

# Nye County EMS Protocols

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EMT and AEMT Levels



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# Introduction

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The purpose of this document is to provide training material for new EMS providers or reference material in urgent situations. This document is not inclusive of all possible situations/treatments and is not meant to take the place of solid EMS training and practice.

Because of the unique needs of the providers in Nye County transporting patients to various hospitals, medical control may be considered to be the nearest, or most practical, facility with whom communications can be established. Online communications/orders from medical control may supersede this document. In cases of communication inability or failure, providers are expected to adhere to these guidelines in a way that is reasonable. The ultimate goal for all providers is to keep the needs of the patient in mind and act in good faith to maintain life or limb if communication is unavailable. In an event of communication failure, continuous efforts should be made to make contact with medical control or dispatch, who may relay information to medical control.

While many EMS systems have already adapted to industry changes that have evolved over the last years, many of these changes are new to Nye County EMS. Adopting these current standards places our providers in a position to practice better, evidence-based, medicine tailored to patients and their individualistic signs and/or symptoms. There should be limited use of practicing “blanket” treatment methods simply because a patient falls under a large umbrella category, for example the umbrella of “trauma”. Instead, responders will investigate the issues with each individual patient and administer appropriate treatments as indicated by signs and symptoms.

It should be noted it is no longer a common practice to administer high flow oxygen via non-rebreathing mask to patients unless there is a specific reason to do so. Current AHA guidelines recommend titrating oxygen administration to focus on maintaining minimum SPO<sub>2</sub> readings  $\geq 94$ . It is possible to create adverse situations by over-oxygenating patients who are not hypoxic.

Another change comes regarding the use of rigid spinal immobilization. It has been concluded that backboards are ineffective for truly immobilizing the spine; they create soft tissue injuries and may exacerbate pain sensation. Furthermore, rescuers create more spinal motion than if a patient self-extricates when possible. As such, cervical/spinal restrictions are now different than years past.

There are also changes to medications and the level of the providers who can administer them.

These protocols are written with goals and growth in mind. There may be new equipment/tools or training mentioned that is not immediately applicable to each station. These will be

**Introduced and training conducted and documented in each area as practically and financially possible with deadlines in mind as outlined below.**

The signatures below indicate these protocols are approved for implementation.

Nye Co. Emergency Management Signature

Nye Co. Emergency Management Name and Date

**SCOTT LEWIS**

8-21-2020

**Medical Director Signature**

Medical Director Name and Date Alex Malone, MD 8/14/20

Medical Director Name and Date Alex Malone, MD 8/14/20

### **Nevada State EMS Signature**

**Nevada State EMS Name and Date**

# Approved Procedures and Medications

\*\* as equipped with mandatory, approved, and documented training

EMT Procedures	AEMT Procedures
Administer medications as listed below	Status of fluid balance/shock
Bleeding control/tourniquet	Establish IV access, including using saline locks
Blood glucose monitoring	Establish IO access in adult and pediatric patients
Cervical/Spinal clearance, restriction	Suction advanced airway devices
CPR/AED as necessary	Supraglottic airways
Establish and maintain airway, OPA/NPA	**Endotracheal Intubation
Mechanical Suction	
Physical Restraint	
Splinting, Traction	
Triage	
** EKG capture 3, 5, or 12 lead (non-interpretive)	
**CPAP	
**Capnography	

EMT Medications	AEMT Medications
Acetaminophen – PO	Ipratropium bromide (Atrovent) - inhalation
Activated Charcoal – PO	Cyanide antidote (Hydroxocobalamin) - IV
Aspirin (ASA) – PO	Dextrose 50% - IV/IO
Diphenhydramine – PO	Diphenhydramine – IV
Glucose – oral	Epinephrine 1:1,000 IM, 1:10,000 IV/IO
Ibuprofen – PO	Glucagon - IM
Naloxone – IM, IN,	IV fluids - normal saline, lactated ringers
Oxygen – Inhalation	Ketorolac (Toradol) – IN, IV, IM
Water based burn gel (only on intact skin) - topical	
<b>Assist with patient's own medication listed below. If patient has no prescribed medication, may give with medical control permission:</b>	Naloxone (Narcan) – IV/IO
*Albuterol (MDI or nebulizer) - Inhalation	Nitrous oxide - inhalation
*Epinephrine – SC/IM	Ondansetron (Zofran) – PO, IV, IN, IM
*Nitroglycerin (spray or tablets) - SL	

For detailed medication info, see “Formulary” section.

# Protocols

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This document is written for EMT and AEMT levels. AEMT level providers should be sure to complete EMT level steps as well as the steps given for AEMT.

# Initial Patient Care

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## Dispatch

Based on information determine response mode, consider additional resources, notify dispatch via radio that unit is en route to the scene

## Scene Size-Up

1. Notify dispatch via radio that unit has arrived on scene
2. Consider and apply body substance isolation (BSI) and/or personal protective equipment (PPE)
3. Evaluate the scene for safety. If unsafe consider how to make it safe. If not possible, do not enter until scene is safe. Consider having ambulatory patient(s) come to you outside the danger zone
4. Determine the number of patients
5. Determine mechanism of injury (MOI) or nature of illness (NOI)
6. Again, consider additional resources



For calls where patient needs exceed the available EMS resources patient assessment and treatment will be conducted in accordance with the **TRIAGE PROTOCOL**.



Condition of the patient will dictate when transport is initiated.

## Assessment

1. **Check responsiveness and breathing.**
  - a. If unresponsive and not breathing, check for a pulse for no more than 10 seconds. If no pulse, begin **CARDIAC ARREST PROTOCOL**.  


Correct life-threatening problems as they are identified. Consider the need for spinal immobilization.
2. **Airway**
  - a. Open airway
  - b. Head tilt, chin lift for no suspected cervical spinal injury
  - c. Jaw thrust for suspected cervical spinal injury
  - d. Consider the need for suction
  - e. If not breathing, begin ventilations with a bag-valve-mask (BVM)
  - f. Oral airway if gag reflex is ABSENT
  - g. Nasal airway if gag reflex is PRESENT

### 3. Breathing

- a. Determine the breathing is adequate in rate, rhythm, quality, and overall appearance of the patient.
- b. If patient is not breathing adequately, provide ventilations via BVM, connected to oxygen at 15 liters whenever possible.
- c. Administer oxygen as appropriate for signs/symptoms of the patient
  - a. Utilize pulse oximetry as available. Oxygen should be titrated to maintain a SPO<sub>2</sub> of 94%, if possible.
  - b. Patients with prescribed home oxygen should receive their prescribed home dosage or an amount sufficient to provide a SPO<sub>2</sub> of 90%.



Treat the patient, not the machine. If signs and symptoms dictate oxygen, apply oxygen.

### 4. Circulation

- a. Assess presence of pulse
- b. Rate, rhythm, and quality as patient condition allows
- c. Begin CPR as needed, see **CARDIAC ARREST PROTOCOL**.



Assess brachial pulse in infants less than 12 months of age. If patient exhibits signs of poor perfusion, is unresponsive or responsive to painful stimuli, and a pulse less than 60 bpm or absent, begin CPR. Infants and children less than 8 years old, consider AED if equipped with child pads, if not available use adult pads placed on patients front and back as size dictates. Older than 8, use adult pads.

### 5. Level of Consciousness

- a. Alert, responds to Verbal stimuli, responds to Painful stimuli, Unresponsive
- b. Assess pulse, motor, and sensory response.

### 6. History and Physical Exam



To assess injuries it may be necessary to remove the patients clothing. Consider patient condition and environment.

**UNSTABLE/UNRESPONSIVE TRAUMA patients:** Rapid trauma assessment, assessing for DCAP-BTLS and/or as noted

- a. Head
- b. Neck - JVD, tracheal deviation
- c. Chest - Crepitus, paradoxical motion, breath sounds
- d. Abdomen - Distention, rigidity, guarding
- e. Pelvis/GU - Pain on motion, blood, urine, feces
- f. Extremities - Pulse, motor, sensory
- g. Posterior
- h. SAMPLE history

- i. Baseline vitals – if patient condition allows on scene, otherwise during transport

**STABLE/RESPONSIVE TRAUMA patients:**

- a. Determine chief complaint
- b. Perform focused exam of injured site/areas
- c. SAMPLE history
- d. Baseline vitals

**UNSTABLE/UNRESPONSIVE MEDICAL patients:**

- a. Perform rapid physical exam
- b. Head and Neck - JVD, medical alert device
- c. Chest - Breath sounds
- d. Abdomen – Distention, rigidity, guarding
- e. Pelvis/GU – Blood, urine, feces
- f. Extremities - Pulse, motor, sensory, medical alert device
- g. Posterior
- h. SAMPLE history, including OPQRST  
Onset, Provokes, Quality, Radiates, Severity, Time
- i. Baseline vitals

**STABLE/RESPONSIVE MEDICAL patients:**

- a. Determine chief complaint
- b. Perform focused exam of injured site/areas
- c. SAMPLE history
- d. Baseline vitals

**7. Treat Shock as Appropriate**

- a. Maintain proper body temperature
- b. Position patient as appropriate. Raising extremities (shock position) is most appropriate. Trendelenburg has limited use and often contraindicated.
- c. Ensure patient is properly perfused. DO NOT over-oxygenate the patient.



Equipment and medications must be appropriate to the size and weight of the patient. Use of the Broselow's tape or similar device is encouraged. Treatment priorities are similar to those of an adult patient. When appropriate, family members should remain with children. Infants and children must be properly restrained prior to and during transport.

**Communicate To Receiving Facility Before Arrival**

- a. Identify patient (43 year old female)
- b. History of the event/episode
- c. Objective findings (LOC, vital signs, exam results found)
- d. Treatments (oxygen, splinting, medications)
- e. Extra info
- f. Estimated time of arrival (ETA)
- g. Ask if receiving facility has questions, or further treatment suggestions

### **Transport/Transfer of Care/Rendezvous**

- CODE 1: Non-emergency response. No lights or siren, following the flow of traffic.
- CODE 2: Emergency response. Lights only. Follow traffic laws, but expedite response.
- CODE 3: Life-threat response. Use of lights and siren required in order to achieve a rapid response. This allows the responding unit to ignore jurisdictional traffic laws, but does not allow the responding unit to operate without due regard to safety.



Code 3 can create a distraction/hazard resulting in a traffic problem and therefore should be used sparingly and only as appropriate.



Because of the rural nature of Nye County and extreme distances to hospitals, transport decisions for critically ill, injured, or unstable patients must be made with time in mind. The ultimate needs of the patient must be weighed against the mode of transport as well as whether the patient needs an immediate higher level of care (rendezvous) or is stable enough for transport to definitive care such as a trauma center, burn unit, etc.

Verbal and/or written assessment and findings will be provided to receiving facility or other emergency service, including SAMPLE findings and a list of interventions performed.

