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PROTOCOL DESIGN AND DIRECTIONS FOR USE (Revised 12/7/2012)

Individual Protocols are divided based on the level of the out-of-hospital emergency care provider (OOHECP) licensure. Start at the top of each page and proceed as far down the page as your individual licensed level and special PMD approvals allow.

Each OOHECP is expected to know his/her own scope of practice and if applicable special Physician Medical Director (PMD) authorized additional skills.

ALL LEVELS
- Items that apply to ALL LEVELS
- Generally this refers to the Routine Assessment and Care Protocol

EMR
- EMR without additional PMD approval stop at this section
- Other levels consider these items and continue

EMR Options if Approved
- EMR with additional PMD approval stop at this section
  - Reminder the PMD may NOT have authorized every Optional Skill/Treatment
  - Other Levels consider these items and continue

EMT
- EMT without additional PMD approval Stop at this section
  - Reminder the PMD may NOT have authorized every Optional Skill/Treatment
  - Other Levels consider these items and continue

EMT Options if Approved
- EMT with additional PMD approval stop at this section
  - Reminder the PMD may NOT have authorized every Optional Skill/Treatment
  - Other Levels consider these items and continue

AEMT
- AEMT stop at this section
- Other levels consider these items and continue

EMT-I
- EMT-I stop at this section
- Other levels consider these items and continue

Paramedic
- Paramedic continue through all considerations including these items

Use of Multiple Protocols May Be Required:
- The OOHECP may have to use several protocols to meet the needs of the patient.

ACKNOWLEDGEMENTS (Revised 12/7/2012)

The Nebraska Board of Emergency Medical Services acknowledges the dedication and extends our gratitude to the hundreds of out-of-hospital emergency care professionals for their service to the citizens of the Great State of Nebraska.

Furthermore, the Board extends our appreciation to the Physician Medical Directors who provide the leadership necessary for effective and efficient care of the out-of-hospital patient throughout our Great State.
Nebraska EMS Model Protocols

Preface

PURPOSE (Revised 12/7/2012)
The purpose of these protocols is to assure safe and effective intervention during the out-of-hospital phase of patient care. In consideration of the unique resources, needs, population, and geography of EMS in Nebraska, individual medical directors may choose to enhance or omit portions of these protocols in accordance with current medical practice and standards. Medical directors are responsible to ensure the EMS personnel using these protocols have the training and skills required, and perform quality assurance activities to assure these protocols are used appropriately.

SCOPE OF PROTOCOLS (Revised 12/7/2012)
These protocols are applicable to Nebraska Licensed Emergency Medical Services functioning with Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Emergency Medical Technician-Intermediates (EMT-I), Advanced Emergency Medical Technician (AEMT), and Paramedics.

PHYSICIAN MEDICAL DIRECTOR APPROVAL AND AUTHORITY (Revised 12/7/2012)
For these protocols to be valid they must be approved by service’s Physician Medical Director (PMD). Certain special skills as listed in these protocols require additional authorization. The Physician Medical Director Authorization document lists the approved protocols, additional skills, and other PMD approved documents which must be signed by the PMD.

The Physician Medical Director retains authority over the medical aspects of the EMS Service and the OOHECP.

AUTHORIZATION TO FUNCTION AS AN OUT-OF-HOSPITAL CARE PROVIDER (Revised 12/7/2012)
To function as an OOHECP under these protocols an individual must;

- Be a member or employee of a Nebraska Licensed Emergency Medical Service; and
- Have a valid Nebraska EMR, EMT, AEMT, EMT-I, Paramedic, Practical Nurse, Registered Nurse, Physician’s Assistant, or Physician license; and
- Have the Authorization of the Physician Medical Director (PMD)

The PMD must authorize the additional skills for the individual OOHECP and the Service (See the Physician Medical Director Authorization document).

ADVANCED LEVEL PROVIDERS FUNCTIONING WITH A BASIC LIFE SUPPORT SERVICE (Revised 12/7/2012)
The licensed AEMT, EMT-I, or Paramedic when functioning as a member or employee of a licensed Basic Life Support Service may only perform the skills and treatments listed within these protocols and listed in the Practices and Procedures section of Title 172 NAC 11 for the Emergency Medical Technician.

Practical and Registered Nurses when functioning as a member or employee of a licensed Basic Life Support Service may only perform the skills and treatments listed under the EMR and EMT sections within these protocols and listed in the Practices and Procedures section of Title 172 NAC 11 for the Emergency Medical Technician. Exception nurses functioning under patient specific orders may, during a hospital to hospital transfer, function within the scope of practice of their nursing license.

Mid-level practitioners and Physician members of a licensed Basic Life Support Service may function within the scope of practice of his/her license with PMD Approval.

The Additional skills for the Emergency Medical Technician as listed in Title 172 NAC 11 may be performed by the advance level providers ONLY when these additional skills and the individual provider has prior Physician Medical Director approval.

RESPONSIBILITY OF THE LICENSED EMERGENCY MEDICAL SERVICE (Revised 12/7/2012)
The EMS service is responsible to have certain PMD approved documents and review these documents with its employees/members. The EMS service may not knowingly allow for unauthorized practice and/or authorize practices
and procedures which require PMD approval. The licensed EMS services are expected to comply with Nebraska Rules and Regulations.

RESPONSIBILITY OF THE LICENSED OUT OF HOSPITAL EMERGENCY CARE PROVIDERS AND OTHER LICENSED PROFESSIONALS (Revised 12/7/2012)
The individual licensed OOHECP or other licensed healthcare professionals fulfilling the role of the OOHECP are responsible to maintain knowledge of these protocols and to function within them. Further the OOHECP may not exceed his/her Practice and Procedures as authorized by the EMS Services PMD and the Nebraska Rules and Regulations.

PROFESSIONALISM AND ETHICS (Revised 12/7/2012)
Regardless whether the OOHECP is paid or volunteers his/her time, the practice of emergency care is a profession. Our patients have a reasonable expectation to have these services provided in an ethical and professional manner. The guiding document of professionalism and ethics for the OOHECP of ALL LEVELS is the EMT Code of Ethics as approved by the National Association of EMTs.

MANDATORY REPORTING REQUIREMENTS (Revised 12/7/2012)
The OOHECP and the Service are expected to comply with mandatory reporting of misdemeanor and felony convictions, limits on practice, disciplinary actions and unprofessional conduct. The full text of the Mandatory Reporting requirement is located in Title 172 NAC 5 – MANDATORY REPORTING BY HEALTH CARE PROFESSIONALS, FACILITIES, PEER REVIEW ORGANIZATIONS, PROFESSIONAL ASSOCIATIONS, and INSURERS. A Summary Table of Mandatory Reporting requirements and the full text of title 172 NAC 5 are available at the Nebraska Health and Human Services Web Site

CONFIDENTIALITY (Revised 12/7/2012)
The patient has a reasonable expectation that his/her patient information will be kept in confidence. The OOHECP is expected to comply with the EMS Practice Act and the Rules and Regulations.

Excerpt from the Nebraska Emergency Medical Services Practice Act

38-1225. Patient data; confidentiality; immunity. (1) No patient data received or recorded by an emergency medical service or an out-of-hospital emergency care provider shall be divulged, made public, or released by an emergency medical service or an out-of-hospital emergency care provider, except that patient data may be released for purposes of treatment, payment, and other health care operations as defined and permitted under the federal Health Insurance Portability and Accountability Act of 1996, as such act existed on January 1, 2007, or as otherwise permitted by law. Such data shall be provided to the department for public health purposes pursuant to rules and regulations of the department. For purposes of this section, patient data means any data received or recorded as part of the records maintenance requirements of the Emergency Medical Services Practice Act

PROTOCOL ACCESS (Revised 12/7/2012)
Each EMS service will make available a copy of these protocols at the service’s base of operations AND a copy in the response unit.

The protocols will be either hard paper copy or an electronic/digital copy.
Universal Precautions Standard
In many calls the OOHECP will not have sufficient information about the patient and therefore is to follow a universal precautions standard with the use of body substance isolation (BSI) for all patient contact in which exposure to blood and/or body fluids may occur. For situations where an airborne pathogen (disease) is suspected the OOHECP should employ a N95 mask or higher form of respiratory protection.

Infection Control PPE
Personal Protective Equipment (PPE) items used to provide protection for the OOHECP should be readily available.

Hand Washing
After patient contact even if BSI was used each out-of-hospital care provider should thoroughly wash his/her hands. In the absence of soap and water an alcohol based gel or foam hand sanitizer should be used.

Service Infection Control Plan
The services PMD Approved Infection Control/Sanitation Plan should be consulted for further guidance on infection control.

SAFETY (Revised 12/7/2012)

Vehicle Operations
The Emergency Vehicle Operator is to operate the emergency vehicle with Due Regard for The Safety of Others in all driving situations. Not every call for EMS nor does every patient require the use of lights and/or sirens during response and/or transport.

Safety and Scene Size Up
Every call should be assessed for potential safety hazards beginning from the moment the call is received and continually assessed until the end of the call.

Each responder should take actions that minimize his/her risks of injury. Utilization of personal protective equipment such as reflective vests, specialized rescue apparel, flotation devices and other equipment should be considered based on the incident type and the potential hazards.

When confronted with a hazardous and/or violent scene, the OOHECP should avoid entry into the scene and call for the appropriate resources.

INCIDENT COMMAND AND PRIMARY CARE PROVIDER (Revised 12/7/2012)
For each incident the service is expected to activate an Incident Command System (ICS) that is compliant with the National Incident Management System (NIMS).

For each patient encounter a Primary Care Provider will be indicated on the Patient Care Report (PCR)

COMMUNICATIONS AND DOCUMENTATION (Revised 12/7/2012)
To allow for regional or local variations, the provider may follow a locally established two-way electronic communications policy/procedure. General guidelines for radio communication include:

- Avoid the use of 10 codes or other codes
- Contact the dispatch agency and advise
  The call was received
  When at the incident location
  When at the Hospital (if applicable)

- Contact the destination hospital and advise
  Patient’s age and gender
  History of the situation – Mechanism of Injury
  Treatments provided
  ETA to destination Hospital

- The response unit is in route
- When leaving the incident
- When Unit/responders back in service

- Patient’s chief complaint
- Level of consciousness and vital signs
- Special Teams Requests (i.e. Trauma Team)
General Guidelines for Face to Face Patient Report
To allow for regional or local variations, and needs, the provider may follow locally adopted face to face report policy/procedure. In absence of a local policy or procedure when transferring care at the destination facility; or to a transport service; or when tiering with another service the OOHECP should give a face-to-face verbal report to a representative of the receiving entity. This verbal report should include the:

- Patient’s name
- Complaint(s)
- Mechanism of injury/nature of illness
- Pertinent medical history
- Medications
- Allergies
- Events leading the injury/illness
- Treatments
- Treatment given by EMS
- Results of treatments

At the conclusion of the report check for understand and ask if there are any questions.

Documentation
A Patient Care Report (PCR) will be completed for each patient transport, refusal, cancelled call, or standby. The PCR will include at least the minimum data required by Rules and Regulations. Additionally, the PCR will be completed by the method, within the time frame, and submitted to the Department of Health and Human Services as defined in the Rules and Regulations.

CONSENT (Revised 12/7/2012)

General Consent Guidelines
Whenever possible the OOHECP should obtain at least verbal consent prior to treatment. The very nature of emergency medical care means that, at times, verbal consent will not be possible and an implied consent concept must be employed. Services are to have a consent form available and providers are to obtain a signature from the patient or a patient representative whenever possible. If a signature cannot be obtained, documentation should reflect the reason why.

Minor Defined
An adult is an individual 19 years old or older or who is or has been married (Neb. Rev. Stat. §43-2101). Consent or refusal cannot be signed by a minor.
- A minor is an individual age 18 or under UNLESS the individual is married.
- A minor can be emancipated and given the rights of an adult.

Suicide Attempts or Threats to Harm Self
When the OOHECP is presented with a patient that has attempted or threatened suicide, the provider should contact law enforcement and request emergency protective custody.

GUIDELINES FOR REFUSAL (Revised 12/7/2012)
Any competent adult may refuse care and/or transportation. Also the patient may allow transport but refuse a specific medical procedure;
- To determine if the patient is competent the OOHECP will;
  - Determine the patient is oriented to person, place, events and approximate time
  - Determine the patient has not, in relation to the current situation, attempted or threatened to commit suicide or harm him/her self
  - A legal guardian or health care power of attorney may consent to or refuse care and/or transportation for an adult or minor patient.

The OOHECP must document refusal of care and/or transport. This documentation is to include;
- All patient data elements to complete the patient care report
- Patient assessment including vital signs and any care the patient allowed
- A signature from the patient or the patients representative acknowledging the refusal of care and/or transport

If the patient refuses to allow vital signs, treatment or provide information the patient care report should have a statement explaining what elements the patient refused.

The OOHECP should reassure the patient that EMS can be called back should the patient wish to seek medical attention at a later time.
DO NOT RESUSCITATE (DNR) (Revised 12/7/2012)
A DNR is a written order by a physician that a patient should not be resuscitated or have CPR performed. A DNR must be signed by a physician, dated, and have the patient’s name.

When confronted with a patient with a DNR and the patient has no pulse, agonal breathing or no respirations the OOHECP may honor the DNR and not initiate resuscitation efforts.

When confronted with a patient with a DNR and the patient is nearing death the OOHECP may provide comfort care including supplemental oxygen and pain management. The patient may be transported at the request of the patient, patient’s family, patient’s physician or medical control.

When confronted with a patient with a DNR and the patient is NOT nearing death the OOHECP may provide the care as directed within these protocols.

ADVANCED DIRECTIVES (Revised 12/7/2012)
Advanced directives are documents that state the patient’s wishes should certain events occur. These documents may be in the form of a “Living Will”. Some of these documents may be of such a length and complexity that the OOHECP may not be able to determine the wishes of the patient for the situation encountered. In these cases, resuscitation efforts should be initiated unless the sign(s) of obvious death are present. If possible, the document should be transported with the patient to the hospital.

FAMILY OBJECTIONS TO DNR – ADVANCED DIRECTIVES (Revised 12/7/2012)
In situation where the family objects to a DNR order or an Advanced Directive the OOHECP should initiate resuscitation efforts unless sign(s) of obvious death are present.

OOHECP ETHICAL OBJECTION (Revised 12/7/2012)
Any OOHECP with an ethical objection to following a DNR or Advanced Directive must inform his/her service prior to responding to these types of situations. These individuals should avoid response to these types of calls whenever possible.

MEDICAL DIRECTION AND PHYSICIAN ORDERS (Revised 12/7/2012)
Medical Direction Orders
The OOHECP may consult with on line medical direction and follow the orders given via this method. HOWEVER, the OOHECP may only provide treatment within the practices and procedures for their level of licensure and the service’s level of licensure.

Patient Physician Orders
The OOHECP may consult on line with the patient’s physician and follow the orders given via this method. HOWEVER the OOHECP may only provide treatment within the practices and procedures for their level of licensure and the service’s level of licensure. The patient care record will state the name of the physician and the orders given.

Physician on Scene
The OOHECP may follow the orders of a physician on scene. HOWEVER the OOHECP may only provide treatment within the practices and procedures for their level of licensure and the service’s level of licensure. The patient care record will state the name of the physician and the orders given.

CONCEALED HANDGUN (Revised 12/7/2012)
The Nebraska Concealed Handgun Permit Act allows certain individuals to obtain a permit to carry a concealed handgun. The rules and regulations necessary to carry out the act are listed in Title 272 Chapter 21.

The OOHECP’s best action when confronted with a situation in which a patient has a concealed weapon is to have law enforcement take possession of the weapon. When this is not possible, the weapon should be secured until it can be turned over to law enforcement.
REPORTING CRIMES AND CRIME SCENES (Revised 12/7/2012)

Mandatory Reporting Certain Suspected Crimes
The OOHECP is directed under the law to report or cause a report to be made to law enforcement the following:
- Abuse and neglect of a child Refer to Neb. Rev. Stat. § 28-711
- Abuse and neglect of a vulnerable adult Refer to Neb. Rev. Stat. § 28-378
- Injuries as a result of a crime Refer to Neb. Rev. Stat. § 28-902

Crime Scenes
The OOHECP will likely care for victim(s) of a crime and therefore should attempt to preserve evidence as best as possible while providing for patient care. Good documentation of the scene and patient’s injuries will also be of benefit in these cases.

COMPLETION OF THE CALL AND PREPARATION FOR NEXT CALL (Revised 12/7/2012)
After the call, the OOHECP should clean and disinfect equipment and the ambulance. The ambulance should be restocked and prepared for the next call.

Providers should consider the call and, if needed, call for a Critical Incident Stress Management (CISM) debriefing.
Adult Routine Assessment and Care
ROUTINE ASSESSMENT AND CARE (Revised 3/22/2018)
This Protocol applies to every patient contact and is the base from which other treatment protocols build upon.

Scene Size Up
- Assess scene safety – use standard/universal precautions – determine # of patients – consider additional resources
- Determine nature of illness/mechanism of trauma

Primary Assessment, Identify and Treat Immediate Life Threats
- If mechanism of trauma indicates – consider manually stabilizing c-spine
- Form a general impression
- Determine level of consciousness – utilize AVPU scale
- If adult patient presents in cardiac arrest start compressions unless obvious signs of death are present
- assess airway
  - Foreign body airway obstruction – clear obstruction
  - Decreased level of consciousness (LOC) and patient cannot maintain own airway (no gag reflex)
    - Trauma suspected – utilize jaw thrust method to open airway
    - Medical patients – utilize head tilt, chin left method to open airway
    - ALL LEVELS
      - Consider oral airway
      - EMT With Approval, AEMT, EMT-I and Paramedic – may consider advanced non-visualized airway
      - EMT-I and Paramedic – may consider intubation
  - Decreased LOC and patient has decreased ability to maintain own airway (gag reflex intact)
    - ALL LEVELS
      - Monitor closely – consider one of simple airway maneuvers above
      - EMT and above – may consider nasal airway
      - Paramedic – may consider RSI
  - Suction oral airway as needed
  - Patient can maintain own airway and no suction needed – no immediate intervention
- Assess Breathing
  - Absent or agonal – begin ventilations with BVM attached to oxygen (alternate may use mouth to mask)
  - Assess quality of breathing and lung sounds
    - Respiratory rate 10 and under OR 30 and above
      - Consider assisted ventilations with BVM attached to oxygen
    - Signs/Symptoms of severe respiratory distress – impending respiratory arrest
      - Consider oxygen by non-rebreather mask
      - Consider assisted ventilations with BVM attached to oxygen
    - Signs/symptoms of moderate respiratory difficulty
      - Consider oxygen by non-rebreather mask
    - Signs/symptoms of mild respiratory difficulty
      - Consider oxygen by nasal cannula
    - No signs/symptoms of respiratory difficulty
      - Consider oxygen appropriate to nature of illness/mechanism of trauma
  - Special note on oxygen administration
    - EMT, AEMT, EMT-I and Paramedic
      - Hyper oxygenation should be avoided for cardiac and suspected CVA patients
      - Utilize oxygen saturation and adjust oxygen device and flow to maintain saturation between 94% and 99% BUT NOT HIGHER
• Assess Circulation
  o Absent pulse – begin CPR – follow Cardiac Arrest Protocols
  o Assess for bleeding
    ▪ Control external bleeding with direct pressure, pressure bandage, pressure points and/or tourniquet
    ▪ Control external bleeding with the use of hemostatic agents with physician medical director approval and direction.
  o Assess quality of pulse
    ▪ Weak – rapid pulse – consider treating for shock
    ▪ Weak slow pulse
      ▪ Assess airway and breathing again and treat as appropriate
      ▪ Assess for possible cause
    ▪ Irregular pulse
      ▪ Assess for possible cause
    ▪ Strength, rate, and rhythm normal – no immediate intervention

• Assess disability – quick neuro exam
  o Obtain Glasgow Coma Scale
  o Utilize a non-invasive stroke scale to rule out possible stroke
  o Check peripheral circulation, movement, and sensory

Obtain Patient History
• Obtain a chief complaint
• Obtain SAMPLE history
• Consider use of OPQRST pneumonic
• Obtain pertinent negatives

Vital Signs
• EMR
  o Pulse
  o Respiratory rate
  o Manual blood pressure
  o Temperature
• EMT, AEMT, EMT-I, Paramedic
  o Pulse
  o Respiratory rate
  o Manual and automatic blood pressure
  o Pulse oximetry reading
  o Non-invasive CO reading
  o Temperature

Additional Monitoring as Appropriate to Patient's Illness/Injury
• EMT-I
  o EtCO2 including capnography
  o Cardiac monitoring Leads I, II, and III
• Paramedic
  o All non-invasive monitoring devices
  o Device to monitor airway/ventilation pressures
  o Invasive monitoring if already established

Secondary Assessment
• Prepare for patient transport
• Expose patient as needed
• Medical – systematic assessment of major body systems
• Trauma – systematic assessment for injuries

Reassessment
• Repeat assessment of patient based on condition
• Monitor vital signs
• Identify changes in patient condition – adjust treatment as needed
### Glasgow Coma Scale

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Adult/Child</th>
<th>Score</th>
<th>Infant</th>
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</thead>
<tbody>
<tr>
<td><strong>Eye Opening</strong></td>
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<tr>
<td>Spontaneous</td>
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<td></td>
<td>Spontaneous</td>
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<tr>
<td>To Verbal</td>
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<td></td>
<td>To Verbal</td>
</tr>
<tr>
<td>To Pain</td>
<td>2</td>
<td></td>
<td>To Pain</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td></td>
<td>No Response</td>
</tr>
<tr>
<td><strong>Best Verbal Response</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oriented</td>
<td>5</td>
<td></td>
<td>Coos, Babbles</td>
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<tr>
<td>Disoriented/Confused</td>
<td>4</td>
<td></td>
<td>Irritable Cry</td>
</tr>
<tr>
<td>Inappropriate Words</td>
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<td></td>
<td>Cries Only to Pain</td>
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<tr>
<td>Incomprehensible Moans/groans</td>
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<td>Moans to Pain</td>
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<tr>
<td>No Response</td>
<td>1</td>
<td></td>
<td>No Response</td>
</tr>
<tr>
<td><strong>Best Motor Response</strong></td>
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<td></td>
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<tr>
<td>Obeys Commands</td>
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<td>Spontaneous</td>
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<tr>
<td>Localizes Pain</td>
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<td>Withdraws from Touch</td>
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<tr>
<td>Withdraws from Pain</td>
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<td></td>
<td>Withdraws from Pain</td>
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<tr>
<td>Abnormal Flexion</td>
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<td>Abnormal Flexion</td>
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<tr>
<td>Abnormal Extension</td>
<td>2</td>
<td></td>
<td>Abnormal Extension</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td></td>
<td>No Response</td>
</tr>
</tbody>
</table>
Nebraska EMS Model Protocols
Adult Medical Protocols
AIRWAY – CHOKING – FOREIGN BODY AIRWAY OBSTRUCTION (Revised 7/7/2016)

**EMR and EMT**

**Complete Airway Obstruction**

- **Conscious**
  - Perform abdominal thrusts

- **Conscious Goes Unconscious**
  - Ease patient into supine position

- **Unconscious**
  - Position patient supine position

**Partial Airway Obstruction**

- Monitor patient – allow patient to cough, be alert for complete obstruction

**EMR Options If Approved**
- Initiate transport

**EMT**
- Initiate transport

**EMT Options If Approved**
- Do not insert advanced airway unless airway cleared and persistent decreased mental status
- Focus on clearing obstructed airway prior to any IV access attempts

**AEMT**
- Do not insert advanced airway unless airway cleared and persistent decreased mental status
- Focus on clearing obstructed airway prior to any IV access attempts

**EMT-I**
- Consider direct visualization with laryngoscope and removal with forceps

**Paramedic**
- Consider cricothyrotomy
ALL LEVELS
- Routine assessment and care

EMR and EMT
- Consider oral airway
- Consider assisted ventilations for inadequate breathing
- Consider oxygen
- Suction as needed
- Positioning
  - Decreased mental status position on side
  - Alert patient allow patient to assume position of comfort
- Be alert for loss of airway due to swelling
- Consider ALS

EMR Options If Approved
- Transport patient in position of comfort if safe to do so

EMT
- Consider nasal airway
- Consider oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Transport patient in position of comfort if safe to do so

EMT Options and AEMT
- Consider advanced airway for persistent decreased mental status
- Consider IV access

EMT-I
- Consider advanced airway for persistent decreased mental status
- Consider bronchodilator for wheezing
- Consider cardiac monitoring

Paramedic
- Consider RSI
**ABDOMINAL PAIN** (Revised 3/22/2018)

**ALL LEVELS**
- Routine assessment and care

**EMR and EMT**
- Consider oxygen
- Consider OPQRST pneumonic for assessment of pain
- Additional assessment concerns
  - Localize pain to abdominal quadrant if possible
  - Obtain bowel and bladder habits
  - Female patients – obtain menstrual cycle history
  - Female patients – consider ectopic pregnancy
- Allow patient to assume a position of comfort
- Consider ALS

