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INTRODUCTION

These guidelines are designed to be used by EMS personnel functioning with Jemez Pueblo EMS. These guidelines were updated by a team of volunteer, career, command and medical director staff to be as efficient and effective as possible for all EMS providers. For six months these guidelines were updated, reviewed, and then updated again. These guidelines were re-formatted from older versions to make referencing needed information quicker which can lead to quicker action on the part of the EMS provider. Additionally, these guidelines have no expiration date but instead are considered a living documented that will be updated as needed. As with most medical professions, changes happen frequently and with those changes, JPEMS wants to have the availability to stay as up to date as possible. Any changes will be communicated with EMS personnel prior to implementation.

JPEMS management encourages providers to review these carefully and often to ensure they understand their expected responsibilities and actions while in the field. Further, because these guidelines are very different in the sense of formatting and use of verbiage, every effort has been made to ensure accuracy both in current best practice standards as well as spelling and grammatical considerations. If you ever note any issues with these, please notify JPEMS management for their review.

JPEMS management encourages feedback at any time to help enhance these guidelines and make the practice of medicine in Jemez Pueblo the best we can for our citizens and visitors. Finally, if you have any questions or clarification is needed, please do not hesitate to ask for clarification from Management.

HOW TO USE THESE GUIDELINES

As you read through the guidelines, you will note that the formatting puts language in associated boxes. Most guidelines have five boxes in vertical order. The top box identifies the guideline and any associated information that may be needed to be conveyed (GENERAL). The following four boxes are color coded for quick reference depending on your level of licensure. Licensed first responders and above will reference the All Providers box (YELLOW), Basics and above will reference the BLS providers box (GREEN), Intermediates and above the ILS box (BLUE), and medics will see the paramedic box (RED). Every provider should start at the top and work their way through the box that correlates to their level of licensure. Some guidelines have a fifth box that may reference notes about the guideline that are to be reviewed by all providers. The guidelines are split into sections that place related guidelines together for quicker reference. As
stated above, providers are encouraged to review these guidelines often to ensure they have a
good basic understanding of where certain guidelines are so when needed, the reference can take
place quickly and patient care can be as efficient as possible.
SECTION 1
ADMINISTRATIVE GUIDELINES
<table>
<thead>
<tr>
<th><strong>GENERAL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ The following Patient Care Guidelines are intended to be used in their entirety by all personnel representing Jemez Pueblo EMS.</td>
</tr>
<tr>
<td>➢ These Guidelines in their entirety are for the career staff to use in the course of their patient care.</td>
</tr>
<tr>
<td>➢ Advanced EMS providers in the volunteer districts will be able to perform within these treatment guidelines based on 1) their level of activity outside of Sandoval County; 2) the Medical Director’s approval to perform those skills/treatments and; 3) signed documentation from the Medical Director for the EMS provider to perform skills/treatments as outlined in the New Mexico Scope of Practice for the level of licensure for that provider.</td>
</tr>
<tr>
<td>➢ In line with New Mexico EMS Regulations, any EMS provider wishing to perform skills identified as requiring “Service Medical Director Approval”, will have a signed authorization form on file prior to performing any of those skills/treatments and will also have a signed acknowledgement of understanding of receiving a copy of the most current JPEMS treatment guidelines.</td>
</tr>
</tbody>
</table>

**APPLICATION FOR USE OF JEMEZ PUEBLO EMS PATIENT CARE GUIDELINES**  
Effective 4/1/17

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<table>
<thead>
<tr>
<th>Medication</th>
<th>FR</th>
<th>EMTB</th>
<th>EMTI</th>
<th>EMTP</th>
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</thead>
<tbody>
<tr>
<td>NAAK (Mark I Kit)</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Aspirin</td>
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<tr>
<td>Oxygen</td>
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<td>X</td>
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<tr>
<td>Oral Glucose</td>
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</tr>
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<td>Albuterol</td>
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</tr>
<tr>
<td>Naloxone</td>
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<td>X</td>
</tr>
<tr>
<td>Epinephrine 1:1,000</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Acetaminophen</td>
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<tr>
<td>Ipratropium</td>
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<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Dextrose (D50; D25; D10)</td>
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<tr>
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<tr>
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<tr>
<td>Fentanyl Citrate</td>
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<td>Glucagon</td>
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<td>Ondansetron</td>
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<td>0.9% Sodium Chloride</td>
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<td>Lidocaine (For IO Administration Only)</td>
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<tr>
<td>Adenosine</td>
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<td>Atropine Sulfate</td>
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<tr>
<td>Calcium Chloride</td>
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<tr>
<td>Dexamethasone</td>
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<tr>
<td>Diazepam</td>
<td>X</td>
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<tr>
<td>Epinephrine / Norepinephrine (Levophed) Drip</td>
<td>X</td>
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<tr>
<td>Furosemide</td>
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<tr>
<td>Lidocaine</td>
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<tr>
<td>Magnesium Sulfate</td>
<td>X</td>
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</tbody>
</table>

JPEMS APPROVED MEDICATIONS

Effective 4/1/17
### Statement of Purpose

**Effective 4/1/17**

These Guidelines are designed to guide the practice of the professionally licensed staff of Jemez Pueblo EMS. When differences between guidelines arise in mutual aid situations, EMS personnel should function according to the guidelines of the EMT in charge of patient care. Although the JPEMS Guidelines define who is in charge of each patient encounter, it may sometimes be helpful to contact on-line medical control in order to resolve conflicts between providers or agencies. Every attempt must be made to provide the best patient care possible in spite of disagreements.

### Disclaimer

**Effective 4/1/17**

Every attempt has been made to reflect sound medical guidelines and guidelines based on currently accepted standards of care for out-of-hospital emergency medicine. The working group urges the reader to speak to their respective service point of contact for any specific questions that may arise. The working group assumes no responsibility directly or indirectly for this document. It is the reader’s responsibility to stay informed of any new changes or recommendations made at the state or service level.

Activities of EMS personnel must be in compliance with all applicable federal, state, county and local laws and regulations including: PRC Regulation 18 NMAC 4.2 “Ambulance and Medical Rescue Services” and the Federal Controlled Substances Act.

This document was developed specifically for the Sandoval County area, and modified specifically for Jemez Pueblo EMS. As such, these guidelines may need to be modified if used in other EMS systems. Other EMS systems may obtain an electronic copy of this guideline by written request. Contact Jemez Pueblo EMS for further information.

<table>
<thead>
<tr>
<th>Drug</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Midazolam</td>
<td>X</td>
</tr>
<tr>
<td>Oxytocin</td>
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</tr>
<tr>
<td>Phenylephrine nasal spray</td>
<td>X</td>
</tr>
<tr>
<td>Sodium Bicarbonate</td>
<td>X</td>
</tr>
<tr>
<td>Tetracaine Ophthalmic solution</td>
<td>X</td>
</tr>
</tbody>
</table>
EMS in Sandoval County is provided by a combination of Career and Volunteer EMS Providers from the 8 County Fire Districts, 3 Tribal Entities (Navajo Nation, Jemez Pueblo and Santo Domingo Pueblo), and providers from the incorporated entities of the Rio Rancho FD, Town of Bernalillo FD, Cochiti FD, Jemez Springs FD, Cuba FD/EMS, and Corrales FD. There will be times that a Medical Helicopter, Santa Fe County Fire, Los Alamos County Fire, Bernalillo County Fire, and Albuquerque Area Transport Units will be involved in EMS incidents in Sandoval County.

In order to achieve the goal of Quality Patient Care, it is critical that interactions between the services be predictable and consistently professional. These guidelines were developed with the intent of facilitating optimal patient care, patient transfer, and scene flow, and so that all field providers can approach scenes with the same expectations and cooperation.

➢ Responders and EMS Providers from the County or Municipal Fire District from where the request for service originated are responsible for initially assuming command of the scene and directing patient care and assessment. This may include:
  • Obtaining patient consent for further treatment and transport if necessary.
  • Requesting additional personnel, specific fire and/or rescue equipment and/or units.
  • Upgrading, downgrading, or canceling incoming units.
  • Obtaining and completing all required documentation.

➢ The first arriving unit will relay any necessary information regarding the scene and incident to subsequent arriving units.

➢ The first arriving EMS Provider with the highest level of EMS training will assume charge of and direct patient care.

➢ Upon arrival of the transporting unit, they shall receive at least an oral report then assume patient care responsibility.

➢ First arriving and primary care providers will continue to assist in patient care under the direction of the transporting EMS Providers.

➢ All agencies will assist each other in every possible way, however, due to risk management considerations, any time there is a patient on a stretcher, employees from that agency will facilitate/supervise proper loading and unloading operations of the stretcher providing for patient safety at all times. Other personnel on scene will be utilized to help lift in the interest of patient/provider safety and comfort.

➢ If a patient has been loaded into the transport unit prior to the County district volunteer providers’ arrival, it is appropriate for the arriving personnel to inquire if they can be of any assistance. Transport will generally not be delayed in order for information gathering and/or report writing if the patient is loaded and ready for transport.

➢ If, in the judgment of the transport provider the transport situation requires additional EMS Providers, Sandoval County Fire Department and/or other personnel may be asked to accompany the patient to the hospital in the transporting unit, and should comply for optimal patient care.

➢ The Sandoval County EMS system follows the Incident Command System structure. Be familiar with the ICS and be able to execute it when called for.
### CONTINUOUS QUALITY IMPROVEMENT/ASSURANCE (CQI/CQA)

**Effective 4/1/17**

#### Departmental Guidelines
- One hundred percent of EMS reports are reviewed by the QI Coordinator. Reports meeting certain criteria (i.e., pediatric transports, code three returns, invasive ALS procedures) will also be sent to the Medical Director for review.
- The CQI/CQA process will be done via the ePCR system ImageTrend.
- Any minor guideline discrepancies will be discussed via the QI note in ImageTrend.
- If a specific QA form needs to be generated by departmental personnel, the form will be forwarded to the Department Director who will then include the Medical Director.
- Any significant discrepancies will require immediate notification of the medical director.

#### Medical Director Guidelines
- EMS runs will be reviewed quarterly or more at the discretion of the Medical Director.
- Case Reviews will be held a minimum of 2-3 times per year. During these sessions, interesting or problematic runs will be discussed and any potential teaching points will be made. These reviews may be combined with other in-service training.
- JPEMS Personnel must attend a minimum of two (2) Medical Director case reviews annually in order to be considered “active” for eligibility to provide patient care where “Medical Director Approval” is required within these treatment guidelines and to be considered eligible for license renewal.

### SITUATIONS REQUIRING IMMEDIATE DIRECTOR & MEDICAL DIRECTOR CONTACT

**Effective 4/1/17**

- The UNM EMS Consortium and Emergency Room Physician is the preferred method of contacting MCEP for these guidelines.
- However, in specific circumstances, it is imperative to notify JPEMS Medical Director Jenna White, MD immediately along with the JPEMS Director.
- Providers are required to immediately contact the **JPEMS Director through dispatch** as soon as possible in the following circumstances. Once the Director is briefed, he will advise the provider what to do next. Either he will contact Dr. Jenna White by phone (708-214-7272) or will have the provider call Dr. White directly:
  - Injury of EMS provider requiring transport or evaluation at hospital
  - Any pediatric cardiac arrest
  - Any incident of medical error, equipment malfunction, or accidental harm inflicted to patient
  - Event involving celebrity, politician, or senior leadership of our organization
  - Any event requiring CISD for providers
  - Event that results in request from media for comment
  - EMS vehicle accident resulting in injury to a citizen
  - Suspected drug diversion
- If Dr. White is not available, contact the UNM EMS CONSORTIUM (505-449-5710)
<table>
<thead>
<tr>
<th>MEDICAL CONTROL/EMS CONSORTIUM PHYSICIANS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective 4/1/17</td>
</tr>
</tbody>
</table>

EMS providers in Sandoval County provide care under their own license. These guidelines are permitted as written as indirect medical control orders and are permitted without direct contact unless otherwise stated within. Direct Medical control is when a physician is in direct communication with the prehospital provider at the time care is being given.

Guidelines for On Scene Direct Medical Control

- If pre-established physician-patient relationship exists and this physician is on scene, it shall take precedence over these guidelines, and said physician shall have direct medical control until he/she expressly relinquishes it to the MCEP. The EMS providers are not bound to follow the orders of this physician, but instead are governed by these guidelines. Every reasonable effort should be made to assist in patient care.

- A physician physically present at the scene who offers to assist in the patient’s care may be allowed to do so if the following conditions are met:
  - The physician identifies self to the EMS provider in charge of patient care as a currently licensed physician in the State of New Mexico.
  - The physician agrees to accompany the patient to the hospital and to provide care until care can be appropriately transferred to hospital medical staff.
  - The physician agrees to sign the EMS Run Form in the "Medical Control" space.
  - If the on-scene medical intervention orders conflict with these guidelines, they shall be placed in contact with the MCEP. If a conflict remains, the EMS personnel shall be obligated to carry out the orders of the MCEP.
  - Emergent Direct Medical Control is available by contacting the MCEP at any hospital with an Emergency Department. It is preferable to make contact with the MCEP at the hospital to which the patient is being transported, but this is not always possible.

MCEP/EMS CONSORTIUM CONSULT

EMS providers are encouraged to request a physician consult for patients that they feel might merit the immediate attention of the receiving Emergency Department Physician, or for on-scene decisions such as patient refusals. When requested, a direct report from the EMS provider to the Physician should be accomplished soon after the patient arrival in the ED. This guideline is intended for both medical and trauma related events. Document all MCEP/EMS CONSORTIUM encounters on the run form including MCEP/EMS CONSORTIUM physician name.

EMS CONSORTIUM PHYSICIANS CAN BE REACHED THROUGH AAS BASE 505-449-5710

Use of the EMS Consortium Emergency Physicians should be for challenging clinical situations or complex refusals. Routine physician consultations should be through your local Emergency Department Physician. On-scene orders received by field providers for a Consortium Physician should be signed for BY THAT PHYSICIAN prior to transport to patient’s receiving hospital, unless the Physician is going along to the hospital or meeting the crew at the hospital.

Involvement of Consortium Physicians in on-scene patient care in no way mandates transport of a patient to UNM facilities.

Consortium Physicians will respond to scenes based on their internal protocols or if requested by EMS personnel. Once on-scene, the Consortium Physician will interact equally with all providers.
CONTROL OF PATIENT CARE

Effective 4/1/17

➢ The individual with the highest level of training is in control of patient care while awaiting a transport unit.
➢ In the event that EMS Providers have the same level of training, the person arriving first on the scene shall be in control of patient care until the transporting crew arrives on scene. At this point, the transport crew shall assume control of patient care and should receive a patient report from the most appropriate on scene EMS Provider.
➢ Providers from outside a given district will be subordinate to providers from the district in which a call originates UNLESS:
  • The patient has been turned over to an outside transport service.
  • A provider of higher training level arrives from a service or district with whom there is a mutual aid agreement.
  • A provider of a higher training level who is known to be licensed in New Mexico arrives on a scene and has permission to treat from the local medical director.
➢ The rank structure for medical care (ICS should still take place when necessary):
  • Local EMS Physician
  • EMT-P
  • EMT-I
  • EMT-B
  • First Responder

*A person who is a recognized active EMS service member, but not an EMT, may assist in patient care up to and within that provider’s scope of practice, BUT only up to the level of the highest pre-hospital provider on scene, subject to the direction, control and approval of the on-scene EMS provider. The presence of other health care providers does not release an EMS service from the staffing requirements as outlined by the Public Regulatory Commission.
DOCUMENTATION OF PATIENT CARE

An EMS run report will be generated for every patient encounter. The DCHARTE format will be used as a guideline for the narrative section of the report. The lead provider will be responsible for ensuring that a Department and Medical Director approved ePCR is generated.

The names of all crewmembers or EMS Providers who participated in patient care should be included in the ePCR or an associated NFIRS report.

When possible, the names of the providers (if known) from whom the transporting medic unit assumes care should also be noted.

Any changes or additions to a report after it has been signed will be documented as an addendum.
- This will include the term: “Addendum,” followed by Time and Date. Then the specific items can be added, followed by the writer’s initials.

All non-patients and patients that are NOT transported will be documented on an EMS Liability Release Form as well as an EMS report form via ePCR.

All reports are confidential and all information will be treated as such and only released as applicable by local, state and federal law. All reports that contain patient information will be kept in a secure area to ensure confidentiality.

Patient reports will be uploaded in the ePCR provider’s site for hospital access within four (4) hours immediately following the unit’s back in service time.

All reporting shall be appropriately documented using approved ePCR software in accordance with State Law and Department guidelines.
DO NOT RESUSCITATE / ADVANCED DIRECTIVES

Effective 4/1/17

LIVING WILL OR OTHER NON-EMS DNR (Physician, Hospital, Nursing Home DNR)

➢ Initiate basic life support (CPR).
➢ Review the document while contacting the EMS Consortium (505-449-5710).
➢ If written documentation is not available, treat to your appropriate level of care and contact the EMS Consortium (505-449-5710).
➢ Continue basic life support and await EMS Consortium Physician Order.

EMS DNR

➢ Basic life support shall proceed until the document is presented.
➢ Once presented, verify the document/marker has appropriate signatures and patient identity.
➢ Once verified, the care provider must proceed as follows:
➢ If the patient is in respiratory and/or cardiac arrest, do not perform:
  • External chest compressions
  • Artificial ventilation
  • Intubation or other advanced airway adjuncts
  • Defibrillation or pacing
  • Cardiac medications

NEW MEXICO MOST (MEDICAL ORDERS FOR SCOPE OF TREATMENT)

The MOST is an advance directive that is written in the form of a physician order. It is designed to be a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining and resuscitative measures. It is a portable, authoritative and immediately actionable physician order that is consistent with the individual’s wishes and medical condition and should be honored across all treatment settings.

➢ If the patient is not in arrest, EMS care providers may administer the following, as long as the patient or authorized decision-maker does not refuse.
  • Basic Airway Management and O2, excluding advanced airways
  • Control of bleeding
  • Paramedics and Intermediates may administer analgesics, as appropriate.
  • Other comfort care to assist the patient

Note: Generally, a Living Will or other advance directive does not exclude palliative care and/or comfort measures.

➢ If a written EMS-DNR or Living Will is provided and honored, attempt to maintain possession or obtain a copy of said document for inclusion into the patient’s medical record.

The patient may revoke the EMS-DNR at any time verbally or by defacing the written order or bracelet. Should this occur, every action consistent with the standard of care should immediately be taken and the EMS Consortium shall be contacted (505-449-5710).

DNR orders should not be followed in cases of suspected homicide or attempted suicide.

➢ Penetrating traumatic arrests with a transport time of more than ten minutes
➢ Sustained time down prior to arrival with presenting rhythm of Asystole in warm adults

Note: Hypothermic arrests, near-drowning events, and most medical pediatric arrests deserve full resuscitative attempts. Contact the **EMS CONSORTIUM (505-449-5710)** for direction as needed.
DEAD AT SCENE
Effective 4/1/17
Upon arrival at a scene in which the patient is obviously dead and resuscitation efforts would be to no avail, resuscitation efforts of any kind may be withheld on the decedent. The following criteria should be used:
➢ Presence of Rigor Mortis or Livor Mortis
➢ Obvious external exsanguination
➢ Decapitation
➢ Decomposition
➢ Visible brain matter in an apneic and pulseless patient
➢ Blunt traumatic arrests (after consideration of potentially reversible causes)
OFFICE OF THE MEDICAL INVESTIGATOR

Effective 4/1/17

The Unattended Home Death

- When a death occurs outside of a licensed nursing home or hospital facility and the private personal physician of the decedent does not attend the death, that death is considered an unattended death. By law, all unattended deaths fall under the jurisdiction of the OMI and it is necessary for the OMI to conduct a full investigation.

- In all cases of unattended death law enforcement must be contacted. EMS personnel will request law enforcement on all deaths. The scene will then be turned over to law enforcement and it will then be up to law enforcement to request OMI.

- All unattended deaths are to be considered a crime scene by EMS until told otherwise by law enforcement on scene. For this reason, extreme care must be exercised for preservation of the crime scene. Any medical equipment that is used on the patient should be left with the patient (example: IV lines, airway devices, etc.). If external blood loss is caused by EMS (example IV attempts) it should be noted in the EMS run report as well as verbalized to the first arriving law enforcement officer.

- The body of the deceased should not be moved until law enforcement is on scene. No one should be allowed to remain in the room of the deceased alone until law enforcement is on scene.

- An EMS field report/notes may be filled out on scene, and a copy left for law enforcement and OMI if requested.

Death of Potential Violent Origin

- In addition to all of the elements outlined in the Unattended Home Death guideline, extra awareness of crime scene preservation must be exercised.

- For motor vehicle accidents, this includes: skid marks, debris scattering patterns, clothing location, etc. EMS personnel should realize that on occasion simple placement of units (unmarked vehicles or privately owned vehicles) might place them into the crime scene and subject them to the control and authority of law enforcement on scene.
  - Weapons or sources of injury should not be touched, moved or altered in any way. The only exception to this is when EMS personnel on scene feel that there is a legitimate threat of harm for themselves or additional personnel on scene. In most cases, this means that the scene was not secure and probably should not have ever been entered. If the scene is not safe and you do not have the resources to make it safe, leave the scene.

Death on Native American Lands

- When a death occurs on Native American Land, assure that Tribal Officials, the police from the specific pueblo (if available), and/or BIA Police are notified and on the scene. The death will be handled by these officials in accordance to the laws and traditions of the specific pueblo, and may or may not involve the Office of the Medical Investigator. Please document the circumstances as appropriate, and leave the report for the law enforcement officials present.
### REPONSE IN PRIVATELY OWNED VEHICLES (POV)

**Effective 4/1/17**
- JPEMS providers should never respond to scenes in their POV (unless extenuating circumstances exist or a disaster is occurring)
- Volunteers with SCFD will sometimes respond in their POV’s and JPEMS providers should expect this.

### VACCINATIONS

**Effective 4/1/17**
To optimize the ability for County EMS personnel to administer immunologic agents within their own or surrounding departments based on New Mexico State Scope of Practice.

<table>
<thead>
<tr>
<th>ALL PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Administration of Immunizations, Vaccines, Biologicals, and TB skin testing is authorized under the following circumstances:</td>
</tr>
<tr>
<td>• To the general public as part of a Department of Health initiative or emergency response, utilizing Department of Health guidelines. The administration of immunizations is to be under the supervision of a public health physician, nurse, or other authorized public health provider.</td>
</tr>
<tr>
<td>• Administer vaccines to EMS and public safety personnel.</td>
</tr>
<tr>
<td>• TB skin tests may be applied and interpreted if the licensed provider has successfully completed required Department of Health training.</td>
</tr>
<tr>
<td>• In the event of a disaster or emergency, the State EMS Medical Director or Chief Medical Officer of the Department of Health may temporarily authorize the administration of other immunizations, vaccines, biologicals, or tests not listed above.</td>
</tr>
</tbody>
</table>
SECTION 2
TRANSPORT GUIDELINES
**GENERAL TRANSPORT CONSIDERATIONS**

*Effective 4/1/17*

**Medical Patients**
- Scene times should be kept to a minimum at all times.
- Procedures which are deemed critical should be initiated at the scene.
- Less critical procedures should be performed enroute when possible.

**Time Sensitive Medical Conditions**
If the patient is exhibiting signs and symptoms suggesting one or more of the following, initiate rapid transport to a core facility:
- Stroke
- STEMI / suspecting cardiac ischemia
- Aortic emergencies
- Pregnancy complications

**Trauma Patients**
- Scene times should be kept to a minimum at all times.
- Procedures which are deemed critical should be initiated at the scene.
- Less critical procedures should be performed enroute when possible.
- Trauma patients meeting the following criteria should be transported to the highest level of trauma center available, which is UNMH, though St. Vincent's or San Juan Regional may be considered if geographically much closer:
  - GCS <14
  - Systolic BP <90mm Hg
  - Respiratory rate <10 or >29 in an adult (or <20 in an infant less than 1 year), or if ventilatory support is needed
  - All penetrating injuries to the head, neck, torso, and extremities proximal to the elbow or knee
  - Chest wall instability or deformity (e.g. flail chest)
  - Two or more proximal long-bone fractures
  - Crushed, degloved, mangled, or pulseless extremity
  - Amputation proximal to wrist or ankle
  - Pelvic fractures
  - Open or depressed skull fractures
  - Paralysis
- Trauma patients who do not meet any of the above criteria, but who have sustained a significant mechanism or injury, or who were involved in a motor vehicle collision where another passenger was killed, can be transported to UNMH, St. Vincent, or San Juan Regional.
- Pediatric patients should preferentially be transported to UNMH
- Any full-thickness burn, partial thickness burns >20% TBSA and those involving joints, the face, the airway, the genitalia, or that are circumferential around an extremity should be transported to UNMH
INVOluntary Restraint & Transport

**Effective 4/1/17**

The application of mechanical restraints is allowed only when all less restrictive measures of controlling a violent, combative and/or uncooperative patient, regardless of cause, have failed, and the patient’s behavior continues to pose a threat to self, the crew or others. Under State Law 24-10B1, EMS Systems ACT, Section 24-10B-13, any person may be transported to a health care facility by an EMT when the EMT makes a good-faith judgment that the person is incapable of making an informed decision about his own safety or need for medical attention and is reasonably likely to suffer disability or death in the absence of medical intervention available at such a facility.

MCEP/EMS CONSORTIUM may be needed to determine if a patient should be transported against their will. Contact the EMS Consortium (505-449-5710) early in these situations and provide the on call physician with as much information as possible so a proper decision can be made. If Law Enforcement needs to use handcuffs or the patient is judged dangerous despite restraint, police will accompany the patient in the back of the transport unit. If a law officer refuses, this should be documented on the patient report. Consider a 2nd EMT in the back of the transport unit for added EMT protection and as a witness when the patient is physically or chemically restrained.

**ALL PROVIDERS**
- Establish Primary Management including LOC.
- Request law enforcement at the earliest opportunity.
- Ensure the presence of sufficient personnel to safely apply restraints.
- Explain to the patient and family why restraints are necessary.
- Apply restraints in a humane manner, affording the patient as much dignity as possible.
- Use the least restrictive method of restraint necessary to protect the patient and still insure provider safety during transport.
- Restraint devices that are appropriate for EMS utilization include: soft restraint, spine board, KED, vacuum splint, soft gauze, blankets and sheets.
- Prone or “hobble” restraints are not appropriate for EMS.
- Obtain vital signs at the earliest opportunity.
- Identify and treat reversible causes.
- All restrained patients require continuous monitoring and reassessment.
- Take a brief history, including drug / alcohol use, medication usage and mental illness.
- Careful documentation including treatment, names of officers, witnesses and the MCEP/EMS CONSORTIUM should be included in the ePCR.
- For Agitation, refer to the Altered Mental Status Guideline as needed.
**HELCOPTER USAGE**

**Effective 4/1/17**

Helicopters are generally used to expedite patient transport. However, helicopters can be requested if rapid ALS is needed or the patient is in need of advanced care beyond the JPEMS Paramedic scope (Blood, chest tube, RSI, additional medications, etc.)

