INTRODUCTION

The following protocols have been developed to provide standardized guidelines for patient care in particular critical situations. In some instances it is necessary to abbreviate or shorten terms to provide the most concise set of guidelines possible. When "ALS" appears in this document, we refer to Paramedic (EMT-P) procedures, care, or transport as outlined by the Emergency Medical Services Branch, Fire and Building Safety Division of the Indiana Department of Homeland Security. When "BLS" appears in this document, we refer to Basic Emergency Medical Technician (EMT-B) procedures, care, or transport as defined by the Emergency Medical Services Branch, Fire and Building Safety Division of the Indiana Department of Homeland Security. Throughout this document the terms "guidelines", "protocols", and "directives" may be used interchangeably.

The following protocols are guidelines to be used in patient care management. These medical guidelines are not intended to be all-inclusive and may not necessarily have covered every situation which may be encountered by the Paramedic/EMT. These guidelines are not meant to serve as a teaching tool, but are written with the understanding that the EMT or Paramedic knows how to perform the procedures. If there are references to procedures, medications, or conditions to which the Paramedic/EMT is not familiar, it is his/her responsibility to attain the appropriate guidance and/or education prior to performing such procedures or using such medications.

The protocols are designed to guide the Paramedic/EMT through the continuity of care for the out-of-hospital patient. ALS procedures are contained within the same protocol as the BLS procedures. This is intended to allow both the EMT and Paramedic to understand where ALS intervention is involved as part of the team of out-of-hospital care providers and where ALS intervention may be necessary in the out-of-hospital care. Some protocols are specific to ALS care as the treatment provided to the patient evolves beyond the BLS level of care.

The protocols are to provide guidelines in the treatment of patients of all ages. Where necessary, protocols unique for specific ages those ages are noted. For the purposes of these protocols, an adult is over the age of 8 years, a child is ages 1 to 8 years, an infant is 1 month to 1 year, and a newborn is from time of delivery up to 28 days (less than 1 month). When certain procedures are contrary to these ages, they are noted in the specific protocol.

Written protocols are not a substitute for direct physician orders and will always be superseded by on-scene EMS Medical Directors/Fellows or on-line medical control. As with all aspects of health care, these patient care protocols should be considered dynamic and will thus be continually evolving.

The Operational Guidelines Section contains guidelines for all affiliates. Some guidelines have specific notations for Indianapolis Emergency Medical Services (IEMS) personnel. These IEMS guidelines are in addition to, NOT substitution for, other guidelines in this section.

These protocols are reviewed and affirmed or revised annually. New or substantially changed material for this year is underlined.

These protocols are to be used by all affiliates. Except where indicated, affiliating agencies may not alter, add to or delete any portion of these protocols without written permission from their Medical Director.
THE GREATER INDIANAPOLIS EMS MEDICAL DIRECTORS COUNCIL
OUT-OF-HOSPITAL CARE PROTOCOLS
January 1st, 2014

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Marion County Advanced and Basic Life Support Protocols are designed to allow pre-hospital care to begin immediately upon arrival of EMS personnel. If the advanced life support provider believes it is appropriate to provide ALS treatment beyond the contents of these protocols, the provider must establish on-line medical control and receive orders for such additional care.

Realizing that each patient's presentation is unique, the EMS provider's care should be stylized for the patient's needs. EMS personnel should take the time for an appropriate and accurate assessment. Most patients will tell the provider what is wrong with them. EMS personnel should take the time to listen. All patients require initial and on-going assessments. Making the assumption that everything is abnormal until proven normal by exam will minimize errors. Communication with the physician or nursing staff as a consult is encouraged. It is all right not to know everything. It is unacceptable not to ask questions. When specifically noted, communication is mandatory for medical direction. Medical control means interaction with a physician either through direct communication or via a nurse or paramedic who has questioned a physician regarding the requested order.

The sequence of care outlined may vary according to the patient's condition and the resources available. Documentation in the patient care report of decisions made is required. EMS providers can accept reasonable and appropriate orders from physicians. They can also refuse orders which do not seem right for the situation. The EMS provider is the individual assessing the patient and further discussion can always occur.

Incident reports by receiving facilities or by the EMS provider should be viewed as quality assurance issues not punishment. Growth and improvement can occur only with a continuous examination of this system and its needs. Concerns and issues that are not directly related to patient care should be documented via an incident report. Patient care reports should be reserved for patient care documentation only.

It is the goal of the Marion County Advanced and Basic Life Support System to provide the best possible care to all patients. The paramedics and EMTs within this system should view themselves as responsible professionals committed to others through service and example. Through their dedication, knowledge, and essential prehospital patient management, the patient's chances for a positive outcome can only be enhanced.
GENERAL GUIDELINES

- Affiliating services, departments, and agencies may not alter any portion of these protocols without written permission from the Medical Director.

- These protocols are not intended to be all-inclusive and may not have covered every situation potentially encountered by EMS personnel. An on-line ED physician must order any other skills or therapies and the EMS provider must have been trained in the skill or therapy.

- This is NOT meant to be a teaching tool. EMS personnel are expected to know how to perform the therapies and procedures. If an EMT or Paramedic is unfamiliar with any condition, treatment, medication, skill, or procedure contained herein, it is that individual’s responsibility to seek the needed education.

- Once contact is made with a patient, the patient remains the EMS provider’s responsibility until one of the following occurs:
  - Care is transferred to receiving facility staff
  - Care is transferred to an appropriate level healthcare provider
  - The patient is deemed non-viable
  - A valid Signature of Release (refusal of transport) is obtained

- Transfer of care at the receiving facility is not complete until a verbal report is given to the medical care provider. It is also required that a written patient care report be submitted to the ED staff unless the EMS provider is sent on an emergency response. When this occurs, the written patient care report must be made available as promptly as possible.

- Throughout these protocols unless otherwise specified, adult is over 8 years old, child is 1 to 8 years old, infant is 1 month to 1 year old, and newborn is birth to 1 month old.

- Throughout these protocols, interventions are listed by certification level. BLS (EMT) personnel may only provide therapies listed as BLS, and Paramedics may provide all therapies listed. When appropriate, the Paramedic may elect to provide a Paramedic level intervention instead of an EMT level intervention (i.e. – Endotracheal intubation instead of placing a non-visualized airway).

- Cases of suspected abuse must be reported according to law.
  - 1-800-800-5556 is the Indiana Child Abuse and Neglect Hotline
  - 1-800-992-6978 is the Indiana Adult Protective Services Hotline

- In the event of the death of a child less than 1 year of age the Sudden Unexpected Infant Death (SUID) form will be filled out and faxed to coroners office (317) 327-4563
COMMUNICATIONS AND ORDERS

A. Establish communications with the intended receiving hospital when:
   1. Patient’s condition is unstable
   2. Patient requires specialized care
   3. Requesting orders
   4. Consulting MD regarding a refusal of transport

B. Radio or phone report should be brief and generally follow this guideline:
   1. State the reason for the report
   2. State patient’s age and gender
   3. State general condition / chief complaint
   4. Give pertinent history, medications, and allergies
   5. State vital signs and pertinent assessment findings
   6. ECG rhythm interpretation and presence of ST elevation (when appropriate)
   7. List treatment performed or in progress and clinical changes with treatment
   8. Give ETA
   9. Request orders (when appropriate)  
      Note: Patient names are not to be given over the radio-patient initials and/or last 4 digits of social security number are permissible if requested by receiving facility

C. Repeat any orders received exactly as heard for confirmation.

D. If, based upon the EMS provider’s training, the orders received are inappropriate and/or dangerous, question the orders three times then verbally refuse to act. Continue to treat the patient according to these protocols.

E. If an order for therapy is denied and the EMS provider believes it to be life-saving, verbally request it three times. The EMS provider may then contact their supervising hospital for further instructions. Continue to treat the patient according to appropriate protocols.

An incident of refusal of orders must be brought to the attention of the appropriate leader at the service, agency, or department and the Medical Director within 48 hours.
**VERIFICATION OF MEDICAL PERSONNEL ON THE SCENE**

A. The EMS provider is operating under the supervision of “medical control”. Medical control is defined as the Medical Director or an on-line ED physician.

B. In general, on scene physicians will be courteously dissuaded from participating in patient care.
   1. This and sections C and D do not apply to the agency’s EMS Medical Director(s), the IUSM Out-of-Hospital Care (EMS) Fellow(s), and the IUSM Emergency Medicine residents when in IEMS vehicles.

C. The paramedic on the scene with the patient will have medical control of the patient except when:
   1. A physician identifies him/herself as a physician and can produce a State of Indiana Professional Licensing Agency license and is willing to assume in advance ALL medical and legal responsibilities for the patient. The physician:
      a. Must be willing to sign the run sheet for all orders given.
      b. Must be willing to sign a required provider specific form (when applicable)
      c. Must make radio or telephone contact with the emergency department physician at the receiving facility and be willing to accompany the patient to the hospital in the ambulance.
   2. The paramedic feels the physician may be helpful in rendering care to the patient within the scope of the ALS protocols or if the physician possesses special knowledge about the patient or can perform special skills the patient may need.

D. If the physician requests an intervention that according to prehospital standards of care is inappropriate or detrimental to the patient, the paramedic will treat the patient as outlined by the **appropriate protocols**. The paramedic will then refer the on-scene physician to the physician at the receiving hospital.

E. At no time should lifesaving medical care be delayed in order to establish identities or medical control. It is the responsibility of the paramedic to institute appropriate medical care ASAP.
ALS AND BLS TEAM APPROACH

A. The EMS provider with the highest level of certification is responsible for the initial assessment of all patients unless the number of patients or the severity of injuries makes this impossible.

B. In the event of a non-transport (refusal or non-viability), the EMS provider with the highest level of certification is responsible for the assessment and documentation unless the number of patients and the severity of injuries make this impossible.

C. In situations where a BLS crew has requested a paramedic for assistance and the paramedic feels BLS transport is indicated, the paramedic will continue to assist the BLS crew throughout the transport.

D. Patient care may be delegated from the Paramedic to the EMT under the following conditions:
   1. The patient is stable and does not meet any of the criteria for ALS transport listed below.
   2. The Paramedic fully informs the EMT of assessment findings and anticipated patient needs.
   3. The EMT is comfortable with accepting responsibility for treatment and transport.
   4. The patient has not received any ALS treatment (i.e. – IV therapy, intubation, etc.)
   5. The Paramedic fully documents assessment findings and treatment up to the point of delegation of patient care to the EMT.

ALS treatment and transport is indicated if the patient has one or more of the following conditions. If the BLS crew is able to deliver the patient to an emergency department in less time than it would take for the ALS crew to make contact, the BLS crew should complete transport. Waiting for ALS to arrive should not cause delays in transporting the patient.

- Shortness of breath or acute dyspnea
- Chest pain or anginal equivalent
- New onset altered level of consciousness
- Uncontrollable bleeding
- Unconsciousness
- Seizures
- Patient meets Trauma Alert Criteria
- Patient meets Medical Alert Criteria
- Shock signs/symptoms (unstable patient)
- OB at >20 weeks with contractions and:
  - Evidence of meconium staining or
  - Vaginal Bleeding
- Childbirth prior to 38 weeks gestation
- Syncope or near-syncope
- Symptomatic with abnormal vital signs
- Any uncertainty about the patient’s status

🌟 Any time the EMS provider believes the patient’s condition warrants ALS treatment and care.
Operations

TRANSPORTATION/DESTINATION

A. A patient is anyone who has either requested an ambulance or has had an ambulance requested for them. All patients who have activated the EMS system will be transported to a hospital campus with EMS radio communication capabilities unless patient refuses transport. (See “Non-Transported Patient”)

B. Patients will be transported to the patient’s hospital of choice when their condition is stable and they do not meet a special needs situation. The EMS provider is responsible for informing the patient that transport to a specific hospital may be better for their specific medical situation.

C. Special needs considerations for hospital choice include:
   1. Patients with multi-systems trauma → Trauma Center
      a. If under the age of 15, consider transport to a designated pediatric trauma center
      b. If adults and children from the same family meet major trauma criteria transport to a facility with trauma capabilities for both age groups
   2. Patients with serious burns → Burn Center (in case of burn diversion closest appropriate trauma center) – See Burn Center criteria
   3. OB in 2nd and 3rd trimester → Hospital with Labor and Delivery
   4. STEMI / CVA → Hospital with resources for that specialty
      a. Patients with ROSC following cardiac arrest should be transported to a PCI-capable facility
   5. Children with known or suspected button battery ingestion should be transported to Riley.

D. If there is an immediate threat to loss of life or limb, the EMS provider may use their judgment and transport the patient to the nearest or most appropriate facility. The EMS provider will advise the patient and the family of this decision. The EMS provider will make every effort to explain the rationale behind the decision.

E. In the interest of safety and well being for EMS providers, patients, and community members, it is realized that red lights and sirens must be used appropriately when transporting to the hospital. If, in the judgment of the EMS provider, there is a "time critical" threat to life or limb, red lights and sirens are appropriate.
**NON-TRANSPORTED PATIENT**

A. Transportation of the patient for additional evaluation and care should always be the goal of EMS providers regardless of the acuity of the patient’s complaint. Should the patient state that they are refusing transportation, the EMS provider will enlist the aid of the patient’s friends and family members present to encourage the patient to agree to additional treatment and transportation. Any fears or concerns the patient might have should be discussed.

B. Medical control must be consulted when a patient is refusing transport and any of the following applies:
   1. Patient has an abnormal mental status, indicated by:
      a. Slurred or abnormal speech
      b. Disorientation to person, place, or time
      c. Inappropriate or irrational thinking
   2. Patient is less than 1 year old.
   3. There are any historical data, symptoms, or signs suggestive of a potentially life threatening illness or injury.
   4. Patient does not have access to a phone or “significant others” to aid in getting further care if needed.

C. When Medical Control is contacted, the physician will be apprised of the situation and whether the SOR is against the EMS personnel’s medical advice. The physician will be asked for recommendations, and may ask to speak directly to the patient. The EMS provider should record the hospital, physician's name, and the recommendations on the patient care report of the Refusal of Transport or Signature of Release form.

D. To accept the patient’s decision not to receive treatment and/or transportation, the following must be performed:
   1. The patient or the patient’s guardian is informed:
      a. That transport is indicated for further evaluation and care by an emergency department physician.
      b. That the patient has not been evaluated by a physician.
      c. That significant medical problems may exist and that these potential problems cannot be fully described at this time, but may possibly lead to significant disability or even death.
      d. To seek follow-up medical care as soon as possible.
      e. That 911 may be called at any time should they change their mind and wish to be transported to a hospital emergency department.
   2. The patient is asked if they understand the risks in refusing further medical care, and additional explanation is provided as needed.
   3. The refusal form is signed by the patient or their guardian after they read (or have read to them) the statement of refusal.
   4. A complete patient care report with all assessment findings and vital signs must be completed by the highest medical authority on scene in addition to the refusal-specific documentation.

E. In the event the patient is less than 18 years old, these persons may take responsibility for the child:
   1. Parent or legal guardian
   2. Individual in loco parentis (someone who assumes the duties and responsibilities in place of a parent, e.g., grandparent, aunt, uncle, babysitter, principal, police officer) if:
      a. There is no parent or legal guardian present; or
      b. The parent or legal guardian is not reasonably present or declines to act; or
      c. The existence of the parent or legal guardian is unknown to the health care provider.
3. Adult sibling of the minor if:
   a. There is no parent, legal guardian, or individual in loco parentis present; or
   b. The parent, legal guardian, or individual in loco parentis is not reasonably present
      or declines to act; or
   c. The existence of the parent, legal guardian, or individual in loco parentis is
      unknown to the health care provider.

4. The minor patient if there is compelling evidence of emancipation as defined under
   Indiana Code 16-36-1-3(a)(2)(A)-(E):
   a. At least 14 years of age; and
   b. Not dependent on a parent for support; and
   c. Living apart from the minor’s parents or from an individual in loco parentis; and
      i. Managing the minor’s own affairs; or
      ii. Is or has been married; or
      iii. Is in the military service of the United States; or
      iv. Is authorized to consent to health care by any other statute.

F. If the patient is a minor and none of the above can be contacted, the patient should be transported
to the closest, most appropriate facility.
LANGUAGE CONSIDERATIONS

Communication is a key to a thorough evaluation of the patient’s condition and determining necessary treatment. All services, agencies, and departments are strongly encouraged to have interpretation services available for EMS personnel to contact in the event of a language barrier.

English/Spanish Translations

<table>
<thead>
<tr>
<th>English</th>
<th>Spanish</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am a paramedic.</td>
<td>Yo soy paramedico.</td>
</tr>
<tr>
<td>How are you?</td>
<td>Como estas:</td>
</tr>
<tr>
<td>What's the matter?</td>
<td>Que pasa?</td>
</tr>
<tr>
<td>Speak slowly please.</td>
<td>Despacio por favor.</td>
</tr>
<tr>
<td>You must go to the hospital.</td>
<td>Tienes que ir al hospital.</td>
</tr>
<tr>
<td>We're going to take you to the hospital, OK?</td>
<td>Te vamos a llevar al hospital, OK?</td>
</tr>
<tr>
<td>Understand?</td>
<td>Comprende?</td>
</tr>
<tr>
<td>What is your name?</td>
<td>Como se llama?</td>
</tr>
<tr>
<td>What is your age?</td>
<td>Cuantos anos tiene?</td>
</tr>
<tr>
<td>Where do you live?</td>
<td>Donde vive?</td>
</tr>
<tr>
<td>Are you allergic to medicine?</td>
<td>Tiene alergia o medicina?</td>
</tr>
<tr>
<td>Where does it hurt?</td>
<td>Donde duele?</td>
</tr>
<tr>
<td>Does it hurt here?</td>
<td>Duele aqui?</td>
</tr>
<tr>
<td>Do you take medications?</td>
<td>Toma medicino?</td>
</tr>
<tr>
<td>Do you have insurance?</td>
<td>Toma seguro?</td>
</tr>
<tr>
<td>What hospital do you want to go to?</td>
<td>Que hospital?</td>
</tr>
<tr>
<td>Sign here please.</td>
<td>Firme aqui por favor.</td>
</tr>
<tr>
<td>Do you feel better?</td>
<td>Se siente mejor?</td>
</tr>
<tr>
<td>Do you take Viagra?</td>
<td>Toma Viagra o otra?</td>
</tr>
<tr>
<td>Please don’t move.</td>
<td>Por favor, no te muevas.</td>
</tr>
<tr>
<td>Any questions?</td>
<td>Tiene preguntas?</td>
</tr>
</tbody>
</table>

Refusal of Transportation Statements

<table>
<thead>
<tr>
<th>English</th>
<th>Spanish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency personnel have offered to transport me to the hospital for further evaluation and care. I refuse this service.</td>
<td>El personal del emergencia me ha ofrecido transporte para el hospital para me propio cuidad medico. Yo no quiero el transporte.</td>
</tr>
<tr>
<td>I understand that I have not been evaluated by a physician and that serious medical problems may still exist which may result in disability or death.</td>
<td>Yo compreendo que no he sido visto por un doctor y que el problema setio que di existir el cual puede causar desavilidad o muerte.</td>
</tr>
<tr>
<td>I understand that I may call 911 or an ambulance at any time if I change my mind and wish to be taken to a hospital.</td>
<td>Yo compreendo que puedo llamar al telefolo 911 o ambulancia si necesito mas tarde.</td>
</tr>
<tr>
<td>I understand that I am assuming full responsibility for my continuing medical care.</td>
<td>Yo compreendo que yo asumo toda la responsabilidad por me cui dado medico.</td>
</tr>
</tbody>
</table>
GUIDELINES FOR INITIATING RESUSCITATION EFFORTS

A. Resuscitation shall not be attempted in the following situations:
   1. Rigor mortis
   2. Livor mortis
   3. Decomposition
   4. **Trauma patients presenting pulseless and apneic on initial assessment, including:**
      a. Decapitation
      b. Transection of the torso
      c. Charring of the body
      d. Crushing of the head or torso
      e. Severe head injury with brain tissue exposed
      f. In the paramedic’s judgment, the injuries are obviously incompatible with life
   5. Valid DNR (see below)

B. If any of the above applies, do not start CPR. Contact the appropriate authorities and complete a patient care report.

C. **HYPOTHERMIC PATIENTS ARE CONSIDERED VIABLE UNTIL REWARMED AND THEN PRONOUNCED BY A PHYSICIAN.**

D. **If in doubt, start CPR.**

E. Resuscitation efforts should begin immediately in all other cases. CPR shall be performed according to current AHA standards. The appropriate protocol shall be followed for further treatment.

F. **Do Not Resuscitate (DNR) / POST Orders / Advanced Directive Orders:**
   1. If persons present at the scene of a patient in cardiopulmonary arrest request that resuscitative measures be withheld, request to see a DNR/POST order which has been signed by the attending physician or chart order (if an ECF patient).
   2. If the DNR/POST order is presented and resuscitative efforts are not attempted, complete a patient care report with assessment findings, contact the attending physician, and contact the appropriate authorities.
   3. In the event the documents cannot be produced immediately, begin resuscitative efforts in accordance with the appropriate protocol and contact the receiving facility for further orders.
   4. If the paramedic questions the validity of the DNR order, resuscitative efforts should be initiated. Contact the emergency department physician at the intended receiving facility for further orders.