**EMR Options If Approved**
- Initiate transport

**EMT**
- Consider oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

**EMT Options**
- Consider advanced airway for persistent decreased LOC
- Consider IV access

**AEMT**
- Consider 2 – 4 mg morphine
- Consider IO access for shock and IV access cannot be obtained

**EMT-I**
- Consider cardiac monitoring

**Paramedic**
- Consider pain management
- For suspected renal calculus (kidney stones)
  - Consider 15 – 30mg Ketorolac IV in addition to opioid class pain medication
ALLERGIC REACTION – ANAPHYLAXIS (Revised 12/7/2012)

ALL LEVELS
- Routine assessment and care

EMR
- Consider oral airway
- Consider assisted ventilations
- Consider oxygen
- Assess severity of reaction

<table>
<thead>
<tr>
<th>Mild Reaction</th>
<th>Moderate Reaction</th>
<th>Severe Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itching and/or hives</td>
<td>Itching and/or hives</td>
<td>Itching and/or hives</td>
</tr>
<tr>
<td>No respiratory symptoms</td>
<td>Mild respiratory symptoms</td>
<td>Respiratory distress</td>
</tr>
<tr>
<td>No airway compromise</td>
<td>No airway compromise</td>
<td>Airway compromise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Signs/symptoms of shock</td>
</tr>
</tbody>
</table>

- Consider ALS

EMR Options if Approved
- Consider 0.3 (adult) epinephrine auto injector for moderate and severe reactions
  - May repeat in 5 minutes if symptoms do not improve
- Initiate transport

EMT
- Consider nasal airway
- Consider oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Consider assisting patient with his/her prescribed meter dosed inhaler
- Consider assisting patient with his/her prescribed epinephrine auto injector
  - May repeat in 5 minutes if symptoms do not improve
- Initiate transport

EMT Options if Approved
- Consider 2.5mg unit dose albuterol nebulizer treatment for moderate and severe reactions
- Consider 0.3mg (adult) epinephrine auto injector for moderate and severe reactions
  - May repeat in 5 minutes if symptoms do not improve
- Consider IV access

AEMT
- Consider 0.3mg epinephrine 1:1000 IM or SubQ for moderate and severe reactions
  - May repeat in 5 minutes if symptoms do not improve
- Consider IO access in moderate and severe reactions when IV access fails

EMT-I
- May consider one of the other EMT-I approved bronchodilators
- May consider 0.3 mg epinephrine 1:10,000 IV/IO as alternate to epi 1:1000 IM or SubQ
- Consider 25 to 50mg Diphenhydramine IV/IO for mild, moderate, and severe reactions
- Consider 125 to 250 mg Methylprednisolone IV/IO for moderate and severe reactions
- Initiate cardiac monitoring

Paramedic
- Consider RSI
- Consider vasopressor agent for anaphylactic shock with hypotension
ALL LEVELS
- Routine assessment and care

EMR and EMT
- Consider oxygen
- Assess for medical or traumatic causes for behavioral changes
- Attempt non-confrontational verbal reassurance to calm patient – give clear direction
- Combative patients
  - Contact law enforcement
  - Consider physically restraining patient **See restraint protocol**
  - Consider use of spit hood
- Consider excited delirium syndrome: patients are truly out of control and have a life-threatening medical emergency they will have some or all of the following sx: paranoia, disorientation, hyperaggression, hallucination, tachycardia, increased strength, hyperthermia
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options If Approved
- Consider obtain blood glucose reading

AEMT and EMT-I
- In absence of other signs and symptoms no additional protocol items

Paramedic
- Consider IV/IO access
- Consider Ketamine 4 mg/kg IM (max 500 mg) for excited delirium
- Consider Lorazepam 0.5 mg to 1 mg IV/IO/MAD
  - or-
  - Midazolam 0.05 mg/kg IV/IO/IM/MAD may repeat 1-2 mg every 10 minutes (no max)
- Consider 2.5 to 5 mg Haloperidol IV/IO/IM for combative patients
- Consider Benzodiazepine for anxiety
The EMR or EMT may be presented with patients in which bystander CPR has been started or the patient presents with certain sign/symptoms of obvious death or a valid DNR.

**Situations where bystander CPR has been initiated OR EMS arrives and no CPR is initiated:**

**Un-Safe Scene**
- If the scene will place the OOHCEP “at risk of serious injury or mortal peril”\(^1\) CPR may be discontinued or withheld

**ALL LEVELS**
- Confirm the Patient Has
  - No Pulse
  - No Respirations or Attempts at Respirations

- May Stop CPR or Not Initiate CPR IF the Patient Presents with **At Least One** of the Following:
  - Rigor mortis
  - Decapitation
  - Decomposition
  - Dependent lividity
  - Traumatic cardiopulmonary arrest with injuries incompatible with life; Examples:
    - Massive blood loss
    - Displacement of brain tissue
    - Blunt Head/Chest Trauma
  - Valid DNR form
  - Physician authorization

- The following will be included in the Patient Care Report;
  - CPR was or was not being performed prior to EMS arrival; OR
  - If CPR was being performed and the time it was discontinued
  - The patient had no respirations and no pulse
  - The additional criteria (from above) use to discontinue or withhold CPR

---

\(^1\) Part 3: Ethics: 2010 AHA CPR and EEC Guild lines *Withholding and Withdrawing CPR(Termination of Resuscitative Efforts) Related to Out-of Hospital Cardiac Arrest*
EMR – EMT – AEMT

EMR Options If Approved
- Place patient on back/CPR board
- Initiate transport
- Call for intercept from backup service

EMT
- Place patient on back/CPR board

EMT Options if Approved and AEMT, Paramedic
After First Cycle of CPR and Shock or No Shock
- Consider an advanced airway
- Consider impedance threshold device
- Consider IV Access with Normal Saline or LR

AEMT
- Consider IO access

EMT/AEMT/Paramedic
- Consider mechanical CPR
CARDIAC ARREST – ADVANCED CARDIAC LIFE SUPPORT (Revised 10/4/2016)

EMT-I AND PARAMEDIC

Adult Cardiac Arrest Algorithm—2015 Update

1. Start CPR
   - Give oxygen
   - Attach monitor/defibrillator

2. Rhythm shockable?
   - Yes
   - VF/pVT
     - Shock
   - CPR 2 min
     - IV/IO access
     - Epinephrine every 3-5 min
     - Consider advanced airway, capnography
   - Rhythm shockable?
     - Yes
     - Shock
     - CPR 2 min
       - Amiodarone
       - Treat reversible causes
     - Rhythm shockable?
       - Yes
       - CPR 2 min
         - Treat reversible causes
         - If no signs of return of spontaneous circulation (ROSC), go to 10 or 11
         - If ROSC, go to Post-Cardiac Arrest Care
   - No
   - Asystole/PEA
     - CPR 2 min
     - IV/IO access
     - Epinephrine every 3-5 min
     - Consider advanced airway, capnography
     - Rhythm shockable?
       - Yes
       - CPR 2 min
         - Treat reversible causes
         - If no signs of return of spontaneous circulation (ROSC), go to 10 or 11
         - If ROSC, go to Post-Cardiac Arrest Care
   - No
   - CPR 2 min
     - IV/IO access
     - Epinephrine every 3-5 min
     - Consider advanced airway, capnography
     - Rhythm shockable?
       - Yes
       - CPR 2 min
         - Treat reversible causes
         - If no signs of return of spontaneous circulation (ROSC), go to 10 or 11
         - If ROSC, go to Post-Cardiac Arrest Care
   - No
   - CPR 2 min
     - IV/IO access
     - Epinephrine every 3-5 min
     - Consider advanced airway, capnography
     - Rhythm shockable?
       - Yes
       - CPR 2 min
         - Treat reversible causes
         - If no signs of return of spontaneous circulation (ROSC), go to 10 or 11
         - If ROSC, go to Post-Cardiac Arrest Care
   - No

CPR Quality
- Push hard (at least 2 inches [5 cm]) and fast (100-120/min) and allow complete chest recoil.
- Minimize interruptions in compressions.
- Avoid excessive ventilation.
- Rotate compressor every 2 minutes, or sooner if fatigued.
- If no advanced airway, 30:2 compression-ventilation ratio.
- Quantitative waveform capnography
  - If PETCO₂ <10 mm Hg, attempt to improve CPR quality.
- Intravascular pressure
  - If relaxation phase (diastolic) pressure <20 mm Hg, attempt to improve CPR quality.

Shock Energy for Defibrillation
- Biphasic: Manufacturer recommendation (eg, initial dose of 120-200 J; if unknown, use maximum available). Second and subsequent doses should be equivalent, and higher doses may be considered.
- Monophasic: 360 J

Drug Therapy
- Epinephrine IV/IO dose: 1 mg every 3-5 minutes
- Amiodarone IV/IO dose: First dose: 300 mg bolus. Second dose: 150 mg.

Advanced Airway
- Endotracheal intubation or supraglottic advanced airway
- Waveform capnography or capnometry to confirm and monitor ET tube placement
- Once advanced airway is in place, give 1 breath every 6 seconds (10 breaths/min) with continuous chest compressions

Return of Spontaneous Circulation (ROSC)
- Pulse and blood pressure
- Abrupt sustained increase in PETCO₂ (typically >40 mm Hg)
- Spontaneous arterial pressure waves with intra-arterial monitoring

Reversible Causes
- Hypovolemia
- Hypoxia
- Hyper/hypokalemia
- Hypothermia
- Tension pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

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ALL LEVELS
- Follow cardiac arrest algorithm with these special considerations

CARDIAC ARREST OF THE OBVIOUS PREGNANT PATIENT

EMR, EMT, AEMT
- Place patient on backboard and tilt patient on backboard approximately 30 degrees to the patient’s left

EMT-I and Paramedic
- Alternative to tilting patient on backboard manually displace gravid uterus to the patient’s left

CARDIAC ARREST IN SUSPECTED HYPOMAGNESEMIA

Paramedic
- Identify if patient has Torsades de Pointes cardiac rhythm and consider 1-2 grams Magnesium Sulfate IV/IO

CARDIAC ARREST IN SUSPECTED HYPERKALEMIA

Paramedic
- Identify if patient has tall spiked T Waves on 12 Lead EKG or Diagnostic Mode three lead
  - Consider
    - 15mg Albuterol Nebulized and ventilated into patient
    - OR 5 to 10ml of 10% Calcium Chloride IV/IO Over 2-5 minutes
    - OR 15 to 30ml 10% Calcium Gluconate IV/IO Over 2-5 minutes

CARDIAC ARREST IN KNOWN TRICYCLIC ANTIDEPRESSANT OVERDOSE

Paramedic
- Confirm patient overdosed on tricyclic antidepressant
- Consider 50mEq 8.4% Sodium Bicarbonate IV/IO

CARDIAC ARREST IN KNOWN OR HIGH SUSPICION OF CYANIDE POISONING

Paramedic
- Consider 5g diluted Hydroxocobalamin in 200ml of NS (recommended), LR or D5 IV/IO infused over 15 minutes

CARDIAC ARREST IN SUSPECTED NARCOTIC – BENZODIAZEPINE – BETA BLOCKER – CALCİUM CHANNEL BLOCKER OVERDOSE

ALL LEVELS
- No additional considerations – antidotes are contra-indicated in cardiac arrest

CARDIAC ARREST IN HYPOTHERMIA–DROWNING

EMR and EMT
- Remove wet clothing and passively warm patient

EMT IV Options If Approved
- Use warmed IV fluids

EMT-I and Paramedic
- May use Epinephrine in severe hypothermia (<87°F)
- Avoid Amiodarone and Lidocaine in severe hypothermia (<87°F)

CARDIAC ARREST IN TRAUMA

ALL LEVELS
- If resuscitation attempted follow appropriate Cardiac Arrest Protocol
ALL LEVELS
- Routine assessment and care

EMR and EMT
- Keep AED attached to patient
- Assist ventilations
- Administer oxygen
- If gag reflex returns removal of oral airway
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Administer Oxygen and adjust delivery device and LPM Flow to Achieve 94 to 99%
- Consider obtaining 12 Lead EKG
- Initiate transport

EMT Options If Approved
- Consider advance airway if not already in place during cardiac arrest
- Consider obtain a blood glucose reading
- Consider IV access

AEMT
- Consider IV or IO access

EMT-I
- Consider intubation if not already in place during cardiac arrest
- Initiate cardiac monitoring
- Treat cardiac dysrhythmias
- Adjust ventilations (Rate, Tidal Volume, FiO2) to maintain these goals
  o O2 Saturation 94 to 99%
  o EtCO2 35 to 45 mmHg

Paramedic
- If patient intubated
  o Consider sedative agent OR
  o Consider sedative agent First then a non-depolarizing paralytic
- Consider inducing hypothermia if patient meet criteria
  o ** See cardiac arrest return of spontaneous circulation induced hypothermia
- Consider vasopressor agent for sustained hypotension
CARDIAC ARREST – RETURN OF SPONTANEOUS CIRCULATION INDUCED HYPOTHERMIA

(Revised 12/7/2012)

EMR – EMT – AEMT – EMT-I
- Not approved for this protocol

Paramedic
- DO NOT attempt hypothermia unless the destination facility has capabilities to maintain/continue the process
- For this protocol to be in effect the following criteria must be met.

<table>
<thead>
<tr>
<th>Destination Facility Criteria</th>
<th>ALS Service Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies and procedures for management of inducing and maintaining hypothermia after ROSC</td>
<td>PMD authorization for this protocol and RSI protocol</td>
</tr>
</tbody>
</table>
| Equipment and supplies to maintain hypothermia | Ability to
  - Maintain two 1,000ml IV bags of NS or LR at 34° to 36° F
  - Monitor body temperature |
| Facility is aware and approves of service to induce hypothermia after ROSC | Medications availability
  - Sedative agent(s)
  - Non-depolarizing paralytic(s)
  - Vasopressor agent |

Patient Criteria

<table>
<thead>
<tr>
<th>Inclusion Criteria:</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCS 8 or less</td>
<td>GCS over 8</td>
</tr>
<tr>
<td>Age 16 and above</td>
<td>Under age 16</td>
</tr>
</tbody>
</table>
| Cardiac arrest due to suspected cardiac problem | Cardiac arrest due to:
  - Trauma
  - Toxins/poisonings
  - Status asthmaticus
  - Status epilepticus |
| Advanced airway in place and confirmed patent | Patient obviously pregnant or confirmed pregnant |
| At least one IV/IO access line - preferably two | Existing DNR or terminal illness |
| Etc02 of 20mmhg or more | Vegetative or comatose patient prior to cardiac arrest |
| Initial body temp of 93°F (34°C) or greater | Anti-coagulated patient |

- The Paramedic will monitor VS including
  - Temperature
  - SaO2 and EtCO2
  - Cardiac rhythm
- Verify inclusion criteria are meet and no exclusion criteria are present
- Administer cold IV fluid in 500ml boluses until patient temp reaches 93 to 94°F or maximum of 2000ml
- Apply cold packs to groin and axillary regions
- Prevent shivering
  - Administer sedative agent first then non-depolarizing paralytic agent
- Treat hypotension with vasopressor agent
- Treatment goals – adjust care as needed
  - Prevent Shivering
  - Body temp of 93°F but NOT colder than 93°F
  - O2 Saturation 94% to 99% but not above 99%
  - EtCO2 of 35 to 45 mmHg
  - Systolic BP 80 to 100
CARDIAC ARREST – TERMINATION OF RESUSCITATION (Revised 12/7/2012)

ALL LEVELS
- Routine assessment

EMR, EMT and AEMT
- Consider termination resuscitation in accordance with the following algorithm
- Consider consultation with medical control or PMD

EMT-I and Paramedic
- Consider termination resuscitation in accordance with the following algorithm

Paramedic
- As an option to above when ALL criteria are not met the paramedic may consider the following
  - Patient presents or develops asystole in three leads
  - 1mg epinephrine administered
  - Advanced airway placed – endotracheal or advanced non-visualized airway
  - Consider termination of resuscitation
Nebraska EMS Model Protocols
Adult Medical Protocols

CARDIAC DYSRHYTHMIA TACHYCARDIA (Revised 12/7/2012)

EMT-I AND PARAMEDIC

Adult Tachycardia
(With Pulse)

1. Assess appropriateness for clinical condition. Heart rate typically ≥150/min if tachyarrhythmia.

2. Identify and treat underlying cause
   - Maintain patent airway; assist breathing as necessary
   - Oxygen (if hypoxemic)
   - Cardiac monitor to identify rhythm; monitor blood pressure and oximetry

3. Persistent tachyarrhythmia causing:
   - Hypotension?
   - Acutely altered mental status?
   - Signs of shock?
   - Ischemic chest discomfort?
   - Acute heart failure?

4. Synchronized cardioversion
   - Consider sedation
   - If regular narrow complex, consider adenosine

5. Wide QRS? ≥0.12 second

6. Yes: IV access and 12-lead ECG if available
   - Consider adenosine only if regular and monomorphic
   - Consider antiarrhythmic infusion
   - Consider expert consultation

7. No: IV access and 12-lead ECG if available
   - Vagal maneuvers
   - Adenosine (if regular)
   - β-Blocker or calcium channel blocker
   - Consider expert consultation

Doses/Details

Synchronized Cardioversion
Initial recommended doses:
- Narrow regular: 50–100 J
- Narrow irregular: 120–200 J biphasic or 200 J monophasic
- Wide regular: 100 J
- Wide irregular: defibrillation dose (NOT synchronized)

Adenosine IV Dose:
First dose: 6 mg rapid IV push; follow with NS flush.
Second dose: 12 mg if required.

Antiarrhythmic Infusions for Stable Wide-QRS Tachycardia

Procainamide IV Dose:
20–50 mg/min until arrhythmia suppressed, hypotension ensues, QRS duration increases >50%, or maximum dose 17 mg/kg given. Maintenance infusion: 1–4 mg/min. Avoid if prolonged QT or CHF.

Amiodarone IV Dose:
First dose: 150 mg over 10 minutes. Repeat as needed if VT recurs. Follow by maintenance infusion of 1 mg/min for first 6 hours.

Sotalol IV Dose:
100 mg (1.5 mg/kg) over 5 minutes. Avoid if prolonged QT.

Paramedic Only Medication
- Procainamide
- Amiodarone Infusion
- Sotalol

EMT-I Must Have Completed ACLS to Perform
- Synchronized Cardioversion
EMT-I AND PARAMEDIC

CARDIAC DYSRHYTHMIA BRADYCARDIA (Revised 12/7/2012)

**Adult Bradycardia**
(With Pulse)

1. Assess appropriateness for clinical condition. Heart rate typically <50/min if bradyarrhythmia.

2. Identify and treat underlying cause
   - Maintain patent airway; assist breathing as necessary
   - Oxygen (if hypoxemic)
   - Cardiac monitor to identify rhythm; monitor blood pressure and oximetry
   - IV access
   - 12-Lead ECG if available; don’t delay therapy

3. Persistent bradyarrhythmia causing:
   - Hypotension?
   - Acutely altered mental status?
   - Signs of shock?
   - Ischemic chest discomfort?
   - Acute heart failure?

4. Monitor and observe

5. Yes: Atropine
   - If atropine ineffective:
     - Transcutaneous pacing OR
     - Dopamine infusion OR
     - Epinephrine infusion

6. Consider:
   - Expert consultation
   - Transvenous pacing

**EMT-I and Paramedic Only Medication/Skill**
- Dopamine infusion
- Epinephrine infusion

**Doses/Details**

**Atropine IV Dose:**
- First dose: 0.5 mg bolus
- Repeat every 3-5 minutes
- Maximum: 3mg

**Dopamine IV Infusion:**
- 2-20 mcg/kg per minute

**Epinephrine IV Infusion:**
- 2-10 mcg per minute

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TALL SPIKED T WAVES

Paramedic
- Consider hyperkalemia
  - Consider continuous albuterol nebulizer treatments

ST ELEVATION

Paramedic
- Consider STEMI event **See ACS Protocol
  - ST elevation in contiguous leads
  - No bundle branch block (unless paramedic has a comparison EKG)
  - Increased suspicion of STEMI if reciprocal to ST elevation – ST depression presents

<table>
<thead>
<tr>
<th>Lead I Lateral Wall</th>
<th>aVR</th>
<th>V1 Septal Wall</th>
<th>V4 Anterior Wall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead II Inferior Wall</td>
<td>aVL Lateral Wall</td>
<td>V2 Septal Wall</td>
<td>V5 Lateral Wall</td>
</tr>
<tr>
<td>Lead III Inferior Wall</td>
<td>aVF Inferior</td>
<td>V3 Anterior Wall</td>
<td>V6 Lateral Wall</td>
</tr>
</tbody>
</table>

- If patient presents with ST elevation in inferior leads
  - Consider use of right sided EKG to determine right ventricular involvement
  - Do not delay transport
- If patient presents with ST elevation in inferior leads with T wave inversion in V1 and V2
  - Consider moving V4, 5 and 6 to position V7, 8, and 9 to determine posterior involvement
  - Do not delay transport

AXIS DEVIATION

Paramedic
- Extreme Right Axis Deviation – Lead I and aVF predominantly negative
  - Be alert for ventricular ectopy including V-Tach
- Right Axis Deviation – Lead I predominantly negative and aVF predominantly positive
  - Consider Right Ventricular Hypertrophy
  - Consider Dextrocardia
- Left Axis Deviation – Lead I predominantly positive, aVF predominantly negative, and Lead II predominantly negative
  - Consider left sided Heart Hypertrophy
  - Inferior wall MI
Nebraska EMS Model Protocols
Adult Medical Protocols
CVA – STROKE (Revised 12/27/2017)

Stroke Guideline

History
- Previous CVA, TIA's
- Previous cardiac / vascular surgery
- Associated diseases: diabetes, hypertension, CAD
- Atrial fibrillation
- Medications (blood thinners)
- History of trauma

Signs and Symptoms
- Altered mental status
- Weakness / Paralysis
- Acute focal neuro deficit
- Blindness or other sensory loss
- Aphasia / Dysarthria
- Syncope
- Vertigo / Dizziness
- Vomiting
- Headache
- Seizures
- Respiratory pattern change
- Hypertension / hypotension

Differential
- Severe Altered Mental Status
- TIA (Transient ischemic attack)
- Seizure
- Todd's Paralysis
- Hypoglycemia
- Stroke
- Tumor
- Trauma
- Dialysis / Renal Failure

SEVERITY-BASED STROKE TRIAGE ALGORITHM FOR EMS

EMS Dispatch: receive immediate response
EMS unit of possible stroke call, EMS crew dispatched per regional stroke protocol or on scene suspicion of acute stroke by EMS providers.

Upon arrival: Provide any needed ABC interventions, request dispatch of higher level of provider if necessary for unstable patients and interview patient, family and other witnesses.

Perform and document results from severity tool used to assess potential LVO (LAMS RACE,
CSTAT, FAST-ED, etc.).

Identity and document Time Last Known Well & Time of symptom discovery.

LVO Suspected? (RACE >5)

NO

YES

Call stroke alert, pre-notify receiving facility and transport to the closest appropriate stroke center (ASRH, PSC, CSC) per your regional stroke systems of care policy.

DIRECT TRANSPORT TO CSC ADDS LESS THAN OR EQUAL TO 15 MINUTES?

NO

YES

Call Stroke Alert, pre-notify receiving facility and transport directly to an appropriately certified CSC that is within the acceptable transport time, if no CSC meets the criteria then transport to the nearest designated EVT-capable center, or closest appropriate stroke center (ASRH/PSC) per your regional stroke system of care plan.

STROKE SCREEN POSITIVE / STROKE SUSPECTED?

NO

YES

Large Vessel Occlusion (LVO)

Transport to CSC will not preclude use of in Alteplase?

