

SECTION: G-01

TITLE: Foundations of Patient Care

REVISED: November 1, 2018

Ada County/City Emergency Services System Standing Written Orders (SWOs)

A. Foundation: These SWOs are the result of the combination of nationally recognized guidelines, local medical practice, and input from the medical directors and the SWO sub-committee. Sources include but are not limited to:

- Basic Life Support (CPR), Advanced Cardiac Life Support (ACLS and ACLS-EP) and associated branch courses
- Pediatric Advanced Life Support (PALS)
- Emergency Pediatric Care (EPC)
- Pediatric Education for Prehospital Professionals (PEPP)
- Neonatal Resuscitation Program (NRP, NALS)
- Advanced Medical Life Support (AMLS)
- International Trauma Life Support (ITLS), Pre-Hospital Trauma Life Support (PHTLS) and associated branch courses, and
- Advanced Burn Life Support (ABLS)

EMS personnel are encouraged to use the guidance and algorithms of these courses to *supplement* SWOs. If contradiction occurs, these SWOs will supersede any other algorithm or guidelines. Alternative courses of action may be utilized, when appropriate, following standard medical control, deviation, and documentation guidelines.

Special Emergency Response Team (SERT) providers face unusual situations often outside the depth of these guidelines, having roles that border on law enforcement functions, or require procedures beyond the scope of normal EMS providers. These special situations may be covered in separate protocols and policies which will supplement this document.

- B.** While this document cannot cover every possible variation of disease or injury encountered in the field, it should provide a foundation for the acute care of the majority of patients seen.
- C.** Each and every protocol should be considered to have, as its first directive, a mandate to maintain universal blood and body fluid precautions/isolation.
- D.** Newer defibrillators using biphasic technology require lower energy doses and self-regulate the appropriate electrical energy. When not specified, or when a different device (than normally used), or if device deployment changes after publication of the SWOs, all protocols assume energy levels as set by the manufacturer recommendations for the device.

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- E. Unless specifically addressed in these protocols, a provider's scope of practice is assumed to include lower levels. For example, a paramedic level guideline is assumed to include the EMT scope as well.
- F. **Time Sensitive Emergencies (TSE):** The state of Idaho has recognized that certain patients may benefit from rapid access to specialty centers under the Time Sensitive Emergencies Program. All TSE patients shall be stabilized and transported as rapidly and efficiently as possible. When treating patients who may benefit from specific interventional therapy (surgery, thrombolytic, catheterization lab) a goal of less than ten minutes on-scene time is desirable (within the bounds of providing quality patient care).
- G. **EARLY NOTIFICATION OF RECEIVING FACILITY IS ESSENTIAL IN SIGNIFICANT CASES**
- H. **General treatment:** All patients shall receive the following general supportive care as appropriate within the scope of practice and sound clinical judgment of the provider:
- Airway control**
- Positioning/suctioning
 - Oral or nasopharyngeal airways
 - Combi-tube, King LTS, LMA (or other adopted advanced airway)
 - Endotracheal intubation (oral, nasal, RSI, digital)
 - Cricothyrotomy (needle, surgical, and similar devices)
 - Use of pharmacological agents to facilitate airway control
 - Use of difficult airway devices, such as the Endotracheal Tube Introducer (a.k.a. the Gum Bougie) to facilitate airway control
 - Use of video laryngoscopes to assist with intubation when available and if appropriate.
- Ventilatory support**
- Supplemental oxygen by appropriate means
 - Bag-valve mask using a traditional face mask, intra-oral mask (IOM) , or similar device
 - Bag-valve ETT
 - Monitoring of pulse oximetry and end tidal CO₂
 - CPAP and BiPAP devices when available
 - Deep tracheal suctioning
 - Use of a mechanical ventilator
- Circulatory support**
- CPR and components of CPR
 - Use of devices to support circulation, including mechanical CPR devices (such as the LUCAS™2, or other devices) and CPR adjuncts

- (such as the ResQPod, ITD, and similar devices) as training and availability allow
- Basic bleeding control, up to and including use of wound packing, hemostatic agents (if trained and available) and tourniquets

Naso-Orogastric tube placement

Spinal immobilization/Restriction: Selective immobilization/restriction using cervical collars, KEDs (or similar devices), spine boards (or similar devices), and improvised devices. This includes screening for appropriate immobilization.

