

Tab 900

Medical Emergency Protocols



**Lucas County Emergency Medical Services
2144 Monroe Street
Toledo, Ohio 43604**

TAB 900
MEDICAL EMERGENCY PROTOCOLS
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MEDICAL EMERGENCY PROTOCOLS
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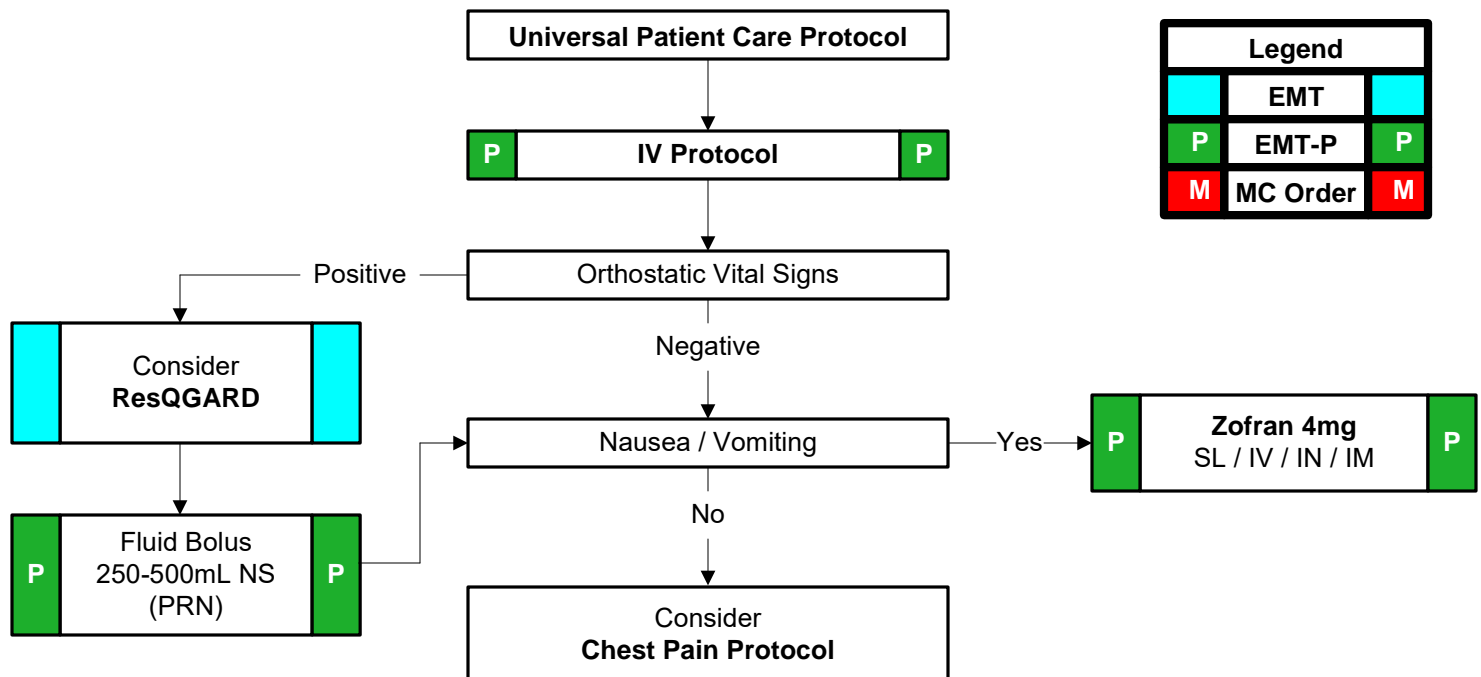
Hypo- / Hyperglycemia	BB
Sepsis / Septic Shock	CC



A Abdominal Pain



History: <ul style="list-style-type: none"> • Age • Past medical / surgical history • Medications • Onset • Palliation / Provocation • Quality (crampy, constant, sharp, dull, etc) • Region / Radiation / Referred • Severity (1-10) • Time (duration / repetition) • Fever • Last meal eaten • Last bowel movement • Menstrual history (pregnancy) 	Signs / Symptoms: <ul style="list-style-type: none"> • Pain (location / migration) • Tenderness • Nausea • Vomiting • Diarrhea • Dysuria • Constipation • Vaginal bleeding / discharge • Pregnancy Associated symptoms: (Helpful to localize source) Fever, headache, weakness, malaise, myalgias, cough, headache, mental status changes, rash	Differential: <ul style="list-style-type: none"> • Pneumonia or Pulmonary embolus • Liver (hepatitis, CHF) • Peptic ulcer disease / Gastritis • Gallbladder • Myocardial infarction • Pancreatitis • Kidney stone • Abdominal aneurysm • Appendicitis • Bladder / Prostate disorder • Pelvic (PID, Ectopic pregnancy, Ovarian cyst) • Spleen enlargement • Diverticulitis • Bowel obstruction • Gastroenteritis (infectious)
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A Abdominal Pain



Special Considerations:

1. The differential (causes) of abdominal pain is numerous, with origin rarely identified in a field setting. Assessment should be centered upon gathering as much information as possible related to the complaint of “abdominal pain.”
2. Pain medication is seldom indicated and may change details of the physical exam necessary for physician diagnosis. Any administered pain medication for abdominal complaints must be authorized by ***On-Line Medical Control***.
3. Consider internal hemorrhage with an associated shock presentation. For blood pressure < 90mmHg, consider initial fluid bolus of 250-500mL NS (repeat PRN for perfusing BP). Elderly patients may have significant hypovolemic shock with blood pressures above 90mmHg.
4. Abdominal pain in women of childbearing age should be treated as an ectopic pregnancy until proven otherwise.
5. The diagnosis of abdominal aneurysm should be considered with abdominal pain in patients over 50.
6. Appendicitis presents with vague, peri-umbilical pain which migrates to the RLQ over time.
7. For severe nausea and/or vomiting administer Zofran 4mg SL / IV / IN / IM. Zofran may be repeated x 1 in 5-10 minutes PRN.

B Airway, Adult



Legend		
	EMT	
P	EMT-P	P
M	MC Order	M

Assess ABC's, respiratory rate, effort, adequacy

Pulse Oximetry

Adequate

Supplemental Oxygen

Inadequate

Basic Maneuvers first -
Open airway;
Nasal / oral airway;
Bag -valve-mask

Assess
Pulse Oximetry
and
Ventilatory Status

Obstruction

Obstructed airway per
AHA Guidelines

Ventilate at < 12bpm
Apply EtCO2

Successful

Combative;
Concern for loss
of airway

Advanced Airway Secured

Fentanyl 50mcg IV/IO
-or- **Versed** 2mg IV/IO

Etomidate 20mg
IV/IO

Vecuronium
0.1mg/Kg IV/IO
(Max. 10mg)

Endotracheal
Intubation or SGA

Up to 3
attempts

Unsuccessful

Modify Technique
and/or
utilize ETTI(Flex-Guide)

Direct
Laryngoscopy



B Airway, Adult



Special Considerations:

1. For this protocol, the adult patient is defined as ≥ 16 years of age.
2. Capnometry/capnography is mandatory with all methods of intubation.
3. Limit intubation attempts to 3 per patient. A single attempt is defined as introduction of the laryngoscope blade into the patient's mouth regardless of attempt to pass ET tube.
4. Maintain C-spine immobilization for patients with suspected head/spinal injury.
5. Sellick's maneuver or the BURP maneuver may be used to assist with difficult intubations.
6. Consider the use of the Flex Guide Endotracheal Tube Introducer (gum-elastic bougie) to facilitate endotracheal intubation on difficult airways.
7. Paramedics should consider using an I-Gel Airway when they are unable to intubate a patient.
8. Continuous EtCO₂ and pulse oximetry monitoring is required on all intubated patients.
9. Consider C-collar/CID to maintain ETT placement for all intubated patients.
10. Surgical cricothyrotomy **is only to be considered** for a complete airway obstruction with no other means for patient ventilation.

B Airway, Adult



Special Considerations (cont.),

11. For combative patients following intubation, and a concern for loss of advanced airway, administer 50mcg Fentanyl IV/IO (in the absence of Fentanyl, administer 2mg Versed IV/IO), 20mg Etomidate IV/IO and Vecuronium (Norcuron) 0.1mg/Kg IV/IO (max. 10 mg). Maintain a blood pressure > 100mmHg. **NOTE: An advanced airway MUST be secured in place before administration of sedative or paralytic agents.** Repeat dosing of sedative or paralytic agents, if necessary during on-going care, may be administered through **On-Line Medical Control** order.

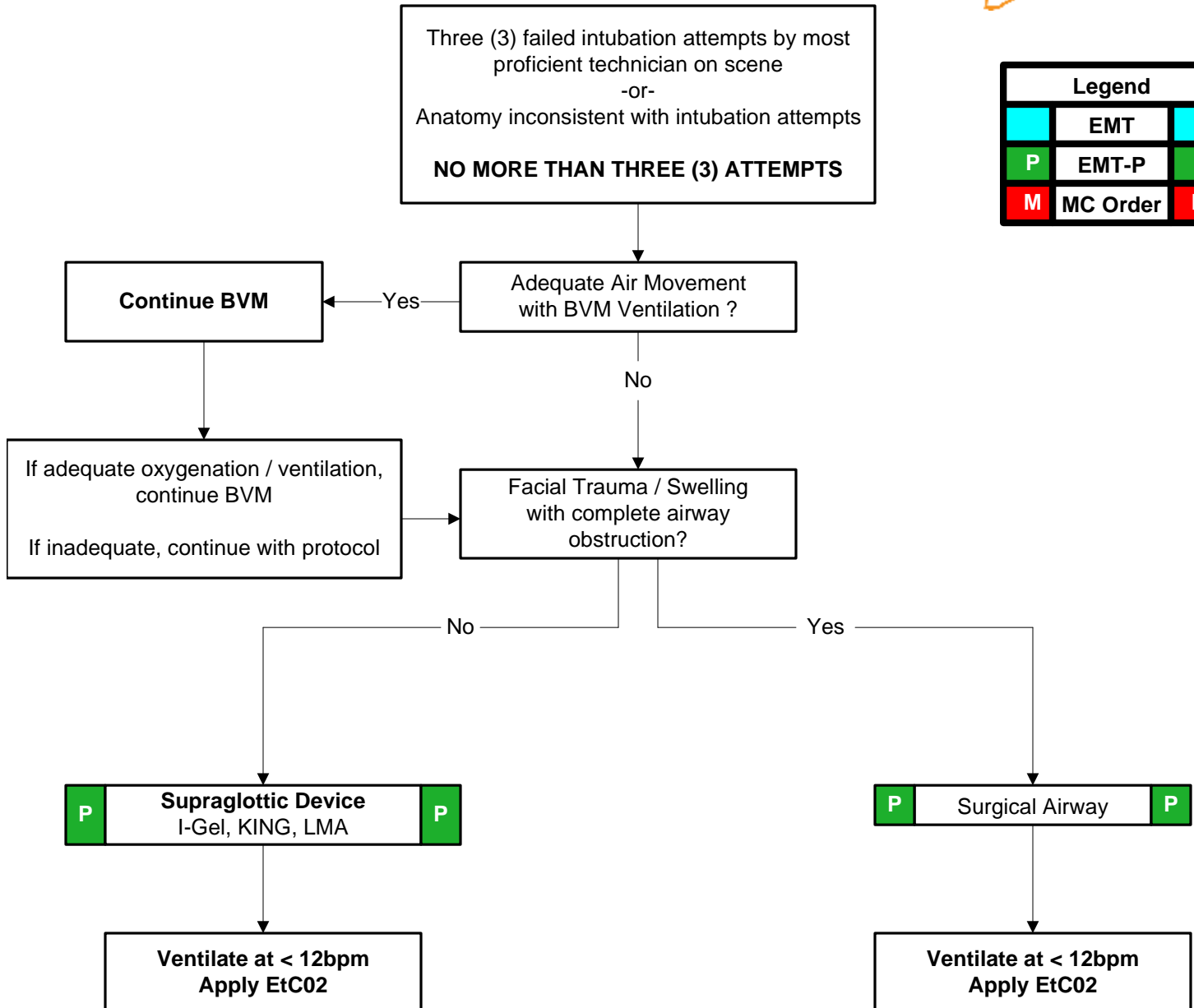
NOTE: The following guidelines must be followed for sedative and paralytic administration following advanced airway placement:

- a. Advanced airway: ETT, I-Gel, KING, LMA
- b. Frequent assessment of advanced airway confirming proper placement:
 - § Direct visualization (if required)
 - § Tube depth
 - § Lack of epigastric sounds
 - § Breath sounds for proper tube placement
 - § Chest expansion
 - § Bag-Valve compliance
 - § End-Tidal CO₂ values
 - § Patient status (sedation vs. tube removal)
 - § Tube secured adequately
 - § Patient secured (C-Collar/CID when appropriate)
- c. Continuous pulse oximetry monitoring
- d. Continuous end-tidal CO₂ monitoring (confirmed capnographic waveform)
- e. Frequent assessment of blood pressure. Maintain SBP > 100mmHg.

C Airway, Adult - Failed



Legend		
	EMT	
P	EMT-P	P
M	MC Order	M





C Airway, Adult - Failed



Special Considerations:

1. For this protocol, the adult patient is defined as ≥ 16 years of age.
2. If first intubation attempt fails, make adjustments and try again:
 - a. Different laryngoscope blade
 - b. Different ETT size
 - c. Change cricoid pressure
 - d. Change head positioning
 - e. Apply **BURP** maneuver (**B**ackward, **U**pward, **R**ight, **P**ressure): push trachea back [posterior], Up, and to the patient's right).
3. Continuous pulse oximetry should be utilized in all patients with inadequate respiratory function.
4. Notify **On-Line Medical Control** as early as possible concerning difficult / failed airway maneuvers.
5. Limit intubation attempts to 3 per patient. A single attempt is defined as introduction of the laryngoscope blade into the patient's mouth regardless of attempt to pass ET tube.
6. Maintain C-spine immobilization for patients with suspected head/spinal injury.
7. Paramedics should consider using an I-Gel / KING airway when they are unable to intubate a patient.
8. Consider the use of the Flex Guide Endotracheal Tube Introducer (gum-elastic bougie) to facilitate endotracheal intubation on difficult airways.
9. Consider C-collar/CID to maintain ETT placement for all intubated patients.
10. Surgical cricothyrotomy **is only to be considered** for a complete airway obstruction with no other means for patient ventilation.

Special Considerations (cont.),

11. For combative patients following intubation, and a concern for loss of advanced airway, administer 50mcg Fentanyl IV/IO (in the absence of Fentanyl, administer 2mg Versed IV/IO), 20mg Etomidate IV/IO and Vecuronium (Norcuron) 0.1mg/Kg IV/IO (max. 10 mg). Maintain a blood pressure > 100mmHg. **NOTE: An advanced airway MUST be secured in place before administration of sedative or paralytic agents.** Repeat dosing of sedative or paralytic agents, if necessary during on-going care, may be administered through **On-Line Medical Control** order.

NOTE: The following guidelines must be followed for Versed administration following advanced airway placement:

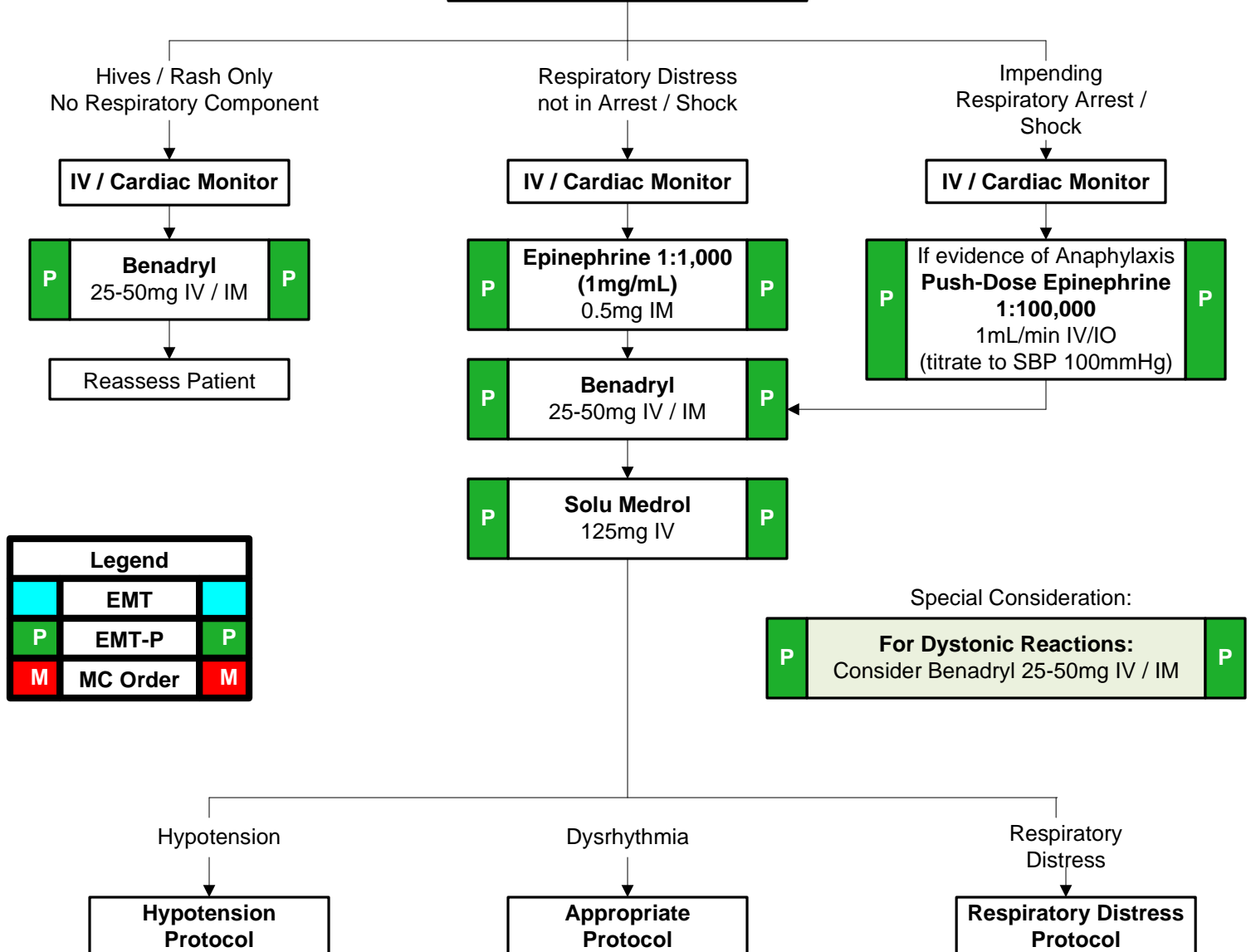
- a. Advanced airway: ETT, KING, LMA
- b. Frequent assessment of advanced airway confirming proper placement:
 - § Direct visualization (if required)
 - § Tube depth
 - § Lack of epigastric sounds
 - § Breath sounds for proper tube placement
 - § Chest expansion
 - § Bag-Valve compliance
 - § End-Tidal C02 values
 - § Patient status (sedation vs. tube removal)
 - § Tube secured adequately
 - § Patient secured (C-Collar/CID when appropriate)
- c. Continuous pulse oximetry monitoring
- d. Continuous end-tidal C02 monitoring (confirmed capnographic waveform)
- e. Frequent assessment of blood pressure. Maintain SBP > 100mmHg.

