PRE-HOSPITAL MEDICAL GUIDELINES

Updated July 2018

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Optimal pre-hospital care results from a combination of careful patient assessment, essential pre-hospital emergency medical services, and appropriate medical consultation. The purpose of this manual is to provide guidance for ALL pre-hospital care providers and Emergency Department Physicians within the Tri-State Ambulance, Inc. and the Tri-State Regional Ambulance, Inc. EMS Systems.

The goal of these guidelines is to standardize pre-hospital patient care. These guidelines are not intended to be absolute treatment doctrines, but to have sufficient flexibility to meet the complex challenges faced by the EMS/ALS provider in the field.

These guidelines have been written in adherence with nationally recognized standards including but not limited to: DOT guidelines, American Heart Association's “Advanced Cardiac Life Support” and “Pediatric Advanced Life Support”, state standards and practices manuals. All providers will adhere to these guidelines as is appropriate for medical circumstance and provider agency level.

To maintain the life of a specific patient, it may be necessary, in rare instances, for the physician providing on-line medical consultation, as part of the EMS consultation system, to direct a pre-hospital provider in rendering care that is not explicitly listed within these guidelines. To proceed with such an order both the telemetry physician and the provider must acknowledge and agree that the patient’s condition and extraordinary care are not addressed elsewhere within these medical guidelines, and that the order is in the best interest of patient care. Additionally, the provider must feel capable, based on the instructions given by the telemetry physician, of correctly performing the directed care. Whenever such care is provided, the telemetry physician and the provider must immediately notify the QA/QI Committee of the extraordinary care situation. All such incidents will be entered into the Quality Improvement Review process.

Occasionally a situation may arise in which a physician's order cannot be carried out; e.g. the provider feels the administration of an ordered medication would endanger the patient, a medication is not available, etc. If this occurs, the provider must immediately notify the telemetry physician as to the reason the order cannot be carried out, and indicate on the pre-hospital care report what was ordered, the time, and the reason the order could not be carried out. In addition, the provider must notify the Quality Assurance Office. All such incidents will be entered into the Quality Improvement Review process.

If “On-line Medical Control” cannot be obtained, the provider may initiate appropriate guidelines as deemed necessary.

Items in **BOLD** and *UNDERLINED* are hyperlinked to the corresponding guideline.

Items in **BOLD** designate a medication or treatment.
FOREWORD (CONTINUED)

Items in [brackets] and italicized designate treatments approved for a specific provider level. A provider level with ** indicates that that level must have additional training AND medical director approval to be able to perform the treatment. Treatments listed with a provider level followed by “Med Control” indicate that orders from online medical control must be obtained, except in situations where online medical control is unavailable.

It is to be understood all treatments listed for a specific level can be used by a provider trained to a more advanced level, but only within the scope of practice to the level of care that the agency they are responding for is licensed/certified by the respective state EMS licensing agency.

Examples:

[EMT] Indicates that all EMTs and every provider level above EMT may provide the treatment as long as the agency they are responding with are licensed/certified at that level. This includes AEMT, EMT-I, Paramedic, and Critical Care Paramedic.

[EMT**, AEMT] Indicates that only EMTs who have received additional training AND Medical Director approval may provide the treatment and that all AEMTs and every provider level above AEMT may provide the treatment as long as the agency they are responding with are licensed/certified at that level. This includes EMT-I, Paramedic, and Critical Care Paramedic.

[Paramedic/Med Control] Indicates that Paramedics and provider levels above may provide the treatment after obtaining orders from online medical control, except in situations where online medical control is unavailable.

These guidelines have been developed specifically for the Tri-State Ambulance, Inc. and the Tri-State Regional Ambulance, Inc. EMS Systems and for all EMS and first response agencies for which medical direction is provided by Gundersen Health System, and represent consensus amongst the Medical Director, QA/QI Committee, EMS Education Department, Clinical Departments and Management Teams for these EMS Systems. The guidelines demonstrate a commitment to a consistent approach to quality patient care.
FOREWORD (CONTINUED)

From time to time, guidelines may be added or revised upon recommendation by the parties previously listed. Additional recommendations are welcome and appreciated at any time. They may be submitted to any of the parties listed below for consideration.

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July 2018
**GENERAL PRINCIPLES OF PATIENT CARE**

**General Scope:** A majority of the following guidelines will begin with “Perform routine medical assessment”. A thorough assessment is needed for treatment of complex medical conditions. It is understood that at times the assessment will need to be interrupted to perform life-saving treatment. Providers shall resume assessment as soon as they are able, after performing life-saving interventions. This shall serve as a general guideline for principles that apply to the assessment of all patients.

**Applies to:** All Medical Staff

**Guideline:**

- Universal precautions and personal protective equipment shall be utilized at all times as is appropriate for the situation.
  - PPE can include but is not limited to:
    - Fluid barrier gloves
    - Safety eye protection
    - Infection control gown
    - Infection control shoe covers
    - Infection control bouffant cap
    - Surgical mask
    - N-95 mask

- A patient is an individual requesting or potentially needing medical evaluation or treatment. The patient-provider relationship is established upon personal contact. It is the providers’ responsibility to ensure all potential patients are offered evaluation, treatment, and/or transport. (See Refusal of Evaluation, Treatment, and/or Transport Guideline)

- All patients shall receive a primary assessment to include, but not limited to the following:
  - Airway patency
  - Breathing (rate and quality)
  - Circulation
    - Pulse
    - Skin color, temp, and condition
    - Assess for and treat life threatening bleeding
  - Level of consciousness
GENERAL PRINCIPLES OF PATIENT CARE (CONTINUED)

- All patients shall receive a secondary assessment to include, but not limited to the following:
  - Vital signs including but not limited to:
    - Pulse
    - Blood Pressure
    - SpO₂
    - Respiratory rate and effort
  - S.A.M.P.L.E. history as possible
  - Rapid trauma and/or focused physical assessment
  - Secondary head-to-toe physical assessment
- Receiving facilities of patients being transported should be notified as soon as practicable.
- All Primary and initial Secondary assessments shall be performed or supervised by the EMS provider with the most advanced level of training nationally recognized.
- All patients shall receive treatment as is appropriate per guideline and on-line medical direction.
- All patients shall be re-assessed after an intervention is performed. The success, secondary effects, and possible side-effect of said intervention evaluated.
  - i.e. if a guideline gives a medication dose such as Fentanyl 25-50 mcg Q 5 minutes; the care provider shall give the initial appropriate dose of 25-50 mcg and perform a re-assessment of the patient to include pain level, level of consciousness, and vital signs prior to giving a second dose.
  - The same principle applies to the titration of a medication. Titration is the adjustment of medication dosing until the desired endpoint is reached. The endpoint is the point at which the titration is complete as determined by an indicator.
- For pediatric patients:
  - Equipment and medications must be appropriate for the size and weight of the patient. Use of the Broselow Tape or equivalent is encouraged.
  - The developmental age of the infant/child must be considered in the communication and evaluation for treatment.
  - Treatment priorities are similar to the adult patient.
  - When appropriate, family members should remain with pediatric patients.
  - Infants and children must be properly restrained prior to and during transport.
- For inter-facility transports:
  - Review interventions already in place for appropriateness, accuracy, and effect.
  - For unfamiliar medications that are infusing, ordered, and/or are to be administered by EMS, complete the WI Patient Side Training Report when appropriate, and refer to it, consult with physician(s), nurse(s), and/or refer to the provided resources such as the drug reference book and/or online resources.
Patients will be transported to the closest appropriate facility per local, state, and federal laws and guidelines.

- If two hospitals are of similar distance and have similar capabilities/resources for the patient’s nature of illness, mechanism of injury, or clinical impression, the patient will be transported to the hospital of their preference.
  If the patient has no preference, the patient will be transported to the hospital providing on-line medical direction at that time.
ABNORMAL DELIVERY

General Scope: Guideline for delivering infants presenting with ominous signs.

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. If prolapsed cord is present:
   a. Do not push cord back in, cover with sterile towel moistened with warm NS
   b. Place mother in Trendelenburg knee to chest position
   c. With gloved hand, push presenting part off cervix to decompress cord and maintain position en route to hospital
3. If infant is breech:
   a. Deliver baby to waist
   b. Rotate to face down position (The head should deliver on its own within 3 minutes)
   c. Create breathing space around baby's face with gloved hand (middle and index finger along the baby's face and up to its nose)
   d. Suprapubic pressure may help keep the head flexed and facilitate delivery
   e. Try to assist delivery by placing finger in baby's mouth and gently pulling
4. If other part is presenting (arm, foot, etc):
   a. Do not pull on part
   b. Cover exposed part with sterile towel moistened with warm NS
   c. Place mother left side down
5. Multiple births:
   a. After initial delivery, tie and cut cord
   b. Proceed with subsequent deliveries
6. After delivery refer to Neonatal Resuscitation Guideline

APGAR SCORING:

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<td>Pulse</td>
<td>Absent</td>
<td>&lt;100</td>
<td>&gt;100</td>
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<tr>
<td>Respirations</td>
<td>Absent</td>
<td>Slow or Irregular</td>
<td>Good Crying</td>
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<tr>
<td>Muscle Tone</td>
<td>Limp</td>
<td>Some flexion</td>
<td>Active motion</td>
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<tr>
<td>Reflex irritability</td>
<td>None</td>
<td>Grimace</td>
<td>Cough or sneeze</td>
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<tr>
<td>Color</td>
<td>Pale or Blue</td>
<td>Pink body/blue extremities</td>
<td>Completely pink</td>
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**AIR AMBULANCE USE**

**General Scope:** Procedure and criteria for air ambulance request.

**Applies to:** All Medical Staff

**Guideline:**

1. Routine medical and/or trauma assessment
2. Determine need for air transport
3. Assess appropriateness of air transport for distance/terrain
   a. Air ambulance is inefficient if ground transport time is <30 minutes or 30 miles
4. Request MedLink AIR or appropriate air transport through agency communications center
5. Assure provision of a secure landing zone
AIRWAY / VENTILATORY MANAGEMENT

**General Scope:** Guideline for airway management

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment  
   a. Consider EtCO$_2$ monitoring if appropriate for scope of practice
2. Titrate SpO$_2$ to >94%  
   a. Use the least amount of supplemental oxygen as necessary
3. If patient presents with bronchospasm  
   a. See Asthma / COPD Guideline
4. If patient presents with pulmonary edema  
   a. See Pulmonary Edema Guideline
5. Observe for signs/symptoms of respiratory failure  
   a. Failure to oxygenate and/or ventilate  
   b. Severe respiratory fatigue  
   c. Inability to successfully use CPAP  
   d. RR <8 or >35 breaths per minute  
   e. SpO$_2$<85% on 100% O$_2$  
   f. Acutely rising EtCO$_2$  
   g. Altered mental status  
   h. Hemodynamic instability  
   i. Paradoxical respiratory efforts
6. [EMR] Provide supplemental Oxygen via appropriate device  
   a. When providing ventilation via BVM, PEEP should be applied at 5-10 mmHg  
   b. Tidal volumes of 6-8 cc/kg of ideal body weight should be attempted. Higher tidal volumes may be harmful to the patient.
7. [Paramedic] Assess expected success of intubation
8. [EMR] Have rescue airway available
9. [Paramedic] If endotracheal intubation success likely  
   a. See Rapid Sequence Intubation Guideline
10. If failed intubation (3 total unsuccessful attempts)  
    a. Consider BVM  
    b. Consider supraglottic airway  
    c. [Paramedic] Consider Surgical Cricothyroidotomy
AIRWAY OBSTRUCTION

General Scope: Guideline for airway obstruction.

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. If patient is unable to speak and is conscious
   a. Perform Heimlich maneuver until the foreign body is expelled or the victim becomes unconscious
3. If patient is unconscious
   a. Perform tongue-jaw lift
   b. Use finger sweep if object is visible
   c. Attempt ventilation
   d. If obstruction persists, reposition and re-attempt ventilation
   e. Give up to five chest thrusts
   f. If obstruction persists perform CPR per current ECC guidelines
4. [EMT] If unable to ventilate attempt direct laryngoscopy and removal with Magill forceps
5. [Paramedic] If unsuccessful in removing foreign body or relieving upper airway obstruction see Surgical Cricothyroidotomy Guideline
ALTERED MENTAL STATUS

General Scope: Guideline for treatment of patients who present with altered mental status

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment (with frequent rechecks every 5-10 minutes)
   a. Attempt to identify cause
      i. Consider, among other causes, hypoxia, hypovolemia, trauma, diabetes, poisoning/overdose, etc.
   b. If suspected trauma, see General Trauma Guideline
   c. If suspected overdose, see Poisoning and Overdose
      i. Consider opiate overdose in patients with respiratory depression/compromise, SBP < 90, and decreased LOC.
   d. If hypo/hypertensive see Blood Pressure Management Guideline
2. Provide Airway support as needed, see Airway / Ventilatory Management Guideline
   a. [Paramedic] Consider intubation for GCS <8, see Rapid Sequence Intubation Guideline as needed
3. [AEMT] Establish IV/IO
4. If blood glucose <60 or >250 see Hypoglycemia/Hyperglycemia Guideline
AMPUTATION

General Scope: Guideline for treatment of patients who have experienced an amputation

Applies to: All Medical Staff

Guideline:

1. Perform routine trauma assessment
2. Consider tourniquet for uncontrolled bleeding
3. [AEMT] Establish IV/IO
4. See Trauma Care Guideline
5. See Pain Management Guideline
6. Irrigate amputated part with NS to remove gross contaminants (do not debride)
7. Place amputated part in sterile gauze moistened in NS
8. Place amputated part in sterile waterproof container if available
9. Place sealed container in ice or place activated cold packs around container
ANAPHYLAXIS/ALLERGIC REACTION

**General Scope:** Guideline for treatment of patients who present severe allergic reaction

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
   a. Remove offending agent
2. Airway support as needed, see [Airway / Ventilatory Management Guideline](#)
3. If signs/symptoms of anaphylaxis:
   a. **EPINEPHRINE** (use with caution in elderly/patients with coronary artery disease)
      i. [EMR**/EMT] Epinephrine auto-injector if available
      ii. [EMR**/EMT] 0.3mg (1mg/mL [1:1,000]) IM
         1. Pediatric (< 8 y/o) – 0.15mg
4. [AEMT] Establish IV/IO but do not delay administration of **EPINEPHRINE**
   a. [Paramedic] **DIPHENHYDRAMINE** 25-50mg IV or 50mg IM
      i. Pediatric (< 8 y/o) – 1.25mg/kg IV/IM
   b. [Paramedic] **METHYL-PREDISOLONE** 125mg IV
5. If SBP <90 see [Blood Pressure Management Guideline](#)
6. If bronchospasm is present:
   a. **ALBUTEROL** via nebulizer
      i. [EMT] Consider 2.5 - 5.0mg
      ii. [Paramedic] Consider continuous albuterol nebulizer (10-20mg)
7. If only a localized reaction
   a. Ice and elevate affected area as practical
   b. [Paramedic] Consider **DIPHENHYDRAMINE** 25-50mg IV or 50mg IM
      i. Pediatric (< 8 y/o) – 1.25mg/kg IV/IM

**Note:**
Anaphylaxis = syndrome of severe hypersensitivity reaction

1. **Presentation:**
   a. Symptoms may begin within seconds or may be delayed up to one hour from exposure
   b. Generalized angioedema
   c. Tightening sensation in throat and chest progressing to laryngeal and bronchial spasm manifested by hoarseness, stridor and wheezing
   d. Frequently see nausea, abdominal cramps, vomiting and diarrhea
   e. Localized redness, swelling and/or itching alone is NOT anaphylaxis
La Crosse Regional Pre-Hospital Guidelines

ASTHMA / COPD

General Scope: Guideline for treatment of asthma and chronic obstructive pulmonary disease

Applies to: All Medical Staff

Guideline:

1. Perform routing medical assessment
2. Begin initial treatment per Airway / Ventilatory Management Guideline
3. If severe attack (Respiratory rate more than twice normal, loud wheezes or silent chest, patient anxious, and/or gray or ashen skin color)
   a. ALBUTEROL via nebulizer
      i. [EMR**/EMT] 2.5-5.0mg
      ii. [Paramedic] Continuous administration
   b. [AEMT] Consider IV NS TKO
   c. [EMT**/AEMT] DUO-NEB nebulizer treatment
   d. [Paramedic/Med Control] METHYL-PREDNISOLONE 125mg IV
      i. Pediatric (< 8 y/o) – 1 mg/kg
   e. [Paramedic/Med Control] MAGNESIUM SULFATE 2 grams IV over 15 minutes
   f. For impending respiratory failure
      i. Consider CPAP
         1. See CPAP Guideline
         2. See Airway / Ventilatory Management Guideline
4. If moderate attack (Marked increase in respiratory rate, wheezes easily heard, and accessory muscle use)
   a. Consider ALBUTEROL via nebulizer
      i. [EMR**/EMT] 2.5-5.0mg
   b. [AEMT] Consider IV NS TKO
5. If mild attack (Slight increase in respiratory rate, mild wheezes, and good skin color)
   a. Consider ALBUTEROL via nebulizer
      i. [EMR**/EMT] 2.5-5.0mg
   b. [AEMT] Consider IV NS TKO
ASYSTOLE

General Scope: Guideline for treatment of a patient in asystolic cardiac arrest

Applies to: EMT-I/ Paramedic

Guideline:

1. Perform routine medical assessment
   a. Refer to Cardiac Arrest Guideline

2. Initiate CPR and continue throughout resuscitation with minimal interruptions

3. Confirm asystole in two leads
   a. If rhythm is unclear, see V-Fib/Pulseless V-Tach Guideline

4. Establish IV/IO

5. [Paramedic] EPINEPHRINE (1mg/10mL [1:10,000]) 1mg IV/IO every 3-5 minutes

6. Establish airway per Airway / Ventilatory Management Guideline

7. Consider possible causes and treatments (H's & T's)
   a. Hypoxia – see Airway / Ventilatory Management Guideline
   b. Hypoglycemia – see Hypoglycemia/Hyperglycemia Guideline
   c. Hypothermia – see Hypothermia Guideline
   d. Hyperkalemia – see Hyperkalemia Guideline
   e. Hypovolemia – consider IV NS bolus
   f. (H+)Preexisting acidosis – Ventilate and for adults only, consider [Paramedic] SODIUM BICARBONATE 25 mEq IV
   g. (Toxins)Drug overdose – see Poisoning and Overdose Guideline
   h. Tension pneumothorax – consider [Paramedic] Needle Decompression
   i. Tamponade (Cardiac Tamponade)
   j. Thrombosis – PE/MI
AUTOMATIC IMPLANTABLE CARDIAC DEFIBRILLATOR (AICD) DEACTIVATION

**General Scope:** Guideline for deactivating AICDs

**Applies to:** Paramedics

**Guideline:**

1. Perform routine medical assessment
2. Patient must remain on cardiac monitor until transfer of care
3. If patient has an AICD that is inappropriately discharging (for a non-shockable rhythm)
   a. Place magnet directly over AICD
   b. Secure magnet in place
   c. Document time of application, underlying rhythm, and if procedure is successful
4. If the patient develops a shockable rhythm, remove the magnet
   a. If AICD does not begin working, see appropriate arrhythmia guideline

**Notes:**

- **This magnet will not stop a pacemaker from functioning**
- Keep magnet away from computers, credit cards, electronics, etc.
**Blood Pressure Management**

