



Your Town EMS
Emergency Medical Services
STANDING DELEGATED ORDERS



Your Town EMS
EMERGENCY MEDICAL SERVICES
STANDING DELEGATED ORDERS
2008-2010

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Prepared
By:

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Approved By:

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Page: A-10	Protocol Name: Medical Director Approval / Duty Status	
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The following standing delegated orders are authorizations for qualified personnel to provide prehospital healthcare. Use and delegation of these orders are subject to:

- ✓ Department personnel, acting in their official capacity while representing their department.

- ✓ These aforementioned personnel must be:
 - Members or employees in active status as defined by department policies or by-laws.
 - Certified or licensed by the Texas Department of State Health Services, holding at least one of the following certifications or licenses:
 1. ECA – Emergency Care Attendant
 2. EMT-B – Emergency Medical Technician – Basic
 3. EMT-I – Emergency Medical Technician – Intermediate
 4. EMT-P – Emergency Medical Technician – Paramedic
 5. LIC-P – Licensed Paramedic
 - The credentials required above must be valid, active, and current.

Individuals meeting all criteria outlined above shall be classified as “On-Duty.”

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Page: A-20	Protocol Name: Geographical Area	
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Use of these protocols are restricted to the following geographical areas:

- ✓ The use of these medical protocols is limited in geographical area to the State of Texas.
- ✓ The transport of a patient or patients to or from the area referenced above, such that the transport does not involve transport of a patient outside the State of Texas.
- ✓ In any geographical area in the State of Texas when officially requested to assist another EMS organization with a mutual aid situation, or backup 911 call.
- ✓ In any geographical area in the State of Texas, in which the need exists for emergency patient care as defined by these protocols, and while on-duty, as defined in Section A-10.

* If your geographic location requires transport outside the State of Texas to maintain standard of care for all patients, the on-duty crew must follow all respective state laws accordingly and with due regard to patient care.

* In cases where the nearest hospital is outside the state of Texas and the patient's condition requires transport to the nearest facility, these standing orders may be followed as long as the patient is in the care of the Ambulance Service's Personnel.

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Page: A-30	Protocol Name: Authority	
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EMS personnel operating as “On-Duty,” as defined herein, must only provide patient care at the level authorized and designated by the Medical Director. Each intervention authorized in these Standing Delegated Orders indicates the minimum requirements to perform the referenced intervention. Additionally, some standing orders may identify additional training or other requirements necessary to perform under the order.

Symbol Minimum requirements to perform under referenced symbol

- A** **Emergency Care Attendant**
- B** **Emergency Medical Technician – Basic**
May administer Epi-Pen. May assist with patient prescribed Nitro.
- * **B2** **Emergency Medical Technician – Basic**
This designation requires special training in advanced airway management and IV placement, Finger Stick Glucose evaluation.
- I** **Emergency Medical Technician – Intermediate**
- * **I2** **Emergency Medical Technician – Intermediate**
This designation requires special training in advanced trauma / cardiac interventions.
- P** **Emergency Medical Technician – Paramedic / Licensed Paramedic**
- * **P2** **Emergency Medical Technician – Paramedic / Licensed Paramedic**
This designation requires special training in 12-lead ECG interpretation.
- * **P3** **Emergency Medical Technician – Paramedic / Licensed Paramedic**
This designation requires special training in advanced airway management.

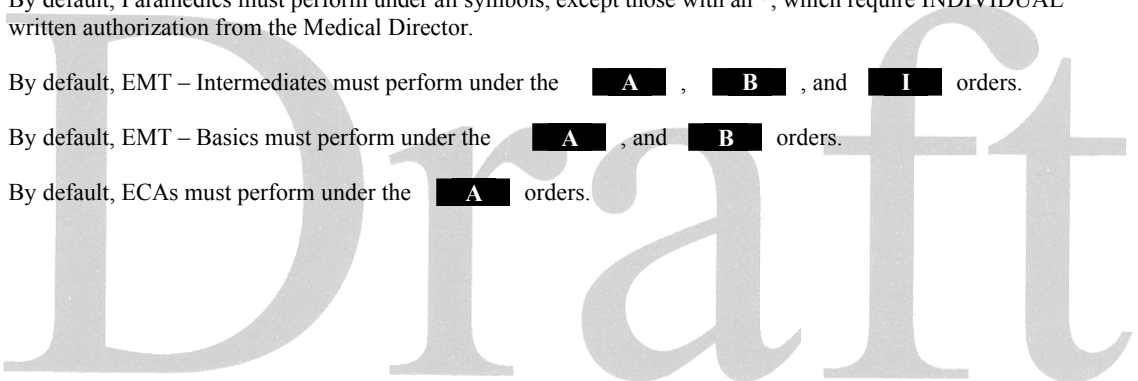
Interventions indicated with * require special written authorization by the Medical Director.

By default, Paramedics must perform under all symbols, except those with an *, which require INDIVIDUAL written authorization from the Medical Director.