D Allergic Reaction



History: <ul style="list-style-type: none"> Onset and location Insect sting or bite Food allergy / exposure Medication allergy / exposure New clothing, soap, detergent Past history of reactions Past medical history Medication history 	Signs / Symptoms: <ul style="list-style-type: none"> Itching or hives Coughing / wheezing or respiratory distress Chest or throat constriction Difficulty swallowing Hypotension or shock Edema 	Differential: <ul style="list-style-type: none"> Urticaria (rash only) Anaphylaxis (systemic effect) Shock (vascular effect) Angioedema (drug induced) Aspiration / Airway obstruction Vasovagal event Asthma or COPD CHF Dystonia
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Universal Patient Care Protocol



D Allergic Reaction



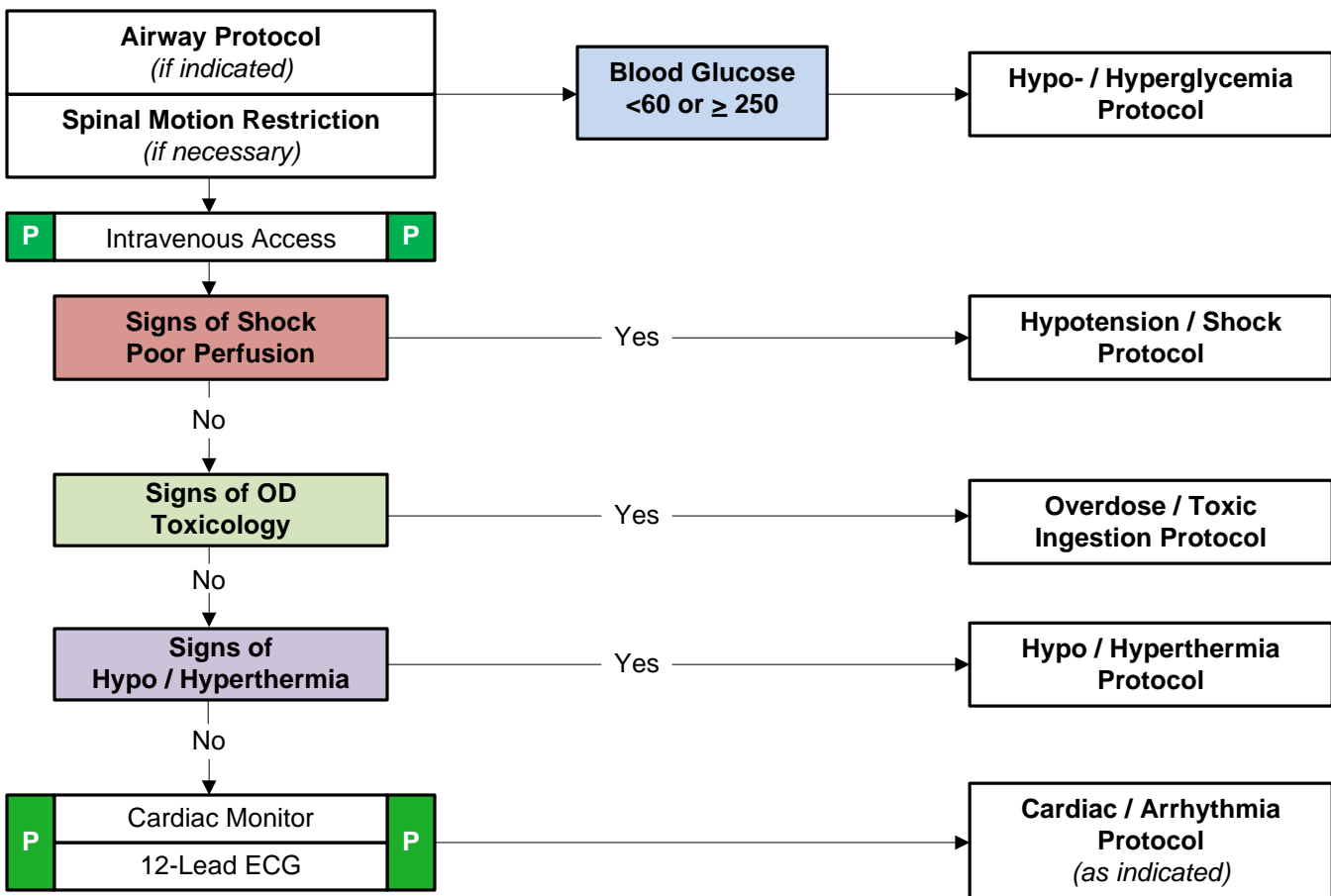
Special Considerations:

1. Patients with allergic reactions can deteriorate quickly. The shorter the onset from symptoms to contact, the more severe the reaction. Maintenance of the patient's airway is of prime importance.
2. Any patient with respiratory symptoms or extensive reaction should receive IV or IM Benadryl.
3. Type I allergic reactions (Anaphylaxis) may cause angioedema to the face and airway. Lethal edema may be localized to the tongue, uvula or other upper airway structures. Be prepared to intubate early before swelling causes a total occlusion of the airway.
4. For severe allergic reactions resulting in loss of a radial pulse or SBP of < 90mm Hg:
 - **Push-Dose Pressor Epinephrine (1:100,000)**
 - Ø Dilute: Discard 9mL of Epi 1:10,000 (0.1mg/mL) and draw up 9mL of normal saline to create Push-Dose Pressor Epi 1:100,000. This will yield 10mcg/mL.
 - § Administer 1mL/minute IV/IO, titrate to maintain SBP 100mmHg.
 - § May repeat X 2 prn by standing order (protocol)
 - § Max total dose 300mcg (30mL)
 - Ø Push-Dose Pressor Epinephrine Precautions:
 - § Rapid (1 minute) onset, short (5-10) minute duration
 - § Monitor heart rate and blood pressure throughout administration
5. **Dystonic** reactions are involuntary, unpleasant motor movements of the trunk, limbs or face following the administration of antipsychotic medications. Dystonic reactions are distressing to the patient, but rarely life threatening. Patients may have had similar symptoms previously. Acute dystonic reactions may be mistaken for anaphylaxis or seizures. Dystonic reactions may last several hours or days. Patient will present awake and conscious, with extrapyramidal symptoms, usually distraught or anxious. Extrapyramidal symptoms often consist of small spasmodic movements or tics of the arms, legs, face or neck muscles with lip smacking, grimacing, tongue protrusion, eye movements or neck twisting. Administer 25 – 50mg Benadryl IV / IM for resolve of dystonia-related extrapyramidal symptoms.

E Altered Mental Status



History: <ul style="list-style-type: none"> Known diabetic, medic alert tag Drugs, drug paraphernalia Report of illicit drug use or toxic ingestion Past medical history Medications History of trauma Change in condition 	Signs / Symptoms: <ul style="list-style-type: none"> Decreased mental status Change in baseline mental status Bizarre behavior Hypoglycemia (cool, diaphoretic skin) Hyperglycemia (warm, dry skin; fruity breath; Kussmaul respirations; signs of dehydration) 	Differential : <ul style="list-style-type: none"> Head trauma CNS (stroke, tumor, seizure, infection) Cardiac (MI, CHF) Infection Thyroid (hyper / hypo) Shock (septic, metabolic, traumatic) Diabetes (hyper / hypoglycemia) Toxicologic Acidosis / Alkalosis Environmental exposure Pulmonary (hypoxia) Electrolyte abnormality Psychiatric disorder
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E Altered Mental Status



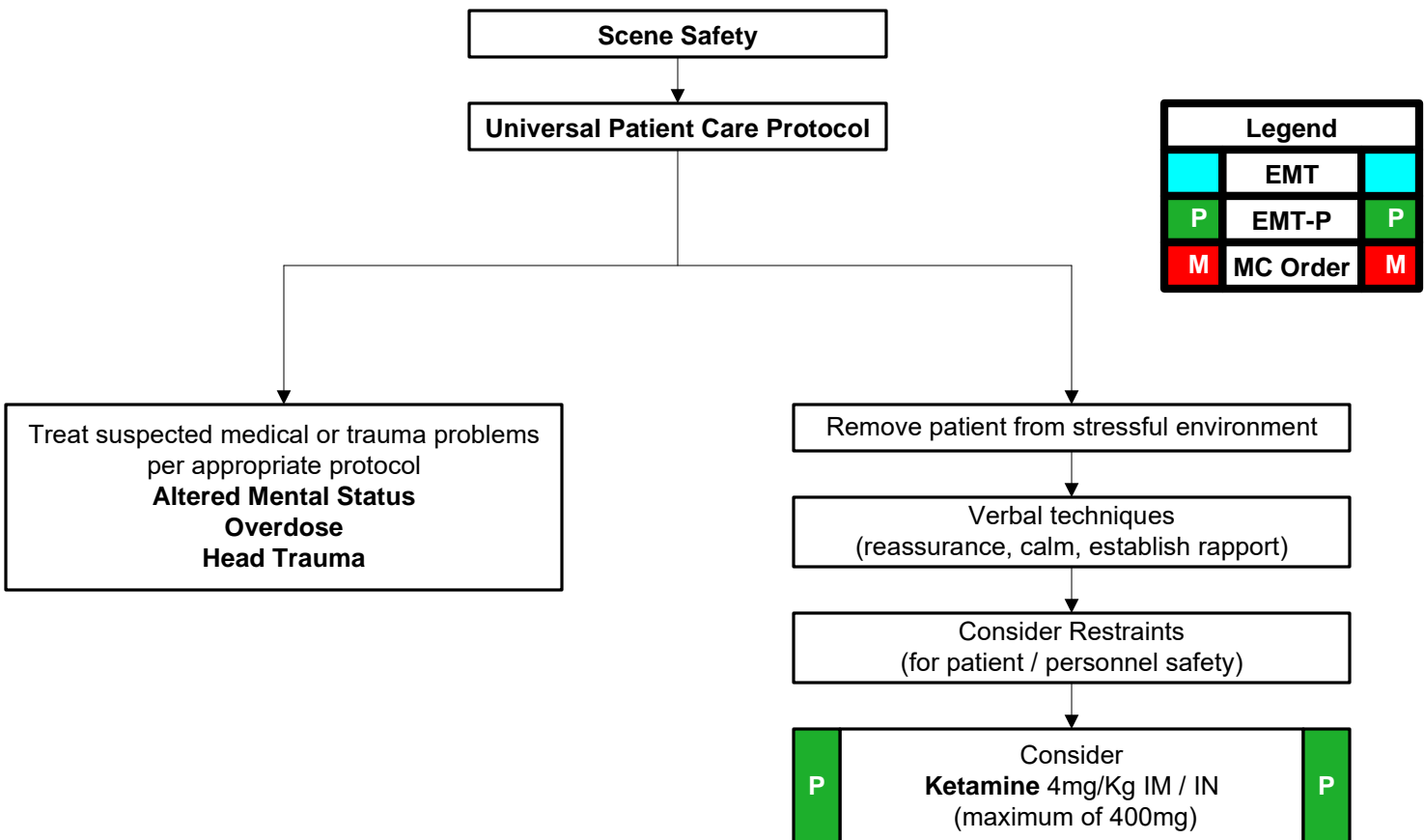
Special Considerations:

1. There are many organic causes for altered mental states. Consider:
 - a. Hypoxia
 - b. Hypoglycemia
 - c. Head Injury
 - d. Hyperthermia
 - e. Postictal states
 - f. Drug overdose / Exposure
 - g. Toxic exposure
 - h. Hypothermia
2. Be aware of altered mental status as a presenting sign of an environmental toxin or Haz-Mat exposure and protect personal safety.
3. Oral glucose should not be given to patients who cannot protect their own airway.
4. Thiamine 100mg IV should be considered prior to Dextrose administration in patients with possible alcoholism or signs of malnutrition.
5. It is safer to assume hypoglycemia than hyperglycemia if doubt exists. Recheck blood glucose after therapy with IV Dextrose or IN / IM Glucagon.
6. Consider alcohol, prescription drugs, illicit drugs and over-the-counter preparations as a potential etiology.
7. For patients with altered mentation and combative / aggressive behavior, consider restraints for patient's and/or personnel's protection.
8. ***On-Line Medical Control*** contact is **required** for refusal of treatment and/or transport with appropriate signatures obtained on the ePCR.
9. The ***Airway Protocol*** should be considered for all patients unable to protect their own airway (i.e., semi-conscious, unconscious).

F Behavioral / Agitated Delirium



History: <ul style="list-style-type: none"> Situational crisis Psychiatric illness / medications Injury to self or threats to others Medic alert tag Substance abuse / overdose Diabetes 	Signs / Symptoms: <ul style="list-style-type: none"> Anxiety, agitation, confusion Affect change, hallucinations Delusional thoughts, bizarre behavior Combative, violent Expression of suicidal / homicidal thoughts 	Differential: <ul style="list-style-type: none"> See Altered Mental Status differential Hypoxia Alcohol intoxication Medication effect / overdose Withdrawal syndromes Depression Bipolar (manic-depressive) Schizophrenia, anxiety disorders, etc.
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F Behavioral / Agitated Delirium



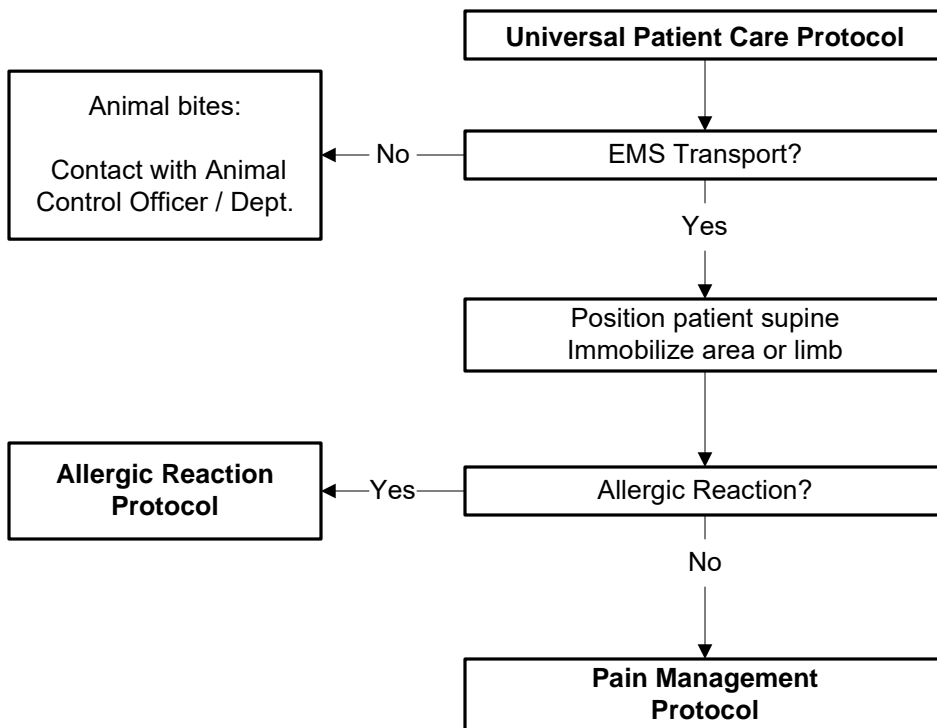
Special Considerations:

1. Consider all possible medical/trauma causes for behavioral change (i.e., hypoglycemia, overdose, substance abuse, hypoxia, head injury, etc.)
2. Do not overlook the possibility of associated domestic violence or abuse.
3. Psychiatric patients must be managed with concern. Don't succumb to the temptation to ignore new complaints which may be an indicator of acute change.
4. Maintain objectivity during evaluation and treatment. Verbal aggression exhibited by patients can quickly escalate to physical violence. Always proceed with calm, reassuring directions for the patient. If a situation appears threatening, sufficient law enforcement presence may be necessary before patient restraint is attempted.
5. Consider your own safety and limitations when physical restraint is required. Engage law enforcement to assist with physical restraint when necessary.
6. Restrained patients should never be left unattended. Continue to evaluate effectiveness of restraints and any compromise that may be caused by the restraint process (i.e., airway, breathing, circulation).
7. In rare circumstances it may be necessary to chemically restrain a patient with a history of acute psychosis and the presentation of Agitated Delirium. **Administer Ketamine 4mg/Kg IM or IN (Maximum dosage 400mg).** Consider titrating dose in intervals due to volume and regard for site (IN or IM) used to administer medication.

G Bites and Envenomations



History: <ul style="list-style-type: none"> Type of bite / sting Description / photo with patient identification of animal involved Time, location, size of bite / sting Previous reaction to bite / sting Domestic vs. Wild Tetanus and Rabies risk Immunocompromised patient 	Signs / Symptoms: <ul style="list-style-type: none"> Rash, skin break, wound Pain, soft tissue swelling, redness Blood oozing from the bite wound Evidence of infection Shortness of breath, wheezing Allergic reaction, hives, itching Hypotension or shock 	Differential: <ul style="list-style-type: none"> Animal bite Human bite Snake bite (poisonous) Spider bite (poisonous) Insect sting / bite (bee, wasp, ant, tick) Infection risk Rabies risk Tetanus risk
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Legend		
	EMT	
P	EMT-P	P
M	MC Order	M



G Bites and Envenomations



Special Considerations:

1. Human bites are much worse than animal bites due to normal mouth bacteria.
2. Carnivore bites are much more likely to become infected and all have risk of Rabies exposure.
3. Cat bites may progress to infection rapidly due to specific bacteria (*Pasteurella multocoda*).
4. Poisonous snake bites in this area are a rare occurrence.
 - a. Amount of envenomation is variable, generally worse with larger snakes and early in spring.
 - b. If no pain or swelling, envenomation is unlikely.
 - c. It is not necessary to take the snake to the ED with the patient.
 - d. The Toledo Zoo may be a contact point through LCEMS dispatch for rare or exotic animal envenomations requiring treatment.
5. Black Widow spider bites tend to be minimally painful, but over a few hours, muscular pain and severe abdominal pain may develop (spider is black with red hourglass on belly).
6. Brown Recluse spider bites are minimally painful to painless. Little reaction is noted initially but tissue necrosis at the site of the bite develops over the next few days (brown spider with fiddle shape on back).
7. Evidence of infection: swelling, redness, drainage, fever, red streaks proximal to wound.
8. Immunocompromised patients are at an increased risk for infection: diabetes, chemotherapy, transplant patients.

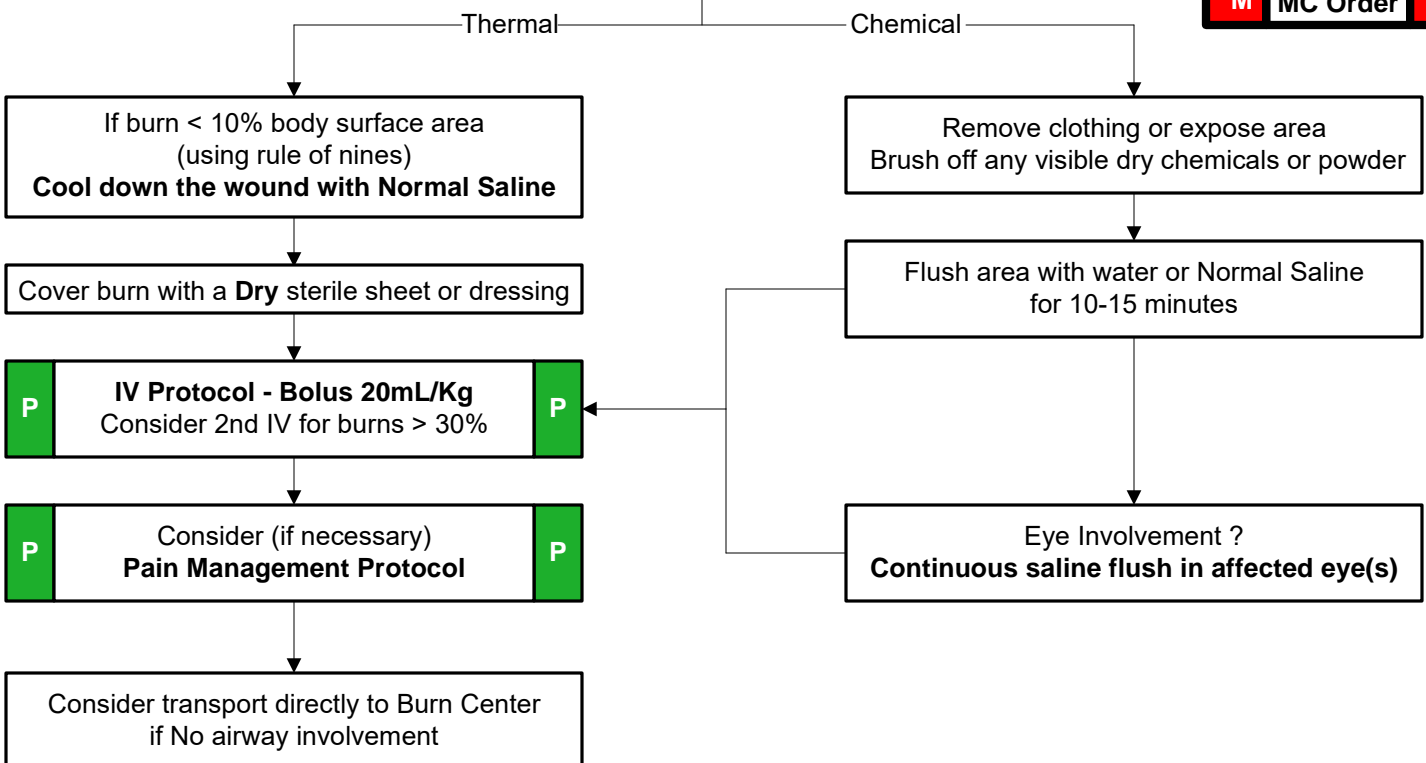


History: <ul style="list-style-type: none"> Type of exposure (heat, gas, chemical) Inhalation injury Time of injury Past medical history Medications Other trauma Loss of consciousness Tetanus/Immunization status 	Signs / Symptoms: <ul style="list-style-type: none"> Burns, pain, swelling Dizziness Loss of consciousness Hypotension / shock Airway compromise / distress Singed facial or nasal hair Hoarseness / wheezing 	Differential: <ul style="list-style-type: none"> Superficial (1st degree) Partial thickness (2nd degree) Full thickness (3rd degree) Chemical Thermal Electrical Radiation
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Universal Patient Care Protocol

Remove rings, bracelets, and other constricting items

Legend		
	EMT	
P	EMT-P	P
M	MC Order	M



H Burns



Special Considerations:

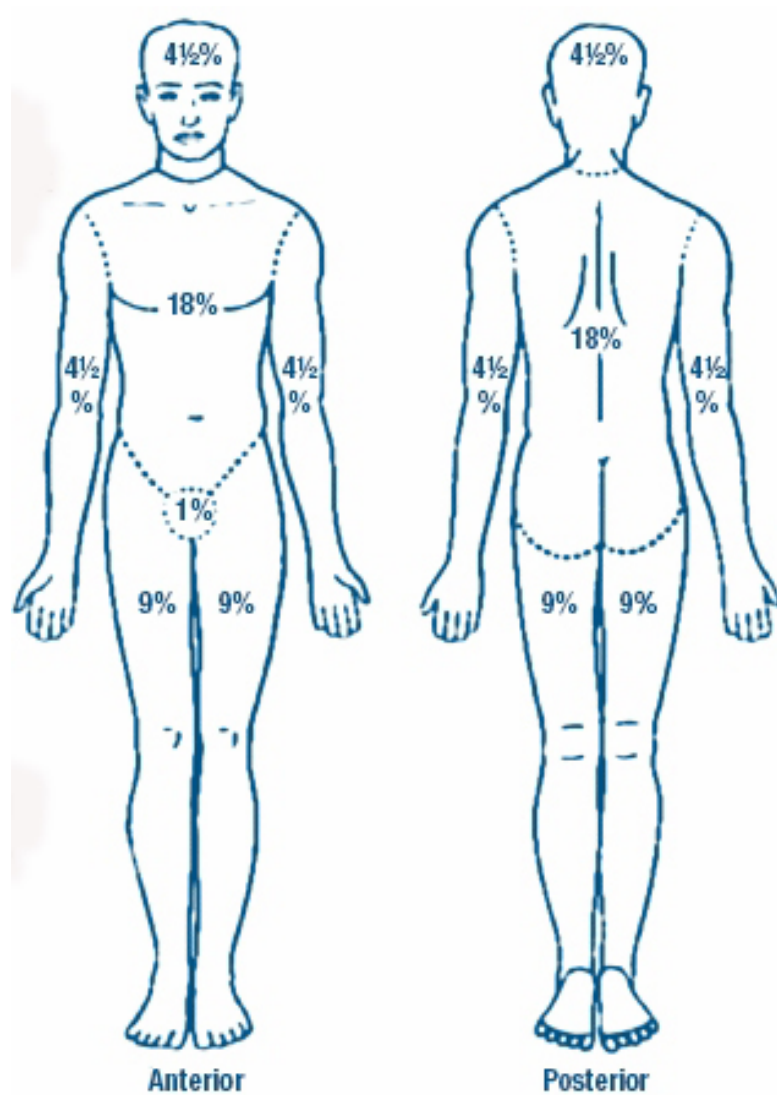
1. Do not overlook the possibility of multiple system trauma.
2. Burn patients are prone to hypothermia. Never apply ice or cool burns that involve > 10% body surface area.
3. Circumferential burns to extremities are dangerous due to potential vascular compromise secondary to soft tissue swelling.
4. Consider potential CO poisoning. Treat with 100% oxygen by mask.
5. Early intubation may be required with significant inhalation injuries.
6. If airway involvement, consider transport to the closest hospital for optimal airway management.
7. **Critical Burns** (Transfer to recognized Burn Center):
 - a. > 20% body surface area (BSA) age > 10.
 - b. > 10% BSA age < 10.
 - c. 3rd degree burns > 5% BSA
 - d. 2nd and 3rd degree burns to face, eyes, hands or feet.
 - e. Electrical burns
 - f. Respiratory burns
 - g. Deep chemical burns
 - h. Burns with extremes of age or chronic disease
 - i. Burns associated with major traumatic injury.
8. For moderate to severe discomfort/pain, consider administration of parenteral analgesics as outlined in **Tab 900 Section T: Pain Management**.

