

Statewide Standard Treatment Protocols

***Paramedic Standing
Orders, Guidelines, and
Policies Mid-Cycle Update
October 2013***

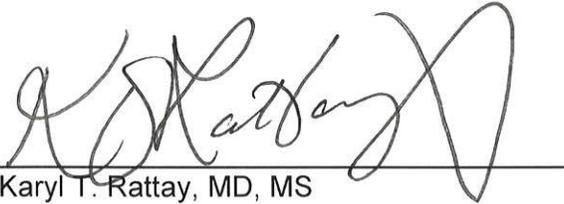


Effective: October 16, 2013

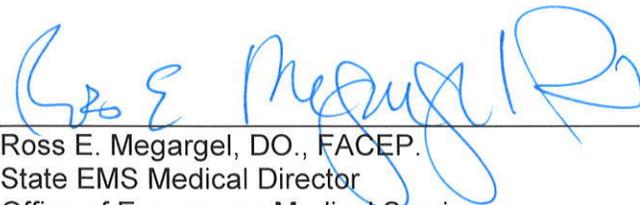
Approved by the EMS Medical Directors: July 2013
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State of Delaware
Department of Health and Social Services
Division of Public Health
Office of Emergency Medical Services

Statewide Standard Treatment Protocols,
Guidelines, Policies,
and
Paramedic Standing Orders



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PARAMEDIC RADIO/TELEPHONE REPORTS GUIDELINES

The paramedic report to medical control should be brief and concise. The goal is to provide enough vital information to medical control so that they may provide informed direction for the patient's continued care and plan for the patient's disposition. Reports generally should not exceed thirty (30) seconds in duration in order to provide economical use of time by the paramedic, the medical control physician, and nursing personnel. The paramedic is to first attempt to contact the Delaware Medical Control facility of intended patient disposition. If a paramedic does not obtain a timely response, they may contact a second Delaware Medical Control facility for orders or consultation. If an out of state hospital is the intended destination, the EMS provider should contact the closest Delaware Medical Control facility.

For ALS Priority I patients or patients requiring online medical direction for orders or consultation following report format is acceptable:

- Paramedic unit number.
- Specific notification or requests such as (DFI, DOPA, Trauma Alert, Trauma Code, Cardiac Arrest, Stroke Alert, Heart Alert, CPAP, Sepsis Alert, etc.)
- Estimated time of arrival.
- Priority.
- Patient age.
- Patient sex.
- Chief complaint and related past medical history (i.e., patient with chest pain, history of MI and CABG or patient with altered mental status and history of insulin dependent diabetes).
- Vital signs.
- Significant physical findings (i.e., patient with shortness of breath found to have wheezing and to be hot to the touch, or the patient complaining of leg pain who has deformity of the mid thigh without distal pulses).
- Care rendered.
- Response to care.
- Orders requested.
- Run case number is required for DOPA

In patients who have an ALS Priority of II or III and are being treated by standing orders with no anticipated requests for orders, the following brief report format is acceptable:

- Paramedic unit number.
- Priority.
- Patient age.
- Patient sex.
- Chief complaint
- Standing Order being followed
- Estimated time of arrival.

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The above information should be more than adequate for most paramedic runs. When additional information is felt to be important for patient care or disposition, the medical control physician is well within their jurisdiction to request more information.

ADULT GENERAL PATIENT CARE

INDICATIONS: Any adult patient requiring pre-hospital medical evaluation by a prehospital healthcare provider in the State of Delaware.

A patient is an individual who is sick, injured, wounded or otherwise incapacitated or helpless and/or seeks immediate medical attention for whom EMS has been activated.

The Adult General Patient Care protocol will be followed in conjunction with all other applicable protocols.

The most current version of the American Heart Association Guidelines for Cardiopulmonary Resuscitation is considered the standard for CPR within these protocols.