By default, EMT – Intermediates must perform under the **A** , **B** , and **I** orders.

By default, EMT – Basics must perform under the **A** , and **B** orders.

By default, ECAs must perform under the **A** orders.





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Page: A-40	Protocol Name: Supplies & Equipment	
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In addition to the supplies and equipment required by the Texas Department of State Health Services, the following list identifies the minimum supplies and equipment required on each ambulance:

Qty	Equipment & Supplies	Qty	Equipment & Supplies
BLS		10	Hand Disinfectant Wipes
1	Protocol Book, Supply & Equipment List, and Drug List	2	Puncture Resistant Sharps Containers
2	Oropharyngeal Airways (sets of pediatric thru Large adult)	2	Red Biohazard Waste Bags
2	Nasopharyngeal Airways (each size)	1	Fire Extinguisher (located in an obvious location)
1	Portable Suction Unit (with supplies necessary for normal operation)	4	Cold Packs
1	Adult Bag Valve Mask	ALS	
1	Child Bag Valve Mask	1	Continuous Positive Airway Pressure Unit ***
1	Infant Bag Valve Mask	1	Nebulizer
2	Adult Non-rebreather Masks	3	Blood draw tubes: one each red, gold, lavender. (Optional)
2	Child Non-rebreather Masks	2	0.9% NaCl 10 mL flush for saline lock (required if saline locks used)
2	Nasal Cannulas	1	Buretrol for pediatric IV
2	Infant Non-rebreather Masks	2	Saline Locks (optional)
2	Portable Oxygen Cylinders (minimum size D)	1	Bougie Introducer (Optional but preferred)
2	Portable Oxygen Regulator	2	Normal Saline (0.9% NaCl) 500 ml IV Solution Bags
1	On-Board Oxygen Cylinder with Regulator (minimum size H)	2	Normal Saline (0.9% NaCl) 1000 ml IV Solution Bags
2	Multi-Trauma Dressing	3	Micro-drip sets (60 gtts/mL)
20	Sterile Gauze Pads	3	Macro-drip sets (10 gtts/mL)
4	Occlusive Dressings	2	IV Catheters of sizes 14, 16, 18, 20, 22, 24 (2 of each size)
12	Kerlix Dressings	2	Tourniquets
4	Rolls of Tape	2	Syringes of Sizes 1 cc, 3 cc, 10 cc, 30 cc (2 of each size)
4	Triangular Bandages	2	Endotracheal Tubes of Sizes 2.5 – 9.0 (2 of each size)
2	Sterile Burn Sheets	1	Endotracheal tube Stylette
2	Adult C-Collars (adjustable size preferred)	1	Laryngoscope Handle
2	Child C-Collars	1	Laryngoscope Blade of Sizes 0-4 (Miller) & 1-4 (Macintosh)
2	Infant C-Collars	1	McGill Forceps
2	Long Spine Boards	1	Cardiac Monitor / Defibrillator Capable of Performing These Protocols
3	Sam ® Splints / Board Splints	1	Quick-Combo Pads Adult
2	Rigid eye shields	1	Quick-Combo Pads Pediatric
2	Eye Protective Goggles – Medical Grade	1	End Tidal CO2 Sensor (optional but preferred)
2	Protective Medical Gowns – Medical Grade	2	ECG Electrode Set
2	Protective Face Masks – Medical Grade	1	Combitube ®
1	Adult Traction Splint	1	Combitube ® S.A.
2	Stethoscopes	1	Quick Trach® Kit
1	Adult and/or Large Adult Blood Pressure Cuff	1	F.A.S.T. 1™ Adult IO Kit**
1	Child Blood Pressure Cuff	2	EZ-IO® Adult Needles**
1	Torch (Pen Light)	1	EZ-IO® Pediatric Needles*
2	Bandage Shears	1	EZ-IO® Driver* (Only required if EZ-IO® needles are used)
1	Sealed Obstetrics Kits with Non-Porous Infant Insulator	1	Jamshidi Pediatric IO needle*
1	Automatic External Defibrillator NOT required on ALS ambulances	2	Nasal atomizers for nasal medication administration (optional)
1	Glucometer and 5 test strips		
1	Multilevel Stretcher		
10	Pair of Protective Non-Porous Gloves (sizes small, medium, & large)		
1	Flashlight		
2	Morgan Lens		
2	Sheets		
2	Sterile Gloves		
2	Blankets		
3	Emergency Warning Flares/ Triangles		
2	“No Smoking” Signs (one in cab and one in patient compartment)		

***Continuous Positive Airway Pressure (CPAP) equipment is referenced with instruction in these protocols. All agencies must have CPAP fully implemented by July 1, 2008.

