

PRE-HOSPITAL MEDICAL

PROTOCOLS EL PASO COUNTY

EMERGENCY SERVICES DISTRICT #2



2022 UPDATE

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INTRODUCTION AND USE

THE FOLLOWING PREHOSPITAL MEDICAL PROTOCOLS HAVE BEEN REVIEWED AND APPROVED FOR USE BY EL PASO COUNTY EMERGENCY SERVICES DISTRICT #2 CERTIFIED MEDICAL PERSONNEL BY THE BOARD CERTIFIED PHYSICIAN LISTED BELOW, ACTING AS MEDICAL DIRECTOR FOR EPCESD #2.

PERSONNEL MUST BE CERTIFIED AS AN EMR, EMT, EMT-I/AEMT OR PARAMEDIC BY THE TEXAS DEPARTMENT OF STATE HEALTH SERVICE. PERSONNEL MUST HOLD A CURRENT STATE EMS/AHA CPR CERTIFICATION AND HAVE CLEARANCE BY DEPARTMENT MEDICAL OFFICER WHEN OPERATING UNDER EPCESD #2 MEDICAL PROTOCOLS. PERSONNEL ARE REQUIRED TO HOLD PROOF OF CERTIFICATIONS AT ALL TIME WHILE OPERATING IN THE CAPACITY OF AN EPCESD #2 MEDICAL RESPONDER.

THE PROTOCOLS ARE WRITTEN TO CURRENT STANDARDS FOR PREHOSPITAL MEDICAL CARE AND WILL BE REVIEWED AND UPDATED, IF NECESSARY EVERY TWO YEARS AT A MINIMUM. CHANGES AND REVISIONS WILL BE ISSUED TO CERTIFIED MEDICAL PERSONNEL ONLY AFTER REVIEW AND APPROVAL BY THE MEDICAL DIRECTOR.

A COPY OF THESE PROTOCOLS WILL BE MADE AVAILABLE TO ALL EPCESD#2 PERSONNEL WHO RESPOND TO MEDICAL CALLS.

SHOULD A DEPARTMENT LOSE THEIR TEXAS DEPARTMENT OF STATE HEALTH SERVICES FIRST RESPONDER AGREEMENT, THESE PROTOCOLS WILL NOT APPLY UNTIL AN AGREEMENT HAS BEEN REESTABLISHED.

EMERGENCY CARE STANDING ORDERS

PREHOSPITAL PROTOCOLS ARE CREATED TO:

- ESTABLISH STANDARDS OF CARE FOR DIFFERENT PATIENT PRESENTATIONS ENCOUNTERED IN THE FIELD
- DEFINE THE MINIMUM EXPECTED TREATMENT AS IMPLEMENTED BY THE MEDICAL DIRECTOR AND STATE/NATIONAL CERTIFYING AGENCIES
- EVALUATE TREATMENT BY CERTIFIED MEDICAL RESPONDERS, AT THEIR SKILL LEVEL
- DEVELOP TRAINING STANDARDS FOR INITIAL AND RECERTIFICATION TRAINING

PROTOCOLS

-ARE TOOLS DESIGNED TO ASSIST MEDICAL RESPONDERS IN ASSESSING AND TREATING THE PATIENT. THEY ARE NOT ABSOLUTE RULES AND SHOULD NOT REPLACE THE CARE PROVIDER'S ABILITY TO THINK AND ACT. HOWEVER, THE DECISION TO FOREGO A PROCEDURE TO PROTOCOLS SHOULD ALWAYS BE DOCUMENTED TO LIMIT LIABILITY

GENERAL INFORMATION

THE FOLLOWING STANDING ORDERS ARE CONCURRENT WITH THE EMERGENCY CARE STANDARDS CURRENTLY RECOGNIZED BY THE U.S. DEPARTMENT OF TRANSPORTATION AND THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES.

CERTIFIED MEDICAL RESPONDERS PROVIDE CARE UNDER A FIRST RESPONDER AGREEMENT RECOGNIZED AND ISSUED BY THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES AND IS RECOGNIZED AS "ADVANCED LIFE SUPPORT LEVEL" CARE, DEPENDANT ON THE CERTIFICATION LEVEL OF THE CARE PROVIDER. CARE PROVIDERS WHO RENDER CARE ABOVE THE BASIC LIFE SUPPORT LEVEL HAVE BEEN TRAINED AND TESTED ON ALL ADVANCED PROCEDURES PRIOR TO BEING APPROVED TO RENDER CARE.

THE FOLLOWING PROTOCOLS DEFINE THE SCOPE OF PRACTICE FOR ALL LEVELS OF CERTIFIED MEDICAL PERSONNEL WORKING UNDER THE FRO AGREEMENT.

THE FOLLOWING PROTOCOLS HAVE BEEN REVIEWED BY A BOARD CERTIFIED EMERGENCY PHYSICIAN FOR ACCURACY. REVISIONS WILL BE MADE AS NECESSARY TO KEEP THE PROTOCOLS AT A CURRENT STATUS.

MEDICAL DIRECTION

MEDICAL CARE PROVIDED THROUGH EPCESD#2 IS CONSIDERED "BASIC LIFE SUPPORT WITH ADVANCED LIFE SUPPORT CAPABILITIES".

THE CURRENT MEDICAL DIRECTOR OF EPCESD#2 HAS REVIEWED AND APPROVED THESE PROTOCOLS FOR ACCURACY AND CURRENT STANDARDS IN PREHOSPITAL MEDICAL CARE. EACH CERTIFIED MEDICAL RESPONDER WILL REVIEW THE PROTOCOLS AND ARE EXPECTED TO PROVIDE MEDICAL CARE AT THEIR LEVEL OF CERTIFICATION, BASED ON PATIENT PRESENTATION.

DOCUMENTATION OF PATIENT CARE INCIDENTS IS THE RESPONSIBILITY OF EACH EPCESD#2 DEPARTMENT. IT IS RECOMMENDED, TO LIMIT EPCESD#2 LIABILITY, THAT ALL INCIDENTS REQUIRING THE EVALUATION AND TREATMENT OF PATIENTS BE DOCUMENTED AND PRESENTED FOR REVIEW BY A DEPARTMENT DESIGNATED MEDICAL OFFICER. ALL PATIENT ENCOUNTERS REQUIRING ADVANCED LIFE SUPPORT WILL REQUIRE THE ADDITIONAL COMPLETION OF AN "ADVANCED LIFE SUPPORT SUMMARY", WHICH IS ATTACHED TO THE INITIAL PATIENT REPORT. A COPY OF THE ALS SUMMARY IS TO BE FORWARDED TO THE FRO ADMINISTRATOR, WHO WILL THEN PRESENT THE ALS SUMMARIES, ONCE A MONTH TO THE MEDICAL DIRECTOR FOR REVIEW.

AN ACTING DEPARTMENT MEDICAL OFFICER SUPERVISES MEDICAL CARE BY REVIEW OF PATIENT CARE DOCUMENTATION AFTER CARE IS RENDERED. EACH PCR IS EVALUATED FOR APPROPRIATE CARE BASED ON PATIENT PRESENTATION. THIS EVALUATION PROVIDES THE MEDICAL OFFICER WITH INFORMATION REGARDING THE ABILITY OF EACH MEDICAL RESPONDER, THE POSSIBLE COMPLICATIONS ENCOUNTERED DURING PROVISION OF CARE AND THE BASIS FOR CHANGES TO PROTOCOLS THAT WILL UPGRADE CARE OR ELIMINATE PROCEDURES THAT ARE INEFFECTIVE. DOCUMENTATION ALSO ALLOWS THE ALTERATION OF TREATMENT STANDARDS WHEN CONFRONTED WITH ENVIRONMENTAL CONSTRAINTS OR UNUSUAL SITUATIONS.

AT THE SCENE OF A MEDICAL EMERGENCY, THE HIGHEST TRAINED MEDICAL RESPONDER SUPERVISES CARE AS IT IS RENDERED. HIS/HER RESPONSIBILITY IS TO ENSURE THE INTEGRITY OF PATIENT CARE, BASED ON THESE PROTOCOLS, AND ABOVE ALL, *TO DO NO HARM.*

INTERVENER PHYSICIAN AT THE SCENE

GENERAL INFORMATION

CONTROL OF THE MEDICAL SCENE IS THE RESPONSIBILITY OF THE HIGHEST TRAINED MEDICAL RESPONDER, OR THE PERSON IN ATTENDANCE, WHO IS MOST APPROPRIATELY TRAINED AND KNOWLEDGEABLE AT THE SCENE, IF SPECIALIZATION IS REQUIRED, I.E., WATER OR HIGH ANGLE RESCUE, HAZMAT, ETC.

WHEN MEDICAL RESPONDERS WHO WORK UNDER A FRO AGREEMENT ARE DISPATCHED TO A MEDICAL CALL, THEY HAVE A LEGAL OBLIGATION TO PROVIDE MEDICAL CARE. IF A PRIVATE PHYSICIAN IS PRESENT AND WISHES TO ASSUME MEDICAL RESPONSIBILITY FOR THE PATIENT, THE EPCESD#2 MEDIC WILL DEFER TO THE PRIVATE PHYSICIAN, ONLY AFTER THE PRIVATE PHYSICIAN ASSUMES FULL RESPONSIBILITY FOR THE PATIENT AND RELIEVES THE MEDICAL RESPONDER OF LIABILITY.

ONCE THE TRANSPORTING AGENCY ARRIVES ON THE SCENE, ALL RESPONSIBILITY FOR THE CARE OF THE PATIENT IS TRANSFERRED TO THEM.

PRESUMED DEAD AT THE SCENE

THE ABSOLUTE TIME LIMIT BEYOND WHICH RESUSCITATION IS NOT INDICATED HAS NOT BEEN ESTABLISHED, SINCE IT MAY BE DIFFICULT FOR THE MEDICAL RESPONDER TO ESTABLISH AN ACCURATE TIME OF CARDIAC OR RESPIRATORY ARREST, AS IN THE CASE OF COLD WATER IMMERSION OR HYPOTHERMIA.

IT IS NEITHER THE RESPONSIBILITY NOR THE LEGAL OBLIGATION OF THE MEDICAL RESPONDER TO PRONOUNCE ANY PATIENT DEAD.

THE MEDICAL RESPONDER MAY SUSPECT THAT THE PATIENT IS DEAD AND MAY FOREGO RESUSCITATION ATTEMPTS IF THE PATIENT IS FOUND TO BE PULSELESS AND APNIC AND HAVE ANY OF THE CONDITIONS LISTED BELOW:

1. DECAPITATION
2. DECOMPOSITION
3. HEMICORPORECTOMY
4. OBVIOUS LIVIDITY
5. RIGOR MORTIS
6. INJURIES INCOMPATIBLE WITH LIFE

THE MEDICAL RESPONDER MAY FACE A SITUATION WHERE HE/SHE ARRIVES ON SCENE TO FIND CPR HAS BEEN STARTED ON A PATIENT WHO IS SHOWING SIGNS OF LIVIDITY AND/OR RIGOR MORTIS. IF THE PATIENT IS SHOWING ANY OF THESE SIGNS LISTED ABOVE, THE HIGHEST MEDICAL RESPONDER ON SCENE WILL MAKE THE DETERMINATION WHETHER OR NOT TO CONTINUE WITH RESUSCITATION EFFORTS, UNTIL CONTRACTED AMBULANCE ARRIVES. AT THAT TIME, DECISION TO CONTINUE CPR WILL LIE WITH AMBULANCE PERSONNEL.

RESPONDER WILL NOTIFY LOCAL LAW ENFORCEMENT OF THE PATIENT'S DEATH, PRESERVING THE SCENE AS BEST AS POSSIBLE UNTIL IT CAN BE TURNED OVER TO LAW ENFORCEMENT.

RESPONDERS WILL CLEARLY DOCUMENT ALL ASPECTS OF THE CALL WITHIN THEIR NFIRS REPORT.

CHANGES TO THIS PROTOCOL MADE 07/2015

DO NOT RESUSCITATE ORDERS (DNR)

A DNR IS A LEGAL DIRECTIVE TO CEASE OR WITHHOLD RESUSCITATION EFFORTS, AS PER THE WISHES OF THE PATIENT OR LEGAL MEDICAL POWER OF ATTORNEY. THE MEDICAL RESPONDER WILL HONOR THE WISHES OF THE PATIENT IF:

1. THE PATIENT IS PULSELESS AND/OR APNEIC.
2. THE PATIENT HAS A STATE APPROVED OUT OF HOSPITAL (OOH) DNR WITH SIGNATURES IN EITHER BOX A, B, OR C IN SECTION 2, AND SIGNATURES IN SECTION 3 AND 4 AND SIGNATURES AGAIN AT THE BOTTOM OF THE FORM. OUT OF HOSPITAL DNRS FROM ANOTHER STATE WILL BE HONORED AS LONG AS THERE IS NO QUESTION TO THE AUTHENTICITY OF THE ORDER.
3. THE PATIENT IS THE PERSON NAMED IN THE DNR, VERIFIED BY A PHOTO ID OR DRIVER'S LICENSE.
4. THE PATIENT IS NOT KNOWN TO BE PREGNANT, AND THERE IS NO INDICATION OF SUSPICIOUS OR UNNATURAL CAUSES. IF IN DOUBT, START OR CONTINUE RESUSCITATION EFFORTS.

ONCE DNR HAS BEEN CONFIRMED TO BE THE PATIENTS, THE MEDICAL RESPONDER WILL TERMINATE RESUSCITATION EFFORTS AND CONTACT LOCAL LAW ENFORCEMENT AND ADVISE THEM OF PATIENT'S DEATH.

THE MEDICAL RESPONDER IS NOT TO WITHHOLD CPR WHEN WAITING FOR A DNR TO BE PRODUCED OR VERIFIED. THE RESPONDER WILL START FULL RESUSCITATION EFFORTS UNTIL DNR STATUS IS CONFIRMED.

A DNR IS NOT AN ORDER TO WITHHOLD TREATMENTS OF PATIENTS WHO ARE STILL BREATHING OR HAVE A PULSE. FULL PATIENT CARE WILL BE RENDERED TO PATIENTS WHO HAVE NOT GONE INTO CARDIAC OR RESPIRATORY ARREST. BE AWARE A DNR ORDER CAN BE REVOKED AT ANY TIME BY THE PATIENT, PATIENT'S LEGAL GUARDIAN/ POWER OF ATTORNEY, QUALIFIED RELATIVE, OR THE PHYSICIAN WHO EXECUTED THE ORDERS.

DECIDING WHO IS A PATIENT

WHEN ARRIVING ON SCENE THERE MAY BE TIMES WHEN THE MEDICAL RESPONDER MUST DETERMINE HOW MANY PATIENTS ARE ON SCENE. UTILIZING THE CRITERIA BELOW WILL ASSIST THE RESPONDER WITH MAKING THE DETERMINATION, IF THE PERSON IN QUESTION IS CONSIDERED TO BE A PATIENT.

1. DOES THE PERSON HAVE A PHYSICAL OR PSYCHOLOGICAL COMPLAINT? DID THE PERSON HAVE ANY COMPLAINTS PRIOR TO YOUR ARRIVAL?
2. DID HE/SHE REQUEST EMS TRANSPORT OR EVALUATION?
3. DOES THE PERSON HAVE ANY SIGNS OR SYMPTOM OF AN ACTIVE SIGNIFICANT ILLNESS OR INJURY?
4. IF TRAUMA WAS PRESENT, IS THERE A SIGNIFICANT MECHANISM OF INJURY THAT WOULD CAUSE THE RESPONDER TO QUESTION POSSIBILITY OF LATENT INJURY?
5. IS THE PERSON UNDER THE INFLUENCE OF DRUGS OR ALCOHOL TO THE POINT OF ALTERED MENTAL STATUS?
6. IS THE PERSON IN CUSTODY OF LAW ENFORCEMENT? IF SO, DID LAW ENFORCEMENT REQUEST EVALUATION OR TRANSPORT BY EMS?
7. IS THE PERSON CONFUSED, HAS AN ALERTED MENTAL STATUS AND CANNOT MAKE COMPETENT DECISIONS FOR HIM/HERSELF? PATIENTS MAY BE INCOMPETENT FOR MANY PHYSIOLOGICAL AND PSYCHOLOGICAL REASONS INCLUDING, BUT NOT LIMITED TO, HYPOXIA, HEAD INJURY, HYPOGLYCEMIA, OR MENTAL INCOMPETENCY.