H Burns



Special Considerations (cont.),

“Rule of Nines” (Adult Scale)

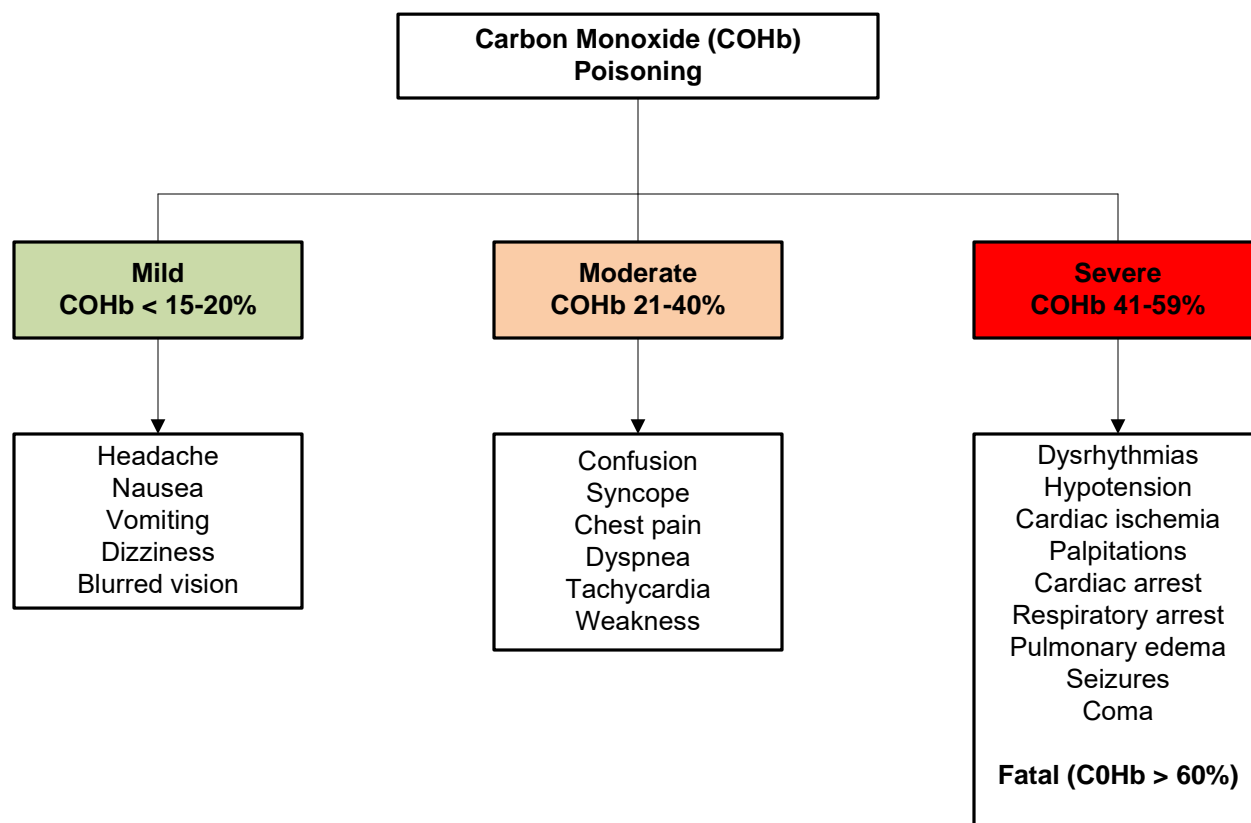


I

Carbon Monoxide Poisoning / Monitoring



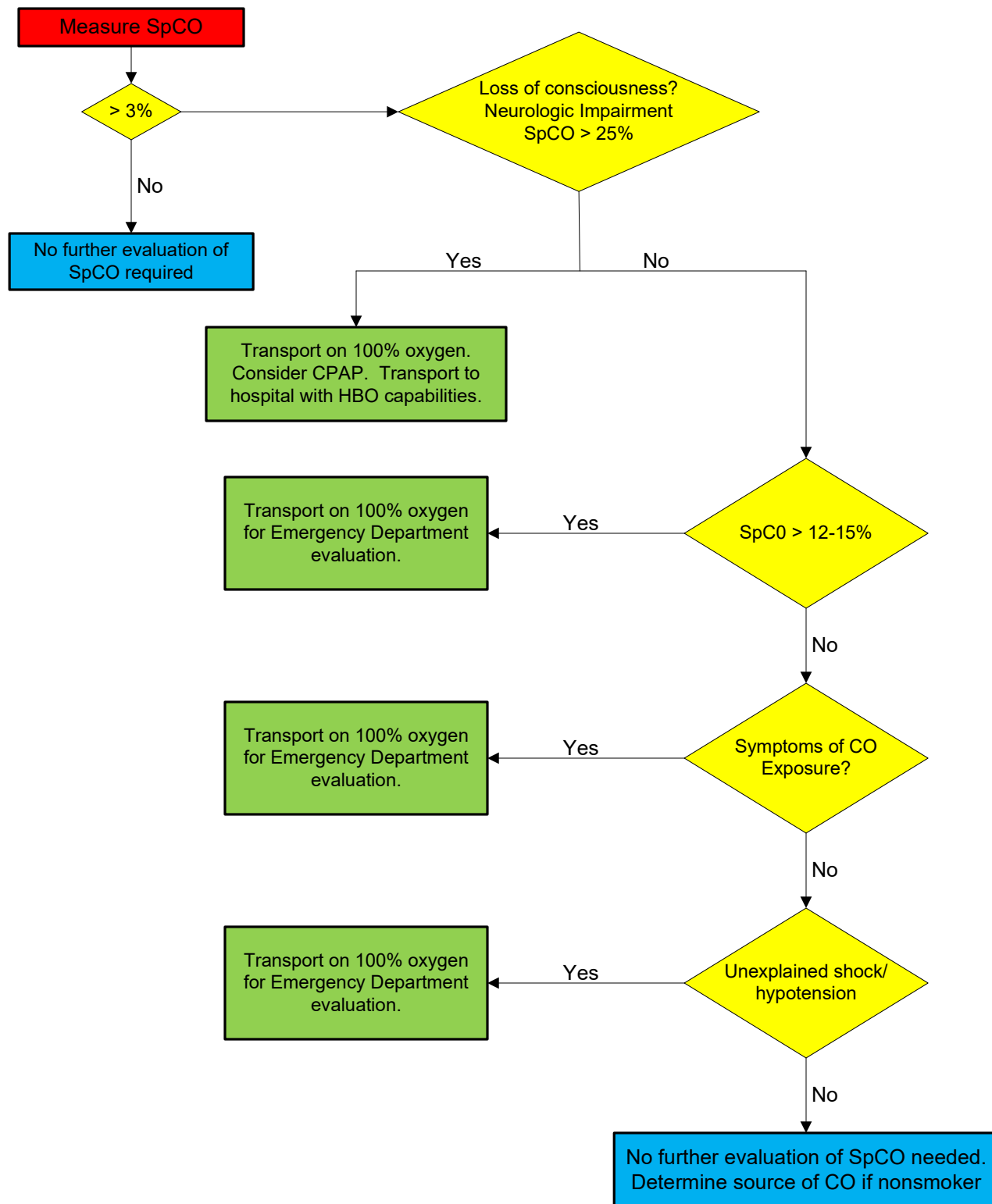
History: <ul style="list-style-type: none"> • CO exposure incidents • Structure fires • Rehab incidents 	Signs / Symptoms (CO Exposure): <ul style="list-style-type: none"> • Flu-like illness • Fatigue • Chest pain • Lethargy • Depression • Nausea • Vomiting • Headaches • Abdominal pain • Drowsiness • Coma 	Differential: <ul style="list-style-type: none"> • Influenza • Gastroenteritis • Alcohol intoxication • Drug overdose • Migraine headache • CVA • Hypoxia • Trauma • Depression • Fire / Rehab incidents
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I Carbon Monoxide Poisoning / Monitoring



Carbon Monoxide Triage Algorithm





I Carbon Monoxide Poisoning / Monitoring



Carbon monoxide poisoning is the most common exposure poisoning in the United States and the rest of the world. It is an odorless, colorless gas that can cause sudden illness and death. As it is found in fumes from combustion, CO is produced from a variety of sources such as vehicles, gasoline engines, camp stoves, lanterns, burning charcoal and wood, gas ranges, heating systems and poorly vented chimneys. Structural fires are another common source of CO exposure for both victims and firefighters.

Carbon monoxide displaces oxygen from hemoglobin. Hemoglobin has an affinity for carbon monoxide that is 200-250 times that of oxygen. Only high concentrations of oxygen can displace carbon monoxide from hemoglobin.

Carbon monoxide poisoning is often called "the great imitator" and carboxyhemoglobin levels do not always correlate with symptoms nor predict sequelae.

Normal Carbon Monoxide Levels (ages 3 – 74):

- Nonsmokers = $0.83 \pm 0.67\%$
- Smokers = $4.30 \pm 2.55\%$
- All persons combined = $1.94 \pm 2.24\%$

Special Considerations:

1. Carbon monoxide poisoning symptoms are non-specific and easy to miss and can lead to death and disability.
2. Poisoning is a particular occupational risk for firefighters.
3. Treatment is generally indicated with SpCO > 12-15%.
4. High-concentration oxygen should be administered to displace carbon monoxide from hemoglobin.
5. Be prepared to treat complications (e.g., seizures, cardiac ischemia).
6. Red skin color is usually a late finding and is an unreliable finding.
7. Efficacy of hyperbaric oxygen therapy is generally reserved for severe poisonings and may aid with tissue hypoxia:
 - a. ***Consider transport to Toledo Hospital for hyperbaric chamber. Consult with On-Line Medical Control for diversion approval.***

Tab 900

Carbon Monoxide Poisoning / Monitoring I-3

06/2012



I Carbon Monoxide Poisoning / Monitoring



Special Considerations, (cont.)

Factors which may reduce the reliability of carbon monoxide readings:

- Poor peripheral circulation (hypovolemia, hypotension, hypothermia).
- Excessive sensor motion
- Fingernail polish (may be removed with finger nail polish remover).
- Irregular heart rhythms (atrial fibrillation, SVT, etc.)
- Jaundice



I Carbon Monoxide Poisoning / Monitoring



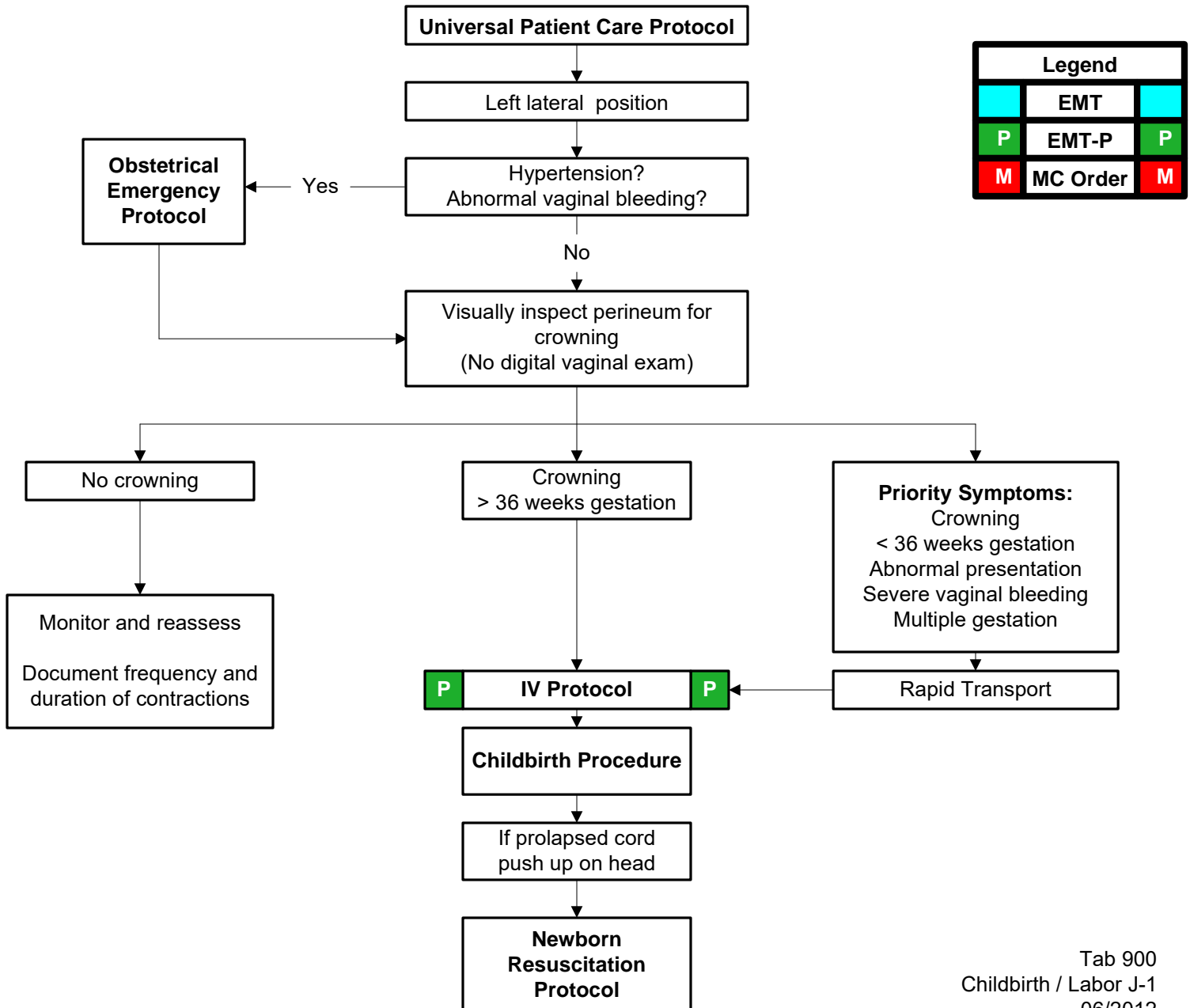
Pulse CO-Oximeter Utilization in the Emergency Scene Rehab Area

Emergency scene operations are dangerous for rescue personnel, and every opportunity to improve safety of the working emergency provider should be utilized. CO-oximetry will significantly improve the ability to assess the wellbeing of emergency workers, by instantly detecting elevated levels of carbon monoxide.

The following guidelines for pulse CO-oximeter utilization in the emergency scene rehab area is for reference only and does not supersede any fire department protocols or standing orders. Always follow protocols and procedures as authorized by your department.

- Values for carbon monoxide oximeter readings will normally be below 5% in non-smokers, and below 8% in smokers.
- On arrival in the rehab area, a reading should be obtained and recorded. Any symptoms should be recorded.
- A detector reading more than 12% indicates moderate carbon monoxide inhalation, and a reading of more than 25% indicates severe inhalation of carbon monoxide.
- Emergency workers with a CO level of more than 8% but below 15% must be given the opportunity to breathe ambient air for 5 minutes, and the result repeated. If still above 8%, they should be given oxygen via mask until the value drops below 5%.
- Workers showing any value of more than 15% need to be given oxygen via mask until the value drops below 5%.
- Any value of more than 25% must be completely evaluated and removed to a hospital, preferentially one which has a hyperbaric oxygen chamber.
- No emergency responder should leave the rehab area until the CO level on the monitor is below 5%. This is intended to improve scene safety and reduce injuries to rescue personnel, by ensuring that working personnel are not impaired by carbon monoxide toxicity.

History: <ul style="list-style-type: none"> • Due date • Time contractions started / how often • Rupture of membranes • Time / amount of any vaginal bleeding • Sensation of fetal activity • Past medical and delivery history • Medications • Drug use • Gravida / Para status • High risk pregnancy 	Signs / Symptoms: <ul style="list-style-type: none"> • Spasmodic pain • Vaginal discharge or bleeding • Crowning or urge to push • Meconium 	Differential: <ul style="list-style-type: none"> • Abnormal presentation <ul style="list-style-type: none"> Buttock Foot Hand • Prolapsed cord • Placenta Previa • Abruptio Placenta
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J Childbirth / Labor



Special Considerations:

1. Document all times (delivery, contraction frequency, and length).
2. If maternal seizures occur, refer to the ***Obstetrical Emergencies Protocol (Tab 900, Section N)***.
3. After delivery, massaging the uterus will promote uterine contraction and help to control post-partum bleeding.
4. Some perineal bleeding is normal with any childbirth. Large quantities of blood or free bleeding are abnormal.
5. Record APGAR at 1 minute and 5 minutes after birth.

K Deceased Persons (D.O.A.)



History: <ul style="list-style-type: none"> • Patient encountered by EMS who meet criteria for obvious death • Patient with DNR order in place who is pulseless and apneic • Patient for whom resuscitation efforts are ceased on-scene 	Signs / Symptoms: <ul style="list-style-type: none"> • Known medical conditions • Last time known to be alive 	Differential: <ul style="list-style-type: none"> • Death of apparent medical causes • Suspicious death (law enforcement)
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- Injury incompatible with life
- Signs of decomposition
- Rigor Mortis
- Extreme Dependent Lividity

Coordinate with Law Enforcement

Patient meets criteria for death?

No

P Patient meets criteria for Discontinuation? P

No

Continue with Resuscitation Per Appropriate Protocol

Yes

Law Enforcement and/or EMS Recognize Suspicious Death?

Yes

Avoid disturbing scene or body

Coordinate with Law Enforcement

No

Coordinate with Law Enforcement

Legend		
	EMT	
P	EMT-P	P
M	MC Order	M



K Deceased Persons D.O.A



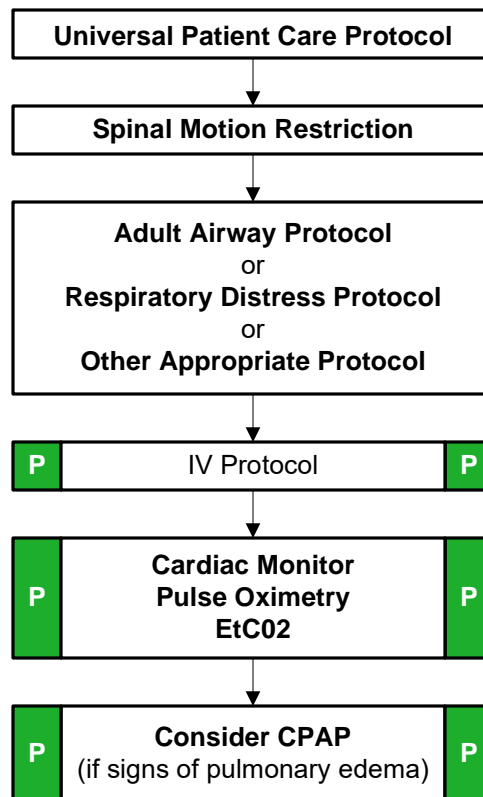
Special Considerations:

1. When a deceased person is encountered, emergency personnel should avoid disturbing the scene or the body as much as possible, unless it is necessary to do so to care for and assist other victims.
2. Once death has been determined, paramedics should transfer responsibility of scene management to a police agency, fire department and/or the coroner's office.
3. The paramedic and/or first responder should not leave the scene until responsibility for management of the scene has been transferred to an appropriate agency.
4. Patient criteria for obvious death:
 - a. **There is injury which is incompatible with life** (e.g., decapitation, hemicorporectomy, burns beyond body recognition).
 - b. **The victim shows signs of decomposition.**
 - c. **The victim shows signs of rigor mortis** (Note: All 4 extremities should be physically assessed for stiffness related to rigor mortis).
 - d. **Extreme dependent lividity** (Physically roll patient to evaluate dependent body areas for signs of blood pooling).
5. ***Criteria for obvious death must be documented in the patient care record (ePCR).***
6. Death cannot be adequately determined in the hypothermic patient who may be asystolic, apneic, stiff and cold to the touch. Follow the guidelines for **Hypothermic Cardiac Arrest (Tab 800, Section H).**
7. If any doubt exists that the patient is dead at the time of arrival of the life squad, resuscitative measures should be instituted immediately and continued until:
 - a. Appropriate DNR is verified
 - b. Arrival at the hospital
 - c. ***On-Line Medical Control*** authorizes discontinuation of prehospital resuscitation as outlined ***in LCEMS protocol Tab 800, Section G.***
 - d. Physician has pronounced the patient dead.

