

**GMVEMSC PREHOSPITAL AEMT STANDING ORDERS  
TRAINING MANUAL  
VERSION January 1, 2016  
Adult: Patients 16 Years Old and Above  
Pediatric: Patients under 16 Years Old**

ADULT and **PEDIATRIC** ORDERS INDEX

<u>TOPIC</u>	<u>PAGE</u>	<u>TOPIC</u>	<u>PAGE</u>
12-Lead EKG	13	Hazardous Drug Exposure	39
2016 Changes	109	HazMat	38
Abbreviations	44	HazMat, Biological	40
Abdominal Pain	29	HazMat, Cyanide	40
Administering Nerve Agent Antidotes	41	HazMat, Hydrofluoric Acid	40
Airway Maintenance	7	HazMat, Organophosphate/Nerve Agent	40
Allergic Reactions	26	HazMat, Pepper Spray	42
Antidote Resources	41	Head Injury	21
APGAR Scores	31	Heat Exposure	24
Asthma/Emphysema/COPD	25	Hemorrhage Control	20
Bradycardia	14	Hospital Capabilities	103
Burns/Smoke Inhalation	23	Hypothermia	22
Capnography	7	Intubation	8
Carbon Monoxide	23	Initial Care	4
Cardiac Arrest-Asystole/PEA	12	IO Insertion	9
Cardiac Arrest-BLS	11	Maintenance Existing Med Pumps	10
Cardiac Arrest-VFIB/Pulseless VT	12	Major Trauma	19
Cardiac Arrest-Pregnancy	30	Nebulized Meds	9
Cardiovascular Emergencies	11	Newborn Resuscitation	31
CHEMPACK	41	Non-Initiation of Care	3
Chest Pain	12	Obstetrical Emergencies	29
Child Abuse	32	Pain Protocol	6
Childbirth	30	Poisoning or Overdose	28
Combative Patient	33	Prehospital Field Triage	16
Communicating with the Hospital	2	PSW Exposure Matrix	105
CPR Chart	11	Psychiatric Patient	33
Crisis Standards of Care	38	Pulmonary Edema	25
Crush Syndrome	20	Reroute Policy	97
Delivery Complications	30	Respiratory Distress	25
Diabetic Refusal	26	Regional Hospital Notification	43
DNR-Comfort Care/Comfort Care Arrest	3	Rights of Medicine Administration	47
Drowning	22	Run Documentation Requirements	47
Drug Bag Exchange Program	82	Safe Harbor	32
Drug Sheets	48	SALT Triage	34
EDD	8	Seizures	27
Elder Abuse	33	Shock	14
End Tidal CO <sub>2</sub> —Colorimetric	8	Skills Sheets	67
Exsanguinating Hemorrhage	14	Spinal Motion Restriction	5
Extrapyramidal Reactions	27	Stipulations	2
Extremity Injuries	22	Stroke	15
Eye Injuries	24	Tachycardia	14
Fever	32	Tension Pneumothorax	9
Field Termination	4	Transport Guidelines	18
Frostbite	23	Trauma Criteria	17
GCS	21	Trauma Emergencies	16

## STIPULATIONS

- This protocol is for use by those individuals operating in and under the authority of the Greater Miami Valley EMS Council (GMVEMSC) Drug Bag Exchange Program and certified by the State of Ohio as an Advanced EMT.
- This protocol is to be used in the field only. Communications must be attempted as soon as practical for potentially unstable patients or for hospitals that request contact on all patients being transferred to their facility.
- Procedures that are marked with a diamond (♦) are never to be performed without Medical Control Physician (MCP) permission.
- No procedures, techniques, or drugs will be used without the proper equipment, or beyond the training or capabilities of the prehospital personnel. Nothing in this protocol may be used without specific pre-approval of the Medical Director for the local department or agency.
- It is the recommendation of the Standing Orders Committee that departments be able to access the humeral head via IO in the adult population.
- It is recommended to use filtered needles when drawing up any medication from an ampule.
- Items enclosed in braces ( { } ) are at the option of the department and its Medical Director.
- EMS personnel of any level are not authorized to intubate unless they have and use appropriate confirmation devices (EtCO<sub>2</sub> detectors or monitors, or Esophageal Detection Devices).
- Any patient being monitored for a significant cardiac event or EtCO<sub>2</sub> shall remain on the monitor until patient care is transferred to hospital staff. In addition, a summary report shall be provided from any device capable of printing one.
- Infrequently, stepwise adherence to specific protocols may not be in the patient's best interest. No protocol can substitute for the EMS professional's judgment. However, at no time should treatment options exceed those authorized without direct consultation with Medical Control. In all such cases, contact with Medical Control should be considered as soon as possible.
- The Adult and **Pediatric Orders** (“Peds”) are combined.
- A** Sections that apply only to Adults are bulleted with a bold “A.”
- P** All Pediatric treatments will be in Pink and bulleted with a bold “P.”
- Sections which apply to both Adult and Peds are indicated with standard bullets.
- G** There are a few sections which apply only to Geriatric patients and are bulleted with a bold “G.”

## COMMUNICATING WITH HOSPITAL OR MEDICAL CONTROL

- There are several reasons to contact the hospital:
  - To notify the hospital when time is needed to set-up for the patient. Examples include major trauma, cardiac arrest, hazardous materials, bedbugs, and Cardiac or Stroke Alerts.
  - Contact all hospitals with all serious patients, e.g., stroke, MI, respiratory distress, shock and major traumas or to obtain orders for procedures or medications indicated by diamonds in these Standing Orders.
  - To obtain advice. For example, guidance from the MCP might be needed before a medication is given, even though Standing Orders allow it to be used without permission. Another situation could be a patient with an unfamiliar condition.
- When contacting the hospital, make sure a clear picture is painted. Hospital personnel cannot see the pt. The ability to communicate findings will directly impact the hospital's response.
- When calling about a trauma patient, include MIVT, ETA, the components of the GCS, and patient assessment findings, especially those relevant to the decision to transport to a Trauma Center.
- If consultation with a physician is desired, the medic should specifically request Medical Control
- EMTs and AEMTs must call the hospital whenever they transmit an EKG.
- When calling with an alert (Trauma, Cardiac, or Stroke) say, “We recommend a \_\_\_\_\_ Alert.”
- Remember that the hospital may have more information, and may or may not decide to act on your recommended alert. Examples:

- Patients who meet Trauma Destination Protocols do NOT always warrant the hospital calling in a surgical team immediately.
- A patient who meets Cardiac Alert criteria may have prior EKGs in their hospital record that indicate that the alert is unnecessary.
- Every crew transporting a patient is expected to provide a full run sheet to the hospital upon delivery or within 3 hours.

### NON-INITIATION OF CARE

- Resuscitation will not be initiated in the following circumstances:
  - Deep, penetrating, cranial injuries
  - Massive truncal wounds
  - DNR Order—present and valid
  - Frozen body
  - Rigor mortis, tissue decomposition, or severe dependent post-mortem lividity
  - Triage demands
  - Blunt trauma found in cardiac arrest *unless* one of the following conditions is present:
    - Patient can be delivered to an emergency department within 5 minutes.
    - The arrest is caused by a medical condition.
    - Focused blunt trauma to the chest (such as a baseball to the chest)
      - An example is Commotio Cordis, a form of sudden cardiac death, seen most often in boys and young men playing sports. It occurs as the result of a blunt, non-penetrating impact to the precordial region from a ball, bat or other projectile.
  - Penetrating trauma found in cardiac arrest when the patient cannot be delivered to an emergency department within 15 minutes.
    - Resuscitation will be initiated on victims of penetrating trauma who arrest after they are in EMS care.
- Once en route, continue care even if the above time limits cannot be met.
- If care began and it is readily apparent to EMS that the patient met non-initiation of care criteria, resuscitation efforts may cease.

### DNR: COMFORT CARE or COMFORT CARE ARREST

#### Do Not Resuscitate-Comfort Care (DNR-CC)

*(Permits any medical treatment to diminish pain or discomfort that is not used to postpone the patient's death)*

The following treatments are permitted:

- Suctioning
- Oxygen
- Splinting and spinal restriction
- Bleeding control
- Pain control

The following treatments are *not* permitted:

- Chest compressions
- Airway adjuncts including CPAP and respiratory assistance
- Resuscitative drugs
- Defibrillation, cardioversion, monitoring

#### Do Not Resuscitate-Comfort Care Arrest (DNR-CCA)

- Allows any appropriate Standing Orders treatment until cardiac or respiratory arrest or agonal breathing occurs.

**NOTE:** When a Durable Power of Attorney for Healthcare (DPA-HC) is present and the “Living Will and Qualifying Condition” box is checked, the DPA-HC cannot override the patient’s DNR status. A patient may change their DNR status at any time verbally, in writing, or by action.

## FIELD TERMINATION OF RESUSCITATION EFFORTS WITHOUT AVAILABLE ALS

### P FIELD TERMINATION DOES NOT APPLY TO PEDIATRICS

- A ♦ When faced with a patient in cardiac arrest without return of spontaneous circulation (ROSC), no paramedics are available at the scene, and transport time to a medical facility will exceed 20 minutes, consider field termination of cardiac arrest patients age 18 years or older who are not in arrest due to hypothermia. Contact MCP for orders to terminate the resuscitation.
- A Patients in asystole with a confirmed correct tube placement and a capnography reading < 10 mm/Hg, which does not improve during resuscitative efforts, have essentially no probability of survival and field termination should be strongly considered.
- A ♦ EMS must contact MCP directly to receive consent for field termination.
  - The intent of this section is to avoid the risks of transporting non-viable patients emergently.
- A **Send a copy of the run sheet to the EMS Coordinator of the authorizing MCP's hospital.**

**NOTE:** If family requests any information about organ donations have them call Life Connection of Ohio @ 800-535-9206.

**NOTE: PEDIATRIC PATIENTS MAY MEET NON-INITIATION OF CARE CRITERIA.**

### INITIAL CARE

- Follow basic and advanced life support and airway algorithms as indicated based on current AHA Guidelines.
- Obtain and document the chief complaint, (OPQRST, see Abdominal Pain), SAMPLE history, and vitals per patient condition.
- SAMPLE: Signs and Symptoms, Allergies, Medications, Past medical history, Last oral intake, Events leading up to present illness or injury.
- Utilize cardiac monitor and other monitoring devices, pulse oximeter, etc. as appropriate.
- IN medication administration must be via Mucosal Atomizer Device (MAD).
- Start IV of **Normal Saline (NS)** or **Saline Lock (SL)** as appropriate.
- **IVs:** Follow shock protocol on page 14.
  - Shock (not related to penetrating trauma): **NS** run wide-open, using macro-drip or blood tubing except for penetrating chest or abdominal trauma. Decrease fluid rate if SBP >100.  
**P NS 20 ml/kg using macro-drip tubing. Titrate to maintain adequate perfusion.**
  - Medical emergencies, head trauma, cardiac problems with stable BP: Use TKO rate.
  - IV medication administration: **Slow IV = over 2 minutes**, unless otherwise specified.
  - Any medication given IV can also be administered IO.
- Use of IO devices for both Adults and Peds is limited to patients who are unresponsive or hemodynamically unstable, and only when less invasive means are not available or are ineffective (e.g., **Glucagon IM, Narcan IN, and Versed IN**).
- ♦ If a patient with an existing IV pump experiences an allergic reaction, call the MCP for an order to discontinue the pump. Otherwise, the IV pump must be maintained.
- Bring medications or a list of the medications; include the dose and frequency administered.
- If glucose < 60, or there is strong suspicion of hypoglycemia despite glucometer readings:
  - A Administer **D10, 250 ml** at wide open rate, (500 ml = 50 g of Dextrose)
  - P D10 (5 ml/kg), maximum single dose of 250 ml.**
  - P For newborn, D10, 2 ml/kg if BS < 40.**
    - Document amount of **D10** administered in milliliters.
    - If unable to establish vascular access, **Glucagon, 1 mg IM.**
- **D10** may be repeated in ten minutes if blood sugar remains < 60.
- In a diabetic patient with an insulin pump and a glucose < 60, treat the hypoglycemia.
- Maintain normothermia. Unconscious diabetics are often hypothermic.

**NOTE:** Oral glucose is indicated for any conscious but disoriented patient with BS < 60, or a strong suspicion of hypoglycemia despite blood sugar readings. Oral glucose may also be administered carefully under the tongue or between the gum and cheek of an unresponsive patient who must be

placed in the lateral recumbent position to promote drainage of secretions away from the airway.

**NOTE:** Take extra tubing and medication packets to the receiving facility with patients with insulin pumps.

**NOTE:** Pedi-Wheel may be used as a reference for pediatric vital signs.

## SPINAL MOTION RESTRICTION (SMR)

### Introduction

Traditionally, EMS has immobilized all patients with *potential* spinal injury to include backboards and associated adjuncts (B/AA). However, studies indicate that traditional spinal restriction with B/AA has risks and may even cause harm in select cases. SMR has been modified to more accurately reflect appropriate indications and methods for spinal restriction. Spinal precautions for at risk patients remain paramount. This protocol does not indicate that EMS no longer immobilizes the spine; it simply provides a different means of restriction in selected patients.

### Blunt trauma (falls, MVC)

1. All patients with clinical indications of a spinal injury (such as focal neurologic deficit including paralysis) and/or with altered levels of consciousness (including those who are combative, confused, or intoxicated, i.e. patients who are unable to follow commands) must be immobilized with both a C-collar and a spinal restriction device (e.g., spine board, KED, vacuum splint).
2. Additionally pediatric trauma patients less than 3 years of age with a GCS of < 15 must be immobilized with both a C-collar and a spinal restriction device (e.g. spine board, KED).
3. Other alert trauma patients, including all those listed below, should have a c-collar placed and moved in-line as a unit to the cot. This is referred to as, “Move patients on hard things; transport on soft things.”
  - Neck pain
  - Midline neck or spinal tenderness
  - Pain on motion of the neck
  - Age  $\geq$  70
  - High risk mechanism (high speed MVC, fall > 10 feet, axial loading injury)
  - Patients who are non-ambulatory (sitting, lying on ground) are to be moved in-line as a unit.
  - Patients who are ambulatory may ambulate to the cot, and then be assisted onto the cot in-line as a unit.

### Penetrating Trauma

- Patients with penetrating trauma to the torso or neck with focal neurological signs or paralysis should be immobilized in a c-collar and with a spinal restriction device.
- Patients without focal neurological signs or paralysis need **NOT** be immobilized.
- Delays in transport for restriction are to be minimized.

### Airway or Ventilatory Management

Patients who are immobilized and require airway and or ventilatory intervention (including intubation) may have the collar removed, with in-line stabilization performed during the intervention. The collar should then be reapplied.

## Other

- Patients who do not tolerate restriction (e.g., shortness of breath, anxiety, and body habitus) should have restriction adjusted to the point of removal if necessary based on clinical response. They should be maintained in the manner of restriction that they can tolerate (e.g., a patient may not tolerate a backboard but may tolerate sitting up with a c-collar).
- Spinal restriction devices may be utilized for movement from a site of injury to the cot. Patients who do not require restriction as above should be removed from the device prior to transport and kept in-line during transport.

## Sporting Injuries

- In an emergency situation with equipment intensive sports such as football, hockey and lacrosse, the protective equipment shall be removed prior to transport to an emergency facility.

## PAIN CONTROL PROTOCOL

### General Considerations

- This protocol is for management of ACUTE moderate to severe pain, including pain from suspected cardiac events, trauma (including thermal and chemical burns, crush syndrome, frostbite, fractures, dislocations, and sprains), and abdominal pain including unilateral flank pain.
- P ♦MCP required before administration of Fentanyl in pediatric patients with abdominal pain.
- It is **NOT** for treatment of exacerbations of **CHRONIC** pain.
- ♦Call for orders if you feel narcotics are needed for pain from a chronic condition.
- Prehospital pain management is important. It significantly reduces time to pain relief, avoids exacerbation of pain during movement and transport, is compassionate, and is good medical care.
- Document patient's reported pain during initial patient contact, during treatment, and after any intervention.
- Use ice packs, position of comfort, and splinting to reduce pain as indicated.

### Specific Care

- A For pain relief when the patient is alert, consider **Fentanyl 50 mcg slow IV** if SBP > 100.
- A If unable to obtain IV, give **Fentanyl 50 mcg IM** or **Fentanyl 100 mcg IN**.
- A May repeat slow IV **Fentanyl 50 mcg** after 5 minutes provided SBP > 100.
- A Repeat dose of **Fentanyl 50 mcg IM** no sooner than 30 minutes.
- A ♦IN Fentanyl may be repeated no sooner than 30 minutes, if a second drug bag is available.
- P **FENTANYL IS NOT TO BE ADMINISTERED TO ANYONE < 2 YEARS OF AGE.**
- P For pain relief when the patient is conscious and alert, consider **Fentanyl 1 mcg/kg, slow IV** (max dose 50 mcg) provided appropriate normal SBP.
- P If unable to obtain IV, give **Fentanyl 1 mcg/kg IM (max dose 50 mcg) or Fentanyl 1 mcg/kg IN (max dose 100 mcg).**
- P ♦May repeat **Fentanyl 1 mcg/kg, slow IV after 5 minutes (max dose 50 mcg)** if still in pain and appropriate SBP.
- P ♦Repeat dose of **Fentanyl 1 mcg/kg IM (max dose 50 mcg, repeat no sooner than 30 minutes).**

## AIRWAY MAINTENANCE

- O<sub>2</sub> as needed. Use the following rates as guidelines:
  - **2 LPM by nasal cannula (NC)** for patients with COPD, unless prescribed higher.
  - **4-6 LPM by NC** for other patients
  - **8-10 LPM for** nebulized meds
  - **12-15 LPM by non-rebreather mask (NRM)** for severe trauma patients, distressed cardiac patients, patients with respiratory distress, and other patients who appear to need high flow O<sub>2</sub>.
- Ventilate symptomatic patients who have insufficient respiratory rate or depth.

### RESPIRATORY RATES BY AGE

Up to 1 year	30-60	7-9 years	16-24
1-3 years	20-40	10-14 years	16-20
4-6 years	20-30	15+ years	12-20

- Intubate if apneic.
- Consider patient airway anatomy and condition for proper airway adjunct selection.
- AEMTs can suction tracheostomies
- A If two attempts with an ETT are not successful, move to an adjunct device.
  - If approved, adjuncts considered “rescue airways” such as the LMA or Dual Lumen Airways } may be appropriate primary airway devices.
- P **LMA is recommended as the primary airway except in extreme cases such as airway edema.**
- Confirm correct placement of advanced airways by at least **five methods**:

### CONFIRMATION METHODS:

- CO<sub>2</sub> detection methods are recommended and Capnography is the “gold standard.”
- Auscultation of the epigastrium, anterior chest, midaxillary areas, and then the epigastrium again
- Rise and fall of the chest
- Repeat visualization of the tube between the vocal cords
- Condensation in the tube
- Depth placement and measurements:
  - Keeping an oral endotracheal tube at the 20-22 cm mark at the teeth will prevent inserting the ETT too far and greatly reduces the chances of a right mainstem bronchus intubation. Don't confuse right mainstem intubation for a pneumothorax.
- P **Proper depth placement of tracheal tube in the pediatric patient can be calculated by the following formula: Depth of insertion (length of tube at teeth or gum line) = tube size x 3.**

### CONFIRMATION DEVICES:

#### Electronic End Tidal CO<sub>2</sub> (ETCO<sub>2</sub>) Monitors—Capnography

Capnography or capnometry is considered the “gold standard” of tube placement confirmation. Waveform ETCO<sub>2</sub> is the preferred confirmation device. These devices measure the amount of carbon dioxide in the exhaled ventilations of patients. They can use mainstream sensors, which are located directly on the endotracheal tube, or sidestream sensors, which sample the ventilation more remotely. Capnography can also be used with patients who are not intubated. In-line ETCO<sub>2</sub> monitors can be used on patients with or without adequate perfusion. Electronic monitors show changes in real-time.

If this equipment is available, it should be used on **EVERY** intubation, and always be one of five confirmation steps. Ventilations should be titrated to ETCO<sub>2</sub> of 35-45 mm/Hg. To increase CO<sub>2</sub>, slow down ventilations and to decrease CO<sub>2</sub>, speed up ventilations. **MAINTAIN THIS DEVICE UNTIL PATIENT CARE IS TRANSFERRED TO THE RECEIVING HOSPITAL STAFF.**

For any department whose monitors have summary capabilities, that summary must be presented with the patient.

Patients in asystole with a confirmed correct tube placement and a capnography reading < 10 mm/Hg, which does not improve during resuscitative efforts, have essentially no probability of survival and field termination should be strongly considered.

### **End Tidal CO<sub>2</sub> Detector (ETCO<sub>2</sub>)—Colorimetric**

#### **Colorimetric Limitations:**

- The Colorimetric ETCO<sub>2</sub> detector may be utilized as a confirmation device for patients in cardiac arrest, **IF** it shows the presence of CO<sub>2</sub> (color change to yellow). If there is no color change, use other confirmation methods. The absence of color change in a properly placed tube may be caused by a lack of perfusion, but it may also indicate esophageal intubation.
- Secretions, emesis, etc. can ruin the device.
- A patient with large amounts of carbonated beverage (e.g., beer) in their stomach can give a false positive result. The device may sense the CO<sub>2</sub> given off by that beverage and indicate that the tube in the trachea, when it is in the esophagus.
- The device can be used for no more than two hours.
- Follow manufacturer's recommendations for weight restrictions.

#### **Medication Issues:**

- Intravenous sodium bicarbonate will produce more carbon dioxide resulting in enhanced color.

### **Esophageal Detector Device (EDD)**

This device confirms tube placement mechanically. It is based on the principle that the esophagus is a collapsible tube, while the trachea is rigid. An EDD looks like a bulb syringe. Collapse the bulb first and then place the device on the end of the ETT prior to first ventilation. As the bulb tries to refill with air, it creates suction. If the tube is in the esophagus, the soft tissues will collapse around the holes in the ETT preventing expansion of the bulb. When the bulb does not refill (or refills very slowly), the tube is presumed to be in the esophagus. If the tube is in the trachea, there is nothing to occlude the movement of air. The bulb will rapidly refill, indicating that the ETT is properly placed.

#### **EDD Limitations:**

- A large amount of gastric air (e.g., caused by carbonated beverage, aggressive ventilations, misplacement of ETT) can give a false positive finding. Tracheal obstructions in patients with morbid obesity, late pregnancy, status asthmaticus, or copious endotracheal secretions may yield misleading results.
- A cold device may give a false negative result. If the rubber bulb is stiff from the cold, it will fail to fill with air. The ETT will seem to be in the esophagus, when it is actually in the trachea.
- It cannot be used continuously. It must be removed after confirmation, though it may be used again after patient movement.
- Use only for confirmation of endotracheal tube placement, not for any other airways (LMA, King, etc.).

**P** May only be used on pediatric patients older than 5 years old weighing at least 20 kg (44 pounds).

## **INTUBATION**

- Always secure the ET tube in place, preferably with a commercial tube-securing device.
- Cervical collar is effective in maintaining patient's head in a neutral position.
- Reassess ET tube placement every time the patient is moved.
- {Lighted Stylet Intubation} or {Camera Assisted Intubation} may be utilized.
- Dual Lumen Airways, e.g., Combitube, Pharyngotracheal Lumen Airway (PtL), King Airway or Laryngeal Mask Airways (LMA), are acceptable airway devices. Use of these devices is limited to patients who need an artificial airway and are apneic.
- If routine ventilation procedures are unsuccessful, try to visualize obstruction with laryngoscope. If a foreign body is seen, attempt to remove it using suction, or Magill forceps.

## TENSION PNEUMOTHORAX RELIEF:

- If there are indications of tension pneumothorax and the patient is hemodynamically unstable, decompress the chest with a 14-gauge, 3 1/4 inch angiocath placed in the second or third intercostal space in the mid-clavicular line (MCL). The MCL is parallel to the sternum, extending down from the midpoint of the clavicle. Placement of a needle too high, too low, too medial, or too lateral increases the risk of complications. Tracheal deviation is a very late sign and therefore an unreliable indicator.
- 3 1/4" angiocaths may not be available from emergency departments. EMS agencies may need to purchase them.

## NEBULIZED MEDICATION

Nebulized medication may be administered while ventilating a patient with a BVM. The process ideally requires two oxygen sources, one attached to the nebulizer and one attached to bag-valve device and an extra elbow. If there is only one oxygen source, attach it to the nebulizer until medication delivery is complete, and then attach to BVM. Refer to the diagram on the skill sheet for further information.

## IO INSERTION

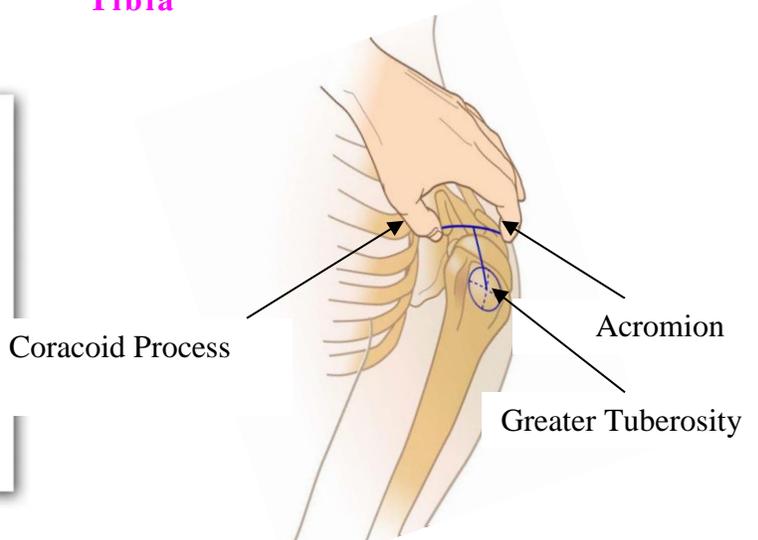
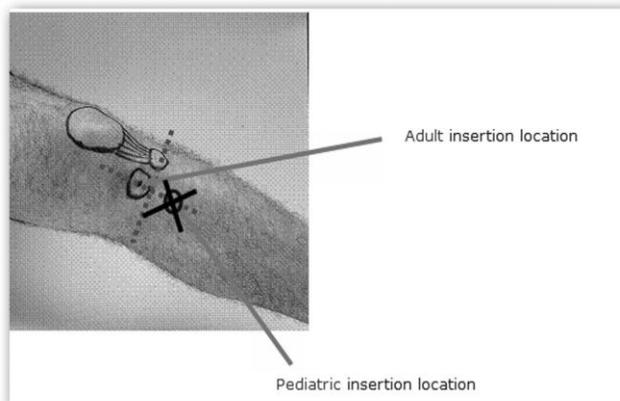
- Use of IO devices is limited to patients who are unresponsive or hemodynamically unstable; and then, only when less invasive means are ineffective or not available (e.g., IM Glucagon, IN Narcan or Versed).
- A** For an adult in cardiac arrest, the preferable order of vascular access is EJ, AC, proximal humeral IO and lastly proximal tibia.
- A** An adult cardiac arrest patient's circulation differs from a pediatric cardiac arrest patient's, and also differs from an adult in deep shock. With the approval of the department's Medical Director, it is recommended that the proximal humerus be the site for IO insertions for adults in cardiac arrest. IV or IO accesses below the diaphragm may be ineffective for patients greater than 8 years old who are receiving CPR. Flow rates are better in the proximal humerus due to decreased bone density. The longer yellow (45 mm) needle should be used for humeral IOs in adults.
- In summary:

**Arrest:**

**Non-arrest:**

**Adults**  
**Humerus**  
**Tibia**

**Pediatric**  
**Tibia**  
**Tibia**



## Proximal Tibia

Find the "flat spot" on the medial aspect of the tibial shaft two finger widths below (distal) the tibial tuberosity. Remember, "Big Toe IO" means to look on the big toe side of the leg for the tibial plateau (the flat spot). Use a similar technique as for the Pediatric tibial insertion.

- **IO Insertion at Proximal Tibia Site**

1. Identify the tibial tuberosity by palpating just below the knee.
2. Locate the consistent flat area of bone 2 cm distal and slightly medial to the tibial tuberosity (to avoid growth plate).
3. Support flexed knee with towel under calf.
4. Prep the skin and insert needle according to manufacturer's directions.
5. Use 10-15° caudal angulation to further decrease risk of hitting growth plate.
6. Needle will stand up on its own with proper placement.
7. Attach syringe and aspirate bone marrow (to further confirm placement).
8. Connect the IV line. If flow is good and extravasation is not evident secure needle with gauze pads and tape.
9. A pressure bag may facilitate infusion.
10. **A Lidocaine 1.5 mg/kg up to 100 mg via IO** for pain associated with infusion.  
**P Lidocaine 2% 0.5 mg/kg (max 100 mg) via IO** for pain associated with infusion.

**NOTE:** The administration of other drug therapy should not be delayed due to the administration of Lidocaine for pain management.

## Humeral Head

The greater tuberosity is located by placing the patient's hand on their navel and relaxing their shoulder and elbow. Draw a straight line between the coracoid process and the acromion. Complete the drawing of a perfect triangle by using the previous line as the base of the triangle and extending the "point" of the triangle over the humeral head. The site is at the downward point of the triangle.

- A IO Insertion at Humeral Head Site**

1. Position patient so shoulder is adducted (moved toward the middle of the body) and the greater tuberosity is most prominent by lying patient supine, arm at their side with palm on their navel.
2. Palpate proximal humerus and identify the greater tuberosity.
3. Prep the skin.
4. Insert the needle at 90-degree angle directly into the greater tuberosity.
5. Needle will stand up on its own with proper placement.
6. The yellow IO needle should be used for humeral IOs.
7. Attach syringe and aspirate bone marrow to further confirm placement.
8. Connect the IV line. If flow is good and extravasation is not evident, secure needle with gauze pads and tape.
9. Pressure bags may facilitate infusion.