IF YES IS THE ANSWER TO ANY OF THESE QUESTIONS, THEN THE PERSON IN QUESTION SHOULD BE CONSIDERED A PATIENT. RESPONDERS SHOULD USE THEIR BEST JUDGMENT WHEN MAKING THIS DECISION.

TREATING PATIENTS AGAINST THEIR WILL

THE MEDICAL RESPONDER WILL BE FACED WITH SITUATIONS WHERE THE PATIENT DOES NOT WISH TO BE TREATED OR TRANSPORTED TO THE HOSPITAL. IT IS IMPORTANT THAT THE RESPONDER UNDERSTANDS THE LEGAL ISSUES THAT COULD ARISE FROM SUCH A SITUATION. HANDLING A PATIENT WHO DOES NOT WISH TO BE TOUCHED CAN POSE A PROBLEM FOR THE RESPONDER IF THAT PATIENT DOES NOT MEET ANY OF THE CRITERIA BELOW. BE SURE TO HAVE LAW ENFORCEMENT PRESENT AND TO CLEARLY DOCUMENT THE MITIGATING CIRCUMSTANCES WHEN FACED WITH SUCH PATIENTS.

1. THE PATIENT MUST POSE A DANGER TO THEMSELVES OR OTHERS. DURING THESE SITUATIONS HAVING LAW ENFORCEMENT ON SCENE DURING OR EVEN PRIOR TO MAKING PATIENT CONTACT IS CRUCIAL. DO NOT PLACE YOURSELF OR ANYONE ELSE AT RISK.
2. THE PATIENT IS NOT COMPETENT ENOUGH TO MAKE MEDICAL DECISIONS FOR THEMSELVES. (MENTAL DISABILITIES, OVERLY INTOXICATED BY DRUGS OR ALCOHOL, CONFUSION FOR ANY REASON.)
3. THE PATIENT IS UNDER THE LEGAL AGE OF CONSENT, NOT EMANCIPATED, AND LEGAL GUARDIANS WISH FOR PATIENT TO BE TREATED. IF THE LEGAL GUARDIAN IS NOT PRESENT, EVERY ATTEMPT SHOULD BE MADE TO CONTACT THEM. IF THE PATIENT'S PARENTS OR GUARDIAN CANNOT BE CONTACTED, THE RESPONDER WILL ACT IN THE BEST INTEREST OF THE MINOR TREATING THEM UNDER THE DOCTRINE OF IMPLIED CONSENT.
4. THE PATIENT IS A MINOR AND CHILD ABUSE IS SUSPECTED. AGAIN, BE SURE TO HAVE LAW ENFORCEMENT PRESENT, SO THAT THE PROPER AUTHORITIES CAN BE CALLED.
5. THE PATIENT IS UNDER THE CUSTODY OF LAW ENFORCEMENT, AND EMS IS NEED TO PERFORM MEDICAL EVALUATION.

IF ANY OF CRITERIA CANNOT BE MET, THE MEDICAL RESPONDER HAS NO RIGHT TO FORCE MEDICAL TREATMENTS ON THOSE PATIENTS. REMEMBER, TALKING TO THE PATIENT CAN GO A LONG WAY. THE RESPONDER SHOULD BE HONEST AND EXPLAIN THE SITUATION TO THE PATIENT IN A WAY THEY CAN UNDERSTAND. IN MOST CASES THE PATIENT WILL AGREE TO TREATMENT OR AT LEAST HAVE AN ASSESSMENT DONE.

DOCUMENTATION

AFTER AN EMERGENCY CALL, A REPORT OF THE INCIDENT MUST BE DOCUMENTED IN NFIRS AS PER YOUR DEPARTMENT'S PROTOCOL. DOCUMENTATION NEEDS TO BE CLEAR AND ACCURATE, GIVING A DESCRIPTION OF WHAT HAPPENED DURING THE CALL. PCRS SHOULD BE INCLUDED IN THE REPORT IF ANY PATIENT CONTACT WAS MADE OR IF TREATMENTS WERE PERFORMED PRIOR TO ARRIVAL OF CONTRACTED AMBULANCE. REPORTS NEED TO BE MADE AS SOON

AS POSSIBLE AFTER THE INCIDENT TO ENSURE ACCURACY. REPORTS AND PCRS WILL BE REVIEWED BY YOUR DEPARTMENT CHIEF OR DESIGNATED REVIEWER FOR CLARITY AND QUALITY ASSURANCE.

REPORT RESPONSIBILITY

YOUR DEPARTMENT'S POLICY WILL DETERMINE WHO WILL BE RESPONSIBLE FOR DOCUMENTING INCIDENTS INTO NFIRS. BELOW ARE SOME GUIDELINES THAT EACH DEPARTMENT SHOULD FOLLOW REGARDING DOCUMENTATION OF MEDICAL EMERGENCIES INTO NFIRS:

1. ALL INCIDENTS WHERE PERSONNEL WERE DISPATCHED TO, MUST HAVE A DESIGNATED RESPONSIBLE MEMBER. EVEN IF PERSONNEL WERE CANCELLED PRIOR TO ARRIVING ON SCENE. THESE CALLS SHOULD STILL BE ENTERED INTO NFIRS WITH DISPATCHED, ENROUTE AND CANCELLATION TIMES TO BE INCLUDED.
2. SOME DEPARTMENTS THAT ALLOW PERSONNEL WITHOUT ANY MEDICAL CERTIFICATIONS RESPOND TO EMERGENCIES TO ASSIST AMBULANCE PERSONNEL WITH LIFTING AND MOVING PATIENTS. THOSE RESPONDERS WILL STILL BE RESPONSIBLE FOR DOCUMENTING THAT CALL IN NFIRS. A PCR MAY NOT BE NEEDED, BUT A DESCRIPTION OF ASSISTANCE PROVIDED AND PATIENT DEPOSITION, STILL NEED TO BE INCLUDED.
3. IF NON-CERTIFIED PERSONNEL ACCOMPANY A CERTIFIED RESPONDER TO A MEDICAL CALL. PERSONNEL WITH MEDICAL CERTIFICATIONS NEEDS TO BE DESIGNATED AS THE RESPONSIBLE MEMBER.
4. THE PERSONNEL DESIGNATED AS THE RESPONSIBLE MEMBER OF THE CALL SHOULD BE CERTIFIED TO THE SCOPE IN WHICH PATIENT CARE WAS RENDERED. FOR INSTANCE, IF AN IV WAS ESTABLISHED BY AN ESD #2 RESPONDER, THE RESPONSIBLE MEMBER WOULD NEED TO BE CERTIFIED AT THE EMT-I LEVEL OR ABOVE.
5. REPORT NARRATIVES SHOULD BE WRITTEN IN THE WORDS OF THE RESPONDER WHO WAS ON SCENE AT THE TIME OF THE INCIDENT AND WAS DESIGNATED AS THE RESPONSIBLE MEMBER OF THE CALL. THIS ENSURES THE MOST ACCURATE DEPICTION OF THE SCENE AND/OR PATIENT'S PRESENTATION.
6. IF INTERVENTIONS WERE PERFORMED THAT REQUIRE AN "ADVANCE LIFE SUPPORT SUMMARY" A COMPLETED COPY OF THAT SUMMARY NEEDS TO BE INCLUDED OR ATTACHED TO THAT PATIENT'S PCR. THE YELLOW COPY ATTACHED SHOULD BE PROVIDED TO TRANSPORTING AGENCY AND AN ADDITIONAL COPY MUST BE FORWARDED TO THE FRO COORDINATOR FOR REVIEW.

PATIENT CARE REPORTS

PCRS SHOULD INCLUDE:

1. HOW THE CALL WAS RECEIVED, AND TYPE OF RESPONSE GIVEN. DID UNITS RESPOND LIGHTS AND SIRENS? DID UNITS HAVE TO STAGE PRIOR TO ARRIVING ON SCENE?
2. THE PATIENT'S CHIEF COMPLAINT, AND SECONDARY COMPLAINTS IF APPLICABLE.
3. A DESCRIPTION OF THE SCENE. HOW WAS THE PATIENT FOUND?
4. ALL CARE PROVIDED PRIOR TO YOUR ARRIVAL, TO INCLUDE CARE GIVEN BY BYSTANDERS, FAMILY MEMBERS, AND LAW ENFORCEMENT.
5. ASSESSMENTS OR EXAMINATIONS OF THE PATIENT. DESCRIBE ANY SIGNS OR SYMPTOMS THE PATIENT EXHIBITED. BE SURE TO INCLUDE VITAL SIGNS, PERTINENT NEGATIVES AND ANY DIFFERENTIAL DIAGNOSIS.
6. DOCUMENT ANY INTERVENTIONS WITH ASSOCIATED TIMES. DESCRIBE HOW THE PATIENT RESPONDED TO THE TREATMENTS, REGARDLESS IF IT WAS NEGATIVE OR POSITIVE.
7. A NARRATIVE THAT CHRONOLOGICALLY DEPICTS ALL ASPECTS OF THE PATIENT ENCOUNTER.
8. DEPOSITION OF PATIENT. DID AMBULANCE OBTAIN A REFUSAL? TRANSPORT? OR DID THE PATIENT LEAVE PRIOR TO ARRIVAL OF AMBULANCE PERSONNEL?

EPCRs

1. ALL TIMES WILL BE RECORDED BY COMMUNICATIONS.
2. ALL INCIDENTS/PATIENT CARE REPORTS (EPCR) SHALL BE ENTERED INTO THE ONLINE MEDICAL RECORD KEEPING PLATFORM (EMERGENCY REPORTING) WITHIN THE FIRST 48 HOURS.
3. QUALITY ASSURANCE WILL BE CONDUCTED BY THE CORRESPONDING MEDICAL COORDINATOR, BY EACH INDIVIDUAL DEPARTMENT.
4. MEDICAL DIRECTOR HAS BEEN GRANTED ACCESS TO ALL EPCRs.

BE SURE TO INCLUDE ALL PCRS ON ALL INCIDENTS WITH MULTIPLE PATIENTS PRIOR TO CLOSING OUT THE CALL ON NFIRS.

MEDICAL NFIRS REVIEWS

ALL CALLS ENTERED INTO TO NFIRS WILL NEED TO BE REVIEWED BY EITHER THE DEPARTMENT'S CHIEF, MEDICAL COORDINATOR OR BY DESIGNATED REVIEWERS. THE PERSONNEL REVIEWING THE CALL SHOULD MAKE SURE INFORMATION ENTERED IS IN THE CORRECT AREAS, IS CLEAR AND ACCURATELY DESCRIBES THE INCIDENT. THESE REVIEWS SHOULD ALSO BE USED AS A TOOL FOR EACH DEPARTMENTS TRAINING PROGRAM TO ENSURE QUALITY PATIENT CARE IS BEING RENDERED.

INDICATIONS FOR INFECTION CONTROL

INFECTION CONTROL WILL BE USED BY ALL ESD #2 RESPONDERS WHO ARRIVE ON SCENE OF A MEDICAL EMERGENCY. GLOVES AND/OR APPROPRIATE PPE WILL WORN WHEN EXPOSURE TO BLOOD OR BODILY FLUIDS IS A POSSIBILITY, SUCH AS, BUT NOT LIMITED TO OBTAINING IV ACCESS, CHILDBIRTH, AIRWAY SUCTIONING, TRAUMATIC CPR, AND INTUBATION. YOU MUST MAKE EVERY EFFORT TO PROTECT YOURSELF AS WELL AS THE PATIENT FROM ANY BODILY FLUID EXPOSURE.

PERSONNAL PROTECTION

WEAR GLOVES BEFORE EVERY PATIENT ENCOUNTER, BE SURE TO CHANGE GLOVES BETWEEN PATIENTS.

WEAR MASK TO WILL EFFECTIVELY PROTECT AGAINST AEROSOLIZATION OR SPLASHING OF BLOOD, FLUIDS OR ANY AIRBORNE CONTAMINATES/INFECTIONS.

WEAR EYE PROTECTION WHEN SPLASHING OF BLOOD OR BODY FLUIDS IS A POSSIBILITY.

AFTER PATIENT CARE HAS BEEN RELEASED TO TRANSPORTING AGENCY OR UNITS ARE CLEARED FROM SCENE, ALWAYS WASH HANDS EVEN IF GLOVES WERE USED.

CONTAMINATED EQUIPMENT

ALWAYS USE APPROPRIATE PPE WHEN HANDLING OR CLEANING EQUIPMENT THAT HAS BEEN EXPOSED TO CONTAMINATE.

DISCARD OF ALL USED DISPOSABLE EQUIPMENT IN RED BAG LABELED BIOHAZARD. DISPOSE OF THE BAG IN APPROPRIATE BIOHAZARD OR REQUEST FOR AMBULANCE PERSONNEL TO DISPOSE OF WASTE IN BIOHAZARD LOCATION AT RECEIVING HOSPITAL.

CLEAN EQUIPMENT WITH APPROPRIATE DISINFECTANT AS PER EQUIPMENT'S MANUFACTURER RECOMMENDATIONS.

POST EXPOSURE PROCEDURES

WASH OR FLUSH ANY EXPOSED SKIN AND/OR MUCOUS MEMBRANES AS SOON AS POSSIBLE. REMOVE ANY CLOTHING THAT MAY HAVE BEEN CONTAMINATED AND BAG IN BIOHAZARD BAG AND DISPOSE APPROPRIATELY ACCORDING TO DEPARTMENTAL PROCEDURE.

ADVISE THE CHARGE NURSE AT THE RECEIVING FACILITY OF THE INCIDENT, AND FOLLOW HOSPITAL'S PROCEDURE WITH OBTAINING BLOOD WORK AND/OR URINE SAMPLES.

REPORT EXPOSURE TO YOUR DEPARTMENT CHIEF, FOLLOW YOUR DEPARTMENT'S PROTOCOL IN REGARDS TO DOCUMENTING EXPOSURE. INCIDENT SHOULD BE REPORTED IN THE NFIRS PCR.

CRITERIA FOR REQUESTING AIR TRANSPORT

THE MEDICAL RESPONDER WILL BASE THE DECISION FOR REQUESTING EVACUATION BY HELICOPTER ON THE FOLLOWING:

-WHEN THE TIME FOR TRANSPORT BY GROUND AMBULANCE POSES A THREAT TO THE PATIENT'S RECOVERY OR SURVIVAL

-WHEN ROAD, TRAFFIC CONDITIONS OR DISTANCE WOULD DELAY THE PATIENT'S ACCESS TO ADVANCED LIFE SUPPORT

-WHEN THE MEDICAL RESPONDER IS FACED WITH A MASS CASUALTY SITUATION DEFINED BY THE PRESENCE OF FOUR OR GREATER PATIENTS, WITH MODERATE TO SEVERE INJURIES, AT THE SCENE, AT ONE TIME

MEDICAL RESPONDERS REQUESTED TO ASSIST OR ACCOMPANY THE AIR AMBULANCE PROVIDER

IF AN AIR AMBULANCE PROVIDER REQUESTS AN EPCESD#2 PARAMEDIC OR ALS MEDICAL PROVIDER TO ACCOMPANY THEM TO THE HOSPITAL, AND THE COUNTY TRANSPORT SERVICE DOES NOT HAVE A PARAMEDIC PROVIDER ON SCENE, AN ESD#2 ACLS CERTIFIED PARAMEDIC MAY ACCOMPANY THE AIR AMBULANCE PROVIDER TO THE HOSPITAL. IF THE COUNTY TRANSPORTER CAN RELEASE A PARAMEDIC PROVIDER, THEIR ASSISTANCE WILL SUPERSEDE PARAMEDIC ALS SUPPORT FROM ESD#2.

ALL CARE RENDERED BY EPCESD#2 PARAMEDICS WILL ADHERE TO CURRENT AHA ACLS STANDARDS AND STANDING PROTOCOLS.

