therapy – patients awaiting transplant or anticipated recovery.**
  - **Destination therapy – advanced heart failure, not candidate for transplant, and will live rest of life with device.**
- **Pump type and assessing pulses:**
  - **Pulsatile flow pumps – older units, not commonly in use now, but generate blood flow with a pulsatile flow and patient will have a palpable pulse.**
  - **Continuous flow pumps – majority of pumps now used and create blood flow in a continuous stream, no pulsatile flow, so patient will not have a palpable pulse.**
  - **Most devices are implanted inside the chest and have an internal pump, a driveline connected from the pump to the controller unit, and a power source consisting of batteries and electrical cord for receptacles.**
- **Common complications:**
  - **Disconnection of power supply, either battery disconnect, or electrical cord to receptacle disconnection.**
  - **Driveline failure or disconnection from controller unit.**
  - **Controller failure**
  - **Blood clot formation, acute stroke, and bleeding (mucosal and gastrointestinal most common sites)**
  - **Infection**
- Abnormal heart rhythm:
  - Pseudo-PEA: Normal cardiac electrical activity in a patient who is alert and well perfused with no palpable pulse.
  - Tachyarrhythmias are usually well tolerated.
- End Tidal CO2 (EtCO2)
  - If EtCO2 is < 10 mmHg, improve chest compressions. Goal is ≥ 20 mmHg.
  - If EtCO2 spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **Cardiac Monitor:** AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.
- **Defibrillation: Manual Defibrillation at the AEMT level is permissible only during pulseless cardiac arrest with VF or VT.**
- Transcutaneous Pacing:
  - Pacing is NOT effective in cardiac arrest and pacing in cardiac arrest does NOT increase chance of survival

Total Artificial Heart

History
- SAMPLE
- Bridge to transplant
- Destination therapy
- Estimated downtime
- LVAD, RVAD, Bi-Vad, TAH
- DNR, MOST, or Living Will
- Contact with LVAD coordinator

Signs and Symptoms
- Unconsciousness
- Pulseless
- Apneic
- Poor capillary refill / skin color
- AMS or decreased mental status
- No electrical activity on ECG
- No heart tones on auscultation

Differential
- See Reversible Causes below
- Infection/Sepsis
- Hypovolemia
- Cardiac arrest
- Hemorrhage

Rapid assessment
Check for signs of life
Assess for adequate perfusion

Contact transplant coordinator:
- As quickly as possible for troubleshooting and treatment advice, but do not delay emergency treatment
- Follow patient specific emergency plan if present

DO NOT USE ECG MONITOR
- Total Artificial Heart does not generate ECG

Criteria for Death / No Resuscitation
Review DNR / MOST Form

YES → Decomposition, Rigor mortis, Dependent lividity, Blunt force trauma
Injury incompatible with life
Extended downtime
Do not begin resuscitation
Follow Deceased Subjects Policy

NO

Pulse Present?

NO → **Go to Page 2**

YES

Preferential to transport to tertiary care facility (Moses Cone, UNC-CH, DUMC, Wake Forest Baptist)

- Airway Protocol(s) AR 1, 2, 3 ***if indicated***
- Respiratory Distress Protocol AR 4 ***if indicated***
- Altered Mental Status Protocol UP 4 ***if indicated***

→ **Check Blood Pressure**

Systolic BP ≥ 150 mmHg

A — **Nitroglycerin 0.3 / 0.4 mg SL**
Repeat every 5 minutes as needed

Maintain SBP ≥ 90 mmHg

P — May assist patient taking their antihypertensive medication

Maintain SBP ≥ 90 mmHg

Systolic BP < 150 mmHg And ≥ 90 mmHg

DO NOT USE:
- Manual or mechanical chest compressions
- ECG/Defibrillation/Pacing/AED devices
- Vasopressor medications
- Antiarrhythmic medications

Systolic BP < 90 mmHg

A — IV / IO Access Protocol UP 6

Normal Saline or Lactated Ringer's Bolus 500 mL IV / IO
May repeat as needed
Maximum 1 L

Notify Destination or Contact Medical Control

Adult Cardiac Protocol Section

Total Artificial Heart

Entering from Page 1
No Pulse Present

DO NOT USE ECG MONITOR
- Total Artificial Heart does not generate ECG

Attempt to restart Total Artificial Heart

Expose Total Artificial Heart control module
Expose Total Artificial Heart power source
Expose Total Artificial Heart driveline

Driveline:
- **Ensure it is connected firmly to control module**
- **Ensure lines are not kinked or bent**

Power source:
- **Ensure all connections firmly to control module (batteries or main power source)**

Battery charge:
- **Check by pressing charge indicator**
- **Replace battery(s) if indicated**

Back up Driver
- **Change to back up driver *if available***

Pulse Present? — YES → **Go to Page 1**

NO

A **Normal Saline or Lactated Ringer's Bolus 500 mL IV / IO**
May repeat as needed

Maximum 1 L

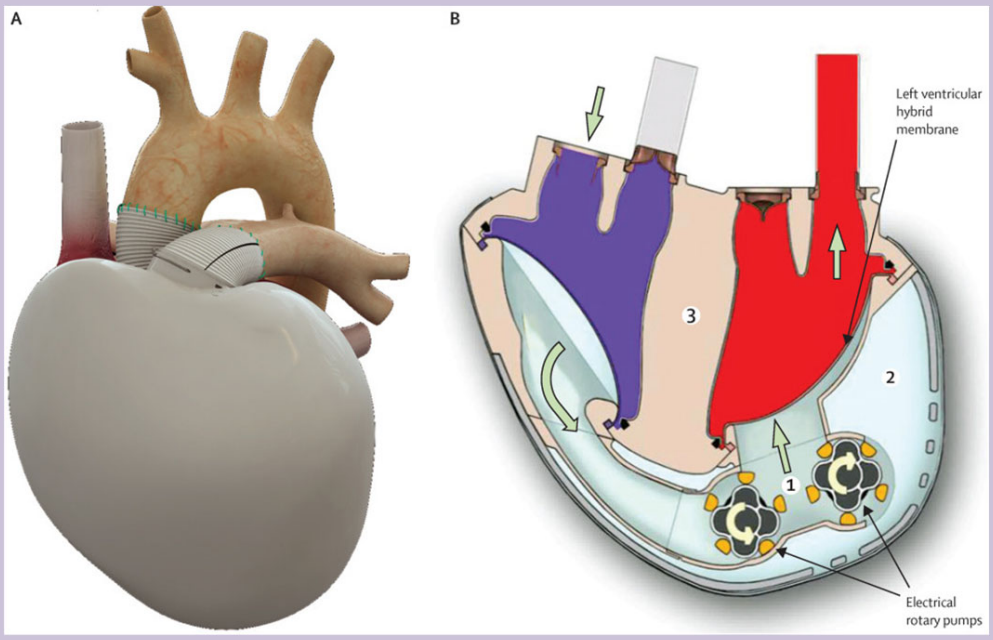
Pulse Present? — YES → **Go to Page 1**

NO

Contact Transplant Coordinator

Notify Destination or Contact Medical Control

Total Artificial Heart



Pearls

- **Recommended exam: Mental status, skin color, capillary refill, peripheral pulses, blood pressure.**
- **Assessment of blood flow and perfusion status:**
  - **Manual and automated BP devices can measure a BP.**
  - **Skin color, skin temperature, capillary refill**
- **ECG and telemetry monitoring:**
  - **The artificial heart does not produce an ECG wave form or tracing.**
  - **Do not use the 12-Lead ECG or ECG monitoring as it will only show asystole.**
- **Total Artificial Heart:**
  - **Different than Ventricular Assist Device (LVAD, RVAD, or Bi-VAD)**
  - **The patient's left and right ventricles are removed and the artificial heart is connected to the right and left atria.**
  - **The patient is totally dependent on the artificial heart for circulatory support – the native heart is removed.**
  - **There are both a right and left side pump, driven by air, and each side driven by a separate driveline.**
  - **The drivelines are not electric, they are driven by air, so kinking can disrupt the pumping action.**
  - **Artificial heart produces a pulsatile wave form so the patient will have a palpable pulse when operational.**
- **Reasons for use:**
  - **Bridge therapy – patients awaiting transplant or anticipated recovery.**
  - **Destination therapy – advanced heart failure, not candidate for transplant, and will live rest of life with device.**
- **Common complications:**
  - **Most common is kinking or bending of the driveline(s) which stops air from moving and stops pumping action.**
  - **Disconnection of power supply, either battery disconnect, or electrical cord to receptacle disconnection.**
  - **Driveline failure or disconnection from controller unit.**
  - **Controller failure**
  - **Blood clot formation, acute stroke, and bleeding (mucosal and gastrointestinal most common sites)**
  - **Infection**
- **Blood pressure:**
  - **Optimal SBP is < 130 mmHg and > 90 mmHg.**
  - **Hypertension puts great strain on the pump and can cause blood to back up into the lungs and cause pulmonary edema and respiratory failure.**
  - **Epinephrine and vasopressors are ineffective, can cause hypertension, and may worsen the patient's condition.**
- Manual or mechanical chest compressions:
  - **Do not use**
- End Tidal CO2 (EtCO2)
  - Helpful in monitoring adequate perfusion status.
- Defibrillation/Cardioversion:
  - Do not use.
- Transcutaneous Pacing:
  - Do not use.

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Wearable Cardioverter Defibrillator Vest

History
- SAMPLE
- Known risk for Sudden Cardiac Death
- Risk for life-threatening arrhythmia
- No implanted defibrillator
- Heart failure – cardiomyopathy
- Decreased ejection fraction

Signs and Symptoms
- Chest pain, dyspnea
- Palpitations
- Received shock from vest
- Poor capillary refill / skin color
- AMS or decreased mental status

Differential
- See Reversible Causes below
- Arrhythmia
- Infection/Sepsis
- Hypovolemia
- Cardiac arrest
- Hemorrhage

Conduct standard patient assessment
Primary/Secondary Surveys

Wearable Cardioverter-Defibrillator Vest Alarming?

YES

Device Silent or Single-Tone Gong Alert
Voice: None – silent
Voice: "Treatment given, call your doctor"
See page 2

NO

Device Siren Alert Two-Tone
Voice: "If patient is not responsive, call for help. Start CPR."
See page 2

Device Siren Alert Two-Tone
Voice: "Press response buttons to delay treatment."
"Bystanders, do not interfere."
See page 2

Cardiac Arrest

YES → Cardiac Arrest Protocol AC 3

NO

Condition requires 12-Lead ECG
And/or
Continuous telemetry monitoring

YES

- Airway Protocol(s) AR 1, 2, 3 ***as indicated***
- Chest Pain and STEMI Protocol AC 4 ***if indicated***
- Age Appropriate Protocol(s) ***as indicated***
- IV / IO Protocol UP 6
- **Remove cardioverter-defibrillator vest**
  1. Remove the battery
  2. Remove the vest
  3. Place ECG electrodes
  4. Place pads anterior-lateral or anterior-posterior
- AED Procedure ***if available***

P
- Cardioversion - Defibrillation Procedure(s)
- Cardiac Monitor

Notify Destination or Contact Medical Control

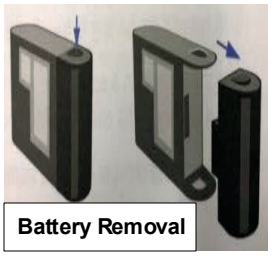
NO

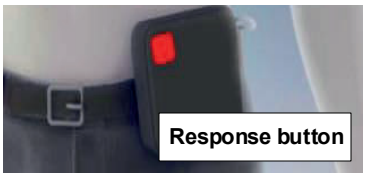
Leave Vest in Place and Operational

Exit to Age Appropriate Protocol(s)

Adult Cardiac Protocol Section

Wearable Cardioverter Defibrillator Vest


Battery Removal


Response button

Pearls

- Recommended exam: Mental status, skin color, capillary refill, peripheral pulses, blood pressure.
- Wearable Cardioverter-Defibrillator Vest:
  - Device is preparing to deliver a shock to the patient:
    - Before device delivers a shock, it tests to see if patient is conscious – voice prompt instructs patient to press the "response" button (see diagram above).
    - Only the patient should press the "response" button.
    - Once a treatable arrhythmia is detected it takes between 25 and 60 seconds to deliver the shock.
- Audible and tactile warning system:
  - The device will provide a vibration, a siren tone, and voice prompts to check if the patient is conscious and give them an opportunity to press the "response" button to abort a shock.
  - See audible warning system above.
- Reasons for use:
  - Currently only device on the market is the Zoll LifeVest.
  - Worn by patients at risk of sudden cardiac arrest or risk of abnormal and/or lethal arrhythmia.
- Blue gel on the patient's skin from the device:
  - Electrode pads release a blue get prior to treatment to improve shock conduction and reduce burning.
  - Do not remove the gel if the vest is left in place during treatment.
  - Remove gel if vest is removed for prehospital care.
- Shock to providers:
  - Do not touch the patient when the device is instructing you that a shock will be delivered.
  - Providers can be shocked by the device during energy delivery if provider is touching the patient.
- Removing the device for prehospital care:
  - The device should only be removed when ECG monitor and defibrillator is available.
  - Continuous ECG monitoring and electrode pads should be in place when vest is removed.
- Defibrillation/cardioversion with vest in place:
  - Disconnect the device from the vest before you deliver a cardioversion or defibrillation
- Transcutaneous Pacing:
  - May be utilized with vest in place – disconnect the device from the vest before you perform transcutaneous pacing.

Allergic Reaction/ Anaphylaxis

History
- Onset and location
- Insect sting or bite
- Food allergy / exposure
- Medication allergy / exposure
- New clothing, soap, detergent
- Past history of reactions
- Past medical history
- Medication history

Signs and Symptoms
- Itching or hives
- Coughing / wheezing or respiratory distress
- Chest or throat constriction
- Difficulty swallowing
- Hypotension or shock
- Edema
- N/V

Differential
- Urticaria (rash only)
- Anaphylaxis (systemic effect)
- Shock (vascular effect)
- Angioedema (drug induced)
- Aspiration / Airway obstruction
- Vasovagal event
- Asthma or COPD
- CHF

Assess Symptom Severity / Suspected Exposure to Allergen

MILD
Skin Only

	Diphenhydramine 25 - 50 mg PO
A	IV or IO Access Protocol UP 6 ***if indicated***
A	**Diphenhydramine 25 - 50 mg PO / IV / IM / IO**
A	**Famotidine (Pepcid) 20 mg IV / IO Infused over 5 – 10 minutes**
B	Monitor and Reassess Monitor for Worsening Signs and Symptoms
	Notify Destination or Contact Medical Control

MODERATE
2 + Body Systems

	Epinephrine 1:1,000 IM 0.3 – 0.5 mg Repeat every 5 minutes if no improvement
	Diphenhydramine 25 - 50 mg PO *See Pearls*
B	**Albuterol Nebulizer 2.5 – 5 mg** Repeat as needed x 3 ***if indicated***
A	**Epinephrine 1:1,000 IM 0.3 – 0.5 mg** Repeat every 5 minutes if no improvement
A	**Diphenhydramine 25 - 50 mg IV / IM / IO *if not given PO (See Pearls)***

SEVERE
2 + Body Systems + hypotension
Or Isolated Hypotension

	Epinephrine 1:1,000 IM 0.3 – 0.5 mg Repeat every 5 minutes if no improvement
B	**Albuterol 2.5 – 5 mg** Nebulizer Repeat as needed x 3 ***if indicated***
A	**Epinephrine 1:1,000 IM 0.3 – 0.5 mg** Repeat every 5 minutes if no improvement
A	**Diphenhydramine 25 - 50 mg IV / IM / IO *if not given PO (See Pearls)***
	Airway Protocol(s) AR 1 - 4 ***if indicated***
	Hypotension/ Shock Protocol AM 5 ***if indicated***

A	IV or IO Access Protocol UP 6
A	**Albuterol Nebulizer 2.5 – 5 mg +/- Ipratropium 0.5 mg (DuoNeb)** Repeat as needed x 3 ***if indicated***
A	**Famotidine (Pepcid) 20 mg IV / IO Infused over 5 – 10 minutes**
A	**Normal Saline or Lactated Ringer's Bolus 500 mL IV / IO** Repeat as needed **Maximum 2 Liters**
P	No improvement with IM Epinephrine **Epinephrine 1:10,000 IV / IO**
A	**Methylprednisolone 125 mg IV / IO**
	Notify Destination or Contact Medical Control

For refractory or peri-arrest anaphylaxis:
0.1 mg (1 ml) IV / IO
May repeat to a total of 0.3 mg (3 ml)

B	**Levalbuterol (Xopenex) May be used in place of Albuterol if necessary**
B	**Levalbuterol (Xopenex) 1.25 mg** Repeat as needed x 3
B	**May Use Patient's Levalbuterol (Xopenex)**
A	**Levalbuterol (Xopenex) 1.25 mg +/- Ipratropium 0.5 mg (DuoNeb)** Repeat as needed x 3 ***if indicated***

Use caution when giving Diphenhydramine to a patient with decreased mental status and/ or hypotension as this may cause nausea, vomiting, and/ or worsening mental status.

Adult Medical Protocol Section

Allergic Reaction/ Anaphylaxis

When giving IM Epinephrine, The lateral thigh is the preferred injection site.

Pearls

- **Recommended Exam: Mental Status, Skin, Heart, Lungs, Abdominal**
- **Anaphylaxis is an acute and potentially lethal multisystem allergic reaction.**
- **Epinephrine and administration:**
  - **Drug of choice and the FIRST drug that should be administered in acute anaphylaxis (Moderate / Severe Symptoms.)**
  - **IM Epinephrine should be administered in priority before or during attempts at IV or IO access.**
- **Diphenhydramine and steroid administration:**
  - **Diphenhydramine/ steroids have no proven benefit in Moderate/ Severe anaphylaxis.**
  - **Diphenhydramine/ steroids should NOT delay initial or repeat Epinephrine administration.**
  - **In Moderate and Severe anaphylaxis, Diphenhydramine may decrease mental status.**
  - **Use caution when giving Diphenhydramine to a patient with decreased mental status and/ or hypotension as this may cause nausea, vomiting, and/ or worsening mental status.**
- **Anaphylaxis unresponsive to repeat doses of IM epinephrine may require IV epinephrine administration by IV push or epinephrine infusion.**
- **For refractory or peri-arrest anaphylaxis, Paramedic may consider Epinephrine 1:10,000 0.1 mg (1 ml) IV/IO. May repeat to a total of 0.3 mg (3 ml).**
- **Symptom Severity Classification:**
  - **Mild symptoms:**
    - **Flushing, hives, itching, erythema with normal blood pressure and perfusion.**
  - **Moderate symptoms:**
    - **Flushing, hives, itching, erythema plus respiratory (wheezing, dyspnea, hypoxia) or gastrointestinal symptoms (nausea, vomiting, abdominal pain) with normal blood pressure and perfusion.**
  - **Severe symptoms:**
    - **Flushing, hives, itching, erythema plus respiratory (wheezing, dyspnea, hypoxia) or gastrointestinal symptoms (nausea, vomiting, abdominal pain) with hypotension/ poor perfusion or isolated hypotension.**
- **Allergic reactions may occur with only respiratory and gastrointestinal symptoms and have no rash/ skin involvement.**
- **Angioedema** is seen in moderate to severe reactions and is swelling involving the face, lips or airway structures. This can also be seen in patients taking blood pressure medications like Prinivil / Zestril (lisinopril)-typically end in **-il.**
- **Hereditary Angioedema** involves swelling of the face, lips, airway structures, extremities, and may cause moderate to severe abdominal pain. Some patients are prescribed specific medications to aid in reversal of swelling.
  Paramedic may assist or administer this medication per patient/ package instructions.
- **Patients with moderate and severe reactions should receive a 12 lead ECG and should be continually monitored, but this should NOT delay administration of epinephrine.**
- **EMR/ EMT:**
  - **The use of Epinephrine IM is limited to the treatment of anaphylaxis and may be given only by autoinjector,** unless manual draw-up is approved by the Agency Medical Director and the NC office of EMS.
  - **Administration of diphenhydramine is limited to the oral route only**.
- **EMT administration of beta-agonist is limited to only patients currently prescribed the medication,** unless approved by the Agency Medical Director and the NC office of EMS.
- Agency Medical Director may require contact of medical control prior to EMT/ EMR administering any medication(s).
- The shorter the onset from exposure to symptoms the more severe the reaction.

Diabetic; Adult

History
- Past medical history
- Medications
- Recent blood glucose check
- Last meal

Signs and Symptoms
- Altered mental status
- Combative / irritable
- Diaphoresis
- Seizures
- Abdominal pain
- Nausea / vomiting
- Weakness
- Dehydration
- Deep / rapid breathing

Differential
- Alcohol / drug use
- Toxic ingestion
- Trauma; head injury
- Seizure
- CVA
- Altered baseline mental status

	Blood Glucose Analysis Procedure
B	12 Lead ECG Procedure ***if indicated***
A	IV or IO Access Protocol UP 6
P	Cardiac Monitor
	Altered Mental Status Protocol UP 4 ***if indicated***
	Hypotension/ Shock Protocol AM 5 ***if indicated***
	Suspected Stroke Protocol UP 14 ***if indicated***
	Seizure Protocol UP 13 ***if indicated***

A	Blood Glucose ≤ 69 mg / dL and symptomatic No venous access **Glucagon 1 – 2 mg IM** Repeat in 15 minutes if needed

Blood Sugar ≤ 69 mg / dL

	Consider Oral Glucose Solution *if available*
	Consider Oral Solution (Juices / Food)
A	<u>If no improvement</u> **D10 125 mL – 250 mL IV / IO** Or **D50 12.5 - 25 gm IV / IO** May repeat until Blood Glucose ≥ 80 mg/dL

Blood Sugar 70 – 249 mg / dL

	Blood Glucose Analysis Procedure ***if condition changes***

Exit to Appropriate Protocol(s)

Blood Sugar ≥ 250 mg / dL

A	**Normal Saline or Lactated Ringer's Bolus** **500 mL IV / IO** May repeat as needed **Then infuse 150 mL / hr**

	Monitor and Reassess Every 5 minutes Until Blood Glucose ≥ 80 mg / dL

Notify Destination or Contact Medical Control

Adult Medical Protocol Section

Diabetic; Adult

Pearls

- **Recommended exam: Mental Status, Skin, Respirations and effort, Neuro.**
- **Patients with prolonged hypoglycemia or those who are malnourished may not respond to glucagon.**
- **Do not administer oral glucose to patients who are not able to swallow or protect their airway.**
- **Quality control checks should be maintained per manufacturer's recommendation for all glucometers.**
- **Patient's refusing transport to medical facility after treatment of hypoglycemia:**
  Blood sugar must be **trending up with 2 or more readings ≥ 80 mg/dL over a 15 minute period**, patient has ability to eat and availability of food with responders on scene.
  Patient must have known history of diabetes and not taking any oral diabetic agents.
  Patient returns to normal mental status and has a normal neurological exam with no new neurological deficits.
  Must demonstrate capacity to make informed health care decisions. See Universal Patient Care Protocol UP-1.
  Otherwise contact medical control.
- **Hypoglycemia with Oral Agents:**
  Patient's taking oral diabetic medications should be encouraged to allow transportation to a medical facility.
  They are at risk of recurrent hypoglycemia that can be delayed for hours and require close monitoring even after normal blood glucose is established.
  Not all oral agents have prolonged action so Contact Medical Control or NC Poison Control Center for advice.
  Patient's who meet criteria to refuse care should be instructed to contact their physician immediately and consume a meal.
- **Hypoglycemia with Insulin Agents:**
  Many forms of insulin now exist. Longer acting insulin places the patient at risk of recurrent hypoglycemia even after a normal blood glucose is established.
  Not all insulins have prolonged action so Contact Medical Control for advice.
  Patient's who meet criteria to refuse care should be instructed to contact their physician immediately and consume a meal.
- **Congestive Heart Failure patients who have Blood Glucose > 250 mg/dL:**
  Limit fluid boluses unless patient has signs of volume depletion such as, dehydration, poor perfusion, hypotension, and/ or shock.
- In extreme circumstances with no IV / IO access and no response to glucagon, D50 can be administered rectally, Contact Medical Control for advice.

Dialysis/ Renal Failure

History
- Peritoneal or Hemodialysis
- Anemia
- Catheter access noted
- Shunt access noted
- Hyperkalemia

Signs and Symptoms
- Hypotension
- Bleeding
- Fever
- Electrolyte imbalance
- Nausea and / or vomiting
- Altered Mental Status
- Seizure
- Arrhythmia

Differential
- Congestive heart failure
- Pericarditis
- Diabetic emergency
- Sepsis
- Cardiac tamponade

Cardiac Arrest — YES →
P: **Calcium Gluconate 2 gm IV / IO (Or Calcium Chloride 1 gm IV / IO)**
Sodium Bicarbonate 50 mEq IV / IO
→ Exit to Appropriate Cardiac Protocol(s) ***as indicated***

NO ↓

Shunt / Fistula Bleeding — YES →
Apply firm finger tip pressure to bleeding site
Apply dressing but avoid bulky dressing
Dressing must not compress fistula / shunt as this will cause clotting of the shunt

NO ↓

Blood Glucose Analysis Procedure
Diabetic Protocol AM 2 ***as indicated***
B: 12 Lead ECG Procedure
A: IV or IO Access Protocol UP 6
P: Cardiac Monitor
CHF / Pulmonary Edema Protocol AC 5 ***as indicated***

NO ↓

Systolic Blood Pressure < 90 — YES →
A: **Normal Saline or Lactated Ringer's Bolus 250 mL** Repeat as needed **Maximum 1 L** *If lungs remain clear*
Hypotensive/ Shock Protocol AM 5 ***as indicated***

NO ↓

Peaked T Wave QRS ≥ 0.12 sec — YES →
P: **Calcium Gluconate 2 gm IV / IO (Or Calcium Chloride 1 gm IV / IO)**
Sodium Bicarbonate 50 mEq IV / IO

NO ↓

Notify Destination or Contact Medical Control

Adult Medical Protocol Section

Dialysis/ Renal Failure

Pearls

- **Recommended exam: Mental status. Neurological. Lungs. Heart. Skin.**
- **Preferably transport to a medical facility capable of providing dialysis treatment.**
- **Do not take Blood Pressure or start IV / IO in extremity which has a shunt/ fistula in place.**
- **Access of shunt indicated in the cardiac arrest or peri-arrest patient only with no IV or IO access.**
- **If hemorrhage cannot be controlled with firm, uninterrupted direct pressure, application of tourniquet with uncontrolled dialysis fistula bleeding is indicated.**
- **Hemodialysis:**
  Process which removes waste from the blood stream and occurs about three times each week.
  Some patients do perform hemodialysis at home.
- **Peritoneal dialysis:**
  If patient complains of fever, abdominal pain, and/ or back pain, bring the Peritoneal Dialysis fluid bag, which has drained from the abdomen, to the hospital.

Complications of Dialysis Treatment:

Hypotension:
Typically responds to small fluid bolus of 250 mL Normal Saline.
May result in angina, AMS, seizure or arrhythmia.

Filtration and decreased blood levels of some medications like some seizure medications:

Disequilibrium syndrome:
Shift of metabolic waste and electrolytes causing weakness, dizziness, nausea and/ or vomiting and seizures.

Equipment malfunction:
Air embolism.
Bleeding.
Electrolyte imbalance.
Fever.

- **Fever:**
  Consider sepsis in a dialysis patient with any catheter extending outside the body.
- Always consider Hyperkalemia in all dialysis or renal failure patients.
- Sodium Bicarbonate and Calcium Chloride/ Gluconate should not be mixed. Ideally give in separate lines.
- Renal dialysis patients have numerous medical problems typically. Hypertension and cardiac disease are prevalent.

Hypertension

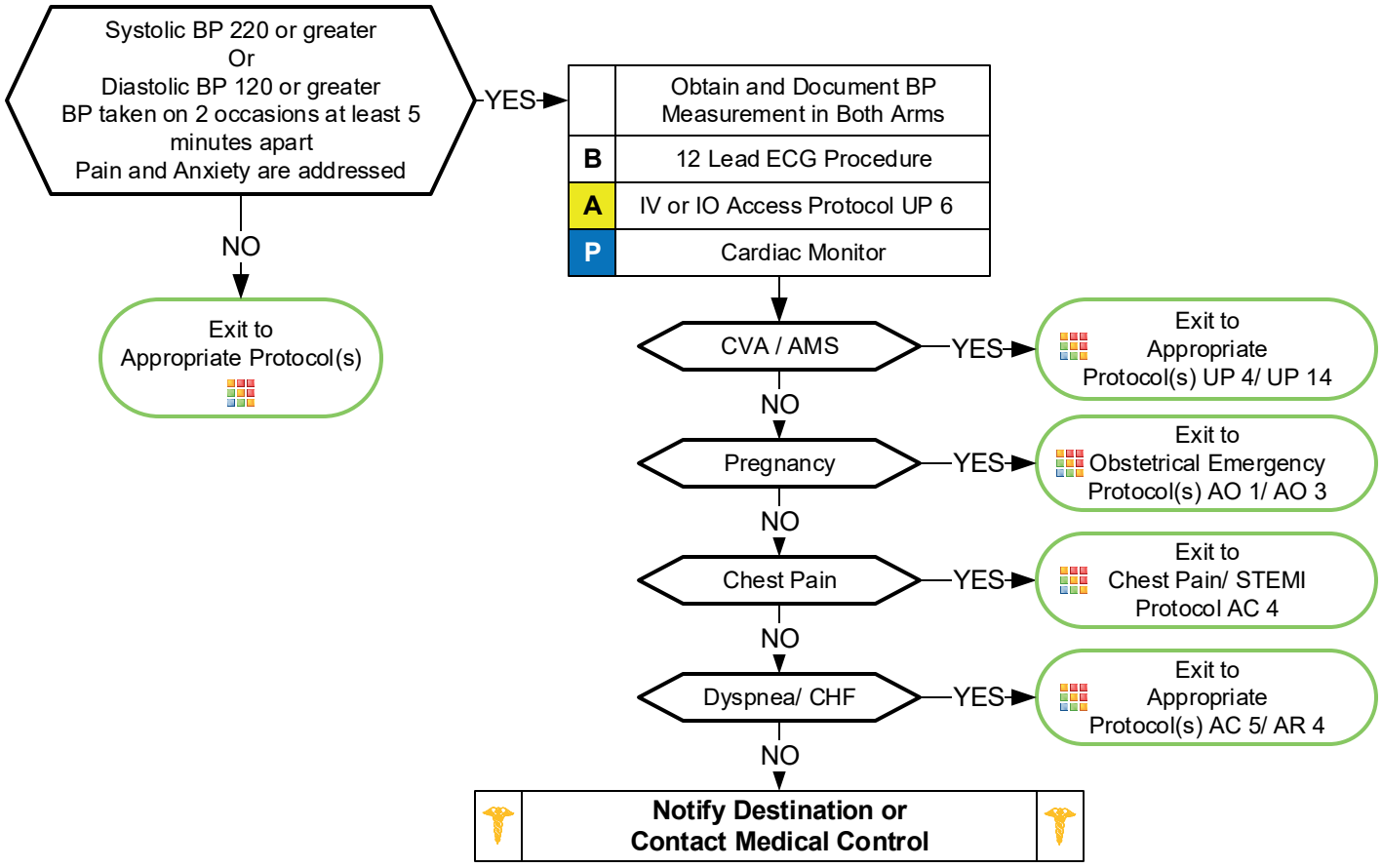
History
- Documented Hypertension
- Related diseases: Diabetes; CVA; Renal Failure; Cardiac Problems
- Medications for Hypertension
- Compliance with Hypertensive Medications
- Erectile Dysfunction medications
- Pregnancy

Signs and Symptoms
One of these
- Systolic BP 220 or greater
- Diastolic BP 120 or greater

AND at least one of these
- Headache
- Chest Pain
- Dyspnea
- Altered Mental Status
- Seizure

Differential
- Hypertensive encephalopathy
- Primary CNS Injury
  - Cushing's Response with Bradycardia and Hypertension
- Myocardial Infarction
- Aortic Dissection / Aneurysm
- Pre-eclampsia / Eclampsia

Hypertension is not uncommon especially in an emergency setting. Hypertension is usually transient and in response to stress and/ or pain. A hypertensive emergency is based on blood pressure along with symptoms which suggest an organ is suffering damage such as MI, CVA or renal failure. This is very difficult to determine in the pre-hospital setting in most cases. Aggressive treatment of hypertension can result in harm. Most patients, even with significant elevation in blood pressure, need only supportive care. Specific complaints such as chest pain, dyspnea, pulmonary edema or altered mental status should be treated based on specific protocols and consultation with Medical Control.



Adult Medical Protocol Section

Pearls
- **Recommended Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro**
- Elevated blood pressure is based on two to three sets of vital signs.
- Symptomatic hypertension is typically revealed through end organ dysfunction to the cardiac, CNS, or renal systems.
- All symptomatic patients with hypertension should be transported with their head elevated at 30 degrees.
- Ensure appropriate size blood pressure cuff utilized for body habitus.

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Hypotension/ Shock

History
- Blood loss - vaginal or gastrointestinal bleeding, AAA, ectopic
- Fluid loss - vomiting, diarrhea, fever
- Infection
- Cardiac ischemia (MI, CHF)
- Medications
- Allergic reaction
- Pregnancy
- History of poor oral intake

Signs and Symptoms
- Restlessness, confusion
- Weakness, dizziness
- Weak, rapid pulse
- Pale, cool, clammy skin
- Delayed capillary refill
- Hypotension
- Coffee-ground emesis
- Tarry stools

Differential
- Ectopic pregnancy
- Dysrhythmias
- Pulmonary embolus
- Tension pneumothorax
- Medication effect / overdose
- Vasovagal
- Physiologic (pregnancy)
- Sepsis

	Blood Glucose Analysis Procedure
B	12 Lead ECG Procedure
A	IV or IO Access Protocol UP 6
P	Cardiac Monitor
	Airway Protocol(s) ***if indicated***
	Diabetic Protocol AM 2 ***if indicated***

History and Exam Suggest Type of Shock

Cardiogenic

Chest Pain: Cardiac and STEMI Protocol AC 4 Appropriate Cardiac Protocol(s) ***if indicated***

Hypovolemic / **Distributive**

- Allergy Protocol AM 1 ***if indicated***
- Suspected Sepsis Protocol UP 15 ***if indicated***
- Multiple Trauma Protocol TB 6 ***if indicated***

Obstructive

P — Chest Decompression-Needle Procedure ***if indicated***

A	**Normal Saline or Lactated Ringer's Bolus 500 mL IV** Repeat to effect SBP > 90 **2 L Maximum**
P	**<u>If SBP <90 mmHg</u> Norepinephrine (Levophed) 1 – 10 mcg / min (Add 4 mg Levophed to 250 ml D5W to make concentration of 16 mcg/ml)** Titrate to SBP ≥ 90 mmHg or MAP ≥ 65mmHg

***The use of vasopressors are contraindicated for Hemorrhagic Shock**

Notify Destination or Contact Medical Control

Adult Medical Protocol Section

Hypotension/ Shock

Levophed – Norepinephrine

- 4mg Levophed = 4000 mcg
- Add to 250 ml D5W (shake bag well)
- Equals 16 mcg / ml
- 4000 mcg ÷ 250 ml D5W = 16 mcg / ml
- Start dosing at 4 mcg / min (15 gtts) (1 gtt every 4 seconds with 60 gtt set)
- Recheck BP every 2 minutes
- Titrate drip rate (+/- 1-2 mcg) to maintain MAP ≥ 65 mmHg or SBP ≥ 90 mmHg
- Add completed Medication Label to bag

Drip Rates

- 1 mcg / min = 3.75 gtts / min
- 2 mcg / min = 7.5 gtts / min
- 4 mcg / min = 15 gtts / min
- 6 mcg / min = 22.5 gtts / min
- 8 mcg / min = 30 gtts / min
- 10 mcg / min = 37.5 gtts / min

Pearls

- **Recommended Exam: Mental Status, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro**
- **Hypotension is defined as a systolic blood pressure less than 90. This is not always reliable and should be interpreted in context and consider patient's typical BP if known.**
- **Shock may be present with a normal blood pressure initially or even elevated blood pressure.**
- **Shock is often present with normal vital signs and may develop insidiously. Tachycardia may be the first and only sign.**
- **Consider all possible causes of shock and treat per appropriate protocol.**
- **Hypovolemic Shock:**

  Hemorrhage, trauma, GI bleeding, ruptured aortic aneurysm or pregnancy-related bleeding.

  Tranexamic Acid (TXA):

  Agencies utilizing TXA must submit letters from their receiving trauma centers for approval by the OEMS Medical Director.

  Receiving trauma centers must agree to continue TXA therapy with repeat dosing.

  TXA is NOT indicated and should NOT be administered where trauma occurred > 3 hours prior to EMS arrival.

Cardiogenic Shock:

Heart failure: MI, Cardiomyopathy, Myocardial contusion, Ruptured ventrical / septum / valve / toxins.

- **Distributive Shock:**

  Sepsis/ Anaphylactic/ Neurogenic/ Toxins

  Hallmark is warm, dry, pink skin with normal capillary refill time and typically alert.

- **Obstructive Shock:**

  Pericardial tamponade. Pulmonary embolus. Tension pneumothorax.

  Signs may include hypotension with distended neck veins, tachycardia, unilateral decreased breath sounds or muffled heart sounds.

- **Acute Adrenal Insufficiency or Congenital Adrenal Hyperplasia:**

  Body cannot produce enough steroids (glucocorticoids/ mineralocorticoids.)

  May have primary or secondary adrenal disease, congenital adrenal hyperplasia, or more commonly have stopped a steroid like prednisone. Injury or illness may precipitate.

  Usually hypotensive with nausea, vomiting, dehydration and/ or abdominal pain.

  If suspected, AEMT or Paramedic should give Methylprednisolone 125 mg IM / IV / IO or Dexamethasone 10 mg IM / IV / IO. Use steroid agent specific to your drug list.

  May administer prescribed steroid carried by patient IM / IV / IO. Patient may have Hydrocortisone (Cortef or Solu-Cortef). Dose: < 1 y.o. give 25 mg, 1-12 y.o. give 50 mg, and > 12 y.o. give 100 mg or dose specified by patient's physician.

Suspected Stroke: Activase/ t-PA
(Is Not Utilized By Alamance County)

Obtain/ Document VS prior to transport

SBP ≥ 185
DBP ≥ 110
YES → Patient must be stabilized BEFORE transport initiated
SBP < 185
DBP < 110

NO

Assess/ Document GCS/ Pupil exam
Nothing by mouth / NPO
Prehospital Stroke Screen
Maintain SaO2 ≥ 92 %

P
Cardiac Monitor
Verify **Activase / t-PA** bolus dose
Verify total dose
Document time infusion initiated
Document estimated time of dose completion
Reassess VS every 15 minutes
Repeat neurological exam every 15 minutes
Obtain BP readings in limb without infusion

Any of following:
Severe headache
Worsening of neurological exam
Nausea / Vomiting
Allergic reaction
Excessive bleeding

P
Stop
IV Activase / t-PA infusion

SBP ≥ 180 and/or DBP ≥ 105
And
NO antihypertensive medication infusion initiated by transferring hospital
YES →
P **Labetalol 10 mg IV / IO**
Contact Medical Control or Receiving Facility

NO

Antihypertensive medication infusion initiated by transferring hospital
YES →
P
Labetalol: Increase 2 mg/min
every 10 minutes
Titrate SBP < 180 mmHg
DBP < 105 mmHg
Maximum 8mg/min
Or
Nicardipine: Increase 2.5 mg/hr
every 5 minutes
Titrate SBP < 180 mmHg
DBP < 105 mmHg
Maximum 15 mg/hr

NO

SBP < 140 and/or DBP < 80
YES →
P
Stop Anti-hypertensive agent
Continue **Activase / t-PA** infusion

NO

P
Reassess VS every 15 minutes
Repeat neurological exam every 15 minutes
Obtain BP readings in limb without infusion

Notify Destination or Contact Medical Control

Is Not Utilized In Alamance County

Suspected Stroke: Activase / t-PA (Is Not Utilized By Alamance County)

Not Utilized In Alamance County

Pearls

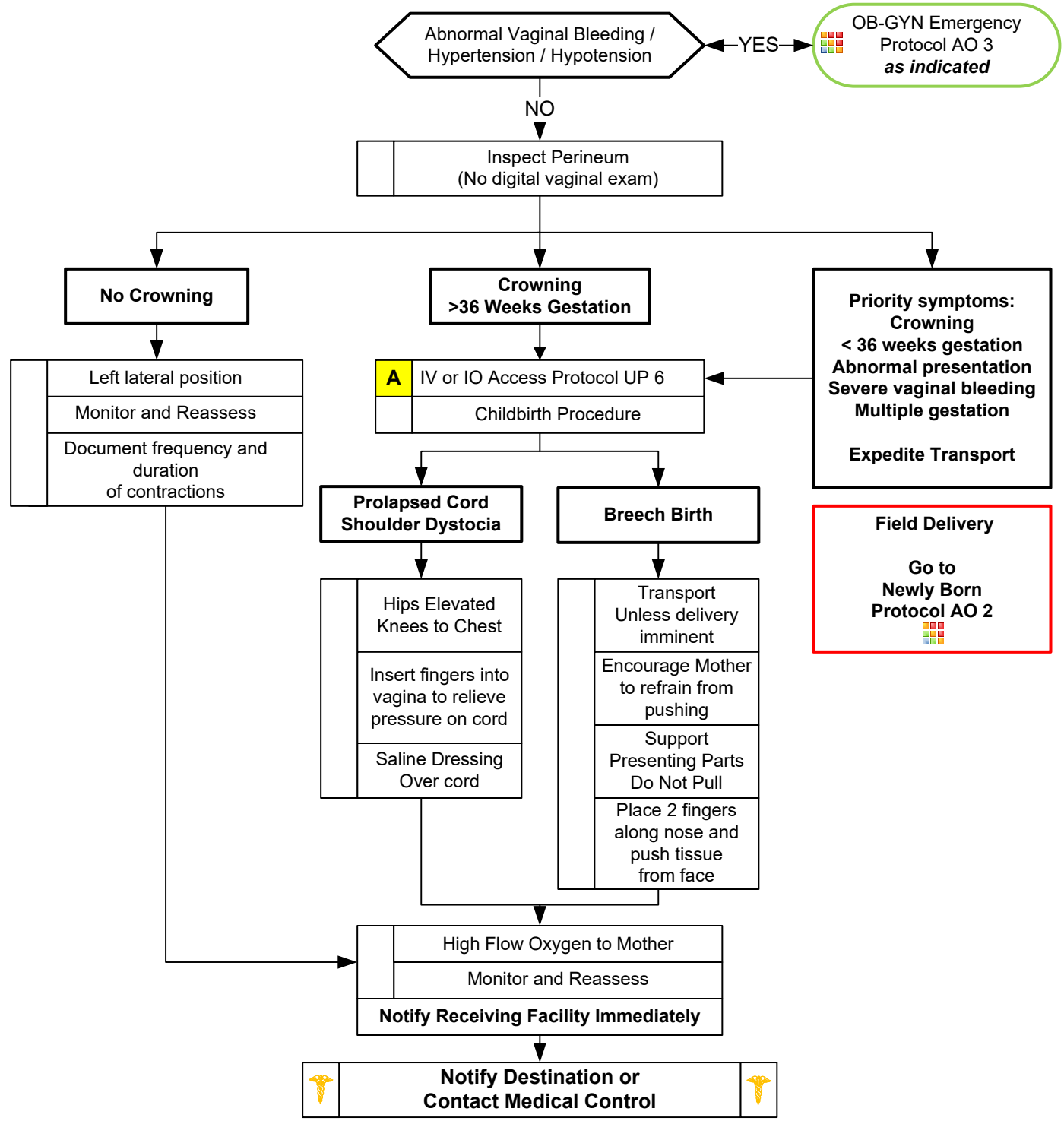
- **Recommended Exam: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremities, Neuro**
- **This protocol is optional. Agencies may develop their own in conjunction with their regional stroke center(s) guidance.**
- **This protocol is intended for interfacility transfer patients only. Medication must be started at initial treating hospital.**
- **Items in Red Text are key performance measures used in protocol compliance.**
- **The Reperfusion Checklist should be completed for any suspected stroke patient.**
- **Time of Onset or Last Seen Normal:**
  - **One of the most important items the pre-hospital provider can obtain, of which all treatment decisions are based.**
  - **Be very precise in gathering data to establish the time of onset and report as an actual time (i.e. 13:47 NOT "about 45 minutes ago.")**
  - **Without this information patient may not be able to receive thrombolytics at facility.**
  - **Wake up stroke: Time starts when patient last awake or symptom free.**
- **Time of Symptom Discovery:**
  - **Time when symptoms of stroke are first noticed by patient, bystanders, witnesses, or family/ caregivers.**
- The differential listed on the Altered Mental Status Protocol should also be considered.
- Be alert for airway problems (swallowing difficulty, vomiting/aspiration).
- Hypoglycemia can present as a localized neurologic deficit, especially in the elderly.
- **Infusion Pump Alarm / No Flow:**
  - Remove drip chamber from Activase / t-PA bag.
  - Spike Activase/ t-PA drip chamber to NS bag.
  - Restart infusion to complete medication remaining in IV tubing.
- **Medication dosing safety:**
  - When IV **Activase/ t-PA** dose administration will continue en route, verify estimated time of completion.
  - Verify with sending hospital that excess **Activase/ t-PA** has been withdrawn from the bottle and wasted.
  - This ensures the bottle will be empty when the full dose is finished. *For example, if the total dose is 70 mg, then 30 cc should be withdrawn and wasted since a 100 mg bottle of **Activase/ t-PA** contains 100 mL of fluid when reconstituted.*
  - Sending hospital should apply a label to **Activase/ t-PA** bottle with the number of mL of fluid that should be in the bottle in case of pump failure during transit.
- **Allergy Anaphylaxis:**
  - **Activase/ t-PA**, is structurally identical to endogenous t-PA and therefore should not induce allergy, single cases of acute hypersensitivity reactions have been reported.
  - ***Angioedema:***
    - Rapid swelling (edema) of the dermis, subcutaneous tissue, mucosa and submucosal tissues. Typically involves the face, lips, tongue and neck.
    - Almost always self limiting but may progress to interfere with airway / breathing so close monitoring is warranted.
  - Utilize the Allergy / Anaphylaxis Protocol as indicated and also for angioedema. Infusion should be stopped.
  - Give all medications related to the Allergy/ Anaphylaxis Protocol by IV route only as patient should remain NPO.

Childbirth/ Labor

History
- 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
- Gravida / Para Status
- High Risk pregnancy

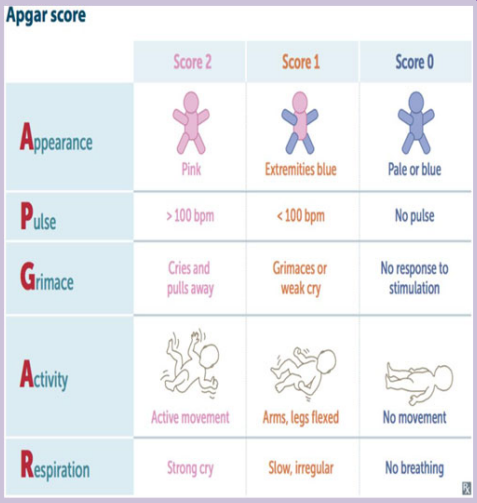
Signs and Symptoms
- Spasmodic pain
- Vaginal discharge or bleeding
- Crowning or urge to push
- Meconium

Differential
- Abnormal presentation
  - Buttock
  - Foot
  - Hand
- Prolapsed cord
- Placenta previa
- Abruptio placenta



Adult Obstetrical Protocol Section

Childbirth/ Labor



Pearls

- **Recommended Exam (of Mother): Mental Status, Heart, Lungs, Abdomen, Neuro**
- **Record APGAR at 1 minute and 5 minutes after birth. Do not delay resuscitation to obtain APGAR.**
- **If neonate requiring resuscitation, move quickly to AO 2 Newly Born Protocol**
- **After delivery, massaging the uterus (lower abdomen) will promote uterine contraction and help to control post-partum bleeding (apply uterine massage only after placenta delivery).**
- **Postpartum hemorrhage:**
  - **Tranexamic Acid (TXA):**
    - **Administer when postpartum hemorrhage is associated with signs and symptoms of shock. CONTRAINDICATED where birth occurs > 3 hours prior to EMS arrival.**
- **Transport or Delivery?**
  - Decision to transport versus remain and deliver is multifactorial and difficult. Generally it is preferable to transport.
  - Factors that will impact decision include: number of previous deliveries; length of previous labors; frequency of contractions; urge to push; and presence of crowning.
- **Maternal positioning for labor:**
  - Supine with head flat or elevated per mother's choice. Maintain flexion of both knees and hips. Elevate buttocks slightly with towel. If delivery not imminent, place mother in the left, lateral recumbent position with right side up about 10 – 20°.
- **Umbilical cord clamping and cutting:**
  - Place first clamp about 10 cm from infant's abdomen and second clamp about 5 cm away from first clamp.
- **Multiple Births:**
  - Twins occur about 1/90 births. Typically manage the same as single gestation. If imminent delivery call for additional resources, if needed. Most twins deliver at about 34 weeks so lower birth weight and hypothermia are common. Twins may share a placenta so clamp and cut umbilical cord after first delivery. Notify receiving facility immediately.
- Document all times (Contraction onset, contraction duration and frequency, delivery, APGAR 1 and 2, and placenta delivery).
- If maternal seizures occur, refer to the Obstetrical Emergencies Protocol.
- Some perineal bleeding is normal with any childbirth. Large quantities of blood or free bleeding are abnormal.

Newly Born

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

Signs and Symptoms
- Respiratory distress
- Peripheral cyanosis or mottling (normal)
- Central cyanosis (abnormal)
- Altered level of responsiveness
- Bradycardia

Differential
- Airway failure, Secretions, or Respiratory drive
- Infection
- Maternal medication effect
- Hypovolemia, Hypoglycemia, Hypothermia
- Congenital heart disease

In a non-vigorous infant whose respirations are not improving after warming, drying, and stimulating within 30 seconds, move quickly to Positive Pressure Ventilation with BVM

Breathing or Crying?
Term Gestation?
Good Muscle Tone?

ALL YES →
- **Warm, Dry, and Stimulate infant**
- **Infant with mother if possible *(skin-to-skin)***
- **Maintain normal temperature**
- Bulb suction airway only if needed
- Monitor and Reassess
- **Notify Destination or Contact Medical Control**

ANY NO ↓

- **Warm, Dry and Stimulate**
- **Bulb suction airway if needed**
- ***If not breathing within 30 seconds move quickly to next step: BVM***

↓

Agonal breathing or Apnea?
Or
Heart Rate < 100 / min
Or
Labored breathing/ Persistent cyanosis
If not improving within 30 seconds move quickly to next step

YES →
- Position and clear airway if necessary
- **BVM Ventilations with or without O_2**
- **Ventilation Rate: 40 – 60 breaths/ minute**
- **B** Pulse Oximetry Right Hand
- **P** Cardiac Monitor 3 or 4 – Lead

↓

Heart Rate < 100

YES →
- Check chest movement
- Change airway position
- Change BVM Technique
- **Add O_2 if not already providing**
- Pediatric Airway Protocol(s) AR 5, 6 ***if no improvement***

NO ↓

Heart Rate < 60

YES →
- **Chest Compressions *See Pearls***
- ***Compression 1:2:3 and BVM breath; repeat***
- Pediatric Airway Protocol(s) AR 5, 6
- IV or IO Access Protocol UP 6
- **A** **Epinephrine 1:10,000**
- **0.01 mg /kg IV / IO**
- Every 3 to 5 minutes as needed
- **A** **Normal Saline or Lactated Ringer's Bolus**
- **10 mL / kg IV / IO**
- If not responding to epinephrine
- *May repeat x 1*
- Blood Glucose Analysis Procedure
- **A** **<u>Blood Glucose < 40 mg/dL</u>**
- **Administer 2 mL/kg of D10 IV / IO**
- Repeat as needed CBG ≥ 40 mg/dL

NO ↓

- ***Supplemental Oxygen***
- ***(See Pearls for expected SpO_2)***
- Maintain warmth
- Monitor and Reassess

↓

Notify Destination or Contact Medical Control

Adult Obstetrical Protocol Section

Newly Born

Pearls

- **Recommended Exam: Quality of Cry, Muscle tone, Respirations, Heart Rate, Pulse Oximetry, and Gestational Age**
- **Majority of newborns do not require resuscitation, only warming, drying, stimulating, and cord clamping.**
  - **With term gestation, strong cry/ breathing, and good muscle tone, generally will not need resuscitation.**
  - **If no resuscitation needed, skin-to-skin contact with the mother is best way to maintain warmth of infant.**
  - **Maintain warmth of infant following delivery, adjuncts; cap/ hat, plastic wrap, thermal mattress, radiant heat.**
  - **Most important vital signs in the newly born are heart rate, respirations, and respiratory effort.**
  - **About 10% of newborns need assistance to help them start breathing after birth.**
  - **About 1% of newborns require intensive resuscitation to restore/ support cardiorespiratory functions.**
- **Airway:**
  - **Positive Pressure Ventilations with BVM is the most important treatment in a newborn with poor respirations and/ or persistent bradycardia (HR < 100 BPM).**
  - **When BVM is needed, ventilation rate is 40 – 60 breaths per minute.**
  - **Adequacy of ventilation/ is measured mainly by increase in heart rate as well as chest rise.**
  - **If heart rate or respirations are not improving after 30 to 60 seconds of resuscitation, place BIAD or endotracheal tube.**
  - **Routine suctioning is no longer recommended, bulb suction only if needed.**
- **Breathing:**
  - **Oxygen is not necessary initially, but if infant is not responding with increased heart rate or adequate breathing, add oxygen to the BVM.**
- **Circulation/ Compressions:**
  - **Heart rate is critical during first few moments of life and is best monitored by 3 or 4 lead ECG, as pulse assessment is difficult in the neonate. Heart Rate is best tool for gauging resuscitation success.**
  - **If heart rate remains < 60 BPM after 30 to 60 seconds of BVM/ resuscitation, begin compressions.**
  - **With BIAD or ETT in place, compressions and ventilation should be coordinated with compression, compression, compression, then ventilation. (3:1 ratio with all events totaling 120 per minute)**
  - **2-thumbs encircling chest and supporting the back is recommended. Limit interruptions of chest compressions.**
- **If infant not responding to BVM, compressions, and/ or epinephrine, consider hypovolemia, pneumothorax, and/ or hypoglycemia (< 40 mg/dL).**
- **Document 1 and 5 minute APGAR in PCR or ePCR. DO NOT delay or interrupt resuscitation to obtain an APGAR score.**
- **Meconium staining:**
  - **Infant born through meconium staining who is NOT vigorous:**
  - **Bulb suction mouth and nose and provide positive pressure ventilation.**
  - **Direct endotracheal suctioning is no longer recommended.**
- **Expected Pulse Oximetry readings following birth:**
  - ***(Accurate only in infant NOT requiring resuscitation)***
  - **1 minute 60 – 65%**
  - **2 minutes 65 – 70%**
  - **3 minutes 70 – 75%**
  - **4 minutes 75 – 80%**
  - **5 minutes 80 – 85%**
  - **10 minutes 85 – 95%**
- Pulse oximetry should be applied to the right upper arm, wrist, or palm.
- Cord clamping:
  - Recommended to delay for 1 minute, unless infant requires resuscitation.
- Maternal sedation or narcotics will sedate infant (Naloxone NO LONGER recommended, use supportive care only).
- D10 = D50 diluted (1 ml of D50 with 4 ml of Normal Saline) or **D10 solution at 2 mL/kg IV / IO.**
- **In the NEONATE, D10 is administered at 2 mL/kg.** *(NOT 5 mL/kg in the pediatric patient after the first month of life.)*

Apgar score

	Score 2	Score 1	Score 0
Appearance	Pink	Extremities blue	Pale or blue
Pulse	> 100 bpm	< 100 bpm	No pulse
Grimace	Cries and pulls away	Grimaces or weak cry	No response to stimulation
Activity	Active movement	Arms, legs flexed	No movement
Respiration	Strong cry	Slow, irregular	No breathing

Obstetrical Emergency

History
- Past medical history
- Hypertension meds
- Prenatal care
- Prior pregnancies / births
- Gravida / Para

Signs and Symptoms
- Vaginal bleeding
- Abdominal pain
- Seizures
- Hypertension
- Severe headache
- Visual changes
- Edema of hands and face

Differential
- Pre-eclampsia / Eclampsia
- Placenta previa
- Placenta abruptio
- Spontaneous abortion

Known or Suspected Pregnancy
Missed Period
Vaginal Bleeding
Abdominal Pain

YES

	Left lateral recumbent position
	Blood Glucose Analysis Procedure
A	IV or IO Access Protocol UP 6
P	Cardiac Monitor
	Abdominal Pain Vomiting and Diarrhea Protocol UP 3 ***if indicated***
	Diabetic Protocol AM 2/ PM 2 ***if indicated***
	Hypotension/ Shock Protocol AM 5/ PM 3 ***if indicated***

TXA Indicators:
V/S parameters

Adult:
- **SBP ≤ 70 mmHg**
  or
- **SBP ≤ 90 mmHg + HR ≥ 110**

NO

Exit to Appropriate Protocol(s)

Uncontrolled vaginal hemorrhage with signs of shock

YES

TXA is only to be administered in patients age ≥ 16 years.

A: **TXA 2 g over 10 minutes in 100 ml D5W or NS IV / IO**
See Pearls

NO

Seizure Activity

YES

P: **Midazolam 2.5 mg IV / IO**
May repeat every 3 – 5 minutes as needed

Midazolam 5 mg IM
May repeat once in 3 – 5 minutes

Maximum 10 mg

A: **Magnesium Sulfate 4 g IV / IO in 250 ml D5W**
Over 2 – 3 minutes

NO

Childbirth / Labor Protocol AO 1 **if indicated**

Monitor and Reassess

Notify Destination or Contact Medical Control

Adult Obstetric Protocol Section

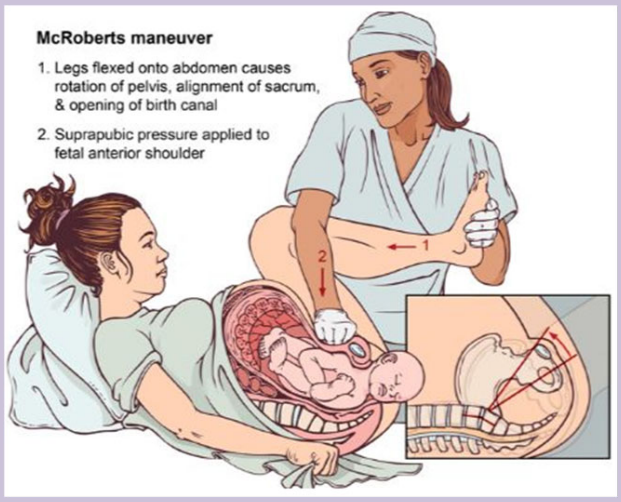
Obstetrical Emergency

Abruptio Placentae:
Abruptio Placentae is the premature separation of the placenta from the uterus. During second half of pregnancy < 5 % of patients will have vaginal bleeding. About 30 % of vaginal bleeding during this period may result from Abruptio Placenta. Bleeding during this period may result in fetal distress and is considered an emergency. Trauma, preeclampsia or maternal hypertension typically precipitate Abruptio Placenta. Other risk factors are women < 20 years of age, advanced maternal age (>35), smoking, prior Abruptio Placenta, multiparity or cocaine use. Patients with vaginal bleeding, contractions, uterine / abdominal tenderness and decreased or no fetal movement may have this condition.

Placenta Previa:
Placenta Previa occurs when the placenta implants over the cervical os (opening.) This is a leading cause of vaginal bleeding in the second half of pregnancy. Bleeding is usually bright and painless though about 20% will have some uterine irritability. Advanced maternal age (>35), multiparity, smoking and prior C-section are risk factors for this condition.

Uterine Rupture:
Often occurs with onset of labor though more commonly after trauma.
This is usually signaled with severe abdominal pain and shock.

Active Seizure with no IV access:
Midazolam is preferred agent, don't delay administration if there is no IV access and give IM if needed! Pediatric patients may be encountered, use weight-based dosing if appropriate. It is very important to administer Magnesium Sulfate as the patient most likely has eclampsia, but give Midazolam IM first while obtaining IV.



McRoberts maneuver with suprapubic pressure:
This maneuver is most useful in mild cases of shoulder dystocia and those caused by an impacted anterior shoulder. It requires use of an assistant to apply pressure suprapubically (not fundally) with the palm or fist, directing the pressure on the anterior shoulder both downward (to below the pubic bone) and laterally (toward the fetal face or sternum) in conjunction with the McRoberts maneuver. Suprapubic pressure is supposed to adduct the shoulders or bring them into an oblique plane, since the oblique diameter is the widest diameter of the maternal pelvis.

Pearls

- **Recommended Exam: Mental Status, Abdomen, Heart, Lungs, Neuro**
- **Midazolam 5 – 10 mg IM is effective in termination of seizures. Do not delay IM administration with difficult or no IV or IO access. With active seizure activity, benzodiazepine is a priority over magnesium sulfate.**
- **Magnesium Sulfate should be administered as quickly as possible. May cause hypotension and decreased respiratory drive, but more likely in doses higher than 6 gm.**
- **Any pregnant patient involved in a MVC should be seen immediately by a physician for evaluation. Greater than 20 weeks generally require 4 to 6 hours of fetal monitoring. DO NOT suggest the patient needs an ultrasound but emphasize patient needs 4 to 6 hours of fetal monitoring.**
- **Tranexamic Acid (TXA):**
  Administer when postpartum hemorrhage is associated with signs and symptoms of shock.
  CONTRAINDICATED where birth occurs > 3 hours prior to EMS arrival.
  Vaginal hemorrhage unrelated to pregnancy, administer with signs and symptoms of shock.
  TXA is only to be administered in patients age ≥ 16 years.
- **Ectopic pregnancy:**
  Implantation of fertilized egg outside the uterus, commonly in or on the fallopian tube. As fetus grows, rupture may occur. Vaginal bleeding may or may not be present. Many women with ectopic pregnancy do not know they are pregnant. Usually occurs within 5 to 10 weeks of implantation. Maintain high index of suspicion with women of childbearing age experiencing abdominal pain.
- **Preeclampsia:**
  Occurs in about 6% of pregnancies. Defined by hypertension and protein in the urine. RUQ pain, epigastric pain, N/V, visual disturbances, headache, and hyperreflexia are common symptoms.
  In the setting of pregnancy, hypertension is defined as a BP > 140 systolic or > 90 diastolic mmHg, or a relative increase of 30 systolic and 20 diastolic from the patient's normal (pre-pregnancy) blood pressure.
  Risk factors: < 20 years of age, first pregnancy, multi-gestational pregnancy, gestational diabetes, obesity, personal or family history of gestational hypertension.
- **Eclampsia:**
  Seizures occurring in the context of preeclampsia. Remember, women may not have been diagnosed with preeclampsia.
- Maintain patient in a left lateral position, right side up 10 - 20° to minimize risk of supine hypotensive syndrome.
- Ask patient to quantify bleeding - number of pads used per hour.

Blast Injury/ Incident

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
- Hearing loss (TM rupture)
- Ocular burns/vision changes
- Multiple trauma/ penetrating trauma
- Hypotension/ shock
- Airway compromise/distress could be indicated by hoarseness/ wheezing
- Pneumothorax/ hemothorax
- Traumatic amputation (tourniquet)

Differential
- Thermal / Chemical / Electrical Burn Injury
  - Superficial
    - (1st Degree) red – painful
    - (Don't include in TBSA)
  - Partial Thickness
    - (2nd Degree) blistering
  - Full Thickness
    - (3rd Degree) painless/charred or leathery skin
- Radiation injury

Nature of Device: Agent/ Amount. Industrial Explosion. Terrorist Incident. Improvised Explosive Device.
Method of Delivery: Incendiary/ Explosive
Nature of Environment: Open / Closed.
Distance from Device: Intervening protective barrier. Other environmental hazards.
Evaluate for: Blunt Trauma/ Crush Injury/ Compartment Syndrome/ Traumatic Brain Injury/ Concussion/ Tympanic Membrane Rupture/ Abdominal hemorrhage or Evisceration, Blast Lung Injury and Penetrating Trauma.

Scene Safety/ Quantify number and Triage Patients/ Load and Go with Assessment/ Treatment Enroute

Call for help/ additional resources
Stage until scene safe

Accidental/ Intentional Explosions
(See Pearls)

- Triage Protocol UP 2 ***as indicated***
- Age Appropriate Airway Protocol(s) AR 1, 2, 3, 5, 6 ***as indicated***
- Multiple Trauma Protocol TB 6 ***if indicated***
- A: IV and IO Access Protocol UP 6 ***if indicated***
- P: Cardiac Monitor ***if indicated***
- Thermal Burn Protocol TB 9
  Chemical and Electrical Burn Protocol TB 2 ***if indicated***
- Crush Injury Protocol TB 3 ***if indicated***
- Radiation Incident Protocol TB 7 ***if indicated***
- Decontamination Procedure USP 2 ***if indicated***
- Pain Control Protocol UP 11 ***if indicated***

Blast Lung Injury — YES → Age Appropriate Airway Protocol(s) AR 4, 7 ***as indicated***

NO

Rapid Transport to appropriate destination using Trauma and Burn: EMS Triage and Destination Plan

Notify Destination or Contact Medical Control

Trauma and Burn Protocol Section

Blast Injury/ Incident

Pearls

- **Types of Blast Injury:**
  - Primary Blast Injury: From the blast pressure (air) wave.
  - Secondary Blast Injury: Impaled objects. Debris which becomes missiles/ shrapnel.
  - Tertiary Blast Injury: Patient falling or being thrown/ pinned by debris.
  - Most Common Cause of Death: Secondary Blast Injuries.
- **Triage of Blast Injury patients:**
  - Blast Injury patients with burn injuries should be triaged using the Thermal Burn/ Chemical and Electrical Burn Protocol Guidelines for Critical/ Serious/ Minor Trauma and Burns and the Trauma and Burn: EMS Triage and Destination Plan.
  - Patients may be hard of hearing due to tympanic membrane rupture.
- **Care of Blast Injury Patients:**
  - Patients may suffer multi-system injuries including blunt and penetrating trauma, shrapnel, barotrauma, burns, and toxic chemical exposure.
  - Consider airway burns, which should prompt early and aggressive airway management as indicated.
  - Cover open chest wounds with semi-occlusive dressing or commercial chest seal product.
  - Use Lactated Ringers (if available) for all Critical or Serious Burns.
  - Minimize IV fluids resuscitation in patients with no signs of shock or poor perfusion.
- **Blast Lung Injury:**
  - Blast Lung Injury is characterized by respiratory difficulty and hypoxia. Can occur (rarely) in patients without external thoracic trauma. More likely to occur in an enclosed space or in close proximity to explosion.
  - Symptoms: Dyspnea, hemoptysis, cough, chest pain, wheezing, and hemodynamic instability.
  - Signs: Apnea, tachypnea, hypopnea, hypoxia, cyanosis, and diminished breath sounds.
  - Air embolism should be considered and patient transported in left-lateral decubitus position.
  - Blast Lung Injury patients may require early intubation but positive pressure ventilation may worsen the injury, avoid hyperventilation, which can cause further injury.
  - Air transport may worsen lung injury, monitor oxygenation and ventilation closely. Tension pneumothorax may occur requiring chest decompression. Be judicious with fluids as volume overload may worsen lung injury.
- **Accidental Explosions or Intentional Explosions:**
  - **All explosions or blasts should be considered intentional until determined otherwise.**
  - **Greatest concern is potential threat for a secondary device.**
  - Attempt to determine the source of the blast to include any potential threat for aerosolization of hazardous materials.
  - Evaluate scene safety including the source of the blast, which may continue to spill explosive liquids or gases.
  - Consider structural collapse, environmental hazard, and fire.
  - Conditions that led to the initial explosion may reoccur and lead to a second explosion.
  - Patients who are physically able, typically will attempt to move as far away from the explosive source as they safely can.
  - Evaluate surroundings for suspicious items; unattended back packs or packages, or unattended vehicles.
  - **If patient(s) is unconscious or there are fatalities and you are evaluating patient(s) for signs of life:**
    - **Before moving, note if there are wires coming from the patient(s), or if it appears the patient(s) is lying on a package/ pack, or bulky item. If so, do not move the patient(s), quickly back away and immediately notify a law enforcement officer.**
  - If there are no indications the patient is connected to a triggering mechanism for a secondary device, expeditiously remove the patient(s) from the scene and begin transport to the hospital.
  - Protect the airway and cervical spine, however beyond the primary survey, care and a more detailed assessment should be deferred until rapid transport begins.
  - If there are signs the patient was carrying the source of the blast, notify law enforcement immediately, and most likely a law enforcement officer will accompany your patient to the hospital.

Chemical and Electrical Burn

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
- Ocular burns/ vision changes
- Loss of consciousness
- Hypotension/ shock
- Compartment syndrome
- Airway compromise/ distress could be indicated by hoarseness/ wheezing
- Electrical burn may be misleading with small contact/ external burn and major internal injury – burn/ trauma center transport is recommended

Differential
- Thermal / Chemical / Electrical Burn Injury
  - Superficial
    - (1st Degree) red – painful
    - (Don't include in TBSA)
  - Partial Thickness
    - (2nd Degree) blistering
  - Full Thickness
    - (3rd Degree) painless/charred or leathery skin
- Radiation injury
- Blast injury

Assure Chemical Source is NOT Hazardous to Responders.
Assure Electrical Source is NO longer in contact with patient before touching patient.

