



Treatment Protocol

4102

Effective
October 1, 2018

Expires
March 31, 2019

Policy:
Universal Patient

Approval: Medical Director
Reza Vaezazizi, MD

Signed

Applies To:
PSP, EMT, AEMT, PM, MICN, BHP, EMS System

Approval: REMSA Director
Bruce Barton

Signed

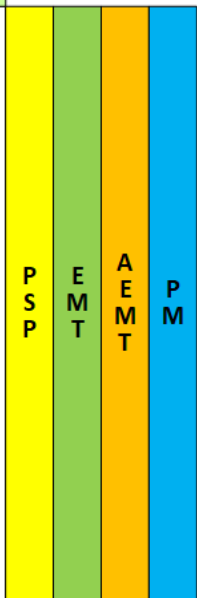
Arrive Scene

Scene Size-up

- Personal, personnel, and patient safety*
- Environmental hazards*
- Nature of event and number of victims*
- Mechanism of injury*
- Additional response and resources needed*
- Need for special operations*

Scene Management

- Ensure safety and security of all personnel
 - Practice body substance isolation (BSI) and use personal protective equipment (PPE)
- Stage as necessary, avoid and/or mitigate hazards
- Access and stabilize scene while maintaining exit, evacuation, and transport routes
- May initiate MCI if 10 or more patients require ambulance transport, or as operationally required
- Request additional response and resources as required
 - Preserve evidence and request law enforcement for any suspected criminal activity
 - Ensure that appropriate first response and special operations equipment are responding
 - Ensure that appropriate transport ambulance is responding
 - Ensure response or request air ambulance as clinically indicated and operationally required
- Cancel, reduce, or increase priority of responding equipment as clinically indicated and operationally required
- Begin special operations as required



Patient Contact

Primary Assessment

- Identify self, then comfort, calm, reassure, restrict activity, position and cover or expose as clinically indicated*
- Formulate general initial impression*

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Primary Assessment (continued)

Perform assessment of:

- Need for cervical spine stabilization
- Responsiveness using AVPU (Alert, Verbal, Pain, Unresponsive)
- Airway patency
- Breathing effort, approximate rate, equality of breath sounds, and adequacy
- Circulation including skin signs, bleeding, approximate rate, strength, and regularity
- Disability

As clinically indicated, determine patient's age, weight, and height:

- Age by written record, report by patient or parent, or estimate by EMS
- Weight by measurement, written record, report by patient or parent, Broselow Tape, or estimate by EMS
- Height by measurement, written record, report by patient or parent, or estimate by EMS

Classify patient as pediatric if appearing or known to be 14 years of age or less

Determine the patient's chief complaint

Perform the clinically indicated physical examination

Team Communication

The provider responsible for medical management must consult with the EMS team regarding:

- Findings on primary assessment
- Intended emergency stabilization

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Emergency Stabilization

Establish, maintain, and ensure the following as clinically indicated:

Cervical Spine Stabilization as clinically indicated by mechanism of injury with any of these clinical indicators:

Neuro deficits / Spinal Tenderness / Altered Mental Status/ Intoxication/ Distracting Injury

The long backboard (LBB) is an extrication tool, to facilitate patient transfer to the stretcher, and is **not** intended or appropriate to obtain spinal stabilization. Judicious application of the LBB for purposes other than extrication, requires that the benefits outweigh the risks of application. **IF** the LBB is used, patients should be removed as soon as is safe and practical.

Airway using manual airway maneuvers, oropharyngeal suction, oropharyngeal airway (OPA)

Breathing using mouth to mask, or bag valve mask (BVM)

Circulation using direct pressure and/or pressure dressing(s) to control bleeding; CPR per current standards

Position

Position patient as clinically indicated for safety, comfort, and to meet physiologic requirements:
Recovery position, left or right lateral recumbent, supine, low to high Fowler's, or seated

Minimal Titratable Oxygen

Give minimal titratable oxygen as clinically indicated

Handoff & Assist

Handoff to arriving EMS providers as required using: Situation Background Assessment Recommendation

Assist REMSA authorized EMS providers with higher credentials as requested, within scope of practice