**General Scope:** Guideline for treatment of patients who present with abnormally high or low blood pressure

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. Airway support as needed, see [Airway / Ventilatory Management Guideline](#)
   - [AEMT] Establish IV/IO
3. If patient is hypertensive per applicable guideline:
   a. [Paramedic/Med Control] **Labetalol** 20mg slow IV push
      i. May repeat at 40mg every 10 minutes to a max of 300mg
   b. [Paramedic/Med Control] Consider **Nitroglycerin Infusion** (20mg/100ml D5W or NS—200mcg/ml)
      i. For patients <75kg, start at 10mcg/min
      ii. For patients >75kg, start at 20mcg/min
      iii. Titrate by 5-10mcg/min every 5-10 minutes to desired response
      iv. Monitor BP every 3-5 minutes
4. If SBP<90 and patient is symptomatic with no signs of fluid overload
   a. [AEMT] 250-500ml NS bolus up to two liters total
5. If SBP<90 and patient is symptomatic with signs of fluid overload or NS bolus unsuccessful
   a. [Paramedic] Consider **Norepinephrine** infusion
      i. Initiate at 0.05 mcg/kg/min via IV pump
      1. Titrate by 0.01-0.05 mcg/kg/min every 3-5 minutes
      2. Maximum of 0.3 mcg/kg/min
6. If patient has inadequate response to fluid or norepinephrine infusion
   a. [Paramedic/Med Control] Consider **Epinephrine** infusion (1mg/100ml D5W or NS—10mcg/ml)
      i. Initiate IV infusion at 2-5 mcg/min
      ii. Titrate by increments of no more than 1 mcg/min every 5 minutes
      iii. Maximum of 10 mcg/min

1. **Nitroglycerine**
   a. Specifically indicated in patients with acute pulmonary edema or myocardial ischemia
   b. Consider lower doses in the elderly
   c. Avoid if any history of PDE 5 inhibitor (Viagra, Levitra, Cialis) use in the past 48 hours
2. **Norepinephrine / Epinephrine**
   a. May worsen underlying ischemia, tachycardia or acidosis
   b. Increases peripheral vascular resistance
BRADYCARDIA

**General Scope:** Guideline for treatment of an adult patient with symptomatic bradycardia

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. Monitor SpO₂
3. Airway support as needed per *Airway / Ventilatory Management Guideline*
4. Identify patient as having serious signs or symptoms
   a. [EMT*] Obtain and transmit a 12-Lead ECG
   b. [EMT-I] Review ECG if available
5. [AEMT] Establish IV/IO
6. If patient is asymptomatic, observe closely
7. [Paramedic] If symptomatic or IV/IO not readily available
   a. Begin **TRANSCUTANEOUS PACING**
      i. Consider *Pain Management Guideline* and/or *Sedation Guideline* as needed
   b. [Paramedic] Administer ATROPINE 0.5mg IV/IO every 3-5 minutes to a max of 0.04mg/kg
   c. [Paramedic] Consider **EPINEPHRINE** infusion (1mg/100ml D₂W or NS—10mcg/ml)
      i. Initiate IV infusion at 2-10 mcg/min
      ii. Titrate every 5 minutes by increments of no more than 1 mcg/min
      iii. Maximum of 10 mcg/min
BURNS

General Scope: Guideline for treatment of patients who have experienced a burn

Applies to: All Medical Staff

Guideline:

1. Perform routine trauma assessment
2. Consider activation of air ambulance for transport to medical center with a specialized burn center
3. Airway support as needed, see Airway / Ventilatory Management Guideline
4. [AEMT] Establish IV/IO per
5. See Trauma Care Guideline
6. See Blood Pressure Management Guideline
7. See Pain Management Guideline
8. If burn is thermal in nature:
   a. Stop the burning process without causing hypothermia
   b. Remove clothing and jewelry (Do not pull away clothing that is stuck to burn)
   c. [AEMT] If burn is >10% BSA and ETA to hospital >15 minutes, IV NS 150ml/hr
   d. [Paramedic] Consider early intubation if signs of airway burns is present
9. If burn is chemical in nature:
   a. Remove agent as appropriate
   b. Irrigate for at least 15 minutes with NS
      i. Use at least 1000ml for eye irrigation
      ii. Use continuous irrigation for alkali burns
10. If burn is electrical in nature (severe high voltage injury):
    a. Once scene is safe, remove the patient from the source
    b. See Cardiac Dysrhythmia Guidelines as needed
    c. [AEMT] IV NS or LR x 2 lines
       i. Run one line with 500-1000ml IV bolus
       ii. [Paramedic/Med Control] Second line with SODIUM BICARBONATE 50mEq per liter at 500-1000ml/hr
11. Dress burned area with non-adhesive plastic wrap ("Saran Wrap")
12. Consider use of burn sheet with additional clean, dry sheet and blanket to conserve body heat
13. DO NOT BREAK BLISTERS. DO NOT APPLY CREAMS, OINTMENTS OR ANTIDOTES TO BURNS
CANCELLATION OF CALL

General Scope: Procedure for cancelling ambulance while en route to a call.

Applies to: All Medical Staff

Guideline:

1. When EMS is activated but a request to cancel is made, dispatch will advise responding crew to continue in a non-emergency fashion
2. TSA/TSRA crew may cancel under the following conditions
   a. At the discretion of the TSA/TSRA shift supervisor with consideration given to call circumstances, system status, and weather
   b. No physical patient exists or patient has left the scene
   c. The call or address has been determined to be false in nature
   d. The patient’s personal physician is in attendance and determines the ambulance is not needed
CARDIAC ARREST (BENCHMARK)

General Scope: Guideline for initiating, performing, and/or terminating resuscitation of a cardiac arrest

Applies to: All Medical Staff

Guideline:

1. INITIATION OF RESUSCITATION
   a. [EMR] Resuscitation must be initiated unless one the following conditions exist
      i. Valid DNR
      ii. Valid POST/POLST form with DNR orders
      iii. Written order from physician
      iv. Order from Medical Control physician
      v. Pulseless and apneic with one or more of the following:
         1. Decomposition
         2. Rigor mortis
         3. Dependent lividity
         4. Decapitation
         5. MCI
         6. Traumatic death with extrication >20 minutes with no CPR
   b. [Paramedic] For adult patients only, BLS resuscitation may be discontinued by paramedic unit without ALS intervention in the following conditions:

      | Arrest was not witnessed |
      | AND |
      | There is no return of spontaneous circulation (ROSC) |
      | after three full rounds of CPR and AED analysis |
      | AND |
      | No AED shocks were delivered at any time |
      | AND |
      | Cardiac rhythm is asystole as verified on cardiac monitor in multiple leads |

2. PERFORMANCE OF RESUSCITATION
   a. [EMR] Resuscitation of the cardiac arrest patient should be performed utilizing current ECC guidelines
      i. Utilize a team approach and pre-plan rotations & interventions
      ii. Emphasis on quality chest compressions with minimal interruptions
         1. Consider use of mechanical CPR when available
      iii. Prevent hyperventilation
      iv. Place advanced airway with no interruption of chest compressions
      v. Refer to appropriate dysrhythmia guideline as needed
   b. [Paramedic] For patients with refractory ventricular fibrillation or ventricular tachycardia (three or more defibrillations without or with transient conversion), consider replacing defibrillation pads with pads in a different vector.
3. TERMINATION OF RESUSCITATION
   a. [EMR] Resuscitation should be continued until one of the following occurs
      i. Valid DNR is provided
      ii. Resuscitation efforts have been transferred to other persons of at least equal
          skill and training
      iii. Effective ROSC and ventilation have been restored
      iv. The rescuers are physically unable or it is unsafe to continue efforts
      v. Medical Control orders efforts to stop
   b. [Paramedic] Resuscitation should be continued until the following criteria are met
      i. High quality CPR has been administered
      ii. Adequate ventilation has been provided via BVM or advanced airway
      iii. IV or IO access has been achieved
      iv. Appropriate cardiac dysrhythmia guidelines have been followed
      v. Persistent asystole or agonal rhythm is present and no reversible causes are
         identified after a minimum of 25 minutes of resuscitation
         1. May consider earlier termination in traumatic arrest with consultation from Medical Control prior to termination.
   c. If transport has been initiated, efforts must continue until patient care has been
      turned over to the receiving hospital
   d. If resuscitation is not initiated or continued, or is terminated, ensure Coroner/Medical Examiner is notified
CARDBIAC ARREST BENCHMARKS

<table>
<thead>
<tr>
<th>CLINICAL BENCHMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>No interruptions of chest compressions &gt; 10 seconds</td>
</tr>
<tr>
<td>Rhythm interpreted every two minutes and defibrillation administered as needed</td>
</tr>
<tr>
<td>First dose of epinephrine administered within five minutes in asystole</td>
</tr>
<tr>
<td>Advanced airway successfully placed on first attempt</td>
</tr>
<tr>
<td>Obtain 12-lead ECG &lt; 10 minutes after ROSC</td>
</tr>
<tr>
<td>If STEMI, transport directly to PCI center</td>
</tr>
<tr>
<td>Compliance with medical guidelines/MD orders</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOCUMENTATION BENCHMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document patient demographics - age and gender</td>
</tr>
<tr>
<td>Document estimated patient weight</td>
</tr>
<tr>
<td>Attach acquired ECGs &amp; rhythm strips</td>
</tr>
<tr>
<td>Document vital signs every five minutes after ROSC</td>
</tr>
<tr>
<td>Document hospital notification time</td>
</tr>
<tr>
<td>Document disposition (ER or Cath Lab)</td>
</tr>
</tbody>
</table>
CEREBROVASCULAR ACCIDENT (Benchmark)

General Scope: Guideline for treatment of patients who present with signs or symptoms of a stroke

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment with FAST-ED scale and determine time of last known well.
   a. If stroke scale is positive, and last known well time is within six hours, transport service to notify receiving hospital within 10 minutes of being at patient side
      i. If FAST-ED score is 1-3, activate STROKE ALERT
      ii. If FAST-ED score is ≥4, activate LVO STROKE ALERT
2. Airway support as needed, see Airway / Ventilatory Management Guideline
   a. [Paramedic] Consider intubation for GCS <8
3. Rule out hypoglycemia, hypoxia, hypovolemia, trauma, or ingestion
4. Consider special situations:
   a. See General Trauma Guideline for suspected trauma
5. [AEMT] Establish IV/IO (≥18g AC Preferred)
6. [Paramedic/Medical Control] If patient is hypertensive with SBP >180 or DBP >110 consider slowly lowering blood pressure.
   a. See Blood Pressure Management Guideline
7. If blood glucose <60 or >250 see Hypoglycemia/Hyperglycemia Guideline
8. [EMR**] Consider NALOXONE 1-4mg IN for decreased LOC
9. [AEMT] Consider NALOXONE 0.4-2 mg IV/IM for decreased LOC

Note:

1. Evaluate vital signs and FAST-ED Stroke Scale every TEN minutes.

<table>
<thead>
<tr>
<th>FAST-ED SCORE</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial weakness</td>
<td>Normal or minor paralysis</td>
<td>Partial or complete paralysis</td>
<td>N/A</td>
</tr>
<tr>
<td>Arm weakness</td>
<td>No drift</td>
<td>Unilateral drift with effort against gravity</td>
<td>No effort against gravity or movement</td>
</tr>
<tr>
<td>Speech changes</td>
<td>No Changes</td>
<td>Mild to moderate</td>
<td>Severe aphasia or mute</td>
</tr>
<tr>
<td>Eye deviation</td>
<td>Absent</td>
<td>Gaze preference</td>
<td>Forced deviation</td>
</tr>
<tr>
<td>Denial/neglect</td>
<td>Absent</td>
<td>Extinction to bilateral simultaneous stimulation</td>
<td>No recognition of own hand; orients to one side only</td>
</tr>
</tbody>
</table>

1. Signs of Herniation: Sudden decrease in level of consciousness, ipsilateral papillary dilation, contralateral hemiparesis, and decerebrate or decorticate posturing
CLINICAL BENCHMARKS

- Obtain and report last known well time
- Perform FAST-ED Stroke Scale every 10 minutes
- Notify hospital of stroke alert within 10 minutes of patient side
- Obtain and document blood glucose level
- Obtain and document vital signs every 10 minutes
- Maintain O₂ saturation of ≥94% with minimum Oxygen necessary
- Establish IV (AC preferred - 18gu or larger); do not delay transport for additional IV access
- Transport with head of bed elevated 30°

DOCUMENTATION BENCHMARKS

- Document patient demographics - age and gender
- Document estimated patient weight
- Document last known well time
- Document FAST-ED Stroke Scale every 10 minutes
- Document blood glucose level
- Document vital signs every 10 minutes
- Document hospital notification time
- Document disposition (ER or CT)
CHILDBIRTH

**General Scope:** Guideline for delivering infants.

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. If ominous signs see [Abnormal Delivery Guideline](#)
3. If imminent delivery:
   a. [AEMT] Establish IV/IO
   b. Place mother in knee to chest position and prepare delivery equipment
   c. Have mother pant through contraction and relax between
   d. As head crowns at perineum, apply slight pressure to prevent explosive delivery
   e. If HR <100 see [Neonatal Resuscitation Guideline](#)
   f. Put baby on mother’s abdomen and prevent heat loss
   g. Take APGAR scores at 1 and 5 minutes
   h. If placenta delivers, place the cord and the placenta in a sack or container to be brought to receiving facility
   i. Massage uterus if bleeding is brisk after delivery of the placenta
   j. If heavy bleeding present see [Post-Partum Hemorrhage Guideline](#)

**APGAR SCORING:**

<table>
<thead>
<tr>
<th>Sign</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse</td>
<td>Absent</td>
<td>&lt;100</td>
<td>&gt;100</td>
</tr>
<tr>
<td>Respiration</td>
<td>Absent</td>
<td>Slow or Irregular</td>
<td>Good Crying</td>
</tr>
<tr>
<td>Muscle Tone</td>
<td>Limp</td>
<td>Some flexion</td>
<td>Active motion</td>
</tr>
<tr>
<td>Reflex irritability</td>
<td>None</td>
<td>Grimace</td>
<td>Cough or sneeze</td>
</tr>
<tr>
<td>Color</td>
<td>Pale or Blue</td>
<td>Pink body/blue extremities</td>
<td>Completely pink</td>
</tr>
</tbody>
</table>
CONTINUOUS POSITIVE AIRWAY PRESSURE

General Scope: Procedure for CPAP

Applies to: EMTs

Guideline:

1. Determine need (Clinical Indications):
2. Moderate to severe respiratory distress with signs and symptoms of pulmonary edema, CHF, or COPD, refractory to initial interventions, and all of the following apply:
   a. Awake and able to follow commands
   b. Over 12 years old and is able to fit the CPAP mask
   c. Has the ability to maintain an open airway
      i. And exhibits two or more of the following:
         1. A respiratory rate > 26 breaths per minute
         2. SPO2 < 92% on high flow oxygen
         3. Use of intercostal or accessory muscles during respirations
         4. Wheezing or wet lung sounds
3. [AEMT] Establish IV/IO
4. Talk patient through procedure and cautiously sedate as needed, see Sedation Guideline
5. Start CPAP at 5-10mmHg or pre-set level

Note:

1. Indications
   a. Acute pulmonary edema as a bridge device
   b. Patients already on CPAP
   c. Mild respiratory failure due to muscle fatigue
   d. COPD
2. Exclusion criteria
   a. Recurrent aspiration
   b. Large volumes of secretions
   c. Inability to protect the airway
   d. Vomiting
   e. Obstructed bowel
   f. Upper airway obstruction
   g. Uncooperative, confused or combative patient
   h. Inability to tolerate a tight mask
   i. Orofacial abnormalities which interfere with mask/face interface
   j. Untreated pneumothorax
CORONARY INSUFFICIENCY (BENCHMARK)

General Scope: Guideline for treatment of patients who present with signs or symptoms of possible cardiac events.

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. Airway support as needed, see Airway / Ventilatory Management Guideline
3. [EMT] Obtain and transmit a 12-Lead ECG
4. [EMT-I] Review ECG
   a. [EMT-I] If 12-Lead is consistent with STEMI contact Medical Communications (MedComm) to activate STEMI Alert
5. [AEMT] Establish IV/IO
6. [EMR**/EMT] Give ASPIRIN 324mg PO
7. [EMT**/AEMT] Give NITROGLYCERIN 0.4mg sublingual every 3-5 minutes until pain free or infusion established. (see below)
   a. IF SBP <120 See Blood Pressure Management Guideline
      i. Do not administer sublingual nitroglycerin until SBP >120
   b. [Paramedic] If SBP >90 consider NITROGLYCERIN INFUSION (20mg/100ml NS or D5W—200mcg/ml)
      i. For patients <75kg, start at 10mcg/min
      ii. For patients >75kg, start at 20mcg/min
      iii. Titrate by 5-10mcg/min every 5-10 minutes to desired response
      iv. Monitor BP every 3-5 minutes
   c. Discontinue NITROGLYCERIN INFUSION if SBP <90
8. [Paramedic] If SBP>100 consider FENTANYL 25-50mcg IV/IO for refractory pain
9. [Paramedic] Consider MIDAZOLAM 0.5-1mg IV/IO

Note:

1. Nitroglycerin
   a. Consider lower doses in the elderly
   b. Avoid if any history of PDE 5 inhibitor (Viagra, Levitra, Cialis) use in the past 48 hours
### STEMI Benchmarks

<table>
<thead>
<tr>
<th>CLINICAL BENCHMARKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Obtain <strong>12-lead ECG</strong> &lt; 10 minutes from patient side</td>
</tr>
<tr>
<td>□ <strong>Notify receiving facility</strong> of STEMI &lt; 15 minutes from patient side</td>
</tr>
<tr>
<td>□ <strong>Transmit ECG</strong> to receiving facility</td>
</tr>
<tr>
<td>□ Perform &quot;<strong>right-sided</strong>&quot; ECG for suspected inferior infarcts</td>
</tr>
<tr>
<td>□ <strong>Maintain O₂ saturation</strong> of ≥94% with minimum Oxygen necessary</td>
</tr>
<tr>
<td>□ <strong>Administer Aspirin</strong> to eligible STEMI patients</td>
</tr>
<tr>
<td>□ <strong>Administer Nitroglycerin</strong> to eligible STEMI patients</td>
</tr>
<tr>
<td>□ <strong>Administer analgesic</strong> to eligible STEMI patients</td>
</tr>
<tr>
<td>□ Prep patient for cath lab (<strong>remove clothing/jewelry and place pads/patches appropriately</strong>)</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>□ Document <strong>patient demographics - age and gender</strong></td>
</tr>
<tr>
<td>□ Document estimated <strong>patient weight</strong></td>
</tr>
<tr>
<td>□ <strong>Attach</strong> all acquired ECGs</td>
</tr>
<tr>
<td>□ Document <strong>vital signs every 10 minutes</strong></td>
</tr>
<tr>
<td>□ Document <strong>pain scores with vital signs</strong></td>
</tr>
<tr>
<td>□ Document <strong>hospital notification time</strong></td>
</tr>
<tr>
<td>□ Document <strong>disposition (ER or Cath Lab)</strong></td>
</tr>
</tbody>
</table>
CRUSH SYNDROME

**General Scope:** Guideline for treatment of patients experiencing crush syndrome. This guideline is also appropriate for suspension trauma.

