A special meeting of PMAC is on:
Wednesday, October 19, 2011
9:00AM – 12:00PM
3900 Sherman Drive
Riverside, CA 92503
Breckenridge Room
951/358-5029

1. **CALL TO ORDER**
Chairman Reza Vaezazizi, MD

2. **PLEDGE OF ALLEGIANCE**
Reza Vaezazizi, MD

3. **ROUNDTABLE INTRODUCTIONS**
Reza Vaezazizi, MD

4. **Draft Policy Review and Discussion (60 Minutes)**
   4.1 4301 Shock Due to Trauma
   4.2 4302 Traumatic Injuries
   4.3 4401 Shock Unrelated to Trauma
   4.4 4404 Symptomatic Tachycardia with Pulses
   4.5 4405 Symptomatic Bradycardia with Pulses

5. **Break (10 Minutes)**

6. **Draft Policy Review and Discussion (60 Minutes)**
   6.1 4407 Neonatal Resuscitation
   6.2 4408 Respiratory Distress
   6.3 4503 Suspected Stroke
   6.4 4601 Allergy / Anaphylaxis
   6.5 4702 Labor and Delivery

7. **Draft of Final Policy Manual (15 Minutes)**

8. **Good of the Order / Announcements (10 Minutes)**
9. **Next Meeting / Adjournment (5 Minutes)**
Regular PMAC Meeting November 14, 2011

Please come prepared to discuss the agenda items. If you have any questions, call Brian MacGavin at (951) 358-5029. PMAC Agendas with attachments are available at our website: [www.rivcoems.org](http://www.rivcoems.org).
Enter from the Universal Patient Treatment Protocol
For specific Emergency Stabilization or Patient Management of Shock Due to Trauma

Pertinent Findings

<table>
<thead>
<tr>
<th>Environment</th>
<th>History</th>
<th>Physical</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic MOI</td>
<td>Mechanism of injury</td>
<td>Pale, cool, wet skin signs</td>
<td>Cardiogenic shock</td>
</tr>
<tr>
<td>Blood loss</td>
<td>Time of event</td>
<td>Tachypnea</td>
<td>Arrhythmia, infarction</td>
</tr>
<tr>
<td>Estimated blood loss</td>
<td>Estimated blood loss</td>
<td>Tachycardia</td>
<td>Distributive shock</td>
</tr>
<tr>
<td>SAMPLE history</td>
<td>SAMPLE history</td>
<td>Hypotension</td>
<td>Anaphylactic, neurogenic, septic</td>
</tr>
<tr>
<td>Antiplatelets or anticoagulants:</td>
<td>Antiplatelets or anticoagulants:</td>
<td>Arrest</td>
<td>Hypovolemic shock</td>
</tr>
<tr>
<td>Aspirin, Plavix, Coumadin, etc.</td>
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<td></td>
<td>Hemorrhagic blood loss, burns</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Obstructive shock</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Embolism, tamponade, tension pneumo</td>
</tr>
</tbody>
</table>

Emergency Stabilization or Patient Management

- Do not delay transport with nonessential treatment of the nonentrapped, transport ready, critical trauma patient
- Remove and bag patient’s clothing, jewelry, etc. with special attention to preventing binding and constriction
- Control bleeding using direct pressure, pressure dressing(s), and/or tourniquet(s) as clinically indicated
- Position patient supine to meet physiologic requirements: Avoid Trendelenburg or elevating legs for shock

Restrict fluid administration for apparent or suspected uncontrolled hemorrhage
- Do not hang fluids, use saline lock extension sets
- Give fluid boluses only as clinically indicated

Warm 0.9% Normal Saline IV/IO bolus
- For symptomatic shock with a systolic blood pressure less than the lower limit of normal
- See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
- May repeat as clinically indicated

Use a volume control chamber IV set during pediatric administration

Perform needle thoracostomy for suspected tension pneumothorax when all of the following are present:
1. Progressively worsening respiratory distress or apnea; and,
2. Unilateral decreased or absent breath sounds on the affected side; and,
3. Hypotension (systolic BP less than 90 mmHg with signs of poor perfusion)
   a. This includes cardiac arrest (PEA may be the presenting rhythm)
**Emergency Stabilization or Patient Management (continued)**