Assess Burn/ Concomitant Injury Severity

< 5% TBSA 2nd/3rd Degree Burn	**5-15% TBSA 2nd/3rd Degree Burn**	**>15% TBSA 2nd/3rd Degree Burn**
No inhalation injury, Not Intubated, Normotensive GCS 14 or Greater Minor Burn	Suspected inhalation injury or requiring intubation for airway stabilization Hypotension or GCS 13 or Less (When reasonably accessible, transport to a Burn Center) Serious Burn	Burns with Multiple Trauma Burns with definitive airway compromise (When reasonably accessible, transport to a Burn Center) Critical Burn

	Age Appropriate Airway Protocol(s) AR 1, 2, 3, 4, 5, 6, 7 ***if indicated***
A	IV or IO Access Protocol UP 6 Consider 2 IV sites if ≥ 15 % TBSA
	Thermal Burn Protocol TB 9
	Pain Control Protocol UP 11 ***if indicated***
	Identify Contact Points
	Eye Involvement Irrigate Involved Eye(s) with Normal Saline for ≥ 30 minutes Continue irrigation during transport
	Chemical Exposure/ Burn Flush Contact Area with Normal Saline for 15 minutes Continue irrigation during transport
	Decontamination Procedure USP 2 ***if indicated***
	Age Appropriate Cardiac Protocol(s) ***if indicated***
	Rapid Transport to appropriate destination using Trauma and Burn: EMS Triage and Destination Plan
	Notify Destination or Contact Medical Control

Trauma and Burn Protocol Section

Chemical and Electrical Burn

Pearls

- **Recommended Exam: Mental Status, HEENT, Neck, Heart, Lungs, Abdomen, Extremities, Back, and Neuro**
- **Green, Yellow, and Red in burn severity do not apply to the Start/ JumpStart Triage System.**
- **Refer to Rule of Nines.**
- **Transport and Destination:**
  - **In general, chemical and electrical burns should be transported to a burn center.**
  - **Burn center should be initial destination choice unless EMS system access is limited by time and/ or distance.**
  - **When EMS transport to burn center is limited, transport to and stabilization at local center is appropriate.**
- **Chemical Burns:**
  - Refer to Decontamination Procedure.
  - With dry powders/ substances, gently brush or wipe off prior to irrigation. Do not aerosolize by brushing too vigorously.
  - Normal Saline or Sterile Water is preferred, however if not available, do not delay irrigation and use tap water. Other water sources may be used based on availability.
  - Flush the area as soon as possible with the cleanest, most readily available water or saline solution and use copious amounts of fluids.
  - Flush contact area for a minimum of 15 minutes and continue until arrival at receiving facility.
  - Hydrofluoric acid burns:
    - Monitor ECG for peaked T waves, which can be sign of hypocalcemia.
  - Eye involvement:
    - Irrigation is recommended for a minimum of 30 minutes and continue until arrival at receiving facility.
- **Electrical Burns:**
  - **Remember the extent of the obvious external burn from an electrical source does not always reflect more extensive internal damage. Small external injury may have large internal injury.**
  - **Do not refer to wounds as an entry and exit wound**.
  - **DO NOT contact patient until you are certain the source of the electrical shock is disconnected.**
  - Attempt to locate contact points (generally there will be two or more.) A point where the patient contacted the source and a point(s) where the patient is grounded.
  - Sites will generally be full thickness (3rd).
  - Cardiac Monitor: Anticipate ventricular or atrial irregularity including VT, VF, atrial fibrillation, and/ or heart blocks.
  - Attempt to identify the nature of the electrical source (AC or DC), the amount of voltage, and the amperage the patient may have been exposed to during the electrical shock.
  - **Lightning strike:**
    - Lightning strike victims are amenable to airway, breathing, cardiac compressions, as well as early defibrillation.
    - **Use concept of reverse triage with multiple casualties. Resuscitate lightning strikes as the priority.**
    - Lightning strike victims found alive do not often deteriorate quickly.

Crush Syndrome Trauma

History
- Entrapped and crushed under heavy load > 30 minutes
- Extremity / body crushed
- Building collapse, trench collapse, industrial accident, pinned under heavy equipment

Signs and Symptoms
- Hypotension
- Hypothermia
- Abnormal ECG findings
- Pain
- Anxiety

Differential
- Entrapment without crush syndrome
- Vascular injury with perfusion deficit
- Compartment syndrome
- Altered mental status

Age Appropriate Airway Protocol(s) AR 1 - 7 ***as indicated***

B	12 Lead ECG Procedure
A	IV or IO Access Protocol UP 6
P	Cardiac Monitor

Multiple Trauma Protocol TB 6 ***if indicated***

Thermal Burn Protocol TB 9
Chemical and Electrical Burn Protocol TB 2 ***if indicated***

Pain Control Protocol UP 11 ***as indicated***

Age Specific Blood Pressure indicating possible shock

Age 0 – 28 days: SBP < 60
Ages ≥ 1 month: SBP < 70
Age 1 – 9: SBP < 70 + (2*x* Age)

Ages 10 – 64: SBP < 90
Ages ≥ 65: SBP < 100

All ages:
Shock Index HR > SBP

P
Consider
Midazolam 0.5 – 2 mg IV / IO
Midazolam 1 – 2 mg IN
Maximum 5 mg
Pediatric: 0.1 – 0.2 mg / kg
IV / IO / IN
Pediatric Maximum 2 mg
Over 2 – 3 minutes as needed

Entrapped < 2 hours

A
Normal Saline or Lactated Ringer's Infusion
1 Liter per hour IV / IO
Pediatric:
3 x maintenance fluid rate

Entrapped > 2 hours

A
Decrease Normal Saline or Lactated Ringer's Infusion
500 mL per hour IV / IO
Pediatric:
Maintenance fluid rate

Abnormal ECG
Peaked T Waves
QRS ≥ 0.12 seconds
QT ≥ 0.46 seconds
Loss of P wave
Or
Hemodynamically Unstable
Or
Asystole / PEA / VF / VT

P
Calcium Gluconate 2 g IV / IO
Or
(Calcium Chloride 1 g IV / IO)
Pediatric: 20 mg / kg IV / IO
Over 2- 3 minutes

Albuterol Nebulizer
2.5 – 5 mg
May repeat x 3

Sodium Bicarbonate
50 mEq IV / IO
Pediatric: 1 mEq / kg IV / IO

Exit to Age Appropriate Cardiac Arrest Protocol AC 3 / PC 4 Arrhythmia Protocol(s) ***if indicated***

Rapid Transport to appropriate destination using Trauma and Burn: EMS Triage and Destination Plan

Notify Destination or Contact Medical Control

Trauma and Burn Protocol Section

Crush Syndrome Trauma

Pearls

- **Recommended exam: Mental Status, Musculoskeletal, Neuro**
- **Scene safety is of paramount importance as typical scenes may pose hazards to rescuers. Call for appropriate resources.**
- **Crush Injury is a localized crush injury with systemic signs and symptoms causing muscle breakdown and release of potentially toxic muscle cell components and electrolytes into the circulation.**
- **Crush syndrome typically manifests after 1 – 4 hours of crush injury.**
- **Fluid resuscitation strategy:**
  If possible, administer IV / IO fluids prior to release of crushed body part, especially with crush > 1 hour.
  If access to patient and initiation of IV / IO fluids occurs after 2 hours, give 2 liters of IV fluids in adults and 20 mL/kg of IV fluids in pediatrics, and then begin > 2 hour dosing regimen.
- **If not able to perform IV / IO fluid resuscitation immediately, place tourniquet on crushed limb until IV / IO fluids can be initiated (even if tourniquet is not being used for hemorrhage control).**

- **Pediatric IV Fluid maintenance rate:**
  4 mL for the first 10 kg of weight +
  2 mL for the second 10 kg of weight +
  1 mL for every additional kg in weight after 20 kg

Example: 28 kg pediatric	
First 10 kg:	4 mL/kg/hr = 40 mL/hr
Second 10 kg:	2 mL/kg/hr = 20 mL/hr
Final 8 Kg:	1 mL/kg//hr = 8 mL/hr
	Total: 68 mL/hr rate

- **Consider all possible causes of shock and treat per appropriate protocol.**
- **Majority of decompensation in pediatrics is airway or respiratory related.**
- **Decreasing heart rate and hypotension occur late in children and are signs of impending cardiac arrest.**
- **Shock may be present with a normal blood pressure initially or even elevated.**
- **Shock often is present with normal vital signs and may develop insidiously. Tachycardia may be the only sign.**
- **Patients may become hypothermic even in warm environments. Maintain warmth.**
- Hyperkalemia from crush syndrome can produce ECG changes described in protocol, but may also be a bizarre, wide complex rhythm. Wide complex rhythms should also be treated using the VF/ Pulseless VT Protocol if indicated (AC 9 VF Pulseless VT Protocol and/ or PC 7 Pediatric VF Pulseless VT Protocol).

Extremity Trauma

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 and/ or swelling
- Deformity
- Altered sensation/ motor function
- Diminished pulse/ capillary refill
- Decreased extremity temperature

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

Wound care
Control Hemorrhage with Direct Pressure
Splinting as indicated

Consider
Topical Hemostatic Agent/ Dressing
if available

Wound Care WTP 4
Tourniquet Procedure WTP 7
if indicated

A: IV or IO Access Protocol UP 6
if indicated

Age Appropriate
Airway Protocol(s) AR 1, 2, 3, 4, 5, 6, 7
if indicated

Multiple Trauma Protocol TB 6
if indicated

Age Appropriate Hypotension/ Shock
Protocol AM 5/ PM 3
if indicated

Pain Protocol UP 11
if indicated

Crush Syndrome Protocol TB 3
as indicated

Amputation and/ or Open Fracture

YES →
- Clean amputated part
- Wrap part in sterile dressing soaked in normal saline or lactated ringers
- Place part/ dressing in air tight container.
- Place container on ice if available.

NO ↓

Monitor and Reassess

Notify Destination or Contact Medical Control

Open Fracture
or
Amputated Part with Bone Fracture
- Best outcomes in patients who receive antibiotics within 60 minutes of injury

A:
Cefazolin 2 g IV / IO
Pediatric: 30 mg / kg IV / IO
(Pediatric Maximum: 2 g)
Over 10 minutes
Withhold if allergy to Cephalosporins or Penicillin allergy

Trauma and Burn Protocol Section

Pearls
- **Recommended Exam: Mental Status, Extremity, Neuro, Perfusion**
- Peripheral neurovascular status is important to assess and document, as well as time of assessment.
- In amputations, time is critical. Transport and notify medical control immediately, so that the appropriate destination can be determined.
- Hip dislocations as well as knee and elbow fracture/ dislocations have a high incidence of vascular compromise.
- Urgently transport any injury with neurological or vascular compromise.
- Blood loss may be concealed or not apparent with extremity injuries.
- Lacerations optimally should be evaluated for repair within 6 hours from the time of injury.
- **Multiple casualty incident: Tourniquet Procedure may be considered first instead of direct pressure.**

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Head Trauma

History
- Time of injury
- Mechanism (blunt vs. penetrating)
- Loss of consciousness
- Bleeding
- Past medical history
- Medications
- Evidence for multi-trauma

Signs and Symptoms
- Pain, swelling, bleeding
- Altered mental status
- Unconscious
- Respiratory distress/ failure
- Vomiting
- Major traumatic mechanism of injury
- Seizure

Differential
- Skull fracture
- Brain injury (Concussion, Contusion, Hemorrhage)
- Epidural hematoma
- Subdural hematoma
- Subarachnoid hemorrhage
- Spinal injury
- Abuse

Prevent hypoxia, hypotension, and hyperventilation

A single episode of hypoxia, hypotension, and hyperventilation increases mortality

	Age Appropriate Airway Protocol(s) AR 1, 2, 3, 5, 6 ***if indicated***
	Obtain and Record GCS
	All patients Titrate **target SpO2 100%** Monitor HR, BP and O2 every 3-5 minutes
	Blood Glucose Analysis Procedure
B	Maintain EtCO2 35 – 45 mmHg
A	IV or IO Access - UP 6 ***if indicated***
P	Cardiac Monitor
	Altered Mental Status - UP 4 ***if indicated***
	Multiple Trauma - TB 6 ***if indicated***
	Age Appropriate Hypotension/ Shock - AM 5/ PM 3 ***if indicated***
	Seizure - UP 13 ***if indicated***
	Spinal Motion Restriction Protocol TB 8 Procedure WTP 2 ***if indicated***
	Pain Control - UP 11 ***if indicated***
	Monitor and Reassess

Rapid Transport to appropriate destination using
Trauma and Burn: EMS Triage and Destination Plan

Notify Destination or Contact Medical Control

Blood Pressure Target Goal For Head Injured Patient

Age 0 – 28 days: SBP ≥ 60
Ages ≥ 1 month: SBP ≥ 70
Age 1 – 14: SBP ≥ 70 + (2*x* Age)

Ages 15 – 49: SBP ≥ 110
Ages 50 – 69: SBP ≥ 100
Ages ≥ 70: SBP ≥ 110

Hyperventilation:
Hyperventilation is NOT recommended in patients who require BVM, BIAD, or ETT.

Maintain ventilation rate to target EtCO2 of 35 – 45 mmHg
See Pearls

Age Specific Blood Pressure indicating possible shock

Age 0 – 28 days: SBP < 60
Ages ≥ 1 month: SBP < 70
Age 1 – 9: SBP < 70 + (2*x* Age)

Ages 10 – 64: SBP < 90
Ages ≥ 65: SBP < 110

All ages Shock Index:
SI = HR ÷ SBP

Use Shock Index, Pediatric Adjusted (SIPA)for children <12 (see pearls)

Trauma and Burn Protocol Section

Head Trauma

Eye Opening Response	Verbal Response	Motor Response
4 = Spontaneous	5 = Oriented	6 = Obeys commands
3 = To verbal stimuli	4 = Confused	5 = Localizes pain
2 = To pain	3 = Inappropriate words	4 = Withdraws from pain
1 = None	2 = Incoherent	3 = Flexion to pain or decorticate
	1 = None	2 = Extension to pain or decerebrate
		1 = None

Age	HR	SBP	SIPA cutoff value
1–3 years	70–110	90–110	1.2
4–6 years	65–110	90–110	1.2
7–12 years	60–100	100–120	1.0
>12 years	55–90	100–135	0.9

SIPA, shock index, pediatric age-adjusted; HR, heart rate; SBP, systolic blood pressure.

Pearls

- **Recommended Exam: Mental Status, HEENT, Heart, Lungs, Abdomen, Extremities, Back, Neuro**
- **Hypoxia:**
  - **Single episode of hypoxia can worsen head injury and double mortality.**
  - **Titrate SpO_2 as close to 100% as possible.**
- **Hyperventilation in head injury requiring advanced airway:**
  - **Hyperventilation lowers CO2 and causes vasoconstriction leading to increased intracranial pressure (ICP).**
  - **Hyperventilation is not recommended and can worsen the brain injury.**
  - **In patients requiring BVM, BIAD, or endotracheal tube, titrate ventilation rate to $EtCO_2$ between 35 - 45 mmHg.**
  - **Recommended ventilation rates with advanced airways:**
    - **Infant/ Toddler: 25 breaths / minute**
    - **Children: 20 Breaths / minute**
    - **Adolescents/ Adults: 10 – 12 Breaths / minute**
- **Hypotension:**
  - **Episodes of hypotension can worsen head injury and increase mortality:**
    - **In adults, minimal SBP is at least 100 mmHg.**
    - **In pediatrics, minimal SBP is at least > 70 + (2 x the age in years).**
  - **Usually indicates shock unrelated to the head injury and should be aggressively treated, otherwise limit fluid administration.**
- **GCS**
  - **Key performance measure used in the EMS Acute Trauma Care Toolkit.**
  - **Serial assessments of GCS with ongoing assessments should be performed.**
- **Do not place in Trendelenburg position as this may increase ICP and worsen blood pressure.**
- **Poorly fitted cervical collars may also increase ICP when applied too tightly.**
- **In areas with short transport times, Drug Assisted Airway protocol is not recommended for patients who are spontaneously breathing and who have oxygen saturations of ≥ 90% with supplemental oxygen including BIAD/ BVM.**
- **Increased intracranial pressure (ICP) may cause hypertension and bradycardia (Cushing's Response).**
- Consider Restraints if necessary for patient's and/ or personnel's protection per the Restraints: Physical Procedure USP 5.
- **Concussions:**
  - Traumatic brain injuries involving any of a number of symptoms including confusion, loss of consciousness, vomiting, or headache.
  - Any prolonged confusion or mental status abnormality which does not return to normal within 15 minutes or any documented loss of consciousness should be evaluated by a physician ASAP.
  - **EMS Providers should not make return-to-play decisions when evaluating an athlete with suspected concussion. This is outside the scope of practice.**

Blood Pressure Target Goal For Head Injured Patient

Age 0 – 28 days: SBP ≥ 60
Ages ≥ 1 month: SBP ≥ 70
Age 1 – 14: SBP ≥ 70 + (2*x* Age)

Ages 15 – 49: SBP ≥ 110
Ages 50 – 69: SBP ≥ 100
Ages ≥ 70: SBP ≥ 110

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 (Life threatening)
- Uncontrolled hemorrhage
- Airway obstruction/ deformity
- Chest:
- Tension pneumothorax
  Flail chest/ Open chest wound
  Pericardial tamponade/ Hemothorax
- Head Trauma Protocol TB 5
- Intra-abdominal bleeding
- Pelvis/ Femur/ Extremity fracture
- Spine fracture/ Cord injury
- Hypothermia

Age Appropriate
Airway Protocol(s) AR 1 - 7
as indicated

P Chest Decompression Procedure WTP 1
if indicated

Control External Hemorrhage
Procedure(s) WTP 4, 5, 7
Consider Pelvic Binding
Splint Fractures Procedure WTP 3

A IV or IO Access Protocol UP 6

Spinal Motion Restriction Procedure WTP 2
Spinal Motion Restriction Protocol TB 8
if indicated

Obtain and Record GCS

VS / Perfusion Abnormal / Shock? YES

Age Appropriate Hypotension/ Shock
Protocol AM 5/ PM 3
if indicated

A **TXA 2 g over 10 minutes in 100 ml D5W or NS IV / IO**
if indicated

TXA is only to be administered in patients age ≥ 16 years.

NO

Head Injury Protocol TB 5
if indicated

Altered Mental Status
Protocol UP 4
if indicated

Pain Control Protocol UP 11
if indicated

Extremity Trauma Protocol TB 4
if indicated

Crush Syndrome Protocol TB 3
if indicated

Repeat Assessment Adult Procedure

Monitor and Reassess

Rapid Transport to appropriate destination using
Trauma and Burn:
EMS Triage and Destination Plan
Limit Scene Time ≤ 10 minutes
Provide Early Notification

Notify Destination or Contact Medical Control

TXA Indicators:
V/S parameters
for blunt or penetrating trauma:

Adult:
- **SBP ≤ 70 mmHg**
  or
- **SBP ≤ 90 mmHg + HR ≥ 110**

- **Age ≥ 65**
  SBP < 100 mmHg + HR > 100

Trauma and Burn Protocol Section

Multiple Trauma

Pearls

- **Recommended Exam: Mental Status, Skin, HEENT, Heart, Lung, Abdomen, Extremities, Back, Neuro**
- **Items in Red Text are key performance measures used in the EMS Acute Trauma Care Toolkit**
- **Scene time should not be delayed for procedures and all should be performed during rapid transport of unstable patients.**
- **Ask all patients if they are taking any anticoagulants and report during facility transition of care.**
- **Airway:**
  - **BVM and BIAD are acceptable for airway management to maintain SpO_2 of 92 – 98%.**
  - **Endotracheal intubation, if performed, should be completed during transport and should not delay scene time.**
- **Breathing:**
  - **Consider Chest Decompression with signs of shock and/ or injury to torso with evidence of tension pneumothorax.**
- **Circulation:**
  - **Control external hemorrhage and prevent hypothermia by keeping patient warm.**
  - **IV or IO access should be established during rapid transport of unstable patients.**
- **Head Injury with multiple trauma (Refer to Head Trauma Protocol TB 5):**
  - **Higher SBP targets are needed to maintain cerebral perfusion pressure.**
  - **Single episodes of Hypotension and/ or hypoxia are associated with worse outcomes in head injured patients.**
  - **Adult SBP target is ≥ 100 mmHg.**
  - **Pediatric SPB target is ≥ 70 + 2(Age) mmHg.**
- **Trauma Triad of Death:**
  - **Metabolic acidosis/ Coagulopathy/ Hypothermia**
  - **Address by appropriate resuscitation measures and keeping patient warm, regardless of ambient temperature, which helps to treat metabolic acidosis, coagulopathy, and hypothermia.**
- **Tranexamic Acid (TXA):**
  - **Agencies utilizing TXA must submit letters from their receiving trauma centers for approval by the OEMS Medical Director.**
  - **Receiving trauma centers must agree to continue TXA therapy with repeat dosing.**
  - **TXA is NOT indicated and should NOT be administered where trauma occurred > 3 hours prior to EMS arrival.**
  - **TXA is only to be administered in patients age ≥ 16 years.**
- **Trauma in Pregnancy:**
  - Providing optimal care for the mother = optimal care for the fetus.
  - After 20 weeks gestation (fundus at or above umbilicus) transport patient on left side with 10 – 20° of elevation.
- **Geriatric Trauma:**
  - **Age ≥ 65: SBP < 110 mmHg or HR > SBP may indicate shock.**
  - Evaluate with a high index of suspicion, occult injuries difficult to recognize and with unexpected patient decompensation.
  - Risk of death with trauma increases after age 55.
  - Low impact mechanisms, such as ground level falls might result in severe injury especially in age over 65.
- See Regional Trauma Guidelines when declaring Trauma Activation.
- Maintain high-index of suspicion for domestic violence or abuse, pediatric non-accidental trauma, or geriatric abuse.
- **Refer to your Regional Trauma Guidelines when declaring Trauma Activation.**
- Severe bleeding from an extremity, not rapidly controlled with direct pressure, needs application of a tourniquet.
- Maintain high-index of suspicion for domestic violence or abuse, pediatric non-accidental trauma, or geriatric abuse.

Radiation Incident

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 could be indicated by hoarseness/ wheezing
- Hypotension
- Thermal or Chemical Injury

Differential
- Thermal / Chemical / Electrical Burn Injury
  - Superficial
    - (1st Degree) red – painful
    - (Don't include in TBSA)
  - Partial Thickness
    - (2nd Degree) blistering
  - Full Thickness
    - (3rd Degree) painless/charred or leathery skin

Scene Safety / Quantify number and Triage Patients/ Load and Go with Assessment/ Treatment Enroute

Assess Burn/ Concomitant Injury Severity

Minor Burn	Serious Burn	Critical Burn
< 5% TBSA 2nd/3rd Degree Burn No inhalation injury, Not Intubated, Normotensive GCS 14 or Greater	**5-15% TBSA 2nd/3rd Degree Burn** Suspected inhalation injury or requiring intubation for airway stabilization Hypotension or GCS 13 or Less *(When reasonably accessible, transport to a Burn Center)*	**>15% TBSA 2nd/3rd Degree Burn** Burns with Multiple Trauma Burns with definitive airway compromise *(When reasonably accessible, transport to a Burn Center)*

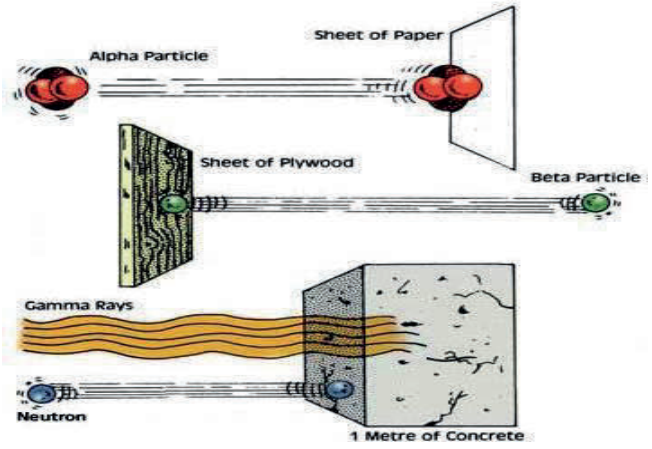
	Age Appropriate Airway Protocol(s) AR 1, 2, 3, 4, 5, 6, 7 ***if indicated***
	Eye Involvement Irrigate Involved Eye(s) with Normal Saline for 15 – 30 minutes May repeat as needed
	Flush Contact Area with Normal Saline for 15 minutes
	Decontamination Procedure USP 2 ***if indicated***
A	IV and IO Access Protocol UP 6 ***if indicated***
	Age Appropriate Cardiac Protocol(s) ***as indicated***
	Thermal Burn Protocol TB 9 ***if indicated***
	Rapid Transport to appropriate destination using Trauma and Burn: EMS Triage and Destination Plan
	Notify Destination or Contact Medical Control

Collateral Injury: Most all injuries immediately seen will be a result of collateral injury, such as heat from the blast, trauma from concussion, treat collateral injury based on typical care for the type of injury displayed.·

Qualify: Determine exposure type; external irradiation, external contamination with radioactive material, internal contamination with radioactive material.·

Quantify: Determine exposure (generally measured in Grays/Gy). *Information may be available from those on site who have monitoring equipment, do not delay transport to acquire this information.*

Radiation Incident



Time Phases of Radiation Injury
(Exposure Dose vs Clinical Outcome)

Exposure Dose (Gy)	Prodrome Severity	Manifest Illness - Symptom Severity			Prognosis
		Hematologic	Gastrointestinal	Neurologic	
0.5 to 1.0	+	+	0	0	Survival almost certain
1.0 to 2.0	+/++	+	0	0	Survival >90 percent
2.0 to 3.5	++	++	0	0	Probable survival
3.5 to 5.5	+++	+++	+	0	Death in 50% at 3.5 to 6 wks
5.5 to 7.5	+++	+++	++	0	Death probable in 2-3 wks
7.5 to 10	+++	+++	+++	0*	Death probable in 1-2.5 wks
10 to 20	+++	+++	+++	+++	Death certain in 5-12 days
> 20	+++	+++	+++	+++**	Death certain in 2-5 days

Abbreviations: Gy: dose in Grey;
0: no effects; +: mild; ++: moderate; +++: severe or marked

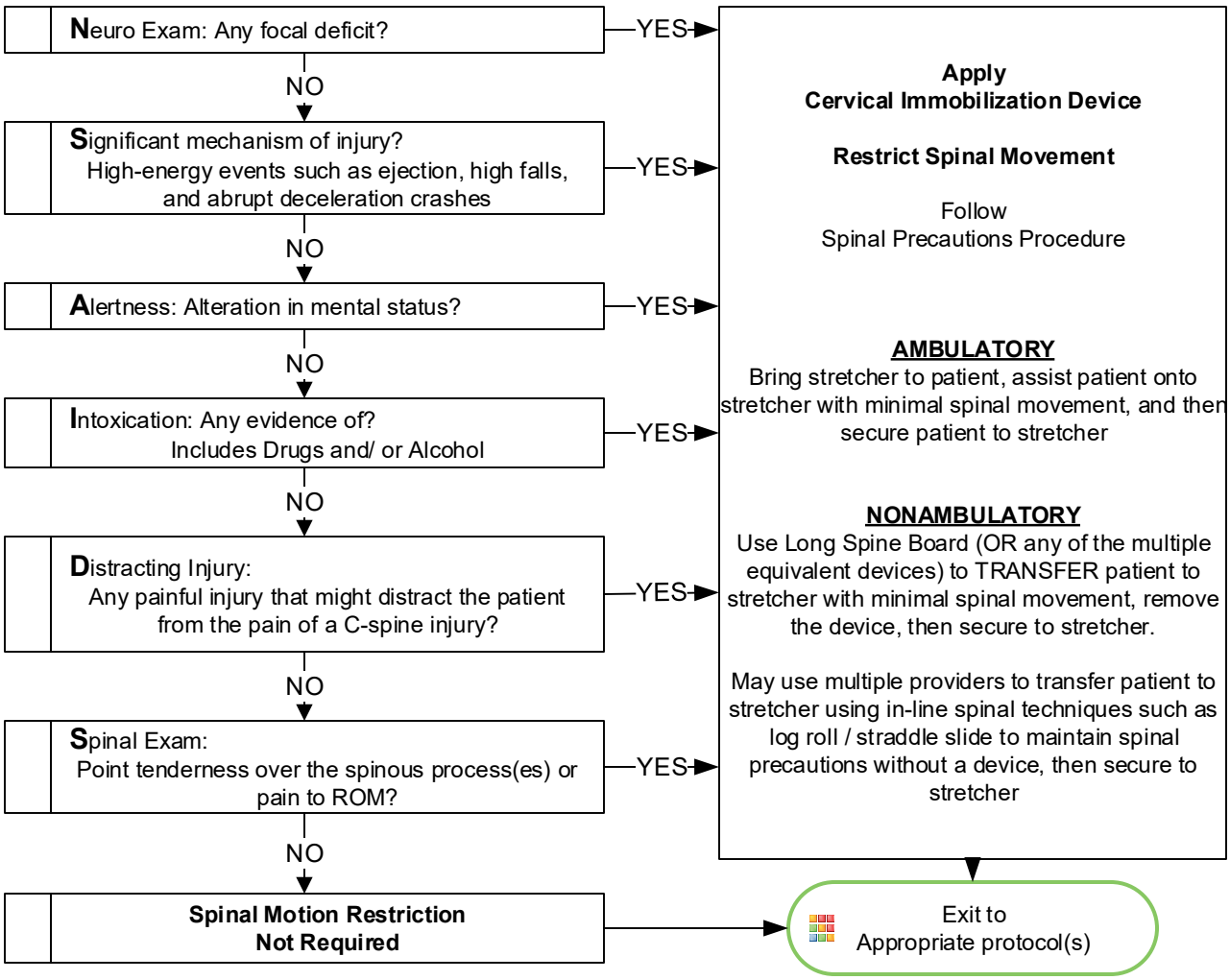
* Hypotension
** Also cardiovascular collapse, fever, shock

Modified from : Waselenko, JK, MacVittie, TJ, Blakely, WF, et al. Medical management of the acute radiation syndrome: Recommendations of the strategic national stockpile radiation working group. Ann Int Med 2004; 140:1039.

Pearls

- **The three primary methods of protection from radiation sources:**
  - **Limiting time of exposure**
  - **Distance from**
  - **Shielding from the source**
- Dealing with a patient with a radiation exposure can be a frightening experience. Do not ignore the ABC's, a dead but decontaminated patient is not a good outcome. Refer to the Decontamination Procedure USP 2 for more information.
- Normal Saline or Sterile Water is preferred, however if not available, do not delay irrigation using tap water. Other water sources may be used based on availability. Flush the area as soon as possible with the cleanest, most readily available water or saline solution using copious amounts of fluids.
- **Three methods of exposure:**
  - External irradiation
  - External contamination
  - Internal contamination
- **Two classes of radiation:**
  - Ionizing radiation (greater energy) is the most dangerous and is generally in one of three states:
    - Alpha Particles, Beta Particles and Gamma Rays.
  - Non-ionizing (lower energy) examples include microwaves, radios, lasers and visible light.
- Radiation burns with early presentation are unlikely, it is more likely this is a combination event with either thermal or chemical burn being presented as well as a radiation exposure. When the burn is from a radiation source, it indicates the patient has been exposed to a significant source, (> 250 rem).
- Patients experiencing radiation poisoning are not contagious. Cross contamination is only a threat with external and internal contamination.
- Typical ionizing radiation sources in the civilian setting include soil density probes used with roadway builders and medical uses such as x-ray sources as well as radiation therapy. Sources used in the production of nuclear energy and spent fuel are rarely exposure threats as is military sources used in weaponry. Nevertheless, these sources are generally highly radioactive and in the unlikely event they are the source, consequences could be significant and the patient's outcome could be grave.
- Dirty bomb ingredients generally include previously used radioactive material and are usually combined with a conventional explosive device to spread and distribute the contaminated material.
- Refer to Decontamination Procedure USP 2/ WMD and Nerve Agent Protocol TE 8 for contamination events.
- If there is a time lag between the time of exposure and the encounter with EMS, key clinical symptom evaluation includes: nausea/ vomiting, hypothermia/ hyperthermia, diarrhea, neurological/ cognitive deficits, headache, and hypotension.
- This event may require an activation of the National Radiation Injury Treatment Network (RITN). UNC Hospitals, Atrium Health Wake Forest Baptist and Duke are the RITN hospitals, with burns managed at UNC and Wake Forest.

Selective Spinal Motion Restriction



Pearls

- Recommended Exam: Mental Status, Skin, Neck, Heart, Lungs, Abdomen, Back, Extremities, Neuro
- Patients meeting all the above criteria do not require spinal motion restriction. However, patients who fail one or more criteria above require spinal motion restriction, but does NOT require use of the long spine board for immobilization.
- Long spine boards are NOT considered standard of care in most cases of potential spinal injury. Spinal motion restriction with cervical collar, and securing patient to cot, while padding all void areas is appropriate.
- True spinal immobilization is not possible. Spine protection and spinal motion restriction do not equal long spine board.
- **Spinal motion restriction is always utilized in at-risk patients. This includes cervical collar, securing to stretcher, minimizing movement/ transfers. and maintenance of in-line spine stabilization during any necessary movement/ transfers. This includes the elderly, or others with body or spine habitus preventing them from lying flat.**
- **Consider spinal motion restriction in patients with arthritis, cancer, dialysis, and underlying spine or bone disease.**
- Range of motion (ROM) is tested by touching chin to chest (look down), extending neck (look up), and turning head from side to side (chin to each shoulder) only in patients without posterior cervical mid-line pain. ROM should NOT be assessed if patient has midline spinal tenderness. Patient's range of motion should not be assisted, they must be able to complete alone.
- **EMR may participate in spinal motion restriction** per Agency Medical Director.
- **Immobilization on a long spine board is not necessary where:**
  Penetrating trauma to the head, neck or torso with no signs and/ or symptoms of spinal injury.
- **Concerning mechanisms that may result in spinal column injury:**
  Fall from ≥ 3 feet and/ or ≥ 5 stairs or steps. Ground level falls in patients ≥ 65 years of age.
  MVC ≥ 30 mph, rollover, and/or ejection
  Motorcycle, bicycle, other mobile device, or pedestrian-vehicle crash
  Diving or axial load to spine
  Electric shock

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Thermal Burn

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 could be indicated by hoarseness/ wheezing

Differential
- Thermal / Chemical / Electrical Burn Injury
  - Superficial (1st Degree) red – painful (Don't include in TBSA)
  - Partial Thickness (2nd Degree) blistering
  - Full Thickness (3rd Degree) painless/charred or leathery skin
- Radiation injury
- Blast injury

Assess Burn/ Concomitant Injury Severity

< 5% TBSA 2nd/3rd Degree Burn
No inhalation injury, Not Intubated, Normotensive
GCS 14 or Greater
Minor Burn

5-15% TBSA 2nd/3rd Degree Burn
Suspected inhalation injury or requiring intubation for airway stabilization
Hypotension or GCS 13 or Less
(When reasonably accessible, transport to a Burn Center)
Serious Burn

>15% TBSA 2nd/3rd Degree Burn
Burns with Multiple Trauma
Burns with definitive airway compromise
(When reasonably accessible, transport to a Burn Center)
Critical Burn

- Airway Protocol(s) AR 1, 2, 3, 5, 6 ***as indicated***
- Multiple Trauma Protocol TB 6 ***if indicated***
- Remove Rings, Bracelets, Constricting Items
- Dry Clean Sheet or Dressings
- **A** IV or IO Access Protocol UP 6
  Consider 2 IV sites if ≥ 15 % TBSA

TBSA estimate at ≥ 20%

NO → **A** **Lactated Ringer's or Normal Saline**
Lactated Ringer's preferred
0.25 mL/kg *X* (TBSA%)/hr

YES → **A** **Lactated Ringer's or Normal Saline**
Lactated Ringer's preferred
Age: ≤ 5 = 125 mL/hr
Age: 6–14 = 250 mL/hr
Age: ≥ 15 = 500 mL/hr

Formula example:
70 kg patient with 15% TBSA

0.25 *x* 70 kg = 17.5
17.5 *x* 15 = 263 mL/hr

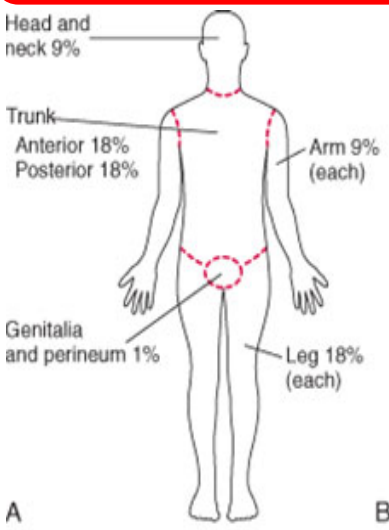
- Pain Control Protocol UP 11 ***if indicated***
- Carbon Monoxide/ Cyanide Protocol TE 2 ***if indicated***
- Monitor and Reassess
- **Rapid Transport** to appropriate destination using Trauma and Burn: EMS Triage and Destination Plan

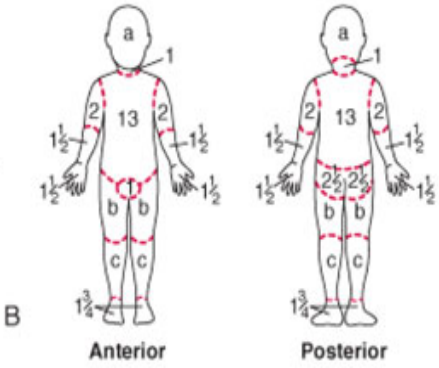
Notify Destination or Contact Medical Control

1. Lactated Ringer's preferred over Normal Saline. Use if available, if not change over once available.

Trauma and Burn Protocol Section

Thermal Burn





Relative percentage of body surface area (% BSA) affected by growth

	Age				
Body Part	0 yr	1 yr	5 yr	10 yr	15 yr
a = 1/2 of head	9 1/2	8 1/2	6 1/2	5 1/2	4 1/2
b = 1/2 of 1 thigh	2 3/4	3 1/4	4	4 1/4	4 1/2
c = 1/2 of 1 lower leg	2 1/2	2 1/2	2 3/4	3	3 1/4

Rule of Nines

- Rarely find a complete isolated body part that is injured as described in the Rule of Nines.
- More likely, it will be portions of one area, portions of another, and an approximation will be needed.
- For the purpose of determining the extent of serious injury, differentiate the area with minimal or 1st degree burn(superficial) from those of partial (2nd) or full (3rd) thickness burns.
- **For the purpose of determining Total Body Surface Area (TBSA) of burn, include only Partial (2nd) and Full Thickness (3rd) burns.** Report the observation of other superficial (1st degree) burns but do not include those burns in your TBSA estimate.
- Some texts will refer to 4th 5th and 6th degree burns. There is significant debate regarding the actual value of identifying a burn injury beyond that of the superficial, partial and full thickness burn at least at the level of emergent and primary care. For our work, all are included in Full Thickness burns

Estimate spotty areas of burn by using the size of the patient's palm as 1 %

Trauma and Burn Protocol Section

Pearls

- **Recommended Exam: Mental Status, HEENT, Neck, Heart, Lungs, Abdomen, Extremities, Back, and Neuro**
- **Green, Yellow, and Red In burn severity do not apply to the Start/ JumpStart Triage System.**
- **Airway considerations:**
  - **For systems performing RSI, Rocuronium is preferred agent (succinylcholine can be used in the first 24-hours)**
  - **Singed nasal hairs, facial burns, and/ or carbonaceous sputum are NOT absolute indications for intubation in a burn patient.**
  - **Utilizing non-rebreather face mask as well as NIPPV (CPAP) procedure are acceptable as tolerated.**
- **Critical or Serious Burns:**
  - **> 5-15% total body surface area (TBSA) 2nd or 3rd degree burns**
  - **3rd (full thickness) degree burns > 5% TBSA for any age group**
  - **Circumferential burns of extremities**
  - **Electrical or lightning injuries**
  - **Suspicion of abuse or neglect**
  - **Inhalation injury**
  - **Chemical burns**
  - **Burns of face, hands, perineum, or feet**
  - **Require direct transport to a Burn Center. Local facility should be utilized only if distance to Burn Center is excessive or critical interventions such as airway management are not available in the field.**
- Burn patients are trauma patients, evaluate for multisystem trauma.
- Assure whatever has caused the burn is no longer contacting the injury. (Stop the burning process!)
- Circumferential burns to extremities are dangerous due to potential vascular compromise secondary to soft tissue swelling.
- Burn patients are prone to hypothermia - never apply ice or cool the burn, must maintain normal body temperature.
- Evaluate the possibility of geriatric abuse with burn injuries in the elderly.
- Do not administer IM pain injections to a burn patient. IM dosing is variable in burn patients and may result in over or under dose.

Traumatic Arrest

Criteria for Death / No Resuscitation
Review DNR / MOST Form

YES → Decomposition
Rigor mortis
Dependent lividity
Blunt Force Trauma
Injury incompatible with life

NO

Blunt Arrest

YES

Apnea — NO

YES

Pulseless — NO

YES

Asystole — NO

YES

Do not begin resuscitation
Follow Deceased Subjects Policy

Penetrating Arrest

YES

NO — Apnea

YES

NO — Pulseless

YES

NO — Asystole

YES

Additional Assessments

Pupil Reflexes — YES

NO

Spontaneous Body Movement — YES

NO

Do not begin resuscitation
Follow Deceased Subjects Policy

A	Downtime ≥ 15 minutes with asystole

DNR/ MOST Form

Do not begin resuscitation

Follow Deceased Subjects Policy

AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.

Team Focused CPR
Protocol AC 11

Airway Protocol(s)
AR 1, 2, 3, 5, 6
if indicated

Control External Hemorrhage Procedure(s)
WTP 4, 5, 7

Consider Pelvic Binding

Splint Suspected Fractures
Procedure WTP 3

A	Chest Decompression-Needle Procedure ***if indicated***

Spinal Motion Restriction
Procedure WTP 2
And
Protocol TB 8
If indicated

A	IV / IO Access Protocol UP 6

Rapid Transport to appropriate destination using
Trauma and Burn:
EMS Triage and Destination Plan
Limit Scene Time ≤ 10 minutes
Provide Early Notification

Notify Destination or Contact Medical Control

Trauma and Burn Protocol Section

Traumatic Arrest

Pearls.

- **Recommended Exam: Mental Status, Skin, HEENT, Heart, Lung, Abdomen, Extremities, Back, Neuro**
- **Items in Red Text are key performance measures used in the EMS Acute Trauma Care Toolkit.**
- **Scene time should not be delayed for procedures and all should be performed during rapid transport.**
- **First arriving EMS personnel should make the assessment concerning agonal respirations, pulselessness, asystole, pupillary reflexes, and spontaneous body movements.**
- **Withholding resuscitative efforts with blunt and penetrating trauma victims who meet criteria, is appropriate.**
- **Airway:**
  - **Airway is a priority in traumatic arrest.**
  - **BVM and BIAD are acceptable for airway management.**
  - **Endotracheal intubation, if performed, should be completed during transport and should not delay scene time.**
- **Breathing:**
  - **Consider Chest Decompression in both blunt and penetrating trauma.**
- **Circulation:**
  - **Control external hemorrhage, including use of tourniquets, and prevent hypothermia by keeping patient warm.**
  - **IV or IO access should be established during rapid transport of unstable patients.**
  - **If transport time to Trauma Center is < 15 minutes, use of ECG monitor may delay resuscitation and transport.**
  - **Rhythm determination is more helpful in rural settings, or where transport to nearest facility is > 15 minutes. Omit from algorithm where appropriate.**
  - **Organized rhythms, for purpose of protocol, include Ventricular Tachycardia, Ventricular Fibrillation, and PEA.**
  - **Wide, bizarre rhythms (Idioventricular and severely bradycardic rhythms < 40 BPM), are not organized rhythms.**
- **Cardiac Monitor:** AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.
- **Defibrillation: Manual Defibrillation at the AEMT level is permissible only during pulseless cardiac arrest with VF or VT.**
- **Trauma Triad of Death:**
  - **Metabolic acidosis/ Coagulopathy/ Hypothermia**
  - **Performance of appropriate resuscitation measures and keeping patient warm, regardless of ambient temperature, helps to treat metabolic acidosis, coagulopathy, and hypothermia.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated.**
- **DO NOT HYPERVENTILATE: If no advanced airway (BIAD, ETT) compressions to ventilations are 30:2. If advanced airway in place ventilate 10 – 12 breaths per minute.**
- **ALS procedures should optimally be performed during rapid transport.**
- **Time considerations:**
  - **From the time cardiac arrest is identified, if CPR is performed ≥ 15 minutes with no ROSC, consider termination of resuscitation on scene.**
  - **From the time cardiac arrest is identified, if transport time to closest Trauma Center is > 15 minutes consider termination of resuscitation on scene.**
- Lightning strike, drowning or in situations causing hypothermia, resuscitation should be initiated.
- Where multiple lightning strike victims are found, use Reverse Triage: Begin CPR in apneic/ pulseless victims.
- Agencies utilizing Targeted Temperature Management Protocol should not cool the trauma patient, but rather make every effort to maintain warmth.

Pediatric Asystole / PEA

History
- Events leading to arrest
- Estimated downtime
- SAMPLE
- Existence of terminal illness
- Airway obstruction
- Hypothermia
- Suspected abuse

Signs and Symptoms
- Pulseless
- Apneic
- No electrical activity on ECG
- No heart tones on auscultation

Differential
- Respiratory failure
- Foreign body
- Infection (croup, epiglottitis)
- Congenital heart disease
- See Reversible Causes below

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Resuscitation Protocol PC 8

As scene and safety allow, consider working on scene for a minimum of 20 minutes (for non-traumatic arrests) before transporting.

Pediatric Pulseless Arrest Protocol

Criteria for Death / No Resuscitation
Review DNR / MOST Form

YES →
Decomposition
Rigor mortis
Dependent lividity
Blunt force trauma
Injury incompatible with life
Extended downtime with asystole

Do not begin resuscitation

Follow Deceased Subjects Policy

NO ↓

Begin CPR Compressions
Push Hard (≥ 1/3 AP Diameter of Chest)
(1.5 inches Infant / 2 inches in Children)
Push Fast (100 - 120 / min)
Change Compressors every 2 minutes
(sooner if fatigued)
(Limit changes / pulse checks ≤ 5 seconds)

Ventilation rate:
No Advanced Airway – 15:2 Compression:Ventilation
Advanced Airway – Continuous Compressions
1 breath every 2 seconds when age < 1
1 breath every 3 seconds when age ≥ 1
Utilize Newly Born protocol AO 2 if applicable
Monitor EtCO2

AED Procedure
if available

Search for Reversible Causes

Blood Glucose Analysis Procedure
if applicable

A Cardiac Monitor

P Consider Chest Decompression-Needle Procedure

A IV or IO Access Protocol UP 6

A **Epinephrine1:10,000**
0.01 mg/kg IV / IO Maximum Single Dose 1mg
Repeat every 4 minutes.

A **Normal Saline or Lactated Ringer's Bolus**
20 mL/kg IV / IO
May repeat as needed
Maximum 60 mL/kg

P **Consider**
Norepinephrine (Levophed) 0.1 – 2 mcg/kg/min IV/IO

Notify Destination or Contact Medical Control

AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.

Consider Early for PEA

1. Repeated Normal Saline or Lactated Ringer's Boluses for possible hypovolemia
2. Dextrose IV/IO
3. Naloxone IV/IO
4. Glucagon IV/IO/IM for suspected beta blocker or calcium channel blocker overdose.
5. Calcium Chloride IV/IO for suspected hyperkalemia, hypocalcemia
6. Sodium Bicarbonate IV/ IO for possible overdose, hyperkalemia, renal failure
7. Chest Decompression

Reversible Causes

Hypovolemia
Hypoxia
Hydrogen ion (acidosis)
Hypothermia
Hypo / Hyperkalemia

Tension pneumothorax
Tamponade; cardiac
Toxins
Thrombosis; pulmonary (PE)
Thrombosis; coronary (MI)

Pediatric Cardiac Protocol Section

Pediatric Asystole / PEA

Pearls

- **Team Focused Approach / Pit-Crew Approach recommended; assigning responders to predetermined tasks.**
- **Refer to protocol AC 11.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated. Compress ≥ 1/3 anterior-posterior diameter of chest, in infants 1.5 inches and in children 2 inches.**
- **Majority of pediatric arrests stem from a respiratory insult or hypoxic event. Compressions should be coupled with ventilations.**
- **When advanced airway not in place perform 15 compressions with 2 ventilations.**
- **Use length-based or weight-based pediatric resuscitation system for medication, equipment, cardioversion, and defibrillation guidance. Pediatric pads should be used in children < 10 kg.**
- **DO NOT HYPERVENTILATE:**
  If advanced airway in place ventilate:
  Age < 1 year: 1 breath every 2 seconds with continuous, uninterrupted compressions.
  Age ≥ 1 year: 1 breath every 3 seconds with continuous, uninterrupted compressions.
- **Airway is a more important intervention in pediatric arrests. This should be accomplished quickly with BVM or BIAD.**
- **Patient survival is often dependent on proper ventilation and oxygenation / airway Interventions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **High-Quality CPR:**
  Make sure chest compressions are being delivered at 100 – 120 / min.
  Make sure chest compressions are adequate depth for age and body habitus.
  Make sure you allow full chest recoil with each compression to provide maximum perfusion.
  Minimize all interruptions in chest compressions to < 10 seconds.
  Use AED or apply ECG monitor / defibrillator as soon as available.
- **Cardiac Monitor:** AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.
- **Defibrillation:** Follow manufacture's recommendations concerning defibrillation / cardioversion energy when specified.
- **End Tidal CO2 (EtCO2)**
  If EtCO2 is < 10 mmHg, improve chest compressions. Goal is ≥ 20 mmHg.
  If EtCO2 spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **IV / IO access and drug delivery are secondary to high-quality chest compressions and early defibrillation**.
- **Follow IV or IO Access Protocol UP 6.**
- **Special Considerations**
  Maternal Arrest - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm. Defibrillation is safe at all energy levels.
  Renal Dialysis / Renal Failure - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.
  Opioid Overdose - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol UP 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.
  Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.

Pediatric Bradycardia With a Pulse

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
- Decreased heart rate
- Delayed capillary refill or cyanosis
- Mottled, cool skin
- Hypotension or arrest
- Altered level of consciousness

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

Bradycardia
Typically HR < 60/min
Hypotension / AMS / Poor Perfusion / Shock

Pediatric Airway Protocol(s) AR 5, 6
as indicated

Identify underlying cause
Search for reversible causes

P — Cardiac Monitor

A — IV or IO Protocol UP 6

Age < 1 year with Heart Rate < 60/min
Persists despite oxygenation and ventilation

YES → Exit to Pediatric Cardiac Arrest Protocol(s) PC 1, 4, 7

NO

Identify underlying cause
Search for reversible causes

Blood Glucose Analysis Procedure

A — IV or IO Protocol UP 6

A — **Normal Saline or Lactated Ringer's Bolus**
20 ml / kg IV / IO
Repeat as needed x 3
Maximum 60 mL / kg

P — **Epinephrine 1:10,000**
0.01 mg/kg IV / IO Maximum Single Dose 1mg
May repeat every 3 – 5 minutes

P — **Atropine 0.02 mg / kg IV / IO**
May repeat x 1
Minimum single dose 0.1 mg
Maximum single dose 0.5 mg

P — **If no improvement**
Consider Transcutaneous Pacing Procedure

Transcutaneous Pacing
Adjust Heart Rate to 100 BPM for a Child

P — Consider Sedation

Midazolam 0.1 mg/kg
IV / IO / IM / IN
To max 2.5 mg initial dose
May repeat in 5-10 minutes as needed to max 5 mg.

Notify Destination or Contact Medical Control

Reversible Causes

Hypovolemia
Hypoxia
Hydrogen ion (acidosis)
Hypothermia
Hypo / Hyperkalemia
Hypoglycemia

Tension pneumothorax
Tamponade; cardiac
Toxins
Thrombosis; pulmonary (PE)
Thrombosis; coronary (MI)

Suspected Beta-Blocker or Calcium Channel Blocker

Follow Pediatric Toxicology Protocol

Pediatric Cardiac Protocol Section

Pediatric Bradycardia With Poor Perfusion

Wt. in kg	3	4	5	6	7	8	9	10	11	12	13	14	15
mg	0.03	0.04	0.05	0.06	0.07	0.08	0.09	0.1	0.11	0.12	0.13	0.14	0.15
Pediatric Epinephrine 1:10,000 Drug Dosage													
ml	0.3	0.4	0.5	0.6	0.7	0.8	0.9	1	1.1	1.2	1.3	1.4	1.5
Use 1, 3, or 5 ml syringe for these Epinephrine 1:10,000 doses													
Wt. in kg	16	17	18	19	20	22	24	26	28	30	32	34	36
mg	0.16	0.17	0.18	0.19	0.2	0.22	0.24	0.26	0.28	0.3	0.32	0.34	0.36
Pediatric Epinephrine 1:10,000 Drug Dosage													
ml	1.6	1.7	1.8	1.9	2	2.2	2.4	2.6	2.8	3	3.2	3.4	3.6

Wt. in kg	3	4	5	6	7	8	9	10	11	12	13	14	15
mg	0.1	0.1	0.1	0.12	0.14	0.16	0.18	0.2	0.22	0.24	0.26	0.28	0.3
Pediatric Atropine Drug Dosage based on 1 mg in 10 ml vial													
ml	1	1	1	1.2	1.4	1.6	1.8	2	2.2	2.4	2.6	2.8	3
Ensure that the appropriate size syringe is used for these Atropine doses													
Wt. in kg	16	17	18	19	20	22	24	26	28	30	32	34	36
mg	0.32	0.34	0.36	0.38	0.4	0.44	0.48	0.5	0.5	0.5	0.5	0.5	0.5
Pediatric Atropine Drug Dosage based on 1 mg in 10 ml vial													
ml	3.2	3.4	3.6	3.8	4	4.4	4.8	5	5	5	5	5	5

Pearls

- Recommended Exam: Mental Status, HEENT, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro
- Bradycardia is often associated with hypoxia so insure patent airway, breathing, and circulation as needed.
- Begin CPR immediately with persistent bradycardia and poor perfusion despite adequate oxygenation and ventilation.
- Use length-based or weight-based pediatric resuscitation system for medication, equipment, cardioversion, and defibrillation guidance. Pediatric pads should be used in children < 10 kg.
- Rhythm should be interpreted in the context of symptoms and pharmacological treatment given only when symptomatic, otherwise monitor and reassess.
- Consider hyperkalemia with wide complex, bizarre appearance of QRS complex, and bradycardia.
- 12-Lead ECG:
  - 12 Lead ECG not necessary to diagnose and treat
  - Obtain when patient is stable and/or following rhythm conversion.
- Unstable condition
  - Condition which acutely impairs vital organ function and cardiac arrest may be imminent.
  - If at any point patient becomes unstable move to unstable arm in algorithm
- Epinephrine is first drug choice for persistent, symptomatic bradycardia.
- Atropine:
  - Second choice, unless there is evidence of increased vagal tone or a primary AV conduction block, then give atropine first.
  - Ineffective and potentially harmful in cardiac transplantation. May cause paradoxical bradycardia.
- Symptomatic bradycardia causing shock or peri-arrest condition:
  - If no IV or IO access immediately available, start Transcutaneous Pacing, establish IV / IO access, and then administer epinephrine.
  - Epinephrine should be administered followed by Atropine if no response.
- Symptomatic condition
  - Arrhythmia is causing symptoms such as palpitations, lightheadedness, or dyspnea, but cardiac arrest is not imminent.
  - Symptomatic bradycardia usually occurs at rates < 60 beats per minute.
  - Search for underlying causes such as hypoxia or impending respiratory failure.
- Serious Signs / Symptoms:
  - Hypotension. Acutely altered mental status. Signs of shock / poor perfusion. Chest pain with evidence of ischemia (STEMI, T wave inversions or depressions.) Acute CHF.
- Transcutaneous Pacing Procedure (TCP)
  - Indicated with unstable bradycardia unresponsive to medical therapy.
  - If time allows transport to specialty center because transcutaneous pacing is a temporizing measure.
  - Transvenous / permanent pacemaker will probably be needed.
  - Immediate TCP with high-degree AV block (2d or 3d degree) with no IV / IO access.
- Most maternal medications pass through breast milk to the infant so maintain high-index of suspicion for OD-toxins.
- Hypoglycemia, severe dehydration and narcotic effects may produce bradycardia. Many other agents a child ingests can cause bradycardia, often in a single dose.

Pediatric Pulmonary Edema / CHF

History
- Congenital Heart Disease
- Chronic Lung Disease
- Congestive heart failure
- Past medical history

Signs/Symptoms
- Infant: Respiratory distress, poor feeding, lethargy, weight gain, +/- cyanosis
- Child/Adolescent: Respiratory distress, bilateral rales, apprehension, orthopnea, jugular vein distention (rare), pink, frothy sputum, peripheral edema, diaphoresis, chest pain
- Hypotension, shock

Differential
- Congestive heart failure
- Asthma
- Anaphylaxis
- Aspiration
- Pleural effusion
- Pneumonia
- Pulmonary embolus
- Pericardial tamponade
- Toxic Exposure

History / Signs / Symptoms consistent with respiratory distress with crackles / rales / known CHF

→ Airway Patent
Ventilations adequate
Oxygenation adequate

NO → Pediatric Airway Protocol(s) 5, 6, 7 ***as indicated***

YES

Allergic Reaction
Anaphylaxis

YES → Pediatric Allergic Reaction Anaphylaxis Protocol PM 1

NO

	Pulse Oximetry Monitoring
B	12 Lead ECG Procedure
	EtCO2 Monitoring
A	IV or IO Protocol UP 6 ***if indicated***
P	Cardiac Monitor

Position child with head of bed in up-position (25-40°)
Flexing hips with support under knees so that they are bent 90°

Transport to a Pediatric Specialty Center ***if available***

Notify Destination or Contact Medical Control

Pediatric Cardiac Protocol Section

Pearls
- **Recommended exam: Mental status, Respiratory, Cardiac, Skin, Neuro**
- **Contact Medical Control early in the care of the pediatric cardiac patient.**
- **Most children with CHF have a congenital heart defect, obtain a precise past medical history.**
- **Congenital heart disease varies by age:**
  - < 1 month: Tetralogy of Fallot, Transposition of the great arteries, Coarctation of the aorta.
  - 2 – 6 months: Ventricular septal defects (VSD), Atrioseptal defects (ASD).
  - Any age: Myocarditis, Pericarditis, SVT, heart blocks.
- **Treatment of Congestive Heart Failure / Pulmonary edema may vary depending on the underlying cause and may include the following with consultation by Medical Control:**
  - **Morphine Sulfate: 0.1 mg/kg IV / IO. Max single dose 5mg/dose**
  - **Fentanyl: 1 mcg/kg IV / IO. Max single dose 50 mcg.**
  - **Nitroglycerin: Dose determined after consultation of Medical Control.**
  - **Agency specific vasopressor.**
- Do not assume all wheezing is pulmonary, especially in a cardiac child: avoid albuterol unless strong history of recurrent wheezing secondary to pulmonary etiology (discuss with Medical Control)

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Pediatric Cardiac Arrest

History
- Time of arrest
- Medical history
- Medications
- Possibility of foreign body
- Hypothermia

Signs and Symptoms
- Unresponsive
- Cardiac arrest

Differential
- Respiratory failure: Foreign body, Secretions, Infection (croup, epiglottitis)
- Hypovolemia (dehydration)
- Congenital heart disease
- Trauma
- Tension pneumothorax, cardiac tamponade, pulmonary embolism
- Hypothermia
- Toxin or medication
- Electrolyte abnormalities (Glucose, K)
- Acidosis

Protocol Age Guidance:

Newborn – 3 days:
AO2 Newly Born

3- days to 15 years:
PC4 Pediatric Cardiac Arrest

≥ 16 years:
AC3 Cardiac Arrest; Adult

Criteria for Death / No Resuscitation
Review DNR / MOST Form

YES → Do not begin resuscitation
Follow Deceased Subjects Policy

NO

Begin CPR Compressions
Push Hard (≥ 1/3 AP Diameter of Chest)
(1.5 inches Infant / 2 inches in Children)
Push Fast (100 - 120 / min)
Change Compressors every 2 minutes
(sooner if fatigued)
(Limit changes / pulse checks ≤ 5 seconds)

Ventilation rate:
No Advanced Airway – 15:2 Compression:Ventilation
Advanced Airway – Continuous Compressions
1 breath every 2 seconds when age < 1
1 breath every 3 seconds when age ≥ 1

As scene and safety allow, consider working on scene for a minimum of 20 minutes (for non-traumatic arrests) before transporting.

ALS Available
- NO → AED Procedure *if available*
- YES → A: Cardiac Monitor

Shockable Rhythm
- NO → Continue CPR 2 Minutes; Repeat and reassess; Pediatric Airway Protocol(s) 5, 6
- YES → Defibrillation Automated

Shockable Rhythm
- NO → Pediatric Asystole / PEA Protocol PC 1; Pediatric Airway Protocol(s) 5, 6
- YES → Pediatric VF / VT Protocol PC 6; Pediatric Tachycardia Protocol PC 5; Pediatric Airway Protocol(s) 5, 6

Arrest secondary to Opioid OD?
- YES → **Naloxone 0.4 – 2 mg IN / IM**
  Peds: 0.1 mg/kg IN
  Maximum 4 mg
  A: **Naloxone 0.4 – 2 mg**
  Peds: 0.1 mg/kg
  IV / IO / IM / IN
  Maximum 4 mg
- NO

AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.

Notify Destination or Contact Medical Control

Pediatric Cardiac Protocol Section

Pediatric Cardiac Arrest

Pearls

- **Team Focused Approach / Pit-Crew Approach recommended; assigning responders to predetermined tasks. Refer to protocol AC 11.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated. Compress ≥ 1/3 anterior-posterior diameter of chest, in infants 1.5 inches and in children 2 inches.**
- **Majority of pediatric arrests stem from a respiratory insult or hypoxic event. Compressions should be coupled with ventilations.**
- **When advanced airway not in place perform 15 compressions with 2 ventilations.**
- **Use length-based or weight-based pediatric resuscitation system for medication, equipment, cardioversion, and defibrillation guidance. Pediatric paddles should be used in children < 10 kg.**
- **DO NOT HYPERVENTILATE:**
  If advanced airway in place ventilate:
  Age < 1 year: 1 breath every 2 seconds with continuous, uninterrupted compressions.
  Age ≥ 1 year: 1 breath every 3 seconds with continuous, uninterrupted compressions.
- **Patient survival is often dependent on proper ventilation and oxygenation / airway Interventions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **High-Quality CPR:**
  Make sure chest compressions are being delivered at 100 – 120 / min.
  Make sure chest compressions are adequate depth for age and body habitus.
  Make sure you allow full chest recoil with each compression to provide maximum perfusion.
  Minimize all interruptions in chest compressions to < 10 seconds.
  Use AED or apply ECG monitor / defibrillator as soon as available.
- **Cardiac Monitor:** AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.
- **Defibrillation:**
  First defibrillation is 2 J/kg, second defibrillation is 4 J/kg, subsequent shocks ≥ 4 J/kg (Maximum 10 J/kg or adult dose).
  Charge defibrillator during chest compressions, near the end of 2-minute cycle, to decrease peri-shock pause.
  Following defibrillation, provider should immediately restart chest compressions with no pulse check until end of next cycle.
  Manual Defibrillation at the AEMT level is permissible only during pulseless cardiac arrest with VF or VT.
- **End Tidal CO2 (EtCO2)**
  If EtCO2 is < 10 mmHg, improve chest compressions. Goal is ≥ 20 mmHg.
  If EtCO2 spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **Transcutaneous Pacing:**
  Pacing is NOT effective in cardiac arrest and pacing in cardiac arrest does NOT increase chance of survival.
- **IV / IO access and drug delivery are secondary to high-quality chest compressions and early defibrillation**.
- **Follow IV or IO Access Protocol UP 6.**
- **Special Considerations**
  Maternal Arrest - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm. Defibrillation is safe at all energy levels.
  Renal Dialysis / Renal Failure - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.
  Opioid Overdose - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol UP 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.
  Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- In order to be successful in pediatric arrests, a cause must be identified and corrected.
- Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.

Pediatric Tachycardia
Narrow Complex (≤ 0.09 sec)

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
- Heart Rate: Child > 180/bpm
  Infant > 220/bpm
- Pale or Cyanosis
- Diaphoresis
- Tachypnea
- Vomiting
- Hypotension
- Altered Level of Consciousness
- Pulmonary Congestion
- Syncope

Differential
- 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

Assess tachycardia in context of clinical condition
Identify and treat underlying cause of tachycardia

Unstable / Serious Signs and Symptoms
AMS, shock, hypotension
HR Typically > 180 Child
HR Typically > 220 Infant

YES →

	Cardiac Monitor
	Cardioversion Procedure
P	**0.5 – 1 J / kg** Repeat and increase to **2 J / Kg** May increase to **4 J / Kg** Or adult maximum
P	Consider sedation Do NOT delay cardioversion **Midazolam 0.1 – 0.2 mg / kg IV / IO / IN** May repeat if needed **Maximum Single Dose 2 mg** **Maximum Total Dose 5 mg**

NO

B	12 Lead ECG Procedure
P	Cardiac Monitor
A	IV or IO Access Protocol UP 6

Single lead ECG able to diagnose and treat arrhythmia

12 Lead ECG not necessary to diagnose and treat, but preferred when patient is stable.

Regular Rhythm?

NO → **Contact Medical Control**

YES

Probable Sinus Tachycardia

Identify and Treat Underlying Cause

Exit to Age Appropriate Protocol(s)

Probable SVT

	Vagal Maneuvers
P	**Adenosine 0.1 mg / kg IV / IO** **Maximum 6 mg** May repeat once **Adenosine 0.2 mg / kg IV / IO** **Maximum 12 mg**
B	Rhythm Converts 12 Lead ECG Procedure

Notify Destination or Contact Medical Control

AT ANY TIME

Pulseless

Go to Pediatric Pulseless Arrest Protocol

Pediatric Cardiac Protocol Section

Pediatric Tachycardia
Narrow Complex (≤ 0.09 sec)

Pearls

- **Recommended Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro**
- **Monomorphic QRS:**
  All QRS complexes in a single lead are similar in shape.
- **Polymorphic QRS:**
  QRS complexes in a single lead will change from complex to complex.
- **Use length-based or weight-based pediatric resuscitation system for medication, equipment, cardioversion, and defibrillation guidance. Pediatric pads should be used in children < 10 kg.**
- **Rhythm should be interpreted in the context of symptoms and pharmacological or electrical treatment given only when symptomatic, otherwise monitor and reassess.**
- **12-Lead ECG:**
  12-Lead ECG not necessary to diagnose and treat.
  Obtain when patient is stable and/or following rhythm conversion.
  When administering adenosine, obtaining a continuous 12-Lead can be helpful to physicians.
- **Unstable condition:**
  Condition which acutely impairs vital organ function and cardiac arrest may be imminent.
  If at any point patient becomes unstable, move to unstable arm in algorithm
  If IV or IO access is in place, may administer adenosine and repeat, prior to synchronized cardioversion.
- **Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.**
- **Serious Signs and Symptoms:**
  Respiratory distress / failure.
  Signs of shock / poor perfusion with or without hypotension.
  AMS
  Sudden collapse with rapid, weak pulse
- **Narrow Complex Tachycardia (≤ 0.09 seconds):**
  Sinus tachycardia: P waves present. Variable R-R waves. Infants usually < 220 beats / minute. Children usually < 180 beats / minute.
  SVT: > 90 % of children with SVT will have a narrow QRS (≤0.09 seconds.) P waves absent or abnormal. R-R waves not variable. Usually abrupt onset. Infants usually > 220 beats / minute. Children usually > 180 beats / minute.
  Atrial Flutter / Fibrillation
- **Vagal Maneuvers:**
  Breath holding. Blowing a glove into a balloon. Have child blow out “birthday candles” or through an obstructed straw. Infants: May put a bag of ice water over the upper half of the face careful not to occlude the airway.
- Separating the child from the caregiver may worsen the child's clinical condition.
- Monitor for respiratory depression and hypotension associated if Diazepam, Lorazepam, or Midazolam is used.
- Continuous pulse oximetry is required for all SVT Patients if available.

Pediatric Tachycardia
Wide Complex (> 0.09 sec)

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
- Heart Rate: Child > 180/bpm
  Infant > 220/bpm
- Pale or Cyanosis
- Diaphoresis
- Tachypnea
- Vomiting
- Hypotension
- Altered Level of Consciousness
- Pulmonary Congestion
- Syncope

Differential
- Heart disease (Congenital)
- Hypothermia/ 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

Assess tachycardia in context of clinical condition
Identify and treat underlying cause of tachycardia

Unstable / Serious Signs and Symptoms
AMS, shock, hypotension
HR Typically > 180 Child
HR Typically > 220 Infant

YES →

	Cardiac Monitor
	Cardioversion Procedure
P	**0.5 – 1 J / kg** Repeat and increase to **2 J / Kg** May increase to **4 J / Kg** Or adult maximum
	Consider sedation Do NOT delay cardioversion **Midazolam 0.1 – 0.2 mg / kg IV / IO / IN** May repeat if needed **Maximum Single Dose 2 mg** **Maximum Total Dose 5 mg**

NO

B	12 Lead ECG Procedure
P	Cardiac Monitor
A	IV or IO Access Protocol UP 6

Single lead ECG able to diagnose and treat arrhythmia

12 Lead ECG not necessary to diagnose and treat, but preferred when patient is stable.

Regular Rhythm? — NO → **Contact Medical Control**

YES

Probable Ventricular Tachycardia

P	**If QRS Regular and Monomorphic** **Adenosine 0.1 mg / kg IV / IO** **Maximum 6 mg** May repeat once **Adenosine 0.2 mg / kg IV / IO** **Maximum 12 mg**
B	Rhythm Converts 12 Lead ECG Procedure
P	**Expert consultation recommended for further medication management and/ or cardioversion procedure**

Notify Destination or Contact Medical Control

AT ANY TIME

Pulseless

Go to Pediatric Pulseless Arrest Protocol

Pediatric Cardiac Protocol Section

Pediatric Tachycardia
Wide Complex (> 0.09 sec)

Pearls

- **Recommended Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Neuro**
- **Monomorphic QRS:**
  All QRS complexes in a single lead are similar in shape.
- **Polymorphic QRS:**
  QRS complexes in a single lead will change from complex to complex.
- **Use length-based or weight-based pediatric resuscitation system for medication, equipment, cardioversion, and defibrillation guidance. Pediatric pads should be used in children < 10 kg.**
- **Rhythm should be interpreted in the context of symptoms and pharmacological or electrical treatment given only when symptomatic, otherwise monitor and reassess.**
- **12-Lead ECG:**
  12-Lead ECG is not necessary to diagnose and treat arrhythmia. A single lead ECG is often all that is needed.
  Obtain 12-Lead when patient is stable and/ or following a rhythm conversion.
  When administering adenosine, obtaining a continuous 12-Lead can be helpful later to physicians.
- **Unstable condition:**
  Condition which acutely impairs vital organ function and cardiac arrest may be imminent.
  If at any point patient becomes unstable move to unstable arm in algorithm
- **Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.**
- **Serious Signs and Symptoms:**
  Respiratory distress/ failure.
  Signs of shock/ poor perfusion with or without hypotension.
  AMS
  Sudden collapse with rapid, weak pulse
- **Serious Signs and Symptoms:**
  Respiratory distress/ failure.
  Signs of shock/ poor perfusion with or without hypotension.
  AMS
  Sudden collapse with rapid, weak pulse
- **Wide Complex Tachycardia (≥ 0.09 seconds):**
  SVT with aberrancy.
  VT: Uncommon in children. Rates may vary from near normal to > 200/ minute.
  Most children with VT have underlying heart disease / cardiac surgery/ long QT syndrome/ cardiomyopathy.
  Amiodarone 5 mg / kg over 20 – 60 minutes IV / IO is recommended agent. Consultation with Medical Control is required when this agent is considered.
- **Torsade's de Pointes/ Polymorphic (multiple shaped) Tachycardia:**
  Rate is typically 150 to 250 beats/ minute.
  Associated with long QT syndrome, hypomagnesemia, hypokalemia, many cardiac drugs.
  May quickly deteriorate to VT.
  Separating the child from the caregiver may worsen the child's clinical condition.
- Monitor for respiratory depression and hypotension associated if Diazepam, Lorazepam, or Midazolam is used.
- Continuous pulse oximetry is required for all SVT patients if available.

