COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

STANDING FIELD TREATMENT PROTOCOLS
(SFTP)

INITIAL TRAINING COURSE

MARCH 2014

GOALS and OBJECTIVES

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Goals

- To prepare paramedics in utilizing the SFTP portion of Reference No. 1200, in situations where they are appropriate and to recognize situations where base hospital contact is required or recommended
- To develop an understanding of how SFTPs fit within the Treatment Protocols and apply them utilizing structured scenarios

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Objectives

At the conclusion of this training program, participants will be able to:

- List two reasons for implementing SFTPs
- Identify the prerequisites for a paramedic to work under SFTPs
- State the minimum information that is necessary in giving an SFTP report to a receiving hospital or specialty center
- Identify the proper methods to resolve issues / concerns with a base hospital or receiving facility
- Identify appropriate interventions and order of treatment for each protocol
- Identify situations where base hospital contact is required when SFTPs are utilized
- Verbalize understanding of the parameters for determination of perfusion
- Verbalize understanding of protocol application using structured scenarios and group discussion

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INTRODUCTION

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What Are SFTPs?

- SFTPs are located within the Los Angeles County Prehospital Care Manual, Section 1200
- There are sixteen (16) specifically selected Treatment Protocols that can be utilized as SFTPs
- SFTPs are based on patient's signs/symptoms and chief complaint
- SFTPs provides the paramedic a way to expedite and improve field care without having to make base contact
- SFTPs are to be followed in sequence until "Establish Base Contact (All)" is reached

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SFTP Advantages

- Expedites patient care by allowing approved providers to move quickly through the Treatment Protocols
- Eliminates multiple treatment guidelines with conflicting instructions
- Increases patient care focus by reducing time spent on hospital communications
- Increases paramedic autonomy AND accountability

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UTILIZING SFTPs

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Who Uses SFTPs Now?

Los Angeles Fire Department	Apr	1997
Culver City Fire Department	Jan	1998
Burbank Fire Department	Oct	1998
Long Beach Fire Department	Apr	1999
Alhambra Fire Department	Apr	1999
San Marino Fire Department	Jun	1999
West Covina Fire Department	Feb	2000
Los Angeles County Sheriff's Dept.	May	2005
Santa Monica Fire Department	Jan	2007
Downey Fire Department	Aug	2008
Torrance Fire Department	Nov	2008
Santa Fe Springs Fire Dept.	Jan	2009
La Verne Fire Department	Feb	2011
Monterey Park Fire Department	Mar	2012

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UTILIZING

STANDING FIELD TREATMENT PROTOCOLS

SFTPs ARE UTILIZED BY PARAMEDICS WHO ARE EMPLOYED BY A PARAMEDIC PROVIDER AGENCY WHICH HAVE BEEN APPROVED AS AN SFTP PROVIDER

PARAMEDICS WHO UTILIZE THESE PROTOCOLS WITHOUT AUTHORIZATION ARE CONSIDERED TO BE FUNCTIONING OUTSIDE OF THE

PARAMEDIC SCOPE OF PRACTICE

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Requirements To Be An SFTP Paramedic

- Paramedic must be employed by a paramedic provider agency that have been approved as an SFTP provider
- At least one of the paramedics assigned to the ALS unit will have a minimum of one (1) year ALS experience as a paramedic
- Both paramedics must be accredited in LA County
- Each paramedic must have completed the standardized SFTP orientation/training
- Only LA County approved SFTPs can be utilized

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Paramedic Responsibilities

- Each SFTP Patient Requires:
  - ✓ Complete assessment and thorough documentation
  - ✓ Accurate documentation - there is no audio-recording
  - ✓ Follow each protocol step-by-step
  - ✓ Know each protocol contents
  - ✓ Know when to make base contact

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When SFTPs CANNOT Be Utilized

- If the unit is operating under a staffing exception (one paramedic), the SFTP portion of Treatment Protocols cannot be used
- Two SFTP-trained paramedics from **different** provider agencies, is not considered an SFTP team and may not utilize the SFTP component of the Treatment Protocols

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List of SFTPs

Medical

- 1202 General ALS
- 1210 Non-Traumatic Cardiac Arrest
- 1243 Altered Level of Consciousness
- 1244 Chest Pain
- 1247 Overdose/ Poisoning
- 1248 Pain Management
- 1249 Respiratory Distress
- 1250 Seizure (Adult)
- 1251 Stroke/Acute Neurological Deficits