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Page: A-50	Protocol Name: Approved Drug List	
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The following list identifies the type and minimum quantities of drugs to be stocked on each ambulance:

Qty	Drug
50 gm	Activated Charcoal with sorbitol
30 mg	Adenosine
10 mg	Albuterol
648 mg	Aspirin (81 mg chewable tablets)
5 mg	Atropine Sulfate
75 gm	Dextrose 50%
20 mg	Diazepam (Valium)
100 mg	Diphenhydramine
1	Dopamine (400 mg / 250 mL)
2	Epinephrine 1:1,000 (1 mg / mL)
6	Epinephrine 1:10,000 (1mg / 10mL)
1	Epi-Pen© Adult (Not required on ambulances staffed by at least one paramedic)
1	Epi-Pen© Junior (Not required on ambulances staffed by at least one paramedic)
120 mg	Furosemide
1	Glucagon (1 mg powder / 1 mL dilute)
10 mg	Haldol (Haloperidol)
2 mg	Ipratropium
40 mg	Labetalol (20 mg / 2 mL vial)
1	Lidocaine HCl (1 g / 250 mL)
300 mg	Lidocaine HCl
10 gm	Magnesium Sulfate
250 mg	Methylprednisolone (Solu-Medrol)
10 mg	Metoclopramide (Reglan)
5 mg	Midazolam (Versed)
20 mg	Morphine Sulfate (5 mg / 10 mL vial)
6 mg	Naloxone (2 mg / 2 mL)
1	Nitroglycerin Sublingual tablets or spray for minimum five doses
2	Oral Glucose Gel
2	Sodium Bicarbonate (50 mEq/ 50 mL 50% solution of 8.4 %)
2 each	Normal Saline (NaCl 0.9%) 100 mL , 500 mL, and 1 L bags for IV therapy
1	Tetracaine Ophthalmic anesthetic (0.5% Bottle / 15 mL)
200 mg	Thiamine HCl (100 mg / mL)
	Tylenol 500 mg tablets (4), Tylenol suppositories (325 mg) (4), Tylenol suspension (160mg/5 mL) (500 mg) OPTIONAL
80 units	Vasopressin (40 IU / 2 mL)

Drug Concentration Statement:

Periodically the aforementioned drugs may be supplied in concentrations or volumes other than those indicated. Regardless of the particular manner in which drugs are supplied, equivalent total amounts must be present. It is the paramedic's responsibility to ensure that the dosage administered to each patient corresponds with the applicable protocols set forth herein. For purposes of these delegated orders, generic drugs and brand name drugs are interchangeable.

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Protocol: B-70	Protocol Name: Chest Pain	
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- A** Complete primary assessment.
- A** Evaluate present and past medical history:
 - ✓ Provocation.
 - ✓ Quality of pain.
 - ✓ Radiation of chest pain.
 - ✓ Relieving Factors.
 - ✓ Severity of pain.
 - ✓ Time of the onset.
 - ✓ Medications and allergies.
- A** Consider treatment if patient has:
 - ✓ Any chest pain.
- A** Consider airway management procedure.
- A** Administer 100% oxygen via NRB mask or BVM if necessary.
- B** Apply cardiac monitor, and obtain 12 lead ECG and print second copy for hospital.
- P** Interpret 12-lead EKG. Notify hospital AT ONCE if **STEMI** present
- B2** Consider blood draw procedure when obtaining IV access. Label name and birthdate.
- B2** Establish an IV, 0.9% NaCl, at 30 mL/hr.
- I** If hypotensive bolus 0.9% NaCl 20 mL/kg IV.
- B** Administer Aspirin, 324 mg (chewed)*
- P** Check blood pressure. If systolic pressure is > 100 mmHg:
 - ✓ Administer Nitroglycerin 0.4 mg sublingual.
- P** If pain is not relieved, MAP > 65 mmHg, and 12-lead EKG **does not** indicate an inferior wall MI:
 - ✓ Nitroglycerin 0.4 mg sublingual can be repeated every 5 minutes until a total of three doses have been administered.
- P** ✓ Administer Morphine 2 – 5 mg IV every 5 minutes, until pain resolved (max 20 mg).
- A** ✓ Monitor for resulting hypotension and decreased respiratory rate.
- P** If pain is not relieved, MAP > 65 mmHg, and 12-lead EKG **does** indicate an inferior wall MI:
 - ✓ Administer fluid bolus of 0.9% NaCl 250 – 500 mL (Avoid if evidence of pulmonary edema is present).
- P** ✓ Administer Morphine 2 – 5 mg IV every 5 minutes, until pain resolved (max 20 mg).
- A** ✓ Monitor for resulting hypotension and decreased respiratory rate.
- A** Transport.
- B** Contact receiving facility. State **CODE STEMI** and indicate abnormal leads if present and note time and person taking report for the hospital.

Notify hospital of **CODE STEMI** if present. Indicate leads in which ST segment elevation is present.

*Do not administer aspirin if Patient has taken aspirin in the last six hours.

Mean Arterial Pressure =

$$\frac{2 \times \text{Diastolic BP} + \text{Systolic BP}}{3}$$

ST elevation in leads II, III, and aVF indicates Acute inferior MI

If 12 lead ECG is not available, administer morphine if indicated and be prepared to give 500 mL bolus for any hypotension.

