VT EMS

DISTRICT 6

AMBULANCE BOARD

POLICY PROTOCOLS & GUIDELINES

PROTOCOLS found within are to be strictly adhered to and are specific to District 6. District 6 has approved and all services must abide by statewide EMS protocols. Note that District 6 protocols are supplementary to Vermont EMS protocols.

GUIDELINES are procedures EMT's should follow in District 6. They are often found and repeated in Vermont EMS protocols. Guidelines are useful for education, training, and referral purposes.

VERMONT EMS
DISTRICT 6
POLICY GUIDELINE

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VERMONT EMS
DISTRICT 6
POLICY GUIDELINE

EFFECTIVE DATE: ______________________________

MEDICAL DIRECTOR: ______________________________

DISTRICT 6 CHAIR: ______________________________

POLICY / PROTOCOL:
Pre-hospital use of Naloxone (Narcan)

PURPOSE:

1. To reverse the effect of opioids (including respiratory depression, sedation, & hypotension) of known or suspected narcotics overdose.

2. Treatment of patients unconscious for unknown reason after administration of D50 has not changed patient condition.

POLICY / PROTOCOL:

1. Provide all and necessary basic life support as indicated.

2. Establish IV line per District 6 IV protocol.

3. If patient is an adult, on line Medical Control orders are not required. Contact Medical Control for minors before administration.

4. Give two (2) mg (one ampul) IV push.

5. Observe two to three (2 – 3) minutes. Repeat if no clinical improvement.

6. If no improvement, and you have not previously administered D50, do so now.

7. If IV cannot be started, with Medical Control on line permission, Naloxone may be given subcutaneously.

8. *Caution:* Administration of Naloxone to patients physically addicted to opiods may precipitate abrupt withdrawal syndrome with nausea, vomiting, diaphoresis, tachycardia, tremulousness, and excitement. This may lead

to behavioral emergencies requiring restraing and psychological care. Before administering Naloxone to patients with signs of chronic IV injections, contact Medical Control if possible to discuss alternative doses.

9. The immediate and proper disposal of needles and contaminated materials into bio-hazard containers must always be carried out.

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EFFECTIVE DATE: ______________________________

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POLICY / PROTOCOL:
Pre-hospital IV Therapy

PURPOSE:

1. To establish an intravenous route for administration of drugs and / or expand intervascular volume of fluid for the prevention and treatment of shock.

POLICY / PROTOCOL:

1. The determination of establishing a running IV or a saline lock will be based on the determination of the EMT-Intermediate and is a standing order in the following situations:

   a. Saline Lock Initiation: A saline lock may be started in the following patients –

      i. Altered mental status (other than suspected hypovolemia.
      ii. Arrhythmia.
      iii. Bites, stings, or envenomation (in the absence of anaphylaxis).
      iv. Chest pain.
      v. Dyspnea.
      vi. Headache.
      vii. Head injury.
      viii. Hypertension.
      ix. Nose bleeding (if bleeding is uncontrolled).
      x. Seizures.

   b. Running IV: All running IV's within District 6 will be of Normal Saline or Lactated Ringers solution. A running IV line is recommended in the following situations –

i. Abdominal pain.
ii. Amputations.
iii. Anaphylaxis.
iv. Burns.
v. Cardiac arrest.
vi. Cold emergencies with Altered Mental Status.
vii. Diabetic emergencies.
viii. Heat exposure.
ix. Hypotension.
x. Multi-system trauma.
xi. Nausea / vomiting.
xii. Pregnancy related emergencies.
xiii. Skeletal injuries of pelvis, femur, or compound fracture.
xiv. Spinal injuries with neurological deficit.
xv. Weakness / malaise.

A running IV or saline lock may be ordered in additional setting by on line Medical Control.

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POLICY / PROTOCOL:
Esophageal obturator airway (EOA)

PURPOSE:

1. To prevent regurgitation in patients suffering cardiac arrest.

POLICY / PROTOCOL:

1. Use in adults who are in cardiac arrest (apneic, pulseless, unresponsive) after defibrillation has been performed or determined inappropriate.

