

ALABAMA EMS PATIENT CARE PROTOCOLS

11th Edition

2025





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STATE HEALTH OFFICER

July 1, 2025

Dear Colleagues:

On behalf of the Alabama Department of Public Health Office of Emergency Medical Services, I would like to express our sincere appreciation to the individuals who were tasked with the responsibility of updating the Alabama EMS Patient Care Protocols. As you should know, creating this type of document is not an easy task by any means; however, it is very important to ensure the advancement of EMS in Alabama, and it is a milestone to which we can all be proud.

I hope that you will agree that collective efforts yielded a great outcome for EMS in Alabama and for the EMS industry. This was only possible through dedication and commitment of time and effort, which is especially notable given the regular responsibilities of our providers and the current situation in our industry. Again, thank you for your continued commitment to the values and mission of the Office of Emergency Medical Services, as we look forward to continuing the progression of EMS in Alabama.

Sincerely,

Jamie Gray, B.S., NRP, TP-C, Director
Office of Emergency Medical Services

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PATIENT CARE PROTOCOLS

TABLE OF CONTENTS

Preface	08
Scope of Practice	09
Emergency Medical Technician (EMT)	10
Advanced EMT (AEMT)	11
Intermediate EMT (EMT-I)	12
Paramedic	13
Community Paramedicine	14
Acute Health Systems	
Trauma System	15
Stroke System	18
Treatment Protocols	
General Patient Care	20
Abdominal Pain	21
Adrenal Insufficiency	23
Allergic Reactions	25
Altered Mental Status	27
Asthma / COPD	29
Bites and Envenomations	31
Cardiac Arrest – Adult	33
Cardiac Arrest - Pediatric	36
Cardiac Dysrhythmias – Adult Bradycardia	38
Cardiac Dysrhythmias – Adult Tachycardia w/ Pulse	40
Cardiac Dysrhythmia – Pediatric	42
Chest Pain or Acute Coronary Syndrome (ACS)	44
Childbirth	47
Congestive Heart Failure	49
Croup or Upper Airway Obstruction	51
Decompression Sickness	53
Electromuscular Incapacitation Device (Taser®)	54
Hemodialysis Emergency Disconnect	55
Hypertensive Emergencies	57
Hyperthermia	58
Hypoglycemia	60
Hypothermia	62
Influenza/Respiratory Illness	64
Nausea / Vomiting	65
Near Drowning	67
Newborn Care	69
Pain Management	72

Poisons and Overdoses	74
Post Intubation Sedation and CPR Consciousness	77
Usage Preeclampsia/Eclampsia	79
Seizure	81
Sepsis	83
Shock	86
Stroke	89
Syncope	92
Vaginal Bleeding	94
General Trauma	96

Medication

Acetaminophen	103
Adenosine	104
Albuterol and Ipratropium	105
Amiodarone	106
Aspirin	108
Atropine Sulfate	109
Calcium Gluconate	111
Calcium Chloride	112
Cardene	113
Cefazolin	114
Ceftriaxone	115
Cleviprex	116
Cyanokit	117
Dexamethasone	118
Dextrose 10%	119
Dextrose 25%	119
Dextrose 50%	119
Diazepam	120
Diltiazem	121
Diphenhydramine	122
Dobutamine	123
Dopamine	124
Epinephrine	125
Esmolol	129
Etomidate	130
Fentanyl	131
Furosemide	133
Glucagon	134
Haloperidol	135
Heparin	136
Hydralazine	137
Hydrocortisone	138
Hypertonic Saline 3%	139
Kepra	140
Ketamine	141

Labetalol	143
Lactated Ringers	144
Lidocaine	145
Lorazepam	146
Magnesium Sulfate	147
Mannitol	149
Metaclopramide	150
Methylprednisolone	151
Metoprolol	152
Midazolam	153
Morphine	154
Naloxone	155
Nitroglycerin	156
Nitroprusside	158
Norepinephrine	159
Ondansetron	160
Oral Glucose	161
Pavulon	162
Pepcid	163
Phenylephrine	164
Pitocin	165
Promethazine	166
Propofol	167
Racemic Epinephrine	168
Rocuronium	169
Sodium Bicarbonate	170
Sodium Chloride	171
Succinylcholine	173
Terbutaline	174
Thiamine	175
Toradol	176
Tranexamic Acid (TXA)	177
Vasopressin	178
Vecuronium Bromide	179
Vitamin K1	180

Reference

Critical Care Guidelines	181
Rule of Nines	194
APGAR Scoring	195
Glasgow Coma Scale	196
Oxygen Percentages	197
Lidocaine Clock	198
Dopamine Table	199
Ideal Body Weight	200
Search and Rescue Marking Systems	201
Triage of Mass Casualties	202

Forms

Request to be Transported to a Hospital on Diversion_____	<u>204</u>
Thrombolytic Checklist (STEMI)_____	<u>205</u>
Thrombolytic Checklist (Stroke)_____	<u>206</u>

Tactical Paramedic

Surgical Cricothyroidotomy_____	<u>207</u>
Blood Transfusion Procedure_____	<u>208</u>

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Preface

These protocols are intended to guide emergency medical services personnel (EMSP) in the response and management of emergency situations and the care and treatment of patients. A request for changes to these protocols should be made in writing to the State Emergency Medical Control Committee:

Dr. William Crawford, State EMS Medical Director

Alabama State Emergency Medical Control Committee

Alabama Department of Public Health (ADPH)

Office of EMS

P.O. Box 303017

Montgomery, AL 36130-3017

Or William.Crawford@adph.state.al.us

This manual contains ALL of the medications and procedures allowed for EMSP in Alabama. EMSP are responsible for their actions within the respective scope of practice of the license that they hold. Online Medical Direction (OLMD) can only order procedures and medication administration within the EMSP scope of practice. EMSP should respectfully decline any orders which would cause them to violate their scope of practice.

The medication section of this manual is provided for informational purposes only. EMSP may administer medications only as listed in the protocol unless OLMD orders a deviation.

This manual also serves as a reference for physicians providing OLMD to EMSP. Treatment direction which is more appropriate to the patient's condition than the protocol should be provided by the physician as long as the EMSP scope of practice is not exceeded. Treatment direction includes basic care, advanced procedures, and medication administration. OLMD can expect an EMSP to respectfully decline any orders which would cause them to violate their scope of practice.

Patient preference of hospital destination supersedes the Acute Health Care System as long as the patient is deemed competent by EMSP and OLMD.

Pediatric information is differentiated by label and font characteristics. Anything pertaining to pediatric patients will be presented in Green Font. Unless otherwise noted in a protocol, a pediatric patient is defined as someone 15 years old or younger. For any concerns regarding pediatric protocols or procedures, please contact:

Dr. Shea Duerring, Assistant State EMS Medical Director for Pediatrics

Alabama State Emergency Medical Control Committee

Alabama Department of Public Health (ADPH)

Office of EMS

P.O. Box 303017

Montgomery, AL 36130-3017

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Scope of Practice

Licensed EMSP are authorized to perform procedures and administer medications as defined by these protocols. Each level of EMSP, as defined by the Office of EMS Rules, has a specific list of authorized procedures and medications as defined by that level's scope of practice. Each scope of practice is in addition to that of any preceding lower levels.

EMSP are prohibited from performing any procedure or utilizing any medication not approved by the State Committee of Public Health even though they may have been taught these medications and procedures in their EMSP curriculum.

Lower level EMSP can assist higher level EMSP with patient care activities as long as the lower level EMSP does not exceed his or her scope of practice regarding administration of medications or performance of procedures. Ultimately, the higher level EMSP is responsible for patient care and documentation.

Emergency Medical Technician (EMT)

An EMT is authorized to perform patient care procedures and administer medications as follows:

1. Patient assessment including taking and recording vital signs and appropriate history.
2. Administration of supplemental oxygen via cannula or mask.
3. Administration of aspirin for suspected cardiac chest pain.
4. Use of oropharyngeal and nasopharyngeal airways.
5. Placement of Blind Insertion Airway Device (BIAD).
6. Use of bag-valve mask.
7. Use of mouth to mask device with or without supplemental oxygen.
8. Use of pulse oximetry devices.
9. Opening and maintaining a patent airway using simple airway maneuvers.
10. Use of suction equipment.
11. Cardiopulmonary resuscitation.
12. Simple management of a cardiac emergency including the use of an AED.
13. Acquiring and transmitting ECGs (if AED is capable).
14. Control of bleeding and shock through positioning, direct pressure, and tourniquet.
15. Use of hemostatic agents.
16. Bandaging.
17. Spinal Motion Restriction and Spinal Precautions.
18. Splinting including traction splint.
19. Joint dislocation immobilization.
20. Assistance with emergency childbirth, NOT including any surgical procedures.
21. Capillary puncture for the purpose of blood glucose monitoring.
22. Use of automated glucometer.
23. Properly lifting and moving a patient.
24. Patient extrication.
25. Mass casualty incident triage including triage tags.
26. Scene management, such as directing traffic, but only when such activities do not interfere with patient care duties and law enforcement personnel are not at the scene.
27. Continuous Positive Airway Pressure (CPAP) or Bilevel Positive Airway Pressure (BiPAP).
28. Use of Capnography.
29. The use of FDA approved equipment may be utilized to perform procedures within the scope of practice.

Medications (for use as specified in treatment protocols):

1. Administration of medications as listed on the EMT Medication Formulary in the EMS setting.
2. Administration of auto-injectors prescribed to the patient.
3. Site maintenance of heparin locks and saline locks.

Advanced Emergency Medical Technician (AEMT)

An AEMT is authorized to perform all patient care procedures and administer all medications as defined in the EMT Scope of Practice AND the additional procedures and medications as follows:

Procedures:

1. Peripheral venipuncture (IV).
2. Adult and pediatric intraosseous cannulation (IO).
 - Adult Sites – Proximal Humerus, Sternal (only with appropriate device approved for sternal use), Proximal Tibia.
 - Pediatric Sites - Proximal Humerus, Proximal Tibia, Distal Femur.
3. ECG Monitoring during Interfacility Transfers and emergency calls for service to recognize lethal rhythms. If recognized, the Advanced EMSP must switch to AED mode only. This may only be performed by individuals who have completed the required training and gained approval from the Provider Service Medical Director. Once training is complete, they may utilize the boxes where cardiac monitoring is appropriate.
4. The use of FDA approved equipment may be utilized to perform procedures within the scope of practice.

Medications (for use as specified in treatment protocols):

1. Administration of medications as listed on the AEMT Medication Formulary in the EMS setting. Medications may be administered via the intravenous, intraosseous, intranasal, subcutaneous, intramuscular, oral, sublingual, and through inhalers if approved for such administration by the State Committee of Public Health.
2. Maintenance of I.V. fluids within the scope of practice of an Advanced EMT for inter-facility transfer patients.

Intermediate Emergency Medical Technician (EMT-I)

An EMT-I is authorized to perform all patient care procedures and administer all medications as defined in the EMT and the AEMT scope of practice AND the additional procedures as follows:

Procedures:

1. Placement of oral and nasal endotracheal tubes.
2. Use of cardiac monitoring equipment, including placement of electrical leads and interpreting ECGs.
3. Delivery of electrical therapy to patients including manual defibrillation and synchronized cardioversion.

Paramedic

A Paramedic is authorized to perform all patient care procedures and administer all medications as defined in the EMT, AEMT, and EMT-I scope of practice AND the additional procedures and medications as follows:

Procedures:

1. External Cardiac Pacing.
2. Nasogastric or Orogastric tube placement.
3. Blood draw for medical purposes only.
4. Blood administration and maintenance.
5. Needle Cricothyroidotomy (Optional procedure with approval from Provider Service Medical Director)
6. The use of FDA approved equipment such as, but not limited to, ventilators, ultrasound, etc, may be utilized to perform procedures within the scope of practice.
7. Needle Decompression at the second or third intercostal space on the anterior chest at the midclavicular line or along the anterior axillary line at the 4th intercostal space on the same side as the tension pneumothorax.

Medications:

1. Administration of medications on the list approved by the State Committee of Public Health for such use in the EMS setting as stated on the Paramedic Medication Formulary. Medications may be administered via the intravenous, intraosseous, intranasal, subcutaneous, intramuscular, oral, sublingual, and rectal routes; and, through inhalers and endotracheal tubes if approved for such administration by the State Committee of Public Health; and,
2. Within the constraints specified in the Office of EMS rules, administration of medications, maintenance of I.V. fluids, and blood administration for inter- hospital transfer patients.

Community Paramedicine

PURPOSE: To provide guidance to EMSP engaged in scheduled patient visits for the purpose of preventing future medical emergencies.

KEY POINTS:

- At this time, no EMSP shall engage in any patient care activities other than BLS interventions during scheduled patient encounters for the sake of EMS prevention.
- When a patient is assessed, the EMSP shall document the encounter and outcome at the conclusion (i.e., Refusal of Transport).
- If at any time during the scheduled visit, the patient or the provider identifies the need for emergency treatment, the EMSP shall perform the necessary interventions within his or her scope of practice and arrange for emergency transport.
- All EMS prevention activities should be approved by the agency's medical director prior to implementation.

Acute Health Systems

This section provides patient entry criteria and guidance for Acute Health Systems procedures.

Trauma System

ENTRY CRITERIA

Physiological Criteria:

1. A systolic BP <90 mm/Hg in an adult **or child 6 years or older <80 mm/Hg in a child 5 or younger.**
This includes any trauma related cardiac arrest that will be treated or transported to the hospital.
2. Respiratory distress - rate < 10 or >29 in adults, **or <20 or >60 in a newborn. <20 or >40 in a child 3 years or younger. <12 or >29 in a child 4 years or older.**
3. Head trauma with Glasgow Coma Scale score of 13 or less **or head trauma with any neurologic changes in a child 5 years or younger.**

Anatomical Criteria:

1. The patient has a flail chest.
2. The patient has two or more obvious proximal long bone fractures (humerus, femur).
3. The patient has penetrating trauma to the head, neck, torso, or extremities proximal to the elbow or knee.
4. The patient has in the same body area a combination of trauma and burns (partial and full thickness) of 15 percent or greater.
5. See Trauma Protocol for criteria to enter a burned patient into the trauma system.
6. The patient has an amputation proximal to the wrist or ankle.
7. The patient has one or more limbs which are paralyzed.
8. The patient has a pelvic fracture, as evidenced by a positive "pelvic movement" exam.
9. The patient has a crushed, degloved, mangled, or pulseless extremity.
10. The patient has an open or depressed skull fracture.
11. The patient meets burn criteria set forth in the Burn Protocol.

Mechanism of the patient injury:

1. A patient with the same method of restraint and in the same seating area as a deceased victim.
2. Ejection of the patient from an enclosed vehicle.

3. Motorcycle/bicycle/ATV crash with the patient being thrown at least 10 feet from the motorcycle/bicycle.
4. Auto versus pedestrian with significant impact with the patient thrown, or run over by a vehicle.
5. An unbroken fall of 20 feet or more onto a hard surface. **Unbroken fall of 10 feet or 3 times the height of the child onto a hard surface.**

EMSP Discretion:

1. If the EMSP is convinced that the patient could have a severe injury which is not yet obvious, the patient should be entered into the Alabama Trauma System.
2. The EMSP's suspicion of severity of trauma/injury may be raised by the following factors:
 - a. Age >55
 - b. **Age <5**
 - c. Environment (hot/cold)
 - d. Patient's previous medical history
 - e. Insulin dependent diabetes or other metabolic disorder
 - f. Bleeding disorder or currently taking anticoagulant medication (e.g. coumadin, heparin)
 - g. COPD/Emphysema
 - h. Renal failure on dialysis
 - i. Pregnancy
 - j. **Child with congenital disorder**
 - k. Extrication time >20 minutes with heavy tools utilized
 - l. Motorcycle crash
 - m. Head trauma with history of more than momentary loss of consciousness.

Entering a Patient into the Alabama Trauma System

An EMSP should call the Alabama Trauma Communication Center (ATCC) to determine patient destination.

ATCC contact number: 1-800-359-0123

The initial unit on-scene should enter the patient into the Alabama Trauma System, but if they have not done so, it becomes the responsibility of the transporting service (ground or air) before the receiving facility is selected.

For helicopter EMS (HEMS) it is preferable to request a preliminary receiving facility from ATCC prior to arrival on the scene and then later enter the patient into the ATCC as soon as is logistically possible. After assessing a trauma situation and making the determination that the patient should be entered into the Alabama Trauma System, the EMSP licensed at the highest level should contact the ATCC at the earliest practical time before the receiving facility is selected and provide the following information; the highest level EMSP on the scene may delegate the call to ATCC to a lower level EMSP if patient care duties require the higher level EMSP's attention:

- 1) EMSP service

- 2) Location of Trauma Scene
- 3) Age and Sex of the patient(s)
- 4) Reason for Entry and Mechanism of Injury
- 5) Patient assessment
 - a) Airway Status
 - b) Vital signs and GCS
 - c) Areas of Injury
 - d) Environmental issues or co-morbid factors
- 6) Transportation type
- 7) Transportation timing

ATCC will provide a unique identification number that must be entered into the e-PCR.

Notify the ATCC of any change in the patient's condition. The receiving trauma center or ATCC should be updated by the transporting unit 5-10 minutes out. This update should only consist of any patient changes and the patient's current condition. A repeat of information used to enter the patient into the Alabama Trauma System is not necessary since this information will be relayed by the ATCC to the receiving trauma center.

After the patient is delivered to the trauma center, the transporting provider should call the ATCC with the patient care report times.

TRAUMA SYSTEM DIVERT TO CLOSEST FACILITY

Criteria for diverting to the closest hospital includes:

- Loss of airway.
- Hemodynamic instability (with no vascular access).
- Uncontrolled bleeding (external).
- Notifying ATCC of intent to divert to closest facility for listed criteria.

Stroke System

The stroke system is for patients who have signs and symptoms of stroke, also defined as an acute episode of neurological deficit without any evidence of trauma. If the patient has altered mental status, other possible causes of their current symptoms such as hypoxia, hypoperfusion, hypoglycemia, trauma, or overdose should be considered and addressed if needed. Any patient treated by EMS using this protocol should be entered into the stroke system as soon as possible.

Perform the Emergency Medical Stroke Assessment (EMSA) stroke scale:

1. **Eye:**
 - Horizontal Gaze:** Ask patients to keep their head still and follow your finger left to right with their eyes. In aphasic patients, call the patient's name on one side and then on the other.
Abnormal: Patient is unable to follow as well in one direction compared to the other.
2. **Motor:**
 - a. **Facial Weakness:** ask patients to show their teeth or smile. In aphasic patients, look for asymmetric grimace to pain.
Abnormal: One side of the face does not move as well as the other.
 - b. **Arm weakness:** Ask the patient to hold out both arms, palms up, for 10 seconds with eyes closed. In aphasic patients, hold the patient's arms up and let go.
Abnormal: One arm does not move or drifts down compared to the other.
 - c. **Leg weakness:** Ask a patient to lift one leg and then the other for 5 seconds. In aphasic patients, hold one leg and let go, then repeat on the other side.
Abnormal: One leg does not move or drifts down compared to the other.
3. **Speech/Aphasia:**
 - a. **Naming:** Ask a patient to name your watch or pen.
Abnormal: Patient slurs words, says the wrong words, or is unable to speak.
 - b. **Repetition:** Ask the patient to repeat "They heard him speak on the radio last night." **Abnormal:** Patient slurs words, says the wrong words, or is unable to speak.

If any component of the EMSA stroke scale is abnormal, the patient is very likely to be suffering from an acute stroke. Greater than or equal to 4 points is a concern for a LVO Stroke (Large Vessel Occlusion) and preferably routed to thrombectomy centers if possible.

EMSP Discretion

1. If the EMSP is convinced that the patient is likely to have a stroke which is not yet obvious, then the patient may be entered into the stroke system.
2. EMSP suspicion of stroke may be raised by the following factors (but these situations alone do not constitute reason for stroke system entry):
Symptoms of stroke occurred and disappeared within a few minutes, even if the patient is presently normal.
3. Patient is awake with spontaneous inability to remember or understand what is said or to express himself (expressive or receptive aphasia).
4. EMSP are to immediately inform the ATCC when a decision is made to enter a patient

into the stroke system using discretion and inform the ATCC of the reason for that decision.

5. It is to be specifically noted in the run report that EMSP discretion is being used to enter a patient into the stroke system and the reason or basis for that decision is to be written on the prehospital e-PCR.

General Patient Care

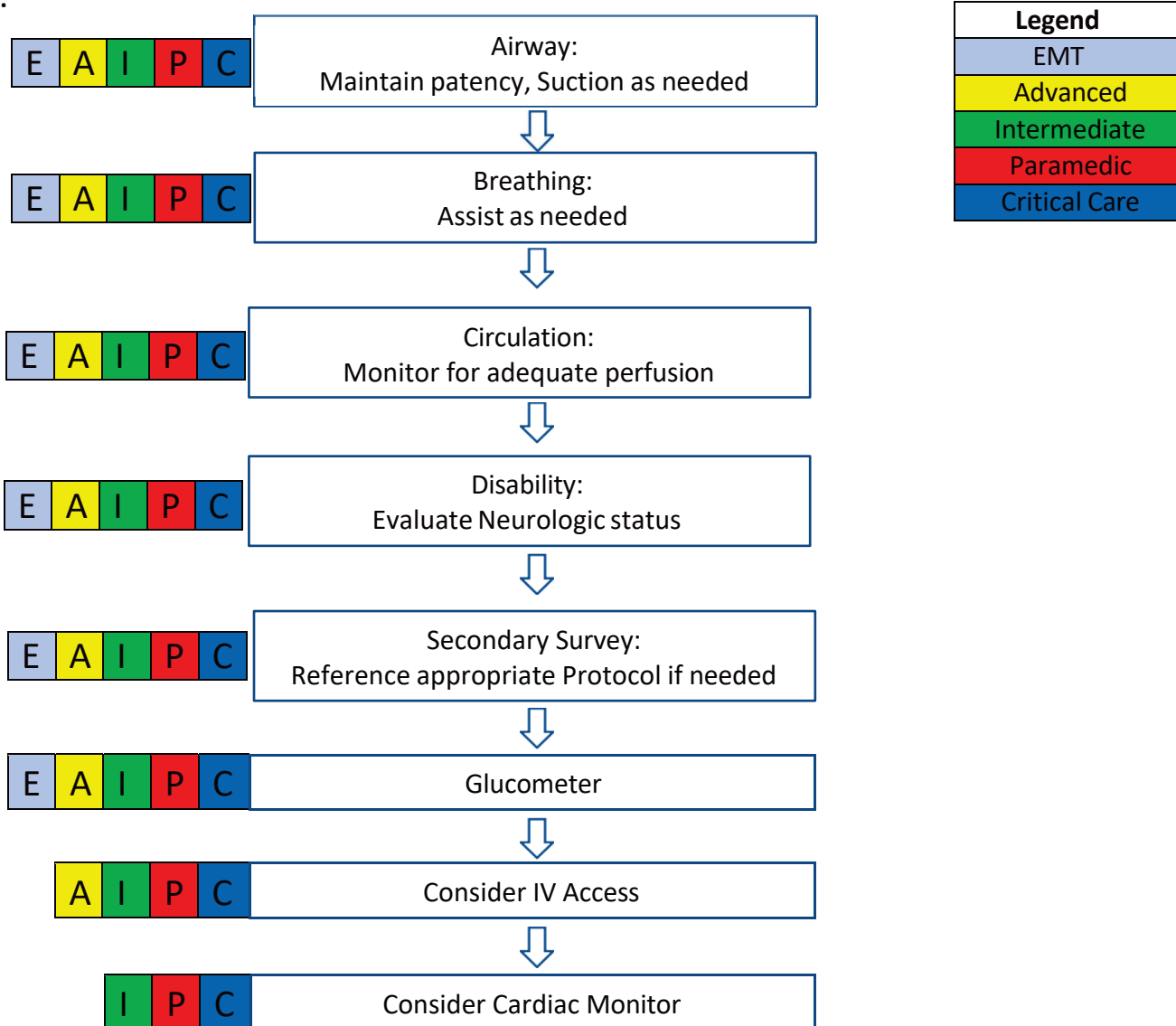
History and Physical Exam

- Primary.
- History (i.e. medical history, medication history, surgical history, etc.).
- Vital signs.
- Secondary survey.

Key Points

- This protocol is the starting point for assessment of every patient. All patients should have an appropriate assessment of “ABCDs” (airway patency, breathing adequacy, circulation, and disability).
- This protocol can be used for documentation purposes when there is no other specific protocol is used.

Treatment:



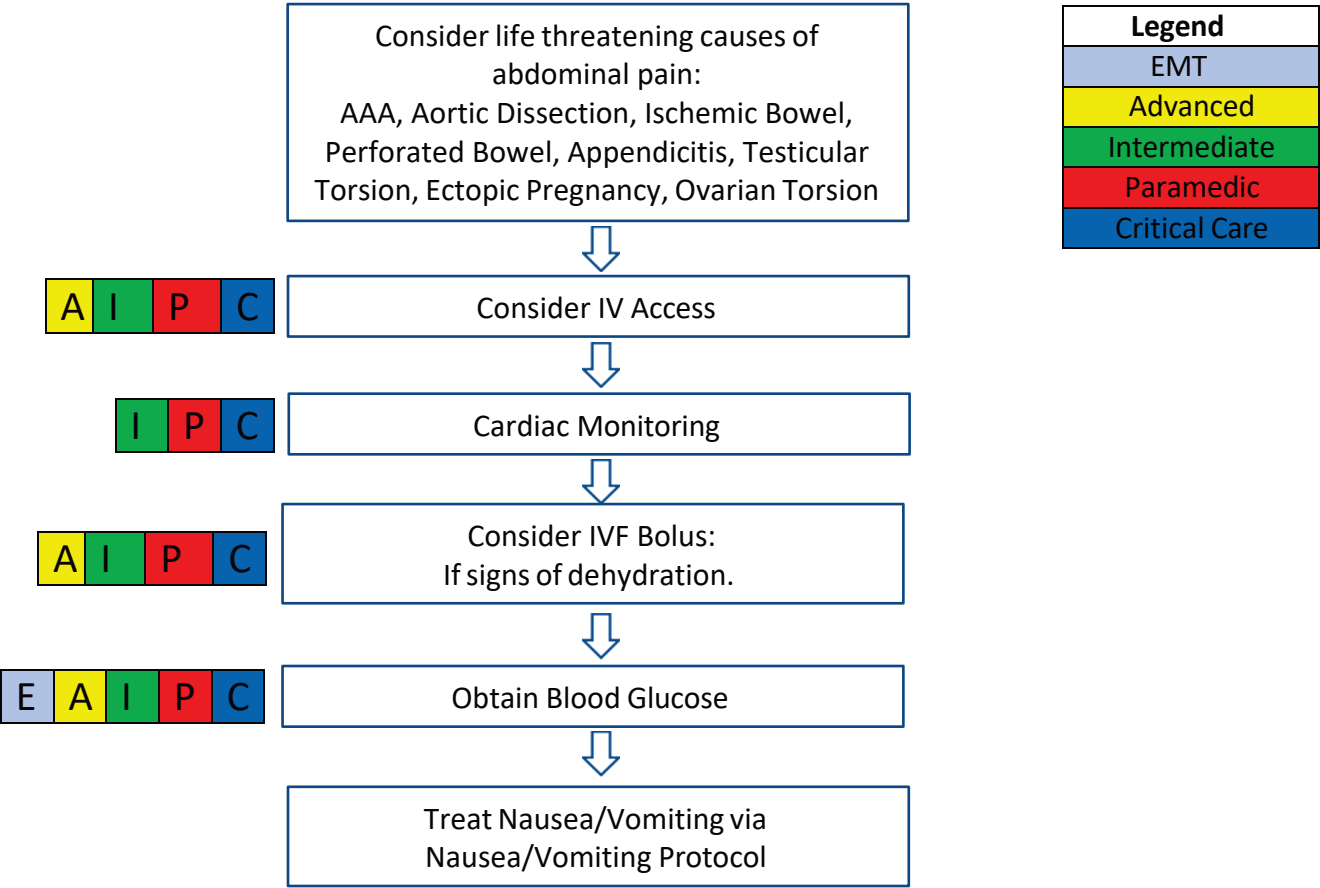
Abdominal Pain

History and Physical Exam

- PQRST: Place, Quality, Radiation, Severity, Time of onset.
- Related Symptoms: Nausea, vomiting (coffee-ground or bright red blood), diarrhea, constipation, melena, rectal bleeding, urinary difficulties, fever.
- Previous History: previous trauma, recent medications, surgical history, menstrual history, the possibility of pregnancy.
- Exam: Tenderness, guarding, rigidity, bowel sounds, distention, pulsating mass, evidence of rectal bleeding.

Key Points

- **Emergent Causes of Abdominal Pain:** AAA, Aortic Dissection, Ischemic bowel, perforated bowel, Appendicitis, Testicular torsion, Ectopic pregnancy, Ovarian torsion.
- Abdominal pain may be the first warning sign of serious internal bleeding leading to hemorrhagic shock. Maintain a high index of suspicion and monitor for early signs of shock.
- Use caution in fluid administration in patients with a suspected ruptured abdominal aortic aneurysm. Do not try to raise blood pressure higher than a systolic of 90 in suspected AAA.
- Nitrous Oxide is contraindicated in abdominal pain due to the risk of abdominal bowel distention.
- Monitor for signs of shock and treat accordingly based on Shock Protocol.
- Give nothing by mouth.
- Re-assess frequently.
- Consider pain control based on Pain Management Protocol.



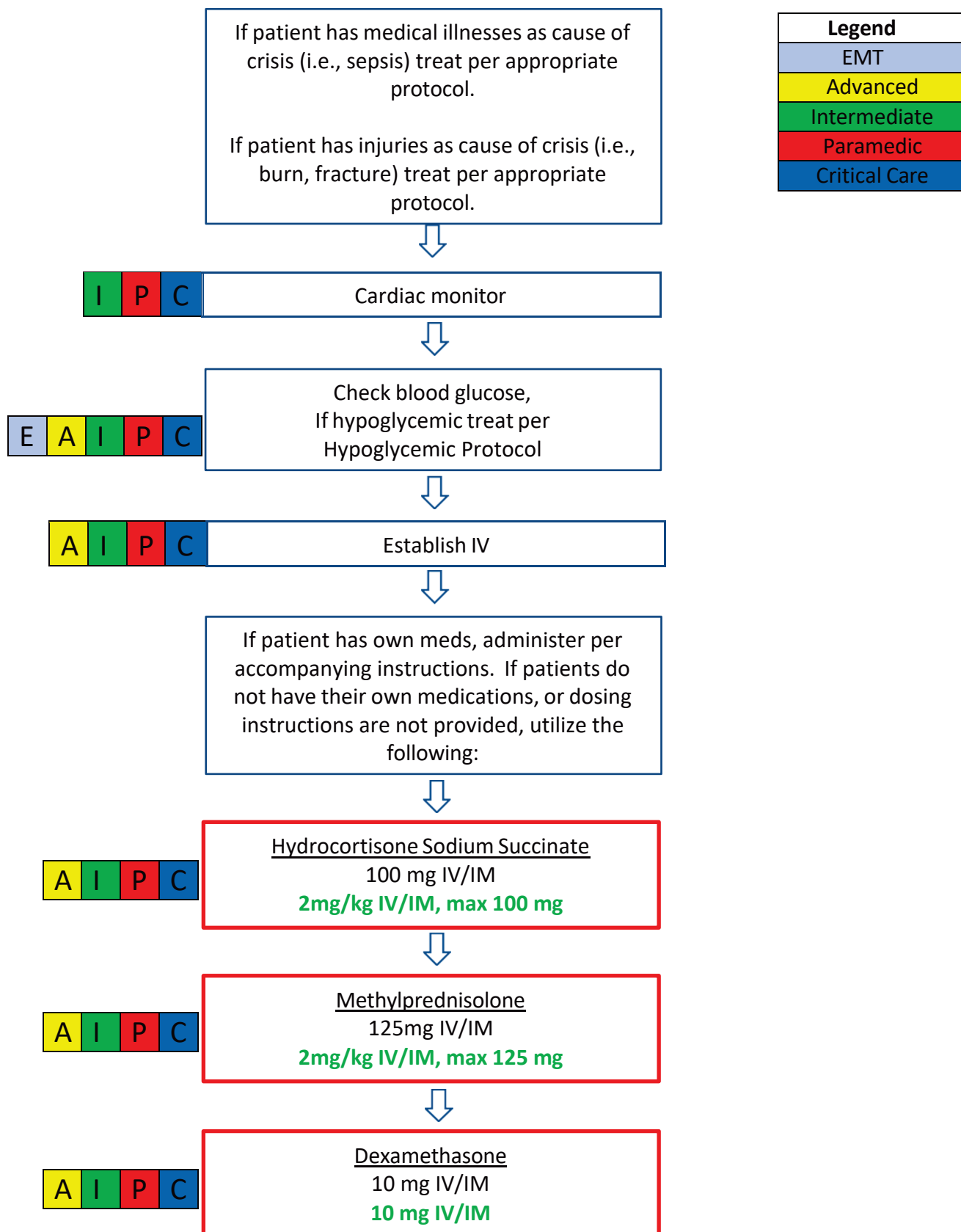
Adrenal Insufficiency

History and Physical Exam

- History of diagnosed Adrenal Insufficiency.
- Many diseases can cause Adrenal Insufficiency, including Primary Adrenal Insufficiency, Congenital Adrenal Hyperplasia (CAH), long-term administration of steroids, pituitary gland problems, auto-immune disease, cancers, and certain infections.
- Early signs of adrenal crisis: pallor, dizziness, headaches, weakness, abdominal pain, nausea, and vomiting.
- Late signs of adrenal crisis: lethargy, hypotension, shock, cardiorespiratory failure, and death.

Key Points

- Adrenal glands make the steroids cortisol and aldosterone, which are both necessary for the body's response to physiology stress such as acute illness or injury.
- Patients with Adrenal Insufficiency are unable to respond to physiologic stressors and may develop hypoglycemia, shock, or cardiovascular collapse that is refractory to treatment until adrenal corticosteroid replacement is given.
- This protocol is only for patients with diagnosed Adrenal Insufficiency and is intended to guide EMSPs in assisting these patients with Adrenal Insufficiency in administration of steroid medication in the setting of acute illness or injury. This is commonly referred to as adrenal crisis.
- All patients receiving steroids using this protocol must be transported to the hospital for further evaluation and treatment.
- Many of these patients will present with infection and shock consistent with sepsis. Providers should refer to the Sepsis Protocol for the remainder of their treatment.



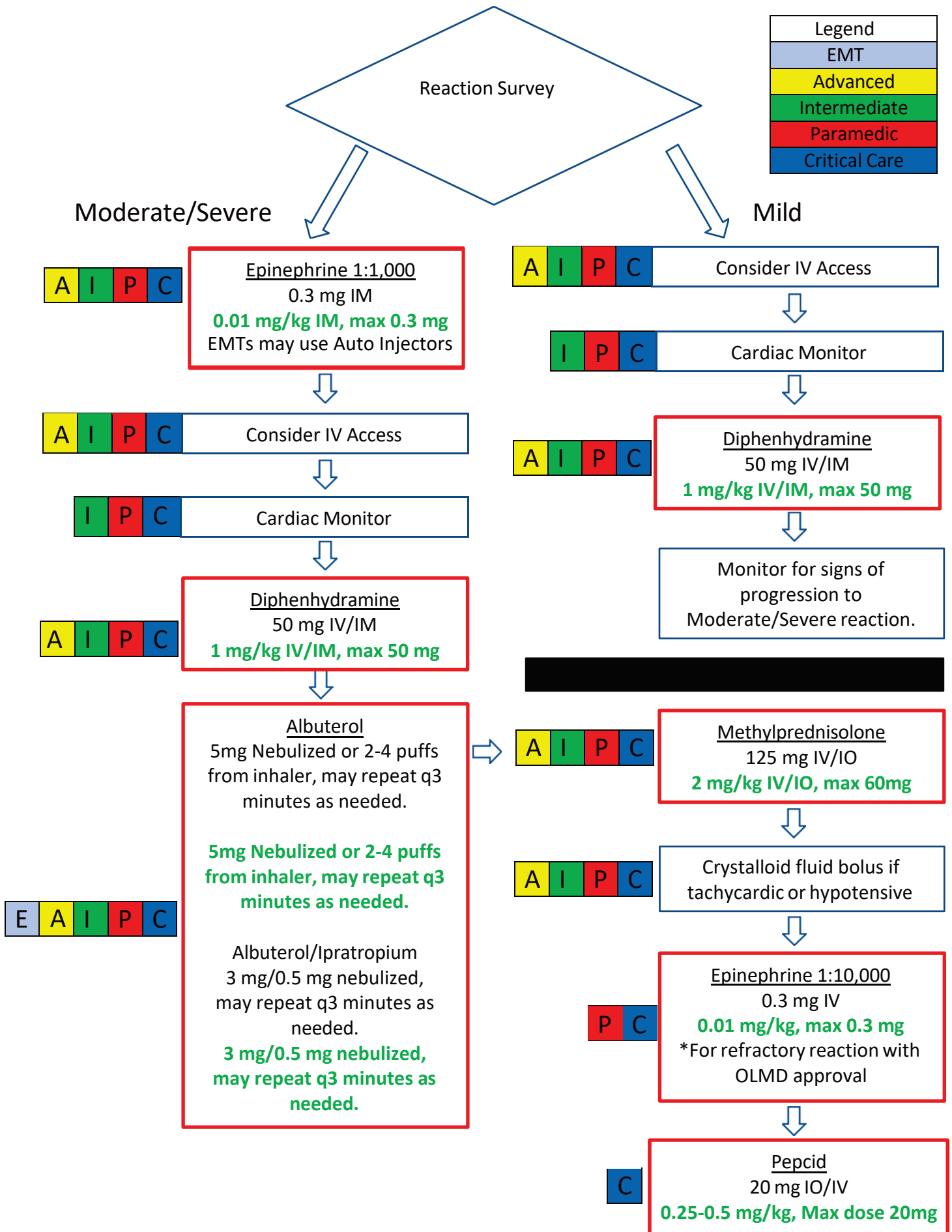
Allergic Reactions

History and Physical Exam

- Possible allergen exposure and route of exposure.
- History and type of any prior allergic reactions.
- Symptoms: itching, dyspnea, sensation of airway closure, generalized weakness.
- Airway: Swelling of the lips or tongue, drooling.
- Pulmonary: Wheezing, stridor, hoarseness, ability to speak.
- Skin: Hives, swelling, or erythema.
- Cardiovascular: Tachycardia, hypotension.

Key Points

- The two forms of Epinephrine must not be confused, or over-dosage may occur. The 1:1,000 dilution is appropriate for IM injections and is the preferred route of administration in anaphylaxis. The 1:10,000 dilution is for IV administration which should only be used in refractory reaction and requires OLMD approval. The 1:1,000 dilution should **NEVER** be given IV.
- An Epi-pen Auto Injector is approved for administration of 1:1,000 Epinephrine IM.
- If the patient has his or her own Epinephrine Auto Injector (Epi-pen, AuviQ, etc.) the EMSP may administer or assist with administration.
- Patients with moderate/severe allergic reactions should be transported without delay due to potential for rapid deterioration, airway compromise, and/or biphasic reaction.
- Minor reactions are limited to skin rashes with no sign of airway, respiratory, or hemodynamic compromise.
- Moderate/Severe Reactions involve skin rashes with the presence of other symptoms such as respiratory symptoms, facial swelling, vomiting, and can include severe respiratory distress including airway compromise and shock.



