

EMT-Intermediate Clinical Care Guidelines, Policies and Procedures

This set replaces all previous editions and becomes effective
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Stamford Hospital EMS Sponsor Hospital Program
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STAMFORD HOSPITAL EMS SPONSOR HOSPITAL PROGRAM

GENERAL OPERATING GUIDELINES

1. These guidelines have been developed in conjunction with the Southwestern Connecticut Emergency Medical Services (EMS) Council and the participating sponsor hospital programs. The following guidelines are to be used by Stamford EMS Sponsor Hospital Program-sponsored EMT-Intermediates and emergency department physicians to ensure quality and standardized medical care, and to establish standards by which pre-hospital care may be audited for continuous quality improvement.
2. Any EMS agency sponsored at the EMT-Intermediate level agrees to utilize a paramedic intercept response protocol according to the criteria established by the Southwest EM S Council.
3. These guidelines are specific for advanced life support intervention and are to be used ONLY by EMT-Intermediates credentialed by the Stamford Sponsor Hospital Program and duly authorized to perform clinical care at that time by their sponsored agency.
4. It is understood that the Southwestern Connecticut EMS Council Basic Life Support Guidelines are always to be initiated in conjunction with the Advanced Life Support guidelines.
5. Those aspects of the treatment procedures requiring OLMC are indicated as UPPER CASE TEXT.
6. No procedure or medication shall be used without the proper equipment or beyond the training, capabilities, or certification level of the EMS personnel.
7. Venous phlebotomy is not allowed in the prehospital setting. Capillary blood sampling to obtain a fingerstick glucose level is permitted.
8. The EMT-Intermediate may contact online medical control (OLMC) at any time necessary. Without OLMC, the EMT-I shall not deviate from these guidelines.
9. Treatment provided during transport, such as oxygen, must be continued during the transfer from the ambulance into the emergency department.
10. When orders obtained from OLMC appear to be inappropriate, the EMT-I must clarify the order, clarify the patient's condition, and document the discussion with the physician.
11. If the physician does not alter or retract the order, the EMT-I should carry out the order unless:
 - a) The EMT-I is neither credentialed nor trained to provide the intervention ordered
 - b) The intervention is not listed in the protocolIn ALL such cases the EMT-I will bring this matter to the attention of the EMS Coordinator.
12. Scene times greater than twenty (20) minutes must be explained in the patient care report.

PROTOCOL REVISION AND REVIEW

1. These guidelines will be reviewed in order to keep current with changing medical standards, treatment modalities and patient population needs based on the data obtained from QA/QI activities.
2. Any recommendations for revisions, deletions or additions to the guidelines should be made in writing to the EMS Coordinator.
3. Changes made to any guidelines will require the notification of all MIC personnel and any applicable training will be done in a timely manner.

MEDICAL AUTHORITY AT THE SCENE

1. Stamford Hospital is the sponsor hospital at the EMT-Intermediate level for Stamford Emergency Medical Services, Darien Emergency Medical Services/Post 53 and Access Ambulance Company, Inc., and as such is responsible for all MIC technicians who institute ALS procedures under these guidelines.
2. The highest credentialed/agency authorized provider on-scene is responsible for the management of the patient(s) and acts as the agent of medical control.
3. It is our collective desire to work collaboratively with appropriately identified healthcare professionals on the scene of a medical emergency to enhance patient care. It is also our collective responsibility to assure that our patients only receive care from appropriate, acceptable practitioners.
4. According to the Connecticut Public Health Code Section 19a-179-13, EMS personnel may release patient care responsibility to an on-scene physician only after:
 - a) The physician has been identified as a Connecticut licensed physician and has offered some form of identification such as a driver's license, which confirms the credentials, and,

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- b) Obtaining from the physician a commitment to accompany the patient to the hospital in the vehicle transporting the patient; and,
- c) Having the physician speak directly to the person responsible for OLMC and receiving authority to release the patient.
- d) In the absence of any of the above factors, the patient may not be released and care will continue under the direction of EMS in consultation with OLMC.

TRAUMA NOTIFICATION

- 1. Purpose
 - a) Stamford Hospital is dedicated to optimal care for the trauma patient. Trauma Activation Criteria is defined to provide a coordinated team approach for prompt intervention for the trauma patient.
- 2. Policy
 - a) EMS will notify the Stamford Hospital Emergency Department via C-Med for a Trauma Code or a Trauma Alert with the specific activation criteria. C-Med will relay this information to the appropriate Emergency Department personnel if needed. The Emergency Department physician will institute the trauma activation.
- 3. Trauma Code
 - a) Physiologic Criteria
 - i) Adult respiratory rate <10 or >29 (Child RR <10 or >60), airway obstruction
 - ii) CONFIRMED Systolic BP < 90 in field or ED (child <1 yr. $<60-70$, >1 yr. $(70 + 2x \text{ age})$)
 - iii) Adult GCS ≤ 8 (Child GCS <12)
 - b) Anatomic Criteria
 - i) Penetrating injury to head, neck, torso or extremities proximal to knee or elbow
 - ii) Major blunt trauma to torso
 - iii) Major burns $>25\%$ TBSA or major burns to face, hands or feet
 - iv) Inhalation injury with respiratory compromise
 - v) Lateralizing neurological signs
 - vi) Limb paralysis
 - vii) Amputation of limb, excluding digits
 - c) Two or more victims with serious injuries and/or DOA on scene
 - d) EMS discretion
 - e) Emergency physician's discretion
- 4. Trauma Alert
 - a) Physiologic Criteria
 - i) GCS: 9-13
 - b) Anatomic Criteria
 - i) Penetrating injury to extremity excluding hands or feet
 - ii) Two or more proximal long-bone fractures
 - iii) Fractures above and below the diaphragm (including flail chest)
 - iv) Injuries to more than two organ system
 - v) Significant facial fractures
 - vi) Burns, third degree or second degree 10-25%
 - vii) Blast or chemical injuries to face
 - c) Mechanism Criteria
 - i) Prolonged Extrication
 - ii) Roller-over with unrestrained occupant
 - iii) Significant vehicle deformity and/or intrusion
 - iv) Death of same car occupant
 - v) Ejection from the vehicle
 - vi) Fall from a height >15 feet (Pediatric falls > 10 feet)
 - vii) Pedestrian thrown or run over
 - viii) Auto pedestrian / auto-bicycle with significant impact
 - ix) Motorcycle crash > 20 m.p.h. or motorcycle crash with rider thrown
 - d) Age >65 on anti-coagulation therapy, or bleeding disorders
 - e) EMS discretion
 - f) Emergency physician's discretion

This guideline should be used on all patients for initial assessment. These guidelines are frequently referred to by other guidelines, which may or may not override them in recommending more specific therapy.