TRIAGE, MULTIPLE CASUALTY INCIDENT

PRINCIPLES OF TRIAGE

- TO DO THE MOST GOOD FOR THE GREATEST NUMBER OF PATIENTS
- SALVAGE OF LIFE TAKES PRECEDENCE OVER SALVAGE OF LIMBS
- THE MOST IMMEDIATE THREATS TO LIFE ARE RESPIRATORY COMPROMISE, CARDIAC ARREST, AND UNCONTROLLED HEMORRHAGE

ALL PATIENTS ARE TRIAGED USING THE S.T.A.R.T. METHOD

S.T.A.R.T.

1. ALL PATIENTS CAN BE RAPIDLY TRIAGED USING THE START METHOD OF TRIAGE
2. INITIAL ASSESSMENT IS BASED ON ABC'S ONLY
3. PATIENTS SHOULD BE TAGGED WITH METTAG
4. ONCE INITIAL TRIAGE IS COMPLETED COMMAND CAN BE ADVISED OF NUMBER OF PATIENTS AND LEVEL (1,2, OR 3)
5. SECONDARY TRIAGE CAN BE CONDUCTED AT A TREATMENT AREA AND EVALUATED FREQUENTLY FOR CHANGE IN STATUS

S.T.A.R.T. CATEGORIES

IMMEDIATE

- RESPIRATIONS INITIAL ABSENT BUT RESUME WHEN AIRWAY IS REPOSITIONED
- RESPIRATIONS >30 PER MINUTE
- RESPIRATIONS < 30 PER MINUTE, BUT NO RADIAL PULSE
- RESPIRATIONS < 30 PER MINUTE, RADIAL PULSE PRESENT, ALTERED LOC

DELAYED

- WALKING WOUNDED, WITHOUT ALTERED LOC
- RESPIRATIONS < 30 PER MINUTE, ADEQUATE PERFUSION, ABLE TO FOLLOW SIMPLE COMMAND

DEAD

- NO RESPIRATIONS
- NO RESPIRATIONS RESTORED WHEN AIRWAY REPOSITIONED

CRITICAL INCIDENT STRESS DEBRIEFING, C.I.S.D.

C.I.S.D. IS A STRUCTURED MEETING THAT ALLOWS EMERGENCY PERSONNEL TO DISCUSS THEIR FEELINGS AND REACTIONS AFTER A CRITICAL INCIDENT. THIS MEETING IS DESIGNED TO REDUCE THE EFFECT OF A CRITICAL INCIDENT AND ACCELERATE THE NORMAL RECOVERY OF PERSONNEL WHO ARE SUFFERING THROUGH NORMAL REACTIONS TO AN ABNORMAL EVENT.

ALL EMERGENCY OPERATIONS CARRY THE RISK OF SERIOUS INJURY AND DEATH. THE EFFECT OF A FATAL ACCIDENT ON EMERGENCY PERSONNEL INVOLVED IN THE OPERATION CAN BE DEVASTATING AND LIFE ALTERING. IT IS THE NATURE OF EMERGENCY PERSONNEL TO DOWNPLAY AND EVEN MASK THEIR RESPONSES TO AN ACCIDENT OF SERIOUS MAGNITUDE TO GET THE JOB DONE.

THE KEY TO WORTHWHILE DEBRIEFING OR DEFUSING IS TO ACT IMMEDIATELY. ALL PERSONNEL DIRECTLY CONNECTED TO THE INCIDENT SHOULD BE DEBRIEFED WITHIN 24 HOURS. ALL MEDICAL FIRST RESPONDERS SHOULD UNDERGO A "DEFUSING" PRIOR TO RESPONDING TO OTHER MEDICAL CALLS.

WHEN DEBRIEFING A GROUP OF EMERGENCY PERSONNEL, ALL MEMBERS OF THE INVOLVED TEAM SHOULD BE DEBRIEFED AT THE SAME TIME. THE OPTIMUM NUMBER OF PERSONS IN EACH GROUP SHOULD BE NO MORE THAN TEN, BUT CAN BE EXCEEDED TO KEEP THE TEAM TOGETHER. FIELD PERSONNEL AND MANAGEMENT SHOULD BE DEBRIEFED SEPARATELY.

PROCEDURE

- MEDIATOR SHOULD BE A TRAINED C.I.S.D. DEBRIEF COUNSELOR OR
- PROVIDE A NON-THREATENING ATMOSPHERE. IT SHOULD BE COMFORTABLE; FOOD AND DRINK ARE APPRECIATED
- THANK PERSONNEL FOR COMING
- ENSURE CONFIDENTIALITY
- REMAIN NON-JUDGMENTAL
- DO NOT DISCUSS OPERATIONAL MATTERS
- NORMALIZE THE SYMPTOMS. EXPLAIN THAT FOR THE DURATION OF THIS INCIDENT AND FOR A PERIOD OF TWO TO THREE WEEKS THAT THEY MAY HAVE A NUMBER OF TROUBLING AND DIFFERENT SYMPTOMS, WHICH ARE ENTIRELY NORMAL, INCLUDING:
 - SLEEPING DISORDERS, EATING DISORDERS, SEXUAL DISORDERS
 - INAPPROPRIATE BEHAVIOR, MEMORY LOSS, FEELINGS OF ISOLATION
 - FEELINGS OF SUICIDAL OR HOMICIDAL IDEATION MAY REQUIRE PROFESSIONAL COUNSELING
- EXPLAIN THAT THIS IS THE START OF A HEALING PROCESS THAT WILL CONTINUE FOR A PERIOD OF TIME
- FOLLOW UP WITH PERSONNEL IF SYMPTOMS PERSIST OR PERSONNEL ARE CONCERNED.
- BE ATTENTIVE
- KEEP THE GROUP ON TRACK
- ENCOURAGE THEM TO VERBALIZE ABOUT ANYTHING THAT STRUCK THEM AS "ODD" OR STOOD OUT IN THEIR MIND ABOUT THE INCIDENT
- ENCOURAGE THEM TO COME AND TALK TO YOU AT ANY TIME.

A C.I.S.D. DEBRIEFING SHOULD TAKE APPROXIMATELY ONE HOUR.

DEFUSING

SOME INCIDENTS ARE NOT AS DIFFICULT TO MANAGE PSYCHOLOGICALLY BUT MAY TROUBLE RESPONDERS TO THE EXTENT THAT THEY NEED TO DISCUSS THE INCIDENT WITH AN UNDERSTANDING DEPARTMENT OFFICER. THIS "DEFUSING" SHOULD TAKE PLACE WITHIN THE FIRST 24 HOURS AFTER THE INCIDENT. THE FOCUS SHOULD BE ON THE RESPONDERS CONCERNS AND FEELINGS, NOT OPERATIONAL MATTERS. IT IS STRICTLY CONFIDENTIAL AND SHOULD BE HANDLED BY A DEPARTMENT OFFICER OR MEMBER WHO IS IN COUNSELING (C.I.S.D.)

SECTION I

TREATMENT STANDARDS

APPROVED SKILLS FOR MEDICAL PERSONNEL

FIRST RESPONDERS WHO ARRIVE BEFORE AMBULANCE WILL BE ABLE TO RENDER CARE ONLY UP TO THEIR SKILL LEVEL. THE HIGHEST MEDICAL RESPONDER WILL BE IN CHARGE OF ALL PATIENT CARE ON SCENE UNTIL CONTRACTED AMBULANCE ARRIVES. WHEN/IF AMBULANCE PERSONNEL ARE ON SCENE, ALL TREATMENT AND INTERVENTIONS WILL BE AT THE DISCRETION OF HIGHEST CERTIFIED PERSON ON AMBULANCE. ESD #2 RESPONDERS WILL BE ABLE TO ASSIST AMBULANCE PERSONNEL WITH TREATMENTS NEEDED, IN ACCORDANCE TO ESD #2 PROTOCOL.

EMR

MAY PERFORM PATIENT ASSESSMENTS AND OBTAIN BASELINE VITALS
MAY MONITOR BLOOD GLUCOSE LEVEL USING GLUCOMETER AND LANCETS
MAY MONITOR PULSE OXIMETRY
MAY PERFORM NECK/SPINAL IMMOBILIZATION
MAY CONTROL BLEEDING BY DIRECT PRESSURE/TOURNIQUET
MAY SPLINT PAINFUL SWOLLEN AND/OR DEFORMED AREAS WITH PADDED BOARD SPLINTS
MAY USE OPA FOR BASIC AIRWAY MANAGEMENT
MAY UTILIZE PORTABLE SUCTION DEVICES WITH RIDGED TIPPED SUCTION CATH (YANKAUER)
MAY ASSIST PATIENT VENTILATIONS USING BMV
MAY ADMINISTER OXYGEN VIA NASAL CANNULA, MASK NON-REBREATHER, AND BVM
MAY ADMINISTER INSTANT ORAL GLUCOSE GEL
MAY PERFORM CPR IN ACCORDANCE WITH AHA GUIDELINES
MAY PERFORM ELECTRICAL DEFIBRILLATION WITH AED IN ACCORDANCE WITH AHA GUIDELINES
MAY PERFORM TORNQUET FOR BLEEDING THAT CANNOT BE CONTROLLED.

EMT BASIC

MAY PERFORM ALL ABOVE LISTED SKILLS
MAY UTILIZE NPA FOR BASIC AIRWAY MANAGEMENT
MAY UTILIZE PORTABLE SUCTION WITH SOFT SUCTION CATHETERS (WHISTLE TIP)
MAY UTILIZE TRACTION SPLINTS FOR FEMUR FRACTURES
MAY ADMINISTER NEBULIZER BREATHING TREATMENTS WITH ALBUTEROL/NS MIXTURE
MAY ASSIST PATIENT WITH ADMINISTRATION WITH PATIENT PRESCRIBED EPI-PEN
MAY ADMINISTER SUB-Q/IM EPINEPHRINE 1:1000 FOR ANAPHYLACTIC SHOCK
MAY UTILIZE KING AIRWAY FOR ADVANCE AIRWAY PROTECTION

EMT-INTERMEDIATE (AEMT)/ EMT-PARAMEDIC

MAY PERFORM ALL ABOVE LISTED SKILLS
MAY PERFORM IV ACCESS
MAY PERFORM ENDOTRACHEAL INTUBATION
MAY UTILIZE MAGILL FORCEPS TO REMOVE FOREIGN BODY AIRWAY OBSTRUCTIONS
MAY ADMINISTER THE FOLLOWING IV MEDICATIONS: NALOXONE (NARCAN), THIAMINE (VITAMIN B1), 50% DEXTROSE (D50)
MAY ADMINISTER ASPIRIN (ASA) PO

INITIAL PATIENT ASSESSMENT

THE FOLLOWING PROCEDURES ARE COMMON TO ALL PATIENT PRESENTATIONS AND SHALL BE PERFORMED BY CERTIFIED MEDICAL PERSONNEL FOR ALL PATIENT ENCOUNTERS:

- ENSURE SCENE SAFETY
- ASSESS AND ASSURE AIRWAY, BREATHING AND CIRCULATORY STATUS
- VITAL SIGNS SHALL BE TAKEN EVERY FIVE MINUTES ON ALL UNSTABLE (OR QUESTIONABLY UNSTABLE) PATIENTS AND EVERY TEN MINUTES ON ALL STABLE PATIENTS
- HISTORY OF CURRENT ILLNESS OR INJURY
- PAST PERTINENT MEDICAL HISTORY
- MEDICATIONS, ALLERGIES

DO NOT DELAY PATIENT TRANSPORT TO OBTAIN A LENGTHY MEDICAL HISTORY

NEUROLOGICAL ASSESSMENT

INITIAL OBSERVATIONS OF A PATIENT'S NEUROLOGICAL STATUS BY THE MEDICAL RESPONDER PROVIDE THE BASIS FOR SEQUENTIAL CHANGES IN THE PATIENT

THE FOLLOWING OBSERVATIONS SHOULD BE MADE IN THE FIELD:

- ORIENTATION TO PERSON, PLACE AND EVENT
- EMOTIONAL STATUS
- MEMORY OR LOSS OF CONSCIOUSNESS
- COORDINATION
- SENSORY EVALUATION TO TOUCH, PAIN AND POSITION
- MOTOR FUNCTION OR MOTOR LOSS

GLASCOW COMA SCALE

1. EYE OPENING

NONE	1
TO PAIN	2
TO VOICE	3
SPONTANEOUSLY	4

2. BEST VERBAL RESPONSE

NONE	1
INCOMPREHENSIBLE	2
INAPPROPRIATE	3
CONFUSED	4
ORIENTED	5

3. BEST MOTOR RESPONSE

NONE	1
EXTENSION	2
FLEXION	3
WITHDRAWS	4
LOCALIZES PAIN	5
OBEYS COMMAND	6

TOTAL: **3-15**

SECTION II

CRITERIA FOR PROCEDURES

INDICATIONS FOR USE OF THE A.E.D.

THE A.E.D. SHALL BE USED ON PATIENTS UNDER THE FOLLOWING CONDITIONS:

- ALL MEDICAL RESPONDERS WHO DEPLOY THE A.E.D. SHALL BE CERTIFIED TO A MINIMUM OF EMERGENCY CARE ATTENDANT BY THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES AND ALSO BE AHA HEALTHCARE PROVIDER CERTIFIED
- FOLLOW STRICT SAFETY PROCEDURES WHEN USING THE A.E.D. TO PREVENT INJURY TO MEDICAL RESPONDERS AND BYSTANDERS
- PATIENT MUST PRESENT IN FULL ARREST: NO PULSE, NO RESPIRATIONS. AN A.E.D IS NOT TO BE APPLIED TO ANY PATIENT WHO PRESENTS OTHERWISE.
- AN A.E.D. MAY BE APPLIED ON PEDIATRIC PATIENTS, IF PEDI ELECTRODES ARE UNAVAILABLE THE USE OF ADULT PADS IS ACCEPTABLE
- AN A.E.D. IS NOT RECOMMENDED FOR USE ON THE TRAUMATIC ARREST PATIENT

DOCUMENTATION MUST BE PROVIDED ON EVERY PATIENT UPON WHICH AN A.E.D. HAS BE UTILIZED REGARDLESS IF THE A.E.D. DISCHARGES. REQUIRED DOCUMENTATION FOLLOWS THIS PAGE. IF A PARAMEDIC PROVIDER UTILIZES MANUAL MONITOR/DEFIBRILLATOR HE/SHE SHOULD ALSO COMPLETE AND RETURN THE A.E.D. DOCUMENTATION, WITH THE APPROPRIATE CHANGES TO THE FORM, INDICATING THE USE OF A MANUAL MONITOR/WATT SECONDS USED.

MANUAL MONITOR/DEFIBRILLATORS

PARAMEDIC CERTIFIED MEDICAL RESPONDERS ONLY MAY UTILIZE MANUAL MONITOR/DEFIBRILLATORS
IN LIEU OF A.E.D.'S. THIS IS CONSIDERED A NON-INVASIVE PROCEDURE IN WHICH THE PARAMEDIC WILL READ THE RHYTHM AND DEFIBRILLATE AS NEEDED.

THE PARAMEDIC CANNOT UTILIZE THE MANUAL MONITOR/DEFIBRILLATOR TO MONITOR CONSCIOUS OR ALERT PATIENTS AS A STANDARD PROCEDURE. THE MONITOR IS TO BE USED ONLY IN THE CAPACITY AS AN A.E.D. ONLY.

THIS PROCEDURE IS WITHIN THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES GUIDELINES AND IS PERFORMED BY ACLS CERTIFIED PARAMEDICS ONLY.

INDICATIONS FOR BASIC AIRWAY MANAGEMENT

GENERAL INFORMATION

THE PRIORITY DURING ASSESSMENT OF ANY PATIENT IS AIRWAY, BREATHING AND CIRCULATION. CHECK TO MAKE SURE THAT PATIENT DOES NOT HAVE AIRWAY OBSTRUCTIONS OR ANY POTENTIAL OBSTRUCTIONS.

IS THE PATIENT ABLE TO MAINTAIN A PATENT AIRWAY WITH EFFECTIVE BREATHING? IS THERE A NEED FOR ASSISTED VENTILATIONS, OR SUPPLEMENTAL O₂? IS PATIENT ALTERED IN MENTAL STATUS, AND IS THERE A NEED TO USE AIRWAY ADJUNCTS TO KEEP AIRWAY CLEAR?

