**TAB 3 ADULT MEDICAL**

**EMERGENCY GUIDELINES**



# TAB 3 GUIDELINE 1 ABDOMINAL PAIN

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Age
* Past medical / surgical history
* Medications
* Onset
* Palliation / Provocation
* Quality (crampy, constant, sharp, dull,

etc)* Region / Radiation / Referred
* Severity (1-10)
* Time (duration / repetition)
* Fever
* Last meal eaten
* Last bowel movement
* Menstrual history (pregnancy)
 | **SIGNS / SYMPTOMS*** Pain (location / migration)
* Tenderness
* Nausea
* Vomiting
* Diarrhea
* Dysuria
* Constipation
* Vaginal bleeding / discharge
* Pregnancy

**ASSOCIATED SYMPTOMS:*** Fever, headache, weakness, malaise, myalgias, cough, headache, mental status changes, rash
 | **DIFFERENTIAL*** Pneumonia or Pulmonary embolus
* Liver (hepatitis, CHF)
* Peptic ulcer disease / Gastritis
* Gallbladder / Pancreatitis
* Myocardial infarction
* Kidney stone
* Abdominal aneurysm
* Appendicitis / Diverticulitis
* Bladder / Prostate disorder
* Pelvic (PID, Ectopic pregnancy, Ovarian

cyst)* Spleen enlargement
* Bowel obstruction
* Gastroenteritis (infectious)
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
| **Make NPO** |
|  |  |

**YES**

**Hypotension / Signs of Dehydration**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**NO**

**Place Supine Position**

**Contact ALS Backup**

-Consider- **ResQGARD**

|  |  |  |
| --- | --- | --- |
|  | **Consider****Chest Pain Guidelines** |  |
|  | **Obtain EKG in****patient age > 40** |  |
| **Perform procedure if able to transmit,****do no delay care to obtain EKG** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

# SPECIAL CONSIDERATIONS:

1. The differential (causes) of abdominal pain is numerous, with origin rarely identified in a field setting. Assessment should be centered upon gathering as much information as possible related to the complaint of “abdominal pain.”
2. Consider internal hemorrhage with an associated shock presentation. For blood pressure < 90 mmHg, consider ResQGARD if available. Elderly patients may have significant hypovolemic shock with blood pressures above 90 mmHg.
3. Abdominal pain in women of childbearing age should be treated as an ectopic pregnancy until proven otherwise.
4. The diagnosis of abdominal aneurysm should be considered with abdominal pain in patients over age 50.
5. Appendicitis presents with vague, peri-umbilical pain which migrates to the RLQ over time.
6. Symptoms of dehydration
	1. Increased thirst / dry mouth
	2. Headache
	3. Weakness / confusion
	4. Dizziness / light headed / fainting
	5. Palpitations
	6. Decreased urine output

# TAB 3 GUIDELINE 2 ALCOHOL INTOXICATION

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Known diabetic, medic alert tag
* Drugs, drug paraphernalia
* Report of illicit drug use or toxic ingestion
* Past medical history
* Medications
* History of trauma
* Change in condition
 | **SIGNS / SYMPTOMS*** Decreased mental status
* Change in baseline mental status
* Bizarre behavior
* Hypoglycemia (cool, diaphoretic skin)
* Hyperglycemia ( warm, dry skin; fruity breath; Kussmaul respirations; signs of dehydration)
 | **DIFFERENTIAL*** Diabetes (hyper / hypoglycemia
* Toxicologic
* Acidosis / Alkalosis
* Environmental exposure
* Electrolyte abnormality
* Trauma
* Sepsis
 |

**Glucose < 60**

**Spinal Immobilization**

(if appropriate)

**Consider Airway Management**

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Clinical Alcohol Intoxication** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose** – grams PO (Mental Status?) |  |

|  |  |  |
| --- | --- | --- |
|  | **Check Blood Glucose** |  |
|  |  |

**Intoxicated patient with any of the following must be transported:**

Does patient have evidence of

**Incapacitating Intoxication**?

**YES**

**Incapacitating Intoxication**

* Inability to maintain airway
* Inability to stand from seated position and walk with minimal assistance
* At immediate risk of environmental exposure or trauma due to unsafe location

**Acute Illness or Injury**

* Abnormal vital signs
* Physical complaints that might indicate an underlying medical emergency (abdominal / chest pain)
* Seizure or hypoglycemia
* Signs of trauma or history of acute trauma
* Signs of head injury, e.g.:

bruising, lacerations, abrasions

**NO**

**Transport to ED**

Does patient have signs of

**Acute Illness or Injury?**

**YES**

**NO**

**Transport to ED**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control if considering release to other party (police, family)****IMPORTANT: individual agency policy may apply** |  |

# TAB 3 GUIDELINE 3 ALLERGIC REACTION | ANAPHYLAXIS

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Onset and location
* Insect sting or bite
* Food allergy / exposure
* Medication history / allergy / exposure
* New clothing, soap, detergent
* Past history of reactions
* Past medical history
 | **SIGNS / SYMPTOMS*** Itching or hives
* Coughing / wheezing or respiratory distress
* Chest or throat constriction
* Difficulty swallowing
* Hypotension or shock
* Hypotension or shock / Edema
* Abdominal cramps
 | **DIFFERENTIAL*** Urticaria (rash only)
* Anaphylaxis (systemic effect)
* Shock (vascular effect)
* Angioedema (drug induced)
* Aspiration / Airway obstruction
* Vasovagal event
* Asthma
* CHF
 |

**Respiratory Distress / Shock**

|  |  |
| --- | --- |
| **Universal Patient Care** |  |
| **Consider ALS Backup** |  |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**Hives / Rash Only**

**Airway Management**

**Pulse Oximetry**

**No Respiratory Component**

**Albuterol**

 . – mg nebulized (May repeat x 2)

**EpiPen Auto-injector**

**Patient Not Improved**

**Patient Improved**

**Reassess Patient**

|  |
| --- |
| **Indications for Use of Epinephrine** |
| **Respiratory Compromise*** Airway occlusion
* Breathy difficulty or inadequate breathing with possible wheezing, stridor, or crowing
 | **Shock*** Absent or weak pulses
* Rapid heartbeat
* Decreased blood pressure (SBP < 90 mmHg)
* Deteriorating mental status
 |

# SPECIAL CONSIDERATIONS:

1. Patients with allergic reactions can deteriorate quickly. Airway is a prime concern.
2. Epinephrine (via Auto-Injector) should be administered for:

# Respiratory Compromise

* + 1. Airway occlusion
		2. Breathy difficulty or inadequate breathing with possible wheezing, stridor, or crowing

# GI Complaint

* + 1. Abdominal cramping, nausea, vomiting

# Shock

* + 1. Absent or weak pulses
		2. Rapid heartbeat
		3. Decreased blood pressure (SBP < 90 mmHg)
		4. Deteriorating mental status
1. Lethal edema may be localized to the tongue, uvula or other upper airway structures.
2. If severe reaction with signs | symptoms of shock and / or airway involvement and ALS not available, then administer Epipen Auto-injector for **weight > 30 Kg (66 lbs)**.
3. Contact **On-Line Medical Control** prior to administering Epinephrine to patients who are > 50 years of age, have a history of cardiac disease, or if the patient’s heart rate is > . Epinephrine may precipitate cardiac ischemia.

# TAB 3 GUIDELINE 4 ALTERED MENTAL STATUS | COMA

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Known diabetic, medic alert tag
* Drugs, drug paraphernalia
* Report of illicit drug use or toxic ingestion
* Past medical history
* Medications
* History of trauma
* Change in condition
 | **SIGNS / SYMPTOMS*** Decreased mental status
* Change in baseline mental status
* Bizarre behavior
* Hypoglycemia
	+ Cool, diaphoretic skin
* Hyperglycemia
	+ Warm, dry skin
	+ Fruity breath
	+ Kussmaul respirations
	+ Signs of dehydration
 | **DIFFERENTIAL*** Head trauma
* CNS (stroke, tumor, seizure, infection)
* Cardiac (MI, CHF)
* Infection / Toxicologic
* Thyroid (hyper / hypo)
* Shock (septic, metabolic, traumatic)
* Diabetes (hyper / hypoglycemia
* Electrolyte abnormality
* Acidosis / Alkalosis
* Environmental exposure
* Pulmonary (hypoxia)
* Psychiatric disorder
 |

**Consider ALS Backup**

**Spinal Immobilization**

(if appropriate)

**Universal Patient Care**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
|  | **Consider Airway Management** |  |

**Combative Patient**

Consider Behavioral | Excited Delirium Guideline

**Glucose 60 –**

**Glucose < 60**

**Return to Baseline**

**Consider other causes:**

Carbon Monoxide (CO) Poisoning Head injury

Hypo / Hyperthermia Hypoxia Overdose

Stroke / Seizure

**Check Blood Glucose**

**Glucose > 250 Signs of Dehydration**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Document Treat and Release, Against Medical Advice -or- Transport to appropriate facility** |

**Oral Glucose**

 – grams PO (Mental Status?)

