

2025 Edition



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## Appendix

OFFICE OF MEDICAL DIRECTION

# ADMINISTRATIVE POLICIES



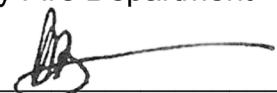


# Introduction

## Authorization

1. The Clinical Care Guidelines (referred to as CCGs going forward in this document) were developed and circulated under the authorization of the below-signed Medical Director for Polk County per Florida Statute 401 and Florida Administrative Code (FAC) 64-J.
2. The information contained within this document is intended to provide and ensure uniform treatment for all patients who receive pre-hospital care by approved Polk County Agencies. These guidelines apply exclusively to the present and future ALS and BLS agencies responding to the activation of the 911 system within Polk County working under the Medical Director. While attempts have been made to cover all patients who access our system, the Medical Director realizes that unforeseen scenarios or situations arise. It is suggested that for those instances, medical personnel will follow the Initial Care Medical/Trauma Guideline or other appropriate guidelines, exercise their best judgment, and contact the Medical Control (hospital-based or designee of the Medical Director) should any questions or problems arise. We aim to provide care when necessary, relieve pain and suffering, and do no harm. The patient's best interest should be the final determinant for all decisions.
3. The CCGs contain the following sections.
  - a. Administrative Policies
  - b. Clinical Care Guidelines
4. Changes in these guidelines can only be made and disseminated by the Medical Director for Polk County. The use or duplications of this document require the written consent of the Office of Medical Direction.
5. The following agencies have agreed to abide by the contents of these CCGs.
  - a. Auburndale Fire Department
  - b. Dundee Fire Department
  - c. Haines City Fire Department
  - d. Lakeland Fire Department
  - e. Bartow Fire Department
  - f. Fort Meade Fire Department
  - g. Lake Alfred Fire Department
  - h. Winter Haven Fire Department
  - i. Davenport Fire Department
  - j. Frostproof Fire Department
  - k. Lake Wales Fire Department
  - l. Polk County Fire Department

6. Approved by:



Pushpal R. Banerjee, D.O.

Medical Director



# Introduction

## Purpose and Rationale

1. The CCG document is written as a treatment parameter for patient care management. The Paramedic and EMT are given the authority through these guidelines to function under the license and approval of the Medical Director. These guidelines intend to facilitate the rapid dispersal of adequate and acceptable measures to stabilize the afflicted and ensure safe and comfortable delivery to an appropriate receiving facility.
2. These guidelines shall not circumvent the need to establish radio contact with Medical Control but will provide a means to initiate care promptly. They are used only when the Paramedic or EMT is on duty and is acting as a duly authorized representative of their particular agency under the direction of the Medical Director of Polk County.
3. Modification
  - a. Modifying these guidelines may be required, and such changes will be dictated by patient assessment to customize the most appropriate treatment for each patient. These modifications will be done in conjunction with Medical Control. Personnel are encouraged to make early and frequent contact with Medical Control whenever doubt exists as to the proper management of any individual patient.
  - b. Medical Control is defined as: PCFR Medical Director, associates, and designated supervisors with paramedic credentials or a physician at the receiving facility where the patient is being transported to.
4. Authority
  - a. Polk County Fire Rescue is charged with the presumption of ultimate responsibility and thus maintains control of all aspects of patient care, including treatment and transport destination decisions. Unless negligent in nature, which will be handled by Medical Control, discrepancies between the transporting Paramedic and the non-transporting Paramedic will be awarded to the transporting Paramedic or officer, if necessary, a PCFR Battalion Chief may be contacted for resolution. The non-transport Paramedic will be allowed to assist in the continuation of patient care under the transporting Paramedic discretion during transport, but at no time will there be more than three people (PCFR, First Responder, LEO, intern, etc.) in the back of the ambulance during transport due to safety concerns. Any conflicts regarding patient care between transporting and non-transporting Paramedics will be reported immediately to each respective supervisory officer.



# Introduction

## Treatment Guidelines

1. These guidelines are designed to rely heavily on the training and good judgment of the individual using them. Appendices are provided for reference and are considered a part of the Polk County Fire Rescue (PCFR) clinical care guidelines. Several guidelines are divided between the care and treatment of the stable patient versus the unstable patient. Most of which revolve around the treatment of tachy arrhythmias and brady arrhythmias. As a matter of general definition, the unstable patient is one who presents with at least one of the following:
  - a. Acute altered mental status
  - b. Mean arterial pressure (MAP) of <70
  - c. Symptoms of shock



## General Measures

The following general measures shall be applied to help promote speed and efficiency when rendering emergency medical care to the sick and injured. These measures provide general parameters for pre-hospital emergency care delivery in Polk County.

### Life Safety

The overall safety of personnel is paramount to quality patient care.

1. Vehicle Operation Safety: all crews are expected to use knowledge, foresight, and judgment at all times while operating an emergency vehicle. This is vital to the response, care, and delivery of the patient to an appropriate facility. Patients should be prioritized in such a manner as to send the most appropriate resource(s) in the most appropriate manner, whether emergency or non-emergency, based upon initial dispatch information.
2. Scene Safety: each scene should be properly evaluated for hazardous materials, fire, violent patients, etc. The scene should be secured by appropriate agencies prior to arrival and before patient contact, if possible.
3. Body Substance Isolation (BSI): proper personal protective equipment (PPE) must be utilized according to Exposure Control Plan Policies.
4. Medical Equipment: Utilize only medical equipment/supplies approved by the Medical Director for patient care. New equipment/supplies may be field-tested (with specific parameters) but only after evaluation and approval by the Medical Director.

### Incident Management

1. Resources: assess the need for additional support and request appropriate resources as necessary. Additional resources should be requested to the scene as early as possible and response mode prioritized by the on-scene incident commander.
2. Mass Casualty: The goal is to rapidly identify patient's injuries and sort them according to their severity and need for treatment. Refer to Triage System Administrative Policy for specific details. Mutual aid from out of county agencies: PCFR Battalion Chief or Administrative Staff must approve all requests for mutual aid transport.
3. Incident Command: A dynamic organizational structure that expands and contracts as needed to manage an event. Every effort will be utilized to follow the incident command structure.
4. Mutual Aid: In case of out of county mutual aid response, PCFR personnel are directed to utilize the PCFR Clinical Care Guidelines for all facets of pre-hospital medical care.



# General Measures

## Patient Care

1. Informed Consent: Always attempt to obtain informed consent before treatment. Respect the patient's right to privacy and dignity. Courtesy, concern, and common sense will ensure the patient receives the best possible care.
2. Rapid Initial Assessment: A Paramedic should generally be able to decide within 3 minutes after patient contact if Advanced Life Support (ALS) will be needed and should be instituted simultaneously with the initial assessment.
  - a. Rapid stabilization should, in most cases, be done on the scene (where the patient is encountered) before movement from the scene to the unit. This includes any airway maintenance and or bleeding control that needs to be addressed.
  - b. A complete set of vitals are to be obtained within the first five (5) minutes of patient contact (to include pulse, blood pressure, pulse oximetry, and respiratory rate). Any delays will be documented in ePCR. Using the first responding unit's vitals can satisfy this five-minute goal.
  - c. A comprehensive exam is appropriate after the patient has been stabilized.
3. Assessment and Care: The assessment and initial therapy (including IV insertion(s)) should be completed within the first 15 minutes after patient contact. Except for extensive extrication or other significantly atypical situations, the patient should be en route to a receiving facility within this time frame. Additional treatment, if indicated, should be continued during transport.
4. Care Level: The Paramedic is ultimately responsible for all patient care and will perform an assessment on all patients to determine their level of care.
  - a. Advanced Life Support (ALS): The Paramedic is required to attend to all patients deemed ALS in the patient compartment during transport. As a general rule, an ALS patient is defined as one who portrays signs/symptoms that fit into one or more of the chief complaints as outlined in the guidelines. Patients who have a pre-hospital intravenous line are not considered BLS patients, regardless of the complaint, and must be tended to by a Paramedic.
  - b. Basic Life Support (BLS): The transport Paramedic may designate an EMT to attend BLS patients, but remains ultimately responsible for patient care. The EMT must document on the run report that the Paramedic, stating name and credentials, initially assessed the BLS patient. An EMT may tend to patients with a non-prehospital Heparin-Lock or Saline-Lock (for example, BLS Transfer from hospital) provided the patient's chief complaint or diagnosis is not ALS in nature. Other examples include isolated upper extremity injury/closed fracture, c-spine precaution/chronic back pain from traumatic injury/general ground-level fall, generalized fever after r/o of possible sepsis, etc.

**Common sense plays a large role in these situations.**



## General Measures

- c. Refusal of Transport: All patients who receive treatment are to be transported by appropriate means to an appropriate receiving facility for further evaluation. If the patient refuses transport, refer to the REFUSAL OF TREATMENT/TRANSPORT ADMINISTRATIVE POLICY.
- d. Personnel with Paramedic Privileges: These are those who have successfully completed all required training and have been authorized by the Medical Director and the Office of Medical Direction to operate as a Paramedic.
- 5. Medication Dosing for Medical Patients: Patients over 13 years of age will be considered Adults for medication dosing purposes. For patients 13 and younger, the HandTevy app will be used to direct medication dosing.

### Initial Medical/Trauma Care

The following is required for each patient encounter.

- 1. Obtain a full set of vitals to include
  - a. Heart rate
  - b. Respiratory rate
  - c. SpO<sub>2</sub>
  - d. Capnography (if indicated)
  - e. Blood pressure
- 2. Assess GCS/AVPU
- 3. Provide airway assistance/oxygen therapy as needed
  - a. If patient's GCS is <8 active airway assistance is required beginning with an OPA.
- 4. If patient is deemed ALS
  - a. Place patient on 4-lead
  - b. Obtain 12-lead
- 5. Proceed on to the appropriate guideline
- 6. If the complaint is trauma related provide bleeding control and proceed to the appropriate guideline.



# Hospital Pre-arrival Report

## General Information

1. A pre-arrival report should be conducted for the stable patient a minimum of five (5) minutes before arriving at the hospital and ten minutes (10) for the unstable.
2. Alerts (trauma, stroke, STEMI, etc.) should be provided as soon as the patient's alert status is determined. Most often, taking place at the patient's side on scenes. This will allow the receiving hospital time to gather the staff and equipment to care for the patient.
3. The purpose of the pre-arrival report is to provide the hospital with a synopsis of pertinent information before your arrival. This information should include:
  - Agency and unit number
  - Patient age, sex, GCS, weight
  - Chief complaint
  - Vitals Signs
    - Blood pressure
    - Heart rate
    - Respiration
    - BGL
  - Temperature
  - ECG interpretation
    - For cardiac alerts and STEMI alerts, 12-lead transmission to the receiving facility is required
  - Treatment initiated
  - Estimated time of arrival (ETA)
4. Physician's Order—When contacting the ER for a physician order, all of the above information should be relayed to the hospital along with the request. Once an order is given, confirm it and obtain the physician's name to be documented in ePCR.



# Documentation

## Requirements

- A. Documentation is an essential part of all prehospital medical care. It must include, but not be limited to, documentation of the event or incident, medical condition, treatment provided, and the patient's medical history. The primary purpose of the Patient Care Report (ePCR) is to document all care and pertinent patient information and serve as a data collection tool for continuous quality improvement.
- B. The documentation in the e-PCR provides vital information necessary for continued care at the hospital. As part of transferring the patient to the Emergency Department Staff, the agency must provide an appropriate medical record that includes the demographics, event/incident, assessment findings, and treatment details upon delivery of the patient.
- C. An e-PCR will be completed each time a transport or non-transport unit is dispatched for any response type. This includes, but is not limited to:
  1. Patients transported to any location
  2. Patients who refuse care and/or transport
  3. Patients treated by one agency and transported by another
  4. Calls where no patient contact is made
  5. Calls were canceled before reaching the scene
  6. Calls where no patient is located
  7. When dispatched for a special event standby
- D. All patient interactions require a complete and thorough patient care report, which must be completed and exported as soon as possible and no later than the end of the employee's shift. Polk County Fire Rescue uses the CHART method of patient documentation.
  1. Required Sections of Information
    - a. **Chart**
    - b. **History**
    - c. **Assessment**
    - d. **Rx (Treatments)**
    - e. **Transport**



# Documentation

## ePCRs

- Failure to leave patient information with the emergency department upon the delivery of the patient may compromise medical treatment and interrupt the continuity of patient care.
- All electronic patient care reports should be completed and closed before the end of the shift during which the patient was treated. There should be no access to patient records on personally owned computers or removable data devices (i.e., USB).
- Employees are not allowed to use personally owned computers for the creation, completion, or storing of any patient information or ePCR's.

## HIPAA

Maintaining confidentiality is an essential part of all health care, including prehospital care. The confidentiality of protected health information (PHI) is covered by numerous state and federal statutes, Policies, Rules, and Regulations, including the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

## Patient Definition

The medical director considers all individuals meeting the above criteria patients. These criteria are intended to be considered in the broadest sense. If there are any questions or doubts, the individual should be considered a patient.

1. Has a complaint suggestive of potential illness or injury
2. Request evaluation for potential illness or injury
3. Has obvious evidence of illness or injury
4. Has experienced an acute event that could reasonably lead to illness or injury
5. Request 911 assistance (i.e. lift assist)



## End of Life

It is the goal of emergency responders to provide the best possible care to all patients who are in need of service. For those patients who are found in cardiopulmonary arrest, the Paramedic should examine the circumstances surrounding the event and take appropriate action as determined by the situations listed below. If End of Life is determined, further supportive care should be given to the family on the scene, so they are better able to cope with this event. Assistance might include, but not be limited to, notification of the patient's physician, Hospice, and funeral home. Patients who deteriorate into cardiopulmonary arrest in the presence of rescue personnel, or for who cardiopulmonary resuscitation is in progress prior to the arrival of rescue personnel, will receive cardiopulmonary resuscitation.

### **Discontinue Cardio Pulmonary Resuscitation when**

- Effective spontaneous ventilation and circulation have been restored
- Resuscitation efforts have been transferred to person of equal or higher skill level than the providers.

### **Cardiopulmonary resuscitation may be terminated in non-hypothermic adults provided all the following criteria have been met**

- Patient must be inside the residence and not outside or in a public location (example restaurant, park, bank) or in Law Enforcement custody (example jail and/or prison).
- Patient must not meet the definition of Unexpected Death or Medical Examiner Case.
- Provided history suggests lengthened "downtime".
- If "downtime" is unknown and the patient does not meet Obvious Death, CPR, and transportation
- must be continued.
- The patient was initially found in asystole on two or more leads (any rhythms changes must be worked to the hospital).
- Airway secured (iGel supraglottic airway or ETT) and confirmed by Capnography, and ETCO<sub>2</sub> is less than or equal to 10 consistently for twenty (20) minutes.
- At least two rounds of Epinephrine have been administered. If there is no response to the above treatments after a minimum of twenty (20) minutes, the Paramedic may elect to discontinue resuscitative efforts without a physician's order provided all EMTs and Paramedics on the scene agree, otherwise, resuscitative efforts will continue, and the patient is to be transported to the closest IRF.
- If there are any deviations from the above criteria, the cessation of resuscitation must be made in conjunction with Medical Control.
- If in doubt, continue all resuscitative efforts.



## End of Life

**For Obvious Death, cardiopulmonary resuscitation may be withheld provided all of the following criteria are met:**

- Pulseless, apneic, no other signs of life, **and**
- Not exposed to an environment likely to produce hypothermia **and**
- The presence of one or more of the following
  - Rigor Mortis (generally starts after 2 hours of death)
  - Decomposition of body tissues (greater than 24 hours depending on a wide variety of individual and environmental conditions)
- Dependent lividity (may present after 20 minutes)
- Incineration
- Evidence of massive blunt or penetrating head or torso trauma, including decapitation (details of the events, the mechanism of injury, scene, and patient assessment must be completely documented)

**Cardiopulmonary resuscitation may be withheld or withdrawn from a patient:**

- When presented with a State of Florida DNR form or State of Florida Yellow DNR device, which is a miniature copy of the DNR form. Note- this form does not expire.
  - The form must be properly completed, including a physician's signature.
  - This form shall be printed on yellow paper. A copy of this form may be made so long as EMS staff has witnessed the validity of the yellow original.
- When presented with a DNR written by a physician (who is verifiable licensed in the State of Florida). Note- these forms expire 30 days from the day it is written and are generally created in a hospital.
- When a physician is on the scene (who is verifiable licensed in the State of Florida) and is willing to write a DNR, the physician must provide a rationale for the DNR and state their relationship to the patient. This information must be recorded in the ePCR and the physician's signature. Remember: a living will is not equal to a DNR.

The DNR form or legal copy shall accompany the patient during each transport. A DNR may be revoked at any time. The revocation may be in writing, by physical destruction, by failure to present the DNR form, or by orally expressing a contrary intent. The DNR may be revoked by:

- A. The patient (if signed by the patient)
- B. The patient's healthcare surrogate
- C. The patient's proxy, court-appointed guardian, or Power of Attorney



## End of Life

Even with a DNR form, the patient shall be provided medically indicated care, comfort, or pain relief (for example, oxygen administration, CPAP, etc.)

Unless the patient is in respiratory or cardiac arrest

<b>Palliative Care parameters for the period prior to respiratory arrest and patient has DNR, as noted above.</b>
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SpO2%	Respiratory Rate	ETCO2	Intervention
90-95%	>9	<35	NC or NRB
80-89%	7-8	<30	BVM
<76%	<6	<25	Intubate

All criteria must be met to intubate. Intubation of the patient should be based on the most unstable clinical signs.

### Documentation Requirements

- Document original body position and location
- ePCR will include all patient information, patient assessment, any treatments performed, DNR noted (if any), events leading up to 911, what physician was contacted and time (if any), name of funeral home body was turned over to (if any) and/or document if body was turned over to PCSO/Medical Examiners Office.

**Disposable supplies will be left in place (example EKG electrodes, airway devices)**

The purpose of this policy is to establish guidelines for how members of PCFR shall handle End of Life issues. PCFR personnel are not trained, equipped, or authorized by law to investigate or determine the cause or manner of death. Any death considered an Unexpected Death (apparent unnatural cause); requires the involvement of the Medical Examiner's Office; has suspicious surroundings or events, or occurs outside or in public, or does not fall under the Expected Death (apparent natural causes) will be turned over to Law Enforcement for investigation.



# End of Life

## Definitions

### **Unexpected Deaths (apparent unnatural causes)**

Law Enforcement will be contacted immediately and assume responsibility of the scene for the deceased falling under the following circumstances:

- Any death that resulted from trauma.
- Any death where unusual or suspicious circumstances exist (signs of suicide, criminal activity, apparent overdose, or body in a state of decomposition).
- Age is not consistent with death and/or death is absent of expected or known terminal or chronic disease process.
- Body is in public, outside or not in their primary residence.
  - In case of law enforcement request to transport an "obvious death", PCFR will transport the patient to the nearest appropriate hospital (not a free-standing)
- Statements of family members/bystanders/associates of the deceased that suggest the death was unsuspected or unnatural.
- Any Medical Examiner Case (see definition).

### **Expected Deaths (apparent natural causes)**

When a death occurred by apparent natural causes and was expected either by family or extensive medical conditions or advanced age, Law Enforcement will not be called or expected to take over an Expected Death (apparent natural causes) scene under the following circumstances:

- The deceased is in a nursing home or assisted living facility
- The Deceased is under Hospice Care
- The deceased is in their primary residence and not outside or in public

### **Medical Examiner Case (must be turned over to Law Enforcement)**

These deaths are required to be investigated by the District Medical Examiner. Examples include any death: of criminal violence, by accident, by suicide, suddenly, when in apparent good health, unattended by practicing physician (see definition), in any prison or penal institution, in police custody, in any suspicious or unusual circumstance, by criminal abortion, by poison, by disease constituting a threat to public safety, by disease, injury, or toxic agent resulting from employment, when a dead body is brought into the State of Florida without proper medical certification, when the body is to be cremated, dissected, or buried at sea. Patients who have not been under the care of a practicing physician or provided prescriptions by a practicing physician for a period greater than one year will also be turned over to the Medical Examiner.



# End of Life

## Procedures

### Arrival on the scene:

- If bystanders or family members are on scene, obtain information regarding:
  - Was the death witnessed? If so, by who?
  - Does anyone present know the deceased (family, friends)?
  - If so, try to obtain contact information.
  - Survey the scene and note anything that appears unusual or suspicious
- If no one is on the scene, determine if the structure is secure.
  - Ascertain if access to the structure is available.
  - Remember, if doors/windows are locked, PCFR personnel may force entry as necessary. Always look for the access point that will cause the least damage to the structure. Be sure to check for unlocked doors and windows before forcing entry.
  - Look for contact information for an alarm company, usually found on the door or windows.
  - If an aggressive dog is present, request Animal Control.

### Once entry is made, survey the scene to determine:

- Does anything appear unusual or suspicious (evidence of a crime, forced entry struggle, trauma, an apparent suicide, indication of overdose, illegal drugs, or paraphernalia are in plain view)? If so, immediately request Law Enforcement. If prescription medications are present, they are to be documented in the ePCR. The medication(s) should be left at the scene. If any unusually high number of pills appear to be missing, turn the scene over to Law Enforcement under a suspicious death.

### Unexpected Deaths (apparent unnatural causes):

- If the body is found under either circumstances listed in the Unexpected Deaths (apparent unnatural causes) or Medical Examiner Cases, immediately notify and turn the scene over to Law Enforcement.
- PCFR members shall remain on the scene and make every reasonable effort to secure the potential crime scene until Law Enforcement's arrival.

### Expected Deaths (apparent natural causes):

- The Paramedic will make attempt(s) to contact the deceased's personal physician or Hospice coordinator (if applicable). Discuss with the physician the events surrounding the death and ask the physician if he/she will sign the death certificate. If the physician agrees to sign the death certificate, inform and assist the next of kin with contacting their desired funeral home. If next of kin is not present or is unable to select a funeral home, use the rotational funeral home provided by the ECC (863)401-2222.



## End of Life

- If unable to contact the personal physician, or the personal physician refuses to sign the death certificate, or is not a State of Florida Licensed Physician:
  - If the family has chosen a funeral home, ensure they will pick up the body without an immediate physician's signature
  - If the family has no choice of the funeral home, contact local funeral homes. they will pick up the body
  - If, after all attempts to have a physician sign the death certificate and/or the funeral home continues to refuse to pick up the body, contact the Medical Examiner's office (863) 298-4600 and request assistance/direction for a funeral home to pick up the body. Contact the desired funeral home and advise the Medical Examiner's office has directed the body to be removed.
- Contact the unit's supervisor and provide a briefing and ETA of body removal or other circumstances.
- Nursing homes and assisted living facilities are responsible for calling the physician and waiting on the funeral home services.
- A complete and thorough ePCR is required, including all demographics and patient assessment. Always document the physician's name who agreed to sign death certificates.

### **Emergency units return to service:**

- It is imperative that transport units are returned to service as soon as possible.
- Notify the unit's supervisor of the circumstances.
- The non-transport unit will stay on the scene awaiting the arrival of the funeral home or next of kin or to provide comfort to the family. The engine will be available for emergency calls.
- Emergency responders should make every effort to remain on scene to assist the family until relieved by the funeral home, removal service, or Hospice representative.
- If dispatched to an emergency call, an engine staffed with three members should leave one member on the scene and respond to the emergency.
- An engine staffed with only two members may remain on scene until the arrival of a supervisor, next of kin, or the funeral home. Two member engines should contact a supervisor as soon as possible to inform them of the situation. The Chief Officer can contact Law Enforcement and request that an Officer/Deputy be dispatched to allow the engine to respond to the reported emergency.



## End of Life

- Municipal Law Enforcement agencies may have different protocols or procedures regarding responses to Expected Death (apparent natural causes). If a municipal Law Enforcement agency is willing to assume responsibility for the incident, transport/non-transport units will relinquish the scene if no further assistance is needed:
- If Polk County Sheriff Office arrives on the scene first-they will be responsible for the scene and removal of the body.
- If a transport/non-transport unit arrives on the scene first, and the scene and the body falls under Expected Death (apparent natural causes) definition, the transport/non-transport unit will be responsible for the scene and removal of the body.

### **Securing the Structure:**

- In the event of an expected natural death (at home) and no family member is on the scene, after the body has been removed, lock all doors and windows and secure residence with keys left inside.



# Refusal of Care/Transport

***In all cases, patients presenting with an illness or injury should be approached with the intent to transport. The option of refusal of treatment and/or transport should be a last resort.***

## General

1. Any patient encountered, regardless of their transport status (i.e. going POV, in-custody of LEO), must have a history and physical exam completed; this includes at least one set of vital signs to rule out threats to life. Providers should attempt to obtain a history and physical in as much detail as the patient permits.
2. Pre-hospital clinicians cannot conduct a medical clearance for a patient refusing care or being in the custody of law enforcement. These patients should be encouraged to be transported to the emergency room for evaluation by a physician.
3. An NPU must be completed on every patient who refuses care/transport against medical advice.
4. The NPU will be completed by the first arriving ALS unit who established patient contact.

## Established Competency

Competency shall be defined as one who is all of the following:

1. 18 years of age or older.
2. Awake, alert, and fully oriented to person, place, time, and incident.
3. Has no signs of injury or illness that may impair the ability to make an informed decision, and is exhibiting no other signs or symptoms of potential mental incapacity, including drug or alcohol intoxication, unsteady gait, slurred speech, etc..
4. Has the mental capacity to understand and appreciate the nature and consequences of his/her condition and ability to make rational decisions.
5. Showing no current evidence of bizarre/psychotic thoughts and/or behavior or displaying behavior that is inconsistent with the circumstances of the situation.
6. Shows no current evidence of suicide ideation's, suicide attempts, or any indication that they may be a danger to themselves or others.

## Consent

With certain exceptions (see Implied Consent), all adult patients and select minor patients have a right to consent to medical evaluation and/or treatment. Two specific forms of consent apply to EMS: Informed and Substituted Consent.



## Refusal of Care/Transport

1. Informed Consent: Is more than a legality. It is a moral responsibility on the provider's part, based on recognizing the individual autonomy, dignity, and the present mental capacity for self-determination. With informed consent, the patient understands the risk(s) of any care provided, procedures performed, medications administered, and the consequences of refusing treatment and/or transport. They should also be aware of their options if they choose not to accept evaluation and/or treatment.
2. Substituted Consent: This is when another competent adult consents for the patient, as in minors, incapacitated patients, incarcerated patients, and those determined by courts to be legally incompetent. Parents or guardians are entitled to provide permission because they have the legal responsibility. In the absence of abuse or neglect, it is assumed they act in the child's best interest. However, there is a moral and ethical need to respect the rights and autonomy of every individual, regardless of age. If the patient is 16 years old, the driver of a vehicle, and not injured, the patient may sign a refusal form for themselves and any other non-injured minor family member involved. This pertains to family members only.
3. Implied Consent: if the patient is unconscious and seriously injured or in need of further medical attention, treat and transport the patient despite the patient's inability to consent or the unavailability of another party to provide consent.

### Who May Refuse Care

#### The Patient

1. If the patient is legally, mentally, and situationally competent (not under the influence of drugs or alcohol, or under custody of law enforcement), the patient has a right to refuse care. Obtain refusal signatures.

#### The Guardian

1. A legal guardian is one who is appointed by a court to act as "guardian of the person" of an individual who has been found by a court to be incapacitated.
2. A legally appointed durable power of attorney may refuse care on behalf of the patient if a power of attorney contains such authorization.
3. The legal guardian may also be appointed in lieu of parents for a minor. If a person indicates they are a legal guardian or durable power of attorney to the patient, attempt to obtain documentation of this fact (court order, etc.). In addition, attach to the ePCR. If no such documentation is available, you may obtain a refusal signature from the guardian as long as you do so in good faith and do not have any evidence or knowledge that the person is misrepresenting himself/herself as a legal guardian of the patient.



## Refusal of Care/Transport

### Minors

The following person(s) may consent or refuse the evaluation, treatment, and/or transportation of a minor:

1. Parent
2. Grandparent
3. Adult (>18) brother or sister
4. Adult (>18) aunt or uncle
5. Educational institution in which the child is enrolled that has received written authorization to consent/refuse from a person having the right to consent/refuse.
6. An adult with actual care, control, and possession of the child and/or has written authorization to consent/refuse from a person with the right to consent/refuse (I.E., daycare camps, soccer moms, carpools, etc.)
7. An adult who has actual care, control, and possession of a child under the jurisdiction of a juvenile court.
8. A court having jurisdiction over a suit affecting the parent-child relationship of which the child is the subject.
9. A peace officer who has lawfully taken custody of the minor if the peace officer has reasonable grounds to believe the minor needs immediate medical treatment.
10. A managing or possessory conservator or guardian.

A provider may be denied access to a minor by a parent or guardian if there is no obvious immediate life threat to the patient. However, in general, parents or guardians cannot refuse lifesaving therapy for a child based on religious or other grounds.

In certain circumstances, a patient under 18 with the legal competence (emancipated) and present mental capacity to consent or refuse evaluation/treatment may do so. In such cases, the law states that a person under 18 years of age may consent to evaluation and/or treatment if the person:

- Is on active duty with the Armed Services of the United States of America.
- Is 16 years of age or older and resides separate and apart from their parents, managing conservator (an individual appointed by the court, usually during divorce proceedings, to have custody of a minor, to make decisions for the minor, and to make a home for the minor), or guardian, with or without the consent of the parents, managing conservator, or guardian regardless of the duration of the residence and managing their financial affairs, regardless of the source of the income.



## Refusal of Care/Transport

- Is consenting to diagnosing and treating an infectious, contagious, or communicable disease required by law or rule to be reported by the licensed physician or dentist to a local health officer or the Florida Department of Health.
- Is consenting to examination and treatment for drug or chemical addiction, drug or chemical dependency, or any other condition directly related to drug or chemical use.
- Is unmarried, pregnant, and consenting to evaluation and/or treatment related to the pregnancy.
- Is unmarried, is the parent of a child, and has actual custody of the child, consenting to the child's evaluation and/or treatment.

A pregnant minor must have adult consent unless she fits within one of the previously mentioned exceptions.

When treating minors, it is essential that there be an interactive process between them and the provider. The interaction should involve developmentally appropriate disclosure about the illness/injury, soliciting the minor's willingness and preferences regarding treatment and decision options. Although this interaction intends to involve the child in decisions, how the participation is framed is important. As with any patient, minors should be treated with respect.

**When a patient is refusing treatment or transport and fails to meet the above competency criteria, Law Enforcement, battalion Chiefs, and/or Medical Control must be actively consulted and participate in determining the outcome. Medical Control and/or Battalion Chiefs must be contacted before any patient is treated and/or transported against their will.**

### Patients in Law Enforcement Custody

1. FSS 901.29 and FSS 394.462 state that a patient cannot refuse treatment/transport if a law enforcement officer feels they require medical treatment.
2. FSS 843.21 states that law enforcement may not refuse treatment/transport to a patient who is requesting assistance.



# Refusal of Care/Transport

## Refusal of Treatment or Transport Against Medical Advice (AMA)

Life-threatening emergencies involve cases where the patient's condition or injury is deemed serious and/or may likely progress to a serious nature. A Battalion Chief must be notified and consulted before securing and accepting the refusal and terminating patient contact.

Life Threatening emergencies include, but are not limited to:

1. Head injury (based on mechanism or signs & symptoms)
  2. ACS patients with complaints of chest pain.
  3. Patients with S&S of CVA or TIA (absent findings upon patient contact)
  4. Patients experiencing shortness of breathing
  5. A Capnography reading of <32
  6. Pregnancy, regardless of gestation age
  7. Seizure activity
  8. Fever with suspicion of sepsis
  9. Presence of alcohol and/or drug intoxication(1)
  10. Significant mechanism of injury and/or trunk ecchymosis (e.g., rollover MVA)
  11. Altered level of consciousness or impaired judgment (2)
  12. Minors (17 years old or younger, regardless of injury)
  13. Situations that involve bypassing a closer hospital.
- 
1. Law enforcement will be called for any intoxicated patient refusing care/transport for possible Marchman Act enforcement.
  2. Implied consent should be considered for any patient experiencing ALOC or impaired judgment.

Life-threatening emergencies process

If the patient is deemed a life-threatening emergency where treatment is determined to be beneficial as prescribed in these protocols, the patient will be informed of the possible consequences of this withholding of care.

- Multiple attempts to treat and transport the patient should be made by the paramedic provider.
- Contact Dispatch and request the area Battalion Chief to contact you on the "talk around channel."
- Provide Battalion Chief with all pertinent information, including High-Risk refusal qualifier,
- patient condition, concerns, and reason for refusal.



## Refusal of Care/Transport

- The Battalion Chief may request to interact with the patient over the radio/apparatus cellphone
- and/or request additional assessment procedures be performed.
- The Battalion Chief may elect to arrive on the scene to assist the crew and interact with
- refusing patients, to encourage transport, and to act as witnesses to treatment and
- transportation attempts.
- Patients will be encouraged to call 911 again if the problem worsens or changes their mind.
- The Battalion Chief will ensure that the responder obtains all paperwork and signatures related to the refusal
- of care and transport of the patient and be an audible witness to the patient's AMA refusal.
- The paramedic provider will select the "refusal of medical care(High-Risk)" as Protocol 1 in the ePCR and select the Battalion Chief's Name.

The patient must sign the ePCR acknowledging their understanding of the decision and providing complete documentation of the care refused.

### Low-Risk Refusal

Low-Risk Refusal: involves cases where the patient's condition or injury is deemed minor and/or will not likely progress to a serious nature. Low-risk refusals do not require Battalion Chief consultation. Patients must have the legal and mental capacities of informed consent to understand the risk of refusal, which cannot be impaired.

**Contact the Battalion Chief if you have any concerns regarding a patient's ability to refuse treatment and transport.**

The patient must sign the ePCR acknowledging their understanding of the decision and providing complete documentation of the care refused.

Low-risk refusals may include:

1. Slow-speed auto collision without injury.
2. Isolated injuries unrelated to an auto accident or other significant mechanism of injury.
3. False calls or "third party" calls where no illness injury or mechanism of injury is apparent.
4. Lifting assistance or "public assist" calls (for which EMS/Fire is called for assistance in moving a patient from chair to bed, floor to bed, car to home, etc.) require a complete ePCR, which should include a refusal of care and/or transport.



# Refusal of Care/Transport

## Documentation Requirements for ALL refusals

1. If the competent patient refuses transport, a patient care report must be completed, including the patient's informed refusal signature. This will be done on all patients with an illness or injury who are refusing service, regardless of how the call was received (911 request, still alarm, third-party caller, etc.). If an incident occurred that prompted the 911 call and symptoms resolved before patient contact, an ePCR must still be written to document the incident and the patient's refusal of service.
2. Rejection or inability to sign refusal: If the patient (or parent or guardian) who is judged competent to refuse care refuses to sign the refusal form, the crew should be prompted to reassess the individual's competency. If the individual is still considered competent to refuse care, the refusal must be documented on the ePCR and preferably witnessed by Law Enforcement. The Battalion Chief must be involved and notified in determining this call.
  - a. Example: Agitated subject in the custody of LEO
3. If the patient (or parent or guardian) cannot sign refusal paperwork, such inability must be documented on the ePCR and witnessed by Law Enforcement. The battalion chief must be involved/ notified when determining this call.
  - a. Example: Quadriplegic patient and false alarm call.
4. The responsibility of completing the patient refusal will fall to the paramedic who obtained the refusal. If the patient refuses transport before the ambulance's arrival, the non-transport paramedic will obtain the refusal. However, if the patient refuses treatment or transport after the arrival of the ambulance, the transport paramedic will obtain the refusal. Please refer to your chain of command for any on-scene issues.

## Hypoglycemia Patient

There may be times when patients are refusing further treatment or transport after a corrected hypoglycemic episode. These patients will be allowed to refuse transportation if all of the following criteria are met:

- There is a documented low glucose reading pre-treatment and a normal glucose reading post-treatment.
- The patient is awake, alert, and oriented x 4 post-treatment (understands current situation)
- The patient will not operate any moving vehicle or equipment immediately after treatment.



## Refusal of Care/Transport

- There is a competent adult who will assume the responsibility of caring for the patient for the next 1-2 hours or no decrease in glucose reading (second regular reading) after 30 minutes.
- There are no other underlying medical or trauma conditions requiring treatment at the time of service.
- The patient is not taking the following medications - Sulfonylureas: Glucotrol, Glipizide, Glyburide, Diabeta, Glynase, Amaryl, and Glimepiride.



## Physician On Scene

**Occasions will arise when a physician on the scene desires to direct pre-hospital care. A standardized plan for dealing with these contingencies will optimize the care given to the patient.**

The physician desiring to assume care of the patient must:

1. Provide documentation of his status as a physician (M.D. or D.O.)
2. Be licensed to practice medicine in the State of Florida
3. Document his or her assumption of care on the patient care report (PCR)

Contact with Medical Control at the receiving facility must be established as soon as possible. The physician assuming responsibility at the scene should be placed in contact with the Medical Control Physician and acknowledgment of his or her acceptance of responsibility confirmed.

Orders provided by the physician assuming responsibility for the patient should be followed as long as they do not, in the judgment of the Paramedic, endanger the wellbeing of the patient. The Paramedic may request the physician to attend the patient during transport if the suggested treatment varies significantly from the guidelines.

If the physician's care is judged by the Paramedic to be potentially harmful to the patient, the Paramedic should:

1. Politely voice his or her objections
2. Immediately place the physician on the scene in contact with Medical Control for resolution of the problem.
3. When conflicts arise between the physician on the scene and Medical Control, rescue personnel should follow the directives of the Medical Control Physician. Offer no assistance in carrying out the order in question, but provide no resistance, to the physician performing this care. If the physician on the scene continues to carry out the order in question, offer no assistance, and enlist the aid of Law Enforcement.

All interactions with physicians on the scene must be completely documented in the patient care report (PCR)



## Controlled Substance

### Controlled Substance Inventory & Key Security

Controlled substance handling, dispensing, storing, ordering, and disposal are regulated by DEA Title 21, FS 499, FS 893, and FAC 64J. The Medical Director is responsible for establishing and enforcing as necessary all guidelines, policies, and/or procedures as related to controlled substances. An employee violating in any form the Polk County Fire Rescue guidelines, policies and/or procedures relating to controlled substances may be subject to removal of their privilege to work under the license of the Medical Director and may be subject to payment of any fines and/or penalties levied because of said violations.

1. Controlled substances are assigned to individual ALS-licensed vehicles. All controlled substances will be inventoried at the beginning of each shift or when a paramedic is relieved during a shift by both the on-coming paramedic and the off-going paramedic.
2. Both on-coming and off-going paramedics will complete the daily log in the PCFR-approved tracking software, including signatures and individual identifier numbers.
3. It will be both Paramedic employees' responsibility when checking the controlled substances, that each individual package will be picked up, the expiration date checked, and each item thoroughly inspected for color, clarity, tampering, or seal breakage. Each vial will be scanned or manually entered into the online tracking software ensuring that the information matches the vials count and ID numbers in the unit's digital inventory. Expiring substances, suspected tampering, seal breakage, incomplete/inaccurate counts, or discrepancies/errors of any nature will be reported to the Station Capitan and Battalion Chief immediately by phone and agency e-mail and the unit will go out of service until the issue is resolved. See below "discrepancies/seal breakage" section.
4. If a 911 call for service is received during drug exchange before the completion of the handoff, the on-coming paramedic will be required to complete the inspection and count of the narcotics as soon as the patient handoff is complete and prior to going back into service. A note will be made in the daily inventory section, noting the call number and time the drug inspection was completed. If any discrepancies are found, the Chain of Command is to be notified, and the unit will remain out of service until cleared by a supervisor.
5. When changing or trading ALS-licensed vehicles, the Paramedic will be responsible for ensuring that the controlled substances are secured in the locked compartment of the ALS-licensed vehicle they will be using.
6. The key to the locked cabinet in the ALS licensed vehicle and/or the key to the locked cash box containing the substances will be kept by the on-duty Paramedic and on their person at all times when working. Individual access codes to the locked drug cabinet shall remain secured and confidential at all times.



## Controlled Substance

### Discrepancies/Seal Breakage/Damaged

1. If at any time when controlled substances are inventoried, there is a discrepancy between the count and what listed in the units digital safe count, there is suspected tampering, a vials RFID tag is damaged or missing, the vial is damaged or broken, or a safety seal found broken, loose or unable to be rotated; it is both Paramedics' responsibility to report such discoveries to the Station Captain and Battalion Chief immediately by phone and agency e-mail. Both Paramedics will remain at the station until permitted to leave by the Station Captain and Battalion Chief and the unit will be placed out of service.
2. If in anticipation of administration, the tamper or safety seal on any substance is broken, the paramedic, before leaving the hospital, is to waste the entire substance in the presence of an RN and document this waste in the tracking software. (See 208.3D)

### Administration/Documentation

1. Controlled Substances may be administered by standing orders or by physician orders. Paramedics are responsible for knowing what controlled substance requires a physician order and what controlled substance may be given without physician order as outlined in the PCFR CCGs.
2. The "run report" inside of the PCFR approved tracking software will be the legally recognized record that will accurately and completely reflect all controlled substance administration and waste documentation. Each vial, syringe, or other supplied forms of controlled substances when administered, wasted, broken or removed from the ALS licensed vehicle is to be accounted for within the tracking software under the "run report" section.
3. The Paramedic that administers or attempts to administer a controlled substance is responsible for the proper completion of the "run report" digital form before leaving the receiving facility or scene of a call if the patient was not transported by their unit. An entry into each field is mandatory either by entering the necessary information or N/A (not applicable). The run number will be entered into the "run report" allowing for proper tracking of the medication.
4. In cases where the Paramedic administers a controlled substance or breaks the tamper or safety seal in anticipation of administration, and then turns patient care over to another unit/agency the RN waste signature for the waste amount will be required to be obtained from a Station Captain or Battalion Chief, a Flight Medic/RN, or a Paramedic from another unit.

(Waste signatures outside of the hospital setting as described above may not be obtained from anyone within the same unit or station)



## Controlled Substance

5. In cases where a Paramedic administers the entire quantity of a controlled substance resulting in no waste, N/A (not applicable) shall be entered in the section for amount wasted. The paramedic will be required to still present the empty vial to the receiving RN for confirmation of zero waste. The RN signature will be recorded in the witnessed section. If no transport made (situation covered under #4, the same policy will be applied to obtain a witness signature).

**At all times the empty container will be shown at the time of waste to confirm identity of the substance being wasted and placed into red sharps container. Under no circumstances are any empty vials of controlled substances permitted in pockets.**

### Resupply/Removal/Monthly Inventory

The current Medical Director's designees are Captain of OMD, Battalion Chiefs and Safety Officers that have received proper training and have been approved by the Medical Director.

1. When a controlled substance inventory is reduced to the minimal par level the on-duty Paramedic must contact their Station Captain and/or Battalion Chief by phone and agency e-mail to advise them of the current inventory. If the station captain was notified it will be their responsibility to relay the information to the Battalion Chief. The Battalion Chief will make arrangements for resupply of that particular substance.
2. Expired Controlled Substances Procedure
  - a. When a controlled substance is set to expire, company officers must make notification to their Battalion Chief a minimum of seven (7) days prior to the date of expiration. This will allow the Battalion Chief(s) the opportunity to develop an organized plan to swap all period, thus preventing a rush or emergency swap out of the expiring medication.
  - b. There should be no need for exchange of the medications on weekends or holidays. Should an emergency exchange be required due to the expiration date on a weekend or holiday, an email from the Battalion Chief will be required to explain the need for a weekend resupply. All controlled medications returned to Logistics will be subject to testing for volume and concentration levels.
3. Completion and/or submission of the electronic monthly drug inventory does not alleviate any on duty Paramedic from their responsibility of making notification of expiring controlled substances as outlined above.
4. 1. Only employees authorized by the Medical Director and trained in proper procedures may be directly involved in the removal, restock, or inspection of any controlled substances.



## Controlled Substance

### Par Levels

Ambulances (Medics/Rescues)	Min.	Max.
Ketamine 500mg/10ml or 500mg/5ml	3	6
Versed 5mg/5ml	3	6
Versed 5mg/ml	3	6
Ketamine 200mg/20ml	1	3
Fentanyl	3	6

Non-Transport ALS (Engines, Squads, Ladders, etc.)	Min.	Max.
Ketamine (any concentration)	0	0
Versed 5mg/5ml	2	4
Versed 5mg/ml	1	2
Fentanyl	2	4



## Interfacility Transport

### Definition

An interfacility transport is the transfer from one ER/Hospital to another ER/Hospital, **this does not include 911 calls from a doctors office and/or nursing home.**

### Sending Facility Responsibilities

The sending facility is responsible for initializing safe interfacility patient transfer. It is the sending facility's responsibility to select the appropriate form of patient transfer. The sending facility will provide the transport paramedic a report and all pertinent patient records, including a complete medical history, current treatments in progress, and medication being administered. The sending facility will also provide any necessary equipment, medication, and/or qualified appropriate personnel in the event that patient care dictates it for transport. (See Hospital Personnel)

### Transferring Agency

Upon patient contact, the paramedic will complete a thorough patient assessment. If the sending facility physician and the transporting Paramedic disagree on the transport readiness of the patient, the Medical Control and/or Battalion Chief with Paramedic credentials will make the final decision utilizing information provided by the sending facility physician and the Paramedic. At no time should the sending facility upgrade a patient's status to emergent in order to hasten the arrival of the PCFR transport vehicle if the situation does not warrant.

### Emergency Interfacility Transfers

This form of transport should be utilized for immediate transfer of patients requiring emergency care not available at the sending facility and where time to definitive care is critical. It is the intent to transport patients to the nearest most appropriate medical facility for the timely care of the patient in a medical facility staffed, equipped, and prepared to administer care for the patient. (Examples are ER to ER, ER to Cath Lab/Surgical Unit, but never ER to room)



# Interfacility Transport

## What qualifies as an Emergent Transfer:

1. STEMI patient or patient needing immediate cardiac catheterization <1 hour
2. Stroke patient
3. Trauma patient needing higher level of care
4. Patient in shock with MAP > 70 with or without pressors
5. Unstable arrhythmias or patients actively receiving rate controlling medication drips
6. Patients needing acute surgical intervention <3 hours
7. Respiratory failure patients who have a secure airway via intubation
8. Patients receiving TPA/TXA/Andexxa and/or blood products with unstable MAP <70 (be advised this will require a RN rider from the facility to ride with the crew for assistance)
9. OB emergencies (example pre-eclampsia) (please see below reference restrictions)

## Disqualified Emergent Transfer Request

1. Patients that are <28 days and/or <5kg
2. Imminent delivery OB patients
3. Patients who's MAP is <70 (excluding patients receiving blood products or TPA/TXA/Andexxa see #8 above)
4. Patients without a secure airway via intubation
5. Patients undergoing active resuscitation efforts

Seek Medical Control guidance if unsure about an interfacility transport.

## Paramedic/hospital personnel transports

The sending facility should be prepared to send appropriate personnel and equipment if patient care required during transport is beyond the scope of practice of the transporting Paramedic. On occasion, in the best interest of patient care, it may be necessary for the transporting crew to request additional personnel to accompany the patient during an interfacility transport (for example, RN, RT, Dr., or as directed by the sending or receiving facility). Responsibility for the patient during transport rests primarily with the transporting Paramedic, while the hospital personnel maintain responsibility within their scopes of practice.



## Interfacility Transport

- If the patient is actively receiving an IV medication not within the PCFR formulary, the following steps should occur:
  1. Hospital personnel should determine the need to continue the medication during transport.
  2. If the medication is to be continued, hospital personnel will provide the Paramedic with brief in-service training specific to the medication(s), including its action, dose, contraindications, side effects, and required actions with the medication/equipment if problems occur or the patient deteriorates.
  3. If the patient is receiving TPA, blood, or insulin, hospital personnel (e.g., a nurse or physician) must attend to the patient with the Paramedic at the receiving hospital.
  4. All borrowed equipment must be returned to the sending facility as soon as possible after the call is completed.
  5. If, after in-service, the Paramedic does not feel comfortable with the medication and/or potential actions to ensure safe patient transport, hospital personnel will be requested to facilitate the transfer. If the Paramedic feels comfortable, no request for hospital personnel will be necessary.
  6. If hospital personnel accompany the patient during transport, PCFR will place themselves OOS after completing the transfer and directly return the hospital employee to the sending facility as soon as possible.

If a physician accompanies the patient during transport, any orders received during transport must be written, dated, and signed by the physician prior to the transfer of care at the receiving facility. The physician is responsible for overall patient care, and the transporting Paramedic is responsible for their own care within their scope of practice.

### Medical Direction

The responsibility of Medical Direction during transport should be established prior to the interfacility transport. The sending and receiving facility physicians should direct what care needs to be continued during transport via standing orders. If unforeseen life-threatening issues arise during transport (for example, imminent cardiac arrest, cardiac arrest, seizures, anaphylaxis, etc.), then the transporting Paramedic should consult the Clinical Care Guidelines. Treatment options and consultation with a Battalion Chief should be utilized if necessary. Transporting crews have the ability to abort the interfacility transfer in this situation and transport the patient to the nearest acute care hospital.



# Interfacility Transport

## Family Transport

During emergency transport, it is highly recommended that the family should travel separately when a patient is being transported emergent. The family should be cautioned not to follow the ambulance as this can be hazardous to the family and the transporting crew, primarily when the ambulance utilizes lights and sirens. It should be further explained that families must obey all traffic laws if, in fact, they choose to follow an ambulance during lights and sirens transport. On occasion, exceptions are made to particular family members. If a family member does accompany the patient on an emergent transport, the individual must be seat belted in the front driver's compartment along with the driver. No family members should be transported in the patient compartment area unless warranted by the transporting Paramedic for patient care purposes (for example, parent of child, interpreter, etc.). It is the transporting Paramedic's discretion to approve/deny transport of the patient's family. Any discrepancy should be discussed with the Battalion Chief.

## Endangerment of Transporting Crew

In the event that the transporting crew feels that it would be unsafe to perform the interfacility transfer (example lack of qualified personnel, inadequate equipment, violent patient, weather conditions, etc.) they should immediately notify their Chain of Command (example Battalion Chief, OMD) and the sending physician about their concerns. All personnel should work together to find an acceptable solution prior to taking the transfer. The Medical Director or designee has a definitive say as to whether or not the transporting crew is permitted to take interfacility transport. If this situation were to occur, it would be the responsibility of the sending and/or receiving facilities to arrange transport of the patient by other means (example Critical Care Transport, NICU Transport, Flight Transport, etc.).

## Documentation

All interfacility transfers involving transporting crews are subject to Quality Assurance review. The transporting crew members are expected to maintain an accurate transport record on the patient to include: patient demographics, medical history, assessment findings, medications, allergies, physical exams, vitals sign trends, and treatment. Crews should also include sending physician orders as well as any other orders given by other physicians (example PCFR Medical Direction, receiving facility physician).



# Interfacility Transport

## Request for Interfacility Transports

Emergency interfacility transports will be assigned to a transport vehicle regardless of time. It is important to understand that with a high call volume system, there may be delays in getting the transport vehicle to the hospital. Dispatch will attempt to make these delays as minimal of an impact on the sending facility and the patient as possible. If these circumstances arise, Dispatch will advise the sending facility of the situation. Requests for service from all other facilities, including physician's offices, clinics, urgent care centers, nursing homes, etc., will be considered either "emergency," and the facilities must utilize the 911 system. All requests for emergent interfacility transports must be called into Dispatch by the facility with medical information. Dispatch will then notify the zone Battalion Chief, who will confirm that it meets the emergent criteria. After the battalion chief approves it, dispatch will dispatch a transport unit to the transfer.

## Transport Assistance for Helicopters

In the event a emergent transfer is requested to assist in movement of a AirMedical team from a landing zone to the facility and back, the following procedure and documentation will take place.

1. AirMedical Team Pickup - the transport crew will respond to the landing zone location and pick up the AirMedical team and transport them to the facility. A ePCR must be completed for this transport. As there is no patient information, the information of the company that was transported will be entered into the ePCR. In the narrative section list the reason for the transport and to which facility you transported the crew to.
2. Return - the transport crew will remain at the hospital while the AirMedical team receives the patient and information. The AirMedical team will be responsible for the patient care, but the transporting paramedic is expected to provide patient care assistance (within the guidelines of the CCG and SOGs) if requested (i.e. movement of the patient, ventilating). The paramedic is expected to remain in the patient compartment during transport back to the landing zone. Another ePCR will be created and completed, this time with the patients name and information. In the narrative document which AirMedical company was transported and the reason for the transport. Also document any assistance that might be provided. Signatures should be obtained from either the Flight Medic or the Flight Nurse.

Any questions/concerns regarding the transport should be made to the Battatlion Chief.