   **These guidelines do not apply to a Living Will**

G. **Termination of CPR:**
   1. Termination of resuscitation may be appropriate for victims of medical cardiac arrest who have no return of spontaneous circulation after 30 minutes of advanced life support. This therapy should include, at a minimum, ventilation with oxygenation, intravenous or intravenous access, and administration of fluids and/or appropriate medications per protocol.
   2. Resuscitation may also be terminated by contacting intended receiving facility.
   3. Requests for termination of resuscitation are not appropriate for patients under 18 years of age, pregnant women, victims of immersion, or victims who are hypothermic.
Medical Alert Criteria

- Suspected acute MI
- Acute neurological deficits of < 6 hours duration
- Inspiratory stridor

Physiological
- Systolic BP (SBP) < 90 mmHg (adults)
- GCS < 13
- Respiratory rate < 10 or > 30 (adults), < 15 or > 45 (peds)
- Heart rate < 40 or > 120
- Temp < 92°F or > 105°F
  - Usually determined in the transferring ED
- Oxygen saturation < 88%

Healthcare provider discretion

Major Trauma Criteria

Physiologic
- Systolic BP < 90 mm Hg
- Glasgow Coma Scale (GCS) ≤ 13
- Respiratory rate < 10 or > 29
- Patient receiving blood to maintain vital signs
- Airway or respiratory compromise as defined by:
  - BVM, Intubation, adjunct airway, or cricothyroidotomy in the field
  - Needle chest decompression

Anatomic
- Penetrating trauma to the head, neck, chest, abdomen, or extremities proximal to the knees and elbows
- Traumatic amputation proximal to the wrist or ankle
- Burns > 15% or high voltage (>1000 volts) electrical injury
- Any crushed, degloved, pulseless, or mangled extremity
- Pelvic fracture
- Two or more long bone fractures
- Flail chest
- Extremity paralysis suggestive of spinal cord injury
- Open or depressed skull fracture
- Victim of hanging who meet above criteria

Healthcare provider discretion

Trauma Alert Criteria

Mechanism of Injury
- Ejection from vehicle
- Vehicle roll-over
- Prolonged extrication from vehicle
- Pedestrian struck by vehicle at speed > 20 MPH
- Falls > 20 feet (adults) or > 3x the child’s height

Healthcare provider discretion
## GLASGOW COMA SCALE

<table>
<thead>
<tr>
<th>Eye Opening</th>
<th>Spontaneous</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To Voice</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>To Pain</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Verbal Response</td>
<td>Oriented</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Confused</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Inappropriate Words</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Incomprehensible Sounds</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Motor Response</td>
<td>Obey Commands</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Purposeful Movement to Pain</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Withdraw to Pain</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Flexion to Pain</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Extension to Pain</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>3 - 15</td>
</tr>
</tbody>
</table>

## PEDIATRIC ADAPTATION OF GLASGOW COMA SCALE  
(for use with children less than school age)

<table>
<thead>
<tr>
<th>Eye Opening</th>
<th>Spontaneous</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To Sounds</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>To Painful Stimuli</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Verbal Response</td>
<td>Appropriate Words or Social Smile</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Cries but Consolable</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Persistently Irritable</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Restless, Agitated</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Motor Response</td>
<td>Spontaneous Movement</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Localizes to Pain</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Withdraw to Pain</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Flexion to Pain</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Extension to Pain</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>3 - 15</td>
</tr>
</tbody>
</table>
START AND JUMP-START TRIAGE

Marion County EMS providers have adopted a simple system for triaging patients in a multiple-patient scenario or a mass casualty incident. *It is acknowledged that, under these circumstances, some patients that EMS could potentially save if encountered individually will not be given the benefit of all necessary resources.*

<table>
<thead>
<tr>
<th>START Triage</th>
<th>Tag:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move the Walking Wounded</td>
<td>Minor</td>
</tr>
<tr>
<td>No Resp. after head tilt – jaw thrust</td>
<td>Dead / Dying</td>
</tr>
<tr>
<td>✅ Respirations: &gt; 30</td>
<td>Immediate</td>
</tr>
<tr>
<td>✅ Pulse: No radial pulse (least injured arm)</td>
<td>Immediate</td>
</tr>
<tr>
<td>✅ Mental status: Unable to follow simple commands</td>
<td>Immediate</td>
</tr>
<tr>
<td>Otherwise...</td>
<td>Delayed</td>
</tr>
</tbody>
</table>

Developed by the Newport Beach, CA Fire & Marine Dept., and the current DOT Standard for EMS providers.
**Operations**

**JUMP-START TRIAGE**

**Jump-START** is a modification of the START triage guidelines for pediatric patients and takes into account the normal variation in respiratory rate on the basis of age, and the fact that primary respiratory failure can be corrected easily.

* An apneic child is more likely to have a primary respiratory problem than an adult. Perfusion may be maintained for a short time and the child may be salvageable.

* A respiratory rate of 30 may either over-triage or under-triage a child, depending on age.

* Capillary refill may not adequately reflect peripheral hemodynamic status in a cool environment.

* Obeying commands may not be an appropriate gauge of mental status for younger children.

<table>
<thead>
<tr>
<th>Jump-START Triage (ages 1-8)</th>
<th>Tag:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Move the Walking Wounded</td>
<td>Minor</td>
</tr>
<tr>
<td>Apneic or irregular respirations: <strong>Open airway</strong></td>
<td></td>
</tr>
<tr>
<td>Resume breathing?</td>
<td>Immediate</td>
</tr>
<tr>
<td>Still apneic and no peripheral pulse?</td>
<td>Dead /Dying</td>
</tr>
<tr>
<td>Still apneic but has a peripheral pulse: <strong>Mouth-to-Mask for 15 seconds (4-5 breaths)</strong></td>
<td></td>
</tr>
<tr>
<td>Resume breathing?</td>
<td>Immediate</td>
</tr>
<tr>
<td>Still apneic?</td>
<td>Dead /Dying</td>
</tr>
<tr>
<td>□ Respirations: &lt; 15 or &gt; 45</td>
<td>Immediate</td>
</tr>
<tr>
<td>□ Pulse: No peripheral pulse (least injured extremity)</td>
<td>Immediate</td>
</tr>
<tr>
<td>□ Mental status: Unresponsive or responsive to pain only</td>
<td>Immediate</td>
</tr>
<tr>
<td>Otherwise...</td>
<td>Delayed</td>
</tr>
<tr>
<td>Age &lt;1:</td>
<td></td>
</tr>
<tr>
<td>If all Jump-START “delayed” criteria are satisfied and there are no significant external injuries, the child may be classified as “ambulatory” and tagged</td>
<td>Minor</td>
</tr>
</tbody>
</table>

Developed by Lou Romig MD, FAAP, FACEP at Miami Children’s Hospital
**DECONTAMINATION OF PATIENTS**

To decrease potential exposure of emergency and health care personnel, patients exposed to hazardous materials should be decontaminated at the scene as indicated by the exposure, given resources and patient condition. This guideline is for the medical treatment and transportation aspects of these patients, and does not encompass the hazardous materials response or mitigation.

A. Ensure that each receiving hospital is notified as early as possible of
   1. suspected agent(s),
   2. route of exposure (e.g., skin vs. inhalation), and
   3. estimated number of patients.

B. Ensure that the Indiana Poison Center (IPC) is notified as early as possible of the suspected agent(s) and likely receiving hospital(s). Med-1 or the IHERN is preferred; the IPC is also available at 962-2323 or (800) 222-1222.

C. Perform decontamination as indicated by the exposure.
   1. Upon completion of decontamination and/or removal of contaminated clothing, patients should be covered (including feet).
   2. If the patient’s clothing is removed, it should remain at the scene; valuables may come with the patient sealed in a plastic bag.

D. Treat and transport patients per appropriate out-of-hospital care guidelines. Utilize appropriate personal protective devices to decrease likelihood of EMS personnel exposure.

E. For each patient transported, notify the receiving hospital en route of the patient’s medical and/or trauma issues, condition, and the type of decontamination performed.

F. Deliver patients to the appropriate area at the Emergency Department.
   1. If additional decontamination is needed, this will typically not be directly into the ED, but rather to the adjacent decontamination area.
   2. Unless otherwise directed, do not drive the ambulance into an enclosed area (e.g., garage).

G. At the conclusion of all out-of-hospital patient assessment and transport activities, ensure that each hospital contacted in #1 and the IPC is notified of
   1. The total number of patients transported (or if no patients are coming).
   2. The conclusion (“all clear”) of out-of-hospital EMS activity at the scene.
UNIVERSAL PRECAUTIONS

SINCE MEDICAL HISTORY AND EXAMINATION CANNOT RELIABLY IDENTIFY ALL PATIENTS INFECTED WITH BLOOD BORNE PATHOGENS, BLOOD AND BODY FLUID, UNIVERSAL PRECAUTIONS SHALL BE USED FOR ALL PATIENTS.

A. Universal blood and body fluid precautions (the use of barriers) shall be used for all patients if contact with blood or body fluids is possible regardless of whether a diagnosis is known. EMS providers are responsible to use the personal protective equipment (PPE) made available by their employer.

B. PPE should be removed immediately after patient contact to avoid contamination of other surfaces (i.e. – steering wheel, door handles, clip boards, pens, etc.)

C. Personnel with patient contact responsibilities, who have any open lesions, cuts, or skin conditions such as eczema, should report such conditions to management personnel prior to beginning their scheduled shift. Management may consult the Medical Director or Occupational Health physician when appropriate.

D. Personnel should have been assessed for the need for immunization against the Hepatitis B Virus.

E. Personnel will, upon hire and annually thereafter receive education and training pertaining to infection control guidelines to be observed for their service.

F. Body fluids include: saliva, sputum, gastric secretions, urine, feces, CSF, breast milk, serosanguineous fluid, semen, or any drainage.

G. Immediately after use, sharps will be disposed of in provided biohazard, puncture resistant containers. Containers will be replaced when 3/4 full. Used needles shall not be sheared, bent, broken, recapped, or resheathed by hand. Used needles shall not be removed from disposable syringes. Do not lay or stick used needles in seat cushions.

H. Exposure to Blood and/or Body fluids:
   1. Personnel sustaining an exposure (needle stick, mucous membrane, or skin contact) to blood and/or body fluids shall immediately cleanse the contaminated area with soap and water. If these are not immediately available, waterless hand cleaner shall be used.
   2. In cases of splattering of blood or body fluids to the eyes and/or mouth, flush with copious amounts of water for 15 minutes.
   3. Notify the employee’s appropriate leadership personnel.
   4. Complete the Indiana State Board of Health REPORT OF BLOOD OR BODY FLUID EXPOSURE form and leave a copy of this at the receiving facility with any other paperwork left following patient care. Remaining copies shall be turned over to Management per the Department policy. This form must be filled out completely and accurately within twenty-four (24) hours.

I. Hand washing is the most important infection control procedure. EMS providers should wash their hands:
   1. after removing PPE
   2. after each patient contact
   3. after handling potentially infectious material
   4. after cleaning/decontaminating equipment
   5. after using the restroom
   6. before eating or preparing food
BLOOD AND BODY FLUID EXPOSURE OF EMS PERSONNEL

Background:

The Ryan White Care Act of 1990 and amended in 1996 contains provisions for the notification of emergency response personnel exposed to infectious diseases while attending, treating, assisting, or transporting a victim. In Indiana, IC 16-41-10 provides for an emergency medical services provider (a firefighter, a law enforcement officer, a paramedic, an emergency medical technician, a physician or nurse licensed in Indiana, or other persons who provide emergency medical services in the course of their employment) who is exposed to potentially infectious blood or body fluids to get this notification in the following manner:

A. EMS Provider must notify provider’s employer within 24 hours of the exposure on a form designated by the EMS Commission and the State Health Department. A copy of the form goes to:

1. The Medical Director of the health care facility to which the patient was taken following the exposure OR in the health care facility where the patient was located at the time of exposure, AND
2. The EMS provider’s employer, AND
3. The State Health Department.

B. A patient (including those unable to consent due to physical or mental incapacity) to whose blood or body fluids the EMS provider is exposed is considered to have consented to:

1. Testing for the presence of dangerous communicable diseases. These diseases are only those which are life-threatening by carrying a substantial risk of death if acquired by a healthy, susceptible host, and the disease can be transmitted from person to person. The diseases are:

   a. Infectious pulmonary tuberculosis
   b. Hepatitis B, C
   c. HIV
   d. Diphtheria
   e. Hemorrhagic fevers
   f. Meningococcal disease
   g. Plague
   h. Rabies

2. Release of the testing results to the Medical director of the health care facility (or other designated physician).

3. However, a medical facility may not restrain a patient in order to test the patient for dangerous communicable diseases, and nothing in the law prohibits a patient from being discharged from the medical facility before such testing is performed or the results of the tests are released.

4. A provider or a facility that tests patient for the presence of a dangerous communicable disease under this law is immune from liability for the performance of the test over the patient’s objections or without the patient’s consent.
C. Within 72 hours of being notified of the exposure, the Medical director of the health care facility (or other designated physician) must notify the Medical Director of the EMS provider’s employer (or other physician designated in writing by the EMS provider) of the results of the test(s).

D. Within 48 hours of being notified of the results of the test(s), the Medical Director of the EMS provider’s employer (or other physician designated by the EMS provider) will

1. Explain, without disclosing information about the patient, the presence or absence of dangerous communicable disease(s) to which the provider was suspected to have been exposed, if any.

2. Provide any medically necessary treatment and/or counseling to the EMS provider. Expenses of testing, treating, or counseling the EMS provider are the responsibility of the EMS provider or the provider’s employer.
INFECTION CONTROL PROCEDURES

A. All body fluids from all patients will be considered potentially to be infectious. All emergency response employees are to use the personal protective equipment (PPE) made available by their employer. It is the employee's responsibility to wear the appropriate PPE in order to have maximum protection against infectious disease.

B. Handwashing is the most important infection control procedure! Emergency response employees will wash hands:
   1. after removing PPE
   2. after each patient contact
   3. after handling potentially infectious materials
   4. after cleaning or decontaminating equipment
   5. after using the bathroom
   6. before eating
   7. before and after handling or preparing food

C. Handwashing will be performed for at least 10-15 seconds, utilizing soap and water or an alcohol-based solution.

D. Eating, drinking, smoking, handling contact lenses, or applying cosmetics or lip balm is prohibited at the scene of EMS operations.

E. Disposable resuscitation equipment and supplies will be used whenever possible. For CPR, the order of preference is:
   1. Disposable bag-valve mask
   2. Disposable pocket mask with one-way valve
   3. Mouth-to-mouth resuscitation

F. After use, all PPE and contaminated disposable patient care materials will be placed in leak proof bags, color coded and marked as a biohazard for disposal as soon as possible.

G. Contaminated work clothes will be removed and exchanged for clean clothes as soon as possible. The crew member will shower if body fluids were in substantial contact with skin under work clothes.

POST EXPOSURE PROTOCOL

A. Any employee exposed to potentially infectious material will immediately wash the exposed area with soap and water or an alcohol-based solution (saline wash if the eyes are involved.)

B. Any employee having an occupational communicable disease exposure will immediately report the exposure to his/her supervisor. Needle stick injuries will be reported to the designated officer immediately.

C. The emergency response employee will fill out the appropriate exposure report forms at the soonest possible time after any exposure occurs.

D. All exposures to infectious or potentially infectious materials should be medically evaluated within the first hour after exposure as some prophylactic treatments are only effective if initiated within that time period. The following events will be considered potentially high risk exposures:
   a. Hollow needle stick injuries.
   b. Breaks in the skin caused by potentially contaminated objects.
c. Splash of blood or other potentially infectious material onto eyes, mucous membranes, or non-intact skin.

E. All potentially high risk exposures will immediately be evaluated by a qualified medical care provider and a plan for prophylactic treatment will be initiated if deemed appropriate:

   a. Blood (and urine sample for UPT, if applicable) may be obtained to establish a baseline.

   b. The decision to initiate anti-retroviral therapy is made without waiting for lab test results.

      i. Current treatment guidelines will be followed.

      ii. The patient will be referred to Occupational Health, Infectious Disease, and/or their private physician as appropriate.

F. Whenever possible, the source patient will be traced to the receiving facility by the designated officer. The designated officer will notify the receiving facility that a communicable disease exposure has taken place, and request an infectious disease determination as provided for in IC 16-41-10.
**REQUEST FOR NEW OR CHANGED PROTOCOL / MEDICAL EQUIPMENT**

A. Documentation of the following information should be submitted to the agency’s EMS Medical Director for review:

1. Executive Summary (one-paragraph summary of everything below)
   
   a. Define the problem.
   
   b. How commonly is the problem encountered (e.g., cases per week, month, or year)
      
      i. This should be data-based – either retrospectively (looking at patient care records) or prospectively (using a survey after calls)
   
   c. What is the proposed solution?
      
      i. Provide a copy of the new protocol (in the usual format) and/or Identify all protocols that will require a change.
      
      ii. What are the benefits? (e.g., reduced morbidity/mortality, increased patient comfort, increased patient care efficiency or effectiveness)
      
      iii. What are the risks (e.g., side effects, complications)?
      
      iv. What is the cost?
         
         1. Direct costs (e.g., to supply all vehicles/kits plus spare supplies at station(s), how soon will it expire/become obsolete?
         
         v. Will special storage be necessary (e.g., refrigeration)?
         
         vi. Indirect costs (e.g., education)
   
   d. What alternatives were considered? Why is the proposed solution the best choice?

B. Include a list of the keywords used for the medical literature search, and a copy of the salient literature.
Section TWO

Treatment
INITIAL MEDICAL CARE

**BLS**

A. Follow the Universal Precautions protocol.
B. Follow the Airway Management protocol to open and maintain a patent airway.
C. Follow the Oxygen Administration protocol when appropriate.
D. Loosen tight clothing and reassure the patient.
E. Place the patient in the position of comfort unless contraindicated by injuries and/or symptoms.
F. Completely assess the patient, including vital signs.
G. Obtain an appropriate history.
H. Refer to appropriate protocol according to patient condition.
I. Reassess patient and record vital signs every 5-10 minutes as condition warrants. Transferred patients must have at least two sets of complete vitals documented. Weight will be recorded in kilograms for all pediatric, overdose/poisoning, and any adult receiving medications.
J. Patient’s body temperature should be preserved, especially infants, children, and the elderly.

**ALS**

K. Establish IV access:
   1. to administer pre-hospital medications, or
   2. for fluid replacement, or
   3. if the patient’s condition is likely to deteriorate before arriving at the hospital.

L. The IV solution is to be NORMAL SALINE unless otherwise stated. *(See Vascular Access Procedures)*

M. If an IV cannot be established and an urgent need for vascular access exists, establish IO access. *(See Vascular Access Procedures)*

N. Pre-existing vascular access devices (PVAD) may be used only if:
   1. The patient is in cardiac arrest, or
   2. There is an emergent need to administer fluids or IV medications and a peripheral IV cannot be established and an IO is not appropriate due to the patient’s condition. *(See Vascular Access Procedures)*

**MEDICAL ALERT CRITERIA**

- Suspected acute MI
- Acute neurological deficits of <6 hours duration
- Inspiratory stridor
- Physiological signs:
  - Systolic BP (SBP) < 90 mmHg (adults)
  - GCS < 13
  - Respiratory rate < 10 or > 30 (adults), < 15 or > 45 (peds)
  - Heart rate < 40 or > 120
  - Temp < 92°F or > 105°F
    - Usually determined in the transferring ED
  - Oxygen saturation < 88%
- Healthcare provider discretion
**General Care Guidelines**

**AIRWAY MANAGEMENT**

**BLS**

A. Open the airway by use of a chin-lift or jaw thrust without head tilt. Remember to protect the cervical spine at all times when the potential for cervical spine injury exists.

B. Suction is indicated in any patient whose airway is obstructed by liquid or solid material which may result in aspiration or interfere with respiration.

C. Use an oropharyngeal or nasopharyngeal airway device as needed to maintain a patent airway.

D. Assist ventilations as needed using a bag-valve device (BVM) and 100% oxygen. *(Pediatric rate - 20 / min., newborns – 40 - 60 / min.)*

E. If the patient is in cardiac or respiratory arrest and has no gag reflex, insert an appropriately sized non-visualized airway, if available.

**ALS**

If the above measures prove to be inadequate or there is risk of aspiration or vomiting in the unconscious patient, intubate adults with an endotracheal tube or non-visualized airway. The guidelines for intubation are as follows:

1. Endotracheal intubation is the preferred advanced airway maneuver for adults. *(See Verification of Endotracheal Tube (ETT) Placement – Procedure)*
   a. The use of the non-visualized airway should be reserved for those adults in whom an endotracheal tube cannot be placed.
   b. If unable to place an endotracheal tube after two attempts, place a non-visualized airway, if available.
   c. If the above are unsuccessful, maintain an airway via basic skills utilizing modified jaw thrust, OP airways, BVM, etc.

2. *Bag-valve-mask ventilation is the preferred method of oxygenating and ventilating pediatric patients. If you cannot adequately ventilate with a BVM, attempt placement of a non-visualized airway if available. If non-visualized airway fails to provide adequate oxygenation, proceed to endotracheal intubation.*

3. Criteria for performance of cricothyrotomy are as follows:
   a. If basic airway management, non-visualized airways, and intubation are inadequate to sustain life, perform a cricothyrotomy.
   b. Surgical cricothyrotomy is to be performed on the patient > /= 8 years old.
      Needle cricothyrotomy is to be performed on the patient < 8 years old *(See Procedures- Cricothyrotomy)*

**IF CRICOPTHYROTOMY IS ATTEMPTED, A COPY OF THE PATIENT CARE REPORT MUST BE MADE AVAILABLE TO PROVIDER AGENCY SUPERVISORY PERSONNEL AND THE MEDICAL DIRECTOR WITHIN 24 HOURS OF THE RUN.**

**THE ENDOTRACHEAL ROUTE OF MEDICATION ADMINISTRATION SHOULD BE RESERVED FOR THOSE SITUATIONS WHERE NO OTHER ACCESS IS AVAILABLE.**
OXYGEN ADMINISTRATION

BLS

A. Any patient who has difficulty breathing or a SaO₂ < 93% should be given oxygen.

1. Patients with mild respiratory distress *(respiratory rate <25, no cyanosis, and no use of accessory muscles)* may be given oxygen by nasal cannula at 4-6 LPM to maintain an oxygen saturation of 94-99%.

2. Patients with moderate respiratory distress *(with or without cyanosis and/or using accessory muscles while breathing)* should be given oxygen by a non-rebreather mask at 10-15 LPM. Liter flow should be enough to maintain inflation of the reservoir with oxygen and to maintain an oxygen saturation of 94-99%.
   - Infants and newborns should have oxygen administered by the blow-by method.

3. Patients with severe respiratory distress should be assisted with ventilations by use of a bag-valve-mask with reservoir and supplemental oxygen (an oropharyngeal or nasopharyngeal airway should be inserted if tolerated). Oxygen should be set to 15 LPM.

4. Spontaneously breathing patients who are suspected to have been exposed to carbon monoxide or who are suspected of having a pneumothorax should receive oxygen by a non-rebreather mask at 10-15 LPM. Liter flow should be enough to maintain inflation of the reservoir with oxygen.
General Care Guidelines

**Obstructed Airway**

**Child or Adult - Conscious**

**BLS**
A. Determine complete airway obstruction.
B. Deliver abdominal thrusts until the obstruction is relieved or the patient becomes unconscious.
C. If patient becomes unconscious, see below.

