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Standing Order Introduction

Introduction

The following Standing Orders are to be performed by paramedics upon recognition of need. The performance of procedures contained in these orders will be in accordance with current certification level. At no time shall it be permissible for any personnel to perform any procedure or attempt to provide any level of care beyond that for which they are certified.

For all patients requiring Pre-hospital Advanced Life Support measures, medical control will be contacted at the paramedic's earliest opportunity without delaying patient care.

ALL paramedics will strictly adhere to these Standing Orders. Failure to comply may result in disciplinary action by the Medical Director.

Communications Failure

This order applies in the event that, due to equipment failure or location contact cannot be made with medical control via cellular telephone, landline telephone, or IHERN. The following will apply:

- EMS personnel may, within the limits of their certifications, perform necessary ALS procedures that, under normal circumstances, would require a direct physician order.
- These procedures shall be the minimum necessary to prevent the loss of life or critical deterioration of a patient's condition.
- All procedures performed under this order and conditions that created the communications failure shall be thoroughly documented.

Attempts MUST be made to establish contact with medical control as soon as possible.

**** NOTE - the medical director or his/her designate will audit ALL runs during which this order is utilized.**

Airway Control/Ventilation

It is a generally accepted concept that control of a patient's airway should be of utmost importance to EMS personnel. For that reason, the following adjuncts have been approved for use by paramedics upon recognition of need.

A. Basic Airways (with high-flow oxygen at 12 to 15 lpm or greater.)

1. Oropharyngeal Airway
2. Nasopharyngeal Airway
3. Combi-Tube
4. King non-visualized airway

B. Advanced Airways (with high-flow oxygen at 12 to 15 lpm or greater.)

1. Endotracheal Intubation
2. Nasotracheal Intubation
   Cricoid Puncture
   Surgical Cricothyrotomy (**This skill requires direct physician order**.)

C. Ventilation/Oxygenation

1. The patient must be ventilated periodically during prolonged efforts to intubate
2. Upon securing a patent airway, assist ventilations as necessary using positive pressure breathing techniques with high-flow supplemental oxygen
3. Monitor the SaO2 of all patients complaining of difficulty breathing via pulse oximeter
4. Intubated patients will be monitored via end-tidal CO2 & Capnography.

D. Cricoid Puncture

May be used in the event of a complete airway obstruction by a foreign body, trauma, or swelling that cannot be managed by normal means. If inadequate, consider Surgical Cricothyrotomy.

Intravenous Lines

This order applies upon recognition of need for at least one of the following:

1. Medical drug route (TKO rate)
2. Fluid or volume replacement where a current or a potential need is evident.

Fluids Available

- 0.9% Sodium Chloride (Normal Saline [NS])
- D5W
- Lactated Ringers (LR)

Intraosseous Lines

A paramedic may establish an intraosseous line in lieu of venous cannulation when a peripheral IV cannot be established if the patient meets the following criteria.

1. **Patients presenting with a life threatening condition (i.e. cardiac dysrhythmias, hypotension)**
2. **Cardiac or Respiratory arrest.**

Existing Central Lines

A paramedic may utilize a patients existing central line. These include

- **Subcutaneous medication ports**
- **Existing external lines**

Fistulas will not be utilized.

E.Z. - I.O.

This order applies when a patient presents with a medical condition that requires immediate vascular access when standard IV access are challenging.

Indications:

- Cardiac arrest
- Respiratory arrest
- Traumatic injuries
- Shock or Hemodynamic instability (Systolic BP of less than 90)
- Burns
- Pre-arrest state

Contraindications:

- Fracture of the bone selected for IO infusion. (Consider alternate site.)
- Absence of adequate anatomical landmarks for proper insertion site identification.
- Pre-existing medical condition on the extremity selected for insertion.
- Infection at area of insertion.
- Previous orthopedic procedure near site.
- Excessive pre-tibial soft tissue.

Required Equipment:

- EZ-IO Driver
- **EZ-IO Adult needle set (Blue) used for patients over 40 kg**
- **EZ-IO Pediatric needle set (Pink) used for patients 3 to 39 kg**
- Alcohol or Betadine wipes.
- 10 ml syringe
- EZ-Connect or Standard extension set.
- Normal Saline, D5w or Lactated Ringer
- Pressure Bag Infuser or Infusion Pump.
- 2% Lidocaine (It is acceptable to use pre-load Lidocaine)
- EZ-IO yellow wristband

Procedure:

- Body Substance Isolation Equipment (BSI)
- Select appropriate Adult or Pediatric needle.
- Locate appropriate insertion site (Proximal/Distal Tibia and Proximal Humerus)
- Prepare insertion site using aseptic technique
- Stabilize site and insert appropriate needle set
- Stabilize catheter hub.
- Confirm placement
- Syringe bolus (flush) the EZ-IO catheter with 10 ml appropriate fluid.
- **No flush = No flow**
- Slowly administer appropriate dose of Lidocaine 2% into IO for conscious patients.
- Utilize pressure (syringe bolus, pressure bag or infusion pump) for continuous infusions where applicable.
- Begin infusion
- Dress site and secure tubing apply wristband.

Medication	Route	Dosing
Lidocaine 2%	**IO**	**Adult – 20 to 40 mg** Slow IV Push **Pediatric- 0.5 mg/kg** Slow IV Push

Continuous Positive Airway Pressure (CPAP)

This order applies when a patient presents with congestive heart failure / Pulmonary edema.

Signs and Symptoms:

- Rales
- Dyspnea (Sudden Onset)
- Tachypnea
- Accessory muscle use

Contraindications:

- Decreased Level of Consciousness or unable to follow commands.
- Systolic B/P less than 90mm Hg.
- Suspected / History of Pneumothorax.
- Apnea
- PMHX of Asthma.
- PMHX of pulmonary aspiration or infection
- Evidence of sepsis or pneumonia.
- Intolerance for CPAP mask or procedure.

Required Equipment:

- Whisper Flow Fixed or Variable Generator.
- 50 psi compressed gas source.
- Quick connect.
- Mask, CPAP valves and tubing.
- Air entrainment port filter

Procedure for Fixed Flow Gererator:

- Assemble the WhisperPak set-up you are going to use.
  - Connect the tubing to the generator outlet
  - Connect the mask to the tubing
  - Attach the headstrap to the mask (attaching it at only 3 points will facilitate the application of the mask to the patient's face. You can attach the fourth point after the patient feels comfortable.)
  - Insert the CPAP valve into the mask

- Apply the mask to the patient. Talk to the patient and tell him it is high flow oxygen with some pressure and the mask needs to fit snugly on his face. He may be more comfortable holding it in place himself if he is fearful. If possible, slip the head strap over his head and attach the fourth point to hold it in place.