# Trauma Care/Transport

## Transport Destination Procedures

1. All trauma patients will be transported to the most appropriate facility or state-approved trauma center (SATC).
2. The Paramedic who finds any trauma patient who meets the criteria using the appropriate trauma scorecard methodology, as required in sections 64J-2.004 or 2.005, F.A.C., shall immediately notify their communications and issue a "Trauma Alert."
3. Refer to Aeromedical Transport Administrative Policies for those patients who may benefit from helicopter transport that is not considered a "Trauma Alert."
4. The Paramedic will advise the communication center of the following information about the
  - a. Trauma Alert scene:
  - b. Total number of patients
  - c. The total number of Trauma Alert Patients
  - d. The mechanism of injury
  - e. Any additional resources needed
5. **The Paramedic must notify the Trauma Center of the Trauma Alert ASAP.**
6. Scene time should be limited to <ten (10) minutes for Trauma Alert unless delayed due to airway management, entrapment, waiting on the helicopter, etc.; delay must be documented on ePCR.

## Guidelines for transportation

- Air transport to a state-approved trauma center (SATC)
  - Transport via air if helicopter response time to the SATC is <45 minutes.
- Ground transport to a state-approved trauma center (SATC)
  - Transport via ground if the helicopter is >45 minutes or if ground transport is <45 minutes
- Air transport to IRH
  - The trauma guideline of the air agency indicates diversion (for example, cardiac arrest, etc.)
  - MCI situations
- Ground transport to an IRH nearest the scene of the incident
  - With orders from the medical direction when:
    - Air transport is not available or helicopter response time is >one(1) hour, and ground transport to SATC is >two(2) hours.
  - Cardiac arrest secondary to trauma/trauma code
    - If any patient care is provided other than to determine life status, the patient will be transported to the closest appropriate IRH.
  - Lack of patient airway
  - MCI situation



## Trauma Care/Transport

- Ground transport of "Trauma Grey"
  - Non-emergency transport (unless deemed necessary) to the closest appropriate trauma center
- Air transport of "Trauma Grey"
  - Only if more than one hour for ground transport to SATC and Battalion Chief approval

### Dispatch Procedure

Communication Center: Polk County Fire Rescue Communications Center is located in Polk County. All EMS calls for the county are received by and dispatched by this center along with several fire departments in Polk County. Enhanced 911 is being utilized in the county and are processed by using a computer-aided dispatch system.

1. The list of information to be obtained from the caller
2. Location and phone number of the patient.
3. Type of injury: Trauma
4. Age of Patient
5. Is the patient conscious? Is the patient breathing?
6. Is there any serious bleeding? Is he/she completely alert?
7. What part of the body was injured? Chest or neck; is he/she having difficulty breathing?
8. Fall; how far did he/she fall? What caused the fall?
9. Vehicle accidents; is anyone pinned? Was anyone thrown from the vehicle?
10. Obvious injuries or serious bleeding?
11. GSW - explosive to head; do you think the patient is beyond any help resuscitation/CPR)?  
Is the assailant still nearby?
12. Scene safety verification for patient and responding unit

### Method Used to Identify and Dispatch the Most Readily Available Unit

1. The Emergency Medical Services dispatcher will dispatch the closest available unit(s)
2. Prior to the first units arrival, multiple response units may be dispatched by the request of the Communications Supervisor or Battalion Chief based on information received from caller(s). The first unit arriving on the scene can request multiple response units.
3. The Battalion Chief will be dispatched to any trauma alert or possible trauma alert.

### Process Used to Request Assistance from Emergency Response Agency

- It is recommended that the fire departments respond to all vehicle accidents, trauma alerts, and unconfirmed trauma alerts.
- Law Enforcement is requested to respond to all vehicle accidents and violent or potentially violent crimes.



## Trauma Care/Transport

- Air support is requested by the Paramedic or on-scene Fire Department Officer on behalf of a Paramedic. In addition, the Communications Supervisor or Battalion Chief can request air support before an EMS unit's arrival based on information received from caller(s).
- Public utility agencies are requested when the need is identified.

**Polk County Fire Rescue Advanced Life Support units and Battalion Chiefs will be dispatched on recorded medical and fire Channels. All other requests for an Emergency Response Agency will be made on recorded Phone Lines.**

**The closest available helicopter will be dispatched to the scene in accordance with established dispatched guidelines.**

### State Approved Trauma Centers

Adult Trauma Centers		
Bayfront Medical Center	700 Sixth St. South	St. Petersburg
Lakeland Regional Health	1324 Lakeland Hills Blvd	Lakeland
Orlando Health	1414 South Kuhl Ave	Orlando
HCA Florida Osceola Regional	700 West Oak St	Kissimmee
Saint Joseph's Hospital	3001 MLK Blvd	Tampa
Tampa General Hospital	1 Tampa General Circle	Tampa
Pedi Trauma Centers		
Arnold Palmer	92 Miller St	Orlando
Saint Joseph's Hospital	3001 MLK Blvd	Tampa
Tampa General Hospital	1 Tampa General Circle	Tampa



## Adult ( $\geq 16$ yo) Trauma Score Card

### Red Criteria (1=Trauma Alert)

- Active airway assistance
- Lack of radial pulse with a sustained heart rate  $>120$ bpm
- BP of  $<90$ mmHg or SBP $<110$  in Pt  $\geq 65$ yo
- GCS  $\leq 8$
- Presence of paralysis
- Suspicion of a spinal cord injury
- Loss of sensation
- 2nd or 3rd degree burns to  $\geq 15\%$  of TBS
- Amputation proximal to the wrist or ankle or any penetrating injury to the head, neck or torso (excluding superficial wounds where the depth of the wound can be determined)
- Penetrating injury to head, neck or torso at or proximal to elbow or knee
- Crush, mangled or pulseless extremity
- Active bleeding requiring a tourniquet or wound packing with continuous pressure
- S/S of two or more long bone fracture sites (humerus, radius/ulna, femur, tibia or fibula)
- Paramedic judgment - if the patient does not meet any of the criteria listed above and the on-scene paramedic believes the patient may benefit from trauma alert criteria due to extenuating circumstances surrounding the incident, the patient may be classified as a "trauma alert" and therefore transported to appropriate facility

### Blue Criteria (2=Trauma Alert)

- $\geq 55$ yo
- Respiratory rate  $>30$ bpm
- Sustained heart rate of  $>120$ bpm
- Head injury with LOC or amnesia/AMS
- Soft tissue loss from major degloving injury or major flap avulsion  $>5"$
- Penetrating injury distal to elbow or knee
- S/S of single long bone fx resulting from MVC or fall from elevation of  $\geq 10$  feet
- Ejection/partial ejection from closed compartment vehicle (excluding motorcycle, moped, ATV, bicycle, or the open body of a pick-up truck)
- Steering wheel deformity
- Intrusion  $>12"$  to compartment or roof immediately adjacent to where patient is seated
- Electrocution or lightning strike with any of the following, LOC, ALOC, AMS, and/or visible signs of injury
- Motorcycle  $>20$ mph
- Pedestrian or bicyclist thrown, run over or impact  $>20$ mph



## Pediatric ( $\leq 15$ yo) Trauma Score Card

### Red Criteria (1=Trauma Alert)

- Active airway assistance
- Respiratory rate  $<1$ yo  $<20$ bpm or  $\geq 1$ yo  $<10$ bpm
- Carotid or femoral pulse that is faint or absent
- SBP < stated in HandTevy for age
- Altered mental status
- Presence of paralysis
- Suspicion of a spinal cord injury or loss of sensation
- 2nd or 3rd degree burns to  $\geq 10\%$  of TBS
- Amputation proximal to the wrist or ankle or any penetrating injury to the head, neck or torso (excluding superficial wounds where the depth of the wound can be determined)
- Penetrating injury to head, neck or torso at or proximal to elbow or knee
- Crush, mangled or pulseless extremity
- Active bleeding requiring a tourniquet or wound packing with continuous pressure
- S/S of two or more long bone fracture sites (humerus, radius/ulna, femur, tibia or fibula)
- Paramedic judgment - if the patient does not meet any of the criteria listed above and the on-scene paramedic believes the patient may benefit from trauma alert criteria due to extenuating circumstances surrounding the incident, the patient may be classified as a "trauma alert" and therefore transported to appropriate facility

### Blue Criteria (2=Trauma Alert)

- Radial pulse that is faint or absent
- Head injury with either LOC or amnesia or AMS
- Soft tissue loss from either a major degloving injury or major flap avulsion  $>5"$
- Penetrating injury distal to elbow or knee
- S/S of a single long bone fracture resulting from MVC or a fall from an elevation of 4 feet or more
- Ejection/partial ejection from a closed compartment vehicle (excluding any motorcycle, moped, ATV, bicycle, or the open body of a pick-up truck)
- Steering wheel deformity
- Intrusion  $>12"$  to compartment or roof immediately adjacent to where patient was sitting
- Intrusion  $>18'$  to compartment opposite to the patient's location
- Electrocution or lightning strike with any of the following: LOC, ALOC, AMS, and/or visible signs of injury
- Motorcycle  $>20$ mph
- Pedestrian or bicyclist thrown, run over, or impact  $>20$ mph



## Trauma Grey Criteria

### Adult ( $\geq 16\text{yo}$ ) Trauma Grey Criteria

- 55 yo or older
- Ecchymosis and/or deformity from blunt trauma in patients on anticoagulants or bleeding disorders
- Seatbelt mark on the torso
- Blunt abdominal or chest trauma in patients with a history of paralysis
- ABD pain with blunt trauma in pregnant patient > 20 weeks of gestation
- Electrocution or lightning strike without symptoms
- Vehicle telemetry data provided from dispatch is consistent with a high risk of injury

### Pediatric ( $\leq 15\text{yo}$ ) Trauma Score Card

- 11kg or less
- Ecchymosis and/or deformity from blunt trauma in patients on anticoagulants or bleeding disorders
- Seatbelt mark on the torso
- Blunt abdominal or chest trauma in patients with a history of paralysis
- Electrocution or lightning strike without symptoms
- Vehicle telemetry data provided from dispatch is consistent with a high risk of injury



## Aeromedical Transport

**Aeromedical transport will be used only for patients who weigh <400lbs; all other patients, regardless of illness or injury, must be ground transported.**

**Criteria that suggest the need for Aeromedical transport may include but are not limited to:**

- Need for ALS services where none are available or will be significantly delayed
- Mass casualty incidents
- Prolonged extrication
- Insufficient numbers of rescue personnel, equipment, or vehicles to manage a multiple casualty incident or single patient encounter.
- Traffic conditions or geographic terrain that prohibit adequate ground access to the victim.
- Patient has suffered:
  - Crushing or maiming injuries to the hand or foot
  - injuries that may require significant neurovascular surgery
  - Injuries that may require extensive cosmetic surgical procedures
- Situations in which the time differential between air and ground transport may substantially impact the outcome of the patient (Cardiac Alert, STEMI Alert, SAH or Stroke Alert).
- Patients who meet the "Trauma Alert" criteria as specified in the PCFR CCGs and in whom the time differential between air and ground transport may substantially impact the outcome of the patient.
- The Paramedic in charge of the patient is responsible for determining if aeromedical transport is warranted. The Paramedic should notify the Communications Center of the need for aeromedical transport as soon as possible in order to minimize response and transport times. The Paramedic in charge should also request assistance from other agencies as needed to help secure the incident site and landing zone. The Communications Center will advise the priority channel on which ground to air communications will occur.
- If initial indications are that air transport may be required, the air transport should be allowed to progress towards the scene in order to decrease response times. Dispatch will notify Battalion Chief.

**When possible all attempts should be made to transport family members to the same facility. There are times this can not be done (adult vs pedi patients) but separation of patients of the same age category should be avoided.**



## Aeromedical Transport

Information	Day	Night
Landing Zone	125 x 125ft	125 x 125ft
Landing Zone Distance	100ft from patient care activities	
Grounds	Fairly Solid	Fairly Solid
Grade (slope)	Max 5'	Max 5'
Hazards	Free of overhead and ground obstructions	
Spectators (people)	Remain clear from landing zone >200ft	
Lighting	If possible, use light to illuminate the landing zone	



## Cardiac Care/Transport

### Recognition

- Identification of the ACS patient requires a high index of suspicion. Typical ischemic chest pain qualifies any adult for inclusion in this guideline. Patients with atypical pain or angina equivalents should be included, especially if they have a history of coronary artery disease or multiple risk factors. Female, diabetics, and the elderly often present with atypical pain or angina equivalents and require special attention.
- Transmission of 12 lead: crews should transmit 12 lead EKGs to the hospital when there is a detected abnormality (i.e. elevation, depression, t-wave inversion or when a physician interpretation is required. Inclusion of the patient's name on the transmitted EKG is a paramount of patient care.

### Classification

- Cardiac Alert
  - A patient presenting with unstable angina, non-stemi, or appearance to a Paramedic that could be in a life-threatening state will be classified as a Cardiac Alert. 12 lead EKG is to be acquired within five (5) minutes or less from patient contact. Scene time should be limited to fifteen (15) minutes or less for STEMI and Cardiac Alerts unless delayed and delay must be documented on ePCR.
  - Unstable angina: patients who possess normal or non-diagnostic changes in the ST segment or T-wave on a 12 lead EKG. These patients are classified by AHA as intermediate/low-risk unstable angina.
  - Non-ST elevation MI: patients who possess ST segment depression or dynamic T-Wave inversion on a 12-lead EKG. These patients are strongly suspicious for ischemia and are classified by AHA as high-risk unstable angina/Non-ST elevation MI.
- STEMI Alert
  - Upon arrival at the scene, the Paramedic will initiate Initial Medical Care and assess the patient using the following methodology as outlined. Those patients that meet the following criteria will be classified as a STEMI Alert. 12-lead is to be obtained within 5 minutes of patient contact.
  - Patients who presents with one or more ACS signs/symptoms including angina equivalents and-
    - ST Elevation  $\geq 1.0$  mm in 2 or more contiguous leads or
    - ST Elevation in V2 and V3 for the following patients:
    - Women ST-elevation  $\geq 1.5$ mm
    - Men  $> 40$ yo ST-elevation  $\geq 2$ mm
    - Men  $< 40$ yo ST-elevation  $\geq 2.5$ mm
  - T-Elevation MI (STEMI Alert): patients who possess ST segment elevation on a 12 lead EKG. These patients are strongly suspicious for injury and are classified by AHA as STElevation MI.



## Cardiac Care/Transport

### Transportation

- For patients who are suspected of having an acute MI as evidenced by Paramedic assessment findings, it is important to make contact with the receiving hospital (on-line Medical Control) as early as possible with the transmission of the 12 lead EKG by telemetry. Additional instructions or orders may include, but are not limited to:
  - Specific destination at the receiving facility such as catheterization lab, cardiac holding area, etc.
  - Additional treatments, interventions or medications
- Patients who meet the above STEMI Alert criteria, as determined by the on-scene Paramedic, will be transported to the nearest PCI center
  - If the transporting Paramedic deems the patient too unstable for transport to the nearest PCI center, the patient should be transported to the closest receiving facility.
  - Aeromedical transport may be utilized provided the following criteria are met:
    - Ground transport time is greater than 45 minutes to appropriate receiving facility and
    - Air support response time is less than 30 minutes

### Hypothermia Care

- Upon successful return of spontaneous circulation (ROSC), the Paramedic will initiate and hypothermia care. ROSC patients will be transported to the nearest appropriate facility.

### CATH Lab Activation

- In partnership with our local PCI centers, any patient who meets STEMI criteria will be assessed for direct CATH lab activation. This will help shorten the “door to balloon” time for patients suffering from an MI.
- If the patient meets CATH lab activation, the receiving facility should be notified immediately. Along with transmission of the 12-lead EKG.



## Cardiac Care/Transport

### CATH Lab Activation

Cath Lab Inclusion	Exclusions
<ul style="list-style-type: none"><li>• Ongoing chest pain/ACS symptoms</li><li>• ST elevation at least 1mm in 2 contiguous leads</li></ul>	<ul style="list-style-type: none"><li>• ST elevation without chest pain</li><li>• Refuses CATH or consent</li><li>• Valid DNR</li><li>• Cognitive impairment that precludes informed consent</li><li>• Any bundle branch block/intra-ventricular conduction defect</li><li>• Paced rhythm obscuring interpretation of EKG</li><li>• Hemodynamic instability</li><li>• Respiratory instability (intubated or unable to secure airway)</li><li>• History of organ failure or malignancy/metastasis</li></ul>



## Stroke Center/Transport

### Recognition

- All patients that present as a potential acute CVA will be evaluated utilizing the BEFAST criteria or AHORA (for Spanish speaking patients).

### Confirmation

- Patients found to be positive for any two (2) or more of the BEFAST/AHORA criteria within the last 24 hours (with time being part of the criteria) should be declared a stroke alert. Identify the time last seen normal, and the m-Rankin Score.
  - If the patient meets Stroke Alert criteria the crew is to notify the Communications Center and issue the Stroke Alert.

### Destination Decision

- The on-scene Paramedic will then utilize the Stroke Alert Checklist to determine the closest appropriate receiving facility and method of transportation to that destination. The decision will be made according to the guidelines for transportation that follow:
- The patient and family will be informed of the patient's need for specialized care and the facility to which the patient is being transported.
- The receiving facility will be notified upon recognition of the stroke alert.
- When determining the appropriate facility, a higher level of care should not be bypassed to transport to a lower level. Comprehensive Stroke Centers can perform Thrombectomy Stroke Center care; therefore, if a patient meets the criteria for a Thrombectomy Stroke Center and a Comprehensive Stroke Center is closer, the patient will be transported to the Comprehensive Center.
- Patients who meet the Stroke Alert criteria as determined by the on-scene Paramedic shall be transported to the nearest appropriate Stroke Center.
- If the transporting Paramedic deems the patient too unstable for transport to the nearest Stroke Center, the patient should be transported to the closest receiving facility.
- All strokes meeting the criteria for transport to a Thrombectomy Stroke Center should be transported by ground.
- All strokes meeting the criteria for transport to a Comprehensive Stroke Center will be transported utilizing the following criteria:
  - Fly if the transport time will be > 1 hour by ground
  - Ground transport if the time to facility will be < 1 hour

**The preferred IV access site will be in the right AC with a 18g (if possible)**



# Triage System

## En route

While you are responding to the scene, you should prepare yourself mentally for what you may find. Perhaps you've been to the same location before. Where might additional resources come from? How long may they take to arrive?

## Initial Assessment

The first thing is to stay calm and get an overview of the scene. This initial size-up will give you an impression of the situation, including the potential number of patients, and possibly the mechanism and severity of their injury. This size-up may clue you as to additional resources that may be needed.

## Initial Report

As you prepare to give the first initial report, use clear and concise information. The key points to communicate are:

- Location of the incident
- Type of incident
- Any hazards
- Approximate number of victims
- Type of additional resources needed

## Sorting the Patients

- It is important not to become involved with the treatment of the first or second patient you initially encounter on scene. Your job is to triage each and every patient as quickly as possible. Each patient should receive a rapid assessment and be assigned to broad categories based on their need for treatment.
- During triage, you will only correct airway and severe bleeding problems. Further treatment will be performed in the treatment area.
- Patients are sorted into four categories and color classifications:
  - **Immediate**
    - **Reserved for a victim who cannot survive without immediate treatment but who has a chance of survival.**
  - **Observation**
    - **Reserved for a victim who required observation (and possibly re-triage). Their condition is stable for the movement and they are not in immediate danger of death. These victims will still need hospital care and would be treated immediately under normal circumstances.**



## Triage System

- Wait
  - Reserved for victims who are capable of walking but do not have any life-threatening condition/injury. These patients can wait for care after the more critical patients have been cared for.
- Expectant
  - Reserved for victims who are deceased or have injuries so extensive that they will not be able to survive given the care.

### The S.T.A.R.T. System

Respiration	Perfusion	Mental Status
>30bpm + one sign of shock = immediate	Absent/weak/irregular distal pulses= immediate	Does not follow simple commands = immediate
<30bpm move to perfusion	Present distal pulses move to mental status	Follows simple commands= observation

A patient who is not breathing or has an injury that is significant where the movement of the patient or attempt of care would not change the patient outcome will be categorized as "Expectant"



# Hospital Diversion/By-Pass

## Purpose

It is imperative that patients in Polk County, Florida have access to expedient and appropriate emergency medical care twenty-four hours a day, seven days a week, 365 days a year. This policy is to provide guidance to pre-hospital providers during times when the resources of the hospitals are taxed. In conjunction with best practices outlined by the American College of Emergency Physicians (ACEP), Emergency Medical Treatment and Active Labor Act (EMTALA) and Consolidated Omnibus Budget Reconciliation Act (COBRA) patient safety is the only reason for a hospital to go on diversion.

## Background

From time to time, the resources of a hospital may become taxed. In an effort to provide optimal patient care, a hospital may request that patients by ambulance be diverted to another facility so that care may be expedited. In doing so, many times, this places an undue responsibility on the pre-hospital provider and a burden upon the patient. From a legal standpoint, a hospital cannot close its Emergency Department. It is obligated to, at a minimum, complete a patient assessment, provide stabilization, and then, if necessary, transfer a patient. This applies to all patients who present themselves to an Emergency Department, regardless of how they arrive in their personal vehicle, walk-in, or ambulance. Because hospitals are able to exercise a certain amount of control over patients being transported by ambulance, they are able to inform prehospital personnel of their status prior to arrival. Hospitals may request to go on diversion. This document establishes a guideline for pre-hospital personnel to use to honor the diversion request.

## Hospital Status

The following terms will be used to describe the hospital bed status:

- Critical care beds full- indicates no critical care/cardiac monitored beds are available
- Non-critical care beds full- indicates no regular hospital beds are available.
- All beds full- indicates no hospital beds are available (except trauma beds in a Trauma Center).
- Emergency department by-pass - indicates all of the resources of the hospital's Emergency Department.
- Trauma by-pass- indicates the resources at a Trauma Center are temporarily and completely involved with trauma patients presently in the Emergency Department. Diversion of trauma patients to another Trauma Center should be considered if practical.
- Any hospital reporting their bed status as set forth in #1-5 above must reconfirm that status to the Battalion Chief hourly. Those hospitals not reconfirming their status within the prescribed time will have their status automatically changed back to fully operational.



# Hospital Diversion/By-Pass

## Diversion Criteria

- No unstable patients are to be diverted regardless of bed status. Such patients require stabilization before any diversion.
- Stable patients may be considered for diversion based upon a hospital status in #1-5 above.
- If all hospitals in a reasonable proximity are on divert status for a given type of patient (i.e., cardiac), an EMT or Paramedic may take a potentially unstable patient to the nearest hospital for further stabilization regardless of bed status.
- Trauma Centers are never closed to trauma regardless of hospital status, though the Emergency Department may be on temporary "Trauma By-Pass" status when full involved with current trauma cases.
- **As a precursor to a hospital requesting diversion status, at any time there are more than three ambulance units waiting for available placement/bed assignment for more than thirty minutes PCFR Battalion Chief will be notified and make a decision for a temporary diversion, up to two hours, that will be enacted for stable patients only unless such patients adamantly refuse transport to a further/more distant facility. Battalion Chiefs will contact the hospital's house supervisor to ensure units are cleared in a timely manner.**

## Diversion Limits

- Diversion will be limited to two-hour events. If the Battalion Chief has not received an update from the designated facility supervisor within the two-hour time limit, the facility will be automatically removed from diversion status.
- Diversion status may be extended once for up to an additional two hours with a maximum diversion time of four hours total in any twenty-four (24) hour period, provided that the designated facility supervisor establishes contact with the Battalion Chief.
- Every effort shall be made by the facility to lift diversion as soon as possible and provide some form of diversion avoidance strategy.
- The occurrence of a Mass Casualty Incident (MCI) or declared State of Emergency shall automatically remove all diversions in the county.

## Notifications

- A request for a diversion event will be made according to the individual facility's Standard Operating Procedure or Guideline. PCFR Medical Director approval will be based on PCFR Policy.



## Hospital Diversion/By-Pass

- The designated facility supervisor will utilize the direct telephone line to the appropriate County Communications Center to gain contact with a PCFR Battalion Chief.
  - The supervisor will identify himself or herself (name and title) to the Communications Center Operator
  - The facility supervisor must state the category of divert being requested, the reason for diverting and estimated termination time to the Battalion Chief.
  - The Battalion Chief or Medical Control will record the information in the diversion log (Type of diversion ALS or BLS and amount of time on diversion).
- The Battalion Chief will notify PCFR units, Office of Medical Control and Staff Duty Officer to include type of diversion (ALS/BLS) and amount of time.

### Diversion Log

A diversion log will be maintained and available for inspection or review by either party, State of Florida EMS Medical Director, State of Florida Dept of Health and/or Affiliates as necessary. The log will consist of the following information: date, time diversion initiated and concluded, type of reasoning for diversion, name of hospital charge nurse or administrator, and the name of the Battalion Chief accepting/acknowledging/approving diversion.



## In-Custody

When a pre-hospital clinician (ALS or BLS) is presented with a patient seeking medical care/transport and is incarcerated or in-custody of Law Enforcement officer (PCSO or Municipal Agencies) transportation destination decision will be as follows:

### Transport Decisions

- Stable on-scene
  - All patients who are stable and do not meet trauma, STEMI or Stroke alert criteria will be taken to the closest appropriate hospital with the following exceptions:
    - Patients in the geographical city limits of Lakeland or nearby surrounding areas will be taken to either Bartow Regional Medical Center or Winter Haven Hospital, including all Sepsis Alert Patients
    - Any variation or alternative destination must be approved by the Battalion Chief
- Unstable on-scene
  - Adult Trauma Alert (not meeting Burn Criteria)
    - East of US 27 will be transported to Osceola Regional
    - West of US 27 will be transported to Lakeland Regional Medical Center
  - STEMI Alert
    - Patient will be transported to the nearest PCI center (as listed in the CCG)
    - The Transport Paramedic will determine the appropriate mode of transport
  - Stroke Alert
    - All strokes meeting the criteria for transport to a PSC will be transported to Winter Haven Hospital by ground.
    - Strokes meeting criteria for transportation to a CSC will be transported by ground, with the incident location being considered
  - Cardiac Arrest
    - All patients in Cardiac Arrest will be transported to the closest receiving hospital.
    - In order to withhold cardiopulmonary resuscitation to a patient in law enforcement custody, the patient must meet the following criteria.
      - Last documented time the patient is seen alive is greater than one hour
  - AND
  - Meets obvious death criteria:
    - Pulseless, apneic, no other signs of life, and
    - Not exposed to an environment likely to produce hypothermia and
    - The presence of one or more of the following:
      - Rigor Mortis (generally starts after 2 hours of death)
      - Decomposition of body tissues



## In-Custody

- Rigor Mortis (generally starts after 2 hours of death)
- Decomposition of body tissues
- Dependent lividity
- Incineration
- Evidence of massive blunt or penetrating head or torso trauma including decapitation (details of the events, the mechanism of injury, scene and patient assessment must be completely documented).

### **Incarcerated patients (Polk County Central or South County Jail)**

Stable and unstable not meeting Trauma/STEMI/Stroke Alert criteria will be transported to either Bartow Regional Medical Center or Winter Haven Hospital unless directed to another hospital by the correction centers health physician.



## Free-Standing ER

Facilities that are associated with a traditional hospital and designed to ease overcrowding of the traditional emergency department while facilitating faster patient care for the non-emergent patient.

### Acceptable Types of Patient Transports to FS ER

The following patient conditions can be transported to a free-standing ER:

- All BLS patients
- Any stable ALS patient including patient conditions listed below
  - Abdominal pain < 40 years old
  - Chest pain with no EKG abnormalities <40 years old
- Isolated bone fractures/soft tissue/muscular-skeletal injuries

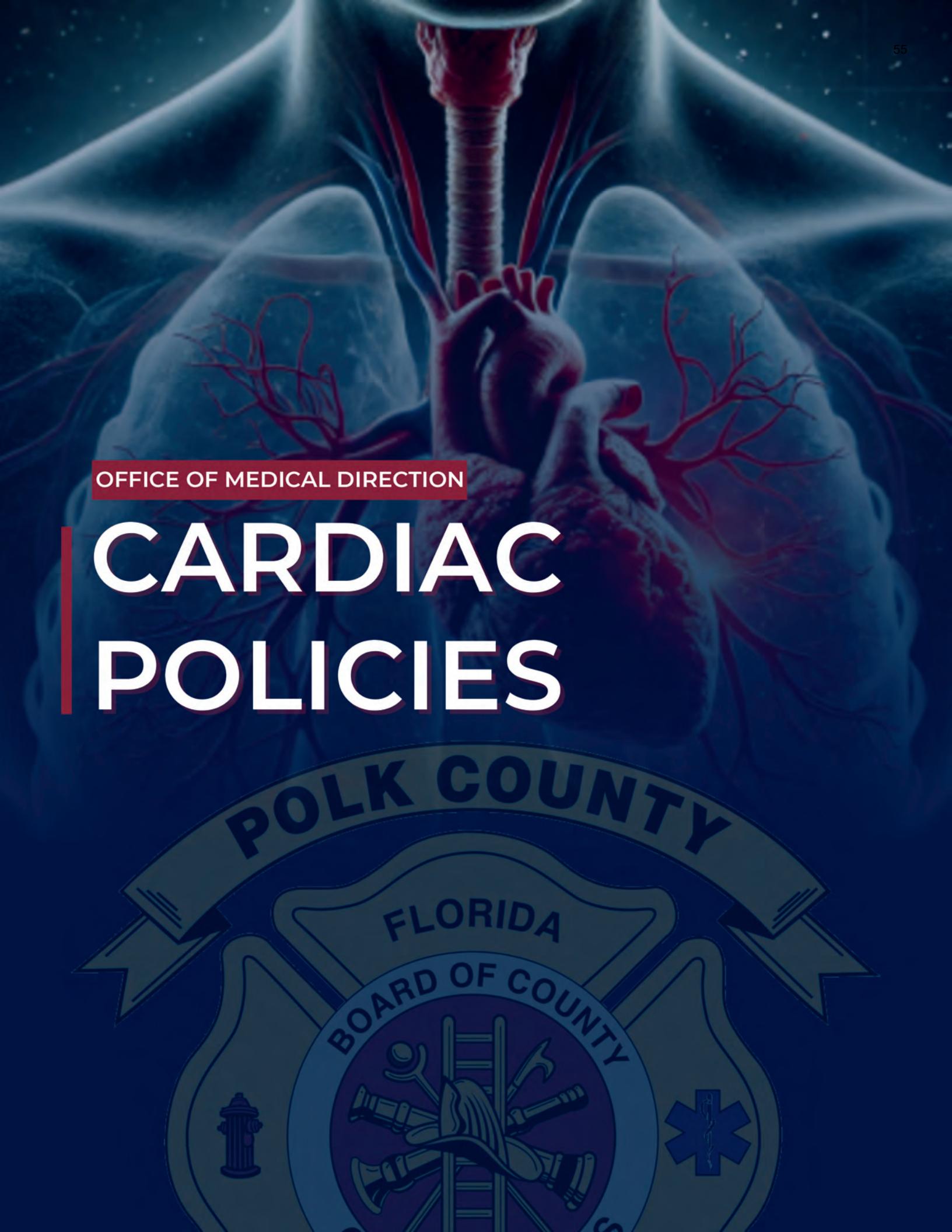
### Restricted from Transport to FS ER

The following patient conditions will not be transported to a free-standing ER:

- Hemodynamic instability (map <70)
- **Adult or pediatric patients meeting any "alert" criteria**
- Cardiac Arrest or ROSC patients of any age
- Patient with any Acute Coronary Syndrome, chest pain, or cardiac arrhythmia >40
- Obstetric patients > 20 weeks gestational age
- Patients with psychiatric complaint, violent behavior, alcohol intoxication, overdose, GCS <15
- Patients with open or complex fractures

### Additional

- Patient must request or be provided with an informed decision and agree to be transported to the Free-Standing ER.
- Traditional hospital ER's should not be bypassed in favor of a more distant Free-Standing ER.
- Free-Standing ER must be approved by PCFR and listed in the ePCR drop down list as a transport destination.
- All documentation requirements need to be obtained including patient and nurse signatures

A detailed anatomical illustration of the human torso focusing on the respiratory and circulatory systems. It shows the heart at the center, with major blood vessels like the superior and inferior vena cava and the aorta branching out. The lungs are visible on either side, with their intricate network of bronchi and capillaries. The trachea and esophagus are also depicted.

OFFICE OF MEDICAL DIRECTION

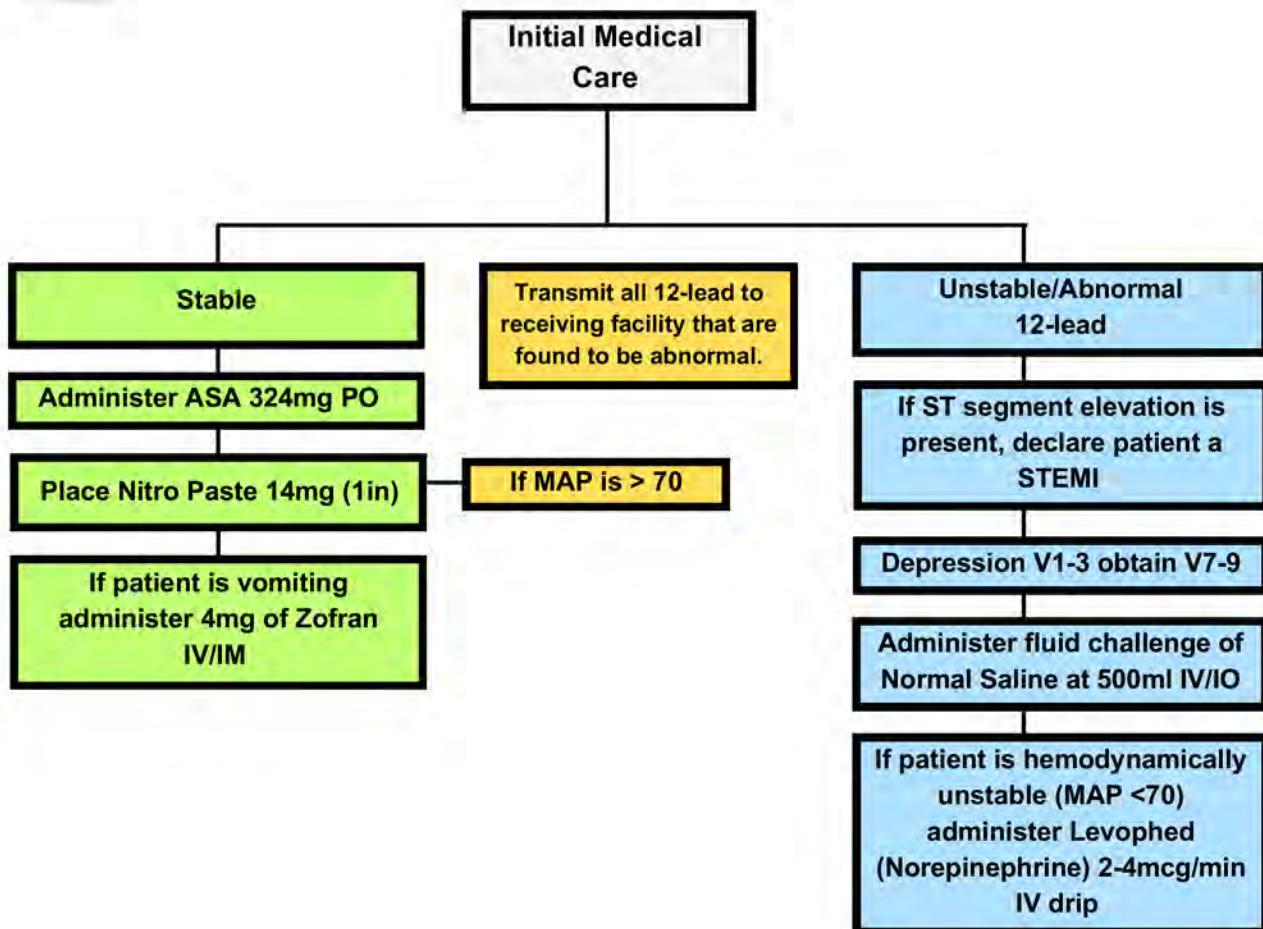
# CARDIAC POLICIES



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## Acute Coronary Syndrome

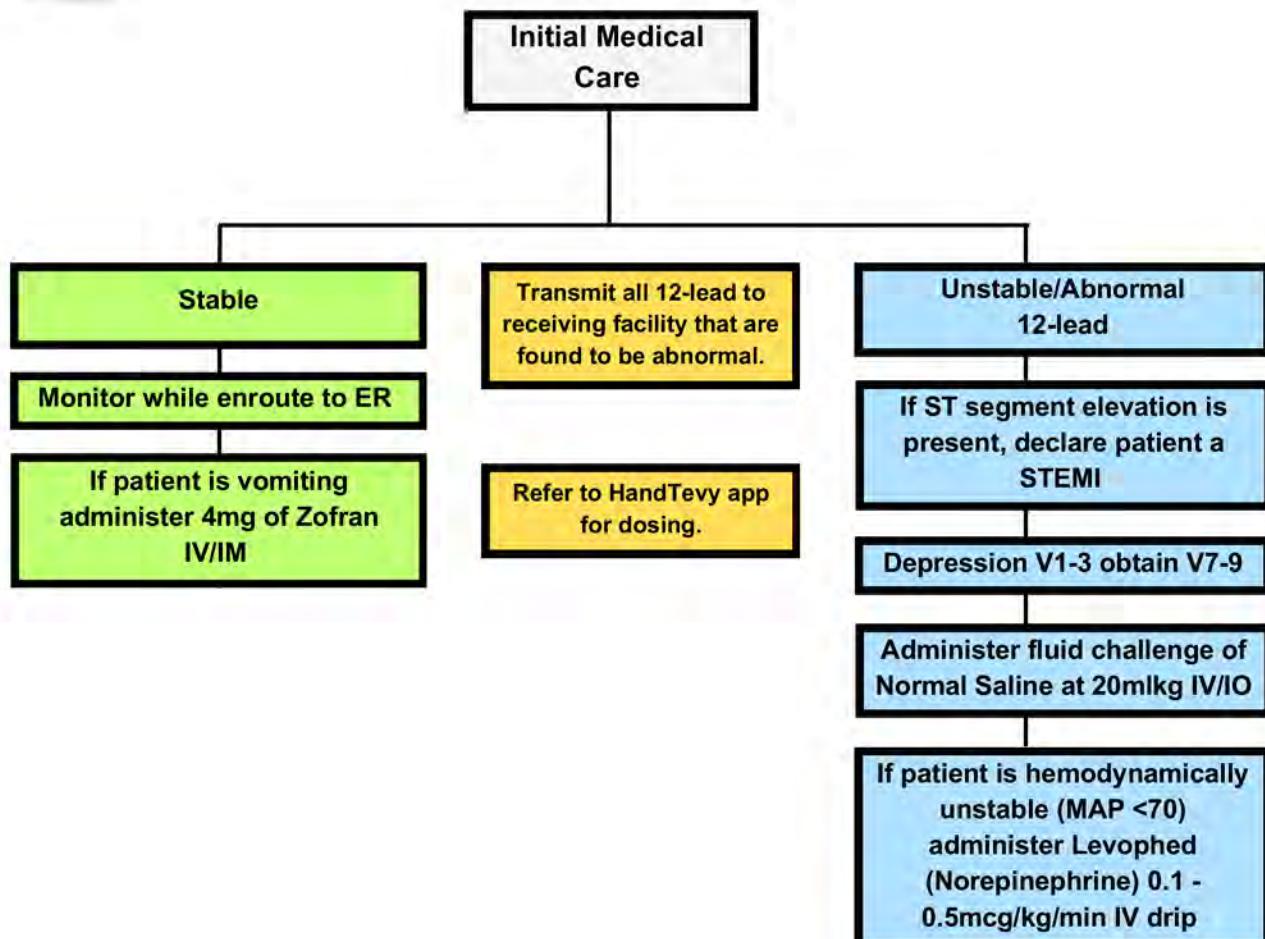


### PEARLS

<p><b>ST Elevation</b> = 1mm or more  <b>ST Depression</b> = 1/2mm or more  <b>ST Elevation in V2/V3</b> =</p> <ul style="list-style-type: none"> <li>• Women 1.5mm or more</li> <li>• Men &gt;40 2mm or more</li> <li>• Men &lt;40 2.5mm or more</li> </ul>	<p><b>STEMI Alert</b> = ST elevation in 2 or more contiguous leads  <b>Cardiac Alert</b> = patient who possess ST segment depression or dynamic T-wave inversion, or a patient presenting with unstable angina, non-STEMI or appearance to paramedic that could be a life-threatening state.</p>	<ul style="list-style-type: none"> <li>• If ST elevation in inferior leads (II, III, AVF) obtain a V4R.</li> <li>• If ST depression in early V leads (V1-V9) obtain a V7-V9.</li> </ul>
<p>EMTs may assist with administering ASA under the guidance of the paramedic.</p>	<p><b>Levophed (Norepinephrine) Drip</b>  Mix 4mg of Levophed into 250ml bag of D5W. This will give you a concentration of 16mcg/ml.</p>	<p>Nitro may be used in a patient with a possible right ventricular infarct, however, use caution.</p>



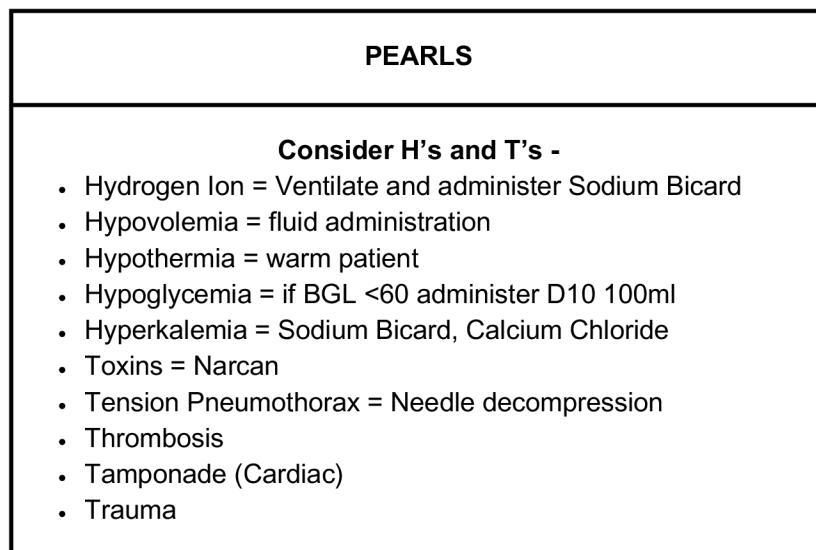
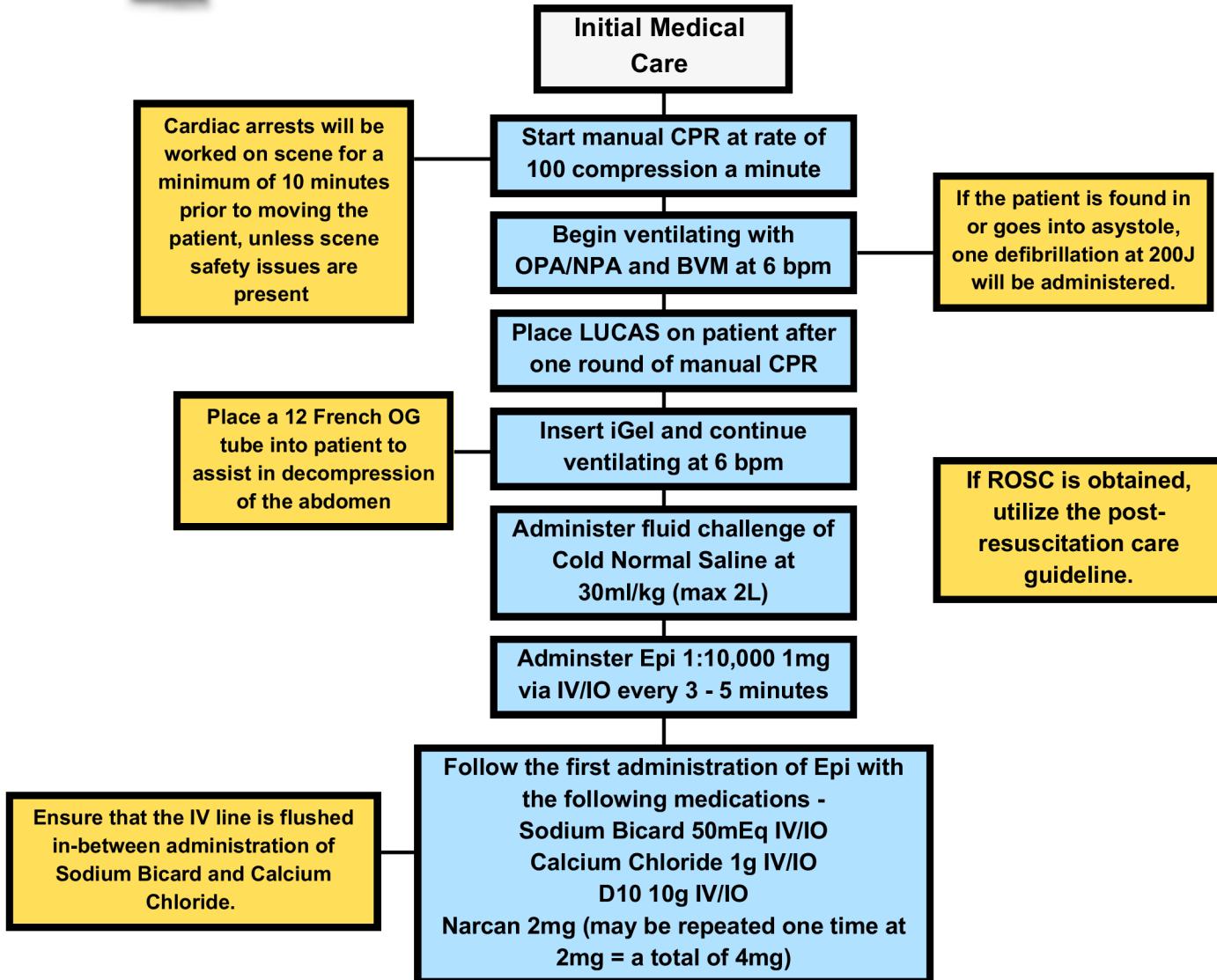
## Acute Coronary Syndrome



### PEARLS

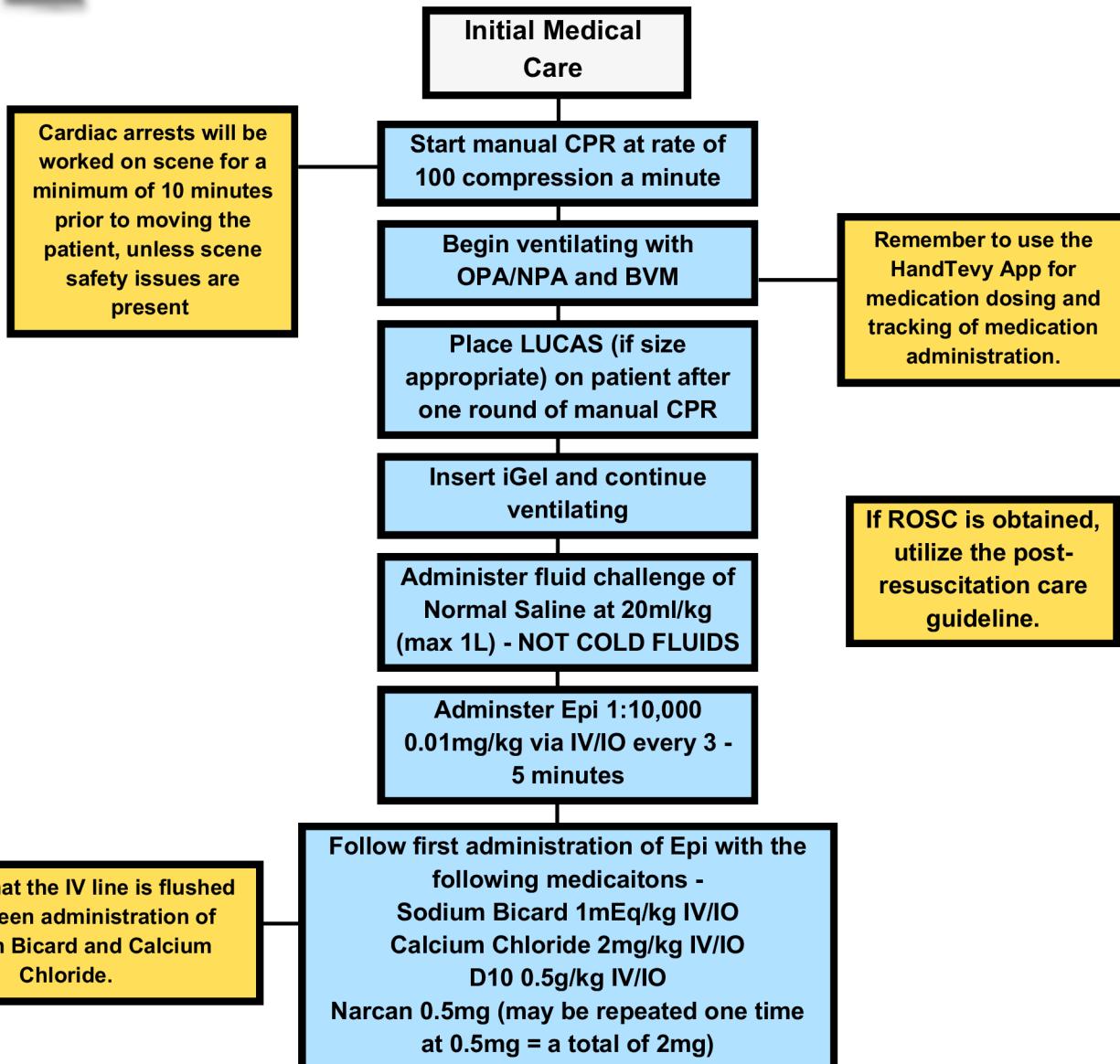
<b>ST Elevation in Limb leads =</b> 1mm or more <b>ST Depression =</b> 1/2mm or more <b>ST Elevation in Precordial Leads =</b> 2mm or more	Causes of ST elevation in pediatric patients = Myocarditis, early repolarization, hyperkalemia, hypercalcemia and pneumothorax	Contact medical control for further guidance as needed.
Zofran may be given IM in absence of IV	<b>Levophed (Norepinephrine) Drip</b> Mix 4mg of Levophed into 250ml bag of D5W. This will give you a concentration of 16mcg/ml.	

## Asystole/PEA





## Asystole/PEA



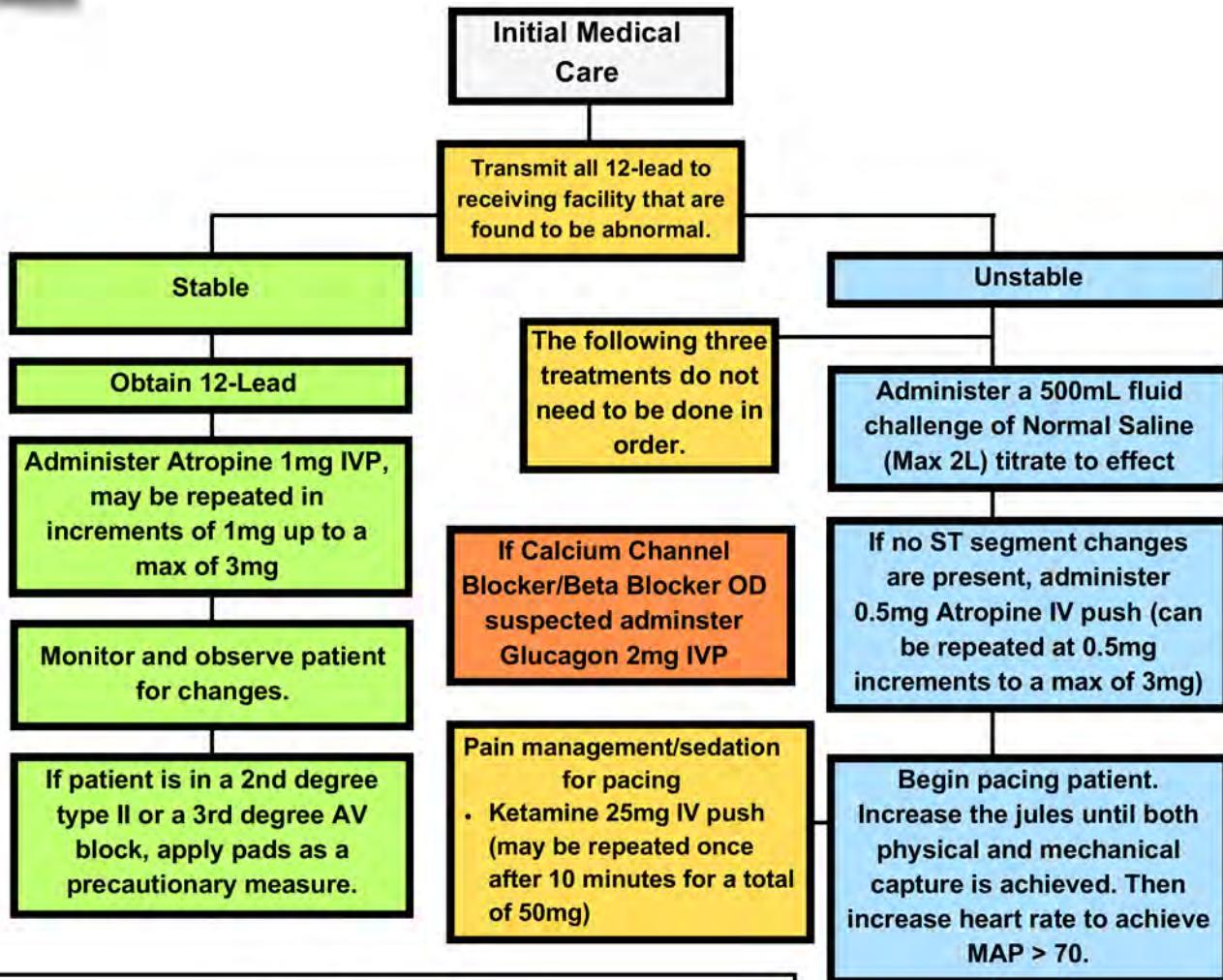
### PEARLS

#### Consider H's and T's -

- Hydrogen Ion = Ventilate and administer Sodium Bicard
- Hypovolemia = fluid administration
- Hypothermia = warm patient
- Hypoglycemia = if BGL <60 administer D10 100ml
- Hyperkalemia = Sodium Bicard, Calcium Chloride
- Toxins = Narcan
- Tension Pneumothorax = Needle decompression
- Thrombosis
- Tamponade (Cardiac)
- Trauma



## Bradycardia



### PEARLS

**Transcutaneous pacing** should be initiated when the patient's heart rate is less than 40 bpm and MAP is <70 and/or patient has ALOC.