ASSESS PATIENT FOR OPEN (PATENT) AIRWAY

IF PATIENT IS CONSCIOUS AND ALERT AND THERE IS NOT ANY POTENTIAL AIRWAY OBSTRUCTIONS, CHECK EFFECTIVENESS OF PATIENTS BREATHING. IF NEEDED USE BVM TO SUPPLEMENT PATIENTS VENTILATION EFFORTS.

IF THE PATIENT IS NOT CONSCIOUS AND NO HEAD OR NECK TRAUMA IS SUSPECTED OPEN AIRWAY USING HEAD-TILT CHIN LIFT METHOD. IF TRAUMA IS SUSPECTED, USE JAW-THRUST MANEUVER TO OPEN AIRWAY.

PATIENTS WITH FOREIGN BODY AIRWAY OBSTRUCTION

IF THE PATIENT IS CONSCIOUS AND A FOREIGN BODY OBSTRUCTION IS SUSPECTED TO BE THE CAUSE OF DISTRESS, ADVISE PATIENT THAT HELP HAS ARRIVED AND USE ABDOMINAL THRUST TO TRY AND CLEAR AIRWAY. BE READY FOR PATIENT TO BECOME UNCONSCIOUS IF ABD THRUST ARE INEFFECTIVE.

IF PATIENT IS UNCONSCIOUS USE APPROPRIATE MEANS TO OPEN AIRWAY, AND VISUALIZE PRESENCE OF AIRWAY OBSTRUCTION, DO NOT USE A BLIND FINGER SWEEP. BE READY FOR THE POTENTIAL OF EMESIS AND HAVE SUCTION NEARBY READY TO USE. IF OBJECT IS NOT VISIBLE START CHEST COMPRESSIONS, CHECKING FOR OBSTRUCTION PRIOR TO ATTEMPTING VENTILATIONS.

FOR ADVANCE MEDICAL RESPONDERS THE USE OF MAGILL FORCEPS WILL BE INDICATED FOR THESE PATIENTS IF GAG REFLEX IS NOT INTACT.

ALL RESPONDERS SHOULD BE ABLE TO UTILIZE PORTABLE SUCTION DEVICES TO CLEAR COMPROMISED AIRWAYS WHEN UNCONSCIOUS PATIENTS HAVE COPIOUS AMOUNTS OF EMESIS OR FLUIDS PREVENTING ADEQUATE VENTILATION. SKILLS SHEETS ON PROPER HARD SUCTION TECHNIQUES SHOULD BE FILED WITH DEPARTMENT MEDICAL COORDINATORS.

FOR MEDICAL RESPONDERS AT THE EMT LEVEL AND ABOVE SHOULD ALSO HAVE SKILLS SHEETS OF PROPER SOFT SUCTION TECHNIQUES FILED WITH DEPARTMENT MEDICAL COORDINATORS.

INDICATIONS FOR AIRWAY ADJUNCTS

IF PATIENT IS UNCONSCIOUS WITHOUT INTACT GAG REFLEX:

SECURE AIRWAY WITH AN OPA AND ADMINISTER HIGH CONCENTRATION O₂ VIA NRM. IF RESPIRATIONS ARE INEFFECTIVE OR LABORED, ASSIST VENTILATION WITH A BVM ATTACHED TO SUPPLEMENTAL O₂. BE READY FOR SPONTANEOUS EMESIS AND HAVE SUCTION ON HAND READY TO USE.

IF PATIENT IS ALTERED MENTAL STATUS OR UNCONSCIOUS WITH AN INTACT GAG REFLEX

AN NPA MAY BE USED TO SECURE AIRWAY WITH PATIENTS THAT STILL HAVE AN INTACT GAG REFLEX IF NO MAXILLOFACIAL TRAUMA EXIST AND THE PATIENT WILL TOLERATE THE DEVICE. ADMINISTER HIGH CONCENTRATION O₂ VIA NRB. IF RESPIRATIONS ARE INEFFECTIVE OR LABORED, ASSIST VENTILATIONS WITH BVM ATTACHED TO SUPPLEMENTAL O₂. BE SURE TO PREPARE FOR SPONTANEOUS EMESIS AND HAVE SUCTION ON HAND READY TO USE.

INDICATIONS FOR ADVANCED AIRWAY MANAGEMENT

SUPRAGLOTTIC AIRWAY PLACEMENT

SUPRAGLOTTIC PLACEMENT WILL BE INDICATED FOR:

-ALL PATIENTS IN FULL ARREST, WHEN ADVANCE MEDICAL PERSONNEL IS UNAVAILABLE OR UNABLE TO OBTAIN INTUBATION VIA ET TUBE.

-UNCONSCIOUS PATIENTS WHO CANNOT MAINTAIN AN OPEN AIRWAY WITH THE EXCEPTIONS BELOW:

1. ANY PATIENT WHO'S CONDITION MAY BE REVERSED BY MEDICATION: D50W, ORAL GLUCOSE, OR NARCAN
2. AN UNCONSCIOUS PATIENT WITH A GAG REFLEX
3. AT THE MEDIC'S DISCRETION, THE AIRWAY MAY BE MAINTAINED WITH AN OPA AND THE PATIENT VENTILATED VIA BVM, IF THE MEDIC DEEMS THAT THE AIRWAY IS SATISFACTORY DUE TO SHORT ETA BY THE AMBULANCE PROVIDER, OR ADVANCE MEDICAL PERSONNEL.

SUPRAGLOTTIC AIRWAY PLACEMENT WILL BE PERFORMED BY MEDICAL PERSONNEL FROM THE EMT-BASIC TO PARAMEDIC LEVEL WHO HAVE:

1. BEEN BRIEFED ON ESD#2 PROTOCOLS BY A DISTRICT DESIGNATED REPRESENTATIVE
2. SATISFACTORILY PERFORMED SUPRAGLOTTIC AIRWAY INSERTION ACCORDING TO THE NATIONAL REGISTRY STANDARDS AND HAS A CURRENT SKILLS EVALUATION ON FILE WITH THE FRO ADMINISTRATOR AND THEIR DEPARTMENT MEDICAL OFFICER
3. HAS BEEN APPROVED FOR THIS PROCEDURE BY THEIR DEPARTMENT CHIEF

Examples of Supraglottic Airway Devices are (KING LTD, IGEL, LMA, combi-tube,etc).

ENDOTRACHEAL INTUBATION

ORAL ENDOTRACHEAL INTUBATION WILL BE INDICATED FOR:

-ALL PATIENTS IN FULL ARREST

-UNCONSCIOUS PATIENTS WHO CANNOT MAINTAIN AN OPEN AIRWAY WITH THE EXCEPTIONS BELOW:

1. ANY PATIENT WHO'S CONDITION MAY BE REVERSED BY MEDICATION: D50W, ORAL GLUCOSE, OR NARCAN
2. AN UNCONSCIOUS PATIENT WITH A GAG REFLEX
3. AT THE MEDICS DISCRETION, THE AIRWAY MAY BE MAINTAINED WITH AN OPA AND THE PATIENT VENTILATED VIA BVM, IF THE MEDIC DEEMS THAT THE AIRWAY IS SATISFACTORY DUE TO SHORT ETA BY THE AMBULANCE PROVIDER, OR THE MEDIC SUSPECTS INTUBATION MAY PROVE TRAUMATIC TO THE PATIENT

INTUBATION WILL BE VIA THE OROTRACHEAL ROUTE ONLY. INTUBATIONS WILL BE PERFORMED BY MEDICAL PERSONNEL FROM THE EMT-INTERMEDIATE TO PARAMEDIC LEVEL WHO HAVE:

1. BEEN BRIEFED ON ESD#2 PROTOCOLS BY A DISTRICT DESIGNATED REPRESENTATIVE
2. SATISFACTORILY PERFORMED ENDOTRACHEAL INTUBATION ACCORDING TO THE NATIONAL REGISTRY STANDARDS AND HAS A CURRENT SKILLS EVALUATION ON FILE WITH THE FRO ADMINISTRATOR AND THEIR DEPARTMENT MEDICAL OFFICER
3. HAS BEEN APPROVED FOR THIS PROCEDURE BY THEIR DEPARTMENT CHIEF

-PROPER PLACEMENT OF THE TUBE WILL BE CONFIRMED VIA TWO METHODS.

1. CAPNOGRAPHY
2. AUSCULTATION
3. COLOMETRIC DEVICE

ALL ADVANCED MEDICAL PERSONNEL WHO PERFORM AN ENDOTRACHEAL INTUBATION, KING AIRWAY PLACEMENT, OR ATTEMPT THEREOF, WILL FILL OUT AND AFFIX AN "ADVANCED LIFE SUPPORT SUMMARY" REPORT TO THE NFIRS REPORT FILED FOR THE MEDICAL CALL IN WHICH THE INTUBATION WAS PERFORMED. A COPY OF THE "ADVANCED LIFE SUPPORT SUMMARY" REPORT WILL BE FORWARDED TO THE FRO ADMINISTRATOR FOR QI; TO BE FORWARDED TO THE DISTRICT MEDICAL DIRECTOR.

INDICATIONS FOR BLOOD GLUCOSE DETERMINATION

A BGL (BLOOD GLUCOSE LEVEL) SHOULD BE TAKEN ON:

- ALL KNOWN DIABETICS WITH AN ALTERATION IN THEIR TYPICAL LEVEL OF CONSCIOUSNESS
- ANY PATIENT WHO HAS EXPERIENCED A SEIZURE WITH A KNOWN HISTORY OF DIABETES, OR SUSPECTED HYPOGLYCEMIA
- ANY PATIENT WITH AN ALTERED LEVEL OF CONSCIOUSNESS, WITH AN UNKNOWN MEDICAL HISTORY
- KNOWN ALCOHOLICS WITH AN ALTERED LEVEL OF CONSCIOUSNESS
- ANY PATIENT WITH SUSPECTED HYPOTHERMIA

A BGL OF 60 WITH ALTERED LOC, OR 50 WITH SIGNS OF AGITATION OR ALTERED PERSONALITY ARE INDICATORS THAT A DRINK THAT CONTAINS SUGAR OR ORAL GLUCOSE SHOULD BE ADMINISTERED, BASED ON THE PATIENT'S ABILITY TO FOLLOW SIMPLE COMMANDS AND TO BE ABLE TO SWALLOW.

FOR USE BY ALL LEVELS OF CERTIFIED MEDICAL PROVIDERS TO DETERMINE THE NECESSITY OF ADMINISTRATION OF ORAL GLUCOSE; EMR THROUGH PARAMEDIC

INDICATIONS FOR IM AND SUB-Q ADMINISTRATION

-ADMINISTRATION OF EPINEPHRINE 1:1000 FOR ANAPHYLAXIS AND/OR STATUS ASTHMATICUS

INTRAMUSCULAR INJECTION

-INFORM THE PATIENT OF NEED FOR MEDICATION AND POSSIBLE SIDE EFFECTS. ASK ABOUT ANY MEDICATION ALLERGIES.

-ENSURE CORRECT MEDICATION IS SELECTED (EPI 1:1000 CONCENTRATION) CHECK FOR CLARITY AND EXPIRATION DATE.

-DRAW 0.3MG TO 0.5MG OF THE MEDICATION FROM GLASS AMPULE WITH 1CC SYRINGE.

-SELECT INJECTION SITE AND CLEAN WITH ALCOHOL PREP

-HOLD SKIN FLAT WITH THUMB AND INDEX FINGER WITH YOUR FREE HAND

-INSERT NEEDLE AT A 90 DEGREE ANGLE THROUGH THE SKIN. PULL BACK PLUNGER, CHECK FOR BLOOD TO ENSURE THAT NEEDLE IS NOT INSERTED INTO AN ARTERY OR VEIN. IF NO BLOOD IS OBTAINED DEPRESS PLUNGER TO ADMINISTER MEDICATION. IF THERE IS BLOOD PRESENT, WITHDRAW NEEDLE, DISCARD SYRINGE, AND START OVER.

SUBCUTANEOUS INJECTION

-INFORM THE PATIENT OF NEED FOR MEDICATION AND POSSIBLE SIDE EFFECTS. ASK ABOUT ANY MEDICATION ALLERGIES.

-ENSURE CORRECT MEDICATION IS SELECTED (EPI 1:1000 CONCENTRATION) CHECK FOR CLARITY AND EXPIRATION DATE.

-DRAW 0.3MG TO 0.5MG OF THE MEDICATION FROM GLASS AMPULE WITH 1CC SYRINGE.

-SELECT INJECTION SITE AND CLEAN WITH ALCOHOL PREP

-HOLD SKIN FLAT WITH THUMB AND INDEX FINGER WITH YOUR FREE HAND.

-INSERT NEEDLE AT A 45 DEGREE ANGLE THROUGH THE SKIN. PULL BACK PLUNGER, CHECK FOR BLOOD TO ENSURE THAT NEEDLE IS NOT INSERTED INTO AN ARTERY OR VEIN. IF NO BLOOD IS OBTAINED DEPRESS PLUNGER TO ADMINISTER MEDICATION. IF THERE IS BLOOD PRESENT, WITHDRAW NEEDLE, DISCARD SYRINGE, AND START OVER

COMPLICATIONS

-INADVERTENT INJECTION INTO ARTERY OR VEIN

-REDNESS, PAIN, LOCALIZED INFECTION

INDICATIONS FOR I.V. ADMINISTRATION

INDICATIONS

-MEDICAL

-CHEST PAIN, RESPIRATORY DISTRESS, CARDIAC ARREST, DRUG OVERDOSE, POISONING,

-ANY CONDITION CAUSING ALTERED MENTAL STATUS, PATIENT'S IN LABOR, PATIENT'S WITH SUSPECTED INTERNAL BLEEDING

-TRAUMA

-PATIENT WITH TRAUMATIC INJURIES THAT COULD LEAD TO SURGERY

-PATIENTS WITH BLUNT TRAUMA, DECELERATION INJURY OR CRUSH INJURIES

-PATIENTS WITH MULTIPLE FRACTURES

FLUIDS:

NORMAL SALINE

USES: MEDICAL PATIENTS, DIABETICS, HYPERTHERMIA, GASTROINTESTINAL COMPLICATIONS, CARDIAC AND RESPIRATORY PATIENTS

LACTATED RINGER'S

USES: TRAUMATIC PATIENTS , BLEEDING PROFUSELY, HYPOVOLEMIC SHOCK DUE TO TRAUMA.

ONE TO TWO LARGE BORE I.V.'S (16 TO 18 GA. ANGIOCATHS WITH A MICRO/MACRO DRIP INFUSION SET)

NOTE: INITIATION OF I.V.'S IS ONLY DONE BY INTERMEDIATE/PARAMEDIC CERTIFIED MEDICAL PERSONNEL. LIMIT ATTEMPTS TO TWO (2). DOCUMENT INITIATION OR ATTEMPTS ON THE ALS SUMMARY SHEET AND FORWARD TO THE FRO ADMINISTRATOR.

NOTE: REPLACEMENT OF ALL I.V. SUPPLIES SHOULD BE THROUGH THE DISTRICT AMBULANCE TRANSPORT SERVICE.

INDICATIONS FOR PULSE OXIMETRY

GENERAL INFORMATION

PULSE OXIMETRY IS A NON-INVASIVE METHOD OF MEASURING, WITH SOME ACCURACY, THE PERCENTAGE OF O₂ IN A PATIENT'S BLOOD.

INDICATIONS

-ANY PATIENT WITH A POTENTIAL OF HYPOXEMIA FROM ANY CAUSE

PRECAUTIONS

-PULSE OXIMETRY READINGS MAY BE ADVERSELY AFFECTED BY (AND PRODUCE FALSE READINGS) FROM STRONG FLUORESCENT LIGHT, CO POISONING, HYPOTHERMIC PATIENTS, PATIENTS WEARING NAIL POLISH, OR PATIENT'S WITH ANEMIA.

VALUES:

NORMAL	95-100%
MILD HYPOXIA	91-94%
MODERATE HYPOXIA	86-90%
SEVERE HYPOXIA	LESS THAN 85%

REGARDLESS OF PATIENT'S SP_{O2} READING, ALL PATIENT'S WITH ANY INDICATION OF HYPOXIA OR THE POTENTIAL FOR HYPOXIA SHOULD BE PLACED ON O₂.

THIS PROCEDURE IS FOR USE BY ALL LEVELS OF MEDICAL RESPONDERS IN ESD#2.