## MAINTENANCE OF EXISTING MEDICATION PUMPS

Do not stop the flow of medication except under direct orders from Medical Control. There are some drugs such as **Flolan** that could kill the patient if stopped. If the patient is experiencing an allergic reaction, call Medical Control.

For a diabetic patient with an insulin pump who is hypoglycemic, treat the hypoglycemia.

## CARDIOVASCULAR EMERGENCIES

### CARDIAC ARREST: BASIC LIFE SUPPORT

- Assess patient for respiratory and cardiac arrest.
- Initiate CPR and utilize an AED or defibrillator using the most current American Heart Association Guidelines.
- A Consider {Impedance Threshold Device}.
- Transport patient as appropriate.

#### General Considerations:

- CPR should not be interrupted for more than 10 seconds until spontaneous pulse is established.
- For pregnant patient in arrest consider need for manual uterine displacement and perform chest compressions slightly higher on the sternum than normal.
- In all cardiac arrests, consider the ACLS “Treatable Causes”: i.e., “Hs” and “Ts”:

<p><b>Hs</b></p> <p>Hypovolemia</p> <p>Hypoxia</p> <p>Hypothermia</p> <p>Hydrogen Ion (Acidosis)</p> <p>Hypoglycemia</p>	<p><b>Ts</b></p> <p>Toxins</p> <p>Trauma</p> <p>Tension Pneumothorax</p>
--	--

### 2010 AHA CPR GUIDELINES

	ADULTS	CHILDREN	INFANTS	NEWBORNS
CPR ORDER	Compression, Airway, Breathing (CAB)			
COMPRESSION DEPTH	At Least 2 Inches	1/3 Depth of Chest (About 2")	1/3 Depth of Chest (About 1½")	1/3 Depth of Chest
COMPRESSION RATE	at least 100 per minute			120 per minute
COMPRESSION NOTES	Minimize Interruptions In Chest Compressions Attempt to Limit Interruptions to < 10 Seconds			
COMPRESSION TO BREATHS RATIO	30:2 1 OR 2 Person CPR	30:2 1 Person CPR 15:2 2 Person CPR		3:1
ADVANCED AIRWAY	1 breath every 6-8 seconds (8-10 breaths/min) About 1 sec per breath duration No interruptions of compressions			40-60 breaths /min
RESCUE BREATHING	1 breath every 5-6 seconds (10-12 breaths/min)	1 breath every 3-5 seconds (12-20 breaths/min)		40-60 breaths/min

## NOTES:

- Use jaw-thrust method to open airway on trauma patients.
  - Allow the chest to fully recoil after each compression.
  - Change person compressing chest every 2 minutes.
  - Minimize interruptions in compressions before and after each shock to less than 10 seconds.
  - Resume CPR beginning with compressions.
  - Attach and use AED as soon as possible.
  - Utilize AED as it is programmed. (Even if it is not to AHA guidelines.)
- P** If available, use age appropriate AEDs or pads.

### CARDIAC ARREST: V-FIB or PULSELESS V-TACH

- If witnessed or unwitnessed arrest, initiate quality CPR and proceed to first defibrillation as soon as possible.
  - First Defib:
    - A** 360 J for monophasic or use manufacturer's recommendations for biphasic.
    - P** 2 J/kg or biphasic equivalent.
  - CPR for 1- 2 minutes
  - Second Defib:
    - A** 360 for monophasic or use manufacturer's recommendations for biphasic.
    - P** 4 J/kg or biphasic equivalent.
  - CPR for 1- 2 minutes
  - Third Defib:
    - A** 360 for monophasic or use manufacturer's recommendations for biphasic.
    - P** 6 J/kg or biphasic equivalent.
  - CPR for 1- 2 minutes
  - Fourth Defib:
    - A** 360 for monophasic or use manufacturer's recommendations for biphasic.
    - P** 8 J/kg or biphasic equivalent.
  - Continue CPR and repeat treatment as indicated.
- P** Fifth and successive defibrillations will be at 10 J/kg or biphasic equivalent.
- Consider treatable causes.

### CARDIAC ARREST: ASYSTOLE/PEA

- CPR
- Consider treatable causes
- Continue CPR and repeat treatment as indicated.

### SUSPECTED CARDIAC CHEST PAIN

**P** Chest pain in the pediatric patient is rarely related to a cardiac event. Assessment of other causes (e.g., muscle pain, respiratory difficulties, injury) should be completed to determine the source of pain. Application of supplemental oxygen and transport should be the mainstay of care for these patients. Contact MCP for further advice when needed.

**P** THE REST OF CHEST PAIN ALGORITHM DOES NOT APPLY TO PEDS.

**A** Cardiac patients should be considered unstable if they are hypotensive, have altered mental status, or chest pain and poor skin color or diaphoresis.

**A** Ask male and female patients if they have taken Viagra, Cialis, Levitra, Revatio or similar medications within the last 24 hours. Do not administer **Nitroglycerin (NTG)** if they have taken the above medications. **NTG** may cause profound hypotension in these patients.

- A Give **Aspirin 324 mg** to every patient  $\geq 25$  years of age with symptoms of Acute Coronary Syndrome (ACS) including anginal chest pain, shortness of breath, syncope, diaphoresis, weakness, nausea or vomiting. Some patients (elderly, or diabetics) often may have atypical symptoms. Patient **MUST CHEW** the **aspirin**.
- A Prior to moving patient, acquire a supine {12-lead EKG} on all patients with ACS symptoms. If a {12-lead EKG} is obtained, it must be transmitted to MCP. Make sure there are two identifiers on the EKG such as name, DOB, Medic number, age and sex. MCP shall determine the destination based upon patient condition. When calling report, include patient's cardiologist.
- A If SBP >100, and the patient is  $\geq 25$  years of age c/o chest pain, administer **Nitroglycerin 0.4 mg SL** every 5 minutes for continued chest pain, up to a total of three pills with vital signs between doses. Prior to **NTG** administration, establish vascular access for patients who have not previously had **NTG**.
- A Consider Pain Control Protocol, provided SBP >100 after first **NTG**. **DO NOT WAIT UNTIL 3 NTGS ARE GIVEN BEFORE CONSIDERING FENTANYL**.
- A **NS, up to 500 ml, IV**, may be administered to a patient with SBP < 100 without pulmonary edema.
- A Consider repeat EKGs during transport.

**NOTE:** Revatio is a drug approved for treatment of pulmonary arterial hypertension (PAH), a disease that may be treated with Flolan at end stage. The drug contains Sildenafil which is Viagra. Organic nitrates are contraindicated with Revatio. Revatio is prescribed for both men and women. Providers should ask patients, especially PAH patients, about both Viagra and Revatio before giving NTG.

### OBTAINING A 12-LEAD EKG

- Limb leads:
  - Left and right shoulders, or anywhere on their arms
  - Leg electrodes anywhere below the waist
- Chest leads:
  - V1: The Angle of Louis is the prominence on the sternum where the manubrium (top third of the sternum), sternal body (bottom two thirds), and the second rib all come together. Locate it by palpating the “bump” on the sternum and then move out along the second rib to the patient's right. Just below the second rib is the second intercostal space. Move down two more intercostal spaces, and position electrode V1 in the fourth intercostal space, just to the right of the patient's sternum.
  - V2: Place an electrode in the fourth intercostal space on the left side of the sternum.
  - V3: Place V4 first, see below.
  - V4: From V2, move down to the fifth intercostal space on the patient's left, then move laterally to the mid-clavicular line. V4 goes at the intersection of the fifth intercostal space, and the mid-clavicular line.
  - V3: Halfway between V4 and V2
  - V5: Find the anterior axillary line by locating the crease where the arm joins the chest. Move down that line to a point just lateral to V4.
  - V6: V6 is placed on the midaxillary line, level with V5.
- If MCP suspects an inferior wall MI, they may ask for V4R. Lead V4R is simply Lead V4 on the patient's **R**ight side, instead of their left. It provides a better picture of the right side of the heart. Capturing Lead V4R is very simple. Just complete the following steps:
  - Perform a normal 12-Lead EKG.
  - Place one additional electrode on the patient's right side, in the same anatomical location as V4 on the patient's left.
  - Move the V4 Lead from the left, to the new electrode on the right.
  - Complete another 12-Lead EKG.
  - Label this EKG with the patient's name, and the time. Label V4 prominently as V4R.
- Skin preparation
  - Use alcohol preps to prep the skin for monitoring electrodes and for 12-Lead EKGs.
  - **DO NOT** use alcohol preps with therapeutic electrodes, such as QuikCombo pads.

- Shave excess hair.
- Dry skin.
- Primary ways to reduce artifact:
  - Thoroughly prep the skin.
    - Remove excess hair.
  - Attach each electrode solidly.
  - Prevent patient movement.
  - Prevent cable movement.
  - Stop the squad.
  - Eliminate electromagnetic interference (EMI):
    - Turn off or move away from electrical devices.
    - Do not allow patient cables to touch power cords.
    - Make sure patient cables and electrodes are in good shape.
- {Transmit the 12 Lead EKG} and call the receiving facility.

### **CARDIAC DYSRHYTHMIAS: BRADYCARDIA or TACHYCARDIA**

A cardiac patient should be considered unstable if they are hypotensive, has altered mental status, or has unresolving chest pain and poor skin color or diaphoresis.

- Obtain and transmit {12-lead EKG}.
- For adequate perfusion, observe and monitor.
- Transport immediately unless paramedic intercept is < 5 minutes.

### **SHOCK**

Perform manual BP on all pts presenting with S/S of shock. SBP is only one component of the overall clinical picture, which may include tachycardia, tachypnea, diaphoresis, restlessness, decreased mentation. Skin may be pale, ashen, cyanotic, cool, or clammy. Be sure to include S/S in report if SBP is < 100.

Only give fluids for specific S/S of shock and not to every trauma patient.

#### **Without Pulmonary Edema**

*(No JVD, edema, or rales noted)*

- A **NS 500 ml IV.** May repeat x 1.
- P **NS 20 ml/kg IV.** Titrate to maintain adequate perfusion.
- A **◆ Additional NS 500 ml IV,** if needed.
- P **◆ Additional NS 20 ml/kg IV,** if needed
- For persistent shock, establish additional vascular access.

#### **With Pulmonary Edema**

*(JVD, edema, or rales present).*

- A Consider **NS 250 ml IV.**

#### **Exsanguinating Hemorrhage:**

- Control external bleeding and treat for hypovolemic shock as indicated.
- **NS to maintain SBP > 100** en route to hospital.
- P **NS 20 ml/kg IV.** May repeat x 2. Titrate to maintain adequate perfusion

## STROKE

- Be prepared to assist ventilations with oral or nasal airway and BVM or {FROPVD (Flow Restricted Oxygen Powered Ventilation Device)}.
- If signs of cerebral herniation are present, ventilate at a rate of 20 respirations per minute.
  - {If numeric EtCO<sub>2</sub> readings are available, ventilate at a rate to maintain readings at approximately 30 mmHg (30 torr)}.
- P** **Ventilate at a rate of ten faster than normal respiratory rate when the signs of cerebral herniation are present.**
- If glucose < 60, or there is strong suspicion of hypoglycemia despite glucometer readings:
  - Administer **D10, IV 250 ml** at wide open rate. (500 ml = 50 g of Dextrose)
- P** **D10, IV (5 ml/kg) maximum single dose of 250 ml**
- Document amount of **D10** administered in milliliters.
- If unable to establish vascular access, **Glucagon, 1 mg IM**
- **D10** may be repeated in ten minutes if blood sugar remains < 60
- If one or more signs of the Cincinnati Prehospital Stroke Scale are abnormal, and < 4 hours since patient was last seen normal, call a Stroke Alert, and transport to a Stroke Center with tPA capabilities.
  - Cincinnati Prehospital Stroke Scale: (normal or abnormal)
    - Facial Droop (pt. shows teeth or smiles).
    - Arm Drift (pt. closes eyes and holds both arms straight out for about 10 seconds).
    - Abnormal Speech (have pt. say “You can’t teach an old dog new tricks.”)
- If patient’s symptoms occurred > 4 hours and < 8 hours from last time they were known to be free of stroke symptoms or awoke abnormal, transport to a Comprehensive Stroke Center.
  - Contact MCP with a Stroke Alert for advice regarding transport destination if greater than 8 hours since last seen normal.
- Transport the patient with the bed flat, if able to tolerate. If showing signs of increased ICP, do not lay patient flat.
- Transport historian with patient both to provide patient history and for permission to treat.

**Telemedicine stroke center with tPA ready**, also known as drip and ship, has tPA capabilities and immediate access to a Neurologist.

**Primary Stroke Center:** facility with capability to administer tPA, also has an ICU. They can either admit patients or move them on.

**Comprehensive Stroke Centers:** facility with 24/7 endovascular capabilities.

- Miami Valley Hospital
- Kettering Medical Center

### Disorders Mimicking Stroke

- Seizure
- Subdural hematoma
- Brain tumor
- Syncope
- Toxic or metabolic disorders (e.g., hypoglycemia)

## TRAUMA EMERGENCIES

### General Considerations:

- Use of on-line MCP for medical direction in the field for difficult cases is encouraged.
  - Minor trauma patients may be transported to non-trauma centers.
  - Major trauma patients are to be transported as soon as possible to the nearest appropriate facility.
  - Scene size-up, with rapid assessment and recognition of major trauma or multiple system trauma and effective evaluation of the mechanism of injury are essential to the subsequent treatment.
  - Hypothermia is a significant and frequent problem in shock for major trauma patients. Maintain patient's body temperature.
  - If patient condition changes, notify hospital.
  - When patient is transported by helicopter, the EMS run sheet should be faxed to the receiving trauma center.
  - The *only* procedures that should take precedence to transport of major trauma patients are:
    - Airway management
    - Stabilization of neck and back or obvious femur and pelvic fractures on a backboard
    - Exsanguinating hemorrhage control
    - Extrication
  - After the trauma patient's extrication, the on-scene time should be limited to **10 minutes or less**, except when there are extenuating circumstances.
  - **Pre-arrival notification of the receiving facility is essential!** Give Mechanism of Injury, Injuries, Vital signs, Treatment (MIVT), GCS with components, and ETA.
  - Take a manual BP on all trauma patients.
  - Repeat vitals on trauma patients every 5 minutes.
- A IVs should be established en route to the hospital unless the patient is trapped, transport is otherwise delayed, or patient has no life threatening injuries, and transport prior to analgesia would be extremely painful. Start the IV with a large bore catheter and macro drip tubing.
- A Up to 1000 ml of 0.9% NS.
- P **Start IV with a large bore catheter, macro drip tubing and 20 ml/kg of NS.**
- **IV** flow rates are as follows:
    - Keep open rate for major head trauma with adequate perfusion
    - IV wide open if the patient has inadequate perfusion (including head trauma) utilizing {IV Pressure Infusion Pump or Bag} or similar equipment if available.
  - Titrate all IV flow rates to maintain SBP ~ 100.
  - **For penetrating trauma to the chest and abdomen:**
    - If a radial pulse is present and the patient is conscious and mentating, load and go.
    - If no radial pulse, infuse **NS in 250 ml boluses** until radial pulse is present and then stop fluid.
  - Consider Pain Control Protocol.

**NOTE:** Studies indicate that surgical emergencies with increased fluid administration cause dilution, lower body temperatures and increase coagulopathies, all of which increase mortality. This is referred to as "permissive hypotension," and means that IV fluids are not administered to these patients unless there is loss of radial pulse.

## PRE-HOSPITAL FIELD TRIAGE

- Patients to be taken to the nearest hospital:
  - Unstable airway
  - Blunt trauma arrest  $\leq 5$  minutes from a hospital or penetrating trauma arrest  $\leq 15$  minutes from hospital
- Drowning; near drowning; strangulation; burns; electromagnetic, chemical, or radiation exposure; heat or cold injury or illness; and asphyxia are considered trauma and these patients should be transported to a Trauma Center.
- List in the EMS run report which of the State Trauma Triage Criteria the patient met.

## TRAUMA CRITERIA

- G** Patients 70 years of age or older will be triaged for evaluation in a Trauma Center for:
  - GCS < 15 with suspected traumatic brain injury (TBI)
  - Systolic BP < 100 mmHg
  - Falls, even from a standing position, with evidence of TBI
  - Pedestrian struck by motor vehicle.
  - Known or suspected proximal long bone (femur/humerus) fracture sustained in MVC.
  - Multiple body regions injured.
- G** Special consideration should be given for the geriatric trauma patient to be evaluated at a Trauma Center if they have diabetes, cardiac disease, clotting disorders, immunosuppressive disorder, are on anticoagulants, or require dialysis.

### Anatomy of Injury:

- All penetrating trauma to head, neck, torso, and extremities proximal to elbow or knee with neurovascular compromise
- Abdominal injury with tenderness, distention, or seat belt sign
- Chest injury: flail chest or tension pneumothorax
- Two or more proximal long bone fractures
- G** One proximal long bone fracture in MVC only (*Geriatric Trauma*)
- Evidence of pelvic fracture (exception: isolated hip fracture)
- Spinal cord injury with paralysis
- A** Burns greater than 10% total body surface area (BSA) or other significant burns involving the face, feet, hands, genitals or airway
- P** Burns greater than 5% total BSA or other significant burns involving the face, feet, hands, genitals or airway
- Amputation proximal to wrist or ankle
- Evidence of serious injury of 2 or more body systems
- Crush injury to head, neck, torso, or extremities proximal to knee or elbow

<b>YES =Transport to Trauma Center</b>	<b>NO – Assess Physiological</b>
<b>Alert Trauma Team</b>	

### Physiological Adult:

- A** GCS less than or equal to 13
- A** Loss of consciousness greater than five minutes at any time
- A** Alteration in level of consciousness with evidence of head injury at time of exam or thereafter
- A** Failure to localize pain
- A** Respirations < 10 or > 29
- A** Intubation
- A** Tension pneumothorax
- A** Pulse > 120 in combination with any other physiologic criteria
- A** SBP < 90 or absent radial pulse with carotid pulse present

### Physiological Pediatric:

- P** GCS less than or equal to 13
- P** Loss of consciousness greater than five minutes at any time
- P** Alteration in level of consciousness with evidence of head injury at time of exam or thereafter
- P** Failure to localize pain
- P** Evidence of poor perfusion (e.g., weak distal pulse, pallor, cyanosis, delayed capillary refill, tachycardia)
- P** Evidence of respiratory distress or failure (e.g., stridor, grunting, retractions, cyanosis, nasal flaring, hoarseness, or difficulty speaking)

**Physiological Geriatric:**

- G GCS < 15 with evidence of TBI
- G Loss of consciousness greater than five minutes at any time
- G Alteration in level of consciousness with evidence of head injury at time of exam or thereafter
- G Failure to localize pain
- G Respirations < 10 or > 29
- G Intubation
- G Tension pneumothorax
- G Pulse > 120 in combination with any other physiologic criteria
- G SBP < 100 or absent radial pulse with carotid pulse present

<b>YES = Transport to Trauma Center</b>	<b>NO = Evaluate Mechanism of Injury</b>
<b>Alert Trauma Team</b>	

**Mechanism of Injury:**

- Auto-pedestrian/auto-bicycle injury with significant (> 5 mph) impact
- Death in same passenger compartment
- Ejection from motor vehicle
- Extrication time > 20 minutes
- A Fall > 20 feet
- P Fall greater than 3 times child’s height
- High-speed auto crash
  - Speed > 40 mph
  - Intrusion into passenger compartment > 12 inches
  - Major auto deformity > 20 inches
- Open motor vehicle crash > 20 mph or with separation of rider from vehicle
- Pedestrian thrown or run over.
- Unrestrained rollover

<b>YES = Consider Trauma Center</b>	<b>NO = Check Special Situations</b>
May consult with Medical Control Physician if needed	

**Special Situations:**

- Pre-existing cardiac or respiratory disease
- Insulin dependent diabetes, cirrhosis, morbid obesity, seizure disorder
- Patient with bleeding disorder or on anticoagulants
- Immuno-suppressed patients (renal dialysis, transplant, cancer, HIV)
- P Congenital disorders

<b>YES = Consider Trauma Center</b>	<b>NO = To Local Hospital</b>
-------------------------------------	-------------------------------

**TRANSPORT GUIDELINES**

**Trauma Center/Facility Capabilities:**

- Level I and II Trauma Centers can care for the same trauma patients.
- Level III Trauma Centers offer services, based on individual hospital resources, that provide for initial assessment, resuscitation, stabilization, and treatment of the trauma patient.
- In some areas of the region a Level III Trauma Center is the only trauma facility within 30 minutes ground transport time. This hospital may act as the primary receiving facility for the critically injured patient.

- In areas where the trauma patient is closer to a Level III Trauma Center, but a Level I or Level II Trauma Center is still within 30 minutes, the EMS Provider should decide whether the patient would benefit more from an immediate evaluation, stabilization, and treatment at the Level III Trauma Center, or from direct transport to a Level I or Level II Trauma Center.
  - In areas of the region where there are no Trauma Centers within 30 minutes ground transport time, the acute care hospital may act as the primary receiving facility for critically injured trauma patients, or EMS Provider may arrange for air medical transport from the scene.
- P If a pediatric patient meets the trauma triage guidelines, transport to a Pediatric Trauma Center. If transportation time is > 30 minutes, transport to the nearest acute care hospital, or EMS providers may arrange for air medical transport from the scene.
- All pregnant trauma patients should be transported to the nearest Adult Trauma Center with labor and delivery capabilities, unless transport time > 30 minutes.

#### **Air Medical Transportation:**

- Prolonged delays at the scene waiting for air medical transport should be avoided.
- Cardiac arrest **not** appropriate for air transport.
- In the rural environment, direct transfer of trauma patients by air medical transport may be appropriate and should be encouraged.
- Consider the time involved in landing, packaging, loading, and unloading the patient in deciding whether air transport is necessary. It is often faster to use ground transport if the patient is within 15 miles of the Trauma Center.

#### **Exceptions to Transportation Guidelines:**

- It is medically necessary to transport the victim to another hospital for initial assessment and stabilization before transfer to a Trauma Center.
- It is unsafe to transport the victim directly to a Trauma Center due to adverse weather or ground conditions or excessive transport time.
- Transporting the victim to a Trauma Center would cause a shortage of local emergency medical services resources.
- No appropriate Trauma Center is able to receive and provide trauma care to the victim without undue delay.
- Before transport begins, the patient requests to be taken to a particular hospital even if it is not a Trauma Center. If the patient is a minor or otherwise considered incapable of making medical decisions, an adult relative or other legal representative may make this request.

## **MAJOR TRAUMA**

Patients meeting criteria for transport to a Trauma Center are considered “Load and Go.”

- Place the patient in a correct position to maintain the airway.
- Open pneumothorax: cover wound with an occlusive dressing, tape down three sides.
- Tension pneumothorax:
  - Lift one side of any occlusive dressing.
  - Use caution not to confuse right mainstem intubation for a pneumothorax.
  - Perform needle decompression.
- If patient in arrest has potential chest trauma, perform bilateral relief of tension pneumothorax.
- Flail chest: immobilize with a bulky dressing or towels taped to the chest.
- Contact Medical Control and advise of patient condition with MIVT, ETA, and GCS components.
- For pregnant patient in arrest consider need for manual uterine displacement and perform chest compressions slightly higher on the sternum than normal.

## CRUSH SYNDROME TRAUMA

- History: Entrapped or under an extreme load and crushed for greater than 60 minutes
  - Contact MCP
  - Signs and symptoms: hypotension, hypothermia, abnormal ECG findings, pain and anxiety
- A 1 liter NS bolus IV. Then 500 ml/hour IV**
- P NS, 20 ml/kg IV**
- Follow pain management protocol
  - If hypotensive and the pt has been entrapped > 1 hour:
    - A Give additional NS, 1 Liter IV.**
    - P Give additional NS, 20 ml/kg IV.**
  - {12 lead}
  - Consider **Midazolam**
    - A 2 mg IV**
    - P 0.1 mg / kg, IV, (max dose 2 mg)**
  - Monitor and reassess
  - Monitor for fluid overload
  - Special considerations:
    - Potential for multiple system trauma
    - Potential for hypo/hyperthermia.

## HEMORRHAGE CONTROL

- Control of life-threatening external hemorrhage takes priority over any other treatment.
- Constant, direct pressure is the primary method of bleeding control.
- If direct pressure fails to control bleeding from extremities, use a tourniquet.
  - {Commercial tourniquets such as the CAT or SOFTT are recommended.}
  - Only use wide, flat materials such as cravats or BP cuffs as improvised tourniquets.
  - Any tourniquet should be placed as proximal on the arm or leg as possible. For injuries to the lower leg or forearm, place two tourniquets as proximal as possible on the femur or humerus.
  - Tighten the tourniquet until the bleeding stops.
  - Document time and location. Be sure that the ER staff is aware of the tourniquet.
- {For life-threatening hemorrhage that can't be controlled by a tourniquet, consider hemostatic dressings, e.g., Combat Gauze or ChitoFlex PRO. These can be used on or in the chest or abdomen. Place in direct contact with the source of bleeding and apply a pressure dressing }.
- **DO NOT USE GRANULAR AGENTS.**
- Treat for hypovolemic shock as indicated.

## HEAD INJURY

Evaluate patient condition including level of consciousness, pupillary size and reaction, GCS.

### GLASGOW COMA SCALE

	<b>&lt; 2 YEARS OLD</b>		<b>ADULT &amp; PEDIATRIC &gt; 2 YEARS OLD</b>	
EYES	SPONTANEOUSLY	4	SPONTANEOUSLY	4
	TO VOICE	3	TO VOICE	3
	TO PAIN	2	TO PAIN	2
	NO RESPONSE	1	NO RESPONSE	1
VERBAL	COOS, BABBLES	5	ORIENTED	5
	IRRITABLE CRY, CONSOLABLE	4	CONFUSED	4
	CRIES TO PAIN	3	INAPPROPRIATE WORDS	3
	MOANS TO PAIN	2	GRUNTS, GARBLED SPEECH	2
	NO RESPONSE	1	NO RESPONSE	1
MOTOR	NORMAL MOVEMENTS	6	OBEYS COMMANDS	6
	WITHDRAWS TO TOUCH	5	LOCALIZES PAIN	5
	WITHDRAWS TO PAIN	4	WITHDRAWS TO PAIN	4
	FLEXION (DECORTICATE)	3	FLEXION (DECORTICATE)	3
	EXTENSION (DECEREBRATE)	2	EXTENSION (DECEREBRATE)	2
	NO RESPONSE	1	NO RESPONSE	1

- Signs of cerebral herniation:
  - Dilated and unresponsive pupils, bradycardia, posturing, decreased mental status.
- Ventilate at 20 breaths per minute when signs of cerebral herniation are present.
  - {Ventilate to maintain EtCO<sub>2</sub> readings of 30 mmHg (30 torr)}.

**P Ventilate at a rate of ten faster than normal respiratory rate when the signs of cerebral herniation are present.**

Maintain good ventilation at rate of about one breath every 5-6 seconds (10-12 per minute), with high flow Oxygen. Prophylactic hyperventilation for head injury is not recommended. Cerebral herniation syndrome is the only situation in which hyperventilation (rate of 20 per minute; **pediatric rate of 10 faster than the normal rate**) is indicated.

Hypoventilation increases the level of CO<sub>2</sub> in the brain causing cerebral vasodilatation and increased swelling. Hyperventilation decreases the level of CO<sub>2</sub> and causes cerebral vasoconstriction, hypoxia, and ischemia. Both hyperventilation and hypoventilation could cause cerebral hypoxia and increases mortality.

In cerebral herniation, there is a sudden rise in intracranial pressure. Portions of the brain may be forced downward, applying great pressure on the brainstem. This is a life-threatening situation characterized by a decreased LOC that rapidly progresses to coma, dilation of the pupil, an outward-downward deviation of the eye on the side of the injury, paralysis of the arm and leg on the side opposite the injury, or decerebrate posturing. When this occurs, the vital signs frequently reveal increased blood pressure and bradycardia. The patient may soon cease all movement, stop breathing, and die. If these signs are developing in a head injury patient, cerebral herniation is imminent and aggressive therapy is needed. Hyperventilation will decrease ICP. In this situation, the danger of immediate herniation outweighs the risk of ischemia.

## EXTREMITY INJURIES

- Assess and document pulse, motor, and sensation both pre/post splinting and during transport.
- For open fractures, control bleeding with direct pressure and cover with dry, sterile dressing.
- Apply appropriate splinting device.
- To reduce swelling, elevate extremity and apply cold pack.
- Consider Pain Control Protocol.

### Good Splinting Practices:

- Document distal sensation and circulation pre & post splinting and pre & post spinal restriction.
- If the extremity is severely angulated and pulses are absent, apply gentle traction in an attempt to bring the limb back into a natural anatomic position. If resistance is encountered, splint the extremity in the angulated position.
- Open wounds should be covered with a sterile dressing before splinting.
- Apply a well-padded splint to immobilize above and below the injury.
- If in doubt, splint a possible injury.

**NOTE:** The patient who requires a load and go approach can be adequately immobilized by careful packaging on the long spine board. Do additional splinting en route to the hospital as time and the patient's condition permit.

## DROWNING AND NEAR DROWNING

- Consider spinal restriction.
- Consider possibility of hypothermia.
- Establish vascular access.
- Evaluate neurological status.
- Near drowning patients should be transported to a Trauma Center.