**Traumatic arrest**
Follow the REMSA Treatment Protocol for Cardiac Arrest
*Do not delay transport with nonessential treatment of the nonentrapped, transport ready, critical trauma patient*

**Patient Disposition**

**Traumatic arrest**
If the criteria of the REMSA Policy for Do Not Attempt Resuscitation / Discontinue Resuscitation does not apply:

Transport the blunt trauma arrest patient to the closest paramedic receiving center (PRC)

Transport the penetrating trauma arrest patient to:
- The closest trauma center if bypassing any PRC increases transport time by no more than 10 minutes
- Otherwise, transport the penetrating trauma arrest patient to the closest PRC

**Return to Universal Patient Treatment Protocol**
*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

**Base Hospital Orders**

0.9% Normal Saline IV/IO bolus
As ordered
For shock due to trauma
*Use a volume control chamber IV set during pediatric administration*

Needle thoracostomy
As ordered
For suspected tension pneumothorax
Enter from the Universal Patient Treatment Protocol
For specific Emergency Stabilization or Patient Management of Traumatic Injuries

Pertinent Findings

**Environment**
- Personal / patient safety
- Environmental hazards
- Nature of event / numbers
- Mechanism of injury
- Additional resources
- Need for special ops

**History**
- Mechanism of injury
- Time of event
- Speed and details
- Damage to vehicle/structure
- Location in vehicle/structure
- Ejection
- Seat belt / air bag / child seat
- Helmet / protective equipment
- Others injured or dead
- SAMPLE history

**Physical**
- Deformity
- Contusion
- Abrasion, avulsion, amputation
- Puncture, penetration
- Paradoxical movement
- Burn
- Laceration
- Swelling
- Tenderness
- Instability
- Crepitus

**Differential**
- Head injury
- Spinal cord / neurologic injury
- Spinal fracture
- Airway obstruction and hypoxia
- Tension pneumothorax
- Pneumothorax / hemothorax
- Fracture chest
- Bleeding and/or hypovolemia
- Pericardial tamponade
- Pelvic or femur fracture
- Dislocation

**Emergency Stabilization or Patient Management**

*Do not delay transport with nonessential treatment of the nonentrapped, transport ready, critical trauma patient*

Remove and bag patient’s clothing, jewelry, etc. with special attention to preventing binding and constriction

**Impaled object**
Support and stabilize object in place
- Remove only if interfering with the airway or with chest compressions

**Suspected traumatic brain injury**
Position the patient supine and assist ventilation as clinically indicated:
- Adult: 10 breaths per minute
- Child: 20 breaths per minute
- Infant: 25 breaths per minute

Increase ventilation for unequal or fixed/dilated pupils and extensor posturing or no motor response:
- Adult: 20 breaths per minute
- Child: 25 breaths per minute
- Infant: 30 breaths per minute
Emergency Stabilization or Patient Management (continued)

Flail chest
Assist ventilations as clinically indicated
*Do not attempt to stabilize the flail segment by sandbagging, splinting, and/or swathing*

Wound care
Dress and bandage abrasions, lacerations, avulsions, punctures and/or penetrations as clinically indicated

Dress open pneumothorax with a petrolatum gauze dressing taped on three sides
  Briefly remove to release pressure when clinically indicated by signs of tension pneumothorax

Dress evisceration with saline soaked dressing
  *Do not intentionally replace evisceration*

Dress exposed bone with saline soaked gauze sponge or non-adherent dressing
  *Do not intentionally replace exposed bone*

Dress injured genitalia with saline soaked dressing, applying direct pressure to control bleeding
  Rinse amputation in saline, wrap in saline soaked dressing, bag, indirectly place on ice, and transport

Fracture or dislocation
Assess distal neurovascular functions using PMS (pulse, motor, sensation) before and after any stabilization, splinting, or manipulation

Stabilize and/or splint fractures as found

Return grossly angulated extremity fractures to the anatomic position as clinically indicated
  *Use gentle traction*
  *Do not intentionally replace exposed bone*

Stabilize and/or splint mid-shaft femur fractures using a traction splint as clinically indicated

Stabilize and/or splint dislocations as found
  *Do not intentionally reduce dislocation*