INDICATIONS FOR PULSE CO-OXIMETRY

GENERAL INFORMATION

CARBOXYHEMOGLOBIN MONITORING IS A NON-INVASIVE METHOD OF MEASURING THE PERCENTAGE OF CARBON MONOXIDE IN A PATIENT'S BLOOD. SPCO READINGS CAN BE USED AS AN ADDITIONAL SCREENING MEASURE TO DETERMINE EXPOSURE TO CARBON MONOXIDE

INDICATIONS

-POST-INCIDENT/REHAB SCREENINGS FOR FIREFIGHTERS WHERE POSSIBILITY OF CARBON MONOXIDE EXPOSURE IS PRESENT INCLUDING BUT NOT LIMITED TO:

- WORKING ON OR NEAR FIRE-GROUND
- CONFINED SPACES
- CO DETECTOR ALARMS PRESENT
- SYMPTOMS INDICATIVE OF CO EXPOSURE (HEADACHE, DIZZINESS, ETC.)
- PATIENTS PRESENTING WITH HEADACHE, DIZZINESS, SYNCOPE, AMS, WEAKNESS, OR LETHARGY

PRECAUTIONS

-SMOKERS MAY HAVE BASELINE SPCO READINGS OF UP TO 10%. INACCURATE READING IF PROBE IS DISLODGED OR MISPLACED, READING ARE NOT TO BE OBTAINED USING "PINKY" FINGER OR THUMB.

VALUES:

NORMAL 0-3% NO TREATMENT REQUIRED

WITH NO SIGNS OR SYMPTOMS 3-12% MONITOR CLOSELY, TREAT WITH O2 VIA NC

WITH SIGNS AND SYMPTOMS 3-12% TREAT WITH HIGH FLOW O2 WITH NRB

WITH SIGNS AND SYMPTOMS >12% TREAT WITH HIGH FLOW O2 VIA NRB, TRANSPORT

FOR PATIENTS WITH PROLONG EXPOSURE OR SPCO OF 25%, CONTACT CLOSEST FACILITY AND INQUIRE ABOUT THE AVAILABILITY OF HYPERBARIC TREATMENT. CONSIDER ASSISTING PATIENT WITH POSITIVE PRESSURE VENTILATIONS AND PREPARE FOR IMMEDIATE TRANSPORT.

THIS PROCEDURE IS FOR USE BY ALL LEVELS OF MEDICAL RESPONDERS IN ESD#2

INDICATIONS FOR SPINAL IMMOBILIZATION

INDICATIONS

- SUSPECTED HEAD, NECK, HIP OR SPINAL INJURY
- UNCONSCIOUS PATIENT WITH UNKNOWN CAUSE
- MOI THAT MAY CAUSE INJURY TO THE SPINE, NECK, HIP, OR HEAD
- MULTIPLE FRACTURES

PROCEDURE

- CERVICAL SPINE STABILIZATION SHOULD BE INITIATED IMMEDIATELY AFTER SUSPECTING AN INJURY TO THE SPINE, NECK, OR HEAD.
- THE CERVICAL SPINE SHOULD BE BROUGHT TO AN IN-LINE POSITION IF NOT ALREADY IN ONE, AND IN-LINE STABILIZATION IS TO BE MANUALLY MAINTAINED BY ONE RESPONDER UNTIL THE PATIENT'S HEAD IS PROPERLY IMMOBILIZED TO A BACKBOARD.
- PERFORM A RAPID TRAUMA ASSESSMENT TO IDENTIFY ANY INJURIES THAT THE IMMOBILIZATION TECHNIQUE WOULD NEED TO BE CHANGED
- APPLY APPROPRIATE SIZED CERVICAL COLLAR TO THE PATIENT. IF THE PATIENT DOES NOT CORRECTLY FIT IN THE AVAILABLE CERVICAL COLLARS, USE TOWELS
- IF THE PATIENT IS IN A SEATED POSITION AND IS TABLE, USE OF A KENDRICK EXTRICATION DEVICE IS ACCEPTABLE TO INITIALLY STABILIZE THE PATIENT'S SPINE.
- THE PATIENT SHOULD BE MOVED AS A UNIT AND PLACED ON THE BACKBOARD. THE PATIENT'S BODY SHOULD BE SECURED FIRST WITH AT LEAST 3 STRAPS FOR AN ADULT OR 2 FOR A CHILD
- THEN THE HEAD SHOULD BE SECURED USING TWO HEAD BLOCKS OR APPROPRIATE IMMOBILIZATION DEVICE AND SECURED TO THE BACKBOARD. AFTER THIS STEP, MANUAL STABILIZATION OF CERVICAL SPINE MAY BE RELEASED.
- ASSESS THE PATIENT TO MAKE SURE IMMOBILIZATION DID NOT COMPROMISE AIRWAY, BREATHING, OR CIRCULATION OR CAUSED EXCESS PAIN TO THE PATIENT
- PREGNANT PATIENTS IN THEIR THIRD TRIMESTER SHOULD HAVE THE BACKBOARD TILTED TO THE LEFT TO AVOID COMPROMISING CIRCULATION.
- BE PREPARED TO SUCTION SECRETIONS, BLOOD, OR VOMITUS FROM THE OROPHARYNX IF PRESENT.

INDICATIONS FOR TRACTION SPLINTING

TRACTION SPLINTING WILL BE INDICATED FOR USE WITH SUSPECTED AND OBVIOUS FEMUR FRACTURES. THE FRACTURES MUST BE CLOSED, AND THE PATIENT MUST BE VITALLY STABLE. THE PATIENT CANNOT HAVE A SUSPECTED HIP FRACTURE OR BI-LATERAL FEMUR FRACTURE. A MINIMUM OF 2 PEOPLE ARE NEEDED TO PERFORM THIS PROCEDURE.

- APPLY MANUAL STABILIZATION TO THE LEG.
- EXPOSE THE EXTREMITY.
- WHILE MAINTAINING STABILIZATION, HAVE 1 RESPONDER BEGIN APPLY MANUAL TRACTION.
- THE RESPONDER HOLDING MANUAL TRACTION MUST CONTINUE HOLDING TRACTION UNTIL SPLINT/MECHANICAL TRACTION IS ESTABLISHED
- ASSESS CIRCULATION, MOTOR FUNCTION, AND SENSATION TO PAIN AND LIGHT TOUCH
- USING THE UNINJURED EXTREMITY, MEASURE THE TRACTION SPLINT FROM THE ISCHIAL BONE TO 8-12 INCHES PAST THE FOOT
- ADJUST THE VELCRO STRAPS SO THERE IS ONE ABOVE THE FRACTURE, ONE BELOW THE FRACTURE, ONE ABOVE THE KNEE, AND ONE ABOVE THE ANKLE. ATTACH THE ISCHIAL STRAP
- CONNECT THE "S" HOOK TO THE RINGS OF THE ANKLE STRAP
- APPLY MECHANICAL TRACTION UNTIL IT IS EQUAL WITH THE MANUAL TRACTION PROVIDED BY THE 2ND RESPONDER
- SECURE VELCRO STRAPS TO THE EXTREMITY AT THE APPROPRIATE SITES, THEN MANUAL TRACTION CAN BE RELEASED.
- REASSESS CIRCULATION, MOTOR FUNCTION, AND SENSATION TO PAIN AND LIGHT TOUCH
- SECURE THE PATIENT ONTO A LONG BACKBOARD.

INDICATIONS FOR TORNIQUET USE

IF BLEEDING REMAINS UNCONTROLLED AFTER TRYING TO STOP BLEEDING WITH DIRECT PRESSURE APPLY A TORNIQUET TO EXTREMITY, PROXIMAL TO BLEEDING SITE UNTIL BLEEDING IS CONTROLLED AND NO DISTAL PULSE(s) IS PALPATED.

- USE COMMERCIAL TORNIQUET FOLLOWING MANUFACTURES INSTRUCTIONS/DIRECTIONS.
- AN IMPROVISED TORNIQUET MAY BE UTILIZED IF A COMMERCIAL TORNIQUET IS NOT AVAILABLE i.e. CRAVAT, BELT, etc.
- ONCE TORNIQUET IS IN PLACE INDICATE TIME OF APPLICATION ON THE TORNIQUET.
- ASSURE TORNIQUET REMAINS VISIBLE AND SHOULD NOT BE COVERED BY CLOTHING, BANDAGES OR SPLINTING.
- NEVER REMOVE TORNIQUET.

INDICATIONS FOR THE USE OF CAPNOGRAPHY DEVICE

CAPNOGRAPHY IS A NON-INVASIVE METHOD OF MONITORING A PATIENT'S VENTILATORY STATUS AND EFFECTIVENESS. IT IS ALSO CONSIDERED THE "GOLD STANDARD" IN ENSURING THAT ADVANCED AIRWAYS ARE PROPERLY PLACED. BY MONITORING CO₂ GAS IN EXHALED AIR, AN INDIVIDUAL CAN DETERMINE IF A PATIENT IS BEING VENTILATED ADEQUATELY AND WHETHER THEY ARE HYPERCAPNIC OR HYPOCAPNIC.

INDICATIONS

1. ANY PATIENT PRESENTING WITH APPARENT RESPIRATORY DISTRESS.
2. ANY PATIENT THAT IS INTUBATED

PROCEDURE:

1. SELECT THE APPROPRIATE SAMPLING DEVICE. A NASAL CANNULA OR AN INLINE ADAPTER IS AVAILABLE FOR INTUBATED OR VENTILATED PATIENT.
2. PLACE SAMPLING DEVICE ON PATIENT
3. CONNECT END CONNECTOR TO CAPNOMETER PORT BY INSERTING INTO PORT.
4. AFTER SEVERAL BREATHS A READING SHOULD BEGIN TO BE DISPLAYED.
5. MOST PATIENTS SHOULD MAINTAIN A ET_{CO2} OF BETWEEN 35 & 45 MM HG

SECTION III- MEDICATIONS

ALBUTEROL, NEBULIZED MEDICATION

ASPIRIN, 81 MG

D50W

EPINEPHRINE, 1:1000

ORAL GLUCOSE

OXYGEN

NALOXONE

THIAMINE

ALBUTEROL

INDICATIONS

-RELIEF OF BRONCHOSPASM IN PATIENTS WITH ASTHMA, BRONCHITIS, EMPHYSEMA, PNEUMONIA, ACUTE ALLERGIC REACTION

CONTRAINDICATIONS

-HYPERSENSITIVITY

DOSAGE/ROUTE

-PREFILLED AMPULES WITH 0.83% IN A 3 ML. VIAL

-USE WITH NEBULIZER MASK

PRECAUTIONS

-MAY PRECIPITATE CHEST PAIN AND ARRHYTHMIAS

-SHOULD ONLY BE ADMINISTERED VIA INHALATION

ALL PERSONNEL WHO ADMINISTER ALBUTEROL WILL FILL OUT AND AFFIX AN "ADVANCED LIFE SUPPORT SUMMARY" REPORT TO THE NFIRS REPORT FILED FOR THE MEDICAL CALL IN WHICH THE ADMINISTRATION OF ALBUTEROL WAS PERFORMED. A COPY OF THE "ADVANCED LIFE SUPPORT SUMMARY" REPORT WILL BE FORWARDED TO THE FRO ADMINISTRATOR FOR QI; TO BE FORWARDED TO THE DISTRICT MEDICAL DIRECTOR

-TO BE ADMINISTERED BY CERTIFIED EMT-BASIC THROUGH PARAMEDIC MEDICAL PERSONNEL

ASPIRIN, A.S.A.

INDICATIONS

-STRONGLY RECOMMENDED FOR ALL PATIENTS EXHIBITING SIGNS AND SYMPTOMS OF A.M.I.

-CHEST PAIN, SHORTNESS OF BREATH, APPREHENSION, EPIGASTRIC PAIN, HISTORY OF PREVIOUS A.M.I. OR ANGINA, FEELING OF IMPENDING DOOM

CONTRAINDICATIONS

-ALLERGY TO ASPIRIN

-PEPTIC ULCER DISEASE, GASTROINTESTINAL BLEEDING

DOSAGE/ROUTE

-CHEWABLE BABY ASPIRIN, 81 MG.

-HAVE PATIENT CHEW, NOT SWALLOW FOUR (4) BABY ASPIRIN, 81 MG

PRECAUTIONS

-INCREASED BLEEDING WITH PATIENT USE OF ANTICOAGULANTS

-INCREASED EFFECTS WITH ORAL HYPOGLYCEMICS AND INSULIN

ALL MEDICAL PERSONNEL WHO ADMINISTER ASA WILL FILL OUT AND AFFIX AN "ADVANCED LIFE SUPPORT SUMMARY" REPORT TO THE NFIRS REPORT FILED FOR THE MEDICAL CALL IN WHICH ASA WAS ADMINISTERED. A COPY OF THE "ADVANCED LIFE SUPPORT SUMMARY" REPORT WILL BE FORWARDED TO THE FRO ADMINISTRATOR FOR QI; TO BE FORWARDED TO THE DISTRICT MEDICAL DIRECTOR

-TO BE ADMINISTERED EMR THROUGH PARAMEDIC MEDICAL PERSONNEL

D50W

INDICATIONS

-HYPOGLYCEMIA, CONFIRMED BY BGL

CONTRAINDICATIONS

-HYPERGLYCEMIA

-HEAD INJURY OR SIGNS OF CVA OR RISING ICP

DOSAGE/ROUTE

25 GRAMS/50 ML, I.V. BOLUS

PRECAUTIONS

-I.V. LINE MUST BE PATENT. D50W CAN CAUSE TISSUE NECROSIS IF IT INFILTRATES

-ADMINISTER 100 MG. THIAMINE IN KNOWN ALCOHOLICS

ALL PERSONNEL WHO ADMINISTER D50W WILL FILL OUT AND AFFIX AN "ADVANCED LIFE SUPPORT SUMMARY" REPORT TO THE NFIRS REPORT FILED FOR THE MEDICAL CALL IN WHICH THE ADMINISTRATION OF D50W WAS PERFORMED. A COPY OF THE "ADVANCED LIFE SUPPORT SUMMARY" REPORT WILL BE FORWARDED TO THE FRO ADMINISTRATOR FOR QI; TO BE FORWARDED TO THE DISTRICT MEDICAL DIRECTOR

-TO BE ADMINISTERED BY CERTIFIED EMT-I THROUGH PARAMEDIC PERSONNEL

EPINEPHRINE, 1:1000

INDICATIONS

-ACUTE ALLERGIC REACTION

CONTRAINDICATIONS

-USE WITH CAUTION IN PATIENTS WITH CARDIOVASCULAR DISEASE

ADVERSE REACTIONS

-TACHYCARDIA, HEADACHE, NAUSEA, RESTLESSNESS, HYPERTENSION, CARDIAC DYSRHYTHMIAS, CHEST PAIN

DOSAGE/ROUTE

-SUPPLIED IN GLASS AMPULES WITH 1 MG/L ML OF 1:1000 EPINEPHRINE

-ADMINISTERED 0.3 TO 0.5 MG IM OR SQ

PRECAUTIONS

-DO NOT ADMINISTER THIS MEDICATION I.V.