**NO**

**YES**

**Perform procedure if able to transmit, do not delay care to obtain EKG**

**Cardiac Monitor / 12-Lead ECG**

**Naloxone** 0.5 – mg IN (with respiratory depression)

**Consider**

**Consider Use of Restraints**

**Release at Scene (RAS)**

* Refusal of transport
* Adult (caregiver) present
* Blood sugar > 100
* Patient has ability to eat meal
* Patient with history of diabetes
* No history of oral diabetic medication

**Against Medical Advice (AMA) for transport of suspected opiate overdose**

Criteria met for refusal

# SPECIAL CONSIDERATIONS:

1. If the patient wishes to refuse transportation to a hospital and you have administered any medications, you must contact on-line MEDICAL CONTROL prior to leaving the patient or completing the Against Medical Advice / Release At Scene form.
2. Non-transport of hypoglycemic patient, Treat and Release guideline.

# Criteria:

* + 1. Patient must be able to refuse transport as per patient exhibiting decisional capacity to make appropriate decisions.
		2. Following treatment of a hypoglycemia state, patient is conscious, alert to time, date and place, and requests that they not be transported to the hospital.
		3. Certain patients should be informed that their hypoglycemic state may not be an isolated issue and it is recommended that they be transported:
			1. Patients with other associated findings such as hypoglycemic episode, including excessive alcohol consumption, shortness of breath, chest pain, fever, etc.
			2. Patients on oral hypoglycemic medication such as glypizide, glyburide or chlorpropamide (hypoglycemic episode may last hours or days).
			3. Patients who when treated with 50% Dextrose take greater than 10 minutes to return to a normal level of consciousness.
			4. Patient’s history does not reveal circumstances that may have contributed to the hypoglycemic episode.
		4. Repeat rapid Glucose test is > 100 mg / dl.
		5. The patient has a repeat SBP > 90 mmHg, pulse rate > 60 BPM.

# Guideline for Treat and Release:

* + 1. If the criteria above are met, then the patient is a candidate for Treat and Release.
		2. The patient must be released to the care of a responsible individual who will remain with the patient as an observer for a reasonable time.
		3. The patient should be given both verbal and written instructions for follow-up care prior to being released.
		4. If another episode occurs, request medical assistance immediately.
1. Non-transport of opiate overdose, Against Medical Advice Guidelines
	1. When dealing with patients that are suspected opiate overdose it is in their best interest to receive an evaluation and monitoring from hospital personnel. Many opiate containing

medications have the potential of causing somnolence and decreased respirations necessitating reversal medication

# Criteria:

* + 1. Patient responded immediately to administration of opiate reversal agents (naloxone)
		2. Age > 18 years of age
		3. Patient must be alert, oriented to person, place, time and event
		4. Patient must be able to refuse transport as per patient exhibiting decisional capacity to make appropriate decisions
		5. Must have been an accidental (non-suicidal) opiate overdose and did not overdose on long acting opiates
		6. Patient is no longer exhibiting any signs of overdose with normal pupil size and vital signs with HR < 100, SBP > 90 mmHg, respiratory rate > 12
		7. Patient has to verbalize the understanding that they can die from the ingestion of opiate medication and that they are refusing transport to hospital for additional evaluation and monitoring by hospital personnel

# Guideline for Release Against Medical Advice

* + 1. If the criteria above are met, then the patient is a candidate for Release Against Medical Advice.
		2. The patient must be released to the care of a responsible individual who will remain with the patient as an observer for a reasonable time.
		3. The patient should be given both verbal and written instructions for follow-up care prior to being released.
		4. If another episode occurs, request medical assistance immediately.
		5. If the patient wishes to refuse transportation to a hospital and you have administered any medications, **you MUST contact on-line MEDICAL CONTROL** prior to leaving the patient or completing the Against Medical Advice / Release At Scene form.
		6. Document in the PCR the physician that you spoke with and that the patient has decisional capacity with the ability to refuse additional medical care.

# TAB 3 GUIDELINE 5 BACK PAIN

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Age
* Past medical / surgical history
* Medications
* Onset of pain / injury
* Previous back injury
* Traumatic mechanism
* Location of pain
* Palliation / Provocation
* Region / Radiation / Referred
* Severity (1-10)
* Time (duration / repetition)
* Fever
 | **SIGNS / SYMPTOMS*** Pain (paraspinour, spinous process)
* Swelling
* Pain with range of motion
* Extremity weakness
* Extremity numbness
* Shooting pain into an extremity
* Bowel / bladder dysfunction
 | **DIFFERENTIAL*** Muscle spasm / strain
* Herniated disc with nerve compression
* Sciatica
* Spine fracture
* Kidney stone
* Pyelonephritis
* Aneurysm
* Pneumonia
* Spinal epidural abscess
* Metastatic Cancer
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

**YES**

**Injury or traumatic mechanism**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Upper back pain with no history of injury obtain bilateral arm pressures** |  |  |
| **Interarm SBP > 20****mmHg difference** |
|  |
|  |  |

**NO**

**Spinal Immobilization**

**YES**

**NO**

**Place Supine Position**

**Contact ALS Backup**

-Consider- **ResQGARD**

|  |  |
| --- | --- |
|  | **Consider Thoracic Dissection** |
| **Make NPO** |
|  |  |

**YES**

**Signs of Shock with**

**SBP < 90 mm g Hg**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

**NO**

**Consider**

* **Abdominal aneurysm age > 50**
* **Kidney Stones with acute flank pain radiating to groin**
* **Epidural abscess with history of IV drug use / previous surgery**

# TAB 3 GUIDELINE 6 BEHAVIORAL | EXCITED DELIRIUM

**Glucose < 60**

**Check Blood Glucose**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose** – grams PO (Mental Status?) |  |

|  |
| --- |
| Treat suspected medical or trauma problems per appropriate protocol**Altered Mental Status Poisoning and Overdose Head Trauma** |
|  |  |

|  |
| --- |
| **Rapid take-down w/ minimum****(4) EMS crew members (If necessary)** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **12-Lead EKG** |  |
| **Perform procedure if able to transmit, do not delay care to obtain EKG** |
|  |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Situational crisis
* Psychiatric illness / medications
* Injury to self or threats to others
* Medic alert tag
* Substance abuse / overdose
* Diabetes
 | **SIGNS / SYMPTOMS*** Anxiety, agitation, confusion
* Affect change, hallucinations
* Delusional thoughts, bizarre behavior
* Expression of suicidal / homicidal thoughts
* Poor concentration, easily distracted,

psychosis* Combative, violent
* Large pupils / light sensitivity
* Tachycardic / Hypertension
 | **DIFFERENTIAL*** See Altered Mental Status differential
* Hypoxia
* Alcohol intoxication
* Medication effect / overdose
* Withdrawal syndromes
* Depression
* Bipolar (manic-depressive)
* Schizophrenia, anxiety disorders, etc.
 |

|  |
| --- |
| **Remove patient from stressful environment** |
|  |  |

|  |
| --- |
| **Verbal techniques (reassurance, calm, establish rapport)** |
|  |  |

|  |  |
| --- | --- |
|  | **Restraints*** **No transport in hobble or prone position.**
* **Do not inhibit patient breathing, ventilations**
 |
| **Consider Restraints****(for patient / personnel safety)** |  |
|  |
|  |  |
| **Cardiac Monitor /** |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

**SPECIAL CONSIDERATIONS:**

1. Excited delirium is an extreme disturbance of consciousness and mental status that occurs in individuals especially when under the influence of stimulants or anti-psychotic medications and it represents an acute **LIFE THREATENING MEDICAL EMERGENCY**
	1. Combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent / bizarre behavior, insensitivity to pain, hyperthermia and increased strength. Potentially life-threatening and associated with use of physical control measures, including physical restraints and Tasers
		1. Need rapid take down, sedation by ALS providers, cooling measures and IV fluid replacement by ALS providers. These patients often suffer respiratory or cardiac arrest once subdued and should be closely monitored and transported by an ALS Unit to closest appropriate facility
	2. Most commonly seen in male subjects with a history of serious mental illness and/or acute or chronic drug abuse, particularly stimulant drugs such as cocaine, crack cocaine, methamphetamine, amphetamines or similar agents
	3. Alcohol withdrawal or head trauma may also contribute to the condition
2. Maintain objectivity during evaluation and treatment. Verbal aggression exhibited by patients can quickly escalate to physical violence. Always proceed with calm, reassuring directions for the patient. If a situation appears threatening, sufficient law enforcement presence may be necessary before patient restraint is attempted
	1. If needing to take the patient down, at minimum, utilize (4) ems crew members / police officers to secure each limb