### **Documentation**

A patient care record (PCR) will be completed for each incident/patient encounter in accordance with county and state regulations within 24 hours of the incident. Cancellations, refusals, standby, etc must also be documented in a PCR within 24 hours.

### **Confidentiality**

Patient confidentiality will be maintained at all times. Any breaches of confidentiality will result in dismissal from Nye County EMS.

### **Professional Conduct**

All patients will be treated to put their needs and best interests first. All patients, family members, or caregivers, will be treated with dignity and respect in a reassuring manner.

# Abdominal Pain (Non-traumatic)

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## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL.
2. Transport in position of comfort.
3. Be alert for vomiting.
4. Consider oxygen.
5. Assess abdomen for pain, guarding, distention. If patient reports an area of pain, you may avoid palpating that area if it will cause further pain or discomfort.

## AEMT:

1. Consider establishing vascular access.
2. Consider fluid challenge if indicated.
3. Consider pain relief as appropriate.
4. Treat other conditions as appropriate.



Nitrous Oxide is contraindicated for abdominal distention.

# Abdominal Pain (Traumatic)

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## EMT:

1. Follow steps above.
2. Consider ALS rendezvous.
3. If abdominal evisceration, cover organs with moist, sterile occlusive dressing.
4. Monitor for abdominal distention, swelling, bruising, or guarding.

## AEMT:

1. Consider establishing vascular access.
2. Consider the need for advanced airways.
3. Consider pain relief as appropriate.
4. Treat other conditions as appropriate.

# Allergy/Anaphylaxis

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## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Look for medical alert device.
3. Assess for signs/symptoms of allergic reaction/anaphylaxis
4. For allergic reaction with no life threats
  - a. Consider oral **diphenhydramine**, adult 25-50mg, child doses, see note below.
  - b. Transport in position of comfort.
5. For anaphylaxis
  - a. Rapid transport in position of comfort.
  - b. Determine if patient has prescribed preloaded epinephrine, (Epi Pen) assist if available.
  - c. If not contact medical control for option to administer **epinephrine 0.5mg 1:1,000 IM** every 15 minutes as indicated by patient condition for a total maximum dose of 1.5 mg.
6. Reassess in two minutes.
7. If condition fails to improve or remains unstable contact medical control for order to give additional epinephrine.
8. Prepare for the possibility of respiratory arrest.

## AEMT:

1. Consider establishing vascular access.
2. Consider:
  - a. Slow push of **diphenhydramine (Benadryl)** 25-50 mg IV/IM.
  - b. Allergic reaction with wheezing, administer **Albuterol (Proventil)** 2.5 mg via nebulizer.
  - c. For severe allergic reaction administer **epinephrine 0.5 mg 1:1,000 IM** every 15 minutes as indicated by patient condition for a total maximum dose of 1.5 mg.
  - d. Contact medical control for repeat doses.
3. Consider advanced airways.
4. Treat other conditions as appropriate.



Pediatric fluid bolus is 20 ml/kg. May repeat as clinically indicated to a maximum of 60 ml/kg.

Consider: Pediatric **Benadryl** dose is slow push 1.0 mg/kg IV/IM, not to exceed 50 mg. Pediatric **Albuterol** 2.5 mg via nebulizer. Pediatric **Epinephrine** dose is 0.01 mg/kg 1:1,000 IM or every 15 minutes as indicated by patient condition with a maximum single dose of 0.15mg. May repeat x 2 for total max dose of 0.45mg

# Altered Mental Status



Consider other causes of altered mental status: e.g. hypoxia, poisoning, or diabetes. Alcohol can cause altered mental status but not commonly a cause of total unresponsiveness.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Look for medical alert device.
3. If the patient is seizing, see SEIZURE PROTOCOL.
4. Determine blood glucose level. Consider oral glucose. Also see DIABETIC EMERGENCY PROTOCOL.
5. If patient is combative, notify medical control and consider soft restraints.
6. Pay special attention to airway and further changes to mental status.
7. If conscious, transport in a position of comfort.
8. If narcotic overdose is known or suspected, consider intranasal naloxone.
  - a. 2mg, given 1mg/ml in each nostril.
  - b. If no response in 5 minutes, give a second dose.
  - c. Contact medical control for instructions for further doses.

## AEMT:

1. If narcotic overdose is known or suspected:
  - a. Consider establishing venous access
  - b. Administer **naloxone** slow I.V. push, 0.5mg at a time, titrate dose to maintain respiratory effort. May need to repeat to maintain respiratory effect.



Pediatric glucose dose: 0.5-1.0 gram/kg up to 2-4 grams/kg.

Pediatric **naloxone** dose: 0.1mg/kg up to 2mg I.V. or IN

2. Consider advanced airway devices.
3. Treat other conditions as appropriate.

# Amputated Part



The goal is to preserve the amputated part by keeping it cool. DO NOT place body parts directly on ice. For transports of more than 30 minutes, contact medical control for guidance regarding possible air transport to a hospital with surgical capabilities.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Control bleeding. Consult BLEEDING PROTOCOL as necessary.
3. Consider oxygen
4. Maintain body temperature.
5. Position patient with legs elevated, if appropriate
6. Consider rapid transport.

### **Care of Amputated Part:**

1. Place part in plastic bag
2. Place bag in container with ice and water.
  - a. Do NOT use ice alone.
  - b. Do NOT use dry ice.
3. Label bag with patient's name, date and time.

## AEMT:

1. Consider establishing venous access and fluid challenge as appropriate to maintain blood pressure  $\geq 90$  systolic. Two lines may be appropriate.
2. Consider the need for advanced airways.
3. Consider pain relief as appropriate.
4. Treat other conditions as appropriate.

# Behavioral Emergency



Assistance from law enforcement should be requested on all calls involving potentially violent patients. Do NOT restrain and transport a patient in the prone position.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Consider medical causes of the patient's behavior
  - a. Hypoxia
  - b. Intoxication/overdose
  - c. Hypoglycemia
3. Implement **SAFER** model.
  - a. Stabilize the situation by containing and lowering the stimuli.
  - b. Assess and acknowledge the crisis.
  - c. Facilitate the identification and activation of resources (chaplain, family, friends, or police).
  - d. Encourage patient to use resources and take actions in his/her best interest.
  - e. Recovery or referral - leave patient in care of responsible person or professional, or transport to appropriate facility.
4. If it is in the best interest of the patient and does not place EMS personnel in danger of physical harm, restraint may be warranted. See RESTRAINT PROCEDURE.

## AEMT:

1. Treat other conditions as appropriate.
2. Consider establishing venous access, if warranted.

# Bites/Stings

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## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Attempt to identify insect/animal. Consider taking photograph of insect/animal if possible.
3. Remove stinger using scraping motion if still present.
4. Clean area with soap/water or antiseptic wipe.
5. Remove jewelry or clothing that may be affected by swelling.
6. For stings, apply ice pack to the area and keep below heart level.
7. Be alert for vomiting or respiratory changes.
8. See ALLERGY/ANAPHYLAXIS PROTOCOL as needed.
9. Mark redness or swelling with a pen to monitor for further swelling.
10. If poisonous snakebite or anaphylaxis develops, consider ALS rendezvous.



Ice packs should NOT be applied to snake bites as it may cause vasoconstriction and further inject poison into the blood stream.

## AEMT:

1. Consider establishing venous access.
2. Consider the need for advanced airways.
3. Consider pain relief as appropriate.
4. Treat other conditions as appropriate.

# Bleeding (External)



New standards have removed elevation, pressure points, and adding layers of gauze over existing layers. Firm, direct pressure or the use of tourniquets are most effective.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Apply direct pressure.
3. If minor bleeding, only use a stack of gauze thick enough to still allow for direct and even pressure on the wound. Gauze can be removed and replaced with a new stack if soaked through.
4. If major bleeding is not immediately controlled, apply tourniquet.
  - a. Note time tourniquet is applied.
  - b. Monitor tourniquet for effectiveness. They often must be retightened during transport.
  - c. Provide rapid transport, consider ALS rendezvous.
5. Consider oxygen.
6. Treat for shock.
7. Consider splinting to restrict movement and possibly assist with pressure, depending on splint type.
8. Consider hemostatic gauze as individual conditions warrant.

## AEMT:

1. Consider venous access and fluid challenge as appropriate to maintain blood pressure  $\geq 90$  systolic. It is better to have a patient who is hypotensive (permissive hypotension) and still perfusing than to overload them with fluid. Two lines may be appropriate.
2. Consider advanced airways as needed.
3. Consider pain relief as appropriate.
4. Treat other conditions as appropriate.



Injuries to the neck and chest may be “sucking” wounds. As such they should be covered with an occlusive dressing to block air from entering the wound. While preparing such a dressing, cover the wound with a gloved hand until the dressing is ready for use. If air has already entered the wound or surrounding tissues, if dressing does not have a relief valve, leave the dressing open on one side to allow air to escape.

# Burns

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## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Stop the burning process with water or saline.
3. Remove smoldering clothing and jewelry.
4. Continually monitor the airway for evidence of obstruction.
5. Cover the burned area with a dry, sterile dressing.
  - a) Water based burn gel may be used on areas with intact skin.
6. Estimate involved body surface area (BSA) using the "Rule of Nines" as well as depth.

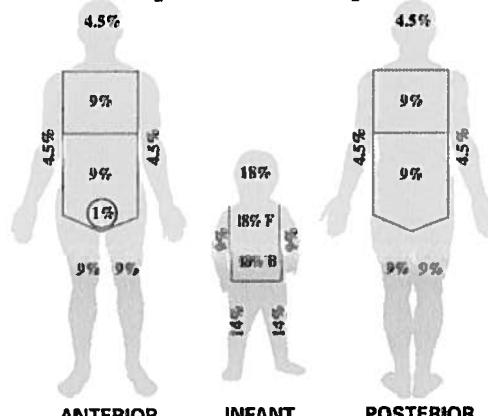
## AEMT:

1. Consider the need for advanced airway devices.
2. Consider establishing venous access using LR solution. Two lines may be appropriate.
3. If vital signs and patient's condition indicate hypo perfusion, **OR** there is greater than 10% BSA involved, consider fluid challenge of 20ml/kg.
4. Burns deeper than superficial layer consider fluid using the Parkland Burn Formula
  - a.  $4\text{ml} \times (\text{kg}) \times \% \text{ of burn} = \text{total fluid in 24 hours}$
  - b.  $\text{Total fluid}/2 = \text{fluid in first 8 hours}$
  - c. Divide the total by 8 for amount of fluid each hour.
5. Consider pain relief as appropriate.



Pediatric fluid bolus is 20ml/kg.  
May repeat as clinically indicated to a maximum of 60 ml/kg.

### [ RULE OF 9'S ]



**PALMAR METHOD**  
(Patient's palm)



# Cardiac Arrest - Adult



Interruptions in chest compressions should be avoided. Contact medical control as early as possible to determine transport necessity or termination of efforts. Patients found in cardiac arrest in hypothermic conditions will receive warming measures before terminating efforts. Extra personnel should attend CPR scenes whenever possible to allow for switching CPR positions and extra help.