NOTE: If the patient's MAP drops below 65 mmHg, and postural positioning is ineffective, refer to the Cardiogenic Shock protocol, B-50.

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Protocol: B-90	Protocol Name: Congestive Heart Failure	
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- A** Complete primary assessment.
- A** Evaluate present and past medical history:
 - ✓ Nocturnal dyspnea.
 - ✓ Orthopnea.
 - ✓ Water retention / dependent edema.
 - ✓ Medication usage (Lasix, furosemide, etc.)
- A** Consider treatment if patient has:
 - ✓ Dyspnea, increasing upon lying down.
 - ✓ Productive cough with pink frothy sputum.
 - ✓ Peripheral edema.
 - ✓ Rales on chest auscultation.
 - ✓ Altered level of consciousness or unconscious.
- A** Consider airway management procedure.
- B** Begin CPAP for CHF exacerbations.
- A** Closely monitor those patients with COPD and be prepared to assist ventilations.
- A** Administer 100% oxygen via NRB mask or BVM if necessary.
- B** Apply cardiac monitor, and obtain 12 lead ECG. Print addition copy for receiving hospital.
- A** Place patient in a sitting position with lower extremities below the level of the patient's heart.
- B** If cardiac cause suspected administer aspirin, 324 mg (chewed).
- B2** Consider blood draw procedure when obtaining IV access.
- B2** Establish an IV, 0.9% NaCl, at 30 mL/hr.
- P** If MAP > 65 mmHg and cardiac cause suspected:
 - ✓ Administer Nitroglycerin 0.4 mg sublingual every 5 minutes (up to three doses).
- P** Administer Furosemide 40 mg IV
 - ✓ If patient is currently taking Furosemide, administer 80 mg IV
- P** Consider Albuterol with Atrovent by nebulization if the patient has wheezing or history of COPD/Asthma.
- P** If patient is critical, an additional dose of Furosemide 40 mg IV may be administered.
- P** If no improvement noted, MAP > 65 mmHg and cardiac cause suspected:
 - ✓ Administer Morphine 2 – 5 mg IV, after inferior MI has been excluded as the cause (max 20 mg).
- A** ✓ Monitor for resulting hypotension and decreased respiratory rate.
- A** Transport.
- A** Contact receiving facility.

Mean Arterial Pressure =

$$\frac{2 \times \text{Diastolic BP} + \text{Systolic BP}}{3}$$



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Protocol: B-190	Protocol Name: Nausea / Vomiting (Persistent)	
Page 1 of 1	Effective Date: January 26, 2004	Expiration Date: March 31, 2010

- A** Complete primary assessment.
- A** Evaluate present and past medical history:
 - ✓ History of ulcers.
 - ✓ Recent illness / infection.
 - ✓ Medications or allergies.
- A** Consider treatment if:
 - ✓ No altered level of consciousness. Contraindicated in bowel obstruction.
 - ✓ Nausea with active & persistent vomiting is present.
- A** Consider airway management procedure.
- A** Administer 100% oxygen via NRB mask or nasal cannula if unable to tolerate.
- B** Apply cardiac monitor, and obtain 12 lead ECG.
- P** Interpret ECG. If **STEMI** present refer to **B-70**.
- B2** Consider blood draw procedure when obtaining IV access.
- B2** Perform a blood glucose level test.
- B2** Establish an IV, 0.9% NaCl, at 30 mL/hr.
- I** If hypotensive bolus 0.9% NaCl 20 mL/kg IV.
- P** If blood sugar level is below 60 mg/dL and the patient is symptomatic:
 - P** ✓ Administer Thiamine 100 mg IV
 - I** ✓ Administer 50% Dextrose, 25 g IV
- P** If vomiting is persistent, administer Metoclopramide 5 – 10 mg IV or IM.
- A** Keep patient NPO. (nothing by mouth). Do not encourage eating or drinking.
- I** If signs of dehydration (dry mucous membranes, anuria, poor skin turgor):
 - ✓ Bolus 0.9% NaCl, 20 mL/kg.
- A** Transport.
- A** Contact receiving facility.

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Protocol: B-220	Protocol Name: Overdose / Poisoning	
Page 1 of 1	Effective Date: March 24, 2008	Expiration Date: March 31, 2010

