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Routine Medical Care[1]

EMT-CC/P

Epinephrine, 1:1000 0.3cc SQ[2]

MEDICAL CONTROL

Consider:

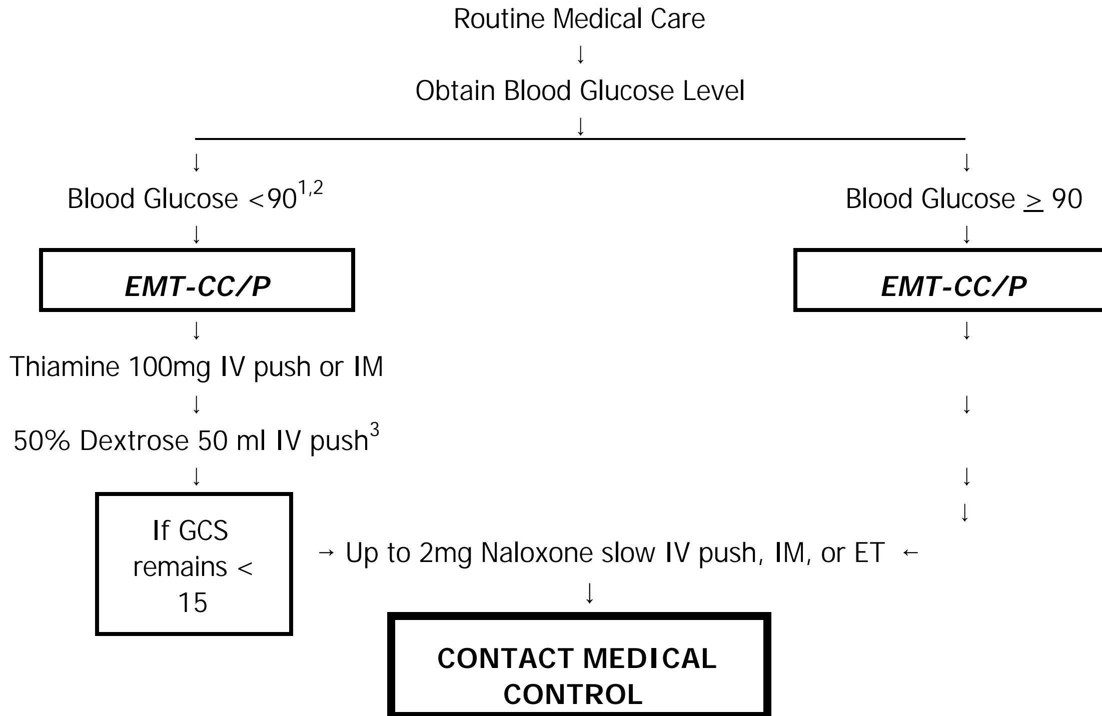
Epinephrine 1:10,000 IV Bolus
Albuterol SVN
Glucagon 1 mg IV, IM for patients on beta blockers

[1]If the patient is hypotensive, administer a rapid infusion of NS; place patient in shock position. Transport; consider MAST.

[2]***Caution:*** Epinephrine should not be given without signs as well as symptoms of anaphylaxis. **Do not rely on history alone.** Hyperventilators may think they are having an allergic reaction. If there is any question, or reactions appear mild, contact Medical Control first.

Routine Medical Care
Patient exhibits signs and symtoms of Allergic Reaction
↓
MEDICAL CONTROL
↓
Consider:
- Diphenhydramine 25-50 mg IM/IV
- Epinephrine 1:1000 0.3 cc SC
- Glucagon 1mg IV, IM for patients on beta blockers