2. Contraindications; do not use on:
   a. Patients under sixteen (16) years of age.
   b. Patients under five (5) feet tall, or over seven (7) feet tall.
   c. Patients with known esophageal disease.
   d. Patients known to have ingested caustics (acid, alkali).
   e. Patients with facial trauma with bleeding in and around the upper airway.

3. Insertion:
   a. Ventilate patient with 100% oxygen.
   b. Insertion should take five (5) seconds, maximum fifteen (15) seconds.
   c. Assure proper placement with auscultation of bilateral breath sounds and no stomach sounds by stethoscope, then inflate cuff.
   d. If after two (2) attempts (separated by CPR and 100% oxygen), the esophagus has not been intubated, further attempts should not be made and the airway should be maintained with an oropharyngeal airway.
   e. If there is any question whether the EOA is in the esophagus, it should be removed.

4. Removal:
    a. Remove the EOA if the patient becomes responsive or placement is in question.
    b. Have suction available.
    c. Turn patient on his or her side.
    d. Deflate the cuff.
    e. Remove airway.

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POLICY / PROTOCOL:
Pre-hospital use of 50% Dextrose (D50)

PURPOSE:
1. To treat diabetic patients with suspected hypoglycemia.

2. To treat patients who are unconscious for unknown reasons.

POLICY / PROTOCOL:
1. Provide all and necessary basic life support as indicated.

2. Establish IV line (per District 6 protocol) with a sixteen (16) or eighteen (18) gauge needle.

3. Contact Medical Control
   a. Give history, patient assessment, and request orders to administer 50% Dextrose.
   b. *IF* you are unable to contact Medical Control by radio or telephone and your patient is diabetic and / or unconscious for an unknown reason, give 50% Dextrose without delay and contact Medical Control as soon as possible).

4. Stick needle of D50 syringe into IV tubing rubber sideport <u>nearest</u> the patient after wiping sideport with alcohol.

5. Shut IV tubing off (clamping or bend it) distal to sideport where D50 will be injected. Inject D50 as fast as possible. Observe IV site while injecting. If there is rapid swelling at puncture site, the D50 is infiltrating and injection must stop. Remove IV catheter and attempt procedure at a new site proximal to infiltrated site.

6. Upon successful injection of D50, remove needle from sideport and reopen line at KVO rate. *NOTE: Known diabetics with prior episodes of hypoglycemia may require two (2) amps of D50. Advise Medical Control, if possible.*

7. If unconscious for unknown reason patient remains unconscious, administer Naolxone.

8. The immediate and proper disposal of needles and contaminated materials into bio-hazard containers must always be carried out.

9. Advise Medical Control of patient status.

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POLICY / PROTOCOL:
Manual and semi-automatic defibrillator monitor

PURPOSE:

1. Defibrillation for conversion of ventricular fibrillation.

2. To monitor cardiac rhythms.

POLICY / PROTOCOL:

1. See following flow sheet for defibrillation of patients in cardiac arrest.

2. Services with monitoring ability should do so on any potential cardiac patient and report any significant findings.

Octopus chart to be inserted

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POLICY / PROTOCOL:
Virginia Caffin, EMS District 6 EMT of the Year

PURPOSE:

1. To honor the memory and dedication of Virginia Caffin; one of the founders of modern EMS in Vermont, starting Cabot Ambulance Service with her husband in 1966, and serving this district as EMS coordinator, trainer, and Board member from its inception in 1972 until her death on March 29, 1999.

2. To identify and award a District 6 EMT who has made exemplary contributions to professional, quality Emergency Medical Services at his or her squad and / or district level.

POLICY / PROTOCOL:

1. In January of each year, the Chair of District 6 shall see that letters are sent to all services in the District and the ED of CVMC, seeking nominations for the V. Caffin EMT of the Year. Nomination deadline will be March 1.

2. A committee of the District 6 Board, consisting of three members and the Medical Director, will meet to review the applications and decide upon the recipient of the award. Keeping the decision confidential, the committee will make all arrangements for the award.

3. The Award will be presented to the honoree in May, as part of EMS Week. A news brief and photo shall be made and submitted to area newspapers.

4. The honoree shall have his or her name, squad affiliation, and year engraved on the yearly plaque displayed in a prominent location in the ED of CVMC, a personal plaque engraved, and be awarded a gift certificate

for two (acknowledging the role of significant others in his or her accomplishments) to a local restaurant.

