UConn Health Center
John Dempsey Hospital

Emergency Medical Services Partners

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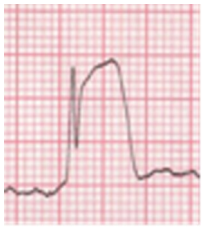
2013 NC Regional EMS Guidelines

North Central Connecticut EMS Council

The North Central EMS Regional 2013 Guidelines will go into effect on July 1, 2013. Here are highlights of the new guidelines. The full document will be available on the regional website at :

http://ww.northcentralctems.org/

STEMI Alert Procedure



1. Acquire a 12-lead on all patients suspected of Acute Coronary Syndrome (active chest pain or equivalent symptoms (SOB, nausea, etc.) on first contact.

2. If 12-lead is diagnostic for STEMI and paramedic believes patient is having STEMI, contact CMED for **STEMI Alert with Medical Control** patch, and transmit ECG if possible.

If possible and less than 30 minutes from PCI center, do not wait until transporting to call hospital. Failure to notify hospital until 5 minutes out will delay reperfusion.

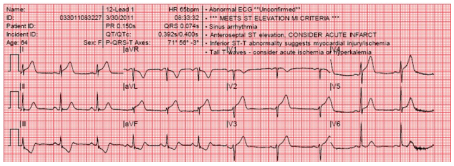
3. When hospital answers phone, confirm MD Control, and state "**I have a STEMI Alert and am requesting STEMI activation**."

If you are uncertain the patient is having a STEMI, say **"I have a Possible STEMI Alert."**

Nontraumatic Cardiac Arrest Scene Care and Transportation

Patients in nontraumatic cardiac arrest should receive full resuscitative efforts on scene. Moving a patient to the ambulance to start ALS resuscitation, to get to the hospital quicker or to meet a paramedic intercept may be counterproductive by lowering the quality of compressions in the critical early period of resuscitation. Any interruption in quality cardiac compressions decreases a patient's chance of survival. Patients should receive at least 20 minutes of resuscitative efforts on scene prior to considering movement. If a patient remains in asystole after twenty minutes of paramedic effort, termination of resuscitation guidelines should be considered. If the decision is made (at any time) to move the patient, care must be maintained to ensure that quality compressions are maintained throughout extrication and transportation. Unless there are special circumstances, it is unlikely that a patient who cannot be resuscitated on scene with quality CPR and defibrillation will be resuscitated either at a paramedic intercept point or at the hospital. Please refer to state Termination of Resuscitation Guidelines.

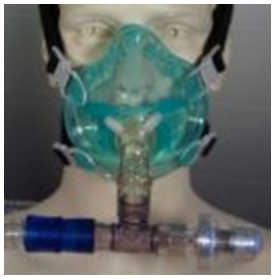
Serial 12-Leads

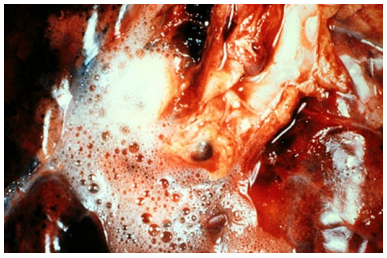


In patients with suspected Acute Coronary Syndrome, a 12-lead ECG should ideally be done on first patient contact, during transport and on arrival at the ED. This will help capture evolving MIs that may not be visible on the first 12-lead.

Acute Pulmonary Edema

CPAP and NTG are the proven mainstay treatments for acute pulmonary edema. The NTG dose has been increased from 0.4 mg SL to 0.4-0.8 mg SL provided the SBP >100 mmHg. Repeat the 0.4—0.8 mg SL dose as needed every 3-5 minutes.





Behavioral Emergencies

Replaces Ativan with Versed as first option. Increases top range of dosing of Versed for violent patients (up to 10 mg IM). Adds option of Zyprexa instead of Haldolol. Zyprexa, like Haldolol can be combined with Ativan or Versed in same syringe.

Angulated Fractures

Paramedics may straighten severely angulated fractures if the distal extremity has signs of decreased perfusion. Premedication with sedation or analgesia should be strongly considered. EMRs, EMTs and AEMTs should splint angulated fractures in position found. In unusual circumstances or extremely prolonged transport times, EMRs, EMTs and AEMTs may contact medical control for authorization to straighten severely angulated fractures if the distal extremity has signs of decreased perfusion.

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.

Seizures

Versed is now the priority option in a seizing patient without an established IV. The latest research shows Versed IM stops seizures quicker than initiating an IV and giving Ativan.

Our new guidelines increases doses of Versed and Ativan. Patients without an established IV should recieve Versed 10 mg IM if greater than >39 kg or Versed 5 mg IM if the patient is <39 kg. Versed can be repeated q 5 minutes to a max total standing order dose of 20 mg if the patient is still seizing. Or if an IV is already established Ativan 4 mg can be given IV if the patient is >39 kg. Ativan 2 mg IV if patient <39 kg>13 kg. Ativan can be repeated q 5 minutes to a max total standing order dose of 8 mg if patient still seizing.

PEARLS

1. In absence of an established IV, Versed IM is the preferred option in status epilepticus as studies have shown it stops the seizure quicker and results in fewer hospital admissions than IV Ativan.
2. In absence of the other drug, Versed can be given IV and Ativan can be given IM.
3. Versed can be given IN, but this route is considered less reliable then IM.
4. The dosing above is intended for convulsing patients in status epilepticus. More moderate doses can be considered in partial seizures.
5. The sooner seizures can be stopped, the easier they are to stop and the less damage the patient may suffer from the seizure.
6. After giving first dose of Versed IM, attempt to get an IV, and if obtained and patient still seizing after 5 minutes, give next dose Ativan IV.
7. Versed when given IN should be given with the 5mg in 1 ml concentration. The 5mg in 1ml concentration is preferred for IM injection.
8. Never give more than 5ccs in an IM injection (Dorsogluteal only). It is preferable to not exceed 3cc in any one IM injection. The thigh is the preferred IM injection site. Do not exceed 1cc in the deltoid. Do not use the deltoid in patients with limited musculature.