- A** Complete primary assessment.
- A** Evaluate present and past medical history:
 - ✓ Name of substance taken.
 - ✓ Amount of substance taken.
 - ✓ Time at which substance was taken.
 - ✓ Gather all pill bottles at scene to transport with the patient.
- A** Consider treatment if:
 - ✓ Decreased level of consciousness.
 - ✓ Unresponsive or unconscious.
 - ✓ History of narcotic / opiate abuse.
 - ✓ History of cyanide poisoning, phenothiazine reaction, or envenomation.
- A** Consider airway management procedure.
- A** Administer 100% oxygen via NRB mask or BVM if necessary.
- B** Apply cardiac monitor, and obtain 12 lead ECG.
- B2** Consider blood draw procedure when obtaining IV access.
- B2** Perform a blood glucose level test.
- B2** Establish an IV, 0.9% NaCl, at 30 mL/hr.
- I** If hypotensive bolus 0.9% NaCl 20 mL/kg IV.
- P** If blood sugar level is below 60 mg/dL:
 - P** ✓ Administer Thiamine 100 mg IV
 - I** ✓ Administer 50% Dextrose 25 g IV
- I** If narcotic involvement is suspected and if respirations are compromised:
 - ✓ Administer Naloxone 2 mg IV /IO / Intranasal (IV may repeat up to 2 times).
- P** If dystonic reaction:
 - ✓ Administer Diphenhydramine 25 mg IV or Diphenhydramine 50 mg IM
- P** If suspected organophosphate poisoning, and symptomatic patient (bradycardia, salivation, lacrimation, etc.):
 - ✓ Administer Atropine 2 mg IV every 10 minutes as needed to relieve muscarinic symptoms
- A** Contact Poison Control – 1-800-222-1222, and follow instructions.
- A** Transport.
- A** Contact receiving facility.

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Protocol: B-250	Protocol Name: Seizures	
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- A** Complete primary assessment.
- A** Evaluate present and past medical history:
 - ✓ Previous head injury.
 - ✓ Pregnancy or epilepsy.
 - ✓ Fever.
 - ✓ Medications and allergies.
- A** Consider treatment if:
 - ✓ Patient is actively seizing.
 - ✓ Patient is in post-ictal state, characterized by lethargy, altered mental status, etc.

- B** Consider airway management procedure including nasopharyngeal airway.
- A** Administer 100% oxygen via NRB mask or BVM if necessary.
- B** Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.
- B2** Consider blood draw procedure when obtaining IV access.
- B2** Establish an IV, 0.9% NaCl, at 30 mL/hr.

P If patient is actively seizing administer benzodiazepine:
 Versed (midazolam) 2.5 - 5 mg IV/ IO or Intranasal, titrated to seizure activity.
OR Valium (diazepam) 5 - 10 mg IV/IO or Intranasal titrated to seizure activity.
 If still seizing in 15 minutes may repeat either . Be prepared to manage airway and support the blood pressure.

Versed (Midazolam)
Administration:

<u>Weight:</u>	<u>Dosage:</u>
40 kg	2 mg
50 kg	2.5 mg
60 kg	3 mg
70 kg	4 mg
≥ 80 kg	5 mg

B2 Perform blood glucose level test.

P If blood sugar level is below 60 mg/dL:
P Administer Thiamine 100 mg IV
I Administer Dextrose 50%, 25 g IV

I If narcotic involvement is suspected :
 Administer Naloxone, 2 mg, slow IV (may repeat up to 2 times).

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A If the patient is febrile:
 Cool patient with water or cool packs.

P If suspected dystonic reaction:
 Administer Diphenhydramine 25 - 50 mg IV/IM.

A Transport.

A Contact receiving facility.

Valium (Diazepam)
Administration:

<u>Weight:</u>	<u>Dosage:</u>
40 kg	5 mg
50 kg	5 mg
60 kg	10 mg
70 kg	10 mg
≥ 80 kg	10 mg

Note: If the patient is eclamptic, refer to Obstetrical Complications protocol, B-210.



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Protocol: B-270	Protocol Name: Transfer Ambulance Calls	
Page 1 of 1	Effective Date: March 24, 2008	Expiration Date: March 31, 2010

- A** For transfer ambulance responses:
 - ✓ Follow appropriate protocols for any injury or illness.
 - ✓ If patient has written orders from a physician, the physician's orders take precedence.
 - ✓ If patient is on a ventilator a respiratory therapist from the transferring hospital must accompany the patient.
 - ✓ If the patient is on IV drips which are outside the scope of these orders a Registered Nurse from the transferring hospital must accompany patient.
 - ✓ If patient's condition worsens or changes out of the scope of the transferring physician's written orders, contact medical control at receiving hospital for further orders. Document information in the patient record.

A Monitor vital signs according to patient's condition.

- P** Monitor all interventions, including:
- ✓ Oxygen therapy.
 - ✓ IV therapy.
 - ✓ ECG monitoring.
 - ✓ Artificial ventilation therapy.
 - ✓ Any other interventions or care necessary.

A Document any changes in the patient's condition while enroute.

A Report all appropriate information to receiving facility.

A Transport.

A Contact receiving facility.

If the Paramedic has any concern about the patient's safety during transport, contact Medical Control.

