GRANT COUNTY

Pre-hospital Patient Care Protocols

INCLUDES BLS, AEMT, PARAMEDIC

Approved, Reviewed, and Revised

December 2013

Dr. Jenarah Tekippe, GC MPD
AGENCY ACCEPTANCE FORM

We have received a copy of the current Grant County Patient Care Protocols; we have read and understand them and agree to abide by them. We also understand that we are required to abide by all “on-line” Medical Direction to us by the MPD or one of his delegated providers over the radio or cell phone.

Additional, we will maintain original Personnel Acceptance Forms for all providers within our agency and will provide to the Washington State Department of Health and/or Jenarah Tekippe, MD upon their request.

Agency License Number(s)______________________________________________

Agency Name_______________________________________________________

Agency Business Address____________________________________________

Phone Number____________________ Fax Number_______________________

Agency Head Name_________________________________________________

Agency Head Signature____________________ Date_____________________

Agency: Please sign this acknowledgment and return it to:

Grant County MPD Jenarah Tekippe, MD
To:                      All Grant County Providers  
From:                    Jenarah Tekippe, MD, Grant County Medical Program Director  
Subject:                 Grant County Patient Care Protocols  

Each of you functions in Grant County under the Certification requirements of the Washington State Department of Health and under the Certification Authority held by me as the Grant County Medical Program Director. It is my license to practice medicine in Washington State that allows you to function in the field.

It is required that I provide you with a current copy of the Grant County Patient Care Protocols. It is imperative that you read, understand and agree to abide by these documents. It is also imperative for you to understand that at any time “on-line” Medical Control is consulted, be it myself or one of my designated providers, the directions given by radio or cell phone are to be followed as well.

Complete the acceptance form below and return a copy to me as soon as possible. Return the original to your primary agency. Your primary agency is required to maintain and provide upon request by the State of Washington Department of Health or myself.

________________________________________

PERSONNEL ACCEPTANCE FORM

I have received a copy of the current Grant County Patient Care Protocols by Jenarah Tekippe, MD, Grant County Medical Program Director. I have read and understand them and agree to abide by them. I also understand that I am required to abide by all “on-line” Medical Direction to me by the MPD or one of his delegated providers over the radio or cell phone. I understand that failure to comply may be a violation of the Washington State Uniform Disciplinary Act (UDA) RCW 18.130

Social Security Number ____________________________________________

Print Name _______________________________________________________

Address __________________________________________________________

Phone Number ___________________________ E-Mail ______________________

Certification Level _______________________________________________

Agency (ies) ____________________________________________________

Signature ___________________________ Date__________________________
As the Medical Program Director, I have recommended you to the Washington State Department of Health, Office of Licensing and Certification, for certification at your level, as a Grant County pre-hospital provider. If and when you receive your certification card from the State, you must comply with the following in order to maintain your card and function under my medical direction.

1. You must follow these written Patient Care Protocols while practicing in Grant County.

2. You are also bound to follow “on-line” Medical Direction provided by me or one of my delegated providers.

   *Failure to follow Patient Care Protocols and/or “On-line” Medical Direction by me or one of my delegated providers is a violation of the Washington State Uniform Disciplinary Act (UDA) RCW 18.130.*

3. You must sign and return documentation indicating that you have accepted, reviewed and will comply with the Patient Care Protocols.

4. Your certification to practice under my direction is your property right. WAC 246.976 requires you to maintain annual continuing medical education and skill requirements. Please reference the appropriate section for your certification level:

   a. First Responder Requirements WAC 246.976.025
   b. EMT Requirements WAC 246.976.035
   c. Special Training WAC 246.976.040
   d. IV Technicians WAC 246.976.055
   e. Airway Technicians WAC 246.976.065
   f. IV/Airway Technicians WAC 246.976.075
   g. ILS Technicians WAC 246.976.077
   h. Paramedics WAC 246.976.085

5. On or before your annual certification date you are required to send me all necessary information demonstrating that your CME and skills are in compliance with the appropriate Washington Administrative Code (WAC). If you fail to provide the information requested, I am required to bring the matter to the attention of the Washington State Department of Health for further action.
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

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<th>SECTION: Administrative</th>
<th>PROTOCOL NO. 102</th>
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<td>NAME: Medical Control</td>
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<td>EFFECTIVE DATE: 5/14/2012</td>
<td>Reviewed: 11/1/2013</td>
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<td>APPROVED BY: Dr. Jenarah Tekippe, GC MPD</td>
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Samaritan Hospital Emergency Department On-Duty Physician, or other MPD delegated providers, shall serve as the ON-LINE MEDICAL CONTROL base station for all pre-hospital Emergency Medical Services activities in Grant County.

Medical Control should be used for, but is not limited to, the following areas:

1. Any and all questions regarding patient disposition.
2. Clarification of orders.
3. General medical information.
4. In cases of disparity between the pre-hospital patient care protocols and the wishes of the patient, family and/or private physician.

On-line Medical Control should be contacted by either of the following two methods:

1. Use the HEAR frequency and the appropriate DTMF code to activate the radio system.
2. Use landline or cell phone and call 509-793-9730

Off-line Medical Control is the responsibility of the Grant County Medical Program Director:

Jenarah Tekippe, MD
Grant County MPD
801 E Wheeler Road
Moses Lake, WA 98837
509-793-9730
All Grant County EMS Providers are to function within their respective scope of practice as defined by their Washington State approved training curriculum and WAC certification regulations.

Should a patient’s clinical assessment indicate the need for a higher level of service than originally dispatched, then the EMS Provider is to follow Grant County and North Central Regional EMS Councils’ Patient Care Procedures. These Patient Care Procedures specifically address dispatch of and rendezvous with a higher level of service (a tiered response system). This applies to both pre-hospital transport and inter-facility transfer.

Questions regarding such should be addressed to the Grant County MPD or On-Line Medical Control. Specific patient treatments should follow Grant County Patient Care Protocols.

Compliance with these directives will be reviewed by the Grant County MPD and the Grant County MPD Quality Assurance Committee.

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PRE-HOSPITAL PATIENT CARE COMMUNICATIONS

All pre-hospital units shall have the ability to communicate with the Multi-Agency Communications Center, receiving facilities within Grant County, Medical Control and on the HEAR frequency. The purpose for having such communications ability will be to facilitate the proper delivery of patient care within Grant County and to insure the ability of pre-hospital units to communicate with Medical Control for the proper treatment and destination of patients.

All transport capable units will transmit a patient care radio report to the receiving facility prior to their arrival at the facility. Providers will make every effort to deliver this report as soon as possible after transport is initiated. The following radio report information shall be provided to Medical Control or the receiving facility as a minimum report:

1. Unit Identification
2. Number of patients (an individual report shall be given for each patient)
3. Age and sex
4. Chief Complaint and status (i.e. critical, stable, CPR in Progress)
5. Brief pertinent history for this event and short past medical history
6. Vital signs
7. Assessment/Exam findings
8. Treatment Plan/Interventions
9. Changes/improvements in patient condition
10. Estimated Time of Arrival (ETA)
11. Request for additional questions, information or treatment orders

If transport is delayed (i.e. extrication required), units shall contact Medical Control prior to initiating transport.

The radio report is not meant to be a full patient report and should relay only pertinent patient care information. Patient identification information is inappropriate for transmission over open radio communications. Where patient care at the hospital will be improved, patient identification information may be given by telephone.

Receiving facilities shall be updated immediately if there are pertinent changes in the patient’s condition after the initial radio report.

If contact via the HEAR system can not be established, then cell phone contact is appropriate. In the event of disrupted communications, pre-hospital providers will act according to protocol and appropriately document in the patient care report. If communications is impossible with MEDCON and deviation from protocol is executed, a written report shall be submitted to the agency supervisor and Grant County MPD within 24-hours of the incident.

TRANSFER OF CARE - PATIENT REPORT

A verbal report to the receiving Physician and/or nurse shall be given after the arrival at the receiving facility. This report should contain full detail concerning the care of the patient. Providers should provide thorough details of the scene, complete assessment of the patient, treatment plan, interventions and medications administered, and outcome as a result of treatment.
All licensed pre-hospital agencies in Grant County shall document their patient contacts using an approved Patient Care Report (PCR) form. This written report is the medical/legal document of the assessment, management and transport of the patient. The importance of the completeness and accuracy of the report cannot be overemphasized. This is a legal record and may be called upon as evidence in any court of law. (Remember: If it is not written, it was not seen nor done.)

The narrative section of the EMS MIR form will be completed using the S.O.A.P. charting format.

**S** Subjective and Scene: This is information that the patient, family, bystanders, or other witnesses tell you. (Age, gender, race, estimated weight, chief complaint, scene description, history of the event, pertinent past medical history, patient's private physician, medications, allergies and extenuating circumstances.)

**O** Objective: This is information you find on your examination and lab evaluation (monitor, EKG, blood sugar, etc.).

**A** Assessment: This is your differential diagnosis based on the Subjective and Objective information gathered.

**P** Plan: This is your plan of treatment based on your Assessment. Document your patient care and its results. Record whether the patient's condition improved, stabilized, or declined.

Vital signs should be reassessed and documented every 15 minutes on a stable patient and every effort should be made to reassess and document vital signs every 5 minutes on unstable patients. Reassess and document vital signs following medical interventions as well.

Document completely all instructions received from Medical Control via radio or phone communication. Document the name of the Medical Control physician giving the orders.

Document any patient refusal of treatment/transport in accordance with the Patient Refusal protocol.

Document rationales for any deviation from protocol.

Times must be documented on the patient care report for it to be complete.

Both a verbal and written report shall be provided to the receiving Physician and/or designee at the time of patient transfer. If a written patient care report cannot be provided at the time of patient transfer (i.e. dispatched to another call), it shall be completed as soon as possible and
no later than 4 hours from the time of transport. Faxing copies of patient recorders to the receiving facility is acceptable.
LOWER CODE/CANCELLATIONS
It is recognized that it is in the best interest of public safety and ultimately patient care to respond to all incidents in a safe and prudent manner at all times. To accomplish this, units responding in the “Emergency Mode” (lights and sirens) may be lowered to a non-emergency response by the first responding unit on the scene to determine that the patient does not require IMMEDIATE emergency medical care for life or limb threatening conditions.

1. First Responders who are members of a licensed pre-hospital agency and are certified by the Department of Health. This does not include law enforcement. Law enforcement may advise units of the situation, but units are not allowed to cancel until patients have been evaluated by a certified BLS, ILS or ALS provider.
2. First responders (fire or police) may cancel responding units, to include BLS, ILS, and ALS, when there is no patient.
3. BLS first response or BLS/ILS transporting units may downgrade responding ILS or ALS units when their evaluation clearly indicates a lack of potential need by the following criteria:
   1. Skin Condition: warm, pink, dry
   2. Heart Rate: 60 or greater but less than 100, with a regular rate
   3. Respiratory Rate: 12 or greater but less than 24, deep and easy
   4. Blood pressure greater than 100 mm/Hg, systolic
   5. Blood pressure less than 90 mm/Hg, diastolic
   6. Patient is conscious, alert and oriented to person, place and time (GCS=14 or 15)
   7. No loss of consciousness now or prior to arrival
   8. No seizure activity now or prior to arrival
   9. No chest pain
   10. No shortness of breath
   11. No abdominal pain
   12. No drug overdose/suicide attempt
   13. No significant mechanism of injury or multiple trauma
   14. No signs or symptoms of CVA or stroke

The patient may then be transported by the BLS/ILS unit (lower level of service) only after Medical Control contact.

CALL DIVERSIONS
A responding EMS unit may be diverted from one 911 call to a second call when all conditions below are met:

1. It is obvious the second call is of a greater life-threatening emergency than the first call.
2. The first EMS unit is decidedly closer to the second call.
3. A second EMS unit is immediately dispatched to the first call.
4. The diversion and response of the first unit to the second call might be vital to the patient’s outcome.
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

SECTION: Administrative

NAME: Patient Treatment Rights (Refusals)

EFFECTIVE DATE: 5/14/2012
APPROVED BY: Dr. Jenarah Tekippe, GC MPD

Definitions
Patient; an individual with a chief complaint or obvious injury
Person; an individual who has no chief complaint or obvious injury
Example: “An individual has fallen and can't get up.” This is a patient.

Competent patients or the guardians of competent patients who wish to refuse any portion of treatment and/or transport will be asked to sign the medical release on an approved Patient Care Report.

Any time a patient or guardian is refusing transport, EMS providers shall contact Medical Control for authorization (if not possible, providers shall follow this protocol and document deviation and contact Medical Control at their earliest convenience). Contact should be made in such a way that Medical Control can speak directly to the patient/family. The EMS provider should be prepared to give a complete patient report to Medical Control and to follow any guidelines Medical Control advises.

Documentation of refusals must follow the Documentation Protocol, which will include vitals, times and a narrative in SOAP format. Documentation of all discussion with the patient/family and Medical Control should be done in the narrative portion of the patient care record. EMS providers shall also document advice given by them to the patient/family directly in the patient care record.

If a patient is conscious and competent, and injuries are not life threatening, every effort should be made to honor a patient’s right to refuse treatment and/or transport when the patient and/or guardian choose to exercise that right.

If a patient is considered incompetent to refuse treatment/transport because medical/mental condition or illness, injury, drugs or alcohol impairs the patient’s judgment, the patient shall be treated/transported if there is any potential threat to life or limb. EMS providers must immediately contact Medical Control for guidelines and support. In cases of threat to life or limb, the risks of loss of life/limb far outweigh the risks of care without consent. At all times attempts will be made to seek the consent of a legal guardian for the patient. (NOTE: EMS providers should never endanger themselves by attempting transport or treatment of combative patients who refuse care. Always seek help from Law Enforcement).

If a patient or guardian requests transport to a facility other than the one indicated by the trauma triage tool or the closest facility in life threatening medical emergencies, the EMS provider should follow the above protocol for refusal. Every effort should be made to let the patient/family know the importance of transport to the appropriate facility. If the patient/family still requests an inappropriate facility, contact Medical Control for guidelines and support. Then have the Medical Release form signed according to the above protocol.

At any time an interpreter is used to translate the refusal form and/or instructions to the patient or guardian, the EMS provider shall have the interpreter sign the form as a witness and the notation “interpreter” should be placed next to the signature. If the interpreter is contacted by telephone, the EMS provider should note the name of the interpreter in the patient care record narrative.
Minor patients who suffer emergent life or limb threatening conditions or traumatic injury should be treated and transported without delay. If an adult responsible for the minor’s well being is not present, the EMS provider should advise Law Enforcement and Medical Control of the course of action being taken.

In the case of a minor patient who suffers illness or injury that should be evaluated, but which is not immediately life or limb threatening and where an adult responsible for the minor's well being is not present, then the EMS provider must make a good faith effort to establish contact with an adult responsible for the minor's well being in order to obtain permission for treatment and/or transport.

If a responsible adult can not be contacted, the EMS provider must document all efforts at contact and then contact Medical Control for direction. If Medical Control advises transport/treatment, Law Enforcement should be notified of the course of action. When a responsible adult is not available and a minor requiring evaluation, treatment and/or transport refuses such care, the EMS provider should again contact Medical Control for guidance and Law Enforcement for assistance as necessary.

Whenever a Grant County EMS service makes contact with a minor who is not transported, the minor must be left in the care of a competent adult and not left solely in the care of other minors. Notify Medical Control (and/or Law Enforcement if indicated or so instructed by Medical Control).

Note: For any patient left at the scene, adult or minor, Medical Control should be advised.
Critical/unstable patients will be transported to the nearest appropriate ER/hospital.

Medical: For medical conditions, patients should be taken to the closest facility capable of ACLS or PALS/APLS care.

Trauma: For trauma patients, Grant County EMS Providers will follow the State of Washington Pre-Hospital Trauma Triage (Destination) Procedures. Trauma patients who meet Washington State Trauma Triage Criteria must be transported to the highest level Trauma Designated Facility within 30 minutes transport time. (Refer to section on Trauma.)

For non-critical/stable patients, the choice of destination hospital shall be based on the following factors:

1. **Patient preference:** The choice of destination hospital shall rest primarily with the patient, their immediate family or the personal physician. On-line Medical Control should be notified if the receiving facility is other than the closest facility.

2. **Medical Control:** If the patient does not have a hospital preference, Medical Control may be consulted if there are extenuating circumstances not to transport the patient to the nearest facility. In selected patients, Medical Control may change the patient's destination based on EMS field assessment and resource availability at the destination facility.

3. **Special Services:** If a provider believes the patient needs special services (i.e. orthopedics, OB) that are not available at the nearest facility, MEDCON will be consulted to approve change in destination.

*At all times, providers should consider transporting to nearest facility if the patient is stable, non-critical and has no preference.*
Any time an EMS Provider cannot provide an adequate airway to a patient within 2 minutes after initial encounter, he/she is required to transport the patient immediately unless there are extenuating circumstances, e.g. imminent arrival of an ILS/ALS unit (in case of BLS first unit on scene) or inability to extricate.

Medical  If at any time the EMS providers have been on scene or predict they will be on scene for more than 20 minutes after initial patient contact, they will contact Medical Control for advice on whether the patient should be transported immediately or have further care rendered.

Patients meeting the Chest Pain protocol should have a scene time limited to 15 minutes or less.

Trauma  In cases that a patient meets the Washington State Trauma Triage Criteria and once extrication has been accomplished, scene time shall be 10 minutes or less.

For patients not meeting the Washington State Trauma Triage Criteria, providers shall keep scene times to 20 minutes or less.

At any time that providers believe that their scene time will exceed these guidelines, contact with Medical Control shall be made.

The EMS provider must clearly document any and all extenuating circumstances in the patient care record.
Inter-facility transport may occur at either the BLS, ILS or ALS level within the following categories and under the following guidelines:

1. Transfer between hospitals for admission for services not available at the initial hospital.
2. Transport of patient to another facility for diagnostic evaluations with return to the initial facility.
3. Transport from an acute care facility to an extended care facility.
4. Transport of patient between facilities at the patient's request.
5. Transport of Mental Health patients to a state designated psychiatric facility.

As a general rule, it is the responsibility of the transferring facility to insure that medical necessities for safe patient transfer are met. Medical instructions and orders of the attending physician will be followed unless specifically contrary to standing orders. If the attending physician accompanies the patient during the transfer, he/she may assume complete authority and direct all care. Medical Control should be aware and in agreement.

Registered nurses who accompany patients on inter-facility transports must have orders to give medications, as they do not have coverage under pre-hospital WAC to do so. Such orders may come from the attending physician, on-line Medical Control, or by the receiving physician. If orders are verbal, they should be clearly documented as such in the pre-hospital patient care record. Further, if an RN attends a patient for ALS transfer, a Grant County certified EMT-Paramedic or EMT with Airway (ET intubation) level skill training shall accompany the patient. (Remember: completion of an ACLS class does not certify one for intubations.)

The responsibility for arranging transfer to another facility resides with the transferring facility. In general patients will not be transferred to another facility without first being stabilized. Stabilization should include adequate evaluation and initiation of treatment to assure that transfer of the patient will not, within reasonable medical probability, result in material deterioration of the medical condition, death, or loss or serious impairment of bodily functions, parts or organs. Evaluation and treatment of patients prior to transfer should include the following:

1. Establish and assure an adequate airway and adequate ventilation;
2. Initiate control of hemorrhage;
3. Stabilize and splint the spine and/or fractures;
4. Establish and maintain adequate access routes for fluid and/or medication administration;
5. Initiate adequate fluid and/or blood product replacement;
6. Determine that the patient’s vital signs (including pulse, respiration, blood pressure and urinary output, if indicated) are sufficient to sustain adequate tissue perfusion.
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

It is understood that circumstances may arise for which full stabilization is not possible or appropriate; however, the potential benefits of transfer should outweigh the risks. It is, further, the transferring facility's responsibility to establish the need for BLS, ILS or ALS care.

For ALS calls not meeting the above criteria for stabilization prior to inter-facility transport, prior to starting the transport, Medical Control shall be contacted and the following may apply:

1. You may initiate pre-hospital protocols and guidelines as appropriate including the establishment of intravenous lines, airway control, vasopressor support, etc.

2. ALS providers shall contact Medical Control for all medications not approved within these protocols. When transporting patients with medications not being covered by these protocols, providers shall obtain the appropriate information concerning the medication (i.e. indications, contraindications, side effects, dosages etc.) and consult with Medical Control.

3. You may refuse to transfer the patient until the facility complies with the previously noted evaluation and/or treatment. Should you decide this is necessary, contact on-line Medical Control for concurrence and consultation or contact the MPD directly, if available.

If BLS or ILS transport is requested and it is the judgment of the BLS or ILS crew that the patient needs ALS support, it is mandated that ALS level care be dispatched and Medical Control contacted. Under no circumstances (except as noted) should a BLS or ILS crew transport a patient, if in their judgment; this is an ALS level transport. (The only exception is a disaster/multi-casualty incident with exhaustion of county and air transport ALS capabilities).