NO

YES

CPS+S=Cardiovascular Pre-Hospital Stroke Score, LAPS+LA Prehospital Stroke Scale, LVO=Large Vessel Occlusion, LWM=Last Known Well
EVT=Endovascular therapy, ASRH=Acute Stroke Ready Hospital, PSC=Primary Stroke Center, CSC=Comprehensive Stroke Center. Page 35
Stroke Guideline

Cincinnati Pre-hospital Stroke Scale

1. FACIAL DROOP: Have patient show teeth or smile. 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. 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%.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Instruction</th>
<th>Result</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facial Palsy</td>
<td>Ask patient to show their teeth (smile)</td>
<td>Absent (symmetrical movement)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mild (slight asymmetrical)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderate to Severe (completely asymmetrical)</td>
<td>2</td>
</tr>
<tr>
<td>Arm Motor Function</td>
<td>Extending the arm of the patient 90° (if sitting) or 45° (if supine)</td>
<td>Normal to Mild (limb uplift more than 10 seconds)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderate (limb uplift less than 10 seconds)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe (patient unable to raise arm against gravity)</td>
<td>2</td>
</tr>
<tr>
<td>Leg Motor Function</td>
<td>Extending the leg of the patient 30° (in supine)</td>
<td>Normal to Mild (limb uplift more than 5 seconds)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderate (limb uplift less than 5 seconds)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe (patient unable to raise leg against gravity)</td>
<td>2</td>
</tr>
<tr>
<td>Head &amp; Gaze Deviation</td>
<td>Observe eyes and head deviation to one side</td>
<td>Absent (eye movements to both sides were possible and no head deviation was observed)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Present (eyes and head deviation to one side was observed)</td>
<td>1</td>
</tr>
<tr>
<td>Aphasia (R/side)</td>
<td>Difficultly understanding spoken or written words. Ask patient to follow two simple commands: 1. Close your eyes. 2. Make a fist.</td>
<td>Normal (performs both tasks requested correctly)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderate (performs only 1 of 2 tasks requested correctly)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe (Cannot perform either task requested correctly)</td>
<td>2</td>
</tr>
<tr>
<td>Agnosia (L/side)</td>
<td>Inability to recognize familiar objects. Ask patient: 1. “Whose arm is this?” (while showing the affected arm) 2. “Can you move your arm?”</td>
<td>Normal (recognizes arm, and attempts to move arm)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moderate (does not recognize arm or is unaware of arm)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe (does not recognize arm and is unaware of arm)</td>
<td>2</td>
</tr>
</tbody>
</table>

If RACE >5, consider Comprehensive Stroke Center

RACE SCALE TOTAL

Pearls

- **Recommended Exam:** Mental Status, HEENT, Heart, Lungs, Abdomen, Extremities, Neuro
- **Time of Onset or Last Seen Normal:** Interview patient, family members, and other witnesses to determine Last Known Well (LKW) time and time of Symptom Discovery.
- Be very precise in gathering data to establish the time of onset and report as an actual time (i.e. 13:47 NOT “about 45 minutes ago.”) Without this information patient may not be able to receive thrombolitics at facility.
- For patients with “Woke up and noticed stroke,” Time starts when patient went to sleep or was last awake and was last known normal.
- Attempt to identify possible stroke mimics (eg. Seizure, migraine, intoxication) and determine if patient has pre-existing substantial disability (need for nursing homecare or inability to walk without help from others).
- Encourage family to go directly to Emergency Department if not transported with patient and obtain mobile number of next of kin and witnesses
- Patients who are eligible for IV Alteplase if transported to nearest Acute Stroke Ready Hospital (ASRH) or PSC should not be rerouted to a CSC or Endovascular Treatment-capable Center if doing so would result in delay that would make them ineligible for IV Alteplase
- **Air Medical:** Important for EMS to be aware of role of air medical. May be needed to transfer a stroke patient to a geographically distant hospital that is capable of providing an advanced level of stroke care.
- With a duration of symptoms of less than 3.5 HOURS or UNDETERMINED, scene times should be limited to ≤ 15 minutes and the patient should be transported to a capable stroke receiving facility. In-field notification of receiving facility should be performed and transport times should be minimized.
- Collect a list of current medications (especially anticoagulants) and obtain patient history including co-morbid conditions (eg. Serious kidney or liver disease, recent surgery, procedures or stroke) that may impact treatment decisions.
ALL LEVELS

Obtain 12-lead ECG with initial vital signs – GOAL – First medical contact (FMC) to ECG ≤ 10 min, scene time: ≤ 15 minutes *To provide early identification and pre-hospital arrival notification for suspected myocardial infarction or STEMI.

1. Chest pain, pressure, tightness or persistent discomfort above the waist in patients ≥ 35 years of age
2. "heartburn" or epigastric pain
3. Complaints of "heart racing" (HR >150 or irregular and >120) or "heart too slow" (HR < 50 and symptomatic)
4. A syncope episode, severe weakness, or unexplained fatigue
5. New onset stroke symptoms (< 24 hours old)
6. Difficulty breathing or shortness of breath (with no obvious non-cardiac cause)
7. ROSC (return of spontaneous circulation) post cardiac arrest
8. Recent cocaine, stimulant and/or other illicit drug use (patients of any age)
9. If initial ECG is not diagnostic but suspicion is high for MI and symptoms persist, obtain serial ECG’s at 5-10 minute intervals

EMR
• Transmit 12-lead ECG to facility for interpretation or present to ALS for interpretation
• Alert hospital staff or qualified ALS personnel if ECG monitor interpretive statement infers “acute myocardial infarction” and patient has signs & symptoms suspect of acute myocardial infarction including chest discomfort and symptoms listed above
• Administer O2 based on assessment findings
• Obtain systolic/diastolic blood pressure (BP) in both arms
• Administer chewable aspirin 324 mg by mouth or rectally

EMT – AEMT – EMT-I
• Evaluate if erectile dysfunction or pulmonary hypertension medications taken in the past 24 hours including: sildenafil (Viagra, Revatio), vardenafil (Levitra, Staxyn), or avanafil (Stendra), tadalafil (Cialis, Adcirca). Hold nitrates for 48 hours following the last dose
• Administer nitroglycerin sublingual 0.4 mg every 5 minutes up to 3 doses if chest discomfort present and SBP > 100. Check BP prior to each administering dose. Hold if SBP < 100 mm HG (note: BLS providers are only able to assist patients with self-administration of their own prescribed sublingual nitroglycerin)
• Request ALS intercept per local protocol
• Establish large bore IV (upper extremity preferred) access per protocol – normal saline IV. Establish a 2nd IV line as time allows.

Paramedic
• 12-lead ECG trained to recognize ST segment elevation of ≥ 1 mm in 2 contiguous leads or confirmed interpretation of STEMI transmitted and reviewed by a physician, nurse practitioner or physician assistant
• ECG monitor interpretive statement infers “acute myocardial infarction” with signs & symptoms suspect of acute myocardial infarction including chest discomfort and symptoms listed above
• ACI-TIPI score of 75 or greater
• Clopidogrel (Plavix) 300 mg by mouth if transferring for PPCI after confirmation by PCI receiving facility and local medical control per protocol
• Establish a nitroglycerine IV drip (if appropriate) if chest discomfort is unrelieved. Delivered via pump only. Initiate @ 5 mcg/min & titrate in increments of 5 mcg/min to maintain a systolic BP of 100 mm/HG or greater. Hold nitrates as indicated
• Administer analgesia as needed for discomfort per protocol

*Based on Mission: Lifeline and the American Heart Association
ALL LEVELS

- If FMC to percutaneous coronary intervention (PCI) can be achieved in less than 90 minutes, arrange for ALS (air or ground) intercept and transport directly to PCI capable receiving hospital for primary PCI
- If FMC to PCI is greater than 90 minutes, transport to the closest appropriate non-PCI capable referring hospital for possible fibrinolytic therapy and urgent transfer to a PCI capable receiving facility for reperfusion
- Activate STEMI alert, transmit 12-lead ECG as able, provide report to receiving hospital

Diversion Criteria

If patient demonstrates instability and/or has any one of the following diversion criteria requiring ED evaluation by a practitioner proceed to closest appropriate hospital:
- Possible need of head CT or neurological intervention / confusion
- Emergent intubation immediate circulatory stabilization
- Chest trauma or MVC victims
- Consider DNR status
- Consider scoring with Sgarbossa criteria

Documentation Reminders

- Provide copy of eNARISIS report with verbal report to registered nurse or physician
- If STEMI/AMI alert is requested of the receiving hospital, document the time
- Provide a printed or electronic copy of pre-hospital 12-lead ECG with report to registered nurse or physician

Patient Care Goals

- Provide early identification of patients and early notification of the hospital for suspected AMI or STEMI
- Utilize an assessment tool that may reduce the time from onset of symptoms to receiving definitive cardiac interventions at the receiving hospital
- Prepare patient for immediate transport with indicated medications administered en route to hospital. Attempt to limit the scene time to the shortest time possible

American Heart Association Mission: Lifeline EMS Best Practice Goals

- All patients with non-traumatic chest discomfort, ≥ 35 years of age, treated and transported by EMS receive a pre-hospital 12-lead electrocardiogram
- All STEMI patients transported directly to a STEMI receiving center, receive a first (pre-hospital) medical contact to PCI time < 90 minutes directly or ≤ 120 minutes for interfacility hospital transfers
- All lytic eligible STEMI patients treated and transported to a referring hospital for fibrinolytic therapy receive a door to needle time ≤ 30 minutes

American Heart Association Mission: Lifeline EMS Reporting Measures

- Time from symptom onset to EMS dispatch
- Time from dispatch to EMS vehicle arrival at receiving or referring hospital door
- Number of suspected AMI/STEMI patients treated and transported by EMS who receive a 12-lead ECG
- Number of STEMI patients treated and transported to a referring hospital for potential reperfusion by fibrinolysis therapy who receive a fibrinolytic checklist screening en route to identify possible contraindications
- Number of STEMI patients who received a pre-hospital ECG, recognized STEMI, and called for a STEMI alert at the receiving or referring hospital prior to arrival

*Based on Mission: Lifeline and the American Heart Association
CHEST PAIN – DISCOMFORT (Revised 3/22/2018)

ALL LEVELS
- Routine assessment and care

EMR
- Consider OPQRST pneumonic for assessment of pain
- Administer Oxygen
  - Minor distress 2-6 LPM nasal cannula
  - Moderate to severe distress 10 – 15 LPM non-rebreather mask
- Consider ALS

EMR Options if Approved
- Consider 4 each 81mg (Total 324mg) Aspirin chewed and swallowed
- Initiate transport

EMT
- Consider oxygen and adjust delivery device and LPM flow to achieve 94 to 99% O2 saturation
- Consider 4 each 81mg (total 324mg) Aspirin chewed and swallowed
- Consider obtaining 12 lead EKG and transmit/handoff for interpretation
- Consider assisting patient with his/her own prescribed nitroglycerin
  - BP must be 110 systolic or greater
  - May repeat every 5 minutes to total of 3 doses as long as BP remains above 110 systolic
- Initiate transport

EMT Options if Approved
- Consider IV access

AEMT
- Consider 0.4mg Nitroglycerin SL
  - BP must be 110 systolic or greater
  - May repeat every 5 minutes to total of 3 doses as long as BP remains above 110 systolic
- Consider Morphine 2 – 4mg IV

EMT-I
- Initiate cardiac monitoring
- Manage dysrhythmia ** See Appropriate Protocol

Paramedic
- Consider 12 lead interpretation
- Consider 0.4 mg Nitroglycerin SL
  - May repeat as needed for continued chest pain if BP remains greater than 100 systolic
  - After 1st dose may consider Nitroglycerin in conjunction with pain management
- Consider pain management
- Consider anti-emetic
  - DO NOT USE Droperidol (Inapsine)
  - Avoid phenothiazine class anti-emetics unless no other option is available, then use with precaution in inferior wall AMI or right ventricular AMI as identified on 12 lead
Nebraska EMS Model Protocols
Adult Medical Protocols
CHEST PAIN – DISCOMFORT – ACUTE CORONARY SYNDROME (Revised 12/7/2012)

EMT – AEMT – EMT-I Actions
- Obtain 12 Lead ECG
- Transmit 12 Lead For Interpretation
- OR Present to ALS For Interpretation

Paramedic Actions
- Obtain 12 Lead ECG
- Review 12 Lead ECG For STEMI

Patient’s Presentation and 12 Lead ECG
Consistent with STEMI (See Below #1 & 2)
OR
ACI-TIPI Score of Greater Than 75

NO

Does The Patient Have Any of The Following?
- Contraindications to Thrombolysis
- Severe CHF
- Hypotension

NO

Follow Chest Pain-Discomfort Protocol
Patient Should Be Transport to Closest Appropriate Facility

YES

From the Time of Patient Contact
Can the Patient Be Move with ALS Care to a PCI Facility Within 120 Minutes

YES

Transport Patient to a Percutaneous Coronary Intervention Facility
See (See Below #3 & 4)

NO

Follow Appropriate Protocol
- Chest Pain-Discomfort
- Congestive Heart Failure
- Shock Protocol
Patient Should Be Transported to Closest Appropriate Facility

Additional Guide Lines

1. Acute Coronary Syndrome (ACS)
   - ACS is defined as patients presenting with angina or angina equivalents such as chest, epigastric, arm, or jaw pain and may be associated with diaphoresis, nausea and shortness of breath/difficulty breathing.

2. 12 Lead ECG Inclusion Criteria for STEMI
   - Anterior – Inferior – Lateral MI: With ST elevation greater than 1mm in two or more contiguous leads and QRS complex 0.12 or narrower
   - Posterior MI – ST depression greater than 1mm in V1 and V2 with an R/S ratio of greater than or equal to one AND QRS complex 0.12 or narrower
   - New Left Bundle Branch Block: if patient has in his/her possession a previous ECG with narrow QRS complex to demonstrate the current wide QRS complex is new onset

3. Notify PCI facility as soon as determination is made

4. If patient is to be flown: move patient to land zone/ staging area and manage until intercept

Page 40
CONGESTIVE HEART FAILURE (Revised 12/7/2012)

ALL LEVELS
- Routine assessment and care

EMR
- Administer Oxygen
  - Minor distress 2-6 LPM nasal cannula
  - Moderate to severe distress 10 – 15 LPM non-rebreather mask
- Consider assisted ventilations
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94 to 99% O2 saturation
- Initiate transport

EMT Options if Approved
- Consider IV access KVO/TKO rate
- Consider CPAP **See Chart Below for Indications and Contra-Indications

AEMT
- Consider 2.5mg Albuterol nebulizer treatment

EMT-I
- Initiate cardiac monitoring
- Consider EtCO2 monitoring
- Manage dysrhythmia ** See Appropriate Protocol
- Consider 0.4mg Nitroglycerin SL if systolic BP at least 100
- May consider one of the other nebulized bronchodilators

Paramedic
- Consider 12 lead interpretation
- Consider CPAP
- Consider minimal sedation with benzodiazepine class sedative
- Consider nitroglycerin **Must have Patent IV/IO Access
  - Systolic BP 180 and Greater
  - Systolic BP 140 to 180
  - Systolic BP 100 to 140
- Consider vasopressor agent for pulmonary edema and hypotension
- Consider RSI

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<td>Decreased /abnormal lung sounds</td>
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</tr>
<tr>
<td>Patient has signs of respiratory distress (not all must be present)</td>
<td>Upper airway partial obstructions (Croup-Epiglottis-Upper Airway Edema-Partial FBAO)</td>
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  - Able to speak only short phrases | Shortness of breath-difficulty breathing with a suspected/known cause of |
  - Retractions                      |  - Pneumothorax                                        |
  - Tripod positioning               |  - Trauma                                              |
| Known or suspected cause of respiratory distress of |  - Respiratory infection without pulmonary edema       |
  - Pulmonary edema – congestive heart failure | Facial deformities in which a mask seal cannot be obtained |
  - Exacerbation of COPD            |                                                        |
  - Exacerbations of asthma not relieved with bronchodilator medication |                                                        |
CPR INDUCED CONSCIOUSNESS SEDATION PROTOCOL (Revised 8/11/16)

ALL LEVELS
- Routine assessment and care
- Assess for signs of consciousness: Spontaneous eye opening, purposeful movement, verbal response to include moaning

EMR, EMT, AEMT
- Continue CPR
- If tiering is available, requires ALS intercept

Paramedic
- Administer Ketamine bolus
  + IV: 0.5-1.0 mg/kg
  + IM: 2-3 mg/kg
- Consider co-administration of midazolam bolus*
  + IV: 1 mg
  + IM: 2 mg
- May repeat Ketamine bolus after 5-10 minutes if needed for continued sedation or if needed for continued sedation start infusion
  + IV bolus dose: 0.5-1.0 mg/kg OR IM: 2-3 mg/kg
  + IV infusion dose: 2-7 mcg/kg/minute

*Co-administration of benzodiazepines with ketamine has been suggested to decrease myocardial oxygen demand
ALL LEVELS
- Routine assessment and care
- Consider 0.4 to 4mg Naloxone
  - IM Auto-Injector/MAD for suspected or known narcotic overdose; or
  - IV/IM/MAD for AEMT and above

EMR
- Consider oral airway and assisted ventilations
- Administer oxygen
- Consider 12 Lead ECG acquisition and transmission
- Utilize a non-invasive stroke scale
- Obtain onset time
- Assess for medical or traumatic cause and utilize additional protocols as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decreased mental status
- Consider IV access
- obtain blood glucose reading – if abnormal go to appropriate protocol

AEMT
- Consider 0.4 to 4mg Naloxone IV/IM/MAD

EMT-I
- Consider intubation for persistent decreased mental status
- Initiate cardiac monitoring

Paramedic
- Consider RSI
ALL LEVELS
- Routine assessment and care

EMR
- Administer oxygen by blow by or non-rebreather mask humidified if possible
- Calm patient
- Allow patient to assume a position where he/she can maintain own airway
- If patient loses airway attempt BVM ventilations
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved and AEMT
- Defer attempts at advanced airway
- Defer IV unless patient loses airway

EMT-I
- Initiate cardiac monitoring

Paramedic
- Consider cricothyroidotomy
HYPOGLYCEMIA – INSULIN SHOCK (Revised 12/27/2017)

ALL LEVELS
- Routine assessment and care

EMR
- Assess for stroke
- Assess for signs and symptoms of hypoglycemia
- If no trauma position patient to protect airway
- Consider oxygen
- IF PATIENT CAN FOLLOW SIMPLE COMMANDS AND PROTECT OWN AIRWAY
  - Consider having patient drink juice, non-diet pop or milk
  - Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94 % or better O2 saturation
- IF PATIENT CAN FOLLOW SIMPLE COMMANDS AND PROTECT OWN AIRWAY
  - Consider 15 grams oral glucose gel or tablets
  - Initiate transport

EMT Options if Approved
- Obtain blood glucose reading
- Consider IV access
- Consider advanced airway for persistent decrease mental status

AEMT
- Consider IO access when:
  - Blood glucose level indicates hypoglycemia
  - AND patient’s mental status is decreased to point where patient cannot maintain an airway
  - AND IV access cannot be obtained
- Consider
  - 12.5 to 25 grams Dextrose 10-50% IV or IO
  - 125-250 ml 10% Dextrose or 100-200 ml of 12.5% Dextrose or 50-100ml of 25% Dextrose or 25-50ml of 50% Dextrose
- RECHECK BLOOD GLUCOSE LEVEL EVERY 15 MINUTES
- ALTERNATE Treatments
  - IF PATIENT CAN FOLLOW SIMPLE COMMANDS AND PROTECT OWN AIRWAY
    - Consider Mixing 12.5 to 25 Grams Dextrose 50% in juice and have patient drink
  - Defer IO and IV and Administer 1mg Glucagon IM or MAD
    - If Glucagon fails to resolve hypoglycemia
    - IF PATIENT CAN FOLLOW SIMPLE COMMANDS AND PROTECT OWN AIRWAY
      - Consider Mixing 12.5 to 25 Grams Dextrose 50% in juice and have patient drink
    - OR Consider IV Access and 12.5 to 50 Grams Dextrose 50% IV 10-50% IV or IO (125-250 ml 10% Dextrose or 50-100ml of 25% Dextrose or 25-50ml of 50% Dextrose)

EMT-I
- Consider intubation for persistent decrease mental status after treatment with dextrose or glucagon
  - Assess for other causes of decreased mental status
  - Consider cardiac monitoring

Paramedic
- Consider 100mg Thiamine prior to Dextrose 50% when patient appears malnourished or chronic alcohol abuse
ALL LEVELS
- Routine assessment and care

EMR
- Consider Oxygen
- Assess for stroke
- Assess for signs and symptoms of hyperglycemia
- If no trauma position patient to protect airway
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Obtain blood glucose reading
- Consider IV access
- Consider fluid bolus
  - Signs and symptoms indicate dehydration
  - OR glucometer indicates ketones
- Consider advanced airway for persistent decrease mental status

AEMT
- Consider IO access when
  - IV access cannot be obtained
    - AND
  - blood glucose reading is 400 or more

EMT-I
- Consider cardiac monitoring
- Consider intubation for persistent decrease mental status

Paramedic
- Assess for DKA and Hyperosmolar Non-Ketotic Coma (Syndrome)
GI HEMORRHAGE (Revised 3/22/2018)

ALL LEVELS
- Routine assessment and care

EMR
- Consider Oxygen
- Consider OPQRST pneumonic for assessment of pain complaints
- Assess-question patient on nausea/vomiting and bowel/stools
- Monitor for shock
- Be prepared for suctioning
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved and AEMT
- Consider advanced airway for persistent decrease mental status
- Consider IV access

AEMT
- Consider IO access for profound shock and IV access cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
- Consider cardiac monitoring
- Consider NG or OG tube for upper GI hemorrhage

Paramedic
ALL LEVELS
- Routine assessment and care

EMR
- Consider Oxygen
- Consider OPQRST pneumonic for assessment of pain
- Assess cause of headache (stroke, trauma, etc.)
- Monitor for shock
- Be prepared for suctioning
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider IV access for severe headache associated with
  - Nausea and vomiting
  - Changes in mental status

EMT-I
- Consider cardiac monitoring

Paramedic
- Consider pain management after paramedic level neuro assessment
ALL LEVELS
- Routine assessment and care

EMR
- Consider Oxygen
- Consider OPQRST pneumonic for assessment of pain
- Assess for cause
- Assess for dehydration
- Be prepared for suctioning
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Examine if possible
  - Emesis for frank blood or coffee ground type emesis **See GI Hemorrhage Protocol**
  - Stools for frank blood or tarry foul smelling stools **See GI Hemorrhage Protocol**
- Initiate transport

EMT Options if Approved
- Consider IV access
- Consider 250 to 500 ml fluid Bolus(es)

EMT-I
- Consider cardiac monitoring

Paramedic
- Consider antiemetic
ALL LEVELS
- Routine assessment and care

EMR
- Consider Oxygen
- Consider OPQRST pneumonic for assessment of pain complaints
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider IV access

AEMT
- Consider IO access if IV cannot be obtained
- Consider 2-4 mg Morphine may repeat to total 10mg

EMT-I
- Consider cardiac monitoring

Paramedic
- Consider pain management
ALL LEVELS
- Routine assessment and care

EMR
- Consider Oxygen by non-rebreather mask or blow by – humidified if possible
- Position patient
  o Sitting upright
  o Head in neutral position
  o Avoid head tilt position
  o If upright not possible consider lateral position
- Pinch nares together
- Direction to patient
  o Spit blood/clot out
  o Try not to swallow blood
  o Do not rub – blow nose or sniff
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider IV access for sign and symptoms of shock
- Consider fluid bolus(es)

AEMT
- Consider IO access for signs and symptoms of shock AND if IV cannot be obtained

EMT-I
- Consider cardiac monitoring
ALL LEVELS
- Routine assessment and care

EMR
- Open airway
  - Trauma suspected use jaw thrust method
  - Non-traumatic use head tilt-chin lift method
- Consider oral airway
- Begin ventilations at 10-12 times a minute with bag-valve-mask or mouth to mask device attached to oxygen
- Suction as needed
- Verify pulse present
- Consider cause use additional protocols if needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Monitor Oxygen saturation adjust ventilation/minute to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider advanced airway
- Consider IV access
- Obtain blood glucose reading

AEMT
- Consider IO access if IV cannot be obtained
- Consider cause use additional protocols if needed

EMT-I
- Consider intubation for persistent decrease mental status
- Utilize EtCO2 monitoring
- Initiate cardiac monitoring
- Consider cause use additional protocols if needed

Paramedic
- Consider cause use additional protocols if needed
RESPIRATORY DISTRESS – ASTHMA (Revised 7/7/2016)

ALL LEVELS
- Routine assessment and care

EMR
- Administer Oxygen
- Consider assisted ventilations
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Administer oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Consider assisting patient with his/her prescribed metered dose inhaler
  - Administer prescribed number of puffs repeat two times every 5-10 minutes if distress continues
  - Consult medical control, PMD, or patient’s physician for additional doses
- Consider assisting patient with his/her prescribed epinephrine auto-injector for Status Asthmaticus
  - Consult medical control, PMD, or patient’s physician for additional doses
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider 2.5mg in 3 ml Albuterol nebulizer treatment repeat two times if symptoms do not improve or patient’s condition deteriorates
- Consider CPAP with inline 2.5 mg in 3 ml albuterol nebulizer treatment **see chart on next page for indications and contra-indications
- If Albuterol nebulizer treatments fail to improve distress
  - Consider 0.3mg (adult) Epinephrine auto-injector for Status Asthmaticus* (See Below)
- Consider IV access

AEMT
- Consider IO access if IV cannot be obtained
- If Albuterol nebulizer treatments fail to improve distress
  - Consider 0.3 to 0.5mg Epinephrine 1:1000 IM for Status Asthmaticus* (See Below)

EMT-I
- Consider intubation for persistent decrease mental status
  - Consider ventilating in a nebulized bronchodilator
- Consider etco2 monitoring
- Consider bronchodilator
- Consider cardiac monitoring
- Consider 125 -250mg Methylprednisolone IV/IO