On all responses, patients shall be evaluated by the highest level of care provider on scene (when not a multiple casualty incident).

1. Scene Size-up
 - a) Review of dispatch information
 - b) Maintain appropriate body substance isolation precautions. Assure scene safety in all patient encounters
 - c) Determine mechanism of injury or nature of illness
 - i) Obtain from parents/family/bystanders if necessary
 - d) Determine number and location of patients
 - e) Determine need for additional resources
2. Initial Assessment
 - a) General impression of patient
 - b) Assess mental status (AVPU) – maintain spinal immobilization as needed
 - c) Assess **airway, breathing, circulation** – pulse, major bleeding, skin color and temperature
 - d) Assess **disability** – movement of extremities / defibrillation
 - e) **Expose** and examine head, neck, chest, abdomen, pelvis, and back (when patient is rolled on side)
 - f) Identify priority patients
3. Initiate Critical Treatment
4. Secondary Assessment
 - a) Conduct a thorough survey
 - b) Neurological assessment
 - i) Glasgow coma score
 - ii) Pupillary response
 - c) Assess vital signs using age and size-appropriate equipment
 - i) Blood pressure
 - ii) Pulse
 - iii) Respirations
 - iv) Capillary refill
 - v) Skin condition
 - (1) Color
 - (2) Temperature
 - (3) Moisture
 - vi) Lung sounds
 - d) Obtain a medical history (obtain from parents/family/bystanders if necessary)
 - i) **S** - symptoms - assessment of chief complaint
 - (1) **O** – onset and location
 - (2) **P** – provocation
 - (3) **Q** – quality
 - (4) **R** – radiation, **R** – referred, **R** – relief
 - (5) **S** – severity
 - (6) **T** – time
 - ii) **A** - allergies
 - iii) **M** - medications
 - iv) **P** - past medical history
 - v) **L** - last oral intake
 - vi) **E** - events leading to illness or injury
5. Other Assessment Techniques
 - a) Glucose determination

AIRWAY MANAGEMENT

1. If spontaneous breathing is present without compromise:
 - a) Monitor breathing during transport
 - b) Administer oxygen via nasal cannula (2-6 L/min) as needed for adults, blow-by for pediatrics
2. If spontaneous breathing is present with compromise:
 - a) Maintain open airway
 - b) Administer oxygen via non-rebreather mask (10-15 L/min)
 - c) If unconscious, insert oropharyngeal or nasopharyngeal airway as needed
 - d) Assist ventilations with BVM as needed
 - i) Newborns should have BVM ventilation done with pop-off valve activated.
 - ii) All other children should have BVM ventilation done without pop-off valve activated.
 - e) Suction as needed
3. If spontaneous breathing is absent or markedly compromised
 - a) Maintain airway
 - i) ii) Position pediatric patients with padding under torso
 - b) If unconscious, insert oropharyngeal or nasopharyngeal airway
 - c) Assist ventilations with BVM
 - i) Newborns should have BVM ventilation done with pop-off valve activated.
 - ii) All other children should have BVM ventilation done without pop-off valve activated.
 - d) Suction as needed

MEDICAL SUPPORTIVE CARE

1. Initiate Initial Assessment and Management Guideline
2. Initiate Airway Management Guideline
3. Maintain warmth and comfort measures
4. Establish vascular access with saline lock or establish IV of 0.9% normal saline with regular infusion set if authorized by patient presentation.

TRAUMA SUPPORTIVE CARE

1. Initiate Initial Assessment and Management Guideline
2. Initiate Airway Management Guideline
3. Correct any open wound/sucking chest wound (occlusive dressing)
4. Correct any massive flail segment that causes respiratory compromise
5. Control hemorrhage
6. Immobilize cervical spine and secure patient to backboard as needed
7. Maintain warmth
8. Expedite transport
 - a) With few exceptions (i.e., unconscious patient), a parent should be allowed to accompany a child in the patient compartment
9. Perform the following steps while not delaying transport:
 - a) Establish IV of 0.9% normal saline solution with regular infusion set if authorized by a specific guideline.
 - b) Complete bandaging, splinting and packaging as needed.
 - c) Establish hospital contact for notification. Initiate trauma alert or trauma code, if applicable

Routine EMS Care is comprised of the Initial Assessment and Treatment, Airway Management, Medical Supportive Care and Trauma Supportive Care guidelines and should be implemented on every patient encounter as appropriate.

CARDIAC GUIDELINES

CARDIAC ARREST OVERVIEW

1. The keys to resuscitation are centered around high quality CPR:
 - a) Chest compressions: Push hard and fast (100/min) and release completely. Minimize interruptions in compressions.
 - i) No advanced airway in place: 30 compressions to 2 breaths
 - ii) Advanced airway in place by paramedic: asynchronous compression to ventilations
 - b) Ventilations: Do not exceed 10 breaths per minute.
2. EMS should be supplied with and utilize biphasic defibrillators.

PEDIATRIC

Cardiac arrest in children is not a sudden event. It is almost always due to a respiratory problem, which leads to hypoxia, bradycardia, and eventually cardiopulmonary arrest. Initial treatment should be directed at establishment of an airway, administration of supplemental oxygen, and mechanical ventilation.

1. Respiratory
 - a) Assessment of a child's respiratory status is crucial to preventing cardiopulmonary arrest.
 - b) Identify signs of respiratory distress early, including tripodding, nasal flaring, retractions, grunting, wheezes, rhonchi and crowing.
 - c) Identify and rapidly treat signs of respiratory failure. Look for changes in mental status, cyanosis, delayed capillary refill, loss of peripheral pulses and cold/mottled extremities.
 - d) Treatment should be focused on:
 - i) Ensuring patency of the airway by suctioning secretions from oral and nasal passages and utilizing airway adjuncts.
 - ii) Positioning of the child, which is critical to maintaining an airway. Padding is needed under the torso of all children, even those being immobilized for c-spine injuries.
 - iii) Providing supplemental oxygen to prevent progression to arrest. Consider use of blow by oxygen to decrease anxiety produced by mask oxygen. Remember that a calm child uses less oxygen than an anxious child. Do not hesitate to assist ventilations with signs of respiratory failure.
2. Cardiovascular Assessment
 - a) Heart Rate
 - i) Tachycardia is an early sign of shock.
 - ii) Bradycardia in a distressed infant or child may indicate hypoxia and is an ominous sign of impending cardiac arrest.
 - b) Peripheral Circulation
 - i) Loss of central pulses is an ominous sign.
 - c) Blood Pressure
 - i) Blood pressure is the last and least important vital sign to obtain in children. Hypotension is a late and often sudden sign of cardiovascular decompensation.
 - ii) The presence of a normal blood pressure does not rule out shock and should not be used to evaluate children with other signs and symptoms of shock.