**Child or Adult - Unconscious**

**BLS**
A. Stabilize cervical spine if potential for injury exists.
B. If the patient has no breathing or agonal gasps, begin CPR, starting with compressions.
C. Continue 2 minute cycles of CPR (30:2 for the adult, 15:2 for the child with more than one rescuer).
D. Prior to giving respirations check for an obstructing object. If an object is visualized, remove it.
E. Attempt to ventilate.
F. If unable to ventilate, repeat above steps until material is dislodged. Suction the patient as needed.
G. If patient remains unconscious, transportation by ALS is preferred.
H. If the object is dislodged, assess airway, breathing, and circulation. Proceed with *appropriate protocol*.

**ALS**
1. Use of the McGill forceps may be necessary to dislodge objects.
General Care Guidelines

PAIN MANAGEMENT

A pain assessment is considered standard of care on every patient, along with an initial set of vitals, and should be documented on the run report along with any pain management intervention and the patient’s response.

BLS
1. Attempt to place patient in position of greatest comfort

ALS
2. Paramedics should consider offering pain medication to any patient describing pain. Medications should be selected by paramedic judgment of pain severity (mild, moderate, severe) and is not necessarily limited to single pharmacologic agent.

Mild Pain
A. Paramedics should consider offering patients describing mild pain acetaminophen for pain management.
   1. Acetaminophen may be administered to patients > 14 years old and > 50 kg as 650 mg PO once
      a. Unless the patient has:
         1. An allergy to acetaminophen
         2. A history of liver dysfunction
         3. Active vomiting
         4. Acetaminophen use within last 4 hours

Moderate Pain
B. Paramedics should consider offering patients describing moderate to severe pain ketorolac (Toradol®) for pain management.
   1. Ketorolac is administered in the following doses:
      For patients > 14 years old: 15 mg IV or 30 mg IM once
      a. Unless the patient has:
         1. An allergy to ketorolac, aspirin, or other NSAIDS
         2. History of renal dysfunction
         3. History of GI bleed
         4. Active bleed or suspicion of active bleed
         5. NSAID use within last 6 hours
         6. Pregnancy

Severe Pain
C. Paramedics should consider offering patients describing severe pain fentanyl for pain management.
   1. Fentanyl is administered in the following doses:
      Patients >14 years old and >50 kg:
      Up to 100 mcg slow IV push or intra-nasal. Up to an additional 50 mcg may be administered every 5 minutes up to a maximum of 300 mcg prn pain > 3/10.

      Patients <14 or < 50 kg:
      Up to 1mcg/kg slow IVP or 1-2 mcg/kg intra-nasal every 5 minutes up to a maximum of 3 mcg/kg prn evidence of significant discomfort.
      a. Unless the patient has:
         1. An allergy to fentanyl; OR
2. A significantly altered level of consciousness (GCS < 14 or below baseline)
2. Additional doses may be administered with approval of Medical Control.

D. Naloxone must be immediately available.

Patient's BP, HR, RR, GCS, and pain scale must be monitored regularly (at least once prior to and once after the dose(s) of medication) and documented on the patient care record.

EXAMPLE PATIENT PAIN ASSESSMENT SCALES

0 – 10 Numeric Rating Scale and Descriptors

<p>| | | | | | | | | | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
</table>
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10
| no pain | little | moderate | quite bad | severe | unbearable pain |

Wong-Baker FACES Pain Rating Scale


Wong-Baker Faces Rating Scale in Spanish

Escala de rostros de dolor

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Muy contento; sin dolor</td>
<td>Siente sólo un poquito de dolor</td>
<td>Siente un poco más de dolor</td>
<td>Siente aún más dolor</td>
<td>Siente mucho dolor</td>
<td>El dolor es el peor que puede imaginarse (no tiene que estar llorando para sentir este dolor tan fuerte)</td>
<td></td>
</tr>
</tbody>
</table>
## General Care Guidelines

### Infant Pain Scale Assessment Tool

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Facial</strong></td>
<td></td>
</tr>
<tr>
<td>Neutral/smiling</td>
<td></td>
</tr>
<tr>
<td>Frowning/grimacing</td>
<td>2</td>
</tr>
<tr>
<td>Clenched teeth</td>
<td>3</td>
</tr>
<tr>
<td>Full cry expression</td>
<td></td>
</tr>
<tr>
<td><strong>Body Movement</strong></td>
<td></td>
</tr>
<tr>
<td>Calm, relaxed</td>
<td></td>
</tr>
<tr>
<td>Restless/fidgeting</td>
<td></td>
</tr>
<tr>
<td>Moderate agitation or</td>
<td></td>
</tr>
<tr>
<td>moderate mobility</td>
<td></td>
</tr>
<tr>
<td>Thrashing, flailing,</td>
<td></td>
</tr>
<tr>
<td>incessant agitation</td>
<td></td>
</tr>
<tr>
<td>or strong voluntary</td>
<td></td>
</tr>
<tr>
<td>immobility</td>
<td></td>
</tr>
<tr>
<td><strong>Sleep</strong></td>
<td></td>
</tr>
<tr>
<td>Sleeping quietly with</td>
<td></td>
</tr>
<tr>
<td>easy respirations</td>
<td></td>
</tr>
<tr>
<td>Restless while asleep</td>
<td></td>
</tr>
<tr>
<td>Sleeps intermittently</td>
<td></td>
</tr>
<tr>
<td>(sleep/awake)</td>
<td></td>
</tr>
<tr>
<td>Sleeping for</td>
<td></td>
</tr>
<tr>
<td>prolonged periods of</td>
<td></td>
</tr>
<tr>
<td>time interrupted by</td>
<td></td>
</tr>
<tr>
<td>jerky movements</td>
<td></td>
</tr>
<tr>
<td>or unable to sleep</td>
<td></td>
</tr>
<tr>
<td>Screaming, high-pitched cry</td>
<td></td>
</tr>
<tr>
<td><strong>Verbal/vocal</strong></td>
<td></td>
</tr>
<tr>
<td>No cry</td>
<td></td>
</tr>
<tr>
<td>Whimpering, complaining</td>
<td></td>
</tr>
<tr>
<td>Pain crying</td>
<td></td>
</tr>
<tr>
<td><strong>Consolability</strong></td>
<td></td>
</tr>
<tr>
<td>Neutral</td>
<td></td>
</tr>
<tr>
<td>Easy to console</td>
<td></td>
</tr>
<tr>
<td>Not easy to console</td>
<td></td>
</tr>
<tr>
<td>Inconsolable</td>
<td></td>
</tr>
<tr>
<td><strong>Response to</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Movement/Touch</strong></td>
<td></td>
</tr>
<tr>
<td>Moves easily</td>
<td></td>
</tr>
<tr>
<td>Wincs when touched/moved</td>
<td></td>
</tr>
<tr>
<td>Cries out when moved/touched</td>
<td></td>
</tr>
<tr>
<td>High-pitched cry or scream when touched or moved</td>
<td></td>
</tr>
</tbody>
</table>
NAUSEA AND/OR VOMITING

Assess for potential life-threatening causes of nausea and vomiting (such as myocardial infarction or shock) and initiate appropriate protocols.

**ALS**

If nausea and/or vomiting persists after initiating other indicated treatment protocols, and if no contraindication is present, you may administer ondansetron.

A. Administer ondansetron:

1. Adults 50 Kg and over: 4-8 mg IV push or via oral-dissolving (ODT) tablet.

2. Less than 50 kg: 0.1 mg/Kg IV push or via an appropriate portion of an oral-dissolving (ODT) tablet (e.g., one-quarter or one-half...).
Respiratory Emergencies

**DIFFICULTY BREATHING: CROUP**

**CRITERIA:** If the patient with difficulty breathing is at least 1 year of age and the cause is suspected to be croup (e.g., the patient has stridor at rest with retractions and/or accessory muscle use):

**BLS**
A. Begin Initial Medical Care.
B. Follow Airway Management protocol.
C. Follow Oxygen Administration protocol.
D. If the patient is in moderate to severe respiratory distress per the Oxygen Administration protocol, call for a paramedic unit.
E. If possible, administer humidified oxygen via the blow-by method.

**ALS**
1. Administer one of the following treatments:
   a. The preferred treatment is 0.5 ml of 2.25% racemic epinephrine (Vaponephrine) diluted with 4.5 ml of 0.9% normal saline (for a total volume of 5 ml) and administered by nebulizer with 5-6 lpm oxygen.
   b. If racemic epinephrine is unavailable administer 5 ml of 1:1,000 epinephrine by nebulizer with 5-6 lpm oxygen.

2. Apply the cardiac monitor.

3. If the patient becomes unresponsive or is markedly short of breath, a nebulizer may be connected to a BVM using a "flex connector" to administer racemic epinephrine or epinephrine. Two oxygen connections will be required. The nebulizer will require an oxygen connection at 5-6 lpm in addition to a high flow connector for the BVM.
Respiratory Emergencies

OBSTRUCTIVE OR REACTIVE AIRWAY DISEASES

BLS
A. Administer oxygen as indicated – (See Oxygen Administration Protocol)

B. If the patient is so short of breath that he/she cannot complete sentences, determine if patient has physician-prescribed hand-held inhaler. If so, assist patient with one dose (2-4 puffs) of albuterol (with or without ipratropium bromide) – use with spacer if possible.

C. Reassess patient. Anticipate need for assisting ventilations with BVM and high flow O₂.

D. Request ALS if not already en route. If the BLS crew is able to deliver the patient to an emergency room within the same time it would take for the ALS crew to respond to the scene, the BLS crew should transport the patient.

ALS
1. Consider immediate placement of the CPAP device if your initial assessment of the patient demonstrates severe respiratory distress as defined by:
   A. Hypoxemia (O₂ < 92%)
   B. RR > 25
   C. Use of accessory muscles
   D. Dyspnea at rest
   E. Rales or wheezes

   This should be immediately followed by appropriate ALS treatment of the underlying pulmonary disorder.

2. Administer albuterol, 2.5 mg and ipratropium 0.5 mg nebulized with 5-6 lpm of oxygen (Albuterol dose should be increased to 5 mg if the patient uses an albuterol nebulizer regularly).

3. Apply the cardiac monitor.

4. If the patient is still markedly short of breath and hypoxemic (oxygen saturation <92% on 100% oxygen) after the second 5 mg of albuterol and 0.5 mg of ipratropium is administered, CPAP may be initiated (see specific protocol) and the nebulizer treatment repeated every 10 minutes as needed. No more than three doses of ipratropium should be administered.

5. Initiate transport.

6. If the patient becomes unresponsive or is markedly short of breath, albuterol and ipratropium may be administered via the BVM (intubate as necessary) and high flow oxygen.

7. Contact the receiving facility for further instructions.
DIFFICULTY BREATHING-PULMONARY EDEMA

**ALS**
If difficulty breathing is suspected from pulmonary edema:

1. If SBP is 90 mm Hg or greater, administer up to three (3) 0.4 mg doses of nitroglycerin sublingually (SL) and repeat up to three 0.4 mg SL doses every 3 minutes until the patient’s respiratory distress is relieved or the SBP is < 90 mm Hg.
   *See note below – Nitroglycerin and Viagra, etc.

2. If the patient is still markedly short of breath and hypoxemic (oxygen saturation <92% on 100% oxygen) after the first dose of nitroglycerin dosing, CPAP may be initiated (see specific protocol)

3. Nitroglycerin should continue to be administered as above every 3 minutes as long as the patient remains dyspneic and systolic BP > 90 mm Hg.

4. Apply the cardiac monitor.

5. Initiate an IV.

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The combination of nitroglycerin and Viagra®, Revatio® (sildenafil), Levitra® (vardenafil), or Cialis® (tadalafil) have been found to cause precipitous and irreversible hypotension.

- Ask every chest pain patient whether or not he/she has been on Viagra, etc. and, if so, when was the last dose? Document this on every run sheet involving the cardiac chest pain patient (even those who deny using Viagra or similar medications).

- **DO NOT** automatically administer nitroglycerin to any patient who has had Viagra, etc. within the past week. Consult with the receiving physician for appropriateness.

- Monitor blood pressure very closely on any patient receiving nitroglycerin. If hypotension occurs, refer to the Suspected Cardiogenic Shock Protocol.
Respiratory Emergencies

DIFFICULTY BREATHING-SMOKE INHALATION

BLS

A. Assess for and manage trauma or burns per the appropriate protocol.

B. Carbon monoxide and cyanide toxicity should be considered for any patient who experiences smoke inhalation in an enclosed space. See Carbon Monoxide Poisoning Protocol.

C. Pulse oximetry monitors may give false readings in patients exposed to cyanide and/or carbon monoxide.

D. Categorize the patient:

<table>
<thead>
<tr>
<th>Responsive patient</th>
<th>Unresponsive patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provide high flow O₂</td>
<td>1. Establish an airway with OP, NP or non-visualized airway</td>
</tr>
<tr>
<td>2. Request ALS if not already en route</td>
<td>2. Provide high flow O₂ by NRB mask or BVM</td>
</tr>
<tr>
<td></td>
<td>3. Request ALS if not already en route</td>
</tr>
<tr>
<td></td>
<td>4. If BLS can transport the patient before ALS can arrive at the scene, do so.</td>
</tr>
</tbody>
</table>

ALS

<table>
<thead>
<tr>
<th>Responsive patient — no evidence of significant cyanide toxicity</th>
<th>Responsive patient with soot in airway and 1) altered level of consciousness or 2) hypotension</th>
<th>Unresponsive patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Provide high flow O₂ by NRB mask</td>
<td>1. Ensure an airway and provide high flow O₂</td>
<td>1. Establish an airway and provide high flow O₂</td>
</tr>
<tr>
<td></td>
<td>2. For wheezing or stridor, treat with 2.5-5 mg nebulized albuterol as needed.</td>
<td>2. For wheezing or stridor, treat with 2.5-5 mg nebulized albuterol as needed.</td>
</tr>
<tr>
<td></td>
<td>3. Establish an IV</td>
<td>3. Establish an IV; if patient is in cardiac arrest, establish 2 IVs</td>
</tr>
<tr>
<td></td>
<td>4. Draw blood samples</td>
<td>4. Draw blood samples</td>
</tr>
<tr>
<td></td>
<td>5. Adult: If available, mix both Cyanokit® 2.5 g vials, each with 100 cc of 0.9%NaCl, and administer all of the fluid over 15 minutes (~15 ml/minute). Pediatrics: If available, mix one or both Cyanokit® 2.5 g vials, each with 100 cc of 0.9%NaCl, and administer 70 mg/Kg over 15 minutes.</td>
<td>Adult: If available, mix both Cyanokit® 2.5 g vials, each with 100 cc of 0.9%NaCl, and administer all of the fluid over 15 minutes (~15 ml/minute). Pediatrics: If available, mix one or both Cyanokit® 2.5 g vials, each with 100 cc of 0.9%NaCl, and administer 70 mg/Kg over 15 minutes.</td>
</tr>
<tr>
<td></td>
<td>6. If hypotensive, consider fluid challenge(s)</td>
<td>6. If hypotensive, consider fluid challenge(s)</td>
</tr>
<tr>
<td></td>
<td>7. Transport emergently to closest appropriate hospital</td>
<td>7. Transport emergently to closest appropriate hospital</td>
</tr>
</tbody>
</table>
Carbon Monoxide Poisoning

Patients suffering from exposure to byproducts of combustion should, when feasible, have a carbon monoxide (CO) level recorded using a co-oximeter device. These situations include fire victims or smoke inhalation exposure to CO, firefighters during rehab activities, patients or families with complaints of general illness or headache. EMS providers should make efforts to assure that firefighters are assessed for elevated levels of CO after structural firefighting activities.

**BLS**

1. Refer to airway management protocol.
2. Obtain vital signs.
3. Apply oxygen 100% NRB and transport to nearest appropriate hospital.

**ALS**

1. Refer to airway management protocol
2. Obtain vital signs and CO determination using a co-oximeter device if available.
3. IV Access when appropriate.
4. Treat arrhythmia per appropriate protocol.
5. CO level 10% or greater and/or symptomatic- 100% NRB O2 and transport to nearest appropriate hospital

**NOTES:**

1. Remember that pulse oximetry should not be used as a determination of oxygenation in the patient with elevated carboxyhemoglobin.
2. Smokers may have a baseline CO level as high as 5-6%
CHEST PAIN – Adult

All patients complaining of chest pain should be treated as having a myocardial infarction, unless other signs indicate pain is obviously from another origin.

BLS
A. Administer oxygen if necessary. (See Administration of Oxygen Protocol)

B. If pain is suspected to be cardiac in origin and if no significant allergy to aspirin exists, administer 324 mg aspirin PO and have the patient chew them.

C. Request ALS if not already en route. If the BLS crew is able to deliver the patient to an emergency room within the same time it would take for the ALS crew to respond to the scene, the BLS crew should transport the patient.

D. If systolic BP is at or above 90 mm Hg and the patient has their own nitroglycerin prescription, assist the patient with taking one dose of his/her nitroglycerin. Nitroglycerin may be administered up to 3 times (every 3-5 minutes) as long as pain is not completely resolved and systolic BP remains above 90 mm Hg.

E. Additional nitroglycerin may be given (beyond the 3 doses) with on-line approval from the receiving facility.

F. Contact receiving facility for further consultation if ALS is not on the scene. Initiate transport.

ALS
1. Apply the cardiac monitor. If dysrhythmias are present, refer to the appropriate protocol. Obtain a 12-lead EKG as soon as possible, and with any significant change in patient condition.
   a. Time permitting, obtain a repeat the 12-lead EKG en route and present both with patient.
   b. If the patient’s 12-lead EKG demonstrates an acute inferior STEMI, consider obtaining another 12-lead with V4R

2. If systolic BP is at or above 90 mm Hg, administer a 0.4 mg dose of nitroglycerin sublingually. Nitroglycerin may be administered every 3 – 5 minutes as long as pain is not completely resolved and systolic BP remains at or above 90.

3. Initiate an IV

4. Scene time should be kept to a minimum, as this is a time-critical condition. Contact the intended receiving facility and alert them of a potential myocardial infarction (Medical Alert).
Cardiovascular Emergencies

**STEMI (ST Segment Elevation Myocardial Infarction) Special Care**

Patients with a STEMI or patients with chest pain thought to be due to myocardial ischemia and a left bundle branch block (LBBB) will be transported to a receiving facility with a cardiac catheterization laboratory (cath lab) available.

5. Call the intended receiving facility as early as possible to activate the cath lab process. Inform the receiving facility that you are bringing in a “STEMI Alert”
   
   a. Patients who are hemodynamically stable will be transported to an appropriate hospital of their choice.
   
   b. Patients who are hypotensive (systolic BP < 90 mm Hg) despite fluids or who have persistent life-threatening dysrhythmias will be transported to the closest hospital with cath lab availability.
   
   c. Current cath lab availability will be displayed on the IndyTrac system.

   
   a. After initial BP obtained, inflate cuff to 200mmHg (if initial systolic blood pressure >200mmHg then inflate to 25mmHg above systolic blood pressure) and hold for 5 minutes.
   
   b. Deflate, while obtaining repeat BP, for 5 minutes.
      
      i. Repeat this cycle up to 4 times total

---

*The combination of nitroglycerin and Viagra®, Revatio® (sildenafil), Levitra® (vardenafil), or Cialis® (tadalafil) have been found to cause precipitous and irreversible hypotension.*

- ✴ Ask every chest pain patient whether or not he/she has been on Viagra, etc. and, if so, when was the last dose? Document this on every run sheet involving the cardiac chest pain patient (even those who deny using Viagra or similar medications).

- ✴ **DO NOT** automatically administer nitroglycerin to any patient who has had Viagra, etc. within the past week. Consult with the receiving physician for appropriateness.

- ✴ Monitor blood pressure very closely on any patient receiving nitroglycerin. If hypotension occurs, refer to the Suspected Cardiogenic Shock Protocol.
DYSRHYTHMIAS: BRADYCARDIA

BRADYCARDIA CRITERIA: Heart rate <60/minute for children (1-8) and adults; <80/minute in infants. Bradycardia with hemodynamic compromise is an ominous sign of impending cardiac arrest in infants and children.

SYMPTOMATIC CRITERIA: SBP <90 mmHg with signs of poor perfusion, altered mentation, chest pain or dyspnea.

BLS
A. Begin Initial Medical Care
B. Follow Airway Management protocol
C. Follow Oxygen Administration protocol
D. If patient is symptomatic, call for ALS unit. If the BLS crew is able to deliver the patient to an emergency room within the same time is would take the ALS crew to respond to the scene, the BLS crew should emergently transport the patient.

ALS
1. Apply cardiac monitor and obtain 12-lead EKG
2. If patient is symptomatic, establish a saline lock or IV with 0.9% NaCl. If an IV cannot be established and an urgent need for vascular access exists, establish IO access.
3. If patient remains symptomatic, perform the following in a step-wise fashion. Reassess after each step and proceed to the next step if there is no improvement.