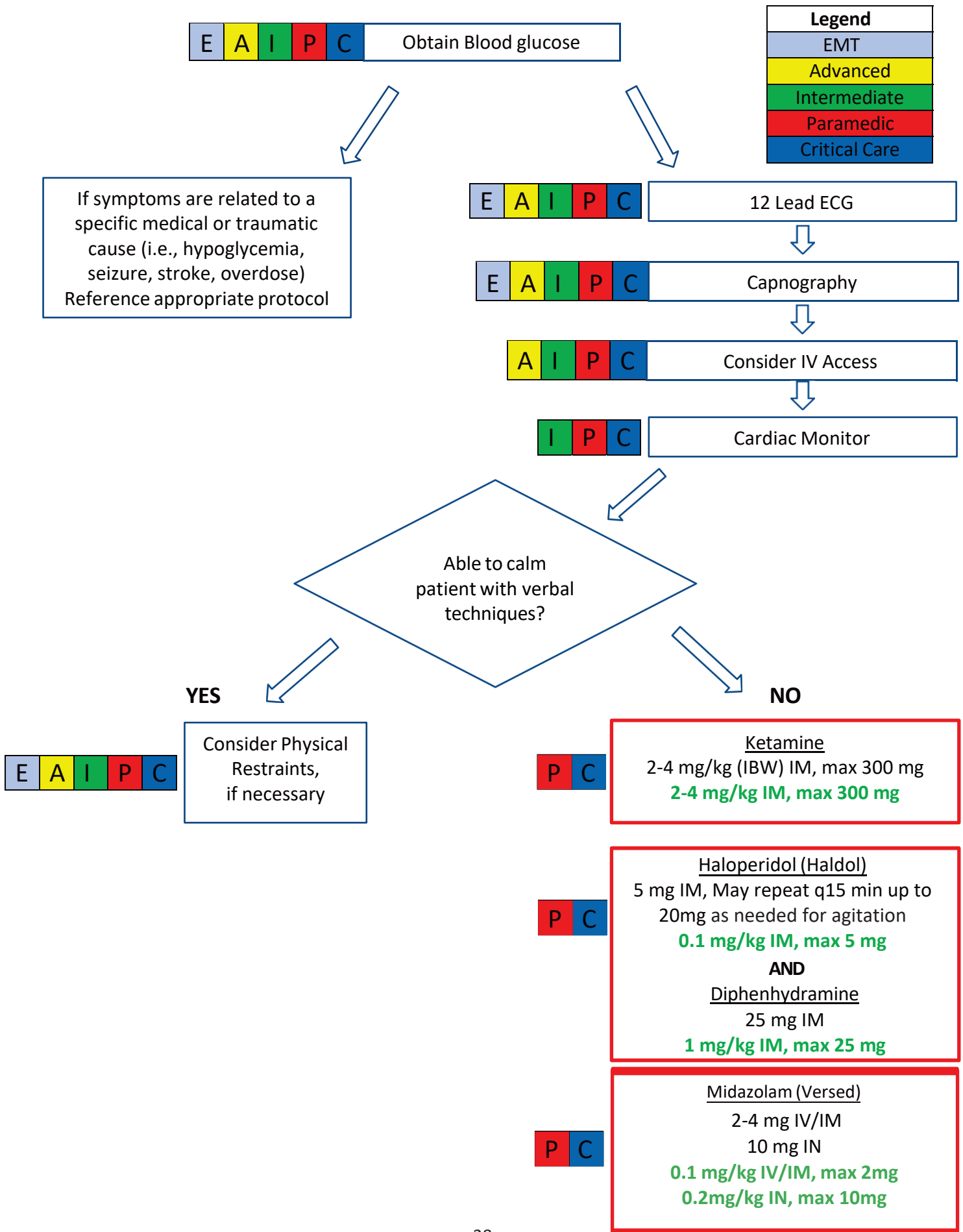
Altered Mental Status

History and Physical Exam

- Last time seen conscious or normal, progression of symptoms; recent symptoms such as headache, seizure, confusion, or trauma, possible toxin exposure.
- History of psychiatric illness, history of recent crisis, bizarre or abrupt changes in behavior, suicidal ideation, alcohol or drug intoxication, psychotropic drug use.
- Medical problems and medication history, toxin exposure, history of seizure or stroke.
- Surroundings: Note any pill bottles, syringes, etc., found with patient, as well as any peculiar odors in the environment.
- Pupils: Size, symmetry, and reactivity.
- Mental Status: Note level of consciousness, neurologic status (including any focal deficits), and any irrational activity (verbal attacks, spitting, combativeness). Document GCS if applicable.
- Look for signs of trauma and evidence of drug use.
- Note any characteristic odor on the patient's breath.

Key Points

- In cases of a dangerous environment, the safety of personnel on scene is paramount.
- Be particularly attentive to airway management. Aspiration of secretions, vomiting, and inadequate ventilations may be present in patients with severely altered mental status.
- Hypoglycemia may present with a focal neurologic deficit or altered mental status, particularly in elderly patients. Follow the Hypoglycemia Protocol if indicated.
- All patients treated using this protocol should have a medical evaluation and not be considered or referred to as a psychiatric patient, unless under a bona fide mental health hold by a physician, mental health professional, or law enforcement officer. Medical causes of altered mental status should be considered first before psychiatric causes of altered mental status.
- CAUTION: Do not leave suicidal patients alone. Suicidal patients and patients with hallucinations or delusions may potentially exhibit violent behavior. Search patients for and remove dangerous objects (i.e., knives, guns, pills).
- NOTE: Ketamine dosing is based on ideal body weight and based on best estimate of height. Any patient that receives a chemical restraint must be placed on capnography and SPO2 monitoring.
- Any patient that receives a chemical restraint must be transported by EMS to a facility for medical evaluation.



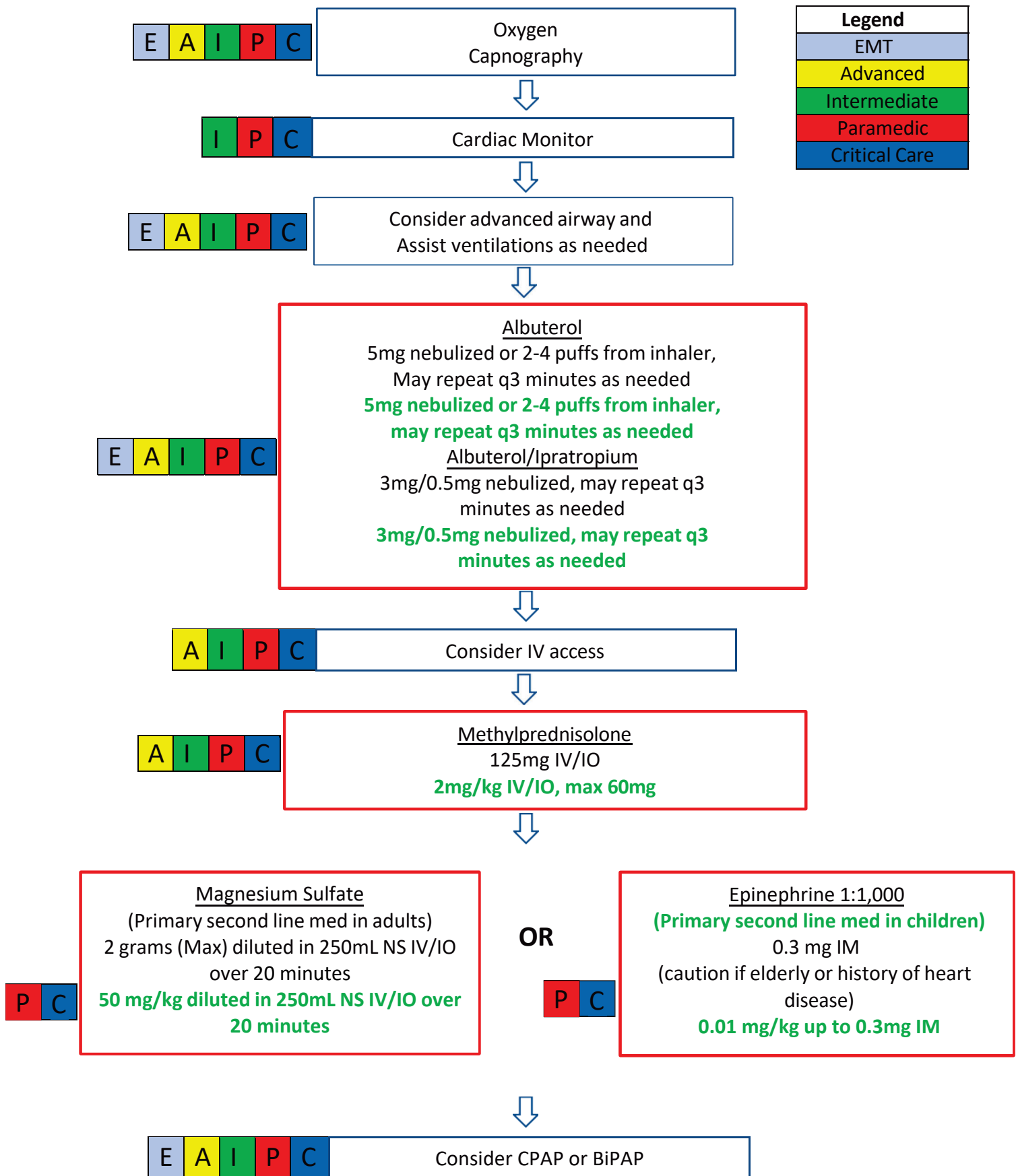
Asthma/COPD

History and Physical Exam

- Onset and timing of symptoms.
- History of respiratory problems such as asthma, COPD CHF, allergic reactions.
- Associated symptoms such as chest pain, palpitations, peripheral edema, fever, production cough.
- Home oxygen usage.
- Evidence of respiratory failure: inability to speak, weakened respiratory effort, increased work of breathing, cyanosis, hypoxia.
- Abnormal lung sounds to suggest lower airway obstruction such as silent chest or wheezing.
- Evidence of allergic reaction which could also cause lower airway obstruction.

Key Points

- Pulse oximetry and capnography should be utilized in all patients with respiratory distress to assess oxygenation and ventilation.
- Patients with lower airway obstruction as in asthma and COPD will usually have wheezing associated with exacerbations; however, severe exacerbations can result in “silent chest” due to poor air movement.
- Waveform capnography will frequently have a “shark fin” pattern in patients with obstruction processes such as asthma or COPD.
- Equipment for airways support and ventilation including intubation equipment, supraglottic airways, and a bag-valve-mask should be readily available in all patients with respiratory distress.
- If patient has unresponsive wheezing, then epinephrine is the preferred second-line agent in children while magnesium is the preferred second line agent in adults.
- If epinephrine is administered in adults, then caution should be used if the patient is elderly or has a history of hypertension or coronary artery disease.
- CPAP can be a useful adjunct in some patients with significant airway obstruction which is unresponsive to other therapies.



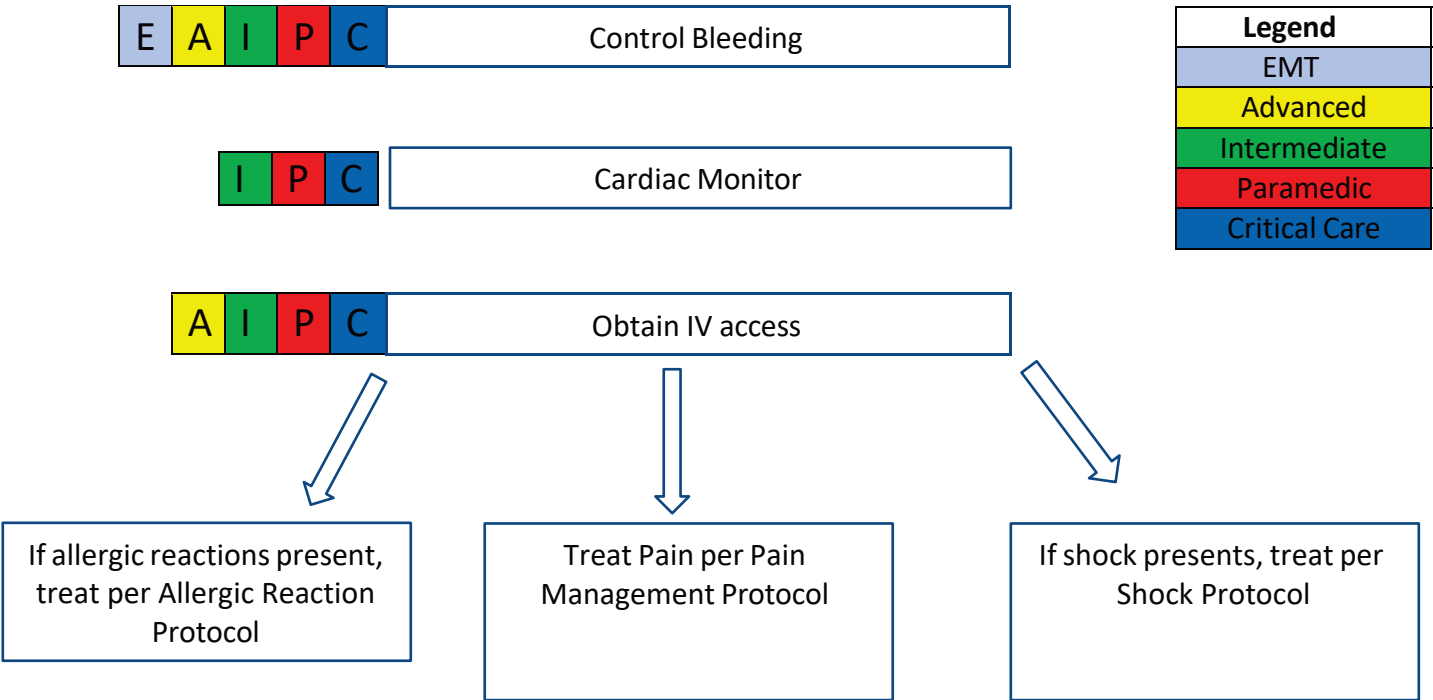
Bites and Envenomations

History and Physical Exam

- Type of bite/sting and description of creature, rabies status of creature.
- Timing, location, size of bite/sting.
- Previous reaction to bite/sting.
- Rash, wound, soft tissue swelling, redness, amount of pain.
- Evidence of allergic reactions such as itching, hives, difficulty breathing, wheezing, hypotension or shock.

Key Points

- Human bites have higher infection rates than animal bites due to normal mouth bacteria.
- Cat bites may progress to infection rapidly due to specific bacteria in their mouths.
- Carnivore bites (such as dogs) have the potential for progression to infection and risk of rabies exposure.
- Venomous snakes in this area are generally of the pit viper family: rattlesnake, copperhead, cottonmouth, and water moccasin. Coral snake bites are rare. The amount of envenomation is variable. It is no longer recommended to use tourniquets or venom extractors to treat snakebites.
- Black widow spider bites tend to be minimally painful at first but, over a few hours, patients develop severe muscular pain and abdominal rigidity.
- Brown recluse spider bites are minimally painful, but progress to tissue necrosis over the course of a few days.
- Jellyfish stings can be very painful. Treat by flushing the skin with salty ocean water and carefully removing any visible tentacles with tweezers. Do not use fresh water to flush the skin as this will cause undischarged nematocysts to rupture and release their toxins.
- Stingray spine punctures can be extremely painful. Impaled barbs should be left in place for transport. The wound can be immersed in non-scalding hot water to tolerance for 30 minutes which attenuate the heat-labile venom of the stingray.
- While identification of the creature is important, remember that the safety of the EMSP is more important than killing and/or identifying the creature. Consider taking a photo of the creature to show to the receiving physician, if a camera is available.



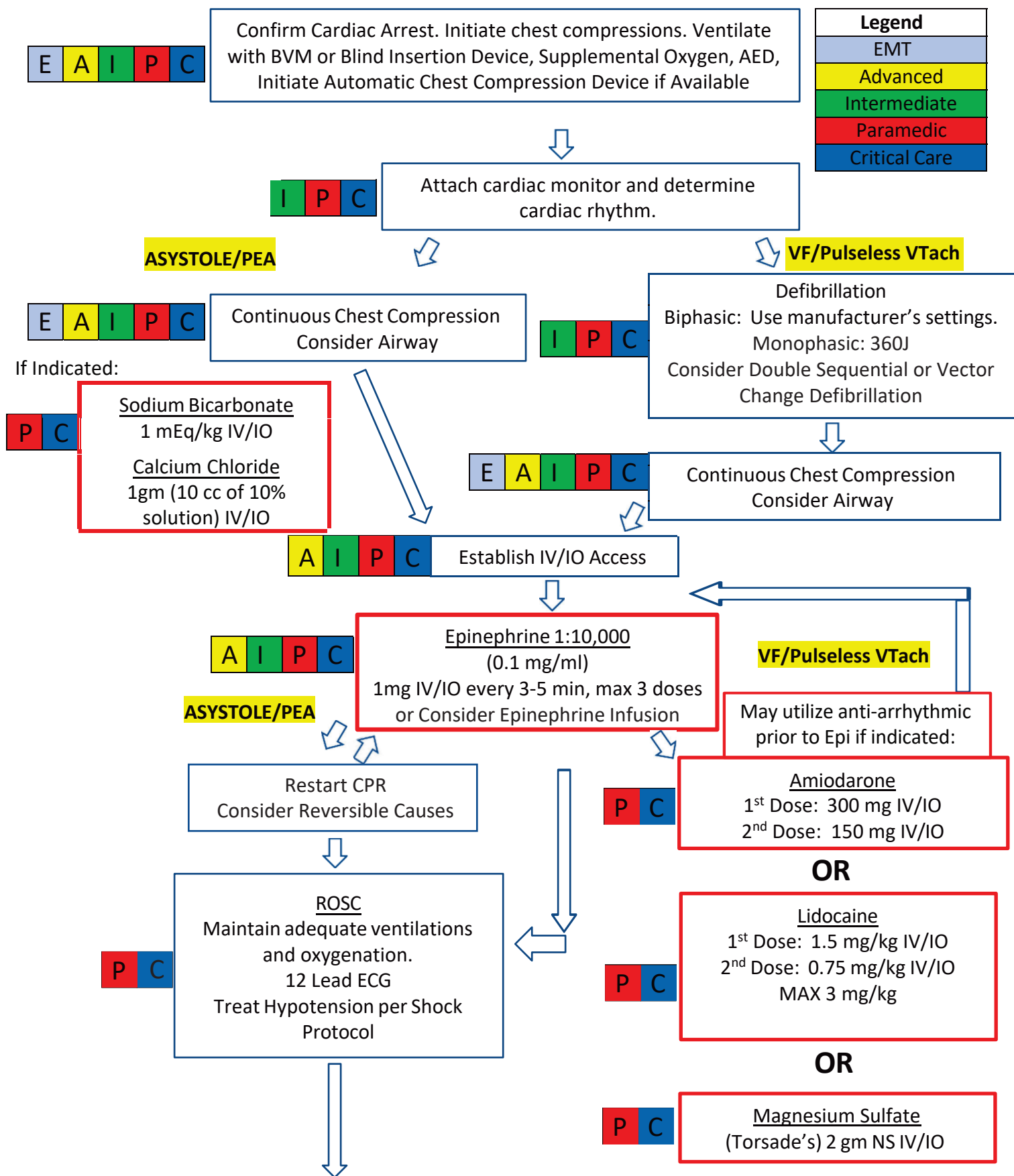
Cardiac Arrest - Adult

History and Physical Exam

- What were the downtime and circumstances? Was the arrest witnessed? Was bystander CPR performed? Were there any preceding symptoms?
- Determine past medical history, allergies, and current medications.
- Rapidly determine the level of consciousness, respiratory effort, and presence of pulses.
- Cardiac Rhythm Analysis.
- Always think about reversible causes of cardiac arrest: Hypovolemia, Hypoxia, Acidosis, Hyperkalemia, Hypothermia, Tension Pneumothorax, Cardiac Tamponade, Toxins, Pulmonary Thromboembolism, Acute MI.

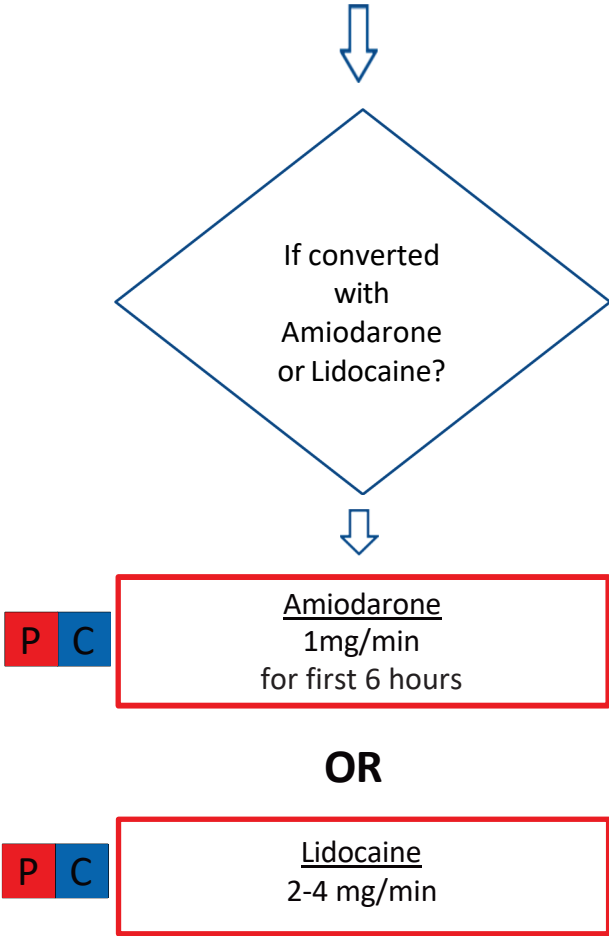
Key Points

- **Performance of high-quality chest compressions at a rate of 100-120 compressions/minute and 2 inches depth allowing for full chest recoil combined with early defibrillation are the most critical elements of the resuscitation. Consider the use of a metronome to ensure proper chest compression rate.**
- Once resuscitative efforts are begun, they should be continued until arrival at the receiving hospital or until a joint decision has been made with OLMD that resuscitation should cease.
- Remember to treat the patient and not the monitor. Treatment decisions must be made considering the patient's condition, not just the rhythm on the monitor.
- Patients with penetrating torso injury and cardiac arrest can sometimes survive. The priority for these patients, as opposed to patients with other etiologies of cardiac arrest, is rapid transport and NOT chest compressions. Chest compressions may still be performed but should not delay transport. These patients should receive IV fluids according to the Shock Protocol.
- If quantitative waveform capnography <10 mm Hg, attempt to improve CPR quality.
- If the patient in cardiac arrest has a venous port or other central venous access devices, the EMSP may use it.
- Consider the use of various devices and neuroprotective strategies such as impedance devices for ventilation, heads up devices for CPR, mechanical CPR devices, if available.
- Follow AHA guidelines for ROSC care:
 - Temperature control: Maintain a constant temperature between 32°C and 37.5°C for at least 24 hours after achieving the target temperature.
 - Seizure activity: Treat seizure activity. Consider a therapeutic trial of a nonsedating antiseizure medication for adult survivors with electroencephalography (EEG) patterns on the ictal-interictal continuum.
 - Oxygenation: Target oxygen saturations of 94–98%.
 - Neurologic assessment: Perform repeat neurologic exams.
 - Pulmonary management: Use lung-protective ventilation.
 - Organ donation: Consider the need for organ donation patients who meet neurological criteria for death or before planned withdrawal of life-sustaining therapies.



*FOLLOW AHA GUIDELINE

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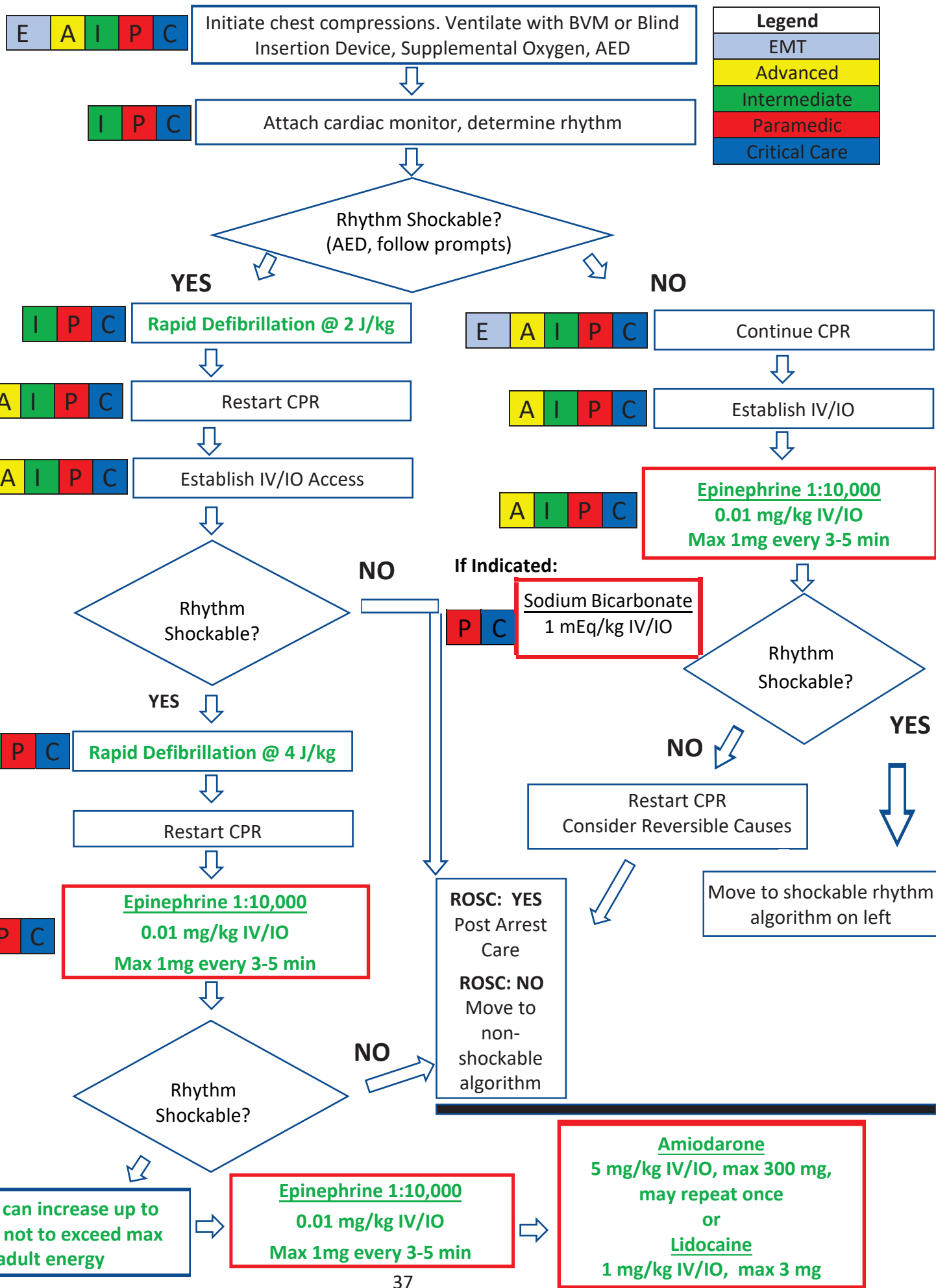
Cardiac Arrest - Pediatric

History and Physical Exam

- Downtime and circumstances: Was the arrest witnessed? Was bystander CPR performed? What lead up to the arrest?
- Patient's past medical history, medications, allergies.
- Quick determination of presence of pulse.
- Cardiac rhythm analysis.
- Consider reversible causes: airway obstruction, hypovolemia, hypoxia, acidosis, hypokalemia, hyperkalemia, hypothermia, tension pneumothorax, cardiac tamponade, toxins.

Key Points

- Rapid initiation of high-quality chest compressions after lack of pulse is determined.
- Chest compressions should be performed at a rate of 100-120 compressions per minute to a depth of 1/3 of the diameter of the chest and allowing for full chest recoil between compressions. Consider the use of a metronome to ensure proper rate.
- A quick determination of rhythm should be made and, if shockable, early defibrillation provided as soon as possible.
- Endotracheal intubation of pediatric patients in cardiac arrest is discouraged and use of supraglottic airways such as the iGel or BLS airways with good bag-valve-mask ventilation is encouraged.
- All patients who have an advanced airway placed (ETT or SGA) should have quantitative waveform capnography utilized.
- Vascular access should be obtained quickly either by IV access or IO access to facilitate timely administration of epinephrine and other medications.
- If the patient in cardiac arrest has a venous port or other central venous access device, the EMSP may utilize it.
- Treatment decisions must be made considering the patient's condition and not just the rhythm on the monitor.
- Even in pediatric patients traumatic out of hospital cardiac arrest is rarely survivable, however, patients with penetrating torso injury can sometime be saved and rapid transport to an appropriate facility is encouraged.
- Consider treatment for opiate overdose per Poisons and Overdoses Protocol if opiate overdose is suspected in the cardiac arrest patient.
- Follow AHA guidelines for ROSC
 - **Temperature control:** Maintain a constant temperature between 32°C and 37.5°C for at least 24 hours after achieving the target temperature.
 - **Seizure activity:** Treat seizure activity. Consider a therapeutic trial of a nonsedating antiseizure medication for adult survivors with electroencephalography (EEG) patterns on the ictal-interictal continuum.
 - **Oxygenation:** Target oxygen saturations of 94–98%.
 - **Neurologic assessment:** Perform repeat neurologic exams.
 - **Pulmonary management:** Use lung-protective ventilation.
 - **Organ donation:** Consider the need for organ donation patients who meet neurological criteria for death or before planned withdrawal of life-sustaining therapies.



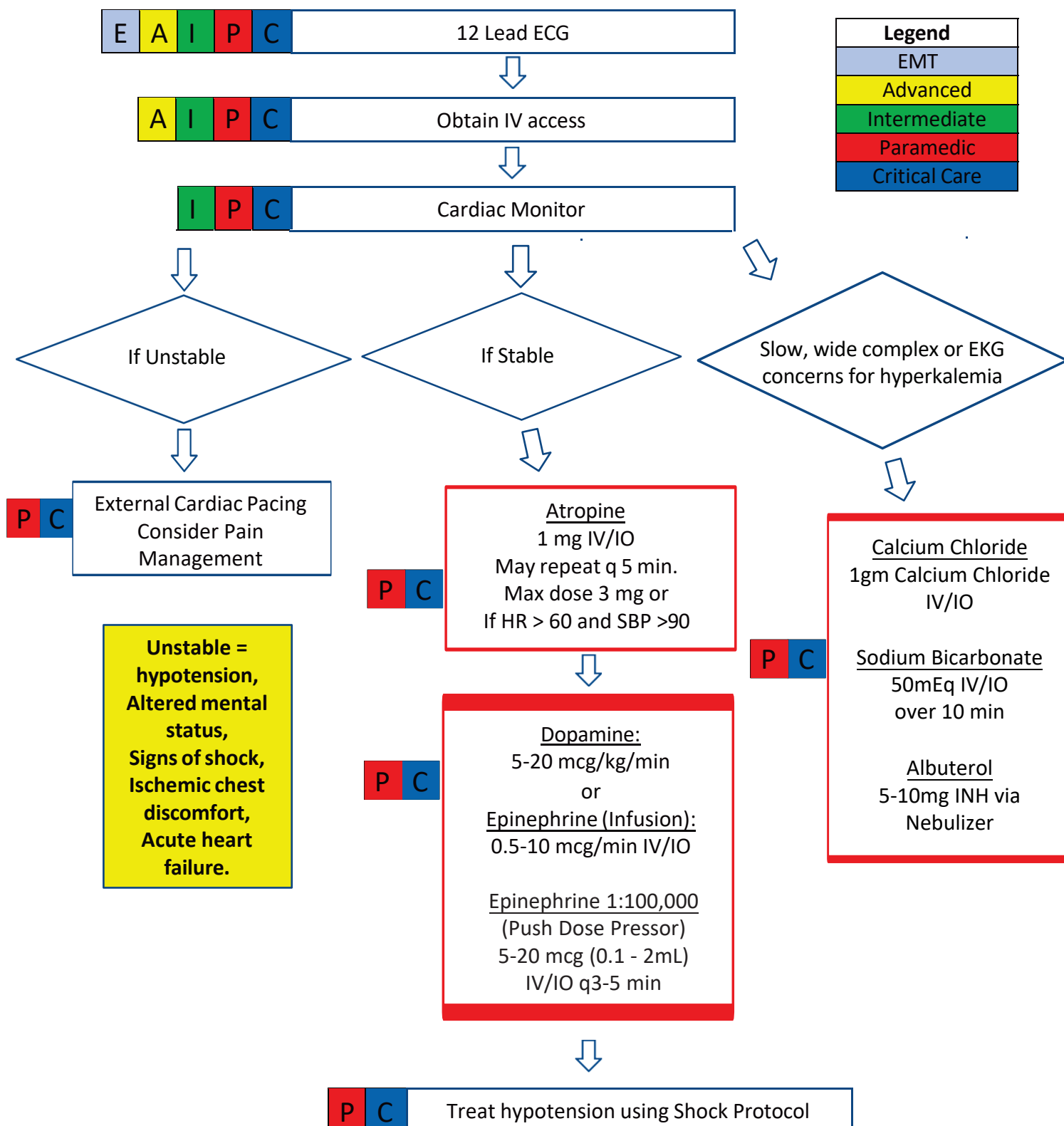
Cardiac Dysrhythmias – Adult Bradycardia

History and Physical Exam

- Chief complaint, onset (sudden or gradual).
- Associated symptoms: palpitations, dizziness, chest pain, syncope, dyspnea.
- Past medical history and medication history.
- Look for evidence of low cardiac output such as altered level of consciousness, presence of shock syndrome, and signs of congestive heart failure.

Key Points

- Cardiac dysrhythmias with signs of impaired perfusion require immediate treatment in the field. However, if the patient has no signs of impaired perfusion, he or she may not require immediate treatment.



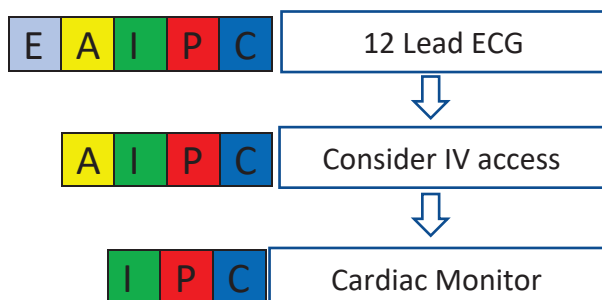
Cardiac Dysrhythmias – Adult Tachycardia w/ Pulse

History and Physical Exam

- Chief complaint, onset (sudden or gradual).
- Associated symptoms: palpitations, dizziness, chest pain, syncope, dyspnea.
- Past medical history and medication history.
- Look for evidence of low cardiac output such as altered level of consciousness, presence of shock syndrome, and signs of congestive heart failure.

Key Points

- Cardiac dysrhythmias with signs of impaired perfusion require immediate treatment in the field. However, if the patient has no signs of impaired perfusion, he or she may not require immediate treatment.



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UNSTABLE

Unstable =
Hypotension,
Altered Mental
Status, signs of
shock,
Ischemic chest
discomfort,
and
Acute Heart Failure

I P C

Synchronized
Cardioversion**STABLE, REGULAR
NARROW QRS**

P C

Attempt vagal
maneuvers

P C

Adenosine
1st Dose:
6mg rapid IV push
2nd Dose:
12mg rapid IV push

**STABLE, IRREGULAR
NARROW QRS**Consider OLMed
Consult

P C

Diltiazem (Cardizem)
10 mg slow IV push,
then maintenance 5-
15 mg/hr drip.
(Titrate pulse 60-100
and SBP>100 mmHg)

May repeat bolus
dose at 20 mg if no
response

P C

Amiodarone
Consider 150 mg
slow IV push

C

Lopressor
5 mg IV/IO
can be repeated
twice as needed

**STABLE, WIDE
COMPLEX QRS**

P C

Amiodarone
150 mg slow IV push
over 10 minutes

Maintenance
Infusion
1 mg/min for first 6
hours

Lidocaine
1st Dose:
1.5 mg/kg IV/IO
2nd Dose:
0.75 mg/kg IV/IO
(max dose 3 mg/kg)

P C

Maintenance
Infusion
2-4 mg/min
(decrease dose by
half if patient has
CHF exacerbation,
>70 y/o, in shock or
has liver disease)

P C

Magnesium
*If Torsade's or
refractory VTach*
2 grams over 20
minutes

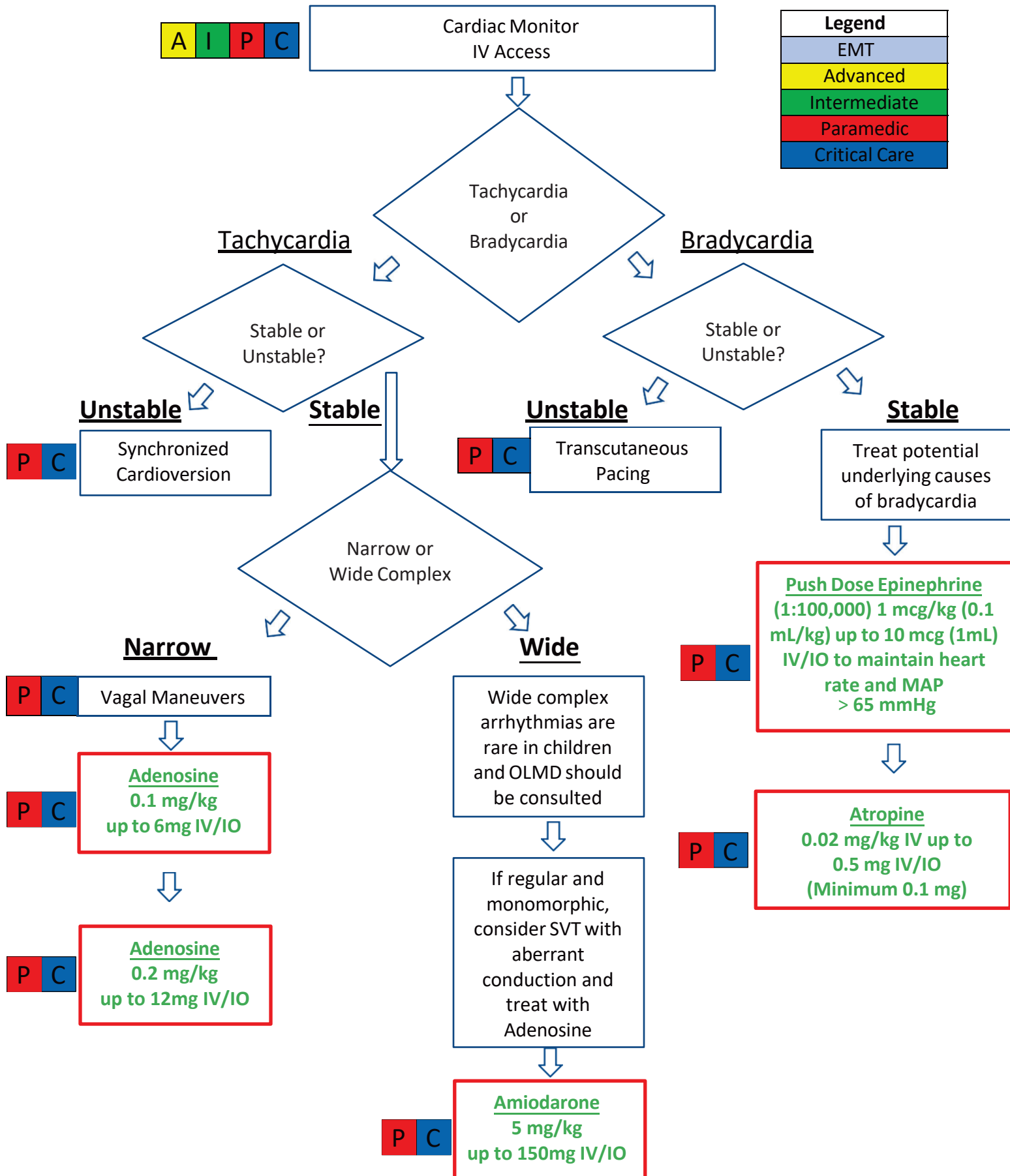
Cardiac Dysrhythmia - Pediatric

History and Physical Exam

- Chief complaint, onset (sudden or gradual).
- Preceding signs or symptoms of illness.
- Related symptoms such as palpitations, dizziness, chest pain, syncope, dyspnea.
- Past medical history and medications.
- Look for evidence of low cardiac output such as altered level of consciousness, presence of shock, signs of heart failure.