**Reference current CPR guidelines in the procedure section.**

## NO INITIATION OF CPR

1. Patient is found to have rigor mortis, lividity, decomposition, obvious mortal injury, or other definitive signs of death, even if CPR was previously initiated by bystanders.
2. Down time greater than 15 minutes reported from a reliable source.
3. DNR, advanced directive, or POLST documentation.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Establish unresponsiveness, apnea, and absence of pulse.
3. Begin **CPR** using current AHA guidelines on scene.
  - a. Crews will remain on scene providing resuscitative care and will only go enroute upon attaining ROSC.
  - b. Crew will remain on scene with exceptions reserved to crew leader discretion in regards to **SCENE SAFETY** and **EMS CREW SAFETY**.

## AEMT:

1. Consider advanced airway.
2. Establish IV/IO venous access.
3. Consider appropriate medications such as **Epinephrine 1:10** Initiate Epi 1:10 for pulseless non shockable rhythms as well as pulseless V-Tach or V-Fib unresponsive to initial defibrillation. (1mg every 3-5 minutes), **naloxone** or **D50**.

## TERMINATION OF RESUSCITATION:

1. If the patient develops rigor mortis or dependent lividity.
2. **EMT level:**
  - a. No witnesses to the event.
  - b. No response, no pulse and consecutive non shockable rhythm for 20 minutes of resuscitative efforts and all reversible causes of death have been considered and treated or ruled out to the ability of the EMS crew. (Time starts as soon as care is initiated).

# Cardiac Arrest – Adult Continued

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- c. While still continuing care, contact medical control for further instructions or pronouncement of death.
  - i. If communications with medical control cannot be established, if patient meets above criteria a deputy coroner may pronounce death.
3. AEMT level –
  - a. No response, no pulse and consecutive non shockable rhythm for 20 minutes of resuscitative efforts and all reversible causes of death have been considered and treated or ruled out to the ability of the EMS crew. (Time starts as soon as care is initiated).
  - b. While still continuing care, contact medical control for further instructions or pronouncement of death.
4. Document the time of death and the name of the physician who issued the order.
5. Leave all medical interventions in place.
6. Notify dispatch.
7. Do not leave a body unattended. (In order to leave the scene, the body must be left with law enforcement, coroner, etc.)
8. Never transport/move a body without permission from law enforcement or the coroner except for assessment or its protection.



If the body is in public view and cannot be isolated, screened, or blocked from view, and is creating an unsafe situation with citizens/family, the body may be covered with a sterile burn sheet.

# Cardiac Arrest – Neonate, Infant, Child



Cardiac arrest in children is most often secondary to respiratory arrest.

## NEONATAL RESUSCITATION – Also consider referencing CHILDBIRTH PROTOCOL.



Suctioning immediately after birth should be reserved for babies with obvious obstruction or those requiring assisted ventilation.



Neonates should be resuscitated on room air only. Excess oxygen can be toxic. Reserve oxygen for neonates who continue to have low levels of oxygen as measured by a pulse oximeter. Do not rely on skin conditions.

### EMT:

1. Confirm the absence of pulse and breathing.
2. If heart rate is less than 60 bpm (Despite Ventilations w/High Flow Oxygen) or patient is pulseless, resuscitate at a rate of three compressions to one breath. (3:1 ratio.)
3. Deliver compressions at a rate of **100 – 120 per minute.**

### AEMT:

1. Avoid Advanced Airways, only use if standard ventilation techniques cannot accomplish chest rise.
2. Establish vascular access. IO is recommended for ease and speed of access.
3. Obtain blood glucose level, administer **glucose** as appropriate
4. Initiate Epi 1:10 for pulseless non shockable rhythms as well as pulseless V-Tach or V-Fib unresponsive to initial defibrillation. Pediatric dose: **0.01 mg/kg or 0.1 ml/kg**
5. Consider narcotic respiratory depression if situation/history warrants. Consider **naloxone**, pediatric dose: **0.1mg/kg up to 2mg IV/IN/IM.**

## INFANT/CHILD RESUSCITATION:

### EMT:

1. Confirm absence of pulse and breathing
2. If heart rate is less than 60 bpm (Despite Ventilations w/High Flow Oxygen) or patient is pulseless, begin CPR using current AHA guidelines & algorithms.
3. Prepare AED, if pediatric pads are unavailable consider placing adult pads on chest and back as patient size dictates.

**AEMT:**

1. Avoid Advanced Airways, only use if standard ventilation techniques cannot accomplish chest rise.
2. Establish vascular access. IO is recommended for ease and speed of access.
3. Obtain blood glucose level, administer glucose as appropriate
4. Initiate Epi 1:10 for pulseless non shockable rhythms as well as pulseless V-Tach or V-Fib unresponsive to initial defibrillation. Pediatric dose: 0.01 mg/kg or 0.1 mg/kg
5. Consider narcotic respiratory depression if situation/history warrants. Consider naloxone, pediatric dose: 0.1mg/kg up to 2mg IV/IN/IM.
6. Treat other conditions as appropriate H's & T's per AHA guidelines & algorithms.

**TERMINATION OF RESUCITATION:**

7. If the patient develops rigor mortis or dependent lividity.
8. **EMT level:**
  - a. No witnesses to the event.
  - b. No response, no pulse and consecutive non shockable rhythm for 20 minutes of resuscitative efforts and all reversible causes of death have been considered and treated or ruled out to the ability of the EMS crew. (Time starts as soon as care is initiated).
  - c. While still continuing care, contact medical control for further instructions or pronouncement of death.
    - i. If communications with medical control cannot be established, if patient meets above criteria a deputy coroner may pronounce death.
9. **AEMT level –**
  - d. No response, no pulse and consecutive non shockable rhythm for 20 minutes of resuscitative efforts and all reversible causes of death have been considered and treated or ruled out to the ability of the EMS crew. (Time starts as soon as care is initiated).
  - e. While still continuing care, contact medical control for further instructions or pronouncement of death.
10. Document the time of death and the name of the physician who issued the order.
11. Leave all medical interventions in place.
12. Notify dispatch.
13. Do not leave a body unattended. (In order to leave the scene, the body must be left with law enforcement, coroner, etc.)
14. Never transport/move a body without permission from law enforcement or the coroner except for assessment or its protection.

# Chest Pain



Consider Acute Myocardial Infarction in patients with atypical chest pain/pressure, arm or jaw pain with no chest discomfort, unexplained respiratory distress, or syncope episode.



Cardiac compromise is one of the known conditions in which high flow oxygen can be counterproductive. Care should be taken to only administer oxygen if it is necessary due to signs/symptoms of hypoperfusion or hypoxia.

## **EMT:**

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Administer oxygen only if patient exhibits signs of hypoperfusion or hypoxia.
3. Assess vital signs, especially blood pressure
4. Assist patient with their own prescribed **nitroglycerin**. One dose if systolic pressure is greater than 100. Repeat in 3-5 minutes if no relief and systolic is still over 100.
5. If patient has taken erectile dysfunction medication within 24 hours, contact medical control prior to administering nitro.
6. If patient does not have prescribed **nitroglycerin**, contact medical control for permission to administer, as well as directions regarding repeat doses.
7. Reassess vital signs and level of chest pain/discomfort.
8. Administer 324 mg (81mg x 4) chewable **aspirin**.
9. CONTRAINDICATIONS of aspirin – allergy, bleeding/anticoagulant history, ulcers.
10. Capture EKG, if equipped, for hospital use.
11. Be prepared for the potential of cardiac arrest.

## **AEMT:**

1. Consider venous access.
2. Administer **nitroglycerin** 0.4mg SL if systolic pressure is greater than 100.
  - a. If patient has taken erectile dysfunction medication within 24 hours, contact medical control prior to administering nitro.
3. Repeat nitro every 5 minutes as needed for a total of 3 doses. Contact medical control if more than 3 doses are needed.
4. Consider advanced airways if needed.
5. Treat other conditions as appropriate.

# Childbirth

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Suctioning should only be reserved for babies with obvious obstruction or those requiring assisted ventilation, even in the presence of meconium.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. If not actively pushing or no crowning is present, begin immediate transport. Left lateral recumbent position if possible.
3. Be prepared to stop the ambulance if delivery occurs.
4. Gather history regarding the pregnancy.
  - a. Prenatal care
  - b. Due date
  - c. Contraction timing
  - d. Bleeding
  - e. Ruptured membranes
5. If delivery begins, watch patient for vaginal bleeding, abnormal presentation, nuchal cord, meconium, crowning, eclampsia, etc. Refer to end of this section as needed.
6. Consider oxygen.
7. Consider the need for another ambulance if problems arise.
8. Use clean or sterile technique as much as possible.
9. Guide and control, but do not impede, delivery of the head.
10. Babies are slippery, be prepared.
11. Keep infant at level of the vagina.
12. Stimulate by drying, keep warm, wrap in blanket.
13. Once cord has stopped pulsing, clamp cord at approximately 6 and 8 inches. Cut between clamps.
14. Calculate first APGAR score (Listed at the end of this section).
  - a. For neonatal resuscitation: see CARDIAC ARREST PROTOCOL/CPR PROCEDURE.
  - b. Neonates should be resuscitated at a 3:1 ratio of compressions and breaths, using only room air (no oxygen), for asphyxial arrest.
  - c. For arrest thought to be cardiac in nature, use the 15:2 ratio.
15. Calculate second APGAR score within 5 minutes.
16. Give infant to mother, allow to nurse.
17. Begin transport. Placenta delivery can be done during transport.
18. Watch patient for excess hemorrhage.
  - a. If present, massage uterus gently.
  - b. Consider ALS rendezvous.

19. Monitor vitals of both mother and infant.

**AEMT**

1. Consider vascular access using large bore needle, run fluid as appropriate for patient condition and blood loss.
2. Consider the need for advanced airways.
3. Treat other conditions as appropriate.



**Other conditions and considerations:**

**Abruptio Placenta:** potentially fatal to mother and infant. Aggressively treat for blood loss and shock. Rapid transport, ALS rendezvous if possible.

**Breech Presentation:** May require gloved fingers inserted in the vagina to form a "V" near the infants face to make way for breathing until the head delivers.

**Limb Presentation:** Cover with moist, sterile dressing and provide prompt transport.

**Nuchal Cord:** Attempt to slip over the head. If unable, consider clamping and cutting cord as necessary.

**Prolapsed Cord:** May require gloved fingers inserted in the vagina to form a "V" and keep pressure off the cord to allow for blood flow. Also consider positioning the patient to remove pressure from the cord such as Trendelenburg or as directed by medical control.