Monitor vital signs and pulse oximetry

If patient presents or becomes unstable do not withhold intubation.

VT/VF

This order applies when a patient presents with pulseless VT or VF

Treatment:

- Place patient on Auto Pulse.
- Initiate CPR for 2 min. (about 5 cycles) if call to response time is longer than 4 to 5 minutes or if un-witnessed arrest.
- Give high flow O2 via BVM in conjunction with OPA or NPA.
- Attach Monitor/Defibrillator.
- Check rhythm and manage appropriately.
- Establish IV/IO access.
- Secure airway and confirm placement. (ET, King or Combi-Tube)
- Intubated patients will be monitored via end-tidal CO2 & Capnography.
- Administer the following medications as they apply.
- Consider underlying causes.

Give 1 Shock @ 120j. and check rhythm.

↓

Resume CPR Immediately for 2 minutes or 5 cycles @ 30 -2

↓

Medication	Route	Dosing
Epinephrine 1:10,000	IV/IO	**1mg** repeat every 3-5 min.

↓

Shockable rhythm?

↓

Give 1 Shock @ 150j. and check rhythm.

↓

Resume CPR Immediately for 2 minutes or 5 cycles @ 30 -2

↓

Medication	Route	Dosing
Amiodarone	IV/IO	300 mg first dose. 150 mg second dose after 3-5 min.

OR

Medication	Route	Dosing
Lidocaine	IV/IO	**1-1.5 mg/kg** first dose **0.5 to 0.75 mg/kg** second & third dose. Max 3 doses or 3 mg/kg

For Torsades de pointes

Medication	Route	Dosing
Magnesium	IV/IO	1-2 g Used only for Torsades de pointes

↓

Additional shocks @ 200 j.

Postresuscitation Maintenance Therapy
Start a maintenance infusion.

Medication	Route	Dosing
Amiodarone Drip	IV Drip	Used if patient is converted with amiodarone. **1 mg/min** Mix 150 mg into 100ml D5W and run at 40 cc/hr
Lidocaine Drip	IV Drip	**1 – 1.5 mg/kg** Loading dose if not received during the arrest **1 – 4 mg/min Drip** If given during arrest start at 2 mg/min

Asystole/PEA

This order applies when a patient presents with no pulse
Treatment: • Initiate CPR for 2 min. (about 5 cycles) if call to response time is longer than 4 to 5 minutes, or if arrest was un-witnessed. • Give high flow O2 via BVM in conjunction with OPA or NPA. • Attach Monitor/Defibrillator. If asystole confirm in at least 2 leads. • Check rhythm and manage appropriately. • Establish IV/IO access. • Initiate fluid bolus of 500 ml for PEA. • Secure airway and confirm placement. (ET, King or Combi-Tube) • Intubated patients will be monitored via end-tidal CO2 & Capnography. • Administer the following medications as they apply. • Consider underlying causes and treat appropriately.

Continue CPR

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Medication	Route	Dosing
Epinephrine 1:10,000 Preload	IV/IO	1mg repeat every 3-5 min.

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Medication	Route	**Dosing**
Atropine	IV/IO	1 mg repeat every 3-5 min Up to 3 doses. (For asystole or PEA less than 60 bpm)

↓

Check rhythm
Shockable rhythm?

Narrow QRS tachycardia with pulses greater than 150 bpm

This order applies when a patient presents with narrow QRS complex tachycardia greater than 150 bpm. and showing serious significant signs and symptoms.

Treatment:

- Give high flow O2 via. NRB.
- Attach Monitor/Defibrillator.
- Is rhythm regular or irregular?
- Is patient stable or unstable?
- Establish IV/IO access.
- 12 lead EKG for stable patients.
- Administer the following medications as they apply.

If pt. presents unstable at any time

(i.e.: decreased LOC, systolic BP less than 90, symcope or CHF)

↓

Synchronized Biphasic cardioversion starting at:
SVT & A-Flutter---50j, 100j, 120j, 150j, 200j.
A-Fib & VT with a pulse--- 100j, 120j, 150, 200j, 300j.

Medications Treatment

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Regular rhythm?

↓

Attempt vagal maneuvers

↓

Medication	Route	Dosing
Adenosine (adenocard)	IV/IO	**6 mg rapid IV push**. (Follow with 20cc NS. Bolus) If no conversion **12 mg rapid IV push X 2** (Follow with 20cc NS. Bolus)

If rhythm does not convert, seek consultation with medical control.

or

If rhythm converts observe for recurrence and treat.

OR

Irregular Rhythm?

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Seek consultation with medical control.

Possible post consultation medications

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Medication	Route	Dosing
Cardizem (Diltiazem)	IV/IO	**0.25 mg/kg slow IVP** Stop bolus when rhythm converts.

Wide QRS tachycardia with pulses greater than 150 bpm.

This order applies when a patient presents with wide QRS complex tachycardia.

Treatment:

- Give high flow O2.
- Attach Monitor/Defibrillator.
- Is rhythm regular or irregular?
- Is patient stable or unstable?
- Establish IV/IO access.
- 12 lead EKG for stable patients.
- Give the following medications as they apply.

If pt. presents unstable at any time

(i.e.: decreased LOC, systolic BP less than 90, symcope or CHF)

↓

Synchronized cardioversion @ 100 j.

Rhythm **Regular**?

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Medication	Route	Dosing
Amiodarone (Cordarone)	**IV/IO Pump**	**150 mg over 10 min.** (Mix 150 mg in 100 ml D5w and run at 600 cc/hr)

If rhythm does not convert, seek consultation with medical control.

Rhythm **Irregular**?

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Rhythm may be A-Fib, A-Flutter or MAT

Seek expert consultation for proper interpretation.

Possible post consultation medications

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Medication	Route	Dosing
Cardizem (Diltiazem)	IV/IO	**0.25 mg/kg slow IVP**
Amiodarone (Cordarone)	IV/IO Pump	**150 mg over 10 min.** (Mix 150 mg in 100 ml D5w and run at 600 /hr)

Ventricular Ectopy

This order applies when a symptomatic patient is experiencing PVC's greater than 6 per minute and showing signs and symptoms as below.