In the event an emergency occurs en route that was not anticipated, pre-hospital patient care protocols will immediately apply. Medical Control should be contacted as appropriate and the receiving facility should be contacted as soon as possible to inform them of changes in the patient's condition.
A DNR (Do Not Resuscitate) Order is an advanced directive document can help people communicate their treatment preferences when they would otherwise be unable to make such decision.

Protocol:

I. **Scene Size-Up/Initial Patient Assessment**

II. **Focused History and Detailed Physical Exam**
   A. Determine the patient is in a Do Not Resuscitate status in one of the following ways:
      1. The patient has an **ORIGINAL**, valid POLST form present, OR
      2. The patient has an EMS-No CPR bracelet that in intact and not defaced. The bracelet can located on either wrist, either ankle, or on a necklace or neck chain worn by the patient, OR
      3. The patient has an **ORIGINAL** EMS No-CPR form present, OR
      4. The patient has other DNR orders (i.e., Living Will, etc.) Healthcare facilities may have their own DNR orders, which may be in patient's chart. When encountering other DNR forms EMS providers shall perform the following:
         a. Verify that the order has a physician signature requesting “Do Not Resuscitate”.
         b. Verify the presence of the patient’s name on the order.
      5. Contact on-line medical control for further consultation. In most cases, on-line medical control will advise to withhold CPR following verification of a valid physician-signed DNR order.

III. **Management**
   A. Begin resuscitation when it is determined no valid DNR order exists.
   B. Do not initiate resuscitation measures when:
      1. The patient is determined to be “obviously dead”.
         a. The “obviously dead” are victims who, in addition to absence of respiration and cardiac activity, have suffered one or more of the following:
            (1) decapitation
            (2) evisceration of the heart or brain
            (3) incineration
            (4) rigor mortis
            (5) decomposition
      2. In your medical judgment, it is determined your patient has attempted suicide or is a victim of a homicide, begin resuscitation.
   C. When a patient has an existing, valid DNR order:
      1. POLST:
a. Provide resuscitation based on patient’s wishes identified on the form.
b. Provide medical interventions identified on the form.
c. Always provide comfort care.

2. EMS No-CPR:
   a. Do not begin resuscitation measures.
   b. Provide comfort care
   c. Contact on-line medical control.

3. Other DNR orders:
   a. Follow specific orders contained in the DNR order based on the standard of care allowed by your level of certification and communications with on-line medical control.

D. If resuscitative efforts have been started before learning of a valid DNR order, STOP these treatment measures:
   1. Basic CPR
   2. Intubation (leave the endotracheal tube in place, but stop positive pressure ventilations.
   3. Cardiac monitoring and defibrillation.
   4. Administration of resuscitation medications.
   5. Any positive pressure ventilation (through bag valve masks, pocket face masks, endotracheal tubes).

E. Revoking the DNR order. The following people can inform the EMS system that the DNR order is revoked:
   1. The patient (by destroying the order, drawing a diagonal line or the word VOID across the front of the form, or by verbally revoking the order).
   2. The physician expressing that patient's revocation of the directive.
   3. The legal surrogate for the patient expressing the patient's revocation of the directive. (The surrogate cannot verbally revoke a patient executed directive).

F. Documentation
   1. Complete a pre-hospital patient care report form.
   2. State in writing in the narrative that the patient was identified as DNR by POLST, EMS No-CAP, or other directive.
   3. Record the name of the patient’s physician and the medical control physician contacted.
   4. Record the reason why the EMS system was activated.

G. Comfort Care Measures – providing comfort care is an important responsibility and service you provide to patients and their families at a crucial moment in their lives.
   1. Comfort care measures for the dying patient may include:
      a. Manually open the airway (do not provide positive pressure ventilation with a bag valve mask, pocket mask or endotracheal tube).
      b. Clear the airway (including stoma) of secretions with the appropriate suction device.
      c. Provide oxygen per nasal cannula at 2-4 LPM.
      d. Positioning for comfort.
      e. Splinting.
      f. Controlling bleeding.
      g. Providing pain medications pertinent to the level of certification.
      h. Providing emotional support.
      i. Provide emotional support.
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

2. Contact on-line medical control.

H. Special situation:
1. The patient’s wishes in regard to resuscitation should always be respected. Sometimes, however, the family may vigorously and persistently insist on CPR even if a valid DNR order is located. These verbal requests are not consistent with the patient’s directive. However, in such circumstances:
   a. Attempt to convince family to honor the patient’s decision to withhold CPR/treatment. If the family persists, then
   b. Initiate resuscitation efforts until relieved by advanced life support providers (for First Responders, BLS and ILS providers).
   c. Advanced life support personnel should continue treatment and consult medical control.

I. Remember – Once a death has occurred, the family and bystanders become your patients.

J. Contact the Coroners office through the dispatch center.

IV. Ongoing Assessment as appropriate.

V. Transport if necessary.
Medical professionals at the scene of an emergency call may provide assistance to the EMS team and should be treated with professional courtesy. Medical professionals who offer assistance should identify themselves. If on scene physicians wish to assume or retain responsibility for direction of patient care, they should provide proof of identification, follow the guidelines below, and accompany the patient to the receiving hospital.

When the patient's private physician is in attendance and has identified him/herself, the EMS team will comply with the private physician's instructions for the patient. Medical Control will be contacted for reporting. If orders are given by the private physician which are in conflict with Grant County EMS Patient Care Protocols, clearance must be obtained through Medical Control.

In such cases, the physician at the scene may:
- Request to talk directly to the Medical Control physician to offer advice and assistance,
- Offer assistance to the EMS team with another pair of eyes, hands and/or suggestions, yet leave the EMS team under Medical Control and established patient care protocols,
- Take total responsibility for the patient with the concurrence of the Medical Control Physician.
(Remember: If the on scene/private physician wishes to take total responsibility for patient care, they will accompany the patient to the receiving hospital.

If, during transport, the patient's condition should warrant treatment other than that requested by the private physician, then Medical Control will be contacted for information and for concurrence with the requested treatment.

These guidelines will also apply to cases where a physician may happen upon the scene of ongoing EMS care and chooses to interact/assist the EMS team.

Medical professionals, other than physicians, may offer assistance to the EMS providers but are not authorized to give orders to the EMS team except in pre-approved circumstances (e.g. a critical care RN accompanying the patient and EMS crew on an inter-facility transport, or arrival of Air Transport/Helicopter flight crews operating under Grant County Protocols for On Scene/Field Air Transport).

For Medical Professionals at the scene who offer assistance, please provide them with the "Thank You for Your Offer of Assistance" card.
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

(Front of Card)

THANK YOU FOR YOUR OFFER OF ASSISTANCE

The EMS team is operating under Washington State Law and EMS policy approved by the Grant County Emergency Medical Services Council. The EMS team is functioning under standing orders from the Medical Program Director of Grant County and is in direct radio contact with an authorized Medical Control Physician at Samaritan Hospital. If you wish to assist, please see the back side of this card for options.

Jenarah Tekippe, MD
Medical Program Director
Grant County EMS

(Back of Card)

In general, the physician who has the most expertise in management of the emergency should take control. This is usually the base hospital physician (on-line Medical Control).

You may:
1. Request to talk directly to the base hospital physician to offer your advice and assistance;
2. Offer your assistance to the EMS team with another pair of eyes, hands, or suggestion, but allow the EMS team to remain under the medical control of the base hospital physician; or
3. If you have an area of special expertise for the patient's problem, you may take total responsibility, if delegated by the base hospital physician, and you accompany the patient to the hospital.
<table>
<thead>
<tr>
<th>SECTION: Administrative</th>
<th>PROTOCOL NO. 114</th>
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</thead>
<tbody>
<tr>
<td>NAME: Legal Blood Draws</td>
<td></td>
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<tr>
<td>EFFECTIVE DATE: 5/14/2012</td>
<td>APPROVED BY: Dr. Jenarah Tekippe, GC MPD</td>
</tr>
<tr>
<td>Reviewed 11/1/2013</td>
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</tbody>
</table>

The Protocol for Legal Blood Draws has been deleted from the MPD Approved Grant County Protocols at the direction of Dr. Jenarah Tekippe, GC MPD.
## BLS TREATMENT

Follow State Protocol for the treatment of Cardiovascular Emergencies

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious
- Not breathing or abnormal breathing
- CP in patient age >40 years
- SOB, nausea or diaphoresis
- Rapid HR with CP or signs of shock
- CP with drug use
- Cardiac history
- Implanted defibrillator shock

## ILS TREATMENT

Follow State Protocol for the treatment of Cardiology Emergencies, Chest Pain

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS Skill is preformed
- MEDCON Orders

## ALS TREATMENT

**Scene Size-up/Initial Assessment**
Focused History and Detailed Physical Exam

Oxygen therapy, per protocol.
ECG, Obtain 12-lead ECG, SpO2
Assist respiratory status as indicated, per protocol.

**ASPIRIN 325mg chew**, unless contraindicated.

Establish peripheral IV access. If the patient’s systolic blood pressure is 120 mmHg or greater, NTG may be given prior to establishing the IV unless RV Infarction is suspected.

**NITROGLYCERIN 0.4mg SL**, if systolic BP >100 mm Hg.
May repeat every 5 minutes until chest pain relieved or systolic BP <100 mm Hg or patient displays signs of inadequate perfusion at a higher BP. (a)

Fluid Bolus of **NS 250mL** if systolic BP <100 mm Hg.

Treatment of nausea and vomiting as per protocol.

Treatment of dysrhythmias shall be according to current ACLS guidelines or appropriate protocol.

Treat other associated signs & symptoms per appropriate protocol.

Narcotic pain relief:
If no relief after SL Nitro x3 doses in 15 minutes and SBP >100, consider **2-4 mg Morphine IV** for pain relief. Be aware of narcotic contraindications and side effect.

**MEDCON CONTACT REQUIRED FOR:**
- Contact MEDCON for analgesic options.
- Consider if transport times are greater than 15-minutes and CP is relieved with SL NITRO administration:

**NITROGLYCERIN 5 mcg/min continuous IV infusion**, titrate to maintain systolic BP greater than 100 mmHg. Maximum rate of 20 mcg/min.

- Repeated IV Narcotic doses.
NOTE:

a. The administration of NITROGLYCERIN shall be withheld if the patient has used phosphodiesterase inhibitors for erectile dysfunction (i.e. Viagra, sildenafil, vardenafil, tadalafil) within last 48 hours.

b. Notify receiving hospital ASAP in transport for suspected STEMI.

c. Leave 12 lead EKG original with receiving Physician.

d. Morphine or Fentanyl is only per MEDCON orders.
### BLS TREATMENT

Follow State Protocol for the treatment of Cardiovascular Emergencies.  (a)(b)

### ILS TREATMENT

Follow State Protocol for the treatment of Cardiology Emergencies.

### ALS TREATMENT

Scene Size-up/Initial Assessment  
Focused History and Detailed Physical Exam

ECG, Rapid Identification of Rhythm  
*Initiate appropriate treatment algorithm according to rhythm interpretation.*

Treat all patients according to AHA ACLS guidelines.  
Reference formulary and specific protocols for variations.

Establish Two (2) Peripheral IV Access sites.

If patient returns to spontaneous circulation following treatment, provide post-resuscitation management as needed.  (c)

Consider termination of efforts if appropriate.  (d)

### MEDCON CONTACT REQUIRED FOR:

- Any deviation from this protocol.
- Prior to termination of any resuscitation efforts.
- May use IO route after One (1) IV attempt failed.

### NOTE:

a. Do not initiate CPR if completed POLST Form or EMS No CPR Banding is present. If a valid DNR documentation is presented, consult MEDCON.

b. If a valid DNR papers are presented after CPR is initiated, CPR may be discontinued after consultation with MEDCON.

c. Consider post arrest sedation to avoid the removal of ET tube, facilitate management and monitoring of the patient.

d. Termination of efforts may be considered after the patient has been effectively ventilated with endotracheal intubation and two rounds of ACLS pharmacology have been administered. Consult with MEDCON.
## GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

**SECTION:** Cardiac  
**NAME:** Bradycardia  
**EFFECTIVE DATE:** 5/14/2012  
**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD

### BLS TREATMENT
- Follow State Protocol for the treatment of Cardiovascular Emergencies.

### ILS TREATMENT

### ALS TREATMENT
- **Scene Size-up/Initial Assessment**
  - Focused History and Detailed Physical Exam
  - Assess respiratory status, treat as indicated.

- **ECG, obtain 12-lead, SpO2**
  - Oxygen Therapy, per protocol

- **Establish IV access.** (a)

- **Fluid bolus 250ml NS if hypotensive,** as indicated.

- **With serious signs & symptoms, manage as follows (b)(c):**
  - **ATROPINE 0.5 mg IVP** every 3-5 minutes, to a maximum of .04 mg/kg.

- Transcutaneous pacing (TCP), per AHA Guidelines.
  - **Administer MIDAZOLAM 2.5-5.0 mg IV** prior to TCP.
  - **Administer analgesics** as per Pain Management protocol.

- **DOPAMINE 5-20 mcg/kg/min IV continuous infusion** to maintain systolic BP >100 after fluid bolus.

- **Treat other associated signs & symptoms per appropriate protocol.**

### NOTE:
- a. TCP should be done first if patient symptomatic and delay in obtaining IV access.
- b. Serious signs and symptoms include: chest pain, dyspnea, hypotension, ALOC, shock, CHF.
- c. In symptomatic 2nd and 3rd degree AV Block, consider TCP before Atropine.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Automatic Request for ALS response.

**MEDCON CONTACT REQUIRED FOR:**
- Administration of other vasopressors may be considered with MEDCON contact:
  - **EPINEPHRINE 2-10 mcg/min IV continuous infusion.**
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## SECTION: Cardiac

### NAME: Non-traumatic Hypotension

### EFFECTIVE DATE: 5/14/2012

### REVIEWED: 11/1/2013

### APPROVED BY: Dr. Jenarah Tekippe, GC MPD

### PROTOCOL NO. 204

## BLS TREATMENT

Follow State Protocol for the treatment of Cardiovascular Emergencies. *(b)*

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious
- Not breathing or abnormal breathing
- SOB, nausea or diaphoresis
- Rapid HR with CP or signs of shock
- CP with drug use
- Cardiac History
- Implanted defibrillator shock

## ILS TREATMENT

Follow State Protocol for the treatment of Cardiology Emergencies. *(b)*

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS Skill performed.
- MEDCON Orders

## ALS TREATMENT

**MEDCON CONTACT REQUIRED FOR:**
- Administration of other vasopressors may be considered with MEDCON contact:

### Scene Size-up/Initial Assessment *(b)*

**Focused History and Detailed Physical Exam**

Assess respiratory status, treat as indicated.

**ECG, obtain 12-lead, SpO2**

**Oxygen Therapy, per protocol**

Establish IV access.

Fluid bolus **250ml NS** if hypotensive. May repeat as indicated up to **1000ml NS.** *(a)*

If hypotension persists, consider administration of **DOPAMINE 5-20 mcg/kg/min IV continuous infusion** to maintain systolic BP >100.

Treat other associated signs & symptoms per appropriate protocol.

### NOTE:

- **a.** Administer fluid bolus after assessment of lung sounds. Be cautious of impending pulmonary edema.
- **b.** Significant Findings include and require the immediate dispatch of ALS: Rapid pulse, diaphoresis, pale grey skin color, irregular pulse, cyanosis, hypotension, SOB, dyspnea, nausea, vomiting.

**EPINEPHRINE 2-10 mcg/min IV continuous infusion.**
## NAME: Tachycardia Narrow Complex

<table>
<thead>
<tr>
<th>EFFECTIVE DATE:</th>
<th>Reviewed 11/1/2013</th>
<th>APPROVED BY:</th>
<th>Dr. Jenarah Tekippe, GC MPD</th>
</tr>
</thead>
</table>

## BLS TREATMENT
- Follow State Protocol for the treatment of Cardiovascular Emergencies.

## ILS TREATMENT

## ALS TREATMENT
### Scene Size-up/Initial Assessment
- Focused History and Detailed Physical Exam
- Assess respiratory status, treat as indicated.
- Cardiac Monitor, 12-lead ECG, SpO2, Oxygen Therapy, per protocol
- Establish IV access.
- If unstable, provide sedation and administer synchronized cardioversion according to AHA guidelines. (a)
- Attempt vagal maneuvers.
- **ADENOSINE 6mg rapid IVP** with 20mL rapid flush, if refractory, administer **ADENOSINE 12 mg rapid IVP** with 20mL rapid flush up to 2 times.
- If atrial fibrillation **DILTIAZEM 0.25 mg/kg IVP over 10 min.** May repeat dose in 15 min at **0.35 mg/kg IVP over 10 min.**
- Treat underlying causes. (b)
- Treat other associated signs & symptoms per appropriate protocol.

## MEDCON CONTACT REQUIRED FOR:
- Any deviation from this protocol.

## NOTE:
- Unstable includes: chest pain, dyspnea, hypotension, ALOC, shock, CHF.
- Underlying causes can include (fever and H’s and T’s)
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

**SECTION:** Cardiac  
**PROTOCOL NO.:** 206

<table>
<thead>
<tr>
<th>NAME: Tachycardia Wide Complex</th>
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<tr>
<td><strong>EFFECTIVE DATE:</strong> 5/14/2012</td>
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<tr>
<td><strong>APPROVED BY:</strong> Dr. Jenarah Tekippe, GC MPD</td>
</tr>
</tbody>
</table>

## BLS TREATMENT

Follow State Protocol for the treatment of Cardiovascular Emergencies.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Automatic Request for ALS response.

## ILS TREATMENT

Follow State Protocol for the treatment of Cardiology Emergencies.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Automatic Request for ALS response.

## ALS TREATMENT

### Scene Size-up/Initial Assessment
- Focused History and Detailed Physical Exam

### Assess respiratory status, treat as indicated.

- Cardiac monitor, 12-lead ECG, SpO2, Oxygen Therapy, per protocol

### Establish IV access.

If unstable, provide sedation and administer synchronized cardio version according to AHA guidelines. (a)

**AMIODARONE 150 mg over 10 minutes.** If not resolved consider:

- If torsades de pointes, administer MAGNESIUM SULFATE 1-2 gm IVP over 5 to 6 minutes.

- If atrial with aberrancy see Tachycardia Narrow Complex.

### Treat underlying causes. (b)

### Treat other associated signs & symptoms per appropriate protocol.

**MEDCON CONTACT REQUIRED FOR:**
- Any deviation from this protocol.
- For the administration of Magnesium Sulfate drip.
- Recurrent tachycardias.

### NOTE:
- Unstable includes: chest pain, dyspnea, hypotension, ALOC, shock, CHF.
- Underlying causes can include (fever and five H’s and five T’s)
## General Medical/Sick/Unknown/Nausea/Vomiting

**Effective Date:** 05/14/2012

**Reviewed:** 11/1/2013

**Approved By:** Dr. Jenarah Tekippe, GC MPD

### BLS Treatment

Follow appropriate State Protocol and General Orders protocol.

- Complete blood glucose check per protocol.

### ILS Treatment

Follow appropriate State Protocol and General Orders protocol.

### ALS Treatment

- Scene Size-up/Initial Assessment
- Focused History and Detailed Physical Exam
- ECG, as needed, SpO2
- Oxygen Therapy as indicated.
- Establish IV access, as indicated.
- Blood glucose check.

For nausea and vomiting administer **ZOFRAN 4 mg IV/IM**

- May repeat once in 10 minutes if no effect.

### MEDCON Contact

- MEDCON Contact for any additional orders.

**NOTE:**

- It should be noted that diabetic patients, women and the elderly who present with general illness might be an atypical presentation of myocardial infarction.
## GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

<table>
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<tr>
<th>SECTION: Medical</th>
<th>PROTOCOL NO. 301</th>
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</thead>
</table>

### NAME: Respiratory Distress

#### EFFECTIVE DATE:
- Reviewed 11/1/2013
- 5/14/2012

#### APPROVED BY:
- Dr. Jenarah Tekippe, GC MPD

---

### BLS TREATMENT

Follow State Protocol for the treatment of Respiratory Emergencies *(a)*

**REQUEST PARAMEDIC INTERCEPT IF:**
- Automatic Request for ALS response.

### ILS TREATMENT

Follow State Protocol for the treatment of Respiratory Emergencies.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Automatic Request for ALS response.

### ALS TREATMENT

- Scene Size-up/Initial Assessment
- Focused History and Detailed Physical Exam
- Assess respiratory status, treat as indicated.
- Oxygen therapy as indicated.
- Cardiac monitor, 12-lead ECG, SpO2
- Establish IV access.

