



Southwest General

Partnering with



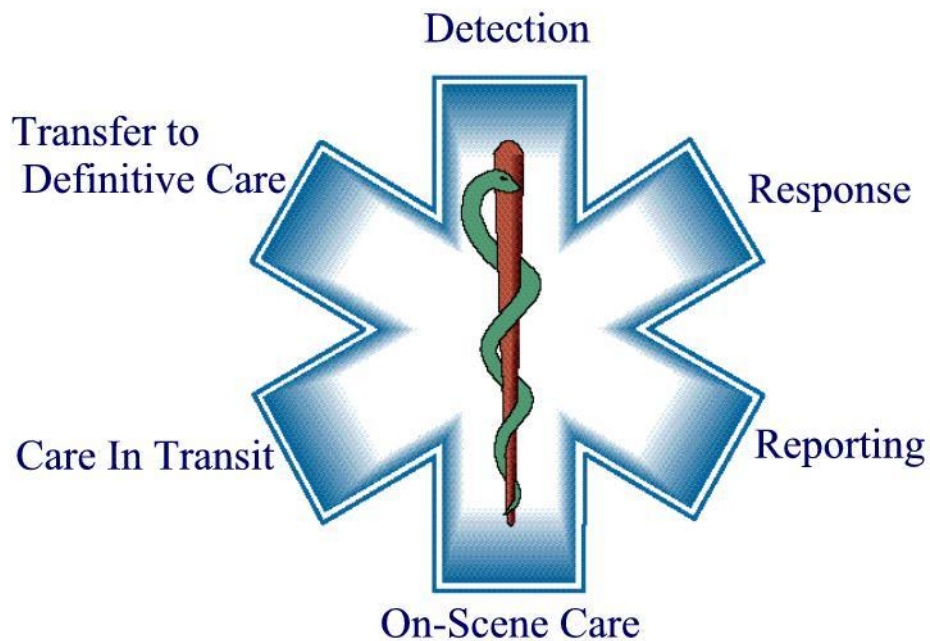
University Hospitals

EMS Services

PRE-HOSPITAL CARE

MEDICAL CONTROL

PROTOCOLS AND PROCEDURES



INTRODUCTION

1

INTRODUCTION

These protocols are for Emergency Medical Technicians (EMT's) functioning under Susan Tout MD, Director of Emergency Medicine and Mark Harris MD, Asst. Medical Director of Emergency Services at Southwest General Health Center. This EMS Medical Control Protocol and Procedures Manual has been developed by the Medical Directors listed above, Southwest General Health Center EMS Services, Southwest Area Fire and Emergency Services (S.A.F.E.S.) and the EMS Advisory Board. These have been developed to establish the minimum standard of care, which will be provided by all Emergency Medical Services organizations under this Medical Control.

These protocols and procedures are to be used as guidelines for operation during EMS calls that require medical direction. They are also intended to be guidelines to ensure that personnel are trained in proper pre-hospital patient care. Procedures are not considered rigid rules, but rather established standards against which EMS practice can be measured.

Treatment protocols are specific orders directing the actions pertaining to techniques and/or medications used by EMS personnel who are required to practice under direct supervision of a physician and Southwest General Health Center.

Emergency Medical Services and their personnel who wish to operate under Southwest General Health Center EMS Medical Control authority may do so only with the express written and signed authorization of their respective EMS Medical Director.

Although not identical, these protocols and procedures are derived from the State of Ohio EMS Guidelines, Cuyahoga County, Northern Medina County and Eastern Lorain County Reigons. Please note that items in this manual are subject to continuous review for the sake of providing members with the most current emergency medical information. Updates to this material may be frequent to maintain a current standard of care to benefit both the patient and the provider of emergency medical care. The bottom of the page shows when the most current version was printed. Please replace older versions with newly updated material as soon as it is issued. Once updated, older versions are to be considered obsolete and thus, are to be discarded to help eliminate confusion. The EMS Advisory Board will review the procedures on a regular basis and will add and/or update this document after review, as mandated by the chairperson of the EMS Advisory Board. Questions regarding procedures as stated in this document can be addressed to any member of the Southwest General Health Center EMS Advisory Board.

INTRODUCTION

2

S.A.F.E.S. / EMS ADVISORY BOARD

Southwest General Health Center works in conjunction with the The Southwest Area Fire and Emergency Services (S.A.F.E.S.) and the EMS Advisory Board. These protocols and procedures have been developed to facilitate the orderly working of the Emergency Medical Services within Southwestern Cuyahoga County, Northern Medina County, and Eastern Lorain County. The structure for the organizations are:

1. The Fire Chief from each community within the Southwest General Health Center EMS System will serve on the S.A.F.E.S. Committee. An appointed individual by the Fire Chief to serve on the EMS Advisory Board.
2. The Medical Directors will be a permanent member of the board.
3. The EMS Coordinator will be a member of the board.
4. The Emergency Department will designate a member of the board.
5. Health Center Administration will designate a member of the board.
6. A member of the Southwest Area Fire / Emergency Service (S.A.F.E.S.) will be a liason member of the board.