## HYPOTHERMIA

- Move patient to warm environment, remove all wet clothing, dry the patient, and cover with blankets.
- Avoid any rough movement that may cause cardiac dysrhythmias or cardiac arrest. It may be beneficial to immobilize the patient on a backboard.
- Minimize movement.
- Assess neurological status.
- It may be necessary to assess pulse and respirations for up to 45 seconds to confirm arrest.
- Consider possibility of other medical conditions (e.g., overdose, hypoglycemia).
- Do not initiate CPR if there is any pulse present, no matter how slow.
- Use the least invasive means possible to secure airway. Intubate if necessary, as gently as possible.
- Hypothermic patients should be transported to a Trauma Center.
- Establish vascular access and consider {warmed} fluids.
- If patient arrests:
  - CPR continuously
  - If severe hypothermia < 86°F (30°C) is strongly suspected, limit defibrillation attempts to 1 and withhold medications except on orders from Medical Control.
  - If body temperature is > 86°F (30°C), follow normal arrest protocols.
  - Intubate and oxygenate the patient with {warmed and humidified} 100% O<sub>2</sub>.
  - Continue resuscitative efforts while in transit, even if there is no response.

## FROSTBITE

- Protect injured areas. Remove clothing and jewelry from injured parts.
- Do not attempt to thaw injured part with local heat.
- Maintain core temperature.
- Severe frostbite injuries should be transported to a Burn Center.
- Establish vascular access and consider {warmed} fluids.
- Consider Pain Control Protocol.

## BURNS or SMOKE INHALATION

### General Considerations

- Stop the burning and minimize contamination.
- Severe burns should be transported to a burn center unless ETA > 30 minutes.
- Keep patient warm.
- Superficial and partial thickness burns < 10% may have wet dressings applied.
- Burns > 10% BSA may be covered with clean, dry sheets or dressings.
- Remove clothing and jewelry from injured parts. **Do not remove items which have adhered to the skin.**
- Inhalation injuries with an unsecured airway should be transported to the nearest facility.
- Chemical burns are Haz-Mat situations and must be grossly decontaminated at the scene.
- BP may be taken over damaged tissue if no other site is accessible.

### Specific Care

- Assess for respiratory distress, stridor, hoarseness, sooty sputum, singed eyebrows and nares, or burns of the face or airway.
- Apply cardiac monitor, especially if patient has suffered a lightning strike or electrical burn.
- Determine type of burn and treat as follows:
  - Radiation burns:
    - Treat other medical emergencies first.
    - Treat as thermal burns except when burn is contaminated with radioactive materials, then treat as a Haz-Mat situation
    - Consider contacting Haz-Mat team for assistance in contamination cases.
  - Inhalation Burns:
    - Provide {humidified} O<sub>2</sub> with **Saline**.
    - If no humidifier is available, administer a **Saline Nebulizer 3 ml**. Repeat PRN.
- {CO oximeter}
- Provide endotracheal intubation if apneic.
- Consider Hyperbaric Oxygen treatment for the following:
  - Underlying cardiovascular or symptoms such as chest pain or shortness of breath
  - > 60 years of age
  - Obvious neurological symptoms, such as any interval of unconsciousness, loss of time, inability to perform simple motor tasks, or loss of memory
  - Pregnancy
- In patients where cyanide is a likely component of the smoke, it is critical to control any seizure activity using Diazepam or Midazolam.

## CARBON MONOXIDE (CO) POISONING

- Provide high flow O<sub>2</sub> to all suspected CO poisonings
- Pulse Oximeter will give false readings and should not be utilized.
- {CO oximeter}
- Consider Hyperbaric Oxygen treatment for the following patients with suspected CO exposure:
  - Underlying cardiovascular disease or symptoms such as chest pain or shortness of breath
  - > 60 years of age
  - Obvious neurological symptoms, such as any interval of unconsciousness, loss of time, inability to perform simple motor tasks or loss of memory
  - Smoke inhalation victims
  - Pregnancy
  - KMC has a 24/7 hyperbaric chamber. You must still remove your patient to an emergency facility and then treatment and destination decisions will be determined.
- Contact Medical Control to discuss transport considerations.

## HEAT EXPOSURE

### General Considerations

- Geriatric patients, pediatric patients, and patients with a history of spinal injury or diabetes mellitus are most likely to suffer heat-related illnesses. Other contributory factors may include heart medications, diuretics, cold medications, and psychiatric medications.
- Heat exposure can occur due to increased environmental temperatures, prolonged exercise, or a combination of both. Environments with temperatures above 90°F and humidity over 60% present the most risk.

### Specific Care

- Move patient to a cool environment.
- Remove patient's clothing. Apply water to the skin to cool the patient.
- Apply cold packs to underarms and groin area.
- Cold water submersion is an acceptable method for cooling heat stroke patients. You may encounter patients in cooling body bags. The goal is to lower temperature to < 102.5°F.
- If conscious and not vomiting or extremely nauseous, provide oral fluids.
- **A NS 500 ml IV** if hypotensive or mental status changes. May repeat x 1 without MCP approval.
- **P NS 20 ml/kg IV (max 500) if hypotensive or mental status changes. May repeat x 1.**
- ♦ Additional NS IV, if indicated.
- Be prepared for seizures.
- Consider other medical conditions (e.g., overdose, hypoglycemia, CVA) and treat accordingly.
- Hyperthermia patients should be transported to a Trauma Center.

## EYE INJURIES

- If possible, contact lenses should be removed. Transport contacts with patient.
- Use nasal cannula with IV tubing for irrigation.
- Chemical Burns:
  - Irrigate immediately with NS or water for a minimum of 30 minutes or until patient transport is completed.
  - Determine chemical involved. Bring MSDS, if available.
- Major Eye Trauma:
  - Do not irrigate if penetrating trauma.
  - Cover both eyes to limit movement.
  - Do not use a pressure or absorbent dressing on or near any eye that may have ruptured, or have any penetrating trauma.
  - Transport with head elevated at least 30°.

## RESPIRATORY DISTRESS

- Evaluate breath sounds:
  - Clear: treat cause (e.g., MI, pulmonary embolism, metabolic disturbance, hyperventilation).
  - Wheezes: treat cause (e.g., pulmonary edema, FBAO, asthma, allergic reaction).
  - Rales: treat cause (e.g., pulmonary edema, pneumonia).
  - Diminished or absent:
    - Unilateral: treat cause (e.g. pneumothorax, hemothorax, pneumonia, unilateral lung).
    - Bilateral: treat cause (e.g., respiratory failure, end stage COPD, asthma).
- Obtain Pulse Oximeter and {capnography} reading.
- Cardiac monitor and {12-lead EKG}

## PULMONARY EDEMA

- Assess for and note cyanosis, clammy skin, absence of fever, coughing, wheezing, labored breathing, diaphoresis, pitting edema, rales in bilateral lower lung fields, tachypnea, apprehension, JVD, and inability to talk.
- CPAP use is encouraged prior to the initiation of drug therapy.
- If patient has SBP > 100, **Nitroglycerin 0.4 mg SL** up to 3, 1 every 5 minutes.

**NOTE:** At times, pneumonia may look like CHF with pulmonary edema. However, the pneumonia patient is often dehydrated and has an elevated temperature.

## ASTHMA, EMPHYSEMA, COPD

- Consider **Albuterol 2.5 mg** and **Ipratropium 0.5 mg**, nebulized with O<sub>2</sub> 8-10 LPM.
- May repeat **Albuterol 2.5 mg nebulized X 2**.
- If patient is intubated, **Albuterol 2.5 mg** by nebulizer into the ETT. If **Ipratropium** not given before intubation, add to first **Albuterol**.
- COPD: CPAP
- After intubation of an asthma patient, limit rate of ventilation to avoid auto-PEEP and hypotension, provided that you can adequately oxygenate the patient at below rate.
  - A 8-10 breaths per minute for adults
  - P 10-15 breaths per minute for pediatric patients
- Consider bilateral needle decompression if:
  - Patient arrests.
  - Patient has unilateral or bilateral diminished breath sounds and is hemodynamically unstable.
- Asthmatics in severe distress:
  - If ≥ 30 kg, give both **Adult EpiPen and EpiPen Jr or Epi (1:1,000) 0.5 mg IM**.
  - ♦ May repeat **Epinephrine (1:1,000) 0.5 mg IM** after 5 minutes.
  - P If < 30 kg, **EpiPen Jr or Epinephrine (1:1,000) 0.01 mg/kg IM (max 0.5 mg)**.
  - P ♦ May repeat **Epinephrine (1:1,000) 0.01 mg/kg IM (max 0.5 mg) after 5 minutes**.
- A patient who has received a breathing treatment should be transported for evaluation.

**NOTE:** National guidelines now recommend higher Epinephrine dosing for asthma and anaphylaxis in the 0.5 mg range as an initial dose for the average adult. That is the reason for the orders change to use either both of the EpiPens in the Drug Bag (0.3 mg + 0.15 mg = 0.45 mg) or ~ 0.5 mg IM.

## ALLERGIC REACTION, ANAPHYLAXIS

- If severe allergic reaction:
  - If  $\geq 30$  kg, give both **Adult EpiPen and EpiPen Jr or Epi (1:1,000) 0.5 mg IM**.
  - ♦ May repeat **Epinephrine (1:1,000) 0.5 mg IM** after 5 minutes.
  - P** If  $< 30$  kg, **EpiPen Jr or Epinephrine (1:1,000) 0.01 mg/kg IM (max 0.5 mg)**.
  - P** ♦ May repeat **Epinephrine (1:1,000) 0.01 mg/kg IM (max 0.5 mg) after 5 minutes**.
- If applicable, apply cold pack.
- If apneic, intubate, possibly with smaller than normal ET tube.
- If patient is wheezing: **Albuterol 2.5 mg and Ipratropium 0.5 mg in nebulizer with O<sub>2</sub> flowing at 8-10 LPM**.
- **Albuterol** may be repeated **X 2**.
- If patient is intubated, **Albuterol 2.5 mg** by nebulizer into the endotracheal tube. If **Ipratropium** not given before intubation, add to first **Albuterol**.
- If hypotensive, **NS IV** to maintain adequate BP.
- P** If hypotensive, **NS 20 ml/kg IV** to maintain adequate BP.
- **Diphenhydramine 50 mg IM/IV**.
- P** **Diphenhydramine 1 mg/kg IM/IV (Max Dose 50 mg)**.
- For patients unresponsive to **Epinephrine, Glucagon, 1mg IV**. If no IV, **Glucagon 1mg IM**.

## DIABETIC EMERGENCIES: REFUSAL OF TRANSPORT

- If glucose  $< 60$ , or there is strong suspicion of hypoglycemia despite glucometer readings:
  - A** Administer **D10, 250 ml**. at wide open rate (500 ml = 50 g of Dextrose)
  - P** **D10, 5 ml/kg, max single dose 250 ml**
    - Document amount of **D10** administered in milliliters.
    - If unable to establish vascular access, **Glucagon, 1 mg IM**.
- **D10** may be continued in ten minutes if blood sugar remains  $< 60$ .
- In a diabetic patient with an insulin pump and a glucose  $< 60$ , treat the hypoglycemia.
- Maintain normothermia.
- Patients **18 years of age** or older may be permitted to refuse. Follow these guidelines:
  - Repeat physical examination and vital signs. Patient must be A&O x3.
  - Warn the patient that there is a significant risk of going back into hypoglycemia, especially if on oral hypoglycemics.
  - Advise the patient to eat something substantial immediately.
  - Advise the patient to contact their family physician as soon as possible to minimize future episodes.
  - Advise the patient to stay with someone.
  - Follow normal patient refusal procedures including documentation of above points.
  - Continue **D10** infusion during the refusal process to provide a “buffer” and reduce the risk of refractive hypoglycemia.

**NOTE:** Oral glucose is indicated for any awake but disoriented patient with BS  $< 60$  or a strong suspicion of hypoglycemia despite blood sugar readings. Oral glucose may also be administered carefully under the tongue or between the gum and cheek of an unresponsive patient who must be placed in the lateral recumbent position to promote drainage of secretions away from the airway.

**NOTE:** Send a copy of the run sheet to the EMS Coordinator of the hospital that replaces your Drug Bag.

## SEIZURES

- BVM and nasopharyngeal airway *during* seizure as needed
- A** If seizing, **Diazepam 5 mg slow IV or Midazolam 10 mg IN** (5 mg in each nostril)
- A** or **Midazolam 2 mg slow IV, or Midazolam 4 mg IM**
- A** Persistent seizing, **repeat Diazepam 5 mg, slow IV, or Midazolam 5 mg IN**, (2.5 mg in each nostril) **or 2 mg slow IV or 4 mg IM.**
- P** If seizing, **Diazepam 0.2 mg/kg** (max dose 5 mg) **slow IV, or Midazolam 0.2 mg/kg IN** (max IN dose 4 mg) **or Midazolam 0.1 mg/kg slow IV** (max IV dose 2 mg) **or Midazolam 0.2 mg/kg IM** (max IM dose 4 mg)
- P** If still seizing, repeat **Diazepam 0.2 mg/kg, slow IV**, or repeat one-half of all initial Midazolam doses except **NO IM REPEAT.**
- P** If no vascular access or MAD, **Diazepam 0.5 mg/kg PR** (max dose 10 mg)
- If glucose < 60, or there is strong suspicion of hypoglycemia despite glucometer readings
  - A** Administer **D10, 250 ml.** at wide open rate (500 ml = 50 g of Dextrose)
  - P** **D10, 5 ml/kg, max single dose 250 ml**
    - Document amount of **D10** administered in milliliters.
- If unable to establish vascular access, **Glucagon, 1 mg IM.**
- **D10** may be continued in ten minutes if blood sugar remains < 60.
- In a diabetic patient with an insulin pump and a glucose < 60, treat the hypoglycemia.
- Maintain normothermia.
- When obtaining history be sure to include the following:
  - Description of seizures, areas of body involved, and duration
  - Other known medical history; (e.g., head injury, diabetes, drugs, alcohol, stroke, heart disease).

## EXTRAPYRAMIDAL (DYSTONIC) REACTIONS

- A patient who is currently on a phenothiazine (e.g., Phenergan, Thorazine Compazine) or a butyrophenone (e.g., Haldol, Droperidol) and exhibiting signs of acute muscle spasm or motor restlessness may be suffering from an Extrapyrarnidal Reaction.
- Physical examination findings may include any of the following:
  - Oculogyric crisis (spasmodic deviation of eyes in all directions generally fixed upward.)
  - Buccolingual crisis (protrusion of tongue with slurred speech)
  - Trismus (closing of the jaw due to spasm of the muscles also called lockjaw.)
  - Difficulty in speaking
  - Facial grimacing
  - Torticollis crisis (stiff neck with deviation of the head with the chin pointing to the other side)
  - Opisthotonus (extreme back arching)
  - Tortipelvic crisis—typically involves hip, pelvis, and abdominal wall muscles, and causes difficulty with walking.
  - Mental status is unaffected.
  - Vital signs are usually normal.
  - Remaining physical examination findings are normal.
- Initiate IV of NS to maintain adequate BP.
- If glucose < 60, or there is strong suspicion of hypoglycemia despite glucometer readings
  - Administer **D10** at wide open rate, 250 ml (500 ml = 50 g of Dextrose)
  - P** **D10 (5 ml/kg)** (max single dose 250 ml)
    - Document amount of **D10** administered in milliliters.
    - If unable to establish vascular access, **Glucagon, 1 mg IM.**
- **D10** may be repeated in ten minutes if blood sugar remains < 60.
- A** ♦ Consider **Diphenhydramine 50 mg IV or IM.**
- P** ♦ **Diphenhydramine 1 mg/kg IV or IM** (max dose 50 mg)

## POISONING or OVERDOSE

EMS personnel should contact MCP for suspected poisonings. Poison Control is intended for use by the general public.

### Narcotic Overdose

- If patient has a pulse, **Naloxone** should be administered *before* inserting an ETT.
- Consider patient restraint before administration of **Naloxone**:
  - If respirations are impaired, or there is suspicion of narcotic overdose, administer **Naloxone, up to 2 mg IN** or **Naloxone 2 mg IV** or **4 mg IM**. Titrate to adequate respirations.
  - May repeat.

### P **Naloxone:**

- ≤ 20 kg **0.1 mg/kg IN, IV, IM** (max dose 2 mg) may repeat x one
- > 20 kg **2 mg, IN, IV, IM** (max dose 2 mg), may repeat x one
- **Naloxone IV** is preferred, but it may be given IN before IV is established.
- Titrate to adequate respirations.

### P **If using IN route and respirations don't improve after 3 minutes, establish IV and administer IV dose.**

- After administration of **Naloxone**, patient transport by EMS is encouraged.

### Crack/Cocaine:

- If chest pain:
  - **Nitroglycerin 0.4 mg SL**, if SBP >100, every 5 minutes to a total of three pills with vital signs between doses
  - **Diazepam 5 mg slow IV**, if SBP > 100 or **Midazolam 10 mg, IN** (5 mg in each nostril) or **Midazolam 2 mg slow IV**, or **Midazolam 4 mg IM**
  - **Repeat Diazepam 5 mg slow IV**, or **Midazolam 5 mg IN** (2.5 mg in each nostril) or **Midazolam 2 mg slow IV** or **Midazolam 4 mg IM**.

### Tricyclic Overdose:

- Tricyclic Antidepressant Examples:
  - Amitriptyline (Elavil, Endep, Etrafon, Limbitrol)
  - Nortriptyline (Pamelor, Aventyl)
  - Amoxapine (Asendin)
  - Clomipramine (Anafranil)
  - Desipramine (Norpramine)
  - Doxepin (Sinequan)
  - Imipramine (Tofranil)
  - Protriptyline (Vivactil)
  - Trimipramine (Surmontil)

**NOTE:** Overdose with tricyclic antidepressant medications may be evidenced by bradycardia, tachycardia, hypotension and prolongation of the QRS complex. Risk of rapid deterioration or sudden onset V Fib is high.

### Calcium Channel Blocker Overdose

- ♦ **Glucagon 1 mg IM or IV**
- Calcium Channel Blocker Examples:
  - Amlodipine (Norvasc)
  - Diltiazem (Cardizem, Dilacos)
  - Felodipine (Plendil)
  - Isradipine (Dynacirc)
  - Nifedipine (Procardia, Adalat)
  - Verapamil (Calan, Isoptin, Verelan)

## Beta Blocker Overdose

- ♦ **Glucagon** 1 mg, IM or IV.
- Beta Blocker Examples:
  - Acebutolol (Sectral)
  - Atenolol (Tenormin)
  - Carvedilol (Coreg)
  - Corzide, Inderide, Lopressor, HCT, Tenoretic, Timolide, Ziac
  - Labetalol (Normodyne, Trandate)
  - Metoprolol (Topral, Lopressor)
  - Nadolol (Corgard)
  - Pindolol (Viskin)
  - Propranolol (Inderal)
  - Sotalol (Betapace)
  - Timolol (Blocadren)

## ABDOMINAL PAIN

- Use inspection, auscultation, and palpation to assess the patient with abdominal pain.
- Assess and document pain using the OPQRST acronym:
  - O = Onset
    - Was the onset sudden or gradual?
  - P = Provocation and Palliation
    - What causes it?
    - What makes it better or worse?
  - Q = Quality
    - What kind of pain is it?
  - R = Region and Radiation
    - Where is the pain located?
    - Does it radiate?
  - S = Severity and Scale
    - Does it interfere with activities?
    - How does it rate on a severity scale of 1 to 10?
  - T = Timing and Type of Onset
    - How often does it occur?
    - When did it begin?
- A Consider **Ondansetron (Zofran) 4 mg PO** for nausea or active vomiting.
- P **Ondansetron 4 mg PO** if pt  $\geq 12$  y/o and wt is  $\geq 40$  kg.
- A For pain relief, including unilateral flank pain, consider Pain Control Protocol.
- P ♦ For pain relief, call MCP for orders

## OBSTETRICAL EMERGENCIES

- Consider the possibility of Ectopic Pregnancy in females of child-bearing age.
- Aggressively treat for hypovolemic shock (do not rely on standard vital sign parameters).
- Give psychological support to patient and family.
- Be sure to take all expelled tissue to the hospital.
- Ask for first day of last menstrual period.
- Pregnant patients of any age  $\geq 20$  weeks gestation should be taken to maternity department;  $< 20$  weeks gestation should go to the emergency department.
- Pregnant trauma patients should be transported to an Adult Trauma Center with labor and delivery capabilities

## CARDIAC ARREST IN PREGNANCY

- Causes of cardiac arrest include: pulmonary embolism, trauma, hemorrhage and congenital or acquired cardiac disease.
- Load and go to closest hospital and follow all cardiac arrest protocols en route.
- To minimize effects of the fetus pressure on venous return, apply continuous manual displacement of the uterus to the left, or place a pillow under the right abdominal flank and hip.
- Administer chest compressions slightly higher on the sternum than normal.

## THIRD TRIMESTER BLEEDING

- Place patient in left lateral recumbent position.
- Apply continuous manual displacement of the uterus to the left, or place a pillow under the right abdominal flank and hip.

## CHILDBIRTH

### General Considerations

- Transport to a hospital with obstetrical capabilities unless delivery is imminent (the baby is crowning during a contraction).
- Visualize the perineal area only when contractions are less than five minutes apart.
- Establish an IV for patients in active labor.
- Place a gloved hand inside the vagina only in the case of breech delivery with entrapped head, or a prolapsed umbilical cord.
- Apply gentle pressure on the baby's head with a flat hand to prevent an explosive delivery.
- Run reports must be completed for each patient. The newborn is a separate patient from the mother.

### Specific Care

- Obtain history of patient condition and pregnancy, including contraction duration and interval, due date, first day of last menstrual period, number of pregnancies, number of live births, prenatal care, multiple births, possible complications, and drug use.
- Keep newborn warm.
- Cut the umbilical cord and then place the baby to suckle at the mother's breast.
- Obtain one, five and ten minute APGAR scores if time and patient condition permit.

**NOTE:** Fundal height refers to the level of the upper part of the uterus.

### Changes in fundal height during pregnancy:

Above the symphysis pubis:	>12-16 weeks gestation
At the level of the umbilicus	20 weeks
Near the xiphoid process	within a few weeks of term

### Delivery Complications:

- Place mother on **O<sub>2</sub>** by NRB.
- **Cord around baby's Neck:**
  - As baby's head passes out of the vaginal opening, feel for the cord.
  - Initially try to slip cord over baby's head.
  - If too tight, clamp cord in two places and cut between clamps.

- **Breech Delivery:**
  - When the appendage or buttocks first become visible, transport patient *immediately* to the nearest facility.
  - If the head is caught, support the body and insert two fingers forming a “V” around the mouth and nose.
  
- **Excessive Bleeding:**
  - Treat for shock.
  - Post-delivery, massage uterus firmly and put baby to mother’s breast.
  
- **Prolapsed Cord:**
  - When the umbilical cord is exposed prior to delivery, check cord for pulse.
  - Transport *immediately* with hips elevated and a moist dressing around cord.
  - Insert two fingers to elevate presenting part away from cord, distribute pressure evenly if occiput presents.
  - Do not attempt to reinsert cord.

Obtain **APGAR** scores at 1, 5, and 10 minutes post-delivery.

SCORE	0	1	2
Appearance	Blue or pale	Body pink; extremities blue	Completely pink
Pulse	Absent	Slow (< 100)	> 100
Grimace	No response	Grimace	Cough or sneeze
Activity	Limp	Some flexion of extremities	Active motion
Resp. effort	Absent	Slow or Irregular	Good crying

## NEWBORN CARE & RESUSCITATION

### General Considerations

- P As soon as the baby is born:
  - Dry.
  - Warm.
  - Maintain airway.
    - Place in the sniffing position (1” towel under shoulders).
    - Suction infant until airway is clear of all secretions.
  
- P If the newborn delivers with meconium-stained amniotic fluid, but is vigorous, with strong respirations, good muscle tone, and heart rate > 100 BPM; follow the same suctioning procedures as for infants with clear fluid.
  
- P If the newborn delivers with meconium-stained amniotic fluid and is depressed, has poor respiratory effort, decreased muscle tone, or heart rate < 100 BPM, suction *before* taking other resuscitative steps.
  
- P Bulb suctioning is preferred. Mechanical suction may be used on infants only if the suction pressure does not exceed 100 mmHg or 136 cmH<sub>2</sub>O.
  
- P If drying and suctioning has not provided enough tactile stimulation, try flicking the infant’s feet or rubbing the infant’s back. If this stimulation does not improve the infant’s breathing, then BVM assist may be necessary.
  
- P Avoid direct application of cool oxygen to infant’s facial area as this may cause respiratory depression due to a strong mammalian dive reflex present immediately after birth.
  
- P Use length-based resuscitation tape (e.g., Broselow Tape).

### Specific Care

- P After delivery of the infant;
  - Assess the airway and breathing.
  - Dry.
  - Position head lower than body.
  
- P Ventilate with BVM 40-60/min:

- To increase HR if < 100
- For apnea or persistent central cyanosis.
- P HR < 60 begin CPR.
  - Compress at 120/min.
  - Compression to Ventilation ratio of 3:1
- P If hypovolemic, NS 10 ml/kg over 5-10 minutes.
- P Consider Naloxone 0.1 mg/kg, IV, IO or IM every 3 minutes until respirations improve.
- P NEWBORN: D10 (2 ml/kg) if blood glucose < 40

### SAFE HARBOR

- P Voluntary Separation of Newborn Infant
- P Safe Harbor (Ohio House Bill 660) is designed to allow desperate parents to separate from their babies to hospitals, EMS, or law enforcement agencies confidentially.
- P Stipulations of separation:
  - Infant can be no more than 30 days old.
  - Infant can have no signs of abuse or neglect.
- P History which should be obtained:
  - Date and time of birth
  - Any pertinent family medical history
  - Information regarding prenatal care
  - Information about birth.
  - Information should be obtained in a manner which will not lead to the revealing of the identity of the parents. Information collected should be based on patient (infant) care needs and assure confidentiality.
- P Transport the infant to the hospital.

### FEVER

- P Transport all infants < 2 months of age with a history or reported temperature of > 38.0°C (100.4 °F) or < 35.6°C (96.0°F).

### CHILD ABUSE or NEGLECT

- P Report all alleged or suspected child abuse or neglect to the appropriate agency. Ohio Revised Code requires providers to report incidents of abuse to their county's public children services agency, or a municipal or county peace officer. Hospitals have copies of the EMS Social Services Referral Form, supplied by GDAHA, for documenting cases of abuse. Use of this form can help providers in providing information needed to their reporting agency, as well as provide for a continuum of care with hospital social services departments.
- P Simply notifying hospital personnel about concerns of maltreatment does not meet mandated EMS reporting responsibilities.

<b>Pediatric Public Social Services Agencies</b>			
<b>County</b>	<b>Phone</b>	<b>After Hours Phone</b>	<b>Fax</b>
Butler	(513) 887-4055	(513) 868-0888	(513) 887-4260
Champaign	(937) 484-1500	Contact County SO (937) 484-6092	(937) 484-1506
Clark	(937) 327-1700	(937) 324-8687	(937) 327-1910
Darke	(937) 548-7129	(937)-548-2020	(937) 548-8723
Greene	(937) 562-6600	(937) 372-4357	(937) 562-6650
Miami	(937) 335-4103	Contact County SO (937) 440-3965	(937) 339-7533
Montgomery	(937) 224-5437	(937) 224-5437 (same as daytime)	(937) 276-6597
Preble	(937) 456-1135	(937) 456-1135 (same as daytime)	(937) 456-6086
Shelby	(937) 498-4981	Contact County SO (937) 498-1111	(937) 498-1492
Warren	(513) 695-1558	(513) 695-1600	(513) 695-1800

## ELDER ABUSE NEGLECT

- EMS MUST, by law, report all alleged or suspected adult abuse or neglect to the appropriate agency. Ohio Revised Code requires providers to report incidents of abuse to their county’s adult protective services agency, or local law enforcement as soon as possible. Simply notifying hospital personnel about concerns of maltreatment does NOT meet the mandated EMS reporting responsibilities.
- Hospitals have copies of the EMS Social Services Referral Form, supplied by GDAHA, for documenting cases of abuse. Use of this form can help providers in providing information needed to their reporting agency, as well as provide for a continuum of care with hospital social services departments. GDAHA (228-1000 or [www.gdaha.org](http://www.gdaha.org)) can also send this form to each department to have on hand.
- Document all efforts that EMS made to report the suspected abuse on the run sheet; include name of agency notified, method used, and name of person contacted.

<b>Adult Public Social Services Agencies</b>			
<b>County</b>	<b>Phone</b>	<b>After Hours Phone</b>	<b>Fax</b>
Butler	(513) 887-4081	Not Listed (County SO: 513-785-1000)	(513) 785-5969
Champaign	(937) 484-1500	Contact County SO (937) 484-6092	(937) 484-1506
Clark	(937) 327-1700	(937) 324-8687	(937) 327-1910
Darke	(937) 548-7129	(937)-548-2020	(937) 548-4928
Greene	(937) 562-6315	Not Listed (County SO: 937-562-4800)	(937) 562-6177
Miami	(937) 440-3471	Contact County SO (937) 440-3965	(937) 335-2225
Montgomery	(937) 225-4906	Not Listed (County SO: 937-225-4357)	(937) 496-7464
Preble	(937) 456-1135	(937) 456-1135 (same as daytime)	(937) 456-6086
Shelby	(937) 498-4981	Contact County SO (937) 498-1111	(937) 498-1492
Warren	(513) 695-1420	(513) 425-1423	(513) 695-2940

### PATIENT COMPETENCY, CONSENT, PSYCHIATRIC and COMBATIVE PATIENTS

Per Ohio Revised Code, an EMT, AEMT, or a Paramedic may not “pink slip” an individual (transport a person to the hospital against their will for mental health evaluation) who is alert and oriented even if they are threatening harm to themselves or others. Only a health officer such as a police officer, crisis worker, psychiatrist, or licensed physician can “pink slip” a person. The GMVEMSC strongly recommends that each EMS department, in consultation with its medical director/advisor and local law enforcement have a procedure to deal with these types of situations.

This does not preclude EMS from taking action to prevent imminent harm to the patient or others, if it is safe to do so.