Key Points

- Treatment of dysrhythmias in the field is only indicated for pediatric patients who are symptomatic.
- Chest compressions should be initiated for a heart rate less than 60 in small children with signs of poor perfusion (altered mental status, hypoxia, hypotension, weak pulse, delayed capillary refill, cyanosis) and treatment should be guided by the Cardiac Arrest (Pediatric) protocol.
- In pediatrics bradycardia is frequently due to an underlying cause (usually hypoxia or hypoglycemia) and should be treated accordingly.
- If underlying causes for bradycardia have been treated and the patient remains bradycardic with symptoms of hemodynamic instability, then treatment with epinephrine is indicated.
- Children with tachyarrhythmias can frequently tolerate them quite well and if stable, EMSPs should consider deferring treatment to the hospital.



Chest Pain or Acute Coronary Syndrome (ACS)

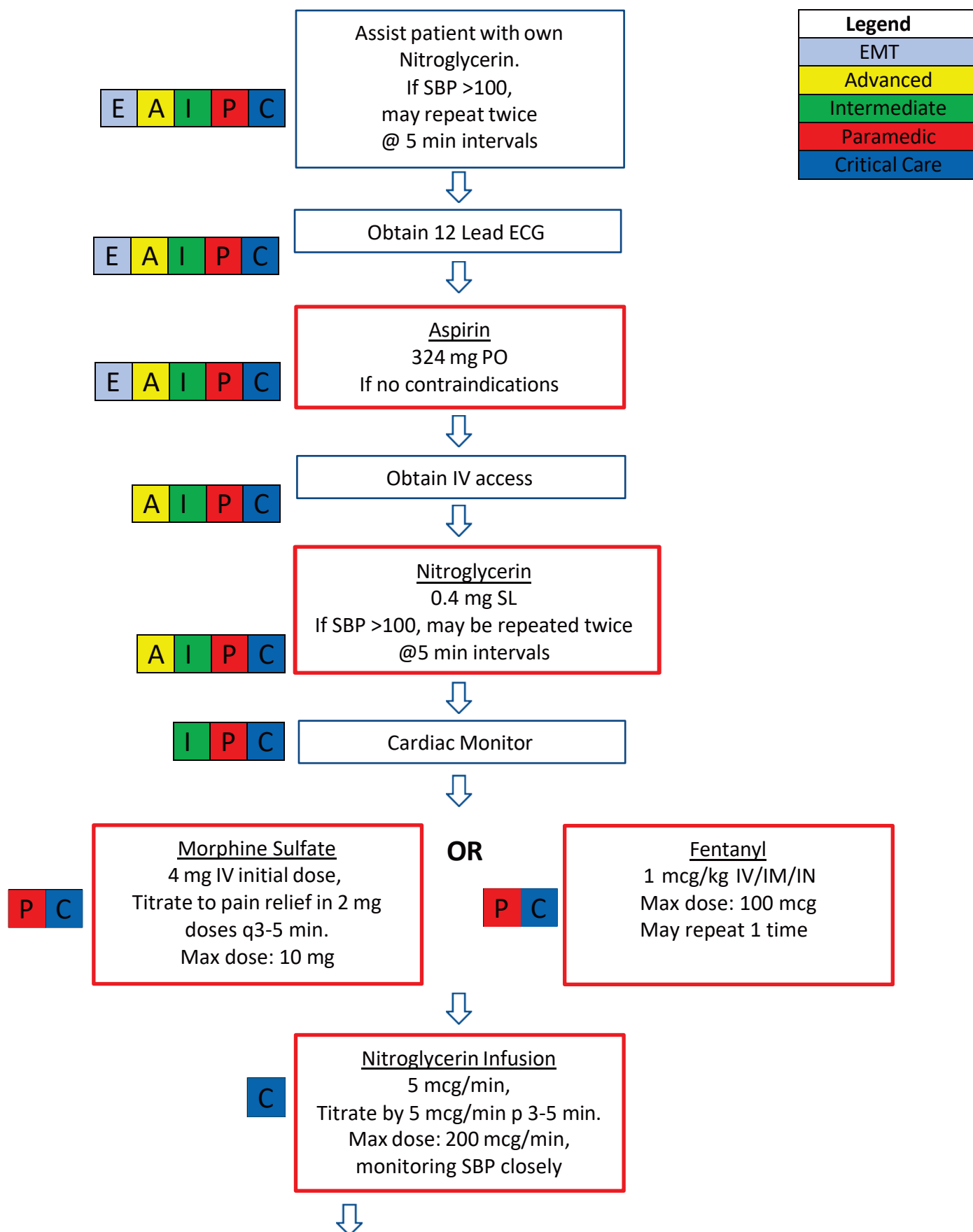
History and Physical Exam

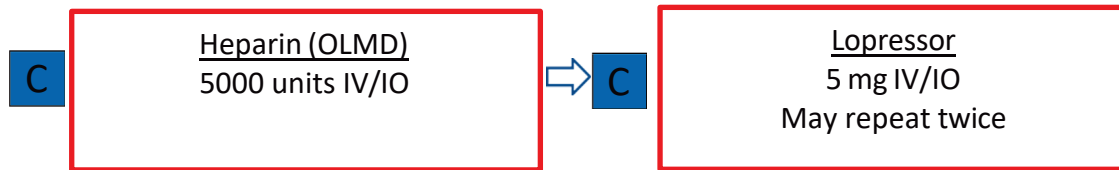
- Access pain: onset, location, quality, radiation, severity, time began.
- Associated symptoms: nausea, vomiting, diaphoresis, shortness of breath.
- History: cardiac or pulmonary events, medications, syncope.
- Risk factors: family history, smoking, obesity, diabetes, hypertension, high cholesterol.
- Repeat vital signs often (every 10 minutes and after each medication administration).
- Check symmetry of pulses and listen to breath sounds.
- Look for signs of congestive heart failure, including neck vein distension, peripheral edema, or pulmonary edema.

Key Points

This protocol is for adults. Contact OLMD for chest pain in pediatric patients.

- Have a high suspicion for cardiac disease in women, diabetics, and all patients >50 years old who have symptoms that might be attributed to ACS (chest pain, shortness of breath, radiation to neck/jaw/arm, diaphoresis, syncope, and nausea/vomiting).
- Obtain a 12 lead ECG on all patients with chest pain, epigastric discomfort, or suspected ACS prior to leaving the scene as ST segment elevation MI (STEMI) can be accurately diagnosed by 12 lead ECG.
- In patients with STEMI, time to reperfusion is critical. Transmitting an ECG to the receiving hospital can significantly shorten the time to reperfusion treatment. Minimize scene times and consider transporting patients with STEMI to hospitals with an available catheterization lab for percutaneous coronary intervention. If unsure of appropriate destination hospital, contact OLMD.
- Chest wall tenderness does not rule out cardiac ischemia.
- Do not give Aspirin to patients who cannot swallow, have an allergy to Aspirin, have current GI bleeding, or have already taken 324mg Aspirin in the last 24 hours.





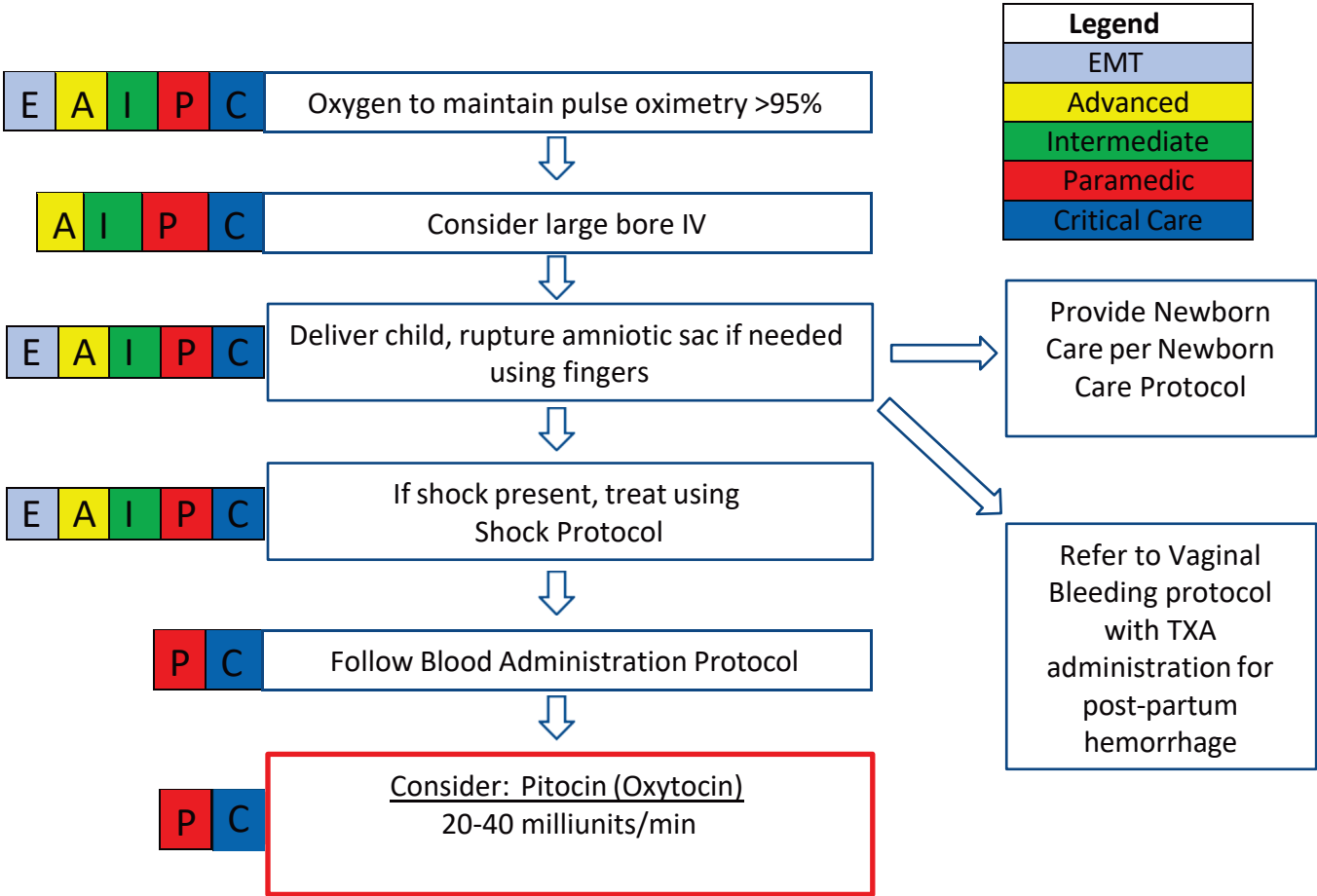
Childbirth

History and Physical Exam

- History of pregnancy: Due date, last menstrual period, is known multiple gestations?
- Does the patient feel that she is in labor or about to deliver (e.g., rectal or vaginal pressure)?
- Recent symptoms such as pain or contractions? Timing and regularity? Vaginal bleeding, ruptured membranes, urge to push?
- Medical history: medications, medical problems, age, number of prior pregnancies.
- Vital signs and fetal heart rate if possible.
- Contractions and relaxation of the uterus.
- Where privacy is possible, inspect perineum for vaginal bleeding or fluid (note color and presence of meconium), crowning (check during contraction), abnormal presentation (foot, arm, cord, or breech).

Key Points

- Do not delay transport particularly for patients with previous cesarean section, known imminent multiple births, abnormal presenting parts, excessive bleeding, and premature labor.
- In case of the prolapsed umbilical cord, place the mother in Trendelenburg or knee- chest position. The elevated presenting body part relieves pressure on the cord and keeps the cord moist with saline gauze if it is exposed. Do not delay transport.
- In the case of a nuchal cord, make an attempt to slide the cord over the fetus' head or, if unable, attempt to relieve pressure on the neck.
- If a non-viable premature fetus is delivered and the fetus is available, place the fetus in a clean container and transport it to the hospital with the mother. Remember to treat the fetus with the same respect as the EMSP would treat any deceased patient.
- Do not delay transport to hospital for delivery of placenta, if placenta is delivered in the field then it needs to be transported to the hospital with the patient.
- Observe fetal heart sounds if equipment is available.



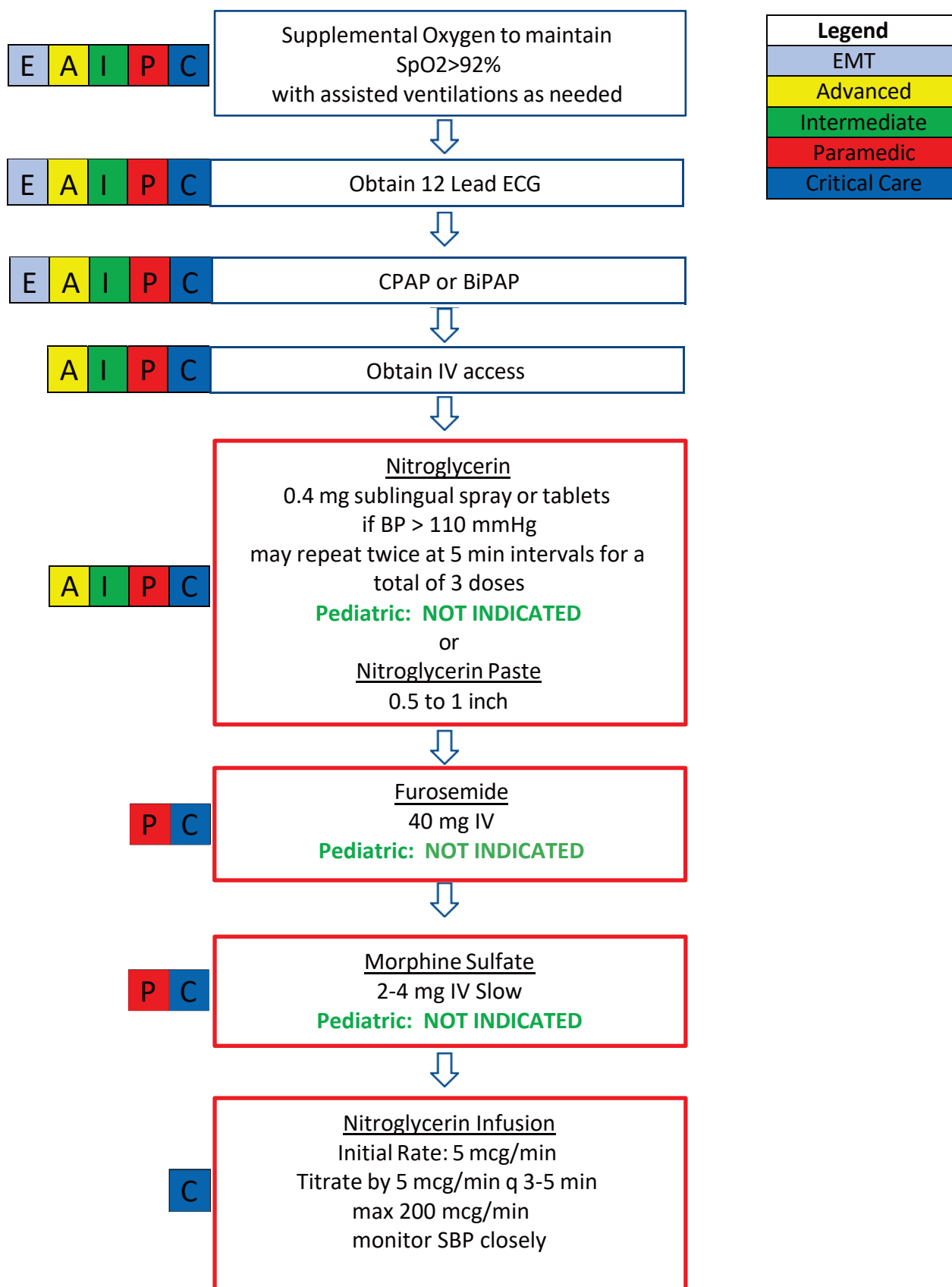
Congestive Heart Failure

History and Physical Exam

- The acuity of onset of symptoms? Obtain careful history of fever, chills, and purulent sputum products.
- History: Chronic lung or heart problems? Medications or home oxygen?
- Associated symptoms: Chest pain.
- Vital signs including pulse oximetry. If the patient is usually on supplemental oxygen, note his or her pulse oximetry on his or her usual amount of oxygen.
- Level of Consciousness.
- Cyanosis.
- Signs of Congestive Heart Failure: distended neck veins, pulmonary edema, cardiac wheezing, frothy sputum, peripheral edema.

Key Points

- An accurate assessment of breath sounds is crucial.
- **Early use of CPAP/BIPAP and nitroglycerin is key to management.**
- Oxygen as needed to maintain SpO₂ levels greater than 92%.
- Upright positioning.
- Cardiac monitor and 12-lead ECG.



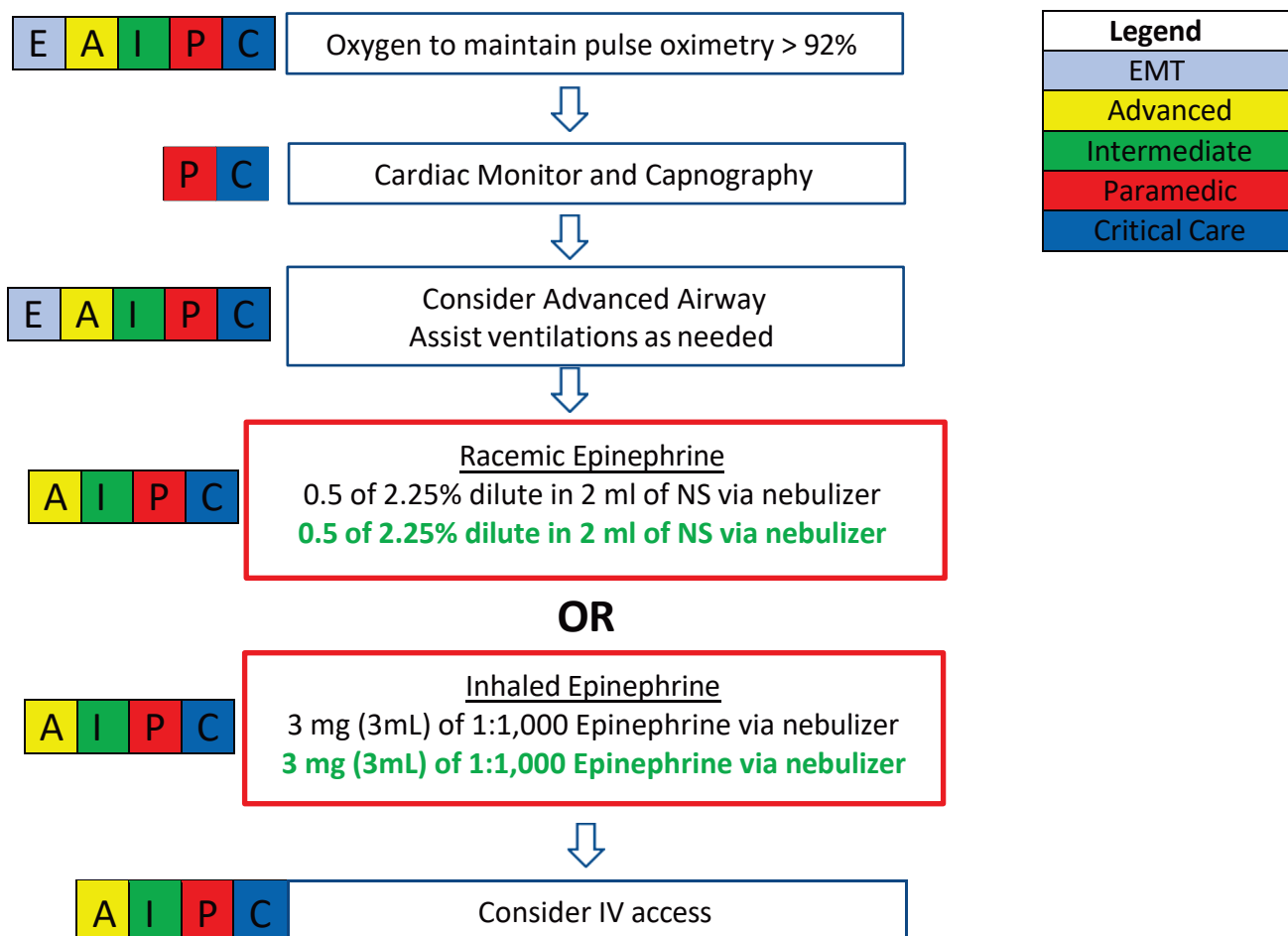
Croup or Upper Airway Obstruction

History and Physical Exam

- Onset and timing of symptoms.
- History of respiratory problems such as asthma, COPD CHF, allergic reactions.
- Croup and upper airway obstruction is usually associated with stridor, a high pitched expiratory noise best heard over the neck and frequently can be heard without a stethoscope.
- Recent history of symptoms associated with croup and upper airways swelling such as congestion, runny nose, barking cough.
- Associated symptoms such as chest pain, palpitations, peripheral edema, fever, production cough.
- Home oxygen usage.
- Evidence of airway obstruction: stridor, drooling, voice changes, coughing.
- Evidence of respiratory failure: inability to speak, weakened respiratory effort, increased work of breathing, cyanosis, hypoxia.
- Evidence of allergic reaction such as hives, airway edema, vomiting, or known exposure which can also be associated with upper airway obstruction.

Key Points

- Pulse oximetry and capnography should be utilized in all patients with respiratory distress to assess oxygenation and ventilation.
- Equipment for airways support and ventilation including intubation equipment, supraglottic airways, and a bag-valve-mask should be readily available in all patients with respiratory distress.
- Upper airway obstruction is caused by swelling in the upper airway which is treated using racemic epinephrine or inhaled epinephrine.
- Upper airway obstruction may also be caused by foreign bodies.



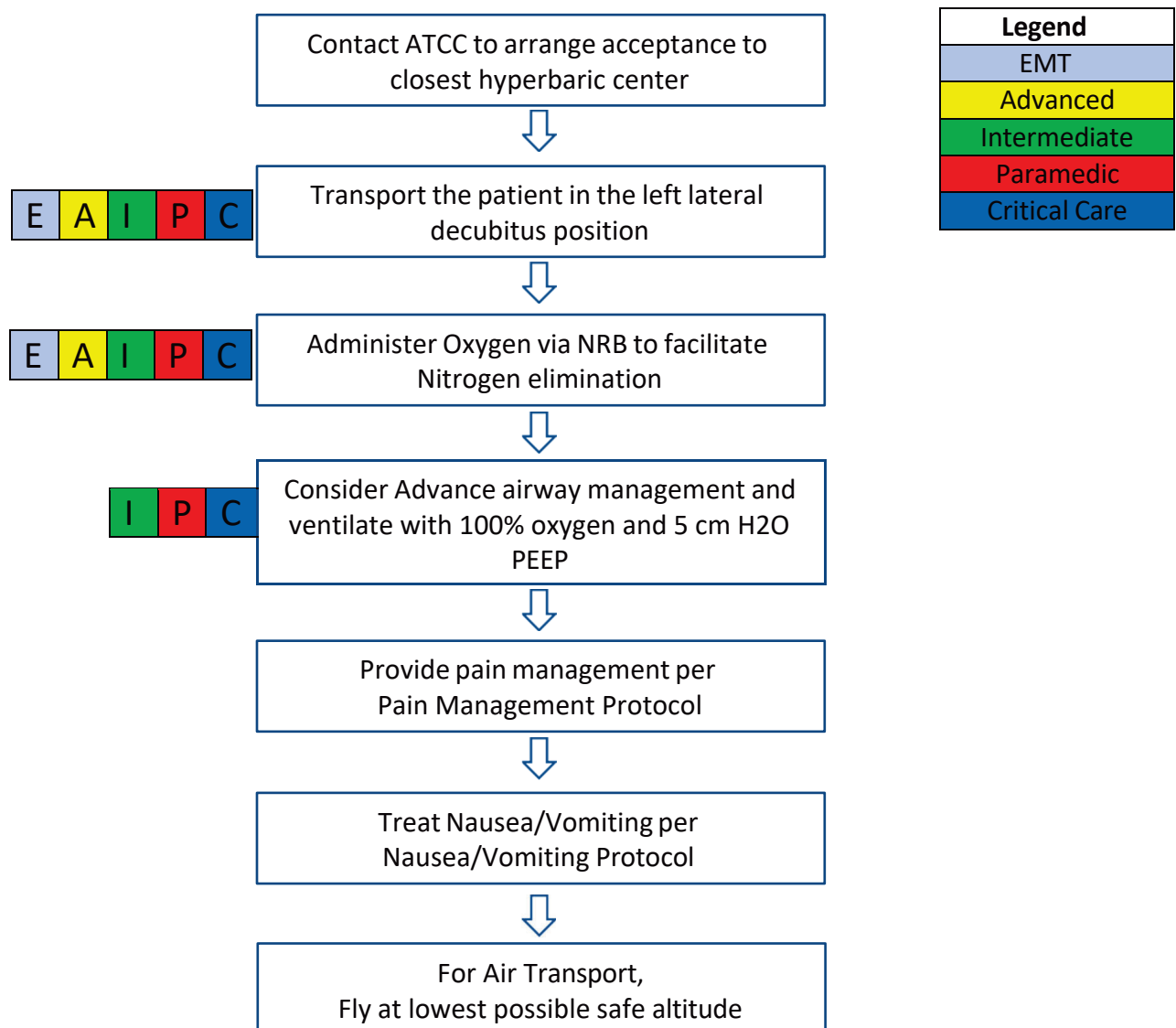
Decompression Sickness

History and Physical Exam

- Obtain appropriate history related to the incident (length of exposure, temperature of liquid medium, type of liquid medium, potential for injury, depth and duration of dive, onset of complications).
- Obtain past medical history and current medications.
- Obtain drug allergies.
- Any history of substance abuse?

Key Points

- Patients should be treated in the left lateral decubitus position.
- Oxygen saturations should be monitored carefully.



Electromuscular Incapacitation Device (Taser)

History and Physical Exam

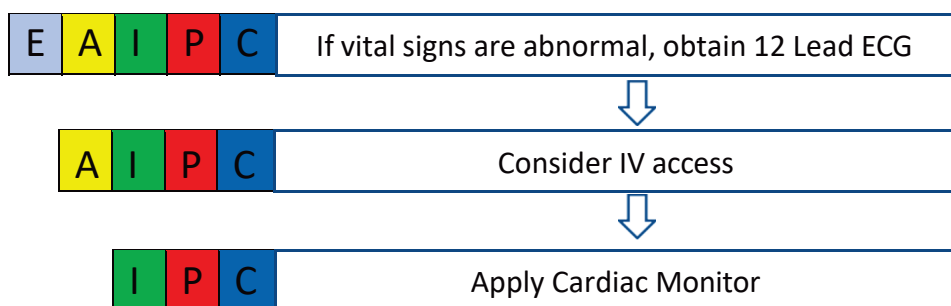
- What was the patient doing that required use of the device?
- History: Illicit drug use (types and frequency), medical problems and medication use, psychotropic or behavioral drug use, previous psychiatric disorders.
- If the device uses barbs, is a barb still penetrating the skin?
- Are the barbs in a sensitive area (eye, eyelid, ear, nose, neck, breast, or genitalia)?
- Do not touch or step on the barbs or wires until the wires have been unattached.
- Perform general patient assessment.

Key Points

- Law enforcement may request EMSP to evaluate a patient who was the target of an electromuscular incapacitation device. The important issue is not removal of barbs, but rather what caused the patient to be combative requiring the use of the electromuscular incapacitation device. Deaths have been recorded after use of these devices: however, it has always been due to an underlying cause of combative behavior (i.e., psychosis, drugs, hypoglycemia, intracranial abnormality, etc.).
- Patients with normal vital signs who have returned to a normal mental status do not require transportation to a hospital unless physician assistance is needed for barb removal, or some other reason is present mandating hospital transport. If there is any doubt whether transport is required, contact OLMD.
- If the patient is under arrest, law enforcement should accompany the patient to the hospital.
- If the patient has altered mental status, reference the AMS Protocol.

Removal of Barbs:

- Treat barbs as contaminated needles.
- Confirm that the Taser has been shut off and that the wires have been removed from the barbs.
- Remove one barb at a time.
- Grab barb firmly and pull straight out in a quick motion, using two fingers of the EMSP's free hand on either side of the barb as a brace.
- Clean the area with betadine or alcohol and apply a dressing.
- Dispose of the barb in a sharp's container or give to law enforcement personnel.
- Barbs in the eye, eyelid, ear, nose, neck, breast, or genitalia should be transported to the hospital for physician removal.



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Hemodialysis Emergency Disconnect

History and Physical Exam

- Some patients are now doing UNATTENDED (i.e., solo) home hemodialysis. In the event an EMSP responds to a scene where such a patient is unable to disconnect themselves from the machine, and no one else is available who knows how to do so, follow this procedure to disconnect the patient from the machine for transport.

Key Points

- If time and patient condition permit, ALS backup should be called for BLS crews.
- If the EMSP is trained in using HD shunt clamps, and such clamps are available, it is acceptable to remove the HD needles from the patient's shunt and apply clamps. If not, this procedure should be followed, leaving the needles in situ as described above and below.
- The dialysis machine will be left at the home.
- If the EMSP can, note (or photograph) any clinically relevant values on the machine's readouts (such as liters removed).
- For a patient with an AV shunt, the result of this procedure is that the patient still has the dialysis needles in his or her AV fistula, ATTACHED to CLAMPED tubing, which is wrapped with gauze to keep the needles and tubing next to the patient's arm (unless HD shunt clamps are used).

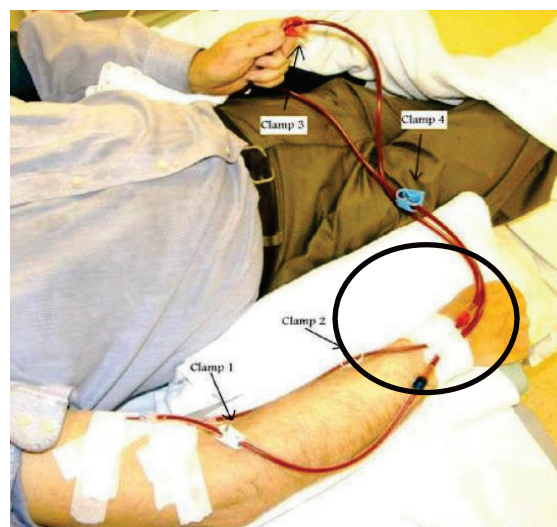
Procedure:

- Push the STOP button on the front of the machine and unplug the machine's power cord.

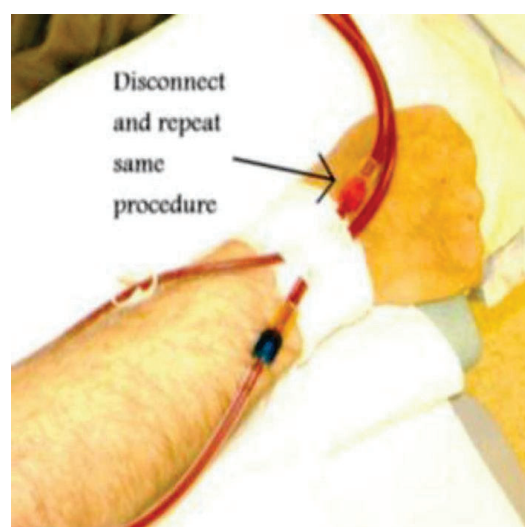
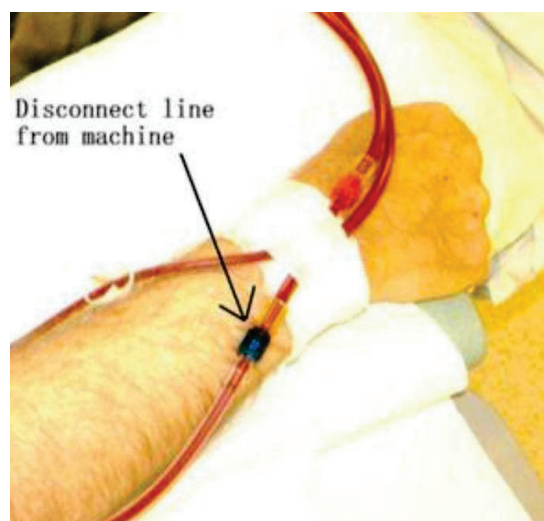


- Identify and close the four clamps on the tubing. If clamps are not on the tubing, use Kelly clamps or plastic clamps (which will usually be on or near the dialysis machine) to clamp off the two tubes both above and below the Luer lock disconnects.

The disconnects are in the center of circles in the pictures below.



- If the EMSP is trained to do so, and has sterile caps or sterile syringes, or is on or near the dialysis machine, then swab each disconnect end-connector with alcohol and attach the cap or syringe.
- The EMSP will now have two needle-tubing pieces still inserted into the patient's fistula. GENTLY tape the tubing to the patient's arm, then LOOSELY wrap gauze around the arm. DO NOT apply a pressure dressing.



If the EMSP accidentally pulls a needle out of the fistula, he or she will have to apply firm manual pressure (again, NOT a pressure dressing) to that bleeding point for approximately 20 minutes. Be prepared to call for additional resources if needed.

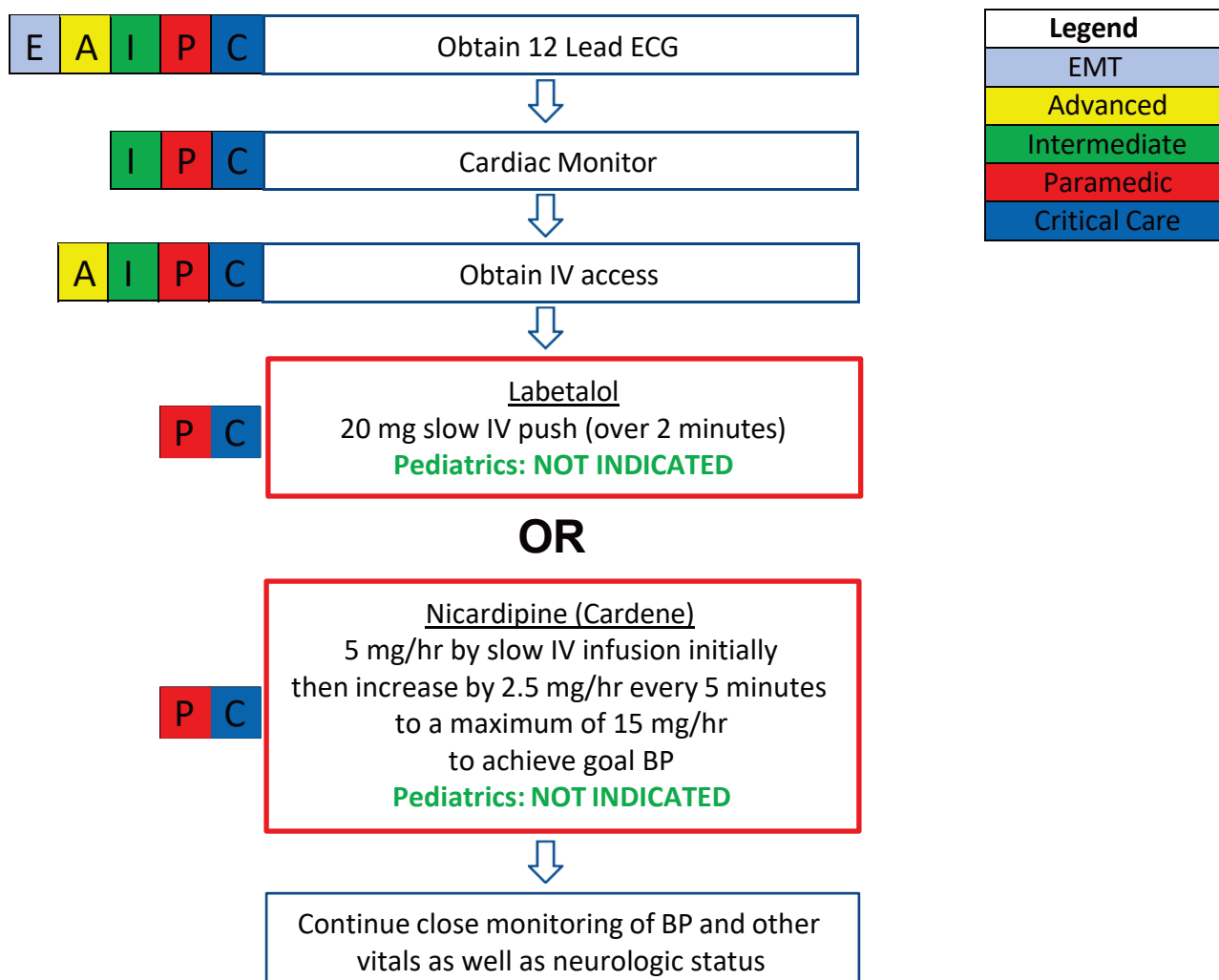
Hypertensive Emergencies

History and Physical Exam

- History of hypertension or other medical problems.
- Medication use or drug ingestion.
- Signs or symptoms of end organ damage such as headache, blurred vision, neurologic deficit, pain, congestive heart failure.
- Signs or symptoms of stroke (focal neurologic deficit, aphasia, etc.).