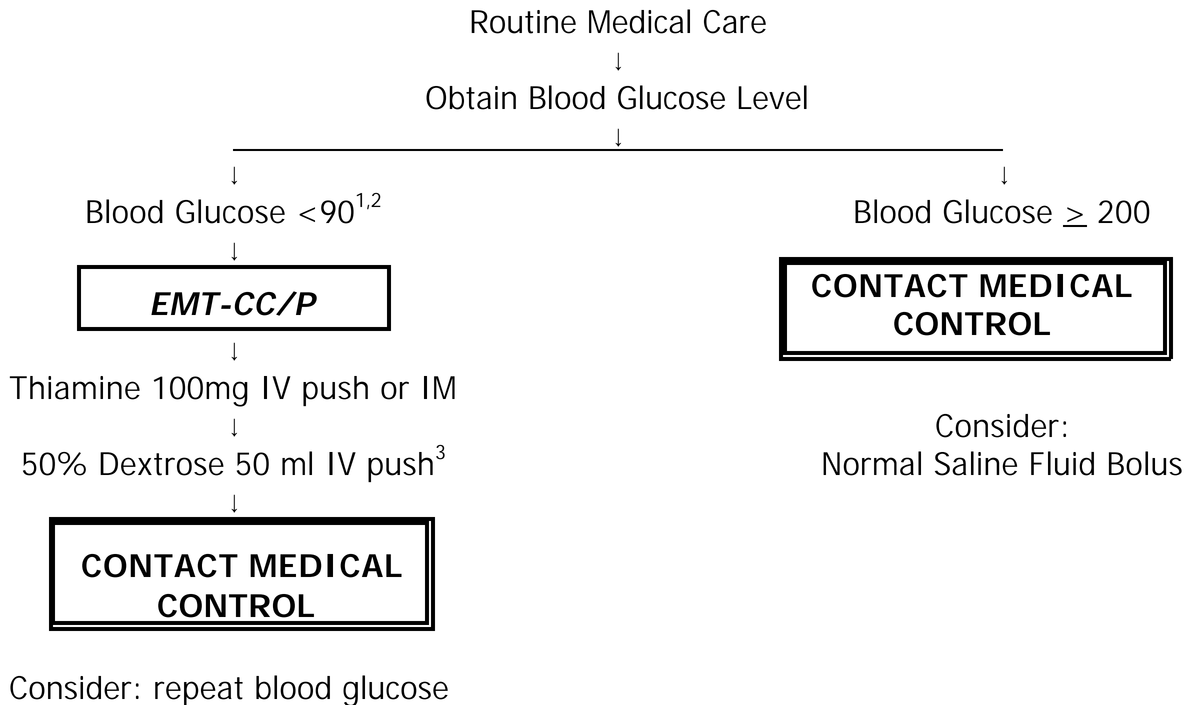
Definition: GCS <15



[1] Glucagon 1 mg IM if unable to obtain IV

[2] **Intermediate:** call Medical Control for possible fluid bolus of D5W.

[3] Blood glucose determination shall be repeated 20 minutes after 50% Dextrose administration and/or according to patient status.



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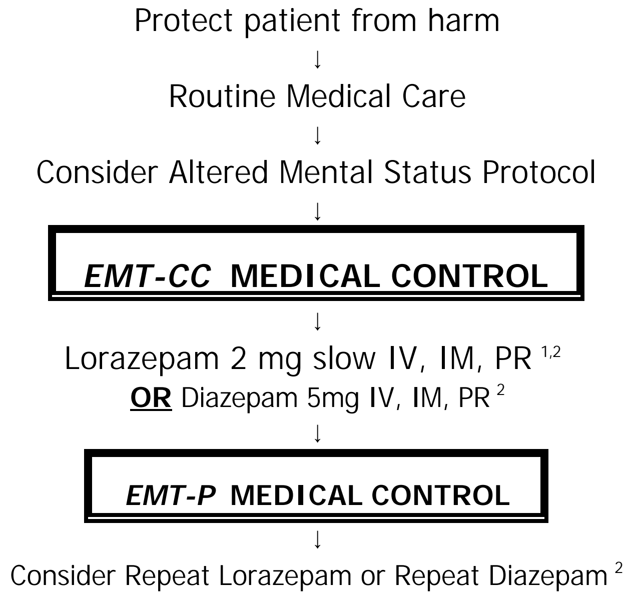


[1] IV administration of lorazepam requires 1:1 dilution with normal saline and administration over 1 minute