Do not administer Atropine to patients in 2nd degree type II or 3rd degree heart blocks or patients with ST segment abnormalities (elevation or depression).

**Levophed (Norepinephrine) Drip**  
Mix 4mg of Levophed into 250ml bag of D5W. This will give you a concentration of 16mcg/ml.

**Epi Drip**  
Mix 1mg of Epi into a 500ml bag of Normal Saline and start at 2mcg/min, increasing by increments of 2mcg Q5 minutes to a max dose of 8mcg/min.

**Stable-** No ALOC and MAP >70

**Unstable-** ALOC and/or MAP < 70

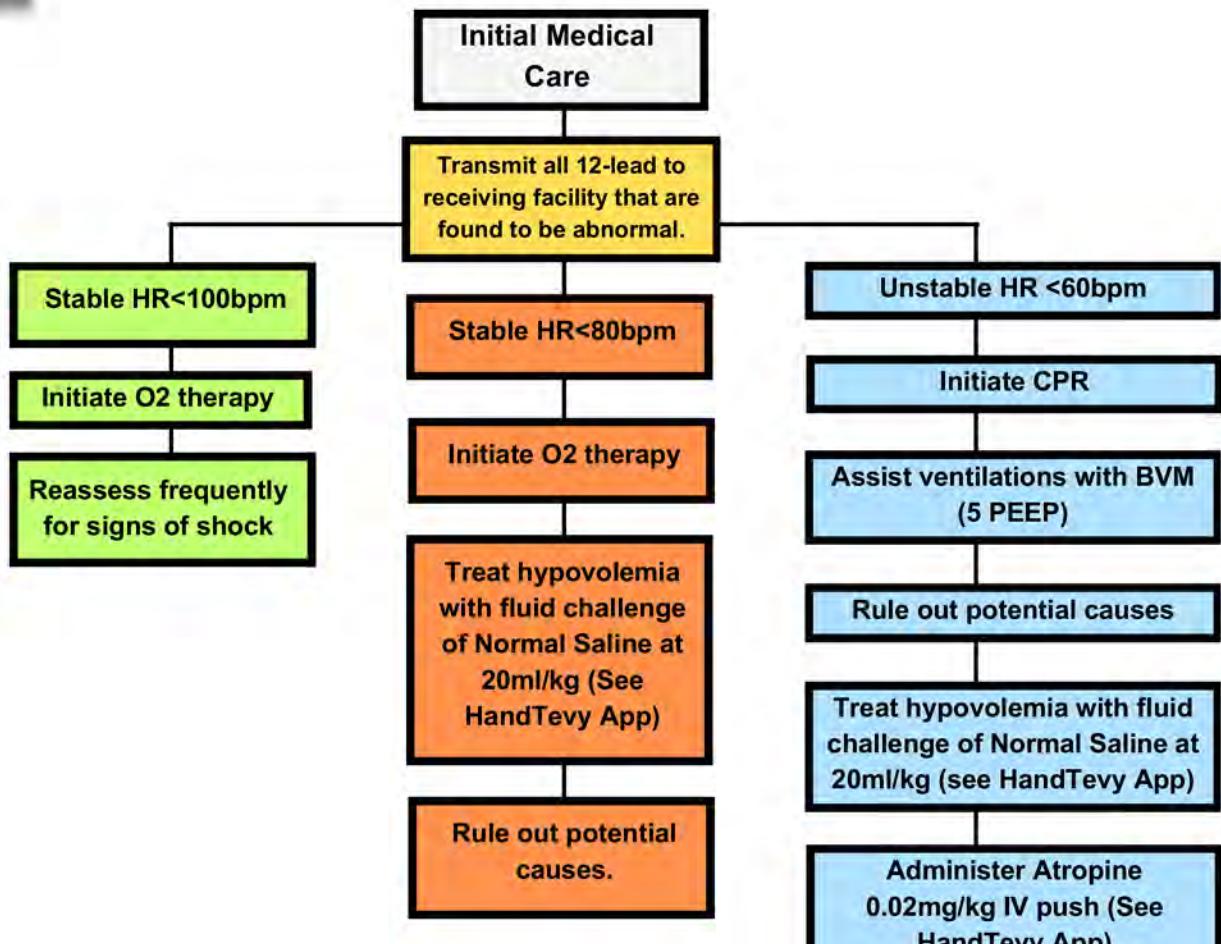
If cardiogenic shock is suspected begin administering one of the following.

- If patient is still perfusing in limbs (radial pulses present) administer Levophed IV drip of 2-4mcg/min
- If patient is not perfusing in limbs (no radial pulses) administer Epi drip of 2-8mcg/min

Administer Calcium Chloride at 1g IVP, no repeat doses



## Bradycardia



### PEARLS

#### Potential Causes

- Hypotension, vagal stimulation, infection, sepsis, toxins, hypoglycemia, trauma, epiglottis, croup, respiratory obstruction

Do not administer Atropine to patients in 2nd degree type II or 3rd degree heart blocks or patients with ST segment abnormalities (elevation or depression).

#### Levophed (Norepinephrine) Drip

Mix 4mg of Levophed into 250ml bag of D5W. This will give you a concentration of 16mcg/ml.

#### Epi Drip

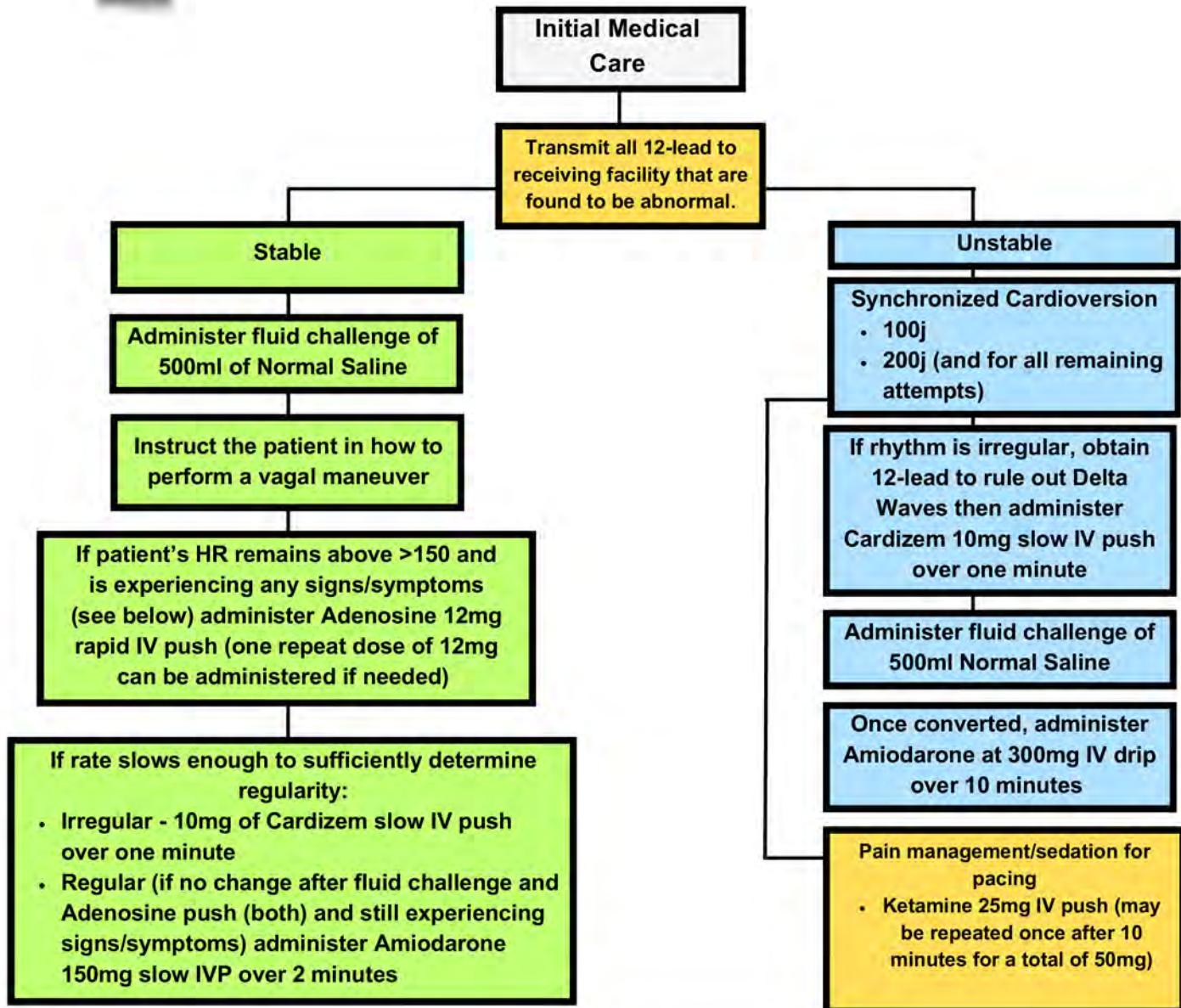
Mix 1mg of Epi into a 500ml bag of Normal Saline and start at 2mcg/min, increasing by increments of 2mcg Q5 minutes to a max dose of 8mcg/min.

**Stable-** No ALOC and SBP > normal for age

**Unstable-** ALOC and/or SBP < normal for age



## Narrow Complex Tachycardia

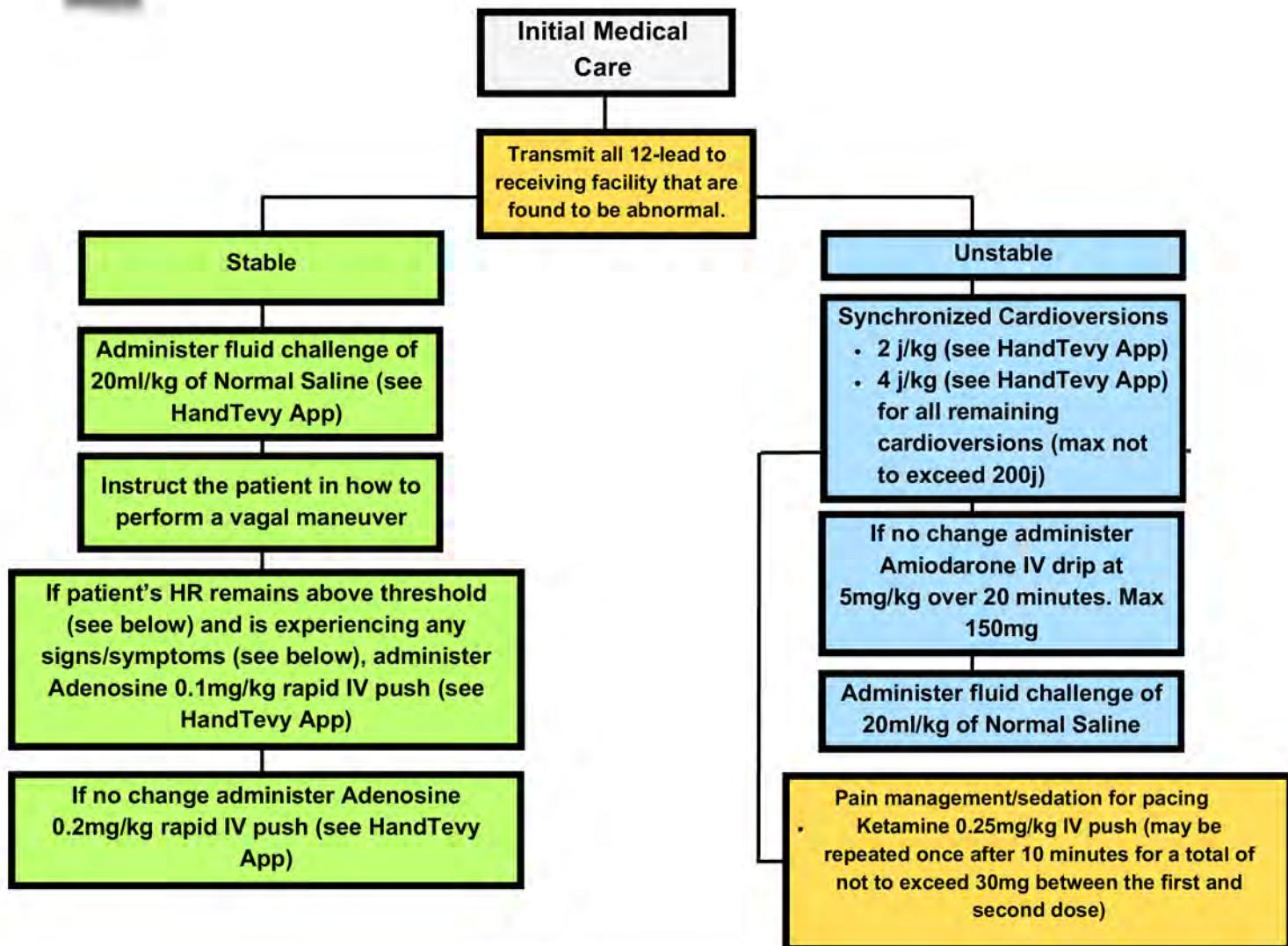


### PEARLS

Treatment of tachycardia is for rate greater than 150bpm	For vagal maneuver, instruct the patient to blow directly into an empty unused 10cc syringe.	To aid in rapid administration of Adenosine utilize a 3-way stopcock.
Cardizem will only be administered after recognizing irregularly irregular rhythm and ruling out the presence of Delta Waves, which are indicative of Wolfe Parkinson White.	<b>Signs/Symptoms</b> <ul style="list-style-type: none"> <li>• HR &gt;150, dizziness, chest pain, dyspnea, nausea, vomiting, heaviness in chest, diaphoretic</li> </ul>	<b>Differential</b> <ul style="list-style-type: none"> <li>• heart disease, sick sinus syndrome, MI, fever, hypovolemia, toxins, PE, pain, trauma, electrolyte imbalance, hypoxia, hyperthyroidism</li> </ul>



## Narrow Complex Tachycardia

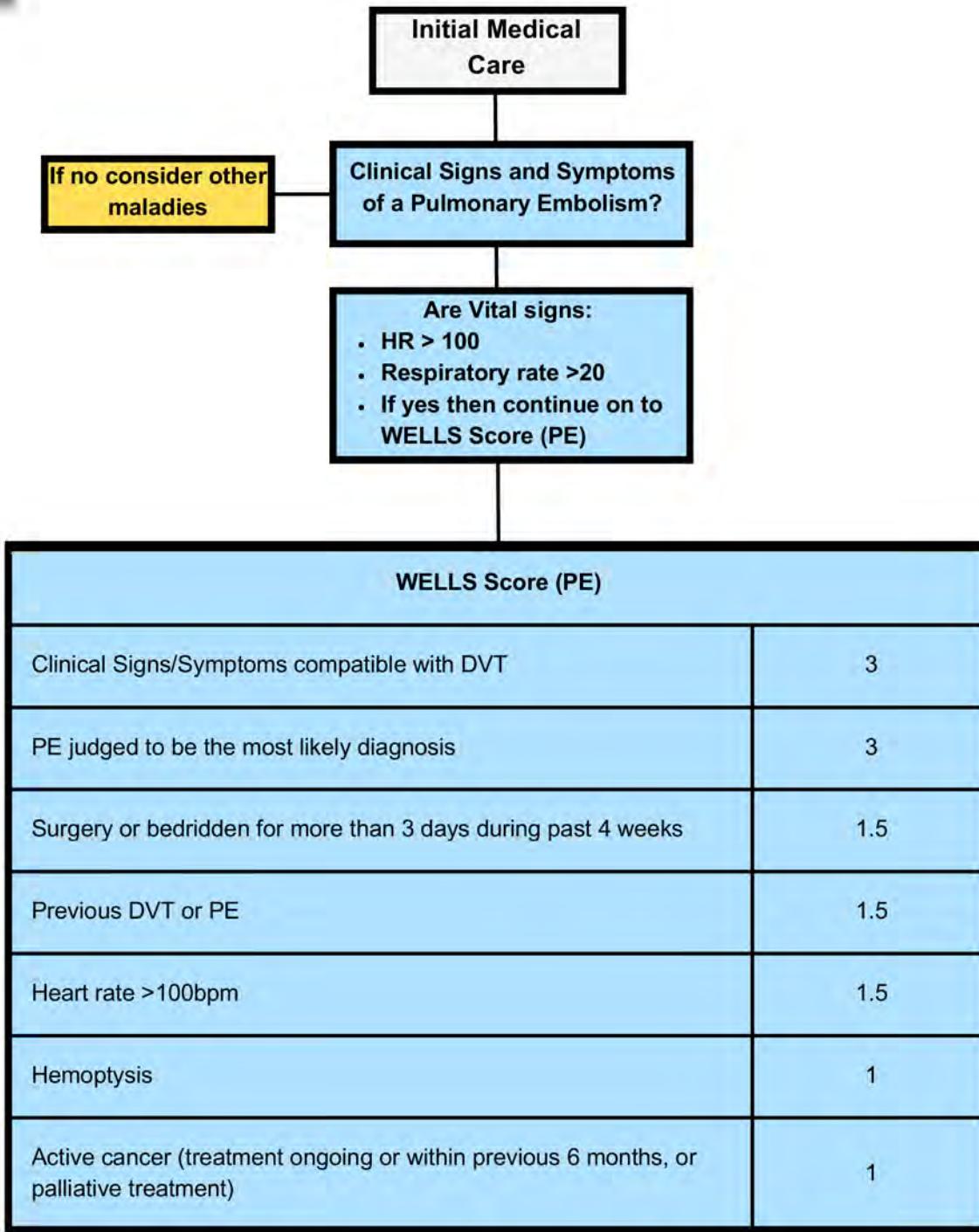


### PEARLS

Treatment of tachycardia is for rate greater than <ul style="list-style-type: none"> <li>• Infants 220bpm</li> <li>• Children 180bpm</li> </ul>	For vagal maneuver, instruct the patient to blow directly into an empty unused 10cc syringe.	To aid in rapid administration of Adenosine utilize a 3-way stopcock.
Signs/Symptoms of unstable tachy pedi patients: <ul style="list-style-type: none"> <li>• Symptoms of poor perfusion, weak or absent peripheral pulses, AMS, lethargy</li> </ul>	<b>Signs/Symptoms</b> <ul style="list-style-type: none"> <li>• pale, cyanosis, ALOC, dizziness, chest pain, dyspnea, nausea, vomiting, diaphoretic, syncope</li> </ul>	<b>Differential</b> <ul style="list-style-type: none"> <li>• heart disease, sick sinus syndrome, MI, fever, hypovolemia, toxins, PE, pain, trauma, electrolyte imbalance, hypoxia, hyperthyroidism</li> </ul>



## Pulmonary Embolism



4 or less = Low probability  
 4.5 to 6 = Moderate probability  
 >6 = High probability

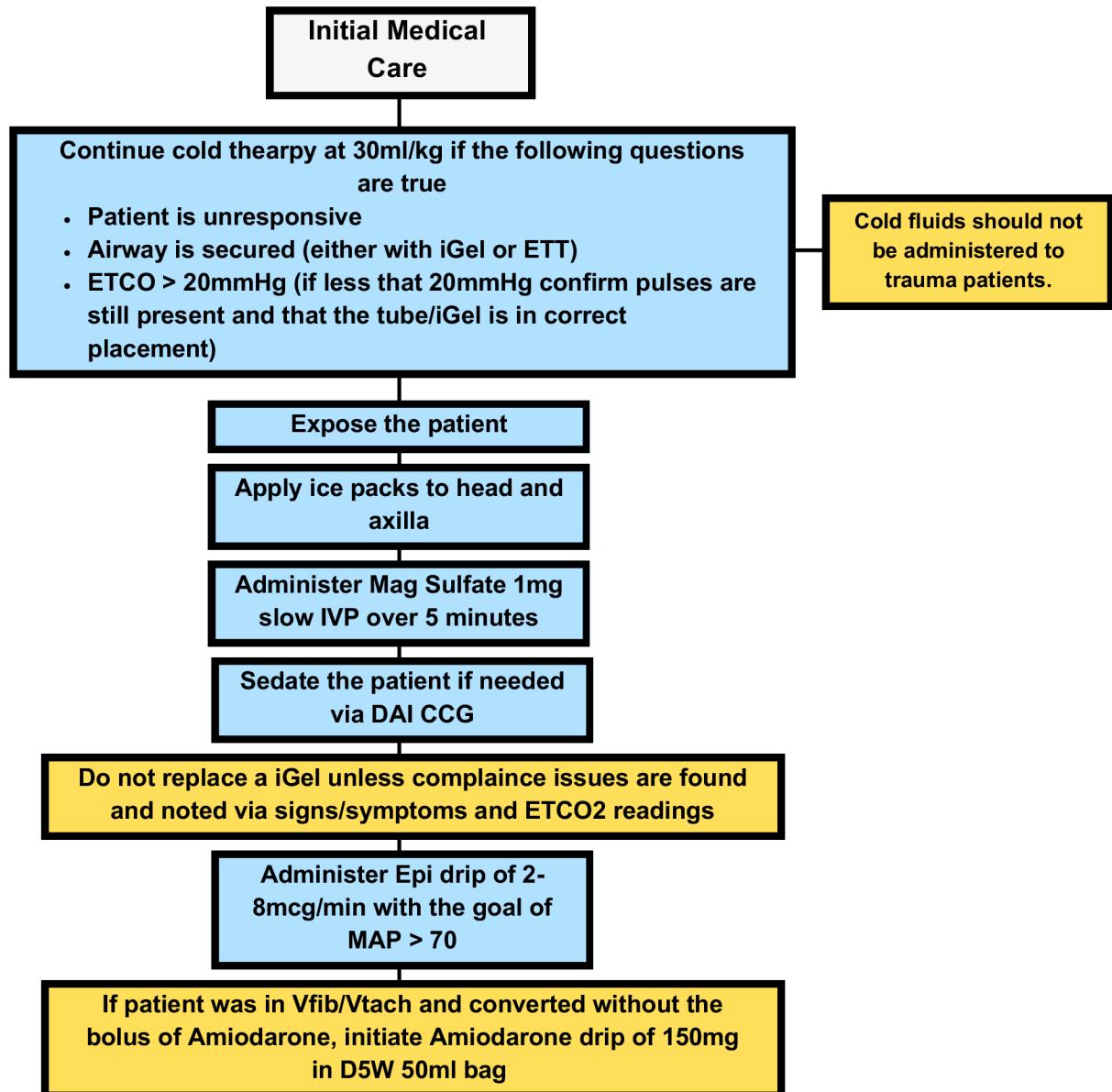
Timely recognition of a possible PE is extremely important to the care and outcome of the patient. If the patient meets any of the risk factors for a PE, notify the ER during the radio report and again to the receiving RN.



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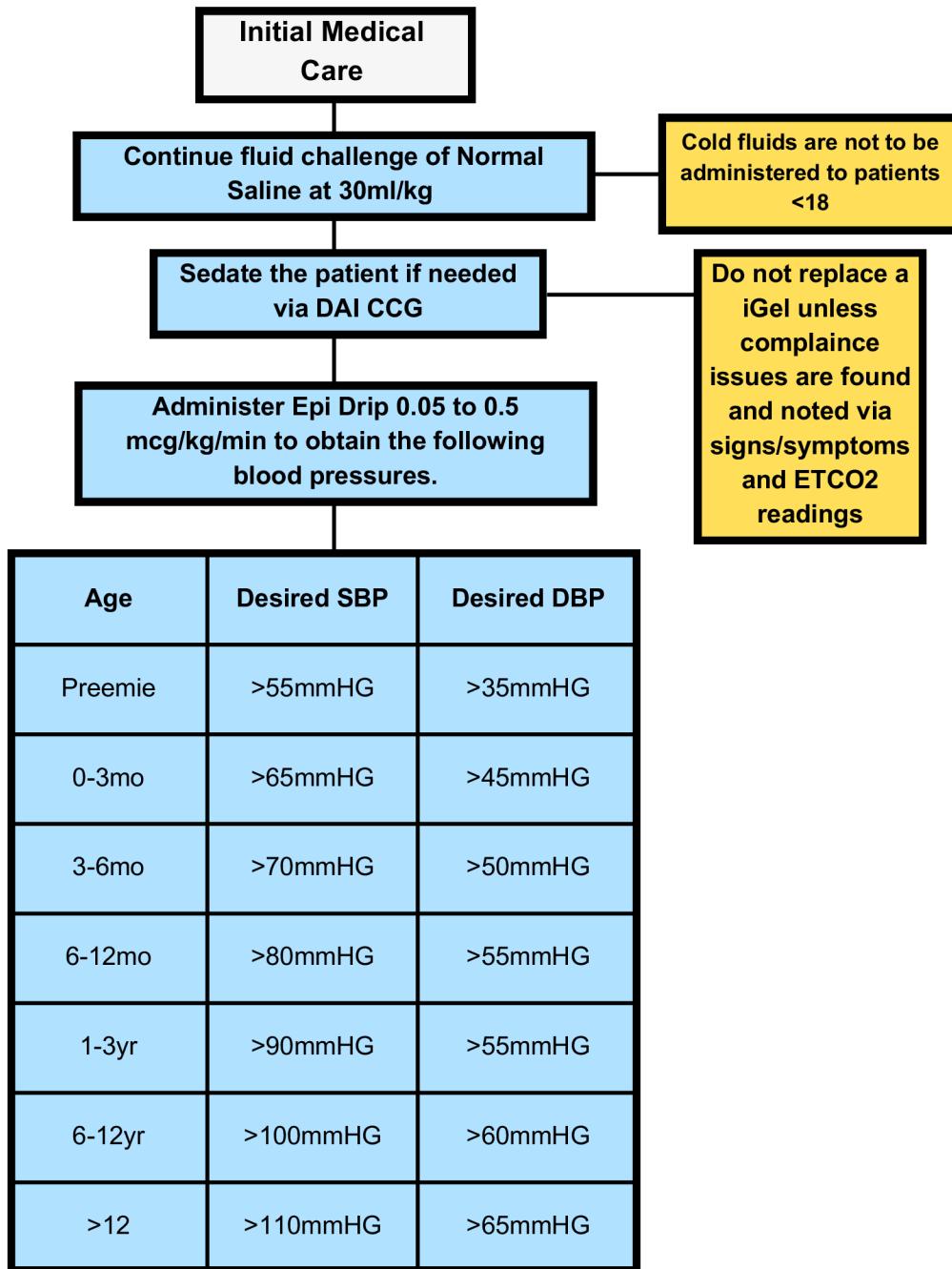
## Post ROSC Care



### PEARLS

<b>Epi Drip</b> Mix 1mg of Epi into a 500ml bag of Normal Saline and start at 2mcg/min, increasing by increments of 2mcg Q5 minutes to a max dose of 8mcg/min.	Be prepared to being pacing if patient becomes bradycardic.	Goal for hypothermic care is to drop the body temperature 1'C. Survival rates drop when cooling is delayed.
Patients can develop metabolic alkalosis with cooling. Do not hyperventilate.	Do not delay transport for cooling measures.	Be mindful of your surroundings when exposing the patient and take steps to preserve the patients modesty.

## Post ROSC Care



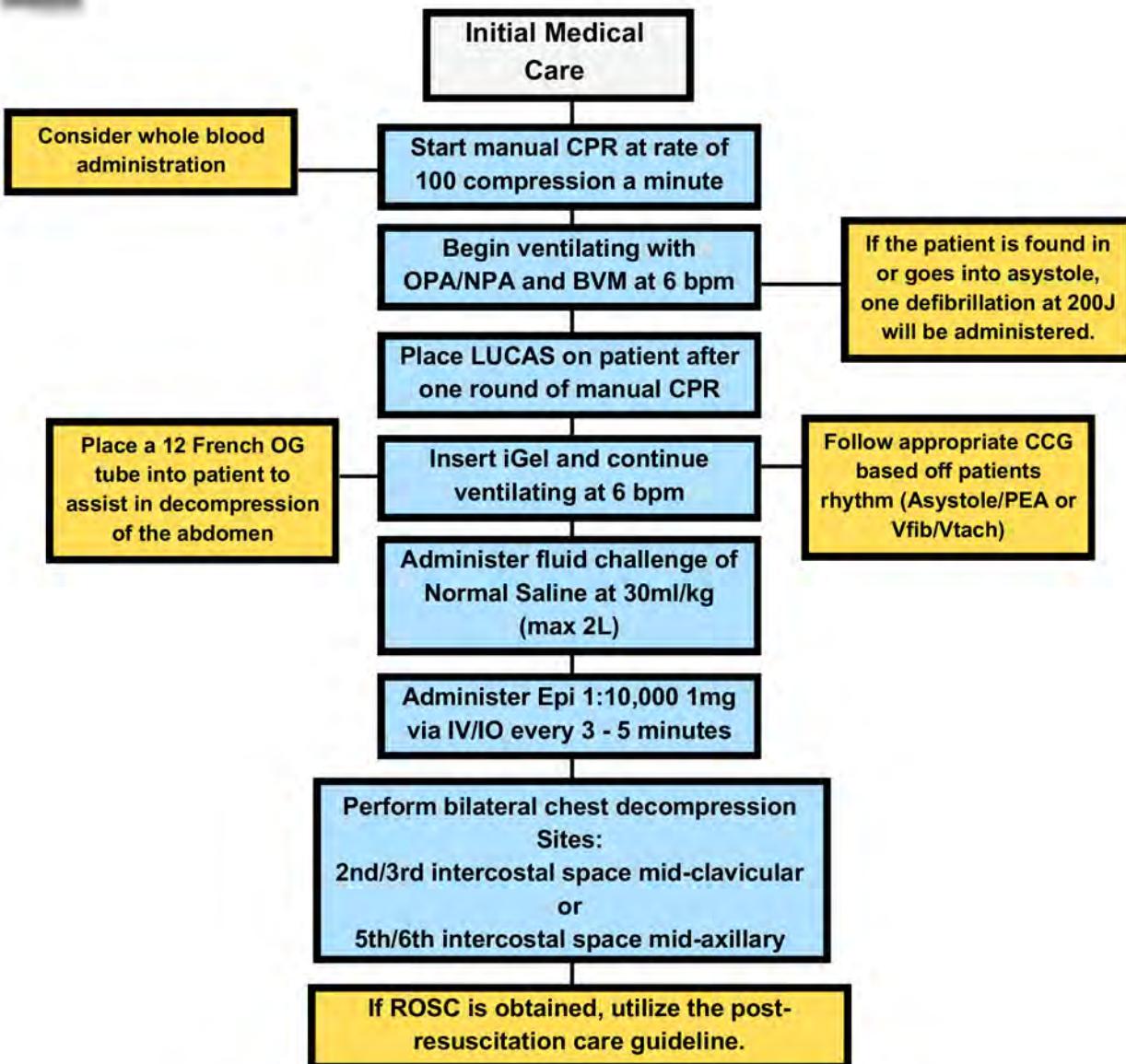
### PEARLS

#### Epi Drip

Mix 1mg of Epi into a 500ml bag of Normal Saline and start at 2mcg/min, increasing by increments of 2mcg Q5 minutes to a max dose of 8mcg/min.



## Traumatic Cardiac Arrest



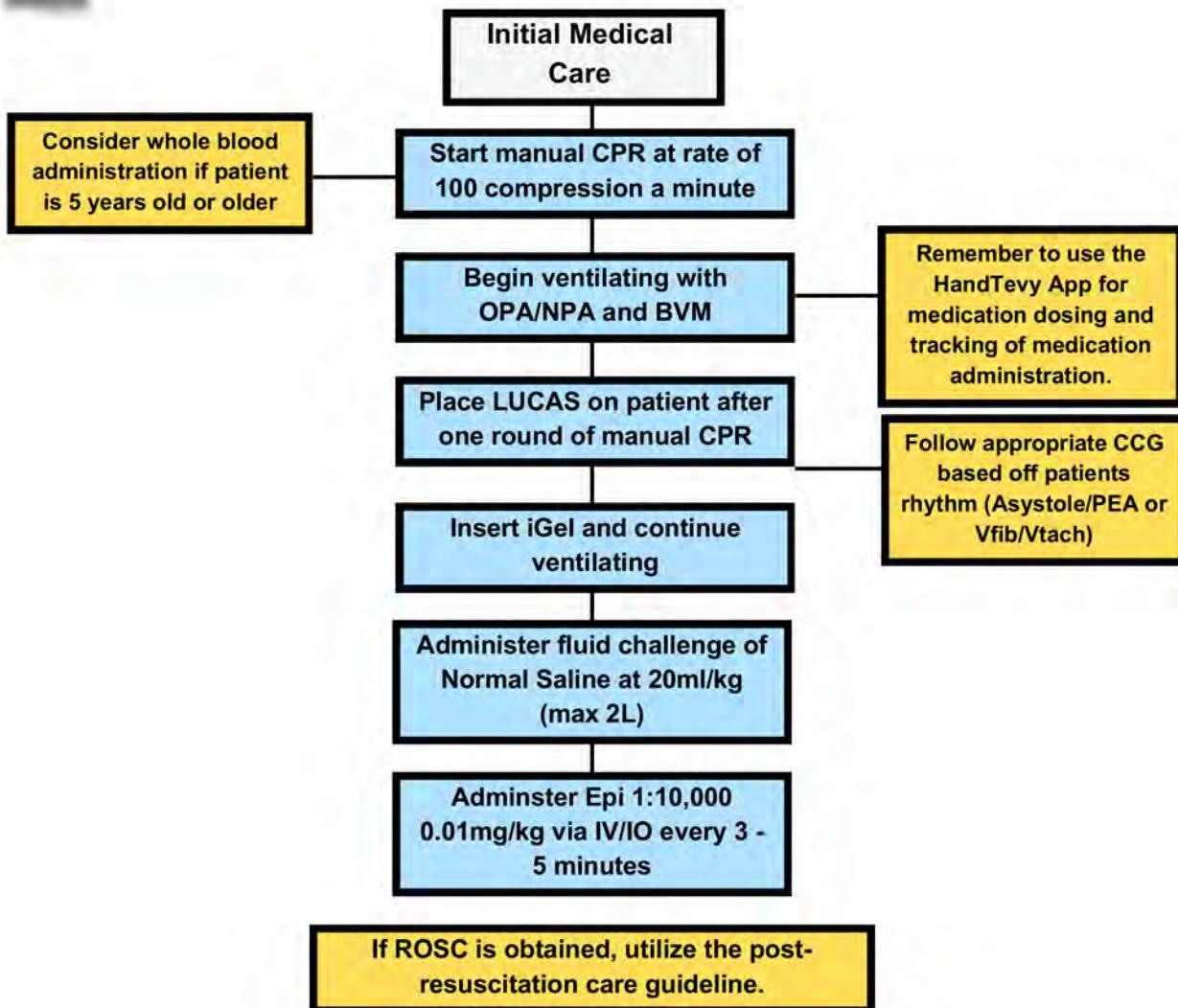
### PEARLS

#### Consider H's and T's -

- Hydrogen Ion = Ventilate and administer Sodium Bicard
- Hypovolemia = fluid administration
- Hypothermia = warm patient
- Hypoglycemia = if BGL <60 administer D10 100ml
- Hyperkalemia = Sodium Bicard, Calcium Chloride
- Toxins = Narcan
- Tension Pneumothorax = Needle decompression
- Thrombosis
- Tamponade (Cardiac)
- Trauma



## Traumatic Cardiac Arrest



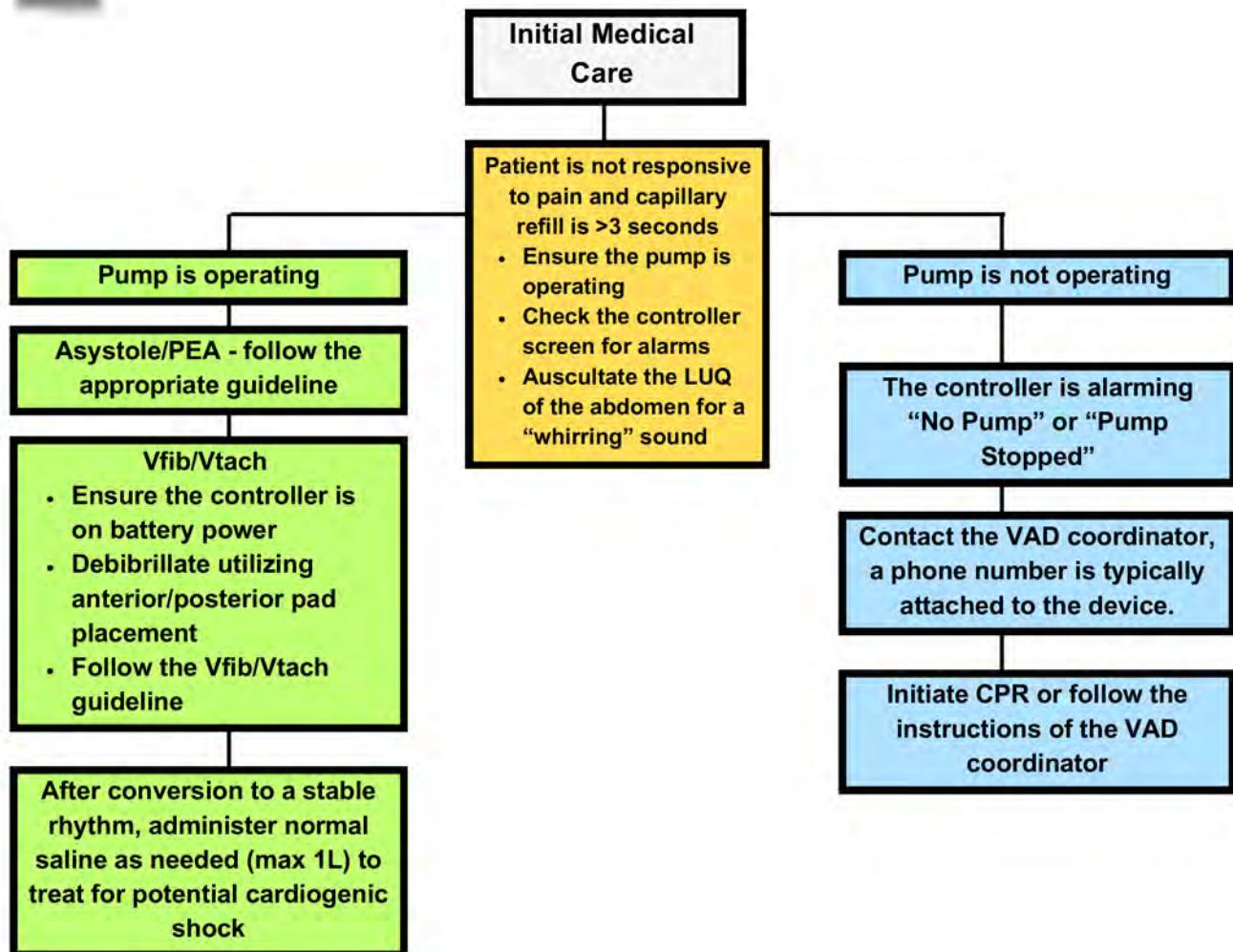
### PEARLS

#### Consider H's and T's -

- Hydrogen Ion = Ventilate and administer Sodium Bicarb
- Hypovolemia = fluid administration
- Hypothermia = warm patient
- Hypoglycemia = if BGL <60 administer D10 100ml
- Hyperkalemia = Sodium Bicarb, Calcium Chloride
- Toxins = Narcan
- Tension Pneumothorax = Needle decompression
- Thrombosis
- Tamponade (Cardiac)
- Trauma



## Ventricular Assist Device



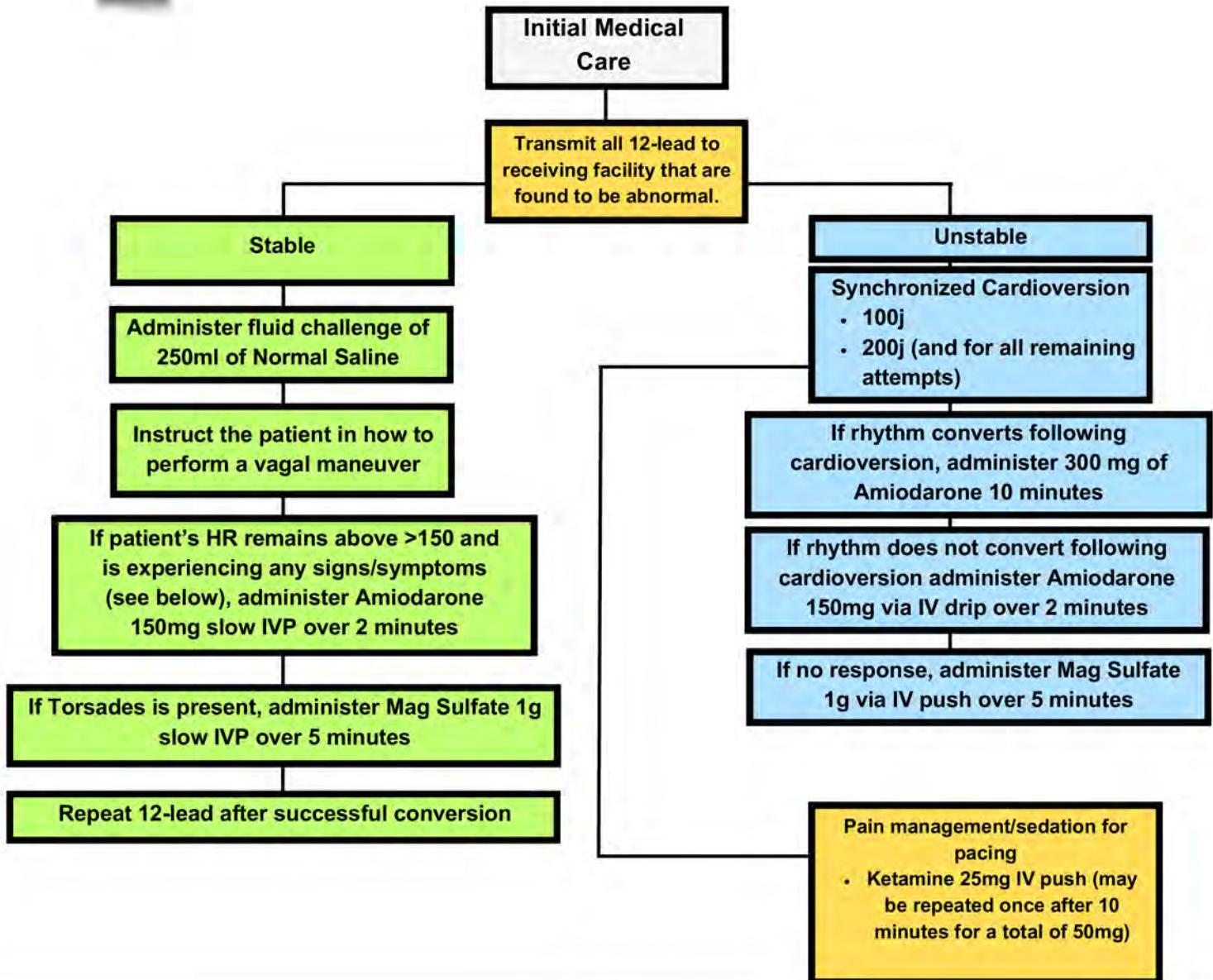
Scan below QR code for device information



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## Wide Complex Tachycardia

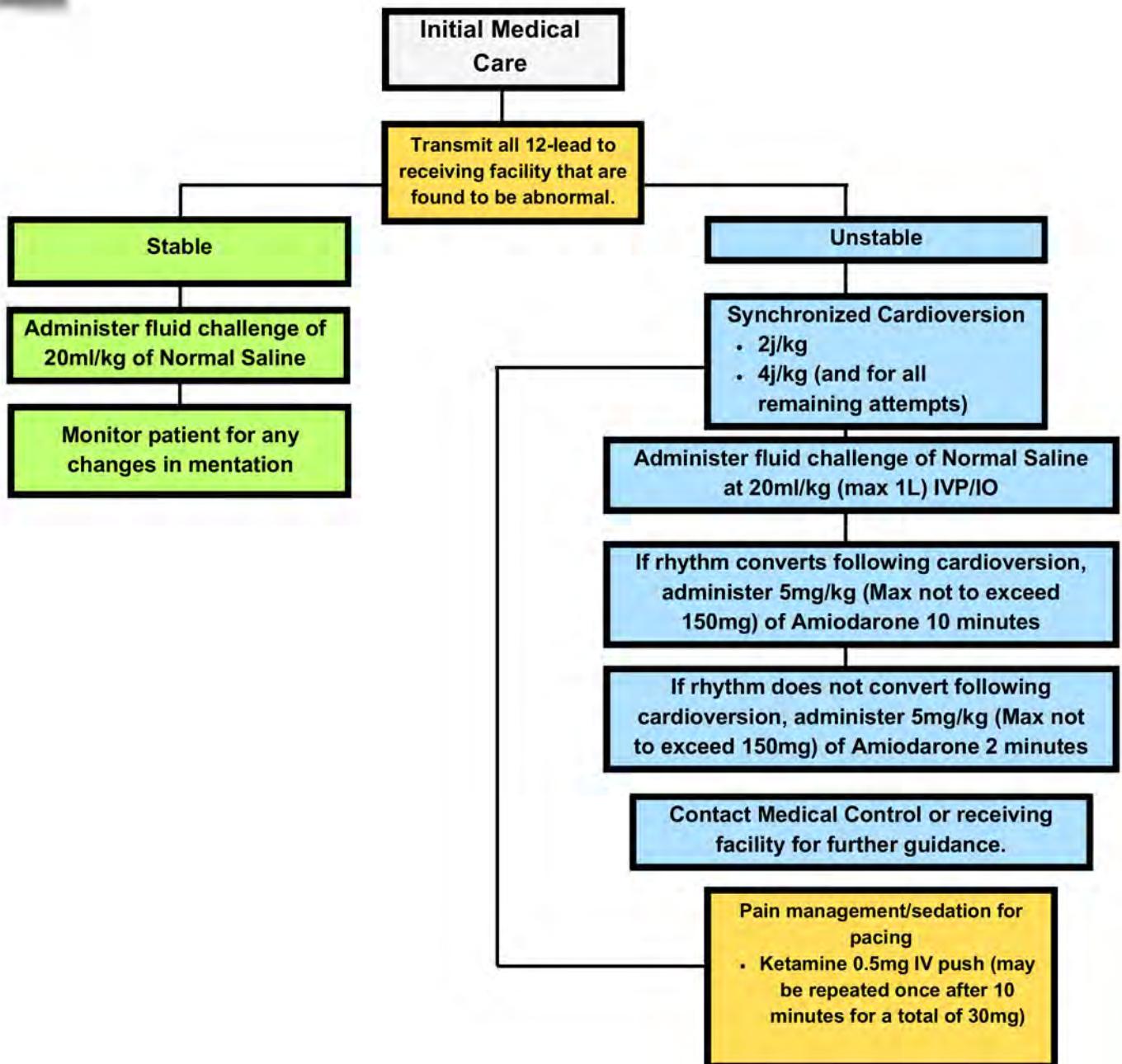


### PEARLS

Treatment of wide complex tachycardia is for a sustained rate greater than 150bpm	For vagal maneuver, instruct the patient to blow directly into an empty unused 10cc syringe.	A sustained run of wide complex tachycardia is defined as 6 or more wide complexes.
Mix 1g of Mag Sulfate in 10ml of Normal Saline to administer over 5 minutes.	<b>Signs/Symptoms</b> <ul style="list-style-type: none"> <li>• HR &gt;150, dizziness, chest pain, dyspnea, nausea, vomiting, heaviness in chest, diaphoretic</li> </ul>	<b>Differential</b> <ul style="list-style-type: none"> <li>• hypoxia, potassium (hypo/hyper), drug overdose, acidosis, hypothermia, device (electrode/lead) error, death</li> </ul>



## Wide Complex Tachycardia



### PEARLS

Treatment of tachycardia is for rate greater than

- Infants 220bpm
- Children 180bpm

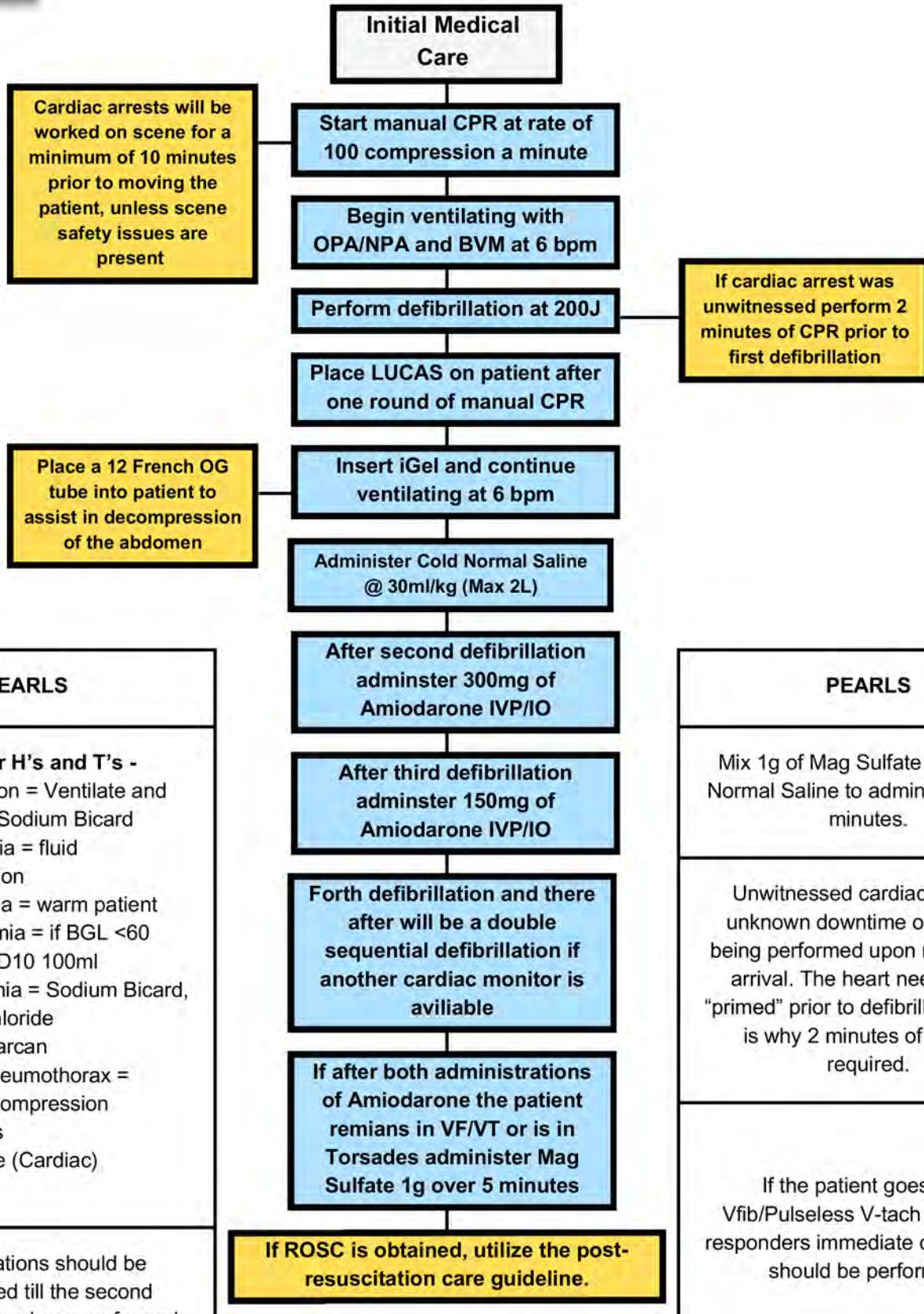
For vagal maneuver, instruct the patient to blow directly into an empty unused 10cc syringe.