Paramedic
- If first line pharmaceutical interventions have minimal or no effect
  - Consider 1 to 2 grams Magnesium Sulfate infused over 10 minutes
  - OR consider 0.5 to 0.75 ml of a 2.5% Racemic Epinephrine nebulizer treatment
  - OR consider 3 to 5 mls 1mg/ml (1:1000) Epinephrine nebulizer treatment
  - OR consider CPAP with inline nebulized bronchodilator
- Consider RSI
  - Consider ventilating in a nebulized bronchodilator

* Status Asthmaticus means sustained asthma not relieved by Oxygen, meter dose inhaler, or nebulizer treatment
RESPIRATORY DISTRESS – EXACERBATION OF COPD (Revised 12/7/2012)

ALL LEVELS
- Routine assessment and care

EMR
- Administer Oxygen
- Consider assisted ventilations
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better o2 saturation
- Consider assisting patient with his/her prescribed metered dose inhaler
  - Administer prescribed number of puffs repeat two times every 5-10 minutes if distress continues
  - Consult medical control, PMD, or patient’s physician for additional doses
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider 2.5mg in 3 ml Albuterol nebulizer treatment repeat two times if symptoms do not improve OR patient’s condition deteriorates
- Consider IV access
- Consider CPAP with inline 2.5 mg in 3 ml albuterol nebulizer treatment **see chart below for indications and indications and contra-indications

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
  - Consider ventilating in a nebulized bronchodilator
- Consider bronchodilator
- Initiate cardiac monitoring
- Consider EtCO2 monitoring

Paramedic
- Consider CPAP with inline nebulized bronchodilator
  - Consider minimal sedation
- Consider RSI
  - Consider ventilating in a nebulized bronchodilator

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RESPIRATORY DISTRESS – SPONTANEOUS PNEUMOTHORAX (Revised 12/7/2012)

ALL LEVELS
- Routine assessment and care

EMR
- Administer Oxygen
- Consider assisted ventilations
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider needle decompression for signs and symptoms of tension pneumothorax
- Initiate cardiac monitoring

Paramedic
- Consider RSI
RESPIRATORY INFECTIONS (Revised 12/7/2012)

ALL LEVELS
- Routine assessment and care

EMR
- Administer Oxygen
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider obtaining a body temperature
- Consider administering Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Consider assisting patient with his/her prescribed metered dose inhaler for signs and symptoms of distress
  - Administer prescribed number of puffs repeat two times every 5-10 minutes if distress continues
  - Consult medical control, PMD, or patient’s physician for additional doses
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider 2.5mg in 3 ml Albuterol nebulizer treatment for signs and symptoms of distress
  - May repeat two times if symptoms do not improve OR patient’s condition deteriorates
- Consider IV access

AEMT
- Consider IO access
  - If IV cannot be obtained, or;
  - If patient in respiratory distress

EMT-I
- Consider intubation for persistent decrease mental status
  - Consider ventilating in a nebulized bronchodilator
- Consider bronchodilator for respiratory distress
- Consider cardiac monitoring
- Consider EtCO2 Monitoring
- Consider 125 – 250mg Methylprednisolone

Paramedic
- Consider RSI
  - Consider ventilating in a nebulized bronchodilator
ALL LEVELS
- Routine assessment and care

EMR
- Consider Oxygen
- Do not use same limb for BP measurement as active dialysis shunt
- Hemorrhage from shunt puncture site
  - Use direct pressure and pressure bandage
  - As last resort use a tourniquet
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access – DO NOT ATTEMPT TO ACCESS SHUNT
  - Limit fluid administration rate

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
- Initiate cardiac monitoring

Paramedic
- Consider 12 lead
- Evaluate 12 lead for tall spiked T waves indicating hyperkalemia
  - Consider calcium gluconate or calcium chloride
  - Consider continuous albuterol nebulizer treatments to total dose of 15 mg
- Consider 100mg Thiamine for signs and symptoms of Wernicke’s Syndrome
ALL LEVELS

- Routine assessment and care

EMR

- Active seizure
  - Administer Oxygen (blow by acceptable during seizure)
  - Protect patient – pads around patient
  - Do not restrain patient
  - Do not insert anything orally
- Postictal period
  - Consider Oxygen
  - Consider assisted ventilations and oral airway for persistent decreased mental status
  - Suction as needed
- Assess for trauma and stroke
- Consider ALS

EMR Options if Approved

- Initiate transport

EMT

- Consider nasal airway for persistent decreased mental status
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved

- Consider advanced airway for persistent decrease mental status
- Consider obtaining blood glucose
- Consider IV access

AEMT

- Consider IO access
  - If IV cannot be obtained, or;
  - If seizures reoccur

EMT-I

- Consider cardiac monitoring
- Consider 2 – 4mg Diazepam IV/IO
  - Repeat if needed to maximum of 10mg
  - Contact medical control for additional doses
- Consider intubation for persistent decrease mental status

Paramedic

- Consider benzodiazepine for repeat or continued seizures
TOXINS – AUTO INJECTOR ANTIDOTE KITS (Revised 12/7/2012)

NERVE AGENT – ORGANOPHOSPHATE EXPOSURE

ALL LEVELS
- Routine assessment and care

EMR and EMT and AEMT
- May administer auto injector antidote kits to a fellow responder or patients in mass numbers when higher level out-of-hospital care providers are overwhelmed.

The EMT-I and Paramedic
- May administer the auto injector antidote kits

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<th>Moderate Symptoms</th>
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<td>Cyanosis</td>
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<th>Do Not Delay Administer</th>
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<tr>
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</table>

- One Each – Atropine and Pralidoxime (Mark I) OR
- One – Atropine/Pralidoxime (DouDote)
- Two Each – Atropine and Pralidoxime(Mark I) OR
- Two – Atropine/Pralidoxime (DouDote)
- Three Each – Atropine and Pralidoxime (Mark I) OR
- Three – Atropine/Pralidoxime (DouDote)
ALL LEVELS
- Routine assessment and care

EMR
- Assess for trauma
- Administer high flow Oxygen
- Consider assisted ventilations
- Consider oral airway
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider nasal airway
- Assess CO level by non-invasive monitor
  - If elevated administer high flow Oxygen
  - If within normal values administer oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- If non-invasive CO monitoring not available
  - Administer high flow Oxygen
- Consider assisting patient with his/her prescribed metered dose inhaler
  - Administer prescribed number of puffs repeat
    - May repeat in 10 minutes if distress continues
    - Total repeat doses is two
  - Consult medical control, PMD, or patient's physician for additional doses
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider 2.5mg in 3 ml Albuterol nebulizer treatment
  - May repeat two times if symptoms do not improve OR patient's condition deteriorates
- Consider IV access

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
  - Consider ventilating in a nebulized bronchodilator
- Consider nebulized bronchodilator
- Initiate cardiac monitoring
- Consider EtCO2 monitoring

Paramedic
- Consider RSI
  - Consider ventilating in a nebulized bronchodilator
ALL LEVELS
- Routine Assessment and Care

EMR
- Consider Oxygen
- Consider Assisted Ventilations
- Consider Oral Airway
- Obtain Name of Medication/Drug
  - See Next Page for Additional Information
- Consider ALS

EMR Options if Approved
- Initiate Transport

EMT
- Consider Nasal Airway
- Consider Administer Oxygen and Adjust Delivery Device and LPM Flow to Achieve 94% or Better O2 Saturation
- Consider Contacting Destination Facility Via Radio/Phone With Name of Medication/Drug
- Consider Contacting Poison Control
- Initiate Transport

EMT Options if Approved
- Consider Advanced Airway for Persistent Decrease Mental Status
- Consider IV Access

AEMT
- Consider IO Access If IV Can Not Be Obtained

EMT-I
- Consider Intubation for Persistent Decrease Mental Status
- Consider Cardiac Monitoring

SPECIAL INSTRUCTIONS FOR SPECIFIC TOXINS (Revised 7/7/2016)

IF LEVEL NOT LISTED USE THE TOXIN – OVERDOSE PROTOCOL ABOVE

STIMULANTS – COCAINE – METHAMPHETAMINE – ECSTASY

EMR-EMT
- Obtain Temperature
- If temperature is over 102°F and infection not suspected consider passive cooling

EMT Options if Approved and AEMT
- Consider Fluid Boluses For Elevated Temps and Signs and Symptoms of Dehydration

EMT-I
- For Patients That Present Awake, Alert with Severe Anxiousness/Anxiety and/or Hallucinations
  - Consider 2 – 4mg Diazepam IV/IO

Paramedic
- For Patients That Present Awake, Alert with Severe Anxiousness/anxiety and/or Hallucinations
  - Consider Benzodiazepine
NARCOTICS – OPIATES – BARBITUATES

ALL LEVELS
- Routine Assessment and Care

EMR-EMT
- Consider 0.4 to 4mg Naloxone IM Auto-Injector/MAD for suspected or known narcotic overdose, or IM/IV/IO/MAD for AEMT and above
  - If symptoms of narcotic overdose reoccur after initial response to Naloxone, re-administer dose

EMT
- Consider 12 Lead ECG acquisition and transmission

AEMT
- Consider Advanced Airway If Naloxone Fails to Improve Respiratory Status

EMT-I and Paramedic
- Consider Intubation If Naloxone Fails to Improve Respiratory Status

TRICYCLIC ANTIDEPRESSANT

ALL LEVELS
- Routine Assessment and Care

Paramedic
- For Patients That Present or Develop Decreased Mental Status, Hypotension and Widen QRS
  - Consider 50mEq 8.4% Sodium Bicarbonate
  - Consider Vasopressor Agent

CALCIUM CHANNEL BLOCKER

ALL LEVELS
- Routine Assessment and Care

Paramedic
- For Known Calcium Channel Blocker Overdose and Patients That Present or Develop Decreased Mental Status, and Hypotension
  - Consider 5ml of 10% Calcium Chloride IV/IO Over 2-5 Minutes
  - OR 15ml of 10% Calcium Gluconate IV/IO Over 2-5 Minutes
  - Consider Vasopressor Agent
- **Avoid Calcium Chloride and Calcium Gluconate when Calcium Channel Blocker Overdose Can NOT be Confirmed OR in Mixed Overdose Situations**
ALL LEVELS
- Routine assessment and care
- Call for special resources to remove patient from hot zone if needed

EMR
- Consider Oxygen
- Decontaminate patient if needed – call for special HAZMAT if needed
  - Dry chemicals brush then flush from skin
  - Wet chemical flush with water
- Obtain name of toxin and route(s) of exposure
- Unless directed by medical control or poison control do not induce/encourage vomiting
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider contacting destination facility via radio/phone with name of toxin
- Consider contacting poison control
- Initiate transport

EMT Options if Approved
- Consider IV access
- Consider advanced airway for persistent decrease mental status

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider cardiac monitoring
- Consider intubation for persistent decrease mental status

SPECIAL INSTRUCTIONS FOR SPECIFIC POISONS (Revised 12/7/2012)

ORGANOPHOSPHATES

EMR – EMT – AEMT
- See above

EMT-I
- Consider Atropine 1mg IV/IO repeat until symptoms improve

Paramedic
- Consider 600mg to 1200mg Pralidoxime over 5 minutes IV/IO or infusion over 15 – 30 minutes

CYANIDE POISONING

EMR-EMT-AEMT-EMT-I
- See above

Paramedic
- Consider 5g Hydroxocobalamin in 200mL NS (recommended), LR or D5 over 15 minutes
SHOCK (Revised 4/13/2015)

ALL LEVELS
- Routine assessment and care

EMR
- Administer Oxygen
- Consider assisted ventilations
- Consider oral airway
- Assess for trauma
  - Control external hemorrhage
  - Manually stabilize c-spine and extremity deformities
- Assess for dehydration
- Assess for potential of allergic reaction **go to Allergic reaction anaphylaxis protocol
- Position supine unless respiratory status does not allow for this
- Conserve body heat
- Consider ALS

EMR Options if Approved
- If trauma present
  - Consider spinal stabilization and extremity stabilization
- Initiate transport

EMT
- Consider nasal airway
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Obtain temperature and if fever present in absence of trauma consider dehydration/sepsis
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access
- Consider fluid boluses 250ml to 500ml then reassess

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
- Initiate cardiac monitoring
- Assess for potential of cardiogenic shock

Paramedic
- Assess for type of shock
- General considerations for shock
  - When considering anti-emetic choose an agent with the least cardiac effects
  - When considering pain management choose an agent with least effect on BP
- Shock types and considerations

<table>
<thead>
<tr>
<th>Hypovolemic</th>
<th>Cardiogenic</th>
<th>Obstructive Shock</th>
<th>Distributive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider 250 to 500ml fluid boluses with frequent reassessments</td>
<td>Consider fluid bolus</td>
<td>Assess for tension pneumothorax – treat with needle decompression</td>
<td>Anaphylaxis – go to allergic reaction anaphylaxis protocol</td>
</tr>
<tr>
<td>Consider 250 to 500ml fluid boluses with frequent reassessments</td>
<td>Consider vasopressor agent Manage dysrhythmias</td>
<td>Assess for cardiac tamponade – alert destination facility</td>
<td>Neurogenic (spine) shock – fluid boluses</td>
</tr>
<tr>
<td>Consider 250 to 500ml fluid boluses with frequent reassessments</td>
<td>Consider fluid boluses</td>
<td></td>
<td>Sepsis</td>
</tr>
<tr>
<td></td>
<td>Consider vasopressor agents</td>
<td></td>
<td>o Consider fluid boluses</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>o Consider vasopressor agents</td>
</tr>
</tbody>
</table>
The goal of the TRAUMA SYSTEM is to get the injured patient to the most appropriate facility by the most appropriate means in a timely manner. EMS should consult with Medical Control/Local Hospital if any patient meets trauma system guidelines so the patient is transported to the most appropriate facility. In some cases the patient may bypass a local hospital or stop only to be stabilized by the local hospital then transferred on to a regional trauma center.

The Nebraska Trauma System is divided into geographic regions each with its own regional advisory board. Each region and specifically designate trauma centers may have additional trauma system activation guidelines. This protocol presents a general overview for the OOHECP.

**GENERAL TRAUMA SYSTEM (TRAUMA TEAM) GUIDELINES:**

1. Considerations for trauma system activation
   - Vitals and LOC
     - Adult heart rate >130
     - Adult systolic BP <85
     - Adult respiratory rate <10 or >29
     - **see Pediatric vital signs and ventilation guidelines**
     - Altered mental status
   - Anatomy of injury
     - Penetrating trauma to head, neck, torso, groin
     - Combinations of burns >20% or face/airway burns
     - Amputation at or above wrist/ankle
     - Spinal cord injury
     - Flail chest
     - Two or more proximal long bone injuries
   - Biomechanics of injury
     - Ejected from vehicle
     - Auto vs. Pedestrian/bicycle >5 mph
     - Motorcycle/ ATV crash
     - Pedestrian thrown or run over
   - Other risk factors
     - Provider impression of unstable patient
     - Extreme(s)
     - Age (<2 >60)
     - Environment (heat/cold)
     - Health/illness (pregnancy, COPD, CHF, Diabetes)
     - Exposure to hazardous materials
   - High energy transfer
     - Rollover
     - Fall >10 feet
     - Extrications > 20 minutes
   - Burn injury
     - 2nd and 3rd degree burns of face, hands, feet, perineum
     - Significant electrical burns
     - Inhalation injury

2. Procedure:
   - Consult with medical control and/or local hospital
   - Request trauma system (trauma team) activation
   - Call for ALS intercept – if available
### Nebraska EMS Model Protocols

**Adult Trauma Protocols**

**TRAUMA CARE HEAD – CHEST – ABDOMEN (Revised 3/22/2018)**

#### ALL LEVELS
- Adult routine assessment and care
- Assess for shock and treat

<table>
<thead>
<tr>
<th>Head/Neck/Spine</th>
<th>Chest</th>
<th>Abdomen</th>
</tr>
</thead>
</table>
| **EMR** | Administer Oxygen  
Consider assisted ventilations  
Consider oral airway  
Consider OPQRST pneumonic for assessment of pain  
Suction as needed  
Manually stabilize head and neck  
Control external bleeding  
Stabilize impaled objects in place  
Assess CMS  
Consider trauma team – trauma system activation  
May Control external bleeding with the use of hemostatic agents with Physician Medical Director approval and direction. | Open trauma  
- *bandage open wounds  
- *consider occlusive dressing for open neck wounds | Open chest trauma – sucking chest wound  
- *seal wound with occlusive dressing  
Closed chest trauma  
- *consider stabilizing fail sections with bulky dressings | Open abdominal trauma – eviscerations  
- *do not attempt to replace contents  
- *place contents on top of abdomen  
- *cover with thick moist dressing  
Closed abdominal trauma  
- *attempt to localize pain to an abdominal region/quadrant |

| EMR Options | Consider Spinal Stabilization  
Consider Extremity Stabilization  
Initiate Transport |
|---------------|--------------------------------|
| **EMT** | Consider oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation  
For signs and symptoms of ICP and GCS of 6 and under – consider hyperventilation of patient  
Initiate transport  
Consider advanced airway for persistent decrease mental status  
Consider IV access  
Assess for shock and administer appropriate fluid boluses |
| **EMT Options** | Consider IO access as first access route in unstable pediatric patients  
Assess for shock and administer appropriate fluid boluses  
Consider Morphine 2 – 4 mg IV/IO/MAD |
| **AEMT** | *Consider Cardiac Monitoring  
*Initiate Cardiac Monitoring  
*needle decompress patient with sign and symptoms of tension pneumothorax  
*Consider Cardiac Monitoring |
| **EMT-I** | *Consider Cardiac Monitoring |

**Paramedic**

- Consider RSI  
- Consider Pain Management  
- Defer insertion of NG tube – use OG tube in suspected head injury  
- Defer insertion of NG AND OG tube in any patients with gastric bypass or gastric banding  
- Consider 100 mg Thiamine IV/IO for patients with gastric bypass or gastric banding

*special consideration for extremity injuries in multi-systems trauma*

- Consider utilizing a full body stabilization device and splint injured extremities to the device and/or patient to allow for rapid scene time and then splint extremities en route to destination  
- Stabilization of suspected pelvic and femur fractures is a high priority
### AMPUTATIONS – EXTREMITY – SOFT TISSUE TRAUMA (Revised 3/22/2018)

**ALL LEVELS**
- Adult routine assessment and care
- Assess for shock and treat

<table>
<thead>
<tr>
<th>Amputations</th>
<th>Extremity</th>
<th>Soft Tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer Oxygen</td>
<td><em>Manually stabilize painful and/or deformed extremity</em></td>
<td><em>Return Avulsion type flaps to anatomic position if possible.</em></td>
</tr>
<tr>
<td>Consider assisted ventilations</td>
<td><em>Apply cold pack to extremity</em></td>
<td><em>Bandage open wounds</em></td>
</tr>
<tr>
<td>Consider oral airway</td>
<td><em>Manually stabilize head and neck</em></td>
<td>Consider removing impaled objects through the cheek into the mouth</td>
</tr>
<tr>
<td>Consider OPQRST pneumonic for assessment of pain</td>
<td><em>Consider traction type splint for femur injuries</em></td>
<td><em>For eye injuries – cover both eyes</em></td>
</tr>
<tr>
<td>Suction as needed</td>
<td><em>Consider pelvic splint for pelvic injuries</em></td>
<td></td>
</tr>
<tr>
<td>Manually stabilize head and neck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control external bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stabilize impaled objects in place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess CMS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consider trauma team activation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMR**
- May control external bleeding with the use of hemostatic agents with Physician Medical Director approval and direction

<table>
<thead>
<tr>
<th>EMR Options</th>
<th>Extremity</th>
<th>Soft Tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider spinal stabilization</td>
<td><em>Consider traction type splint for femur injuries</em></td>
<td></td>
</tr>
<tr>
<td>Consider extremity stabilization</td>
<td><em>Consider pelvic splint for pelvic injuries</em></td>
<td></td>
</tr>
<tr>
<td>Initiate transport</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMT**
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation

**EMT Options**
- Consider advanced airway for persistent decrease mental status
- Consider IV access
- Assess for shock and administer appropriate fluid boluses

**AEMT**
- Consider IO access as first access route in unstable pediatric patients
- Assess for shock and administer appropriate fluid boluses
- Consider Morphine 2 – 4 mg IV/IO/MAD

**EMT-I**
- *Consider Cardiac Monitoring*
- *Consider Cardiac Monitoring*
- *Consider Cardiac Monitoring*

**Paramedic**
- Consider RSI
- Consider pain management
- Consider reduction of deformed fractures or dislocations only if there is loss of signs of circulation, loss of sensation distal to the deformity, OR if it is necessary in order to otherwise care for and transport the patient
- For stable patient’s consider on-scene pain management to ease pain of movement/splinting
- Defer insertion of NG and OG tube in any patient with gastric bypass or gastric banding
- Consider 100 mg thiamine IV/IO for patients with gastric bypass or gastric banding

*Special consideration for extremity injuries in multi-systems trauma*
- Consider utilizing a full body stabilization device and splint injured extremities to the device and/or patient to allow for rapid scene time and then splint extremities in route to destination
- Stabilization of suspected pelvic and femur fractures is a high priority
ALL LEVELS
- See adult assessment model
- See general management of the trauma patient appropriate to level of provider
- EMT and EMR specific assessment and care
  - Obtain GCS score
  - Consider OPQRST pneumonic
- Assess for location, type and duration of pain
- Assess circulation sensation and movement in extremities
  - Manually stabilize head/neck
  - Control external bleeding
    - Control external bleeding with direct pressure, pressure bandage, pressure points and/or tourniquet
    - May control external bleeding with the use of hemostatic agents with physician medical director approval and direction.
  - Stabilize impaled objects
  - Reassess circulation sensation and movement distal to injury
  - For inadequate breathing ventilate patient at 10 to 12 times a minute
- Avoid hyperventilating patient unless patient has:
  - GCS of eye opening 1 – verbal 2 or less – motor 2 or less, AND;
  - Serial increases in BP, AND;
  - Serial decreases in pulse, AND;
  - Erratic respiratory pattern
- Prepare for transport
- If BLS service, consider ALS

EMR Options if Approved
- Consider spinal stabilization

EMT, AEMT, EMT-I, and Paramedic
- Consider spinal stabilization

Appropriate patients to be stabilized with a backboard may include those with:
- Blunt trauma and altered level of consciousness
- Spinal pain or tenderness
- Neurologic complain (e.g., numbness or motor weakness)
- Anatomic deformity of the spine
- High-energy mechanism of injury and any of the following:
  - Suspected drug or alcohol intoxication
  - Inability to communicate
  - Distracting injury

Patients for whom stabilization on a backboard is not necessary include those with all of the following:
- Normal level of consciousness (Glasgow Coma Score [GCS] 15)
- No spine tenderness or anatomic abnormality
- No neurologic findings or complaints
- No distracting injury
- No suspected drug or alcohol intoxication

Patients with penetrating trauma to the head, neck, or torso and no evidence of spinal injury should not be stabilized on a backboard.
If extrication is required from a vehicle:
- After placing a cervical collar, if indicated, children in a booster seat and adults should be allowed to self-extricate.
- For infants already strapped in a car seat with built-in harness, extricate the child while strapped in his/her car seat.

Spinal precautions can be maintained by application of a rigid cervical collar and securing the patient firmly to the EMS stretcher, and may be most appropriate for:
- Patients who are found to be ambulatory at the scene
- Patients who must be transported for a protracted time, particularly prior to inter-facility transfer
- Patients for whom a backboard is not otherwise indicated

Whether or not a backboard is used, attention to spinal precautions among at-risk patients is paramount. These include application of a cervical collar, adequate security to a stretcher, minimal movement/transfers, and maintenance of in-line stabilization during any necessary movement/transfers.