BEHAVIORAL EMERGENCIES - PATIENT RESTRAINT

1. Purpose
 - a) To establish a standard/guideline to be utilized only when necessary and in those situations where the patient is exhibiting behavior that the prehospital care provider believes presents a danger to the patient and/or others. This procedure applies to patients being treated under implied consent, Police Emergency Exam Request, Court Decree of Incapacity or as Authorized by OLMC. Patients who are refusing treatment should not be subjected to this procedure unless police are on scene.
2. Guiding Principles
 - a) Respect the dignity of the patient.
 - b) Assure physical safety of patient and EMS personnel.
 - c) Diagnose and treat organic causes of behavioral disturbances such as hypoglycemia, hypoxia, or poisoning.
 - d) Use reasonable physical force only if attempts at verbal control are unsuccessful. Reasonable force is defined as the minimum amount of force necessary to control the patient and prevent harm to the patient or others.
 - e) Teamwork between EMS personnel and law enforcement will improve patient care.
3. Statement
 - a) Use of a physical restraint on patients is permissible if the patient poses a danger to himself or others. Only reasonable force is allowed. The use of a chemical restraint on a patient is indicated where safe physical restraint poses a risk of injury to the providers and/or the patient AND where the patient continues to fight against physical restraints.
4. Indications: Restraints Are To Be Applied To Patients Only In Limited Circumstances:
 - a) Behavior or threats that create or imply a danger to the patient or others.
 - b) Safe and controlled access for medical procedures.
 - c) Changes in mental status that impede the treatment of the patient.
 - d) Involuntary evaluation or treatment of incompetent combative patients.
 - e) A written order by the Physician ordering the transfer or an "OLMC" order allowing the restraints to be utilized in the prehospital arena.
 - f) The patient is being transported in the custody of the police department and the arresting officer is in the presence of the patient.
5. Precautions
 - a) Restraints shall be used only when necessary to prevent a patient from seriously injuring him/herself or others. They MUST NOT be used as a punishment or for the convenience of the ambulance crew, but for the provision of safe transportation and treatment.
 - b) Any attempt to restrain a patient involves risk to the patient and the pre-hospital provider. Efforts to restrain a patient shall be done only when there is adequate assistance present.
 - c) During restraint procedures, every attempt should be made to avoid positions that may be associated with traumatic asphyxia.
 - d) Patients must have a physical examination performed (if permitted) prior to applying restraints. They should be assessed for extremity injury and for any neurological, metabolic or traumatic injury. Pre-existing conditions, such as but not limited to: hypoxia, hypoglycemia, narcotic overdose, should be treated utilizing the appropriate patient care guideline.
 - e) A post restraint physical examination must be performed. Assessment and documentation of Pulses, Motor and Sensation distal of each restraint and any injuries that may have occurred during the restraint process must be included.
 - f) Ensure that law enforcement personnel have searched the patient for weapons.
 - g) In the case of a violent or threatening patient, immediately contact the local Police Department for assistance.
 - h) Any patient in handcuffs, shackles or "in custody" must have law enforcement, Department of Corrections or Sheriffs/Marshals with the patient at all times, including in the patient compartment of the ambulance during transport.

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6. Verbal De-Escalation Procedure
 - a) Guidelines
 - i) Make every attempt not to aggravate or worsen pre-existing injuries or medical conditions
 - ii) Attempt to control the patient with non-violent crisis intervention techniques
 - b) Procedure
 - i) Be aware of Proxemics
 - (1) Avoid invasion of the patient's personal space
 - (2) Maintain a safe distance and refrain from touching
 - ii) Be aware of Kinesics
 - (1) Do not use intimidating body language
 - (2) Keep your hands in front of your body in a non-threatening manner
 - (3) Use a supportive body stance while protecting your exits
 - iii) Use Empathic Listening techniques
 - (1) Use therapeutic rapport
 - (2) Listen to patient's concerns
 - (3) Only one provider should communicate with the patient
 - (4) Empathize, use positive feedback
 - iv) Be aware of your Paraverbal Communications
 - (1) Maintain a soothing tone of voice
 - (2) Control your tone, volume and cadence of speech
 - v) Set Limits as needed
 - (1) Limits should be simple, clear, reasonable and enforceable
 - (2) Limit the number of choices
 - (3) Calmly set boundaries of acceptable behavior
7. Patient Capacity Issues
 - a) Medical decision making capacity is defined as the ability to give informed consent to go through a particular medical test or intervention or the ability to refuse such intervention.
 - b) When tasked to determine the mental capacity of a patient to refuse treatment, ask yourself these questions about your patient:
 - i) Is the patient in danger of hurting himself or others?
 - ii) Is there or could there be an underlying medical emergency that may lead to death or worsen considerably if not treated soon?
 - iii) Is there an emergency medical intervention that must be made to avoid a worsening in your patient's condition?
 - iv) Does your patient understand the risks of refusing these treatments or interventions? Have you made those clear?
 - v) These questions apply only to the patient's immediate situation, not to long-term medical care.
8. Physical Restraint Guidelines
 - a) Use the minimum physical restraint required to accomplish necessary patient care and ensure safe transportation:
 - i) If law enforcement or additional personnel are needed, call for it prior to attempting restraint procedures
 - ii) Do not endanger yourself or your crew
 - iii) Patients that are actively seizing should never be restrained.
 - b) The acceptable physical restraints are soft in nature and pose no threat to the patient's extremities and/or physical presentation. These devices should be used to restrain the patient and not injure.
 - c) Avoid placing restraints in such a way as to preclude evaluation of the patient's medical status (airway, breathing, and circulation). Consider whether placement of restraints will interfere with necessary patient care activities or will cause further harm.
 - d) Patient will be restrained in a face up position.
 - e) Restraint Types:
 - i) The recommended physical restraint device is a medical soft restraint. Other acceptable means may be a tied (not taped) pillowcase or towel.
 - ii) Only the extremities shall be restrained and the patient must be assessed every five minutes.
 - iii) If necessary, use cervical spine precautions (CID) to control violent head or body movements