L Drowning / Submersion-Immersion



History: <ul style="list-style-type: none"> • Submersion/immersion in water regardless of depth • Possible history of trauma (i.e., diving board) • Duration of submersion/immersion • Temperature of water • Fresh / Salt water 	Signs / Symptoms: <ul style="list-style-type: none"> • Unresponsive • Mental status changes • Decreased or absent vital signs • Vomiting • Coughing 	Differential: <ul style="list-style-type: none"> • Trauma • Pre-existing medical problem • Pressure injury (diving) • Barotrauma • Decompression sickness
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Legend		
	EMT	
P	EMT-P	P
M	MC Order	M



L Drowning / Submersion-Immersion



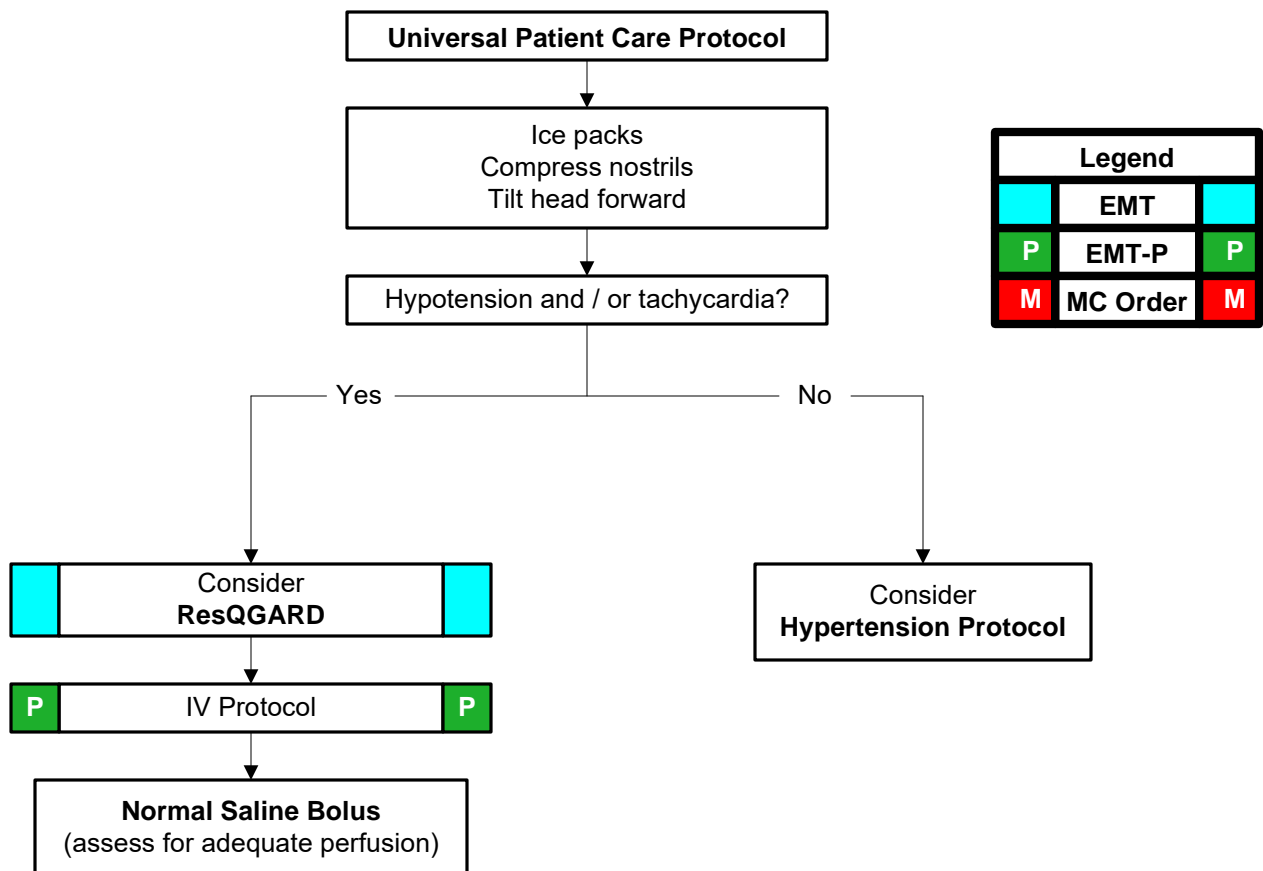
Special Considerations:

1. All victims of submersion/immersion injury should be transported for evaluation due to the potential for worsening over the next several hours.
2. Allow appropriately trained and certified rescuers to remove victims from areas of danger. Drowning is the leading cause of death among would-be rescuers.
3. Consider spinal motion restriction on all drowning victims. C-spine injury many times goes unrecognized.
4. Consider CPAP application for submersion/immersion victims that present with pulmonary edema. Patients must be awake, responsive and able to manage their own airway. Set initial pressure valve setting at 5cm H₂O.
5. Consider temperature monitoring for cold water exposures.
6. Aggressively resuscitate cold-water drowning victims. Remember – with cold water there is no time limit.
7. With pressure injuries (decompression / barotraumas), consider transport or availability of a hyperbaric chamber.

M Epistaxis



History: <ul style="list-style-type: none"> • Age • Past medical history • Medications (HTN, anticoagulants) • Previous episodes of epistaxis • Trauma • Duration of bleeding • Quantity of bleeding 	Signs / Symptoms: <ul style="list-style-type: none"> • Bleeding from nasal passage • Pain • Nausea • Vomiting 	Differential: <ul style="list-style-type: none"> • Trauma • Infection (viral URI or Sinusitis) • Allergic rhinitis • Lesions (polyps, ulcers) • Hypertension
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M Epistaxis



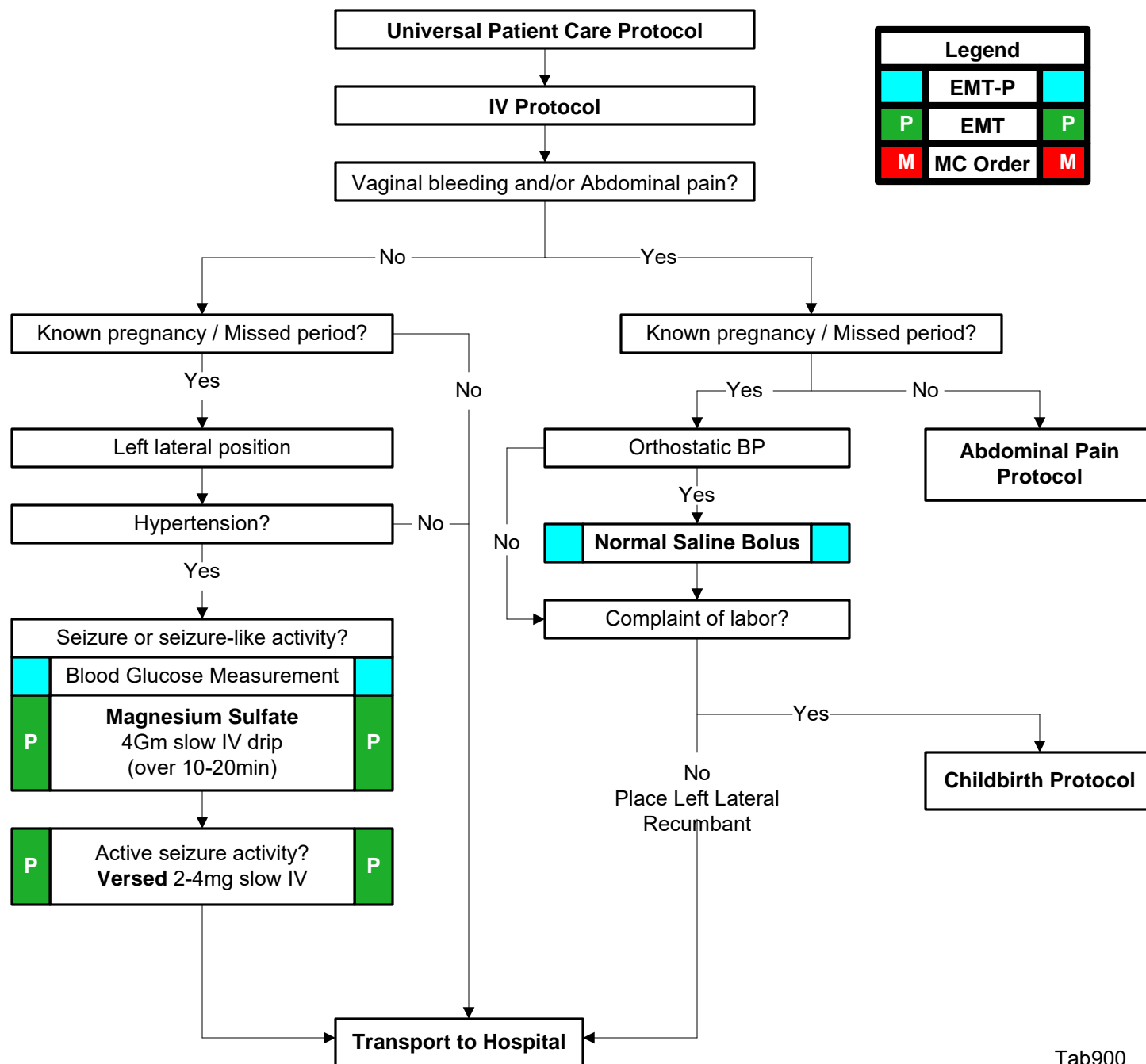
Special Considerations:

1. It is very difficult to quantify amount of blood loss with epistaxis
2. Bleeding may be occurring posteriorly.
3. Patients may be on anticoagulant therapy which will complicate bleeding control.
Common anticoagulants include:
 - a. Aspirin
 - b. Coumadin
 - c. Non-steroidal anti-inflammatory medications (Ibuprofen)
 - d. Many OTC headache relief powders

N Gynecological / Obstetrical Emergency



History: <ul style="list-style-type: none"> Past medical history Hypertension medications Prenatal care Prior pregnancies / births Gravida / Para 	Signs / Symptoms: <ul style="list-style-type: none"> Vaginal bleeding Abdominal pain Seizures Hypertension Severe headache Visual changes Edema of hands and face 	Differential: <ul style="list-style-type: none"> Pre-eclampsia / Eclampsia Placenta previa Placenta abruptio Spontaneous abortion
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Legend		
	EMT-P	
P	EMT	P
M	MC Order	M



N

Gynecological / Obstetrical Emergency



Special Considerations:

1. The amount of vaginal bleeding may be difficult to estimate. Visual estimates from sheets and towels can be misleading. Ask the patient to quantify bleeding – number of saturated pads used in the last hour.
2. Always consider pregnancy as a cause of vaginal bleeding. Discreet inspection of the perineum may be helpful to determine if there has been passage of tissue or clots. When possible, collect any passed tissue or clots for hospital analysis.
3. Severe headache, vision changes, or RUQ pain may indicate preeclampsia. History may reflect pre-existing pregnancy-induced hypertension.
4. In the setting of pregnancy, hypertension is defined as a BP greater than 140 systolic or greater than 90 diastolic. A relative increase of 30 systolic and 20 diastolic from the patient's normal (pre-pregnancy) blood pressure would also qualify as hypertension.
5. Maintain pregnant patients in a left lateral position to minimize risk of supine hypotension syndrome.
6. Any pregnant patient involved in a MVC should be transported for immediate evaluation and fetal monitoring.
7. For seizure or seizure-like activity associated with eclampsia administer 4Gm Magnesium Sulfate over 10-20 minutes. Magnesium Sulfate administration can be accomplished by mixing 4 Grams of Magnesium Sulfate in 50mL bag of D5W. With administration set to mini-drip (60gtts), run wide open. Medication will be delivered over 10-20 minutes.



N Gynecological / Obstetrical Emergency



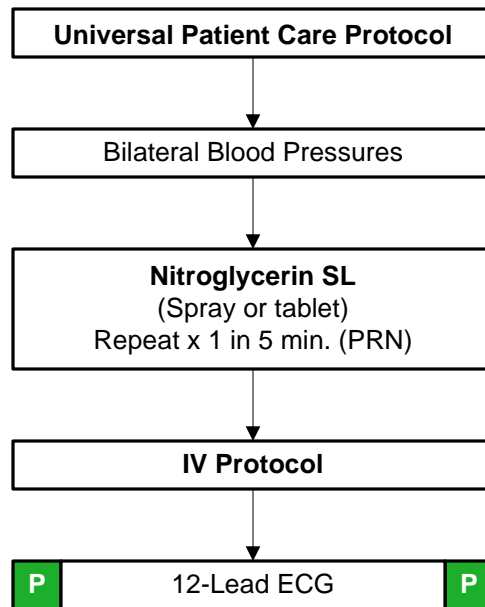
Special Considerations (cont.),

8. For continued seizure activity after Magnesium Sulfate, administer Versed 2-4mg IV. If loss of IV access, administer Versed IN. Any additional dosing of Versed must be authorized by ***On-Line Medical Control***. **NOTE: The following guidelines must be followed for Versed administration:**
 - a. Frequent assessment of airway for compromise requiring assistance.
 - b. Continuous pulse oximetry monitoring
 - c. If advance airway placed, continuous end-tidal CO₂ monitoring (confirmed capnographic waveform).
 - d. Frequent assessment of blood pressure. Maintain SBP > 100mmHg.

O Hypertensive Emergency



History: <ul style="list-style-type: none"> Documented hypertension Related diseases: diabetes, CVA, renal failure, cardiac Medications (compliance?) Viagra, Levitra, Cialis Pregnancy 	Signs / Symptoms: <p>One of these:</p> <ul style="list-style-type: none"> Systolic BP 200 or greater Diastolic BP 130 or greater <p>And at least one of these:</p> <ul style="list-style-type: none"> Headache Nosebleed Blurred vision Dizziness 	Differential: <ul style="list-style-type: none"> Hypertensive encephalopathy Primary CNS injury (Cushing's response = bradycardia with hypertension) Myocardial infarction Aortic dissection (aneurysm) Pre-eclampsia / Eclampsia
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Legend		
	EMT	
P	EMT-P	P
M	MC Order	M

O Hypertensive Emergency



Special Considerations:

1. The level of blood pressure alone does not determine a hypertensive emergency; rather, it is the degree of target organ involvement that will determine the rapidity with which blood pressure should be reduced to a safer level to prevent or limit target organ damage. **Elevated blood pressure of itself rarely requires emergency therapy.** Initial triage should quickly identify those patients who have an elevated BP without any evidence of significant target organ damage or any other impending cardiovascular events.
2. The physical examination should begin with an assessment of blood pressure using an appropriately sized cuff in both upper extremities. Radial, brachial, and carotid pulses should be assessed. A careful cardiovascular examination, as well as a thorough neurologic examination, including mental status, should be conducted.
3. The initial goal for BP reduction is not to obtain a normal BP, but to achieve a progressive controlled reduction to minimize the risk of hypoperfusion to vital organs. **Initial reduction in mean arterial pressure should not exceed 20-25% below the pretreatment BP. As an alternative, mean arterial pressure can be reduced within the first 30-60 minutes to 110–115mmHg.** Excessively rapid reductions in BP have been associated with acute deterioration in renal function, ischemic cardiac or cerebral events, and occasional retinal artery occlusion and acute blindness.

Example: BP – 240/130 = MAP of 167 (1/3 pulse pressure + Diastolic)
(Treatment Goal: reduction of MAP to 110-115mmHg)

4. Signs and symptoms of a hypertensive emergency:
 - a. Rapid rise in diastolic pressure over 130mmHg
 - b. New onset symptoms that accompany rise in BP:
 - i. Agitation
 - ii. Severe headache
 - iii. Dizziness
 - iv. Nausea / vomiting
 - v. Mental confusion
 - vi. Visual impairment (may include transient blindness)
 - vii. Difficulty breathing



O Hypertensive Emergency



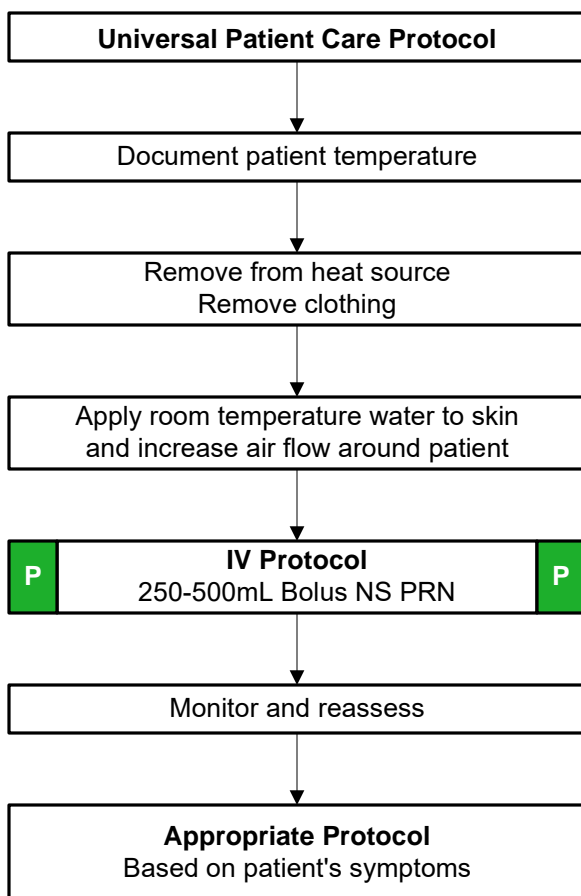
Special Considerations (cont.),

5. For symptomatic hypertensive emergencies, administer Nitroglycerin 0.4mg (tablet or spray). Repeat x 1 PRN for controlled reduction in blood pressure. ***Initial reduction in mean arterial pressure should not exceed 20-25% below the pretreatment BP. Mean arterial pressure can be reduced within the first 30-60 minutes to 110–115mmHg.***

P Hyperthermia



History: <ul style="list-style-type: none"> • Age • Exposure to increased temperatures and / or humidity • Past medical history • Extreme exertion • Time and length of exposure • Poor PO intake • Fatigue and / or muscle cramping 	Signs / Symptoms: <ul style="list-style-type: none"> • Altered mental status or unconsciousness • Hot, dry or sweaty skin • Hypotension or shock • Seizures • Nausea 	Differential: <ul style="list-style-type: none"> • Fever (Infection) • Dehydration • Medications • Hyperthyroidism (Storm) • Delirium tremens (DT's) • Heat cramps • Heat exhaustion • Heat stroke • CNS lesions or tumors
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Legend		
	EMT	
P	EMT-P	P
M	MC Order	M

P Hyperthermia



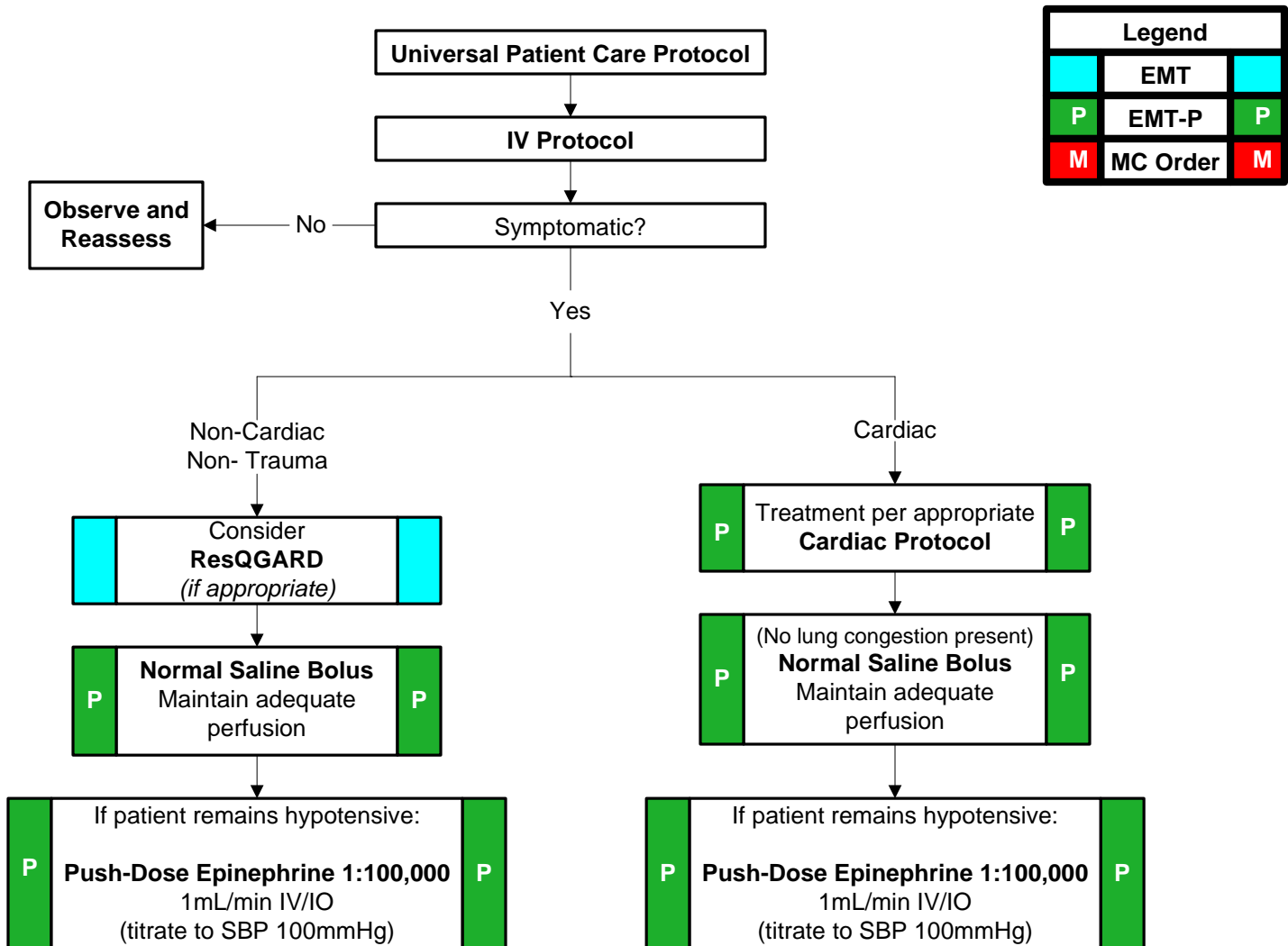
Special Considerations:

1. Extremes of age are more prone to heat emergencies (i.e., young and old). Predisposed by use of Tricyclic Antidepressants, Phenothiazines, Anticholinergic medications, and alcohol. Cocaine, Amphetamines, and Salicylates may elevate body temperature.
2. The body's "sweating" mechanism generally disappears as body temperature rises above 104°F (40°C). Intense shivering may occur as the patient is cooled.
3. Hyperthermia differential:
 - a. **Heat Cramps** – consists of benign muscle cramping secondary to dehydration and is not associated with an elevated temperature.
 - b. **Heat Exhaustion** – consists of dehydration, salt depletion, dizziness, fever, weakness, mental status changes, headache, cramping, nausea and vomiting. Vital signs usually consist of tachycardia, hypotension, and an elevated temperature.
 - c. **Heat Stroke** – consists of dehydration, tachycardia, hypotension, temperature > 104°F (40°C), and an altered mental status.
4. Initial cooling measures for heat exhaustion/stroke can be accomplished by applying cold packs (neck, axilla, and groin) or water-soaked sheets. Ensure adequate airflow over patient for evaporative loss. Do not let cooling measures in the field delay transport.
5. For signs of hypovolemia, initiate fluid bolus of normal saline to maintain adequate perfusion.
6. Seizure activity associated with hyperthermia should be treated according to the ***Seizure Protocol (Tab 900, Section V)***.