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POLICY / PROTOCOL:
Aeromedical on-scene transport

PURPOSE:

1. To assure appropriate utilization of aeromedical transport in the pre-hospital setting. The decision to use aeromedical transport involves complex medical, logistical, and timing considerations in which the speed of initiating and planning the call for aeromedical transport is important for the effective use of this service.

POLICY / PROTOCOL:

1. Ambulance services shall certify with aeromedical service(s) regarding their protocols, policies, and standard operating procedures.

2. In accordance with their ambulance service procedures, on-scene EMTs will determine the appropriateness of aeromedical transport and immediately contact the aeromedical transport service to determine if service can be promptly initiated.

3. On-scene EMTs will then immediately contact Medical Control and advise them of the initiation of aeromedical transport and provide a 'snapshot' description of the scene and injuries requiring use of aeromedical transport.

4. If Medical Control makes initial contact with an aeromedical transport service, all subsequent contact will be made by on-scene EMTs or Landing Zone Coordinator.

5. For purposes of quality control, services using aeromedical transport shall submit the yellow copy of their run report and a supplemental written

review of the incident to Medical Control (or designee) within one (1) week.

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POLICY / PROTOCOL:
Pre-hospital use of Epinephrine (Adrenaline) for anaphylaxis

PURPOSE:
1. To reverse signs and symptoms of anaphylaxis through the use of Epinephrine (Adrenaline). These signs include generalized hives, tightness in the throat, difficulty breathing, and shock.

POLICY / PROTOCOL:
1. Equipment: Epinephrine 1:1,000 can be carried in pre-loaded syringes, multi-dose vials, auto-injector, or ampules in District 6. Dependent on how the Adrenaline is carried, additional equipment may include a syringe, alcohol pads, and BSI equipment.

2. Dosage:
    a. Adults and children over the age of twelve (12) years – administer 0.3 cc (0.3 mg) subcutaneously.
    b. Children under the age of twelve (12) years – administer 0.15 cc (0.15 mg) subcutaneously.

3. EMT–Intermediate Administration: On line Medical Control order must be obtained prior to administration of Adrenaline to adult or pediatric patients. If Medical Control cannot be contacted due to mechanical failure and severe reaction is evident, administer appropriate dosage without delay and contact Medical Control as soon as possible.

4. EMT–Basic Administration: On line Medical Control order. If Adrenaline is issued by the provider's agency in an autoinjector devise, an EMT–Basic can administer Adrenaline in either of the following two situations –

a. Situation One: The patient has their prescribed Epi auto-injector device and is in date. The EMT–Basic can assist in administration with an on line Medical Control order.
b. Situation Two: The EMT–Basic can visually verify the patient's prescription for Adrenaline (Epinephrine) **AND** the patient has already administered their Adrenaline (epinephrine) *or* the patient's dose has expired.

5. Infection Control: The wearing of exam gloves is required during administration of injectable medications. Immediate disposal of all sharps (needles) into an approved sharp container is required.

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POLICY / PROTOCOL:
Back-up policy

PURPOSE:

1. To identify service to a community when that area's ambulance is not available for immediate response.

POLICY / PROTOCOL:

1. Back-up arrangement for all ambulance services in District 6 should be made with the closes service that is able to provide back-up without diminishing that service's emergency response capabilities.

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POLICY / PROTOCOL:
Dispatch of ambulances

PURPOSE:

1. To assure ambulance response is initiated immediately. **"IF EVER IN DOUBT, SEND THEM OUT"**

POLICY / PROTOCOL:

1. District 6 requests that all dispatch centers in our District alert an appropriate EMS agency to the following types of calls:
    a. Known medical.
    b. Unknown medical.
    c. Potential medical.
    d. Suspected injury.
    e. Anytime ambulance or EMS assistance is requested.

2. Please ask, **"DO YOU NEED AN AMBULANCE?"**

3. An attempt should be made after initial dispatch to gather as much information as possible on all unknowns and forward this information on to the appropriate responders.