Medical/Peds/Trauma

- 1252 Syncope
- 1261 Emergency Childbirth (Mother)
- 1262 Emergency Childbirth (Newborn/Neonatal Resuscitation)
- 1264 Pediatric Seizure
- 1271 Burns
- 1275 General Trauma
- 1277 Traumatic Arrest

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NOT Covered Under SFTPs

- All symptomatic dysrhythmias
- Poor perfusion (excluding Trauma)
- Environmental situations
- Agitated Dilirium
- Allergic Reactions
- Crush Syndrome
- Dystonic Reaction
- Non-Traumatic Hypotension
- Pediatric Arrest
- Pediatric symptomatic bradycardia / trachycardia

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Medications NOT Covered Under SFTPs

- Benadryl
- Adenosine
- Calcium Chloride
- Atropine
- Fluid Challenge (except under cardiac arrest and trauma protocols)

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When To Make Base Hospital Contact

- Establish Base Hospital contact when:
  - Indicated by the protocol
  - Additional or unlisted treatments are required
  - Signs/Symptoms not clearly addressed in protocol
  - Patient initially presented with or develops poor perfusion **(except medical CA, BU and Trauma)**
  - Consultation with the base hospital would be helpful
  - Specialty Centers patients
    - SFTP provider is to contact the receiving facility
    - If receiving facility is not a base station, then the base station is to be notified either prior to or after the call is complete
    - Purpose: enters patient into database

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Base Hospital Requesting Full Report

- Provide additional information as requested
- If interpersonal issues arise, address them with the individual, the PCC and/or the paramedic coordinator at the conclusion of the run, not during

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Paramedic Wanting Second Opinion

- If paramedics is uncomfortable for any reason or has questions about an aspect of patient care, establish base contact at any point in the Treatment Protocol
- All treatments rendered prior to contact should be reported to the base hospital

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Requesting Hospital Diversion Status

- Each provider agency has a department-specific plan for identifying hospitals on diversion
- Current mechanisms:
  - Agreement with base hospital
  - Agreement with receiving hospital
  - ReddiNet in dispatch
  - ReddiNet in each ALS Unit

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Hospital Notification

- Each provider agency has a department-specific plan on the mechanism in which the provider is to notify the receiving hospital
- All protocol patients are to have the predetermined minimal information reported to the receiving hospitals, plus additional information for patients requiring specialty centers.

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Hospital Notification

ALL PATIENTS

- Provider Code/Unit #
- Sequence Number
- Location (if 9-1-1 transfer)
- Chief Complaint
- Age & Units / Gender
- Level of Distress
- Name of Protocol (number optional)
- Glasgow Coma Scale (GCS), if altered
- Airway adjuncts utilized, if applicable
- Destination/ETA

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Hospital Notification

Additional information required if:

- **Trauma Complaint**
- **Pediatric Patients**
- **STEMI Patients**
- **If mLAPPS performed**

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Hospital Notification

Trauma Patients, add the following information:

- MOI
- Complete vital signs and GCS
- Location of Injuries
- Pertinent information
  - Flail segment, rigid abdomen, evisceration, etc

Pediatric Patients, add the following information:

- Pediatric Weight (in kg) and Color Code

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Hospital Notification

STEMI Patients, add the following information:

- 12-Lead ECG rhythm/interpretation (include quality)

If mLAPSS Performed, add the following information:

- If positive/met
- Last known well date and time
- Blood Glucose

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Using Trauma Center Protocol

- Patients meeting Trauma Criteria **must** be transported to the Trauma Center
- Patients meeting Trauma Guidelines and/or Special Considerations – transporting patient to Trauma Center is advisable
- Extremis Patients – goes to MAR ("obstructed airway")
- In most cases, paramedics will contact the trauma center directly

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Against Medical Advice

- If patient meets Reference No. 808 (Section I):

  Base Contact is Required
- Base Contact Recommended: Any time medication is given and patient wants to leave AMA
- Documentation MUST be complete (high risk incidents)

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Transferring Patient Care

Reminder: SFTPs may be utilized only if:

- Two SFTP-trained paramedics are with the patient
- Both SFTP-trained paramedics are from the same provider agency
- Both SFTP-trained paramedics accompany that patient to the hospital