**Apgar Score:**

<b>SIGN</b>	<b>0 Point</b>	<b>1 Point</b>	<b>2 Points</b>
<b>Apppearance</b>	Blue-gray, pale all over	Normal, except extremities	Normal over entire body
<b>Pulse</b>	Absent	Below 100 beats/min	Above 100 beats/min
<b>Grimace (reflex)</b>	No response	Grimace	Pulls away, cough
<b>Activity (muscle tone)</b>	Absent	Arms/Legs flexed	Active movement
<b>Respiration</b>	Absent	Slow, irregular	Good, crying

# Cold Emergencies



If possible, humidify oxygen. Warm I.V. fluids, if used.  
A hypothermic heart may be unresponsive to defibrillation.  
Core body temperature should be 86 degrees before attempting defibrillation.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Protect the patient from further heat loss
  - a. Remove from the cold environment
  - b. Do NOT re-expose to cold
  - c. Remove wet clothing, cover with a blanket, and keep warm
  - d. Consider applying heat packs to the neck, armpits, and groin
3. Handle the patient gently
  - a. Do NOT rub or massage extremities
  - b. Cover any frostbitten parts with dry, sterile dressings
4. Remove jewelry
5. Do not allow the patient to walk or exert themselves
6. Do not give the patient anything to eat or drink
7. Obtain vitals every 5 minutes, including body temperature

## AEMT:

1. Treat other conditions as appropriate.
2. Consider establishing venous access.
  - a. Consider warming the fluids.
3. Consider the need for advanced airway devices.



Patients, especially infants, are susceptible to losing heat through the head.  
Cover the head to help maintain body heat.

# Congestive Heart Failure/Pulmonary Edema



Fluid buildup in the lungs occurs due to the heart being unable to function properly. Excess fluid can aggravate this condition. Use caution with I.V. fluid unless warranted by other circumstances.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Place patient in position of comfort.
3. Consider high flow oxygen, consider CPAP if available
  - a. See appendix for CPAP
4. Rapid transport

## AEMT:

1. Consider establishing venous access.
2. Consider the need for advanced airway devices.
3. Treat other conditions as appropriate.

# Cyanide Exposure



Cyanide exposure can come from industrial settings, especially the many active mining operations scattered throughout the region. Cyanide is also present in smoke from residential and industrial fires. Cyanide has been used as a chemical warfare agent, and could be used in a terrorist attack. While the priority is to administer an antidote as quickly as possible, as with any chemical, EMS personnel should wear the appropriate PPE. When the patient is ready for transport be sure the patient has been decontaminated before being placed in an ambulance.



The principal acute care concerns are hemodynamic instability and cerebral edema. The continuous cardiac monitoring, respiratory and cardiovascular support, and neurologic evaluation these patients need is best provided in an intensive care unit. Make arrangements for air transport to an appropriate facility as quickly as possible.



The skin of a cyanide-poisoned person can sometimes be unusually pink or cherry-red because oxygen will stay in the blood and not get into the cells. The person may also breathe very fast and have either a very fast or very slow heartbeat.

## EMT:

1. Initiate plans for a higher level rendezvous as soon as cyanide exposure is known or suspected. Advanced providers and above can administer the antidote.
2. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
3. Monitor and maintain respiratory and circulatory function.
4. Administer high flow oxygen.
5. Rapid transport.



Depending on the route and severity of exposure, signs and symptoms of cyanide poisoning can range from mild to severe. **Hydroxocobalamin** should be used in patients with deteriorating or severe symptoms including: AMS, headache, seizure, coma, nausea, vomiting, chest tightness, cardiovascular collapse, difficulty breathing, tachypnea (early sign), bradypnea (late sign), hypertension (late sign). When in doubt about try cyanide exposure, contact poison control/medical control.

## AEMT:

1. Establish venous access.
2. Administer **hydroxocobalamin**
  - a. 5 g, intravenously, as a single infusion over 15 minutes. May repeat a second 5 g dose, depending on the severity of poisoning and clinical response, for a maximum cumulative dose of 10 g. For Cyanokit, follow package directions.
  - b. Treat other conditions as appropriate.

# Diabetic Emergencies

## EMT:

1. Follow **INITIAL PATIENT CARE PROTOCOL** as appropriate.
2. Consider blood glucose level with glucometer.
  - a. If hypoglycemic and conscious, administer **oral glucose**
  - b. If hypoglycemic and unresponsive, attempt rendezvous with higher level providers.
  - c. If hyperglycemic, attempt rendezvous with higher level providers.
3. Consider rapid transport
4. Repeat doses of oral glucose may be necessary if the patient is very low or for long transport times.

## AEMT:

1. Consider establishing venous access.
2. Consider IV administration of **D50** if hypoglycemic.
  - a. If IV access is not available, consider **IM glucagon**, 1mg, may repeat in 10 minutes.
    - i. Glucagon is most effective when used in conjunction with D50.
    - ii. If patient doesn't respond to second dose of glucagon, D50 must be given.
3. If hyperglycemic, administer fluid bolus of 20mL/kg normal saline for adults and pediatric patients.
4. If patient is exhibiting signs/symptoms of diabetic ketoacidosis administer 500 – 1000ml of fluid wide open as based on blood pressure and lung sounds, then TKO.
5. Consider oxygen if patient exhibits signs of hypoperfusion.
6. Consider the need for advanced airways.



### **D50 dose for children 3 months to 7 years:**

Empty half the syringe of D50 and draw up normal saline to refill it. This will give a concentration of D25 if prefilled D25 syringe is not available.

### **Newborns to 3 months old:**

Put 2 mL of D50 in a syringe and add 8 mL of normal saline. Concentration is D10.



**Dose of glucagon** is 0.5mg/kg for children who weigh less than 20kg. Children over 20kg the dose is the same as for adults, 1mg.

# Heat Emergencies/Fever



High body temperatures can cause seizures. Rapid cooling may cause vomiting. Heat emergencies may be environmental, caused by fever, or neurologic in nature.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Remove from the hot environment and place in cool environment
3. Loosen or remove clothing
4. If unresponsive, place in recovery position
5. Cool patient with water and fanning and/or cool packs to neck, armpits, and groin
6. If patient is alert, stable, and not nauseous give small sips of cool water
  - a. If patient is vomiting, transport on their side
7. For fevers, consider oral acetaminophen or ibuprofen
  - a. Adult Dose acetaminophen: 325 - 650 mg every 4-6 hours.
  - b. Adult Dose ibuprofen: 200 – 400mg every 4-6 hours.



Pediatric dose acetaminophen: 10-15mg/kg.  
Pediatric dose ibuprofen: 5mg/kg.

## AEMT:

1. Consider establishing venous access.
2. Consider the need for advanced airway devices.
3. Treat other conditions as appropriate.



Treat febrile seizures in infants and children by sponging down the skin with cool water during transport. If shivering occurs, stop sponging.  
Consider an I.V. Pediatric fluid bolus is 20ml/kg.

# Musculoskeletal Injury



**PASG/MAST: This device is no longer included in the protocols.**

This device has been proven to be an unreliable method for combating shock.

Hip/pelvis injuries are best managed with a pelvic stabilization device. Leg injuries should be splinted with rigid, vacuum, air, or traction splints.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate
2. Consult BLEEDING CONTROL PROTOCOL as needed.
3. Consider RICES –
  - a) Rest
  - b) Ice
  - c) Compression
  - d) Elevation
  - e) Splinting
4. If splinting –
  - a) Confirm the presence of pulse, motor, and sensory functions. If not present, gently move limb in natural position and recheck.
  - b) If all functions present, splint, then recheck.
  - c) If functions are not present or weak, consult medical control for further direction and provide prompt transport.
5. Splinting can be performed using any splinting materials available that will immobilize the joint above and below the injury as appropriate.
6. Do not place straps or other securing devices directly over wounds if possible. Attempt to maintain access to wounds to maintain or monitor bleeding control.
7. Provide open access to fingers or toes as appropriate to monitor circulation.

## AEMT:

1. Consider establishing venous access.
2. Consider the need for advanced airway devices.
3. Consider pain relief as appropriate
4. Treat other conditions as appropriate.

# Overdose (containing narcotic substance)

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. If possible, identify and estimate amount of substance ingested
3. Be prepared for nausea, vomiting, and possible airway compromise.
4. Consider IN or IM **naloxone**.
  - a. Intranasal - 2mg, given 1mg/ml in each nostril. If no response in 5 minutes, give a second dose.
  - b. IM – 0.4mg – 2mg, up to 10mg for adults. If no response in 5 minutes, give a second dose.
  - c. Titrate dose to support/maintain respiratory effort. Contact medical control for instructions for further doses.



Pediatric **naloxone** dose: 0.1mg/kg up to 2mg IM, IN, or I.V.

## AEMT:

1. Consider establishing venous access.
2. Consider **naloxone** slow I.V. push, 0.5mg at a time, titrate dose to maintain respiratory effort. Repeat doses to maintain respiratory effect as needed up to 10mg.
3. Consider the need for advanced airway devices.
4. Treat other conditions as appropriate.

5.

## Poisoning (Ingested)

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### **EMT:**

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. If possible, identify and estimate amount of substance ingested
3. Be prepared for nausea, vomiting, and possible airway compromise.
4. Contact medical direction and/or poison control with the information
  - a. Poison Control (800) 222-1222.
  - b. Advise you are an EMT.
  - c. Follow given directions, as possible.
  - d. Note the case number given by poison control.
5. If advised, administer activated charcoal
  - a. Contraindications of activated charcoal are petroleum, acid, or alkali ingestions
  - b. Usual adult dose is 25 - 50 grams



Pediatric dose of activated charcoal is 1gm/kg with a maximum of 25 grams. If unable to identify the substance a child has ingested, check for burns of the lips or mouth. If present, do NOT give activated charcoal.

### **AEMT:**

1. Consider establishing venous access.
2. Consider the need for advanced airway devices.
3. Treat other conditions as appropriate.

# Respiratory Distress

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## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Place patient in position of comfort.
3. Assess respiratory effort.
4. Assess lung sounds.
5. Consider oxygen.
  - a. Titrate to maintain pulse oximetry to 94%, if possible.
6. Assist patient with their metered dose inhaler if prescribed.
  - a. If no MDI available, contact medical control for permission to administer albuterol via nebulizer.
7. Consider CPAP.
8. Consider ventilation if appropriate.
9. Rapid transport.

## AEMT:

1. Consider advanced airways if needed.
2. Consider establishing venous access.
  - a. Abnormal lung sounds should not receive large amounts of fluid.
3. Consider medications:
  - a. **Albuterol** – 2.5 mg in 3 mL NS. May repeat every 15 minutes for maximum three doses. Contact medical control if more doses seem warranted.
  - b. **Atrovent (ipratropium bromide)** – 0.5mg in 0.02% solution. May be mixed with albuterol and administered together if albuterol alone provides no relief. Patient may receive two doses every 15 minutes.
4. Consider other conditions causing respiratory distress such as pneumothorax, cardiac condition, pulmonary edema, anaphylaxis, etc.
5. Treat other conditions as appropriate.