Q Hypotension Shock (Non-Trauma)



History: <ul style="list-style-type: none"> • Blood loss - vaginal or gastrointestinal bleeding, AAA, ectopic pregnancy • Fluid loss - vomiting, diarrhea, fever • Infection • Cardiac ischemia (MI, CHF) • Medications • Allergic reaction • Pregnancy • History of poor oral intake 	Signs / Symptoms: <ul style="list-style-type: none"> • Restlessness, confusion • Weakness, dizziness • Weak, rapid pulse • Pale, cool, clammy skin • Delayed capillary refill • Hypotension • Coffee-ground emesis • Tarry stools 	Differential: <ul style="list-style-type: none"> • Shock • Hypovolemia • Cardiogenic • Septic • Neurogenic • Anaphylactic • Ectopic pregnancy • Dysrhythmias • Pulmonary embolus • Tension pneumothorax • Medication effect / overdose • Vasovagal • Physiologic (pregnancy)
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Legend		
	EMT	
P	EMT-P	P
M	MC Order	M



Q Hypotension Shock (Non-Trauma)



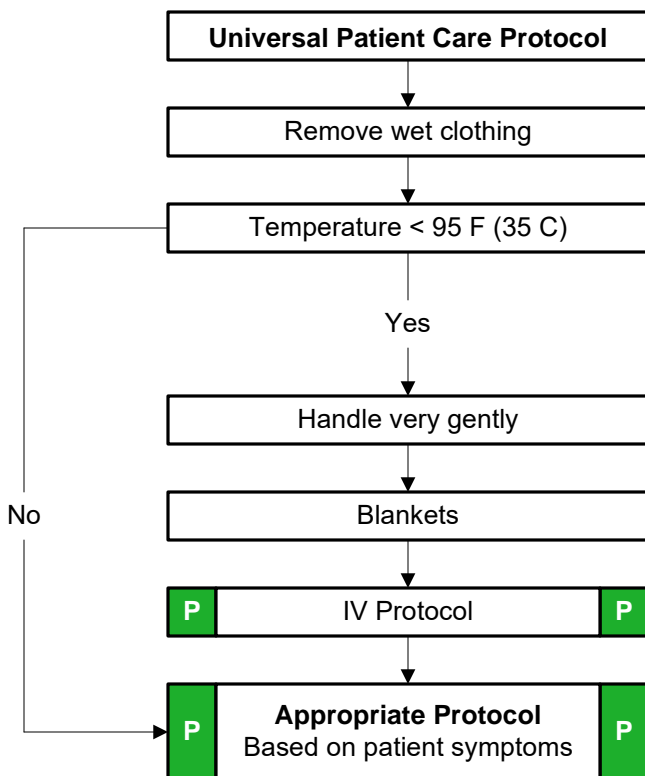
Special Considerations:

1. Hypotension can be defined as a systolic blood pressure < 90mmHg.
2. Consider all possible causes of shock and treat per appropriate protocol.
3. Consider performing orthostatic vital signs on patients in non-trauma situations if suspected blood or fluid loss.
4. Consider application of the ResQGARD for patients \geq 25 lbs. who are experiencing symptoms of low blood circulation secondary to a variety of causes such as:
 - a. Hypovolemia
 - § Internal hemorrhage
 - § External hemorrhage
 - § Dehydration
 - b. Hypotension
 - § Dialysis
 - § Sepsis
 - § Orthostatic intolerance
 - § Medication reaction
5. For signs of hypovolemia, initiate fluid bolus to maintain adequate perfusion.
6. Patients that remain hypotensive following standard fluid resuscitation:
 - **Push-Dose Pressor Epinephrine (1:100,000)**
 - Ø Dilute: Discard 9mL of Epi 1:10,000 (0.1mg/mL) and draw up 9mL of normal saline to create Push-Dose Pressor Epi 1:100,000. This will yield 10mcg/mL.
 - § Administer 1mL/minute IV/IO, titrate to maintain SBP 100mmHg.
 - § May repeat X 2 prn by standing order (protocol)
 - § Max total dose 300mcg (30mL)
 - Ø **Push-Dose Pressor Epinephrine Precautions:**
 - § Rapid (1 minute) onset, short (5-10) minute duration
 - § Monitor heart rate and blood pressure throughout administration

R Hypothermia



History: <ul style="list-style-type: none"> • Past medical history • Medications • Exposure to environment even in normal temperatures • Exposure to extreme cold • Extremes of age • Drug use: Alcohol, barbiturates • Infections / Sepsis • Length of exposure / wetness 	Signs / Symptoms: <ul style="list-style-type: none"> • Cold, clammy • Shivering • Mental status changes • Extremity pain or sensory abnormality • Bradycardia • Hypotension or shock 	Differential: <ul style="list-style-type: none"> • Sepsis • Environmental exposure • Hypoglycemia • CNS dysfunction <ul style="list-style-type: none"> Stroke Head injury Spinal cord injury
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Legend		
	EMT	
P	EMT-P	P
M	MC Order	M

R

Hypothermia



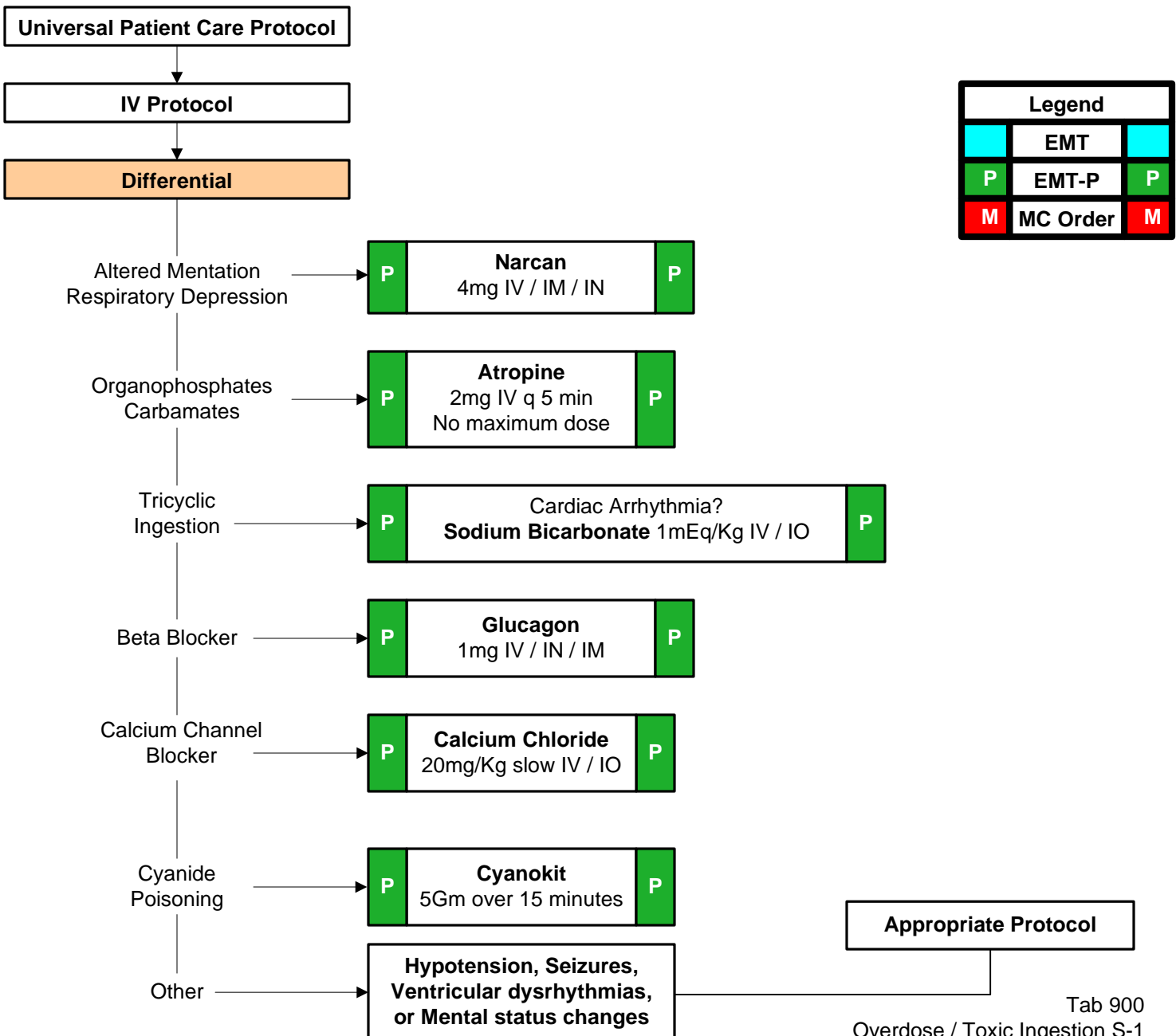
Special Considerations:

1. Hypothermia is defined as a core body temperature $< 35^{\circ}\text{C}$ (95°F).
2. The body “shivering” mechanism fails below 32°C (90°F). Severely hypothermic patients may no longer experience a feeling of cold and occasionally will even undress and appear vasodilated.
3. If the body temperature is unable to be measured, treat the patient based on the suspected temperature.
4. With temperatures less than 31°C (88°F) ventricular fibrillation is a common cause of death. Handling patient gently may prevent this.
5. Extremes of age are more susceptible to hypothermia (i.e., young and old).
6. Hypothermia may produce severe bradycardia.
7. Patients who appear dead after prolonged exposure to cold air or water should not be declared “dead” until they have been rewarmed. Full recovery from hypothermia with undetectable vital signs, severe bradycardia and even periods of cardiac arrest have been reported.

S Overdose / Toxic Ingestion



History: <ul style="list-style-type: none"> • Ingestion or suspected ingestion of a potentially toxic substance • Substance ingested, route, quantity • Time of ingestion • Reason (suicidal, accidental, criminal) • Available medication in home • Past medical history, medications 	Signs / Symptoms: <ul style="list-style-type: none"> • Mental status changes • Hypotension / Hypertension • Decreased respiratory rate • Tachycardia, dysrhythmias • Seizures 	Differential: <ul style="list-style-type: none"> • Tricyclic antidepressants (TCAs) • Acetaminophen (Tylenol) • Depressants • Stimulants • Anticholinergic • Cardiac medications • Solvents, alcohols, cleaning agents • Insecticides (organophosphates) • Cyanide Exposure
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S Overdose / Toxic Ingestion



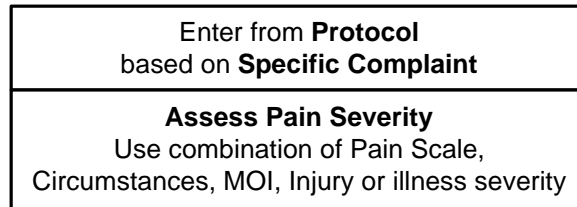
Special Considerations:

1. Do not rely on patient history of ingestion, especially in suicide attempts.
2. All empty containers of ingested material should accompany patient to the hospital. All emesis should be saved for analysis.
3. For blood glucose values < 60mg/dl, administer Dextrose IV. Thiamine 100mg IV should be considered prior to Dextrose administration in patients with possible alcoholism or signs of malnutrition.
4. Overdose / Ingestion concerns:
 - a. **Tricyclic** – 4 major areas of toxicity: seizures, dysrhythmias, hypotension, decreased mental status or coma; rapid progression from alert mental status to death.
 - b. **Acetaminophen** – Initial presentation normal or nausea/vomiting. If not detected and treated, will cause irreversible liver failure.
 - c. **Depressants** – decreased HR, decreased temperature, decreased respirations, non-specific pupils.
 - d. **Stimulants** – increased HR increased BP, increased temperature, dilated pupils, seizures.
 - e. **Anticholinergic** – increased HR, increased temperature, dilated pupils, mental status changes.
 - f. **Cardiac Medications** – dysrhythmias and mental status changes.
 - g. **Solvents** – nausea, vomiting, and mental status changes.
 - h. **Insecticides** – increased or decreased HR, increased secretions, nausea, vomiting, diarrhea, pinpoint pupils.
5. For patients with altered mentation and combative / aggressive behavior, consider restraints for patient's and/or personnel's protection.
6. The **Airway Protocol** should be considered for all patients unable to protect their own airway (i.e., semi-conscious, unconscious).

T Pain Management



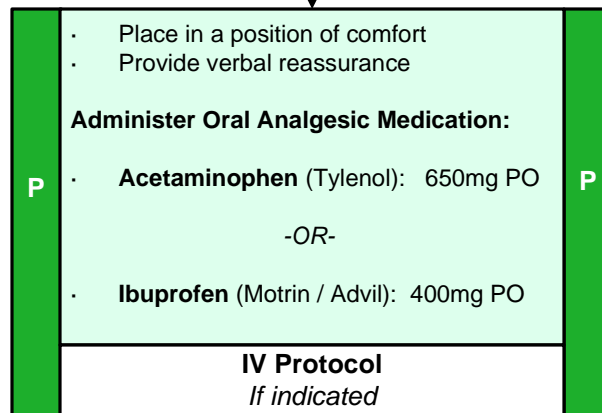
History: <ul style="list-style-type: none"> Age Location Duration Severity (1-10) Past medical history Medications Drug allergies 	Signs / Symptoms: <ul style="list-style-type: none"> Severity (pain scale) Quality (sharp, dull, etc.) Radiation Relation to movement, respiration Increased with palpation of area 	Differential: <ul style="list-style-type: none"> Per specific protocol Musculoskeletal Visceral (abdominal) Cardiac Pleural / Respiratory Neurogenic Renal (colic)
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	EMT	
P	EMT-P	P
M	MC Order	M

Mild to Moderate pain
-AND-
Oral Medication not contraindicated

Musculoskeletal Trauma
Non-Traumatic
Pain Management



Notify Destination or
Contact Medical Control

T Pain Management



History: <ul style="list-style-type: none"> Age Location Duration Severity (1-10) Past medical history Medications Drug allergies 	Signs / Symptoms: <ul style="list-style-type: none"> Severity (pain scale) Quality (sharp, dull, etc.) Radiation Relation to movement, respiration Increased with palpation of area 	Differential: <ul style="list-style-type: none"> Per specific protocol Musculoskeletal Visceral (abdominal) Cardiac Pleural / Respiratory Neurogenic Renal (colic)
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Enter from Protocol based on Specific Complaint
Assess Pain Severity Use combination of Pain Scale, Circumstances, MOI, Injury or illness severity

	EMT	
P	EMT-P	P
M	MC Order	M

Acute Coronary Syndromes

Burns

Musculoskeletal Trauma

P	OPIOID ANALGESIC OPTIONS (Choose one) Fentanyl 50-100mcg IV/IO (1mcg/Kg) Maximum 100mcg/dose May repeat ½ dose every 5 min PRN maximum of 300mcg -OR- Morphine Sulfate 2-10mg IV (0.1mg/Kg) Maximum 10mg/dose May repeat dose every 5 min PRN maximum of 20mg	ANALGESIC MEDICATION OPTIONS (Choose one) Fentanyl 50-100mcg IV/IO/IM/IN (1mcg/Kg) Maximum 100mcg/dose May repeat ½ dose every 5 min PRN maximum of 300mcg -OR- Morphine Sulfate 2-10mg IV/IO/IM (0.1mg/Kg) Maximum 10mg/dose May repeat dose every 5 min PRN maximum of 20mg -OR- Ketamine 0.25mg/Kg in 50mL D5W given IV/IO over 10 min (maximum 30mg)	ANALGESIC MEDICATION OPTIONS (Choose one) Fentanyl 50-100mcg IV/IO/IM/IN (1mcg/Kg) Maximum 100mcg/dose May repeat ½ dose every 5 min PRN maximum of 300mcg -OR- Morphine Sulfate 2-5mg IV/IO/IM (0.1mg/Kg) Maximum 10mg/dose May repeat dose every 5 min PRN maximum of 20mg -OR- Ketorolac 15mg IV/IO (30mg IM) -OR- Ketamine 0.25mg/Kg in 50mL D5W given IV/IO over 10 min (maximum 30mg)	P

T Pain Management



History: <ul style="list-style-type: none"> • Age • Location • Duration • Severity (1-10) • Past medical history • Medications • Drug allergies 	Signs / Symptoms: <ul style="list-style-type: none"> • Severity (pain scale) • Quality (sharp, dull, etc.) • Radiation • Relation to movement, respiration • Increased with palpation of area 	Differential: <ul style="list-style-type: none"> • Per specific protocol • Musculoskeletal • Visceral (abdominal) • Cardiac • Pleural / Respiratory • Neurogenic • Renal (colic)
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Enter from Protocol based on Specific Complaint
Assess Pain Severity Use combination of Pain Scale, Circumstances, MOI, Injury or illness severity

	EMT	
P	EMT-P	P
M	MC Order	M

Non-Traumatic Pain Management

P	NON-OPIOID ANALGESIC MEDICATION OPTIONS (Choose one) MC MUST order any opioid medication	P
	Ketorolac 15mg IV/IO (30mg IM) IV administration preferred if kidney stone suspected. -OR- Ketamine 0.25mg/Kg in 50mL D5W given IV/IO over 10 min (maximum 30mg)	



T Pain Management



The practice of prehospital emergency medicine requires expertise in a wide variety of pharmacological and non-pharmacological techniques to treat acute pain resulting from myriad injuries and illnesses. Approaches to pain relief are designed to be safe and effective in the dynamic prehospital environment. The degree of pain and hemodynamic status of the patient will determine the urgency and extent of analgesic interventions.

A discussion with the patient regarding realistic expectations for pain control is an element within the process of pain management that is frequently overlooked. Multiple factors that include, but are not limited to, type and severity of illness or injury, individual pain tolerance, extrication processes, and transport times are variables that may impact levels of pain as well as pain management. Dependent upon patient condition, scenario, and patient's pain tolerance, the goal of pain management may be pain control or reduction of discomfort rather than complete elimination of pain.

Objective measures or pain ratings improve pain management by:

- Balancing imprecise clinician pain assessment
- Tracking success of pain management

Pain Assessment:

- Numeric rating scale (1-10)
- Visual analog scale (pain level marked on a horizontal line)
- Verbal rating scale (none, mild, moderate, severe, unbearable)
- Wong-Baker FACES Scale (pediatrics)

A number of studies have shown that early administration of analgesics allows patients to relax, removes voluntary guarding and permits better assessment of localized tenderness.

Safe Use of Analgesics:

- A. Be aware of the effects of combining drugs: Adding one CNS depressant or hemodynamic depressant to another can create unpredictable changes.
- B. Don't forget about medication allergies: Adding IV analgesics on top of recently taken oral sedatives, analgesics or muscle relaxants may cause unpredictable additive effects as well.
- C. Know your pain management goal: Your goal may actually be different for different types of patients (Reduction of pain vs. removal of pain).



T Pain Management



Pain Management, continued

- D. Reassess your patient frequently: Hemodynamic status and pain scale.
- E. Give a complete report to ED staff: Drugs given, time, results, and adverse effects.

This guideline does not address pain management for the following patient presentations (for these patients, consultation with medical direction is recommended):

1. Pregnancy with active labor
2. Dental Pain
3. Patients with care plans that prohibit the use of parenteral analgesics by EMS
4. Patients with chronic pain who are not enrolled in a hospice or palliative care plan

Pain Management PEARLS:

- Assess serial vital signs with emphasis on blood pressure, respiratory status and level of consciousness.
- **Analgesics administered in the field must be transported by a Lucas County EMS life squad or ALS service recognized by Lucas County EMS.**
- **Analgesic administration may preclude a patient's ability to refuse transport due to possible altered mentation.**

General Considerations:

- A. Determine the patient's onset and level of pain. A self-reported numeric scale is usually applicable to the adult population; however, variable levels of pain tolerance makes the measurement subjective.
- B. Utilize verbal reassurance to control anxiety.
- C. If available, consider the use of non-pharmaceutical pain management techniques:
 - Placement of the patient in a position of comfort.
 - Application of ice packs and/or splints for pain secondary to trauma.