Key Points

- Hypertensive emergency is only treated if signs and symptoms of end organ damage are present and Diastolic BP > 115.
- Patients who appear to be having a stroke usually do not have their BP treated in the prehospital setting.
- Use caution in patients who have a potential underlying shock with hypertension (e.g. sepsis).
- See CHF Protocol for signs and symptoms of CHF with HTN



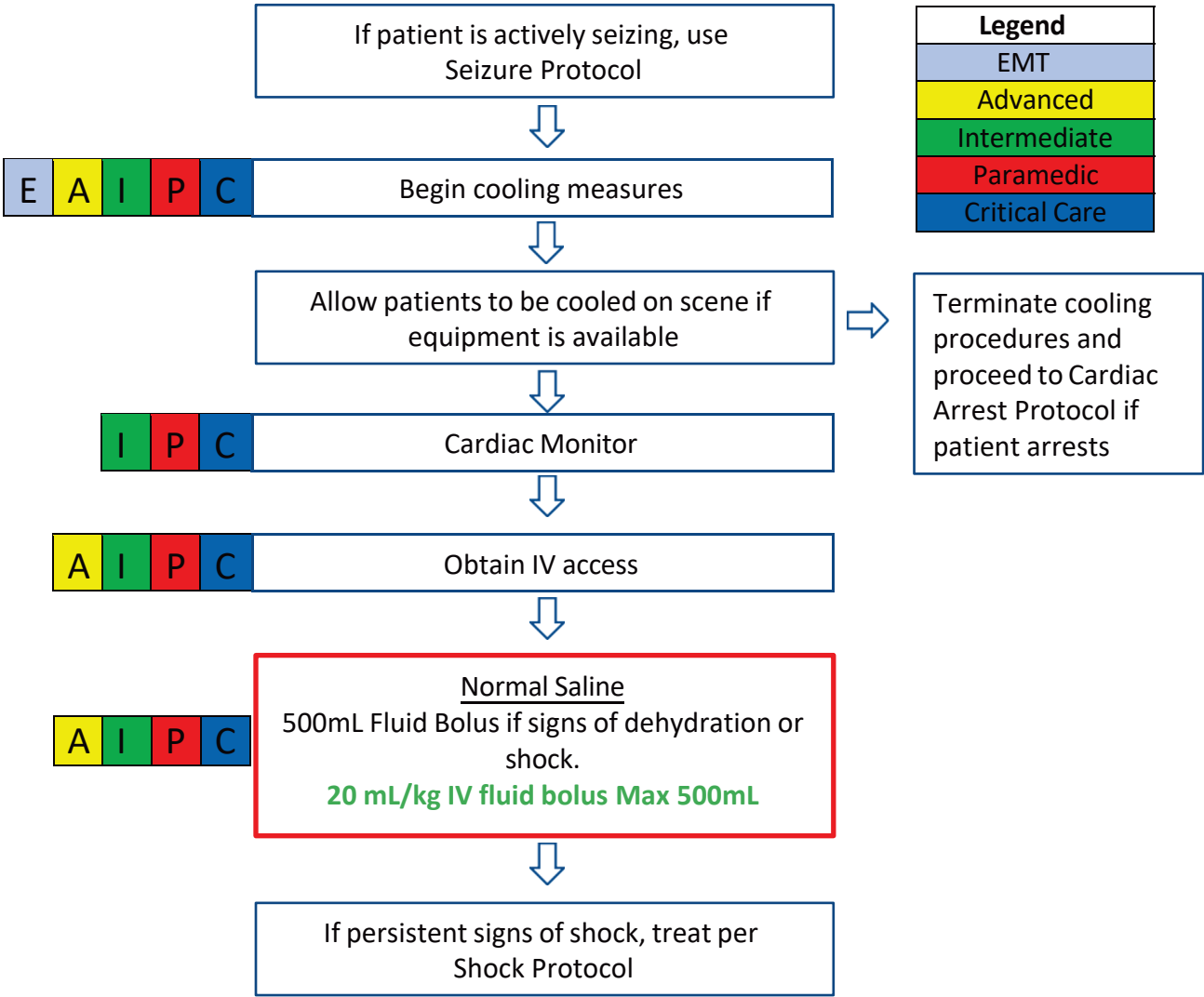
Hyperthermia

History and Physical Exam

- Sudden collapse or gradual development?
- Exercise induced?
- Environmental conditions?
- Previous history of hyperthermia?
- Vital signs: Oral or rectal temperature (if available) greater than 104°F or 40°C usually consistent with heat stroke, but lower temperatures can be seen.
- Skin: temperature, presence or absence of sweat.

Key Points

- There are three classic syndromes of hyperthermia – heat cramps, heat exhaustion, and heat stroke. Heat cramps occur secondary to inadequate intake of fluids and electrolytes resulting in muscle cramping. Heat cramps can progress to heat exhaustion resulting in dehydration, nausea and vomiting, and generalized weakness. Higher temperatures are usually seen with heat exhaustion (101-104°F or 38.3-40°C). Heat exhaustion can progress to heat stroke.
- Heat stroke is a medical emergency. It is defined as hyperthermia (usually >104°F or 40°C) with altered mental status.
- Suspect hyperthermia/heat stroke in patients with acute psychosis or seizure on a hot, humid day.
- If a physician with expertise in hyperthermia management is on scene, contact OLMD to relinquish control.
- Cool patient if possible while transporting. If ice water bath equipment or iced towels are immediately available, immerse the patient until his or her core temperature returns to normal. Wet sheets wrapped over a patient without good air flow may increase temperature and should be avoided.
- Patient temperature should be acquired and monitored frequently using a patient contact method such as orally, axillary, rectally, etc., rather than utilizing a “non-touch” thermometer.



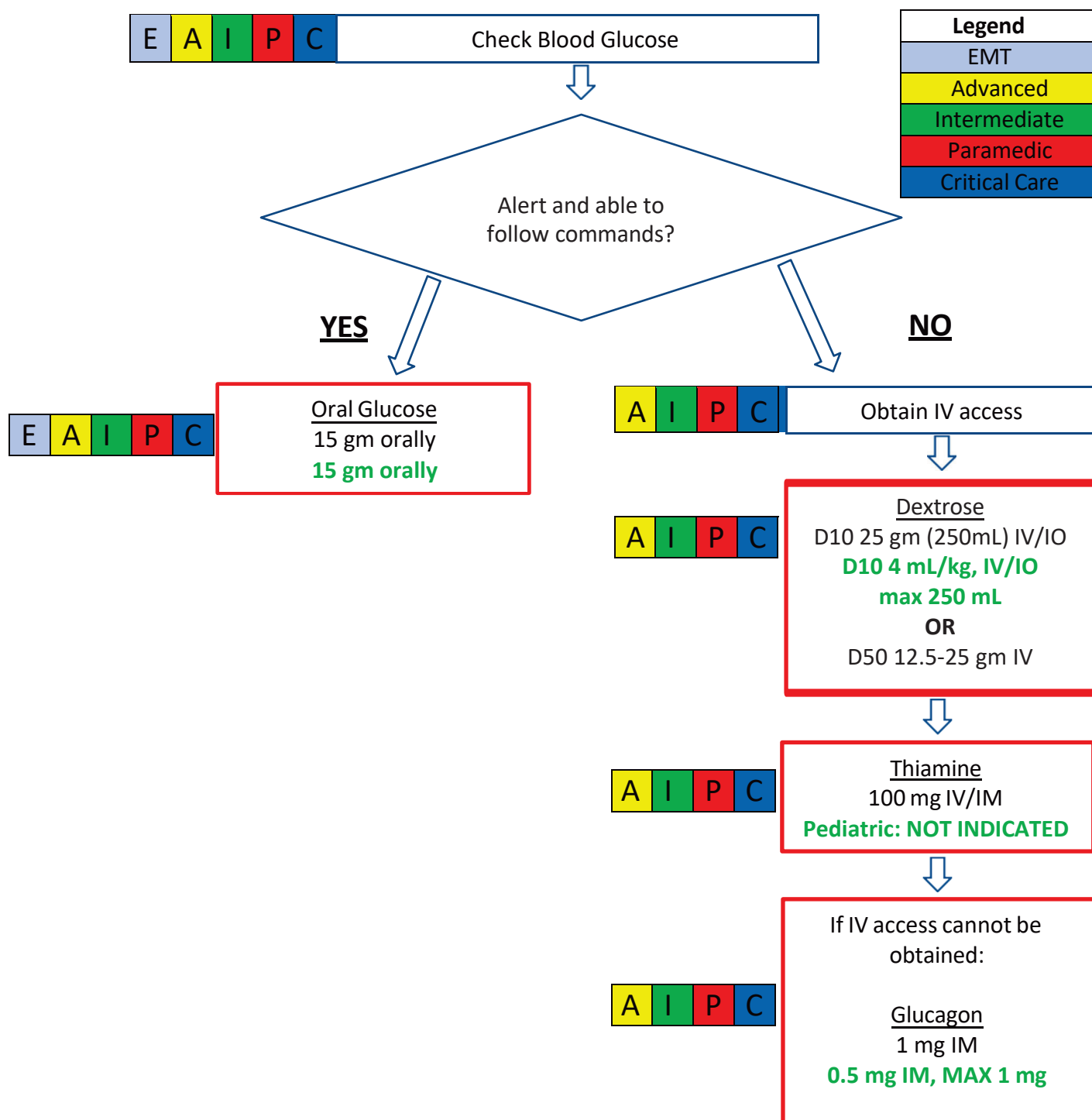
Hypoglycemia

History and Physical Exam

- Onset of symptoms sudden or gradual? When was patient last well?
- Recent stress either emotional or physical, last meal, or another oral intake.
- History of Diabetes Mellitus, medical alert tag.
- Medication history, including insulin (time/amount), and oral hypoglycemic agents.
- Rate and quality of respiration, odor on breath.
- Mental Status.
- Skin color, temperature, and hydration.
- Signs of adrenaline effect: diaphoresis, tachycardia, tremor, and/or seizures.

Key Points

- The diabetic will frequently know what is needed - listen to the patient, but remember hypoglycemia is often associated with mental confusion.
- Hypoglycemia can present as seizures, coma, altered mental status, or stroke-like symptoms with focal neurologic deficits (particularly in elderly patients).
- Patients who are elderly, or who have been hypoglycemic for prolonged periods of time may be slower to awaken once hypoglycemia has been treated.
- Hypoglycemia is not an indication for use of IO access except in extreme circumstances.
All such uses of IO will be reviewed by the Office of EMS.
- Treat Hypoglycemia with Dextrose. Give Oral Glucose Paste, juice, syrup, or other sugar containing food if patient is awake enough to follow commands.
 - Adult Glucose <70
 - **Pediatric Glucose <60**
- If the patient is comatose and IV access cannot be obtained, give Glucagon IM.



Hypothermia

Mild to Moderate Hypothermia (90-95°F)

Patients may present with a history of exposure to cold, altered mental status, shivering, stiffening of muscles, stumbling or staggering gait, cool or cold skin, or mottled/pale skin.

Severe Hypothermia (<90°F)

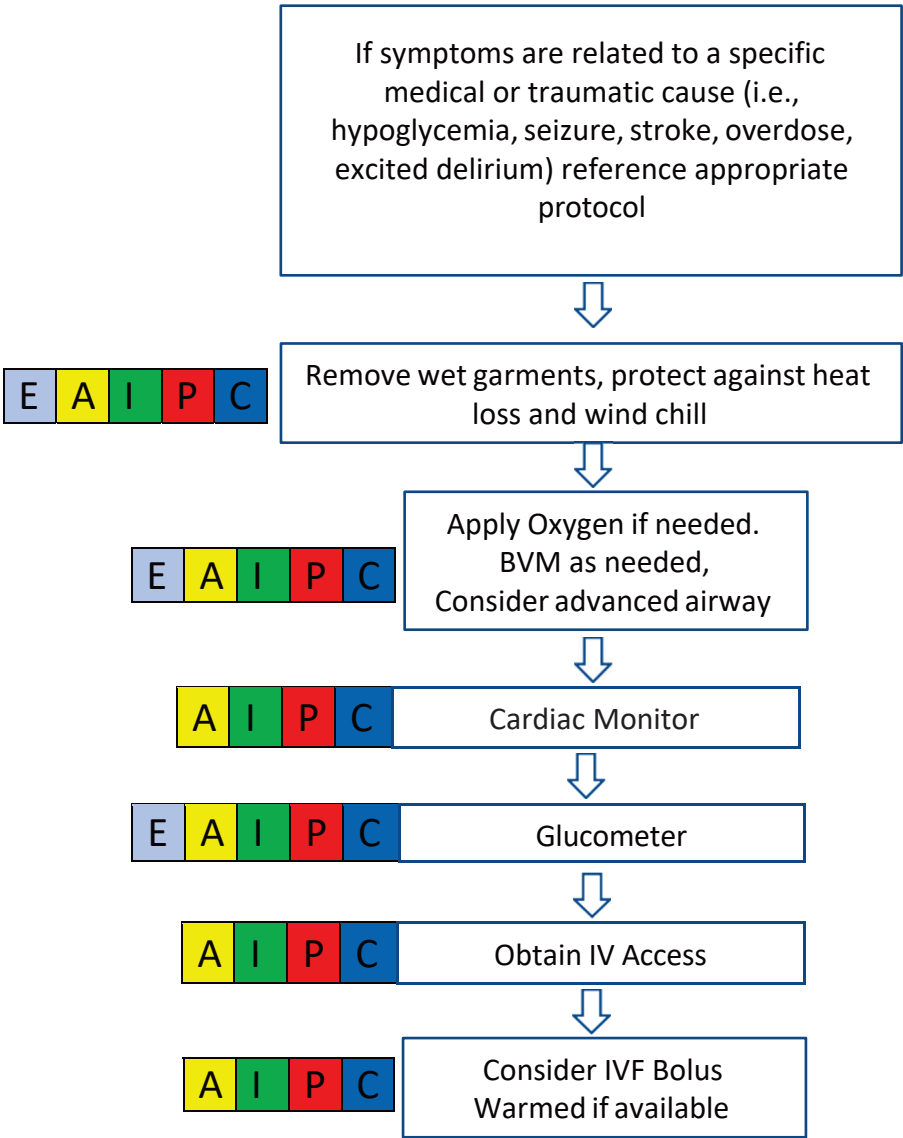
Patients may present with any of the symptoms listed above (except shivering), absent or diminished respiratory effort, or absent or diminished peripheral pulses. They may also present with respiratory and/or cardiac arrest.

History and Physical Exam

- Length of exposure.
- Environmental conditions.
- Observe for respiratory effort and check pulses.
- Assess cardiac rhythm.
- Determine level of consciousness by verbal and motor responsiveness.

Key Points

- If terrain is difficult, evacuate patients first and treat second.
- Do chest compressions only if the chest is compressible and the patient has a disorganized rhythm. Max of three shocks should be performed for VF/VT.
- In cases of severe hypothermia, there is some evidence that metabolism of antiarrhythmic drugs is slowed, which can lead to accumulation of drugs to toxic levels. Therefore, it is recommended that in these cases, OLMD be consulted for advice prior to administration of antiarrhythmic drugs.
- Medications should not be given below 86 Degrees.
- Patient temperature should be acquired and monitored frequently using a patient contact method such as orally, axillary, rectally, etc., rather than utilizing a “non-touch” thermometer.



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Paramedic
Critical Care

Influenza, Respiratory Illness

History and Physical Exam

- Signs and symptoms of influenza like illnesses:
Rapid onset of symptoms, Fever, Pleuritic Chest Pain, Nasal Congestion, Body Aches, Difficulty Breathing, Cough, Chills, Sore Throat, Runny nose, Headache

Key Points

- All EMSP engaged in aerosol generating activities (e.g., endotracheal intubation, bag valve mask ventilation, nebulizer treatment, CPAP, or BiPAP [use expiratory filter]) should wear the PPE as described in this treatment protocol.
- When transporting a patient with symptoms of acute febrile respiratory illness, notify the receiving healthcare facility so that appropriate infection control precautions may be taken prior to patient arrival.
- Any non-essential equipment that can be removed from the patient compartment of the ambulance before transport will hasten the time needed to disinfect and return to service.
- After the patient has been removed and prior to cleaning, the air within the vehicle may be exhausted by opening the doors and windows of the vehicle while the ventilation system is running. This should be done outdoors and away from pedestrian traffic.
- Routine cleaning methods should be employed throughout the vehicle and on non disposable equipment. Routine cleaning with soap or detergent and water to remove soil and organic matter, followed by the proper use of disinfectants, are the basic components of effective environmental management of influenza. Reducing the number of influenza virus particles on a surface through these steps can reduce the chance of hand transfer of virus particles. Influenza viruses are susceptible to inactivation by a number of chemical disinfectants readily available from consumer and commercial sources.

Treatment

- Treat using General Patient Care Protocol.
- Use appropriate standard infectious disease precautions.
- Appropriate PPE for suspected cases of influenza includes disposable N-95 mask, eye protection, and disposable non-sterile gloves. Disposable non-sterile gown is optional depending on the situation (follow guidance of service medical director).
- If dispatch advises the EMSP of the potential for acute febrile respiratory illness symptoms on scene, don PPE for suspected cases of influenza prior to entering the scene.
- If the EMSP encounters individuals with symptoms of acute febrile respiratory illness prior to donning PPE, stay more than 6 feet away from individuals with symptoms and exercise appropriate routine respiratory droplet precautions. If a patient has signs or symptoms of influenza or acute febrile respiratory illness, don the PPE described above before coming into close contact with them.
- All patients with acute febrile respiratory illness should wear a surgical mask, if tolerated by the patient.
- Encourage good patient compartment vehicle airflow/ventilation (turn on exhaust fan) to reduce the concentration of aerosol accumulation when possible.

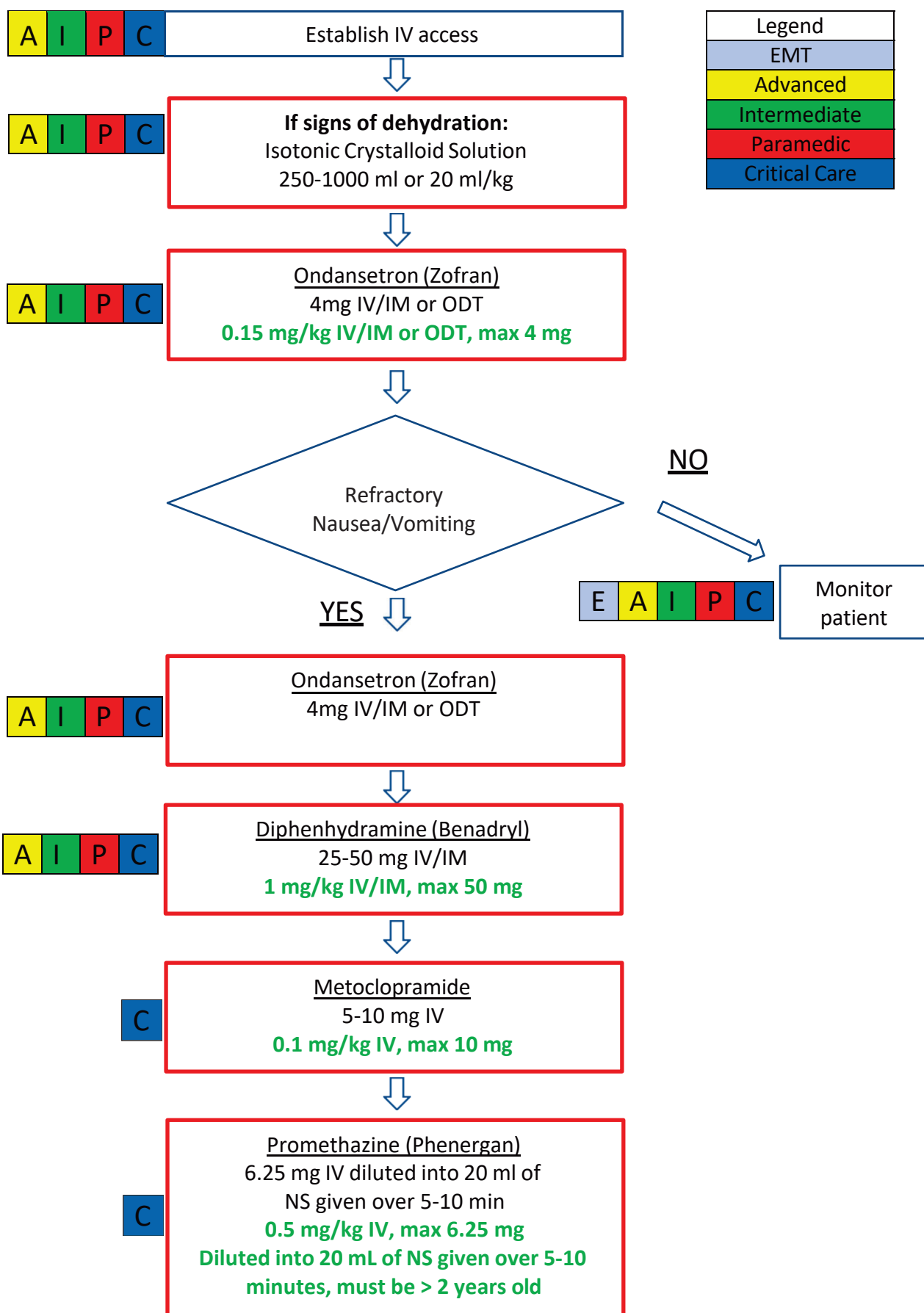
Nausea/ Vomiting

History and Physical Exam

- Symptom onset.
- Associated symptoms such as abdominal pain, diarrhea, and headache.
- If vomiting, is there any blood or coffee-ground like material in the vomitus.
- History of ingestion of potential poison or spoiled food.
- If female of child-bearing age, inquire if the patient could be pregnant.
- History of recent head injury.
- Signs of dehydration (poor skin turgor, dry mucous membranes, sunken fontanelle in babies).
- Jaundice.
- Evidence of head trauma.
- Abdominal tenderness, rigidity, distention, guarding, and bowel sounds.
- Neurologic exam: level of consciousness, pupils, focal neurologic findings.

Key Points

- Ondansetron may be used in cases of nausea to prevent vomiting.
- Ondansetron may be used to prevent nausea when administering narcotic medications, especially if there is a history of nausea after receiving narcotics.
- Diphenhydramine, Metoclopramide, and Promethazine are other medications which can be used for refractory nausea/vomiting.
- Care should be used in the administration of Metoclopramide and Promethazine as they can be associated with extrapyramidal effects.



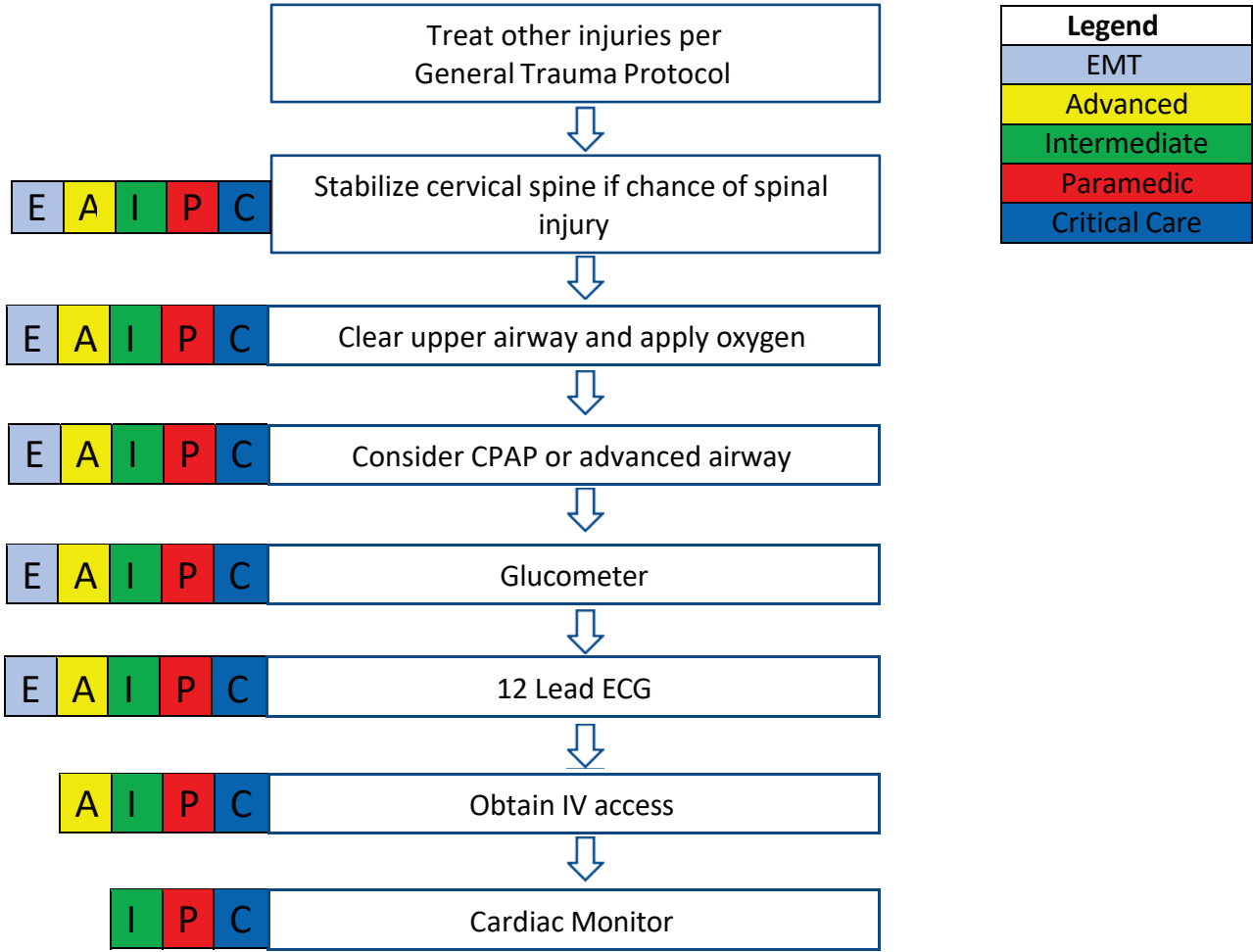
Near Drowning / Submersion Injury

History and Physical Exam

- Length of submersion.
- Approximate temperature of water.
- Any associated trauma.
- History of scuba diving.
- Resuscitation history (if applicable): time of arrest, bystander CPR, other interventions.
- Respiratory status.
- Neurologic status.

Key Points

- If a patient is still in water, rescue by trained, equipped personnel only.
- Near drowning patients are likely to vomit. Use caution and protect the airway.
- All near drowning patients should be transported. Patients may appear well initially, but rapid deterioration can occur. Monitor closely for pulmonary edema.
- It is a common error to underestimate injuries (i.e., from diving, jumping, MVC, etc.).
- If a scuba diving injury is possibly related to a decompression issue, refer to Decompression Sickness Protocol.
- Reference Trauma Protocol as needed.



Newborn Care

History and Physical

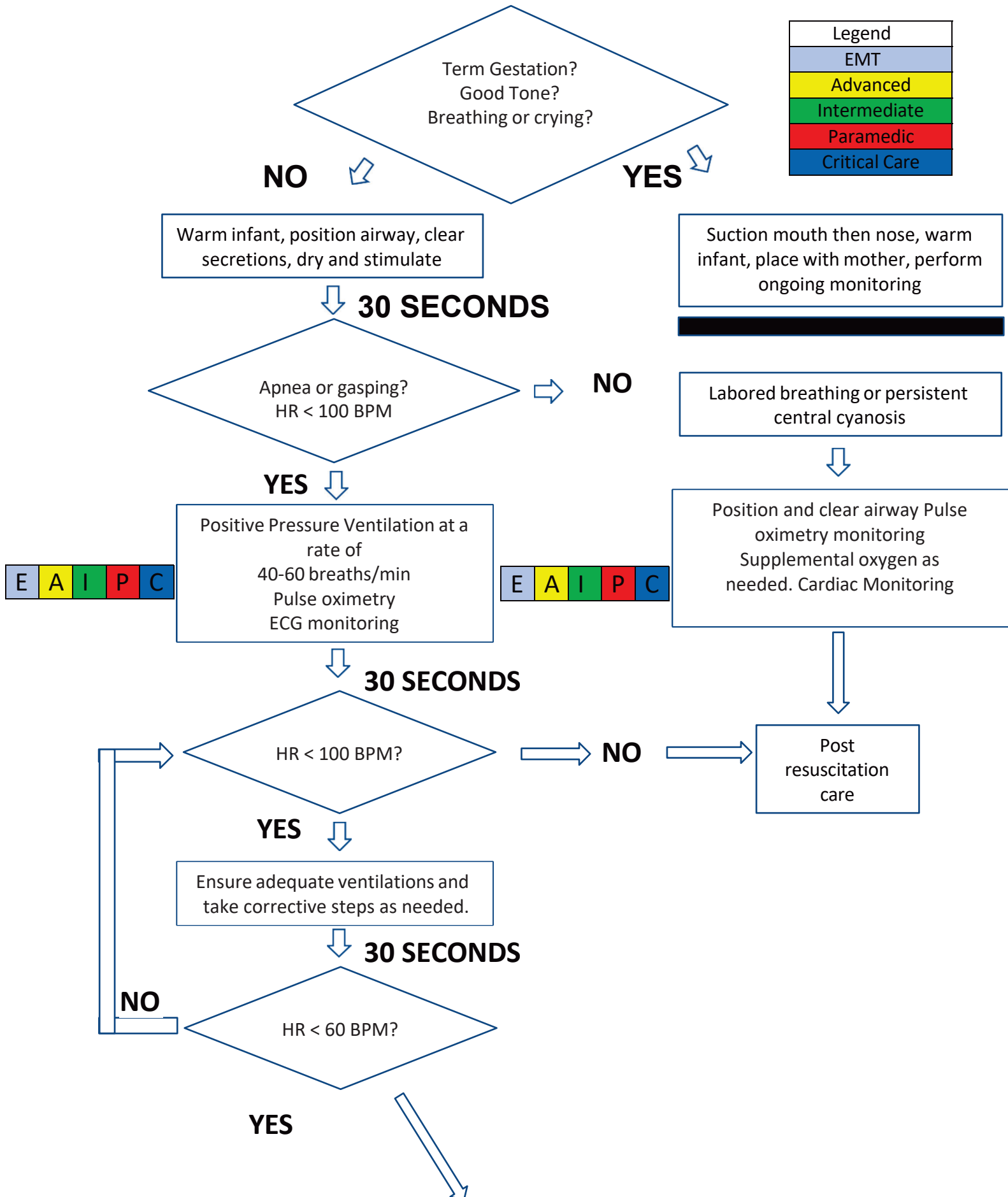
- How far along is the pregnancy?
- Have they received any prenatal care?
- Have there been any complications with the pregnancy?
- Are there any known issues with the baby or the pregnancy?
- Was there meconium at delivery?
- Is the baby active and crying?
- Does the baby have good tone?
- Is the baby gasping or apneic?
- What is the baby's heart rate?

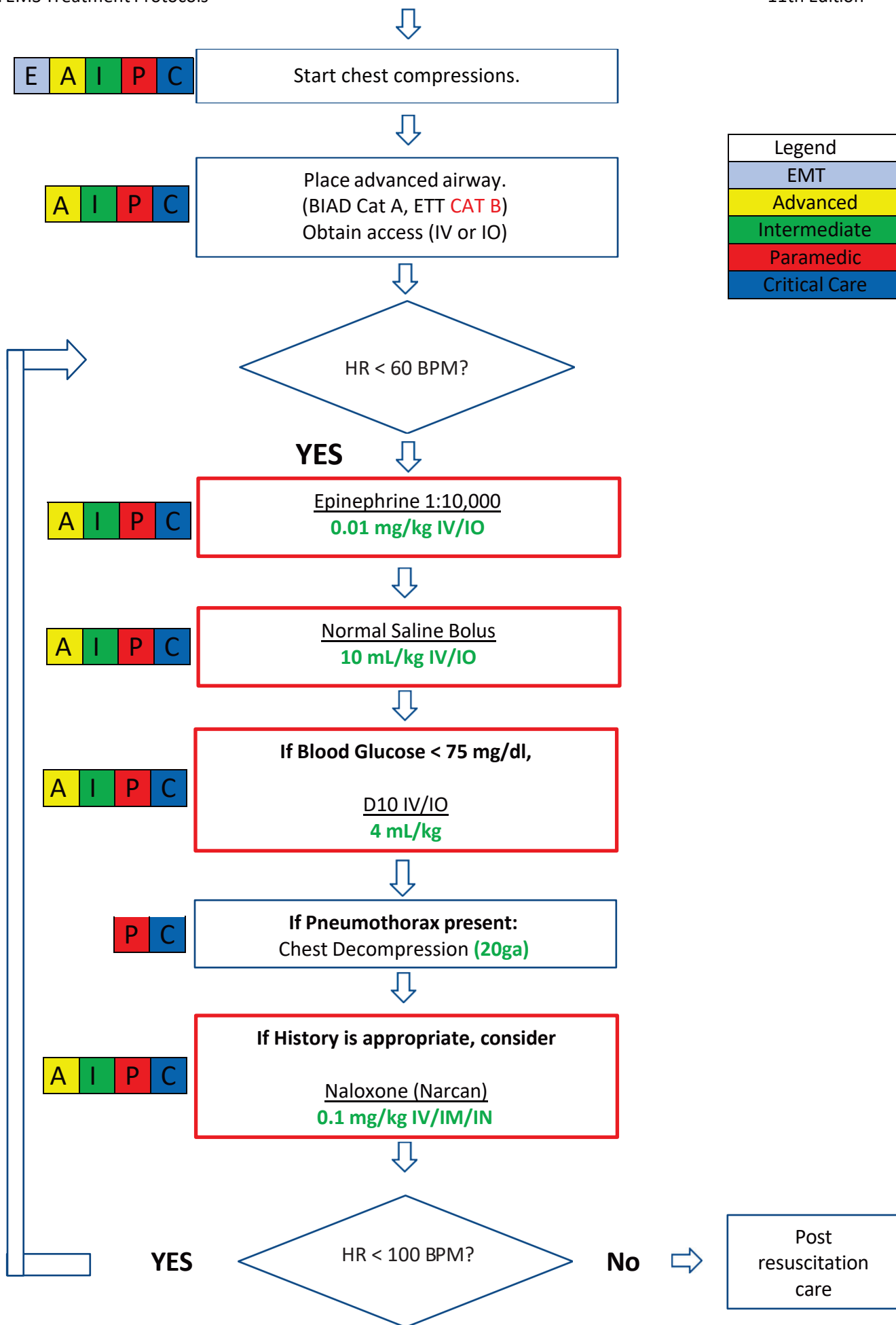
Key Points

- Once the baby is born, if it is full term, active and crying, and has good tone, routine newborn care should be delivered, the baby given to mother and kept warm. Skin-to-skin contact with the mother is preferred.
- Newborn heart rate is best assessed by using a stethoscope or by palpating the base of the umbilical stump. The rate will be high and tapping out the rhythm can be helpful in assessing the rate quickly until a cardiac monitor can be applied.
- Inflation and ventilation of the lungs are the priority in newly born infants who need support after birth.
- A rise in heart rate is the most important indicator of effective ventilations and response to resuscitative interventions.
- Pulse oximetry is used to guide oxygen therapy and meet saturation goals. The pulse-ox probe should be applied to the right upper extremity to ensure the saturation is preductal.
- Oxygen saturations are initially low and will normalize over time following birth.

Target Preductal SpO2 after Birth	
1 min	60-65%
2 min	65-70%
3 min	70-75%
4 min	75-80%
5 min	80-85%
6 min	85-95%

- Use of a PEEP valve in BVM ventilations is important and PEEP should be set to 5cmH2O.
- Chest compressions are provided if there is a poor heart rate response to ventilations after appropriate ventilation corrective steps which preferably include placement of an advanced airway.
- If the response to chest compressions is poor, it is reasonable to provide epinephrine, preferably by the IV or IO route. The distal femur is the preferred IO site in small, newborn infants.
- Failure to respond to epinephrine should prompt further evaluation in treatment including possible IV fluid bolus for volume expansion, evaluation for hypoglycemia, and possible naloxone administration if there is a maternal history of drug usage.





Pain Management

History and Physical Exam

- When did the pain start?
- What was happening when the pain started?
- What is the quality and severity of the pain?
- Is there any radiation of the pain?
- Has the patient ever experienced pain like this before?
- Does the patient have any underlying medical conditions which could relate to the pain?
- Has the patient experienced any recent injuries?
- Uncomfortable appearance?
- Tenderness.
- Location of injuries.

Key Points

- Morphine or Fentanyl should be used as primary analgesics.
- **Fentanyl can be given intranasally for children to avoid IV sticks.**
- Ketamine can be used for refractory pain or if other medications are in shortage.
- Toradol is an NSAID medication which can be used for pain control as well, but should not be used in patients with known renal history or who have already taken NSAIDs for pain, or who may be pregnant.
- Mild pain can be treated with oral acetaminophen (Tylenol). Tylenol should not be given to any patient with a history of liver disorders or any patient who has already taken Tylenol in the last 8 hours.
- If pain is cardiac in nature, refer to Adult Chest Pain Protocol.
- All injuries should be treated per the appropriate protocol.
- Consider co-administration of Ondansetron, especially in patients with known nausea/vomiting related to pain medication (see Nausea and Vomiting protocol).
- **Analgesic pain medication should be used with caution in children less than 1 and elderly patients.**
- Relative contraindications to narcotic pain medication include altered mental status and hypotension and online medical control should be utilized prior to administration of pain medication to these patients.
- Ketamine should be dosed on ideal body weight.
- Consider monitoring EtCO₂ and watch for respiratory depression if multiple doses are given.

If pain is related to a specific medical cause
(i.e., cardiac) please reference appropriate
protocol

If pain is trauma related (i.e., burn, fracture)
treat injuries per the appropriate protocol

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Pain > 5/10 with no
relative contraindications
to administration

⇒ **NO**

E A I P C

Consider
Tylenol
1000mg PO
**15 mg/kg PO up to
1000mg**

or
Contact OLMD

↓ **YES**

Morphine

2-4 mg IV/IM, may repeat q5
minutes as needed

**0.1 mg/kg IV/IM, max 4 mg
may repeat x3**

P C

Fentanyl

25-50 mcg IV/IM/IN
may repeat q5 minutes as
needed. Max 100mcg

**1 mcg/kg IV, max 50 mcg or
1.5mcg/kg IN, max 75 mcg may
repeat q20 min as needed x3**

P C

Toradol (Ketorolac)

15 mg IV/IM

**0.5 mg/kg IV/IM, max 15 mg
Must be > 1 Year Old**

A I P C



Refractory Pain

YES



P C

Ketamine
0.2 mg/kg slow IVP, max 25mg
0.5 mg/kg IM, max 50 mg
q10 minutes if needed
**0.2 mg/kg slow IVP, max 25mg
0.5 mg/kg IM, max 50 mg
1 mg/kg IN, max 50 mg**

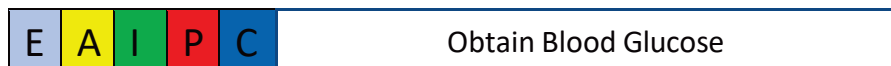
Poisons and Overdoses

History and Physical Exam

- Scene safety: Do not enter an area that is possibly contaminated with a hazardous material unless properly protected. Do not enter the scene if physical danger is present. Wait for the police and/or hazardous materials units to clear or secure a dangerous scene.
- Type of ingestion: What, when, and how much was ingested? Bring the poison, the container, and everything questionable in the area with the patient to the ED. Look for multiple patients with the same signs and symptoms.
- Reason for ingestion: Screen for child neglect, and/or suicidal ideation.
- History: Medications, diseases, psychiatric history, and/or drug abuse.
- Action taken by bystanders: Induced emesis, “antidote” given.
- Level of Consciousness.
- Breath odor.
- Neurologic status, pupillary findings.
- Vomitus.
- Needle marks or track marks.
- SLUDGES (Salivation, Lacrimation, Urination, Defecation, Gastric Emesis, and Sweating). These symptoms are consistent with cholinergic toxicity.