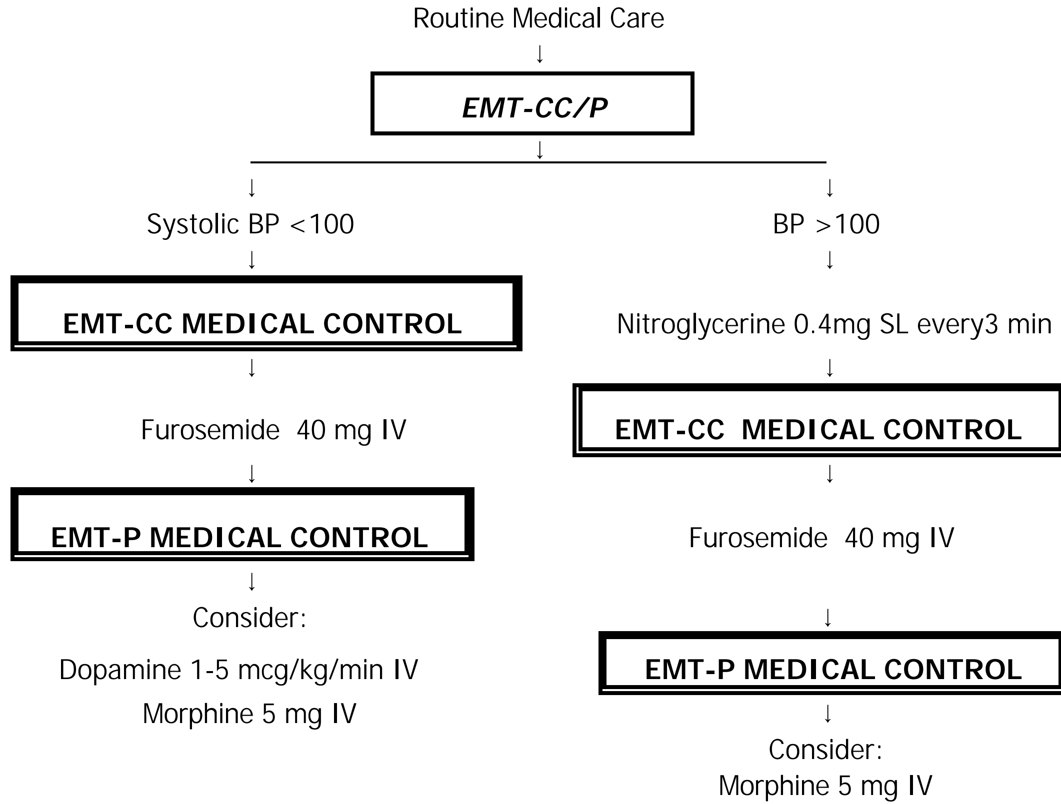
[2] Observe for respiratory depression

Routine Medical Care

Administer Albuterol 2.5 mg and Ipratropium 0.5 mg SVN

EMT-CC/P **MEDICAL CONTROL**

If asthma, consider Epinephrine 1:1,000 SC


Routine Medical Care
EMT-CC/P
Systolic BP <100
BP >100
EMT-CC MEDICAL CONTROL
Nitroglycerine 0.4mg SL every3 min
Furosemide 40 mg IV
EMT-CC MEDICAL CONTROL
EMT-P MEDICAL CONTROL
Furosemide 40 mg IV
Consider:
Dopamine 1-5 mcg/kg/min IV
Morphine 5 mg IV
EMT-P MEDICAL CONTROL
Consider:
Morphine 5 mg IV

EMT-P

↓

If tension pneumothorax exists,
perform needle thoracostomy

↓

***EMT-P* MEDICAL CONTROL**

Routine Medical Care

Initiate basic life support obstructed airway procedures
per AHA or ARC guidelines for ***two repetitions.***

Perform direct laryngoscopy if BLS steps are unsuccessful
and patient becomes unconscious.
Attempt to manually remove foreign body, using Magill forceps.

If airway remains obstructed, transport immediately,
continuing BLS obstructed airway procedures.

EMT-CC **MEDICAL CONTROL**

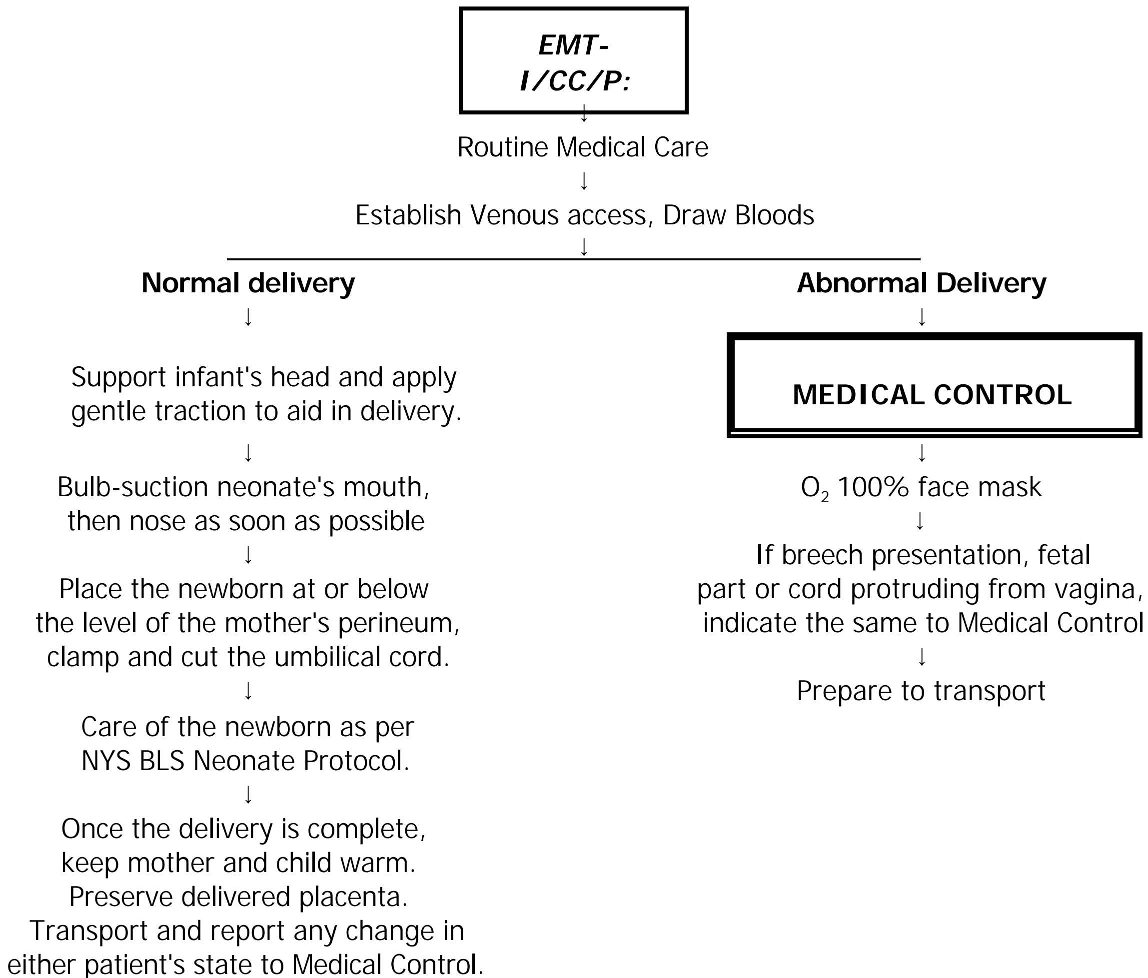
Trans-tracheal jet insufflation or
Cricothyrotomy Kit

