

2016 EDCEMS POLICY REVISION SUMMARY

POLICY PROCEDURE PROTOCOL	REVISIONS
ETT VERIFICATION	<p>ADDED: An attempt at visual confirmation should be made following intubation with any device including nasal intubation.</p> <p>Documentation should include monitor strip of EtCO₂ tracing whenever instituted</p>
AMA	<p>DELETED: Release at scene policy</p> <p>ADDED: Consider involvement of law enforcement early if:</p> <ul style="list-style-type: none"> • There is a threat to self or others • Threat of grave disability. • The patient is a Minor who is adamantly refusing treatment and/or transport. <p>Consent for a Minor to refuse treatment and transport may be acquired by phone, if a legal guardian can be reached. The Medic should document to whom they spoke with, and phone number they were reached by.</p>
MD AT SCENE	Reviewed, No revision.
BLS MED	ADDED: Narcan
MEDICAL AUTHORITY	Reviewed, No revision
SPINE IMMOBILIZATION	DELETED: taping of the head with full spinal immobilization
EMS AIRCRAFT	<p>ADDED: Observe for drones operating in the area Determine proper size 100' X 100'</p> <p>UPDATED: AAMS and CAMTS definitions</p>
MCI	<p>DELTEED: EMSA Policy unnecessary duplicate to MCI Plan</p> <p>REVISED: MPI definition – An incident involving more than two (2) patients, up to five (5) patients.</p> <p>Added CQI review component for all MPI/MCI</p>
INTERCOUNTY	Reviewed, no revision
5150	ADDED: restraint wavier requires a base order.
PHYSICAL RESTRAINT	Reviewed, no revision
TASER	<p>ADDED:</p> <p>Consider the potential for Sudden Unexpected Death Syndrome the vast majority of patients that have died in police custody have shown signs of Excited Delirium: a state in which a person is in a psychotic and extremely agitated state. Due to extreme over function of organs, patient can develop Multiple Organ Dysfunction Syndrome.</p> <p>Procedure to remove taser barbs if interfere with treatment</p>

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PSYCH IFT	<p>ADDED: The attitude portrayed in approaching the patient is of paramount importance. Convey to the patient that the purpose of extremity restraints is both required by policy and intended for patient safety during transport as with any other gurney security systems (i.e. seatbelt and gurney locking mechanism to ambulance floor.)</p> <p>A chaperone to accompany the patient will be made in concert with Mental Health personnel and the Attending Physician.</p>
CONTROL SUB	<p>ADDED: For daily inspection and adding medication supply will be signed into stock by 2 paramedics or 1 paramedic and 1 company officer. In circumstances where the afore mentioned staff are not available, an EMT signature may be used.</p>
SAFE BABY	<p>No changes were made to the policy the authority was updated.</p>
ON SCENE PHOTO	<p>Policy was completely revised.</p> <ul style="list-style-type: none"> • No photo or video with personal devices permitted, only department issued equipment. • All images are solely the property of El Dorado County EMS Agency. • All personnel are prohibited from posting • Photographs or video may be taken of rescue situations, mechanism of Injury at MVC and patient care without identifiable features. • Photographs or video inside the patient compartment of an ambulance or private residence are NOT permitted • Defined ways photo/video may be used
NERVE AGENT	<p>Minor revision needed regarding champak deployment and documenting treatment on triage tags.</p>
PANDEMIC FLU	<p>ADDED: N95 or equivalent mask, updated the links to the EPA disinfectant lists</p>
SUSPECTED ABUSE	<p>ADDED: Link to the EMS Agency abuse reporting forms</p>
AIR ABULANCE EQUIP	<p>DELETED: the entire inventory list and inserted the statement requiring the air ambulance agencies to submit a copy of their inventory lists to the medical directory annually for approval</p>
ETT	<p>DELETED: Routine use of atropine for pediatric intubation to follow new AHA guidelines.</p>
KING AIRWAY	<p>Reviewed No revision.</p>
ETAD	<p>DISCONTINUED: Procedure no longer in use.</p>
STOMA ETT	<p>ADDED:</p> <ul style="list-style-type: none"> • Remove existing tube from stoma if airway is compromised. Do not attempt to reinsert a dislodged pre-existing tracheostomy tube. • Assure an adequate BLS airway. Cover stoma with gloved hand or occlusive dressing when using a bag-valve-mask. Oxygenate with 100% oxygen. • PCR documentation shall include verification of airway placement including a monitor strip of EtCO2 tracing whenever instituted.