### Differential

hypoxia, potassium (hypo/hyper), drug overdose, acidosis, hypothermia, device (electrode/lead) error, death

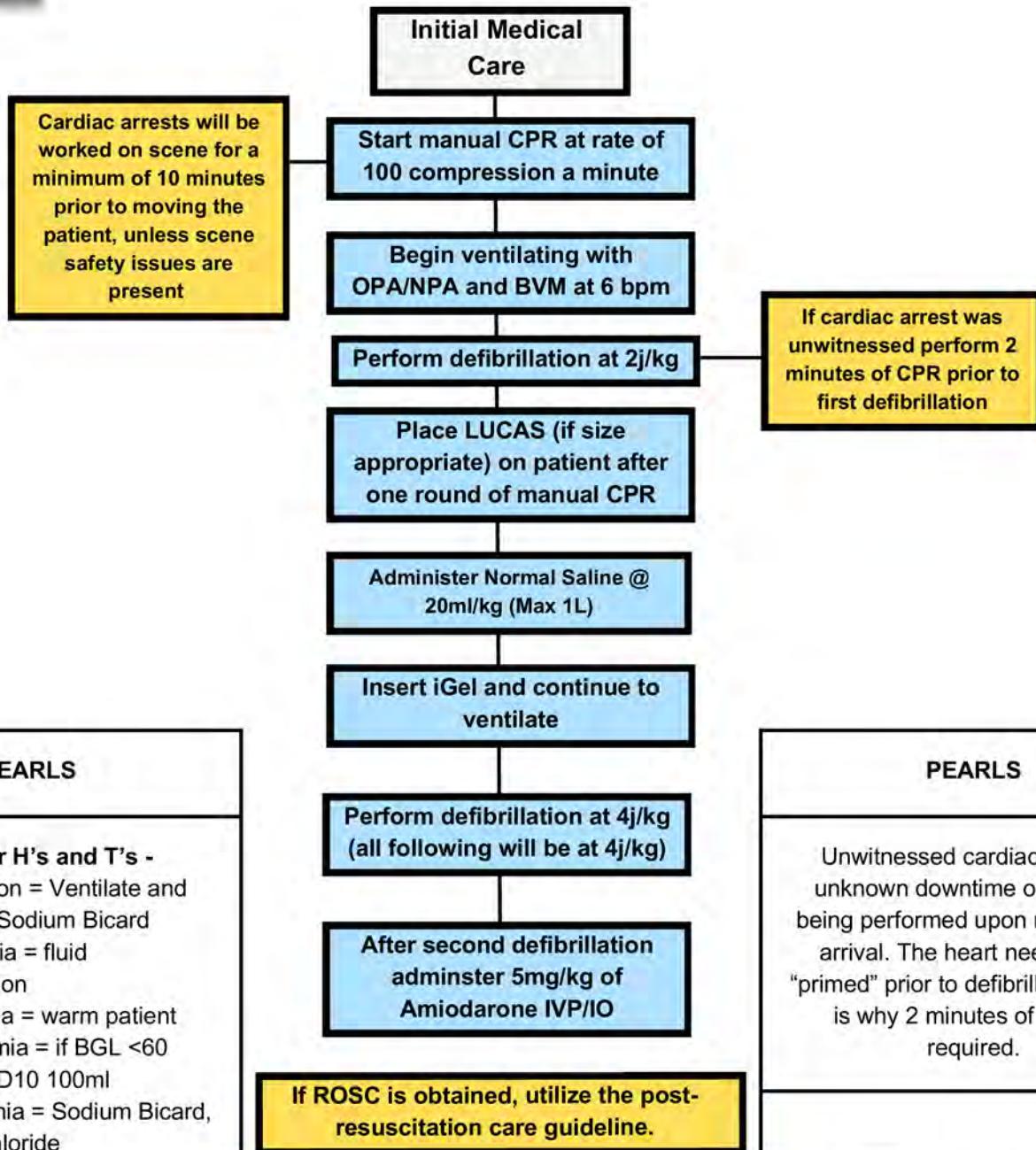


## V-Fib/Pulseless V-Tac



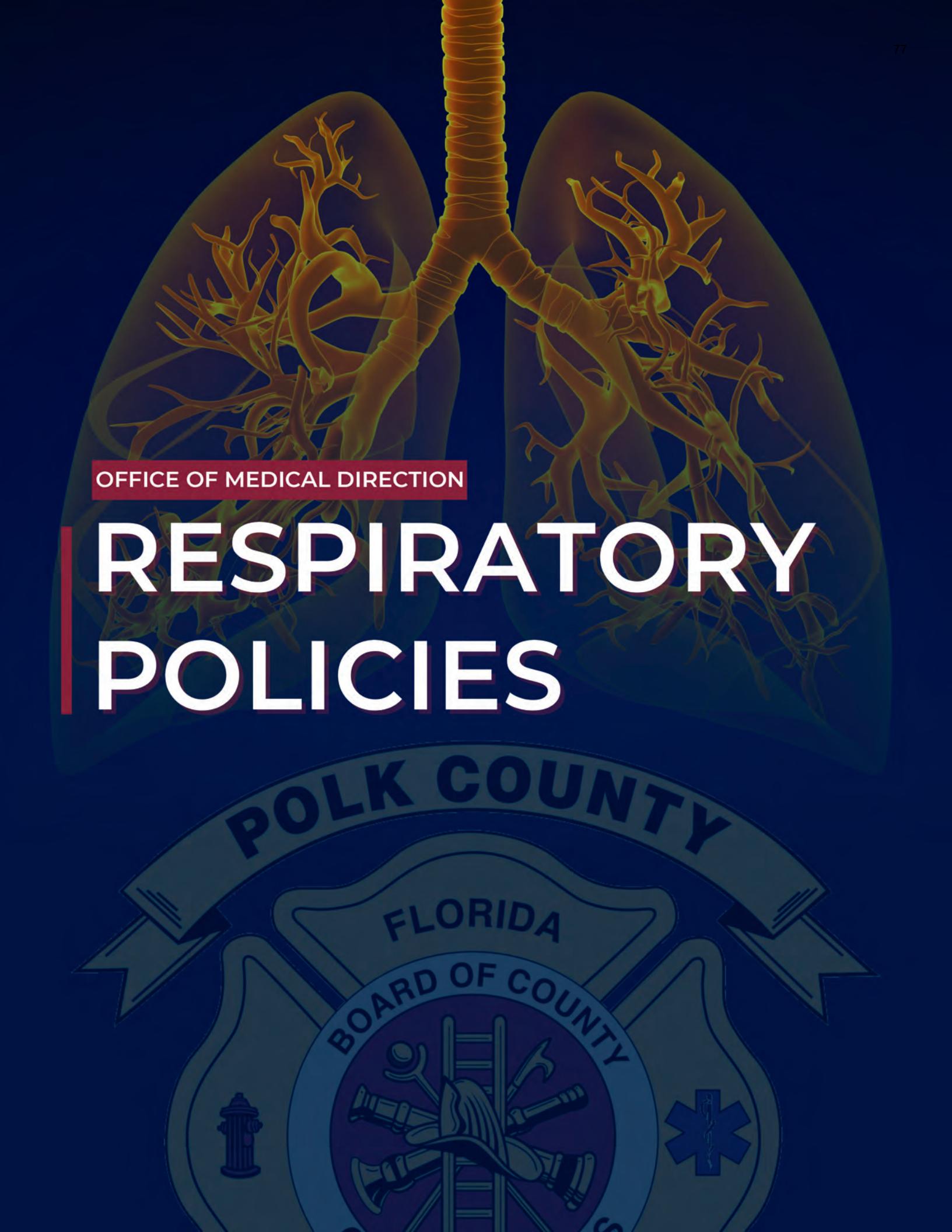


## V-Fib/Pulseless V-Tac



No medications should be administered till the second defibrillation has been performed

If the patient goes in to Vfib/Pulseless V-tach in front of responders immediate defibrillation should be performed.

A detailed anatomical illustration of a human respiratory system. It features two large, light blue lungs with intricate orange and yellow branching networks representing the bronchial tree. A thick, yellowish-orange tube representing the trachea descends from the top center, branching into the two lungs.

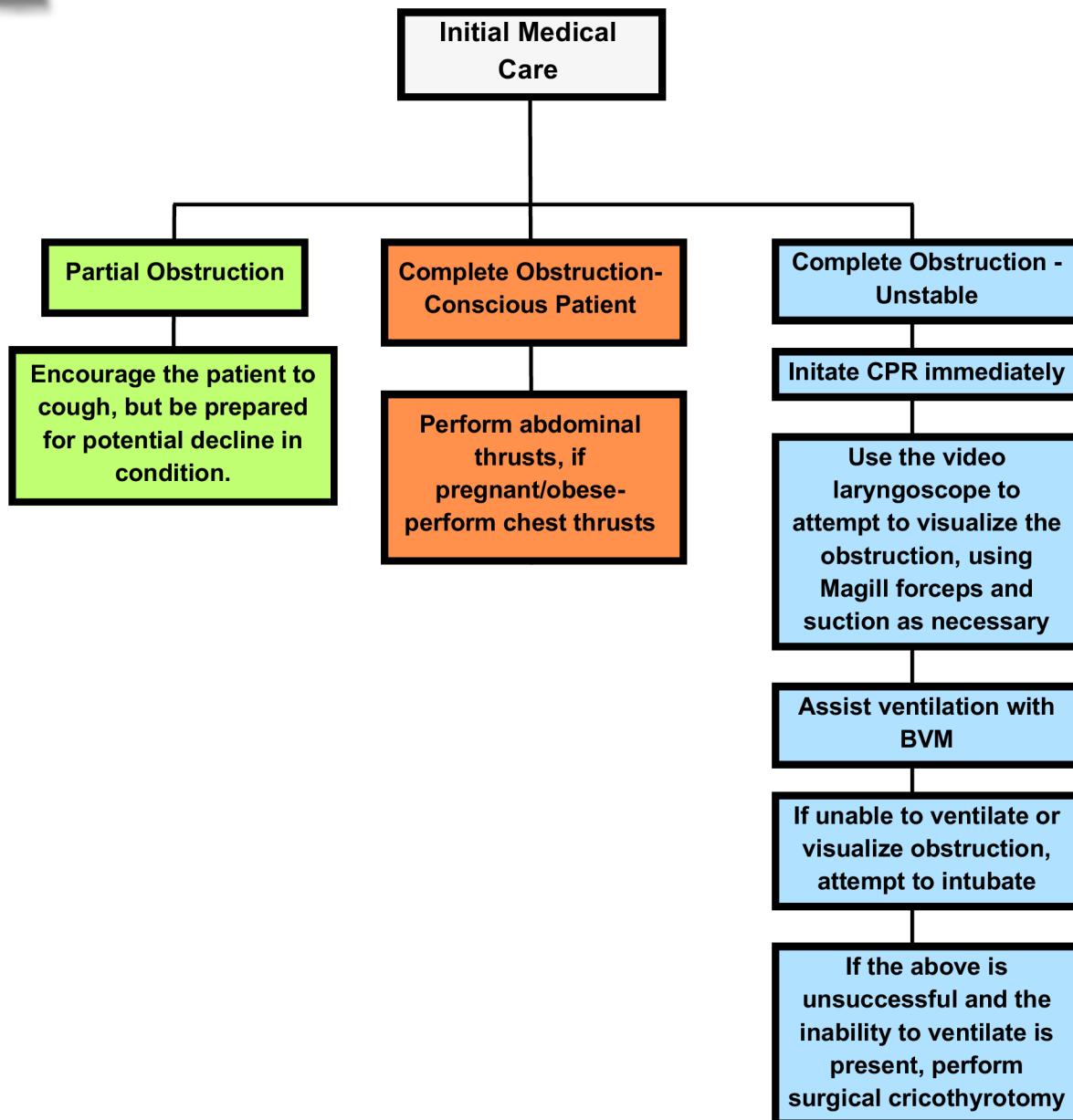
OFFICE OF MEDICAL DIRECTION

# RESPIRATORY POLICIES



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# Airway Obstruction



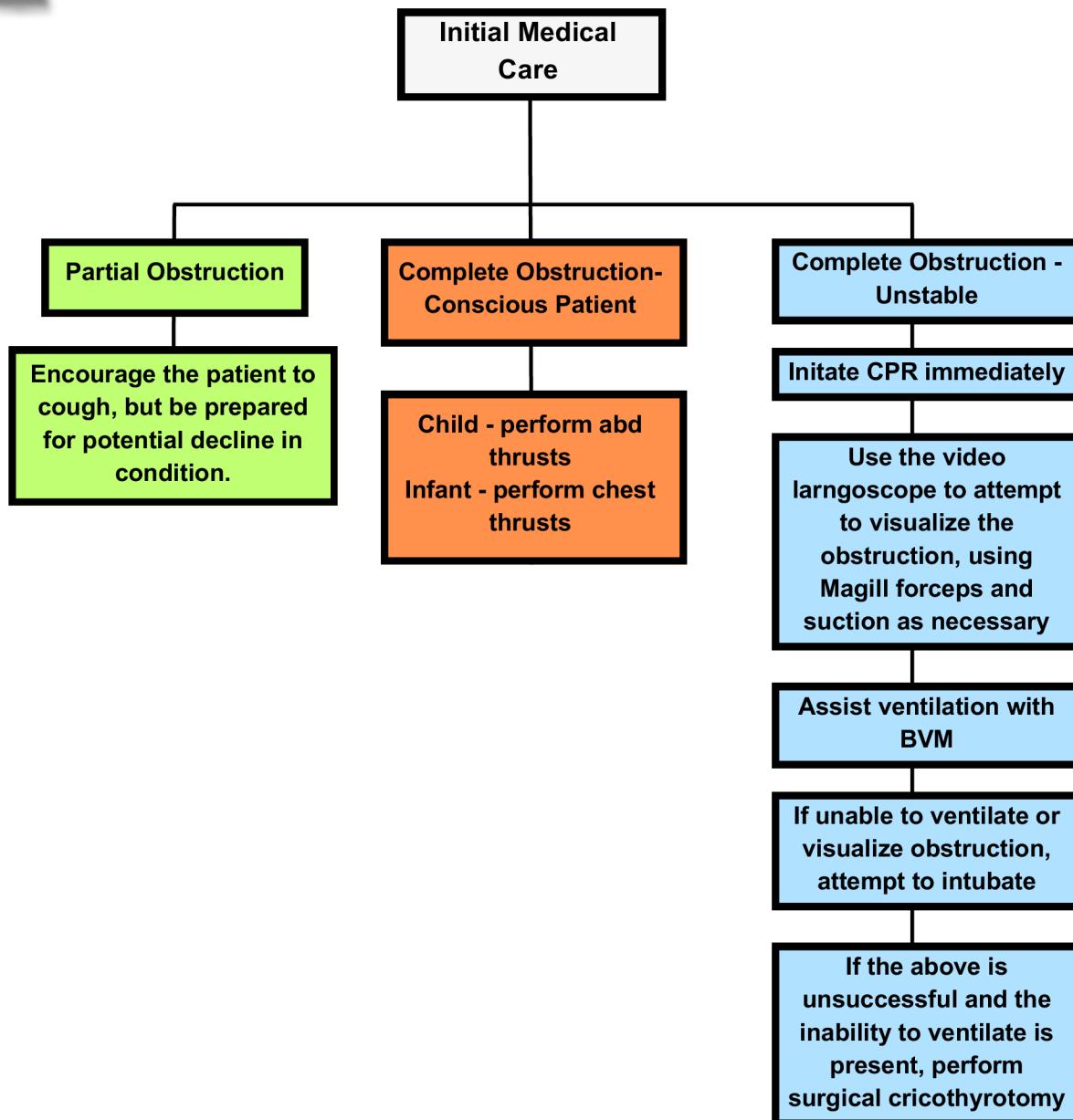
## PEARLS

Utilize nasal capnography for conscious patients and end-tidal ETCO<sub>2</sub> for unconscious patients.

Never blindly insert anything into oropharynx or perform a blind finger sweep.

Alternate ventilations and clearing techniques. Once airway is cleared, support ventilations as needed with oxygen.

## Airway Obstruction



### PEARLS

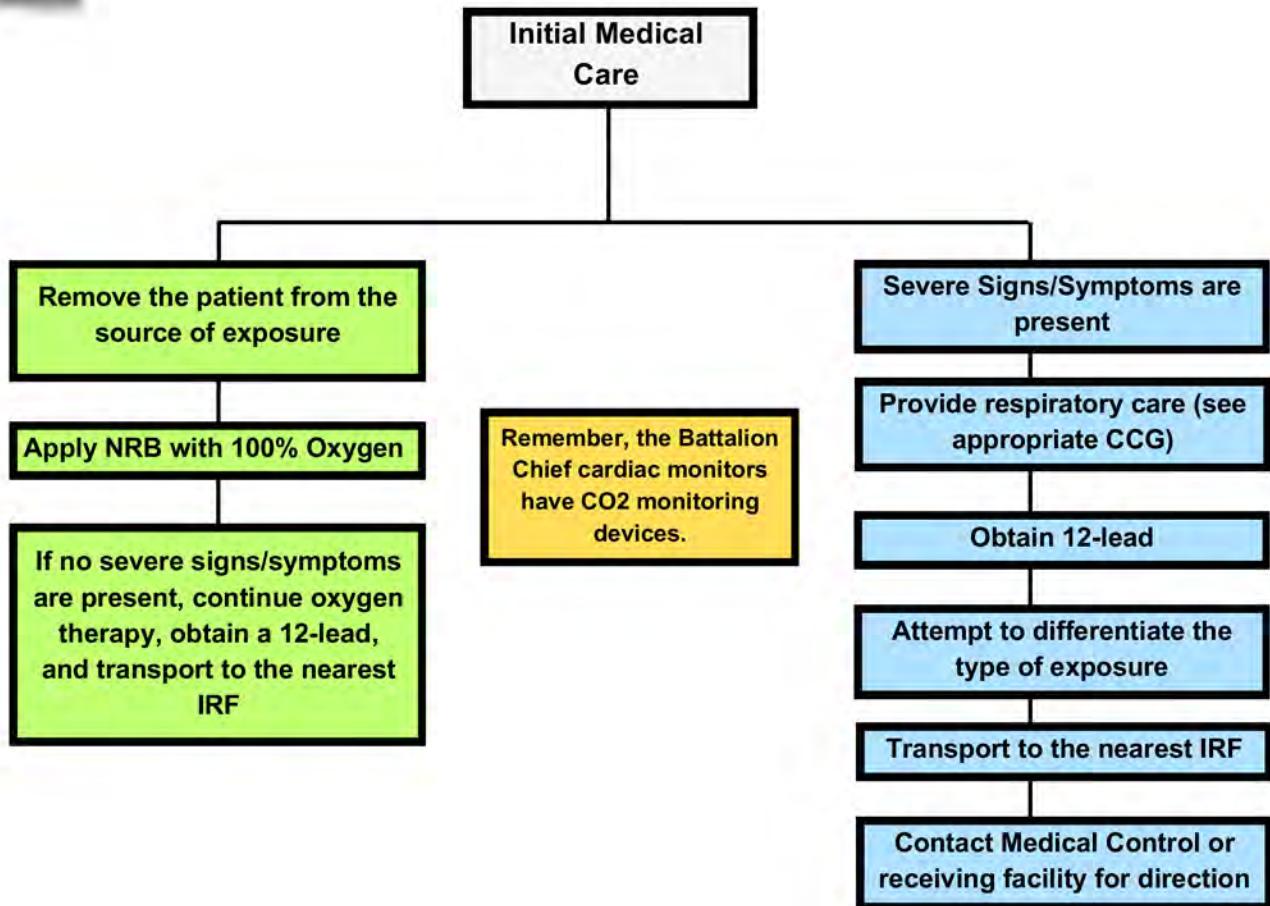
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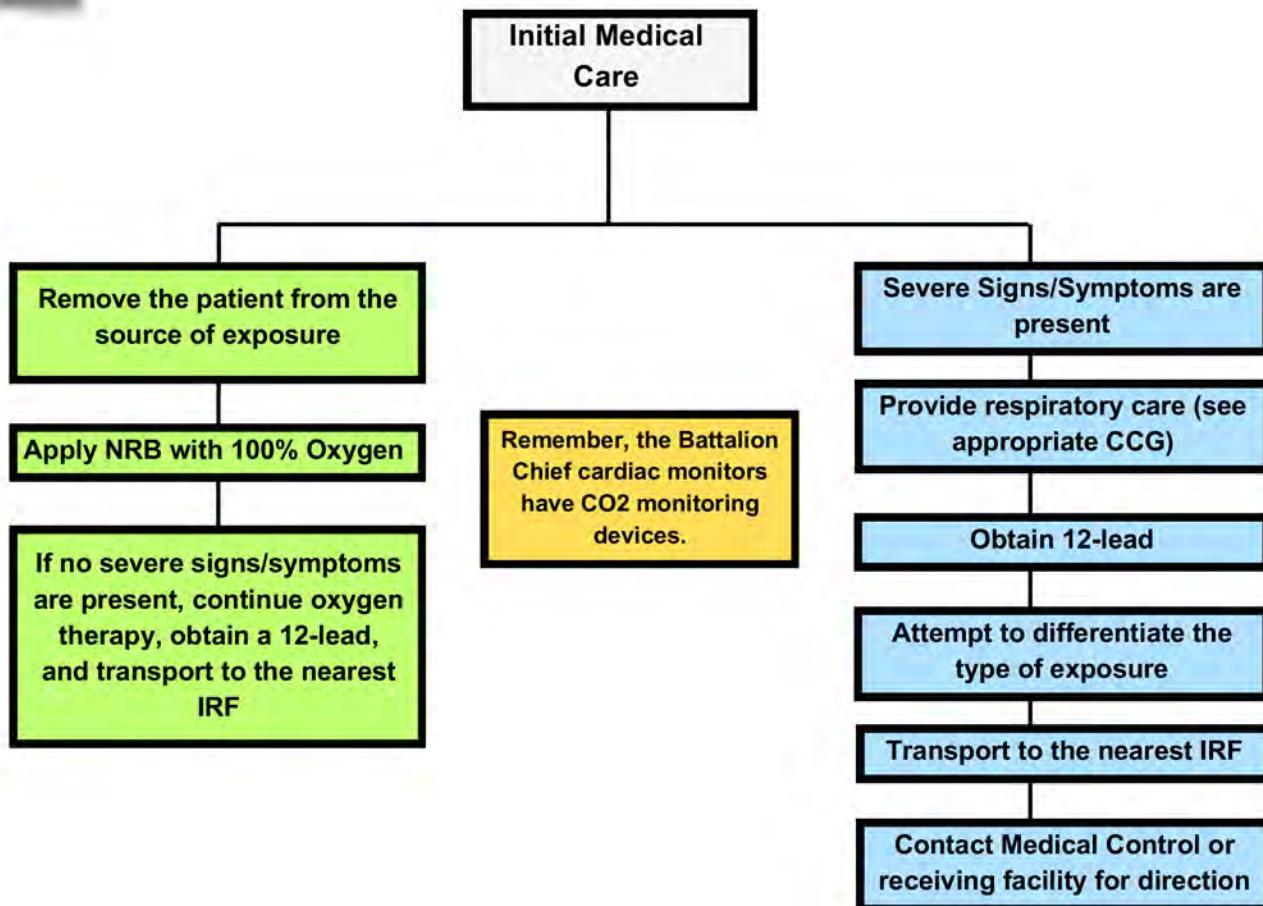


## Carbon Monoxide/Cyanide Exposure





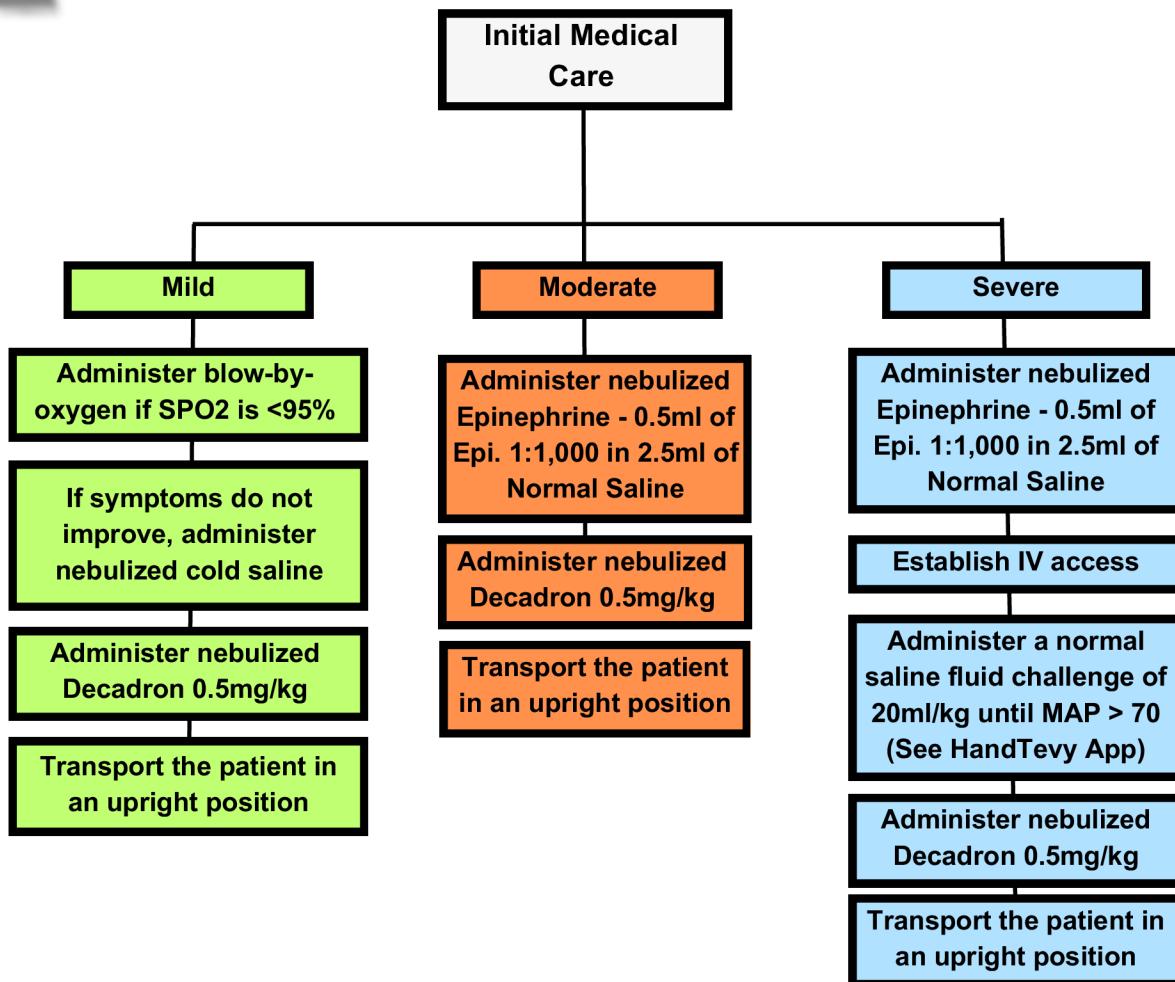
## Carbon Monoxide/Cyanide Exposure



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## Croup



### PEARLS

<p>Croup refers to an infection of the upper airway, which obstructs breathing and causes a barking cough.</p>	<p>The cough and other signs and symptoms of croup are the result of swelling around the voice box (larynx), windpipe (trachea) and bronchial tubes (bronchi). When a cough forces air through this narrowed passageway, the swollen vocal cords produce a noise similar to a seal barking. Likewise, taking a breath often produces a high pitched whistling sound (stridor).</p>	<p>Providers should attempt to keep the patient calm and limit any unnecessary agitation (i.e. IV access, Nebulizer).</p>
<p>Croup is usually caused by a viral infection.</p>	<p>Most at risk age group is usually between the ages of 6 months and 3 years.</p>	



## Drug Assisted Intubation

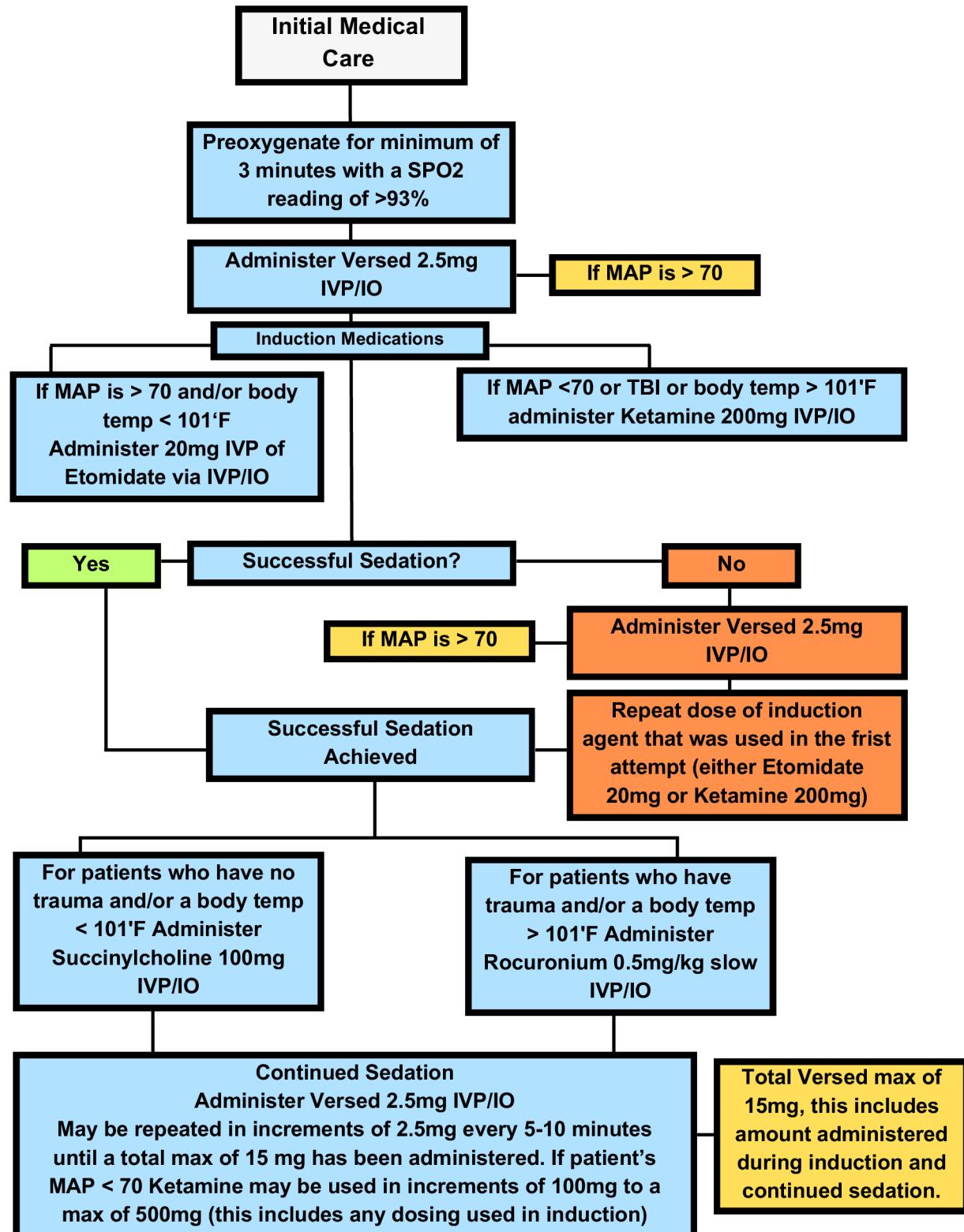
### PEARLS

Video laryngoscope will be the initial type of intubation attempt. Direct visualization will only be used if video laryngoscope is not available.

To prevent delay in ventilations only 2 attempts can be made for ETT then a iGel will be utilized. Attempt= stopping ventilation and inserting the blade into the patients mouth. This does not mean 2 attempts per paramedic, this is 2 attempts period.

If a successful airway can not be obtained and ventilation with BLS measures are not successful, surgical cricothyrotomy should be considered.

Patients with a GCS of 8 or less will require airway protection if corrective measures are unsuccessful.



### Continued Sedation

If transport time is > 15 minutes and Versed/Ketamine maxes have been reached and you are unable to call for additional orders, Rocuronium 0.5mg/kg slow IVP over 2 minutes may be administered. This can be repeated one time at 0.5mg/kg for a total max of 1mg/kg or 100mg.



## Drug Assisted Intubation

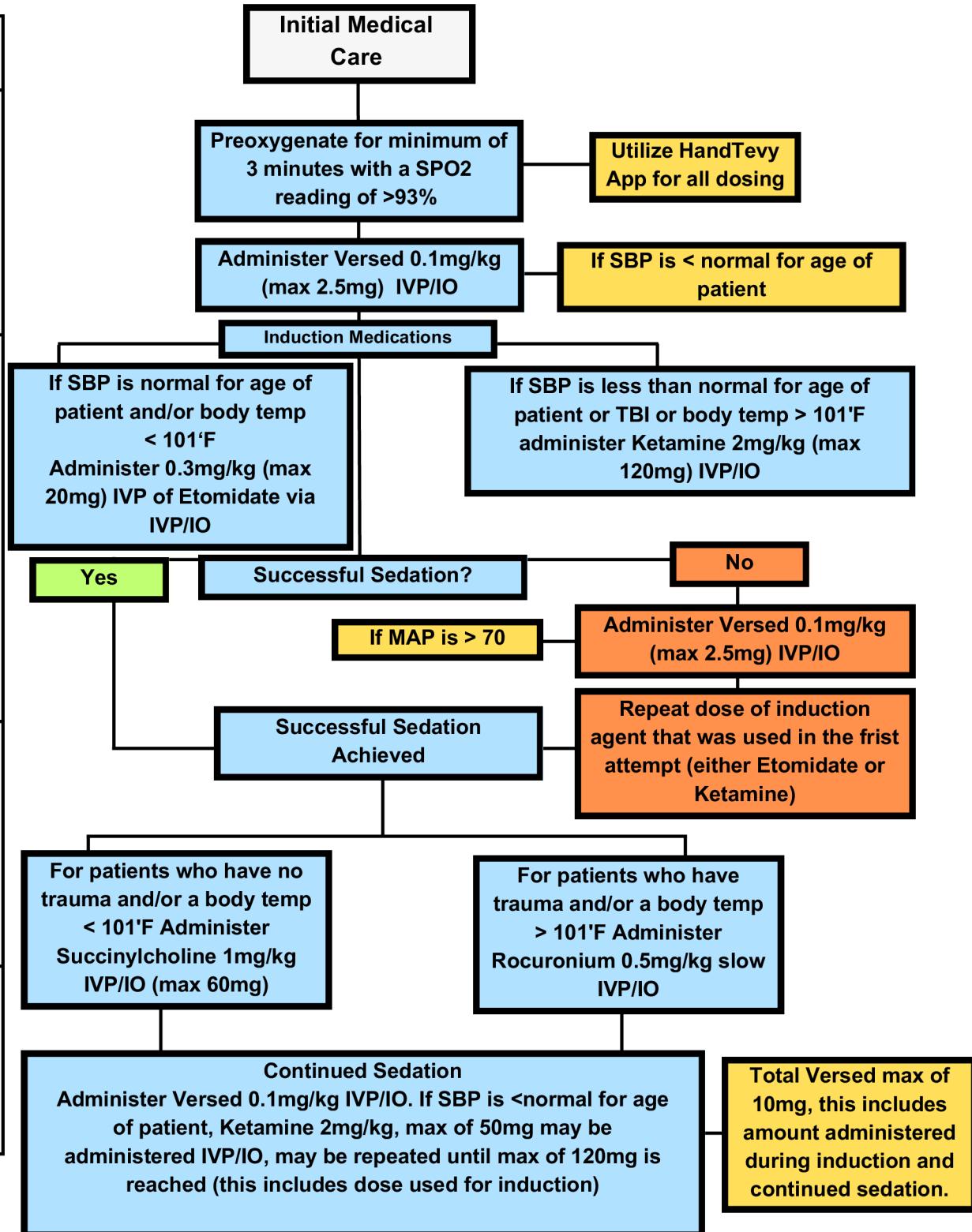
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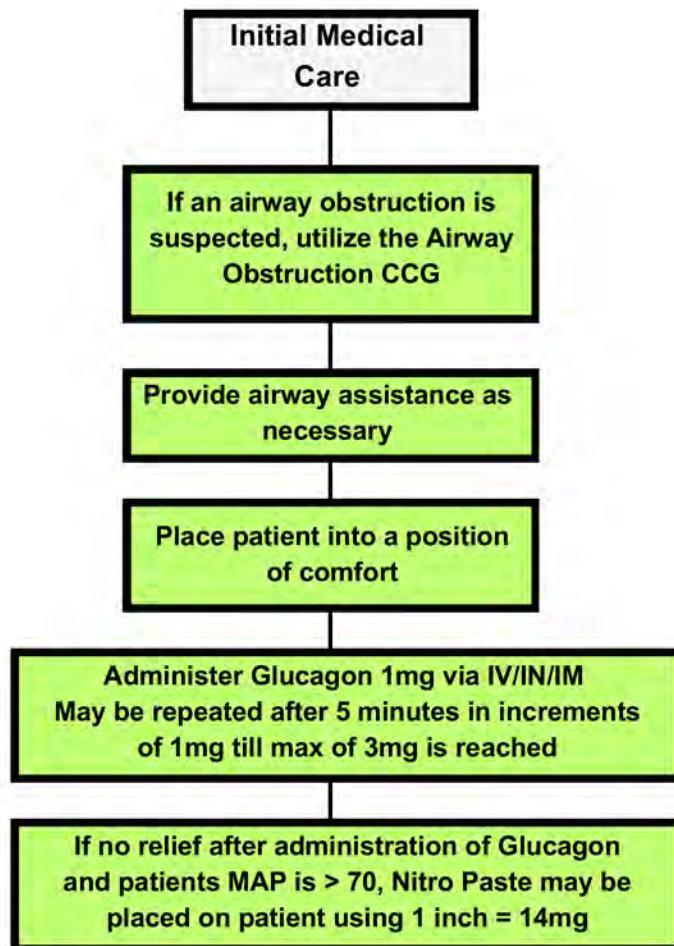
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## Esophageal Obstruction

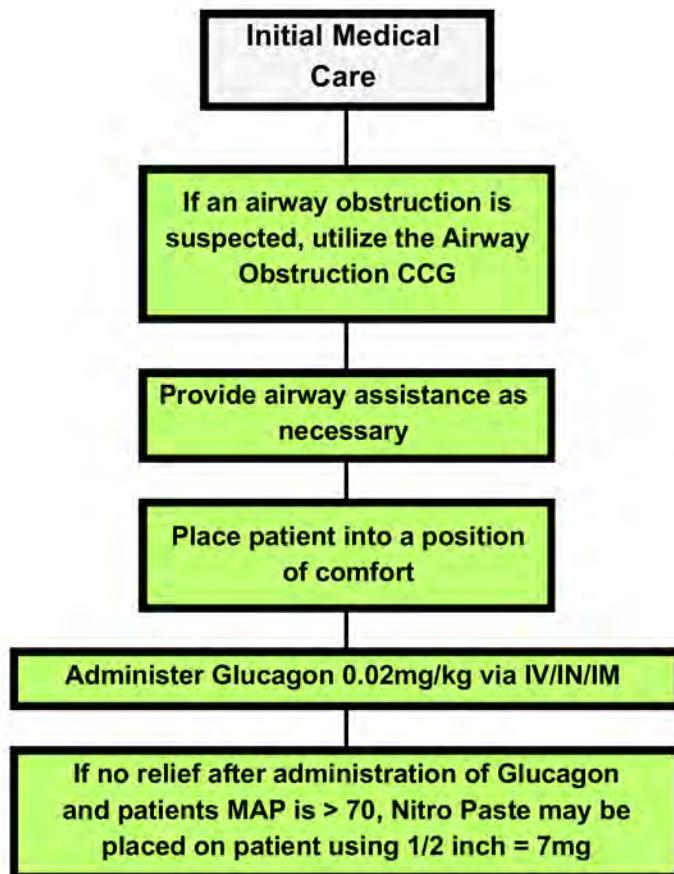


### PEARLS

Signs/Symptoms	Differentials	
Coughing, difficulty/inability swallowing, drooling, apparent distress, throat pain, gagging, blood-stained saliva, chest pain	Esophagitis, croup, epiglottitis, upper respiratory tract infection	Glucagon decreases lower esophageal sphincter tone without interfering with esophageal contractions (acts as smooth muscle relaxer)



## Esophageal Obstruction



### PEARLS

<b>Signs/Symptoms</b> Coughing, difficulty/inability swallowing, drooling, apparent distress, throat pain, gagging, blood-stained saliva, chest pain	<b>Differentials</b> Esophagitis, croup, epiglottitis, upper respiratory tract infection	Glucagon decreases lower esophageal sphincter tone without interfering with esophageal contractions (acts as smooth muscle relaxer)
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# Respiratory Distress



## Initial Medical Care

Administer oxygen therapy with the appropriate device based on patient presentation. If respiratory rate is <10 or >30 assist ventilation with BVM

Rales or CHF

Place patient on BiLevel or CPAP (10 PEEP)

If MAP >70 place Nitro Paste (on left side of patient's chest) 1in = 14mg

If patient's condition does not improve prepare for possible intubation

### IMPORTANT

Each box presents possible progressions as needed. Each patient does not require all the medications listed. Use these to treat your patient accordingly and progress as the patient requires.

COPD or Wheezing

Administer Albuterol and Atrovent if HR <120bpm or the patient has not self-administered 3 home treatments or more in past 2 hours via neb treatments

If patient's HR >120bpm or the patient has administered 3 or more home treatments within the past 2 hours administer Xopenex and Atrovent to the patient via neb treatment

Administer Decadron 4mg slow IVP over 2 minutes

If no improvement considered use of CPAP (5-7.5 PEEP) or BiLevel

Administer Ketamine 0.5mg/kg IVP over 2 minutes

If patient's condition does not improve prepare for possible intubation

Asthma

Administer Albuterol and Atrovent if HR <120bpm or the patient has not self-administered 3 home treatments or more in past 2 hours via neb treatments

If patient's HR >120bpm or the patient has administered 3 or more home treatments within the past 2 hours administer Xopenex and Atrovent to the patient via neb treatment

Administer Decadron 4mg slow IVP over 2 minutes

Administer Mag Sulfate 1g slow IVP over 5 minutes

Administer Ketamine 0.5mg/kg IVP over 2 minutes

Administer Epi 1:1000 at 0.3mg IM

If patient's condition does not improve prepare for possible intubation

## PEARLS

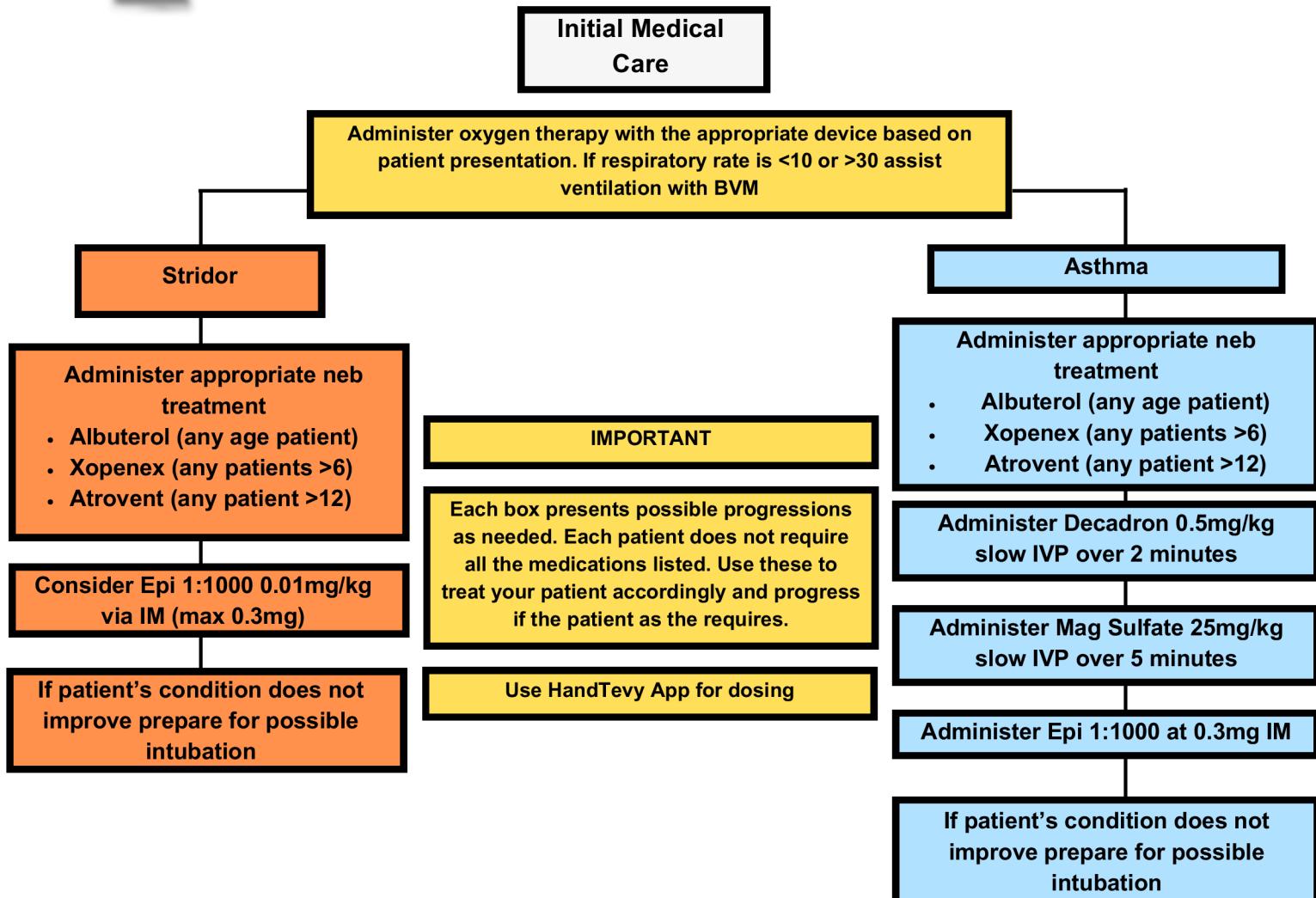
Each respiratory distress patient requires ETO2 monitoring via nasal capno.

Patient presentation will determine where you begin in the treatment flow chart. If patient is in severe distress begin with more advanced treatments.

Be prepared to assist the patients ventilations should the need arise.



# **Respiratory Distress**



PEARLS

Each respiratory distress patient requires ETO<sub>2</sub> monitoring via nasal capno.

Patient presentation will determine where you begin in the treatment flow chart. If patient is in severe distress being with more advanced treatments.

Be prepared to assist the patients ventilations should the need arise



## Respiratory Distress - Viral Alert

### Initial Medical Care

Administer oxygen therapy with the appropriate device based on patient presentation. If respiratory rate is <10 or >30 assist ventilation with BVM

Administer Albuterol and Atrovent if HR <120bpm or the patient has not self-administered 3 home treatments or more in past 2 hours via neb treatments

If patient's HR >120bpm or the patient has administered 3 or more home treatments within the past 2 hours administer Xopenex and Atrovent to the patient via neb treatment

#### IMPORTANT

Due to potential viral infection, only progress to invasive airway maintenance as the CCG flow chart states. Any neb treatments must be completed outside of the ambulance.

Administer Decadron 4mg slow IVP over 2 minutes

If SPO<sub>2</sub> <80% or ETCO<sub>2</sub> is 30-35mmHG place patient on CPAP (7.5-10 PEEP) or BiLevel

If SPO<sub>2</sub> <70% or ETCO<sub>2</sub> is 25-30mmHG place the patient on CPAP (7.5 to 10 PEEP) or BiLevel  
Administer Ketamine 0.5mg/kg slow IVP over 2 minutes

If SPO<sub>2</sub> <60% or ETCO<sub>2</sub> is <25mmHG place the patient on CPAP (7.5 to 10 PEEP) or BiLevel

Administer Ketamine 0.5mg/kg slow IVP over 2 minutes and consider advanced airway control if all the following are met:

- SPO<sub>2</sub> <40%
- RR >40
- GCS<8

If advanced airway is needed use only iGel, no intubation attempt is to be made. Place patient on ventilator.

### PEARLS

Each respiratory distress patient requires ETO<sub>2</sub> monitoring via nasal capno.

Radio reports to the hospital should reflect the viral alert status to allow the hospital staff time to prepare.



## Respiratory Distress - Viral Alert

### Initial Medical Care

Administer oxygen therapy with the appropriate device based on patient presentation. If respiratory rate is <10 or >30 assist ventilation with BVM

#### Administer appropriate neb treatment

- Albuterol (any age patient)
- Xopenex (any patients >6)
- Atrovent (any patient >12)

Administer Decadron 0.5mg/kg slow IVP over 2 minutes

If advanced airway is needed use only iGel, no intubation attempt is to be made. Place patient on ventilator.

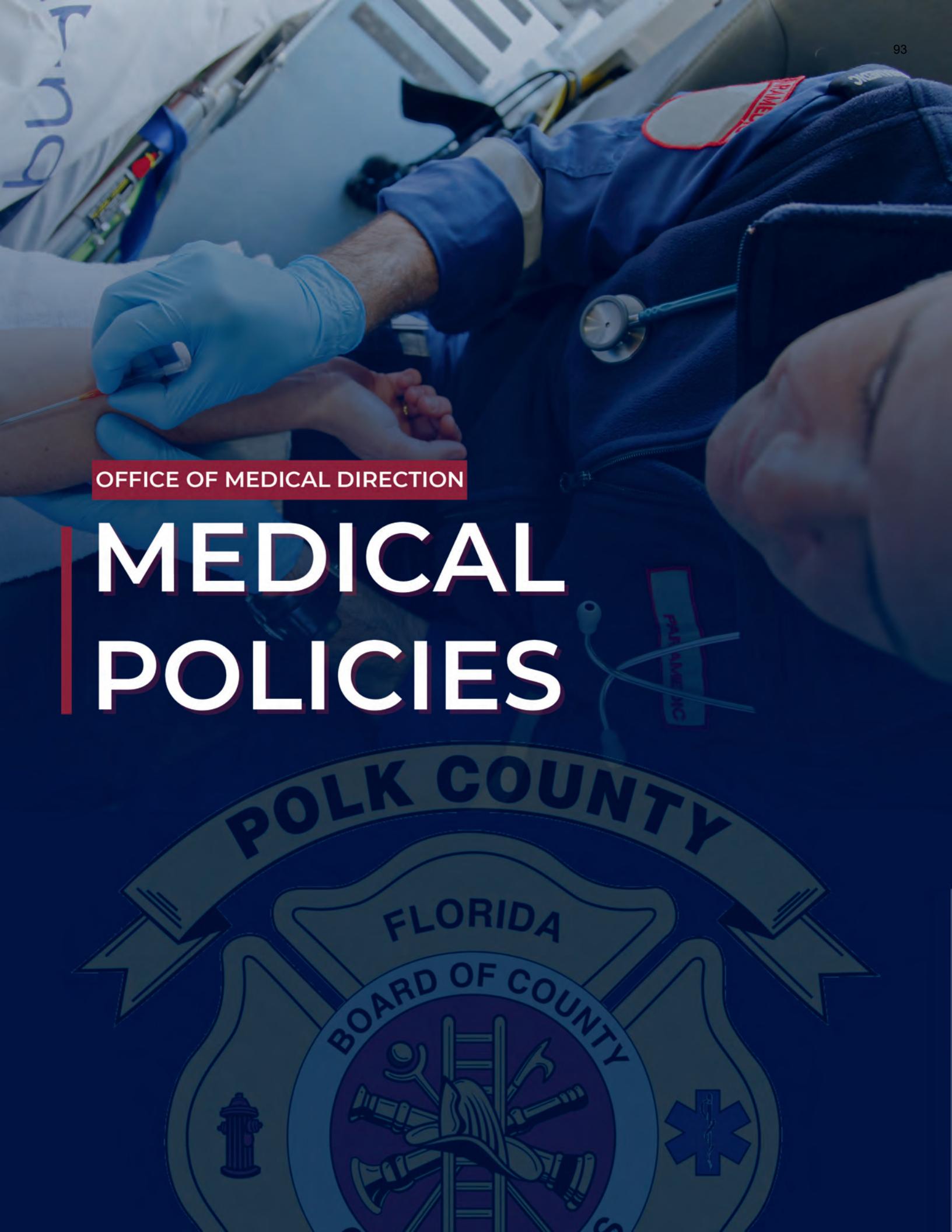
### IMPORTANT

Due to potential viral infection, only progress to invasive airway maintenance as the CCG flow chart states. Any neb treatments must be completed outside of the ambulance.