Orthopedic Care: Using cold packs, pillows, cardboard splints, vacuum splints, traction devices, pelvic binding and other improvised devices as appropriate and available. Paramedics may reduce patellar dislocations. Paramedics may reduce angulated extremity injuries with neurological compromise as appropriate.

Vascular access

- Single or multiple lumens
- Peripheral or intraosseous access, including pre-established lines
- Crystalloid (i.e. Normal Saline, Lactated Ringers etc.) infusions and saline/medication locks as appropriate
- Use and maintenance of other crystalloid solutions via pre-established vascular access, including PICC lines, Hickman catheters, hemodialysis lines, and other routes of vascular access (as provider training and comfort level allows)
- While AEMT providers are often limited in the number of IV attempts and fluid administration by this document, ALS providers may exceed those guidelines when functioning under the general direction of the Paramedic in charge of the patient. Likewise, Paramedics are limited by sound clinical judgment rather than an arbitrary number of “attempts” at vascular access

EKG/Electrical therapy: Defibrillation/cardioversion/pacing, including AEDs and manual devices. EKG and 12-lead monitoring.

- Patients in which EKG monitoring has been initiated for any reason will be considered ALS patients; these patients shall be attended by a Paramedic at all times.
- Medication administration will be considered an indication for EKG monitoring, **particularly those with sedative, analgesic, or cardiovascular properties**; with the following exceptions:
 - Administration of Oxygen (Specific complaints such as Shortness of breath notwithstanding)
 - Administration of crystalloid intravenous fluids (without medication)
 - Administration of Oral Glucose or Dextrose containing intravenous solutions

- Administration of Neo-Syneprine for epistaxis
- Administration of *over-the-counter* (OTC) oral medications.
- Chronic and routine use of patient prescribed medications self-administered by the patient.
- Patients who have recently received medications which from another healthcare provider (such as a transport from one ER to another) shall receive the same consideration for EKG monitoring as if the ACCESS provider had administered the medication.

Needle thoracostomy (chest decompression)

Blood glucose monitoring

Medication administration: Medications may be administered by numerous routes and methods as indicated by the SWO's or medical order. Patient safety and clinical judgement is paramount. To facilitate patient safety:

- Careful attention to the 5 Rights of Medication Administration should be adhered to prevent avoidable errors. These include: Right Patient, Right Medication, Right Dose, Right Route, and Right Time.
- Whenever possible, confirmation of proper medication administration should be verified with another ACCESS medical provider.
- ALS providers may decrease the dosage or prolong the administration intervals of any medication with sedative properties when doing so would decrease adverse effects and still likely obtain the clinical goal.

Monitoring and titration of medication infusions, including medications on pumps when appropriate and training allows.

Monitoring/maintenance of blood product infusions

Physical restraints as required for patient and provider safety. This does not imply that EMS providers assume law enforcement functions.

Optional Modules: Some providers, particularly EMTs, may have received additional optional module (AKA "O.M.") training to perform skills or interventions that may be outside of the normal scope of practice in the State of Idaho. A provider should not perform any skill or intervention that he has not been credentialed/approved by the ACCESS medical directors or their designees. The currently approved optional modules are:

EMR

- Cervical Collar Application

EMT:

- 12-Lead EKG Acquisition
- ETCO2 monitoring/Capnography
- Co-oximetry
- IM administration injection (epinephrine)
- SQ Injection (Epinephrine)
- Suctioning-Tracheal Via Adv. Airway
- Pelvic Immobilization Device
- Taser Barb Removal
- Blood Glucose Monitoring

AEMT (I-85)

- 12 lead acquisition
- Asa administration for chest pain
- Blood glucose monitoring
- CPAP
- Co-oximetry
- ETCO2
- IM/SQ administration of epi
- Lidocaine administration as adjunct for IO
- Pelvic immobilization devices
- Pulse oximetry
- Tracheal suctioning
- Taser barb removal
- Vascular access IO - adult

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AEMT (2011)

- 12-Lead EKG Acquisition
- ETCO₂ monitoring/Capnography
- Co-oximetry
- Pelvic Immobilization Device
- Taser Barb Removal
- ETCO₂
- CPAP
- Lidocaine Administration - IO adjunct only
- Pelvic Immobilization Device

Paramedic

- Co-Oximetry
- Intubation-Medication Assisted (RSI, Paralytics)
- Pelvic Immobilization Device
- Taser Barb Removal
- Cricothyrotomy – Surgical
- IV Programmable Volume Infusion Device