-CAN BE INACTIVATED BY ALKALINE SOLUTIONS

ALL PERSONNEL WHO ADMINISTER EPI WILL FILL OUT AND AFFIX AN "ADVANCED LIFE SUPPORT SUMMARY" REPORT TO THE NFIRS REPORT FILED FOR THE MEDICAL CALL IN WHICH THE ADMINISTRATION OF EPI WAS PERFORMED. A COPY OF THE "ADVANCED LIFE SUPPORT SUMMARY" REPORT WILL BE FORWARDED TO THE FRO ADMINISTRATOR FOR QI; TO BE FORWARDED TO THE DISTRICT MEDICAL DIRECTOR

-TO BE ADMINISTERED BY CERTIFIED EMT-BASIC THROUGH PARAMEDIC MEDICAL PERSONNEL

ORAL GLUCOSE

INDICATIONS

-TO REVERSE HYPOGLYCEMIA IN KNOWN DIABETICS, BASED ON ALTERED LOC, OR
BGL VERIFIED BY GLUCOMETER

CONTRAINDICATIONS

- PATIENT UNABLE TO SWALLOW
- UNCONSCIOUS PATIENT
- PATIENT WITH A PROBABLE CEREBRAL VASCULAR ACCIDENT
- PATIENT WITH KNOWN HYPERGLYCEMIA

DOSAGE/ROUTE

- PREFILLED TUBE OF 15 GRAMS OF ORAL GLUCOSE
- PATIENT TO BE ADMINISTERED ONE TUBE, BUCALLY, OR A PART THEREOF UNTIL THE PATIENT IS CAPABLE OF RESPONDING TO SIMPLE COMMANDS OR CAN SELF-ADMINISTER A SOFT DRINK

PRECAUTIONS

- PATIENT MUST BE ABLE TO SWALLOW OR ORAL GLUCOSE MAY BECOME A CHOKING HAZARD
- ADMINISTRATION SHOULD BE BASED ON BGL OF 60 OR LESS, OR PATIENT EXHIBITING SIGNS OF ALTERED LOC
- ADMINISTERED BY CERTIFIED EMR'S THROUGH PARAMEDIC MEDICAL PERSONNEL

OXYGEN

INDICATIONS

- HYPOXIA, ISCHEMIC CONDITIONS
- CONDITIONS THAT INCREASE METABOLIC OXYGEN DEMAND
- PATIENTS WHO THE RESPONDERS FEEL WOULD BENEFIT FROM O2

CONTRAINDICATIONS

- NONE

DOSAGE/ROUTE

- 1 TO 6 LPM FOR HEMODYNAMICALLY STABLE PATIENTS VIA NASAL CANNULA
- 10 TO 15 LPM OR ENOUGH TO MAINTAIN BAG INFLATION FOR ALL CRITICAL PATIENTS OR PATIENTS IN RESPIRATORY DISTRESS VIA NON-REBREATHER MASK
- 6 LPM BLOW BY FOR NEWBORNS VIA OXYGEN TUBING OR NON-REBREATHER

PRECAUTIONS

- DO NOT WITHHOLD OXYGEN TO CO2 RETAINING PATIENTS (COPD) BUT ALWAYS BE READY TO ASSIST VENTILATIONS IF NEEDED.
- OXYGEN TOXICITY IN NEWBORNS AND PREMATURE INFANTS. LONG TERM EXPOSURE TO HIGH LEVELS OF OXYGEN CAN CAUSE TOXICITY AND RETINAL DAMAGE.
- ADMINISTERED BY CERTIFIED EMR'S THROUGH PARAMEDIC MEDICAL PERSONNEL

NALOXONE, NARCAN

INDICATIONS

- UNCONSCIOUS PATIENT WITH KNOWN OR SUSPECTED NARCOTIC OVERDOSE
- UNCONSCIOUS PATIENT, UNKNOWN NON-TRAUMATIC CAUSE

CONTRAINDICATIONS

- NONE

DOSAGE/ROUTE

- 0.4 MG TO 2.0 MG AMPULE OR MULTIDOSE VIAL
- INITIAL DOSE; 0.4 MG UP TO 2.0 MG
- TITRATE DOSAGE TO PATIENT'S RESPIRATORY DRIVE
- ADMINISTER SLOWLY I.V.

PRECAUTIONS

- RAPID ADMINISTRATION CAN CAUSE PROJECTILE VOMITING

ALL PERSONNEL WHO ADMINISTER NARCAN WILL FILL OUT AND AFFIX AN "ADVANCED LIFE SUPPORT SUMMARY" REPORT TO THE NFIRS REPORT FILED FOR THE MEDICAL CALL IN WHICH THE ADMINISTRATION OF NARCAN WAS PERFORMED. A COPY OF THE "ADVANCED LIFE SUPPORT SUMMARY" REPORT WILL BE FORWARDED TO THE FRO ADMINISTRATOR FOR QI; TO BE FORWARDED TO THE DISTRICT MEDICAL DIRECTOR

- TO BE ADMINISTERED BY CERTIFIED EMT-I AND PARAMEDIC PERSONNEL

THIAMINE

INDICATIONS

-CONFIRMED HYPOGLYCEMIA.

-HYPOGLYCEMIA WITH UNKNOWN HISTORY, POSSIBLE ETOH WITHDRAWAL
PATIENT

CONTRAINDICATIONS

-NONE

DOSAGE/ROUTE

-100 MG. I.V., MAY BE ADDED TO D50W

PRECAUTIONS

-NONE

-TO BE ADMINISTERED BY CERTIFIED EMT-I THROUGH PARAMEDIC PERSONNEL

ALL PERSONNEL WHO ADMINISTER THIAMINE WILL FILL OUT AND AFFIX AN
"ADVANCED LIFE SUPPORT SUMMARY" REPORT TO THE NFIRS REPORT FILED FOR
THE MEDICAL CALL IN WHICH THE ADMINISTRATION OF THIAMINE WAS
PERFORMED. A COPY OF THE "ADVANCED LIFE SUPPORT SUMMARY" REPORT
WILL BE FORWARDED TO THE FRO ADMINISTRATOR FOR QI; TO BE FORWARDED
TO THE DISTRICT MEDICAL DIRECTOR

SECTION IV

TRAUMA MANAGEMENT

TRAUMA MANAGEMENT

GENERAL INFORMATION

AS A MEDICAL RESPONDER YOUR FIRST OBLIGATION IS TO PROVIDE A THOROUGH AND RAPID ASSESSMENT ON ANY PATIENT TO IDENTIFY OBVIOUS OR POTENTIAL LIFE THREATENING INJURIES AND PROVIDE CARE BASED ON YOUR ASSESSMENT. TREATMENT WILL BE LIMITED BY THE FACTORS THAT DIRECTLY RELATE TO THE PATIENT'S VIABILITY.

EXPECTED COMPONENTS OF PROVISION OF CARE

- SCENE SAFETY
- AIRWAY WITH C-SPINE PRECAUTIONS, BREATHING AND SUPPORT OF CIRCULATION
- NEUROLOGICAL ASSESSMENT AND LOC
- ASSESS CIRCULATORY COMPROMISE AND HEMORRHAGE

SECONDARY ASSESSMENT

- VITAL SIGNS
- RAPID HEAD-TO-TOE ASSESSMENT WITH ATTENTION TO MULTI-SYSTEMS COMPLICATIONS
- COMPLETE IMMOBILIZATION
- HIGH FLOW O₂ WITH VENTILATORY ASSISTANCE, IF INDICATED
- SHOCK MANAGEMENT, POSITION, FLUID REPLACEMENT
- APPROPRIATE, RAPID TRANSPORT

SIGNIFICANT MECHANISM OF INJURY

- GLASCOW COMA SCALE <13
- B/P < 90 MM/HG SYSTOLIC
- RESPIRATIONS <10 OR >30 PER MINUTE
- PENETRATING INJURIES TO THE HEAD, CHEST, ABDOMEN, PELVIS OR GROIN
- FRACTURE OF TWO OR MORE PROXIMAL LONG BONES
- COMBINATION OF BURNS THAT COMPROMISE AIRWAY OR 15% BSA TOTAL

EVIDENCE OF SIGNIFICANT MECHANISM OF INJURY

- FALLS OF 20 FEET FOR AND ADULT, OR 3 TIMES THE HEIGHT FOR CHILDREN
- MVC WITH EVIDENCE OF MAJOR IMPACT, 12" INTRUSION INTO OCCUPANT COMPARTMENT OR 18" ON ANY SIDE OF VEHICLE
- ROLLOVER
- EJECTION OF OCCUPANT
- DEATH OF OCCUPANT IN THE SAME VEHICLE
- PEDESTRIAN ON FOOT OR BICYCLE, STRUCK BY VEHICLE
- PATIENT OVER 55 YOA WITH MAJOR TRAUMATIC INJURIES
- PATIENT WITH PERTINENT MEDICAL HISTORY, WITH TRAUMATIC INJURIES
- FIRST RESPONDER DISCRETION; "GUT INSTINCT"

SECTION V TRAUMA EMERGENCIES

ABDOMINAL TRAUMA

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. NOTE MOI. PROTECT C-SPINE
3. STOP ALL EXTERNAL HEMORRHAGE WITH APPROPRIATE MEANS
4. ADMINISTER HIGH FLOW O₂, NRM
5. STABILIZE IMPALED OBJECTS
6. COVER EVISCERATED BOWEL WITH WET, STERILE DRESSING, THEN COVER WITH AN OCCLUSIVE DRESSING TO KEEP MOIST. COVER OCCLUSIVE DRESSING WITH DRY BULKY DRESSING, SUCH AS TOWELS OR A BLANKET TO MAINTAIN BODY HEAT.
7. GIVE THE PATIENT NOTHING BY MOUTH (NPO)
8. KEEP KNEES BENT
9. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INITIATE I.V. THERAPY TO MAINTAIN A SYSTOLIC B/P OF 90 MM/HG; N/S

AMPUTATIONS

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. NOTE MOI, PROTECT C-SPINE
3. STOP ALL EXTERNAL HEMORRHAGE; DIRECT PRESSURE FIRST, THEN TK. NOTE TIME OF APPLICATION AND WRITE TK TIME ON TAPE; PLACE ON PATIENT'S FOREHEAD. ESTIMATE BLOOD LOSS AS MINIMAL, MODERATE OR SEVERE
4. ELEVATE AFFECTED PART AND SPLINT
5. ADMINISTER HIGH FLOW O2 VIA NRM
6. GIVE NOTHING BY MOUTH
7. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INITIATE I.V. THERAPY TO MAINTAIN A SYSTOLIC B/P OF 90 MM/HG

MANAGEMENT OF PARTS

1. DO NOT DELAY TRANSPORT TO LOCATE MISSING PARTS
2. WASH OFF PARTS WITH STERILE WATER/SALINE. TAP WATER CAN BE USED IF NOTHING ELSE IS AVAILABLE
3. PLACE IN A DRY, STERILE OR VERY CLEAN CONTAINER (IF POSSIBLE) AND PLACE CONTAINER IN WATER AND ICE. DO NOT IMMERSE PART IN ICE WATER OR ALLOW TO FREEZE.
4. FOR TEETH, PLACE IN MILK. DO NOT BRUSH OFF OR REMOVE ANY DEBRIS FOUND ON TOOTH
5. FOR FINGERS, TOES, OR OTHER SMALL PARTS, PLACE IN A STERILE GLOVE, TIE OFF AND KEEP COOL
6. IF PART IS PARTIALLY AMPUTATED OR AVULSED, BRUSH OR WASH OFF DEBRIS, PLACE IN NORMAL POSITION AND BANDAGE IN PLACE
7. IF BONE, TENDON, OR CARTILAGE IS EXPOSED, COVER INITIALLY WITH SALINE SOAKED DRESSING AND COVER WITH A BULKY, STERILE DRESSING
8. DO NOT REMOVE IMPALED OBJECTS
9. PREPARE FOR IMMEDIATE TRANSPORT

CHEST TRAUMA

GENERAL INFORMATION

CHEST TRAUMA CAN BE RAPIDLY CATASTROPHIC OR SLOWLY PROGRESS TO A TERMINAL POINT.
THE DIFFERENCE BETWEEN A VIABLE PATIENT AND ONE THAT IS UNSALVAGEABLE MAY BE DEPENDENT UPON THE TIME THAT HAS LAPSED BETWEEN THE INJURY AND SURGICAL INTERVENTION. PATIENTS WITH DECELERATION INJURIES, CRUSHING INJURIES, OR PENETRATING CHEST TRAUMA MUST BE TRANSPORTED WITHOUT DELAY.

TREATMENT

BLS-

1. ESTABLISH ABC'S. ASSIST VENTILATIONS, IF NECESSARY, VIA BVM WITH SUPPLEMENTAL
02. IF NOT NEEDED, ADMINISTER HIGH FLOW 02, VIA NRM.
2. NOTE MOI. PROTECT C-SPINE
3. STOP ALL EXTERNAL HEMORRHAGE
4. PREPARE FOR IMMEDIATE TRANSPORT

OPEN CHEST WOUND

1. FOLLOW TREATMENT PROTOCOL ABOVE
2. COVER WOUND WITH OCCLUSIVE DRESSING, CLOSED ON THREE SIDES
3. MONITOR FOR SIGNS OF DEVELOPING TENSION PNEUMOTHORAX

FLAIL CHEST

1. FOLLOW TREATMENT PROTOCOL ABOVE
2. IF PATIENT IS IN RESPIRATORY DISTRESS AND UNABLE TO EXPAND CHEST, VENTILATE, WITH CAUTION, WITH BVM, ATTACHED TO SUPPLEMENTAL 02
3. IF RESPIRATIONS ARE 10 PER MINUTE OR LESS, PATIENT SHOULD BE VENTILATED WITH A BVM, ATTACHED TO SUPPLEMENTAL 02

ALS-

INTUBATE IF NECESSARY
INITIATE I.V. THERAPY TO MAINTAIN A SYSTOLIC B/P OF 90 MM/HG

FRACTURES AND DISLOCATIONS

TREATMENT

BLS-

1. ESTABLISH ABC'S.
2. CONSIDER MOI AND IMMOBILIZE IF NEEDED
3. ADMINISTER HIGH FLOW O2 VIA NRM
4. CONTROL EXTERNAL BLEEDING
5. SUSPECT NON-ORTHOPEDIC INJURIES
6. SPLINT FRACTURES IN POSITION FOUND WITH LIGHT MANUAL ALIGNMENT, WITH THE FOLLOWING EXCEPTIONS:
 - LOSS OF DISTAL PULSE: GENTLY REALIGN ANGULATED FRACTURES TO ATTEMPT TO RESTORE CIRCULATION
 - IF NOT RESTORED, RESPLINT AND PREPARE FOR IMMEDIATE TRANSPORT
7. SUPPORT SIMPLE FEMUR FRACTURES WITH TRACTION SPLINT. DO NOT USE ON ANY LEG WITH A POTENTIAL INJURY TO THE KNEE OR PELVIS OF THE SAME LEG
10. SPLINT ELBOW, KNEE, WRIST, SHOULDER AND ANKLE IN POSITION FOUND
11. REMOVE ANY CONSTRICTING CLOTHING AND JEWELRY
12. MONITOR DISTAL PULSES BEFORE AND AFTER SPLINTING AND AFTER MOVING PATIENT
13. ADMINISTER HIGH FLOW O2 IF NEEDED

ALS-

INITIATE I.V.'S TO MAINTAIN SYSTOLIC BP OF 90 MM/HG SYSTOLIC

HEAD TRAUMA

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. NOTE MECHANISM: PROTECT C-SPINE AND FULLY IMMOBILIZE PATIENT
3. MONITOR VITAL SIGNS: NOTE CHANGES TO B/P, PULSE, AND RESPIRATIONS

CUSHING'S TRIAD

CHANGES IN RESPIRATIONS, OFTEN IRREGULAR WITH VARYING TIDAL VOLUME

(CHEYNE-STOKES)

WIDENING PULSE PRESSURES, ELEVATION OF SYSTOLIC AND DROPPING DIASTOLIC, BRADYCARDIA

4. IF PATIENT IS UNCONSCIOUS, INSERT OPA AND VENTILATE WITH ABVM, ATTACHED TO SUPPLEMENTAL O₂. ADMINISTER VENTILATIONS
5. IF PATIENT IS CONSCIOUS, ADMINISTER HIGH FLOW O₂ VIA NRM
6. STOP ALL EXTERNAL HEMORRHAGE
7. PERFORM COMPLETE ASSESSMENT
8. GIVE NOTHING BY MOUTH
9. BE ALERT FOR SEIZURE ACTIVITY
10. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INTUBATE AS NECESSARY
INITIATE I.V. TO MAINTAIN SYSTOLIC BP OF 90 MM/HG. DO NOT OVERHYDRATE

MULTI-SYSTEMS TRAUMA

TREATMENT

BLS-

1. ESTABLISH ABC'S.
2. NOTE MOI; PROTECT C-SPINE
3. ADMINISTER HIGH FLOW O₂ VIA NRM.
4. STOP ALL EXTERNAL HEMORRHAGE
5. FULLY IMMOBILIZE PATIENT
6. SPLINT FRACTURES
7. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INTUBATE AS NECESSARY
INITIATE ONE TO TWO LARGE BORE (16-18 GA.) I.V.'S TO MAINTAIN SYSTOLIC BP
OF 90 MM/HG