### PEARLS

Each respiratory distress patient requires ETO2 monitoring via nasal capno.

Radio reports to the hospital should reflect the viral alert status to allow the hospital staff time to prepare.



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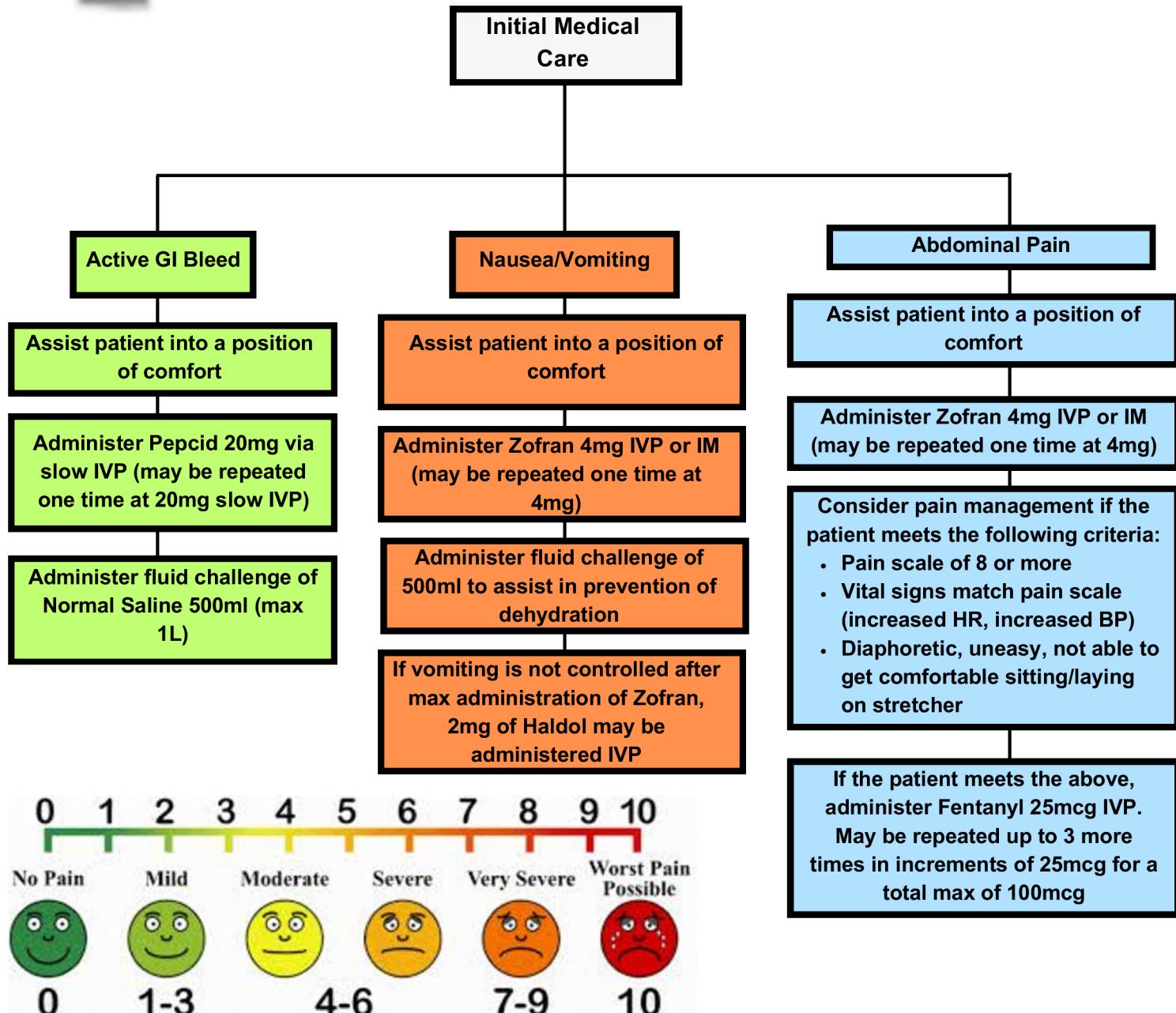
# MEDICAL POLICIES



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## Abdominal Disorders



### PEARLS

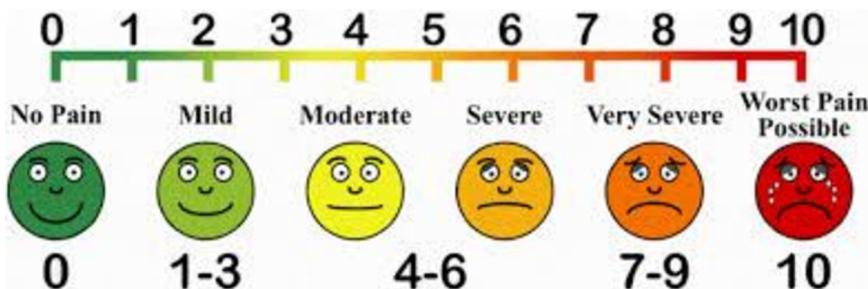
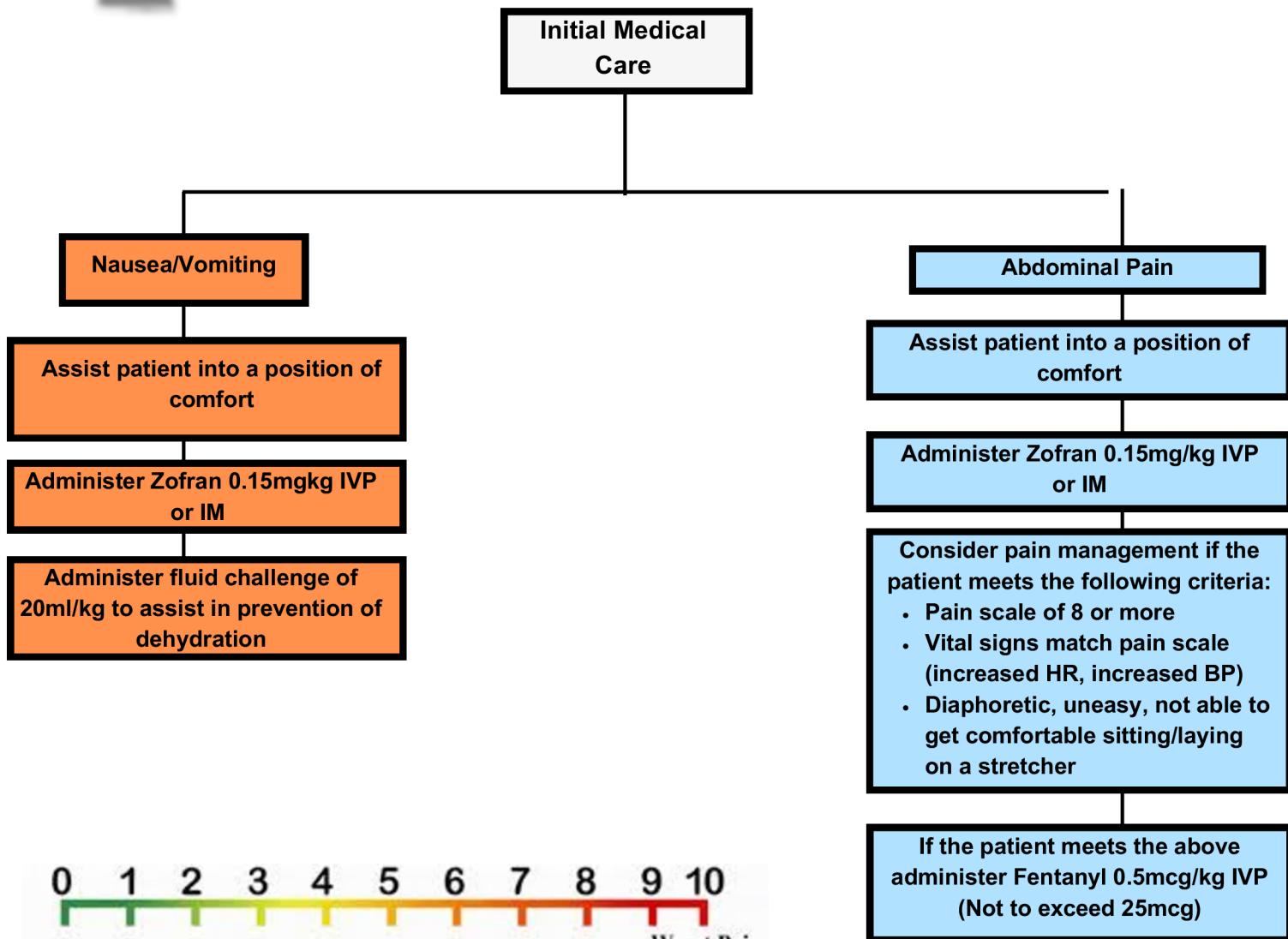
Consider possible ectopic pregnancy in female patients of child bearing age.

Consider possible abdominal aortic aneurysm in patients presenting with abd pain and/or flank pain who are >50 years of age.

Do not administer pain management to female patients who are pregnant or unsure if pregnant.



## Abdominal Disorders

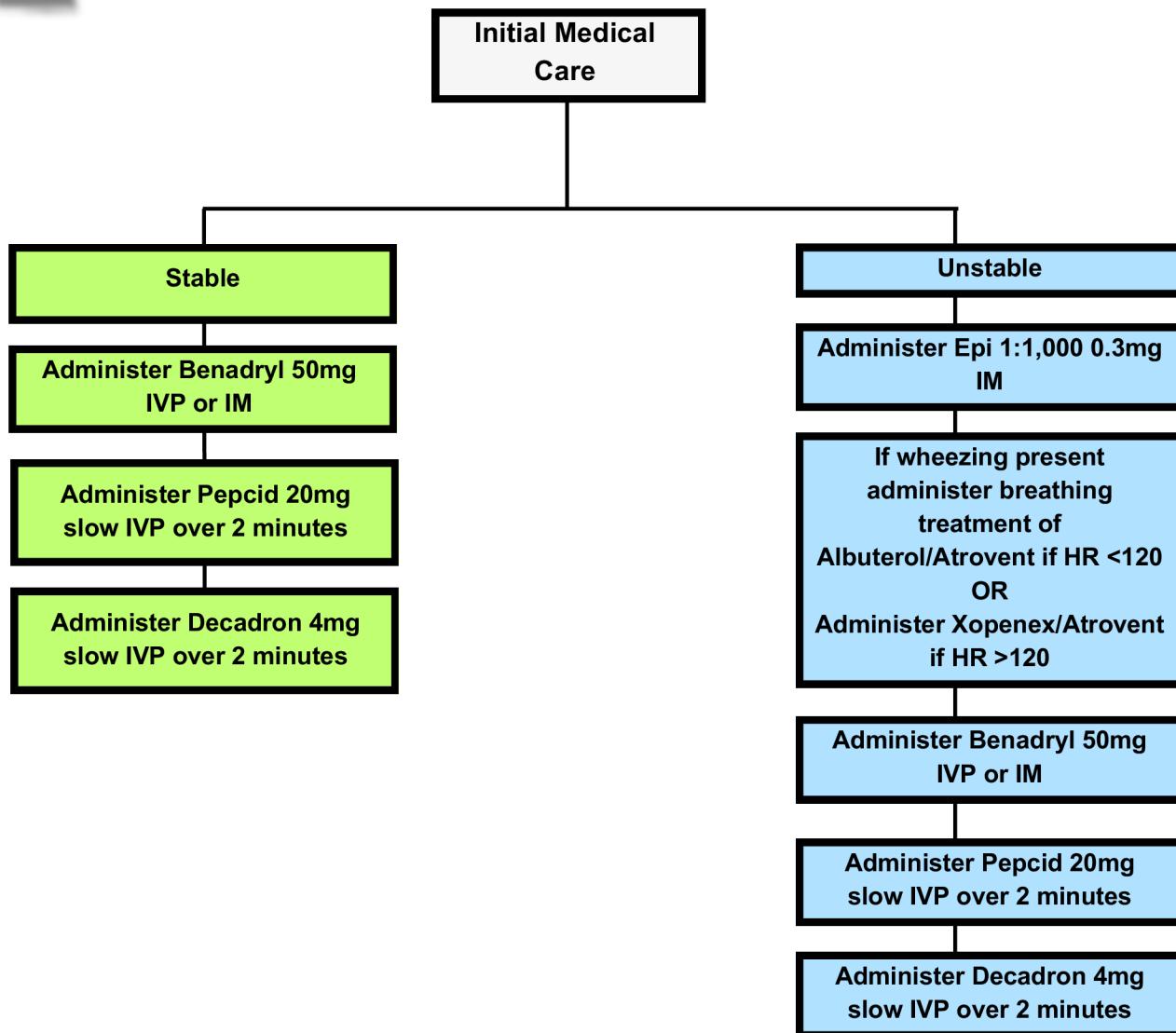


### PEARLS

Appendicitis presents with lower right quadrant.	<b>Signs/Symptoms</b> Pain, tenderness, nausea, vomiting, diarrhea, dysuria, constipation	Do not administer pain management to female patients of child bearing age who are pregnant or unsure if pregnant.
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## Allergic Reaction

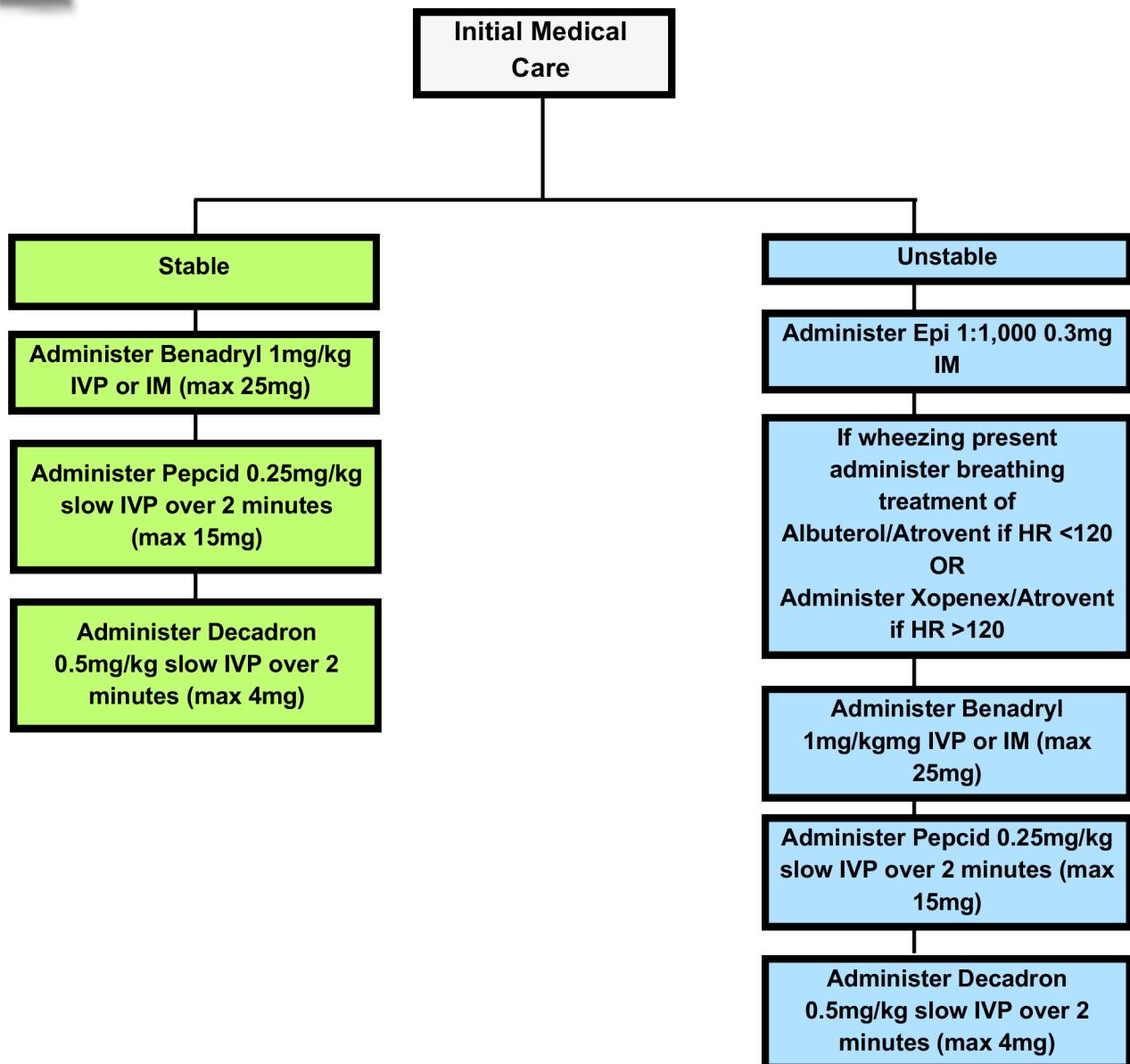


### PEARLS

The shorter the onset from symptoms to contact, the worse the reaction most likely is.	<b>Signs/Symptoms of unstable</b> Coughing, wheezing, swelling in airway, hives throughout body, hypotension, edema, throat constriction	<b>Signs/Symptoms of Stable</b> Localize hives/swelling, itching
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## Allergic Reaction



### PEARLS

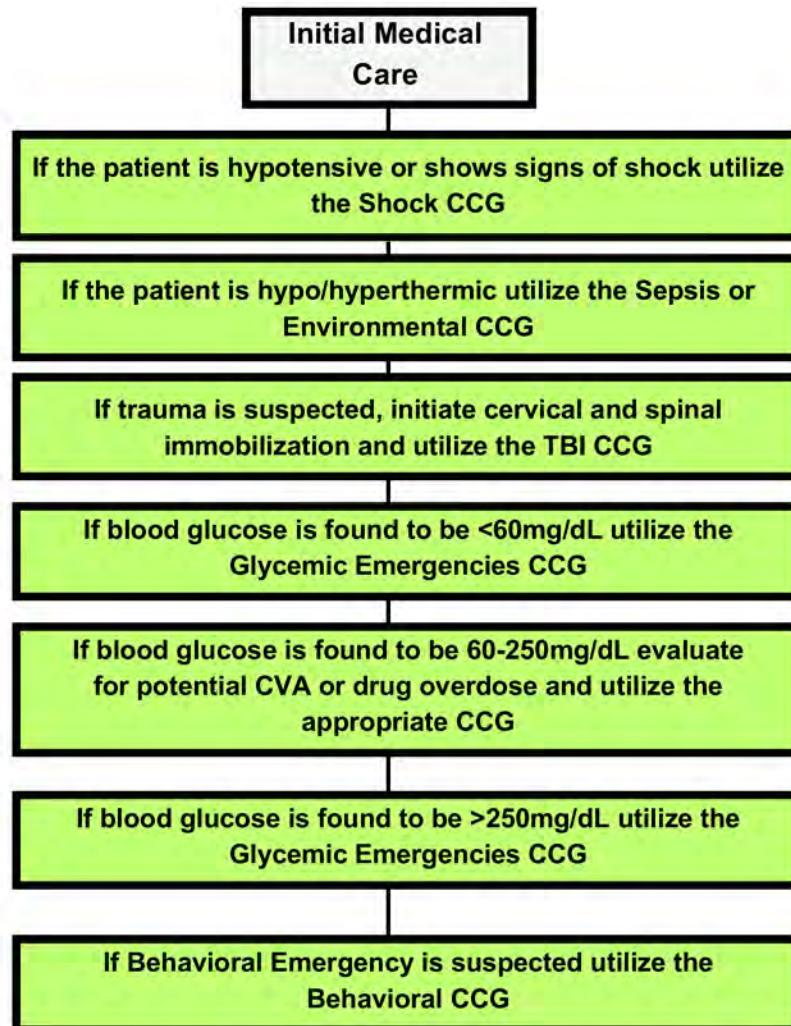
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**Signs/Symptoms of unstable**  
Coughing, wheezing, swelling in airway, hives throughout body, hypotension, edema, throat constriction

**Signs/Symptoms of Stable**  
Localize hives/swelling, itching

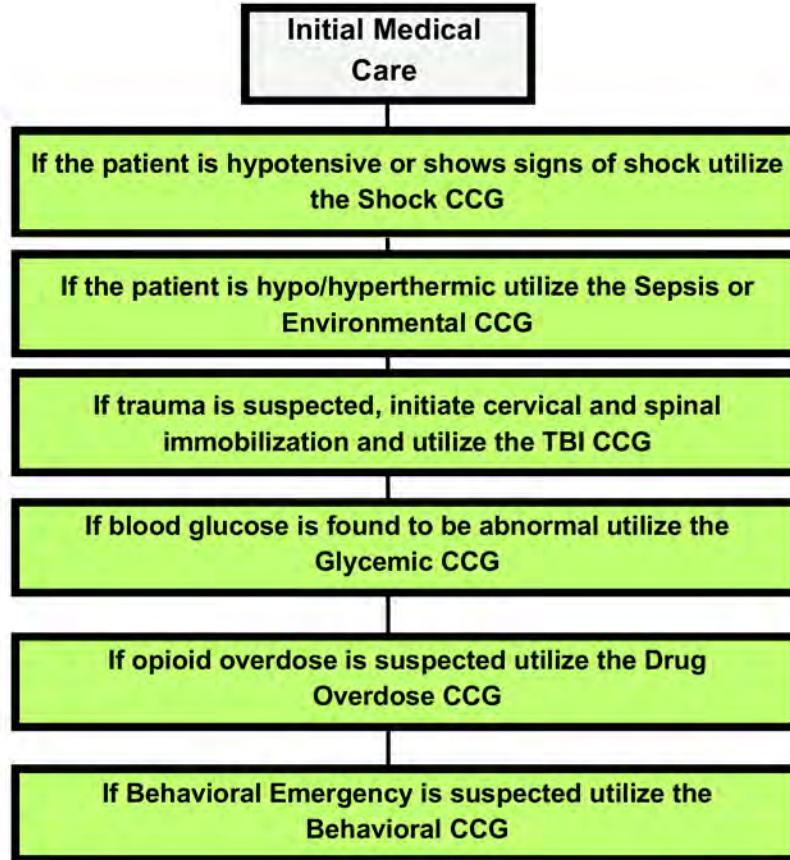


## Altered Mental Status



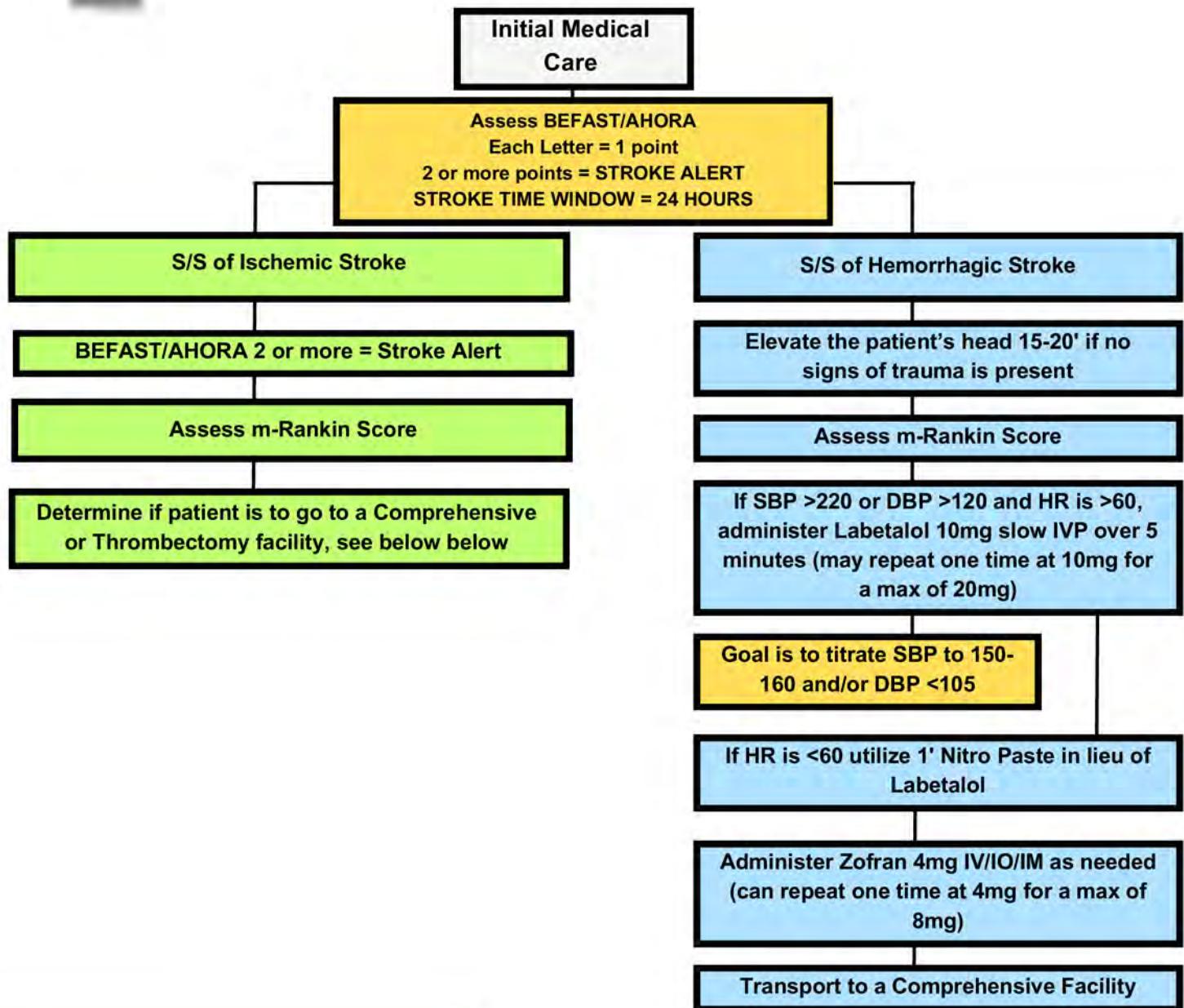


## Altered Mental Status





## Cerebrovascular Accident

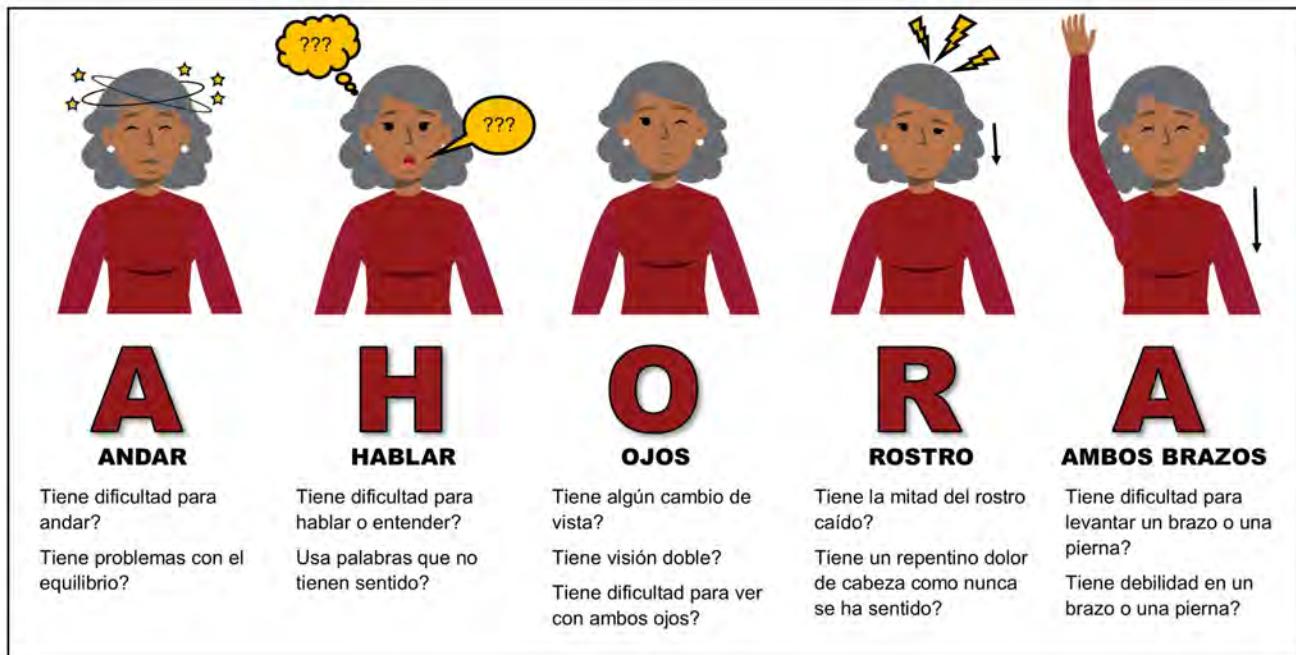
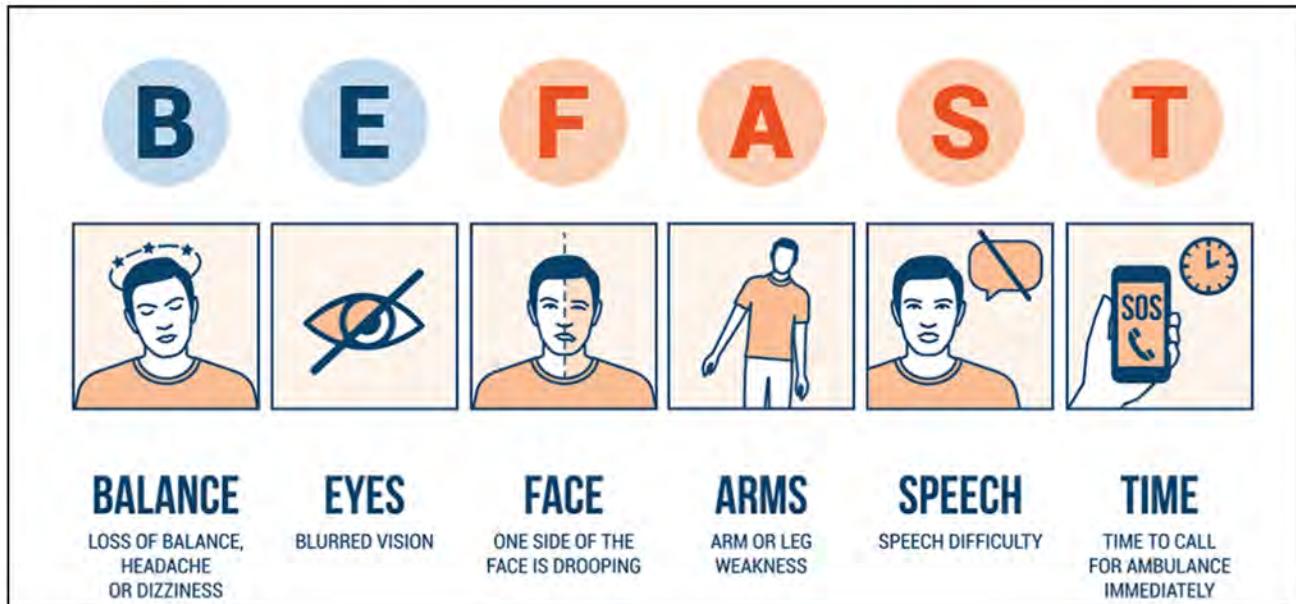


Transport patient to Comprehensive Facility if:

- BEFAST 2 or more and patient meets any of the below criteria.
  - Suspected Hemorrhagic Stroke (See chart to right)
  - GCS 8 or less
  - Active airway assistance
  - Takes anticoagulants

### Signs of Hemorrhagic Stroke

Witnessed LOC, AMS, first/worst/different headache, thunderclap headache, new onset of seizure activity, SBP>220 and/or DBP >120, sudden onset of nausea/vomiting, neck pain or stiffness with flexion



## Drug Overdose

### Initial Medical Care

Do not engage in an aggressive or confrontational manner, request Law Enforcement to respond to the scene for possible Baker Act. Do not cancel their response and stage as appropriate.

Initiate oxygen therapy and monitor with nasal capno.

If abnormal, consider utilizing the Glycemic Emergencies CCG

If altered mental status is present, consider a differential diagnosis and utilize the appropriate CCG

Contact Poison Control for guidance  
1-800-222-1222

Any advice given from Poison Control is to be considered online medical control and documented as such

If an opioid overdose is suspected

- If respiratory rate is <12 and ETCO<sub>2</sub> is <30 or >50, initiate oxygen therapy
  - Place nasal cannula on patient at 15LPM
  - Ventilate patient with BVM and NPA
- If no change occurs after 3-minutes
  - Administer 0.5mg of Narcan IV/IM (may be repeated after 5 minutes in increments of 0.5mg to a max of 4mg)

### PEARLS

Any Narcan administered by Law Enforcement counts towards the total max of 4mg and should be documented as administered PTA.

Narcan should only be administered to patients in respiratory distress.

Remember to ventilate the patient for a minimum of 3 minutes prior to first administration of Narcan.



## Drug Overdose

### Initial Medical Care

Do not engage in an aggressive or confrontational manner, request Law Enforcement to respond to the scene for possible Baker Act. Do not cancel their response and stage as appropriate.

Initiate oxygen therapy and monitor with nasal capno.

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Contact Poison Control for guidance  
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If an opioid overdose is suspected

- If respiratory rate is <12 and ETCO<sub>2</sub> is <30 or >50, initiate oxygen therapy
  - Place nasal cannula on patient at 10LPM
  - Ventilate patient with BVM and NPA
- If no change occurs after 3-minutes
  - Administer 0.1mg/kg of Narcan IV/IN/IM, single dose not to exceed 0.5mg (may be repeated after 5 minutes in increments of 0.1mg/kg to a max of 4mg)

### PEARLS

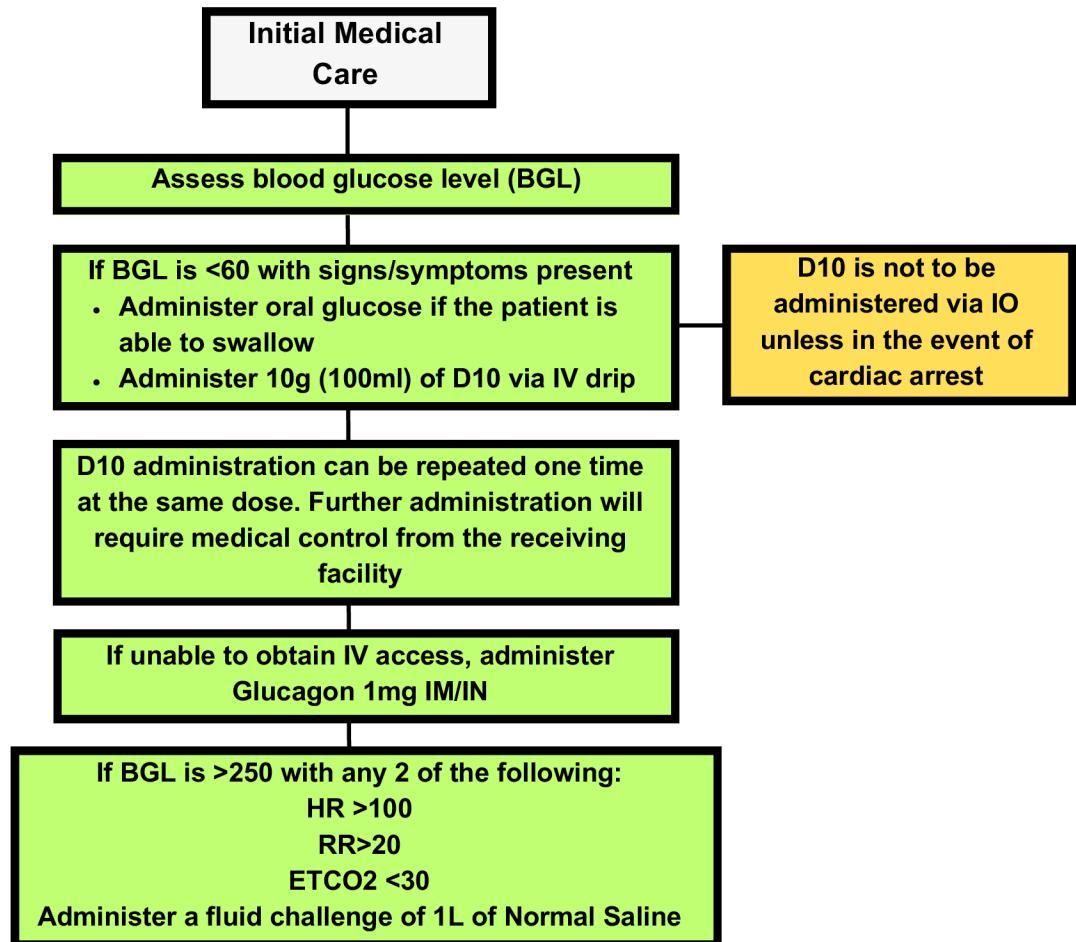
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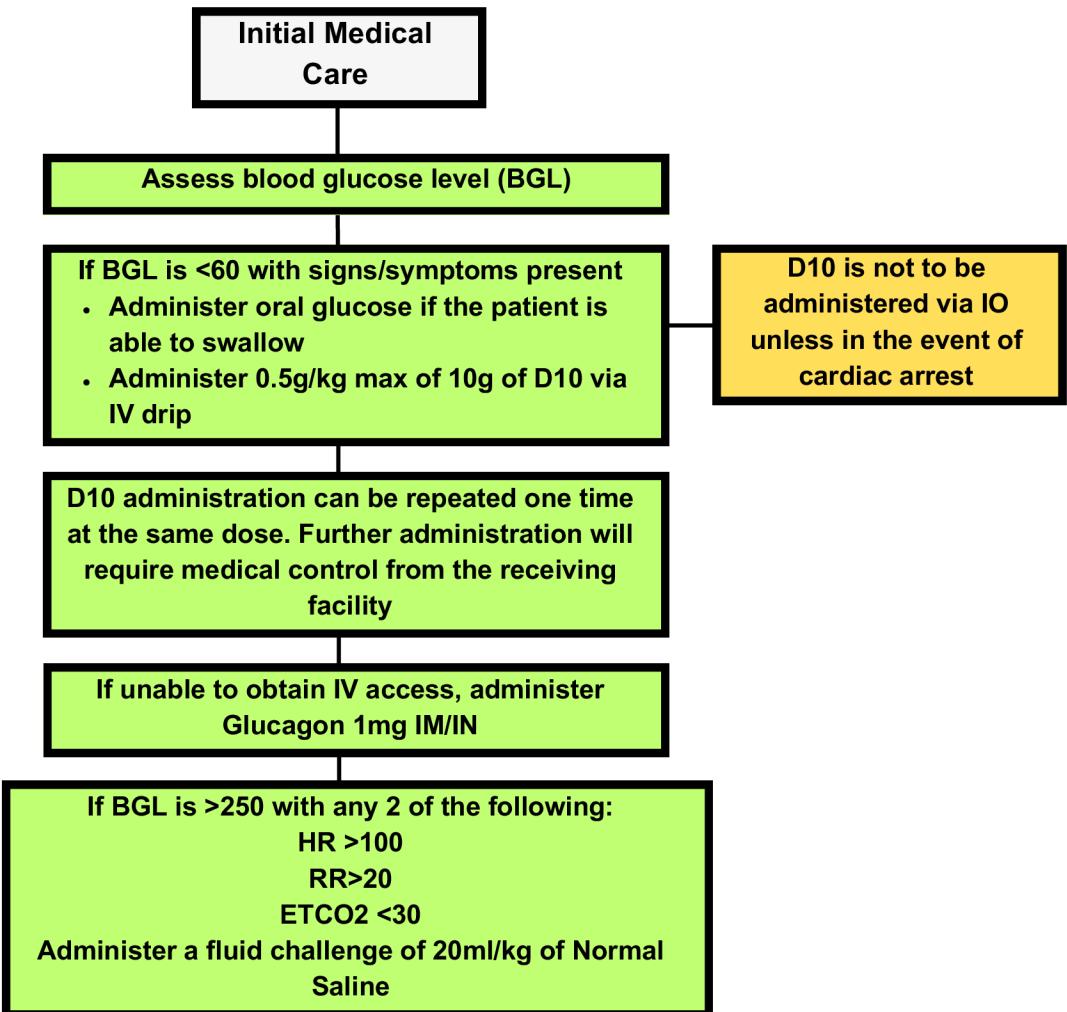
## Glycemic Emergencies



PEARLS		
Minimize the number of IV attempts to <3 in these patients. If unable to establish IV, utilize IM/IN Glucagon.	<b>Signs/Symptoms</b> AMS, confusion, diaphoresis, abd pain, increased urination, increased thirst, dry mouth, nausea, vomiting	<b>Differential</b> AMS, hypoglycemia, hyperglycemia, CNS disorder
D10 in 250ml should be administered with 60gtts set using 100ml to equal 10g	<b>Signs/Symptoms of DKA</b> Fast, deep breathing, dry skin and mouth, flushed face, headache, muscle stiffness or aches, weakness or fatigue, blurred vision, fruity smelling breath	



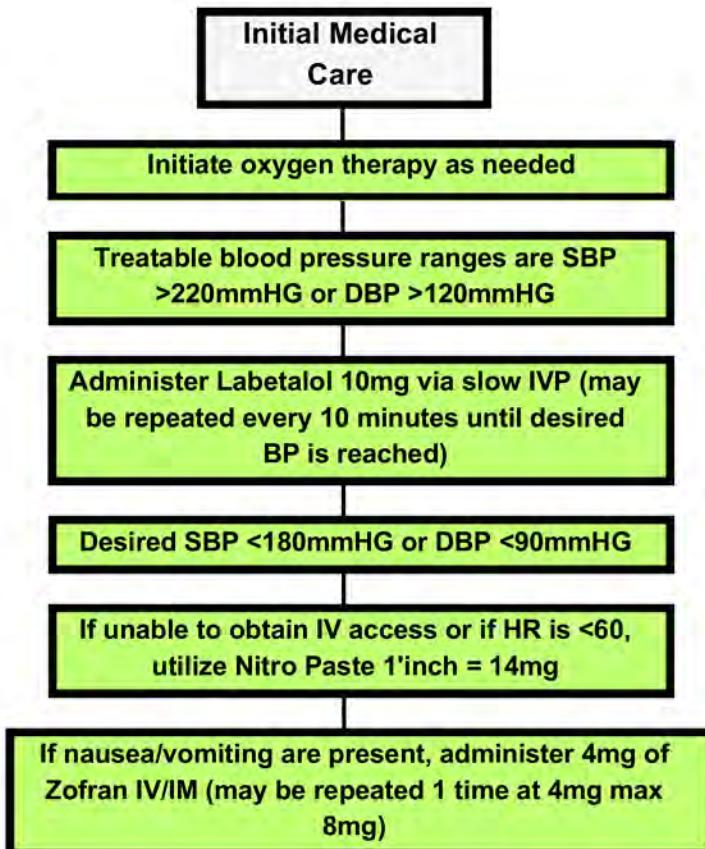
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## Hypertensive Crisis



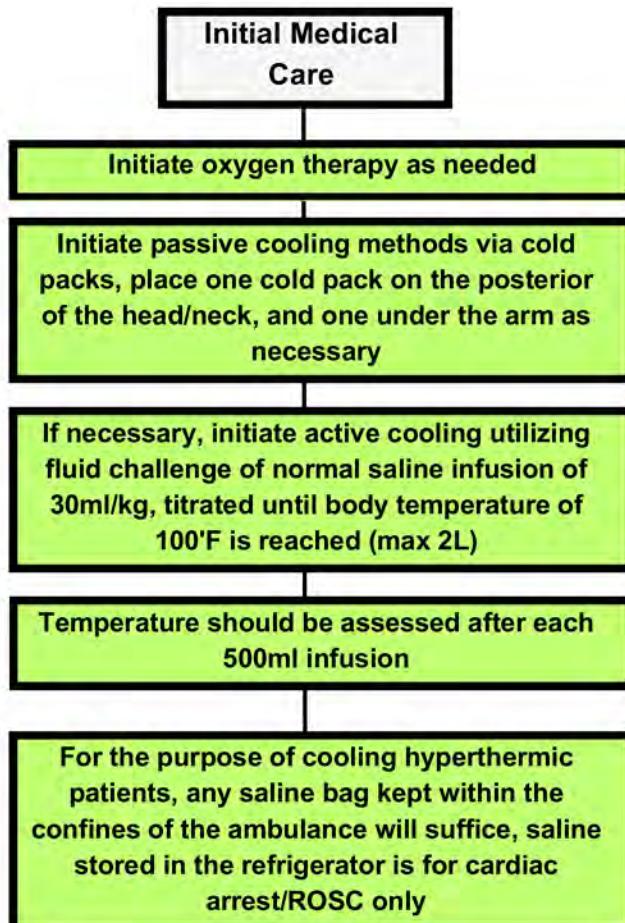
PEARLS		
Labetalol should not be used in combination with Versed. This may cause a significant decrease in blood pressure. If intubating a patient who is hypertensive, consider using Nitro paste as an alternative to Labetalol to lower BP.	<b>Signs/Symptoms</b> Headache, nausea, vomiting, nose bleed, dizziness, syncope, visual disturbances	<b>Differential</b> Overdose, Stroke, SAH



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## Non-Environmental Hyperthermia



### PEARLS

Hyperthermia is a temperature of 102°F or higher

Do not decrease the temperature below 100°F

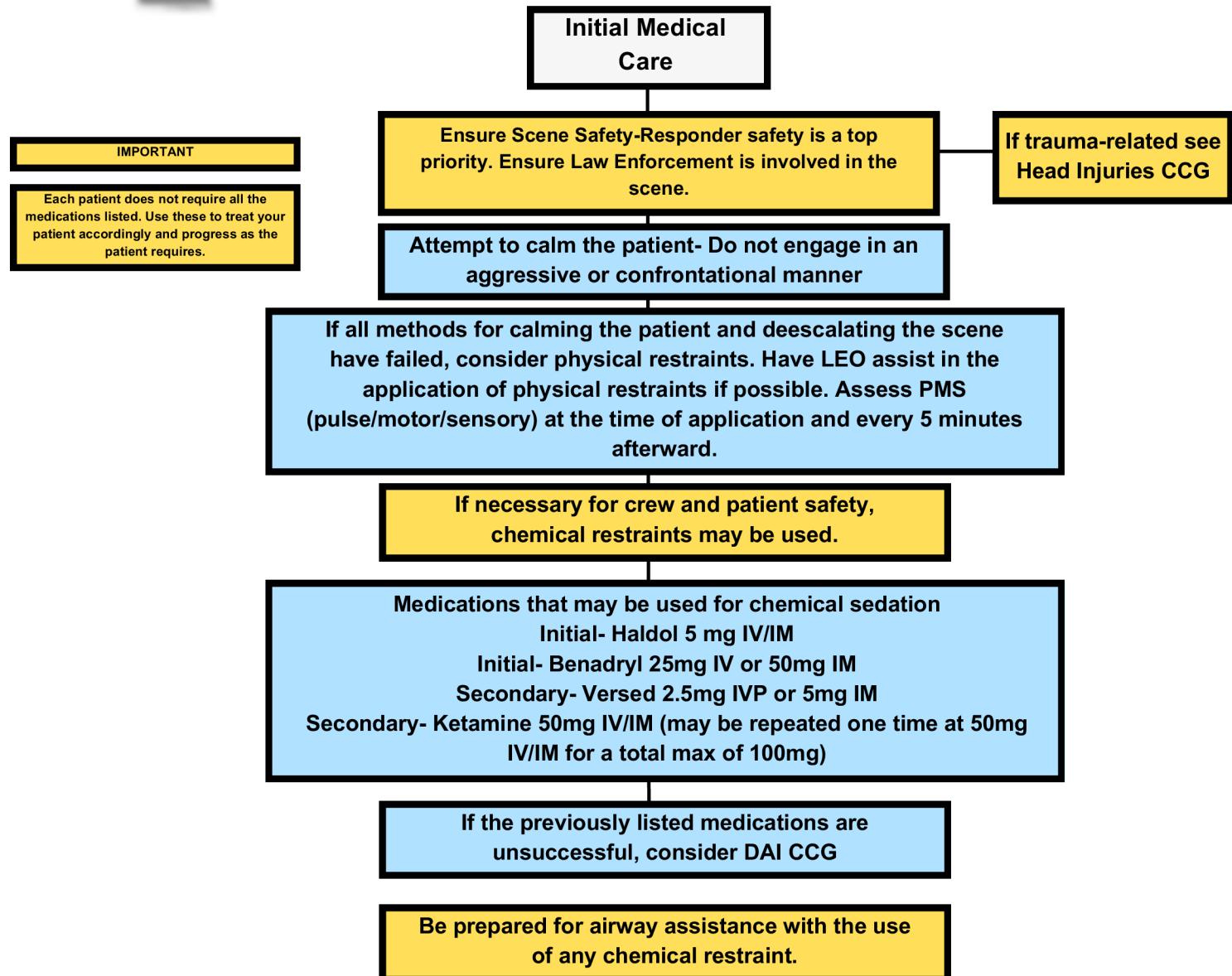
Some possible causes include but are not limited to, infectious disease, anesthesia, and drug use



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## Psychological/Behavioral Crisis

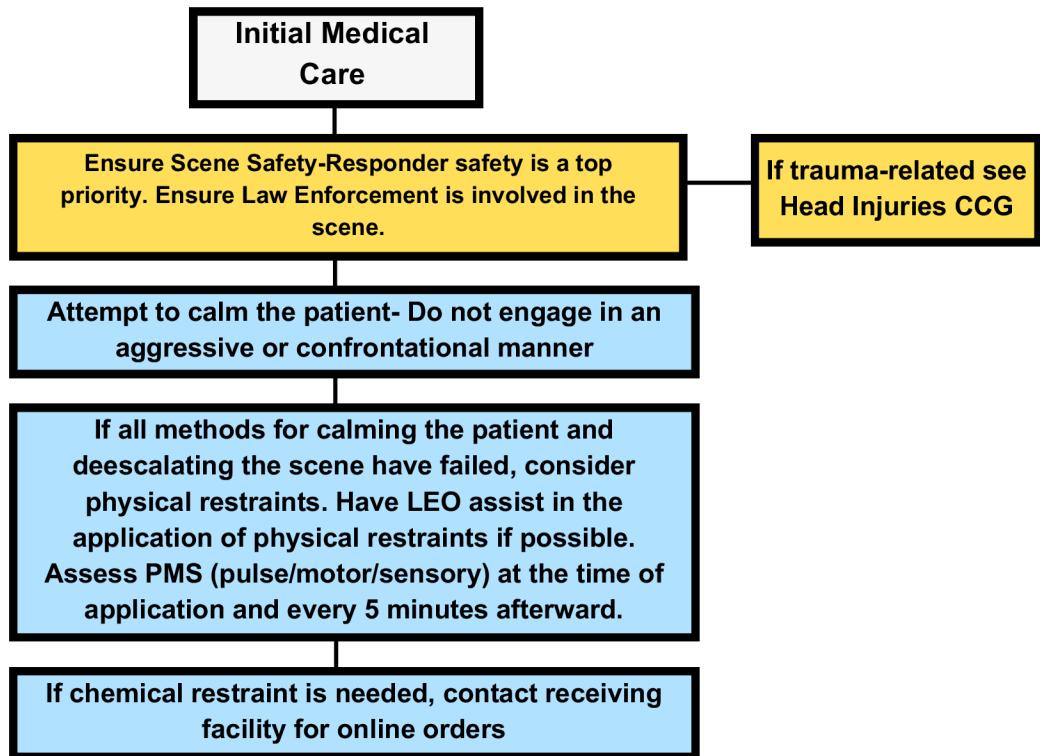


### PEARLS

Detailed documentation is needed as to what harm the patient caused to themselves and or threatened.	Chemical sedation should be a last resort when/if deescalation and physical restraints fail.	After administration of chemical sedation, place patient on Nasal ETCO <sub>2</sub> and monitor all vitals signs.
Be sure to consider all possible medical/trauma causes for behavior issues (special Needs citizen, autism, overdose, TBI)	If the patient is known to have any cognitive delays, work with family members or care takers to calm the patient.	If patient is physically restrained ensure Law Enforcement follows the unit to the hospital.