EMT-P **MEDICAL CONTROL**

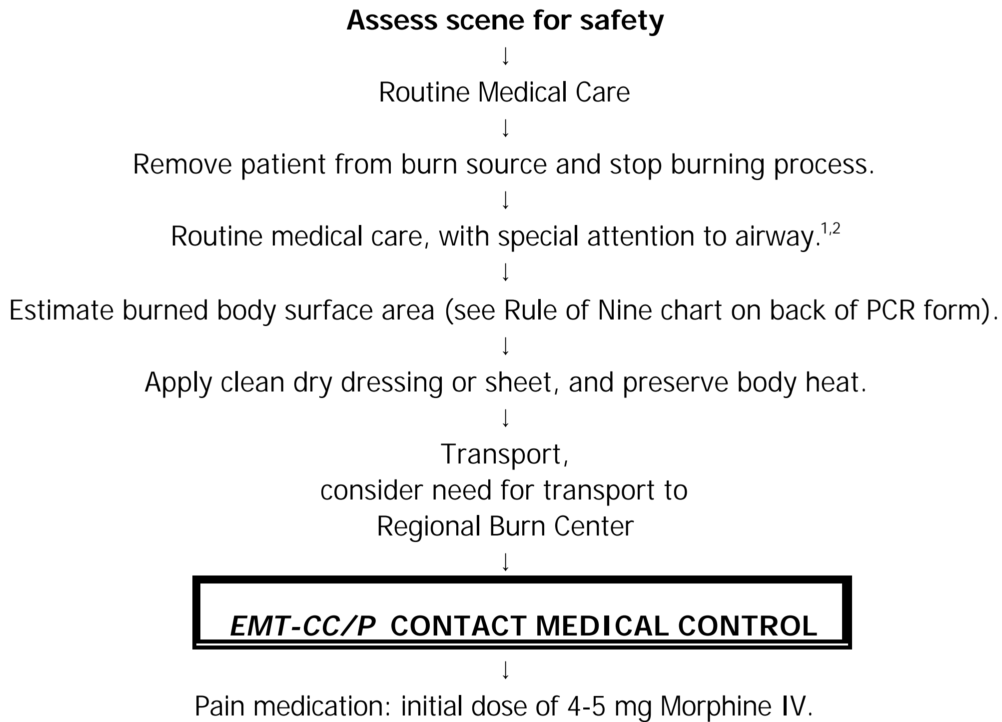
1. Obtain medical and obstetrical history, including:
   a. Number of pregnancies and number of children (*parity, gravida*)
   b. Due date (estimated date of confinement)
   c. Possibility of multiple fetuses
   d. The time of onset, frequency, and duration of contractions
   e. The presence of a vaginal discharge, bloody show, urge to move bowels, and/or rupturing of membranes.
   f. Any medication or illicit drug in past 24 hours.

2. If contractions are 3 minutes apart or less, and greater than 60 seconds duration, visualize perineum, check for crowning.

3. Options:
   a. Transport
   b. **<u>AT SITE DELIVERY:</u>**



BURNS



[1]Endotracheal intubation may be difficult due to vocal cord swelling. Do not delay transport if intubation cannot be accomplished within two attempts.

[2]If total airway occlusion occurs, follow Obstructed Airway Protocol.