- Determine patient competency and consent.
- Obtain medical history:
  - Suicidal or violent history
  - Previous psychiatric hospitalization, when and where
  - Location where patient receives mental health care
  - Medications
  - Recreational drugs or alcohol: amount, names
- Do not judge, just treat.

- Transport all patients who are not making rational decisions and who are a threat to themselves or others for medical evaluation. Threat of suicide, overdose of medication, drugs or alcohol and threats to the health and well-being of others are considered not rational.
  - Consider a patient to be incapable to make medical decisions if they are:
    - Suicidal
    - Confused
    - Severely developmentally or mentally disabled
    - Intoxicated
    - Injured or ill with an altered mental status
    - Physically or verbally hostile
    - Unconscious
  - Consider and treat possible medical causes for patient's condition:
    - Hypoxia
    - Hypoglycemia
    - Drug intoxication/side effects/drug withdrawal
    - Seizures and postictal states
    - Intracranial hemorrhages
  - Consider staging until police have made the scene safe.
  - Have patient searched for weapons.
  - Do not transport a restrained patient in the prone position with hands and feet behind their back or sandwiched between backboards or other items.
  - Recheck often a restrained patient's ability to breathe and distal circulation.
  - Have the ability at hand to remove restraints if the patient vomits or develops respiratory distress.
  - Explain the need for restraint to the patient. Severe agitation is a medical emergency, and should be treated aggressively with medication.
  - Document thoroughly the restraints used, on which limbs, and justification for restraints
  - A patient may be combative due to either a medical condition or an injury.
- A Midazolam 10 mg IN** (5 mg each nostril), or **Midazolam 2 mg slow IV** or **Midazolam 4 mg IM**.
- P Midazolam 0.2 mg/kg IN** (max dose 4 mg) or **Midazolam 0.1 mg/kg slow IV** (max dose 2 mg) or **Midazolam 0.2 mg/kg IM** (max dose 4 mg) as a chemical restraint.
- A** Midazolam may be repeated for combative patients.
- P** ♦ **Call MCP for repeat Midazolam.**
- A** In most cases transport a mental health patient to the facility where the individual has been previously treated since they will have the patient's records.  
In all other cases, patients should be transported to the closest ED.
- P** **Pediatric patients with mental health issues should be transported to Dayton Children's Hospital.**

### **SALT TRIAGE SYSTEM (MCI)**

The **SALT** (Sort, Assess, Life-Saving Intervention, Treatment/Transport) triage system was developed by the Centers for Disease Control and Prevention (CDC) to address limitations in **START** and other triage systems. It has been endorsed by numerous national EMS groups. It is designed to reduce triage time and has an additional triage category to better utilize resources, and CDC has proposed **SALT** as the national standard for **MCI** triage.

Use **SALT** triage to assess any significant number of victims rapidly. It can be used easily and effectively by all EMS personnel. Triage materials, such as new tags, were provided to EMS agencies throughout our region by a federal grant through Dayton MMRS.

#### **Primary and Secondary Triage Prior to Transport**

- Initial Triage
  - Use triage ribbons (color-coded strips), not triage tags, during initial triage. One should be tied to an upper extremity in a **VISIBLE** location (on the right wrist, if possible).
    - **RED** – Immediate

- YELLOW – Delayed
  - GREEN – Minimal
  - GRAY – Expectant\*
  - BLACK – Dead (both ribbons and triage tags use a black & white Zebra stripe rather than black for easier visibility in low light).
  - ORANGE and Polka Dot Ribbon - used in addition to one of the above ribbons to indicate victim has been contaminated with a hazardous material. The dots are to make the Orange easier to distinguish from Red.
- Move as quickly and safely as possible, making quick decisions. Remember that the victim will be re-triaged, probably multiple times, and the category will be revised, up or down, whenever needed.
- Over-triage can be as harmful as under-triage. If everyone is tagged red, those who are truly red will receive delayed treatment, delayed transport, and delayed definitive care.
- \*Note: Expectant does NOT mean dead.
  - It means the patient is unlikely to survive given the current resources.
  - Treatment and transport should be delayed until more resources, field or hospital, are available. If there are delays in the field, consider requesting orders for palliative care, e.g., pain medications if time and resources allow.
- Secondary Triage
  - Secondary Triage **must** be performed on all victims prior to transport.
  - Treatment Area may also be the Casualty Collection Point (CCP), or the CCP may be separate.
    - Patients should be reassessed periodically, including when moved to a CCP, or when their condition or resources change.
  - Utilize Triage Tags and complete pertinent and available information on the tag.
    - Affix the tag to the victim **using the triage ribbon**.
    - Tags are applied after patients enter the Treatment Area or CCP, or by Transport Group if the patient is being directly removed without going to the Treatment Area.
  - Orange Ribbons (indicating contaminated patients) are removed during decon.
    - EMS always has responsibility for performing primary decontamination prior to transport, however, the hospital must be aware of both contamination and decontamination.
    - When contaminated patients are discovered, each of those patients initially receives two ribbons: one with a triage category (Red, Yellow, Green, Gray, or Black Zebra, and the other the Orange polka-dot ribbon.
    - Make sure to decon under the ribbons.
    - After patients are deconned, the orange ribbon is removed
    - Triage Tags for such patients get two check marks on the Orange strip: both Dirty and Decontaminated. That way the hospitals know the patient has had field decon, but may still be somewhat “dirty”.
    - **Notify hospitals of an MCI involving victim contamination.** Consider use of the Regional Hospital Notification System.
  - Use Triage Tags with individual barcodes consistent with this Standing Order and the Ohio patient tracking system (OHTrac).
- Priority for transport is determined in the Treatment Area or by the Transport Group.
- Patient allocation, that is, distribution of patients among various hospitals, is one of EMS’ most crucial tasks.
  - **Do not overload any hospital**, regardless of transport distance to other hospitals.
  - In an MCI, many trauma patients will need to be transported to non-Trauma Centers. **All hospitals** will accept and stabilize trauma patients during MCIs.
  - As Transport assigns patient allocation, consider the likelihood that the closest hospitals may be overwhelmed by patients who were not transported by EMS.
  - In large scenarios, consider activation of the Forward Movement of Patients Plan.
    - An introduction to Forward Movement of Patients is included in these Standing Orders under the heading Crisis Standards of Care in Massive Events. Full information on the process can be found in the Dayton MMRS Regional MCI Plan Template.

## **SORT, ASSESS, LIFE-SAVING INTERVENTION, TREATMENT/TRANSPORT PROCESS**

### **S – Sort**

- Global Sorting: Action 1
  - Action: “Everyone who can hear me please move to [designated area] and we will help you” (use loud speaker if available)
  - Goal: Group ambulatory patients using voice commands
  - Result: Those who follow this command – last priority for individual assessment (Green)
  - Assign someone to keep them together (e.g., PD, FD, a bystander) and notify Incident Command or EMS Group/Branch of number of patients and their location. ***Do not forget these victims.*** Someone must re-triage them as soon as possible.
  - In smaller incidents, such as a motor vehicle crash with a few victims where you do not want any of them to move on their own, skip Action 1, and go to Global Sorting Action 2
- Global Sorting: Action 2
  - Action: “If you need help, wave your arm or move your leg and we will be there to help you as soon as possible”
  - Goal: Identify non-ambulatory patients who can follow commands or make purposeful movements
  - Result: Those who follow this command – second priority for individual assessment
- Global Sorting: Result
  - Casualties are now prioritized for individual assessment
    - Priority 1: Still, and those with obvious life threat
    - Priority 2: Waving or purposeful movements
    - Priority 3: Walking
- Begin assessing all non-ambulatory victims where they lie, performing the four Life Saving Interventions (LSIs) as needed, but only within your scope of practice, and only if the equipment is readily available.
- Each victim must be triaged as quickly as possible.

### **Assess:**

- **Is the patient breathing?**
  - If not, open the airway. In children, consider giving two rescue breaths.
  - If the patient is still not breathing, triage them to **BLACK**, using a zebra-striped ribbon. Do not move the patient except to gain access to a living patient.
  - If patient is breathing, conduct next assessment.
- **Assess for the following:**
  - Can the patient follow commands or make purposeful movements?
  - Does the patient have a peripheral pulse?
  - Is the patient not in respiratory distress?
  - Is hemorrhaging under control?
    - If the answer to **any** of those questions is **no** and the patient **IS likely to survive** given current resources, tag them as **RED (Immediate)**.
    - If the answer to **any** of those questions is **no** and the patient is **NOT likely to survive** given current resources, tag them as **GRAY (Expectant)**.
    - If the answer to **all** of those questions is **yes** but injuries are not minor and require care, tag patient as **YELLOW (Delayed)**.
      - **YELLOWs** have serious injuries and need care, though not as urgently as REDs. On secondary triage, some Yellows will need higher priority transport than others.
        - If the answers to **all** of those questions is **yes** and the injuries are minor, tag patient as **GREEN (Minimal)**.
- **Two mnemonics for the four Assess Questions:**
  - CRAP:
    - C – Follows Commands
    - R – No Respiratory Distress

- A – No (uncontrolled) Arterial bleeding
- P – Peripheral Pulse Present
- A second mnemonic is the use of good or bad. Don't be confused by the double negatives in two of the questions. Instead, think of the questions in terms of "bad" or "good". If the answer to the questions is "bad" (i.e., can't follow commands, absent peripheral pulse, respiratory distress, or uncontrolled hemorrhage are all "bad"), then the patient is tagged either RED or GRAY.

**Life Saving Interventions:**

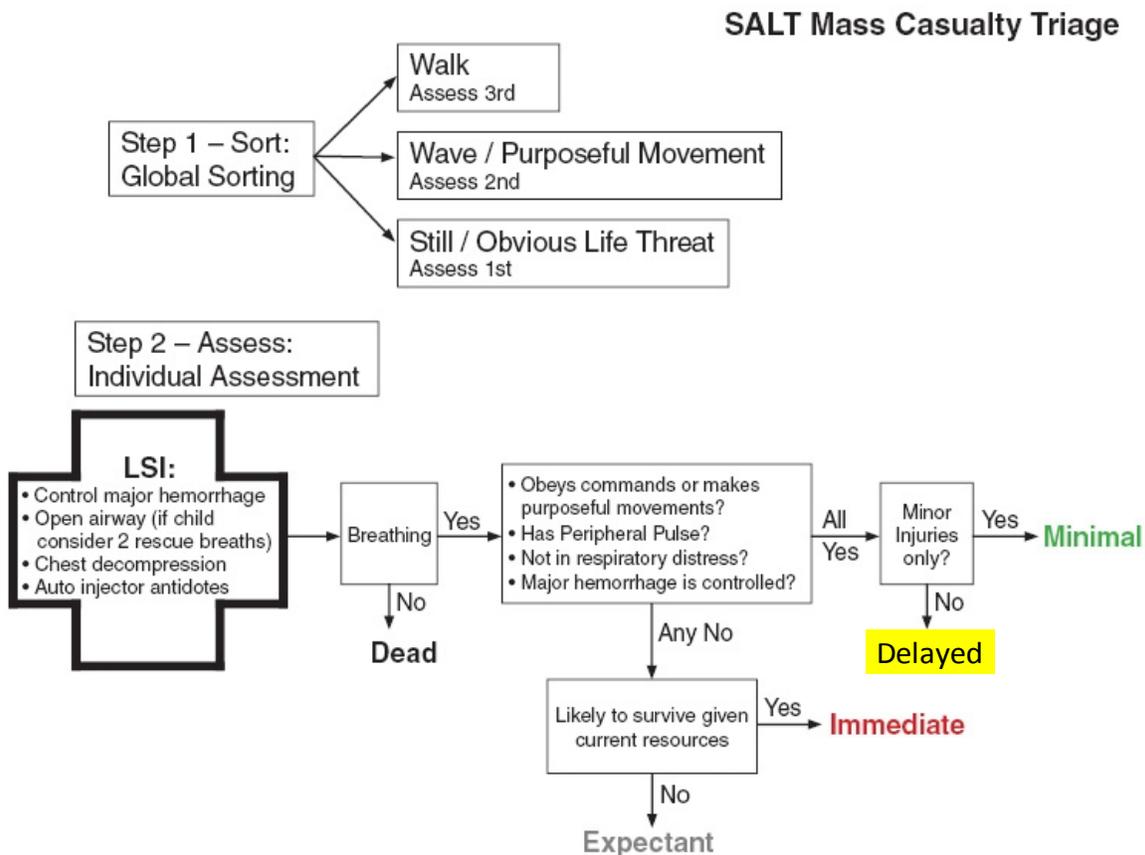
- **Only** correct life-threatening problems during triage.
  - Control major hemorrhage
  - Open airway (if child, consider giving two rescue breaths)
  - Needle chest decompression
  - Auto injector antidotes

**Treatment/Transport:**

- Transport/treatment priority is typically given to **RED (Immediate)**, **YELLOW (Delayed)**, then **GREEN (Minimal)**.
  - **GRAY (Expectant)** patients should be treated/transported as resources allow.
- Patients should be reassessed periodically, including when moved to the CCP, or when their condition or resources change.

**Special Considerations:**

- Even after applying Triage Tags, the main indicator of patient condition is the Triage Ribbon. If the patient's condition or the triage priority changes, indicate that on the tag. **Continue to use the same tag, even if the condition changes repeatedly, changing the ribbon to indicate the patient's current condition.**



## CRISIS STANDARDS OF CARE IN MASSIVE EVENTS

Some incidents are so large as to require extraordinary EMS procedures. Those scenarios are sometimes referred to as Mass Casualty Events (MCEs), instead of Mass Casualty Incidents (MCIs). This Standing Order introduces EMS procedures which could be utilized in very large emergency scenarios, or when the duration is extended.

“Crisis Standards of Care” is a new term, but not a new concept. EMS uses altered standards during triage. With concerns about pandemics, there is more planning for possible crises. Crisis Standards of Care during an MCE may be partially issued by the State, and could result in a temporary expansion of the EMS scope of practice.

In some circumstances, EMS may be authorized to triage selected patients for transport to other healthcare facilities. These could include Urgent Care Centers, an “Acute Care Center” (ACC) or a “Neighborhood Emergency Help Center” (NEHC), or a Disaster Medical Assistance Team (DMAT).

Dayton MMRS is required to have a plan called, “Forward Movement of Patients.” The intent of this plan is to relieve the burden on local hospitals by transporting patients, possibly directly from the scene, to more distant hospitals.

In the event of an MCE, especially one lasting days or longer, Greater Miami Valley EMS Council, with the approval of the Regional Physicians Advisory Board (RPAB), may promulgate “Just in Time Standing Orders” (JITSO). With approval from Ohio Department of Public Safety, these orders might include triage standards for transport to other healthcare facilities and other crisis standards of care; possibly exceeding the standard scope of practice for EMS.

A regional protocol for Functional Needs Shelter Triage has been added to the Optional Standing Orders Manual and is also available at [gmvemsc.org](http://gmvemsc.org) on the Training Materials page. The protocol is used to help determine whether individuals with functional needs can be safely sheltered in a Red Cross Shelter during a disaster.

This Shelter Triage Protocol is a pre-approved Just-In-Time Standing Order (JITSO), authorized by the RPAB for use by an EMS agency assisting the Red Cross with shelter Triage. It is intended to be printed and given to paramedics, nurses, and other healthcare personnel at the time of a shelter operation.

At the option of local department chiefs and medical directors, the same protocol can be used during a disaster to determine patients who would be more appropriate for transport to Red Cross Shelters than to hospitals. That concept was endorsed by RPAB, and was used on the East Coast during Hurricane Sandy. In those cases, EMS should, if possible, contact the shelter before transporting. If locations or contact information for shelters is not known, contact the County EMA or the Red Cross. When transporting these non-emergency patients to shelters, it is critical that the patients bring their medications and medical equipment with them.

## HAZ-MAT

### Initial Actions

- Personnel safety
  - Consider potential for secondary devices.
  - PPE
  - Personnel & Equipment staging
- Call for additional resources.
  - (Medic Units, Engines for personnel, resources, Decon, **Haz-Mat**, Law Enforcement, etc.)
- Field Decontamination
  - Remove **all** contaminated clothing. This action may remove as much as 85% of solid or liquid and virtually all of gaseous contaminants.
  - Thoroughly wash with {Dawn} dishwashing detergents paying special attention to skin folds and other areas where simple irrigation may not remove it.
  - If a patient has been contaminated with any fuel, irrigate well. For example, diesel fuel can cause chemical burns if left in contact with the skin.
  - Do not transport a patient until gross decon is completed.
  - Obtain permission from hospital upon arrival **before** entering with a potentially contaminated patient or crew.
  - Decontaminate EMS vehicle prior to leaving hospital.

- Contact Medical Control and the hospital immediately to allow time for their set-up of decontamination equipment.
  - Provide the following information:
    - Estimated number of confirmed or potential adult and pediatric patients
    - Signs and symptoms exhibited by the patients
    - Name and identification information of the contaminant if known, or as much information as possible
    - Form of the contaminant (liquid, gas, etc.) if known
    - Routes of exposure of the patients (percutaneous, inhalation, ingestion, etc.) if known
    - Additional anticipated decontamination needs if necessary
  - ♦ In the event of an MCI involving cyanide or nerve agents, request an “Antidote free” order, allowing you to treat all of the patients on the scene with the appropriate antidote, rather than calling for patient orders individually.

### **Hazardous Drug: Exposures and Spills:**

- Hazardous drug situations include:
  - Patients who have continuous IV chemotherapy at home.
  - Patients who have just had IV chemotherapy at the clinic or hospital and their body fluids could have traces of hazardous drug for 48 hours.
  - Patients taking oral chemotherapy drugs.
- Potential routes of exposure include:
  - Absorption through skin or mucous membranes
  - Accidental injection by needle stick or contaminated sharps
  - Inhalation of drug aerosols, dust, or droplets
  - Ingestion through contaminated food, tobacco products, beverage, or other hand-to-mouth behavior
- EMS should don PPE whenever there is a risk of hazardous drug being released into the environment.
  - Handling leakage from tubing, syringe, and connection sites
  - Disposing of hazardous drugs and items contaminated by hazardous drugs
  - Handling the body fluids of a patient who received hazardous drugs in the past 48 hours
  - Cleaning hazardous drug spills
- Guidelines for PPE:
  - Gloves: Double gloves are recommended. Latex gloves provide no chemical protection. Nitrile gloves are recommended for routine patient care of Haz-mat patients including chemo patients. Change gloves every 30 minutes.
  - Disposable non-permeable gowns
  - Respirators: NIOSH-approved respirator mask
  - Eye and face protection: wear a face shield whenever there is a possibility of splashing.
- Procedures:
  - Use universal precautions when handling any body fluids of a patient who has received chemotherapy within 48 hours.
  - Accidental skin exposure: Remove contaminated garments, place in leak-proof plastic bag, and immediately wash contaminated skin with soap and water. Rinse thoroughly.
  - Accidental eye exposure: immediately flush eye with saline solution or water for at least 30 minutes or until patient transport is completed.
  - Wipe up liquids with an absorbent pad or spill-control pillow.
  - Disposal of hazardous drugs and materials contaminated with hazardous drugs per MSDS or Haz Mat Team direction
  - Report and document spills as required.
- For more information, contact:
  - The homecare agency that is supplying the infusion.
  - The physician who ordered the infusion.
  - A hospital pharmacy, if necessary (there should be a label on the IV bag with the drug’s name, concentration and dosage).
  - Consult with the appropriate Haz-Mat team.

### **Hazmat: Biological**

- ♦ {In preparation for the possibility of a bioterrorist attack, Departments may store a supply of **Ciprofloxacin (Cipro)** or **Doxycycline**. They can provide prophylaxis against Anthrax, Cholera, and some protection against Plague.}
- Dayton MMRS maintains a supply of **Cipro** and **Doxy** sufficient to provide treatment for the first three days for all firefighters, EMS personnel, law enforcement officers, EMA personnel, public safety dispatchers, and their immediate families for use in a bioterrorist attack. These may be obtained when needed by contacting **937-333-USAR (8727)**.

### **Haz-Mat: Cyanide**

In any case of known or strongly suspected cyanide intoxication, Cyanide antidote caches provided by Dayton MMRS are located throughout the region. To request a cache, call the Montgomery County RDC at **937-333-USAR (8727)**, and they will contact the cache agency closest to your incident. Those agencies have all agreed to respond on a mutual aid basis to your incident. If there are no paramedics on scene, be sure to request that the responding agency come with a paramedic.

It is strongly recommended that agencies immediately call for the cyanide antidote cache whenever any of the following occur:

- Dispatched on a report of a person trapped in a structure fire
  - Dispatched on a report of an incident involving cyanide
  - Report of a Mayday or firefighter down in a structure fire
- Provide 100% **O<sub>2</sub>**
    - If unconscious, provide 100% **O<sub>2</sub>** by BVM, preferably via endotracheal tube.
    - CPR if indicated.
    - If possible establish two IV lines, one for standard code drugs, and one for cyanide antidotes.
  - It is critical to control any seizure activity, using **Diazepam** or **Midazolam**

### **Haz-Mat: Hydrofluoric Acid (Hf)**

- Deaths have been reported from burns involving < 3% Body Surface Area. Ensure safety of EMS.
- Begin decon and irrigate the chemical burn with water as quickly as possible.
- Flush affected eyes and skin with copious amounts of water or **Normal Saline** for a minimum of 30 minutes or until patient transport is completed.
- If ingested, do not induce vomiting. Dilute with water or milk,
- Intubate if apneic.
- {Perform a 12-lead EKG, transmit to hospital} and monitor for cardiac arrest.
- Consider Pain Control Protocol.

### **Hazmat: Organophosphate or Nerve Agent Exposure and Treatment**

#### **General Considerations:**

- Signs and Symptoms:
  - SLUDGEMM: Salivation, Lacrimation, Urination, Defecation, GI Upset, Emesis, Miosis, Muscle Twitching
- Mild to moderate cases should be treated with one or two doses of **Atropine** and **2-PAM**
- Severe cases will generally require repeating every 5 minutes up to 3 doses.
- Atropine in these circumstances is **not** for bradycardia, which may or may not be present.
- Primary endpoints for treatment are diminished airway secretions (lungs are clear to auscultation), hypoxia improves, airway resistance decreases, and dyspnea improves
- Organophosphate poisonings may require more Atropine (> 3 Mark I Kits or 3 DuoDotes).
- Ohio law and GMVEMSC Standing Orders permit First Responders and EMTs to administer Organophosphate/nerve agent antidotes by autoinjector only.
- Nerve agent or organophosphate antidotes are to be used to treat symptomatic patients, not given prophylactically.

### Specific Care: Organophosphate or Nerve Gas Poisoning

- Oxygen
- Treat any case of known or suspected Organophosphate or Carbamate (e.g., insecticides such as Parathion or Malathion); or nerve agent (e.g., Tabun, Sarin, Soman, VX) exposure as below:
- ♦ Administer **Atropine** every 5 minutes, as available until lungs are clear to auscultation. **Atropine** may be given IM or by **Mark I** autoinjector #1 (adults and children weighing over 90 pounds), by **AtroPen** autoinjector for children, or by **DuoDote**.
- ♦ Adults and children > 90 pounds, give Mark I **Atropine autoinjector**, **DuoDote**, or **Atropine 2 mg IM**
- P ♦ Children weighing 40 - 90 pounds, give **1.0 mg Atropine**, or the **1.0 mg Atropen autoinjector**.
- P ♦ Children weighing less than 40 pounds, give **0.5 mg Atropine**, or the **0.5 mg Atropen autoinjector**.
- ♦ Follow **Atropine** with **2-PAM (Pralidoxime) 600 mg IM**, which is **Mark I autoinjector Item 2** for older children and adults, or **1 gram IM**. If **DuoDote** was used, no second autoinjector is needed.
- P ♦ Infants and young children should receive **Pralidoxime, 25-50 mg/kg IM**, if available.
- ♦ Treat seizures with **Diazepam**, **Midazolam**, or **Diazepam Autoinjector (CANA)**.

### Administering the Nerve Agent Antidote Auto-Injector Kit:

- Anterolateral thigh is the recommended auto-injector site for both adults and pediatrics.
- Using the Mark I:
  1. Grasp syringe #1 (**Atropine**) and position the green tip of the AtroPen on victim's outer thigh. Push firmly until auto-injector fires. Hold in place for 10 seconds to ensure Atropine has been properly delivered.
  2. Grasp syringe #2 (**2-Pam**) and position the black tip of the Combo Pen on victim's outer thigh. Push firmly until auto-injector fires. Hold in place for 10 seconds to ensure Pralidoxime has been properly delivered
- Procedures for DuoDotes, pediatric AtroPens, and **Diazepam** autoinjectors are similar.

### Antidote Resources:

- {EMS Departments are authorized to stockpile large quantities of **Atropine**, **2-PAM**, autoinjectors, and supplies (e.g., needles, syringes)}.
- GMVEMSC drug bags include:
  - **2 DuoDotes (Atropine)** (2 mg) and **2-PAM** (600 mg) administered through a single auto-injector).
  - **2 Pediatric AtroPens** (1 each: 0.5 mg, 1.0 mg)
  - 1 Multi-dose 1 mg vial of **Atropine**
- **Dayton MMRS maintains additional supplies of organophosphate and cyanide antidotes in each county in Ohio Homeland Security Region 3.**
  - To obtain Dayton MMRS antidotes: call **937-333-USAR (8727)**. The closest department with an antidote cache will respond as a mutual aid request.
  - Dayton MMRS antidotes may be requested for incidents too small to require a CHEMPACK.
  - If requesting a CHEMPACK, **simultaneously call 937-333-USAR (8727)** and request MMRS antidotes.

### CHEMPACK Resources:

- Containers with enough antidotes to treat about 500 victims of a nerve agent or organophosphate incident
- CHEMPACK procurement:
  - ♦ Obtain MCP approval
- ♦ In an MCI, contact OSP Central Dispatch **866-599-LERP (5377)** and request a CHEMPACK and indicate that it meets both of the following criteria:
  - The Organophosphate or nerve agent has been identified, or patients are exhibiting signs and symptoms of exposure.

- **AND** the need for antidotes is greater than the available resources.
- Simultaneously contact **937-333-USAR(8727)** and request additional Nerve Agent Antidotes:
  - Regional drug cache to be used for incidents too small for a CHEMPACK
  - Has additional drugs that are not available in the CHEMPACK (e.g., Cyanide antidotes)
- OSP Central Dispatch will:
  - Notify closest CHEMPACK hospital
  - Dispatch Troopers to deliver the CHEMPACK to the MCI's staging area.
  - Troopers will expect EMS to sign a form indicating receipt.
- CHEMPACK contains:
  - **Atropine**—blocks effects of excess acetylcholine
    - 0.5 mg AtroPen autoinjectors (for patients < 40 pounds)
    - 1.0 mg AtroPen autoinjectors (for patients 40-90 pounds)
    - Multi-dose vials
  - **Pralidoxime Chloride (2-PAM)**—reduces levels of acetylcholine
    - 600 mg autoinjectors
    - Multi-dose vials
  - **Diazepam (Valium)**—treats seizures.
    - **Convulsive Antidote, Nerve Agent (CANA)** (10mg **Diazepam** autoinjector)
    - Multi-dose vials
  - Mark I Kits (for patients > 90 pounds)
    - 2 mg **Atropine** autoinjector
    - 600 mg **2-Pam** autoinjector
- CHEMPACK types (both contain same drugs)
  - Hospital CHEMPACK contains more multi-dose vials for more precise dosing of children and long-term patients. Hospital CHEMPACKs are partitioned into thirds, each being marked with a red, yellow, or blue dot. Hospitals have the option to keep the red dot materials for potential use at their hospital. If a hospital opens its CHEMPACK, it must notify OSP Central Dispatch. (Hospitals may also request material from Dayton MMRS by calling **937-333-USAR (8727)**).
  - EMS CHEMPACK contains more auto-injectors for ease of administration in the field.
- Limitations of CHEMPACKs:
  - Only useful against nerve agents or organophosphate
  - Only to be utilized when other resources are inadequate for number of victims.
  - CHEMPACKs opened contrary to guidelines will not be replaced by CDC and will result in the loss of a \$250,000 asset.

### **Hazmat: Pepper Spray**

- **{Sudecon Wipes}** can assist in the decontamination of patients or public safety personnel who have been sprayed with Pepper Spray.

## REGIONAL HOSPITAL NOTIFICATION SYSTEM (RHNS)

Our area now has a Regional Hospital Notification System. The purpose is to provide one number for EMS, hospitals, and EMAs to call that will make rapid, simultaneous notifications in a Mass Casualty Incident or Event (MCI or MCE), or other major emergency.

The system can be used when an incident could involve a significant number of the region's hospitals. To activate the system, an incident commander calls **937-333-USAR (8727)**, and requests a "Regional Hospital Notification." The agency calling must ask for a Dispatch Supervisor, and should provide the information below:

- Name of agency
- Nature of emergency
- Location of emergency
- General statement on severity, such as approximate number of victims
- Any other information to be conveyed

The Montgomery County Regional Dispatch Center (RDC) will immediately put out a computerized message to the RHNS Group with that information.

Activation of the RHNS will send simultaneous notifications to all of the following:

88 <sup>th</sup> Medical WPAFB	Joint Township Memorial	Reg. Public Health Coord.
Atrium Medical Center	Kettering Medical Center	Reid Memorial Hospital
Dayton Children's Hospital	Kindred Hospital	Soin
Community Blood Center	Lifecare Hospital	Southview Hospital
Dayton MMRS Med. Director	Mercy Hospital	Springfield Reg. Med. Cen.
GDAHA	Miami Valley Hospital	Sycamore
Good Samaritan Hospital	Miami Valley Hospital South	Upper Valley Medical Center
Grandview Hospital	Miami Valley - Jamestown	VA Medical Center
Greene Memorial Hospital	Mont. Co. Off. of Emer Mgmt	Wayne Healthcare
Huber Heights	Reg. Healthcare Syst. Coord.	Wilson Memorial Hospital
	Reg. MMRS/RMRS Coord.	