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical and trauma assessment
2. Airway support as needed, see [Airway / Ventilatory Management Guideline](#)
3. [AEMT] Establish IV/IO (initiate volume replacement prior to extrication if possible)
   a. [AEMT] IV/IO NS up to 2L bolus
4. See [Trauma Care Guideline](#)
5. Evaluate for hypothermia, see [Hypothermia Guideline](#)
6. Apply direct pressure to control external bleeding
7. [EMR**/EMT] Consider using a tourniquet on affected limb before extrication if possible
   a. Leave the tourniquet in place for the transport
   b. [Paramedic] If transport >20 minutes, slowly release the tourniquet
8. Early stabilization of all extremity fractures aids in controlling blood loss
9. [Paramedic/Med Control] Consider IV/IO NS with SODIUM BICARBONATE infusion (50mEq per liter) at 500-1000ml/hr
10. See [Pain Management Guideline](#)
**DECOMPRESSION SICKNESS**

**General Scope:** Guideline for treatment of patients with potential decompression sickness.

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical and trauma assessment
2. Place patient on 100% O₂ via tight fitting mask if spontaneously breathing, see [Airway / Ventilatory Management Guideline](#)
3. [AEMT] Establish IV/IO
4. Evaluate for hypothermia, see [Hypothermia Guideline](#)
5. See [Blood Pressure Management Guideline](#)
6. See [Pain Management Guideline](#)
7. Transport to the nearest hyperbaric chamber (consider air transport). Medical Control must call to ensure chamber is available and working and establish an accepting physician
   a. Contact:
      i. Divers’ Alert Network 919-694-8111, ask for diving emergencies
      ii. Hennepin County Medical Center
         1. 800-424-4262 ED Physician
         2. 612-873-3132 ED
         3. 612-873-7420 Hyperbaric Department
      iii. St. Lukes, Milwaukee 414-649-6577
      iv. University of IA, Iowa City
         1. 319-356-7706 (8-5)
         2. 319-356-2233 (after hours)
         3. 319-356-8220 HBO Physician

**Note:**

A. Decompression illness occurs when the gas dissolved in the body fluids separates from those fluids to form bubbles.

B. In a rapid ascent, the pressure differential between the body tissues and blood and alveoli becomes great enough to cause separation of nitrogen from the liquid phase resulting in the formation of bubbles in the tissues or blood.

C. Predisposing factors that increase the incidence of decompression illness
   1. Dehydration
   2. Cold temperatures
   3. Obesity
   4. Exercise during the dive
   5. Older individuals
   6. Previous joint injury
   7. Previous recent dives
   8. Flying after recent dive

D. Decompression illness can occur during ascent or up to 72 hours after a dive (especially if multiple dives/day)

E. Manifestations
   1. Pain
      i. Limb pain
      ii. Girdle pain
   2. Cutaneous eg. itching, lymphedema
   3. Neurological (including audio-vestibular, i.e. loss of balance)
   4. Pulmonary eg. CHF, cough, dyspnea
   5. Constitutional (malaise, anorexia, fatigue)
   6. Hypotension
   7. Barotraumas (lung, sinus, ear, dental)

F. Important information
   1. Time of onset
   2. Gas burden (depth-time profile): Depth of dive, dive time and number of dives.
ENVENOMATION

General Scope: Guideline for treatment of patients with potential envenomation.

Applies to: All Medical Staff

Guideline:

1. Perform routine medical and trauma assessment
2. Obtain and document history of time and type of bite (bring offending agent if safe to do so)
3. [AEMT] Establish IV/IO
4. See Blood Pressure Management Guideline
5. See Pain Management Guideline
General Medical

**General Scope:** Guideline for treatment of patients with medical emergencies

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. Check respirations, SpO$_2$, and apply oxygen if needed, see [Airway / Ventilatory Management Guideline](#)
3. Check pulse and apply cardiac monitor, see appropriate [Cardiac Dysrhythmia Guideline](#)
4. Check blood pressure, see [Blood Pressure Management Guideline](#)
5. Consider checking blood glucose, see [Hypoglycemia/Hyperglycemia Guideline](#)
6. [AEMT] Establish IV/IO
La Crosse Regional Pre-Hospital Guidelines

GENERAL TRAUMA

General Scope: Guideline for treatment of all patients with potential traumatic injuries.

Applies to: All Medical Staff

Guideline:

1. Perform routine trauma assessment
2. Consider Trauma Activation (Appendix D-1) with transport to nearest appropriate trauma center as per state trauma guidelines
4. Airway support as needed, see Airway / Ventilatory Management Guideline
5. Direct pressure for external hemorrhage
   a. Consider tourniquet for uncontrolled hemorrhage
   b. Consider hemostatic agent per Hemostatic Agent Guideline
6. Apply occlusive dressing for sucking chest wound
   a. Consider intubation
7. [AEMT] Establish IV/IO
   a. Avoid excessive fluid administration
   b. Goal of maintaining SBP~90mmHg
   c. See Blood Pressure Management Guideline
8. See Shock Guideline
9. See Pain Management Guideline

Splint extremity fractures
10. Use a pelvic binder or wrap and secure a sheet around the pelvis for suspected pelvic fractures and splint lower extremity fractures
11. See Pain Management Guideline

July 2018
HEAD INJURY

General Scope: Guideline for treatment of all patients with potential head injuries.

Applies to: All Medical Staff

Guideline:

1. Perform routine medical and trauma assessment
2. See General Trauma Guideline
4. [AEMT] Establish IV/IO
   a. Goal to maintain SBP>90
   b. Do not give excessive fluids
5. If no signs of herniation
   a. Maintain normal EtCO$_2$ of 35-45mmHg
   b. See guidelines as needed
      i. Nausea, Vomiting, Vertigo Guideline
         1. [Paramedic] ONDANSETRON 4-8mg IV
            a. Pediatric (< 8 y/o) – <40kg - 0.1mg/kg, >40kg - 4mg
      ii. Seizure Guideline
6. If signs of herniation are present
   a. Mildly hyperventilate patient (14-16 breaths/minute) to maintain EtCO$_2$ 30-35mmHg

Note:

Elevate head of bed approximately 30° for transport if possible.

1. Signs of Herniation: Sudden decrease in level of consciousness, ipsilateral papillary dilation, contralateral hemiparesis, and decerebrate or decorticate posturing
HEAT RELATED ILLNESS

**General Scope:** Guideline for treatment of all patients with potential heat related illnesses.

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. Remove from heat source
3. Maintain cool air flow over patient
4. If suspected Heat Exhaustion (patient alert)
   a. Administer oral fluids as tolerated / available.
   b. [AEMT] Establish IV/IO
5. If suspected Heat Stroke (patient with altered LOC)
   a. Airway support as needed, see [Airway / Ventilatory Management Guideline](#)
   b. See [Altered Mental Status Guideline](#) as needed
   c. Cool patient immediately
      i. Remove clothing as necessary
      ii. Cool packs to lateral chest wall, groin, axilla, carotid arteries, temples, and behind knees
      iii. Sponge with cool water or cover with wet sheet and fan the body
   d. [AEMT] Establish IV/IO
   e. Place cold packs around distal IV tubing
   f. [AEMT] If SBP < 100mmHg, give 500ml-1L IV/IO NS bolus, see [Blood Pressure Management Guideline](#)
6. For seizures, see [Seizure Guideline](#)
Hemostatic Agent Use

General Scope: Procedure for use of hemostatic gauze

Applies to: EMR**/Paramedic

Guideline:

1. Identify source of bleeding
   a. Place proximal tourniquet if appropriate
   b. Wipe pooled blood from wound if necessary
2. Apply hemostatic gauze, packing into wound as per manufacturer’s instructions
3. Pack entire length of gauze into wound
4. Apply direct pressure for 1-3 minutes with hemostatic gauze
   a. If bleed-through occurs entire dressing must be removed before repacking
5. Apply standard dressing and bandage

Note: Specific brand of hemostatic gauze must not cause thermal reaction.
HYPERKALEMIA

**General Scope:** Guideline for treatment of patients who are or suspected to be hyperkalemic

**Applies to:** Paramedic

**Guideline:**

1. Perform routine medical assessment
2. Identify as symptomatic: Patients with profound weakness or shock with EKG changes as below AND history of dialysis, or renal failure, or severe burns/trauma/crush injury, or laboratory confirmed diagnosis of hyperkalemia
3. Airway support as needed, see [Airway / Ventilatory Management Guideline](#)
4. Obtain 12-lead EKG
5. [AEMT] Establish IV/IO
6. [Paramedic] **CALCIUM GLUCONATE** 1gram/10cc in 100ml D5W or NS over 10 minutes
   a. This is the preferred treatment for pre-arrest or arrest situations
   b. Do not mix this with sodium bicarbonate
7. [Paramedic] **ALBUTEROL** – continuous nebulizer
8. [Paramedic] **SODIUM BICARBONATE** 50mEq IV over 10 minutes
   a. May repeat up to 2 total doses
   b. Avoid in dialysis and CHF patients
   c. Do not mix with calcium gluconate

**Note:**

1. Cardiac effects (may or may not be present)
   a. 5.6-6.0mEq/L - peaked T waves due to increased repolarization
   b. 6.0-6.5mEq/L - prolonged PR & QT intervals
   c. 6.5-7.0mEq/L - diminished P waves and depressed ST segments; may result in an intracardiac block affecting in the following order: atria, AV node, ventricles
   d. 7.5-8.0mEq/L - P waves disappear, QRS complex widens, S & T waves tend to merge
   e. 10-12mEq/L - classic sine wave occurs which represents loss of P wave and wide QRS complexes.
2. Other effects
3. Skeletal muscle weakness to flaccid paralysis with preservation of diaphragm muscle function
   a. Paresthesias
   b. Respiratory depression
HYPOGLYCEMIA/HYPERGLYCEMIA

General Scope: Protocol for treatment of patients who present with diabetic emergencies

Applies to: All Medical Staff

Protocol:

1. Perform routine medical assessment with blood glucose check
2. Airway support as needed, see Airway Management Protocol
3. Establish IV/IO per Vascular Access Protocol with 10% dextrose solution (D_10) if hypoglycemic. Use normal saline if hyperglycemic.
4. If blood glucose < 60 mg/dL
   a. Assess patient for insulin pump and suspend if found
      i. Be sure to resume or advise patient of your intervention after treatment
   b. Consider ORAL GLUCOSE if patient is conscious and able to follow commands
   c. [EMT] GLUCAGON 1mg IM/SQ or [EMT-I**] 2mg IN
      i. [EMR**] May only assist with a patient prescribed auto-injector
      ii. Pediatric (< 8 y/o) – 0.5mg IM/SQ or 1mg IN
   iii. First response agencies: Contact responding transport ambulance for ETA to the scene prior to glucagon administration. **Glucagon may be administered only if transport ambulance ETA is > 10 minutes.**
   d. [AEMT] Administer 10% dextrose solution (D_10) to achieve improved blood glucose level and mental status (GCS)

<table>
<thead>
<tr>
<th>Patients under 20 kg</th>
<th>Patients over 20 kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Administer bolus of 5 mL/kg D_10. Slow infusion to TKO and evaluate response for at least two minutes. Re-assess blood glucose level and mental status.</td>
<td>1. Administer 100mL bolus of D_10 (10 G dextrose). Slow infusion to TKO and evaluate response for at least two minutes. Re-assess blood glucose level and mental status.</td>
</tr>
<tr>
<td>2. If desired results not achieved, administer additional 2 mL/kg boluses of D_10 every two minutes until improvement in blood glucose level and mental status.</td>
<td>2. If desired results not achieved, administer additional 50mL boluses of D_10 (5 G dextrose) every two minutes until improvement in blood glucose level and mental status.</td>
</tr>
</tbody>
</table>

a. Determine any prescribed anti-diabetic medications and recent history of administration.
   i. If patient is prescribed and uses an oral hypoglycemic agent, transport is strongly encouraged due to potential for rebound hypoglycemia.
2. If blood glucose > 250 mg/dL
   a. Assess patient of underlying illness or infection that could be cause. [Sepsis]
   b. [AEMT] NS 500 ml bolus IV
      i. Pediatric (< 8 y/o) – 20ml/kg/hr
HYPOTHERMIA

General Scope: Guideline for treatment of all patients with potential hypothermia.

Applies to: All Medical Staff

Guideline:

1. Perform routine medical and trauma assessment
2. If patient is responsive
   a. Remove wet clothing, cover with warm blankets, apply heat packs to axilla, groin, neck, and thorax
   b. If signs of frostbite:
      i. Protect injured part (blisters) with light sterile dressings. Avoid pressure to area
      ii. Cover affected part with warm blankets and prevent re-exposure to cold or refreezing of part
   c. [AEMT] Establish IV/IO
   d. [AEMT] Give up to 2 liters of warmed NS IV
3. If patient is unresponsive
   a. Airway support as needed, see Airway / Ventilatory Management Guideline
      [AEMT] Establish IV/IO
   b. [AEMT] Give up to 2 liters of warmed NS IV
   c. If bradycardic do not start CPR
   d. If patient is pulseless
      i. Check for pulse, respirations, and/or viable rhythm for at least 1 minute
      ii. If patient is pulseless:
         1. Start CPR
         2. Follow appropriate cardiac arrest guideline
         3. Consider transport as soon as possible for rewarming

***The field resuscitation may be withheld if the victim has obvious lethal injuries or if the body is frozen so that nose and mouth are blocked by ice and chest compression is impossible.
INTER-FACILITY PRE-TRANSPORT CARE

General Scope: Establishment of pre-transport standards of care for all intra/inter-facility transports.

Applies to: All Transport Medical Staff

Guideline:

1. Establish contact with referring facility and patient
2. Complete “Primary Survey”
   a. Resuscitate if necessary
3. Complete “Secondary Survey”
   a. To include Vital Signs, SpO2, Cardiac Monitor
4. Assess pre-arrival diagnostics and interventions
   a. Paramedics can continue all antibiotics and electrolyte solutions. They can also transport other medications not found in the guideline with the use of Patient Side Training Report
   b. If you are unfamiliar with any medication please utilize the tools provided (patient side training report, RN on scene, MD on scene, Drug Handbook located in each ambulance) to insure you have a general understanding of the medication order, dose, and side effects.
5. Confirm correct placement and position of ETT, NGT, IV’s, Foley catheter, etc
6. Review X-rays, lab results, and EKG’s
7. Prepare to load patient, consider spinal immobilization for trauma patients
IFT OF TPA (TISSUE PLASMINOGEN ACTIVATOR)

General scope: Guideline for the IFT transport of TPA infusion

Applies to: Paramedic

Guideline:

1. Perform routine medical assessment with Cincinnati Stroke Scale, repeat stroke scale q15
2. [Sending Hospital RN] Bolus – 0.09 mg/kg (10% of total), Max 9mg via pump over a minute, USE DEDICATED LINE. NO IV fluids running with Alteplase during bolus or infusion.
3. [Sending Hospital RN] Continuous Infusion: 0.81 mg/kg (90% of total), Max 81 mg via pump over 60 minutes beginning immediately following the bolus.
4. Verify total dose given. Document total tPA dose to be administered, start and stop times; Start tPA on IVAC pump. Half set may be needed to insure no medication loss.
5. BP goal during and after TPA SBP <180 and DBP <105
6. [Paramedic/Med Control] Start with 10mg LABETALOL IV push over 1-2 minutes if BP is not within range. Re-contact Med Control for further orders if needed
7. If excess medication remains in the bag after correct amount is given do not flush primary tubing. Disconnect Alteplase tubing from the patient, then remove from the pump and discard immediately.
8. If the complete bag needs to be given in order to receive the correct dose, follow tPA administration with a NS infusion at the same rate. Make sure this is done before the pump alarms “air in line”.

Stop Infusion if:

a. Neurologic deterioration and / or new headache
b. SBP >180 or DBP > 105 – after treatment with medication. Contact Medical Control
c. Symptoms of internal bleeding. See Cerebrovascular Accident guideline
d. Nausea / Vomiting
e. Allergic reaction including: rash, itching, anaphylaxis or angioedema

Notify Medical control:

1. If infusion was stopped
2. Change in patients condition (improved or deteriorating)
3. Temp > 38.5
4. Pulse <50 or >100
5. RR <10 or >24

Notes:

1. Ensure patient has two IVs [at least one AC if possible] – do not delay transport to establish
2. If receiving hospital does not have a half set ready you may need to wait or leave IVAC pump.
3. Never discard TPA if you are unsure if complete dose was given. TPA has a significant cost and should never be discarded in error.
INTRANASAL MEDICATIONS

**General Scope:** Procedure for administration of intranasal medications via the Mucosal Atomization Device (MAD). Acceptable intranasal medications are: Fentanyl, Midazolam, Naloxone.

**Applies to:** EMR**

**Guideline:**

1. Determine MAD/Intranasal indications
2. Rule out contraindications
   a. Epistaxis
   b. Nasal trauma
   c. Nasal septal abnormalities
   d. Significant nasal congestion/discharge
3. Draw up medication not to exceed 2ml total volume
4. Attach MAD to syringe and place MAD in nostril
5. Briskly compress syringe to administer atomized medication
   a. Point outwards and upwards
   b. Do not to exceed 1ml total volume per nostril

   Medications may be repeated in 5-10 minutes as needed and indicated
MEDICAL PERSONNEL ON SCENE

**General Scope:** Guideline for dealing with extraneous medical professionals on the scene of a call

**Applies to:** All Medical Staff

**Guideline:**

1. If bystander is non-physician they may assist as crew deems appropriate, but may not direct care
2. If bystander is a physician, involvement options include:
   a. Assist and/or offer suggestions while EMS act under guideline and medical control
   b. Request to talk to medical control and directly offer medical advice and assistance if medical control deems it appropriate
   c. Request to direct patient care (must meet ALL of the following criteria):
      i. Show valid state medical license unless known to crew
      ii. Contact medical control who must relinquish control to on scene physician
      iii. Physically accompany patient to hospital
      iv. Give orders which are reasonable, accurate, and within the scope of practice for the EMS crew

If orders are given that the crew members feel to be unreasonable, medically inaccurate, and/or not within their capabilities, the crew members DO NOT have to do that which they know by their training, skill, and experience would be detrimental to the patient.
MULTIPLE PATIENT INCIDENT

General Scope: Procedure for MCI

Applies to: All Medical Staff

Guideline:

1. Incident with three or more patients
2. Utilize START triage system & triage tags
3. Implement Incident Command System as appropriate
4. Notify possible receiving facilities as soon as possible
   a. Notification should be done by designated “officer” within ICS system
NARROW COMPLEX TACHYCARDIA

General Scope: Guideline for treatment of an adult patient with symptomatic narrow complex tachycardia

Applies to: EMT-I

Guideline:
1. Perform routine medical assessment
2. Determine cardiac rhythm and assess for stability
   a. [AEMT] Attempt IV/IO (antecubital IV preferred)
3. If ventricular rate is >150 beats/minute and patient is unstable:
   a. Consider sedation per Sedation Guideline
   b. [Paramedic] Perform SYNCHRONIZED CARDIOVERSION
      i. Utilize dose range of 100-200J
   c. Consider pharmacological intervention (see #5b)
4. If ventricular rate is >150 beats/minute and patient is stable and rhythm is atrial fibrillation or atrial flutter:
   a. [EMT-I] Perform MODIFIED VALSALVA MANEUVER
   b. Obtain 12-lead ECG if not converted
   c. [Paramedic] DILTIAZEM 5mg over 2 minutes
      i. [Paramedic] If inadequate response, consider repeat doses of 5mg to max of 25mg
   d. [Paramedic] Consider AMIODARONE 150mg IV over 10 minutes
5. If ventricular rate is >180 beats/minute and patient is stable and rhythm is SVT
   a. [EMT-I] Perform MODIFIED VALSALVA MANEUVER
   b. Obtain 12-lead ECG if not converted
   c. [Paramedic] ADENOSINE 6mg rapid IV push
      i. [Paramedic] Repeat at 12mg [May repeat twice]
      ii. [Paramedic] Consider AMIODARONE 150mg IV over 10 minutes

Notes:
2. Diltiazem in contraindicated:
   i. Sick-Sinus syndrome
   ii. 2nd or 3rd degree heart block
   iii. WPW or short PR syndrome
4. Lopressor should be used with caution if evidence of CHF/Pulmonary edema
5. Amiodarone precautions:
   i. Hypotension secondary to vasodilation
   ii. May prolong QT interval
   iii. Negative inotropic effects
   iv. Use with caution in renal failure
Nasogastric/Orogastric Tube

General Scope: Procedure for NG/OG tube placement.