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- iv) Place padding under patient's head and wherever else needed to prevent the patient from further harming him/herself or restricting circulation
 - v) OLMC MUST approve any variation of a restraint device.
 - vi) Unacceptable Device/Methods: Some unacceptable means of restraint are:
 - (1) Leather restraints, oxygen tubing, tape, string/rope
 - (2) Handcuffs (not in the custody of an accompanying police officer/corrections officer etc.).
 - (3) Any restraint tied around the head, neck or chest.
 - (4) Restraining a patient's hands and feet together behind the patient is not allowed.
 - (5) "Sandwiching" between long board and scoop is not allowed.
 - (6) Restraining in the prone position is NOT ALLOWED. This position has been associated with traumatic asphyxia and death.
 - (7) Any position that may limit breathing, airway management or treatment/evaluation.
 - vii) Any patient in handcuffs, shackles or "in custody" must have law enforcement, Department of Corrections or Sheriffs/Marshals with the patient at all times, including the patient compartment of the ambulance during transport.
 - f) Complications of Restraints:
 - i) Aspiration can occur, particularly if the patient is supine. It is the responsibility of the EMS provider to continually monitor the patient's airway and level of consciousness.
 - ii) Nerve injury or soft tissue damage may occur from restraints that are applied tightly.
 - iii) Traumatic Asphyxia.
 - g) PEDIATRIC CONSIDERATIONS:
 - i) EMS personnel should attempt to notify and coordinate with parents when restraining children, if time permits and the situation is appropriate.
 - h) PREGNANCY CONSIDERATIONS:
 - i) Pregnant women should be restrained in a semi-reclining or left lateral recumbent position.
9. Treatment Of Post Law Enforcement Non-Lethal Device Use
- a) OC, capicum, Mace, etc.
 - i) Move patient to open space and allow time for substance to dissipate
 - ii) Decontaminate and irrigate with water. DO NOT use 0.9% sodium chloride or soap
 - b) Conducted Energy Weapon
 - i) If police request an EMS response for an individual struck by a Taser® or similar weapon, EMS personnel shall assess and treat the patient under appropriate guidelines. Be especially alert for spinal injury and cardiac dysrhythmia.
 - ii) Unless otherwise contraindicated, the patient should be adequately and safely restrained in an upright position prior to transport.
 - iii) All patients who have been struck by a Taser® will be transported to a hospital emergency department for evaluation and are not allowed to refuse medical transportation. If a competent and capable adult adamantly insists on refusing medical care and transportation, OLMC will be contacted immediately.
 - iv) Law enforcement personnel are expected to assist in the safe transport of patients to a hospital emergency department for evaluation. Patients in police custody and/or restrained by law enforcement devices cannot be transported in the ambulance without a law enforcement officer in the patient compartment who is capable of removing the restraint.
 - v) When safe to do so, patients should be immediately evaluated, with particular attention to signs and symptoms of fall-related trauma and agitated delirium.
 - vi) Any injuries or medical conditions will be treated according to the appropriate guideline.
 - vii) Impaled probes will not be removed by EMS personnel unless necessary to provide life or limb-saving treatment.
 - (1) Verify the wires to the probes have been severed.
 - (2) Using routine biohazard precautions place one hand on the patient in the area where the probe is embedded and stabilize the skin surrounding the puncture site between two fingers. Keep your hand several inches away from the probe. With your other hand, in one fluid motion pull the probe straight out.
 - (3) Secure the probes in an unused biohazard container and return to law enforcement.
 - (4) Apply direct pressure for bleeding, and apply a sterile dressing to the wound site.

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- viii) If the Taser® probes impale in a dangerous area (e.g., face, neck, hand, bone, groin or spinal column), do NOT remove the barbs. Transport in an appropriate position.
 - c) Bean Bag Round
 - i) Evaluate for trauma at impact site
 - ii) Impact sites of head, abdomen and chest have high incidence of serious injury and should receive extra assessment and treatment if needed.
 - d) Document device(s) used, impact sites and trauma inflicted on PCR
10. Required Documentation (Minimum)
- a) An emergency existed
 - b) The need for treatment was explained to the patient (regardless of competence)
 - c) The patient refused treatment or was unable to consent to treatment
 - d) Evidence of the patient's incompetence to refuse treatment
 - e) Failures of less restrictive methods of control (such as VERBAL DE-ESCALATION)
 - f) The restraints were used for the safety of the patient or others
 - g) The reasons for restraint were explained to the patient (regardless of competence)
 - h) The type/method of restraint used and which limbs were restrained
 - i) Injuries that occur during the restraint procedure
 - j) Which agency(s) placed the restraints and which agency assisted (i.e.: PD, FD, etc.)
 - k) The ongoing assessment of PMS (distal to the restraints) and the patient's ability to breathe
 - l) Any assistance used for restraining

NOTE:

- Constant evaluation of your patient's airway status and documentation of such is extremely important.

1. Purpose
 - a) Timely and appropriate communications can allow EMS personnel to obtain online medical control (OLMC), and
 - b) can allow the receiving facility to plan for appropriate distribution of resources, activate clinical response guidelines, and improve overall hospital patient flow management.
2. Policy
 - a) In complex cases involving a high acuity patient or multiple patients, early notification with limited but accurate information is more important than a detailed report made just prior to arriving at the hospital. Whenever possible, initiate field to hospital communications prior to leaving the scene.
 - b) All SHSHP-sponsored response vehicles shall have two-way voice communication equipment to provide direct contact with hospital emergency departments throughout the duration of an ambulance call within their primary operating area.
 - c) Any incident involving three (3) or more patients should be considered for implementation of an Incident Command System (ICS). Communication to the hospital(s) should be centralized through the transportation group.
3. Procedure
 - a) To establish contact with Stamford Hospital:
 - i) Contact SW C-Med by radio or phone and request a "patch" to Stamford Hospital
 - ii) Identify whether you wish to give report to or consult with medical direction.
 - iii) Identify any special circumstance qualifiers (i.e. PAMI Alert, Stroke Alert, Haz Mat)
 - iv) When consulting OLMC, verify that a physician is on the line and obtain identification prior to initiating report.
 - v) For the high-acuity patient, the report should include the following:
 - (1) Age and gender
 - (2) Immediate pertinent history
 - (3) Chief complaint
 - (4) Vital signs and pertinent positive and negative assessment findings
 - (5) Treatment initiated and patient response
 - (6) Estimated time if arrival
 - (7) Specific needs (i.e. security, lift assistance, etc.)
 - vi) For the non-emergent patient, the report can be shortened and only the following provided:
 - (1) Age and gender
 - (2) Chief complaint with brief summary of event, illness, and Vital signs
 - (3) Estimated time if arrival
 - (4) Specific needs (i.e. security, lift assistance, etc.)
4. Online Medical Control (OLMC)
 - a) It is often necessary or desirable to contact a physician for assistance with patient care/transport decisions or to approve specific clinical treatment.
 - b) If contact with OLMC is required, it should be requested from the facility that the patient is being transported to. In cases where the patient is requesting a facility that conflicts with protocol, Stamford Hospital OLMC will be contacted. Unless an alternate facility is approved by OLMC, the patient should be transported to the contacted facility.
 - c) To ensure continuity of care, once OLMC has been established, the Intermediate will follow the physician's medical orders within the scope of the guidelines.
 - d) Orders from OLMC must be conveyed via a C-Med-recorded channel or over a recorded phone line and fully documented on the run report.
 - e) When an order is given by OLMC, repeat the order to verify its accuracy.
 - f) Verify receipt of information and wait for OLMC to verify conclusion of communications.