All Levels

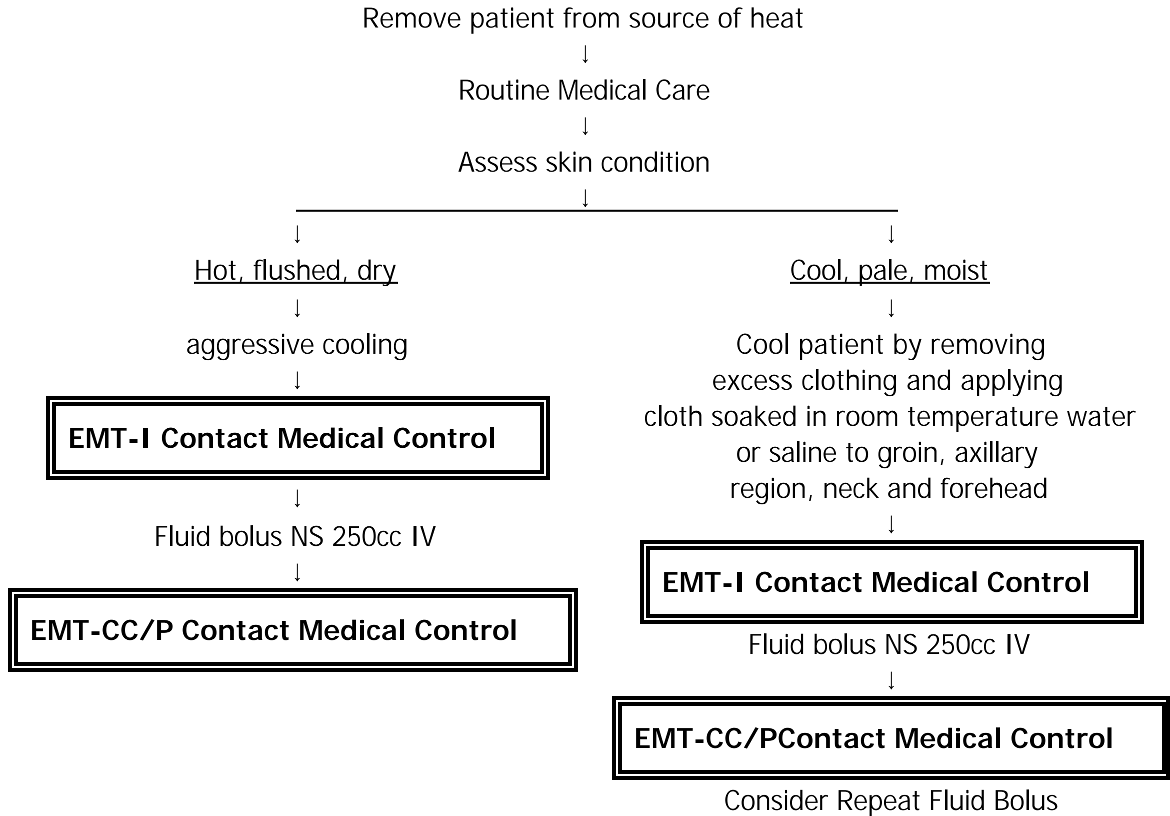
Routine Medical Care
↓
Patient conscious?
↓

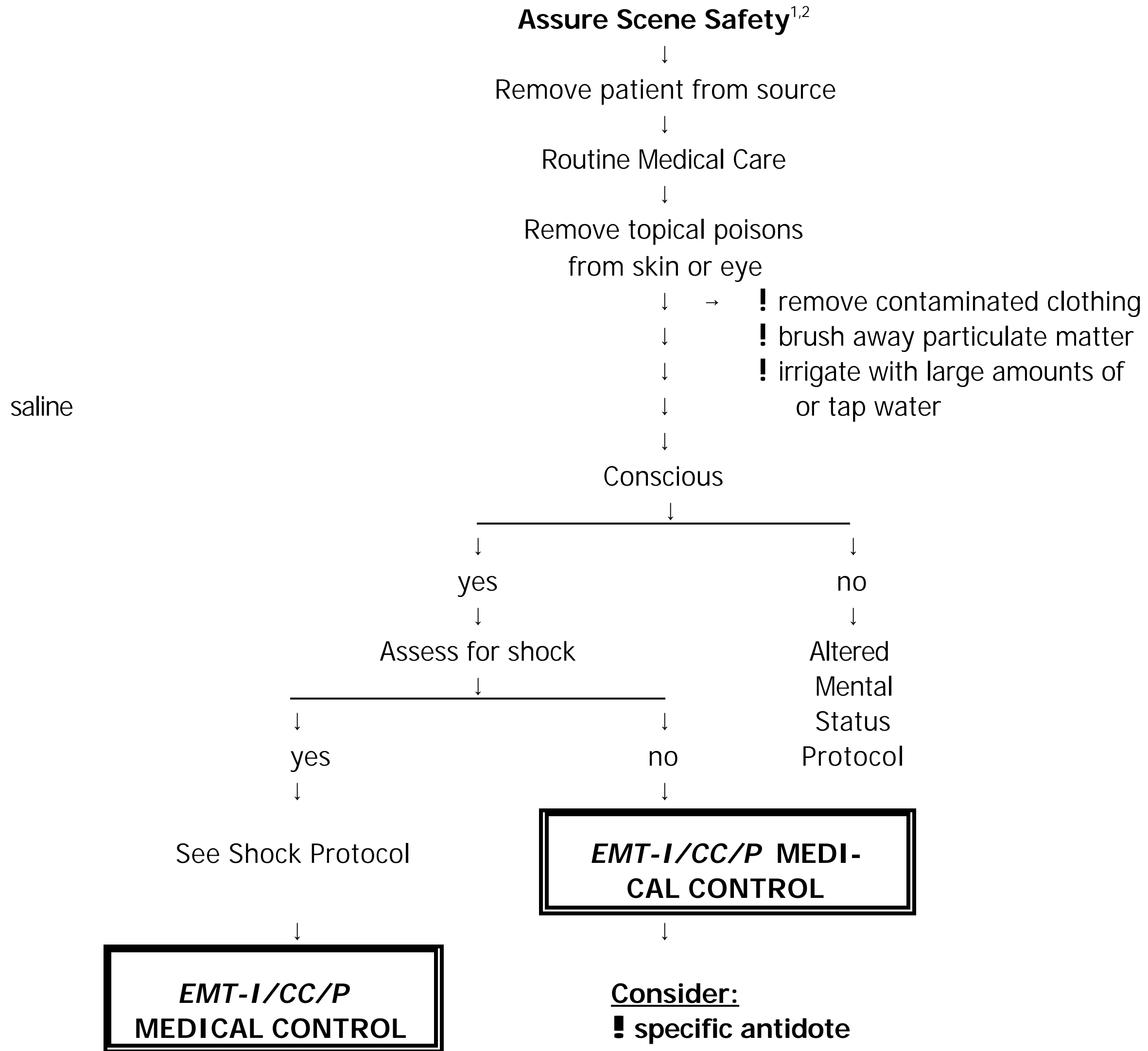
- **yes** → shivering?
  - yes → Preserve body heat → **EMT-CC/P MEDICAL CONTROL** → Transport
  - no → DO NOT REWARM PATIENT, preserve body heat → **EMT-CC/P MEDICAL CONTROL** → Transport
- **no** → shivering?
  - yes → ***EMT-CC/P*** Altered Mental Status Protocol → **EMT-CC/P MEDICAL CONTROL** → If VF persists, consider Bretylium IV; Transport
  - no → vital signs
    - yes → **EMT-CC/P MEDICAL CONTROL** → If VF persists, consider Bretylium IV; Transport
    - no → CPR → assess rhythm: if VF, shock up to 3 times[1] → **EMT-CC/P MEDICAL CONTROL** → If VF persists, consider Bretylium IV; Transport