<table>
<thead>
<tr>
<th>BRADYCARDIA-ADULT</th>
<th>BRADYCARDIA-PEDIATRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administer atropine 0.5 mg every 2 minutes until pulse rate is greater than 60 beats per minutes or a total dose of 3 mg is given.</td>
<td>1. Perform CPR if HR &lt;60</td>
</tr>
<tr>
<td>2. Implement pacing procedures:</td>
<td>2. Intubate only if BVM ventilations/oxygenation is inadequate</td>
</tr>
<tr>
<td>3. Set rate at 70 bpm</td>
<td>3. Administer epinephrine 0.01 mg/kg (1:10,000, 0.1 mL/kg) IV or IO every 3-5 minutes.</td>
</tr>
<tr>
<td>4. Start mA at 10 and gradually increase until the point of electrical capture</td>
<td>4. For increased vagal tone or primary AV block administer atropine 0.02 mg/kg (min. dose 0.1 mg, max single dose 0.5 mg) IV or IO; may repeat one time 3-5 minutes after initial dose.</td>
</tr>
<tr>
<td>5. Verify mechanical capture by feeling for a femoral or radial pulse. Muscle contractures initiated by the pacemaker make a carotid pulse unreliable while externally pacing.</td>
<td>5. Continue searching for possible reversible causes of hypoxia</td>
</tr>
<tr>
<td>6. If sedation or analgesia is indicated during the pacing procedure, 2-5 mg Versed may be administered SIVP.</td>
<td></td>
</tr>
</tbody>
</table>
**Cardiovascular Emergencies**

**DYSRHYTHMIAS - TACHYCARDIA**

**BLS**
A. Begin Initial Medical Care  
B. Follow Airway Management protocol  
C. Follow Oxygen Administration protocol  
D. If patient is symptomatic, call for ALS  
E. Rule out underlying causes of tachycardia

**ALS**
1. Apply cardiac monitor and obtain 12-lead EKG  
2. If patient is symptomatic, establish a saline lock or IV with 0.9% NaCl. If an IV cannot be established and an urgent need for vascular access exists, establish IO access.  
3. If the patient has no signs or symptoms of pulmonary edema, administer 250 mL bolus of 0.9% NaCl solution. Repeat 250 mL boluses every 5 minutes as long as SBP remains below 90 mmHg and no signs of pulmonary edema exist. (For peds, 20 mL/kg boluses)  
4. If patient remains symptomatic, perform the following in a step-wise fashion. Reassess after each step and proceed to the next step if there is no improvement.  
5. For pediatric patients, refer to Pediatric Emergency weight/length-based tape

| NARROW COMPLEX-ADULT  
QRS < 0.12 sec | NARROW COMPLEX-PEDIATRIC  
QRS < 0.12 sec |
|---------------------|---------------------|
| **Urgent:** angina chest pain, hypotension, and/or pulmonary edema | **Urgent:** Infants-rate usually >220/min  
*Children-* rate usually > 180/min |
| 1. Have patient perform Valsalva maneuver  
2. If rhythm has not converted to a sinus rhythm, and in your judgment the rhythm is believed to be SVT, administer:  
   a. Adenosine, 6 mg RIVP, followed with 10 mL fluid flush  
   i. Observe and anticipate AV block(s) and/or transient asystole  
   b. If, after 1-2 minutes, the rhythm does not convert, or no AV block/transient asystole has occurred, repeat adenosine at 12 mg RIVP, followed with 10 mL fluid flush  
3. If unable to rapidly establish IV access, or if no response to adenosine, or a rhythm other than SVT is observed, transport. | 1. Consider Valsalva maneuvers  
2. If probable SVT:  
   a. Adenosine 0.1 mg/kg (max 6 mg) RIVP, followed with 10 mL fluid flush  
   b. Second dose of adenosine, 0.2 mg/kg (max 12 mg) RIVP, followed by 10 mL fluid flush. |
<p>| <strong>Emergent:</strong> Unconscious or no obtainable BP | <strong>Emergent:</strong> Hypotension, acutely altered mentation, signs of shock |
| Perform synchronous cardioversion in an escalating fashion at dosages recommended by the manufacturer. | Perform synchronous cardioversion in an escalating fashion at dosages recommended by the manufacturer. |</p>
<table>
<thead>
<tr>
<th>WIDE COMPLEX-ADULT (QRS &gt; 0.12 sec)</th>
<th>WIDE COMPLEX-PEDIATRIC (QRS &gt; 0.12 sec)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asymptomatic</strong></td>
<td><strong>Asymptomatic</strong></td>
</tr>
<tr>
<td>1. Establish IV access and monitor patient for changes</td>
<td>1. Establish IV access and contact medical control for further instructions</td>
</tr>
<tr>
<td><strong>Mild Symptoms—chest pain, dyspnea, or decreased level of consciousness</strong></td>
<td></td>
</tr>
<tr>
<td>1. If regular/monomorphic administer adenosine 6 mg RIVP; immediately follow with 10 mL fluid flush.</td>
<td>1. Contact medical control for further instructions</td>
</tr>
<tr>
<td>2. If irregular or VT does not resolve, administer amiodarone 150 mg IV over 10 minutes</td>
<td></td>
</tr>
<tr>
<td>3. If VT does not resolve, begin emergent transport.</td>
<td></td>
</tr>
<tr>
<td>4. En route, an additional 150 mg amiodarone may be administered over 10 minutes</td>
<td></td>
</tr>
<tr>
<td>5. If VT persists, contact medical control regarding additional doses of amiodarone</td>
<td></td>
</tr>
<tr>
<td><strong>Serious Symptoms—pulmonary edema, SBP&lt;90, or unconscious with pulse</strong></td>
<td><strong>Serious Symptoms:</strong> Hypotension, acutely altered mentation, signs of shock</td>
</tr>
<tr>
<td>1. Perform synchronous cardioversion in an escalating fashion at energy levels recommended by the manufacturer</td>
<td>1. Perform synchronous cardioversion beginning with 0.5-1 j/kg; if not effective, increase to 2 j/kg</td>
</tr>
<tr>
<td>2. Administer amiodarone 150 mg IV over 10 minutes</td>
<td>2. Contact medical control for further instructions</td>
</tr>
<tr>
<td>3. If VT persists, cardiovert with maximum electrical output</td>
<td></td>
</tr>
<tr>
<td>4. If VT recurs, administer additional amiodarone 150 mg IV over 10 minutes and cardiovert at the energy level that was previously successful</td>
<td></td>
</tr>
<tr>
<td>5. If VT persists, contact medical control regarding additional doses of amiodarone</td>
<td></td>
</tr>
<tr>
<td><strong>Unconscious without Pulses</strong></td>
<td><strong>Unconscious without Pulses</strong></td>
</tr>
<tr>
<td>Treat as Cardiac Arrest, VF/VT</td>
<td>Treat as Cardiac Arrest, VF/VT</td>
</tr>
</tbody>
</table>
Cardiovascular Emergencies

**SHOCK-CARDIOGENIC**

**Criteria:** Symptomatic hypotension due to a suspected cardiac event with heart rate between 60-150 per minute.

**BLS**
A. Begin Initial Medical Care  
B. Follow Airway Management protocol  
C. Follow Oxygen Administration protocol  
D. Request ALS if not already en route. If the BLS crew is able to deliver the patient to an emergency room within the same time it would take for the ALS crew to respond to the scene, the BLS crew should transport the patient.

**ALS**
1. Apply cardiac monitor and obtain 12-lead EKG; if dysrhythmias are present, treat according to the appropriate protocol. If STEMI is suspected, notify the intended receiving facility  
2. Establish an IV with 0.9% NaCl. If an IV cannot be established and an urgent need for vascular access exists, establish IO access.  
3. If the patient has no signs or symptoms of pulmonary edema, administer 250 mL bolus of 0.9% NaCl solution (20ml/Kg in pediatrics).  
4. Contact medical control at the intended receiving facility to discuss additional fluid boluses and/or a dopamine infusion (typically beginning at 5 mcg/kg/min and titrated to a systolic BP of 90 mmHg).

**SHOCK-NONCARDIOGENIC**

**BLS**
A. Follow A-D in Shock-Cardiogenic protocol  
B. If evidence of trauma or hemorrhage present see Initial Trauma Care Protocol  
C. Consider other causes of shock

**ALS**

<table>
<thead>
<tr>
<th>ADULT</th>
<th>PEDIATRIC</th>
</tr>
</thead>
</table>
| 1. Apply the cardiac monitor  
2. Initiate two large bore IVs (or IO, if IV access in not available) of NaCl and titrate to a systolic BP of 90 mmHg if patient has no signs or symptoms of fluid overload  
3. Reassess vital signs and peripheral perfusion; reassess for signs of pulmonary edema. | 1. Administer 20 mL/kg IV or IO NaCl solution as rapidly as possible.  
2. Reassess vital signs and peripheral perfusion; reassess for signs of pulmonary edema.  
3. If no improvement in vital signs, peripheral perfusion, and no indication of pulmonary edema is present, repeat NaCl bolus of 20 mL/kg  
4. In cases of hypotension involving infants, perform glucose analysis. If blood glucose suggest hypoglycemia administer 4 mL/kg D\textsubscript{25} |
Cardiovascular Emergencies

CARDIAC ARREST, GENERAL CARE

Adults: (>18 yrs) Quick defibrillation is key!

Pediatric/Infant/Neonate: Oxygenation and ventilation is of utmost importance in cardiac arrest care! Use the Broselow® tape (or appropriate equivalent) to assess and determine correct dosing regimen.

BLS
A. Initiate chest compressions according to current AHA guidelines for healthcare providers.
B. Call for ALS if not already en route.
C. Attach AED and follow prompts.
   1. If "no shock advised," perform CPR for 2 minutes, then check pulse. Re-analyze rhythm if no pulse is found.
D. Initial airway management
   1. Provide oxygen via 100% NRB @ 15lpm
   2. OP/NP with NRB Only if gag reflex absent – No non-visualized airway
   3. Follow protocol specific airway for cardiac arrest after 3rd cycle of CPR
E. If the patient regains a pulse, follow Post Cardiac Arrest Care protocol.

ALS
A. Establish an IV/IO with 0.9% NaCl
B. Apply cardiac monitor and follow appropriate Cardiac Arrest Dysrhythmia protocol
C. VF/VT witnessed arrest primary goal is high quality UNINTERRUPTED CPR and basic airway maneuvers with NP/OP with NRB only- no non-visualized airway
   1. Provide oxygen via 100% NRB @15lpm
   2. OP/NP with NRB Only if gag reflex absent- No Non-Visualized Airway
   3. Follow protocol specific airway for cardiac arrest after 3rd cycle of CPR
D. Follow protocol specific airway for cardiac arrest after 3rd cycle of CPR

odefibrillation is the treatment priority when advised by the AED. Bare and dry chest, remove any medication patch. Place patient on hard surface.

Defibrillate at setting recommended by the manufacturer.

Try to minimize interruptions in chest compressions

Respiratory rate of 6-8/minute is adequate for patients in cardiac arrest – do not hyperventilate.
Cardiovascular Emergencies

**CARDIAC ARREST-VF/VT**

**BLS**

A. Perform chest compressions until defibrillator is attached. (Provide 2 minutes of chest compressions prior to defibrillation for unwitnessed arrest.) Compressions should be performed at a rate of 100-120/minute.

B. Refer to Cardiac Arrest, General Care guidelines

**ALS**

<table>
<thead>
<tr>
<th>Persistent or Recurrent VF/VT</th>
<th>Persistent or Recurrent VF/VT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CARDIAC ARREST-ADULT</strong></td>
<td><strong>CARDIAC ARREST-PEDIATRIC</strong></td>
</tr>
<tr>
<td>V-Fib/VT</td>
<td>V-Fib/VT</td>
</tr>
</tbody>
</table>

1. For witnessed arrest apply pads and defibrillate at maximum settings as recommended by the manufacturer.

2. Immediately resume CPR for 2 minutes. Place OP or NP airway and provide oxygen via 100% NRB. Establish IV/IO

3. ASAP administer 1 mg epinephrine 1:10,000 IV or IO push and repeat every 3-5 min.

4. Check for an organized rhythm at 2-minute intervals. Shock if indicated. Immediately resume CPR.

5. If still in V/VT after 3rd cycle of CPR and shock consider advanced airway techniques or BVM at rate of 8-10/min (this can include prior treatment by fire/BLS)

6. Administer 300 mg amiodarone IV or IO. May repeat one time at half dose (150 mg)

7. Resuscitative efforts should rotate on 2 minute cycles. Pattern should be shock, CPR, drug.

8. If no response to amiodarone, consider 2 grams magnesium sulfate IV or IO. May repeat one time in 3-5 mins.

1. Defibrillate, if indicated at 2J/Kg. Subsequent shocks should be at 4 J/Kg.

   *The use of pediatric defibrillation pads is preferred. If adult pads are used, they should be placed in an anterior-posterior configuration.*

2. Defibrillate, immediately resume CPR for 2 minutes and begin BVM ventilation and oxygenation. Establish an IV (or an IO line, if IV access is not available).

3. Administer 0.01 mg/Kg (0.1 mL/Kg) 1:10,000 epinephrine IV or IO every 3-5 minutes

4. Check for an organized rhythm at 2-minute intervals. Shock if indicated. Immediately resume CPR.

5. Administer amiodarone 5 mg/Kg IV or IO.

6. Resuscitative efforts should rotate on a 2-minute cycle. Pattern should be shock, CPR, drug.
<table>
<thead>
<tr>
<th><strong>Once VF/VT has Resolved - ADULT</strong></th>
<th><strong>Once VF/VT has Resolved - PEDIATRICS</strong></th>
</tr>
</thead>
</table>
| 1. Administer amiodarone if the 300 mg bolus was not given previously:  
   a. Add 150 mg amiodarone to a 50 mL 5% dextrose IV bag  
   b. Infuse over 10 minutes  
     • 100 gtt/min using 20 gtt/mL drip set  
     • 80 gtt/min using 15 gtt/mL drip set  
     • 50 gtt/min using 10 gtt/mL drip set  
| 2. Begin a magnesium IV infusion at 33 mg/min (2 g/h) if the 2 g magnesium bolus was used  
   a. Add 2 g magnesium sulfate to a 50 mL 0.9% saline or 5% dextrose IV bag  
   b. Infuse at 50 gtt/min using the 60 gtt/mL drip set. | 1. Contact medical control for further instructions. |
# Cardiovascular Emergencies

## Cardiac Arrest—Pulseless Electrical Activity/Asystole

Consider possible reversible causes of **PEA** such as hypovolemia, hypoxia, tension pneumothorax, cardiac tamponade, hypothermia, acidosis, drug overdose, hyperkalemia, massive acute MI, or pulmonary embolism.

Consider possible reversible causes of **Asystole** such as hypoxia, preexisting acidosis, drug overdose, or hypothermia.

### Cardiac Arrest—Adult

<table>
<thead>
<tr>
<th>PEA/Asystole</th>
<th>Cardiac Arrest—Pediatric</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If the rhythm is unclear and possibly ventricular fibrillation, defibrillate as for VF.</td>
<td>1. If the rhythm is unclear and possibly ventricular fibrillation, defibrillate as for VF.</td>
</tr>
<tr>
<td>2. <strong>Immediately</strong> resume CPR for 2 minutes. Apply 100% NRB with OP/NP if no gag reflex present. No Non-Visualized Airway. <strong>Establish IV/IO.</strong></td>
<td>2. Resume CPR immediately and begin BVM ventilation and oxygenation. Intubate the patient only if BVM ventilation/oxygenation is inadequate.</td>
</tr>
<tr>
<td>3. <strong>ASAP</strong> Administer 1 mg epinephrine 1:10,000 IV or IO push and repeat every 3-5 min.</td>
<td>3. Establish IV (or an IO line, if IV access is not available)</td>
</tr>
<tr>
<td>4. Check for an organized rhythm at 2-minute intervals. Shock if indicated. Immediately resume CPR.</td>
<td>4. Administer 0.01 mg/kg epinephrine: (1:10,000, 0.1 mL/Kg) IV or IO every 3-5 minutes.</td>
</tr>
<tr>
<td>5. If after 2nd round pt still is asystole/PEA may consider advanced airway maneuvers and/or BVM at rate of 8-10/min</td>
<td>5. If patient remains asystolic, contact the receiving facility for possible termination of resuscitation efforts.</td>
</tr>
<tr>
<td>6. Continue resuscitative efforts for 30 minutes total. Contact receiving facility for further consultation as needed.</td>
<td></td>
</tr>
</tbody>
</table>
Cardiovascular Emergencies

POST CARDIAC ARREST CARE

A. Applies to patients resuscitated from cardio-respiratory arrest who have a perfusing rhythm and pulse, and who remain unresponsive.

B. Secure the airway. If not previously accomplished, the airway should be secured with an ET tube or a non-visualized airway.

C. Maintain normoventilation. Initially, ventilate at 8-10 breaths per minute. Do NOT hyperventilate. If end-tidal capnography is available, titrate ventilation to an EtCO₂ of 35-40 mm Hg.

D. Stabilize dysrhythmias:
   a. Unstable tachydysrhythmias – treat with cardioversion
   b. Unstable bradydysrhythmias – consider external pacing
   c. Stable tachycardia or bradycardia – treat per protocols

E. If initial arrest rhythm was v-fib or v-tach, give amiodarone 150 mg IV over 10 minutes if not already given during resuscitation. If significant ventricular ectopy persists, repeat amiodarone per protocol.

F. Support blood pressure
   1. If cold saline is not available (see below), administer 250 mL boluses of 0.9 NS to maintain SBP between 110 and 140 mm Hg
   2. If the patient’s SBP is less than 90 mm Hg after 500 mL of fluid (cold or room-temperature), begin dopamine and titrate to a SBP >110 and < 140.

G. Therapeutic hypothermia: If possible, infuse up to 2,000 ml iced 0.9% saline through an 18 ga (or larger) IV using a pressure bag inflated to 300 mmHg.
   a. Avoid in patients in whom cardiac arrest is thought to be due to trauma, suspected significant ongoing hemorrhage, significant head injury, significant pulmonary edema, arrest caused by hypothermia, in women who are obviously pregnant, in children (< 18 years), and for patients who have a severe pre-existing neurologic impairment or terminal illness.
   b. If shivering develops, administer midazolam 5 mg IVP. This may be repeated every 5 minutes as needed.
   c. If significant dysrhythmias develop, stop cooling and treat as noted above.

H. Obtain a 12-lead EKG and transmit, if possible. Notify the receiving facility as soon as a STEMI is suspected.

I. Check glucose and treat per protocol

J. Seizure activity – monitor for seizure activity and treat per protocol.
Cardiovascular Emergencies

**LEFT VENTRICULAR ASSIST DEVICE (LVAD)**

A. The most valuable resource for the LVAD patient is their caregiver. They are trained and familiar with all of the LVAD equipment. The caregiver will be transported with the patient to the Emergency department.

B. Contact VAD coordinator (found on card the patient will give you) for additional guidance.

C. All ALS and BLS protocols are valid for the LVAD patient.

D. You must use clinical judgment to determine the need for CPR. (warm, pink, with good capillary refill)
   a. Peripheral pulses may not be present.
   b. BP can only be measured with a Doppler ultrasound.
   c. Pulse oximetry is not reliable (there is no pulse).
   d. Listen over the pump for a mechanical whirring sound.
      1. If this is present no need for CPR.
      2. Look for another cause of the patient’s decompensated state.
   e. If CPR is initiated transport patient to the hospital.

E. CPR is performed in the usual manner.

F. Defibrillation and cardioversion are performed in the usual manner.
   a. Not all dysrhythmias need to be treated.
      1. If the patient is warm, pink with good capillary refill is not necessary
   b. Do not place defibrillator pads over the “pump”

G. If the pump is not working (no mechanical whirring sound):
   a. Check System control panel for alarms.
   b. Check Power Supply connection.
   c. Never disconnect both batteries at the same time.
   d. Contact VAD coordinator (found on card the patient will give you) for additional guidance.

H. Always transport patient with Travel Bag containing extra controller, batteries and cables and if stable transport to a VAD center.

I. Most patients are on sildenafil (Viagra®, Revatio®) and nitrates should not be administered.
ALERTED LEVEL OF CONSCIOUSNESS

BLS
A. Begin “Initial Medical Care” and call for ALS.
B. Follow “Airway Management” protocol.
C. Follow “Oxygen Administration” protocol.
D. Investigate for possible causes (medical history, medications, medic alert tag, recent trauma).

ALS
A. Establish a saline lock or an IV with 0.9% NaCl.
B. Apply cardiac monitor. Obtain a 12-lead electrocardiograph (ECG).
C. If an IV cannot be established and an urgent need for vascular access exists, establish IO access.
D. Perform blood glucose analysis.

HYPOGLYCEMIA-ADULT
1. Perform blood glucose analysis. If blood glucose < 70 mg/dL, administer 50% dextrose 4 mL IVP for every 10 mg/dL under 100 mg/dL.
   - Glucose  50% Dextrose
   - 60-69    16 mL
   - 50-59    20 mL
   - 40-49    24 mL
   - 30-39    28 mL
   - 20-29    32 mL
   - 10-19    36 mL
2. If unable to establish IV after 2 attempts, administer glucagon 1 mg IM or intra-nasally.
3. Oral glucose may be considered for patients that, in the providers best judgment can tolerate oral medications.

HYPOGLYCEMIA-PEDIATRIC
1. Perform blood glucose analysis. If blood glucose suggests hypoglycemia (neonates < 40, pediatrics < 60), administer 4 mL/Kg 25% dextrose IV push to infants or 2 mL/Kg of 50% dextrose for older children (not to exceed 50 mL).
2. If unable to establish IV after 2 attempts, administer glucagon 0.5 mg IM or intra-nasal for children < 20 Kg, 1 mg IM or intra-nasal for children ≥ 20Kg.
3. Oral glucose may be considered for patients that, in the providers best judgment can tolerate oral medications.

OPIATE INGESTION-ADULT
1. If the patient has respiratory depression and a history suggestive of possible opiate overdose, administer 0.4 mg Naloxone IVP or intra-nasally.
2. If respiratory depression persists after 2 minutes, repeat IV or intra-nasal via alternating nostrils until respirations are adequate or a total of 2 mg of naloxone has been administered.

OPIATE INGESTION-PEDIATRIC
1. If the patient has respiratory depression and a history suggestive of possible opiate overdose, administer 0.01 mg/kg (up to 0.4 mg) Naloxone IVP or intra-nasally.
2. If respiratory depression persists after 2 minutes, repeat IV, IM, or intra-nasal via alternating nostrils until respirations are adequate or a total of 2mg of Naloxone has been administered.
BEHAVIORAL EMERGENCIES/RESTRAINT

A. General approach

1. Violent behavior may be a manifestation of a medical condition such as head injury, drug or alcohol intoxication, metabolic disorders, hypoxia, stroke, or post-ictal state. Field personnel should consider these medical conditions first, and then consider psychiatric disorders in the approach to violent patients. Field personnel should obtain a detailed history from family members, bystanders, and law enforcement personnel, and make particular note of patient surroundings for clues to the cause of the behavior (e.g., drug paraphernalia, medication bottles).

2. EMS personnel shall attempt to de-escalate verbally aggressive behavior with a calm and reassuring approach and manner.

B. Physical Restraint Issues

1. Restrained patients shall be placed in a supine position, Fowler’s or semi-Fowler’s position. Patients shall not be transported in a prone position or “hog-tied.” Patients shall not be “sandwiched” between scoop stretchers, backboards, and/or mattresses during transport.

2. Four-point restraint is preferred; additional tethering of the thorax may be necessary. A surgical mask may be placed on the patient to prevent spitting.