Conditions in which providers may request helicopter transport include but are not limited to:

- Extended ground transport times that can be detrimental to the patient
- Multiple victims
- Disaster situations
- Inability of ground personnel to manage and/or transport adequately.
- Patients in situations where ground transport is compromised
  - Mechanical failure, remote location, poor road conditions, etc
- Trauma victims with long extrication times
- Requests shall be made via Fire Control

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**RESCUE UNIT TRANSPORT TO HOSPITAL**

**Effective 4/1/17**

On occasion, it is necessary that registered medical rescue units transport patients. This may occur if no certified ambulance service is available or in an MCI situation. This is permissible and encouraged if in the best interests of the patient(s). The transporting vehicle must be configured as an ambulance with an enclosed patient compartment. There must be a minimum of one EMT-B in the patient compartment. Request ALS intercept anytime if the patient's condition warrants.

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**RESCUE UNIT TRANSPORT TO INTERCEPT**

**Effective 4/1/17**

Emergency transport of a critically ill/injured patient to the nearest appropriate certificated ambulance service may be appropriate in the following conditions and only after all appropriate assessment and treatment modalities have been initiated. The Medical Rescue vehicle must comply with the intent of Regulation 18 NMAC 4.2 regarding minimum equipment requirements.

Situations that are permissible include:

- The nearest appropriate certificated ambulance provider is greater than 15 minutes away.
- There is a life threatening patient presentation including but not limited to:
  - Acute respiratory distress
  - Overdoses resulting in unconsciousness
  - Critical burns, as defined within the guidelines
  - Multi-Systems Trauma with hemodynamic instability
  - Penetrating Trauma to the head, neck, chest, abdomen
- Transporting a critical patient to a helicopter landing zone may be appropriate if the patient has one or more of the above conditions.
ALS INTERCEPT

Effective 4/1/17

Advanced Life Support intercept is necessary when a patient transported by a rescue or ambulance needs care from a provider of a higher training level. The benefit should outweigh the risk of time delay and roadside danger.

➢ This should be arranged as far in advance as possible.
➢ A safe rendezvous location and time should be arranged over the radio.

CHOICE OF HOSPITAL

Effective 4/1/17

➢ Sandoval County, being primarily a rural setting, lends itself to long transport times. The patient’s choice of hospitals will often take the transport unit out of service for a longer period of time without adequate coverage for its district. All efforts should be made to reasonably shorten the time at the hospital and return to district.
➢ In cases of medical cardiac arrest, the patient should be transported to the closest facility capable of caring for the patient.
➢ Patients without a preference should be transported to the closest facility capable of treating the patient.

DIVERSION OF EMS UNITS

Effective 4/1/17

All hospital systems must work to keep their facilities on an open status, however hospitals may divert within their own hospital system. Current guidelines for patient destination should be maintained including patient request and closest hospital.

Cardiac arrest or unstable airway patients will still go to the closest appropriate facility, unless they are on “totally closed”. MCI guidelines may alter the patient destination decisions.

If a circumstance arises when a field paramedic feels it is mandatory to override a divert because of risk to the patient or provider, they should advise the receiving hospital that they are overriding and give a med report and ETA. These cases will prompt mandatory QI reporting to the appropriate medical director and JPEMS Director.

If a unit is on the property of a hospital (crosses the driveway), you should not leave the facility. Advise the facility you are already on the hospital grounds.
MINOR (UNDER 18 YEARS) TRANSPORT GUIDELINES

Effective 4/1/17

For a minor to make a decision regarding healthcare, they must be emancipated. To be legally emancipated, they must be at least 16 years of age and:

- Married
- Divorced
- Active military
- Legally declared emancipated in a court of law.

Pregnancy in and of itself does not emancipate a minor.

- An emancipated minor can make decisions for her minor child.
- When in doubt, contact an MCEP.

Notes: When dealing with the emancipation issues, document statements made by the parties involved when the appropriate documentation (marriage certificate, court order, etc.) is not readily available. Remember to err on the side of patient care.

THE LAWS SURROUNDING EMANCIPATED MINORS IN NEW MEXICO:

24-7A-6.2. Consent to health care for certain minors fourteen years of age or older.

A. An unemancipated minor fourteen years of age or older who has the capacity to consent may give consent for medically necessary health care provided that the minor is:
   (1) living apart from the minor’s parents or legal guardian; or
   (2) the parent of a child.

B. For purposes of this section, "medically necessary health care" means clinical and rehabilitative, physical, mental or behavioral health services that are:
   (1) essential to prevent, diagnose or treat medical conditions or that are essential to enable an unemancipated minor to attain, maintain or regain functional capacity;
   (2) delivered in the amount and setting with the duration and scope that is clinically appropriate to the specific physical, mental and behavioral health-care needs of the minor;
   (3) provided within professionally accepted standards of practice and national guidelines; and
   (4) required to meet the physical, mental and behavioral health needs of the minor, but not primarily required for convenience of the minor, health-care provider or payer.

C. The consent of the unemancipated minor to examination or treatment pursuant to this section shall not be disaffirmed because of minority.

D. The parent or legal guardian of an unemancipated minor who receives medically necessary health care is not liable for payment for those services unless the parent or legal guardian has consented to such medically necessary health care; provided that the provisions of this subsection do not relieve a parent or legal guardian of liability for payment for emergency health care provided to an unemancipated minor.

E. A health-care provider or a health-care institution shall not be liable for reasonably relying on statements made by an unemancipated minor that the minor is eligible to give consent pursuant to Subsection A of this section.

F. Nothing in this section shall otherwise limit the rights of an unemancipated minor to consent to treatment, nor shall this section be read to conflict with the rights of parents and children pursuant to the Children's Mental Health and Developmental Disabilities Act [32A-6A-1 NMSA 1978].


24-1-13. Pregnancy; capacity to consent to examination and diagnosis.

Any person, regardless of age, has the capacity to consent to an examination and diagnosis by a licensed physician for pregnancy.

MENTAL HEALTH PICK-UP ORDERS

Effective 4/1/17

The following procedure will apply when law enforcement receives a Certificate for Evaluation (Pick-up Order):

➢ The Police/S.O. supervisor will review the order and confirm the information on the order and the location to which the subject will be transported. If there is any missing information the Police/S.O. supervisor will confirm before attempting to serve the order.

➢ Once all the information is verified, the Police/S.O. supervisor along with at least one other officer will attempt to locate the individual. Upon contact with the individual, the Police/S.O. supervisor will advise them of the order and advise them they will need to be transported to the location in the order. The individual will be handcuffed for their safety BY the officers and placed in the back seat as per department procedures.

➢ If the Police/S.O. supervisor observes any medical condition that would require EMS to respond, the Police/S.O. supervisor will request EMS to respond and treat the individual prior to the officer transporting.

➢ If the patient has a medical condition, EMS will treat and transport if necessary, requesting that a Police/S.O. officer accompany in the patient compartment during the transport.

Note: Under NO circumstances will EMS attempt to execute and/or respond to a Pick-Up order at the request of Dispatch only. Police/S.O. units must be on scene and requesting EMS.
EMERGENCY DEPARTMENT PATIENT TURNOVER

Effective 4/1/17

➢ It is assumed that the responsibility for patient care reverts to the ED staff when the patient enters the ED, rather than after a formal turnover report. EMS personnel will strive to do what is right for the patient and keep continuity of care until report is given.
➢ It is expected that ED staff will receive pre-hospital personnel in a timely manner on arrival to ED and direct them to the appropriate bed or ED area.
➢ Pre-hospital personnel will assist in moving patient to the hospital gurney and give a complete pre-hospital report.
➢ It is expected that complete turnover will be completed within 15 minutes of ED arrival.
➢ If the above criteria is not met and the patient remains on the pre-hospital gurney greater than 15 minutes, pre-hospital personnel will seek a safe place to unload the patient. A complete handwritten chart shall be completed and left with the patient. The crew shall notify a medical member of the ED staff and provide a verbal report if possible. The crew shall then return to service.

EMTALA RISK

➢ When circumstances arise and an EMS transport unit is on a hospital’s property, the EMS unit will not divert to another hospital.
➢ If you get a divert order from the facility and you are on their property, you will advise the facility that you are on their property and will not be diverting.
➢ Upon arrival, advise the staff of the EMTALA risk and tell them that an internal quality assurance will be generated and will be reviewed by the medical director.
➢ Radio reports will be done as early as possible during transport to minimize EMTALA risk.
As emergency service providers, we should respond to all calls with the intention of providing appropriate pre-hospital patient care. At no time should we try to talk the patient out of going to the hospital. Whatever their decision, it must be theirs alone. If the patient asks you whether he/she really needs to go to the hospital, it is recommended that you tell them, “We can't make that determination. If you would like to go to the emergency room to be seen by a doctor, we will provide transportation for you to the hospital of your choice, if available”.

Certain criteria must be met before a patient may sign a refusal of treatment and/or transport:

**Age Criteria:**
- Adult - 18 years of age or older
- Emancipated Minor

**Patient Assessment Criteria:**
- Patient must be alert and able to maintain coherent thought and speech.
- Patient must be oriented and able to reference Time/Place/Person/Situation.
- Patient judgement must not be clouded with alcohol or drug use.
- Patient must not have evidence of suicidal tendencies and must not have evidence that they are a danger to themselves or others.
- Patient must not exhibit evidence of abnormal bizarre or psychotic thought behavior.
- Patient vital signs must be within normal limits.
- Patient must have a neurologic exam including coordination and gait that is normal or consistent with their past medical history.
- Patient must not have evidence of life or limb threatening injury or illness.
  - If above criteria are met and the patient refuses treatment or transport, they must demonstrate an understanding of their medical situation and the risks associated with refusal. They must be READ ALOUD the liability release and sign the appropriate areas either on hard copy or on ePCR.
  - If the patient does not meet the above criteria, attempt to persuade the patient of the need for treatment/transport. If the patient continues to refuse, consider transporting the patient involuntarily (see involuntary restraint and transport guideline).
- Consider contacting the EMS Consortium (505-449-5710) for complicated and high risk refusals (syncope, cardiac, ALTE, psych, substance abuse, pediatrics, etc.).
- Each Refusal shall be documented in ImageTrend including name, date of birth and demographics, even for non-patient refusals.
- If a paper refusal is being used, the document must be completed fully including all appropriate signatures to ensure the document is legal. This document shall then be uploaded and attached to the ePCR.
- If the refusal will be documented via the ePCR, appropriate signatures must be obtained on the signatures tab including witnesses.
- Documentation for refusal of treatment should include:
  - LOC: Patient is awake, oriented and able to comprehend the seriousness of their situation and unimpaired by drugs or alcohol.
  - Vital signs: Should be within normal limits. If they are not, advise the patient of the abnormality and document it in your narrative.
  - Careful explanation to the patient and/or family of the possible implications of the injury/illness including possibility of death, if applicable. Ascertain understanding of these consequences by the patient/family, and document this.
- Ask the patient or legal guardian to sign a refusal of treatment form or ePCR (the patient cannot be forced to do this).
  - Witness signatures (2) for refusal must be obtained, even if patient did not sign. It is preferable to obtain this from a family member, law enforcement, or another department member, but EMS personnel are adequate, if necessary.
➢ Advise that EMS can be called back to the scene if patient condition deteriorates or if patient reconsiders transport.
➢ If the patient is awake, oriented and able to comprehend the seriousness of the injury or illness and refuses treatment of a potentially life-threatening process, an attempt should be made to put the patient and/or family in contact with an MCEP.
➢ If the patient is ill/injured, but is not awake, not oriented, or not able to comprehend his/her illness (impaired from alcohol, drugs, head injury, chronic disease, etc.):
  • Law Enforcement should be summoned to assist and the patient should be transported based on the Involuntary Restraint and Transport guideline.
  • After MCEP/Police intervention, transport the patient if there is a reasonable possibility of danger to life or limb or the patient may not have access to care.
No person shall be refused treatment or transport because of inability to pay, race, color, creed, religion, or type of illness.
TRANSFER OF CARE RESPONSIBILITY & DELEGATION

Effective 4/1/17

- Generally, an EMS provider will remain with the patient and remain responsible for patient care until another licensed EMS provider of equal or higher training and capability receives an oral report and assumes responsibility for patient care.
- It will be the expectation that anytime a request for a JPEMS intercept occurs, the JPEMS unit will become the transporting unit and will release the requesting unit back into service upon transfer of patient care.
  - An exception to this guideline would be in the case of an MCI, even if a higher level of care is desirable, to ensure the greatest benefit for the greatest number of patients.
  - Inappropriate intercept requests will have a negative effect on the overall emergency system. If a Medic Unit is concerned regarding inappropriate requests for intercepts, a written QI request should be generated.
- Paramedics are not required to remain with a patient if ALS care has not been initiated, and is not warranted or required.
- A Paramedic may transfer care to an EMT-Intermediate level of care if there is no reasonable expectation that the patient will require a higher level of care following a full patient assessment and examination. However, the Paramedic is ultimately responsible for overall patient care after his/her visual assessment.
- Transfer to a lower level of care is acceptable in a MCI, even if a higher level of care is desirable, to ensure the greatest benefit for the greatest number of patients.
- Law enforcement has NO AUTHORITY in transport decisions unless a law enforcement officer elects to take a patient into custody. The law enforcement officer is then responsible for ALL actions and decisions occurring as a result of their direct orders. Liability and system consequences should be clearly relayed to law enforcement officers and documented in the ePCR. Whenever a conflict exists, contact the EMS CONSORTIUM (505-449-5710).
- EMS transport personnel will maintain being in charge and control of the patient after arrival at the hospital until:
  - Proper unloading has occurred. EMS personnel are solely responsible for unloading. Hospital personnel should stay outside the ambulance unless assistance is required.
  - A full patient report is provided to the appropriate receiving personnel.
TRAUMA DESIGNATION ALGORITHM - ALBUQUERQUE METRO

(FOR REFERENCE ONLY)

Effective 4/1/17

Category 1 Trauma
Assess physiologic status
- Hemodynamic compromise ¹
- Respiratory compromise ²
- Unconscious or deteriorating mental status

Category 2 Trauma
Assess anatomical injury
- All penetrating injuries to head, neck, torso, or proximal extremities³
- Flail chest
- Trauma with burns of 10% or > or inhalation injuries
- 2 or more suspected proximal long bone fractures
- Potential multi-system trauma
- Limb paralysis
- Amputation proximal to distal phalangeal joint
- Open or suspected depressed skull fracture
- Unstable pelvis or suspected pelvic fracture
- Altered mental status ⁴

Category 3 Trauma
Assess mechanism of injury and risk for occult injury
- Ejection from vehicle
- Death in same vehicle
- Falls > 15 feet
- Pregnant > 20 weeks
- Evidence of high energy event of clinical significance ⁵,⁶

If the patient has none of the indicators listed for Category 1, 2, or 3, then the patient meets “non-category” trauma criteria and may be transported to the requested or closest facility

Footnotes
¹. Hypotension, pallor, tachycardia, or diaphoresis
². Tachypnea (hyperventilation) alone will not necessarily initiate this level of response
³. Non-life threatening, minor injuries excluded
⁴. Altered mental status (secondary to sedative or hypnotic will not necessarily initiate this level of response)
⁵. High-energy event of clinical significance = large release of uncontrolled energy to patient. These events may include rollover crashes, motorcycle, ATV or bicycle crashes, auto versus pedestrian impacts, significant assaults or altercations, or extrication times > 20 minutes. Assume patient is injured until proven otherwise (multi-system injuries may be present) and exercise clinical judgment considering direction and velocity of impact, patient kinematics, physical size and vehicle damage. Age and co-morbid factors/conditions should be considered in triage level decisions.
⁶. IF a patient with evidence of a high energy event of clinical significance but without any clinical signs or symptoms of injury refuses transport to the trauma center and requests another facility, the paramedic will contact the MCEP-EMS CONSORTIUM at the requested facility and follow their guidance.
**TRAUMA & MEDICAL DESIGNATION – ST. VINCENT’S HOSPITAL**
(FOR REFERENCE ONLY)

Effective 4/1/17

St. Vincent’s Hospital in Santa Fe does not utilize the Category I, 2, 3 system. Instead, they simply refer to their trauma and medical patient’s as Stable, Serious, or Critical as per below. Additionally, crews should refer to the Trauma Stat activation guideline in the Appendix for further direction on transporting trauma to St. Vincent’s Hospital.

### Medical and Trauma Designation Criteria

<table>
<thead>
<tr>
<th>Designation</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stable</strong></td>
<td>Patient is stable, with no apparent risk of developing a life-threatening or disabling condition. Non-emergent transport is appropriate.</td>
</tr>
<tr>
<td><strong>Serious</strong></td>
<td>Patient is at moderate risk of developing a life-threatening or disabling condition. Most circumstances will merit non-emergent transport.</td>
</tr>
<tr>
<td><strong>Critical</strong></td>
<td>Patient has a severe and acute life-threatening or disabling condition. Immediate intervention is required. Emergency transport is at the EMS provider's discretion. Examples include penetrating and/or blunt trauma injuries to chest and/or abdominopelvic cavity with unstable vitals, or if patient presents with vitals indicating s/he is likely to deteriorate.</td>
</tr>
</tbody>
</table>
UNMH OPERATION ROOM SATURATION PROTOCOL

Effective 4/1/17

➢ As the area’s only trauma center, UNMH is in the position to be overwhelmed by multiple trauma patients. Although a clear distribution plan exists for single MCI’s, multiple serious incidents could also result in a compromise in patient care. For those reasons, UNMH and Albuquerque Ambulance Base (AAS) will work in conjunction to distribute patients to other core facilities as necessary.

➢ Because all EMS units report into UNMH via the Lifeguard dispatch center, Lifeguard has the unique ability to match the resources available in the ER with inbound patients.

➢ Albuquerque Ambulance Base, once notified that UNMH bannered an OR SATURATION:
  • Albuquerque Ambulance Base will facilitate all category trauma patients diverting to other facilities.
    o AAS will reach out to units transporting to UNM to ascertain if the patient is a trauma patient and which color they are (Red, Yellow, Green) and, if so, inform them of the OR SATURATION and the new designated destination for that unit.
    ▪ Units should inform Albuquerque Ambulance Base if they are transporting a pediatric or OB patient.
  • Albuquerque Ambulance Base will distribute all incoming trauma patients to the appropriate facilities, determined by the MCI Distribution plan and the current usage in the system both in the field and in hospital.
    o If diverted, pediatric patients should be distributed to Presbyterian whenever possible due to PICU capabilities.
    o OB patients can be transported to Presbyterian, Lovelace Westside, Rust, or Women’s hospitals for NICU capabilities.
  • Medical Patients will continue to be transported to the initially intended facility.
  • Lifeguard or UNMH will cancel the OR SATURATION in conjunction with UNMH staff, and notify AAS as the situation resolves.
  • Sandoval County units should consider facilities north of the Albuquerque Metro if appropriate in these situations.
In the event that 4 patients or more are needing to be transported to the hospital from the same incident, the following steps will be completed:

- First arriving will notify the duty officer (if not already done)
- Duty officer or designee will banner the event (EMSystems)
- Patients will be distributed according to the following algorithm

**IMMEDIATEs (CRITICAL)**

**FIRST WAVE**
- **TIER I HOSPITAL**
  - UNMH
  - 4 RED PATIENTS ARE TRANSPORTED TO UNMH IN THE FIRST DISTRIBUTION

**TIER II HOSPITALS**
- PRES DT-LOVELACE DT-RUST
  - (CONSIDER TRAVEL TIMES)
  - 2 RED PATIENTS PER FACILITY

**TIER III HOSPITALS**
- WOMENS-SRMC-HEART-KASEMAN-WEST MESA
  - (CONSIDER TRAVEL TIMES)
  - 1 RED PATIENT PER FACILITY

**DELAYED**

**(STABLE, INJURED, NON-AMBULATORY)**

- PATIENTS THAT ARE STABLE SHALL NOT DELAY THE TRANSPORT OF RED PATIENTS
- DELAYED PATIENTS SHOULD BE EVENLY DISTRIBUTED TO TIER II AND TIER III FACILITIES FIRST IF FEASIBLE.
- DELAYED PATIENTS CAN BE TRANSPORTED WITH RED PATIENTS AT THE DISCRETION OF THE TRANSPORTING CREW AND TRANSPORT OFFICER

**MINOR (WALKING WOUNDED)**

- PATIENTS THAT ARE STABLE SHALL NOT DELAY THE TRANSPORT OF RED PATIENTS
- CONSIDER USE OF PATIENT POV OR OTHER MEANS (BUS/VAN/ETC.) FOR MINOR PATIENTS REQUESTING TRANSPORT
- TREAT PATIENTS ON SCENE UNTIL TRANSPORT BECOMES AVAILABLE
- MINOR PATIENTS SHOULD BE EVENLY DISTRIBUTED TO TIER III FACILITIES FIRST IF FEASIBLE
- MINOR PATIENTS CAN BE TRANSPORTED WITH RED PATIENTS AT THE DISCRETION OF THE TRANSPORTING CREW AND TRANSPORT OFFICER

**SUBSEQUENT WAVES**

- 2 RED TO TIER I FACILITY
- 2 RED TO TIER II FACILITIES
- 1 RED TO TIER III FACILITIES
- REPEAT AS NEEDED

**KEY POINTS**

1. Remember that treatment and transport of RED patients without delay is priority
2. Consider transport to Tier II / Tier III first for RED patients if transport time is extended and the extra time to Tier I will be detrimental to the patient
3. Command page is required for all MCI events
In the event that 4 patients or more are needing to be transported to the hospital from the same incident, the following steps will be completed:

- First arriving will notify the duty officer (if not already done)
- Duty officer or designee will banner the event (EMSSystems)
- Patients will be distributed according to the following algorithm

**IMMEDIATE (CRITICAL)**

**FIRST WAVE**

- TIER I HOSPITAL
  - UNMH
  - 4 RED PATIENTS ARE TRANSPORTED TO UNMH IN THE FIRST DISTRIBUTION

**TIER II HOSPITALS**

- PRES DT-LOVELACE DT-RUST-ST VINCENT-LOS ALAMOS-FARMINGTON (CONSIDER TRAVEL TIMES)
  - 2 RED PATIENTS PER FACILITY

**TIER III HOSPITALS**

- WOMENS-SRMC-HEART-KASEMAN-WEST MESA-CROWNPOINT (CONSIDER TRAVEL TIMES)
  - 1 RED PATIENT PER FACILITY

**DELAYED (STABLE, INJURED, NON-AMBULATORY)**

- PATIENTS THAT ARE STABLE SHALL NOT DELAY THE TRANSPORT OF RED PATIENTS
- DELAYED PATIENTS SHOULD BE EVENLY DISTRIBUTED TO TIER I AND TIER III FACILITIES FIRST IF FEASIBLE
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- MINOR PATIENTS SHOULD BE EVENLY DISTRIBUTED TO TIER III FACILITIES FIRST IF FEASIBLE
- MINOR PATIENTS CAN BE TRANSPORTED WITH RED PATIENTS AT THE DISCRETION OF THE TRANSPORTING CREW AND TRANSPORT OFFICER

**SUBSEQUENT WAVES**

- 2 RED TO TIER I FACILITY
- 2 RED TO TIER II FACILITIES
- 1 RED TO TIER III FACILITIES
- REPEAT AS NEEDED

**KEY POINTS**

1. Remember that treatment and transport of RED patients without delay is priority
2. Consider transport to Tier II / Tier III first for RED patients if transport time is extended and the extra time to Tier I will be detrimental to the patient
3. Command page is required for all MCI events
SECTION 3
GENERAL GUIDELINES
A complete assessment up to the responder's capability includes the following, as appropriate:

- Level of consciousness and Mental Status exam
- History of present injury or illness
- Pertinent past medical history
- Physical exam including lung sounds
- Neurological exam, including pupillary reaction, coordination and general movement
- Vital Signs, including:
  - Respiratory effort, rate and depth
  - Pulse rate, strength, regularity, and site
  - Blood Pressure
  - Oxygen Saturation
  - BGL
  - CO
  - Temperature
  - Skin color / temperature
  - Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable
- Full documentation on appropriate EMS response form
### PRIMARY MANAGEMENT GUIDELINE

**Effective 4/1/17**

ENSURE PATIENT AIRWAY, BREATHING, VENTILATION AND CIRCULATION

<table>
<thead>
<tr>
<th>GENERAL</th>
</tr>
</thead>
</table>
| ➢ Reference General Assessment  
➢ Basic Airway Maneuvers and Oxygenation  
➢ LMA or similar device  
➢ Pertinent medical history  
➢ Vital Signs  
➢ If available, capnometry/capnography  
➢ Patient Positioning  
➢ CPR  
➢ AED |

<table>
<thead>
<tr>
<th>ALL PROVIDERS</th>
</tr>
</thead>
</table>
| ➢ Advanced Airway  
➢ CPAP |

<table>
<thead>
<tr>
<th>BASIC</th>
</tr>
</thead>
</table>
| ➢ Peripheral IV access, for fluid and/or medication administration  
➢ Establishment of pediatric intraosseous (IO) vascular access as defined by State Regulations and current PALS  
➢ Establishment of adult intraosseous (IO) vascular access |

<table>
<thead>
<tr>
<th>INTERMEDIATE</th>
</tr>
</thead>
</table>
| ➢ Suction (endotracheal)  
➢ Laryngoscopic visualization  
➢ Magill forceps manipulation  
➢ Nasotracheal intubation (blind or visualized) – age 13 or greater  
➢ Endotracheal intubation – age 13 or older  
➢ Automatic Transport Ventilator, if available  
➢ Stomal intubation  
➢ Surgical Cricothyrotomy  
➢ Needle chest decompression  
➢ Utilize pre-existing vascular access as primary site, as necessary: ACLS as per specific guidelines, defined herein or per current ACLS. |
ADMINISTERING A PATIENT’S OWN MEDICATIONS

**Effective 4/1/17**

**GENERAL**

The only situation in which this guideline should be put to use is when (1) an EMS Provider arrives on scene and does not have these medications in their response pack, (2) the additional personnel who do have these medications are delayed, and (3) the delay is deemed detrimental to the patient.

Medications allowed are:

- Bronchodilators (such as albuterol inhalers) for acute bronchoconstriction
- Epi-Pen for life threatening bronchoconstrictive conditions
- Nitroglycerin for pain from suspected acute coronary syndrome.

Administering a patient’s own medication may be performed only when the EMS Provider:

- Establishes that medications are the patient’s, are not expired and that they are for the current appropriate complaint.
- Asks the patient if they have taken these or any other medication as of yet and if so, how much.
- Obtains a list of the medications that the patient is prescribed.
- Obtains a complete set of vital signs
- Contact the EMS CONSORTIUM (505-449-5710). If the physician agrees, the EMT may appropriately administer the medication.
  - If EMS Consortium contact is impossible, and the patient is suffering from a life-threatening allergic or bronchial constriction process and will benefit from the administration of the patient’s Epi-Pen or bronchodilator, then the EMT may administer these drugs per the prescription instructions.
  - If the EMT is considering the administration of nitroglycerin, the EMT must have MCEP/EMS Consortium contact. If this contact is impossible, nitroglycerin may not be administered.
EZ-IO GUIDELINE
Effective 4/1/17

For use in patients where rapid access is needed and peripheral IV access is difficult or limited.