## BREATH SOUNDS IN RESPIRATORY DISTRESS

Auscultation	Location	Possible diagnosis
Clear	Bilateral	MI, metabolic, pulmonary embolus, anxiety, toxin
Decreased	Bilateral	COPD
Decreased	Localized	COPD, pneumothorax, pulmonary embolus, pneumonia
Rales	Bilateral	Pulmonary edema, pneumonia
	Localized	Pneumonia, pulmonary edema
Wheezes	Bilateral	Asthma, occasionally pulmonary edema, embolus
	Localized	Foreign body, embolus, COPD
Rhonchi	Bilateral	Bronchitis, COPD

# Seizure



Consider other causes of seizure: e.g. hypoxia, poisoning, alcohol, head injury, or diabetes.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. If patient is actively seizing, move hazards. Protect patients head.
3. Check for medical alert tags.
4. Gather history of the seizure if possible.
5. Assess and maintain airway.
6. Consider oxygen.
7. Consider placing patient in left lateral recumbent position if not alert.
8. Obtain checking blood glucose level.
9. Obtain body temperature.
10. Consider rapid transport or ALS rendezvous for patient with no previous history of seizure.

## AEMT:

1. Consider establishing vascular access.
  - a. Consider **naloxone** and/or **D50** as appropriate
2. Consider advanced airways.
3. Treat other conditions as appropriate.



Patients who have a history of seizure disorder that present with no abnormal exam or vitals, who are taking their medication, have a physician, and the seizure is not different from previous seizures may not require transport. If in doubt, consult medical direction.

# Stroke/CVA



Stroke/CVA is one of the known conditions in which high flow oxygen can be counterproductive to rescue efforts. Care should be taken to only administer oxygen if it is necessary due to signs/symptoms of hypoperfusion or hypoxia.

## EMT:

1. Follow INITIAL PATIENT CARE PROTOCOL.
2. Utilize the Cincinnati Stroke Scale to assess
  - a. Arm drift
  - b. Facial droop such as smile, show teeth, stick out tongue
  - c. "The sky is always blue in Cincinnati" phrase
3. Assess neurological status in all extremities.
4. Assist ventilation as appropriate, including suction.
  - a. If oxygen is warranted, apply nasal cannula and titrate to 90% pulse oximeter.
5. Determine when patient last appeared "normal".
6. Consider hypoglycemia.
7. Transport in lateral recumbent position to protect airway.
8. Protect extremities the patient may not have control over.
9. Rapid transport.

## AEMT:

1. Consider establishing vascular access.
2. Consider advanced airways.
3. Treat other conditions as appropriate.

# PROCEDURES

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The following are approved for all levels unless otherwise noted. This is not an all-inclusive list. Approved procedures are listed under “Approved Procedures and Medications”.

# Advanced Airway Devices\*

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## **\*AEMT LEVEL ONLY**

In most cases, effective airway management can be achieved with simple adjuncts or supraglottic airways. In cases of edema (burns, anaphylaxis, and severe neck trauma) subglottic airway devices are more effective at maintaining an airway.

All advanced airway devices are reserved for unresponsive patients who are apneic with no gag reflex. Ideally, advanced airways should be placed quickly, however pulse oximetry readings  $\geq 92$  and successful placement take precedent over a specific amount of time.

Ventilation rates change CPR once an advanced airway is placed. Refer to CPR PROCEDURE.

For suctioning methods of advanced airways, see SUCTION PROCEDURE. (McGill forceps may be used to remove foreign bodies visualized with a laryngoscope.)

## **SUPRAGLOTTIC AIRWAY DEVICES**

### **Combitube Procedure:**

1. Before inserting airway, check both cuffs to ensure they hold air.
2. Lubricate the tube.
3. With patient's head in neutral position, using your non-dominant hand, insert gloved hand into the mouth and lift the jaw.
4. Insert until the teeth are between the two black lines on the device.
5. Inflate the cuffs. The larger is 100-140ml of air, the smaller is 15ml of air.
6. Ventilate through the longest tube first. Check for lung sounds and chest rise and fall.
7. If no results, ventilate the shorter tube.
8. Confirm placement with lung sounds and chest rise and fall.
9. Secure device.

**Contraindications of Combitube:** Patients too short for device, have esophageal disease, ingested a caustic substance, or airway burns.

### **King Airway Procedure:**

1. Choose appropriately sized device based on patient height.
2. Before inserting airway, check both cuffs to ensure they hold air.
3. Lubricate the tube.
4. With patient's head in neutral position, using your non-dominant hand, insert gloved hand into the mouth and lift the jaw.
5. Insert the tip into the corner of the mouth, while rotating the device advance until it's behind the base of the tongue and blue line faces the patient's chin.

6. Continue to advance until the connector base is aligned with patient's teeth.
7. Inflate cuff with recommended amount of air. (Varies based on size of device)
8. Ventilate and confirm placement.
9. Secure device.

**Contraindications of King Airway:** Patients too short for device, have esophageal disease, ingested a caustic substance, or airway burns.

### **SUBGLOTTIC AIRWAY DEVICE**

**Endotracheal Intubation:** This method is preferred for patients who may require prolonged artificial ventilation or have airway edema.

**Size selection:** For pediatric patients, the preferred method is to use a length-based resuscitation tape. For adults, the pinky finger should be used as a guide. Most common size for women is 7, men is 8 but considerations should be made for overall body stature.

Consider one size smaller for instances of epiglottitis, croup, and airway burns.

#### **Endotracheal Intubation Procedure: (orotracheal method)**

1. Before inserting airway, gather and prep all necessary equipment
2. Check tube cuff to ensure it holds air.
  - a) Infant and smaller pediatric sizes are usually not cuffed.
3. Lubricate the tube.
4. Position the patient's head. For better visualization, align the ears level with the sternum. Use padding under the head and shoulders as needed.
5. Remove any dentures.
6. Ensure patient is well ventilated
7. Holding laryngoscope, displace tongue and elevate mandible. Do NOT touch the teeth.
8. Insert and advance the tube until the cuff passes the cords. Do not insert beyond the black markings on the tube.
9. Inflate cuff and disconnect syringe.
10. Ventilate and auscultate to confirm placement. If breath sounds are decreased or absent on the left deflate cuff and withdraw 1-2 cm. Inflate cuff and auscultate again.
  - a) If improper placement, ventilate patient before another attempt.
11. Apply capnography or colorimetric device.
12. Note tube depth.
13. Secure tube.

# Cervical/Spinal Motion Restriction

## Motion Restriction Criteria

If the patient exhibits any of the following, motion restriction is indicated. If findings are negative for all criteria, no restriction is necessary.

- Altered level of alertness and orientation
- Midline pain, tenderness, or deformity of the spine.
- Neurological deficits (pulse, motor, sensory) in any extremity not previously present.
- Evidence of drugs/alcohol use.
- Painful, distracting injuries.



Patient's found in motor vehicles may self-extricate and be assisted to a soft stretcher and secured for transport. Patients unable to self-extricate should be removed with an appropriate extrication method for the situation.



Motion restrictions are contraindicated for: cardiac arrest patients, injuries in which a collar would compromise assessment, airway management, or bleeding control. Penetrating trauma wounds to the head or neck, or mechanism of injury alone are not indicators to apply cervical stabilization.

If patient has positive findings to any of the above guidelines or is unresponsive:

1. Follow INITIAL PATIENT CARE PROTOCOL as appropriate.
2. Assess for pulse, motor, and sensory functions in all extremities
3. Assess for priapism.
4. Place c-collar on patient.
5. Spinal injuries in the cervical and thoracic regions may impeded breathing. Be prepared to assist breathing.
6. Move and secure patient to soft stretcher in a position of comfort.
7. Reassess pulse, motor, and sensory functions in all extremities, also for priapism.
8. Watch for signs of respiratory distress.
9. Children may be restricted in car seats that have a back section if seat is not damaged. A commercial pediatric stabilization device may be used but not if placing the patient in the device causes excess movement or they fight against it.

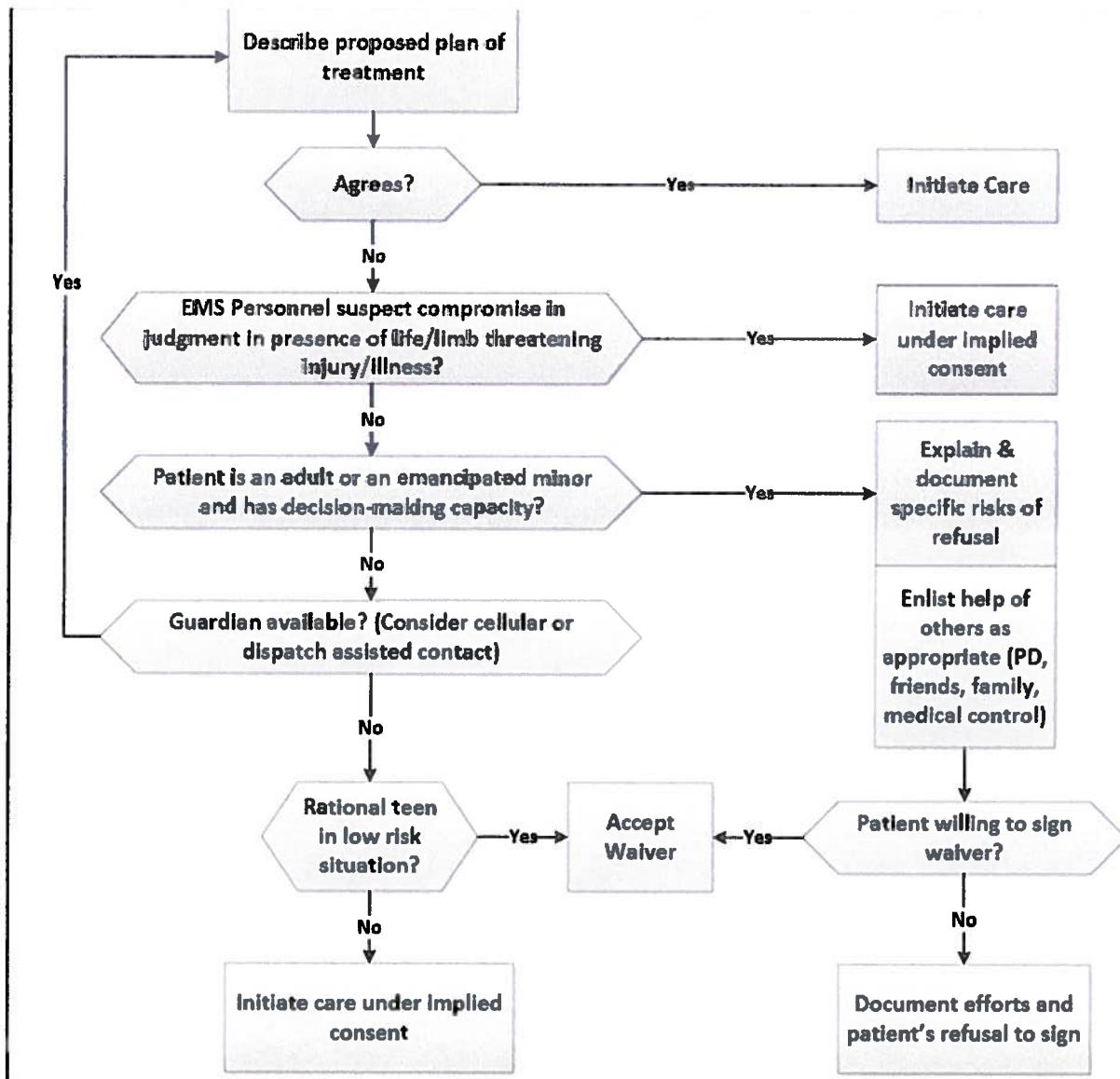


Backboards are indicated for extrication and patient movement devices. Patients are not to be transported on backboards unless removing them would cause a delay in transport or treatment of life threats. Tape, head straps, wedges, etc are not recommended.