# If a patient suspected of excited delirium suffers cardiac arrest, consider a fluid bolus and sodium bicarbonate early

1. Patients requiring physical restraint should be placed in the lateral recumbent position when possible. Consider your own safety and limitations when physical restraint is required.
	1. Restrained patients should never be left unattended. Continue to evaluate effectiveness of restraints and any compromise that may be caused by the restraint process (i.e., airway, breathing, circulation)
	2. Positional asphyxia – very large ventilation volumes are needed to oxygenate and blow off carbon dioxide overload. They should never be left prone or face down in handcuffs and should never by “hog-tied”
2. Do not overlook the possibility of associated domestic violence or abuse

# TAB 3 GUIDELINE 7 DENTAL PAIN

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Age
* Past medical history
* Medications
* Onset of pain / injury
* Trauma with "knocked out" tooth
* Location of tooth
* Whole vs. partial tooth injury
 | **SIGNS / SYMPTOMS*** Bleeding
* Pain
* Fever
* Swelling of face / buccal mucosa
* Tooth missing or fractured
 | **DIFFERENTIAL*** Decay
* Infection
* Fracture
* Avulsion
* Abscess
* Facial cellulitis
* Impacted tooth (wisdom)
* TMJ syndrome
* Myocardial infarction
 |

 **YES**

**Dental or Jaw Pain suspicious for Cardiac**

**Consider ALS Backup**

**Universal Patient Care**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
|  | **Cardiac Monitor /****12-Lead EKG** |  |
| **Perform procedure if able to transmit,****do not delay care to obtain EKG** |
| **Go to Chest Pain Guidelines** |

**NO**

**YES**

**Significant or Multi-System Trauma**

**Go to Appropriate Trauma Guidelines**

**NO**

 **YES**

**Bleeding**

|  |  |  |
| --- | --- | --- |
|  | **Control Bleeding with Direct Pressure (Small gauze rolled into a square and placed into socket with patient closing teeth to exert pressure** |  |

|  |  |
| --- | --- |
| **Place tooth in Milk -or- Normal Saline -or- Comm ercial Preparation****May rinse gross contamination****Do not rub or scrub tooth** | **YES** |
|  |  |

**NO**

**NO**

**Dental Avulsion**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

# SPECIAL CONSIDERATIONS:

1. Recommended Exam: Mental Status, HEENT, Neck, Chest, Lungs, Neurology
2. Significant soft tissue swelling to the face or oral cavity can represent a cellulitis or abscess.
3. Scene and transport times should be minimized in complete tooth avulsions. Re-implantation is possible within 4 hours if the tooth is properly cared for.
4. All pain associated with teeth should be associated with a tooth which is tender to tapping or touch (or sensitivity to cold or hot).

# TAB 3 GUIDELINE 8 DIALYSIS / RENAL FAILURE

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Past medical history
* Medications
* Peritoneal or Hemodialysis
* Shunt access noted
* Crush Injury
 | **SIGNS / SYMPTOMS*** EKG abnormality
	+ Peaked T waves
	+ Wide complex, bizarre appearance with slow rhythm
* Shortness of breath
* Hypotension
* Bleeding
* Seizure
* Altered Mental Status
 | **DIFFERENTIAL*** End Stage Renal Disease
* Electrolyte imbalance
* Crush Injury
* Prolonged immobilization
* Rhabdomyolisis
* Congestive Heart Failure
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

**YES**

**CHF / Pulmonary Edema**

**Shunt / Fistula Bleeding**

|  |  |  |
| --- | --- | --- |
|  | **Apply firm finger tip pressure to bleeding site** |  |
| Apply dressing but avoid bulky dressing |
| Dressing must not compress fistula / shunt as this will cause clotting of the shunt |
| If direct pressure and dressing not effective and significant hemorrhage, apply tourniquet to affected extremity far away from shunt / fistula |
|  |  |  |

**NO**

**Serious Signs / Symptoms**

**Cardiac Arrest**

**NO**

**NO**

**NO**

**YES**

**YES**

**AMS | COMA Guidelines**

**YES**

**SBP < 90 mmHg**

**YES**

**CHF Guideline**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**YES**

**Blood Sugar < 60 or > 250**

**Cardiac Arrest Guideline**

**Check Blood Glucose**

**NO**

**Hemodialysis in past 4 hours**

**NO**

|  |  |  |
| --- | --- | --- |
|  | **Place Supine Position Contact ALS Backup**-Consider- **ResQGARD** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

# TAB 3 GUIDELINE 9 EPISTAXIS

* Most nose bleeding is from an anterior

source and may be easily controlled

* Avoid phenylephrine in pts with known

CAD

* Anticoagulation with aspirin,

clopidogrel (Plavix), warfarin

(Coumadin) will make epistaxis much harder to control. Note if your patient is taking these or other anticoagulant medications

* Posterior epistaxis is a true emergency

and may require advanced ED techniques. Do not delay transport. Be prepared for potential airway issues.

* Patients using nasal cannula oxygen

may have cannula placed in mouth while nares are clamped or compressed for nosebleed

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Age
* Past medical history
* Medications (HTN, anticoagulants,

ibuprofen / OTC headache relief powder)* Previous episodes of epistaxis
* Trauma
* Duration of bleeding
* Quantity of bleeding
 | **SIGNS / SYMPTOMS*** Bleeding from nasal passage
* Pain
* Nausea
* Vomiting
 | **DIFFERENTIAL*** Trauma
* Infection (viral URI or Sinusitis)
* Allergic rhinitis
* Lesions (polyps, ulcers)
* Hypertension
 |

**YES NO**

**NO**

**Bleeding Controlled**

**Hypotension and / or tachycardia**

|  |  |  |
| --- | --- | --- |
|  | **Tilt head forward Have Patient Blow Nose to expel clot****Ice pack to nose** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Compress nostrils with clamp or fingers, pinching over fleshy part of nose, not nasal bridge** |  |
|  |  |

**YES**

**Place Supine Position Contact ALS Backup**

-Consider- **ResQGARD**

Consider

**Hypertensive Emergency**

**Guideline**

# TAB 3 GUIDELINE 10

**FOREIGN BODY AIRWAY OBSTRUCTION - ADULT**

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Events leading up to incident
* Trauma
* Aspiration
* Medication
* Allergic reaction
 | **SIGNS / SYMPTOMS*** Anxiety
* No air movement
* Clutching throat
* Unresponsive
* Sore throat, fever,
* “Hot potato” voice, drooling
 | **DIFFERENTIAL*** Foreign Body
* Infection
* Trauma
* Laryngeal or tracheal fracture
* Oropharyngeal laceration
 |

**NO YES**

**Attem pt breaths, if air does not enter retilt head and reattempt breaths**

**Chest Compressions**

**Unresponsive**

**Conscious**

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Signs of Airway Obstruction** |
|  |  |

**Perform Abdominal**

**Thrusts**

**NO**

**NO**

**Check airway / perform**

**blind finger sweep**

**Airway Obstruction Cleared**

**PULSE YES**

**NO**

**Airway Obstruction Cleared**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

**Cardiac Arrest Guideline**

|  |  |
| --- | --- |
| **Mild Airway Obstruction Signs** | **Severe Airway Obstruction Signs** |
| * Good air exchange
 | * Poor or no air exchange
 |
| * Responsive and can cough forcefully
 | * Weak, ineffective cough or no cough at all
 |
| * May wheeze between coughs
 | * High-pitched noise while inhaling or no noise at all
 |
|  | * Increased respiratory difficulty
 |
|  | * Possible cyanosis (turning blue)
 |
|  | * Unable to speak or move air
 |
|  | * Clutching the neck with the thumb and fingers
 |
|  | * Unresponsive
 |

# TAB 3 GUIDELINE 11 HYPERTENSIVE EMERGENCY

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Bilateral Blood Pressures** |
|  |  |

|  |
| --- |
| **SBP > 180 mmHg or DBP > 110 mm Hg** |
|  |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Documented hypertension
* Related diseases: diabetes, CVA, renal failure, cardiac
* Medications (compliance?)
* **Viagra, Levitra, Cialis**
* Pregnancy
 | **SIGNS / SYMPTOMS****One of these:*** Systolic BP 180 or greater
* Diastolic BP 110 or greater

**And at least one of these:*** Chest Pain
* Headache / Blurred Vision
* Nosebleed
* Dizziness
 | **DIFFERENTIAL*** Hypertensive encephalopathy
* Primary CNS injury (Cushing's response = bradycardia with hypertension
* Myocardial infarction
* Aortic dissection (aneurysm)
* Pre-eclampsia / Eclampsia
 |

|  |  |  |
| --- | --- | --- |
|  | **Cardiac Monitor /****12-Lead ECG** |  |
| **Perform procedure if able to transmit, do not delay care to obtain EKG** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

**SPECIAL CONSIDERATIONS:**

1. **Elevated blood pressure of itself rarely requires emergency therapy.**
	1. Initial triage should quickly identify those patients who have an elevated BP without any evidence of significant target organ damage or any other impending cardiovascular events.
		1. Secondary hypertension in response to stress or pain is a common field finding. It does not require field treatment.
		2. Hypertension can also be from a severe head injury and intracranial bleeding. Treatment should be for the actual intracranial problem and not the blood pressure problem.
	2. A careful cardiovascular examination, as well as a thorough neurologic examination, including mental status, should be conducted.
	3. Improper BP cuff size can produce falsely high or low blood pressure measurements
2. Initial goal for BP reduction is not to obtain a normal BP, but to achieve a progressive controlled reduction to minimize the risk of hypoperfusion to vital organs.