## ABBREVIATIONS

Some abbreviations are case sensitive while others are content sensitive. Any words that can be readily abbreviated using a period have been left out of this list.

abdomen	abd
abdominal aortic aneurysm	AAA
abortion	Ab
acute coronary syndrome	ACS
acute myocardial infarction	AMI
acute pulmonary edema	APE
acute renal failure	ARF
acute respiratory distress/syndrome	ARD/ARDS
administer rectally	p.r.
advanced cardiac life support	ACLS
advanced directive	AD
advanced life support	ALS
after	̄
against medical advice	AMA
alcohol	ETOH
alert & oriented	A&O
alert/verbal/pain/unresponsive	AVPU
antecubital fossa	AC
arteriosclerotic heart disease	ASHD
as necessary or needed	prn
as soon as possible	ASAP
aspirin	ASA
at	@
at bedtime	h.s.
atrial fibrillation	a-fib
atrial flutter/ tachycardia	AF/AT
atrioventricular	AV
automatic external defibrillator	AED
automatic transport ventilator	ATV
backboard	BB
bag-valve mask	BVM
basic life support	BLS
before	ā
below the knee amputation	BKA
births, number of	para
black	B
blood pressure	BP
blood sugar	BS
body substance isolation	BSI
body surface area	BSA
bowel movement	BM
bradycardia	brady
breaths per minute	bpm
by mouth	po
by or through	per
cancer	CA
capillary refill time	CRT
carbon dioxide	CO <sub>2</sub>
carbon monoxide	CO
centimeter	cm.

cerebral palsy	CP
cerebrospinal fluid	CSF
cerebrovascular accident	CVA
cervical immobilization device	CID
cervical spine	C-spine
change	Δ
chest pain	CP
chief complaint	CC
chronic obstructive pulmonary disease	COPD
chronic renal failure	CRF
circulatory/sensory/motor	CSM
clear to auscultation bilaterally	CTAB
complaining of	c/o
congestive heart failure	CHF
coronary artery bypass graft	CABG
coronary artery disease	CAD
cubic centimeter	cc.
date of birth	DOB
dead on arrival	DOA
decreasing	↓
degree(s)	°
delirium tremens	DT's
Dextrose in water – 50%	D50
dextrose in water - 10%	D10
diabetes mellitus	DM
diagnosis	Dx
dilation & curettage	D&C
discontinue	d/c
disease	DZ
do not resuscitate	DNR
Drop (s)	gtt (s)
dyspnea on exertion	DOE
electrocardiogram	ECG / EKG
emergency department	ED / ER
endotracheal tube	ETT
epinephrine	EPI
Equal to or greater than	≥
Equal to or less than	≤
esophageal detection device	EDD
esophageal obturator airway	EOA
estimated	Est.
estimated time of arrival	ETA
every	̄
external jugular vein	EJV
fever of unknown origin	FUO
for example	e.g.
foreign body	FB
four times a day	q.i.d.
fracture	fx

French	Fr.
gallbladder	GB
gastrointestinal	GI
gauge	Ga
Glasgow Coma Scale	GCS
gram	g or gm
greater than	>
gunshot wound	GSW
hazardous materials	HazMat
head, ears, eyes, nose, throat	HEENT
Headache	H/a
heart block	HB
heart rate	HR
history	Hx
hypertension	HTN
Incident Command	IC
increasing	↑
inferior	inf.
insulin dependent diabetes	IDDM
intercostal space	ICS
intracranial pressure	ICP
intramuscular	IM
intranasal	IN
intraosseous	IO
intravenous	IV
intravenous push	IVP
joule	J
jugular venous distension	JVD
Kendrick Extrication Device	KED
kilogram	kg
labor & delivery	L&D
last normal menstrual period	LNMP
left	(L)
Left lower/upper extremity	LLE/LUE
Left lower/upper lobe	LLL/ LUL
left lower/upper quadrant	LLQ/LUQ
left bundle branch block	LBBB
less than	<
lights and siren	L&S
liters per minute	lpm
liter	L.
loss or level of consciousness	LOC
mass casualty event	MCE
mechanism of injury	MOI
medial	med.
medical control physician	MCP
metered dose inhaler	MDI
microgram	mcg.
milliequivalent	mEq
milligram	mg.
milliliter (same as cc.)	ml.
motor vehicle collision	MVC
multiple casualty incident	MCI
multiple sclerosis	MS

myocardial infarction	MI
nasal cannula	NC
nasopharyngeal airway	NPA
nausea & vomiting	N&V
newborn	NB
nitroglycerine	NTG
no known drug allergies	NKDA/NKA
non-rebreather mask	NRM
nonsteroidal anti-inflammatory	NSAID
normal saline	NS
normal saline lock	NSL
normal sinus rhythm	NSR
not applicable / available	n/a
nothing by mouth	NPO
O2 % of arterial blood	SpO2
obstetrics	OB
oropharyngeal airway	OPA
over the counter	OTC
overdose	OD
packs per day	p/d
parts per million	ppm
past medical history	PMH
patient	pt.
pelvic inflammatory disease	PID
penicillin	PCN
peptic ulcer disease	PUD
peripheral inserted central cath	PICC
pharyngo tracheal lumen airway	PtL
pregnancies, number of	Gravida
premature ventricular complex	PVC
prior to my arrival	PTA
pulmonary embolism	PE
pulse	P
pulse, motor, sensation	PMS
pulseless electrical activity	PEA
pupils (=) round reactive to light & accommodation	PERRLA
right bundle branch block	RBBB
right lower/upper extremity	RLE/RUE
right lower/upper lobe	RLL/RUL
right middle lobe	RML
rapid sequence induction	RSI
respiratory rate	RR
returned to service	RTS
rheumatic heart disease	RHD
right	R
right lower/upper quadrant	RLQ/ RUQ
secondary / second degree	2°
sedate to intubate	StI
sexually transmitted disease	STD
shortness of breath	SOB
signs/symptoms	S/S
sino-atrial	SA
sinus bradycardia	SB

sinus tachycardia	ST
standard operating procedure	SOP
standing orders	SO
ST Elevation MI	STEMI
subcutaneous	SQ
sublingual	SL
sudden infant death syndrome	SIDS
supraventricular tachycardia	SVT
symptoms	Sxs
systolic blood pressure	SBP
tachycardia	tach(y)
temperature	T
temporomandibular joint	TMJ
that is	i.e.
three times a day	tid
tibia	Tib
times	×
to keep open	TKO
tourniquet	TQ
tracheal deviation	TD
transport	Tx
transcutaneous pacing	TCP
transfer	x-fer
transient ischemic attack	TIA
treatment/medication	Rx
tuberculosis	TB
twice a day	bid
unconscious	unc.
unequal / not equal	≠
Unified Command	UC
unknown	unk.
upper/lower	U/L
upper respiratory infection	URI
urinary tract infection	UTI
ventricular fibrillation	VF/ VFib
ventricular tachycardia	VT/ VTach
vital signs	VS
warm & dry	w/d
week	wk.
weight	wt.
white	W
with	c̄
within normal limits	WNL
without	̄s or w/o
Wolff Parkinson-White	WPW
year	yr.
years old	y/o or yo

## RIGHTS OF MEDICATION ADMINISTRATION

1. Right Medication
  - a. Make sure that the medication is the correct medication indicated by the GMV Standing Orders and check it against the medication label.
  - b. Double-check the generic vs. non-generic names of medications. Many names are similar and have a potential for error. If not sure, reference SO Manual or Quick Reference Guide.
  - c. Check the expiration date on the label.
2. Right Patient:
  - a. Confirm patient ID and confirm absence of allergies or other contraindications for the patient.
  - b. In multiple patient or mass casualty situations, confirm that the medication is being delivered to the correct patient.
3. Right Dose:
  - a. Check the SO dose against the medication label for the **correct concentration**.
  - b. Recheck dosage calculations and verify accuracy.
  - c. Confirm that the correct dose has been drawn.
  - d. Use your references!
4. Right Route:
  - a. Check the standing order and the medication label for the correct route.
  - b. Confirm the route of administration for the medication; IM, IV, PO, IN, PR, IO, Neb, ocular.
  - c. Confirm that the dose is correct for the chosen route, since some dosages vary depending on the route.
  - d. Make sure the route is accessible; e.g., is the IV site patent?
5. Right Time:
  - a. Give the medication over the proper time duration per the Standing Orders.
6. Right Documentation:
  - a. Document medication, dose, and time of administration and duration of administration, route, and patient response.

## RUN DOCUMENTATION REQUIREMENTS

Every crew transporting a patient is expected to provide a full run sheet to the hospital. An abbreviated version of a run report, sometimes called a “quick sheet” may be left at the time of transport, but the hospital **MUST** receive a full, final copy of the run sheet within three hours (with rare exceptions, e.g., major incidents). When a quick sheet is used, it **MUST** include (at a minimum) all the following:

- Patient’s full name
- Age
- Chief complaint
- History of the Present Illness or MOI
- PMH
- Medications
- Allergies
- Vital signs with times
- Prehospital assessment and interventions along with the timing of any medication or intervention and patient response to such interventions

**ALBUTEROL  
(Proventil)**

**PACKAGED:** 2.5 mg in 3 ml plastic ampule

**INDICATIONS:**

Asthma, Emphysema, COPD  
Bronchospasm in Asthma, COPD  
Allergic reaction with wheezing

**ADULT:**

2.5 mg (3 ml), nebulized with O<sub>2</sub> at 8-10 LPM  
Combine Ipratropium with first dose of Albuterol.  
May repeat Albuterol up to 2 times for a total of 3 doses

**PEDI:**

2.5 mg (3 ml), nebulized with O<sub>2</sub> at 8-10 LPM  
Combine Ipratropium with first dose of Albuterol.  
May repeat Albuterol up to 2 times for a total of 3 doses

**THERAPEUTIC ACTION:**

Bronchodilator

**CONTRAINDICATIONS:**

Prior hypersensitivity reaction to Albuterol,  
Cardiac dysrhythmias associated with tachycardia.

**PRECAUTIONS AND SIDE EFFECTS:**

Once initiated, the patient should be removed by EMS.  
Usually dose related. Restlessness, apprehension, dizziness, palpitations, tachycardia, dysrhythmias  
May precipitate angina pectoris and dysrhythmias

**REQUIRES MCP:**

**ADULT: No**

**PEDI: No**

**ASPIRIN**  
**(Abbreviated as ASA)**

**PACKAGED:** 81mg. tablets in blister pack, times 4

**INDICATION:**

Suspected Cardiac chest pain, patient must be at least 25 years old.  
Give as soon as possible to the patient with AMI

**ADULT:**

324 mg. = 4 chewable 81 mg tablets – MUST CHEW.

**PEDI:**

N/A

**THERAPEUTIC ACTION:**

Anti-platelet

**CONTRAINDICATIONS:**

Hypersensitivity to salicylates,  
Active ulcer disease  
Bleeding disorders  
Third trimester

**PRECAUTIONS AND SIDE EFFECTS:**

Stomach irritation, heartburn or indigestion, nausea or vomiting, allergic reaction

**REQUIRES MCP:**

**ADULT:** No

**PEDI:** N/A

## ATROPINE

**PACKAGED:** 1mg in 10ml prefilled syringe; (3 in drug bag)  
1 mg in 1 ml vial; (HM bag in drug bags)  
2 mg AtroPen autoinjector (in Chempack, Drug Caches and HM bag in drug bags)  
1 mg AtroPen autoinjector (in Chempack, Drug Caches and HM bag in drug bags)  
0.5 mg AtroPen autoinjector (in Chempack, Drug Caches and HM bag in drug bags)  
Multidose vial 8 mg in 20 ml, 0.4 mg/ml; (in Chempack)

**NOTE:**

Atropine is also one component of the Mark 1 kits or as a DuoDote (in with the HazMat Drugs in GMVEMSC Drug Bags).

**INDICATION:**

Organophosphate or Nerve Agent poisoning (regardless of cardiac rate)

**ADULT:**

Organophosphate or Nerve Gas poisoning: Mark 1 Kit Item one, or Duodote until lungs are clear to auscultation. There is no max dose for Atropine for Organophosphate or Nerve Agent poisoning.

**PEDI:**

Organophosphate or Nerve Gas poisoning: Atropine or (AtroPen) autoinjector  
< 40 lbs: 0.5 mg AtroPen Autoinjector  
40 lbs to 90 lbs: 1.0 mg AtroPen Autoinjector  
> 90 lbs: 2.0 mg AtroPen Autoinjector  
There is no max dose for Atropine for Organophosphate or Nerve Agent poisoning.

**THERAPEUTIC ACTION:**

Anticholinergic

**CONTRAINDICATIONS:**

**None for severe organophosphate exposure.**

Tachycardia

Hypersensitivity to atropine

Obstructive disease of GI tract

Obstructive neuropathy

Unstable cardiovascular status in acute hemorrhage with myocardial ischemia

Narrow angle glaucoma

Thyrotoxicosis

**PRECAUTIONS AND SIDE EFFECTS:**

Tachycardia, paradoxical bradycardia when pushed too slowly or when used at doses less than 0.5 mg, palpitations, dysrhythmias, headache, dizziness, anticholinergic effects (dry mouth, nose, skin, photophobia, blurred vision, urinary retention, constipation), nausea, vomiting, flushed hot dry skin, allergic reactions.

Atropine causes papillary dilation rendering the pupils nonreactive. Pupil response may not be useful in monitoring CNS status.

**REQUIRES MCP:**

**ADULT:**

Organophosphate Nerve Agent Poisoning-Yes

**PEDI:**

Organophosphate Nerve Agent Poisoning-Yes

## D10

**PACKAGED: 500 ml of D10W, contains 50 g Dextrose**

### INDICATIONS:

Diabetic with mental status changes  
Evidence of hypoglycemia in cardiac arrest  
Generalized hypothermia with or without arrest  
Altered level of consciousness of unknown cause  
Seizures with BS < 60  
No blood sugar monitor is available or a strong suspicion of hypoglycemia despite BS readings.

### ADULT;

**D10, 250 ml IV**, at wide open rate  
May repeat in 10 min. if pt. fails to respond or BS remains < 60.  
Max total dose is 500 ml.

### PEDI:

**D10, 5ml/kg** (max single dose is 250 ml)  
Max total dose is 500 ml

### NEWBORN:

**D10 2 ml/kg** if BS < 40

### THERAPEUTIC ACTION:

Principal form of carbohydrate utilized by the body

### CONTRAINDICATIONS:

Known or suspected CVA in the absence of hypoglycemia

### PRECAUTIONS AND SIDE EFFECTS:

Warmth, pain, burning from medication infusion, hyperglycemia, thrombophlebitis  
May precipitate severe neurologic symptoms in thiamine deficient patients

### REQUIRES MCP:

**ADULT: No**

**PEDI: No**

**DIAZEPAM  
(Valium)**

**PACKAGED:** 10 mg in 2 ml vial, 5 mg/1ml

**INDICATION:**

Seizures

Recent cocaine/crack use with significant hypertension or hemodynamically significant tachycardia (HR > 100)

**ADULT:**

Seizures: 5 mg slow IV; may repeat dose once.

Cocaine or crack use: 5 mg slow IV; may repeat dose once.

**PEDI:**

Seizures: 0.2 mg/kg slow IV over 2 min. (max dose 5 mg IV)

OR {0.5 mg/kg rectally (Max dose 10 mg. rectally)}

May repeat 0.2 mg/kg slow IV over 2 min up to 5 mg, max slow IV

**THERAPEUTIC ACTION:**

Treats alcohol withdrawal and grand mal seizure activity, used to treat anxiety and stress

**CONTRAINDICATIONS:**

**PRECAUTIONS AND SIDE EFFECTS:**

Hypotension, reflex tachycardia (rare), respiratory depression, ataxia, psychomotor impairment, confusion, nausea

May cause local venous irritation

**REQUIRES MCP:**

**ADULT: No**

**PEDI: No**

**DIAZEPAM**

(Valium) CANA Pen

**PACKAGED:** 10mg autoinjector

Seizures associated with Organophosphate or Nerve Agent MCI.

**NOTE:** Available in CHEMPACK and Drug Cache.

**DOSE:**

**ADULT:** 10 mg IM Autoinjector.

**PEDI:** 10 mg IM Autoinjector.

**REQUIRES MCP:**

**ADULT: Yes**

**PEDI: Yes**

**DIPHENHYDRAMINE  
(Benadryl)**

**PACKAGED:** 50 mg in 1ml vial

**INDICATION:**

Allergic Reaction/Anaphylaxis

In anaphylaxis patient who goes into arrest if not already given.

Extrapyramidal Reactions

**ADULT:**

50 mg IM or slow IV

**PEDI:**

1 mg/kg (max dose 50 mg) IM or slow IV

**THERAPEUTIC ACTION:**

Prevents the physiologic actions of histamine by blocking histamine receptors

**CONTRAINDICATIONS:**

**PRECAUTIONS AND SIDE EFFECTS:**

Dose related drowsiness, sedation, disturbed coordination, hypotension, palpitations, tachycardia, bradycardia, thickening of bronchial secretions, and dry mouth and throat. Use cautiously in patients with CNS depression or lower respiratory diseases such as asthma.

**REQUIRES MCP:**

**ADULT:** No

**PEDI:** No

## DUODOTE

**PACKAGED:** Autoinjector 2 mg Atropine and 600 mg Pralidoxime Chloride (2-Pam)

**NOTE:** Available in CHEMPACK, Haz-Mat drugs in drug bag and Drug Cache.

**INDICATION:**

Organophosphate or Nerve Agent Poisoning

**ADULT:**

Single Autoinjector containing 2 mg Atropine and 600 mg 2-Pam  
(See individual drug listing for specific information on drugs)

**PEDI:**

Single Autoinjector containing 2 mg Atropine and 600 mg 2-Pam

**THERAPEUTIC ACTION:**

Anticholinergic as a result of WMD MCI  
Also reactivates cholinesterase

**CONTRAINDICATION:**

**PRECAUTIONS AND SIDE EFFECTS:**

Tachycardia, paradoxical bradycardia when pushed too slowly or when used at doses less than 0.5 mg, palpitations, dysrhythmias, headache, dizziness, anticholinergic effects (dry mouth, dry skin, dry nose, photophobia, blurred vision, urinary retention, constipation), nausea, vomiting, flushed hot dry skin, allergic reactions. Atropine causes papillary dilation rendering the pupils nonreactive. Pupil response may not be useful in monitoring CNS status. Use with caution in myasthenia gravis, renal impairment, pregnancy, lactation or children.

**REQUIRES MCP:**

**ADULT:** Yes      **PEDI:** Yes

## EPINEPHRINE EPIPEN

**PACKAGED:** 30 ml vial, 1 mg/ml  
Autoinjector: Adult 0.3 mg  
Or JR 0.15 mg

### INDICATIONS:

Asthma in severe distress  
Anaphylaxis Allergic Reaction, or Anaphylaxis in patients who remain hypotensive after fluid bolus.

### ADULT:

Asthma, Anaphylaxis:

If  $\geq 30$  kg, give both Adult EpiPen and EpiPen Jr or Epi (1:1,000) 0.5 mg IM

- ◆ May repeat Epinephrine (1:1,000) 0.5 mg IM in 5 minutes.

### PEDI:

Asthma, Anaphylaxis:

Patient  $< 30$  kg EpiPen Jr. (0.15 mg of 1:1,000) IM or Epinephrine (1:1,000) 0.01 mg/kg IM

- ◆ May be repeated in 5 minutes.

### THERAPEUTIC ACTION:

Directly stimulates alpha and beta adrenergic receptors in dose-related fashion, causes bronchodilation, vasoconstriction, and increased cardiac output

### CONTRAINDICATIONS:

### PRECAUTIONS AND SIDE EFFECTS:

Headache, nausea, restlessness, weakness, dysrhythmias, including ventricular tachycardia and ventricular fib, hypertension, precipitation of angina pectoris, tachycardia  
May increase myocardial oxygen demand  
Syncope has occurred following epinephrine administration to asthmatic children.

### REQUIRES MCP:

**ADULT:** For repeat in asthmas, anaphylaxis – Yes

**PEDI:** For repeat in asthmas, anaphylaxis – Yes

**FENTANYL  
(SUBLIMAZE)**

**PACKAGED:** 100 mcg/2 mL (50 mcg/ml) vial

**INDICATIONS:**

Suspected Cardiac Chest Pain, Trauma Emergencies, Extremity Fractures, Dislocations, Sprains, Frostbite, Abdominal Pain, Haz-Mat: Hydrofluoric Acid (Hf)

**ADULT:**

Fentanyl 100 mcg IN, may repeat no sooner than 30 minutes.

Fentanyl administered up to 50 mcg slow IV provided SBP > 100.

Repeat Dose: May repeat up to 50 mcg after 5 minutes

If unable to establish IV, Fentanyl 50 mcg IM; Repeat no sooner than 30 minutes and is only indicated when transport is greater than 30 minutes.

**PEDI:**

**P FENTANYL IS NOT TO BE ADMINISTERED TO ANYONE < 2 YEARS OF AGE.**

**P** For severe pain relief when the patient is conscious and alert, consider Fentanyl 1 mcg/kg, slow IV (max dose 50 mcg) provided appropriate normal SBP.

**P** If unable to obtain IV, give Fentanyl 1 mcg/kg IM (max dose 50 mcg) or Fentanyl 1 mcg/kg IN (max dose 100 mcg).

**P** ♦ May repeat Fentanyl 1 mcg/kg, slow IV after 5 minutes (max dose 50 mcg) if still in pain and appropriate SBP.

**P** ♦ Repeat dose of Fentanyl 1 mcg/kg IM (max dose 50 mcg, repeat no sooner than 30 minutes).

**THERAPEUTIC ACTION:**

Provides analgesia, reduces cardiac preload by increasing venous capacitance and decreasing afterload

**CONTRAINDICATIONS:**

Hypersensitivity to drug/class/components

**PRECAUTIONS AND SIDE EFFECTS:**

Apnea

CNS depression

Chest wall rigidity ("wooden chest syndrome") may occur preventing adequate chest wall excursion and ventilation. This syndrome typically occurs with high doses (6-7 mcg/kg) or with rapid administration. Reversible with naloxone.

Bradycardia which may be transient. Ensure adequate ventilation and oxygenation first.

**REQUIRES MCP:**

**ADULT: No**

**PEDI: Yes for repeat doses**

**Yes for abdominal pain in peds**

## GLUCAGON

**PACKAGED:** 1 mg dose; combine liquid and powder vials, then administer.

### **INDICATIONS:**

Hypoglycemia if no IV access

Generalized hypothermia without arrest

Altered level of consciousness of unknown cause

Seizures with BS < 60

No monitor is available or a strong suspicion of hypoglycemia despite BS reading and no IV access

Calcium Channel Blocker or Beta Blocker OD

### **ADULT:**

Hypoglycemia with no IV: 1 mg IM

Calcium Channel Blocker or Beta Blocker OD: 1 mg IV or IM

.

### **PEDI:**

Hypoglycemia with no IV: 1 mg IM

Calcium Channel Blocker or Beta Blocker OD: 1 mg IV or IM

### **THERAPEUTIC ACTION:**

Increases breakdown of glycogen to glucose and stimulates glucose synthesis thereby raising blood sugar

### **CONTRAINDICATION:**

### **PRECAUTIONS AND SIDE EFFECTS:**

Tachycardia, hypotension, nausea and vomiting, urticaria

Should not be considered a first line choice

### **REQUIRES MCP:**

#### **ADULT:**

Hypoglycemia: No

Calcium Channel Blocker or Beta Blocker OD: Yes

#### **PEDI:**

Hypoglycemia: No

Calcium Channel Blocker or Beta Blocker OD: Yes

**IPRATROPIUM  
(Atrovent)**

**PACKAGED:** 0.5 mg in 2.5 ml plastic ampule

**INDICATIONS:**

Bronchospasm in Asthma or COPD  
Allergic Reaction or Anaphylaxis with wheezing

**ADULT:**

0.5 mg (2.5 ml), nebulized with O2 at 8-10 LPM  
Combined with first dose of Albuterol

**PEDI:**

0.5 mg (2.5 ml) nebulized with O2 at 8-10 LPM  
Combined with first dose of Albuterol

**THERAPEUTIC ACTION:**

Causes bronchodilation by anticholinergic effect

**CONTRAINDICATION:**

**PRECAUTIONS AND SIDE EFFECTS:**

Use with caution in patients with narrow-angle glaucoma and lactating mothers.

**REQUIRES MCP:**

**ADULT:** No

**PEDI:** No

## LIDOCAINE 2%

**PACKAGED:** 100 mg in 5 ml syringe, 20 mg/ml

**INDICATIONS:**

For pain caused by pressure of intraosseous fluid administration

**ADULT:**

Pain associated with IO infusion: 1.5 mg/kg up to 100 mg via IO

**PEDI:**

Pain associated with IO infusion: 0.5 mg/kg via IO (max 100 mg)

**THERAPEUTIC ACTION:**

Decreases automaticity

**CONTRAINDICATION:**

Hypersensitivity

Second or third degree heart block in absence of an artificial pacemaker

**PRECAUTIONS AND SIDE EFFECTS:**

Lightheadedness, confusion, blurred vision, hypotension, cardiovascular collapse, bradycardia, altered level of consciousness, irritability, muscle twitching, seizures with high doses

Use extreme caution in patients with hepatic disease, heart failure, marked hypoxia, severe respiratory depression, hypovolemia or shock, incomplete heart block or bradycardia and atrial fib.

**REQUIRES MCP:**

**ADULT: No**

**Pedi: No**

**MIDAZOLAM  
(Versed)**

**PACKAGED:** 10 mg in 2 ml vial, (5 mg/ml) (2 in drug bag)

**INDICATIONS:**

For seizure  
After intubation, if patient is resisting and SBP is normal for age.  
As chemical restraint for combative patient  
Chest pain associated with crack/cocaine  
Crush syndrome

**ADULT:**

Seizures: 10 mg IN (5 mg in each nostril) or 2 mg slow IV or 4 mg IM  
If seizure persists: Repeat 5 mg IN or 2 mg slow IV or 4 mg IM.  
Chemical restraint: 2 mg slow IV OR 10 mg IN or 4 mg IM

**PEDI:**

Sedation: 0.1 mg/kg (max dose 2 mg) slow IV

Seizures: 0.2 mg/kg IN (max dose 4 mg) or 0.1 mg/kg slow IV (max dose 2 mg) or 0.2 mg/kg IM (max dose 4 mg)

If still seizing: Repeat one-half of initial Midazolam doses except **NO IM ROUTE REPEAT**

Chemical restraint: Call MCP for repeat doses. 0.2 mg/kg IN (half dose each nostril, max dose 4 mg) or 0.1 mg/kg slow IV (max dose 2 mg), or 0.2 mg/kg IM (max dose 4 mg)

**THERAPEUTIC ACTION:**

Provides sedation

**CONTRAINDICATIONS:**

**PRECAUTIONS AND SIDE EFFECTS:**

Be prepared to monitor respirations and intubate and ventilate if necessary.  
Use with caution with lactating mothers.  
Geriatric & debilitated patients require lower doses & are more prone to side effects.  
Provide continuous monitoring of respiratory & cardiac function.  
Can cause respiratory depression

**REQUIRES MCP:**

**ADULT: No**

**PEDI: No for seizures, Yes for chemical restraint repeat**

## MORPHINE

### JITSO

**PACKAGED:** 5 mg in 1ml vial

**INDICATIONS:**

Pain relief in AMI and other acute painful conditions excluding back pain

**ADULT:**

Up to 5 mg slow IV based on patient's weight, provided SBP > 100

Repeat dose: May repeat up to 5 mg after 5 minutes.

If unable to establish IV, Morphine IM 5 mg.

**PEDI:**

Pain relief in peds at least 2 years old

0.1 mg/kg slow IV (max dose 5 mg) provided appropriate SBP

Repeat dose: May repeat up to 5 mg after 5 minutes

If unable to establish IV, Morphine IM 5 mg

**THERAPEUTIC ACTION:**

Provides analgesia, reduces cardiac preload by increasing venous capacitance and decreasing afterload.

**CONTRAINDICATIONS:**

Hypersensitivity to narcotics

Hypotension

Head injury, increased ICP

Severe respiratory depression

Patients who have taken MAO inhibitors within 14 days

**PRECAUTIONS AND SIDE EFFECTS:**

Hypotension, tachycardia, bradycardia, palpitations, syncope, facial flushing, respiratory depression, euphoria, bronchospasm, dry mouth, allergic reaction

Use with caution in the elderly, those with asthma, and in those susceptible to CNS depression.

May worsen bradycardia or heart block in inferior MI (vagotonic effect)

**REQUIRES MCP:**

**ADULT: Initial dose: No Repeat IM dose: Yes**

**PEDI: Initial dose: No Repeat dose: Yes**

**NALOXONE**  
**(Narcan)**

**PACKAGED:** 2 mg in 2 ml vial, 1 mg/ml

**NOTE:** Naloxone administration should be to improve respirations in an unresponsive patient with a hypoventilation condition, and not to awaken an unconscious patient. It should be given slowly, titrated to effect. Narcan can precipitate narcotic withdrawal with all of its problems. If the patient has a pulse, Naloxone should be given before intubation. Once Naloxone is administered, it is encouraged that the patient be removed by EMS, even if the patient becomes responsive.

**INDICATIONS:**

Respirations depressed or high index of suspicion of narcotic overdose.  
Suspicion of drug abuse in cardiac arrest

**ADULT:**

Up to 2 mg IN or 2 mg IV. If IV unsuccessful, up to 4 mg IM. Titrate to adequate respirations.  
Repeat doses may be given.

**PEDI:**

**P Naloxone:**

- ≤ 20 kg **0.1 mg/kg IN, IV, IM** (max dose 2 mg) may repeat x one
- > 20 kg **2 mg, IN, IV, IM** (max dose 2 mg), may repeat x one
- **Naloxone IV** is preferred, but it may be given IN before IV is established.
- Titrate to adequate respirations.