Applies to: Paramedics

Guideline:

1. Assessment reveals the following:
   a. Vomiting and/or abdominal pain with distended, tympanic abdomen and possible frequent high-pitched bowel sounds
   b. Distended abdomen after resuscitative efforts (air-filled stomach)
   c. Avoid in patients with significant facial and head injuries
2. If conscious see Sedation Guideline and Pain Management Guideline as needed
3. Determine length of insertion (tip of nose -> earlobe -> bottom of sternum)
4. Lubricate Gastric Tube (GT) with water-based lubricant
5. Nasogastric (NG) Tube Placement (typically conscious patients)
   a. Maintain patient with head in neutral or slightly flexed position
   b. Insert GT through nose to determined length
   c. Visualize mouth for coiled GT
6. Orogastric (OG) Tube Placement (typically unconscious patients)
   a. Carefully place patient’s head in neutral or slightly flexed position
   b. Insert GT through mouth to determined length
   c. Inspect for coiled GT
7. Inject air through GT and auscultate over epigastrium
8. Tape GT to nose (NG) or mouth (OG) and connect to low continuous suction
**NAUSEA / VOMITING / VERTIGO**

**General Scope:** Guideline for treatment of patients who have complaints of nausea, vomiting, or vertigo

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. Airway support as needed, see [Airway / Ventilatory Management Guideline](#)
3. Suction as needed
4. [AEMT] Establish IV/IO
5. [Paramedic] **ONDANSETRON** 4mg, repeat once if needed
   a. Pediatric (< 8 y/o) - 0.1 mg/kg up to 4mg
6. [Paramedic] **MIDAZOLAM** 0.5-1mg for extreme cases after failure of ondansetron
NEEDLE CRICOTHYROIDOTOMY

General Scope: Procedure for needle cricothyroidotomy.

Applies to: Paramedics

Guideline:

1. Determine need
2. Palpate cricothyroid membrane and clean area with antiseptic wipe
3. Puncture membrane with 14ga catheter, advance caudally drawing back on syringe until air return
4. Withdraw needle and attach 3.0mm pediatric ETT adapter with BVM
5. Auscultate chest and secure device
NEEDLE DECOMPRESSION

General Scope: Procedure for needle chest decompression

Applies to: Paramedics

Guideline:

1. Determine need
2. If conscious see Sedation Guideline
3. Cleanse site with antiseptic wipe
   a. 5th intercostal space mid-axillary is preferred
   b. 2nd intercostal space mid-clavicular is secondary
4. Insert 10g - 14g catheter
5. Listen for rush of air
6. Remove needle leaving catheter in place
7. Auscultate chest and secure device
NEONATAL RESUSCITATION

General Scope: Guideline for resuscitation of a neonatal patient.

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
   a. Oxygen saturation should be measured on right extremity
2. Position and clear airway
   a. Routine intubation for tracheal suction is no longer recommended in meconium staining (NRP 865)
3. Dry and warm infant
4. Tactile stimulation
5. If cardiac arrest
   a. Start CPR see appropriate Pediatric Dysrhythmia Guideline
      i. Ventilate 40-60/minute
      ii. Chest compressions 120/minute (1:3 ratio)
      iii. [Paramedic] INTUBATE
      iv. [AEMT] Establish IV/IO
      v. [Paramedic] Give EPINEPHERINE (1:10,000) 0.01-0.03mg/kg IV/IO
      vi. [Paramedic] Consider NS 10ml/kg IV/IO bolus
      vii. [Paramedic] Consider NALOXONE 0.5mg IV/IO
      viii. [Paramedic] Consider NEEDLE DECOMPRESSION if suspected pneumothorax
6. If heart rate <60
   a. Start CPR
      i. Ventilate 40-60/minute
      ii. Chest compression 120/minute (1:3 ratio)
   b. Recheck: If HR <80
      i. [Paramedic] INTUBATE
      ii. [AEMT] Establish IV/IO
      iii. [Paramedic] Give EPINEPHERINE (1:10,000) 0.01-0.03mg/kg IV/IO
      iv. [Paramedic] Consider NS 10ml/kg IV/IO bolus
      v. [Paramedic] Consider NALOXONE 0.5mg IV/IO
7. If heart rate <100
   a. Ventilate via BVM 40-60/minute
8. Consider blood glucose check, see Hypoglycemia/Hyperglycemia Guideline
9. Transport, keep warm, and maintain HR >80
PAIN MANAGEMENT

General Scope: Guideline for treatment of patients who are or suspected to be experiencing pain

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. Airway support as needed, see Airway / Ventilatory Management Guideline
3. Treat underlying cause of pain
   a. Splint and pad known or suspected fractures and dislocations
   b. Apply ice packs to suspected fractures and dislocations
   c. Elevate injured extremities when possible
4. Consider the chart below for determining pain management options
5. [AEMT] Consider IV/IO

<table>
<thead>
<tr>
<th>MILD – MODERATE PAIN</th>
<th>SEVERE PAIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wong Baker 1-6</td>
<td>Wong Baker 7-10</td>
</tr>
<tr>
<td>a) [Paramedic] KETORALAC1</td>
<td>a) [Paramedic] FENTANYL3-6</td>
</tr>
<tr>
<td>a. 15 mg IV/ 30 mg IM</td>
<td>a. 25-50mcg IV Q 5-10 minutes (50 mcg IN Q 10 minutes)</td>
</tr>
<tr>
<td>b) [Paramedic] ACETAMINOPHEN2 650mg PO</td>
<td>i. Pediatric (&lt; 8 y/o) - 1-2 mcg/kg IV or 2-3mcg/kg Intranasal</td>
</tr>
<tr>
<td>a. Evidence suggests that the administration of an NSAID + acetaminophen is as effective as opiate medications.</td>
<td>b. Recheck vital signs between doses</td>
</tr>
<tr>
<td>b. It is OK to administer only one if other is contraindicated</td>
<td>c. If reversal is required, giveNALOXONE 0.4-2mg IV Q 5 minutes PRN</td>
</tr>
<tr>
<td></td>
<td>i. Pediatric (&lt; 8 y/o) - 0.01 mg/kg up to 0.8mg Q 5 minutes PRN</td>
</tr>
<tr>
<td></td>
<td>b) [Paramedic] KETAMINE 0.25mg/kg</td>
</tr>
<tr>
<td>c) [Paramedic] Consider MIDAZOLAM 1-2mg</td>
<td></td>
</tr>
</tbody>
</table>

6. For transports >15 minutes, patients treated with FENTANYL, KETAMINE, or MIDAZOLAM should have end tidal CO₂ monitoring

NOTES

1. Ketoralac is contraindicated for patients over 49, with known renal insufficiency, or hypersensitivity to NSAIDs.
2. Acetaminophen is contraindicated for use in patients with abdominal pain, nausea/vomiting, inability to swallow, known sensitivity to acetaminophen, or if patient has taken acetaminophen in last four hours.
3. Fentanyl
   a. May cause worsening of hypotension secondary to the direct action on vascular smooth muscle resulting in peripheral pooling; avoid in patients with an unstable cardiovascular status.
   b. Use caution in elderly. Consider starting at lower end of dosing range.
   c. Skeletal and thoracic muscle rigidity occurs especially following rapid IV administration; if it occurs, assist breathing with bag-valve mask ventilations. Neuromuscular blockade may be required.
   d. Histamine release rarely occurs. If evident: [Paramedic] DIPHENHYDRAMINE 25-50 mg IV.
PEDiatrics ASYSTOLE/PEA

**General Scope:** Guideline for treatment of a pediatric patient in asystolic cardiac arrest

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. **Initiate CPR and continue throughout resuscitation with minimal interruptions**
3. Consider possible causes and treatments
   a. Hypoxia – ventilation see [Airway / Ventilatory Management Guideline](#)
   b. Preexisting acidosis – Increase ventilations
   c. Drug overdose – see [Poisoning and Overdose Guideline](#)
   d. Hypothermia – see [Hypothermia Guideline](#)
   e. Hyperkalemia – see [Hyperkalemia Guideline](#)
4. **[Paramedic]** Confirm asystole in two leads
   a. If rhythm is unclear, see [Pediatric V-Fib/Pulseless V-Tach Guideline](#)
5. **[AEMT]** Establish IV/IO
6. Establish airway per [Airway / Ventilatory Management Guideline](#)
7. **[Paramedic]** Administer **EPINEPHRINE** (1:10,000) 0.01mg/kg IV/IO Q 3-5 minutes
**PEDIATRIC BRADYCARDIA**

**General Scope:** Guideline for treatment of a pediatric patient with symptomatic bradycardia

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. Monitor SpO₂
   a. Airway support as needed per *Airway / Ventilatory Management Guideline*
3. If heart rate <60; start CPR
4. Identify patient as having serious signs or symptoms
   a. [EMT] Obtain/review ECG if available
5. [AEMT] Establish IV/IO
6. [Paramedic] Administer **EPINEPHRINE** 0.01mg/kg (1:10,000) IV/IO Q 3-5 minutes
7. [Paramedic] Consider **TRANSCUTANEOUS PACING** (rate at 100-120)
PEDIATRIC TACHYCARDIA WITH ADEQUATE PERFUSION

General Scope: Guideline for treatment of a pediatric patient with tachycardia

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. [Paramedic] Determine cardiac rhythm and assess for stability/significant tachycardia
   a. HR > 180 for ages 1-8 years
   b. HR > 220 for ages newborn – 1 year
3. [AEMT] Attempt IV/IO
4. If QRS ≥ 0.09 seconds:
   a. [Paramedic] Evaluate rhythm
   b. If likely ventricular tachycardia:
      i. [Paramedic] AMIODARONE 5mg/kg IV over 10 minutes
      ii. [Paramedic/Medical Control] Perform SYNCHRONIZED CARDIOVERSION 0.5-1 J/kg
   c. If likely SVT with aberrancy:
      i. Attempt Modified Valsalva Maneuver if possible
      ii. [Paramedic] ADENOSINE 0.1mg/kg rapid IV push
         1. [Paramedic] Repeat at 0.2mg/kg (May repeat twice)
5. If QRS ≤ 0.09 seconds:
   a. [Paramedic] Evaluate rhythm
   b. If likely SVT:
      i. Attempt Modified Valsalva Maneuver if possible
      ii. [Paramedic] ADENOSINE 0.1mg/kg rapid IV push
         1. [Paramedic] Repeat at 0.2mg/kg (May repeat twice)
   c. If likely Sinus Tachycardia:
      i. Search for and treat causes
Pediatric Tachycardia with Poor Perfusion

General Scope: Guideline for treatment of a pediatric patient with symptomatic tachycardia

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. [Paramedic] Determine cardiac rhythm and assess for stability/significant tachycardia
   a. HR >180 for ages 1-8 years
   b. HR >220 for ages newborn – 1 year
3. [AEMT] Attempt IV/IO
4. If QRS≥0.09 seconds and cardiopulmonary compromise:
   a. Consider sedation per Sedation Guideline
   b. [Paramedic] Perform SYNCHRONIZED CARDIOVERSION 0.5-1 J/kg
      i. Repeat as needed at 2-4 J/kg
5. If QRS≤0.09 seconds:
   a. [Paramedic] Evaluate rhythm
   b. If SVT:
      i. [Paramedic] Perform SYNCHRONIZED CARDIOVERSION 0.5-1 J/kg
         1. Repeat as needed at 2-4 J/kg
      ii. [Paramedic] AMIODARONE 5mg/kg IV over 10 minutes
   c. If likely sinus tachycardia:
      i. Search for and treat causes
PEDIATRIC VENTRICULAR FIBRILLATION / PULSELESS VENTRICULAR TACHYCARDIA

General Scope: Guideline for treatment of a pediatric patient presenting with ventricular fibrillation or pulseless ventricular tachycardia in cardiac arrest

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. Initiate CPR and continue throughout resuscitation with minimal interruptions
3. Apply defibrillator or AED
   a. [Paramedic] Defibrillate at 2 - 4J/kg
4. [AEMT] Establish IV/IO
5. Establish airway per Airway / Ventilatory Management Guideline
6. [Paramedic] Administer EPINEPHRINE (1mg/10mL [1:10,000]) 0.01mg/kg IV/IO Q 3-5 minutes
7. [Paramedic] Defibrillate at 4J/kg
   a. Any time a shockable rhythm is present at pulse check
8. [Paramedic] Administer AMIODARONE 5mg/kg IV/IO
   a. [Paramedic] May repeat 5mg/kg IV/IO up to two times
9. If pulse is returned see Post Arrest Guideline
POISONING AND OVERDOSE

General Scope: Guideline for treatment of patients who have been exposed to a toxic substance or have experienced an accidental or intentional overdose.

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
   a. Special consideration given to time of exposure
   b. Obtain blood glucose level to rule in/out Hypoglycemia/Hyperglycemia
2. Airway support as needed, see Airway / Ventilatory Management Guideline
3. Check blood pressure. See Blood Pressure Management Guideline
4. Frequently assess of level of consciousness throughout patient care
5. Determine type of toxic agent
6. If agent is on skin and can possibly be dermally absorbed
   a. Remove clothing
   b. Brush any remaining toxic agent off skin
   c. Flush affected areas with water for a minimum of 15 minutes prior to transport
7. If agent has been inhaled
   a. Remove patient from environment
   b. Remove clothing
   c. Provide high concentration oxygen, see Airway / Ventilatory Management Guideline
   d. If bronchospasm present see Asthma / COPD Guideline
8. If ingested
   a. [AEMT] Establish IV/IO
   b. If agent is potentially a narcotic and patient exhibiting toxicity (Respiratory depression/compromise, SBP<90, decreased LOC)
      i. [EMR] Give NALOXONE 1-4mg IN (not to exceed 1ml per nostril)
      ii. [AEMT] Give NALOXONE 0.4-4mg IV/1-4mg IN Q 5 minutes PRN
         1. Pediatric (< 8 y/o) – 0.01mg/kg up to 0.4-0.8mg
   c. If agent is a tricyclic antidepressant and patient exhibiting toxicity (HR>120, SBP<90, decreased LOC, and/or widening of QRS)
      i. [Paramedic] Give SODIUM BICARBONATE 25mEq followed by 25mEq in 1000 ml NS over 1 hour
POSTPARTUM HEMORRHAGE

**General Scope:** Guideline for post-delivery hemorrhage.

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. Airway support as needed, see [Airway / Ventilatory Management Guideline](#)
3. Maintain blood pressure, see [Blood Pressure Management Guideline](#)
4. [AEMT] Establish IV/IO
5. Attempt to identify cause of postpartum hemorrhage
6. Apply direct pressure to any area of genital tract trauma
7. Perform uterine massage to promote uterine tone
POST ARREST (ROSC) (BENCHMARK)

General Scope: Guideline for treatment of a patient who has regained a pulse following cardiac resuscitation.

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. [AEMT] Establish IV/IO if not previously initiated
3. Establish airway per Airway / Ventilatory Management Guideline
4. [AEMT] Monitor EtCO₂
   a. Target range is 30-35 mmHg with RR ≥10
   b. DO NOT HYPERVENTILATE
5. [Paramedic] If patient received >2 minutes of CPR consider NG per Nasogastric Tube Guideline
6. Continuous monitoring of vital signs
7. If patient is hypotensive see Blood Pressure Management Guideline
8. If patient has significant cardiac dysrhythmia see appropriate guideline
9. If patient has bradycardia see Bradycardia Guideline
10. [EMT] Obtain and transmit a 12-Lead ECG to the receiving facility
    a. [Paramedic] If 12-Lead is consistent with STEMI contact Medical Communications (MedComm) to activate STEMI Alert
    b. If STEMI, consider transport directly to PCI center
11. If arrest reoccurs revert to appropriate guideline
## Post Arrest (ROSC) Benchmarks

| Patients with EMS arrival within county contract minutes 90\(^{th}\) % |
| Field ROSC with 12 lead acquired |
| compliance with medical guidelines/ MD orders |
| field ROSC with transport to a STEMI center |
PRE-ECLAMPSIA / ECLAMPSIA

**General Scope:** Guideline for pre-eclamptic or eclamptic patients.

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. Airway support as needed, see [Airway / Ventilatory Management Guideline](#)
3. [AEMT] Establish IV/IO
4. If patient is seizing:
   a. [Paramedic] Give **MAGNESIUM SULFATE** 4 grams over 20 minutes
   b. [Paramedic] Give **MIDAZOLAM** 2 mg Q 2 minutes
      i. See [Seizure Guideline](#)
   c. [Paramedic] Consider more **MAGNESIUM SULFATE**
5. If patient is not seizing:
   a. Place patient in position of comfort
   b. [Paramedic] Give **MAGNESIUM SULFATE** 4 grams IV over 20 minutes
   c. See [Blood Pressure Management Guideline*](#)
      i. *Nitroglycerin should not be given to a pregnant patient*

**Notes:**

1. Preeclampsia: Toxic state which occurs in the last half of pregnancy or early postpartum period in which mother exhibits the following:
   a. Hypertension (SBP > 160, DBP > 90 or an increase in DBP of 15 mmHg from previous baseline)
   b. Hyperreflexia
   c. Generalized peripheral edema
   d. Proteinuria
2. Hyperreflexia and visual changes indicate imminent seizure
3. Magnesium
   a. Stop or decrease if knee jerk absent, respiratory depression occurs, or cardiac arrest
   b. Antidote is [Paramedic] **CALCIUM GLUCONATE** 1g in 100ml over 10 minutes
   c. Caution if maternal renal disorder or history of Myasthenia Gravis
PULMONARY EDEMA

General Scope: Guideline for management of patients with suspected pulmonary edema

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. Position patient in upright sitting position
3. If respiratory arrest is imminent
   a. See Airway / Ventilatory Management Guideline
   b. Add PEEP 5-10mmHg
4. If moderate to severe respiratory distress
   a. [EMT**] Start CPAP at 5-10mmHg
   b. [Paramedic] See Sedation Guideline as needed
5. [AEMT] IV NS TKO
6. If SBP<90 mmHg
   a. See Blood Pressure Management Guideline
7. If SBP>120 mmHg
   a. [AEMT] NITROGLYCERINE 0.4mg SL Q 3-5 minutes
   b. [Paramedic] NITROGLYCERINE INFUSION (20mg/100ml D5W or NS—200mcg/ml)
      i. Start at 20 mcg/min
      ii. Titrate by 10mcg/min every 5-10 minutes to desired response
      iii. Monitor BP every 3-5 minutes

Note:
Cardiogenic Pulmonary Edema (CPE)

2. Conditions associated with CPE
   a. LV failure from acute MI, cardiomyopathies and valvular heart disease
   b. Volume overload
2. Clinical features of CPE include:
   a. Cough
   b. Diaphoresis
   c. Dyspnea
   d. Fatigue
   e. Wheezing
   f. Pink tinged frothy sputum

Avoid use of NTG if any history of PDE 5 inhibitor (Viagra, Levitra, Cialis) use in the past 48 hours

July 2018
PULSELESS ELECTRICAL ACTIVITY

**General Scope:** Guideline for treatment of a patient presenting with PEA in cardiac arrest

**Applies to:** EMT-I and Paramedic

**Guideline:**

1. Perform routine medical assessment
2. **Initiate CPR and continue throughout resuscitation with minimal interruptions**
3. Consider possible causes and treatments (H’s & T’s)
   a. Hypoxia – ventilation see *Airway / Ventilatory Management Guideline*
   b. Hypoglycemia – see *Hypoglycemia/Hyperglycemia Guideline*
   c. Hypothermia – see *Hypothermia Guideline*
   d. Hyperkalemia – see *Hyperkalemia Guideline*
   e. Hypovolemia – consider 250-500mL IV NS boluses
   f. (H+)Preexisting acidosis – Ventilations, consider [Paramedic] SODIUM BICARBONATE 25mEq
   g. (Toxins)Drug overdose – see *Poisoning and Overdose Guideline*
   h. Tension pneumothorax – consider [Paramedic] Needle Decompression
   i. Tamponade (Cardiac Tamponade)
   j. Thrombosis – PE/MI
4. [AEMT] Establish IV/IO
5. [Paramedic] Administer **EPINEPHRINE** (1mg/10mL [1:10,000]) 1mg IV/IO Q 3-5 minutes
6. Establish airway per *Airway / Ventilatory Management Guideline*
RADIO REPORT OUTLINE

General Scope: To Provide a general guideline for EMS to hospital patient report.