S/S:

- Multi-focal PVC's
- R on T Pattern
- Frequent couplets or runs of three or more PVC's (i.e. runs of Ventricular Tachycardia.

Treatment:

- Give high flow O2 via NRB
- Attach Monitor/Defibrillator.
- Check rhythm and manage appropriately.
- Establish IV/IO access.
- Is the patient symptomatic or non-symptomatic?
- Administer the following medications as they apply.
- **Consider underlying causes.**

Non-Symptomatic?

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Observe and monitor patient

Symptomatic?

↓

Medication	Route	Dosing
Lidocaine	IV/IO	1mg/kg slow IVP. First dose. 0.5 mg/kg given every 5 – 10 minutes to a total of 3 mg/kg.

No changes?

↓

Seek consultation with medical control.

Bradycardia

This order applies when a patient presents with heart rate less than 60 bpm and inadequate for clinical conditions.

Treatment:

- Give high flow O2 via NRB
- Attach Monitor/Defibillator. Pads should be placed anterior/posterior for pacing.
- Check rhythm and manage appropriately.
- Establish IV/IO access.
- Is the patient stable or unstable?
- Give the following medications as they apply.
- Consider underlying causes.

S/S:

- Altered LOC
- On going chest pain
- Hypotension
- Other signs of shock.

Unstable Patient?

↓

Immediate Transcutaneous Pacing
Use without delay for high-degree block (type II second-degree block or thire-degree AV block)

While awaiting pacer consider trial medications as follows:

First Line Medication

Medication	Route	Dosing
Atropine	IV/IO	**0.5mg** may repeat to a total dose of 3mg (If ineffective begin pacing)

Second Line Medication if no response to Atropine

Medication	Route	Dosing
Dopamine Drip (Intropin)	IV/IO Drip	**2 –10 ug/kg/min**
Epinephrine Drip	IV/IO Drip	**2 – 10 ug/min** (mix 2 mg in 100 ml of D5W)

Sedation Medication

Medication	Route	Dosing
Versed (midazoliam)	IV/IO	**2 – 5 mg** (Used to sedate awake patient)
Etomidate (amidate)	IV/IO	**0.3 mg/kg** (Used to sedate awake patient)

Stable Patient?

↓

Observe and monitor patient

Synchronized Cardioversion

This order is to be utilized only for the cardioversion of hemodynamically unstable patients except on direct order from Medical Control.

Treatment:

- Give high flow O2 via NRB
- Attach Monitor/Defibrillator.
- Check rhythm and manage appropriately.
- Establish IV/IO access.
- Is the patient stable or unstable?
- Administer the following medications to sedate awake patients.

Adult Patients:

Biphasic

PSVT / A-Flutter	VT / A-Fib
• 50j • 100j • 120j • 150j • 200j	• 100j • 120j • 150j • 200j • 300j

Pediatric Patients:

Biphasic

1. **0.5 joules/kg**
2. **1 joules/kg**
3. **2 joules/kg**

Sedation Medication	Route	Dosing
Versed (Midazolam)	IV	**2.0 – 5.0 mg Adult** 0.1 mg/kg to max of 2.5 mg For patients under 10 years of age.
Etomidate (amidate)	IV	**0.3 mg/kg**

Auto Pulse

This standing order applies to the use of the Zoll Auto Pulse in place of manual compressions during CPR.

Indications:

- The Auto Pulse will be used for all patients 8 years of age and older in cardiac arrest, where CPR would otherwise be used. In cases of mechanical malfunction of the Auto Pulse the technician will resort back to manual CPR for patient care.

Contra-indications:

- Patients under the age of 8 years.

Procedure:

- Place the patient in a seated upright position.
- Cut clothing down the back and remove.
- Place the Auto Pulse behind the patient's back while still in a seated upright position.
- Lay the Auto Pulse and patient down to the ground.
- Place defibrillation pads on the patient's chest and back.
- Turn the Auto Pulse on.
- Connect Chest / Life Band across the chest of the patient.
- Lift the chest band straight up to ensure it is free of twists.
- Push the "green" button once to start the sizing cycle.
- Place a towel under the patients head to help stabilize in place.
- Compression rate is 30 to 2 respirations, per new ACLS guidelines.
- Ventilate patient during compression pause.
- Replace battery at 30 minutes or when low battery warning is heard.
- Upon resuscitation, shocking or to check for pulse press the "orange" button to pause compressions.

Complications:

- Care should be used when moving patients with a large abdomen. (shifting of excess flesh may cause the life band to move or break.)
- If disruption or malfunction of life band occurs **Revert Back to Manual CPR.**

Chest Pain / Acute Coronary Syndrome

This order applies when a patient is complaining of chest pain or discomfort or assessment indicates ACS.

Treatment:

- Secure airway and apply high flow O2
- Obtain a S.A.M.P.L.E. & O. P.Q.R.S.T. history.
- Obtain a base set of vitals and repeat after each medication administration.
- Begin three lead cardiac monitoring.
- Obtain 12 lead ECG.
- Administer the following medications as they apply.

Medication	Route	Dosing
ASA	PO	Administer ASA even if patient has received daily dose. **324 mg (4 x 81 mg tablets)** unless patient is allergic to aspirin, has a markedly diminished LOC, or has a history of ulcers
Nitroglycerin	S/L Spray	**0.4 mg x 3 doses @ 5 min. intervals.** Do not administer Nitroglycerin in any form if systolic BP is less than 90 mm/Hg. Also if patients are taking medication for erectile dysfunction i.e. Viagra. (If patient has a prescription for Nitroglycerin, one 0.4 mg dose may be given prior to initiating the IV.)
	IV **Pump Required**	If pain is not relieved, or is relieved transiently by SL dose(s) **Start at 5 mcg/min**. (Increase for pain in 5 mcg/min increments as long as pt.'s SBP is greater than 90 mm/hg) Do not administer Nitroglycerin in any form if systolic BP is less than 90 mm/Hg. Also if patients are taking medication for erectile dysfunction i.e. Viagra.
Morphine	IV	**2 mg to a max of 4 mg** If pain is severe and/or is refractory to initial SL dose of Nitroglycerin.
Lopressor (metoprolol)	IV	Used for pt.'s presenting with an acute M.I. with ST elevations. (STEMI) **5 mg slow IV push** Do not administer to patients with heart rates less than 60, a systolic BP less than 100 mm/Hg, CHF, heart blocks, or PMHX of asthma or bronchospastic disease.