The S.A.F.E.S. and EMS Advisory Board will meet the first Thursday of the month with no less than six meetings to be held per year.

**MEDICAL CONTROL PROTOCOLS AND
PROCEDURES GUIDELINES**


1. The patient history should not be obtained at the expense of the patient. Life-threatening problems detected during the primary assessment must be treated first.
2. Cardiac arrest due to trauma is not treated by medical cardiac arrest protocols. Trauma patients should be transported promptly with CPR, control of hemorrhage, cervical spine immobilization, and other indicated procedures attempted enroute.
3. In patients with non-life-threatening emergencies who require IV's, only two attempts at IV insertion should be attempted in the field, additional attempts must be enroute.
4. Patient transport, or other needed treatments, must not be delayed for multiple attempts at endotracheal intubation.
5. Verbally repeat all orders received before their initiation.
6. Any patient with a cardiac history, irregular pulse, unstable blood pressure, dyspnea, or chest pain must be placed on a cardiac monitor and a copy of the EKG must be attached to the EMS Run Sheet.
7. Transferring patient care should be performed between caregivers describing initial patient presentation and care rendered to the point of transfer.
8. If the patient's condition does not seem to fit a protocol or protocols, contact Medical Control for guidance.
9. All trauma patients with mechanisms or history for multiple system traumas will be transported as soon as possible. The scene time should be 10 minutes or less.
10. Medical patients will be transported in the most efficient manner possible considering medical condition. Advanced life support therapy should be provided at the scene if it would positively impact patient care. Justification for scene times greater than 20 minutes should be documented.

INTRODUCTION

ACKNOWLEDGEMENTS

Appreciation is extended to all those who assisted in the development and revision of these protocols.


Susan Tout M.D.
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E.M.S. Coordinator


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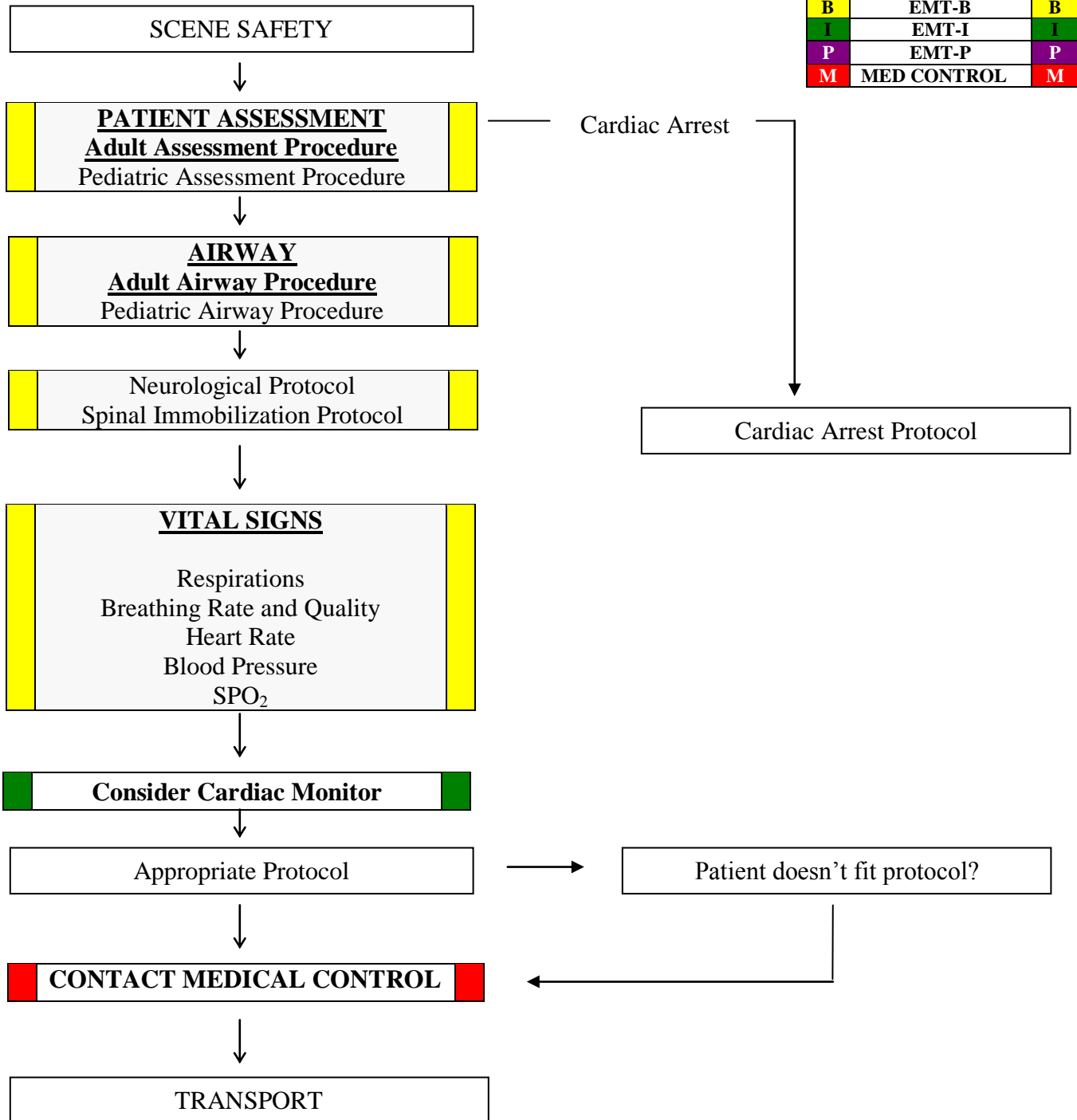