Applies to: All Transport Medical Staff

Guideline:

1. Radio report should be provided as soon as practicable
2. Identify service, unit number, radio frequency
3. Communicate patient’s age, sex, and level of consciousness
4. Communicate patient’s chief complaint and/or primary impression
5. Communicate history of injury/illness and pertinent past medical history
6. Relate pertinent assessment and findings including vital signs
7. Communicate any treatment initiated
   a. EMS staff can request orders from on-line medical control at this time, but it is often more expedient to initiate a request for orders prior to giving patient report
8. Give estimated time of arrival
RAPID SEQUENCE INTUBATION (Benchmark)

**General Scope:** Procedure for rapid sequence intubation. This procedure may only be initiated when two paramedics are at patient side.

**Applies to:** Paramedics

**Guideline:**

1. Ensure adequate ventilation/pre-oxygenation via appropriate adjunct
2. High flow (15L/min) O2 via nasal cannula for apneic oxygenation
3. Prepare equipment, medication, and patient
   a. See Airway Management Checklist
4. If systolic blood pressure <70, consider **PUSH DOSE EPINEPHRINE** (10mcg/1mL)
   a. Administer 5-10mcg (0.5-1mL) **PUSH DOSE EPINEPHRINE** (10mcg/1mL) at least one minute prior to sedation and every 2-5 minutes as needed
   b. If persistent hypotension is present, see Blood Pressure Management guideline
5. Administer **KETAMINE** 1-2mg/kg IV
   a. For patients with systolic blood pressure <90, use 1mg/kg dose.
6. Administer **ROCURONIUM** 1mg/kg IV max of 100mg (~20 min duration)
7. Secure airway
8. Confirm placement with waveform capnography and auscultation
9. Monitor EtCO₂, SpO₂, and secure ETT
10. Re-sedation & provide pain management as needed; consider lower doses in patients with continued hemodynamic compromise
   a. **KETAMINE** 1mg/kg
   b. **MIDAZOLAM** 1-2mg
      i. Pediatric (< 8 y/o) – 0.05mg/kg
   c. **FENTANYL** 25-50mcg
      i. Pediatric (< 8 y/o) – 1mcg/kg
11. Only re-paralyze with **ROCURONIUM** 0.5mg/kg if sedation/pain management fails.

**Note:**

1. Pediatric airway differences:
   a. The larynx is located more anteriorly and cephalad
   b. The epiglottis is shorter and u-shaped (vs. flat in the adult)
   c. The tongue is relatively large while obviously the larynx and trachea are much smaller in the pediatric patient compared to the adult
   d. Be careful not to hyperextend the neck, as the trachea is very pliable and can collapse during intubation
   e. Straight laryngoscope blades are recommended in neonates and infants while either straight or curved can be used in older children
2. Use of midazolam and rocuronium do not block pain receptors; patients often still require pain control.
### AIRWAY MANAGEMENT CHECKLIST

<table>
<thead>
<tr>
<th>Step</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess airway for difficulty. (LEMON)</td>
<td></td>
</tr>
<tr>
<td>(RSI) Perform neurologic exam before paralytics are administered.</td>
<td></td>
</tr>
<tr>
<td>Monitor vital signs (HR, SaO₂, ECG, ETCO₂). Consider defibrillator</td>
<td></td>
</tr>
<tr>
<td>pads.</td>
<td></td>
</tr>
<tr>
<td>Place basic airway adjunct. (Nasopharyngeal airway or oropharyngeal</td>
<td></td>
</tr>
<tr>
<td>airway)</td>
<td></td>
</tr>
<tr>
<td>Ensure sniffing positioning. (Ear to sternal notch/facj parallel to</td>
<td></td>
</tr>
<tr>
<td>ceiling)</td>
<td></td>
</tr>
<tr>
<td>Pre-oxygenate w/ NRB, CPAP, or BVM. (Goal to reach 94% for several</td>
<td></td>
</tr>
<tr>
<td>minutes)</td>
<td></td>
</tr>
<tr>
<td>Perform apneic oxygenation. (Regular nasal cannula at 15L/min)</td>
<td></td>
</tr>
<tr>
<td>Prepare bag-valve mask. (Attached to oxygen, mask present, PEEP valve</td>
<td></td>
</tr>
<tr>
<td>attached)</td>
<td></td>
</tr>
<tr>
<td>Prepare intubation equipment. (Laryngoscope, ETT, syringe, securing</td>
<td></td>
</tr>
<tr>
<td>device, bougie)</td>
<td></td>
</tr>
<tr>
<td>Ready alternative airways. (Supraglottic airway, surgical airway)</td>
<td></td>
</tr>
<tr>
<td>Prepare suction. Turn on. (Suction catheter within reach [under</td>
<td></td>
</tr>
<tr>
<td>shoulder] &amp; check function)</td>
<td></td>
</tr>
<tr>
<td>Ensure IV access. (Suction catheter within reach [under shoulder] &amp;</td>
<td></td>
</tr>
<tr>
<td>check function)</td>
<td></td>
</tr>
<tr>
<td>(RSI) Administer push dose epinephrine (0.1mg/10mL) as needed for</td>
<td></td>
</tr>
<tr>
<td>hemodynamic compromise</td>
<td></td>
</tr>
<tr>
<td>(RSI) Administer induction agents. (0.5²-2 mg/kg ketamine, 1 mg/kg</td>
<td></td>
</tr>
<tr>
<td>rocuronium)</td>
<td></td>
</tr>
<tr>
<td>Lubricate endotracheal tube.</td>
<td></td>
</tr>
<tr>
<td>Perform intubation without significant change in status.</td>
<td></td>
</tr>
<tr>
<td>Retain necessary equipment in case of problem. (Syringe, BVM mask,</td>
<td></td>
</tr>
<tr>
<td>laryngoscope, and medications)</td>
<td></td>
</tr>
<tr>
<td>Confirm placement with waveform capnometry &amp; print strip. Confirm</td>
<td></td>
</tr>
<tr>
<td>lung sounds and no epigastric sounds.</td>
<td></td>
</tr>
<tr>
<td>Secure endotracheal tube using commercial device or properly placed</td>
<td></td>
</tr>
<tr>
<td>tape. Stabilize head.</td>
<td></td>
</tr>
<tr>
<td>Provide sedation and pain management as needed. Re-paralyze if</td>
<td></td>
</tr>
<tr>
<td>necessary.</td>
<td></td>
</tr>
<tr>
<td>Re-assess through completion of patient contact. (Vital signs and</td>
<td></td>
</tr>
<tr>
<td>interventions)</td>
<td></td>
</tr>
<tr>
<td>Use DOPES mnemonic to troubleshoot if necessary.</td>
<td></td>
</tr>
</tbody>
</table>

1. **LEMON law**: assess indicators of a difficult airway
   a. Look externally (obesity, retracted mandible, beard, abnormal dentition, etc.)
   b. Evaluate the 3-2-2 rule (mouth opening, chin to hyoid and mandible to thyroid)
   c. Mallampati classification (how much of the posterior pharynx is able to be seen)
   d. Obstruction (epiglottitis, tumor, trauma, abscess, etc.)
   e. Neck mobility (c-spine immobilization, arthritis, previous stabilization)
2. Ketamine doses as low as 0.5 mg/kg should be used with hemodynamic compromise. Standard dose is 1.5-2mg/kg.
### RSI Benchmarks

<table>
<thead>
<tr>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scene time less than 30 minutes for RSI</td>
</tr>
<tr>
<td>Documentation of patients weight</td>
</tr>
<tr>
<td>Appropriate EMD (P1 response)</td>
</tr>
<tr>
<td>3 or less intubation attempts</td>
</tr>
<tr>
<td>ET outcome %</td>
</tr>
<tr>
<td>ET success rate %</td>
</tr>
<tr>
<td>Advanced airway outcome</td>
</tr>
<tr>
<td>ETCO2 confirmation</td>
</tr>
<tr>
<td>EKG strips attached to chart</td>
</tr>
<tr>
<td>Vitals q 10 minutes</td>
</tr>
<tr>
<td>Preoxygenation guideline prior to RSI</td>
</tr>
<tr>
<td>Sedation when not contraindicated</td>
</tr>
</tbody>
</table>
REFUSAL OF EVALUATION, TREATMENT, AND/OR TRANSPORT

General Scope: Procedure for patient refusal of evaluation, treatment and/or transport.

Applies to: All Transport Staff

Guideline:

Determining capacity to refuse

Patients are considered to be capable of refusing care if they do not endorse suicidal or homicidal ideation, are oriented to person, place, time, and event (or to their baseline mental status), and can express understanding of the risks of refusal.

The use of alcohol or other drugs should not be used solely as a criterion for rendering a person incapable of making a medical decision. Rather, the circumstances of the event should be taken into account. For example, the patient who has used alcohol or other drugs with a potential for head trauma and altered mental status will be transported under implied consent whereas the substance-using patient in their home with no evidence of trauma who meets the capacity criteria above may be capable of making a medical decision.

1. Upon identification of a patient, recommend evaluation, treatment, and/or transport
2. Determine mental status and extent of illness and/or injury
   a. If subject is believed to lack capacity to refuse
      i. Treat/transport under implied consent if possible
      ii. Consider law enforcement involvement for possible chapter hold
3. Provide appropriate assessment and treatment as allowed
4. Advise patient and/or representative of potential risks of refusal and obtain acknowledgement of understanding and acceptance of risks and responsibility
5. Consider contacting Medical Control for consultation about and/or with the patient and/or representative
6. Read to the patient and/or representative the General Refusal Statement below
7. Advise the patient and/or representative call 911 for additional service if needed

"General Refusal Statement"

You understand that the EMS personnel are not physicians and our care is not a substitute for that of a physician. You recognize that you may have a serious injury or illness which could get worse without medical attention even though you (or the patient on whose behalf I legally sign this document) may feel fine at the present time.
RESTRAINT USE

General Scope: Procedure for restraint of a combative or agitated patient

Applies to: All Medical Staff

Guideline:

1. Routine medical and/or trauma assessment
2. Determine need (patient is danger to themselves or others)
3. Rule out hypoglycemia, hypoxia, hypovolemia, etc.
4. [AEMT] Establish IV/IO
5. Choose appropriate restraint or combination of restraints
6. Physical
   a. Soft restraints
      i. Secure patient to cot by use of up to four point soft restraints
      ii. Assess to ensure airway patency
      iii. Assure adequate distal circulation of all extremities
   b. Handcuffs
      i. Law enforcement must always accompany a patient in handcuffs
      ii. The goal is to transition to soft restraints when safe to do so
7. Chemical
   a. [Paramedic] Consider MIDAZOLAM IV/IO/IM
      i. 1-5mg IV/IO
         1. Pediatric (< 8 y/o) – 0.05mg/kg IV/IO
      ii. 5-10mg IM
         1. Pediatric (< 8 y/o) – 0.1mg/kg IM
   b. [Paramedic] Consider MIDAZOLAM infusion (5mg/100ml D5W or NS=0.05mg/ml) at 0.15mg/kg/hr IV/IO
   c. [Paramedic] ZIPRASADONE 10-20mg IM
      i. Use with extreme caution in the elderly
      ii. Postural hypotension can result, patients receiving ziprasadone should remain supine or lateral recumbent position
   d. [Paramedic] KETAMINE 1-2mg/kg IV/IO/IM
8. Document
   a. Reason for restraint
   b. Method used
   c. Frequent vital signs including SpO2 and LOC
SCENE REHABILITATION

**General Scope:** Guideline for rehabilitation of rescue personnel when requested to a standby

**Applies to:** All Medical Staff

**Guideline:**

1. Establish rehab area in consultation with incident command
2. Encourage removal of all PPE including bunker pants pushed down to boots
3. Rest, active cooling, and oral hydration
4. Recommend transport if any of the following criteria is met:
   a. Chest pain
   b. Shortness of breath
   c. Arrhythmia other than sinus tachycardia
   d. Syncope, confusion, or disorientation
   e. Grossly abnormal vital signs
   f. Vomiting or inability to maintain oral intake
   g. Request for transport
5. If pulse is >85% max for age
   a. Have person stand for 2 minutes and observe for symptoms
   b. Perform orthostatic vital signs
   c. If HR increase >20 or SBP drop >20
      i. [AEMT] IV rehydration up to 2 L NS
      ii. Release but not allowed to return to scene duties
6. If any of the following is met the patient must take mandatory rest, rehydration, and re-evaluation. Will require transport if no improvement within 30 minutes
   a. SBP >220
   b. RR <8 or >40
   c. Temp >101°F
   d. SpO₂ <91%
7. If none of the above is met the patient may return to full duty
8. Firefighters should report to rehab after 45 minutes or two (2) thirty minute air bottles

**Notes:**

<table>
<thead>
<tr>
<th>Age</th>
<th>Max HR</th>
<th>Age</th>
<th>Max HR</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>200</td>
<td>45</td>
<td>175</td>
</tr>
<tr>
<td>25</td>
<td>195</td>
<td>50</td>
<td>170</td>
</tr>
<tr>
<td>30</td>
<td>190</td>
<td>55</td>
<td>165</td>
</tr>
<tr>
<td>35</td>
<td>185</td>
<td>60</td>
<td>160</td>
</tr>
<tr>
<td>40</td>
<td>180</td>
<td>65</td>
<td>155</td>
</tr>
</tbody>
</table>

July 2018
SEDATION

**General Scope:** Guideline for treatment of patients who require sedation in the prehospital setting. All patients who receive sedation should have continuous monitoring of vital signs including cardiac monitoring.

**Applies to:** All Medical Staff

**Guideline:**

1. Perform routine medical assessment
2. Airway support as needed, see [Airway / Ventilatory Management Guideline](#)
3. Consider hypoxia or hypovolemia
4. If patient is combative, maintain adequate restraints, see [Restraint Guideline](#)
   a. Consider [Spit Hood](#) if needed
5. [AEMT] Establish IV/IO if possible
6. [Paramedic] MIDAZOLAM
   i. 1-5mg IV/IO
   ii. 5-10mg IM
   iii. Pediatric (< 8 y/o) – 0.05mg/kg IV/IO or 0.1mg/kg IM
7. [Paramedic] ZIPRASADONE 10-20mg IM
   i. Use caution in the elderly
8. [Paramedic] KETAMINE 1-2mg/kg IV/IO
SEIZURE

General Scope: Guideline for treatment of patients who are or suspected to be experiencing seizures

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. Airway support as needed, see Airway / Ventilatory Management Guideline
3. Consider pregnancy, see Pre-Eclampsia / Eclampsia Guideline
4. Rule out hypoglycemia, trauma, infection, hypoxia, withdrawal, or toxins
   a. If blood glucose < 60 or > 250 see Diabetic Emergency Guideline
   b. See Altered Mental Status Guideline
5. If actively seizing:
   a. [AEMT] Establish IV/IO
   b. [Paramedic] MIDAZOLAM
      i. 1-5mg IV/IO
      ii. 5-10mg IM
      iii. Pediatric (< 8 y/o) – 0.05 mg/kg IV/IO or 0.1 mg/kg IM
6. If seizure has resolved and patient is postictal
   a. [AEMT] Establish IV/IO
Sepsis / Septic Shock

General Scope: Guideline for identification and treatment of adult patients with sepsis and septic shock. For children, contact medical control if concerns of sepsis.

Applies to: All Medical Staff

Protocol:

1. Perform routine medical assessment
   a. Special attention should be paid to mental status, blood pressure, heart rate, and respiratory rate
   b. Additional vital signs to be obtained include temperature and ETCO₂

2. Compare assessment results to below chart to help determine sepsis vs septic shock

<table>
<thead>
<tr>
<th>Sepsis</th>
<th>Septic Shock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known or suspected infection or patient is at high risk of infection.</td>
<td>Presence or suspicion of sepsis. AND At least one of the following in each category:</td>
</tr>
<tr>
<td>o i.e., Immunocompromised, residents of SNFs, and those with indwelling devices (PICC line, Foley, trach, etc.)</td>
<td>Perfusion</td>
</tr>
<tr>
<td>AND</td>
<td>o Systolic blood pressure &lt; 90</td>
</tr>
<tr>
<td>Two or more of the following:</td>
<td>o Mean Arterial Pressure (MAP) &lt; 65</td>
</tr>
<tr>
<td>o Acutely altered mental status</td>
<td>Cellular Metabolism</td>
</tr>
<tr>
<td>o Temperature &gt; 100.4°F OR &lt; 96.8°F</td>
<td>o ETCO₂ of ≤ 25 mmHg</td>
</tr>
<tr>
<td>o Respiratory Rate &gt; 22 breaths/min</td>
<td>o Lactate &gt; 4 mMol</td>
</tr>
<tr>
<td>o Heart Rate &gt; 90 beats/min</td>
<td></td>
</tr>
</tbody>
</table>

3. Administer high-flow Oxygen via non-rebreather mask
   a. Establish airway per Airway / Ventilatory Management Guideline if necessary

4. [AEMT] Establish IV/IO

5. Treat as described in chart below. (Intercept recommended if BLS & septic shock)

<table>
<thead>
<tr>
<th>Sepsis</th>
<th>Septic Shock</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer normal saline at rate of 500 mL/hr</td>
<td>Establish second IV per guideline</td>
</tr>
<tr>
<td></td>
<td>Administer fluid bolus of one to two liters over 60 minutes if not contraindicated</td>
</tr>
<tr>
<td></td>
<td>If inadequate response; concurrently administer Norepinephrine infusion¹; titrated to reach MAP of &gt; 65 mmHg</td>
</tr>
<tr>
<td></td>
<td>If inadequate response to fluid &amp; norepinephrine infusion, additionally administer Epinephrine infusion²; titrated to reach MAP of &gt; 65 mmHg</td>
</tr>
</tbody>
</table>

6. Notify hospital of sepsis/septic shock patient as soon as possible.

¹ Norepinephrine: Initiate at 0.05 mcg/kg/min; titrate by 0.01-0.05 mcg/kg/min every 3-5 minutes (Max: 0.3 mcg/kg/min)
² Epinephrine: Initiate at 2-5 mcg/min; titrate by increments of no more than 1 mcg/min every 5 minutes (Max: 10 mcg/min)
SHOCK

**General Scope:** Guideline for management of shock in all patients

**Applies to:** All Medical Staff

**Guideline:**

1. Control obvious hemorrhage
2. Position patient supine when possible
3. [AEMT] Establish IV/IO
   a. Two access points if evidence of ≥ Class II shock; do not delay transport for access
   b. Titrate NS with a SBP goal of ≥ 80 in trauma patients (permissive hypotension except in patients with significant head injuries), ≥ 90 in medical patients
4. [Paramedic] For hemorrhagic shock: **Tranexamic acid (TXA)** 1g in 100ml D;W or NS IV over 10 minutes (faster may result in hypotension); use a filter needle to draw up
   a. Follow by an infusion of 1g in 500ml NS over 8 hours (*at receiving facility*)
   b. Indications: Evidence of acute blood loss—Class II or greater
   c. Administration as soon as possible but no later than 3 hours after initial injury
   d. Considerations:
      i. Contact Medical Control for patients <16
      ii. Contact Medical Control for non-traumatic hemorrhagic shock (≥ Class II)
   e. Exclusions:
      i. Known time of injury greater than 3 hours or unknown time
      ii. Known DIC
      iii. Recent history of thrombosis or thromboembolism (DVT, PE, embolic stroke).
5. If evidence of anaphylaxis, see [Anaphylaxis/Allergic Reaction Guideline](#)
6. **Shock Classifications**

<table>
<thead>
<tr>
<th>CLASS I</th>
<th>CLASS II</th>
<th>CLASS III</th>
<th>CLASS IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Loss (mL)</td>
<td>Up to 750</td>
<td>750-1500</td>
<td>1500-2000</td>
</tr>
<tr>
<td>Blood Loss (%BV)</td>
<td>Up to 15%</td>
<td>15-30%</td>
<td>30-40%</td>
</tr>
<tr>
<td>Pulse Rate</td>
<td>&lt;100</td>
<td>&gt;100</td>
<td>&gt;120</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Normal</td>
<td>Normal</td>
<td>Decreased</td>
</tr>
<tr>
<td>Pulse Pressure (mmHg)</td>
<td>Normal or increased</td>
<td>Decreased</td>
<td>Decreased</td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>14-20</td>
<td>20-30</td>
<td>30-40</td>
</tr>
<tr>
<td>Urine Output (mL/hr)</td>
<td>&gt;30</td>
<td>20-30</td>
<td>5-15</td>
</tr>
<tr>
<td>CNS/Mental Status</td>
<td>Slightly anxious</td>
<td>Mildly anxious</td>
<td>Anxious and confused</td>
</tr>
<tr>
<td>Fluid Replacement (3:1)</td>
<td>Crystalloid</td>
<td>Crystalloid</td>
<td>Crystalloid and blood</td>
</tr>
</tbody>
</table>
SELECTIVE SPINAL PRECAUTIONS

General Scope: Criteria to exclude patients selectively from spinal precautions when a low index of suspicion of injury and reassuring assessment is present.