- Respond using lights and sirens in accordance with Priority Medical Dispatch® (PMD®) protocols currently approved by Delaware EMS Medical Directors.
- Perform scene survey. *Delaware EMS Medical Directors recommend that all EMS crews carry "room" carbon monoxide detectors with an audible alert on their first-in bag for provider and patient protection.*
- Observe universal precautions.
 - Follow your agency's infection control policy.
 - Delaware EMS Medical Directors recommend wearing masks when caring for patients with active coughing. Consider masking the patient pending respiratory status.
- Consider the need for additional resources.
- Determine responsiveness using AVPU.
- Evaluate Airway, Breathing, Circulation, and Disability, Exposing the patient as necessary.
- Secure a patent airway appropriately.
- Manage cervical spine appropriately.
- Treat life-threatening conditions as necessary per specific treatment protocols.
- The paramedic is to first attempt to contact the Delaware Medical Control facility of intended patient disposition. If a paramedic does not obtain a timely response, they may contact a second Delaware Medical Control facility for orders or consultation. If an out of state hospital is the intended destination, the EMS provider should contact the closest Delaware Medical Control facility.
- **Contact medical control** for consideration of a needle chest decompression.
- Assess body systems as appropriate.
- Monitor patient via the use of pulse oximetry and/or capnography (nasal prong/ET), as appropriate.

- Administer oxygen as appropriate (maintain a SaO₂ of at least 92%).
- Obtain medical history (HPI, PMH, allergies, and medications).
- Evaluate blood pressure, pulses, respiratory rate, and tactile (or measured) temperature. Reassess with a frequency indicated by patient condition.
- Monitor blood glucose levels as appropriate.
- Monitor cardiac rhythm and/or 12 lead ECG as appropriate.
- Assign treatment priority and make transport decision.
- Establish intravenous access with normal saline infused as appropriate.
- Consider intraosseous access if IV access cannot readily be obtained for Priority 1 patients in extremis that are in need of medication or fluid resuscitation.
 - Administer 20 – 40 mg lidocaine IO over 1 minute in the conscious patient if not contraindicated
 - Administer 10 ml NSS rapid IO push
 - All IV medications can be administered IO
- Consider the insertion of an orogastric tube after the patient is successfully intubated.
- Consider the administration of 8 mg Zofran (Ondasteron[®]) ODT, IV or IM for nausea or vomiting.
- Monitor lactate level as appropriate (optional).
- Monitor PT or INR level as appropriate (optional).
- Contact medical control as soon as possible.
- Contact medical control for BLS release if appropriate.
- Secure patient in ambulance using appropriate equipment per ambulance design and agency standard operating procedures.
- Consider proposed receiving facility's diversion status and inform patient (family) as appropriate.
- Transport patient to an appropriate medical facility via appropriate mode of transportation without delay. Transport should be made safely and in a manner as to prevent further injury through the appropriate use of lights and sirens or no lights and sirens. **The highest medically trained practitioner engaged in patient care will determine the medically appropriate mode of transportation based upon the patient's presenting medical condition. This practitioner will communicate with the transporting EMS vehicle's operator and advise him/her as to the transport mode to be utilized.**
- Patients should be taken to the approved facility's emergency department, labor and delivery area or to an inpatient bed if arranged prior to arrival at the facility. If there are questions or doubts as to the appropriate facility or point of delivery, the medical control physician will be the arbitrator. All unstable patients should be transported directly to an emergency facility.
- Patients are to be transported to Delaware Office of EMS approved facilities within the EMS agency's usual operations area.

- On scene direction of medical care is provided by the Delaware EMS provider with the highest level of licensure.
- Patient care does not end until transfer of care of the patient to an appropriately trained health care provider is completed and the patient care report is completed and delivered to the receiving facility.
- Document relevant findings and treatments.

Priority I	Patient suffering from an immediate life or limb threatening injury or illness. It is the consensus of the EMS medical directors that during transport to the hospital lights and sirens are not medically indicated for many Priority I patients.
Priority II	Patients suffering from an injury or illness that if left untreated could potentially threaten life or limb. It is the consensus of the EMS medical directors that during transport to the hospital, lights and sirens are not medically indicated for Priority II patients.
Priority III	Patient suffering from an injury or illness that requires medical attention but does not threaten life or limb. It is the consensus of the EMS medical directors that during transport to the hospital, lights and sirens are not medically indicated for Priority III patients.

"Any person, agency, organization or entity who knows or in good faith suspects child abuse or neglect shall make a report in accordance with § 904 of this title (Title 16 of Delaware Code). For purposes of this section, "person" shall include, but shall not be limited to, any physician, any other person in the healing arts including any person licensed to render services in medicine, osteopathy or dentistry, any intern, resident, nurse, school employee, social worker, psychologist, medical examiner, hospital, health care institution, the Medical Society of Delaware or law enforcement agency."

Child Abuse Reporting Phone Contact:1-800-292-9582

Any person having reasonable cause to believe that an adult person is infirm or incapacitated as defined in § 3902 of this title (Title 39 of Delaware Code) and is in need of protective services as defined in § 3904 of this title shall report such information to the Department of Health and Social Services.