1. Handle the hypothermic patient carefully to prevent cardiac arrest from ventricular fibrillation.
2. Assure that the patient's airway is open and that breathing and circulation are adequate.
3. Administer high concentration oxygen, heated if possible.
4. Place patient in a warm, draft-free environment.
5. Remove wet clothing gently.
6. Wrap the patient in dry blankets.

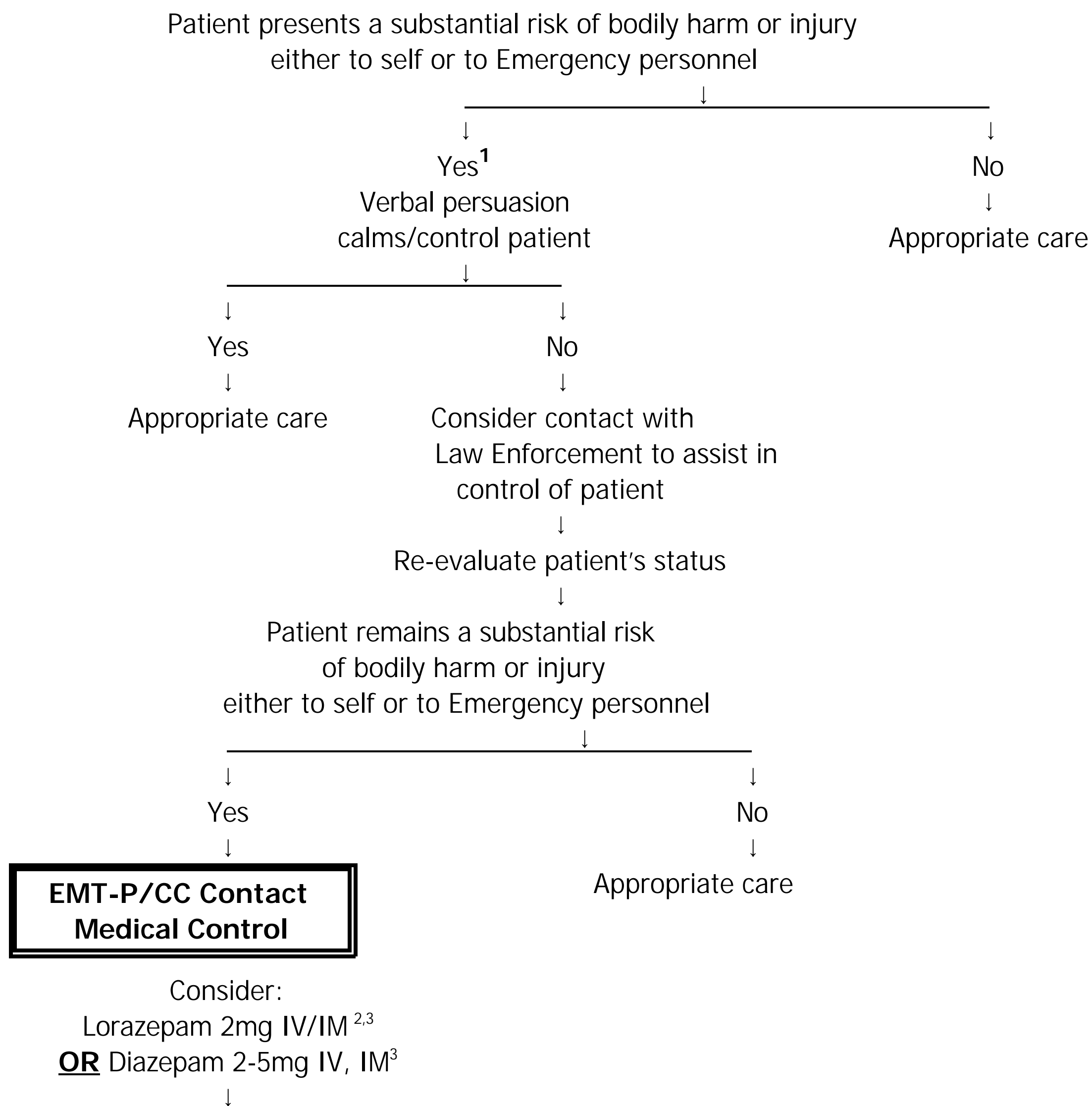
VITAL SIGNS SHOULD BE TAKEN FOR A LONGER PERIOD OF TIME THAN USUAL SO AS NOT TO MISS A VERY SLOW PULSE OR RESPIRATORY RATE. IF A PULSE OR RESPIRATIONS ARE DETECTED, *DO NOT PERFORM CPR!*