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Emergency Stabilization (continued)				
<p>Airway using nasopharyngeal airway (NPA) Breathing using manometer and waveform capnography with BVM Circulation using tourniquet(s) to control bleeding</p> <p>SpO₂ Attach, interpret, titrate oxygen/ventilation, monitor and maintain SpO₂ of 94% or greater when equipped</p> <p>Home Glucometry Assist patient with home glucometry as necessary</p> <p>Assist Prepare for ALS procedures under the direction of REMSA authorized EMS providers with higher credentials</p> <p>ECG Attach ECG monitor when paramedic is present</p> <p>Blood Glucose Obtain and evaluate blood glucose as clinically indicated when the AEMT or paramedic is present.</p>		E M T	A E M T	P M
<p>Prepare for Transport Package and prepare for transport, appropriately covering patient for heat regulation, privacy and dignity</p> <p>When the alert cooperative patient requires cervical spine stabilization: Consider maintaining cervical spine stabilization on the ambulance cot, without the LBB The LBB is an extrication tool, to facilitate patient transfer to the stretcher, and is not intended or appropriate to obtain spinal stabilization. Judicious application of the LBB for purposes other than extrication, requires that the benefits outweigh the risks of application. IF the LBB is used, patients should be removed as soon as is safe and practical.</p>	P S P	E M T	A E M T	P M
<p>Discontinue cervical spine stabilization in the absence of clinical indicators.</p>				P M
<p>Assist Lift and Move Assist, lift and move patient as clinically indicated for safety, comfort and to meet physiologic requirements: Use standard techniques and/or authorized lifting or moving devices</p> <p>Consider the patient's need for assistance, ability to cooperate, and to: Position, stabilize, and protect himself or herself Safely transfer between positions, surfaces, and lifting or moving devices Safely walk short distances</p>	P S P	E M T	A E M T	P M
<p>King Airway Establish, maintain, and ensure airway using King Airway when required for emergency stabilization See REMSA Calculation Chart for pediatric application in patients appearing to be greater than 4 feet tall</p> <p>Attach, interpret, and monitor CO₂ by colorimetric detector or PETCO₂ by capnography</p>			A E M T	P M
<p>Attach, interpret, and continuously monitor PETCO₂ by capnography Capnography is mandatory following King Airway placement</p>				P M

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Emergency Stabilization (continued)

Venous/Vascular Access and Fluids
 Establish, maintain, and ensure peripheral IV access when required for emergency stabilization
 Consider the need for: additional sites, and small or large bore catheters as clinically indicated
 Establish IV access during transport of the non-entrapped, transport ready critical trauma patient

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Establish, maintain, and ensure pediatric IO access when required for emergency stabilization

Establish, maintain, and ensure adult IO access when required for emergency stabilization.

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0.9% Normal Saline IV lock or TKO; or IO TKO
 As clinically indicated for emergency stabilization
Use a volume control chamber IV set during pediatric administration

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0.9% Normal Saline IV bolus
 As clinically indicated for emergency stabilization
 See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
 May repeat as clinically indicated
Use a volume control chamber IV set during pediatric administration

Note: Despite proper IO placement, pressure infusion may be needed to achieve the required flow rates.
 The AEMT may not initiate adult IO access

Lidocaine 2% slow IO push over 1 minute, wait 1 minute before infusing fluids
 For IO infusion pain in the conscious patient
 See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
Repetition requires a base hospital order (BHO)

Airway using direct laryngoscopy and Magill forceps as clinically indicated

Endotracheal Intubation
 Establish, maintain, and ensure airway using endotracheal intubation when required for emergency stabilization
Patient length must exceed the Broselow Tape for endotracheal intubation

Attach, interpret, and continuously monitor PETCO₂ by capnography
Waveform capnography placement and clinical interpretation is mandatory following endotracheal intubation.

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Suction trachea as clinically indicated
 Introduce 3 mL Normal Saline as needed to loosen thick secretions

ECG
 Interpret and continuously monitor ECG
 Interpret 12 lead ECG
 Transmit 12 lead ECG to a REMSA authorized STEMI Receiving Center. Transmit to STEMI Base Hospital as clinically indicated for STEMI BH orders, including:
 Machine identified STEMI, paramedic identified STEMI, any requested transmission

Insert Treatment Protocols for Emergency Stabilization
 Follow clinically indicated Treatment Protocols when required for emergency stabilization

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Secondary Assessment

Complete physical examination (head to toe)

Perform assessment of:

Responsiveness including pupils, level of consciousness and orientation to PPTe (person, place, time and event)

Airway including capnography to confirm airway patency and placement

Breathing rate, breath sounds, and SpO₂

Circulation including capillary refill time, rate, systolic/diastolic BP, and ECG monitor/12 lead ECG

Disability including GCS (Glasgow Coma Scale), and as clinically required: mLAPSS (Modified Los Angeles Prehospital Stroke Screen), LAMS (Los Angeles Motor Scale) and V/CBG (venous or capillary blood glucose)

Detailed history of chief complaint

Signs and symptoms

Allergies

Medications (including dose, route and frequency)