Contact a base hospital (BH) for any fracture or dislocation that causes neuro and/or vascular compromise

Amputation
Rinse amputated body part(s) with normal saline
Wrap with saline soaked dressing
Place in a bag
Keep part(s) cool but don’t place directly on ice

Avulsed tooth
Handle tooth by the crown
  *Do not touch any part of the tooth that normally exists below the gum line*
In the alert and cooperative patient, attempt to replace tooth in its socket
  If unable, wrap in milk or normal saline soaked gauze sponge and transport

Eye injury
Rinse with saline as clinically indicated, apply saline soaked dressing, and bandage and/or patch bilaterally
### Emergency Stabilization or Patient Management (continued)

**Pain management**
Apply disposable cold pack(s) as clinically indicated for pain associated with traumatic injury

**Crush injuries**
0.9% Normal Saline IV/IO bolus
For suspected rhabdomyolysis and/or hyperkalemia associated with crush injuries
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
May repeat as clinically indicated
*Use a volume control chamber IV set during pediatric administration*

**Pain management**
Morphine Sulfate slow IV/IO push or IM
For pain associated with isolated traumatic injury to an extremity or the appendicular skeleton
While systolic BP remains greater than 90 mmHg
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
May repeat once
*Further repetition requires a base hospital order (BHO)*

### Return to Universal Patient Treatment Protocol
*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

<table>
<thead>
<tr>
<th>Base Hospital Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.9% Normal Saline IV/IO bolus</td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For shock associated with traumatic injury</td>
</tr>
<tr>
<td><em>Use a volume control chamber IV set during pediatric administration</em></td>
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<tr>
<td>Midazolam (Versed) slow IV/IO push or IM</td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For anxiety associated with traumatic injury</td>
</tr>
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<tr>
<th>Base Hospital Orders</th>
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<tbody>
<tr>
<td>Sodium Bicarbonate 8.4%</td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For suspected rhabdomyolysis and/or hyperkalemia associated with crush injuries</td>
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<td>Albuterol HHN or in-line with a ventilatory device</td>
</tr>
<tr>
<td>As ordered</td>
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<tr>
<td>For suspected hyperkalemia associated with crush injuries</td>
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<tr>
<td>Calcium Chloride 10%</td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For suspected hyperkalemia associated with crush injuries</td>
</tr>
</tbody>
</table>
Effective April 1, 2012
Expires March 31, 2013

Policy:
Shock Unrelated to Trauma

Approval: REMSA Medical Director
Humberto Ochoa, MD

Signature

Applies To:
EMR, EMT, AEMT, PM, EMS System

Approval: REMSA Director
Bruce Barton, CCEMT-P

Signature

Enter from the Universal Patient Treatment Protocol
For specific Emergency Stabilization or Patient Management of Shock Unrelated to Trauma

Pertinent Findings

Environment
Blood in:
Emesis
Stool
Urine

History
SAMPLE history
Antiplatelets or anticoagulants:
Aspirin, Plavix, Coumadin, etc.

Physical
Pallor
Tachypnea
Tachycardia
Hypotension

Differential
Cardiogenic shock
Arrhythmia, infarction
Distributive shock
Anaphylactic, neurogenic, septic
Hypovolemic shock
Hemorrhagic blood loss, burns
Obstructive shock
Embolism, tamponade, tension pneumo

Emergency Stabilization or Patient Management

Position patient supine to meet physiologic requirements: Avoid Trendelenburg or elevating legs for shock

Consider the causes of shock and act as indicated by REMSA policies, protocols, and standards

0.9% Normal Saline IV/IO bolus
For symptomatic shock with a systolic blood pressure less than the lower limit of normal
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
May repeat as clinically indicated
Use a volume control chamber IV set during pediatric administration

Return to Universal Patient Treatment Protocol
For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management

***** ***** Base Hospital Orders ***** *****

0.9% Normal Saline IV/IO bolus
As ordered
For shock
Use a volume control chamber IV set during pediatric administration
Enter from the Universal Patient Treatment Protocol
For specific Emergency Stabilization or Patient Management of Symptomatic Tachycardia with Pulses