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DETERMINATION OF DEATH/DISCONTINUATION OF PRE-HOSPITAL RESUSCITATION


FOR ADULTS AGE 18 AND OVER, NON-MASS CASUALTY SITUATIONS

1. PROCEDURE FOR DETERMINATION OF DEATH
 - a) All clinically dead patients will receive all available resuscitative measures including cardiopulmonary resuscitation (CPR) unless contraindicated by one of the exceptions defined below. A clinically dead patient is defined as any unresponsive patient found without respirations and without a palpable carotid pulse.
 - b) The person who has the highest level of currently valid EMS certification, and who has direct voice communication for OLMC, who is affiliated with an EMS organization present at the scene will be responsible for, and have the authority to direct, resuscitative activities.
 - c) In the event there is a personal physician present at the scene, who has an ongoing relationship with the patient, that physician may decide if resuscitation is to be initiated. In the event there is a registered nurse from a home health care or hospice agency present at the scene who has an ongoing relationship with the patient and who is operating under orders from the patient's private physician, that nurse may decide if resuscitation is to be initiated. If the physician or nurse decides resuscitation is to be initiated, usual Medical Control procedures will be followed.
 - d) Resuscitation must be started on all patients who are found apneic and pulseless unless:
 - i) The patient has a valid Do Not Resuscitate Order (DNR).
 - ii) The patient shows signs of decomposition putrefaction, decapitation, hemicorporectomy, or incineration.
 - iii) Dependent lividity and/or rigor mortis require additional assessment: (NOTE: THIS SECTION DOES NOT APPLY IN CASES OF HYPOTHERMIA, LIGHTNING STRIKES, OR DROWNING)
 - (1) Reposition the airway and look, listen, and feel for at least 30 seconds for spontaneous respirations or auscultate for lung sounds. If ventilations are present, establish resuscitative care immediately. If respiration is absent:
 - (2) Palpate the carotid pulse for at least 30 seconds or auscultate for heart sounds. If pulses and/or heart sounds are present, establish resuscitative care immediately. If pulse or heart sound is absent:
 - (3) Examine the pupils of both eyes with a light. If pupils react, establish resuscitative care immediately. If both pupils are non-reactive:
 - iv) Injuries incompatible with life (such as massive crush injury, complete exsanguination, severe displacement of brain matter) require additional assessment as in #3 above.
2. SPECIAL CIRCUMSTANCES:
 - a) A private physician at the scene who has an on-going relationship with the patient must produce identification showing the name and license number (MD/DO). That physician may pronounce death on a clinically dead patient in the presence of EMS personnel. This physician pronouncement relieves the EMS personnel at the scene of responsibility to begin or continue resuscitative measures. The Medical Control hospital will be notified and the information will be documented on the EMS patient care form.
 - b) A registered nurse from a home health care or hospice agency at the scene must produce identification showing the name and license number, who has an ongoing relationship with the patient, and who is operating under orders from the patient's private physician and is authorized by law to pronounce death, may pronounce a clinically dead patient dead even if EMS personnel are present. The nurse's pronouncement relieves the emergency personnel of the responsibility to begin or continue resuscitative measures. The Medical Control hospital will be notified and the information will be documented on the EMS patient care form.
3. Determination of Death/Discontinuation of Resuscitation Notes:
 - a) Consider the needs of survivors when considering the discontinuation of resuscitation, especially if crisis management services may be needed.
 - b) Scene management may prevent withholding resuscitation.
 - c) Documentation of all encounters with the patient's family, personal physician, medical examiner, law enforcement, and medical control should be on the ACR.

1. The purpose of this guideline is to provide a verification/authentication of DNR orders at the scene and/or during transport, and to clarify the role and responsibilities of EMS Personnel for situations when resuscitation should not be initiated.
2. Whenever any likelihood of survival exists, resuscitation should proceed unless the patient has clearly been identified as not to receive extraordinary means of resuscitation (State of Connecticut DNR). In any situation when pre-hospital personnel have a good faith basis to doubt the continued validity of the DNR order, resuscitative measures must be initiated. Patients suspected to be hypothermic should be administered resuscitative care unless any of the other criteria apply or OLMC advises otherwise.
3. If there is a DNR bracelet or DNR Transfer Form and there are signs of life:
 - a) CONTACT OLMC BEFORE INTRODUCING ANY ADVANCED AIRWAY PROCEDURES OR SIGNIFICANT THERAPIES.
4. If there are no signs of life:
 - a) If a valid DNR Bracelet or DNR Transfer Form exists, DO NOT start CPR:
 - i) DNR Bracelet
 - (1) A DNR bracelet shall be the only valid indication recognized by EMS providers that a DNR order exists for patients outside a healthcare institution, other than those patients received by an EMS provider directly from a healthcare institution.
 - (2) A valid DNR bracelet shall:
 - (a) be the correct color – orange
 - (b) have the correct logo
 - (c) be affixed to the patient's wrist or ankle
 - (d) display the patient's name and attending physician's name
 - (e) not have been cut or broken at any time.
 - ii) DNR Transfer Form
 - (1) To transmit a DNR order during transport by an EMS provider between healthcare institutions, the DNR order shall be documented on the DNR transfer form.
 - (2) The DNR transfer form shall be signed by a licensed physician or a registered nurse and shall be recognized as such and followed by EMS providers.
 - (3) The DNR remains in place during transport as well as to the point of admission to the receiving facility.
 - iii) Revocation of the DNR
 - (1) The patient or authorized representative may verbally tell a certified or licensed EMS provider they wish to alter their DNR status.
 - (2) This statement must be entered on the prehospital care report.
 - (3) This statement should be supported by any witnesses present.
5. Other forms of DNR and/or limitations of care will not routinely be honored by EMS, as per State of Connecticut laws and regulations. If the EMS provider questions the level of care a patient shall receive, OLMC should be contacted as early as possible.
 - a) If unable to contact OLMC, full care will be provided.

STAMFORD HOSPITAL EMS SPONSOR HOSPITAL PROGRAM

State of Connecticut DNR Bracelet



STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES


DO NOT RESUSCITATE (DNR) BRACELET

This is a picture of the DNR bracelet approved by the Department of Public Health. It is key to implementing the regulations for "Do Not Resuscitate" orders in out of facility settings.