3. The method of restraint must allow for adequate monitoring of pulse and respirations, and should not restrict the patient or rescuer’s ability to protect the airway should vomiting occur. EMS personnel must provide sufficient slack in the restraint device(s) to allow the patient to straighten the abdomen and chest and to take full tidal-volume breaths. The neck may not be compromised.

4. Once the patient has been restrained, he/she should never be left alone.

5. Restrained extremities should be monitored for circulation, motor function, and sensory function every 10 minutes and upon arrival at the hospital. It is recognized that the evaluation of motor and sensory status requires patient cooperation, and thus may be difficult or impossible to achieve.

6. Out-of-hospital documentation should include behavior, reason for restraint, that the restraints were “applied for the patient’s safety”, identification of personnel/agency applying restraint, other pertinent clinical information, vital signs, and documentation of monitoring of restrained extremities.

7. Unless mandated for emergency care, restraints are to be left in place until the patient is turned over to hospital ED staff and preparations are made for a smooth and safe transfer.

8. Metal handcuffs for initial restraint may only be applied by law enforcement personnel. Metal handcuffs may be replaced with another method of restraint (e.g., those listed above or hard plastic flex-cuffs) prior to transport. Metal handcuffs may only be used for restraint during transport when law enforcement personnel accompany the patient. Only law enforcement personnel may remove metal handcuffs.
Law enforcement responsibilities:

a. Law enforcement personnel are responsible for the capture and/or restraint of potentially violent patients. EMS personnel should obtain assistance from law enforcement to prepare patients for transport.

b. Law enforcement agencies retain primary responsibility for safe transport of patients under arrest or involuntary detention.

c. Patients under arrest or involuntary detention shall be searched thoroughly by law enforcement personnel prior to being placed in the ambulance.
   i. Patients under arrest must always be accompanied by law enforcement personnel.
   ii. EMS and law enforcement personnel should mutually agree on need for law enforcement assistance during transport of involuntary detention patients.

C. Transport Issues

1. If an unrestrained patient becomes violent during transport, EMS personnel shall request law enforcement assistance and make reasonable efforts to calm and reassure the patient.

2. If the crew believes that their personal safety is at risk, they should not inhibit a patient’s attempt to leave the ambulance. Every effort should be made to release the patient into a safe environment. EMS personnel are to remain on scene until law enforcement arrives to take control of the situation.

**CHEMICAL RESTRAINT**

Chemical restraint is to be used only where the patient can be adequately and repeatedly monitored by EMT-P providers. It is to be reserved for patients who cannot otherwise be restrained or restrained only at the risk of significant harm to the patient, law enforcement, and EMS providers.

**ALS**

1. Consider other causes of combative or irrational behavior, including but not limited to hypoxia and hypoglycemia.

2. Administer midazolam IV, IM, or via intra-nasal spray
   a. If patient > 50 kg, administer 10 mg (5 mg in each nostril)
   b. If patient < 50 kg, administer 5 mg

3. Patient should be isolated and placed in an ALS ambulance as soon as possible.

4. Airway, mental status, and vital signs (including pulse oximetry and heart rhythm) must be examined and documented every 5 minutes.

5. All patients will be transported to the closest most appropriate facility for further evaluation, and released to law enforcement thereafter.

If chemical restraint is used, a copy of the run record must be made available to the Medical Director through the CQI Coordinator within 24 hours.
DIALYSIS PATIENTS

The use of Body Substance Isolation Procedures is especially important because of the possibility of exposure to blood and body fluids and the probability of dialysis patients being carriers of the hepatitis B virus. Treat any presenting problems according to the appropriate protocol and note the following modifications:

BLS

A. Do not take vital signs in an extremity containing a graft or fistula.

B. If the patient is on the hemodialysis machine, have the dialysis technician disconnect the patient from the machine. If the dialysis technician is not present, or is unable to disconnect the patient, turn off the machine.

1. Clamp off the access device and disconnect the patient from the machine.

2. Remove or have technician remove the needles. Apply pressure as the needle is removed so as to avoid cutting the access device.

C. If the patient is on continuous ambulatory peritoneal dialysis (CAPD), unclamp drainage tube and allow fluid in the peritoneal cavity to drain back into the bag.

D. Be alert for pathological fractures or fractures that might occur.

E. If a venous or arterial air embolus is suspected, immediately place the patient in Trendelenburg position on the left side.

F. If the site is persistently bleeding, apply direct pressure and elevate the limb. Do NOT apply a tourniquet device.

ALS

1. Initiate an IV in an extremity containing a shunt or fistula only if an immediate life-threatening situation exists and there is no other IV site. NOTE: This does not mean that inserting an IV into the shunt or fistula is allowed – only that another IV site in that same arm is allowed.

2. For patients who have missed one or more dialysis treatments, AND exhibit a wide QRS (≥ 0.12 sec), hypotension or refractory ventricular fibrillation, give the following medications:

   a. Calcium chloride 1 g SLOW IV push

   b. Albuterol 5 mg nebs back-to-back/continuously for the spontaneously breathing patient, and

   c. Sodium Bicarbonate, 100 mEq IV push, if lung sounds are clear.
**Medical Emergencies**

**DRUG OVERDOSE/POISONING-SUSPECTED**

**BLS**

A. Protect yourself from exposure to poisons.

B. Begin Initial Medical Care when safe to do so.

C. Obtain the following information:
   1. Type of poison/medication.
   2. Type of exposure - ingestion, injection, absorption, inhalation.
   3. Time of exposure.
   4. Amount of poison exposure (quantity, strength of agent(s)).
   5. Time exposure took place.
   6. If an ingestion, poison/medication taken with water/alcohol/etc.?
   7. Time of last food and alcohol intake.
   8. Weight of patient (in Kg).

D. Remove the patient from the source of contamination, if necessary, without endangering responders.
   In the event of topical poisons, decontaminate the patient with copious amounts of water. Brush away powdered substances prior to irrigation.

E. Categorize type of poison
   1. Injected poisons - (e.g., bites, stings, or open wounds caused by an object contaminated with a poisonous substance) – apply a venous constricting band above the site of injection on an extremity, immobilize the extremity and keep it below the level of the heart. For stings, scrape stinger away, do not squeeze stinger.
   2. Suspected allergic reactions *(See Allergic Reaction Protocol)*
   3. Inhaled poisons - Administer high flow oxygen to all patients with poisoning by inhalation or who meet criteria for oxygen administration or airway management procedures. *(See Administration of Oxygen Protocol and/or Airway Management Protocol)*

F. If level of consciousness is decreased or vital signs abnormal, transportation by advanced life support is preferred. *(See Altered Level of Consciousness Protocol)*

G. Gather containers or remaining medications that can be taken to the hospital safely.
H. Consider contacting the Indiana Poison Center (IPC) on Med-1 or the IHERN for information on expected toxicity. The Poison Center may be used as a resource for information, NOT for orders for patient care. The IPC is also available at 962-2323, (800) 222-1222, on via the IHERN (EMS-M1).

**ALS**

1. Follow appropriate protocol for specific presentation/toxin.

<table>
<thead>
<tr>
<th><strong>BETA BLOCKER OVERDOSE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucagon 3 mg IVP over 3 minutes may be indicated for the treatment of beta-blocker overdose with hypotension (SBP &lt; 90 mm Hg).</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CALCIUM CHANNEL BLOCKER OVERDOSE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium chloride 1 gram slow IVP, may be indicated for the treatment of calcium channel blocker overdose with bradycardia (heart rate &lt; 60) and hypotension (SBP &lt; 90 mm Hg).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>CYCLIC ANTIDEPRESSANT OVERDOSE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sodium bicarbonate 1 mEq/Kg IVP may be indicated for the treatment of cyclic antidepressant overdose with wide QRS complex (≥ 0.12 sec), hypotension (SBP &lt; 90 mm Hg), or seizures.</td>
</tr>
</tbody>
</table>
Medical Emergencies

SEIZURES

A. Administer high flow oxygen. (See Oxygen Administration)
B. Protect patient from injury while patient is seizing. DO NOT RESTRAIN PATIENT. DO NOT FORCE A BITE STICK INTO THE PATIENT'S MOUTH. Determine the duration of the seizure. Observe the type of seizure activity and what part(s) of the body it affects.

Not in Status Seizures

1. Initiate transport.
   a. Adult patients who are no longer post-ictal may request not to be transported. You should consult with the hospital for authorization not to transport. (See Non-Transported Patient Protocol)

Status Seizures

Criteria: Continuous seizure activity for longer than 3 minutes or two or more consecutive seizures without regaining consciousness

BLS

1. Assist ventilations. (See Airway Management Protocol)

2. Contact receiving facility for further orders if ALS is not on scene. Request advanced life support.

ALS

<table>
<thead>
<tr>
<th>STATUS SEIZURE-ADULT</th>
<th>STATUS SEIZURE-PEDIATRIC</th>
</tr>
</thead>
</table>
| 1. Perform blood glucose analysis. If blood glucose < 70 mg/dL, administer 50% dextrose 4 mL IVP for every 10 mg/dL under 100 mg/dL. Glucose 50% Dextrose 60-69 16 mL 50-59 20 mL 40-49 24 mL 30-39 28 mL 20-29 32 mL 10-19 36 mL 2. If unable to establish IV after 2 attempts, administer glucagon 1 mg IM or intra-nasal 3. Apply the cardiac monitor and pulse oximeter. 4. Administer midazolam IV, IM, or intra-nasal:
   a. If patient ≥ 50 kg, administer 5 mg
   b. If patient < 50 kg, administer 2.5 mg
   c. Dose may be repeated in 5 minutes, if needed; use other nare if administered intranasally | 1. Perform blood glucose analysis. If blood glucose suggests hypoglycemia, administer 4 mL/Kg 25% dextrose IV push to infants or 2 mL/Kg of 50% dextrose for older children (not to exceed 50 mL). 2. If unable to establish IV after 2 attempts, administer glucagon 0.5 mg IM or intra-nasal for children < 20 Kg, 1 mg IM or intra-nasal for children ≥ 20Kg. 3. Apply the cardiac monitor and pulse oximeter 4. Administer midazolam IV, IM, or intra-nasal:
   a. 0.1mg/kg of midazolam (up to a maximum of 2.5 mg)
   b. If intra-nasal, divide the dose so that each nares receives half
   c. The dose may be repeated in 5 minutes if needed. 5. Contact the receiving facility for further instructions |

If the patient is pregnant in the 3rd trimester, administer 2 grams magnesium IVP over 2 minutes.
STROKE (CVA)

This protocol is intended to reduce the time to thrombolysis in the acute stroke patient. Patient with symptoms of less than 6 hours duration are considered “time-critical.” Patients may present as having fallen, unable to walk, or with altered level of consciousness.

BLS
A. Administer oxygen as indicated. (See Oxygen Administration protocol)
B. Evaluate patient using the Cincinnati Prehospital Stroke Scale
C. Contact the emergency department at the intended receiving facility and include the following information: time of onset of signs/symptoms, Cincinnati Prehospital Stroke Scale, and blood glucose results. Record results on run sheet.
D. Encourage a close family member to accompany the patient to the hospital to provide information on baseline function, onset of symptoms, and possible consent for tPA. If a family member is unable to accompany the patient, obtain a phone number for a family member to provide the hospital with this same information.
E. If level of consciousness is decreased or vital signs abnormal, transportation by advanced life support is preferred.

ALS
1. Perform blood glucose analysis. If blood glucose < 70 mg/dL, administer 50% dextrose 4 mL IVP for every 10 mg/dL under 100 mg/dL.

<table>
<thead>
<tr>
<th>BGL</th>
<th>50% Dextrose</th>
</tr>
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<tbody>
<tr>
<td>60-69</td>
<td>16 mL</td>
</tr>
<tr>
<td>50-59</td>
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</tr>
<tr>
<td>40-49</td>
<td>24 mL</td>
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<tr>
<td>30-39</td>
<td>28 mL</td>
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<tr>
<td>20-29</td>
<td>32 mL</td>
</tr>
<tr>
<td>10-19</td>
<td>36 mL</td>
</tr>
</tbody>
</table>

2. If unable to establish an IV after 2 attempts, administer Glucagon 1 mg IM or intra-nasally
3. Obtain a 12-lead EKG
4. Do not treat hypertension

Cincinnati Prehospital Stroke Scale

**Facial Droop** (have patient show teeth or smile):
- Normal – both sides of face move equally well
- Abnormal – one side of face does not move as well as the other side

**Arm Drift** (have patient close eyes and hold both arms out, palms up):
- Normal – both arms move the same or both arms do not move at all
- Abnormal – one arm does not move or one arm drifts down compared with the other

**Speech** (have the patient say “you can’t teach old dog new tricks”):
- Normal – patient uses correct words with no slurring
- Abnormal – patient slurs words, uses inappropriate words, or is unable to speak
Medical Emergencies

SYNCOPE

**BLS**

A. If patient’s mental status remains altered, refer to Altered Level of Consciousness Protocol.
B. Place patient in position of comfort.
C. Perform Cincinnati Prehospital Stroke Scale, if abnormal, refer to Suspected Stroke (CVA) Protocol.

<table>
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<tr>
<th><strong>Cincinnati Prehospital Stroke Scale</strong></th>
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**ALS**

1. Apply the cardiac monitor
2. Obtain 12-lead EKG
3. If the patient’s mental status is not completely normal or there is a slow response to baseline, measure blood glucose.
   a. If less than 70 mg/dL, refer to Altered Mental Status Protocol.
   b. Treat abnormal vital signs appropriately.
**ALLERGIC REACTION**

### BLS

A. Begin “Initial Medical Care”.
B. Follow “Airway Management” protocol.
C. Follow “Oxygen Administration” protocol.
D. Call for an ALS unit if patient has wheezing, stridor, or shows other signs of respiratory distress or nausea/vomiting.
E. If patient has a prescribed Epi auto-injector and is experiencing stridor and/or hypotension, assist patient with or administer one dose of the patient’s own Epi auto-injector.

### ALS

A. Establish a saline lock or an IV with 0.9% NaCl. Titrate fluids to a SBP of 90 mmHg.
B. Apply cardiac monitor.
C. Medicate according to signs/symptoms as below.

<table>
<thead>
<tr>
<th>ISOLATED ITCHY RASH/HIVES-ADULT</th>
<th>ISOLATED ITCHY RASH/HIVES-PEDIATRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer Diphenhydramine 25-50mg IV or IM.</td>
<td>Administer Diphenhydramine 0.5 mg/kg IV or IM. (Max 50 mg)</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>RASH/HIVES &amp; WHEEZING-ADULT</th>
<th>RASH/HIVES &amp; WHEEZING-PEDIATRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administer 0.3 mg Epinephrine 1:1,000 IM.</td>
<td>1. Administer 0.01 mg/kg Epinephrine 1:1,000 IM. (Max 0.3 mg)</td>
</tr>
<tr>
<td>2. Administer 2.5 mg nebulized Albuterol at a flow sufficient to produce a mist.</td>
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<td>2. Administer 0.3 mg Epinephrine 1:1,000 IM.</td>
<td>2. Administer 0.01 mg/kg Epinephrine 1:1,000 IM. (Max 0.3 mg)</td>
</tr>
<tr>
<td>3. Administer Diphenhydramine 25-50 mg IV or IM.</td>
<td>3. Be prepared for emergent airway management.</td>
</tr>
<tr>
<td>4. <strong>If condition remains unchanged or worsens after 3 minutes, administer additional dose of 0.3mg Epinephrine 1:1,000 IM.</strong></td>
<td>4. Administer Diphenhydramine 0.5 mg/kg IV or IM. (Max 50 mg)</td>
</tr>
<tr>
<td>5. <strong>If after 3 minutes and second dose of epinephrine condition remains unchanged, administer 0.1 mg Epinephrine 1:100,000 slow IVP. Titrate to improvement of symptoms.</strong></td>
<td>5. <strong>If condition is unchanged after 3 min. or worsens, administer additional dose of 0.01mg/kg Epinephrine 1:1,000 IM.</strong></td>
</tr>
<tr>
<td>6. <strong>If after 3 minutes and second dose of epinephrine condition remains unchanged administer 0.1 mg Epinephrine 1:100,000 slow IVP. Titrate to improvement of symptoms.</strong></td>
<td>6. <strong>If condition is unchanged after 3 min. or worsens, administer additional dose of 0.01mg/kg Epinephrine 1:1,000 IM.</strong></td>
</tr>
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**Note:** Call medical control for children <1y/o or < 10kg BEFORE administering IV Epi

---

Epi 1:100,000 concentration MUST be mixed by expelling 9 mL of 10 mL prefilled Epi 1:10,000 and drawing 9 mL saline into the prefilled syringe. Concentration after mixing is 0.1 mg/10mL Epinephrine 1:100,000
DROWNING/NEAR DROWNING

A. PROTECT YOURSELF! Do not enter a body of water unless you are certified in water rescue and have the appropriate equipment.

B. Administer high flow oxygen *(See Oxygen Administration)*

C. Immobilize cervical spine if potential exists for cervical injury.

D. Treat patients for problems as indicated by *appropriate protocol*.

E. If a cold water drowning exists consider hypothermia *(See Hypothermia protocol)*.

F. Transportation by ALS is preferred.

G. All near drowning patients should be transported to a hospital—such complications such as pulmonary edema may be delayed.
Environmental Emergencies

HYPERTHERMIA

A. Administer high flow oxygen. *(See Oxygen Administration)*

B. Move patient to cool environment.

C. Remove clothing. Cool patient with cold packs around the abdominal, axillary, neck, and groin areas.

D. Do not allow patient to shiver during cooling. If shivering occurs, remove cold packs.

E. If patient presents with altered level of consciousness, *(See Altered Level of Consciousness).*

*If patient appears unstable:*

**BLS**

F. Request ALS if not already en route and initiate transport. Contact receiving facility for further orders if ALS is not on scene.

**ALS**

1. Apply the cardiac monitor

2. Initiate an IV and titrate flow to a systolic BP of 90 mmHg.
Environmental Emergencies

HYPOTHERMIA

Any patient with a suspected core body temperature of 96°F or less. Hypothermic patients are considered viable until rewarmed and pronounced dead by a physician.

A. Administer oxygen at 10-15 LPM per non-rebreather (See Administration of Oxygen Protocol)
   1. If you need to assist ventilations with BVM, do not induce a gag reflex, do not hyperventilate, and do not insert a non-visualized airway or OP airway.

B. On all patient procedures, handle gently. Do not let the patient walk.

C. Remove wet clothing. Cover patient with dry blankets. Do not rub patient’s extremities.

D. Assess vital signs (Check pulse for one full minute).

Pulse Present

BLS/ALS

A. If patient presents with altered level of consciousness, see Altered Level of Consciousness protocol

Pulse Absent

BLS

A. Begin CPR and request ALS.

ALS

1. If monitor shows an organized rhythm, do not initiate CPR.

2. Initiate CPR if the patient is found to be in asystole or ventricular fibrillation.

3. Intubate if there are no spontaneous respirations. Do not hyperventilate (rapid correction of acidosis may induce ventricular fibrillation).
Trauma

INITIAL TRAUMA CARE

- To be performed on all patients following a traumatic or suspected traumatic event.
- As scene evaluation, initial assessment, rapid trauma assessment, focused assessment, on-going assessment, and detailed physical exam are part of the training of EMTs and paramedic, the details of those steps will not be provided in this protocol. It is expected that EMS personnel will perform in accordance to their training.

BLS

A. Begin Initial Medical Care.
B. Follow Airway Management protocol.
C. Follow Oxygen Administration protocol.
D. Record LOC using AVPU method. Obtain an initial GCS as early as possible.
E. Control all significant external bleeding. If direct pressure, elevation, and pressure points do not rapidly stop the bleeding in an extremity, apply a tourniquet.
F. Direct pressure is the method of choice to control bleeding.
G. Expose patient to perform a detailed physical exam.
H. Cover and keep patient warm between assessments in order to conserve body heat.
I. If patient’s presentation, or the mechanism of injury, meets “Trauma Alert” criteria:
   1. Call for a paramedic unit. See “ALS and BLS Team Approach”.
   2. Rapidly extricate with cervical spine immobilization.
   3. Try to keep scene time to 10 minutes or less. If scene time exceeds 10 minutes, document the reason for the delay.
J. Patients with major multiple system trauma or penetrating trauma to the head, neck, chest or abdomen should be transported to a Trauma Center. Patients with serious burns should be transported to a Burn Center. If the patient can be transported by BLS to a Trauma or Burn Center in less time than it would take for ALS to arrive, then transport by BLS.

ALS

K. During transport – Establish 2 large bore IV’s of 0.9% NaCl. Titrate fluids to a SBP of 90 mmHg.
L. Apply cardiac monitor.
M. Intubation with C-spine control may be necessary to maintain a patent airway and/or to prevent aspiration of vomitus. Do not nasally intubate patients with facial trauma.
N. If an IV cannot be established and an urgent need for vascular access exists, establish IO access.
Trauma

MAJOR TRAUMA CRITERIA

Physiologic
- Systolic BP < 90 mm Hg
- Glasgow Coma Scale (GCS) ≤ 13
- Respiratory rate < 10 or > 29
- Patient receiving blood to maintain vital signs
- Airway or respiratory compromise as defined by:
  - BVM, Intubation, adjunct airway, or cricothyroidotomy in the field
  - Needle chest decompression

Anatomic
- Penetrating trauma to the head, neck, chest, abdomen, or extremities proximal to the knees and elbows
- Traumatic amputation proximal to the wrist or ankle
- Burns > 15% or high voltage (>1000 volts) electrical injury
- Any crushed, degloved, pulseless, or mangled extremity
- Pelvic fracture
- Two or more long bone fractures (tibia/fibula or radius/ulna count as only 1 bone)
- Flail chest
- Extremity paralysis suggestive of spinal cord injury
- Open or depressed skull fracture
- Victim of hanging who meet above criteria

حصر Healthcare provider discretion

TRAUMA ALERT CRITERIA

Mechanism of Injury
- Ejection from vehicle
- Vehicle roll-over
- Prolonged extrication from vehicle
- Pedestrian struck by vehicle at speed > 20 MPH
- Falls > 20 feet (adults) or > 3x the child’s height

حصر Healthcare provider discretion
Trauma

OUT-OF-HOSPITAL SPINAL CLEARING/IMMOBILIZATION

A. Spinal immobilization is to be provided to blunt trauma patients only if significant evidence of spinal injury exists, see below.