Division of Services for Aging and Adults with Physical Disabilities (DSAAPD): 1-800-223-9074.

The approved pharmacology manual should be used for medication reference.

Zofran (Ondasteron[®]) ODT means oral dissolving tablet

CO-oximetry may be performed as an option by agencies carrying CO monitoring equipment.

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It should be noted that the General Patient Care protocol above is a guideline to be followed in as much as it aids in providing appropriate and timely medical care. The ALS provider may change the order or omit steps listed above as dictated by sound judgment of the care provider and/or presentation of the patient(s).

The following information should be passed on in either verbal or written form at the time of patient transfer: HPI, PMH, allergies, medications, vital signs, SaO₂, EtCO₂, cardiac rhythm, prehospital treatments, and patient's response to those treatments.

STABLE TACHYCARDIA

INDICATIONS: A wide complex tachycardia (QRS \geq 0.12 seconds) presumed to be ventricular tachycardia (VT), or a narrow complex tachycardia (QRS $<$ 0.12 seconds) other than sinus tachycardia. There should be no evidence of trauma, hypovolemia, fever or sepsis.

For purposes of this Standing Order, STABLE is defined as a patient with a systolic blood pressure greater than 90 mmHg.

- Obtain 12-lead EKG
- If the rhythm is a **wide complex tachycardia** at a rate exceeding 150 bpm:
 - Administer 150 mg amiodarone (Cordarone[®]) IV infused over 10 minutes.
- If the rhythm is a **narrow complex tachycardia**, other than sinus tachycardia, atrial fibrillation or atrial flutter, at a rate exceeding 150 bpm:
 - Consider Valsalva maneuver. (Carotid massage may not be performed).
 - Administer 6 mg adenosine (Adenocard[®]) IV rapidly.
 - If there is no response to the initial 6 mg dose, administer 12 mg adenosine.
 - If there is no response to the second dose, administer 12 mg adenosine.
 - Administer 0.25 mg/kg diltiazem (Cardizem[®]) IV (maximum dose is 25 mg) over 2 minutes.
 - If there is no response to the initial dose of diltiazem after 15 minutes, **contact medical control** for consideration of administration of 0.35 mg/kg diltiazem IV (maximum dose of 35 mg) over 2 minutes.
- If the rhythm is a **narrow complex atrial fibrillation or atrial flutter** at a sustained rate exceeding 120 bpm and the patient is without signs or symptoms of congestive heart failure:
 - Administer 0.25 mg/kg diltiazem (Cardizem[®]) IV (maximum dose is 25 mg) over 2 minutes.
 - If there is no response to the initial dose of diltiazem after 15 minutes, **contact medical control** for consideration of administration of 0.35 mg/kg diltiazem IV (maximum dose of 35 mg) over 2 minutes.

Contact medical control for orders to administer calcium chloride and possibly sodium bicarbonate, if the patient has a history of chronic renal failure and either hemodialysis or peritoneal dialysis.

Adenosine: potentiated by dipyridamole (Persantine), use half (1/2) doses. Use with caution with patients on carbamazepine (Tegretol), digoxin and verapamil.

Diltiazem (Cardizem) use with caution, contact medical control when patients are on digoxin.

GUIDELINES REGARDING DO NOT RESUSCITATE ORDERS

Living Will:*

- Living wills do not apply to out-of-hospital care.
- A living will has no impact on the decision of whether or not to initiate or continue resuscitative efforts or any other care.

Do Not Resuscitate Order (DNR):

- Contact medical control immediately.

**If a question should arise regarding DNR's, PACDs, MOLST or living wills at any time during treatment, medical control should be contacted*

PROTOCOL FOR THE TELEMETRIC PRONOUNCEMENT OF DEATH

- Upon arrival at the scene of a patient with an illness or injury, the paramedics will follow applicable standing orders. If resuscitative efforts have been initiated by Ambulance Attendants or bystanders, the paramedics should proceed with patient assessment.
- In the following circumstances the paramedic may contact the medical control physician to request that the patient be pronounced dead at the scene.

Injuries which are obviously incompatible with life.

- Decapitation
- Body fragmentation
- Severe crush injury to head (without vital signs)
- Severe crush injury to chest (without vital signs)
- Severe thermal burns (without vital signs)
- Gunshot wounds to the head with lateral entrance wound and an opposite side exit wound (without vital signs)

Decomposition of the body.