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POLICY / PROTOCOL:
Emergency Care Transports

PURPOSE:

1. To transport patients requiring emergency medical treatment.

POLICY / PROTOCOL:

1. All patients requiring emergency medical care who are transported by District 6 ambulances shall be transported to Central Vermont Medical Center (CVMC) unless, in the opinion of Medical Control, the patient's medical needs indicate transportation to a tertiary care center directly from the scene. In the event that CVMC cannot provide definitive care, patients shall be stabilized at CVMC and transferred to an appropriate medical facility by an ambulance service able to provide out-of-district transport.

2. District 6 ambulances may require permission, or Medical Control may direct, that patients requiring emergency care be transported directly to an out-of-district hospital if transport time to such a facility is not significantly longer than transport time would be to CVMC. All requests for out-of-district transport initiated by an ambulance service shall be approved by Medical Control.

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POLICY / PROTOCOL:
Glucometer / Chemstrip use

PURPOSE:
1. To determine blood sugar level of patients.

POLICY / PROTOCOL:
1. District 6 approves the use of glucometers and chemstrips for pre-hospital use by EMTs to determine, within the known limits of these instruments, the blood sugar level of a patient.

2. Use is indicated for patients known to be diabetic, exhibiting signs of hypoglycemia or keto-acidosis.

3. Within Medical Control approval or direction, patients with no history of diabetes exhibiting non-specific signs of generalized weakness may be tested.

4. In no case shall definitive treatment be based solely on the numbers obtained.

5. EMTs shall be trained with the specific instrument carried by the service and re-train a minimum of once a year.

6. Glucometers shall be maintained and tested in recommendation of the manufacturer and documentation shall remain on record with the service.

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POLICY / PROTOCOL:
Pneumatic anti-shock garmet (PASG)

PURPOSE:
1. To treat shock or impending shock.

2. To control external and / or suspected internal bleeding.

3. To stabilize suspected pelvis and / or lower extremity fractures.

POLICY / PROTOCOL:
1. PASG should be applied (not inflated) in any situation that the EMT feels shock may be present or imminent.

2. With on line Medical Control permission, PASG may be inflated in patients exhibiting signs of shock and when systolic blood pressure is less than 90. (In the case of advanced pregnancy, impaled foreign object, or evisceration, only the leg segments will be inflated.) Leg segments are always inflated *before* the abdomen.

3. Contraindications of PASG use are pulmonary edema and cardiac arrest resulting from MI. Other conditions that must have on line Medical Control contact include hypothermia, advanced pregnancy, evisceration, impaled object, and head injury.

4. If the patient complains of tenderness in the pelvis or has multiple lower extremity fractures, EMTs should place PASG on the patient and inflate to splinting pressure. Splinting pressure is defined as the amount of air that can be inflated by mouth. This allows support for pelvis without restricting blood circulation. This does not replace traction splinting in cases of

known or suspected femur fracture. PASG should be used under a traction splint when necessary.

5. PASG should not be deflated in pre-hospital setting.

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POLICY / PROTOCOL:
Non-emergency transports

PURPOSE:

1. Statement of condition for non-emergency transports.

POLICY / PROTOCOL:

1. It is the policy of the District 6 EMS Board that no ambulance service will perform non-emergency transfers unless they do so without diminishing emergency response capability and without increasing emergency response time or time of transport to a care facility.

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POLICY / PROTOCOL:
Non-transport of patients

PURPOSE:

1. To establish a consistent procedure for patients not needing, or refusing, ambulance transport to the hospital.

POLICY / PROTOCOL:

1. Assess patient's condition.

2. Take at least one complete set of vitals.

3. Get on line permission from Medical Control not to transport.

4. Advise the patient to recall the ambulance or follow up with ED of CVMC or their local medical doctor, if they feel they require further evaluation.

5. Document all of the above on a run report and obtain signature of patient and witness (if available).

6. Within seven (7) days, send run report to CVMC.

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POLICY / PROTOCOL:
Pre-hospital use of pulse-oximeters

PURPOSE:

1. To help evaluate the status of patient's oxygenation in the pre-hospital setting.

POLICY / PROTOCOL:

1. Equipment: Ohmeda 7300 Biox Oximeter (or comparable machine), probes should be available for adult fingers, adult ears, and pediatric fingers.