COLORS


- Orange information insert border
- Black lettering of "EMS ALERT" and logo
- Orange plaid wrist strap

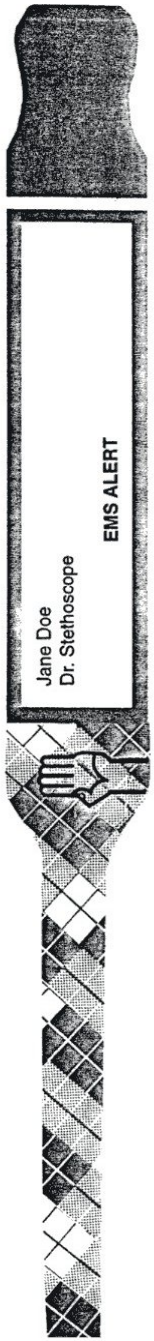
A VALID DNR BRACELET:

1. is on the wrist or ankle
2. is intact; it has not been cut or broken
3. has the correct logo ----- 
4. is the correct color --- orange.

PLEASE SEE YOUR CHIEF OF SERVICE FOR THE REGULATIONS AND MORE COMPLETE INFORMATION

Phone: (860) 509-7975
Telephone Device for the Deaf (860) 509-7191
410 Capital Avenue - MS # 12 EMS
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer





Jane Doe
Dr. Stethoscope

EMS ALERT

STAMFORD HOSPITAL EMS SPONSOR HOSPITAL PROGRAM

State of Connecticut Transfer of DNR Form



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



TRANSFER OF "DO NOT RESUSCITATE" ORDER



Name _____ Identification Number _____

Healthcare Institution _____

I, the undersigned, attest that the above named person has a valid "Do Not

Resuscitate" order which was written on _____

by _____, M.D. and is retained in this

person's medical record at the above location.

Signature of MD or RN

Printed Name

Date

1. Policy
 - a) At a minimum, all patient care documentation by any sponsored provider shall:
 - i) Be truthful, accurate, objective, pertinent, legible, and complete with appropriate spelling,
 - ii) abbreviations and grammar
 - iii) Reflect the patient's chief complaint and a complete history or sequence of events that led to their current request or need for care
 - iv) Detail the assessment of the nature of the patient's complaints and the rationale for that assessment.
 - v) Reflect initial physical findings, a complete set of initial vital signs, all details of abnormal findings considered important to an accurate assessment and significant changes important to patient care.
 - vi) Reflect ongoing monitoring of abnormal findings
 - vii) Summarize all assessments, interventions and the results of the interventions with appropriate detail so that the reader may fully understand and recreate the events
 - viii) Include an explanation for why an indicated and appropriate assessment, intervention, or action that is part of the Southwestern Connecticut BLS Guidelines or the Stamford Hospital ALS Guidelines did NOT occur.
 - ix) Clearly describe the circumstances and findings associated with any complex call or out-of-the ordinary situations.
 - x) Remain confidential and be shared only with legally acceptable entities.
 - b) Any patient contact with Stamford Sponsor Hospital-sponsored ALS personnel must result in submission of complete patient care documentation.
 - c) Run reports will be completed prior to departing the emergency department. In the event the report cannot be completed prior to the EMS unit's dispatch to another call, the run report will be completed and delivered as soon as possible after that call, within that working shift.
 - i) In cases of traumatic injury, the EMS crew will NOT depart the hospital until the patient care report is submitted. In cases where the crew must respond to another call, the Stamford Hospital Interim EMS Trauma Report will be filled out completely and left with the nurse in charge of the patient's care.
2. Procedure
 - a) Run reports will be completed in accordance with Stamford Hospital EMS Sponsor Hospital policy.
3. Hospital Copy
 - a) The hospital copy of the run report or an authorized equivalent will be left with Emergency Department Unit Coordinator and placed in the designated bin.
4. EMS Coordinator Copy
 - a) For EMS Charts users, only the Hospital Copy will be printed and submitted.
 - b) For paper ACR users, a copy of the run report will be left in the locked box provided for this purpose in the designated EMS write-up area.
 - c) For patients transported to a receiving facility other than Stamford Hospital, a copy of the run report must be submitted to the Stamford Hospital EMS Coordinator.

1. Purpose
 - a) To provide a consistent approach to patients who refuse assessment, treatment and care, and/or transportation by Stamford Hospital-sponsored EMS providers.
2. Policy
 - a) The U.S. Supreme Court has recognized that a "person has a constitutionally protected liberty interest in refusing unwanted medical treatment" even if refusal could result in death. Although courts protect a patient's rights to refuse care, "preservation of life, prevention of suicide, maintenance of the ethical integrity of the medical profession, and protection of innocent third parties" also may be considered when evaluating a patient's wish to refuse treatment. Each case must be examined individually.
 - b) There are three components to a valid RMA. Absence of any of these components will most likely result in an invalid RMA. The three components are as follows:
 - i) Competence: In general, a patient who is an adult or a legally emancipated minor is considered legally competent to refuse care. A parent or legal guardian who is on-scene may refuse care on his or her minor children's behalf.
 - ii) Capacity: In order to refuse medical assistance a patient must have the capacity to understand the nature of his or her medical condition, the risks and benefits associated with the proposed treatment, and the risks associated with refusal of care.
 - iii) Informed Refusal: A patient must be fully informed about his or her medical condition, the risks and benefits associated with the proposed treatment and the risks associated with refusing care.
 - c) The prudent provider tries to explore the reasons for refusing therapy. If the patient continues to decline treatment, document this discussion and refusal. This will be done on a service-provided patient refusal report.
 - d) Prehospital care personnel will make every reasonable effort to convince reluctant patients to access medical care at the emergency department via the emergency medical service system before accepting a Refusal of Medical Attention as a final disposition. On-line medical control (OLMC) MUST be contacted for all patients who present a threat to themselves, present with an altered level of consciousness or diminished mental capacity, or would otherwise qualify for require advanced life support intervention.
3. Procedure
 - a) Any patient contact with EMS personnel must result in complete documentation of a Patient Care Report. When dealing with patients who are refusing treatment and/or transportation, thorough documentation is critical.
 - i) Several specific items must be documented:
 - (1) Accurate patient information, times of occurrence, and date.
 - (2) The name of the person who called 911, their relationship to the patient and the reason they called.
 - (3) Complete physical exam, including two (2) complete sets of vital signs.
 - (4) History of present illness and chief complaint.
 - (5) Documentation of patient mental status and their reason for refusal.
 - (6) Signature of patient and witness.
 - ii) The patient signature is required on the release form. This is to be witnessed by a police officer or other reliable non-EMS personnel, if possible.
 - b) Itemized refusals (i.e. refusing an IV or spinal immobilization, but accepting transport and oxygen) should be documented next to the Release Form and signed as above. The non-relevant parts of the release form may be crossed out.
4. OLMC is a resource that should be accessed at any time to assist in preventing an RMA or in determining the need for protective custody as an option.
 - a) Direct communication with OLMC shall be established prior to the release of any patient in the following categories:
 - i) History or examination would have dictated ALS response and care.