Applies to: Paramedic or Transport Ambulance**

Guideline:

1. Perform routine trauma assessment while cervical spine is manually immobilized
2. [Paramedic] Determine if patient meets any of the following Spinal Precautions criteria. If referred to spinal precaution guidelines at any time, subsequent exams are unnecessary
   a. Altered level of consciousness? If YES see spinal precautions guideline
   b. >65 y/o or <5 y/o with significant mechanism of Injury? If YES see spinal precautions guideline
   c. Evidence of impairment by drugs/alcohol? If YES see spinal precautions guideline
   d. Painful distracting injuries? If YES see spinal precautions guideline
   e. Perform Neuro Exam: Does the patient have any focal deficit? If YES see spinal precautions guideline
   f. Perform Spinal Exam: Point tenderness over the spinous process(es)? If YES see spinal precautions guideline
   g. Perform range of motion exam: pain during motion? If YES see spinal precautions guideline
3. [Paramedic] If the answer is NO to all the above, spinal precautions may be deferred
   a. All deferred spinal precautions shall have the criteria above documented on the patient care report. When in doubt always refer to spinal precautions guideline

Pearls

You should not assume a walking patient has a clear C-Spine

Consider precautions in any patient with arthritis, cancer, dialysis or other underlying spinal or bone disease.

When present, the decision to NOT implement spinal precautions in a patient is the responsibility of the paramedic solely.

In very old and very young, a normal exam may not be sufficient to rule out spinal injury.

Range of motion should NOT be assessed if patient has midline spinal tenderness. Patient’s range of motion should not be assisted. The patient should touch his chin to his chest, extend his neck (look up), and turn his head from side to side (shoulder to shoulder) without spinal pain.
Spinal Precautions

General Scope: Transport Ambulance Guideline for spinal precautions

Applies to: All Medical staff

Guideline:

a. Explain the procedure to the patient
b. Assess CMS
c. Measure and place cervical collar while maintaining in-line stabilization of the C-Spine by a second provider.
d. If cervical collar does not fit due to obesity or physical abnormality, attempt stabilization with blanket roll
e. If patient is supine or prone place the patient on a backboard/scoop by the safest method available (i.e. log-roll, lift, etc.). For the patient in a vehicle or seated position or otherwise unable to be placed prone or supine, and the patient condition does not allow them to self-extricate to adjacent cot (i.e. other injury, pain, altered level of consciousness), place him or her on a backboard/scoop stretcher by the safest method available that allows maintenance of in-line spinal stability.
f. Using straps, secure patient to the movement device (backboard/scoop stretcher).
g. Once extricated and moved, patients should be taken off the backboard or scoop stretcher if possible, and be placed directly on the ambulance stretcher. It is acceptable to leave a patient on a backboard for transport (transports < 5 min, or life threatening patient condition), but every effort should be made to secure the patient to the stretcher and not the backboard/scoop during transport.
h. Once backboard/scoop is removed or patient self-extricates to adjacent ambulance stretcher, spinal precautions for at-risk patients is paramount. These include cervical collar, blanket/padding rolls around head, securing to stretcher with all cot straps (including shoulder belts), minimal movement/transfers, and maintenance of in-line spine stabilization during necessary movement/transfers.

Note:

Spinal precautions may be achieved by many appropriate methods. In addition, some patients, due to size or age, will not be able to be immobilized through in-line stabilization with standard devices and C-collars. Never force a patient into a non-neutral position to immobilize him or her. Manual stabilization may be required during transport. Special situations such as athletes in full shoulder pads and helmet may remain immobilized with helmet and pads in place, unless a sports medicine trainer that is knowledgeable regarding the proper removal of that athletic equipment is present. The sports medicine trainer may be the most appropriate person involved in the care of the athlete to properly remove athletic equipment.

Patient with penetrating traumatic injuries should only be immobilized if a focal neurological deficit is noted on physical exam.
Spinal Examination

**General Scope:** This procedure details the spinal examination process and must be used in conjunction with the spinal precautions clearance guideline.

**Applies to:** Paramedic/Transport Ambulance

**Guideline:**

a. Explain to the patient the actions you are going to take. Ask the patient to immediately report any pain, and to answer questions with a “yes” or “no” rather than shaking the head

b. With the patient’s spine supported to limit movement, begin palpation at the base of the skull at the midline of the spine

c. Palpate the vertebrae individually from the base of the skull to the bottom of the sacrum

d. On palpation of each vertebral body, look for evidence of pain and ask the patient if they are experiencing pain. If evidence of pain along the spinal column is encountered, the patient should be immobilized

e. If the capable patient is found to be pain free, ask the patient to turn their head first to one side (so that the chin is pointing toward the shoulder on the same side as the head is rotating) then, if pain free, to the other. If there is evidence of pain the patient should be immobilized

f. With the head rotated back to its normal position, ask the patient to flex and extend their neck. If there is evidence of pain the patient use [spinal precautions guideline](#)
SPINAL PRECAUTIONS FOR NON-TRANSPORT EMT/EMR

**General Scope:** Guideline for spinal precautions for agencies that have spinal precautions training but do not transport.

**Applies to:** Non-Transport EMT/EMR

**Guideline:**

a. Explain the procedure to the patient
b. Asses CMS
c. Measure and place cervical collar while maintaining in-line stabilization of the C-spine by a second provider.
d. If cervical collar does not fit due to obesity or physical abnormality, attempt stabilization with blanket roll
e. If patient does not need to be moved do not place patient on longboard/scoop and await transport ambulance arrival.
f. If patient does require movement proceed to next step.
g. If indicated, place the patient on a long spine board with the log-roll technique if the patient is supine or prone. For the patient in a vehicle or otherwise unable to be placed prone or supine, place him or her on a backboard by the safest method available that allows maintenance of in-line spinal stability.
h. Stabilize the patient with straps and head rolls/tape or other similar device. Once the head is secured to the backboard, the second rescuer may release manual in-line stabilization.

**Note:**

Spinal precautions may be achieved by many appropriate methods. In addition, some patients, due to size or age, will not be able to be immobilized through in-line stabilization with standard devices and C-collars. Never force a patient into a non-neutral position to immobilize him or her. Manual stabilization may be required during transport. Special situations such as athletes in full shoulder pads and helmet may remain immobilized with helmet and pads in place, unless a sports medicine trainer that is knowledgeable regarding the proper removal of that athletic equipment is present. The sports medicine trainer may be the most appropriate person involved in the care of the athlete to properly remove athletic equipment.

Patients with penetrating traumatic injuries should only be immobilized if a focal neurological deficit is noted on physical exam.

July 2018
SPIT HOOD

General Scope: Guideline for use of protective hoods. This guideline should be used for patients whom are combative and/or aggressive, and purposely attempting to spit on providers or other public safety personnel. Spitting carries potential risk of disease transmission. Use of a protective hood minimizes said risk.

Applies to: All Medical Staff

Guideline:

1. Use of one-piece surgical mask or oxygen mask is preferred for minimizing risk of disease transmission by patients whom are purposely spitting.
2. CONDITIONS FOR USE
   a. DO NOT USE unless patient is under control and restrained.
   b. DO NOT USE on anyone that is vomiting, having difficulty breathing, or is bleeding profusely from the area around the mouth or nose.
   c. Patient must be under constant visual supervision and should never be left unattended.
   d. Remove patient's jewelry and eyewear before application.
   e. If there is difficulty applying due to large size head, discontinue use.
   f. Conditions for use should be constantly monitored during patient encounter.
3. PROCEDURE FOR USE
   a. Open and remove the spit hood
   b. Place the spit hood over the head of the person with the mesh fabric positioned just below the eyes to allow the person to see.
   c. For the best fit, place the center elastic under the nose and over the ears. For better protection, the elastic may be placed above the nostrils.
   d. Carefully push the plastic Secure-Lock Tab down toward the top of the head while holding the top of the mesh fabric. This should take the slack out of the top and help secure the spit hood in position.
      i. ** DO NOT push so tightly as to be uncomfortable or impair the vision of the wearer.
   e. See manufacturer instructions included in packaging for visual representation of procedure for use.
   f. Patient should be transported in either left or right lateral position.
   g. CONTINUOUSLY monitor patient’s airway, respiratory status, and pulse oximetry.
   h. IMMEDIATELY remove surgical mask, oxygen mask, or spit hood if any question of airway patency or potential compromise.
SURGICAL CRICOPTHYROIDOTOMY

**General Scope:** Procedure for surgical cricothyroidotomy.

**Applies to:** Paramedics

**Guideline:**

1. Attempt to provide optimal O\(_2\) saturation prior to starting
2. Palpate cricothyroid membrane and clean area with antiseptic wipe
3. Make midline incision with scalpel over cricothyroid membrane
4. Insert trach hook and provide upward and caudal traction
5. Use scalpel to open transversely into trachea keeping blade near or against trach hook
6. Introduce 6.0 mm ETT
   a. Inflate with 5-10ml air
7. Auscultate chest and secure device

**Notes:**

- **Needle Cricothyroidotomy** is recommended for children under 10 years old.
SUSTAINED VENTRICULAR TACHYCARDIA / WIDE COMPLEX TACHYCARDIA

General Scope: Guideline for treatment of a patient in presenting in a wide or ventricular tachycardic rhythm

Applies to: EMT-I (identification) and Paramedic

Guideline:

1. Perform routine medical assessment
2. [AEMT] Establish IV/IO
3. If patient is hemodynamically unstable
   a. [Paramedic] Consider sedation per Sedation Guideline
   b. [Paramedic] SYNCHRONIZED CARDIOVERSION starting at 100] – 200]
      i. [Paramedic] If successful begin AMIODARONE infusion (150 mg in 100 D5W or NS=1.5mg/ml) at 1mg/min IV/IO (40cc/hr =1mg/min)
4. If patient is hemodynamically stable
   a. [EMT] Obtain 12-lead ECG
   b. [Paramedic] If rhythm is regular & monomorphic consider ADENOSINE 6 mg IV/IO
      i. [Paramedic] Repeat at 12mg (may repeat twice)
   c. [Paramedic] Administer AMIODARONE 150 mg IV/IO over 10 minutes
      i. [Paramedic] If successful begin AMIODARONE drip (150 mg in 100 D5W or NS=1.5mg/ml) at 1mg/min IV/IO (40cc/hr =1mg/min)
      ii. [Paramedic] If unsuccessful consider cardioversion (see #3)
5. [Paramedic] Consider MAGNESIUM SULFATE 2 grams (2G in 100ml D5W or NS) IV/IO over 1-2 minutes for polymorphic wide complex tachycardia (Torsades de Pointes)

Note:

- For rates less than 150 bpm, evaluate for non-cardiac causes of the tachycardia (hypovolemia, infection, bleeding, pain, etc.)
- Amiodarone Precautions
  - Hypotension secondary to vasodilatation
  - May prolong QT interval
  - Negative inotropic effects
  - Use with caution in renal failure; long T1/2 life
THORACIC/ABDOMINAL AORTIC ANEURYSM/DISSECTION

General Scope: Guideline for treatment of patients who present with signs and symptoms consistent with that of an aortic aneurysm

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. Airway support as needed, see Airway / Ventilatory Management Guideline
3. [AEMT] Establish IV/IO (Two large bore lines if possible)
4. Treat pain per Pain Management Guideline
5. If patient SBP >130:
   a. [Paramedic/Med Control] NITROGLYCERINE INFUSION (20mg/100ml D$_5$W or NS—200mcg/ml)
      i. For patients <75kg, start at 10mcg/min
      ii. For patients >75kg, start at 20mcg/min
      iii. Titrate by 5-10mcg/min every 5-10 minutes to SBP~110
      iv. Monitor BP every 3-5 minutes
   b. [Paramedic/Med Control] Labetalol 20mg Slow IV
      i. May repeat at 40mg every 10 minutes to a max of 300mg
6. If patient SBP <90
   a. [AEMT] 250-500ml NS bolus up to 2-3 liters total
   b. [Paramedic] Consider NOREPINEPHRINE infusion
      i. Initiate at 0.05 mcg/kg/min via IV pump
         1. Titrate by 0.01-0.05 mcg/kg/min every 3-5 minutes
         2. Maximum of 0.3 mcg/kg/min

Note:
Patient assessment
1. History:
   a. Thoracic:
      i. Relatively sudden onset
      ii. Severe "tearing" chest pain with possible radiation to back
   b. Abdominal:
      i. Intermittent or constant abdominal pain commonly localized to left middle or lower quadrant
      ii. Back pain and flank pain are the next most common symptoms
2. Physical exam:
   a. Possible hypotension
   b. Pulse discrepancy side-to-side or upper versus lower extremities
   c. Pulsatile abdominal or groin mass with or without a bruit
TRAUMA IN PREGNANCY

General Scope: Guideline for treatment of all potentially pregnant patients with potential trauma.

Applies to: All Medical Staff

Guideline:

1. Perform routine medical and trauma assessment
2. See General Trauma Guideline
3. Position patient on left side (minimize uterine compression on the inferior vena cava)
4. [AEMT] Establish IV/IO
5. Maintain blood pressure, see Blood Pressure Management Guideline
   a. SBP & DBP is usually 5-15mmHg less starting in second trimester
   b. HR is usually 15-20 BPM more during third trimester
   c. Shock is not always obvious in the pregnant patient (Because of an increase in circulating blood volume during pregnancy, the pregnant female will show signs of hypovolemia later in their course)
VENTRICULAR FIBRILLATION / PULSELESS VENTRICULAR TACHYCARDIA

General Scope: Guideline for treatment of a patient presenting with ventricular fibrillation or pulseless ventricular tachycardia in cardiac arrest

Applies to: All Medical Staff

Guideline:

1. Perform routine medical assessment
2. Initiate high-quality CPR and continue throughout resuscitation with minimal interruptions
   a. [Paramedic] May administer precordial thump if witnessed arrest
3. Apply defibrillator or AED
   a. If manual; defibrillate at manufacturer recommended energy settings, typically 120J-200J
   b. Repeat defibrillation (consider escalating energy if available) every 2 minutes with medications administered as listed below
4. [AEMT] Establish IV/IO
5. Establish airway per Airway / Ventilatory Management Guideline
6. [Paramedic] Administer EPINEPHRINE (1mg/10mL [1:10,000]) 1mg IV/IO Q 3-5 minutes
7. [Paramedic] Administer AMIODARONE 300mg IV/IO
   a. [Paramedic] May repeat with 150mg IV/IO
8. [Paramedic] Consider MAGNESIUM SULFATE 2 grams (2g in 100ml D5W or NS) IV over 1-2 minutes for torsades de pointes
9. [Paramedic] Consider SODIUM BICARBONATE 50mEq IV/IO
10. If pulse is returned see Post Arrest Guideline
APPENDIX A-1: AMIODARONE INFUSION

**General Scope:** Infusion rate and medication dose

**Applies to:** Paramedics

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**APPENDIX A-2: DOPAMINE INFUSION**

**General Scope:** Infusion rate and medication dose

**Applies to:** Paramedics

### 200mg/250cc D_5W (800 mcg/mL)

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### 200mg/250cc D_5W (800 mcg/mL)

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APPENDIX A-3: EPINEPHRINE INFUSION

**General Scope:** Infusion rate and medication dose

**Applies to:** Paramedics

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## APPENDIX A-4: LIDOCAINE INFUSION

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**Lidocaine Infusion Premixed (4 mg/ml)**
## APPENDIX A-5: NITROGLYCERINE INFUSION

**General Scope:** Infusion rate and medication dose

**Applies to:** Paramedics

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# Appendix A-6: Norepinephrine Infusion

**General Scope:** Infusion rate and medication dose

**Applies to:** Paramedics

---

### 4mg/250cc D5W (16 mcg/mL)

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*Note: The infusion rate is given in ml/hr.*
APPENDIX A-7: PUSH DOSE EPINEPHRINE

General Scope: Procedure for dilution/creation of “push dose epinephrine”

Applies to: Paramedics**

Procedure:

1. Expel one milliliter of normal saline from a 10 mL preloaded normal saline syringe
2. Attach needle to preloaded normal saline syringe and draw one milliliter of 1:10,000 epinephrine (1mg/10mL – “cardiac epinephrine”)
3. Verify syringe now contains 0.1mg epinephrine in 10mL of solution
   a. Concentration is now 100 mcg/10mL or 10mcg/mL
4. Label syringe with appropriate notation
Appendix B-1: Chest Tube Monitoring

General Scope: Chest tube monitoring.

Applies to: Paramedics and Critical Care Paramedics

Indications: Chest tubes are indicated for pneumothorax, hemothorax and pleural empyema.