Acute Pulmonary Edema / C.H.F.

This order applies when a patient is complaining of trouble breathing and is showing signs and symptoms of:

- Acute onset of pulmonary edema.
- Rales or wheezing on auscultation of breath sounds.
- Labored breathing.
- Decreased oxygen saturations.

Patients with slow onset, fever and dehydrations are contraindicated for this order.

Treatment:

- Secure airway and apply high flow O2.
- Apply CPAP
- Obtain a S.A.M.P.L.E. history.
- Obtain a base set of vitals and repeat after each medication administration.
- Begin three lead cardiac monitoring.
- Initiate I.V.
- Obtain 12 lead e.c.g.
- Administer the following medications as they apply.

Medication	Route	Dosing
Nitroglycerin	**S/L Spray**	**0.4 mg x 3 doses @ 5 min. intervals**. Do not administer Nitroglycerin in any form if systolic BP is less than 90 mm/Hg. Also if patients are taking medication for erectile dysfunction i.e. Viagra. (If patient has a prescription for Nitroglycerin, one 0.4 mg dose may be given prior to initiating the IV.)
Nitroglycerin Drip	**IV Pump Required**	If necessary may use nitroglycerin for further treatment of pulmonary edema. **Start at 5 mcg/min**. (Increase for pain in 5 mcg/min increments as long as pt.'s SBP in greater than 90 mm/hg) Do not administer Nitroglycerin in any form if systolic BP is less than 90 mm/Hg. Also if patients are taking medication for erectile dysfunction i.e. Viagra.
Atrovent (Ipratropium)	Nebulized	**May be mixed with 1st dose of Albuterol 0.5 mg in 2.5 ml. One time dose. (Nebulized with 5 to 6 lpm O2)** Requires physician order for Pt.'s under 60 lbs.
Albuterol (Proventil)	Nebulized	**2.5 mg in 3ml (Nebulized with 5 to 6 lpm O2)** Requires physician order for Pt.'s under 60 lbs. Albuterol may be repeated once if no signs of improvement are noted.
Lasix (Furosemide)	IV	If pt. **is not** prescribed lasix use **40mg** If pt. **is** prescribed lasix use **80mg** Slow IVP, not to exceed 80 mg without physician order.
Morphine	IV	**2 to 4 mg** Slow IVP. Do not administer Morphine if systolic BP is less than 90 mm/Hg
Dopamaine (Intropin)	IV Drip	If systolic BP is less than 90 mm/hg **5 to 20 ug/kg/min.**

If patient presents or becomes unstable do not withhold intubation.

Acute Asthma / COPD / Pneumonia

This order applies when a patient is complaining of trouble breathing and is showing signs and symptoms of:

- Acute asthma attack.
- Wheezing on auscultation of breath sounds.
- Labored breathing.
- Decreased oxygen saturations.

Treatment:

- Secure airway and apply O2.
- Obtain a S.A.M.P.L.E. history.
- Obtain a base line set of vitals and repeat after each medication administration.
- Begin three lead cardiac monitoring.
- Initiate I.V. **(If necessary for medication route.)**
- Obtain 12 lead EKG.
- Administer the following medications as they apply.

Medication	Route	Dosing
Albuterol (Proventil)	Nebulized	**2.5 mg in 3ml (Nebulized with 5 to 6 lpm O2)** Requires physician order for Pt.'s under 60 lbs. Albuterol may be repeated once if no signs of improvement are noted.
Atrovent (Ipratropium)	Nebulized	**May be mixed with 1st dose of Albuterol** **0.5 mg in 2.5 ml. One time dose. (Nebulized with 5 to 6 lpm O2)** Requires physician order for Pt.'s under 60 lbs.
Brethine (Terbutaline)	SQ	**0.25 mg** **Used for pt.'s over the age of 40 or cardiac Hx.**
Epinephrine (Adrenalin)	SQ	**0.3 mg of 1:1,000** **Used for pt.'s under the age of 40 and without cardiac Hx.**
Solu Medrol (Methylpredisone)	IV	**125 mg Slow IV Push over 2 minutes.**

If patient presents or becomes unstable do not withhold intubation.

Unresponsive Patients

This order applies to all patients who are unresponsive or have a markedly altered LOC due to suspected hypoglycemia or unknown etiology.

Treatment:

- Secure airway and apply O2.
- Obtain a S.A.M.P.L.E. history.
- Obtain a base line set of vitals and repeat after each medication administration.
- Begin three lead cardiac monitoring.
- Initiate I.V. or I.O.
- Check glucose
- Look for underlying causes.
- Administer the following medications as they apply.

Medication	Route	Dosing
Dextrose D50	IV/IO	**25 g** given as a slow IVP (Given to pt.'s with a glucose level less than 70 mg/dl)
Glucagon	IM	**1 Unit** (Used if IV attempts are not successful)
Narcan (Naloxone)	IV/IO	**2 mg** **(If pt. responds to loading dose, it may be repeated as necessary to support vital functions)**
Thiamine (Betalin)	IV/IO	**50 mg** (Used for pt. with suspected ETOH abuse)

Anaphylaxis

This order applies when a patient is showing signs and symptoms of anaphylactic reactions.

Treatment:

- Secure airway and apply high flow O2. for respiratory distress
- Monitor patients Spo2.
- Obtain a S.A.M.P.L.E. history.
- Obtain a base line set of vitals and repeat after each medication administration.
- Begin three lead cardiac monitoring.
- Initiate I.V.or I.O.
- Obtain 12 lead ECG.
- Administer the following medications as they apply.

Medication	Route	Dosing
Albuterol (Proventil)	Nebulized	**2.5 mg in 3ml** Requires physician order for Pt.'s under 60 lbs. Albuterol may be repeated once if no signs of improvement are noted.
Atrovent (Ipratropium)	Nebulized	May be mixed with 1st dose of Albuterol **0.5 mg in 2.5 ml. One time dose.** Requires physician order for Pt.'s under 60 lbs.
Epinephrine 1:1,000	SQ	**0.3 mg (Used for moderate to sever respiratory distress)**
Epinephrine 1:10,000 Preload	IV/IO	**0.3 to 0.5 mg IV (Used on pt.'s displaying signs of schock)**
Benadryl (Diphenhydramine)	IV/IM/IO	**25 mg IV slow IVP or 50 mg IM**
Solu Medrol (Methylprednisone)	IV/IO	**125 mg Slow IV Push.**

Stroke/CVA

This order applies when a patient presents with signs & symptoms of Stroke/CVA.

