UConn Health Center
John Dempsey Hospital

Emergency Medical Services
Partners

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2012 NC Regional EMS Guidelines

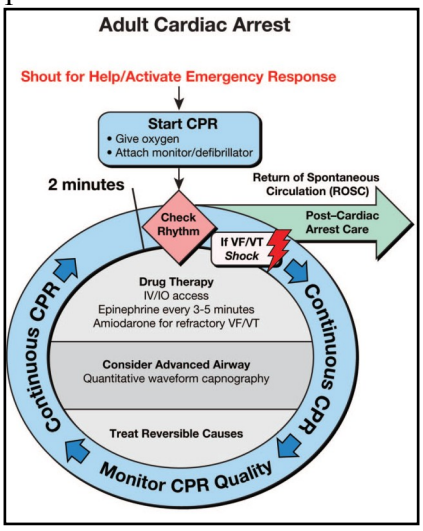
North Central Connecticut EMS Council

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://ww.northcentralctems.org/

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.

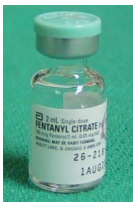
Minimize Interruptions. Consider rotating compressors every two minutes.

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, Combitube, LMA and King LT are all considered first-line airways. Capnography shall be utilized on all advanced airways (ET, Combi-tube, LMA, King LT).

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 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.

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 <u>back-up</u> 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.

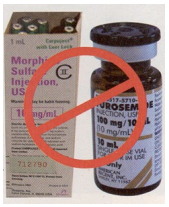
Atropine in Cardiac Arrest

Atropine should no longer be routinely used in PEA and asystolic cardiac arrests.

Nausea and Vomiting

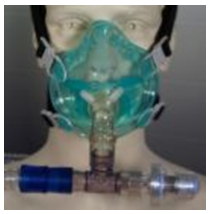
Ondansetron (Zofran) should be used as the front-line anti-emetic agent. Phenergan has been removed from protocol.

Acute Pulmonary Edema



Lasix/Bumex, Morphine and Nitropaste have been removed from the guidelines. CPAP and NTG SL are now the mainstays of CHF treatment.

CPAP

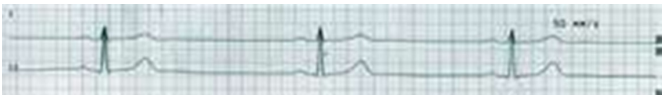


Ativan 0.5 mg up to a max of 1 mg may be given on standing order for patient with extreme anxiety if the medic judges that lessening their anxiety will enable them to better tolerate CPAP. The requirement that a patient must have a systolic blood pressure >100 mm HG has been removed. Use caution when using CPAP with hypotensive patients.

Tachycardia

For unstable atrial fibrillation/aflutter, if patient is on no meds for tachycardia or on Ca+ channel blocker, Diltiazem will be first line. If already on beta blocker then Lopressor will be used. Lopressor standing order will be 5 mg IV q 5 minutes x 3 doses if needed.

Adult Bradycardia



Action rate has been reduced from <60 to <50. If atropine ineffective, try transcutaneous pacing. If pacing ineffective, consider Dopamine infusion.

Anaphylaxis

For severe anaphylaxis unresponsive to IM epi, you may give epi 1:10,000 0.1 mg <u>slow</u> IV over 3 minutes, can be repeated to a max dose of 0.3 mg. <u>Epi 1:1000 should NEVER be used IV.</u>

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.