T Pain Management



Pain Management, continued

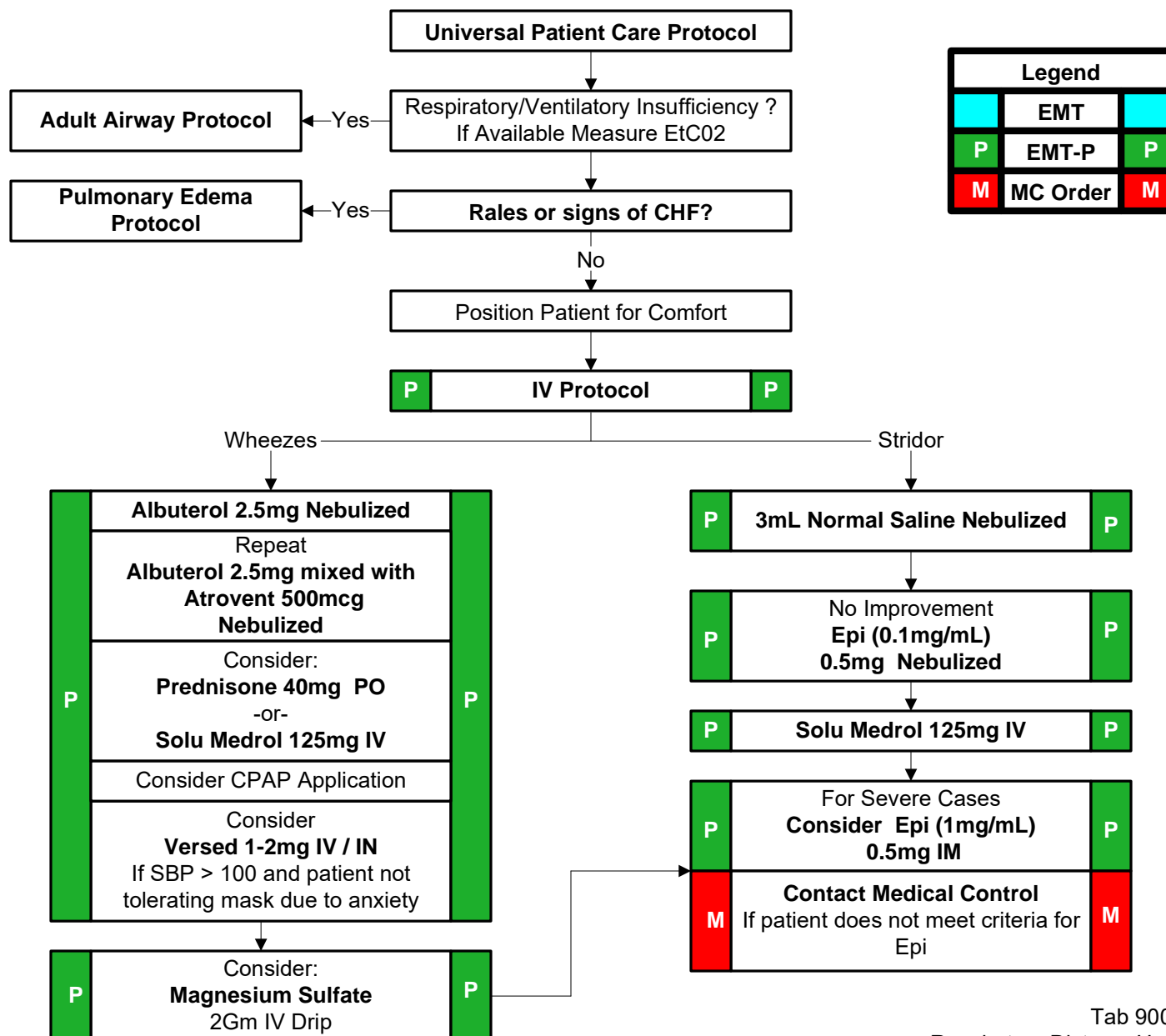
- D. Apply a cardiac monitor if indicated based upon patient assessment.
- E. If the patient is experiencing moderate discomfort, or if patient positioning and/or the application of ice packs and/or splints provides inadequate pain control, consider the administration of analgesics.
- F. If the patient is experiencing severe to excruciating pain or the treatment provided to control moderate pain is ineffective or clinically inadequate, consider the administration of parenteral analgesics.
- G. **Titrate dosing of parenteral analgesics based upon patient presentation, vital signs and relief of pain/discomfort. (Example: The total initial dose of parenteral analgesic DOES NOT have to be administered if pain/discomfort control is achieved with lesser amount of analgesic administered.)**
- H. The administration of oral or intravenous Ondansetron (Zofran) **may** be indicated to prevent nausea and vomiting from the use of analgesics and/or pain.

Pain management for patient presentations not addressed by this protocol should receive On-Line Medical Control authorization before administration.

U Respiratory Distress



History: <ul style="list-style-type: none"> Asthma COPD - chronic bronchitis, emphysema, congestive heart failure Home treatment (oxygen, nebulizer) Medications (theophylline, steroids, inhalers) Toxic exposure, smoke inhalation 	Signs / Symptoms: <ul style="list-style-type: none"> Shortness of breath Pursed lip breathing Decreased ability to speak Increased respiratory rate / effort Wheezing, rhonchi, rales, stridor Use of accessory muscles Fever, cough Tachycardia 	Differential: <ul style="list-style-type: none"> Asthma Anaphylaxis Aspiration COPD (emphysema, bronchitis) Pleural effusion Pneumonia Pulmonary Embolus Pneumothorax Cardiac (MI or CHF) Pericardial tamponade Hyperventilation Inhaled toxin (carbon monoxide, etc)
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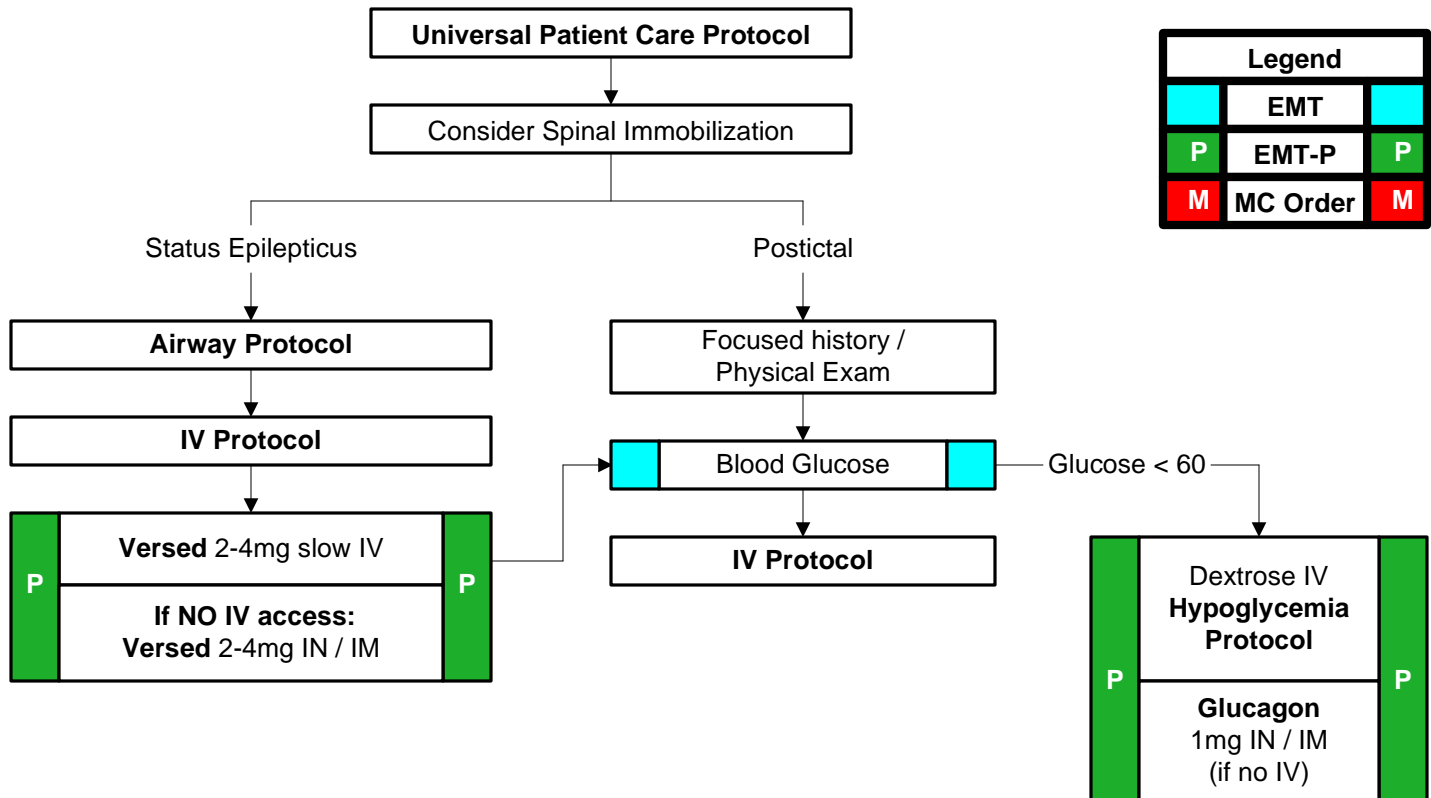
Special Considerations:

1. Wheezing is a hallmark indicator of lower airway compromise or obstruction. If there is no patient history of asthma or COPD, consider other processes which may produce wheezing (i.e., foreign body aspiration, pneumonia, pulmonary edema or poisoning).
2. Asthmatics with severe bronchospasm may present with a “silent chest” due to poor air movement through small airways. Forced exhalation or coughing will often accentuate wheezing and careful auscultation of peripheral lung fields will confirm the absence of normal breath sounds.
3. Life-threatening complications of asthma include pneumothorax, cardiac dysrhythmia, bronchial plugging and respiratory failure. Lungs that are hyper-inflated due to air trapping increase the risk of pneumothorax and pneumomediastinum (evaluate for decreased unilateral aeration, subcutaneous emphysema, or acute patient decompensation).
4. Chronic Obstructive Pulmonary Disease (COPD) is characterized by permanent abnormal enlargement of the air spaces beyond the terminal bronchioles and destruction of the alveoli. Life-threatening complications of COPD may include pulmonary hypertension which may lead to Cor Pulmonale.
5. Continuous Positive Airway Pressure (CPAP) has been shown to rapidly improve vital signs, gas exchange, reduce the work of breathing, decrease the sense of dyspnea, and decrease the need for endotracheal intubation in patients who suffer from shortness of breath from asthma, COPD, and pneumonia. Consider CPAP in patients non-responsive to initial treatments. For COPD, Asthma, and Pneumonia start with a 5.0 cm pressure valve setting. If no improvement, and patient is tolerating CPAP, increase pressure valve setting to 7.5 cm. When necessary, bronchodilators should be administered during CPAP operation.
6. With patient anxiety related to CPAP application, consider **Versed 1-2mg IV if SBP > 100mmHg**. Absent IV access, administer Versed IN. Maximum dose of Versed is 2mg IV / IN. Any additional Versed dosing must be authorized by **On-Line Medical Control**.

Special Considerations (cont.),

7. For patients who present with suspected cardiogenic pulmonary edema, follow the ***Pulmonary Edema Protocol***.
8. Monitor End-Tidal CO₂ via O₂ / CO₂ Nasal FilterLine during field treatments (i.e., CPAP, Nebulized Aerosols). Monitor for obstructive capnogram (waveform).
9. Pulse oximetry should be monitored continuously if initial saturation is $\leq 96\%$, or there is a decline in the patient's status despite normal pulse oximetry readings.
10. Nebulized Albuterol (1 unit dose – 2.5mg) should be utilized for initial bronchodilator therapy. Patients requiring treatment, and on home Ipratropium Bromide (Atrovent), may have nebulized Atrovent (500mcg) initiated in lieu of Albuterol.
11. For continued auscultated wheezes after initial bronchodilator therapy, continue aerosol treatment with Albuterol (1 unit dose) mixed with Atrovent (1 unit dose). ***This combination therapy is only to be administered once.***
12. For patients with a history of steroid-dependant asthma/COPD, or a patient in continued respiratory distress refractory to nebulized treatments, administer Prednisone 40mg PO. If the patient is unable to swallow, administer Solu-Medrol 125mg IV. **NOTE: Do not administer steroid therapy for patients with history of severe depression or suicidal ideation.**
13. Magnesium Sulfate administration can be accomplished by mixing 2 Grams of Magnesium Sulfate in 50mL bag of D5W. With administration set to mini-drip (60gtts), run wide open. Medication will be delivered over 10-20 minutes.
14. Contact ***On-Line Medical Control*** prior to administering Epinephrine to patients who are > 50 years of age, have a history of cardiac disease, or if the patient's heart rate is > 150. Epinephrine may precipitate cardiac ischemia.
15. Xopenex may be substituted for Albuterol and mixed with Atrovent. Use the patient current dose (0.31 – 1.25mg).

History: <ul style="list-style-type: none"> Reported / witnessed seizure activity Previous seizure history Medical alert tag information Seizure medications History of trauma History of diabetes History of pregnancy 	Signs / Symptoms: <ul style="list-style-type: none"> Decreased mental status Sleepiness Incontinence Observed seizure activity Evidence of trauma Unconsciousness 	Differential: <ul style="list-style-type: none"> CNS (Head) trauma Tumor Metabolic, Hepatic, or Renal failure Hypoxia Electrolyte abnormality (Na, Ca, Mg) Drugs, medications, non-compliance Infection / fever Alcohol withdrawal Eclampsia Stroke Hyperthermia Hypoglycemia
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Legend		
	EMT	
P	EMT-P	P
M	MC Order	M

V Seizures



Special Considerations:

1. If an actively seizing patient is encountered, move hazardous material away from the patient. Protect the patient's head from injury. Remember to always immediately check for pulses after seizure activity stops.
2. Trauma to the tongue during seizure activity is unlikely to cause serious problems. Attempts to force anything into the patient's airway may cause complete obstruction.
3. **Status epilepticus** is defined as two or more successive seizures without a period of consciousness or recovery. This is a true emergency requiring rapid airway control, treatment, and transport. **Grand Mal seizures (generalized)** are associated with loss of consciousness, incontinence, and tongue trauma. **Focal seizures (petit mal)** effect only a part of the body and are not usually associated with a loss of consciousness. **Jacksonian seizures** are seizures that start as a focal seizure and become generalized.
4. Assess possibility of occult trauma and substance abuse. If evidence or suspicion of trauma, consider appropriate spinal motion restriction (SMR).
5. Be prepared for airway problems with continued seizures. The **Airway Protocol** should be considered for all patients unable to protect their own airway (i.e., semi-conscious, unconscious).
6. Thiamine 100mg IV should be considered prior to Dextrose administration in patients with possible alcoholism or signs of malnutrition.
7. For active and/or ongoing seizure activity, administer Versed 2-4mg slow IV. If no intravascular access, administer Versed 2-4mg IN (4mg IM). Maintain a blood pressure > 100mmHg. Versed may be repeated in 5 minutes x 1 for cessation of seizure activity. Any additional dosing of Versed must be authorized by **On-Line Medical Control**. **NOTE: The following guidelines must be followed for Versed administration:**
 - a. Frequent assessment of airway for compromise requiring assistance
 - b. Continuous pulse oximetry monitoring
 - c. If advanced airway placed, continuous end-tidal CO₂ monitoring (confirmed capnographic waveform).
 - d. Frequent assessment of blood pressure. Maintain SBP > 100mmHg.



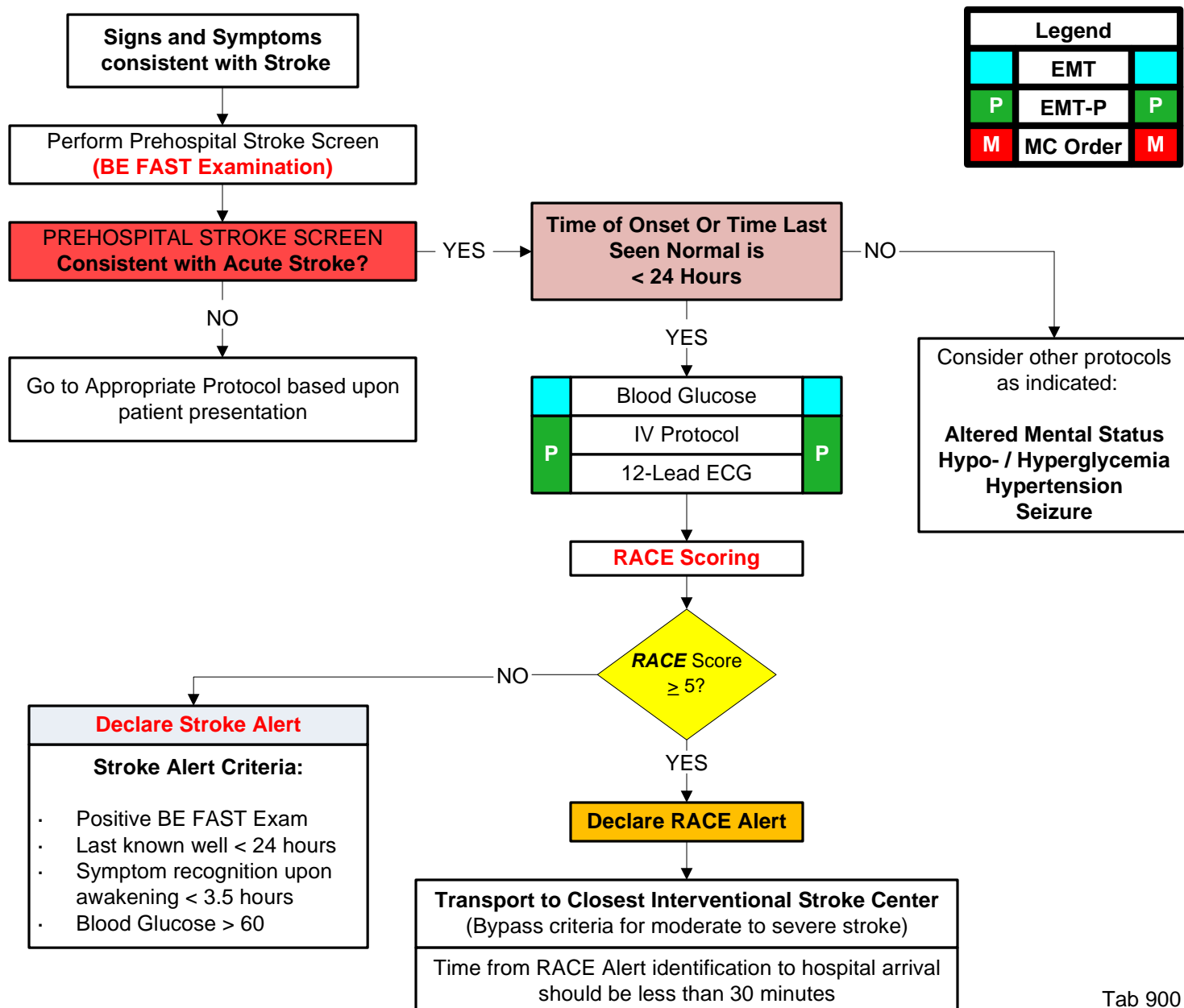
V Seizures



Special Considerations (cont.),

8. For seizure activity related to Eclampsia, follow the **Obstetrical Emergencies Protocol (Tab 900, Section N)**.

History: <ul style="list-style-type: none"> Previous CVA, TIA's Previous cardiac / vascular surgery Associated diseases: diabetes, hypertension, CAD Atrial fibrillation Medications (blood thinners) History of trauma 	Signs / Symptoms: <ul style="list-style-type: none"> Altered mental status Weakness / Paralysis Blindness or other sensory loss Aphasia / Dysarthria Syncope Vertigo / Dizziness Vomiting Headache Seizures Respiratory pattern change Hypertension / hypotension 	Differential: <ul style="list-style-type: none"> See Altered Mental Status TIA (Transient Ischemic Attack) Seizure Hypoglycemia Stroke <ul style="list-style-type: none"> Thrombotic, Embolic (85%) Hemorrhagic (15%) Tumor Trauma Dialysis / Renal Failure
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W Stroke / CVA



Special Considerations:

1. A stroke is a sudden interruption in blood flow to the brain resulting in neurological deficit. It affects 750,000 Americans each year, is the 3rd leading cause of death and is the leading cause of adult disability. With new treatment options available, EMS personnel should alert Medical Control as quickly as possible whenever a potential stroke patient is identified.
2. The most common causes of stroke are:
 - a. **Cerebral thrombosis** (a blood clot obstructing the artery).
 - b. **Cerebral embolus** (a mass or air bubble obstructing the artery).
 - c. **Cerebral hemorrhage** (ruptured artery / ruptured aneurysm).
3. Signs and symptoms of stroke include:
 - a. Hemiplegia (paralysis on one side of the body)
 - b. Hemiparesis (weakness on one side of the body)
 - c. Decreased sensation or numbness without trauma
 - d. Facial droop
 - e. Unequal grips
 - f. Dizziness, vertigo or syncope
 - g. Aphasia or slurred speech
 - h. Altered level of consciousness or seizures
 - i. Sudden, severe headache with no known cause
 - j. Visual disturbances (e.g. blurred vision, double vision)
 - k. Generalized weakness
 - l. Frequent or unexplained falls
4. Risk factors that increase the likelihood of stroke are:
 - a. Hypertension
 - b. Atherosclerosis / coronary artery disease
 - c. Atrial fibrillation
 - d. Hyperlipidemia
 - e. Diabetes
 - f. Vasculitis
 - g. Lupus



W Stroke / CVA



Special Considerations (cont.),

5. To facilitate accuracy in diagnosing stroke and to expedite transport, an easy-to-use neurological examination tool is recommended. Utilize the **BE FAST** criteria for evaluation of acute, non-comatose, non-traumatic neurovascular complaints. (Sudden loss of **B**alance; **E**yes – check for vision loss; **F**acial Palsy; **A**rm weakness; **S**peech abnormalities; **T**ime of Onset)
6. Onset of stroke symptoms (**Time Last Seen Normal**) is defined as the last witnessed time the patient was symptom-free (this would also include symptom recognition upon awakening < 3.5 hours). With duration of symptoms less than 24 hours, scene times should be limited to 10-15 minutes, early notification of receiving facility should be performed and transport times should be minimized.
7. Patients assessed with a RACE Score of ≥ 5 (moderate to severe stroke) should be transported/diverted to the closest Interventional Stroke Center. Declare a **RACE ALERT** through LCEMS dispatch and the appropriate RACE Center will be assigned for Medical Control Contact and transport. (**RACE Interventional Stroke Centers: UPMC; Promedica Toledo; Mercy St. Vincent**).
8. Pediatric patients with a RACE Score of ≥ 5 (moderate to severe stroke) should be transported /diverted to the closest Interventional Stroke Center. Declare a **RACE ALERT** through LCEMS dispatch and the appropriate RACE Center will be assigned for Medical Control Contact and transport. (**RACE Interventional Stroke Centers for pediatrics: Promedica Toledo; Mercy St. Vincent**).
9. Patients with a positive **BE FAST** exam and a RACE Score of 5 will be transported to the closest Primary Stroke Center. Declare a **Stroke Alert** through RCOG EMS Dispatch and the appropriate Primary Stroke Center will be assigned for Medical Control Contact and transport. (**Primary Stroke Centers: UPMC; Promedica Toledo; Mercy St. Vincent; Promedica Flower; Promedica Bay Park; Mercy St. Charles and Mercy St. Anne**).