**MEDCON CONTACT REQUIRED FOR:**
- Any deviation from this protocol.

---

### NOTE:

- Use caution in respiratory distress patients without specific signs and symptoms as they may be masking myocardial ischemia.
**GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL**

**SECTION:** Medical  
**PROTOCOL NO.:** 302

| NAME: COPD/SEVERE ASTHMA |  
|---|---|
| REVISED DATE: 11/01/2013 | APPROVED BY: Dr. Jenarah Tekippe, GC MPD |

### BLS TREATMENT

Follow State Protocol for the treatment of Respiratory Emergencies.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Automatic Request for ALS response.

### ILS TREATMENT

Follow State Protocol for the treatment of Respiratory Emergencies.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Automatic Request for ALS response.

### ALS TREATMENT

**Scene Size-up/Initial Assessment**  
Focused History and Detailed Physical Exam

Assess respiratory status, treat as indicated.

Oxygen therapy as indicated.

Cardiac monitor, 12-lead ECG, SpO2

Establish IV access.

Administer either **ALBUTEROL 2.5mg in 3ml NS** via nebulizer or 2 puffs MDI with spacer OR Albuterol 2.5 mg and Ipratropium Bromide 0.5 mg/3mL NS (**DUONEB**) via inhaled nebulizer.

May repeat **ALBUTEROL ALONE 2.5 mg/3mL** up to 3 doses if symptoms persist.

**MEDCON CONTACT REQUIRED FOR:**
- Any deviation from this protocol.
- For transports over 20 minutes consider **METHYLPREDNISOLONE 125mg IV**.
- Consider **MAGNESIUM 2 GM** diluted and administered over 5-10 minutes via nebulizer.

### NOTE:

- Flow of protocol assumes the condition is continuing.
**SECTION:** Medical  
**NAME:** Asthma  
**REVISED DATE:** 5/14/2012  
**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD  
**PROTOCOL NO:** 303

### BLS TREATMENT

- Follow State Protocol for the treatment of Respiratory Emergencies
- **REQUEST PARAMEDIC INTERCEPT IF:**
  - Automatic Request for ALS response.

### ILS TREATMENT

- **REQUEST PARAMEDIC INTERCEPT IF:**
  - Automatic Request for ALS response.

### ALS TREATMENT

- Scene Size-up/Initial Assessment  
  - Focused History and Detailed Physical Exam
- Assess respiratory status, treat as indicated.  
- Oxygen therapy as indicated.  
- Cardiac monitor, 12-lead ECG, SpO2  
- Administer **ALBUTEROL 2.5mg diluted in 3ml NS** via nebulizer or 2 puffs MDI with spacer.  
  - Repeat up to 3 doses if symptoms persist.
- **EPINEPHRINE 0.3mg IM** only for patients in severe distress (a).  
  - Repeat in 10 minutes if symptoms persist.
- Establish IV access.
- **MEDCON CONTACT REQUIRED FOR:**
  - Any deviation from this protocol.
  - For transports over 20 minutes consider **METHYLEPREDNISOLONE 125mg IV**.
  - Consider **MAGNESIUM 2 GM** diluted and administered over 5-10 minutes.

### NOTE:

a. **Severe distress** - oxygen saturation less than 85%, unable to speak, signs of decreased level of consciousness
## BLS TREATMENT

Follow State Protocol for the treatment of Respiratory Emergencies

**REQUEST PARAMEDIC INTERCEPT IF:**
- Automatic Request for ALS response.

## ILS TREATMENT

Follow State Protocol for the treatment of Respiratory Emergencies.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Automatic Request for ALS response.

## ALS TREATMENT

**Scene Size-up/Initial Assessment**

Focused History and Detailed Physical Exam

Assess respiratory status, treat as indicated.

Oxygen therapy as indicated.

Cardiac monitor, 12-lead ECG as indicated, SpO2

Establish peripheral IV access. IV shall be established prior to the administration of **NITROGLYCERINE**.

Administer **NITROGLYCERIN 0.4mg SL** repeat every 5 minutes PRN. Maintain systolic BP greater than 100 systolic.

Administer **FUROSEMIDE 40mg Slow IVP** over 2-4 minutes. If patient is currently on Furosemide, administer **FUROSEMIDE 80mg Slow IVP** over 2 to 4. Maintain systolic BP greater than 100 systolic.

If patient does not have chest pain:
Administer **MORPHINE 2-4 mg IV** every 5 minutes to a maximum dose of 8 mg. Maintain systolic BP greater than 100 systolic.

**MEDCON CONTACT REQUIRED FOR:**
- Any deviation from this protocol.
- **DOPAMINE 5-20 mcg/kg/min** for hypotension in presence of CHF.
- Consider **NITROGLYCERIN drip at 5mcg/min** titrate to maintain systolic BP greater than 100mmHg. Maximum rate of **NITROGLYCERIN administration 20mcg/min**.

---

**NOTE:**

- CPAP if available.
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## NAME: Anaphylaxis/Allergic Reaction

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### BLS TREATMENT

Follow State protocol for Allergic Reaction/Anaphylaxis.

(a)(b) REQUEST PARAMEDIC INTERCEPT IF:
- Unconscious
- Not breathing
- Respiratory distress
- Swelling in throat or difficulty swallowing
- Unable to speak in full sentences
- Diaphoresis
- Syncope
- History of anaphylaxis
- Snake bite
- Swarm attack (bee, wasp, hornet)
- Condition worsening

### ILS TREATMENT

Follow State protocol for Allergic Reaction/Anaphylaxis.

REQUEST PARAMEDIC INTERCEPT IF:
- Any ILS skills performed
- MEDCON Orders

### ALS TREATMENT

Scene Size-up/Initial Assessment  
Focused History and Detailed Physical Exam

For severe distress, administer  
Adults: **EPINEPHRINE 1:10,000 0.3-0.5mg IM**, may repeat every 10 minutes.  
Peds: **EPINEPHRINE 1:10,000 0.01mg/kg IV or 1:1,000 0.1mg IM** may repeat every 10 minutes.

Consider immediate advanced airway procedures if obstructed, impending arrest or acute condition presents.

Cardiac monitor, 12-lead ECG, SpO2.  
Oxygen Therapy as indicated.

Establish IV access. Treat hypotension with fluid challenge.

Adults: **DIPHENHYDRAMINE 25-50mg IM/IV**  
Peds: **DIPHENHYDRAMINE 1mg/kg** (to a maximum of 100mg) IM/IV

Severe anaphylaxis, administer:  
Adults: **GLUCAGON 2-4mg IV/IO/IM**  
Peds: **GLUCAGON 1mg IV/IO/IM**

Treat other associated signs & symptoms per appropriate protocol.

MEDCON CONTACT REQUIRED FOR:
- Transports over 20-minutes in length, administer:  
  **METHYLPREDNISOLONE 125 mg IV**
- For persistent hypotension, administer **DOPAMINE 5-20mcg/kg/min continuous IV infusion** titrated to systolic BP of 100mmHg or greater.
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

NOTE:

a. Anaphylaxis is an extreme emergency since cardiac arrest can occur. Do not delay transport.
b. Administer Epinephrine in accordance with appropriate State Protocol.
c. EPINEPHRINE VIAL or AMPULE or EPI PEN.

da. ADULT ANAPHYLAXIS:
   i. Indication for drug administration: Vital signs, work of breathing, lung sounds, skin signs, and ability to speak.
   ii. Adult Does: 0.30 mg of 1:1,000
   iii. Scrub the skin vigorously with an alcohol wipe
   iv. Allow to air dry. (do not touch, blow on, or fan the injection site)
   v. Break open ampule, or, if using a vial, cleanse vile with alcohol wipe.
   vi. Insert the needle into the ampule or vial. Withdraw the appropriate volume of medication.
   vii. Fill to 0.1 ml more than the desired dose.
   viii. Hold the needle upright. Push any air bubbles and extra medication out of the syringe.
   ix. Broadly hold the muscle. Do not pinch the skin. Use Deltoid muscle for adult dose. Lateral thigh can also be used.
   x. Hold the syringe like a dart. Insert the needle with a quick stab at a 90° angle to the skin surface.
   xi. Depress the plunger with a slow, steady motion until the syringe is empty and the needle automatically retracts. Discard in sharps container.
   xii. Cover the puncture site with an adhesive bandage. Reassess your patient. Take vitals every 5 minutes.
   xiii. Prepare for transport by ALS.
   b. If patient’s vitals and signs/symptoms have not improved within 10 minutes; call MEDCON or incoming Medic Unit for permission to give a second equivalent dose.

d. PEDIATRICS: 0.15 mg of 1:1,000. The Anterolateral thigh is the best site for infants and children.
## GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

<table>
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<th>SECTION: Medical</th>
<th>PROTOCOL NO. 306</th>
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**NAME:** Seizures  
**EFFECTIVE DATE:** 5/14/2012  
**REVIEWED 11/1/2013**  
**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD

### BLS TREATMENT

Follow State protocol for Seizures. (c)

Check blood glucose per protocol. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious
- Not breathing or abnormal breathing
- Seizures > 5min
- Status Seizures
- First time seizures
- Diabetic
- Pregnant
- Cardiac history
- Secondary to legend drug use
- Secondary to recent head injury
- Seizure, unknown cause

### ILS TREATMENT

Follow State protocol for Seizures. (c)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

### ALS TREATMENT

**Scene Size-up/Initial Assessment**
**Focused History and Detailed Physical Exam (c)**

Assess respiratory status, treat as indicated.

ECG, SpO2  
Oxygen Therapy as indicated.

Establish IV access.

Check Blood glucose.

**VALIUM 2-10 mg IV/IM/IO/Rectal,** repeat as indicated (b)

or

**MIDAZOLAM 2.5-5.0 mg IV/IM/IO/IN,** repeat as indicated (b)

Treat other associated signs & symptoms per appropriate protocol.

**MEDCON CONTACT REQUIRED FOR:**
- Administration of MAGNESIUM.

### NOTE:

- Normal glucose levels are 60-120 mg/dl.
- Refer to Broslow tape for Pediatric dosage.
- Complete a detailed history, to include seizures, pregnancy, pre-eclampsia, diabetes, recent head trauma, drug abuse, etc.
This protocol includes all patients with Altered Mental Status, Unconscious, Syncope, Near Syncope and Unresponsive.

**BLS TREATMENT**

Follow State protocol for Altered Mental Status.

Check blood glucose per protocol. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious
- Not breathing or abnormal breathing
- Multiple syncope episodes in same day
- Combined drug and alcohol OD
- Respiratory distress
- Syncope associated with headache, CP or discomfort, palpitations, abdominal pain, GI/vaginal bleeding
- Single or near syncope episode and >35 years of age
- Alcohol intoxication < 17 years of age
- Obvious DOA, cold, stiff

**ILS TREATMENT**

Follow State protocol for Altered Mental Status and Coma.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

**ALS TREATMENT**

Scene Size-up/Initial Assessment
Focused History and Detailed Physical Exam

Assess respiratory status, treat per protocol.

ECG, 12-lead, SpO2.

Oxygen Therapy.

Establish IV access.

Check blood glucose, treat according to protocol. (a)

If suspected OD, treat according to appropriate protocol.

Treat other associated signs & symptoms per appropriate protocol.

**MEDCON CONTACT REQUIRED FOR:**
- Any deviation from this protocol.

**NOTE:**
- Normal glucose levels are 60-120 mg/dl.
## GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

### SECTION: Medical

**NAME:** Neurological Emergencies/CVA

| EFFECTIVE DATE: | 5/14/2012 |
| Reviewed | 11/1/2013 |

**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD

### BLS TREATMENT

Follow State protocol for Altered Mental Status.

Check blood glucose per protocol. (a)

### ILS TREATMENT

Follow State protocol for Neurological Emergencies.

### ALS TREATMENT

**Scene Size-up/Initial Assessment**

Focused History and Detailed Physical Exam

Assess respiratory status, treat as indicated.

ECG, obtain 12-lead, SpO2

Oxygen Therapy as indicated.

Establish IV access.

Check blood glucose, treat according to protocol.

Perform F.A.S.T. exam (also known as the Cincinnati Prehospital Stroke Scale + Time) (b)

Call receiving hospital with “Code Stroke Alert” as appropriate.

Treat other associated signs & symptoms per appropriate protocol.

### MEDCON CONTACT REQUIRED FOR:

- Consult MEDCON before treatment of hypertension, consider:
  - Consult with MEDCON for destination decision for facilities without CT availability.

### NOTE:

- Normal glucose levels are 60-120 mg/dl.
- Determine time of onset of symptoms if possible. Time is critical for intervention. Patients that have onset of symptoms < 3 hours should be immediately transported to a facility with CT capabilities.
# Diabetic Emergencies

**Effective Date:** 5/14/2012

**Approved By:** Dr. Jenarah Tekippe, GC MPD

## BLS Treatment

Follow State protocol for Diabetic Emergencies.

Check blood glucose per protocol. *(a)*

## ILS Treatment

Follow State protocol for Endocrinology Emergencies.

## ALS Treatment

Scene Size-up/Initial Assessment

Focused History and Detailed Physical Exam

Assess respiratory status, treat as indicated.

ECG, 12-lead if complaint of CP, SpO2

Oxygen Therapy as indicated.

Establish IV access.

Check blood glucose.

### Hypoglycemia Management: *(b)*

**Adult:**

**Dextrose 50% 25-50 Gm IV,** may repeat in 5 minutes if no change in patient condition.

**Glucagon 1mg IM** (for patients greater than 20 kg) *(c)*

**Peds:**

**Dextrose 25% 2ml/kg IV/IO over 2 minutes,** may repeat in 5 minutes if no change in patient condition.

**Glucagon 0.5mg IM** (for patients less than 20kg) *(c)*

### Hyperglycemia Management:

Patients displaying signs and symptoms of ketoacidosis, administer **Normal Saline at a rate of 500ml/hr,** monitor closely for signs of pulmonary congestion.

Treat other associated signs & symptoms per appropriate protocol.

## Medcon Contact Required For:

- Any deviation from this protocol.

### Note:

a. Normal glucose levels are 60-120 mg/dl.
b. Follow this management algorithm if glucose level is less than 60 mg/dl or patient is symptomatic.
c. Administer GLUCAGON only if IV access cannot be obtained.
d. Consider administration of Dextrose via NG Tube if unable to establish IV access or if above treatments are unsuccessful.
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

<table>
<thead>
<tr>
<th>SECTION: Medical</th>
<th>PROTOCOL NO. 310</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME: Abdominal Pain (non-traumatic)</td>
<td></td>
</tr>
</tbody>
</table>

| EFFECTIVE DATE: Reviewed 5/14/2012 | APPROVED BY: Dr. Jenarah Tekippe, GC MPD |

**BLS TREATMENT**

Follow State protocol for General Medical Assessment.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress
- Vomiting red blood
- Black, tarry stools
- Lower abdominal pain, women age 12-50 with dizziness, syncope, or heavy vaginal bleeding
- Abdominal/back pain with syncope or near syncope when sitting
- Orthostatic changes >30 SBP and/or >than 30 BPM.

**ILS TREATMENT**

Follow State protocol for General Orders.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

**ALS TREATMENT**

Scene Size-up/Initial Assessment
Focused History and Detailed Physical Exam (a)(b)

Assess respiratory status, treat as indicated.

ECG, SpO2, Oxygen Therapy as indicated.

Establish IV access.

If patient shows signs of hypovolemic shock, fluid bolus.

Provide pain control per protocol.

Treat other associated signs & symptoms per appropriate protocol.

**MEDCON CONTACT REQUIRED FOR:**
- 

**NOTE:**

a. Abdominal pain may be the first sign of an impending rupture of the appendix, liver, spleen, ectopic pregnancy or aneurysm. Monitor for signs of hypovolemic shock.

b. If pulsating mass is felt, suspect abdominal aortic aneurysm and discontinue palpation. Transport immediately.
## BLS Treatment

Follow State protocol for Poisoning/Overdose.

Check blood glucose per protocol.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress
- Altered Mental Status
- Intentional/Accidental with prescription medications
- Difficulty swallowing
- Combined alcohol and drug overdose
- Chest Pain or Seizures

## ILS Treatment

Follow State protocol for Toxicology.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

## ALS Treatment
<table>
<thead>
<tr>
<th>Scene Size-up/Initial Assessment</th>
<th>MEDCON CONTACT REQUIRED FOR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focused History and Detailed Physical Exam</td>
<td>• Contact MEDCON as soon as possible to assist in identification and specific management of the poisoning.</td>
</tr>
<tr>
<td>Consider immediate advanced airway procedures if obstructed, impending arrest or acute condition presents.</td>
<td></td>
</tr>
<tr>
<td>ECG, SpO2, Oxygen Therapy as indicated.</td>
<td></td>
</tr>
<tr>
<td>Establish IV access.</td>
<td></td>
</tr>
<tr>
<td>Check blood glucose. Treat as indicated, per protocol.</td>
<td></td>
</tr>
<tr>
<td>Identify chemical or substance, reference DOT Emergency Response Handbook for specific immediate interventions/guidelines with HAZMAT incidents or contact Poison Control at 1-800-732-6985.</td>
<td></td>
</tr>
<tr>
<td>Do not delay transport of patients with acute symptoms. Complete DECON procedures and transport immediately.</td>
<td></td>
</tr>
</tbody>
</table>

**EXTERNAL CONTAMINATION:**
Provide appropriate DECON procedures.

**INHALATION CONTAMINATION:**
Patient should be removed from area of toxic substance. Provide appropriate DECON procedures. Treat dyspnea according to protocol.

**INGESTED SUBSTANCE:**
Provide immediate airway management per protocol. Contact MEDCON for further guidance.

Treat all signs and symptoms according to specific protocols.
## GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

<table>
<thead>
<tr>
<th>SECTION: Medical</th>
<th>PROTOCOL NO. 312</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME: Overdose</td>
<td></td>
</tr>
</tbody>
</table>

**EFFECTIVE DATE:**
- Reviewed 11/1/2013
- 5/14/2012 APPROVED BY: Dr. Jenarah Tekippe, GC MPD

### BLS TREATMENT

Follow State protocol for Poisoning/Overdose.

Check blood glucose per protocol. *(a)*

### ILS TREATMENT

Follow State protocol for Toxicology.

### ALS TREATMENT

- **Scene Size-up/Initial Assessment**
  - Focused History and Detailed Physical Exam

- Assess respiratory status, treat as indicated.
  - *(Consider an advanced airway procedure ONLY if patient does not respond to NARCAN).*

- Cardiac Monitor, 12-lead ECG, SpO2.

- Oxygen Therapy as indicated.

- Establish IV access. Fluid bolus with **NS 500mL to 1000mL** as indicated.

- Check blood glucose. Treat as indicated, per protocol. *(a)*

- Treat specific overdoses according to specific protocol.

- Treat other associated signs & symptoms per appropriate protocol.

### MEDCON CONTACT REQUIRED FOR:

- **Any deviation from protocol.**

### MEDCON CONTACT REQUIRED FOR:

- **Any deviation from protocol.**

### REQUEST PARAMEDIC INTERCEPT IF:

- Unconscious/not breathing
- Respiratory distress
- Altered Mental Status
- Intentional/Accidental with prescription medications
- Difficulty swallowing
- Combined alcohol and drug overdose
- Chest Pain
- Seizures

### NOTE:

- Normal glucose levels are 60-120 mg/dl.
- Bring associated pill bottles to ED if possible.
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

<table>
<thead>
<tr>
<th>SECTION:</th>
<th>Medical</th>
<th>PROTOCOL NO.</th>
<th>313</th>
</tr>
</thead>
</table>

## NAME: Opioid Overdose

### EFFECTIVE DATE:
- Reviewed 11/1/2013
- 5/14/2012 Approved by Dr. Jenarah Tekippe, GC MPD

---

## BLS TREATMENT

Follow State protocol for Poisoning/Overdose.

Check blood glucose per protocol. (a)

### REQUEST PARAMEDIC INTERCEPT IF:
- Unconscious/not breathing
- Respiratory distress
- Altered Mental Status
- Intentional/Accidental with prescription medications
- Difficulty swallowing
- Combined alcohol and drug overdose
- Chest Pain
- Seizures

---

## ILS TREATMENT

Follow State protocol for Toxicology.

### REQUEST PARAMEDIC INTERCEPT IF:
- Any ILS skills performed
- MEDCON Orders

---

## ALS TREATMENT

Scene Size-up/Initial Assessment

Focused History and Detailed Physical Exam (b)

Assess respiratory status, treat as indicated.
(Consider an advanced airway procedure ONLY if patient does not respond to **NARCAN**).

Cardiac Monitor, 12-lead ECG, SpO2.

Oxygen Therapy as indicated.

Establish IV access.

Check blood glucose. Treat as indicated, per protocol. (a)

Administer for suspected opioid overdose **NARCAN 0.4 - 2.0mg IV/IM/IO** in 0.4 mg increments to maintain a respiratory rate of 12/min.