SPINAL INJURY

TREATMENT

BLS-

1. ESTABLISH ABC'S. ASSIST VENTILATIONS AS NECESSARY WITH BVM ATTACHED TO SUPPLEMENTAL O₂
2. NOTE MOI; PROTECT C-SPINE. FULLY IMMOBILIZE PATIENT
3. STOP ALL EXTERNAL HEMORRHAGE
4. IF PATIENT IS STANDING, HAVE ANOTHER RESPONDER MAINTAIN C-SPINE AND PLACE PATIENT IN A SITTING POSITION OR LOWER ONTO A BACKBOARD. IT IS RECOMMENDED NOT TO IMMOBILIZE A PATIENT IN A STANDING POSITION
5. PERFORM COMPLETE ASSESSMENT
6. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INITIATE I.V.'S TO MAINTAIN A SYSTOLIC BP OF 90 MM/HG

SECTION VI ENVIRONMENTAL EMERGENCIES

ALLERGIC REACTION/ANAPHYLAXIS

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. ADMINISTER HIGH FLOW O₂ VIA NRM, ASSIST INADEQUATE VENTILATIONS WITH BVM ATTACHED TO SUPPLEMENTAL O₂
3. PLACE PATIENT IN SUPINE POSITION WITH LEGS ELEVATED. IF THIS CAUSES PATIENT MORE RESPIRATORY DISTRESS, ASSISTING VENTILATIONS MAY BE REQUIRED
4. MONITOR VITAL SIGNS Q. 5
5. PREPARE FOR IMMEDIATE TRANSPORT

IF PATIENT EXHIBITS SIGNS OF SERIOUS ANAPHYLAXIS AS EVIDENCED BY RESPIRATORY DISTRESS, HIVES AND URTICARIA, AND FALLING BLOOD PRESSURE, EMT AND ABOVE ADMINISTER EPINEPHRINE:

SQ OR IM, 0.3 TO 0.5 MG 1:1000

ALS-

INTUBATE AS NECESSARY, MAY USE ET TUBE ONE SIZE SMALLER THAN USUAL
MAY INITIATE I.V.'S TO MAINTAIN SYSTOLIC BP OF 90MM/HG

BLACK WIDOW SPIDER BITE

GENERAL INFORMATION

BLACK WIDOW SPIDERS ACCOUNT FOR MAJOR ENVENOMATIONS IN THE UNITED STATES AND ARE FOUND IN ALL STATES EXCEPT ALASKA. THEY POSE THE GREATEST RISK TO THE ELDERLY, THE YOUNG, PATIENTS WITH A HISTORY OF HYPERTENSION, AND PATIENTS WHO ARE HYPERSENSITIVE TO THE BITE.

SIGNS AND SYMPTOMS:

BITE MAY BE PAINLESS, WITH A SMALL PAPULE WITHOUT PAIN OR SWELLING WITHIN FIRST HOUR, PATIENT MAY EXHIBIT MUSCLE SPASM, CRAMPS, ABDOMINAL PAIN WITH NO TENDERNESS ON PALPATION, PARESTHESIAS, SEVERE PAIN TO THE SOLES OF THE FEET, THREADY PULSE, DIAPHORESIS, DIZZINESS, HEADACHE, NAUSEA AND VOMITING, AND SEVERE HYPERTENSION. BITE IS SELF-LIMITING AND SYMPTOMS LAST 8-10 HOURS

TREATMENT

BLS-

1. INITIATE EARLY AND AGGRESSIVELY
2. ESTABLISH ABC'S
3. ADMINISTER HIGH FLOW O2 VIA NRM
4. LOCATE AND CLEAN WOUND WITH SOAP AND WATER
5. ALL PATIENT'S UNDER THE AGE OF 15 AND OVER 50, OR WHO HAVE A HISTORY OF HTN SHOULD BE TRANSPORTED TO A HOSPITAL
6. IF PATIENT EXHIBITS SIGNS OF ANAPHYLAXIS, REFER TO THAT PROTOCOL

BURNS: THERMAL, CHEMICAL AND ELECTRICAL

TREATMENT

BLS-

1. MOVE PATIENT TO A SAFE LOCATION. DO NOT PLACE YOURSELF AT RISK
2. USE EXTREME CAUTION WITH ELECTROCUTIONS. DO NOT ASSUME POWER IS OFF UNTIL TURNED OFF BY UTILITY COMPANY
3. BREAK CONTACT WITH THE AGENT: EXTINGUISH FLAMES, BRUSH OFF CHEMICAL AND FLUSH WITH WATER
4. ESTABLISH ABC'S WITH CONCURRENT C-SPINE PRECAUTIONS
5. IF PATIENT HAS EXPERIENCED LOC, EXPECT CHEMICAL OR TOXIC INHALATION
6. ADMINISTER HIGH FLOW O₂ VIA NRM. ASSIST VENTILATION AS NEEDED
7. WRAP PATIENT IN STERILE BURN SHEETS; DO NOT PULL OFF CLOTHING THAT IS ADHERED TO BURNED TISSUE
8. REMOVE ALL CONSTRICTING JEWELRY AND CLOTHING
9. TREAT ALL OTHER INJURIES
10. MONITOR AIRWAY CLOSELY FOR SIGNS OF AIRWAY INVOLVEMENT
11. APPROXIMATE BSA BURNED. FOR EACH "PALM SIZED" AREA OF BURNED TISSUE (PATIENT'S PALM, NOT YOURS) CONSIDER IT 1% BSA
12. FOR BURNS LARGER THAN 18% BSA COVER WITH DRY DRESSING. IF SMALLER, COVER WITH WET, STERILE DRESSINGS
13. PREPARE FOR IMMEDIATE TRANSPORT

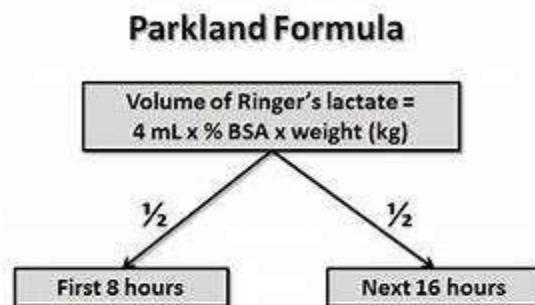
ALS-

INITIATE I.V.'S TO MAINTAIN A SYSTOLIC BP OF 90 MM/HG IF PATIENT IS HYPOTENSIVE

ADMINISTER APPROPRIATE FLUID THERAPY

PARKLAND FORMULA

4 TIMES THE PATIENT'S WEIGHT IN KG, TIMES % OF BSA BURNED EQUALS TOTAL AMOUNT OF FLUID FOR 24 HOURS. ADMINISTER HALF THAT AMOUNT IN THE FIRST 8 HOURS.



DROWNING

TREATMENT

BLS-

1. ESTABLISH ABC'S AND SUSPECT C-SPINE INJURY
2. INITIATE CPR IS NECESSARY
3. FULLY IMMOBILIZE PATIENT
4. ADMINISTER HIGH FLOW O2 VIA BVM
5. CONSIDER SUPRAGLOTTIC AIRWAY DEVICE
5. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INTUBATE AS NECESSARY
INITIATE I.V.'S TO MAINTAIN A SYSTOLIC BP OF 90 MM/HG

HEAT EMERGENCIES

TREATMENT

HEAT CRAMPS

-SIGNS AND SYMPTOMS: NAUSEA, DECREASED BP, INCREASED PULSE, DIAPHRESIS, ABDOMINAL CRAMPING AND PAIN.

HEAT EXHAUSTION

-SYNCOPE, HEADACHE, NAUSEA AND VOMITING, WEAKNESS, DIAPHORESIS, PALLOR, WEAK AND RAPID PULSE, AND RAPID RESPIRATIONS

HEAT STROKE

-ALTERED LOC, COMA, SEIZURES, HOT (USUALLY) DRY SKIN, BOUNDING PULSE.

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. REMOVE PATIENT FROM HOT ENVIRONMENT
3. ADMINISTER HIGH FLOW O₂ VIA NRM
4. IF PATIENT IS CONSCIOUS AND CAN SWALLOW ADMINISTER ½ STRENGTH GATORADE OR LIGHTLY SALTED WATER
5. IF PATIENT IS LETHARGIC OR HAS ALTERED LOC, PREPARE FOR IMMEDIATE TRANSPORT

HEAT STROKE

1. ESTABLISH ABC'S AND ADMINISTER HIGH FLOW O₂; ASSIST VENTILATIONS IF NECESSARY
2. INITIATE RAPID COOLING MEASURES
3. SUCTION AS NEEDED
4. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INTUBATE AS NECESSARY
INITIATE I.V.'S TO MAINTAIN A SYSTOLIC BP OF 90 MM/HG

COLD EMERGENCIES

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. FOR MILD HYPOTHERMIA:
REMOVE PATIENT FROM COLD ENVIRONMENT REMOVE WET CLOTHING AND DRY PATIENT OFF. COVER WITH WARM BLANKETS.
3. CHECK BLOOD GLUCOSE LEVEL WITH GLUCOMETER. A PATIENT WITH A READING BELOW 60 WITH SIGNS OF ALTERED LOC SHOULD BE GIVEN ORAL GLUCOSE OR A DRINK WITH SUGAR IN IT, BASED ON PATIENT'S ABILITY TO SWALLOW
4. YOU MAY INITIATE PASSIVE REWARMING, WITH HOT WATER BOTTLES PLACED AT THE NECK, GROIN AND ARMPITS
5. FOR SEVERE HYPOTHERMIA:
REMOVE PATIENT FROM COLD ENVIRONMENT. HANDLE GENTLY. CHECK A PULSE FOR A MINIMUM OF 30 SECONDS AND IF NONE, INITIATE CPR. AED MAY BE USED AND PATIENT DEFIBRILLATED UP TO THREE TIMES
6. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INTUBATE AS NECESSARY
INITIATE I.V.'S TO MAINTAIN SYSTOLIC BP AT 90 MM/HG
ADMINISTER D50W, 25 GRAMS, BASED ON BGL

INHALATION INJURY

TREATMENT

BLS-

1. DO NOT PUT YOURSELF AT RISK. WEAR SCBA, IF INDICATED, OR WAIT UNTIL PATIENT IS CARRIED TO YOUR LOCATION
2. ESTABLISH ABC'S AND ASSIST VENTILATIONS, IF NEEDED, WITH BVM AND SUPPLEMENTAL O₂
3. CONSIDER NEBULIZED ALBUTEROL 2.5MG/3ML NS
4. MONITOR VITAL SIGNS CLOSELY
5. WATCH FOR SIGN OF LARYNGEAL EDEMA
6. IF POSSIBLE, DETERMINE TYPE OF EXPOSURE AND DURATION
7. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INTUBATE AS NEEDED
INITIATE I.V.'S TO MAINTAIN SYSTOLIC BP OF 90 MM/HG

POISONING

PROTECT YOURSELF WHEN DEALING WITH POISONOUS EXPOSURES, ESPECIALLY CHEMICALS AND ORGANOPHOSPHATES

TREATMENT

BLS-

1. WEAR PPE, AND ESTABLISH ABC'S
2. ADMINISTER HIGH FLOW O₂; ASSIST VENTILATIONS IF NEEDED
3. MONITOR VITAL SIGNS Q. 5 MINUTES
4. WATCH FOR SIGNS OF LARYNGEAL EDEMA AND ALLERGIC REACTION
5. MONITOR RESPIRATORY STATUS AND LOC CONTINUOUSLY
6. PREPARE FOR IMMEDIATE TRANSPORT
7. CONTACT POISON CONTROL CENTER IF NEEDED

BASIC THROUGH PARAMEDIC

IF PATIENT EXHIBITS RESPIRATORY DISTRESS, ALBUTEROL MAY BE ADMINISTERED VIA A NEBULIZER MASK

ALS-

INTUBATE PATIENT AS NECESSARY
INITIATE I.V.'S TO MAINTAIN A SYSTOLIC BP OF 90 MM/HG



SNAKEBITES

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. ADMINISTER O2 VIA N/C UNLESS PATIENT EXHIBITS SIGNS OF ALLERGIC REACTION
3. KEEP PATIENT STILL AND QUIET. PLACE IN POSITION OF COMFORT WITH BITTEN EXTREMITY IN A POSITION LOWER THAN THE HEART.
4. SPLINT EXTREMITY TO AVOID MOVEMENT
5. IF THE BITE IS LESS THAN 10 MINUTES OLD, WASH WITH SOAP AND WATER AND APPLY AN SAWYER EXTRACTOR
6. DO NOT "SUCK AND CUT" OR USE A TK
7. WATCH FOR SIGNS OF ALLERGIC REACTION

ATTEMPT TO IDENTIFY SNAKE, BUT DO NOT HANDLE OR TAKE TO THE EMERGENCY DEPARTMENT

SECTION VII MEDICAL EMERGENCIES

ABDOMINAL PAIN, NON-TRAUMATIC

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. ADMINISTER LOW FLOW O₂, BASED ON PATIENT NEED,
3. KEEP PATIENT WARM
4. PLACE IN POSITION OF COMFORT, WITH KNEES FLEXED
5. ANTICIPATE VOMITING
6. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INITIATE I.V. TO MAINTAIN SYSTOLIC BP OF 90 MM/HG

ALTERED MENTAL STATUS

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. ADMINISTER HIGH FLOW O2 BY NRM IF RESPIRATIONS ARE ADEQUATE. IF NOT, ASSIST VENTILATIONS WITH BVM AND SUPPLEMENTAL O2
3. CHECK BGL AND ADMINISTER ORAL GLUCOSE IF PATIENT CAN FOLLOW SIMPLE COMMANDS AND SWALLOW
4. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INITIATE I.V.'S AND ADMINISTER THIAMINE, D50W BASED ON BGL
IF NO RESPONSE, ADMINISTER NARCAN 0.4 MG TO 2.0, TITRATED TO RESPONSE
INTUBATE IF NEEDED, ONLY IF PATIENT DOES NOT RESPOND TO MEDICATION

ASTHMA, STATUS ASTHMATICUS

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. ADMINISTER HIGH FLOW O₂ VIA NRM
3. ALLOW PATIENT TO ASSUME POSITION OF COMFORT
4. CHECK TO SEE IF PATIENT HAS USED THEIR MDI, IF NOT ASSIST IN TAKING IT
5. IF PATIENT GOES INTO RESPIRATORY ARREST. ASSIST VENTILATIONS WITH BVM AND SUPPLEMENTAL O₂

EMT

ADMINISTER NEBULIZED ALBUTEROL PER PROTOCOL

ALS-

INTUBATE AS NECESSARY
INITIATE I.V.'S TO MAINTAIN A SYSTOLIC BP OF 90MM/HG
IF RESPIRATORY DISTRESS IS NOT RESOLVED WITH NEBULIZED ALBUTEROL
CONSIDER PATIENT TO BE IN STATUS ASTHMATICUS AND ADMINISTER 0.3 TO 0.5
EPI 1:1000 SUB-Q, IM

BEHAVIORAL EMERGENCIES

TREATMENT

BLS-

1. REQUEST POLICE ASSISTANCE
2. REMOVE OTHER PEOPLE, BYSTANDERS OR FAMILY MEMBERS FROM THE SCENE WHO MAY CAUSE OR AGGRAVATE THE SITUATION, OR REMOVE PATIENT FROM THE AREA TO THE AMBULANCE
3. BE CALM AND PROFESSIONAL
4. REMOVE OR BE AWARE OF POTENTIAL WEAPONS
5. BE AWARE OF INCREASING HOSTILITY, ANGER OR AGITATION FROM PATIENT
6. SECURE THE PATIENT'S ABC'S
7. TRY TO ASCERTAIN IF THE PATIENT HAS TAKEN ANY DRUGS OR ALCOHOL
8. DO NOT LEAVE SUICIDAL PATIENTS ALONE
9. IF THE PATIENT BECOMES VIOLENT AND YOU DO NOT HAVE A MINIMUM OF FOUR OTHER RESPONDERS WITH YOU, LEAVE THE SCENE. IF YOU HAVE ADEQUATE ASSISTANCE, PATIENT MAY NEED TO BE RESTRAINED. USE ONLY ENOUGH FORCE AS NECESSARY TO RESTRAIN THE PATIENT
10. ONCE RESTRAINED, DO NOT REMOVE THE RESTRAINTS
11. CHECK THE PATIENT'S BGL. PATIENT MAY BE HYPOGLYCEMIC. REFER TO DIABETIC EMERGENCY PROTOCOL (P. 52)
12. PREPARE FOR TRANSPORT. DO NOT REQUEST AIR EVACUATION.