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Protocol: C-90	Protocol Name: Pediatric Fracture / Dislocation	
Page 1 of 1	Effective Date: March 24, 2008	Expiration Date: March 31, 2010

- A** Complete primary assessment.
- A** Evaluate present and past medical history:
 - ✓ Mechanism of injury.
 - ✓ Medications or allergies.
- A** Consider treatment if:
 - ✓ Suspected closed fracture / dislocation.
 - ✓ Open fracture / dislocation.
 - ✓ Pain and deformity.
- A** Consider airway management procedure.
- A** Administer 100% oxygen via NRB mask or BVM if necessary.
- B** Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG.
- B2** Consider blood draw procedure when obtaining IV access.
- B2** Establish an IV, 0.9% NaCl, at 30 mL/hr.
- I** If hypotensive, bolus 0.9% NaCl 20 mL/kg.
- A** Check for pulse distal and proximal to fracture or dislocation, and capillary refill.
- A** Immobilize the joint above and below the fracture or dislocation.
- A** Protect any exposed bone ends, and dress / bandage all open wounds prior to splinting.
- A** Splint in the position found. See splinting procedure.
- A** For closed, mid-shaft femur fractures, apply traction splint.
- P** Consider Morphine 0.1 mg/kg IV/IM every 5 minutes for pain (max 5 mg).
 - ✓ Monitor for resulting hypotension and decreased respiratory rate.
- P** For dislocations or severely angulated fractures associated with swelling, distal pulselessness, or paresthesia:
 - ✓ Reposition the limb in anatomical alignment.
 - ✓ Gently apply traction and counter-traction.
 - ✓ Move limb to attempt to regain distal pulse.
 - ✓ Attempt movement only once, and if unsuccessful, transport as soon as possible.
- A** Transport.
- A** Contact receiving facility.



Use Weight/Lengthtape for medication dose if applicable.
To convert to kilograms:

Weight in pounds divided by 2, then subtract 10%

Example: weight 70 pounds. Divide by 2 = 35
Subtract 10 % = 31.5 kg (can round to 32 kg)



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Protocol: C-150	Protocol Name: Pediatric Respiratory Distress	
Page 1 of 1	Effective Date: March 24, 2008	Expiration Date: March 31, 2010

- A** Complete primary assessment.
- A** Evaluate present and past medical history:
 - ✓ Previous home breathing treatments.
 - ✓ Past cardiac history.
 - ✓ Past respiratory problems.
 - ✓ Medications and allergies.
- A** Consider treatment if:
 - ✓ Tachypneic, dyspnea, S.O.B., wheezing.
 - ✓ Diaphoretic, tachycardic, pale.
 - ✓ Use of accessory muscles during inspiration.
 - ✓ Unable to speak.
 - ✓ Prolonged forced exhalation.
- A** Consider airway management procedure.
- A** Administer 100% oxygen via NRB mask or BVM if necessary.
- B** Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.
- A** If applicable, encourage the patient to a sitting or upright position to aid their respiratory effort.
- B** Administer Albuterol 2.5 mg in 3 mL NaCl, via nebulizer mask at 6 lpm
- A** Reassess patient's respiratory efforts and vital signs.
- A** If treatment is successful, add 3 – 5 cc NaCl to nebulizer for humidified oxygen.
- B** If still wheezing with increased work of breathing, administer additional Albuterol, 2.5 mg in 3 mL NaCl, via nebulizer mask
- B** If no improvement, or patient has decreased level of consciousness or loses consciousness:
 - ✓ Perform airway management procedure and assist ventilations with BVM.
- P** If severe bronchoconstriction makes ventilations difficult:
 - ✓ Administer Epinephrine (1:1,000), 0.1mg IM
- B2** If patient condition does not improve, establish an IV, 0.9% NaCl, at 30 mL/hr.
- P** If respiratory arrest occurs and IV access is unobtainable after 2 attempts or 60 seconds, establish IO access, 0.9% NaCl, at 30 mL/hr, bolus 20 mL/kg if patient is hypotensive.
- A** Transport.
- A** Contact receiving facility.



Figure 1: Pediatric NRB



Figure 2: Albuterol Treatment

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Protocol: C-160	Protocol Name: Pediatric Seizures	
Page 1 of 1	Effective Date: March 24, 2008	Expiration Date: March 31, 2010

- A** Complete primary assessment.
- A** Evaluate present and past medical history:
 - ✓ Previous head injury.
 - ✓ Fever.
 - ✓ Medications and allergies.
- A** Consider treatment if:
 - ✓ Patient is actively seizing.
 - ✓ Patient is in post-ictal state, characterized by lethargy, altered mental status, etc.

A Consider airway management procedure including nasopharyngeal airway.

A Administer 100% oxygen via NRB mask or BVM if necessary.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

- P** If patient is actively seizing:
- ✓ Administer Versed (midazolam) 0.05 – 0.1 mg/kg IV/IM/IO or Intranasal
 - ✓ If still seizing after 5 minutes repeat Versed 0.05 – 0.1 mg/kg IV/IM/IO/Intranasal
 - ✓ Be prepared to manage airway

Use **Weight/Length Tape** for weight and drug dosages.

B2 Perform blood glucose level test.

- I** If blood sugar level is below 60 mg/dL:
- ✓ Administer 25% Dextrose 2 mL/kg IV or IO *

* 25% Dextrose is made by diluting 50% Dextrose with an equal volume (1:1 solution) of sterile water (for injection).