Pediatric Ventricular Fibrillation
Pulseless Ventricular Tachycardia

History
- Events leading to arrest
- Estimated downtime
- Past medical history
- Medications
- Existence of terminal illness
- Airway obstruction
- Hypothermia

Signs and Symptoms
- Unresponsive
- Cardiac Arrest

Differential
- Respiratory failure / Airway obstruction
- Hyper / hypokalemia, Hypovolemia
- Hypothermia, Hypoglycemia, Acidosis
- Tension pneumothorax, Tamponade
- Toxin or medication
- Thrombosis: Coronary / Pulmonary Embolism
- Congenital heart disease

Pediatric Pulseless Arrest Protocol PC 4

Begin CPR Compressions
Push Hard (≥ 1/3 AP Diameter of Chest)
(1.5 inches Infant / 2 inches in Children)
Push Fast (100 - 120 / min)
Change Compressors every 2 minutes
(sooner if fatigued)
(Limit changes / pulse checks ≤ 5 seconds)

Ventilation rate:
No Advanced Airway – 15:2 Compression:Ventilation
Advanced Airway – Continuous Compressions
1 breath every 2 seconds when age < 1
1 breath every 3 seconds when age ≥ 1

Automated Defibrillation Procedure

A

Defibrillation Manual Procedure
- First shock: 2 J / Kg
- Second shock: 4 J / Kg
- Subsequent shocks ≥ 4 J / kg

Maximum 10 J / kg or adult dose

IV / IO Protocol UP 6

Epinephrine 1:10,000
0.01 mg/kg IV / IO Maximum 1mg
Repeat every 4 minutes

If Rhythm Refractory to defibrillation
- **Continue CPR and give Agency specific Anti-arrhythmic(s) in a drug-shock-drug-shock pattern.**
- **Continue CPR up to point where you are ready to defibrillate with device charged.**

Repeat pattern during resuscitation.

P

Amiodarone 5 mg / kg IV / IO
(Maximum initial dose 300 mg).
Maximum repeat dosage 150mg, Maximum total dose of 15 mg / kg

A

Persistent VF / VT
Or
Torsades de Points

Magnesium Sulfate
40 mg/kg
slow IV / IO push

May repeat
every 5 minutes
Maximum 2 g

Notify Destination or Contact Medical Control

AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.

AT ANY TIME

Return of Spontaneous Circulation

Go to Post Resuscitation Protocol

Reversible Causes

Hypovolemia
Hypoxia
Hydrogen ion (acidosis)
Hypothermia
Hypo / Hyperkalemia
Hypoglycemia

Tension pneumothorax
Tamponade; cardiac
Toxins
Thrombosis; pulmonary (PE)
Thrombosis; coronary (MI)

Pediatric Cardiac Protocol Section

Pediatric Ventricular Fibrillation
Pulseless Ventricular Tachycardia

Pearls

- **Team Focused Approach / Pit-Crew Approach recommended; assigning responders to predetermined tasks. Refer to protocol AC 11.**
- **Efforts should be directed at high quality and continuous compressions with limited interruptions and early defibrillation when indicated. Compress ≥ 1/3 anterior-posterior diameter of chest, in infants 1.5 inches and in children 2 inches.**
- **Majority of pediatric arrests stem from a respiratory insult or hypoxic event. Compressions should be coupled with ventilations.**
- **When advanced airway not in place perform 15 compressions with 2 ventilations.**
- **Use length-based or weight-based pediatric resuscitation system for medication, equipment, cardioversion, and defibrillation guidance. Pediatric paddles should be used in children < 10 kg.**
- **DO NOT HYPERVENTILATE:**
  If advanced airway in place ventilate:
  Age < 1 year: 1 breath every 2 seconds with continuous, uninterrupted compressions.
  Age ≥ 1 year: 1 breath every 3 seconds with continuous, uninterrupted compressions.
- **Patient survival is often dependent on proper ventilation and oxygenation / airway Interventions.**
- **Do not interrupt compressions to place endotracheal tube. Consider BIAD first to limit interruptions.**
- **High-Quality CPR:**
  Make sure chest compressions are being delivered at 100 – 120 / min.
  Make sure chest compressions are adequate depth for age and body habitus.
  Make sure you allow full chest recoil with each compression to provide maximum perfusion.
  Minimize all interruptions in chest compressions to < 5 seconds.
  Use AED or apply ECG monitor / defibrillator as soon as available.
- **Cardiac Monitor:** AEMT may only interpret lethal arrythmias – Ventricular Fibrillation, Pulseless Ventricular Tachycardia, and Asystole.
- **Defibrillation:**
  First defibrillation is 2 J/kg, second defibrillation is 4 J/kg, subsequent shocks ≥ 4 J/kg (Maximum 10 J/kg or adult dose).
  Charge defibrillator during chest compressions, near the end of 2-minute cycle, to decrease peri-shock pause.
  Following defibrillation, provider should immediately restart chest compressions with no pulse check until end of next cycle.
  Manual Defibrillation at the AEMT level is permissible only during pulseless cardiac arrest with VF or VT.
- **End Tidal CO2 (EtCO2)**
  If EtCO2 is < 10 mmHg, improve chest compressions. Goal is ≥ 20 mmHg.
  If EtCO2 spikes, typically > 40 mmHg, consider Return of Spontaneous Circulation (ROSC)
- **IV / IO access and drug delivery are secondary to high-quality chest compressions and early defibrillation**.
- **Follow IV or IO Access Protocol UP 6.**
- **Special Considerations**
  Maternal Arrest - Treat mother per appropriate protocol with immediate notification to Medical Control and rapid transport preferably to obstetrical center if available and proximate. Place mother supine and perform Manual Left Uterine Displacement moving uterus to the patient's left side. IV/IO access preferably above diaphragm. Defibrillation is safe at all energy levels.
  Renal Dialysis / Renal Failure - Refer to Dialysis / Renal Failure Protocol AM 3 caveats when faced with dialysis / renal failure patient experiencing cardiac arrest.
  Opioid Overdose - If suspected, administer Naloxone per Overdose / Toxic Ingestion Protocol UP 7 while ensuring airway, oxygenation, ventilations, and high-quality chest compressions.
  Drowning / Suffocation / Asphyxiation / Hanging / Lightning Strike – Hypoxic associated cardiac arrest and prompt attention to airway and ventilation is priority followed by high-quality and continuous chest compressions and early defibrillation.
- Success is based on proper planning and execution. Procedures require space and patient access. Make room to work.
- In order to be successful in pediatric arrests, a cause must be identified and corrected.

Pediatric Post Resuscitation

History
- Respiratory arrest
- Cardiac arrest

Signs/Symptoms
- Return of pulse

Differential
- Continue to address specific differentials associated with the original dysrhythmia

Transport Destination Decision

Post-resuscitation patient is medically complex.

Consider facility capabilities:
- Pediatric ICU service
- Pediatric Cardiology service
- Pediatric Neurology service
- Targeted Temperature Management

	Pediatric Airway Protocol(s) AR 5 - 7 ***as needed***
	Monitor Vital Signs / Reassess
	Blood Glucose Analysis Procedure
	Optimize Ventilation and Oxygenation • Maintain SpO2 ≥ 92 – 98% • Advanced airway if indicated • Age Appropriate Respiratory Rate • Remove Impedence Threshold Device **DO NOT HYPERVENTILATE**
	ETCO2 ideally 35 – 45 mm Hg
B	12 Lead ECG Procedure
A	IV or IO Protocol UP 6
P	Cardiac Monitor
	Pediatric Diabetic Protocol PM 2 ***if indicated***
	Pediatric Hypotension / Shock Protocol PM 3 ***if indicated***
	Pediatric Bradycardia Protocol PC 2 ***if indicated***
	Pediatric Tachycardia Protocol PC 5, 6 ***as indicated***

Hypotension Age Based

0 – 31 Days
< 60 mmHg

1 Month to 1 Year
< 70 mmHg

> than 1 Year
< 70 + (2 x age) mmHg

Arrhythmias are common and usually self limiting after ROSC

If Arrhythmia Persists follow Rhythm Appropriate Protocol

Post-intubation / BIAD Management Protocol AR 8

Notify Destination or Contact Medical Control

Pediatric Cardiac Protocol Section

Pediatric Post Resuscitation

Pearls

- Recommended Exam: Mental Status, Neck, Skin, Lungs, Heart, Abdomen, Extremities, Neuro
- Goals of care are to preserve neurologic function, prevent secondary organ damage, treat the underlying cause of illness, and optimize prehospital care. Frequent reassessment is necessary.
- Hyperventilation is a significant cause of hypotension and recurrence of cardiac arrest in the post resuscitation phase and must be avoided. Titrate FiO_2 to maintain SpO_2 of 92 - 98%.
- Use length-based or weight-based pediatric resuscitation system for medication, equipment, cardioversion, and defibrillation guidance. Pediatric paddles should be used in children < 10 kg.
- **Pain/sedation:**
  - Patients requiring advanced airways and ventilation commonly experience pain and anxiety.
  - Unrelieved pain can lead to increased catecholamine release, ischemia, immunosuppression, and prolonged hospitalization.
  - Ventilated patients cannot communicate pain / anxiety and providers are poor at recognizing pain / anxiety.
  - Vital signs such has tachycardia and / or hypertension can provide clues to inadequate sedation, however they both are not always reliable indicators of patient's lack of adequate sedation.
  - Pain must be addressed first, before anxiety. Opioids are typically the first line agents before benzodiazepines. Ketamine is also a reasonable first choice agent.
- **Ventilator / Ventilation strategies:**
  - Tailored to individual patient presentations. Medical Control can indicate different strategies above.
  - In general ventilation with BVM should cause chest rise. With mechanical ventilation a reasonable tidal volume should be about 6 mL/kg and peak pressures should be < 30 cmH20.
  - Continuous pulse oximetry and capnography should be maintained during transport for monitoring.
  - Head of bed should be maintained at least 10 – 20 degrees of elevation when possible to decrease aspiration risk.
- **EtCO2 Monitoring:**
  - Initial End tidal CO2 may be elevated immediately post-resuscitation, but will usually normalize.
  - Goal is 35 – 45 mmHg but DO NOT hyperventilate to achieve.
  - EtCO2 should be continually monitored with advanced airway in place.
- Administer resuscitation fluids and vasopressor agents to maintain SBP at targets listed on page 1. This table represents minimal SBP targets.
- Targeted Temperature Management is recommended in pediatrics, but prehospital use is not associated with improved outcomes. Transport to facility capable of intensive pediatric care.
- Consider transport to facility capable of managing the post-arrest patient including hypothermia therapy, cardiology / cardiac catheterization, intensive care service, and neurology services.
- The condition of post-resuscitation patients fluctuates rapidly and continuously, and they require close monitoring. Appropriate post-resuscitation management may best be planned in consultation with Medical Control.

Pediatric Allergic Reaction

History
- Onset and location
- Insect sting or bite
- Food allergy/ exposure
- Medication allergy/ exposure
- New clothing, soap, detergent
- Past medical history/ reactions
- Medication history

Signs and Symptoms
- Itching or hives
- Coughing/ wheezing or respiratory distress
- Chest or throat constriction
- Difficulty swallowing
- Hypotension or shock
- Edema

Differential
- Urticaria (rash only)
- Anaphylaxis (systemic effect)
- Shock (vascular effect)
- Angioedema (drug induced)
- Aspiration/ Airway obstruction
- Vasovagal event
- Asthma/ COPD /CHF

Assess Symptom Severity

MILD
Skin Only

	Diphenhydramine **1 mg/kg PO** **Maximum 50 mg** *See Pearls*
A	IV or IO Access Protocol UP 6 ***If indicated***
A	**Diphenhydramine** **1 mg/kg IV / IM / IO / PO**
A	**Famotidine (Pepcid)** **0.5 mg/kg IV / IO** **Maximum dose of 20 mg** **Infused over 10 – 15 minutes**
B	Monitor and Reassess Monitor for Worsening Signs and Symptoms
	Notify Destination or Contact Medical Control

MODERATE
2+ Body Systems

	Epinephrine 1:1,000 IM **≥ 30 kg 0.3 – 0.5 mg IM** **< 30 kg 0.15 mg IM** Repeat every 5 minutes if no improvement
	Diphenhydramine **1 mg/kg PO** **Maximum 50 mg** *See Pearls*
B	**Albuterol Nebulizer** **2.5 – 5 mg** Repeat as needed x 3 ***if indicated***
A	**Epinephrine 1:1,000 IM** **≥ 30 kg 0.3 – 0.5 mg IM** **< 30 kg 0.15 mg IM** Repeat every 5 minutes if no improvement
A	**Diphenhydramine** **1 mg/kg IV / IM / IO / PO** **Maximum 50 mg**

SEVERE
2 + Body Systems + hypotension
Or Isolated Hypotension

	Epinephrine 1:1,000 IM **≥ 30 kg 0.3 – 0.5 mg IM** **< 30 kg 0.15 mg IM** Repeat every 5 minutes if no improvement
B	**Albuterol Nebulizer** **2.5 – 5 mg** Repeat as needed x 3 ***if indicated***
A	**Epinephrine 1:1,000 IM** **≥ 30 kg 0.3 – 0.5 mg IM** **< 30 kg 0.15 mg IM** Repeat every 5 minutes if no improvement
	Airway Pediatric Protocol(s) ***if indicated***
	Pediatric Hypotension/ Shock Protocol PM 3 ***if indicated***

A	IV or IO Access Protocol UP 6
A	**Albuterol Nebulizer** **2.5 – 5 mg** **+/- Ipratropium 0.5 mg (DuoNeb)** Repeat as needed x 3 ***if indicated***
A	**Famotidine (Pepcid)** **0.5 mg/kg IV / IO** **Maximum dose of 20 mg** **Infused over 10 – 15 minutes**
A	**Normal Saline or Lactated Ringer's Bolus** **20 mL/kg IV / IO** Repeat as needed **Maximum 60 mL/kg Liter(s)**
P	No improvement with IM Epinephrine **Epinephrine 1:10,000 IV / IO** **Contact Medical Control**
A	**Methylprednisolone** **2 mg/kg IV** **Maximum 125 mg**

Epinephrine 1:10,000 IV / IO
WITH MEDICAL CONTROL AUTHORIZATION
0.01 mg/kg (0.1 ml/kg)
Max single dose 0.1 mg
May repeat to a maximum 0.3 mg

Use caution when giving Diphenhydramine to a patient with decreased mental status and/ or hypotension as this may cause nausea, vomiting, and/ or worsening mental status.

B	**Levalbuterol (Xopenex)** **May be used in place of Albuterol if necessary**
B	**Levalbuterol (Xopenex) 1.25 mg** Repeat as needed x 3
B	**May Use Patient's Levalbuterol (Xopenex)**
A	**Levalbuterol (Xopenex) 1.25 mg** **+/- Ipratropium 0.5 mg (DuoNeb)** Repeat as needed x 3 ***if indicated***

Notify Destination or Contact Medical Control

Pediatric Medical Protocol Section

Pediatric Allergic Reaction

When giving IM Epinephrine, the lateral thigh is the preferred injection site.

Pearls

- **Recommended Exam: Mental Status, Skin, Heart, Lungs, Abdomen**
- **Anaphylaxis is an acute and potentially lethal multisystem allergic reaction.**
- **Epinephrine administration:**
  - **Drug of choice and the FIRST drug that should be administered in acute anaphylaxis (Moderate/ Severe Symptoms.)**
  - **IM Epinephrine should be administered in priority before or during attempts at IV or IO access.**
- **Diphenhydramine and steroid administration:**
  - **Diphenhydramine/ steroids have no proven benefit in Moderate/ Severe anaphylaxis.**
  - **Diphenhydramine/ steroids should NOT delay initial or repeat Epinephrine administration.**
  - **In Moderate and Severe anaphylaxis, Diphenhydramine may decrease mental status.**
  - **Use caution when giving Diphenhydramine to a patient with decreased mental status and/ or a hypotensive patient as this may cause nausea, vomiting, and/ or worsening mental status.**
- **Anaphylaxis unresponsive to repeat doses of IM epinephrine may require IV epinephrine administration by IV push or epinephrine infusion. Contact Medical Control for appropriate dosing.**
- **Severe or refractory anaphylaxis: Paramedic may administer Epinephrine 1:10,000 0.01 mg/kg (0.1 ml/kg) with MEDICAL CONTROL AUTHORIZATION. Max single dose 0.1 mg. May repeat IV/IO Epinephrine to a maximum 0.3 mg.**
- **Symptom Severity Classification:**
  - **Mild symptoms:**
    - **Flushing, hives, itching, erythema with normal blood pressure and perfusion.**
  - **Moderate symptoms:**
    - **Flushing, hives, itching, erythema plus respiratory (wheezing, dyspnea, hypoxia) or gastrointestinal symptoms (nausea, vomiting, abdominal pain) with normal blood pressure and perfusion.**
  - **Severe symptoms:**
    - **Flushing, hives, itching, erythema plus respiratory (wheezing, dyspnea, hypoxia) or gastrointestinal symptoms (nausea, vomiting, abdominal pain) with hypotension and poor perfusion.**
- **Allergic reactions may occur with only respiratory and gastrointestinal symptoms and have no rash/ skin involvement.**
- **Angioedema** is seen in moderate to severe reactions and is swelling involving the face, lips or airway structures. This can also be seen in patients taking blood pressure medications like Prinivil / Zestril (lisinopril)-typically end in **-il**.
- **Hereditary Angioedema** involves swelling of the face, lips, airway structures, extremities, and may cause moderate to severe abdominal pain. Some patients are prescribed specific medications to aid in reversal of swelling. **Paramedic may assist or administer this medication per patient/ package instructions.**
- **Fluids and Medication titrated to maintain a SBP >70 + (age in years x 2) mmHg.**
- **Patients with moderate and severe reactions should receive a 12-Lead ECG and should be continually monitored, but this should NOT delay administration of epinephrine.**
- **EMR/ EMT:**
  - **The use of Epinephrine IM is limited to the treatment of anaphylaxis and may be given only by autoinjector,** unless manual draw-up is approved by the Agency Medical Director and the NC Office of EMS.
  - **Administration of diphenhydramine is limited to the oral route only**.
- **EMT administration of beta-agonist is limited to only patients currently prescribed the medication,** unless approved by the Agency Medical Director and the NC Office of EMS.
- Agency Medical Director may require contact of medical control prior to EMT/ EMR administering any medication(s). Medical Director may require contact of medical control prior to EMT/ EMR administering any medication.
- The shorter the onset from exposure to symptoms the more severe the reaction.

Pediatric Diabetic

History
- Past medical history
- Medications
- Recent blood glucose check
- Last meal

Signs and Symptoms
- Altered mental status
- Combative/ irritable
- Diaphoresis
- Seizures
- Abdominal pain
- Nausea/ vomiting
- Weakness
- Dehydration
- Deep/ rapid breathing

Differential
- Alcohol/ drug use
- Toxic ingestion
- Trauma; head injury
- Seizure
- CVA
- Altered baseline mental status.

	Blood Glucose Analysis Procedure
B	12 Lead ECG Procedure ***if indicated***
A	IV or IO Access Protocol UP 6
P	Cardiac Monitor
	Altered Mental Status Protocol UP 4 ***if indicated***
	Hypotension/ Shock Protocol AM 5 ***if indicated***
	Seizure Protocol UP 13 ***if indicated***

A

Blood glucose ≤ 69 mg/dL Symptomatic with NO IV / IO Access: Awake, alert and able to tolerate oral agent:
Give **oral glucose solution**.
If unable to tolerate oral: **Glucagon 0.1 mg/kg IM (Maximum 1 mg)**
Repeat every 15 minutes as needed to keep Blood glucose > 60 mg / dL.

Dextrose Infusion IV / IO
Use D10W Premixed Solution if available.

Blood Sugar ≤ 69 mg / dL

Oral Glucose
½ to 1 Tube
If age appropriate

Consider Oral Solution (Juices / Food)

A

< 1 Year of Age:
D10: 5 mL/kg IV / IO
Repeat as needed until BG ≥ 69

1 to 2 Years:
D10: 5 ml/kg IV / IO
Or
D25: 2 mL/kg IV / IO
Repeat as needed until BG ≥ 69

> 2 Years:
For patients under 50 kg (110 lbs)
D10: 5 ml/kg IV / IO
For patients over 50 kg (110 lbs)
D10: Premixed 250 ml Bag
Titrate to patient's condition and response.
Or
D50: 1 mL/kg IV / IO
Maximum 25 g per dose
Repeat as needed until BG ≥ 69

Blood Sugar 70 – 249 mg / dL

Blood Glucose Analysis Procedure ***if condition changes***

Exit to Appropriate Protocol(s)

Blood Sugar ≥ 250 mg / dL

A

Normal Saline or Lactated Ringer's Bolus
10 - 20 mL/kg IV / IO

Maximum 20 mL/kg

Monitor and Reassess Every 5 minutes Until Blood Glucose ≥ 80 mg / dL

Notify Destination or Contact Medical Control

Pediatric Medical Protocol Section

Pediatric Diabetic

If D10W is out of supply, an alternative for children > 2 years: D50W 1ml/kg IV/IO

Pearls

- **Recommended Exam: Mental Status, HEENT, Skin, Respirations and effort, Abdomen, Neuro.**
- **Patients with prolonged hypoglycemia or those who are malnourished my not respond to glucagon.**
- **Do not administer oral glucose to patients that are not able to swallow or protect their airway.**
- **Quality control checks should be maintained per manufacturer's recommendation for all glucometers.**
- **D10/ D25 Preparation:**
  - **D10: Remove 10 mL of D50 from a D50 vial. Add 40 mL of NS with the 10 mL of D50 with a total volume of 50 mL.**
  - **D10: Alternative, Discard 40 mL from the D50 vial and draw up 40 mL of NS with a total volume of 50 mL.**
  - **D25: Remove 25 mL of D50 and draw up 25 mL of NS with a total volume of 50 mL.**
- In extreme circumstances with no IV and no response to glucagon, Dextrose 50 % can be administered rectally. Contact medical control for advice.
- **Patient's refusing transport to medical facility after treatment of hypoglycemia:**
  - Adult caregiver must be present with pediatric patient.
  - Blood sugar must be **trending up with 2 or more readings ≥ 80 mg/dL over a 15 minute period**, patient has ability to eat and availability of food with responders on scene.
  - Patient must have known history of diabetes and not taking any oral diabetic agents.
  - Patient returns to normal mental status and has a normal neurological exam with no new neurological deficits.
  - Must demonstrate capacity to make informed health care decisions. See Universal Patient Care Protocol UP-1.
  - Otherwise contact medical control.
- **Hypoglycemia with Oral Agents:**
  - Patients taking oral diabetic medications should be strongly encouraged to allow transportation to a medical facility.
  - They are at risk of recurrent hypoglycemia that can be delayed for hours and require close monitoring even after normal blood glucose is established.
  - Not all oral agents have prolonged action so Contact Medical Control or NC Poison Control Center for advice.
  - Patients who meet criteria to refuse care should be instructed to contact their physician immediately and consume a meal.
- **Hypoglycemia with Insulin Agents:**
  - Many forms of insulin now exist. Longer acting insulin places the patient at risk of recurrent hypoglycemia even after a normal blood glucose is established.
  - Not all insulins have prolonged action so Contact Medical Control for advice. Patients who meet criteria to refuse care should be instructed to contact their physician immediately and consume a meal.
- **Hyperglycemia** in pediatrics, especially with no history of diabetes, may indicate a (first) episode of diabetic ketoacidosis, a life-threatening condition. Recognition of the possibility of the condition and SLOW volume replacement are goals of prehospital care. Rapid or excessive volume replacement could cause cerebral edema. Consider monitoring EtCO2 to detect metabolic acidosis, and consultation with the receiving pediatric specialty receiving center for any hypotension (normal pediatric BP = 70 + 2 x age in years) or patient in extremis.

Pediatric Hypotension/ Shock

History
- Blood loss
- Fluid loss
- Vomiting
- Diarrhea
- Fever
- Infection

Signs and Symptoms
- Restlessness, confusion, weakness
- Dizziness
- Tachycardia
- Hypotension (Late sign)
- Pale, cool, clammy skin
- Delayed capillary refill
- Dark-tarry stools

Differential
- Shock
  - Hypovolemic
  - Cardiogenic
  - Septic
  - Neurogenic
  - Anaphylactic
- Trauma
- Infection
- Dehydration
- Congenital heart disease
- Medication or Toxin

	Blood Glucose Analysis Procedure
A	IV or IO Access Protocol UP 6
P	Cardiac Monitor
	Pediatric Airway Protocol(s) ***if indicated***
	Diabetic Protocol PM 2 ***if indicated***

Age Specific Blood Pressure indicating possible shock

Age 0 – 28 days: SBP < 60
Ages ≥ 1 month: SBP < 70
Age 1 – 9: SBP < 70 + (2*x* Age)

Ages 10 – 64: SBP < 90
Ages ≥ 65: SBP < 110

All ages Shock Index: HR > SBP

History and Exam Suggest Type of Shock

Cardiogenic

Chest Pain: Cardiac and STEMI Protocol AC 4
Appropriate Pediatric Arrhythmia Protocol(s) ***if indicated***

A — **Normal Saline or Lactated Ringer's Bolus**
5 – 10 mL / kg IV / IO
Titrate to age appropriate SBP ≥ 70 + (2 x Age)
Maximum 10 mL / kg

Hypovolemic / Distributive

Pediatric Allergy Protocol PM 1 ***if indicated***
Suspected Sepsis Protocol UP 15 ***if indicated***
Multiple Trauma Protocol TB 6 ***if indicated***

A — **Normal Saline or Lactated Ringer's Bolus**
20 mL / kg IV / IO
Titrate to age appropriate SBP ≥ 70 + (2 x Age)
Maximum 60 mL / kg

P — **Norepinephrine (Levophed)**
0.1 – 2 mcg/kg/min IV/IO
Titrate To Age Specific SBP

Obstructive

P — Chest Decompression-Needle Procedure ***if indicated***

***The use of vasopressors are contraindicated for Hemorrhagic Shock**

Notify Destination or Contact Medical Control

Pediatric Medical Protocol Section

Pediatric Hypotension/ Shock

Pearls

- **Recommended Exam: Mental Status, Skin, Heart, Lungs, Abdomen, Back, Extremities, Neuro**
- **Consider all possible causes of shock and treat per appropriate protocol. Majority of decompensation in pediatrics is airway or respiratory related.**
- **Decreasing heart rate and hypotension occur late in children and are signs of impending cardiac arrest.**
- **Shock may be present with a normal blood pressure initially or even elevated.**
- **Shock often is present with normal vital signs and may develop insidiously. Tachycardia may be the first and only sign.**
- **Consider all possible causes of shock and treat per appropriate protocol.**
- **Hypovolemic Shock:**
  Hemorrhage, trauma, GI bleeding, or pregnancy-related bleeding.
- **Cardiogenic Shock:**
  Heart failure: MI, Cardiomyopathy, Myocardial contusion, Ruptured ventricle/ septum/ valve/ toxins.
- **Distributive Shock:**
  Septic/ Anaphylactic/ Neurogenic/ Toxic
  Hallmark is warm, dry, pink skin with normal capillary refill time and typically alert.
- **Obstructive Shock:**
  Pericardial tamponade. Pulmonary embolus. Tension pneumothorax.
  Signs may include hypotension with distended neck veins, tachycardia, unilateral decreased breath sounds or muffled heart sounds.
- **Acute Adrenal Insufficiency or Congenital Adrenal Hyperplasia:**
  Body cannot produce enough steroids (glucocorticoids/ mineralocorticoids.)
  May have primary or secondary adrenal disease, congenital adrenal hyperplasia, or more commonly have stopped a steroid like prednisone. Injury or illness may precipitate.
  Usually hypotensive with nausea, vomiting, dehydration and/ or abdominal pain.
  If suspected, AEMT or Paramedic should give Methylprednisolone 2 mg / kg IM / IV / IO up to a maximum of 125 mg or Dexamethasone 4 mg IM / IV / IO.
  Use steroid agent specific to your drug list.
  May administer prescribed steroid carried by patient IM / IV / IO. Patient may have Hydrocortisone (Cortef or Solu-Cortef). Dose: < 1y.o. give 25 mg, 1-12 y.o. give 50 mg, and > 12 y.o. give 100 mg or dose specified by patient's physician.

Bites and Envenomations

History
- Type of bite/ sting
- Description/ photo for identification
- Time, location, size of bite/ sting
- Previous reaction to bite/ sting
- Domestic vs. Wild
- Tetanus and Rabies risk
- Immunocompromised patient

Signs and Symptoms
- Rash, skin break, wound
- Pain, soft tissue swelling, redness
- Blood oozing from the bite wound
- Evidence of infection
- Shortness of breath, wheezing
- Allergic reaction, hives, itching
- Hypotension or shock

Differential
- Animal bite
- Human bite
- Snake bite (poisonous)
- Spider bite (poisonous)
- Insect sting / bite (bee, wasp, ant, tick)
- Infection risk
- Rabies risk
- Tetanus risk

Call for help/ additional resources
Stage until scene safe

Contact
Carolinas Poison Control
1-800-222-1222

- General Wound Care Procedure
- Immobilize Injury
- Remove any constricting clothing/ bands/ jewelry
- **A** IV or IO Access Protocol UP 6 ***if indicated***
- Age Appropriate Trauma Protocol(s) TB 4, 5, 6 ***if indicated***
- Age Appropriate Allergic Reaction/ Anaphylaxis Protocol AM 1/ PM 1 ***if indicated***
- Age Appropriate Hypotension/ Shock Protocol AM 5 / PM 3 ***if indicated***
- Pain Control Protocol UP 11 ***if indicated***
- Extremity Trauma Protocol TB 4 ***if indicated***

Identification of Animal

Spider Bite/ Bee or Wasp Sting
Venomous

- Keep bite at level of heart ***if able***
- Apply Ice Packs
- **P** **<u>Muscle Spasm</u>**
  Midazolam 2 – 2.5 mg IV / IO
  Over 2 to 3 minutes
  Midazolam IN See Page 2
  Maximum 10 mg
  Pediatrics:
  Midazolam 0.1 – 0.2 mg / kg
  IV / IO / IM / IN
  Over 2 to 3 minutes
  Maximum 5 mg IM

Snake Bite
Venomous

- Keep bite at level of heart ***if able***
- Remove any constricting clothing/ bands
- **DO NOT apply ICE**
- Mark Margin of Swelling / Redness and Time

Mammal Bite

Transport
- NO → Contact and Document contact with Animal Control Officer
- YES

Monitor and Reassess

Notify Destination or Contact Medical Control

Toxin-Environmental Protocol Section

Bites and Envenomations

Pearls

- **Recommended Exam: Mental Status, Skin, Extremities (Location of injury), and a complete Neck, Lung, Heart, Abdomen, Back, and Neuro exam if systemic effects are noted**
- **Immunocompromised patients are at an increased risk for infection: diabetes, chemotherapy, transplant patients.**
- **Consider contacting the North Carolina Poison Control Center for guidance (1-800-222-1222).**
- **Do not put responders in danger attempting to capture an animal or insect for identification purposes.**
- **Evidence of infection: swelling, redness, drainage, fever, red streaks proximal to wound.**
- **Human bites:**
  Human bites have higher infection rates than animal bites due to normal mouth bacteria.
  Hand and foot bites have highest rates of infection.
- **Dog/ Cat/ Carnivore bites:**
  Carnivore bites are much more likely to become infected and all have risk of Rabies exposure.
  Cat bites may progress to infection rapidly due to a specific bacteria (Pasteurella multicoda).
- **Snake bites:**
  Poisonous snakes in this area are generally of the pit viper family: rattlesnake and copperhead.
  Coral snake bites are rare: Very little pain but very toxic. "Red on yellow - kill a fellow, red on black - venom lack."
  Amount of envenomation is variable, generally worse with larger snakes and early in spring.
  Snake bites are treated based on signs and symptoms and progression.
  It is not important to attempt to identify the type of snake and attempts may endanger providers.
  Do not bring a snake to the facility for identification as accidental bites to providers may occur.
- **Spider bites:**
  Black Widow spider bites tend to be minimally painful, but over a few hours, muscular pain and severe abdominal pain may develop (spider is black with red hourglass on belly).
  Brown Recluse spider bites are minimally painful to painless. Little reaction is noted initially but tissue necrosis at the site of the bite develops over the next few days (brown spider with fiddle shape on back).
- **Animal bite(s) in subjects declining transport to a medical facility for evaluation:**
  NCGS 130A-196 requires that all animal bites be reported to the local health department even if the bite is by the owner's animal, and even if accidental.
  Reporting requirements can be satisfied by reporting to local animal control official.

Carbon Monoxide/ Cyanide

History
- Smoke inhalation
- Ingestion of cyanide
- Eating large quantity of fruit pits
- Industrial exposure
- Trauma
- Reason: Suicide, criminal, accidental
- Past Medical History
- Time/ Duration of exposure

Signs and Symptoms
- AMS
- Malaise, weakness, flu like illness
- Dyspnea
- GI Symptoms; N/V; cramping
- Dizziness
- Seizures
- Syncope
- Reddened skin
- Chest pain

Differential
- Diabetic related
- Infection
- MI
- Anaphylaxis
- Renal failure/ dialysis problem
- Head injury/ trauma
- Co-ingestant or exposures

	Immediately Remove from Exposure
	Appropriate Airway Protocol(s) 1 - 7 ***as indicated***
	High Flow Oxygen
	Blood Glucose Analysis Procedure
B	12 Lead ECG Procedure
A	IV or IO Access Protocol UP 6
P	Cardiac Monitor/ CO Monitor
	Altered Mental Status Protocol UP 4 ***if indicated***
	Age Appropriate Diabetic Protocol AM 2/ PM 2 ***if indicated***
	Age Appropriate Multiple Trauma Protocol TB 6 Head Injury TB 5 ***if indicated***
	Age Appropriate Hypotension/ Shock Protocol AM 5/ PM 3 ***if indicated***

Contact
Carolinas Poison Control
1-800-222-1222

SpCO Abnormal

> 5 (Non-Smoker)

> 10 (Smoker)

High Suspicion of Cyanide

YES → P: **Hydroxocobalamin 70 mg / kg IV / IO**
Maximum 5 g
If available

NO

	Continue Care Continue High Flow Oxygen
	Monitor and Reasses

Notify Destination or Contact Medical Control

Toxin-Environmental Protocol Section

Pearls
- **Recommended exam: Neuro, Skin, Heart, Lungs, Abdomen, Extremities**
- **Scene safety is priority.**
- Consider CO and Cyanide with any product of combustion.
- Normal environmental CO level does not exclude CO poisoning.
- Symptoms present with lower CO levels in pregnancy, children, and the elderly.
- Continue high flow oxygen regardless of pulse ox readings.

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Drowning

History
- Submersion in water regardless of depth
- Possible history of trauma
- Slammed into shore wave break
- Duration of submersion/ immersion
- Temperature of water or possibility of hypothermia

Signs and Symptoms
- Unresponsive
- Mental status changes
- Decreased or absent vital signs
- Foaming/ Vomiting
- Coughing, Wheezing, Rales, Rhonchi, Stridor
- Apnea

Differential
- Trauma
- Pre-existing medical problem
  - Hypoglycemia
  - Cardiac Dysrhythmia
- Pressure injury (SCUBA diving)
  - Barotrauma
  - Decompression sickness
- Post-immersion syndrome

Awake and Alert

- Supplemental Oxygen ***as tolerated***
- Spinal Motion Restriction Procedure/ Protocol TB 8 ***if indicated***
- Remove wet clothing Dry/ Warm Patient
- Monitor and Reassess
- **Encourage transport and evaluation even if asymptomatic or with minimal symptoms** *Asymptomatic drowning patients (refusing transport) should be instructed to seek medical care/call 911 if they develop any symptoms within 6 hours*
- A: IV or IO Access Protocol UP 6 ***if indicated***
- P: Cardiac Monitor ***as indicated***

Awake but with AMS

- **5 Breaths via BVM**/ mouth-to-mouth ***as tolerated***
- Supplemental Oxygen ***as tolerated***
- Age Appropriate Airway Protocol(s) 1 - 7 ***as indicated***
- Spinal Motion Restriction Procedure/ Protocol TB 8 ***if indicated***
- Altered Mental Status Protocol UP 4 ***as indicated***
- Remove wet clothing Dry/ Warm Patient
- A: IV or IO Access Protocol UP 6
- P: Cardiac Monitor

Age Appropriate Airway Protocol(s) AR 1 - 7 ***as indicated***

Notify Destination or Contact Medical Control

Unresponsive

- **5 Breaths via BVM**/ mouth-to-mouth ***as tolerated***

Pulse
- YES → Age Appropriate Airway Protocol(s) 1 - 7 ***as indicated***
- NO → Exit to Age Appropriate Cardiac Arrest Protocol(s) AC 3/ PC 4

Airway Protocol(s) AR 1 - 7
Spinal Motion Restriction Protocol TB 8 ***as indicated***

Dive Accident / Barotrauma
Divers Alert Network
1-919-684-9111

Transport patients requiring hyperbaric therapy to Duke University Medical Center

Toxic-Environmental Protocol Section

Pearls
- **Recommended Exam: Respiratory, Mental status, Trauma Survey, Skin, Neuro**
- **Drowning is the process of experiencing respiratory impairment (any respiratory symptom) from submersion/ immersion in a liquid.**
- **Begin with BVM ventilations, if patient does not tolerate, then apply appropriate mode of supplemental oxygen.**
- **Ensure scene safety. Drowning is a leading cause of death among would-be rescuers.**
- **When feasible, only appropriately trained and certified rescuers should remove patients from areas of danger.**
- **Regardless of water temperature – resuscitate all patients with known submersion time of ≤ 25 minutes.**
- **Regardless of water temperature – If submersion time ≥ 1 hour consider moving to recovery phase instead of rescue.**
- **Foam is usually present in airway and may be copious, DO NOT waste time attempting to suction. Ventilate with BVM through foam (suction water and vomit only when present.)**
- **Cardiac arrest in drowning is caused by hypoxia, airway and ventilation are equally important to high-quality CPR.**
- **Encourage transport of all symptomatic patients (cough, foam, dyspnea, abnormal lung sounds, hypoxia) due to potential worsening over the next 6 hours.**
- Predicting prognosis in prehospital setting is difficult and does not correlate with mental status. Unless obvious death, transport.
- Hypothermia is often associated with drowning and submersion injuries even with warm ambient conditions.
- Drowning patient typically has <1 – 3 mL/kg of water in lungs (does not require suction) Primary treatment is reversal of hypoxia.
- Spinal motion restriction is usually unnecessary. When indicated it should not interrupt ventilation, oxygenation and/ or CPR.

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Hyperthermia

History
- Age, very young and old
- Exposure to increased temperatures and / or humidity
- Past medical history / Medications
- Time and duration of exposure
- Poor PO intake, extreme exertion
- Fatigue and / or muscle cramping

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

Differential
- Fever (Infection)
- Dehydration
- Medications
- Hyperthyroidism (Thyroid Storm)
- Delirium tremens (DT's)
- Heat cramps, exhaustion, stroke
- CNS lesions or tumors

Temperature Measurement Procedure
if available

Temperature Measurement should NOT delay treatment of hyperthermia

- Remove from heat source to cool environment
- Cooling measures
- Remove tight clothing
- Blood Glucose Analysis Procedure
- Age Appropriate Diabetic Protocol AM 2/ PM 2 ***as indicated***

Heat Stroke

Classic Heat Stroke
- Not common type
- Hot and Dry
- Altered Mental Status

Exertional Heat Stroke
- **Most common type**
- Wet with prior sweating
- Altered Mental Status

Assess Symptom Severity

HEAT CRAMPS
Normal to elevated body temperature
Warm, moist skin
Weakness, Muscle cramping

- PO Fluids as tolerated
- Monitor and Reassess

HEAT EXHAUSTION
Elevated body temperature
Cool, moist skin
Weakness, Anxious, Tachypnea

HEAT STROKE
Fever, usually > 104°F (40°C)
Hot, dry skin
Hypotension, AMS / Coma

- Age Appropriate Airway Protocol(s) AR 1 - 7 ***as indicated***
- Altered Mental Status Protocol UP 4 ***as indicated***
- Active cooling measures Target Temp < 102.5° F (39°C)
- B: 12 Lead ECG Procedure
- IV or IO Access Protocol UP 6
- P: Cardiac Monitor
- A: **Normal Saline or Lactated Ringer's Bolus 500 mL IV / IO** Repeat to effect SBP > 90 **Maximum 2 L** **PED: Bolus 20 mL/kg IV / IO** Repeat to effect Age appropriate SBP ≥ 70 + 2 *x* Age **Maximum 60 mL/kg**
- Age Appropriate Hypotension/ Shock Protocol AM 5/ PM 3 ***as indicated***
- Monitor and Reassess

Notify Destination or Contact Medical Control

Toxic-Environmental Protocol Section

Hyperthermia

Pearls

- **Recommended Exam: Mental Status, Skin, HEENT, Heart, Lungs, Neuro**
- **Extremes of age are more prone to heat emergencies (i.e. very young and very old).**
- **Temperature measurement:**
  - **Obtain and document patient temperature if able.**
  - **Many thermometers and routes of measurement are available.**
  - **Order of preference for route of measurement: Rectal > oral > temporal > axillary.**
- Heat illness is predisposed by use of: tricyclic antidepressants, phenothiazines, anticholinergic medications, and alcohol.
- Cocaine, Amphetamines, and Salicylates may elevate body temperatures.
- Intense 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 an altered mental status.
  - Sweating generally disappears as body temperature rises above 104°F (40°C).
  - The young and elderly are more prone to be dry with no sweating.
  - **Exertional Heat Stroke:**
  - **In exertional heat stroke (athletes, hard labor), the patient may have sweated profusely and be wet on exam.**
  - **Rapid cooling takes precedence over transport as early cooling decreases morbidity and mortality.**
  - **If available, immerse in an ice water bath for 20 minutes. Monitor rectal temperature and remove patient when temperature reaches 102.5°F (39°C). Your goal is to decrease rectal temperature below 104°F (40°C) with target of 102.5°F (39°C) within 15 minutes. Stirring the water aids in cooling.**
  - **Nearly 66% of all exertional heat strokes occur in high school athletes during the month of August.**
  - **In NC, it is mandatory that all high school field houses have a dunk tank and available ice and water.**
  - **Other methods include cold wet towels below and above the body or spraying cold water over body continuously.**
- **Neuroleptic Malignant Syndrome (NMS):**
  - Neuroleptic Malignant Syndrome is a hyperthermic emergency which is not related to heat exposure.
  - It occurs after taking neuroleptic antipsychotic medications.
  - This is a rare but often lethal syndrome characterized by muscular rigidity, AMS, tachycardia and hyperthermia.
  - **Drugs Associated with Neuroleptic Malignant Syndrome:**
  - Prochlorperazine (Compazine), promethazine (Phenergan), clozapine (Clozaril), risperidone (Risperdal) metoclopramide (Reglan), amoxapine (Ascendin), and lithium.
  - **Management of NMS:**
  - Supportive care with attention to hypotension and volume depletion.
  - Use benzodiazepines such as diazepam or midazolam for seizures and/ or muscular rigidity.

Hypothermia/ Frostbite

History
- Age, very young and old
- Exposure to decreased temperatures but may occur in normal temperatures
- Past medical history / Medications
- Drug use: Alcohol, barbituates
- Infections/ Sepsis
- Length of exposure/ Wetness/ Wind chill

Signs and Symptoms
- Altered mental status/ coma
- Cold, clammy
- Shivering
- Extremity pain or sensory abnormality
- Bradycardia
- Hypotension or shock

Differential
- Sepsis
- Environmental exposure
- Hypothyroidism
- Hypoglycemia
- CNS dysfunction
  - Stroke
  - Head injury
  - Spinal cord injury

Temperature Measurement Procedure ***if available***

Temperature Measurement should NOT delay treatment of hypothermia

Remove wet clothing
Dry/ Warm Patient

Passive warming measures

Blood Glucose Analysis Procedure

Age Appropriate
Diabetic Protocol AM 2/ PM 2
as indicated

Hypothermia / Frost Bite

Systemic Hypothermia

Localized Cold Injury

Awake with / without AMS

Unresponsive

Pulse

YES

NO

Exit to
Age Appropriate
Cardiac Protocol(s)
See Pearls

General Wound Care

DO NOT Rub Skin to warm
DO NOT Massage
Skin to warm

DO NOT allow refreezing

Age Appropriate
Airway Protocol(s) AR 1 - 7
as indicated

Altered Mental Status
Protocol UP 4
as indicated

Active warming measures

B — 12 Lead ECG Procedure

IV or IO Access Protocol UP 6

A — **Normal Saline or Lactated Ringer's Bolus**
500 mL IV / IO
Repeat to titrate SBP > 90 mmHg
Maximum 2 L
Pediatric: 20 mL / kg IV / IO
Repeat to titrate Age Appropriate SBP ≥ 70 + 2 x Age
Maximum 60 mL / kg

P — Cardiac Monitor

Age Appropriate
Hypotension/ Shock
Protocol AM 5/ PM 3
Multiple Trauma Protocol TB 6
as indicated

Monitor and Reassess

Notify Destination or Contact Medical Control

Toxic-Environmental Protocol Section

Hypothermia/ Frostbite

Pearls

- **Recommended Exam: Mental Status, Heart, Lungs, Abdomen, Extremities, Neuro**
- **NO PATIENT IS DEAD UNTIL WARM AND DEAD (Body temperature ≥ 93.2° F, 32° C.)**
- **Temperature measurement:**
  - **Obtain and document patient temperature if able.**
  - **Many thermometers and routes of measurement are available.**
  - **Order of preference for route of measurement: Rectal > oral > temporal > axillary.**
  - **Many thermometers do not register temperature below 93.2° F.**
- **Hypothermia categories:**
  - Mild 90 – 95° F (32 – 35° C)
  - Moderate 82 – 90° F (28 – 32° C)
  - Severe < 82° F (< 28° C)
- **Mechanisms of hypothermia:**
  - Radiation: Heat loss to surrounding objects via infrared energy (60% of most heat loss.)
  - Convection: Direct transfer of heat to the surrounding air.
  - Conduction: Direct transfer of heat to direct contact with cooler objects (important in submersion.)
  - Evaporation: Vaporization of water from sweat or other body water losses.
- Contributing factors of hypothermia: Extremes of age, malnutrition, alcohol or other drug use.
- If the temperature is unable to be measured, treat the patient based on the suspected temperature.
- **CPR:**
  - **Severe hypothermia may cause cardiac instability and rough handling of the patient theoretically can cause ventricular fibrillation. This has not been demonstrated or confirmed by current evidence. Intubation and CPR techniques should not be with-held due to this concern.**
  - **Intubation can cause ventricular fibrillation, so it should be done gently by the most experienced provider(s).**
  - **Below 86°F (30° C) antiarrhythmics may not work and if given, should be given at increased time intervals. Contact medical control for direction. Epinephrine can be administered.**
  - **Below 86° F (30°C) pacing should not be utilized.**
  - **Consider withholding CPR if patient has organized rhythm or has other signs of life. Contact Medical Control.**
  - **If the patient is below 86° F (30° C) then defibrillate 1 time if defibrillation is required. Deferring further attempts until more warming occurs is controversial. Contact medical control for direction.**
  - **Hypothermia may produce severe bradycardia so take at least 60 seconds to palpate a pulse.**
- **Active Warming:**
  - Remove from cold environment and into warm environment protected from wind and wet conditions.
  - Remove wet clothing and provide warm blankets/ warming blankets.
  - 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.

Marine Envenomation/ Injury

History
- Type of bite/ sting
- Identification of organism
- Previous reaction to marine organism
- Immunocompromised
- Household pet

Signs and Symptoms
- Intense localized pain
- Increased oral secretions
- Nausea/ vomiting
- Abdominal cramping
- Allergic reaction / anaphylaxis

Differential
- Jellyfish sting
- Sea Urchin sting
- Sting ray barb
- Coral sting
- Swimmers itch
- Cone Shell sting
- Fish bite
- Lion Fish sting

Call for help/ additional resources
Stage until scene safe

Contact
Carolinas Poison Control
1-800-222-1222

- General Wound Care Procedure
- A: IV or IO Access Protocol UP 6 ***if indicated***
- P: Cardiac Monitor ***if indicated***
- Drowning Protocol TE 3 ***if indicated***
- Age Appropriate Allergy/ Anaphylaxis Protocol AM 1/ PM 1 ***if indicated***
- Age Appropriate Hypotension/ Shock Protocol AM 5/ PM 3 ***if indicated***
- Pain Control Protocol UP 11 ***if indicated***

Identification of Sea Creature

Jelly Fish
Anemone
Man-O-War

- Immobilize injury
- Lift away tentacles
  Do Not brush or rub
- Immerse in Hot Water
  110 – 114°F (43 - 46°C)
  if available
- Apply Vinegar Rinse
  If available
  Otherwise wash with clean seawater
  DO NOT
  use fresh water or ice

Sting Ray
Lion Fish
Urchin / Starfish

- Immobilize injury
- Remove Barb or Spine
  If large Barb in thorax or abdomen stabilize object
- Immerse in Hot Water
  110 – 114°F (43 - 46°C)
  if available

Large
Organism

- Immobilize injury
- Multiple Trauma Protocol TB 6 ***if indicated***
- Extremity Trauma Protocol TB 4 ***if indicated***

- Monitor and Reassess

Notify Destination or
Contact Medical Control

Toxic-Environmental Protocol Section

Marine Envenomation/ Injury

Pearls

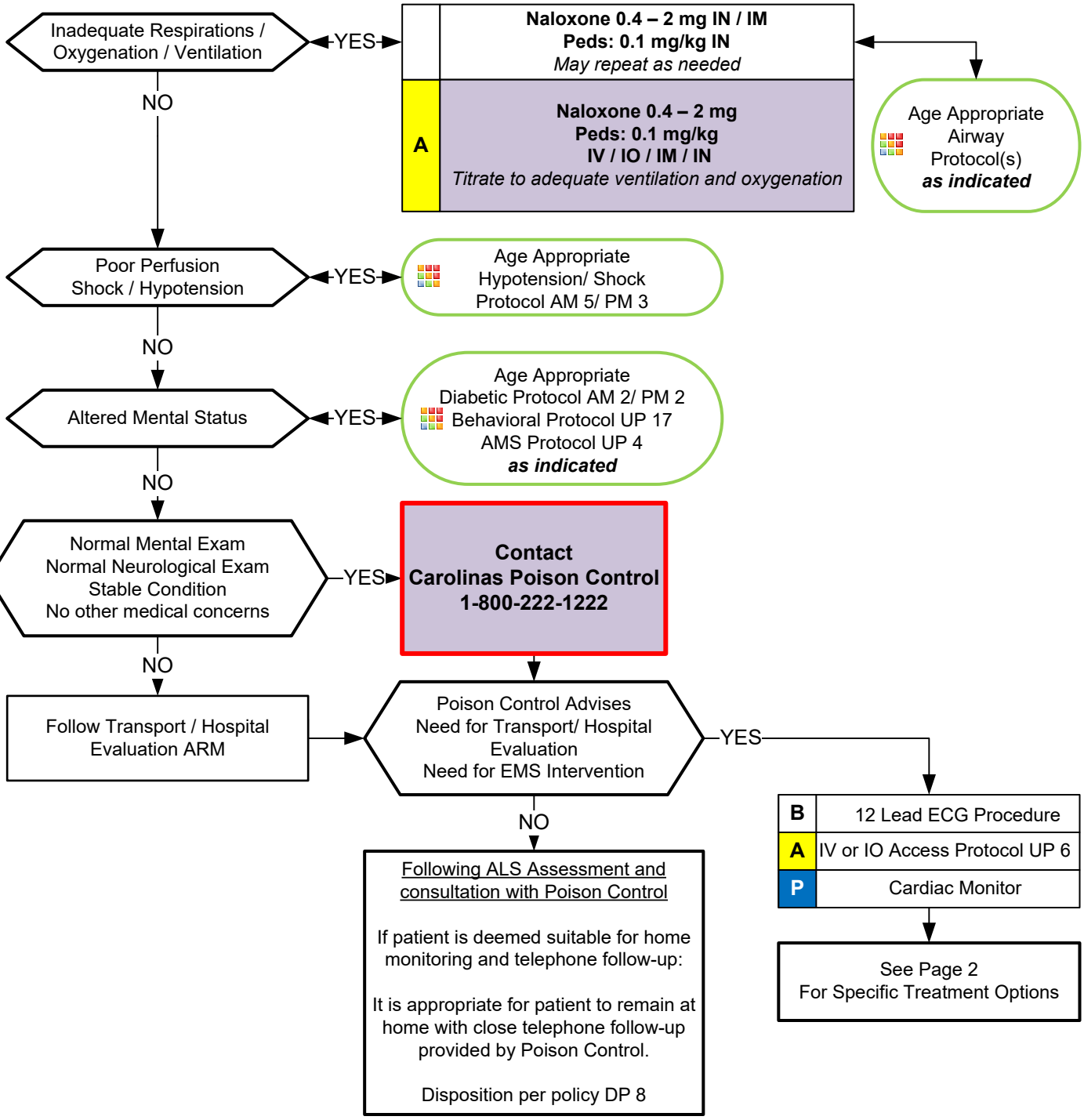
- **Ensure your safety: Avoid the organism or fragments of the organism as they may impart further sting or injury.**
- **Priority is removal of the patient from the water to prevent drowning.**
- **Coral:**
  - Coral is covered by various living organisms which are easily dislodged from the structure.
  - Victim may swim into coral causing small cuts and abrasions and the coral may enter into cuts, causing little if any symptoms initially, but later causing inflammation, pain and/ or infection.
  - The next 24 – 48 hours may reveal an inflammatory reaction with swelling, redness, itching, tenderness, and ulceration.
  - Treatment is flushing with large amounts of fresh water or soapy water then repeating.
- **Jelly Fish/ Anemone/ Man-O-War:**
  - Wash the area with fresh seawater to remove tentacles and nematocysts.
  - Do not apply fresh water or ice as this will cause nematocysts firing as well.
  - Recent evidence does not demonstrate a clear choice of any solution that neutralizes nematocysts.
  - Vinegar (immersion for 30 seconds), 50:50 mixture of Baking Soda and Seawater, and even meat tenderizer may have similar effects.
  - Immersion in warm water for 20 minutes, 110 – 114°F (43 - 46°C), is effective in pain control.
  - Shaving cream may be useful in removing the tentacles and nematocysts with a sharp edge (card).
  - Stimulation of the nematocysts by pressure or rubbing will cause the nematocyst to fire even if detached from the jellyfish.
  - Lift away tentacles as scraping or rubbing will cause nematocysts firing.
  - Typically symptoms are immediate stinging sensation on contact, intensity increases over 10 minutes.
  - Redness and itching usually occur.
  - Papules, vesicles and pustules may be noted and ulcers may form on the skin.
  - Increased oral secretions and gastrointestinal cramping, nausea, pain, or vomiting may occur.
  - Muscle spasm, respiratory, and cardiovascular collapse may follow.
- **Lionfish:**
  - In North Carolina this would typically occur in a residence/ business as lionfish are often kept as pets in saltwater aquariums.
  - Remove any obvious protruding spines and irrigate area with copious amounts of saline.
  - The venom is heat labile so immersion in hot water, 110 – 114°F for 30 to 90 minutes is the treatment of choice but do not delay transport if indicated.
- **Stingrays:**
  - Typical injury is swimmer stepping on ray and muscular tail drives 1 – 4 barbs into victim.
  - Venom released when barb is broken.
  - Typical symptoms are immediate pain which increases over 1 – 2 hours.
  - Bleeding may be profuse due to deep puncture wound.
  - Nausea, vomiting, diarrhea, muscle cramping, and increased urination and salivation may occur.
  - Seizures, hypotension, and respiratory or cardiovascular collapse may occur.
  - Irrigate wound with saline. Extract the spine or barb unless in the abdomen or thorax, Contact Medical Control for advice.
  - Immerse in hot water, 110 – 114°F if available, for 30 to 90 minutes but do not delay transport.
- Patients can suffer cardiovascular collapse from both the venom and/ or anaphylaxis even in seemingly minor envenomation.
- Sea creature stings and bites impart moderate to severe pain.
- Arrest the envenomation by inactivation of the venom as appropriate.
- Ensure good wound care, immobilization and pain control.

Overdose/ Toxic Ingestion

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
- Hypotension / hypertension
- Decreased respiratory rate
- Tachycardia, dysrhythmias
- Seizures
- S.L.U.D.G.E.
- D.U.M.B.B.E.L.S

Differential
- Tricyclic antidepressants (TCAs)
- Acetaminophen (Tylenol)
- Aspirin
- Depressants
- Stimulants
- Anticholinergic
- Cardiac medications
- Solvents, Alcohols, Cleaning agents
- Insecticides (organophosphates)



Toxin-Environmental Protocol Section

Overdose/ Toxic Ingestion

Acetaminophen
Tylenol®
APAP Containing Product

NO

Aspirin
Salicylate Containing Product

YES

NO

Beta Blocker

NO

Calcium Channel Blocker

YES

NO

Cyanide/
Carbon Monoxide

YES → Exit to Carbon Monoxide/ Cyanide Protocol TE 2

NO

Organophosphate
WMD/ Nerve Agent Exposure

YES → Exit to WMD/ Nerve Agent Protocol TE 8

NO

Tricyclic
Antidepressant

YES →

P **QRS ≥ 0.12 sec or Peds: 0.09 sec**
Sodium Bicarbonate
50 mEq IV / IO
Peds: 1 mEq/kg IV / IO
Repeat in 10 minutes as needed

A **Treat if symptomatic:**
Heart Rate < 50 or SBP < 90 mmHg or AMS

A **Glucagon is preferred agent in Beta Blocker Overdose**

Glucagon 2 – 4 mg IV / IO / IM
Peds: 0.1 mg/kg IV / IO / IM
May repeat in 15 minutes as needed

P **Calcium administered if no improvement with Glucagon**

Calcium is preferred agent in Calcium Channel Blocker Overdose

Calcium Gluconate 2 g IV / IO
Or
(Calcium Chloride 1 g IV / IO)
Pediatric: 20 mg / kg IV / IO
Over 2 - 3 minutes

A **Glucagon administered if no improvement with Calcium**

P Consider
Cardiac External Pacing Procedure for Severe Cases

Age Appropriate Hypotension/ Shock
Protocol AM 5/ PM 3
if indicated

Symptomatic Care
as needed

Monitor and Reassess

Notify Destination or
Contact Medical Control

Toxin-Environmental Protocol Section

Overdose/ Toxic Ingestion

Pearls

- **Recommended Exam: Mental Status, Skin, HEENT, Heart, Lungs, Abdomen, Extremities, Neuro**
- **Opioids and opiates may require higher doses of Naloxone to improve respiration, in certain circumstances up to 10 mg.**
- **Time of Ingestion:**
  1. **Most important aspect is the TIME OF INGESTION, the substance(s), amount ingested, and any co-ingestants.**
  2. **Every effort should be made to elicit this information before leaving the scene.**
- **Do not rely on patient history of ingestion, especially in suicide attempts. Make sure patient is still not carrying/ hiding other medications or has any weapons.**
- **Pediatric:**
  Age specific blood pressure 0 – 28 days > 60 mmHg, 1 month - 1 year > 70 mmHg, 1 - 10 years > 70 + (2 x age)mmHg and > 10 years > 90 mmHg.
  Pediatric IV Fluid maintenance rate:
  4 mL for the first 10 kg of weight +
  2 mL for the second 10 kg of weight +
  1 mL for every additional kg in weight after 20 kg
- **Bring bottles, contents, emesis to ED.**
- **S.L.U.D.G.E: Salivation, Lacrimation, Urination, Defecation, GI distress, Emesis.**
- **D.U.M.B.B.E.L.S: Diarrhea, Urination, Miosis, Bradycardia, Bronchorrhea, Emesis, Lacrimation, Salivation.**
- **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.
- **Aspirin**: Early signs consist of abdominal pain and vomiting. Tachypnea and altered mental status may occur later. Renal dysfunction, liver failure, and or cerebral edema among other things can take place later.
- **Depressants:** decreased HR, decreased BP, decreased temperature, decreased respirations, non-specific pupils.
- **Stimulants:** increased HR, increased BP, increased temperature, dilated pupils, seizures.
- **Anticholinergic:** increased HR, increased temperature, dilated pupils, mental status changes.
- **Cardiac Medications:** dysrhythmias and mental status changes.
- **Solvents:** nausea, coughing, vomiting, and mental status changes.
- **Insecticides:** increased or decreased HR, increased secretions, nausea, vomiting, diarrhea, pinpoint pupils.
- **Nerve Agent Antidote kits** contain 2 mg of Atropine and 600 mg of pralidoxime in an autoinjector for self administration or patient care. These kits may be available as part of the domestic preparedness for Weapons of Mass Destruction.
- **EMR and EMT may administer naloxone by IN / IM route only and may administer from EMS supply. Agency medical director may require Contact of Medical Control prior to administration and may restrict locally.**
- **When appropriate contact the North Carolina Poison Control Center for guidance, reference Policy 18.**
- Consider restraints if necessary for patient's and/or personnel's protection per the Restraint Procedure.

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WMD-Nerve Agent Protocol

History
- Exposure to chemical, biologic, radiologic, or nuclear hazard
- Potential exposure to unknown substance/hazard

Signs and Symptoms
- **S**alivation
- **L**acrimation
- **U**rination; increased, loss of control
- **D**efecation / Diarrhea
- **G**I Upset; Abdominal pain / cramping
- **E**mesis
- **M**uscle Twitching
- Seizure Activity
- Respiratory Arrest

Differential
- Nerve agent exposure (e.g., VX, Sarin, Soman, etc.)
- Organophosphate exposure (pesticide)
- Vesicant exposure (e.g., Mustard Gas, etc.)
- Respiratory Irritant Exposure (e.g., Hydrogen Sulfide, Ammonia, Chlorine, etc.)

Call for help/ additional resources
Stage until scene safe

Obtain history of exposure
Observe for specific toxidromes
Initiate triage and/or decontamination as indicated.

Contact
Carolinas Poison Control
1-800-222-1222

Symptom Severity

Asymptomatic
Monitor and Reassess
Every 15 minutes for symptoms
Initiate Treatment per Appropriate Arm

Minor Symptoms:
Respiratory Distress + SLUDGEM

A	IV or IO Access Protocol UP 6
	Nerve Agent Kit IM **2 Doses Rapidly** ***if available***

Major Symptoms:
Altered Mental Status, Seizures, Respiratory Distress, Respiratory Arrest

A	IV or IO Access Protocol UP 6
	Nerve Agent Kit IM **3 Doses Rapidly** ***if available***
P	**Atropine 2 mg IV / IO / IM** **Pediatric: See Pearls** **IV / IO / IM** Repeat every 3 to 5 minutes until symptoms resolve
P	**Pralidoxime (2PAM)** **600 mg IV / IO / IM** **Pediatric: 15 – 25 mg / kg** **IV / IO / IM** Over 30 minutes
	Seizure Protocol UP 13

CDC/ ASPR
CHEMPACK Program
NC -57 EMS containers
-43 locations

Almost all citizens within 50 miles of CHEMPACK
See Page 2 and Pearls

Multiple Patients — YES → Consider Activation and deployment of CHEMPACK
CHEMPACK ACTIVATION:
Contact ARMC Pharmacy 1st (336)538-7799
Contact Cone EM 2nd (704)202-0340
If no answer contact Cone EM On-Call (336)832-8800
Healthcare Coalition Activation:
Contact UNC MCRHC (919)883-8948

NO

Notify Destination or Contact Medical Control

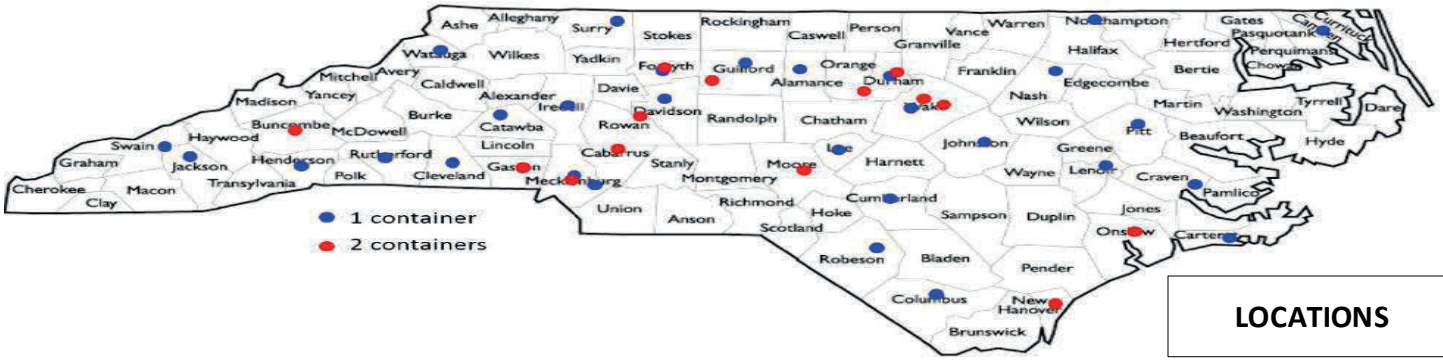
Toxic-Environmental Protocol Section

WMD-Nerve Agent Protocol

Pearls

- **Recommended Exam: Mental Status, Skin, HEENT, Heart, Lungs, Gastrointestinal, Neuro**
- **Follow local HAZMAT protocols for decontamination and use of personal protective equipment.**
- **Adult/ Pediatric Atropine Dosing Guides:**
  - **Confirmed attack: Begin with 1 Nerve Agent Kit for patients less than 7 years of age, 2 Nerve Agent Kits from 8 to 14 years of age, and 3 Nerve Agent Kits for patients 15 years of age and over.**
  - **If Triage/ MCI issues exhaust supply of Nerve Agent Kits, use pediatric atropines (if available).**
  - **Usual pediatric doses: 0.5 mg ≤ 40 pounds (18 kg), 1 mg dose if patient weighs between 40 to 90 pounds (18 to 40 kg), and 2 mg dose ≥ 90 pounds (≥ 40 kg).**
- **Each Nerve Agent Kit contains 600 mg of Pralidoxime (2-PAM) and 2 mg of Atropine.**
- **Seizure Activity: Any benzodiazepine by IV / IO / IM is acceptable.**
- For patients with major symptoms, there is no limit for atropine dosing.
- Carefully evaluate patients to ensure they do not have exposure to other agent(s) (e.g., narcotics, vesicants, etc.)
- The main symptom that the atropine addresses is excessive secretions, so atropine should be given until secretions improve/ dry.
- EMS personnel, public safety officers and EMR/ EMT may carry, self-administer, or administer atropine/ pralidoxime to others by protocol. Agency medical director may require Contact of Medical Control prior to administration.
- **CHEMPACK Program:**
  - For multiple patients, call for **CHEMPACK** deployment per local emergency management and **healthcare coalition plans.**
  - **1 EMS CHEMPACK supports 454 patients.**
  - Medication in CHEMPACK may be used regardless of expiration date.

EMS Type CHEMPACK Container 454 Person Treatment Capacity			
Product	**Cases**	**Units per case**	**Total Units**
Mark 1 Auto-injector	5	240	1,200
-OR			
ATNAA Auto-injector	6	200	1,200
-OR-			
Atropen 2mg Auto-injector	9	136	1,224
Pralidoxime 300mg Auto-injector	5	240	1,200
-AND-			
Diazepam 10mg Auto-injector	2	300	600
Seizalam (Midazolam) 5mg/ml vial 10ml	1	100	100
Atropen 0.5mg Auto-injector	1	225	225
Atropen 1mg Auto-injector	1	225	225
Atropine Sulfate 0.4mg/ml vial 20ml	1	100	100
Pralidoxime 1gm inj. 20ml	1	276	276
Sterile Water 20ml vials	1	150	150



LOCATIONS

Suspected Viral Hemorrhagic Fever
Ebola

EMS Dispatch Center

1. Use Emerging Infectious Disease (EID) Surveillance Tool with the following chief complaints:
   - **Typical Flu-Like Symptoms**
     and/or
   - **Unexpected Bleeding**
     (not trauma or isolated nose bleed related)

2. Use EID Card (or equivalent) with the following protocols (or equivalent)
   - EMD 6 Breathing Problem
   - EMD 10 Chest Pain
   - EMD 18 Headache
   - EMD 21 Hemorrhage (medical)
   - EMD 26 Sick Person

3. Ask the following:
   - In the past 21 days have you been to Africa or been exposed to someone who has?
   - If YES:
   - Do you have a fever?