W **Stroke / CVA**



Special Considerations (cont.),

10. ALS care for stroke patients should be directed at continuing or establishing care, conducting a thorough patient assessment, stabilizing the patient's perfusion and preparing for/providing patient transportation. Maintain the head/neck in neutral alignment. Elevate the head of the cot 30 degrees if the systolic BP is > 100mmHg (this will facilitate venous drainage and help reduce ICP).
11. Blood pressure increase is common with CVA. Evaluate if BP increase is acceptable or due to causative factors (i.e., Hypoxia, Full Bladder, Pain, etc.). Consider treating hypertension if SBP is > 220mmHg or DBP > 120-140mmHg.
12. Whenever possible, a family member should accompany the patient to the hospital to provide additional history and/or consent.
13. Be alert for airway problems (difficulty swallowing, vomiting).
14. Hypoglycemia can present as a localized neurologic deficit, especially in the elderly. If BS is < 60mg/dl, administer Dextrose IV. Thiamine 100mg IV should be considered prior to Dextrose administration in patients with possible alcoholism or signs of malnutrition.
15. Bradycardia may be present in a suspected stroke patient due to increased ICP. Do not give Atropine if the patient's BP is normal or elevated.
16. SMR precautions should be provided if the patient sustained a fall or other trauma.

W Stroke / CVA



BE FAST Examination

Balance Watch for sudden loss of balance / gait impairment

Eyes Check for all or partial vision loss

Facial Droop Normal: Both sides of face move equally
Abnormal: One side of face does not move at all



Arm Drift Normal: Both arms move equally or not at all
Abnormal: One arm drifts compared to the other



Speech Normal: Patient uses correct words with no slurring
Abnormal: Slurred or inappropriate words or mute

Time of Onset

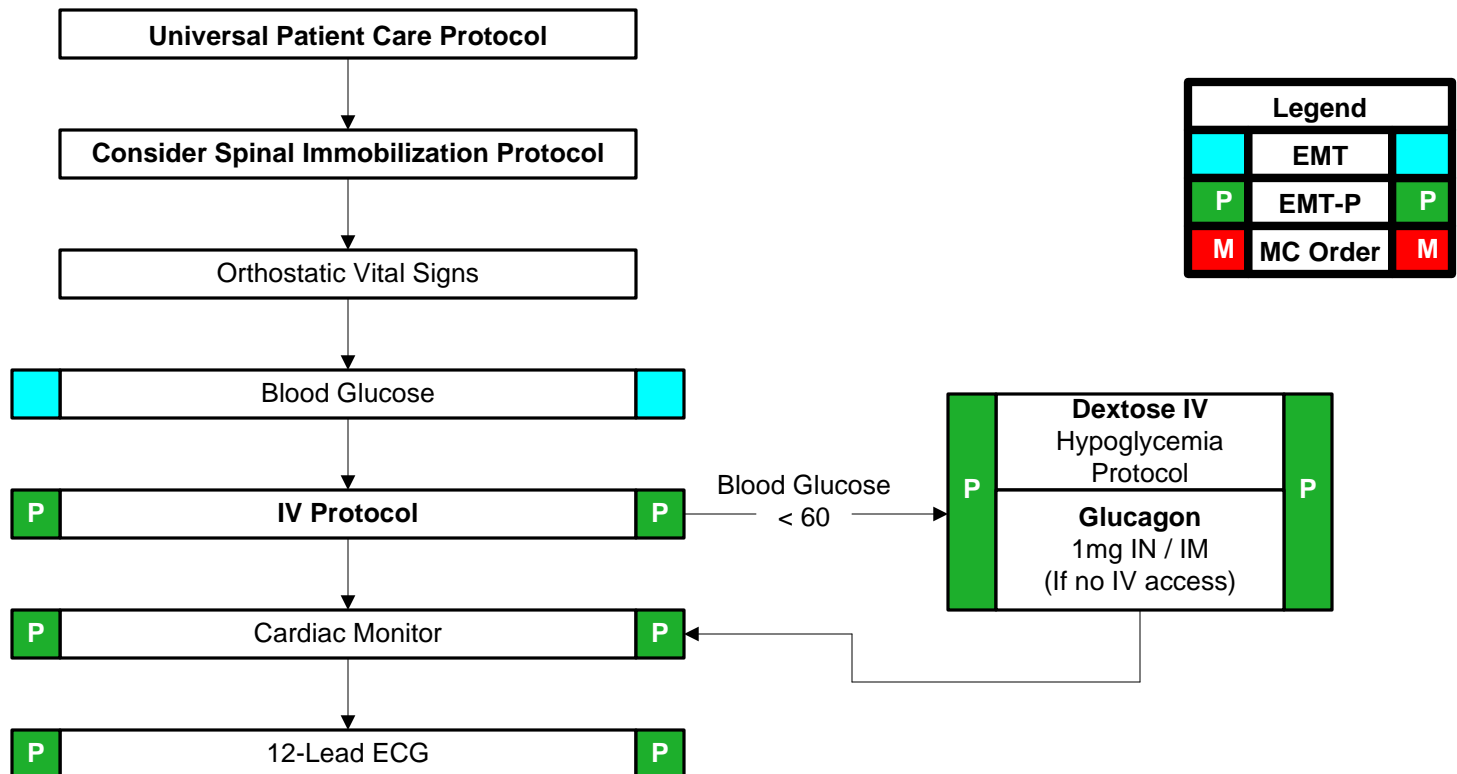
RACE Score Sheet: Circle one number for each item

Item	Instruction	Patient Response	RACE Score
Facial Palsy	Ask the patient to show teeth	Absent (symmetrical movement)	0
		Mild (slightly asymmetrical)	1
		Moderate to Severe (completely asymmetrical)	2
Arm Motor Function	Extending the arm of the patient 90 degrees (if sitting) or 45 degrees (if supine)	Normal to Mild (limb upheld more than 10 seconds)	0
		Moderate (limb upheld less than 10 seconds)	1
		Severe (patient does not raise the arm against gravity)	2
Leg Motor Function	Extending the leg of the patient 30 degrees (in supine position)	Normal to Mild (limb upheld more than 5 seconds)	0
		Moderate (limb upheld less than 5 seconds)	1
		Severe (patient does not raise leg against gravity)	2
Head / Gaze Deviation	Observe eyes and head deviation to one side	Absent (eye movements to both sides were possible and no head deviation observed)	0
		Present (eyes and head deviation to one side observed)	1
Aphasia (if right hemiparesis)	Ask the patient two verbal orders: -“close your eyes” -“make a fist”	Normal (performs both tasks correctly)	0
		Moderate (performs one task correctly)	1
		Severe (performs neither task)	2
Agnosia/Neglect (if left hemiparesis)	Asking: -“Whose arm is this?” while showing him/her the impaired arm -“Does this arm feel weak to you?”	Normal (recognizes arm and the impairment)	0
		Moderate (does not recognize arm or impairment)	1
		Severe (does not recognize arm and impairment)	2
	RACE Score Total:		<div></div>

X Syncope



History: <ul style="list-style-type: none"> Cardiac history, stroke, seizure Occult blood loss (GI, ectopic) Females: LMP, vaginal bleeding Fluid loss: nausea, vomiting, diarrhea Past medical history Medications 	Signs / Symptoms: <ul style="list-style-type: none"> Loss of consciousness with recovery Lightheadedness, dizziness Palpitations, slow or rapid pulse Pulse irregularity Decreased blood pressure 	Differential: <ul style="list-style-type: none"> Vasovagal Orthostatic hypotension Cardiac syncope Micturition / Defecation syncope Psychiatric Stroke Hypoglycemia Seizure Shock (see Shock Protocol) Toxicologic (Alcohol) Medication effect (hypotension)
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AT ANY TIME

If relevant signs / symptoms found go to appropriate protocol:

Dysrhythmia
Altered Mental Status
Hypotension



X Syncope



Special Considerations:

1. Syncope is defined as a transient state of unconsciousness from which the patient has recovered. If patients present with altered mentation, treat per the **Altered Mental Status Protocol (Tab 900, Section E)**.
2. Most syncope is vasovagal in nature and characterized by dizziness progressing to fainting/unconsciousness which may last for several minutes. For many patients, recumbent positioning may be sufficient to restore vital signs and level of consciousness to within normal values. Syncope which occurs without warning is potentially serious and often caused by cardiac arrhythmia.
3. Assess for signs and symptoms of trauma if associated or questionable fall with syncope.
4. Consider dysrhythmias, GI bleed, ectopic pregnancy, and seizure as possible cause of syncope. More than 25% of geriatric syncope is cardiac arrhythmia based.
5. Orthostatic measurement of vital signs can help determine if a patient requires fluid replacement or more extensive testing or treatment. When appropriate, orthostatic vital signs should be acquired to assess for possible volume depletion. Follow the **Orthostatic Vital Signs Protocol (Tab 500)**.
6. Thiamine 100mg IV should be considered prior to Dextrose administration in patients with possible alcoholism or signs of malnutrition.

Y Universal Patient Care Protocol



Scene Safety
Bring all necessary equipment to patient's side
Demonstrate professionalism and courtesy

PPE (Consider Airborne or Droplet if indicated)

Initial Assessment

BLS Maneuvers
Consider Spinal Immobilization
If Pediatric Patient, consider Broselow Tape

Airway Procedures (if required)
(Adult or Pediatric)

Vital Signs

(Temperature and Blood Glucose measurement
when appropriate)

Consider
Pulse SP02-CO Oximetry/Supplemental O2

Consider
Cardiac Monitor/12-Lead ECG

Appropriate Protocol

Legend		
	EMT	
P	EMT-P	P
M	MC Order	M

Cardiac Arrest

Go to appropriate protocol:

Cardiac Arrest
Ventricular Fibrillation
Pulseless Ventricular Tachycardia
Pulseless Electrical Activity
Asystole
Pediatric Pulseless Arrest

M Patient doesn't fit a protocol?
Contact **On-Line Medical Control** **M**



Y Universal Patient Care



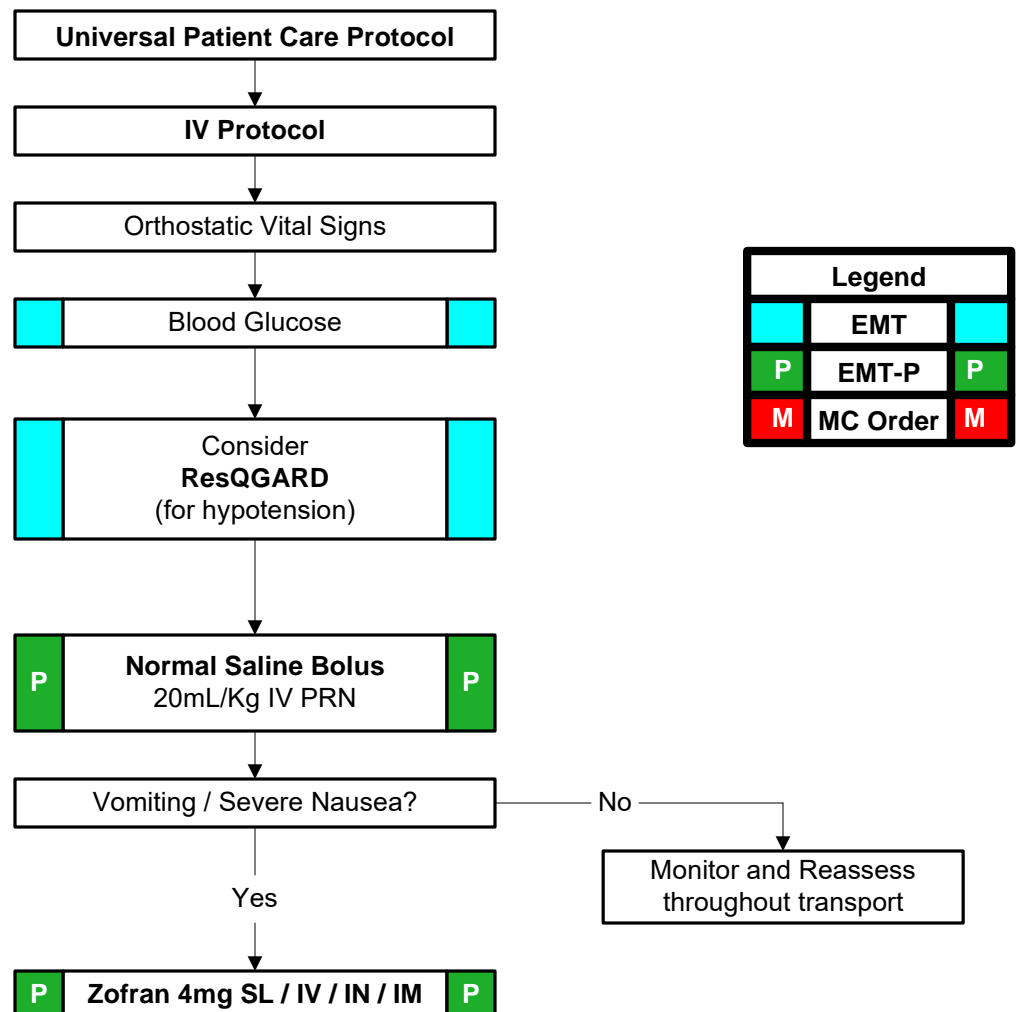
Special Considerations:

1. Any patient contact which does not result in a Life Squad transport, regardless of ***On-Line Medical Control*** contact, must have a complete ePCR tablet entry.
2. Minimal patient exam, if not noted on specific protocol includes: Vital signs, mental status, and location of injury or complaint.
3. Required vital signs on every patient include blood pressure, pulse, respirations, pain/ severity.
4. Pulse SpO2/CO oximetry, glucose measurement and temperature documentation is dependent on the specific complaint.
5. Timing of transport, if indicated, should be based upon the patient's clinical condition and the transport policy.

Z Vomiting and Diarrhea



History: <ul style="list-style-type: none"> • Age • Time of last meal • Last bowel movement/ emesis • Improvement or worsening with food or activity • Duration of problem • Other sick contacts • Past medical history • Medications • Menstrual history (pregnancy) • Travel history • Bloody emesis / diarrhea 	Signs / Symptoms: <ul style="list-style-type: none"> • Pain • Character of pain • Distention • Constipation • Diarrhea • Anorexia • Radiation Associated symptoms: (Helpful to localize source) Fever, headache, blurred vision, weakness, malaise, cough, headache, dysuria, mental status changes, rash	Differential: <ul style="list-style-type: none"> • CNS • Myocardial infarction • Drugs (NSAID's, antibiotics, narcotics, chemotherapy) • GI or renal disorders • Diabetic ketoacidosis • Gynecologic disease • Infections (pneumonia, influenza) • Electrolyte abnormalities • food or toxin induced • Medication or substance abuse • Pregnancy • Psychological
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Z **Vomiting and Diarrhea**



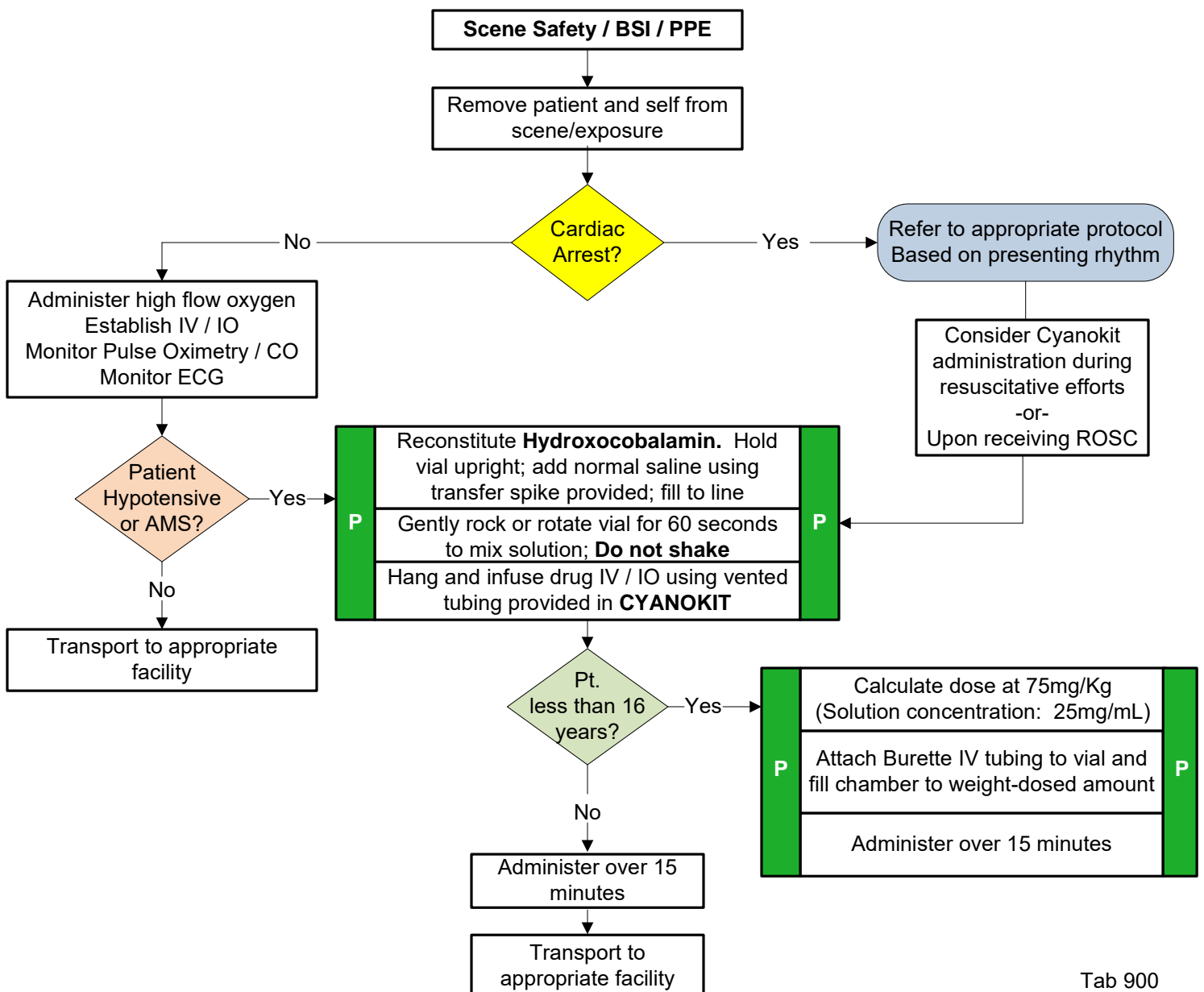
Special Considerations:

1. The list of differentials for nausea and vomiting is long. Attempt to identify underlying conditions.
2. Vomiting and diarrhea may be symptoms of a more serious underlying problem. Maintain high suspicion of a cardiac event for persons with diabetes or neuropathies.
3. For severe nausea and/or vomiting administer Zofran 4mg SL / IV / IN / IM. Zofran may be repeated x 1 in 5-10 minutes PRN.