Contraindications for use include:
➢ Fracture proximal to the proposed insertion site
➢ History of Osteogenesis Imperfecta (brittle bone disease)
➢ Current or recent infection at proposed insertion site
➢ Previous joint replacement at proposed insertion site
➢ Previous IO insertion/attempt within past 24 hours at proposed insertion site
➢ Inability to locate landmarks or excessive tissue

The Easy IO should be your IO of choice in most patients for the services that have them. The Jamshidi IO Needle will be the primary device for those services that do not carry the Easy IO as well as being the back-up needle for those who carry the Easy IO.

Providers may provide an initial flush of 1cc (20 mg) of 2% Lidocaine to the adult patient:
• infuse over 15-30 seconds
• follow with a 10 cc NS flush
• an additional 1 cc (20 mg) of 2% Lidocaine may be administered following the NS flush to help with any additional pain

Acceptable ADULT sites include:
• Humeral head
• Proximal tibia
• Distal tibia

Acceptable pediatric sites include
• ONLY the proximal tibia

Lidocaine may be used in Pediatric Patients as well as outlined above

Acceptable sites for all patients include:
• Humeral head
• Proximal tibia
• Distal tibia
Firefighters die of stress and overexertion illnesses more often than burns/injuries from structural events. Key principles of Emergency Incident Rehabilitation (EIR) include the following:

- Adequate hydration and rest should be maintained at all times while on shift.
- Provide continuous medical monitoring to allow early identification of stress and heat related illness.
- Immediately ID and treat any potentially serious medical condition detected during an emergency incident.
- Treat traumatic injuries.
- Baseline VS should be recorded for all FF prior to their involvement in an incident, if possible.
- Keep resting and post-aerobic VS for each member confidential but accessible to the rehab sector.
- Pay special attention to members on beta-blockers, calcium channel blockers, or diuretics as those drugs alter one’s response to heat and cardiovascular stress.
Establish Primary Management

- Gather vital signs, HR, BP, Pulse Oximetry, CO (when available). If HR > 120, consider obtaining tympanic temperature and record it.
- Question personnel and evaluate for medical history and current symptoms.
- Based on the assessments and re-assessments of the personnel, there can be several dispositions as follows:
  - Triaged to Rest and Rehabilitation:
    - Reassess VS after 20 minutes; if within normal limits, may return to duty.
    - If cannot take or keep down oral re-hydration, reassign to treatment area.
  - Triaged to Medical Evaluation and Treatment Area:
    - If FF has injuries, HR > 120 at entry, BP > 200 systolic or between 100 - 120 diastolic, or < 90 systolic, re-assess VS after 10 - 20 minutes and log VS.
    - If after 20 minutes with oral re-hydration and rest VS have not returned to normal, remove from duty.
    - If HR > 140 after approximately 20 minutes, or cannot take or keep down oral fluids, initiate IV, NS 1 L bolus, and re-assess. May repeat twice prior to MCEP/EMS CONSORTIUM consultation. If HR, BP, temp return to normal and FF is able to take oral fluids and keep them down, may return to duty.
  - Immediate Transport to Hospital Required:
    - If temperature is > 101, HR is > 140 after 20 minutes, or any of the following signs or symptoms of heat exhaustion/stroke or other serious illness are present:
      - Headache
      - Vomiting
      - Chest Pain
      - SOB
      - Altered Mental Status
    - Irregular pulse
    - Pulse > 140 after cool down
    - Systolic BP > 200 after cool-down, and diastolic > 130 at any time
    - If transport is initiated, reference the appropriate guideline for treatment

General Guidelines for Rehab:

- Unusual symptoms such as excessive salivation, runny nose, and diarrhea may indicate organophosphate exposure/poisoning. Burning eyes could indicate exposure to chemicals or metal gases. These and any other unusual symptoms should be reported to IC immediately.
- Adequate water, electrolyte containing fluid and energy containing carbohydrates should be available. Do not provide products that contain caffeine. Cool fluids and shade in warm weather should be a goal, as should warm fluids, warm rehab area in cold weather.
- Notify IC of disposition of personnel, per Department SOG.
**GENERAL**

**TASER PROBE REMOVAL**

Effective 4/1/17

- Establish Primary Management
- Cardiac monitor to capture rhythm and obtain 12 lead ECG, if available/applicable
- Confirm that the Air Taser has been shut off and is no longer connected to the TASER.
- Obtain vital signs at the earliest opportunity. Violent and combative behavior may be secondary to hypoxia, hypoglycemia, or CNS abnormalities.
- Treat trauma and seizure, if applicable.
- If patient is not alert, transport to hospital will be required.
- Evaluate the anatomical location of the probe(s) puncture zones. High-risk/sensitive zones will require transport to a medical facility for removal. They include:
  - Head region including eyes and ears; Neck region; Breast; Groin region; Hands or Feet; Joints
- Make sure that the EMS Provider stabilizes the hand against the body of the subject during probe removal and is at least eight inches away from the probe in order to avoid “raking” the barbed tip across the hand.
- Examine the probe and the patient closely in an effort to make sure the probe tips did not break off during removal.
- Thoroughly clean the puncture site. If the barb remains in the subject, the patient will need to be transported to a medical facility for removal.
- Promptly release the probe to Law Enforcement personnel for storage as evidence.
- Inform patient of basic wound care and the need to seek additional care in event that signs of infection occur.
- Clear and thorough documentation is required

**ALL PROVIDERS**

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
- Interpret 12 lead
THE “NO GUIDELINE” GUIDELINE
Effective 4/1/17

GENERAL

It is understood that no set of guidelines could ever be “all inclusive.” With that understanding, occasionally EMS providers will be faced with situations that do not fit a certain guideline, or no guideline exists addressing the situation. In these circumstances the EMS Provider on scene may consider all allowable treatment options within the Sandoval County Fire Department Treatment Guidelines and the New Mexico Scope of Practice and discuss appropriate management options with an MCEP, if he or she believes that such interventions are necessary and in the best interests of the patient.

The EMS Provider must inform the MCEP/EMS CONSORTIUM that no guideline exists to cover this particular situation, and the MCEP/EMS CONSORTIUM will then advise the paramedic as to how to proceed with the treatment of that patient.

There are also times when communications with an MCEP/EMS CONSORTIUM is not possible due to remote locations throughout the County and where access through radio or cell phones is not available. In these circumstances the EMS Provider on scene may consider all allowable treatment options within the Sandoval County Fire Department Treatment Guidelines and the New Mexico Scope of Practice; if he or she believes that interventions are necessary and in the best interest of the patient, he or she may perform those interventions without the actual contact of the MCEP/EMS CONSORTIUM as may be required by the Treatment Guidelines or New Mexico Scope of Practice.

If the “No Guideline” Guideline is used in delivering patient care, it will be the responsibility of that EMS Provider to notify the receiving MCEP/EMS CONSORTIUM of the care that was done under this Guideline as soon as communications can be established, and to also immediately notify the JPEMS Director who will notify the appropriate personnel of the situation that had occurred as soon as the call is complete. A Run QA/QI form will be generated by the provider in ImageTrend upon completion of the call so that the circumstances of the call can be reviewed as soon as practical.

Situations may arise involving patients with uncommon conditions requiring specific out of hospital administered medications or procedures; family members or the designated EMS Provider trained and knowledgeable of the special needs of the patient should be recognized as the expert regarding the care of the patient; EMS can offer assistance only. If the provider is not sure how s/he can assist, call the EMS CONSORTIUM (505-449-5710)
SECTION 4
AIRWAY MANAGEMENT GUIDELINES
## AIRWAY MANAGEMENT

**Effective 4/1/17**

### ALL PROVIDERS
- Follow Primary Management Guideline
- Spinal Motion Restriction as appropriate
- Positioning
- Suction
- BVM
- OPA/NPA
- If airway is not able to be maintained with simple maneuvers
  - LMA or similar device (excludes combi-tubes and King Airway) and verify placement

### BASIC
- Consider advanced airway and verify placement

### PARAMEDIC
- Consider oral intubation in the apneic patient (age 13 and above)
- Consider nasotracheal in the patient who is still breathing but requires aggressive airway intervention (age > 13)
  - Consider nasotracheal intubation only if facial bones appear intact and landmarks are easily identified
- Consider Surgical Cricothyrotomy
- If the patient is agitated, refer to the Altered Mental Status guideline
**INTUBATION**

**Effective 4/1/17**

**GENERAL**

**ORAL INDICATIONS**
- Apneic or agonal patients that cannot be managed effectively with BVM
- Age < 13 or an intact gag reflex

**ORAL CONTRAINDICATIONS**

**NASAL INDICATIONS**
- The patient is not apneic or in cardiac arrest, but is experiencing, or is likely to experience, upper airway compromise
- The patient has edema, which may result in complete obstruction
- The patient's mouth cannot be opened
- The patient has oral or maxillofacial fractures
- The patient is conscious or unconscious, but unable to protect their airway.

**NASAL CONTRAINDICATIONS**
- Apnea
- Nasal fractures or obstruction or deviated nasal septum
- Basilar skull fractures
- Age < 13

**PROCEDURE**
- Ensure pre-oxygenation of the patient
- If the patient is extremely agitated for any reason (hypoxia, head trauma, etc.), refer to the Altered Mental Status guideline
- The use of a Bougie is encouraged for all intubation
- Immediately following intubation, the ET tube must be confirmed by at least three indicators and appropriately documented. Indicators include, but are not limited to the following:
  - Visualize tube passing through the cords, misting in the tube, bilateral equal breath sounds, absence of breath sounds over the epigastrium, pulse oximetry, equal chest rise, improving/stabilizing vital signs and skin condition
  - Continuous end-tidal CO2 capnography **MUST** be initiated immediately following intubation of all patients. Numerical values and waveforms must be recorded on the ePCR. Ventilation rate and depth should be adjusted to reflect optimal ETCO2 values for each specific patient complaint
- Utilize the Transport Ventilators if able
  - Target ventilator rate, tidal volume, and pressure settings to obtain an End Tidal Reading of 35-45 mmHg
- Prior to releasing an intubated patient to a receiving hospital physician or respiratory therapist, the Paramedic must confirm & document tube placement and patency with receiving personnel and obtain signature verification from the receiving personnel.
### CRICOTHYROTOMY

**Effective 4/1/17**

Cricothyrotomy may be attempted on an unconscious adult patient with immediate life threatening airway compromise and when other modalities of airway management are ineffective or contraindicated.

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>CONTRAINDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Patient &gt;13 years of age requiring airway management where non-invasive techniques are insufficient and other invasive techniques are either unsuccessful or not practical.</td>
<td>➢ Age &lt;13</td>
</tr>
<tr>
<td>➢ Unable to locate proper anatomical structures</td>
<td>➢ Unable to locate proper anatomical structures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Establish Primary Management</td>
</tr>
<tr>
<td>➢ Identify the structures and locate the incision point</td>
</tr>
<tr>
<td>➢ Clean with chlorascrub</td>
</tr>
<tr>
<td>➢ Make a vertical incision through the skin over the cricothyroid membrane 2 - 3 cm in length with sufficient depth to expose the cricothyroid membrane</td>
</tr>
<tr>
<td>➢ Horizontally puncture the membrane with the scalpel to facilitate access to the trachea</td>
</tr>
<tr>
<td>• Insert and maintain airway with a cuffed Endotracheal tube</td>
</tr>
<tr>
<td>• BOUGIE-ASSISTED CRIC may be beneficial to the provider as well</td>
</tr>
<tr>
<td>• Confirm tube placement by required methods, including Capnography, and document</td>
</tr>
<tr>
<td>• Verify correct placement and secure the tube while providing ventilation</td>
</tr>
<tr>
<td>• JPEMS QI and Medical Direction will review all cricothyrotomy cases</td>
</tr>
</tbody>
</table>

JPEMS QI and Medical Direction will review all cricothyrotomy cases.
GENERAL OBSTRUCTION
Effective 4/1/17

ALL PROVIDERS
➢ Establish Primary Management
➢ Follow current AHA CPR guidelines

PARAMEDIC
➢ If able, proceed to direct laryngoscope and remove the foreign body with Magill forceps.
➢ The provider may attempt to place an endotracheal tube in an attempt to push the object into a mainstem bronchus which may allow for some ventilation and oxygenation.
➢ If unsuccessful and still unable to clear airway, Surgical Cricothyrotomy may be used.
➢ In a patient with a tracheostomy whose tracheostomy tube has become dislodged, attempt to replace the tracheostomy tube immediately. If unsuccessful, place an appropriately-sized ETT through the tracheotomy.

GENERAL CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)
Effective 4/1/17
**INDICATIONS**

- Severe dyspnea secondary to asthma, chronic obstructive pulmonary disease, pulmonary edema, CHF and patients with severe pulmonary compromise who are awake, oriented, and have the ability to maintain an open airway
- Systolic blood pressures >90
- Near Drowning patients who are conscious and able to follow directions

**CONTRAINDICATIONS**

- Severe Facial Trauma
- Respiratory or cardiac arrest
- Head trauma with SxS of increased intracranial pressure
- Profoundly diminished Level of Response
- Decreased Cardiac output
- Gastric distention
- Hypotension secondary to hypovolemia
- Vomiting or active G.I. bleed
- Penetrating chest trauma
- Pneumothorax
- Explosive Barotrauma
- Suspected Pneumonia is a relative contraindication

**PROCEDURE**

- Follow the appropriate Respiratory Distress guideline
- Decrease work of breathing by placing patient in an upright & seated position
- Continually assess vital signs
- Prepare CPAP and check for leaks
- Explain procedure to patient and reassure them as much as possible
- Obtain correctly sized facemask and attach mask to tubing
- Turn unit on and place mask on face of patient and secure in place. Readjust as needed to maintain a tight seal without leaks
- Start with device setting of 5 cm H2O and titrate upward as needed to a max of 15 cm H2O Continually assess patient for changes and needs for additional interventions, medications. Be prepared to intubate as required
- Patients with severe hypoxia and hypersensitivity to the mask may not tolerate CPAP procedure, and may require sedation per the agitation guideline
- Monitor patient at all times. Do not leave patient unattended while CPAP is in place
- Monitor Oxygen Levels in tank and be prepared to utilize additional cylinders
SECTION 5
MEDICAL GUIDELINES
The patient will present with severe pain/discomfort from any of the following and have a minimum GCS of 11, a minimum systolic pressure of 90, and no signs of head/brain injury:

- Isolated extremity injury
- Multisystem Trauma
- Burn(s)
- Chest Pain
- Back Pain
- Recurrent or current pain indicative of renal colic (kidney stone)
- Abdominal / flank pain of unknown origin
  - Including potential ectopic pregnancy

Continual monitoring, including vital signs and respiratory effort before and after medication administration is required.

**ALL PROVIDERS**
- Establish Primary Management
- Provide comfort care as best as possible
- Position of Comfort
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable

**BASIC**
- An JPEMS Paramedic may authorize an EMT-Intermediate to administer pain medication under their direct oversight. The EMT-Intermediate may continue to provide primary patient care, however the Paramedic has ultimate responsibility of that patient.
- If a JPEMS Paramedic is not on scene, the ILS EMS Provider must contact the EMS Consortium (505-449-5710) for orders and administer as below with a maximum amount designated by the physician.
- As needed, initiate an IV/O; titrate to the patient’s hemodynamic and perfusion status.
- If the EMT-Intermediate is unable to make contact with the EMS Consortium and no JPEMS Paramedic is on scene, the EMT-Intermediate may proceed with the administration of pain medications following the below dosing. As soon as radio/phone contact is able to be made following administration, the EMT-Intermediate shall contact the EMS Consortium and advise them of the situation. This will require notifying the JPEMS Duty Officer and Medical Direction for QA.

**INTERMEDIATE**
- Fentanyl:
  - Adult Dose: 25 – 150 mcg dose IV/O/IM/IN q 5 min as needed
  - Pediatric Dose: 0.5 – 1.5 mcg/kg dose IV/O/IM/IN q 5 min as needed
    - If available, Fentanyl Dosing > 300mcg requires capnography/capnometry
<table>
<thead>
<tr>
<th>Level</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PARAMEDIC</strong></td>
<td></td>
</tr>
<tr>
<td>Fentanyl Dose</td>
<td>– same as for EMT-Intermediate</td>
</tr>
<tr>
<td>Midazolam</td>
<td>1-2 mg IV/IO/IM, may be considered for patient comfort if you suspect muscle spasm is playing a role in the patient’s discomfort (0.2mg/kg; max 2mg for pediatric).</td>
</tr>
<tr>
<td>Special Considerations for Midazolam administration:</td>
<td></td>
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<tr>
<td>o Patient must be under age 65</td>
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<tr>
<td>o Patient must be placed on capnography</td>
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<tr>
<td>o 2 mg is the maximum dose without MCEP/EMS CONSORTIUM consult</td>
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</tr>
<tr>
<td>o Be prepared to provide ventilatory support to the patient</td>
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<tr>
<td><strong>GENERAL</strong></td>
<td></td>
</tr>
<tr>
<td><strong>ABDOMINAL / FLANK PAIN</strong></td>
<td></td>
</tr>
<tr>
<td>Causes can include appendicitis, food poisoning, abdominal aortic aneurysm, gastritis, gall bladder problems, kidney stone, intestinal obstruction, ectopic pregnancy, ulcers, ovarian cyst, and more.</td>
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<tr>
<td><strong>ALL PROVIDERS</strong></td>
<td></td>
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<tr>
<td>Primary Management</td>
<td></td>
</tr>
<tr>
<td>Place patient in POC, transport, ILS/ALS if needed.</td>
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</tr>
<tr>
<td>Gather patient history carefully. Consider ectopic pregnancy for female patients of childbearing age.</td>
<td></td>
</tr>
<tr>
<td>Watch for shock, treat and transport expeditiously.</td>
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</tr>
<tr>
<td>Reference Pain Management Guideline.</td>
<td></td>
</tr>
<tr>
<td>Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable.</td>
<td></td>
</tr>
<tr>
<td>ECG is required (if available) for patients with upper abdominal pain, nausea, or vomiting if patient is greater than 40 years of age</td>
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<tr>
<td><strong>BASIC</strong></td>
<td></td>
</tr>
<tr>
<td>If vital signs are abnormal, consider sepsis guideline.</td>
<td></td>
</tr>
<tr>
<td><strong>INTERMEDIATE</strong></td>
<td></td>
</tr>
<tr>
<td>As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status.</td>
<td></td>
</tr>
<tr>
<td><strong>PARAMEDIC</strong></td>
<td></td>
</tr>
<tr>
<td>Interpret 12 Lead.</td>
<td></td>
</tr>
</tbody>
</table>
Diffuse pain
- Acute pancreatitis
- Aortic dissection or ruptured abdominal aortic aneurysm
- Bowel obstruction
- Early appendicitis
- Gastroenteritis
- Mesenteric ischemia
- Perforated bowel
- Peritonitis
- Sickle cell crisis

Right upper quadrant
- Acute cholecystitis and biliary colic
- Acute hepatitis
- Acute pancreatitis
- Appendicitis
- Hepatic abscess
- Hepatomegaly/congestive heart failure
- Herpes zoster
- Myocardial ischemia
- Perforated duodenal ulcer
- Right lower lobe pneumonia

Left upper quadrant
- Acute pancreatitis
- Gastric ulcer
- Gastritis
- Left lower lobe pneumonia
- Myocardial ischemia
- Spleen enlargement, rupture, infarction or aneurysm

Right lower quadrant
- Abdominal wall hematoma
- Appendicitis
- Cecal diverticulitis
- Endometriosis
- Incarcerated or strangulated inguinal hernia
- Medial’s diverticulitis
- Mesenteric adenitis
- Mittelschmerz
- Pelvic inflammatory disease
- Psoas abscess
- Regional enteritis
- Ruptured abdominal aortic aneurysm
- Ruptured ectopic pregnancy
- Seminal vesiculitis
- Terminal ileitis (Crohn’s disease)
- Torsed ovarian cyst
- Urinary calculi

Left lower quadrant
- Endometriosis
- Incarcerated or strangulated inguinal hernia
- Mittelschmerz
- Pelvic inflammatory disease
- Psoas abscess
- Regional enteritis
- Ruptured abdominal aortic aneurysm
- Ruptured ectopic pregnancy
- Seminal vesiculitis
- Sigmoid diverticulitis
- Torsed ovarian cyst
- Urinary calculi
# Adult Respiratory Distress

**Effective 4/1/17**

Asthma, Anaphylaxis, COPD, Pneumonia, Hyperventilation, Pulmonary Edema, Epiglottitis

For pediatric doses, see Pediatric Respiratory Distress Guideline

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## General

- Establish Primary Management
- Initiate Rapid Transport and arrange for ILS/ALS intercept as needed
- Coach breathing if patient accepts
- Consider CPAP at 5-15 cm H2O
- Keep patient calm and in position of comfort
- Apply Oxygen to achieve SpO2 of >94%

### Wheezing Present

- **Albuterol:**
  - Adult Dose: 2.5 – 10 mg nebulized;
  - Additional albuterol doses require MCEP/EMS CONSORTIUM approval
  - Cardiac monitoring required for patient receiving 10mg or more if available

- Be prepared for more aggressive airway interventions
- Auscultate Breath Sounds
- Secure airway and administer oxygen per respiratory distress guideline
- Remove offending agent (e.g. – stinger) in appropriate manner (scrape, not tweezers)
- Do brief history and physical and check vital signs and lung sounds
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable

---

## All Providers

- Wheezing Present
  - Albuterol as above
  - Ipratropium (Atrovent)
    - Adult Dose: 0.5 mg prediluted with first or second dose of Albuterol.
  - If patient is unable to hold nebulizer, use NRB or BVM to assist
- Stridor Present
  - Humidified Oxygen
- If the patient is in SEVERE respiratory distress and/or cardiovascular compromise with SxS of shock (unresponsive to above or anaphylaxis/status asthmatics)

### Adult Epinephrine dose 1:1000 – 0.3 mg using the below guidelines

- Administration of Epinephrine, 1:1000, no single dose greater than 0.3 mL, SQ or IM injection with a pre-measured syringe or 0.3 mL TB syringe **under on-line medical control**. When on-line medical control is unavailable, administration is allowed under off-line medical control if the licensed provider is working under medical direction using these approved written medical guidelines.
- Repeat doses require online medical control.

**Cardiac monitoring is required for all patients receiving >0.6 mg Epinephrine and all patients receiving at least 10 mg of Albuterol meeting the above criteria.**
For significant respiratory distress or hypotension, administer Epinephrine 1:1000
- Adult Dose: 0.3 mg 1:1000 SQ or IM
- May repeat Epinephrine as needed q 3 - 5 minutes up to a maximum of three doses. Contact an MCEP/EMS CONSORTIUM if additional doses are needed.

As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
- Consider diphenhydramine IV or IM
  - Adult dosage: 25 – 50 mg

Initiate ET CO₂ monitoring
- Interpret 12 lead
- For adult patient’s refractory to the above treatments, and anaphylaxis or asthma is cause, consider:
  - Dexamethasone:
    - Adult Dose: 4-10mg IV or IM
  - Magnesium Sulfate:
    - Dose: 2 g MgSO₄ diluted in 50 – 100 cc slow IV push over several minutes

For adult patient’s refractory to the above treatments, and SHOCK is cause:
- Epinephrine 1:100,000 (discard 9cc of Epi 1:10,000 and replace with 9cc NS)
  - Adult Dose: 2-10cc (2-10mcg) IVP
- Consider Epinephrine Drip
  - Dose – Dilute 4mg of 1:1,000 into 250cc NS = 16mcg/mL with 60gtts tubbing.
  - Begin at 4mcg per minute (15 drops)
  - Increase dosing rate 2mcg per minute every 5 minutes, titrating up to maximum administration rate of 10mcg per minute

For Stridor thought to be of infections causes and patient is less than age 35
- Consider Dexamethasone
  - Adult Dose: 10mg IV
- Consider nebulized Epinephrine for worsening distress and/or impending respiratory FAILURE
  - Dose: mix 1 mg (1cc) of Epinephrine 1:1000 in 3 cc of normal saline, and administer via nebulizer.
  - Repeat this once after twenty minutes if the patient is severe and did not significantly improve after the first administration

Consider Intubation per airway management guideline
- Reference Altered Mental Status Guideline as needed
- If complete occlusion occurs, proceed to cricothyrotomy
# ALTERED MENTAL STATUS

**Effective 4/1/17**

A confused, agitated, and potentially harmful or depressed level of consciousness resulting from any reason, which may include hypoxia, head injury, stroke, alcohol and other drug use, delirium secondary to another illness, metabolic disturbances, etc.