In situations when utilization of a backboard is indicated:
- Assess circulation sensation and movement distal in extremities
- Select appropriate sized cervical collar and place on patient
- Select and apply spinal stabilization device
- Reassess circulation sensation and movement distal in extremities
  - Consider extremity stabilization
ALL LEVELS
- Routine assessment and care
- Assess for shock and treat

EMR
- Consider Oxygen
- Consider OPQRST for assessment of pain
- Control any external bleeding
- Consider manual stabilization of affected extremity
- Human bites and animal bites
  - Bandage wound
- Snake bite
  - Attempt to identify breed of snake
  - Slow venous return
- Insect bites
  - Remove stinger/venom sac
- Spider bites
  - Consider cold pack
- Assess for allergic reaction go to allergic reaction – **See Anaphylaxis Protocol**
- Consider ALS

EMR Options if Approved
- Consider extremity stabilization
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider IV access
  - **Minor bites without associated sign and symptoms, IV should be deferred**

AEMT
- Consider IV access for pain management
- Consider IO access if IV cannot be obtained
- Consider 2 – 4mg Morphine IV/IO

EMT-I
- Consider cardiac monitoring

Paramedic
- Consider pain management
ALL LEVELS
- Routine assessment and care
- Assess for shock and treat

### Burn Type and Treatment Chart

<table>
<thead>
<tr>
<th>Thermal Burns</th>
<th>Electrical Burns</th>
<th>Radiation Burns</th>
<th>Chemical Burns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>THINK SAFETY</strong> Remember scene safety and appropriate PPE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop burning process</td>
<td>Verify the electrical source is de-energized</td>
<td>Patient and radiation source need to be separated</td>
<td>Brush dry chemicals from skin – flush with water</td>
</tr>
<tr>
<td>Do Not Apply Any Ointments or Creams</td>
<td>Assess for entrance and exit wounds</td>
<td>Decontaminate patient prior to transport</td>
<td>Wet chemicals flush with water</td>
</tr>
<tr>
<td>Do not intentionally rupture blisters</td>
<td>Decontaminate patient prior to transport</td>
<td>Decontaminate patient prior to transport</td>
<td></td>
</tr>
<tr>
<td>Cover burns/wounds with dry dressings</td>
<td>Wrap patient with dry sheet</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### EMR
- Administer Oxygen
- Consider assisted ventilations
- Consider oral airway
- Consider OPQRST for assessment of pain
- Consider manually stabilize head/neck
- Estimate body surface area burned and extend of burn
- Consider trauma system activation
- Consider ALS

### EMR Options if Approved
- Consider spinal stabilization
- Consider extremity stabilization
- Initiate transport

### EMT
- Defer nasal airway in facial burns and inhalation of super-heated air
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

### EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access

### AEMT
- Consider IO access if IV cannot be obtained
- Consider 2 – 4mg Morphine IV/IO

### EMT-I
- Consider intubation for persistent decrease mental status
- Initiate cardiac monitor for all electrical burns – consider for all other burns

### Paramedic
- Consider RSI for burns to airway – inhaled superheated gases – inhaled chemicals
- Consider pain management

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Nebraska EMS Model Protocols
Adult Trauma Protocols
BURNS (Revised 3/22/2018)

Parkland Formula for Fluid Resuscitation in Thermal Burn Patients

4 ml \( \times \) body surface area burned \( \times \) patient weight in kg = total fluid over 24 hours
Half given in 1st eight hours
CRUSH INJURY (Revised 3/22/2018)

All Levels
- Routine assessment and care
- Assess for shock and treat
- Initiate transport

EMR
- Administer Oxygen
- Manually stabilize head/neck
- Consider oral airway
- Consider assisted ventilations
- Consider OPQRST for assessment of pain
- Control external bleeding
  - Control external bleeding with direct pressure, pressure bandage, pressure points and/or tourniquet
  - May control external bleeding with the use of hemostatic agents with physician medical director approval and direction.
- Consider trauma system activation
- Consider ALS

EMR Options if Approved
- Consider spinal stabilization
- Consider extremity stabilization

EMT
- Consider nasal airway
- Administer oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Pre – release
  - Consider two large bore IV access sites
  - Administer fluid bolus(es) to maintain 90 systolic BP
- Release – during process to free patient
  - Administer fluid bolus(es) to maintain 90 systolic BP
- Post release
  - Administer fluid bolus(es) to maintain 90 systolic BP

AEMT
- Consider single IO access if unable to obtain IV access
- Consider 2 – 4mg Morphine if BP stabilizes above 100 systolic

EMT-I
- Consider intubation for persistent decrease mental status
- Initiate cardiac monitoring

Paramedic
- Consider RSI
- Consider pain management
- Pre – release
  - For entrapment over 60 minutes and systolic BP 90mmHg or greater
    - Consider adding 50mEq Sodium Bicarbonate to 1000 ml NS infuse bolus 500 ml then remain 500 ml over 30 minutes
  - Release – during process to free patient
    - Administer fluid bolus(es) to maintain 90 systolic BP
- Consider diagnostic mode 3 lead or 12 lead and evaluate for tall spiked T waves indicating hyperkalemia
  - Consider Calcium Gluconate or Calcium Chloride
  - Consider continuous Albuterol nebulizer treatments to total dose 15mg
ENVIRONMENTAL TRAUMA – EXPOSURE TO HEAT AND COLD (Revised 3/22/2018)

ALL LEVELS
- Routine assessment and care
- Assess for shock and treat

EMR
- Administer Oxygen
- Manually stabilize head/neck
- Consider assisted ventilations
- Consider OPQRST for assessment of pain
- Exposure to cold – hypothermia
  - Gently move patient to warm area if no spinal injury suspected
  - Remove wet clothing
  - Frozen/ near frozen extremities
    - Expose to warm surroundings
    - Consider dry dressing to pad
  - Body wide hypothermia
    - Passively warm patients with warm packs and blankets
- Exposure to heat
  - Gently move patient to cool area if no spinal injury suspected
  - Remove excessive clothing
  - Normal mental status and perspiration intact
    - Passive cool patient with fanning and cool dressing
  - Decrease mental status and/or no perspiration
    - Aggressive cooling with wet sheet, fanning and cold packs
- Consider trauma system activation
- Consider ALS

EMR Options if Approved
- Consider spinal stabilization
- Consider extremity stabilization
- Initiate transport

EMT
- Consider nasal airway
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
- Initiate cardiac monitoring

Paramedic
- Consider RSI
- When passive warming frozen extremities consider pain management
ALL LEVELS

- Routine assessment and care
- Assess for shock and treat

EMR

- Administer high flow Oxygen
- Monitor mental status – track/document AVPU and GCS
- Consider OPQRST for assessment of pain
- Assess and monitor CMS
- Assess dive history
  - Time of dive
  - Length of time of dive
  - Depth
  - Any problems with dive
- Consider ALS

EMR Options if Approved

- Consider spinal stabilization
- Initiate transport

EMT

- Administer Oxygen and adjust delivery device and lpm flow to achieve 94% or better o2 saturation
- Initiate transport

EMT Options if Approved

- Consider IV access

AEMT

- Consider IO access  if iv can not be obtained
- Consider 2 – 4mg Morphine IV/IO

EMT-I

- Consider cardiac monitoring

Paramedic

- Consider pain management
ALL LEVELS
- Routine assessment and care
- Assess for shock and treat

EMR
- Consider Oxygen
- Consider OPQRST for assessment of pain
- Manage open wounds
- Stabilize impaled objects in place
- Encourage patient not to wash or shower
- Consider trauma system activation
- If possible have ems provider of same sex as patient provide assessment and treatment
- Consider ALS

EMR Options if Approved
- Consider spinal stabilization
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and lpm flow to achieve 94% or better o2 saturation
- Initiate transport

EMT Options if Approved
- Consider IV access
- Consider advanced airway for persistent decrease mental status

AEMT
- Consider IO access if iv can not be obtained
- Consider 2 – 4 mg Morphine IV/IO

EMT-I
- Consider cardiac monitoring

Paramedic
- Consider pain management
ALL LEVELS
- Routine assessment and care
- Assess for shock and treat

EMR
- Consider Oxygen
- Consider assisted ventilations
- Manually stabilize head/neck
- Monitor mental status – track/document AVPU and GCS
- Consider OPQRST for assessment of pain
- Stabilize impaled objects in place
- Assess and monitor CMS
- Position patient on left side or sitting position
- Consider trauma system activation
- Consider ALS

EMR Options if Approved
- Consider spinal stabilization
  - Consider vest type device extrication device (KED, xp-1) and position patient semi-fowlers or on left side
  - Tilt backboard approximately 30 degrees
- Initiate transport

EMT
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
- Consider cardiac monitoring

Paramedic
- Consider pain management
ALL LEVELS
- Routine assessment and care

EMR and EMT
- Consider Oxygen
- Additional assessment concerns
  - Localize pain to abdominal quadrant if possible
  - Assess for trauma
  - Obtain bowel and bladder habits
  - Obtain menstrual cycle history
  - Obtain gynecological history
  - Consider ectopic pregnancy
- Allow patient to assume a position of comfort
- Consider ALS

EMR Options If Approved
- Transport patient in position of comfort if safe to do so

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Transport patient in position of comfort if safe to do so

EMT Options
- Consider advanced airway for persistent decreased LOC
- Consider IV access

AEMT
- Consider 2 – 4mg Morphine IV/IM

EMT-I
- Consider cardiac monitoring

Paramedic
- Consider pain management
ALL LEVELS
- Routine assessment and care

EMR and EMT
- Administer Oxygen
- Obtain bowel and bladder habits
- Obtain pregnancy history
- Complications
  - Seizures (eclampsia) – protect patient – call for ALS
  - Hypertension possible (pre-eclampsia) – monitor vitals – reduce stimuli
  - Hypotension – place patient on left side
  - Hypoglycemia/Hyperglycemia – See hypoglycemia or hyperglycemia protocol
  - Miscarriage – monitor for shock – may place OB pad over genitals
- Allow patient to assume a position of comfort
- Consider ALS

EMR Options If Approved
- Initiate transport

EMT
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options
- Consider advanced airway for persistent decreased LOC
- Obtain blood glucose reading
- Consider IV access

AEMT
- Consider IO access if IV access cannot be obtain
- Complications
  - Hypoglycemia – See Hypoglycemia or Hyperglycemia Protocol

EMT-I
- Initiate cardiac monitoring

Paramedic
- Complications
  - Pre-eclampsia – hypertension
    - Consider 1 – 2 grams Magnesium Sulfate diluted in 25 to 250ml infused slowly
    - If SBP > 160 mmHg or DBP is > 110 mmHg, consider:
      - Labetalol 10-20 mg slow iv push (over 2 min). May repeat every 10 min with additional doses of 40 mg then 80 mg to a max dose of 300 mg until DBP <100.
      - If BP is responsive consider labetalol drip at 2 - 8 mg/min administered by mechanical infusion pump
      - If BP is not responsive to Labetalol then consider administration of Hydralazine 5 mg IV repeated as needed every 20 min at a dose of 5 – 10 mg IV to a total dose of 40 mg.
      - Monitor patient for sudden decreases in blood pressure. To avoid sudden reduction in perfusion to the placenta, diastolic blood pressure should not be reduced to < 100 mmHg.
  - Eclampsia– seizures
    - Consider 2 – 4 grams Magnesium Sulfate diluted in 25 to 250ml infused slowly;
    - Contact medical control or PMD for additional doses beyond max doses
    - If somnolence, muscular paralysis, or respiratory depression occurs, discontinue Magnesium Sulfate infusion and consider Calcium Gluconate 1 g of 10% solution over 1 – 2 min. If Calcium Gluconate is not available, consider Calcium Chloride 500 mg slow IV injection (not to exceed 1 ml/min).
    - Refer to seizure protocol
ALL LEVELS
- Routine assessment and care

EMR and EMT
- Consider Oxygen
- Obtain pregnancy status
  - Known complications
  - Due date
  - Number previous pregnancies
  - Number of previous live births
  - Has amniotic fluid passed (water broke)
- Time contractions
- Prepare for field delivery if
  - Contraction are regular and 2 minutes or sooner together
  - Patient has urge to push
  - Exam genital region for bulging
- Do not perform vaginal exam
- Consider ALS

EMR Options If Approved
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options and AEMT
- Consider IV access

EMT-I and Paramedic
- Consider cardiac monitoring
ALL LEVELS

- Routine assessment and care
- For complicated deliveries (breech, limb presentation or prolapsed umbilical cord) see Delivery Complicated Protocol

EMR and EMT

- Consider Oxygen
- Obtain pregnancy status
  - Known complications
  - Due date
  - Number previous pregnancies
  - Number of previous live births
  - Has amniotic fluid passed (water broke)
- Time contractions
- Do not perform vaginal exam
- Obtain field delivery kit (OB kit)
- Uncomplicated delivery
  - Provide gentle pressure/support as head emerges
  - Suction nose and mouth with bulb syringe as head emerges – assess for meconium staining
  - Examine for cord around neck and free if needed
  - Allow infant’s head/shoulders to turn
  - Support infant throughout rest of birth
  - Suction nose and mouth
  - See neonatal care protocol for care of infant
- Reassess mother
  - Prepare for delivery of placenta
- Consider ALS

EMR Options If Approved

- Initiate transport

EMT

- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options and AEMT

- Consider IV access

EMT-I and Paramedic

- Consider cardiac monitoring
ALL LEVELS
- Routine assessment and care

EMR and EMT
- Consider Oxygen
- Obtain pregnancy status
  o Known complications
  o Due date
  o Number previous pregnancies
  o Number of previous live births
  o Has amniotic fluid passed (water broke)
- Time contractions
- Do not perform vaginal exam
- Obtain field delivery kit (OB kit)
- Consider positioning patient in head down buttocks up position
- Encourage patient to breathe through contractions
- Consider ALS

EMR Options If Approved
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Breech birth
  o Support buttocks and body as it emerges
  o Create airway – two fingers inserted vaginally making a V shape and pushing vaginal wall from nose/mouth
  o Examine for cord around neck and free if needed
  o Suction nose and mouth with bulb syringe as head emerges – assess form meconium staining
  o If labor stalls – head does not deliver insert two fingers vaginally create V in birth canal around infant’s nose/mouth – suction if possible
- Limb presentation
  o Position patient in head down buttocks up position
  o Encourage patient to breathe through contractions
- Prolapsed umbilical cord
  o Position patient in head down buttocks up position
  o Insert two or three fingers vaginally provide gentle pressure against infant’s head
  o Wrap cord with moist dressing
  o Encourage patient to breathe through contractions
- Initiate transport

EMT Options and AEMT
- Consider IV access on mother

EMT-I and Paramedic
- Consider cardiac monitoring
NEW BORN CARE (Revised 12/7/2012)

**APGAR Scale – Score New Born at 1 Minute and 5 Minutes After Birth**

<table>
<thead>
<tr>
<th></th>
<th>0 Points</th>
<th>1 Point</th>
<th>2 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Heart Rate</strong></td>
<td>Absent</td>
<td>&lt;100</td>
<td>&gt;100</td>
</tr>
<tr>
<td><strong>Respiratory Effort</strong></td>
<td>Absent</td>
<td>Slow Irregular</td>
<td>Strong Cry</td>
</tr>
<tr>
<td><strong>Muscle Tone</strong></td>
<td>Flaccid</td>
<td>Some Flexion</td>
<td>Active Motion</td>
</tr>
<tr>
<td><strong>Irritability</strong></td>
<td>No Response</td>
<td>Some</td>
<td>Vigorous</td>
</tr>
<tr>
<td><strong>Color</strong></td>
<td>Blue/Pale Centrally</td>
<td>Body Pink – Extremity Blue/Pale</td>
<td>Fully Pink</td>
</tr>
</tbody>
</table>

**Targeted Preductal Spo₂ After Birth**

<table>
<thead>
<tr>
<th>Time (min)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 min</td>
<td>60%-65%</td>
</tr>
<tr>
<td>2 min</td>
<td>65%-70%</td>
</tr>
<tr>
<td>3 min</td>
<td>70%-75%</td>
</tr>
<tr>
<td>4 min</td>
<td>75%-80%</td>
</tr>
<tr>
<td>5 min</td>
<td>80%-85%</td>
</tr>
<tr>
<td>10 min</td>
<td>85%-95%</td>
</tr>
</tbody>
</table>

**Consider IO Access**

© 2010 American Heart Association
Pediatric General Principals
PROTOCOLS (Revised 12/7/2012)
A copy of these protocols should be carried on each ambulance/first responder unit and be in a location that the care provider has access to them.

PEDIATRIC REFERENCE AND RESUSCITATION TAPE (Revised 12/7/2012)
It is the recommendation of these protocols that each ambulance or first responder unit should have available pediatric specific reference(s) and/or resuscitation tape carried on the unit preferably in a pediatric dedicated response kit/bag.
Examples:
- EMS field guide/ handbook with pediatric specific section
- Pediatric charts – graphs
- Broselow tape

RECOMMENDATIONS FOR PEDIATRIC EQUIPMENT (Revised 7/7/2016)
It is the recommendation of these protocols that each ambulance or first responder unit should have available pediatric specific equipment.

ALS and BLS equipment recommendations
- Car seat type device for safe transport of infants and small children
- Pediatric spinal stabilization device
- Pediatric C-collar(s)
- Pediatric extremity splints
- Infant bag valve mask
- Child bag valve mask
- Pediatric sized oral airways
- Pediatric Oxygen mask
- Pediatric nasal cannula
- Pediatric capable AED
- Pediatric capable pulse oximeter
- Selection of BP cuffs for children
- If approved
  - Pediatric sized non-visualized advanced airways
  - 0.15 Epinephrine Auto-Injector

ALS equipment recommendations
- Selection endotracheal tubes sizes 3 to 5.5
- Selection of laryngoscope blades for pediatric patients
- Pediatric ET tube holder
- Selection of IV catheters sizes 20 to 24
- Devices or means for measured flow of IV fluids
- Arm board
- IO device
- Pediatric capable monitoring equipment
PEDIATRIC ASSESSMENT MODEL (Revised 12/7/2012)

Conduct a Scene Size Up
Employ Use of BSI

Pediatric Assessment Triangle – General Impression

- Appearance
- Breathing
- Circulation

- Appearance – Normal/Abnormal
  Mental Status
  Muscle Tone

- Work of Breathing – Normal / Abnormal
  Body Position
  Increased Effort
  Audible Breathing Sounds

- Normal or Abnormal Circulation
  Skin Color

Airway assessment
Assume manual C-spine stabilization on suspected trauma patients

Breathing Assessment
Circulatory Assessment
Identify and Control Bleeding

Level of Consciousness – AVPU

Expose as Necessary

Determine Chief Complaint

Obtain a Patient History

Obtain Vital Signs

Conduct a Physical Exam Appropriate to the Complaint/Problem

Reassess as Appropriate to the Patient’s Condition

Detect and Manage Life

Develop & Carry Out a Treatment

Primary Assessment

History Taking

Secondary Assessment
Pediatric Routine Assessment and Care
This Protocol applies to every patient contact and is the base from which other treatment protocols build upon.

**Scene Size Up**
- Assess scene safety – use standard/universal precautions – determine # of patients – consider additional resources
- Determine nature of illness/mechanism of trauma
- Determine age and estimated or stated weight
  - Newborn to 1 year is defined as an infant for resuscitation
  - 1 year to onset of puberty is defined as a child for resuscitation

**Primary Assessment, Identify and Treat Immediate Life Threats**
- If mechanism of trauma indicates
  - Consider manually stabilizing c-spine
- Form a general impression
- Determine level of consciousness – utilize AVPU scale
- If infant or child presents in cardiac arrest begin chest compressions
- Assess airway
  - Foreign body airway obstruction – clear obstruction
    - Trauma suspected – utilize jaw thrust method to open airway
    - Medical patients – utilize head tilt, chin left method to open airway
    - ALL LEVELS
      - Consider oral airway
      - EMT with approval, AEMT, EMT-I and Paramedic
        - May consider appropriate sized advanced non visualized airway
      - EMT-I and Paramedic
        - May consider intubation
        - Monitor closely – consider one of simple airway maneuvers above
      - EMT and above
        - May consider nasal airway
        - Paramedic
          - May consider RSI
          - Suction oral airway as needed
          - Patient can maintain own airway and no suction needed – no immediate intervention
- Assess breathing
  - Absent or agonal – begin ventilations with BVM attached to oxygen
  - Assess quality of breathing and lung sounds
    - Signs/symptoms of severe respiratory distress – impending respiratory arrest
      - Consider Oxygen by non-rebreather mask
      - Consider assisted ventilations with BVM attached to oxygen at 5 to 6 per minute
    - Signs/symptoms of moderate respiratory difficulty
      - Consider Oxygen by non-rebreather mask
    - Signs/symptoms of mild respiratory difficulty
      - Consider Oxygen by nasal cannula
    - No signs/symptoms of respiratory difficulty
      - Consider Oxygen appropriate to nature of illness/mechanism of trauma
  - Assisted ventilations chart

<table>
<thead>
<tr>
<th>Age</th>
<th>Ventilations/Minute</th>
<th>Ventilations/Second</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>40-60</td>
<td>1 Every Second</td>
</tr>
<tr>
<td>Infant</td>
<td>30-40</td>
<td>1 Every 2 Seconds</td>
</tr>
<tr>
<td>1-6 Years</td>
<td>20-30</td>
<td>1 Every 3 Seconds</td>
</tr>
<tr>
<td>6-12 Years</td>
<td>16-20</td>
<td>1 Every 3 to 4 Seconds</td>
</tr>
<tr>
<td>12-16 Years</td>
<td>12-16</td>
<td>1 Every 5 Seconds</td>
</tr>
<tr>
<td>Adult</td>
<td>10-12</td>
<td>1 Every 5 to 6 Seconds</td>
</tr>
</tbody>
</table>
• Assess circulation
  o Absent or pulse 60 or less – begin CPR – follow Cardiac Arrest Protocols
  o Assess for bleeding
    ▪ Control external bleeding with direct pressure, pressure bandage, pressure points and/or tourniquet
    ▪ May control external bleeding with the use of hemostatic agents with physician medical director approval and direction.
  o Assess quality of pulse
    ▪ Weak – rapid pulse, poor skin color, poor cap refill
      • Consider treating for shock
      • Consider assisted ventilations
    ▪ Weak slow pulse
      60 or less begin compressions
      Reassess airway and breathing – consider assisted ventilations
      Assess for possible cause
    ▪ Irregular pulse
      • Assess for possible cause
      • Strength, rate, rhythm normal, and skin normal – no immediate intervention
  • Assess disability – quick neuro exam
    o Obtain Glasgow Coma Scale
    o Utilize a non-invasive scales and scores
    o Check peripheral circulation, movement, and sensory

Obtain Patient History
• Obtain a chief complaint
• Obtain SAMPLE history
• Consider use of OPQRST pneumonic
• Obtain pertinent negatives

Vital Signs
• EMR
  o Pulse
  o Respiratory rate
  o Manual blood pressure
• EMT, AEMT, EMT-I, Paramedic
  o Pulse
  o Respiratory rate
  o Manual and automatic blood pressure
  o Pulse oximetry reading
  o Non-invasive CO reading
  o Temperature

Hypotension Guidelines
- Neonates (0 to 28 Days) Systolic BP Under 60
- Infants (1 Month to 12 Months) Systolic BP Under 70
- Child (1 Year to 10 Years) Systolic BP Under 70 + 2 X Age in Years
- Child (Over 10) Systolic BP Under 90

Hypotension should be interpreted within the context of the entire Patient Assessment

Additional Monitoring as Appropriate to Patient’s Illness/Injury
• EMT-I
  o EtCO2 including capnography
  o Cardiac monitoring lead i, ii, and iii
• Paramedic
  o All non-invasive monitoring devices
  o Device to monitor airway/ventilation pressures
  o Invasive monitoring if already established
**Secondary Assessment**
- Prepare for patient transport
- Expose patient as needed
- Medical
  - Systematic assessment of major body systems
- Trauma
  - Systematic assessment for injuries

**Reassessment**
- Repeat assessment of patient based on condition
- Monitor vital signs
- Identify changes in patient condition adjust treatment as needed

---

**Pediatric Normal Vital Signs**

<table>
<thead>
<tr>
<th>Age</th>
<th>Average Heart Rate</th>
<th>Heart Rate Range</th>
<th>Respiratory Range</th>
<th>Average Systolic BP</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>140</td>
<td>110 – 180</td>
<td>40 – 60</td>
<td>72</td>
<td>52 – 92</td>
</tr>
<tr>
<td>1 Month</td>
<td>135</td>
<td>90 – 170</td>
<td>30 – 50</td>
<td>82</td>
<td>60 – 104</td>
</tr>
<tr>
<td>1 Year</td>
<td>120</td>
<td>80 – 160</td>
<td>20 – 30</td>
<td>94</td>
<td>70 – 118</td>
</tr>
<tr>
<td>2 Years</td>
<td>110</td>
<td>80 – 130</td>
<td>20 – 30</td>
<td>95</td>
<td>73 – 117</td>
</tr>
<tr>
<td>4 Years</td>
<td>105</td>
<td>80 – 120</td>
<td>20 – 30</td>
<td>96</td>
<td>65 – 117</td>
</tr>
<tr>
<td>6 Years</td>
<td>100</td>
<td>75 – 115</td>
<td>18 – 24</td>
<td>97</td>
<td>76 – 116</td>
</tr>
<tr>
<td>8 Years</td>
<td>90</td>
<td>70 – 110</td>
<td>18 – 22</td>
<td>99</td>
<td>79 – 119</td>
</tr>
<tr>
<td>10 Years</td>
<td>90</td>
<td>70 – 110</td>
<td>16 – 20</td>
<td>102</td>
<td>82 – 122</td>
</tr>
<tr>
<td>12 years</td>
<td>85</td>
<td>60 – 110</td>
<td>16 – 20</td>
<td>106</td>
<td>84 – 128</td>
</tr>
<tr>
<td>14 years</td>
<td>80</td>
<td>60 – 105</td>
<td>16 – 20</td>
<td>110</td>
<td>84 – 136</td>
</tr>
</tbody>
</table>