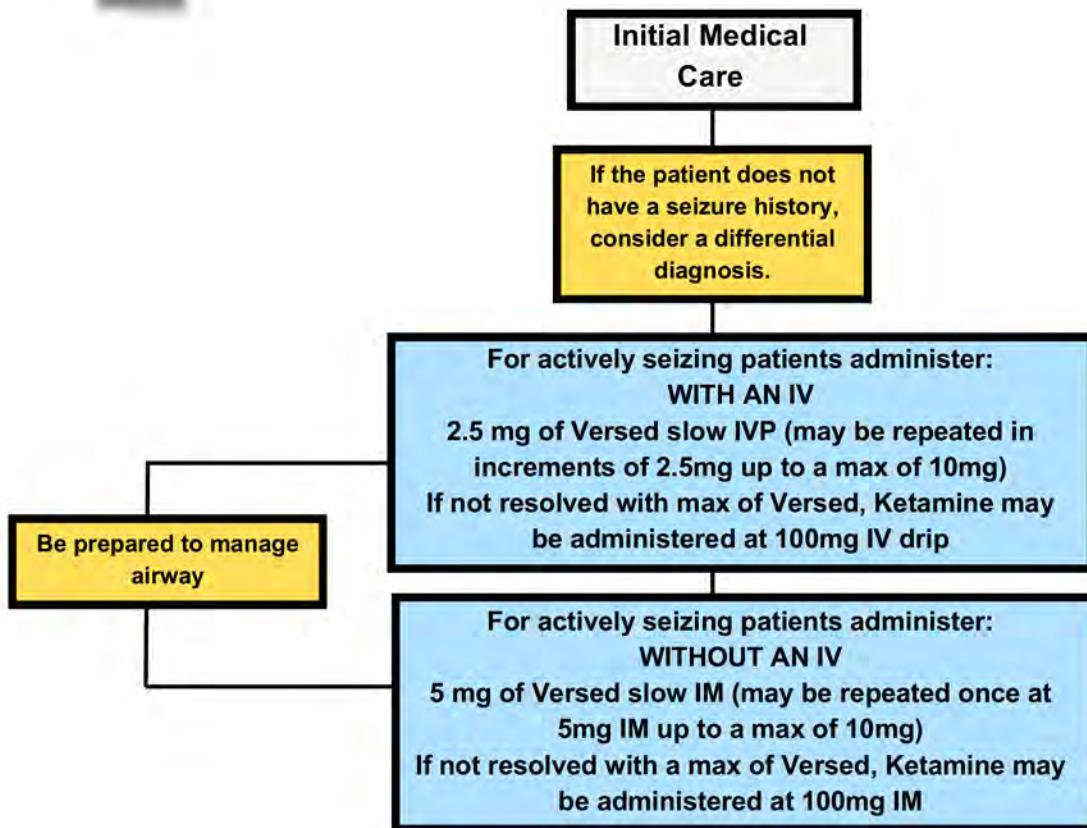
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## Seizures



### PEARLS

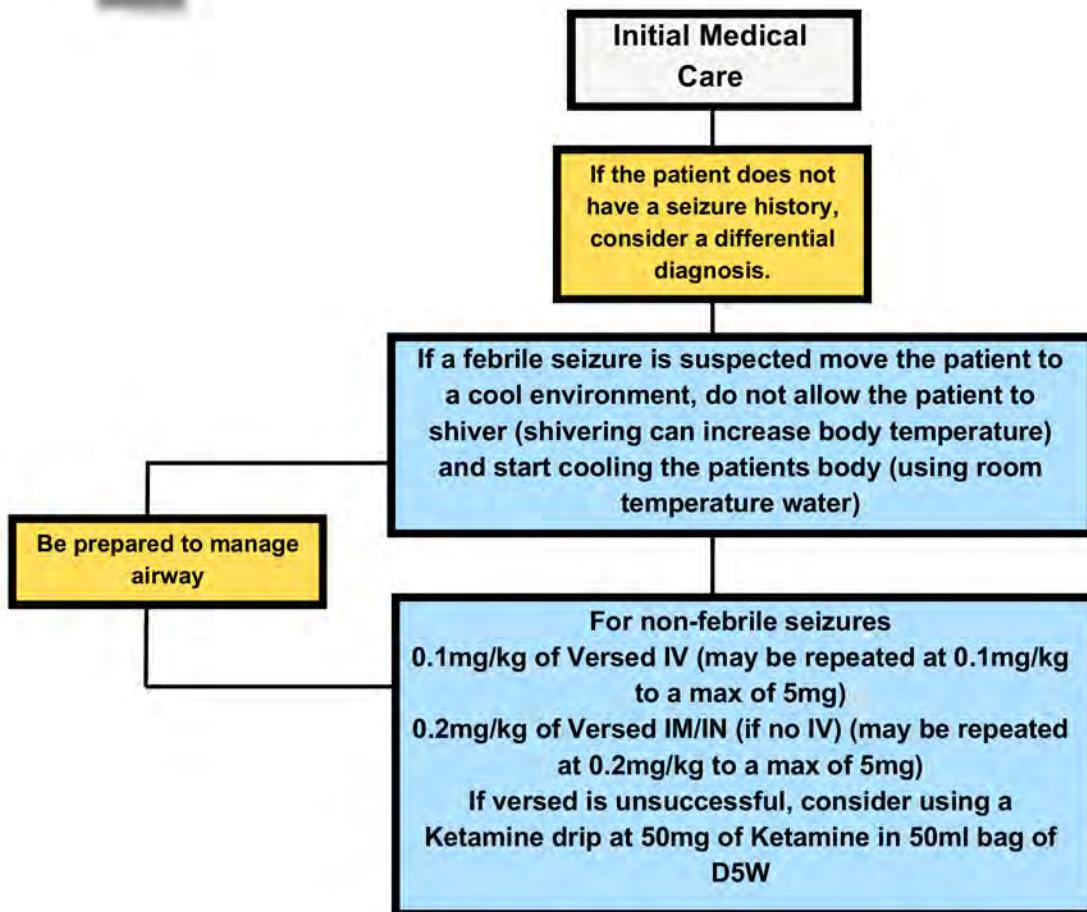
To create Ketamine drip - Using a 250ml bag of D5W inject 250mg of Ketamine which will =1mg/ml. Administer 100ml = 100mg.

Remember that the Ketamine used in the 250ml bag must be accounted for as a narcotic waste and disposed of properly.

Status Epilepticus is defined as two or more successive seizures without a period of consciousness or recovery.



## Seizures



### PEARLS

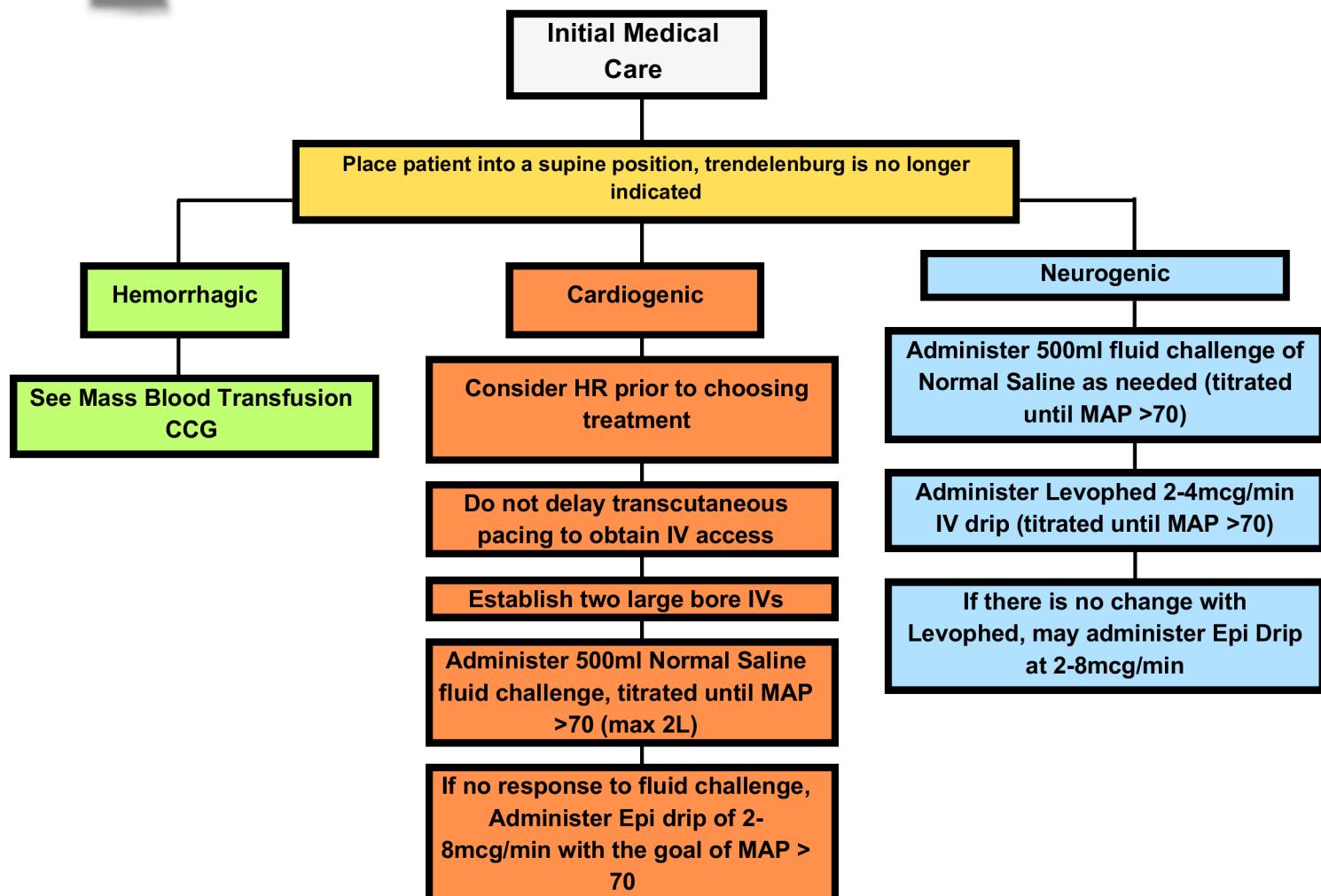
To create Ketamine drip - Using a 50ml bag of D5W inject 50mg of Ketamine which will =1mg/ml. Administer 50ml = 50mg.

Remember that the Ketamine used in the 50ml bag must be accounted for as a narcotic waste and disposed of properly.

Status Epilepticus is defined as two or more successive seizures without a period of consciousness or recovery.



## Shock

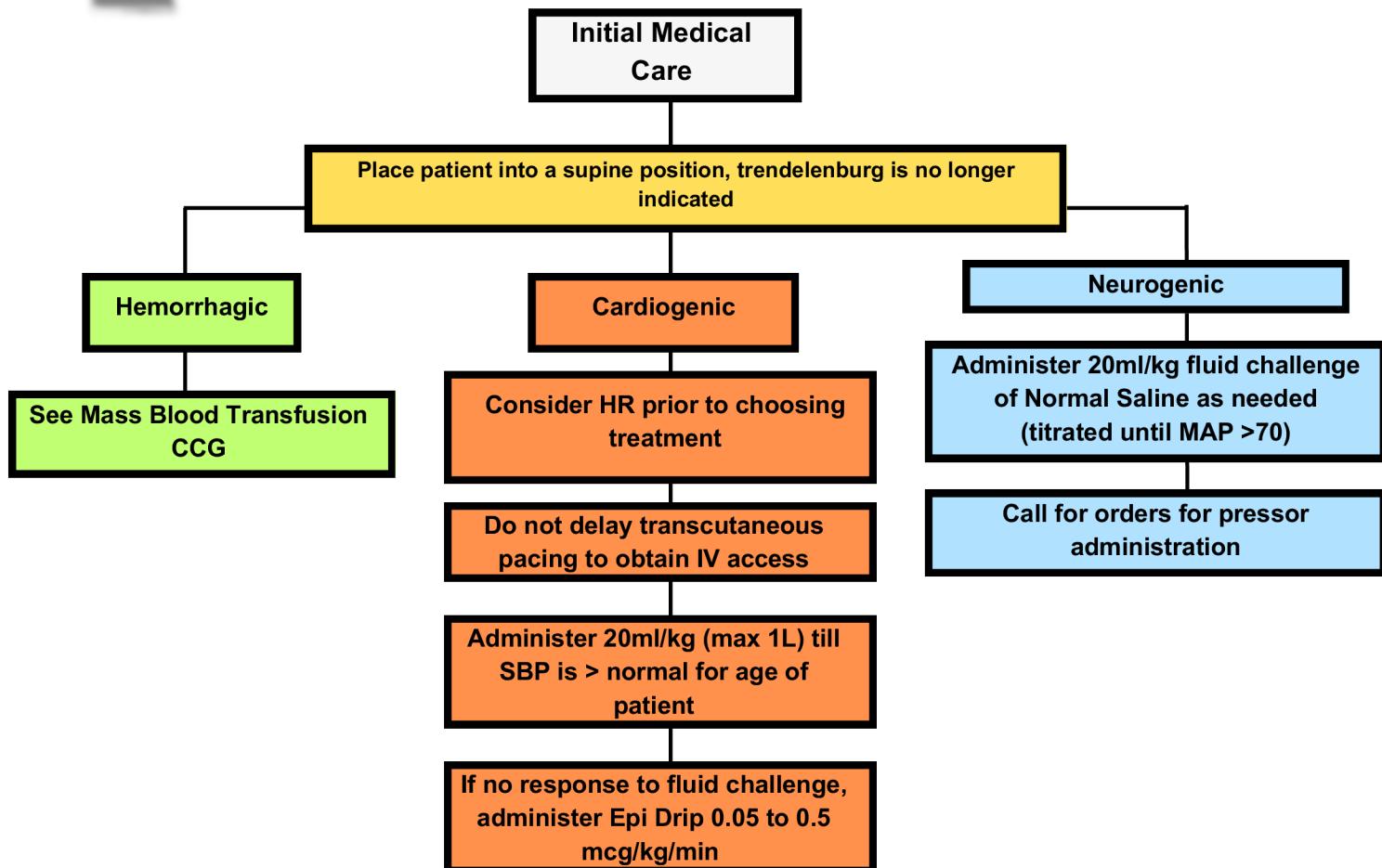


### PEARLS

Levophed (Norepinephrine) Drip Mix 4mg of Levophed into 250ml bag of D5W. This will give you a concentration of 16mcg/ml.	Epi Drip Mix 1mg of Epi into a 500ml bag of Normal Saline and start at 2mcg/min, increasing by increments of 2mcg Q5 minutes to a max dose of 8mcg/min.	Transcutaneous pacing should be initiated when the patient's heart rate is less than 40 bpm and MAP is <70 and/or patient has ALOC.
Consider Cardiogenic Shock when patient presents with an EKG that shows ST elevation or depression and sustained MAP <70 and/or HR <40.	Neurogenic Shock- pressors will be needed to maintain BP	Two large bore IVs should be established in all shock patients when possible.



## Shock



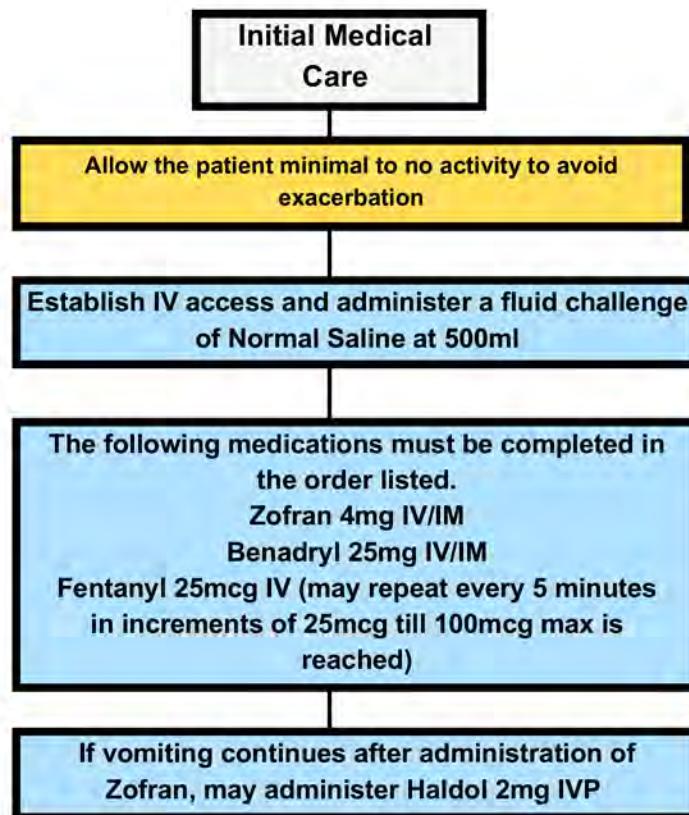
### PEARLS

Consider all possible causes of shock entry per appropriate guideline.

Relative hypovolemia: neurologic, septic, metabolic, psychogenic, or other volume depleted states.

When determining pediatric shock: consider age-appropriate vital signs and symptoms of poor perfusion – weakness or absent peripheral pulses with altered mental status or lethargy.

## Sickle Cell Crisis

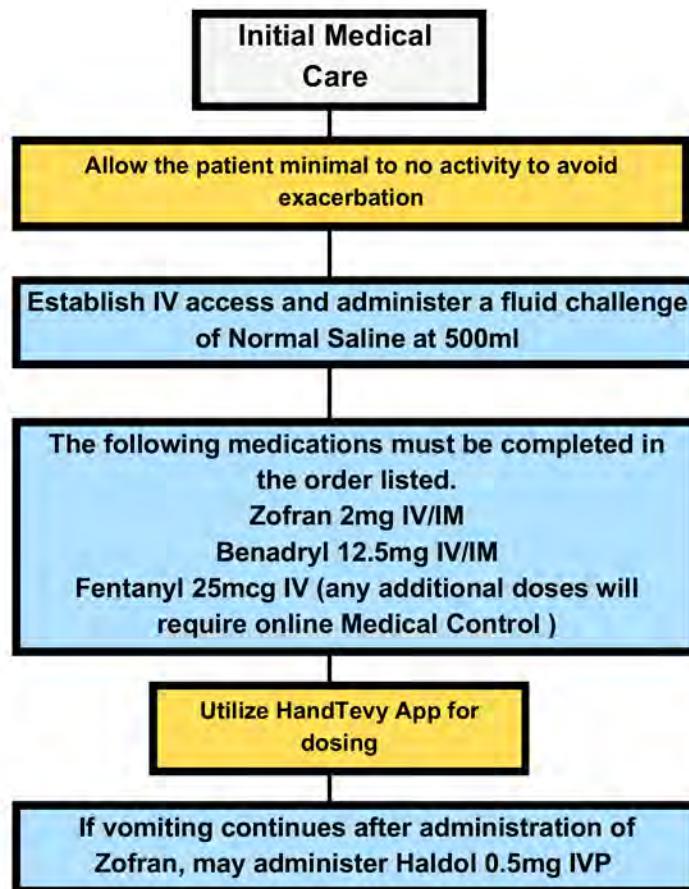


### PEARLS

<p>The highest frequency of sickle cell disease is found in tropical regions, particularly sub-saharan, Africa, Tibial regions of India, and the Middle-East.</p>	<p>Sickle-cell disease is a hereditary blood disorder. It is characterized by an abnormality in the oxygen-carrying hemoglobin molecule in red blood cells. This leads to a propensity for the cells to assume an abnormal, rigid sickle-like shape under certain circumstances.</p>	<p>Sickle-cell disease is associated with a number of acute and chronic health problems, such as severe infections, attacks of severe pain (sickle-cell crisis) and stroke. There is an increased risk of death associated with sickle-cell disease.</p>
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## Sickle Cell Crisis

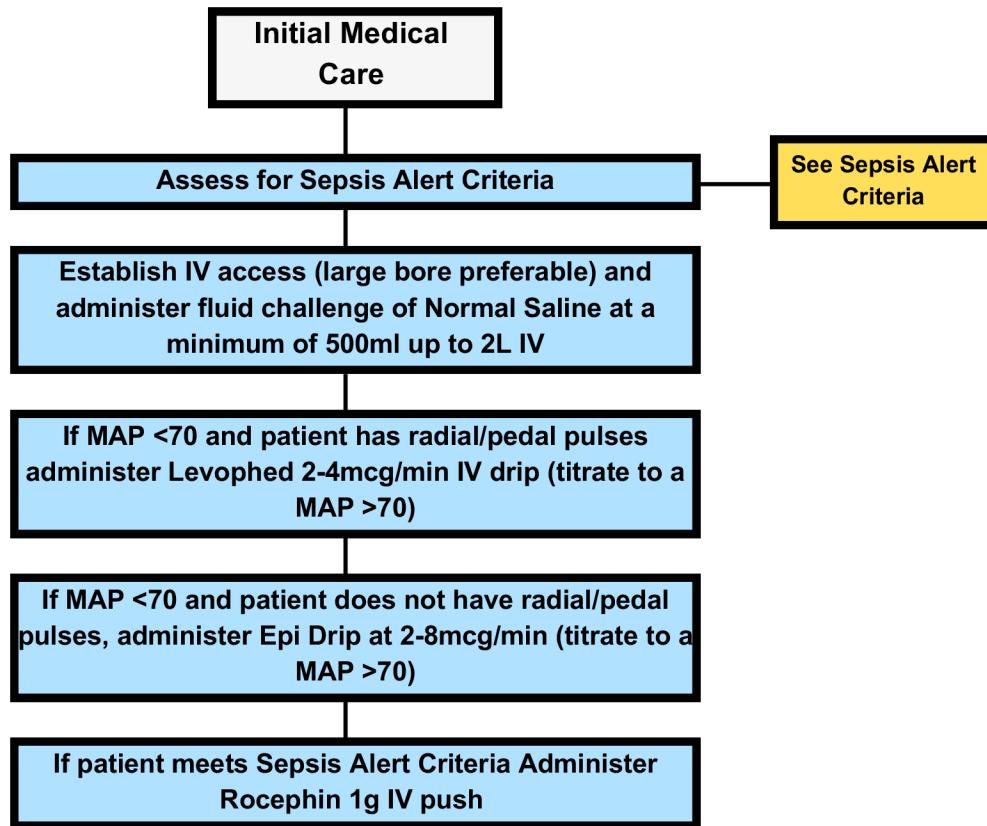


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## SIRS/Sepsis



### PEARLS

<p><b>Levophed (Norepinephrine) Drip</b> Mix 4mg of Levophed into 250ml bag of D5W. This will give you a concentration of 16mcg/ml.</p>	<p>The Key priority in the care of a sepsis patient is: Recognize the patient is in severe sepsis, provide fluid challenge to assist in preventing hypotension, antibiotics started prehospital, and assist with any airway management that may be needed.</p>	<p><b>Epi Drip</b> Mix 1mg of Epi into a 500ml bag of Normal Saline and start at 2mcg/min, increasing by increments of 2mcg Q5 minutes to a max dose of 8mcg/min.</p>
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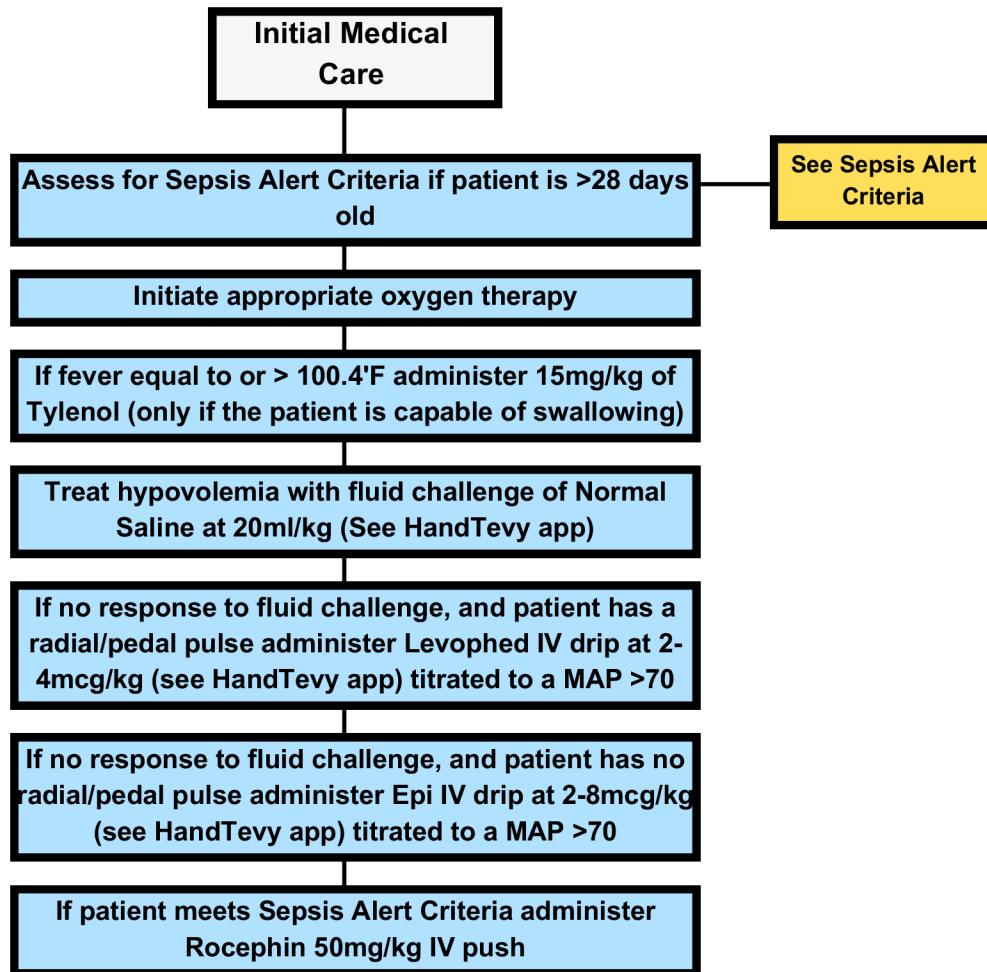


## SIRS/Sepsis Checklist

Sepsis Criteria	Yes/No
Source of infection (example UTI, wound, bed sores, respiratory illness)	
Risk factors present (nursing home resident, cancer patient, immunocompromised, indwelling foley catheters)	
<b>If yes to one of these, move on to next section.</b>	
Temperature <96.8°F or >100.4°F	
Heart rate >90bpm	
Systolic Blood Pressure <90 or MAP<70	
GCS <15 or Altered Mentation (when compared to baseline)	
Respiratory Rate > 20 or ETCO2 < 32mmHg	
<b>If yes to two of these, move to next section.</b>	
Shock index >1 (HR/Systolic)	
<b>IF YES TO ABOVE SECTION = ADULT SEPSIS ALERT</b>	



## SIRS/Sepsis



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Rocephin can only be administered to patients 1 year and older.

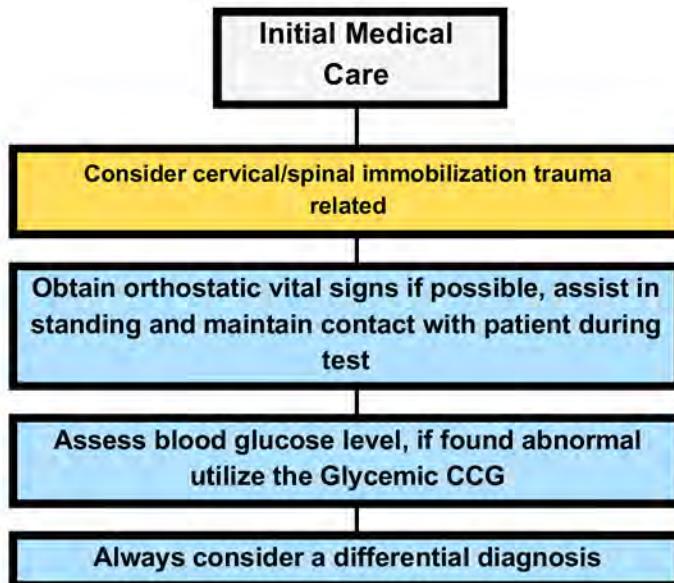


## SIRS/Sepsis Checklist

Sepsis Criteria	Yes/No
Suspected or present source of infection	
<b>If yes move on to next section.</b>	
Temperature <96.8°F or >100.4°F	
Newborn or 3 months or less (age)	
Heart rate greater than normal for age	
Respiratory rate greater than normal for age	
Systolic blood pressure lower than normal for age	
ETCO <sub>2</sub> <32mmHg	
AMS or Lethargy	
Shock index >1 (HR/Systolic)	
Modified Shock Index <0.7 or >1.3 (HR/MAP)	
<b>IF THE PATIENT PRESENTS WITH 3 OR MORE CRITERIA = PEDI SEPSIS ALERT</b>	



## Syncope/Weakness



### PEARLS

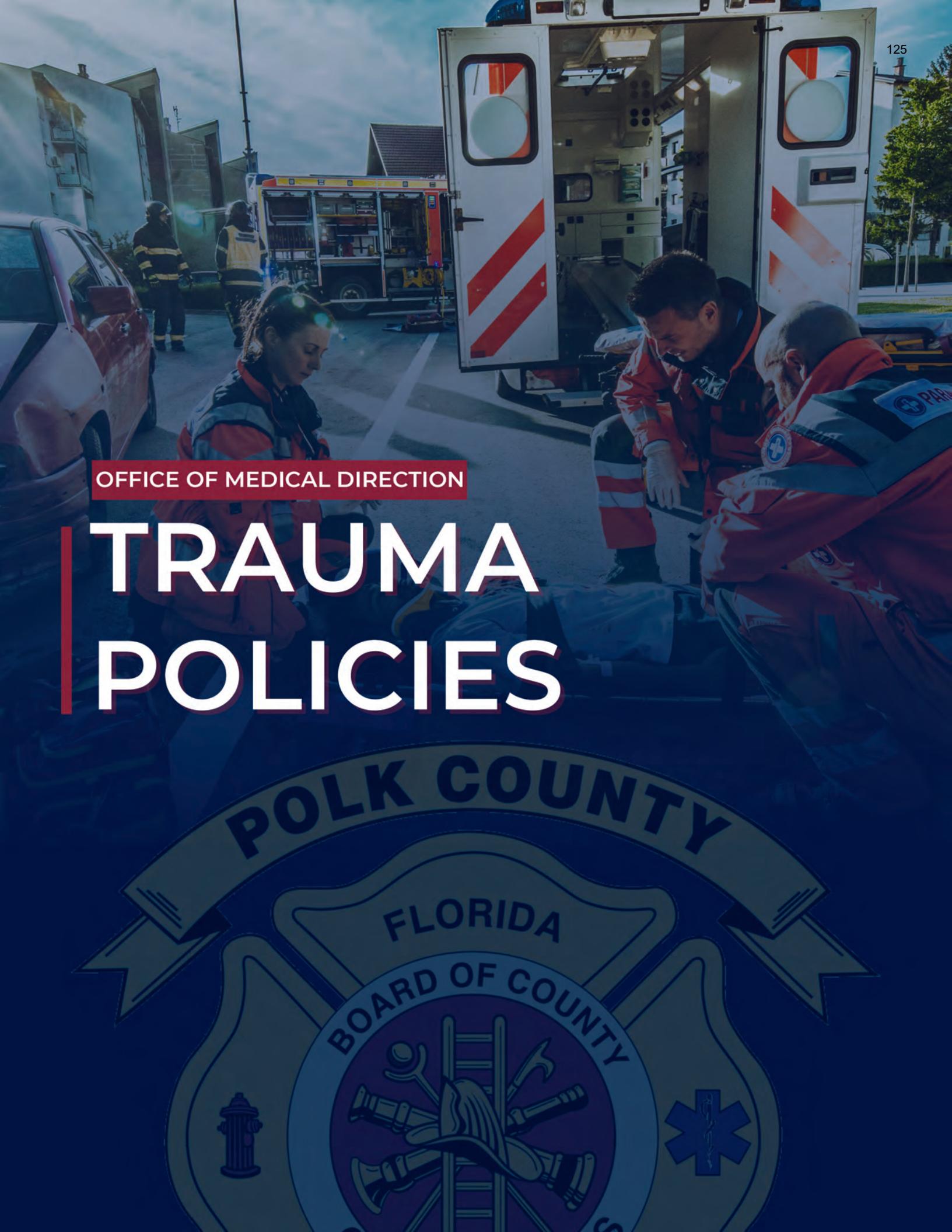
More than 25% of geriatric syncope is cardiac dysrhythmia based.	Rule out s/s of stroke	Orthostatic changes= lying, sitting and standing. Positive change if HR increased and BP decreases between sitting/lying and standing
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Pedi

The Office of Medical Direction<sup>124</sup>

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OFFICE OF MEDICAL DIRECTION

# TRAUMA POLICIES





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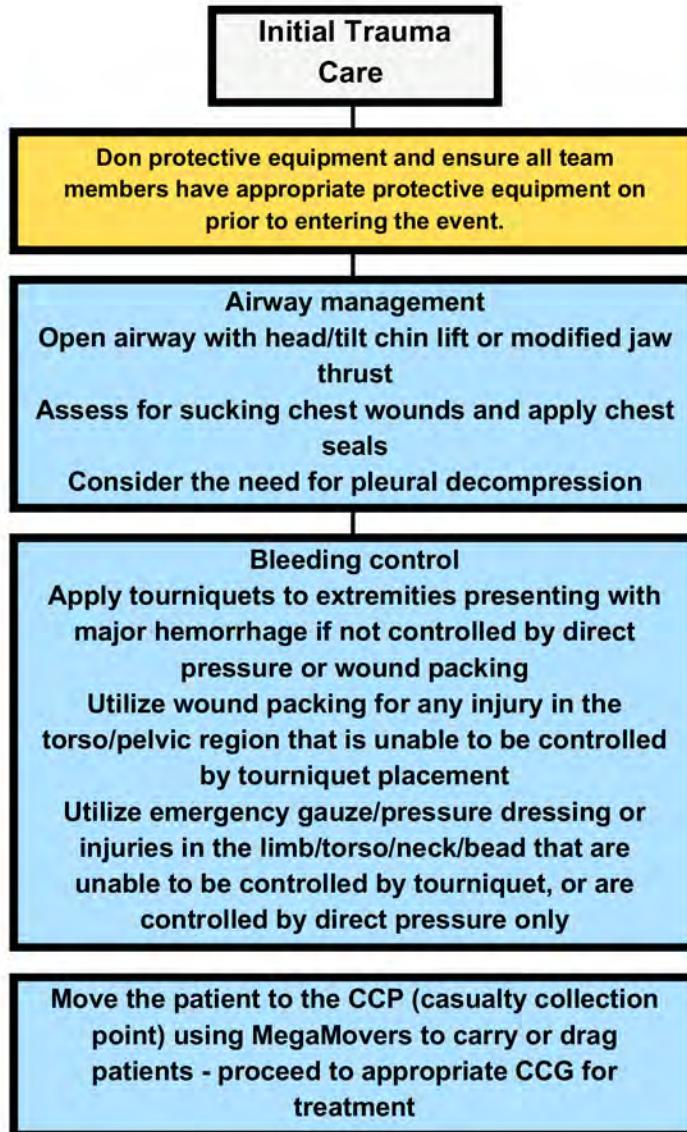


## Active Shooter/Hostile Event Response



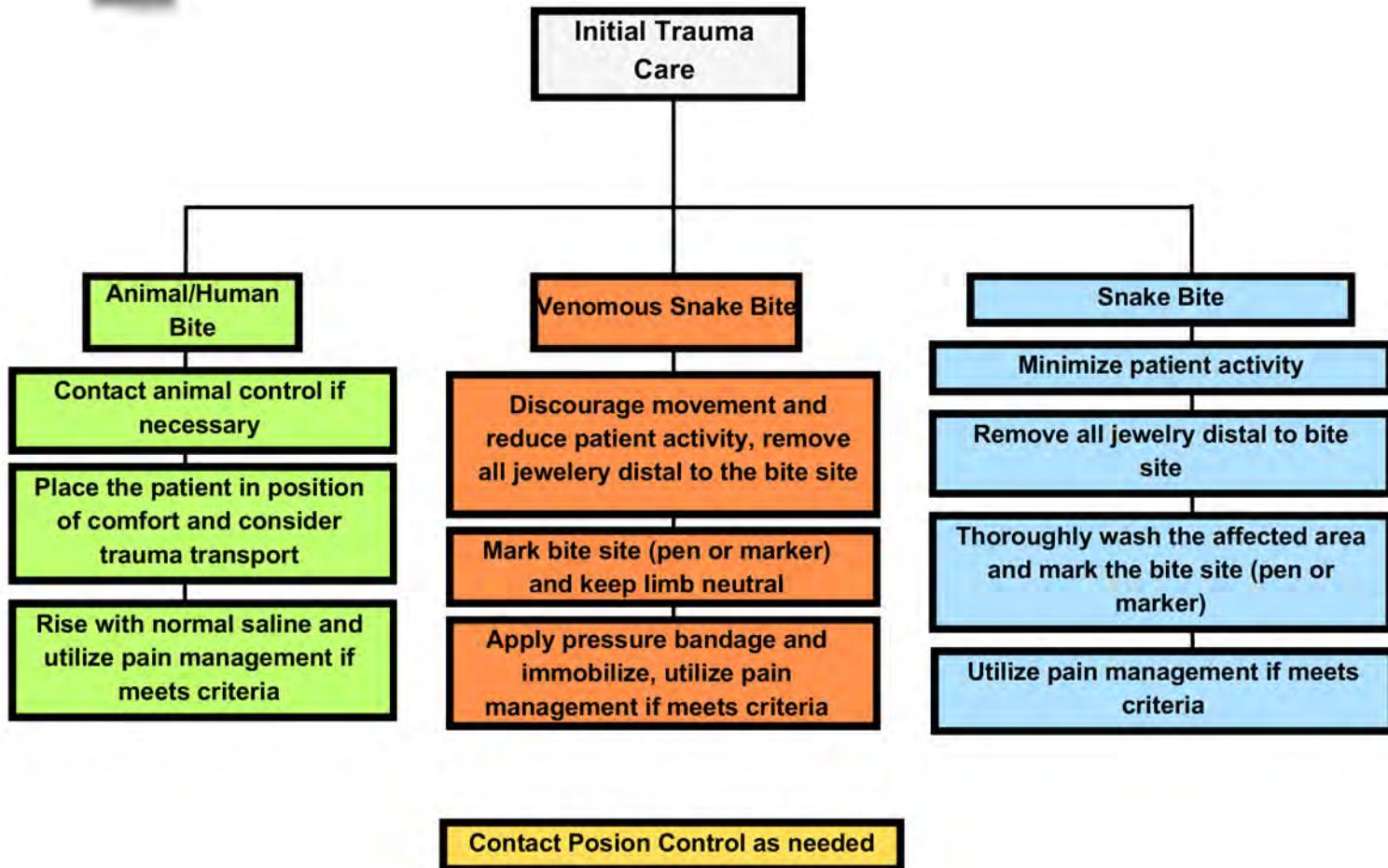


## Active Shooter/Hostile Event Response



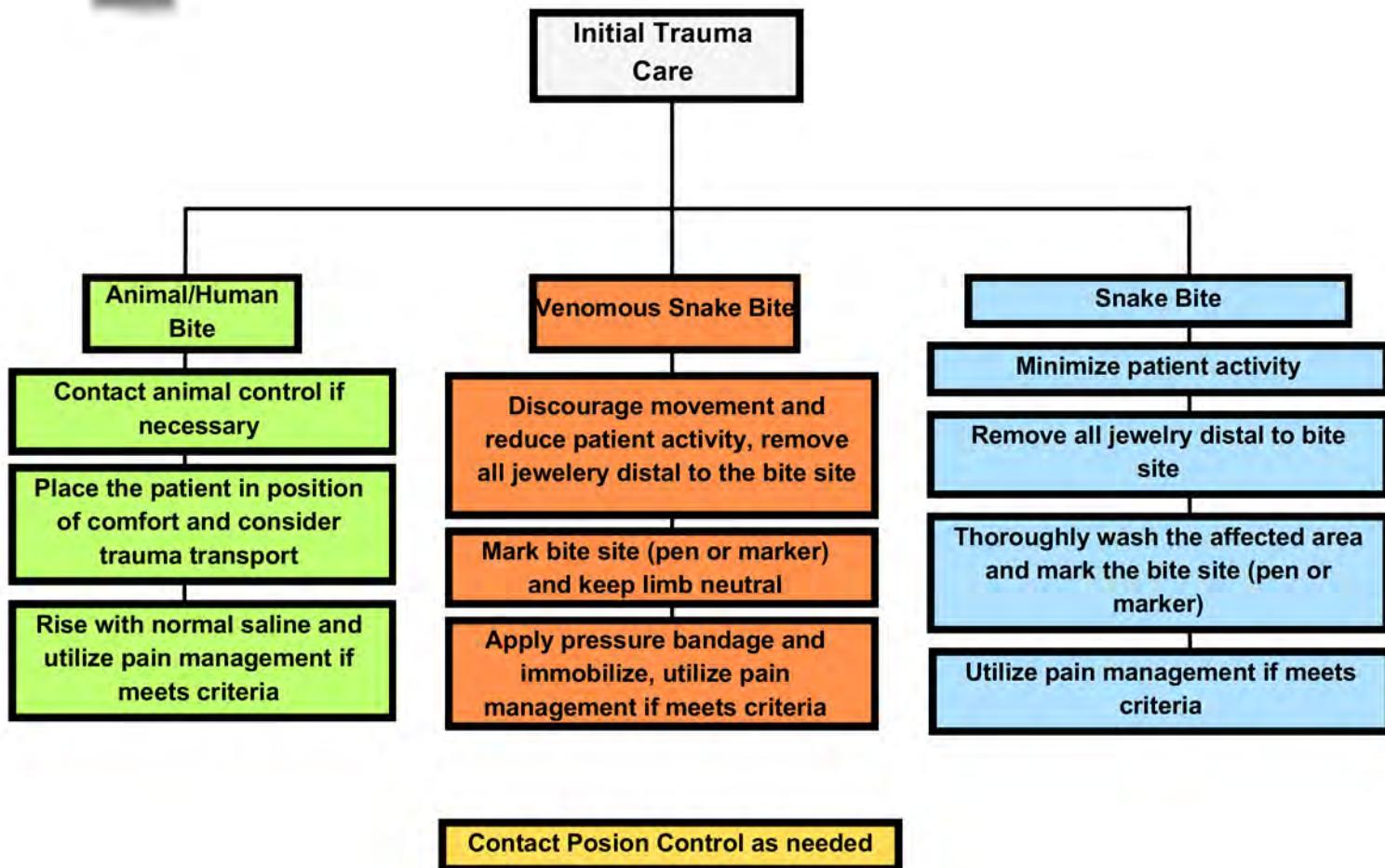


## Animal/Snake Bite



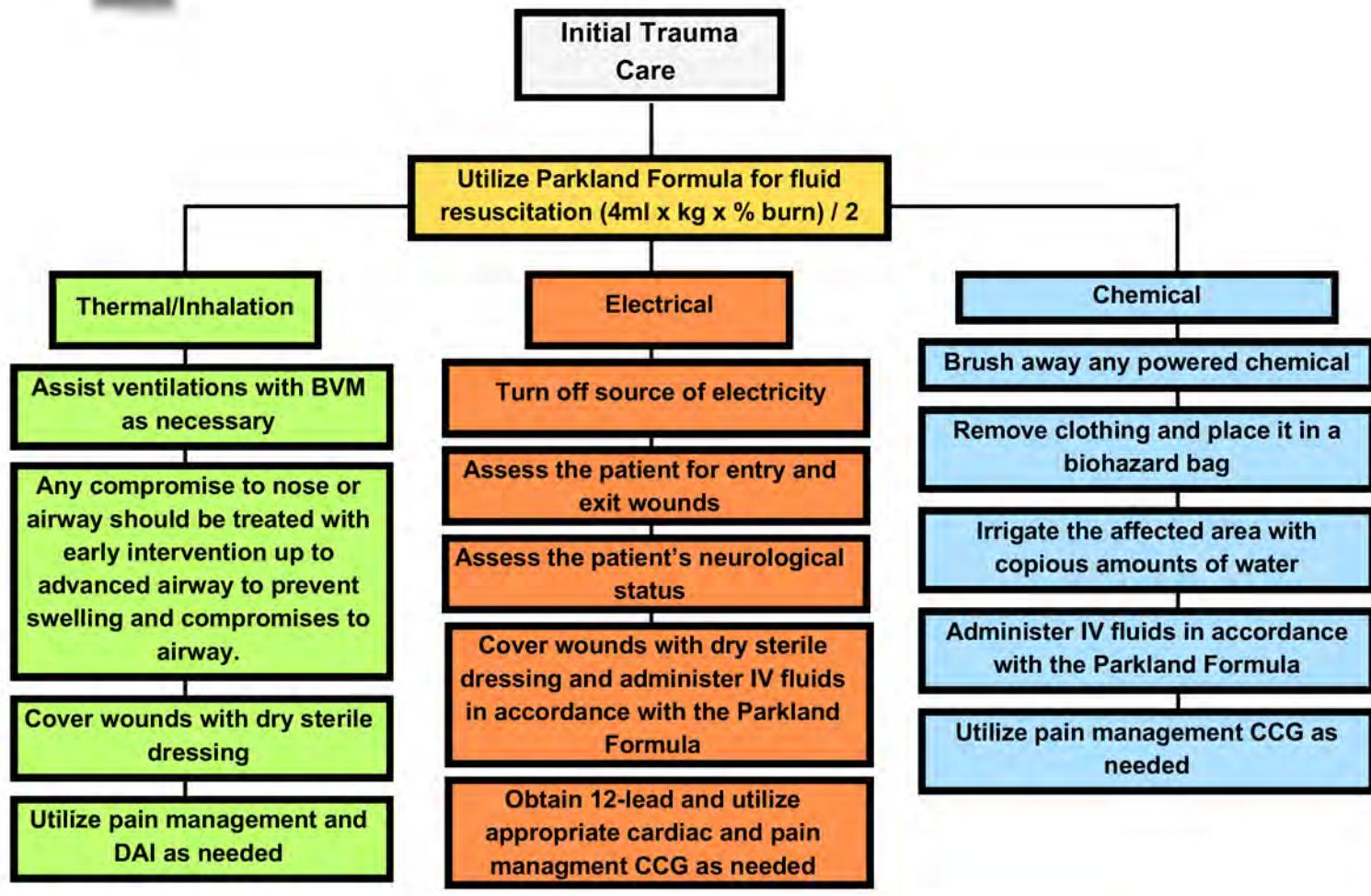


## Animal/Snake Bite





## Burns



**Burns to 15% or more of TBS = Trauma Alert**

If patient meets Trauma Alert utilize a burn blanket or trauma blanket

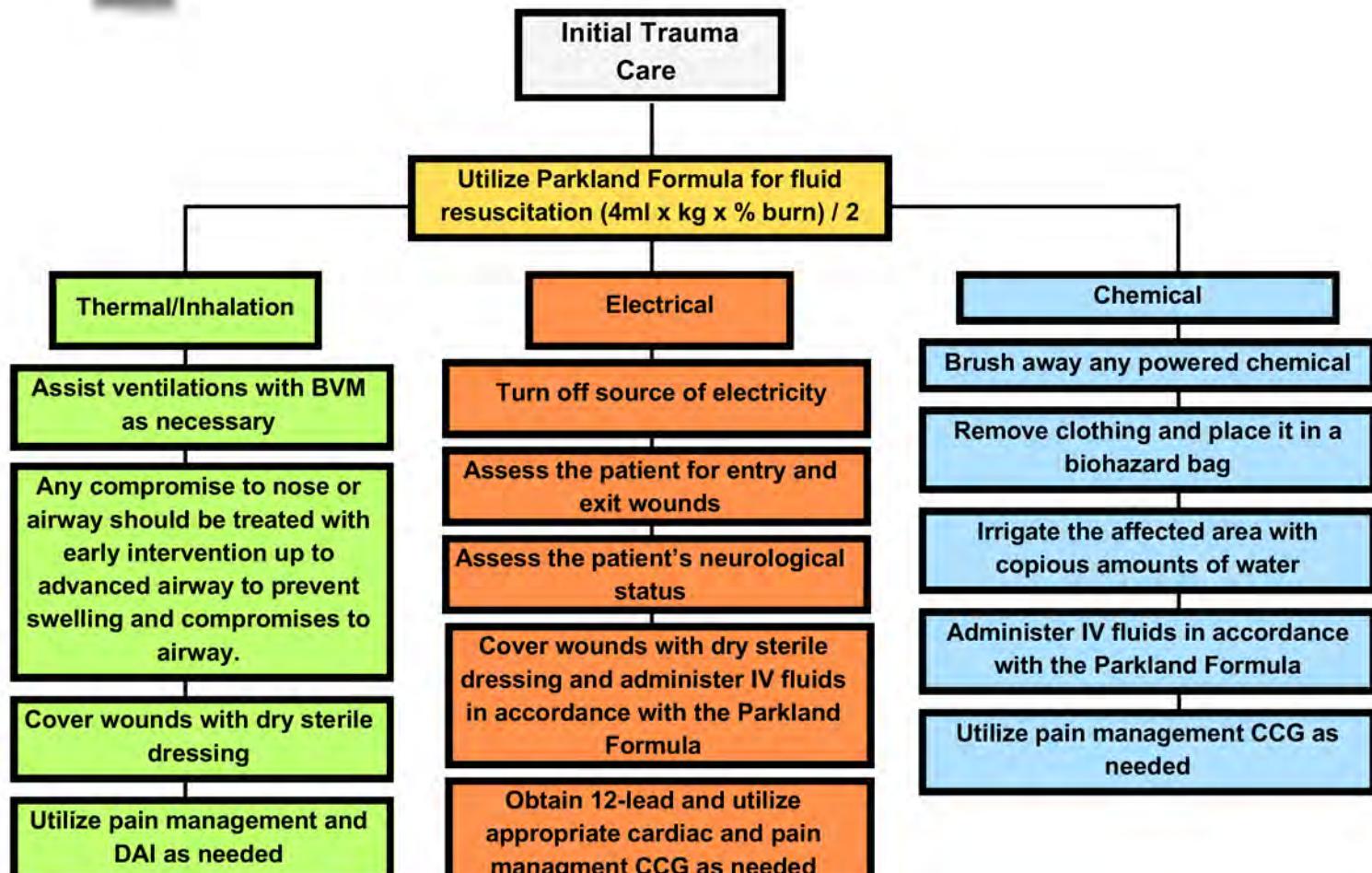
### PEARLS

Refer to pain management for 2nd and 3rd degree burns

- Classify and evaluate the burn in three ways:
- Source: Never assume agent or source of the burn
  - Degree: Burns involving the skin are classified as superficial, partial thickness, and full thickness; or first, second, third degree.
  - Evaluate depth of burn and estimate percentage using the Rule of Nines



## Burns



Burns to 10% or more of TBS = Trauma Alert

If patient meets Trauma Alert utilize a burn blanket or trauma blanket

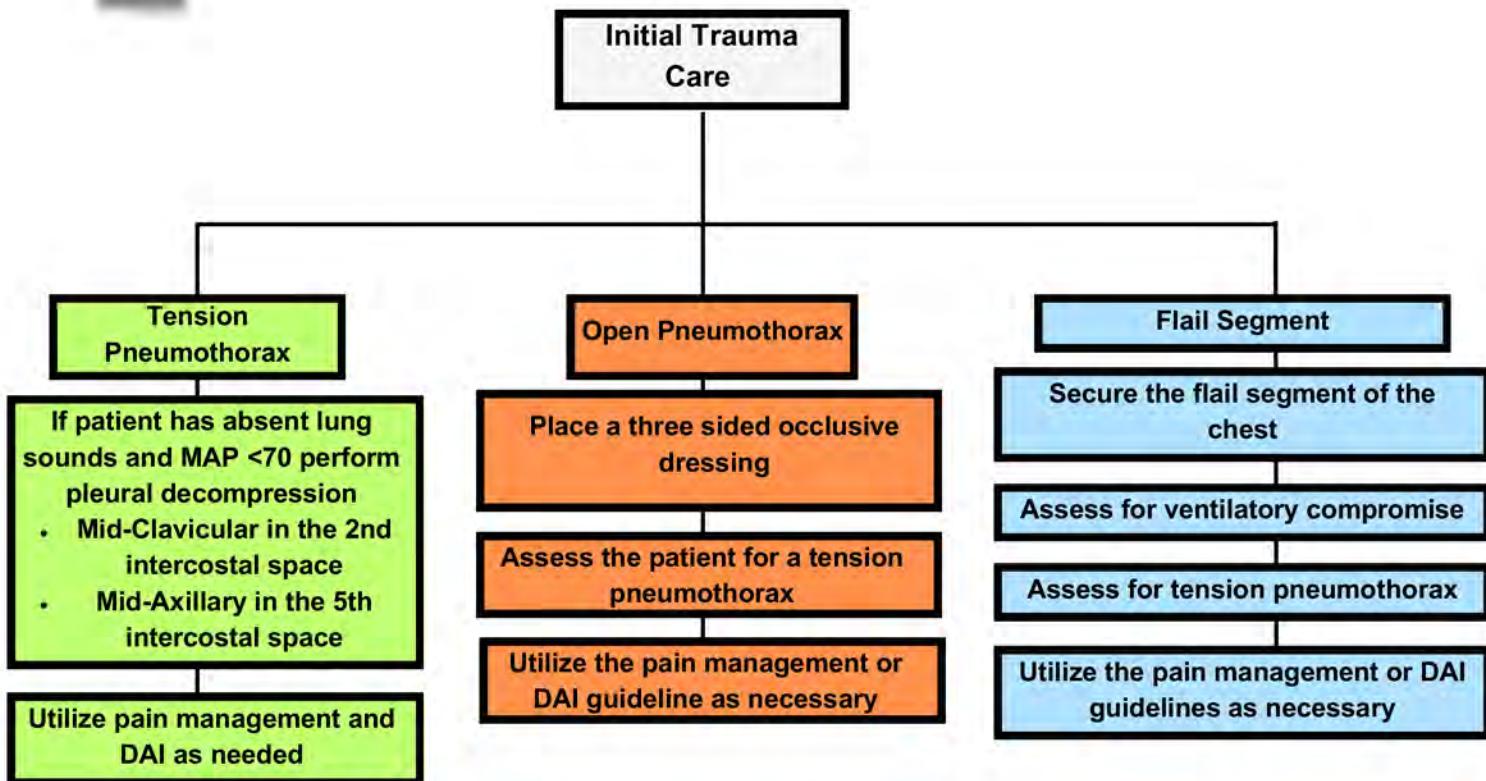
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## Chest Injuries



If patient meets Trauma Red Criteria, patient must be placed in trauma blanket

### PEARLS

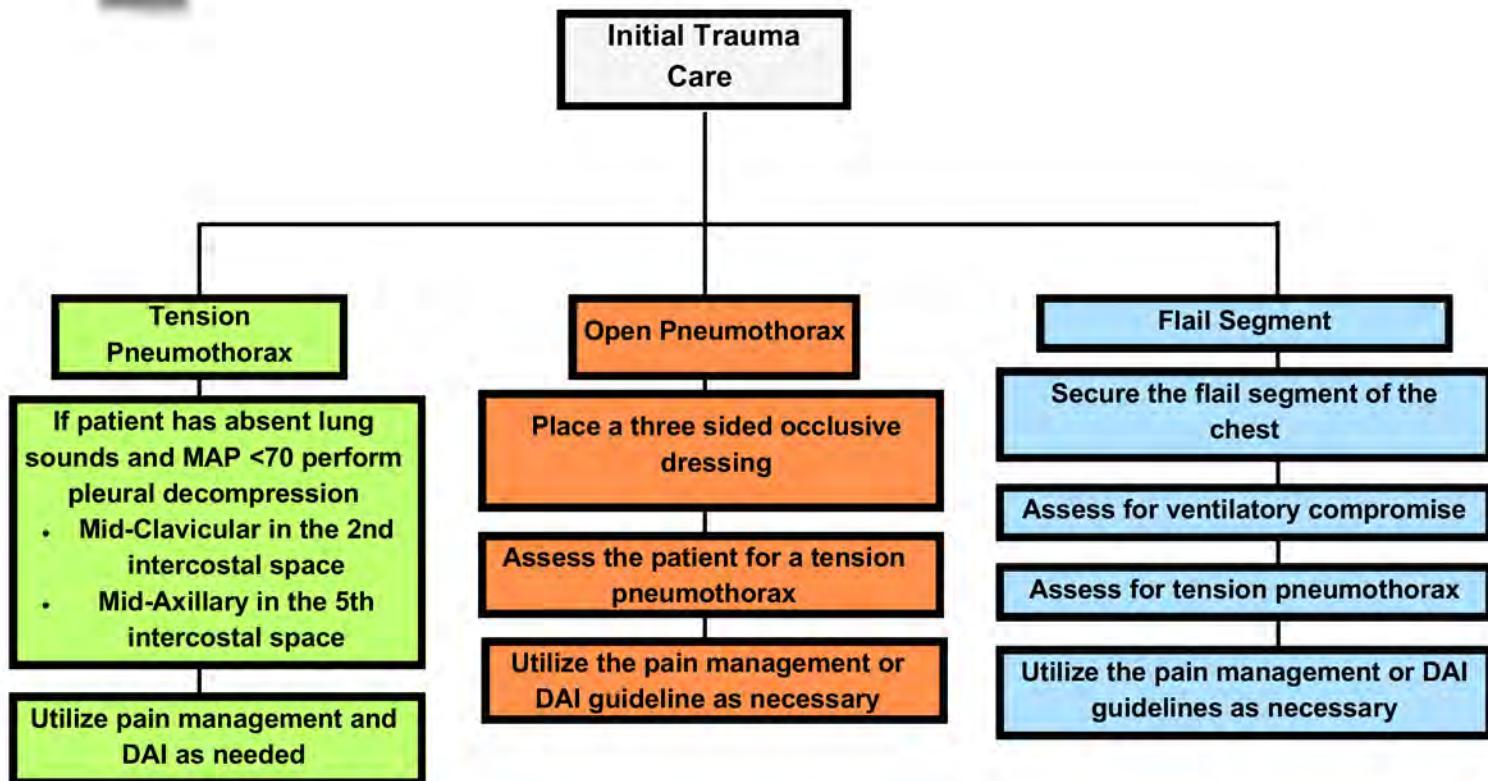
Pericardial Tamponade Suspected — Assess for Beck's Triad: (Narrowing Pulse Pressures, JVD, Muffled Heart Sounds).