# Initial reduction in mean arterial pressure should not exceed 20 – 25% below the pretreatment BP. As an alternative, mean arterial pressure can be reduced within the first 30 – 60 minutes to 110 – 115mmHg.

* 1. Excessively rapid reductions in BP have been associated with acute deterioration in renal function, ischemic cardiac or cerebral events, and occasional retinal artery occlusion and acute blindness.
1. Signs and symptoms of a hypertensive emergency:
	1. Rapid rise in diastolic pressure over 130mmHg
	2. New onset symptoms that accompany rise in BP:
		1. Chest pressure / Difficulty breathing.
		2. Mental confusion / Agitation.
		3. Severe headache.
		4. Light-headed / Dizziness.
		5. Nausea / vomiting.
		6. Visual impairment (may include transient blindness).

# TAB 3 GUIDELINE 12 HYPOTENSION (SHOCK)

**NO**

**YES**

**Trauma**

**Non-Cardiac**

**Non-Trauma**

**Cardiac**

**Symptomatic**

**Observe and Reassess**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Blood loss - vaginal or gastrointestinal

bleeding, AAA, ectopic pregnancy* Fluid loss - vomiting, diarrhea, fever
* Infection
* Cardiac ischemia (MI, CHF)
* Medications
* Allergic reaction
* Pregnancy
* History of poor oral intake
 | **SIGNS / SYMPTOMS*** Restlessness, confusion
* Weakness, dizziness
* Weak, rapid pulse
* Pale, cool, clammy skin
* Delayed capillary refill
* Hypotension
* Coffee-ground emesis
* Tarry stools
 | **DIFFERENTIAL*** Shock
	+ Hypovolemia
	+ Cardiogenic
	+ Septic
	+ Neurogenic
	+ Anaphylactic
* Ectopic pregnancy
* Dysrhythmias
* Pulmonary embolus
* Tension pneumothorax
* Medication effect / overdose
* Vasovagal
* Physiologic (pregnancy)
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Cardiac Monitor /****12-Lead EKG** |  |  |
| **Perform procedure if able to transmit,****do not delay care to obtain EKG** |
|  |  |
|  |  |

|  |
| --- |
| Treatment per appropriate**Trauma Guideline** |
|  |  |

**Place Supine Position**

**Contact ALS Backup**

-Consider- **ResQGARD**

Treatment per appropriate **Cardiogenic Shock Guideline**

Consider **ResQGARD (If hemorrhage rate unknown)**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

**SPECIAL CONSIDERATIONS:**

1. Hypotension can be defined as a mean arterial pressure (MAP) < 65 mmHg
2. Consider all possible causes of shock and treat per appropriate guideline
	1. Anaphylactic – reaction to substance to which patient is hypersensitive or allergic
	2. Cardiogenic – myocardial infection with damage to heart muscle
	3. Hemorrhagic – severe bleeding or loss of body fluid from trauma, burns, surgery or dehydration from severe nausea and vomiting
	4. Metabolic – body homeostasis impaired; have disturbance in acid-base balance
	5. Neurogenic – injury or trauma to the nervous system
	6. Obstructive – compression of the great vessels leading back to the heart or compression on the heart itself by masses, fluid, etc that causes a limitation on preload
	7. Septic – acute infection
3. If no evidence of cardiogenic cause, institute general treatment measures.
	1. Place patient supine; if respiratory distress results, place patient in position of comfort
	2. Consider application of the ResQGARD for patients > 25 lbs. who are experiencing symptoms of low blood circulation secondary to a variety of causes such as:

|  |  |
| --- | --- |
| * Hypovolemia
	+ Internal Hemorrhage
	+ External Hemorrhage
	+ Dehydration
 | * Hypotension
	+ Dialysis
	+ Sepsis
	+ Orthostatic intolerance
	+ Medication reaction
 |

# TAB 3 GUIDELINE 13 INFLUENZA LIKE ILLNESS (ILI)

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Immunization
* Previous influenza
* Pregnancy
* Diabetic
* HIV / Immunocompromised
* Medication – chemotherapy, steroids, immunosuppressant
 | **SIGNS / SYMPTOMS*** Fever / Chills
* Coughing
* Sore throat
* Runny or stuffy nose
* Headaches
* Body aches
* Fatigue
* Vomiting / Diarrhea
 | **DIFFERENTIAL*** Common cold
* Carbon monoxide poisoning
* Other viral syndromes
* Pneumonia
* Meningitis
* Mononucleosis
* HIV
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

**Airway Management**

**Pulse Oximetry**

|  |
| --- |
| **Hypotension / Signs of Dehydration** |
|  |  |

**YES**

**YES**

**NO**

**Respiratory Insufficiency ?**

**Position of patient comfort**

|  |
| --- |
| **Use HEPA filter on expiratory end****of aerosol circuit** |
|  | **Albuterol** . – mg nebulized (May repeat x 2) |  |
|  |  |
|  | **Consider CPAP** |
|  |  |

**Wheezing**

**NO**

**Glucose < 60**

**Place Supine Position Contact ALS Backup**

-Consider- **ResQGARD**

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose** – grams PO (Mental Status?) |  |

|  |  |  |
| --- | --- | --- |
|  | **Check Blood Glucose** |  |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Exposure control**(PPE) |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

# SPECIAL CONSIDERATIONS:

1. Influenza or “the flu” is caused by a number of unique influenza viruses. The patient is contagious for 48 hours prior to the onset of symptoms and as long as febrile or coughing which may be over 1 week after onset of symptoms.
2. Required personal protective equipment (PPE).
	1. Gloves / Goggles or eye shields.
	2. Fit tested N-95 respirator or Air Purifying Respirator (APR) or Powered APR (PAPR).
	3. Gown if gross contamination possible.
	4. Place plain surgical mask on patient and apply oxygen on top (**patients never use N-95 respirators**).
3. Disinfection.
	1. Vehicle will be left open for 5 – 10 minutes with ventilation running and doors and windows open.
	2. Fully recommended PPE will be used during decontamination process.
	3. Gross contamination will be removed and washed with soap / water.
	4. All exposed surfaces will be cleaned with approved hospital grade disinfectant and allowed to air dry to include benches, cots, counters and exposed walls.
	5. PPE will be removed with no cross contamination (remove one glove, remove mask by straps).
	6. Strict hand washing from elbows down with soap and water for minimal of 20 seconds or if unavailable waterless hand cleaner will be used.

# TAB 3 GUIDELINE 14 POISONING | OVERDOSE | TOXIC INGESTION

**Duodote** IM 1 – 3 injectors

**Other**

**Hypotension, Seizures, Ventricular**

**dysrhythmias, or Mental status changes**

**CO Poisoning**

**Altered Mental Status Blood Sugar < 60 mg / dl -or-**

**Respiratory Depression**

**Appropriate Guideline**

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose** 15 – 30 grams PO (Mental Status?) |  |
|  | **Nalaxone** 0.5 - 4 mg IN(with respiratory depression) |  |

|  |  |  |
| --- | --- | --- |
|  | **NRB Mask @ 15 L O2** |  |
|  | **CPAP with PEEP @ 5 cm H2O** |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** What type of ingestion
* When did ingestion occur
* How Much
* Reason for ingestion
* Actions of bystanders
* Previous psychiatric disorders
* Diseases / Medications: ie depressants
* Medical alert tags
 | **SIGNS / SYMPTOMS*** Increased salivation
* Soot or burns in mouth
* Irritation of the eyes
* Sweating and skin burns
* Decreased respiratory rate
* Lung findings (ie edema)
* Delayed capillary refill
* Tachycardia / Arrhythmias
* Seizures
 | **ENVIRONMENT*** Acetaminophen
* Anticholinergic
* Aspirin
* Cardiac medications
* Insecticides (organophosphates)
* Solvents, alcohols, cleaning agents
* Stimulants
 |

|  |
| --- |
| **Organophosphate / Nerve Agent** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