<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>Actions</th>
</tr>
</thead>
</table>
| **GENERAL** | - Establish Primary Management  
- Reference Respiratory distress guideline as needed  
- Reference Ingestion/Poisoning/Overdose guideline as needed  
- Brief history and vital signs, if possible  
- Perform glucometry; if hypoglycemia is confirmed, reference Hypoglycemia guideline  
- Begin transport and arrange ALS / ILS intercept as needed  
- Restrain as necessary according to restraint guideline, and consider police involvement |

| **BASIC** | - If the patient's agitation appears to be due to hypoxia or head trauma, attempt to ventilate the patient with a BVM.  
- Patient may awaken quickly and be combative. Consider law enforcement involvement; be prepared to restraint if needed. |

| **INTERMEDIATE** | - As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status.  
- If hypoglycemia is confirmed, administer D50 per hypoglycemia guideline. |

| **PARAMEDIC** | - Consider Intubation, if needed.  
- Monitor for cardiac changes.  
- Midazolam may be used if the Paramedic determines that sedation is crucial to adequately care for the patient or to protect patient/crew safety.  
  - Adult Dose: 2 – 10mg IV/IO/IM/IN  
  - Pediatric Dose: 0.2 mg/kg IV/IO/IM up to 5 mg  
    - Prepare to manage the airway and ventilation status of the patient |

| **NOTES** | - If the patient is known or suspected to have overdosed on narcotics, it is appropriate to try naloxone prior to ruling out hypoglycemia.  
- Persons chronically dependent upon opioids may go into acute withdrawal when given naloxone; be prepared for nausea/vomiting and agitation.  
- A dose of glucose will not harm diabetics in ketoacidosis.  
- In the event of a national shortage of Midazolam, JPEMS Medical Direction may approve additional benzodiazepine medications for use in this Guideline. |
### General
- Ensure scene safety and use respiratory protection if needed and/or ventilation / decon
- Utilize a gas monitor if indicated
- Establish Primary Management and remove patient from dangerous area if applicable
- Reference altered Mental Status as needed
- Reference Respiratory distress guideline as needed
- Brief history and vital signs if possible including CO monitoring as needed
- Begin rapid transport and arrange ALS / ILS intercept as needed
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable
- Restrain as necessary according to restraint guideline, and consider police involvement
- Determine substance, time of exposure, quantity and concentration / dose of substance
- Determine if accidental of intentional
  - If intentional, evaluate for suicidal ideation
- Collect containers, bottles, or other material that contains substance to be transported with the transporting unit if able and safe
- Assess blood glucose level
- If narcotics are suspected consider Naloxone (Narcan)
  - First Responder Adult Dose: IN increments of 2 mg
  - First Responder Pediatric Dose: Initial dose of 0.01 mg/kg; if ineffective, then subsequent dosing at 0.1 mg/kg IN up to 2 mg/dose
- If CO, reference algorithm below
- If Organophosphate, remember SLUDGEM
  - S = Excessive Salivation
  - L = Excessive Lacrimation (tearing)
  - U = Urination
  - D = Defecation
  - G = Gastric irritability
  - E = Emesis
  - M = Miosis

### All Providers
- Assess blood glucose level
- If narcotics are suspected consider Naloxone (Narcan)
  - Adult Dose: IV / IM / IO / SQ / IN: increments of 0.4 - 2 mg as needed
  - Pediatric Dose: Initial dose of 0.01 mg/kg; if ineffective then subsequent dosing at 0.1 mg/kg slow IV / IM / SQ / IO / IN up to 2 mg/dose
  - Additional doses may be given if no response or propoxyphene (Darvon), Clonidine or Carfentanil overdose is suspected or multi-substance abuse
➢ As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
➢ If still unresponsive, consider airway management and reference Altered Mental Status Guideline

INTERMEDIATE

➢ Interpret 12 lead
➢ Consider Intubation
➢ Consider Atropine for Organophosphate OD
  • Adult Dose: 1mg q 3-5 minutes as needed
  • Pediatric Dose: 0.02mg/kg q 3-5 minutes as needed
➢ Consider Sodium Bicarb administration for TCA
  • A Terminal R wave in lead AVR on the 12 lead may be an early sign of TCA OD
  • Wide Complex tachycardia is another classic sign
  • Adult Dose: 50cc every 3-5 minutes as needed until symptoms subside
  • Pediatric Dose: 1 mEq/kg IV
➢ Treat vital sign abnormalities symptomatically. Consider transcutaneous pacing for severe bradycardia, or the initiation of vasopressor therapy for profound hypotension if unresponsive to fluid boluses
➢ Symptomatic Calcium Channel Blocker overdose exhibiting hypotension (unresponsive to fluid bolus) and/or dysrhythmias
  • High Dose Epinephrine (3 mg 1:1000) every 5 minutes IV/IO
  • Calcium Chloride 10% - 20 mg/kg IV/IO Slow IV
  • Call for Pediatric Doses
➢ Common Calcium Channel Blockers can Include:
  • Amlodipine (Norvasc), Diltiazem (Cardizem, Tiazac), Felodipine, Irs dipine, Nicardipine, Nitidipine (Adalat CC, Afeditab CR, Procardia), Nisoldipine (Sular), Verapamil (Calan, Verelan)

PARAMEDIC

➢ POISON CONTROL #: 1-800-222-1222 Or 505-272-2222
➢ Poison Control is NOT recognized as ON-LINE Medical Control. Poison Control does have a value in identifying certain medications/substances and providing treatment guidelines to the receiving facility.
➢ Hyperbaric Chambers are available only at St. Vincent’s Hospital Santa Fe. Unless crew is in the northern part of the I-25 corridor, transport to a Sandoval/Bernalillo County Hospital as per respiratory distress guideline.
Measure SpCO

> 3%

No further evaluation of SpCO required.

- Loss of consciousness?
- Neurological impairment?
- SpCO > 26%?

Yes

Transport on 100% oxygen. Consider CPAP. Transport to hospital with HBO capabilities.

No

SpCO > 12-15%?

Yes

Transport on 100% oxygen for Emergency Department evaluation

No

Symptoms of CO exposure?

Yes

Consider concomitant carbon monoxide and/or cyanide poisoning.

No

Unexplained shock, hypotension?

Yes

No further evaluation of SpCO needed. Determine source of CO if nonsmoker.
### GENERAL DIABETIC EMERGENCIES

**Effective 4/1/17**

#### ALL PROVIDERS

- Establish Primary Management
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable
- Dextrose (oral or IV/IO) may be given regardless of field glucose reading if your suspicion of hypoglycemia is high.
- Insulin pumps: If the patient is hypoglycemic and conscious, have the patient or family turn the pump off and treat per Guideline. If provider is comfortable, they may turn off the pump. As a last resort, in the profoundly hypoglycemic patient, if the pump cannot be turned off at the switch, the EMS provider should gently disconnect the infusion set at the pump. If this does not work, attempt to remove the batteries. If this does not work, then gently remove the catheter from the skin and treat per Guideline. Assure the pump stays with the patient and is not misplaced.
- **DO NOT GIVE ANYTHING BY MOUTH UNLESS PATIENT IS CAPABLE OF SELF-ADMINISTRATION.**
- If hypoglycemic, (<60 for adults and <45 in neonates) administer simple sugar or up to 15 gram oral glucose preparation.
- If hyperglycemic (greater than 300 mg/dl), transport and request ILS/ALS.
- If the patient has altered mental status or is unstable, request ILS/ALS intercept.

#### BASIC

- If mental status is diminished, consider airway management.
- If vital signs are abnormal, consider sepsis guideline.

#### INTERMEDIATE

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status.
- IF HYPERGLYCEMIC, bolus 250cc increments, re-evaluate LOC, VS, and lung sounds between boluses.
- IF HYPOGLYCEMIC, Administer Dextrose:
  - Adult Dose: 25 grams of Dextrose 50% IV. Titrate to the patient’s mental status.
  - Pediatric Dose: 1 gram/kg of D25% solution IV or IO.
  - Neonate Dose: 1 gram/kg of D10% IV or IO
- If the patient regains consciousness and maintains their airway, give oral carbohydrates.
- Watch for nausea, vomiting, hypotension and/or anaphylaxis.

#### PARAMEDIC

- If patient regains airway, give oral carbohydrates.
- 12 Lead if needed.
MCEP/EMS CONSORTIUM contact is NOT required if the patient meets ALL refusal criteria AND all of the following:

- Patient is only on a short-acting insulin or insulin analog, or on a pre-mixed insulin analog (e.g. Novalog 70/30 or Humalog 70/30)
- Patient displayed an adequate response (normal vital signs, normal mentation, and a BGL within normal limits) to ONE dose of dextrose
- Patient has no acute co-morbid medical condition (liver disease, kidney disease, alcoholism, or febrile illness)
- Patient is not actively vomiting
- Patient has tolerated food by mouth and has access to additional food at home or present location
- Patient is released to a competent adult for observation for 2-3 hours.

MCEP/EMS CONSORTIUM contact is MANDATORY in the following situations:

- If the patient is known to take, or has access to, an oral diabetic medication in the sulfonylurea class. These patients are at very high risk and must be strongly encouraged to be transported to a hospital for further evaluation.

Examples:

- Sulfonylurea Medications:
  1. Glyburide (Micronase, Diabeta, Glynase)
  2. Glyburide + Metformin (Glucovance)
  3. Glypizide (GlycatrolXL, Glucatrol)
  4. Glimepiride (Amaryl)

- Long-Acting Insulin Analogs:
  1. Glargine (Lantus)
  2. Detemir (Levemir)

- Intermediate-Long-Acting Insulins:
  1. Lente
  2. NPH
  3. Ultralente

- If any of the above refusal criteria are not met – contact MCEP
**EXTRA-PYRAMIDAL REACTIONS**

Effective 4/1/17

A response to a particular medication, typically a phenothiazine (Phenergan, Thorazine) or a butyrophenone (Haldol, Droperidol) marked by acute dystonia (muscle spasms) or akathisia (motor restlessness).

<table>
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<tr>
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<tbody>
<tr>
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<td>➢ Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable</td>
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<table>
<thead>
<tr>
<th>ALL PROVIDERS</th>
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<tbody>
<tr>
<td>➢ As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status</td>
</tr>
<tr>
<td>➢ If altered LOC, assess Blood Glucose Level</td>
</tr>
<tr>
<td>➢ Administer Diphenhydramine</td>
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<tr>
<td>• Adult Dose: 25 – 50 mg IV/IO/IM</td>
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<tr>
<td>• Pediatric Dose: 1 – 2 mg/kg IV/IO/IM</td>
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<tr>
<td>➢ Midazolam may be considered 2-10mg IV/IO/IM if known to be allergic to diphenhydramine (0.2mg/kg max 2.5mg/dose for pediatric)</td>
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<tr>
<th>INTERMEDIATE</th>
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<tr>
<td>➢ Interpret 12 lead</td>
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## FAINTING / SYNCOPE

**Effective 4/1/17**

A thorough history is vital as it may lead the EMS care provider to the source of the problem. Syncope is almost always a result of another medical emergency, and should be considered a cardiac event until ruled out through thorough assessment.

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<td>➢ Establish Primary Management</td>
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<tr>
<td>➢ Detailed past medical history and history of present illness is required.</td>
</tr>
<tr>
<td>➢ Obtain base line vital signs, including orthostatics, if possible.</td>
</tr>
<tr>
<td>➢ Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable</td>
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<tr>
<th>ALL PROVIDERS</th>
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<tbody>
<tr>
<td>➢ Assess blood glucose level.</td>
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<tr>
<td>➢ Interpret ECG and treat as needed.</td>
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</thead>
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</table>
# FEVER

**Effective 4/1/17**

## ALL PROVIDERS
- Establish Primary Management
- Attempt to determine cause of fever (environmental, sickness, etc.)
- Consider Sepsis Guideline
- Temperature > 101.5 degrees Fahrenheit (38.6 Celsius) or if patient feels extremely hot, responders may apply cool moist towels to the body to slowly lower the temperature. Do not make the patient shiver.
- In environmental hyperthermia, or in extreme fever associated with infection (>105 degrees Fahrenheit), proceed with aggressive cooling measures.
- If conscious and alert, patient may drink fluids.
- Consider other possibilities of elevated body temperature such as thyroid storm, serotonin syndrome, neuroleptic malignant syndrome, heat stroke.

## BASIC
- Consider ALS intercept
- For pediatric patients with fever due to a suspected infectious cause
  - Acetaminophen administration if transport time is over 20 minutes
    - Patient must be alert, and not be allergic to acetaminophen
    - Pediatric Dose: 15 mg/kg

## INTERMEDIATE
- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status.
- If febrile seizures occur, follow seizure guideline and gently cool patient by whatever reasonable means possible.
- Do not use cold IV fluid.

## PARAMEDIC
- Treat recurrent seizures per the seizure guideline.
# NAUSEA

**Effective 4/1/17**

## ALL PROVIDERS
- Establish Primary Management
- Reference Abdominal Pain Guideline as needed
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable

## BASIC
- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
- Zofran (Ondansetron HCL)
  - Adult Dose: 4 – 8 mg IV or PO
  - Pediatric Dose: MCEP/EMS CONSORTIUM Consult
- Any additional administrations require MCEP/EMS CONSORTIUM Consult

## INTERMEDIATE
- Interpret 12 lead ECG

## PARAMEDIC
- Interpret 12 lead ECG

## NOTES
- Use caution in patients with documented prolonged Q-T interval as Zofran has been found (usually at high doses) to prolong the Q-T interval leading to Torsades
## GENERAL PSYCHIATRIC EMERGENCIES

### Signs and symptoms may include:
- Depression and suicidal behavior/ideation,
- Hallucinations, pressured speech, loose associations, racing thoughts, grandiose or paranoid ideation, delusions, hysteria, extreme anxiety, or any other aggressive actions that could cause harm to the patient or others.

### ALL PROVIDERS
- Establish Primary Management
- Consider Altered Mental Status Guideline
- Make sure the scene is safe
- Limit the number of providers making contact and approach cautiously
- Protect the patient from injury. Involuntary restraint should be considered if indicated by patient behavior and if necessary to render care and protect rescuers
- Be sure to consider and treat all possible trauma/medical causes for aberrant behavior per guidelines.
- Conduct thorough assessment and rule out other potential causes
- All patients will be assessed and evaluated by EMS regardless of transport status
- Transport will usually go to local ED of patient choice or closest facility
- Patient can be transported directly to UNM Mental Health or Kaseman if they are not requiring assessment for injury or ingestion and the facility is notified and accepted the patient. Criteria of enacting transport to these facilities requires:
  - Heart Rate between 60-120
  - Respiratory Rate between 12-25
  - Oxygen saturation greater than 90%
  - Systolic BP 90-160
  - BGL 60-200
- Law Enforcement officers may transport directly to a mental health facility if vital signs fall within normal limits and the paramedic does not suspect any other underlying traumatic or medical causes
- If vitals are not within normal limits, or if the patient requests medical evaluation, the patient shall be directly transported to the emergency department.
| ALL PROVIDERS | ➢ Establish Primary Management  
➢ Protect patient and provider from injury. Maintain airway and place nothing in the mouth  
➢ Oxygen at 10-15 LPM  
➢ Have suction available  
➢ Obtain history of seizure activity including onset, duration, type, medication taken and prior seizure history  
➢ See Eclampsia guideline for treatment of pregnancy related seizures.  
➢ Request ALS |
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<tbody>
<tr>
<td>BASIC</td>
<td>➢ Assess blood glucose level</td>
</tr>
</tbody>
</table>
| INTERMEDIATE | ➢ As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status  
➢ Request ALS for Status Epilepticus |
| PARAMEDIC | ➢ If paramedic witnesses seizure activity, administer Midazolam.  
• Adult Dose: 2-10mg IV/IO/IM  
• Pediatric: 0.2 mg/kg IV/IM/IO up to 5 mg  
➢ As with any benzodiazepine administration, prepare to actively manage the patient’s airway due to respiratory depression.  
➢ Monitor ETCO2 |
| NOTES | ➢ Status Epilepticus exists when witnessed seizure activity continues for > 10 minutes or multiple seizures recur without a return to full mental capacity. These require paramedic level intervention.  
• Notify Medical Control early, and consult for any additional medications. |
### SEPSIS

**Modified SIRS Criteria** = Suspicion of Infection plus two of the following:
- Temperature > 38.3°C or < 36°C (> 100.1°F or < 96.8°F)
- Heart Rate > 90
- Respiratory Rate > 20

**Other considerations:**
- History or suspicion of fever
- Altered mental status
- EtCO2 < 20 mmHg or > 60 mmHg (if available)
- Hypotension with SBP < 90 mmHg or 40 mmHg known drop in patients with hypertensive history
- Hyperglycemia > 140 mg/dL without history of diabetes
- Peripheral edema (end organ failure)
- Jaundice (hyperbilirubinemia)
- Documented serum lactate > 4 mmol/L (if available)

### ALL PROVIDERS
- Establish Primary Management
- Initiate rapid transport and request ALS
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable

### BASIC
- Assess blood glucose level, treat if < 60 mg/dl

### INTERMEDIATE
- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
- Aggressive fluid bolus may be required

### PARAMEDIC
- Interpret 12 lead ECG and EtCO2
- For patients in septic shock
  - Epinephrine 1:100,000 (discard 9cc of Epi 1:10,000 and replace with 9cc NS)
    - Adult Dose: 2-10cc (2-10mcg) IVP
    - Pediatric Dose: 0.1cc/kg (1mcg/kg up to adult dose)
  - Norepinephrine (Levophed)
    - Dose: Dilute 4mg into 250cc NS = 16mcg/mL with 60gtts tubing.
    - Begin at 4mcg per minute (15 drops)
    - Increase dosing rate 2mcg per minute every 5 minutes, titrating up to maximum administration rate of 10mcg per minute
### GENERAL
- Establish Primary Management
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable
- Perform pre-hospital stroke assessment (Cincinnati Pre-Hospital Stroke Scale).
- A detailed history and time of onset is critical.
- Initiate rapid transport to a CORE facility with a CT Scanner.
- Notify the E.D. of stroke patient early.
- Administer oxygen to an oxygen saturation of at least 94%, and closely monitor and maintain the patient’s airway if necessary.

### ALL PROVIDERS
- Assess blood glucose level, treat if < 60 mg/dl.
- Request ALS for Status Epilepticus.

### BASIC
- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status.

### INTERMEDIATE
- Interpret 12 lead.
- If patient is being ventilated, ensure that ETCO2 is maintained at 35-45 mmHg.
- Consider airway management guidelines as appropriate.
- Consider Altered Mental Status guideline if necessary.

### PARAMEDIC
- Interpret 12 lead.
- If patient is being ventilated, ensure that ETCO2 is maintained at 35-45 mmHg.
- Consider airway management guidelines as appropriate.
- Consider Altered Mental Status guideline if necessary.

---

**Cincinnati Pre-hospital Stroke Scale**

1. **FACIAL DROOP**: Have the patient show teeth or smile.
   - **Normal**: Both sides of the face move equally.
   - **Abnormal**: One side of the face does not move as well as the other side.

2. **ARM DRIFT**: Patient closes eyes & holds both arms out for 10 sec.
   - **Normal**: Both arms move the same or both arms move at all.
   - **Abnormal**: One arm does not move or drifts down compared to the other.

3. **ABNORMAL SPEECH**: Have the patient say “you can’t teach an old dog new tricks.”
   - **Normal**: Patient uses correct words with no slurring.
   - **Abnormal**: Patient slurs words, uses the wrong words, or is unable to speak.

**INTERPRETATION**: If any 1 of these 3 signs is abnormal, the probability of a stroke is 72%.
SECTION 6
ADULT CARDIAC GUIDELINES
<table>
<thead>
<tr>
<th>GENERAL CARDIAC GUIDELINES</th>
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<td>Effective 4/1/17</td>
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**ALL PROVIDERS**
- Establish Primary Management
- Oxygen as needed
- Position of comfort unless in shock
- Request ALS for cardiac emergencies
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available

**BASIC**
- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status

**INTERMEDIATE**
- Adhere to ACLS guidelines
- Documentation of the ECG with interpretation shall be uploaded to the ePCR
- All patients in cardiac arrest for whom resuscitation is initiated require immediate advanced airway, intravenous / intraosseous line, rhythm appropriate medications and cardiac monitoring, although defibrillation may take precedence.
- For Cardiac Arrest, consider ROSC or Termination of Resuscitation guideline
### CHEST PAIN

**Effective 4/1/17**

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<tr>
<td>➢ Establish Primary Management</td>
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<tr>
<td>➢ Start oxygen, titrate to an oxygen saturation of 94%</td>
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<tr>
<td>➢ May give four (4) 81mg chewable aspirin or a total of 325mg if not allergic, no history of current bleeding disorders and suspect the chest pain is cardiac related</td>
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<tr>
<td>➢ Transport as soon as feasible</td>
</tr>
<tr>
<td>➢ Allow patient to assume position of comfort. Assist the patient as much as possible</td>
</tr>
<tr>
<td>➢ Arrange early ALS intercept for all chest pain patients</td>
</tr>
<tr>
<td>➢ Cardiac monitor to capture rhythm and obtain 12 lead ECG if available</td>
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<tr>
<td>➢ If patient has their own prescription nitroglycerin with a systolic BP greater than 120 mmHg and a HR greater than 60 bpm, contact MCEP/EMS CONSORTIUM for potential administration at 0.4mg increments to max dose of 1.2mg</td>
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<td>➢ As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status</td>
</tr>
<tr>
<td>➢ If SBP &gt;120/HR&gt;60 give NTG 0.4 mg SL every 5 minutes to a maximum of 3 doses</td>
</tr>
<tr>
<td>You must have an IV started prior to giving NTG. (NTG contraindicated if patient has taken Viagra, Cialis, Levitra, or any other medication for erectile dysfunction in prior 48 hours.)</td>
</tr>
<tr>
<td>➢ If vitals within normal limits, consider Pain Management Guideline</td>
</tr>
<tr>
<td>➢ If time permits, a second IV NS should be started at a keep open rate</td>
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<thead>
<tr>
<th>PARAMEDIC</th>
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<tbody>
<tr>
<td>➢ Follow current AHA Guidelines</td>
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<tr>
<td>➢ Interpret 12 lead ECG and transmission as needed</td>
</tr>
<tr>
<td>➢ Consider Pain Management Guideline</td>
</tr>
<tr>
<td>• Fentanyl and Nitro can be given concurrently as long as patient remains stable</td>
</tr>
</tbody>
</table>

### NOTE

➢ Recent data is showing a positive outcome associated with Remote Ischemic Pre-Conditioning (RIPC). AHA has not approved this treatment yet; however, should an MCEP/EMS CONSORTIUM recommend treatment and the provider feels comfortable with the procedure, this can be used under on-line medical control.
### ATRIAL FIBRILLATION / ATRIAL FLUTTER

**Effective 4/1/17**

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<tbody>
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<tr>
<td>➢ Start oxygen, titrate to an oxygen saturation of 94%</td>
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<tr>
<td>➢ Determine if this is new onset or chronic rhythm</td>
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# BRADYCARDIA

**Effective 4/1/17**

## ALL PROVIDERS

- Establish Primary Management
- Start oxygen, titrate to an oxygen saturation of 94%
- Determine if this is new onset or chronic rhythm
- Initiate transport and request ALS
- Consider causes of the bradycardia including Beta Blocker or Calcium Channel Blocker and hypothermia
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available

## BASIC

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status

## INTERMEDIATE

- Interpret 12 Lead ECG
- Consider Atropine for patients with no symptoms of myocardial ischemia and/or no high degree block
  - Dose: 0.5mg IV/dose to max of 3mg
- For UNSTABLE patient
  - Consider midazolam 2–10mg IV/IO/IM if time permits
  - Begin pacing at 60 bpm with 20mAmps
  - Increase quickly to obtain electrical capture
  - Then increase by 5mAmps increments until mechanical capture
- Check Vital Signs
- Consider 250cc bolus after ensuring lung sounds are clear
- Consider increasing rate to 70 if symptoms have not improved
- If above treatment is not effective or no pacer available:
  - Epinephrine Drip
    - Dose: Dilute 4mg of 1:1,000 into 250cc NS = 16mcg/mL with 60gtts tubing.
      - Begin at 4mcg per minute (15 drops per min)
      - Increase dosing rate 2mcg per minute every 5 minutes, titrating up to maximum administration rate of 10mcg per minute
## NARROW COMPLEX TACHYCARDIA (SVT)

**Effective 4/1/17**

### ALL PROVIDERS
- Establish Primary Management
- Request ALS
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available

### BASIC
- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status

### INTERMEDIATE
- Stable
  - Interpret 12 Lead ECG
  - Attempt Vagal Maneuvers
  - Consider modified Valsalva maneuver
    - Blow thru a straw/syringe for 15 seconds then immediately place patient supine and elevate the legs
  - Adenosine 6 mg rapid IV followed by 20 cc NS flush
  - If unchanged, repeat Adenosine at 12 mg rapid IVP followed by 20 cc NS flush
- Unstable
  - Consider Adenosine administration if time allows while preparing for synchronized cardioversion however, do no delay cardioversion in the unstable patient
  - Consider Sedation with Midazolam 2–10mg IV/IM/IO if time allows
  - Synchronized Biphasic cardioversion at 50 Joules; if ineffective,
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  - Synchronized Biphasic cardioversion at 300 Joules; if ineffective,
  - Synchronized Biphasic cardioversion at 360 Joules; repeat if ineffective
  - Consult MCEP

### PARAMEDIC
- Synchronized Biphasic cardioversion at 300 Joules; if ineffective,
### CARDIOGENIC SHOCK

**Effective 4/1/17**

#### ALL PROVIDERS
- Establish Primary Management
- High Flow oxygen via non-breather
- If necessary, assist the patient’s ventilations with a BVM
- ALS intercept required
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available

#### GENERAL

#### BASIC
- As needed, initiate an IV/IO; titrate to the patient's hemodynamic and perfusion status

#### INTERMEDIATE
- Interpret 12 lead ECG
- If problem is rate-related, reference appropriate guideline to correct rate
- Epinephrine 1:100,000 (discard 9cc of Epi 1:10,000 and replace with 9cc NS)
  - Adult Dose: 2-10cc (2-10mcg) IVP
  - Pediatric Dose: 0.1cc/kg (1mcg/kg up to adult dose)

#### PARAMEDIC
- Epinephrine Drip
  - Dose: Dilute 4mg of 1:1,000 into 250cc NS = 16mcg/mL with 60gtts tubing.
  - Begin at 4mcg per minute (15 drops)
  - Increase dosing rate 2mcg per minute every 5 minutes, titrating up to maximum administration rate of 10mcg per minute
- Treat pulmonary edema as needed
# Congestive Heart Failure Exacerbation

**Effective 4/1/17**

## General
- Establish Primary Management
- Position of comfort
- High Flow oxygen via non-rebreather
- If necessary, assist the patient’s ventilations with a BVM
- Request ALS
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available

## All Providers
- Consider CPAP Guideline

## Basic
- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status

## Intermediate
- Interpret 12 lead ECG
- CPAP Guideline
- If Systolic BP is >120 and IV in place and no contraindications:
  - Nitro 0.4mg every 3-5 minutes until SOB is relieved or systolic BP drops below 90
- If extended transport, consider Lasix 20-80mg IV
  - If patient is prescribed Lasix, consider doubling the patient’s normal dose
## WIDE COMPLEX TACHYCARDIA

**Effective 4/1/17**

### ALL PROVIDERS
- Establish Primary Management
- Request ALS
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available

### BASIC
- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status

### INTERMEDIATE
- Follow Current ACLS
- Interpret 12 Lead ECG
- If rate is less than 150, do not give anti-dysrhythmic
- Rate greater than 150 – Lidocaine per ACLS
- Consider Ingestion/Poisoning/Overdose guideline
- Consider hyperkalemia as cause and treat with calcium 10% (10cc over 10 minutes)
- For stable/symptomatic monomorphic tachycardia, consider lidocaine (1mg/kg)
- For stable/symptomatic polymorphic tachycardia or electrolyte imbalance, consider Magnesium (2G in 50-100cc SIVP)
- For any unstable tachycardia with pulse, proceed with synchronized cardioversion
  - Consider Midazolam 2–10mg IV/IM/IO for sedation
  - Prepare to manage airway
  - For Monomorphic, start at 100 joules and increase as needed per ACLS
  - For Polymorphic, start at 200 joules and increase as needed per ACLS

### PARAMEDIC
- Continue established therapy
- For unstable tachycardia without pulse, proceed with synchronized cardioversion
  - For Monomorphic, start at 200 joules and increase as needed per ACLS
  - For Polymorphic, start at 300 joules and increase as needed per ACLS
### ADULT CARDIAC ARREST  
**NON-TRAUMATIC**

**Effective 4/1/17**

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<tbody>
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<tr>
<td>- Establish Primary Management</td>
</tr>
<tr>
<td>- Ensure ALS response</td>
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<tr>
<td>- Inquire about down time and advanced directives</td>
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<tr>
<td>- Follow current AHA CPR Guidelines</td>
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<tr>
<td>- If multiple defibrillation attempts (3) are unsuccessful, consider a vector change</td>
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<tr>
<td>- After 30 minutes, consider MCEP/EMS CONSORTIUM for discontinuing resuscitation efforts</td>
</tr>
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| **BASIC INTERMEDIATE PARAMEDIC** |
| - As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status |
| - Epinephrine 1:10,000 q 3-5 minutes for the duration of the rhythm |

| **PARAMEDIC** |
| - Interpret 12 lead |
| - Follow current ACLS |
| - Consider H’s and T’s |

**NOTE**  
Reference ROSC or Termination of Resuscitation Guideline as needed
**Cardiac Arrest – Hypothermia**

**Effective 4/1/17**

Cardiac arrest with the presence of a suspected or confirmed depressed core temperature <95 degrees Fahrenheit.

