



Emergency Medical Services *Partners*

October 2015, Issue 65

uconnems.uhc.edu

The QA Issue: Based on our own QA and discussions with other hospitals at the Regional EMS meetings, we have identified some of the biggest areas for improvement.

1 BLS Downgrades

Paramedic downgrade to BLS care should only occur when:

1. No ALS care or diagnostics (e.g. 12 lead) are indicated (per the EMS Patient Care Guidelines) and
2. The paramedic provider has a reasonable belief no deterioration in patient condition will occur en route.



An overview of some conditions where ALS care is mandated is contained within the “Transfer of Adult Care from Paramedic to Basic Life Support” regional guideline. Some additional examples of complaints where ALS care is indicated but has sometimes been overlooked include:

Abdominal pain, alcohol withdrawal symptoms, non-traumatic chest pain regardless of location, character or reproducibility, moderate to severe pain in any anatomical location, nausea/vomiting, and profound weakness.

If the paramedic provider determines BLS-only care is indicated, the paramedic must document their findings and rationale in the EMS record.

Regional hospitals have seen numerous examples where paramedics have either downgraded to BLS transport units or have driven while their BLS partner has attended the patient, and the patient has required aggressive care in the ED when paramedic care on the scene would have made a difference in patient mortality and morbidity.

The North Central Connecticut Regional Medical Advisory Committee will soon be issuing an updated policy on downgrades to address these issues.

#2 Inappropriate Naloxone

Indication: The only indication for Naloxone is hypoventilation due to suspected opiate abuse. Naloxone should not be given for patients on opiates in absence of documented respiratory depression. Naloxone should not be given for coma of unknown etiology (as in older protocols), especially in cases where the patient is ventilating on their own.

Dose: If Naloxone is given IV, it should be given slowly and titrated in small doses until the person can ventilate on their own. It is not necessary to fully arouse the person up. Avoid putting the patient into withdrawal. Consider starting at 0.4 mg (or lower) SIVP, and titrate as necessary. The IN Naloxone dose should remain at 2 mg (1 mg per nare).

Intubated Patients: Do not give Naloxone to patients who are intubated. The patient is already being ventilated.

Cardiac Arrest: Do not give Naloxone to patients in cardiac arrest (even those caused by opiates). Naloxone does not reverse hypoxia induced cardiac arrest.

*Naloxone has no role in the management of cardiac arrest.—
AHA 2010 Guidelines*



3 Pain Management

Only 32% of elderly hip fracture patients brought to John Dempsey from EMS over the last year received analgesia in the field. While this continues an uptrend, we still have a long way to go. It is important to remember that aside from the simple ability to ease someone’s suffering, studies have shown the quicker someone receives pain medicine, the better their outcome. Failure to treat acute pain can lead to development of lifelong chronic pain.

Run form documentation should include an assessment of the patient’s pain, the nature of the pain, treatment of the pain, a reassessment of the pain, and patient satisfaction with pain relief efforts. If a paramedic chooses not to medicate a patient in moderate to severe pain, the reasons for withholding analgesia must be documented.



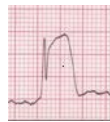
#4 Work Medical Cardiac Arrests On Scene

A patient in cardiac arrest needs quality CPR to have a chance at survival. Paramedics should, unless there are significant extenuating circumstances, work medical cardiac arrests on scene, per regional guidelines, for a minimum of 20 minutes. Loading and going will inevitably lead to pauses in CPR and CPR of lower quality. Paramedics have all the tools to resuscitate medical arrests on scene. Areas of the country that have adopted this method and followed it, have shown much higher rates of survival.



#5 Early STEMI Notification

Every minute of extra early notification for a STEMI patient is a minute of saved heart muscle. EMS can be the dispatcher for the cath lab team, which on nights and weekends, may require 30 minutes lead time to ready the cath lab table. Call from the scene. It is not necessary to have an IV before you notify. Thanks to early notification we have significantly reduced our door-to-balloon time, yet we are still often not getting the notification until the ambulance is already en route. Remember do your 12-Lead ECG on first scene contact, and if diagnostic for a STEMI, notify immediately with a STEMI ALERT Medical Control patch.



#6 Consider Stroke in Your Diagnosis

EMS only recognizes two of every three strokes. If your patient scores a 0 on the Cincinnati Stroke Scale, ask these questions:

- | | |
|----------------|---|
| S- Sudden | Did the patient's symptoms happen suddenly and without an explanation such as trauma or intoxication? |
| A - Altered | Does the patient present with altered mental status? |
| V- Vision | Is the patient experiencing a sudden vision problem? |
| E- Equilibrium | Does the patient have an altered equilibrium or vertigo? |



A yes to the first question and a yes to any of the following three questions should heighten your suspicion of stroke as a possible cause of the patient's condition.

UConn Health EMS Website

For news, educational information, CME schedule and past copies of our newsletter *Partners*, check out our website at:

uconnems.uhc.edu

EMS Honor Roll

Acute Stroke

American Medical Response paramedic and EMT John Spencer. **40 Minutes Door-to-TPA, 59 Minutes FMC to TPA.**

American Medical Response paramedic Keith Slater and EMT Michael Lawrence. **37 Minutes Door-to-TPA, 59 Minutes FMC to TPA.**

Granby Ambulance paramedic Michael Mayo and EMT partner Liz Hayes.

October 21, 2015 UCONN CME

Topics To Be Announced

East Farms Fire

94 South Road, Farmington, CT

8:30-11:30 A.M.



2015 UConn EMS CONTINUING EDUCATION

Monthly Morning CME

October 21, 2015

November 18, 2015*

December 16, 2015

Held at East Farms Fire

94 South Road, Farmington, CT

8:30-11:30 A.M.

*November CME will be in Keller Auditorium

Bagels and Coffee will be served

For Questions, email Peter Canning at canning@uchc.edu

ALL EMS RESPONDERS AND GENERAL PUBLIC WELCOME



Save the Date for this Excellent Program EMS, Veterans and Post Traumatic Stress Disorder:

Keller Auditorium

UConn Health/John Dempsey Hospital

November 18, 2015

8:30-11:30 A.M.

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.