Pneumothorax/Hemothorax suspected: Refer to Pleural Decompression.

Reassess lung sounds often when the above are suspected.



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## Crush Syndrome

### Initial Trauma Care

Assess the impingement time- if the time impinged is >45 minutes complete the following

Obtain 12-lead every 15 minutes

Establish two large bore IVs and keep patient warm

Administer Normal Saline at maximum flow rate up to 2L while patient is entrapped

Just prior to the impingement being released,  
administer the following.

Sodium Bicarb 50mEq slow IVP

Thoroughly flush the line

Calcium Chloride 1g over 10 minutes

If patient meets Trauma Red criteria, patient must be placed in trauma blanket

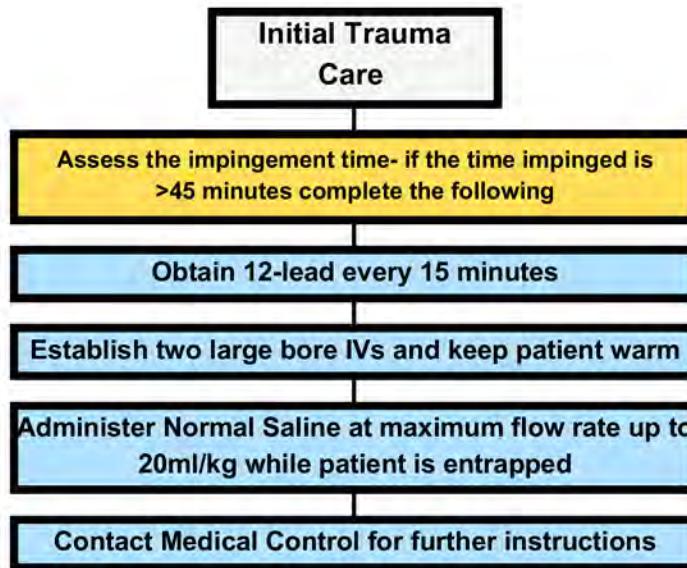
### PEARLS

Beware of complications of Rhabdomyolysis:  
Muscle pain, tenderness, swelling, hypovolemic state, decreased urine output, peaked T-waves (possible hyperkalemia)

Other possible s/s of crush syndrome:  
skin may be bruised/discolored, but can remain intact, pain after pressure is released can be excruciating, pulses may or may not be present



## Crush Syndrome



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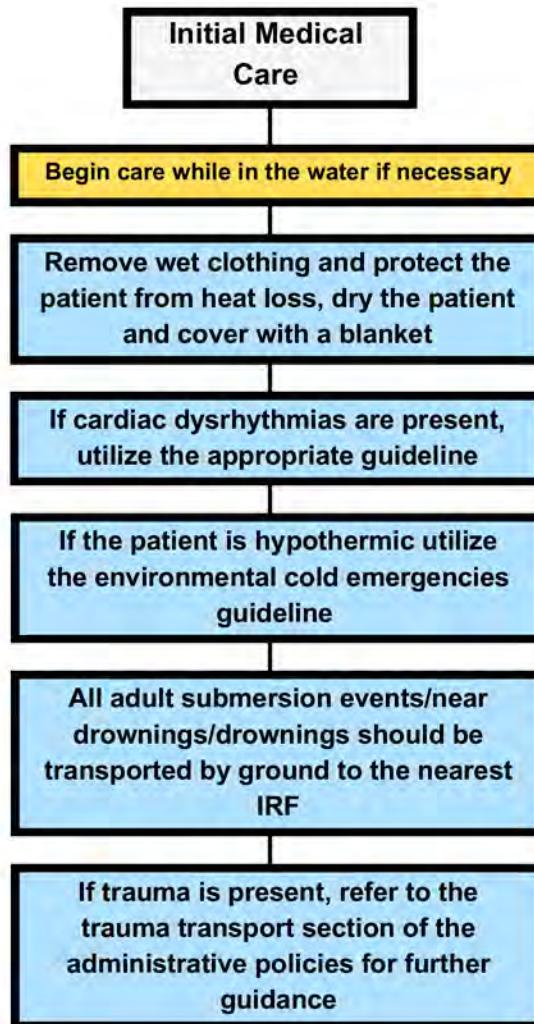
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## Drowning/Near Drowning



### PEARLS

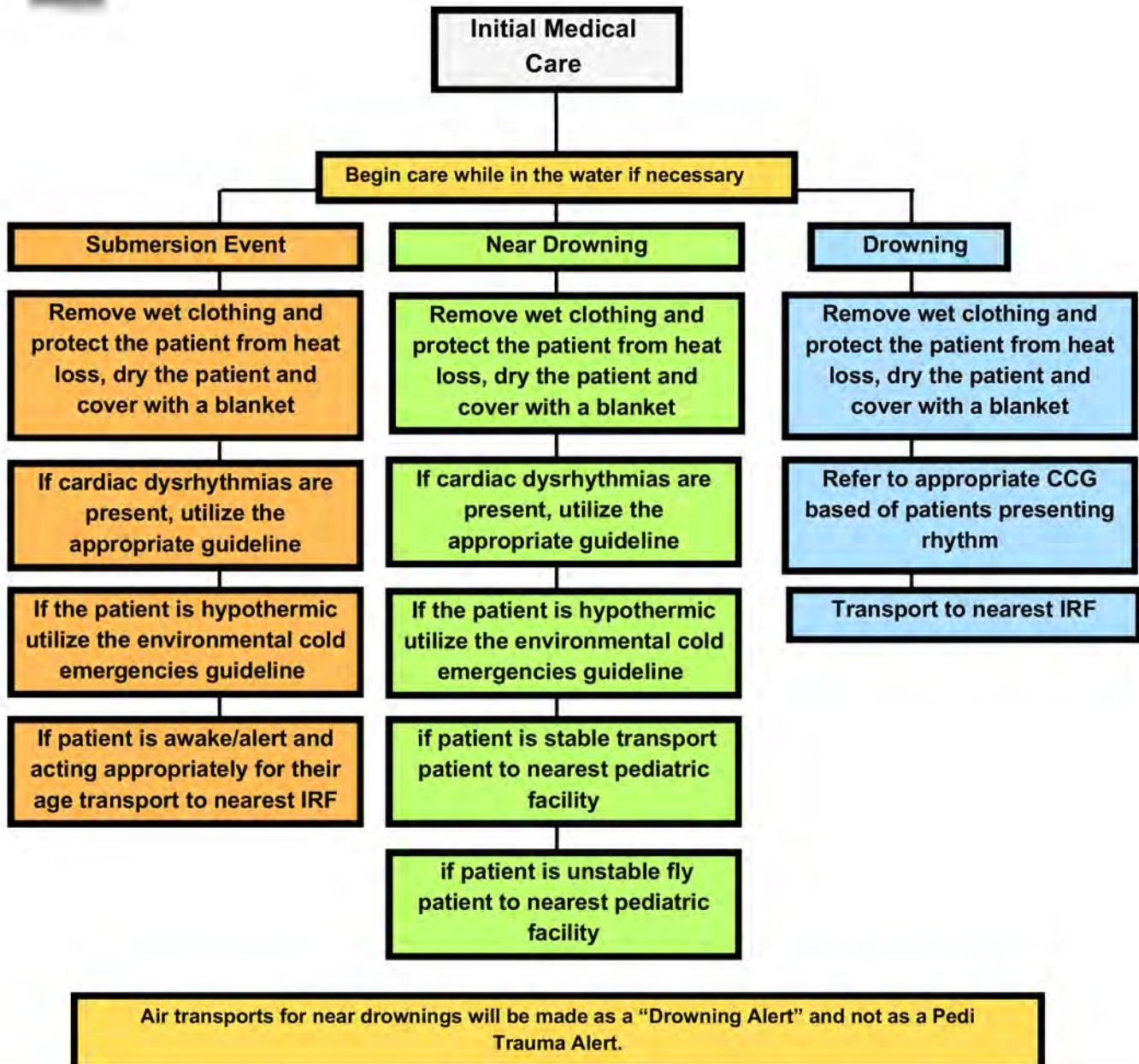
Near Drowning; submersion event where pulses were lost and/or respiratory arrest occurred and ROSC either before or after arrival of emergency crews  
Drowning; submersion event where patient remains in cardiac arrest

Submersion Event is defined as an emergency event in which a person experiences some swimming related distress that is sufficient to require Emergency Services support in the field and transport to a hospital.

With cold water no time limit - resuscitate all.



## Drowning/Near Drowning

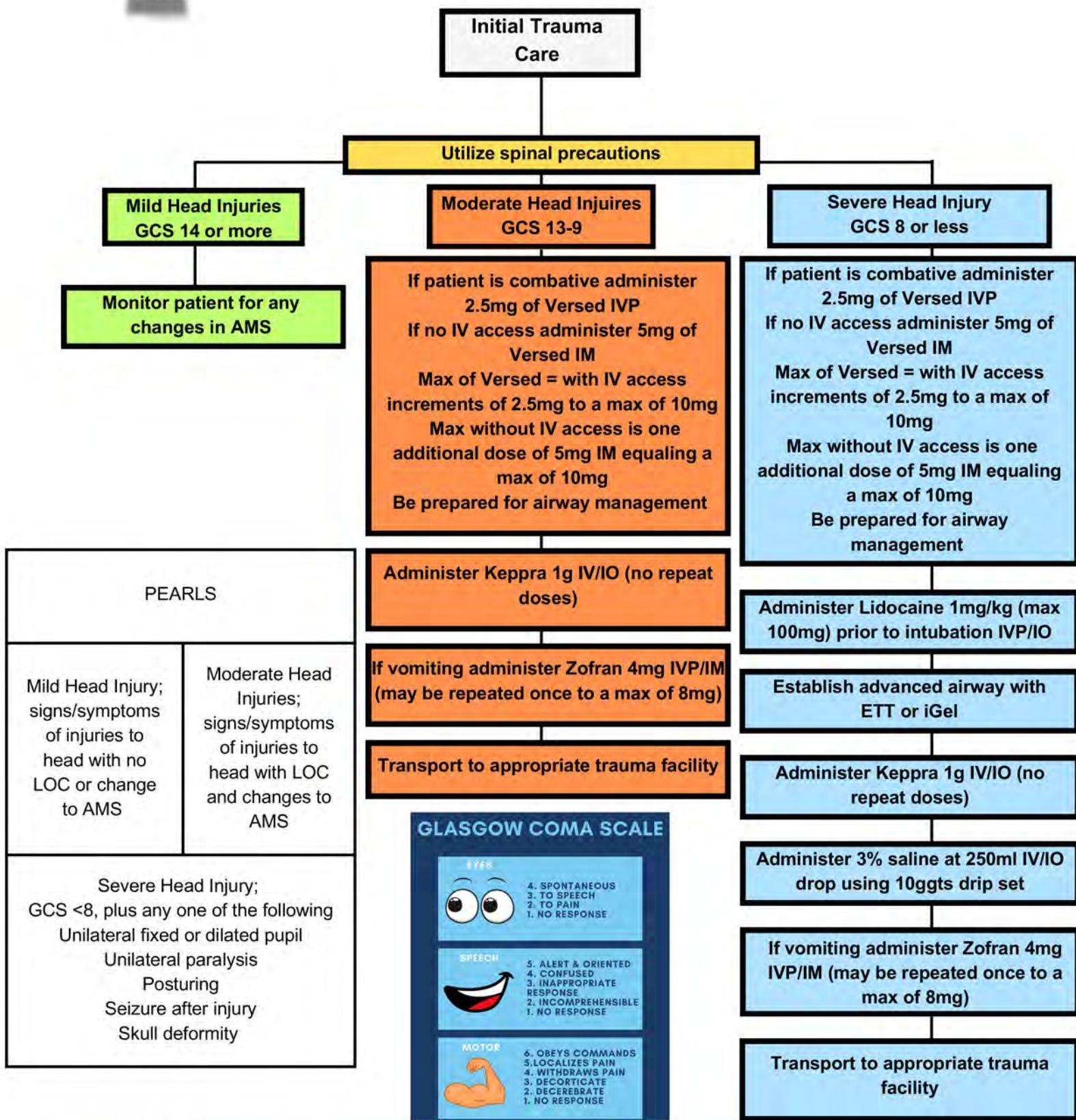


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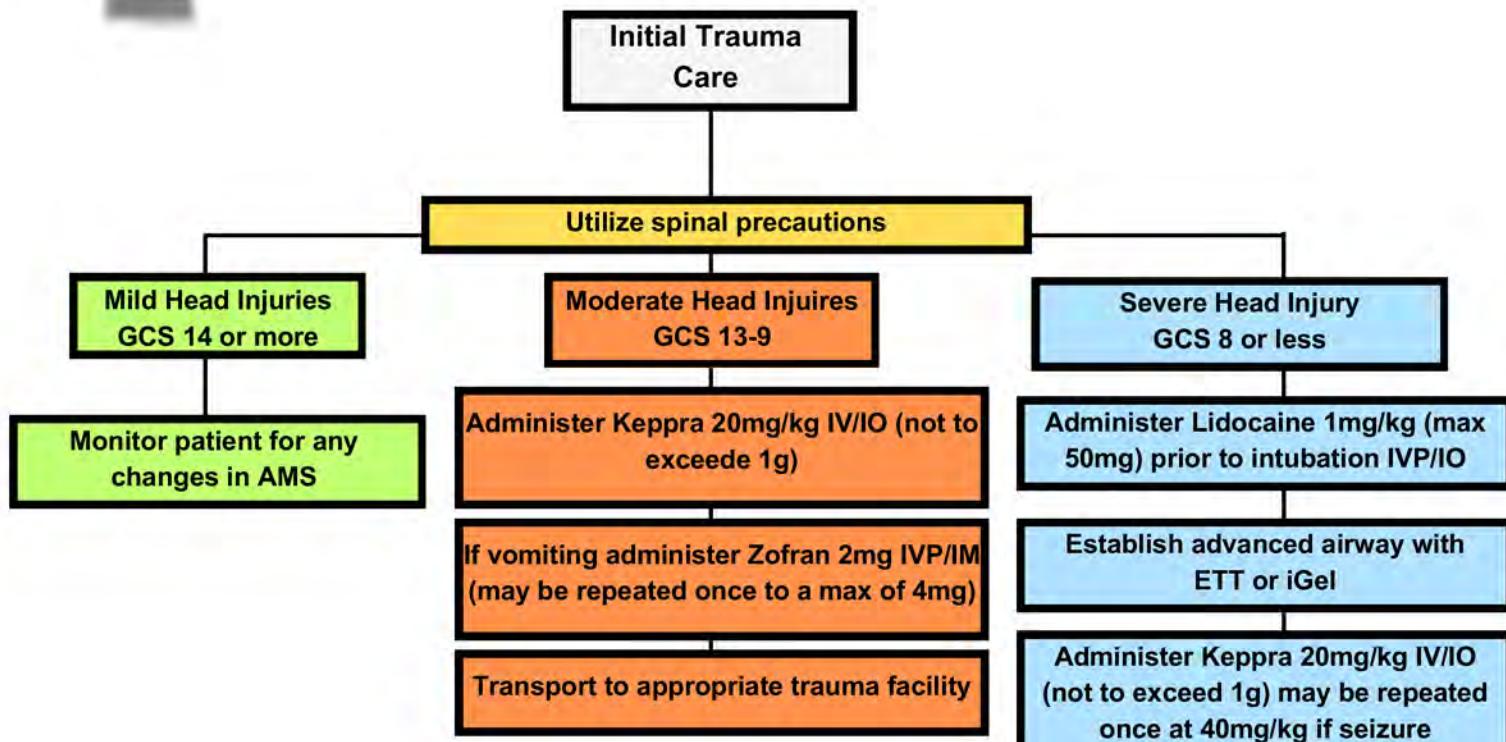


## Head Injuries





## Head Injuries



### PEARLS

Mild Head Injury;  
signs/symptoms of injuries to head with no LOC or change to AMS

Moderate Head Injuries;  
signs/symptoms of injuries to head with LOC and changes to AMS

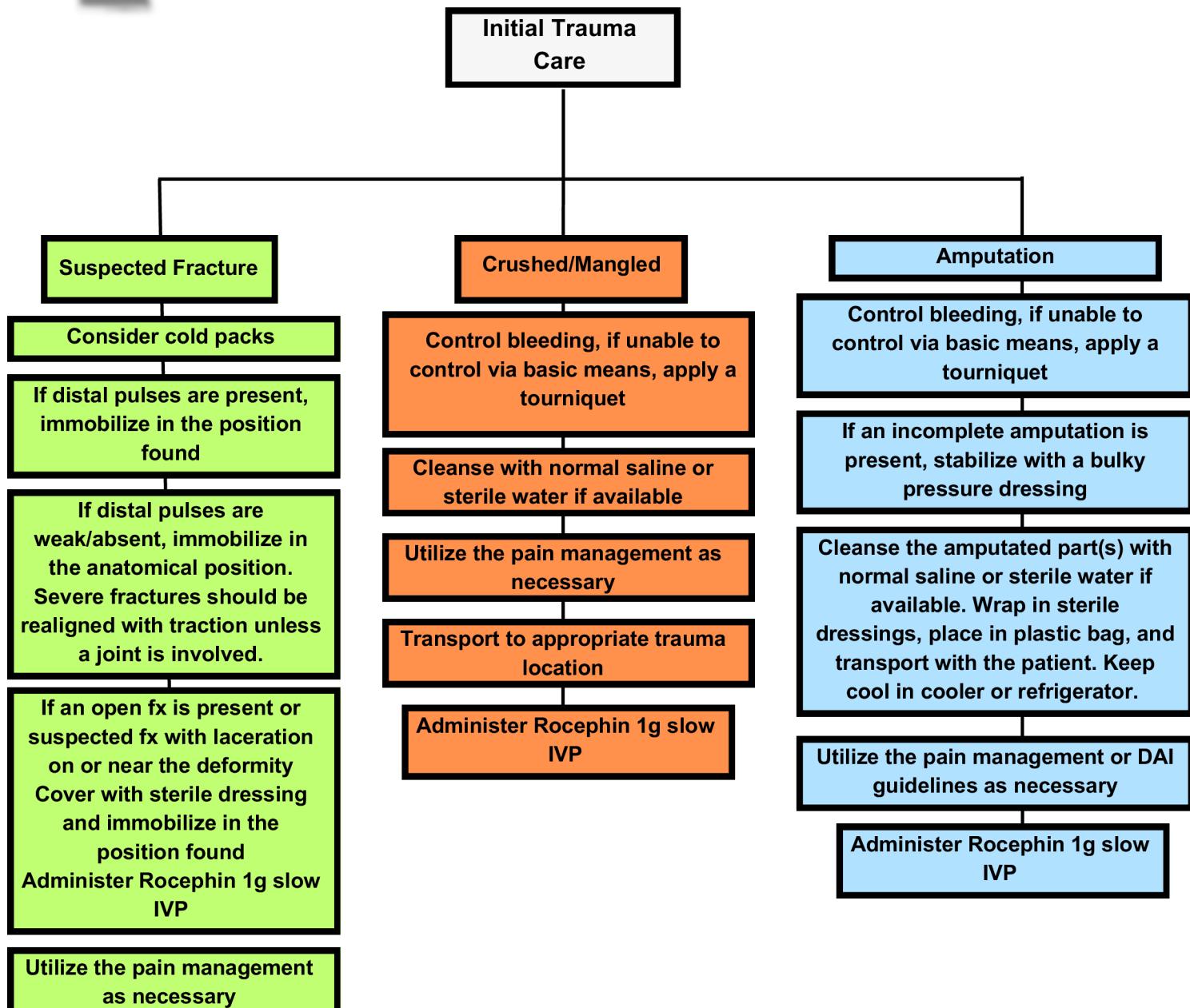
Severe Head Injury;  
GCS <8, plus any one of the following  
Unilateral fixed or dilated pupil  
Unilateral paralysis  
Posturing  
Seizure after injury  
Skull deformity

### GLASGOW COMA SCALE

<b>EYES</b>	4. SPONTANEOUS 3. TO SPEECH 2. TO PAIN 1. NO RESPONSE
<b>SPEECH</b>	5. ALERT & ORIENTED 4. CONFUSED 3. INAPPROPRIATE RESPONSE 2. INCOMPREHENSIBLE 1. NO RESPONSE
<b>MOTOR</b>	6. OBEYS COMMANDS 5. LOCALIZES PAIN 4. WITHDRAWS PAIN 3. DECORTICATE 2. DECEREBRATE 1. NO RESPONSE



## Isolated Extremity Trauma



Transport locations for patients with injuries to the hand(s) or fingers will be to either Tampa General Hospital or Orlando Regional, which have reattachment capabilities. This will be done via ground transport.

Patients who;

Amputations of more than one complete finger

Amputations of thumb

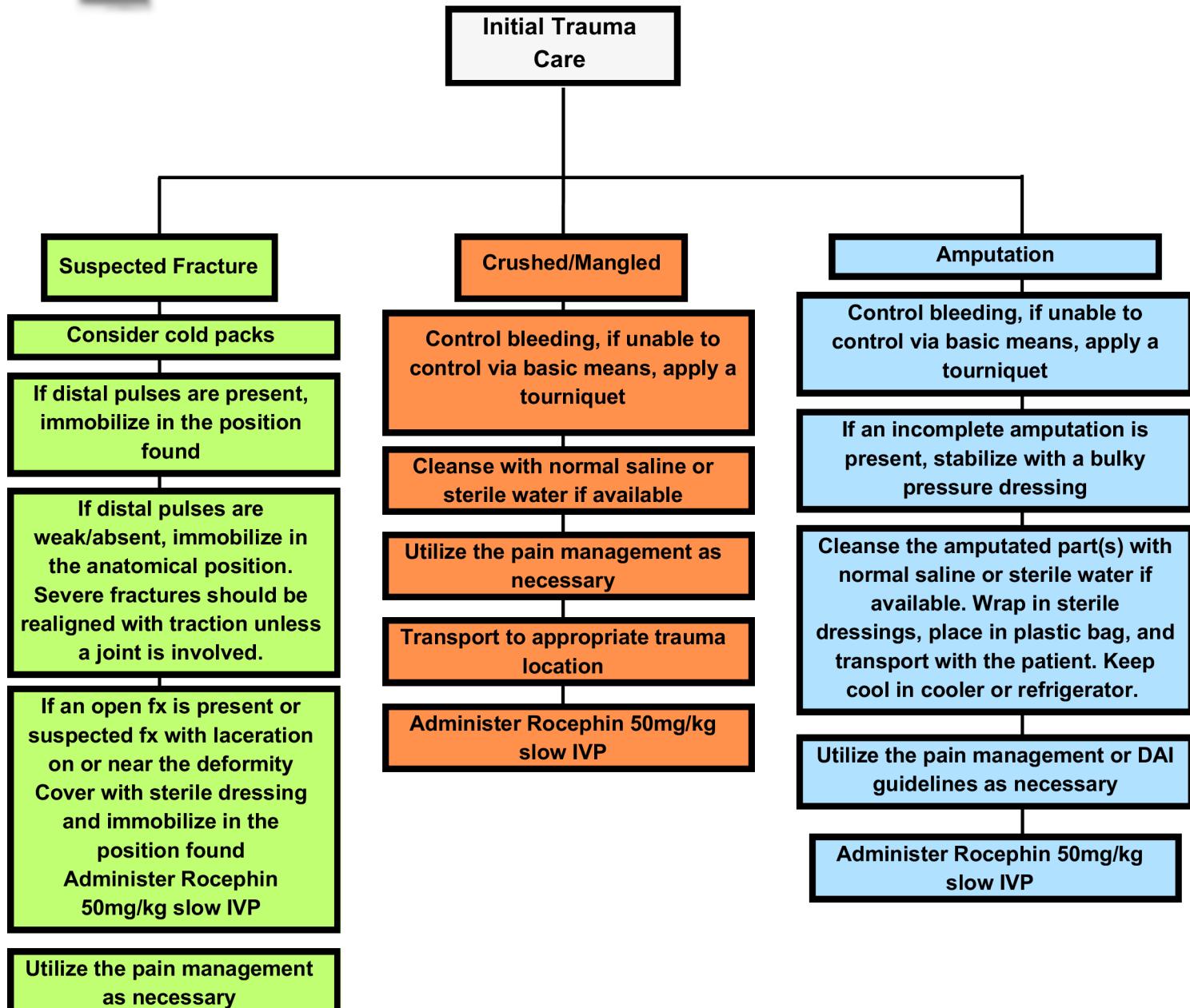
Amputation distal to the wrist on hand and/or distal to the ankle

Amputations of more than one complete toe

Notify the receiving facility as soon as possible



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Amputations of thumb

Amputation distal to the wrist on hand and/or distal to the ankle

Amputations of more than one complete toe

Notify the receiving facility as soon as possible



## Mass Blood Transfusion

### Initial Trauma Care

To qualify for the Adult MBT protocol the patient must be 16 years or older, meet **RED** trauma alert criteria, have a shock index  $>1$  (HR/Systolic), and a minimum of one criteria from both clinical and physiological sections.

<u>Clinical Indicators</u>	<u>Physiological Parameters</u>
<ul style="list-style-type: none"><li>• Multi-system Trauma</li><li>• Penetrating Trauma</li><li>• Partial or complete amputation</li><li>• Pelvic Fx (with significant MOI)</li><li>• ALOC (with significant MOI)</li></ul>	<ul style="list-style-type: none"><li>• Systolic BP <math>&lt;90</math>mmHg</li><li>• HR <math>&gt;110</math>bpm</li><li>• ETCO<sub>2</sub> <math>&lt;25</math></li><li>• MAP <math>&lt;70</math></li><li>• Known or presumed anticoagulant use, or dual anti-platelet therapy</li><li>• Signs of hemorrhage (high index of suspicion of active internal bleeding)</li></ul>

Establish an advanced airway if indicated

Establish two 18g or larger IVs (preferred site AC)

Administer 1 unit of Whole Blood rapidly via IV

Administer TXA 2g IV drip over 10 minutes in separate IV site from blood infusion

After administration of whole blood is complete, administer Calcium 1g IV followed by a normal saline flush

#### Important Reminders

- TXA can be administered prior to whole blood, and can be administered while awaiting MBT unit to arrive
- Do not administer to patients who have religious objection to receiving treatment
- Temperature control is critical for these patients, place patients in trauma blankets to aid in keeping warm
- Permissive hypotension is allowed with these patients, aim for a MAP  $>80$



## Mass Blood Transfusion

### Initial Trauma Care

To qualify for the Adult MBT protocol the patient must be 3 years or older and meet **RED** trauma alert criteria, have a shock index >1 (HR/Systolic), and minimum of one criteria from both clinical and physiological sections.

<u>Clinical Indicators</u>	<u>Physiological Parameters</u>
<ul style="list-style-type: none"><li>• Multi-system Trauma</li><li>• Penetrating Trauma</li><li>• Partial or complete amputation</li><li>• Pelvic Fx (with significant MOI)</li><li>• ALOC (with significant MOI)</li></ul>	<ul style="list-style-type: none"><li>• Systolic BP &lt; normal for age</li><li>• HR &gt; greater than normal for age</li><li>• ETCO<sub>2</sub> &lt;25</li><li>• Known or presumed anticoagulant use, or dual anti-platelet therapy</li><li>• Signs of hemorrhage (high index of suspicion of active internal bleeding)</li></ul>

Establish an advanced airway if indicated

Establish two large bore IVs (preferred site AC)

Administer 20ml/kg unit of Whole Blood rapidly via IV, may be repeated once. (max 1 unit)

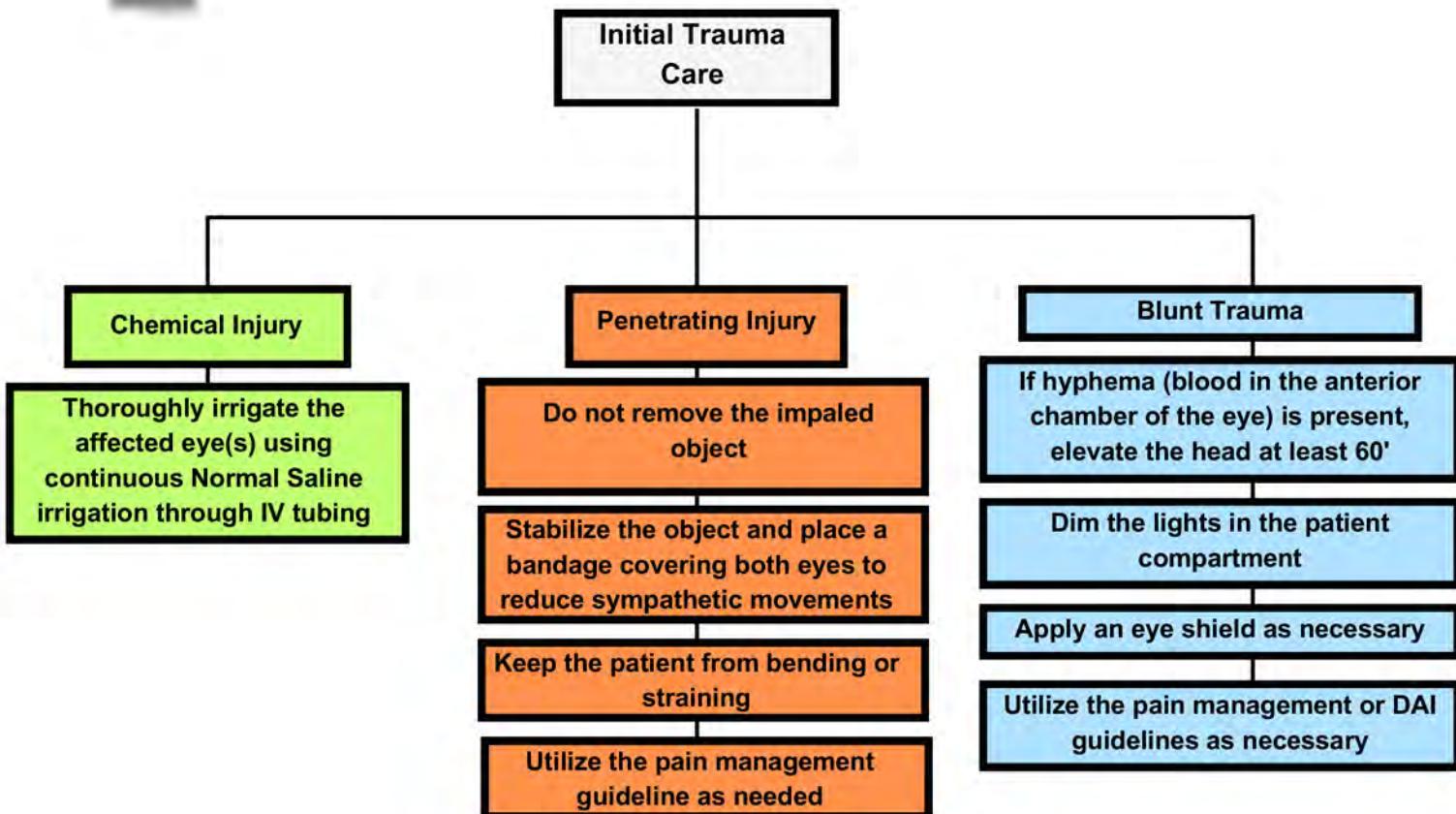
Administer TXA 15mg/kg IV drip over 10 minutes in separate IV site from blood infusion

#### Important Reminders

- TXA can be administered prior to whole blood, and can be administered while awaiting MBT unit to arrive
- Do not administer to patients who have religious objection to receiving treatment
- Temperature control is critical for these patients, place patients in trauma blankets to aid in keeping warm
- Permissive hypotension is allowed with these patients, aim for a MAP >80

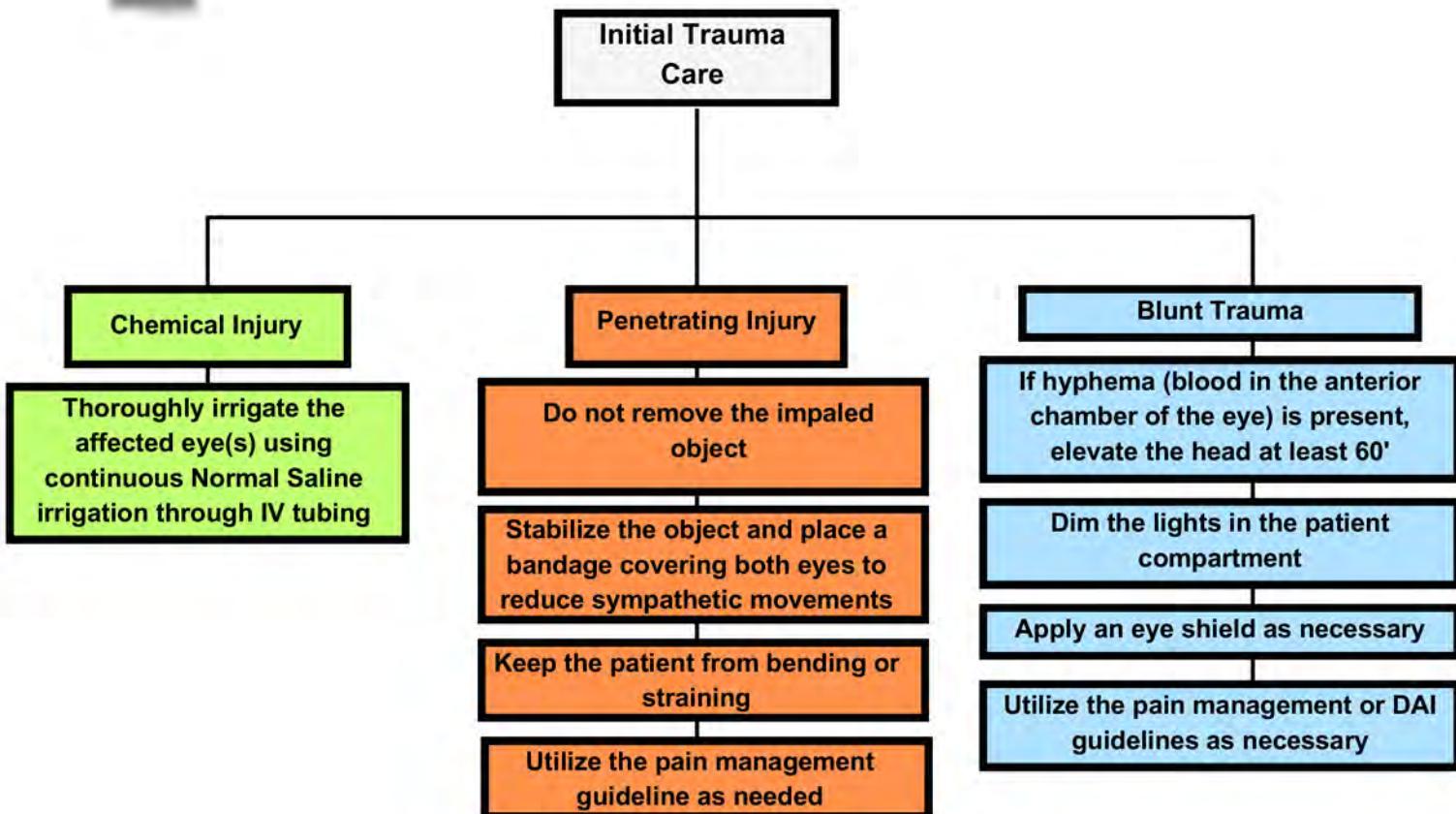


## Ophthalmic Injuries





## Ophthalmic Injuries



## Pain Management

### Initial Medical Care

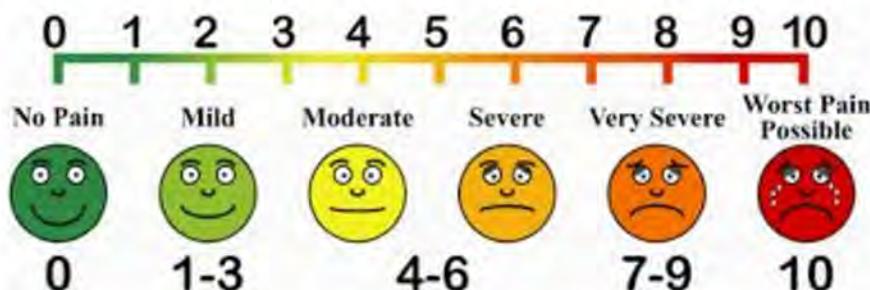
Consider pain management if the patient meets the following criteria and the associated CCG calls for the use of pain management.

- Pain scale of 8 or more
- Vital signs match pain scale (increased HR, increased BP)
- Diphoretic, uneasy, not able to get comfortable sitting/laying on stretcher

If the patient meets the above administer Fentanyl 25mcg IVP.  
May be repeated up to 3 more times in increments of 25mcg for a total max of 100mcg

If the patient becomes nauseated or begins vomiting following pain management administer Zofran 4mg IVP (may be repeated once to a max of 8mg)

If Fentanyl is not available, Ketamine 25mg slow IVP may be administered (may be repeated one time at 25mg slow IVP to a max of 50mg)



## Pain Management

### Initial Medical Care

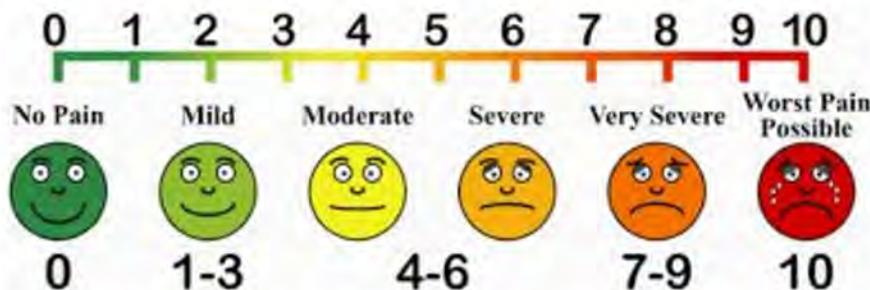
Consider pain management if the patient meets the following criteria and the associated CCG calls for the use of pain management.

- Pain scale of 8 or more
- Vital signs match pain scale (increased HR, increased BP)
- Diphoretic, uneasy, not able to get comfortable sitting/laying on stretcher

If the patient meets the above, administer Fentanyl 0.5mcg/kg IVP. (max 25mcg) no-repeat doses (see HandTevy app for dosing)

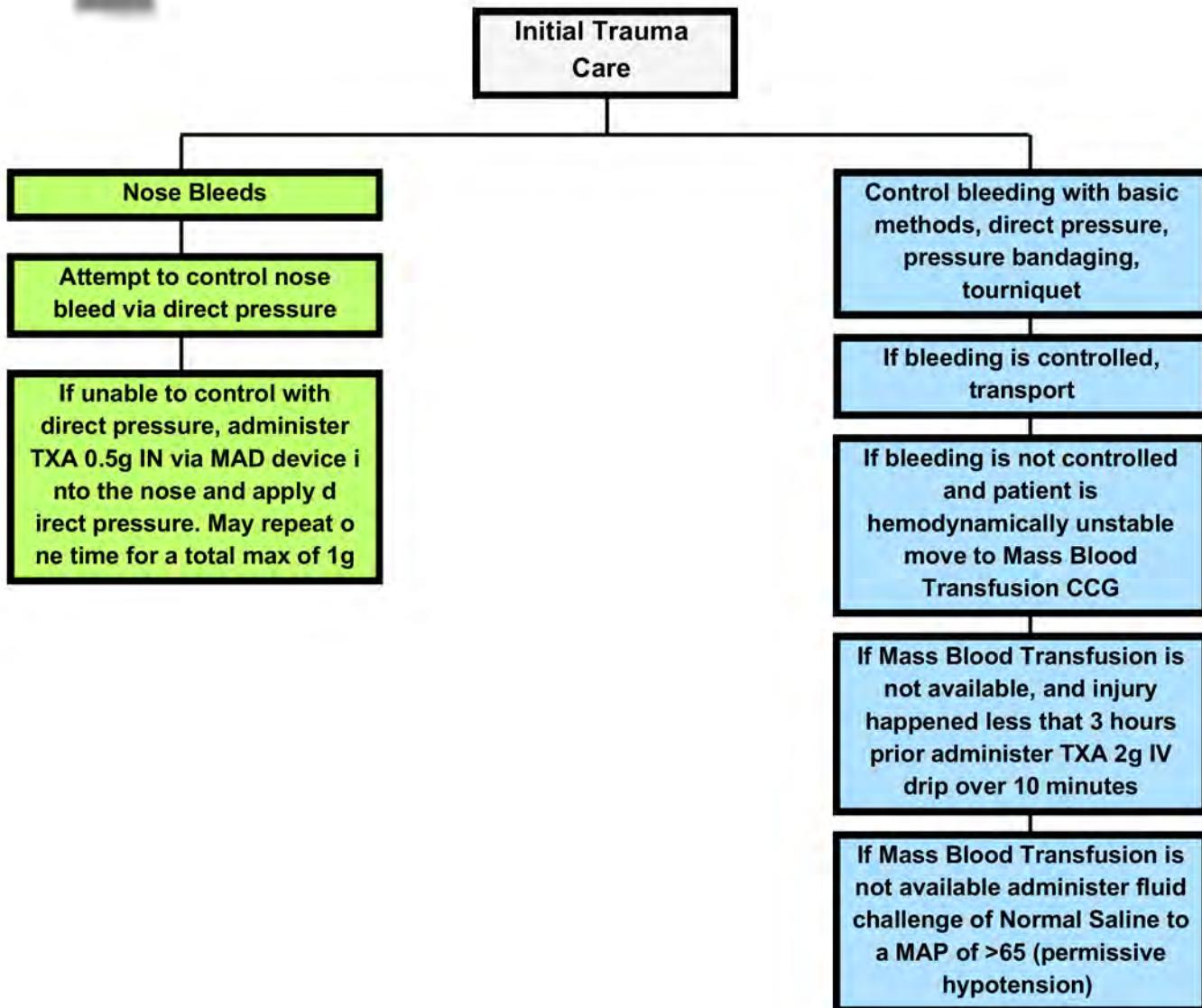
If the patient becomes nauseated or begins vomiting following pain management administer Zofran 0.15mg/kg IVP max 4mg

If Fentanyl is not available, Ketamine 0.25mg/kg slow IVP may be administered (max 25mg)





## Significant Hemorrhage



### PEARLS

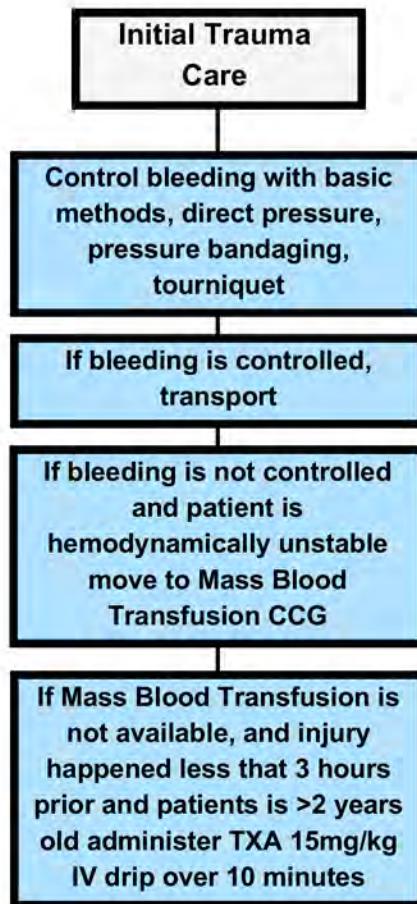
#### TXA drip

Inject 2g of TXA into a 50ml bag of normal saline and administer with a 10 drop set at 50 drops per minute

Do not delay transport for MBT CCG. Consider having the MBT unit intercept during transport to allow transport to begin.



## Significant Hemorrhage



### PEARLS

**TXA drip**

Inject 2g of TXA into a 50ml bag of normal saline and administer with a 10 drop set

Do not delay transport for MBT CCG. Consider having the MBT unit intercept during transport to allow transport to begin.



## Spider Bite

Initial Trauma Care

Monitor for deterioration and signs/symptoms

Position the patient supine

Remove all jewelry distal to the bite site

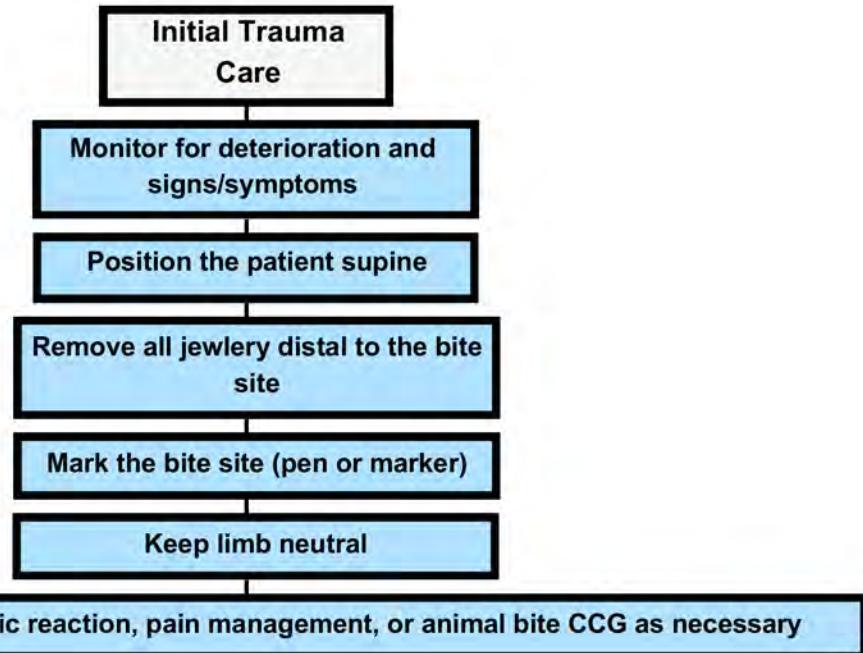
Mark the bite site (pen or marker)

Keep limb neutral

Utilize the allergic reaction, pain management, or animal bite CCG as necessary



## Spider Bite





## Spinal Motion Restriction

### Initial Trauma Care

Patients who experience a physically traumatic event who meet the following criteria must be spinal immobilized:

- Any neurological deficits
- GCS <15 from trauma
- Any evidence of intoxication or impairment
- Any spinal tenderness
- Findings indicative of head, neck, or spinal injury

Patients who cannot tolerate a Long Spine board are to be transported with a C-Collar in the position of comfort with appropriate documentation of complication.

If the patient does not have any of the previously mentioned signs/symptoms, full spinal immobilization is not required. Apply a cervical collar and transport in a position of comfort.

### PEARLS

Evidence of Intoxication: Refers to any physical, behavioral, or chemical indication suggesting that an individual has impaired cognitive or motor function due to the consumption of alcohol, illicit drugs, prescription medications, or other substances.



