

EXPLANATION OF SUGGESTED CHANGES TO PATIENT CARE PROTOCOLS
PARAMEDIC
JUNE, 2009

Note : the word “drug” has been changed to “medication” throughout the document.

Title Page: Changed to fifth edition and added new date

Table of Contents: Has been alphabetized and renumbered (except General Patient Care and Communications were left as #1 and #2 in treatment protocols)

Preface: Corrected email address and clarified the EMT’s responsibility to refuse to accept orders that are not in their scope of privilege. Also added that a pediatric patient is defined as someone aged 15 years or younger unless otherwise noted in the protocols. Noted that anything pertaining to a pediatric patient will be in the Tahoma Font, in bold and colored green.

Section 2: Corrected #6 to explain that families of patients do not have the same rights as the patients themselves. While as a general rule the EMT should take the patient to the hospital the family wants, if the hospital is inappropriate or is on diversion, OLMD must be called and his/her orders followed.

#7: added that while an ambulance service does not have to take a patient out of town if it leaves the community without ambulance service, that is not a license to ignore the trauma system and always take the patient to the local hospital. If the ambulance service is unable to comply with the trauma system plan, they must contact the office of EMS & Trauma to develop a plan to correct this.

Section 3.3: Clarifies that medication orders may be signed by an OLMD physician or by the service’s medical director.

Section 3.4: Added list of pediatric CAT A and CAT B Medications

Section 3.4: Added Hemostatic Agents, CPAP, and Ondansetron to the list of Category A medications and procedures (**required**). CPAP remains optional to ALS nontransport services. List has been alphabetized.

Section 3.5: Removed CPAP and Hemostatic Agents from the list of optional medications and procedures and added Bougie for difficult intubations. CPAP is still optional for ALS nontransport services. List has been alphabetized.

Protocol 4.1: Clarified that when filling out the ePCR, the General Patient Care protocol can be listed if there is no specific protocol for use in treating the patient.

Protocol 4.2: Added that the EMT may notify the nurse or paramedic at the receiving hospital (some hospitals have paramedics answer the phone).

Protocol 4.5: Combined Coma 4.15 with Altered Mental Status.

Protocol 4.7: In the burn protocol changed Albuterol to Cat. A for Adults.

Protocol 4.8: Added that if the patient is in cardiac arrest, if the patient has a venous port you may access it if you are trained and have the proper equipment.

Protocol 4.9: Changed pediatric sodium bicarbonate to “dilute 50% with NS” rather than D5W. Also changed the dose from 1 mEq/kg to 1 mEq/kg initial dose

Protocol 4.10: Added note that Acute Coronary Syndrome protocol is for adults only. EMTs are to contact OLMD for chest pain in pediatric patients (age 15 years and younger). Aspirin to be given to adults if at least 324 mg have not been given in the last 24 hours.

Protocol 4.11: for PEDIATRIC BRADYCARDIA: added that both epinephrine and atropine are CAT A and external pacing is CAT B and only for age 14 and above.

Epinephrine can be repeated every 3-5 minutes until pulse is 80 or greater
Atropine can be repeated once in 5 minutes if pulse is not 80 or greater.

Protocol 4.12: moved the order of clamping and cutting the cord to the correct place in the sequence of care.

Protocol 4.14: For congestive heart failure, added that the patient should be put in the Upright sitting position and made nitroglycerin and CPAP Cat A and left lasix and morphine as Cat B. This is to bring treatment in line with current treatment of CHF.

Protocol 4.15: Combined Coma with the Altered Mental Status protocol. Deleted Coma protocol.

Protocol 4.22: Added near drowning as a Cat. A indication for use of CPAP.

Protocol 4.23: In poison protocol deleted the conditions in which you should not induce vomiting since EMTs no longer carry ipecac. Simply states “do not induce vomiting.”

Protocol 4.25: In respiratory distress protocol added that for pulmonary edema nitroglycerin and CPAP are Cat. A and all other treatments (lasix and morphine) are Cat. B. This reflects current treatment of pulmonary edema.

Protocol 4.26: Lorazepam was initially added to the medication list because for a time diazepam was unavailable. Though diazepam is now commonly available, many Medical Direction physicians prefer lorazepam and would like to continue using it for seizures. The protocol has been changed to allow use of either diazepam or lorazepam for seizures. The only drawback to lorazepam is that it has only a 60-day unrefrigerated shelf-life.

Protocol 4.27: Added that if external bleeding from an extremity cannot be controlled by pressure, application of a tourniquet is the reasonable next step in hemorrhage control. This reflects the current treatment and the current testing used by the National Registry. Also added to use a hemostatic agent if unable to stop severe bleeding with pressure or a tourniquet. Also added that if the patient is in hypovolemic shock and the patient has a venous port you may access it if trained and you have the proper equipment.

Protocol 4.28: rewrote the Stroke protocol to reflect current standard of care.

Protocol 4.32: Changed treatment for vomiting from diphenhydramine to ondansetron (Zofran). The cost of injectable ondansetron is now inexpensive.

Protocol 5.3: Added Burns and CHF as Adult CAT A uses of Albuterol. Still CAT B for burns for peds.

Protocol 5.5: Added that use of aspirin is Cat. B for pediatric patients because it may be associated with Reye's Syndrome.

Protocol 5.10: Changed diphenhydramine to secondary medication for treating vomiting.

Protocol 5.13: Added Pediatric dose for Furosemide (Cat. B).

Protocol 5.17: Added that lorazepam may be used in place of diazepam.

Protocol 5.18: Added Pediatric dose for Magnesium Sulfate for Torsade

Protocol 5.21: Added that use of nitroglycerin is contraindicated for pediatric patients in the EMS setting.

Protocol 5.22: Added that Nitrous Oxide is Cat. B for pediatric patients.

Protocol 5.24: added new protocol for Ondansetron (Zofran).

Protocol 5.26: Added that for children between one month and 8 years of age you should dilute sodium bicarbonate 50% with NS.

- Protocol 5.27: Added that there is almost no indication for thiamine (Cat. B) use in a child.
- Protocol 5.28: Added that vasopressin use is contraindicated for pediatric cardiac arrest.
- Protocol 6.3: Added near drowning as an indication for use of CPAP and added a note that CPAP is not used in children under the age of 12 because of lack of complete development of their respiratory system.
- Protocol 6.5: added that orotracheal intubation is Cat. B for children and nasotracheal intubation is contraindicated in children
- Protocol 8.2: Added that ePCRs must be completed and transmitted to the office of EMS & Trauma within 168 hours of the provided medical care.
- Protocol 8.5: Changed the Trauma System Protocol to reflect suggestions made by the pediatric workgroup and the State Trauma Advisory Council.
- Protocol 9.2: Added Bougie to list of acceptable equipment.
- Protocol 9.4: Added Becton Dickinson Angiocath 14 gauge by 3.25 inches long to the list of acceptable devices to use for chest decompression.
- Protocol 9.5: Added QuikClot Combat Gauze and WoundStat hemostatic agents to the list of acceptable agents. QuikClot Combat Gauze (Kaolin based) is currently what the military is using in combat.
- Protocol 10.3: Rewrote the Stroke Checklist to reflect the new Stroke protocol.
- Protocol 10.4 Removed “the patients family” as being able to sign to take the patient to a hospital on diversion.