Guideline:

1. Routine Trauma and/or Medical Assessment.
2. Assure that the chest tube(s) is securely fastened to the patient.
3. Check chest tube(s) for patency and proper function prior to transport.
4. Assure that the long flexible tubing is securely fastened to the container that acts as a drainage device, water seal and suction control device. Assure that the tubing is free of kinks.
5. Make note of the fluid and blood levels in the drainage and water seal compartments.
6. Obtain orders as to the water seal level.
7. When suction is used, assure that there is bubbling in the suction control chamber. (if not, check the suction unit).
8. If the water seal fails to stop bubbling after the lung is re-inflated or later begins to bubble:
   a. Momentarily clamp the flexible tubing near the chest. If the bubbles quit emanating from the tube while it is clamped, then the problem is either a persistent air leak in the patient’s lung or the chest tube is not sealed at the chest wall.
   b. Never leave the clamp on for more than a few seconds.
   c. Evaluate the insertion site.
   d. Apply occlusive dressings to the site.
   e. Evaluate the patient for distress.
   f. Consult physician immediately if needed.
   g. If the bubbling does not cease during the clamping of the proximal end, then suspect a leak at a connection site in the tubing or the tubing itself.
      i. Check all connections and secure with tape.
      ii. Seal the leak with occlusive dressing and tape or replace the tubing. When replacing the tubing, remember to clamp the distal end of the chest tube to avoid the formation of a pneumothorax.
9. If water seal device becomes damaged, a temporary water seal can be accomplished by putting flexible tubing into a bottle of sterile saline. Keep this device and tubing below chest level.
10. Consult with the physician/staff for the best patient positioning.
11. If the chest tube is not functioning and a tension pneumothorax is suspected, perform a needle decompression of the affected side.
APPENDIX B-2: VENTILATOR / BiPAP USE

**General Scope:** Guideline and criteria for transport ventilator and BiPAP use.

**Applies to:** All Critical Care Staff

**Guideline:**

1. **VENTILATOR SETTINGS**
   a. If time allows during response, turn on ventilator connected to test lung.
   b. Mode: Set at Assist Control or SIMV
   c. Go to Powerup setting. Change to Powerup with user 1. Go to Save Setting and save user 1 settings. This should allow the vent to turn on with your recent settings. Note: This will only save the most basic settings, such as Mode, Vt and I:E ratio. This will not save high and low pressure alarm setting or Trigger level settings.
   d. Turn Vent off until patient side.
   e. Turn vent on
   f. Set High and Low pressure alarms to desired setting.
   g. Press menu button.
   h. Adjust trigger level to desired setting
   i. Adjust Contrast to desired setting
   j. Initial tidal volume: 6-8 cc/kg **IDEAL BODY WEIGHT**; max of 800cc.
   k. FiO2 100% or adjust FiO2 to maintain SaO2 at >95%
   l. PEEP: 5 cm. Titrate in increments of 2 cm (max of 10 cm) every 15 minutes to increase oxygenation saturations where other measures (sedation, paralysis) have failed and SBP is > 90mmHg.
   m. RR: 8-10
      i. If attempting to decrease intracranial pressure [ICP] hyperventilate keeping EtCO2 between 30-35. Start at a rate of 10 and increase or decrease rate in increments of 2 to obtain desired EtCO2
      ii. If RR 16-20, use no PEEP
   n. Be aware of pneumothorax risk (especially with traumatic chest injuries)
   o. Maintain EtCO2 between 35-40 for most patients; 30-35 if evidence of lateralizing signs
   p. Pressure alarm: monitor patient’s inspiratory pressure and set at 10 cm above Peak Inspiratory Pressure
   q. Increase sensitivity slowly if ventilator doesn’t capture inspiratory effort
   r. Monitor I:E ratio and maintain at a minimum of 1:2 if patient is prone to air-trapping
APPENDIX B-2: VENTILATOR / BiPAP USE (CONTINUED)

2. NPPV (BiPAP)
   a. NPPV delivers CPAP but also senses when an inspiratory effort is being made and delivers a higher pressure during inspiration. This positive pressure wave during inspirations unloads the diaphragm decreasing the work of breathing.
   b. Indications
      i. Recent and rapid worsening of dyspnea
      ii. Respiratory rate > 30
      iii. pH < 7.28
      iv. PaCO2 > 50mmHg
      v. Hypoxemia
         1. Pneumonia
         2. Fluid overload
      vi. CHF
      vii. Moderate to severe respiratory failure
      viii. Post-op patients with rising EtCO2 levels
      ix. COPD patients with acute-on-chronic respiratory failure
   c. Exclusion criteria
      i. Recurrent aspiration
      ii. Large volumes of secretions
      iii. Inability to protect the airway
      iv. Vomiting
      v. Obstructed bowel
      vi. Upper airway obstruction
      vii. Uncooperative, confused or combative patient
      viii. ARDS
      ix. Inability to tolerate a tight mask
      x. Orofacial abnormalities which interfere with mask/face interface
      xi. Hemodynamic instability
      xii. Untreated pneumothorax

3. Settings for Impact Ventilator BiPAP.
   a. Preset alarms and settings by turning the unit on: let the vent start in default mode.
   b. Select CPAP under the mode menu. Then change PPV to NPPV in the upper right hand corner of the mode menu. Always make sure to use the green check mark when changing a setting.
   c. If the BiPAP setting are unknown start with 10 over 5. This is done by setting the PEEP at 5 and the pressure support to 5. Remember pressure support is found in the secondary PIP menu. This is achieved by pressing and holding the PIP menu button for greater than 5 seconds.
   d. Pressure support of 5 and PEEP of 5 is equal to BiPAP of 10/5
   e. Use a standard resuscitation mask with blue elbow and the head strap when providing BiPAP with the Impact ventilator.
   f. If improvement in ventilation and oxygenation is not achieved, discontinue NPPV and consider tracheal intubation
APPENDIX B-2: VENTILATOR / BIPAP USE (CONTINUED)

4. Pediatric recommendations
   a. Less than 1 year of age
      i. Assist control pressure ventilation mode
      ii. PIP 15 (increase pressure only if needed to get normal chest rise)
      iii. Inspiratory time 0.7 seconds
      iv. Rate of 15 (increase by increments of 5 to maintain EtCO\textsubscript{2} between 40-50)
      v. PEEP of 4
      vi. FiO\textsubscript{2} to maintain sats > 95%
      vii. Monitor TV
   b. Greater than 1 year of age
      i. Assist control volume mode
      ii. Start with default Pediatric settings
      iii. Change to Volume Mode; calculate 10 ml/kg TV
      iv. Inspiratory time 0.7 seconds
      v. Rate of 15 (increase by increments of 5 to maintain EtCO\textsubscript{2} between 40-50)
      vi. PEEP of 4
      vii. FiO\textsubscript{2} to maintain sats > 95%
      viii. Monitor TV

5. Recommended settings for specific scenarios
   a. Severely brain injured i.e. localizing signs such as dilated pupil and posturing
      i. Assist control
      ii. RR 8-12
      iii. TV 6-8 cc/kg ideal body weight
      iv. PEEP 5 cm
      v. FiO\textsubscript{2} 100% or adjust FiO\textsubscript{2} to maintain SaO\textsubscript{2} at >95%
   b. Depressed respiratory drive, eg. intoxicated or overdose patient
      i. Assist control or SIMV
      ii. RR 6-15
      iii. TV 6-8 cc/kg ideal body weight
      iv. PEEP 5 cm
      v. FiO\textsubscript{2} 100% or adjust FiO\textsubscript{2} to maintain SaO\textsubscript{2} at >95%
   c. Acute bronchospasm
      i. Assist control
      ii. RR 8-10
      iii. TV 6-8 cc/kg ideal body weight
      iv. PEEP 5 cm
      v. FiO\textsubscript{2} 100% or adjust FiO\textsubscript{2} to maintain SaO\textsubscript{2} at >95%
      vi. May need to increase peak flow setting to 50-80 lpm
      vii. Consider decreased inspiration time
   d. Multilobar disease, eg. pneumonia, pulmonary edema/ARDS, extensive disease patterns
      i. Assist control
      ii. RR 10-20
      iii. TV 6-8 cc/kg ideal body weight
      iv. PEEP 5 cm with titration to maintain oxygen saturations
      v. FiO\textsubscript{2} 100% or adjust FiO\textsubscript{2} to maintain SaO\textsubscript{2} at >95%
      vi. Set inspiratory flow rate above patient demand, usually greater than 80 lpm
APPENDIX B-3: BLOOD TRANSFUSION CONTINUATION & MONITORING

General Scope: Guideline and criteria for transport infusion of blood product.

Applies to: Paramedics & Critical Care Paramedics

Guideline:

1. Obtain written order for rate and total volume of blood product to be infused, confirm with RN or physician
2. Confirm with RN or physician that name on patient’s wristband matches the name on the infusing blood product. The patient must have a wristband, no exceptions.
3. Infusion of blood products
   a. [Paramedic] Blood product infusion must be initiated prior to transport of patient
   b. [Critical Care Paramedic] Blood product infusion may be initiated during transport
4. Vital signs (including body temperature) must be recorded pre-transport and q10 minutes during transport
5. If the patient develops any sign of allergy/sensitivity reaction, including; chills, fever, chest pain, flank pain, hives, wheezing, urticaria, or the patient shows signs of shock; the following actions should be taken immediately:
   a. Infusion of blood product must be immediately stopped, disconnected, and all tubing and product saved for delivery to the receiving facility.
   b. IV/IO NS initiated
   c. See Blood Pressure Management Guideline
   d. See Anaphylaxis Guideline
   e. Hemolytic reactions (fever, chills, chest pain, flank pain, and/or shock) may occur.
      Contact Medical Control if a hemolytic reaction is suspected.
6. Written orders must accompany patient and be included in the patient care report.

Note:

- Blood products that are not infusing at the time of transport should remain in a cooler; must be provided by sending facility.
APPENDIX B-4: ARTERIAL LINE, CENTRAL LINE, AND CVP MONITORING

**General Scope:** Guideline and criteria for accessing central lines, and monitoring arterial lines and central venous pressure.

**Applies to:** All Critical Care Staff

**Guideline:**

**Arterial Line Monitoring**

1. Ensure the pressure bag is pressurized to 300 mm Hg
2. Use steps 3-6 if using arterial line to measure arterial blood pressure
3. With the transducer connected to the monitor, select arterial monitor, and perform a transducer check by fast flushing the line. As you do this, you should see a change in the waveform. This is called a square wave test.
4. Zero the transducer and monitor
   a. Place the transducer at the phlebostatic axis of the patient.
   b. Close the line off to patient and open to air.
   c. Press zero on the monitor.
   d. To monitor pressure, close the port off to an air and open to patient.
5. Connect the catheter and fast flush to clear the catheter of blood.
6. Check for good waveform.

**Central Line Access**

1. To access the line first clamp off the hub line you intend to use.
   a. It’s important to clamp off the line to prevent air from being sucked in to the line and blood stream.
   b. Any of the hub lines can be used, they all go to the same place and work the same way.
2. Once you have the line clamped off, expose the end of the hub (it may have a cap or be taped over) clean it well with an alcohol prep and put an INT hub on it.
3. With the INT hub in place, unclamp the tubing and let the INT hub seal out air.
4. Clean the INT hub and attach an empty 10 cc syringe to the INT hub
   a. Aspirate about 5ml of blood and heparin to confirm the line is in place,
      i. There should be no resistance to aspiration.
   b. Discard the syringe and contents as biohazard waste.
5. Attach a saline flush syringe to INT hub and flush it gently.
6. Attach a flushed 60 drop set (or blood set if you think you need volume replacement) and saline bag and run it into the line at a TKO rate.
7. Use the y-sites on the IV tubing to give meds as needed; make sure to clean the y-site correctly and flush with the saline IV line after each med.
Continuous Venous Pressure Monitoring:

1. Assemble A-line set up as per arterial line monitoring system or Swan-Ganz multi-lumen monitoring system instructions.
2. Make sure there are no air bubbles in the system.
3. Connect pressurized tubing to central venous catheter.
4. Zero and calibrate transducer system.
5. Validate waveform on monitor. Obtain 'mean' pressure reading.
APPENDIX B-5: PICC LINE USAGE

General Scope: Guideline and criteria for accessing and using PICC lines

Applies to: Paramedic

Guideline:

1. May administer medications through previously placed PICC lines when no other option is available.
   a. Maintenance of aseptic technique is of significant importance.
   b. If inter-facility transport, consult with referral facility RN for port selection
   c. If cardiac arrest, use any port
   d. Flush medication with 10ml NS using at least a 10cc syringe.
      i. Syringes smaller than 10cc can exert excessive pressure on PICC lines.
   e. Maintain dressing at PICC site.
APPENDIX B-6: TRANSVENOUS PACEMAKER

General Scope: Guideline and criteria for transporting a patient with a transvenous pacemaker

Applies to: All Critical Care Staff

Guideline:

1. Locate pacemaker generator
2. Ensure battery is fresh
3. Identify each wire set as atrial or ventricular
   a. Epicedial ventricular wires exit from the left side of the chest
   b. Atrial wires exit from the right side of the chest generally
4. Verify wires are attached to the appropriate sites
5. Ensure power is on the pulse generator
6. Confirm set rate based on need and physician orders
7. Confirm amperage settings
8. Confirm sensitivity
   a. Start at 2-5mV
   b. If failure occurs turn sensitivity DOWN
   c. If pacer is sensing beats not present turn sensitivity UP
9. Observe patient for response
10. Secure all wires, connections, and pacemaker in a safe location
APPENDIX B-7: FOLEY CATHETER INSERTION

General Scope: Guideline and criteria for foley catheter insertion

Applies to: All Critical Care Staff

Guideline:

1. Gather equipment.
2. Explain procedure to the patient.
3. Assist patient into supine position with legs spread and feet together.
4. Open catheterization kit and catheter.
5. Prepare sterile field, apply sterile gloves.
6. Check balloon for patency.
7. Generously coat the distal portion (2-5 cm) of the catheter with lubricant.
8. Apply sterile drape.
9. If female, separate labia using non-dominant hand. If male, hold the penis with the non-dominant hand. Maintain hand position until preparing to inflate balloon.
10. Using dominant hand to handle forceps, cleanse peri-urethral mucosa with cleansing solution. Cleanse anterior to posterior, inner to outer, one swipe per swab, discard swab away from sterile field.
11. Pick up catheter with gloved (and still sterile) dominant hand. Hold end of catheter loosely coiled in palm of dominant hand.
12. In the male, lift the penis to a position perpendicular to patient’s body and apply light upward traction (with non-dominant hand).
13. Identify the urinary meatus and gently insert until 1 to 2 inches beyond where urine is noted.
14. Inflate balloon, using correct amount of sterile liquid (usually 10 cc but check actual balloon size).
15. Gently pull catheter until inflation balloon is snug against bladder neck.
16. Connect catheter to drainage system.
17. Secure catheter to abdomen or thigh, without tension on tubing.
18. Place drainage bag below level of bladder.
19. Evaluate catheter function and amount, color, odor, and quality of urine.
20. Remove gloves, dispose of equipment appropriately, wash hands.
APPENDIX B-8: CRITICAL CARE SEDATION (ADULT)

**General Scope:** Guideline for treatment of adult patients who require sedation during critical care transports. All patients who receive sedation should have continuous monitoring of vital signs including cardiac monitoring.

**Applies to:** Critical Care Paramedics

**Guideline:**

1. Perform routine medical assessment
2. Airway support as needed, see Airway / Ventilatory Management Guideline
3. Consider hypoxia or hypovolemia
4. If patient is combative, maintain adequate restraints, see Restraint Guideline
5. Establish IV/IO
6. For routine sedation see Sedation Guideline
7. If patient is intubated:
   a. PROPOFOL Infusion
      i. Use PROPOFOL calc function on pump
      ii. 5-50 mcg/kg/min. If greater than 50 mcg is required contact medical control. Absolute maximum dose is 80 mcg/kg/min
      iii. May increase 5-10 mcg/kg/min every five minutes based on required sedation
      iv. Bolus dosing 0.1-0.5 mg/kg IVP slowly to quickly increase depth of sedation for patients not at risk for hypotension
   b. MIDAZOLAM Infusion
      i. Use MIDAZOLAM calc function on pump
      ii. Mix 10 mg in 100 mL NS
      iii. 1-7 mg/hr
   c. KETAMINE Infusion
      i. Use GENERIC drug calc function on pump
      ii. Mix 500 mg in 250 mL NS
      iii. 50 mcg/kg/hr
APPENDIX B-9: CRITICAL CARE SEDATION (PEDIATRICS)

**General Scope:** Guideline for treatment of pediatric patients who require sedation during critical care transports. Pediatric patients are considered such between 5kg and 49.9kg. All patients who receive sedation should have continuous monitoring of vital signs including cardiac monitoring.

**Applies to:** Critical Care Paramedics

1. Perform routine medical assessment
2. Airway support as needed, see [Airway / Ventilatory Management Guideline](#)
3. Consider hypoxia or hypovolemia
4. If patient is combative, maintain adequate restraints, see [Restraint Guideline](#)
5. Establish IV/IO
6. For routine sedation see [Sedation Guideline](#)
7. If patient is intubated:
   a. **PROPOFOL** Infusion
      i. Use PROPOFOL calc function on pump
      ii. Start at 125 mcg/kg/min
      iii. May increase 5-10 mcg/kg/min every five minutes up to 300 mcg/kg/min
      iv. Bolus dosing 0.1-0.5 mg/kg IVP slowly to quickly increase depth of sedation for patients not at risk for hypotension
   b. **MIDAZOLAM** Infusion
      i. Use GENERIC drug calc function on pump
      ii. Mix 5 mg in 100mL NS
      iii. 1 mcg/kg/min
   c. **FENTANYL** Infusion
      i. Use GENERIC drug calc function on pump
      ii. Mix 100 mcg in 100 mL NS
      iii. 0.5 mcg/kg/hr
APPENDIX B-10: IDEAL BODY WEIGHT CHART

<table>
<thead>
<tr>
<th>Height</th>
<th>Male</th>
<th>Ideal Weight</th>
<th>Male</th>
<th>Ideal Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>4’ 6”</td>
<td>63 - 77 lbs.</td>
<td>5’ 0”</td>
<td>95 - 117 lbs.</td>
<td></td>
</tr>
<tr>
<td>4’ 7”</td>
<td>68 - 84 lbs.</td>
<td>5’ 1”</td>
<td>101 - 123 lbs.</td>
<td></td>
</tr>
<tr>
<td>4’ 8”</td>
<td>74 - 90 lbs.</td>
<td>5’ 2”</td>
<td>106 - 130 lbs.</td>
<td></td>
</tr>
<tr>
<td>4’ 9”</td>
<td>79 - 97 lbs.</td>
<td>5’ 3”</td>
<td>112 - 136 lbs.</td>
<td></td>
</tr>
<tr>
<td>4’ 10”</td>
<td>85 - 103 lbs.</td>
<td>5’ 4”</td>
<td>117 - 143 lbs.</td>
<td></td>
</tr>
<tr>
<td>4’ 11”</td>
<td>90 - 110 lbs.</td>
<td>5’ 5”</td>
<td>122 - 150 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 0”</td>
<td>95 - 117 lbs.</td>
<td>5’ 6”</td>
<td>128 - 156 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 1”</td>
<td>101 - 123 lbs.</td>
<td>5’ 7”</td>
<td>133 - 163 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 2”</td>
<td>106 - 130 lbs.</td>
<td>5’ 8”</td>
<td>139 - 169 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 3”</td>
<td>112 - 136 lbs.</td>
<td>5’ 9”</td>
<td>144 - 176 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 4”</td>
<td>117 - 143 lbs.</td>
<td>5’ 10”</td>
<td>149 - 183 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 5”</td>
<td>122 - 150 lbs.</td>
<td>5’ 11”</td>
<td>155 - 189 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 6”</td>
<td>128 - 156 lbs.</td>
<td>6’ 0”</td>
<td>160 - 196 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 7”</td>
<td>133 - 163 lbs.</td>
<td>6’ 1”</td>
<td>166 - 202 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 8”</td>
<td>139 - 169 lbs.</td>
<td>6’ 2”</td>
<td>171 - 209 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 9”</td>
<td>144 - 176 lbs.</td>
<td>6’ 3”</td>
<td>176 - 216 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 10”</td>
<td>149 - 183 lbs.</td>
<td>6’ 4”</td>
<td>182 - 222 lbs.</td>
<td></td>
</tr>
<tr>
<td>5’ 11”</td>
<td>155 - 189 lbs.</td>
<td>6’ 5”</td>
<td>187 - 229 lbs.</td>
<td></td>
</tr>
<tr>
<td>6’ 0”</td>
<td>160 - 196 lbs.</td>
<td>6’ 6”</td>
<td>193 - 235 lbs.</td>
<td></td>
</tr>
<tr>
<td>6’ 1”</td>
<td>166 - 202 lbs.</td>
<td>6’ 7”</td>
<td>198 - 242 lbs.</td>
<td></td>
</tr>
<tr>
<td>6’ 2”</td>
<td>171 - 209 lbs.</td>
<td>6’ 8”</td>
<td>203 - 249 lbs.</td>
<td></td>
</tr>
<tr>
<td>6’ 3”</td>
<td>176 - 216 lbs.</td>
<td>6’ 9”</td>
<td>209 - 255 lbs.</td>
<td></td>
</tr>
<tr>
<td>6’ 4”</td>
<td>182 - 222 lbs.</td>
<td>6’ 10”</td>
<td>214 - 262 lbs.</td>
<td></td>
</tr>
<tr>
<td>6’ 5”</td>
<td>187 - 229 lbs.</td>
<td>6’ 11”</td>
<td>220 - 268 lbs.</td>
<td></td>
</tr>
<tr>
<td>6’ 6”</td>
<td>193 - 235 lbs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6’ 7”</td>
<td>198 - 242 lbs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6’ 8”</td>
<td>203 - 249 lbs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6’ 9”</td>
<td>209 - 255 lbs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6’ 10”</td>
<td>214 - 262 lbs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6’ 11”</td>
<td>220 - 268 lbs.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**APPENDIX C-1: TRAUMA ACTIVATION**