Key Points

- Inhalation poisoning is particularly dangerous to rescuers. Recognize an environment with continuing contamination and extricate rapidly by properly trained and equipped personnel.
- Do not induce vomiting.
- Do not try to neutralize acids with strong alkalis. Do not try to neutralize alkalis with acids.
- OLMD is encouraged to involve Poison Control Center when needed, 1-800-222-1222.
- Calcium Chloride can be interchanged for Calcium Gluconate.
- Follow local Hazardous Material Plan.
- Protect medical personnel.
- Remove the patient from the contaminated area and/or remove the contaminant from the patient.
- Flush contaminated skin and eyes with copious amounts of water unless substance is Lyme.
- If **cholinergic or organophosphate poisoning**, administer atropine.
- If **depressed respirations or altered mental status**, consider naloxone.
- Treat hypoglycemia using Hypoglycemia Protocol.
- If **Tricyclic Antidepressant overdose**, administer Sodium Bicarbonate, especially if QRS > 100 msec or the patient has altered mental status. Do not delay transport, rapid deterioration may occur. Monitor for seizure activity.
- If **Beta Blocker Overdose**, administer Glucagon.
- If **Calcium Channel Overdose**, administer Calcium Chloride, Glucagon. NOTE: flush the line between giving calcium and glucagon to prevent precipitation.
- If **Cyanide** - May be from cyanide exposure or from smoke inhalation. In a patient who shows signs of shock or cardiac collapse in the setting of a closed space smoke exposure, consider Cyanokit.



Opioid OD:



Naloxone (Narcan)

2-4 mg **IN** q3 min

If desired, EMSP may give 0.5 mg and titrate to effect

Pediatric: 2-4 mg IN (all ages and weights)



Opioid OD:



Naloxone (Narcan)

2-4 mg **IV/IN/IM** q 3minutes

**Pediatric: <5 years or <20 kg: 0.1 mg/kg
IV/IN/IM**

>5 years or >20 kg: 2-4 mg IV/IN/IM

Organophosphate/Cholinergic OD:



Atropine

2 mg **IV/IM** every 5 minutes; may titrate to effect

**Pediatric: 0.02 mg/kg IV/IM
min dose 0.1 mg.**

Max single dose 0.5 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Tricyclic Acid OD:

P C

Sodium Bicarbonate
1 mEq/kg IV

Pediatric: 1 mEq/kg IV

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Calcium Channel/ Beta Blocker:

P C

Glucagon
5 mg IV/IM

Pediatric: 0.5 mg IV/IM

Calcium Channel Blocker:

P C

Calcium Chloride or Calcium Gluconate
1 gm (10cc of 10% solution) slow IV

**Pediatric: 20 mg/kg (0.2 mL/kg) of 10%
solution slow IV. Max 1 gm**

Cyanide:

P C

Cyanokit
5 gm IV over 15 min

**Pediatric: 70 mg/kg IV
Max 5 gm over 15 mins**

Benadryl OD:

P C

Sodium Bicarbonate
1 mEq/kg IV

Pediatric: 1 mEq/kg IV

Post Intubation Sedation and CPR Induce Consciousness Usage

Usage:

- Protocol to be used for patient comfort and sedation after intubation on scene or to during interfacility transfer.

Key Points

Select dose based on assessment and clinical considerations:

- Ventilator Pneumonia Prevention - Closed circuit suction, head up 30-45 degrees, suction and ET cuff pressure to 20 - 30.
- Consider OG.
- Initially use repeat bolus administration until the pain and sedation goal.
- Anticipate pain and agitation during transport and treat accordingly.
- Sedation goal for this guideline is a RASS -1 to -5.
- Use the lower part of the dose range or reduce the normal dose of all sedatives by the patient is hemodynamically unstable.
- A sedative should be added if opioids fully control pain, but sedation goals cannot be met. Choose only one sedative to use.
- A long-acting paralytic should only be utilized if appropriate analgesia and effective.
- Have the receiving physician verify tube placement and chart.
- It is required that the airway be monitored continuously throughout transport capnography and pulse oximetry.
- Reassess airway placement frequently and with every patient.
- Benzodiazepines should be used along with opiates for both sedation and pain control.
- Ketamine can be used as a single pain/agitation treatment or used in conjunction with opiates.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Infusions:

Fentanyl Infusion

1-2 mcg/kg/hr IV

1-2 mcg/kg/hr IV

Ketamine Infusion

0.5 - 4 mg/kg/hr IV

0.5 - 4 mg/kg/hr IV

Propofol

Infusion titrate 5-10 mcg/kg/min q5 min to maintain sedation.

(Range: 5-50 mcg/kg/min)

Infusion titrate 5-10 mcg/kg/min q5 min to maintain sedation.

(Range: 5-50 mcg/kg/min)

Bolus 0.5-1 mg/kg IVP q3 minutes
May be used to supplement infusion
If needed

Bolus 0.5-1 mg/kg IVP q3 minutes
May be used to supplement infusion
If needed

Fentanyl

1 mcg/kg IV/IO,

Max 100 mcg

may repeat as needed q3-5 min

1 mcg/kg IV/IO,

Max 100 mcg

may repeat as needed q3-5 min

Midazolam

0.1 mg/kg IV/IO,

Max 10 mg

may repeat as needed q20-30 min

0.1 mg/kg IV/IO,

Max 10 mg

may repeat as needed q20-30 min

Lorazepam

2-4 mg IV/IO,

may repeat as needed q20-30 min

0.1 mg/kg IV/IO,

Max 4 mg

may repeat as needed q10-20 min

Ketamine

2 mg/kg IBW IV/IO,

may repeat as needed q10 min, max 200mg

May 1/2 dose if vitals are unstable

2 mg/kg IBW IV/IO,

may repeat as needed q10 min, max 150mg

Below may be repeated as needed.

Ensure adequate sedation prior to administration of repeat paralytics

Vecuronium (Norcuron)

0.1 mg/kg IBW IV/IO, max 10 mg

0.1 mg/kg IBW IV/IO, max 10 mg

Rocuronium (Zemuron)

1 mg/kg IBW IV/IO, max 100 mg

1 mg/kg IBW IV/IO, max 100 mg

Pavulon (Pancuronium)

0.1 mg/kg IBW IV/IO

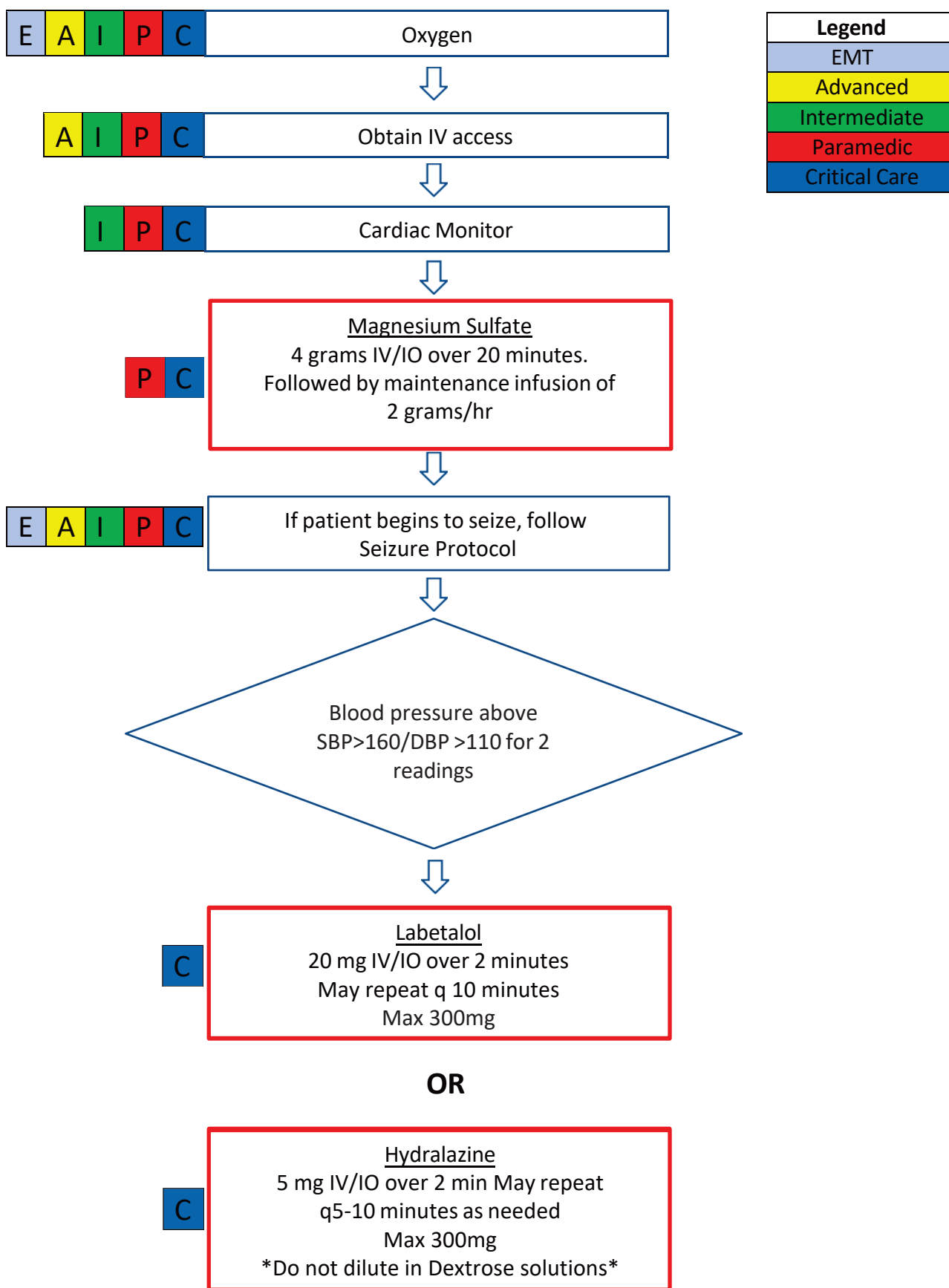
Preeclampsia/Eclampsia

History and Physical Exam

- Prenatal care.
- History of seizure disorder (seizure with no prior history is more likely to be eclampsia).
- History of headache, vision changes, right upper quadrant pain, peripheral edema.
- Vital Signs:
 - Blood pressure normally decreases during pregnancy.
 - In the setting of pregnancy, hypertension is defined as BP >140/90 or a relative increase of 30 mm hg SBP or 20 mm hg DBP from the patient's pre-pregnancy blood pressure.
- Seizure activity.

Key Points

- The disease of unknown origin.
- Field diagnosis of preeclampsia based on findings of pregnancy, hypertension, and edema.
- Usually occurs after the 20th week of gestation. May occur up to 6 weeks postpartum.
- Eclampsia occurs with the signs/symptoms of preeclampsia with seizures or coma.
- Magnesium can cause respiratory depression and hypotension.



Seizure

History and Physical Exam

- Onset and duration.
- History and description of seizures.
- Medications and compliance.
- History or evidence of trauma, particularly head trauma.
- History of diabetes, headache, recreational drug or alcohol use, or pregnancy.
- Level of consciousness, ongoing seizure activity, incontinence, focal neurologic signs.

Key Points

- Don't force items into the seizing patient's mouth.
- Note: Seizures may be caused by arrhythmias, particularly in patients over 50 years old.
- Seizure activity may also be caused by cerebral hypoxia from cardiac arrest. **Always check a pulse. Follow appropriate protocol if arrhythmia or cardiac arrest is found.**
- **Seizures in pediatric patients are commonly febrile seizures and are usually benign and short lived.**
- Seizures in a pregnant woman may be due to eclampsia. Use the appropriate protocol.



Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

NOTE:

If symptoms are related to a specific medical or traumatic cause (i.e., hypoglycemia, cardiac arrest, stroke, overdose) reference appropriate protocol.

P	C
---	---

Lorazepam (Ativan)
1-2 mg IV
0.1 mg/kg IV (max 2 mg)

OR

P	C
---	---

Midazolam (Versed)
2 mg IV/IM
10 mg IN
(Advanced EMT's may ONLY use the IN dose and route)
0.1 mg/kg IV/IM, max 2 mg OR
0.2 mg/kg IN via atomizer, max 10 mg
(Preferred route: IN)

OR

P	C
---	---

Diazepam (Valium)
5-10 mg IV
0.1 mg/kg IV, max 5 mg
0.5 mg/kg Rectal, max 20 mg



C

Keppra
6000 mg IV/IO over 15 minutes
60 mg/kg IV/IO, over 15 minutes,
max 6000 mg

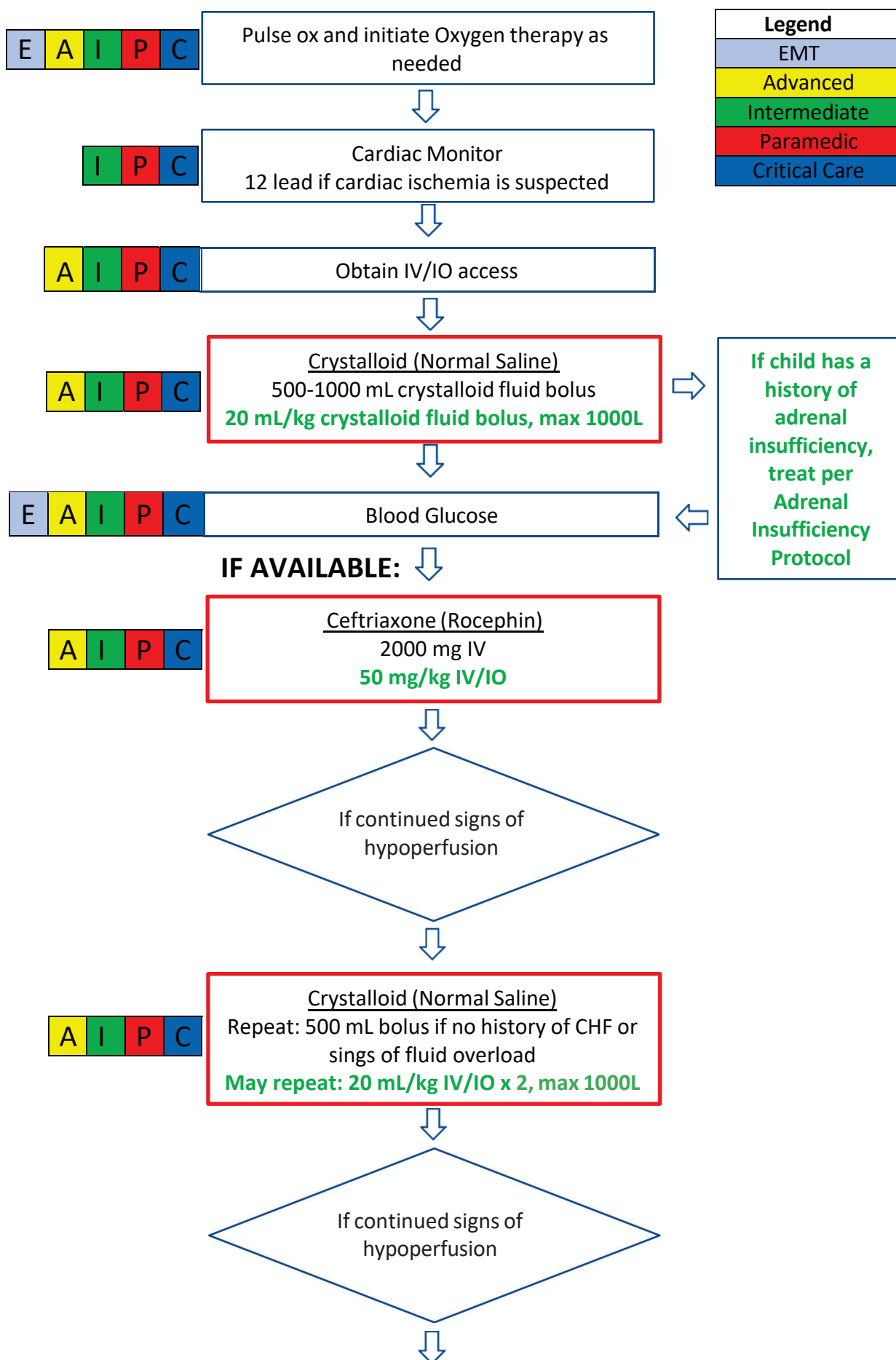
Sepsis

History and Physical Exam

- Onset of illness.
- Changes in mental status.
- Urine output.
- Any underlying medical conditions which make the patient susceptible to infection.
- Presence of fever.
- Heart rate and blood pressure.
- Capillary refill.
- Shock index >1.0.

Key Points

- Sepsis is a life-threatening condition and requires aggressive management.
- Early identification and rapid intervention are key to the survival of sepsis.
- Early effective fluid resuscitation is the first step in management and crucial for the stabilization of sepsis-induced tissue hypoperfusion or septic shock.
- Given the urgent nature of this medical emergency, initial fluid resuscitation should begin immediately upon recognizing a patient with sepsis and/or hypotension.
- Fluid amounts should be reduced in patients with heart failure or signs of fluid overload.
- Prehospital antibiotics have been shown to reduce mortality in patients with septic shock and, if available, should be rapidly administered after initiation of fluid resuscitation.
- Blood cultures should be obtained prior to initiation of antibiotics if available, however, this should not delay the initiation of antibiotic therapy.
- Vasopressor therapy should be utilized to maintain a goal MAP >65mmHg in adults and **normal BP for age in children.**
- Receiving facilities should be alerted that the patient is septic.





Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

P C

Epinephrine 1:100,000 Push Dose Pressor)
5-20 mcg (0.5-2 mL) q3-5 min IV/IO
1 mcg/kg (0.1 mL/kg) up to 10 mcg IV/IO
q3 minutes

P C

Norepinephrine (Levophed)
2-40 mcg/min IV/IO
0.05 – 2 mcg/kg/min IV/IO

P C

Dopamine (Intropin)
5-20 mcg/kg/min IV/IO
5-20 mcg/kg/min IV/IO

P C

Epinephrine (Infusion):
0.5-10 mcg/min IV/IO
0.1-1 mcg/kg/min IV/IO

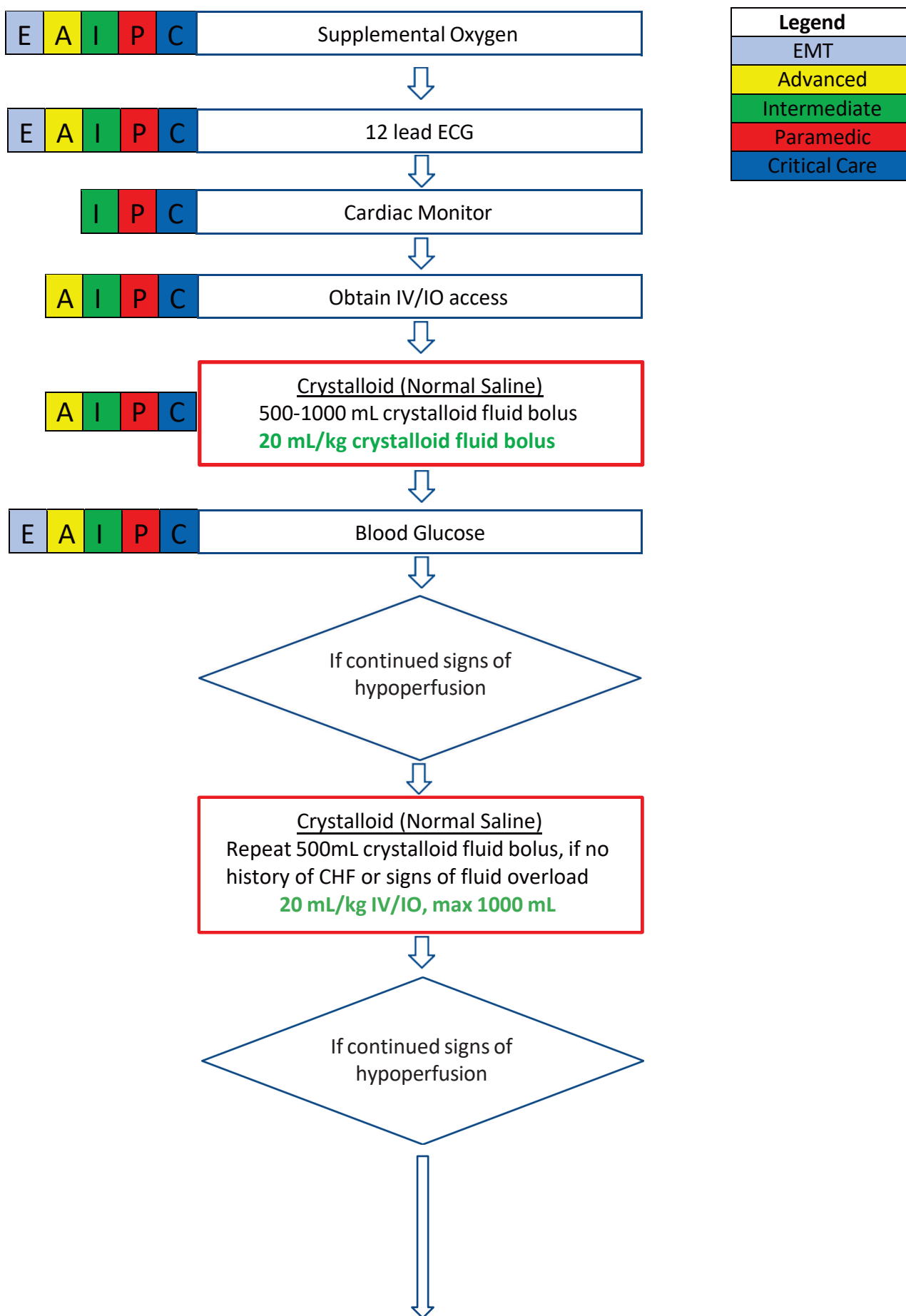
Shock

History and Physical Exam

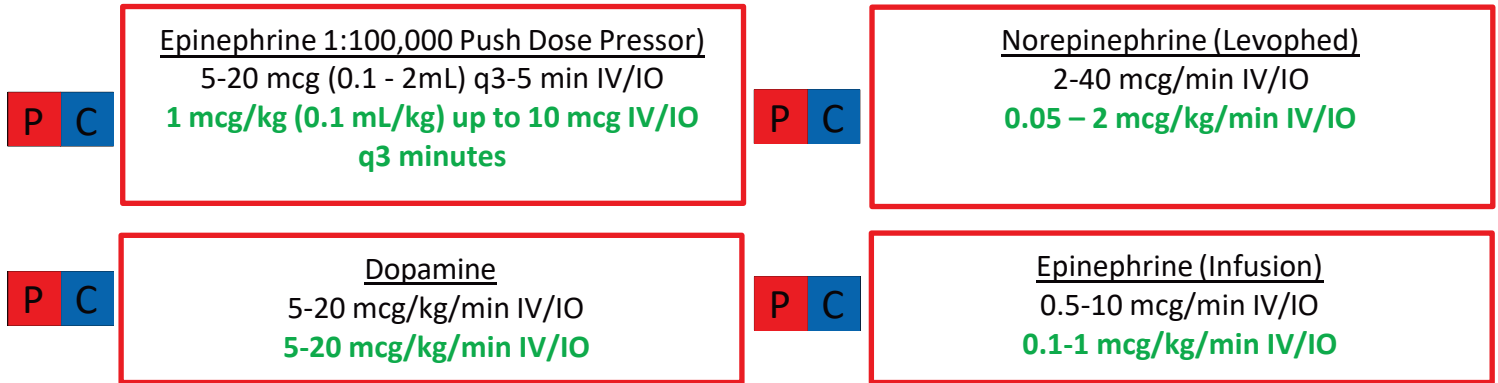
- Evidence of inadequate organ perfusion: tachycardia, hypotension, delayed capillary refill, skin cold and clammy, altered mental status.

Key Points

- Types of Shock:
 - **Hypovolemic:** Loss of circulating blood volume. This may be due to hemorrhage or through loss of fluids such as vomiting, diarrhea, poor intake, or burns.
 - **Cardiogenic:** Pump failure (i.e., Heart Failure, Massive MI, myocarditis).
 - **Distributive:** Decreased vascular tone. Includes anaphylaxis, sepsis, and neurogenic shock.
 - **Obstructive:** mechanical obstruction to blood flow to, or from the heart. Includes cardiac tamponade, tension pneumothorax, aortic dissection, and pulmonary embolism.



Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care



Consider Blood Transfusion
(Shock Trauma)



Phenylephrine (Push Dose Pressor)
 0.5-2 mL (50-200 mcg) IV/IO q 3-5 min
 Infusion: 40-180 mcg/min
0.1-3 mcg/kg/min



Dobutamine Infusion
 5-20 mcg/kg/min IV/IO
5-20 mcg/kg/min IV/IO



Vasopressin Infusion
 0.04 units/min
Pediatrics: Not Indicated

**Drip Rate Charts on following
medication pages:
Dopamine
Norepinephrine (Levophed)**

Stroke

History and Physical Exam

- Last time patient was seen normal.
- Existing previous neurological deficit.
- Stroke risk factors (Hypertension, diabetes, heart disease, smoking, dysrhythmias, blood thinner use, or previous stroke).
- Has the patient had any recent similar events?
- Level of Consciousness: Alert, Responds to Voice, Responds to Pain, Unconscious.

Perform EMSA stroke scale (Eye, Motor, Speech, Aphasia):

1. Eye:

- a. **Horizontal Gaze:** Ask patients to keep their head still and follow your finger left to right with their eyes. In aphasic patients, call the patient's name on one side and then on the other.
Abnormal: Patient is unable to follow as well in one direction compared to the other.

2. Motor:

- a. **Facial Weakness:** ask patients to show their teeth or smile. In aphasic patients, look for asymmetric grimace to pain.
Abnormal: One side of the face does not move as well as the other.
- b. **Arm weakness:** Ask the patient to hold out both arms, palms up, for 10 seconds with eyes closed. In Aphasic patients, hold the patient's arms up and let go.
Abnormal: One arm does not move or drifts down compared to the other.
- c. **Leg weakness:** Ask a patient to lift one leg and then the other for 5 seconds. In aphasic patients, hold one leg and let go, then repeat on the other side.
Abnormal: One leg does not move or drifts down compared to the other.

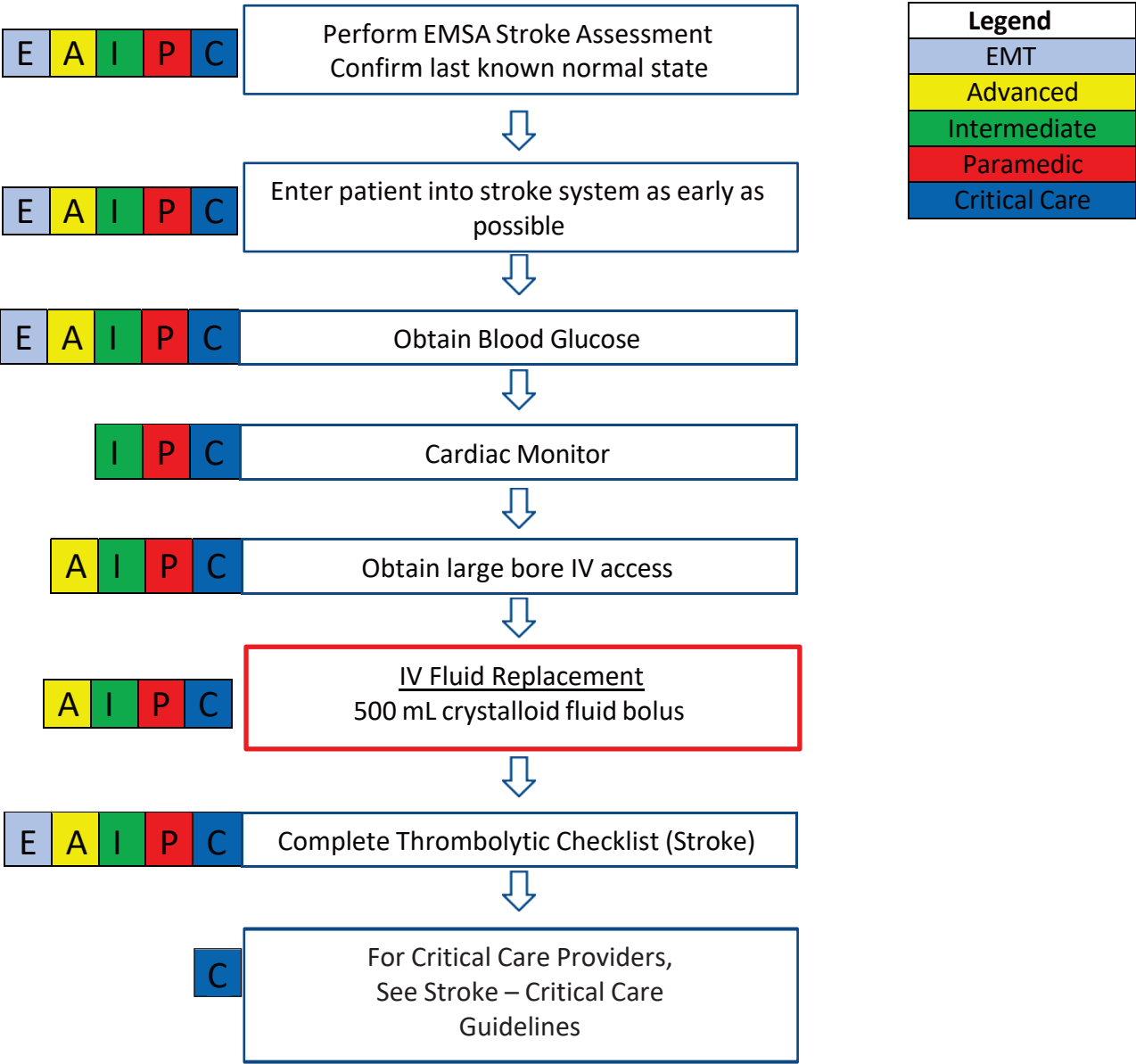
3. Speech/Aphasia:

- a. **Naming:** Ask a patient to name your watch or pen.
Abnormal: Patient slurs words, says the wrong words, or is unable to speak.
- b. **Repetition:** Ask the patient to repeat "They heard him speak on the radio last night." After you.
Abnormal: Patient slurs words, says the wrong words, or is unable to speak.

If any component of the EMSA stroke scale is abnormal, the patient is very likely to be suffering from an acute stroke. Greater than or equal to 4 points is a concern for a LVO Stroke (Large Vessel Occlusion).

Key Points

- This protocol is for patients who have an acute episode of neurologic deficit without any evidence of trauma. If the patient has altered mental status, treat using the Altered Mental Status Protocol.
- Determining the exact time of symptom onset is critical since administration of thrombolytic drugs for the treatment of stroke are time dependent.
- High blood pressure during an acute stroke may be compensatory, do not attempt to lower it without consulting OLMD.
- If in a region with a stroke system, notify the ATCC and transport the patient to the appropriate stroke-ready center.
- When possible, bring a knowledgeable friend or family member with the patient to assist with providing the patient's history at the hospital. If it is not possible for that person to accompany the patient, attempt to obtain a cell phone number for someone who can provide the receiving hospital with patient history and details of the event.
- Give nothing by mouth.
- A blood glucose should be obtained on all suspected stroke patients.
- If a patient has no signs of congestive heart failure or volume overload give Normal Saline.
- If patient can tolerate, place in supine position.
- Monitor neurological function frequently.
- Complete the "Thrombolytic Checklist (Stroke)".



Legend

E

A

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Advanced

Intermediate

Paramedic

Critical Care

Syncope

History and Physical Exam

- Description of event: Onset, duration, seizure activity, precipitating factors, activity when syncope occurred.
- Other symptoms: vertigo, nausea, chest pain, abdominal pain.
- Pregnancy status.
- Medications, past medical history, history of syncope.
- Neurologic exam.
- Evidence of head trauma.

Key Points

- Syncope is a transient state of unconsciousness from which the patient has recovered. If the patient is still unconscious, treat using the Altered Mental Status or Shock protocols as indicated.
- Most syncope is vasovagal. Placing the patient in the recumbent position should be sufficient to restore vital signs and level of consciousness to normal. However, other causes may be cardiac dysrhythmias, hypotension, aortic dissection, GI bleed, hypoglycemia, seizure, stroke, and transient ischemic attack.
- Syncope while in the recumbent position or in middle aged or elderly patient is concerning for a cardiac etiology.



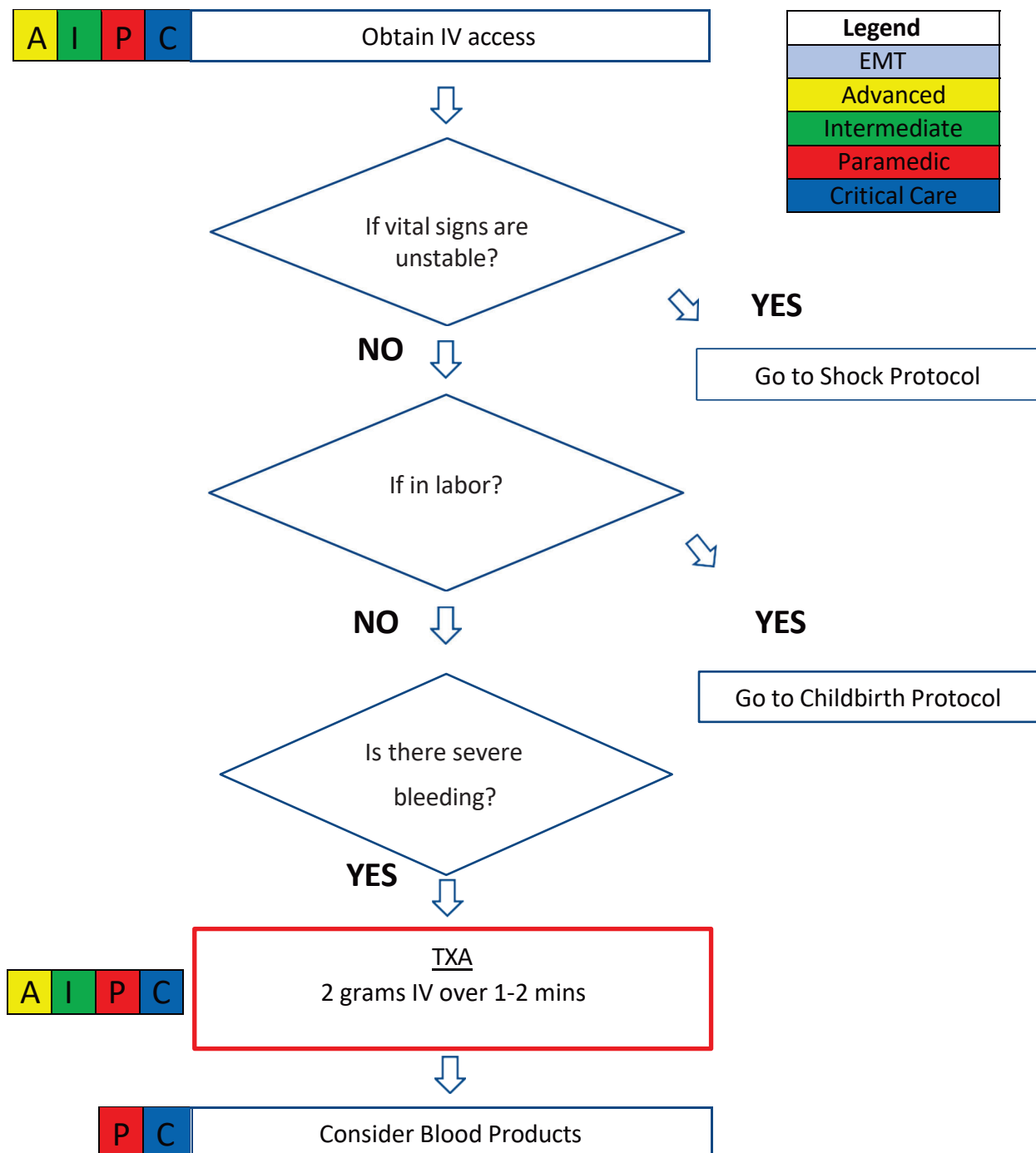
Vaginal Bleeding

History and Physical Exam

- Onset and duration of bleeding, amount, passage of clots or tissue, number of menstrual pads used.
- Last menstrual period, pregnancy status, birth control method.
- Pregnant patients: Due date, estimated gestation age.
- Postpartum patients: Time and place of delivery, history of complications.
- Bleeding disorders or anticoagulant medications.
- Evidence of blood loss, clots or tissue fragments.
- Fever.
- Signs of hypovolemic shock.

Key Points

- Amount of vaginal bleeding is difficult to estimate. Try to get an estimate of the number of saturated pads in the previous 6 hours. Discreet inspection of the perineum may be useful to determine if clots or tissue are being passed.
- Patients in shock from vaginal bleeding should be treated using the Shock Protocol.
- Always consider pregnancy or ectopic pregnancy as the cause of bleeding.
- If a non-viable premature fetus is delivered and the fetus is available, place the fetus in a clean container or sheet and transport to the hospital with the mother.



General Trauma

History and Physical Exam

- General impression of patient.
- Primary assessment and obtain vital signs.
- Determine level of consciousness (AVPU).
- Secondary survey.

Key Points

- Consult OLMD as needed.
- Scene safety and PPE.
- If injuries meet Trauma Criteria, declare Trauma Alert to receiving facility.
- Transport the patient to a trauma facility unless the patient is unstable and requires immediate stabilization or intervention.
- Control massive hemorrhage prior to airway.

Treatment:

Airway:

- Maintain patency.
- Suction as needed.
- Consider spinal immobilization restrictions inappropriate situations.



Breathing:

- Assist ventilations as needed.
- Occlusive dressing for any thoracic penetrating trauma (remove/replace if signs of tension develop).
- Chest decompression for tension pneumothorax.



Circulation:

- Hemorrhage control with direct pressure, hemostatic agents, tourniquets.
- Consider IVF, TXA, and blood products (pRBC or FFP).

Disability:

- Consider head injury: Prevent hypoxia and hypotension as able, hyperventilation ONLY if signs of active herniation.
- Spinal motion restriction (back boards and C collar) only for focal deficits.



Exposure and Vital Signs:

- Expose and assess patient relative to complaints.
- Obtain Vital Signs.
- Prevent hypothermia.