**SPECIAL CONSIDERATIONS:**

1. General:
	1. Improve the care of patients with poisonings, and environmental/biochemical terrorism exposures in the pre-hospital setting. Provide for the most timely and appropriate level of care to the patient, including the decision to transport or treat on the scene
	2. If no immediate life threat or need for transport is identified, EMS personnel may conference the patient/caller with the Poison Center Specialist at the **Poison Control Center at 800-222-1222**.
		1. The Poison Center Specialist at the State Poison Center will evaluate the exposure and make recommendations regarding the need for on-site treatment and/or hospital transport in a timely manner
		2. If the patient is determined to need EMS transport, the poison control center Specialist will contact the receiving hospital and provide information regarding the poisoning, including treatment recommendations. EMS may contact medical control for further instructions or to discuss transport options.
		3. If the patient is determined not to require EMS transport, personnel will give the phone number of the patient/caller to the Poison Control Center Specialist. The Specialist will initiate a minimum of one follow-up call to the patient/caller to determine the status of patient.
		4. Minimal information that should be obtained from the patient for the state poison center includes:

|  |  |
| --- | --- |
| Name and age of patient | Substance(s) involved |
| Time of exposure | Any treatment given |
| Signs and symptoms |  |

* + 1. Minimal information which should be provided to the State Poison Center for mass poisonings, including biochemical terrorism and HazMat, includes:

|  |  |
| --- | --- |
| Substance(s) involved | Time exposure |
| Signs and symptoms | Any treatment given |

* 1. Do not induce vomiting for

|  |  |  |
| --- | --- | --- |
| * Hydrocarbons
 |  | * Strong Acids  Strong Base Iodides
 |
| * Silver Nitrate
1. Do not neutralize acids w
2. Product labels and home
 |  | * Strychnine  Who are not alert ith alkali or Do not neutralize alkali with acids

kits may be misleading and dangerous |

1. All empty containers of ingested material should accompany patient to the hospital
2. Do not rely on patient history of ingestion, especially in suicide attempts
3. Overdose / Ingestion concerns:
	1. **Acetaminophen:** Initial presentation normal or nausea/vomiting. If not detected and treated, will cause irreversible liver failure
	2. **Anticholinergic:** Increased HR, increased temperature, dilated pupils, mental status changes
	3. **Aspirin:** Early signs consist of abdominal pain, vomiting ringing in the ears. Tachypnea and altered mental status may occur later. Renal dysfunction, liver failure, and or cerebral edema among other things can take place later
	4. **Cardiac Medications:** Dysrhythmias and mental status changes
	5. **Depressants:** Decreased HR, decreased BP, decreased temperature, decreased respirations, non-specific pupils
	6. **Insecticides:** Increased or decreased HR, increased secretions, nausea, vomiting, diarrhea, pinpoint pupils
	7. **Solvents**: Nausea, vomiting, and mental status changes
	8. **Stimulants:** Increased HR increased BP, increased temperature, dilated pupils, and seizures
	9. **Tricyclics:** 4 major areas of toxicity: seizures; dysrhythmias; hypotension; decreased mental status or coma; rapid progression from alert mental status to death

|  |  |
| --- | --- |
| **Condition** | **Treatment** |
| Carbon Monoxide | * Carbon monoxide is produced from a variety of sources such as vehicles, gasoline engines, camp stoves, lanterns, burning charcoal and wood, gas ranges, heating systems and poorly vented chimneys. Structural fires are another common source of CO exposure.
* Normal Carbon Monoxide Levels (ages 3 – 74).
	+ Nonsmokers = 0.83 + 0.67%.
	+ Smokers = 4.30 + 2.55%.
* Factors which may reduce the reliability of carbon monoxide readings:
	+ Poor peripheral circulation (hypovolemia, hypotension, hypothermia).
	+ Excessive sensor motion.
 |

|  |  |
| --- | --- |
|  | * Fingernail polish (may be removed with finger nail polish remover).
* Irregular heart rhythms (atrial fibrillation, SVT, etc.).
* Jaundice**.**
* **Consider transport to hospital with hyperbaric chamber for potential hyper oxygen therapy. Consult with On-Line Medical Control for diversion approval.**
 |
| Cyanide | * Any smoke inhalation victim with mental status changes should also be treated for Cyanide Poisoning if medication is available, or if known exposure to Cyanide. Any patient or firefighter that goes into cardiac arrest after exposure to smoke from a fire.
* Present history: when last well, progression of present state, prior symptoms such as increase in respirations, convulsions, coma.
* Check for bottles and read ingredient label. If patient is in an industrial setting, ask if they use Cyanide.
* Principal manifestations of poisoning with these compounds are rapid respirations, blood pressure fall, convulsions and coma; may also cause lightheadedness, vomiting, flushing, headache, drowsiness, hypotension, rapid pulse and unconsciousness.
* Check for odor of “BITTER ALMONDS”.
 |
| Hydrofluoric Acid | * EMT should continue the therapy initiated by previous EMS providers in

regard to dermal or inhalation therapy of Calcium Gluconate. |
| Nerve Agent Exposure / Organophosphate Poisoning | * Mild symptoms:
	+ 1 Duodote
* Moderate: Unable to ambulate but still conscious
	+ 1 Duodote
* Severe: Unconscious / seizures
	+ 3 Duodote

**Do not administer more than three (3) DuoDote Auto-Injectors or three (3) Mark 1 Kits** unless definitive medical care is available. The limit of 3 doses is specific to the pralidoxime component of the DuoDote and Mark 1 Kit. **If necessary, additional doses of atropine can be administered if the 3 doses of****DuoDote or Mark 1 Kit injections do not produce an adequate response.** |

# TAB 3 GUIDELINE 15 POISONING | OVERDOSE | OPIATE

|  |  |  |
| --- | --- | --- |
| **HISTORY*** What type of ingestion
* When did ingestion occur
* How Much
* Reason for ingestion
* Actions of bystanders
* Previous psychiatric disorders
* Diseases / Medications: ie depressants
* Medical alert tags
 | **SIGNS / SYMPTOMS*** Increased salivation
* Soot or burns in mouth
* Irritation of the eyes
* Sweating and skin burns
* Decreased respiratory rate
* Lung findings (ie edema)
* Delayed capillary refill
* Tachycardia / Arrhythmias
* Seizures
 | **ENVIRONMENT*** Acetaminophen
* Anticholinergic
* Aspirin
* Cardiac medications
* Insecticides (organophosphates)
* Solvents, alcohols, cleaning agents
* Stimulants
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
| **Exposure control**(PPE = Non-Porous Gloves / EyeProtection / N95 Mask / Gown) |
| **Ensure crew safety Avoid evidence tampering** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**Respiratory Rate < 12**

**YES NO**

**Glucose < 60**

**Altered Mental Status Presumed Opiate Overdose Respiratory Rate < 8**

**Appropriate Guideline**

|  |  |  |
| --- | --- | --- |
|  | **Apply Pulse Ox** |  |
| **Administer Oxygen for Saturation < 94%** |
| **Airway Management** |
|  |  |

|  |
| --- |
| **Position of patient comfort** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Check Blood Glucose** |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose** – grams PO (Mental Status?) |  |

|  |  |  |
| --- | --- | --- |
|  | **Cardiac Monitor /****12-Lead ECG** |  |
| **Perform procedure if able to transmit, do not delay care to****obtain EKG** |
|  |  |

**Naloxone** 0.5 – mg IN (administer at 0.5 mg / dose every 1 – minutes)

**Against Medical Advice (AMA) for transport of suspected opiate overdose**

Criteria met for refusal

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |
| **Decontaminate Ambulance and Equipment after Transport** |

# SPECIAL CONSIDERATIONS:

1. The main focus for treatment is to ensure proper respiratory and oxygen saturation status. The goal is “**NOT TO WAKE”** the patient up. Naloxone administration should be at no more than

0.5 mg aliquots every 1 – 2 minutes. While naloxone is being administered ensure that proper ventilation is being performed with bag-valve mask and oxygen

1. All suspected patients with opiate overdose should be handled using non-porous type gloves (nitrile style, non-latex) and eye protection. Consider wearing N-95 mask and gowns for any patient that has visible powder on body, or if there is visible powder in patient care area
2. Non-transport of opiate overdose, Against Medical Advice Guidelines
	1. When dealing with patients that are suspected opiate overdose it is in their best interest to receive an evaluation and monitoring from hospital personnel. Many opiate containing medications have the potential of causing somnolence and decreased respirations necessitating reversal medication

# Criteria:

* + 1. Patient responded immediately to administration of opiate reversal agents (naloxone)
		2. Age > 18 years of age
		3. Patient must be alert, oriented to person, place, time and event
		4. Patient must be able to refuse transport as per patient exhibiting decisional capacity to make appropriate decisions
		5. Must have been an accidental (non-suicidal) opiate overdose and **DID NOT** overdose on long acting opiates (methadone, oxycontin, buprenorphine, long acting morphine)
		6. Patient is no longer exhibiting any signs of overdose with normal pupil size and vital signs with HR < 100, SBP > 90 mmHg, respiratory rate > 12
		7. Patient **MUST** verbalize the understanding that they can die from the ingestion of opiate medication and that they are refusing transport to hospital for additional evaluation and monitoring by hospital personnel