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ETCO2	<p>ADDED:</p> <ul style="list-style-type: none"> • EtCO2 values were changed to 35-45 to reflect more normal values, 10-20 mmHg during CPR and 35-45 mmHg without CPR should be noted for confirmation of ETT placement. <ul style="list-style-type: none"> a. Tube displacement or esophageal intubation – <u>diminished or no waveform</u> b. Obstructed airway or ventilation device failure – <u>diminished or no waveform</u> c. Hyperventilation – <u>low numeric value</u> d. Hypoventilation – <u>high numeric value</u> • Upon transfer of care of the patient another strip is to be printed showing ETCO2 waveform and numeric value which will be placed in the patient care record. Additional copy should be left for the hospital record.
NEEDLE CRIC	Reviewed, no revision
NCD	<p>ADDED:</p> <ul style="list-style-type: none"> • Indications for NCD are Traumatic Arrest OR Hypoxia & Hypotension with other signs and symptoms • Complication: Laceration of liver or spleen (lateral sites) • Lateral instructions: Pull the tissue up and away towards the chest and count the ribs. <p>REVISED: Needle catheter Sizes to reflect current practice, 10 gauge 3.25" (Adult) 14 gauge 2"-2.5" (Peds), Must carry both sizes</p>
AED	REVISED: Condensed to one page removed duplicate language.
PACING	<p>REVISED: Title to Transcutaneous Pacing from External Cardiac Pacing</p> <p>ADDED:</p> <ul style="list-style-type: none"> • Indication signs and symptoms: Hypotension, Acute ALOC, Shock, chest pain. • Increase current by 10mA increments until observed evidence of pacing capture. Set current to 10mA above the threshold level to ensure continued capture. Generally occurs between 40-100mA. • Withhold pain medication if systolic Bp < 100.
BRADYCARDIA	REVISED: Format changed to match tachycardia protocol using the stable and unstable algorithm
PULSELESS ARREST	<p>REVISED: BLS Treatment section per 2015 AHA Guidelines</p> <ul style="list-style-type: none"> • Ensure scene safety and confirm unresponsiveness. • Simultaneously check for pulse and no breathing or only gasping • Prior to defibrillation: Ensure skin is clean and dry. Remove metal necklaces and underwire bras. Check for implanted medical devices or piercings, place pads at least 1 inch away. • CPR should be initiated while the AED/defibrillator equipment is being retrieved and applied. Defibrillation should be attempted as soon as the device is ready for use. If no shock advised continue CPR <p>ADDED: Consider Amiodarone 150 mg IV over 10 minutes for recurrent VF/VT with periods of ROSC where no antiarrhythmic has yet been given.</p>