### ALL PROVIDERS

- Establish Primary Management
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable
- Rapid transport (gently move the patient)
- Secure airway
- Gentle passive rewarming only
- Ventilate with warm humidified oxygen, if available, at a maximum rate of 10 per minute.
- Check pulse for 60 seconds.
- If ANY pulse is detected, continue passive rewarming and transport with no further treatment.
- If the patient is in cardiac arrest, begin CPR.
- Defibrillate if indicated.
- If the patient’s core temperature is below 86°F, additional defibrillation should be deferred until the temperature is above 86°F. If core temperature is not obtainable, then proceed per the Cardiac Arrest Guideline, with modifications as noted below.
- Termination may be considered in patients who are both cold and dead, such as ice in airway or frozen solid chest.
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available
- Contact EMS CONSORTIUM (505-449-5710) for consult

### BASIC

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
- Administer 1 mg of Epinephrine 1:10,000.
- If the patient’s core temperature is below 86°F, additional Epinephrine should be deferred until the temperature is above 86°F. If core temperature is not obtainable, then proceed per the Cardiac Arrest Guideline, except doubling the time interval between repeated Epinephrine administrations to 6 – 10 minutes instead of 3 – 5 minutes.

### INTERMEDIATE

- Continue rewarming
- Interpret 12 Lead
- Do not treat bradycardias
- If pulse is present regardless of rhythm, consult MCEP/EMS CONSORTIUM before treatment

### PARAMEDIC

- Continue rewarming
- Interpret 12 Lead
- Do not treat bradycardias
- If pulse is present regardless of rhythm, consult MCEP/EMS CONSORTIUM before treatment
# RETURN OF SPONTANEOUS CIRCULATION

**Effective 4/1/17**

### GENERAL
- Establish Primary Management
- **Confirm ROSC** with palpable pulse and blood pressure
- Look for the cause of the arrest and focus on reversing the cause if not yet fixed
- Avoid hyper-oxygenation. Administer oxygen sufficient to maintain SpO2 94%.
- If unconscious, assure proper placement of advanced airway.
- Avoid hyperventilation. If patient requires assisted ventilation, ventilate 10-12 times per minute with just enough volume to create visible chest rise.
- Apply waveform capnography if available.
- Monitor vital signs frequently.
- If pulses lost, reference cardiac arrest guideline
- **Do not move patient until stable for at least 5 minutes.**
- After 5 minutes and pulses remain, calmly move patient to ambulance and transport to a core facility with cath capabilities.
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available.

### ALL PROVIDERS

### BASIC
- As needed, initiate an IV/IO; titrate to the patient's hemodynamic and perfusion status
- Reference Cardiogenic Shock Guideline

### INTERMEDIATE
- Interpret 12 Lead ECG
- Consider advanced airway and ventilator as available
- Monitor airway with end-tidal capnography
- Titrate ventilations to EtCO2 35-45 mmHg
- If cause of cardiac arrest is evident, treat per ACLS guidelines
- If needed, reference Altered Mental Status for sedation
- If hypotensive, reference the Cardiogenic Shock Guideline
### TERMINATION OF RESUSCITATION EFFORTS

**Effective 4/1/17**

#### ALL PROVIDERS
- Termination of resuscitation efforts in the field may be considered if all the following conditions apply:
  - Interventions have been implemented for at least **30 minutes**, and
  - The terminal rhythm is asystole
  - The arrest is not the result of hypothermia
  - Resuscitation time frame shall increase to 40 minutes for any patient that presents in any of the following rhythms at any point during resuscitation efforts:
    - Ventricular Fibrillation
    - Ventricular Tachycardia
    - PEA >40 bpm
- LVAD patients should generally be transported regardless of presenting rhythm; contact EMS Consortium (505-449-5710) for guidance as needed.

#### BASIC
- If no ILS or ALS is available and the BLS provider has performed resuscitation efforts for 30 minutes or greater without any changes, contact EMS Consortium (505-449-5710)

#### INTERMEDIATE
- If no ALS is available and the ILS provider has performed resuscitation efforts for 30 minutes or greater without any changes, contact EMS Consortium (505-449-5710)

#### PARAMEDIC
- Termination of unsuccessful resuscitation via standing orders may be made by JPEMS career Paramedics, however, MCEP/EMS CONSORTIUM contact is recommended
  - Excluding hypothermic and/or pediatric patients. MCEP/EMS CONSORTIUM contact should be made on hypothermic and/or pediatric patients prior to termination of a resuscitation.
- Be alert to sudden changes in EtCO2 changes. Sudden increases can indicate ROSC, whereas sudden decreases can indicate loss of pulses.
- Cardiac Arrest Patients with EtCO2 levels above 30mmHg should be resuscitated until ROSC is achieved. If no ROSC achieved after 30 minutes and EtCO2 still elevated, contact EMS Consortium (505-449-5710).
SECTION 7
TRAUMA GUIDELINES
ASSAULT / RAPE
(CRIMINAL SEXUAL PENETRATION AND/OR ASSAULT)

Effective 4/1/17

GENERAL

Any victim of sexual assault should be encouraged to receive a Sexual Assault Exam at an Emergency Department or at the Sexual Assault Nurse Examiner (SANE) Facility. NM State law mandates reporting of all suspected child abuse cases, and Child Protective Services should be contacted if appropriate.

ALL PROVIDERS

➢ Establish Primary Management
➢ Ensure Law enforcement activation and response
➢ Protect and preserve evidence and the scene.
➢ Comfort and reassure the victim.
➢ Advise the patient against, eating, drinking, bathing, smoking and urinating, if possible.
➢ Encourage the patient to wear or at least bring the clothing he or she was wearing at the time of the assault, if possible.
➢ Treat injuries as appropriate.
➢ Transport any patient to the appropriate Emergency Department presenting with any of the following conditions:
  • Any history of loss of consciousness or other sign of head injury; incoherent or combative behavior; an altered mental status, or suspected intoxication/overdose
  • An oxygen saturation <90%, or a pulse >110, or a systolic BP <90 mmHg or >180 mmHg, or any dysrhythmia
  • Any history of compromised airway, or the potential for such based on a history of attempted strangulation or ligature restraint
  • Significant trauma and/or uncontrolled bleeding
  • Any indication of suicidal behavior or ideation
➢ Minimize the number of EMS Providers having contact with the patient.
➢ Unless significant uncontrolled bleeding is suspected, vaginal and perianal exposure and examination is not appropriate.
➢ If the patient is otherwise uninjured and does not want or need transport to an Emergency Department, but wants the Sexual Assault Exam and further counseling and information, you may contact the SANE (Sexual Assault Nurse Examiner) Facility at 505-883-8720. You will speak with a SANE nurse, and will inform them that you have an individual who is appropriate for transport to meet with the SANE personnel at the Family Advocacy Center, 625 Silver, SW. It is preferable that the patient be transported via privately owned vehicle or law enforcement. However, if JPEMS is the only alternative, the patient should be offered transport, but only if SANE has agreed to accept the patient from SC JPEMS FD and will have staff on site.
➢ In the instance that JPEMS transports a patient to SANE, the JPEMS Provider should give a report to the SANE nurse via phone.
**BURNS**

Effective 4/1/17

Rules of Nines: (Table represents anterior & posterior)

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<tr>
<th></th>
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<tr>
<td>HEAD</td>
<td>9%</td>
<td>18%</td>
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<tr>
<td>CHEST-BACK</td>
<td>18%</td>
<td>18%</td>
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<tr>
<td>ARM</td>
<td>9%</td>
<td>9%</td>
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<tr>
<td>LEG</td>
<td>18%</td>
<td>14%</td>
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<tr>
<td>PUBIC-PERINEUM</td>
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➢ The palm of a patient’s hand represents 1% body surface area.
➢ Be alert for patients with respiratory problems from smoke or chemical inhalation, respiratory tract burns or burns involving the face, head or chest.
➢ Major burns should be rapidly transported
➢ Local stabilization may be required before transport.
➢ Major burns are categorized as:
   • Partial thickness burns > 10% in adults and > 5% in children.
   • Full Thickness injuries > 5% body surface area.
   • All severe full-thickness burns involving hands, face, eyes, ears, feet and perineum.
   • Circumferential burns.
   • All burns that compromise circulation.
   • All burns with evidence of respiratory involvement or inhalation.
   • All high voltage electrical injuries.
   • Burns with associated multi-system trauma.
   • All high-risk patients (underlying medical problems, especially respiratory).
### ALL PROVIDERS

- Establish Primary Management
- Chemical Burns – identify contaminant, flush with water for a minimum of 10 minutes.
- Brush off dry chemicals before irrigation.
- Gently wash with water for a minimum of 10 minutes if burning process has started.
- Estimate depth and percent of area injured.
- Partial Thickness burns <10% of adult and <5% of child, may be cooled with water for 10 – 15 minutes and covered.
- Keep warm.
- Burns with <20% BSA can be covered using sterile moist dressing or commercial burn dressing (i.e. burn gel dressing).
- Burns with >20% BSA shall receive dry sterile dressing or commercial burn dressing (i.e. burn gel dressing).
- When burns are associated with severe trauma, trauma guidelines will supersede burn guidelines.
- Burns with suspected airway involvement and burns >20% body surface area require paramedic intervention.
- All major and moderate burns deserve paramedic assessment and intervention.
- Immediate stabilization should take place at closest hospital facility with early activation of aeromedical transport.

### BASIC

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
  - 2” catheters are preferred.
- Bolus patient with 20cc/kg for severe burns.
- Consider repeating bolus of 20cc/kg as necessary.
- DO NOT place IV in burned skin region unless absolutely necessary.
- For pain control, see pain management guideline.

### INTERMEDIATE

- In patients in extreme distress, anxiety or agitation consider the administration of 2–10mg of midazolam IV/IO/IM (0.2mg/kg; max 2.5mg/dose for pediatric).
- For airway control in the presence of a respiratory burn with signs of airway compromise, refer to ALS Provider Airway Guideline.
- Contact MCEP/EMS CONSORTIUM for additional pain medication orders as needed.

### PARAMEDIC

- In patients in extreme distress, anxiety or agitation consider the administration of 2–10mg of midazolam IV/IO/IM (0.2mg/kg; max 2.5mg/dose for pediatric).
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**CRUSH INJURY**

**Definitions:**
- **Crush Injury:** prolonged continuous pressure on large muscles (arms or legs), which results in muscle disintegration.
- **Compartment Syndrome:** associated with deep tissue injury that results in a restriction of outward swelling caused by a collection of blood in the injured tissue due to inflexible muscle fasciae, which results in increased pressure in the compartment, causing restriction of blood flow, ischemia, swelling, and potentially tissue necrosis.

**Causes of Crush Injury/Compartment Syndrome:**
- Trauma
- Compression under body weight for extended periods of time
- Muscle overuse (rhabdomyolysis)

**Signs and Symptoms:**
- Metabolic acidosis
- Arrhythmias (ventricular fibrillation most common)
- Hyperkalemia

---

**GENERAL**

**Establish Primary Management / monitor vital signs frequently**
- Consider SMR
- Reference Traumatic hemorrhage as needed
- Consider ALS response
- Object should usually be removed slowly and in a coordinated fashion
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable

---

**ALL PROVIDERS**

- As needed, initiate an IV/IO; titrate to the patient's hemodynamic and perfusion status
  - Consider fluid resuscitation to hydrate patient prior to releasing of the compressive force to minimize hypovolemia and to dilute cellular toxins
  - Consider MCEP/EMS CONSORTIUM for specific fluid needs
- Consider pain management
- Cardiac monitor

---

**INTERMEDIATE**

- Interpret 12 lead
- Continually monitor ECG
- Consider **Sodium Bicarbonate** if ischemia or crush injury time > 30 minutes
  - 1mEq/kg
- Consider **Calcium** if ECG indicative of Hyperkalemia
  - 1gram over 10 minutes
  - Prepare medication prior to extrication

---

**PARAMEDIC**

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### FRACTURES – EXTREMITY

**Effective 4/1/17**

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<tr>
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<tr>
<td>➢</td>
<td>If patient is stable or if isolated injury exists, check distal pulses and sensation before and after splinting, and reassess frequently.</td>
</tr>
<tr>
<td>➢</td>
<td>Splint injuries in position found. If limb must be moved for extrication or transport, gently straighten and splint. Immobilize the joints proximal and distal to the injury.</td>
</tr>
<tr>
<td>➢</td>
<td>If extremity or joint is severely angulated with absent pulses, or loss of sensation or strength distally, gently straighten to anatomically correct positioning. Reassess circulation.</td>
</tr>
<tr>
<td>➢</td>
<td>Most isolated hip, acetabular and high femur fractures are best managed WITHOUT the use of a rigid device such as a backboard and/or vacuum splint. Carefully placing the patient on a soft gurney will dramatically increase comfort and minimize pain during transport.</td>
</tr>
<tr>
<td>➢</td>
<td>Reference Traumatic Hemorrhage Guideline as needed</td>
</tr>
<tr>
<td>➢</td>
<td>Reference Pain Management Guideline</td>
</tr>
</tbody>
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<tr>
<th>PROVIDERS</th>
<th>BASIC</th>
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<tbody>
<tr>
<td>➢</td>
<td>As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status</td>
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<tr>
<th>PROVIDERS</th>
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<tr>
<th>PROVIDERS</th>
<th>PARAMEDIC</th>
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</table>
### GENERAL

**EYE INJURIES**

The patient will present with signs and symptoms of eye pain due to superficial corneal abrasions, mace or pepper spray exposure or welders burns.

### ALL PROVIDERS

- Establish Primary Management
- For Chemicals or Foreign Objects
  - Assess for obvious trauma to globe or cornea. If found, do not irrigate, cover both eyes with a loose dry dressing.
  - Where there is no obvious trauma to the globe, gently flush eyes with NS for at least 15 minutes, or until 1 L of NS has been used. Do not be concerned with removal of contact lenses in the field unless torn or broken. Treat by irrigation, like any foreign body.
  - In the case of exposure to law enforcement type chemical agents such as Pepper Spray, transport may not be required following eye flushing if symptoms of eye irritation are resolved.
  - Consider covering both eyes to help decrease eye movement.
  - Do not patch any penetrating or open eye injury. May cover without any pressure on the globe (e.g., with a cup).

### BASIC

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status

### INTERMEDIATE

- Tetracaine Hydrochloride can be used before irrigation
  - 2 drops into the affected eye
  - Tetracaine is contraindicated in the presence of penetrating eye injuries

### PARAMEDIC

- Consult MCEP/EMS CONSORTIUM (505-449-5710) if further guidance needed
# Head Injury – Increasing Intracranial Pressure

**General**

The patient will be suspected of having increased intracranial pressure due to traumatic injury. A history of trauma associated with any or all of the following: slowing pulse rate, increasing blood pressure, increasingly irregular respiratory pattern, altered level of consciousness, unequal pupils, repetitive speech patterns, seizures, or presence of Cerebral Spinal Fluid leak.

<table>
<thead>
<tr>
<th>ALL PROVIDERS</th>
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<tbody>
<tr>
<td>Establish Primary Management</td>
</tr>
<tr>
<td>Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable</td>
</tr>
<tr>
<td>Monitor serial vital signs including GCS and document every 5 minutes</td>
</tr>
<tr>
<td>Ensure adequate oxygenation - SaO₂ &gt; 94%</td>
</tr>
<tr>
<td>Ensure adequate perfusion - Systolic BP &gt; 90 – 100 mmHg</td>
</tr>
<tr>
<td>If BVM ventilation is needed, patients will be ventilated at a rate of 10 ventilations per minute</td>
</tr>
<tr>
<td>For pediatric patients, the ventilation rate should be 20 ventilations per minute.</td>
</tr>
<tr>
<td>Request ALS intercept for patients with GCS &lt; 8 and prolonged transport if not already enroute</td>
</tr>
<tr>
<td>Check BGL, if altered mentation</td>
</tr>
<tr>
<td>Aggressive advance airways shall only be considered if the airway is failing. If BLS is adequate to ventilate the patient, the provider should not proceed to more aggressive tools</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Basic</th>
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<tbody>
<tr>
<td>As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status</td>
</tr>
<tr>
<td>SYSTOLIC &gt; 90 – 100 mmHg</td>
</tr>
<tr>
<td>If BGL &lt; 60 mg/dl, administer 12.5 g D50W and reassess, continue treatment if indicated</td>
</tr>
<tr>
<td>Do not administer nitroglycerine or otherwise attempt to lower the blood pressure for ANY patient with hypertension from head injury</td>
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<thead>
<tr>
<th>Intermediate</th>
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<tbody>
<tr>
<td>If patient is being ventilated, ensure that ETCO₂ is maintained at 35 – 45 mmHg.</td>
</tr>
<tr>
<td>Follow airway management guidelines as appropriate and Altered Mental Status guideline if necessary</td>
</tr>
<tr>
<td>Interpret 12 lead</td>
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**Effective 4/1/17**
<table>
<thead>
<tr>
<th>GENERAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Establish Primary Management</td>
</tr>
<tr>
<td>➢ Rapid Transport, notify receiving facility of possible septic patient</td>
</tr>
<tr>
<td>➢ Oxygen titrated to &gt;94%</td>
</tr>
<tr>
<td>➢ Bleeding control as needed (consider tourniquet)</td>
</tr>
<tr>
<td>➢ Modified Trendelenburg, keep patient warm and give nothing by mouth (NPO)</td>
</tr>
<tr>
<td>➢ If possible, treat the specific cause of the hypotension, i.e. anaphylaxis</td>
</tr>
<tr>
<td>➢ Consider use of pelvic binders (if applicable) to help control any internal hemorrhage in the pelvis</td>
</tr>
<tr>
<td>➢ Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable</td>
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<table>
<thead>
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<td>➢ As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status</td>
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<table>
<thead>
<tr>
<th>BASIC</th>
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</thead>
<tbody>
<tr>
<td>➢ Interpret 12 lead</td>
</tr>
<tr>
<td>➢ EtCO2 monitoring</td>
</tr>
<tr>
<td>➢ Advanced airway as needed.</td>
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</tbody>
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<tr>
<th>INTERMEDIATE</th>
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<tbody>
<tr>
<td>➢ If all treatable causes of hypotension in the trauma patient have been addressed and the patient continues to have profound hypotension, consider Epi Mini bolus as a temporizing measure until patient can receive blood products.</td>
</tr>
<tr>
<td>• Epinephrine 1:100,000 (discard 9cc of Epi 1:10,000 and replace with 9cc NS)</td>
</tr>
<tr>
<td>o Adult Dose: 2-10cc (2-10mcg) IVP</td>
</tr>
<tr>
<td>o Pediatric Dose: 0.1cc/kg (1mcg/kg up to adult dose)</td>
</tr>
</tbody>
</table>
### General

- When in doubt, limit patient movement and provide in-line stabilization until arrival of higher trained personnel.
- The following patients should receive SMR:
  - Patients with a significant mechanism of injury, or who have an altered level of consciousness, or who are complaining of mid-line C-spine and/or vertebral column pain.
  - Patients who have a significant distracting injury and may not be able to fully perceive and appreciate their pain along the vertebral column.
  - Patients displaying symptoms of neurological deficits after a traumatic incident.
  - Victims of penetrating trauma if:
    - There is evidence of neurological deficit at or below the level of injury.
    - There is a suspicion of spinal injury based on the location of the wound.

### ALL PROVIDERS

- **Field Treatment**
  - Rigid Cervical Collars - properly sized collars shall be used in conjunction with SMR whenever practical.
  - Critical trauma patients shall be extricated using rapid extrication standards.
  - With a fully cooperative and stable patient, extricate the patient onto a long board using manual support in conjunction with a C-Collar; remove the board once patient prepared for transport. Patients who are unconscious should be extricated rapidly using appropriate, available equipment and personnel for the situation.
  - If the patient is able to ambulate or move into a supine position on their own, the patient should be permitted to do so with assistance from EMS Personnel after application of C-collar and no backboard is needed.

- SMR may not be required if:
  - The patient is conscious, alert, oriented, able to perceive pain, neurologically intact, and, in progressive order, is determined to:
    - Not be suffering from a significant distracting injury.
    - Not be intoxicated or under the influence of mind altering drugs/medications.
    - Have no evidence of closed head injury.
    - Have no vertebral column pain or discomfort by self-evaluation or palpation.
    - Have no pain or discomfort of vertebral column with active movement.

### NOTE

Remember that SMR is not a benign procedure. You are assuming total control of a patient’s airway if you immobilize a patient. Decubitus ulcers may result within twenty minutes in spinal cord injured patients and unconscious patients.
Any Suspicion of MOI for Spine Injury

Manual Spine Immobilization!

Critical MOI
- Multi-Trauma
- MVC Ejection
- Long Falls
- Direct Spine Injury

Possible MOI
- Nearly all traumas
- MVCs
- Falls
- Violence

Minimal MOI
- Very Low or No Energy Applied to patient

Posterior neck pain or midline Thoracic/Lumbar pain or history of acute paraesthesias or > 65 yo

Unreliable Exam?
- Altered LOC:
  - Head Injury
  - Intoxication
- Distracting Injury
- Language Barrier

Reliable Exam?
- Alert
- Appropriate
- Cooperative

Good Distal Neuros
- Normal X 4:
  - Extension
  - Flexion
  - Light Touch
  - Sharp Touch

No Spinal Tenderness
No Spine Pain on Exam
No Spine Deformity
No Pain w/ Movement

Possible MOI
- Reliable Exam
- Good Neuros
- No Spine tenderness

Spinal Tenderness
Any Spinal abnormalities or pain

Abnormal Distal Neuros
Any impairment:
  - Motor
  - Sensory
  - Circulatory

SMR

N O SMR
**GENERAL AMPUTATIONS**

Effective 4/1/17

<table>
<thead>
<tr>
<th>ALL PROVIDERS</th>
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<tbody>
<tr>
<td>✓ Establish Primary Management</td>
</tr>
<tr>
<td>✓ Control Bleeding (consider tourniquet post direct pressure)</td>
</tr>
<tr>
<td>✓ Enroute, gently rinse the amputated parts with NS to remove loose debris and wrap in dry gauze. DO NOT scrub.</td>
</tr>
<tr>
<td>✓ Transport to appropriate surgical facility</td>
</tr>
<tr>
<td>✓ Reference Traumatic Hemorrhage Guideline as needed</td>
</tr>
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<thead>
<tr>
<th>BASIC</th>
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<tbody>
<tr>
<td>✓ As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status</td>
</tr>
<tr>
<td>✓ Consider Pain Management Guideline for pain control</td>
</tr>
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<thead>
<tr>
<th>INTERMEDIATE</th>
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<tr>
<th>PARAMEDIC</th>
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</thead>
</table>
# GENERAL PENETRATING, BLUNT AND MULTISYSTEM TRAUMA

**Effective 4/1/17**

## ALL PROVIDERS
- Establish Primary Management
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable
- Initiate Rapid transport
  - Prolongation of scene time is **unacceptable** for the following:
    - To await the arrival of a helicopter - may rendezvous enroute when necessary if ground transport is going to take longer than 30 – 40 minutes.
    - To begin IVs at the scene, when ground transport is available
- Consider SMR
- Reference Traumatic Hemorrhage Guideline as needed
- If penetrating object remains in patient, DO NOT REMOVE
- Stabilize the object and transport if able. Consider requesting EMS Consortium rendezvous for assistance (505-449-5710)
- If unable to remove patient, call additional resources and consider requesting EMS Consortium response

## BASIC
- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
- If hypotensive, bolus 20 cc/kg as needed and reassess OR TO SYSTOLIC OF 90
- Critically unstable presentation - rapid transport and ALS required
- For pain control, see pain management guideline.

## INTERMEDIATE
- Advanced Airway procedures as necessary
- Interpret 12 lead
- If hypotension persists despite bleeding control and IV bolus consider:
  - Needle Decompression
  - Pelvic Binder (if possible)
  - Thorough secondary assessment to identify other soft tissue injuries

## PARAMEDIC
- Advanced Airway procedures as necessary
- Interpret 12 lead
- If hypotension persists despite bleeding control and IV bolus consider:
  - Needle Decompression
  - Pelvic Binder (if possible)
  - Thorough secondary assessment to identify other soft tissue injuries
Establish Primary Management
➢ Evaluation at Birth: The APGAR scoring system:
➢ Obtain APGAR assessment score at earliest reasonable opportunity (1 & 5 minutes)

<table>
<thead>
<tr>
<th>Evaluation Factor</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance (Skin Color)</td>
<td>Body and Extremities blue, pale</td>
<td>Body pink, extremities blue</td>
<td>Completely pink</td>
</tr>
<tr>
<td>Pulse rate</td>
<td>Absent</td>
<td>Below 100 per minute</td>
<td>100 per minute or above</td>
</tr>
<tr>
<td>Grimace (Irritability)</td>
<td>No Response</td>
<td>Grimace</td>
<td>Cough, sneeze, or cry</td>
</tr>
<tr>
<td>Activity (Muscle Tone)</td>
<td>Limp</td>
<td>Some flexion of extremities</td>
<td>Active motion</td>
</tr>
<tr>
<td>Respiratory effort</td>
<td>Absent</td>
<td>Slow and irregular</td>
<td>Strong Cry</td>
</tr>
</tbody>
</table>

➢ Position the mother appropriately.
➢ Prepare PPE and OB Kit.
➢ As the baby’s head emerges, if the amniotic sac has ruptured, look for signs of meconium staining and prepare to treat appropriately.
➢ Apply gentle counter – pressure to the baby’s head with the palm of a hand to prevent an unexpected precipitous delivery.
➢ The head should turn towards the mother’s left or right; with the mother’s next contraction, gently guide the baby’s head downward (toward the mother’s buttocks) to allow delivery of the upper shoulder, and then guide the baby’s body upward (toward the mother’s abdomen) to deliver the lower shoulder. The EMS Provider must be prepared to support the infant’s body as it emerges.
➢ Once fully delivered, note the time of birth, and initiate drying, warming, positioning, appropriate suctioning and, if necessary, stimulation of the infant. Clean, dry and wrap baby in clean sheet, towel, or blanket. Cover the baby’s head, and put the baby to the mother’s breast, if she intends to breast feed.
➢ Aggressive suctioning can cause bradycardia, tissue trauma, and irritation of nasal membranes that causes rebound mucous production & nasal congestion. Use your best judgment, and gently suction the baby as soon as you feel it is necessary.
➢ Perform the APGAR assessment on the baby (detailed above).
➢ If the baby’s respirations and movement are depressed or abnormal despite above, refer to the Neonatal Resuscitation guideline.
➢ Cutting the cord is not necessarily a priority, and in fact, delaying the cord cutting until it at least stops pulsating is beneficial to the baby. Transport should not be delayed to cut the cord. If cutting the cord during transport is indicated, then once the cord stops pulsating clamp the umbilical cord about 6 - 7 inches from the baby, and again about 9 - 10 inches from the baby, and cut the cord between the clamps.
➢ The placenta may take up to 30 minutes to deliver. After it delivers, gently massage the uterine fundus to help decrease maternal hemorrhage.
➢ Reference neonatal resuscitation guideline as needed
➢ Cardiac monitor to capture rhythm and obtain 12 lead ECG, if available/applicable
<table>
<thead>
<tr>
<th>Level</th>
<th>Task Description</th>
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<tbody>
<tr>
<td>BASIC</td>
<td>As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status</td>
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<tr>
<td>INTERMEDIATE</td>
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<tr>
<td>PARAMEDIC</td>
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CHILDBIRTH – ABNORMAL

➢ Breech birth, Limb presentation or Prolapsed cord.
➢ ALS response is required for all the following abnormal or critical situations.
➢ Consider a helicopter response if available.
➢ Initiate emergent transport at the earliest opportunity, and meet ALS enroute.
➢ Specific care for particular abnormal presentations is found in the following guidelines.