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- ii) Any patient for whom ALS was initiated or attempted prior to their refusal, regardless of success.
 - iii) Suicidal ideation resulting in any gesture or attempt at self-harm, or any verbal or written expression of suicidal ideation regardless of any apparent ability to complete a suicide.
 - iv) Minors (< 18 years of age)
 - v) Any patient who has an altered level of consciousness due to any cause and may be impaired from making decisions in their best interest.
- b) The physician is to be provided all relevant information and may need to converse directly with the patient by radio or landline.
 - c) The physician will determine if protective custody is to be pursued via the Police Department.
 - d) If the patient is allowed to RMA then the EMS personnel will secure the physician's signature on the Patient Care Report upon completion of assignment, and a QA copy of the report with all relevant documents will be left in the EMS Coordinator's tray for quality assurance purposes.

1. Purpose
 - a) To guide the prehospital provider in identifying and managing the patient with acute ischemic stroke.
2. Policy
 - a) Acute Ischemic Stroke (embolic stroke) may now be treated with thrombolytics in the emergency department and like acute myocardial infarction, success is time-dependent. A 3-hour window for treatment limits the number of patients that can benefit from thrombolytic therapy and in that time period the patient must have a CAT scan and neurologic evaluation. Patients that may meet inclusion criteria should be identified in the field and transported to the hospital with the same urgency as MI or trauma patients and notification of the ED.
 - b) The following guideline applies to patients with signs or symptoms of acute ischemic (embolic) stroke that present for treatment and evaluation in less than 2 hours.
3. Procedure
 - a) Indications and contraindications
 - i) Symptoms must have clearly started within less than 2 hours. The onset of symptoms MUST be reliably identified (for instance, patients waking with stroke symptoms are excluded). Inability to define onset time is a contraindication.
 - ii) Signs and symptoms may include: hemiplegia, hemiparesis, slurred speech or dysphasia, or alterations in mental status not related to hypoglycemia, trauma, dysrhythmia or other underlying medical condition.
 - iii) The patient is between the ages of 18 and 80 years old.
 - iv) Signs of increased intracranial pressure (vomiting, headache, blurred vision) are NOT present.
 - b) Prehospital care is rendered. Transportation is not delayed.
 - i) Routine care, Cincinnati Prehospital Stroke Scale is completed, limit peripheral venipunctures.
 - ii) Administer oxygen.
 - iii) Management of concurrent medical conditions (i.e., Altered Mental Status, Respiratory Distress) is initiated if indicated.
4. When notifying the Emergency Department through C-MED, indicate what priority is required and "Attention Medical Direction – Stroke Alert" Advise the ED physician that you have a suspected acute ischemic stroke patient with no contraindication to thrombolysis, and state onset time.
5. Cincinnati Prehospital Stroke Scale
 - a) This test is used to assess a patient's facial muscles, arm movement and speech function. Abnormality in any one strongly suggests stroke.
 - b) The patient is asked to show teeth or smile
 - i) Normal – both sides of face move equally well
 - ii) Abnormal – one side of face does not move as well as the other side
 - c) The patient is asked to close both eyes and hold both arms straight out for 10 seconds
 - i) Normal – both arms move the same or both arms do not move at all
 - ii) Abnormal – one arm does not move or one arm drifts down
 - d) The patient is asked to repeat a simple phrase, such as "You can't teach an old dog new tricks"
 - i) Normal – patient uses correct words with no slurring
 - ii) Abnormal – patient slurs words, uses the wrong words or is unable to speak
 - e) EMS personnel should also try to extract as much of the patient's medical information as possible at the scene. The more information that can be relayed in advance to the hospital, the faster a diagnosis can be made and an appropriate treatment plan initiated.

Conforms to Connecticut State Trauma Regulations

The Stamford Hospital EMS Sponsor Hospital Program supports a patient's right to reasonably determine their destination facility within the parameters of state regulation and sound clinical judgment.

Trauma patients who request transportation to a hospital not designated by the Connecticut Department of Public Health as a Level I or Level II Trauma Center or is geographically farther than Stamford Hospital must be vetted through the procedure below.

1. Field Triage Protocols
 - a) The following field triage protocol shall provide criteria to categorize trauma patients and determine destination hospitals with resources appropriate to meet the patient's needs:
 - i) Assess the physiologic signs. Trauma patients with any of the following physiologic signs shall be taken to a Level I or Level II trauma facility:
 - (1) Glasgow Coma Scale of twelve (12) or less
 - (2) Systolic blood pressure of less than ninety (90) mm Hg
 - (3) Respiratory rate of less than ten (10) or more than twenty-nine (29) breaths per minute
 - b) Assess the anatomy of the injury. Trauma patients with any of the following injuries shall be taken to a Level I or Level II trauma facility:
 - i) Gunshot wound to chest, head, neck, abdomen, or groin
 - ii) Third degree burns covering more than fifteen (15) percent of the body, or significant burns of face, or airway involvement
 - iii) Spinal cord injury
 - iv) Amputation, other than digits
 - v) Two (2) or more obvious proximal long bone fractures
 - c) Assess the mechanism of injury and other factors and, if any of the following is present, determination of destination hospital shall be in accordance with OLMC:
 - i) Mechanisms of injury:
 - (1) Falls from over twenty (20) feet
 - (2) Apparent high speed impact
 - (3) Ejection of patient from vehicle
 - (4) Death of same car occupant
 - (5) Pedestrian hit by car going faster than twenty (20) mph
 - (6) Rollover or significant vehicle deformity - especially steering wheel
 - ii) Other factors:
 - (1) Less than five (5) or greater than fifty-five (55) years of age
 - (2) Known cardiac or respiratory disease
 - (3) Penetrating injury to thorax, abdomen, neck, or groin other than gunshot wounds
 - d) When transport to a Level I or II trauma facility is indicated but the ground transport time to that hospital is judged to be greater than twenty (20) minutes, determination of destination hospital shall be in accordance with OLMC.
 - e) If, despite therapy, the trauma patient's carotid or femoral pulses cannot be palpated, airway cannot be managed, or external bleeding is uncontrollable, determination of destination hospital shall be in accordance with OLMC.
 - f) When in doubt regarding determination of destination hospital, contact OLMC.
 2. All EMS providers transporting trauma patients to hospitals shall provide receiving hospitals with a completed OEMS approved patient care form prior to departing from the hospital.