ALS-

IF CAUSE OF BEHAVIORAL EMERGENCY IS HYPOGLYCEMIA, AND I.V. MAY BE INITIATED AND D50W MAY BE ADMINISTERED, IF PATIENT IS UNABLE TO SWALLOW

CARDIAC EMERGENCIES

CARDIAC ARREST

BLS-

1. ESTABLISH FULL ARREST; NO PULSE, NO RESPIRATIONS
2. INITIATE CPR, ATTACH AED
3. ESTABLISH AIRWAY WITH ORAL ADJUNCTS. (OPA,NPA)
- 4.. PROVIDE VENTILATIONS WITH BVM AND SUPPLEMENTAL O2.
- 5.. PREPARE PATIENT FOR TRANSPORT; LONG BOARD, SECURED TO LONG BOARD WITH STRAPS

EMT THROUGH PARAMEDIC

KING LT AIRWAY

ALS-

INTUBATE

INITIATE I.V.

CHEST PAIN POSSIBLE AMI

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. ADMINISTER O2 TO MAINTAIN O2 SATURATION OF 94% VIA RA/NC/NRB
3. DO NOT ALLOW PATIENT TO WALK, USE BATHROOM OR WALK TO THE STRETCHER
4. KEEP THE PATIENT CALM; PROVIDE REASSURANCE
5. KEEP THE AED CLOSE BY AND HAVE A LONG BOARD READY
6. DO NOT PLACE THE AED ON ANY PATIENT WITH A PULSE
7. PREPARE FOR IMMEDIATE TRANSPORT
8. ADMINISTER 4-81 MG BABY ASPIRIN BY MOUTH. HAVE PATIENT CHEW, NOT SWALLOW

ALS-

INITIATE I.V. TO MAINTAIN B/P OF 90 MM/HG SYSTOLIC

INTUBATE IF NECESSARY

CEREBROVASCULAR EMERGENCIES

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. ADMINISTER O2 TO MAINTAIN SPO2 OF 94% VIA RA/NC/NRB. SUCTION AS NEEDED
3. ANTICIPATE VOMITING AND SEIZURES
4. PROTECT PARALYZED PARTS
5. MONITOR VITAL SIGNS; TAKE BILATERAL BLOOD PRESSURES
6. PROVIDE REASSURANCE
7. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INITIATE I.V. THERAPY, TKO

USE LA STROKE SCALE FOR EVALUATION TO INCLUDE THE FOLLOWING:

AGE < 45 YEARS OF AGE
NO HISTORY OF SEIZURES OF EPILEPSY
PT IS NOT WHEELCHAIR OR BEDRIDDEN
BGL-BETWEEN 60-400 MG/DL
OBVIOUS ASYMMETRY (RIGHT VS. LEFT) IN ANY OF THE FOLLOWING EXAMS:
FACIAL SMILE/GRIMACE
GRIPS
ARM STRENGTH (ARM DRIFT)

DIABETIC EMERGENCIES

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. CHECK BGL WITH THE GLUCOMETER. IF THE PATIENT IS HYPOGLYCEMIC AND CAN SWALLOW, ADMINISTER ORAL GLUCOSE OR A SUGARY DRINK. DO NOT GIVE THE PATIENT HARD CANDY, WHICH COULD BECOME AN AIRWAY OBSTRUCTION
3. IF PATIENT IS UNCONSCIOUS, PLACE THEM ON THEIR SIDE AND SUCTION AS NECESSARY
4. MONITOR VITAL SIGNS AND AIRWAY CONSTANTLY
5. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INITIATE I.V. TKO AND ADMINISTER D50W, 25 GRAMS, BASED ON BGL
2ND DOSE MAY BE ADMINISTERED FOR LOW BGL WITHOUT A RESPONSE TO THE INITIAL DOSE OF D50W

GASTROINTESTINAL BLEEDING

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. ADMINISTER HIGH FLOW O2, VIA NRM
3. MONITOR AIRWAY, ANTICIPATE VOMITING
4. IF PATIENT EXHIBITS SIGNS OF SHOCK, PLACE THEM IN A SUPINE POSITION WITH LEGS ELEVATED
6. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INITIATE I.V.'S TO MAINTAIN A SYSTOLIC BP OF 90 MM/HG

HYPERTENSIVE CRISIS

TREATMENT

BLS-

1. .ESTABLISH ABC'S
2. ADMINISTER HIGH FLOW O2 VIA NRM
3. MONITOR AIRWAY; ANTICIPATE VOMITING
4. HTN CRISIS IS SAID TO EXIST WHEN THE SYSTOLIC BP IS OVER 150 AND DIASTOLIC BP IS OVER 100 AND PATIENT IS COMPLAINING OR A SEVERE HEADACHE, DIZZINESS, OR EPISTAXIS

CONTRAINDICATIONS

- SYSTOLIC B/P LESS THAN 100
- SIGNS OF A CVA

ALS-

INITIATE I.V. TKO

OBSTRETICAL EMERGENCIES

TREATMENT

BLS-

1. DETERMINE IF BIRTH IS IMMINENT. CHECK FOR CROWNING, URGE TO PUSH.
2. ESTABLISH MOTHER'S ABC'S.
3. ADMINISTER LOW FLOW O2. N/C
4. ALLOW BABY'S HEAD TO DELIVER NORMALLY, APPLYING GENTLE PRESSURE TO THE BABY'S CROWN TO PREVENT RAPID DELIVERY
5. SUCTION MOUTH, THEN NOSE
6. CHECK FOR CORD AROUND BABY'S NECK; SLIP OVER SHOULDER IF POSSIBLE. IF NOT, CAREFULLY CLAMP CORD IN TWO PLACES AND CUT BETWEEN
7. DELIVER BABY AND CHECK FOR BREATHING AND PULSE. DRY BABY OFF AND WRAP IN TOWEL, COVERING HEAD
8. NOTE TIME OF BIRTH
9. CLAMP AND CUT CORD. PLACE FIRST CLAMP SIX INCHES FROM BABY'S BODY. PLACE SECOND CLAMP TWO INCHES HIGHER ON CORD. CUT BETWEEN OR HAVE FATHER CUT THE CORD
10. IF MOTHER IS ABLE, GIVE BABY TO MOTHER TO NURSE
11. MASSAGE MOTHER'S UTERUS.
12. ALLOW PLACENTA TO DELIVER NATURALLY. DO NOT PULL ON CORD
13. PLACE A STERILE OB PAD BETWEEN MOTHER'S LEGS

ALS-

INITIATE IV TO MOTHER
MONITOR VITAL SIGNS

PROLAPSED CORD

IF CORD PRECEDES BABY, PLACE THE MOTHER IN A KNEE CHEST POSITION AND PLACE A GLOVED HAND IN THE VAGINA AND PUSH BABY'S HEAD OFF THE CORD. KEEP THE CORD WET USING A WET ABD PAD OR CLOTH. DO NOT REMOVE YOUR HAND UNTIL THE MOTHER HAS BEEN DELIVERED TO THE HOSPITAL. IF THE BABY'S HEAD PUTS TOO MUCH PRESSURE ON THE CORD, IT WILL CUT OFF THE CIRCULATION TO THE BABY.

OVERDOSE

TREATMENT

BLS-

1. ESTABLISH ABC'S.
2. PAY CAREFUL ATTENTION TO PATIENT'S RESPIRATORY STATUS. ASSIST VENTILATIONS WITH BVM AND SUPPLEMENTAL O₂
3. TRY TO DETERMINE TYPE OF DRUG, WHEN TAKEN AND IF PATIENT HAS ALSO HAD ANY ALCOHOL
4. ASCERTAIN BGL WITH GLUCOMETER
5. ASK IF PATIENT HAS VOMITED, AND IF PATIENT DOES IN YOUR PRESENCE, TAKE A SAMPLE FOR THE HOSPITAL
6. TRY TO DETERMINE IF OD IS ACCIDENTAL OR INTENTIONAL
7. PATIENT MAY REQUIRE RESTRAINT

ALS-

DO NOT INTUBATE UNTIL AFTER MEDICATION THERAPY IS ATTEMPTED

INITIATE I.V. TKO

ADMINISTER D50W, BASED ON BGL

ADMINISTER NARCAN, 0.4 MG TO 2.0 MG, TITRATED TO RESPIRATORY EFFORT

SEIZURE ACTIVITY

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. IF YOU ARE PRESENT WHEN SEIZURE OCCURS, NOTE:
 - DURATION OF SEIZURE
 - PART (S) OF BODY INVOLVED
 - EYE DEVIATION
3. ADMINISTER HIGH FLOW O₂, VIA NRM. ASSIST VENTILATIONS AND SUCTION AS NEEDED
4. DO NOT RESTRAIN PATIENT. PROTECT THE PATIENT FROM HARM
5. ASCERTAIN IF THE PATIENT HAS A HISTORY AND IF SO, ARE THEY COMPLIANT WITH THEIR MEDICATION?
6. CHECK PATIENT'S BGL AND IF PATIENT CAN SWALLOW, ADMINISTER ORAL GLUCOSE, BASED ON BGL

ALS-

INITIATE I.V. TKO
ADMINISTER D50W, 25 GRAMS BASED ON BGL

DO NOT INTUBATE IF CONDITION CAN BE REVERSED WITH MEDICATION

UNCONSCIOUS PATIENT

TREATMENT

BLS-

1. IF PATIENT IS FOUND UNCONSCIOUS AND NO HISTORY IS AVAILABLE CONSIDER TRAUMA AND SECURE PATIENT'S C-SPINE
2. CHECK PATIENT'S PULSE
3. ADMINISTER HIGH FLOW O₂ VIA NRM. ASSIST VENTILATIONS IF THEY ARE TOO SHALLOW OR SLOW.
4. ANTICIPATE SEIZURES
5. ASCERTAIN BGL USING A GLUCOMETER
6. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INITIATE I.V. TO MAINTAIN SYSTOLIC BP OF 90 MM/HG

BASED ON BGL, ADMINISTER D50W, 25 GRAMS

2ND DOSE MAY BE ADMINISTERED IF NOT RESPONSE OR BGL IS VERY LOW
ADMINISTER NARCAN, 0.4 TO 2.0 MG. TITRATED TO RESPIRATORY RATE, IF OD IS SUSPECTED

INTUBATE ONCE MEDICATION IS ADMINISTERED WITH NO RESPONSE

SECTION VI PEDIATRIC EMERGENCIES

UNCONSCIOUS

TREATMENT

BLS-

1. IF PATIENT IS FOUND UNCONSCIOUS AND NO HISTORY IS AVAILABLE CONSIDER TRAUMA AND SECURE PATIENT'S C-SPINE
2. CHECK PATIENT'S PULSE
3. ADMINISTER HIGH FLOW O₂ VIA NRM. ASSIST VENTILATIONS IF THEY ARE TOO SHALLOW OR SLOW.
4. ANTICIPATE SEIZURES
5. ASCERTAIN BGL USING A GLUCOMETER
6. PREPARE FOR IMMEDIATE TRANSPORT

ALS-

INITIATE I.V. TO MAINTAIN SYSTOLIC BP OF 90 MM/HG

BASED ON BGL, ADMINISTER:

< 6 MONTHS

0.25-0.5 G/KG/DOSE (1-2 ML/KG/DOSE OF 25% SOLUTION) IV; NOT TO EXCEED 25 G/DOSE

INFANTS > 6 MONTHS AND CHILDREN

0.5-1 G/KG UP TO 25 G (2-4 ML/KG/DOSE OF 25% SOLUTION) IV; NOT TO EXCEED 25 G/DOSE

ADOLESCENTS

IV: 10-25 G (IE, 20-50 ML 50% SOLUTION OR 40-100 ML OF 25%)

2ND DOSE MAY BE ADMINISTERED IF NOT RESPONSE OR BGL IS VERY LOW
ADMINISTER NARCAN, 0.4 TO 2.0 MG. TITRATED TO RESPIRATORY RATE, IF OD IS SUSPECTED

INTUBATE ONCE MEDICATION IS ADMINISTERED WITH NO RESPONSE

SUSPECTED CHILD ABUSE

TREATMENT:

BLS-

1. ESTABLISH ABC'S.
2. APPLY OXYGEN AS NEEDED.
3. TREAT INJURIES AS INDICATED (SUSPECT C-SPINE INJURIES)
4. MONITOR VITAL SIGNS AND REPORT OUR FINDINGS.

ALS-

PEDIATRIC SEIZURES

TREATMENT:

BLS-

1. ESTABLISH ABC'S.
2. DO NOT FORCE ANYTHING BETWEEN TEETH.
3. ANTICIPATE VOMITING. HAVE SUCTION AVAILABLE.
4. ADMINISTER OXYGEN BY NON-REBREATHING MASK WHEN SEIZURE ACTIVITY ALLOWS. ASSIST VENTILATION AS NEEDED.
5. PROTECT PATIENT FROM INJURY AND PROTECT THE HEAD/C-SPINE FROM INJURY.
6. MONITOR VITAL SIGNS AND NEUROLOGICAL STATUS CAREFULLY.
7. CHECK TEMPERATURE

ALS-

1. INITIATE IV OF NS AT 20 CC/KG NORMAL SALINE.
2. MEASURE GLUCOSE.
3. INITIATE IV.

PEDIATRIC SHOCK

TREATMENT:

BLS-

1. ESTABLISH ABC'S.
2. ADMINISTER OXYGEN BY MASK.
3. ASSIST VENTILATION AS NEEDED.
4. CONTROL BLEEDING IF PRESENT.
5. COVER CHILD TO PREVENT LOSS OF BODY HEAT.

ALS-

1. ESTABLISH AN IV.
2. IMMEDIATE FLUID BOLUS (20 CC/KG) IF NEEDED.
3. REASSESS.

PEDIATRIC DIABETIC EMERGENCIES

TREATMENT

BLS-

1. ESTABLISH ABC's
2. ADMINISTER OXYGEN BY MASK
3. ASSIST VENTILATIONS AS NEEDED
4. OBTAIN BGL
5. MAINTAIN VITAL SIGNS

ALS-

BASED ON BGL, ADMINISTER:

< 6 MONTHS

0.25-0.5 G/KG/DOSE (1-2 ML/KG/DOSE OF 25% SOLUTION) IV; NOT TO EXCEED 25 G/DOSE

INFANTS > 6 MONTHS AND CHILDREN

0.5-1 G/KG UP TO 25 G (2-4 ML/KG/DOSE OF 25% SOLUTION) IV; NOT TO EXCEED 25 G/DOSE

ADOLESCENTS

IV: 10-25 G (IE, 20-50 ML 50% SOLUTION OR 40-100 ML OF 25%)

PEDIATRIC ASTHMA/STATUS ASTHMATICUS

TREATMENT

BLS-

1. ESTABLISH ABC'S
2. ADMINISTER OXYGEN VIA MASK
3. PULSE OXIMETRY
4. ADMINISTER ALBUTEROL VIA NEBULIZER (0.1 TO 0.15 MG/KG)
5. MAINTAIN VITAL SIGNS
6. PREPARE FOR TRANSPORT

ALS-

INTUBATE IF NECESSARY
ESTABLISH IV
MAY ADMINISTER EPI 1:1000 SQ (0.01 MG/KG)

SECTION VIII BIOHAZARD/MEDICAL WASTE DISPOSAL PROTOCOL

1. ALL BIOHAZARD/MEDICAL WASTE MATERIAL IS DISPOSED OF WITH THE CORRESPONDING EMS AGENCY AT THE END OF CALL.

THE FOLLOWING STANDING MEDICAL PROTOCLS HAVE BEEN REVISED AND APPROVED
BY THE FOLLOWING PERSONNEL FOR THE USE OF LICENSED EL PASO COUNTY ESD 2
PERSONNEL.

MEDICAL DIRECTOR DATE

SIGNATURE

EL PASO Co ESD 2 FRO DATE

SIGNATURE