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SCENARIOS

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Transferring Patient Care

Scenario One:

- **SFTP team members treat and transport the patient**
  - SFTP team transports with the patient
  - **Base Contact** - not required

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Transferring Patient Care

Scenario Two:

- **SFTP team members treat patient on scene, one of the SFTP medics accompany patient to hospital**
  - SFTP medic stays with patient and continues with same protocol
  - **Base Contact** - not required, unless...
    - Further orders are needed or patient's condition deteriorates

Rationale: In order to utilize an SFTP, there must be two SFTP trained medics at the patient's side

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Transferring Patient Care

Scenario Three:

- **SFTP team members treat patient on scene, releases patient to non-SFTP paramedic unit**
  - SFTP medic must establish **Base Contact** before releasing patient to non-SFTP (ALS) provider
  - If patient needs further treatment by non-SFTP (ALS) provider, **Base Contact** – REQUIRED

Rationale: If both SFTP medics do not accompany the patient to the hospital, they are essentially working under Ref. 806, requiring base contact once treatment has been initiated

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Transferring Patient Care

Scenario Four:

- **SFTP team members treat patient on scene, patient downgraded and released to BLS unit**
  - **Base Contact** – REQUUIRED by the SFTP paramedic before releasing patient to BLS unit

Rationale: Once SFTP is started, SFTP team member must accompany the patient to hospital

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Transferring Patient Care

Scenario Five:

- **Non-SFTP (ALS) provider treats patient on scene (Ref. No. 806) and releases patient to SFTP provider**
  - Base Contact – REQUIRED by the first, non-SFTP provider, prior to releasing patient to the SFTP provider
  - If further treatment is required by the second ALS team, Base Contact - REQUIRED. SFTPs cannot be utilized.

Rationale: Once patient has received treatment from a non-SFTP provider, that patient may not receive SFTP treatment.

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Paramedic Interns

- Paramedic Interns may utilize SFTP, however:
  - Must be informed that SFTPs are only utilized by SFTP provider agencies
  - Not allowed to utilize SFTP outside their internship unless they receive the approved SFTP training course
  - Interns are not to be evaluated on their knowledge of SFTPs
  - Allow paramedic interns to perform radio communication skills

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GENERAL INSTRUCTIONS FOR TREATMENT PROTOCOLS

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General Instructions

- Los Angeles County Treatment Protocols *(Section 1200)*
- SFTPs must be followed in the order it is written
- Treatment Protocols are aligned with Reference No. 806.1
- Up to two protocols may be used during each patient contact; treatment beyond two protocols requires Base Contact
- Not all Treatment Protocols are utilized as SFTP. The non-SFTP patients required Base Contact. (ie, symptomatic arrythmias, allergic reactions, non-traumatic hypotension, etc.)
- Non-SFTP providers must establish **Base Contact** at the first point it is indicated in the Treatment Protocol

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General Instructions

- SFTP portion of Treatment Protocols can only be utilized by approved SFTP provider agencies.
- Approved SFTP providers may continue the steps of the protocol until "**Base Contact All**" is reached.
- Continue to reassess the patient after each medication and/or treatment and throughout the call

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Pulse Oximetry

- Required on ALL Patients
- Pulse Oximetry determines if O_2 is needed
- SpO_2 Goals:
  - COPD: 88-92%
  - Carbon Monoxide Poisoning: 100%
  - Traumatic Brain Injury: 100%

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Oxygen Therapy

- Oxygen - Treat as any other drug
- Administer O_2 only during signs &/or symptoms of hypoxia
- Hypoxia S&S include:
  - Pulse Oximetry less than 94%, in patients with:
    - Respiratory distress or,
    - ALOC or,
    - Changes in skin signs
- Newborn if positive-pressure is needed:
  - Ventilate 90 seconds with ROOM AIR
  - If heart rate less that 100 –> O_2 15 L

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Oxygen Therapy

- Stable Patient w/ Mild Hypoxia (below 94%)
  - Oxygen: 2-6 L (NC) or 8-10 L (Mask)
- Critical Patient (impending arrest)
  - Oxygen: 15 L (Mask, BVM, ET, King, CPAP)

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Capnography

- Required on all BVM and advanced airway patients
- Monitor and Record Waveform Capnography:
  - Every 5 minutes
  - After any patient movement
  - Upon transfer of care
  - Change in patient condition

