The North Central EMS Regional 2012 Guidelines will go into effect on February 1, 2012. Here are highlights of the new guidelines. The full document will be available on the regional website at:

http://www.northcentralctems.org/

Pain Management
To better manage patients in acute pain standing orders dosing for Fentanyl and Morphine have been increased. Patients may receive up to a total maximum of 3 mcg/kg Fentanyl up to 300 mcg or 0.2 mg/kg Morphine up to a max of 20 mg on standing orders. Maximum single doses are 1 mcg/kg or 100 mcg Fentanyl and 0.1 mg/kg or 10 mg Morphine. Wait ten minutes between full doses. Dosing cycles for patients over 65 should be cut in half with the patient receiving a half dose, followed by the second half dose, if necessary five minutes after the first half dose. Pediatric dosing is the same as adult and is always weight based. Fentanyl may now be given intranasally. Torodol has been removed from the guidelines.

2010 American Heart Guidelines
The NC 2012 EMS Regional Guidelines will be incorporating most of the changes from the recently released AHA 2010 Guidelines for Cardiac Care, and their emphasis on quality chest compressions and avoiding hyperventilation:

Initiate chest compressions before giving rescue breaths (C-A-B rather than A-B-C).

Push hard (>2 inches) and fast (> 100/min) and allow complete chest recoil.

Minimize Interruptions. Consider rotating compressors every two minutes.

Deliver each rescue breath over 1 second. Give a sufficient tidal volume to produce visible chest rise. Ventilate with 600 ml of an adult ambu bag. 8-10 a minute.

Airway Management
The Adult Airway Guideline has been revised to emphasize that the airway gold standard is an effectively managed airway, not always an ET tube. ET, Combi-tube, LMA and King LT are all considered first-line airways. Capnography shall be utilized on all advanced airways (ET, Combi-tube, LMA, King LT).

Patient Controlled Analgesia
When administering pain medicine to patients with ACUTE pain (pain 4 or more on the pain scale) unresponsive to BLS interventions, ask Would You Like Some Pain Medicine? If, yes, administer first dose. If, after prescribed interval, patient is still a 4 or more and has no contraindications, ask: Would You Like Some More Pain Medicine? This should continue at appropriate intervals until pain is relieved, patient declines further pain medicine or there are contraindications.
**Altered Level of Consciousness**
Dextrose can be given in any concentration to hypoglycemic patients. D50, D25 or D10. Dextrose should only be given in the amounts necessary to return the patient to baseline. Studies have shown a lower concentration and gradual administration may be better for patients than the standard 25 gram D50 IV push.

**Alcohol Withdrawal**
Patients undergoing alcohol withdrawal including tremors, tachycardia and or seizures should receive 1-2 mg Lorazepam on standing order. Fluid bolus should be considered. Additional Lorazepam can be given after contact with medical control.

**Oxygen**
Supplemental oxygen is not needed for patients without evidence of respiratory distress, heart failure or shock if the oxyhemoglobin saturation is > 94%. Hyperoxia can be harmful to patients.

**IV/IO Access**
IV access is preferred. If it is not readily available then use IO as back-up vascular access device in critical patients.

**Nitro and Inferior MIs**
Paramedics should perform 12-lead prior to administration of NTG. If 12-lead shows inferior STEMI, do not administer NTG prior to performing a right sided ECG. If right side leads reveal possible right ventricular infarct, establish a large bore IV. Giving NTG to patients with right ventricular infarction is contraindicated.

**Nausea and Vomiting**
Ondansetron (Zofran) should be used as the front-line anti-emetic agent. Phenergan has been removed from protocol.

**Contact Us:**
Any questions or suggestions about EMS? Looking for patient follow-up?
Contact EMS Coordinator Peter Canning at canning@uchc.edu or call (860) 679-3485.