Signs and Symptoms:

- Sudden weakness or numbness of the face, arm, or leg, especially on one side of the body.
- Sudden confusion.
- Trouble speaking or understanding.
- Sudden trouble seeing in one or both eyes.
- Sudden trouble walking.
- Dizziness or loss of balance or coordination.
- Sudden severe headache with no known cause.

Treatment:

- Secure airway and apply O2 via NRB.
- Perform Cincinnati Prehospital Stroke Scale (CPSS) to identify possible patients with stroke.
- **Obtain a time of onset.**
- Obtain a base line set of vitals.
- Check blood glucose levels. (Do not delay transport)
- Begin three lead cardiac monitoring. (Do not delay transport)
- Obtain 12 lead ECG. (Do not delay transport)
- Initiate I.V. or I.O. (If necessary for medications route)
- Advise medical control that you are transporting a possible stroke patient.

Do not delay transport for any intervention once a possible stroke is recognized

Cincinnati Prehospital Stroke Scale

Test	Findings
Facial Droop: Have the patient show teeth of smile.	**Normal** – both sides of face move equally **Abnormal** – one side of face does not move as well as the other side.
Arm Drift: Patient closes eyes and extends both arms straight out, with palms up, for 10 seconds.	**Normal** – both arms move the same or both arms do not move at all. **Abnormal** – one arm does not move or one arm drifts down compared with the other.
Abnormal Speech: Have the patient say "you can't teach an old dog new tricks."	**Normal** – patient uses correct words with no slurring. **Abnormal** – patient slurs words, uses the wrong words, or is unable to speak.

Signal 10 transport is required for patients presenting with a possible stroke.

Time Critical Trauma

This order applies to time-critical trauma patients. The intent is to ensure rapid assessment and transportation of trauma patients with life-threatening injuries to the nearest appropriate medical facility.

Treatment:

- C-Spine Precautions.
- CPR if necessary.
- Secure airway and apply high flow O2.
- Control major bleeding.
- Obtain a base line set of vitals and repeat every 5 minutes.
- Begin three lead cardiac monitoring.
- Initiate (2) large bore IV/IO's
- Apply MAST if indicated (see below)
- Scene times should be limited to 10 minutes unless complicated by extrication or other unforeseen circumstances. Most of the above can be performed en route to the hospital. Do not delay transport to perform any treatment unless absolutely necessary.

Indications for application of MAST:

- Splinting and control of pelvic fractures.
- Neurogenic shock.

Contraindications for application of MAST:

- Pulmonary Edema.
- Known diaphragm rupture.
- Uncontrolled hemorrhage outside confines of garment (i.e. – thoracic, upper extremity, scalp, face, or neck injury.)

Pleural Decompression

This order applies when a patient presents with one of the following:

- Tension Pneumothorax.
- Severe Multi-System trauma and/or traumatic cardiac arrest with clinical evidence of a potential tension pneumothorax.
- Spontaneous Pneumothorax.

Signs and Symptoms:

- Decreased or absent breath sounds.
- Flail chest.
- Paradoxical movement.
- Tracheal deviation.
- Subcutaneous emphysema.

Required Equipment:

- Cook decompression kit.
- 14 or 16 gauge IV catheter (2-2.5 inch.)
- Flutter valve (Omit if patient is intubated.)
- Betadine swabs.
- Dressing and tape.

Location

1. 2nd or 3rd intercostal space, mid-clavicular line. This location is preferred unless inaccessible. (i.e.- due to trauma or defib. pad placement)
2. 4th or 5th intercostal space, mid axillary line, if unable to access location #1.

Procedure:

- Place patient on high flow oxygen.
- Position patient upright if C-spine injury has been ruled out and patient is not in cardiac arrest.
- Consider Versed or Etomidate to sedate if patient is conscious.
- Select location and prep the area with betadine.
- Insert the catheter over the top of the rib until air rushes out, then remove the needle leaving the catheter in place.
- Attach the flutter valve and secure with tape. (may be omitted if intubated)

Medication	Route	Dosing
Versed (Midazolam)	IV	2 to 5 mg Given for awake patients.
Etomidate (Amidate)	IV	0.3 mg/kg Given for awake patients.

Burns

This order applies when a patient presents with the following burns:

- Electricity
- Thermal
- Inhalation Injury
- Chemicals
- Radiation

Treatment:

- Stop the burning.
- Secure airway and apply high flow O2.
- Intubate if necessary.
- Obtain a S.A.M.P.L.E. history.
- Obtain a base line set of vitals and repeat after each medication administration.
- Begin single lead cardiac monitoring.
- Initiate I.V. or I.O. of Lactated Ringers Note: Avoid placing I.O. into burned tissue.
- Place clean dry dressings on all burns.
- Give the following medications as they apply.

Medication	Route	Dosing
Fentanyl (Sublimaze)	IV	**1 – 1.5 ug/kg** repeated every 3 – 5 min. PRN Adult and Ped
Morphine	IV	Adult:**5 mg** increments up to a total of 15 mg Pediatric: **0.1 mg/kg** up to a total of 0.4 mg/kg
Versed (Midazolam)	IV	Adult: **2.0 – 5.0 mg** Patient under 10 years: **0.1 mg/kg** to max of **2.5 mg**
Etomidate (Amidate)	IV	**0.3 mg/kg** Given for awake patients.

Note: If able, remove all jewelry from burned extremities.

Consideration should be given for transportation directly to the regional burn center for patients with severe burns to the face and/or genitalia or burns greater than 30% partial or full thickness.

No-Code Orders

This order applies to patients with a No-Code Order, which has been issued by the patient's primary physician, and have either been found or become pulseless and apneic in your presence. To utilize this order you MUST have in your possession the original or legible copy of the actual No-Code order, which must be signed by both the physician and either the patient or the patient's legal guardian within the past twelve (12) months; or you must receive a direct verbal order from the treating physician.
If the above criteria are met and you are transporting to Wabash County medical facility, you will perform the following steps:

- Note the time that the patient was found to be in cardio-respiratory arrest.
- Note the exact location of the arrest.
- DO NOT attempt to resuscitate.
- Contact Medical Control and advise them of the situation.
- Transport the patient, in a routine status, to whichever facility is requested by the Hospital.
- If in doubt, contact medical control for advice.
- If at the scene, transportation may be provided by another source (i.e. – funeral home.)