B. Penetrating trauma patients do NOT require full spinal immobilization on backboard for transport.

C. Patients that are ambulatory upon arrival do NOT require full spinal immobilization on backboard for transport.

BLS/ALS

1. Cervical collar immobilization should be used for trauma patients meeting any of the following:
   a. Presence of midline bony tenderness of c-spine to palpation or with movement
   b. Focal neurologic deficit present or reported
   c. Age <8 or >65
   d. Intoxication
   e. Distracting injury present
   f. High risk injury/mechanism of injury or medic discretion

2. Cervical collar and long spine board immobilization should be provided to patients meeting Trauma Alert criteria and any of the following
   a. Unconscious or altered mental status on exam
   b. Neurologic deficit present or reported
   c. Midline spinal tenderness or deformity
   d. Intoxication

   ✴ If a long spine board is used for extrication purposes only, and the patient does not meet the above criteria, the patient does NOT need full spinal immobilization for transport unless necessary for patient safety. The patient can be moved onto the stretcher.

   ✴ Patients who are ambulatory upon arrival do NOT require full spinal immobilization on a backboard for transport.

SPINAL IMMOBILIZATION FOR THE PREGNANT TRAUMA PATIENT

A. During the third trimester, transport the patient in the left lateral recumbent position (tilted 20-30 degrees to the left by securing the patient to the backboard and tilting the backboard with pillow or blankets).

B. If the patient is hypotensive, transport the patient in the left lateral recumbent position (tilted 20-30 degrees to the left) and re-check the vital signs.
Special Trauma Situations

**EYE INJURIES**

A. Assess for the following:

1. Intact globe (do not touch the globe).
2. Hemorrhage, lacerations, contusions.
3. Ability of both eyes to move together.
4. Fluid from the globe.
5. Decreased visual acuity (unable to see light, hand motion, or count fingers)
6. Visible foreign bodies.

B. Cover both eyes when bandaging, but avoid pressure on the eyes.

C. Do not remove impaled objects – stabilize.

D. Cover avulsed eye with paper cup if available.

E. For chemical burns, irrigate the eye with normal saline or water for 20 minutes and then bandage both eyes. If initiating transport will not interrupt eye irrigation, continue irrigation en route to the hospital.

**CHEST INJURIES**

**BLS**

A. Assess for flail segments or rib fractures. If present, use a bulky dressing or blanket to stabilize. Do not use sandbags.

B. Cover open chest wounds with an occlusive dressing. Apply on exhalation. Watch for signs of increased respiratory distress and decreasing blood pressure. If this occurs lift one edge of the dressing long enough to allow air to escape.

C. Stabilize impaled objects. Secure occlusive (e.g., Vaseline®) gauze at base of impaled objects.

D. Assess breath sounds every 5 minutes.

E. If level of consciousness is decreased or vital signs abnormal; transportation by advanced life support is preferred.

**ALS**

1. If tension pneumothorax is suspected perform needle decompression (see Needle Chest Decompression).
Special Trauma Situations

**ABDOMINAL INJURIES**

A. If an evisceration is present, keep it covered with moist sterile, non-adherent dressings. Use normal saline. Do not attempt to replace organs. Do not use Vaseline dressing.

B. Transportation by ALS is preferred.

**MUSCULOSKELETAL INJURIES**

A. Assess distal circulation, movement, and sensation before moving the injured extremity.

B. Cover open wounds with a sterile dressing. If bone is exposed, use a moist, sterile saline dressing.

C. Splint the injured extremity.

D. Do not attempt to straighten the extremity unless pulses are absent. Never attempt to straighten an injury involving a joint. If resistance is met while straightening a limb, splint the injury as it is.

E. Reassess distal circulation, movement and sensation.

F. Elevate the extremity in a supported position and apply cold packs.

G. When in doubt, splint.

H. If the patient is in more pain after splinting of the injured part, reassess and re-splint.

I. Care of amputated parts:

   1. Rinse away gross contamination with sterile saline.

   2. Cover the injured site on the amputated part with a moist, sterile saline dressing and bulky bandage.

   3. Place the amputated part in a plastic bag. If ice is immediately available, place the plastic bag on ice. Do not delay transport to obtain ice.

   4. Do not clamp bleeders. Apply a compression dressing.
BURNS

A. Protect yourself!

B. Remove the patient from the source, put out fire on the patient and remove burned clothing.

C. Address the more life threatening injuries first, and then treat burns.

D. Maintain sterility when treating burns.

E. Estimate the percentage and degree of burns using the rule of nines, or as an alternative for burns less than 10 percent, the palm of the patient’s hand is equivalent to ~1% BSA.

F. Categorize type of burn and provide appropriate treatment:

Thermal burns –

1. Suspect inhalation injury in any patient with facial burns or involvement in any fire in an enclosed space.

2. For first and second degree thermal burns involving < 10% body surface, soak area with sterile water for 10-15 minutes until temperature is the same as the normal skin, then cover. Do not apply cold packs to burned areas.

3. For all other thermal burns, cover with dry, sterile dressings or burn sheets (If in doubt whether to soak burns, leave dry.)

4. Leave unbroken blisters intact.

Chemical burns –

1. Brush off excess dry agent

2. Copious irrigation with saline or water for at least 20-30 minutes.

3. Transport in dry sterile sheets.

4. Keep warm – protect from hypothermia associated with wet skin.

Electrical burns –

1. Turn off the source.

2. Be aware of musculoskeletal injuries and an irregular pulse.

3. Look for entrance and exit wounds.

G. Place the patient on high flow oxygen with a non-rebreather at 10 – 15 LPM.
H. ALS is preferred for:
   1. Any burns complicated by fractures
   2. All electrical burns
   3. Any burns complicated by smoke inhalation, damage to the airway or confinement in an enclosed space.
   4. Pediatric patients
   5. Partial or full-thickness burns of > 10% BSA.
   6. Burns involving hands, feet, face, genitalia or joints
   7. Patients meeting medical alert criteria
   8. Patients meeting trauma criteria

ALS

1. Intubate the patient if indicated. Strongly consider oral intubation if LOC is decreasing and one or more of the following signs are present:
   a. Obvious oral inhalation injury (e.g., increasing hoarseness, stridor)
   b. Soot in the airway or nasal hair burned

2. Apply the cardiac monitor to non-burned skin.

3. Initiate an IV with normal saline for partial or full thickness burns > 20% BSA, other associated trauma, significant dysrhythmias, or need for intubation.
   a. Insert IV catheter preferentially through non-burned skin.
   b. Run wide open until arrival at hospital or 1000 mL infused.
   c. Document total IV fluids given in the field and advise receiving facility upon arrival.

4. Administer fentanyl as appropriate (See Pain Management protocol)

* Burn injuries that should be referred to a burn center include:

- Partial thickness burns greater than 10% total body surface area (TBSA).
- Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
- Third degree burns in any age group.
- Electrical burns, including lightning injury.
- Chemical burns.
- Inhalation injury.
- Burn injury in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
- Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit. Paramedic judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
- Burned children in hospitals without qualified personnel or equipment for the care of children.
- Burn injury in patients who will require special social, emotional, or rehabilitative intervention.
BURN SEVERITY

<table>
<thead>
<tr>
<th>BSA</th>
<th>Superficial</th>
<th>Partial Thickness</th>
<th>Full Thickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Moderate &gt;50%</td>
<td>Critical &lt;30%</td>
<td>Critical &lt;10%</td>
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<tr>
<td>90%</td>
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<td>80%</td>
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<td>2%</td>
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<tr>
<td>0%</td>
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</tbody>
</table>

Critical Any partial or full thickness burn involving hands, feet, face, genitalia, or joints
Special Trauma Situations

**EMD WEAPON (e.g., Taser®) INJURIES**

This protocol is intended to provide guidelines for care of patients following the use of EMD weapons (e.g., the X26 TASER®). For situations involving altered level of consciousness, significant secondary trauma or other medical problems, follow the applicable protocol(s).

A. Assure the scene is secure. Use of this type of weapon to subdue a violent person implies he/she was a risk to him/herself or others.

B. Evaluate and treat for secondary injuries/altered level of consciousness as indicated.

C. Stabilize dart(s) in place and transport patient to ED if the dart(s) is/are embedded in the eyelid/globe of eye, genitalia, or face/neck.

D. Darts in other locations may be carefully removed by gently pulling backwards in the same plane as they entered the body. Assure the dart is intact and no portion of the dart remains inside the patient’s skin.

E. Provide the darts to law enforcement officers.

F. Control minor bleeding and clean the wound area(s) with alcohol and/or povidone-iodine solution. Cover with an adhesive bandage.

G. If all darts are out, any minor bleeding is controlled, and no other injuries or symptoms exist, EMS transport is not indicated and an SOR may be obtained.
TRAUMATIC BRAIN INJURIES

A. Identify patients with physical trauma and a mechanism consistent with the potential to have induced brain injury and:
   1. GCS of 12 or less
   2. GCS <15 with decreasing mental status
   3. Multisystem trauma requiring intubation (whether the primary need for intubation was from TBI or from other potential injuries)
   4. Post-traumatic seizures (whether status or not).

B. Elevate head of gurney 30° if possible.

C. Start 6 L/min O₂ via nasal cannula and obtain IV access when applicable.

D. Monitor O₂, BP, HR, and neurologic status every 3-5 minutes.

E. Maintain oxygen saturation > 90%.
   1. If oxygen saturation falls below 90% despite nasal cannula, reposition airway and increase to NRB mask (see Airway Management protocol).
   2. If continued saturation <90%, start BVM ventilation with airway adjuncts (eg, OP or NP airway when appropriate).
   3. If airway compromise or hypoxia persists after these interventions, a non-visualized airway or ETI should be considered (see Airway Management protocol).

F. Maintain Normo-Ventilation.
   1. If there is evidence of hypoventilation (ineffective respiratory rate, shallow or irregular respirations or periods of apnea) despite high-flow O₂, assist ventilation with BVM and if ineffective, consider non-visualized airway or ETI (see Airway protocol).
   2. When assisting ventilation with BVM, maintain respiratory rate according to the following:
      - 25 breaths per minute in infants (0-24 mo)
      - 20 bpm in children (2 yo-14 yo)
      - 10 bpm in children aged 15 or older
      - 10 breaths per minute in adults
   3. In intubated patients, use BVM to maintain ETCO₂ between 35 and 45 mmHg.

G. Maintain blood pressure according to the following:
   - >70 mmHg for infants 0-24 mo
   - >80 mmHg for children 2 yo-7 yo
   - >90 mmHg for children 8 yo and older and all adults
Prevent even a single isolated episode of hypotension by IV fluid resuscitation with initial bolus of 1 L NS, followed by repeat boluses of 500 ml NS to keep SBP>90 mmHg in adults. 20 ml/kg for pediatric patients, followed by repeat boluses of 10 ml/kg NS or at sufficient rate to keep SBP as above. Do not treat hypertension, but restrict IVF TKO in adults with SBP >140 mmHg, infants with SBP >100 mm Hg and older children/adolescents with SBP >130 mmHg.

H. Check for hypoglycemia.

1. For blood sugar < 70 mg/dL, follow Hypoglycemia protocol.
2. Recheck blood sugar 10 minutes after administration of dextrose, and repeat treatment X 1 if BS <70 mg/dL.

H. Evaluate for impending herniation, including dilated/unresponsive pupils; GCS <9 or rapid deterioration in GCS by >2 points; extensor posturing; asymmetric pupils (one or both non-reactive to light).

1. In presence of impending herniation, proceed with moderate hyperventilation at
   
   - 20 breaths/min OR enough to maintain ETCO$_2$ 28-31 in adults
   - 30 breaths/min in infants (0-24 mo)
   - 25 bpm in children (2 yo-14 yo)
   - 20 bpm in adolescents (15 yo-17 yo) OR enough to maintain ETCO$_2$ 28-31.

2. Avoid ETCO$_2$ <28 mmHg.
MATERNAL BLEEDING DURING PREGNANCY

BLS
A. Begin Initial Medical Care.
B. Follow “Airway Management” protocol.
C. Administer oxygen at 10-15 lpm by NRB mask.
D. If patient has signs/symptoms of shock, call for a paramedic unit. See “ALS and BLS Team Approach”.
E. Have patient estimate the number of pads soaked per hour. Determine when bleeding began.
F. Prepare to treat for shock.
G. Transport emergent in left lateral recumbent position if ≥ 20 weeks gestation or if uncontrollable bleeding is present.

ALS
1. Establish 2 large bore IV’s of 0.9% NaCl. Titrate fluid to a SBP of 90 mmHg.

Refer to Non-Cardiogenic Shock and other protocols as patient condition requires.

PREECLAMPSIA/ECLAMPSIA

Any pregnant or recently delivered (within 4 weeks) woman with the presence of hypertension (BP >140/90) and marked edema of the face, hands, and/or feet.

A. Begin Initial Medical Care.
B. Administer high flow oxygen to mother. (See Administration of Oxygen Protocol)
C. Transport non-emergently (without lights or siren) in a darkened ambulance.
D. If patient begins to have seizures, see Seizures Protocol – Note that midazolam is still given before the magnesium.

PROLAPSED UMBILICAL CORD
A. Administer high flow oxygen to the mother. (See Administration of Oxygen Protocol)
B. Place patient in left lateral recumbent position.
C. Elevate presenting part off of the umbilical cord by using a gloved hand in vagina. Keep elevated until relieved at hospital.
D. Call for ALS and initiate transport.
E. Contact receiving facility as early as possible
Obstetrical Emergencies

BREECH PRESENTATION

A. Administer high flow oxygen to the mother. *(See Administration of Oxygen Protocol)*

B. Place patient in left lateral recumbent position.

C. Check for prolapsed cord.

D. Contact receiving facility as early as possible

POSTPARTUM HEMORRHAGE

*Any patient who has an estimated blood loss exceeding 500 ml following childbirth.*

BLS

A. Contact receiving facility for further orders if ALS is not on scene.

B. Call for ALS and initiate transport.

C. Administer high flow oxygen to mother. *(See Administration of Oxygen Protocol)*

D. Massage the fundus of the uterus after delivery of the placenta until firm. Check fundus every 5 minutes for firmness and repeat massage as necessary.

ALS

1. Insert 2 large bore IV’s with normal saline and run wide open to maintain a SBP of 90mm Hg.

2. Contact receiving facility as early as possible
Newborn Care

DEVELOPMENT OF THE NEWBORN

| If delivery is determined to be imminent, follow the guidelines below. Delivery may be imminent even though the bag of waters has not broken. If the mother is not at full term, or if signs of meconium stain are present, call for ALS. |

A. Obtain the following information:

1. Due date.
2. Frequency of contractions.
3. Number of pregnancies (gravida), number of children born (para)
4. History of pre-term or post-term deliveries.
5. Sensation of the need to move bowels (delivery is imminent).
6. Presence of crowning (delivery is imminent).

B. If no crowning is present, begin transportation in the left lateral recumbent position. If crowning is present, prepare to deliver the infant.

C. Administer high flow oxygen to the mother. *(See Administration of Oxygen Protocol)*

D. Assist with the delivery. *(See Newborn Care Protocol)*

1. Guide and control but do not try to stop the delivery.
2. Don't pull on infant or put traction on cord.
3. If cord is around the neck of the infant, slip it over the head. If unable to slip the cord over the head, immediately clamp the cord in two places and cut between the clamps. Continue with delivery.
4. Look for presence of meconium staining. *(See Meconium Staining)*
5. After completion of delivery, vigorously stimulate the infant.
6. Wait at least one minute before clamping the newborn’s cord.

E. Provide post-partum care to the mother. After the placenta is delivered (or 5 minutes after the baby is born, whichever comes first), initiate patient transportation. Massage the fundus of the uterus after delivery of the placenta. Wrap up the delivered placenta and take it to the hospital.

F. Contact the receiving facility for early notification.
**NEWBORN CARE**

A. Stimulate the infant to cry by rubbing the back. Keep infant warm and dry – cover the body and head.

B. Keep baby at the same level of the perineum for at least 1 minute. Clamp and cut the cord. Place one clamp six inches from the infant, the second clamp three inches distal from the first clamp. Cut the cord between the clamps. If cord continues to bleed, apply additional clamps.

C. Record the time of birth. Determine APGAR scores at one and five minutes after birth.

D. Normal respiratory rate is 40-60 minute and pulse is 120-160 minute.

E. Contact the receiving facility for early notification.

<table>
<thead>
<tr>
<th>SIGN</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIVITY</td>
<td>Limp</td>
<td>Some extremity flexion</td>
<td>Good extremity flexion</td>
</tr>
<tr>
<td>PULSE</td>
<td>Absent</td>
<td>&lt;100</td>
<td>≥100</td>
</tr>
<tr>
<td>GRIMACE</td>
<td>Absent</td>
<td>Some facial grimace</td>
<td>Strong grimace</td>
</tr>
<tr>
<td>APPEARANCE</td>
<td>Blue</td>
<td>Blue extremities, pink torso</td>
<td>All pink</td>
</tr>
<tr>
<td>RESPIRATORY EFFORT</td>
<td>Absent</td>
<td>Weak cry</td>
<td>Strong cry</td>
</tr>
</tbody>
</table>

**MECONIUM STAINING**

Presence of green amniotic fluid or green/black particulate material on face or in upper airway.

A. After completion of delivery, using a catheter or bulb syringe, suction mouth and then nose of newborn.

B. Wipe away any collection of meconium in the upper airway with gauze-wrapped finger.

**BLS**

1. Request ALS if not already en route and initiate transport. Avoid stimulating infant. Contact receiving facility for further orders if ALS is not on scene.

**ALS**

1. In the nonvigorous infant only, insert endotracheal tube and suction. Use meconium aspirator if available.
Newborn Care

NEWBORN RESUSCITATION (TIME OF DELIVERY)

If any of the following are present:
- respiratory rate < 30
- heart rate < 100
- presence of central cyanosis

Perform the following procedures in a stepwise fashion as indicated.
Reassess after each step before proceeding to the next.

BLS

A. Perform tactile stimulation: drying, warming, and positioning.

B. Administer blow-by oxygen at 5-6 lpm. If infant is apneic, gasping, or has a HR < 100 skip blow-by O2 and move on to next step

C. Suction only if an obvious obstruction is seen or the neonate requires positive pressure ventilation.

E. Ventilate using bag-valve-mask at a rate of 40-60/minute.

F. If HR is < 60 BPM perform 30 seconds of BVM only. IF HR CONTINUES TO BE < 60BPM after 30 seconds of BVM add chest compressions.
   1. Chest compressions should be performed at 90 compressions per minute
   2. BVM should be given at a rate of 30 breaths/minute
      a. Ratio is 3:1 of compressions to breath

* Continue until heart rate is ≥ 60 bpm

G. Request ALS if not already en route and initiate transport. Contact receiving facility for further orders if ALS is not on scene.

ALS

1. Intubate the patient only if BVM ventilation/oxygenation is inadequate.
Section THREE

Procedures
Procedures

VERIFICATION OF ENDOTRACHEAL TUBE AND SUPRAGLOTTIC AIRWAY
DEVICE PLACEMENT-ALS

End-Tidal-Carbon-Dioxide detection (EtCO2) should be used to confirm the initial placement of the ETT on ALL intubated patients (in addition to physical exam) per EtCO2 standard operating procedure, on any ambulance that has the capability of performing capnography. Continuous EtCO2 monitoring should be used throughout patient encounter on ALL intubated patients.

Endotracheal Tubes are to be confirmed and secured prior to moving the patient. Any time the patient has been moved (i.e. from the scene to the vehicle, in the vehicle, from the vehicle to the ED) the ETT placement is to be re-confirmed.

This will also apply to supraglottic airway devices (King airway, LMA, etc)

Documentation on the run sheet is to include:

1. Bilateral breath sounds, absence of epigastric sounds
2. Size of ETT and depth of insertion (in centimeters)
3. Method of securing the ETT
4. EtCO2 measurement (initial reading and any changes during patient encounter)

Confirmation signature at the receiving facility is required upon ETT placement verification in the Emergency Department.

Capnography Waveform Review

![Normal waveform](image1)

“Shark fins” – indicates bronchospasm
Displaced ET tube / Apnea

Hypoventilation

Hyperventilation

Air trapping or inadequate exhalation as in COPD or asthma
Procedures

VERIFICATION OF ENDOTRACHEAL TUBE PLACEMENT
WITH ESOPHAGEAL DETECTOR DEVICE/COLORIMETRIC-ALS

The following shall be used **ONLY** if capnography is not available:

If capnography available, see “Verification of Endotracheal Tube (ETT) and Supraglottic Airway Device Placement Procedure”

The Esophageal Detector Device (EDD) may be used to verify initial tube placement:

1. Intubate the patient
2. Inflate the cuff
3. Apply the EDD
   a. Pull back on plunger
   b. Measure ease of filling of EDD*

<table>
<thead>
<tr>
<th>Correct Placement</th>
<th>Incorrect Placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy filling / plunger moves easily to 40 ml.</td>
<td>Poor filling / plunger resistant at 10 ml</td>
</tr>
<tr>
<td></td>
<td>Reassess tube and return to step 1 (one).</td>
</tr>
</tbody>
</table>

* False negatives may include obesity, blood in the airway, pulmonary edema, pneumothorax, and deep mainstem intubation. False positives may be seen with excessive gastric insufflation prior to intubation.

4. Auscultate for positive breath sounds and negative epigastrium sounds.
5. Secure the tube.

A. The colorimetric carbon dioxide detector may be used to verify initial tube placement in patients who have a palpable pulse:

1. Place colorimetric carbon dioxide detector and ventilate patient 6 times.
   a. Observe for color changes to “C”/yellow range – this is suggestive of appropriate tube placement.
   b. Observe for no change (remains in “A”/purple range) or minimal change (goes to “B”/tan range). Critically evaluate tube placement and rule out low cardiac output.

The Colorimetric C02 Detector and Esophageal Detector Device are adjuncts to assessment of the ETT placement. They are not substitutes for other methods of evaluation (e.g., auscultation of breath/epigastric sounds).
CRICOTHYROTOMY-ALS

SURGICAL CRICOTHYROTOMY

A. Position adult patient (age greater than 8 years) by hyperextending the neck unless c-spine concerns mandate neutral positioning.