CHILDBIRTH – FULL BREECH DELIVERY

Effective 4/1/17
➢ Establish Primary Management
➢ Prepare for delivery.
➢ Mother positioning should include elevating the hips by placing pelvis on top of a bedpan or stack of towels to help facilitate delivery.
➢ Breech deliveries are better dealt with in a hospital. Positioning the mother on her left side, and asking her if she can avoid pushing and breathe through contractions, may delay birth until she can be transported to an appropriate facility. But with the long transports in Sandoval County, delivery may be imminent and unavoidable.
➢ Once the breech delivery begins, the lower extremities will often quickly deliver. Support the infant’s body, and if the baby’s head delivers spontaneously, proceed with suctioning airway (mouth and nose), then dry and wrap baby as you would with a normal delivery.
➢ Once the umbilical cord is visualized, if it is pulled taut, it should be pulled gently down and out of the vagina to create slack for the remainder of the delivery. To reduce the risk of asphyxia, the head should be born within 5 minutes of this point.
➢ The shoulders are usually not a problem to deliver, but if there is any difficulty, they are usually delivered by depression of the buttocks and extracting the anterior shoulder with a gloved finger. The baby’s body is then raised gently, and the posterior shoulder should deliver.
➢ The baby will now rotate towards the mother’s tailbone, support the baby and allow the rotation.
➢ Do NOT pull on the baby, despite the temptation. Lift the body slightly.
➢ Have an EMS Provider apply gentle pressure directly above the pubic bone to flex the baby’s head down. When the mother pushes, the head will usually deliver.
➢ If the head does not deliver, continue rapid transport and assure ALS intercept.
➢ Keep the baby’s body warm by draping with towels, etc., and keep the umbilical cord warm and moist if it is still pulsating.
➢ If the head does not deliver within 4 – 6 minutes, perform the MAURICEAU Maneuver as defined below:
• Having a EMS Provider support the body, insert your gloved hand with two gloved fingers in a “V” shape, much as described previously for creating an airway for the baby.
• Place your fingers on the fetal maxilla, applying enough pressure to tuck and flex the child’s head. The maneuver is to tuck, NOT PULL, the head.
• Place your other hand gently over the occiput to aid in flexion.
• During the mother’s next contraction, have her push hard, during which another EMS Provider should apply suprapubic pressure to assist with the flexion of the head and assist with the delivery.
➢ Be prepared for maternal hemorrhage, with or without successful delivery of the baby.
Limb presentations occur when the fetus is in a transverse lie in the uterus, and the arm or leg protrudes from the vagina. This is seen in less than 1% of deliveries, and is most often associated with preterm birth and multiple gestation situations. This is a life-threatening situation for the fetus.

Establish Primary Management
Place mother in knee-chest position (prone, resting on her knees and upper chest), and secure her as well as possible for transport. Deliver high flow oxygen to the mother.
Transport immediately to a hospital with cesarean section capability. Air support is certainly a consideration if your transport time will be more than 30 – 40 minutes.
### CHILDBIRTH – PROLAPSED CORD

**Effective 4/1/17**

Umbilical cord prolapse occurs when the umbilical cord precedes the fetal presenting part, causing the cord to be compressed between the fetus and the bony pelvis. This shuts off fetal circulation, potentially a fatal event for the fetus.

**ALL PROVIDERS**

- Establish Primary Management
- Place mother in knee-chest position (prone, resting on her knees and upper chest), and secure her as well as possible for transport. Administer high flow oxygen to the mother.
- Insert a gloved hand into the vagina and gently but effectively push the presenting part that is compressing the cord.
- Uterine contractions will be forcing the baby down toward you at regular intervals.
- Once your hand is in the vagina, the EMS Provider will often remain in that situation until the baby is delivered by caesarian section at the hospital.
- Once this maneuver is completed, a pulsating cord is reassuring if the EMS Provider feels it against their hand.
- If the cord protrudes outside of the vagina, keep it moist and warm as possible with saline and dressings.
- The fetus’ best hope for survival is rapid transport and early cesarean section. Air support is certainly a consideration if your transport time will be more than 30 – 40 minutes.
### GENERAL

This occurs when the umbilical cord wraps around the fetal neck. When found during an otherwise normal delivery, intervention is required. This is a fairly common condition.

### ALL PROVIDERS

- Establish Primary Management
- As soon as possible during delivery of the head, check for a nuchal umbilical cord. If present, slip it over the head.
- If it is too tight to do this, quickly but carefully place two umbilical clamps about 2 inches apart and cut the cord between the clamps.
- If the rather drastic action of cutting a nuchal cord is taken, the baby’s only supply of oxygen is cut off. The remainder of the delivery should take place as quickly as possible to facilitate stimulation of the baby’s respiratory effort.

### BASIC

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status

### INTERMEDIATE

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
Shoulder dystocia is one of the most frequently occurring complications of delivery.
➢ Establish Primary Management
➢ If the mother is on the gurney (or the floor), create space beneath her bottom by placing pillows or a bedpan under her buttocks. This will allow for more room for the head later.
➢ Assure ALS response, initiate transport, and utilize air transport if appropriate.
➢ Do NOT pull on the baby’s head; initiate O2 therapy for mother.
➢ McRobert’s Maneuver
   • Have the mother grasp her knees and pull her thighs back onto or alongside her abdomen, as if she was trying to put her knees into her armpits.
   • Have another EMS Provider stand on the mom’s side that the baby is facing away from, and apply deep pressure straight down just above the mother’s pubic bone. The EMS Provider should use a steady pressure initially, but if unsuccessful, should apply the pressure in a rocking motion.
   • With both of these maneuvers applied, have the mother push with a focused effort. Guide the head downward with a gentle pressure, but do not stress the neck.
   • If the shoulder is released, be prepared for a quick delivery.
➢ If McRobert’s maneuver is unsuccessful, try the Gaskin Maneuver
   • Have the mother flip herself over to her hands and knees.
   • Grasp the fetal head, and gently guide it downward attempting to deliver the posterior shoulder (which is now uppermost).
   • Repeat the above maneuvers as needed while initiating rapid transport.
   • If delivery is accomplished, the baby will often need aggressive resuscitation.
   • Prepare for significant postpartum bleeding, and treat appropriately.

➢ As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
### GENERAL

**CHILDBIRTH – POSTPARTUM HEMORRHAGE**

Effective 4/1/17

Postpartum hemorrhage is the loss of more than 500 cc of blood immediately following delivery, occurring in about 5% of deliveries.

- Establish Primary Management
- Initiate RAPID TRANSPORT
- Direct pressure on perineum
- Firmly massage the fundus after the delivery of the placenta.
- Place dressings against the vaginal area. DO NOT place anything inside the vagina.
- Put baby to breast as suckling may assist in stopping bleeding.
- Consider treatment for shock.

### ALL PROVIDERS

- As needed, initiate an IV/IO; titrate to the patient's hemodynamic and perfusion status

### PARAMEDIC

- If bleeding is not controlled with above methods and is concerning to the paramedic, administer Pitocin.
  - Dose: 10 units IM
  - Consider MCEP/EMS CONSORTIUM for additional Pitocin orders or consult.
**PRE-ECLAMPSIA – MILD AND SEVERE**

Effective 4/1/17

Pre-eclampsia is a hypertensive disorder of pregnancy. Pre-eclampsia is categorized as either mild pre-eclampsia or severe pre-eclampsia. Pre-eclampsia can occur up to six weeks after delivery.

**MILD PRE-ECLAMPSIA**

Mild pre-eclampsia is defined as a sustained BP of 140/90 or above.

**SEVERE PRE-ECLAMPSIA**

Severe pre-eclampsia may develop suddenly and present with any of the following: a systolic pressure of 160 mm/Hg or greater and/or a diastolic pressure of 110 mm/Hg or greater

Or

Systolic pressure >150 and/or diastolic >100 AND exhibits at least 2 signs and symptoms of severe pre-eclampsia (severe headache, blurred vision, abdominal pain)

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### GENERAL

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<thead>
<tr>
<th>Rule</th>
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<tbody>
<tr>
<td>Establish Primary Management.</td>
</tr>
<tr>
<td>Perform BGL.</td>
</tr>
<tr>
<td>If patient begins seizing, see Eclampsia Guideline.</td>
</tr>
<tr>
<td>Cardiac monitor to capture rhythm and obtain 12 lead ECG, if available/applicable.</td>
</tr>
</tbody>
</table>

### ALL PROVIDERS

- Establish Primary Management.
- Perform BGL.
- If patient begins seizing, see Eclampsia Guideline.
- Cardiac monitor to capture rhythm and obtain 12 lead ECG, if available/applicable.

### BASIC

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status.
- Perform field glucose determination. If < 60 mg/dl, administer D50 per guideline.

### INTERMEDIATE

- Contact an MCEP/EMS CONSORTIUM for magnesium sulfate consideration if symptoms are severe and seizure is impending.
**ECLAMPSIA**

**Effective 4/1/17**

When pre-eclampsia progresses to seizures. Some patients will progress directly into coma without an observed seizure. Most patients who develop eclampsia show marked edema, increased BP and other SxS of severe pre-eclampsia but up to 30% of eclampsia patients do not have these classic SxS.

Note: Pre-eclampsia/Eclampsia can occur up to six weeks after delivery.

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<th>GENREAL</th>
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<tbody>
<tr>
<td>➢ Establish Primary Management</td>
</tr>
<tr>
<td>➢ Protect the patient from injury.</td>
</tr>
<tr>
<td>➢ Perform BGL</td>
</tr>
<tr>
<td>➢ Airway management as needed</td>
</tr>
<tr>
<td>➢ Rapid Transport / ALS intercept</td>
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<td>➢ Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable</td>
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<td>➢ As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status.</td>
</tr>
<tr>
<td>➢ Perform field glucose determination. If &lt; 60 mg/dl, administer D50 per guideline.</td>
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<tr>
<td>➢ Dilute 4 G MgSO₄ in 25cc and administer slow IV push while IV runs wide open.</td>
</tr>
<tr>
<td>➢ Initiate a MgSO₄ drip</td>
</tr>
<tr>
<td>• Mix 2 G of MgSO₄ in 250 cc NS, and run over 1 hour</td>
</tr>
<tr>
<td>• With 60 mgtts tubing = 250 drops/min = approx. 4 drops/sec.</td>
</tr>
<tr>
<td>o Magnesium is contraindicated in patients with renal failure.</td>
</tr>
<tr>
<td>o If magnesium is administered too rapidly or the patient receives an overdose, severe hypotension, arrhythmia, respiratory and/or cardiac arrest may occur. In this event, and if your transport time is greater than 15 minutes, contact MCEP/EMS CONSORTIUM for possible order of:</td>
</tr>
<tr>
<td>▪ 10 mL Calcium Chloride 10% over 10 minutes.</td>
</tr>
<tr>
<td>➢ If seizure continues after MgSO₄, proceed to midazolam 2-10mg IM/IV/IO.</td>
</tr>
<tr>
<td>➢ Transport ASAP.</td>
</tr>
</tbody>
</table>

Commented [EM2]: MayoClinic reference
An episode that is frightening to the parent or EMS Provider and that is characterized by some combination of the following observations:

➢ Apnea (absence of breathing for at least 3 breaths and not simple gasping).
➢ Skin color change (cyanosis or recognized paleness).
➢ Marked change in muscle tone (unexplained rigidity or flaccidity).
➢ Unexplained choking or gagging (i.e., not choking or gagging episodes that commonly occur with feeding or rhinorrhea). In some cases the observer has feared the infant had died, and initiated CPR.

An apparent life-threatening event (ALTE) describes a set of symptoms and is associated with a wide variety of illnesses, including: gastroesophageal reflux, pertussis, RSV infection, UTI, metabolic disorders, cardiac dysrhythmias, seizures, sepsis, and child abuse.

The Majority of Infants with an ALTE will appear to be in no acute distress when evaluated by EMS personnel. Therefore the signs and symptoms noted by the parent/guardian should be considered credible – even when they do not match the observations of EMS providers.

➢ Establish Primary Management
➢ Reference Pediatric Respiratory Distress Guideline as needed
➢ Reference Seizure Guideline as needed
➢ Reference Fever Guideline as needed
➢ Reference Trauma Guidelines as needed
➢ Parents / Guardians shall be strongly encouraged to allow EMS to transport the patient to an appropriate facility due to the high risk of other underlying factors
➢ If parent / guardian refuses EMS transport, MCEP/EMS CONSORTIUM consult is required

Commented [JW3]: High risk situation. Protocol should include language about strongly encouraging family to permit transport. VERY LOW threshold for contacting MCEP/EMS CONSORTIUM (REQUIRED MCEP/EMS CONSORTIUM contact if refusal???)
### GENERAL

**PEDIATRIC CARDIAC ARREST**  
**(NON TRAUMATIC)**  

**Effective 4/1/17**

- Establish Primary Management
- Ensure ALS response
- Establish adequate ventilation and oxygenation
- Inquire about down time and advanced directives
- Consider Poisoning Ingestion Guideline
- Follow current AHA CPR Guidelines
- After 30 minutes, consider MCEP/EMS CONSORTIUM for discontinuing resuscitation efforts
- Specific Dosing below, or, Utilize Broselow for accurate dosing
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable

### ALL PROVIDERS

- Follow current AHA CPR Guidelines
- After 30 minutes, consider MCEP/EMS CONSORTIUM for discontinuing resuscitation efforts
- Specific Dosing below, or, Utilize Broselow for accurate dosing
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable

### BASIC

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
- Epinephrine 1:10,000, IV/IO, q 3 – 5 minutes for the duration of the rhythm
  - Dose: 0.01mg/kg to max of 1mg/dose
- Hypoglycemia
  - Dextrose 25% - 1g/kg
### Paramedic

- If defibrillation indicated, defibrillate once at 2 Joules/kg, followed by 2 minutes of CPR.
- Ensure secure airway
- After 2 minutes of CPR, check a pulse and determine the patient's rhythm. If indicated, defibrillate at 4 Joules/kg, and initiate CPR for 2 minutes.
  - Additional shocks, as indicated, shall be at 4 Joules/kg
- Continue Epinephrine 1:10,000
- Continue pattern of "Defib - 2 minutes of CPR – Pulse/Rhythm Check – Defib" as indicated for the duration of the resuscitation.
- Monomorphic ventricular tachycardia or ventricular fibrillation:
  - Lidocaine 1mg/kg IV/IO, q 5 minutes to a maximum total dose of 100 mg
  - Magnesium Sulfate 50 mg/kg (maximum of 2 grams) in 10cc syringe backfilling remainder of syringe with NS. Administer this over 4 minutes.
- Known or suspected hyperkalemia, renal failure, or hypocalcemia:
  - Calcium Chloride 10% - 20 mg/kg slow IV/IO

### Continued Next Page

- Calcium channel blocker overdose:
  - High Dose Epinephrine (3 mg 1:1000) every 5 minutes IV/IO
  - Calcium Chloride 10% - 20 mg/kg IV/IO Slow IV
- Tricyclic Overdose:
  - 1 mEq/kg Sodium Bicarbonate
  - Follow with an infusion of 1 mEq/kg in 1 liter of NS at 500 cc/hr

### General

#### Pediatric Bradycardia

*Effective 4/1/17*

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**NOTE**

Reference ROSC or Termination of Resuscitation Guideline as needed
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<td>➢ Establish Primary Management</td>
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<td>➢ Assure oxygenation ventilation</td>
</tr>
<tr>
<td>➢ Initiate rapid transport and request ALS</td>
</tr>
<tr>
<td>➢ If HR &lt;60 with signs of poor perfusion despite oxygenation &amp; ventilation, begin compressions at 30 compressions to 2 ventilation, or if two rescuers are providing CPR, 15 compressions to 2 ventilations.</td>
</tr>
<tr>
<td>➢ If patient’s HR is &gt;60, but the respiratory effort is inadequate, initiate ventilations with a BVM @ 12 – 20</td>
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<tr>
<td>➢ Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable</td>
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<th>PEDIATRIC NARROW COMPLEX TACHYCARDIA</th>
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As needed, initiate an IV/IO; titrate to the patient's hemodynamic and perfusion status

Interpret 12 Lead ECG

STABLE
- Assure treatment of possible causes: hypovolemia, hypoxia, acidosis, hypoglycemia, etc.
- Transport

UNSTABLE – Patient showing signs and symptoms of hypoperfusion
- Adenosine 0.1 mg/kg, maximum dose of 6mg, followed by rapid 5-10cc bolus
- Adenosine can be doubled and repeated once if SVT persists. Max 12mg
- If no response, consider sedation with 0.2 mg/kg midazolam (max dose of 2.5mg) IV/IO/IM and proceed with synchronized cardioversion @ 1 joule/kg; repeat @ 2 joules/kg
<table>
<thead>
<tr>
<th>GENERAL</th>
<th>PEDIATRIC WIDE COMPLEX TACHYCARDIA</th>
<th>Effective 4/1/17</th>
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<tbody>
<tr>
<td>➢ Establish Primary Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>➢ Assure oxygenation, ventilation</td>
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</tr>
<tr>
<td>➢ Explore treatment of possible causes: hypovolemia, hypoxia, acidosis, hypoglycemia, etc.</td>
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<tr>
<td>➢ Utilize Broselow for accurate dosing</td>
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<td>➢ Expeditious Transport with ALS intercept</td>
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<tr>
<td>➢ STABLE</td>
</tr>
<tr>
<td>• Interpret 12 lead ECG</td>
</tr>
<tr>
<td>• Initiate Rapid Transport</td>
</tr>
<tr>
<td>• Contact EMS CONSORTIUM (505-449-5710) for consult if needed</td>
</tr>
<tr>
<td>➢ UNSTABLE – Patient showing signs and symptoms of hypoperfusion</td>
</tr>
<tr>
<td>• If venous access is in place, sedate if needed and if time allows, with midazolam 0.2 mg/kg (max dose of 2.5 mg) IV/IO/IM</td>
</tr>
<tr>
<td>• Perform synchronized cardioversion @ 1 Joule/kg</td>
</tr>
<tr>
<td>• If unsuccessful, repeat synchronized cardioversion @ 2.0 joules/kg</td>
</tr>
<tr>
<td>o If unsuccessful, administer 1mg/kg Lidocaine</td>
</tr>
<tr>
<td>o Wait 1 minute, then perform the third synchronized cardioversion @ 2 joules/kg.</td>
</tr>
<tr>
<td>• If the third cardioversion is unsuccessful, wait 5 minutes and repeat the Lidocaine at 1 mg/kg (max total dose of 100mg),</td>
</tr>
<tr>
<td>o Wait 1 minute, and perform synchronized cardioversion @ 2 joules/kg.</td>
</tr>
<tr>
<td>• If rhythm converts after any defibrillation, administer lido drip.</td>
</tr>
<tr>
<td>• At any time, consider MCEP/EMS CONSORTIUM for consultation and additional orders</td>
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<th>INTERMEDIATE</th>
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<thead>
<tr>
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</table>
# NEONATAL RESUSCITATION

The patient is a newborn (28 days old or less) who requires resuscitative intervention.

## ALL PROVIDERS
- Establish Primary Management
- Assure oxygenation, ventilation
- DO NOT delay delivery if birth appears imminent.
- Determine APGAR
- Check blood sugar but do not administer oral glucose.
- Initiate blow-by high flow oxygen if the baby has adequate respiratory effort.
- If respiratory rate is less than 30 breaths per minute, or the baby is apneic, gasping, or has persistent central cyanosis despite high flow blow-by oxygen AND/OR the baby's HR< 100, begin ventilations with the appropriate bag valve mask and 100% oxygen at a rate of 40 to 60 ventilations per minute, and provide tactile stimulation.
- If the heart rate is less than 60 or absent, begin compressions per AHA guidelines.
- If the heart rate increases to above 60 bpm, discontinue compressions, but do not hesitate to begin compressions if the HR drops below 60 at any time.
- Rapid Transport / Request ALS.

## BASIC
- As needed, initiate an IV/IO; titrate to the patient's hemodynamic and perfusion status
- Perform BGL
- If BGL is < 60 mg/dl, administer 1g/kg slow IV push of D10% over several minutes
- If non-addict mother has used narcotics within the past four hours, consider naloxone
- DO NOT administer naloxone to infants of addicted mothers.

## INTERMEDIATE
- If meconium is present and the baby's APGAR is < 7 after delivery and stimulation, consider meconium aspiration.
- If IV or IO access has been obtained, bolus the neonate with 10cc/kg of NS. Repeat if necessary.
- Administer medications ONLY if compressions and positive pressure ventilation with 100% oxygen do not raise the HR >60.
  - If all of the above treatments have not increased the baby's HR to >60, proceed to:
    - Epinephrine 1:10,000 IV, 0.01mg/kg. Repeat every 3-5 minutes.
PEDIATRIC RESPIRATORY DISTRESS

Croup: a viral infection of the upper respiratory tract. Rarely, can cause airway obstruction. Most frequently found in children with a recent history of upper respiratory infection. Presents with a hallmark barking cough, stridor, sore throat, and rapid onset of a low-grade fever. Treat with humidified oxygen and if patient is acutely ill, nebulized epinephrine.

Epiglottitis: an acute, severe, life-threatening disease of the upper airway. Often begins as a local infection of the epiglottis. The epiglottis and surrounding structures become inflamed and edematous, which can cause airway compromise. Presents with rapid onset of fever, onset of drooling, and signs of upper respiratory compromise (inspiratory stridor). Patient may present in the sniffing position. Treat with high flow oxygen and transport; minimize assessment of airway, as it may hasten the rate of respiratory compromise.

Bronchiolitis: an acute infectious process of the lower respiratory tract. The most well-known form is respiratory syncytial virus (RSV). Presents with fever, tachycardia and/or tachypnea, shortness of breath, chest tightness, wheezing, and coughing. Treat the same as asthma (correct hypoxia, reverse bronchospasm, treat inflammation).

Asthma: a long-term inflammatory process that targets the lower airways and can lead to bronchospasm. Presents with wheezing, shortness of breath, chest tightness, and coughing. Treat by correcting hypoxia, reversing bronchospasm, and treating inflammation.

ALL PROVIDERS

➢ Primary Management
➢ Assure oxygenation / ventilation
➢ Position of comfort
➢ For stridor consider nebulized saline
➢ For wheezing consider albuterol
➢ Albuterol Dose 2.5-5mg inhalation max of 10mg
➢ Consider Foreign Body Obstruction Guideline
➢ Consider Airway Management Guidelines
➢ No invasive procedures unless lifesaving intervention is required
➢ Notify receiving facility ASAP

BASIC

➢ Can consider albuterol for stridor if nebulized saline ineffective
➢ If wheezing is severe and anaphylaxis or status asthmatics suspected
  • Epinephrine 1:1,000 SQ using a premeasured 0.3cc TB syringe with MCEP
  o Pediatric Dose: 0.01mg/kg up to 0.3mg/dose
  o Any dose greater than 0.6mg requires cardiac monitor
➢ For Wheezing consider CPAP if continued respiratory distress
### INTERMEDIATE

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status.

### PARAMEDIC

- Continuous EtCO2 monitoring
- For STRIDOR:
  - Consider Dexamethasone
    - Pediatric dose: 0.6 mg/kg IV or IM
    - Pediatric Dose: 0.1cc/kg (1mcg/kg up to adult dose)
- For WHEEZING:
  - Consider Dexamethasone IF history of Reactive Airway Disease or Age > 2 years
    - Pediatric dose: 0.6 mg/kg IV or IM
  - Consider Magnesium Sulfate if minimal/no response to all other interventions and still wheezing
    - Pediatric Dose: 25-50mg/kg (max of 2g) over 10-20 minutes
- Consider nebulized Epinephrine for worsening distress and/or impending respiratory FAILURE
  - Dose: mix 1 mg (1cc) of Epinephrine 1:1000 in 3 cc of normal saline, and administer via nebulizer.
  - Repeat this once after twenty minutes if the patient is severe and did not significantly improve after the first administration.
- For patient’s refractory to the above treatments, and SHOCK is cause:
  - Epinephrine 1:100,000 (discard 9cc of Epi 1:10,000 and replace with 9cc NS)
    - Dose: 2-10cc (2-10mcg) IVP
  - Consider Epinephrine Drip
    - Dose – Dilute 2mg of 1:1,000 into 250cc NS = 8mcg/mL with 60gtts tubbing.
    - Begin at 0.1mcg/kg and titrate to max of 1mcg/kg
- Consider MCEP/EMS Consortium consult.
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</tr>
<tr>
<td>➢ <strong>Confirm ROSC</strong> with palpable pulse and blood pressure.</td>
</tr>
<tr>
<td>➢ Look for the cause of the arrest and focus on reversing the cause if not yet fixed</td>
</tr>
<tr>
<td>➢ Avoid hyper-oxygenation, Administer oxygen sufficient to maintain SpO2 &gt;94%.</td>
</tr>
<tr>
<td>➢ If unconscious, assure proper placement of advanced airway.</td>
</tr>
<tr>
<td>➢ Avoid hyperventilation. If patient requires assisted ventilation, ventilate 10-12 times per minute with just enough volume to create visible chest rise.</td>
</tr>
<tr>
<td>➢ Apply waveform capnography if available.</td>
</tr>
<tr>
<td>➢ Monitor vital signs frequently.</td>
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<td>➢ Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable.</td>
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<td>➢ If pulses lost, reference pediatric cardiac arrest guideline.</td>
</tr>
<tr>
<td>➢ <strong>Do not move patient until stable for at least 5 minutes.</strong></td>
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<tr>
<td>➢ After 5 minutes and pulses remain, calmly move patient to ambulance and transport to a core facility with pediatric capabilities.</td>
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<td>➢ Consider advanced airway and ventilator as available</td>
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<tr>
<td>➢ Monitor airway with end-tidal capnography</td>
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<tr>
<td>➢ Titrate ventilations to EtCO2 35-45 mmHg</td>
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<td>➢ If needed, reference Altered Mental Status for sedation</td>
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<td>PEDIATRIC TERMINATION OF RESUSCITATION EFFORTS</td>
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<td><strong>Effective 4/1/17</strong></td>
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**ALL PROVIDERS**
- Termination of resuscitation efforts in the field may be considered if all the following conditions apply:
  - Interventions have been implemented for at least 30 minutes, and
  - The terminal rhythm is asystole
  - The arrest is not the result of hypothermia
  - Resuscitation time frame shall increase to 40 minutes for any patient that presents in any of the following rhythms at any point during resuscitation efforts:
    - Ventricular Fibrillation
    - Ventricular Tachycardia
    - PEA >40 bpm
- LVAD patients should generally be transported regardless of presenting rhythm, contact EMS Consortium (505-449-5710) for guidance as needed.