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Determination of Perfusion

Perfusion status = combination of parameters

(Blood pressure, heart rate, tissue color and mentation)

- **Perfusion:** adequate circulation of blood through organs and tissues, manifested by normal blood pressure, pulse, tissue color, and level of consciousness
- **Poor Perfusion:** inadequate circulation of blood through organs and tissues, manifested by abnormal blood pressure, pulse, tissue color, and level of consciousness. May also include chest pain and shortness of breath
- Initiate **Base Contact** on poorly perfused patients or if perfusion status is borderline

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Fentanyl

- Provider must have EMS Agency approval prior to utilization
- Fentanyl and Morphine are not to be on ALS unit at the same time

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Fentanyl

Classification: Opioid Analgesic
Indication: Moderate – Severe pain
Routes: IV/IO, IN, IM
Side Effects: NV, Drowsiness
Contricted Pupils
Dizziness

Respiratory Depression
Sedation
Bradycardia
Hypotension
Contraindications:
Known hypersensitivity
Respiratory Depression
Hypotension (BP < 90)

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Fentanyl

Dosage: Adult: IV/IO
50-100 mcg slow
May repeat every 5 minutes
Adult: IM/IN
50-100 mcg IM/IN one time
Maximum adult dose - 200 mcg

Pediatric: IV/IO
1 mcg/kg slow over 2 minutes
May repeat every 5 minutes
Pediatric: IM one time
1 mcg/kg
Pediatric: IN one time
1.5 mcg/kg
Maximum peds dose - 50 mcg

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SFTPs
The Protocols

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Reference No. 2202
General ALS

Patients with vague complaints, provide:
- Basic Airway
- Pulse Oximetry

- PRN: Spinal Immobilization / control bleeding
- PRN: Oxygen, Advance Airway
- PRN: Cardiac monitor, Venous access, Blood Glucose
- **Dextrose & Zofran** - *(if indicated)*
- **Base Contact** as directed in the protocol

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Reference No. 1210

Non-Traumatic Cardiac Arrest

- Basic Airway
- Unwitnessed by EMS:
  - 2 minute CPR (100/min prior to defibrillation)
- Cardiac Monitor
  - Asystole: confirm in more than one lead
  - PEA: consider causes
  - V-fib/Pulseless V-tach: defibrillate
- Venous Access (IV or IO)
- **Epinephrine**
- Advanced Airway and capnography

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Reference No. 1210

Non-Traumatic Cardiac Arrest *(continued)*

- If rhythm change:
  - Pulse Check (less than 10 seconds)
  - If no pulse, immediately resume chest compressions
- Provide 2 minutes of CPR between interventions
- If resuscitative efforts are successful (ROSC):
  - 12-lead ECG
  - Transport to SRC
- If resuscitative efforts are unsuccessful
  - Consider pronouncement
  - Base Contact

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Reference No. 1243

Altered Level of Consciousness

- Basic Airway
- Pulse Oximetry
- IV Access
- Blood Glucose (less than 60 -> give **Dextrose**)

- PRN:
  - Spinal Immobilization
  - Oxygen / Advanced Airway
  - Cardiac Monitor
- Use the appropriate protocol, if assessment indicates:
  - 1247, Overdose/Poisoning (***Narcan***)
  - 1250, Seizure (Adult) (***Midazolam***)
  - 1251, Stroke/Acute neurological deficit

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Reference No. 1244

Chest Pain

- ALL Chest Pains:
  - Basic Airway
  - Pulse Oximetry (Oxygen prn)
  - Cardiac Monitor
- Suspected Cardiac Origin
  - 12 Lead ECG
    - NTG x3 / ASA 162mg / MS 2-12mg (Fentanyl 50-100mcg)
  - If CP continues after max MS (20mg) or **Fentanyl** (200mcg), **Base Contact** required
  - **Ondansetron** prior to MS/Fentanyl

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Reference No. 1244

Chest Pain

- BASE CONTACT REQUIRED
  - Poor Perfusion (Give ASA and then make Base Contact)
  - Medication orders if patient with chest pain is 30 years of age or younger

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Reference No. 1247

Overdose/Poisoning

- Basic Airway
- Pulse Oximetry

- PRN: Oxygen, Venous Access, Advanced Airway
- PRN: Cardiac Monitor
- PRN: Blood glucose (less than 60 -> give **Dextrose**)