Do Not Resuscitate

When confronted with a possible DNR situation, the medic must consider the four areas listed below:

1. Patient Viability
2. When Not To Resuscitate
3. Special Considerations
4. Written DNR/No-Code Orders

I. Patient Viability

a. Any possibility that life exists --> resuscitate
b. When in doubt --> resuscitate
c. Clinical signs are misleading (pupils, downtime, presenting rhythm) - DO NOT base your decision on these alone!

II. When Not To Resuscitate

a. Decapitation
b. Decomposition
c. Rigors mortis
d. Dependent lividity
e. Transverse dissection at the midsection
f. Any other injuries that are conclusively incompatible with life (i.e. - massive head and/or chest) and no evidence of life is present

III. Special Considerations

a. Multiple casualties - use triage
b. Living wills - DO NOT ACCEPT --> RESUSCITATE
c. Direct or telephone contact with patient's physician, who requests DNR

IV. Written DNR/No-Code Orders

a. See No-Code Orders Standing Order

Procedure for Out of Hospital Death

<u>If patient meets any criteria from section II above the paramedic will…</u>

Request law enforcement to respond to the scene If apparent natural causes death contact the family physician. If family physician cannot be contacted, he/she refuses to sign the Death Certificate or death appears in any way suspicious request the Coroner to respond to the scene

Seizures

This order applies when a patient presents with persistent (status) seizure that interferes with vital functions.

Treatment:

- Secure airway and apply O2.
- Obtain a S.A.M.P.L.E. history.
- Obtain a base line set of vitals and repeat after each medication administration.
- Begin three lead cardiac monitoring.
- Check blood glucose levels.
- Initiate I.V. (If necessary for medication route.)
- Administer the following medications as they apply.

Medication	Route	Dosing
Valium (Diazepam)	IV/Rectal	5 – 10 mg, slow IVP
Versed (Midazolam)	IV/IM	**2.5 mg IV repeat every 5 min up to a total of 10 mg.** **5 mg** given IM
Magnesium Sulfate	IV	**2 – 4 Grams**, slow IVP over 2 minutes. (Used for pregnancy if eclampsia is suspected prior to valium.)

If patient presents hypoglycemic give

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Medication	Route	Dosing
Dextrose D50	IV	**25 g** given as a slow IVP (Given to pt.'s with a glucose level less than 70 mg/dl)

If seizures persist consider paralytic treatment. (See paralytic administration S.O.)

Hypotension

This order applies when patients presents with a sustained systolic BP of 90 mm/Hg or less accompanied by clinical signs of hypoperfusion or shock.

Treatment:

- Secure airway and apply O2.
- Obtain a S.A.M.P.L.E. history.
- Obtain a base line set of vitals and repeat after each medication administration.
- Began three lead cardiac monitoring.
- Initiate I.V. or I.O.
    - Adult – Give fluid bolus of 250 to 500 ml of NS or LR.
    - Pediatric – Give fluid bolus of 20 ml/kg of NS or LR.
- Obtain 12 lead e.c.g.
- Administer the following medications as they apply.

Medication	Route	Dosing
Dopamaine (Intropin)	IV Drip	If systolic BP is less than 90 mm/hg and pressure does not increase with fluid boluses. **5 to 20 ug/kg/min.**

Transportation of Patients with Nipride Drips

Whenever possible, patients will not be transported between facilities with a Nipride (sodium nitroprusside) drip running. When it cannot be avoided paramedics are authorized to transport this medication only if the following requirements have been satisfied.

1. Written Physician Order - This order must specify the acceptable dosage range, target blood pressure, and any other information or cautionary statements specific to this patient that the physician feels are necessary.
2. Blood Pressure Reading - Must be taken at no less than five (5) minute intervals. If during transport, this becomes impossible, for any reason, you will immediately contact Medical Control (either Wabash County Hospital or the receiving facility if closer) at the earliest opportunity for further instructions.

If both of these requirements cannot be satisfied the patient may not be transported with Nipride running.

Cold Water Drowning

A patient who is submerged in cold water (70˚ F or colder) for 1 hour or less and is pulseless and apneic shall be considered a COLD WATER DROWNING. With the suspected cold water drowning all circulation, both central and peripheral, is shut down *. For this reason you **SHALL NOT** administer medications or delay transport to attempt to initiate an IV.

Indications:

- Evidence of submersion in cold water for 1 hour or less
- Pulseless and Apneic

Procedure:

- Check pulse, if absent and patient is apneic...
- Begin CPR and ventilate via BVM with supplemental high-flow oxygen
- Apply defib pads
- Determine rhythm - If necessary you may defibrillate up to three (3) times
- Secure airway per Standing Order - Use care during airway placement as this may induce V-Fib.
- Notify Medical Control ASAP.
- This is a "***load and go***" situation - TRANSPORT ASAP.

* You may attempt to initiate an IV/IO en route to the hospital –

DO NOT DELAY TRANSPORT TO ACCOMPLISH THIS!

- Even though your efforts may appear to be in vain, do not give up. Remember - A patient is not dead until he/she is warm and dead. This type of resuscitation often takes a considerable amount of time.
- If a delay in transport is inevitable (i.e. - you are not on the scene yet; patient still in the water) consider aeromedical transport from the scene.

NOTE: Patients may not present in V-Fib, but they are highly susceptible to it and must be treated very carefully.

Pain Control

This order is to allow paramedics to provide a level of analgesia to patients who complain of isolated severe orthopedic pain that cannot be controlled by other means (i.e. position, splinting, etc.)

Treatment:

- Secure airway and apply O2.
- Obtain a S.A.M.P.L.E. history.
- Obtain a base line set of vitals and repeat after each medication administration.
- Begin three lead cardiac monitoring.
- Initiate I.V./ I.O.
- Give the following medications as they apply.