Evolving Protocol:
Protocol subject to change at any time dependent on changing outbreak locations.

Monitor for protocol updates.

Viral Hemorrhagic Fevers:
Ebola is one of many.

YES → **DO NOT DISPATCH FIRST RESPONDERS**

Dispatch EMS Unit only
Discretely notify EMS Supervisor or command staff

NO

EMS

Do not rely solely on EMD personnel to identify a potential viral hemorrhagic fever patient – constrained by time and caller information

Obtain a travel history / exposure history and assess for clinical signs and symptoms

EMS Immediate Concern

1. Traveler from area with known VHF (Ebola) with or without symptoms
2. Traveler from a Country, with active Ebola outbreak, within past 21 days

AND

Fever, Headache	Joint and Muscle aches	Weakness, Fatigue
Vomiting and/or Diarrhea	Abdominal Pain	Anorexia
Bleeding		

NO → Exit to Appropriate Protocol(s)

YES

EMS Personal Protective Equipment → Refer to page 2
Place surgical mask on patient
Use Non-rebreather mask if Oxygen Needed
Donning and Doffing Guidelines

NO Routine Aerosol Generating Procedures → Avoid aerosol generating procedures unless medically necessary
NIPPV (CPAP) / Nebulizer therapy / Intubation / BIAD / Suctioning

No Routine IV or IO Lines → Avoid routine IV or IO access unless medically necessary
If IV / IO necessary:
Stop vehicle to lessen exposure risk

EMS Personnel / Equipment / Transport Unit Requires Decontamination → Refer to Page 3

Notify Destination as soon and as discretely as possible
DO NOT ENTER facility with patient until instructed
Follow entry directions from hospital staff

Special Circumstances Section

Suspected Viral Hemorrhagic Fever
Ebola

PARTICULAR ATTENTION MUST BE PAID TO PROTECTING MUCOUS MEMBRANES OF THE EYES, NOSE, and MOUTH FROM SPLASHES OF INFECTIOUS MATERIAL OR SELF INOCULATION FROM SOILED PPE / GLOVES.
THERE SHOULD BE NO EXPOSED SKIN

DONNING PPE: **BEFORE** you enter the patient area.

Recommended PPE

PAPR: A PAPR with a full face shield, helmet, or headpiece. Any reusable helmet or headpiece must be covered with a single-use (disposable) hood that extends to the shoulders and fully covers the neck and is compatible with the selected PAPR.

N95 Respirator: Single-use (disposable) N95 respirator in combination with single-use (disposable) surgical hood extending to shoulders and single-use (disposable) full face shield. If N95 respirators are used instead of PAPRs, careful observation is required to ensure healthcare workers are not inadvertently touching their faces under the face shield during patient care.

Single-use (disposable) fluid-resistant or impermeable gown that extends to at least mid-calf or coverall without integrated hood. Coveralls with or without integrated socks are acceptable.

Single-use (disposable) nitrile examination gloves with extended cuffs. Two pairs of gloves should be worn. At a minimum, outer gloves should have extended cuffs.

Single-use (disposable), fluid-resistant or impermeable boot covers that extend to at least mid-calf or single-use (disposable) shoe covers. Boot and shoe covers should allow for ease of movement and not present a slip hazard to the worker.

Single-use (disposable) fluid-resistant or impermeable shoe covers are acceptable only if they will be used in combination with a coverall with integrated socks.

Single-use (disposable), fluid-resistant or impermeable apron that covers the torso to the level of the mid-calf should be used if Ebola patients have vomiting or diarrhea. An apron provides additional protection against exposure of the front of the body to body fluids or excrement. If a PAPR will be worn, consider selecting an apron that ties behind the neck to facilitate easier removal during the doffing procedure.

DOFFING PPE: OUTSIDE OF PPE IS CONTAMINATED! DO NOT TOUCH

1) PPE must be carefully removed without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials.
Use great care while doffing your PPE so as not to contaminate yourself (e.g. Do not remove your N-95 facemask or eye protection BEFORE you remove your gown). There should be a dedicated monitor to observe donning and doffing of PPE. It is very easy for personnel to contaminate themselves when doffing. A dedicated monitor should observe doffing to insure it is done correctly. Follow CDC guidance on doffing.
2) PPE must be double bagged and placed into a regulated medical waste container and disposed of in an appropriate location.
3) Appropriate PPE must be worn while decontaminating / disinfecting EMS equipment or unit.
3) Re-useable PPE should be cleaned and disinfected according to the manufacturer's reprocessing instructions.

Hand Hygiene should be performed by washing with soap and water with hand friction for a minimum of 20 seconds.
Alcohol-based hand rubs may be used if soap and water are not available.
EVEN IF AN ALCOHOL-BASED HAND RUB IS USED, WASH HANDS WITH SOAP AND WATER AS SOON AS FEASIBLE.

THE USE OF GLOVES IS NOT A SUBSTITUTE FOR HAND WASHING WITH SOAP & WATER

For any provider exposure or contamination contact occupational health.
If the patient is being transported via stretcher then a disposable sheet can be placed over them.

Special Circumstances Section

Pearls

- **Transmission to another individual is the greatest after a patient develops fever. Once there is fever, the viral load in the bodily fluids appears to be very high and thus a heightened level of PPE is required.**
- **Patient contact precautions are the most important consideration.**
- **Incubation period 2-21 days**
- **Ebola must be taken seriously; however using your training, protocols, procedures and proper Personal Protective Equipment (PPE), patients can be cared for safely.**
- When an infection does occur in humans, the virus can be spread in several ways to others. The virus is spread through direct contact (through broken skin or mucous membranes) with a sick person's blood or body fluids (urine, saliva, feces, vomit, and semen) objects (such as needles) that have been contaminated with infected body fluids.
- Limit the use of needles and other sharps as much as possible. All needles and sharps should be handled with extreme care and disposed in puncture-proof, sealed containers. Safety devices must be employed immediately after use.
- **Ebola Information: For a complete review of Ebola go to:**
  http://www.cdc.gov/vhf/ebola/index.html
  https://www.cdc.gov/vhf/ebola/clinicians/emergency-services/ems-systems.html

This protocol has been altered from the original NCCEP Protocol by the local EMS Medical Director

Suspected Viral Hemorrhagic Fever
Ebola

EMS Personal
Requires Decontamination

If EMS personnel are exposured to blood, bodily fluids, secretions, or excretions from a patient with suspected or confirmed Ebola should immediately:

1) Stop working and wash the affected skin surfaces with soap and water.
2) Mucous membranes (e.g., conjunctiva) should be irrigated with a large amount of water or eyewash solution;

EMS Equipment / Transport Unit
Requires Decontamination

1) EMS personnel performing decontamination / disinfection should wear recommended PPE
   When performing Decontamination EMS Personnel MUST wear appropriate PPE, which includes:
   - •Gloves (Double glove)
   - •Fluid resistant (impervious) Tyvek Like Full length (Coveralls)
   - •Eye protection (Goggles)
   - •N-95 face mask
   - •Fluid resistant (impervious)-Head covers
   - •Fluid resistant (impervious)-Shoe / Boot covers
2) Face protection (N-95 facemask with goggles) should be worn since tasks such as liquid waste disposal can generate splashes.
3) Patient-care surfaces (including stretchers, railings, medical equipment control panels, and adjacent flooring, walls and work surfaces) are likely to become contaminated and should be decontaminated and disinfected after transport.
4) A blood spill or spill of other body fluid or substance (e.g., feces or vomit) should be managed through removal of bulk spill matter, cleaning the site, and then disinfecting the site. For large spills, a chemical disinfectant with sufficient potency is needed to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant's active ingredient. An EPA-registered hospital disinfectant with label claims for viruses that share some technical similarities to Ebola (such as, norovirus, rotavirus, adenovirus, poliovirus) and instructions for cleaning and decontaminating surfaces or objects soiled with blood or body fluids should be used according to those instructions.
   (Alternatively, a 1:10 dilution of household bleach (final working concentration of 500 parts per million or 0.5% hypochlorite solution) that is prepared fresh daily (i.e., within 12 hours) can be used to treat the spill before covering with absorbent material and wiping up. After the bulk waste is wiped up, the surface should be disinfected as described in the section above).
5) Contaminated reusable patient care equipment should be placed in biohazard bags (double-bagged) and labeled for decontamination and disinfection.
6) Reusable equipment should be cleaned and disinfected according to manufacturer's instructions by appropriately trained personnel wearing correct PPE.
7) Avoid contamination of reusable porous surfaces that cannot be made single use. Use only a mattress and pillow with plastic or other covering that fluids cannot get through.
8) To reduce exposure, all potentially contaminated textiles (cloth products) should be discarded. This includes non-fluid-impermeable pillows or mattresses. They should be considered regulated medical waste and placed in biohazard red bags. They must be double-bagged prior to being placed into regulated medical waste containers.

Pearls

- **Ebola Information:** For a complete review of Ebola EMS Vehicle Disinfection go to: https://www.cdc.gov/vhf/ebola/clinicians/emergency-services/ems-systems.html

This protocol has been altered from the original NCCEP Protocol by the local EMS Medical Director

Suspected Viral Hemorrhagic Fever
Ebola

Special Circumstances Section

Decedent Known or suspected carrier of VHF / Ebola Requires Transportation

Only personnel trained in handling infected human remains, and wearing full PPE, should touch, or move any Ebola-infected remains.
Handling human remains should be kept to a minimum.

Donning / Doffing PPE

PPE should be in place **BEFORE** contact with the body

1) Prior to contact with body, postmortem care personnel must wear PPE consisting of: surgical scrub suit, surgical cap, impervious Tyvex-Coveralls, eye protection (e.g., face shield, goggles), facemask, shoe covers, and double surgical gloves.

2) Additional PPE (leg coverings,) might be required in certain situations (e.g., copious amounts of blood, vomit, feces, or other body fluids that can contaminate the environment).

PPE should be removed immediately after and discarded as regulated medical waste.

1) Use caution when removing PPE as to avoid contaminating the wearer.

2) Hand hygiene (washing your hands thoroughly with soap and water or an alcohol based hand rub) should be performed immediately following the removal of PPE. If hands are visibly soiled, use soap and water.

Preparation of Body Prior to Transport

1) At the site of death, the body should be wrapped in a plastic shroud. Wrapping of the body should be done in a way that prevents contamination of the outside of the shroud.
2) Change your gown or gloves if they become heavily contaminated with blood or body fluids.
3) Leave any intravenous lines or endotracheal tubes that may be present in place.
4) Avoid washing or cleaning the body.
5) After wrapping, the body should be immediately placed in a leak-proof plastic bag not less than 150 µm thick and zippered closed The bagged body should then be placed in another leak-proof plastic bag not less than 150 µm thick and zippered closed before being transported to the morgue.

Surface Decontamination

1) Prior to transport to the morgue, perform surface decontamination of the corpse-containing body bags by removing visible soil on outer bag surfaces with EPA-registered disinfectants which can kill a wide range of viruses.
2) Follow the product's label instructions. Once the visible soil has been removed, reapply the disinfectant to the entire bag surface and allow to air dry.
3) Following the removal of the body, the patient room should be cleaned and disinfected.
4) Reusable equipment should be cleaned and disinfected according to standard procedures.

Transportation of VHF / Ebola Remains

PPE is required for individuals driving or riding in a vehicle carrying human remains. DO NOT handle the remains of a suspected / confirmed case of Ebola The remains must be safely contained in a body bag where the outer surface of the body bag has been disinfected prior to the transport.

Pearls

- **Ebola Information:** **For a complete review of Handling Remains of Ebola Infected Patients go to:**
  http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html

This protocol has been altered from the original NCCEP Protocol by the local EMS Medical Director

High Consequence Pathogens (March 2023)
(Respiratory Diseases, SARS, MERS-CoV, COVID-19)

EMS Dispatch Center Screening (EIDS Tool) - [Updated March 2023]

When the EIDS Tool is positive:
1. Notify responding unit(s) over the radio of "Positive Screen".

First Responders and EMS Screening

Do not rely solely on EMD personnel to identify a potential exposure patient:

- EMD may be constrained by time and caller information.
- **First arriving provider (FR or EMS):**
  - If call nature allows, send only 1 provider into the scene to complete a quick screen.
  - Stand at a distance of ≥ 6 feet and perform screening questions.
  - Ask patient about any potential COVID-19/Influenza symptoms they may be experiencing. Screen for fever, cough, shortness of breath, or other respiratory symptoms. Other common symptoms to screen for include chills, body aches, sore throat, or sudden loss of taste or smell.
  - **Place mask or covering over patient's mouth and nose** and **provider dons appropriate PPE**. Eye protection and surgical mask or N95 is recommended. First Responders should stage and limit the number of providers entering the scene to that only necessary for care to limit potential exposures. Request additional resources as needed. See Page 5.

Negative
FR or EMS Screening

Exit to Appropriate Protocol(s)

Positive
FR or EMS Screening

EMS PPE

Patient:
- Use non-rebreather mask or nasal cannula with surgical mask
- If unable to tolerate mask, have patient cover mouth and nose when coughing

Providers utilize:
- Follow recommended PPE precautions listed below:
- Eye protection
- Surgical mask {N95 mask (or higher) or PAPR for aerosol-producing treatments}
- Exam gloves
- Face Shield / Goggles (aerosol generating)
- Disposable gown
- Create negative pressure in care compartment (See Pearls).

Personnel in ambulance cab utilize:
- Surgical mask for driver and passenger

EMS
General Treatment
Considerations

Aerosol generating procedures:
NIPPV(CPAP)/ Nebulizer therapy / Intubation / BIAD / Suctioning / CPR
Using all PPE devices and strategies listed above is STRONGLY RECOMMENDED.
- **Notify receiving facility of infection control requirements prior to arrival.**

Exit to Appropriate Protocol(s)

Special Circumstances Section

High Consequence Pathogens
(Respiratory Diseases, SARS, MERS-CoV, COVID-19)

First Responders and EMS

General precautions for all calls:
With COVID-19 remaining present in our community, **it remains reasonable that all responders consider wearing a surgical mask and gloves on all patient encounters**.

Precautions for COVID-19 or suspected COVID-19:
If patient has been diagnosed with COVID-19 in the past 10 days or has symptoms suspicious for COVID-19 infection, providers should strongly consider utilizing eye protection, surgical mask, and gloves. Gown use may not always be practical, however remains reasonable (especially if direct patient contact.) When performing aerosol generating procedures it is **STRONGLY RECOMMENDED** to use an N95 (or higher) or PAPR, exam gloves, face shield / goggles, and disposable gown.

Paramedics: when an advanced airway is used, the King airway should be preferred with intubation used secondary (especially if COVID-19 is suspected). A brief, less than 10 second, pause of CPR is acceptable during intubation to decrease exposure risk to provider performing. **BVMs and ventilator equipment should be equipped with Viral/HEPA filtration**.

Entering Healthcare Facilities:

Long-term care facilities: Please comply with screening and PPE requests of facilities. They are working to protect a very vulnerable patient population.

High Consequence Pathogens
(Respiratory Diseases, SARS, MERS-CoV, COVID-19)

Pearls

- **Reasonable to wear a surgical mask during the entire duty-shift when not able to maintain social distance of > 6 feet among fellow providers when not engaged in patient care.**
- **Negative Pressure in care compartment:**

  Door or window available to separate driver's and care compartment space:
  Close door/window between driver's and care compartment and operate rear exhaust fan on full.
  No door or window available to separate driver's and care compartment space:
  Open outside air vent in driver's compartment and set rear exhaust fan to full.
  Set vehicle ventilation system to non-recirculating to bring in maximum outside air.
  Use recirculating HEPA ventilation system if equipped.
- **Airborne precautions:**
  Standard PPE with fit-tested N95 mask (or PAPR respirator) and utilization of a gown or coveralls, change of gloves after every patient contact, and strict hand washing precautions. This level is utilized with Aspergillus, SARS/MERS/COVID-19, Tuberculosis, Measles (rubeola) Chickenpox (varicella-zoster), Smallpox, Influenza, disseminated herpes zoster, or Adenovirus/Rhinovirus.
- **Contact precautions:**
  Standard PPE with utilization of a gown or coveralls, change of gloves after every patient contact, and strict hand washing precautions. This level is utilized with GI complaints, blood or body fluids, C diff, scabies, wound and skin infections, MRSA.
  Clostridium difficile (C diff) is not inactivated by alcohol-based cleaners and washing with soap and water is indicated.
- **Droplet precautions:**
  Standard PPE plus a standard surgical mask for providers who accompany patients in the treatment compartment and a surgical mask or NRB O2 mask for the patient.
  This level is utilized when Influenza, Meningitis, Mumps, Streptococcal pharyngitis, Pertussis, Adenovirus, Rhinovirus, and undiagnosed rashes.
- **All-hazards precautions:**
  Standard PPE plus airborne precautions plus contact precautions.
  This level is utilized during the initial phases of an outbreak when the etiology of the infection is unknown or when the causative agent is found to be highly contagious (e.g. SARS, MERS-CoV, COVID-19).

High Consequence Pathogens
(Respiratory Diseases, SARS, MERS-CoV, COVID-19)

Decontamination Recommendations

EMS Personnel Requires Decontamination

Driver:

- Should wear PPE as described when caring for patient.
- Remove all PPE, except mask or PAPR and perform hand hygiene prior to entering cab of vehicle to prevent contamination of driver's compartment. **Cab occupants only need to wear surgical masks if N95 not already used.**

Wash hands:

- Thoroughly after transferring patient care and/or cleaning ambulance

Maintain records:

- All prehospital providers exposed to patient at the scene and during ambulance transport (self-monitoring for symptoms for 14 days is recommended, even if wearing appropriate PPE).
  This does not mean the providers can no longer work.
- List all prehospital provider names (students, observers, supervisors, first response etc.) in the Patient Care Report.

EMS Equipment / Transport Unit Requires Decontamination

Safely clean vehicles used for transport:

- Follow standard operating procedures for the containment and disposal of regulated medical waste.
- Follow standard operating procedures for containing and reprocessing used linen.

Wear appropriate PPE when:

- Removing soiled linen from the vehicle. Avoid shaking the linen.
- Clean and disinfect the vehicle in accordance with agency standard operating procedures.
- All surfaces that may have come in contact with the patient or materials contaminated during patient care (e.g., stretcher, rails, control panels, floors, walls, work surfaces) should be thoroughly cleaned and disinfected using an **EPA-registered disinfectant** appropriate for SARS, MERS-CoV, or coronavirus in healthcare settings in accordance with manufacturer's recommendations.

EMS Provider Exposure Risk and Monitoring Recommendations

Refer to most up to date CDC recommendations.
"Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2"
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Direct any exposure questions to the Alamance County Health Depatment

Mass Vaccination/Immunization Medication Distribution

History

- Follow local public health department criteria for specific immunization or medication administered.
- Patient receiving medication or vaccination must be without evidence of active infection.
- AEMT and Paramedic providers may participate
- EMT may participate when DHHS/NCMB allows special provision during local or state emergency.

Situation

- Local implementation of this protocol must be done as a component of the EMS system's local public health department community immunization or medication distribution program.
- May initiate protocol when a community has limited public health department resources or when local or state health emergency is declared.

B

Review immunization/vaccination or medication guide provided by the local public health department:

- Patient selection criteria per local public health department (may vary)
- Vaccine/immunization or medication indications
- Vaccine/immunization or medication contraindications
- Vaccine/immunization or medication distribution procedure

- EMT may provide vaccinations when DHHS/NCMB allows special provision during local or state emergency.

Confirm patient eligibility for the vaccination or medication including:

- Age
- Medical history
- Contraindications
- Allergies

Eligibility confirmed?

YES

NO

Do not administer:

- Refer to local public health department providers/ officials for further care and instructions.

Allergic Reaction or Complications

- Exit to age appropriate Protocol(s)
- Notify appropriate local public health department provider/ official

B

Administer vaccination or medication:

- Dose dependent on local public health department
- Route dependent on local public health department (PO, IN, IM, IV, SQ)

Administer Over-the-Counter medication and/or vaccination *(if applicable)*:

- Undergo specific "just-in-time" training
- Dose dependent on local public health department
- Route dependent on local public health department (PO, IN, IM). SQ when specified by NCOEMS.
- Complete required local public health department documentation
- Provide post immunization or medication written instructions and monitoring

Special Circumstances Section

Pearls

- **Purpose:**
  Provide protocol driven process for EMS providers to assist with public health immunization or medication distribution initiatives.
- **Documentation of the immunization or medication:**
  Complete using local public health department approved record system.
  Creation of an EMS patient care report is not required and is not required to submit to NCOEMS.
  Must create a log of all patient contacts associated with the immunization or mediation distribution program maintained by the EMS system.
  If local public health department is maintaining a log of all patients, EMS may use the public health log and keep copies in the EMS system.
- Injection site:
  Most common injection site for subcutaneous is tissue of an upper arm; follow procedure USP-4 otherwise.
  Injection volume is limited to 1 - 2 mL per site unless specific guidance is given per local public health department.
  Most common sites for intramuscular injections are upper arm, buttocks, and thighs, follow procedure USP-4.
  Injection volume is limited to 1 mL in the upper arm, unless specific guidance is given per local public health department; follow procedure USP-4 otherwise.
  Injection volume is limited to 2 mL (1 mL in pediatrics) in buttocks an thighs, unless specific guidance is given per local public health department; follow procedure USP-4 otherwise.

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Alamance County EMS System – Monkeypox Guidance

Monkeypox

Introduction

- Monkeypox is a viral disease caused by infection with the monkeypox virus
- Virus is part of the same family of viruses as variola virus (virus causing smallpox)
- Symptoms are like smallpox symptoms, but milder and rarely fatal
- Monkeypox is not related to chickenpox
- Incubation period: 7 – 14 days
- Illness duration: 2 – 4 weeks
    - Can be spread from the time symptoms start until the rash has fully healed and a fresh layer of skin has formed
- Spread
    - Large respiratory droplets
    - Typically, during prolonged, face-to-face contact, or during intimate physical contact
    - Direct contact with lesions
    - Direct contact with bodily fluids or contaminated clothing/bedding
    - Direct contact with infected animals / animal products

Signs and Symptoms

- Fever/chills
    - Typically occurs 1 – 2 days prior to rash development
- Rash
    - Well circumscribed vesicles/pustules
    - May be fluid or pus filled
    - Typically, same size and same stage on a single site
    - Typically, more lesions on extremities and face vs. torso
    - Lesions may occur on palms and soles
    - Lesions scab over & resolve
- Enlarged lymph nodes
- Fatigue
- Headache
- Myalgias

Screening Questions

- Reported contact with person with a similar rash or diagnosed with monkeypox
- Seeking care for rash associated with possible sexually transmitted infection (STI)
- Genital lesions
- Men who have sex with men
- Travel outside U.S. to country with confirmed cases of monkeypox

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Revision: 08/26/2022 - This guidance is intended for the Alamance County EMS System. If it is determined that management decisions must fall outside of this guideline, contact Medical Control with clinical care-related questions or EMS Supervisor (101) for EMS operations-related questions. Credit to Medic (Charlotte, NC) who developed the baseline for this guidance.

Alamance County EMS System – Monkeypox Guidance

Personal Protection Equipment (PPE) - Utilize when providing care for any patient suspected to have symptoms consistent with Monkey Pox

- N95 or equivalent
- Gloves
- Gown
- Eye protection

Prehospital Management

1. When a patient is suspected to have Monkeypox, use **N95, gown, gloves, and eye protection**

2. Screening questions should be noted for patients with a complaint of fever or rash (see above)

3. Surgical mask should be placed on all patients

4. Initial assessment and treatments as guided via **Universal Patient Care (UP1)** protocol

- Perform **patient care and treatment as per standard (traditional) protocols with careful attention to use of appropriate PPE** by EMS system personnel. Airway management, treatments, medications, and resuscitative considerations as per traditional EMS care protocols/practices.

Exposure Risk and Monitoring

- EMS System Personnel with concerns for potential exposure or potential symptoms of Monkeypox should report to:
  - Alamance EMS Staff report to: EMS Supervisor (101)
  - First Responders/Rescue: Report to appropriate administrator or leadership within your organization
- Questions regarding exposure management may be directed to Alamance County Health Department, preferably to:
  - Christie Sykes, RN - Communicable Disease Nursing Supervisor
    Alamance County Health Department
    christie.sykes@alamance-nc.com
    Office: 336-513-2259

Additional Considerations

- Ensure encode to the receiving emergency department includes presumptive suspicion of monkeypox
- Do not shake any potentially contaminated bedding
- Disinfect all surfaces utilizing standard disinfection practices
- Clinical care for monkeypox involves supportive care and isolation practices
- Vaccine may be available for post exposure in high-risk individuals

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Alamance County EMS System – Monkeypox Guidance

Photos of Money Pox Lesions

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Scene Rehabilitation: General

Injury / Illness / Complaint should be treated using appropriate treatment protocol beyond need for oral or IV hydration.

Initial Process
1. Personnel logged into General Rehabilitation Section
2. VS Assessed / Recorded (If HR > 110 then obtain Temp)
   Carbon Monoxide monitoring if indicated
3. Personnel assessed for signs / symptoms
4. Remove PPE, Body Armor, Haz-Mat Suits, Turnout Gear,
   Other equipment as indicated

Significant Injury
Cardiac Complaint: Signs / Symptoms
Respiratory Complaint: Serious Signs / Symptoms
Respiratory Rate < 8 or > 40
Systolic Blood Pressure ≤ 80

YES → Exit to Scene Rehabilitation Responder Protocol

NO

Heat or Cold stress

YES → **HEAT STRESS**

Active Cooling Measures
Forearm immersion, cool shirts, cool mist fans etc.
Rest 10 – 20 Minutes

Rehydration Techniques
12 – 32 oz Oral Fluid over 20 minutes
Oral Rehydration may occur along with Active Cooling Measures
Firefighters should consume 8 ounces of fluid between SCBA change-out

YES → **COLD STRESS**

Active Warming Measures
Dry responder, place in warm area
Hot packs to axilla and / or groin
Rest 10 – 20 minutes

Rehydration Techniques
12 – 32 oz Oral Fluid over 20 minutes
Oral Rehydration may occur along with Active Warming Measures
Firefighters should consume 8 ounces of fluid between SCBA change-out

NO

Reassess responder after 20 Minutes in General Rehabilitation Section
Reassess VS

HR ≥ 110 — YES → Extend Rehabilitation Time Until VS Improve
NO

Temp ≥ 100.6 — YES → Extend Rehabilitation Time Until VS Improve
NO

Temp ≥ 100.6 — YES → Extend Rehabilitation Time Until VS Improve
NO

HR ≥ 110 — YES → Extend Rehabilitation Time Until VS Improve
NO

Responder Cannot Wear Protective Gear
Extend Rehabilitation Time Until VS Improve

Discharge Responder from General Rehabilitation Section
Reports for Reassignment

VITAL SIGN CAVEATS

Blood Pressure:
Prone to inaccuracy on scenes. Must be interpreted in context.

Firefighters have elevated blood pressure due to physical exertion and is not typically pathologic.

Firefighters with Systolic BP ≥ 160 or Diastolic BP ≥ 100 may need extended rehabilitation. However this does not necessarily prevent them from returning to duty.

Temperature:
Firefighters may have increased temperature during rehabilitation.

Special Operations Section

Scene Rehabilitation: General

Pearls

- **Rehabilitation officer has full authority in deciding when responders may return to duty and may adjust rest / rehabilitation time frames depending on existing conditions.**
- **Rehabilitation goals:**
  - **Relief from climatic conditions.**
  - **Rest, recovery, and hydration prior to incident, during, and following incident.**
  - **Active and / or passive cooling or warming as needed for incident type and climate conditions.**
- **May be utilized with adult responders on fire, law enforcement, rescue, EMS and training scenes.**
- **Responders taking anti-histamines, blood pressure medication, diuretics or stimulants are at increased risk for cold and heat stress.**
- **General indications for rehabilitation:**
  - 20-minute rehabilitation following use of a second 30-minute SCBA, 45-minute SCBA or single 60-minute SCBA cylinder.
  - 20-minute rehabilitation following 40 minutes of intense work without SCBA.
- **General work-rest cycles:**
  - 10-minute self-rehabilitation following use of one 30-minute SCBA cylinder or performing 20 minutes of intense work without SCBA.
- **Serious signs / symptoms:**
  - Chest pain, dizziness, dyspnea, weakness, nausea, or headache.
  - Symptoms of heat stress (cramps) or cold stress.
  - Changes in gait, speech, or behavior.
  - Altered Mental Status.
  - Abnormal Vital Signs per agency SOP or Policy / Procedure.
- **Rehabilitation Section:**
  - Integral function within the Incident Management System.
  - Establish section such that it provides shelter / shade, privacy and freedom from smoke or other hazards
  - Large enough to accommodate expected number of personnel.
  - Separate area to remove PPE.
  - Accessible to EMS transport units and water supply.
  - Away from media agencies and spectators / bystanders.

Fire/Rescue Rehabilitation

Any injury, illness, or complaint beyond the need for rest or oral hydration should be treated using an appropriate treatment protocol.

As Safety and the Environment Allow, Remove:
PPE
Body Armor
Chemical Suits
SCBA
Turnout Gear
Other equipment as indicated

Initial Process
1. **Sign In** to Rehabilitation
2. Obtain and Record **Vital Signs**
3. Assess for **Injury, Signs, Symptoms**

Injury, Illness, or Complaint → Yes → Exit to Appropriate Protocol
Move to Treatment Area

No

10 Minute Rest Period and 16 oz fluid PO

Respiratory Rate ≤ 8 or ≥ 40?
Systolic BP ≥ 160, Diastolic ≥ 90?
Heart Rate ≥ 110?

No / Yes

Body Temp ≥ 100.4 F ?

Yes → Additional 10 minute rest and 8 oz fluid PO

No / Yes

All Vital Signs Meet Return Criteria?
HR < 110
Systolic < 160, Diastolic < 100
Resp. Rate 10-20, Pulse Ox ≥ 95%
Temp < 100.4 F
SpCO < 5 (nonsmoker), < 10 (smoker)

Initiate Active Cooling
Measures as Appropriate for Environment and Conditions.

30 Minutes Additional Rest

Consider Transport to Hospital if Not Improving

Active Cooling:
Cool Vest
Cold Towels
Misters
Fans
Forearm Submersion

Yes / No

Sign Out of Rehab

Responder to Report for Reassignment

Exit to Appropriate Protocol
Universal Patient Care
Hyperthermia
Hypothermia
Hypotension

Special Operations Section

Pearls

- **EMS providers overseeing Fire/Rescue Rehab. have authority to decide if responders are not safe to return to duty.**
- **Safety Officer or Fire Department Command shall assure that personnel on scene cycle through Rehab using a"two bottle" / 45 minute rule.**
- **All personnel must (1) rest at least 10 minutes, (2) drink 16 oz of fluid PO, and (3) have vital signs assessed by Rehab providers.**
- **If at any time personnel exhibit concerning signs, symptoms, or injuries follow appropriate protocol(s) and transport for emergency care as indicated.**
- All personnel must be checked in and out of the Rehab area.
- This protocol is to be used for public safety responders, generally firefighters, on the scene of an incident.
- This protocol may be utilized with adult responders on fire, law enforcement, rescue, EMS and training scenes.
- Firefighters with Systolic BP ≥ 160 or Diastolic BP ≥ 90 may required extended Rehab, however this should not necessarily prevent them from returning to duty. Blood pressure readings on scenes may be prone to inaccuracy and should be interpreted in the context that firefighters may have elevated blood pressures due to physical exertion, which is often not pathologic.
- Responders taking anti-histamines, blood pressure medication, diuretics or stimulants are at risk for cold and heat stress.
- Establish section such that it provides shelter, privacy and freedom from smoke or other hazards. The Rehab Section should have ready and clear exits for transport vehicles, food, and water.

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Pediatric
EMS Triage and Destination Plan

Pediatric Patient

* **Any patient less than 16 years of age with a life-threatening illness (Not Trauma)**

Life Threatening Illness

* **Decreased Mental Status (GCS<13)**
* **Non-Responsive Respiratory Distress**
* **Intubation**
* **Post Cardiac Arrest**
* **Non-Responsive Hypotension (shock)**
* **Severe Hypothermia or Hyperthermia**
* **Status Epilepticus**
* **Potential Dangerous Envenomation**
* **Life Threatening Ingestion/Chemical Exposure**
* **Children with Special Healthcare Needs** (and destination choice based on parental request)

The Purpose of this plan is to:

* Rapidly identify pediatric patients who call 911 or present to EMS with a life-threatening illness
* Minimize the time from EMS contact to definitive care
* Quickly diagnose patients with pediatric life-threatening illness for EMS treatment and stabilization
* Rapidly identify the best hospital destination based on symptom onset time, vital signs, response to treatment, and predicted transport time
* Early activation/notification to the hospital prior to patient arrival
* Minimize scene time with a “load and go” approach
* Provide quality EMS service and patient care to the EMS community
* Continuously evaluate the EMS System based on North Carolina’s EMS performance measures

Pediatric Patient with Life Threatening Illness
(Not Trauma/Injury)

Pediatric Patient too unstable to transport beyond closest hospital?

Yes → **Transport to closest Community Hospital Listed**
Early Notification/Activation if Life Threatening

Alamance Regional Medical Center
or
UNC Hillsborough
or
UNC Chatham

No

Pediatric Capable Hospital within a 50 minute EMS transport?

No → (to Community Hospital)

Yes

Transport to closest Pediatric Capable Hospital Listed
Early Notification/Activation

Duke University Medical Center
or
Moses H Cone Hospital
or
UNC Hospital (Chapel Hill)

Pediatric EMS Triage and Destination Plan

Pearls and Definitions

* **All Pediatric Patients with a life-threatening illness must be triaged and transported using this plan. This plan is in effect 24/7/365.**
* **The Trauma and Burn Triage and Destination Plan should be used for all injured patients regardless of age.**
* **All Patient Care is based on the EMS Pediatric Protocol**
* **Pediatric Capable Hospital** = a hospital with an emergency and pediatric intensive care capability including but not limited to:
  * Emergency Department staffed 24 hours per day with board certified Emergency Physicians
  * An inpatient Pediatric Intensive Care Unit (with a physician pediatric intensivist available in-house or on call 24/7/365)
  * Accepts all EMS patients regardless of bed availability
  * Provides outcome and performance measure feedback to EMS including case review
* **Community Hospital** = a local hospital within the EMS System’s service area which provides emergency care but does not meet the criteria of a Pediatric Capable Hospital
* **Pediatric Specialty Care Transport Program** = an air or ground based specialty care transport program that has specific pediatric training and equipment addressing the needs of a pediatric patient that can assume care of a pediatric patient from EMS or a Community Hospital and transport the patient to a Pediatric Capable Hospital.

Alamance County EMS System

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STEMI
EMS Triage and Destination Plan

STEMI Patient
(ST Elevation Myocardial Infarction)

- **Cardiac symptoms greater than 15 minutes and less than 12 hours**

And

- **12 lead ECG criteria of 1 mm ST elevation in 2 or more contiguous leads**

The Purpose of this plan is to:

- Rapidly identify STEMI patients who call 911 or present to EMS
- Minimize the time from onset of STEMI symptoms to coronary reperfusion
- Quickly diagnose a STEMI by 12 lead ECG
- Complete a reperfusion checklist (unless being transported directly to a PCI hospital) to determine thrombolytic eligibility
- Rapidly identify the best hospital destination based on symptom onset time, reperfusion checklist, and predicted transport time
- Early activation/notification to the hospital prior to patient arrival
- Minimize scene time to 15 minutes or less (including a 12 lead ECG)
- Provide quality EMS service and patient care to the EMS Systems citizens
- Continuously evaluate the EMS System based on North Carolina's STEMI EMS performance measures

Active Symptoms of Cardiac Chest Pain
12 Lead ECG Findings = STEMI

PCI Capable Hospital within 30 minutes EMS transport time?

Yes → **Transport to closest PCI Capable Hospital Listed**
Early Notification/Activation

Alamance Regional Medical Center or
Duke University Medical Center or
Moses H Cone Hospital or
UNC Hospital (Chapel Hill)

No

Reperfusion Checklist

Contraindications to Thrombolysis

No → **Closest Non-PCI Hospital within 50 minutes EMS transport time?**

Yes

Air Medical SCTP within 30 minutes of patient's location?

Yes

Activate Air Medical SCTP

Transport to closest PCI Capable Hospital Listed
Early Notification/Activation

Duke University Medical Center
or
UNC Hospital (Chapel Hill)

No (Air Medical SCTP within 30 minutes of patient's location?)

No (Closest Non-PCI Hospital within 50 minutes EMS transport time?)

Yes (Closest Non-PCI Hospital within 50 minutes EMS transport time?)

Transport to closest Non-PCI Hospital Listed
Early Notification/Activation

N/A

STEMI EMS Triage and Destination Plan

Pearls and Definitions

- **All STEMI Patients must be triaged and transported using this plan. This plan is in effect 24/7/365**
- **All Patient Care is based on the EMS Chest Pain and STEMI Protocol**
- **Consider implementing a prehospital thrombolytic program if a STEMI patient cannot reach a hospital within 90 minutes using air or ground EMS transport.**
- **PCI (Percutaneous Coronary Intervention) Capable Hospital** = a hospital with an emergency interventional cardiac catheterization laboratory capable of providing the following services to acute STEMI patients. Free standing emergency departments and satellite facilities are not considered part of the PCI Capable Hospital.
  - 24/7 PCI capability within 30 minutes of notification (interventional cardiologist present at the start of the case)
  - Single Call Activation number for use by EMS
  - Accepts all patients regardless of bed availability
  - Provides outcome and performance measure feedback to EMS including case review
- **Non-PCI Hospital** = a local hospital within the EMS System's service area which provides emergency care, including thrombolytic administration, to an acute STEMI patient but does NOT provide PCI services.
- **Specialty Care Transport Program** = an air or ground based specialty care transport program which can assume care of an acute STEMI patient from EMS or a Non-PCI hospital and transport the patient to a PCI capable hospital.

Alamance County EMS System

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Acute Stroke & Large Vessel Occlusion (LVO)
EMS Triage and Destination Plan

Stroke Patient

* **A patient with symptoms of an acute Stroke as identified by the EMS Stroke Screen**

Time of Symptom Onset

* **Defined as the last witnessed time the patient was symptom free (i.e. the time of onset for a patient awakening with stroke symptoms would the last time he/she was known to be symptom free before the sleep period)**

The Purpose of this plan is to:

* Rapidly identify acute Stroke patients who call 911 or present to EMS
* Minimize the time from onset of Stroke symptoms to definitive care
* Quickly diagnose a Stroke using validated EMS Stroke Screen
* Complete a reperfusion checklist (unless being transported directly to a Stroke Capable Hospital) to determine thrombolytic eligibility
* Rapidly identify the best hospital destination based on symptom onset time, reperfusion checklist, and predicted transport time
* Early activation/notification to the hospital prior to patient arrival
* Minimize scene time to 10 minutes or less
* Provide quality EMS service and patient care to the EMS Systems citizens
* Continuously evaluate the EMS System based on North Carolina's Stroke EMS performance measures

Symptoms of Acute Stroke

Positive Stroke Screen

↓

Positive LVO Screen
(FAST ED greater than or equals 4)

Yes →

"Code Stroke with LVO"
Transport to Closest
Comprehensive Stroke Center
Early Activation

Duke Univ. Medical Center

Moses H. Cone Hospital

Univ. of North Carolina – Chapel Hill

No ↓

"Code Stroke"
Transport to closest Stroke Center
Early Activation

Alamance Regional Medical Center

Duke Univ. Medical Center

Moses H. Cone Hospital

Univ. of North Carolina – Chapel Hill

Stroke EMS Triage and Destination Plan

Pearls and Definitions

* **All Stroke Patients must be triaged and transported using this plan. This plan is in effect 24/7/365**
* **All Patient Care is based on the EMS Suspected Stroke Protocol**
* **Primary Stroke Center** = a hospital that is currently accredited by the Joint Commission as a Primary Stroke Center. Free standing emergency departments and satellite facilities are not considered part of the Primary Stroke Center.
* **Stroke Capable Hospital** = a hospital which provides emergency care with a commitment to Stroke and the following capabilities:
  * CT availability with in-house technician availability 24/7/365
  * Ability to rapidly evaluate an acute stroke patient to identify patients who would benefit from thrombolytic administration
  * Ability and willingness to administer thrombolytic agents to eligible acute Stroke patients
  * Accepts all patients regardless of bed availability
  * Provides outcome and performance measure feedback to EMS including case review
* **Community Hospital** = a local hospital within the EMS System's service area which provides emergency care but does not meet the criteria for a Primary Stroke Center or Stroke Capable Hospital
* **Specialty Care Transport Program** = an air or ground based specialty care transport program which can assume care of an acute Stroke patient from EMS or a Hospital and transport the patient to a Primary Stroke Center.

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Trauma and Burn
EMS Triage and Destination Plan

Trauma or Burn Patient = Any patient with a significant injury or burn (regardless of age)

The Purpose of this plan:

- Rapidly perform Primary and Secondary Survey, measure Vital Signs, and assess level of consciousness.
- Rapidly identify injured patient presenting to the 911 system and minimize time from injury to definitive trauma care.
- Rapidly identify life or limb threatening injuries for EMS treatment and stabilization.
- Rapidly identify most appropriate hospital destination based on time from injury, severity of injury, and estimated transport time.
- Provide early activation/ notification to the receiving hospital of a trauma patient prior to EMS arrival.
- Minimize scene time to ≤ 10 minutes from patient extrication.
- Provide quality EMS service and patient care to citizens within the EMS system.
- Continuously evaluate the EMS system based on NCOEMS performance measures.

AIRWAY BREATHING

- SpO_2 < 90%
- Respiratory Rate < 10 or > 29 breaths/minute
- Respiratory distress or need for respiratory support
- Chest wall instability, deformity, or suspected flail segment

CIRCULATION

Age 10 – 64 years:
- SBP < 90mmHg ***or*** HR > SBP

Age ≥ 65 years:
- SBP < 110mmHg ***or*** HR > SBP

Age 0 – 9 years:
- SBP < 70mmHg + (2 *x* age in years)

HEMORRHAGE

- Active bleeding requiring a tourniquet or Requiring wound packing and continuous pressure
- Penetrating injuries to: Head, neck, chest, back, abdomen; Above elbows or knees
- Suspected skull fracture/ skull deformity
- Suspected pelvic fracture
- Suspected fracture of ≥ 2 bones above elbows or knees
- Crushed, degloved, mangled, or pulseless extremity *(or any pulse deficit)*

Amputation proximal to wrist or ankle

DISABILITY

- GCS Motor Component < 6 (Unable to follow commands)
- Suspected spinal injury with new motor or sensory loss *(or any motor or sensory deficit)*

BURN INJURIES

- Critical or Serious Burns (per Burn Protocol)

Acutely Injured or Burned Patient with Extreme Shock or Unmanageable Airway

Transport to Nearest Hospital for Stabilization unless minimal additional time to Trauma Center

Notify Hospital Early
Consider Air Medical Intercept

ANY SINGLE CRITERIA OR ANY OTHER CRITERIA MET

YES → **Transport to:**
Level 1 Or Level 2 Trauma Center

Duke University Medical Center

Moses Cone

UNC – Chapel Hill

NO → **Transport to closest appropriate facility**

Isolated Burn Injuries

UNC – Chapel Hill

OTHER CRITERIA

High-Risk MVC:
- Partial or complete ejection
- Significant intrusion into passenger space: > 12 inches occupant side or > 18 inches any site; Need for extrication
- Death in passenger compartment
- Vehicle telemetry data consistent with severe injury
- Rider separated from vehicle with significant impact
- Pedestrian/bicycle rider: Ejected, run over, or with significant impact
- Pregnancy > 20 weeks

OTHER CRITERIA

- Fall > 10 feet (all ages)
- **≥ 65 years of age:**

Low level falls with:
- Large Laceration
- Large Hematoma
- Possible Skull Fracture
- New Onset Altered Mental Status
- Loss of Consciousness After Fall

- Anticoagulant use with signs of head injury
- Medically complex patients at baseline

(multiple medical problems/ needs special resources)
- **Pediatrics:**
- Triage preferentially to pediatric capable hospitals
- Suspected child abuse
- Falls with significant head impact when ≤ 5 years of age
- Child (0 – 9) improperly restrained or secured

Trauma EMS Triage and Destination Plan

Trauma and Burn
EMS Triage and Destination Plan

Pearls

- If unstable airway or unstable hemodynamic condition, may divert transport to closest appropriate facility.
- All trauma patients should be triaged and transported using this plan daily.
- Patients not meeting RED or YELLOW criteria should be triaged to most appropriate facility in the usual fashion.
- Expectation: EMS agency will collaborate with their regional Trauma Center/ TRAC resources to establish point-to-point and inter-facility transport workflows for patient requiring higher level of acute care in consideration of potential EMS system impact and regional approach to trauma care.
- Designated Trauma Centers:
  - Hospital currently designated or with provisional level status by NCOEMS.
  - Level I, II, or III designated centers are recognized.
  - Level I and Level II are essentially equivalent in regards to clinical care.
    - Level I may have specialty care not available at Level II, such as limb reimplantation or spinal care/ rehabilitation. Where differences occur, a plan should be addressed with input from regional trauma centers and the TRAC, for appropriate destination choices.
  - Free standing emergency departments are not considered part of the trauma center.
- Burns:
  - Isolated burn patients should be transported to UNC Chapel Hill.
  - Burns with other penetrating or blunt trauma should be transported to UNC Chapel Hill.
- Designated Burn Center:
  - American Burn Association (ABA) verified Burn Center co-located with a designated Trauma Center.
- EMS Transport Times in Destination Decisions:
  - EMS transport times should be set based on collaboration with all trauma centers/ TRAC where EMS agency routinely transports in the regional trauma system.
- Anticoagulants:
  - Warfarin (Coumadin, Jantoven), Apixaban (Eliquis), Rivaroxaban (Xarelto), Edoxaban (Savaysa), Fondaparinux (Arixtra), Heparin (Hep-Lock), Dalteparin (Fragmin), Enoxaparin (Lovenox), Argatroban (Acova), Bivalirudin (Angiomax), Dabigatran (Pradaxa), Desirudin (Iprivask)
- Helicopter EMS (HEMS):
  - There is no clear evidence that define strict criteria as to which patients may benefit from HEMS transport.
  - There is no clear evidence that define transport time considerations when assessing the need for HEMS transport.
  - HEMS service should be incorporated into the regional EMS plan and participate in agency Peer Review.
  - HEMS utilization is strictly a medical decision and while life saving, can be very costly to the patient.
- Considerations when utilizing HEMS:
  - Patients meeting Trauma Triage and Destination RED criteria:
    - When transport times are > 30 – 45 minutes from the Trauma Center.
    - When geographic distance is > 45 minutes from the Trauma Center.
    - When faced with an entangled or entrapped victim, add estimated extrication time to transport time.
- Modality of transport in acute trauma depends on multiple factors, but safest and fastest should be considered, whether ground EMS, air medical EMS, or specialty/critical care ground transport.

Patient Transport
EMS Triage and Destination Plan

Patient Transport

Most patient transports should be non-emergency. On the rare occasion of a life threatening condition and/or time sensitive emergency, emergency transports must be done in a cautious manner and at the discretion of the EMS attendant.

In determining medical facility destination, ARMC is the preferred destination in order to provide care for the immediate patient, while also maintaining ambulance availability for the next patient. Patient transport to a medical facility destination is determined based on the following:

Patient meets criteria for transport via **EMS Triage and Destination Plan?** **(STEMI, Stroke, Trauma/Burn, Pediatric)**

YES → Follow appropriate **EMS Triage and Destination Plan**

NO ↓

Based on **ACEMS provider's clinical judgement, patient assessment, and consideration for diagnosis** is transport to an out-of-county hospital* felt to be indicated? [Consider **consultation with medical control** physician.]

YES → **Offer transport to appropriate out-of-county hospital***

NO ↓

Patient currently **receiving care at an out-of-county hospital* for a concern or diagnosis related** to their current presentation
OR
Patient has a highly specialized condition (LVAD, Total Artificial Heart, organ transplant)

YES → Offer transport to **Patient's hospital of choice***

NO ↓

Transport to:
Alamance Regional Medical Center (ARMC)
Or
UNC-Hillsborough or UNC-Chatham Hospital (Upon patient request and if no further distance than ARMC. See section on limitations of capabilities.)

Patients **will not be refused transport** regardless of injury or illness.

Contact on-duty EMS Supervisor (101) if either ACEMS provider or patient have questions or concerns regarding selection of hospital destination.

*Approved out-of-county hospital destinations are limited to the following unless approved by on-duty EMS Supervisor:
Cone Health – Moses Cone, Wesley Long, Women's and Children's Hospital
Duke – Duke Regional, Duke University Medical Center
UNC – Chapel Hill, Chatham (see section of limited capabilities) Hillsborough (see section of limited capabilities)
VA – Durham

****Resource / Operational Constraints such as, unit availability, weather, hospital diversion, may not allow for transport of a patient to their hospital of choice****

Transports to UNC Hillsborough ED or Chatham Hospital ED

Purpose:

To identify which patients are appropriate to transport to UNC Hillsborough or Chatham Hospital

Plan:

1. EMS Personnel will adhere to the Triage and Destination Plans contained in the ACEMS protocol set.
2. Based on limited capabilities, **NO** patients in any of the following categories will be transported to UNC Hillsborough or Chatham Hospital
    a. Patients meeting the Pediatric, STEMI, Stroke, Trauma and Burn destination plans
    b. Pregnancy related complaint or active labor greater than 19 weeks
    c. Open fractures
    d. Unstable pediatric patients
    e. Renal/Dialysis
    f. Psychiatric
    g. Seizure
3. In rare instances of a failed airway, impending arrest, difficult childbirth or other circumstances when the EMS crew needs urgent assistance AND they are in close proximity of UNC Hillsborough or Chatham Hospital, crews should consider diverting to their ER for stabilization.

4. EMS personnel are ultimately responsible for the best care of the patient including the appropriate destination decision.

Prior to transport of unconscious patients, an effort should be made to obtain identification of the patient.

In cold or inclement weather, patients and/or family members should be encouraged to take shoes, coats, and other clothing to the hospital.

Upon leaving the scene, ACEMS personnel must show their unit transporting and enter the destination on the MCT.

Patient Transport
EMS Triage and Destination Plan

During patient transport, the ACEMS attendant providing patient care must notify the receiving facility by radio and/or recorded phone line through C-COM, the following information, including but not limited to:

- The intention to deliver a patient to their facility
- Pertinent patient care information
- Medical care that has been rendered
- Findings during patient assessment
- Estimated time of arrival

The ACEMS attendant should obtain acknowledgement from the receiving facility and should respond to any questions regarding patient care or acknowledge instructions provided by the receiving facility.

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Criteria for Death / Withholding Resuscitation

Policy:
CPR, BLS and ALS treatment are to be withheld only if the patient is obviously dead (see procedure section) or a valid (*properly completed, signed, dated, and unexpired*) **North Carolina Do Not Resuscitate (DNR)** form and/or **Medical Orders for Scope of Treatment (MOST)** form is present (Disposition Policy 5).

EMS personnel shall also honor a valid **POLST (Physician Orders for Life Sustaining Treatment), POST (Physician Orders for Scope of Treatment), MOST and/or DNR** (*properly completed, signed, dated, and unexpired*) from another state or US military form. NCGS Article 23: 90-320.

Purpose:
The purpose of this policy is to:

- Honor those who have obviously expired prior to EMS arrival.
- To honor the terminal wishes of the patient
- To prevent the initiation of unwanted resuscitation

Procedure:

1. If a patient is in complete cardiopulmonary arrest (clinically dead) and meets one or more of the criteria below, CPR and ALS therapy need not be initiated:

   - Body decomposition
   - Rigor mortis
   - Dependent lividity
   - Injury not compatible with life (i.e., decapitation, burned beyond recognition, massive open or penetrating trauma to the head or chest with obvious organ destruction)
   - Meets criteria established in TB 10 Traumatic Arrest Protocol
   - **A** Extended downtime (> 15 minutes) with Asystole on the ECG

A	Rhythm strip run and uploaded when resuscitation not initiated in patient downtime > 15 minutes

2. If a bystander or first responder has initiated CPR or automated defibrillation prior to Paramedic or AEMT arrival and any of the above criteria (signs of obvious death) are present, the ALS provider may discontinue CPR / resuscitation efforts. All other EMS personnel levels must communicate with medical control prior to discontinuation of the resuscitative efforts unless specifically addressed in DP 3 Discontinuation of Prehospital Resuscitation Policy and/ or TB 10 Traumatic Arrest Protocol.

3. If doubt exists, start resuscitation immediately. Once resuscitation is initiated, continue resuscitation efforts until either:
   a) Resuscitation efforts meet the criteria for implementing the **Discontinuation of Prehospital Resuscitation Policy** (Disposition Policy 3).
   b) Patient care responsibilities are transferred to the destination hospital staff.

Deceased Subjects

Policy:

EMS will handle the disposition of deceased subjects in a uniform, professional, and timely manner.

Purpose:

The purpose of this policy is to:

- Organize and provide for a timely disposition of any deceased subject
- Maintain respect for the deceased and family
- Allow EMS to return to service in a timely manner.

Procedure:

1. Do not remove lines or tubes from unsuccessful cardiac arrests/codes unless directed below.

2. Notify the law enforcement agency with jurisdiction if applicable.

3. If subject was found deceased by EMS, the scene is turned over to law enforcement.

4. If EMS has attempted to resuscitate the patient and then terminated the resuscitative efforts, EMS personnel should contact the primary care provider (medical cases) or medical examiner (traumatic cases or primary care provider unavailable) to provide information about the resuscitative efforts.

   <u>Cases that require notification of the Medical Examiner when death results from:</u>

   Accident — Poisoning
   Homicide — Suicide
   Violence
   Occurring in jail, prison, correctional institution, or in LEO custody
   Occurring under suspicious, unusual, or unnatural circumstances
   Sudden unexpected death when in otherwise good health
   No current primary care or specialty physician care

5. Transport arrangements should be made in concert with law enforcement and the family's wishes.

6. If the deceased subject's death is not under the jurisdiction of the medical examiner, any line(s) or tube(s) placed by EMS should be removed prior to transport.

7. Document the situation, name of primary care provider or Medical Examiner contacted, the patient care report form (PCR).

8. Physician Assistants and/or Nurse Practitioners may sign a North Carolina death certificate when specially authorized by their supervising physician.

9. Follow Disposition Policy 9 Organ Procurement Agency Notification

Discontinuation of Prehospital Resuscitation

Policy:

Unsuccessful cardiopulmonary resuscitation (CPR), basic life support (BLS), and other advanced life support (ALS) interventions may be discontinued prior to transport or arrival at the hospital when this policy is followed.

If resuscitation started by First Responder or EMS, EMT and AEMT must consult Medical Control prior to discontinuation.

Purpose:

The purpose of this policy is to:

- Allow for discontinuation of prehospital resuscitation after the delivery of adequate and appropriate BLS and ALS therapy.

Procedure:

1. Discontinuation of CPR and ALS intervention may be implemented **prior to contact with Medical Control if <u>ALL</u>** of the following criteria have been met:

   - Patient must be **18 years of age or older.**
   - **Adequate CPR** has been administered.
   - Airway has been successfully managed **with verification of device placement utilizing <u>End-Tidal CO_2</u>**. Acceptable management techniques include orotracheal intubation, Blind Insertion Airway Device (BIAD) placement, or cricothyrotomy.
   - IV or IO access has been achieved.
   - Persistent asystole or agonal rhythm is present and no reversible cause identified after a **<u>minimum of 30 minutes of resuscitation</u>**.
   - No evidence or suspicion of any of the following:
     -Hypothermia (body temperature ≤ 93.2°F or 32°C)
   - Rhythm appropriate medications and defibrillation have been administered according to Alamance County EMS Protocols for a total of 3 cycles of drug therapy without return of spontaneous circulation (palpable pulse).
   - All EMS System personnel involved in the patient's care agree that discontinuation of the resuscitation is appropriate.

A	Rhythm strip run and uploaded when resuscitation not initiated in patient downtime > 15 minutes

2. If all of the above criteria are not met and discontinuation of prehospital resuscitation is desired, **contact Medical Control**.

3. The **Deceased Subjects Policy** should be followed.

Document all patient care and interactions with the patient's family, personal physician, medical examiner, law enforcement, and medical control in the EMS patient care report (PCR).

Disposition (Patient Instructions)

Policy:

All patient encounters responded to by EMS will result in the accurate and timely completion of:

- The Patient Care Report (PCR) for all patients transported by EMS
- The Patient Disposition Form for all patients not transported by EMS

Purpose:

To provide for the documentation of:

- The evaluation and care of the patient
- The patient's refusal of the evaluation, treatment, and/or transportation
- The patient's disposition instructions
- The patient's EMS encounter to protect the local EMS system and its personnel from undue risk and liability.

Procedure:

1. All patient encounters, which result in some component of an evaluation, must have a Patient Care Report completed.

2. All patients who refuse any component of the evaluation or treatment, based on the complaint, must have a Disposition Form completed.

3. All patients who are NOT transported by EMS must have a Disposition (patient instruction) Form completed including the Patient Instruction Section.

4. A copy of the Patient Disposition Form should be maintained with the official Patient Care Report (PCR)

North Carolina Do Not Resuscitate and MOST Form

Policy:

CPR, BLS and ALS treatment are to be withheld only if the patient is obviously dead (see procedure section) or a valid (*properly completed, signed, dated, and unexpired*) **North Carolina Do Not Resuscitate (DNR)** form and/or **Medical Orders for Scope of Treatment (MOST)** form is present (Disposition Policy 5).

EMS personnel shall also honor a valid **POLST (Physician Orders for Life Sustaining Treatment), POST (Physician Orders for Scope of Treatment), MOST and/or DNR** (*properly completed, signed, dated, and unexpired*) from another state or US military form. NCGS Article 23: 90-320.

Purpose:

- Honor those who have obviously expired prior to EMS arrival.
- To honor the terminal wishes of the patient
- To prevent the initiation of unwanted resuscitation

Procedure:

1. When confronted with a patient or situation involving the NC DNR and/or MOST form(s), the following form content must be verified before honoring the form(s) request.

    - The form(s) must be either an original North Carolina DNR or North Carolina MOST form
    - The effective date and expiration date must be completed and current
    - The DNR and/or MOST Form must be signed by a physician, physician's assistant, or nurse practitioner.
    - <u>Out-of-state or US military form:</u>
        Must be an original MOST, DNR, POLST (Physician Orders for Life Sustaining Treatment) or POST (Physician Orders for Scope of Treatment).
        The effective date and expiration date must be completed and current
        The DNR and/or MOST Form must be signed by a physician, physician's assistant, or nurse practitioner
2. A valid DNR or MOST form may be overridden by the request of (N.C.G.S. 90-21.13):
    Court appointed guardian
    Health care power of attorney
    Spouse
    Majority of patient's reasonably available parents and/or children who are ≥ 18 years old
    Majority of patient's reasonably available siblings who are ≥ 18 years old
    Patient's attending physician
    *EMS personnel should contact **Medical Control** to obtain assistance and direction if clarification is necessary.*
3. A living will (other legal document) that identifies the patient's desire to withhold CPR or other medical care may be honored with the approval of **Medical Control**. Ideally, consultation with patient's family and personal physician is suggested as time allows.

Patient Without a Protocol

Policy:

Anyone requesting EMS services will receive a professional evaluation, treatment, and transportation (if needed) in a systematic, orderly fashion regardless of the patient's problem or condition.

Purpose:

- To ensure the provision of appropriate medical care for every patient regardless of the patient's problem or condition.

Procedure:

1. Treatment and medical direction for all patient encounters, which can be triaged into an EMS patient care protocol, is to be initiated by protocol.

2. When confronted with an emergency or situation that does not fit into an existing EMS patient care protocol, the patient should be treated by the **Universal Patient Care Protocol** and a **Medical Control Physician** should be contacted for further instructions.

Physician on Scene

Policy:

The medical direction of prehospital care at the scene of an emergency is the responsibility of those most appropriately trained in providing such care. All care should be provided within the rules and regulations of the state of North Carolina.

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.

Opioid Overdose/Misuse

Policy:
Patients who have experienced an opioid overdose/misuse should be offered a variety of options to more appropriately manage their care where available in the community. All care should be provided within the rules and regulations of the state of North Carolina.

Purpose:
- To ensure patients are offered options for treatment of opioid misuse where available.
- Provide harm reduction measures related to opioid misuse.

Procedure:
1. Patients must be over 18 years of age and experienced unintentional overdose or misuse of an opioid medication(s) only. Patients must NOT have experienced cardiac arrest defined as administration of chest compressions by first responders or EMS during the incident.

2. The patient must regain a normal mental status and respiratory effort after the administration of naloxone, NOT have suicidal or homicidal ideations/intentions, and NOT ingested substance(s) for intentional self-harm.

3. Patients who have co-ingested other substances should be treated based on appropriate protocol. Consult Carolina Poison Center at 1-800-222-1222 for advice if needed.

4. Transport to an Emergency Department should be offered to all patients. For patients who decline transport to an Emergency Department, alternative destinations should be offered if available in the community. Options may include assistance with accessing inpatient treatment centers, outpatient facilities, mobile crisis solutions, addiction specialists, and/or other local treatment options.

5. In order to decline transport, the patient must meet the following criteria:
    a) Be 18 years or older
    b) Maintain a GCS of 15 (alert, and oriented to time, place, person, and situation)
    c) Demonstrate decision-making capacity as outlined in Universal Protocol (UP 1) Pearls.

6. If patient declines transport to an Emergency Department, an additional dose of naloxone should be offered by EMS if patient consents to additional treatment. IN administration is preferable to limit the possibility of provider needle stick injury. If patient has no sober and responsible party to monitor them, EMS should offer IM administration of naloxone if patient consents to treatment. If available, a naloxone kit should be left with the patient, family, and/or friends on scene. EMS should provide brief education on how to properly use these kits and refer them to read all package related material and instructions provided by the manufacturer.

7. In addition to naloxone kits, the following items should be offered where possible/available:
    a) Offer to properly dispose of any dirty needles following your agency policy
    b) Provide clean needles/syringes where possible following your agency policy
    c) Refer to a community peer support team if available
    d) Provide literature outlining resources for substance misuse treatment programs in the community

Organ Procurement Organization Notification

Policy:

When cardiopulmonary resuscitation (CPR), basic life support (BLS), and advanced life support (ALS) interventions are withheld or discontinued on scene, EMS will report the death to the appropriate organ procurement organization (OPO) in the county where death occurred in a timely manner. EMS will share pertinent information related to the donation process with the appropriate OPO.

Purpose:

To ensure an OPO is notified of deaths pronounced in the field by EMS in order to:

- Honor the decedent's registered declaration of eye and/or tissue donation.
- Preserve family's opportunity to support eye and/or tissue donation.
- Service the public health by facilitating eye and tissue donation.

Procedure:

EMS will notify the appropriate OPO of deaths pronounced in the field by an EMS provider. Potential donors for referral include all decedents between the ages of newborn to 100 years old.

Essential information to be provided to the OPO includes:

- EMS provider's name, title, EMS agency, and contact information
- Patient demographics (name, DOB, race, height, and weight)
- Decedents last known or seen alive date/ time and EMS time of death pronouncement
- Circumstances of death (notify OPO even if Medical Examiner is or will be involved)
- Medical interventions performed and past medical history of the decendent
- Next of kin name and contact information
- Who is taking custody of the decedent's body (eg. LEO, ME, funeral home, hospital, morgue, etc.)
- EMS **SHOULD NOT** discuss eye and/ or tissue donation with next of kin. OPO coordinators specializing in family bereavement support will attempt to contact appropriate next of kin to offer opportunities for tissue and/ or eye donation.
- Document all patient care and interactions with the patient's family, personal physician, medical examiner, law enforcement, and medical control in the EMS electronic patient care report (ePCR).

Contact information for Organ Procurement Organizations:

HonorBridge 1-800-252-2672

EMS Offload/ Facility Transition of Care

Policy:
EMS represents a valuable community asset and timely availability of transport units is paramount to successful system operations. Turn Around Times after transport destination arrival can often decrease availability of units in the community. It is the expectation that medical facilities will accept care in a timely fashion after arrival of EMS and that EMS will transition care to medical facility staff in a timely manner.

Once EMS arrives at a hospital facility, EMS recognizes that the receiving hospital becomes responsible for patient care and receiving the patient for continued care. The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal law that states once a patient arrives within 250 yards of a hospital's main building(s), the hospital is responsible for care of the patient, and is obligated to perform a medical screening exam. Hospitals are not permitted to delay receiving of a patient(s) due to their EMTALA obligation. If an EMS transport unit arrives on hospital property that has declared diversionary status, the hospital is not relieved of it's EMTALA obligations and must receive the patient.

Purpose:
The purpose of this policy is to:

- Ensure timely transfer of patient care to the receiving medical facility.
- Provide for the transfer of appropriate care information to the receiving facility.
- Ensure adequate number of transport units available to the community is not delayed due to prolonged Turn Around Times at receiving facilities.
- Promote teamwork and collegiality in transferring care of patients between EMS and hospital personnel with the goal of optimal patient care in focus.

Procedure:
1. EMS will provide an oral report to hospital personnel describing patient status, mechanism of injury or illness, vital signs, therapies provided, procedures performed, and response to treatment.
2. Verbal patient report, paper transition of care/ written hand-off report, PCR copy, or ePCR transmission of patient care is provided to hospital personnel at time of transition of care.
   - Demographic information shall be accurate (to the extent known).
   - Summary of care provided.
   - Vital sign summary.
   - Procedures performed summary.
3. Assist in moving patient from EMS manner of conveyance to designated hospital area identified by hospital personnel.
4. Obtain the name and title of the receiving hospital personnel and document in the EMS PCR or ePCR.
5. Attempt to obtain the signature of the receiving hospital personnel and document in the EMS PCR or ePCR.
   - In the event hospital personnel refuse to sign acknowledging receipt of the patient, document the name and title of the hospital personnel and note hospital personnel refused to sign in the narrative portion of the PCR or ePCR or other area designated by agency.

EMS Documentation and Data Quality

Policy:

The complete EMS documentation associated with service delivery and patient care shall be electronically recorded into a Patient Care Report (PCR) within 24 hours of the completion of the EMS event, with an EMS Data Score at/or above the state average.

Definition:

EMS documentation of a Patient Care Report (PCR) is based on the appropriate and complete documentation of the EMS data elements as required and defined within the North Carolina College of Emergency Physician's EMS Standards. Since each EMS event and/or patient scenario is unique, only the data elements relevant to that EMS event and/or patient scenario should be completed.

The EMS Data Score is calculated on each EMS PCR as it is electronically processed into the North Carolina Office of EMS Repository Data Quality Scores and are provided within the Repository. The best possible score is a 100 and with each missing data element a point is deducted from the data quality score.

A complete Patient Care Report (PCR) must contain the following information (as it relates to each EMS event and/or patient):

- Service delivery and crew information regarding the EMS Agency's response
- Dispatch information regarding the dispatch complaint, and EMD card number
- Patient care provided prior to EMS arrival
- Patient assessment as required by each specific complaint based protocol
- Past medical history, medications, allergies, and DNR/MOST status
- Trauma and cardiac arrest information if relevant to the EMS event or patient
- All times related to the event
- All procedures and their associated time
- All medications administered with their associated time
- Disposition and/or transport information
- Communication with medical control
- Appropriate signatures (written and/or electronic)

Purpose:

The purpose of this policy is to:

- Promote timely and complete EMS documentation.
- Promote quality documentation that can be used to evaluate and improve EMS service delivery, personnel performance, and patient care to the county's citizens.
- Promote quality documentation that will decrease EMS legal and risk management liability.
- Provide a means for continuous evaluation to assure policy compliance.

EMS Documentation and Data Quality

Procedure:

The following procedures shall be implemented to assure policy compliance:

1. All patient encounters, which result in an evaluation, must have an EMS Patient Care Report (PCR) completed and documented.

2. The EMS Patient Care Report (PCR) shall be completed as soon as possible after the time of the patient encounter.

3. Verbal patient report, paper transition of care/ written hand-off report, PCR copy, or ePCR transmission of patient care is provided to hospital personnel at time of transition of care.

4. The PCR must be electronically submitted to the Repository within 24 hours of the EMS event or patient encounter's completion. The EMS data quality feedback provided at the time of the electronic submission should be reviewed and when possible, any identified errors will be corrected within each PCR. Each PCR may be electronically resubmitted as many times as needed.

5. The North Carolina OEMS Repository uses errors and warnings as data validity checks to ensure complete and high-quality data during the collection, reporting and submission process. Errors will cause records to fail submission, while warnings will result in point deductions from the EMS Data Quality Score. In case of failed submissions, the agency must try to resolve the reason for the failure as soon as possible. The EMS Data Quality Scores for the EMS system, EMS agency and the individual EMS personnel will be reviewed regularly within the EMS System Peer Review Committee. The EMS Data Quality Scores for the EMS System, EMS Agency, and individual EMS personnel will be reviewed regularly within the EMS System Peer Review Committee.

6. Agencies that are required to submit data elements to the North Carolina Office of EMS should only use vendors that have achieved National Medical Services Information System (NEMSIS) compliance for the current version of elements. The current version of elements that OEMS accepts can be found at https://oems.nc.gov/data.

Documentation of Vital Signs

Policy:

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 insure:

- Evaluation of every patient's volume and cardiovascular status
- Documentation of a complete set of vital signs

Procedure:

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)
    - GCS for Injured Patients

2. When no ALS treatment is provided, palpated blood pressures are acceptable for **REPEAT** vital signs.

3. Based on patient condition and complaint, vital signs may also include:
    - Pulse Oximetry
    - Temperature
    - End Tidal CO2
    - Breath Sounds
    - Level of Response

4. If the patient refuses this evaluation, the patient's mental status and the reason for refusal of evaluation must be documented. A patient disposition form must also be completed.

5. Document situations that preclude the evaluation of a complete set of vital signs.

6. Record the time vital signs were obtained.

7. Any abnormal vital sign should be repeated and monitored closely.

EMS Dispatch Center Time

Policy:

The EMS Dispatch Center Time will be less than 90 seconds, 90% of the time, for all events identified and classified as an emergent or hot (with lights and siren) response.