### MEDCON CONTACT REQUIRED FOR:
- Escalating doses of **NARCAN**.
- Any deviation from this protocol.

---

### NOTE:

- Normal glucose levels are 60-120 mg/dl.
- Bring associated pill bottles to ED if possible.
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## Tricyclic Antidepressant (TCA) Overdose

<table>
<thead>
<tr>
<th>SECTION: Medical</th>
<th>PROTOCOL NO. 314</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME:</td>
<td>Tricyclic Antidepressant (TCA) Overdose</td>
</tr>
<tr>
<td>EFFECTIVE DATE:</td>
<td>Reviewed 11/1/2013 5/14/2012</td>
</tr>
<tr>
<td>APPROVED BY:</td>
<td>Dr. Jenarah Tekippe, GC MPD</td>
</tr>
</tbody>
</table>

### BLS TREATMENT

Follow State protocol for Poisoning/Overdose. (c)

Check blood glucose per protocol. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress
- Altered Mental Status
- Intentional/Accidental with prescription medications
- Difficulty swallowing
- Combined alcohol and drug overdose
- Chest Pain
- Seizures

### ILS TREATMENT

Follow State protocol for Toxicology.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

### ALS TREATMENT

**MEDCON CONTACT REQUIRED FOR:**
- Any deviation from this protocol

**Scene Size-up/Initial Assessment (c)**
- Focused History and Detailed Physical Exam (b)

Assess respiratory status, treat as indicated.
(Consider immediate advanced airway procedures if obstructed, impending arrest or acute condition presents).

Cardiac monitor, 12-lead ECG, SpO2.

Oxygen Therapy as indicated.

Establish IV access. Fluid bolus with **NS 500mL to 1000mL** as indicated.

Administer **ACTIVATED CHARCOAL 50gm** orally to patients that have overdosed on oral medications and have a normal level of consciousness.

For symptomatic patients, administer **SODIUM BICARBONATE 1-2 meq/kg** over 1-2 minutes. If patient improves following administration, start continuous IV infusion of **SODIUM BICARBONATE** per formulary.

### NOTE:

- Normal blood glucose level range is 60-120 mg/dl.
- Obtain as accurate a history as possible, to include: What was taken? How much was taken? How was it taken? When was it taken? Why was it taken? What else was taken? If containers are available, bring to ED.
- Signs of TCA overdose: QRS widening and prolongation, ventricular dysrhythmias, hypotension, seizures, respiratory arrest.
d. Bring associated pill bottles to ED if possible.
### BLS TREATMENT

Follow State protocol for Poisoning/Overdose.

Check blood glucose per protocol. *(a)*

### ILS TREATMENT

Follow State protocol for Toxicology.

### ALS TREATMENT

Scene Size-up/Initial Assessment
Focused History and Detailed Physical Exam

Assess respiratory status, treat as indicated.
(Consider immediate advanced airway procedures if obstructed, impending arrest or acute condition presents).

Cardiac Monitor, 12-lead ECG, SpO2.

Oxygen therapy as indicated.

Check blood glucose, treat per protocol. *(a)*

Establish IV access. Fluid bolus with **NS 500mL to 1000mL** as indicated.

Administered **AMIODORONE 150 mg IV over 10 minutes** for treatment of ventricular arrhythmias.

Treat other associated signs & symptoms per appropriate protocol. *(b)*

### MEDCON CONTACT REQUIRED FOR:

- Any deviation from protocol.
- For suspected stimulants (sympathomimetic) ingestion/absorption, administer VALIUM 5mg IV repeat in 5 minutes if symptoms persist.

### NOTE:

- Normal blood glucose level range is 60-120 mg/dl.
- Refer to Chest Pain/AMI or Respiratory protocols as indicated.
- Bring associated pill bottles to ED if possible.
**GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL**

**SECTION:** Medical

**NAME:** Beta Blocker Overdose

**EFFECTIVE DATE: Reviewd 11/1/2013**

**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD

### BLS TREATMENT

Follow State protocol for Poisoning/Overdose.

Check blood glucose per protocol. *(a)*

----

### ILS TREATMENT

Follow State protocol for Toxicology.

----

### ALS TREATMENT

Scene Size-up/Initial Assessment
Focused History and Detailed Physical Exam

Assess respiratory status, treat as indicated. (Consider immediate advanced airway procedures if obstructed, impending arrest or acute condition presents).

Cardiac monitor, 12-lead ECG, SpO2.

Oxygen Therapy as indicated.

Administer **ACTIVATED CHARCOAL 50gm** orally to patients that have overdosed on oral medications and have a normal level of consciousness.

Establish IV access. Fluid bolus with **NS 500mL to 1000mL** as indicated.

If patient is hemodynamically unstable, administer **EPINEPHRINE drip 2-10 mcg/min** and **GLUCAGON 1 to 5 mg IV**.

Consider TCP if symptomatic bradycardia and is unresponsive to above treatments.

----

**NOTE:**

- Normal blood glucose level range is 60-120 mg/dl.
- Bring associated pill bottles to ED if possible.

**MEDCON CONTACT REQUIRED FOR:**

- Any deviation from this protocol.
- For increased rate of **EPINEPHRINE Drip**.
## BLS Treatment

Follow State protocol for Poisoning/Overdose.

Check blood glucose per protocol. *(a)*

### REQUEST PARAMEDIC INTERCEPT IF:
- Unconscious/not breathing
- Respiratory distress
- Altered Mental Status
- Intentional/Accidental with prescription medications
- Difficulty swallowing
- Combined alcohol and drug overdose
- Chest Pain
- Seizures

## ILS Treatment

Follow State protocol for Toxicology.

### REQUEST PARAMEDIC INTERCEPT IF:
- Any ILS skills performed
- MEDCON Orders

## ALS Treatment

**Scene Size-up/Initial Assessment**
Focused History and Detailed Physical Exam

Assess respiratory status, treat as indicated.
(Consider immediate advanced airway procedures if obstructed, impending arrest or acute condition presents).

Cardiac Monitor, 12-lead ECG, SpO2.

Oxygen Therapy as indicated.

Administer **ACTIVATED CHARCOAL 50gm** orally to patients that have overdosed on oral medications and have a normal level of consciousness.

Establish IV access. Fluid bolus with **NS 500mL to 1000mL** as indicated.

If patient presents with symptomatic bradycardia and with verification of the medication taken, administer **CALCIUM CHLORIDE 1gm IV**.

If patient is hemodynamically unstable, administer **EPINEPHRINE drip 2-10 mcg/min** and **GLUCAGON 1 to 5 mg IV**.

Consider TCP if symptomatic bradycardia and is unresponsive to above treatments.

### MEDCON CONTACT REQUIRED FOR:
- Any deviation from this protocol.
- For increased rate of **EPINEPHRINE Drip**.

---

**NOTE:**

a. Normal blood glucose level range is 60-120 mg/dl.
b. Bring associated pill bottles to ED if possible.
### GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

**SECTION:** Medical  
**NAME:** Cholinergic Overdose  
**EFFECTIVE DATE:** 5/14/2012  
**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD

#### BLS TREATMENT

Follow State protocol for Poisoning/Overdose.

Check blood glucose per protocol. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress
- Altered Mental Status
- Intentional/Accidental with prescription medications
- Difficulty swallowing
- Combined alcohol and drug overdose
- Chest Pain
- Seizures

#### ILS TREATMENT

Follow State protocol for Toxicology.

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

#### ALS TREATMENT

**Scene Size-up/Initial Assessment**  
Focused History and Detailed Physical Exam

Assess respiratory status, treat as indicated.  
(Consider immediate advanced airway procedures if obstructed, impending arrest or acute condition presents).

Cardiac monitor, 12-lead ECG, SpO2.

Oxygen Therapy as indicated.

Establish IV access. Fluid bolus with \textbf{NS 500mL to 1000mL} as indicated.

Check blood glucose. Treat as indicated, per protocol. (a)

For suspected Organophosphate Poisoning if patient is symptomatic, administer \textbf{ATROPINE 2mg IV} repeat every 5 minutes until HR is greater than 80 BPM or symptoms are resolved.

Administer \textbf{ACTIVATED CHARCOAL 50gm} orally to patients that have overdosed on oral medications and have a normal level of consciousness.

**MEDCON CONTACT REQUIRED FOR:**
- Escalating doses of Atropine in the case of ongoing symptomatic Organophosphate poisoning.

#### NOTE:

- Normal blood glucose level range is 60-120 mg/dl.
- Bring associated pill bottles to ED if possible.
## GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

### NAME: Anticholinergics

<table>
<thead>
<tr>
<th>EFFECTIVE DATE:</th>
<th>Reviewed 11/1/2013</th>
<th>APPROVED BY:</th>
<th>Dr. Jenarah Tekippe, GC MPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFFECTIVE DATE:</td>
<td>5/14/2012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BLS TREATMENT

Follow State protocol for Poisoning/Overdose.

Check blood glucose per protocol. *(a)*

### ILS TREATMENT

Follow State protocol for Toxicology.

### ALS TREATMENT

<table>
<thead>
<tr>
<th>Scene Size-up/Initial Assessment</th>
<th>MEDCON CONTACT REQUIRED FOR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focused History and Detailed Physical Exam</td>
<td>Any deviation from this protocol.</td>
</tr>
</tbody>
</table>

Assess respiratory status, treat as indicated.

(Consider immediate advanced airway procedures if obstructed, impending arrest or acute condition presents).

Cardiac monitor 12-lead ECG, SpO2.

Oxygen Therapy as indicated.

Establish IV access. Fluid bolus with **NS 500mL to 1000mL** as indicated.

Check blood glucose. Treat if indicated, per protocol. *(a)*

Administer **ACTIVATED CHARCOAL 50gm** orally to patients that have overdosed on oral medications and have a normal level of consciousness.

### NOTE:

a. Normal blood glucose level range is 60-120 mg/dl.

b. Bring associated pill bottles to ED if possible.
**GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL**

<table>
<thead>
<tr>
<th>SECTION: Medical</th>
<th>PROTOCOL NO. 320</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME: Cardiac Glycosides</td>
<td>5/14/2012</td>
</tr>
<tr>
<td>EFFECTIVE DATE: Reviewed 11/1/2013</td>
<td>APPROVED BY: Dr. Jenarah Tekippe, GC MPD</td>
</tr>
</tbody>
</table>

### BLS TREATMENT

Follow State protocol for Poisoning/Overdose.

Check blood glucose per protocol. \(a\)

### ILS TREATMENT

Follow State protocol for Toxicology.

### ALS TREATMENT

**Scene Size-up/Initial Assessment**
- Focused History and Detailed Physical Exam

Assess respiratory status, treat as indicated.
- (Consider immediate advanced airway procedures if obstructed, impending arrest or acute condition presents).

Cardiac monitor, 12-lead ECG, SpO2.

Oxygen Therapy as indicated.

Establish IV access. Fluid bolus with **NS 500mL to 1000mL** as indicated.

Check blood glucose. Treat as indicated, per protocol. \(a\)

Administer **ACTIVATED CHARCOAL 50gm orally ONLY** to patients that have overdosed on oral medications and have a normal level of consciousness.

### NOTE:

a. Normal blood glucose level range is 60-120 mg/dl.

b. Bring associated pill bottles to ED if possible.
**Behavioral Emergencies covers a wide variety of different mental health illness and issues, poses a danger to self, danger to others, gravely disabled, and including patients with delusions, hallucinations, depression, suicidal behavior and possible significant self-inflicted injuries. Remember that personal safety and safety of other providers takes priority over the treatment and management of these patients. Law Enforcement should be involved from the beginning of these types of emergencies.**

### BLS TREATMENT

- Follow State protocol for Behavioral Emergencies.
- Check blood glucose per protocol. (a)

### ILS TREATMENT

- Follow State protocol for Behavioral Emergencies.
- REQUEST PARAMEDIC INTERCEPT IF:
  - Unconscious/not breathing
  - Respiratory distress
  - Altered Mental Status
  - Suicidal
  - Self inflicted injuries

### ALS TREATMENT

- Scene Size-up/Initial Assessment
- Focused History and Detailed Physical Exam
- Assess respiratory status, treat as indicated.
- ECG, SpO2, Oxygen Therapy as indicated.
- Restrain patient as needed for safety. (b)
- For patients who are out of control, a danger to themselves or other persons, may be chemically restrained with HALOPERIDOL 5mg IM.
- Establish IV access.
- Check blood glucose. Treat as indicated, per protocol. (a)
- If medication is administered, ECG and supportive measures should be initiated to manage the patient. Be prepared to manage the airway per protocol.
- Treat other associated signs & symptoms per appropriate protocol.

### MEDCON CONTACT REQUIRED FOR:

- Repeat HALOPERIDOL.
- Request for other sedative medications such as MIDAZOLAM or VALIUM.

### NOTE:

- Normal blood glucose level range is 60-120 mg/dl.
- If restraining the patient is not possible or the pre-hospital care provider feels they are in danger, they should withdraw from patient contact until scene safety can be established.
For any trauma patient, the goal is to minimize the time from the injury to definitive treatment and utilize only those pre-hospital treatments which will increase the patient’s probability for an improved outcome. Field trauma resuscitation should be primarily performed en-route to the hospital. Reduction of the pre-hospital time is the most important intervention for the injured patient and will have the greatest impact on the patient’s outcome.

This protocol is intended to cover general trauma and treatment guidelines to deal with patients that are not covered by a specific protocol, but have a mechanism of injury that indicates transport to the hospital.

### BLS TREATMENT

Follow State protocol for Trauma Injuries. (b)

Check blood glucose per protocol. (a)

### ILS TREATMENT

Follow State protocol for Trauma Injuries. (b)

### ALS TREATMENT

Scene Size-up/Initial Assessment

Focused History and Detailed Physical Exam (b)

Assess respiratory status, treat as indicated.

ECG, SpO2, Oxygen Therapy as indicated.

C-spine and immobilize patient as indicated.

Initiate transport to facility prior to establishing IV access, unless airway is compromised or patient is entrapped.

Establish large-bore IV access.

Check blood glucose. Treat as indicated, per protocol. (a)

Treat other associated signs & symptoms per appropriate protocol.

### MEDCON CONTACT REQUIRED FOR:

- Activate Pre-hospital Trauma System as indicated.
- Contact MEDCON as required by WA State Trauma Triage (Destination) Procedure.

### REQUEST PARAMEDIC INTERCEPT IF:

- Unconscious/not breathing
- Respiratory distress
- Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities.
- Altered Mental Status
- Uncontrolled bleeding
- Seizures secondary to head injury

### NOTE:

- Normal glucose range level 60-120 mg/dl.
- All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.
The leading cause of death in persons up to age 44 years in the United States is trauma, and head injury accounts for approximately half of the deaths related to trauma. The mortality rate from severe head injury is approximately 35 percent, and functional recovery occurs in only 40 to 50 percent of patients with severe head injury.

### BLS TREATMENT

Follow State protocol for Head and Spine Injuries. (b)

Check blood glucose per protocol. (a)

### ILS TREATMENT

Follow State protocol for Head and Spine injuries. (b)

### ALS TREATMENT

Scene Size-up/Initial Assessment

Focused History and Detailed Physical Exam (b)

Consider early advanced airway management in patients presenting with compromise, ALOC and GCS < 8. Intubate following protocol. (c)

ECG, SpO2, EtCO2 monitoring if available, Oxygen Therapy as indicated.

C-spine and immobilize patient as indicated.

Establish large-bore IV. Establish second IV as indicated. (d)

Check blood glucose. Treat as indicated, per protocol. (e)

Treat other associated signs & symptoms per appropriate protocol.

### REQUEST PARAMEDIC INTERCEPT IF:

- Unconscious/not breathing
- Respiratory distress
- Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities.
- Altered Mental Status
- Uncontrolled bleeding
- Patient displaying signs of neurological deficits.
- Seizures secondary to head injury

### MEDCON CONTACT REQUIRED FOR:

- Activate Pre-hospital Trauma System as needed.
- Contact MEDCON as required by WA State Trauma Triage (Destination) Procedure.

### NOTE:

a. Normal glucose levels are 60-120 mg/dl.
b. All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.
c. Patient should be ventilated according to SpO2, ETCO2 between 35-45.
d. Do not over bolus patient with isolated head injuries as it will result in increased ICP.
Do not withhold DEXTROSE if patient has glucose less than 60 mg/dl.
# Neck and Spine Injuries

**BLS TREATMENT**

Follow State protocol for Head and Spine Injuries. *(b)*

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress
- Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities.
- Altered Mental Status
- Patient displaying signs of neurological deficits
- Falls associated dizziness, headache or diabetic problems
- Uncontrolled bleeding
- Seizures secondary to head injury

**ILS TREATMENT**

Follow State protocol for Head and Spine injuries. *(b)*

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

**ALS TREATMENT**

Scene Size-up/Initial Assessment

Focused History and Detailed Physical Exam *(b)*

Assess respiratory status, treat as indicated. *(Consider early advanced airway management in patients presenting with compromise, ALOC and GCS < 8. Intubate following RSI protocol).*

ECG, SpO2, Oxygen Therapy as indicated.

C-spine and immobilize patient as indicated.

Establish large-bore IV. Establish second IV as indicated.

Consider analgesics options for pain, per protocol.

Treat other associated signs & symptoms per appropriate protocol.

**MEDCON CONTACT REQUIRED FOR:**
- Activate Pre-hospital Trauma System as indicated.
- Contact MEDCON as required by WA State Trauma Triage (Destination) Procedure.
- In cases of spinal trauma with hypotension uncorrectable with fluid challenge, consider DOPAMINE 5-20 mcg/kg/min continuous IV infusion to maintain systolic BP > 100 mmHg.

**NOTE:**
- Normal glucose levels are 60-120 mg/dl.
- All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.
## BLS TREATMENT

Follow State protocol for Chest Injuries. *(a)*

### REQUEST PARAMEDIC INTERCEPT IF:
- Unconscious/not breathing
- Respiratory distress
- Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities.
- Altered Mental Status
- Patient displaying signs of neurological deficits
- Uncontrolled bleeding

## ILS TREATMENT

Follow State protocol for Chest injuries. *(a)*

### REQUEST PARAMEDIC INTERCEPT IF:
- Any ILS skills performed
- MEDCON Orders

## ALS TREATMENT

### Scene Size-up/Initial Assessment
Focused History and Detailed Physical Exam *(a)*

Assess respiratory status, treat as indicated. (Consider early advanced airway management in patients presenting with compromise, ALOC and GCS < 8. Intubate following RSI protocol).

ECG, SpO2, Oxygen Therapy as indicated.

C-spine and immobilize patient as indicated.

Establish large-bore IV. Establish second IV as indicated.

**Pneumothorax/Tension Pneumothorax:** *(b)*
If symptomatic, consider needle decompression per protocol.

**Sucking Chest Wound:** *(b)*
Treat with occlusive dressing, create flutter valve. Monitor closely for development of tension pneumothorax.

**Cardiac Tamponade:**
Assess for Beck’s Triad, distended neck veins, muffled heart sounds, pulsus paradoxus with blood pressure out of proportion with blood loss.

**Myocardial Contusion:**
If suspected, requires ECG monitoring and 12-lead, be prepared to treat various dysrhythmias according to cardiac protocols.

### MEDCON CONTACT REQUIRED FOR:
- Activate Pre-hospital Trauma System as indicated.
- Contact MEDCON as required by WA State Trauma Triage (Destination) Procedure.
CHEST INJURIES continued

<table>
<thead>
<tr>
<th>ALS TREATMENT</th>
<th>MEDCON CONTACT REQUIRED FOR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flail Chest/Fractures: (b)</td>
<td>• Activate Pre-hospital Trauma System as indicated.</td>
</tr>
<tr>
<td>Transport position of comfort, support respiratory as needed. Monitor for signs of developing pneumothorax</td>
<td>• Contact MEDCON as required by WA State Trauma Triage (Destination) Procedure.</td>
</tr>
<tr>
<td>Consider analgesics options for pain, per protocol.</td>
<td></td>
</tr>
<tr>
<td>Treat other associated signs &amp; symptoms per appropriate protocol.</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:**

a. All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.
b. Be prepared to provide aggressive airway management with these patients. If needle decompression is required, consider analgesic options.
**NAME:** Abdominal Injuries  
**EFFECTIVE DATE:** 5/14/2012  
**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD

### BLS TREATMENT
Follow State protocol for Abdominal Injuries. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress
- Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities.
- Altered Mental Status
- Patient displaying signs of neurological deficits
- Uncontrolled bleeding

### ILS TREATMENT
Follow State protocol for Abdominal injuries. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

### ALS TREATMENT
Scene Size-up/Initial Assessment  
Focused History and Detailed Physical Exam (a)(b)

Assess respiratory status, treat as indicated.  
(Consider early advanced airway management in patients presenting with compromise, ALOC and GCS < 8. Intubate following RSI protocol).