Past medical history

Last oral intake

Events leading to injury or illness

Formulate prehospital provider impression

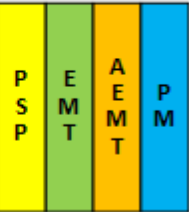
Team Communication

The provider responsible for medical management must consult with the EMS team regarding:

Results of emergency stabilization

Findings on secondary assessment

Intended patient disposition and management



Patient Disposition

Determine Destination

Determine destination while considering: patient's preference, clinical needs, and operational requirements

Base Hospital Contact and Report

Prior to Transport, Contact a single REMSA authorized base hospital (BH) as required by REMSA Policy, and in all:

Critical trauma – contact a REMSA authorized Trauma BH

Critical burns

Fracture or dislocation with neuro and/or vascular compromise

MCI/MPI (Multi Casualty/Multi-Patient Incident)

Suspected stroke

Symptomatic bradycardia with pulses, symptomatic tachycardia with pulses

Mechanical Circulatory Support Device Patients (VAD, TAH)

Pre-eclampsia, eclampsia, complications of childbirth, or neonatal resuscitation

Sexual assault, or law enforcement request for "OK to book"

Atypical presentation, circumstance, or provider uncertainty



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Patient Disposition (continued)

Give base hospital report including:
 Call sign/identifier, individual provider's title and name, contact for "medical direction"
 Age, sex, weight (Broselow color if pediatric), in mild/moderate/severe condition
 Chief complaint and mechanism of injury / history of present illness
 Pertinent findings upon assessment of responsiveness, airway, breathing, circulation, and disability
 Vital signs
 Pertinent past medical history, medications, and allergies
 Interventions performed
 Intended destination, alternative destinations, and ETAs
 Requested orders

Assess, clarify, monitor, treat within scope of practice, and determine or change destination as directed by BH

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Insert Treatment Protocols for Patient Disposition
 Follow operationally indicated Treatment Protocols when required for patient disposition

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Transport

Patient Management

Transport
 Transport with continuous monitoring, reassessment, and treatment per applicable protocols

ECG
 Perform 12 Lead ECG as clinically indicated when paramedic is present

Blood Glucose
 Obtain and evaluate blood glucose as clinically indicated when AEMT or paramedic is present

Prehospital Receiving Center Notification
 Confirm receiving notification by BH, or notify receiving including:
 Call sign/identifier, individual provider's title and name, contact for "receiving notification", and ETA
 Age, sex, weight (Broselow color if pediatric), in mild/moderate/severe condition
 Chief complaint and mechanism of injury / history of present illness
 Pertinent findings upon assessment of responsiveness, airway, breathing, circulation, and disability
 Vital signs
 Pertinent past medical history, medications, and allergies
 Interventions

Establish Venous Access
 Establish, maintain, and ensure peripheral IV access as clinically indicated
 Consider the need for: additional sites, and small or large bore catheters
 Avoid the antecubital fossa unless required for emergency stabilization

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Patient Management (continued)

0.9% Normal Saline IV lock or TKO
As clinically indicated for patient management
Use a volume control chamber IV set during pediatric administration

0.9% Normal Saline IV bolus
As clinically indicated for patient management
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
May repeat as clinically indicated
Use a volume control chamber IV set during pediatric administration

Draw Blood Samples
Draw venous blood samples as clinically indicated/requested
Label tubes with:

1. Patient's name
2. Date and time drawn
3. Drawer's initials

Store tubes in a biohazard bag and handoff to receiving staff

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ECG
Interpret and continuously monitor ECG
Interpret 12 lead ECG
Transmit 12 lead ECG to a REMSA authorized STEMI Receiving Center. Transmit to STEMI Base Hospital as clinically indicated for STEMI BH orders, including:
Machine identified STEMI, paramedic identified STEMI, any requested transmission

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Insert Treatment Protocols for Patient Management
Follow clinically indicated Treatment Protocols when required for patient management

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Re-Assessment

Focused physical examination

Perform re-assessment of:
Responsiveness including AVPU, pupils, level of consciousness and orientation to PPTE
Airway patency, including capnography to confirm airway placement
Breathing effort, rate, equality, adequacy, breath sounds, and SpO₂
Circulation including skin signs, bleeding, capillary refill time, rate, strength, regularity, s/d BP, and ECG/12 lead
Disability including GCS, mLAPSS, LAMS, and V/CBG

Repeat as clinically indicated, at least every:
5 minutes for unstable patients
15 minutes for apparently stable patients during the first hour of care
30 minutes for apparently stable patients following the first hour of care

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