STAMFORD HOSPITAL EMS SPONSOR HOSPITAL PROGRAM

ALS PROCEDURES

ANTICHOLINESTERASE ANTIDOTE ADMINISTRATION – MARK 1 KIT

1. Purpose
 - a) To provide emergency administration of antidote to EMS responders in the event of a nerve agent release.

2. Indication
 - a) Mark 1 kits are to be used when personnel are exposed to nerve agents (Sarin, Suman, Tabun, VX) and have signs and symptoms of nerve agent exposure.
 - b) SLUDGEM acronym for parasympathetic nervous system response to an organophosphate or nerve agent exposure: salivation, lacrimation, urination, defecation, gastro-intestinal aggravation, emesis, muscular twitching. Response symptoms are proportional to the degree of exposure.

Exposure	Signs & Symptoms
Mild	✓ Unexplained runny nose
	✓ Tightness in the chest
	✓ Difficulty breathing
	✓ Bronchospasm
	✓ Pinpoint pupils resulting in blurred vision
	✓ Drooling
	✓ Excessive sweating
	✓ Nausea and/or vomiting
	✓ Abdominal cramps
	✓ Involuntary urination and/or defecation
Moderate	✓ Jerking, twitching and staggering
	✓ Headache
	✓ Drowsiness
	✓ Coma
Severe	✓ Convulsions
	✓ Apnea

3. Procedure
 - a) Remove the antidote kit from the foam carrying case.
 - b) With your non-dominant hand, hold the autoinjector by the plastic clip so that the larger autoinjector is on top and both are positioned in front of you at eye level.
 - c) With your dominant hand grasp the atropine autoinjector with the thumb and first two fingers. DO NOT cover or hold the needle end with your hand, thumb, or fingers. The atropine is the shorter of the two autoinjectors and has a green needle port.
 - d) Pull the injector out of the clip with a smooth motion. Ensure that the yellow safety cap has been removed. The autoinjector is now armed.
 - e) Position the green (needle) end of the injector against the injection site (thigh or buttock). If thinly-built, inject into the upper outer quadrant of the buttock.
 - f) Apply firm, even pressure (not jabbing motion) to the injector until it pushes the needle into your thigh or buttocks. Using a jabbing motion may result in an improper injection or injury to the thigh or buttocks.
 - g) Hold the injector firmly in place for at least 10 seconds.
 - h) Carefully remove the autoinjector from the injection site.
 - i) Place the used atropine injector carefully between the little finger and the ring finger of the hand that is holding the remaining autoinjector and the clip.
 - j) Pull the 2 PAM CL injector out of the clip. Ensure that the gray safety cap has been removed.
 - k) Inject yourself in the same manner as you did with the atropine, holding the black (needle) end against your outer thigh (or buttocks). Massage the injection sites, as time permits.
 - l) After administering one set of injections, you should initiate decontamination procedures.

1. All critically ill patients should have IV access established in anticipation of future potential problems, when fluid and/or medication resuscitation may be necessary.
2. Indications For Initiating Standing Order IV Access:
 - a) Respiratory arrest
 - b) Severe respiratory distress
 - c) Unconscious
 - d) Altered mental status
 - e) Active AMI or Stroke symptoms
 - i) Perform only one attempt at venous cannulation
 - f) Signs and symptoms of shock are present, whether compensated or decompensated
 - g) Potential for shock state exists based on the MOI or nature of illness
 - i) Unless patient is entrapped, IV administration should be initiated **enroute** to the hospital with one large bore catheter.
 - ii) Unless prolonged extrication, initiation of an IV should not distract the EMT-I from completing the physical assessment and managing life-threatening conditions such as airway and breathing insufficiency.
3. Fluid Replacement Volume, KVO Rate, Or Saline Lock
 - a) If patient is hemodynamically unstable (hypotensive AND tachycardic AND lung sounds are clear to auscultation in all fields)
 - i) Normal Saline (0.9% NaCl), 250 cc IV bolus with large bore IV catheter if possible
 - (1) Reassess lung sounds and perfusion status after fluid is infused
 - (2) If no improvement, repeat 250 cc bolus
 - (3) Set infusion to KVO rate once BP is adequate or crackles (rales) or diminished lung sounds are auscultated
 - ii) Fluid resuscitation may be required for the trauma patient, in which case at least one large bore (14-18 gauge) IV catheter should be inserted.
 - b) If patient is hemodynamically stable or auscultation reveals rales or diminished lung sounds, establish a saline lock or IV at a KVO rate, 25-30 ml/Hr.
4. Standing order sites for IV administration
 - a) Forearm
 - b) Antecubital space
 - c) The back of the hand
5. SITES THAT REQUIRE OLMC CONSULTATION
 - a) INJURED AREA OR DISTAL TO AN INJURED AREA
 - b) CVA PATIENT'S AFFECTED SIDE
 - c) SAME SIDE AS MASTECTOMY
6. Sites that are contraindicated
 - a) Lower extremities
 - b) Neck veins
 - c) CVA patient's affected side
 - d) Extremities that have massive edema, burns, or injury
 - e) Areas of cellulitis
 - f) Extremities with an indwelling fistula (i.e. dialysis shunt)
 - g) Upper extremities on the same side of a mastectomy
7. CONTACT OLMC PRIOR TO INITIATING VASCULAR ACCESS FOR:
 - a) AGE < 8 Y/O
 - b) RENAL DIALYSIS PATIENT (DO NOT ACCESS SHUNT)
8. CONTACT OLMC PRIOR TO VOLUME INFUSION FOR:

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- a) CONGESTIVE HEART FAILURE OR PULMONARY EDEMA FROM ANY CAUSE
 - b) CARDIOGENIC SHOCK
 - c) PATIENTS NOT MEETING THE STANDING ORDER REQUIREMENTS FOR IV ACCESS
9. Equipment
- a) The Stamford Hospital requires the use of the CLAVE® NeedleFree Connector System. All vascular access equipment must be CLAVE® needleless items.
 - b) Approved IV Fluid
 - i) 0.9% NaCl normal saline
 - c) Drip sets
 - i) Macro drip set (10-15 gtts/cc)
 - ii) Minidrip set (60 gtts/cc)
 - d) Saline lock extension set
 - e) IV Catheters
 - i) The Stamford Hospital requires the use of a catheter-over-the-needle safety IV catheter
 - ii) Approved sizes: 16g, 18g, 20g, 22g
10. Time Considerations
- a) A KVO line is instituted early, but only AFTER standard BLS patient assessment and intervention have been performed.
 - b) The starting of a KVO line must not cause any delay in bringing the patient to the emergency department or intercepting with a paramedic unit.
11. Documentation
- a) Label IV site with the EMT-I initials, time, date, and gauge of catheter.
 - b) Have the physician in the Emergency Department sign the Ambulance Call Report.