Definition:

The EMS Dispatch Center Time is defined as the time interval beginning with the time the initial 911 phone call rings at the 911 Communications Center requesting emergency medical services and ending with the dispatch time of the EMS Unit responding to the event.

Purpose:

The purpose of this policy is to:

- Provide the safest and most appropriate level of response to all EMS events within the EMS System.
- Provide a timely and reliable response for all EMS events within the EMS System.
- Provide quality EMS service and patient care to the county's citizens.
- Provide a means for continuous evaluation to assure policy compliance.

Procedure:

The following procedures shall be implemented to assure policy compliance:

1. A public calls into the 911 Communications Center requesting emergency medical assistance will never be required to speak with more than two persons before a formal EMS Unit is dispatched.

2. In EMS Dispatch Centers where Emergency Medical Dispatch (EMD) has been implemented, EMS Units will be dispatched by EMD certified personnel in accordance with the standards developed by the Medical Director and the Emergency Medical Dispatch Protocols.

3. EMS Units will be dispatched hot (with lights and sirens) or cold (no lights and sirens) by the 911 Call Center based on predetermined criteria. If First Responders are dispatched as a component of the EMS response, they should typically be dispatched hot (with lights and sirens).

4. Without question, exception, or hesitation, EMS Units will respond as dispatched (hot or cold). This includes both requests to respond on active calls and requests to "move-up" to cover areas of the System that have limited EMS resources available.

5. EMS Units may, at their discretion, request for a First Responder on Non-First Responder calls in situations where additional resources are required such as manpower, extreme response time of the EMS Unit, need for forcible entry, etc.

EMS Dispatch Center Time

6. EMS Units dispatched with a cold (no lights and sirens) response, will not upgrade to a hot (with lights and sirens) response **UNLESS**:
   - Public Safety personnel on-scene requests a hot (with lights and sirens) response.
   - Communications Center determines that the patient's condition has changed, and requests you to upgrade to a hot (with lights and sirens) response.

7. An EMS Unit may divert from a current cold (no lights and sirens) call to a higher priority hot (with lights and sirens) call **ONLY IF:**
   - The EMS Unit can get to the higher priority call before it can reach the lower priority call. Examples of High Priority Calls: Chest Pain, Respiratory Distress, CVA, etc.
   - The diverting EMS Unit must notify the EMS Dispatch Center that they are diverting to the higher priority call.
   - The diverting EMS Unit ensures that the EMS Dispatch Center dispatches an EMS Unit to their original call.
   - Once a call has been diverted, the next EMS Unit dispatched must respond to the original call. A call cannot be diverted more than one (1) time.

8. Any EMS Dispatch Center Time delays resulting in a prolonged EMS Dispatch Center Time for emergent hot (with lights and sirens) events will be documented in Patient Care Report (PCR) as an "EMS Dispatch Delay" as required and defined in the North Carolina College of Emergency Physicians (NCCEP) EMS Dataset Standards Document.

9. All EMS Dispatch Delays will be reviewed regularly within the EMS System Peer Review Committee.

Drug Assisted Airway

Policy:

Drug Assisted Intubation (DAI) requires an EMS System or Agency to follow these guidelines to ensure that this invasive procedure is performed in a safe and effective manner to benefit the citizens and guest of North Carolina.

Purpose:

The purpose of this policy is to:

- Ensure that the procedure is performed in a safe and effective manner
- Facilitate airway management in appropriate patients

Procedure:

1. In addition to other monitoring devices, Waveform Capnography and Pulse Oximetry are required to perform Drug Assisted Airways and must be monitored throughout the procedure.

2. Two Paramedics or higher-level providers must be present and participate in the airway management of the patient during the procedure.

3. All staff must be trained and signed off by the EMS Medical Director prior to performing Drug Assisted Airways.

4. A printed copy or electronic download from the monitor defibrillator including the pulse oximetry, heart rate, heart rhythm, waveform capnography, and blood pressure must be stored with the patient care report.

5. An EMS Airway Evaluation Form must be completed on all Drug Assisted Airway Attempts.

6. The EMS Airway Evaluation Form must be reviewed and signed by the EMS Medical Director within 14 days of the Drug Assisted Airway attempts.

7. All Drug Assisted Airways must be reviewed by the EMS System or Agency and issues identified addressed through the System Peer Review Committee.

8. A copy of the EMS Airway Evaluation form for each Drug Assisted Airways must be submitted to OEMS Regional Office at the end of each month for state review.

In addition, the NC EMS Airway Evaluation Form has been revised to a one page document to improve provider compliance and promote receiving/confirming physician acceptance.

Not Utilized In Alamance County

Ketamine Program Requirements

Policy:

When administered outside of the AR 3 Airway Drug Assisted Intubation Protocol, an EMS System or Agency must be approved by the State Medical Director and follow the guidelines below when administering Ketamine.

Purpose:

The purpose of this policy is to:

- Ensure that Ketamine is administered in a safe and effective manner
- Facilitate use of Ketamine in appropriate patients
- Establish a reporting mechanism for state review

Procedure:

1. The EMS system or Agency must adopt NCCEP protocols unchanged or submit equivalent protocols for review.

2. Letters of support must be obtained from all receiving hospitals where patients will be delivered after administration. These letters must be submitted to the OEMS prior to approval.

3. All personnel must be trained prior to implementation.

4. All administrations must be reviewed through the established PI/QA Medical Oversight process to include hospital outcome feedback. Concerns identified must be reviewed by the Peer Review/QA committee.

5. NCOEMS reporting:

   a. The EMS system or agency must submit to the OEMS a Ketamine Adverse Outcome Reporting Form and ePCR within 14 days for administrations that result in any of the following;
      1) Cardiac Arrest (pre-hospital or ED)
      2) Unanticipated intubation required after administration (pre-hospital or ED).

*Contact your Regional OEMS Systems Specialist for link to submit adverse outcome reports.

Not Utilized In Alamance County

Saline Conservation Measures

Policy:

IV fluids should be preserved for our most critical patients, due to an urgent supply disruption caused by Hurricane Helene.

Purpose:

Hurricane Helene caused damage and disruption to Baxter International's major manufacturing plant in Marion, NC, and that facility is currently closed. IV fluid product allocations have been implemented by all suppliers for all customers, to include EMS systems, hospitals, and other health care facilities. The primary products affected at the moment are larger "bolus volume" fluids (e.g. 250-1000mL normal saline) while smaller volumes of fluids, diluents, etc, may still be available.

Procedure:

Do not give a saline bolus to a patient unless the patient is hypotensive due to hypovolemia (SBP < 90 for adults, SBP < 70 + 2x age in years for peds) or in shock (shock index > 1, i.e. HR greater than SBP).

The following changes to all state EMS protocols should take effect and last until supply chain inventories improve in the wake of Hurricane Helene:

1. IV fluid boluses (i.e. hanging a bag of 1000mL or 250mL normal saline for the purpose of giving volume) should only be given to patients who are hypotensive or in shock and fluid is indicated (SBP < 90 in an adult, or HR > SBP and hypovolemia is suspected), with rare exceptions.

2. Exceptions to the above include Environmental Heat Emergency patients (temp > 102 due to environment, NOT fever), patients with altered mental status and blood glucose reading "high" on the glucometer, some cardiac arrest patients, and patients being transported to the burn center.

    a. For cardiac arrest, **DO NOT** give cold fluids solely for therapeutic temperature management (TTM) unless the patient is hyperthermic. There is no difference in outcomes whether TTM is started in the field or at the hospital. Some patients in cardiac arrest may benefit from a saline bolus. If you suspect hypovolemia could be a contributing cause of arrest, please follow usual protocol and these patients may receive saline bolus.

    b. Patients that meet criteria to be transported to the burn center may have fluids initiated per protocol. Consider withholding fluids for small burns going to the burn center only due to burn location (e.g. hands, feet, genitalia). This decision can be left up to the receiving facility regarding the use of IV normal saline.

3. Continue to use current protocols and procedures to mix medications requiring fluid dilution (e.g. amiodarone kits). When you start a bag of saline on a patient, if the patient no longer needs the fluid and/or you arrive at the hospital, **DO NOT** disconnect/discard the remainder of the bag. Leave it connected at "KVO" as the hospital will likely continue to use EMS fluids as part of their own conservation measures, if fluid is indicated later for the patient.

There may be patients in whom IV fluid is indicated for critical illness who are not covered by these temporary protocols. If you have a patient that you feel needs IV fluid that does not meet these guidelines, you may contact medical control for further guidance. **DO NOT** administer IV fluid outside of these guidelines without contacting medical control. We will be sure to provide updates and any necessary changes in guidance as the situation evolves.

Child with Special Health Care Needs (NC Kidbase)

Policy:

Medical technology, changes in the healthcare industry, and increased home health capabilities have created a special population of patients that interface with the EMS system. It is important for EMS to understand and provide quality care to children with special health care needs.

Purpose:

The purpose of this policy is to:

- Provide quality patient care and EMS services to children with special health care needs.
- Understand the need to communicate with the parents and caregivers regarding healthcare needs and devices that EMS may not have experience with.
- Promote, request, and use the "Kidbase" form, which catalogs the health care problems, needs, and issues of each child with a special healthcare need.

Procedure:

1. Caregivers who call 911 to report an emergency involving a child with special health care needs may report that the emergency involves a "Kidbase child" (if they are familiar with the NC Kidbase program) or may state that the situation involves a special needs child.

2. Responding EMS personnel should ask the caregiver of a special needs child for a copy of the "Kidbase Form", which is the North Carolina terminology for the Emergency Information Form (EIF).

3. EMS personnel may choose to contact the child's primary care physician for assistance with specific conditions or devices or for advice regarding appropriate treatment and/or transport of the child in the specific situation.

4. Transportation of the child, if necessary, will be made to the hospital appropriate for the specific condition of the child. In some cases this may involve bypassing the closest facility for a more distant yet more medically appropriate destination.

Infant Abandonment

Policy:

Article 5A, “Safe Surrender of Infants”, of the North Carolina General Statute provides a mechanism for unwanted infants to be taken under temporary custody by a law enforcement officer, social services worker, healthcare provider, or EMS personnel if an infant is presented by the parent and are no more than 30 days old. Emergency Medical Services will accept and protect infants who are presented to EMS in this manner, until custody of the child can be released to the Department of Social Services. The provisions of this Article apply exclusively to safely surrendered infants as defined in G.S. 7B-101(19a).

A first responder, including a law enforcement officer, a **certified emergency medical services worker**, or a firefighter shall, without a court order, take into temporary custody an infant reasonably believed to be not more than 30 days of age that is voluntarily delivered to the individual by the infant's parent who does not express an intent to return for the infant.

“An individual who takes an infant into temporary custody under this subsection shall perform any act necessary to protect the physical health and well-being of the infant and shall immediately notify the department of social services. Any individual who takes an infant into temporary custody under this subsection may inquire as to the parents' identities and as to any relevant medical history, but the parent is not required to provide this information.”

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 Newly Born Protocol as appropriate.
3. Initiate other treatment as appropriate and transport to medical facility as per local protocol.
4. Keep infant warm.
5. Call local Department of Social Services or the county equivalent as soon as infant is stabilized.
6. Document protocols, procedures, and agency notifications in the PCR.

EMS Back in Service Time

Policy:

All EMS Units transporting a patient to a medical facility shall transfer the care of the patient and complete all required operational tasks to be back in service for the next potential EMS event within 30 minutes of arrival to the medical facility, 90% of the time.

Definition:

The EMS Back in Service Time is defined as the time interval beginning with the time the transporting EMS Unit arrives at the medical facility destination and ending with the time the EMS Unit checks back in service and available for the next EMS event.

Purpose:

The purpose of this policy is to:

- Assure that the care of each EMS patient transported to a medical facility is transferred to the medical facility staff in a timely manner.
- Assure that the EMS unit is cleaned, disinfected, restocked, and available for the next EMS event in a timely manner.
- Assure that an interim or complete EMS patient care report (PCR) is completed and left with the receiving medical facility documenting, at a minimum, the evaluation and care provided by EMS for that patient (It is acceptable to leave the PreMIS Preliminary Report or equivalent if the final PCR cannot be completed before leaving the facility).
- Provide quality EMS service and patient care to the county's citizens.
- Provide a means for continuous evaluation to assure policy compliance.

Procedure:

The following procedures shall be implemented to assure policy compliance:

1. The EMS Unit's priority upon arrival at the medical facility will be to transfer the care of the patient to medical facility staff as soon as possible.

2. EMS personnel will provide a verbal patient report on to the receiving medical facility staff.

3. EMS personnel will provide an interim (PreMIS Preliminary Report or equivalent) or final Patient Care Report (PCR) to the receiving medical facility staff, prior to leaving the facility, that documents at a minimum the patient's evaluation and care provided by EMS prior to arrival at the medical facility. A complete PCR should be completed as soon as possible but should not cause a delay in the EMS Back in Service Time.

4. The EMS Unit will be cleaned, disinfected, and restocked (if necessary) during the EMS Back in Service Time interval.

5. Any EMS Back in Service Time delay resulting in a prolonged EMS Back in Service Time will be documented in Patient Care Report (PCR) as an "EMS Turn-Around Delay" as required and defined in the North Carolina College of Emergency Physicians (NCCEP) EMS Dataset Standards Document.

6. All EMS Turn-Around Delays will be reviewed regularly within the EMS System Peer Review Committee.

EMS Wheels Rolling (Turn-Out) Time

Policy:

The EMS Wheels Rolling (Turn-out) Time will be less than 90 seconds, 90% of the time, for all events identified and classified as an emergent or hot (with lights and siren) response.

Definition:

The EMS Wheels Rolling (Turn-out) Time is defined as the time interval beginning with the time the EMS Dispatch Center notifies an EMS Unit to respond to a specific EMS event and ending with the time the EMS Unit is moving en route to the scene of the event.

Purpose:

The purpose of this policy is to:

- Provide a timely and reliable response for all EMS events within the EMS System.
- Provide quality EMS service and patient care to the county's citizens.
- Provide a means for continuous evaluation to assure policy compliance.

Procedure:

The following procedures shall be implemented to assure policy compliance:

1. In EMS Dispatch Centers where Emergency Medical Dispatch (EMD) has been implemented, EMS Units will be dispatched by EMD certified personnel in accordance with the standards developed by the Medical Director and the Emergency Medical Dispatch Protocols.
2. The EMS Unit Wheels Rolling (Turn-out) time will be less than 90 seconds from time of dispatch, 90% of the time. If a unit fails to check en route within 2:59 (mm:ss), the next available EMS unit will be dispatched.
3. Without question, exception, or hesitation, EMS Units will respond as dispatched (hot or cold). This includes both requests to respond on active calls and requests to "move-up" to cover areas of the System that have limited EMS resources available.
4. An EMS Unit may divert from a current cold (no lights and sirens) call to a higher priority hot (with lights and sirens) call **ONLY IF:**
   - The EMS Unit can get to the higher priority call before it can reach the lower priority call. Examples of High Priority Calls: Chest Pain, Respiratory Distress, CVA, etc.
   - The diverting EMS Unit must notify the EMS Dispatch Center that they are diverting to the higher priority call.
   - The diverting EMS Unit ensures that the EMS Dispatch Center dispatches an EMS Unit to their original call.
   - Once a call has been diverted, the next EMS Unit dispatched must respond to the original call. A call cannot be diverted more than one (1) time.
5. Any EMS Wheels Rolling (Turn-out) Time delay resulting in a prolonged EMS Response Time for emergent hot (with lights and sirens) events will be documented in Patient Care Report (PCR) as an "EMS Response Delay" as required and defined in the North Carolina College of Emergency Physicians (NCCEP) EMS Dataset Standards Document.
6. All EMS Response Delays will be reviewed regularly within the EMS System Peer Review Committee.

Child Abuse Reporting and Recognition

Policy:

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 excessive 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.

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) and to Alamance County Dept. of Social Services (336)229-2908. After office hours, the child protective services worker on call can be contacted by the Alamance County Communications Center (336)570-6777. While law enforcement may also be notified, North Carolina law (NCGS 7B-301) requires any person or institution who has cause to suspect that any juvenile is abused (physically, mentally and/or sexually), neglected, dependent, or dies due to maltreatment report the suspicion of abuse to DSS. 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.

Standards Policy: System Compliance Policy Section
Domestic Violence (Partner and/or Elder Abuse) Recognition and Reporting

Policy:

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

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 wellbeing 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 patient(s) for any psychological characteristics of abuse, including excessive passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, behavioral disorders, substance abuse, medical non-compliance, or repeated EMS requests. This is typically best done in private with the patient.
2. Assess the patient for any physical signs of abuse, especially any injuries that are inconsistent with the reported mechanism of injury. Defensive injuries (e.g. to forearms), and injuries during pregnancy are also suggestive of abuse. Injuries in different stages of healing may indicate repeated episodes of violence.
3. Assess all patients for signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition.
4. Immediately report any suspicious findings to the receiving hospital (if transported). If an elder or disabled adult is involved, NCGS 108A-102 requires any person having a reasonable suspicion to also contact the Alamance County Department of Social Services (DSS) (336)229-2908. After office hours, the adult social services worker on call can be contacted by the Alamance County Communications Center (336)570-6777.
5. EMS personnel should attempt in private to provide the patient with the phone number of the Alamance County Family Justice Center (336)570-6019, or the **National Domestic Abuse Hotline, 1-800-799-SAFE**.

EMS System Roster Requirements

Policy:

All emergency medical personnel functioning within the Alamance County EMS System shall be entered into their respective agency's North Carolina Office of EMS Continuum roster. It is the responsibility of each agency to maintain the agency's North Carolina Office of EMS Continuum roster.

Definition:

Continuum is a database used by the NC Office of EMS to monitor and provide credentials to EMS personnel, ambulances, and EMS agencies.

The Continuum system tracks and documents EMS personnel education, credentials, disciplinary actions, and contact information. Grades from completed courses are posted within the system by instructors to be referenced by students, EMS agencies, and the state office. The system links with the Administrative Office of the Courts (AOC) allowing background checks to be conducted daily on all personnel.

Continuum also stores ambulance permits, inspection information, and EMS agency permits. Within Continuum, hospital personnel can review vital patient care information from EMS patient care reports (PCR) and link the information to critical data registries such as Trauma and Stroke to improve the delivery of system-wide health care.

Public information can be accessed and viewed for verification of credentials by clicking on "Choose State Public Access: North Carolina" on the bottom of the logon page.

To access Continuum go to: https://continuum.emspic.org/login

Purpose:

The purpose of this policy is to:

- Assure that each member of an agency within the Alamance County EMS System is added to, or removed from their agency's Continuum roster in a timely manner upon their hiring or separation from the agency.
- Provide a means to each agency within the Alamance County EMS System to verify prospective member's NC EMS credential.
- Assure that each agency administrator has a mechanism to be notified of the impending expiration, suspension, or revocation of a member's NC EMS credential.

Procedure:

The following procedures shall be implemented to assure policy compliance:

1. All prospective emergency medical personnel candidates for membership in an agency within the Alamance County EMS System shall have their NC EMS Credential verified in Continuum prior to participating in medical care.

2. All members of an agency within the Alamance County EMS System shall be added to, or removed from their agency's Continuum roster within (5) business days of their hiring or separation from the agency.

EMS Clinical and Safety Review Procedure

Purpose:

To define the procedure for fair and constructive evaluation and provide due process for all ACEMS System personnel regardless of the agency they work for.

Policy Requirements:

- The Medical Director has final authority for the medical care provided by EMS Personnel in Alamance County. The Alamance County Personnel Policy defines the disciplinary process for Alamance County Emergency Medical Services (“ACEMS”) personnel.

- Practicing within the training, credentials, and authority delegated by the ACEMS Medical Director is the individual responsibility of all personnel.

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Disciplinary Process Procedure:

- The disciplinary review process begins with identification of a potential issue including, but not limited to:
  - Noncompliance or deviation from protocol without sufficient documentation as to necessity
  - deviation from medical care policy
  - procedural incompetence
  - adverse patient outcome
  - unusual or unexpected patient problem
  - poor medical decision-making
  - complaint about care
  - non-compliance with continuing education policies

- If an issue is identified, the ACEMS Director will appoint a designee to conduct an investigation which could include, but is not limited to:
  - Review of the PCR
  - Review of written complaints from patients or the public
  - Interviews with other responders who were present

- A Summary of the investigation must be provided to the ACEMS Director.

- Once the investigation is complete, the outcome may include one or more of the following:
  - No action required
  - Supervisory guidance and remediation
  - Medical Review Committee
  - Immediate referral to the medical director for review

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EMS Clinical and Safety Review Procedure

- The Medical Review Committee includes (all members are not required to be present for the committee to conduct business):
  - Alamance County Emergency Medical Services Medical Director
  - Alamance County Emergency Medical Services Director and/or Deputy Director
  - Alamance County Emergency Medical Services Training Officer and/or Quality Manager
  - Alamance County Emergency Medical Services Shift Supervisor or designee
  - Duties
    - Review all material gathered during the investigation
    - Request additional material as needed
    - Meet with the appropriate personnel involved
    - Meet with any other person needed to obtain a complete and unbiased account of the issues
    - Make a determination regarding restorative/corrective action which may include, but not limited to:
      - No action required
      - Supervisory guidance
      - Remediation
      - Documented, Verbal Medical Practice Warning
      - Written Medical Practice Warning
      - Referral to ACEMS or appropriate agency for disciplinary action
      - Suspension of practice privileges for up to 30 calendar days
      - Repeat preceptorship and functional requirements for the approved level
      - Permanent suspension from EMS practice with the ACEMS System
      - Referral to the North Carolina Office of EMS
    - A formal written summary of the findings of the panel must be completed.
  - Pursuant to NCGS 131E-95(b), the proceedings of a medical review committee, the records and materials it produces and the materials it considers shall be **confidential and not considered public records.**

- If the practice privilege of an individual is permanently suspended by the Medical Director, the NC Office of EMS may be notified in writing of the decision.

- Appeals
  - Disciplinary decisions of the ACEMS System resulting from these determinations may be appealed or grieved as outlined in the Personnel Policy.
  - The decision of the medical director is final.

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EMS Clinical and Safety Review Procedure

Suspension of practice privileges may result in further action being taken against an ACEMS employee based on the Alamance County Personnel Policy.

Although the most highly certified medical person on scene is ultimately responsible for the care provided by ACEMS, all providers on scene share in the responsibility for providing excellent patient care.

EMS Practice includes assessment, treatment, and the interpersonal skills necessary to appropriately interact with patients, families, bystanders, and other medical professionals.

Approved by Dr. Mark Quale (Medical Director), July 1, 2022

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State Poison Center

Policy:

The state poison center should be utilized by the 911 centers and the responding EMS services to obtain assistance with the prehospital triage and treatment of patients who have a potential or actual poisoning.

Purpose:

The purpose of this policy is to:

- Improve the care of patients with poisonings, envenomations, and environmental/biochemical terrorism exposures in the prehospital setting.
- Provide for the most timely and appropriate level of care to the patient, including the decision to transport or treat on the scene.
- Integrate the State Poison Center into the prehospital response for hazardous materials and biochemical terrorism responses

Procedure:

1. The 911 call center will identify and if EMD capable, complete key questions for the Overdose/ Poisoning, Animal Bites/Attacks, or Carbon Monoxide/Inhalation/HazMat emergency medical dispatch complaints and dispatch the appropriate EMS services and/or directly contact the State Poison Center for consultation.
2. If no immediate life threat or need for transport is identified, EMS personnel may conference the patient/caller with the Poison Center Specialist at the **State Poison Center at 800-222-1222**. If possible, dispatch personnel should remain on the line during conference evaluation.
3. The Poison Center Specialist at the State Poison Center will evaluate the exposure and make recommendations regarding the need for on-site treatment and/or hospital transport in a timely manner. If dispatch personnel are not on-line, the Specialist will recontact the 911 center and communicate these recommendations.
4. If the patient is determined to need EMS transport, the poison center Specialist will contact the receiving hospital and provide information regarding the poisoning, including treatment recommendations. EMS may contact medical control for further instructions or to discuss transport options.
5. If the patient is determined not to require EMS transport, personnel will give the phone number of the patient/caller to the Poison Center Specialist. The Specialist will initiate a minimum of one follow-up call to the patient/caller to determine the status of patient.
6. Minimal information that should be obtained from the patient for the state poison center includes:
    - Name and age of patient
    - Time of exposure
    - Signs and symptoms
    - Substance(s) involved
    - Any treatment given
7. Minimal information which should be provided to the state poison center for mass poisonings, including biochemical terrorism and HazMat, includes:
    - Substance(s) involved
    - Signs and symptoms
    - Time of exposure
    - Any treatment given

Air Transport

Policy:

For the purposes of this policy, air transport refers to rotary wing aircraft or helicopter (HEMS). HEMS should be considered whenever time-dependent conditions in patient care can be improved by decreasing transport time or by giving advanced care not commonly available from ground EMS services (i.e. blood products, advanced procedures, or advanced monitoring).

Purpose:

The purpose of this policy is to:

- Improve patient care in the prehospital setting by decreasing out of hospital time in time-dependent conditions.
- Allow for expedient transport in time-dependent conditions or mass casualty settings.
- Provide life-saving treatment such as blood products or advanced monitoring.
- Provide more timely access to interventional care in acute Stroke and ST-elevation myocardial infarction (STEMI) patients.
- Time-dependent conditions:
  ST Elevation Myocardial Infarction (STEMI)
  Stroke and Large Vessel Occlusion Stroke
  Moderate to Severe traumatic conditions

Procedure:

There is no clear evidence that define strict criteria as to which patients may benefit or time consideration benefit when assessing the need for HEMS.

Patient transportation via ground EMS should not be delayed to wait for HEMS transportation. If the patient is packaged and ready for transport and HEMS is not on scene, or within a reasonable distance, transportation should be initiated by ground EMS.

Air transport should be considered if any of the following criteria apply:

- High priority patient with > 30 - 45 minute transport times.
- High priority patient with geographic hospital transport distance > 45 miles.
- Entrapped patients with > 20 minute estimated extrication time.
- Multiple casualty incident with red/ yellow tag patients.
- Multi-trauma or medical patient requiring life-saving treatment not available in prehospital environment (i.e., blood transfusion, invasive procedure, operative intervention).
- Time dependent medical conditions such as acute ST-elevation myocardial infarctions (STEMI) or acute Stroke that could benefit from the resources at a specialty center as per the EMS System's Stroke and STEMI Plans.

If a potential need for HEMS is anticipated, but not confirmed, HEMS can be placed on standby (*this significantly decreases flight time without the need for auto-launch*).

If scene conditions or patient situation improves after activation of HEMS, and later determined not to be necessary, ALS personnel or administrative personnel may cancel the request for HEMS.

Minimal Information which should be provided to HEMS include:

- Number and Age of patient(s)
- Weight of patient(s)
- Mechanism of injury or nature of illness.
- Potential hazards or HazMat involvement.

Safe Transport of Pediatric Patients

Policy:

Without special considerations children are at risk of injury when transported by EMS. EMS must provide appropriate stabilization and protection to pediatric patients during EMS transport.

Purpose:

To provide:

- Provide a safe method of transporting pediatric patients within an ambulance.
- Protect the EMS system and personnel from potential harm and liability associated with the transportation of pediatric patients.

Procedure:

1. Drive cautiously at safe speeds observing traffic laws.
2. Tightly secure all monitoring devices and other equipment.
3. Insure that all pediatric patient less than 40 lbs are restrained with an approved child restraint device secured appropriately to the stretcher or captains chair.
3. Insure that all EMS personnel use the available restraint systems during the transport.
4. Transport adults and children who are not patients, properly restrained, in an alternate passenger vehicle, whenever possible.
5. Do not allow parents, caregivers, or other passengers to be unrestrained during transport.
6. NEVER attempt to hold or allow the parents or caregivers to hold the patient during transport.

Transport

Policy:

All individuals served by the EMS system will be evaluated, treated, and 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. All trauma patients with significant mechanism or history for multiple system trauma will be transported as soon as possible. The scene time should be 10 minutes or less.

2. All acute Stroke and acute ST-Elevation Myocardial Infarction patients will be transported as soon as possible. The scene time should be 10 minutes or less for acute Stroke patients and 15 minutes or less (with 12 Lead ECG) for STEMI patients

2. Other 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.

3. No patients will be transported in initial response non-transport vehicles.

4. In unusual circumstances, transport in other vehicles may be appropriate when directed by EMS administration.

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Transport of Patients Requiring Infusion Pumps and/or Mechanical Ventilation by Alamance County Emergency Medical Services – Additional Personnel (RN/RCP) are Required & Transport of Patients Requiring Antibiotics Which Do Not Require a Pump – Revision 8/3/2015

Situation: Alamance County EMS receives occasional requests to transport patients between hospitals with a running infusion pump (IV pump) and/or mechanical ventilation.

Background: Alamance County EMS providers (EMTs and Paramedics) are not trained in the routine use of infusion pumps or mechanical ventilators. In addition, Alamance County EMS providers are only allowed to administer medications carried by the service with an exception for antibiotics which do not require an infusion pump. Oftentimes, medications being run via infusion pumps (examples: heparin, nicardipine, propofol) are not allowed to be used by Alamance County EMS providers. Additionally, Alamance County EMS providers are not routinely trained in the use of mechanical ventilators.

Assessment: It is the desire of Alamance County EMS to provide services to assist in the safe transport of critically ill patients who require time-sensitive transportation between hospitals when no critical care or specialty care transport service is reasonably available. North Carolina's State Trauma and EMS Rules clarify who is authorized to assist in the transport of patients between hospitals via ambulance. Registered Nurses (RN) and Respiratory Care Practitioner (RCP) are allowed by state rules (10A NCAC 13P .0221) to be a part of the patient care team on an ambulance. Because of the expertise required to operate and oversee the use of infusion pumps and mechanical ventilators, Alamance County EMS requires that a registered nurse and/or respiratory care practitioner be present on the transporting care team to transfer a patient on an infusion pump or mechanical ventilator respectively.

Plan:

Infusion Pumps: Alamance County EMS may only transport a patient receiving medication through an infusion pump if a registered nurse (who is qualified in the use of the hospital-supplied infusion pump by the sending hospital) is present and able to provide care to the patient throughout the transfer between hospitals. The registered nurse is responsible for the function of the infusion pump and overseeing the safe delivery of the medication administered through the pump during transport. Orders for appropriate medication infusion rates and titration must be given by the transferring physician.

Mechanical Ventilation: Alamance County EMS may only transport a patient who is receiving mechanical ventilation if a respiratory care practitioner (who is qualified in the use of the hospital-supplied mechanical ventilator by the sending hospital) is present and able to provide care to the patient throughout the transfer between hospitals. The respiratory care practitioner is responsible for the function of the mechanical ventilator and associated respiratory devices (and overseeing correct use and function) plus advanced airway care during transport. Orders for appropriate mechanical ventilation settings must be initiated by the transferring physician.

Transport Safety: Any patient being transported with an infusion pump or mechanical ventilator must be accompanied by at a minimum two Alamance EMS providers, one must be a Paramedic who will also be present to assist in caring for the patient throughout the transfer. The EMS crew (EMT, Paramedic) will handle operation of the EMS stretcher, ambulance, and existing on-board equipment consistent with traditional safety standards utilized by Alamance County EMS. Safety restraints (seat belts, etc.) are to be used at all times within the constraints allowable by patient care activities. An appropriate seat with safety restraint must be available for

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each person onboard the ambulance. Any infusion pumps or mechanical ventilators must be safely secured throughout transport.

Continuation of Antibiotic Infusions: Alamance County EMS Paramedics may continue the administration of antibiotics which do not need an infusion pump during interfacility transfers when clear administration orders are given by the sending physician. The antibiotic infusion must be started by the sending facility. Administration orders must include the **name of the medication**, total **dose**, **route** of administration, and **length** of infusion. The sending physician shall be responsible for assuring correct ordering of antibiotic medications and assuring the patient has no allergies to the antibiotic provided and should notify the transporting paramedic of adverse reactions to monitor for during administration. If ever a question of any adverse reaction occurs (examples: itching, swelling, redness, chest pain, etc.) for a patient receiving an antibiotic infusion, the paramedic shall stop the drug and contact medical control for treatment recommendations. The paramedic must have clear administration orders given by the sending physician and these orders shall be recorded by the paramedic in the patient care report.

Medical Oversight: The transferring hospital/physician is responsible for assuring that any equipment, medications, and personnel (registered nurse or respiratory care practitioner) is qualified and capable of safely accompanying the patient during transport. No patient should be transported on a ventilator or infusion pump without clear orders given, and any question/concerns addressed, by the transferring facilities physician prior to transport. Online medical control is available via radio and phone line through the on-duty emergency physician at Alamance Regional Medical Center.

Full details on qualifications and position statements from the North Carolina Board of Nursing and North Carolina Respiratory Therapy Care Board are available at:

NC Board of Nursing

North Carolina Respiratory Therapy Care Board (www.ncrcb.org)

http://www.ncrcb.org/uploads/declaratoryrulings/Declaratory%20Ruling-%20RCP%20Ground%20Ambulance%20Transport%202014.pdf

Dr. Mark Quale

Alamance County EMS Medical Director

8/3/2015

Airway: BIAD-Combitube

B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications for Blind Insertion Airway Device (BIAD) Use:

- Inability to adequately ventilate a patient with a Bag Valve Mask (BVM) or longer EMS transport distances require a more advanced airway.
- Appropriate intubation is impossible due to patient access or difficult airway anatomy.
- Inability to secure an endotracheal tube in a patient who does not have a gag reflex where at least one failed intubation attempt has occurred.
- Patient must be ≥ 5 feet and ≥16 years of age and must be unconscious.

Procedure:

1. Preoxygenate the patient.
2. Lubricate the tube.
3. Grasp the patient's tongue and jaw with your gloved hand and pull forward.
4. Gently insert the tube until the teeth are between the printed rings.
5. Inflate line 1 (blue pilot balloon) leading to the pharyngeal cuff with 100 cc of air.
6. Inflate line 2 (white pilot balloon) leading to the distal cuff with 15 cc of air.
7. **Ventilate the patient through the longer blue tube**.
   - Auscultate for breath sounds and sounds over the epigastrium.
   - Look for the chest to rise and fall.
8. **If breath sounds are positive and epigastric sounds are negative, continue ventilation through the blue tube. The tube is in the esophagus.**
   - In the esophageal mode, stomach contents can be aspirated through the #2, white tube relieving gastric distention.
9. If breath sounds are negative and epigastric sounds are positive, attempt ventilation through the shorter, #2 white tube and reassess for lung and epigastric sounds. If breath sounds are present and the chest rises, you have intubated the trachea and continue ventilation through the shorter tube.
10. The device is secured by the large pharyngeal balloon.
11. **Confirm tube placement using end-tidal CO_2 detector or esophageal bulb device.**
12. **EtCO2 monitoring is mandatory following placement of a BIAD once available on scene**
13. **It is strongly recommended that an Airway Evaluation Form be completed with any BIAD use.**

- **Endotracheal intubation with a Combitube in Place (Only if ventilation unsuccessful):**
  - If you cannot ventilate with the Combitube in place, you should remove the tube, open and suction the airway, and ventilate with a BVM prior to intubation or re-establishment of another BIAD.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Airway: BIAD King

B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications for Blind Insertion Airway Device (BIAD) Use:

- Inability to adequately ventilate a patient with a Bag Valve Mask or longer EMS transport distances require a more advanced airway.
- Appropriate intubation is impossible due to patient access or difficult airway anatomy.
- Inability to secure an endotracheal tube in a patient who does not have a gag reflex where at least one failed intubation attempt has occurred.
- Patient must be unconscious.

Procedure:

1. Preoxygenate the patient.
2. Select the appropriate tube size for the patient.
3. Lubricate the tube.
4. Grasp the patient's tongue and jaw with your gloved hand and pull forward.
5. Gently insert the tube rotated laterally 45-90 degrees so that the blue orientation line is touching the corner of the mouth. Once the tip is at the base of the tongue, rotate the tube back to midline. Insert the airway until the base of the connector is in line with the teeth and gums.
6. Inflate the pilot balloon with 45-90 ml of air depending on the size of the device used.
7. **Ventilate the patient while gently withdrawing the airway until the patient is easily ventilated**.
8. Auscultate for breath sounds and sounds over the epigastrium and look for the chest to rise and fall.
9. The large pharyngeal balloon secures the device.
10. **Confirm tube placement using end-tidal CO_2 detector.**
11. **EtCO2 and Pulse Oximetry monitoring is mandatory following placement of a BIAD once available on scene.**
12. **Reverify airway placement after every patient move and upon arrival at the emergency department.**
13. **It is strongly recommended that an Airway Evaluation Form be completed with any BIAD use.**

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Airway: BIAD-Laryngeal Mask Airway (LMA)

B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications for Blind Insertion Airway Device (BIAD) Use:

- Inability to adequately ventilate a patient with a Bag Valve Mask or longer EMS transport distances require a more advanced airway.
- Inability to secure an endotracheal tube in a patient who does not have a gag reflex where at least one failed intubation attempt has occurred.
- Appropriate intubation is impossible due to patient access or difficult airway anatomy.
- **This airway does not prevent aspiration of stomach contents.**

Clinical Contraindications:

- Deforming Facial Trauma
- Pulmonary Fibrosis
- Morbid Obesity

Procedure:

1. Select the appropriate tube size for the patient.
2. Check the tube for proper inflation and deflation.
3. Completely deflate the tube prior to insertion.
4. Lubricate with a water-soluble jelly.
5. Pre-Oxygenate the patient with 100% Oxygen
6. Insert the LMA into the hypopharynx until resistance is met.
7. Inflate the cuff until a seal is obtained.
8. Connect the LMA to an ambu bag and assess for breath sounds and air entry.
9. **Confirm tube placement using end-tidal CO_2 detector or esophageal bulb device.**
10. Monitor oxygen saturation with pulse oximetry and heart rhythm with ECG.
11. **EtCO2 monitoring is mandatory following placement of a BIAD once available on scene.**
12. Re-verify LMA placement after every move and upon arrival in the ED.
13. Document the procedure, time, and result (success) on/with the patient care report (PCR)
14. **It is strongly recommended that an Airway Evaluation Form be completed with any BIAD use.**

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation once per certification cycle.

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Airway: BIAD-i-Gel pg. 1/5

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications for Blind Insertion Airway Device (BIAD) Use:

- Inability to adequately ventilate a patient with a Bag Valve Mask or longer EMS transport distances require a more advanced airway.
- Inability to secure an endotracheal tube in a patient who does not have a gag reflex.
- Appropriate intubation is impossible due to patient access or difficult airway anatomy.
- Do not leave in place for ≥ 4 hours.

Clinical Contraindications:

- Deforming Facial Trauma

Procedure:

1. Pre-Oxygenate the patient with 100% Oxygen
2. Select the appropriate tube size for the patient.
3. Open the sachet of supplied lubricant and place a small bolus onto the middle of the smooth surface of the protective cradle in preparation for lubrication. Do not use silicone based lubricants.

4. Grasp the i-gel O_2 with the opposite (free) hand along the integral bite block and lubricate the back, sides, and front of the cuff with a thin layer of lubricant.

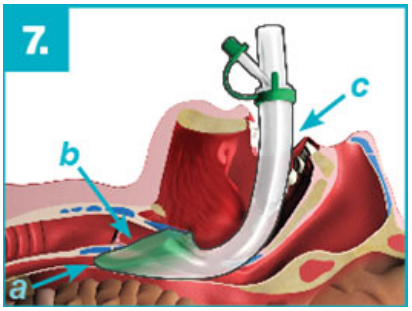
5. Place the i-gel O_2 back into the protective cradle in preparation for insertion.

Airway: BIAD-i-Gel pg. 2/5

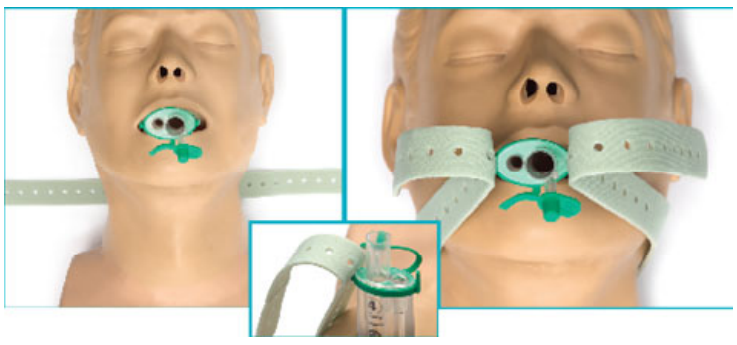
	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

6. Remove the i-gel O_2 from the protective cradle. Grasp the lubricated i-gel O_2 firmly along the integral bite block. Position the device so that the i-gel O_2 cuff is facing towards the chin of the patient. The patient should be in the sniffing position with head extended and neck flexed. The chin should be gently pressed down before proceeding. Introduce the leading soft tip into the mouth of the patient in a direction towards the hard palate.

7. Glide the device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt. The tip of the airway should be located into the upper esophageal opening (a) and the cuff should be located against the laryngeal framework (b). The incisors should be resting on the integral bite block (c).

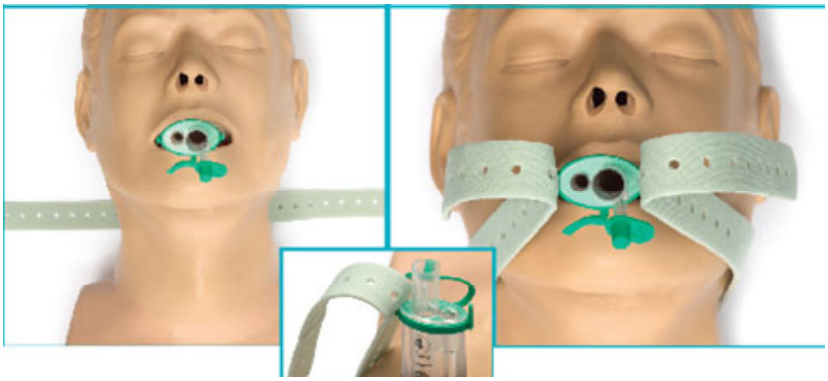


8. The i-gel O_2 should be taped down from maxilla to maxilla or secured with the support strap provided.



	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

9. The strap should be slid under the patient's neck until the wide central band of the strap is located directly under the neck of the patient. One end of the strap should then be lifted over the patient's face and secured to the i-gel O_2 by placing an appropriate hole on the strap over the lug of the hook ring located at the top of the integral bite block. The other end of the strap should then be lifted over the other side of the patient's face and secured in the same manner, ensuring there is sufficient tension to hold the i-gel O_2 securely in place, but not an excessive tension that may cause trauma to the patient's neck or face or that may cause unwanted downward pressure of the i-gel O_2.



10. Connect the i-Gel to a BVM and assess for breath sounds and air entry.
11. **Confirm tube placement using end-tidal CO_2 detector.**
12. Monitor oxygen saturation with pulse oximetry and heart rhythm with ECG.
13. **EtCO2 and Pulse Oximetry monitoring is mandatory following placement of a BIAD once available on scene and should be documented at least every five minutes.**
14. Unless contraindicated, an orogastric tube should be inserted in the gastric channel for the cardiac arrest patient to clear stomach contents after the airway is secured with an i-Gel [Orogastric tube insertion is only approved for EMT that is a member of Alamance EMS].
15. Re-verify i-Gel placement after every move and upon arrival in the ED.
16. Document the procedure, time, and result (success) on/with the patient care report (PCR).

Certification Requirements:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation once per certification cycle.

i-gel® Ideal Body Weight Size Chart

HEIGHT Feet and Inches	Inches	Ideal Body Weight (kg) MALE	FEMALE	
4'7"	55	38.5	40.5	
4'8"	56	40.8	42.2	i-gel size 3
4'9"	57	43.1	43.9	30 - 60 kg
4'10"	58	45.4	45.6	
4'11"	59	47.7	47.3	
5'	60	50	49	
5'1"	61	52.3	50.7	
5'2"	62	54.6	52.4	
5'3"	63	56.9	54.1	
5'4"	64	59.2	55.8	
5'5"	65	61.5	57.5	
5'6"	66	63.8	59.2	
5'7"	67	66.1	60.9	
5'8"	68	68.4	62.6	
5'9"	69	70.7	64.3	
5'10"	70	73	66	i-gel size 4
5'11"	71	75.3	67.7	50 - 90 kg
6'	72	77.6	69.4	
6'1"	73	79.9	71.1	
6'2"	74	82.2	72.8	
6'3"	75	84.5	74.5	
6'4"	76	86.8	76.2	
6'5"	77	89.1	77.9	
6'6"	78	91.4	79.6	
6'7"	79	93.7	81.3	
6'8"	80	96	83	
6'9"	81	98.3	84.7	
6'10"	82	100.6	86.4	
6'11"	83	102.9	88.1	
7'	84	105.2	89.8	
7'1"	85	107.5	91.5	i-gel size 5
7'2"	86	109.8	93.2	90 kg +

The i-gel O_2 Resus Pack

i-gel O_2™

Preparations for use

Open the i-gel O_2 package and take out the protective cradle containing the device. Remove the accessory pack containing the sachet of lubricant and airway support strap from the protective cradle and place to one side.

Remove the i-gel O_2 and transfer it to the palm of the same hand that is holding the protective cradle, supporting the device between the thumb and index finger.

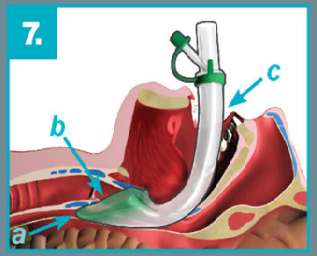
Open the sachet of supplied lubricant and place a small bolus onto the middle of the smooth surface of the protective cradle in preparation for lubrication. Do not use silicone based lubricants.

Grasp the i-gel O_2 with the opposite (free) hand along the integral bite block and lubricate the back, sides and front of the cuff with a thin layer of lubricant.

Place the i-gel O_2 back into the protective cradle in preparation for insertion.

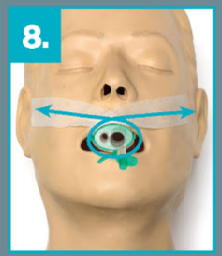
Insertion technique

Remove the i-gel O_2 from the protective cradle. Grasp the lubricated i-gel O_2 firmly along the integral bite block. Position the device so that the i-gel O_2 cuff outlet is facing towards the chin of the patient. The patient should be in the 'sniffing the morning air' position with head extended and neck flexed. The chin should be gently pressed down before proceeding. Introduce the leading soft tip into the mouth of the patient in a direction towards the hard palate.



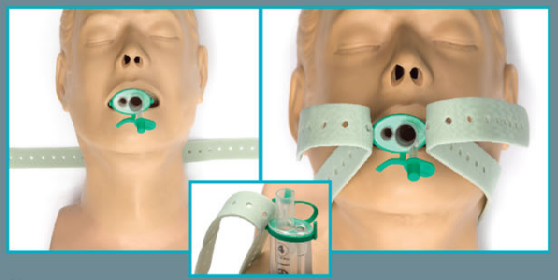
Glide the device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt.

The tip of the airway should be located into the upper esophageal opening (a) and the cuff should be located against the laryngeal framework (b). The incisors should be resting on the integral bite-block (c).



Taping

The i-gel O_2 should be taped down from 'maxilla to maxilla' or secured with the support strap provided.



Airway support strap

The strap should be slid under the patient's neck until the wide central band of the strap is located directly under the neck of the patient. One end of the strap should then be lifted over the patient's face and secured to the i-gel O_2 by placing an appropriate hole on the strap over the lug of the hook ring located at the top of the integral bite block. The other end of the strap should then be lifted over the other side of the patient's face and secured in the same manner, ensuring there is sufficient tension to hold the i-gel O_2 securely in place, but not an excessive tension that may cause trauma to the patients neck or face or that may cause unwanted downward pressure of the i-gel O_2.

	Patient Size	i-gel® Size	Patient Weight Guidance
●	Small adult	3	30-60kg (65-130lbs)
●	Medium adult	4	50-90kg (110-200lbs)
●	Large adult	5	90+kg (200 +lbs)

Important notes to the recommended insertion technique

Sometimes a feel of 'give-way' is felt before the end point resistance is met. This is due to the passage of the bowl of the i-gel O_2 through the faucial pillars. It is important to continue to insert the device until a definitive resistance is felt.

Once definitive resistance is met and the teeth are located on the integral bite block, do not repeatedly push the i-gel O_2 down or apply excessive force during insertion.

It is not necessary to insert fingers or thumbs into the patient's mouth during the process of inserting the device.

Visit the i-gel website www.i-gel.com

This poster does NOT constitute a comprehensive guide to the preparation, insertion and use of the i-gel O_2. The user should first familiarise themselves with the Instructions for Use supplied with the product before attempting to use the i-gel O_2.
The i-gel must always be separated from the protective cradle prior to insertion. The cradle is not an introducer and must never be inserted into the patient's mouth.
The i-gel O_2 has been designed to facilitate ventilation as part of standard resuscitation protocols, such as those designated by the European Resuscitation Council (ERC) and the American Heart Association (AHA). However, the i-gel O_2 incorporates a supplementary oxygen port, so can also be used for the delivery of passive oxygenation, or Passive Airway Management™ (PAM), as part of an appropriate CardioCerebral Resuscitation (CCR) protocol. For more information on passive oxygenation, please refer to the instructions for use or contact us.

INTERSURGICAL® COMPLETE RESPIRATORY SYSTEMS
6757 Kinne Street, East Syracuse, New York 13057
315-451-2900 or 800-828-9633
support@intersurgicalinc.com
www.intersurgical.com

I-GELO2POSTER_US issue 2 01.17

Airway: Cricothyrotomy-Surgical pg. 1/2

Clinical Indications:

P Paramedic P

- Failed Airway Protocol
- Orotracheal intubation or BIAD attempt unsuccessful or contraindicated.
- Airway obstruction unrelieved using Foreign Body Obstruction Procedure.
- Inability to intubate and/or ventilate patient due to obstruction, hemorrhage, trismus, obstructing lesions, and traumatic or congenital deformities.
- Management of an airway when standard airway procedures cannot be performed or have failed in a patient ≥ 10 years old.

Contraindications:

- Pediatric patient <10 years of age.
- Possible or known transection of the trachea, fractured larynx, or laryngotracheal disruption.

Procedure:

1. Have supplies (Control-Cric™) and suction available and ready.
2. Locate the cricothyroid membrane utilizing anatomical landmarks. (1a)
3. Prep the area with an antiseptic swab (Betadine or Chlorhexidine).
4. Stabilize trachea with non-dominant hand.
5. Make horizontal stab incision (1-2 cm) through both skin and cricothyroid membrane using Cric-Knife™ with tracheal hook facing superiorly. A vertical incision can be made if excessive tissue makes identifying cricothyroid membrane difficult. (1b&c)
6. Prior to removal of Cric-Knife™ advance the tracheal hook, hooking the thyroid cartilage. Stabilize thyroid cartilage and remove blade. (2a)
7. Advance tracheostomy tube with Cric-Key™ in place. Feeling for tactile feedback of tracheal rings. (2b&c)
8. Remove Cric-Key™ and inflate cuff. Secure tracheostomy tube with neck strap. (3a&b)
9. All standard assessment techniques for insuring proper tube placement should be performed (auscultation, chest rise and fall, **end-tidal CO_2**, etc.).
10. Document the time, procedure, and results in the Patient Care report (PCR).
11. See page 2 for Illustration and Manufacturer Quick Reference Guide

Certification Requirements:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

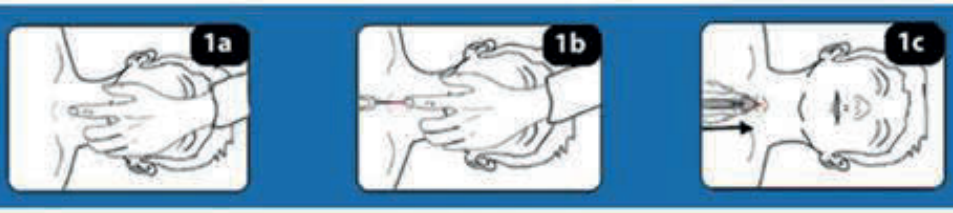
Airway: Cricothyrotomy-Surgical pg. 2/2

Control-Cric™ Training Kit Quick Reference Guide

Items Included in Kit:

- 1 Cric-Key™
- 1 Cric-Knife™
- 1 Package of Lubricant
- 1 Neck Strap
- 1 Extension Tube
- 1 Wedge

1

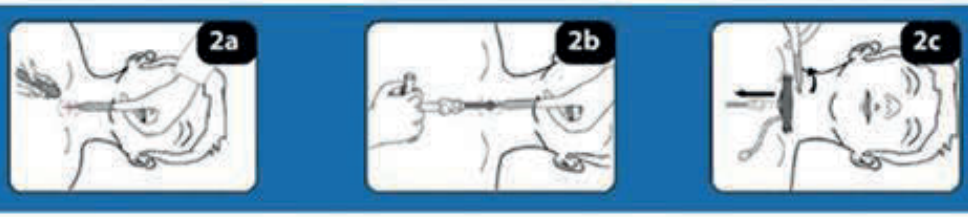


A. Position patient supine and identify the cricothyroid membrane. Stabilize the larynx with thumb and middle finger with non-dominant hand.

B. Use the Cric-Knife to incise skin. A vertical skin incision from mid-thyroid cartilage to the cricoid cartilage is recommended (usually about 2 finger breadths). In patients with a thick neck a longer incision may be needed. A horizontal skin incision may be used when landmarks are evident.

C. After palpating the cricothyroid membrane, turn the Cric-Knife to a horizontal position over the cricothyroid membrane. Push the blade downward, perpendicular to the trachea, until the blade is fully inserted and the airway is entered.

2



A. While maintaining downward force, slide the tracheal hook down the handle with your thumb until the hook is felt to enter the trachea, and it disengages from the handle. Grab the tracheal hook with the non-dominant hand, lifting up on the thyroid cartilage.

B. Insert Cric-Key through incision. Confirm placement by moving the device along anterior wall of trachea to feel for the tracheal rings. Indicators of incorrect placement could be: tenting of the skin, difficulty advancing the Cric-Key tube, or lack of tactile feedback from the tracheal rings.

C. Once placement has been confirmed, advance Cric-Key tube to the flange. Stabilize the Cric-Key tube and pivot the tracheal hook toward the patient's shoulder to remove from airway.

3

A. While stabilizing the Cric-Key tube, remove the Cric-Key introducer. Inflate the cuff until resistance is met.

B. Confirm placement. Secure with stabilizing strap.

C. Attach manual resuscitator. Ventilate and auscultate lung fields. Reassess.

This procedure has been altered from the original NCCEP Procedure by the local EMS Medical Director

Airway: Intubation Oral Tracheal

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Inability to adequately ventilate a patient with a Bag Valve Mask or longer EMS transport distances require a more advanced airway.
- An unconscious patient without a gag reflex who is apneic or is demonstrating inadequate respiratory effort.
- A component of Drug Assisted Intubation

Procedure:

1. Prepare, position and oxygenate the patient with 100% Oxygen.
2. Select proper ET tube (and stylette, if used), have suction ready.
3. Using laryngoscope, visualize vocal cords. (Use Sellick maneuver/BURP to assist you).
4. Limit each intubation attempt to 30 seconds with BVM between attempts.
5. Visualize tube passing through vocal cords.
6. **Confirm and document tube placement using end-tidal CO_2 monitoring.**
7. Inflate the cuff with 3 to10 cc of air; secure the tube to the patient's face.
8. Auscultate for bilaterally equal breath sounds and absence of sounds over the epigastrium. If you are unsure of placement, remove tube and ventilate patient with bag-valve mask.
9. Consider using a Blind Insertion Airway Device if intubation efforts are unsuccessful.
10. If Available apply end tidal carbon dioxide monitor (Capnography) and record readings on scene, en route to the hospital, and at the hospital.
11. Document ETT size, time, result (success), and placement location by the centimeter marks either at the patient's teeth or lips on/with the patient care report (PCR). Document all devices used to confirm initial tube placement. Also document positive or negative breath sounds before and after each movement of the patient.
12. Unless contraindicated, Paramedic should place an orogastric tube in the intubated cardiac arrest patient to clear stomach contents after the airway is secured with an ET tube.
13. **End-tidal (EtCO2) and Pulse Oximetry monitoring is mandatory following placement of an endotracheal tube and should be documented at least every five minutes.**
14. **An Airway Evaluation Form shall be completed at the end of the patient care encounter and submitted to the Quality Manager at Alamance County EMS for review.**

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Airway: Intubation Nasotracheal

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- A spontaneously breathing patient in need of intubation (inadequate respiratory effort, evidence of hypoxia or carbon dioxide retention, or need for airway protection).
- Rigidity or clenched teeth prohibiting other airway procedures.
- Patient must be 12 years of age or older.

Procedure:

1. Premedicate the patient with nasal spray.
2. Select the largest and least obstructed nostril and insert a lubricated nasal airway to help dilate the nasal passage.
3. Preoxygenate the patient. Lubricate the tube. The use of a BAAM device is recommended.
4. Remove the nasal airway and gently insert the tube keeping the bevel of the tube toward the septum.
5. Continue to pass the tube listening for air movement and looking for to and fro vapor condensation in the tube. As the tube approaches the larynx, the air movement gets louder.
6. Gently and evenly advance the tube through the glottic opening on the inspiration. This facilitates passage of the tube and reduces the incidence of trauma to the vocal cords.
7. Upon entering the trachea, the tube may cause the patient to cough, buck, strain, or gag. Do not remove the tube! This is normal, but be prepared to control the cervical spine and the patient, and be alert for vomiting.
8. Auscultate for bilaterally equal breath sounds and absence of sounds of the epigastrium. Observe for symmetrical chest expansion. The 15mm adapter usually rests close to the nostril with proper positioning.
9. Inflate the cuff with 5-10 cc of air.
10. **Confirm tube placement using an end-tidal CO_2 monitoring or esophageal bulb device.**
11. Secure the tube.
12. Reassess airway and breath sounds after transfer to the stretcher and during transport. These tubes are easily dislodged and require close monitoring and frequent reassessment.
13. Document the procedure, time, and result (success) on/with the patient care report (PCR).
14. **End-tidal (EtCO2) monitoring is mandatory following placement of a nasotracheal tube.**
15. **It is strongly recommended that an airway evaluation form be completed with all intubations.**

Not Utilized In Alamance County

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Airway: Video Laryngoscopy Glidescope

Clinical Indications:

P PARAMEDIC P

- Patient requires advanced airway.

Procedure:

1. Preoxygenate the patient and use in conjunction with procedure ASP - 6.
2. Select the appropriate ETT size and GlideRite Rigid Stylette for the patient. Ready suction.
3. Power on GlideScope and allow 30 seconds for anti-fog mechanism to warm.
4. Using GlideScope visualize the vocal cords and facilitate the intubation:
   - **In the mouth:** looking directly into the patient's mouth and with the VL blade in left hand, introduce GlideScope VL into the midline of the oral pharynx.
     Look into the mouth to prevent soft tissue damage.
   - **At the screen:** With GlideScope VL inserted, look to monitor to identify the epiglottis, then manipulate the scope to obtain the best glottic view.
   - **In the mouth:** Looking directly into the patient's mouth, not at screen, carefully guide the distal tip of the ETT into position near the tip of the GlideScope VL.
     Insert the ETT behind or adjacent to the VL blade.
   - **At the screen:** Look to the monitor to complete tracheal intubation. Gently rotate or angle the ETT to redirect as needed.
     Avoid excessive lifting or pushing of the glottis with the VL blade.
     Reducing the elevation applied to the VL blade may facilitate intubation.
   - **Advance the ETT** while simultaneously withdrawing the stylette with the thumb.
     Withdraw the stylette approximately 5 cm (2 inches).
     Do not insert the stylette into the larynx during intubation – this will prevent passing into the glottis.
   - **Secure and verify the proper ETT placement.**

5. Auscultate for breath sounds and sounds over the epigastrium and look for the chest to rise and fall.
6. Secure the ETT tube with tape or mechanical tube holder.
7. **Confirm tube placement using end-tidal CO_2 detector.**
8. **End-tidal (EtCO2) and Pulse Oximetry monitoring is mandatory following placement of an endotracheal tube.**
9. **An Airway Evaluation Form shall be completed at the end of the patient care encounter and submitted to the Quality Manager at Alamance County EMS for review.**

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Airway: Drug Assisted Airway

Clinical Indications:

P PARAMEDIC P

- Need for advanced airway control in a patient who has a gag reflex or trismus (jaw clinching)
- Failure to protect the airway. Unable to ventilate and / or oxygenate. Impending airway compromise
- A minimum of 2 EMT-Paramedics on scene able to participate in patient care
- This protocol is only for use in patients with patients longer than a Length-based Resuscitation Tape except in agencies utilizing Ketamine for pediatric airway management with direct online medical control via system medical director or assistant medical director.

Clinical Contraindications:

- Refer to drug list for contraindications regarding use of Succinylcholine and Rocuronium.

Procedure:

1. Perform focused neurological exam
2. Evaluate for difficult airway (LEMON)-see appendix
3. Prepare equipment (intubation kit, BVM, suction, DAI medications, BIAD, Cricothyrotomy kit, waveform capnography, other airway adjuncts as available)
4. Pre-oxygenate patient with 100% oxygen via NRB mask or BVM. Apneic oxygenation: May continue high-flow oxygen via NC during entire procedure
5. Monitor oxygen saturation with pulse oximetry and heart rhythm with ECG
6. Ensure functioning IV / IO access. Two (2) IV sites are preferable
8. In-line c-spine stabilization by second caregiver (in setting of trauma)
9. Administer Etomidate or Ketamine by rapid IV push
10. Administer Succinylcholine or Rocuronium, await fasciculation and jaw relaxation
11. Perform external laryngeal manipulation to improve view during laryngoscopy with the right hand.
12. Intubate trachea or place BIAD if intubation unsuccessful or felt to be unsuccessful during procedure.
13. Verify ET placement through auscultation, Capnography, and Pulse Oximetry
14. May repeat Succinylcholine or Rocuronium if inadequate relaxation
15. Release cricoid pressure (if utilized) and secure tube
16. **Continuous Capnography and Pulse Oximetry is required for DAI. Pre-intubation, minimal during intubation, and post-intubation readings must be recorded in the PCR.**
17. Re-verify tube placement after every move and upon arrival in the ED
18. Document ETT or BIAD size, time, result (success), and placement location by the centimeter marks either at the patient's teeth or lips on/with the patient care report (PCR). Document all devices/methods used to confirm initial tube placement initially and with patient movement.
19. Consider placing a gastric tube to clear stomach contents after the airway is secured.
20. **Completion of the Airway Evaluation Form is required including a signature from the receiving physician at the Emergency Department confirming proper tube placement.**

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Not Utilized In Alamance County

Airway: Tracheostomy Tube Change

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Presence of Tracheostomy site.
- Urgent or emergent indication to change the tube, such as obstruction that will not clear with suction, dislodgement, or inability to oxygenate/ventilate the patient without other obvious explanation.

Procedure:

1. Have all airway equipment prepared for standard airway management, including equipment of orotracheal intubation and failed airway.
2. Have airway device (endotracheal tube or tracheostomy tube) of the same size as the tracheostomy tube currently in place as well as 0.5 size smaller available (e.g., if the patient has a #6.0 Shilley, then have a 6.0 and a 5.5 tube).
3. Lubricate the replacement tube(s) and check the cuff.
4. Remove the tracheostomy tube from mechanical ventilation devices and use a bag-valve apparatus to pre-oxygenate the patient as much as possible.
5. Once all equipment is in place, remove devices securing the tracheostomy tube, including sutures and/or supporting bandages.
6. If applicable, deflate the cuff on the tube. If unable to aspirate air with a syringe, cut the balloon off to allow the cuff to lose pressure.
7. Remove the tracheostomy tube.
8. Insert the replacement tube. Confirm placement via standard measures except for esophageal detection (which is ineffective for surgical airways).
9. If there is any difficultly placing the tube, re-attempt procedure with the smaller tube.
10. If difficulty is still encountered, use standard airway procedures such as oral bag-valve mask or endotracheal intubation (as per protocol). **More difficulty with tube changing can be anticipated for tracheostomy sites that are immature – i.e., less than two weeks old. Great caution should be exercised in attempts to change immature tracheotomy sites.**
11. Document procedure, confirmation, patient response, and any complications in the PCR

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment for this skill should include direct observation at least once per certification cycle.

Airway: Endotracheal Tube Introducer (Bougie)

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Patients meet clinical indications for oral intubation
- Initial intubation attempt(s) unsuccessful
- Predicted difficult intubation

Contraindications:

- Three attempts at orotracheal intubation (utilize failed airway protocol)
- Age less than eight (8) or ETT size less than 6.5 mm

Procedure:

1. Prepare, position and oxygenate the patient with 100% oxygen;
2. Select proper ET tube without stylet, test cuff and prepare suction;
3. Lubricate the distal end and cuff of the endotracheal tube (ETT) and the distal 1/2 of the Endotracheal Tube Introducer (Bougie) (note: Failure to lubricate the Bougie and the ETT may result in being unable to pass the ETT);
4. Using laryngoscopic techniques, visualize the vocal cords if possible using Sellick's/BURP as needed;
5. Introduce the Bougie with curved tip anteriorly and visualize the tip passing the vocal cords or above the arytenoids if the cords cannot be visualized;
6. Once inserted, gently advance the Bougie until you meet resistance or "hold-up" (if you do not meet resistance you have a probable esophageal intubation and insertion should be re-attempted or the failed airway protocol implemented as indicated);
7. Withdraw the Bougie ONLY to a depth sufficient to allow loading of the ETT while maintaining proximal control of the Bougie;
8. Gently advance the Bougie and loaded ET tube until you have hold-up again, thereby assuring tracheal placement and minimizing the risk of accidental displacement of the Bougie;
9. While maintaining a firm grasp on the proximal Bougie, introduce the ET tube over the Bougie passing the tube to its appropriate depth;
10. If you are unable to advance the ETT into the trachea and the Bougie and ETT are adequately lubricated, withdraw the ETT slightly and rotate the ETT 90 degrees COUNTER clockwise to turn the bevel of the ETT posteriorly. If this technique fails to facilitate passing of the ETT you may attempt direct laryngoscopy while advancing the ETT(this will require an assistant to maintain the position of the Bougie and, if so desired, advance the ETT);
11. Once the ETT is correctly placed, hold the ET tube securely and remove the Bougie;
12. Confirm tracheal placement according to the intubation protocol, inflate the cuff with 3 to 10 cc of air, auscultate for equal breath sounds and reposition accordingly;
13. When final position is determined secure the ET tube, reassess breath sounds, apply end tidal CO_2 monitor, and record and monitor readings to assure continued tracheal intubation.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Standards Procedure (Skill) Airway Section
Airway Intubation Confirmation – End-Tidal CO_2 Detector

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- The End-Tidal CO_2 detector shall be used with any Endotracheal Tube or Blind Insertion Airway Device use.

It is required that continuous Capnography be used in place of, or in addition to the use of an End-Tidal CO_2 detector when available.

Procedure:

1. Attach End-Tidal CO_2 detector to the Blind Insertion Airway Device or the Endotracheal Tube.
2. Note color change. A color change or CO_2 detection will be documented on each respiratory failure or cardiac arrest patient.
3. The CO_2 detector shall remain in place with the airway and monitored throughout the prehospital care and transport unless continuous Capnography is used. Any loss of CO_2 detection or color change is to be documented and monitored as procedures are done to verify or correct the airway problem.
4. Tube placement should be verified frequently and always with each patient move or loss of color change in the End-Tidal CO_2 detector.
5. Document the procedure and the results on/with the Patient Care Report (PCR) as well as on the Airway Evaluation Form.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Airway: Foreign Body Obstruction

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Sudden onset of respiratory distress often with coughing, wheezing, gagging, or stridor due to a foreign-body obstruction of the upper airway.

Procedure:

1. Assess the degree of foreign body obstruction
   - Do not interfere with a mild obstruction allowing the patient to clear their airway by coughing.
   - In severe foreign-body obstructions, the patient may not be able to make a sound. The victim my clutch his/her neck in the universal choking sign.
2. **For an infant**, deliver 5 back blows (slaps) followed by 5 chest thrusts repeatedly until the object is expelled or the victim becomes unresponsive.
3. **For a child**, perform a subdiaphragmatic abdominal thrust (Heimlich Maneuver) until the object is expelled or the victim becomes unresponsive.
4. **For adults**, a combination of maneuvers may be required.
   - First, subdiaphragmatic abdominal thrusts (Heimlich Maneuver) should be used in rapid sequence until the obstruction is relieved.
   - If abdominal thrusts are ineffective, chest thrusts should be used. Chest thrusts should be used primarily in morbidly obese patients and in the patients who are in the late stages of pregnancy
5. If the victim becomes unresponsive, begin CPR immediately but look in the mouth before administering any ventilations. If a foreign-body is visible, remove it.
6. **Do not perform blind finger sweeps in the mouth and posterior pharynx. This may push the object farther into the airway.**
7. In unresponsive patients, AEMT and Paramedic level professionals should visualize the posterior pharynx with a laryngoscope to potentially identify and remove the foreign-body using Magill forceps.
8. Document the methods used and result of these procedures in the patient care report (PCR).

Certification Requirements:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Airway: Post-Endotracheal Intubation Checklist

A	AEMT	A
P	PARAMEDIC	P

Clinical Indication:

- Immediately after Endotracheal Intubation Procedure is performed.