[1]**Shock up to 3 times, at 200, 300, then 360. IV meds are contraindicated at this time.**


Remove patient from source of heat
↓
Routine Medical Care
↓
Assess skin condition
↓
Hot, flushed, dry
↓
aggressive cooling
↓
EMT-I Contact Medical Control
↓
Fluid bolus NS 250cc IV
↓
EMT-CC/P Contact Medical Control
Cool, pale, moist
↓
Cool patient by removing excess clothing and applying cloth soaked in room temperature water or saline to groin, axillary region, neck and forehead
↓
EMT-I Contact Medical Control
Fluid bolus NS 250cc IV
↓
EMT-CC/PContact Medical Control
Consider Repeat Fluid Bolus



[1] **Consider Hazmat Team intervention**
[2] **Contact Poison Control**



[1] Consider Altered Mental Status Protocol

[2] IV administration of lorazepam requires 1:1 dilution with Normal Saline and administration over 1 minute

[3] Observe for respiratory depression

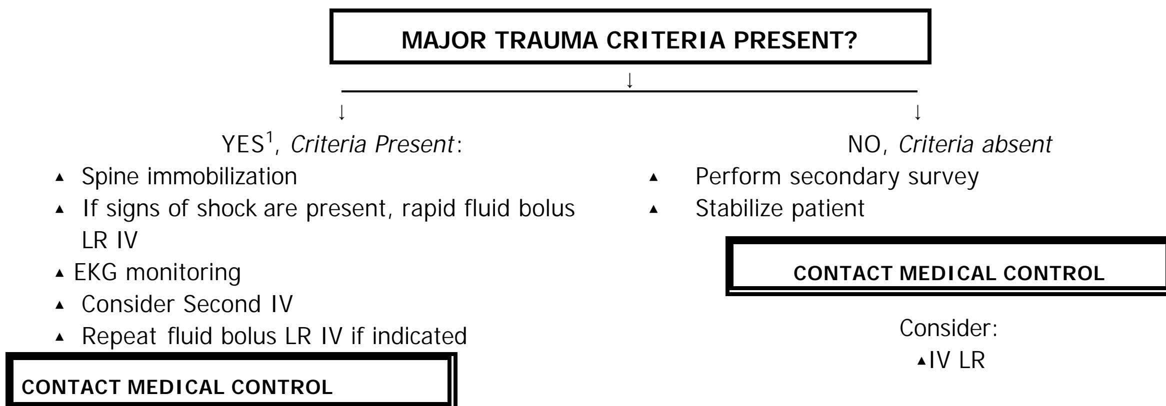
Perform the following procedures on all trauma patients:

- Airway management, ventilation assistance, oxygen[1], and IV therapy as appropriate
- Appropriate spinal precautions and control of external bleeding.
- Serial vital signs and repeated assessments enroute to hospital.
- Evaluate for major trauma criteria as follows:

MAJOR TRAUMA CRITERIA

Mechanism Of Injury	Physical Findings
• Ejection or partial ejection from an automobile • Death in same passenger compartment • Extrication time in excess of 20 minutes • Vehicle collision resulting in 12 inches of intrusion into passenger compartment • Motorcycle crash>20MPH or with separation of rider from motorcycle • Falls from greater than 20 feet • Vehicle rollover (90 degree vehicle rotation or more) with unrestrained passenger • Vehicle vs pedestrian or bicycle collision above 5 MPH	• Glasgow coma scale less than or equal to 13 • Respiratory rate <10 or >29 breaths/min • Pulse less than 50 beats/min or greater than 120 beats/min • Systolic BP is less than 90 mm Hg • Penetrating injury to head/neck/torso or proximal extremities • Two or more proximal long bone fractures • Suspected Flail Chest • Suspected Spinal cord injury or limb paralysis • Amputation (except digits) • Suspected Pelvic Fracture • Open or depressed Skull fracture

If the patient meets any one of the above major trauma criteria, OR you are ordered by Medical Control to do so, **TRANSPORT TO A TRAUMA CENTER IS REQUIRED**. If time from injury to estimated arrival at the trauma center exceeds one hour, contact Medical Control. For traumatic arrest or obstructed airways, transport immediately to nearest facility. **On-scene time should not exceed ten minutes.**