- Cardiac monitor, 12-lead ECG as indicated, SpO2.  
- Oxygen Therapy as indicated.

- C-spine and immobilize patient as indicated.

- Establish large-bore IV. Establish second IV as indicated.

- Treat nausea/vomiting according to protocol.

- Treat other associated signs & symptoms per appropriate protocol.

**MEDCON CONTACT REQUIRED FOR:**
- Activate Pre-hospital Trauma System as indicated.
- Contact MEDCON as required by WA State Trauma Triage (Destination) Procedure.

### NOTE:
- All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.
- Assessment of the abdomen includes both pelvis and lower chest. Injuries in these areas are commonly associated to injuries in other regions. Be cautious of internal bleeding in other regions from any penetrating injuries.
### BLS TREATMENT

Follow State protocol for Shock/bleeding control. (a)

- REQUEST PARAMEDIC INTERCEPT IF:
  - Unconscious/not breathing
  - Respiratory distress
  - Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities.
  - Altered Mental Status
  - Patient displaying signs of neurological deficits
  - Uncontrolled bleeding

### ILS TREATMENT

Follow State protocol for Shock/Bleeding control. (a)

- REQUEST PARAMEDIC INTERCEPT IF:
  - Any ILS skills performed
  - MEDCON Orders

### ALS TREATMENT

Scene Size-up/Initial Assessment

- Focused History and Detailed Physical Exam (a)(b)

- Assess respiratory status, treat as indicated.
  (Consider early advanced airway management in patients presenting with compromise, ALOC and GCS < 8. Intubate following RSI protocol).

- ECG, SpO2, Oxygen Therapy as indicated.

- Immediately control external bleeding. Direct pressure, elevation, pressure points, or tourniquet. If tourniquet is used, note time it is applied.

- C-spine and immobilize patient as indicated.

- Establish large-bore IV. Establish second IV as indicated. (Do not delay transport for IV’s).

- Treat other associated signs & symptoms per appropriate protocol.

- MEDCON CONTACT REQUIRED FOR:
  - Activate Pre-hospital Trauma System as indicated.
  - Contact MEDCON as required by WA State Trauma Triage (Destination) Procedure.

### NOTE:

a. All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.

b. Assessment of the abdomen includes both pelvis and lower chest. Injuries in these areas are commonly associated to injuries in other regions. Be cautious of internal bleeding in other regions from any penetrating injuries.
# Extremity Injuries

**Effective Date:** 5/14/2012

**Approved By:** Dr. Jenarah Tekippe, GC MPD

## BLS Treatment

Follow State protocol for Extremity Injuries. (a)

**Request Paramedic Intercept If:**
- Unconscious/not breathing
- Respiratory distress
- Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities.
- Altered Mental Status
- Patient displaying signs of neurological deficits
- Uncontrolled bleeding

## ILS Treatment

Follow State protocol for Extremity Injuries. (a)

**Request Paramedic Intercept If:**
- Any ILS skills performed
- MEDCON Orders

## ALS Treatment

**Scene Size-up/Initial Assessment**

Focused History and Detailed Physical Exam (a)

- Assess respiratory status, treat as indicated.
- ECG, SpO2, Oxygen Therapy as indicated.
- C-spine and immobilize patient as indicated.
- Establish large-bore IV. Establish second IV as indicated.
- Treat pain according to protocol.
- Treat nausea/vomiting according to protocol.
- Treat other associated signs & symptoms per appropriate protocol.

**Medcon Contact Required For:**
- Contact for additional analgesic options if more is indicated.
- Activate Pre-hospital Trauma System as indicated.
- Contact MEDCON as required by WA State Trauma Triage (Destination) Procedure.

## Note:

a. All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.
b. Remember extremity injuries are considered a distracting injury; completely assess the patient for other injuries.
Care for the Amputated part:
- Rinse part with normal saline to remove debris, wrap amputated part in gauze moistened with saline.
- Place teeth in container filled with saline, do not scrub.
- Place wrapped part in a plastic bag and seal with tape. Do not fill bag with fluid.
- Label with name, date, and time. Place bag in container filled with ice and water if available. Do not submerge bag or allow part to freeze. Transport amputated part with patient when possible.

### BLS Treatment

Follow State protocol for Amputations. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress
- Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities.
- Altered Mental Status
- Patient displaying signs of neurological deficits
- Uncontrolled bleeding

### ILS Treatment

Follow State protocol for Amputation injuries. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

### ALS Treatment

Scene Size-up/Initial Assessment
Focused History and Detailed Physical Exam (a)

Assess respiratory status, treat as indicated.

ECG, SpO2, Oxygen Therapy as indicated.

C-spine and immobilize patient as indicated.

Establish large-bore IV. Establish second IV as indicated.

Treat pain according to protocol.

Treat nausea/vomiting according to protocol.

Treat other associated signs & symptoms per appropriate protocol.

**MEDCON CONTACT REQUIRED FOR:**
- Contact for additional analgesic if indicated.
- Contact MEDCON as required by WA State Trauma Triage (Destination) Procedure if appropriate.

### NOTE:
- All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.
Keep patient warm at all times.

**Chemical on skin:**
- Remove contaminated clothing/jewelry and flood with water for 10 minutes; wash gently with soap and water rinse.
- If contaminate is powder brush off prior to washing
- Identify contaminate
- Wrap the disrobed patient in sterile burn sheets and or dressings. Remember to wrap limbs and digits separately so that burned tissue does not stick together.

**Chemical in eyes:**
- Flood eyes with saline or lukewarm water for 15 minutes
- Identify the contaminate

**Electrical burn**
- Be sure that the source is de-energized
- Be alert for cardiac arrest; follow AHA guidelines
- Be alert for possible spinal injury
- Identify the electrical contact points
- Establish time of electrical contact

Use the rule of 9's to determine % of body burned

### BLS TREATMENT

Follow State protocol for Burns/electrical Injuries. *(a)*

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress
- Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities.
- Altered Mental Status
- Patient displaying signs of neurological deficits
- Uncontrolled bleeding

### ILS TREATMENT

Follow State protocol for Burns/electrical injuries. *(a)*

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

### ALS TREATMENT

Scene Size-up/Initial Assessment
Focused History and Detailed Physical Exam *(a)*

Assess respiratory status, treat as indicated.
*(Consider early advanced airway management in patients presenting with compromise, ALOC and GCS < 8. Intubate following RSI protocol.)*

**MEDCON CONTACT REQUIRED FOR:**
- Contact for additional analgesic options as indicated.
- Activate Pre-hospital Trauma System as indicated.
## GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

| ECG, SpO2, Oxygen Therapy as indicated. | • Contact MEDCON as required by WA State Trauma Triage (Destination) Procedure. |
| C-spine and immobilize patient as needed. | |
| Establish large-bore IV. Establish second IV as needed. | |
| (b)(c) Treat pain according to protocol. | |
| Treat nausea/vomiting according to protocol. | |
| Treat other associated signs & symptoms per appropriate protocol. | |

**NOTE:**

- All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.
- **Parkland Burn Formula** unless patient is hypotensive; run at rate to titrate BP. Establish second IV if possible.
- **Parkland Burn Formula Adult:** 4 ml/kg x %BSA/24 hours. (1/2 amount over first 8 hours then ¼ amount each subsequent 8 hour period).
Diving Accidents

1. Victims should only be rescued from the water by appropriately trained personnel.
2. Hypothermia should be considered an aggravating factor in every aquatic accident victim and re-warming should be started.
3. If air embolism is suspected, transport in the head down left lateral decubitus position to prevent additional gas emboli from traveling to brain, if not contraindicated by other injuries.
4. Obtain a detailed history if possible, including: type of diving engaged in; the number, depth, bottom time, and surface interval between repetitive dives for the past 72 hours; in water decompression; site of dive and environmental conditions (temperature, and amount of surge); presence of pre-disposing factors; dive complications; pre and post dive activities; onset of symptoms.
5. Patient needs stabilization in ED first and definitive care to the nearest hyperbaric chamber.
6. Consider bringing dive buddy for history assessment.

**BLS Treatment**

Follow State Protocol for Trauma Injuries. (b)

Check blood glucose per protocol. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious
- Not breathing or abnormal breathing
- Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities
- Altered Mental Status
- Uncontrolled bleeding
- Seizures secondary to head injury

**ILS Treatment**

Follow State Protocol for Trauma Injuries (b)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS Skill is preformed
- MEDCON Orders

**ALS Treatment**

Scene Size-up/Initial Assessment

Focused History and Detailed Physical Exam (b)

Assess respiratory status.

ECG, SpO2, Oxygen Therapy as indicated.

C-spine, immobilize, LBB, package.

Establish large-bore IV access.

Check blood glucose. Treat as indicated, per protocol. (a)

Treat all patients according to AHA ACLS guidelines. Reference formulary and specific protocols for variations.

Treat other associated signs & symptoms per appropriate protocol.

**MEDCON CONTACT REQUIRED FOR:**
- Activation of Pre-hospital Trauma System per protocol.
- Any deviation from protocol.

**NOTE:**
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

a. Normal glucose range level 60-120 mg/dL.
b. All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## SECTION: Environmental

### NAME: Heat Emergencies

### EFFECTIVE DATE:
- Reviewed 11/1/2013
- 5/14/2012

### APPROVED BY:
Dr. Jenarah Tekippe, GC MPD

### GENERAL TREATMENT:
1. Remove patient from heat source and remove excessive clothing.
2. Place cold packs in groin and axilla and cover patient in cool wet sheets to start to cool patient.
3. If patient is alert and oriented: encourage slow oral fluid intake, if tolerated and medical control concurs.
4. High body temperature may cause seizures, particularly in pediatrics and patients with seizure disorders (see seizure protocol for treatment).

### BLS TREATMENT

Follow State protocol for Environmental Emergencies. (b)

Check blood glucose per protocol. (a)

### ILS TREATMENT

Follow State protocol for Environmental Emergencies. (b)

### ALS TREATMENT

Scene Size-up/Initial Assessment
- Focused History and Detailed Physical Exam (b)(c)
- Assess respiratory status, treat as indicated.
- ECG, SpO2, Oxygen Therapy as indicated.
- C-spine and immobilize patient as indicated.
- Establish large-bore IV access.
- Check blood glucose. Treat as indicated, per protocol. (a)
- Treat all patients according to AHA ACLS guidelines. Reference formulary and specific protocols for variations.
- Treat other associated signs & symptoms per appropriate protocol.

### MEDCON CONTACT REQUIRED FOR:
- Activation of Pre-hospital Trauma System per protocol.
- If patient is intubated.
- Any deviation from protocol.

### NOTE:
- Normal glucose range level 60-120 mg/dL.
- All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.
- Not all heat emergencies are environmental in nature. They may have infectious, neurological or pharmacological etiology.
# Cold Emergencies

**GENERAL TREATMENT:**
1. Remove all wet clothing and maintain patient in a warm, draft free environment.
2. Do not allow frost bitten extremity to thaw if there is any chance the limb may refreeze before evacuation complete.
3. If limb has started to thaw, do not allow patient to ambulate.
4. HANDLE ALL HYPOTHERMIC PATIENTS WITH CARE; rough handling may precipitate Ventricular Fibrillation.
5. Place heat packs in groin and axilla and cover with blankets to prevent further heat loss.
6. If patient is alert and oriented: encourage oral intake of warm fluids if tolerated and medical control concurs.
7. Trend temperatures rectally (if available).
8. CPR should NOT be initiated if: the chest is frozen/non-compliant or obvious lethal injury is present.
9. Check for pulse for extended period of time because hypothermic functional cardiac activity can be present, but difficult to detect due to cardiac causes (bradycardic, low blood pressure) or due to environmental factors (cold/numb fingers).
10. Chest compressions should NEVER be preformed in clinical signs of functional cardiac activity are present even if a pulse is not palpable under field conditions. This includes: any movement by patient, spontaneous respirations, responsiveness to positive pressure ventilations, organized rhythm on cardiac monitor, audible heart tones, or other signs of life.
11. Chest compressions should be done if functional cardiac activity is absent, if the victim looses a palpable pulse.

## BLS TREATMENT

Follow State Protocol for Hypothermia. (b)

Check blood glucose per protocol. (a)

## ILS TREATMENT

Follow State Protocol for Hypothermia. (b)

## ALS TREATMENT

Scene Size-up/Initial Assessment
Focused History and Detailed Physical Exam (b)

ECG, SpO2, Oxygen Therapy as indicated.
Assess respiratory status.

C-spine, immobilize, LBB, package.

Establish large-bore IV access; infuse warm IV fluids at

REQUEST PARAMEDIC INTERCEPT IF:
- Unconscious
- Not breathing or abnormal breathing
- Crushing, penetrating or significant blunt trauma to head, neck, chest, abdomen, and lower extremities
- Altered Mental Status
- Uncontrolled bleeding
- Seizures secondary to head injury

REQUEST PARAMEDIC INTERCEPT IF:
- Any ILS Skill is preformed
- MEDCON Orders

MEDCON CONTACT REQUIRED FOR:
- Any deviation from protocol.
**GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL**

| |  
|---|---|
| appropriate rate for BP. |  
| Check blood glucose. Treat as indicated, per protocol. (a) |  
| Treat all patients according to AHA ACLS guidelines. Reference formulary and specific protocols for variations. (c) |  
| Treat other associated signs & symptoms per appropriate protocol. |  

**NOTE:**

a. Normal glucose range level 60-120 mg/dL.

b. All trauma patients shall receive a GCS Score. Reference GCS Scale in Appendix.

c. Anti-dysrythmic medications require core temperature of >86°F to be effective. Further, as metabolism is slowed with hypothermia, anti-dysrythmics rapidly reach toxic levels. Do not give unless core temperature is >86°F.
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## SECTION: OB/GYN Emergencies

<table>
<thead>
<tr>
<th>NAME:</th>
<th><strong>Sexual Assault</strong></th>
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<table>
<thead>
<tr>
<th>EFFECTIVE DATE:</th>
<th>5/14/2012</th>
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<tbody>
<tr>
<td>Reviewed</td>
<td>11/1/2013</td>
</tr>
<tr>
<td>APPROVED BY:</td>
<td>Dr. Jenarah Tekippe, GC MPD</td>
</tr>
</tbody>
</table>

## BLS TREATMENT

Follow State protocol for OB/GYN Emergencies (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress
- Altered Mental Status
- Uncontrolled bleeding

## ILS TREATMENT

Follow State protocol for OB/GYN Emergencies (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

## ALS TREATMENT

**TREATMENT**

A. Treat the patient per medical/trauma protocol based upon assessment

B. Actions of the first persons on the scene may have a vital impact on the future psychological well being of the patient. Every effort should be made to relieve feelings of shame of guilt and treat the patient with a sense of dignity and professionalism. This will aid the patient on the road to recovery

C. Recognize that the victim’s body is part of the crime scene

1. Do not destroy stains on the victims clothing with scissors or alcohol

2. Wear gloves at **ALL** times

3. If the patient has changed clothes, and they are close at hand, retrieve and transport them with the patient. When possible use a paper bag for clothing

4. If you do not have paper bags in which to store all evidence, then **DO NOT TOUCH IT**. Leave in place and notify law enforcement so that they can collect it properly.

**MEDCON CONTACT REQUIRED FOR:**
- Any deviation from this protocol

## NOTE:

A. Keep questioning to a minimum. Focus on the information required for prehospital treatment of the patient. Specific details of the assault are **NOT** necessary in the field.

B. Keep the number of healthcare providers in contact with the patient and the crime scene to a minimum

C. Safety and treatment are the first priority

D. Approach victim in a gentle supportive manner

Approved by: Dr. Terry Murphy
E. Assure the victim of their safety

F. Speak softly avoiding any aggressive or forceful behavior

G. Minimize unwarranted attention and publicity. Protect the patient's privacy

H. If the victim is requesting a same sex provider, one should be provided if possible

I. If the patient is over the age of 18 and decides NOT to be transported to the hospital or report the incident, respect their decision and leave the patient with the following information:
   1. Phone numbers for available services
      a. Samaritan ER: 509-793-9730
      b. SANE Direct Line (M-F Hrs: 8-4): 509-667-3350
      c. Domestic Violence Help Line: 509-663-7446
   2. Patient care for sexual assault is billed to the state of Washington Crime Victims Fund.
   3. If the patient decides not to make a report even after they are seen at the hospital for the incident, their confidentiality is preserved. Sexual assault of an adult is NOT a reportable incident by healthcare providers. The patient must decide to make the report

J. All supplies and waste from your treatment on scene should be removed so as not to contaminate the crime scene. Designate one person to be in charge of ensuring that all remnants of your care leave with you.

Approved by: Dr. Terry Murphy
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## OB/GYN EMERGENCIES PROTOCOL NO. 602

**NAME:** Emergency Deliveries  
**EFFECTIVE DATE:** 5/14/2012  
**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD  
**REVIEWS:** 11/1/2013  
**APPROVED BY:**

### BLS TREATMENT

Follow State protocol for OB/GYN protocols. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress.
- Altered Mental Status
- Seizure activity
- Uncontrolled bleeding

### ILS TREATMENT

Follow State protocol for OB/GYN protocols (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Any ILS skills performed
- MEDCON Orders

### ALS TREATMENT

Scene Size-up/Initial Assessment  
Focused History and Detailed Physical Exam (a)(b)

SpO2  
Oxygen Therapy – NRB 15 LPM or BVM 100% O2.

### Treatment

A. Open OB kit, don sterile gloves, create sterile delivery Field

B. Consider O2 for patient

C. Consider requesting second medic unit

D. Establish IV access

E. Position the patient supine knees bent

F. Proceed with delivery (either on scene or enroute to hospital:
   1. Control delivery of head using gentle counter pressure with one hand and a sterile towel in other hand at the perineum. Gently wipe baby’s face. Suction the mouth first and then the nose with bulb syringe.
   2. As the neck is delivering, check for a nuchal cord. If present, gently loosen and slip over baby’s head. If unable to loosen, double clamp and cut cord
   3. If necessary, gently assist delivery of anterior shoulder by placing your hands on the side baby’s heads and exerting mild downward pressure. Then use a gentle upward motion to aid in delivery of the posterior shoulder. The rest of the body usually follows without difficulty. Do not exert traction to pull the baby from the birth canal.

**MEDCON CONTACT REQUIRED FOR:** Any deviation from this protocol
G. Once delivered hold the baby at or slightly below the level of the birth canal for 60 seconds prior to clamping the cord
H. Thoroughly suction the mouth, then nose
I. Dry and stimulate the baby with sterile towels and keep covered to prevent heat loss
J. Place clamps at 6 and 8 inches from baby’s abdomen and cut the cord between the clamps with sterile scissors
K. Place pink, vigorous baby on mother’s chest
L. Placental delivery: the placenta usually delivers spontaneously within 5-10 minutes after the baby. As the placenta passes through the birth canal, lift it away with both hands. Never exert traction on the cord to pull the placenta from the uterus. Place placenta in a plastic bag or other container and give to hospital personnel
M. If maternal bleeding is severe after placental delivery and the uterus does not feel firm, massage the uterine fundus by supporting the lower uterine segment with one hand just above the symphysis pubis, and massaging the uterus with the other hand.