B. Locate the cricothyroid membrane.

C. Clean the incision site, if possible.

D. Incise the skin vertically over the membrane.

E. Bluntly dissect down to the cricothyroid membrane.

F. Incise the lower portion of the membrane horizontally with scalpel and rotate the blade 90°.

G. Enlarge and maintain the opening with hemostats or the end of the scalpel.

H. Insert cuffed endotracheal tube and inflate cuff.

I. Confirm correct placement by use of the EtCO2, if available, or Esophageal Detector Device/colorimetric ETCO2 detector and auscultating for breath sounds over both lungs and stomach.

J. Cover wound with occlusive dressings and secure the tube.

K. Reassess breath sounds.

### COMPLICATIONS OF CRICOTHYROTOMY

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoxemia</td>
<td>Injury to the thyroid/parathyroid glands</td>
</tr>
<tr>
<td>Hypercarbia (CO2 toxicity)</td>
<td>Subcutaneous and mediastinal emphysema</td>
</tr>
<tr>
<td>Perforation of the esophagus</td>
<td>Infection</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>Damage to tracheal cartilage involving disruption of vocal cords</td>
</tr>
</tbody>
</table>

**If cricothyrotomy is attempted, a copy of the run record must be made available to the Medical Director through the CQI Coordinator within 24 hours of the run.**
Procedures

**CRICOTHYROTOMY-ALS**

**NEEDLE CRICOTHYROTOMY**

A. Position pediatric patient (age 8 years or less) by hyperextending the neck unless c-spine concerns mandate neutral positioning.

B. Locate the cricothyroid membrane.

C. Clean the puncture site, if possible.

D. Connect a syringe to the end of the catheter/needle.

E. Insert the catheter/needle into the cricothyroid space at less than 90 degrees to the longitudinal axis of the neck and caudally. Maintain suction with the syringe until air freely flows into the syringe or until bubbles are noted (if the syringe is partially filled with saline).

F. Advance the catheter over the needle, and then remove the needle.

G. Reconfirm placement with free-flow aspiration or the syringe bubble technique.

H. Attach a mechanism to provide high flow oxygen through the catheter (e.g., a 3.0 ET tube adapter plus BVM or an oxygen supply tubing, 3-way stopcock, and extension set) and begin oxygenation.

I. Watch for prompt chest inflation and auscultate for breath sounds over both lungs and stomach.

J. Secure the catheter carefully; avoiding kinking the cannula.

K. Reassess breath sounds.

<table>
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If cricothyrotomy is attempted, a copy of the run record must be made available to the Medical Director through the CQI Coordinator within 24 hours of the run.
CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)

Indication: Along with medical (pharmacologic) management, treatment for respiratory distress as evidenced by:
- Persistent dyspnea/hypoxemia
- History consistent with heart failure, volume overload, COPD or asthma exacerbation

Patients must meet the following criteria for CPAP administration:
1. Age greater than or equal to 18 y/o
2. Has the ability to maintain and protect an open airway
3. Systolic BP at or above 90 mm Hg
4. Pulse oximetry < 92% on 100% oxygen plus at least two (2) of the following:
   - Severe or sudden onset of shortness of breath
   - RR rate > 25/minute
   - Use of accessory muscles
   - Dyspnea at rest
   - Rales or wheezes

Contraindications:
1. Respiratory or cardiac arrest
2. Agonal respirations
3. Suspected or confirmed pneumothorax or penetrating chest trauma
4. Inability to maintain a patent airway
5. Any impediment to proper mask placement or seal (facial trauma, stroke, facial anomalies, epistaxis)
6. Tracheostomy
7. Persistent nausea and vomiting/Upper GI bleeding
8. Inability to comply with the device due to severe anxiety or altered mental status

Procedure
1. Assure patent airway, place patient on EKG monitor and pulse oximetry; capnography if available.
2. Explain procedure to the patient and reassure.
3. CPAP does not replace pharmacology – initiate medications first if applicable:
   a. If suspected pulmonary edema and SBP > 90 mm Hg, administer three 0.4 mg doses of NTG SL and repeat three 0.4 mg doses every 3 minutes if SBP remains at or above 90 mm Hg and patient remains dyspneic.
      1) Remember to avoid the use of NTG in the setting of Viagra, Levitra, Cialis, or other ED drug use.
   b. If asthma or COPD is suspected, administer 5 mg albuterol and 0.5 mg ipratropium per nebulizer and repeat every 10 minutes if the patient remains dyspneic (not to exceed 3 doses of ipratropium).
   c. If the 2nd round of pharmacologic therapy (above) fails to resolve the patient’s dyspnea, and they remain hypoxemic (oxygen saturation < 92% on 100% oxygen), then CPAP may be initiated.
4. Ensure adequate oxygen supply to device, if needed, set manufacturers recommended liter flow.
5. Place mask and hold in place as patient adjusts to ventilatory support. Encourage patient to breathe deeply.
6. Secure mask, check for air leaks and if recommended by manufacturer, increase liter flow as needed.
7. Contact receiving hospital as early as possible to allow Respiratory Therapy to prepare their equipment.
8. Monitor and document patient VS and pulse oximetry (watch for decreased respiratory rate and/or mental status).
9. If patient deteriorates, remove device and consider BVM ventilations or ET intubation.

**Documentation**

Documentation should include all of the following:

1. CPAP level (cm H$_2$O)
2. SpO$_2$ every 5 minutes
3. Vital signs (HR, RR, BP)
4. Response to treatment including, SpO$_2$, RR and work of breathing
5. Adverse reactions
6. Clinical Impression on patient care form (respiratory distress and/or CHF/Asthma/COPD)
Procedures

**NEEDLE DECOMPRESSION-ALS**

A. Auscultate the chest to confirm which side has a suspected tension pneumothorax (indicated by absence/decrease in breath sounds, hypotension, and significant respiratory distress)

B. Locate the second intercostal space at the midclavicular line.

C. Clean the skin.

D. Insert a 3” needle over the superior border of the 3rd rib perpendicular to the floor/cot and with the bevel pointing toward the midline.

   1. When the needle reaches the visceral pleura, you may feel a “pop” and/or air may rush out

E. Reassess and re-auscultate for improvement of breath sounds, pulse, respirations, and blood pressure.

F. Remove the needle and tape the catheter in place.

G. Reassess and re-auscultate for improvement of breath sounds, pulse, respirations, and blood pressure.

<table>
<thead>
<tr>
<th>COMPLICATIONS OF NEEDLE DECOMPRESSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhage from laceration of intercostal vessels</td>
</tr>
<tr>
<td>Hemorrhage from laceration of a pulmonary vessel</td>
</tr>
<tr>
<td>Puncture of the lung</td>
</tr>
</tbody>
</table>

If needle decompression is attempted, a copy of the run record must be made available to the Medical Director through the CQI Coordinator within 24 hours of the run.
Procedures

APPLICATION OF EXTERNAL PACEMAKER-ALS

Criteria:  Any patient 18 years or older with a non-traumatic presentation of atropine-refractory symptomatic bradycardia

A. Assess for signs of instability.
   1. Heart rate < 60/min and
   2. SBP < 90 mmHg and
   3. Signs and symptoms of shock

B. Apply pacing electrodes.
   1. The anterior-posterior (AP) placement of the pacing electrodes is preferred. If absolutely necessary, anterior-anterior (AA) placement may be used.

   **AP placement**
   
   a. Place negative electrode on left anterior chest halfway between the xyphoid process and the left nipple with the upper edge of the electrode below the nipple line.
   
   b. Place the positive electrode on the left posterior chest beneath the scapula and lateral to the spine.

   **AA placement**
   
   a. Place negative electrode on left chest, midaxillary over the fourth intercostal space.
   
   b. Place positive electrode on anterior right chest, inferior to clavicle.
   
   c. This position should only be used if AP placement is not possible.

C. Pacing procedure:
   1. Maintain EKG monitoring during pacing procedure.
   
   2. Attach pacing electrodes and connect pacing cable to pacemaker.
   
   3. Power up pacemaker.

D. Observe monitor for a "sense" marker. One mark should appear on each QRS complex. If it does not appear or only appears intermittently, the pacemaker is not sensing the intrinsic rhythm of the patient. Adjust EKG size (larger) or change from Lead II to Lead I or III in order to achieve sensing. If more than one sensing mark appears for each QRS, the EKG size is probably too high. If intrinsic beats are not present, omit this step.

E. Adjust milliamp (mA) output to start at 10 mA. Gradually increase mA until electrical capture is noticed on the monitor.
F. Adjust pacing rate to 70 bpm.

G. Assess for mechanical capture by checking for a pulse and blood pressure.
*If electrical capture is present but no pulse is present, increasing the mA is of no benefit.

H. Record time of application and obtain rhythm strips before and after application.

* If the patient’s intrinsic rate exceeds the pacing rate, the pacemaker will sense the activity and not discharge.

* Musculoskeletal discomfort may accompany external pacing. If this is a problem and the patient’s vital signs will allow it, sedation and/or analgesia may be appropriate.
GUIDELINES FOR IV/IO-ALS

A. IVs should only be initiated for patients needing out-of-hospital IV medication administration, rapid fluid replacement, or for those patients who are likely to decompensate before arriving at the hospital.

1. Aseptic technique must be observed.
2. Peripheral sites, including the external jugular, are the routes of choice. Upper extremity placement is preferred to lower.
3. IV/IO placement attempts should not delay appropriate and timely patient care.

B. An IO may be considered if an IV cannot be placed in the following patient situations:

1. Cardiac arrest (medical or traumatic)
2. Profound hypovolemia (shock) with significantly altered mental status
3. Emergent need for an IV but veins are not immediately available

Whenever an IO has been established or attempted unsuccessfully, identify the site(s) and/or the attempt(s) to the receiving hospital personnel. Document the time of insertion.

C. An IO may not be attempted more than one time in the same extremity.

D. In order to minimize dislodgement, humeral head placement requires securing the upper extremity to limit external rotation.

E. Basic-Advanced EMT’s may initiate IV’s in order to assist the paramedic. Patient care and transport are to be continued by the paramedic.

COMPLICATIONS

- Abscess from prolonged insertion
- Leakage around the needle with compartment syndrome
- Tibia fractures
- Osteomyelitis from prolonged insertion
- Potential injury to the bone marrow cavity
- Skin necrosis
**ADULT INTRAOSSEOUS INFUSION-ALS**

A. Prepare the IO insertion device and needle

B. Locate insertion site
   1. Proximal humerus (preferred)
   2. Tibia plateau

C. Cleanse insertion site.

D. Stabilize extremity and insert the needle following the manufacturer’s recommendations.

E. Remove driver from needle set while stabilizing catheter hub

F. Remove stylette from needle set and secure until it can be placed in a sharps container.

G. Confirm placement. It may be possible to aspirate bone marrow at this point with a 20 or 30 mL syringe.

H. If the patient is awake and alert administer *prime all tubing with lidocaine instead of saline and 2 mL 2% lidocaine slowly over 60 seconds, then allow 30-60 seconds for the lidocaine to affect the visceral nerves. Follow with a brisk 10 mL saline flush. Another 1 mL 2% lidocaine may be administered in the same manner.*

I. Connect primed IV line and begin infusion

J. Place a pressure bag (or IV infusion pump) on solution being infused where applicable

K. Secure tubing and dress site using commercial stabilizer if available, secure tubing

L. Frequently monitor IO catheter site and patient condition

<table>
<thead>
<tr>
<th>COMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Abscess from prolonged insertion</td>
</tr>
<tr>
<td>● Leakage around the needle with compartment syndrome</td>
</tr>
<tr>
<td>● Tibia fractures</td>
</tr>
<tr>
<td>● Osteomyelitis from prolonged insertion</td>
</tr>
<tr>
<td>● Potential injury to the bone marrow cavity</td>
</tr>
<tr>
<td>● Skin necrosis</td>
</tr>
</tbody>
</table>
Procedures

PEDIATRIC INTRAOSSEOUS INFUSION-ALS

A. Place the child in the supine position.

B. Identify the tibia tuberosity, 1-3 cm below the tuberosity on the medial surface of the tibia, approximately one finger’s breath below and just medial to the tuberosity.

1. Alternatively, 1 - 2 cm proximal to the medial malleolus on the anteromedial surface of the distal tibia.

C. Clean the skin.

D. The leg should be supported on a firm surface. Grasp the thigh and knee above and lateral to the insertion site. Do not allow any portion of your hand to rest behind the insertion point.

E. With the stylette in place, insert the needle at a 90°angle to the skin.

1. Using gentle pressure that is steady, begin to advance the needle through the skin until you touch the bone, then check needle depth. If at least 5mm of needle remains exposed (the last black line) drill through the bone.

2. Stop advancing the needle when a sudden decrease in resistance to forward motion of the needle is felt. Do not pull back or recoil when entering the medullary space. Unscrew the cap and remove the stylette. It may be possible to aspirate bone marrow at this point with a 20 or 30 mL syringe.

F. Stabilize the IO.

G. If the patient is awake and alert, prime all tubing with lidocaine instead of saline and administer 1 mL 2% lidocaine over 60 seconds, and then allow 30-60 seconds to affect the visceral nerves. Follow with a brisk 10 mL irrigation of saline. A second dose of 0.5 mL 2% lidocaine may be repeated in the same manner.

H. Check for any signs of increased resistance to injection, increased circumference of the soft tissues of the calf, or increased firmness of the tissue.

1. The needle is in the bone marrow when:
   a. there is a lack of resistance
   b. the needle passes through the cortex
   c. the needle stands upright without resistance
   d. there is no infiltration
   e. blood and marrow are aspirated (less common)
   f. fluid flows freely through the needle without evidence of subcutaneous infiltration
I. Attach the IV tubing and begin the infusion. A pressure infusion bag or in-line 60 mL syringe may be required to infuse the solution.

J. If unsuccessful, remove the needle and move to the other leg.

K. **Secure tubing and** use commercial stabilizer if available or secure with tape.

<table>
<thead>
<tr>
<th>COMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Abscess from prolonged insertion</td>
</tr>
<tr>
<td>● Leakage around the needle with compartment syndrome</td>
</tr>
<tr>
<td>● Tibia fractures</td>
</tr>
<tr>
<td>● Osteomyelitis from prolonged insertion</td>
</tr>
<tr>
<td>● Potential injury to the bone marrow cavity</td>
</tr>
<tr>
<td>● Skin necrosis</td>
</tr>
</tbody>
</table>
Pre-existing Vascular Access Device (PVAD) Use-ALS

PVADs (pre-existing vascular access devices) include any indwelling catheter/device placed into one of the central veins to provide vascular access for those patients requiring long term intravenous therapy and hemodialysis shunts or grafts.

A. Types of Catheters

1. External indwelling catheters/devices

   a. Heparin/Saline Lock - A temporary venous catheter placed in a peripheral vein and occluded with a cap. Heparin or saline is instilled periodically to maintain its patency. It may be accessed directly through the injection cap.

   b. Peripherally inserted central catheter (PICC) - A long catheter inserted in the upper arm or antecubital into the subclavian vein or superior vena cava. It may be accessed through the injection cap.

   c. “Broviac®”, “Hickman®”, “Groshong®”, and others - A long catheter that is inserted into the right atrium through a central vein. The catheter enters the skin through an incision in the chest. The line may be heparinized and may be accessed directly through the injection cap. These catheters are usually multi-lumened and any lumen can be used, but a red-colored port is preferred.

2. Internal indwelling devices – NOT TO BE USED

   a. Internal subcutaneous infusion ports - an access device embedded subcutaneously and must be accessed through the skin using special equipment.

   b. Hemodialysis fistula or graft - A permanent access device that diverts blood flow from an artery to a vein and is usually located in the forearm or upper arm. It is used for dialysis.

B. Indication for use of external indwelling catheters/devices (other than a heparin/saline lock, which may be used as needed):

1. Cardiac arrest

2. Other emergent need to administer fluids and/or medications:
   a. which can only be given by the IV route, and
   b. a peripheral IV site is not readily/immediately available (after 2 tries), and
   c. intraosseous access is not appropriate due to the patient’s condition, and
   d. with approval by on-line medical control.

3. All ALS medications and fluids (approved for IV administration) may be given through a PVAD.

C. Procedure for external indwelling catheters/devices:

   1. Assemble necessary equipment
      a. 10 mL syringe
      b. 0.9 normal saline for injection
      c. IV tubing and fluid
      d. alcohol wipes
      e. 18 gauge needles
2. Disconnect any existing IV lines.
3. Prepare syringe with 10 mL NS and set up IV line.
4. Clean injection cap or needleless-port with alcohol wipe.
   - If there is a red port, use this preferentially
5. If clamped, unclamp catheter.
6. Slowly inject 5 ml of saline – if resistance is met, discontinue procedure.
7. Attach IV tubing to port (using an 18 ga. Needle if an injection cap is in place) and initiate fluid and/or medication therapy
8. Flush line with IV fluid after medication administration.

D. Complications

1. Infection. Due to the location of the catheter end, strict adherence to aseptic technique is crucial when handling these devices. The injection cap or needleless port must be cleansed thoroughly. Sterile gloves are preferred. Care must be used not to contaminate the needle used to access the line or the IV tubing used.
2. Air embolism. These devices provide a direct line into the circulation; therefore the introduction of any air into the device will go straight to the heart. Do not ever remove the injection cap or needleless port from the catheter. Do not allow IV fluids to run dry. Clear all air from the IV tubing and syringes prior to administration of fluids or medications.
3. Thrombosis. Improper handling and maintenance of the device may dislodge a clot causing pulmonary embolus or vascular damage. Check patency of the line by slowly injecting 5 mL of NS. Do not inject medications or infuse fluids if resistance is met when establishing patency of the catheter. Flush line with 5 mL of normal saline after medication administration.
4. Catheter damage. These catheters are meant for long-term use. They usually require an invasive or surgical procedure and are costly to insert. Care must be taken to avoid any damage to the catheter. If damage to the catheter outside the skin occurs, immediately clamp the catheter between the skin exit site and the damaged area to prevent air embolism or blood loss. Always use a 10 mL or larger syringe to prevent catheter damage from excess pressure when injecting directly. Use caution when inserting the needle into the injection port.
### Abbreviation List

The following is a list of acceptable abbreviations to be used when completing patient care records. This list is not all inclusive but to be used as a quick reference of more commonly used abbreviations. If other abbreviations are used, be sure they are proper and widely understood.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Asian</td>
</tr>
<tr>
<td>A&amp;O</td>
<td>alert and oriented</td>
</tr>
<tr>
<td>ab</td>
<td>abortion</td>
</tr>
<tr>
<td>abd</td>
<td>abdomen</td>
</tr>
<tr>
<td>ACLS</td>
<td>Advanced Cardiac Life Support</td>
</tr>
<tr>
<td>AED</td>
<td>automatic external defibrillator</td>
</tr>
<tr>
<td>adm</td>
<td>administered</td>
</tr>
<tr>
<td>Af or afib</td>
<td>atrial fibrillation</td>
</tr>
<tr>
<td>AF</td>
<td>atrial flutter</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AKA</td>
<td>above the knee (amputation)</td>
</tr>
<tr>
<td>AMI</td>
<td>acute myocardial infarction</td>
</tr>
<tr>
<td>amt.</td>
<td>amount</td>
</tr>
<tr>
<td>ant.</td>
<td>anterior</td>
</tr>
<tr>
<td>AP</td>
<td>anteroposterior</td>
</tr>
<tr>
<td>AT</td>
<td>atrial tachycardia dc'd</td>
</tr>
<tr>
<td>AVPU</td>
<td>alert, responsive to verbal stimuli, painful stimuli, or unresponsive</td>
</tr>
<tr>
<td>B</td>
<td>Black (Race)</td>
</tr>
<tr>
<td>BBB</td>
<td>bundle branch block</td>
</tr>
<tr>
<td>BBS</td>
<td>bilateral breath sounds</td>
</tr>
<tr>
<td>BKA</td>
<td>below the knee (amputation)</td>
</tr>
<tr>
<td>Bld.</td>
<td>blood</td>
</tr>
<tr>
<td>BOW</td>
<td>bag of waters</td>
</tr>
<tr>
<td>BS</td>
<td>blood sugar, breath sounds, or bowel sounds</td>
</tr>
<tr>
<td>Brady</td>
<td>bradycardia</td>
</tr>
<tr>
<td>BSA</td>
<td>body surface area</td>
</tr>
<tr>
<td>BVM</td>
<td>bag valve mask</td>
</tr>
<tr>
<td>BW</td>
<td>body weight</td>
</tr>
<tr>
<td>C-c</td>
<td>cervical collar</td>
</tr>
<tr>
<td>C-spine</td>
<td>cervical spine</td>
</tr>
<tr>
<td>C1, C2...C7</td>
<td>1st cervical vertebrae, etc.</td>
</tr>
<tr>
<td>CA or ca</td>
<td>carcinoma, cancer</td>
</tr>
<tr>
<td>CAD</td>
<td>coronary artery disease</td>
</tr>
<tr>
<td>CC</td>
<td>chief complaint</td>
</tr>
<tr>
<td>c/e or c&amp;e</td>
<td>clear and equal</td>
</tr>
<tr>
<td>CHF</td>
<td>congested heart failure</td>
</tr>
<tr>
<td>CHI</td>
<td>closed head injury</td>
</tr>
<tr>
<td>CHD</td>
<td>coronary heart disease</td>
</tr>
<tr>
<td>CNS</td>
<td>central nervous system</td>
</tr>
<tr>
<td>C/O</td>
<td>complains of</td>
</tr>
<tr>
<td>CO</td>
<td>carbon monoxide</td>
</tr>
<tr>
<td>CO₂</td>
<td>carbon dioxide</td>
</tr>
<tr>
<td>COPD</td>
<td>chronic obstructive</td>
</tr>
<tr>
<td>CP</td>
<td>chest pain</td>
</tr>
<tr>
<td>CSF</td>
<td>cerebral spinal fluid</td>
</tr>
<tr>
<td>D₃W</td>
<td>dextrose 5% in water</td>
</tr>
<tr>
<td>d/c</td>
<td>discontinue</td>
</tr>
<tr>
<td>DAP-BTLS</td>
<td>Deformities, Contusions, Abrasions, Punctures, Burns, Tenderness, Lacerations, Swelling</td>
</tr>
<tr>
<td>DEX or DS</td>
<td>dextrostick</td>
</tr>
<tr>
<td>disp</td>
<td>disposition</td>
</tr>
<tr>
<td>DKA</td>
<td>diabetic ketoacidosis</td>
</tr>
<tr>
<td>DM</td>
<td>diabetes</td>
</tr>
<tr>
<td>DNR</td>
<td>Do Not Resuscitate</td>
</tr>
<tr>
<td>DOA</td>
<td>dead on arrival</td>
</tr>
<tr>
<td>DOB</td>
<td>date of birth</td>
</tr>
<tr>
<td>DOE</td>
<td>dyspnea on exertion</td>
</tr>
<tr>
<td>DSD</td>
<td>dry sterile dressing</td>
</tr>
<tr>
<td>DT's</td>
<td>delirium tremens</td>
</tr>
<tr>
<td>Dx</td>
<td>diagnosis</td>
</tr>
<tr>
<td>ECG or EKG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>EMT</td>
<td>Emergency Medical Technician</td>
</tr>
<tr>
<td>EMT-P</td>
<td>Paramedic</td>
</tr>
<tr>
<td>ER (ED)</td>
<td>emergency room (emergency dept)</td>
</tr>
<tr>
<td>ETOH or EtOH</td>
<td>alcohol/ethanol</td>
</tr>
<tr>
<td>FB</td>
<td>foreign body</td>
</tr>
<tr>
<td>Fibr</td>
<td>fibrillation</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>------------</td>
</tr>
<tr>
<td>FH or FHx</td>
<td>family history</td>
</tr>
<tr>
<td>FROM</td>
<td>full range of motion</td>
</tr>
<tr>
<td>FSP</td>
<td>Full spinal precautions (c-collar and long back board)</td>
</tr>
<tr>
<td>Ft</td>
<td>foot</td>
</tr>
<tr>
<td>F/U</td>
<td>follow-up</td>
</tr>
<tr>
<td>Rx</td>
<td>fracture</td>
</tr>
<tr>
<td>GCS</td>
<td>Glasgow coma scale</td>
</tr>
<tr>
<td>G-1, 2...</td>
<td>primigravida, second pregnancy...</td>
</tr>
<tr>
<td>GSW</td>
<td>gunshot wound</td>
</tr>
<tr>
<td>gtt(s)</td>
<td>drop(s)</td>
</tr>
<tr>
<td>H</td>
<td>Hispanic</td>
</tr>
<tr>
<td>H/A</td>
<td>headache</td>
</tr>
<tr>
<td>HBP</td>
<td>high blood pressure (HTN)</td>
</tr>
<tr>
<td>HEENT</td>
<td>head, eyes, ears, nose, throat</td>
</tr>
<tr>
<td>Hep. A</td>
<td>hepatitis A</td>
</tr>
<tr>
<td>Hep. B</td>
<td>hepatitis B</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immune Virus</td>
</tr>
<tr>
<td>H/O</td>
<td>history of</td>
</tr>
<tr>
<td>HPI</td>
<td>history of present illness</td>
</tr>
<tr>
<td>HR</td>
<td>heart rate</td>
</tr>
<tr>
<td>HTN</td>
<td>hypertension</td>
</tr>
<tr>
<td>Hx</td>
<td>history</td>
</tr>
<tr>
<td>IDDM</td>
<td>insulin dependent diabetes</td>
</tr>
<tr>
<td>i.e.,</td>
<td>that is</td>
</tr>
<tr>
<td>IM</td>
<td>intramuscular</td>
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<tr>
<td>imp</td>
<td>impression</td>
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<tr>
<td>inf.</td>
<td>inferior</td>
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<tr>
<td>Inj</td>
<td>injection</td>
</tr>
<tr>
<td>Insp</td>
<td>inspiration</td>
</tr>
<tr>
<td>ICS</td>
<td>intercostal space</td>
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<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>IVF</td>
<td>IV fluids</td>
</tr>
<tr>
<td>IVP</td>
<td>IV push</td>
</tr>
<tr>
<td>IVPB</td>
<td>intravenous piggyback</td>
</tr>
<tr>
<td>Jt</td>
<td>joint</td>
</tr>
<tr>
<td>JVD</td>
<td>jugular venous distention</td>
</tr>
<tr>
<td>I</td>
<td>liter</td>
</tr>
<tr>
<td>lpm</td>
<td>liters per minute</td>
</tr>
<tr>
<td>L1, L2-L5</td>
<td>1st lumbar vertebrae, etc.</td>
</tr>
<tr>
<td>L-spine</td>
<td>lumbar spine</td>
</tr>
<tr>
<td>lac</td>
<td>laceration</td>
</tr>
<tr>
<td>lat</td>
<td>lateral</td>
</tr>
</tbody>
</table>