**P** If using IN route and respirations don't improve after 3 minutes, establish IV and administer IV dose.

**THERAPEUTIC ACTION:**

A competitive narcotic antagonist

**CONTRAINDICATIONS:**

Hypersensitivity

Use with caution in narcotic-dependent patients who may experience withdrawal syndrome (including neonates of narcotic-dependent mothers).

**PRECAUTIONS AND SIDE EFFECTS:**

Tachycardia, hypertension, dysrhythmias, nausea and vomiting, diaphoresis, blurred vision, opiate withdrawal

May not reverse hypotension

Caution should be exercised when administering to narcotic addicts (may precipitate withdrawal with hypertension, tachycardia and combative behavior).

After administration of **Naloxone**, patient transport is encouraged by EMS.

**REQUIRES MCP:**

**ADULT: No**

**PEDI: No**

**NITROGLYCERINE**  
**(Abbreviated as NTG in the orders)**  
**(Nitrostat)**

**PACKAGED:** Glass bottle, 0.4 mg SL tablet

**INDICATIONS:**

Use only on patients who are at least 25 years old or have been prescribed Nitroglycerine.  
Cardiac related chest pain  
Pulmonary edema with systolic BP over 100 mmHg Crack/Cocaine Overdose with chest pain

**ADULT:**

0.4 mg SL every 5 min for continued chest pain up to a total of 3 tablets.

**PEDI:**

N/A

**THERAPEUTIC ACTION:**

Vasodilator which decreased preload and to a lesser extent, decreased afterload

**CONTRAINDICATIONS:**

Hypersensitivity  
Hypotension  
Use of sexual enhancement drugs in last 24 hours  
Taking Revatio (a pulmonary hypertension medication)  
Head injury

**PRECAUTIONS AND SIDE EFFECTS:**

Transient headache, reflex tachycardia, hypotension, nausea & vomiting, postural syncope, diaphoresis

**REQUIRES MCP:**

**ADULT:** No

**PEDI:** N/A

**ONDANSETRON  
(Zofran)**

**PACKAGED:** 4 mg tablet

**INDICATION:**

For nausea or active vomiting

**ADULT:**

4 mg PO

**PEDI:**

**4 mg PO** if pt  $\geq 12$  y/o and wt is  $\geq 40$  kg.

Transport time should be considered prior to administration.

**THERAPEUTIC ACTION:**

Stimulation of 5-HT<sub>3</sub> receptors causes transmission of sensory signals to the vomiting center via vagal afferent fibers to induce vomiting. By binding to 5-HT<sub>3</sub> receptors, Ondansetron blocks vomiting mediated by serotonin release.

**CONTRAINDICATION:**

Known hypersensitivity to Ondansetron

**PRECAUTIONS AND SIDE EFFECTS:**

During pregnancy it should only be used where clearly needed.

Sudden blindness of 2-3 minute duration has occurred. It is suggested that the speed of delivery may contribute to the blindness.

Constipation, diarrhea, fever, headache

**REQUIRES MCP:**

**ADULT: No**

**PEDI: No**

## ORAL GLUCOSE

**PACKAGED:** Tube; concentration varies, check label

**INDICATIONS:**

Hypoglycemia, if no IV access or available Glucagon

Generalized hypothermia without arrest

Altered level of consciousness of unknown causes

Seizures with BS < 60, no BS monitor available or strong suspicion of hypoglycemia despite BS reading and no IV access

**ADULT:**

1 tube

May be repeated in 10 min. if BS remains < 60

**PEDI:**

1 tube

May be repeated in 10 min. if BS remains < 60

**THERAPEUTIC ACTION:**

Raise blood glucose concentration

**CONTRAINDICATION:**

None if blood glucose level is low

**PRECAUTIONS AND SIDE EFFECTS:**

Inability to control the airway

**REQUIRES MCP:**

**ADULT: No**

**PEDI: No**

**PRALDOXIME (2-PAM)  
(Mark I Autoinjector, Item 2)**

**PACKAGED:** 600 mg Autoinjector

**INDICATION:**

To be used following Atropine in Organophosphate, or Nerve Gas Poisoning; both for treatment of civilian patients at the scene, as well as for protection of public safety personnel who walk into scene & become unexpectedly contaminated.

**ADULT:**

600 mg IM Autoinjector

**PEDI:**

Children >20 kg: 600 mg IM Autoinjector

**THERAPEUTIC ACTION:**

Reactivates cholinesterase after poisoning with anticholinesterase agents (Organophosphate or Nerve Gas)

Reverses muscle paralysis after organophosphate poisoning.

**CONTRAINDICATION:**

Hypersensitivity

**PRECAUTIONS AND SIDE EFFECTS:**

Use with caution in myasthenia gravis, renal impairment, pregnancy, children. Can spread to child through breast feeding

**REQUIRES MCP:**

**ADULT:** Yes

**PEDI:** Yes

**GREATER MIAMI VALLEY EMS COUNCIL**

**2016 AEMT SKILL SHEETS**

**Revised 11/2015**

**AEMT:** Use these skill sheets and protocol to study for Skills Testing.

**SKILLS TESTERS:** Record Pass/Fail on Individual's Test Summary Sheet. Use these and additional adult/pediatric mega code sheets as guidelines for grading. It is only necessary to make enough copies of this packet for testers (those who have gone through Train the Trainer sessions).

**Adult Mega Code** - Separate AEMT Mega Code sheets used for testing.

Manual External Defibrillator (covered in Mega Code)	
Orotracheal Intubation of Non-trauma Patient-----	70
Automated External Defibrillator -----	74
CPAP-----	68

**Pediatric Mega Code** - Separate AEMT Mega Code sheets used for testing.

Orotracheal Intubation-----	72
Laryngeal Mask Airway-----	81
Intraosseous Infusion -----	75
Use of Length / Weight Based Tape (covered in Mega Code)	

**IV and Medications**

Nebulizer with Bag-Valve Device -----	76
Complex Medication Administration-----	77
Intranasal Medication Administration-----	69

**Trauma**

Inline Orotracheal Intubation of the Trauma Patient -----	71
Chest Decompression-----	73

**Optional Skills**

Acquisition of 12-lead EKG-----	80
---------------------------------	----

## Adult Protocol Skill Evaluation CPAP Assessment and Application

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Level:    \_\_\_ EMT    \_\_\_ Advanced    \_\_\_ Paramedic

STEPS	1 <sup>st</sup> Test	2 <sup>nd</sup> Test	3 <sup>rd</sup> Test
<b>Prepares patient:</b>			
Takes or verbalizes appropriate PPE precautions			
Assures adequate blood pressure 100 Systolic			
Positions patient in a position that will optimize ease of ventilation			
<b>Assesses patient to identify indications for CPAP:</b>			
Asthmatic			
Congestive heart failure			
Pulmonary edema			
COPD			
<b>Assesses patient to identify contraindications for CPAP:</b>			
Unconscious, unresponsive, inability to protect airway or inability to speak			
Inability to sit up			
Respiratory arrest or agonal respiration			
Nausea/vomiting			
Hypotension – Systolic <100			
Suspected pneumothorax			
Cariogenic shock			
Penetrating chest trauma			
Facial anomalies/trauma/burns			
Closed head injury			
Active upper GI bleeding or history of recent gastric surgery			
Pt must be age 16 or older			
<b>Selects, checks and assembles equipment:</b>			
Assembles mask and tubing according to manufacturer instructions			
Coaches patient how to breathe through mask			
Connects CPAP unit to suitable O2 supply and attaches breathing circuit to device			
Turns on oxygen			
Sets device parameters, if applicable (goal of 10 cm /H <sub>2</sub> O)			
<b>Performs procedure:</b>			
Places mask over patients mouth and nose (leave EtCO <sub>2</sub> in place, if applicable)			
Goal of 10 cm H <sub>2</sub> O for treatment			
Coaches patient to breathe normally			
<b>Frequently reassesses patient for desired effects</b>			
Decreased ventilatory distress			
SpO <sub>2</sub> >92%			
Decreased adventitious lung sounds			
Absence of reactions (barotrauma, pneumothorax)			
Records settings/readings and documents appropriately			

**Adult Protocol Skill Evaluation  
Intranasal Medication Administration**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Level: EMR \_\_\_ EMT \_\_\_ Advanced \_\_\_ Paramedic \_\_\_

STEPS	1 <sup>st</sup> Test	2 <sup>nd</sup> Test	3 <sup>rd</sup> Test
Assures that patient is being ventilated adequately, if necessary			
Asks patient for known allergies			
Clearly explains procedure to patient			
<b>Selects, checks and assembles equipment</b>			
Medication			
Appropriate syringe, needle and mucosal atomizer device (MAD®)			
Sharps container			
Alcohol swabs			
Sterile gauze			
<b>Administers medication</b>			
Selects correct medication by identifying			
Right patient			
Right medication			
Right dosage/concentration			
Right time			
Right route			
Also checks medication for:			
Clarity			
Expiration date			
Assembles syringe and needle while maintaining sterility			
Cleanses rubber stopper, draws appropriate amount of medication into syringe and dispels air while maintaining sterility			
Reaffirms medication			
Disposes of needle in proper container and attaches mucosal atomizer device			
Takes or verbalized appropriate PPE precautions			
Stops ventilation of patient, if necessary and removes mask			
Inserts mucosal atomizer device into nostril and briskly depresses the syringe plunger (1/2 medication up each nostril)			
Disposes/verbalizes proper disposal of syringe and MAD			
Resumes ventilation of patient, if necessary			
Verbalizes need to observe patient for desired effect and side effects			

**ADULT PROTOCOL SKILL EVALUATION**  
**SUBJECT: OROTRACHEAL INTUBATION OF THE NON-TRAUMA PATIENT**

NAME \_\_\_\_\_

DATE \_\_\_\_\_

LEVEL: \_\_\_\_\_ Paramedic

\_\_\_\_\_ AEMT

<b>STEPS</b>	<b>1<sup>st</sup> Test</b>	<b>2<sup>nd</sup> Test</b>	<b>3<sup>rd</sup> Test</b>
A. List the indications for endotracheal intubation, with emphasis on situations in addition to cardiac arrest.			
B. List the equipment required to perform endotracheal intubation.			
C. List the potential complications of endotracheal intubation.			
D. Open the airway.			
E. Pre-oxygenate patient during preparations to intubate.			
F. Demonstrate the performance of cricoid pressure.			
G. Assemble equipment.			
H. Insert laryngoscope.			
I. Elevate the mandible.			
J. Insert the proper size ET tube.			
K. Remove the stylet.			
L. Document ETT at 20-22 cm at front teeth.			
M. Inflate the cuff with 5 to 10 ml. of air.			
N. Ventilate the patient.			
O. Confirm tube placement, using Capnography, Colorimetry or EDD. Be able to discuss the indications and limitations of each device.			
P. Confirm tube placement with at least 5 methods of verification and document the outcomes. <ul style="list-style-type: none"> <li>• Auscultation of epigastrium, anterior chest, midaxillary areas, epigastrium again</li> <li>• Condensation in the ETT</li> <li>• Visualization of tube passing between vocal cords</li> <li>A Depth of insertion of 20-22 cm marking at the teeth</li> <li>• Chest rise and fall</li> <li>• Improvement in patient's color</li> <li>• Improved pulse-ox readings</li> </ul>			
Q. Secure tube in place & reassess placement after any movement of patient.			
R. Consider applying cervical collar to prevent extubation			

**EQUIPMENT:**

- |                                  |                            |  |
|----------------------------------|----------------------------|--|
| 1. Proper size endotracheal tube | 4. Magill forceps          | 9. Commercial tube holder or proper taping method. |
| 2. Stylet                        | 5. 10 ml. syringe          | 10. Confirmation Device                            |
| 3. Laryngoscope Blade & handle   | 6. Suction equipment       | 11. C-collar                                       |
|                                  | 7. Stethoscope             | 12. Adult Intubation Manikin                       |
|                                  | 8. Gloves & Eye protection |  |

When preparing for this skill evaluation, be sure that you are able to meet the objectives A, B, C, G, and O. If you need a reminder, the material is readily available in any standard textbook.

**ADULT PROTOCOL SKILL EVALUATION**  
**SUBJECT: IN-LINE OROTRACHEAL INTUBATION OF THE TRAUMA PATIENT**

NAME \_\_\_\_\_

DATE \_\_\_\_\_

LEVEL: \_\_\_\_\_ Paramedic

\_\_\_\_\_ AEMT

STEPS	1 <sup>st</sup> Test	2 <sup>nd</sup> Test	3 <sup>rd</sup> Test
A. List the indications for endotracheal intubation, with emphasis on situations in addition to cardiac arrest.			
B. List the equipment required to perform endotracheal intubation.			
C. List the potential complications of endotracheal intubation.			
D. Open the airway using c-spine precautions.			
E. Pre-oxygenate patient during preparations to intubate.			
F. Demonstrate performance of cricoid pressure.			
G. Assemble equipment.			
H. Insert laryngoscope.			
I. Elevate the mandible.			
J. Insert the ET tube.			
K. Remove the stylet.			
L. Document ETT at 20-22 cm at front teeth.			
M. Inflate the cuff with 5 to 10 ml. of air.			
N. Ventilate the patient.			
O. Confirm tube placement, using Capnography, Colorimetry, or EDD. Be able to discuss the indications and limitations of each device.			
P. Confirm tube placement with at least 5 methods of verification and document the outcomes. <ul style="list-style-type: none"> <li>• Auscultation of epigastrium, anterior chest, midaxillary areas, epigastrium again</li> <li>• Condensation in the ETT</li> <li>• Visualization of tube passing between vocal cords</li> <li>A Depth of insertion of 20-22 cm marking at the teeth</li> <li>• Chest rise and fall</li> <li>• Improvement in patient's color</li> <li>• Improved pulse-ox readings</li> </ul>			
Q. Secure tube in place & reassess placement after any movement of patient.			
R. Apply cervical collar.			

**EQUIPMENT:**

- |                                  |  |                              |
|----------------------------------|--|------------------------------|
| 1. Proper size endotracheal tube | 5. 10 ml. syringe                                  | 10. Confirmation device      |
| 2. Stylet                        | 6. Suction equipment                               | 11. C-collar                 |
| 3. Laryngoscope blade & handle   | 7. Stethoscope                                     | 12. Adult intubation manikin |
| 4. Magill forceps                | 8. Gloves & eye protection                         |                              |
|                                  | 9. Commercial tube holder or proper taping method. |                              |

When preparing for this skill evaluation, be sure that you are able to meet the objectives A, B, C, G, and O. If you need a reminder, the material is readily available in any standard textbook

**PEDIATRIC PROTOCOL SKILL EVALUATION**  
**SUBJECT: PEDIATRIC OROTRACHEAL INTUBATION**

NAME \_\_\_\_\_

DATE \_\_\_\_\_

LEVEL: \_\_\_\_\_ Paramedic

\_\_\_\_\_ AEMT

STEPS	1 <sup>st</sup> Test	2 <sup>nd</sup> Test	3 <sup>rd</sup> Test
A. List the indications for endotracheal intubation, with emphasis on situations in addition to cardiac arrest.			
B. List the equipment required to perform endotracheal intubation.			
C. List the potential complications of endotracheal intubation.			
D. Open the airway.			
E. Pre-oxygenate patient during preparations to intubate.			
F. Assemble equipment, select proper size ETT and laryngoscope blade (use length-based tape).			
G. Insert laryngoscope.			
H. Elevate the mandible.			
I. Insert the ET tube.			
J. Remove the stylet.			
K. Document ETT depth at front teeth. Tube marking at teeth = 3 x tube size			
L. Ventilate the patient.			
M. Confirm tube placement, using Capnography, Colorimetry, or EDD. Be able to discuss the indications and limitations of each device. <ul style="list-style-type: none"> <li>• EDD is contraindicated in pregnancy, or children under 5 y/o or 20 kg.</li> </ul>			
N. Confirm tube placement with at least 5 methods of verification and document the outcomes. <ul style="list-style-type: none"> <li>• Auscultation of epigastrium, anterior chest, midaxillary areas, epigastrium again</li> <li>• Condensation in the ETT</li> <li>• Visualization of tube passing between vocal cords</li> <li style="color: magenta;">P Depth of insertion = tube size x 3</li> <li>• Chest rise and fall</li> <li>• Improvement in patient's color</li> <li>• Improved pulse-ox readings</li> </ul>			
O. Secure tube in place & reassess placement after any movement of patient.			
P. Consider applying cervical collar/towel roll to prevent extubation.			

**EQUIPMENT:**

- |                                  |  |
|----------------------------------|--|
| 1. Proper size endotracheal tube | 6. Stethoscope                                     |
| 2. Proper size stylet            | 7. Gloves & eye protection                         |
| 3. Laryngoscope blade & handle   | 8. Commercial tube holder or proper taping method. |
| 4. Magill forceps                | 9. Confirmation Device                             |
| 5. Suction equipment             | 10. C-collar or towel roll                         |
|                                  | 11. Pedi intubation manikin                        |

When preparing for this skill evaluation, be sure that you are able to meet the objectives A, B, C, F, and M. If you need a reminder, the material is readily available in any standard textbook.

**ADULT PROTOCOL SKILL EVALUATION**  
**SUBJECT: CHEST DECOMPRESSION**

NAME \_\_\_\_\_

DATE \_\_\_\_\_

LEVEL: \_\_\_\_\_ Paramedic

\_\_\_\_\_ AEMT

**INDICATION IS A HEMODYNAMICALLY UNSTABLE PATIENT.**

STEPS	1 <sup>st</sup> Test	2 <sup>nd</sup> Test	3 <sup>rd</sup> Test
A. List inclusion criteria: <ul style="list-style-type: none"> <li>• MOI</li> <li>• Respiratory Distress or Failure</li> <li>• Diminished or absent breath sounds</li> <li>• Hemodynamic instability:</li> <li>• Trauma arrest <ul style="list-style-type: none"> <li>○ Potential chest injury MOI with diminished/absent breath sounds</li> </ul> </li> <li>• Cardiac arrest in the asthmatic patient with diminished breath sounds either unilateral or bilateral</li> </ul>			
B. List exclusion criteria <ul style="list-style-type: none"> <li>• Lack of inclusion criteria</li> <li>• <b>Needle decompression is not to be performed unless patient is hemodynamically unstable</b></li> </ul>			
C. BSI			
D. Prepare equipment.			
E. Explain procedure to the patient.			
F. Administer high concentration Oxygen			
G. If patient has a sucking chest wound, place non-porous dressing taped on 3 sides over wound so air can escape.			
H. Identify landmarks: Angle of Louis or 2 <sup>nd</sup> or 3 <sup>rd</sup> intercostal space at the mid-clavicular line on the affected side. Insertion site should be just superior to the rib margin.			
I. Prepare the skin with antiseptic.			
J. Insert the needle at a 90 degree angle into the pleural cavity, just above the rib margin. Puncture the skin and advance the needle (perpendicular to chest) until you encounter a “pop” or rush of air.			
K. Remove the needle, keeping the catheter in place. Securely tape the catheter. Watch for kinks			
L. Reassess the patient for signs of improvement or complications <ul style="list-style-type: none"> <li>• Possible complications: <ul style="list-style-type: none"> <li>○ Local hematoma</li> <li>○ Pneumothorax/Hemothorax</li> <li>○ Infection</li> </ul> </li> </ul> <b>NOTE:</b> Insert the needle over (superior to) the rib to avoid striking vital structures such as nerves and vascular structures that lie at the inferior margins of the ribs.			

**EQUIPMENT:**

1. 14 ga 3 1/4” Angiocatheter (preferred)
2. Safety glasses and gloves
3. Stethoscope
4. Alcohol preps
5. Tape

## AUTOMATED EXTERNAL DEFIBRILLATORS

NAME \_\_\_\_\_

DATE \_\_\_\_\_

LEVEL:    \_\_\_ Paramedic    \_\_\_ AEMT    \_\_\_ EMT    \_\_\_ First Responder

STEPS	1 <sup>st</sup> Test	2 <sup>nd</sup> Test	3 <sup>rd</sup> Test
A. Perform an initial assessment of the patient.			
B. Begin CPR with 100% oxygen while preparing AED.			
• CPR continuously until AED is set-up and attached to patient			
○ If witnessed arrest: Defibrillate immediately.			
○ If unwitnessed arrest: Perform CPR for 1-2 minutes prior to defibrillation.			
• CPR continuously until AED is attached to patient.			
C. Turn on the AED.			
D. Place the defibrillator pads on the patient.			
E. Stop CPR. Allow AED to analyze rhythm.			
F. If shock is advised, clear all personnel from around the patient, and administer a shock.			
G. Resume CPR with compressions immediately if there is no patient response to the shock.			
H. Repeat steps E, F and G in 1-2 minutes if needed.			

### EQUIPMENT:

1. A.E.D. per organization type
2. Simulator

**PROTOCOL SKILL EVALUATION**  
**SUBJECT: INTRAOSSEOUS INFUSION**

NAME \_\_\_\_\_

DATE \_\_\_\_\_

LEVEL: \_\_\_\_\_ Paramedic

\_\_\_\_\_ AEMT

STEPS	1 <sup>st</sup> Test	2 <sup>nd</sup> Test	3 <sup>rd</sup> Test
A. List the indications for intraosseous infusion.			
B. List the potential complications of intraosseous infusion.			
C. Select the appropriate site for children: Anteromedial aspect of proximal tibial shaft, two fingerbreadths below the tibial tuberosity.			
D. Position leg for IO.			
E. Prepare the skin with appropriate antiseptic.			
F. Adjust the depth guard on the needle.			
G. Demonstrate proper insertion of the needle using the device approved by your department.			
H. Remove inner stylet and attach 10 cc syringe with 5 ml IV fluid. Aspirate for blood/marrow. Inject 5 ml of fluid to insure free flow.			
I. Attach IV tubing. Infuse fluid or medication using pressure infuser.			
J. Secure the I.O. Tape the tubing to the skin.			
K. List the signs of possible infiltration.			
L. Indicate proper site and positioning for adult insertion: <ul style="list-style-type: none"> <li>• Proximal tibia:               <ul style="list-style-type: none"> <li>○ Two fingerbreadths below the patella and 1-2cm medial to tibial tuberosity</li> </ul> </li> <li>• Distal tibia:               <ul style="list-style-type: none"> <li>○ Flat portion of the distal tibia, just proximal to medial malleolus</li> </ul> </li> <li>• Humeral head:               <ul style="list-style-type: none"> <li>○ 90<sup>o</sup> angle directly into greater tuberosity</li> </ul> </li> <li>• Distal femur—site of last resort:               <ul style="list-style-type: none"> <li>○ Anterior midline above external epicondyles, 1-3 cm above femoral plateau.</li> </ul> </li> </ul>			

**EQUIPMENT:**

1. Bone Marrow Aspiration needle (or BIG, EZ IO)
2. Alcohol prep
3. Towels
4. IV Solution and tubing
5. 10 ml. syringe
6. Tape, 4x4s
7. Gloves & eye protection
8. 2 rolls of Kerlix.
9. IO manikin

When preparing for this skill evaluation, be sure that you are able to meet the objectives A, B, C, G, and K. If you need a reminder, the material is readily available in any standard textbook. This skill sheet is a guideline to use; you may tailor it to the appropriate I.O. device carried by your department. Follow manufacturer's recommendations for the device.

**ADULT PROTOCOL SKILL EVALUATION**  
**SUBJECT: USE OF NEBULIZER WITH BAG-VALVE DEVICE**

NAME \_\_\_\_\_

DATE \_\_\_\_\_

LEVEL: \_\_\_\_\_ Paramedic

\_\_\_\_\_ AEMT

STEPS	1 <sup>st</sup> Test	2 <sup>nd</sup> Test	3 <sup>rd</sup> Test
A. List the indications for the use of nebulized drugs with bag-valve device.			
B. Connect bag-valve to nebulizer unit without mouthpiece as shown in drawing.			
C. Connect mask to elbow, then connect elbow to nebulizer as shown in drawing.			
D. Place medications and saline solution in the reservoir well of the nebulizer.			
E. Connect 1st oxygen supply to nebulizer @ 8-10 LPM. and. 2nd oxygen supply to bag-valve @ 12-15 LPM. (If only one oxygen source, attach it to nebulizer.)			
F. Use mask with non-intubated patient or attach elbow to endotracheal tube of intubated patient.			
G. Begin bagging patient, being careful to keep reservoir well of the nebulizer in an upright position.			
H. If only one oxygen source is available, reconnect oxygen tubing to bag-valve device after medication has been administered.			
I. Monitor patient for effects of medications.			

Equipment as shown in the illustration:



**Note:** It is recommended that departments have the inline nebulizer set prepackaged and available for providers.



Cleanse with alcohol prep		
Inject air and withdraw proper amount of medication		
I. Hold the syringe with the needle pointed straight up and depress the plunger until all air is ejected.		
J. Check the label and desired dosage again.		
K. Protect the needle until ready to administer the medication.		
L. Dispose of used ampule and remaining glass in appropriate container.		
N. Insert the needle into the injection site. Insert the needle quickly to minimize any pain.		
O. Pull back slightly on the plunger to ascertain that there is no blood return. Presence of blood return indicates that if the medication were given, it would be injected intravenously.		
P. Inject the contents of the syringe at a slow, steady rate.		
Q. Withdraw the needle quickly and smoothly at the same angle in which it was inserted.		
R. Apply direct pressure over the injection site with a sterile 2x2, then apply a sterile adhesive strip.		
S. Dispose of equipment appropriately.		
T. Note any effect of medication on the patient.		
U. Document on run report - time medication given; name, concentration, and dosage given; and medication's effect on patient.		
<b>EPIPEN ADMINISTRATION</b>		
A. Evaluate the patient, with attention to S&S of anaphylaxis.		
B. Demonstrate or voice infection precautions.		
C. Obtain the EpiPen auto-injector. Indicate when both EpiPens are needed. (Indicate Adult and Pedi doses)		
D. Check the medication for expiration date and for cloudiness or discoloration.		
E. Remove the safety cap.		
F. Select the injection site.		
G. Push the injector firmly against the site.		
H. Properly discard the injector.		
I. Monitor the patient and record the results of the treatment.		
J. Discuss precautions and side effects		
<b>D10</b>		
A. List the indication for use		
B. Demonstrate or voice infection precautions.		
C. Indicate dose and administration Adults and Peds		
D. Check the medication for expiration date and for cloudiness or discoloration.		
E. Discuss precautions and side effects (administer in continuously running IV)		
<b>GLUCAGON</b>		
A. List the indication for use		
B. Demonstrate or voice infection precautions.		
C. Indicate dose and administration Adults and Peds		
D. Check the medication for expiration date and for cloudiness or discoloration.		
E. Discuss precautions and side effects		

<b>NALOXONE</b>		
A. List the indication for use		
B. Demonstrate or voice infection precautions.		
C. Indicate dose and administration Adults and Peds		
D. Check the medication for expiration date and for cloudiness or discoloration.		
E. Discuss precautions and side effects		
<b>FENTANYL</b>		
A. List indications for use		
B. Demonstrate or voice infection precautions		
C. Indicate dose and routes of administration for Adults and Peds		
D. Check the medication for expiration date and for cloudiness or discoloration.		
E. Discuss precautions and side effects		
<b>LIDOCAINE</b>		
A. List indications for use		
B. Demonstrate or voice infection precautions		
C. Indicate dose and routes of administration for Adults and Peds		
D. Check the medication for expiration date and for cloudiness or discoloration.		
E. Discuss precautions and side effects		

Revised: 11/2015

**ADULT PROTOCOL SKILL EVALUATION**  
**SUBJECT: 12-Lead EKG Acquisition**

NAME \_\_\_\_\_

DATE \_\_\_\_\_

LEVEL:    \_\_\_ Paramedic    \_\_\_ AEMT    \_\_\_ EMT

<b>STEPS</b>	<b>1<sup>st</sup> Test</b>	<b>2<sup>nd</sup> Test</b>	<b>3<sup>rd</sup> Test</b>
Student will demonstrate how to acquire a 12-lead EKG, completing the following steps within two minutes:			
Expose chest			
Limb lead placement, and placement options			
Precordial (chest) lead placement, with <u>no</u> deviation			
Speed (all ten leads must be placed within two minutes)			
When to acquire according to optional Standing Orders			
Interface with hospital: Notify if you or machine suspect MI Rapid transport Transmit EKG			
Monitor quality vs. Diagnostic quality			
Frequency response Must use printed EKG for ST segment analysis			
Calibration			
Paper speeds			
Various limb lead placements			
Importance of anatomical uniformity with precordial leads			
Need for note on chart and EKG if non-standard position			
Negative complex in aVR as "test" for lead placement			
Hair removal			
Artifact, and what to do about it: Skin prep Electrode attachment Patient movement Cable movement Vehicle movement EMI			

## LARYNGEAL MASK AIRWAY

NAME \_\_\_\_\_ DATE \_\_\_\_\_

LEVEL:    \_\_\_ Paramedic    \_\_\_ AEMT    \_\_\_ EMT

STEPS	1 <sup>st</sup> Test	2 <sup>nd</sup> Test	3 <sup>rd</sup> Test
A. List the indications for insertion of an LMA.			
B. Select correct size LMA (See guidelines below).			
C. Check cuff by inserting air, then withdraw air.			
D. Deflate the cuff so that it forms a smooth “spoon-shape”.			
E. Lubricate the posterior surface of the mask with water-soluble lubricant.			
F. Hold the LMA like a pen, with the index finger placed at the junction of the cuff and tube.			
G. Non-Trauma Patient: With the head extended and the neck flexed, carefully flatten the LMA tip against the hard palate. Trauma Patient: With second person maintaining inline stabilization, carefully flatten the LMA tip against the hard palate.			
H. Use the index finger to push cranially, maintaining pressure on the tube with the finger.			
I. Advance the mask until definite resistance is felt at the base of the hypopharynx.			
J. Gently maintain cranial pressure with the non-dominant hand while removing the index finger.			
K. Without holding the tube, inflate the cuff with just enough air to obtain a seal (to a pressure of approximately 60 cm. H2O). See the instructions for appropriate volumes. Never overinflate the cuff.			
L. Ventilate & check breath sounds			
M. Confirm sufficient cuff inflation using the End Tidal CO2 Detector (EDD cannot be used). CAUTION: Do Not give medications via the LMA.			