Procedure:

1.Ensure cuff of endotracheal tube is inflated per Endotracheal Intubation procedure.
2. Monitor continuous (EtCO2) waveform capnography to ensure that waveform is consistent with correct airway placement.
3. If no waveform capnography (ETCO2) is observed on the monitor, **IMMEDIATELY** remove endotracheal tube from airway and provide Bag Valve Mask ventilations with appropriate oxygen source connected and flowing.
   - Escalate per protocol and as needed with airway adjuncts and BIAD. If BIAD is utilized as a rescue device, immediately confirm placement with ETCO2 waveform capnography.
4. If cricothyrotomy procedure is being considered, follow protocol for procedure as indicated. After placement confirm that ETCO2 waveform is present.
5. Provide the patient with Bag Valve ventilations and ensure appropriate oxygen source is flowing.
6. Listen to the lungs for equal breath sounds in the upper and lower lung fields, bilaterally; also, check for the absence of sounds over the epigastrium / center of the upper abdomen.
7. Continue appropriate ventilation by bag ventilation or confirm clinically appropriate ventilator settings on the ventilator. Re-confirm Bag Valve ventilations or that ventilator is connected to appropriate oxygen source that is flowing.
8. Secure the airway device with a commercially available product. If ETT, document placement location by the centimeter mark either at the patient's teeth or lips on the patient care report (PCR).
9. If using a mechanical ventilator follow RSP 6 Procedure: Ventilator Operation
10. Document all devices used to confirm initial tube placement. Also, document presence or absence of breath sounds before and after each movement of the patient.
11. Re-check and document vital signs including ETCO2 immediately after intubation and at least every 5 minutes.
12. Follow post-intubation protocol for analgesia, sedation and neuro-muscular blockade as indicated.
13. It is strongly recommended that an airway evaluation form be completed with all intubations.

Airway: Post Intubation Checklist

Procedure (continued):

14. Record ETCO2 monitor readings on scene, en-route to hospital, and at the hospital after patient is moved to a hospital stretcher.
15. Verify tube placement frequently and always with each movement of patient.
16. Consider placing an Orogastric tube to clear stomach contents after airway device is secured with ET tube or Supraglottic airway with a gastric tube port.
17. Assess for worsening abdominal distention with every delivered breath, or concern of aspiration of gastric contents.

Certification Requirements:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS system.

Assessment: Adult

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Any patient requesting a medical evaluation that is too large to be measured with a Length-based **2017** Resuscitation Tape.

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.
10. Document all findings and information associated with the assessment, performed procedures, and any administration of medications on the PCR.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Pain Assessment and Documentation

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

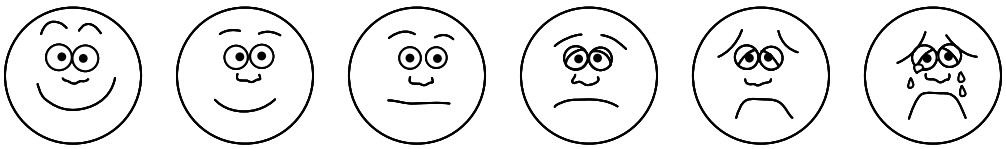
- Any patient with pain.

Definitions:

- Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage.
- Pain is subjective (whatever the patient says it is).

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 in the PCR 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. Three pain scales are available: the 0 – 10, the Wong - Baker "faces", and the FLACC.
   - 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.
   - 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.



0	2	4	6	8	10
No hurt	Hurts little bit	Hurts little more	Hurts even more	Hurts whole lot	Hurts worst

From Hockenberry MJ, Wilson D, Winkelstein ML: Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p. 1259. Used with permission. Copyright, Mosby.

   - FLACC scale: this scale has been validated for measuring pain in children with mild to severe cognitive impairment and in pre-verbal children (including infants).

CATEGORIES	SCORING		
	0	1	2
FACE	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested.	Frequent to constant quivering chin, clenched jaw.
LEGS	Normal position or relaxed.	Uneasy, restless, tense.	Kicking, or legs drawn up.
ACTIVITY	Lying quietly, normal position moves easily.	Squirming, shifting back and forth, tense.	Arched, rigid or jerking.
CRY	No cry, (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints.
CONSOLABILITY	Content, relaxed.	Reassured by occasional touching hugging or being talked to, distractable.	Difficulty to console or comfort

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Assessment: Pediatric

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Any child that can be measured with a Length-based Resuscitation Tape.

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-Luten 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

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Blood Glucose Analysis

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Patients with suspected hypoglycemia (diabetic emergencies, change in mental status, bizarre behavior, etc.)

Procedure:

1. Gather and prepare equipment.
2. Blood samples for performing glucose analysis can be obtained through a finger-stick or when possible simultaneously with intravenous access.
3. Place correct amount of blood on reagent strip or site on 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.
7. Perform Quality Assurance per manufacture recommendation.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Capnography

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Capnography shall be used when available with the use of all invasive airway procedures including endotracheal, nasotracheal, cricothyrotomy, or Blind Insertion Airway Devices (BIAD).
- Capnography should also be used when possible with CPAP.

Procedure:

1. Attach capnography sensor to the BIAD, endotracheal tube, or oxygen delivery device.
2. Note CO_2 level and waveform changes. These will be documented on each respiratory failure, cardiac arrest, or respiratory distress patient.
3. The capnometer shall remain in place with the airway and be monitored throughout the prehospital care and transport.
4. Any loss of CO_2 detection or waveform indicates an airway problem and should be documented.
5. The capnogram should be monitored as procedures are performed to verify or correct the airway problem.
6. Document the procedure and results on/with the Patient Care Report (PCR) and the Airway Evaluation Form.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Pulse Oximetry

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Patients with suspected hypoxemia.

Procedure:

1. Apply probe to patient's finger or any other digit as recommended by the device manufacturer.
2. Allow machine to register saturation level.
3. Record time and initial saturation percent on room air if possible on/with the patient care report (PCR).
4. Verify pulse rate on machine with actual pulse of the patient.
5. 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.
6. Document percent of oxygen saturation every time vital signs are recorded and in response to therapy to correct hypoxemia.
7. In general, normal saturation is 97-99%. Below 94%, suspect a respiratory compromise.
8. Use the pulse oximetry as an added tool for patient evaluation. Treat the patient, not the data provided by the device.
9. 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. Supplemental oxygen is not required if the oxyhemoglobin saturation is >= 94%, unless there are obvious signs of heart failure, dyspneic, or hypoxic to maintain to 94%.
10. Factors which may reduce the reliability of the pulse oximetry reading include but are not limited to:
    - Poor peripheral circulation (blood volume, hypotension, hypothermia)
    - Excessive pulse oximeter sensor motion
    - Fingernail polish (may be removed with acetone pad)
    - Carbon monoxide bound to hemoglobin
    - Irregular heart rhythms (atrial fibrillation, SVT, etc.)
    - Jaundice
    - Placement of BP cuff on same extremity as pulse ox probe.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

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Reperfusion Checklist (Optional)

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

Rapid evaluation of a patient with suspected acute stroke and/or acute myocardial infarction (STEMI) to:

- Determine eligibility and potential benefit from fibrinolysis..
- Rapid identification of patients who are not eligible for fibrinolysis and will require interventional therapy.

Procedure:

1. Follow the appropriate protocol for the patient's complaint to assess and identify an acute condition which could potentially benefit from fibrinolysis. If a positive finding is noted on one of the following assessments, proceed to step 2.
   - Perform a 12-lead ECG to identify an acute ST elevation myocardial infarction (STEMI).
   - Perform the Cincinnati Pre-hospital Stroke Screen to identify an acute stroke
2. Complete the Reperfusion Check Sheet to identify any potential contraindications to fibrinolysis. (See Appendix)
   - Systolic Blood Pressure greater than 180 mm Hg
   - Diastolic Blood Pressure greater than 110 mm Hg
   - Right vs. Left Arm Systolic Blood Pressure difference of greater than 15 mm Hg
   - History of structural Central Nervous System disease (age >= 18, history of aneurysm or AV-malformation, tumors, masses, hemorrhage, etc.)
   - Significant closed head or facial trauma within the previous 3 months
   - Recent (within 6 weeks) major trauma, surgery (including laser eye surgery), gastrointestinal bleeding, or severe genital-urinary bleeding
   - Bleeding or clotting problem or on blood thinners
   - CPR performed greater than 10 minutes
   - Currently Pregnant
   - Serious Systemic Disease such as advanced/terminal cancer or severe liver or kidney failure.
3. Identify if the patient is currently in heart failure or cardiogenic shock. For these patients, a percutaneous coronary intervention is more effective.
   - Presence of pulmonary edema (rales greater than halfway up lung fields)
   - Systemic hypoperfusion (cool and clammy)
4. If any contraindication is noted using the check list and an acute Stroke is suspected by exam or a STEMI is confirmed by ECG, activate the EMS Stroke Plan or EMS STEMI Plan for fibrinolytic ineligable patients. This may require the EMS Agency, an Air Medical Service, or a Specialty Care Transport Service to transport directly to an specialty center capable of interventional care within the therapeutic window of time.
5. Record all findings in the Patient Care Report (PCR).

Certification Requirements:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Stroke Screen: Cincinnati Prehospital Stroke Scale

	MR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Suspected Stroke Patient

Procedure:

1. Assess and treat suspected stroke patients as per protocol.
2. The Cincinnati Prehospital Stroke Scale (CPSS) should be completed for all suspected stroke patients.

3. Perform Cincinnati Prehospital Stroke Scale

A. Facial Droop

Ask patient to smile and show their teeth

- ☐ Normal: Both sides of face move equally
- ☐ **Abnormal: One side of face does not move at all**

B. Arm Drift:

Ask patient to hold both arms straight out for 10 seconds

- ☐ Normal: Both arms move equally or not at all
- ☐ **Abnormal: One arm drifts compared to the other**

C. Speech:

Ask patient to repeat phrase: “You can’t teach an old dog new tricks”

- ☐ Normal: Patient uses correct words with no slurring
- ☐ **Abnormal: Slurred or inappropriate words or mute**

4. If **ANY of components of the CPSS are ABNORMAL, the stroke screen is POSITIVE.**
5. All sections of the CPSS form must be completed.
6. The completed CPSS form should be documented in the PCR.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Stroke Screen: Cincinnati Prehospital Stroke Scale

The Cincinnati Prehospital Stroke Scale

Facial Droop (have patient show teeth or smile):

- Normal—both sides of face move equally
- Abnormal—one side of face does not move as well as the other side

Left: Normal. Right: Stroke patient with facial droop (right side of face).

Arm Drift (patient closes eyes and extends both arms straight out, with palms up, for 10 seconds):

- Normal—both arms move the same *or* both arms do not move at all (other findings, such as pronator drift, may be helpful)
- Abnormal—one arm does not move *or* one arm drifts down compared with the other

Left: Normal. Right: One-sided motor weakness (right arm).

Abnormal Speech (have the patient say "you can't teach an old dog new tricks"):

- Normal—patient uses correct words with no slurring
- Abnormal—patient slurs words, uses the wrong words, or is unable to speak

Interpretation: If any 1 of these 3 signs is abnormal, the probability of a stroke is 72%.

Modified from Kothari RU, Pancioli A, Liu T, Brott T, Broderick J. Cincinnati Prehospital Stroke Scale: reproducibility and validity. *Ann Emerg Med.* 1999;33:373-378. With permission from Elsevier.

Stroke Screen: FAST – ED (*for EMS use)

*FAST-ED to be used as both the primary stroke screen and LVO screen by Alamance County EMS Personnel. First responders utilize Cincinnati Prehospital Stroke Scale (ASP 8)

	MR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Suspected Stroke Patient from 0 – 24 hours of symptom onset. To identify patients with **possible stroke (any score greater than 0 on steps A-C)** and **Large Vessel Occlusion (total score greater than or equal to 4)**.

Procedure: For patients with suspected stroke, perform the FAST-ED exam. The scale is rated from 0 – 9.

A. Facial Palsy	
Normal or minor paralysis	0
Partial or complete paralysis	1
B. Arm Weakness	
No drift	0
Drift or some effort against gravity	1
No effort against gravity / no movement	2
C. Speech Changes	
Absent	0
Mild to moderate	1
Severe, global, aphasia or mute	2

Stroke Screen
(Any score greater than 0 is a positive stroke screen)

D. Eye Deviation	
Absent	0
Partial	1
Forced Deviation	2
E. Denial / Neglect	
Absent	0
Extinction to bilateral simultaneous stimulation in only one sensory modality	1
Does not recognize own hand or orients to only one side of the body	2

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Temperature Measurement

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Monitoring body temperature in a patient with suspected infection, hypothermia, hyperthermia, or to assist in evaluating resuscitation efforts.

Procedure:

1. For adult patients that are conscious, cooperative, and in no respiratory distress, an oral temperature is preferred (steps 2 to 4 below). For infants or adults that do not meet the criteria above, a rectal temperature is preferred (steps 6 to 8 below).
2. To obtain an oral temperature, ensure the patient has no significant oral trauma and place the thermometer under the patient's tongue with appropriate sterile covering.
3. Have the patient seal their mouth closed around thermometer.
4. If using an electric thermometer, leave the device in place until there is indication an accurate temperature has been recorded (per the "beep" or other indicator specific to the device). If using a traditional thermometer, leave it in place until there is no change in the reading for at least 30 seconds (usually 2 to 3 minutes). Proceed to step 8.
5. Prior to obtaining a rectal temperature, assess whether the patient has suffered any rectal trauma by history and/or brief examination as appropriate for patient's complaint.
6. To obtain a rectal temperature, cover the thermometer with an appropriate sterile cover, apply lubricant, and insert into rectum no more than 1 to 2 cm beyond the external anal sphincter.
7. Follow guidelines in step 5 above to obtain temperature.
8. Record time, temperature, method (oral, rectal), and scale (C° or F°) in Patient Care Report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

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Orthostatic Blood Pressure Measurement

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Patient situations with suspected blood, fluid loss, or dehydration with no indication for spinal immobilization. Orthostatic vital signs are not routinely recommended.
- Patients ≥ 8 years of age, or patients larger than the Broselow-Luten tape
- Orthostatic Vital Signs are not sensitive nor specific for volume loss / dehydration and may induce syncope in some cases. Assessment of orthostatic vital signs are not routinely recommended. Local Medical Director should indicate and educate on situations where they may be helpful.

Procedure:

1. Gather and prepare standard sphygmomanometer and stethoscope.
2. With the patient supine, obtain pulse and blood pressure.
3. Have the patient sit upright.
4. After 30 seconds, obtain blood pressure and pulse.
5. If the systolic blood pressure falls more than 30 mmHg or the pulse rises more than 20 bpm, the patient is considered to be orthostatic.
6. If a patient experiences dizziness upon sitting or is obviously dehydrated based on history or physical exam, formal orthostatic examination should be omitted and fluid resuscitation initiated.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Standards Procedure (Skill) Assessment / Screening Section

Verbal De-escalation

Agency Name:	SATISFACTORY ☐
Provider Name: Paramedic	UNSATISFACTORY ☐
Instructor Name: EMT AEMT Paramedic Physician	

Instructor:
1. Evaluate providers skill performance using the check off list below.
2. Circle performance indicator:
   - YES = Provider completed skill with no assistance from instructor.
   - NO = Provider unable to complete skill satisfactorily following instructor intervention.
   - IL = Provider able to complete skill satisfactorily following Instructor Led (teaching) intervention.

Satisfactory performance indicated with ≥ 8 YES / IL completions. (Combination of both YES and IL)

	EMR	
B	EMT	B
A	AEMT	A
P	Paramedic	P

YES NO IL	Verbalizes indications for Verbal de-escalation techniques: 1. Behavioral Health Crisis 2. Behavior Activity Rating Score ≥ 5
YES NO IL	Verbalizes contraindications: None
YES NO IL	**Demonstrates respect of patient's personal space** • Maintain about 6 feet of distance and do not position yourself between the patient and only exit • Both you and patient should be able to exit the room without feeing blocked-in
YES NO IL	**Does not provoke patient during interaction** • Your body language must convey that you want to listen and that you do not want to inflict harm Your hands should be visible and open Do not face the patient head-on. Always stand at an angle Avoid prolonged staring or direct eye contact • Make sure others are not provoking the patient (providers, family members, bystanders, providers, police officers)
YES NO IL	**Establishes rapport, initiates and maintains verbal contact** • One person should make and maintain verbal contact, introduce yourself and explain your role Multiple providers talking to the patient will create confusion and may escalate patient's behavior • Emphasize you are there to keep the patient safe • Ask the patient their name and how they want to be addressed
YES NO IL	**Use concise statements when talking** • Agitation creates problems in a patient's ability to process information • Keep your conversation simple and short in nature allowing time for patient to process information • Repeat your statements, requests, or commands to ensure understanding This is called a loop, you may need to repeat 2 – 12 times before patient understands
YES NO IL	**Identify wants, feelings, and stress causing the crisis** "When you called 911, how did you think we could help you?" "I would like to know what caused you to become upset today so we can help you" • Identifying a need can help to quickly de-escalate the situation
YES NO IL	**Listen closely to patient** • You should be able to repeat back what is said by the patient "Tell me if I have all this right" "Let me make sure I understand what you said"
YES NO IL	**Agree or agree to disagree** • If statements are truthful, then agree with the truth • Agree in principle, maybe patient's statement is not true, but you can agree, that in general, the idea is true • Agree with the odds, anyone may be upset by the same circumstances • Do not agree with delusions, at that point you can agree to disagree
YES NO IL	**Set clear limits on acceptable behavior** • Set limits in a positive, matter-of-fact manner, and not in a threatening manner • Inform the patient that harm to self or other providers will not be tolerated • If the patient's behavior is frightening to providers, tell the patient so • Remind the patient you are there to help, keep them safe, but the providers cannot be abused in the process
YES NO IL	**Offer choices to patient (if available) and remain positive in your interactions** • Offer choices that are realistic and that may provide comfort such as drinks, food, blankets, etc. • If medication is needed, offer choice between PO and IM/IV, offer medication early in encounter
YES NO IL	**Debrief provider team following the incident (if restraints necessary, debrief patient as well)** What went well? What could have gone better? What did we learn? Who needs to know?

Instructor notes:

Verbal De-escalation

Clinical Information for Verbal De-escalation

Objective of Procedure:
Verbal engagement with patient and establishing collaborative relationship with patient
Preventing violent behavior
Avoiding use of restraintes
Reducing patient anger and frustration
Maintaining staff and patient safety
Enabling patients to manage their emotions and regain personal control

Scope of Practice: EMR EMT AEMT Paramedic

Indications:
1. Behavioral Health Crisis
2. Behavior Activity Rating Score ≥ 5

Contraindications:
None

Clinical Presentation:
Patient experiencing a behavioral crisis defined as:
- Significantly deviates from society's expectations and commonly held normal behavior
- Behavior that is unusual for patient's baseline
- Bizarre
- Threatening
- Dangerous to self and/or others
- Alarming to patient, family, or bystanders
- Interferes with the patients ability to perform basic life functions and activities of daily living

Behavior Activity Rating Score ≥ 5

Potential Complications:
Injury to patient, provider, or bystander
Need to move to restraint procedure
Exacerbation of agitated condition

Procedure references:
1. Palmer J. (2019). Joint Commission Issues De-escalation Guidebook for Healthcare Facilities and Workers. Patient Safety and Quality Healthcare (PSQH). https://www.psqh.com/analysis/joint-commission-issues-de-escalation-guidebook-for-healthcare-facilities-and-workers/
2. Richmond JS, Berlin JS, Fishkind AV, et al. (2012). Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. West J Emerg Med 13(1):17-25. doi: 10.5811/westjem.2011.9.6864

Interpreter Services pg. 1/3

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Patient's with a language barrier for communication with EMS personnel.
- This service shall be offered to any patient with a language barrier and is unable to communicate with EMS personnel for the purposes of patient assessment, treatment, and/or transport.

Procedure:

1. DIAL: 866-874-3972
2. PROVIDE AGENCY CODE: 697657
3. INDICATE: the language you need
4. PROVIDE: additional information, if required.
5. Document the interpreter name and ID number for your reference. Brief the interpreter and give any special instructions.
6. See attached Interpreter Quick Reference Guide (page 2) and Partnering With An Interpreter (page 3) for additional information.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

LanguageLine Solutions®

Quick Reference Guide

Alamance County EMS

HOW TO ACCESS AN INTERPRETER

1. DIAL: **866-874-3972**
2. PROVIDE: **697657**
3. INDICATE: the language you need
4. PROVIDE: additional information, if required.

Document the interpreter name and ID number for your reference.
Brief the interpreter and give any special instructions.

IMPORTANT INFORMATION:

WORKING WITH AN INTERPRETER - At the beginning of the call, interpreters identify themselves by name and ID number. Note this information for reference. Then tell the interpreter the nature of the call. Speak directly to the limited English proficient or Deaf or Hard of Hearing individual, not to the interpreter, pausing at the end of a complete thought. To ensure accuracy, your interpreter may ask for clarification or repetition.

3-WAY CALL – INITIATING/RECEIVING A CALL - Use the conference feature on your phone and follow the instructions provided to connect to an interpreter. If you are initiating the call, get the interpreter on the line first, then call the limited English proficient individual. If you are receiving a call, ask the caller to "Please Hold," and then conference in the interpreter.

PHONE INTERPRETING EQUIPMENT - If you have interpreting equipment, use one handset to call into LanguageLine, once connected to the interpreter, give the second handset to the limited English proficient individual.

CUSTOMER SERVICE - To provide feedback, commend an interpreter, or report any service concerns, visit www.LanguageLine.com and click on the "Client Resources" tab, scroll to "Voice of the Customer" and complete the form.

LEARN MORE Visit www.LanguageLine.com or call 1-800-752-6096 for more information on our language access solutions.

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Partnering With An Interpreter

LanguageLine Solutions®

Partnering with Your LanguageLine Solutions® Interpreter to Ensure Effective Communication

1

STARTING THE SESSION

- Allow the interpreter to start the session by giving you their name and Interpreter ID. Document this information for reference.
- Introduce yourself to the interpreter.
- Brief the interpreter and state the goal of the session and provide any specific instructions.
- Introduce yourself and the interpreter to the limited English proficient, Deaf, or Hard-of-Hearing individual.

2

DURING THE SESSION

- Address the limited English proficient, Deaf, or Hard-of-Hearing individual, not the interpreter. The interpreter will be your voice. Keep in mind that everything stated will be interpreted.
- State information in short, concise sentences. When stating complicated or detailed information, speak at a slow pace and pause often. This allows the interpreter to note, retain, and relay the information. The interpreter may sometimes ask for repetitions or clarification.
- Avoid technical jargon and try to explain specialized terms or concepts.
- Avoid interrupting the interpreter or talking at the same time.
- Do not ask interpreters for their opinion.

3

ENDING THE SESSION

- Ask the limited English proficient, Deaf or Hard-of-Hearing individual if they understood, or if they have any questions or concerns.
- Allow the interpreter to interpret everything before ending the session.

FOR MORE INFORMATION

www.LanguageLine.com / 1-800-752-6096

Onsite Interpreters

Phone Interpreters

Video Interpreters

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Enabling Communication in Any Situation.℠ www.LanguageLine.com

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Cardiac: 12 Lead ECG

B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

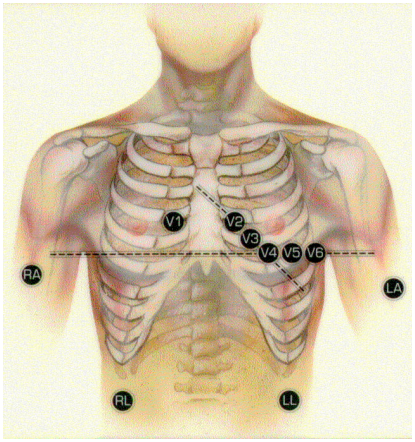
- Suspected cardiac patient
- Suspected tricyclic overdose
- Electrical injuries
- Syncope

EMT and AEMT providers are NOT permitted to interpret 12 Lead ECG.

12 Lead ECG performed by EMT or AEMT should be interpreted by Paramedic or utilize ECG software interpretation AND transmitted to Medical Control for interpretation.

Procedure:

1. Assess patient and monitor cardiac status.
2. Administer oxygen as patient condition warrants.
3. If patient is unstable, definitive treatment is the priority. If patient is stable or stabilized after treatment, perform a 12 Lead ECG.
4. Prepare ECG monitor and connect patient cable with electrodes.
5. Enter the required patient information (patient name, etc.) into the 12 lead ECG device.
6. Expose chest and prep as necessary. Modesty of the patient should be respected.
7. Apply chest leads and extremity leads using the following landmarks:
   - RA -Right arm
   - LA -Left arm
   - RL -Right leg
   - LL -Left leg
   - V1 -4th intercostal space at right sternal border
   - V2 -4th intercostal space at left sternal border
   - V3 -Directly between V2 and V4
   - V4 -5th intercostal space at midclavicular line
   - V5 -Level with V4 at left anterior axillary line
   - V6 -Level with V5 at left midaxillary line



8. Instruct patient to remain still.
9. Press the appropriate button to acquire the 12 Lead ECG.
10. If the monitor detects signal noise (such as patient motion or a disconnected electrode), the 12 Lead acquisition will be interrupted until the noise is removed.
11. Once acquired, transmit the ECG data by fax to the appropriate hospital.
12. Contact the receiving hospital to notify them that a 12 Lead ECG has been sent.
13. Monitor the patient while continuing with the treatment protocol.
14. Download data as per guidelines and attach a copy of the 12 lead to the PCR.
15. Document the procedure, time, and results on/with the patient care report (PCR)

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Cardiac: 15 Lead ECG

Clinical Indications:

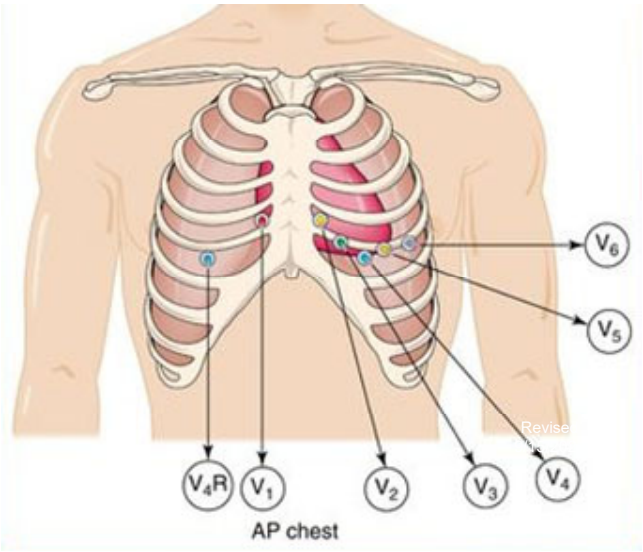
Suspected cardiac patient with right ventricular involvement
Suspected cardiac patient with posterior heart involvement
Suspected cardiac patient with no ST abnormalities observed

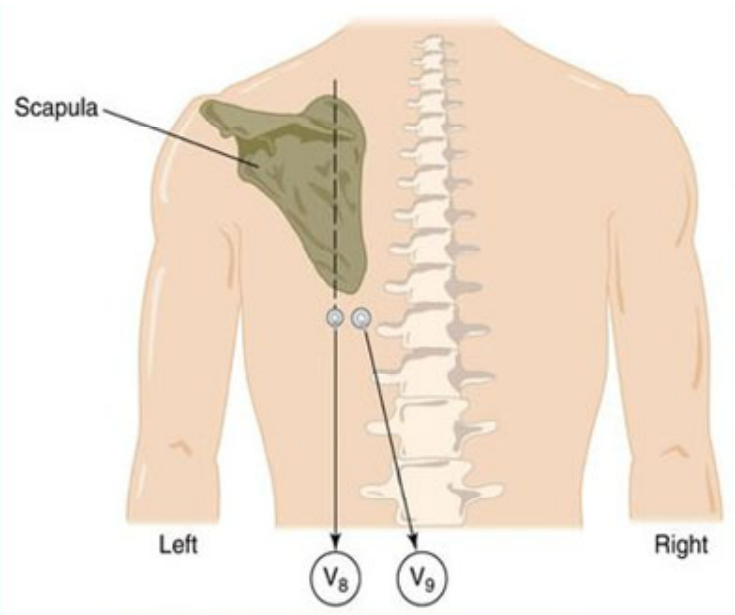
B	EMT	B
A	AEMT	A
P	Paramedic	P

Procedure:

1. After obtaining 12 lead ECG, move chest leads using the following landmarks:
2. Keep extremity leads in place and V1, V2, and V3 in place as you had them with your 12 lead ECG.
3. Remove V4, V5, and V6.
4. Place V4 in the 5th IC space, mid clavicular line right side (same as V4 on the left).
5. Place V5 in the 5th IC space mid scapular.
6. Place V6 in the 5th IC space between V5 and spine.
7. Press the 12 lead button to obtain tracing.
8. V4 now becomes V4R, V5 now becomes V8 and V6 becomes V9.
9. Once the 15 Lead is printed, re-label the leads accordingly.

- Elevation in V4R is diagnostic for a Right Ventricular Infarction (RVI).
- Elevation in leads V8 and V9 are diagnostic of a Posterior Wall M.I.





Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Cardiac: Cardioversion

P PARAMEDIC P

Clinical Indications:

- Unstable patient with a tachydysrhythmia (rapid atrial fibrillation, supraventricular tachycardia, ventricular tachycardia)
- Patient is not pulseless (the pulseless patient requires unsynchronized cardioversion, i.e., defibrillation)

Procedure:

1. Ensure the patient is attached properly to a monitor/defibrillator capable of synchronized cardioversion.
2. Have all equipment prepared for unsynchronized cardioversion/defibrillation if the patient fails synchronized cardioversion and the condition worsens.
3. Consider the use of pain or sedating medications.
4. Set energy selection to the appropriate setting.
5. Set monitor/defibrillator to synchronized cardioversion mode.
6. Make certain all personnel are clear of patient.
7. Press and hold the shock button to cardiovert. Stay clear of the patient until you are certain the energy has been delivered. NOTE: It may take the monitor/defibrillator several cardiac cycles to “synchronize”, so there may a delay between activating the cardioversion and the actual delivery of energy.
8. Note patient response and perform immediate unsynchronized cardioversion/defibrillation if the patient’s rhythm has deteriorated into pulseless ventricular tachycardia/ventricular fibrillation, following the procedure for Defibrillation-Manual.
9. If the patient’s condition is unchanged, repeat steps 2 to 8 above, using escalating energy settings.
10. Repeat until maximum setting or until efforts succeed. Consider discussion with medical control if cardioversion is unsucessful after 2 attempts.
11. Note procedure, response, and time in the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle., or other mechanisms as deemed appropriate by the local EMS System.

Cardiac: External Pacing

P PARAMEDIC P

Clinical Indications:

- Patients with symptomatic bradycardia (less than 60 per minute) with signs and symptoms of inadequate cerebral or cardiac perfusion such as:
  - Chest Pain
  - Hypotension
  - Pulmonary Edema
  - Altered Mental Status, Confusion, etc.
  - Ventricular Ectopy

Procedure:

1. Attach standard four-lead monitor.
2. Apply defibrillation/pacing pads to chest and back:
   - One pad to left mid chest next to sternum
   - One pad to mid left posterior chest next to spine.
3. Rotate selector switch to pacing option.
4. Adjust heart rate to 70 BPM for an adult and 100 BPM for a child.
5. Note pacer spikes on EKG screen.
6. Slowly increase output until capture of electrical rhythm on the monitor.
7. If unable to capture while at maximum current output, stop pacing immediately.
8. If capture observed on monitor, check for corresponding pulse and assess vital signs.
9. Consider the use of sedation or analgesia if patient is uncomfortable.
10. Document the dysrhythmia and the response to external pacing with ECG strips in the PCR.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Cardiac: Cardiopulmonary Resuscitation (CPR)

	EMR
B	EMT
A	AEMT
P	PARAMEDIC

Clinical Indications:

- Basic life support for the patient in cardiac arrest

Procedure:

1. Assess the patient's level of responsiveness.
2. If no response, open the patient's airway with the head-tilt, chin-lift and look, listen, and feel for respiratory effort. If the patient may have sustained C-spine trauma, use the modified jaw thrust while maintaining immobilization of the C-spine. For infants, positioning the head in the sniffing position is the most effective method for opening the airway.
3. Check for pulse (carotid for adults and older children, brachial for infants) for at least 10 seconds. If no pulse, begin chest compressions based on chart below:

Age	Location	Depth	Rate
Infant	Over sternum, between nipples (inter-mammary line), 2-3 fingers	At least 1/3 AP diameter of chest About 1.5 inches 4 cm	Continuous compressions at least 100 – 120/minute
Child	Over sternum, just cephalad from xyphoid process, heel of one hand	At least 1/3 AP diameter of chest About 2 inches 5 cm	Continuous compressions at least 100 – 120/minute
Adult	Over sternum, just cephalad from xyphoid process, hands with interlocked fingers	At least 2 inches 5 cm	Continuous compressions at least 100 – 120/minute

4. If patient is an adult, go to step 5. If no respiratory effort in a pediatric patient, give two ventilations. If air moves successfully, go to step 5. If air movement fails, proceed to the Airway Obstruction Procedure.
5. Go to Cardiac Arrest Procedure. Begin ventilations in the adult as directed in the Cardiac Arrest Procedure
6. Provide 1 breath every 6 seconds with the BVM or BIAD. Use EtCO2 to guide your ventilations as directed in the Cardiac Arrest Protocol.
7. Chest compressions should be provided in an uninterrupted manner. Only brief interruptions (< 5 seconds with a maximum of 10 seconds) are allowed for rhythm analysis, defibrillation, and performance of procedures
8. Document the time and procedure in the Patient Care Report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Cardiac: Defibrillation-Automated

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Patients in cardiac arrest (pulseless, non-breathing).
- Age < 8 years, use Pediatric Pads if available.

Contraindication:

- Pediatric patients who are so small that the pads cannot be placed without touching one another.

Procedure:

1. **If multiple rescuers available, one rescuer should provide uninterrupted chest compressions while the AED is being prepared for use.**
2. Apply defibrillator pads per manufacturer recommendations. Based on 2010 guidelines, place pads preferably in AP or AL position when implanted devices (pacemakers, AICDs) occupy preferred pad positions and attempt to avoid placing directly over device.
3. Remove any medication patches on the chest and wipe off any residue.
4. If necessary, connect defibrillator leads: white to the anterior chest pad and the red to the posterior pad.
5. Activate AED for analysis of rhythm.
6. **Stop CPR and clear the patient** for rhythm analysis. Keep interruption in CPR as brief as possible.
7. Defibrillate if appropriate by depressing the "shock" button. **Assertively state "CLEAR" and visualize that no one, including yourself, is in contact with the patient prior to defibrillation.** The sequence of defibrillation charges is preprogrammed for monophasic defibrillators. Biphasic defibrillators will determine the correct joules accordingly.
8. Begin CPR (chest compressions and ventilations) immediately after the delivery of the defibrillation.
9. After 2 minutes of CPR, analyze rhythm and defibrillate if indicated. Repeat this step every 2 minutes.
10. If "no shock advised" appears, perform CPR for two minutes and then reanalyze.
11. Transport and continue treatment as indicated.
12. **Keep interruption of CPR compressions as brief as possible. Adequate CPR is a key to successful resuscitation.**
13. **If pulse returns please use the Post Resuscitation Protocol**

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Cardiac: Defibrillation-Manual

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Cardiac arrest with ventricular fibrillation or pulseless ventricular tachycardia

Procedure:

1. **Ensure that Chest Compressions are adequate and interrupted only when absolutely necessary.**
2. Clinically confirm the diagnosis of cardiac arrest and identify the need for defibrillation.
3. After application of an appropriate conductive agent if needed, apply defibrillation hands free pads (recommended to allow more continuous CPR) or paddles to the patient's chest in the proper position
   - Paddles: right of sternum at 2nd ICS and anterior axillary line at 5th ICS
   - Pads: anterior-posterior position

   For patients with implanted pacers/defibrillators, paddles or pads can be in AP or AL positions. The presence of implanted pacers/defibrillators should not delay defibrillation. Attempt to avoid placing paddles or pads directly above device.
4. Set the appropriate energy level
5. Charge the defibrillator to the selected energy level. **Continue chest compressions while the defibrillator is charging.**
6. If using paddles, assure proper contact by applying 25 pounds of pressure on each paddle.
7. **Hold Compressions, assertively state, "CLEAR" and visualize that no one, including yourself, is in contact with the patient.**
8. Deliver the countershock by depressing the discharge button(s) when using paddles, or depress the **shock button** for hands free operation.
9. Immediately resume chest compressions and ventilations for 2 minutes. After 2 minutes of CPR, analyze rhythm and check for pulse only if appropriate for rhythm.
10. Repeat the procedure every two minutes as indicated by patient response and ECG rhythm.
11. Keep interruption of CPR compressions as brief as possible. Adequate CPR is a key to successful resuscitation.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Cardiac: Defibrillation-Dual or Double

Clinical Indications:

P PARAMEDIC P

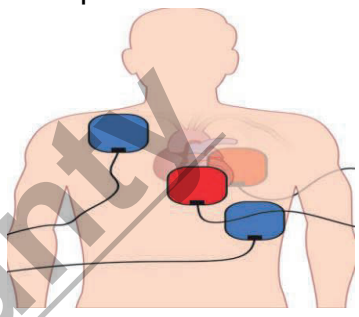
- Cardiac arrest with persistent ventricular fibrillation or pulseless ventricular tachycardia.
- Refractory ventricular fibrillation or pulseless ventricular tachycardia where ≥ 3 shocks delivered.

Procedure:

1. Ensure that Chest Compressions are adequate and interrupted only when absolutely necessary.

2. Clinically confirm the diagnosis of cardiac arrest and identify the need for defibrillation.

3. Prepare sites for second pad set attachment and apply defibrillation hands free pads:



- Pads: First defibrillator pads in anterior-posterior position
- Pads: Second defibrillator pads in anterior-lateral position:
- Ensure pads are not in contact with one another.

For patients with implanted pacers/defibrillators:
Avoid placing paddles or pads directly above device.

4. Set the appropriate energy level and assure controls for both defibrillator / monitors are accessible to provider performing defibrillation.

5. At next pulse / rhythm check, if refractory or persistent VF/VT continues:

Charge the defibrillator to the selected energy level.
Continue chest compressions while the defibrillator is charging.

6. Optional: Agencies may provide a single shock at this point with the second defibrillator / monitor to provide a change in energy vector delivered to the heart then move to step 7 if VF / VT persists.

7. When both monitor / defibrillators have reached selected energy setting:

Hold Compressions, assertively state, "CLEAR" and visualize that no one, including yourself, is in contact with the patient.

2 options at this point:

Option 1 (double simultaneous): Provider depresses both defibrillator shock buttons simultaneously.

Option 2 (dual sequential): Provider depresses monitor 1 shock button and then immediately following, depresses monitor 2 shock button.

8. Immediately resume chest compressions and ventilations for 2 minutes. After 2 minutes of CPR, analyze rhythm and check for pulse only if appropriate for rhythm.

9. Repeat the procedure every two minutes as indicated by patient response and ECG rhythm.

10. Keep interruption of CPR compressions as brief as possible. Adequate CPR is a key to successful resuscitation.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Not Utilized In Alamance County

Cardiac: Mechanical CPR (Lucas)

B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

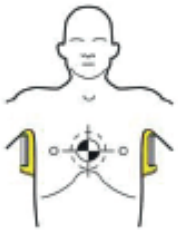
- The Lucas Device will be considered for use by EMS personnel for the treatment of cardiac arrest. The Lucas Devices will be carried on the supervisors vehicle as well as the three medic trucks. Manual Compressions or defibrillation **Will Not** be delayed while the Lucas is being setup or deployed. If mechanical failure of the Lucas occurs, manual chest compressions will be provided immediately.

Contraindications: Do not use the Lucas Device if; 1) It is not possible to position safely or correctly on the patient's chest. 2) The patient is too small. If the Lucas alerts with 3 fast signals when lowering the suction cup, it will not enter the activate mode. 3)The patient is too large. If you cannot lock the upper part of the Lucas to the back plate without compressing the patients chest.

Procedure:

LUCAS does not initially take the place of good, high quality chest compressions.

1. Manual high quality Chest Compression will be administered according to current protocols.
2. Defibrillation / Pacing pads must be positioned so that the pads and cables are not under the suction cup.
3. Open the Lucas case and push the On/Off button on the control panel for 1 second and it will start the self test.
4. Remove the back board from the case. Communicate with other team members as to when and how the back board will be deployed on the next rhythm check.
5. On the next pulse check (end of 2 minute cycle) Make sure the patients head is supported and carefully place the back plate under the patient, immediately below the arm pits. Use one of these procedures:
    - Raise the patient up by list the shoulders or pulling their arms a small distance to get the board under.
    - Roll the patient, insert board and roll back again.
6. Immediately Defibrillate (if needed) and resume manual chest compressions.
7. Hold the handles on the support legs to remove the LUCAS from the case. Pull the release rings to assure the claw locks are open. Let go of the release rings.
8. Attach the support leg to the back plate opposite of the compressor. During the last thirty seconds of the 2 minute cycle, bring the LUCAS over the chest and lock it into position while manual compressions continue.
9. At the end of the compression cycle, assure Lucas is in adjust mode (button 1), with two fingers, push down the suction cup until the pressure pad touches the patients chest.



Cardiac: Mechanical CPR (Lucas)

B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Procedure: Continued

10. Press the pause button (button 2) to lock the start position.
11. Press the Active (Continuous) button (button 3) to start the device.
12. Pause for rhythm / pulse checks every 2 minutes for no longer than 5 seconds. Resume compression while defibrillating.
13. Remove the cushion strap from the carrying case and assure the straps are extended.
14. Place the cushion behind the patients neck as close to the shoulders as possible.
15. Connect the buckles on the cushion straps to the support legs.
16. Hold the support legs stable and tighten the cushion strap tightly.
17. When you move the patient, you can secure the patient's arms on the Lucas.

- **Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.**

Parenteral Access: Arterial Blood Draw

Clinical Indications:

P PARAMEDIC P

- Arterial blood gas (ABG) analysis
- Other needs for arterial blood as indicated by medical control

Procedure:

1. Assemble ABG kit, ice, alcohol wipes, and gloves.
2. Determine if there is any history of trauma or any other difficulties with circulation to either hand. If a problem does exist, do not use that extremity for the blood draw.
3. Palpate the radial pulse just proximal to the wrist.
4. Clean the skin with an alcohol wipe.
5. Insert the ABG syringe at a 45 to 60 degree angle over the area of the pulse.
6. Slowly advance the syringe, watching for return of arterial blood. You do not need to aspirate but rather allow the syringe to fill from the arterial pressure.
7. Once the sample has been acquired, remove and discard the needle in an approved fashion.
8. Place the small airtight cap over the needle port on the syringe. Remove air from the sample by inverting the syringe and pressing the plunger on the syringe until a small amount of the sample enters the airtight cap.
9. Place the sample on ice as soon as possible
10. Hold pressure over the blood draw sight for at least 5 minutes before checking to ensure hemostasis.
11. Record procedure, time, and any complications in patient care report (PCR)

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Not Utilized in Alamance County

Parenteral Access: Arterial Line Maintenance

Clinical Indications:

P PARAMEDIC P

- Transport of a patient with an existing arterial line.

Procedure:

1. Make certain arterial line is secured prior to transport, including intersection of arterial catheter and IV/Monitoring lines.
2. Use available equipment for monitoring of arterial pressures via arterial line.
3. Do not use the arterial line for administration of any fluids or medications.
4. If there is any question regarding dislodgement of the arterial line and bleeding results, remove the line and apply direct pressure over the site for at least five minutes before checking to ensure hemostasis.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Parenteral Access: Venous Blood Draw

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Collection of a patient's blood for laboratory analysis

Procedure:

1. Utilize universal precautions as per OSHA.
2. Select vein and prep as usual.
3. Select appropriate blood-drawing devices.
4. Draw appropriate tubes of blood for lab testing.
5. Assure that the blood samples are labeled with the correct information (a minimum of the patients name, along with the date and time the sample was collected).
6. Deliver the blood tubes to the appropriate individual at the hospital.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Parenteral Access: Central Line Maintenance

Clinical Indications:

P PARAMEDIC P

- Transport of a patient with a central venous pressure line already in place

Procedure:

1. Prior to transportation, ensure the line is secure.
2. Medications and IV fluids may be administered through a central venous pressure line. Such infusions must be held while the central venous pressure is transduced to obtain a central venous pressure, but may be restarted afterwards.
3. Do not manipulate the central venous catheter.
4. If the central venous catheter becomes dysfunctional, does not allow drug administration, or becomes dislodged, contact medical control.
5. Document the time of any pressure measurements, the pressure obtained, and any medication administration in the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Parenteral Access: Epidural Catheter Maintenance

Clinical Indications:

P PARAMEDIC P

- Presence of an epidural catheter in a patient requiring transport

Procedure:

1. Prior to transport, ensure catheter is secure and that transport personnel are familiar with medication(s) being delivered and devices used to control medication administration.
2. No adjustments in catheter position are to be attempted.
3. No adjustments in medication dosage or administration are to be attempted without direct approval from on-line medical control.
4. Report any complications immediately to on-line medical control.
5. Document the time and dose of any medication administration or rate adjustment in the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Parenteral Access: Ventricular Catheter Maintenance

P PARAMEDIC P

Clinical Indications:

- Transport of a patient with an intra-ventricular catheter in place

Procedure:

1. Prior to transport, ensure the catheter is secure.
2. Prior to transport, determine from the referring hospital/physician the desired patient position (e.g., supine, head of bed elevated 30 degrees, etc.).
3. Prior to transport, determine the height at which the drain is to be maintained, given the patient position desired from #2 above (if applicable).
4. Do not manipulate or move the drain.
5. If the patient or height of the drain is altered, immediately correct based on the pre-determined configuration in step 2 and 3 above.
6. Report any problems immediately to on-line medical control.
7. Document the time and any adjustments or problems in the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Standards Procedure (Skill) Parenteral Access Section
Parenteral Access: Existing Catheters

Agency Name:	
Provider Name:	Paramedic
Instructor Name:	EMT AEMT Paramedic Physician

SATISFACTORY ☐

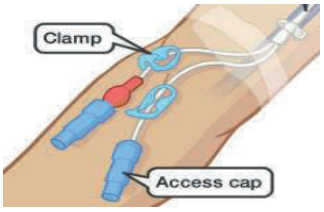
UNSATISFACTORY ☐

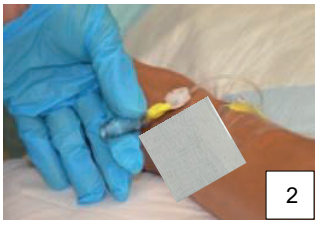
P Paramedic P

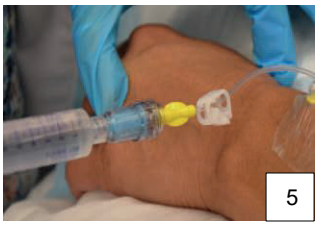
Instructor:
1. Evaluate providers skill performance using the check off list below.
2. Circle performance indicator.
   - YES = Provider completed skill with no assistance from instructor.
   - NO = Provider unable to complete skill satisfactorily following instructor intervention.
   - IL = Provider able to complete skill satisfactorily following Instructor Led (teaching) intervention.

Satisfactory performance indicated with ≥ 12 YES / IL completions. (Combination of both YES and IL)

YES NO IL	Verbalizes at least 3 indications for access of existing parenteral access device: 1. Inability to obtain adequate peripheral access 2. Access of an existing venous catheter for medication or fluid administration 3. Patient requests use of existing parenteral access 4. Device is placed in the venous system and is NOT used for dialysis 5. Access for patient in cardiac arrest 6. Typical catheters: PICC ((Peripherally Inserted Central Catheter); Central Line with 1 to multiple ports; Peripheral IV	
YES NO IL	Verbalizes at least 2 contraindications in access of existing parenteral access device: 1. Catheter used primarily for Hemodialysis and patient is NOT in cardiac arrest 2. Catheter is clogged, clotted, or damaged	
YES NO IL	Perform hand hygiene with soap and water or hand sanitizer	1
YES NO IL	Wear appropriate PPE including gloves (sterile or non-sterile)	2
YES NO IL	Open catheter clamps proximal to access ports	2
YES NO IL	Place sterile dressing between catheter access ports and skin or clothing to provide clean bed to prevent contamination after port cleaning	2
YES NO IL	Generously clean access ports with at least 2 alcohol preps per port or chlorhexidine swab	3
YES NO IL	Hold access ports away from skin or clothing after cleaning until access completed or place ports on sterile dressing to prevent contamination	3
YES NO IL	Insert 10 mL or 20 mL syringe into access port and twist to secure Withdraw 5 – 10 mL of blood and discard in sharps container	4
YES NO IL	Insert 10 mL or 20 mL syringe of Normal Saline into access port and twist to secure connection Flush the catheter with 5 – 10 mL of Normal Saline	5
YES NO IL	If no resistance, no evidence of infiltration, or pain, the begin medication or fluid administration and continue to observe for evidence of infiltration or pain	
YES NO IL	If resistance encountered: Ensure catheter clamps are not closed, open if closed Ensure syringe connection is secure If still unable to flush the catheter, do not use catheter and search for other sites for peripheral access or IO access	
YES NO IL	Record procedure and any complications in Patient Care Report (PCR) Record medication and/or fluid administration in the Patient Care Report (PCR)	







Instructor notes:

Parenteral Access: Existing Catheters

Parenteral Access: Existing Catheters

Objective of Procedure:

Administration of IV medications, IV fluids, blood products and to obtain blood sample through existing access.

Scope of Practice: Paramedic

Indications:

Inability to obtain adequate peripheral access
Access of an existing venous catheter for medication or fluid administration
Patient requests use of existing parenteral access
Device is placed in the venous system and is NOT used for dialysis
Access for patient in cardiac arrest
Typical catheters: PICC ((Peripherally Inserted Central Catheter); Central Line with 1 to multiple ports; Peripheral IV

Contraindications:

Catheter used primarily for Hemodialysis and patient is NOT in cardiac arrest
Catheter is clogged, clotted, damaged, or has signs or symptoms of catheter infection

Clinical Presentation:

Chronic medical conditions requiring recurrent need for IV access for medication, hydration, blood sampling, nutrition, or chemotherapy
Medical condition requiring medication administration outside the hospital.
End-Stage Renal Disease requiring hemodialysis.
Poor peripheral IV access in patients with chronic medical conditions.

Potential Complications:

Pneumothorax
Bleeding
Infection (later finding)
Blood clot
Air embolism

Procedure references:

1. Witt SH, Carr CM, and Krywko DM. (2019). Indwelling Vascular Access Devices: Emergency Access and Management.. Roberts and Hedges' Clinical Procedures in Emergency Medicine and Acute Care. 7th ed.(pp 447-460). Philadelphia, PA. Elsevier. .
2. Paro AP. (2017). Patients with Special Challenges. Emergency Care and Transportation of the Sick and Injured. AAOS. 11th ed. (pp 1336). Burlington, MA. Jones and Bartlett Learning.
3. Practice Parameter. (2012). Practice Guidelines for Central Venous Access: A Report by the American Society of Anesthesiologists Task Force on Central Venous Access.
Anesthesiology 3 2012, Vol.116, 539-573. doi:https://doi.org/10.1097/ALN.0b013e31823c9569

Any local EMS System changes to this document must follow the NC OEMS Protocol Change Policy and be approved by OEMS

Parenteral Access: External Jugular Access

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- External jugular vein cannulation is indicated in a critically ill patient ≥ 8 years of age who requires intravenous access for fluid or medication administration and in whom an extremity vein is not obtainable.
- External jugular cannulation can be attempted initially in life threatening events where no obvious peripheral site is noted.

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. Prep the site as per peripheral IV site.
4. Align the catheter with the vein and aim toward the same side shoulder.
5. "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.
6. Attach the IV and secure the catheter avoiding circumferential dressing or taping.
7. Document the procedure, time, and result (success) on/with the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Parenteral Access: Venous-Extremity

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Any patient where intravenous access is indicated (significant trauma, emergent or potentially emergent medical condition).

Procedure:

1. Saline locks may be used as an alternative to an IV tubing and IV fluid in every protocol at the discretion of the ALS professional.
2. Paramedic/AEMT can use intraosseous access where threat to life exists as provided for in the Venous Access-Intraosseous procedure.
3. Use the largest catheter bore necessary based upon the patient's condition and size of veins.
4. Fluid and setup choice is preferably:
   - Lactated Ringers with a macro drip (10 gtt/cc) for burns
   - Normal Saline with a macro drip (10 gtt/cc) for medical conditions, trauma or hypotension
   - Normal Saline with a micro drip (60 gtt/cc) for medication infusions
5. Inspect the IV solution for expiration date, cloudiness, discoloration, leaks, or the presence of particles.
6. 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.
7. Place a tourniquet around the patient's extremity to restrict venous flow only.
8. Select a vein and an appropriate gauge catheter for the vein and the patient's condition.
9. Prep the skin with an antiseptic solution.
10. Insert the needle with the bevel up into the skin in a steady, deliberate motion until the bloody flashback is visualized in the catheter.
11. Advance the catheter into the vein. **Never** reinsert the needle through the catheter. Dispose of the needle into the proper container without recapping.
12. Draw blood samples when appropriate.
13. Remove the tourniquet and connect the IV tubing or saline lock.
14. Open the IV to assure free flow of the fluid and then adjust the flow rate as per protocol or as clinically indicated.

    Rates are preferably:
    - Adult: KVO: 60 cc/hr (1 gtt/ 6 sec for a macro drip set)
    - Pediatric: KVO: 30 cc/hr (1 gtt/ 12 sec for a macro drip set)

    If shock is present:
    - Adult: 500 cc fluid boluses repeated as long as lungs are dry and BP < 90. Consider a second IV line.
    - Pediatric: 20 cc/kg blouses repeated PRN for poor perfusion.
15. Cover the site with a sterile dressing and secure the IV and tubing.
16. Label the IV with date and time, catheter gauge, and name/ID of the person starting the IV.
17. Document the procedure, time and result (success) on/with the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Parenteral Access: Intraosseous

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Rapid, regular IV access is unavailable with any of the following:
- Cardiac arrest.
- Multisystem trauma with severe hypovolemia.
- Severe dehydration with vascular collapse and/or loss of consciousness.
- Respiratory failure / Respiratory arrest.
- Burns.

Contraindications:

- Fracture proximal to proposed intraosseous site.
- History of Osteogenesis Imperfecta
- Current or prior infection at proposed intraosseous site.
- Previous intraosseous insertion or joint replacement at the selected site.

Procedure:

1. Don personal protective equipment (gloves, eye protection, etc.).
2. **Proximal tibia:** Identify anterior-medial aspect of the proximal tibia (bony prominence below the knee cap). The insertion location will be 1-2 cm (2 finger widths) below this.
   Distal tibia: If this site is not suitable, and patient is an adult, identify the anterior-medial aspect of the distal tibia (2 cm proximal to the medial malleolus).
   Distal femur: If this site is not suitable, and patient is a pediatric, identify the patella with the leg out-stretched to prevent bending of the knee. The insertion site is approximately 1 cm above the patella and approximately 1 – 2 cm medially.
   Proximal humerus: Acceptable insertion site for adult patients. Locate the insertion site 1 – 2 cm above the surgical neck on the most prominent aspect of the greater tubercle. This is located on the lateral aspect of the ball of the humerus. Direct the needle at a 45 degree angle or toward the opposite hip.
3. Prep the site recommended by the device manufacturer with chlorhexidine solution.
4. **IMPORTANT: DO NOT USE EXCESSIVE FORCE.** Use minimal (gentle) steady downward insertion pressure.

5a. For the EZ-IO or BD-IO intraosseous device, hold the intraosseous needle at a 60 to 90 degree angle, aimed away from the nearby joint and epiphyseal plate, power the driver until a “pop” or “give” is felt indicating loss of resistance. Do not advance the needle any further. Blue (25mm) IO needle is typically recommended for tibial IO placement (adults and children), Yellow (45 mm) IO needle is typically utilized for proximal humerus, and Pink (15 mm) should only be utilized in neonates. IO needle choice may vary based on a patient’s body habitus, or abnormal weight for age.

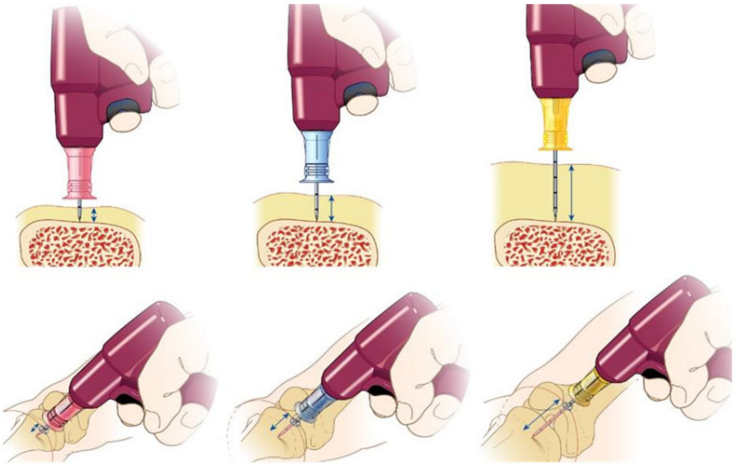
5b. For use of EZ-IO or BD-IO as a manual device, hold the intraosseous needle at a 60 to 90 degree angle, aimed away from the nearby joint and epiphyseal plate, twist the needle handle with a rotating grinding motion applying controlled downward force until a “pop” or “give” is felt indicating loss of resistance. Do not advance the needle any further.

6. Remove the stylette and place in an approved sharps container.
7. Attach a syringe filled with at least 5 cc NS; aspirate bone marrow for manual devices only, to verify placement; then inject at least 5 cc of NS to clear the lumen of the needle.
8. Attach the IV line and adjust flow rate. A pressure bag may assist with achieving desired flows.
9. Stabilize and secure the needle with dressings and tape.
10. Paramedics and AEMT may administer 20 to 50 mg (1 to 2.5 ml) of 2% Lidocaine in adult patients who experience infusion-related pain. This may be repeated prn to a maximum of 60 mg (3 ml). For infant/child dose is 0.5mg/kg, Not to exceed 40mg.
11. Following the administration of any IO medications, flush the IO line with 10 cc of IV fluid.
12. Document the procedure, time, and result (success) on/with the patient care report (PCR).

Parenteral Access: Intraosseous

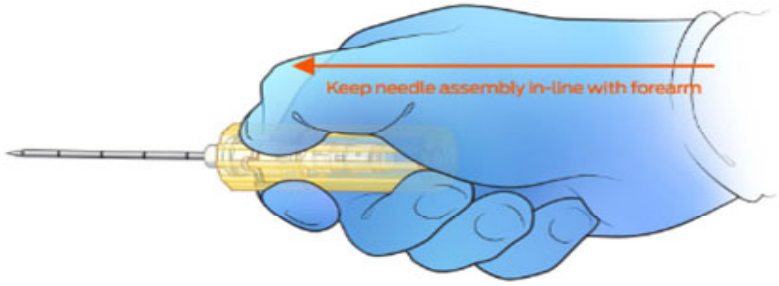
A	AEMT	A
P	PARAMEDIC	P

EZ-IO



With the tip of the needle set touching bone, at least one black line must be visible above the skin (applies to EZ-IO and BD-IO).

BD-IO & EZ-IO



In the event of driver failure, grasp entire needle assembly and disconnect from driver. While holding needle assembly, use gentle downward pressure, while alternately rotating (twisting back and forth) to advance needle assembly into medullary space.

- **Certification Requirements:**

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation at least once per certification cycle.

Parenteral Access: Swan-Ganz Catheter Maintenance

P PARAMEDIC P

Clinical Indications:

- Transport of a patient with a Swan-Ganz catheter that is in place prior to transport.

Procedure:

1. Make certain catheter is secure prior to transport.
2. Under the supervision of the nurse or physician caring for the patient, make certain the transport personnel are aware of the depth at which the catheter is secured.
3. **UNDER NO CIRCUMSTANCES SHOULD TRANSPORT PERSONNEL ADVANCE THE SWAN-GANZ CATHETER.**
4. The sterile plastic sheath that surrounds the catheter should not be manipulated.
5. The ports of the catheter may be used to continue administration of medications or IV fluids that were initiated prior to transport. These should be used as any other IV port with attention to sterile technique.
6. If applicable, measurements from the catheter may be obtained during transport and used to guide care as per local protocols and medical control orders.
7. If at anytime during the transport difficulties with the function of the Swan-Ganz catheter is noted, contact medical control.
8. Document the time and any adjustments or problems associated with the catheter in the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Airway: Suctioning-Advanced

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- 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 naso-tracheal tube, endotracheal tube, Combitube, tracheostomy tube, or a cricothyrotomy tube.

Procedure:

1. Ensure suction device is in proper working order.
2. Preoxygenate the patient as is possible.
3. Attach suction catheter to suction device, keeping sterile plastic covering over catheter.
4. Using the suprasternal notch and the end of the airway into the catheter will be placed as guides, measure the depth desired for the catheter (judgment must be used regarding the depth of suctioning with cricothyrotomy and tracheostomy tubes).
5. If applicable, remove ventilation devices from the airway.
6. With the thumb port of the catheter uncovered, insert the catheter through the airway device.
7. Once the desired depth (measured in #4 above) has been reached, occlude the thumb port and remove the suction catheter slowly.
8. A small amount of Normal Saline (10 ml) may be used if needed to loosen secretions for suctioning.
9. Reattach ventilation device (e.g., bag-valve mask) and ventilate the patient
10. Document time and result in the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Respiratory: Suctioning-Basic

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Obstruction of the airway (secondary to secretions, blood, or any other substance) in a patient who cannot maintain or keep the airway clear.

Procedure:

1. Ensure suction device is in proper working order with suction tip in place.
2. Preoxygenate the patient as is possible.
3. Explain the procedure to the patient if they are coherent.
4. Examine the oropharynx and remove any potential foreign bodies or material which may occlude the airway if dislodged by the suction device.
5. If applicable, remove ventilation devices from the airway.
6. Use the suction device to remove any secretions, blood, or other substance.
7. The alert patient may assist with this procedure.
8. Reattach ventilation device (e.g., bag-valve mask) and ventilate or assist the patient
9. Record the time and result of the suctioning in the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Respiratory: Nebulizer Inhalation Therapy

B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Patients experiencing bronchospasm.

Procedure:

1. Gather the necessary equipment.
2. Assemble the nebulizer kit.
3. Instill the premixed drug (such as Albuterol or other approved drug) into the reservoir well of the nebulizer.
4. Connect the nebulizer device to oxygen at 4 - 6 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.
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.
8. Assess and document peak flows before and after nebulizer treatments.
9. Document the treatment, dose, and route on/with the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Standards Procedure (Skill) Respiratory Section
Respiratory: NIPPV (CPAP)
(Non-Invasive Positive Pressure)

B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Non-Invasive Positive Airway Pressure (NIPPV) or (CPAP) is indicated in all patients whom inadequate ventilation is suspected.
  This could be as a result of Pulmonary Edema, CHF, COPD, Pneumonia, or Asthma.
- Agencies may utilize Continuous and/or Bi-Level Positive Airway Pressure Devices

Clinical Contraindications:

- Decreased Mental Status.
- Facial features or deformities that prevent an adequate mask seal.
- Excessive respiratory secretions.

Procedure:

1. Ensure adequate oxygen supply to ventilation device.
2. Explain the procedure to the patient.
3. Consider placement of a nasopharyngeal airway.
4. Place the delivery mask over the mouth and nose. Oxygen should be flowing through the device at this point.
5. Secure the mask with provided straps starting with the lower straps until minimal air leak occurs.
6. If the Positive Pressure is adjustable on the NIPPV(CPAP) device adjust and slowly titrate to achieve a positive pressure as follows:

<u>Continuous pressure device:</u>

5 – 25 cmH_20 for Pulmonary Edema, CHF, COPD, Asthma, Drowning, possible aspiration, or pneumonia.

<u>Bi-Level pressure device:</u>

IPAP 10 – 15 over EPAP 5 – 7 cmH_2O for Pulmonary Edema, CHF, COPD, Asthma, Drowning, possible aspiration, or pneumonia.

During titration keep IPAP – EPAP at least a difference of 5 cmH_2O

25 cmH_20 is maximum pressure that should be utilized with NIPPV(CPAP).
Increasing positive pressure can cause hypotension.
Use caution or remove and re-evaluate with Systolic Blood Pressures consistently < 100 mmHg.

7. Evaluate the response of the patient assessing breath sounds, oxygen saturation, and general appearance.
8. Titrate oxygen levels to the patient's response. Many patients respond to low FIO2 (30-50%).
9. Encourage the patient to allow forced ventilation to occur. Observe closely for signs of complications. The patient must be breathing for use of the NIPPV(CPAP) device.
10. Document time and response on patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Respiratory: Respirator Operation

A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Transport of an intubated patient

Procedure:

1. Confirm the placement of tube as per airway protocol.
2. Ensure adequate oxygen delivery to the respirator device.
3. Preoxygenate the patient as much as possible with bag-valve mask.
4. Remove BVM and attach tube to respiration device.
5. Per instructions of device, set initial respiration values. For example, set an inspiratory:expiratory ratio of 1:4 (for every 1 second of inspiration, allow 4 seconds and expiration) with a rate of 12 to 20.
6. Assess breath sounds. Allow for adequate expiratory time. Adjust respirator setting as clinically indicated.
7. **It is required that patients on a transport ventilator should be monitored continuously through Capnography and Pulse Oximetry. The ventilatory rate should adjusted to maintain a pulse oximetry of >90 (preferably ≥ 94%) while maintaining a pCO2 of 30-35.**
8. If any worsening of patient condition, decrease in oxygen saturation, or any question regarding the function of the respirator, remove the respirator and resume bag-valve mask ventilations.
9. Document time, complications, and patient response on the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Respiratory: Ventilator Operation

P PARAMEDIC P

Clinical Indications:

- Management of the ventilation of a patient during a prolonged or interfacility transport of an intubated patient.

Procedure:

1. Transporting personnel should review the operation of the ventilator with the treating personnel (physician, nurse, or respiratory therapy) in the referring facility prior to transport if possible.
2. All ventilator settings, including respiratory rate, FiO_2, mode of ventilation, and tidal volumes should be recorded prior to initiating transport. Additionally, the recent trends in oxygen saturation experienced by the patient should be noted.
3. Prior to transport, specific orders regarding any anticipated changes to ventilator settings as well as causes for significant alarm should be reviewed with the referring medical personnel as well as medical control.
4. Once in the transporting unit, confirm adequate oxygen delivery to the ventilator.
5. Frequently assess breath sounds to assess for possible tube dislodgment during transfer.
6. Frequently assess the patient's respiratory status, noting any decreases in oxygen saturation or changes in tidal volumes, peak pressures, etc.
7. Note any changes in ventilator settings or patient condition in the PCR.
8. Consider placing an NG or OG tube to clear stomach contents.
9. **End-tidal (EtCO2) monitoring is mandatory following placement of an endotracheal tube.**
10. If any significant change in patient condition, including vital signs or oxygen saturation or there is a concern regarding ventilator performance/alarms, remove the ventilator from the endotracheal tube and use a bag-valve mask with 100% O_2. Contact medical control immediately.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Not Utilized In Alamance County

Childbirth

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Imminent delivery with crowning

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.
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.
10. Follow the **Newly Born Protocol** for further treatment.
11. The placenta will deliver spontaneously, usually within 5 minutes of the infant. Do not force the placenta to deliver.
12. Massaging the uterus may facilitate delivery of the placenta and decrease bleeding by facilitating uterine contractions.
13. Continue transport to the hospital.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Decontamination

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Any patient who may have been exposed to significant hazardous materials, including chemical, biological, or radiological weapons.

Procedure:

1. In coordination with HazMAT 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.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Gastric Tube Insertion

B	EMT
A	AEMT
P	PARAMEDIC

Clinical Indications:

- Gastric decompression in intubated patients
- Gastric decompression in patients with an i-gel

Contraindications:

- Patients who have received TPA or other thrombolytic
- Patients with basal skull fractures
- History of esophageal varices

EMT and AEMT may only insert orogastric tube when utilizing the gastric channel of an i-gel. EMT may only perform this skill when functioning as a member of Alamance County EMS.

Procedure:

Patient who is intubated or with an i-gel in place:

1. Estimate gastric tube insertion length by superimposing the tube over the body from the mouth to the stomach.
2. Lubricate the distal end of the gastric tube:

P PARAMEDIC P **Intubated**: pass the tube orally with gentle pressure and direct downward toward the pharynx

B EMT B **i-gel**: pass the tube (size 10 French recommended) through the i-gel's gastric channel

3. Continue to advance the tube gently until the appropriate distance is reached. If the tube will not advance with gentle pressure, do not attempt to force it to pass-- reattempt or discontinue
4. Confirm placement by injecting 20cc of air and auscultate for the swish or bubbling of the air over the stomach. Additionally, aspirate gastric contents to confirm proper placement.
5. Secure the tube.
6. Decompress the stomach of air and food either by connecting the tube to suction or manually aspirating with the large catheter tip syringe.
7. **Do not use a gastric tube to instill any contents into the patient.**
8. Document the procedure, time, and result (success) on/with the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Injections: Subcutaneous and Intramuscular

B	*EMT**	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- When medication administration is necessary and the medication must be given via the SQ or IM route (not auto-injector), or as an alternative route in selected medications.

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 cc.
5. The possible injection sites for intramuscular injections include the arm, buttock and thigh.
    - Injection volume should not exceed 1 cc for the arm
    - Injection volume should not exceed 2 cc in the thigh or buttock.
6. The thigh should be used for injections in pediatric patients and injection volume should not exceed 1 cc.
7. Expose the selected area and cleanse the injection site with alcohol.
8. Insert the needle into the skin with a smooth, steady motion

SQ: 45-degree angle skin pinched **IM: 90-degree angle skin flattened**

9. Aspirate for blood
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.
14. Document the medication, dose, route, and time on/with the patient care report (PCR).