Note: This table contains common medical abbreviations and their definitions. Each abbreviation is paired with its full form for clarity.
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ox3</td>
<td>oriented to person, place and time</td>
</tr>
<tr>
<td>O₂</td>
<td>oxygen</td>
</tr>
<tr>
<td>O₂ sat.</td>
<td>oxygen saturation</td>
</tr>
<tr>
<td>O/A</td>
<td>on arrival</td>
</tr>
<tr>
<td>Ob</td>
<td>obstetrics</td>
</tr>
<tr>
<td>obs</td>
<td>observation</td>
</tr>
<tr>
<td>Occ</td>
<td>occasional</td>
</tr>
<tr>
<td>OD</td>
<td>overdose</td>
</tr>
<tr>
<td>opp</td>
<td>opposite</td>
</tr>
<tr>
<td>p</td>
<td>pulse</td>
</tr>
<tr>
<td>P0, P1…</td>
<td>nulliparous, 1 child born…</td>
</tr>
<tr>
<td>PAT</td>
<td>paroxysmal atrial tachycardia</td>
</tr>
<tr>
<td>PCN</td>
<td>penicillin</td>
</tr>
<tr>
<td>PE</td>
<td>physical exam</td>
</tr>
<tr>
<td>PEA</td>
<td>pulseless electrical activity</td>
</tr>
<tr>
<td>Ped.</td>
<td>pediatric</td>
</tr>
<tr>
<td>PERL</td>
<td>pupils equal/react to light tach.</td>
</tr>
<tr>
<td>PERLA</td>
<td>pupils equal/reactive to light tach and accommodation</td>
</tr>
<tr>
<td>PERRLA</td>
<td>pupils equal, round, reactive to light and accommodation</td>
</tr>
<tr>
<td>P/W/D</td>
<td>pink, warm, and dry trach.</td>
</tr>
<tr>
<td>PIV</td>
<td>peripheral IV Tx</td>
</tr>
<tr>
<td>PMH or PMHx</td>
<td>past medical history</td>
</tr>
<tr>
<td>pn</td>
<td>pain (described as n/10)</td>
</tr>
<tr>
<td>PO</td>
<td>by mouth</td>
</tr>
<tr>
<td>post</td>
<td>posterior</td>
</tr>
<tr>
<td>PSVT</td>
<td>paroxysmal supraventricular tachycardia</td>
</tr>
<tr>
<td>Pt</td>
<td>patient vol.</td>
</tr>
<tr>
<td>PVC</td>
<td>premature ventricular tachycardia</td>
</tr>
<tr>
<td>rec'd</td>
<td>received</td>
</tr>
<tr>
<td>Resp</td>
<td>respirations W</td>
</tr>
<tr>
<td>ROM</td>
<td>range of motion WC or W/C</td>
</tr>
<tr>
<td>RR</td>
<td>respiratory rate W/D or WD</td>
</tr>
<tr>
<td>RSR</td>
<td>regular sinus rhythm wt</td>
</tr>
<tr>
<td>RUE</td>
<td>right upper extremity wk</td>
</tr>
<tr>
<td>RUL</td>
<td>right upper lobe (lung exam) wks.</td>
</tr>
<tr>
<td>RUQ</td>
<td>right upper quadrant (abdomen) WNL</td>
</tr>
<tr>
<td>Rx</td>
<td>treatment x</td>
</tr>
<tr>
<td>SAED</td>
<td>semiautomatic external defibrillator YOF or Y/F</td>
</tr>
<tr>
<td>SCA</td>
<td>sickle cell anemia YOM or Y/M</td>
</tr>
<tr>
<td>SCC</td>
<td>sickle cell crisis</td>
</tr>
<tr>
<td>SCD</td>
<td>sickle cell disease</td>
</tr>
<tr>
<td>Sev</td>
<td>Severe</td>
</tr>
<tr>
<td>SIDS</td>
<td>sudden infant death syndrome</td>
</tr>
<tr>
<td>SL</td>
<td>sublingual</td>
</tr>
<tr>
<td>SOB</td>
<td>short of breath solution</td>
</tr>
<tr>
<td>SOR</td>
<td>signature of release</td>
</tr>
<tr>
<td>subq.</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>S/S</td>
<td>signs and symptoms</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted diseases</td>
</tr>
<tr>
<td>T1, T2-T12</td>
<td>1st thoracic vertebrae, etc.</td>
</tr>
<tr>
<td>T-spine</td>
<td>thoracic vertebrae</td>
</tr>
<tr>
<td>Tach</td>
<td>tachycardia</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TCA</td>
<td>tricyclic antidepressant</td>
</tr>
<tr>
<td>TIA</td>
<td>transient ischemic attack</td>
</tr>
<tr>
<td>TKO</td>
<td>to keep open</td>
</tr>
<tr>
<td>Trach</td>
<td>tracheostomy</td>
</tr>
<tr>
<td>Tx</td>
<td>treatment</td>
</tr>
<tr>
<td>UE</td>
<td>upper extremity</td>
</tr>
<tr>
<td>Unk</td>
<td>unknown</td>
</tr>
<tr>
<td>UTI</td>
<td>urinary tract infection</td>
</tr>
<tr>
<td>V-fib or VF</td>
<td>ventricular fibrillation</td>
</tr>
<tr>
<td>VS</td>
<td>vital signs</td>
</tr>
<tr>
<td>VSS</td>
<td>vital signs stable</td>
</tr>
<tr>
<td>V-Tach or VT</td>
<td>ventricular tachycardia</td>
</tr>
<tr>
<td>Vol</td>
<td>volume</td>
</tr>
<tr>
<td>W</td>
<td>White (Race)</td>
</tr>
<tr>
<td>WC or W/C</td>
<td>wheelchair</td>
</tr>
<tr>
<td>W/D or WD</td>
<td>warm and dry</td>
</tr>
<tr>
<td>Wt</td>
<td>weight</td>
</tr>
<tr>
<td>Wk</td>
<td>week</td>
</tr>
<tr>
<td>Wks</td>
<td>weeks (gestational age)</td>
</tr>
<tr>
<td>WNL</td>
<td>within normal limits</td>
</tr>
<tr>
<td>YOF or Y/F</td>
<td>year old female</td>
</tr>
<tr>
<td>YOM or Y/M</td>
<td>year old male</td>
</tr>
</tbody>
</table>
## Legend of Symbols

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
<th>Example</th>
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<tbody>
<tr>
<td>≈ or ~</td>
<td>approximately</td>
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</tr>
<tr>
<td>Δ</td>
<td>change</td>
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</tr>
<tr>
<td>↓</td>
<td>decrease</td>
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<tr>
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<td>increase</td>
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<tr>
<td>/</td>
<td>per</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>percent</td>
<td></td>
</tr>
<tr>
<td>1°</td>
<td>primary, first degree</td>
<td></td>
</tr>
<tr>
<td>2°</td>
<td>secondary, second degree</td>
<td></td>
</tr>
<tr>
<td>3°</td>
<td>tertiary, third degree</td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>with (line over top)</td>
<td></td>
</tr>
<tr>
<td>s</td>
<td>without (line over top)</td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>before (line over top)</td>
<td></td>
</tr>
<tr>
<td>p</td>
<td>after (line over top)</td>
<td></td>
</tr>
<tr>
<td>x</td>
<td>except (line over top)</td>
<td></td>
</tr>
<tr>
<td>m</td>
<td>murmur (circle around like @)</td>
<td></td>
</tr>
<tr>
<td>♀</td>
<td>female</td>
<td></td>
</tr>
<tr>
<td>♂</td>
<td>male</td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>left (circle around)</td>
<td></td>
</tr>
<tr>
<td>*</td>
<td>right (circle around)</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>bilateral (circle around)</td>
<td></td>
</tr>
<tr>
<td>&lt;</td>
<td>less than</td>
<td></td>
</tr>
<tr>
<td>&gt;</td>
<td>greater than</td>
<td></td>
</tr>
<tr>
<td>+</td>
<td>positive (circle around)</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>negative (circle around)</td>
<td></td>
</tr>
<tr>
<td>&amp;</td>
<td>and</td>
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<td>@</td>
<td>at</td>
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</table>
Appendix

TREATMENT GUIDELINES FOR HBIG ADMINISTRATION
FOR PROPHYLACTIC TREATMENT OF HEPATITIS B

Indications for HBIG (hepatitis B immune globulin):

- Post exposure prophylaxis to Hepatitis B as soon as possible after exposure, preferably within 24 hours, no longer than 7 days.

- If exposed patient has received any Hepatitis B immunizations or has history of Hepatitis B infection, determine antibody status. If Hepatitis antibody and titer are negative, then HBIG is indicated for prophylactic protection.

- May give HBIG and Hepatitis B immunization booster and/or initiate Hepatitis B immunizations.

- If Hepatitis B immunizations refused, advice patient that second dose of HBIG should be administered within one month.

Contraindications:

- Do not give IG if giving HBIG.

- Do not give to a pregnant patient. Refer to infectious disease physician and primary physician.

- Give with caution to patients with a history of prior systemic allergic reactions following administration of human immunoglobulin preparation or in patients with severe thrombocytopenia or any coagulation disorder that would contraindicate intramuscular injections.

Adverse reactions:

- Local pain and tenderness at injections site, urticaria and angioedema may occur.

- Anaphylactic reactions are rare.

Dosage and administration:

- Patient must sign consent or declination if refused. Use “Consent for Hepatitis B Immune Globulin” or if patient refuses use “Information about Hepatitis B Immune Globulin”.

- Give 0.06 ml/kg of body weight, IM.

- 3cc syringes – maximum dosage per injection site is 3 ml, preferably in gluteus or deltoid; 21 gauge needle recommended due to viscosity.
PROVISIONAL PUBLIC HEALTH SERVICE RECOMMENDATION FOR CHEMOPROPHYLAXIS AFTER OCCUPATIONAL EXPOSURE TO HIV

A. Definitions:

1. Source material:
   
a. **Highest risk:** Both larger volume of blood (e.g., deep injury with large diameter hollow needle previously in source patient’s vein or artery, especially involving an injection of source patient’s blood) and blood containing a high titer of HIV (e.g., source with acute retroviral illness or end-stage AIDS).

b. **Increased Risk:** Either exposure to larger volume of blood or blood with a high titer of HIV. For skin, risk is increased for exposures involving a high titer of HIV, prolonged contact, an extensive area, or an area in which skin integrity is visibly compromised. For skin exposures without increased risk, the risk for drug toxicity outweighs the benefit of post-exposure prophylaxis.

c. **No Increased Risk:** Neither exposure to larger volume of blood nor blood with a high titer of HIV (e.g., solid suture needle injury from source patient with asymptomatic HIV infection)

2. **Other potentially infectious fluid:** semen, vaginal secretions, cerebrospinal, synovial, pleural, peritoneal, pericardial and amniotic fluids.

3. Treatment per current CDC guidelines.
## Protocol Medications

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>INDICATION</th>
<th>SIDE EFFECTS</th>
<th>CONSIDERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>adenosine</td>
<td>PSVT, monomorphic (regular) VT</td>
<td>Dyspnea, chest pain, atrial tachy-dysrhythmias, nausea, throat tightness, AV block, asystole.</td>
<td><strong>DO NOT GIVE:</strong> AV block, sick sinus syndrome, atrial flutter, atrial fib, VT.</td>
</tr>
<tr>
<td>albuterol</td>
<td>Asthma</td>
<td>Tremors, anxiety. Rare: tachycardia, hypertension, dysrhythmias.</td>
<td><strong>USE WITH CAUTION:</strong> Cardiac disorder, hyperthyroidism, hypertension.</td>
</tr>
<tr>
<td>amiodarone</td>
<td>Tachy-dysrhythmias (especially VT or VF)</td>
<td>Hypotension, bradycardia</td>
<td><strong>In the non-arrest situation, 150 mg must be administered slowly over 10 minutes.</strong></td>
</tr>
<tr>
<td>aspirin</td>
<td>Chest pain/discomfort suspected to be of cardiac origin</td>
<td>Tinnitus, nausea / vomiting. GI bleeding</td>
<td><strong>DO NOT GIVE:</strong> If known hypersensitivity to aspirin</td>
</tr>
<tr>
<td>atropine</td>
<td>Brady-dysrhythmias, organophosphate poisoning.</td>
<td>Dilated pupils, headache, Dry mouth, tachycardia, PVC’s.</td>
<td><strong>DO NOT GIVE:</strong> Tachydysrhythmias <strong>USE WITH CAUTION:</strong> Pregnancy, CHF, hyperthyroidism, COPD, hepatic disease.</td>
</tr>
<tr>
<td>calcium chloride</td>
<td>Hypocalcaemia, calcium channel blocker overdose, hyperkalemia associated ventricular arrhythmias</td>
<td>Possible heart block, VF.</td>
<td><strong>USE WITH CAUTION:</strong> Pt. on digitalis, renal failure <strong>DO NOT MIX WITH:</strong> sodium bicarbonate</td>
</tr>
<tr>
<td>Dextrose 25%</td>
<td>Hypoglycemia</td>
<td>Impaired neurologic recovery following stroke or cardiac arrest</td>
<td>**Tissue necrosis if infiltrates. Should not be used in cardiac arrest or in ischemic CVA unless documented hypoglycemia.</td>
</tr>
<tr>
<td>Dextrose 50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>Side Effects</td>
<td>Precautions/Contraindications</td>
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<td>-----------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
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<tr>
<td>diphenhydramine</td>
<td>Allergic reaction.</td>
<td>DO NOT USE: Acute asthma&lt;br&gt;USE WITH CAUTION: Renal disease, cardiac disease, HTN, asthma, seizure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DO NOT USE:</td>
<td></td>
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<tr>
<td></td>
<td>Dizzy, drowsy, hypotension, dry mouth, tachycardia, dilated pupils, blurred vision.</td>
<td></td>
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</tr>
<tr>
<td>dopamine</td>
<td>Shock NOT of hypovolemic origin, bradycardia in lieu of pacing.</td>
<td>DO NOT USE: Uncorrected hypovolemic shock, pheochromocytoma or VF. Tissue necrosis if infiltrates. Monitor VS q 2 to 3 minutes.</td>
<td></td>
</tr>
<tr>
<td>Epinephrine 1:10,000</td>
<td>Cardiac arrest, anaphylaxis, asthma.</td>
<td>USE WITH CAUTION: Angina, hypertension, hyperthyroidism&lt;br&gt;NO CONTRA-INDICATIONS IN CARDIAC ARREST</td>
<td></td>
</tr>
<tr>
<td>Epinephrine 1:1,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epinephrine, Racemic</td>
<td>Croup</td>
<td>USE WITH CAUTION: Known cardiac problems, HTN</td>
<td></td>
</tr>
<tr>
<td>fentanyl</td>
<td>Pain</td>
<td>USE caution if hypotensive, significant head injury, or other depressants (e.g., EtOH) taken.</td>
<td></td>
</tr>
<tr>
<td>glucagon</td>
<td>Hypoglycemia β-blocker OD</td>
<td>Additional carbohydrates needed for patient after awakening.</td>
<td></td>
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<tr>
<td>Ipratropium</td>
<td>Respiratory distress, wheezing</td>
<td>Cough, headache, dizziness, palpitations</td>
<td>Always administered with albuterol. Do not give more than three (3) 0.5 mg doses</td>
</tr>
<tr>
<td>Ketorolac</td>
<td>Pain</td>
<td>Headache, dizziness, nausea</td>
<td>DO NOT USE: Renal insufficiency, PUD, GI bleed, 1st trimester pregnancy, allergy to NSAIDS, head bleed</td>
</tr>
<tr>
<td>Lidocaine</td>
<td>Pain from IO infusion</td>
<td>Drowsiness, confusion, seizures, hypotension, heart blocks</td>
<td>DO NOT USE: Heart rate &lt; 60, heart block USE WITH CAUTION: Renal or liver disease, CHF, pts &gt; 60 years old</td>
</tr>
<tr>
<td>Magnesium Sulfate 50%</td>
<td>Pregnant pts. experiencing severe pre-eclampsia or eclampsia; Alcoholic patient with prolonged seizures Refractory VF/VT</td>
<td>Decreased muscle strength which may lead to hypoventilation, esp. if patient is also taking depressant medications.</td>
<td>May occasionally lead to A-V block &amp;/or respiratory arrest. Calcium chloride may reverse these effects. NOT INDICATED in patients with heart block or significant heart disease.</td>
</tr>
<tr>
<td>Midazolam (Versed®)</td>
<td>Seizures and chemical restraint</td>
<td>Respiratory depression and respiratory arrest</td>
<td>Hypersensitivity, acute narrow angle glaucoma, shock, hypotension, head injury, and drug or alcohol use.</td>
</tr>
<tr>
<td>Naloxone (Narcan®)</td>
<td>Narcotic overdose</td>
<td>Vomiting, acute withdrawal, ventricular dysrhythmias</td>
<td>Titrate to improve respirations only. Do not fully arouse addicted patient.</td>
</tr>
<tr>
<td><strong>nitroglycerin</strong></td>
<td>Angina, chest pain of suspected cardiac origin, pulmonary edema.</td>
<td>Hypotension, headache, dizziness, flushing.</td>
<td><strong>DO NOT USE:</strong> Systolic BP&lt;90, increased ICP. <strong>USE WITH CAUTION:</strong> Acute MI.</td>
</tr>
<tr>
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<td>---------------------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>ondansetron</strong></td>
<td>Nausea and/or vomiting</td>
<td>Constipation, headache, lightheadedness</td>
<td><strong>Minimal sedation, if at all</strong></td>
</tr>
<tr>
<td><strong>(Zofran®)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>sodium bicarbonate</strong></td>
<td>Metabolic acidosis in cardiac arrest; ventricular arrhythmias secondary to tricyclic OD</td>
<td>Alkalosis, hypervolemia, hypokalemia, tetany.</td>
<td><strong>DO NOT USE during first 10 minutes of cardiac arrest.</strong> <strong>USE WITH CAUTION:</strong> CHF, renal disease, toxemia, cirrhosis. <strong>DO NOT MIX with epinephrine or calcium. Hyerpventilate patient after administration.</strong></td>
</tr>
</tbody>
</table>
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