# Consent



When in doubt regarding any decisions of treatment or transport contact medical control.



# CPAP – Continuous positive airway pressure

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For crews who are equipped and trained.

## Indications:

This procedure may be performed on any patient 18 years old or older in CHF, respiratory distress with bronchospasm, and pneumonia, who has TWO of the following:

1. Retractions or accessory muscle use
2. Respiratory rate >25 per minute
3. SpO<sub>2</sub>≤94%

## Contraindications:

1. Apnea
2. Vomiting or active GI bleed
3. Major trauma/pneumothorax
4. Altered mental status
5. Hypotension

Use device per manufacturer instructions.

## Procedure considerations:

1. Assess patient and document vital signs, SpO<sub>2</sub> and ETCO<sub>2</sub> (when available) prior to applying oxygen.
2. Select the appropriate size face mask for the patient.
3. Inform patient about procedure process.
4. Gradually increase the flow rate, slowly reaching the desired CPAP pressure.
  - a. EMT level can apply maximum of 5cm/h<sub>2</sub>O
  - b. AEMT level can apply maximum of 10cm/h<sub>2</sub>O
5. Secure face mask onto patient face using the head harness.
6. Check the mask and tubing for leaks.
7. Reassess patient and document every five minutes.
8. If patient develops any of the contraindications or requires definitive airway control, discontinue CPAP and provide necessary airway control

# CPR 2015 American Heart Assoc. Guidelines

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**Table 2** Summary of High-Quality CPR Components for BLS Providers

Component	Adults and Adolescents	Children (Age 1 Year to Puberty)	Infants (Age Less Than 1 Year, Excluding Newborns)
<b>Scene safety</b>	Make sure the environment is safe for rescuers and victim		
<b>Recognition of cardiac arrest</b>	Check for responsiveness No breathing or only gasping (ie, no normal breathing) No definite pulse felt within 10 seconds (Breathing and pulse check can be performed simultaneously in less than 10 seconds)		
<b>Activation of emergency response system</b>	If you are alone with no mobile phone, leave the victim to activate the emergency response system and get the AED before beginning CPR Otherwise, send someone and begin CPR immediately; use the AED as soon as it is available	<b>Witnessed collapse</b> Follow steps for adults and adolescents on the left <b>Unwitnessed collapse</b> Give 2 minutes of CPR Leave the victim to activate the emergency response system and get the AED Return to the child or infant and resume CPR; use the AED as soon as it is available	
<b>Compression-ventilation ratio without advanced airway</b>	<b>1 or 2 rescuers</b> 30:2	<b>1 rescuer</b> 30:2 <b>2 or more rescuers</b> 15:2	
<b>Compression-ventilation ratio with advanced airway</b>	Continuous compressions at a rate of 100-120/min Give 1 breath every 6 seconds (10 breaths/min)		
<b>Compression rate</b>	100-120/min		
<b>Compression depth</b>	At least 2 inches (5 cm)* About 2 inches (5 cm)	At least one third AP diameter of chest About 2 inches (5 cm)	At least one third AP diameter of chest About 1½ inches (4 cm)
<b>Hand placement</b>	2 hands on the lower half of the breastbone (sternum)	2 hands or 1 hand (optional for very small child) on the lower half of the breastbone (sternum)	<b>1 rescuer</b> 2 fingers in the center of the chest, just below the nipple line <b>2 or more rescuers</b> 2 thumb-encircling hands in the center of the chest, just below the nipple line
<b>Chest recoil</b>	Allow full recoil of chest after each compression; do not lean on the chest after each compression		
<b>Minimizing interruptions</b>	Limit interruptions in chest compressions to less than 10 seconds		

\*Compression depth should be no more than 2.4 inches (6 cm).

Abbreviations: AED, automated external defibrillator; AP, anteroposterior; CPR, cardiopulmonary resuscitation.

# Medication Administration

---

Before administering any medication, all personnel will confirm the following:

1. Right patient
2. Right medication
3. Right dose
4. Right route
5. Right time including expiration date
6. Right documentation

If further information is necessary regarding medications, please see the FORMULARY section.

# Physical Restraint

---

## Indications for physical restraint:

1. Patients needing to be transported for medical care, but are refusing transport or care, and are not competent to refuse.
2. A person that appears to be mentally ill and that, as a result of such mental illness, appears to be an imminent danger to others or to themselves.
3. Patients that have verbally stated their intent to attempt suicide or made some actual attempt to harm themselves, and who are not cooperating with your efforts to transport by ambulance.
4. Inform medical control as soon as possible, consult for questionable situations.

## Precautions:

1. Any attempt at restraint involves risk to patient and responders. Do not attempt to restrain a patient without adequate assistance.
2. Physical restraints are a last resort. Attempt verbal persuasion first.
3. A patient that is alert, oriented, aware of his condition, and capable of understanding the consequences of his refusal is entitled to refuse treatment. He may not be restrained and treated against his will. (Review CONSENT PROCEDURE.)
4. If there is potential for vomiting (e.g., intoxicants, withdrawal states), consider restraining in a lateral position to decrease risk of aspiration.

## Procedure:

1. Determine that patient requires ambulance transport AND that patient lacks decision-making capacity, OR that there is a basis for law enforcement or mental health hold.
2. Assign at least one person to each limb. A fifth person can coordinate the procedure.
3. Inform the patient of your need to restrain him. Explain the procedure to the patient.
4. Restrain arms and legs. Avoid body restraints as they may result in strangulation.
5. Check restraints frequently thereafter to ensure no injury to extremities.
6. NRB masks (with adequate oxygen/air supply) may be useful to control spitting or biting.
7. Once in restraints -- do not leave the patient at any time.
8. Remove restraints only with sufficient personnel available to control patient -- generally, only in the hospital.
9. Document indication for restraints, type of restraints, monitoring during transport, and condition on arrival at emergency department



Do NOT overlook medical causes that may contribute to the patient to being combative. Thorough assessment is of the upmost importance.

# Suction



The most important consideration when using suction is creating a clear airway. It does no good to withdraw suction based on time limits while foreign material is still present in the airway when using ventilation techniques. Suctioning should be done as thoroughly as possible in as short amount of time as possible to avoid complications.

1. Assemble all necessary equipment, including extra PPE such as goggles or face shield.
2. Test suction and ensure adequate vacuum pressure.
3. Measure the catheter from the corner of the patient's mouth to the tip of the earlobe.
4. Ensure the patient is properly oxygenated.
5. Insert the catheter and suction as you withdraw.
6. If solid material is too large to suction, roll the patient to their side and clear the mouth with your gloved finger.
7. If material is accumulating as fast as you can suction, you may need to alternate suctioning and ventilation.

## Suction ET tube:

1. Use sterile technique if possible. Do not reinsert a catheter that is not sterile.
2. Oxygenate the patient up to a minute before suctioning.
3. Measure suction tubing from patient's nose, to ear, to xiphoid process.
4. Gently insert the suction catheter until resistance is met or reaching measured length.
5. Apply suction as catheter is withdrawn.
  - a. It may be necessary to inject 3-5ml of sterile water down the ET tube to loosen secretions.
6. Continue to ventilate the patient.

## Suction King LTS-D:

1. Suction and ventilation can take place simultaneously. Nasogastric tube up to 18 french may be used.
2. Measure from patient's nose, to ear, to umbilicus.
3. Gently insert suction catheter until meeting resistance or measured length.
4. Suction with the intent to clear stomach contents.



**AEMT level**

McGill forceps may be used to remove foreign objects visualized with a laryngoscope.

# Traction Splint

---

## Indications:

Performed on any patient with a closed midshaft femur fracture to

1. Stabilize the fracture to prevent excess movement.
2. Align the limb sufficiently to allow it to be placed in a splint.
3. Avoid potential neurovascular compromise.
4. Don't delay transport of a critical patient. This can be done in the ambulance.

## Contraindications:

1. Pelvic fracture or instability
2. Knee, lower leg, or ankle instability

## Procedure considerations:

1. Check for pulse, motor, and sensory functions.
2. Stabilize the leg by placing a hand behind the knee.
3. Have a second person stabilize the leg under the injury.
4. Using the least amount of force necessary, apply manual traction until the limb is in an approximately "normal" position.
5. Maintain manual traction until the mechanical traction device can be applied.
6. Mechanical traction should be applied to equal 10% the patients weight, not to exceed 15 pounds of traction, unless extenuating circumstances are present.
7. Recheck for pulse, motor, and sensory functions.



If the patient strongly resists the traction or it causes even more severe pain, splint the limb in the deformed position and provide rapid transport. Frequently monitor for pulse, motor, and sensory functions.

# Triage



Due to the rural nature of Nye county consider additional resources as early as possible for disaster situations.

**START Triage** stands for Simple Triage and Rapid Treat. It assesses respiratory status, pulse, neurologic status and ability to walk.

**GREEN:** Patients who are able to walk to a designated location

**YELLOW:** Patients who have serious but non life threatening injuries, transport is delayed

**RED:** Treatable life-threatening injuries requiring immediate transport

**BLACK:** Those with fatal injuries or dead

1. Any patients who can walk are given directions for a designated location for treatment.
2. Assessment then begins with non-walking patients.
3. Assess respiratory status
  - a. If no breathing
    - i. position airway, if patient does not breathe triage as black.
    - ii. If breathing begins, tag as red and place in recovery position.
  - b. If breathing
    - i. Make quick estimate of breathing rate
      1. Faster than 30 or slower than 10 is red.
      2. 10-29 move to next assessment step.
  4. Assess for bilateral radial pulses
    - a. If absent, triage as red.
    - b. If present, go to next step.
  5. Assess neurological status by having patient follow simple commands
    - a. If unresponsive, or unable to follow commands, triage as red.
    - b. If patient who can comply triage as yellow.