- Consider **Narcan** (prior to advanced airway)
- **Base Contact** if drugs for specific history are needed

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Reference No. 1248

Pain Management

- Basic Airway
- Pulse Oximetry

- PRN: Oxygen, Venous Access, Spinal Immobilization
- PRN: Cardiac monitor
- **PRN: Morphine / Fentanyl** *(consider Ondansetron)*

- Document non-invasive pain management techniques
- Refer to the following Treatment Protocols, if applicable:
  - ✓ Burn injury (1271) Chest pain (1244)
  - ✓ Child Birth (1261)

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Reference No. 1249

Respiratory Distress

- Basic Airway
- Pulse Oximetry
- Cardiac Monitor

- PRN: Oxygen, IV Access

- Consider CPAP for patients with moderate-severe respiratory distress who are:
  - Greater than 14 years of age
  - Awake, Cooperative and able to follow commands
  - SBP equal to or greater than 90mmHg

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Reference No. 1249

Respiratory Distress *(continued)*

- Treatment Protocol is divided into four columns:
  - ➢ Stridor
  - ➢ Wheezing
  - ➢ Basilar rales, cardiac etiology
  - ➢ Poor perfusion

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Reference No. 1249

Respiratory Distress *(continued)*

- STRIDOR:
  - Follow Steps 1-9
  - If Severe Respiratory Distress & Croup:
    - **Epinephrine*** (1:1000) via HHN
    - Hold - if HR greater than 200
    - Dose is based on age: See chart
  - SFTP providers may continue the treatment steps to the end of the Stridor column

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Reference No. 1249

Respiratory Distress *(continued)*

***Inhalation Epinephrine**

- Epinephrine 1:1000 (1mg/mL)
- Indications: Severe respiratory distress with Croup (What is Croup?)
- Age greater than 1 year:
  - 5 mg diluted in 5 mL NS
- Age less than 1 year:
  - 2.5 mg diluted in 5 mL NS
- Hand-held Nebulizer
- Total Dose: 5 mg
- Hold if HR greater than 200 bpm
- Use filtered needle to withdraw medication

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Reference No. 1249

Respiratory Distress *(continued)*

- WHEEZING
  - Follow Step 1-9
  - If suspecting allergic reaction – begin Albuteral and make base contact
  - **Albuterol 5mg**
    - Hand held nebulizer or hand held mask
    - Consider cardiovascular effects
    - Reevaluate lung sounds frequently
- If patient ***deteriorates*** after 1st Albuterol
  Epinephrine (1:1000) 0.3mg IM

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Reference No. 1249

Respiratory Distress *(continued)*

- BASILAR RALES *(Cardiac Etiology)*
  - Follow Steps 1-9
  - *Nitroglycerin SL
    - Dose is BP dependent
  - Consider non-cardiac causes for rales
    - pneumonia is the most common
  - If Wheezing – is it pulmonary edema? Allergic Rx?
    - **Albuteral 5mg HHN**
    - ✓ Breath sounds frequently
  - Monitor cardiovascular status carefully!
  - **Base Contact ?**

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Reference No. 1249

Respiratory Distress *(continued)*

*Nitroglycerin

- Aggressive NTG therapy is utilized to reduce preload and afterload
- Hold if:
  - SBP less than 100 or
  - if patient takes sexually enhancing drugs (SED)
- If hypotension develops – place patient supine / prepare to assist ventilations and make **Base Contact**

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Reference No. 1249

Respiratory Distress *(continued)*

- POOR PERFUSION

Base Contact ALL

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Reference No. 1250

Seizure (Adult)

- Basic Airway
- Pulse Oximetry

- PRN
  - Spinal Immobilization
  - Oxygen, Cardiac Monitor, Venous Access, Advanced Airway
  - ✓ Blood glucose (if less than 60 -> **Dextrose / Glucagon**)
- Active Seizure
  - **Midazolam**

When would you make **Base Contact**?

When would a Trauma Center be considered?