### EQUIPMENT:

1. LMA (correct size)
2. Water-soluble lubricant
3. 50 ml. syringe
4. Bag-valve mask
5. Stethoscope
6. End tidal CO2 detector
7. Suction

LMA SELECTION GUIDELINES		
LMA Airway Size	Patient Size	Maximum Cuff Inflation Volumes
1	Neonates/Infants up to 5 kg. (11 lb.)	4 ml. air
1.5	Infants 5 - 10 kg. (22 lb.)	7 ml. air
2	Infants/Children 10 - 20 kg. (44 lb.)	10 ml. air
2.5	Children 20 - 30 kg. (66 lb.)	14 ml. air
3	Children 30 - 50 kg. (110 lb.)	20 ml. air
4	Adults 50 - 70 kg. (154 lb.)	30 ml. air
5	Adults 70 - 100 kg. (220 lb.)	40 ml. air
6	Adults > 100 kg. (220 lb.)	50 ml. air

## **DRUG BAG EXCHANGE PROGRAM**

### **PURPOSE**

To administer and monitor a drug bag exchange program between participating Fire, EMS and Private Ambulance departments and hospitals.

### **DRUG BAG EXCHANGE COMMITTEE**

Co-Chairpersons: 1 Hospital EMS coordinator  
1 Hospital pharmacy representative from each participating county

Members: EMS Coordinator from each participating hospital  
Pharmacy representative from each participating hospital  
Any interested GMVEMS Council member

### **MEETINGS**

Scheduled: Two meetings per year: March and September  
Unscheduled: As needed to discuss problem areas

### **OPERATING GUIDELINES**

#### **General**

- There are two types of drug bags: **ALS/BLS** and **BLS** (fanny pack style).
- All drug bags, both ALS/BLS and BLS, are the property of the Greater Miami Valley EMS Council.
- There is an initiation fee for each new bag that EMS agencies add to the program.
- There is an annual maintenance fee for each ALS/BLS bag and BLS bag.
- There is an approved policy for replacement of lost or stolen drug bags (see Addendum A).
- To maintain the integrity of the drug bag contents, pharmacy departments' seal each compartment of stocked drug bags with a blue plastic device. The seal should only be broken for administration of prehospital emergency medical treatment by approved EMS personnel. After prehospital emergency medical treatment use, the drug bag should be cleaned and resealed with the red plastic device contained inside each drug bag compartment.
- The following actions may be taken for any department found to be in non-compliance with the Drug Bag Exchange Program Operating Guideline regarding opening and resealing the drug bag:
  - Notification of the Fire Chief, EMS Administrator, or Private Ambulance Administrator.
  - The governing agency, e.g., city council, trustees, EMFTS for private ambulance service, will be notified that action is being initiated for the Fire, EMS and Private ambulance service.
  - Removal of all drug bags from all locations of said Fire, EMS and Private ambulance service.
  - Written notification to the following that the said service is in violation of the operating policy of the Drug Bag Exchange Program:
    - Medical Director
    - Regional Physician Advisory Board
    - OH State Pharmacy Board
    - OH Division of EMS
    - All hospitals participating in the drug bag exchange program
- GMVEMS Council maintains an information database for all EMS personnel authorized to participate in the Drug Bag Exchange Program.
- Rosters with certification expiration dates for EMS providers are available via an online database for review and updates.

### **PARTICIPATION REQUIREMENTS**

- Active membership in the GMVEMS Council.
- Each agency in GMVEMSC must understand that Council typically communicates with departments and agencies via email, and that some of those messages concern changes to

Standing Orders, pharmaceuticals in our Drug Bags, or other critical issues. Council maintains two lists of emails:

- The GMVEMSC Listserve
- A distribution list of Agency Contacts
- ***As such, to participate in the Drug Bag Program, each agency must provide a minimum of one functioning email contact for each of those lists (may be the same person or different). Council desires to communicate as freely and effectively as possible, and agencies may provide as many as they like for each list, but must have at least one person who can reliably receive messages. Since in rare cases, these messages may be urgent, we encourage use of the “three-deep” rule: provide Council with three (or more) emails for each list.***
- **ADDITIONAL REQUIREMENTS FOR DRUG BAG PROGRAM**
  - The protocol testing compliance letter (Addendum I) must be signed by the Chief within two weeks after completion of the CBT cycle, and then faxed to Council.
  - The copy of your license needs to go to Council by April 30 of the calendar year. This is required, as the Pharmacy at each hospital needs your license on file in order to exchange drug bags with your department.
  - Complete drug bag updates when scheduled. This is essential. The Pharmacy Board has made it very clear that updates must be completed on time.
  - Provide a signed letter (Addendum C) from each department or agency acknowledging that they must comply with the requirements. This letter will be kept on file with Council.
- **No department which participates in the Drug Bag Exchange Program shall possess a DEA License.**
- Area hospital participation according to Council guidelines. (See Addendum B).
- Document medical advisor approval for the use of the GMVEMS Council Operating Protocols with a signed, notarized letter, which is attached to the drug license renewal application form with a copy submitted to Council. Notarized letter is not required for renewal unless medications are added or there is a change in Medical Director from previous year.
- Signed agreement to abide by the GMVEMS Council Operating Guidelines for the Drug Bag Exchange Program (see Addendum C).
- Agreement to complete the GMVEMSC annual skills and annual written test between 1 January and 31 May unless otherwise scheduled by Council (see Non-Compliance Procedures).
- Maintain all drugs at all times in a clean, temperature-controlled environment per Rule 4729-33-03(E) of the OH State Pharmacy Board Administrative Code. The rules can be seen at: <http://pharmacy.ohio.gov/rules/4729-33-03.pdf>
- The ideal temperature span is 59-86 degrees F.
- In order to utilize an ALS/BLS or BLS drug bag in the pre-hospital emergency setting, the following equipment shall be available 1 January 2016 unless otherwise noted.
  - **BLS Provider:**

<ul style="list-style-type: none"><li>▪ Oxygen</li><li>▪ Pulse Oximetry</li><li>▪ Extraglottic Airways</li><li>▪ CPAP administration and management</li><li>▪ Oral Glucose</li></ul>	<ul style="list-style-type: none"><li>▪ Glucometry</li><li>▪ Ice Packs</li><li>▪ Suction (manual is acceptable)</li><li>▪ AED (if approved by Medical Advisor)</li></ul>
--	--
  - **ALS Provider:**

<ul style="list-style-type: none"><li>▪ Oxygen</li><li>▪ EtCO<sub>2</sub> detection for intubated patients day 1</li><li>▪ EtCO<sub>2</sub> waveform 2021</li><li>▪ 12-Lead acquisition, transmission and interpretation by 2021</li><li>▪ MAD</li></ul>	<ul style="list-style-type: none"><li>▪ IO and device</li><li>▪ BAAM</li><li>▪ Digital intubation</li><li>▪ IV pressure infuser</li><li>▪ Suction (manual is acceptable)</li><li>▪ Monitor/defibrillator or AED &amp; intubation equipment</li></ul>
--	--

## LEVELS OF PARTICIPATION

- **Paramedic Level**
  - Each drug bag consists of a navy, standard issue drug bag. A Paramedic can access any of the compartments of bag to obtain medications per their protocol.
  - Each standard issue bag is labeled with a metal tag from 850 – up.
  - Upon completion of a transport, the entire bag is exchanged at the receiving hospital with the appropriate paperwork following the steps above.
- **AEMT Level**
  - A side compartment labeled “intermediate”
  - The AEMT can access compartments to obtain medications per their protocol. They cannot access the Center Inside Compartment or the Center Controlled Medication Compartment.
  - Upon completion of a transport, the entire bag is exchanged at the receiving hospital with the appropriate paperwork following the steps above.
- **Basic Life Support**
  - The RED BLS compartment on an ALS/BLS bag or BLS fanny-pack style bag will carry the following medications ONLY: Nitrostat, EpiPen, EpiPen Jr. and baby Aspirin. The EMT can only access this compartment and the Naloxone compartment to treat their patient per protocol.
  - Each bag is labeled with a numeric code.
  - Upon completion of a transport, the bag is exchanged at the receiving hospital *with the appropriate paperwork following the steps above.*

## EXCHANGE PROCESS

- Each department is assigned to a "home" hospital. The assigned hospital is the central resource for initial fulfillment of medications for the drug bags and wholesale exchanges, replacement, or additions as required by revisions to the GMVEMS Council Standing Orders Protocols. Under normal operating parameters, drug bags can be exchanged at any participating hospital or within the same department.
  - ALS/BLS bags may be exchanged one-for-one with another ALS/BLS bag. BLS bags may be exchanged one-for-one with another BLS bag.
- **EMS providers are required to inventory each opened compartment, discard any used sharps and** clean any contaminants from bag used, and apply a red seal before exchanging for a replacement bag. The red seal will be looped through the proximal portion of the zipper tab (not the outermost portion of the zipper tab).
- Once you have verified the contents, seal the compartment with the RED tag, **placing the blue seal from the opened compartment back in that compartment, unless there is a discrepancy.** If any old blue seals (from previous runs) are found in the compartment, remove them, and send them to the EMS Coordinator for the receiving hospital.
- Any discrepancies (missing meds, expired meds, wrong meds or dose, altered or tampered meds, drug bag number discrepancy, etc.) that are identified shall be reported to the GMVEMSC using the Drug Bag Discrepancy Report. (See discrepancy procedure)
- The primary care provider for the patient is responsible for the inventory of the drug bag prior to sealing it. If two departments have accessed a drug bag, they should jointly seal the drug bag.
- Each hospital designates a specific location for the exchange of drug bags. EMS personnel are required to complete the Sign In/Out log when exchanging a drug bag. Once sealed, any provider can exchange the drug bag.
- EMS Providers are responsible for ensuring that all blue seals on the new bag are intact when logging out an exchanged bag.

### DOCUMENTATION OF DRUG USAGE

- Fentanyl, Ketamine, Morphine, Versed and Valium are controlled drugs. They must be tracked from the time they are dispensed into the drug bag through the time of administration.
- To insure the medications are properly accounted for, all AEMTs and Paramedics will document:
  - The drug name
  - The amount used
  - The amount wasted
  - The signature of the two witnesses if wastage (the person wasting the medication can sign as a witness).
- The GMVEMSC run sheets have a dedicated area for this documentation and required signature lines. Those using other types of run sheets should document the above information and the required signatures. **Some hospitals also require the use of the GMVEMSC approved Controlled Drug Usage Form in addition to documentation on the run sheet. This GMVEMSC approved form must be filled out for any controlled drug use, even if there is no wastage.** This information shall be on both the original EMS department form and the hospital copy for reference if needed.

### WASTED DRUG PROCEDURE

- Fentanyl, Ketamine, Morphine, Versed and Valium are controlled drugs. If a medication is only partially administered, the paramedic or AEMT must account for the all of the unused portion.
- To insure the medications are properly accounted for, all Paramedics and AEMTs will document:
  - The drug name
  - The amount used
  - The amount wasted
  - The signature of a second witness if there is wastage.
- One witness will be the paramedic or AEMT wasting the medication and the second witness signature will be the nurse, physician, pharmacist or EMT who witnessed the disposal of the medication. Both witnesses will sign the run sheet.
- It is preferred to have a nurse or physician witness drug wastage. A pharmacist can also be a witness if a nurse or physician is not available. Using another EMS provider to witness wastage should be avoided unless the EMS provider cannot obtain a nurse, physician, or pharmacist as a witness. EMS personnel witnessing drug wastage can be of higher, equal or lower certification level.

### GENERAL NON-COMPLIANCE PROCEDURES

- Each department and department medical director(s) will be notified if the annual written test and skills check-off has not been completed within the prescribed time period.
- The Ohio State Board of Pharmacy will be notified that a department or individual members of a department have not completed the annual written test and skills check-off within the prescribed time period.
- Hospital EMS coordinators and pharmacy departments will receive a list of departments or individuals within a department that are not in compliance with the operating guidelines. At the end of the testing season, if a department does not have 100% of their personnel completing both skill and written tests (or explanations for individuals not in compliance) noted in the Standing Orders database, then appropriate action, up to and including the removal of department from the Drug Bag program, may be taken by the chair of the drug bag committee.
- If copy of drug license(s) is not received by due date, GMVEMS Council notifies EMS department medical director. GMVEMS Council reserves the right to initiate the non-compliance action process for any Fire/EMS/Private Ambulance service that does not provide documentation for drug license(s) renewal.

## DRUG BAG DISCREPANCIES

- **EMS providers are required to inventory each opened pouch prior to applying the red seal.**
- All discrepancies (missing meds, expired meds, wrong med or dose, altered or tampered meds, drug bag number discrepancy, etc.) that are identified shall be reported to GMVEMSC using the Drug Bag Discrepancy Report (Addendum E).
- **If at any time, an EMS provider encounters a discrepancy they will:**
  - Notify their EMS Officer of the discrepancy.
  - If the discrepancy was discovered after opening the bag, retain the blue seal and the hospital sticker that was attached to the drug bag in question.
  - If the EMS provider is at the hospital, they will log the bag in using the normal procedure at that hospital while retaining the blue seal.
  - They will advise the pharmacist or EMS Coordinator of the discrepancy and that they will be initiating the Discrepancy form as described below (pharmacist may request a copy of the Discrepancy form).
  - The EMS Officer may contact the EMS Coordinator if assistance is needed.

### Discrepancies Involving Controlled Drugs or Potential Tampering:

- When an issue arises concerning any of the following, a collaborative effort between the EMS organization and provider and the Hospital EMS Coordinator or pharmacist shall be made in an attempt to resolve the issue:
  - A controlled drug (Fentanyl, Ketamine, Valium, Versed, or Morphine)
  - A stolen, missing or lost bag
  - Any medication that appears to have been altered or tampered with.
- If the issue cannot be resolved, the following steps shall be taken:
  - If the discrepancy was discovered by the EMS organization/provider, the person designated by the organization/provider shall comply with the requirements of OAC 4729-9-15 and GMVEMSC requirements as indicated below.
  - If the discrepancy was discovered by the hospital, the person designated by the hospital shall comply with the requirements of OAC 4729-9-15 and GMVEMSC requirements as indicated below.
- Required reporting for unresolved issues involving Controlled Drug or potential/suspected tampering or lost or stolen drug bags pursuant Federal and State Laws and GMVEMSC Protocol include:
  - Contact the Ohio State Board of Pharmacy by telephone at (614) 466-4143. Advise them you want to report a dangerous drug discrepancy. They will connect you with the appropriate person. (OAC 4729-9-15)
  - File a report with the appropriate law enforcement authorities (ORC 2921.22).
  - Notify the Drug Enforcement Agency (DEA) within 30 days of discovery using DEA Form 106 available electronically at: <https://www.deadiversion.usdoj.gov/webforms/app106Login.jsp>. A 30-day extension may be requested in writing from the DEA. (CFR 1301.76(b)).
  - Submit a completed GMVEMSC Drug Bag Discrepancy Report located at Addendum #E, with appropriate supporting documentation, to the GMVEMSC.

### Discrepancies not involving Controlled Drugs or Potential Tampering

- Examples may include:
  - Non-controlled drugs that were not in the bag
  - Wrong number of medications or doses
  - Wrong drug concentration
  - Expired medications found
  - No expiration date on tag
  - Medications improperly labeled
  - Empty vials or packages left in bag
  - Unsealed medications
  - Wrong medication administered

- Unsealed pouch discovered
- Bag logged out with red seal (used bag)
- If discovered by EMS, the EMS Officer will initiate the Discrepancy form. They shall provide a copy of the form and the Blue Seal to the Hospital EMS Coordinator and shall fax a copy of the report to the GMVEMSC (937-228-1035).
- If the Hospital discovers the discrepancy, the EMS Coordinator will initiate the Discrepancy Form and submit to GMVEMSC. If the EMS Coordinator is able to determine which EMS agency/hospital is responsible for the discrepancy, the agency or hospital will be notified and will receive a copy of the Discrepancy Form and the Blue Seal if applicable.

**The GMVEMSC will:**

- Maintain a record of all discrepancies that occur.
- Follow up with the agencies involved as needed.
- Advise the Drug Bag Chairperson of any and all discrepancies and action taken.

**The Drug Bag Committee Chairperson will:**

- Report at the bi-annual Drug Bag Committee meetings for discussion and resolutions to all discrepancies encountered.
- Assist the Council and or affected departments with any issues or questions that may result.

**DRUG BAG BLUE SEALS**

- **Blue seals:**
  - Blue seals are used by the pharmacy that inventories and restocks the ALS/BLS drug bags. The blue seals will have a hospital sticker attached to the seal that identifies the hospital and pharmacist that inventoried the bag and the expiration date of the next drug to expire. The inner compartment of the ALS bag and Intermediate will be sealed with a blue seal and will have the expiration date noted. The blue seal will be looped through the proximal portion of the zipper tab (not the outermost portion of the zipper tab). EMS should verify the blue seal is intact and has an expiration date before accepting the bag. When EMS opens a drug bag compartment, keep the blue seal in your possession until you have verified the contents are accounted for. Once you have verified the contents, seal compartment with RED tag, placing the blue seal in the compartment, unless there is a discrepancy.
- **Red Seals:**
  - Red seals identify ALS/BLS bags as being used. EMS providers are required to inventory each opened pouch, discard any used sharps and clean any contaminants from bag used and then take red seal from the inside compartment (supplied by pharmacy when restocking the ALS/BLS bag) and seal the used compartment. The red seal will be looped through the proximal portion of the zipper tab (not the outermost portion of the zipper tab).

Hospital Pharmacies should use the same style colored seals to maintain continuity of the system. Hospital pharmacists can purchase these seals through the GMVEMSC office.

## ADDENDUM A

### Lost or Stolen Drug Bag Policy

RE: Lost or Stolen Drug Bags  
APPROVED: June 1994  
PURPOSE: To provide a uniform mechanism for the investigation and reporting of lost or stolen drug bags.

#### EMS DEPARTMENT SHALL:

- Develop and implement an internal investigation mechanism for lost or stolen drug bags. The internal investigation mechanism should include:
  - Determine if drug bag was left at the scene.
  - Determine if drug bag was not exchanged on last run.
  - Determine if drug bag is in the wrong vehicle.
  - Interview all personnel who had access to the drug bag.
- The GMVEMSC will seek the assistance of the Drug Bag Co-Chair to check with all hospitals to determine if the bag might be in inventory or be alerted if it shows up at one of the hospitals.
- EMS Officer will initiate the Drug Bag Discrepancy Form and follow instructions for reporting lost or stolen drug bags. Completed paperwork and reports will be submitted to GMVEMSC.
- The GMVEMSC will contact the hospital EMS Coordinator with whom the EMS Department is assigned to work out a drug bag replacement. The EMS Coordinator will contact *GMVEMSC for a drug bag replacement after all paperwork is submitted and GMVEMSC will assess a fee for replacement bag to be paid for by the EMS Department receiving the replacement bag.*

## **ADDENDUM B**

### **HOSPITAL PARTICIPATION POLICY**

APPROVED: 29 November 2001

#### **GENERAL PURPOSE:**

To assure uniformity of hospital pharmacy participation in the DBEP.

#### **The Hospital Shall:**

- Purchase (at cost), fill, and maintain a supply of bags sufficient to meeting the needs of an average day, plus a few extra to meet peak demands for bag replacement.
- Accept responsibility for filling new bags for departments or vehicles as assigned by Council, at hospital expense.
- Assign one licensed pharmacist and an EMS coordinator to attend and participate in the Standing Orders and Drug Bag Exchange Program Committees.
- Agree to pay annual dues and any fees assessed by Council that are approved by the DBEP Committee and the GMVEMSC Council that pertain to the DBEP.

#### **GMVEMSC SHALL:**

- Maintain a current State Drug Licenses for all participants in the DBEP.
- Furnish hospital pharmacy with a current listing of all departmental personnel authorized to access the GMVEMSC drug bags and copy of the protocol.
- Assign departments to hospitals in both a geographic and otherwise equitable fashion.

**ADDENDUM C**

**AGREEMENT LETTER**

*Please type or print legibly*

*DEPARTMENT/SERVICE:* \_\_\_\_\_

*CONTACT PERSON:* \_\_\_\_\_

*TELEPHONE:* \_\_\_\_\_

*FAX:* \_\_\_\_\_

*This department/service agrees to abide by the GMVEMS Council Drug Bag Exchange Program and Standing Orders operating guidelines.*

*SIGNATURE:* \_\_\_\_\_

Fire Chief, EMS Administrator, or Private Ambulance Administrator

*DATE:* \_\_\_\_\_

**Return to:**

GMVEMSC

2 Riverplace, Suite 400

Dayton OH 45405

Phone: 937-228-1288

Fax: 937-228-1035

## ADDENDUM D

### **New Member Policy requiring Drug (ALS/BLS) bag for licensure of their ALS/BLS unit**

Those Agencies who have applied for membership and require a GMVEMSC drug bag to license their units may request a GMVEMSC drug Bag to be available 24 hours prior to the Ohio Medical Transportation Board (OMTB) inspection date providing they have done the following:

1. Have applied for a GMVEMSC membership
2. They have provided a copy of their State Pharmacy License
3. Have been given a provisional membership by the GMVEMSC Executive Committee if the inspection is before regularly scheduled Council meeting.
4. Personnel must be checked off on Standing Orders and data entered on GMVEMSC data base.
5. Medical Director must submit a notarized letter to the State Pharmacy Board with License application stating they approve their department to use the GMVEMSC protocols.
  - i. Medical Directors have the right to limit their personnel from using certain medications or procedures within the scope of the GMVEMSC protocols.
  - ii. Medical Directors may elect to change or add medications or procedures to the protocol. The Medical Director must include those protocols in addendum to the GMVEMSC, be responsible for the training and documentation of training in of their protocol as well as purchasing and maintaining those drugs that are not included in the standard inventory of the GMVEMSC ALS or BLS.

The agency has 72 hours to show proof of a temporary permit from the date of inspection to the GMVEMS Council office. If they cannot demonstrate an OMTB permit in that time the Drug bag must be returned to the Hospital to which the agency is assigned or the hospital that provided the drug bag.

**ADDENDUM E**  
**GMVEMSC Drug Bag Discrepancy Report**

**If at any time an EMS provider encounters a discrepancy they will notify their EMS Officer of the discrepancy. If the discrepancy was discovered after opening the bag, retain the blue seal and the hospital sticker that was attached to the drug bag in question. If the EMS provider is at the hospital, they will log the bag in using the normal procedure at that hospital. They will advise the pharmacist or EMS Coordinator of the discrepancy and that they will be initiating the Discrepancy form as described below (pharmacist may request a copy of the Discrepancy form).**

Date of report: \_\_\_\_\_ Bag Number: \_\_\_\_\_ Date Discrepancy discovered: \_\_\_\_\_  
 Discovered by: \_\_\_\_\_ Hospital/EMS Dept making discovery: \_\_\_\_\_

Have blue Hospital seal? YES/NO If yes - Attach seal to report

**Tracking:**

Date bag was logged out: \_\_\_\_\_ from (hospital) \_\_\_\_\_ To (EMS agency) \_\_\_\_\_ Date Bag turned in: \_\_\_\_\_ to (hospital) \_\_\_\_\_

**Description of the discrepancy:** (Attach addendum if additional space needed)

---



---

**Describe efforts to resolve the discrepancy:** (Attach addendum if additional space needed)

---



---

Was the discrepancy satisfactorily resolved? \_\_\_\_\_ If not, what steps are to be taken: \_\_\_\_\_

---



---

Who will be responsible for any required reporting: \_\_\_\_\_

**Reporting requirements:**

Was a police report filed? \_\_\_\_\_ Date: \_\_\_\_\_ by whom? \_\_\_\_\_

Was a DEA report filed? \_\_\_\_\_ Date: \_\_\_\_\_ by whom? \_\_\_\_\_

Required documents submitted to GMVEMSC By: \_\_\_\_\_ Date: \_\_\_\_\_

For Drug Bag committee use:

Wrong Med stocked		Bag logged out with red seal	
Expired meds found		Empty vials/packages found	
Wrong dose packaged		Open pouch found	
Missing Meds		Unsealed bottles found	
Wrong number packaged		Med found in wrong compartment	
No exp date on tag		Wrong med administered	
Atrovent/Albuterol not labeled		Lost or stolen bag	
Damaged medications		Other:	
Other:			

## **ADDENDUM F**

### **OAC 4729-9-15**

#### **Report of theft or loss of dangerous drugs, controlled substances, and drug documents.**

(A) Each prescriber, terminal distributor of dangerous drugs, or wholesale distributor of dangerous drugs shall notify the following upon discovery of the theft or significant loss of any dangerous drug or controlled substance, including drugs in transit that were either shipped from or to the prescriber, terminal distributor of dangerous drugs, or wholesale distributor of dangerous drugs:

- (1) The state board of pharmacy, by telephone immediately upon discovery of the theft or significant loss;
- (2) If a controlled substance, the drug enforcement administration (DEA) pursuant to section 1301.76(b), Code of Federal Regulations;
- (3) Law enforcement authorities pursuant to section 2921.22 of the Revised Code.

(B) Controlled substance thefts must also be reported by using the Federal DEA Report form whether or not the controlled substances are subsequently recovered and/or the responsible parties are identified and action taken against them. A copy of the federal form regarding such theft or loss shall be filed with the State Board of Pharmacy within thirty days following the discovery of such theft or loss.

- (1) An exemption may be obtained upon sufficient cause if the federal form cannot be filed within thirty days.
- (2) A request for a waiver of the thirty-day limit must be requested in writing.

(C) Each prescriber, terminal distributor of dangerous drugs, or wholesale distributor of dangerous drugs immediately upon discovery of any theft or loss of:

- (1) Uncompleted prescription blank(s) used for writing a prescription, written prescription order(s) not yet dispensed, and original prescription order(s) that have been dispensed, shall notify the state board of pharmacy and law enforcement authorities.
- (2) Official written order form(s) as defined in division (Q) of section 3719.01 of the Revised Code shall notify the state board of pharmacy and law enforcement authorities, and the drug enforcement administration (DEA) pursuant to section 1305.12(b), Code of Federal Regulations.

**ADDENDUM G**  
**OAC 4729-33-03 Security and storage of dangerous drugs**

(A) Overall supervision and control of dangerous drugs is the responsibility of the responsible person. The responsible person may delegate the day-to-day tasks to the emergency medical service (EMS) organization personnel who hold appropriate certification to access the dangerous drugs for which they are responsible.

(B) All dangerous drugs must be secured in a tamper-evident setting with access limited to EMS personnel based on their certification status except for sealed, tamper-evident solutions labeled for irrigation use. All registrants shall provide effective and approved controls and procedures to deter and detect theft and diversion of dangerous drugs.

(C) Only emergency medical technician-paramedics, AEMTs, registered nurses, physicians, and pharmacists who are associated with that EMS organization may have access to any controlled substances maintained by the EMS organization. Other persons employed by the EMS organization may have access to controlled substances only under the direct and immediate supervision of an emergency medical technician-paramedic, an AEMT as defined in rules 4765-16-01 and 4765-16-02 of the Administrative Code, a registered nurse, or a physician in emergency situations.

(D) Administration of dangerous drugs by EMS personnel is limited to the scope of practice, as determined by the State Board of Emergency Medical Services, for the individual's certification level and the protocols as established by the medical director or when the individual is acting within their certification level pursuant to direct prescriber's orders received over an active communication link.

(E) All dangerous drugs will be maintained in a clean and temperature-controlled environment.

(F) Any dangerous drug that reaches its expiration date is considered adulterated and must be separated from the active stock to prevent possible administration to patients.

(G) Any non-controlled dangerous drug that is outdated may be returned to the supplier where the drug was obtained or may be disposed of in the proper manner.

(I) Destruction of outdated controlled substances may only be done by a State Board of Pharmacy agent or by prior written permission from the State Board of Pharmacy office.

(J) Destruction of partially used controlled substances can be accomplished, with the appropriate documentation, by two licensed health care personnel, one of which must have at least an AEMT, as defined in rules 4765-16-01 and 4765-16-02 of the Administrative Code, level of training.

(K) Any loss or theft of dangerous drugs must be reported upon discovery, by telephone, to the State Board of Pharmacy, local law enforcement and, if controlled substances are involved, to the Drug Enforcement Administration. A report must be filed with the State Board of Pharmacy of any loss or theft of the vehicle or storage cabinets containing dangerous drugs used by the EMS organization.

(L) Any dangerous drug showing evidence of damage or tampering shall be removed from stock and replaced immediately.

## ADDENDUM H

### Ambulance Restocking Policy

EMS Supply Exchange Program  
September 23, 2014

#### History

The member hospitals of GDAHA have supported Emergency Medical Services agencies in the region for decades. In 1998, GDAHA received permission (Advisory Opinion No. 98.7) from the Department of Health & Human Services to continue to exchange drugs (GMVEMSC Drug Bag Program) and supplies with EMS agencies and avoid violating the anti-kickback (safe harbor) statute of the Social Security Act. The hospitals named in the advisory are in the eight (8) county West Central Region: Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble and Shelby.

In December 2001, the Centers for Medicare and Medicaid Services issued an Ambulance Final Rule on Ambulance Restocking Safe Harbor. Elements of the Safe Harbor include: 1) Billing and Claim Submission; 2) Documentation; 3) Not Tied to Referrals; and 4) Compliance with other laws.