# Guideline for Release Against Medical Advice

* + 1. If the criteria above are met, then the patient is a candidate for Release Against Medical Advice
		2. The patient must be released to the care of a responsible individual who will remain with the patient as an observer for a reasonable time
		3. The patient should be given both verbal and written instructions for follow-up care prior to being released
		4. If another episode occurs, request medical assistance immediately.
		5. If the patient wishes to refuse transportation to a hospital and you have administered any medications, you **MUST contact on-line MEDICAL CONTROL** prior to leaving the patient or completing the Against Medical Advice / Release At Scene form
		6. Document in the PCR the physician that you spoke with and that the patient has decisional capacity with the ability to refuse additional medical care
1. Vehicle and Equipment Decontamination
	1. Any concern for opiate contamination within the vehicle or on the equipment should be cleaned using N95 mask with non-porous type gloves (nitrile style, non-latex) and eye protection
	2. Spill Clean Up Instructions
		1. Wear appropriate PPE
		2. Add one teaspoon full of powder OxiClean™ to mL water
		3. Shake gently until all powder is in solution
		4. Completely cover spill with spray
		5. Within 15 minutes, scrub with a paper towel until dry (solution evaporates over time and this decreases the effectiveness of decontamination)
		6. All PPE (except goggles) and paper towels must be disposed of in a biohazardous waste bin

# TAB 3 GUIDELINE 16 PSYCHIATRIC PATIENT

**Consider Use of Restraints (for patient / personnel safety)**

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose** – grams PO (Mental Status?) |  |

|  |  |  |
| --- | --- | --- |
|  | **Check Blood Glucose** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Situational crisis
* Psychiatric illness / medications
* Injury to self or threats to others
* Medic alert tag
* Substance abuse / overdose
* Diabetes
 | **SIGNS / SYMPTOMS*** Anxiety, agitation, confusion
* Affect change, hallucinations
* Delusional thoughts, bizarre behavior
* Expression of suicidal / homicidal thoughts
* Poor concentration, easily distracted,

psychosis* Combative, violent
 | **DIFFERENTIAL*** See Altered Mental Status differential
* Hypoxia
* Alcohol intoxication
* Medication effect / overdose
* Withdrawal syndromes
* Depression
* Bipolar (manic-depressive)
* Schizophrenia, anxiety disorders, etc.
 |

**NO**

**Patient Agitated / Aggressive**

**Behavioral | Excited Delirium Guideline**

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Back-Up** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Remove patient from stressful environment** |
|  |  |

**Patient having anxiety attack**

**NO**

**YES**

**Restraints**

* **No transport in hobble or prone position.**
* **Do not inhibit patient breathing, ventilations**

**Patient Depressed / Suicidal / Homicidal**

**Consider Mental Health Hold (Pink Slip)**

|  |
| --- |
| **Rapid take-down w/ minimum****(4) EMS crew members (If necessary)** |
|  |  |

|  |
| --- |
| **Verbal techniques (reassurance, calm, establish rapport)** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

# SPECIAL CONSIDERATIONS:

1. **Mental Health Holds (Pink Slip)**
	1. If a patient has an isolated mental health complaint (e.g. suicidality), and does not have a medical complaint or need specific medical intervention, then that patient may be appropriately transported by law enforcement according to their guidelines.
	2. If a patient has a psychiatric complaint with associated illness or injury (e.g. overdose, altered mental status, chest pain, etc), then the patient should be transported by EMS
	3. If a patient with a psychiatric complaint is intoxicated or otherwise lacks decisio n making capacity for any other reason, then no Mental Health Hold is needed and such a patient should be brought to an emergency department for evaluation and stabilization with implied consent.
	4. If EMS is called to evaluate a patient with an isolated psychiatric complaint who is not intoxicated, or otherwise lacking decision making capacity, and who refuses treatment or transport, and law enforcement are not willing to transport patient, then EMS should contact **MEDICAL CONTROL**.
		1. If there is a reasonable concern for suicidal or homicidal ideation, or grave disability from another mental health condition, then **MEDICAL CONTROL** may give a verbal order placing the patient on a Mental Health Hold and direct EMS personnel to transport the patient against his or her will in accordance with State of Ohio statutes.
		2. The physician’s name, and time and date of the Mental Health Hold must be recorded on the PCR. Effort should be made to obtain consent for transport from the patient, and to preserve the patient’s dignity throughout the process.
		3. A patient being transported on a Mental Health Hold may be transported to any appropriate receiving emergency department.

# TAB 3 GUIDELINE 17 RESPIRATORY DISTRESS

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Asthma
* COPD - chronic bronchitis, emphysema,

congestive heart failure* Home treatment (oxygen, nebulizer)
* Medications (theophylline, steroids,

inhalers* Toxic exposure, smoke inhalation
 | **SIGNS / SYMPTOMS*** Shortness of breath
* Pursed lip breathing
* Decreased ability to speak
* Increased respiratory rate / effort
* Wheezing, rhonchi, rales, stridor
* Use of accessory muscles
* Fever, cough
* Tachycardia
 | **DIFFERENTIAL*** Asthma / COPD (emphysema, bronchitis)
* Anaphylaxis
* Aspiration
* Pneumonia / Pleural effusion
* Pulmonary Embolus
* Pneumothorax
* Cardiac (MI or CHF)
* Pericardial tamponade
* Hyperventilation
* Inhaled toxin (carbon monoxide, etc)
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

**YES NO**

**Pulse Oxim etry**

**Respiratory Insufficiency**

**Position of**

**patient comfort**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
|  | **Airway****Management** |  |

**Rales or signs**

**of CHF**

**Wheezing**

**CHF | Acute Pulmonary Edema Guideline**

|  |
| --- |
| **Return to Baseline** |
|  |  |

**Albuterol** 2.5 – 5 mg nebulized (May repeat x 2)

**Release at Scene (RAS)** Refusal of transport Respiratory rate 12 – 20 No audible Wheezing

|  |  |  |
| --- | --- | --- |
|  | **CPAP****Initiate Peep at 5 cm H**2**O** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Document Treat and Release -or-****Transport to appropriate facility** |

# SPECIAL CONSIDERATIONS:

1. Patients with COPD, the goal for SpO2 and use of oxygen should be 88 – 94%.
2. Non-transport of asthmatic patient, Treat and Release guideline.

# Criteria:

* + 1. Patient must be able to refuse transport as per patient exhibiting decisional capacity to make appropriate decisions.
		2. Following treatment of an asthmatic exacerbation patient is conscious, alert to time, date and place, and requests that they not be transported to the hospital.
		3. Patient lung sounds on auscultation are back to baseline.

# Guideline for Treat and Release:

* + 1. If the criteria above are met, then the patient is a candidate for Treat and Release.
		2. The patient must be released to the care of a responsible individual who will remain with the patient as an observer for a reasonable time.
		3. The patient should be given both verbal and written instructions for follow-up care prior to being released:
			1. Take action to prevent a recurrent episode such as remain in the care of a responsible individual.
			2. Use medication as directed.

# TAB 3 GUIDELINE 18 SEIZURE

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Fever
* Prior history of seizures
* Seizure medications
* Reported seizure activity
* History of recent head trauma
* Congenital abnormality
 | **SIGNS / SYMPTOMS*** Observed seizure activity
* Altered mental status
* Hot, dry skin or elevated body temperature
 | **DIFFERENTIAL*** Infection / Fever
* Head trauma
* Medication or toxin
* Hypoxia or respiratory failure
* Hypoglycemia
* Metabolic abnormality / acidosis
* Tumor
 |

**Universal Patient Care**

Glucose < 60

**Febrile**

Tympanic temperature measurement

**Consider ALS Backup**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Consider Spinal Immobilization** |
|  | **Airway Management** |  |
|  | **Check Blood Glucose** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose** – grams PO (Mental Status?) |  |

NO

YES

**Active Seizure**

NO YES

|  |
| --- |
| **Cooling Measures** |
|  |  |

**Contact ALS Backup**

|  |
| --- |
| **Focused History / Physical Exam** |
| Evidence of shock or trauma ? |
| **Appropriate Guideline** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

# SPECIAL CONSIDERATIONS:

1. If an actively seizing patient is encountered, move hazardous materials away from the patient. Protect the patient’s head from injury. Remember to always immediately check for pulses after seizure activity stops.
	1. Trauma to the tongue during seizure activity is unlikely to cause serious problems. Attempts to force anything into the patient’s airway may cause complete obstruction.
2. Seizure Types
	1. **Status epilepticus** is defined as two or more successive seizures without a period of consciousness or recovery. This is a true emergency requiring rapid airway control, treatment, and transport.
	2. **Grand Mal seizures (generalized)** are associated with loss of consciousness, incontinence, and tongue trauma.
	3. **Focal seizures (petit mal)** effect only a part of the body and are not usually associated with a loss of consciousness.
	4. **Jacksonian seizures** are seizures that start as a focal seizure and become generalized.
3. Assess possibility of occult trauma and substance abuse. If evidence or suspicion of trauma, full c-spine immobilization is required.
4. Be prepared for airway problems with continued seizures. The **Airway Guideline** should be considered for all patients unable to protect their own airway (i.e., semi-conscious, unconscious).

