

Summer 2011 CQI Learning Points:

ASA:

- ✚ When treating suspected ACS patients who have already taken their own aspirin, go ahead and give them an additional 162 mg dose from your drug box/bag.
- ✚ If encountering a patient in a healthcare setting (i.e., doctor's office, clinic, nursing center, etc.) and the staff has already given the patient aspirin; it is up to the paramedic's discretion. If in doubt, give it. The benefit outweighs any potential risk, especially considering our small dose of 162 milligrams.

iPCR:

- ✚ When writing your narrative please do not attempt to abbreviate pertinent negatives by using a hyphen as a negative sign. It is far easier to understand if you just write the word "no" or "negative" before listing them.

NCD:

- ✚ If you decompress a tension pneumothorax with an NCD, please thoroughly document all of the details in your treatment narrative. Please include: what landmarks you used, location of the insertion, confirmation of a rush of air/blood, outcome, etc. This is a very high risk/low frequency procedure that should be carefully described in your narrative.

Transfer of Care Sheets:

- ✚ Please remember to leave a copy of the transfer of care sheet before departing the emergency department. This is especially critical for trauma patients, critically ill patients, and anytime you have given a medication.
- ✚ This is a County EMS requirement for situations where a PCR is not left following transfer of care.

Trauma in the Elderly:

- ✚ Marshall has asked us to up the triage (be more suspicious of injuries) in all elderly patients that are the victims of significant blunt trauma. There have been a few recent cases where serious injuries have been found following x-rays and CT scans. Marshall Medical Center will be activating their trauma team if they receive an elderly trauma patient who has more than one isolated injury. This is their new protocol, so don't be offended if this happens to your patient.

Compensated Shock:

- ✚ Not all shock patients have obvious hypotension. Tachycardia, tachypnea, delayed capillary refill, cyanosis, dizziness, ALOC, dry mucous membranes, poor skin turgor (tenting), pale, cool, and clammy skin signs, and positive orthostatic vitals (see below) are just some of the signs and symptoms that present before the BP starts to drop in the shock patient. Don't

withhold IV fluids in patients with suspected (compensated) shock, just because their BP hasn't begun to drop yet.

- ✚ If not contraindicated by wet lungs sounds (rales) or severe hypertension, IV fluid boluses should be administered ASAP to prevent a patient from going into uncompensated shock. The earlier you begin this, the better!

Orthostatic Vital Signs:

- ✚ Have the patient lie supine for at least 2 minutes then move them to a standing position.
- ✚ Wait at least **30 seconds** before you take the BP. If during this time the patient has symptoms of dizziness, or cannot remain standing, this is a **positive** result for **orthostatic hypotension**. You do not need to go any further (please have the patient lie down again).
- ✚ Positive OH is defined as a decrease in systolic BP 20mmHg or greater; a decrease in diastolic BP 10mmHg or greater; and/or an increase in heart rate of 20 bpm or greater.