

2012

Wyoming EMS Best Practices

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Wyoming Office of Emergency Medical Services
“Best Practice”
Guidelines

INTRODUCTION

These “Best Practice” Guidelines are provided by the State of Wyoming, Office of Emergency Medical Services (OEMS). They are endorsed by the Wyoming Physician Task Force on Emergency Medical Services and are designed to be used by Emergency Medical Services and their Physician Medical Directors in determining a standard of care for patients. They are not a “stand-alone” document, but rather should be used in conjunction with the Rules and Regulations for “Wyoming Emergency Medical Services Act of 1977”, W.S. 33-36-101 (2008 Revision), appropriate curriculum, and other relevant documents from the Office of EMS.

General Operations

- 1) No EMT or paramedic should function as such without written documentation of competency in EMS Service Protocols by the Medical Director.
- 2) EMS agencies should have two documents:
 - 1) **Treatment Protocols** – contains standing orders and protocols for the treatment of any single patient, complaint or suspected condition
 - 2) **Operational Guidelines** – Addresses operational matters not included in protocols such as response area, staffing, resource management, transfers, weather, etc.
- 3) With rare exceptions, the EMS care of a patient terminates in one of two ways:
 - a) Transport to an emergency room
 - b) A properly executed form documenting refusal of treatment and transportation to include the signature of the patient acknowledging they understand the risks to their person if they refuse treatment and transportation, and a witness signature from an objective third party.
- 4) For each and every call, the first directives are scene safety and body substance isolation precautions.
- 5) The minimal equipment required for all patient calls:
 - a) When the patient is in close proximity to the vehicle: jump bag, cardiac monitor, and oxygen or other equipment as may be indicated by the nature of call.
 - b) When the patient is not in close proximity of the unit or vehicle: the above equipment, stretcher and any other equipment that may be needed as dictated by the nature of the call.
- 6) EMTs are expected to perform their duties in accordance with Wyoming statute, duly promulgated rules, and the standards of practice.
- 7) In potential crime scenes, any movement of the body, clothing, or immediate surroundings should be documented and the on scene law enforcement officer notified of such.

- 8) Although protocols and standing orders generally have a numerical or linear order, it may be necessary to change the sequence order or even omit a procedure due to patient condition, the availability of assistance, or equipment. Any deviations from protocols or standing orders should be documented.

General Care of Any Patient

- 1) A complete patient assessment, vital signs, treatments and continued patient evaluation are to be initiated immediately upon contact with patient and continued until patient care is transferred to a higher level of medical care. Refer to Patient Assessment Flow Chart on page 6.
- 2) The initial blood pressure MUST be taken manually. If subsequent blood pressures taken by machine vary more than 15 points in the systolic pressure, then the machine reading should be verified by a manual blood pressure.
- 3) Treat the patient not the monitor.
- 4) The on-going assessment times are considered:
 - a) High Priority Acute Patients - Every 5 minutes or less
 - b) Low Priority Non-acute Patients - Every 15 minutes or less
- 3) It is the responsibility of the EMT to ensure transmission of all aspects of the patient assessment and care to the receiving facility.
- 4) The attending EMT has the ultimate responsibility to ensure that all records and reports are properly completed.
- 5) For any drug administration or procedures not included in the agencies protocols or standing orders, the provider must receive authorization from Medical Control.
- 6) EMS providers that are enroute to a scene are not authorized to issue medication orders.
- 7) When reporting a disposition to Medical Control or another responding unit, provide the following minimum information:
 - a) Patient's age and chief complaint.
 - b) Is patient stable (define) or unstable (define), including complete vital signs and Level-of-Consciousness
 - c) Interventions performed.
 - d) Provide other information as requested.
- 8) Upon arrival at the receiving hospital, all treatment(s) initiated in the field will be continued until patient care has been assumed by hospital personnel.

Care of the Trauma Patient

- 1) EMS should have scene times no longer than 10 minutes with patients that are identified as an emergent trauma patient. If the scene time is delayed for greater than 10 minutes (for example, an extrication) documentation should reflect the reason for the delay.
- 2) Delaying transport on an emergent trauma patient to initiate IV therapy is not an acceptable practice.

- 3) Use of Pneumatic Anti-Shock Device (PASG):
 - a) The chance of patient's survival without the use of the PASG device should be evaluated prior to utilizing the PASG device. Orders must be received from Medical Control prior to inflation when used in the treatment of hypovolemia. The use of PASG should be considered if the systolic pressure falls to 50 mmHg.
 - b) The use of the PASG as an air splint is based on the current DOT curriculum and may be used at the discretion of the EMT responsible for patient care.
 - c) Other treatments will be based on the mechanism of injury and signs and symptoms of the patient.

Care of Patients with Altered Mental Status

- 1) Normal blood sugar values are 60 – 120 mg/dL
- 2) Blood Glucose and Stroke Screening should be performed on all patients with altered mental status
- 3) If glucometer readings are greater than 40 mg/dL, the patient is asymptomatic, and is able to protect his airway, it is acceptable to attempt to treat by administering oral glucose. If a glucometer reading is less than 80 mg/dL and patient is symptomatic, start an IV NS and administer 25 grams of Dextrose 50%.
- 4) Any administration of Dextrose must be done thru an IV line, not INTs.

Management of Cardiac Arrest

- 1) In the adult cardiac arrest:
 - a) All IV/IO drugs given are to be followed by a 10 cc NS bolus
 - b) Elevate the extremity after bolus when given IV
 - c) CPR is most effective when done continuously, with minimum interruption
 - d) Consider non tracheal airway maneuvers whenever endotracheal intubation takes longer than 30 seconds.
- 2) In the pediatric cardiac arrest, all IV/IO drugs given should be followed by a bolus of at least 5 ml and elevation of the extremity.
- 3) Defibrillation and synchronized cardioversion joules are based on the use of biphasic monitor/defibrillator.
- 4) In the case of cardiac arrest where venous access is not readily available, the use of an intra-osseous route is acceptable.

Management of the Airway

- 1) Airway maintenance appropriate for the patient's condition indicates any airway maneuver, adjunct, or insertions of tubes that provides and maintains a patent airway.
- 2) Pulse oximetry should be utilized for all patients complaining of respiratory distress or chest pain (regardless of source).

- 3) Esophageal Intubation detectors and End Tidal CO₂ or capnography should be used for all intubations except double-lumen airways. Reliability may be limited in patients less than 20 kg. Use other methods to assist in confirmation.
- 4) The use of cervical collars post intubation (double lumen or ET) is recommended to reduce the chance of accidental extubation. This is in addition to the tube securing devices currently in use
- 5) Supportive care indicates any emotional and/or physical care including oxygen therapy, repositioning patient, comfort measures and patient family education.
- 6) All patients should be transported to the most appropriate facility according to the patient or family request or to the facility that has the level of care commensurate with the patient's condition. Certain medical emergencies may require transport to a facility with specialized capability.

IV Therapy

- 1) The patient condition must give some indication that the insertion of an IV or saline lock is warranted.
- 2) Continued attempts to establish an IV should be weighed against the relative needs of the patient.
- 3) Drug administration should be followed by a minimum of 10cc of fluid to flush the catheter.
- 4) IV and IO access should not be attempted in an injured extremity.
- 5) TKO (To Keep Open) indicates a flow rate of approximately 50 cc's per hour.
- 6) IVs will not be started in arms with shunts.
- 7) A bolus of fluid is 20cc/kg for all patients.
- 8) For external jugular IVs attempted by paramedics in adult patients, IV catheters should be 18 gauge or larger diameter based on the patient.

Suggested Algorithm for Patient Management.