**SECTION V TREATMENT PROTOCOLS: OB – GYN:**

**Specific precautions**

A. Be alert to complications such as presence of meconium, or baby appearing cyanotic, limp or depressed

B. **Shoulder Dystocia** occurs when an infant’s shoulders are larger than its head. This happens most commonly with diabetic and obese mothers
   1. Flex the mother’s legs and push toward her head
   2. Apply firm pressure with an open hand above symphysis pubis
   3. Do not pull on baby’s head

C. **Breech presentation:**
   1. **Buttocks and Double Footling Presentation:**
      a. Hold the mothers legs in a flexed position
      b. Support the infant’s legs as they deliver – **Do not pull on the legs**
      c. Allow baby to be delivered with contractions
      d. Continue to support the infant
      e. As the head passes the pubis, apply gentle upward traction until the mouth appears
      f. If the head is stuck support the infant throughout the transport and insert two fingers into the vaginal
      g. Transport immediately
      h. Notify the Receiving Hospital

   2. **Single limb Presentation:** Deliver of a single limb presentation must be accomplished at the hospital since Cesarean section usually is required
      a. Support the baby with your hands
      b. Provide an airway for the baby using your fingers
      c. Transport immediately – **Do not attempt delivery in the field.**

   3. **Prolapsed Cord:** If you see the umbilical cord in the vagina, presenting before the baby, initiate the
**GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL**

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>a.</td>
<td>Place the mother in the knee-chest position</td>
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<tr>
<td>b.</td>
<td>Check the umbilical cord for pulsation</td>
</tr>
<tr>
<td>c.</td>
<td>If there are no pulsations, you will need to press the presenting part of the fetus away from the umbilical cord, toward the mother's head. This will take the baby's weight off the cord.</td>
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<tr>
<td>d.</td>
<td>To do so: insert your hand into the vagina. Push the presenting part (usually the head) with the flat part of your fingers and palm. Use as much surface area of your fingers and palm as possible to distribute pressure across the baby's head. Avoid pushing with the tips of your fingers only</td>
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<tr>
<td>e.</td>
<td>Re-check the cord for pulsation</td>
</tr>
<tr>
<td>f.</td>
<td>Administer O2 to the mother</td>
</tr>
<tr>
<td>g.</td>
<td>Transport immediately. The fetus will die quickly without rapid intervention.</td>
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<tr>
<td>h.</td>
<td>Continue holding the presenting part of the baby away from the umbilical cord.</td>
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<tr>
<td>i.</td>
<td>Apply a moistened dressing on the exposed umbilical cord.</td>
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<tr>
<td>j.</td>
<td>Do not push the umbilical cord back into the vagina</td>
</tr>
</tbody>
</table>

**NOTE:**
## Postpartum Hemorrhage

### EFFECTIVE DATE:
5/14/2012

### APPROVED BY:
Dr. Jenarah Tekippe, GC MPD

### BLS TREATMENT

Follow State protocol for OB/GYN Emergencies. (a)

REQUEST PARAMEDIC INTERCEPT IF:
- Unconscious/not breathing
- Respiratory distress
- Altered Mental Status
- Uncontrolled bleeding

### ILS TREATMENT

Follow State protocol for OB/GYN Emergencies. (a)

REQUEST PARAMEDIC INTERCEPT IF:
- Any ILS skills performed
- MEDCON Orders

### ALS TREATMENT

**Treatment**

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>A.</td>
<td>Administer O2</td>
</tr>
<tr>
<td>B.</td>
<td>Establish venous access</td>
</tr>
<tr>
<td>C.</td>
<td>Consider cardiac monitor</td>
</tr>
<tr>
<td>D.</td>
<td>In the hypotensive patient give 20 - 40 cc/kg NS bolus and establish second IV</td>
</tr>
<tr>
<td>E.</td>
<td>In the immediate postpartum period, external uterine massage is indicated and/or have the mother attempt to nurse</td>
</tr>
</tbody>
</table>

**MEDCON CONTACT REQUIRED FOR:**
- Any deviation from this protocol

### NOTE:

A. Remember that some blood loss is normal post partum, but it should not continue to be active bleeding

B. Don’t forget about the newly delivered baby, which may need assistance as well. Calling for a backup unit may be necessary if both mother and infant require significant care

C. Postpartum hemorrhage that occurs more than 24 hours from delivery is likely from retained products of conception, rather than uterine atony or pelvic trauma. These are the patients that you will be called to after they have been discharged home

Approved by: Dr. Terry Murphy
### GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

**SECTION:** OB/GYN Emergencies  
**PROTOCOL NO.:** 604

**NAME:** Pre-Eclampsia and Eclampsia

<table>
<thead>
<tr>
<th>EFFECTIVE DATE</th>
<th>APPROVED BY</th>
<th>REVIEWED 11/1/2013</th>
<th>DR. JENARAH TEKIPPE, GC MPD</th>
</tr>
</thead>
</table>

### BLT TREATMENT

Follow State protocol for OB/GYN Emergencies. (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Respiratory distress.
- Altered Mental Status
- Uncontrolled bleeding

### ALS TREATMENT

A. Administer O2, assist airway and respiratory status as indicated.

B. Place patient in a position of comfort, semi left lateral recumbent

C. Recheck BP, with special attention to correct cuff size and placement

D. Establish venous access

E. For seizure activity:
   1. Suction as indicated
   2. Protect patient from injury
   3. For continued seizure activity:
      a. Infuse **Magnesium Sulfate** 6 gm IV over 20 minutes
      b. **Diazepam** 5-10 mg IV, IM or PR
   4. **Check pulse immediately after seizure stops**

F. Check blood glucose

G. Treat other associated signs and symptoms per protocol

H. Monitor cardiac rhythm and vital signs

**MEDCON CONTACT REQUIRED FOR:**
- Any deviation from this protocol

### NOTE:

A. Remember that a seemingly normal BP may in fact represent preeclampsia for certain patients
B. Remember that eclamptic seizures have been reported up to 1 month post delivery. Therefore seizures in a newly postpartum patient should be treated as eclamptic
C. Mix Magnesium Sulfate 6 gm in 50-100 cc NS and give over 20 minutes
D. Monitor BP very closely during magnesium infusion, and slow down infusion for significant drop in BP

Approved by: Dr. Terry Murphy
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

<table>
<thead>
<tr>
<th>SECTION: Pediatrics</th>
<th>PROTOCOL NO. 701</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME: Fever</td>
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</table>

**EFFECTIVE DATE:**
- Reviewed 11/1/2013
- 5/14/2012 APPROVED BY: Dr. Jenarah Tekippe, GC MPD

### BLS TREATMENT

Follow State protocol for Pediatrics - Fever. (c)
Check blood glucose per protocol. (a)

### ILS TREATMENT

Follow State protocol for Pediatrics. (c)

### ALS TREATMENT

Scene Size-up/Initial Assessment (c)
Focused History and Detailed Physical Exam
ECG, SpO2, Oxygen Therapy as indicated.
Assist respiratory status as indicated.
Establish IV access, as indicated.
Check blood glucose per protocol. (a)
Check temperature. (b)

If transport time is greater than 20 minutes, administer **ACETAMINOPHEN 15mg/kg PO** or with rectal suppository. (b)

Treat other associated signs & symptoms per appropriate protocol.

### MEDCON CONTACT REQUIRED FOR:
- Any deviation from this protocol.

### REQUEST PARAMEDIC INTERCEPT IF:
- Unconscious/not breathing
- Respiratory distress
- Altered Mental Status
- Seizures

- Any ILS skills performed
- MEDCON Orders

### NOTE:

- Normal glucose range level 60-120 mg/dl.
- Patient is considered to have a fever with temperatures at or greater than 100.5 degrees Fahrenheit (38 degrees Celsius).
- Fever is a common chief complaint of children encountered in the pre-hospital environment. It is important to recognize that a fever typically represents symptoms of an underlying illness or cause. Febrile Seizures typically occur once from a rapid rise in temperature, usually above 101.8 degrees Fahrenheit (38.8 degrees Celsius). If more than one seizure occurs, suspect causes other than fever. The first occurrence of a seizure warrants the most concern, because the benign nature of the illness has not been established.
**GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL**

<table>
<thead>
<tr>
<th>SECTION: Pediatrics</th>
<th>PROTOCOL NO. 702</th>
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<tr>
<td>NAME: Bronchospasms</td>
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**EFFECTIVE DATE:**
- Reviewed 11/1/2013
- 5/14/2012 APPROVED BY: Dr. Jenarah Tekippe, GC MPD

### BLS TREATMENT

Follow State protocol for Pediatric Assessment.
Follow State protocol for Respiratory Emergencies.
Check blood glucose per protocol. (a)

### ILS TREATMENT

Follow State Protocol for General Orders - Pediatric
Follow State protocol for Respiratory Emergencies

### ALS TREATMENT

Scene Size-up/Initial Assessment
Focused History and Detailed Physical Exam
Assess respiratory status, treat as indicated.
Oxygen therapy as needed.
Cardiac monitor, 12-lead ECG as indicated, SpO2

Administer **ALBUTEROL 2.5mg diluted in 3ml NS via nebulizer.** Repeat up to 3 doses if symptoms persist.

**EPINEPHRINE 1:1000 0.01 mg/kg to maximum 0.3mg IM**
only for patients in severe distress (b). Repeat in 10 minutes if symptoms persist.

Establish IV access.
Check blood glucose per protocol. (a)

Treat other associated signs & symptoms per appropriate protocol.

### MEDCON CONTACT REQUIRED FOR:
- Any deviation from this protocol.
- For pediatric RSI procedure.

### REQUEST PARAMEDIC INTERCEPT IF:
- Unconscious/not breathing
- Respiratory distress
- Altered Mental Status
- Seizures

### NOTE:
- **Normal glucose range level 60-120 mg/dl.**
- **Severe distress** - oxygen saturation less than 85%, unable to speak, signs of decreased level of consciousness, restlessness, or retractions.
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## NAME: Croup or Epiglottitis

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<thead>
<tr>
<th>SECTION</th>
<th>Pediatrics</th>
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<tbody>
<tr>
<td>PROTOCOL NO.</td>
<td>703</td>
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## BLS TREATMENT

Follow State protocol for Pediatric Assessment

Follow State protocol for Respiratory Emergencies (a)

## ILS TREATMENT

Follow State protocol for Respiratory Emergencies (a) (Epiglottitis – Pediatric Emergencies)

## ALS TREATMENT

### Scene Size-up/Initial Assessment

Focused History and Detailed Physical Exam (a)

Assess respiratory status, treat as indicated.

ECG, SpO2, Oxygen Therapy as indicated.

Assist respiratory status as indicated.

Humidified O2 via Nebulizer.

Establish IV access, as indicated.

Check blood glucose per protocol. (b)

Unable to ventilate attempt intubation with tube 1 size smaller than usual for age.

Treat other associated signs & symptoms per appropriate protocol.

### REQUEST PARAMEDIC INTERCEPT IF:

<table>
<thead>
<tr>
<th>Condition</th>
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</thead>
<tbody>
<tr>
<td>Unconscious / not breathing</td>
</tr>
<tr>
<td>ALOC</td>
</tr>
<tr>
<td>Respiratory Distress</td>
</tr>
<tr>
<td>Inhaled toxic substance</td>
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<tr>
<td>Unable to speak in full sentences</td>
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<tr>
<td>Drooling / difficulty swallowing</td>
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### MEDCON CONTACT REQUIRED FOR:

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<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>Any deviation from this protocol.</td>
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<tr>
<td>For pediatric RSI</td>
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<tr>
<td>Racemic Epinephrine via small volume nebulizer:</td>
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**Dosing:**

- Patient >2 years: 0.5 ml (2.25%) diluted in 3 ml NS
- Patient <2 years: 0.25 ml (2.25%) diluted in 3 ml NS

### NOTE:

- Transport patient as soon as possible – Procedures should be done en-route to hospital.
- Normal glucose range level 60-120 mg/dl.
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## NAME: Seizures (includes Febrile)

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</table>

### BLS TREATMENT
- Follow State Protocol for Pediatric Assessment
- Follow State Protocol for Altered Seizures
- Follow State Protocol for Febrile Seizures
- Check Blood glucose per protocol

### ILS TREATMENT
- ABC’s, Airway Management, Administer Oxygen,
- Establish Venous or Intraosseous Access
- Check blood glucose per protocol

### ALS TREATMENT
- Scene Size up / initial Assessment
- Focused History and Detailed Physical Exam
- EKG, SPO2
- Oxygen Therapy as indicated.
- Establish IV/IO Access as indicated.
- Check Blood Sugar

**Midazolam** 0.1 mg/kg IV/IO/Intra-Nasal for a maximum single dose of 4mg. May repeat once in 3-5 minutes.
If no IV/IO access may administer **Midazolam** 0.2 mg/kg IM for a maximum single dose of 4mg. May repeat once in 10-15 minutes.

Or

**Valium** 0.1 mg/kg IV/IO to a maximum of 0.3mg/kg repeat as indicated.
If no IV/IO access available may administer **Valium** 0.5mg/kg Rectally to a maximum of 10mg.

If Seizures continue, then give IV **Dextrose**
  a. <3 months, give **D10W** 2-4 cc/kg bolus
  b. >3 months, give **D25W** 2 cc/kg bolus

If patient is febrile initiate cooling measures including ice packs, removing any and all clothing

---

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Cardiac Arrest

**REQUEST PARAMEDIC INTERCEPT IF:**
- MEDCON Orders
- Cardiac Arrest
- Unconscious and or not breathing

**MEDCON Contact Required for:**
- Any Deviation from this Protocol
- Administration of Epinephrine or Dopamine
- Continuous IV infusion (Reference Formulary)
# Narrow Complex Tachycardia with Pulses

**BLS TREATMENT**

Follow State Protocol for Pediatric Assessment  
Follow State Protocol for Cardiovascular Emergencies  
Check Blood Glucose per Protocol (a)

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing  
- Seizures > 5 min  
- Status Seizures  
- First Time Seizure  
- Diabetic

**ILS TREATMENT**

ABC’s, Airway Management, Administer Oxygen,  
Establish Venous or Intraosseous Access

**REQUEST PARAMEDIC INTERCEPT IF:**
- MEDCON Orders

**ALS TREATMENT**

Scene Size up / Initial Assessment  
Focused History and Physical Exam  
Assess Respiratory Status, Treat as indicated.

Cardiac Monitor, 12-Lead ECG, SPO2  
Oxygen Therapy as indicated.

Check Blood Glucose and treat as indicated.

For Stable Patients:  
Perform Valsalva Maneuver

If no response to the Valsalva Maneuver –  
Administer Adenosine 0.1mg/kg Rapid IVP with 5ml NS Flush  
Max first dose of 6mg.

If no response after initial administration of Adenosine –  
Administer Adenosine 0.2mg/kg rapid IVP with 5ml NS Flush  
Maximum second dose of 12mg.

If unstable or refractory to above medications, perform  
Synchronized Cardioversion.  
Begin with 0.5 – 1 J/kg if not effective increase to 2j/kg

Consider Sedation prior to procedure:  
Midazolam 0.1 mg/kg IV/IO/Intra-Nasal in 3 to 5 ml NS.

Treat other associated signs and symptoms per appropriate protocol.

**MEDCON CONTACT REQUIRED FOR:**

Amiodarone (refractory to Valsalva Maneuver and or Adenosine  
5mg/kg over 20-60 minutes (max dose 300mg may repeat to maximum daily dose of 15mg/kg (2.2 in Adolescent)

**NOTE:**

a. Normal Glucose 60-120
b. SVT is a heart rate greater than 220/min for infants and 180/min for children.
c. Unstable SVT should have associated signs and symptoms: Altered Mental Status, Respiratory Distress, Difficulty Speaking, Chest pain, and/or Poor Perfusion
d. A Narrow QRS complex is less than 0.12 seconds in duration
e. Differentiating sinus tachycardia versus SVT in the pediatric patient can be difficult. The response to shock may drive the heart rate over 200 beats/min. In general rates over 230 are generally not sinus tachycardia. One should at least consider SVT when rates are over 200, though rates less than 200 can also be SVT. An early fluid bolus may bring down the heart rate, thus assisting in determining the origin of the tachycardia.
### GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

**SECTION:** Pediatrics  
**PROTOCOL NO.:** 706  
**NAME:** Bradycardia

<table>
<thead>
<tr>
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#### BLS TREATMENT
Follow State Protocol for Pediatric Assessment  
Follow State Protocol Altered Mental Status  
Check Blood glucose per protocol  

**REQUEST PARAMEDIC INTERCEPT IF:**  
- Unconscious/not breathing  
- Cardiac Arrest

#### ILS TREATMENT
ABC’s, Airway Management, Administer Oxygen,  
Establish Venous or Intraosseous Access  
Check blood glucose per protocol  

**REQUEST PARAMEDIC INTERCEPT IF:**  
- MEDCON Orders  
- Cardiac Arrest  
- Unconscious / not breathing

#### ALS TREATMENT
Scene Size up and Initial Assessment  
Focused History and Detailed Physical Exam  

Assess Respiratory Status – treat as indicated.  
Cardiac Monitor, 12-lead ECG, SP02.  
Oxygen Therapy as indicated.  
Establish IV/IO Access as indicated.  
Check Blood Sugar  
Start CPR if HR is less than 60 following treatment with high flow oxygen, ventilations and poor perfusion.  
Administer **Epinephrine** 0.01 mg/kg (0.1 ml/kg) of 1:10,000  
Repeat every 3-5 minutes as indicated.  
If increased vagal tone or primary AV block, administer **Atropine** 0.02 mg/kg IV/IO, minimum dose of 0.1mg and maximum single dose of 0.5mg  
Consider Transcutaneous Pacing (TCP) per AHA Guidelines

**MEDCON CONTACT REQUIRED FOR:**  
Any Deviation from this Protocol  
Contact MEDCON for:  
Administration of Epinephrine or Dopamine  
Continuous IV infusion (Reference Formulary)
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

**SECTION:** Pediatrics  
**PROTOCOL NO.:** 707

**NAME:** Neonatal Resuscitation

**EFFECTIVE DATE:**  
Reviewed 5/14/2012  
Approved 11/1/2013  
**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD

## BLS TREATMENT

Follow State Protocol for Pediatric Assessment  
Follow State Protocol Altered Mental Status  
Check Blood Sugar  
**REQUEST PARAMEDIC INTERCEPT IF:**  
- Unconscious/not breathing  
- Cardiac Arrest

## ILS TREATMENT

ABC’s, Airway Management, Administer Oxygen,  
Establish Venous or Intraosseous Access  
Check Blood Sugar  
**REQUEST PARAMEDIC INTERCEPT IF:**  
- MEDCON Orders  
- Cardiac Arrest  
- Unconscious / not breathing

## ALS TREATMENT

- Following delivery, manage airway  
- If particulate or thick meconium is present, Do Not Stimulate Babe, immediately suction with meconium aspirator and ETT until clear  
- Place in supine position and open / maintain airway  
- Provide warmth  
- Dry Baby  
- Tactile Stimulation of feet / back  
- If baby is breathing, HR > 100 with good color, provide observational care.  
- If breathing with HR >100 with central cyanosis, provide high flow blow by oxygen  
- If apneic or HR <100, provide 100% oxygen via BVM at 40-60 breaths/minute.  
- Intubate as indicated  
- If HR is <60 begin CPR 3:1 compressions: ventilation ratio until intubated  
- Cardiac Monitor  
- Establish IV / IO Access  
- **Administer Epinephrine**  
  IV/IO: (1:10,000) 0.01 mg/kg (0.1 ml/kg)  
  ET: (1:10,000) 0.1mg/kg (1 ml/kg)  
  Repeat every 3-5 minutes  
  For ET administration, follow with NS flush not to exceed 3 ml.  
- **Administer NS 10cc/kg IV bolus. Repeat as indicated.**  
- **Consider Narcan:**  
  If non addict mother has used narcotics within the past 4 hours consider Narcan dose of 0.1 mg/kg IV/IO.  
  If no response consider second dose of 0.1 mg/kg IV/IO. Max single dose of 2 mg.  
- **Sodium Bicarbonate 4.2% Solution**  
- **Dextrose**  
  If blood glucose is <60mg/dl, administer 1 gram/kg IV of D10W (10ml/kg).  
  Administer slowly over 20 minutes  
  May require dilution from D50 or D25  
- For prolonged resuscitation:
| 1-2 mEq/kg IV |
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## NAME:
**Altered Mental Status**

**EFFECTIVE DATE:** 5/14/2012

**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD

### BLS TREATMENT
- Follow State Protocol for Pediatric Assessment
- Follow State Protocol Altered Mental Status
- Check Blood Sugar
- Administer Oral Glucose as appropriate

**REQUEST PARAMEDIC INTERCEPT IF:**
- Unconscious/not breathing
- Cardiac Arrest

### ILS TREATMENT
- ABC’s, Airway Management, Administer Oxygen,
- Establish Venous or Intraosseous Access
- Check Blood Sugar

**REQUEST PARAMEDIC INTERCEPT IF:**
- MEDCON Orders
- Cardiac Arrest
- Unconscious / not breathing

### ALS TREATMENT
- Ensure patent Airway and Secure as indicated.
- Administer oxygen as indicated.
- Assist ventilations as indicated, consider endotracheal intubation as indicated.
- Establish venous access. As indicated, administer 20cc/kg NS Fluid Bolus.
- Monitor Cardiac Rhythm
- Obtain Blood sample, and if blood glucose is < 60 mg/dl administer glucose:
  1. If patient is < 3 months old: 2-4 cc/kg D10W IV
  2. If patient is > 3 months old: 2-4 cc/kg D25W IV
- If blood glucose is < 60mg/dl and unable to establish IV access:
  - Administer: Glucagon 0.1mg/kg up to 1mg IM
- Administer Narcan
  1. > 5 or > 20kg Administer Adult Dose
  2. <5 or < 20kg give 0.01 – 0.1mg/kg IVP Max 2mg

**MEDCON CONTACT REQUIRED FOR:**
- Contact MEDCON to consider additional interventions or termination of efforts.
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## SECTION: Pediatrics

### NAME: Pulseless Electrical Activity (PEA) or Asystole

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<th>EFFECTIVE DATE:</th>
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## BLS TREATMENT

- Follow State Protocol for Pediatric Assessment
- Follow State Protocol for Cardiac Arrest
- CPR as per AHA Guidelines

### REQUEST PARAMEDIC INTERCEPT IF:
- Unconscious/not breathing
- Cardiac Arrest

## ILS TREATMENT

- ABC’s, Airway Management, Administer Oxygen, Establish Venous or Intraosseous Access
- CPR as per AHA Guidelines

### REQUEST PARAMEDIC INTERCEPT IF:
- MEDCON Orders
- Cardiac Arrest
- Unconscious / not breathing

## ALS TREATMENT

- Scene Size up / Initial Assessment
- Focused History and Physical Exam
- Assess Respiratory Status, Treat as indicated.