Contraindications:

- Patients with head injury
- Patients with undiagnosed abdominal pain.
- Any signs or symptom that is not associated with isolated orthopedic trauma. (i.e. decreased LOC, thorax or abdominal trauma)

Medication	Route	Dosing
Fentanyl (Sublimaze)	IV/IO	**1 – 1.5 ug/kg Slow I.V. push.** repeated every 3 – 5 min. PRN Adult and Ped
Morphine	IV/IO	**5 mg** may repeat again once in 3 – 5 min. for a total of **10 mg**

Phenergan Administration

This order applies when a patient presents with persistent:

1. Nausea and Vomiting
2. Motion Sickness

Treatment:

- Secure airway and apply O2.
- Obtain a S.A.M.P.L.E. history.
- Obtain a base line set of vitals and repeat after each medication administration.
- Begin three lead cardiac monitoring.
- Initiate I.V.
- Obtain 12 lead ECG.
- Administer the following medications as they apply.

Medication	Route	Dosing
Phenergan (promethazine)	IV/IM	12.5 mg IV 25 mg IM Contraindicated in comatose patients and patients who have received a large amount of depressants.

Paralytic Administration

Indications:

- To facilitate intubation in patients for whom **Etomidate or Versed** alone are not effective.
- Combative head injury patients
- Status seizures that can not be controlled by the seizure standing order

Contraindications:

- Conscious, non-sedated patients
- Patients who, for any reason cannot be ventilated with a BVM.

Treatment:

- Suction and clear the airway and apply high flow O2.
- Ventilate the pt via BVM.
- Obtain a base line set of vitals and repeat after each medication administration.
- Begin three lead cardiac monitoring.
- Initiate I.V. or I.O. **(If trauma related initiate two large bore IV.'s)**
- Assemble all equipment necessary to intubate.
- Warm up EtC02/Capnography
- Monitor SpO2 & EtCo2/Capnography.
- Administer the following medications as they apply.

Premedication

Premedication Medication	Route	Dosing
Lidocaine (Zylocaine)	IV/IO	**1.5 mg/kg** (Used for patients presenting with head injury with S/S of increased ICP or asthma)
Atropine	IV/IO	**0.02 mg/kg minimum of 0.1 mg** (used for pediatric patients less than 8 years)
Fentanyl (Sublimaze)	IV/IO	**1 – 1.5 ug/kg** Use for adult and pediatric

Induction

Induction Medications	Route	Dosing
Etomidate (Amidate)	IV/IO	**0.3 mg/kg** (Use if patient is greater than 10 years old.)
Succinylcholine (Anectine quelicin)	IV/IO	**May only be given once** **2.0 mg/kg Adult & Pediatric** Contraindications: S/S of known hyperkalemia, crush injuries greater than 5 days old, burn injuries greater than 8 hours old, penetrating eye injuries and history of malignant hyperthermia
Norcuron (Vecuronium)	IV/IO	**0.1 mg/kg Adult & Pediatric** Note effects last approx. 20-25 minutes. **.05 mg/kg Adult & Pediatric Maintenance dose**

Sedation

Sedation	Route	Dosing
Etomidate (Amidate)	IV/IO	**0.3 mg/kg** Resedation required every 15 minutes.
Versed (Medazolam)	IV/IO	**2.0 – 5.0 mg Adult** **0.1 mg/kg to max of 2.5 mg For patients under 10 years of age**. Resedation required every 15 minutes.
Valium (diazepam)	IV/IO	**5.0 mg Adult** Resedation required every 15 minutes.

Pediatric Pulseless VT or VF

This order applies when a pediatric patient presents with pulseless V-T or V-Fib.
(Note: AHA defines a pediatric patient 1 year of life to puberty.)

Treatment:

- Place patient on Auto Pulse. Only if patient is greater than 8 years old.
- Initiate CPR.
- Give high flow O2 via BVM in conjunction with OPA or NPA.
- Attach Monitor/Defibrillator.
- Check rhythm and manage appropriately.
- Establish IV/IO access.
- Secure airway and confirm placement. (ET, King or Combi-Tube)
- Intubated patients will be monitored via end-tidal CO2 & Capnography.
- Give the following medications as they apply. (Reference Broselow tape.)
- Consider underlying causes and treat appropriately.

Give 1 Shock @ 2 j/kg and check rhythm.

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Medication	Route	Dosing
Epinephrine 1:10,000	IV/IO	0.01 mg/kg (0.1ml/kg) Given once.

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Give 2nd & additional shocks @ 4 j/kg

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Medication	Route	Dosing
Epinephrine 1,1,000	IV/IO	0.1 mg/kg (0.1ml/kg) Repeated every 3-5 minutes.
Lidocaine (Xylocaine)	IV/IO	1 mg/kg Repeated in 3 – 5 minutes.

If resuscitation is successful initiate the following drip.

Medication Drip	Route	Dosing
Lidocaine Drip	IV/IO	1 mg/kg Bolus (If not already used in resuscitation) **Or** **20 to 50 ug/kg/min Drip**

Pediatric Asystole/PEA

This order applies when a pediatric patient presents with asystole. (Note: AHA defines a pediatric patient 1 year of life to puberty.)

Treatment:

- Place patient on Auto Pulse. Only if patient is greater than 8 years old.
- Initiate CPR.
- Give high flow O2 via BVM in conjunction with OPA or NPA.
- Attach Monitor/Defibrillator.
- Check rhythm and manage appropriately. (Check in two leads)
- Establish IV/IO access.
- Secure airway and confirm placement. (ET, King or Combi-Tube)
- Intubated patients will be monitored via end-tidal CO2 & Capnography.
- Give the following medications as they apply. (Reference broselow tape)
- Consider underlying causes and manage appropriately.

If patient is in PEA Give patient 20 ml/kg Fluid Challenge

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Medication	Route	Dosing
Epinephrine 1:10,000 Preload	IV/IO	0.01 mg/kg (0.1ml/kg) Given once.
Epinephrine 1,1,000	IV/IO	0.1 mg/kg (0.1ml/kg) Repeated every 3-5 minutes.

Dosing For Pediatric Patients

When treating a pediatric patient (age 14 and under) for which there is no pediatric Standing Order, the following drug dosages and defibrillation energies will be substituted for the adult dosages referred to in Standing Orders and Protocols.