# TAB 3 GUIDELINE 19 STROKE [SUSPECTED OR KNOWN]

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Previous CVA, TIA's
* Previous cardiac / vascular surgery
* Cardiac history, Atrial fibrillation, CAD, seizure, diabetes, HTN
* Medications (blood thinners)
* History of trauma
* Occult blood loss (GI, ectopic)
* Females: LMP, vaginal bleeding
* Fluid loss: nausea, vomiting, diarrhea
* Medications
 | **SIGNS / SYMPTOMS*** Altered mental status
* Weakness / Paralysis
* Blindness or other sensory loss
* Aphasia / Dysarthria
* Syncope / Loss of consciousness with recovery
* Vertigo / Dizziness
* Vomiting
* Headache / Seizures
* Respiratory pattern change
* Hypertension / hypotension
* Palpitations, slow or rapid pulse
 | **DIFFERENTIAL*** See Altered Mental Status
* TIA (Transient Ischemic Attack)
* Seizure
* Hypoglycemia
* Stroke
	+ Thrombotic, Embolic (85%)
	+ Hemorrhagic (15%)
* Tumor
* Trauma
* Orthostatic hypotension
* Cardiac syncope
* Hypoglycemia
 |

**Glucose < 60**

**Airway Management**

**Consider Spinal Immobilization**

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
| **Patient with weakness, numbness, slurring of speech, difficulty walking** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
|  | **Cardiac Monitor / 12-Lead ECG** |  |
| **Perform procedure if able to transmit, do not delay care to obtain EKG** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose** – grams PO (Mental Status?) |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

|  |  |  |
| --- | --- | --- |
|  | **Check Blood Glucose** |  |
|  |  |

|  |  |
| --- | --- |
|  |  |
| **Onset Symptoms > 12 hours*** Treat SBP > 200 mmHg or DBP > 110 mmHg
 |

|  |
| --- |
| **Cincinnati Prehospital Stroke Screen** |
| **Face . Arms . Speech . Time** |
|  |  |

YES

* **Patient is DNR / comfort Care**
* **Symptoms started > 12 hours ago**
* **Abnormal blood sugar or Drug Overdose**

|  |  |
| --- | --- |
|  |  |
| **Consider other guidelines :*** **Altered Mental Status**
* **Dysrhythmia**
* **Hypertension**
* **Hypotension**
* **Overdose**
* **Seizure / Post-Ictyl Paralysis**
 |

NO

* **RACE Score > 5 -or-**
* **Patient is obtunded, RACE score cannot be completed**

|  |
| --- |
| **If positive and symptoms < 12 hours Limit scene time to 10 minutes** |
| * **Keep head elevated 30 Degrees**
* **NPO**
 |
|  |  |

|  |
| --- |
| **If positive and symptoms < 12 hours Limit scene time to 10 minutes** |
| * **Keep head elevated 30 Degrees**
* **NPO**
 |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to Stroke Intervention Center** |

NO YES

# SPECIAL CONSIDERATIONS:

1. The most common causes of stroke are:
	1. **Cerebral thrombosis** (a blood clot obstructing the artery).
	2. **Cerebral embolus** (a mass or air bubble obstructing the artery).
	3. **Cerebral hemorrhage** (ruptured artery / ruptured aneurysm).
2. To facilitate accuracy in diagnosing stroke and to expedite transport, an easy-to-use neurological examination tool is recommended. Utilize the **Cincinnati Prehospital Stroke Screen (CPSS)** for evaluation of acute, non-comatose, non-traumatic neurovascular complaints. The CPSS evaluates using **F.A.S.T.T.** criteria (**F**acial palsy, **A**rm weakness, **S**peech abnormalities, **T**ime of onset/**T**ransport). **If any one of the three components of the CPSS is abnormal, the probability of stroke is 72%.**
	1. Onset of stroke symptoms is defined as the last witnessed time the patient was symptom- free (i.e., awakening with stroke symptoms would be defined as an onset time of the previous evening when the patient was symptom-free).
3. Not all neurologic deficits are caused by a stroke. Look for other treatable medical conditions such as:

|  |  |  |
| --- | --- | --- |
| * Hypoglycemia
 | * Hypothermia
 | * Hypotension
 |
| * Hypoxia
 | * Hyperthermia
 |  |

1. Potential concerns:
	1. A patient with a stroke can present with aphasia and still is completely alert. Talk to the patient, explain everything that you are doing and avoid comments that you would not want to hear yourself. This patient needs a tremendous amount of reassurance.
	2. Be alert for airway problems (difficulty swallowing, vomiting).
	3. Spinal immobilization should be provided if the patient sustained a fall or other trauma.
	4. Bradycardia may be present in a suspected stroke patient due to increased ICP.
2. Definitions
	1. Aphasia – inability to speak
	2. Agnosia – inability to process sensory information. Often loss of ability to recognize objects, persons, sounds, shapes or smells.
	3. Asomatognosia – deficit in body awareness. Can take the form of forgetting, ignoring, denying, disowning or misperceiving their own body (entirely or partially).
	4. Anosognosia – inability to gain feedback about one’s own condition.

|  |
| --- |
| **Cincinnati Prehospital Stroke Scale (CPSS)** |
| **Sign/Symptom** | **How Tested** | **Normal** | **Abnormal** |
| * **F**acial Droop
 | **Have the patient show their teeth or smile** | **Both sides of the face move equally** | **One side of the face does not move as well as the other** |
| * **A**rm Drift
 | **The patient closes their eyes and extends both arms straight out for 10 seconds** | **Both arms move the same, or both do not move at all** | **One arm either does not move, or one arm drifts downward compared to the other** |
| * **S**peech
 | **The patient repeats “The sky is blue in Cincinnati”** | **The patient says correct words with no slurring of words** | **The patient slurs words, says the wrong words, or is unable to speak** |
| * **T**ime of onset
 | **Observed by a valid historian (symptoms < 3 hours – Limit scene time to 15 minutes)** |
| * **T**ransport
 | **The patient is considered a possible CVA patient if any of the tested signs or symptoms is abnormal.** |

|  |
| --- |
| **Rapid Arterial Occlusion Evaluation Scale (RACE SCORE)** |
|  |  | Absent | Symmetrical movement | 0 |
| **Facial palsy** | Ask the patient to show teeth | Mild | Slightly asymmetrical | 1 |
|  |  | Moderate to severe | Completely asymmetrical | 2 |
| **Arm motor function** | Extending the arm of the patient 90 degrees (if sitting) or 45 degrees (ifsupine) | Normal to mild ModerateSevere | Limb upheld more than 10 seconds Limb upheld less than 10 secondsPatient do not raise the arm against gravity | 012 |
| **Leg motor function** | Extending the leg of the patient 30 degrees (in supine) | Normal to mild ModerateSevere | Limb upheld more than 5 seconds Limb upheld less than 5 secondsPatient do not raise the leg against gravity | 012 |
| **Head and gaze deviation** | Observe eyes and cephalic deviation to one side | Absent Present | Eye movements to both sides were possible and no cephalic deviation was observedEyes and cephalic deviation to one sidewas observed | 01 |
| **If right** | Ask the patient two verbal orders | Normal | Performs both tasks correctly | 0 |
| **hemiparesis****(Aphasia)** | * Close your eyes
* Make a fist
 | ModerateSevere | Performs one task correctlyPerforms neither task | 12 |
|  | Ask: | Normal Moderate Severe | No asomatognosia or anosognosia Asomatognosia or anosognosia Both of them present | 012 |
| **If left** | **Asomatognosia** |
| **hemiparesis** | Whose arm is this? (while showing |
| **(Agnosia)** | him/her the paretic arm) |
|  | **Anosognosia** |
|  | How well can you move this arm? |
| **Score Total (0 – 9)** |  |

# TAB 3 GUIDELINE 20 SUSPECTED ABUSE | NEGLECT

**To Be Transported to Trauma Center**

|  |
| --- |
| **Universal Patient Care** |
| **Ensure scene safety and offender is not near the victim** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Consider Spinal Immobilization** |
|  | **Airway Management** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Events leading up to call
* Has individual gone to the bathroom, showered
* History of trauma
 | **SIGNS / SYMPTOMS*** Bruising to extremities
* Vaginal injury
* Withdrawal from caregiver / EMS provder
 | **DIFFERENTIAL*** Sexual abuse
* Neglect
* Traumatic injuries
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Provide appropriate emergency medical treatment for all injuries found** |  |  |
|  | **Be calm and assuring with sensitivity toward the patient** |  |
|  | **DO NOT make unnecessary physical contact with the patient** |  |
|  |  |
|  |