- Skeletalization
- Severe bloating (without vital signs)
- Skin slough (without vital signs)

Absence of signs of life.*

- Pulselessness
- Apnea
- Fixed and dilated pupils
- Dependent lividity, **
- Generalized rigor mortis, ** (prior to lysis)
- Asystole on the ECG monitor (an ECG strip must be attached to the patient care report in every case).

* All must be present for a "medical patient" to be pronounced.

** In the case of blunt trauma patients, the medical control physician may waive requirement #4 and #5.

- Only the medical control physician may pronounce a patient dead, while in direct contact with the paramedic. It is not acceptable for the information on death pronouncement to be transmitted from the paramedic to the physician through an intermediary. The medical control physician must be physically present at the radio or telephone to receive the information directly from the paramedic.
- Once the medical control physician has pronounced the patient dead, the paramedic will notify the appropriate police department and the Delaware Medical Examiner's Office if not already done.
- Removal of the decedent, once properly pronounced, is performed only if authorized by jurisdictional police agencies and the Medical Examiner.

- Once the patient is pronounced dead, the paramedic will obtain a case number from the dispatch center. In situations where more than one patient has been pronounced dead, identification will be assured by using the case number followed by a letter, beginning with "A" and progressing in alphabetical order (i.e. case #234567-A, #234567-B, #234567-C, etc.).
- The case number is to be used by the paramedic to identify the decedent to the medical control physician for purposes of completing the death certificate.
- Upon pronouncement of a patient's death, the medical control physician will immediately complete a death certificate (under pronouncing physician section). The physician will include the assigned case number on the left upper margin of the death certificate. The death certificate will then be placed in a secure, but convenient location within the medical command facility, to be retrieved by the Medical Examiner's Investigator when the death falls within the jurisdiction of the Medical Examiner, or by the family-assigned funeral director in non-Medical Examiner's cases. A base report will be completed in the usual manner.
- After the patient has been pronounced dead, the paramedic will place a tag or hospital type band around the patient's right ankle (any extremity is acceptable if right ankle is not present). The band should contain the following written information:
 - Case/Incident number
 - Paramedic identification number
 - Medical command facility name
 - Medical control physician identification number
 - Time and date of death pronouncement
 - Other information deemed appropriate by the paramedic crew
- Under normal circumstances, paramedics should comply with the above provisions. In the event a representative from the jurisdictional law enforcement agency requests that the DOA tag not be affixed to the patient, the paramedic should perform the following steps:
 - The name, rank department identification number and agency of the police officer should be obtained by the paramedics.
 - The paramedics should specifically document that the listed police officer requested the DOA tag not be affixed to the patient.
 - The time the completed tag was given to the specified police officer should be documented on the PCR filed by the paramedic unit.
- The paramedic will notify the responsible family member that the patient is dead. Paramedics are encouraged to utilize appropriate support services to assist family members in grieving.
- Upon arrival of the police, paramedic supervisor or the investigator for the Medical Examiner, the paramedics and ambulance attendants will return to active status.
 - In the case of a nursing home facility resident DOPA, the patient may be turned over to a Registered Nurse or on duty clinical supervisor and units may return to active status.
- Prior to completion of his/her work shift, the paramedic will file a complete, standard run report detailing in the usual manner the pertinent aspects of the case. The run report is to be distributed to the usual locations along with a copy to the pronouncing medical command facility. This paramedic run report is to be available at the medical command facility within twelve (12) hours of the run. If the paramedic is able to complete the run report prior to leaving

the scene, copies of the run report are to be distributed in the usual manner so as to assure patient confidentiality. A copy may be left with an authorized Medical Examiner.

- The circumstances of death must be investigated by the Medical Examiner's office and/or the police having jurisdiction over the geographic area of pronouncement. Should the death be deemed a Medical Examiner's case, the Medical Examiner's office shall be responsible for the transportation of the body and the collection and completion of all necessary legal documents.
- Should the case not be deemed a Medical Examiner's case, the body may be transported by a licensed funeral director to the funeral home of the family's choosing. The collection and completion of all necessary legal documents shall be coordinated by the funeral director.
- The decedent may be taken to a hospital emergency department in select circumstances.