### Pertinent Findings

<table>
<thead>
<tr>
<th>Environment</th>
<th>History</th>
<th>Physical</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Differential mechanism</td>
<td>PSVT or PAT</td>
<td>Anxiety</td>
<td>Hypovolemic etiology</td>
</tr>
<tr>
<td>Overdose</td>
<td>Atrial-fib and/or flutter</td>
<td>Chest tightness</td>
<td>AMI (acute myocardial infarction)</td>
</tr>
<tr>
<td></td>
<td>Wolff-Parkinson-White</td>
<td>Palpitations</td>
<td>Congenital heart defect</td>
</tr>
<tr>
<td></td>
<td>Ventricular tachycardia</td>
<td>Tachycardia</td>
<td>Supraventricular tachycardia</td>
</tr>
<tr>
<td></td>
<td>Medications</td>
<td>Hypotension</td>
<td>Atrial fibrillation and/or flutter</td>
</tr>
<tr>
<td></td>
<td>Override pacemaker / ICD</td>
<td>Shortness of breath</td>
<td>Wolff-Parkinson-White Syndrome</td>
</tr>
<tr>
<td></td>
<td>Ablation</td>
<td>Altered mental status</td>
<td>Ventricular tachycardia</td>
</tr>
<tr>
<td></td>
<td>Heart surgery</td>
<td>Syncope</td>
<td></td>
</tr>
</tbody>
</table>

### Emergency Stabilization or Patient Management

Consider the non-cardiogenic causes of tachycardia and act as indicated by REMSA policies and protocols:
- Hypovolemia
- Hypoxia

0.9% Normal Saline IV/IO bolus
As clinically indicated for symptomatic tachycardia with pulses
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
May repeat as clinically indicated

Valsalva Maneuver
For symptomatic supraventricular tachycardia (SVT) with pulses
May repeat as clinically indicated

Midazolam (Versed) slow IV/IO push or IN
As clinically indicated for amnestic effects prior to synchronized cardioversion
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
Repetition requires a base hospital order (BHO)
Pediatric administration requires a base hospital order (BHO)

Synchronized Cardioversion
For symptomatic supraventricular tachycardia (SVT) or ventricular tachycardia (V-tach) with pulses
See the REMSA Calculation Chart for patient specific energy settings for both initial and subsequent shocks
Pediatric application requires a base hospital order (BHO)
Emergency Stabilization or Patient Management *(continued)*

Contact a single REMSA authorized base hospital (BH) in all symptomatic tachycardia with pulses

Return to Universal Patient Treatment Protocol

*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

<table>
<thead>
<tr>
<th>Base Hospital Physician Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Valsalva Maneuver</strong></td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For symptomatic tachycardia with pulses</td>
</tr>
<tr>
<td><strong>Adenosine</strong></td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For symptomatic tachycardia with pulses</td>
</tr>
<tr>
<td><strong>Midazolam (Versed)</strong></td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For amnesic effects prior to synchronized cardioversion</td>
</tr>
<tr>
<td><strong>Synchronized Cardioversion</strong></td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For symptomatic tachycardia with pulses</td>
</tr>
<tr>
<td><strong>Verapamil (Calan or Isoptin)</strong></td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For symptomatic tachycardia with pulses</td>
</tr>
<tr>
<td><strong>Amiodarone (Cordarone)</strong></td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For symptomatic tachycardia with pulses</td>
</tr>
<tr>
<td><strong>Lidocaine 2% (Xylocaine)</strong></td>
</tr>
<tr>
<td>As ordered</td>
</tr>
<tr>
<td>For symptomatic tachycardia with pulses</td>
</tr>
</tbody>
</table>
# Treatment Protocol

**Policy:** Symptomatic Bradycardia with Pulses

**Effective:** April 1, 2012

**Expires:** March 31, 2013

**Approval:** REMSA Medical Director
Humberto Ochoa, MD

**Applies To:** EMR, EMT, AEMT, PM, EMS System

**Approval:** REMSA Director
Bruce Barton, CCEMT-P

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**Enter from the Universal Patient Treatment Protocol**

For specific Emergency Stabilization or Patient Management of Symptomatic Bradycardia with Pulses