### Pulseless Electrical Activity (PEA)
- Consider the Possible Causes:
  - Hypoxia – Check tube placement
  - Hypovolemia – IV/IO Fluid Bolus (20cc/kg NS)
  - Drug Overdose
  - Hypothermia
  - Acidosis – Ventilation / consider Sodium Bicarbonate
  - Tension Pneumothorax – Chest Decompression (per protocol)
  - Hyperkalemia – Calcium Chloride 0.2ml/kg
  - Cardiac Tamponade

- Administer **Epinephrine**
  - IV/IO: 0.01 mg/kg (1:10,000; 0.1ml/kg)
  - ET: 0.1 mg/kg (1:1000; 0.1ml/kg)

- If HR is < 60 Administer **Atropine Sulfate**
  - 0.02 mg/kg IV q 3-5minutes
  - Minimum dose 0.1mg; max = 1 mg

### Asystole
- Confirm rhythm in at least 2 different leads

- Administer **Epinephrine**
  - IV/IO: 0.01 mg/kg (1:10,000; 0.1 ml/kg)
  - ET: 0.1 mg/kg (1:1000; 0.1ml/kg)

- Continue CPR

- Repeat **Epinephrine** q 3-5 minutes

- If continued, re-confirm in at least 2 leads

## MEDCON CONTACT REQUIRED FOR:

- Contact MEDCON to consider additional interventions or termination of efforts.

## NOTE:
## Ventricular Fibrillation / Pulseless Ventricular Tachycardia

### BLS Treatment
- Follow State Protocol for Pediatric Assessment
- Follow State Protocol for Cardiac Arrest
- CPR as per AHA Guidelines
- Proper Utilization of the AED

### ILS Treatment
- ABC’s, Airway Management, Administer Oxygen,
- Establish Venous or Intraosseous Access
- CPR as per AHA Guidelines
- Proper utilization of the AED

### ALS Treatment
- Pulseless VT / VF
  - CPR while charging
  - Establish venous or IO access
  - Hyperventilate 100% FIO2
  - Endotracheal Intubation
  - Epinephrine
    - IV/IO: 0.01 mg/kg (1:10,000) or
    - ET: 0.1 mg/kg (1:1000)
    - Repeat every 3-5 minutes
  - Defibrillate: 4 j/kg
  - Amiodarone
    - IV/IO: 5 mg/kg
    - Max dose: 300mg
    - May repeat up to 3 times
  - OR
  - Lidocaine
    - IV/IO: 1 mg/kg
    - May repeat x1 @ 0.5 mg/kg
  - Defibrillate: 4 j/kg
  - Repeat Cycle as indicated.
  - Initiate Transport

### MEDCON Contact Required For:
- Contact MEDCON to consider additional interventions or termination of efforts.

### Note:
- Prolonged QT Syndrome may cause VT. Consider Magnesium Sulfate 25-50mg/kg IV/IO if rhythm is suspicious for torsades de pointes.
# GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

## SECTION: Pediatrics

### NAME: Wide Complex Tachycardia with Pulses

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### PRE-TREATMENT

**BLS TREATMENT**

1. **ABC’s, Airway Management, Administer 02**

### REQUEST PARAMEDIC INTERCEPT IF:

- Unconscious/not breathing
- Respiratory distress.
- Altered Mental Status
- Seizure activity
- Uncontrolled bleeding

**ILS TREATMENT**

1. **ABC’s, Airway Management, Administer Oxygen, Establish Venous or Intraosseous Access**

### REQUEST PARAMEDIC INTERCEPT IF:

- MEDCON Orders

**ALS TREATMENT**

1. **If patient is conscious, alert and without signs of poor perfusion.**

   - Administer:
     - Lidocaine: 1mg/kg IV/IO
     - Amiodarone: 5mg/kg IV/IO up to 300mg over 20 minutes

2. **If patient is unconscious, disoriented, and has signs of poor perfusion.**

   - Synchronize Cardioversion
     - Start at 0.5 J/kg
     - Lidocaine: 1mg/kg IV/IO push
     - Amiodarone: 5mg/kg IV/IO up to 300mg over 20 minutes

### MEDCON CONTACT REQUIRED FOR:

- Consider: Lidocaine Drip 0.02-0.05mg/min If greater than 10 minutes from receiving facility or if patient requires a second bolus.
- If rhythm persists consider Magnesium Sulfate 25-50mg/kg IV/10 over 5-10 minutes. (If polymorphic wave form)

### NOTE:

A. Though rare, cases of primary VT do occur in the pediatric population. A wide complex tachycardia in the pediatric patient should always be considered ventricular in origin since aberrancy is almost unheard of in this population.

B. A wide QRS complex is considered 0.12 seconds or more

C. For Synchronized Cardioversion consider versed 0.1-0.5 mg/kg

D. Do not delay transport to treat a stable rhythm.
The following Blood Glucose procedure is authorized for all levels of providers within Grant County. BLS providers should reference the appropriate patient care protocol for indicating when to obtain a blood glucose reading. ILS and ALS providers are provided the ability to obtain a blood glucose reading when ever it is necessary to assess a patient.

All agencies within Grant County that are licensed and use certified providers at the EMT-Basic level or higher have the option, unless required by RCW or WAC, to maintain blood glucose measuring equipment on their vehicles. Agencies that maintain blood glucose meters shall insure that they are regularly inspected and kept in compliance with the manufactures guidelines for the specific unit.

To insure that accurate readings are obtained, providers shall only use blood glucose meters that are provided by their respective agencies. The only exception is if there is not a meter available on the responding unit or it malfunctions, then the patients meter may be utilized.

Procedure:

1. Determine that a blood glucose reading is needed for the treatment of the patient (refer to protocols for BLS providers)

2. Prep the site, preferably a finger, with an alcohol or betadine prep to help reduce chances of infection.

3. Use a lancet device to obtain blood from the site (blood obtained from an IV start may be used as long as the glucose meter is capable of reading venous blood).

4. Apply blood to the glucose meter strip in accordance with manufacturer’s guidelines.

5. Treatment of the blood glucose reading and patient presentation should be in according with protocol. Normal range is 60 to 120.

6. Bandage the site with appropriate bandaging to aid in preventing infection.


8. Repeat this procedure as indicated.

Providers need to remember that testing a patient’s blood glucose is only a tool to aid in the treatment of patients. Clinical assessment of the patient and past medical history should be used as a primary means of determining the appropriate treatment plan for the patient.
Pain Management Protocol: Narcotic Administration

Specific information needed:
A. The use of this protocol is for pain management and is to be used when directed by another protocol “consider analgesia per protocol”
B. Some protocols (such as chest pain) specify that a particular narcotic is to be used and the dosing to be used is described in that protocol. This protocol does not apply to those situations.
C. When specifically directed to “consider narcotic analgesia per protocol”, the provider may:
   a. Choose to administer Morphine Sulfate or Fentanyl (rare exception in drug shortages, Dilaudid may be substituted. Refer to formulary for dosing).
   b. Once a particular narcotic is given, prior authorization from Medical Control must be obtained prior to switching to a different narcotic for treatment.
   c. A blood pressure must be taken and recorded prior to and within 5 minutes of every dose of narcotic medication.
   d. All patients will be placed on oxygen and continuous pulse oximetry and cardiac monitoring once they are given a narcotic analgesic.
   e. Any additional narcotic dosing above the limit specified, must be authorized by Medical Control.
   f. Consider 25 mg of Benadryl prior to first dose of Morphine for patients who state they have itching with this medication to reduce the histamine release associated with this medication.
D. Narcotic dosing*
   a. Morphine Sulfate
      i. Initially administer 0.1 mg/kg IV up to 10 mg. Consider 25 mg of Benadryl prior to first dose to prevent hypotension in patients that have a blood pressure <120 mmHg systolic (blocks histamine release and associated hypotension).
      ii. Further titration at 0.05 mg/kg (max 4 mg) can be given q10 minutes to a maximum total dose of 15 mg. Hold for systolic BP <100 mmHg. Contact medical control for any further dosing recommendations.
   b. Fentanyl
      i. Initially administer Fentanyl 1 mcg/kg IV push up to a max of 100 mcg. Consider 25 mg of Benadryl prior to first dose to prevent hypotension in patients with a systolic BP <120 mmHg.
      ii. Further titration at 0.5 mcg/kg (max 25 mcg) q5 minutes may be given to a total maximum of 200 mcg. Hold for systolic BP <100 mmHg. Contact medical control for any further dosing recommendations.

Special Precautions
A. *Elderly patients (>60 years old) are much more sensitive to narcotic analgesia and are also not able to metabolize narcotic medications very well, the cumulative effects such as sedation are much more pronounced and often delayed.
   a. **Use half dose of any narcotic medication in these patients.**
B. When providing interfacility transport where a patient has already received narcotic analgesia, do not use or start with the loading dose. Use the smaller titration dose only.
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

SECTION: Procedures

NAME: Pelvic Stabilization

EFFECTIVE DATE:
Reviewed 5/14/2012
11/1/2013

APPROVED BY: Dr. Jenarah Tekippe, GC MPD

Purpose
Fractures of the pelvic ring are associated with a mortality rate of up to 25%. The high rate of early mortality is mostly due to bleeding caused by the laceration of the vascular structures located in the presacral area. Early stabilization of pelvic fractures is the most effective intervention to limit hemorrhage by providing indirect tamponade. Also, stabilization decreases motion at the fracture site and prevents dislodgement of blood clots.

Indications
The pelvis should be palpated ONCE for stability. Tenderness with palpation is the most reliable sign of pelvic fracture. Since palpation can aggravate hemorrhage, however, this exam step should not be repeated. Palpation is accomplished by first gently applying lateral, and then medial, pressure to the iliac crest bilaterally. The hand is then moved to the symphysis pubis and gentle posterior pressure is exerted, again evaluating for pain and abnormal movement. Hemorrhage should be suspected if there is any evidence of instability, asymmetry, ecchymosis about the flank or pubis, scrotal hematoma, pain in the pelvic region/lower abdomen, or the patient had a mechanism of significant blunt trauma.

Procedure

Method 1: Stabilization using the KED
Slide the KED under the patient with the head support toward the feet. Firmly secure the straps around the waist and legs. Scoop the patient to a backboard. Secure patient with straps and elevate foot of backboard six to eight inches.

Method 2: Stabilization using a bed sheet
• Fold the bed sheet lengthwise four times so that you have one long piece approximately eight inches (8") in width.

• Slide the eight inch (8") end under the arch of the patient’s back, then pull it through the other side.

• Center the patient’s pelvis in the middle of the sheet. Cross either end of the sheet back over the patient. One crew member on each side should hold on to each end of the sheet and pull tightly.

• Twist each end twice. Tuck both ends underneath each side of the patient as far as possible, so that patient’s weight will secure them in place, or:

• Tie a square knot. Tuck the ends underneath the patient.

• Scoop the patient onto a backboard.

• Secure patient with straps and elevate foot of backboard six to eight inches.

NOTE:
a. If a KED or linen sheets are not available, a belt may be used as a last resort to secure the pelvis.
# ALS ONLY PROCEDURE

## Purpose

To relieve intra-thoracic pressure caused by tension pneumothorax.

## Indications

Patients maybe treated with this procedure if one or more of the following presents:

- Suspected Tension Pneumothorax
- Decreased breath sounds
- Tracheal shift
- Unequal chest wall expansion
- JVD
- Agitation
- Cyanosis
- Hypotension
- Tachycardia
- Subcutaneous Emphysema

## Procedure

1. High flow Oxygen, Assist ventilations as necessary, intubation as indicated.
2. Locate insertion site at second inter-costal space mid-clavicular line on effected side
3. Cleanse site with betadine.
4. Insert 10-16 Gauge IV catheter over the rib into the intercostals space. Use caution not to lacerate vessels or nerves running under the rib.
5. Advance needle until reaching the pleural space.
6. Place a one way valve onto the catheter if the patient is not receiving positive pressure ventilations.

## NOTE

a. Use a 20g. angiocatheter in case of infant or child with same landmarks described above.
**Adult – Rapid Sequence Intubation (RSI)**

**Indications for RSI**
- Respiratory Failure
- Airway Protection (e.g. unconscious, trauma, anaphylaxis)
- Consider Intubation if:
  1. SpO2 <90% despite therapy
  2. Respiratory rate <10 >29
  3. GCS <8, despite treatment

**Document the following:**
- Respiratory Status
- Lung Sounds
- 02 Saturation and ETCO2 as available
- Level of Consciousness
- Response to treatment
- Verification of ETT placement
- ETT Size
- ETT depth at teeth

**If Unable to Intubate, Consider:**
- Bag Valve Mask Ventilation
- Combitube
- Cricothyrotomy

**Steps:**
1. Pre-Oxygenate 100% Oxygen
2. Assist Ventilations
3. Monitor SpO2
4. Secure IV/IO access, Suction, Bag-valve mask, endotracheal
5. Pre-Oxygenate with 100% Oxygen
6. Bradycardic?
7. Atropine 0.5-1 mg IV
8. Etomidate 0.3mg/kg IVP/IO
9. Succinylcholine 1.5 – 2 mg/kg IVP/IO
10. Apply Cricoid Pressure
11. Intubate
12. Capnography (as available) or CO2 Detector Device
   2. Auscultate breath sounds.
   3. Listen over epigastrium.
   4. Monitor SpO2 (and ETCO2 as available).
14. *IF* Continued Paralysis or Prolonged Transport: Vecuronium (Norcuron) 0.1 mg/kg IV
15. Continued Sedation / Pain Control: Midazolam (Versed) 0.05 – 0.1mg/kg IV
   Fentanyl 0.5-1 mcg/kg IV max. dosage of 2 mcg/kg
16. Auscultate breath sounds FREQUENTLY

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① ETT: Have on hand, one size smaller and one size larger.
② Sedating dose: Note – Midazolam (Versed) 2-5mg IVP may be used if allergic to Etomidate (see next note)
③ Hypotension is a relative contraindication for the use of Midazolam (Versed).
④ Obtain history regarding allergies if possible. Do not administer if familial history of Malignant Hyperthermia.
The onset of Succinylcholine is 30-60 seconds; duration is 8-10 minutes. In cases where Succinylcholine is contraindicated, you may use Vecuronium 0.1 mg/kg IV push. Note that the onset of action of Vecuronium is 2-3 minutes, much longer than Succinylcholine, and the duration is approximately 45 minutes.

Vecuronium obliterates the ability to obtain a neurological exam for approx. 45 minutes. Use only if necessary.

Consider pain control measures (morphine, Fentanyl IV) if the patient was experiencing pain.
Indications:

- The unconscious patient with an unprotected airway.
- Failed Endotracheal Intubation

Contraindications:

- Intact gag reflex

Parameters:

- Small adult Combitube® - Four feet and above in height

Note: Recent studies have shown that the curvature of the small adult fits better in the adult patient regardless of the patient’s height.

Procedure:

- Pre-Oxygenate patient for 1-2 minutes via BVM.
- Check for gag reflex.
- Test both cuffs with syringes to assure cuffs a patent.
- Place some water-based lubricant to the distal portion of the tube.
- Check for and remove, if possible, any dentures/plates in the patient’s mouth.

Insertion:

- Position head in a neutral position and with gloved hand, move the tongue forward.
- Insert the Combitube® following the natural curvature of the airway. If significant resistance is encountered, remove the Combitube®, ventilate briefly and re-attempt.
- Insert the Combitube® until the patients teeth are positioned just above the highest black ring of the main tube (it will slide up when inflated to the center of the rings).
- Inflate the BLUE PILOT BALLOON with the amount of air listed on the balloon. This will inflate the proximal cuff. This will advance the tube a small distance out of the mouth.
- Inflate the WHITE PILOT BALLOON with the amount of air listed on the balloon. This will inflate the distal cuff.

Assess Placement:

- Attach the BVM to the Blue Tube and ventilate the patient.
- Expected tube placement is the esophagus. Esophageal placement will result in chest rise; positive lung sounds, and absent epigastric sounds when ventilated through the blue tube.
- Tracheal placement will result in epigastric sounds only and no lung sounds or chest rise. If this occurs, remove the BVM from the BLUE TUBE and attach it to the WHITE TUBE. If placed in the trachea, chest rise and lung sounds will now be noted.
- Placement should be reassessed every time the patient is moved.
• Check the inflation of both cuffs by squeezing the respective pilot balloons. The balloons should re-inflate quickly if you have adequate air in the cuffs. If the pilot balloons inflate slowly this is an indication that you do not have adequate air pressure in the cuff. If the pilot balloon is empty or does not re-inflate this is an indication of a leak in the cuff. Remove and replace with a new Combitube®.
• Immobilize head with C-collar.

Stomach Decompression

• Once esophageal placement of the tube is confirmed, place a French suction catheter down via the WHITE TUBE and evacuate air and/or stomach contents. Once this is accomplished the suction tube may be removed.

Combitube® Removal without ET Tube Placement

Indications:

• Return of gag reflex / regains consciousness

Procedure:

• Turn on suction device
• Deflate the proximal cuff by withdrawing the appropriate amount of air written on the BLUE PILOT BALLOON Tube.
• Turn the patient on his or her side and be prepared to suction.
• Deflate the distal cuff by withdrawing the appropriate amount of air written on the WHITE PILOT BALLOON Tube.
• Remove the Combitube® and suction as indicated.

No medication administration is allowed through Combitube®.
### GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

**SECTION:** Procedures

**NAME:** Pediatric – Rapid Sequence Intubation (RSI)

**EFFECTIVE DATE:** 5/14/2012

**APPROVED BY:** Dr. Jenarah Tekippe, GC MPD

### ALS PROCEDURE ONLY – CONTACT MEDCON FOR ORDERS.

- ABC’s
- Pre-oxygenate 100% Oxygen
- Assist Ventilations
- Monitor SpO2
- ECG

### Preparation

- Secure IV/IO access, suction, BVM device, Endotracheal Tube (reference Broslow tape)

### Pre-Oxygenate with 100% Oxygen

- Atropine 0.02 mg/kg IV (maximum: 1 mg)
- Etomidate 0.3 mg/kg
- Succinyllcholine 2 mg/kg IVP
- Apply Cricoid Pressure

### Intubate

- Verify ETT Placement
  - Auscultate breath sounds
  - Listen over epigastrium
  - Monitor SpO2

### Capnography (as available) or CO2 Detector Device

- Secure ET Tube
- *Apply C-Collar

### Continued Sedation and Pain Control

- Midazolam 0.1-0.2 mg/kg (max dose 4 mg)
- Fentanyl 0.1 mcg/kg

### Indications for RSI:

- Respiratory Failure
- Airway protection
- Unconsciousness
- Trauma
- Anaphylaxis
- SpO2 <90% despite Therapy
- Respiratory rate per age
- GCS < 8 despite treatment
- > 20 min transport time

### Document the following:

- Respiratory Status
- Lung Sounds
- SpO2
- ETCO2 as available
- Level of Consciousness
- Response to treatment
- Verification of ETT placement
- ETT Size
- ETT depth at teeth

### If unable to intubate, Consider:

- Assisted Ventilations with BVM
- Cricothyrotomy (Only if age > 12)
- Combitube and/or King LT (Only if >4 feet tall)
- Rapid Transport.

### Estimating Endotracheal Tube Size and Depth of Insertion

#### Tube Size

- Uncuffed ET Tube: \((\text{mm ID}) = (\text{age in years} / 4) + 4\)
- Cuffed ET Tube: \((\text{mm ID}) = (\text{age in years} / 4) + 3\)

#### Depth of Insertion

- Depth of Insertion: \((\text{cm}) \times (\text{age in years} / 2) + 12\)

During preparation for intubation, providers also should have ready at the bedside uncuffed ET Tubes 0.5mm smaller and larger than that estimated from the above formula.

**Continued Paralysis indicated:**

- Vecuronium 0.1-0.2 mg/kg

**Estimating Endotracheal Tube Size and Depth of Insertion**

**Tube Size**

- Uncuffed ET Tube: \((\text{mm ID}) = (\text{age in years} / 4) + 4\)
- Cuffed ET Tube: \((\text{mm ID}) = (\text{age in years} / 4) + 3\)

**Depth of Insertion**

- Depth of Insertion: \((\text{cm}) \times (\text{age in years} / 2) + 12\)
## NG or Oral Gastric Tube Insertion

### Purpose:
To prevent gastric distention and aspiration in pediatric and adult patients.

### Indications:
- To prevent gastric distention during prolonged BVM or Intubation.
- When gastric distention impedes ventilation in patients being ventilated by either BVM or endotracheal tube.
- In patients at risk of aspiration who are actively vomiting. (after Intubation)
- For the administration of activated charcoal, as indicated.
- When otherwise deemed appropriate by the base station physician.