Medications

Adenosine **Initial dose: 0.1 mg/kg**
Add'l doses: 0.2 mg/kg
Maximum single dose is 12 mg

Albuterol **Consult with medical control first, unless patient has a prescription (then use the prescribed dose)**

Dextrose 50% **0.5 gm/kg if <3 yrs.**

Epinephrine **For Anaphylaxis/Asthma: SC - 0.01 mg/kg of 1:1000 (up to 0.3 mg)**

Lidocaine Infusion **20-50 ug/kg/minute**

Narcan **0.1 mg/kg**

Sodium Bicarbonate **1 mEq/kg per dose**

Solu-Medrol **1 mg/kg over 5 minutes**

Succinylcholine **2.0 mg/kg, Infant 3.0 mg/kg**

Valium **0.25 mg/kg (up to 10 mg)**

Versed **0.03 mg/kg**

Fluid Challenge **20 ml/kg**

Patient Restraint

Purpose

The use of restraints may be necessary for the protection of the patient or health care providers to enable the provision of treatment and transport for the patient.

Indications

A. When necessary to restrain a sick or injured (non-mentally ill) person who because of central nervous impairment is behaving in such a manner as to interfere with his/her examination, care and treatment to the extent they endanger their own life or the safety of others.
B. When restraining and transporting a mentally ill patient at the request of a police officer.

Procedure

A. Assure that enough personnel are available to properly control the patient and establish the restraints.
B. Explain to family and bystanders the purpose of the restraints. Clear the area of family and bystanders as necessary.
C. Physically control the patient and apply the restraints.
D. If the patient is restrained secondary to central nervous system impairment and is at risk of vomiting, keep patient in a left lateral-recumbent position.
E. Assure the restraints do not impair circulation and do not damage soft tissue.
F. Patient should be secured to a backboard or stretcher only. Patients must never be secured to a vehicle or immovable object.
G. Transport patient. CONTACT MEDICAL CONTROL.
H. Inform the hospital that restraints are in place and assistance will be necessary at the hospital to continue restraints of the patient.

Special Considerations

A. Restraints should be of a soft nature, i.e. cravats, sheets, cloth restraints, etc., applied to the wrists and ankles. A restraint may also be needed across the chest and/or pelvis.
B. Make a plan before any attempt at restraint, assigning specific duties to each member of the team. Designate a team leader.
C. A show of force may initially be sufficient to gain the cooperation of the patient and is preferable to the actual use of force as a first step. No threat should ever be made to a patient.
D. Use only as much force as is required. Never strike a patient.
E. If secured to a stretcher, the patient should be secured by straps or sheets at the chest, pelvis and legs.
F. Once restraints have been applied, they should never be removed until the patient is safely in the hospital.
G. Stay with a restrained patient at all times. Be observant for possible vomiting and be prepared to turn the patient and suction if necessary.
H. Document the time that restraints were applied and the rationale for their use. Assess circulation, movement, and sensation of extremity distal to the restraint prior to and after restraint application. CMS should be assessed every 15 minutes while the patient is restrained.
I. Remain between the patient and vehicle doors.
J. **Handcuffed Patients** – If requested or ordered by a police officer to transport a handcuffed patient, the police officer must accompany the patient in the ambulance at all times.

Protocols Section

Surgical Cricothyrotomy

(PHYSICIAN ORDER REQUIRED!)

Indications

Permission to perform a Surgical Cricothyrotomy should be requested from Medical Control for any patient who is more than four (4) years old and has at least one of the following conditions...

- Complete airway obstruction that cannot be managed by other BLS/ALS methods
- Massive facial trauma that makes intubation impossible

Procedure

1. Expose the neck; hyperextend if not trauma related.
2. Locate and palpate the cricothyroid membrane.
3. Make a 1-2 cm *vertical* incision over the membrane.
4. Spread skin to expose the cricothyroid membrane.
5. Make a small horizontal incision through the membrane. Insert the handle of the scalpel into the incision and rotate it 90 degrees to open the airway (may also use a hemostat or McGill forceps).
6. Insert an appropriately sized cuffed ET-Tube or tracheostomy tube into the incision, directing the tube distally into the trachea. When in place inflate the cuff.
7. Ventilate the patient and confirm correct placement by observing the chest rise and auscultating breath sounds.
8. Secure the ET-Tube or tracheostomy tube to the patient to prevent dislodging.
9. Dress with Vaseline gauze or other occlusive dressing as necessary.

ALS/BLS Transport Protocol

Once the paramedic unit has arrived on scene, patient contact must be made. Patient contact is defined as a thorough assessment of the patient's condition and consideration of the possible complications of releasing patient care to the ALS/BLS unit. The paramedic will assess the patient, render appropriate medical care, and transport the patient(s).

1. If, after Paramedic contact and assessment of the patient, the Paramedic(s) and EMT's determine that BLS transport is appropriate, MEDICAL CONTROL will be contacted and will make the final determination.
2. When BLS transport is approved by Medical Control, a full "No Transport" chart will be written. This will include all patient demographics and a full assessment including, but not limited to, vitals. Medical Control's signature is not required.
3. When the patient's condition warrants Paramedic intervention and the Paramedic unit is greater than 5 minutes away, the BLS unit will package the patient and begin transport. The Paramedic unit will meet the transporting unit en route.
4. If the BLS/ALS unit that is en route with the patient is less than 5 minutes from the hospital, transport will not be interrupted except for a Cardiac Arrest or Severe Airway Compromise.
5. The practice of two ambulances running red lights and siren to the hospital with one patient is strictly prohibited.
6. In the event the Paramedic is in the BLS ambulance and is unable to utilize cellular communications, IHERN will be used for all traffic with the hospital.

Physician at Scene Protocol

Purpose

To give paramedics and physicians a clarification of Medical Control procedures when a physician is present at the scene of an accident or illness. The following procedure will be implemented.

Procedure

A. Upon request by any physician to give orders or directions at the scene of an accident or illness, the paramedic(s) will:

Inform the physician that they are in direct radio contact with a base station physician.
Inform the physician that they can take orders only from the base station physician
Inform the physician of the procedure for taking over medical control.

B. If the physician at the scene insists on taking over medical control, the paramedic(s) will:

1. Inform the base station physician of the request.
2. Allow the physician at the scene to speak with the base station physician as necessary.
3. Follow directions of the base station physician.

C. Should, at any time, the physician at the scene give absolutely contraindicated or inappropriate directions, orders which could adversely affect patient care, or refuse to accompany the paramedics to the hospital as required by the base station physician, the paramedic(s) will:

1. Immediately contact the base station physician and inform him/her of the situation.
2. Follow directions and orders from the base station physician.

Approved Medications and IV Supplies

Revisions and Review

Revision or Review	S.O. change	"R" Number	Date	Medical Director Signature
Revision	Effective Date of New 2007 S.O.'s	R03/07		