2. Indications: Any patient who, by history or physical exam, may be at risk for hypo-ventilation.

3. Follow the instructions for the use you use. Be aware of the limitations of pulse-oximeters in general, and in the particular unit you use.

4. Oxygen therapy should *not* be determined by the oxygen level indicated by the pulse-oximeter. Many conditions make the pulse-oximeter inaccurate. (The pulse-oximeter should be used as an adjunct in evaluating patients and should never replace careful patient assessment in determining a patient's need for oxygen therapy.)

5. Education: Squads using a pulse-oximeter must provide education in the proper use of this equipment to all personnel who will use it.

6. Calibration: The equipment should be calibrated per manufacturer's instructions, or more frequently at the discretion of the Medical Director of District 6.

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POLICY / PROTOCOL:
Radio Communications with Central Vermont Medical Center – Medical Control (CVMC-MC)

PURPOSE:

1. To inform hospital of calls and location of District 6 ambulances.

POLICY / PROTOCOL:

1. Within District call:
    a. "Out of quarters en route to __________."
    b. "On scene __________."
    c. On scene report, "Patient's chief complaint and condition __________."
    d. E.T.A.
    e. Update on patient's condition as new information is available, or if significant changes are noted.
    f. Arrival at CVMC.
    g. Document all of the above on run report.

2. Out-of-District call:
    a. "Out of quarters en route to __________."
    b. "On scene __________."
    c. On scene report, "Patient's chief complaint and condition __________."
    d. "Request to transfer out of District __________."
    e. Notify Medical Control when back in District.
    f. Document all of the above on run report.

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POLICY / PROTOCOL:
Non-emergency Transports

PURPOSE:
1. Statement of condition for non-emergency transports.

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1. It is the policy of the District 6 that no ambulance service will perform non-emergency transfers unless they do so without diminishing emergency response capability and without increasing emergency response time or time of transport to a care facility.

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POLICY / PROTOCOL:
Combitube exchange.

PURPOSE:
1. Unspecified.

POLICY / PROTOCOL:
1. If a Combitube is utilized on a patient, CVMC will supply a replacement to the squad at no cost. This is for successful, as well as unsuccessful, placements.

2. When you arrive at CVMC, ask the secretary or charge nurse for the key to the video cabinet in the EMT room.

3. Replacement Combitubes will be kept in this cabinet. Also in the cabinet, there will be the *required* QA form for the EMT-I to complete.

4. Complete the QA form and take one (1) Combitube. Lock the cabinet and give the QA form to the receiving physician to complete.

5. If there are only two (2) Combitubes left in the cabinet after you remove yours, inform the charge nurse that the supply is low immediately.

6. If Combitubes turn up missing without documentation, then this system will immediately be replaced by a more rigid program. This is set up on the honor system and has only one chance to succeed.

7. Please contact Scott Supernaw, EMS Liason, CVMC, with any questions or problems with the system. 371-4516.

Suggestions, merely suggestions, no offense to anyone who wrote or will edit these!

-
- Be careful of “you” and “EMT”. Most have “EMT” or a generic term.
- Have capitalized all references to “Medical Control”
- Have created consistencies between “CVMC” and “CVH”
- Have created consistencies between “District 6”, “District #6”, “District 6 EMS”, and “District 6 EMS Board”. All read “District 6”
- You need to create consistencies between “EMT – I” and “EMT-Intermediate”. I did not.
- Sam made most (all but one, I think) Purpose statements in to “TO” statements
- Pick either 50% Dextrose or D50, don’t switch back and forth, especially in the same protocol! It is acceptable grammatically to say “50% Dextrose (D50)” and use “D50” for the rest of the protocol. OR add a definitions page “D50 = 50% Dextrose”, CVMC = Central Vermont Medical Center, etc. You get the idea.
- Think chronological sequence of events. Don’t say do blah, blah, blah, AFTER you do yada yada yada. You should say do yada yada yada, then do blah blah blah.
- Also, Contents lists things in alphabetical order, but they aren’t in alpha order. If you want them in alpha order, then we can cut and paste in alpha order.
- ALSO, I took out numbering systems. Some had numbers, some didn’t.