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Reference No. 1251

Stroke/Acute Neurological Deficits

- Basic Airway
- Pulse Oximetry
- Cardiac Monitor
- Blood glucose check
- mLAPSS / Last known well date & time

- PRN: Spinal Immobilization
- PRN: Oxygen, Advanced Airway, IV Access

- If shock, refer to Ref. No. 1246, Non-traumatic Hypotension Treatment Protocol

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Reference No. 1252

Syncope

- Basic Airway
- Pulse Oximetry
- Cardiac Monitor
- ✓ Blood glucose (if less than 60 -> **Dextrose / Glucagon**)

- PRN: Spinal Immobilization
- PRN: Oxygen, Advanced Airway, Venous Access

- Approved SFTP providers may repeat **Dextrose** if needed
- If shock, refer to Ref. No. 1246, Non-traumatic Hypotension Treatment Protocol (Requires Base Contact)

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Reference No. 1261

Emergency Childbirth - Mother

- Basic Airway
- Pulse Oximetry

- PRN: Oxygen, Advanced Airway, IV Access
- Immediate **Base Contact** if:
  - abnormal presentation
  - multiple gestation
  - maternal hypotension

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Reference No. 1261

Emergency Childbirth - Mother

- If suspected eclampsia, DO NOT delay transport for treatment
- If delivery occurs in the field, transport mother and newborn to a Perinatal Center with an EDAP designation (Reference No. 511, Perinatal Patient Destination)

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Reference No. 1262

Newborn/Neonatal Resuscitation

- Assist deliver – check cord
- If amniotic sac in tact – break membrane by pinch/twist
- Basic Airway
  - Suction mouth then nostrils only if thick meconium
- Clamp / cut cord
- Stimulate & Dry newborn
- Wrap in dry/warm blanket
- Oxygen - Assist Respirations w/BVM (squeeze-release-release)
- Reassess every 30 seconds
- Check pulse

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Reference No. 1262

Newborn/Neonatal Resuscitation

(continued)

- **If Pulse Greater than 100:**
  - If poor respiratory rate/effort or central cyanosis =
    - BVM x90 seconds (Room Air)
      - Squeeze-release-release
  - Check pulse every 30 seconds: If pulse is less than 100 at 90sec, start BVM with 15L oxygen
  - BASE CONTACT
- **If Pulse 60 - 100**
  - BVM x90 seconds (Room Air)
    - Squeeze-release-release
  - Check pulse every 30 seconds: If pulse is less than 100 at 90sec, start BVM with 15L oxygen
  - BASE CONTACT

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Reference No. 1262

Newborn/Neonatal Resuscitation *(continued)*

- **If Pulse Less than 60:**
  - BVM
  - If pulse remains under 60 bpm
    - Chest compressions (120/min at 3:1 ratio)
  - If pulse greater than 60 bpm
    - Discontinue compressions, but continue BVM

If Pulse remains under 100:

ESTABLISH BASE CONTACT (ALL)

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Reference No. 1264

Seizure (Pediatric)

- Basic Airway
- Pulse Oximetry

- PRN: Spinal Immobilization
- PRN: Oxygen, Assist respirations, Advanced Airway
- PRN: Cardiac Monitor, IV Access
- PRN:✓ Blood Glucose (if no fever)
- If active seizure:
  - **Midazolam** 0.1 mg/kg slow IVP, IM, IN
  - **Refer to Color Code Charts for medication dosage**
  - If child is taller than BROSLOW and is adult size, move to the Adult Protocol and Adult dosing

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Reference No. 1264

Seizure (Pediatric) *(continued)*

- Narcan administration
  - If hypoventilation and strong suspicion of narcotic overdose
  - Slow IV, IM or IN (0.1mg/kg)

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Reference No. 1271

Burns

- Basic Airway
- Pulse Oximetry
- PRN: Spinal Immobilization
- Oxygen, Advanced Airway
  - Essential with known or potential respiratory injury
  - If evidence of inhalation injury, facial burn, singed nasal hair or soot in the oropharynx, be aware of the potential for rapid respiratory deterioration.
- Use appropriate column *(Thermal, Chemical or Electrical)*

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Reference No. 1271

Burns

- Transport to Trauma Center/PTC, if patient meets criteria or guidelines
- If patient does not meet TC/PTC criteria, transport to closest MAR appropriate to age

- **Fluid Challenge:** *(prn)* (Base Contact not required)
  - **Adult:** 10mL/kg **Peds:** 20mL/kg
- **Morphine** **Adult:** 2-12mg Slow IV **Peds:** 0.1mg/kg IV
- **Fentanyl** **Adult:** 50-100mcg Slow IV/IM/IN
  Peds: 1mcg/kg Slow IV/IM/IN