**BASIC**
- If no ILS or ALS is available and the BLS provider has performed resuscitation efforts for 30 minutes or greater without any changes, contact EMS Consortium (505-449-5710).

**INTERMEDIATE**
- If no ALS is available and the ILS provider has performed resuscitation efforts for 30 minutes or greater without any changes, contact EMS Consortium (505-449-5710).

**PARAMEDIC**
- EMS CONSORTIUM should be contacted on all pediatric patients prior to termination of a resuscitation.
- Be alert to sudden changes in EtCO2 changes. Sudden increases can indicate ROSC whereas sudden decreases can indicate loss of pulses.
- Cardiac Arrest Patients with EtCO2 levels above 30mmHg should be resuscitated until ROSC is achieved. If no ROSC achieved after 30 minutes and EtCO2 still elevated, contact EMS Consortium (505-449-5710).
SECTION 10
ENVIRONMENTAL GUIDELINES
### Acute Mountain Sickness (AMS)

**Effective 4/1/17**

Complications of AMS include the following life threatening conditions:

- **High Altitude Pulmonary Edema (HAPE)** – Caused by extracellular fluid shifts within the lungs. Signs and symptoms include: SOB, hypoxia, cyanosis, wet cough (rales/rhonchi), and possibly blood tinged sputum.
- **High Altitude Cerebral Edema (HACE)** – Caused by fluid redistribution resulting in cerebral edema, thought to be vasogenic, may be multi-factoral. Signs and symptoms include headache, nausea/vomiting, altered LOC, and syncope.

### All Providers

- Establish Primary Management
- Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable
- Descend to a lower altitude
- Position of comfort
- Pulse Oximetry
- Oxygenation
- If HAPE is cause, consider referencing Respiratory Distress Guideline and CPAP

### Basic

- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
- Advanced airway management as necessary, initiate IV NS, support vital signs as appropriate.
- For patients with HAPE, consult MCEP/EMS CONSORTIUM before other treatments.
- Hyperbaric chambers are available at St. Vincent’s Hospital.

###_intermediate

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**Pueblo of Jemez**

Page 128 of 153
**Bites: Animal/Insect/Snake/Human**

**Effective 4/1/17**

**Animal/Insect Bite:** Animal bites, except in rare instances, are not life or limb threatening. More limbs are endangered because of inappropriate treatment than from the bite itself.

**Human Bite:** All human bites should be evaluated in an emergency department because of the high risk for infection.

**Snake Bite:** More limbs are lost because of inappropriate treatment with ice, tourniquets and “cut and suck” than from the bites. Try to determine type of snake. Do not delay transport.

### ALL PROVIDERS
- Ensure Law Enforcement or Animal Control are dispatched
- Establish Primary Management
- Remove constrictive clothing and jewelry
- Rapid Transport
- Flush with sterile saline; keep patient calm
- Control bleeding and use sterile dressings
- Mark inflammation boundaries, if present
- Notify the hospital to assure anti-venom resources
- Maintain extremity in neutral position
- If patient has anaphylactic type response, treat appropriately per respiratory distress guideline
- For Snake Bites, splint the extremity at or below the level of the heart
  - A light Kerlix wrap to secure the splint is recommended starting above the bite location and working distally

### Basic
- As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status
- For pain control, see pain management guideline on Page 44.

### Intermediate
- If the patient was bitten by a Black Widow and severe signs and symptoms are present, consider administering 2 – 10 mg of midazolam IV/IM/IO (0.2mg/kg; max 2.5mg/dose for pediatric)
### COLD RELATED EMERGENCIES

**Effective 4/1/17**

Depressed core temperature < 95 degrees Fahrenheit.

<table>
<thead>
<tr>
<th>PROVIDERS</th>
<th>ACTION</th>
</tr>
</thead>
</table>
| **GENERAL** | Establish Primary Management  
Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable  
Handle the hypothermic patient gently; rough handling may cause Ventricular Fibrillation  
Remove victim from cold environment  
Remove any wet/cold clothing  
Monitor vital signs for one full minute at the carotid or by auscultation of heart sounds.  
If any pulse is detected, do not perform CPR  
If no pulse is detected, refer to the Hypothermia Cardiac Arrest guideline  
Assist respirations with warm humidified Oxygen, if available, at a rate of 8 – 10 per minute  
Cover torso with warm blankets  
Consider wrapping heat packs and placing them under the patient’s arms, groin, and posterior neck |
| **ALL PROVIDERS** | As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status  
• Use warm fluid if available |
| **PARAMEDIC** | Interpret 12 lead  
Consider midazolam 2-10 mg for seizure if present IV/IO/IM (0.2mg/kg; max 2.5mg/dose for pediatric) |
<table>
<thead>
<tr>
<th>GENERAL</th>
<th>HEAT RELATED EMERGENCIES</th>
</tr>
</thead>
</table>
| ➢ Establish Primary Management.  
➢ Cardiac monitor to capture rhythm and obtain 12 lead ECG if available/applicable.  
➢ Remove patient from warm environment.  
➢ Rapidly cool patient by whatever reasonable means possible (minimize shivering).  
➢ Cool misting is an approved method to cool patients.  
➢ If patient is alert without nausea, encourage oral hydration using an electrolyte solution when available.  
➢ If LOC deteriorates further, place cold packs under patient's arms, and at neck, ankles and head. Consider cooling with cold, wet dressings.  
➢ If patient is seizing, request ALS and reference seizure guideline. |

<table>
<thead>
<tr>
<th>ALL PROVIDERS</th>
<th>BASIC</th>
<th>INTERMEDIATE</th>
<th>PARAMEDIC</th>
</tr>
</thead>
</table>
| ➢ As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status.  
➢ Bolus in 250 - 500 cc increments, re-evaluate LOC, VS, and lung sounds between boluses.  
➢ If there is a question about the source of the patient’s diminished level of response, refer to altered mental status guideline as needed. | ➢ Consider advanced airway per the airway guidelines.  
➢ Interpret 12 lead.  
➢ Consider midazolam 2-10 mg for seizure or if severe shivering occurs due to overcooling IV/IO/IM (0.2mg/kg; max 2.5mg/dose for pediatric). | ➢ | ➢ |
<table>
<thead>
<tr>
<th>LEVEL</th>
<th>PROCEDURE</th>
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</table>
| GENERAL | Establish Primary Management  
Remove victim from cold environment and protect areas from further injury.  
Remove any wet/cold clothing.  
Cover with dry sterile dressings.  
Superficial frostbite can be warmed with ambient heat.  
Deep frozen areas must be protected from further injury – do not attempt field re-warming.  
Do not massage, apply ointments, break blisters or engage in aggressive warming of injured area. |
| BASIC   | As needed, initiate an IV/IO; titrate to the patient’s hemodynamic and perfusion status  
If the frostbite is localized to fingers and/or toes, and the patient is complaining of severe pain, see pain management guideline |
| INTERMEDIATE |                                                                                                                                                                                                                       |
| PARAMEDIC |                                                                                                                                                                                                                       |
MULTI-CASUALTY INCIDENT – MCI

This guideline provides organization and structure for managing emergencies that result in multiple patient injuries, illnesses, or deaths, regardless of the cause. Implementation of the procedures detailed here are directed toward the goal of producing the largest number of survivors while providing for responder and community safety, accountability, welfare and environmental concerns.

This document provides specific guidance for an MCI and uses the NIMS Incident Command System (ICS) as required by the State of New Mexico.

Definitions:
➢ System Level MCI:
   • An incident that taxes the immediate area EMS system.
➢ Low Level MCI:
   • An incident with 4 - 12 or less patients of which 5 or less are Red Tag (critical) patients.
➢ High Level MCI:
   • An incident with more than 12 patients, or more than 5 Red Tag (critical) patients.
➢ DISASTER
   • An incident with more than 100 patients. This will require a request of state and federal resources.

Procedures:
➢ Scene Size Up:
   • The first unit on scene will commit to the following actions (DO NOT BEGIN TREATMENT):
     • Assume Command, establish ICS and confirm that an MCI exists
     • Ensure Dispatch notifies and dispatches the JPEMS Director
     • Rapidly assess the incident
     • Estimate the number of patients
     • Determine the need for additional EMS resources
     • Determine the need for additional other agencies including mutual aid assistance

Notification of Hospitals:
➢ The appropriate notification to area hospitals concerning the existence of a MCI should occur as soon as possible.
   • Hospital Notification SHALL occur through the JPEMS Director or by request on Med Channel 2 to AAS Base
   • The JPEMS Director (or designee) or AAS Base will utilize EMSystems to make proper notifications
     o EMSystems will also allow the receiving facilities to determine how many patients they can accept. That information shall then be conveyed to the Incident Commander or Transport Officer.
     o EMSystems is a REQUIRED step in the MCI guideline. This prepares the hospital but also alerts other agencies of the situation. Also, in the event of multiple scenes in different parts of the metro area, it is essential to coordinate effectively utilizing EMSystems.
   • If St. Vincent Hospital will be getting patients, have Sandoval County Regional Dispatch contact and advise them of the situation.
   • The transport officer shall coordinate transport destination(s) with AAS Dispatch based on MCI Distribution Plan.
   • Transporting units should not be making individual radio reports in a large scale MCI unless there is a significant change in patient condition.

Assignment of Officers:
➢ The Incident Commander (IC) may assign the following positions as needed:
ALL PROVIDERS

➢ Ensure Scene Safety
➢ Establish Primary Management
➢ If assigned to triage, utilize START TRIAGE to identify patients
➢ If assigned to transport, treat per appropriate guideline within these guidelines

START / JUMPSTART TRIAGE

Each transport capable unit shall be equipped with the commercially available START Triage Kit, and each member of the crew should be familiar with the START Triage system (diagram below).

RED (IMMEDIATE/CRITICAL): These are the patients of the highest priority, which in most circumstances, are removed and treated first. This category EXCLUDES patients that are in cardiopulmonary arrest, or are near death and have, in the judgment of the Triage Officer, fatal injuries.

YELLOW (DELAYED/SERIOUS): Patients whose injury/illness is serious and needs attention. However, treatment and transport may be delayed until viable RED patients have been treated and transported.

GREEN (MINOR/STABLE): Patients who may have treatment and/or transport delayed.

BLACK (DECEASED): Patients who are already dead or so severely injured that death is certain within a short timeframe, regardless of treatment given.

CONTAMINATED: These patients may be from any triage category but need to be grossly decontaminated prior to transport.
APPENDIX B
SHOCK ALGORITHM
Effective 4/1/17

**SHOCK**
- Recognition
  - Low Systolic BP
  - Poor Perfusion

Ensure Primary Management
Establish IV
Ensure Adequate Oxygenation

**HYPOVOLEMIC SHOCK**
- Trauma or Bleeding
  - Dehydration
    - Diuresis Glousses
- Control Source of Bleeding
  - Bolus IV Fluids to Systolic BP 90mmHg

**CARDIOGENIC SHOCK (PUMP FAILURE)**
- Treat Reversible Causes
  - i.e. arrhythmia
- Bolus IV Fluids 10cc/kg
- Epinephrine Mini Bolus or Epinephrine Drip

**OBSTRUCTIVE SHOCK (heart cannot fill or blood cannot leave the heart)**
- Treat Reversible Causes
  - i.e. pneumo
- Bolus IV Fluids 10cc/kg
- Epinephrine Mini Bolus or Epinephrine Drip

**DISTRIBUTIVE SHOCK**
- Septic Shock
  - Anaphylaxis / Neurogenic
- Bolus IV Fluids up to 2L (Adult) or 60ml/kg (Pediatric)
- Consider Epinephrine Mini Bolus or EPI Drip
- If still hypotensive begin Levophed Drip
A small list of some common acronyms used in the guidelines (not all inclusive)

AED – Automated External Defibrillator
AHA – American Heart Association
ALS – Advanced Life Support
ALTE – Apparent Life Threatening Event
APGAR – used to evaluate newborns, developed by Dr. Virginia Apgar
BGL – Blood glucose reading
BIA – Bureau of Indian Affairs
BLS – Basic Life Support
BSA – Body Surface Area
CQA – Continuous Quality Assurance
CQI – Continuous Quality Improvement
CPAP – Continuous Positive Airway Pressure
CPR – Cardiopulmonary resuscitation
CVA – Cerebral Vascular Attack
DNR – Do Not Resuscitate
ECG – Electrocardiogram
EMS – Emergency Medical Services
EMT – Emergency Medical Technician
EMTALA – Emergency Medical Treatment and Labor Act
ePCR – Electronic Patient Care Record
EtCO2 – End tidal Carbon Dioxide
FR – First Responder
GCS – Glasgow Coma Scale
ICS – Incident Command System
ILS – Intermediate Life Support
IO – Intraosseous
JPEMS – Jemez Pueblo Emergency Medical Services
KED – Kendrick Extrication Device
LOC – Level of Consciousness
MAD – Mucosal Atomization Device
MCEP – Medical Control Emergency Physician
MCI – Mass Casualty Incident
mmHg – millimeters of mercury
MOST – Medical Orders for Scope of Treatment
NFIRS – National fire incident reporting system
NTG – Nitroglycerin
POC – Position of Comfort
PRC – Public Regulation Committee
NMAC – New Mexico Association of Counties
OMI – Office of the Medical Investigator
POV – Privately Owned Vehicle
ROSC – Return of Spontaneous Circulation
RSI – Rapid Sequence Intubation
SCFD – Sandoval County Fire Department
STEMI – ST segment Elevation Myocardial Infarction
SxS – Signs and Symptoms
VS – Vital signs
TITLE 7
HEALTH
CHAPTER 27
EMERGENCY MEDICAL SERVICES
PART 11
SUPPLEMENTAL LICENSING PROVISIONS

7.27.11.1 ISSUING AGENCY: New Mexico Department of Health, Epidemiology and Response Division, Emergency Medical Systems Bureau.
[7.27.11.1 NMAC - Rp, 7.27.11.1 NMAC, 8/15/14]

7.27.11.2 SCOPE: These rules apply to New Mexico emergency medical services, including the service directors and medical directors of those services; approved New Mexico EMS training programs and graduates of approved New Mexico EMS training programs; New Mexico licensed EMS personnel including those previously licensed; persons trained, certified or licensed in another state or territory seeking to acquire licensure in New Mexico; EMS licensing commission; national registry of emergency medical technicians; and any other entity associated with the licensing of emergency medical services personnel in New Mexico.
[7.27.11.2 NMAC - Rp, 7.27.11.2 NMAC, 8/15/14]

7.27.11.3 STATUTORY AUTHORITY: These rules are promulgated pursuant to the following statutory authorities: 1) the New Mexico Department of Health Act, Subsection E of Section 9-7-6 NMSA 1978, which authorizes the secretary of the department of health to “make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions,” and, 2) the Emergency Medical Services Act, NMSA 1978, Section 24-10B-4 (“Bureau; duties”).
[7.27.11.3 NMAC - Rp, 7.27.11.3 NMAC, 8/15/14]

7.27.11.4 DURATION: Permanent.
[7.27.11.4 NMAC - Rp, 7.27.11.4 NMAC, 8/15/14]

7.27.11.5 EFFECTIVE DATE: August 15, 2014, unless a later date is cited at the end of a section.
[7.27.11.5 NMAC - Rp, 7.27.11.5 NMAC, 8/15/14]

7.27.11.6 OBJECTIVE: These rules are intended to supplement the emergency medical services licensure requirements for emergency medical services personnel, to provide supplemental and additional standards for the licensure of emergency medical dispatchers, emergency medical dispatch-instructors, emergency medical services first responders and emergency medical technicians, and to assist in the provision of a comprehensive system of emergency medical services in the state of New Mexico.
[7.27.11.6 NMAC - Rp, 7.27.11.6 NMAC, 8/15/14]

7.27.11.7 DEFINITIONS:
[Refer to 7.27.2.7 NMAC]

7.27.11.8 SCOPES OF PRACTICE FOR LICENSED EMERGENCY MEDICAL SERVICES PERSONNEL:
A. Medical director means a physician functioning as the service EMS medical director as defined and described in 7.27.3 NMAC, Medical Direction for Emergency Medical Services. Medical control means supervision provided by or under the direction of a physician.
B. Prior to approving a new skill, technique, medication, or procedure, it shall be documented by the service director, medical director, or approved EMS training institution that the EMS provider has been appropriately trained to perform those new skills, techniques, medications, or procedures.
C. Service medical director approved: All service medical director approved skills, techniques, medications, or procedures are considered advanced life support. Prior to utilizing any skill, technique, medication or procedure designated as service medical director approved, it shall be documented by the service director, medical director, or approved EMS training institution that the EMS provider has been appropriately trained to administer the medications or perform the skills, techniques, medications or procedures. Additionally, each EMS provider must have a signed authorization from the service’s medical director on file at the EMS service’s headquarters or administrative offices.
D. Any device in an EMS agency’s treatment guideline/protocol designed and utilized to facilitate successful completion of a skill or other treatment modality, including but not limited to CPR devices, intravenous placement devices, and positive pressure ventilation devices, must be approved by the service medical director.

E. Wilderness protocols: The following skills shall only be used by providers who have a current wilderness certification from a bureau approved wilderness caregiver course, who are functioning in a wilderness environment as a wilderness provider (an environment in which time to a hospital is expected to exceed two hours, except in the case of an anaphylactic reaction, in which no minimum transport time is required), and are authorized by their medical director to provide the treatment:

1. minor wound cleaning and management;
2. cessation of CPR;
3. field clearance of the cervical spine;
4. reduction of dislocations resulting from indirect force of the patella, digit, and anterior shoulder.

F. Community emergency medical services programs: Community EMS programs shall be provided by EMS caregivers who, after completing a bureau approved community EMS caregiver course, are functioning as part of a community emergency medical services program that has been reviewed and approved by the EMS bureau. The providers must be authorized by their medical director to perform the skills listed in their application as part of the community EMS program. These programs may include referrals that involve transport to non-hospital locations, and for non-transport decisions. Skills and interventions may include any of the approved skills and interventions for the appropriate level; any skill that exceeds the scope of practice must be approved through the special skill process. Skills may include, but are not limited to:

1. education of patients in self-medications administration, and assessment of compliance with physician recommendations for health conditions;
2. assessments for preventing falls and other sources of injury by identifying risks in patient homes;
3. provide education on disease prevention;
4. administering immunizations;
5. in collaboration with a healthcare team, assist in developing a care plan, and educate the patient in following the care plan;
6. perform in-home patient assessments commensurate with level of education and licensure in order to provide information to a care team as to the progress or condition of a patient receiving therapies for medical conditions;
7. provide assistance in locating and contacting appropriate providers of needed social services;
8. treat discovered acute healthcare issues, transporting to emergency department if necessary;
9. for chronic and non-acute issues, confirmed with online medical direction and agreed to by the patient, options other than EMS transport may be considered, including:
   a. arrange for non-emergent and non-EMS transportation to and care at an appropriate facility, such as a physician’s office or urgent care center;
   b. provide referral information and arrange for follow up by appropriate care team members and/or social service personnel;
10. assist with ongoing prescribed wound care.

G. Critical Care Transport services skills: Paramedic critical care transport skills shall be used only by paramedic providers who have successfully completed a bureau approved critical care transport paramedic or critical care flight paramedic course. Subsequent to completing the approved course, the critical care paramedic must successfully complete a bureau administered or approved third party exam within one year. Additionally, the paramedics shall be functioning as part of a ground or air EMS agency with an approved critical care transport special skill and authorized by the agency medical director to utilize these skills. Critical care transport program skills are only authorized for use during inter-facility critical care transport activities, with the exception of air ambulance agencies providing emergency scene response; or ground critical care agencies requested to a scene by the local authorized and certified 911 response and transport agencies. Critical care transport special skills and medications that may be administered include, but are not limited to any of the below skills and medications; service specific skills and medication requests must be listed on the EMS agency critical care transport special skill application completed per 7.27.11.10 NMAC:

1. monitoring of infusions including but not limited to anti-arhythmics, nitrates, vasopressors, blood products, thrombolytics, sedation, pain management and antihypertensive medications that have required titration within the past two hours and may need to have their dosages adjusted during transport;
2. performance of skills not listed in the paramedic scope of practice, such as but not limited to escharotomy, fasciotomy, insertion of chest tubes, pericardiocentesis, blood administration, and nerve blocks;
3. administration of medications, initiation of infusions, and utilization of routes, not listed on the paramedic scope but requested in the EMS agency’s special skill application and approved by the medical direction committee and EMS bureau;
4. utilization of advanced patient monitoring, such as invasive hemodynamic monitoring via monitoring of central venous pressure, pulmonary artery pressure, intracranial pressure monitoring, Swan-Ganz catheters, arterial lines, fetal monitoring, point of care lab values, and other monitoring or tests not listed in the paramedic scope, but requested in the EMS agency’s special skill application and approved by the medical direction committee and EMS Bureau.
(5) utilization of ICU level ventilator support, to include ventilators delivering positive end expiratory pressure, with multiple adjustable mode and setting parameters that include inspiratory plateau pressures, pressure regulated volume control, pressure support ventilation, pressure control ventilation, airway pressure release ventilation and others; also, any ventilator delivering a mixture of nitric oxide or other beneficial gas mixtures;

(6) transport of patients with intra-aortic balloon pump, temporary internal cardiac pacing, left ventricular assist device or a bi-ventricular assist device and other appropriate devices to address hemodynamic instability as requested in the EMS agency’s special skill application and approved by the medical direction committee and EMS bureau;

(7) administer paralytics and sedatives to maintain airway control previously initiated, and administer and perform rapid sequence airway pharmacology and techniques in order to secure an airway in response to patient condition, as requested in the EMS agency’s special skill application and approved by the medical direction committee and EMS bureau;

(8) pediatric intubation or endotracheal tube management as requested in the EMS agency’s special skill application and approved by the medical direction committee and EMS bureau.

H. Utilization of pharmacological agents for the primary purpose of sedation, induction, or muscle relaxation to facilitate placement of an advanced airway requires medical direction committee special skills approval.

I. Over the counter (OTC) medications and products. A physician medical director may approve a list of over the counter (OTC) medications and products (i.e. NSAID’s, antihistamines, anti-diarrheal, laxatives, antacids, vitamin supplements, hygiene products and other products) for distribution by an EMS caregiver working under medical direction to a requesting individual during scheduled stand-by situations. Examples are long-term wildfire responses, public events (concerts, rodeos, etc), various industry situations such as movie production & ski patrol, long-term construction & manufacturing projects, long-term search and rescue or tactical operations, and other situations where scheduled stand-by EMS is provided.

(1) The OTC medication/product must be properly labeled in individual dose packaging when distributed to the patient. Distribution from a bulk or multi-dose container is not permitted by this scope of practice, as well as other state and federal laws and regulations; medications will be distributed per manufacturer recommendations and labeling directions.

(2) The agency/EMS caregiver must develop a method of documentation for the appropriate distribution of the OTC medications/products and the conditions for which they may be distributed. Specific dosing information and indications for pediatric patients must be included.

(3) The EMS agency/EMS caregiver must develop a method of documentation for the appropriate distribution of the OTC medications/products. This documentation shall include the OTC medication documentation and appropriate patient care report, per 7.27.10.12 NMAC (Records and Data Collection) and 7.27.11.11 NMAC. PRC certified ambulance agencies shall complete patient care documentation per 18.3.14.24 NMAC.

(4) OTC medications/products are distributed for the patient’s self-administration and use. EMS caregivers will not administer OTC medications/products, unless approved elsewhere in the scope of practice for specific EMS patient care situations. The agency/EMS caregiver must maintain a written guideline that contains the list of physician approved OTC medications/products, unless approved elsewhere in the scope of practice for specific EMS patient care situations.

J. Licensed emergency medical dispatcher (EMD). (1) Medical direction is required for all items in the EMD scope of practice.

(2) The following allowable skills may be performed by EMDs who are licensed by the EMS bureau and functioning with an EMS bureau certified New Mexico emergency medical dispatch agency utilizing protocols and any EMD priority reference system approved by the EMS bureau and service medical director.

(a) Process calls for medical assistance in a standardized manner, eliciting required information for evaluating, advising, and treating sick or injured individuals, and dispatching an appropriate EMS response.

(b) Provide pre-arrival instructions to the patient through the caller when possible and appropriate to do so while functioning in compliance with an emergency medical dispatch priority reference system (EMDPRS).

K. EMS first responders (EMFR). (1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:

(a) basic airway management;

(b) use of basic adjunctive airway equipment;

(c) suctioning;

(d) cardiopulmonary resuscitation, according to current ECC guidelines;

(e) obstructed airway management;

(f) bleeding control via direct pressure and appropriate tourniquet use;

(g) spine immobilization;

(h) splinting (does not include femoral traction splinting);

(i) scene assessment, triage, scene safety;

(j) use of statewide EMS communications system;

(k) emergency childbirth;

(l) glucometry;

(m) oxygen;
other non-invasive procedures as taught in first responder courses adhering to DOT curricula.

(2) The following require service medical director approval:

(a) allowable skills:

(i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, FiO2, and pressure relief/alarm and does not have multiple automatic ventilation modes;

(ii) application and use of semi-automatic defibrillators, including cardiac rhythm acquisition for ALS caregiver interpretation or transmission to a care facility; this includes multi-lead documentation;

(iii) hemostatic dressings for control of bleeding;

(iv) insertion of laryngeal and supraglottic airway devices (examples: king airway, LMA), excluding multi-lumen airways);

(b) administration of approved medications via the following routes:

(i) nebulized inhalation;

(ii) nasal mucosal atomization (MA);

(iii) intramuscular;

(iv) oral (PO);

(c) allowable drugs:

(i) oral glucose preparations;

(ii) aspirin PO for adults with suspected cardiac chest pain;

(iii) atropine and pralidoxime via IM auto-injection for treatment of chemical or nerve agent exposure;

(iv) albuterol (including isomers) via inhaled administration;

(v) naloxone via nasal mucosal atomizer;

(vi) epinephrine via auto-injection device;

(d) patient's own medication that may be administered:

(i) bronchodilators using pre-measured or metered dose inhalation device;

(ii) naloxone, if provided with a nasal MA or IM delivery system.

L. EMT-BASIC (EMT-B):

(1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:

(a) basic airway management;

(b) use of basic adjunctive airway equipment;

(c) suctioning;

(d) cardiopulmonary resuscitation, according to current ECC guidelines;

(e) obstructed airway management;

(f) bleeding control to include appropriate tourniquet usage;

(g) spine immobilization;

(h) splinting;

(i) scene assessment, triage, scene safety;

(j) use of statewide EMS communications system;

(k) childbirth (imminent delivery);

(l) glucometry;

(m) oxygen;

(n) other non-invasive procedures as taught in EMT-B courses adhering to DOT curricula;

(o) wound management.