**JUMPSTART Triage** is intended for patients younger than 8 years or weigh less than 100 pounds

1. Identify walking wounded. Infants not developed enough to walk or special needs children should be taken to a treatment area for secondary triage.
2. For remaining patients, assess breathing.
  - a. If no breathing, assess pulse.
    - i. If no pulse, triage as black.
    - ii. If pulse, open airway.

1. If no breathing, give five rescue breaths and reassess. If no breathing triage as black.
3. Assess respiration rate
  - a. Fewer than 15 or more than 45 triage as red
  - b. If 15-45 continue to next step
4. Assess for distal pulse, this does not have to be the brachial pulse. Use what you are comfortable with.
  - a. If distal pulse is absent, triage as red.
  - b. If present, continue to next step
5. Assess neurological status. Because of developmental differences in infants and children their responses will vary.
  - a. Unresponsive, posturing, incomprehensible sounds, or unable to localize pain, triage as red.
  - b. Responds to pain by localizing or withdrawing from it, or is alert, triage as yellow.

**Special Considerations:**

1. Disruptive or hysterical patients may need to be an immediate transport priority, even if not severely injured, to free up rescuers.
2. Any rescuer who becomes ill or injured becomes an immediate priority.
3. HazMat or Terrorist scenes may require transport delays to allow for decontamination.
  - a. Multiple areas of triage and decon may be necessary.
4. While it may seem practical to send all priority patients to the nearest hospital this may overwhelm their capabilities. Consider distributing patients of varying severities to the same hospital and send the priority patients to several different facilities as possible.

# Vascular Access – IV, IO\*

## \*AEMT LEVEL ONLY

**Venous access** may be achieved on scene or while en route to the hospital, whichever is most appropriate for overall patient condition without causing unnecessary transport delay.

1. Access can be achieved using:
  - a. Saline lock – for stable patients not requiring fluid
  - b. Normal Saline or Lactated Ringer solution(s)
  - c. Preexisting venous port during life-threatening emergency if other access is unobtainable – as long as blood can be freely aspirated from the port.
2. Fluid administration:
  - a. TKO – slow drip for fluids.
  - b. Wide open – for large amounts of fluid delivery.
  - c. Fluid challenge – consider bolus 20cc/kg or bolus of 500ml wide open.
  - d. Maintain rate as ordered by medical control.
3. If vital signs indicate hypovolemia, consider initial fluid challenge of 500 ml NS or 20cc/kg. If patient's condition does not improve, administer additional challenges as needed, not to exceed 2,000 ml, unless other conditions exist that limits fluid amounts. Attempt to maintain a systolic blood pressure of at least 90.
4. Medication delivery should be followed by 10-20ml flush or bolus.



Fluid challenge for pediatric patients: 20cc/kg. May repeat as clinically indicated to a maximum of 60 ml/kg.

### Contraindications for IV access: none

**Intraosseous access** is for life threatening conditions when I.V. access is unobtainable after three attempts, or access needs to be established within 90 seconds, in both adult and pediatric patients. IO devices are inserted into the proximal tibia. Any fluid or medication that can be used with an IV can be used with an IO. Only one attempt may be made per leg.

1. Access should only be achieved on adult patients using the EZ-IO drill or other mechanically assisted device.
2. Access can be achieved in pediatric patients using a mechanically assisted device or with a manually inserted IO needle.
3. If the patient is still responsive, after placement is confirmed, 1% Lidocaine 20-40mg may be injected into the IO prior to administering fluids or medications.

### Contraindications for IO access: Placement in, or distal to, a fractured bone.

# FORMULARY

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# Acetaminophen

---

**Provider level:** EMT and AEMT

**Class of drug:**

Analgesic, Antipyretic

**Indications:**

Fever

Pain from mild to moderate injury

**Contraindications:**

Known sensitivity to the drug, hepatic failure or impairment

**Possible side effects:**

Nausea, vomiting, abdominal pain, rash

**Drug interactions:**

Phenothiazines - may produce hypothermia

Phenobarbital - increase hepatic toxicity

**How supplied:**

325mg tablet, caplet

Oral suspension

**Administration:**

Pediatric: 10-15 mg/kg orally

Adult: 325 - 650 mg every 4-6 hours

**Special notes:**

Acetaminophen use in the scope of practice is intended for fever control.

# Acetylsalicylic Acid (Aspirin)

---

**Provider level:** EMT and AEMT

**Classification:**

Antiplatelet

**Indications:**

Unstable angina, acute myocardial infarction, chest pain of possible cardiac nature

**Contraindications:** known drug sensitivity, GI bleeding, active ulcer disease, hemorrhagic stroke, bleeding disorders, children with flulike symptoms

**Possible side effects:**

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

**How Supplied:**

81 mg chewable tablet

**Administration:**

324mg aspirin in the form of four (4) 81mg chewable aspirin PO, if the patient is able to swallow voluntarily and has a patent airway.

**Special Notes:**

Aspirin is not to be given for analgesic purposes such as headaches or orthopedic injuries. Some asthmatics are sensitive to aspirin products. Ingestion of aspirin can worsen or precipitate an asthma attack in these individuals.

If the patient states they have already taken their own aspirin, confirm the product they took is actually aspirin and not Tylenol, Advil, etc.

Aspirin is commonly abbreviated as ASA.

# Activated Charcoal

---

**Provider level:** EMT and AEMT

**Class of drug:**

Gastrointestinal Adsorbent

**Indications:**

Activated charcoal is used in the treatment of certain cases of poisoning and overdose in the alert patient.

**Contraindications:**

Acid, alkali, or petroleum ingestion

GI obstruction

**Possible side effects:**

May indirectly induce nausea or vomiting

May cause constipation or mild, transient diarrhea

**Drug interaction:**

Contact medical control before giving in acetaminophen overdose. Charcoal interferes with the function of N-Acetylcysteine, an antidote for acetaminophen.

Milk products decreases effectiveness.

**Administration:**

Adult: 1gm/kg, usually 25-50 grams PO.

Pediatric: 1gm/kg PO

**Special notes:**

Patients must be capable of following instructions and protecting their airway.

When possible contact poison control (800) 222-1222 for directions before administering.

# Albuterol

---

**Provider level:** EMT (with medical control contact) and AEMT

**Classification:**

Bronchial dilator

**Indications:**

Albuterol is indicated as a bronchodilator for asthma, and for reversible bronchospasm associated with bronchitis and emphysema (COPD), and anaphylaxis.

**Contraindications:**

Known drug sensitivity, cardiac dysrhythmias with tachycardia

**Possible side effects:**

Restlessness, dizziness, palpitations, tachycardia, dysrhythmia, tremors

**Precautions:**

Use with caution in patients who have a history of cardiovascular disorders such as hypertension, coronary artery disease, congestive heart failure, or hyperthyroidism. May lower seizure threshold in susceptible patients. If it appears the patient is getting worse discontinue the treatment and contact medical control.

**How Supplied:**

Patient's own MDI

3 ml of premixed 0.083% solution (2.5 mg)

**Administration:**

**Adults and children (2 years and older)** - Administer one premix solution by nebulizer

May repeat or even administer as a continuous nebulization during transport if necessary.

**Infants or children (under 2 years)** - Administer half of the premixed solution diluted with an additional 2 ml of saline. May repeat or even administer as a continuous nebulization during transport if necessary.

# Diphenhydramine (Benadryl)

---

**Provider level:** EMT (PO), AEMT (IV, IM)

**Classification:**

Antihistamine

**Indications:**

Moderate to severe allergic reaction, anaphylaxis

**Contraindications:**

Known drug sensitivity, during acute asthma attack, glaucoma, newborns and nursing mothers

**Possible side effects:**

Drowsiness or excitability, disturbed coordination, hypotension, palpitations, tachycardia, bradycardia, thickened bronchial secretions, dry mouth and throat

**Precautions:**

Alcohol or other depressants may increase depressant effects

**How Supplied:**

50mg/ml prefilled syringe or vial

**Administration:**

**Adult:** 10-50mg, EMT - PO, AEMT - slow IV push or deep IM

**Pediatric:** 1-2mg/kg, EMT - PO, AEMT - slow IV push or deep IM

**Special Notes:**

Use cautiously in patients with central nervous system depression

# Epinephrine

---

**Provider level:** EMT (auto-inj – patient's own or IM with medical control permission) AEMT (IM, IV)

**Classification:**

Sympathomimetic

**Indications:**

**Auto-injector and 1:1000 or 1:1 IM** – Severe Allergic Reaction, Anaphylaxis or Status Asthmaticus  
**1:10,000 or 1:10 IV/IO** – Cardiac Arrest (Pulseless Electrical Activity), (Ventricular Fibrillation and Pulseless Ventricular Tachycardia unresponsive to initial defibrillation).

**Contraindications:**

Known drug sensitivity (Contact Medical Control in an Emergency), hypovolemic shock, myocardial ischemia, pulmonary edema, hypertension, hypothermia

**Possible side effects:**

Headache, nausea and vomiting, restlessness, weakness, dysrhythmias, hypertension, tachycardia, tremors, dyspnea

**Precautions:**

Due to peripheral vasoconstriction, should be used with caution in patients with poor peripheral circulation

**How Supplied:**

Auto-injector: 0.15mg/ml and 0.3mg/ml  
Parenteral: 1:1000 – 1mg/ml ampule or vial  
1:10,000 – 1mg in 10ml or 0.1mg/ml prefilled syringe

**Administration:**

Adult auto-injector: 0.3mg/ml, Pediatric auto-injector: 0.15mg/ml  
**1:1: AEMT Adult – 0.3 to 0.5mg IM, Pediatric – 0.01mg/kg (0.01ml/kg) max of 0.15 IM**  
**1:10: AEMT Adult (Cardiac Arrest 1mg or 10ml IV or IO push every 3-5 Minutes during resuscitation, Pediatric – (0.01mg/kg) or (0.1ml/kg) IV or IO**  
Refer to current American Heart Association ACLS & PALS Cardiac Arrest Guidelines per 1:10 Epinephrine administration.

**Special Notes:**

May increase myocardial oxygen demand resulting in angina pectoris

# Glucagon

---

**Provider level:** AEMT

**Classification:**

Hormone

**Indications:**

Hypoglycemia

**Contraindications:**

Known drug sensitivity

**Possible side effects:**

Tachycardia, hypotension, nausea and vomiting, urticaria

**Precautions:**

Glucagon should not be considered a first-line choice for hypoglycemia. Intravenous glucose must be administered if patient does not respond to second dose of glucagon.

**How Supplied:**

Glucagon and solution: 1mg of white powder and 1ml of diluting solution

**Administration:**

Adult: 0.5 – 1mg IM every 7-10 mins.

Pediatric: weight over 20kg, 0.5 – 1mg IM

**Special Notes:**

May cause nausea and vomiting, as well as hyperglycemia.