AA Cyanide Exposure Cyanokit (Hydroxocobalamin)



History: <ul style="list-style-type: none"> • Patient extricated from fire with hypotension, AMS, or cardiac arrest • Patient found in area with known or suspected cyanide exposure 	Signs / Symptoms (CN Exposure): <ul style="list-style-type: none"> • Dyspnea • Tachypnea • Tachycardia / Bradycardia • Headache • Dizziness / Confusion • Generalized weakness • Bizarre behavior • Excessive sleepiness / Coma • Flushed • Bitter almonds smell • Cardiac Arrest 	Differential: <ul style="list-style-type: none"> • Possible cyanide poisoning
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AA Cyanide Exposure Cyanokit® (Hydroxocobalamin)



Cyanide can be found in a liquid (solutions of cyanide salts), solid (cyanide salts), or gaseous (hydrogen cyanide) form. In solid form, it is white and has a faint almond odor (20% of the population is genetically unable to detect the odor). Hydrogen cyanide gas may be formed when acid is added to cyanide salt, a nitrite, or when plastics burn. If a large amount of liquid or solid cyanide material is present on the victim's clothing or skin, it poses a significant risk of exposure to rescuers. Exposure can occur through skin absorption, eye contact, inhalation, and ingestion. If the patient is unconscious and is being rescued from a fire, there is a high probability of concurrent carbon monoxide and cyanide poisoning; both conditions must be treated.

Cyanide (CN) is an often unrecognized danger in closed-space fires:

- CN can be released by virtually any material containing carbon and nitrogen when burned under high temperature and low oxygen conditions.
- There is potential for CN toxicity due to the increased use of synthetic materials that produce CN during combustion in closed-space fires.
- Moderate to high concentrations of CN can cause severe injury or death in minutes.
- CN poisoning may also cause central nervous system side effects including intellectual impairment, Parkinson-type effects, and personality changes.

Common building materials known to release high levels of CN during combustion:

- Glass fiber (building insulation wool)
- Melamine (laminate for building construction)
- PIR (thermal insulation foam)
- Nitrile rubber (tubing insulation)
- Rigid PUR (building insulation foam)
- Particle board (laminate for building base material)

Currently there is no diagnostic test to confirm CN poisoning within the limited window for initiating lifesaving intervention:

- Even at most hospitals, rapid measurements of CN are not available.
- Lactate levels may be tested as levels increase proportionally with the amount of CN poisoning because of metabolic acidosis.

AA Cyanide Exposure Cyanokit® (Hydroxocobalamin)



Cyanide Exposure / Cyanokit, (cont.)

CN and carbon monoxide (CO) poisoning can be difficult to differentiate due to common signs and symptoms.

Moderate to Severe Poisoning Signs / Symptoms

Cyanide	Common to Both	Carbon Monoxide
Cardiovascular collapse	Altered level of consciousness	Severe headache
Hypotension	Respiratory arrest	Shock and death
Almond odor on breath	Cardiac dysrhythmia	
	Seizure	
	Lactic acidemia	

Because CN poisoning prevents cells from using oxygen, signs and symptoms of CN poisoning also mimic those of oxygen deprivation.

Identifying Patients with Cyanide Poisoning:

The presence and extent of cyanide poisoning are often initially unknown. Treatment decisions must be made on the basis of clinical history and signs and symptoms of cyanide intoxication. If clinical suspicion of cyanide poisoning is high, Cyanokit should be administered without delay.

Common Signs and Symptoms of Cyanide Poisoning

Symptoms	Signs
• Headache	• Altered Mental Status
• Confusion	• Seizures or Coma
• Dyspnea	• Mydriasis
• Chest tightness	• Tachypnea (early)
• Nausea	• Hypotension (late)
	• Bradypnea / Apnea (late)
	• Hypertension (early)
	• Cardiovascular collapse
	• Vomiting



AA Cyanide Exposure Cyanokit® (Hydroxocobalamin)



Cyanide Exposure / Cyanokit, (cont.)

Smoke Inhalation

Not all smoke inhalation victims will have cyanide poisoning and may present with burns, trauma, and exposure to other toxic substances making a diagnosis of cyanide poisoning particularly difficult. Prior to administration of Cyanokit, smoke inhalation victims should be assessed for the following:

When to suspect Cyanide Poisoning:

- Exposure to fire or smoke in an enclosed area
- Soot around the mouth, nose, or back of mouth
- Altered mental status (eg, confusion, disorientation)

Cyanokit® Dosage and Administration

Comprehensive treatment of acute cyanide intoxication requires support of vital functions. Cyanokit should be administered in conjunction with appropriate airway, ventilatory and circulatory support.

NOTE:

- **If patient is exposed to gas only and does not have skin or ocular irritation, no decontamination is needed.**
- **If patient is exposed to liquid, decontamination required. Avoid self-contamination**

The starting dose of Hydroxocobalamine for adults is 5Gm administered as an intravenous infusion over 15 minutes (approximately 15mL/min). Administration of the entire vial constitutes a complete starting dose.

Preparation of Solution for Infusion

1. Initiate a dedicated IV line.
2. Reconstitution: Add 200mL of 0.9% sodium chloride injection to the vial using the supplied sterile transfer spike. Fill to the line (with the vial in an upright position).
3. Mix: Rock, swirl, or rotate the vial for 60 seconds to mix the solution. Do not shake
4. Infuse the contents of the vial: Use vented IV tubing (included with kit) and piggyback to IV line. Infuse over 15 minutes

Tab 900
Cyanide Exposure / Cyanokit AA-4
06/2015

AA Cyanide Exposure Cyanokit® (Hydroxocobalamin)



Cyanide Exposure / Cyanokit, (cont.)

Pediatric Considerations for Cyanokit Administration (< 16 years of age)

- Calculate dose at 75mg/Kg (Solution concentration: 25mg/mL).
- Attach Burette IV tubing to vial and fill chamber to weight-dosed amount.
- Infuse over 15 minutes

Cyanokit Dosing Pediatric (< 16 years of age)

Weight in Kg	Dose in ML
3kg	9mL
5kg	15mL
7kg	21mL
9kg	27mL
11kg	33mL
13kg	39mL
15kg	45mL
20kg	60mL
25kg	75mL
30kg	90mL
35kg	105mL
40kg	120mL
45kg	135mL
50kg	150mL
55kg	165mL
60kg	180mL
65kg	195mL
70kg ≤	200mL/ Full Dose

AA
Cyanide Exposure
Cyanokit® (Hydroxocobalamin)



BB Hypo- / Hyperglycemia

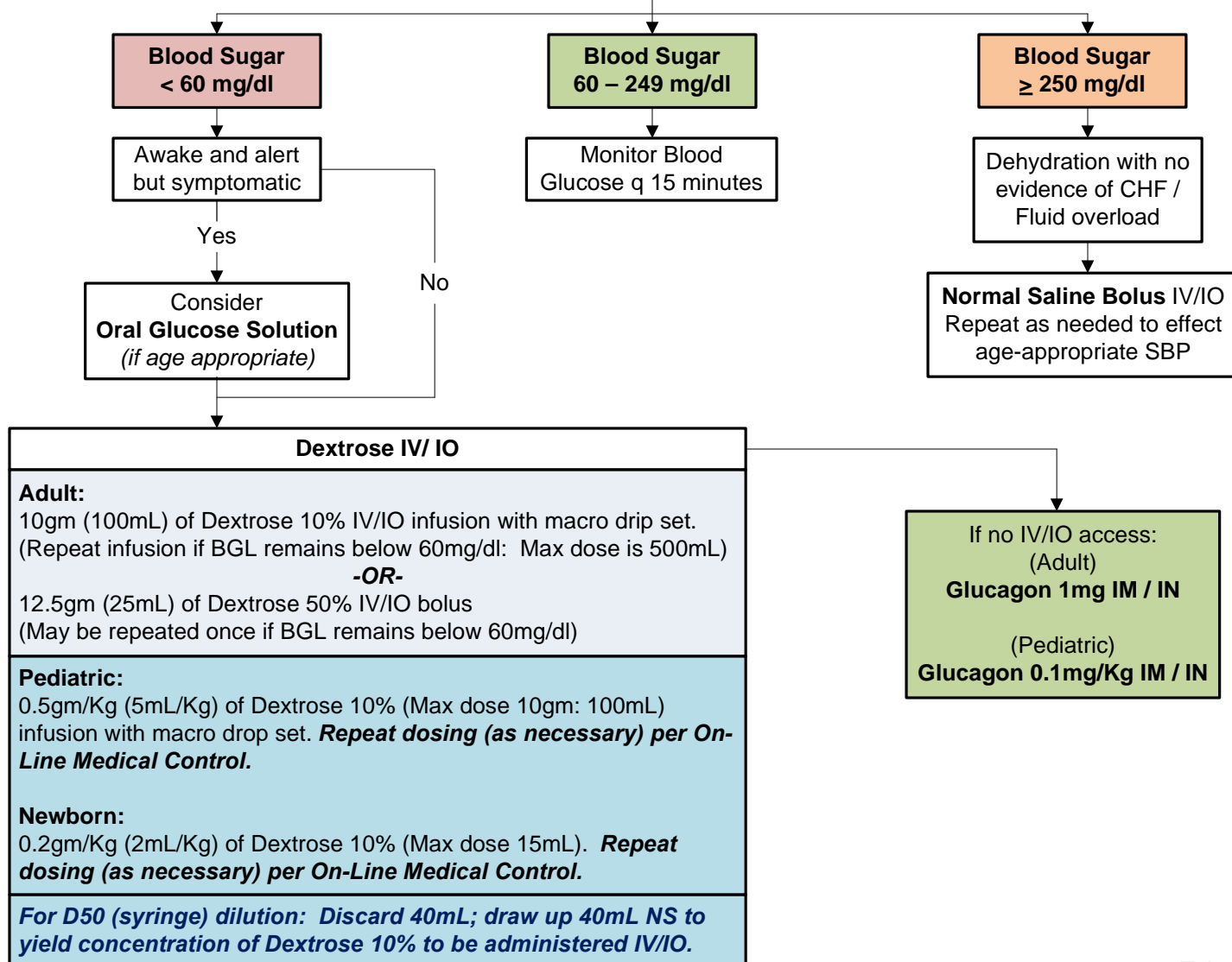


History: <ul style="list-style-type: none"> Past medical history Known diabetic, medic alert tag Medications Recent illness Recent blood glucose check Last meal Change in condition 	Signs / Symptoms: <ul style="list-style-type: none"> Altered mental status Combative / irritable Diaphoresis Seizures Abdominal pain Nausea / vomiting Weakness Dehydration Deep / rapid breathing 	Differential: <ul style="list-style-type: none"> Alcohol / drug use Toxic ingestion Trauma; head injury Seizure CVA Altered baseline mental status
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Blood Glucose Analysis

P **Intravenous Access** **P**
(as indicated)

P **EMT-P** **P**



BB Hypo- / Hyperglycemia



Important Dosing Information:

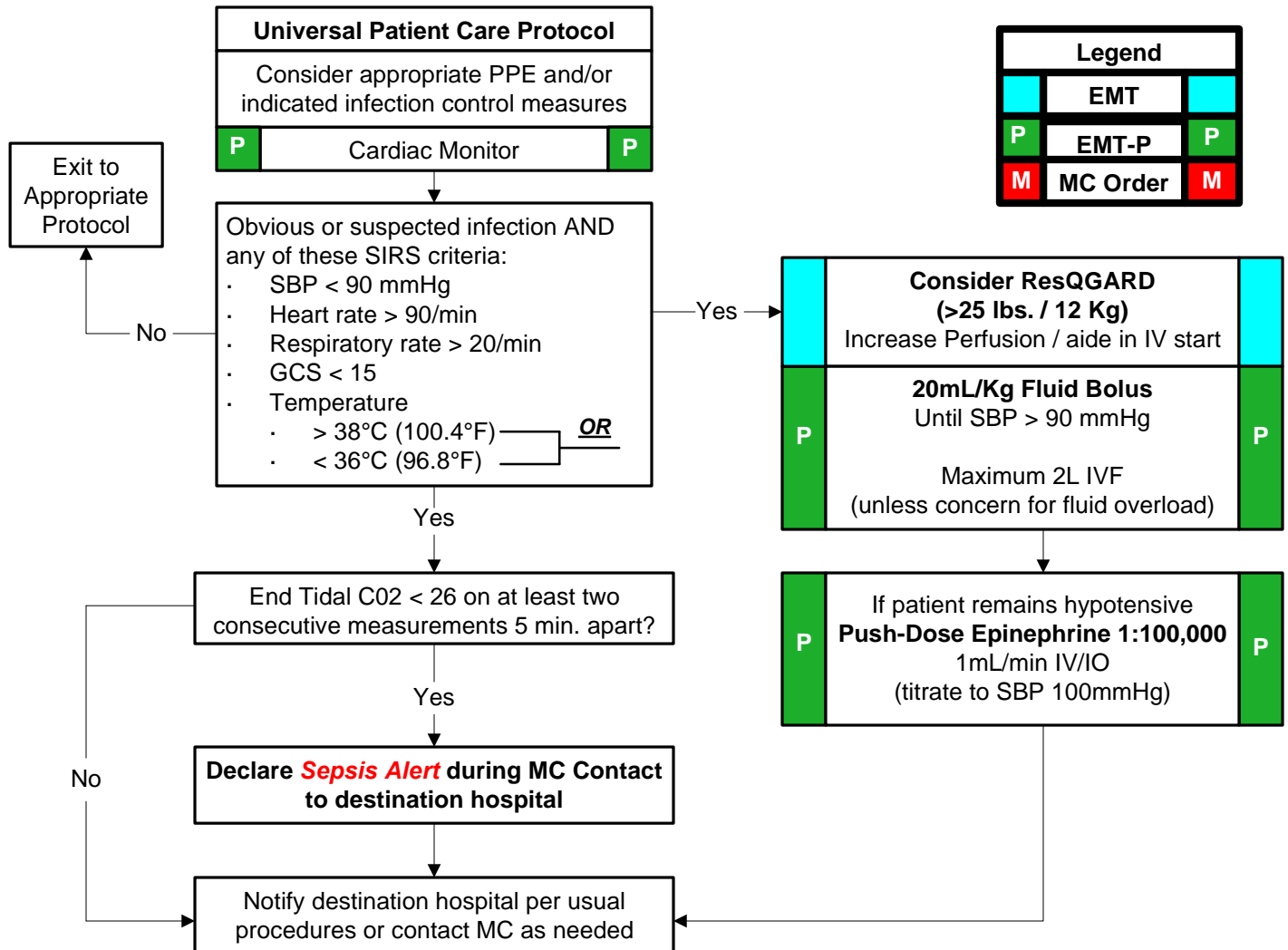
(Manufacturer allocation and supply dictates inventory of Dextrose that is available for patient administration. Dextrose 10% is the preferred concentration for patient use. In the event that Dextrose 10% is not available, protocol provisions allow for alternate dosing using Dextrose 50% if available. Always follow the dosing guidelines provided within this protocol/document.)

Special Considerations:

1. It is safer to assume hypoglycemia than hyperglycemia if doubt exists. Recheck blood glucose after therapy with Dextrose or IN / IM Glucagon.
2. Do not administer oral glucose to patients that are not able to swallow or protect their own airway.
3. Thiamine 100mg IV / IO should be considered prior to Dextrose administration in patients with possible alcoholism or signs of malnutrition.
4. For symptomatic patients with low blood sugar values, and absent intravenous access, administer Glucagon IN / IM (age-appropriate dosing).
5. Patients with prolonged hypoglycemia may not respond to Glucagon.
6. For patients with altered mentation and combative (or aggressive) behavior, consider restraints for patient and/or personnel's protection.
7. ***On-Line Medical Control*** contact is **required** for any treat/release or refusal of treatment and/or transport with appropriate documentation and signatures obtained in the ePCR.



History: <ul style="list-style-type: none"> Age (common in elderly and very young) Presence and duration of fever Previously documented infection or illness (UTI, pneumonia, meningitis, encephalitis, cellulitis, abscess, etc.) Recent surgery or invasive procedure Immunocompromised (transplant, HIV, diabetes, cancer) Bedridden or immobile patients Prosthetic or indwelling devices Immunization status 	Signs / Symptoms: <ul style="list-style-type: none"> Hyper- or hypothermia Rash and/or excessive bruising Chills Myalgia (muscle aches) Markedly decreased urine output Altered mentation Delayed capillary refill Elevated blood glucose (unless diabetic) 	Differential: <ul style="list-style-type: none"> Cardiogenic shock Hypovolemic shock Dehydration Hyperthyroidism Medication / drug interaction Non-septic infection Allergic reaction / anaphylaxis Toxicological emergency
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CC Sepsis / Septic Shock



Sepsis is a rapidly progressing, life-threatening condition due to systemic infection. Sepsis must be recognized early and treated aggressively to prevent progression to shock and death. Sepsis can be identified when the following marker of the Systemic Inflammatory Response Syndrome (SIRS) are present in a patient with suspected infection.

- Temperature $> 38^{\circ}\text{C}$ (100.4°F) OR $< 36^{\circ}\text{C}$ (96.8°F)
- Respiratory rate > 20 breaths/min
- Heart Rate > 90 beats/min
- End tidal $\text{CO}_2 < 26$ mmHg OR Lactate $> 4\text{mMol}$

In addition to physiologic markers of SIRS, severe sepsis may cause hypoxia and inadequate organ perfusion, resulting in metabolic acidosis marked by elevated blood lactate levels and decreased ETCO_2 levels (measured by capnography).

Special Considerations for Sepsis:

1. Early recognition of Sepsis allows for attentive care and early administration of antibiotics.
2. Aggressive IV fluid therapy is the most important pre-hospital treatment for sepsis. Suspected septic patients should receive 20mL/Kg fluid bolus (to a maximum of 2 Liters) while being checked for signs of pulmonary edema, especially patients with known history of CHF or ESRD on dialysis. STOP fluid administration in the setting of pulmonary edema.
3. Attempt to identify source infection (skin, respiratory, etc.) and relay previous treatments and related history to the receiving ED physician.
4. Elevated serum lactate levels are a useful marker of hypo-perfusion in sepsis and often become elevated prior to the onset of hypotension. End tidal CO_2 levels are correlated with lactate levels.
5. Disseminated Intravascular Coagulation (DIC) is an ominous, late stage of manifestation of sepsis characterized by frank, extensive bruising, bleeding from multiple sites and finally tissue death.

Special Considerations for Sepsis (cont.):

Sepsis Alert

The purpose of a Sepsis Alert is to provide pre-arrival Emergency Department notification in order to facilitate rapid assessment and treatment of a suspected severe sepsis patient. Sepsis Alert patients should be transported to a hospital with on-site intensive care service (NOT a Free-Standing Emergency Department).

A **Sepsis Alert** will be declared for patients meeting the following 3 criteria:

1. Suspected infection
2. Two or more of the following
 - Temperature > 38°C (100.4°F) OR < 36°C (96.8°F)
 - Respiratory rate > 20 breaths/min
 - Heart rate > 90 beats/min
3. ETCO₂ < 26 mmHg OR Lactate > 4mMol

Advanced Life Support:

- Full ALS assessment and treatment
- Notify hospital of incoming **Sepsis Alert** prior to arrival
- Consider ResQGARD (ITD) to increase perfusion / aide in IV start
- Administer 20mL/Kg fluid bolus until SBP > 90 mmHg
- If SBP remains < 90 mmHg following fluid administration.

Patients that remain hypotensive following standard fluid resuscitation:

- **Push-Dose Pressor Epinephrine (1:100,000)**
 - Dilute: Discard 9mL of Epi 1:10,000 (0.1mg/mL) and draw up 9mL of normal saline to create Push-Dose Pressor Epi 1:100,000. This will yield 10mcg/mL.
 - ü Administer 1mL/minute IV/IO, titrate to maintain SBP 100mmHg.
 - ü May repeat X 2 prn by standing order (protocol)
 - ü Max total dose 300mcg (30mL)
- **Push-Dose Pressor Epinephrine Precautions:**
 - ü Rapid (1 minute) onset, short (5-10) minute duration
 - ü Monitor heart rate and blood pressure throughout administration

Special Considerations for Sepsis (cont.):

Pediatric Considerations (Sepsis):

- Consider possible sources of infection in the pediatric population:
 - ü Ears (otitis media)
 - ü Infected wounds
 - ü Strep Pharyngitis
 - ü Conjunctivitis
 - ü Etc.
- Up to 15% of febrile patients between the age of 3 and 36 months with no obvious source of infection will have occult bacterial infections
- The mortality rate for sepsis is age-dependent. The neonate has the highest morbidity and mortality from serious bacterial infection.
- A septic child may look ill and have ashen color, pallor and/or cyanosis. He or she may be irritable or lethargic, febrile, normothermic or hypothermic. Most have tachycardia and tachypnea. In the late stages, the child may hypoventilate with poor perfusion. Parents usually report the child has been fussy, lethargic, anorectic, and perhaps sleeping more than usual.
- **Differential (PEDS):** There are numerous disorders that can cause a child to appear septic including viral infections, cardiac diseases, endocrine, genitourinary, metabolic, hematologic, gastrointestinal disorders, neurologic disease and child abuse.
- IV fluid therapy is the most important pre-hospital treatment for sepsis. Suspected pediatric septic patients should receive 20mL/Kg fluid bolus to maintain age-appropriate SBP ($SBP \geq 70 + 2 \times \text{age}$). Maximum of 2 Liters while checking patient frequently for signs of pulmonary edema. STOP fluid administration in the setting of pulmonary edema.
- For the pediatric patient follow the Handtevy dosing guide for fluid therapy. Patients that remain hypotensive following standard fluid resuscitation should receive push-dose pressor Epinephrine following the guidelines provided:



Special Considerations for Sepsis (cont.):

Patients that remain hypotensive following standard fluid resuscitation:

- **Push-Dose Pressor Epinephrine (1:100,000)**
 - Dilute: Discard 9mL of Epi 1:10,000 (0.1mg/mL) and draw up 9mL of normal saline to create Push-Dose Pressor Epi 1:100,000. This will yield 10mcg/mL.
 - ü Administer 1mL/minute IV/IO, titrate to maintain SBP 100mmHg.
 - ü May repeat X 2 prn by standing order (protocol)
 - ü Max total dose 300mcg (30mL)
- **Push-Dose Pressor Epinephrine Precautions:**
 - ü Rapid (1 minute) onset, short (5-10) minute duration
 - ü Monitor heart rate and blood pressure throughout administration