(2) The following require service medical director approval:

(a) allowable skills:

(i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, FiO2, and pressure relief/alarm and does not have multiple automatic ventilation modes; this skill includes devices that provide non-invasive positive pressure ventilation via continuous positive airway pressure (CPAP);

(ii) use of multi-lumen, supraglottic, and laryngeal airway devices (examples: PTLA, combi-tube, king airway, LMA) to include gastric suctioning;

(iii) application and use of semi-automatic defibrillators, including cardiac rhythm acquisition for ALS caregiver interpretation or transmission to a care facility; this includes multi-lead documentation;

(iv) acupressure;

(v) transport of patients with nasogastric tubes, urinary catheters, heparin/saline locks, PEG tubes, or vascular access devices intended for outpatient use;

(vi) performing point of care testing; examples include serum lactate values, cardiac enzymes, electrolytes, and other diagnostic values;
(vii) hemostatic dressings for control of bleeding;
(b) administration of approved medications via the following routes:
(i) nebulized inhalation;
(ii) subcutaneous;
(iii) intramuscular;
(iv) nasal mucosal atomization (MA);
(v) oral (PO);
(vi) intradermal;
(c) allowable drugs:
(i) oral glucose preparations;
(ii) aspirin PO for adults with suspected cardiac chest pain;
(iii) activated charcoal PO;
(iv) acetaminophen PO in pediatric patients with fever;
(v) atropine and pralidoxime via IM autoinjection for treatment of chemical and/or nerve agent exposure;
(vi) albuterol (including isomers), via inhaled administration;
(vii) ipratropium, via inhaled administration, in combination with or after albuterol administration;
(viii) naloxone by SQ, IM, or IN route;
(ix) epinephrine, 1:1000, no single dose greater than 0.3 mL subcutaneous or intramuscular injection with a pre-measured syringe (including autoinjector) or 0.3 mL TB syringe for anaphylaxis or status asthmaticus refractory to other treatments;
(d) patient’s own medication that may be administered:
(i) bronchodilators using pre-measured or metered dose inhalation device;
(ii) sublingual nitroglycerin for unrelieved chest pain, with on-line medical control only;
(iii) situations may arise involving patients with uncommon conditions requiring specific out of hospital administered medications or procedures; family members or the designated caregiver trained and knowledgeable of the special needs of the patient should be recognized as the expert regarding the care of the patient. EMS can offer assistance in airway management appropriate to their level of licensure, and administer the patient’s prescribed medications where appropriate only if the medication is in the EMS provider’s scope of practice; EMS services are not expected to provide the prescribed medications for these special needs patients;
(3) Immunizations and biologicals: Administration of immunizations, vaccines, biologicals, and TB skin testing is authorized under the following circumstances:
(a) to the general public as part of a department of health initiative or emergency response, utilizing department of health protocols; the administration of immunizations is to be under the supervision of a physician, nurse, or other authorized health provider;
(b) TB skin tests may be applied and interpreted if the licensed provider has successfully completed required department of health training;
(c) in the event of a disaster or emergency, the state EMS medical director or chief medical officer of the department of health may temporarily authorize the administration of pharmaceuticals or tests not listed above.

M. EMT-INTERMEDIATE (EMT-I):
(1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:
(a) basic airway management;
(b) use of basic adjunctive airway equipment;
(c) suctioning;
(d) cardiopulmonary resuscitation, according to ECC guidelines;
(e) obstructed airway management;
(f) bleeding control including appropriate use of tourniquet;
(g) spine immobilization;
(h) splinting;
(i) scene assessment, triage, scene safety;
(j) use of statewide EMS communications system;
(k) childbirth (imminent delivery);
(l) glucometry;
(m) oxygen;
(n) wound management.
(2) The following require service medical director approval:
(a) allowable skills:
(i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, 
FiO₂, and pressure relief/alarm and does not have multiple automatic ventilation modes; this skill includes devices that provide non-invasive positive pressure ventilation via continuous positive airway pressure (CPAP);
(ii) use of multi-lumen, supraglottic, and laryngeal airway devices (examples: PTLA, combi-tube, king 
airway, LMA) to include gastric suctioning;
(iii) application and use of semi-automatic defibrillators, including cardiac rhythm acquisition for ALS 
caregiver interpretation or transmission to a care facility; this includes multi-lead documentation;
(iv) acupressure;
(v) transport of patients with nasogastric tubes, urinary catheters, heparin/saline locks, PEG tubes, or 
vascular access devices intended for outpatient use;
(vi) peripheral venous puncture/access;
(vii) blood drawing;
(viii) pediatric intraosseous tibial access;
(ix) adult intraosseous access;
(x) point of care testing; examples include serum lactate values, cardiac enzymes, electrolytes, and other 
diagnostic values;
(xi) hemostatic dressings for control of bleeding;
(b) administration of approved medications via the following routes:
(i) intravenous;
(ii) nasal mucosal atomization (MA);
(iii) nebulized inhalation;
(iv) sublingual;
(v) intradermal;
(vi) intraosseous;
(vii) endotracheal (for administration of epinephrine only, under the direct supervision of an EMT-
paramedic, or if the EMS service has an approved special skill for endotracheal intubation);
(viii) oral (PO);
(ix) intramuscular;
(x) subcutaneous;
(c) allowable drugs:
(i) oral glucose preparations;
(ii) aspirin PO for adults with suspected cardiac chest pain;
(iii) activated charcoal PO;
(iv) acetaminophen PO in pediatric patients with fever;
(v) IM autoinjection of the following agents for treatment of chemical or nerve agent exposure: atropine, 
pralidoxime;
(s) albuterol (including isomers) via inhaled administration;
(vii) neostigmine, via inhaled administration in combination with or after albuterol administration;
(viii) naloxone;
(ix) I.V. fluid therapy (except blood or blood products);
(x) dextrose;
(xi) epinephrine (1:1000), SQ or IM (including autoinjector) for anaphylaxis and known asthmatics in 
severe respiratory distress (no single dose greater than 0.3 cc);
(xii) epinephrine (1:10,000) in pulseless cardiac arrest for both adult and pediatric patients; epinephrine 
may be administered via the endotracheal tube in accordance with most current ACLS and PALS guidelines;
(xiii) nitroglycerin (sublingual) for chest pain associated with suspected acute coronary syndromes; must 
have intravenous access established prior to administration or approval of online medical control if IV access is unavailable;
(xiv) morphine, fentanyl, or dilaudid for use in pain control with approval of on-line medical control;
(xv) diphenhydramine for allergic reactions or dystonic reactions;
(xvi) glucagon, to treat hypoglycemia in diabetic patients when intravenous access is not obtainable;
(xvii) anti-emetic agents; for use as an anti-emetic only;
(xviii) methylprednisolone for reactive airway disease/acute asthma exacerbation;
(xix) Hydrocortisone;
(xx) lidocaine (2%, preservative and epinephrine free for IV use) for administration into the intraosseous 
space on pain responsive adult patients while receiving intraosseous fluids or medications;
(d) patient’s own medication that may be administered:
(i) bronchodilators using pre-measured or metered dose inhalation device;
sublingual nitroglycerin for unrelieved chest pain; must have intravenous access established prior to administration or approval of online medical control if IV access is unavailable;

(iii) glucagon;

(iv) situations may arise involving patients with uncommon conditions requiring specific out of hospital administered medications or procedures; family members or the designated caregiver trained and knowledgeable of the special needs of the patient should be recognized as the expert regarding the care of the patient; EMS can offer assistance in airway management appropriate to their level of licensure, IV access, and the administration of the patient’s prescribed medications where appropriate only if the medication is in the EMS provider’s scope of practice; online (direct contact) medical control communication must be established with the medical control physician approving the intervention; EMS services are not expected to provide the prescribed medications for these special needs patients;

e) drugs allowed for monitoring during interfacility transport:

(i) potassium; intermediate EMT’s may monitor IV solutions that contain potassium during transport (not to exceed 20 mEq/1000cc or more than 10 mEq/hour);

(ii) antibiotics and other anti-infectives utilizing an infusion pump; intermediate EMT’s may monitor antibiotic or other anti-infective agents, provided a hospital initiated infusion has been running for a minimum of 30 minutes prior to the intermediate initiating the transfer, and the intermediate EMT is aware of reactions for which to monitor and the appropriate action to take before assuming responsibility for patient care;

(f) immunizations and biologicals: administration of immunizations, vaccines, biologicals, and TB skin testing is authorized under the following circumstances:

(i) to the general public as part of a department of health initiative or emergency response, utilizing department of health protocols; the administration of immunizations is to be under the supervision of a physician, nurse, or other authorized health provider;

(ii) administer vaccines to EMS and public safety personnel;

(iii) TB skin tests may be applied and interpreted if the licensed provider has successfully completed required department of health training;

(iv) in the event of a disaster or emergency, the state EMS medical director or chief medical officer of the department of health may temporarily authorize the administration of pharmaceuticals or tests not listed above.

N. EMT-PARAMEDIC (EMT-P):

(1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:

(a) basic airway management;
(b) use of basic adjunctive airway equipment;
(c) suctioning;
(d) cardiopulmonary resuscitation, according to current ECC guidelines;
(e) obstructed airway management;
(f) bleeding control including the appropriate use of tourniquet;
(g) spine immobilization;
(h) splinting;
(i) scene assessment, triage, scene safety;
(j) use of statewide EMS communications system;
(k) childbirth (imminent delivery);
(l) glucometry;
(m) oxygen;
(n) wound management.

(2) The following require service medical director approval:

(a) allowable skills:

(i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, FiO2, and pressure relief/alarm and has multiple automatic ventilation modes; this skill includes devices that provide non-invasive positive pressure ventilation (including continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BPAP);

(ii) use of multi-lumen, supraglottic, and laryngeal airway devices (examples: PTLA, combi-tube, king airway, LMA) to include gastric suctioning;

(iii) transport of patients with nasogastric tubes, urinary catheters, heparin/saline locks, PEG tubes, or vascular access devices intended for outpatient use;

(iv) application and use of semi-automatic defibrillators;

(v) acupressure;

(vi) peripheral venous puncture/access;

(vii) blood drawing;
(viii) I.V. fluid therapy;
(ix) direct laryngoscopy for endotracheal intubation and removal of foreign body in patients 13 and older; for patients 12 and under, for removal of foreign body only;
(x) endotracheal intubation for patients over the age of 12;
(xi) thoracic decompression (needle thoracostomy);
(xii) insertion of nasogastric tubes;
(xiii) external cardiac pacing;
(xiv) cardiac monitoring;
(xv) use of infusion pumps;
(xvi) initiation of blood and blood products with on-line medical control;
(xvii) intraosseous access;
(xviii) performing point of care testing: examples include serum lactate values, cardiac enzymes, electrolytes, and other diagnostic values;
(xix) hemostatic dressings for control of bleeding;
(xx) vagal maneuvers.

(b) administration of approved medications via the following routes:
(i) intravenous;
(ii) nasal mucosal atomization (MA);
(iii) nebulized inhalation;
(iv) sublingual;
(v) intradermal;
(vi) intraosseous;
(vii) endotracheal;
(viii) oral (PO);
(ix) intramuscular;
(x) topical;
(xi) rectal;
(xii) IV drip;
(xiii) subcutaneous;

(c) allowable drugs:
(i) acetaminophen;
(ii) activated charcoal;
(iii) adenosine;
(iv) albuterol (including isomers);
(v) amiodarone;
(vi) aspirin;
(vii) atropine sulfate;
(viii) benzo diazepines;
(ix) calcium preparations;
(x) corticosteroids;
(xi) dextrose;
(xii) diphenhydramine;
(xiii) epinephrine;
(xiv) furosemide;
(xv) glucagon;
(xvi) hydroxycobalamine;
(xvii) ipratropium;
(xviii) lidocaine;
(xix) magnesium sulfate;
(xx) naloxone;
(xxi) narcotic analgesics;
(xxii) nitroglycerin;
(xxiii) oral glucose preparations;
(xxiv) oxytocin;
(xxv) phenylephrine nasal spray;
pralidoxime, IM auto-injection for treatment of chemical and nerve agent exposure;
anti-emetic agents, for use as an anti-emetic only;
sodium bicarbonate;
thiamine;
topical anesthetic ophthalmic solutions;
vaporsor agents;
intravenous fluids

(3) Drugs allowed for monitoring during inter-facility transports (initiated and administered by the sending facility with defined dosing parameters and requiring an infusion pump when given by continuous infusion unless otherwise specified); the infusion may be terminated by the paramedic if appropriate, but if further adjustments are anticipated, appropriate hospital personnel should accompany the patient, or a critical care transport unit should be utilized:
(a) potassium (no infusion pump needed if concentration not greater than 20mEq/1000cc);
(b) anticoagulation type blood modifying agents (such as fibrolytic drugs, heparin, glycoprotein IIb-IIIa inhibitors/antagonists);
(c) procainamide;
(d) mannitol;
(e) blood and blood products (no pump required);
(f) aminophylline;
(g) antibiotics and other anti-infective agents;
(h) dobutamine;
(i) sodium nitroprusside;
(j) insulin;
(k) terbutaline;
(l) norepinephrine;
(m) octreotide;
(n) nutritional supplements;
(o) beta blockers;
(p) calcium channel blockers;
(q) niacinamide;
(r) propofol in patients that are intubated prior to transport;
(s) proton pump inhibitors and H2 antagonists;
(t) crotalidae polyvalent immune fab (ovine) (“crofab”); crofab may be monitored during inter-facility transport provided the physician initiated crofab infusion has been running for a minimum of 30 minutes prior to the paramedic initiating the transfer and assuming responsibility for patient care.

(4) Immunizations and biologicals: administration of immunizations, vaccines, biologicals, and TB skin testing is authorized under the following circumstances:
(a) to the general public as part of a department of health initiative or emergency response, utilizing department of health protocols; the administration of immunizations is to be under the supervision of a physician, nurse, or other authorized health provider;
(b) administer vaccines to EMS and public safety personnel;
(c) TB skin tests may be applied and interpreted if the licensed provider has successfully completed required department of health training;
(d) in the event of a disaster or emergency, the state EMS medical director or chief medical officer of the department of health may temporarily authorize the administration of other pharmaceuticals or tests not listed above.

(5) Skills approved for monitoring in transport:
(a) internal cardiac pacing;
(b) chest tubes.

(6) Medications for administration during patient transfer:
(a) retavase (second dose only);
(b) protamine sulfate;
(c) non-depolarizing neuromuscular blocking agents in patients that are intubated prior to transport;
(d) acetylcysteine;

(7) Patient’s own medication that may be administered:
(a) epoprostenol sodium, treprostinil sodium, or other medications utilized for certain types of pulmonary hypertension;
(b) bronchodilators using pre-measured or metered dose inhalation device;
(c) sublingual nitroglycerin for unrelieved chest pain; must have intravenous access established prior to administration;

(d) glucagon;

(e) situations may arise involving patients with uncommon conditions requiring specific out of hospital administered medications or procedures; family members or the designated caregiver trained and knowledgeable of the special needs of the patient should be recognized as the expert regarding the care of the patient; EMS can offer assistance in airway management appropriate to their level of licensure, IV access, and the administration of the patient’s prescribed medications where appropriate only if the medication is in the EMS provider’s scope of practice; online (direct contact) medical control communication must be established with the medical control physician approving the intervention; EMS services are not expected to provide the prescribed medications for these special needs patients.

7.27.11.9 APPROVED TRAINING PROGRAMS: “Approved emergency medical services training program” means a New Mexico emergency medical services training program that is sponsored by a post-secondary educational institution, is accredited by the national accrediting organization for emergency medical services or active in the accreditation process, and is approved by the joint organization on education (JOE) and participates in the joint organization on education. Currently, there are five approved EMS training programs.

A. Emergency medical services academy. University of New Mexico, (700 Camino De Salud NE, Albuquerque, New Mexico 87106, Tel: 505-272-5737). The EMS academy is designated as the lead training agency for providers in New Mexico as stated in Section 24-10B-12 NMSA 1978. The EMS academy teaches formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

B. Dona Ana branch community college. New Mexico state university, (Box 30001, Las Cruces, NM 88003-0001, Tel: 505-527-7530). Dona Ana branch community college teaches formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

C. Eastern New Mexico university. EMS program, (Box 6000, Roswell, NM 88202-6000, Tel: 505-624-7000). The eastern New Mexico university teaches formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

D. Central New Mexico community college. EMS program, (525 Buena Vista Rd. SE, Albuquerque, NM 87106, Tel: 505-224-4000). Central New Mexico community college teaches formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

E. San Juan college EMS Program. (4601 College Blvd, Farmington, NM 87402; 505-566-3857). San Juan College conducts formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

7.27.11.10 SPECIAL SKILLS APPLICATION AND REPORTING PROCEDURES:

A. Purpose: Special skills are those skills, procedures, and medications that are requested by an EMS service to enhance emergency treatment capabilities beyond the normal scope of practice, as defined in the Emergency Medical Services Act. Use the enclosed procedures for application, reporting and renewal for special skills. Applications are reviewed and approved or disapproved by the medical direction committee, and once approved, become a legally recognized addition to the service capabilities.

B. General: All levels of EMS personnel, including licensed EMS first responders and all levels of licensed EMTs are eligible for special skills consideration for any procedure, skill or medication.

C. Application procedure: The EMS service medical director, or his designee, shall coordinate with the EMS service director, and shall apply for special skills to the EMS medical direction committee.

D. Application document: The application document for a special skill must be tailored to the level of the request. While the degree of detail in each section may vary to match the nature of the skill requested, all applications should include the following elements, in order:

(1) application cover page: titled to state the requested special skill, date of application, name of service, service director name and medical director name;

(2) contact information page: must include address and contact information for the service, service director and medical director;

(3) letters of support: must include individual letters of support from the service director and medical director; additional letters of support from the local medical community or evidence of notification of the local medical community may be required; the need for letters of notification and support from the local medical community and who provides the letters must be adjusted to match the nature of the special skill requested;

(4) service description: provide a concise description of the EMS service; this includes such items as basic call demographics relevant to the applicant, level of licensure of providers and names of locations of the primary receiving medical facilities;
(5) description of the special skill; provide a description of the procedure, medication or requested skill; include information on risks, benefits, indications and contraindications;

(6) justification and statement of need: provide a statement explaining why the special skill is needed; this should include a description of the current medical intervention or alternative practice to the special skill and a risk or benefit analysis that supports the special skill requested; the estimated number of potential interventions per year, other relevant statistical data and a statement indicating the level of current scientific information/studies to support the requested special skill; the level of scientific justification can be adjusted to match the level of the special skill requested;

(7) protocol: provide a copy of the treatment protocol; include other operational protocols relevant to the special skill, if applicable;

(8) training: provide a training syllabus; this must include learning objectives and the training hours for initial and continuing education; this section should also include a description of the instructors, how training will be completed, and a description of the method used to initially evaluate the skill; once initial training is completed, a list of trained and approved personnel shall be provided to the medical direction committee; these special skill authorized licensed EMS personnel must appear on the service’s personnel list on the New Mexico EMS tracking and reporting system database.

(9) QA/QI program: provide a description of the QA/QI process for the special skill, including frequency of evaluation, names and qualifications of the personnel involved in the process; include a copy of the evaluation tool or forms that will be used, if applicable; and

(10) the application and all supporting documentation shall be submitted to the EMS bureau, attn: state EMS training coordinator.

E. Applicants may involve the EMS regional offices when preparing a special skill request and include a letter evidencing regional review. Applicants shall forward a copy of their application to their EMS regional office when completed.

F. Upon receipt, the state EMS medical director and state EMS training coordinator will review the application. The service will be notified if the application is found to be incomplete or to contain significant errors.

G. Applications must be received at the bureau at least 45 days prior to the next regularly scheduled medical direction committee meeting to be placed on the agenda of that meeting for consideration by the medical direction committee.

H. The medical direction committee shall take action on all special skills applications on the agenda at their regularly scheduled meeting. The medical direction committee may take the following actions on the application: approved with limitations or restrictions, denied or tabled with a request for a formal presentation or additional information by the requesting service medical director or their designee.

I. The medical direction committee may give an approval subject to specific conditions, limitations or restrictions. This may include a written and practical examination.

J. Within 10 working days following the decision of the medical direction committee, the state EMS training coordinator shall provide a written response to the applicant regarding the action of the medical direction committee.

K. Special skills may not be utilized until receipt of the special skill approval letter from the bureau. Any specific conditions or limitations will be evidenced in the approval letter from the bureau.

L. Monitoring: It is expected that EMS services with approved special skills will continuously comply with the requirements of their application and approval letter. This includes, but is not limited to, such items as training curricula, approved instructors, quality assurance, protocols and data collection. Any changes to the approved application shall be sent to the state EMS training coordinator for concurrence/coordination with the medical direction committee.

M. The medical direction committee may immediately suspend or revoke special skill privileges for an individual or service that loses medical direction, or fails to comply with the stated requirements, or for any other reason to protect the health and welfare of the people of New Mexico.

N. If a new medical director assumes control of a service with an active special skill program, the bureau shall receive a letter of support from the new medical director within 30 days or the special skill approval may be withdrawn.

O. The service shall maintain a current list of all providers trained and approved to utilize the special skill. This list must be provided to the bureau upon request.

P. Reporting: The service shall provide to the state EMS training coordinator periodic written special skill reports. During the first year, the report shall be due semi-annually, occurring on June 1 and December 1. Subsequent reports shall be due annually on June 1.

Q. Report document: The written special skill report shall include the following minimum elements:

(1) report cover page: titled to state the special skill reported, date, name of service, service director and medical director;

(2) contact information page: shall include address and contact information for the service, service director and medical director;

(3) letters of support: must include individual letters of continued support from the service director and service medical director;
statistics and outcome data: provide data on the utilization and patient outcomes involving the special skill; do not include patient identifiers; all adverse outcomes related to the special skill must be reported;

continuing education: provide evidence of the continuing education program and refresher program;

personnel list: provide a list of all personnel authorized to perform the special skill; these special skill authorized licensed EMS personnel must appear on the service’s personnel list required for the New Mexico EMS tracking and reporting system database.

QA/QI program: provide evidence of the ongoing QA/QI program;

renewal: during a regularly scheduled meeting, the medical direction committee shall review all ongoing individual special skills programs on their three year anniversary and make a determination on renewal;

if the medical direction committee determines not to provide automatic renewal on an ongoing special skill program, the state EMS training coordinator shall provide a written notification to the service director and the service medical director within 10 working days; and

the special skills program will be placed on the agenda of the next, or subsequent, regularly scheduled meeting of the medical direction committee and final determination regarding renewal will be made.

Special skills programs will remain active until a final determination regarding renewal has been made.

Special skills application:

1. general section;
2. EMS service name;
3. address;
4. service chief/director;
5. contact phone number;
6. physician medical director;
7. physician medical director contact phone number;
8. special skill proposed;
9. estimated number of personnel to be trained;
10. estimated date of initial training;
11. training/quality assurance;
12. describe or identify the curriculum, including learning objectives, training hours, etc.;
13. please identify the lead instructor and provide a brief summary of their qualifications or attach a resume;
14. resumes required for new instructors;
15. if training/experience is required, provide a letter of commitment from the supporting institution;
16. describe or attach a proposed continuing education plan;
17. attach a description of quality assurance plan, including periodic case reviews and ongoing problems;
18. identification and steps for remedial action if necessary;
19. signatures; person completing the application, service chief/service director and medical director;
20. submit 10 copies of the application in its entirety to: EMS bureau, state EMS training coordinator, (1301 Siler Rd., Building F, Santa Fe, NM 87507);
21. submit one copy to the regional office.

EMS PERSONNEL JOB DESCRIPTIONS:

A. Introduction: The bureau is providing the following general position description for the New Mexico EMS provider positions for first responder, EMT-basic, EMT-intermediate, and EMT-paramedic. It is the ultimate responsibility of an employer to define specific job descriptions within each EMS service.

B. Qualifications:

1. successfully complete a recognized training course from an approved EMS training institution;
2. possess a valid course completion certificate, and accomplish all state licensure examination application requirements;
3. additionally, applicants shall meet all established requirements for initial licensing as identified by the current EMS licensure regulations;
4. a copy of these regulations is available through the EMS bureau;
5. generally, the knowledge and skills required demonstrate the need for a high school education or equivalent;
6. ability to communicate verbally; via telephone and radio equipment;
7. ability to lift, carry, and balance up to 125 pounds (250 pounds with assistance);
8. ability to interpret written, oral, and diagnostic form instructions;
9. ability to use good judgment and to remain calm in high-stress situations;
must demonstrate competency handling emergencies utilizing all basic life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of first responder, to include the ability to demonstrate competency for all skills and procedures currently approved for the first responder, as identified by the current scope of practice document.

2. Emergency medical technician-basic: Must demonstrate competency handling emergencies utilizing all basic life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of EMT-basic, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-basic, as identified by the current scope of practice document.

3. Emergency medical technician-intermediate: Must demonstrate competency handling emergencies utilizing all basic life support and intermediate life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of EMT-intermediate, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-intermediate, as identified by the current scope of practice document.

4. Emergency medical technician-paramedic: Must demonstrate competency handling emergencies utilizing all basic life support and advanced life support equipment and skills in accordance with all behavioral objectives of an approved New Mexico curriculum of EMT-paramedic, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-paramedic, as identified by the current scope of practice document.

D. Description of tasks for all EMS levels:

1. Receives call from dispatcher, responds verbally to emergency calls, reads maps, may drive emergency vehicle to emergency site, uses most expeditious route, and observes traffic ordinances and regulations.

2. Determines nature and extent of illness or injury, takes pulse, blood pressure, visually observes changes in skin color, auscultate breath sounds, makes determination regarding patient status, establishes priority for emergency care, may administer intravenous drugs or fluid replacement as authorized by level of licensure and scope of practice.

3. May use equipment and other devices and procedures as authorized by level of licensure and scope of practice.

4. Assists in lifting, carrying, and transporting patient to an ambulance and to a medical facility.

5. Reassures patients and bystanders and searches for medical identification emblem to aid in care.

6. Extricates patient from entrapment, assesses extent of injury, uses prescribed techniques and appliances, radio dispatcher for additional assistance or services, provides light rescue service if required and trained, provides additional emergency care following service established protocols.

7. Complies with regulations in handling deceased, notifies authorities, arranges for protection of property and evidence at scene.

8. Determines appropriate facility to which patient will be transported, report nature and extent of injuries or illness to the facility, asks for direction from hospital physician or emergency department staff.

9. Observes patient in route and administers care as directed by physician or service established protocols.

10. Identifies diagnostic signs that require communication with facility.

11. Assists in removing patient(s) from ambulance and into emergency facility.

12. Reports verbally, and in writing, observations about and care of patient at the scene, en-route to facility, and to the receiving facility. Written reports shall be completed for all patient interactions, which include any visual, verbal, or physical patient contact, by the most appropriate EMS caregiver, whether or not the patient was transported to a facility, including patient referrals.

13. Provides assistance to emergency department staff as required.

14. Replaces supplies, sends used supplies for sterilization, checks all equipment for future readiness, maintains ambulance in operable condition, ensures ambulance cleanliness and orderliness of equipment and supplies, decontaminates vehicle
interior, determines vehicle readiness by checking oil, gas, water in battery and radiator, and tire pressure, maintains familiarity with all specialized equipment.

[7.27.11.11 NMAC - Rp, 7.27.11.12 NMAC, 8/15/14]

HISTORY OF 7.27.11 NMAC:

History of Repealed Material:
7.27.11 NMAC, Supplemental Licensing Provisions (filed 12/17/2012) repealed 8/15/14.