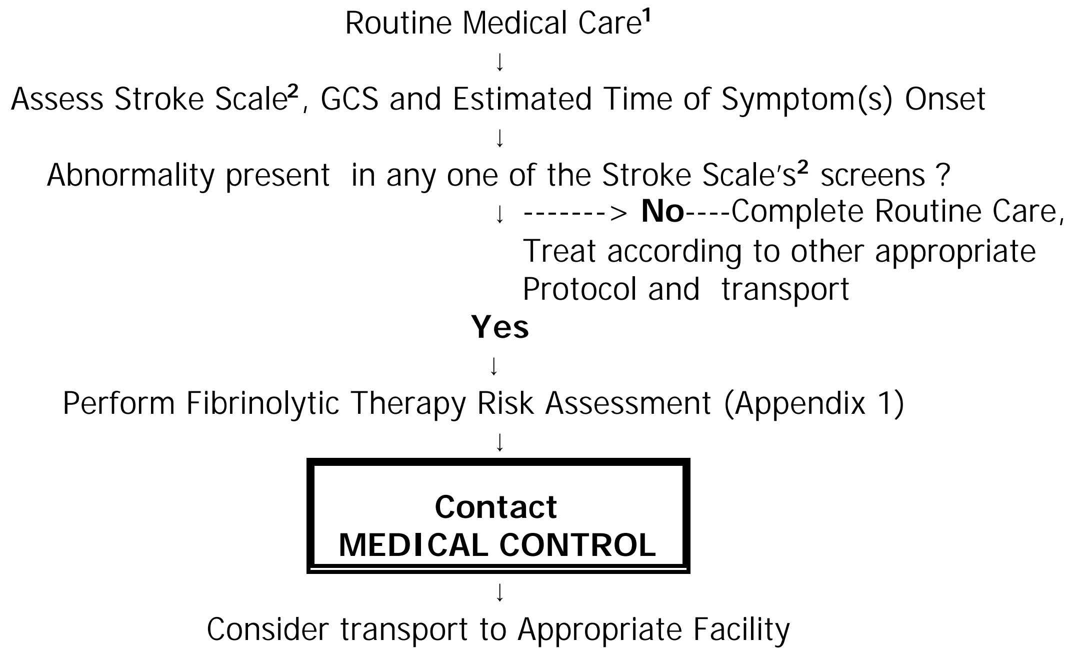
See Notes on next page.

If a patient does not have any of the Major Trauma Criteria, but has sustained an injury and has one or more of the following **High Risk** criteria, they are considered a "High Risk Patient". Consider contacting Medical Control or consider transportation to a Trauma Center

High Risk Criteria:

- Bleeding disorders or patients who are on anticoagulant medications
- Cardiac Disease and/or respiratory disease
- Insulin dependent diabetes, cirrhosis or morbid obesity
- Immunosupressed patients (HIV disease, transplant patients, and patients on chemotherapy
- Age > 55

[1] ***If head trauma is present, contact Medical Control to consider hyperventilating patient.***



[1]Do NOT delay transport to establish an IV or Obtain ECG. Perform both en route if possible.

[2]Use Cincinnati Prehospital Stroke Scale as below:

Cincinnati Prehospital Stroke Scale

Try to elicit **one** of the following signs **(abnormality in any one is strongly suggestive of stroke):**

Facial Droop (have patient show teeth or smile):

Normal:	both sides of face move equally well
Abnormal:	one side of face does not move as well as the other side

Arm Drift (have patient close eyes and hold both arms straight out for 10 seconds):

Normal:	both arms move the same or both arms do not move at all (other findings, such as pronator drift, may be helpful)
Abnormal:	one arm does not move or one arm drifts down

Abnormal Speech (have the patient say "you can't teach an old dog new tricks"):

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

FIBRINOLYTIC THERAPY RISK ASSESSMENT

Report to Medical Control **and** Confirm and document on the PCR that the patient HAS **NOT** HAD any of the following:

- ❐ Previous Hemorrhagic Stroke at any time
- ❐ Previous Stroke or Cerebrovascular event in the previous year
- ❐ Known Intracranial Neoplasm
- ❐ Active Internal Bleeding (except menses)
- ❐ Suspected Aortic Dissection

Report to Medical Control **and** Confirm and document on the PCR that the patient HAS any of the following:

- ❐ Known bleeding or clotting problem
- ❐ Has received or taken an anticoagulant recently
- ❐ Recent Trauma
- ❐ Major surgery in last three weeks
- ❐ Intracranial surgery in previous three months
- ❐ Recent Non compressible arterial puncture
- ❐ Lumbar Puncture in the previous seven days
- ❐ History of witnessed seizure, myocardial infarction, arteriovenous malformation, aneurysm, or chronic severe hypertension
- ❐ Is pregnant
- ❐ Active Peptic Ulcer Disease

Page(s)	Revision Date	STREMAC Approval	Council Approval
ALL	--	February 2004	March 2004