## Spinal Motion Restriction

### Initial Trauma Care

Patients who experience a physically traumatic event who meet the following criteria must be spinal immobilized:

- Any neurological deficits
- GCS <15 from trauma
- Any evidence of intoxication or impairment
- Any spinal tenderness
- Signs and Symptoms of head, neck or spinal injuries

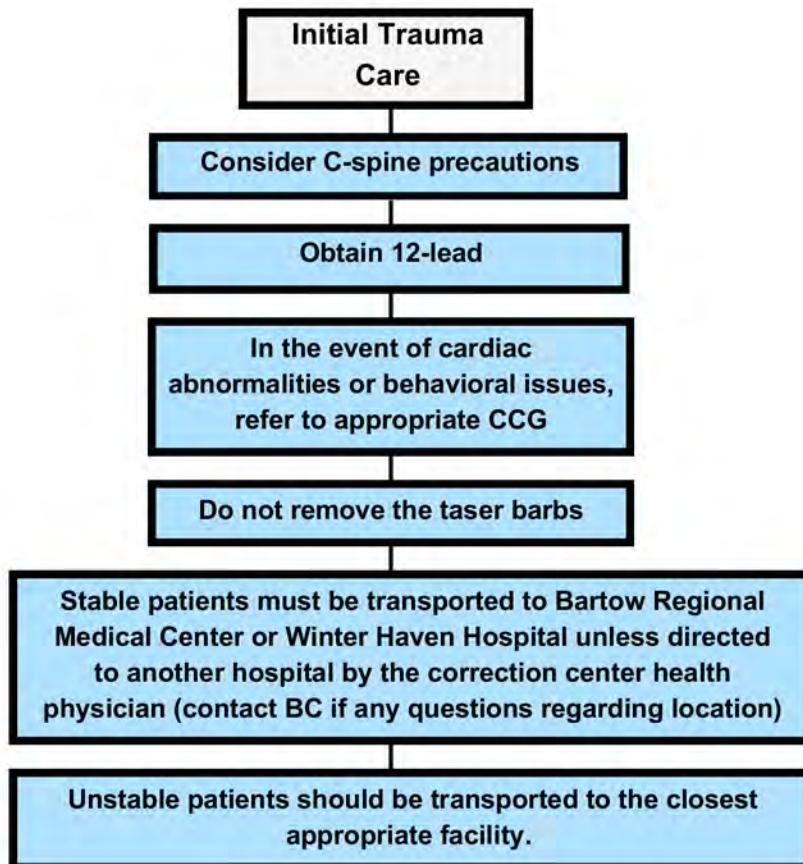
Patients who cannot tolerate a Long Spine board are to be transported with a C-Collar in the position of comfort with appropriate documentation of complication.

If the patient does not have any of the previously mentioned signs/symptoms, full spinal immobilization is not required. Apply a cervical collar and transport in a position of comfort.

If patient is in car seat, they can be immobilized within the car seat and seat secured to stretcher



## Taser Deployment



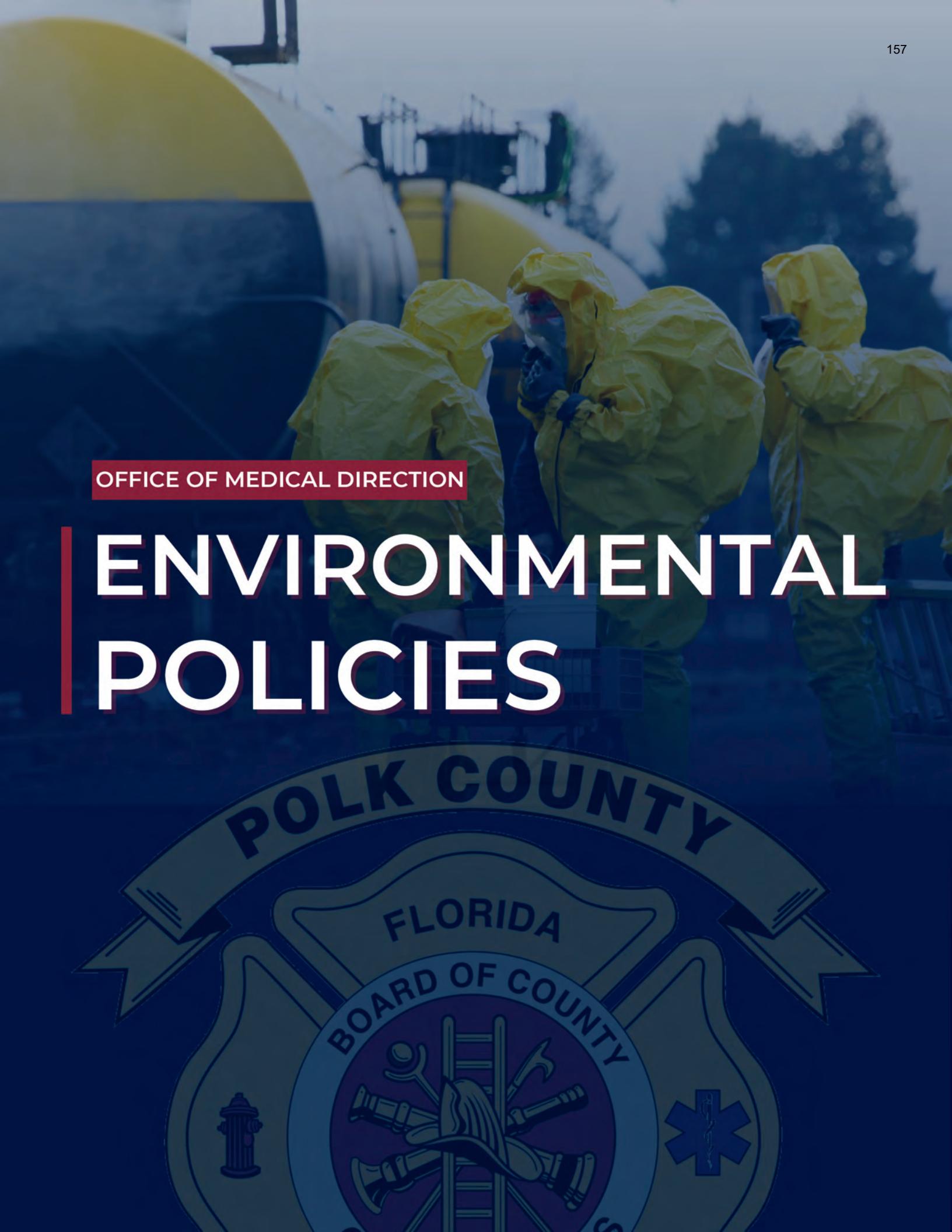
All Taser deployment patients must be transported to a medical facility for further evaluation.



Pedi

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A photograph showing several individuals wearing full-body yellow protective suits and hoods. They appear to be inspecting or working on a large, cylindrical white industrial tank, possibly a storage tank for hazardous materials. The background shows some trees and a clear sky.

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# ENVIRONMENTAL POLICIES

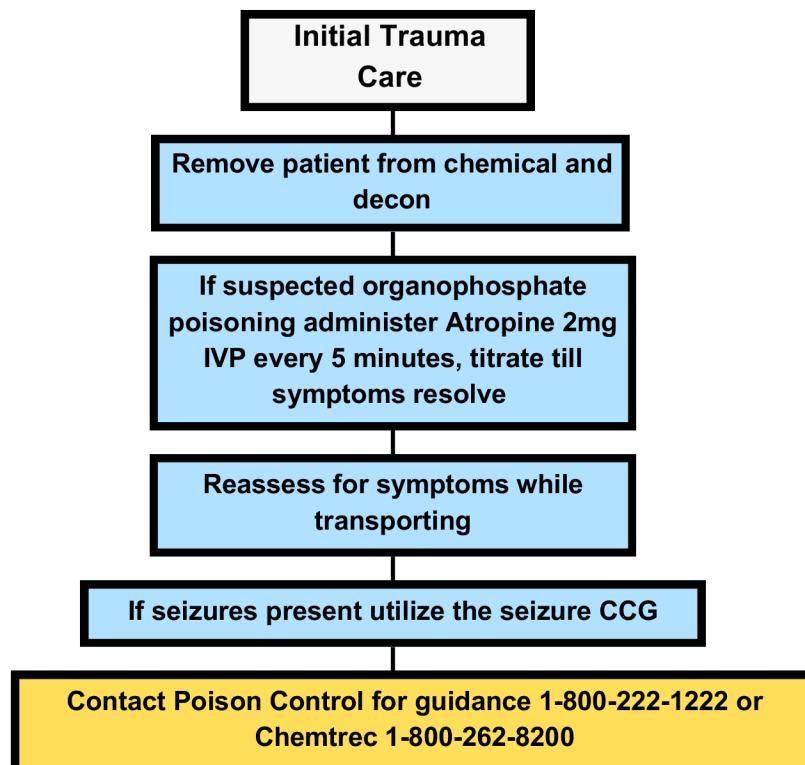




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## Chemical Agent Exposure



### PEARLS

Signs/symptoms of organophosphate poisoning. (SLUDGE) Salivation, lacrimation, urination, diarrhea, diaphoresis, gastrointestinal motility, emesis

Request Special Ops Battalion Chief and Special Ops unit respond

Mild Symptoms of Organophosphate Poisoning  
Blurred vision, miosis (excessive constriction of the pupils), excessive, unexplained teary eyes, excessive, unexplained runny nose , increased salivation, such as sudden drooling, chest tightness or difficulty breathing,



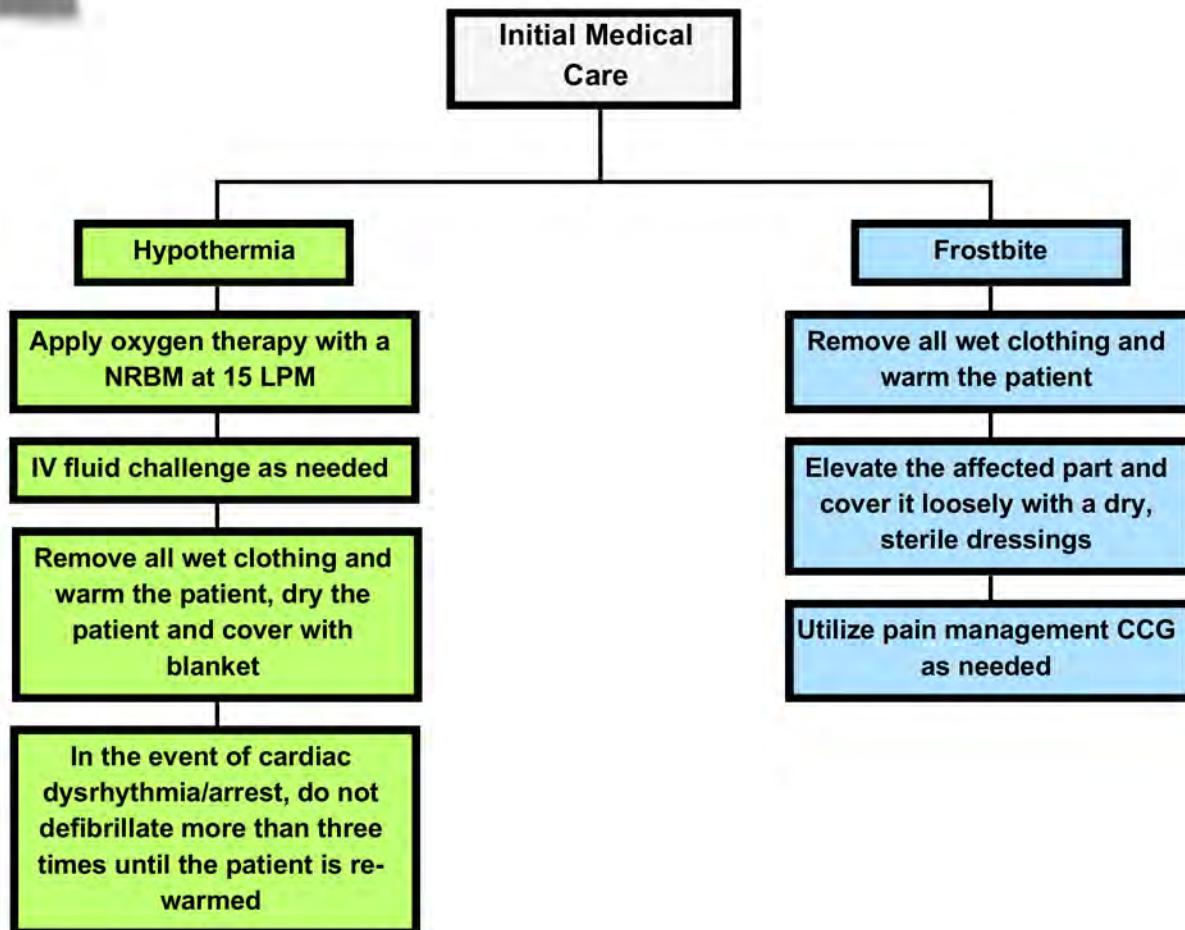
Pedi

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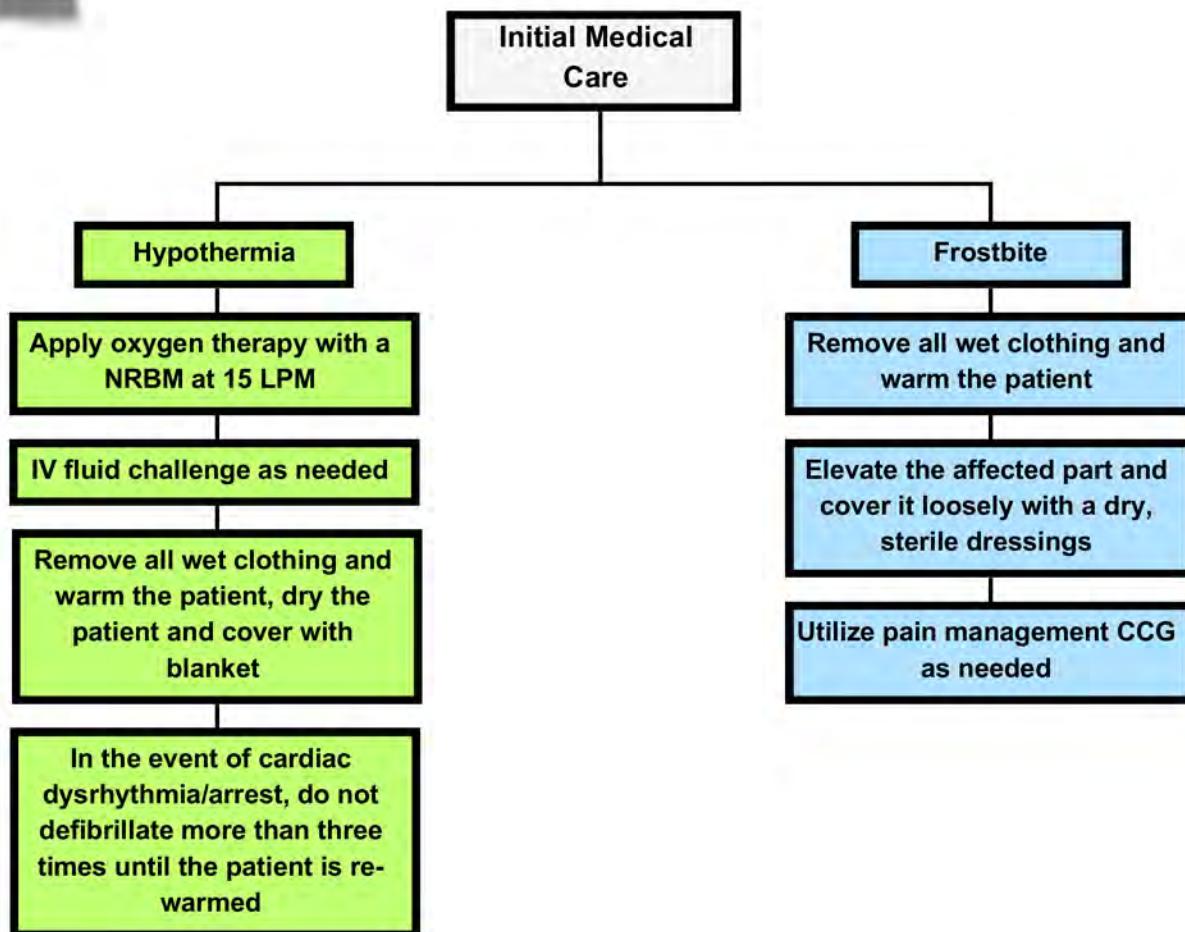


## Environmental Cold Emergencies





## Environmental Cold Emergencies





## Firefighter Rehab

### Initial Medical Care

#### Begin passive/active cooling

Preliminary Rehab - if the firefighter presents as unstable, transport and utilize the appropriate CCG for presenting symptoms

#### Ten Minute Rehab

- Depletion of one 45-minute SCBA cylinder
- After twenty minutes of intense work without SCBA
- If members enter the rehab before going through two 45-minute SCBA cylinders

#### Twenty Minute Rehab

- Depletion of two 45 min SCBA cylinders
- One 60 min SCBA cylinder
- Whenever encapsulating chemical protective clothing is worn
- After 45 min of intense work without an SCBA

Revitalization provides rest, rehydration (2-4oz/20min), nourishment, and repeat medical evaluation, drinks should be cool not cold.

#### 10 Minute Rehab

Mandatory 10 minute rest period

2-4oz of fluid (water) PO for every 20 minutes of work completed

#### 20 Minute Rehab

Mandatory 20 minute rest period

12 oz of fluid (water) PO for every 20 minutes of work completed

Reassess vitals including blood pressure, SPO<sub>2</sub> and temperatures every 10 minutes. If vitals are found to be abnormal evaluate ECG and 12-lead.

Obtain a BGL. If after 10 additional minutes patients vitals do not improve, establish IV and administer Normal Saline fluid challenge up to 1L. Move patient to cool environment and reassess. A full ePCR must be created and completed.

For the purpose of cooling hyperthermic patients, any saline bag kept within the confines of the ambulance is cool enough, do not utilize the Normal Saline bags kept in refrigerator. Those are for cardiac arrest only.

Transport if no improvements in total rehab time of 30 minutes

#### Abnormal Vitals Signs Reference

HR >100bpm

Temperature 100.6°F

Systolic BP >160 or Diastolic BP >100

Respiratory >20bpm or SpO<sub>2</sub> <92%



Pedi

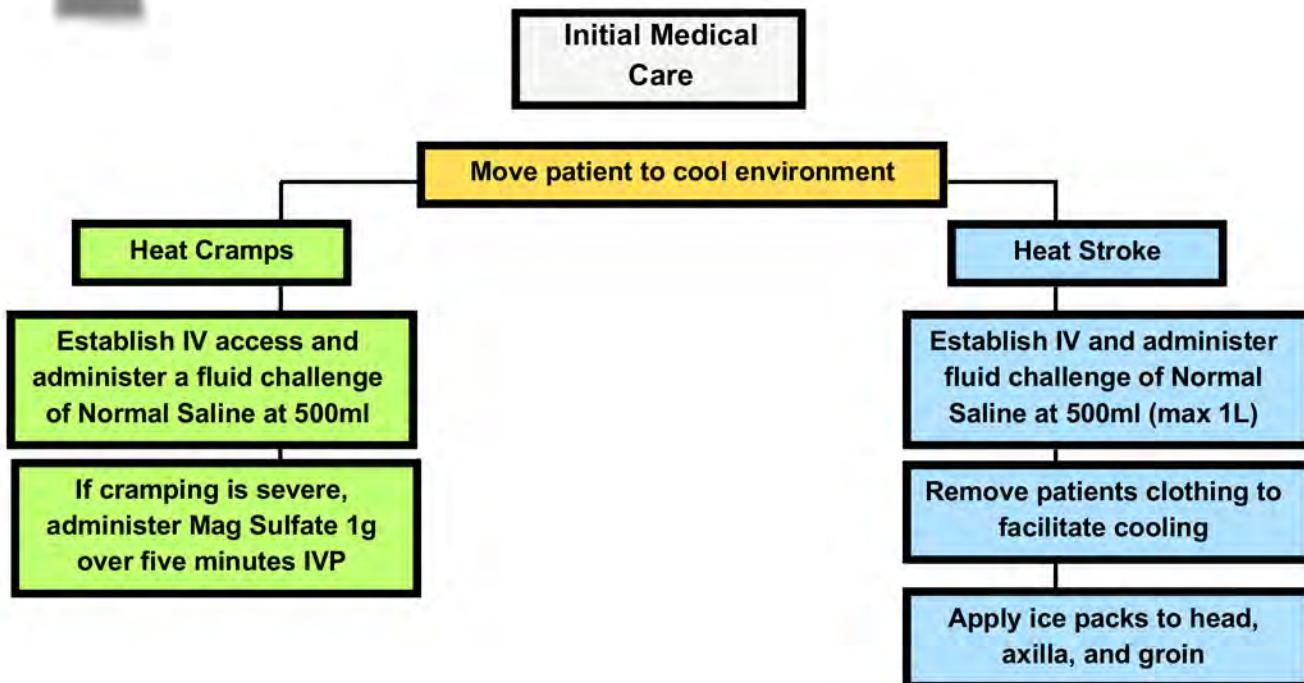
The Office of Medical Direction

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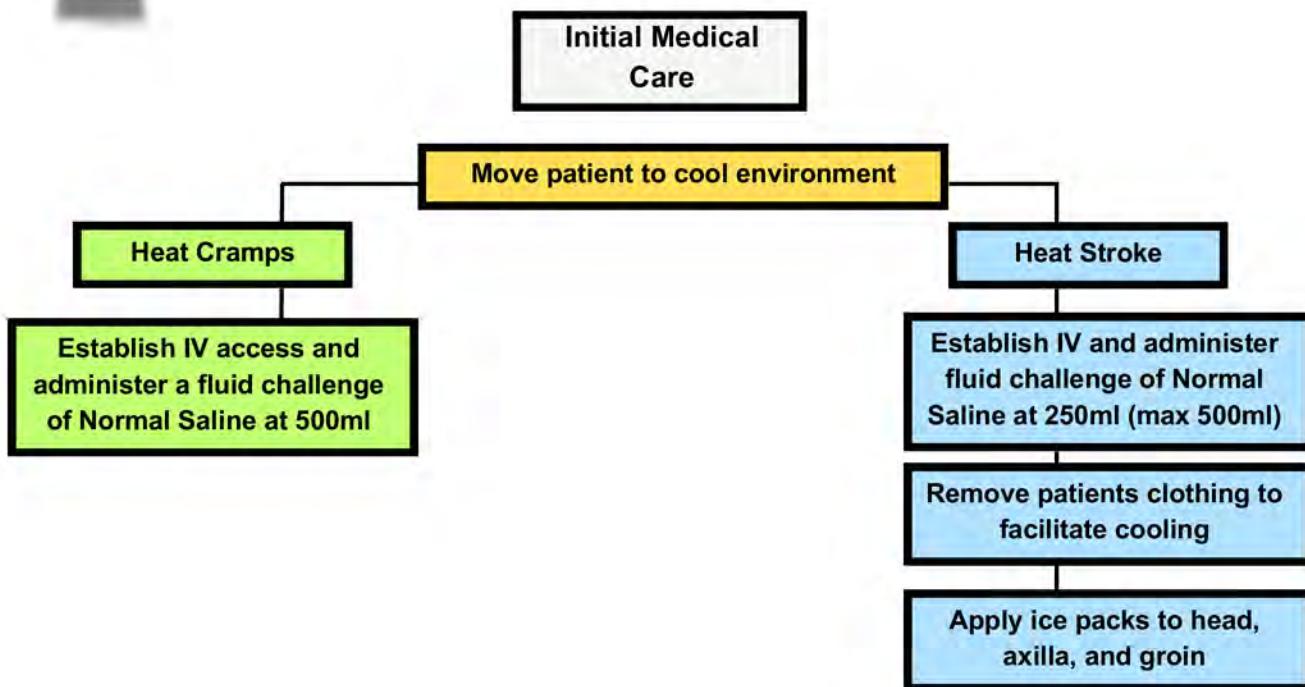


## Environmental Heat Emergencies





## Environmental Heat Emergencies



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# OBSTETRIC POLICIES

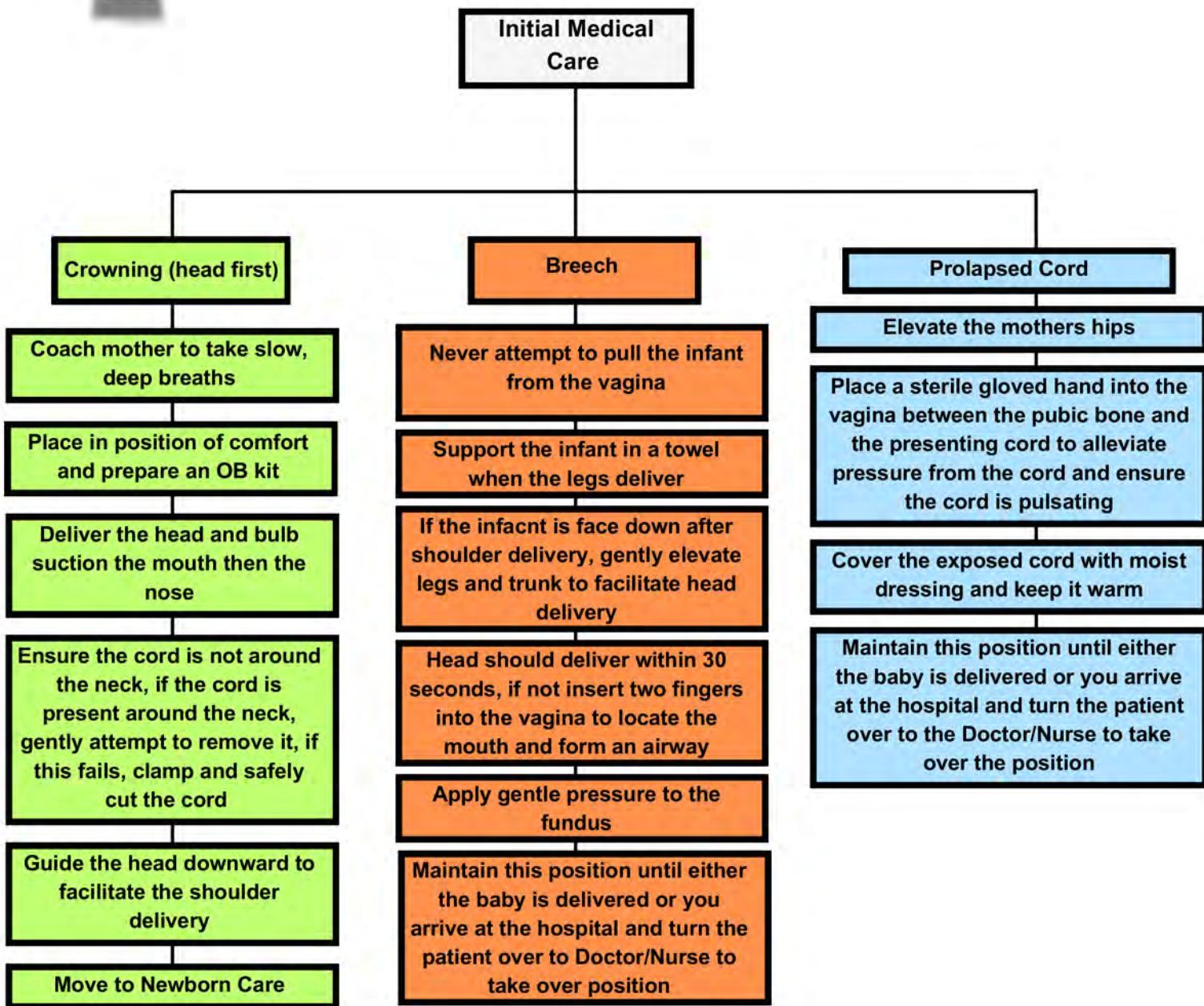




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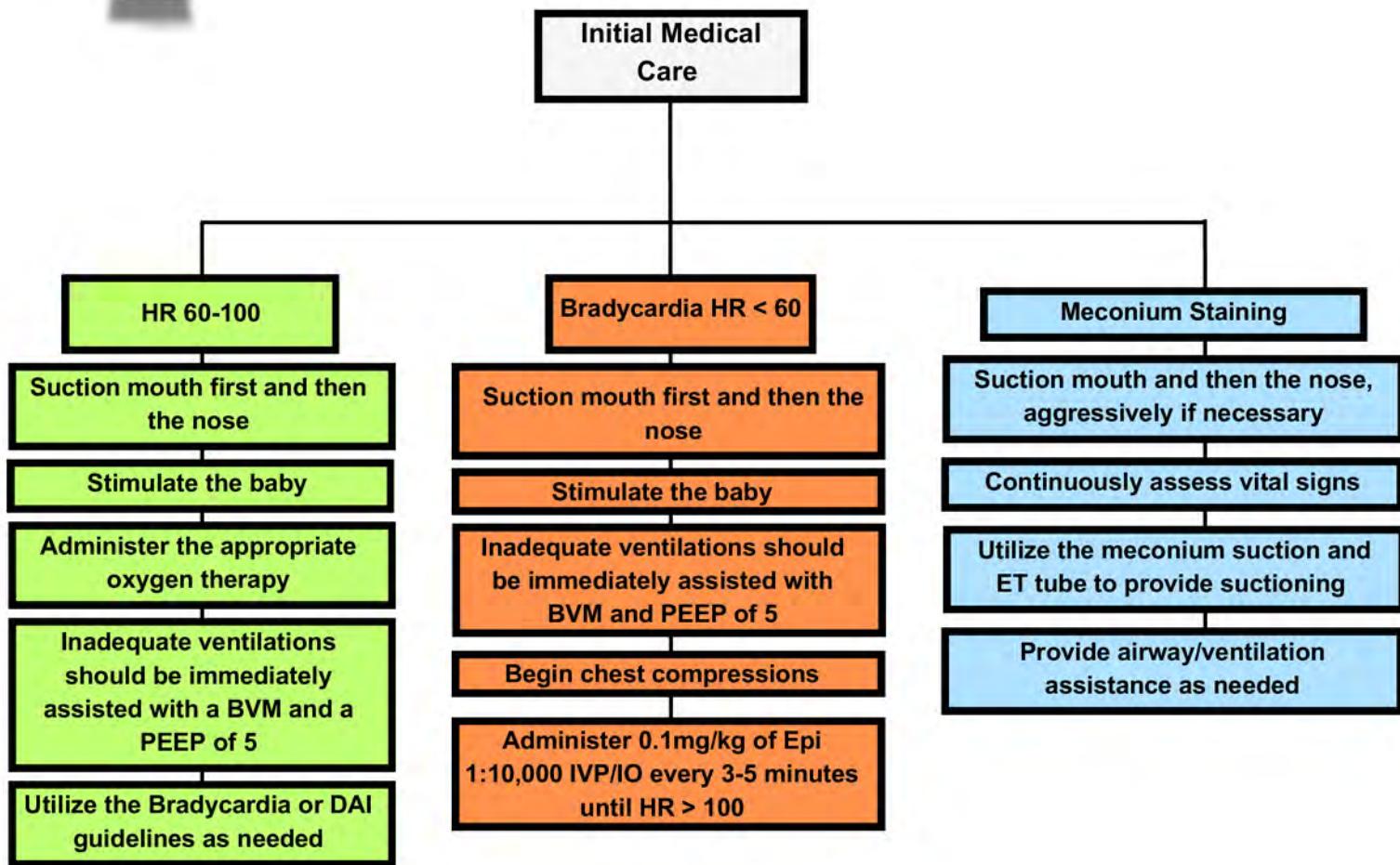


## Childbirth/Newborn Care





## Childbirth/Newborn Care

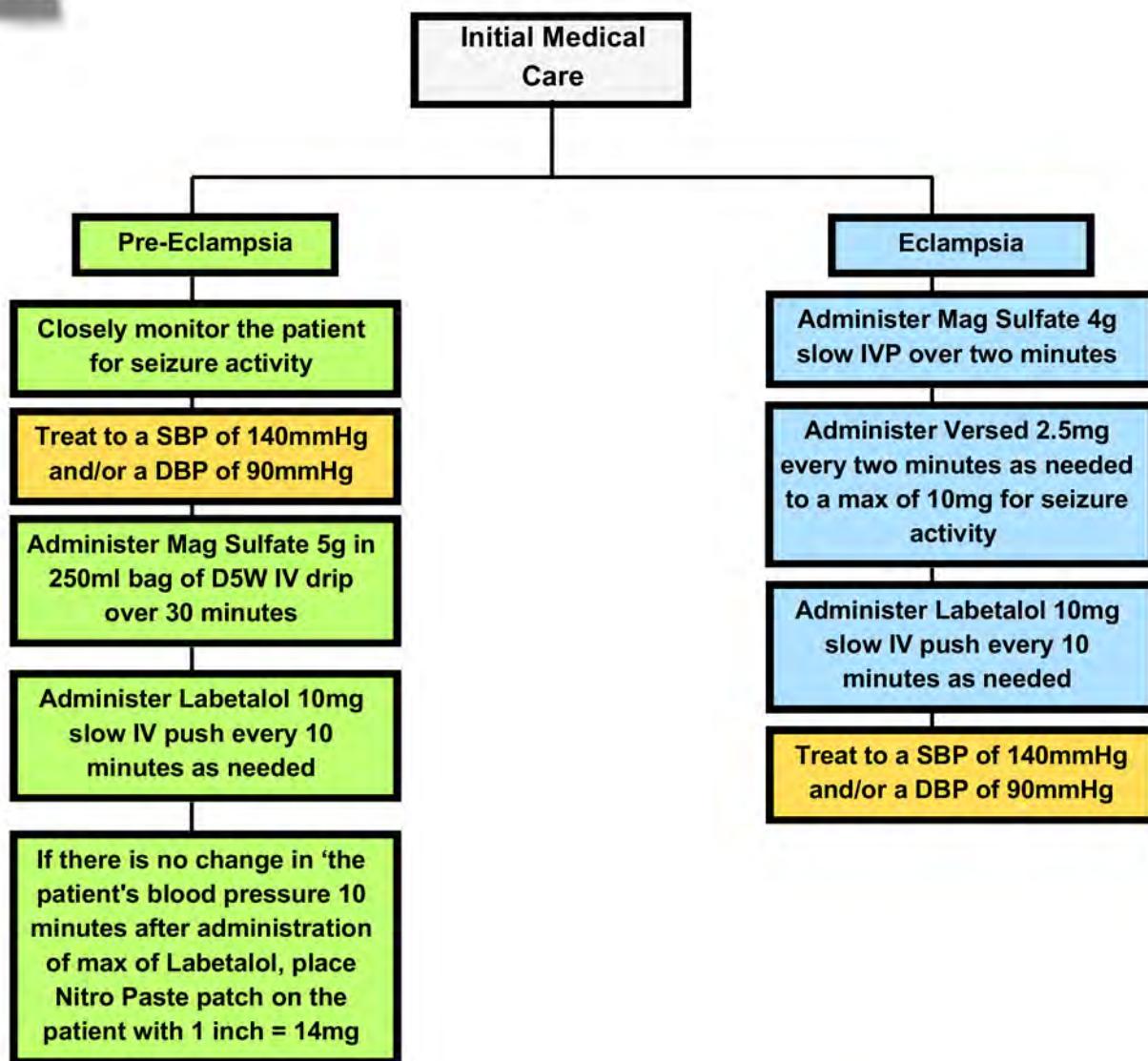


Remember to assess and record the APGAR score at the 1 minute and 5 minute mark.

INDICATOR	0 POINTS	1 POINTS	2 POINTS
A Appearance (skin color)	Blue; Pale	Pink Body; Blue Extremities	Pink
P Pulse	Absent	Below 100 bpm	Over 100 bpm
G Grimace (reflex irritability)	Floppy	Minimal Response to Stimulation	Prompt Response to Stimulation
A Activity (muscle tone)	Absent	Flexed Arms and Legs	Active
R Respiration	Absent	Slow and Irregular	Vigorous Cry



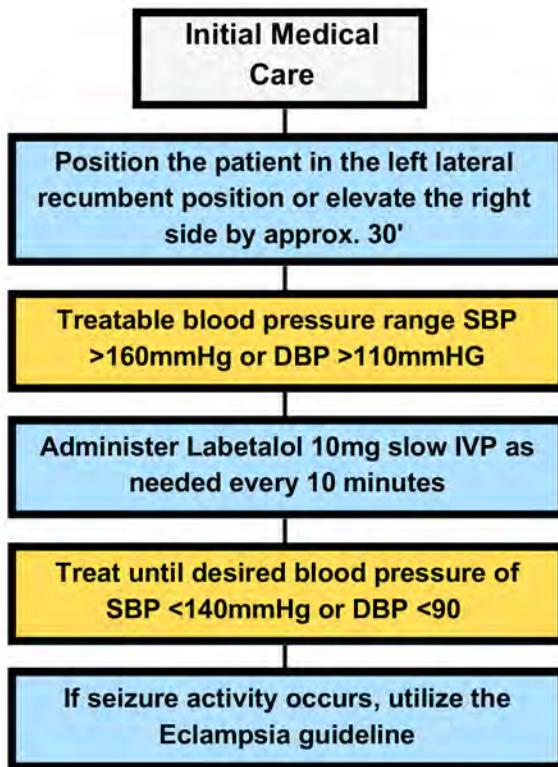
## Pre-Eclampsia/Eclampsia



This CCG may be used up to 6 weeks after childbirth.

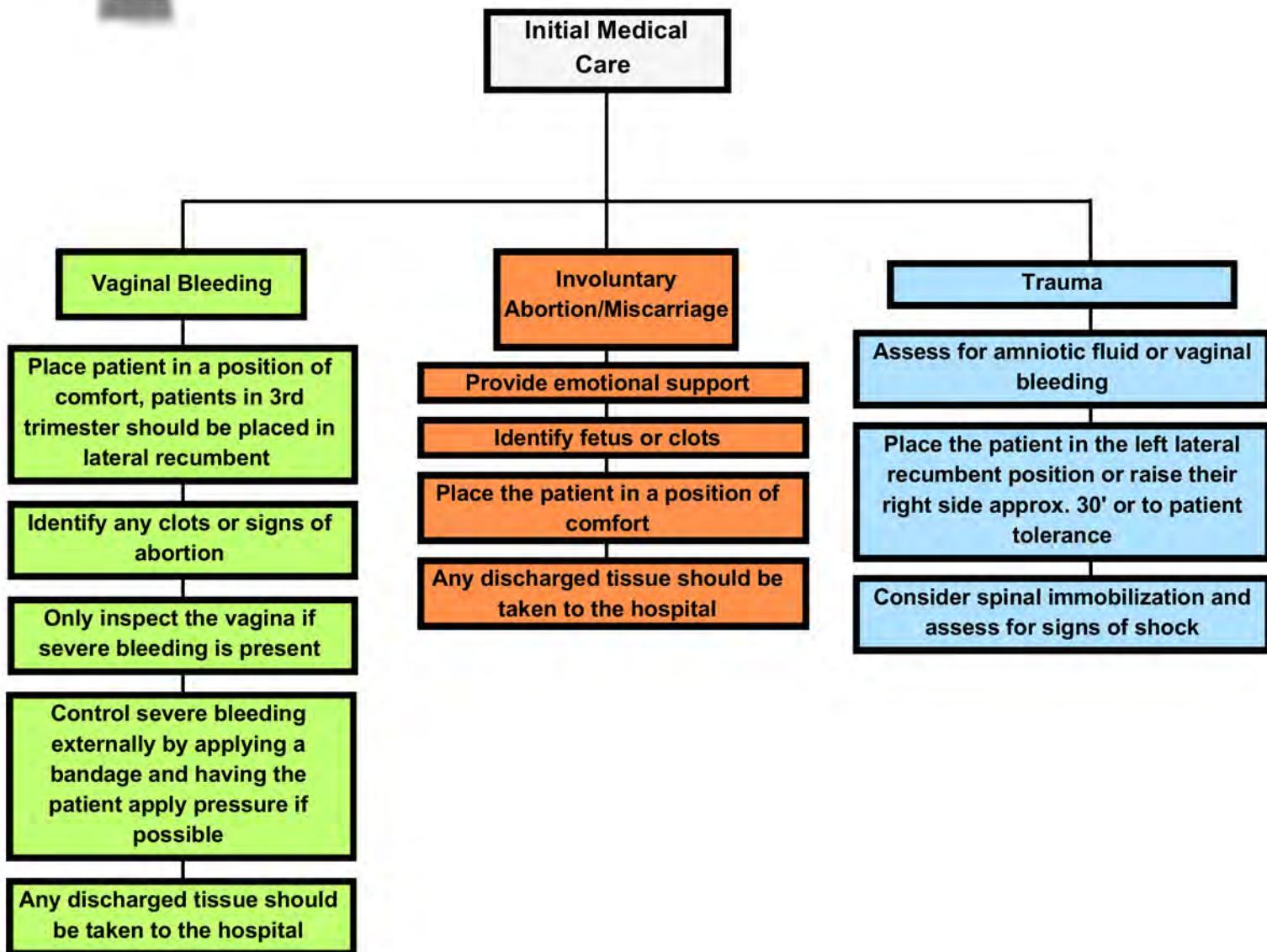


## Pregnancy Induced Hypertension





## Prenatal Emergencies



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# APPENDIX





# Formulary

Medication Name	Dosing	Contraindications
Acetaminophen (Tylenol)	Pediatric Sepsis- 15mg/kg PO	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Ingestion of products containing alcohol</li> <li>Severe hepatic impairment</li> </ul>
Adenosine (Adenocard)	<ul style="list-style-type: none"> <li>Adult Narrow Complex Tachycardia- 12mg Rapid IV push may repeat once at 12mg Rapid IV push</li> <li>Pediatric Narrow Complex Tachycardia- 0.1mg/kg Rapid IV Push second dose 0.2mg/kg Rapid IV push</li> </ul>	<ul style="list-style-type: none"> <li>High-degree AV blocks</li> <li>Sick sinus syndrome</li> <li>Hypersensitivity</li> <li>PICC line administration</li> </ul>
Albuterol (Ventolin)	<ul style="list-style-type: none"> <li>Respiratory Distress- 2.5mg nebulizer solution</li> </ul>	<ul style="list-style-type: none"> <li>Hypertension</li> <li>Tachycardia &gt;120 in adults, &gt;150 in children</li> <li>Severe cardiac disease</li> <li>Hypersensitivity</li> </ul>
Amiodarone (Cordarone)	<ul style="list-style-type: none"> <li>Adult Narrow Complex Tach-Stable 150mg IV drip over 5 minutes</li> <li>Pediatric Narrow Complex Tach-Unstable 5mg/kg IV drip over 20 minutes (max 150mg)</li> <li>Adult VF/VT- 300mg IV push, 150mg IV push</li> <li>Pediatric VF/VT- 5mg/kg IVP</li> <li>Adult Wide Complex Tach-Stable 150mg IV drip over 10 minutes, Unstable 150mg IV drip over 2 minutes</li> </ul>	<ul style="list-style-type: none"> <li>Cardiogenic shock</li> <li>Sinus bradycardia</li> <li>High degree AV blocks</li> <li>Hypersensitivity</li> <li>Iodine sensitivity</li> </ul>



# Formulary

Medication Name	Dosing	Contraindications
Aspirin (Bufferin)	Acute Coronary Syndromes- 324mg PO	<ul style="list-style-type: none"> <li>Hypersensitivity to NSAIDs</li> <li>Bleeding disorders including GI hemorrhage and hemophilia</li> </ul>
Atropine (Atropen)	<ul style="list-style-type: none"> <li>Adult Bradycardia- 0.5mg IV push (max 3mg)</li> <li>Pedi Bradycardia- 0.02mg/kg IV push</li> <li>Organophosphate Poisoning- 2mg may repeat as many times as needed to relieve symptoms</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>ST segment changes</li> <li>High degree AV blocks</li> </ul>
Calcium Chloride	<ul style="list-style-type: none"> <li>Asystole/PEA- 2mg/kg</li> <li>Crush Injuries- 1g over 10 minutes (administer just prior to releasing the impingement)</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>ST segment changes</li> <li>High degree AV blocks</li> </ul>
Cardizem (Diltiazem)	<ul style="list-style-type: none"> <li>Adult Narrow Complex Tach- 10mg slow IV push over two minutes, may repeat once after 10 minutes</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Hypotension</li> <li>Myocardial infarction</li> <li>Ventricular Tachycardia</li> <li>Wolf Parkinson White Syndrome</li> </ul>
Decadron (Dexamethasone)	<ul style="list-style-type: none"> <li>Adult Respiratory Distress- 4mg slow IV push over two minutes</li> <li>Pedi Respiratory Distress- 0.5mg/kg</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Cardiogenic Shock</li> <li>Acute myocardial infarction</li> </ul>
Dextrose	<ul style="list-style-type: none"> <li>Adult Glycemic Emergencies- 10g</li> <li>Pediatric Glycemic Emergencies- 0.5g/kg</li> </ul>	



# Formulary

Medication Name	Dosing	Contraindications
Diphenhydramine (Benadryl)	<ul style="list-style-type: none"> <li>Adult Allergic Reaction- 50mg IV push or IM</li> <li>Pediatric Allergic Reaction- 1mg/kg (max 25mg) IV push or IM</li> <li>Adult Sickle Cell Crisis- 25mg IV push or IM</li> <li>Psychological Emergencies- 25mg IV Push or 50mg IM</li> </ul>	<ul style="list-style-type: none"> <li>Glaucoma</li> <li>Acute asthma exacerbation</li> <li>COPD</li> </ul>
Epinephrine (Adrenalin)	<ul style="list-style-type: none"> <li>Asystole/PEA- 1mg 1:10,000</li> <li>Pedi Cardiac Arrest- 0.01mg/kg 1:10,000</li> <li>Adult Brady/Sepsis/Sock- 2- 8mcg/min IV drip</li> <li>Pedi Brady/Sepsis/Shock- 0.05- 0.5mcg/kg/min IV drip</li> <li>Adult allergic reaction- 0.3mg 1:1,000 IM</li> <li>Pedi allergic reaction- 0.01mg/kg 1:1,000 IM</li> </ul>	<ul style="list-style-type: none"> <li>Severe/uncontrolled hypertension</li> <li>Hypovolemic shock</li> <li>Hypersensitivity</li> </ul>
Etomidate (Amidate)	<ul style="list-style-type: none"> <li>Adult DAI- 20mg IV push or IO</li> <li>Pedi DAI- 0.3mg/kg IV push or IO</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Renal impairment</li> </ul>
Fentanyl (Sublimaze)	<ul style="list-style-type: none"> <li>Adult Pain Management- 25mcg may be repeated up to max of 100mcg</li> <li>Pedi Pain Management- 0.5mcg/kg (max 25mcg) may not be repeated</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Hypovolemia</li> </ul>



## Formulary

Medication Name	Dosing	Contraindications
Glucagon	<ul style="list-style-type: none"> <li>Adult Glycemic Emergencies- 1mg IM/IN</li> <li>Pedi Glycemic Emergencies- 0.5mg</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> </ul>
Haldol (Haloperidol)	<ul style="list-style-type: none"> <li>Adult Behavioral Emergencies- 5mg IV/IM</li> <li>Vomiting 2mg IVP</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Agitation secondary to hypoxia, shock or trauma</li> </ul>
Ipratropium	<ul style="list-style-type: none"> <li>Adult and Pedi Respiratory Distress- 0.5mg nebulized solution</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Patients &lt;12 years old</li> </ul>
Kepra	<ul style="list-style-type: none"> <li>Adult TBI- 1g IV push or IO</li> <li>Pedi TBI- 20mg/kg IV push or IO, may be repeated at 40mg/kg IV push or IO (total not to exceed 1g)</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> </ul>
Ketamine	<ul style="list-style-type: none"> <li>Adult DAI- Induction 200mg IV push or IO, continued sedation 100mg IV push or IO</li> <li>Pedi DAI- Induction 2mg/kg IV push or IO (max 120mg) may be repeated once</li> <li>Adult Behavioral Emergencies- 50mg IV/IM (max 100mg)</li> <li>Adult Pain Management- 25mg IV push or IO (may be repeated one time for a max of 50mg)</li> <li>Pedi Pain Management- 0.25mg/kg IV push or IO (max 25mg)</li> <li>Adult Status Epilepticus- 100mg IV drip or 100mg IM</li> <li>Pedi Status Epilepticus- 50mg IV drip</li> <li>Adult Respiratory Distress- 0.5mg/kg IVP over two minutes</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> </ul>



# Formulary

Medication Name	Dosing	Contraindications
Labetalol (Trandate)	<ul style="list-style-type: none"> <li>Adult Hypertension- 10mg slow IV push (may be repeated one time after 10 minutes)</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Pulmonary edema</li> <li>Cardiogenic shock</li> <li>Bradycardia/heart blocks</li> <li>Bronchospasm</li> </ul>
Levophed (Norepinephrine)	<ul style="list-style-type: none"> <li>Adult Shock/Hypotension- 2-4mcg/min IV drip</li> <li>Pedi Shock/Hypotension- 0.1-0.5mcg/kg/min IV drip</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Hypertension</li> </ul>
Lidocane	<ul style="list-style-type: none"> <li>Adult head injury- 1mg/kg (max 100mg)</li> <li>Pedi head injury- 1mg/kg (max 50mg)</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> </ul>
Magnesium Sulfate	<ul style="list-style-type: none"> <li>Adult VF/VT, Wide Complex Tach, Respiratory Distress, Heat Emergencies and ROSC- 1g slow IVP over 5 minutes</li> <li>Pedi Respiratory Distress- 25mg/kg slow IV push over 5 minutes</li> <li>Eclampsia- 4g slow IV push over 2 minutes</li> <li>Pre-Eclampsia- 4g slow IV push over 30 minutes</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>3rd degree heart block</li> <li>Diabetic coma</li> <li>Hypermagesemia</li> </ul>
Midazolam (Versed)	<ul style="list-style-type: none"> <li>Adult DAI- 2.5mg IVP or IO (max 15mg)</li> <li>Pedi Adult DIA-0.1mg/kg IVP or IO one time dose</li> <li>Adult seizures- 2.5mg IVP/IO or 5mg IM (max 10mg)</li> <li>Pedi Seizures- 0.1mg/kg IV push or 0.2mg/kg IM/IN</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Hypotension</li> <li>Acute angle glaucoma</li> </ul>



# Formulary

Medication Name	Dosing	Contraindications
Naloxone (Narcan)	<ul style="list-style-type: none"> <li>Adult drug overdose- 0.5mg IVP or IO/IN (max 4mg)</li> <li>Adult Cardiac Arrest- 2mg IVP/IO (max 4mg)</li> <li>Pediatric Drug Overdose- 0.1mg/kg</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> </ul>
Nitroglycerin Paste (Nitrobid)	<ul style="list-style-type: none"> <li>Adult Acute Coronary Syndrome- 1" = 14mg of paste</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Bradycardia</li> <li>Increased ICP</li> <li>Hypotension</li> <li>Recent use of anti-impotence medications</li> </ul>
Normal Saline	<ul style="list-style-type: none"> <li>Adult 30ml/kg up to 2L depending on CCG</li> <li>Pedi 20ml/kg up to 1L depending on CCG</li> </ul>	<ul style="list-style-type: none"> <li>If saline administration would result in potential electrolyte imbalances, hyperhydration, pulmonary edema, etc. then the use would be discouraged</li> </ul>
Ondansetron (Zofran)	<ul style="list-style-type: none"> <li>Adult Vomiting- 4mg IV push or IM, may be repeated once for a 8mg max</li> <li>Pedi Vomiting- 0.15mg/kg IV push or IM</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Prolonged Q-T intervals</li> <li>Patients who take Apomorphine (used to treat Parkinsons)</li> </ul>
Pepcid (Famotidine)	<p>Adult Allergic Reaction and Abd pain (GI bleed)- 20mg slow IVP over two minutes</p> <p>Pedi Allergic Reaction- 0.25mg/kg, max 15mg</p>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> </ul>
Rocephin (Ceftriaxone)	<p>Adult Sepsis- 1g slow IVP</p> <p>Pedi Sepsis- 50mg/kg IVP, max 1g</p> <p>Adult Isolated Extremity Trauma- 1g IVP</p>	<ul style="list-style-type: none"> <li>Known hypersensitivity to beta-lactam antibiotics or aminopenicillins</li> <li>Administration of any calcium containing or based medications</li> </ul>



# Formulary

Medication Name	Dosing	Contraindications
Rocuronium	Adult and Pedi DAI- 0.5mg/kg	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Lack of ventilatory support</li> <li>Neuromuscular disease</li> </ul>
Sodium Bicarbonate	Adult- 50mEq IVP/IO Pediatric 1mEq/kg IVP/IO	<ul style="list-style-type: none"> <li>Hypersensitivity</li> </ul>
Succinylcholine (Anectine)	<ul style="list-style-type: none"> <li>Adult DAI- 100mg IVP</li> <li>Pedi DAI- 1mg/kg IVP, max 100mg</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Hyperkalemia</li> <li>Penetrating eye injuries</li> <li>Malignant hyperthermia</li> <li>Larynx fracture</li> </ul>
Tranexamic Acid (TXA)	<ul style="list-style-type: none"> <li>Adult Significant Hemorrhage- 2g IV drip over 10 minutes, administer in the same manner as Amiodarone</li> <li>Pedi Significant Hemorrhage- 15mg/kg IV drip over 10 minutes, administer in the same manner as Amiodarone</li> </ul>	<ul style="list-style-type: none"> <li>If saline administration would result in potential electrolyte imbalances, hyperhydration, pulmonary edema, etc. then the use would be discouraged</li> </ul>
Xopenex (Levalbuterol)	<ul style="list-style-type: none"> <li>Adult and Pedi Respiratory Distress- 0.63mg nebulized solution</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity</li> <li>Use of MAOIs</li> <li>Patients &lt;6 years of age</li> </ul>
3% Normal Saline	<ul style="list-style-type: none"> <li>Adult TBI- 250ml IV drip/IO</li> <li>Pedi TBI- 5ml/kg IV drip/IO, max 250ml</li> </ul>	<ul style="list-style-type: none"> <li>Hypersensitivity.</li> <li>Hypernatremia.</li> <li>Fluid retention</li> </ul>