#### Current Situation

EMS agencies and personnel need to understand the benefits of the EMS Supply exchange program, as offered by GDAHA members participating in this program. EMS agencies and personnel must also realize that they must adhere to the agreement, particularly the areas highlighted below:

1. **Written records describing each of the medical supplies and/or medications utilized by the patient during the transport.** For all transports to Member Hospitals, the EMS agencies will provide the receiving Hospital Member with copies of such written records **upon arrival at the Hospital.**
2. Participating hospital members will restock EMS agency ambulances, at no charge to EMS agency, with the medical supplies and/or medications which were **utilized by the patient during the transport to the receiving Hospital.**

**Hospitals will not restock items used on patients delivered to another hospital.** It is the responsibility of the EMS agencies to restock items used on patients delivered to a hospital that is not a participant in the Agreement. **Participating hospitals will restock drug bags.**

Hospitals are not required to participate in this restocking program. This is a benefit to EMS Agencies in the region. Restocking an ambulance at a participating hospital for items used on a patient delivered to a hospital not participating in the agreement, will jeopardize this program.

Hospitals will not provide medical supplies to a new ambulance, or an old ambulance being returned to service. These ambulances must be stocked for the first time by the EMS agency.

**ADDENDUM I**

**Protocol Testing Compliance**

I, \_\_\_\_\_ (Chief's Name Printed), do hereby certify that all

members of \_\_\_\_\_ (Agency/ Department Name)

have completed the \_\_\_\_\_ (Year) GMVEMSC Protocol Testing as of \_\_\_\_\_ (Date

of Completion) with the exception of the following personnel:

(List anyone who has not completed testing)

\_\_\_\_\_  
Chief's Signature

**GREATER DAYTON AREA HOSPITAL ASSOCIATION  
GREATER MIAMI VALLEY EMERGENCY MEDICAL SERVICES COUNCIL  
GREATER MONTGOMERY COUNTY FIRE CHIEFS' ASSOCIATION  
POLICY STATEMENT FOR  
TEMPORARY REROUTING OF EMERGENCY PATIENTS**

To avoid misunderstanding, all parties are cautioned to use the word **“rerouting,” never “closed.”**

Patients are never rerouted for patient’s economic considerations.

The following patients are NOT rerouted:

**RESPIRATORY AND/OR CARDIAC ARREST  
CARDIAC & STROKE ALERT CRITERIA PATIENTS  
MAJOR TRAUMA  
MATERNITY  
SERIOUS BURNS  
HIGH RISK NEONATAL  
DIALYSIS PATIENT  
AIR MEDICAL TRANSPORT  
HYPERBARIC  
RECENTLY DISCHARGED PATIENTS (48 hours)**

When conditions exist that may hinder the timely treatment of additional emergency cases, the Designated Hospital Official will declare the “Rerouting of Emergency Patients to be in Effect.” The hospital will update the “GDAHA SurgeNet Web Page.” The Hospital will notify their appropriate dispatch center, identify the hospital, name and title of caller, as needed. The hospital will then notify (by prior agreement, this can be via the SurgeNet Web Page) at least the following organizations:

1. The emergency department of each metropolitan hospital:
  - a. The Children’s Medical Center
  - b. Good Samaritan Hospital
  - c. Grandview Medical Center
  - d. Kettering Medical Center
  - e. Miami Valley Hospital
  - f. Miami Valley Hospital South
  - g. Southview Medical Center
  - h. Sycamore Medical Center
  
2. The appropriate emergency medical services – refer to individual hospital call list
  
3. The emergency department of non-metropolitan hospitals:
  - a. Wayne Hospital, Greenville
  - b. Atrium Medical Center, Middletown
  - c. Wilson Memorial Hospital, Sidney
  - d. Springfield Regional Medical Center
  - e. Mercy Memorial Hospital, Urbana
  - f. Upper Valley Medical Center, Troy
  - g. Greene Memorial Hospital, Xenia
  - h. Department of Veterans Affairs - Medical Center
  - i. 88<sup>th</sup> Medical Center, WPAFB

Communicate the following information:

Rerouting of emergency patients is requested by \_\_\_\_\_ name \_\_\_\_\_ hospital due to overcrowding. One of the following categories of rerouting may be requested. Hospitals MUST specify what category is being rerouted using the following options:

**Reroute all Emergency Patients  
Reroute all but major trauma (Trauma Centers Only)  
Reroute Intensive and/or Coronary Care Patients Only.**

*After two (2) hours hospitals will be notified by page and/or email to review their reroute status.*

It will be the responsibility of the **rerouting hospital to cancel their rerouting status and:**

1. Update the GDAHA SurgeNet Web Page
2. Use the same notification protocols used to initiate the rerouting procedure as appropriate

**LOCKDOWN:** the hospital has activated its disaster plan because of an internal emergency, bomb threat, or other situation rendering it unable to accept patients.

**INFORMATIONAL CATEGORIES:**

On occasion, hospitals will not be able to handle a certain category of patients. For example:

- CAT Scan is not available; stroke or head trauma patients should be diverted;
- Haz-mat patients should be diverted;
- A physician specialty is not available;

The hospital that is diverting this certain category of patients will not be considered rerouting in these circumstances. This will be shown on the web page as SPECIAL SITUATION – see Notes/Call.

**THREE HOSPITALS NEED TO REROUTE**

In the event that overcrowding and rerouting exists at the same time at two (2) hospitals in close geographic proximity (Addendum A) and the third hospital in the same geographic area needs to reroute, by prior agreement, all hospitals will terminate their rerouting **for a minimum of two hours (Forced Open)**. It will be the responsibility of the third hospital to initiate communication with the other rerouting hospitals' individuals responsible for reroute to review the situation. If any of the rerouted hospitals can stop rerouting they will do so, to avoid all hospitals having to stop rerouting.

**REROUTING EMERGENCY**

**If none of the three hospitals can stop rerouting, then a “rerouting emergency” will be declared and the following procedures will be followed.**

1. Update the GDAHA SurgeNet Web Page
2. All three hospitals will call previously notified agencies and inform them that rerouting emergency has been declared.
3. When a rerouting emergency is declared, Children’s Medical Center will remain available to accept patients up to 21 years of age (*no maternity patients*).
4. Squads should transport patients to their assigned reroute emergency “home base” hospital(s) (See Addendum B):

***Note: During mutual aid or out of district transport as aided agency/district.***

When emergency medical service personnel respond to an emergency call and the patient and/or physician requests him to proceed to a hospital which is rerouted, the emergency medical services personnel will have the responsibility of advising the patient and/or physician that “due to overcrowding of the hospital patient care may be jeopardized.” **If the patient and/or physician still requests to be transported to the rerouted hospital, the emergency medical services personnel will contact and consult with a Medical Control physician in the emergency department of the rerouted hospital.**

**All concerned parties should acknowledge the situation in which emergency medical services personnel (in the absence of a physician’s judgment) may determine the victim to be in critical need of immediate medical care and decide to transport the victim to the nearest hospital, even though overcrowded conditions exist in the hospital. Any discussion concerning the decision of the emergency medical services personnel should be done privately and after the patient care has been initiated.**

Emergency medical service personnel should use their radios, cellular phone or dispatcher to notify the rerouting hospital in unusual circumstances (critical illness or injury, multi-victim incidents, etc.).

**GREATER DAYTON AREA HOSPITAL ASSOCIATION**

**POLICY STATEMENT FOR  
TEMPORARY REROUTING OF EMERGENCY PATIENTS**

**ADDENDUM A**

**Geographic Areas:**

1. In the event that overcrowding and rerouting exists at the same time at two (2) hospitals in the list below and a third hospital in the list below needs to reroute, by prior agreement no hospitals will reroute for two (2) hours.
  - a. Good Samaritan Hospital
  - b. Grandview Medical Center
  - c. Kettering Medical Center
  - d. Miami Valley Hospital
  
2. In the event that overcrowding and rerouting exists at the same time at two (2) hospitals in the geographic groups below and a third hospital needs to reroute, by prior agreement no hospitals will reroute for two (2) hours.
  - a. Greene Memorial and two (2) of the following: Miami Valley, Kettering, Grandview, Southview or Miami Valley Hospital South.
  - b. Upper Valley Medical Center and two (2) of the following: Good Samaritan, Grandview, Miami Valley, or Wilson Memorial Hospital in Sidney.
  - c. Any three (3) of the following: Atrium Medical Center, Southview, Sycamore, Kettering and Miami Valley South.
  - d. Wayne Hospital, Good Samaritan and Grandview.

PKB/pbt  
8-24-09

**ADDENDUM B  
GREATER DAYTON AREA HOSPITAL ASSOCIATION**

**REROUTE EMERGENCY  
EMS – HOSPITAL PROPOSED PAIRING**

Reroute Emergency is declared when three or more hospitals in the same geographic area are extremely overcrowded and none of the three hospitals feel that they can stop rerouting. When a rerouting emergency is declared the following procedures will be followed.

1. The third rerouting hospital will coordinate communications with the designated administrative person in charge, at the other rerouting hospitals.
2. **Each GDAHA hospital** will notify the home base EMS agencies assigned to them, as well as other squads that they normally notify out of the GDAHA service area, and inform them that a **Rerouting Emergency** has been declared. Squads should transport patient to their assigned “*home base*” hospital. Only Good Samaritan Hospital will notify Harrison Township. Only Miami Valley Hospital will notify Dayton Fire Department. Only Sycamore Hospital will notify Miami Township.
3. Following notification of EMS, hospitals able to maintain Normal Operation should not change their status on the web page to Reroute Emergency, until conditions warrant that change.
4. Squads should CONSIDER utilizing outlying hospitals or other hospitals in normal status.
5. Children’s Medical Center will remain available to accept patients up to 21 years of age. (*No maternity patients.*)
6. Rerouting Emergency **DOES NOT** apply to the following categories of patients: respiratory and/or cardiac arrest; Trauma, maternity, serious burns, high risk neonatal, dialysis patient, air medical transport, hyperbaric, **cardiac or stroke** alert patients, or recently discharged patients (48 hours).
7. **After a maximum of two (2) hours all hospitals in Reroute Emergency must reevaluate their status.**
8. ***Squads should transport patients to their assigned reroute emergency “home base” hospital(s) as follows:***  
***Note: During mutual aid or out of district transport as aided agency/district***

**Good Samaritan Hospital**  
Brookville  
Clayton, Englewood, Union  
Dayton Fire Department #16  
Eaton  
Harrison – Turner Road  
New Lebanon  
Lewisburg  
Trotwood  
West Alexandria  
North Central  
Phillipsburg

**McCullough Hyde Hospital-Oxford**  
Camden

**Upper Valley Medical Center**  
Miami County Squads

**Greene Memorial Hospital**  
Cedarville Township  
Cedarville University  
Central State University  
Jefferson Township  
Miami Township  
New Jasper Township  
Silvercreek Township  
Spring Valley  
Xenia  
Xenia Township

**Grandview Medical Center**  
Box 21  
Butler Township  
Dayton Fire Department #2, 8, 13, 14  
Harrison – I-75 & Needmore  
Vandalia

**Kettering Medical Center**  
Dayton Fire Department #15, 18  
Kettering (4 units)  
Miami Valley Fire District #55  
Moraine (4 units)

**Miami Valley Hospital**  
Dayton Fire Department #11, 10  
Jefferson Township  
Oakwood  
Riverside  
University of Dayton Public Safety

**Miami Valley Hospital South**  
Bellbrook  
Kettering #36  
Sugarcreek (2 units)  
Washington Township #44

**Southview Medical Center**  
Clearcreek Township  
Miami Valley Fire District #52  
Washington Township #41, 42, 43, 45  
Wayne Township

**Sycamore Medical Center**  
Farmersville  
Miami Valley Fire District #51, 53, 54  
West Carrollton  
Germantown  
JEMS

**Springfield Reg. Med Center**  
Hustead EMS  
Madison Township  
Harmony Township  
Springfield Township  
Pleasant Township  
SFRD Medic  
German Township  
Pike Township  
Bethel Township  
Mad River Township  
Moorefield Township

**Wayne Healthcare**  
Darke County Squads

**Wilson Memorial Hospital**  
Shelby County Squads

**Atrium Medical Center**  
Gratis  
Lebanon  
Mason  
Monroe  
Turtlecreek  
Middletown

**Clinton Memorial Hospital-Wilmington**  
Massie Township

**Reid Hospital-Richmond, Indiana**  
NW Fire – New Paris

**Huber Heights Emergency**  
Huber Heights  
New Carlisle  
Bethel Miami

**Soin Medical Center**  
Beavercreek  
Fairborn

Pkb/pbt  
8-24-09

## ADDENDUM C

### GREATER DAYTON AREA HOSPITAL ASSOCIATION EMS REROUTE PAGER

A summary of the hospital reroute status is sent every 15 minutes. The following is an explanation of the abbreviations used

#### HOSPITAL NAME ABBREVIATIONS

**CMC** – Children’s Medical Center  
**GSH** – Good Samaritan Hospital  
**GVH** – Grandview Medical Center  
**GMH** – Greene Memorial Hospital  
**KMC** – Kettering Medical Center  
**SRMC** – Springfield Regional Medical Center  
**MVH** – Miami Valley Hospital  
**MVS** – Miami Valley Hospital South  
**AMC** – Atrium Medical Center, Franklin  
**SVH** – Southview Medical Center  
**SYC** – Sycamore Medical Center  
**UV** – Upper Valley Medical Center  
**VA** – Department of Veterans Affairs Medical Center  
**WAY** – Wayne Hospital, Greenville  
**WMH** – Wilson Memorial Hospital  
**WP** – 88<sup>th</sup> Medical Center, WPAFB

#### HOSPITAL STATUS ABBREVIATIONS

**NORM** – Normal Operations  
**ALL** – Reroute all Emergency Patients  
**MTO** – Reroute all but major trauma (Major Trauma Only)  
**ICOR** - Reroute Intensive and/or Coronary Care Patients Only  
**FO** – Forced Open  
**EMR** – Emergency Reroute  
**CALL** – Special Situation Call the ED  
**LOCK** – Internal Emergency ED is Closed

**HOSPITAL CAPABILITIES CHART**

<b>HOSPITAL</b>	<b>Trauma Center Level A or P</b>	<b>Burn Center</b>	<b>Interventional Cardiac Cath Lab 24/7</b>	<b>Stroke Telemedicine with tPA ready 0-4 hrs</b>	<b>Stroke Primary tPA 0-4 hrs</b>	<b>Stroke Comprehensive 24/7 0-8 hrs</b>	<b>L &amp; D</b>
Atrium	A 3		Cardiac	Y	Y		Y
Children's	P 2	Y					
Fort Hamilton			Cardiac	Y	Y		Y
Franklin Emer Ctr				Y			
Good Sam			Cardiac	Y	Y		Y
GSH North				Y			
Grandview	A 3		Cardiac	Y	Y		
Greene	A 3			Y			
Huber Emer Ctr				Y			
Jamestown				Y			
Kettering	A 2		Cardiac	Y	Y	KMC	Y
Mason				Y			
McCullough-Hyde				Y			
Mercy Urbana				Y			
Miami Valley	A 1	Y	Cardiac	Y	Y	MVH	Y
MVH South				Y			Y
Preble Emer Ctr				Y			
Reid			Cardiac	Y			Y
Soin Medical	A 3			Y	Y		Y
Southview			Cardiac	Y	Y		Y
Springfield RMC			Cardiac	Y			Y
Sycamore				Y	Y		
Upper Valley				Y			Y
VA							
Wayne				Y			Y
West Chester	A 3		Cardiac	Y			Y
Wilson				Y			Y
WPAFB							Y

**Notes:** Comprehensive stroke centers have the capability of endovascular intervention 24/7.  
 Primary stroke centers have CT and tPA capabilities and focus on evaluating patients for intravenous tPA.  
 Telemedicine with tPA ready offers immediate access to a Neurologist.

	TRAUMA CENTER LEVEL A or P	BURN CENTER	CARDIAC Interventional Cath 24/7	STROKE 0-4 Hours Telemedicine tPA Ready	STROKE 0-4 Hours Primary Center	STROKE 24/7 0-8 Hours Comprehensive Endovascular Interventional	L & D
<b>HOSPITALS</b>							
Atrium	A 3						
Children's	P 2						
Fort Hamilton							
Franklin Emer Ctr							
Good Sam							
GSH North							
Grandview	A 3						
Greene	A 3						
Huber Emer Ctr							
Jamestown							
Kettering	A 2						
Mason							
McCullough-Hyde							
Mercy - Urbana							
Miami Valley	A 1						
Miami Valley South							
Preble Emer Ctr							
Reid							
Soin Medical	A 3						
Southview							
Springfield RMC							
Sycamore							
Upper Valley							
VAMC							
Wayne Healthcare							
West Chester	A 3						
Wilson Health							
WPAFB							

**Notes:** Comprehensive stroke centers have the capability of endovascular intervention 24/7.  
 Primary stroke centers have CT and tPA capabilities and focus on evaluating patients for intravenous tPA.  
 Telemedicine with tPA ready offers immediate access to a Neurologist.

Step	Atrium	CMC	GSH	GVH/SVH	GMH	KMH/SYC	MVH	MVH South	UVMC	SRMC	MMH	Wayne	Wilson
Updated	May-09	Sep-04	Sep-07	Sep-07	Sep-07	Sep-07				Sep-07	Sep-07	Sep-07	Jul-09
Wash Area	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Notify EMS Supervisor	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Report to hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hospital Contact	ED Charge Nurse > EMS Coordinator	NICU Charge Nurse	ED staff or Infection Control	ED Staff -> EMS Coord.	ED Staff -> EMS Coord.	ED Staff -> Infection Control	Security -> AOC	Charge Nurse	Resource Supervisor	Infection Control	Infection Control	Infection Control	ED Staff
Complete "Request for Information Form for HCWs"	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Register w/ ED	Encouraged	If desired	If desired	Y	Y	If desired	If desired	If desired	Y	Y	Y	Y	Y
Have your lab drawn	If Desired	If source is high risk (not routine)	If indicated	Y	Y	If desired	If desired	If desired	If desired	If Indicated	If indicated	If indicated	If indicated
Have source lab drawn (HIV, Hep B, Hep C)	Y (Rapid HIV Available)	Y	Y (Rapid HIV avail.)	Y (Rapid HIV avail.)	Y	Y	Y (Rapid HIV avail)	Y (Rapid HIV avail)	Y (Rapid HIV avail.)	Y (Rapid HIV avail.)	Y	Y	Y (Rapid HIV available)
Follow-up Consult <b>YOUR Fire/EMS Dept</b> policies/procedures	EMS Coordinator	Follow dept policy	Infection Control	EMS Coord. or designee & Follow dept policy	Work Plus Dept	Infection Control & Follow dept policy	Infection Control or Admin Officer	Infection Control or Admin Officer	Occupational Health	Infection Control	Infection Control	Infection Control	Follow EMS policy
Comments	Have request for information forwarded to EMS Coordinator Anti-Viral medication available in ER if indicated	Infection Control Doc available 24/7 for RN contact if needed	Infection Control is notified of Exposure Incident by EMS coordinator	EMS Coord. is to be paged 24/7 by ED or Prehospital care provider	Give form to EMS Coord. Who forwards to Infection Control for follow up	Infection Control to be paged 24/7 by ED	Security page Infection Control Mon-Fri 8-4. Admin Officer to be paged at all other times including holidays	Charge Nurse to page Infection Control M-F 8-4 Admin officer to be paged at all other times including holidays	Place form in locked box in EMS Room for EMS Managr to forward to Occupational Health	Give form to EMS Coord who forwards to Infection Control for follow up	Give form to EMS Coord who forwards to Infection Control for follow up	Give form to Infection Control, ED Manager or House Supervisor	Hosp ED sends white copy of "Request for Info by EMS Worker" to Inf. Preventionist. Yellow copy to EMS coordinator. Inf. Preventionist oversees communication of results & related documentation has been completed per policy.

**Hospitals' Guide for Public Safety Workers' (PSW) Exposures**  
Updated 10-6-11(Data subject to change – check periodically to ensure most current)

Hospitals in **bold type** ask to be called for every patient.

	<b>PHONE</b>	<b>FAX</b>
Atrium Medical Center, Middletown	513-424-3924	513-420-5133
<b>Children's Medical Center</b>	<b>937-641-4444</b>	<b>937-641-5301</b>
Fort Hamilton	513-867-2144	513-867-2581
Franklin Emer Ctr	937-458-4728	937-458-4737
Good Samaritan Hospital <b>Maternity</b>	937-275-9722 <b>937-734-7579</b>	937-276-8217
Grandview Hospital	937-723-3419	937-461-0020
GSHN	937-540-1067	937-734-5992
Greene Memorial Hospital, Xenia	937-372-2297	937-352-3501
Huber Heights Emer Ctr	937-558-3301	937-552-3349
Jamestown (MVH)	937-374-5274	937-374-5275
Kettering Medical Center	937-395-8080	937-395-8347
Mercy Memorial Hospital, Urbana	937-484-6160	937-484-6183
<b>McCullough-Hyde Hospital, Oxford</b>	<b>513-524-5353</b>	<b>513-523-0144</b>
Miami Valley Hospital <b>Maternity</b>	937-208-2440 <b>937-208-2408</b>	937-208-2521 <b>937-208-2651</b>
Miami Valley South Health Center <b>Maternity</b>	937-438-2662 <b>937-438-5817</b>	937-438-2262
Preble Emer Ctr	937-456-8328	937-456-8377
<b>Reid Memorial Hospital, Richmond, IN</b>	<b>765-983-3161</b>	<b>765-983-3038</b>
Soin Medical Center	937-702-4525	937-702-4509
Southview Hospital <b>Maternity</b>	937-435-1832 <b>937-401-6850</b>	937-401-6158 <b>937-401-6861</b>
<b>Springfield Regional Medical Center</b>	<b>937-523-1400</b>	<b>937-523-1950</b>
Sycamore Hospital	937-384-8766	937-384-8729
Upper Valley Medical Center, Troy	937-440-4600	937-440-4346
<b>Veterans Administration Medical Center</b>	<b>937-262-2172</b>	<b>937-267-5364</b>
<b>Wayne Hospital, Greenville</b>	<b>937-547-5777</b>	<b>937-547-5790</b>
West Chester Hospital	513-298-8888	513-298-8978
Wilson Memorial Hospital, Sidney	937-498-5300	937-498-4201
<b>WPAFB Medical Center, Fairborn</b>	<b>937-257-3295</b>	<b>937-656-1673</b>

Hospitals in **bold type** ask to be called for every patient.

Region 2 EMS Providers,

This Training Manual has been produced as a result of countless hours of work by a diverse cross section of the EMS community in the Region. The members of the Standing Orders and Continuing Education Committees, and the RPAB have put countless hours into this document. The groups have responded to changes in medication availability, procedural changes and have used your input to improve these documents.

There are companion documents and additional resources that are available for you to either view online or/ download for further explanation on the Training and Testing process for 2016. The first of these is the “2016 Implementation Guide”. It addresses the new philosophy, CEUs, and other important information regarding the testing. The other is the Ohio Public Safety “Scope of Practice” document. We hope to have additional supplemental material posted on the website soon.

The Training Manuals and processes would not have been possible without the strong foundation left by the past chairpersons of the Continuing Education Committee: Anne Boyd, Steve Stein and David Gerstner. David has worked on the EMS Council for 30 continuous years. A special debt of gratitude is owed to Pat Kincer, who has not only provided invaluable feedback for the AEMT Orders, but contributed numerous hours of editing to make all four of our Standing Orders books better, more concise and eminently more readable. Thank you to all who have volunteered and critiqued these manuals.

I would like to take time for a special thank you to Bill Mangas and Terri Norris who have managed the written testing process for many years. Terri has managed the GMVEMSC website for years. She has moved on to new adventures. Best wishes!

I would also like to thank Dr. Randy Marriott and all RPAB members.

Sincerely,

Jack A. Mix  
Standing Orders Co-Chair

## 2015 AEMT STANDING ORDERS CHANGES

### Assessment & Treatment

Do not d/c a pump needle assembly or hitting suspend on the pump. Just treat the hypoglycemia.  
Under cardiac arrest changed CPR time to 1-2 minutes  
Perform manual BP on all pts presenting with S/S of shock.  
Reworded combat gauze sentences  
Cold water submersion is an acceptable method for cooling heat stroke patients. You will see this more with athletic trainers cooling athletes in bags.  
Additional APGAR Score should be done at 10 minutes postnatal.  
Asthmatic added as indication for CPAP  
Zofran added to abd. pain protocol.

### Crush Syndrome

Crush syndrome protocol added

### Drugs

Pedi dose of Midazolam modified  
Changed wording and order of Naloxone to reflect the order of use: IN, IV, IM.  
IM route of Midazolam as last resort has been deleted.  
Fentanyl dosing for Peds amended.  
Zofran added to scope of practice

### Drug Bag Exchange Program

Additional requirements for drug bag program  
Drug bags can only be exchanged between the same department, and not different departments.

### Indications/Contraindication changes:

ASA	Glucagon
Dextrose	Ipratropium
Diazepam	Lidocaine
Diphenhydramine	Midazolam
Duodotes	Nitro
Epi	

### Policies

Added Addendum H: Ambulance Restocking Policy  
Added Addendum I: Protocol Testing Compliance  
Changes in phone numbers and hospital capabilities

### Spinal Restriction

Spinal Restriction Protocol has been amended to include pediatric patients.  
Spinal Restriction Protocol age of 70 matches trauma triage age.

### Stroke

Changed wording about transporting a stroke pt flat.  
Changed wording about transport destinations for stroke pts.

### Terminology

The term Intermediate has been changed to AEMT.

## 2016 AEMT Changes

- P. 2 Deleted hospital contact bullet. Info in back of book.
- P. 2 It is recommended to use filtered needles when drawing up any medication from an ampule.
- P. 2 Any patient being monitored for a significant cardiac event or EtCO<sub>2</sub> shall remain on the monitor until patient care is transferred to hospital staff. In addition, a summary report shall be provided from any device capable of printing one.
- P. 2 Deleted list of hospitals to call for on all calls. Already listed in the back of the book.
  
- P. 4 Added statement concerning field termination: Patients in unwitnessed asystole and a capnography reading < 10 mm/Hg do not survive and should not be transported.
  
- P. 5 Changed title Spinal Immobilization Protocol to Spinal Motion Restriction. Changed immobilization to restriction as appropriate throughout the manual.
- P. 6 Reiterated Fentanyl IN can be repeated after 30 minutes with MCP
- P. 6 Under SMR, added statement about the removal of athletic equipment for the injured athlete prior to transport to any facility.
- P. 7. Added line about summary requirements for intubated patients.
- P.7 Added statement under capnography: Patients with a capnography reading < 10 mm/Hg do not survive and should not be transported.
- P. 9 Deleted under IO Insertion, and as a last resort, proximal tibial IO. Studies show that proximal tibial IO doesn't demonstrate drugs reaching their useful destinations.
- P. 12 Deleted Cardiac Arrest: {Intra-arrest Therapeutic Hypothermia}, moved to Optional Skills manual.
- P. 15 Changed Interventional Facility to Comprehensive Stroke Center 2 times on page.
- P. 15 Deleted sentence about completing stroke check list.
- P. 15 Added definitions of stroke centers.
- P. 16 Repeat vitals on trauma patients every 5 minutes.
- P. 18 Added statement about destination of pregnant trauma patients.
- P.23 Added statement about KMC has a 24/7 hyperbaric chamber
- P. 25 Under anaphylaxis, changed to if no IV, Glucagon 1 mg IM. IV is the preferred route.
- P. 25 Deleted unconscious unknown, information already covered in other sections of book
- P. 26 Added new content on Extrapyrarnidal Reactions
- P. 26 Deleted Unconscious Unknown, as the content is covered in other sections.
- P. 29 Added statement about destination of pregnant trauma patients.
- P. 29 Abdominal pain relief for Peds is a call for order.
- P. 33 Added statement concerning transport of mental health patients.
  
- P. 47 Deleted Suspected Stroke Checklist
- P. 56 Changed MCP needed for abdominal pain control for pediatrics
- P. 76 Corrected picture for nebulized medication administration.
- P. 82 Modified equipment requirements to participate in the drug bag program beginning 1 Jan 2016
  
- P. 103 Hospital Capabilities list modified
  
- Deleted ETT medication administration throughout manual
  
- Deleted IN as optional throughout manual
  
- Hospital phone numbers changed

## ADDENDUM

### **PATIENT COMPETENCY, CONSENT, PSYCHIATRIC and COMBATIVE PATIENTS**

- Our region has limited inpatient hospital beds for mental/behavioral health (MH/BH) patients. Most hospitals in our region do not have an inpatient MH/BH unit.
- In many cases resulting from a general 9-1-1 call for MH/BH issues, the patient will be treated and released, and can adequately be cared for in **any** ED. Further, all of these patients require medical screening.
- It is difficult for law enforcement or EMS to triage MH/BH patients who require inpatient treatment from those who don't.
- When patients have been seen on the same day by a MH/BH professional (e.g., Crisis Care, Eastway, etc.) who indicates to EMS that the patient will need inpatient hospitalization, the MH/BH professional should provide appropriate paperwork at the time of transport, and may indicate where the patient should be transported, with one option being the closest hospital.
- When calls are received directly from adult patients, take the patient preferentially to a facility where the individual has previously been treated and where the patient's medical records and providers are available.
- In all other cases, adult patients should be transported to the closest ED.
- **Pediatric patients (< age 16) with MH/BH issues, including those with underlying medical issues, should be transported to Dayton Children's Hospital Emergency Department.**
- Exceptions to the above:
  - It is medically necessary to transport the patient to the closest hospital for stabilization.
  - It is unsafe to transport the patient to the preferred/recommended facility due to adverse weather or ground conditions or excessive transport time.
  - Transporting the patient to the preferred/recommended facility would cause a critical shortage of local EMS resources.
  - Patient requests transport to a different facility.