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**Pertinent Findings**

<table>
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<tr>
<th>Environment</th>
<th>History</th>
<th>Physical</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drowning</td>
<td>OPQRST</td>
<td>Syncope</td>
<td>Respiratory etiology, especially in pediatrics</td>
</tr>
<tr>
<td>Cold Exposure</td>
<td>SAMPLE history</td>
<td>Slow heart rate</td>
<td>AMI (acute myocardial infarction)</td>
</tr>
<tr>
<td>Overdose</td>
<td>Medications</td>
<td>Hypotension</td>
<td>Congenital heart defect</td>
</tr>
<tr>
<td>Insulin</td>
<td>Heart surgery</td>
<td>Ischemic chest discomfort</td>
<td>Myocarditis</td>
</tr>
<tr>
<td>Long term care</td>
<td>Heart transplant</td>
<td>Signs of acute heart failure</td>
<td>Beta blockers/Calcium channel blockers/Electrolytes</td>
</tr>
<tr>
<td></td>
<td>Pacemaker, ICD, or VAD</td>
<td>Respiratory distress</td>
<td>Hypothermia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hypoglycemia</td>
</tr>
</tbody>
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**Emergency Stabilization or Patient Management**

**Epinephrine 1:10,000 IV/IO push**
For symptomatic bradycardia with pulses
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
Pediatric administration and/or repetition requires a base hospital order (BHO).
**Adult administration is not indicated**

**Atropine IV/IO push**
For symptomatic bradycardia with pulses
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
May repeat up to five times in adults at 3 - 5 minute intervals
Pediatric administration and/or repetition requires a base hospital order (BHO)

**Midazolam (Versed) slow IV/IO push**
For amnesic effects prior to transcutaneous pacing (TCP)
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
Repetition requires a base hospital order (BHO)
Pediatric administration requires a base hospital order (BHO)

**Transcutaneous Pacing (TCP)**
For symptomatic bradycardia with pulses
Begin at 20 mA and 70 bpm
Titrating in 5 mA increments to find the minimum current required to maintain capture
Increase in 10 bpm increments, up to 100 bpm maximum, to gain adequate cardiac output and tissue perfusion
Pediatric application requires a base hospital order (BHO)
### Emergency Stabilization or Patient Management (continued)

- Morphine Sulfate slow IV/IO push
- For discomfort during transcutaneous pacing (TCP)
- While systolic BP remains within normal limits
- See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
- May repeat once

Further repetition requires a base hospital order (BHO)

Pediatric administration and/or repetition requires a base hospital order (BHO)

Contact a single REMSA authorized base hospital (BH) in all symptomatic bradycardia with pulses

### Return to Universal Patient Treatment Protocol

*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

### Base Hospital Physician Orders

- **Epinephrine**
  - As ordered
  - For symptomatic bradycardia with pulses in pediatrics

- **Atropine**
  - As ordered
  - For symptomatic bradycardia with pulses

- **Midazolam (Versed)**
  - As ordered
  - For amnesic effects related to transcutaneous pacing (TCP)

- **Morphine**
  - As ordered
  - For discomfort during transcutaneous pacing (TCP)

- **Glucagon**
  - As ordered
  - For suspected beta blocker or calcium channel blocker overdose

- **Calcium Chloride 10%**
  - As ordered
  - (typically in 50 mL Normal Saline IV/IO drip over 10 minutes)
  - For suspected beta blocker or calcium channel blocker overdose
Enter from the Universal Patient Treatment Protocol
For specific Emergency Stabilization or Patient Management of Neonatal Resuscitation

Pertinent Findings

Environment
Emergency childbirth

History
Prenatal care and findings
Issues encountered during labor including: meconium staining, abnormal presentation, etc.
Time of birth
Full term or premature
APGAR at 1 and 5 minutes

Physical
Appearance
Pulse
Grimace
Activity
Respiration

Differential
Non-viable delivery
Hypovolemia
Pneumothorax

Emergency Stabilization or Patient Management

Dry, stimulate, swaddle in dry receiving blanket and head cover, then place with mother as clinically indicated

As clinically indicated, provide positive pressure ventilation (PPV) and CPR according to current AHA Guidelines

Contact a single REMSA authorized base hospital (BH) in all neonatal resuscitation