**Pediatric Glasgow Coma Score**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Adult/Child</th>
<th>Infant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spontaneous</td>
<td>4</td>
<td>Spontaneous</td>
</tr>
<tr>
<td>To Verbal</td>
<td>3</td>
<td>To Verbal</td>
</tr>
<tr>
<td>To Pain</td>
<td>2</td>
<td>To Pain</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>No Response</td>
</tr>
<tr>
<td>Best Verbal Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oriented</td>
<td>5</td>
<td>Coos, Babbles</td>
</tr>
<tr>
<td>Disoriented/Confused</td>
<td>4</td>
<td>Irritable Cry</td>
</tr>
<tr>
<td>Inappropriate Words</td>
<td>3</td>
<td>Cries Only to Pain</td>
</tr>
<tr>
<td>Incomprehensible – Moans/groans</td>
<td>2</td>
<td>Moans to Pain</td>
</tr>
<tr>
<td>No Response</td>
<td>1</td>
<td>No Response</td>
</tr>
</tbody>
</table>

| Best Motor Response          |                            |          |
| Obey Commands                | 6                          | Spontaneous |
| Localizes Pain               | 5                          | Withdraws from Touch |
| Withdraws from Pain          | 4                          | Withdraws from Pain |
| Abnormal Flexion             | 3                          | Abnormal Flexion |
| Abnormal Extension           | 2                          | Abnormal Extension |
| No Response                  | 1                          | No Response |

---

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AIRWAY – CHOKING – FOREIGN BODY AIRWAY OBSTRUCTION

**EMR and EMT**

**Complete Airway Obstruction UNDER 1 Year Old**

<table>
<thead>
<tr>
<th>Conscious</th>
<th>Conscious Goes Unconscious</th>
<th>Unconscious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform Black Slaps/Chest Thrusts</td>
<td>Place Patient into a Supine Position</td>
<td>Position Patient into a Supine Position</td>
</tr>
<tr>
<td>Repeat Abdominal Thrusts Until Airway Cleared OR Patient Becomes Unconscious Then Go to Next Column</td>
<td>Perform Chest Compressions</td>
<td>Perform Chest Compressions</td>
</tr>
<tr>
<td>Repeat Chest Compressions Until Airway Cleared</td>
<td>Repeat Chest Compressions Until Airway Cleared</td>
<td>Repeat Chest Compressions Until Airway Cleared</td>
</tr>
<tr>
<td><strong>If Airway Does Not Clear Request ALS Intercept</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Complete Airway Obstruction 1 Year to Adolescent**

<table>
<thead>
<tr>
<th>Conscious</th>
<th>Conscious Goes Unconscious</th>
<th>Unconscious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform Back Blows Perform Abdominal Thrusts</td>
<td>Place Patient into a Supine Position</td>
<td>Position Patient into a Supine Position</td>
</tr>
<tr>
<td>Repeat Abdominal Thrusts Until Airway Cleared OR Patient Becomes Unconscious Then Go to Next Column</td>
<td>Perform Chest Compressions</td>
<td>Perform Chest Compressions</td>
</tr>
<tr>
<td>Repeat Chest Compressions Until Airway Cleared</td>
<td>Repeat Chest Compressions Until Airway Cleared</td>
<td>Repeat Chest Compressions</td>
</tr>
<tr>
<td><strong>If Airway Does Not Clear Request ALS Intercept</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Partial Airway Obstruction**

Monitor Patient Allow Patient to Cough, Be Alert for Complete Obstruction

**EMR Options If Approved**
- Initiate transport

**EMT**
- Initiate transport

**EMT Options If Approved**
- Do not insert advanced airway unless airway cleared and persistent decreased mental status
- focus on clearing obstructed airway prior to any IV access attempts

**AEMT**
- Do not insert advanced airway unless airway cleared and persistent decreased mental status
- focus on clearing obstructed airway prior to any IV access attempts

**EMT-I**
- Consider direct visualization with laryngoscope and removal with forceps

**Paramedic**
- Consider Cricothyrotomy
AIRWAY – POST AIRWAY OBSTRUCTION (Revised 12/7/2012)

ALL LEVELS
- Pediatric routine assessment and care

EMR and EMT
- Be alert for loss of airway due to swelling
- Consider Oxygen
- Considered assisted ventilations for inadequate breathing
- Positioning
  - Decreased mental status position on side
  - Alert patient allow patient to assume position of comfort
- Suction as needed
- Consider ALS

EMR Options If Approved
- Initiate transport
  - Consider use of car seat type restraint device

EMT
- Initiate transport
  - Consider use of car seat type restraint device

EMT Options and AEMT
- Consider advanced airway for persistent decreased mental status
- Consider IV access

EMT-I
- Consider advanced airway for persistent decreased mental status
- Consider bronchodilator for wheezing
- Consider cardiac monitoring

Paramedic
- Consider RSI for airway edema
ALL LEVELS
- Pediatric routine assessment and care

EMR and EMT
- Additional assessment concerns
  - Localize pain to abdominal quadrant if possible
  - Obtain bowel and bladder habits
- Consider OPQRST pneumonic for assessment of pain
- Allow patient to assume a position of comfort
- Consider ALS

EMR Options If Approved
- Initiate transport
  - Consider use of car seat type restraint device

EMT
- Initiate transport
  - Consider use of car seat type restraint device

EMT Options If Approved
- Consider advanced airway for persistent decreased LOC
- Consider IV access

AEMT
- Consider IO access for shock and IV access cannot be obtained
- Consider 0.05 to 0.2 mg/kg to 4 mg max Morphine IV/IO/IM/MAD

EMT-I
- Consider cardiac monitoring

Paramedic
- Consider pain management
ALL LEVELS
- Pediatric routine assessment and care

EMR
- Assess severity of reaction
  - Itching and/or hives
  - No respiratory symptoms
- Administer Oxygen
- Consider assisted ventilations for severe reactions
- Consider ALS

EMR Options if Approved
- Consider 0.15mg (pediatric) epinephrine auto injector for moderate and severe reactions
  - May repeat in 5 minutes if symptoms do not improve
- Initiate transport
  - Consider use of car seat type restraint device

EMT
- Consider assisting patient with his/her prescribed meter dosed inhaler
- Consider assisting patient with his/her prescribed epinephrine auto injector
  - IM epinephrine if PMD approved
  - May repeat in 5 minutes if symptoms do not improve
- Initiate transport
  - Consider use of car seat type restraint device

EMT Options if Approved
- Consider 2.5mg unit dose Albuterol nebulizer treatment for moderate and severe reactions
- Patient 30kg and under
  - Consider 0.15mg (pediatric) epinephrine auto injector for moderate and severe reactions
    - May repeat in 5 minutes if symptoms do not improve
- Patient over 30kg
  - Consider 0.3mg (adult) epinephrine auto injector for moderate and severe reactions
    - May repeat in 5 minutes if symptoms do not improve
- Consider IV access

AEMT
- Consider 0.01mg/kg (0.01ml/kg) (0.5 ml (0.5 mg) Max Dose) 1mg/ml (1:1000) Epinephrine IM for moderate and severe reactions
  - May repeat in 5 minutes if symptoms do not improve
- Consider IO access in moderate and severe reactions

EMT-I
- Consider bronchodilator
- Consider 1 to 2 mg/kg (50 mg max dose) Diphenhydramine IV/IO/IM for mild, moderate, and severe reactions
- Consider 2 mg/kg (125 mg max dose) Methylprednisolone IV/IO for moderate and severe reactions
- Initiate cardiac monitoring

Paramedic
- Consider RSI
- Consider vasopressor agent for anaphylactic shock with hypotension
Nebraska EMS Model Protocols
Pediatric Medical Protocols

CARDIAC ARREST – DISCONTINUING BYSTANDER CPR AND WITHHOLDING CPR (Revised 12/7/2012)

The EMR or EMT may be presented with patients in which bystander CPR has been started or the patient presents with certain sign/symptoms of obvious death or a valid DNR.

Situations where bystander CPR has been initiated OR EMS arrives and no CPR is initiated:

Un-Safe Scene
If the scene will place the OOHECP “at risk of serious injury or mortal peril” CPR may be discontinued or withheld

ALL LEVELS
- Confirm the patient has
  - No pulse
  - No respirations or attempts at respirations
- May Stop CPR or Not Initiate CPR IF the Patient Presents with At Least One of the Following:
  - Rigor mortis
  - Decapitation
  - Decomposition
  - Dependent lividity
  - Traumatic cardiopulmonary arrest with injuries incompatible with life; Examples
    - Massive blood loss
    - Displacement of brain tissue
    - Blunt Head/Chest Trauma
  - Valid DNR form
  - Physician authorization
- The following will be included in the Patient Care Report;
  - CPR was or was not being performed prior to EMS arrival OR
  - If CPR was being performed the time it was discontinued
  - The patient had No Respirations and No Pulse
  - The additional criteria (from above) use to discontinue or withhold CPR

2 Part 3: Ethics: 2010 AHA CPR and EEC Guild lines Withholding and Withdrawing CPR(Termination of Resuscitative Efforts) Related to Out-of Hospital Cardiac Arrest

Page 97
EMR – EMT - AEMT

Pediatric BLS Healthcare Providers

1. Unresponsive
   Not breathing or only gasping
   Send someone to activate emergency response system, get AED/defibrillator

2. Lone Rescuer: For SUDDEN COLLAPSE, activate emergency response system, get AED/defibrillator

3. Check pulse: DEFINITE pulse within 10 seconds?
   - Yes
     3A. Define Pulse
     - Give 1 breath every 3 seconds
     - Add compressions if pulse remains <60/min with poor perfusion despite adequate oxygenation and ventilation
     - Recheck pulse every 2 minutes
   - No Pulse

4. One Rescuer: Begin cycles of 30 COMPRESSIONS and 2 BREATHS
   Two Rescues: Begin cycles of 15 COMPRESSIONS and 2 BREATHS

5. After about 2 minutes, activate emergency response system and get AED/defibrillator (if not already done).
   Use AED as soon as available.

6. Check rhythm
   - Shockable
     7. Give 1 shock
     8. Resume CPR immediately for 2 minutes
   - Not Shockable

EMR Options If Approved
- Place patient on back/CPR board
- Initiate transport
- Call for intercept from backup service

EMT Options if Approved and AEMT
- After First Cycle of CPR and Shock or No Shock
  - Consider an advanced airway
  - Consider IV access with normal saline or LR

AEMT
- Consider IO access
CARDIAC ARREST – ADVANCED CARDIAC LIFE SUPPORT (Revised 12/7/2012)

EMT-I and Paramedic

Doses/Details

CPR Quality
- Push hard (1/3 of anterior-posterior diameter of chest) and fast (at least 100/min) and allow complete chest recoil
- Minimize interruptions in compressions
- Avoid excessive ventilation
- Rotate compressor every 2 minutes
- If no advanced airway, 15:2 compression-ventilation ratio. If advanced airway, 8-10 breaths per minute with continuous chest compressions

Shock Energy for Defibrillation
First shock 2 J/kg, second shock 4 J/kg, subsequent shocks >4 J/kg, maximum 10 J/kg or adult dose.

Drug Therapy
- Epinephrine IO/IV Dose: 0.01 mg/kg (0.1 mL/kg of 1:1000 concentration). Repeat every 3-5 minutes. If no IO/IV access, may give endotracheal dose: 0.1 mg/kg (0.1 mL/kg of 1:1000 concentration).
- Amlodarone IO/IV Dose: 5 mg/kg bolus during cardiac arrest. May repeat up to 2 times for refractory VF/pulseless VT.

Advanced Airway
- Endotracheal intubation or supraglottic advanced airway
- Waveform capnography or capnometry to confirm and monitor ET tube placement
- Once advanced airway in place give 1 breath every 6-8 seconds (8-10 breaths per minute)

Return of Spontaneous Circulation (ROSC)
- Pulse and blood pressure
- Spontaneous arterial pressure waves with intra-arterial monitoring

Reversible Causes
- Hypovolemia
- Hypoxia
- Hydrogen ion (acidosis)
- Hypoglycemia
- Hypo-hyperkalemia
- Hypothermia
- Tension pneumothorax
- Tamponade, cardiac
- Toxins
- Thrombosis, pulmonary
- Thrombosis, coronary

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ALL LEVELS
• Follow cardiac arrest algorithm with these considerations

Cardiac Arrest in Suspected Narcotic – Benzodiazepine – Beta Blocker – Calcium Channel Blocker Overdose – Tricyclic Antidepressant Overdose

ALL LEVELS
• Consider consultation with medical control or PMD
• No additional considerations

CARDIAC ARREST IN HYPOThERMIA–DROWNING

EMR and EMT
• Remove wet clothing and passively warm patient

EMT Options If Approved
• Use warmed IV fluids

EMT-I and Paramedic
• May use Epinephrine and Vasopressin in severe hypothermia (<87°F)
• Avoid Amiodarone and Lidocaine in severe hypothermia (<87°F)

CARDIAC ARREST IN TRAUMA

ALL LEVELS
• If resuscitation attempted follow appropriate cardiac arrest protocol
ALL LEVELS
- Pediatric routine assessment and care

EMR and EMT
- Keep AED attached to patient
- Assist ventilations
- If gag reflex returns removal oral airway
- Suction as needed
- Consider obtaining 12 lead EKG
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Initiate transport

EMT Options If Approved
- Consider advance airway if not already in place during cardiac arrest
- Consider obtaining a blood glucose reading
- Consider IV access

AEMT
- Consider IV or IO access

EMT-I
- Consider intubation if not already in place during cardiac arrest
- Initiate cardiac monitoring
- Treat cardiac dysrhythmias
- Adjust ventilations (rate, tidal volume, fiO2) to maintain these goals
  - O2 saturation 94% or better
  - EtCO2 35 to 45 mmHg

Paramedic
- Consider vasopressor agent for sustained hypotension
- If patient intubated
  - Consider sedative agent
  - OR consider sedative agent first then a non-depolarizing paralytic
**CARDIAC DYSRHYTHMIA TACHYCARDIA (Revised 12/7/2012)**

**EMT-I and Paramedic**

**Pediatric Tachycardia**
**With a Pulse and Poor Perfusion**

1. **Identify and treat underlying cause**
   - Maintain patent airway; assist breathing as necessary
   - Oxygen
   - Cardiac monitor to identify rhythm; monitor blood pressure and oximetry
   - IO/IV access
   - 12-Lead ECG if available; don’t delay therapy

2. **Evaluate QRS duration**
   - **Narrow (<0.09 sec)**
   - **Wide (>0.09 sec)**

3. **Evaluate rhythm with 12-lead ECG or monitor**

4. **Probable sinus tachycardia**
   - Compatible history consistent with known cause
   - P waves present/normal
   - Variable R-R; constant PR
   - Infants: rate usually <220/min
   - Children: rate usually <160/min

5. **Probable supraventricular tachycardia**
   - Compatible history (vague, nonspecific); history of abrupt rate changes
   - P waves absent/abnormal
   - HR not variable
   - Infants: rate usually ≥220/min
   - Children: rate usually ≥180/min

6. **Search for and treat cause**

7. **Consider vagal maneuvers (No delays)**

8. **If IO/IV access present, give adenosine OR**
   - If IO/IV access not available, or if adenosine ineffective, synchronized cardioversion

9. **Possible ventricular tachycardia**

10. **Cardiopulmonary compromise?**
    - Hypotension
    - Acutely altered mental status
    - Signs of shock

11. **Synchronized cardioversion**
    - Yes

12. **Consider adenosine if rhythm regular and QRS monomorphic**

13. **Expert consultation advised**
    - Amiodarone
    - Procainamide

---

**Doses/Details**

**Synchronized Cardioversion:**
Begin with 0.5-1 J/kg; if not effective, increase to 2 J/kg.
Sedate if needed, but don’t delay cardioversion.

**Adenosine IO/IV Dose:**
First dose: 0.1 mg/kg rapid bolus (maximum: 6 mg).
Second dose: 0.2 mg/kg rapid bolus (maximum second dose 12 mg).

**Amiodarone IO/IV Dose:**
5 mg/kg over 20-60 minutes

**Procainamide IO/IV Dose:**
15 mg/kg over 30-60 minutes
Do not routinely administer amiodarone and procainamide together.

---

**Paramedic Only Medication**
Procainamide

**EMT-I Must Have Completed PALS to Perform**
Synchronized cardioversion
CARDIAC DYSRHYTHMIA BRADYCARDIA

EMT-I and Paramedic

**Pediatric Bradycardia**

*With a Pulse and Poor Perfusion*

1. **Identify and treat underlying cause**
   - Maintain patent airway; assist breathing as necessary
   - Oxygen
   - Cardiac monitor to identify rhythm; monitor blood pressure and oximetry
   - IO/IV access
   - 12-Lead ECG if available; don’t delay therapy

2. **Cardiopulmonary compromise continues?**
   - **No**
   - If HR < 60/min with poor perfusion despite oxygenation and ventilation

3. **CPR if HR < 60/min**
   - **Yes**
   - Hypotension
   - Acutely altered mental status
   - Signs of shock

4a. **Consider assisted ventilations**
   - Support ABCs
   - Give oxygen
   - Observe
   - Consider expert consultation

4. **Bradycardia persists?**
   - **No**
   - **Yes**

5. **Doses/Details**
   - **Epinephrine IO/IV Dose:** 0.01 mg/kg (0.1 ml/kg of 0.1 mg/ml (1:10,000)). Repeat every 3-5 minutes. If IO/IV access not available but endotracheal (ET) tube in place, may give ET dose: 0.1 mg/kg (0.1 ml/kg of 1 mg/ml (1:1,000)).
   - **Atropine IO/IV Dose:** 0.02 mg/kg. May repeat once. Minimum dose 0.1 mg and maximum single dose 0.5 mg.

6. **If pulseless arrest develops, go to Cardiac Arrest Algorithm**

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DECREASED LEVEL OF CONSCIOUSNESS – DECREASED MENTAL STATUS (Revised 7/7/2016)

ALL LEVELS

- Pediatric routine assessment and care
- Consider 0.1mg/kg to max of 4mg Naloxone
  - IM Auto-Injector/MAD for suspected or known narcotic overdose, or;
  - IM/IV/IO/MAD for AEMT and above

EMR

- Consider oral airway and assisted ventilations
- Administer Oxygen
- Utilize a non-invasive stroke scale
- Obtain onset time
- Assess for medical or traumatic cause and utilize additional protocols as needed
- Consider ALS

EMR Options if Approved

- Consider 12 lead ECG acquisition and transmission
- Initiate transport

EMT

- Consider nasal airway in older children
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved

- Consider IV access
- Obtain blood glucose reading-if abnormal go to appropriate protocol

EMT Options if Approved or AEMT

- Consider advanced airway for persistent decreased mental status

EMT-I

- Consider Intubation for persistent decreased mental status

Paramedic

- Consider RSI
ALL LEVELS
- Pediatric routine assessment and care

EMR
- Allow patient to assume a position where he/she can maintain own airway
- If patient loses airway attempt BVM ventilations
- Administer Oxygen by blow by or non-rebreather mask humidified if possible
- Calm patient
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved and AEMT
- Defer attempts at advanced airway
- Defer IV unless patient loses airway

EMT-I
- Initiate cardiac monitoring

Paramedic
- Consider cricothyroidotomy
ALL LEVELS

- Pediatric routine assessment and care

EMR

- If no trauma position patient to protect airway
- Consider Oxygen
- Assess for stroke
- IF PATIENT CAN FOLLOW SIMPLE COMMANDS AND PROTECT OWN AIRWAY
  - Consider for children old enough to drink from glass having patient drink juice, non-diet pop or milk
  - Consider ALS

EMR Options if Approved

- Initiate transport

EMT

- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- IF PATIENT CAN PROTECT OWN AIRWAY
  - Consider oral glucose gel
    - Infants rub small amounts of oral glucose gel along gums
    - Children 7.5 to 15 grams oral glucose gel
  - Initiate transport

EMT Options if Approved

- Consider advanced airway for persistent decrease mental status
- Obtain blood glucose reading
- Consider IV access

AEMT

- Consider IO access when:
  - Blood glucose level indicates hypoglycemia
  - Patient symptomatic
  - And IV access cannot be obtained
- Consider dextrose
  - Infant to age 1 year:
    - 5 ml/kg to a max 6 grams **Dextrose 10%**
    - 4 ml/kg to a max 6 grams **Dextrose 12.5%**
  - Child to age 8 years:
    - 5 ml/kg to a max 6 grams **Dextrose 10%**
    - 4 ml/kg to a max 6 grams **Dextrose 12.5%**
    - 2 ml/kg to a max 6 grams **Dextrose 25%**
  - Age 8 to onset puberty
    - 4 ml/kg to a max 6 grams **Dextrose 12.5%**
    - 2 ml/kg to a max 25 grams **Dextrose 25%**
  - Recheck blood glucose every 15 minutes
- Alternate treatments
  - If patient can protect own airway
    - Consider oral glucose see EMT above
  - Defer IO and IV and administer 0.5mg under 25kg to 1mg over 25kg glucagon IM or MAD
    - If Glucagon fails to full resolve hypoglycemia **See Dextrose Treatment Above**

EMT-1 and Paramedic

- Consider intubation for persistent decrease mental status after treatment with Dextrose or Glucagon
- Assess for other causes of decreased mental status
- Consider cardiac monitoring
ALL LEVELS
• Pediatric routine assessment and care

EMR
• If no trauma position patient to protect airway
• Consider Oxygen
• Assess for stroke
• Consider ALS

EMR Options if Approved
• Initiate transport

EMT
• Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
• Initiate transport

EMT Options if Approved
• Consider advanced airway for persistent decrease mental status
• Obtain blood glucose reading
• Consider IV access
  o Consider 20ml/kg fluid bolus for dehydration and shock

AEMT
• Consider IO access when IV access cannot be obtained
• OR blood glucose 400 or greater
• OR dehydration and/or shock

EMT-I
• Consider intubation for persistent decrease mental status
• Consider cardiac monitoring

Paramedic
• Assess for DKA
NAUSEA – VOMITING – DIARRHEA (Revised 3/22/2018)

ALL LEVELS

- Pediatric routine assessment and care

EMR

- Consider Oxygen
- Be prepared for suctioning
- Assess for cause of nausea
- Assess for dehydration
- Consider ALS

EMR Options if Approved

- Initiate transport

EMT

- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved and AEMT

- Consider IV access for sign and symptoms of dehydration
- Consider 20ml/kg fluid bolus

AEMT

- Consider IO access for sign and symptoms of dehydration with decreased mental status

EMT-I

- Consider cardiac monitoring

Paramedic

- Consider antiemetic
ALL LEVELS
- Pediatric routine assessment and care

EMR
- Consider Oxygen by non-rebreather mask or blow by – humidified if possible
- Position patient
  - Sitting upright
  - Head in neutral position
  - Avoid head tilt position
  - If upright not possible consider lateral position
- Pinch nares together
- Direction to patient
  - Spit blood/clot out
  - Try not to swallow blood
  - Do not rub – blow nose or sniff
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider IV access for sign and symptoms of shock

AEMT
- Consider IO access for signs and symptoms of shock AND if IV cannot be obtained

EMT-I
- Consider cardiac monitoring
ALL LEVELS
- Pediatric routine assessment and care

EMR
- Open airway
  - Trauma suspected use jaw thrust method
  - Non-traumatic use head tilt-chin lift method
- Consider oral airway
- Begin ventilations with bag-valve-mask or mouth to mask device attached to Oxygen
  - Infants 1 and under – 30 ventilations/min
  - Child 1 to 8 years – 24 ventilations/min
  - Child over age 8 to onset of puberty – 15 ventilation/min
- Suction as needed
- Consider cause use additional protocols if needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Monitor Oxygen saturation adjust ventilation/minute to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider IV access
- Consider advanced airway
- Obtain blood glucose reading

AEMT
- Consider IO access if IV cannot be obtained
- Consider cause use additional protocols if needed

EMT-I
- Consider intubation for persistent decrease mental status
- Adjust ventilation (rate/tidal volume/fiO2) to maintain
  - Oxygen saturation 94% or better
  - EtCO2 of 35 to 45 mmHg
- Initiate cardiac monitoring
- Consider cause use additional protocols if needed

Paramedic
- Consider cause use additional protocols if needed
ALL LEVELS
- Pediatric routine assessment and care