** EMT may administer Epinephrine for anaphylaxis, by IM route, if approved by the system medical director.*

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Standards Procedure (Skill) Universal Section
Injections:

Guidelines for Intramuscular and Subcutaneous Injection Administration

Intramuscular Injections[2]

SITE[1]	Infant	Toddler	Preschool-Aged	School-Aged	Adolescent/Adult
Vastus lateralis (lateral thigh)	Needle length: 5/8 inch Volume: 0.5 mL **recommended for infants < 7 months of age	Needle length: 5/8 – 1 inch Volume: 0.5 – 1 mL	Needle length: 1 inch Volume: 1 mL	Needle length: 1 inch Volume: 1.5 –2 mL	Needle length:1-3 inches Volume: 1-5 mL
Ventrogluteal (just below the iliac crest on the lateral thigh)	Needle length:5/8 inch Volume: 0.5 mL **recommended for infants > 7 months of age	Needle length: 5/8 – 1 inch Volume: 1 mL	Needle length: 1 inch Volume: 1.5 mL	Needle length: 1-1.5 inches Volume: 1.5-2 mL	Needle length: 1-3 inches Volume: 1-5 mL
Deltoid (shoulder)	Not recommended	Needle length: 5/8 – 1 inch Volume: 0.5 mL	Needle length: 5/8 – 1 inch Volume: 0.5 mL	Needle length: 5/8 – 1 inch Volume: 0.5 – 1 mL	Needle length: 1-3 inches Volume: 0.5 –2 mL
Dorsogluteal (buttocks)	Not recommended	Not recommended	Not recommended	Needle length: 1/2-1.5 inches Volume: 1.5-2 mL	Needle length: 1-3 inches Volume: 1-5 mL

Subcutaneous Injections[2]: May be given in upper outer arm, anterior thigh, abdomen, upper back, or buttocks

Infant or Child	Adolescent or Adult	Obese Person
Needle length: 3/8 inch Needle gauge: 25 Volume: *no more than 0.1 mL for intradermal *no more than 0.5 mL for small child * no more than 1 mL preschool or school-aged child	Needle length: ½ - 5/8 inch Needle gauge: 25-27 Volume: 0.5 – 1 mL	Needle length: 7/8 inch Needle gauge: 25-27 Volume: 0.5 – 1 mL

[1]Follow manufacture's instructions for required administration sites.

[2]Needle length should be sufficient to reach muscle.

References:

Bowden, V, R., & Greenberg, C. S. (2003). Medication administration: Intramuscular. *Pediatric Nursing Procedures* (pp. 374-375). Philadelphia: Lippincott, Williams, & Wilkins.

Bowden, V, R., & Greenberg, C. S. (2003). Medication administration: Subcutaneous. *Pediatric Nursing Procedures* (pp. 37415-416). Philadelphia: Lippincott, Williams, & Wilkins.

(2000). Intramuscular injections. *Nursing Procedures*. Philadelphia: Lippincott, Williams, & Wilkins.

Alamance County EMS Standards Procedure (Skill)

Medication Administration: Epinephrine 1:1,000

	MR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications for Epinephrine 1:1,000 Administration (Vial or Ampule):

· In an effort to control costs associated with health care, the use of manually delivered Epinephrine 1:1,000 will be utilized by our Medical Responder (MR) and EMT-B personnel.

· Epinephrine 1:1,000 IM is used in moderate to severe allergic reactions / anaphylaxis (protocols AM-1 and PM-1). MR / EMT-B may use Epinephrine 1:1,000 Auto injector if available. If auto injector is not available, then use Epinephrine 1:1,000 vial or ampule.

Relative Contraindications for Epinephrine 1:1,000 Administration (Vial or Ampule):

Mild reactions (Flushing, hives, itching, erythema with normal blood pressure and perfusion.) Advanced cardiac disease such as during a congestive heart failure exacerbation.

Procedure:

1. Receive and confirm medication order or perform according to protocol standing orders.
2. Prepare the equipment and observe standard personal protection measures.
3. Explain the procedure to the patient and confirm the patient is not allergic to Epinephrine.
4. Examine the medication, including the name and expiration date, inspect for discoloration or particles in the medication. Do Not administer if discolored or if particles are present.
5. If using a vial, remove the top, attach a 21 - 25 gauge 1 ½ inch needle to a 1 ml syringe, insert the needle into the vial and withdraw the medication. Invert the syringe to expel any air. Skip to step # 10.
6. If using a glass ampule, “shake down” the ampule. This will force the liquid to the lower portion of the ampule so that it can be broken without medication loss.
7. If using a glass ampule, break the ampule with a 2 x 2 gauze pad to prevent injury.
8. If using a glass ampule, draw out medication using a filter needle with a 1 ml syringe and invert the syringe to expel any air.
9. If using a glass ampule, change the needle to a 21 - 25 gauge 1 ½ inch to administer the medication.
10. Choose a suitable site. The mid, lateral thigh is preferable in adults, and should be used in all pediatric patients. An alternative site is the deltoid muscle in the upper arm.
11. Prepare the site by cleaning it with povidone-iodine or alcohol preparation using a firm circular motion. (If using povidone-iodine make sure patient is not allergic to iodine.)
12. Insert the needle into the muscle at a 90 degree angle with a smooth, steady motion.
13. Aspirate the syringe to assess for blood. If you have blood return, withdraw the needle and reattempt in another site. (change needles)
14. Inject the medication.
15. Withdraw the needle and syringe quickly. Do Not recap the needle.
16. Apply pressure over the site.
17. Dispose of the syringe and needle only in an approved sharps container.
18. Cover with an adhesive strip (band aid).
19. Closely monitor the patient for the desired therapeutic effects and possible undesired side effects.
20. Document medication, dose, route and time in patient care report and patient effects.

Certification Requirements:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms.

Alamance County EMS Standards Procedure (Skill)

Medication Administration: Epinephrine 1:1,000

	MR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Specific requirements for Medical Responder / EMT-B personnel:

· In an effort to control costs associated with health care, the use of manually delivered Epinephrine 1:1,000 will be utilized by our Medical Responder MR and EMT-B personnel.

· Two medication doses will be utilized for simplicity.

1. Weight ≥ 30 kg or about 60 pounds will utilize 0.3 mg of Epinephrine 1:1,000 IM.

2. Weight < 30 kg or about 60 pounds will utilize 0.15 mg of Epinephrine 1:1,000 IM.

Program requirements (ALL Personnel must maintain proficiency in):

1. Basic knowledge, skill and judgment to assess the appropriateness of Epinephrine 1:1,000 IM administration including indications and contraindications.
2. Basic knowledge of the actions, interactions, dose, IM route, side effects and adverse effects of the drug.
3. Ability to calculate dosage correctly.
4. Ability to prepare the Epinephrine 1:1,000 IM correctly.
5. Ability to properly administer Epinephrine 1:1,000 IM in either the deltoid or thigh muscle.
6. Ability to evaluate the effects of the medication.
7. Demonstrate proper documentation techniques including the process and outcomes.
8. Report any adverse side effect or medication error immediately to the Alamance County EMS Training Officer, Quality Manager, EMS Director, or EMS Medical Director. This is an absolute must in order to identify and correct mistakes and is not punitive.

Basic Rules of Medication Administration:

1. Right medication
2. Right dose
3. Right route
4. Right time
5. Right patient

Credentialing Requirements:

· Complete basic continuing education course specific to Epinephrine which includes elements found under Program Requirements and Basic Rules of Medication Administration. Passing a “hands-on” test is required which covers the procedure, signs and symptoms of anaphylaxis and practicum.

· Repeat continuing education course annually. Includes practical demonstration of medication preparation and administration.

· Ability to demonstrate correct preparation and administration at any time to EMS Medical Director or his (her) designee.

· Every MR or EMT-B Epinephrine 1:1,000 administration will be reviewed by the Alamance County EMS Quality Manager or Training Officer. Administration must be reported to Alamance County EMS Training Officer, Quality Manager, or EMS Director via phone, phone message or email message.

· Credential records will be maintained for a period of no less than 3 years by agency.

· Personnel must be in good standing with his or her primary agency.

Standards Procedure (Skill) Universal Section

Restraints: Physical

Agency Name:

Provider Name:

Instructor Name: EMT AEMT Paramedic Physician

SATISFACTORY ☐

UNSATISFACTORY ☐

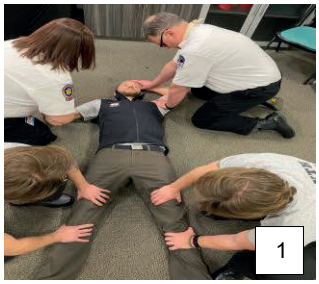
Instructor:
1. Evaluate providers skill performance using the check off list below.
2. Circle performance indicator.
   YES = Provider completed skill with no assistance from instructor.
   NO = Provider unable to complete skill satisfactorily following instructor intervention.
   IL = Provider able to complete skill satisfactorily following Instructor Led (teaching) intervention.

Satisfactory performance indicated with ≥ 12 YES / IL completions. (Combination of both YES and IL)

	EMR	
B	EMT	B
A	AEMT	A
P	Paramedic	P

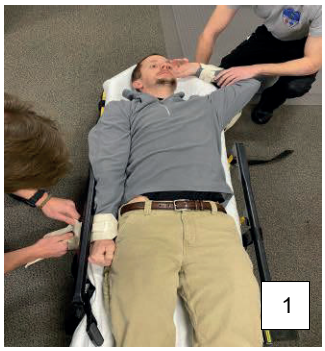
YES NO IL

Verbalizes indications for physical restraints:
1. Used to ensure the physical safety of the patient, provider, or others
2. Clear and immediate danger to the patient (self), provider, or others
3. When less restrictive alternatives are unsuccessful (e.g.. verbal de-escalation)
4. Delay in restraint will subject patient (self) , providers, or others to risk of serious harm



YES NO IL

Verbalizes contraindications for physical restraints:
1. Patient has medical decision-making capacity and refuses care
2. Patient is not a danger to self, provider, or others
3. Less restrictive alternatives have not been considered or used



YES NO IL

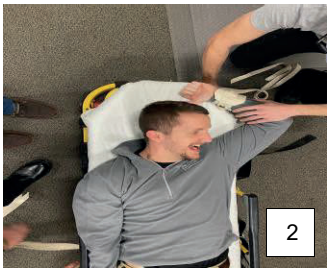
Verbalizes assessment of resource needs:
Request Law Enforcement if indicated
Contact Medical Control if indicated
Call for additional providers if indicated
Withdraw from scene if unsafe

YES NO IL

Assemble appropriate equipment and personnel:
1. 3 – 6 providers preferably
2. Don appropriate PPE
3. Soft nylon or leather restraints specifically manufactured for use as restraints

YES NO IL

Remove potential items from all providers that can be used as weapons:
1. Stethoscope, shears or scissors, hemostats, writing pens, badges, pins
2. Window punch, pocket knives, communication devices



YES NO IL

Team leader assign roles to providers and discusses plans and strategies:
Team leader explains procedure to patient:
If patient standing and will not follow directions use Procedure USP – 6.
If patient already on cot or flat surface:
- 1 Provider to control the head and airway
- 1 Provider for each extremity

1

Team leader attempts verbal instructions to move patient to cot if possible:
- 2 Providers take control of both wrists and elbows
- 2 Providers take control of both ankles and knees
- 1 Provider controls head/airway and 1 Provider is available for medications
- **May place in lateral decubitus position – DO NOT place prone:**

YES NO IL

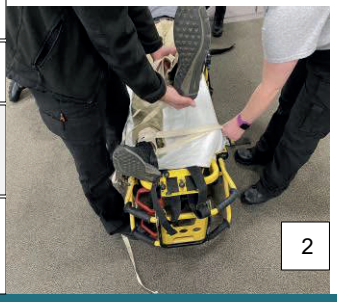
Soft nylon or leather manufacture restraints are applied to wrist and ankles
Secure restraints to cot with quick-release tie
Examine patient for potential injuries following restrain application

YES NO IL

Both lower extremities restrained extended, cross restraints beneath lower extremities
One upper extremity restrained extended by patient's side
One upper extremity restrained flexed over patient's head

2

Do not tie restraint to cot undercarriage



YES NO IL

Assess pulse, motor, and sensory immediately following application
Perform pulse, motor, and sensory assessments every 15 minutes afterwards

YES NO IL

Patient must remain under constant observation by EMS at all times
Appropriate monitoring equipment required based on clinical circumstances. E.g.:
Cardiac monitor, continuous EtCO2, pulse oximetry.

YES NO IL

Patient care report documentation requirements (restraint checklist recommended):
Indication for restraint use. Type of restraint applied and time of application
Pulse, motor, and sensory exams and time of exam

Restraints: Physical

Clinical Information for physical restraints

Objective of Procedure:

To protect a patient from self-harm and/or protection of providers or others on scene
Used when less restrictive alternatives have failed
Used as last resort

Scope of Practice: EMR, EMT, AEMT, and Paramedic

Indications:

Physically combative patient not responding to less restrictive means of de-escalation
Immediate danger of self-harm or harm to providers, or others on scene

Contraindications:

Less restrictive techniques have not been used or considered prior to physical restraint
Intact medical decision-making capacity refusing treatment and not a danger to self or others

Clinical Presentation:

Behavioral health crisis
Altered Mental Status with combativeness
Agitation and violence

Potential Complications:

Positional asphyxiation
Injury to patient, providers, or others
Increased mental stress to patient
Injury following escape from restraints
Bodily fluid exposure

Positioning Considerations:

Do not place patient in a supine position or place objects on top of patient
One arm should be restrained above the head
Both legs should be restrained fully extended
May place in a lateral decubitus position, supine is preferred
Head of bed should be elevated to about 30°

Procedure references:

1. Kowalski JM. (2019). Physical and Chemical Restraint. Roberts and Hedges' Clinical Procedures in Emergency Medicine and Acute Care. 7th ed.(pp 1481 - 1498). Philadelphia, PA. Elsevier.
2. Heiner JD, Moore GP. (2018). The combative and difficult. Rosen's Emergency Medicine: Concepts and Clinical Practice. 9th ed. (pp 2375 - 2386). Philadelphia, PA. Elsevier.
3. Booth JS. (2018, Dec 19). Four-Point Restraint. Retrieved from https://emedicine.medscape.com/article/1941454-overview.
4. Bradley S. (2017). Psychiatric Emergencies. AAOS Emergency Care and Transportation of the Sick and Injured. 11th ed. (pp.802 – 827). Burlington, MA. Jones and Bartlett Learning.

Standards Procedure (Skill) Universal Section

Restraints: Therapeutic Take Down

Agency Name:	
Provider Name:	Paramedic
Instructor Name:	EMT AEMT Paramedic Physician

SATISFACTORY ☐

UNSATISFACTORY ☐

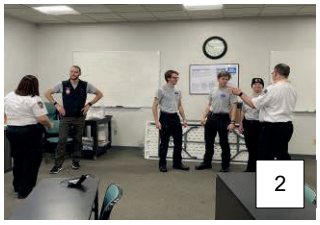
Instructor:
1. Evaluate providers skill performance using the check off list below.
2. Circle performance indicator.
   - YES = Provider completed skill with no assistance from instructor.
   - NO = Provider unable to complete skill satisfactorily following instructor intervention.
   - IL = Provider able to complete skill satisfactorily following Instructor Led (teaching) intervention.

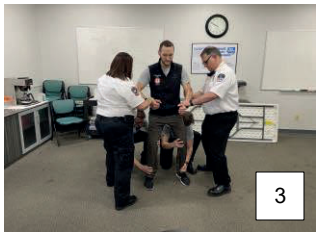
Satisfactory performance indicated with ≥ 12 YES / IL completions. (Combination of both YES and IL)

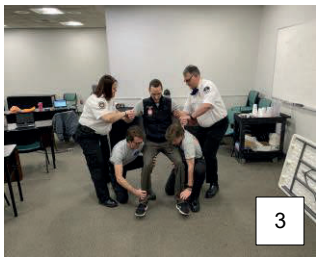
	EMR	
B	EMT	B
A	AEMT	A
P	Paramedic	P

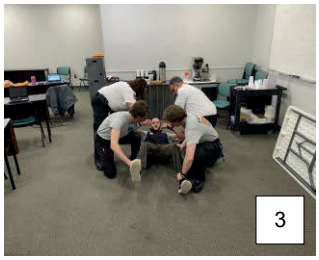
YES NO IL	Verbalizes indications for physical restraints: 1. Used to ensure the physical safety of the patient, provider, or others 2. Clear and immediate danger to the patient (self), provider, or others 3. When less restrictive alternatives are unsuccessful (e.g.. verbal de-escalation) 4. Delay in restraint will subject patient (self) , providers, or others to risk of serious harm	1
YES NO IL	Verbalizes contraindications for physical restraints: 1. Patient has medical decision-making capacity and refuses care 2. Patient is not a danger to self, provider, or others 3. Less restrictive alternatives have not been considered or used	1
YES NO IL	Verbalizes assessment of resource needs: Request Law Enforcement if indicated Contact Medical Control if indicated Call for additional providers if indicated Withdraw from scene if unsafe	2
YES NO IL	Assemble appropriate equipment and personnel: 1. 4 – 6 providers preferably 2. Don appropriate PPE 3. Soft nylon or leather restraints specifically manufactured for use as restraints	2
YES NO IL	Remove potential items from all providers that can be used as weapons: 1. Stethoscope, shears or scissors, hemostats, writing pens, badges, pins 2. Window punch, pocket knives, communication devices	
YES NO IL	Team leader assign roles to providers and discusses plans and strategies: Team leader explains procedure to patient If patient already on cot: 1 Provider to control the head and airway 1 Provider for each extremity 1 Provider to administer medications, if indicated If patient standing or walking: Team leader attempts verbal instructions to move patient to cot if possible 2 Providers approach from front and take control of both wrists and elbows 2 Providers approach from rear and take control of both ankles and knees 1 Provider controls head/airway and 1 Provider is available for medications	3
YES NO IL	With patient supine on cot (may place in lateral decubitus – DO NOT place prone): 2 Providers approach from front and take control of both wrists and elbows 2 Providers approach from rear and take control of both ankles and knees 1 Provider controls head/airway and 1 Provider is available for medications	
YES NO IL	Soft nylon or leather manufacture restraints are applied to wrist and ankles Secure restraints to cot with quick-release tie Examine patient for potential injuries following restrain application	
YES NO IL	Assess pulse, motor, and sensory immediately following application Perform pulse, motor, and sensory assessments every 15 minutes afterwards	
YES NO IL	Patient must remain under constant observation by EMS at all times Appropriate monitoring equipment required based on clinical circumstances	
YES NO IL	Patient care report documentation requirements (restraint checklist recommended): Indication for restraint use Type of restrain applied and time of application Pulse, motor, and sensory exams and time of exam	

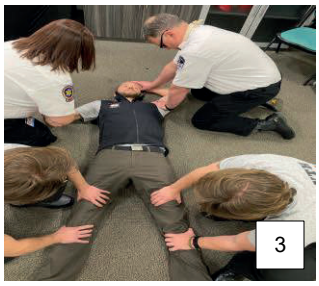
Instructor notes:











Restraints: Therapeutic Take Down

Clinical Information for physical restraints

Objective of Procedure:

To protect a patient from self-harm and/or protection of providers or others on scene
Used when less restrictive alternatives have failed
Used as last resort

Scope of Practice: EMR, EMT, AEMT, and Paramedic

Indications:

Physically combative patient not responding to less restrictive means of de-escalation
Immediate danger of self-harm or harm to providers, or others on scene

Contraindications:

Less restrictive techniques have not been used or considered prior to physical restraint
Intact medical decision-making capacity refusing treatment and not a danger to self or others

Clinical Presentation:

Behavioral health crisis
Altered Mental Status with combativeness
Agitation and violence

Potential Complications:

Positional asphyxiation
Injury to patient, providers, or others
Increased mental stress to patient
Injury following escape from restraints
Bodily fluid exposure

Positioning Considerations:

Do not place patient in a supine position or place objects on top of patient
One arm should be restrained above the head
May place in a lateral decubitus position, supine is preferred
Head of bed should be elevated to about 30°

Procedure references:

1. Kowalski JM. (2019). Physical and Chemical Restraint. Roberts and Hedges' Clinical Procedures in Emergency Medicine and Acute Care. 7th ed.(pp 1481 - 1498). Philadelphia, PA. Elsevier.
2. Heiner JD, Moore GP. (2018). The combative and difficult. Rosen's Emergency Medicine: Concepts and Clinical Practice. 9th ed. (pp 2375 - 2386). Philadelphia, PA. Elsevier.
3. Booth JS. (2018, Dec 19). Four-Point Restraint. Retrieved from https://emedicine.medscape.com/article/1941454-overview.
4. Bradley S. (2017). Psychiatric Emergencies. AAOS Emergency Care and Transportation of the Sick and Injured. 11th ed. (pp.802 – 827). Burlington, MA. Jones and Bartlett Learning.

Chest Decompression

A	AEMT
P	PARAMEDIC

Clinical Indications:

- Patients with hypotension (SBP <90), clinical signs of shock, and at least one of the following signs:
  - Jugular vein distention.
  - Tracheal deviation away from the side of the injury (often a late sign).
  - Absent or decreased breath sounds on the affected side.
  - Hyper-resonance to percussion on the affected side.
  - Increased resistance when ventilating a patient.

- Patients in traumatic arrest with chest or abdominal trauma for whom resuscitation is indicated. These patients may require bilateral chest decompression even in the absence of the signs above.

- **AEMT may only perform chest decompression in the setting of traumatic pulseless cardiac arrest.**

Procedure:

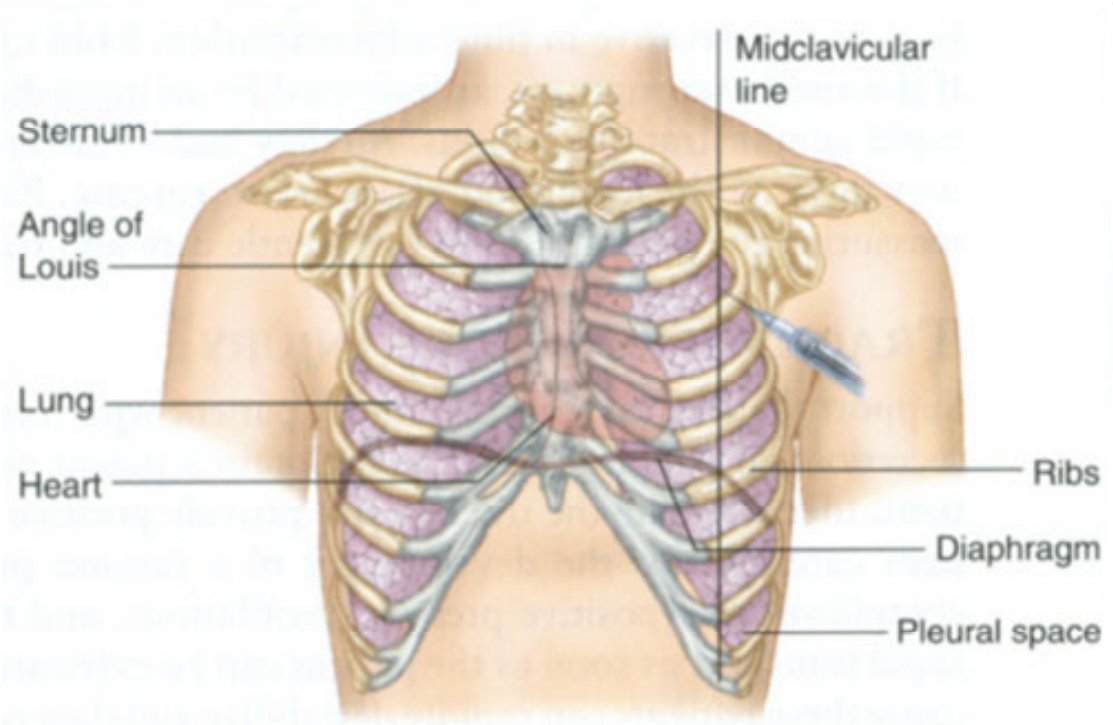
1. Don personal protective equipment (gloves, eye protection, etc.).
2. Administer high flow oxygen.
3. Identify and prep the site:
   - **Preferred Site:** Locate the second intercostal space in the mid-clavicular line on the same side as the pneumothorax.
   - If unable to place anteriorly, lateral placement may be used at the fourth ICS mid-axillary line.
   - Prepare the site with povidone-iodine ointment or Chlorhexidine solution.
4. Insert the catheter (14 gauge for adults) into the skin over the third rib and direct it just over the top of the rib (superior border) into the interspace.
5. Advance the catheter through the parietal pleura until a “pop” is felt and air or blood exits under pressure through the catheter, then advance catheter only to chest wall.
6. Remove the needle, leaving the plastic catheter in place.
7. Secure the catheter hub to the chest wall with dressings and tape.
8. Consider placing a finger cut from an exam glove over the catheter hub. Cut a small hole in the end of the finger to make a flutter valve. Secure the glove finger with tape or a rubber band. (Note – don’t waste much time preparing the flutter valve; if necessary control the air flow through the catheter hub with your gloved thumb.)

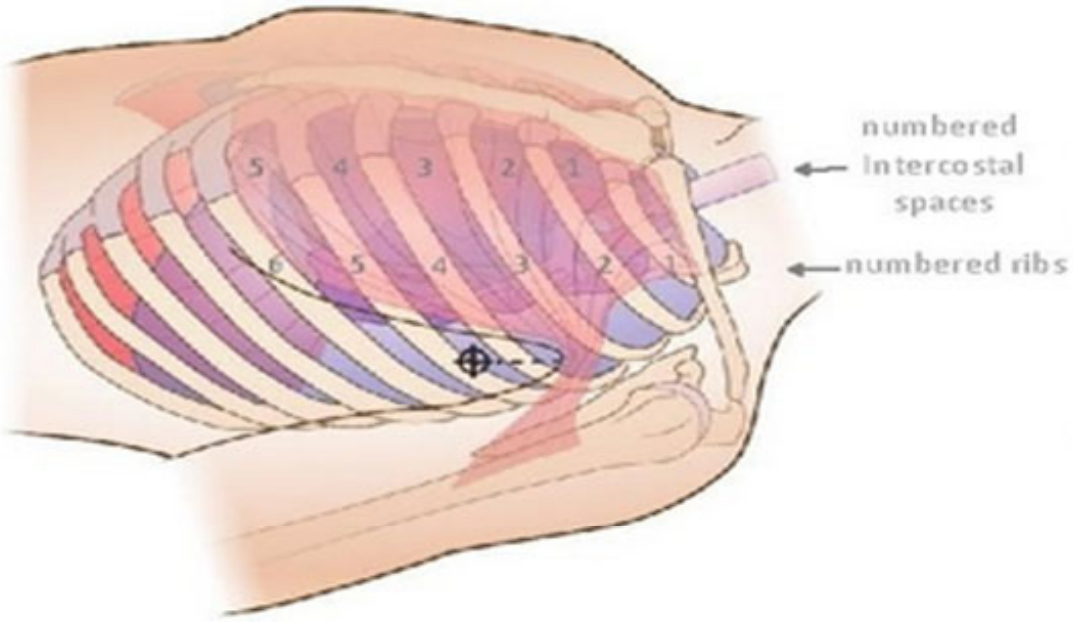
Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation once per certification cycle.

Chest Decompression

A	AEMT
P	PARAMEDIC





4th intercostal space – anterior axillary line

site located superior to 5th rib

Spinal Motion Restriction

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Need for Spinal Motion Restriction as determined by protocol.
- **<u>Guidelines for appropriate use of long spine board (LSB) OR any equivalent device below:</u>**

1. **Spine boards or similar rigid devices, should NOT be used during transport or during inter-facility transfers.** They should be utilized for extrication and / or patient transfers, as well as support for chest compressions. They DO NOT improve outcomes and can induce pain, agitation / anxiety, respiratory compromise, and decreased tissue perfusion at pressure points.

2. Devices such as the long or short spine board, scoop stretcher, soft-body splints, etc., should be considered extrication devices rather than transport-devices. Instead, use of Spinal Motion Restriction which includes a rigid cervical collar, manual in-line spine stabilization, maintaining spinal alignment with movement and transfers, and securing to the ambulance stretcher.
3. Penetrating trauma to head, torso, or back with no evidence of spinal injury does not require Spinal Motion Restriction.

Procedure:

1. Gather LSB, scoop, ambulance cot, or other Spinal Motion Restriction device, securing devices, and appropriate C-collar.
2. Explain the procedure to the patient and assess / record neurological exam and pulse status.
3. Place the patient in an appropriately sized C-collar while maintaining in-line stabilization of the C-spine by second provider. In-line stabilization should not involve traction / tension, but rather maintain the head in a neutral, midline position while the first rescuer applies the collar.
4. Once the collar is secure, the second rescuer should still maintain their position to ensure stabilization (the collar is helpful but will not do the job by itself.)
5. If indicated, place patient on a Spinal Motion Restriction device with log-roll or similar technique dependent on circumstances, if patient is supine or prone. During extrication or where otherwise unable to be placed prone or supine, place on Spinal Motion Restriction device by the safest method available that allows maintenance of in-line spinal stability.
6. Stabilize the patient with straps / head rolls / tape / other devices as needed. Once the head is secured to the Spinal Motion Restriction device / stretcher, the second rescuer may release manual in-line stabilization. **Once the patient arrives at the stretcher, REMOVE the rigid Spinal Motion Restriction device while maintaining spinal alignment using log-roll or multi-rescuer lift techniques and transfer and secure to the stretcher for transport.**
7. NOTE: Spinal precautions may be achieved by many methods. Never force a patient into a certain position to immobilize them. Such situations may require a second rescuer to maintain manual stabilization throughout the transport to the hospital. Special equipment such as football players in full pads and helmet may remain immobilized with helmet and pads in place.
8. Document the time of the procedure in the patient care report (PCR).

Certification Requirements:

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Splinting

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Immobilization of an extremity for transport, either due to suspected fracture, sprain, or injury.
- Immobilization of an extremity for transport to secure medically necessary devices such as intravenous catheters

Procedure:

1. Assess and document pulses, sensation, and motor function prior to placement of the splint. If no pulses are present and a fracture is suspected, consider reduction of the fracture prior to placement of the splint.
2. Remove all clothing from the extremity.
3. Select a site to secure the splint both proximal and distal to the area of suspected injury, or the area where the medical device will be placed.
4. Do not secure the splint directly over the injury or device.
5. Place the splint and secure with Velcro, straps, or bandage material (e.g., kling, kerlex, cloth bandage, etc.) depending on the splint manufacturer and design.
6. Document pulses, sensation, and motor function after placement of the splint. If there has been a deterioration in any of these 3 parameters, remove the splint and reassess
7. If a femur fracture is suspected and there is no evidence of pelvic fracture or instability, the following procedure may be followed for placement of a femoral traction splint:
    - Assess neurovascular function as in #1 above.
    - Place the ankle device over the ankle.
    - Place the proximal end of the traction splint on the posterior side of the affected extremity, being careful to avoid placing too much pressure on genitalia or open wounds. Make certain the splint extends proximal to the suspected fracture. If the splint will not extend in such a manner, reassess possible involvement of the pelvis
    - Extend the distal end of the splint at least 6 inches beyond the foot.
    - Attach the ankle device to the traction crank.
    - Twist until moderate resistance is met.
    - Reassess alignment, pulses, sensation, and motor function. If there has been deterioration in any of these 3 parameters, release traction and reassess.
8. Document the time, type of splint, and the pre and post assessment of pulse, sensation, and motor function in the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Wound Care-General

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Protection and care for open wounds prior to and during transport.

Procedure:

1. Use personal protective equipment, including gloves, gown, and mask as indicated.
2. If active bleeding, elevate the affected area if possible and hold direct pressure. Do not rely on "compression" bandage to control bleeding. Direct pressure is much more effective.
3. Once bleeding is controlled, irrigate contaminated wounds with saline as appropriate (this may have to be avoided if bleeding was difficult to control). Consider analgesia per protocol prior to irrigation.
4. Cover wounds with sterile gauze/dressings. Check distal pulses, sensation, and motor function to ensure the bandage is not too tight.
5. Monitor wounds and/or dressings throughout transport for bleeding.
6. Document the wound and assessment and care in the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Wound Care-Hemostatic Agent

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Serious hemorrhage that can not be controlled by other means.

Contraindications:

- Wounds involving open thoracic or abdominal cavities.

Procedure:

1. Apply approved non-heat-generating hemostatic agent per manufacturer's instructions.
2. Supplement with direct pressure and standard hemorrhage control techniques.
3. Apply dressing.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Wound Care-Conducted Electrical Weapon Removal

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Patient with uncomplicated conducted electrical weapon probes embedded subcutaneously in non-sensitive areas of skin.
- Conducted electrical weapon probes are barbed metal projectiles that may embed themselves up to 13 mm into the skin.

Contraindications:

- Patients with conducted electrical weapon probe penetration in vulnerable areas of body as mentioned below should be transported for further evaluation and probe removal
- Probes embedded in skin above level of clavicles, female breasts, or genitalia
- Suspicion that probe might be embedded in bone, blood vessel, or other sensitive structure.

Procedure:

- Ensure wires are disconnected from weapon.
- Stabilize skin around probe using non-dominant hand.
- Grasp probe by metal body with pliers or hemostats to prevent puncture wounds to EMS personnel.
- Remove probe in single quick motion.
- Wipe wound with antiseptic wipe and apply dressing.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Wound Care-Tourniquet

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Life threatening extremity hemorrhage that can not be controlled by other means.
- Serious or life threatening extremity hemorrhage and tactical considerations prevent the use of standard hemorrhage control techniques.

Contraindications:

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

Procedure:

1. Place tourniquet proximal to wound
2. Tighten per manufacturer instructions until hemorrhage stops and/or distal pulses in affected extremity disappear.
3. Secure tourniquet per manufacturer instructions
4. Note time of tourniquet application and communicate this to receiving care providers
5. Dress wounds per standard wound care protocol
6. If delayed or prolonged transport and tourniquet application time > 45 minutes: consider reattempting standard hemorrhage control techniques and removing tourniquet

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

Open Pneumothorax – Hyfin® Chest Seal

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

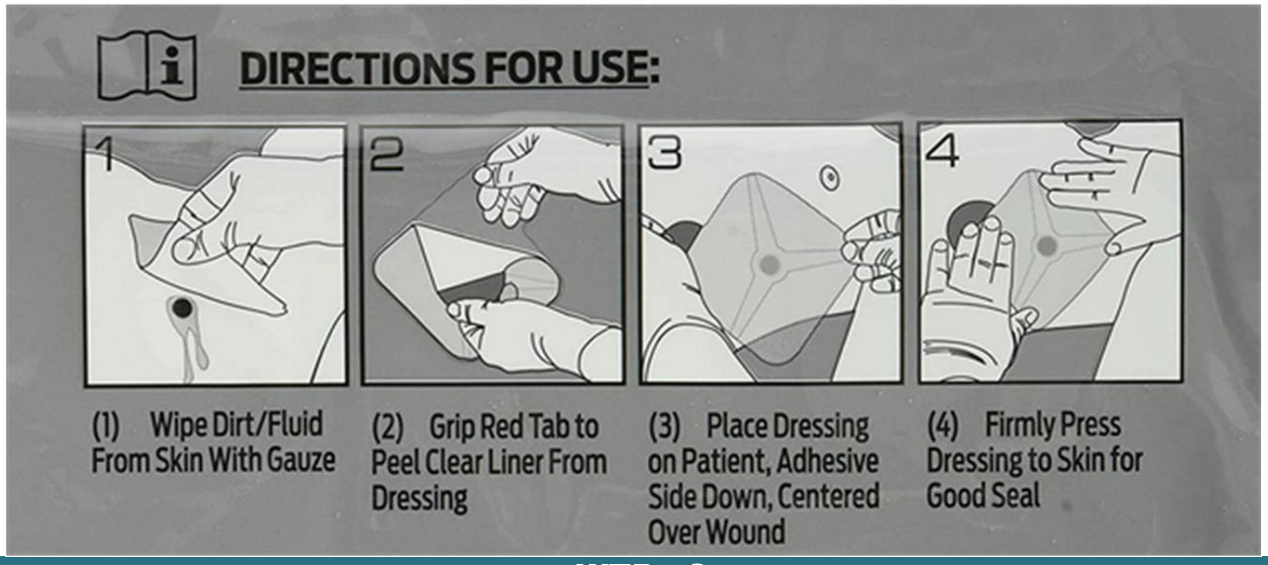
- Penetrating chest trauma.
- Wound present to the chest wall that is sucking air into the chest and visibly frothing or bubbling with evidence of an underlying pneumothorax.

Procedure:

1. Don personal protective equipment (gloves, eye protection, etc.).
2. Administer high flow oxygen.
3. Remove clothing in area of wound.
4. Open package using external red tabs.
5. Identify and prep the site:
   - Wipe dirt/fluid from skin with gauze.
6. Grip red tab to peel clear liner from dressing.
7. Place dressing on patient, adhesive side down, centered over wound.
8. Firmly press dressing to skin for good seal.
9. Smooth out all edges flat against the skin.
10. Assess front and back of patient carefully for additional wounds and apply second seal as indicated.
11. Monitor patient for development of tension pneumothorax if blood accumulates in all three vented channels of the chest seal.

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System. Assessment should include direct observation once per certification cycle.



Wound Care – Compression Bandage

	EMR	
B	EMT	B
A	AEMT	A
P	PARAMEDIC	P

Clinical Indications:

- Moderate to severe hemorrhage from an extremity not requiring a tourniquet application, the trunk, or a head wound.

Procedure:

1. Use personal protective equipment, including gloves, gown, and mask as indicated.
2. If active bleeding, elevate the affected area if possible and hold direct pressure.
3. Apply pressure dressing such as Israeli Bandage over wound.
4. Place sterile non-adherent pad over wound and wrap bandage.
5. When the bandage reaches the pressure bar, insert the fabric into the pressure bar and reverse the direction of the wrap.
6. Wrap the bandage to cover the edges of the pressure bar.
7. Secure the bandage by hooking the ends of the closure bar into the fabric.
8. Monitor wounds and/or dressings throughout transport for bleeding.
9. Document the wound and assessment and care in the patient care report (PCR).

Certification Requirements:

- Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of this knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skills stations, or other mechanisms as deemed appropriate by the local EMS System.

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Disposition Instruction Form

Instructions

The EMS Patient Disposition Information (PDI) form has been designed to be used by EMS personnel to legally document a variety of situations. This duplicate form consists of a single page. The front of the page is used to describe the situation and the back lists a variety of specific patient instructions by complaint.

The form should be used to document any refusal of care by a patient (complete refusal or refusal of specific aspects of care) and to document the patient / guardian's understanding of medical instructions.

To understand the intent of this form, it is probably simplest to walk through several common patient encounter situations.

1. Complete refusal of EMS care or transport: The first box "Patient Refusal" should be marked. In the first section, the appropriate blocks for "paramedic recommendation" should also be marked. This section should be explained to the patient or guardian, who should understand that their refusal may result in complications up to and including death. The patient or guardian should be asked to sign the form, indicating that he/she understands the seriousness of the situation and the information provided. If the situation warrants, the paramedic should explain the risks of the refusal using the patient instructions section and the back of the form for assistance. If the instructions section is used, the appropriate blocks should also checked.

2. Refusal of a specific procedure (IV therapy, for example): The first box "Patient Refusal" should be marked. In the first section, the specific refused procedure should be marked. The first section should be explained to the patient or guardian, who should understand the potential consequences of their refusal. The patient or guardian should be asked to sign the form, indicating that he/she understands the seriousness of the situation.

3. The box "Patient Instructions" and the appropriate blocks in that section should be marked. This section and the specific instructions (on the back) should all be carefully explained to the patient and/or guardian, who must understand them. The patient or guardian should be asked to sign the form, indicating that he/she understands the instructions and the seriousness of the situation.

In all situations, the top part of the form should be completed, and as much of the signature portion as necessary. It is preferable to have witnesses, particularly if the patient or guardian refuses to sign. The original form should be kept on file, while a duplicate copy should be provided for the patient or guardian.

ALAMANCE COUNTY EMERGENCY MEDICAL SERVICES
REFUSAL FOR TREATMENT OR TRANSPORT

Patient's Name	Date of Birth	Date PCR Number
Patient's Address	Phone	EMS Professional's Name No.

PATIENT REFUSAL

☐ ***This section only applies if this box is marked***

The EMS Provider has recommended:

- ☐ A complete physical exam of the patient
- ☐ Measuring the patient's blood pressure
- ☐ A backboard and neck collar for the patient
- ☐ Ambulance transportation for the patient
- ☐ Giving the patient oxygen
- ☐ Starting an IV for the patient
- ☐ Giving the patient medicine _____
- ☐ Other _____

I refuse the care that the EMS Provider has recommended. I understand that my refusal may result in serious injury or death of the patient. I accept full responsibility for this decision. I assume all risks and consequences resulting from my refusal of care. I will not hold Alamance County EMS or its officers, agents or employees responsible for any bad things that happen to the patient because of my refusal.

My signature below attests that I understand what has been recommended, what the consequences may be if that is not done, and I still refuse to have the recommended care provided by Alamance County EMS.

PATIENT INSTRUCTIONS

☐ ***This section only applies if this box is marked***

- ☐ You have not been evaluated by a Physician.
- ☐ You should contact or see your Physician immediately.
- ☐ The patient is being released to: ☐ Family member ☐ Guardian ☐ Law Enforcement Officer ☐ Other:

Follow the Instructions (printed on the back of this form as indicated:

- ☐ Abdominal Pain
- ☐ Fever
- ☐ Respiratory
- ☐ Back Pain
- ☐ Head Injury
- ☐ Vomiting/Diarrhea
- ☒ **Universal**
- ☐ Extremity Injury
- ☐ Insect Bite/Sting
- ☐ Wound Care

Other Instructions:

Guardian's Name (Printed)		☐ Patient ☐ Guardian ☐ Refused to Sign	Patient/Guardian Signature	
Guardian's Address ☐ Same as Patient			Date of Signatures	EMS Personnel's Signature
Witness Signature	Witness Signature	Patient's Physician Name/Phone Number		

(EMS-Word)

Discharge Instructions

UNIVERSAL INSTRUCTIONS:

• YOU HAVE NOT RECEIVED A COMPLETE MEDICAL EVALUATION. SEE A PHYSICIAN AS SOON AS POSSIBLE.

• IF AT ANY TIME AFTER YOU HAVE TAKEN ANY MEDICATION, YOU HAVE TROUBLE BREATHING, START WHEEZING, GET HIVES OR A RASH, OR HAVE ANY UNEXPECTED REACTION, CALL 911 IMMEDIATELY.

• IF YOUR SYMPTOMS WORSEN AT ANY TIME, YOU SHOULD SEE YOUR DOCTOR, GO TO THE EMERGENCY DEPARTMENT OR CALL 911.

ABDOMINAL PAIN:

- Abdominal pain is also called belly pain. Many illnesses can cause abdominal pain and it is very difficult for EMS to identify the cause.
- Take your temperature every 4 hours.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Your pain gets worse or is now only in 1 area
- You vomit (throw up) blood or find blood in your bowel movement
- You become dizzy or faint
- Your abdomen becomes distended or swollen
- You have a temperature over 100° F
- You have trouble passing urine
- You have trouble breathing

BACK PAIN:

- Apply heat to the painful area to help relieve pain. You may use a warm heating pad, whirlpool bath, or warm, moist towels for 10 to 20 minutes every hour.
- Stay in bed as much as possible the first 24 hours.
- Begin normal activities when you can do them without causing pain.
- When picking things up, bend at the hips and knees. Never bend from the waist only.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- You have shooting pains into your buttocks, groin, legs, or arms or the pain increases.
- You have trouble urinating or lose control of your stools or urine.
- You have numbness or weakness in your legs, feet, arms, or hands.

FEVER:

- Always take medications as directed. Tylenol and Ibuprofen can be taken at the same time.
- If you are taking antibiotics, take them until they are gone, not until you are feeling better.
- Drink extra liquids (1 glass of water, soft drink or gatorade per hour of fever for an adult)
- If the temperature is above 103° F, it can be brought down by a sponge bath with room temperature water. Do not use cold water, a fan, or an alcohol bath.
- Temperature should be taken every 4 hours .

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Temperature is greater than 101° F for 24 hours
- A child becomes less active or alert.
- The Temperature does not come down with Acetaminophen (Tylenol) or Ibuprofen with the appropriate dose.

HEAD INJURY:

- Immediately after a blow to the head, nausea, and vomiting may occur.
- Individuals who have sustained a head injury must be checked, and if necessary awakened, every 2 hours for the first 24 hours.
- Ice may be placed on the injured area to decrease pain and swelling.
- Only drink clear liquids such as juices, soft drinks, or water the first 12 hours after injury..
- Acetaminophen (Tylenol) or Ibuprofen only may be used for pain.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- The injured person has persistent vomiting, is not able to be awakened, has trouble walking or using an arm or leg, has a seizure, develops unequal pupils, has a clear or bloody fluid coming from the ears or nose, or has strange behavior.

INSECT BITE/STING:

- A bite or sting typically is a red lump which may have a hole in the center. You may have pain, swelling and a rash. Severe stings may cause a headache and an upset stomach (vomiting).
- Some individuals will have an allergic reaction to a bite or sting. Difficulty breathing or chest pain is an emergency requiring medical care.
- Elevation of the injured area and ice (applied to the area 10 to 20 minutes each hour) will decrease pain and swelling.
- Diphenhydramine (Benadryl) may be used as directed to control itching and hives.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- You develop any chest pain or difficulty breathing.
- The area becomes red, warm, tender, and swollen beyond the area of the bite or sting.
- You develop a temperature above 101° F.

RESPIRATORY DISTRESS:

- Respiratory Distress is also known as shortness of breath or difficulty breathing.
- Causes of Respiratory Distress include reactions to pollen, dust, animals, molds, foods, drugs, infections, smoke, and respiratory conditions such as Asthma and COPD. If possible avoid any causes which produce respiratory distress.
- If you have seen a physician for this problem, take all medication's as directed.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Temperature is greater than 101° F.
- The cough, wheezing, or breathing difficulty becomes worse or does not improve even when taking medications.
- You have Chest Pain.
- Sputum (spit) changes from clear to yellow, green, grey, or becomes bloody.
- You are not able to perform normal activities.

EXTREMITY INJURY:

- Extremity Injuries may consist of cuts, scrapes, bruises, sprains, or broken bones (fractures).
- Apply ice on the injury for 15 to 20 minutes each hour for the first 1 to 2 days.
- Elevate the extremity above the heart as possible for the first 48 hours to decrease pain and swelling.
- Use the extremity as pain allows.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Temperature is greater than 101° F.
- The bruising, swelling, or pain gets worse despite the treatment listed above.
- Any problems listed on the **Wound Care instructions** are noted.
- You are unable to move the extremity or if numbness or tingling is noted.
- You are not improved in 24 to 48 hours or you are not normal in 7 to 10 days.

VOMITING/DIARRHEA:

- Vomiting (throwing up) can be caused by many things. It is common in children, but should be watched closely.
- Diarrhea is most often caused by either a food reaction or infection.
- Dehydration is the most serious problem associated with vomiting or diarrhea.
- Drink clear liquids such as water, apple juice, soft drinks, or gatorade for the first 12 hours or until things improve. Adults should drink 8 to 12 glasses of fluids per day with diarrhea. Children should drink 1 cup of fluid for each loose bowel movement.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- Temperature is greater than 101° F.
- Vomiting or Diarrhea lasts longer than 24 hours, gets worse, or blood is noted.
- You cannot keep fluids down or no urination **is** noted in 8 hours.

WOUND CARE:

- Wounds include cuts, scrapes, bites, abrasions, or puncture wounds.
- If the wound begins to bleed, apply pressure over the wound with a clean bandage and elevate the wound above the heart for 5 to 10 minutes.
- Unless instructed otherwise, clean the wound twice daily with soapy water, and keep the wound dry. It is safe to take a shower but do not place the wound in bath or dish water.
- See a physician for a tetanus shot if it has been 10 years or more since your last one.

Call or see a physician, go to the emergency department, or call 911 immediately if:

- See the **Extremity Injury instructions**.
- Temperature is greater than 101° F.
- Bruising, swelling, or pain gets worse or bleeding is not controlled as directed above.
- Any signs of infection, such as redness, drainage of yellow fluid or pus, red streaks extending from the wound, or a bad smell is noted.

On-Scene Physician Form

This EMS service would like to thank you for your effort and assistance. Please be advised that the EMS Professionals are operating under strict protocols and guidelines established by their medical director and the State of North Carolina. As a licensed physician, you may assume medical care of the patient. In order to do so, you will need to:

1. Receive approval to assume the patient's medical care from the EMS Agencies Online Medical Control physician.
2. Show proper identification including current North Carolina Medical Board Registration/ Licensure.
3. Accompany the patient to the hospital.
4. Carry out any interventions that do not conform to the EMS Agencies Protocols. EMS personnel cannot perform any interventions or administer medications that are not included in their protocols.
5. Sign all orders on the EMS Patient Care Report.
6. Assume all medico-legal responsibility for all patient care activities until the patient's care is transferred to another physician at the destination hospital.
7. Complete the "Assumption of Medical Care" section of this form below.

Assumption of Medical Care

I, _____, MD; License #: _____,
(Please Print your Name Here)

have assumed authority and responsibility for the medical care and patient management for

_____.
(Insert Patient's Name Here)

I understand that I must accompany the patient to the Emergency Department. I further understand that all EMS personnel must follow North Carolina EMS Rules and Regulations as well as local EMS System protocols.

_____, MD Date: _____/_____/_____Time: _____AM/PM
(Physician Signature Here)

_____, EMS _____ Witness
(EMS Lead Crew Member Signature Here) **(Witness Signature Here)**

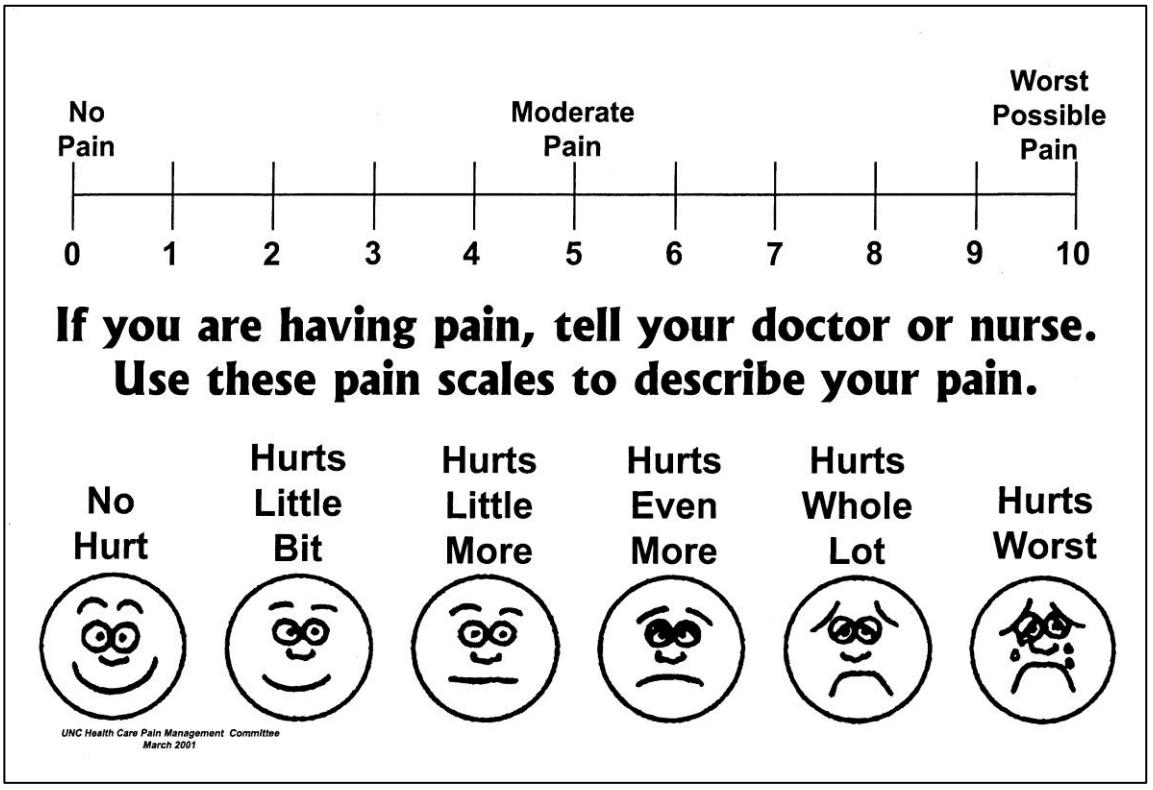
Apgar Score

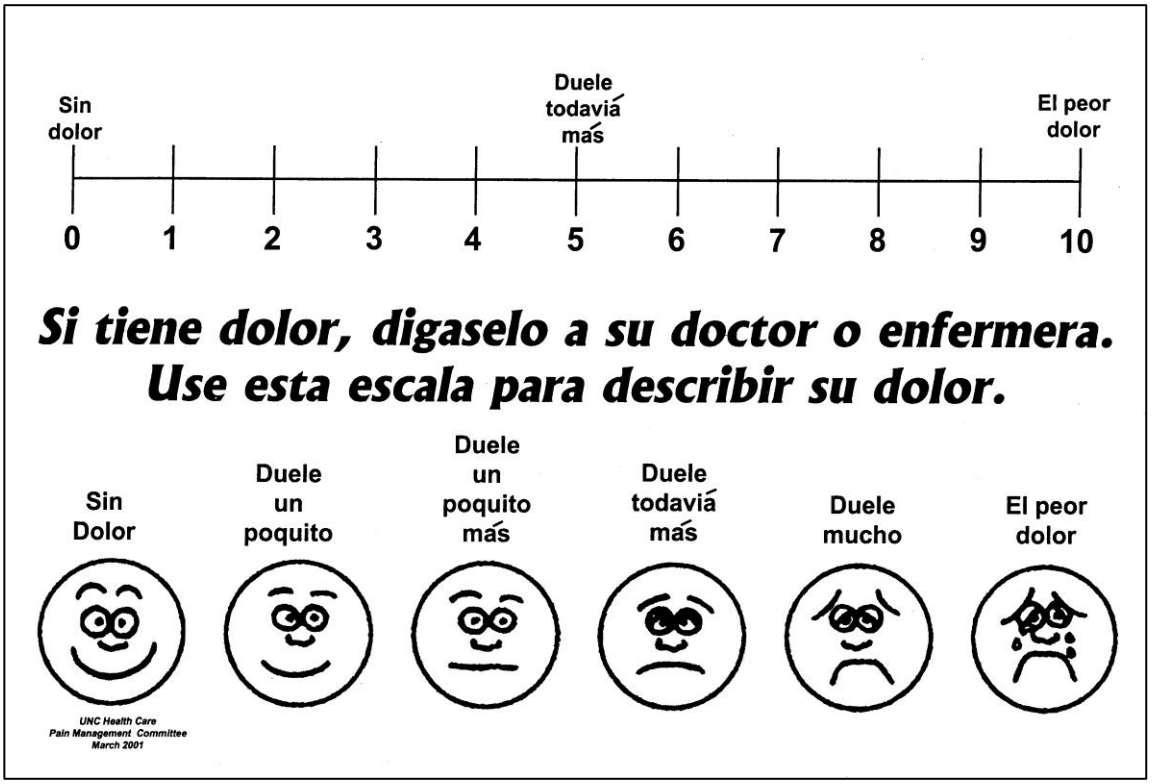
The Apgar score should be obtained and recorded initially and at 5 minutes with the birth of delivery of any infant.

- Each of the 5 parameters should be scored and then totaled.
- The Minimum score is 0
- The Maximum score is 10

Sign	0	1	2
Heart Rate	Absent	<100 min.	>100 min.
Respiratory Effort	Absent	Weak Cry	Strong Cry
Muscle Tone	Limp	Some Flexion	Good Flexion
Reflex Irritability (when feet stimulated)	No Response	Some Motion	Cry
Color	Blue; Pale	Body Pink Extremities Blue	Pink

Pain Scale Forms





From Hockenberry MJ, Wilson D, Winkelstein ML; Wong's Essentials of Pediatric Nursing, ed. 7, St. Louis, 2005, p. 1259. Used with permission. Copyright, Mosby.

Restraint Checklist

Patient's Name: _____

PCR Number:_____ **Date:** _____

It is recommended that a Restraint Checklist be completed with any restraint use.

1. Reason for restraint (check all that apply):

- ☐ Patient attempting to hurt self
- ☐ Patient attempting to hurt others
- ☐ Patient attempting to remove medically necessary devices

2. Attempted verbal reassurance / redirection?

- ☐ Yes
- ☐ No

3. Attempted environmental modification? (i.e. remove patient from stressful environment)

- ☐ Yes
- ☐ No

4. Received medical control order for restraints?

- ☐ Yes _____, MD
- ☐ No **(Medical Control Physician Name Here)**

5. Time and Type of restraint applied (check all that apply):

Date: _____/_____/_____Time: _____AM/PM

Limb restraints:

- ☐ LUE
- ☐ RUE
- ☐ LLE
- ☐ RLE

Chemical Restraint:

- ☐ Yes
- ☐ No

If Yes: Drug Used: _____

Total Dose: _____

6. Vital signs and extremity neurovascular exam should be taken every 15 minutes.

7. Transport Position (Patient should <u>NOT</u> be in prone position)

- ☐ Supine position for transport
- ☐ Lateral recumbent position for transport

Signature: _____

(EMS Lead Crew Member)

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

Most commonly used abbreviations:

A/O x 4	Alert and oriented to person, place, time, and situation
AED	Automated External Defibrillator
AFIB	Atrial Fibrillation
AICD	Automated Internal Cardioverter – Defibrillator
AMA	Against Medical Advice
AMS	Altered Mental Status
ASA	Aspirin
BVM	Bag-Valve-Mask
CA	Cancer
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CBG	Capillary Blood Glucose
CC or C/C	Chief Complaint
CHF	Congestive Heart Failure
COPD	Chronic Obstructive Pulmonary Disease
CVA	Cerebrovascular Accident (Stroke)
DNR	Do Not Resuscitate
ECG or EKG	Electrocardiogram
ED	Emergency Department
GCS	Glasgow Coma Score
GSW	Gunshot wound
HR	Heart rate
HTN	Hypertension
HX	History
LVO	Large Vessel Occlusion
SOB	Shortness of Breath
STEMI	ST Segment Elevation Myocardial Infarction

Agency specific hospital/ facilities abbreviations:
(list medical facilities (hospitals, offices, rehabilitation, skilled nursing facilities, etc. used in your agency)

ARMC	Alamance Regional Medical Center
BHUC	RHA Behavioral Health Urgent Care
DRH	Duke Regional Hospital
DUMC	Duke University Medical Center
UNC-CH	University of North Carolina Hospital – Chapel Hill
UNC-H	University of North Carolina Hospital – Hillsborough
MCO	Moses Cone Hospital
CH-WC	Cone Health Women and Children's Hospital
CH-WL	Cone Health Wesley Long
VA	Veteran's Administration Hospital
WFUBMC	Wake Forest University Baptist Medical Center

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

A:

AAA	Abdominal Aortic Aneurysm
AAL	Anterior Axillary Line
ABC	Airway, Breathing, Circulation
ABD	Abdomen or Abdominal
ABCH	Airway, Breathing, Circulation, Hemorrhage
AC	Antecubital fossa
ACLS	Advanced Cardiac Life Support
ACV	Assist-Control Volume
ACP	Assist-Control Pressure
A/O x 3	Alert and oriented to person, place, and time
A/O x 4	Alert and oriented to person, place, time, and situation
AED	Automated External Defibrillator
AEMT	Advanced Emergency Medical Technician
AFIB	Atrial Fibrillation
AFLT	Atrial Flutter
AFIBRVR	Atrial Fibrillation with Rapid Ventricular Response
AFLTRVR	Atrial Flutter with Rapid Ventricular Response
AI	Adrenal Insufficiency
AICD	Automated Internal Cardioverter – Defibrillator
AIDS	Acquired Immunodeficient Syndrome
AIVR	Accelerated Idioventricular Rhythm
AKA	Above Knee Amputation
ALS	Advanced Life Support
AOSTF	Arrived on scene to find
AM	Morning
AMA	Against Medical Advice
AMB	Ambulance
AMI	Anterior Myocardial Infarction
AMS	Altered Mental Status
AMT	Amount
APGAR	Appearance, Pulse, Grimace, Activity, Respiratory
APPROX or ~	Approximately

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

A:

ASA	Aspirin
ASSOC	Associated or Association
AVB	AV Block / Atrioventricular Block
AVPU	Alert, Responsive to Verbal, Responsive to Pain, Unresponsive

B:

BB	Beta-blockers
BBS	Bilateral Breath Sounds
BILAT or B/L	Bilateral
BIAD	Blind Insertion Airway Device
BI-VAD	Bi-Ventricular Assist Device
BG or BGL	Blood Glucose
BKA	Below Knee Amputation
BL	Bilevel Positive Airway Pressure
BLS	Basic Life Support
BM	Bowel Movement
BP	Blood Pressure
BPM	Breaths per Minute or Beats per Minute
BS	Breath Sounds
BSI	Body Substance Isolation
BVM	Bag-Valve-Mask

C:

CA	Cancer
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CATH	Catheter
Cap refill	Capillary refill
CBG	Capillary Blood Glucose
CC or C/C	Chief Complaint

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

C:

CCP	Casualty Collection Point
CCU	Coronary Care Unit
CHF	Congestive Heart Failure
CHI	Closed Head Injury
CKD	Chronic Kidney Disease
CNA	Certified Nursing Assistant
CNS	Central Nervous System
COMM	Command
COMMP	Command Post
CO2	Carbon Dioxide
C/O	Complains Of
COPD	Chronic Obstructive Pulmonary Disease
CO	Carbon Monoxide
CP	Chest Pain
CPAP	Continuous Positive Airway Pressure
CPR	Cardiopulmonary Resuscitation
CVA	Cerebrovascular Accident (Stroke)
CS	Cervical Spine
CSIC	Cervical Spine Immobilization Collar
CSF	Cerebrospinal Fluid
C-SECT	Cesarean Section
CT	Cat Scan
CTA	Clear to Auscultation

D:

D5W	5% Dextrose in Water
D5NS	5% Dextrose in Normal Saline
D5LR	5% Dextrose in Lactate Ringers
D10	10% Dextrose in Water or 10% Dextrose
D50	50% Dextrose

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

D:

D25	25% Dextrose
DBP	Diastolic Blood Pressure
DC or D/C	Discontinue
DCAPBTLS	Deformities, contusions, abrasions, penetrations, burns, tenderness, lacerations and swelling
Defib	Defibrillation
DKA	Diabetic Ketoacidosis
DL	Direct Laryngoscopy
DNEB	DuoNeb
DNI	Do Not Intubate
DNR	Do Not Resuscitate
DM	Diabetes Mellitus
DOA	Dead on Arrival
DOB	Date of Birth
DOE	Dyspnea on Exertion
DAA	Drug Assisted Airway
DT	Delirium Tremens
DVT	Deep Venous Thrombosis
DX or Dx	Diagnosis

E:

EBL	Estimated Blood Loss
ECG or EKG	Electrocardiogram
ED	Emergency Department
eFAST	Enhanced Focused Assessment with Sonography in Trauma
EEG	Electroencephalogram
EGA	Extra-glottic Airway
EJ	External Jugular
eKit	Emergency (Hospice) Kit
EQ or =	Equal

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

E:

EMD	Emergency Medical Dispatcher
EMR	Emergency Medical Responder
EMT	Emergency Medical Technician
EOC	Emergency Operations Center
ePCR	Electronic Patient Care Report
ESRD	End Stage Renal Disease
ET	Endotracheal
ETA	Estimated Time of Arrival
ETCO2	End-Tidal Carbon Dioxide
ETT	Endotracheal Tube
ETOH	Ethanol or Alcohol
EXT	External or Extension

F:

F or ♀	Female
FAST	Focused Assessment with Sonography in Trauma
FB	Foreign body
FF	Firefighter
FiO2	Fraction of Inspired Oxygen Concentration
FR	First Responder
FSBS	Finger Stick Blood Sugar
FLEX	Flexion
FX	Fracture

G:

g	Gram(s)
G	Gravida
gtts	Drops
>	Greater
≥	Greater than or equal to

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

G:

GCS	Glasgow Coma Score
GI	Gastrointestinal
GIB	Gastrointestinal Bleed (ing)
GSW	Gunshot wound
GU	Genitourinary
GYN	Gynecology or Gynecological

H:

HA	Headache
HazMat	Hazardous Material(s)
HCPOA	Health Care Power of Attorney
HEENT	Head, Eyes, Ears, Nose, Throat
HD	Hemodialysis
HI	Homicidal Ideation
HIV	Human Immunodeficiency Virus
HOB	Head of Bed
HOSP	Hospital
HR	Heart rate
HTN	Hypertension
HTX	Hemothorax
HX	History

I:

IABP	Intra-Aortic Balloon Pump
ICP	Intracranial pressure
ICS	Incident Command System
ICU	Intensive care unit
I:E	Inspiratory to Expiratory Ratio
IM	Intramuscular
IN	Intranasal

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

I:

IO	Intraosseous
IU	International Unit
IUD	Intrauterine Device
IV	Intravenous
IVP	Intravenous Push
IVR	Idioventricular Rhythm
IVPB	IV Piggy Back
IOP	Intraosseous Push

J:

J	Joules
JVD	Jugular Vein Distension

K:

KED	Kendrick Extrication Device
Kg or kg	Kilogram
KTD	Kendrick Traction Device
KVO	Keep Vein Open

L:

L	Liter
LAC	Laceration
LBBB	Left Bundle Branch Block
LEO	Law Enforcement Officer
<	Less
≤	Less than or equal to
LKW	Last Known Well
L-SPINE	Lumbar spine
LS	Lumbosacral spine
L&D	Labor and delivery

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

L:

LAT	Lateral
Lbs.	Pound or Pounds
LLE	Left Lower Extremity
LLQ	Left Lower Quadrant
LUE	Left Upper Extremity
LMA	Laryngeal Mask Airway
LMP	Last Menstrual Period
LOC	Level of Consciousness
LPN	Licensed Practical Nurse
LR	Lactated ringers
LS	Lumbar Spine
LSB	Long Spine Board
LSN	Last Seen Normal
LUQ	Left Upper Quadrant
LVAD	Left Ventricular Assist Device
LVO	Large Vessel Occlusion

M:

M or ♂	Male
MAE	Moves All Extremities
MAP	Mean Arterial Pressure
MCI	Mass Casualty Incident
MCL	Mid Clavicular Line
mcg	Microgram(s)
MDI	Metered Dose Inhaler
ME	Medical Examiner
MED	Medicine
MERT	Medical Emergency Response Team
mEq	Milliequivalent
Mg or mg	Milligram(s)

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

M:

MI	Myocardial Infarction (heart attack)
min	Minute
mL	Milliliter
MOI	Mechanism of Injury
MOST	Medical Order for Scope of Treatment
mm	Millimeter
MS	Mental status
MSC	Mental status change
msec	Miliseconds
MV	Mechanical Ventilation
MVC	Motor Vehicle Crash

N:

N/A	Not applicable
N/V	Nausea/Vomiting
N/V/D	Nausea/Vomiting/Diarrhea
NAD	No Apparent (or Acute) Distress
NAEMSP	National Association of EMS Physicians
NC	Nasal Cannula
NCCEP	North Carolina Chapter of Emergency Physicians
NCOEMS	North Carolina Office of EMS
NEB	Nebulizer
NEG or -	Negative
NGT	Nasogastric Tube
NH	Nursing Home
NIPPV	Non-Invasive Positive Pressure Ventilation
NKDA	No Known Drug Allergies
NO	Nitrous Oxide
NPO	Nothing by Mouth
NPA	Nasopharyngeal Airway

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

N:

NRB	Non-rebreather Face Mask
NREMT	National Registry of EMT
NS	Normal Saline
NSAID	Non-steroidal Anti-inflammatory Drug
NSR	Normal Sinus Rhythm
NSTEMI	Non ST-Segment Myocardial Infarction
NTG	Nitroglycerin
NTI	Nasotracheal Intubation

O:

O2	Oxygen
OBGYN	Obstetrics and Gynecology
OHCA	Out-of-Hospital Cardiac Arrest
OD	Overdose
OGT	Orogastric Tube
OME	Oral Morphine Equivalents
OPA	Oropharyngeal Airway
OPO	Organ Procurement Organization
OTI	Orotracheal Intubation
OTC	Over-the-counter (medications)
OZ	Ounces

P:

P	Para
PA	Physician Assistant
PALP	Palpation
PAC	Premature Atrial Contraction
PBW	Predicted Body Weight
PCI	Percutaneous Coronary Intervention
PCP	Primary Care Provider
PCR	Patient Care Report

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

P:

PD	Peritoneal Dialysis
PE	Pulmonary embolus
PEA	Pulseless Electrical Activity
PEEP	Positive End Expiratory Pressure
PEARL	Pupils equal and reactive to light
PICC	Peripheral Inserted Central Catheter
PIP	Peak Inspiratory Pressure
PJC	Premature Junctional Contraction
PMH	Past Medical History
PM	Evening
PMS	Pulse, Motor, Sensory
PO	Oral or By Mouth
POCUS	Point of Care Ultrasound
POS or +	Positive
POV	Privately Owned Vehicle
PP	Plateau Pressure
PPE	Personal Protective Equipment
PPH	Post partum Hemorrhage
PRN	As needed
PSVT	Paroxysmal Supraventricular Tachycardia
PSY or Ψ	Psychiatric
PT	Patient
PTA	Prior to Arrival
PTX	Pneumothorax
PVC	Premature Ventricular Contraction

Q:

q	Every
QRV	Quick Response Vehicle
QUES or ?	Question or questionable

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

R:

RBBB	Right Bundle Branch Block
ROM	Range of Motion
RLE	Right Lower Extremity
RLQ	Right Lower Quadrant
RUE	Right Upper Ex
ROSC	Return of Spontaneous Circulation
RN	Registered Nurse
RR	Respiratory Rate
RSA	Rapid Sequence Airway
RSI	Rapid Sequence Intubation
RT or RCP	Respiratory Therapist or Respiratory Care Provider
RTF	Rescue Task Force
RUQ	Right Upper Quadrant
RVAD	Right Ventricular Assist Device
RXN	Reaction

S:

SA	Sinus Arrhythmia
SBP	Systolic Blood Pressure
SCBA	Self-Contained Breathing Appartus
S/P	Status Post
sec	Seconds
SGA	Supraglottic Airway
SI	Suicidal Ideation
SIx	Shock Index
SIMV	Synchronized Intermittent Mandatory Ventilation
SL	Sublingual
SOB	Shortness of Breath
SQ	Subcutaneous
SNF	Skill Nursing Facility

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

S:

SOG	Standard Operating Guideline(s)
SOP	Standard Operating Procedure(s)
SPO2	Pulse Oximetry
SMR	Spinal Motion Restriction
SSB	Short Spine Board
SSN	Social Security Number
SSS	Sick Sinus Syndrome
ST	Sinus Tachycardia
STEMI	ST Segment Elevation Myocardial Infarction
SVD	Spontaneous Vaginal Delivery
SVT	Supraventricular Tachycardia
SWAT	Special Weapons and Tactics Team
SX or Sx	Symptom(s)
Sync	Synchronized
SZ or Sz	Seizure

T:

T	Temperature
TAH	Total Artificial Heart
TBSA	Total Body Surface Area
TCP	Transcutaneous Pacing
TFCPR	Team Focused Cardiopulmonary Resuscitation
TIA	Transient Ischemic Attack
TK or TQ	Tourniquet
TKO	To Keep Open
TOB	Time of Birth
TOD	Time of Death
TOI	Time of Ingestion
TOO	Time of Onset
TOR	Termination of Resuscitation

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

T:

tPA	Tissue Plasminogen Activator
T-POD	Trauma Pelvic Orthotic Device
TS	Thoracic Spine
TTP	Targeted Temperature Management
TV	Tidal Volume
TX or Tx	Treatment
TXA	Tranexamic Acid

U:

UOA	Upon Our Arrival
URI	Upper Respiratory Infection
US	Ultrasound
USIV	Ultrasound IV
UTI	Urinary Tract Infection

V:

VAD	Ventricular Assist Device
VF	Ventricular Fibrillation
VL	Video Laryngoscopy
VS or V/S	Vital Signs
VSS	Vital Signs Stable
VT	Ventricular Tachycardia

W:

WAP	Wandering Atrial Pacemaker
WCD	Wearable Cardio-Defibrillator Vest
WMD	Weapon of Mass Destruction
WNL	Within Normal Limits
WPW	Wolf Parkinson White syndrome
W/S	Watts per Second

Approved Medical Abbreviations

The following is a list of approved medical abbreviations. Providers should use only these abbreviations in medical documentation or other agency specific approved abbreviations.

