UCONN HEALTH

Emergency Medical Services Partners

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2015 NC Regional EMS Guidelines

North Central Connecticut EMS Council

The North Central EMS Regional 2015 Guidelines will go into effect on July 1, 2015. Highlights include a revision of the regional stroke guideline and a stroke destination policy. The full document is available on the regional website at :
http://www.ctemscouncils.org/pages/northcentral.html
A complete summary of changes is available in the front of the document. Here are a few of the changes.

Stroke Destination Determination

Suspected stroke patients should be brought to closest certified stroke center or stroke-ready hospital.*

*Stroke ready hospital shall have:
1) Access to 24 Hour CT Scan
2) Access to a neurologist either in person or through telemedicine
3) Ability to conduct emergency lab testing
4) Ability to give TPA
5) Policies in place to transfer patients to primary or comprehensive stroke center.

Consider patient preference/history if multiple stroke centers are in similar proximity.

In all instances, those patients requiring immediate hemodynamic or airway stabilization should be transported to the closest appropriate facility.

As of the date of this guideline, all hospitals in the North Central Connecticut Region meet stroke-ready criteria.

Stroke Care Pearls

Early notification to the receiving hospital is essential to ensure the immediate availability of an appropriate in-hospital response.

Try to limit scene time to 15 minutes or less, and transport rapidly. Transport should be equivalent to trauma or acute myocardial infarction calls.

BLS should not delay transport to await arrival of ALS.

Contact receiving hospital for ACUTE STROKE ALERT and include following information: • Time of symptom onset/Last Known Well Time • Description of neurologic deficits (include Cincinnati stroke scale) • Blood glucose.

When contacting CMED say, “I need a radio patch to (Hospital) for a Stroke Alert.” This will help prioritize your patch. It is not necessary to ask for Medical Control.

Limit IV attempts due to possibility of patient receiving TPA. Use 18 or 20 gauge IV if possible.

If patient tolerates, elevate head of stretcher 30 degrees.

Perform and document vital signs and neuro exam every 5 (five) minutes (on both 911 calls and interfacility transfers involving stroke patients). Neuro exam should include repeat F.A.S.T./Cincinnati Stroke Screen and pupil evaluation.

Remember: Time is Brain. Do Not Delay and Provide Advance Notification to Speed Time to TPA when patient meets criteria.

The FDA approved window for IV TPA is 3 hours from symptom onset. However, some patients may receive IV TPA up to 4.5 hours from symptom onset.

Adult Shock/Blood Pressure

Added branch points to Sepsis and Anaphylaxis and Hemorrhagic guidelines with titrating resuscitation to SBP of 90mmHg instead of 100mmHg. Created pathway for paramedics to administer IV fluids to patients with evidence of volume depletion of other etiology.

Septic Shock/Sepsis Alert Guideline

Identification of Possible Septic Shock
Suspected infection – YES
Evidence of sepsis criteria – YES (2 or more):
 Temperature < 96.8 °F or > 100.4 °F (if available)
 Heart rate > 90 bpm.
 Respiratory rate > 20 bpm.
 Systolic blood pressure < 90 mmHg.
 New onset altered mental status OR increasing mental status change with previously altered mental status
Routine Patient Care.
 Administer oxygen at a rate to keep oxygen saturation .94%.
 Do not delay transport.
 Notify ED of possible **SEPSIS A**LERT patient.
Initiate up to two (2) large-bore IVs. Do not delay transport to start IV.
 Administer 0.9% NaCl to maintain systolic blood pressure >90mmHg in 500ml boluses. Total volume should not exceed 4,000ml.
 Patients should be reassessed frequently, with special attention given to the lung examination to ensure volume overload does not occur.
If there is no response after 2,000 ml IV fluid infused, continue up to 4,000 mL IV fluid and consider:
o Norepinephrine 4 – 30 micrograms/minute
o Dopamine infusion 5 – 20 micrograms/kg/minute. (Use only if not carrying Norepinephrine)

Anaphylaxis Definition (changed)

Definition/Indications:
 Hypotension or respiratory compromise with known allergen exposure

Or
 Acute onset of symptoms and 2 or more of the following:
o Respiratory compromise (dyspnea, wheeze, stridor)
o Angioedema or facial/lip/tongue swelling
o Widespread hives, itching, swelling
o Persistent gastrointestinal involvement (vomiting, diarrhea, abdominal pain)
o Altered mental status, syncope, cyanosis, delayed capillary refill, or decreased level of consciousness associated with known/suspected allergenic exposure
o Signs of shock

F.A.S.T. Stroke Screen

All EMS personnel should utilize the FAST Stroke Screen, (which incorporates the Cincinnati Scale).
F Face Drooping – Does one side of the face droop or is it numb? Ask the person to smile. Is the person's smile uneven?
A Arm Weakness – Is one arm weak or numb? Ask the person to raise both arms. Does one arm drift downward?
S Speech Difficulty – Is speech slurred? Is the person unable to speak or hard to understand? Ask the person to repeat a simple sentence, like "The sky is blue." Is the sentence repeated correctly?
T Time - If someone shows any of these symptoms, even if the symptoms go away, Time is Critical. Record time when the first symptoms appeared.

Pulmonary Edema (Clarified NTG Dosing)

If SBP >100 mmHg, Nitroglycerin 0.4 – 0.8 mg SL.
If pulmonary edema persists, may repeat Nitroglycerine every 3-5 minutes as needed provided SBP >100 mmHg.

If unable to administer nitroglycerine SL due to CPAP (such as concern regarding re-establishing mask seal) and if Systolic BP is >150mmHG, then Nitroglycerin Paste 1.5 inches, if >200 then 2 inches .
Nitro Paste is only to be used in conjunction with CPAP

Spinal Trauma

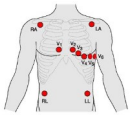
State spinal trauma/spinal motion restriction guidelines have been inserted into protocols to limit use of long backboards.

Norepinephrine

Changed adult dosing to 4-30 mcg/min throughout all guidelines. Added guidance regarding titration in the norepinephrine formulary section.

12 Lead Procedure:

Added specific landmarks for precordial lead placement. Added reference to EMT 12 lead acquisition and transmission as part of a sponsor hospital approved BLS 12 lead program.



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.