- P** If narcotic involvement is suspected:
- ✓ Administer Naloxone 2 mg slow IV/IO/Intranasal if pt > 4 yo or > 20 kg (max dose 6 mg).
 - ✓ Administer Naloxone 0.1 mg/kg if pt is < 5 yo or < 20 kg (max dose 4 mg).

May administer Intranasal for first 2 mg. Total IN volume only 1 mL/nostril

- P** If the patient is febrile:
- ✓ Tylenol rectally (if available) and cool patient.

Tylenol 15 mg/kg

- P** If suspected dystonic reaction:
- ✓ Administer Diphenhydramine 1 mg/kg IV (max 50 mg).

- A** Transport.
- A** Contact receiving facility.

Weight/Length Tape	Weight	Midazolam IV
Gray	3-5 kg	0.15 to 0.25 mg
Pink	6-7 kg	0.35 mg
Red	8-9 kg	0.45 mg
Purple	10-11 kg	0.55 mg
Yellow	12-14 kg	0.7 mg
White	15-18 kg	0.9 mg
Blue	19-22 kg	1.1 mg
Orange	24-28 kg	1.4 mg
Green	30-36 kg	1.8 mg



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Procedure: D-100	Procedure: Continuous Positive Airway Pressure Device: Boussignac	
Page 2 of 2	Effective: November 4, 2008	Expiration: March 31, 2010

Indication
 Respiratory distress secondary to CHF or COPD exacerbation

Signs & Symptoms
 Dyspnea and Tachypnea
 Chest Pain, Tachycardia, Hypertension
 Anxiety, Restlessness, Altered Level of Conscious
 Peripheral Edema, JVD, Rales, Wheezes



The Boussignac CPAP System is designed for a single use and can easily be carried in an airway bag.

- B** 1. Always use universal precautions.
- B** 2. Have patient sit in Fowler's position.
- B** 3. Assist patient in holding mask to face as the flow of oxygen begins
- B** 4. Attach CPAP mask to oxygen capable of 10 – 25 L/min flow rate
- B** 5. Connect tubing to CPAP unit and face mask. Begin to seat mask to patient's face and obtain secure seal. Attach straps around head to secure mask.
- B** 6. Begin with oxygen at 10 L/min which gives CPAP of 2.5 – 3 cm H₂ O.
- B** 7. Titrate flow rate for patient comfort and respiratory rate.
- B** 8. Oxygen flow rate of 15 L/min gives 4.5 – 5 cm H₂ O.
- B** 9. Oxygen flow rate of 20 L/min gives 7 – 8 cm H₂ O.
- B** 10. Oxygen flow rate of 25 L/min gives 8.5 – 10 cm H₂ O
- B** 11. Adjust CPAP unit as needed to improve the patient's respiratory distress .
 ✓ If CPAP is not effective after five minutes at initial setting, increase oxygen flow to increase CPAP. Maximum level of 10 cm H₂ O is obtained at 25 L/minute flow rate.
- B** 11. Reassess the patient for hemodynamic stability.
- B** 12. Continuously monitor patient throughout transport.
- B** 13. Return to appropriate treatment protocol.
- P** 14. Albuterol and or Atrovent can be nebulized through the Boussignac.

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25 L/minute flow rate will deplete a full D cylinder in 14 minutes.

25 L/ minute flow rate wil deplete a full E cylinder(in 23 minutes.

If the Boussignac unit is used, the oxygen tank for the ambulance must be assessed before another run is made to assure adequate oxygen on board.



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Procedure: D-135	Procedure: Drug Administration – Intranasal Atomization	
Page 1 of 1	Effective: November 4, 2008	Expiration: March 31, 2010

Indication

Indications per referring treatment protocol.

- P** 1. Always use universal precautions.
Always inquire about medication allergies.
- P** 2. Select ordered medication, and inspect the medication for the following:
 - Tampering
 - Color & Clarity
 - Expiration Date
- P** 3. Attach an 18 – 25 gauge needle (3/4") to a 3 mL syringe, and draw up appropriate dose.
Expel all air from syringe.
- P** 5. Remove needle and place in sharps protected container
- P** 6. Attach the atomizer nozzle to the syringe.
- P** 7. Place the atomizer to the nostril and inject 1 mL per nostril.
Brisk injection is required to atomize the volume correctly.
If another mL of drug needs to be atomized repeat procedure in second nostril
- P** 8. Dispose of atomizer and syringe in appropriate container.
- P** 11. Document the time/route.volume of drug delivery.
- P** 12. Monitor the patient for possible medication reaction.
- P** 13. Return to appropriate treatment protocol.



Figure 1: Brisk delivery for proper atomization of drug

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Procedure: D-165	Procedure: EZ-IO® Intraosseous Infusion Therapy	
Page 1 of 1	Effective Date: November 1, 2007	Expiration Date: November 1, 2009

Indications

Cardiac and/or respiratory arrest.
Unstable patient requiring immediate fluids or medications
After two (2) unsuccessful attempts at peripheral venous access, or if access is delayed by 60 seconds.