**General Scope:** Guideline/criteria for activation of trauma team at Gundersen Health System

**Applies to:** Tri-State Ambulance Personnel (Reference for all other agencies)

<table>
<thead>
<tr>
<th>RED ACTIVATION</th>
<th>YELLOW ACTIVATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic arrest: active or history of</td>
<td>• Extrication greater than 20 minutes</td>
</tr>
<tr>
<td>Intubated, advanced airway adjunct and/or respiratory compromise, obstruction, stridor, or grunting in children</td>
<td>• Combination of trauma with burns</td>
</tr>
<tr>
<td>Systolic blood pressure, confirmed by sequential readings of:</td>
<td>Burns</td>
</tr>
<tr>
<td>Adult</td>
<td>• Burns</td>
</tr>
<tr>
<td>Pediatric</td>
<td>Adult &gt; 20% TBSA or involving face or airway</td>
</tr>
<tr>
<td>&lt; 90 mmHg</td>
<td>Pediatric &gt; 15% TBSA</td>
</tr>
<tr>
<td>&lt; 60 mmHg (0-6 months)</td>
<td>Evisceration</td>
</tr>
<tr>
<td>&lt; 70 mmHg (6 months-5 yrs)</td>
<td>• Ejection from enclosed vehicle</td>
</tr>
<tr>
<td>&lt; 80 mmHg (over 5 yrs)</td>
<td>Falls</td>
</tr>
<tr>
<td>Penetrating injury to torso, neck, or head</td>
<td>Adult &gt; 20 feet</td>
</tr>
<tr>
<td>Extremity injuries</td>
<td>Pediatric &gt; 15 feet</td>
</tr>
<tr>
<td>Penetrating injury to extremity with pulsatile bleeding</td>
<td>Auto-pedestrian/auto-bicycle with speeds &gt; 20 mph</td>
</tr>
<tr>
<td>Complete or partial amputation proximal to wrist or ankle</td>
<td>High-voltage electrocution</td>
</tr>
<tr>
<td>Crushed, degloved, or mangled</td>
<td>Moderate hypothermia (core temp 28° C - 32.2° C)</td>
</tr>
<tr>
<td>Evisceration</td>
<td>• Transport by aeromedical crew</td>
</tr>
<tr>
<td>GCS ≤ 8 with mechanism attributed to trauma, including isolated hanging, suffocation, or cold water drowning and signs of life</td>
<td></td>
</tr>
<tr>
<td>Flail chest or multiple rib fractures (&gt; 4 ribs unilaterally)</td>
<td></td>
</tr>
<tr>
<td>Pelvic Fracture: unstable or open/displaced/comminuted</td>
<td></td>
</tr>
<tr>
<td>Severe hypothermia (core body temp &lt; 28° C)</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion in ED or PTA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TRANSPORT TO HIGHEST LEVEL TRAUMA CENTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasgow Coma Scale &lt; 14</td>
</tr>
<tr>
<td>Open/depressed skull fracture</td>
</tr>
</tbody>
</table>

July 2018
APPENDIX C-2: TRAUMA DESTINATION DETERMINATION

General Scope: Guideline/criteria for activation of trauma team at Gundersen Health System

Applies to: Tri-State Ambulance Personnel (Reference for all other agencies)

Trauma Destination Determination

- Per the State of Wisconsin and CDC Guidelines, when in doubt, transport to a level 1 or 2 trauma center.
- Trauma patients who do not meet the above criteria may be transported to a level 3 or 4 center.

Notes:

- If the patient is not ventilating or cannot be ventilated, transport to the closest appropriate hospital or request ALS/Air Medical intercept for RSI/definitive airway management
- According to federal and state trauma guidelines, level 1 and 2 trauma centers are clinically equivalent
- Patients who meet Trauma Red or the four designated Trauma Yellow criteria and are requesting to be transported to a non-level 1 or 2 trauma center, should be advised that based on their injuries, state and federal guidelines recommend they go to the highest level trauma center in the region. Transport to non-level 1 or 2 trauma center may then continue if the patient still wishes not go to the highest level and the facility accepts the patient.
APPENDIX C-3: SUPRAGLOTTIC AIRWAY – KING LT-D/LTS-D

General Scope: Procedure for placement of King LT-D/LTS-D

Applies to: All Medical Staff

Procedure:

1. Spinal precautions as needed
2. Select proper King Airway Device size (See table below)
3. Test cuff inflation (with volume as listed on table) and remove air prior to insertion
4. Apply water-based lubricant to beveled distal tip and posterior tube (avoid vent openings)
5. Position head as able
   a. “Sniffing position” is ideal but neutral position is acceptable
6. Open mouth and apply chin lift (unless suspected c-spine injury)
7. Insert King Airway Device rotated laterally 45-90°
8. Introduce tip into mouth and advance behind base of tongue
9. As tube passes tongue rotate back to midline
10. Advance until base of connector is aligned with teeth or gums
11. Inflate cuff with manufacturer recommended volume of air
12. Confirm proper position with auscultation and waveform capnography
13. If unable to ventilate patient, gently and slowly pull back on King Airway Device until proper position is confirmed.
14. Upon verification of placement, secure using commercial device or tape
15. Reassess as needed
16. Suction as needed
17. For King LTS-D, decompress stomach as needed
   a. Gastric access lumen allows insertion of up to a 18Fr gastric tube
   b. Measure gastric tube from nose to earlobe to xiphoid process
   c. Lubricate gastric tube prior to insertion
   d. Advance gastric tube total distance noted in step b
   e. Use least amount of suction that effectively decompresses the stomach

<table>
<thead>
<tr>
<th>Size</th>
<th>Patient Height</th>
<th>Color</th>
<th>Inflation LT-D</th>
<th>Inflation LTS-D</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>4-5 feet</td>
<td>Yellow</td>
<td>45-60 ml</td>
<td>40-55 ml</td>
</tr>
<tr>
<td>4</td>
<td>5-6 feet</td>
<td>Red</td>
<td>50-70 ml</td>
<td>50-70 ml</td>
</tr>
<tr>
<td>5</td>
<td>Greater than six feet</td>
<td>Purple</td>
<td>60-80 ml</td>
<td>60-80 ml</td>
</tr>
</tbody>
</table>
APPENDIX C-4: SUPRAGLOTTIC AIRWAY – I-GEL

General Scope: Procedure for placement of i-gel

Applies to: All Medical Staff

Procedure:

1. Consider spinal precautions as needed
2. Select proper i-gel size (See table below)
3. Apply water-based lubricant to the anterior, posterior, and lateral edges of the gel cuff
4. Position head as able
   a. “Sniffing position” is ideal but neutral position is acceptable
5. Hold the i-gel at the integrated bite block
6. Open mouth and apply chin lift, unless contraindicated
7. Position the device so the gel cuff outlet faces the patient’s chin
8. Advance tip into the patient’s mouth toward the midline of the hard palate
9. Without exerting excessive force, advance the device downward and backward along the hard palate until a definitive resistance is felt
10. Confirm proper position with auscultation and waveform capnography
11. Upon verification of placement, secure using commercial device or tape
12. Reassess as needed
13. Suction as needed
14. For sizes 1.5-5, decompress stomach as needed
   a. Gastric channel allows insertion of the following sized gastric tubes
      i. Size 1.5 – 10 fr
      ii. Size 2-4 – 12 fr
      iii. Size 5 – 14 fr
   b. Measure gastric tube from tip of i-gel to earlobe to xiphoid process
   c. Lubricate gastric tube prior to insertion
   d. Advance gastric tube total distance noted in step b
15. Use least amount of suction that effectively decompresses the stomach

<table>
<thead>
<tr>
<th>Size</th>
<th>Color</th>
<th>Patient Category</th>
<th>Patient Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pink</td>
<td>Neonate</td>
<td>2-5 kg</td>
</tr>
<tr>
<td>1.5</td>
<td>Blue</td>
<td>Infant</td>
<td>5-12 kg</td>
</tr>
<tr>
<td>2</td>
<td>Gray</td>
<td>Small pediatric</td>
<td>10-25 kg</td>
</tr>
<tr>
<td>2.5</td>
<td>White</td>
<td>Large pediatric</td>
<td>25-35 kg</td>
</tr>
<tr>
<td>3</td>
<td>Yellow</td>
<td>Small adult</td>
<td>30-60 kg</td>
</tr>
<tr>
<td>4</td>
<td>Green</td>
<td>Medium Adult</td>
<td>50-90 kg</td>
</tr>
<tr>
<td>5</td>
<td>Orange</td>
<td>Large Adult</td>
<td>90+ kg</td>
</tr>
</tbody>
</table>
Appendix C-5: Mechanical CPR – LUCAS

**General Scope:** Procedure for use of LUCAS mechanical CPR device

**Applies to:** All Medical Staff**

**Procedure:**

1. **DO NOT DELAY MANUAL CHEST COMPRESSIONS FOR PLACEMENT OF MECHANICAL CPR**
2. Be sure to turn device on immediately upon opening case to allow for self-test
3. Ensure that defibrillator pads, CPR feedback devices, and ECG cables will not interfere with suction cup placement
4. Stage backplate and stabilization strap superior to the patient’s head prior to placement
5. Place backplate at the next **natural pause** in the resuscitation
   a. Coordinate placement of backplate with compressor to ensure **minimal interruption of chest compressions**.
   b. Lift patient’s shoulders and slide backplate under patient’s head until the top of the backplate is just below the patient’s armpits (center of should align with nipple line)
      i. May also roll patient side to side and place backplate as described above.
6. Resume manual chest compressions immediately upon placement of backplate
7. Remove LUCAS from case and pull on both release rings to assure that claw locks are open
8. Attach claw to backplate on opposite side of compressor while **chest compressions continue**
9. Coordinate with compressor to place the device at the next natural pause in resuscitation
   a. Pivot the device through the manual compressors arms and lock the opposite claw
   b. Pull up on device once to ensure that claws are locked
10. Position the suction cup so that the lower edge is just proximal to the xiphoid process
    a. Assure that nothing interferes with placement of suction cup
11. Push suction cup down with two fingers until pressure pad touches the patient’s chest
12. Press 2 (PAUSE) button to lock the start position and remove fingers from suction cup
    a. Verify position is correct. If not, press 1 (ADJUST), pull suction cup up, and reposition.
    b. If patient is too large or too small, remove device and immediately restart manual compressions
13. Press appropriate 3 (ACTIVE) button
    a. Use 30:2 when no advanced airway is present and **CONTINUOUS** when one is
14. Secure stabilization strap and mark on superior location of suction cup on patient’s chest
15. Place patient’s wrists/arms in appropriate straps on device
APPENDIX C-5: MECHANICAL CPR – LUCAS (CONTINUED)

LUCAS considerations

- Defibrillation can and should be performed with the LUCAS device in place and in operation.
- If the pressure pad and suction cup are incorrectly positioned, there is an increased risk of damage to the rib cage and the internal organs, and cardiac output is further decreased.
- If the position of the suction cup changes during operation, immediately press 2 (ADJUST) and adjust the position. Always use the stabilization strap to help maintain the correct position.
- The upper part of the device must remain vertical relative to the patient’s chest at all times. Reposition if the device goes off-axis.

LUCAS troubleshooting

- A red alarm LED will illuminate and a high priority alarm will sound if there is any malfunction during operation.
  - In the event of an alarm, remove the battery for one to three seconds and replace.
    - If alarm condition is no longer present, follow steps 10-13 above.
    - If alarm condition remains, immediately remove LUCAS and resume manual chest compressions.

LUCAS references
## APPENDIX D-1: PARAMEDIC MEDICATIONS

### General Scope:
The following medications are the medications that have been state approved to be transported by Tri-State Ambulance at the Paramedic level. Medications may be transported (added) using the Patient Side Training Report.

<table>
<thead>
<tr>
<th># / A - D</th>
<th>E - N</th>
<th>O - Z</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.45% sodium chloride ( ½ NS)</td>
<td>Enalaprilat</td>
<td>Octreotide (SandoSTATIN)</td>
</tr>
<tr>
<td>5% dextrose in 0.45% NaCl (D₅ ½ NS)</td>
<td>Epinephrine</td>
<td>Ondansetron (Zofran)</td>
</tr>
<tr>
<td>5% dextrose in LR</td>
<td>Esmolol</td>
<td>Oxygen</td>
</tr>
<tr>
<td>5% dextrose in water (D₅W)</td>
<td>Etidimotide (Amidate)</td>
<td>Oxytocin (Pitocin)</td>
</tr>
<tr>
<td>Abciximab (Reopro)</td>
<td>Famotidine (Pepcid)</td>
<td>Pancuronium (Pavulon)</td>
</tr>
<tr>
<td>Acetominophen (Tylenol)</td>
<td>Fentanyl (Sublimaze)</td>
<td>Phenergan (Promethazine)</td>
</tr>
<tr>
<td>Acetylcysteine (Mucomyst)</td>
<td>Flumazenil (Romazicon)</td>
<td>Phenytoin (Dilantin)</td>
</tr>
<tr>
<td>Activated charcoal</td>
<td>Fosphenytoin (Cerebyx)</td>
<td>Potassium</td>
</tr>
<tr>
<td>Adenosine (Adenocard)</td>
<td>Furosemide (Lasix)</td>
<td>Pralidoxime (2-pam chloride)</td>
</tr>
<tr>
<td>Aggrastat (Tirofiban)</td>
<td>Glucose</td>
<td>Procaainamide</td>
</tr>
<tr>
<td>Albuterol</td>
<td>Haloperidol (Haldol)</td>
<td>Prochlorperazine (Compazine)</td>
</tr>
<tr>
<td>Alteplase (Activase)</td>
<td>Heparin</td>
<td>Propranolol</td>
</tr>
<tr>
<td>Amiodarone (Cordarone)</td>
<td>Hydromorphone (Dilaudid)</td>
<td>Protamine Sulfate</td>
</tr>
<tr>
<td>Antibiotics (if hung by facility)</td>
<td>Insulin</td>
<td>Proton Pump Inhibitors (ALL)</td>
</tr>
<tr>
<td>Argatroban</td>
<td>Ipratropium (Atrovent)</td>
<td>Racemic Epinephrine</td>
</tr>
<tr>
<td>Aspirin</td>
<td>Ketamine (Ketalar)</td>
<td>Retepase (Retavase)</td>
</tr>
<tr>
<td>Atropine</td>
<td>Ketorolac (Toradol)</td>
<td>Rocuronium (Zemuron)</td>
</tr>
<tr>
<td>Blood</td>
<td>Labatol</td>
<td>Sodium bicarbonate</td>
</tr>
<tr>
<td>Blood products</td>
<td>Lactated Ringer’s</td>
<td>Succinylcholine (Anectine)</td>
</tr>
<tr>
<td>Calcium chloride</td>
<td>Levalbuterol (Xopenex)</td>
<td>Terbutaline (Brethine)</td>
</tr>
<tr>
<td>Calcium gluconate</td>
<td>Levetiracetam (Keppra)</td>
<td>Ticagrelor (Brilinta)</td>
</tr>
<tr>
<td>Ceftiuxone (Rocephin)</td>
<td>Lidocaine (xylocaine)</td>
<td>Thiamine</td>
</tr>
<tr>
<td>Clonazepam (Klonopin)</td>
<td>Lorazepam (Ativan)</td>
<td>Toradol</td>
</tr>
<tr>
<td>Clopidogrel (Plavix) - oral only</td>
<td>Magnesium sulfate</td>
<td>TPA(tissue plasminogen activator)</td>
</tr>
<tr>
<td>Cyanide antidote package (Cyanokit)</td>
<td>Mannitol (Osmotrol)</td>
<td>TPN (total parental nutrition)</td>
</tr>
<tr>
<td>Amyl nitrate</td>
<td>Methyldprednisolone (Solu-medrol)</td>
<td>Tranexamic acid (TXA)</td>
</tr>
<tr>
<td>Sodium nitrate</td>
<td>Metoclopramide (Reglan)</td>
<td>Vasopressin (Pitressin)</td>
</tr>
<tr>
<td>Sodium thiosulfate</td>
<td>Metoprolol (Lopressor)</td>
<td>Vasotec</td>
</tr>
<tr>
<td>Dexamethasone (Decadron)</td>
<td>Midazolam (Versed)</td>
<td>Vecuronium (Norcuron)</td>
</tr>
<tr>
<td>Dextrose (50%, 25%, 10%)</td>
<td>Morphine</td>
<td>Ziprasidone (Geodon)</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>Nalbuphine (Nubain)</td>
<td></td>
</tr>
<tr>
<td>Diltiazem (Cardizem)</td>
<td>Naloxone (Narcan)</td>
<td></td>
</tr>
<tr>
<td>Diphenhydramine (Benadryl)</td>
<td>Nicardipine</td>
<td></td>
</tr>
<tr>
<td>Divalproex sodium (Depakote)</td>
<td>Nifedipine (Procardia)</td>
<td></td>
</tr>
<tr>
<td>Dobutamine</td>
<td>Nitroglycerin</td>
<td></td>
</tr>
<tr>
<td>Dopamine</td>
<td>Nitrous oxide</td>
<td></td>
</tr>
<tr>
<td>Droperidol (Inapsine)</td>
<td>Norepinephrine (Levophed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Normal saline (0.9% sodium chloride)</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D-2: CRITICAL CARE PARAMEDIC MEDICATIONS

General Scope: Along with all medications included on the Paramedic Medication list, the following medications are the medications that have been state approved to be transported by Tri-State Ambulance at the Critical Care Paramedic level. Medications may be transported (added) using the Patient Side Training Report.

<table>
<thead>
<tr>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin (Zithromax)</td>
</tr>
<tr>
<td>Clonidine HCL (Catapres, Dixaril)</td>
</tr>
<tr>
<td>Eptifibatide (Integrilin)</td>
</tr>
<tr>
<td>Gentamicin (Garamycin, Cidomycin)</td>
</tr>
<tr>
<td>Nalbuphine (Nubain)</td>
</tr>
<tr>
<td>Nitroprusside (Nipride)</td>
</tr>
<tr>
<td>Propofol (Diprivan)</td>
</tr>
</tbody>
</table>