EMR
- Administer Oxygen
- Consider assisted ventilations
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Consider assisting patient with his/her prescribed metered dose inhaler
  o Administer prescribed number of puffs repeat two times every 5-10 minutes if distress continues
  o Consult medical control, PMD, or patient’s physician for additional doses
- Consider assisting patient with his/her prescribed epinephrine auto-injector for Status Asthmaticus* (See below)
  o Consult medical control, PMD, or patient’s physician for additional doses
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access
- Consider 2.5mg in 3 ml Albuterol nebulizer treatment
  o May repeat two times if symptoms do not improve or patient’s condition deteriorates
- If Albuterol nebulizer treatments fail to improve distress
  o Patient 30kg and under
    ▪ Consider 0.15mg (pediatric) epinephrine auto injector for Status Asthmaticus* (See below)
  o Patient over 30kg
    ▪ Consider 0.3mg (adult) epinephrine auto injector for Status Asthmaticus* (See Below)

AEMT
- Consider IO access if IV cannot be obtained
- If Albuterol nebulizer treatments fail to improve distress
  o Consider 0.01mg/kg (0.01ml/kg) epinephrine 1mg/ml (1:1000) IM for Status Asthmaticus* (See Below)

EMT-I
- Consider intubation for persistent decrease mental status
- Consider cardiac monitoring
- If first line bronchodilators nebulizer treatments fail to improve distress or patient deteriorates
  o Consider 0.01mg/kg (0.01ml/kg) epinephrine 1mg/ml (1:1000) IM
- Consider 2mg/kg to max 125mg Methylprednisolone IV/IO

Paramedic
- If first line pharmaceutical interventions have minimal or no effect
  o Consider 25 mg/kg to max 2 grams Magnesium Sulfate infused over 10 minutes
  o OR consider 0.5 to 0.75 ml of a 2.5% racemic epinephrine nebulizer treatment
  o OR consider 3 to 5 mg 1mg/ml (1:1000) epinephrine nebulizer treatment
- Consider RSI with inline nebulized bronchodilator

*Status Asthmaticus Means – sustained asthma not relieved by Oxygen, meter dose inhaler, or nebulizer treatment
**RESPIRATORY DISTRESS – CROUP (Revised 12/7/2012)**

**ALL LEVELS**
- Pediatric routine assessment and care

**EMR**
- Administer Oxygen
- Consider assisted ventilations
- Suction as needed
- Consider ALS

**EMR Options if Approved**
- Initiate transport

**EMT**
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Consider assisting patient with his/her prescribed metered dose inhaler
  - Administer prescribed number of puffs
- Initiate transport

**EMT Options if Approved**
- Consider advanced airway for persistent decrease mental status
- Consider IV access
- Consider 2.5mg in 3 ml Albuterol nebulizer treatment
  - Repeat two times if symptoms do not improve OR patient’s condition deteriorates

**AEMT**
- Consider IO access if IV cannot be obtained

**EMT-I**
- Consider intubation for persistent decrease mental status
- Consider cardiac monitoring

**Paramedic**
- May consider racemic epinephrine or epinephrine 1mg/ml (1:1000) nebulized as a first line therapy
- Consider 0.5 to 0.75 ml of a 2.5% racemic epinephrine nebulizer treatment
- **OR** consider 1mg/ml (1:1000) epinephrine nebulizer treatment
  - Age 4 and under 0.5ml/kg to max of 2.5ml in 3ml ns nebulized
  - Age 5 and older 0.5ml/kg to max of 5ml in 3 ml ns nebulized
RESPIRATORY DISTRESS – SPONTANEOUS PNEUMOTHORAX (Revised 12/7/2012)

ALL LEVELS
- Pediatric routine assessment and care

EMR
- Administer Oxygen
- Consider assisted ventilations
- Suction as needed
- Assess for trauma
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider needle decompression for signs and symptoms of tension pneumothorax
- Initiate cardiac monitoring

Paramedic
- Consider RSI
ALL LEVELS
- Pediatric routine assessment and care

EMR
- Administer Oxygen
- Consider assisted ventilations
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Consider assisting patient with his/her prescribed metered dose inhaler for sign and symptoms of distress
  - Administer prescribed number of puffs repeat two times every 5-10 minutes if distress continues
  - Consult medical control, PMD, or patient’s physician for additional doses
- Consider obtaining a body temperature
- Assess for dehydration
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider 2.5mg in 3 ml Albuterol nebulizer treatment
  - Repeat two times if symptoms do not improve or patient’s condition deteriorates
- Consider IV access
  - Administer 20ml/kg bolus for dehydration – reassess

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
- Consider cardiac monitoring

Paramedic
- As Alternate for albuterol in suspected RSV
  - Consider 0.5 to 0.75 ml of a 2.5% racemic epinephrine nebulizer treatment
  - OR consider 3 to 5 mg 1mg/ml (1:1000) epinephrine nebulizer treatment
- If albuterol does not improve symptoms or patient’s condition deteriorates
  - Consider 0.5 to 0.75 ml of a 2.5% racemic epinephrine nebulizer treatment
  - OR consider 3 to 5 mg 1mg/ml (1:1000) epinephrine nebulizer treatment
- Consider rsi with inline nebulized bronchodilator
Nebraska EMS Model Protocols  
Pediatric Medical Protocols  
SEIZURE AND POSTICTAL PERIOD (Revised 12/7/2012)

ALL LEVELS
- Pediatric routine assessment and care

EMR
- Active seizure
  - Administer Oxygen (blow by acceptable during seizure)
  - Protect patient – pads around patient
  - Do not restrain patient
  - Do not insert anything orally
- Postictal period
  - Consider oxygen
  - Consider assisted ventilations and oral airway for persistent decreased mental status
  - Suction as needed
- Assess for trauma and stroke
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider nasal airway for persistent decreased mental status in older children
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider obtaining blood glucose
- Consider IV access

AEMT
- Consider IO access
  - If IV cannot be obtained
  - Seizures reoccur

EMT-I
- Consider intubation for persistent decrease mental status
- Consider cardiac monitoring
- Consider 0.04 to 0.2 mg/kg max single dose Diazepam IV/IO/rectal
  - May repeat if needed to maximum of 10mg

Paramedic
- Consider benzodiazepine for repeat or continued seizures
NERVE AGENT – ORGANOPHOSPHATE EXPOSURE

ALL LEVELS
- Pediatric routine assessment and care

EMR and EMT and AEMT
- May administer auto injector antidote kits to a fellow responder or patients in mass numbers when higher level OOHECP are overwhelmed.

EMT-I and Paramedic
- May administer the auto injector antidote kits

Pediatric Auto-Injector Antidote Kit Dosing Chart

<table>
<thead>
<tr>
<th>Severity</th>
<th>Mild Symptoms</th>
<th>Moderate Symptoms</th>
<th>Severe Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signs And Symptoms</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pinpoint pupils (miosis)</td>
<td>Severe chest tightness</td>
<td>Cyanosis</td>
<td></td>
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<tr>
<td>Excessive sweating</td>
<td>Wheezing</td>
<td>Seizures</td>
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<tr>
<td>Tearing (lacrimation)</td>
<td>Profuse airway secretions</td>
<td>Coma</td>
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<tr>
<td>Drooling (salivation)</td>
<td>Respiratory distress</td>
<td>Flaccid paralysis</td>
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<tr>
<td>Runny nose</td>
<td>Vomiting, abdominal cramps</td>
<td>Respiratory failure</td>
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<tr>
<td>Mild chest tightness</td>
<td>Diarrhea</td>
<td>Apnea</td>
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<tr>
<td>Mild shortness of breath</td>
<td>Muscle weakness</td>
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<tr>
<td>Treatment</td>
<td>Evacuate to a Safe Area</td>
<td>Do Not Delay</td>
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<tr>
<td>Administer</td>
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<tr>
<td>One Each – Atropine and Pralidoxime (Mark I)</td>
<td>3 – 7 years old – One Each – Atropine and Pralidoxime (Mark I)</td>
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<td>OR</td>
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<tr>
<td>One – Atropine/Pralidoxime (DouDote)</td>
<td>One - Atropine/Pralidoxime (DouDote)</td>
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<tr>
<td>8 – 12 years old – Two Each – Atropine and Pralidoxime (Mark I)</td>
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<td>OR</td>
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<tr>
<td>Two – Atropine/Pralidoxime (DouDote)</td>
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<tr>
<td>12 and over use adult dose</td>
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</tbody>
</table>
ALL LEVELS
- Pediatric routine assessment and care

EMR
- Administer Oxygen
- Consider assisted ventilations
- Assess for trauma
- Suction as needed
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Assess CO level by non-invasive monitor
  - If elevated begin high flow Oxygen
  - If within normal values administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Consider assisting patient with his/her prescribed metered dose inhaler
  - Administer prescribed number of puffs repeat two times every 5-10 minutes if distress continues
  - Consult medical control, PMD, or patient’s physician for additional doses
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider 2.5mg in 3ml Albuterol nebulizer treatment
  - Repeat two times if symptoms do not improve or patient’s condition deteriorates
- Consider IV access

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
- Consider bronchodilator
- Initiate cardiac monitoring

Paramedic
- Consider RSI with inline nebulized bronchodilator
ALL LEVELS
- Pediatric routine assessment and care

EMR
- Consider Oxygen
- Obtain name of medication/drug
  - See Next Page for additional information
- Consider ALS

EMR Options if Approved
- Initiate transport

EMT
- Consider contacting destination facility via radio/phone with name of medication/drug
- Consider contacting poison control
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider iv access

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
- Consider cardiac monitoring

SPECIAL INSTRUCTIONS FOR SPECIFIC OVERDOSES (Revised 12/7/2012)

IF LEVEL NOT LISTED USE THE TOXIN – OVERDOSE PROTOCOL ABOVE

Stimulants – Cocaine – Methamphetamine – Ecstasy
EMR-EMT
- Obtain temperature
- If temp over 102°F and an infection is not suspected consider passive cooling

EMT Options if Approved and AEMT
- Consider fluid boluses for elevated temps and signs and symptoms of dehydration

EMT-I
- For patients over 1 year old that present awake, alert with severe anxiousness/anxiety and/or hallucinations
  - Consider 0.04 to 0.2mg/kg Diazepam IV/IO

Paramedic
- For patients over 1 year old that present awake, alert with severe anxiousness/anxiety and/or hallucinations
  - Consider benzodiazepine
Narcotics – Opiates – Barbituates

**ALL LEVELS**
- Consider 0.1mg/kg to Max of 4mg Naloxone IM Auto-Injector/MAD for suspected or known narcotic overdose, or IM/IV/IO/MAD for AEMT and above
  - If symptoms of narcotic overdose reoccur after initial response to Naloxone, re-administer dose

**AEMT**
- Consider 0.1mg/kg to max of 4mg Naloxone IV/IO/MAD
- Consider advanced airway if naloxone fails to improve respiratory status

**EMT-I and Paramedic**
- Consider intubation if naloxone fails to improve respiratory status

**Tricyclic Antidepressant**

**Paramedic**
- For patients that present or develop decreased mental status, hypotension and widen QRS
  - Confirmed tricyclic antidepressant overdose/poisoning
  - Consider
    - Age 8 and under 1mEq/kg 4.2% sodium bicarbonate slow IV/IO
    - Over age 8 1mEq/kg 8.4% sodium bicarbonate slow IV/IO
  - Consider vasopressor agent

**Calcium Channel Blocker**

**Paramedic**
- For patients that present or develop decreased mental status, and hypotension
  - Contact medical control/poison center for consult on calcium chloride
  - OR calcium gluconate
  - Consider vasopressor agent

**Organophosphates**

**EMT-I**
- Consider 0.02mg/kg Atropine-minimum single dose 0.1mg max single dose 1mg IV/IO
- May repeat until symptoms improve

**Paramedic**
- Consider 20 to 50mg/kg to max of 1200mg Pralidoxime IV/IO
**SHOCK (Revised 4/13/15)**

### ALL LEVELS
- Pediatric routine assessment and care

#### EMR
- Administer Oxygen
- Assess for trauma
  - Control external hemorrhage
  - Manually stabilize c-spine and extremity deformities
- Assess for dehydration
- Assess for potential of allergic reaction **go to Allergic Reaction Anaphylaxis Protocol**
- Position supine unless respiratory status do not allow for this
- Conserve body heat
- Consider ALS

#### EMR Options if Approved
- If trauma present
  - Consider spinal stabilization and extremity stabilization
- Initiate transport

#### EMT
- Administer Oxygen and adjust delivery device and lpm flow to achieve 94% or better o2 saturation
- Obtain temperature and if fever consider dehydration/sepsis
- Initiate transport

#### EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access
- Consider fluid bolus(es) 20ml/kg then reassess and repeat
  - **EXCEPT Cardiogenic Shock – consider fluid bolus(es) 10 ml/Kg then reassess and repeat**

#### AEMT
- Consider IO access if IV cannot be obtained

#### EMT-I
- Initiate cardiac monitoring
- Assess for potential of cardiogenic shock

#### Paramedic
- Assess for type of shock
- General considerations for shock
  - When considering anti-emetic choose an agent with the least cardiac effects
  - When considering pain management choose an agent with least effect on BP
- Shock types and considerations

<table>
<thead>
<tr>
<th>Hypovolemic</th>
<th>Cardiogenic</th>
<th>Obstructive Shock</th>
<th>Distributive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider 20 ml/kg fluid boluses with frequent reassessments</td>
<td>Consider 10 ml/kg fluid bolus(es) Consider vasopressor agent Manage dysrhythmias</td>
<td>Assess for tension pneumothorax – treat with needle decompression Assess for cardiac tamponade – alert destination facility</td>
<td>Anaphylaxis – Go To Allergic Reaction Anaphylaxis Protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neurogenic (spine) shock – consider 20 ml/kg fluid boluses</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sepsis – consider 20 ml/kg fluid boluses Consider vasopressor agents</td>
</tr>
</tbody>
</table>
### Nebraska EMS Model Protocols
#### Pediatric Trauma Protocols

**TRAUMA CARE HEAD – CHEST – ABDOMEN (Revised 3/22/2018)**

**ALL LEVELS**
- Pediatric routine assessment and care
- Assess for shock and treat

<table>
<thead>
<tr>
<th>Head/Neck/Spine</th>
<th>Chest</th>
<th>Abdomen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer Oxygen</td>
<td>Consider assisted ventilations</td>
<td>Consider OQRST pneumonic for assessment of pain</td>
</tr>
<tr>
<td>Consider oral airway</td>
<td>Suction as needed</td>
<td>Manually stabilize head and neck</td>
</tr>
<tr>
<td>Consider OQRST pneumonic for assessment of pain</td>
<td>Control external bleeding</td>
<td>Stabilize impaled objects in place</td>
</tr>
<tr>
<td>Manually stabilize head and neck</td>
<td>Assess CMS</td>
<td>Consider trauma team – trauma system activation</td>
</tr>
<tr>
<td>Control external bleeding</td>
<td>May Control external bleeding with the use of hemostatic agents with Physician Medical Director approval and direction.</td>
<td></td>
</tr>
<tr>
<td>Stabilize impaled objects in place</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMR**

- Open Trauma: *Bandage open wounds* *Consider occlusive dressing for open neck wounds*
- Closed Trauma: *Consider cold pack to areas of edema*

- Open chest trauma – sucking chest wound: *Seal wound with occlusive dressing*

- Closed chest trauma: *Consider stabilizing failing sections with bulky dressings*

**EMR Options**

- Consider spinal stabilization with pediatric sized device
- Consider extremity stabilization with pediatric sized device
- Initiate transport

**EMT**

- Consider Oxygen and Adjust Delivery Device and LPM Flow to Achieve 94% or Better O2 Saturation
- For Signs and Symptoms of ICP AND GCS of 6 and under – consider hyperventilation of patient initiate transport

**EMT Options**
- Consider advanced airway for persistent decrease mental status
- Consider IV access
- Assess for shock and administer appropriate fluid boluses

**AEMT**

- Consider IO access as first access route in unstable pediatric patients
- Assess for shock and administer appropriate fluid boluses
- Consider Morphine 2 – 4 mg IV/IO/MAD

**EMT-I**

- *Consider Cardiac Monitoring*
- *Initiate Cardiac Monitoring*
- *Needle decompress patient for sign* and symptoms of tension pneumothorax

**Paramedic**

- Consider RSI
- Consider Pain Management

**Special consideration for extremity injuries in multi-systems trauma**
- *Consider utilizing a full body stabilization device and splint injured extremities to the device and/or patient to allow for rapid scene time and then splint extremities enroute to destination*
- *Stabilization of suspected pelvic and femur fractures is a high priority*
### Nebraska EMS Model Protocols
**Pediatric Trauma Protocols**

**AMPUTATIONS – EXTREMITY – SOFT TISSUE TRAUMA (Revised 3/22/2018)**

#### ALL LEVELS

- Pediatric routine assessment and care
- Assess for shock and treat

<table>
<thead>
<tr>
<th>Amputations</th>
<th>Extremity</th>
<th>Soft Tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer Oxygen</td>
<td><em>Manually stabilize painful and/or deformed extremity</em></td>
<td><em>Return avulsion type flaps to anatomic position if possible.</em></td>
</tr>
<tr>
<td>Consider assisted ventilations</td>
<td><em>Apply cold pack</em></td>
<td><em>Bandage open wounds</em></td>
</tr>
<tr>
<td>Consider oral airway</td>
<td></td>
<td><em>Consider removing impaled objects through the cheek into the mouth.</em></td>
</tr>
<tr>
<td>Consider OPQRST pneumonic for assessment of pain</td>
<td></td>
<td><em>For eye injuries – cover both eyes.</em></td>
</tr>
<tr>
<td>Suction as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manually stabilize head and neck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control external bleeding</td>
<td></td>
<td></td>
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<tr>
<td>Stabilize impaled objects in place</td>
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<td></td>
</tr>
<tr>
<td>Assess CMS</td>
<td></td>
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<tr>
<td>Consider trauma team activation</td>
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</tr>
</tbody>
</table>

**EMR**

May control external bleeding with the use of hemostatic agents with Physician Medical Director approval and direction.

- *Wrap amputated part in dressing and keep cool*
- *Do not place tissue directly on ice*

**EMR Options**

- Consider spinal stabilization with pediatric sized device
- Consider extremity stabilization with pediatric sized device
- Initiate transport

- *Consider traction type splint for femur injuries*
- *Consider pelvic splint for pelvic injuries*

**EMT**

- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

**EMT Options**

- Consider advanced airway for persistent decrease mental status
- Consider IV access
- Assess for shock and administer 20ml/kg fluid boluses (max single bolus 500ml)

**AEMT**

- Consider IO access as first access route in unstable pediatric patients
- Assess for shock and administer appropriate fluid boluses
- Consider Morphine 0.05 to 0.2 mg/kg IV/IO/MAD

**EMT-I**

- *Consider Cardiac Monitoring*

**Paramedic**

- Consider RSI
- Consider pain management
- Consider reduction of deformed fractures or dislocations **ONLY** if there is loss of signs of circulation, loss of sensation distal to the deformity, or if it is necessary in order to otherwise care for and transport the patient
- *for stable patient consider on scene pain management to ease pain of movement/splinting*
- Defer insertion of NG and OG tube in any patient with gastric bypass or gastric banding
- Consider 100 mg Thiamine IV/IO for adolescent patients with gastric bypass or gastric banding

**Special Consideration for Extremity Injuries in Multi-Systems Trauma**

- *Consider utilizing a full body stabilization device and splint injured extremities to the device and/or patient to allow for rapid scene time and then splint extremities in-route to destination*
- *Stabilization of suspected pelvic and femur fractures is a high priority*
BITES AND ENVENOMATION (Revised 3/22/2018)

ALL LEVELS
- Pediatric routine assessment and care
- Assess for shock and treat

EMR
- Consider Oxygen
- Consider OPQRST for assessment of pain
- Control any external bleeding
- Consider manual stabilization of affected extremity
- Human bites and animal bites
  - Bandage wound
- Snake bite
  - Attempt to identify breed of snake
  - Slow venous return
- Insect bites
  - Remove stinger/venom sac
- Spider bites
  - Consider cold pack
- Assess for allergic reaction go to Allergic Reaction – Anaphylaxis Protocol
- Consider ALS

EMR Options if Approved
- Consider extremity stabilization
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider IV access
  - **Minor bites without associated sign and symptoms IV should be deferred

AEMT
- Consider IV access for pain management
- Consider IO access if IV cannot be obtained
- Consider 0.05 to 0.2mg/kg to max 4mg Morphine IV/IO/MAD

EMT-I
- Consider cardiac monitoring

Paramedic
- Consider pain management
ALL LEVELS
- Pediatric routine assessment and care
- Assess for shock and treat

EMR
- Administer Oxygen
- Consider assisted ventilations
- Consider oral airway
- Consider opqrst for assessment of pain
- Consider manually stabilize head/neck

<table>
<thead>
<tr>
<th>Thermal Burns</th>
<th>Electrical Burns</th>
<th>Radiation Burns</th>
<th>Chemical Burns</th>
</tr>
</thead>
<tbody>
<tr>
<td>THINK SAFETY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remember Scene Safety And Appropriate PPE</td>
<td></td>
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</tr>
<tr>
<td>Stop burning process</td>
<td>Verify the electrical source is de-energized</td>
<td>Patient and radiation source need to be separated</td>
<td>Brush dry chemicals from skin flush with water</td>
</tr>
<tr>
<td>Do not intentionally rupture blisters</td>
<td>Assess for entrance and exit wounds</td>
<td>Decontaminate patient prior to transport</td>
<td>Wet chemicals – flush with water</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Flush eyes continuously</td>
</tr>
<tr>
<td></td>
<td>Cover burns/wounds with dry dressings</td>
<td>Wrap patient with dry sheet</td>
<td></td>
</tr>
</tbody>
</table>

EMR Options if Approved
- Consider spinal stabilization
- Consider extremity stabilization
- Initiate transport

EMT
- Defer nasal airway in facial burns and inhalation of super-heated air
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Estimate body surface area burned and extend of burn
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access

AEMT
- Consider IO access if IV cannot be obtained
- Consider 0.05 to 0.2mg/kg to max Morphine IV/IO/MAD

EMT-I
- Consider intubation for persistent decrease mental status
- Initiate cardiac monitor for all electrical burns – consider for all other burns

Paramedic
- Consider RSI for burns to airway – inhaled superheated gases – inhaled chemicals
- Consider pain management

Pediatric Modified Parkland Formula for Fluid Resuscitation in Thermal Burn Patients

\[
3 \text{ ml} \times \text{Body Surface Area Burned} \times \text{Patient Weight in Kg} = \text{Total Fluid Over 24 Hours}
\]

Half Given In 1st Eight Hours
CRUSH INJURY

All Levels
- Routine assessment and care
- Assess for shock and treat

EMR
- Administer Oxygen
- Manually stabilize head/neck
- Consider oral airway
- Consider assisted ventilations
- Consider OPQRST for assessment of pain
- Control external bleeding
  - Control external bleeding with direct pressure, pressure bandage, pressure points and/or tourniquet
  - Control external bleeding with the use of hemostatic agents with physician medical director approval and direction.
- Consider trauma system activation
- Consider ALS

EMR Options if Approved
- Consider spinal stabilization
- Consider extremity stabilization
- Initiate transport

EMT
- Consider nasal airway
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport once freed

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Pre – release
  - Consider two IV access points
  - Administer fluid 20ml/kg bolus(es) to maintain BP within 5 to 10 points of normal for age
- Release – during process to free patient
  - Administer fluid 20ml/kg bolus(es) to maintain BP within 5 to 10 points of normal for age
- Post release
  - Administer fluid 20ml/kg bolus(es) to maintain BP within 5 to 10 points of normal for age

AEMT
- Single IO access if unable to obtain IO access
- Consider 0.05 to 0.2 mg/kg to 4 mg max Morphine if BP stabilizes with normal systolic range for patient's Age

EMT-I
- Consider intubation for persistent decrease mental status
- Initiate cardiac monitoring

Paramedic
- Consider RSI
- Consider pain management
- Consider consult with medical control for entrapment over 60 minutes
  - 1meg/kg sodium bicarbonate
- Consider diagnostic mode 3 lead or 12 lead and evaluate for tall spiked T waves indicating hyperkalemia
  - Consider continuous albuterol nebulizer treatments age 1 and under total dose 2.5mg
  - Consider continuous albuterol nebulizer treatments age 1 to adolescent total dose 5mg
  - Consider continuous albuterol nebulizer treatments adolescent total dose 15mg
ENVIRONMENTAL TRAUMA – EXPOSURE TO HEAT AND COLD (Revised 3/22/2018)

ALL LEVELS
- Pediatric routine assessment and care
- Assess for shock and treat

EMR
- Administer Oxygen
- Manually stabilize head/neck
- Consider assisted ventilations
- Consider OPQRST for assessment of pain
- Exposure to cold – hypothermia
  - Gently move patient to warm area if no spinal injury suspected
  - Remove wet clothing
  - Frozen/ near frozen extremities
    - Expose to warm surroundings
    - Consider dry dressing to pad
  - Body wide hypothermia
    - Passively warm patients with warm packs and blankets
- Exposure to heat
  - Gently move patient to cool area if no spinal injury suspected
  - Remove excessive clothing
  - Normal mental status and perspiration intact
    - Passive cool patient with fanning and cool dressing
  - Decrease mental status and/or no perspiration
    - Aggressive cooling with wet sheet, fanning and col packs
- Consider trauma system activation
- Consider ALS