Secondary:

- Splint suspected fractures and perform wound care as indicated.
- System entry as indicated.
- Consider pain control.
- Reassess bleeding control

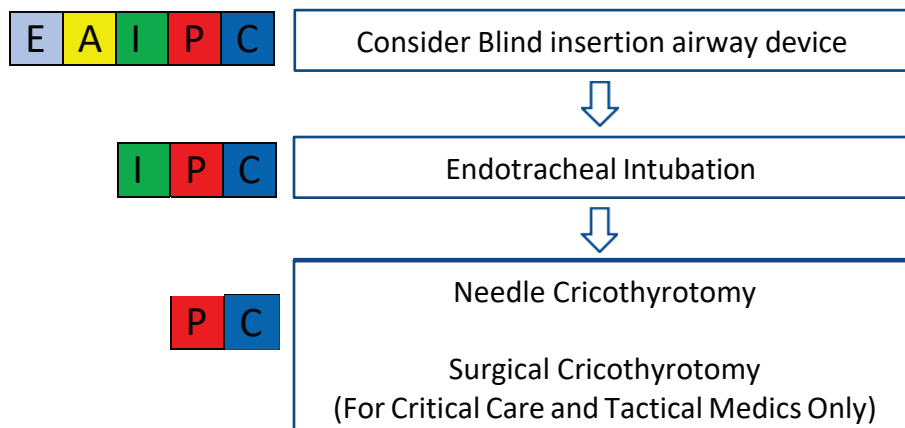


Trauma Specific Considerations

Airway Management:

- Ensure open airway by positioning, adjuncts, or invasive interventions:
 - Head tilt chin lift or jaw thrust (in suspected spinal injury).
 - NPA (caution with suspected closed head injury) or OPA (caution with intact gag reflex).
 - Suction to clear the airway as needed.
 - Administer oxygen to maintain O₂ saturation >94%.
 - Utilize capnography monitoring for all multi-system trauma patients and all invasive airway interventions.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care



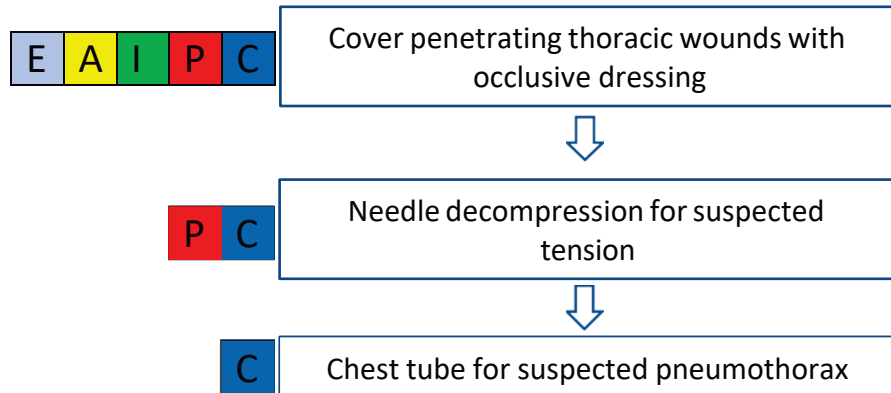
Mental Status Assessment:

- Determine GCS and frequently reevaluate.
- Establish patient's level of consciousness:
 - A = Alert
 - V = Responsive to verbal stimulus
 - P = Responsive to painful stimulus
 - U = Unresponsive to all stimulus

Respirations:

- Assess respiratory rate.
- Consider occlusive dressings on penetrating chest and/or abdominal wounds (neck to umbilicus).
- Evaluate for pneumothorax (mechanism of injury + one of the following is concerning for pneumothorax).
 - Progressive respiratory distress
 - Diminished or absent breath sounds
 - Tachypnea/SpO₂ <90%
- Needle decompression for tension pneumothorax (14G or 10G needle) or for flail chest and the use of positive pressure ventilation. Tension pneumothorax is defined as clinical signs consistent with pneumothorax and evidence of tension which is cardiovascular compromise (i.e., Cardiac arrest or AMS plus signs of significant cardiovascular compromise.)

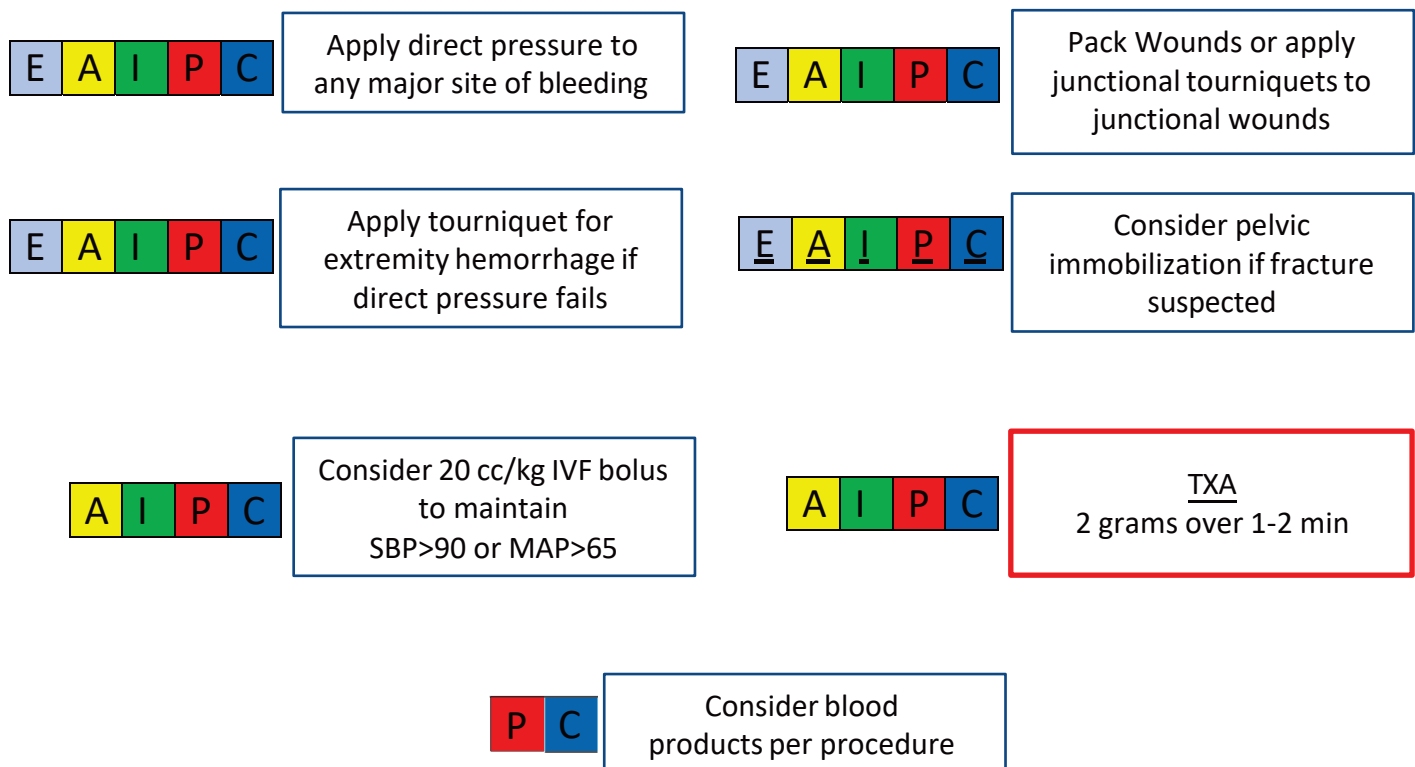
- Lateral = 4th-5th intercostal space anterior axillary line
- Anterior = 2nd-3rd intercostal space mid clavicular line
- Repeat PRN



Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Massive Hemorrhage:

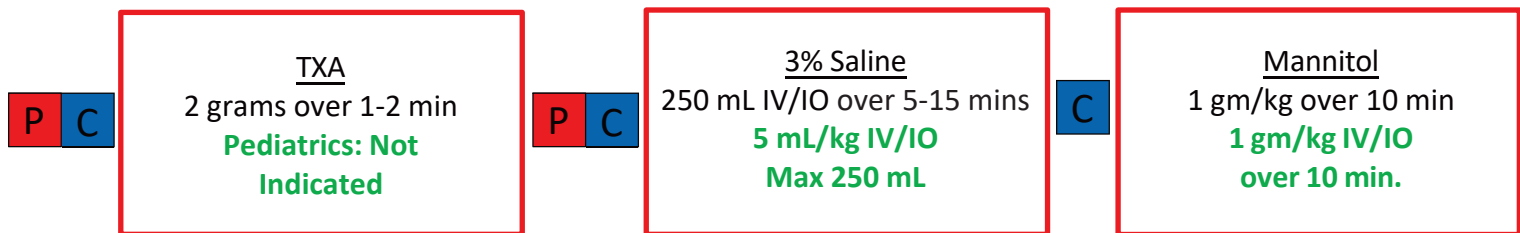
- Note time of tourniquet application to inform receiving facility.
- Do not place hemostatic pressure dressings into the chest or abdomen.
- LR preferred for IVF in trauma.



Head Injury

- History: Mechanism of injury, level of consciousness changes, protective device use (helmet), past medical history.
- Physical Exam: Document GCS (Eyes, Verbal, and Motor), pupillary exam, external evidence of head trauma (bleeding from ears, CSF draining from ears/nose/mouth, scalp laceration).
- Always consider cervical spine injury in patients with head trauma.
- Hyperventilation can cause cerebral edema. Maintain a rate of 8 breaths per minute or capnography reading of 35-45. Hyperventilation may be used if there are signs of cerebral herniation (extensor posturing, dilated or nonreactive pupils, decrease in GCS of >2 or if initial GCS >9).
- Eye injuries: Perform gross visual acuity exam. Place a rigid eye shield.
- Treatment: Sit patient up or elevate head of stretcher if able.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care



Spinal Injury:

- History: Mechanism of injury (Axial loading, blunt trauma to head or neck, MVC, Fall >3 feet, any violent mechanism with high energy transfer), history of arthritis of spine
- Assessment for spinal injury can only be utilized if the patient is alert, calm, cooperative, and not intoxicated. Any painful injury might distract the patient from the pain of a spine injury. If the patient's spine or neurologic exam cannot be appropriately assessed, the spine cannot be cleared clinically.
- Physical Exam: Palpate the entire spine. Perform both gross motor and sensory exam.
- Treatment: Spinal precautions and spinal motion restriction (SMR).
 - Spinal precautions include the use of a cervical collar and securing the patient firmly to the stretcher maintaining the spine in neutral alignment. Spinal precautions may be appropriate for patients found ambulatory at the scene, patients who must be transported for a prolonged amount of time, or patients for whom a backboard is not otherwise indicated.
 - Spinal motion restriction (SMR) includes the use of a cervical collar, head immobilizer device, spinal motion restriction, padding, and adequate straps so that the patient remains securely in place, even when rolling to clear the airway. Full SMR is not always in the patient's best interest, as complications can develop quickly. Other appropriate devices may be needed, depending on the patient's situation. Follow the manufacturer's guidelines when utilizing any SMR device. Only patients with evidence of paralysis after blunt trauma should receive full SMR.
 - If any motion restriction technique causes an increase in pain or neurologic deficit, the patient should be stabilized in the position found or position of greatest comfort.

Neurogenic Shock:

- Mild-moderate: Hypotension (may have widened pulse pressure), bradycardia, warm/flushed skin, or priapism.
- Severe: Above plus shortness of breath, chest pain, weakness, cyanosis, faint pulse, or hypothermia.
- If unresponsive to fluid, early pressors should be started.
- See Shock Protocol.

Pain:

- See Pain Protocol.

Fractures and Dislocations:

- History: History of trauma and mechanism of injury.
- Physical Exam: Localized tenderness, instability, or crepitus; evaluate pulses, motor function, and sensation; evaluate for obvious deformity, angulation, deep lacerations, and exposed bone fragments.
- Extremity injuries benefit from appropriate care but are of low priority with multiple injuries. Be aware that fractures do not necessarily lead to deformity or loss of function.
- Splinting:
 - Check PMS before and after splinting.
 - Immobilize the joint above and below the suspected fracture.
 - Consider traction splint for suspected femur fractures.
 - If a limb is angulated or has no pulse, one attempt may be made to place the limb in position of function to restore distal pulse.
 - Consider pelvic immobilization for possible pelvic fractures.
- See Pain Protocol for treatment of pain.
- Open fractures, give antibiotics.



Cefazolin
(preferred)
2 grams IV/IM
50 mg/kg IV/IM up to 2 grams

OR

Ceftriaxone (Rocephin)
2 gm IV/IM
50 mg/kg IV/IO up to 2 gm

Amputation:

- History: Timing and mechanism of amputation, history bleeding disorder (including blood thinner medication use).
- Physical Exam: Approximate amount of blood loss, note structural attachments in partial amputations.
- **Amputated part**: Wrap the amputated part in a sterile dressing moistened with sterile saline and place in a plastic bag. Then place the bag in ice water. Transport the part with the patient if possible. Do not immerse the amputated part in liquid or dry ice.
- **Partial amputation**: Control the bleeding. Saturate the wound with sterile saline and cover with a dry sterile dressing. Splint in anatomical position.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

- Timing is of the greatest importance to assure viability. If the extrication time is prolonged, consider sending the amputated part ahead to be surgically prepared for reimplantation.
- If bleeding cannot be controlled by direct pressure and elevation, a tourniquet should be applied. The tourniquet should not be covered. Note the time of tourniquet placement.
- See Massive Hemorrhage section above or Shock Protocol for uncontrolled bleeding.
- See Pain Protocol for treatment of pain.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Hypothermia:

- Remove wet clothing, utilize blankets, provide warm environment in ambulance.
- Consider warmed fluids (if possible).
- See Hypothermia Protocol.

Trauma Considerations in Pregnant Patients:

- Treat life threats initially with protocol above. Contact OLMD to discuss medication administration.
 - All pregnant patients should be transported for further evaluation. See appropriate OB/GYN Protocols as needed.
 - All pregnant patients should be transported in the left lateral decubitus position.
 - All pregnant patients should receive high flow O2.

Burns:

- History: Environmental hazards (smoke, toxic chemicals or fumes, potential for explosion, electrical sources), type of exposure, duration of exposure, associated trauma or blast injury, history of loss of consciousness, past medical history (especially cardiac and pulmonary disorders).
- Scene hazards: electrical wires, chemical fumes, carbon monoxide, and fire. Do not attempt rescue in a hazardous environment unless trained in this area.
- Physical Exam: Identify severity of burns and extent of burns (rule of nines), evaluate for associated trauma.
 - Superficial: reddened only, partial thickness: blistered areas, full thickness: scarred or leathery areas.
- Inhalation exposure can cause airway compromise. Note presence of stridor, facial swelling, carbonaceous sputum, and singed nasal hair or drooling. Be prepared to support the patient's ventilations or secure the airway if necessary.
- Smoke or chemical exposure can cause bronchospasm. Note the presence of wheezing.
- Carbon monoxide poisoning can cause dyspnea. In carbon monoxide poisoning the pulse oximeter can give a false high reading. Carbon monoxide can also cause cerebral anoxia. Check for headache, confusion, or decreased level of consciousness.
- Large burns cause severe fluid loss. Note tachycardia, signs of volume depletion, and hypotension.

- If the patient is unconscious, consider the possibility of head or cervical spine injury.
- Consider the possibility of abuse when certain burns are encountered. These include cigarette burns, iron burns, grill burns, and any burns in the elderly or children where the described mechanism of injury appears unlikely.
- Consider possible myocardial injury, ischemia, or arrhythmia in patients with electrical burns or inhalation injury.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

- **Treatment:**

- Stop the burning process by removing burning clothing and cooling with adequate sterile water. Brush off dry chemicals present on skin before flushing with large amounts of water.
- Liquid chemical should be flushed with copious amounts of normal saline.
- Eyes may be irrigated with normal saline.
- Cover affected areas with a dry burn sheet.
- Place patients with electrical injury or inhalational injury on a cardiac monitor.
- Start a large bore IV on patients with electrical burns, significant chemical exposures, inhalational injuries, any loss of consciousness, or other significant related trauma or burns.
- Consider IVF in patients with >20% TBSA burns if hospital arrival time will be >20 minutes. Do not delay transport in seriously burned patients to administer IVF as fluid loss occurs over the course of hours.
- For suspected or known cyanide exposure; suspected or known inhalational injury; evidence of closed space smoke exposure; or if the patient is comatose, in shock, or in cardiac arrest, consider Hydroxocobalamin.
- If shock is present, refer to the Shock Protocol.
- For pain control, see the Pain Protocol.

A	I	P	C	Consider IV access
---	---	---	---	--------------------

I	P	C	Cardiac Monitor
---	---	---	-----------------

Consider if wheezing present:

A	I	P	C	<u>Albuterol</u> 5 mg nebulized 5 mg nebulized
---	---	---	---	---

Consider:

P	C	<u>Hydroxocobalamin</u> 70 mg/kg IV, max 5 grams over 15 mins
---	---	---

Consider for burns >20% TBSA:

A	I	P	C	Lactated Ringers IVF bolus
---	---	---	---	----------------------------

Consider:

P	C	Pain Control
---	---	--------------

Medication Formulary

Acetaminophen (Tylenol)

Indications

Pain
Fever

Contraindications

Avoid patients with severe liver disease

Side Effects

Nausea
Vomiting

Pain Management:

E	A	I	P	C
---	---	---	---	---

Consider
Tylenol
1000mg PO
15 mg/kg PO up to 1000mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Disseminated Intravascular Coagulation:

Critical Care Protocol

A	I	P	C
---	---	---	---

Tylenol (Acetaminophen)
325 mg PO

Medication Formulary

Adenosine (Adenocard)

Indications

PSVT
SVT

Contraindications

Second- or third-degree AV block, WPW.

Side Effects

Short-lasting, 2nd or 3rd AV block, Transient asystole, Various arrhythmias lasting only a few seconds.

Cardiac dysrhythmias – Adult Tach w/ Pulse:

Stable, Regular Narrow QRS

P C

Adenosine
1st Dose:
6mg rapid IV push
2nd Dose:
12mg rapid IV push

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Cardiac Dysrhythmia - **Pediatric**

Tachycardic, Stable, Narrow Complex

P C

Adenosine
0.1mg/kg up
to 6mg IV/IO

P C

Adenosine
0.2mg/kg
up to 12mg IV/IO

Medication Formulary

Albuterol and Ipratropium (Ventolin, Proventil, DuoNeb)

Indications

Acute Bronchospasm
Cardiac arrest associated with asthma.
Hyperkalemia.
Crush Syndrome.

Side Effects

Tremor, Dizziness, Nervousness, Headache, Nausea, Tachycardia, Bronchospasm

Allergic Reactions:

Moderate/Severe

E A I P C

Albuterol

5mg Nebulized or 2-4 puffs from inhaler, may repeat q3 minutes as needed.

5mg Nebulized or 2-4 puffs from inhaler, may repeat q3 minutes as needed

Albuterol/Ipratropium
3 mg/0.5 mg nebulized, may repeat q3 minutes as needed.
3 mg/0.5 mg nebulized, may repeat q3 minutes as needed

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Asthma/COPD:

E A I P C

Albuterol

5mg Nebulized or 2-4 puffs from inhaler, may repeat q3 minutes as needed.

5mg Nebulized or 2-4 puffs from inhaler, may repeat q3 minutes as needed

Albuterol/Ipratropium
3 mg/0.5 mg nebulized, may repeat q3 minutes as needed.
3 mg/0.5 mg nebulized, may repeat q3 minutes as needed

Medication Formulary

Amiodarone (Cordarone)

Indications

Shock resistant V-Fib or Pulseless V-Tach
Ventricular Tachycardia
Refractory A-fib/Flutter

Contraindications

Cardiogenic shock
Marked Sinus Bradycardia
2nd or 3rd degree AV Block

Side Effects

Hypotension
Bradycardia
AV

Cardiac Arrest – Adults:

P C

Amiodarone
1st Dose: 300 mg IV/IO
2nd Dose: 150 mg IV/IO

IF converted with Amiodarone Infusion:

P C

Amiodarone
1mg/min

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Cardiac dysrhythmias – Adult Tach w/ Pulse:

Stable, Irregular Narrow QRS

P C

Amiodarone
Consider 150 mg slow IV push over
10 min.

Stable, Wide Complex QRS

P C

Amiodarone
150 mg slow IV push over 10 minutes.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Maintenance infusion after Lidocaine:

P C

Amiodarone

Maintenance Infusion
1 mg/min for first 6 hours

Cardiac Dysrhythmia - Pediatric

Tachycardic, Stable, Wide Complex

P C

Amiodarone
5 mg/kg
up to 150mg IV/IO

Cardiac Arrest – Pediatric:

P C

Amiodarone
5 mg/kg IV/IO, max 300 mg,
may repeat once

Medication Formulary

Aspirin

Indications

Adult patients with acute coronary syndrome.

Contraindications

Aspirin allergy or aspirin induced asthma

Active GI bleeding

If patient has taken 324 mg within the last 24 hours

Side Effects

May cause GI discomfort and nausea

May cause wheezing

Chest Pain or Suspected Acute Coronary Syndrome (ACS)

E	A	I	P	C
---	---	---	---	---

Aspirin
324 mg PO
If no contraindications.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Atropine Sulfate

Indications

Anticholinergic drug used in bradycardias.

Organophosphate poisoning (to block the parasympathetic response)

Increased secretions for individuals receiving ketamine

Refractory Bradycardia in pediatric patients.

Contraindications

Tachycardia

Glaucoma

A-Fib/Flutter w/RVR

Side Effects

Tachycardia, dry mouth, thirst, flushing of skin, blurred vision, headache, pupillary dilation, urinary retention

Cardiac Dysrhythmias – Adult Bradycardia:

P C

Atropine
1 mg IV/IO
May repeat q 5 min.
Max dose 3 mg or
If HR > 60 and SBP >90

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Cardiac Dysrhythmia – Pediatric:

Bradycardic, Stable

P C

Atropine
0.02 mg/kg IV up
to 0.5 mg IV/IO
(Minimum 0.1 mg)

Poisons and Overdoses:

Organophosphate/Cholinergic OD

P C

Atropine

2 mg IV/IM every 5 minutes; titrate to effect

**Pediatric: 0.02 mg/kg IV/IM min dose 0.1 mg.
Max single dose 0.5 mg**

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Calcium Gluconate

(Kalcinate)

Indications

Calcium Channel Blocker overdose
Magnesium Sulfate drip toxicity
Hypocalcemia / Hyperkalemia
Crush Syndrome

Contraindications

Use with extreme caution in patients taking digitalis

Side Effects

Hypotension
Bradycardia
Arrhythmia
Cardiac arrest
Chalky or metallic taste

Poisons and Overdoses:

Calcium Channel Blocker

P C

Calcium Gluconate (Calcium Channel Blocker)

1 gm (10cc of 10% solution) slow IV

**Pediatric: 20 mg/kg (0.2 mL/kg) of 10%
solution slow IV. Max 1 gm**

Legend

EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Calcium Chloride

Indications

Calcium Channel Blocker overdose
Magnesium Sulfate drip toxicity
Hypocalcemia / Hyperkalemia
Crush Syndrome

Contraindications

Use with extreme caution in patients taking digitalis

Side Effects

Hypotension
Bradycardia
Arrhythmia
Cardiac arrest
Chalky or metallic taste

Poisons and Overdoses:

Calcium Channel Blocker

P C

Calcium Chloride (Calcium Channel Blocker)
1 gm (10cc of 10% solution) slow IV

**Pediatric: 20 mg/kg (0.2 mL/kg) of 10%
solution slow IV. Max 1 gm**

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Cardene (Nicardipine)

Indications

Systolic BP > 180 mmHg, OR diastolic BP > 110 mmHg

Contraindications

Patients who have aortic valve stenosis

Side Effects

Hypotension

Hypertensive Emergencies:

P C

Cardene (Nicardipine)
5 mg/hr by slow IV infusion initially
then increase by 2.5 mg/hr every 5 minutes to a
maximum of 15 mg/hr
to achieve goal BP
Pediatrics: NOT INDICATED

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Thoracic Aortic Dissection/Aortic Aneurysm:

C

Cardene (Nicardipine)
2.5 mg/hr IV/IO infusion
Titrate 2.5 mg/hr every 5-15 min.
Max: 15 mg/hr.
Once titration is reached, titrate down by
2.5 – 3.0 mg/hr.

Medication Formulary

Cefazolin (Ancef)

Indications

Sepsis/Open Fracture
Large open wound

Contraindications

Hypersensitivity or known allergy.

Side Effects

Nausea
Vomiting
Diarrhea
Pain at injection site

Trauma -Fractures and dislocations:

A I P C

Cefazolin (Ancef)
2 gm IV/IM
50 mg/kg IV/IO up to 2 gm

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Ceftriaxone (Rocephin)

Indications

Sepsis/Open Fracture

Contraindications

Hypersensitivity or known allergy.

Side Effects

Nausea

Vomiting

Diarrhea

Pain at injection site

Sepsis:

A I P C

Ceftriaxone (Rocephin)
2000mg IV
50 mg/kg IV/IO

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Cleviprex (Clevidipine)

Indications

Systolic BP > 180 mmHg, OR diastolic BP > 110 mmHg

Contraindications

Patients who have aortic valve stenosis

Allergies to soy or egg products

Defective lipid metabolism

Side Effects

Hypotension

Reflex

Tachycardia

C

Clevidipine
1 mg/hour initial dose
May double every 90 seconds up to
21 mg/hour
If no contraindications.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Cyanokit

Indications

Suspected cyanide poisoning.

Contraindications

High blood pressure.

Heart disease.

Congestive heart failure.

Liver disease.

Kidney disease (or if you are on dialysis); or.

If you have ever had a severe allergic reaction to hydroxocobalamin, Vitamin B12, or cyanocobalamin (Nascobal, Cobolin, Cyomin, and others).

Side Effects

Red coloring of your skin or urine (this may last up to 2 to 5 weeks)

Nausea.

Vomiting.

Diarrhea.

Stomach pain.

Acne.

Skin rash or itching.

Warmth or redness under your skin.

Poisons and Overdoses:



Cyanokit
5 gm IV over 15 min.

Pediatric: 70 mg/kg IV
Max 5 gm over 15 mins

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Dexamethasone

Indications

Inflammation
Severe allergies
Adrenal problems
Arthritis problems
Asthma
Kidney problems
Skin conditions
Multiple Sclerosis flair up

Contraindications

Active, untreated tuberculosis
Inactive tuberculosis
Herpes simplex infection of the eye
Herpes simplex infection
Fungus infection
Intestinal infection caused by the roundworm
Strongyloides
Condition with low thyroid hormone levels
Diabetes

Side Effects

Aggression
Agitation
Anxiety
Decrease in the amount of urine
Fast, slow, pounding, or irregular heartbeat or pulse
Headache
Mental depression
Mood changes

Adrenal Insufficiency:



Dexamethasone
10mg IV/IM
10mg IV/IM

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Dextrose

(D10, D25, D50)

Indications

Suspected hypoglycemia

Contraindications

Intracranial hemorrhage

Known CVA

Side Effects

Local irritation

May precipitate severe neurologic symptoms in alcoholics

Hypoglycemia:

A I P C

Dextrose
D10 25 gm (250mL) IV
D10 4 mL/kg, max 250 mL
or
D50 12.5-25 gm IV

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Newborn Care:

A I P C

If Blood Glucose < 75 mg/dl,

D10 IV/IO
4 mL/kg

NOTE: Use D25 and D50 per local protocol. Adjust dosage as needed.

Medication Formulary

Diazepam (Valium)

Indications

Anxiety disorders
Seizures

Contraindications

Myasthenia gravis
Severe respiratory insufficiency
Severe hepatic insufficiency
Sleep apnea syndrome

Side Effects

Feeling sleepy or drowsy
Do not drive, cycle, or use tools or machinery until feelings subside
Confusion
Problems with coordination or controlling movements
Shaky hands (tremors)

Seizure:

P C

Diazepam
5-10 mg IV
0.1 mg/kg IV, max 5 mg
0.5 mg/kg Rectal, max 20 mg

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Diltiazem

(Cardizem)

Indications

Rate control in refractory atrial fibrillation and SVT

Contraindications

Concurrent or recent use of Beta Blockers

Side Effects

Hypotension, heart block

Cardiac dysrhythmias – Adult Tachycardia w/ Pulse:

Stable, Irregular Narrow QRS

P C

Diltiazem (Cardizem)
10 mg slow IV push,
then maintenance 5-15
mg/hr drip.
(Titrate pulse 60-100
and SBP>100 mmHg)

May repeat bolus dose
at 20 mg if no
response.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Diphenhydramine

(Benadryl)

Indications

Anaphylaxis
Allergic reactions
Urticaria
Extrapyramidal reaction
Asthma

Contraindications

COPD
Pregnancy
Nursing mother
Acute glaucoma

Side Effects

Sedation
Dries bronchial secretions
Blurred vision
Headache
Palpations

Allergic Reactions:**Mild and Moderate/Severe**

Diphenhydramine
50 mg IV/IM
1 mg/kg IV/IM, max 50 mg

Altered Mental Status:

Diphenhydramine
25 mg IM
1 mg/kg IM, max 25 mg

Nausea/ Vomiting:

Diphenhydramine (Benadryl)
25-50 mg IV/IM
1 mg/kg IV/IM, max 50 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Dobutamine

(Dobutrex)

Indications

Cardiogenic shock associated with hypotension.

Contraindications

Hypersensitivity to drug

Side Effects

Tachydysrhythmia

Ectopy

Headache

Angina

Nausea/vomiting

Hypotension

Hypertension

Shock:

C

Dobutamine Infusion
5-20 mcg/kg/min IV/IO
5-20 mcg/kg/min IV/IO

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Dopamine (Intronpin)

Indications

Cardiogenic shock associated with hypotension
Bradycardia

Contraindications

Hypovolemic shock where complete fluid resuscitation has not occurred
Uncorrected tachydysrhythmias or V-fib.

Side Effects

Tachydysrhythmias
Ectopy
Headache
Angina
Nausea/vomiting

Sepsis:

P C

Dopamine (Intropin)
5-20 mcg/kg/min IV/IO
5-20 mcg/kg/min IV/IO

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Shock:

P C

Dopamine
5-20 mcg/kg/min IV/IO
5-20 mcg/kg/min IV/IO

Medication Formulary

Epinephrine (Adrenalin)

Indications

V-Fib
Pulseless V-Tach
Asystole
PEA
Anaphylaxis
Bronchospasm
Hypotension

Contraindications

Hypertension

Side Effects

Palpitations
Hypertension
Dysrhythmias
Anxiety
Tremors

Allergic Reactions:

A I P C

Moderate/Severe

Epinephrine 1:1,000
0.3 mg IM
(EMT may use autoinjector)
0.01 mg/kg IM, max 0.3 mg

P C

Epinephrine 1:10,000
0.3 mg IV
0.01 mg/kg, max 0.3 mg
*For refractory reaction with
OLMD approval

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Asthma/COPD:

P C

Epinephrine 1:1,000
(Primary second line med in children)
 0.3 mg IM
 (caution if elderly or history of heart disease)
0.01 mg/kg up to 0.3mg IM

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Cardiac Arrest – Adults:

A I P C

Epinephrine 1:10,000
 (0.1 mg/ml)
 1mg IV/IO every 3-5 min
 Max 3 doses
 or Consider EPI infusion

Epinephrine 1:10,000 Infusion
 2-3 mg in 250mL
 of Normal Saline
 Micro Drip wide open

Cardiac Arrest – Pediatric:

A I P C

Epinephrine 1:10,000
 (0.01 mg/ml)
0.01mg/kg IV/IO every 3-5 min

Cardiac Dysrhythmia – Adults:

P C

Epinephrine (Infusion)
0.5-10 mcg/min IV/IO

Cardiac Dysrhythmia – Pediatric:**Bradycardic, Stable**

P C

Push Dose Epinephrine
(1:100,000) 1 mcg/kg (0.1 mL/kg) up to 10 mcg (1mL) IV/IO to maintain heart rate and MAP > 65 mmHg

Croup & Upper Airway Obstruction:

A I P C

Racemic Epinephrine
0.5 of 2.25% dilute in 2 ml of NS
via nebulizer.

**0.5 of 2.25% dilute in 2 ml of NS
via nebulizer**

OR

A I P C

Inhaled Epinephrine
3 mg (3mL) of 1:1,000
Epinephrine via
nebulizer. **3 mg (3mL) of
1:1,000 Epinephrine via
nebulizer**

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Newborn Care:

Heart Rate < 60 bpm

A I P C

Epinephrine 1:10,000
0.01 mg/kg IV/IO

Sepsis:

P C

Epinephrine 1:100,000 Push
Dose Pressor)
5-20 mcg (0.5-2 mL) q3-5 min
IV/IO
**1 mcg/kg (0.1 mL/kg) up to 10
mcg IV/IO q3 minutes**

Maintenance Infusion

P C

Epinephrine (Infusion):
0.5-10 mcg/min IV/IO
0.1-1 mcg/kg/min IV/IO

Shock:**P C**

Epinephrine 1:100,000 Push Dose
Pressor)

0.5-20 mcg (0.5 - 2mL) q3-5 min
IV/IO

**1 mcg/kg (0.1 mL/kg) up to 10
mcg (1 ml) q3-5 minutes IV/IO**

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Maintenance Infusion**P C**

Epinephrine (Infusion)

0.5-10 mcg/min IV/IO

0.1-1 mcg/kg/min IV/IO

Medication Formulary

Esmolol (Brevibloc)

Indications

Control rapid heart rate or abnormal heart rhythms

Contraindications

Sinus bradycardia
Sick Sinus Syndrome
Atrioventricular heart block
Heart failure
Cardiogenic Shock
Pulmonary hypotension

Side Effects

Blue lips and fingernails.
Burning, crawling, itching, numbness, prickling, "pins and needles", or tingling feelings
Changes in skin color
Changes in visio
Convulsions
Coughing that sometimes produces a pink frothy sputum
Decrease in frequency of urination
Decrease in urine volume

Thoracic Aortic Dissection/Aortic Aneurysm:

C

Esmolol
500 mcg/kg IV/IO over 1 min.
Then infusion @ 50 mcg/kg/min. Titrate by
50 mcg/kg/min every 5-15 min,
Max: 300 mcg/kg/min

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Etomidate (Amidate)

Indications

For use in RSI Protocol – for induction

Contraindications

Adrenal Insufficiency

Sepsis

Side Effects

Respiratory depression

Venous pain

Skeletal muscle movement

Critical Care – RSI – Induction agents:

C

Etomidate
0.3 mg/kg IV/IO
Max: 40 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Fentanyl (Sublimaze)

Indications

Pain control

Contraindications

Bronchial asthma
Concomitant MAO inhibitors
Myasthenia gravis
Parkinson's Disease

Side Effects

Muscle rigidity
Respiratory depression
Bradycardia
Myoclonic movements
Tachycardia
Vein irritation
Dermatitis

Chest Pain or ACS:

P C

Fentanyl
1 mcg/kg IV/IM/IN
Max dose: 100 mcg
May repeat 1 time

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Pain Management:

P C

Fentanyl
25-50 mcg IV/IM/IN
may repeat q5
minutes as needed x3 then call OLMD
Max 100mcg
**1 mcg/kg IV, max 50 mcg or 1.5mcg/
kg IN, max 75 mcg may repeat q20 min
as needed x3**

Post Intubation Sedation:

P C

Fentanyl
 1 mcg/kg IV/IO,
 Max 100 mcg
 may repeat as needed q3-5 min.
 Max 3 dose then call OLMD
1 mcg/kg IV/IO,
Max 100 mcg
may repeat as needed q3-5 min

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Maintenance Infusion

C

Fentanyl Infusion
 1-2 mcg/kg/hr IV
 1-2 mcg/kg/hr IV

CRITICAL CARE – PAIN & AGITATION:

P C

Fentanyl
 1 mcg/kg IV/IO
 Max: 100 mg.
 May repeat as needed.
 Consider:
 Infusion @ 1-2 mcg/kg/hr if
 continued boluses are needed

Medication Formulary

Furosemide

(Lasix)

Indications

Acute Pulmonary Edema such as CHF

Contraindications

Hypersensitivity

Side Effects

Hypovolemia

Hypotension

Hyponatremia

Hypokalemia

Congestive Heart Failure:

P C

Furosemide
40 mg IV
Pediatric: NOT INDICATED

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Glucagon (GlucaGen)

Indications

Hypoglycemia

Contraindications

Insulinoma

Pheochromocytoma

Side Effects

Nausea/vomiting

Urticarial

Hypoglycemia:



If IV access cannot be
obtained:

Glucagon

1 mg IM

0.5 mg IM, MAX 1 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Poisons and Overdoses:

Calcium Channel/ Beta Blocker



Glucagon

5 mg IV/IM

Pediatric: 0.5 mg IV/IM

Medication Formulary

Haloperidol (Haldol)

Indications

Altered Mental Status when patient is combative and a potential for harm to his or herself and/or any personnel present

Contraindications

Patients with known reversible cause of altered mental
QT prolongation or history of torsade's de pointes

Side Effects

Give with diphenhydramine to prevent extrapyramidal symptoms

Use caution when treating elderly patients who may require smaller doses to achieve therapeutic effect

Haloperidol has been associated with cardiac arrest in patients with prolonged QT intervals. Patients who receive haloperidol should be closely monitored for cardiac arrhythmia, particularly when the medication is given IV. May cause neuroleptic malignant syndrome

Altered Mental Status:

P **C**

Haloperidol (Haldol)
5 mg IM
May repeat q15 min up to total 20
mg as needed for agitation
0.1 mg/kg IM, max 5 mg (CAT B)

NOTE: Give Diphenhydramine with this medication

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Heparin

Authorized Services Only

Indications

Anticoagulant therapy

Contraindications

Severe thrombocytopenia

Uncontrolled active bleeding

Side Effects

No immediate side effects

Late side effects include hemorrhage

Chest Pain or ACS:

C

Heparin (OLMD)
5000 units IV/IO

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Pulmonary Embolism:

C

Heparin

For confirmed pulmonary embolism on inter-facility transfers, consider a Heparin bolus of 80 units/kg (max of 4,000 to 7,500 units), followed by an infusion of 18 units/kg/hr
Max of 7500mg

Medication Formulary

Hydralazine (Apresoline)

Indications

Severe hypertension

Contraindications

Hypotension

Coronary artery disease

Hypovolemia

Lupus

Side Effects

Hypotension

Tachycardia

Preeclampsia/Eclampsia:

C

Hydralazine

5 mg IV/IO over 2 min. May repeat q 5-10 min

Max 300mg

Do not dilute in Dextrose solutions

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Hydrocortisone

(Cortisol)

Indications

Severe allergic reactions
 Dermatologic diseases
 Endocrine disorders
 Gastrointestinal diseases
 Renal Disease
 Nervous system conditions
 Ophthalmic diseases
 Respiratory diseases
 Rheumatic Diseases

Contraindications

Inactive TB
 Herpes simplex infections in eye
 Fungus infections
 Intestinal infections due to roundworm
 Pheochromocytoma
 Diabetic

Side Effects

Upset stomach
 Headache
 Dizziness
 Trouble Sleeping
 Appetite Changes
 Acne
 Menstrual period changes
 Injections site pain/redness/swelling

Adrenal Insufficiency:

A I P C

Hydrocortisone Sodium Succinate

100 mg IV/IM

2mg/kg IV/IM, max 100 mg

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

3% Saline

(Hypertonic Saline)

Indications

Increased intracranial pressure with suspected herniation

Contraindications

Patients without suspected cerebral edema

Side Effects

Dehydration

Brain Herniation (Cerebral Edema) Syndrome:

P C

Hypertonic Saline (3%)
250 mL IV/IO over 5-15 min
1-2 ml/kg over 5-15 min

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Keppra
(Levetiracetam)

Indications

Continued seizures after administration of a Benzodiazepine

Contraindications

Use with caution in pregnancy and renal impairment

Side Effects

Angioedema

Seizure:

C

Keppra
6000 mg IV/IO over 15 minutes.
60 mg/kg IV, over 15 minutes,
max 6000 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Ketamine

(Ketalar)

Indications

Induction agent for RSI
Pain Management
Sedation

Contraindications

<3mos age for pain/agitation
Known schizophrenia
Severe HTN

Side Effects

Hallucinations
Respiratory depression
Elevated BP

PT WEIGHT IN LBS.	PT WEIGHT IN KG	0.5mg/kg/hr ml/hr	1 mg /kg /hr ml/hr
110	50	25	50
121	55	27	55
132	60	30	60
143	65	32	65
154	70	35	70
165	75	37	75
176	80	40	80
187	85	42	85
198	90	45	90
209	95	47	95
220	100	50	100
231	105	52	105
242	110	55	110
253	115	57	115
264	120	60	120
275	125	62	125
286	130	65	130
297	135	67	135
308	140	70	140

Altered Mental Status:

P C

Ketamine
 2-4 mg/kg IM, max 300 mg
2-4 mg/kg IM, max 300 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Pain Management:

P C

Ketamine
 0.2 mg/kg slow IVP, max 25mg
 q10 min if needed
 0.5 mg/kg IM, max 50 mg q10
 min if needed
0.2 mg/kg slow IVP, max 25mg
0.5 mg/kg IM, max 50 mg
1 mg/kg IN, max 50 mg

Post Intubation Sedation:

P C

Ketamine
 2 mg/kg IBW IV/IO,
 Max 200mg
 May ½ dose if vitals are still
 unstable
2 mg/kg IBW IV/IO,
may repeat as needed q10 min

Maintenance Infusion

C

Ketamine Infusion
 0.5 - 4 mg/kg/hr IV
0.5 - 4 mg/kg/hr IV

Critical Care – RSI – Induction agent:

C

Ketamine
 2 mg/kg IBW IV/IO
 Max: 200 mg.
 May ½ dose if vitals are still
 unstable

Critical Care – Pain & Agitation:

C

Ketamine
 1 mg/kg IV/IO
 May repeat every 10 min if
 needed.
 Consider:
 Infusion 0.5-4 mg/kg/hr if
 continued boluses are needed

Medication Formulary

Labetalol

Indications

Hypertension

Contraindications

Bronchial asthma

Overt cardiac failure

Cardiogenic shock

Bradycardia

Hypotension

Use with caution for potential OD

Side Effects

Dizziness

Lightheaded

Headache

Nausea/vomiting

Chest pain

Shortness of breath

Fatigue

Hypertensive Emergencies:

P C

Labetalol
20 mg slow IV push (over 2 minutes)
Max 300mg
Pediatrics: NOT INDICATED

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Preeclampsia/Eclampsia:

C

Labetalol
20 mg IV/IO over 2 min
May repeat q 10 min
Max 300mg

Thoracic Aortic Dissection/Aortic Aneurysm:

C

Labetalol
10-20 mg slow IV/IO push (over 2 min)
Repeat every 10 minutes with additional
doses doubled
Max 300 mg

Medication Formulary

(For Dosing, See Appropriate Protocol)

Lactated Ringers

(LR)

Indications

Hypovolemic Shock Dehydration
Burns
Obstetrical emergencies

Contraindications

Severe metabolic acidosis or alkalosis

Side Effects

Volume overload
Agitation

Consider for burns >20% TBSA:



Lactated Ringers IVF bolus

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Lidocaine (Xylocaine)

Indications

Pain Management for IO insertion
Cardiac Arrest

Contraindications

Known sensitivity

Side Effects

Hypotension
Decreased LOC
Irritability
Muscle twitching & eventually seizures

Cardiac Arrest - Adults

P C

Lidocaine
1st Dose: 1.5 mg/kg IV/IO
2nd Dose: 0.75 mg/kg IV/IO
MAX 3 mg/kg

If converted with Lidocaine:
Infusion:

P C

Lidocaine
2-4 mg/min

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Cardiac dysrhythmias – Adult Tach w/ Pulse:

Stable, Wide Complex QRS

P C

Lidocaine
1st Dose:
1.5 mg/kg IV/IO

2nd Dose:
0.75 mg/kg IV/IO

Maintenance Infusion
2-4 mg/min (decrease dose by half if
patient has CHF exacerbation, >70
y/o, in shock or has liver disease)

Medication Formulary

Lorazepam (Ativan)

Indications

Seizures and Status Epilepticus
Conscious sedation
Skeletal muscle relaxant
Acute anxiety states
Combative patients

Contraindications

Respiratory depression

Side Effects

Respiratory/cardiac arrest
Decreased LOC
Hypotension

Post Intubation Sedation:

P **C**

Lorazepam
2-4 mg IV/IO,
may repeat as needed q20-30 min.
0.1 mg/kg IV/IO,
Max 4 mg
may repeat as needed q10-20 min

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Seizure:

P **C**

Lorazepam
1-2 mg IV
0.1 mg/kg IV, Max 2mg

CRITICAL CARE – Pain & Agitation – Sedatives:

C

Ativan
1-2 mg IV/IO
May repeat every 10-20 min as needed

Medication Formulary

Magnesium Sulfate

Indications

Torsade's de Pointe
 Digitalis induced ventricular arrhythmias
 Anticonvulsant in eclampsia
 Suspected Hypomagnesemia
 Asthma/respiratory distress

Contraindications

Hypermagnesemia, Hypocalcemia, Anuria, Heart block, Active labor

Side Effects

Bradycardia, Hypotension, Hyporeflexia, Diaphoresis, Drowsiness,
 Decreased respiratory rate
 Flaccid paralysis

Asthma/COPD:

P C

Magnesium Sulfate
 (Primary second line med in adults)
 2 grams diluted in 250mL NS IV/IO over 20
 minutes.
**50 mg/kg diluted in 250mL NS IV/IO over 20
 minutes**

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Cardiac Arrest – Adults:

P C

Magnesium Sulfate
 (Torsade's) 2 gm NS IV/IO

Cardiac dysrhythmias – Adult Tach w/ Pulse: Stable, Wide Complex QRS

P C

Magnesium
If Torsade's or refractory
VTach 2 grams over 20
 minutes

Preeclampsia/Eclampsia:**P C**

Magnesium Sulfate
4 grams IV/IO over 20
minutes. Followed by
maintenance infusion of
2 grams/hr

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Mannitol

Indications

Signs and symptoms of increased intracranial pressure associated with cerebral edema

Contraindications

Known hypersensitivity

Renal Disease

Active Intracranial

Pulmonary Edema/CHF

Side Effects

Dizziness

Fever

Headache

Seizures

Angina

Edema

Hypotension

Tachycardia

Blurred vision

Dehydration

Urticaria

Chills

Thrombophlebitis

Fluid and electrolyte imbalance

CHF

GI distress

Brain Herniation (Cerebral Edema) Syndrome:

C

Mannitol
1 g/kg IV/IO over 10 min

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary**Metoclopramide**

(Reglan)

Indications

Gastroparesis

Nausea

Vomiting

Heartburn

Contraindications

Pheochromocytoma

Seizures

Depression

Parkinson's disease

Side Effects

Chills

Clay-colored stools

Difficulty with breathing

Difficulty with speaking or swallowing

Dizziness or fainting

Fast or irregular heartbeat

General feeling of tiredness or weakness

Headache (severe or continuing)

Nausea/ Vomiting:**C**Metoclopramide

5-10 mg IV

0.1 mg/kg IV, max 10 mg**Legend**

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Methylprednisolone (Solu-Medrol)

Indications

Steroid used in respiratory distress to reverse inflammatory and allergic reactions

Contraindications

TB

Fungal Infection

Side Effects

Arrhythmias

Bradycardia

Headache

Depression

May increase BGL

Adrenal Insufficiency:



Methylprednisolone
125mg IV/IM
2mg/kg IV/IM, max 125 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Allergic Reactions:

Moderate/Severe



Methylprednisolone
125 mg IV/IO
2 mg/kg IV/IO, max 60mg

Asthma/COPD:



Methylprednisolone
125mg IV/IO
2mg/kg IV/IO, max 60mg

Medication Formulary

Metoprolol (Lopressor)

Indications

Acute Coronary
Syndromes
Hypertension
Tachydysrhythmias

Contraindications

Bradycardia
Heart Block
Cardiogenic Shock/Heart Failure

Side Effects

Hypotension
Bradycardia
Headache
GI discomfort
Shortness of breath

Cardiac dysrhythmias – Adult Tach w/ Pulse:

C

Lopressor
5 mg IV/IO
can be repeated twice
as needed.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Chest Pain or ACS:

C

Lopressor
5 mg IV/IO
May repeat twice.

Thoracic Aortic Dissection/Aortic Aneurysm:

C

Metoprolol (Lopressor)
5 mg IV/IO every 5 min
Max 3 doses

Medication Formulary

Midazolam

(Versed)

Indications

Seizures and Status Epilepticus, Conscious sedation, Skeletal muscle relaxant
Acute anxiety states, Combative patients

Contraindications

Glaucoma, Shock, ETOH, Renal failure, Coma

Side Effects

Apnea, Cardiac arrhythmias, Hypotension

Post Intubation Sedation:

P C

Midazolam (Versed)
0.1 mg/kg IV/IO,
Max 10 mg
may repeat as needed q20-30 min.
**0.1 mg/kg IV/IO,
Max 10 mg
may repeat as needed q20-30 min**

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Seizure:

P C

Midazolam (Versed)
0.1 mg/kg IV/IM
10 mg IN
(Advanced EMT's may ONLY use the IN dose
and route)
**0.1mg/kg IV/IM, max 2 mg OR
0.2 mg/kg IN via atomizer, max 10 mg
(Preferred route: IN)**

Airway Management - Pain & Agitation – Sedative:

P C

Midazolam (Versed)
2-4mg IV/IO
Max 10 mg
May repeat every 20-60 min as needed

Medication Formulary

Morphine

Indications

Pain Management
Pulmonary Edema

Contraindications

Avoid use with hypotension
Avoid in the presence of RV/Inferior wall MI

Side Effects

Hypotension
AMS
Nausea/vomiting

Chest Pain or ACS:

P C

Morphine Sulfate
4 mg IV initial dose,
Titrate to pain relief in 2 mg doses
q3-5 min.
Max dose: 10 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Congestive Heart Failure:

P C

Morphine Sulfate
2-4 mg IV Slow
Pediatric: NOT INDICATED

Pain Management:

P C

Morphine Sulfate
2-4 mg IV/IM may repeat q5
minutes as needed
**0.1 mg/kg IV/IM,
max 4 mg**

Medication Formulary

Naloxone
(Narcan)

Indications

Narcotic overdose

Contraindications

Palpitations, Hypertension, Dysrhythmias, Anxiety
Tremors

Side Effects

Vomiting with rapid administration Ventricular dysrhythmias
Acute narcotic withdrawal Seizures
Hypertension

Newborn Care:

If History is appropriate, consider

Naloxone (Narcan)
0.1 mg/kg IV/IM/IN

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Poisons and Overdoses:**Opioid OD**

Naloxone (Narcan)
2-4 mg IN q3minutes

If desired, EMSP may give 0.5 mg and titrate to effect.

Pediatric: 2-4 mg IN (all ages and weights)

Naloxone (Narcan)
2-4 mg IV/IN/IM q 3minutes

**Pediatric: <5 years or <20 kg: 0.1 mg/kg
IV/IN/IM
>5 years or >20 kg: 2-4 mg IV/IN/IM**



Medication Formulary

Nitroglycerin

(Nitro, Nitrostat, Nitro-Bid)

Indications

Chest pain
Pulmonary edema

Contraindications

Increased ICP
Hypotension / Shock
Glaucoma
Use of Viagra, Levitra (within 24 hours) or Cialis (within 36 hours)

Side Effects

Headache, dizziness, hypotension

Nitroglycerin Infusion Chart

Dose in mcg/min	50 mg/250 mL D5W 100 mg/500 mL D5W	25 mg/250 mL D5W 50 mg/500 mL D5W
10	3 ml/hr	6
15	4.5	9
20	6	12
25	7.5	15
30	9	18
35	10.5	21
40	12	24
45	13.5	27
50	15	30

Chest Pain or ACS:

E A I P C

Nitroglycerin
 Assist patient with own
 medication If SBP >100,
 may repeat twice
 @ 5 min intervals, Max 3 doses

A I P C

Nitroglycerin
 0.4 mg SL
 If SBP >100, may repeat twice @
 5 min intervals, Max 3 doses

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Maintenance Infusion

C

Nitroglycerin Infusion
 Initial Rate: 5 mcg/min,
 Titrate by 5 mcg/min p 3-5 min.
 Max dose: 200 mcg/min for pain control

Congestive Heart Failure:

A I P C

Nitroglycerin
 0.4 mg sublingual spray or tablets
 if BP > 110 mmHg
 may repeat twice at 5 min intervals for a
 total of 3 doses.

Pediatric: NOT INDICATED
 or

Nitroglycerin Paste
 0.5 to 1 inch

Maintenance Infusion

C

Nitroglycerin Infusion
 Initial Rate: 5 mcg/min titrate
 by 5 mcg/min q 3-5 min.
 Max 200 mcg/min
 monitor SBP closely

Medication Formulary

Nitroprusside (Nipride)

Indications

Hypertension

Contraindications

Hypersensitivity

Compensatory hypertension secondary to AV shunt or aortic insufficiency

Side Effects

Headache

Dizziness

Hypotension

Coma

Dilated pupils

Diaphoresis

GI distress

Acidosis (cyanogen's toxicity)

Tachycardia.

Thoracic Aortic Dissection/Aortic Aneurysm:

C

Nitroprusside (Nipride)
0.5 – 10 mcg/kg/min IV/
IO Titrated to goal BP

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Norepinephrine

(Levophed)

Indications

Hypotension

Contraindications

Hypotension from blood volume deficits, mesenteric or peripheral vascular thrombosis

Side Effects

Tissue hypoxia, bradycardia, anxiety, headache, respiratory difficulty, extravasation necrosis

Mix 4 mg of Norepinephrine in 250 ml of D5W = 16 mcg/ml concentration

Dose (mcg/min)	2	3	4	5	6	7	8	9	10	11	12
Rate (ml/hr)	7.6	11.2	15	18.8	22.6	26.2	30	33.8	37.6	41.2	45

Dose (mcg/min)	13	14	15	16	18	20	22	24	26	28	30
Rate (ml/hr)	48.8	52.6	56.4	60	67.6	75	82.6	90	97	105	112.6

Sepsis:

P C

Norepinephrine (Levophed)
2-40 mcg/min IV/IO
0.05 – 2 mcg/kg/min IV/IO

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Shock:

P C

Norepinephrine (Levophed)
2-40 mcg/min IV/IO
0.05 – 2 mcg/kg/min IV/IO

Medication Formulary

Ondansetron

(Zofran)

Indications

Nausea/vomiting

Contraindications

Patients with prolonged QT syndrome

Side Effects

None

Nausea/ Vomiting:

A I P C

Ondansetron (Zofran)
4mg IV/IM or ODT
0.15 mg/kg IV/IM or ODT, max 4 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Oral Glucose

(Glucose, Insta-Glucose)

Indications

Altered mental status
History of Diabetes
Blood glucose < 60mg/dL
The ability to swallow

Contraindications

Decreased kidney function
Diarrhea
Glucose-6-phosphate dehydrogenase (G6PD) deficiency
High amount of oxalic acid in urine
Iron metabolism disorder causing increased iron storage
Sickle cell anemia
Calcium oxalate kidney stones
Anemia from pyruvate kinase and G6PD deficiencies

Side Effects

Lightheaded feeling
Fever
Swelling in hands or feet
Sweating
Pale skin
Severe shortness of breath
Chest Pain

Hypoglycemia:

E A I P C

Oral Glucose
15 gm orally
15 gm orally

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Pavulon (Pancuronium)

Indications

Facilitates endotracheal intubation by paralysis of skeletal muscle to increase pulmonary compliance during mechanical ventilation

Contraindications

Myasthenia Gravis
Acidosis

Side Effects

Tachycardia
Hypertension
Apnea

Post Intubation Sedation:

C

Pavulon (Pancuronium)
0.1 mg/kg IBW IV/IO

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

CRITICAL CARE – Airway Management - Pain & Agitation – Long Term Paralytics:

C

Pavulon (Pancuronium)
0.1 mg/kg IV/IO

Medication Formulary

Pepcid (Famotidine)

Indications

H-2 Blocker sed for allergic reactions

Contraindications

Advanced Kidney Disease

Side Effects

Fever
Fatigue
Arrhythmia
Urticaria
Depression
Anxiety
Tinnitus

Pain Management:

C

Pepcid
20 mg IO/IV
0.25-0.5 mg/kg, Max dose
20mg

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Phenylephrine (Neo-Synephrine)

Indications

Hypotension, Cardiogenic Shock, Neurogenic and Spinal Shock

Contraindications

Hypovolemia

Side Effects

Hypertension, Bradycardia, Headache, Dizziness, Dysrhythmias

Shock:

C

Phenylephrine (Push Dose Pressor)
0.5-2 mL (50-200 mcg) IV/IO q 3-5 min
Infusion: 40-180 mcg/min
0.1-3 mcg/kg/min

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Pitocin

(Oxytocin)

Indications

Post-partum hemorrhage

Contraindications

Uterine rupture

Incomplete delivery

Hypertension

Side Effects

Hypotension

Dysrhythmias

Tachycardia

Childbirth:



Consider: Pitocin (Oxytocin)

20-40 milliunits/min

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Promethazine (Phenergan)

Indications

Nausea/vomiting

Contraindications

Lactating females

MAOI use

COPD

HTN

Pregnancy

Side Effects

Dizziness

Drowsiness

Nausea/ Vomiting:

C

Promethazine (Phenergan)
6.25 mg IV diluted into 20 ml of
NS given over 5-10 min.
0.5 mg/kg IV, max 6.25 mg
Diluted into 20 mL of NS given over 5-10
minutes, must be > 2 years old

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Propofol (Diprivan)

Indications

Sedation of mechanically ventilated patients

Contraindications

Hypotension
Hypersensitivity

Side Effects

Hypotension

Post Intubation Sedation:

C

Propofol
Infusion titrate 5-10 mcg/kg/min q5 min to maintain sedation.
(Range: 5-50 mcg/kg/min)
Infusion titrate 5-10 mcg/kg/min q5 min to maintain sedation.
(Range: 5-50 mcg/kg/min)

Bolus 0.5-1 mg/kg IVP q3 minutes
May be used to supplement infusion
If needed.
Bolus 0.5-1 mg/kg IVP q3 minutes
May be used to supplement infusion
If needed

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

CRITICAL CARE – Airway Management - Pain & Agitation – Sedatives:

C

Propofol
Titrate 5-10 mcg/kg/min ~ every 5 min to sedation goal
(Range 5-50 mcg/kg/min.)
0.5-1 mg/kg IVP may be used to supplement infusion, repeat every 3 min if needed

Medication Formulary

Racemic Epinephrine (Vaponephrine)

Indications

Bronchospasm in bronchiolitis
Stridor at rest in croup
Suspected epiglottitis

Contraindications

Hypersensitivity

Side Effects

Tachycardia
Palpitations

Croup/Upper Airway Obstruction:

A I P C

Racemic Epinephrine
0.5 of 2.25% dilute in 2 ml of NS via nebulizer
0.5 of 2.25% dilute in 2 ml of NS via nebulizer

OR

A I P C

Inhaled Epinephrine
3 mg (3mL) of 1:1,000 Epinephrine via nebulizer
3 mg (3mL) of 1:1,000 Epinephrine via nebulizer

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Rocuronium (Zemuron)

Indications

Facilitates endotracheal intubation by paralysis of skeletal muscle to increase pulmonary compliance during mechanical ventilation

Contraindications

Severe Acidosis or Alkalosis

Side Effects

Hypotension, hypertension, increased pulmonary vascular resistance

Critical Care – RSI – Paralytic agents:

C

Rocuronium
1 mg/kg IBW IV/IO Max 100 mg
1 mg/kg IBW IV/IO Max 100 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Critical Care – RSI – Paralytic agents – Long term:

C

Rocuronium
1 mg/kg IV/IO
Max: 100 mg

Medication Formulary

Sodium Bicarbonate

(NaHCO₃)

Indications

Severe metabolic acidosis
Cardiac arrest
Hyperkalemia

Contraindications

Hypokalemia

Side Effects

Metabolic alkalosis, increased vascular volume, pulmonary edema, dysrhythmias through serum potassium depletion, transient raises the arterial PCO₂.

Cardiac Arrest – Adults:

P **C**

Sodium Bicarbonate
1 mEq/kg IV/IO

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Cardiac Arrest – **Pediatric:**

P **C**

Sodium Bicarbonate
1 mEq/kg IV/IO

Poisons and Overdoses:

Tricyclic Acid OD

P **C**

Sodium Bicarbonate
1 mEq/kg IV

Pediatric: 1 mEq/kg IV

Medication Formulary

Sodium Chloride (Normal Saline)

Indications

Heat exhaustion
Diabetic disorders
Freshwater drowning
Head injury
Hypovolemia

Contraindications

Congestive Heart Failure

Side Effects

Volume overload, congestive heart failure, diuresis, thirst

Hyperthermia:

A I P C

Crystalloid (Normal Saline)
500 mL Fluid Bolus if signs of dehydration or shock.
20 mL/kg IV fluid bolus

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Newborn Care:

A I P C

Crystalloid (Normal Saline) Bolus
10 mL/kg IV/IO

Sepsis:

A I P C

Crystalloid (Normal Saline)
500-1000 mL crystalloid fluid bolus
20 mL/kg crystalloid fluid bolus

If signs of Hypoperfusion continues:

A I P C

Crystalloid (Normal Saline)
 Repeat: 500 mL IV/IO if no history of CHF
 or signs of fluid overload
May repeat: 20 mL/kg IV/IO twice

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Shock:

A I P C

Crystalloid (Normal Saline)
 500-1000 mL crystalloid fluid bolus
20 mL/kg crystalloid fluid bolus

Stroke:

A I P C

Crystalloid (Normal Saline)
 500 mL crystalloid fluid bolus

Syncope:

A I P C

Crystalloid (Normal Saline)
 500 mL crystalloid fluid bolus
 (20 mL/kg)

Medication Formulary

Succinylcholine

(Anectine)

Indications

Skeletal muscle relaxation

Facilitate management of patients undergoing mechanical ventilation

Contraindications

Malignant hyperthermia

Skeletal muscle myopathies

Penetrating eye injury

Hyperkalemia

Side Effects

Cardiac arrhythmias increased intraocular pressure

Muscle fasciculation

Critical Care – RSI – Paralytic agents:

C

Succinylcholine
2 mg/kg IV/IO

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Terbutaline (Brethine)

Indications

Asthma/ COPD

Contraindications

Hypersensitivity

Side Effects

Dry mouth

Nausea/Vomiting

Drowsiness

Asthma/COPD:

C

Terbutaline (Brethine)
0.25 mg subcutaneous
May be repeated every 15 mins

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Thiamine (Vitamin B1)

Indications

Vitamin B1 Deficiency
Wernicke-Korsakoff Syndrome
Chronic Alcohol Abuse

Contraindications

Hypersensitivity

Side Effects

Weakness
Restlessness

Hypoglycemia:



Thiamine
100 mg IV/IM
Pediatric: NOT INDICATED

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Toradol (Ketorolac)

Indications

Pain Management in isolated hip or extremity trauma
Burns
Renal colic
Musculoskeletal pain
Possible kidney stones

Contraindications

Renal complications
Excessive age
Hypersensitivity
NSAID/Ibuprofen use in 24 hrs
CVA/TBI in last 24 hrs
Anticoagulation therapy
Active bleeding
GI bleeding
Pregnancy

Side Effects

Bleeding
GI discomfort

Pain Management:

A I P C

Toradol
15 mg IV/IM
0.5 mg/kg IV/IM, max 15 mg
Must be > 1 Year old

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Tranexamic Acid (TXA) (Cyklokapron)

Indications

Patient > 15 years old
 Signs and symptoms of severe hemorrhage (internal or external)
 Hemodynamic Instability:
 SBP < 90
 Pulse rate > 110 bpm
 Respiratory rate > 24 breaths per minute
 Evidence of peripheral vasoconstriction
 Duration from initial injury is less than 180 min

Contraindications

Patient <15 years old

Time of initial traumatic injury > 180 min
 Patients who have contraindications to Antifibrinolytic therapy agents
 Medical control discretion

Side Effects

Nausea
 Vomiting
 GI issues

Vaginal Bleeding:



TXA
 2 grams IV over 1-2 mins

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Medication Formulary

Vasopressin (Vasopressin)

Indications

Hypertension

Prevention and treatment of postoperative abdominal distention

Diabetes insipidus

Contraindications

Vascular disease

Chronic nephritis

Side Effects

Abdominal or stomach pain, usually after eating a meal

Agitation

Back pain

Chest tightness or heaviness

Decreased urine output

Difficulty with swallowing

Shock:

C

Vasopressin Infusion
0.04 units/min
Pediatrics: Not Indicated

Legend

EMT

Advanced

Intermediate

Paramedic

Critical Care

Medication Formulary

Vecuronium Bromide (Norcuron)

Indications

Facilitates endotracheal intubation by paralysis of skeletal muscle to increase pulmonary compliance during mechanical ventilation

Contraindications

Myasthenia Gravis

Side Effects

Hypotension

Hypertension

Increased pulmonary vascular resistance

Post Intubation Sedation:

C

Vecuronium (Norcuron)
0.1 mg/kg IBW IV/IO, max 10 mg
0.1 mg/kg IBW IV/IO, max 10 mg

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Critical Care – RSI – Paralytic agents:

C

Vecuronium (Norcuron)
0.1 mg/kg IV/IO Max: 10 mg

Critical Care – RSI – Paralytic agents – Long Term:

C

Vecuronium (Norcuron)
0.1 mg/kg IV/IO Max: 10 mg

Medication Formulary

Vitamin K1 (Phytonadione)

Indications

Reversal of Warfarin (Coumadin) overdose
Major bleeding with elevated INR
Intracranial hemorrhage with elevated INR

Contraindications

Hypersensitivity

Side Effects

Tachycardia
Dizziness
Sweating
Prolonged Warfarin (Coumadin) reversal

Poisons and Overdoses:

C

Vitamin K1 (Phytonadione)
2-10 mg IM/SC
Diluted in 50 ml of 0.9%
saline or D5W Administer
over 20 min

Legend

EMT

Advanced

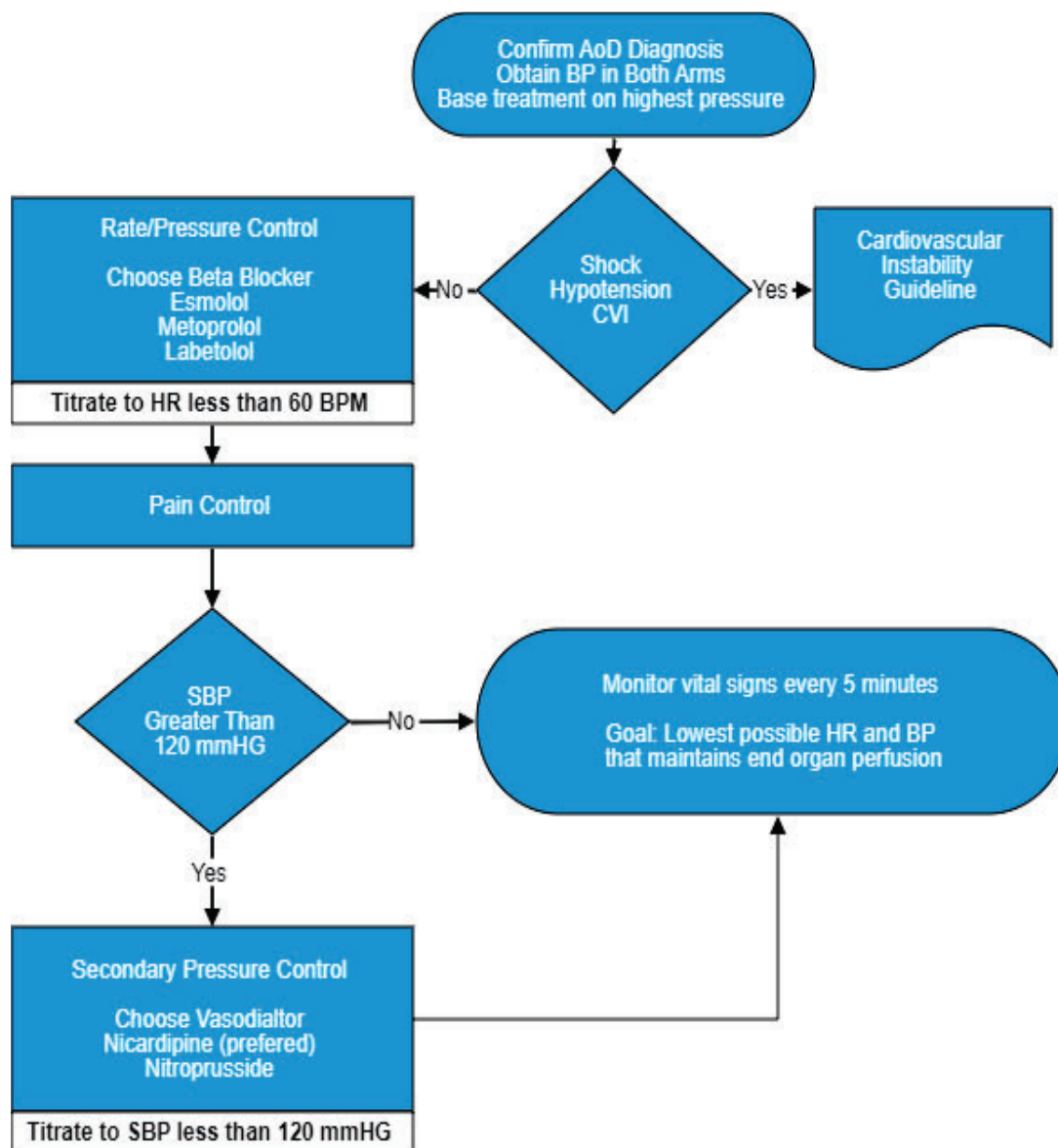
Intermediate

Paramedic

Critical Care

Critical Care Supplement**Thoracic Aortic Dissection/Aortic Aneurysm**

- Monitor non-invasive blood pressure every 5 minutes or continuously if an arterial line is available.



Critical Care Medications

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

C

Esmolol
 500 mcg/kg IV/IO over 1 min.
 Then infusion @ 50 mcg/kg/min. Titrate
 by 50 mcg/kg/min every 5-15 min, Max:
 300 mcg/kg/min

C

Labetalol
 10-20 mg slow IV/IO push (over 2 min.)
 Repeat every 10 minutes with additional doses
 doubled.
 Max 300 mg

C

Metoprolol
 5 mg IV/IO every 5
 min Max 3 doses

C

Cardene (Nicardipine)
 2.5 mg/hr IV/IO infusion
 Titrate 2.5 mg/hr every 5-15 min.
 Max: 15 mg/hr.
 Once titration is reached, titrate down by
 2.5 – 3.0 mg/hr

C

Nitroprusside (Nipride)
 0.5 – 10 mcg/kg/min IV/
 IO Titrated to goal BP

C

Clevidipine
 Initiate infusion at 1-2 mg/hr
 Dose may initially be doubled every 90 sec
 As BP approaches goal, reduce the rate of
 increase by less than double and lengthen time
 between dose adjustments to every 5–10 min.
 Max dose 32 mg/hr

Stroke

- For inter-facility transfers with known intracranial hemorrhage, maintain a goal BP of < 160 Systolic, while maintaining a MAP >90. Individual cases should be discussed with the sending and/or receiving physician or OLMD.
- For inter-facility transfers where tPA was initiated, continue therapy and complete the NIH paperwork as indicated. Maintain a goal BP of <180 Systolic, or as directed by the receiving neurologist.
- For patients who receive thrombolytic treatment, the blood pressure should be maintained at or below 180/105 mmHg for at least 24 hours after treatment.

Brain Herniation:

- Brain herniation can occur with expanding mass lesions due to intracranial hemorrhage, stroke, abscess, tumors, and hydrocephalus. If practicable, medical crews should manage herniation syndrome collaboratively with treating providers or program medical directors.

Signs:

- Neurogenic breathing patterns (Cheyne-Stokes, Hyperventilation, ataxic).
- Abnormal pupils and pupil response (asymmetrical dilation, fixed).
- Abnormal motor response.
- Cushing reflex (bradycardia, respiratory depression, and hypertension).

Treatment:

C	<u>Hypertonic Saline (3%)</u> 250 mL IV/IO over 5-15 min. 1-2 ml/kg over 5-15 min
C	<u>Mannitol</u> 1 gm/kg IV/IO over 30-60 min.

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Pulmonary Embolism:

- Pulmonary emboli to the lung can result in syndromes ranging from mild pleuritis, to an acute asthmatic attack, to a sudden onset supraventricular tachycardia, to a cardiopulmonary arrest.
- For interfacility transfers, evaluate lab results to include D-dimer.

CHeparin

For confirmed pulmonary embolism on inter-facility transfers, consider a Heparin bolus of 80 units/kg (max of 4,000 to 7,500 units), followed by an infusion of 18 units/kg/hr
Max of 7500mg

CLovenox

For interfacility transfers, discuss Lovenox 1mg/kg SQ with the sending physician

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care

Disseminated Intravascular Coagulation:

Assessment/Indications:

- Abnormal clotting profiles.
- Prolong PT and/or aPTT.
- Suppressed clotting factors.
- Positive D-dimer.
- Underlying or associative causes for DIC include shock states (sepsis, anaphylactic, circulatory), blood transfusions reactions, neoplasms, vascular and hematopoietic disorders, obstetric complications (retained fetus, eclampsia, septic abortion, and abruption placentae), crush and tissue injury, or necrosis and liver disease.

Treatments:

- Continue infusion of blood products if already initiated such as: PRBCs, platelets, FFP (to correct clotting factors consumption), cryoprecipitate (factor VIII) to correct hypofibrinogenemia; utilize CBC, INR and ABG if available.
- Fluid resuscitation will be needed to maintain cardiac output, urine output, and blood pressure.
- Consider mechanical ventilation w/sedation, analgesia, and NMBA as needed.
- Invasive hemodynamic monitoring if available.

B	A	I	P	C
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<u>Tylenol (Acetaminophen)</u> 325 mg PO

A	I	P	C
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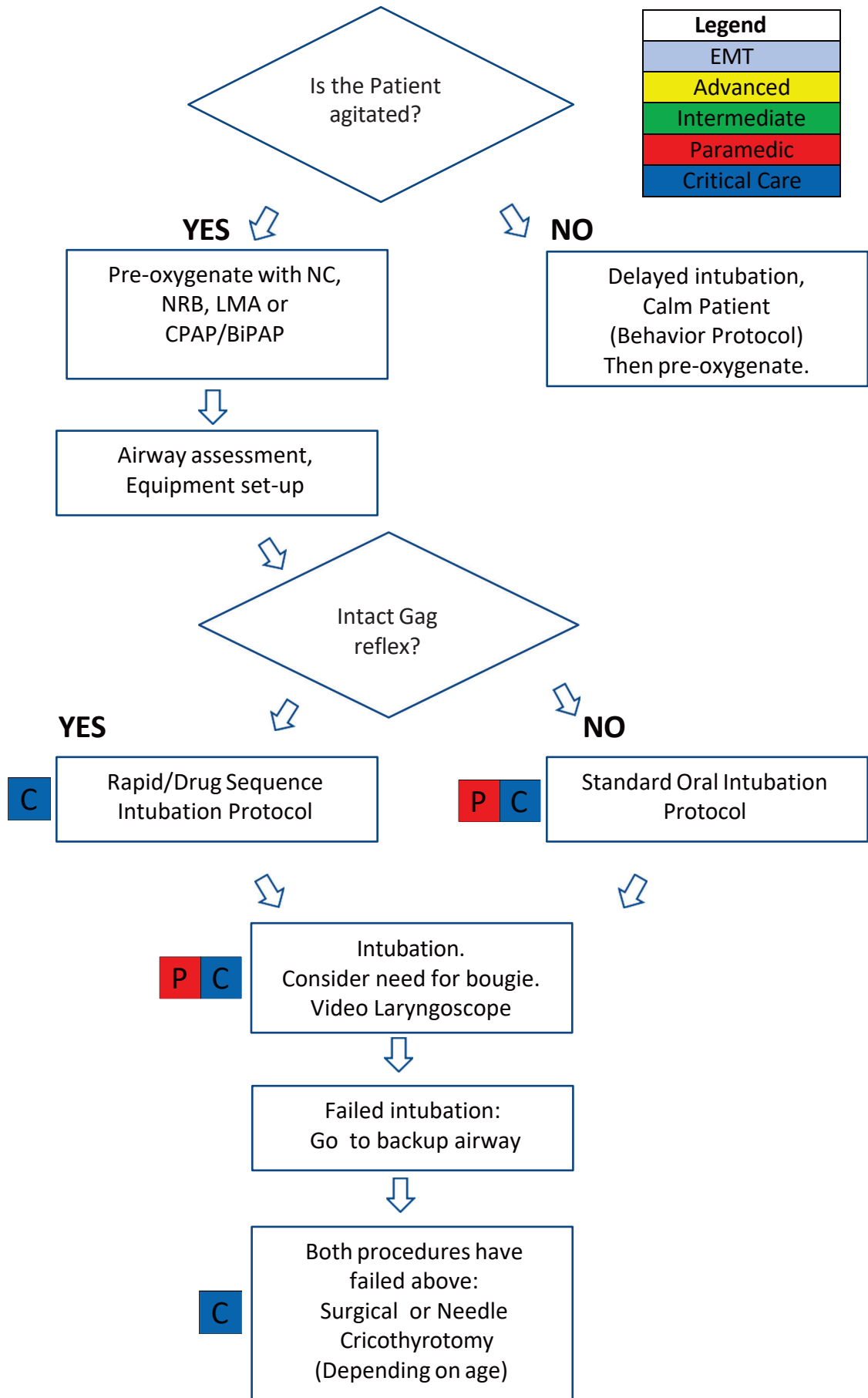
<u>Toradol (Ketorolac)</u> 30 mg IV
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Airway Management:**Assessment:**

1. Assess for airway, breathing, circulation, disability, and neurological function.
2. Assess for adequate effort and rate of breathing. If adequate, administer oxygen to maintain oxygen saturations between 94% – 99%.

Decision Making:

1. Any of the following should have an adequate airway placed:
 - Failure to maintain or protect the airway.
 - Failure of ventilation or oxygenation.
 - The anticipated clinical course will likely lead to deterioration.
2. Airway assessment should be performed for difficult intubation.
 - Airway assessment for difficult intubation (e.g., LEMONS, RODS, MOANS, SMART).
 - Intubation, RSI medications, and positive pressure ventilation can cause or worsen hypotension, hypoxia, and acidosis resulting in critical cardiovascular instability.
 - Airway difficulties must be identified and mitigated to ensure the best possible airway management outcomes.
 - The failure to evaluate the airway and identify difficult airway situations is the single most important factor leading to peri-intubation complications.
3. Metabolic acidosis
 - When intubating the patient with metabolic acidosis, whatever the cause, consideration must be made of the patient's minute ventilation and every attempt must be made to match that minute ventilation, pre, peri and post intubation.