**Assess for signs of neglect**

**Assess for physical abuse**

**Assess for psychological characteristics of abuse**

**Make Patient NPO**

**Concern to Physical Abuse**

**Don t allow patient to change clothes or wash**

**Discourage patient going to bathroom**

**Make Patient NPO**

**Concern to Sexual Abuse**

|  |  |  |
| --- | --- | --- |
|  | **Document careful physical exam and any comments made by victim, family, bystanders** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility, severely injured patients should be transported to trauma center** |
| **Report suspected case of elder abuse, neglect or exploitation to adult protective services (855-644-6277)** |

**Stabbing Choking Electrocution Burn**

# SPECIAL CONSIDERATIONS:

1. Reporting concern of abuse, neglect or exploitation
	1. Per Ohio Revised Codes (ORC) 2151.421 and 5101.61 EMS and Fire personnel are **REQUIRED** to report abuse, neglect or exploitation of adult (elderly) or child (under the age of 18)
	2. Report suspected child abuse, neglect or exploitation to Ohio’s Public Children Service Agencies for your respective county or free hotline at 855-642-4453
	3. Report suspected elderly abuse, neglect or exploitation to Ohio’s Adult Protective Services for your respective county or free hotline at 855-644-6277
2. If possible, have a witness the same gender as the victim present at all times
3. Wrap a plastic sheet around the victim if possible
4. DO NOT inspect genitals unless evidence of uncontrolled hemorrhage, trauma, or severe pain is present
5. DO NOT allow patient to shower or douche
6. Collect patient’s clothing when possible
	1. Place clothing in plastic sheet or separate plastic/paper bags with ID labels and found location
	2. Leave all sheets placed in plastic/paper bag with patient at facility
	3. Notify all staff of clothing samples

# TAB 3 GUIDELINE 21 SYNCOPE

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Previous CVA, TIA's
* Previous cardiac / vascular surgery
* Cardiac history, Atrial fibrillation, CAD, seizure, diabetes, HTN
* Medications (blood thinners)
* History of trauma
* Occult blood loss (GI, ectopic)
* Females: LMP, vaginal bleeding
* Fluid loss: nausea, vomiting, diarrhea
* Medications
 | **SIGNS / SYMPTOMS*** Altered mental status
* Weakness / Paralysis
* Blindness or other sensory loss
* Aphasia / Dysarthria
* Syncope / Loss of consciousness with recovery
* Vertigo / Dizziness
* Vomiting
* Headache
* Seizures
* Respiratory pattern change
* Hypertension / hypotension
* Palpitations, slow or rapid pulse
 | **DIFFERENTIAL*** See Altered Mental Status
* TIA (Transient Ischemic Attack)
* Seizure
* Hypoglycemia
* Stroke
	+ Thrombotic, Embolic (85%)
	+ Hemorrhagic (15%)
* Tumor
* Trauma
* Orthostatic hypotension
* Cardiac syncope
* Hypoglycemia
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

**YES**

**Patient with weakness, numbness, slurring of speech, difficulty walking**

**Stroke Guideline**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**NO**

|  |
| --- |
| **Consider Spinal Immobilization** |
|  |  |

**Glucose < 60**

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose** – grams PO (Mental Status?) |  |

|  |  |  |
| --- | --- | --- |
|  | **Check Blood Glucose** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Cardiac Monitor / 12-Lead ECG** |  |
| **Perform procedure if able to transmit, do not delay care to obtain EKG** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

# SPECIAL CONSIDERATIONS:

1. Syncope is defined as a transient state of unconsciousness from which the patient has recovered. If patients present with altered mentation, treat per the **Altered Mental Status Guideline.**
2. Most syncope is vasovagal in nature and characterized by dizziness progressing to fainting/unconsciousness which may last for several minutes. For many patients, recumbent positioning may be sufficient to restore vital signs and level of consciousness to within normal values. Syncope which occurs without warning is potentially serious and often caused by cardiac arrhythmia.
3. Assess for signs and symptoms of trauma if associated or questionable fall with syncope.

# Patients over the age of 40 with syncope even though apparently normal, should be transported.

* 1. In middle aged or elderly patients, syncope can be due to a number of potentially serious conditions. The most important things to recognize are:
		1. Arrhythmias.
		2. Occult GI bleeding.
		3. Seizures.
		4. Ruptured abdominal aortic aneurysm.
		5. Cerebral hemorrhage.

# TAB 3 GUIDELINE 22 VOMITING AND DIARRHEA

**Glucose < 60**

**Check Blood Glucose**

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
| **Make NPO** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose** – grams PO (Mental Status?) |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Age
* Time of last meal
* Last bowel movement/emesis
* Improvement or worsening with food or activity
* Duration of problem
* Other sick contacts
* Past medical history
* Medications
* Menstrual history (pregnancy)
* Travel history
* Bloody emesis / diarrhea
 | **SIGNS / SYMPTOMS*** Pain
* Character of pain
* Distention
* Diarrhea / Constipation
* Anorexia
* Radiation
* Fever, headache, blurred vision, weakness, malaise, cough, headache, dysuria, mental status changes, rash
 | **DIFFERENTIAL*** CNS / Psychological
* Myocardial infarction
* Drugs (NSAID's, antibiotics, narcotics, chemotherapy)
* GI or renal disorders
* Diabetic ketoacidosis
* Gynecologic disease
* Infections (pneumonia, influenza)
* Electrolyte abnormalities
* Food or toxin induced
* Medication or substance abuse
* Pregnancy
 |

**Place Supine Position Contact ALS Backup**

-Consider- **ResQGARD**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

**SPECIAL CONSIDERATIONS:**

1. Vomiting and diarrhea may be symptoms of more serious problems, but all represent some degree of hypovolemia. The most serious causes are GI bleed or other intra-abdominal catastrophe.
2. Check at the house for evidence of overdose; patient who doesn’t call the squad for medication ingestions may call later when GI symptoms become severe.
3. Blood in the GI tract is an irritant: it causes vomiting and diarrhea. Only if upper tract bleeding is extremely brisk will the blood reach the rectum undigested.
4. GI bleeders may be very sick and hypovolemic without showing an obvious source of their problem. A rapid transport guideline is necessary for potential improved patient outcome.

# TAB 3 GUIDELINE 23 WELL PERSON CHECK

|  |  |  |
| --- | --- | --- |
| **HISTORY** | **SIGNS / SYMPTOMS** | **DIFFERENTIAL** |
| * Patient presents requesting “blood pressure check”
* EMS responds to “assist invalid”
* Someone else called 911; patient did not

request* Other situation in which patient does not

have a medical complaint or obvious | * Assess for medical complaint
* For patients with hypertension, particularly check for chest pain, shortness of breath, and/or neurologic changes
* For assist invalid calls, particularly check

for syncope, trauma from fall, or inabilityto ambulate | * Hypertensive urgency
* Hypertensive emergency
* Syncope
* Cardiac ischemia
* Cardiac dysrhythmia
* Fracture
* Head trauma
 |
| injury |  |  |

**Universal Patient Care**

**YES**

**Patient has medical complaint**

**or obvious trauma**

**Go to appropriate guideline and**

**recommend transport**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**NO**

**Obtain Vital Signs:**

**HR, RR, BP, Sp02, Blood Glucose**

**YES**

* **Pulse > 110 or < 60**
* **SBP > 180 or < 90, DBP > 110**
* **RR > 24 or < 8**
* **Pulse ox < 92%**
* **Blood Glucose < 60 or > 250?**
* **Recommend transport for evaluation.**
* **Have patient sign refusal if transport**

**declined.**

**NO**

* **Re-Confirm patient has no medical complaint.**
* **Provide patient with vital sign results**

**and have them contact their doctor to**

**report results.**

* **Advise patient to call 9-1-1 if they**

**develop any symptoms.**

* **Complete PCR and document elements of this GUIDELINE.**

# SPECIAL CONSIDERATIONS:

1. Patients who are denying more severe symptoms may initially present for a “routine check”. Please confirm with the patient at least twice that they have no medical complaints.
2. All persons who request service are considered patients and shall have a PCR completed.
3. For patient in this category, the PCR may be brief but must include vital signs and documentation of the lack of a medical complaint. Additionally, patients with a potential mechanism for trauma should have a trauma exam completed.
4. Should a patient refuse evaluation and/or decline further evaluation once have started, document as much as you can.
5. Even patients who refuse vital signs can be observed and respirations measured. The PCR narrative is IMPORTANT in these and all cases, and must accurately and thoroughly describe the patient encounter