As clinically indicated, monitor SpO₂ while attached to the right upper extremity (a peductal location)
### Return to Universal Patient Treatment Protocol
*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

#### Base Hospital Orders

- **0.9% Normal Saline**
  - As ordered
  - For neonatal resuscitation

- **Naloxone (Narcan) IN/IM**
  - As ordered
  - For neonatal resuscitation

- **Dextrose 25%**
  - As ordered
  - For neonatal resuscitation

- **Epinephrine**
  - As ordered
  - For neonatal resuscitation

- **Sodium Bicarbonate 8.4%**
  - As ordered
  - For neonatal resuscitation

- **Naloxone (Narcan)**
  - As ordered
  - For neonatal resuscitation
### Treatment Protocol 4408

**Effective**

April 1, 2012

**Expires**

March 31, 2013

<table>
<thead>
<tr>
<th>Policy:</th>
<th>Approval: REMSA Medical Director Humberto Ochoa, MD</th>
<th>Signature</th>
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<tbody>
<tr>
<td>Respiratory Distress</td>
<td>Approval: REMSA Director Bruce Barton, CCEMT-P</td>
<td>Signature</td>
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Applies To: 
EMR, EMT, AEMT, PM, EMS System

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**Enter from the Universal Patient Treatment Protocol**

*For specific Emergency Stabilization or Patient Management of Respiratory Distress*

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### Pertinent Findings

**Environment**
- Smoking
- Home O₂
- Metered dose inhaler (MDI)

**History**
- Upper respiratory infection
- Cough, fever, sore throat
- Chronic disease
- SAMPLE history

**Physical**
- Anxiety
- Dyspnea and/or tachypnea
- Wheezing, stridor, rhonchi, rales
- Diminished breath sounds
- Barrel chest, pursed lip breathing
- Prolonged expiration
- Accessory muscle use, tripoding
- Chest pain
- Cough and/or hemoptysis
- Cyanosis
- Altered mental status

**Differential**
- Asthma
- COPD, emphysema, bronchitis
- Croup
- Epiglottitis
- Pneumonia
- Pulmonary edema
- FBAO
- Allergy/anaphylaxis
- Heart failure
- Myocardial infarction

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### Emergency Stabilization or Patient Management

- If epiglottitis is suspected, do not visualize throat
  - Position the patient upright and leaning forward to allow drainage of secretions
  - Minimize stimulation, movement and manipulation of the mouth, throat and neck

- Assist patient with the administration of physician prescribed medication
  - Retrieve patient’s prescribed MDI or other medication
  - Monitor and record patient’s self administration as prescribed

- Albuterol 0.083% (Proventil or Ventolin) HHN or in-line with a ventilatory device
  - For bronchospasm
  - See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
  - May repeat as clinically indicated

- Ipratropium Bromide 0.02% (Atrovent) HHN or in-line with a ventilatory device
  - For bronchospasm
  - See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
  - Mix with Albuterol as ordered above and administer both medications simultaneously
  - Repetition requires a base hospital order (BHO)
Return to Universal Patient Treatment Protocol
For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management

***** ***** Base Hospital Orders ***** *****

Albuterol 0.083% (Proventil or Ventolin) HHN or in-line with a ventilatory device
As ordered
For respiratory distress

Epinephrine 1:1,000 IM/SQ
As ordered
For respiratory distress

Ipratropium Bromide 0.02% (Atrovent) HHN or in-line with a ventilatory device
As ordered
For respiratory distress

CPAP up to 20 cmH₂O
As ordered
For respiratory distress

Midazolam (Versed)
As ordered
For relief of anxiety related to CPAP
### REMSA 2012 Policy 4503 — Suspected Stroke

**Effective:** April 1, 2012  
**Expires:** March 31, 2013

#### Policy: Suspected Stroke

**Approval:** REMSA Medical Director  
Humberto Ochoa, MD  
**Signature:**

**Applies To:**  
EMR, EMT, AEMT, PM, EMS System  
**Approval:** REMSA Director  
Bruce Barton, CCEMT-P  
**Signature:**

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**Enter from the Universal Patient Treatment Protocol**  
*For specific Emergency Stabilization or Patient Management of Suspected Stroke*