Lieutenant Matt Lynch
President of the E.M.S. Advisory Board

Thanks to the Associates of the E.M.S. Department of Southwest General Health Center along with the many dedicated Pre-Hospital Care Providers in our region who have given endless hours towards protocol development.

INTRODUCTION

5

UNIVERSAL MEDICAL CARE PROTOCOL



- Any patient contact, which does not result in an EMS transport, must have documentation and run report.
- Exam: minimal exam, vital signs, mental status and location of injury or complaint.
- Required: vital signs on every patient, include blood pressure, pulse, respirations and pain scale.
- The Broselow-Luten tape defines a pediatric patient. If the patient does not fit on the tape, they are considered an adult.
- Timing of transport should be based on patient's clinical condition and the transport policy.

General

- All patient care and documentation must be appropriate for your level of training and within the standard of care of the State of Ohio.
- Only functioning paramedics can perform ALS procedures.
- Use the standard AHA guidelines for CPR and rescue breathing.
- It may be necessary to reference several protocols while treating a patient.
- Refer to the appropriate protocol and provide the required interventions as indicated.
- Additional focus may be needed in specific areas as indicated by the patient's chief complaint.
- Airway management and oxygen administration should be initiated based upon the results of the patient assessment and the protocols.
- IV's should be initiated in all patients based upon the results of the patient assessment, and the Intravenous Access Procedure.
- Check blood glucose based on patient assessment.
- Administer cardiac monitoring (3-Lead) and perform a 12-Lead EKG based upon the results of the patient assessment or the protocols.
- If indicated and possible, perform a 12-Lead EKG before moving to the squad and before any medication administration.
- When assessing for pain, use a 0-10 pain scale; 0 = no pain; 10 = worst pain ever experienced.
- It is mandatory to document the reason why an intervention was not performed if it was indicated.
- Continuous quantitative waveform capnography is now recommended for intubated patients throughout the periarrest period. When quantitative waveform capnography is used for adults, applications now include recommendations for confirming tracheal tube placement and for monitoring CPR quality and detecting ROSC based on end-tidal carbon dioxide (PETCO₂) values.
- If Medical Control requests that a functioning paramedic perform an intervention outside of the protocol; the functioning paramedic may follow the orders as long as **ALL** of the following applies:
 1. Medical Control was notified that the intervention is not in the protocol.
 2. The intervention is in the recognized scope of practice for paramedics in the state of Ohio.
 3. The patient's condition could be severely affected if the intervention was not performed.
 4. The paramedic has documented training in the intervention within the last 2 years.
 5. The paramedic has received permission to perform the intervention from Medical Control.

Adult

- Patients who are taking beta-blockers may not have an elevated heart rate, but may be in shock.
- Patients on anticoagulants are at a higher risk of hypovolemic shock and non-apparent bleeding, especially the elderly.
- General weakness can be a symptom of a life threatening illness.
- Hip fractures and dislocations in the elderly have a high mortality rate.
- What would be considered a minor or moderate injury in the adult patient can be life threatening in the elderly.
- Diabetic patients may have abnormal presentations of AMI and other conditions due to neuropathy.
- A medical cardiac arrest is not a "load and go" situation. It is in the best interest of the patient to perform all initial interventions (Defib, CPR, ETT, IV) and 1-2 rounds of medications prior to extrication.
- An adult patient is considered hypotensive if their systolic BP is 90 or less.
- An elderly patient (70 or older) is considered hypotensive if their systolic BP is 120 or less.
- Assess the patient every 300 mL of normal saline, and continue with fluid resuscitation until it is no longer indicated.

Pediatric

- Assess the pediatric patient after every 20 mL/kg fluid bolus of normal saline, and continue with fluid resuscitation until it is no longer indicated.
- Refer to the Pediatric Intraosseous Procedure, if indicated.
- It may be necessary to alter the order of the assessment (except for the Initial Assessment) based upon the developmental stage of the patient.
- A pediatric trauma patient is any trauma patient who is 15 years old or younger.