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SEVERLY AGITATED	Reviewed, No revisions
SEPSIS	<p>NEW PROTOCOL:</p> <ul style="list-style-type: none"> SIRS CRITERIA consists of 2 or more of the following: TEMP >100.4 OR < 96.8, HR > 90, RR > 20. If history is suggestive of infection and 2 or more SIRS criteria are present Sepsis should be suspected. Report these findings to base station. Establish 2 large bore IVs, Use IO if unable to establish IV. ADMINISTER: 1000ml fluid bolus, Repeat 500ml fluid bolus if BP<100 systolic Repeat fluid bolus up to 30ml/kg. Do not withhold fluid boluses even in the presence of “wet lungs” if BP does not improve. <p>CONTACT BASE STATION: If BP is refractory to fluid boluses (If hypotension persists in <u>non-hypovolemic</u> shock): DOPAMINE- 5-20 µg/kg/min IV/IO infusion may be ordered. The initial treatment of Sepsis involves maximizing perfusion with intravenous fluid boluses not vasopressor.</p>
COLD EXPOSURE	REVISED: Removed Frostbite from ALS treatment section.
HEAT EXPOSURE	<p>ADDED: Obtain and document temperature if able.</p> <ul style="list-style-type: none"> Definitions for types of heat emergencies: Cramps, Exhaustion, Stroke Establish IV/IO, Adults: Give NS 1000ml bolus, may repeat 500ml bolus to maintain a SBP of at least 100mm/Hg. Peds: Give NS 20ml/kg, repeat to effect age appropriate SBP of at least (70 + (2 x Age)).
SNAKEBITE	Reviewed, no revision.
CHILDBIRTH	<p>ADDED: Questions to maternal history:</p> <ul style="list-style-type: none"> Is the patient under a doctor’s care? Past medical history, current medications? What is the due date? Gravida and Para Status; single fetus or twins? Any problems with this or other pregnancy / delivery? When did contractions start, how far apart, how long do they last Has the water broken? What color was fluid, was there an odor? Is there sensation of fetal activity? <p>Placing baby skin to skin with mother is good way to keep baby warm.</p> <p>REVISED: Clamp cord After 30 seconds per new 2015 AHA guidelines</p>
NEONATE	<p>ADDED: Information and procedures to BLS treatments regarding stimulating and drying neonate, most cardiac arrest is due to asphyxia and assess Apgar at 1 and 5 minutes MONITOR - EKG for the rapid and accurate measurement of the newborn’s heart rate. State of oxygenation is optimally determined by a pulse oximeter rather than by simple assessment of color.</p> <p>DELETED: Per 2015 AHA Guidelines: Giving O2 for neonate not requiring resuscitation. Intubation and suctioning for meconium fluid.</p> <ul style="list-style-type: none"> Routine intubation for tracheal suction is <u>no</u> longer recommended if meconium is present. Appropriate intervention to support ventilation and oxygenation should be initiated as indicated for each individual infant. This may include intubation and suction if the airway is obstructed.

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SHOCK	<p>ADDED: Signs and symptoms for shock</p> <ul style="list-style-type: none"> • Restlessness, confusion, ALOC • Weakness, dizziness • Weak, rapid pulse • Pale, cool, clammy skin • Delayed capillary refill • Hypotension • Coffee-ground emesis • Tarry stools <p>Definitions for shock types Algorithm for shock types, adult and peds</p>
HEAD TRAUMA	<p>REVISED: Routine medical care</p> <p>ADDED: Establish 2 large bore IVs macro drip tubing. Place IO if unable to establish IV. If patient is in shock or is compensating for impending shock, refer to SHOCK protocol. Hypotensive patients with head injuries should have IV fluid resuscitation to maintain appropriate systolic BP.</p> <p>Blood tubing deleted – remove from minimum equipment list</p>
CRUSH SYNDROME	Reviewed, No revision
FORMS	Updated STEMI form to simplify. The medic completes the top section and returns to EMSA. Trauma Decision Scheme added call trauma alert for patients meeting criteria. Trauma Triage Report Form updated to reflect the current policy.
FORMULARY	<p>REVISED:</p> <p><u>Atropine:</u> Contraindication is None, moved Neonate note to comments. Removed as a pre-intubation med for peds.</p> <p><u>Midazolam:</u> May only be used for TCP if patient has an allergy to Opioids</p> <p><u>Ondansetron:</u> <u>Added to Contraindications:</u> Pregnancy, Concomitant use with Apomorphine (Parkinson’s medication,) and Congenital Long Q-T syndrome.</p> <p><u>Revised Administration:</u> IV/IO should be given over 2-5 minutes and not less than 30 seconds. Dose revised to 4 - 8mg.</p> <p><u>Added to Comments:</u></p> <ul style="list-style-type: none"> • Can cause profound hypotension. Pill splitter is required for 2 mg ODT dose in pediatrics. ECG monitoring is recommended in patients with electrolyte abnormalities (hypokalemia or hypomagnesemia), CHF, bradyarrhythmias or patients taking other medicinal products that lead to QT prolongation. • Can develop Serotonin Syndrome with concomitant use of SSRI’s, SNRI’s, MAOI’s, mirtazapine, fentanyl, lithium, tramadol, S/S can include: ALOC, tachycardia, labile blood pressure, neuromuscular symptoms, seizures.