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Reference No. 1275

General Trauma

- Basic Airway
- Pulse Oximetry
- Bleeding Control
- Venous Access (enroute)

- PRN: Spinal Immobilization
- PRN: Oxygen, Advanced Airway, Cardiac monitor
- DO NOT DELAY TRANSPORTING patients with Penetrating torso trauma with hypotension in order to apply spinal immobilization
- All treatment should occur enroute!
  - **Morphine / Fentanyl**
  - Fluid Challenge

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Reference No. 1275

General Trauma *(continued)*

- Trauma Center notification must be established for all patients who meet Trauma Criteria and/or Guidelines.
- If patient meeting Trauma Criteria has sustained minor injuries, **Base Contact** must be made with full report in order to consider diverting from a Trauma Center.
- Determine diversion status of receiving hospital or trauma center to make early notification
- If patient is ALOC, consider other medical protocols (ALOC - 1243 and OD - 1247)

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Reference No. 1277

Traumatic Arrest

- **Consider Ref. No. 814, Determination/ Pronouncement of Death in the Field**
- Rapid Transport – Do not delay for treatment
- Basic Airway
- CPR
- Cardiac Monitor
  - Defibrillate – If V-fib or Pulseless V-Tach

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Reference No. 1277

Traumatic Arrest

- PRN: Spinal Immobilization
- PRN: Control Bleeding
- PRN: Advanced Airway - If unable to maintain basic airway
- NO MEDICATIONS
- Needle Thoracostomy - If chest trauma and difficult ventilation and/or diminished breath sounds
- Venous Access en route - Consider immediate placement of IO if any difficulty or delay in IV access
- Fluid Resuscitation

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GENERAL REVIEW

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Utilizing SFTPs

- Both paramedic must be employed by an SFTP provider
- Both Paramedics must have received the initial SFTP training in Los Angeles County SFTPs
- At least one member of the paramedic team must have a minimum of one year experience working as a paramedic
- Only the paramedics who have received the initial SFTP training (and subsequent updates) are to utilize SFTPs
- Paramedics can only utilize SFTPs that are approved and authorized by the EMS Agency Medical Director

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Things to Remember

- Utilize Reference No. 806.1, Procedures Prior to Base Contact, when appropriate
- Do the basics: Airway, Pulse Ox, Reassessment
- Oxygen, when indicated
- Assess perfusion status (Base Contact if poor perfusion)
- Combine protocols if the patient's condition warrants
- Document thoroughly
- Establish saline locks, when appropriate
- Transport when/where appropriate

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Documentation

- "B. Contact" box
  - If utilizing SFTP protocol, insert "PRO"
  - If base contact was established for medical control, insert the three-letter hospital designator
- "Protocol" box
  - Enter the four-digit treatment protocol number/s (ie., 1244)
- "B. Ntfd" box
  - Enter the 3-letter base hospital designator when a base hospital is contacted for a destination decision or notification of patient in route. (No medical control is provided)

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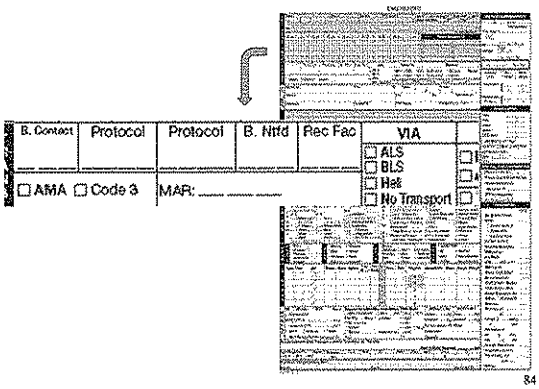

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SFTP Quality Improvement

- Part of the Departmental QI Plan
- Provider Agency reviews 100% of SFTP calls
- Outcome data from Base and Receiving hospitals
- Quarterly reports given to the EMS Agency
- EMS Agency review

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Issue Resolution

- Discuss with involved individuals *after* Base Contact has concluded
- Discuss with PCC and Paramedic Coordinator
- Submit an EMS Agency Situation Report, if unable to resolve

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OPEN DISCUSSION

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The End

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