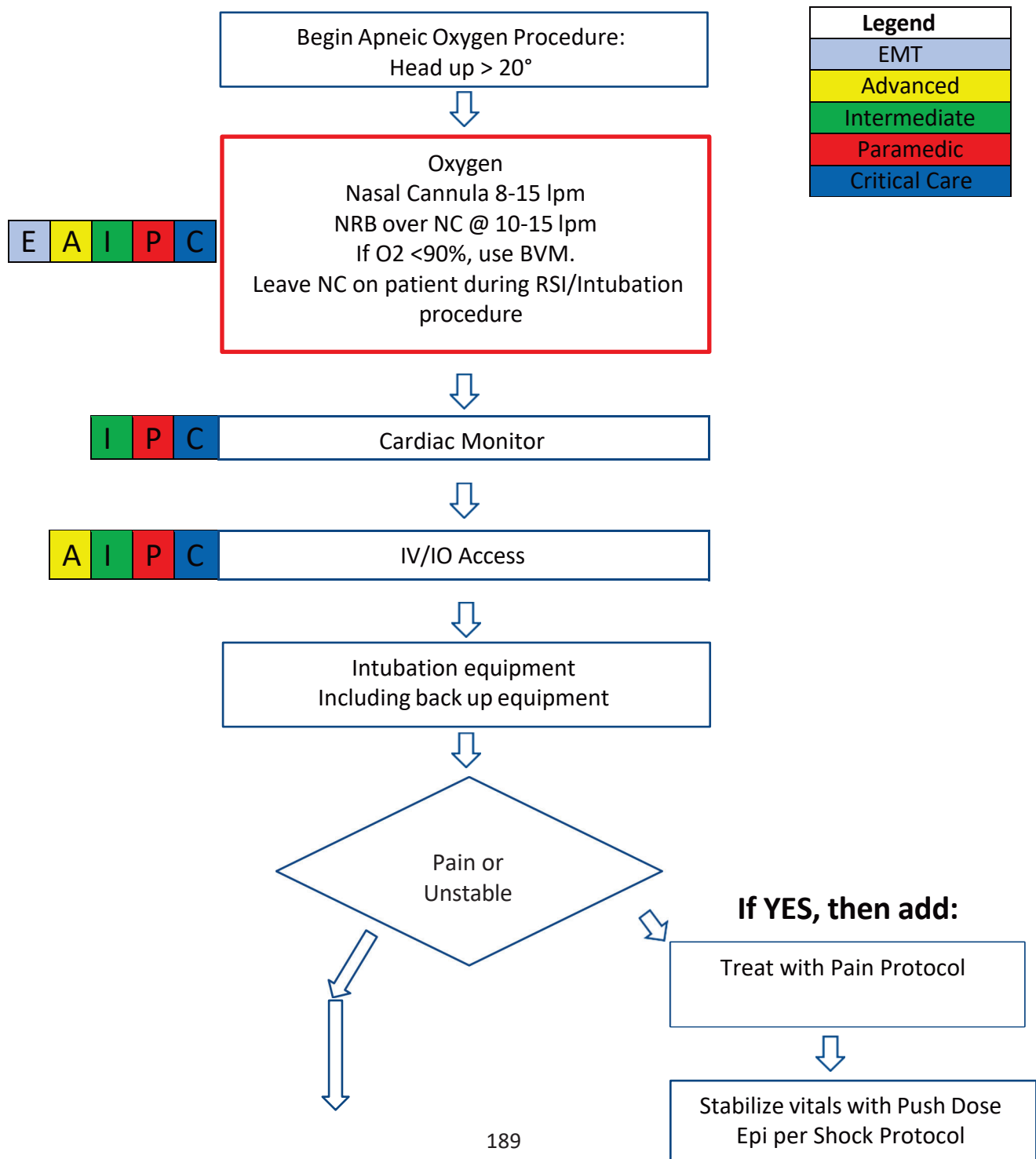


Rapid Sequence Intubation:**Clinical Indications:**

- A patient with the inability to maintain a patent airway.

Contraindications:

- Ketamine should not be used as an induction agent for infants < 3 months old, patients with a known history of schizophrenia, or in patients with severe uncontrolled hypertension.
- Etomidate should not be used in patients with known sepsis.



INDUCTION AGENTS:

C
Ketamine
 2 mg/kg IBW IV/IO
 Max: 200 mg.
 May ½ dose if vitals are still unstable

OR

C
Etomidate 0.3
 mg/kg IV/IO
 Max: 40 mg

**PARALYTIC AGENTS:**

C
Succinylcholine
 2 mg/kg IV/IO

OR

C
Rocuronium 1
 mg/kg IV/IO

OR

C
Vecuronium
 0.1 mg/kg IV/IO
 Max: 10 mg

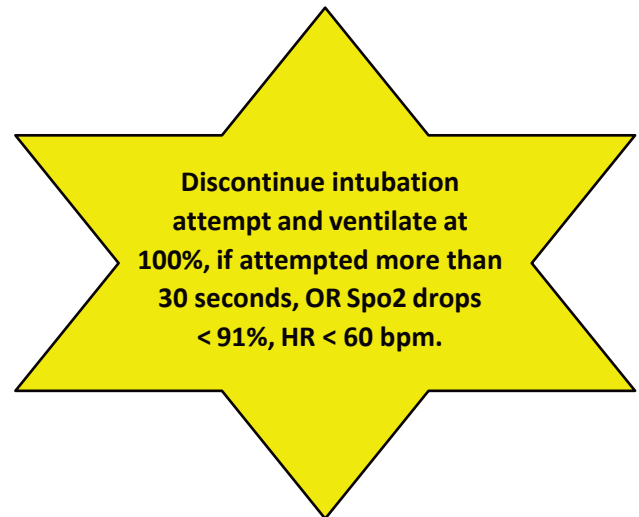


Confirm ET placement:
 Bilateral breath sounds
 Chest rise and fall
 Absence of gastric sounds
 Waveform capnography
 Continuous Spo2 readings



Secure tube and consider cervical immobilization during transport

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care



Post Intubation Protocol

- Consider NG/OG Tube.
- Practice Ventilator Pneumonia Prevention.
 - Closed circuit suction.
 - Head up to 30-45n degrees.
 - Inline suction.
 - Maintain ET cuff pressure 20 to 30.

Decision Making:

Select dose based on assessment and clinical considerations.

- Initially use repeat bolus administration until the pain and sedation goal is attained.
- After initial goal is attained use scheduled bolus or infusion to maintain goal.
- Anticipate pain and agitation during transport and treat preemptively by bolus.
- Sedation goal for this guideline is a RASS -1 to -5.
- Use the lower part of the dose range or reduce the normal dose of all sedatives by 1/2 to 1/4 if the patient is hemodynamically unstable.
- A Sedative should be added if opioids fully control pain, but sedation goals cannot be met.
Choose only one sedative to use.
- A long-acting paralytic should only be utilized if appropriate analgesia and sedation are not effective.
- Have the receiving physician verify tube placement and chart findings. It is required that the airway be monitored continuously throughout transport via waveform capnography and pulse oximetry. Reassess airway placement frequently and with every patient move.

Score	Classification	(RASS)
+4	Combative	Overtly combative or violent; immediate danger to staff
+3	Very agitated	Pulls on or removes tube(s) or catheter(s) or has aggressive behavior toward staff
+2	Agitated	Frequent non-purposeful movement or patient-ventilator dyssynchrony
+1	Restless	Anxious or apprehensive but movements not aggressive or vigorous
0	Alert and calm	Spontaneously pays attention to caregiver
-1	Drowsy	Not fully alert, but has sustained (more than 10 seconds) awakening, with eye contact, to voice
-2	Light sedation	Briefly (less than 10 seconds) awakens with eye contact to voice
-3	Moderate sedation	Any movement (but no eye contact) to voice
-4	Deep sedation	No response to voice, but any movement to physical stimulation
-5	Unarousable	No response to voice or physical stimulation

<https://doi.org/10.1371/journal.pone.0207174.t001>

Pain and Agitation:

Choose accordingly:

P C

Fentanyl
1 mcg/kg IV/IO
Max: 100 mg.
May repeat as needed.
Consider:
Infusion @ 1-2 mcg/kg/hr if
continued boluses are needed

OR

P C

Ketamine
1 mg/kg IV/IO
May repeat every 10 min if
needed.
Consider:
Infusion 0.5-4 mg/kg/hr if
continued boluses are needed

Legend
EMT
Advanced
Intermediate
Paramedic
Critical Care



ONE SEDATIVE**P C**

Versed
0.1 mg/kg IV/IO
Max 10 mg.
May repeat every 20-60 min as
needed

OR**C**

Ativan
1-2 mg IV/IO
May repeat every 10-20 min as
needed

OR**C**

Propofol
Titrate 5-10 mcg/kg/min ~ every
5 min to sedation goal.
(Range 5-50 mcg/kg/min.) 0.5-1
mg/kg IVP may be used to
supplement infusion, repeat
every 3 min if needed

**Long Term Paralytic****C**

Vecuronium (Norcuron)
0.1 mg/kg IV/IO Max:
10 mg

OR**C**

Rocuronium (Zemuron)
1 mg/kg IV/IO
Max: 100 mg

OR**C**

Pavulon (Pancuronium)
0.1 mg/kg IV/IO

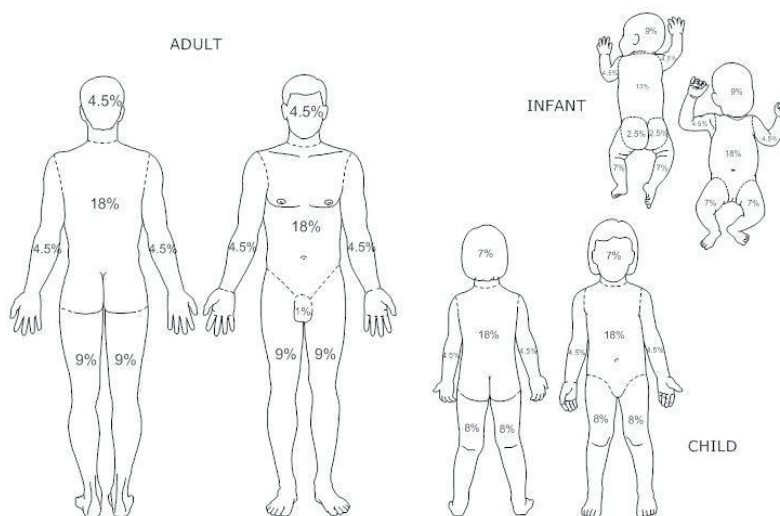
RULE OF NINES

When it is necessary to estimate the percentage of Total Body Surface (TBS) burns, such as making the decision to transport directly to a burn center, the rule of nines is useful. **In children, relatively more area is taken up by the head and less by the lower extremities. Accordingly, the rule of nines is modified.** An accurate description of the burn, including location and severity, should be provided to the receiving facility. The rule of nines is not intended to replace such a description.

ADULT Body Part	Percentage of Total Body Surface (TBS)
Arm (shoulder to fingertips)	9 %
Head and neck	9 %
Leg (groin to toes)	18 %
Anterior trunk	18 %
Posterior trunk	18 %
Perineum	1%

CHILD Body Part	Percentage of Total Body Surface (TBS)
Arm (shoulder to fingertips)	9 %
Head and neck	18 %
Leg (groin to toes)	14 %
Anterior trunk	18 %
Posterior trunk & Buttocks	18 %

INFANT Body Part	Percentage of Total Body Surface (TBS)
Arm (shoulder to fingertips)	9 %
Head and neck	14 %
Leg (groin to toes)	16 %
Anterior trunk	18 %
Posterior trunk	18 %



APGAR SCORING

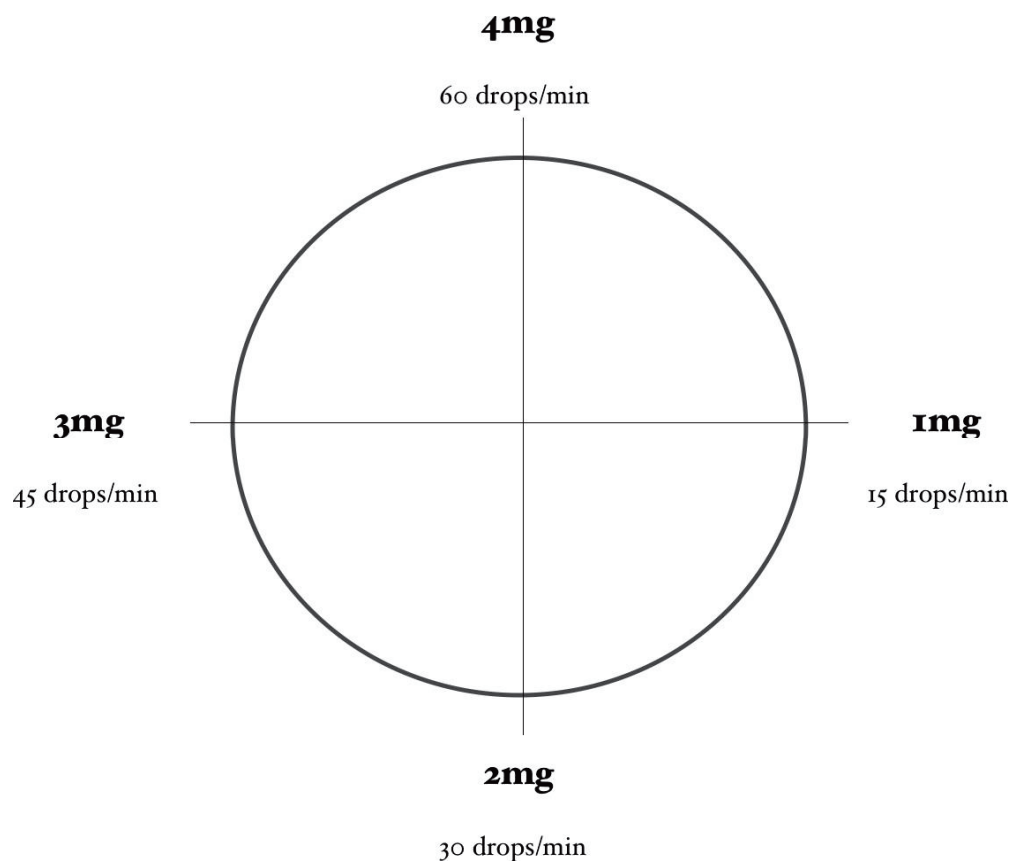
	0 POINTS	1 POINT	2 POINTS
HEART RATE	ABSENT	<100 BPM	>100 BPM
RESPIRATORY EFFORT	ABSENT	WEAK CRY	STRONG CRY
MUSCLE TONE	FLACCID	SOME FLEXTION	ACTIVE MOTION
REFLEX IRRITABILITY	NO RESPONSE	GRIMACE	VIGOROUS CRY
COLOR	BLUE, PALE	BODY PINK, EXTREMITIES BLUE	BODY PINK, EXTREMITIES PINK

Glasgow Coma Scale		
Response	Scale	Score
Eye Opening Response	Eyes open spontaneously	4 Points
	Eyes open to verbal command, speech, or shout	3 Points
	Eyes open to pain (not applied to face)	2 Points
	No eye opening	1 Point
Verbal Response	Oriented	5 Points
	Confused conversation, but able to answer questions	4 Points
	Inappropriate responses, words discernible	3 Points
	Incomprehensible sounds or speech	2 Points
	No verbal response	1 Point
Motor Response	Obeys commands for movement	6 Points
	Purposeful movement to painful stimulus	5 Points
	Withdraws from pain	4 Points
	Abnormal (spastic) flexion, decorticate posture	3 Points
	Extensor (rigid) response, decerebrate posture	2 Points
	No motor response	1 Point
Minor Brain Injury = 13-15 points; Moderate Brain Injury = 9-12 points; Severe Brain Injury = 3-8 points		

Oxygen Percentages

Method	Flow Rate	O ₂ % Inspired Air
Room Air		21%
Nasal Cannula (prongs)	1 L/min	24%
	2 L/min	28%
Face Mask	6 L/min	44%
Oxygen Reservoir (mask)	10-12 L/min	90%
Bag-Valve Mask with 100% valve and reservoir	High flow regulated to inflate reservoir at proper rate	90%+

Lidocaine Clock



800 mg dopamine per 500 mL NS (400 mg dopamine per 250 mL) NS for a concentration of 1600 mcg dopamine per mL. The following table assumes using a 60 drops per mL (microdrop) infusion set.

DOPAMINE TABLE

PT WEIGHT		DESIRED DOSE (drops/min)		
Lbs	Kg	5 mcg/kg/min	10 mcg/kg/min	20 mcg/kg/min
88	40	8	15	30
100	45	8	17	34
110	50	9	19	38
120	55	10	21	41
132	60	11	23	45
143	65	12	24	49
154	70	13	26	53
165	75	14	28	56
176	80	15	30	60
187	85	16	32	64
198	90	17	34	68
209	95	18	36	71
220	100	19	38	75
231	105	20	39	79
242	110	21	41	83
253	115	22	43	86
264	120	23	45	90
275	125	23	47	94
286	130	24	49	98
297	135	25	51	102
308	140	26	53	106


USING THE DOPAMINE TABLE:


Find patient weight and then move across row to the column for the desired dose. Set dial-a-flow to the corresponding flow rate.

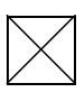
NIH PREDICTED BODY WEIGHT (PBW) / TIDAL VOLUME CHART															
MALES								FEMALES							
HEIGHT		PBW	4	5	6	7	8	HEIGHT		PBW	4	5	6	7	8
Feet	Inches	Male	ml/kg	ml/kg	ml/kg	ml/kg	ml/kg	Feet	Inches	Female	ml/kg	ml/kg	ml/kg	ml/kg	ml/kg
4' 10"	58	45.4	180	230	270	320	360	4' 7"	55	34	140	170	200	240	270
4' 11"	59	47.7	190	240	290	330	380	4' 8"	56	36.3	150	180	220	250	290
5' 0"	60	50	200	250	300	350	400	4' 9"	57	38.6	150	190	230	270	310
5' 1"	61	52.3	210	260	310	370	420	4' 10"	58	40.9	160	200	250	290	330
5' 2"	62	54.6	220	270	330	380	440	4' 11"	59	43.2	170	220	260	300	350
5' 3"	63	56.9	230	280	340	400	460	5' 0"	60	45.5	180	230	270	320	360
5' 4"	64	59.2	240	300	360	410	470	5' 1"	61	47.8	190	240	290	330	380
5' 5"	65	61.5	250	310	370	430	490	5' 2"	62	50.1	200	250	300	350	400
5' 6"	66	63.8	260	320	380	450	510	5' 3"	63	52.4	210	260	310	370	420
5' 7"	67	66.1	260	330	400	460	530	5' 4"	64	54.7	220	270	330	380	440
5' 8"	68	68.4	270	340	410	480	550	5' 5"	65	57	230	290	340	400	460
5' 9"	69	70.7	280	350	420	490	570	5' 6"	66	59.3	240	300	360	420	470
5' 10"	70	73	290	370	440	510	580	5' 7"	67	61.6	250	310	370	430	490
5' 11"	71	75.3	300	380	450	530	600	5' 8"	68	63.9	260	320	380	450	510
6' 0"	72	77.6	310	390	470	540	620	5' 9"	69	66.2	260	330	400	460	530
6' 1"	73	79.9	320	400	480	560	640	5' 10"	70	68.5	270	340	410	480	550
6' 2"	74	82.2	330	410	490	580	660	5' 11"	71	70.8	280	350	420	500	570
6' 3"	75	84.5	340	420	510	590	680	6' 0"	72	73.1	290	370	440	510	580
6' 4"	76	86.8	350	430	520	610	690	6' 1"	73	75.4	300	380	450	530	600
6' 5"	77	89.1	360	450	530	620	710	6' 2"	74	77.7	310	390	470	540	620
6' 6"	78	91.4	370	460	550	640	730	6' 3"	75	80	320	400	480	560	640


STRUCTURE MARKING SYSTEM

Begin by using orange spray paint or lumber crayon to draw a 2-foot box. Then use the box to alert subsequent rescuers to building conditions or earlier findings.


 Damage is minor with little danger of further collapse. Structure is safe for search and rescue operations.

 Damage is significant. Shoring, bracing or removal of hazards is necessary.

 Structure is not safe for search and rescue operations. Remote search operations may proceed at significant risk. Safe havens and evacuation routes should be established.


 ← Direction to safely enter building.


HM Hazardous material is present. Type of hazard may also be noted.

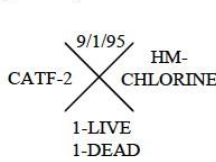
 9/1/95 0800
HM-CHLORINE
CATF-2

Write date, time, hazardous materials present and team identification on the right-hand side of the box. For example, this building was searched Sept. 1, 1995, at 8a.m., chlorine was found, and the search was conducted by Los Angeles County CATF-2.

SEARCH MARKING SYSTEM

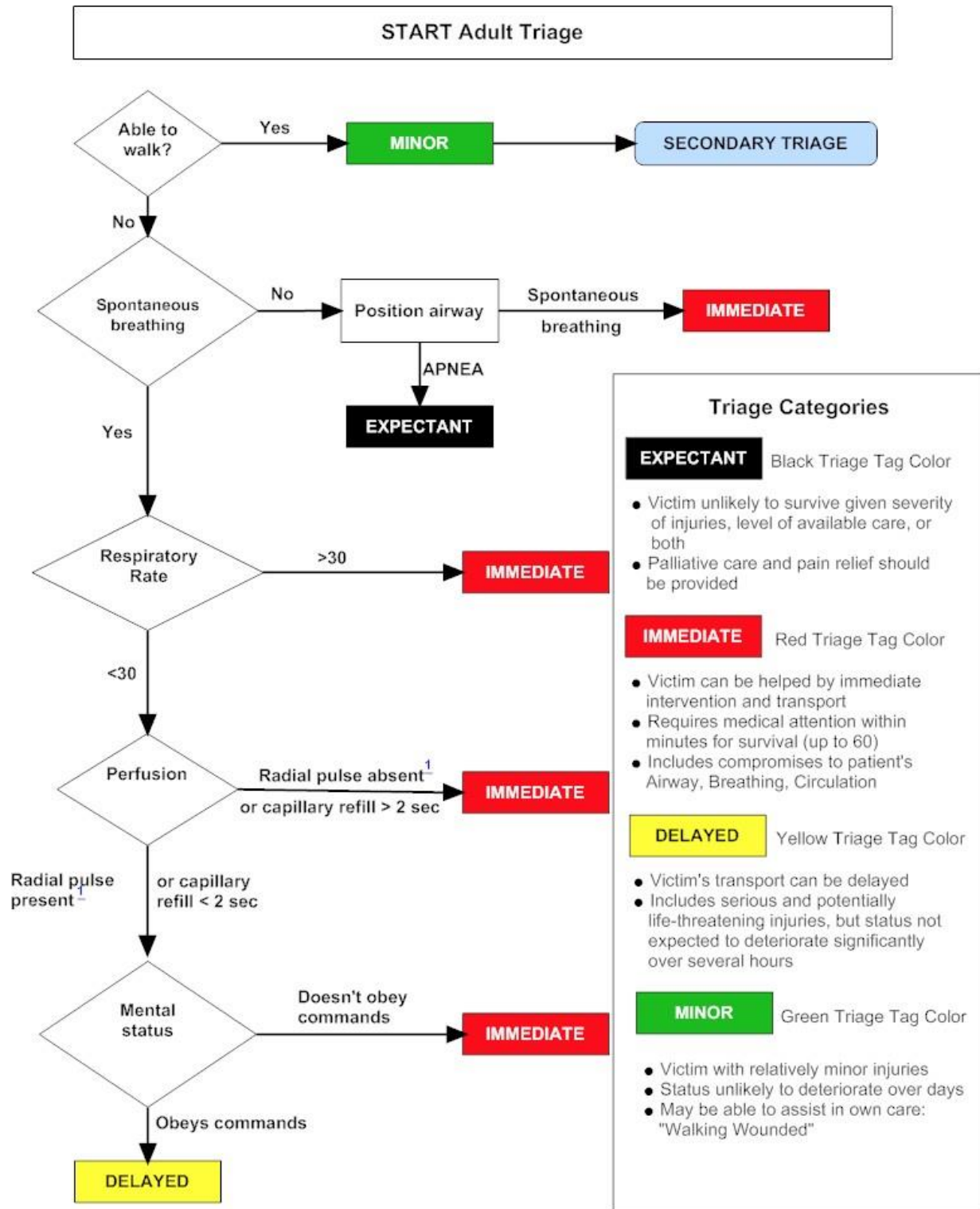
 Search operations are currently in progress. (ORANGE)

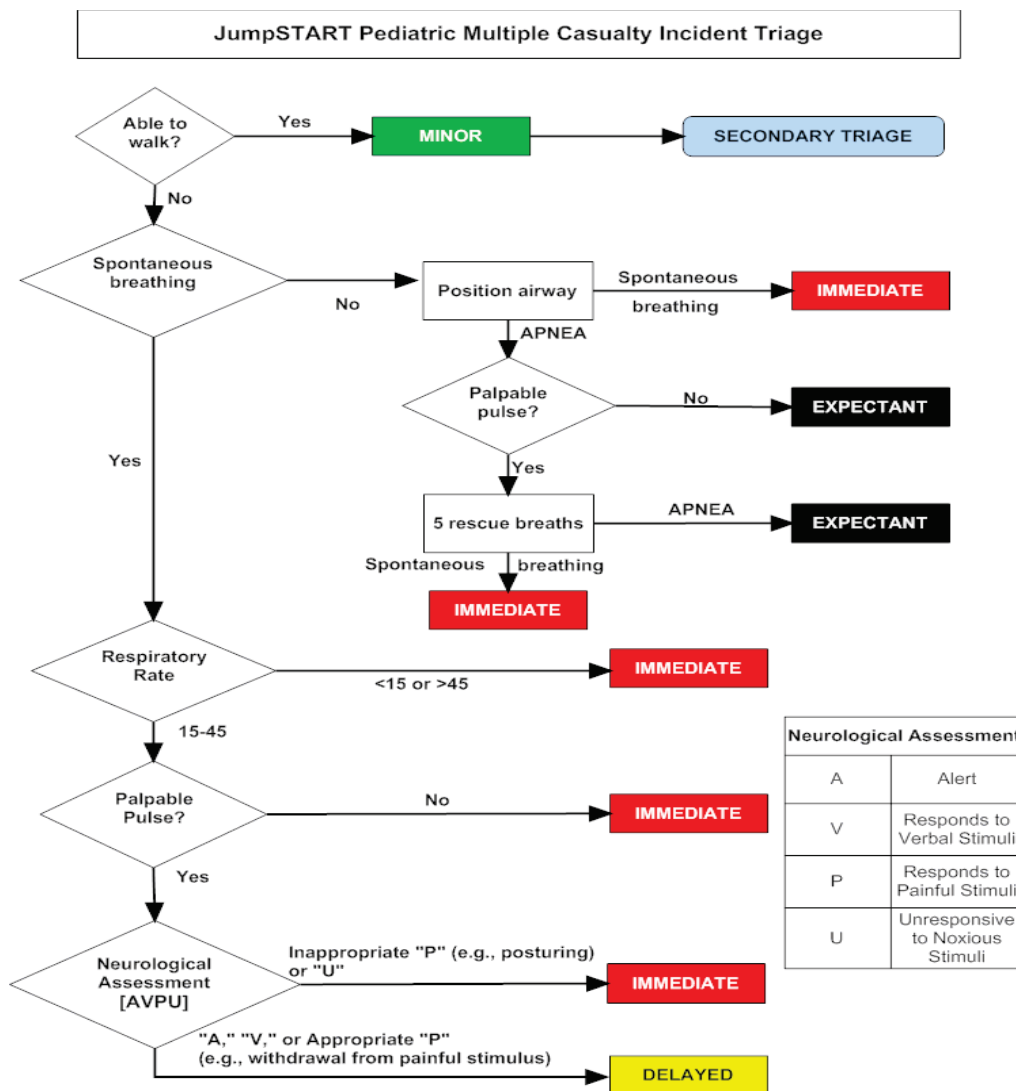
 Personnel have exited the structure. (ORANGE)



Left quadrant – Team identifier.
Top quadrant – Time and date team left the structure.
Right quadrant – Hazards found.
Bottom Quadrant - Number of live and dead victims still inside the structure. *Written in Black Marker or lumber crayon/chalk*

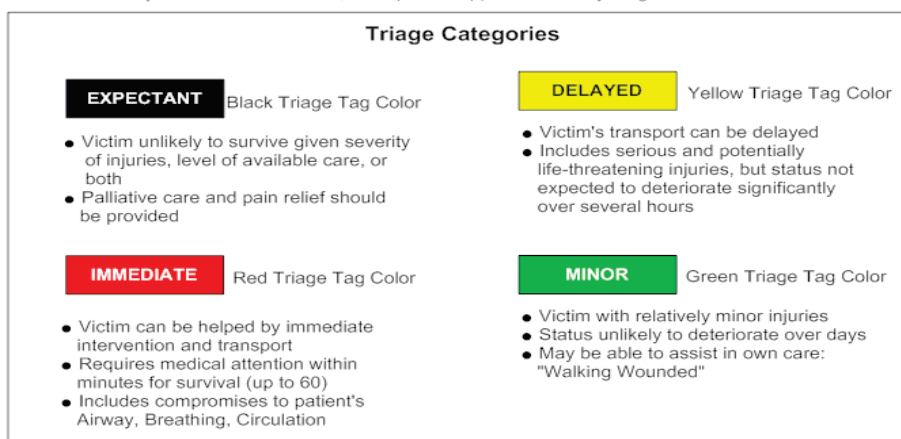
Source: Federal Emergency Management Agency Urban Search and Rescue Task Force System.





Use JumpSTART if the Patient appears to be a child.

Use an adult system, such as START, if the patient appears to be a young adult.



Request to be Transported to Hospital on Divert**Complete this form for a patient that chooses to be taken to a hospital on diversion****PURPOSE**

This form should be used when a patient requests transport to a hospital that is on diversion. The patient should be informed of the diversion and what the diversion means. If the patient is adamant that he/she be transported to the hospital on diversion, complete this form and have the patient sign the Statement of Understanding below.

EMS TRANSPORT PROVIDER: MARK ALL THAT APPLY

- ☐ Patient transported to a hospital that was on "diversion."
- ☐ Patient was informed and voiced understanding that an extended wait is possible.
- ☐ Patient was informed and voiced understanding that transfer to another hospital is possible.
- ☐ Patient was diverted to this hospital because _____ hospital is on Emergency Department, Critical Care, Med/Surg, Psych, CT, Labor & Delivery diversion. (Enter hospital name and circle appropriate reason for diversion).

STATEMENT OF UNDERSTANDING

It has been explained to me that _____ hospital is on diversion, and that I may have an extended wait to see the doctor, get a bed, or may need to be transferred to another hospital. I still wish to be transported to this hospital.

Acknowledgment of Patient

Date_____
Print Name_____
Signature

Thrombolytic Checklist (STEMI)

Complete this checklist for any patient with a STEMI

EVENT INFORMATION						
Date:		ATCC Number:		Time:		AM PM
Destination:						
Patient Name:				Patient DOB:		

12-LEAD
Chief Complaint/Reason for 12-Lead: _____
12-Lead Acquired: Yes _____ No _____ 12-Lead Transmitted: Yes _____ No _____
Number of Transmission Attempts: _____ Mode of Transmission: _____
EMSP Assessment of 12-Lead: _____

DOES PATIENT HAVE:	YES	NO
Chest pain or equivalent characteristic of myocardial ischemia, for at least 30 minutes. Pain has not lapsed and is not relieved by NTG or position changes		
ECG ST segment elevation of at least 1 mm in at least two contiguous leads reflecting a single myocardial region (Q waves are not a contraindication)		
Elapsed time from onset of ischemia to evaluation less than twelve hours		
EXCLUSION CRITERIA: POTENTIAL ABSOLUTE CONTRAINDICATIONS	YES	NO
Active internal bleeding		
Past of present bleeding disorder		
History of any stroke, intracranial neoplasm, arteriovenous malformations or aneurysm		
Intracranial or intraspinal surgery or trauma in the last 2 months		
Intracranial neoplasm, arteriovenous malformation, or aneurysm		
Uncontrolled hypertension - systolic > 180 mm Hg, diastolic > 110 mm Hg		
Pregnancy		
EXCLUSION CRITERIA: POTENTIAL RELATIVE CONTRAINDICATIONS	YES	NO
Diabetic hemorrhagic retinopathy or other hemorrhagic ophthalmic conditions		
Prolonged CPR (longer than 10 minutes)		
Major surgery at <u>non-compressible</u> site (eg. CABG) within 10 days		
Documented cerebrovascular disease		
Gastrointestinal or genitourinary bleeding within last 7 days		
Significant liver dysfunction		
PHYSICALLY advanced age (>75 years with multiple disease states beyond AMI).		
Patients currently receiving oral anticoagulants		
Previous thrombolytic therapy		
Trauma to the head in the last 2 weeks		
Any trauma in the last 2 weeks		
Surgery in the last 2 weeks		

Thrombolytic Checklist (Stroke)

Complete this checklist when treating any patient with an acute stroke

EVENT INFORMATION					
Date:		ATCC Number:		Time:	
Destination:		Historian Cell Phone #:			
Patient Name:		Patient DOB:			

EMSA ASSESSMENT
<p>1. Eyes: <i>Horizontal Gaze</i></p> <ul style="list-style-type: none"> Ask patient to keep their head still and follow your finger left to right with their eyes. In aphasic patients, call the patient's name on one side and then the other. Abnormal – Patient is unable to follow as well in one direction compared to the other. <p>2. Motor: <i>Facial Weakness</i></p> <ul style="list-style-type: none"> Ask patient to show their teeth or smile. In aphasic patients, look for asymmetric grimace to pain. Abnormal – One side of the face does not move as well as the other. <p style="margin-left: 40px;"><i>Arm Weakness</i></p> <ul style="list-style-type: none"> Ask patient to hold out both arms, palms up, for 10 seconds with eyes closed. In aphasic patients, hold the patients arms up and let go. Abnormal – One arm does not move, or drifts down compared to the other. <p style="margin-left: 40px;"><i>Leg Weakness</i></p> <ul style="list-style-type: none"> Ask patient to lift one leg and then the other for 5 seconds. In aphasic patients, hold up one leg and let go, then repeat on the other side. Abnormal – One leg does not move, or drifts down compared to the other. <p>3. Slurred Speech or Aphasia:</p> <p style="margin-left: 40px;"><i>Naming</i></p> <ul style="list-style-type: none"> Ask patient to name your watch and pen. Abnormal – Patient slurs words, says the wrong words, or is unable to speak. <p style="margin-left: 40px;"><i>Repetition</i></p> <ul style="list-style-type: none"> Ask patient to repeat "They heard him speak on the radio last night" after you. Abnormal – Patient slurs words, says the wrong words, or is unable to speak. <p>_____: Time last known well _____ < 4.5hrs _____ < 6 hrs. _____ < 24 hrs. _____ > 24 hrs.</p> <p>Level of consciousness: Alert _____ Responds to Voice _____ Responds to Pain _____ Unresponsive _____</p> <p>GLUCOMETER READING: _____ mg/dL Was bolus given? Yes _____ No _____ Unknown _____</p>

QUESTIONS	YES	NO
History of stroke, brain tumor, aneurysm, arteriovenous malformations		
Patient Pregnant		
Past or Present Bleeding disorders		
Surgery in last 2 weeks		
Anticoagulant medications taken Last Taken:		
Intracranial or intraspinal surgery or trauma in the last 2 months		
Gastrointestinal or genitourinary bleeding within last 7 days		

Leave a copy with the patient

Received by: _____ Date: _____

Surgical Cricothyroidotomy

Tactical Paramedic Only

Description:

Surgical cricothyroidotomy involves passing a tube through an incision in the cricothyroid membrane in order to provide an airway to oxygenate and ventilate a patient when less invasive airway management techniques cannot be accomplished or have failed.

Indications:

This procedure is to be used only when standard airway management procedures cannot be accomplished or have failed.

Precautions:

Caution should be used in patients with:

- Laryngeal injury.
- Tracheal rupture.
- Anterior neck swelling that obscures anatomical landmarks.
- Anatomic anomalies or distortion of the larynx and trachea.
- Bleeding disorders.

Procedure:

Adult

- Have suction supplies available and ready.
- Locate the cricothyroid membrane utilizing anatomical landmarks.
- Use the non-dominant hand to secure the membrane.
- Prepare the site for incision. Quickly cleanse the site with antiseptic solution. Start from the membrane and wipe in widening circles until a broad margin around the site is cleansed.
- Make a vertical incision in the skin 1.5 to 2.5 cm in length over the cricothyroid membrane.
- Use blunt dissection to expose the cricothyroid membrane.
- Once the membrane is exposed, make a horizontal incision through the membrane.
- Insert the endotracheal tube until the cuff is in the trachea, inferior to the incision site. Consider the use of a Bougie as a guide into the trachea.
- Inflate the cuff.
- Secure the tube with a commercial tube holder if available or prepackaged tube securing tie.
- Confirm placement as you would an ETT.
- Note the depth on insertion.

Pediatric

Not Recommended.

Blood Transfusion Procedure

Clinical Indications

- Hypotension is the setting of known traumatic injury
- Obvious massive bleeding
- Significant GI bleeding
- Vaginal bleeding

Contraindications

- Known personal or religious objection to blood products
- Patient less than 3 yrs of age and/or less than 15kg

Procedure:

- If patient has not already received crystalloid fluid administer 1-2 L NS or LR, **20-40mL/kg NR or LR**
- Obtain secondary access with large bore IV or IO for blood administration
- Ensure blood temperature has been appropriately maintained
- Gently agitate blood product bag and use only filtered blood tubing for administration
- Setup and prime line as required
- Utilize blood warmer for administration
- Administer 1 unit PRBCs with 1 unit FFP, **10mL/kg PRBCs with 10mL/kg FFP**
- Alternatively administer 1 unit whole blood, 10mL/kg whole blood
- Monitor closely for transfusion reaction, if transfusion reaction occurs immediately stop transfusion and see section below for treatment of transfusion reactions
- May repeat 2nd unit, **10mL/kg**, of PRBCs/FFP or whole blood if hypotension persists
- When blood is complete, remove blood tubing and flush line
- Any remaining blood should be left with patient at receiving facility

Documentation Requirements

- Document that consent was obtained if possible
- Indication for blood product administration
- Blood administration start and stop time
- Blood product unit ID and type (eg O-)
- Type of product, rate, and total volume infused
- Vitals should be documented every 5-15 minutes at minimum
- Presence or absence of blood transfusion reaction
- Interventions performed if blood transfusion reaction occurs
- Patient response to blood administration
- Patient status at infusion completion
- Disposition of infused blood

Blood Transfusion Reaction

- Signs/Symptoms
 - Localized erythema at infusion site
 - Hives or itching
 - Flushing
 - Fever
 - Chills
 - Chest pain or pressure
 - Tachycardia
 - Difficulty breathing
- Treatment
 - Stop blood immediately
 - Flush line and start crystalloid solution through line
 - Administer 50mg (**1mg/kg, max 50mg**) diphenhydramine IV
 - Administer 125mg (**2mg/kg, max 125mg**) methylprednisolone IV
 - For anaphylactic/significant reaction see Allergic Reaction Protocol

End of Document