W:

WT or Wt	Weight

Y:

Y/O	Year(s) Old
YOF	Year Old Female
YOM	Year Old Male
YONB	Year Old Nonbinary

Z:

ZED	Zee Extrication Device

Symbol Chart:

~	Approximate, approximately, approximation
&	And
@	At
Δ	Change
°	Degree (s)
=	Equal (s)
♀	Female
>	Greater than
≥	Greater than or equal to
<	Less than
≤	Less than or equal to
♂	Male
-	Negative
#	Number
%	Percent, percentage
+	Positive
Ψ	Psychiatry, psychiatric
?	Question, questionable

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Reperfusion Checklist

The Reperfusion Checklist is an important component in the initial evaluation, treatment, and transport of patients suffering from an acute ST-elevation myocardial infarction (STEMI) or acute Stroke. Both of these conditions can be successfully treated using fibrinolysis (thrombolytics) if the patient arrives at the appropriate hospital within the therapeutic window of time.

This form should be completed for all acute STEMI and acute Stroke patients.

Patient's Name: _____

PCR Number:_____ Date: _____

1. Has the patient experienced chest discomfort for greater than 15 minutes and less than 12 hours?

☐ Yes ☐ No

2. Has the patient developed a sudden neurologic deficit with a positive Cincinnati Prehospital Stroke Screen?

☐ Yes ☐ No

3. Are there any contraindications to fibrinolysis?

If any of the following are checked "Yes", fibrinolysis MAY be contraindicated.

☐ Yes ☐ No Systolic Blood Pressure greater than 180 mm Hg
☐ Yes ☐ No Diastolic Blood Pressure greater than 110 mm Hg
☐ Yes ☐ No Right vs. Left Arm Systolic Blood Pressure difference of greater than 15 mm Hg
☐ Yes ☐ No History of structural Central Nervous System disease (tumors, masses, hemorrhage, etc.)
☐ Yes ☐ No Significant closed head or facial trauma within the previous 3 months
☐ Yes ☐ No Recent (within 6 weeks) major trauma, surgery (including laser eye surgery), gastrointestinal bleeding, or severe genital-urinary bleeding
☐ Yes ☐ No Bleeding or clotting problem or on blood thinners
☐ Yes ☐ No CPR performed greater than 10 minutes
☐ Yes ☐ No Currently Pregnant
☐ Yes ☐ No Serious Systemic Disease such as advanced/terminal cancer or severe liver or kidney failure.

4. (STEMI Patients Only) Does the patient have severe heart failure or cardiogenic shock?
These patients may benefit more from a percutaneous coronary intervention (PCI) capable hospital.

☐ Yes ☐ No Presence of pulmonary edema (rales greater than halfway up lung fields)
☐ Yes ☐ No Systemic hypoperfusion (cool and clammy)

<u>If any contraindication is checked as "Yes" and an acute Stroke is suspected by exam or a STEMI is confirmed by ECG, activate the EMS Stroke Plan or EMS STEMI Plan for fibrinolytic ineligible patients.</u> This may require the EMS Agency, an Air Medical Service, or a Specialty Care Transport Service to transport directly to an specialty center capable of interventional care within the therapeutic window of time.

Difficult Airway Evaluation

Evaluating for the difficult airway

Between 1 – 3% of patients who require endotracheal intubation have airways that make intubation difficult. Recognizing those patients who may have a difficult airway allows the paramedic to proceed with caution and to keep as many options open as possible. It also allows the paramedic to prepare additional equipment (such as a cricothyrotomy kit) that may not ordinarily be part of a standard airway kit. The pneumonic LEMON is useful in evaluating patients for signs that may be consistent with a difficult airway and should raise the paramedic's index of suspicion.

Look externally

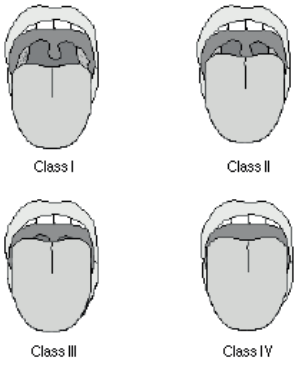
External indicators of either difficult intubation or difficult ventilation include: presence of a beard or moustache, abnormal facial shape, extreme cachexia, edentulous mouth, facial trauma, obesity, large front teeth or "buck teeth", high arching palate, receding mandible, short bull neck.

Evaluate 3-3-2 Rule

3 fingers between the patient's teeth (patient's mouth should open adequately to permit three fingers to be placed between the upper and lower teeth)
3 fingers between the tip of the jaw and the beginning of the neck (under the chin)
2 fingers between the thyroid notch and the floor of the mandible (top of the neck)

Mallampati

This scoring system is based on the work of Mallampati et al published in the Canadian Anaesthesia Society Journal in 1985. The system takes into account the anatomy of the mouth and the view of various anatomical structures when the patient opens his mouth as wide as possible. This test is performed with the patient in the sitting position, the head held in a neutral position, the mouth wide open, and the tongue protruding to the maximum. Inappropriate scoring may occur if the patient is in the supine position (instead of sitting), if the patient phonates or if the patient arches his or her tongue.



Class I (easy) = visualization of the soft palate, fauces, uvula, anterior and posterior pillars.
Class II = visualization of the soft palate, fauces and uvula.
Class III = visualization of the soft palate and the base of the uvula.
Class IV (difficult) = soft palate is not visible at all.

Obstruction?

Besides the obvious difficulty if the airway is obstructed with a foreign body, the paramedic should also consider other obstructers such as tumor, abscess, epiglottis, or expanding hematoma.

Neck Mobility

Ask the patient to place their chin on their chest and to tilt their head backward as far as possible. Obviously, this will not be possible in the immobilized trauma patient.

North Carolina EMS Airway Evaluation Form

The NC EMS Airway Evaluation Form is required to be completed with all patients receiving Drug-Assisted Intubation in the Pre-hospital Environment.

FOR ORAL ROUTE:
Each Insertion of Blade into Oropharynx = 1 Attempt

FOR NASAL ROUTE:
Pass of Tube Past the Nares = 1 Attempt

1. Patient Demographic Information

Date: ___/___/___ Dispatch Time: ___:___ am/pm

PCR # _____

EMS Agency Name:_____

Patient Age (yr): _____ Patient Sex: ❑ M ❑ F

2. Glasgow Coma Score (GCS) before intubation

Eye ❑ (1) ❑ (2) ❑ (3) ❑ (4)

Verbal ❑ (1) ❑ (2) ❑ (3) ❑ (4) ❑ (5)

Motor ❑ (1) ❑ (2) ❑ (3) ❑ (4) ❑ (5) ❑ (6)

3. Was ETI successful for the overall encounter?

❑ Yes ❑ No ❑ Uncertain

4. Was intubation attempt due to Trauma?

❑ Yes ❑ No

5. Level of training of each rescuer assisting with intubation

Rescuer A	Rescuer B	Rescuer C
State ID:	**State ID:**	**State ID:**
❑ Paramedic	❑ Paramedic	❑ Paramedic
❑ EMT-I	❑ EMT-I	❑ EMT-I
❑ Medic Student	❑ Medic Student	❑ Medic Student
❑ Nurse	❑ Nurse	❑ Nurse
❑ Phys. Assist	❑ Phys. Assist	❑ Phys. Assist
❑ MD/DO	❑ MD/DO	❑ MD/DO
❑ Other: _____	❑ Other: _____	❑ Other: _____

6. Indicate drugs given to facilitate intubation

❑ Atropine _____ mg
❑ Etomidate _____ mg
❑ Lidocaine _____ mg
❑ Midazolam _____ mg
❑ Rocuronium _____ mg
❑ Succinylcholine _____ mg
❑ Vecuronium _____ mg
❑ Other–Specify _____–_____ mg
❑ Other–Specify _____–_____ mg

7. Times and Vital Signs

	Time	Heart Rate	Resp. Rate	Blood Pressure	Pulse Oximetry	ECTO$_2$
Pre-Airway Assessment Values	:			/		
Successful Airway Obtained	:					
Post-Airway Assessment Values	:			/		

8. Provide information for each laryngoscopy attempt.

Attempt	ETI Method	Rescuer	Successful?
1	❑ Direct ❑ Nasal ❑ Video	❑ A ❑ B ❑ C	❑ Yes ❑ No
2	❑ Direct ❑ Nasal ❑ Video	❑ A ❑ B ❑ C	❑ Yes ❑ No
3	❑ Direct ❑ Nasal ❑ Video	❑ A ❑ B ❑ C	❑ Yes ❑ No
4	❑ Direct ❑ Nasal ❑ Video	❑ A ❑ B ❑ C	❑ Yes ❑ No

9. Who verified placement of ET Tube?

❑ Rescuer performing intubation
❑ Another rescuer on the same team
❑ Receiving helicopter/EMS crew
❑ Receiving hospital team
❑ Other: _____

10. If all attempts FAILED, indicate secondary airway technique used (Check *all* that apply)

❑ Bag-Valve-Mask (BVM) ❑ Combitube
❑ Open Cricothyroidotomy ❑ King LTD
❑ LMA ❑ Other_____

11. Endotracheal tube confirmation

	Auscultation	ETCO2	Breath Sounds	Absent Epigastric
Placement Confirmation	❑	❑	❑	❑
Tube Size		**Tube Depth**		
Security Method				

12. Were pulses maintained while under agencies care?

❑ Yes ❑ No

13. Signature of Receiving Physician/Healthcare Provider (Confirming Destination/Transfer Tube Placement)

❑ Yes ❑ No ❑ Uncertain

Date and Time: _____ : _____ am/pm

14. Signature of EMS Medical Director (Confirming Review of Completed Form)

❑ Chart Review Done ❑ Remediation Required ❑ Approved

Date:

Burns Resources

Fluid Formula

Formula for Fluid Resuscitation of the Burn Patient (Also known as the Parkland Formula)

Pts Wt kg x %TBSA x 4.0cc LR infused over 24 hours with half given in the first 8 hours.

(For the equation, the abbreviations are: PW x TBSA x 4.0 cc)

EMS focuses on the care given during the 1st hour or several hours following the event. Thus the formula as adapted for EMS and the first 8 hours is:

PW x TBSA x 4.0 cc, divide by 2

to take this to the hourly rate, divide that solution by 8 and the equation becomes:

PW x TBSA x 4.0cc / 2 / 8 = total to be infused for each of the first 8 hours.

Another way to state the equation is to use:
PW x TBSA x 0.25cc = total to be infused for each hour of the first 8 hours.

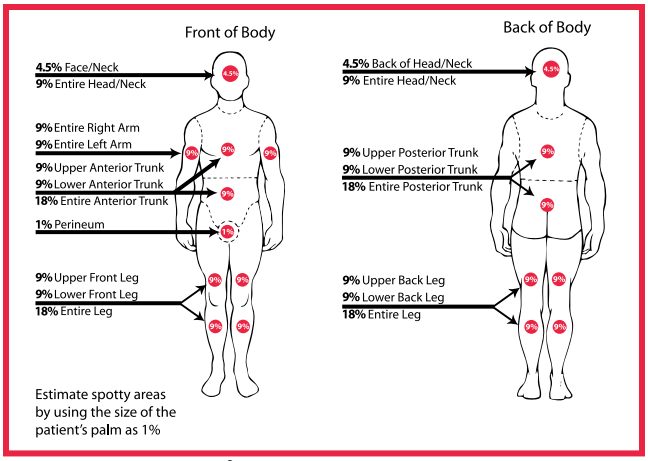
Example, 80 kg patient with 50 %TBSA x 0.25 cc = 1000 cc/hr.

Remember:
Patient's Weight in kg (2.2 lbs = 1.0 kg) example: 220 lbs adult = 100 kg

% TSBA = Rule of Nine Total Body Surface Area

Factor for the 1st hr. and each hr. for the 1st 8 hrs. = 0.25

(Reminder, if two IV's are running, divide total amount to be infused each hr. by 2)



Wt (kg)	% TBSA	Factor	/Hr for 1st 8 Hrs of Care	60 gtt set, gtt/ min	20 gtt set, gtt/ min	15 gtt set, gtt/ min	10 gtt set, gtt/ min
10	10	0.25	25	25	8.3	6.3	4.2
10	20	0.25	50	50	16.7	12.5	8.3
10	30	0.25	75	75	25.0	18.8	12.5
10	40	0.25	100	100	33.3	25.0	16.7
10	50	0.25	125	125	41.7	31.3	20.8
20	10	0.25	50	50	16.7	12.5	8.3
20	20	0.25	100	100	33.3	25.0	16.7
20	30	0.25	150	150	50.0	37.5	25.0
20	40	0.25	200	200	66.7	50.0	33.3
20	50	0.25	250	250	83.3	62.5	41.7
30	10	0.25	75	75	25.0	18.8	12.5
30	20	0.25	150	150	50.0	37.5	25.0
30	30	0.25	225	225	75.0	56.3	37.5
30	40	0.25	300	300	100.0	75.0	50.0
30	50	0.25	375	375	125.0	93.8	62.5
40	10	0.25	100	100	33.3	25.0	16.7
40	20	0.25	200	200	66.7	50.0	33.3
40	30	0.25	300	300	100.0	75.0	50.0
40	40	0.25	400	400	133.3	100.0	66.7
40	50	0.25	500	500	166.7	125.0	83.3
50	10	0.25	125	125	41.7	31.3	20.8
50	20	0.25	250	250	83.3	62.5	41.7
50	30	0.25	375	375	125.0	93.8	62.5
50	40	0.25	500	500	166.7	125.0	83.3
50	50	0.25	625	625	208.3	156.3	104.2
60	10	0.25	150	150	50.0	37.5	25.0
60	20	0.25	300	300	100.0	75.0	50.0
60	30	0.25	450	450	150.0	112.5	75.0
60	40	0.25	600	600	200.0	150.0	100.0
60	50	0.25	750	750	250.0	187.5	125.0
70	10	0.25	175	175	58.3	43.8	29.2
70	20	0.25	350	350	116.7	87.5	58.3
70	30	0.25	525	525	175.0	131.3	87.5
70	40	0.25	700	700	233.3	175.0	116.7
70	50	0.25	875	875	291.7	218.8	145.8
80	10	0.25	200	200	66.7	50.0	33.3
80	20	0.25	400	400	133.3	100.0	66.7
80	30	0.25	600	600	200.0	150.0	100.0
80	40	0.25	800	800	266.7	200.0	133.3
80	50	0.25	1000	1000	333.3	250.0	166.7
90	10	0.25	225	225	75.0	56.3	37.5
90	20	0.25	450	450	150.0	112.5	75.0
90	30	0.25	675	675	225.0	168.8	112.5
90	40	0.25	900	900	300.0	225.0	150.0
90	50	0.25	1125	1125	375.0	281.3	187.5
100	10	0.25	250	250	83.3	62.5	41.7
100	20	0.25	500	500	166.7	125.0	83.3
100	30	0.25	750	750	250.0	187.5	125.0
100	40	0.25	1000	1000	333.3	250.0	166.7
100	50	0.25	1250	1250	416.7	312.5	208.3

Critical (Red)

>15% TBSA 2nd/3rd Degree Burn
Burns with Multiple Trauma
Burns with definitive airway compromise
(When reasonable accessible, transport to a Burn Center)

Serious (Yellow)

5-15% TBSA 2nd/3rd Degree Burn
Suspected Inhalation injury or requiring intubation for airway stabilization
Hypotension
GCS < 14
(When reasonable accessible, transport to either a Level I Burn Center or a Trauma Center)

Minor (Green)

< 5% TBSA 2nd/3rd Degree Burn
No inhalation injury, Not Intubated, Normotensive
GCS>14
(Transport to the Local Hospital)

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HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders
for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name:	Effective Date of Form:
Patient's First Name, Middle Initial:	Patient's Date of Birth:

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C**, and **D**.

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C *Check One Box Only*

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated**	☐ **Feeding tube long-term if indicated**
☐ **IV fluids for a defined trial period**	☐ **Feeding tube for a defined trial period**
☐ **No IV fluids** (provide other measures to ensure comfort)	☐ **No feeding tube**

Other Instructions _____

Section E *Check The Appropriate Box*

DISCUSSED WITH AND AGREED TO BY:

☐ Patient
☐ Parent or guardian if patient is a minor
☐ Health care agent
☐ Legal guardian of the patient
☐ Attorney-in-fact with power to make health care decisions
☐ Spouse
☐ Majority of patient's reasonably available parents and adult children
☐ Majority of patient's reasonably available adult siblings
☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Basis for order must be documented in medical record.

MD/DO, PA, or NP Name (Print):	**MD/DO, PA, or NP Signature and Date** (Required):	**Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

SAMPLE

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information			
Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be signed and dated by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or his/her representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N. C. G en. Stat. 90-21.17.

Reviewing MOST

Review of the MOST form is recommended when:

- The patient is admitted to and/or discharged from a health care facility; or
- There is a substantial change in the patient's health status.

This MOST must be reviewed if:

- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A – E and write "VOID" in large letters.

Revocation of MOST

A patient with capacity or the patient's representative (if the patient lacks capacity) can revoke the MOST at any time and request alternative treatment based on the known preferences of the patient or, if unknown, the patient's best interests.

Review of MOST

Review Date	Reviewer and location of review	MD/DO, PA, or NP Signature (required)	Signature of patient or representative (preferred)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

SAMPLE

NCDHHS/DHSR/OEMS
112

North Carolina Department of Health and Human Services • Division of Health Service Regulation • Office of Emergency Medical Services
www.ncdhhs.gov • www.ncdhhs.gov/dhsr/EMS/ems.htm
N.C. DHHS is an equal opportunity employer and provider. 56,000 copies of this public document were printed at a cost of $4,407.80 or $.04 each. 6/2014

STOP
DO NOT
Resuscitate

Effective Date: _____

Expiration Date, if any _____

☐ Check box if no expiration

DO NOT RESUSCITATE ORDER

SAMPLE

Patient's full name _____

In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.

_____

Signature of Attending Physician/Physician Assistant/Nurse Practitioner

_____

Printed Name of Attending Physician

_____

Address

_____

City, State, Zip

Telephone Number (office) _____

Telephone Number (emergency) _____

Do Not Copy **Do Not Alter**

Coordinated Care of Student Athletes with Potential Spinal Injury
Joint Position Statement
North Carolina High School Athletic Association & North Carolina Office of Emergency Medical Services

In a collaborative effort to provide guidance to Athletic Staff and EMS Professionals in the care of student athletes with potential spinal injury, the North Carolina High School Athletic Association (NCHSAA) and the North Carolina Office of Emergency Medical Services (NCOEMS) have agreed to publish a Joint Position Statement. The goal of both the NCHSAA and NCOEMS is to provide the best care to student athletes in accordance with evidence based medicine.

The NCHSAA's mission is to provide governance and leadership for interscholastic athletic programs that support and enrich the educational experience of students. Health and Safety is a priority of the NCHSAA's Strategic Plan. With both the Mission and Strategic Plan in mind, the NCHSAA wholeheartedly embraces collaboration with the North Carolina Office of Emergency Medical Services.

NCOEMS has the responsibility of protection of the public through credentialing, licensing and statewide prehospital medical oversight of EMS Professionals. NCOEMS embraces collaboration with the North Carolina High School Athletic Association.

- The NCHSAA appreciates and respects the expertise and standard of care afforded to the student athletes in our member schools by the Emergency Medical Service (EMS).
- NCOEMS appreciates and respects the specialized expertise of Athletic Staff and the unique challenges associated with caring for student athletes.
- The NCHSAA looks forward, with great anticipation, to collaborating with the EMS to develop and then communicate to our member schools best practice standards for pre-hospital care of student-athletes with acute cervical spine injury.
- NCOEMS appreciates the opportunity to work with the NCHSAA in this endeavor and is committed to build a strong relationship so that our student athletes, and their families, can participate in sporting events knowing that Athletic Staff and EMS Professionals are working together to ensure proper care will be rendered in the event of an emergency.

The NCHSAA encourages Licensed Athletic Trainers (LAT) to follow recommendations from the National Athletic Trainers Association (NATA) contained in the documents sited below.

Appropriate Pre-Hospital Management of the Spine-Injured Athlete Update

https://www.nata.org/sites/default/files/Executive-Summary-Spine-Injury.pdf

EMS Changes to Pre-Hospital Care of the Athlete with Acute Cervical Spine Injury

https://www.nata.org/sites/default/files/c-spine-management.pdf

NCOEMS encourages EMS agencies to refer to their local protocols and work with their local Medical Director and CE Coordinator to ensure all staff are up to date on the standard of care when dealing with these injuries. Please refer to NCCEP Protocol TB-8.

Selective Spinal Motion Restriction – Protocol TB-8

https://bit.ly/2KX6Q70

With those statements being the foundation of this joint position statement, we would offer the following guidance to both Athletic Staff and EMS Professionals:

Coordinated Care of Student Athletes with Potential Spinal Injury
Joint Position Statement
North Carolina High School Athletic Association & North Carolina Office of Emergency Medical Services

Premise: There are many athletic events that EMS may be standing by or called to that traverse the contact and collision spectrums. The potential for a spinal injury is small, but improper management may result in long term disability.

Goal: To provide a reference and guide for training and management of athletic injuries that crosses the multidisciplinary fields of EMS and sports medicine.

Assumptions: EMS providers are skilled in injury situations with potential spinal injury. Athletic trainers and school staff are skilled in the knowledge of the protective equipment worn by the athletes and personally know the individual players.

Background:
--There are approximately 12,000 spinal cord injuries per year in the US with ~9% coming from athletic events.
--Evidence based medicine has shown the continued use of a spine board to transport the patient can be detrimental to their well-being.
--National Athletic Trainers Association has a document with updates that guides training and care of injured athletes. (Prehospital Care of the Spine Injured Athlete, 1998; Updated in 2015/2016)

Educational points:
--Evidence based medicine shows no improvement with leaving any person (including athletes) on a backboard for transport to hospital.

--Athletic trainers and equipment managers are the experts in the protective equipment worn by athletes.

--Athletic teams--school based and recreation league--should have an emergency action plan (EAP) developed in conjunction with EMS (required by general statute for all Public North Carolina High Schools). As part of that plan, a thorough discussion about use of backboards, per local EMS system protocol, should occur.

--EAP drills should occur at least annually, at the start of football season, with documentation kept by the athletic program and EMS agencies. Those EMS providers rendering care at athletic events are highly encouraged to have specialty training to handle such events (with documentation maintained by the agency)

--EAP drills should review game response and practice field response, as predeployed resources may not be present

--"Pre-game" meetings should occur between the athletic program staff and EMS before the game to review equipment and procedures (if EMS on site).

--Spinal equipment, face mask removal equipment, and a system for notification to EMS to come onto the field (suggested "raised fist") should be reviewed prior to the game.

--The EMS unit should have the stretcher out of the ambulance loaded with equipment and response ready during games. (inclement weather dictates modification)

--An athlete with a suspected spinal injury should have the face mask removed on the field.
    --Pathway for removal:
        1. quick release mounts
        2. cordless screwdriver
        3. manual screwdriver
        4. cutting tool

Coordinated Care of Student Athletes with Potential Spinal Injury
Joint Position Statement
North Carolina High School Athletic Association & North Carolina Office of Emergency Medical Services

--EMS and athletic programs should agree upon the method of spinal motion restriction and the plan to leave on or remove protective equipment. Preferably, this discussion should occur during the EAP drill; but, at a minimum, during pre-game.

Options (gear on for transport)
-1. Place athlete on spine board (remove from board prior to transport)
-2. Place athlete on scoop stretcher or similar device (remove device prior to transport)
-After procedure 1 or 2, secure helmet to ambulance cot with tape and devices

Options (gear removed on field)
-Place cervical collar
-1. Place athlete on spine board (remove from board prior to transport)
-2. Place athlete on scoop stretcher or similar device (remove device prior to transport)
-Secure athlete to ambulance cot after procedure 1 or 2

--Method of placing athlete on device (spine board, scoop stretcher or similar device)

Supine preferred method: 8-man lift
Log roll no longer recommended except for prone athlete
Personnel: EMS crew, sports medicine professionals and coaches from schools

Prone preferred method: One motion roll from prone onto device
Each movement increases risk of injury, plan for minimal patient moves
Prefer log "push" to roll athlete rather that log "pull"

--Helmet and Pad Removal

Requires a minimum 4 people
Levitation method of rescuers at following positions
Helmet
Neck
Each shoulder
Suggested to be performed prior to transport as school personnel and EMS have the most experience with removal but this is a local medical direction decision
Can be done on field or once removed from field

--Educational video from Childress Institute for Pediatric Trauma and NC EMS-C to address training issues for football events, is now available for the 2017 season via the following link: https://youtu.be/OBeKqd2cr28

Que Tucker, Commissioner
North Carolina High School Athletic Association

Tom Mitchell, Chief
North Carolina Office of EMS

Jim Bazluki, MAEd, LAT, ATC, EMT
North Carolina Athletic Trainer's Association

Coordinated Care of Student Athletes with Potential Spinal Injury
Joint Position Statement
North Carolina High School Athletic Association & North Carolina Office of Emergency Medical Services

Executive Summary Update for 2019

Pregame EAP Review

Effective this football season the recommended "pre-game time out" for medical personnel to meet and review emergency plans (mentioned in the 2017 Spinal Injury Management Joint Position Statement between OEMS, NCATA, and NCHSAA) has now been made a requirement by the NC High School Athletic Association. The new meeting is known as the Pregame Emergency Action Plan Review (PEAPR).

Following roles must meet prior to the game and complete a NCHSAA form:

- School game representative
- Both schools sports medicine providers (ATC for sports first responder)
- Lead official
- EMS (if present at game)

Considerations and educational points:

1. EMS standby at football is recommended but not required by the NCHSAA

2. Agencies that do game coverage are suggested to contact the local school and determine time for the meeting (most schools are choosing 30 minutes prior to kickoff)

3. Determine location (most schools are choosing to meet at the ambulance or emergency vehicle if present)

Coordinated Care of Student Athletes with Potential Spinal Injury
Joint Position Statement
North Carolina High School Athletic Association & North Carolina Office of Emergency Medical Services

Heat Illness Updates

Recognition of Exertional Heat Illnesses:

* The two main diagnostic criteria for exertional heat stroke are profound central nervous system (CNS) dysfunction and a core body temperature above 105°F.
* Rectal temperature is the only method of obtaining an immediate and accurate measurement of core body temperature in an exercising individual.

Treatment of Exertional Heat Illnesses:

- The goal for any exertional heat stroke victim is to lower core body temperature to less than 102.5°F within 30 minutes of collapse.

- Cold water immersion is the most effective way to treat a patient with exertional heat stroke. The water should be 35-59°F and continuously stirred to maximize cooling.

Recommendation of assessing rectal temperature if exertional heat stroke is suspected:

- Best practices strongly advise the use of rectal temperature for the assessment of body temperature in a suspected exertional heat stroke patient. It is discouraged to use inaccurate devices such as oral, tympanic, etc.

Specific protocol for the treatment of exertional heat stroke:

- The new guidelines suggest a specific step-by-step protocol for cold water immersion for the sports medicine professionals to implement with an exertional heat stroke patient. This protocol is backed by research exhibiting a 100 percent survival rate when initiated quickly and properly.

Identification of approximate cooling rates for an exertional heat stroke patient:

- While cooling rates may vary, the cooling rate for cold water immersion will be approximately about 1°F every three minutes when considering the entire immersion period for an exertional heat stroke patient. This provides an approximate treatment time for clinicians if rectal temperature monitoring is not possible during treatment.

Recommendation of "cool first, transport second":
The current document now states that a patient suspected of having exertional heat stroke must be cooled via cold water immersion for the full treatment time prior to being transported to a hospital.

Coordinated Care of Student Athletes with Potential Spinal Injury
Joint Position Statement
North Carolina High School Athletic Association & North Carolina Office of Emergency Medical Services

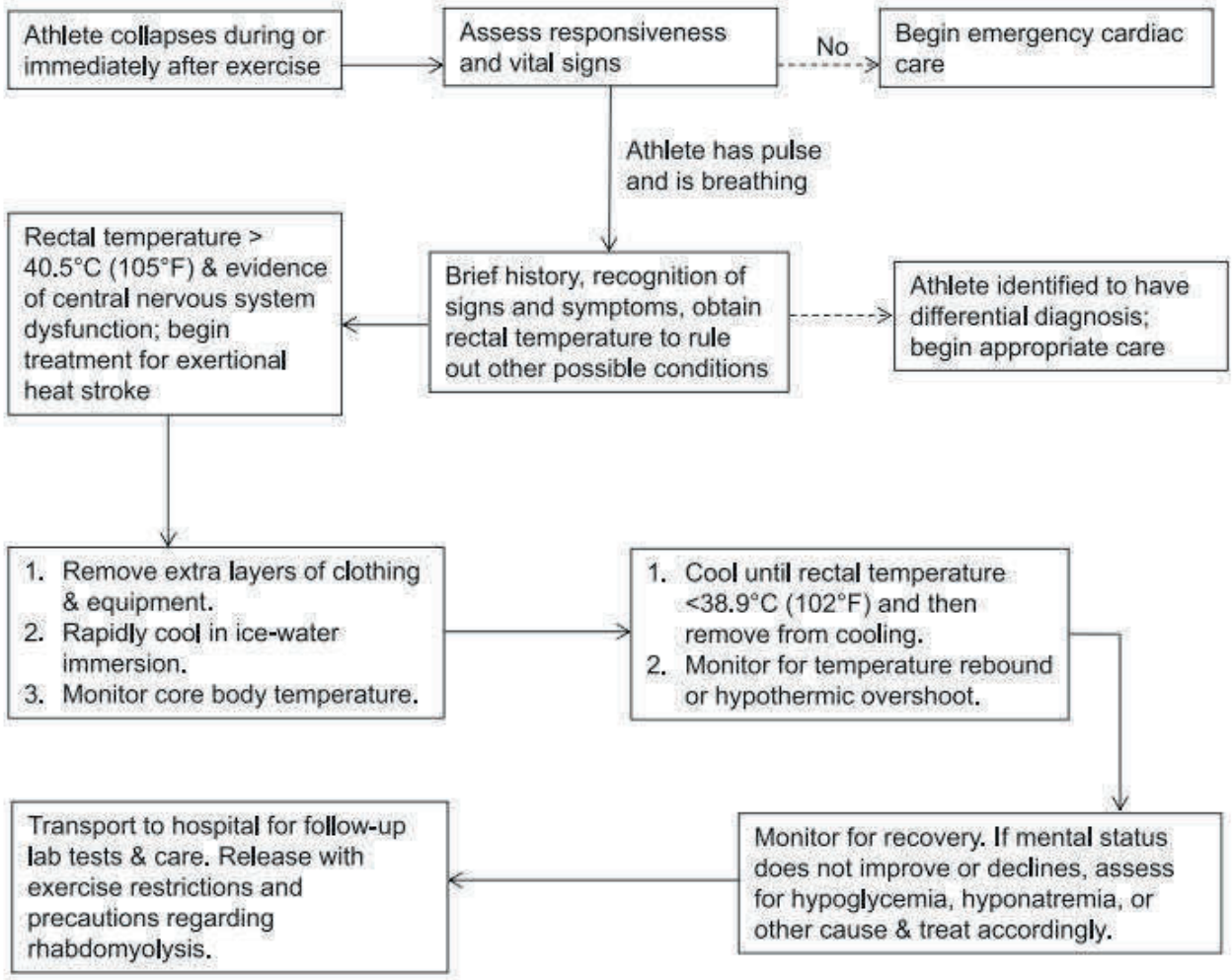

Figure 3. Algorithm for treatment of exertional heat stroke.

Recommended EMS Guidelines for Children and Youth with Special Health Care Needs (CYSHCN)*

Office of Emergency Medical Services
NC EMSC Advisory Committee
2009

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*** These guidelines are meant to provide general guidance only and are not meant to supercede state and local medical protocols. Perform procedures in line with current scope of practice and consult local medical control when necessary.**

I. Important Considerations for Providing Care to Children and Youth with Special Health Care Needs

- Treat ABCs first
    - Treat the child, not the equipment
    - If the emergency is secondary to the child's equipment, use your own equipment
- Remember to always speak with the family since they are the experts on their child. Find out the child's baseline vital signs, medications, allergies, and other medical information, which may not be typical.
    - CYSHCN have many allergies. Ask about LATEX allergy, especially for patients with spina bifida. Make sure latex-free equipment is stocked ahead of time.
    - Ask for help from the parents and home health staff. They are generally trained to troubleshoot equipment and respond to emergencies. Practice TEAM (Trust Every Available Member)
- Physical handicaps do not necessarily imply mental deficits. Remember to communicate with the child. Assess and communicate with the child based on his/her developmental age, not chronological age.
- Ask for the ***"go bag"*** which generally has the child's spare equipment and supplies and bring this with you during transport. Also, this may have equipment you need on scene.
- Do not use excessive force to straighten or manipulate contracted extremities. The patient may be osteopenic and prone to fractures. (Some CYSHCN will not be able to straighten extremities beyond a nominal degree)
    - A slow, careful transfer with two or more people is preferable.
- Know which children in a given geographic area have special needs
    - Ask if they have a brief emergency medical information form, card, or notebook.
        - KIDBASE form
    - Look for MedicAlert® jewelry
- Transfer the child if possible to their medical "home" hospital.

II. Respiratory Distress in the Child with a Tracheostomy Tube

1. Secure the scene
2. ABCs
    a. Open the airway using a head tilt/chin lift

3. Assess the tracheostomy tube
    a. Is the tube in place?
    b. Has the obturator (stylet) been removed?
    c. In a double lumen trach tube, is the inner cannula in place?
    d. Has a decannulation plug or speaking valve been removed?

4. Breathing
    a. Assess rate, auscultation, inspection, effort and adequacy of chest rise
    b. ALS: Check pulse oximetry, EtCO2
    c. Respiratory distress (retractions, altered mental status, hypoxia, etc.)?
        i. Mucous or debris obstructing the tracheostomy tube is very common
    d. Attempt to suction the trach tube.
        i. Ask if family has a suction catheter. If so, use theirs, as it will be appropriately sized.
        ii. If no suction catheter, ask family and use the size they generally use.
        iii. If they do not know size, estimate the suction catheter size by doubling the inner diameter of trach and rounding down to an available catheter size, or use the largest size that will easily pass.
        iv. Determine suction depth: ask family, or length of spare trach, or no more than 3-6 cm. **Suction with 100 mm Hg and instill 2-3 cc of saline before suctioning if secretions are thick.** Do not suction for more than 10 seconds and attempt to preoxygenate before getting started. NEVER FORCE THE CATHETER.
        v. For a double lumen trach: take inner cannula out to suction then replace before assisted ventilations.
    e. If unable to pass suction catheter the tracheostomy tube should be changed.
        i. Direct Technique:
            - Allow the family to help change the tracheostomy tube.
            - For a double lumen trach, remove the inner cannula before insertion, and then, once inserted, replace inner cannula before confirming placement with BVM.
            - If the old trach has a cuff, deflate the cuff before removal.
            - Remove the old trach by pulling outward and toward the patient's feet.
            - Gently insert the new tracheostomy tube in the anatomical direction: curve downward and the tube aimed toward the

patient's feet... Make sure the obturator is in place for insertion then remove once trach is placed.

ii. *Facilitated Technique:*
- Allow the family to help change the tracheostomy tube.
- If the old trach has a cuff, deflate the cuff before removal.
- Remove the old trach by pulling outward and toward the patient's feet.
- Before placing the new trach, slide a catheter through the trach.
- Pass the suction catheter into the stoma and gently advance 3-6 cm
- Advance the new trach over the suction catheter, using the catheter as a guide.
- Once the trach is in place, remove the suction catheter.

iii. If the new trach tube does not pass, attempt again with a smaller tube.

iv. Confirm placement by assessment of breath sounds and adequacy of chest expansion.

f. If a new tracheostomy tube cannot be placed, one is not available or it does not advance easily, place a similar or smaller internal-diameter size endotracheal tube (preferably cuffed) and advance only as far as a tracheostomy tube would have been advanced.

g. If a new trach or ETT cannot be placed through the stoma, attempt orotracheal intubation if possible.
   i. If orotracheal intubation is unsuccessful, use mask-to-mouth bag ventilation with stoma occluded.
   ii. If ventilation still inadequate, attempt infant mask-to-stoma bag ventilation.

h. For severe respiratory distress despite suctioning, persistent hypoxia, or respiratory arrest, begin assisted ventilations through trach tube with appropriate ventilation bag with 100% high flow oxygen.

5. Reassess frequently. Monitor pulse oximetry and EtCO2

6. If the patient has a trach and bronchospasm present: follow Wheezing protocol.

7. Assess circulation and follow appropriate protocols.

8. Keep warm. Expose only if necessary.

9. Contact Medical Control as necessary.

10. Remember: DOPE
    a. D-displaced, dislodged or damaged
    b. O-obstructed (mucus, food, blood, secretions)
    c. P-pulmonary problems

d. E-equipment failure (bent tubing, ventilator malfunction, depleted oxygen supply

III. Emergencies Involving Indwelling Central Lines

General Information:

- Types of central venous catheter:
  - Tunneled catheter-Broviac or Hickman
  - Implanted catheter-Mediport
  - Peripheral inserted catheter-PICC
- These catheters are used to deliver nutritional substances or special medications directly into a central vein.
- Most emergencies with lines include: blockage of the line, complete or partial accidental removal, or complete or partial laceration of the line
- Children with indwelling catheters are always at risk for blood stream and catheter infections. Always use strict sterile technique when dressing or accessing the catheter.

1. Ask parents/caretakers about child's underlying condition: may be experiencing complications from underlying medical condition
2. Obtain a complete medical history for the patient, including a history of the present illness and the past medical history
3. Whenever assessing a child who has a central intravenous catheter, check the site where the tube is placed to see if it appears clean and well maintained.
4. Identify location of central line:
   a. Check for blockage of the line
   b. Check for accidental removal or laceration of the line

5. ***If line is blocked***, do not attempt to force catheter open

6. ***If line is lacerated***, clamp proximal to laceration utilizing a padded clamp and do not use.

7. ***If line is out or partially out:***
   a. Do not push the line back in
   b. Apply direct pressure to skin site
   c. Stop any infusions*
   d. Always bring line with you to the hospital

8. Estimate blood loss and assess for signs and symptoms of an air embolism (tachypnea, chest pain, shortness of breath, or loss of consciousness) or blood clots. If an air embolism is suspected, clamp the central line with the clamp on the tube itself, place the child on the left side in a head down position, and administer high flow oxygen.

9. If the indwelling catheter is not damaged, is functioning, and does not have a continuous infusion already running, it may be used for fluid and medication administration.
    a. Allow caregiver or home health personnel to access implanted catheters.
    b. Use strict sterile technique when accessing an indwelling catheter.
    c. In the event of a cardiac arrest, the indwelling central catheter is the preferred route of medication administration.

***There are some infusions that may be detrimental to stop, even briefly. Ask the caregiver if it is all right to stop or change the infusion first. Contact Medical Control for additional instructions.**

Summary:

D	Displaced, dislodged, or damaged	Stop infusing and do not use Direct pressure if bleeding from site Clamp or tie tubing if bleeding from catheter
O	Obstructed (blood clot, medication)	If line does not flush easily it needs to be replaced
P	Pulmonary Embolism	Clamp catheter and lie patient on left side with head down
E	Equipment failure (bent tubing, infusion pump malfunction	If tube flushes easily the problem is probably with the pump

IV: Emergencies in Children with Gastrostomy Tubes and/or Feeding Tubes

Definitions:

- *Non-surgical feeding tubes:* Used for short term use:
    - Nasogastric tube (NGT): runs through the nose to the stomach
    - Nasojejunal Tube (NJT): runs through the nose into the small intestine
    - Orogastric tube (OGT): runs through the mouth into the stomach

- *Surgical Feeding Tubes:*
    - Gastrostomy Tube (GT): passes through the abdomen into the stomach
    - Jejunostomy Tube (JT): passes through the abdomen into the small intestine

<u>Complications with gastrostomy tubes include: obstruction or dislodgement</u>

1. When examining a child with a surgically implanted feeding tube, check for irritation and bleeding at the site where the tube enters the skin.
    a. Treat minor bleeding with direct pressure and sterile dressings
    b. A leaking feeding tube may cause skin irritation.
        i. If there are any signs of infection at the entry site, the child should be transported for further medical attention.
        ii. Cover the site with a sterile dressing and assess the abdomen.

2. Obstruction is usually not an emergency but the child requires transport. If the child is dependent on the feeds then the tube will need correction immediately.
3. Dislodgement is not life threatening but the tube should be replaced as soon as possible.
    a. Keep the child flat on his/her back to prevent gastric fluid from leaking
    b. If a new gastrostomy tube is available and stoma is open, attempt to reinsert the new tube.
    c. If any resistance is met when inserting the gastrostomy tube STOP and cover the site with a clean dressing and assess the abdomen
    d. If the new tube passes easily, secure with sterile dressing and tape BUT DO NOT REINFLATE BALLOON.
    e. If caregiver is trained to replace gastrostomy tube, assist in placing new tube. If the new gastrostomy tube is successfully placed, DISCUSS TRANSPORT OPTIONS WITH CAREGIVER AND MEDICAL DIRECTOR
    f. If no new gastrostomy tube is available, a foley catheter (same size or one size smaller) may be used and inserted…please follow same recommendations as above.
    g. If tube does not pass easily: *Do not attempt to replace the tube; it is not as easy as it seems and there may be other complications.* Bring the dislodged tube with the child to the hospital.
    h. Remember to cover the site with a clean dressing and control any bleeding with direct pressure
4. If there is formula infusing through the feeding tube, determine the nature of the fluids and the time that the fluids were started and stopped.
5. Assess for dehydration and/or hypoglycemia. Treat as necessary.
6. For non-surgical tubes (nasal or oral), assess for respiratory symptoms which may be a sign of placement in the respiratory tract.
    a. If respiratory distress severe, remove tube carefully and treat respiratory symptoms.
7. Non-emergent transport to the nearest facility capable of replacing the tube.
8. If the parent has extra replacement tubes, bring these to the hospital.

V. Emergencies in Children on Ventilators

General Information:

- Children on mechanical ventilators may have a sudden or gradual deterioration, cardiac arrest, increased oxygen demand, increased respiratory rate, retractions, or change in mental status. This may be related to malfunction of the ventilator or due to worsening in their underlying disease.
- Common reasons for chronic mechanical ventilation in children include chronic respiratory failure and neurologic disease causing impaired airway control or respiratory effort.

- Some children requiring chronic mechanical ventilation never have a "normal" respiratory exam. Parents and other caregivers can provide information about the child's baseline exam.

1. Pulse oximetry and End-tidal CO2
2. If there is no increased respiratory distress, normal pulse oximetry, normal End-tidal CO2, and normal mental status, the child should be transported on ventilator on current settings.
3. If there is respiratory distress, desaturation below baseline levels, or altered mental status:
   a) Examine the child quickly for possible causes of distress which can be easily corrected: detached oxygen source, dislodged or obstructed tracheostomy tube, detached ventilator circuit.
   b) Look at the ventilator and determine alarm code (i.e. apnea, low respiratory rate, low minute ventilation, high pressure, etc.) (See "Ventilator Troubleshooting" below)
      - Do not delay treatment while assessing the ventilator. Treat the patient, not the machine.
   c) Remove the child from the ventilator and manually bag with a secure oxygen source
   d) Look for normal chest rise, breath sounds on both sides, and improvement in oxygen saturation.
   e) If the chest rise is shallow, adjust the patient's airway position, check to see that the bag-value device is securely connected to the tracheostomy tube, and use higher pressure if necessary.
   f) Assess and treat problems with tracheostomy according to protocol.
4. Obtain relevant history of the present illness, past medical history and interventions taken to correct the emergency before EMS arrival.
5. Obtain any medical information forms that the caregivers may have for emergency medical providers.
6. Transport the child to the appropriate medical facility. Bring the ventilator to the hospital.
7. Some caregivers carry a "go bag" for their children with extra supplies. Bring this with the child if available.

Ventilator Troubleshooting

Alarm	***Possible Causes***	***Interventions***
Low pressure/apnea	Loose or disconnected circuit Leak in circuit Leak around tracheostomy site	Ensure all circuits are connected Check tracheostomy balloon Ensure tracheostomy well seated
Low power	Internal battery depleted	Plug the ventilator into a power outlet
High Pressure	Plugged or obstructed airway	Clear obstruction Suction tracheostomy

	Coughing/bronchospasm	Administer bronchodilator
Setting Error	Settings incorrectly adjusted	Manually ventilate patient Transport ventilator and patient
Power Switchover	Unit switched from AC to internal battery	Press "Alarm silent" button after ensuring battery is powering ventilator

Remember if the problem can not be remedied, EMS provider should remove the child from the ventilator, ventilate the child with a BVM, and take the ventilator with them to the hospital so a more qualified person can troubleshoot.

VI. Emergencies in Children with Urinary Drainage Catheters

General Information:

- Types of Urinary catheters:
  - Foleys: From urethra to bladder
  - Nephrostomy: From skin directly into kidney
  - Suprapubic: From skin directly into bladder
  - Ureterostomy: From skin into ureter
- These catheters are used to drain urine.
- Most emergencies with catheters include: Blockage, bleeding or dislodgement.

1. Ask caretakers about child's underlying condition: may be experiencing complications from underlying medical condition
2. Obtain a complete medical history for the patient, including a history of the present illness and the past medical history
3. Most skin catheters will make the skin slightly erythematous and encrusted

If catheter is blocked:

a. Flush once with 5cc of saline.
b. Do not flush more than once.
c. If catheter works well after flushing, discuss with caregiver and medical director.
d. If catheter remains blocked, transport to appropriate medical facility.

If catheter is lacerated:

a. Do not remove.
b. Tape in place to avoid dislodgement
c. Allow to continue to drain
d. Transport to appropriate medical facility

If catheter is partially out:

a. Do not push the line back in
b. Secure to skin to avoid complete dislodgement
c. Transport to appropriate medical facility

If catheter is completely out:

a. Cover opening with sterile gauze
b. Transport to appropriate medical facility

If blood is seen in catheter:

a. Allow catheter to drain
b. Secure to skin to prevent dislodgement
c. Transport to appropriate medical facility

VII. Emergencies in Children with Hemodialysis Lines

General Information:

- Types of hemodialysis catheters:
  - Hemodialysis catheters (External tubing from a large artery to the skin)
  - Hemodialysis grafts (Gortex tubing under skin to artery and vein)
- These catheters are used to filter/clean the blood in patients with renal failure.
- Most emergencies with lines include: Infection of the line, bleeding from the line, and complete or partial dislodgement from trauma
- Children with indwelling catheters are always at risk for blood and catheter infections. Always use strict sterile technique when dressing or accessing the catheter.

1. Ask caretakers about child's underlying condition: may be experiencing complications from underlying medical condition.

2. Obtain a complete medical history for the patient, including a history of the present illness and the past medical history.

3. Whenever assessing a child who has a hemodialysis catheter, check the site where the tube is placed to see if it appears clean and well maintained.

4. Identify location of DIALYSIS LINE:
   a. Check for accidental removal or laceration of the line

5. ***If line is blocked*** DO NOT MANIPULATE

6. ***If line is lacerated***, clamp proximal to laceration utilizing a padded clamp and do not use.

7***. If line is out or partially out:***

- Do not push the line back in
- Apply direct pressure to skin site
- Stop any infusions*
- Always bring line with you to the hospital

8. Estimate blood loss and assess for signs and symptoms of an air embolism (tachypnea, chest pain, shortness of breath, or loss of consciousness) or blood clots. If an air embolism is suspected, clamp the central line with the clamp on the tube itself, place the child on the left side in a head down position, and administer high flow oxygen.

9. If the indwelling catheter is not damaged, UNLIKE CENTRAL LINES, do not use for IV access. Infection and sepsis are frequent in large bore dialysis catheters compared to Broviacs.

10. In a life threatening emergency these large lines are excellent for IV access and can be used.

***There are some infusions that may be detrimental to stop, even briefly. Ask the caregiver if it is all right to stop or change the infusion first. Contact Medical Control for additional instructions.**

Transport all patients with hemodialysis lines to the appropriate medical facility.

VIII. Emergencies in Children with Peritoneal Dialysis Catheters

General Information:

- Peritoneal dialysis catheters run from the skin into the peritoneum.
- Dialysis is done by using the peritoneal lining as the dialysis membrane.
- Fluid is placed into the peritoneum and left for hours or overnight
- It is then drained removing extra electrolytes, acid, etc. from the patient.
- Dialysis is usually done at home by the patient or a nurse.
- Most emergencies with catheters include: Infection of the abdomen (peritonitis), infection of the catheter entry site, fracture of the catheter, bleeding from the catheter, and complete or partial dislodgement.
- Children with indwelling catheters are at risk for catheter infections. Always use strict sterile technique when dressing or accessing the catheter.
- These are not vascular lines and ***can not*** be used for IV access.

There are two major complications of peritoneal catheters: Infection and Outflow obstruction.

Exit Site Infections:

Drainage with blood and/or pus from the exit site
Associated with redness, tenderness, overgrown granulation tissue and swelling

Peritonitis:

Staphylococcus aureus
Caused by auto-inoculation by touch or contamination with respiratory secretions

Symptoms:

- Abdominal pain
- Abdominal tenderness
- Abdominal distention
- Cloudy peritoneal dialysis fluid
- Fever
- Nausea and vomiting

1. Ask Caretakers about child's underlying condition: may be experiencing complications from underlying medical condition

2. Obtain a complete medical history for the patient, including whether there is fluid presently in the abdomen or if it is drained.

3. Whenever assessing a child who has a peritoneal dialysis catheter, check the site where the tube is placed to see if it appears clean and well maintained.

4. ***If catheter is blocked*** DO NOT MANIPULATE.

5. ***If catheter is fractured***, clamp proximal to fractured utilizing a padded clamp and do not use.

6. ***If catheter is out or partially out:***

- Do not push back in
- Apply direct pressure to skin site if bleeding.
- Stop any infusions
- Always bring catheter with you to the hospital

7. ***If the catheter is leaking clear fluid:***

- Cover with sterile gauze.

Transport all patients with peritoneal dialysis catheters to the appropriate medical facility.

IX. Care of the Following Equipment:

a. Tracheostomy tubes (included in protocol I.)
b. Central lines (included in protocol III.)
c. Feeding tubes (included in protocol IV.)
d. Ventilators (included in protocol V.)
e. Apnea monitors
f. VP shunts
g. Internal pacemakers
h. Vagal nerve stimulators
i. Colostomy bags

e. Apnea Monitors

ABCs
Pulse oximetry

If the patient is not breathing, open airway and begin bag-valve ventilation with 100% oxygen
Check the pulse: if no pulse, start chest compressions
Assess circulation and perfusion
Ask the caregiver for baseline vital signs
Look at the apnea monitor and determine the alarm code (i.e. heart rate, apnea etc.)
Check the electrodes or monitor chest belt and ensure proper placement
Make sure the monitor is powered and is not low on batteries

If the child has respiratory distress or cardiac arrest, call for ALS support and follow the appropriate algorithm and transport to the nearest appropriate facility.

Bring any of the child's emergency medical records and supplies or "go bag" with the patient to assist in the care of the child.

Bring the apnea monitor to the hospital with the child, so that it may be evaluated and stored information can be downloaded for analysis.

f. VP shunts

A cerebral spinal fluid shunt (CSF shunt) is a catheter that is inserted into the ventricles within the brain and then threaded under the skin from the skull to the right atrium (VA shunt) or the peritoneum of the abdomen (VP shunt). It drains excess CSF that would otherwise build up in the brain.

The child with a CSF shunt is vulnerable to brain infections. The shunt can develop an obstruction, and if this occurs it can result in any of the following signs & symptoms:

*Have a heightened awareness of the following:**
Altered mental status
Irritability
Listlessness
Increased sleep
High-pitched cry
Nausea and vomiting
Fever
Headaches
Blurred vision
Difficulty walking
Apnea
Bradycardia or other arrhythmias
Seizures
Redness along the shunt track
Rapid worsening of mental status

Prehospital personnel should… Provide appropriate initial intervention and transport:
Establish responsiveness
Assess the patient's airway and breathing: ABCs
Maintain a patent airway
Provide high flow oxygen, positive pressure with bag-valve-mask mask if necessary
Check pulse, if no pulse, begin chest compressions
Assess circulation and perfusion
Ask caregiver for the child's baseline vital signs
Assess for signs and symptoms of shunt obstruction or infection*
Obtain a complete history of present illness and past medical history
Rapid transport to the appropriate facility

g. Internal Pacemakers

Pacemakers are implanted medical devices that regulate the heart rate.

For the child with an internal pacemaker, the following questions need to be asked:
What type of heart problem does the child have?
What is the child's baseline rhythm and rate?
What type of pacemaker does the child have?
Is the child dependent on the pacemaker?
How long has the child had the pacemaker? (Generally 3-5yr battery life)

An internal cardiac defibrillator (ICD) or automatic implantable cardiac defibrillator (AICD) is an electronic device implanted under the skin. It monitors the heart rhythm and can slow down or stop excessively fast rates that originate in the ventricles.

For the child with an internal defibrillator:
What type of heart problem does the child have?

What is the child's baseline rhythm and rate?
What heart rate causes the defibrillator to fire?
How many shocks has the child felt?
Has the child experienced any of the following?
- Felt more than 3 shocks in a row
- Unusual symptoms like dizziness or palpitations after a shock
- Sensation of dizziness, lightheadedness or palpitations, for a period of time without any shocks

When was the defibrillator implanted? (3-5yr battery life)

EMS Care Tips

The internal pacemaker can easily be felt near the clavicle or in a small child in the abdomen.
Never place defibrillator paddles, or pacing patches directly over the internal pacemaker or defibrillator generator.
Remember the battery life is 3-5 years

Common Problem: Failure

1. Assess heart rate and perfusion
2. Treat for shock
3. Follow ABCs
4. Transport

h. Vagal Nerve Stimulators (VNS)

What is a vagal nerve stimulator? Device that is surgically implanted in the patient's chest, under the skin with the electrodes to the vagus nerve on the left side of the neck. This device produces electrical energy which works to dissipate seizures.

Ask the following questions:

Any recent trauma to the left side of neck or chest over the device?
Has the patient noticed anything different regarding the device?
When was the VNS implanted?
When was the VNS last checked?
What are the current settings?
Is the child having seizures when the device is functioning properly?
If seizures are still present, is the magnet being used?
Have you noticed any change in your child's seizures recently?
- Increased intensity?
- Increase in frequency?

i. Colostomies and Ileostomies

Colostomy or ileostomy: a portion of the large or small intestine is attached to the abdominal wall and an external bag is in place to collect the digestive waste.

Assess carefully for signs or symptoms of dehydration and/or shock, particularly if there has been any history of diarrhea or decreased oral intake.

Check the ostomy site for signs of infection or irritation:

Signs of infection include: red, warm, tender skin spreading away from the site
Ask the child or parents if the area is more tender than usual.
If any concerns, transport for further evaluation.

If the ostomy bag breaks, the parent or caregiver can usually help and replace it.

If another bag is not available, circle the ostomy with moist gauze and attach any available bag that can serve as a substitute until a proper replacement bag is obtained.

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This document was compiled by the members of the North Carolina Emergency Medical Services for Children Advisory Committee. The main contributors were Donna Moro-Sutherland, MD (Chair of the EMSC Research and Education Committee) and Ben Alexander, MD (Past Chair of the EMSC Advisory Committee).

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The NC Eye Bank EMS Referral Policy

Policy:

EMS will refer all appropriate field deaths to The North Carolina Eye Bank, using established criteria, in a timely and consistent manner.

Purpose:

- Enable the North Carolina Eye Bank to offer donation opportunities to families.
- Ensure the notification of The North Carolina Eye Bank for facilitating donation options.
- Honor donation wishes of registered donors at the time of death.

Procedure:

- EMS will call The North Carolina Eye Bank.

- EMS will use following criteria:
    1. Ages 2-75.
    2. Last Seen Alive Time <6 hours.
    3. No John/Jane Does. (unless pending investigation)

- Essential information that should be provided to The North Carolina Eye Bank is as follows:
    1. Caller name and title
    2. Patient demographics
    3. Last seen alive date and time/time of death
    4. Circumstances of death
    5. Next of kin name and contact information
    6. Where the body is going (ex: funeral home, hospital, M.E.)

- The North Carolina Eye Bank is responsible for approaching families about donation when appropriate.

The North Carolina
EYE BANK

24 hour Referral Hotline: 1-800-552-9956

North Carolina Medical Board
Approved Medications for Credentialed EMS Personnel

EMS personnel at any level who administer medications must do so with medical oversight. Personnel must complete appropriate medical education. All EMS System and SCTP protocols, policies and procedures must be reviewed and approved by the Medical Director of the Office of EMS

All items highlighted in "red" are required by NCCEP in all systems with EMS personnel credentialed at the specified level. Specialty Care (SCTP) required items are not listed here, as they can be found on the Specialized Ambulance Protocol Summary (SAPS) form.

Medications	EMR	EMT	AEMT	MEDIC
ACE inhibitors				X
Acetaminophen	X	X	X[15]	X
Adenosine				X
Aminophylline				X
Amiodarone				X
Anti-arrhythmic				X[12]
Antibiotics			X	X
Anti-emetic preparations			X	X
Antipsychotic (Typical and Atypical)		X[19]	X[20]	X[20]
Antivirals			X	X
Aspirin	X	X	X	X
Atropine	X[4]	X[4]	X[4]	X
Barbiturates				X
Benzodiazepine preparations				X[14]
Beta agonist preparations		X[2]	X	X
Beta blockers				X[13]
Bretylium				X
C1 Esterase-Inhibitors				X
Calcium channel blockers				X[13]
Calcium chloride/gluconate				X
Calcium Paste		X	X	X
Charcoal		X	X	X
Clonidine				X
Clopidogrel				X
CroFab (Crotalidae Polyvalent Immune Fab)				X[8]
Crystalloid solutions			X	X
Cyanide poisoning antidote kit				X
Digoxin				X
Diphenhydramine	X[3]	X[3]	X	X
Diuretics				X
Dobutamine				X
Dopamine				X
Droperidol				X
Epinephrine	X[1]	X[1]	X	X
Etomidate				X
Flumazenil				X
Glucagon		X	X	X
Glucose, oral	X	X	X	X
Glucose solutions			X	X
Haloperidol				X
Heparin (unfractionated and low molecular weight)				X
Histamine 2 blockers			X	X

Medications	EMR	EMT	AEMT	MEDIC
Hydroxocobalamin				X
Immunizations		X[21]	X[6]	X[6]
Insulin				X
Ipratropium			X	X
Isoproterenol				X
Ketamine				X[7]
Levetiracetam				X
Lidocaine			X[18]	X
Magnesium sulfate			X	X
Mannitol				X
Methylene blue				X
Milrinone				X
Monoclonal Antibodies			X	X
N-acetylcysteine				X
Narcotic analgesics				X
Narcotic antagonists	X[9,10]	X[9,10]	X	X
Nasal spray decongestant		X	X	X
Nesiritide				X
Nitroglycerin		X[2]	X	X
Nitroprusside sodium				X
Nitrous oxide		X	X	X
Non-prescription medications		X	X	X
Non-steroidal anti-inflammatory		X	X[15]	X
Norepinephrine				X
Octreotide				X
Oxygen	X[5]	X[5]	X[5]	X[5]
Oxytocin				X
Paralytic agents				X[17]
Phenothiazine preparations				X
Phenylephrine				X
Phenytoin preparations				X
Plasma protein fraction				X
Platelet g-II/IIIa inhibitors				X
Potassium chloride				X
Pralidoxime	X[4]	X[4]	X[4]	X
Procainamide				X
Procaine				X
Proparacaine				X
Propofol				X[8]
Proton pump inhibitors				X
Sodium bicarbonate				X
Steroid preparations			X	X
Thiamine			X	X
Thrombolytic agents				X
Topical hemostatic agents	X	X	X	X
Total Parenteral Nutrition				X
Tranexamic Acid (TXA)			X	X[11]
Tuberculosis skin test			X[6]	X[6]
Valprocic acid				X
Vasopressin			X	X
Vasopressor				X[16]
Whole blood and components				X
Ziprasidone				X

[1] EMR and EMT use of epinephrine is limited to the treatment of anaphylaxis and may be administered only by auto injector, unless approved by EMS System Medical Director and OEMS.

[2] EMT use of beta-agonists and nitroglycerine is limited to patients who currently are prescribed the medication unless approved by the EMS System Medical Director and OEMS as part of the expanded scope. EMTs may administer these medications from EMS supplies.

[3] EMR/EMT administration of diphenhydramine is limited to the oral route.

[4] As a component of preparedness for domestic terrorism, EMS personnel, public safety officers, and other first responders recognized by the EMS system, may carry, self-administer, or administer to a patient atropine and/or pralidoxime, based on written protocols and medical direction. All personnel except for Paramedics must administer these medications by an auto injector.

[5] Administration of oxygen does not require medical direction.

[6] Administration of immunizations and TB skin tests are not limited to public health initiatives.

[7] Ketamine use is restricted to programs that have been approved by the OEMS State Medical Director. It can be used as an induction or post intubation sedation agent in approved DAI programs. Use outside of DAI programs must meet all the requirements outlined in Medical Policy 2 'Ketamine Program Requirements'.

[8] Propofol use is restricted to programs that have been approved by the OEMS State Medical Director. EMS Systems and SCTP's must submit a policy and education plan to the OEMS prior to approval. EMS personnel cannot initiate Propofol, it can only be used for interfacility transport where infusion has already been started at transferring facility. **EMS units cannot stock Propofol or CroFab. This medication must be provided by the transferring hospital.**

[9] FR, EMR, and EMT administration of Naloxone is limited to the intra-nasal (IN), intra-muscular (IM), and auto-injector routes.

[10] First Responders (FR) who administer Naloxone must do so under the medical oversight of the County EMS Medical Director, following protocols and procedures approved by the OEMS State Medical Director. FR administration must be monitored by the EMS Systems peer review program.

[11] For an EMS System to use Tranexamic Acid (TXA), they must submit for approval by the OEMS State Medical Director a signed letter from any Trauma Centers that would be the recipient of the patient that the destination Trauma Center agrees with its use and will give the 2nd required dose of Tranexamic Acid (TXA).

[12] All Paramedic systems must carry some form of anti-arrhythmic agent. This must either be amiodarone, lidocaine, **or** procainamide.

[13] Paramedic systems must carry either a calcium channel blocker **or** beta-blocker.

[14] All Paramedic systems must carry some form of injectable benzodiazepine.

[15] AEMT systems must carry either acetaminophen **or** a non-steroidal anti-inflammatory.

[16] All Paramedic systems must carry an approved vasopressor. This must either be dobutamine, dopamine, epinephrine, norepinephrine, phenylephrine, **or** vasopressin.

[17] Paralytic agent use is restricted to Drug Assisted Intubation (DAI) programs approved by the OEMS State Medical Director. They require the submission of; signed NCCEP DAI policy by local medical director, unaltered NCCEP DAI protocols, training documentation, and process for peer review of cases. All DAI must have an EMS Airway Evaluation form completed and signed by local medical director in accordance with the NCCEP DAI policy. Systems utilizing must submit monthly airway forms and cases to the OEMS for review.

[18] AEMT administration of Lidocaine is allowed for analgesic use only.

[19] EMTs may only administer antipsychotic medications orally and if the patient has a current prescription.

[20] Long-acting antipsychotics may only be used in pilot programs that are approved by the OEMS State Medical Director in conjunction with the State Mental Health Medical Director.

[21] EMTs may administer immunizations in conjunction with public health initiatives.

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North Carolina Medical Board
Approved Skills for Credentialed EMS Personnel

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Skills	EMR	EMT	AEMT	MEDIC
12-Lead ECG Acquisition & Transmission		X	X	X
12-Lead ECG Interpretation				X
15-Lead ECG Acquisition				X
Airway Adjuncts (NPA/OPA)	X	X	X	X
Arterial Access - Blood Draw				X
Arterial Line maintenance				X
Blind Insertion Airway Device (BIAD)	X[1]	X[1]	X	X
Capnography (Waveform)	X[6]	X[6]	X[6]	X[6]
Carbon Monoxide Measurement (non-invasive)	X	X	X	X
Cardiac Monitoring		X[4]	X[4]	X
Cardiac Pacing				X
Cardiopulmonary Resuscitation	X	X	X	X
Cardioversion				X
Carotid Massage				X
Central Venous Pressure Line Maintenance				X
Chest Compression-External Device	X	X	X	X
Chest Decompression-Needle			X[11]	X
Chest Tube Maintenance				X
Childbirth	X	X	X	X
Cricothyrotomy-Needle				X
Cricothyrotomy-Surgical				X[5]
Decontamination	X	X	X	X
Defibrillation-Automated	X	X	X	X
Defibrillation-Manual			X[12]	X
Direct Laryngoscopy			X	X
Drug Assisted Intubation (DAI)				X[5,6]
Endotracheal Tube Introducer			X	X
Epidural Catheter Maintenance				X
Foreign Body Airway Obstruction	X	X	X	X
Gastric Intubation		X[3]	X[3]	X
Glucose Measurement	X	X	X	X
Hemostatic Agent	X	X	X	X
Injections – Subcutaneous and Intramuscular		X[2]	X	X
Intra-Ventricular Catheter Maintenance				X
Intubation - Nasotracheal			X	X
Intubation - Orotracheal			X[6]	X[6,7]
Intubation Confirmation - Capnometry (color)			X	X
Medication Administration	X[2]	X[2]	X[2]	X[2]
Nebulizer Inhalation Therapy		X	X	X
Non-Invasive Positive Pressure Ventilation	X[9]	X	X	X
Orthostatic Blood Pressure	X	X	X	X
Oxygen Administration	X	X	X	X
Patient Assessment	X	X	X	X
Pulse Oximetry	X	X	X	X

Skills	EMR	EMT	AEMT	MEDIC
Reperfusion Checklist	X	X	X	X
Respirator Operation		X	X	X
Restraints		X	X	X
Specimen Collection		X	X	X
Spinal Motion Restriction	X	X	X	X
Splinting	X	X	X	X
Stroke Screen	X	X	X	X
Suction-Basic	X	X	X	X
Suction-Advanced			X[10]	X[10]
Swan-Ganz Catheter maintenance				X
Taser Probe Removal	X	X	X	X
Temperature Measurement	X	X	X	X
Tourniquet Application	X	X	X	X
Tracheostomy Tube Change			X	X
Urinary Catheterization				X
Venous Access-Blood Draw			X	X
Venous Access-Existing catheters				X
Venous Access-Femoral Line				X
Venous Access-Intraosseous			X	X
Venous Access-Peripheral			X	X
Ventilator Operation		X[8]	X[8]	X
Wound Care	X	X	X	X

[1] EMRs and EMTs using blind insertion airway devices must be functioning in EMS systems with medical direction and written treatment protocols.

[2] EMS personnel educated in approved programs, credentialed by the OEMS, and functioning under physician medical oversight may perform acts and administer intravenous fluids and medications as allowed by the North Carolina Medical Board pursuant to G.S. 143-514. The administration of oxygen does not require medical direction.

[3] Gastric tube insertion may be performed only when utilized in conjunction with a blind insertion airway device.

[4] EMT and AEMT may use the cardiac monitor for vital sign monitoring and EKG transmission.

[5] Systems performing drug assisted intubation (DAI) must have the ability to perform surgical cricothyrotomy. Commercial cricothyrotomy or tracheostomy kits that create an airway comparable to a surgical cricothyrotomy are acceptable.

[6] End-tidal (EtCO2) monitoring is mandatory following placement of an endotracheal tube. EtCO2 monitoring is mandatory following placement of a BIAD once available on scene.

[7] Pediatric intubation is an optional skill/procedure.

[8] Ventilator patients may be transported by EMT/AEMT when all the following conditions are met:
-Patient is receiving home (or skilled nursing) ventilator therapy.
-The ventilator is portable and can continue to ventilate the patient during transport.
-The patient is accompanied by a non-EMS adult (from either the home or facility) who is knowledgeable, capable, and willing to maintain the ventilator during the EMS transport.
-While in transit, the patient is monitored using pulse oximetry.

[9] Bag Valve Mask ONLY

[10] For a patient currently being assisted by an airway adjunct such as a naso-tracheal tube, endotracheal tube, BIAD, tracheostomy tube or a cricothyrotomy tube.

[11] Use of needle chest decompression at the AEMT level is for traumatic arrest only.

[12] AEMT use of manual defibrillation is for pulseless arrest only.

-EMD personnel are responsible for:

1) Pre-arrival instructions to callers
2) Determining and dispatching appropriate EMS resources
3) All EMD skills must be performed in EMS systems with medical oversight and written EMS protocols.

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