Contraindications

Fracture in bone selected for IO, Infection at the insertion site, excessive tissue at site.
Joint surgery in the bone selected (look for overlying surgical scar)

Equipment

- EZ IO AD® or PD® needle set with EZ connect and wristband
- Towel roll, gauze, tape to stabilize after insertion
- Alcohol wipes.
- 10 mL syringe.
- IV set up, including IV solution and tubing.
- Cardiac Lidocaine (preservative free) for conscious patients

P

1. Prepare insertion site with aseptic technique
2. Prepare EZ IO® driver and appropriate needle set
3. Prepare the EZ-Connect® by flushing with saline
4. Stabilize the site and insert the needle
5. Stabilize the hub and remove the driver
6. Remove stylette from the needle set while stabilizing the hub
7. Place stylette in the shuttle or sharps container
8. Confirm placement
9. Attach the primed EZ-Connect®
10. If conscious and NOT in heart block, give Lidocaine:
Pediatric dose is 0.5 mg/kg of 2% preservative free Lidocaine
Adult dose is 40 mg of 2% preservative free Lidocaine
11. Connect syringe to the EZ-Connect® and flush with the correct bolus
Pedi flush 5 ml normal saline as a bolus
Adult flush 10 ml of normal saline as a bolus
12. Attach Normal Saline and deliver indicated fluid bolus and any other medications indicated per standing delegated orders. Deliver fluids with pressure bag or pressure cuff on 0.9% NaCl bag, or syringe bolus as indicated
13. Dress site and secure EZ-Connect tubing. Apply wristband indicating time and date the IO was established
14. Monitor EZ IO® site and patient condition
15. Remove catheter within 24 hours



Fig 1 Pediatric IO



Fig 2 Adult IO



Fig 3 Proximal Tibia Site



Fig 4 Connect EZ-Connect®



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Procedure: D-230	Procedure: Quick Trach®	
Page 1 of 1	Effective Date: March 24, 2008	Expiration Date: March 31, 2010

Indication

Airway control in patients with maxillofacial trauma with upper airway obstruction.
When endotracheal intubation and Combitube® fail.
Immediate relief in upper airway obstruction.



- P3** 1. Preoxygenate the patient with a BVM and high flow oxygen.
- P3** 2. As with intubation, have all necessary supplies ready, including suction.
- P3** 3. Preoxygenate the patient with a BVM if possible.
- P3** 4. Locate the cricothyroid membrane, between the cricoid & thyroid cartilages.
- P3** 5. Clean the proposed procedure area with alcohol or betadine (preferred).
- P3** 6. Inspect Quick Trach® kit for all required components.
- P3** 7. If spinal injury is unlikely, or no mechanism of spinal injury exists:
Support the patient's neck with a towel roll, if available.
- P3** 8. Insert the Quick Trach® needle through cricothyroid membrane at 45° angle to skin.
The needle should point towards the patient's feet.
- P3** 9. The needle should be inserted to the white plastic stopper.
- P3** 10. Once you get free air return in the syringe, stabilize the hub and remove syringe.
- P3** 11. Detach the white plastic stopper and advance remaining portion of hub.
- P3** 12. Secure hub with the strap provided. Fasten loosely around the patient's neck.
- 13. Continue with referring protocol.

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Protocol: E-70	Protocol Name: Diazepam (Valium)	
Page 1 of 1	Effective Date: January 1, 2008	Expiration Date: January 1, 2010

Description
Depresses the central nervous system at the limbic and subcortical levels of the brain. As an anticonvulsant suppresses the spread of seizure activity produced by epileptogenic foci in the cortex, thalamus, and limbic structures.

Indications
Status epilepticus and acute anxiety.

Contraindications
Patients under the influence of a sedative or alcohol, or hypotensive.

Precautions
Reduce dosage for patients over 70 years of age. May cause hypotension, confusion, stupor, cardiac arrest, or dizziness. Caution should be taken with patients that have consumed alcohol as Diazepam is well known to cause respiratory depression in these patients.

Dosage
Adults: 2-5 mg. slow IV or IM for patients in status epilepticus or acute anxiety.
Pediatrics: 0.2 mg/kg slow IV or IM to maximum of 5 mg, or 0.4 mg/kg rectal with maximum dose of 10 mg titrated to seizure activity in pediatrics.

Route
Intravenous, intramuscular.

How Supplied
10 mg preload syringe or ampule.
May carry as vial or ampule .



Length/Weight Tape	Weight	Diazepam IV
Gray	3-4-5 kg	0.6-0.8- 1 mg
Pink	6-7 kg	1.3 mg
Red	8-9 kg	1.7 mg
Purple	10-11 kg	2 mg
Yellow	12-14 kg	2.6 mg
White	15-18 kg	3.3 mg
Blue	19-22 kg	4.2 mg
Orange	24-28 kg	5.3 mg
Green	30-36 kg	6.6 mg