### Contraindications:
- Recent Esophageal surgery.
- Presence of a percutaneous gastric tube.
- Orogastric intubation should be performed in lieu of nasogastric insertion in patients with severe facial trauma or in patients who have recently had nasopharyngeal surgery.
- Ingestion of Acidic Substance.
- Known liver disease or varices.

### Procedure:
1. Select the appropriate tube size:
   - Infant – 8 French (reference Broslow)
   - Child – 12 French
   - Adult – 14 or 16 French

2. Measure the tube from the patient’s mid abdomen, around their ear to the tip of the patient’s nose to determine the proper length of insertion.

3. Lubricate the tube and insert it directed posteriorly along the floor of the nose.

4. Confirm placement by injecting 5-20 ml of air into the stomach while auscultating over the left upper quadrant.

5. Secure the tube to the patients face with tape.
# ALS Procedure Only

## Purpose:
To establish immediate vascular access in the critically ill or injured adult or pediatric patient.

## Indications:
Adult and pediatric patients who are unable to be successfully intravenously cannulated in two (2) attempts and who need administration of medication/intravenous fluids (IV) for:
- Cardiac Arrest
- IMMEDIATE NEED for an intravenous medication or intravenous fluids for patients in extremis.

## Complications:
- Local infiltration of fluids and/or medications into the subcutaneous tissue from improper needle placement
- Possible fat or bone emboli
- Ostemyelitis may be found when device is left in over 24-hours

## Contraindications:
- Recent fracture of involved bone (fluid may extravasate into SQ tissue)
- Infection at the site selected for insertion
- Excessive tissue at insertion site with the absence of anatomical landmarks
- Previous significant orthopedic procedures in insertion area (prosthetics)
- Previous IO within 24 hours on that extremity
- Compromised extremity

## Procedure:
1. **USE BODY SUBSTANCE ISOLATION PRECAUTIONS**
2. Prepare site for IO Insertion
3. Prepare and assemble equipment in accordance with manufactures recommendations or use – this is dependant on IO System that you are using (EZ IO, B.I.G. IO or manual IO insertion device)
4. Locate appropriate site for insertion
   - 1st Choice: A non-traumatized proximal tibia
   - 2nd Choice: A non-traumatized humerus
   - 3rd Choice: A non-traumatized distal tibia
5. Position the patient so that the site is accessible
6. Prepare the insertion site using aseptic technique
7. Stabilize site and insert appropriate IO Device.
8. Flush the site after insertion with 10mL of normal saline in an adult (5mL in a pediatric or neonatal) via connection port/extension set tubing.
9. Administer medications using syringe or preload as appropriate.
10. Utilize pressure (pressure bag or infusion pump) for continuous IO infusions.
11. Dress site, secure tubing and monitor intraosseous site and patient condition.
NOTE:
If the adult patient complains of pain with infusion, administer 2 mL of 2% preservative free LIDOCAINE (20mg) via IO. If pediatric patients complain of pain, administer 0.5 mg/kg of 2% preservative free LIDOCAINE via IO.

**IO LINES WILL NOT BE ESTABLISHED AS PRECAUTIONARY ACCESS.**

All other uses of the IO route require a base station order.

The preferred site for infusion is a peripheral vein. Before an IO attempt is considered, it will be ascertained that the peripheral sites are not available and that no pre-existing central line access is available. This information will be documented on the PCR.

There will only be one attempt per extremity at establishing an IO infusion. No more than two (2) total attempts will be allowed for IO infusion. Scene times will not be delayed for IO infusion attempts. Generally, make one attempt at scene; second en-route. Any deviation from one attempt on scene must be documented as to the reason.
ALS PROCEDURE ONLY

**Purpose:**
The intranasal (IN) route is to be used as an optional route of medication administration.

**Indications:**
As indicated by protocol for the administration of Versed and Narcan.

**Contraindications:**
- Facial Trauma
- Epistaxis
- Nasal congestion or discharge
- Any recognized mucosal abnormality

**Relative Contraindication:**
- Recent use of vasoconstricting medications (e.g. antihistamines, cocaine, etc.)

**Procedure:**
1. USE BODY SUBSTANCE ISOLATION PRECAUTIONS
2. Draw up appropriate medication into a 1mL or 3mL luer-lock syringe.
3. Expel any remaining air from syringe.
4. Firmly attach atomizing device to syringe.
5. Briskly compress the syringe plunger to expel and atomize the medication.

Maximum of 1mL of medication per nostril for adults and 0.5mL per nostril for pediatrics should be administered.

Patient may be in any position for IN administration.
Continuous Positive Airway Pressure (CPAP)

Purpose:
To avoid intubation and the associated complications of intubation; and to improve oxygenation and ventilation in appropriate patients. CPAP also decreases work of breathing and improves functional reserve capacity.

Indications:
Patients in severe respiratory distress defined as increased respiratory effort, low oxygen saturation, inability to speak, and/or increased respiratory rate with severe congestive heart failure with acute pulmonary edema.

Contraindications:
- Pediatric patients (patients <34 kg or who fit within the limits of the Broselow tape)
- Respiratory or cardiac arrest
- Signs & symptoms of pneumothorax
- Major chest and/or facial trauma
- Vomiting
- Patients with Tracheostomy
- History of Pulmonary Fibrosis
- Hypotension
- Complications
- Tension pneumothorax
- Hypotension
- Aspiration

Relative Contraindication:
- Use with caution in patients that retain CO2
- If the patient’s blood pressure drops >20 mmHg systolic, reduce to 5cm valve. If patient’s condition continues to deteriorate discontinue CPAP.
- Monitor VS every five (5) minutes
- Monitor for signs of potential vomiting to prevent aspiration

Procedure:
1. Place patient in a position of comfort
2. Obtain baseline vital signs including oxygen saturation
3. Set up CPAP system according to manufacturer’s instructions. Start with 7.5 cm valve.
4. Explain procedure to patient and apply mask.
5. Continuously reevaluate patient and record vital signs every five (5) minutes
6. Administer medications per protocol as appropriate
7. Adjust oxygen flow rate, titrating oxygen to patient’s condition
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

8. Advise receiving hospital the patient is on CPAP
9. Discontinue use if patient’s condition worsens or the patient requires intubation
10. Reassurance and calm communication with the patient increases successful treatment with CPAP.
Facial Droop (have the patient show teeth or smile):

Normal – both sides of face move equally

Abnormal – one side of face does not move as well as the other side

Arm Drift (patient closes eyes and extends both arms straight out, with palms up for 10 seconds):

Normal – both arms move the same or both arms do not move at all (other findings, such as pronator drift, may be helpful)

Abnormal – one arm does not move or one arm drifts down compared with the other.

Speech (have the patient say “you can’t teach an old dog a new trick”):

Normal – patient uses correct words with no slurring

Abnormal – patient slurs words, uses the wrong words, or is unable to speak

Interpretation: If any 1 of these 3 signs is abnormal, the probability of a stroke is 72%.

Time: As the patient, family, or bystanders “the last time the patient was seen normal?”

Information in this section from the WA State Department of Health Prehospital Stroke Triage Procedures.3/17/2010
Facial Droop (have the patient show teeth or smile):

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Information in this section from the WA State Department of Health Prehospital Stroke Triage Procedures. 3/17/2010
State of Washington
Prehospital Cardiac Triage Destination Procedure

Assess Applicability for Triage
☐ Post cardiac arrest with ROSC
☐ ≥ 21 years of age with symptoms lasting more than 10 minutes but less than 12 hours suspected to be caused by coronary artery disease:
  - Chest discomfort (pressure, crushing pain, tightness, heaviness, cramping, burning, aching sensation), usually in the center of the chest lasting more than a few minutes, or that goes away and comes back.
  - Pain or discomfort in 1 or both arms, neck, jaws, shoulders, or back.
  - Shortness of breath with or without chest discomfort.
  - Epigastric (stomach) discomfort, such as unexplained indigestion, belching, or pain.
  - Other symptoms may include sweating, nausea/vomiting, lightheadedness.

NOTE: Women, diabetics, and geriatric patients might not have chest discomfort or pain. Instead they might have nausea/vomiting, back or jaw pain, fatigue/weakness, or generalized complaints.

Assess Immediate Criteria
☐ Post cardiac arrest with return of spontaneous circulation
☐ Hypotension or pulmonary edema
☐ EKG positive for STEMI (if available)

Assess Transport Time and Determine Destination by Level of Prehospital Care

<table>
<thead>
<tr>
<th>BLS/ILS</th>
<th>ALS</th>
</tr>
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<tbody>
<tr>
<td>Level I Cardiac Hospital w/in 30 minutes</td>
<td>Level I Cardiac Hospital w/in 60 minutes</td>
</tr>
</tbody>
</table>

YES

Go to Level I Cardiac Hospital and alert destination hospital en route ASAP

NO

Level II Cardiac Hospital 30 minutes closer than Level I?

YES

Go to closest Level II Cardiac Hospital and alert destination hospital en route ASAP

NO

Go to Level I Cardiac Hospital and alert destination hospital en route ASAP

Assess High Risk Criteria
In addition to symptoms in Box 1, pt. has 4 or more of the following:
☐ Age ≥ 55
☐ 3 or more CAD risk factors:
  - family history
  - high blood pressure
  - high cholesterol
  - diabetes
  - current smoker
☐ Aspirin use in last 7 days
☐ ≥2 anginal events in last 24 hours, including current episode
☐ Known coronary disease
☐ ST deviation ≥ 0.5 (if available)
☐ Elevated cardiac markers (if available)

If EMS personnel still suspect an acute coronary event, contact medical control for destination. If not, transport per regional patient care procedures.

Unstable patients (life-threatening arrhythmias, severe respiratory distress, shock) unresponsive to EMS treatment should be taken to the closest hospital.

* Slight modifications to the transport times may be made in county operating procedures. See page 2. Consider ALS and air transport for all transports greater than 30 minutes.
If there are two or more Level I facilities to choose from within the transport timeframe, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in determining destination. This also applies if there are two or more Level II facilities to choose from.
State of Washington
Prehospital Cardiac Triage Destination Procedure

Why triage cardiac patients?
The faster a patient having a heart attack or who’s been resuscitated gets treatment, the less likely he or she will die or be permanently disabled. Patients with unstable angina and non-ST elevation acute coronary syndromes (UA/NSTE) are included in the triage procedure because they often need immediate specialized cardiac care. This triage procedure is intended to be part of a coordinated regional system of care that includes dispatch, EMS, and both Level I and Level II Cardiac Hospitals.

How do I use the Cardiac Triage Destination Procedure?
A. Assess applicability for triage – If a patient is post cardiac arrest with ROSC, or is over 21 and has any of the symptoms listed, the triage tool is applicable to the patient. Go to the “Assess Immediate Criteria” box. NOTE: Women, diabetics, and geriatric patients often have symptoms other than chest pain/discomfort so review all symptoms with the patient.
B. Assess immediate criteria – If the patient meets any one of these criteria, he or she is very likely experiencing a heart attack or other heart emergency needing immediate specialized cardiac care. Go to “Assess Transport Time and Determine Destination” box. If the patient does not meet immediate criteria, or you can’t do an ECG, go to the “Assess High Risk Criteria” box.
C. Assess high risk criteria – If, in addition to meeting criteria in box 1, the patient meets four or more of these high risk criteria, he or she is considered high risk for a heart attack or other heart emergency needing immediate specialized cardiac care. These criteria are based on the TIMI risk assessment for unstable angina/non-STEMI. If the patient does not meet the high risk criteria in this box, but you believe the patient is having an acute coronary event based on presentation and history, consult with medical control to determine appropriate destination. High risk criteria definitions:
- 3 or more CAD (coronary artery disease) risk factors:
  - Age ≥ 55: epidemiological data for WA show that incidence of heart attack increases at this age
  - Family history: father or brother with heart disease before 55, or mother or sister before 65
  - High blood pressure: ≥140/90, or patient/family report, or patient on blood pressure medication
  - High cholesterol: patient/family report or patient on cholesterol medication
  - Diabetes: patient/family report
  - Current smoker: patient/family report.
- Aspirin use in last 7 days: any aspirin use in last 7 days.
- ≥2 anginal events in last 24 hours: 2 or more episodes of symptoms described in box 1 of the triage tool, including the current event.
- Known coronary disease: history of angina, heart attack, cardiac arrest, congestive heart failure, balloon angioplasty, stent, or bypass surgery.
- ST deviation ≥ 0.5 mm (if available): ST depression ≥ 0.5 mm is significant; transient ST elevation ≥ 0.5 mm for < 20 minutes is treated as ST-segment depression and is high risk; ST elevation >1 mm for more than 20 minutes places these patients in the STEMI treatment category.
- Elevated cardiac markers (if available): CK-MB or Troponin I in the "high probability" range of the device used. Only definitely positive results should be used in triage decisions.
D. Determine destination – The general guideline is to take a patient meeting the triage criteria directly to a Level I Cardiac Hospital within reasonable transport times. For BLS, this is generally within 30 minutes transport time, and for ALS, generally 60 minutes transport time. See below for further guidance. Regional patient care procedures and county operating procedures may provide additional guidance.
E. Inform the hospital en route so staff can activate the cath lab and call in staff if necessary.

What if a Level I Cardiac Hospital is just a little farther down the road than a Level II?
You can make slight changes to the 30/60 minute timeframe. The benefits of opening an artery faster at a Level I can outweigh the extra transport time. To determine whether to transport beyond the 30 or 60 minutes, figure the difference in transport time between the Level I Cardiac Hospital and the Level II Cardiac Hospital. For BLS, if the difference is more than 30 minutes, go to the Level II Cardiac Hospital. For ALS, if the difference is more than 60 minutes, go to the level II Cardiac Hospital.

BLS examples: A) minutes to Level I minus minutes to Level II = 29: go to Level I
            B) Minutes to Level I minus minutes to Level II = 35: go to Level II

ALS examples: A) minutes to Level I minus minutes to Level II = 45: go to Level I
            B) Minutes to Level I minus minutes to Level II = 68: go to Level II

NOTE: We recommend ALS use a fibrinolytic checklist to determine if a patient is ineligible for fibrinolysis. If ineligible, transport to closest Level I hospital even if it’s greater than 60 minutes or rendezvous with air transport.

What if there are two or more Level I or II facilities to choose from?
If there are two or more of the same level facilities to choose from within the transport times, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in destination decision.
GRANT COUNTY PRE-HOSPITAL PATIENT CARE PROTOCOL

SECTION: Appendix
PROTOCOL NO. A4

NAME: General Transport Ventilator Guidelines

EFFECTIVE DATE: 11/01/2013
APPROVED BY: Dr. Nara Tekippe, GC MPD

General Information
Transport ventilator may be used for patients that are intubated and being transported between hospitals. They may also be used for emergent patients in the field where transport times are longer than 30 minutes. All ventilators should be used based on manufacturer’s specifications and each paramedic MUST have received training on the functioning and use of the specific ventilator. The following is only a general guideline.

Ventilator Setting Guidelines
The following settings should be used only when the patient has not been under a Doctor or Respiratory Therapist’s care. When at all possible, use identical settings if a patient has already been on a ventilator previously. (ie. Interfacility transport of a ventilated patient)

A. Rate: 14
B. Tidal Volume: 5-10 cc/kg of Ideal body weight (IBW = 50 kg + 2.3 kg for each inch over 5 feet in height)
C. FiO2 : 100%
D. PEEP: 5 cm H2O
E. Provide sedation AND analgesic as needed:
   i. Midazolam 2-4 mg IV every 5 minutes PRN agitation and SBP>100. Call Medical Control if more than 20 mg required.
   ii. Consider PRN Narcotic analgesic per Protocol.
   iii. IF THE PATIENT IS PARALYZED, MONITOR HEART RATE AS YOU CANNOT RELY ON MOVEMENT FOR SIGNS OF AGITATION
       1. Strongly consider sedation before paralysis during transport.
       2. Adequate sedation often obviates the need for paralysis!
       3. Consider soft restraints for safety with intubated patients.

Specific precautions
A. Ventilation monitoring is MANDATORY at ALL TIMES with SpO2 and ETCO2.
B. Keep manual resuscitation bag ready/available at all times. If monitoring fails, take patient off ventilator and bag manually.
C. If a defect or alarm is detected and/or the function of the ventilator cannot be guaranteed, change to manual resuscitation bag.
D. IF YOU HAVE ANY QUESTIONS ABOUT VENT SETTING CONTROLS OF CHANGES IN SPO2 and ETCO2, CONTACT MEDICAL CONTROL OR SWITCH TO MANUAL BAGGING.
State of Washington
Prehospital Stroke Triage Destination Procedure

Assess Applicability for Triage
Report from patient or bystander of one or more sudden:
- Numbness or weakness of the face, arm or leg, especially on one side of the body
- Confusion, trouble speaking or understanding
- Trouble seeing in one or both eyes
- Trouble walking, dizziness, loss of balance or coordination
- Severe headache with no known cause

YES

Perform F.A.S.T. Assessment
- Face: unilateral facial droop?
- Arms: unilateral drift or weakness?
- Speech: abnormal or slurred?
- Time last normal (determine time patient last known normal)
  Yes to any one sign (Face, Arms, Speech) = YES
  No to all three signs = NO

YES

Determine Destination*
Estimate time patient last normal to arrival at stroke center emergency department

≤ 3.5 hrs

Transport patient to the nearest highest level 1, 2, or 3 stroke center within 30 minutes transport time per regional patient care procedures.

≥3.5 hrs to ≤ 6 hrs

Transport patient to nearest:
- Level 1 stroke center within 60 minutes transport time, or
- Level 2 stroke center with intra-arterial interventional capability within 60 minutes transport time.

>6 hrs or unknown

Transport patient to level 1, 2, or 3 stroke center within 30 minutes transport time per regional patient care procedures and patient/family preference.

Limit scene time and alert destination hospital en route ASAP

*If unable to manage airway, consider rendezvous with ALS or intermediate stop at nearest facility capable of definitive airway management.

If a stroke center is not available within transport times by ground, consider air transport or contact medical control for destination decision.

If there are two or more facilities to choose from within the transport timeframe, patient preference, insurance, physician practice patterns, and local rotation agreements may be considered.
State of Washington
Prehospital Stroke Triage Destination Procedure

Purpose
The purpose of the Stroke Triage and Destination Procedure is to help you identify stroke patients in the field so you can take them to the most appropriate hospital. Like trauma, stroke treatment is time-critical—the sooner a patient is treated, the better their chances of survival. Fast treatment can mean less disability, too. For strokes caused by a blood clot in the brain (ischemic), clot-busting medication must be administered within 4.5 hours from the time they first have symptoms. For bleeding strokes (hemorrhagic), time is also critical. As an emergency responder, you play a crucial role in getting patients to treatment in time.

Stroke Assessment – F.A.S.T.
The F.A.S.T. assessment tool (also known as the Cincinnati Prehospital Stroke Scale + Time) is a simple but pretty accurate way to tell if someone might be having a stroke. It’s easy to remember: Facial droop, Arm drift, Speech, + Time. If face, arms, or speech is abnormal, it’s likely your patient is having a stroke. You should immediately transport the patient to a stroke center. Regional patient care procedures and county operating procedures may provide additional guidance. Alert the hospital on the way. Transport should not be delayed for IV and EKG monitoring.

<table>
<thead>
<tr>
<th>TEST</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial droop: Ask the patient to show his or her teeth or smile.</td>
<td>Both sides of the face move equally.</td>
<td>One side of the face does not move as well as the other.</td>
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<tr>
<td>Arm drift: Ask the patient to close his or her eyes and extend both arms straight out for 10 seconds. The palms should be up, thumbs pointing out.</td>
<td>Both arms move the same or both arms do not move at all.</td>
<td>One arm drifts down, or one arm does not move at all.</td>
</tr>
<tr>
<td>Speech: Ask the patient to repeat a simple phrase such as “Firefighters are my friends.”</td>
<td>The patient says it correctly, with no slurring.</td>
<td>The patient slurs, says the wrong words, or is unable to speak.</td>
</tr>
<tr>
<td>Time: Ask the patient, family or bystanders the last time the patient was seen normal.</td>
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</tbody>
</table>

Stroke warning signs:
- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden, severe headache with no known cause

Encourage family to go to the hospital to provide medical history, or obtain contact information for a person who can provide medical history.

Report to ED:
Possible IV t-PA contraindications: symptom onset more than 180 minutes • head trauma or seizure at onset • recent surgery, hemorrhage, or heart attack • any history of intracranial hemorrhage • minor or resolving stroke • sustained BP> 185/110, but EMS do not treat!