# Glucose/Dextrose (D50)

---

Provider level: EMT – oral glucose, AEMT - Dextrose

Classification:

Carbohydrate

Indications:

Hypoglycemia, suspected or measured blood glucose less than 60mg/dl

Altered mental state in a known diabetic that might be caused by hypoglycemia

Coma, seizure, or cardiac arrest of unknown origin

Contraindications:

Known drug sensitivity, intracranial hemorrhage, increased intracranial pressure, known or suspected stroke with no hypoglycemia

Possible side effects:

Hyperglycemia, pain or burning at IV site

Precautions:

Dextrose can cause necrosis of tissue. IV should be secure and free return of blood into the syringe or tubing should be checked 2-3 times during administration.

How Supplied:

Glucose gel– prefilled tube

Dextrose 50%: 25 Gm in 50 ml pre-filled syringe.

Administration:

**Oral Glucose** – If patient can swallow and protect own airway, place glucose on patients finger or tongue depressor and place between cheek and gum. One tube equals one dose.

**Dextrose – AEMT Adult:** 12.5-25 gm slow IV push into secure vein if patient unable to tolerate oral glucose. **Pediatric:** 2 ml/kg of 25% dextrose IV push. **Neonates:** 5 ml/kg of 10% dextrose IV push.

Special Notes:

Effect may be delayed in elderly people with poor circulation or patients who have been hypoglycemic for a prolonged period of time.

Older patients with CVA or stroke may be made worse by D50. Unfortunately, these stroke-like presentations can be the result of hypoglycemia. It is important to test blood glucose levels prior to the administration of dextrose. If situation is unclear contact medical control.

# Hydroxocobalamin

---

**Provider level:** AEMT

**Classification:**

Vitamin

**Indications:**

Confirmed or suspected cyanide exposure

**Contraindications:**

Known drug sensitivity

**Possible side effects:**

Hypertension, headache, rash, nausea, injection site reactions, and allergic reaction

**Precautions:**

If used in combination with any other IV medications, they must be administered in separate lines.

**How Supplied:**

Cyanokit – 5g lyophilized hydroxocobalamin power. After reconstitution using sodium chloride 0.9%, vial contains 25mg/ml.

**Administration:**

5g by IV over 15 minutes

**Special Notes:**

Significant increases in blood pressure may occur following administration.

# Ibuprofen

---

**Provider level:** EMT and AEMT

**Classification:**

Antipyretic, analgesic

**Indications:**

Fever - if patient is already taking acetaminophen or acetaminophen is not well tolerated.  
Pain from mild to moderate injury with no bleeding.

**Contraindications:**

Known drug sensitivity, aspirin sensitivity, pregnancy, severe renal disease, ulcer, GI bleed, ingestion of alcohol

**Possible side effects:**

Headache, drowsiness, anxiety, nausea, vomiting, diarrhea, increased bleeding time, rash

**Precautions:**

Should not be given to those who chronically use this medication, ingest alcohol, or have experienced significant trauma

**How Supplied:**

200mg tablet, caplet, liquid gel capsule

Oral suspension

**Administration:**

Adult – 200-400mg PO

Pediatric – 6 months to 12 years, 5mg/kg PO

**Special Notes:**

# Ipratropium (Atrovent)

---

**Provider level:** AEMT

**Classification:**

Anticholinergic bronchodilator

**Indications:**

Persistent bronchospasm.

**Contraindications:**

Known drug sensitivity, atropine sensitivity, soy or peanut allergy

**Possible side effects:**

Nausea and vomiting, cramps, cough, worsening symptoms, headache, tachycardia, dry mouth, blurred vision, anxiety

**Precautions:**

Use with caution in patients with urinary retention

**How Supplied:**

2.5ml of premixed 0.02% solution (0.5mg)

**Administration:**

0.5mg of solution nebulized, may be mixed with albuterol

**Special Notes:**

Significant side effects must always be weighed against the therapeutic affect.

# IV Fluids (Normal Saline, Lactated Ringers)

---

**Provider level:** AEMT

**Classification:**

Isotonic volume expander, electrolyte replacement

**Indications:**

Fluid replacement, medication administration

**Normal Saline** – dehydration, diabetic ketoacidosis, neurogenic shock

**Lactated Ringers** – Hypovolemic shock, burns

**Contraindications:**

**Normal Saline** – congestive heart failure (may easily induce overload)

**Lactated Ringers** – congestive heart failure, renal failure

**Possible side effects:**

Rare in therapeutic dosages

**Precautions:**

Certain medication will complicate a line when using Lactated Ringers solution. When administering meds, a Y site must be used and flushed with 10-20ml of NS before and after each drug administration.

**How Supplied:**

Saline flush prefilled syringe

1000ml bag

**Administration:**

TKO – slow drip for fluids.

Wide open – for large amounts of fluid delivery.

Fluid challenge – consider bolus 20cc/kg or bolus of 500ml wide open.

As directed by medical control

**Special Notes:**

Lactated ringers contain sodium, potassium, and calcium, as well as lactate which can act as a buffer to neutralize acidity caused by some conditions/shock.

Blood pressure measurements are useful but not the only determination regarding fluid replacement. Some patients with hypertension need fluid, i.e. diabetic ketoacidosis. Monitor all vital signs, including lung sounds and respiratory effort when fluids are being administered.

# Ketorolac (Toradol)

---

**Provider level:** AEMT

**Classification:**

Nonsteroidal anti inflammatory

**Indications:**

Moderate to severe pain

**Contraindications:**

Known sensitivity to drug, allergies to aspirin or other nonsteroidal anti-inflammatory drugs, bleeding disorders, renal failure, active peptic ulcer disease

**Possible side effects:**

Anaphylaxis from hypersensitivity, edema, sedation, bleeding disorders, rash, nausea, headache

**Precautions:**

Use with caution and reduce dose for elderly patients.

**How Supplied:**

30mg/ml, 2ml vial

**Administration:**

Adults only: IM - 60mg for patients <65 years old, 30mg for patients >65, have renal impairment or weigh less than 50kg.

IV – 30mg for patients <65, 15 mg for patients >65, have renal impairment or weigh less than 50kg. IN – Patients weighing 50kg or more, 30mg. 50kg or less, 15 mg.

**Special Notes:**

# Naloxone (Narcan)

---

**Provider level:** EMT – IN, IM AEMT - IV

**Classification:**

Opioid antagonist

**Indications:**

Opioid induced central nervous system and respiratory depression

**Contraindications:**

Known drug sensitivity

**Possible side effects:**

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

**Precautions:**

May induce withdrawal symptoms in narcotic dependent patients

**How Supplied:**

1mg/ml, 2ml vial or prefilled syringe

**Administration:**

Titrate dose to maintain respiratory effort. May need to repeat to maintain respiratory effect.

**Adult:** EMT – IN: 1mg per nostril total 2mg, IM: 0.4mg – 2mg up to 10mg. AEMT - 0.5mg at a time, slow IV push.

**Pediatric:** 0.1mg/kg up to 2mg I.V. or IN

**Special Notes:**

Use smaller doses when administering to narcotic addicts. Naloxone may not reverse hypotension. Rare anaphylactic reactions have been reported.

# Nitroglycerin

---

**Provider level:** EMT (may assist with patient's medication or administer after permission from medical control) and AEMT

**Classification:**

Vasodilator

**Indications:**

Chest pain, suspected AMI

**Contraindications:**

Known drug sensitivity, hypotension <100 systolic, head injury, bradycardia <50, cerebral hemorrhage

**Possible side effects:**

Headache, tachycardia, hypotension, nausea and vomiting, postural syncope, diaphoresis, flushing

**Precautions:**

Ensure patient has not had erectile dysfunction drugs within the past 24 hours. Ideally patients with systolic pressures in the lower 100's should have an IV line placed before administering, especially multiple doses.

**How Supplied:**

0.4mg tablet

0.4mg metered spray

**Administration:**

Sublingual dose repeated in 5 minute intervals, maximum 3 doses. Contact medical control if more doses are needed.

**Special Notes:**

Nitroglycerin decomposes when exposed to light and must be kept in airtight containers.

# Nitrous Oxide (Nitronox)

---

**Provider level:** AEMT

**Classification:**

Analgesic

**Indications:**

Moderate to severe pain

**Contraindications:**

Known drug sensitivity, altered level of consciousness, head injury, pneumothorax, inability to follow instructions, decompression sickness, undiagnosed abdominal pain, bowel obstruction, abdominal distension, hypotension, shock, COPD, pregnancy

**Possible side effects:**

Dizziness, apnea, cyanosis, nausea and vomiting

**Precautions:**

Invert cylinder several times before use. Patients can become momentarily unconscious but will reverse with a few breaths of room air or oxygen.

**How Supplied:**

50/50 mix nitrous oxide/oxygen

**Administration:**

Instruct the patient to inhale with the mask or mouthpiece as needed

**Special Notes:**

Patient must hold mask/mouthpiece and self-administer

# Ondansetron (Zofran)

---

**Provider level:** AEMT

**Classification:**

Antiemetic

**Indications:**

Nausea, vomiting

**Contraindications:**

Known drug sensitivity, liver disease, GI obstruction

**Possible side effects:**

EKG irregularities (rare), hiccups, pruritus, flushing, chills, headache, dizziness, drowsiness, shivering, hypoxia, non-voluntary movements

**Precautions:**

Tablets should be gently removed from foil, not pushed through the package

**How Supplied:**

4mg tablet or dissolving wafer

2mg/ml vial or prefilled syringe

**Administration:**

Adults only: 4-8mg PO, or 2-4mg IV over 2-5 minutes, 4mg IM in well developed muscle

**Special Notes:**

# Oxygen

---

**Provider level:** EMT and AEMT

**Classification:**

Atmospheric gas

**Indications:**

Confirmed or suspected hypoxia, oxygen saturation <94%, ischemic chest pain, respiratory insufficiency, confirmed or suspected carbon monoxide poisoning, other causes of decreased tissue oxygenation

**Contraindications:**

Over-oxygenation is a possibility that comes with its own set of complications. When oxygen is warranted consider the ideal method of delivery and amount.

**Possible side effects:**

High concentrations may cause decreased level of consciousness or respiratory depression in patients with chronic carbon dioxide retention.

**Precautions:**

Oxygen supports combustion

**How Supplied:**

Compressed gas cylinder

**Administration:**

After initial evaluation and stabilization evaluate delivery methods to maintain oxygen saturation  $\geq 94$ .

High concentration: 10-15 lpm via non rebreathing mask

Low concentration: 1-6 lpm via nasal cannula

Blow-by method as appropriate.

**Special Notes:**

Oxygen should not be withheld in the hypo perfused or hypoxic patient.

# Acknowledgement of Receiving Protocol

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I verify that I have received the protocol document and agree to follow the guidelines. I also agree that if I do not administer patient care in an appropriate manner, I may be dismissed from Nye County Emergency Services.

---

Printed Name

Date

---

Signature

Date