PEDIATRIC GENERAL PATIENT CARE

INDICATIONS: *Any patient who is 12 years of age or less (neonates are defined as a patient age 30 days and under) requiring pre-hospital medical evaluation by a pre-hospital health care provider in the State of Delaware.*

A patient is an individual who is sick, injured, wounded or otherwise incapacitated or helpless and/or seeks immediate medical attention for whom EMS has been activated.

The Pediatric General Patient Care protocol will be followed in conjunction with all other applicable protocols.

The most current version of the American Heart Association Guidelines for Cardiopulmonary resuscitation are considered the standard for CPR within these protocols.

- Respond using lights and sirens in accordance with Priority Medical Dispatch® (PMD®) protocols currently approved by Delaware EMS Medical Directors.
- Perform scene survey.
- Observe universal precautions.
 - Follow your agency's infection control policy.
- Consider the need for additional resources.
- Determine responsiveness using AVPU.
- Evaluate Airway, Breathing, Circulation, and Disability, Exposing the patient as necessary.
- Secure a patent airway appropriately.
- Manage cervical spine appropriately.
- Treat life-threatening conditions as necessary per specific treatment protocols.
- The paramedic is to first attempt to contact the Delaware Medical Control facility of intended patient disposition. If a paramedic does not obtain a timely response, they may contact a second Delaware Medical Control facility for orders or consultation. If an out of state hospital is the intended destination, the EMS provider should contact the closest Delaware Medical Control facility.
- **Contact medical control** for consideration of a needle chest decompression.
- Assess body systems as appropriate.
- Monitor patient via the use of pulse oximetry and/or capnography (nasal prong/ET), as appropriate.
- Monitor blood glucose level as appropriate.
- Administer oxygen as appropriate. (Maintain a SaO₂ of at least 92%)

- Obtain medical history (HPI, PMH, allergies, and medications).
- Evaluate blood pressure, pulses, respiratory rate, and tactile temperature. Reassess with a frequency indicated by patient condition.
- Monitor cardiac rhythm and/or 12 lead ECG as appropriate.
- Assign treatment priority and make transport decision.
- Establish intravenous access with normal saline infused as appropriate.
- **Use the Broselowtm tape to estimate drug dosages.**
- Consider intraosseous access, if IV access cannot readily be obtained for Priority 1 patients in extremis that are in need of medication or fluid resuscitation. If IO access is obtained, all IV medications can be administered IO.
 - Administer 0.5 - 1 mg/kg lidocaine IO over 1 minute in the conscious patient if not contraindicated
 - Administer 10 ml NSS rapid IO push
 - All IV medications can be administered IO
- For all other patients who are not in extremis, contact medical control for consideration of intraosseous access if IV access cannot readily be obtained for all other Priority 1 patients.
- Consider the insertion of an orogastric tube if the patient is successfully intubated.
- Consider the administration of 2 mg (older than 2 years and under the age of 6 years) or 4 mg (6 years or older) Zofran (Ondansetron[®]) ODT, IV or IM for nausea and vomiting.
- Monitor lactate level as appropriate (optional).
- Monitor PT or INR level as appropriate (optional).
- Contact medical control as soon as possible.
- Contact medical control for BLS release if appropriate.
- Secure patient in ambulance using appropriate equipment per ambulance design and agency standard operating procedures.
- Consider proposed receiving facility's diversion status and inform patient (family) as appropriate.
- Transport patient to an appropriate medical facility via appropriate mode of transportation without delay. Transport should be made safely and in a manner as to prevent further injury through the appropriate use of lights and sirens or no lights and sirens. **The highest medically trained practitioner engaged in patient care will determine the medically appropriate mode of transportation based upon the patient's presenting medical condition. This practitioner will communicate with the transporting EMS vehicle's operator and advise him/her as to the transport mode to be utilized.**
- Patients should be taken to the approved facility's emergency department, labor and delivery area or to an inpatient bed if arranged prior to arrival at the facility. If there are questions - doubt as to the appropriate facility or point of delivery, the medical control physician will be the arbitrator.*
- Patients are to be transported to Delaware Office of EMS approved facilities within the EMS agency's usual operations area.

- Responsibility of care does not end until transfer care of the patient to an appropriately trained health care provider and the patient care report is completed and delivered to the receiving facility.
- Document relevant findings and treatments.

* The Office of Emergency Medical Services (OEMS) will periodically compile and publish a list of approved receiving facilities based on the receiving facilities level of certification and available types of care. This list should be considered when determining the most appropriate destination for patients. The list is available on the OEMS web site www.dhss.delaware.gov/dhss/dph/ems/ems.html

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