<table>
<thead>
<tr>
<th>Environment</th>
<th>History</th>
<th>Physical</th>
<th>Differential</th>
</tr>
</thead>
</table>
| Medical alert tag | Family history  
History of stroke / preexisting deficits  
Transient symptoms  
Neurological deficits  
Elapsed time  
LAPSS  
SAMPLE history | Headache  
Visual problems  
Speech disturbances  
Motor weakness, paralysis  
Altered mental status | Alcohol, Epilepsy, Insulin,  
Overdose, Uremia, Trauma,  
Infection, Psychosis, Stroke |

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**Emergency Stabilization or Patient Management**

- Assure that patient can protect airway against aspiration  
  *Give nothing by mouth*
- Protect patient from injury, loosen restrictive clothing, avoid unnecessary movement, preserve privacy  
  *Position patient as clinically indicated to meet physiologic requirements*
- Perform LAPSS (Los Angeles Prehospital Stroke Screen)
- Obtain and evaluate blood glucose when AEMT or paramedic is present

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**Patient Disposition**

- Contact a single REMSA authorized base hospital (BH) in all cases of:  
  Suspected stroke / CVA (cerebrovascular accident)  
  Possible TIA (transient ischemic attack)
- The base hospital will determine destination while considering patient’s preference and their clinical needs
Return to Universal Patient Treatment Protocol
For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management

***** ***** Base Hospital Orders ***** *****
Assess, clarify, monitor, treat within scope of practice, and determine or change disposition and/or destination As ordered
## Treatment Protocol 4601

### Effective
April 1, 2012

### Expires
March 31, 2013

**Policy:**
Allergy/Anaphylaxis

**Approval:**
REM SA Medical Director
Humberto Ochoa, MD

**Approval:**
REM SA Director
Bruce Barton, CCEMT-P

### Applies To:
EMR, EMT, AEMT, PM, EMS System

### Enter from the Universal Patient Treatment Protocol
*For specific Emergency Stabilization or Patient Management of Allergy/Anaphylaxis*

### Pertinent Findings

<table>
<thead>
<tr>
<th>Environment</th>
<th>History</th>
<th>Physical</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergen</td>
<td>Allergy</td>
<td>Anxiety</td>
<td>Asthma</td>
</tr>
<tr>
<td>Stinger</td>
<td>Anaphylaxis</td>
<td>Tightness in the chest</td>
<td>Shock</td>
</tr>
<tr>
<td>EpiPen</td>
<td>Exposure to allergen</td>
<td>Difficulty swallowing, airway swelling, dyspnea, wheezing, stridor</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SAMPLE history</td>
<td>Redness, itching, hives, angioedema</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tachycardia</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hypotension</td>
<td></td>
</tr>
</tbody>
</table>

### Emergency Stabilization or Patient Management

Remove patient from contact with the allergen

Assist patient with the administration of physician prescribed medication
- Retrieve patient’s prescribed EpiPen or other medication
- Monitor and record patient’s self administration as prescribed

Epinephrine 1:1,000 IM/SQ
For suspected allergy/anaphylaxis
See the REM SA Calculation Chart for concentration, and patient specific dosage and volume

Repetition requires a base hospital order (BHO)

Albuterol 0.083% (Proventil or Ventolin) HHN or in-line with a ventilatory device
For bronchospasm associated with allergy/anaphylaxis
See the REM SA Calculation Chart for concentration, and patient specific dosage and volume
May repeat as clinically indicated

0.9% Normal Saline IV/IO bolus
For symptomatic shock associated with allergy/anaphylaxis
See the REM SA Calculation Chart for concentration, and patient specific dosage and volume
May repeat as clinically indicated

*Use a volume control chamber IV set during pediatric administration*
### Emergency Stabilization or Patient Management (continued)

- Diphenhydramine (Benadryl) IM or slow IV/IO push
- For suspected allergy/anaphylaxis
- See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
- Repetition requires a base hospital order (BHO)

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#### Return to Universal Patient Treatment Protocol

*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

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#### Base Hospital Orders

- **Epinephrine 1:1,000 IM/SQ**
  - As ordered
  - For suspected allergy/anaphylaxis

- **Albuterol 0.083% (Proventil or Ventolin) HHN or in-line with a ventilatory device**
  - As ordered
  - For bronchospasm associated with allergy/anaphylaxis

- **0.9% Normal Saline IV/IO bolus**
  - As ordered
  - For suspected allergy/anaphylaxis

- **Diphenhydramine (Benadryl)**
  - As ordered
  - For suspected allergy/anaphylaxis

- **Epinephrine 1:10,000 IV/IO**
  - As ordered
  - For suspected anaphylaxis
**Treatment Protocol 4702**

**Policy:** Labor and Delivery  
**Applies To:** EMR, EMT, AEMT, PM, EMS System

- **Effective:** April 1, 2012  
- **Expires:** March 31, 2013

**Approval:**  
- REMSA Medical Director Humberto Ochoa, MD  
- REMSA Director Bruce Barton, CCEMT-P

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**Enter from the Universal Patient Treatment Protocol**  
For specific Emergency Stabilization or Patient Management of Labor and Delivery

### Pertinent Findings

<table>
<thead>
<tr>
<th>Environment</th>
<th>History</th>
<th>Physical</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household preparations</td>
<td>Gravida (pregnancies)</td>
<td>Abdominal and/or back pain</td>
<td>Miscarriage</td>
</tr>
<tr>
<td>Attempted homebirth</td>
<td>Para (viable births at 20 weeks plus)</td>
<td>Mucous plug/bloody show</td>
<td>Ectopic pregnancy</td>
</tr>
<tr>
<td>Emergency childbirth</td>
<td>Abortus (lost pregnancies)</td>
<td>ROM (rupture of membranes):</td>
<td>Pre-ecclampsia/ecclampsia</td>
</tr>
<tr>
<td>Trauma</td>
<td>LMP (last menstrual period)</td>
<td>Color and quantity of fluid</td>
<td>Braxton Hicks contractions</td>
</tr>
<tr>
<td></td>
<td><strong>EDC</strong> (estimated date of confinement: first day of LMP + 280 days)</td>
<td>Contractions:</td>
<td>Placenta previa</td>
</tr>
<tr>
<td></td>
<td>Prenatal care and findings</td>
<td>Onset (time began)</td>
<td>Placenta abruption</td>
</tr>
<tr>
<td></td>
<td>Multi-fetal pregnancy</td>
<td>Interval (rate and regularity)</td>
<td>Uterine rupture</td>
</tr>
<tr>
<td></td>
<td>Planned caesarean section</td>
<td>Duration (length)</td>
<td>Prolapsed cord</td>
</tr>
<tr>
<td></td>
<td>Maternal age and lifestyle</td>
<td>Intensity (strength)</td>
<td>Extremity presentation</td>
</tr>
<tr>
<td></td>
<td>Infectious disease status</td>
<td>Desire to push</td>
<td>Breech presentation</td>
</tr>
<tr>
<td></td>
<td>Plans to place infant for adoption</td>
<td>Bleeding, bulging, crowning</td>
<td>Nuchal (neck) cord</td>
</tr>
</tbody>
</table>

**APGAR**

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Pulse</th>
<th>Grime</th>
<th>Activity</th>
<th>Respiration</th>
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<th>2</th>
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</thead>
<tbody>
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<td>Absent</td>
<td>Absent</td>
<td>Absent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Both</td>
<td>Slow</td>
<td>Weak</td>
<td>Weak</td>
<td>Pink</td>
<td>Fast</td>
<td>Strong</td>
</tr>
<tr>
<td>1</td>
<td>Both</td>
<td>Slow</td>
<td>Weak</td>
<td>Weak</td>
<td>Pink</td>
<td>Fast</td>
<td>Strong</td>
</tr>
</tbody>
</table>

- **Emergency Stabilization or Patient Management**

If delivery appears imminent:  
Prepare for and/or perform obstetrical delivery

Contact a single REMSA authorized base hospital (BH) in all obstetrical deliveries with:  
- Prolapsed cord  
- Breech presentation  
- Other complications of childbirth

0.9% Normal Saline IV/IO bolus  
For systolic BP less than 90 mmHg following control of bleeding  
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume  
May repeat as clinically indicated