EMR Options if Approved
- Consider spinal stabilization
- Consider extremity stabilization
- Initiate transport

EMT
- Consider nasal airway
- Administer Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider advanced airway for persistent decrease mental status
- Consider IV access

AEMT
- Consider IO access if IV cannot be obtained

EMT-I
- Consider intubation for persistent decrease mental status
- Initiate cardiac monitoring

Paramedic
- Consider RSI
- When passive warming frozen extremities consider pain management
ALL LEVELS
- Routine assessment and care
- Assess for shock and treat
- Document
  - Factually injuries
  - Patient statements
- Report suspicions to destination facility and law enforcement

EMR
- Consider Oxygen
- Consider OPQRST for assessment of pain
- Manage open wounds
- Stabilize impaled objects in place
- Consider trauma system activation
- If possible have EMS provider of same sex as patient provide assessment and treatment
- Consider ALS

EMR Options if Approved
- Consider spinal stabilization
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options if Approved
- Consider IV access
- Consider advanced airway for persistent decrease in mental status

AEMT
- Consider IO access if IV cannot be obtained
- Consider 0.05 to 0.2mg/kg to max morphine IV/IO/MAD

EMT-I
- Consider cardiac monitoring

Paramedic
- Consider pain management
Specialty Medical Treatments
EMR, EMT, AEMT, and EMT-I

- Not approved for this protocol

Paramedic

- Field administration – emergency administration due to a delay in transport
  - Must have medical control approval
  - Must have type O negative blood
  - Or in cases of extreme entrapment have type and matched blood delivered to scene

- Inter-facility administration
  - Obtain order for transport
  - Obtain blood – blood product

- Blood – blood product administration
  - Obtain order
  - Obtain consent for blood-blood product administration
  - Obtain blood/blood product verify type and assignment to patient
  - Utilize blood Y with filter administration set
  - Set up administration with one port to normal saline and other port to blood
  - Flush administration set with normal saline
  - Obtain baseline vitals including temperature
  - Ensure a patent IV line size 18 or larger
  - Attach administration set and start flow of normal saline to verify IV is patent
  - Stop normal saline begin blood
  - Set rate
  - Monitor vital signs every 15 minutes until 30 minutes after blood completed
  - If patient develops transfusion reaction
    - Stop blood
    - Flush IV site
    - Consider 25 to 50mg diphenhydramine
  - When blood complete flush administration set with normal saline
# PAIN MANAGEMENT (Revised 6/7/2019)

**ALL LEVELS**
- Routine assessment and care

**EMR**
- Consider applying cold pack to painful/deformed extremity

**EMR Options if Approved and EMT**
- Consider stabilization

**EMT Options if Approved**
- Consider IV access

**AEMT and EMT-I**
- Consider

### AEMT and EMT-I Pain Management Procedure

#### Assess and Monitor
- Vital Signs
  - Pulse, BP, Respiratory Rate
  - Pulse Oximetry
  - Consider
    - Electronic EtCO2 and Cardiac Monitor
- Pain Level

#### Preparation
- Evaluate patient for potential of difficult airway
- Have intubation equipment and supplies available
- Have alternate non-visualized advanced airway available
- Have suction available
- Have naloxone available

#### Oxygenation
- Deliver Oxygen to maintain O2 saturations of 94% to 99%

#### Medication Administration
- Morphine
  - Adult: 2 – 4mg IV/IO/IM or MAD
  - Pediatric: 0.05 – 0.2mg/kg to Max 2mg IV/IO/IM/MAD
- Acetaminophen (Tylenol)
  - IV EMT-I and Paramedic only
  - PO EMT and above
    - Adult:
      - <50 kg: 12.5 mg/kg IV q 4 hr OR 15 mg/kg IV q 6 hr; not to exceed 750 mg/dose or 3.75 g/day
      - ≥50 kg: 650 mg IV q 4 hr OR 1000 mg IV q 6 hr; not to exceed 4 g/day
      - 325-1000 mg PO q 4-6 hr prn; Max: 1 g/4h and 4 g/day from all sources
    - Pediatric:
      - <2 years: Safety and efficacy not established
      - 2-12 years: 12.5 mg/kg IV q4hr OR 15 mg/kg IV q6hr; not to exceed 75 mg/kg/day
      - ≥13 years
        - <50 kg: 12.5 mg/kg IV q 4 hr OR 15 mg/kg IV q 6 hr; not to exceed 750 mg/dose or 3.75 g/day
        - ≥50 kg: 650 mg IV q 4 hr OR 1000 mg IV q 6
        - Dose: 325-650 mg PO q 4-6 hr prn; Max: 1 g/4h and 4 g/day from all sources
        - Neonates: 10-15 mg/kg PO q 6-8 hr prn; Max: 60 mg/kg/day from all sources
        - Infants/Children: 10-15 mg/kg PO q 4-6 hr prn; Max: 75 mg/kg/day up to 1 g/4h and 4 g/day from all sources

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### Ibuprofen (Motrin)
- **Adult:** 400 mg PO q4-6h prn; Max: 2400 mg/day
- **Pediatric:**
  - **6 mo-11:** Dose: 5-10 mg/kg PO q6-8h prn; Max: 40 mg/kg/day
  - **12 and older:** Dose: 400 mg PO q4-6h prn; Max: 2400 mg/day

### Reassess
- **Vital Signs**
  - Pulse, BP, Respiratory Rate
  - Pulse Oximetry
  - Consider – EMT-I
    - Electronic EtCO2 and Cardiac Monitor
- **Pain Level**

### Re- Dose for desired effect
- **Titrate Morphine**
  - **Adult:** 2mg IV/IO/IM/MAD
  - **Pediatric:** 0.05 – 0.2 mg/kg to Max 2mg IV/IO/IM/MAD

### Goal – Reduction of Pain Not Necessarily Elimination of Pain
**Paramedic**
The Paramedic may consider minimal to moderate sedation in conjunction with an analgesic to manage the patient’s pain OR analgesic only to manage the pain. THE PARAMEDIC IS EXPECTED TO RECEIVE TRAINING ON THE MEDICATIONS CARRIED BY THE SERVICE.

**Minimal Sedation means** the patient responds normally to verbal commands. Cognitive function and coordination may be impaired, but respiratory and cardiovascular functions are unaffected.

**Moderate Sedation means** the patient responds purposefully to verbal commands alone or when accompanied by light touch. Protective airway reflexes and adequate ventilation are maintained without intervention. Cardiovascular function remains stable.

<table>
<thead>
<tr>
<th>Sedation and Analgesic Option Procedure</th>
<th>Analgesic Only Option Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess and Monitor</strong></td>
<td></td>
</tr>
<tr>
<td>• Vital Signs</td>
<td></td>
</tr>
<tr>
<td>o Pulse, BP, Respiratory Rate</td>
<td></td>
</tr>
<tr>
<td>o Pulse Oximetry</td>
<td></td>
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<tr>
<td>o Electronic EtCO2</td>
<td></td>
</tr>
<tr>
<td>o Cardiac Rhythm</td>
<td></td>
</tr>
<tr>
<td>• Pain Level</td>
<td></td>
</tr>
<tr>
<td><strong>Preparation</strong></td>
<td></td>
</tr>
<tr>
<td>• Evaluate patient for potential of</td>
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<tr>
<td>difficult airway</td>
<td></td>
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<tr>
<td>• Have intubation equipment and</td>
<td></td>
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<tr>
<td>supplies available</td>
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<tr>
<td>• Have alternate non-visualized advanced airway available</td>
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<tr>
<td>• Have suction available</td>
<td></td>
</tr>
<tr>
<td>• Have naloxone available</td>
<td></td>
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<tr>
<td><strong>Oxygenation</strong></td>
<td></td>
</tr>
<tr>
<td>• Deliver Oxygen to maintain O2</td>
<td></td>
</tr>
<tr>
<td>saturations of 94% to 99%</td>
<td></td>
</tr>
<tr>
<td><strong>Medication Administration</strong></td>
<td></td>
</tr>
<tr>
<td>• Administer Sedative *See Approved</td>
<td></td>
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<tr>
<td>Sedative Chart</td>
<td></td>
</tr>
<tr>
<td>• Administer Analgesic *See Approved</td>
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<tr>
<td>Analgesic Chart</td>
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<tr>
<td>• Consider Anti-Emetic</td>
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<tr>
<td>o Preferred</td>
<td></td>
</tr>
<tr>
<td>▪ Ondansetron (Zofran)</td>
<td></td>
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<tr>
<td>▪ Dolasetron (Anzemet)</td>
<td></td>
</tr>
<tr>
<td>o Acceptable But Monitor For EPR and Cardiac Effects</td>
<td></td>
</tr>
<tr>
<td>▪ Promethazine (Phenergan)</td>
<td></td>
</tr>
<tr>
<td>▪ Prochlorperazine (Compazine)</td>
<td></td>
</tr>
<tr>
<td><strong>Reassess</strong></td>
<td></td>
</tr>
<tr>
<td>• Vital Signs</td>
<td></td>
</tr>
<tr>
<td>o Pulse, BP, respiratory rate</td>
<td></td>
</tr>
<tr>
<td>o Pulse Oximetry</td>
<td></td>
</tr>
<tr>
<td>o EtCO2</td>
<td></td>
</tr>
<tr>
<td>o Cardiac rhythm</td>
<td></td>
</tr>
<tr>
<td>• Adjust Oxygen delivery as needed</td>
<td></td>
</tr>
<tr>
<td>• Pain Level</td>
<td></td>
</tr>
<tr>
<td><strong>Re-Dose for desired effect</strong></td>
<td></td>
</tr>
<tr>
<td>• Titrate sedative</td>
<td></td>
</tr>
<tr>
<td>• Titrate analgesic</td>
<td></td>
</tr>
<tr>
<td><strong>Reassess and Re-Dose</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Goal</strong></td>
<td></td>
</tr>
<tr>
<td>• Obtain minimal to moderate sedation</td>
<td></td>
</tr>
<tr>
<td>level using the least amount of</td>
<td></td>
</tr>
<tr>
<td>medication</td>
<td></td>
</tr>
<tr>
<td>• Reduction of pain</td>
<td></td>
</tr>
</tbody>
</table>

| Analgesic Only Option Procedure       |                                 |
| • Vital Signs                          |                                 |
|   o Pulse, BP, Respiratory Rate        |                                 |
|   o Pulse Oximetry                     |                                 |
|   o Consider                           |                                 |
|     ▪ Electronic EtCO2 and Cardiac      |                                 |
|   Monitor                              |                                 |
| • Pain Level                           |                                 |
| **Preparation**                        |                                 |
| • Evaluate patient for potential of    |                                 |
|   difficult airway                     |                                 |
| • Have intubation equipment and        |                                 |
|   supplies available                   |                                 |
| • Have alternate non-visualized advanced airway available | |
| • Have suction available                |                                 |
| • Have naloxone available              |                                 |
| **Oxygenation**                        |                                 |
| • Deliver Oxygen to maintain O2        |                                 |
|   saturations of 94% to 99%            |                                 |
| **Medication Administration**          |                                 |
| • Administer Analgesic *See Approved   |                                 |
|   Analgesic Chart                      |                                 |
| • Consider Anti-Emetic                 |                                 |
|   o Preferred                          |                                 |
|     ▪ Ondansetron (Zofran)              |                                 |
|     ▪ Dolasetron (Anzemet)             |                                 |
|   o Acceptable But Monitor For EPR and Cardiac Effects | |
|     ▪ Promethazine (Phenergan)         |                                 |
|     ▪ Prochlorperazine (Compazine)     |                                 |
| **Reassess**                           |                                 |
| • Vital Signs                          |                                 |
|   o Pulse, BP, respiratory rate        |                                 |
|   o Pulse Oximetry                     |                                 |
|   o Consider                           |                                 |
|     ▪ Electronic EtCO2 and cardiac      |                                 |
|   Monitor                              |                                 |
| • Pain Level                           |                                 |
| **Re-Dose for desired effect**         |                                 |
| • Titrate analgesic                    |                                 |
| **Reassess and Re-Dose**               |                                 |
| **Goal**                               |                                 |
| • Reduction of pain not necessarily    |                                 |
|   elimination of pain                  |                                 |
**Use lowest dose in the elderly or patients with impaired hepatic and or renal function**

<table>
<thead>
<tr>
<th>Medication Name Generic (Brand Name)</th>
<th>Adult Dose</th>
<th>Pediatric Dose *Maximum Does Not To Exceed Adult Dose</th>
<th>Special Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benzodiazepine – Most Class Preferred Class</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>2.0- 4.0mg IV/IO/Rectal \ May repeat to maintain sedation</td>
<td>0.04 -0.2 mg/kg IV./IO/ Rectal (6 Mo to 12 years) \ May repeat to maintain sedation</td>
<td>Reversal Agent – Flumazenil (Romazicon) Use with caution as rapid reversal may lead to seizures especially in patient with history of seizure disorder</td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>0.5 - 1.0mg IV/O \ May repeat to maintain sedation \ *Approved to be given by MAD but due to viscosity of may be an ineffective method of administration</td>
<td>0.05 mg/kg (6 Mo to 12 years) \ May repeat to maintain sedation IV/O</td>
<td></td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>1.0- 2.0mg IV/O/IM/MAD \ May repeat to maintain sedation</td>
<td>0.1 mg/kg (6 Months and Older) \ May repeat to maintain sedation</td>
<td></td>
</tr>
<tr>
<td><strong>Carboxylated Imidazole Derivative Class – Most Preferred Alternative to Benzodiazepine Class for Adult Sedation Acceptable Alternative to Benzodiazepine Class for Certain Pediatric Patients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Etomidate</td>
<td>0.1 – 0.15 mg/kg IV/O \ 0.05 mg/kg every 3 to 5 minutes to maintain sedation</td>
<td>0.1 – 0.2 mg/kg IV/O \ 0.05 mg/kg every 3 to 5 minutes to maintain sedation</td>
<td>Avoid if patient 10 years old or younger \ May cause adrenal suppression</td>
</tr>
<tr>
<td><strong>NMDA Receptor Antagonist Class – Most Preferred Alternative to Benzodiazepine Class for Pediatric Sedation Acceptable Alternative to Benzodiazepine Class for Adult Sedation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketamine</td>
<td>1.5 – 2.0mg/kg IV/O \ 0.25 – 0.5 mg/kg every 5 to 10 minutes to maintain sedation</td>
<td>For Patient’s Over 6 Months Old \ 2.0 – 4.0 mg/kg IM \ 1.0 – 2.0 mg/kg IV/O \ 0.25 – 0.5 mg/kg every 5 to 10 minutes to maintain sedation</td>
<td>Consider Atropine for increased secretions \ 0.02 mg/kg with a minimal dose of 0.1 mg and a maximum of 0.5 mg for Pediatric \ 0.5mg Single Dose for Adults</td>
</tr>
<tr>
<td><strong>Phenothiazine Class Least Desirable Alternative – Reserved To Incidents When No Other Alternatives Are Available</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prochlorperazine (Compazine)</td>
<td>5mg IV/O \ May Repeat Once</td>
<td>Not Approved \ May cause dystonic reactions</td>
<td>Use Lowest possible dose to prevent extra pyramidal reactions \ For EPR consider \ Diphenhydramine (Benadryl) 12.5 to 25mg Peds \ 25 to 50mg Adults</td>
</tr>
<tr>
<td>Promethazine (Phenergan)</td>
<td>25 mg IV/O \ May Repeat Once</td>
<td>Not Approved \ May cause dystonic reactions</td>
<td></td>
</tr>
</tbody>
</table>
# APPROVED ANALGESIA CHART

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Adult Dose</th>
<th>Pediatric Dose *Maximum Does Not To Exceed Adult Dose</th>
<th>Special Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>2 – 4 mg IV/IO/IM/MAD</td>
<td>0.05 – 0.2mg/kg IV/IO/IM/MAD</td>
<td>Reversal Agent – Nalxone (Narcan)</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>25 to 100 mcg IV/IO/IM/MAD</td>
<td>1.0 – 2.0 mcg/kg IV/IO/IM/MAD</td>
<td></td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid)</td>
<td>0.2 – 0.6 mg IV/IO</td>
<td>0.03 to 0.08mg/kg IV/IO Over 6 Months</td>
<td></td>
</tr>
<tr>
<td>Nalbuphine (Nubain)</td>
<td>10 to 20mg IV/IO</td>
<td>0.05 to 0.1mg/kg IV/IO</td>
<td></td>
</tr>
<tr>
<td>Stadol</td>
<td>0.5mg to 2mg IV/IO</td>
<td>Not Approved Under Age 18</td>
<td></td>
</tr>
</tbody>
</table>

**Opioid Class**

**Least Desirable Alternative – But Acceptable**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Adult Dose</th>
<th>Pediatric Dose</th>
<th>Special Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meperidine (Demerol)</td>
<td>50 – 100mg IV/IO/IM</td>
<td>1mg/kg IV/IO/IM</td>
<td>Reversal Agent – Nalxone (Narcan)</td>
</tr>
</tbody>
</table>

**NSAID Class**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Adult Dose</th>
<th>Pediatric Dose</th>
<th>Special Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ketorolac (Toradol)</td>
<td>15 to 30mg IV/IM</td>
<td>0.5mg/kg to maximum dose of 30mg</td>
<td>Defer in suspected CVA, GI bleeding, or other indications of internal bleeding and external bleeding not easily controlled with direct pressure</td>
</tr>
<tr>
<td>Ibuprofen (Motrin)</td>
<td>400 mg PO q4-6h prn Max: 2400 mg/day</td>
<td>6 mo-11: Dose: 5-10 mg/kg PO q6-8h prn; Max: 40 mg/kg/day 12 and older: Dose: 400 mg PO q4-6h prn; Max: 2400 mg/day</td>
<td></td>
</tr>
</tbody>
</table>

**Analgesic Class**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Adult Dose</th>
<th>Pediatric Dose</th>
<th>Special Information</th>
</tr>
</thead>
</table>
| Acetaminophen (Tylenol) | <50 kg: 12.5 mg/kg IV q 4 hr OR 15 mg/kg IV q 6 hr; not to exceed 750 mg/dose or 3.75 g/day  
≥50 kg: 650 mg IV q 4 hr OR 1000 mg IV q 6 hr; not to exceed 4 g/day Infuse IV over at least 15 minutes (also see | 0-2 years: Safety and efficacy not established 2-12 years: 12.5 mg/kg IV q4hr OR 15 mg/kg IV q6hr; not to exceed 75 mg/kg/day  
≥13 years: <50 kg: 12.5 mg/kg IV q 4 hr OR 15 mg/kg IV q 6 hr; not to exceed 750 mg/dose or 3.75 g/day  
≥50 kg: 650 mg IV q 4 hr OR 1000 mg IV q 6 hr; not to exceed 4 g/day | Indicated for mild-to-moderate pain and moderate-to-severe pain with adjunctive opioid analgesics; also indicated for reduction of fever injectable solution: 10mg/mL |
| Acetaminophen (Tylenol) | 325-1000 mg PO q 4-6 hr prn| Max: 1 g/4h and 4 g/day from all sources | Neonates: Dose: 10-15 mg/kg PO q 6-8 hr prn; Max: 60 mg/kg/day from all sources Infants/Children: Dose: 10-15 mg/kg PO q 4-6 hr prn; Max: 75 mg/kg/day up to 1 g/4h and 4 g/day from all sources 12 and older: Dose: 325-650 mg PO q 4-6 hr prn; Max: 1 g/4h and 4 g/day from all sources | |

**Routes of Administration:** IV – Intravenous  IO – Intraosseous  IM – Intramuscular  MAD – Mucosal Atomization Device

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Page 135
Paramedic Only

RSI Decision Making Algorithm

Patient Meets At Least One Indication Criteria
Patient Unable to Protect Airway With or Without Trismus
GCS ≤ 8 or Rapid Decreasing GCS
Respiratory Failure/ Rapidly Decreasing Respiratory Status
Impending Airway Compromise
Head Injuries, Major CVA with Decreased LOC and Inability to Protect Airway

Yes – Patient Meets Criteria
No – Patient Does Not Meet Criteria

Risk vs. Benefit – Incident Assessment Considerations
Delay of RSI will lead to Aspiration, Respiratory Collapse, and/or Hypoxia
Distance/Time to Receiving Hospital is extended
Short Scene/Transport Times Scene is Such That Rapid Transport is Delayed Rarely Require RSI

Yes – Risk Benefit Acceptable
No – Risk vs. Benefit is Unacceptable

Risk vs. Benefit – Difficult Intubation Assessment Considerations
This Factors all Increase the Risk of An Unsuccessful of Procedure
Pediatric Patients
Bariatric Patients
Entrapped Patients
Decreased Visualization of Uvula
Mouth Opening Under Three Fingers Widths
Tip of Chin to Neck without Displacing Tissue under Three Finger Widths
Base of Mandible to Hyoid without Displacing Tissue under Three Finger Widths

Yes – Risk Benefit Acceptable
No – Risk vs. Benefit is Unacceptable

Intubation Providers Available and Skill Level
Skill Level of Provider Is Adequate for This Patient

Yes – Provider Criteria Met
No – Provider Criteria Not Met

Backup Advanced Airway Options Available
An Advanced Non-Visualized Airway of the Appropriate Size for the Patient is Immediately Available

Yes – Back Up Criteria Met
No - Backup Criteria Not Met

Consider RSI Procedure

Do Not Perform RSI Procedure
The **Paramedic** may consider RSI for patients of sufficient size and/or age in which the **Paramedic** has immediately available to a correctly sized advanced non-visualized airway to be used in event the intubation procedure fails.

### Rapid Sequence Intubation Procedure

<table>
<thead>
<tr>
<th>Criteria For Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• GCS &lt; 8</td>
</tr>
<tr>
<td>• Patient unable to protect airway with or without trismus</td>
</tr>
<tr>
<td>• Respiratory failure/ rapidly decreasing respiratory status</td>
</tr>
<tr>
<td>• Head injuries, major CVA with decreased LOC and inability to protect airway</td>
</tr>
<tr>
<td>• Impending airway compromise – such as airway burns, edema, trauma to larynx</td>
</tr>
</tbody>
</table>

#### Assess and Monitor
- For difficult airway – intubation
- Risk vs. Benefit of procedure
- Monitor patient's vital signs
  - Pulse, BP, Respiratory Rate
  - Pulse Oximetry, EtCO2, Cardiac Rhythm

#### Prepare
- Intubation equipment and select tube size
- Alternate correctly sized non-visualized advanced airway available
  - If alternate advanced airway is not available – DO NOT attempt procedure
- Surgical or needle cricothyrotomy equipment available
- Suction available
- Establish IV or IO access
- Consider anti-emetic

#### Oxygenation
- Pre – Oxygenate with 100% FiO2 for 2-3 minutes By BVM
  - Consider cricoid pressure – Sellick’s Maneuver
- OR Pre-Oxygenate with 100%FiO2 for 5 minutes by non-rebreather mask

#### Pre-sedation/induction medication considerations
- For signs and symptoms/ high index of suspicion of increased ICP
  - Consider lidocaine 1.0-1.5mg/kg
- For pediatric patients
  - Consider atropine 0.01 to 0.02mg/kg to a maximum of 0.5mg (minimum dose 0.1mg)
  - When using ketamine as sedative/induction agent
    - Consider atropine 0.01 to 0.02mg/kg to a maximum of 0.5mg for pediatric patients
    - Consider atropine 0.5 mg for adult patients

**Administer Sedation/Induction Agent – MUST HAVE SEDATION/INDUCTION MEDICATION ON BOARD PRIOR TO PARALYTIC AGENT**
- Administer Sedative/Induction Agent – See Chart

#### Administer paralytic agent
- Administer succinylcholine
  - 1.5 mg/kg IV/IO – adult
  - 2.0 mg/kg IV/IO – small children
- May consider Rocuronium 0.6 – 1.2mg/kg when
  - Succinylcholine is contra-indicated
  - Succinylcholine is unavailable
  - Or PMD has authorized Rocuronium as primary agent

#### Assess
- For jaw relaxation and apnea
- Decreased resistance to BVM ventilations

#### Intubation
- Perform oral intubation
- If not successful in 15 seconds perform BVM ventilation and reattempt
- If unsuccessful after 3 attempts use alternate advanced airway
Confirm placement
- Visualized tube pass through vocal cords
- Observe chest rise and fall
- Auscultate for lung sounds – no epigastric sounds
- Secondary devices
  - Free air pull/inflate on esophageal detector device (EDD)
  - Positive EtCO2

Ventilate and secure tube
- Ventilate patient at appropriate rate and depth
  - Goals – O2 Sat 94 to 99% and EtCO2 35 to 45
  - Consider use of PEEP and PIP if available
- Secure tube with commercial device or other method
- Place rigid c-collar even if no trauma to assist in maintaining neutral position
- Consider soft restraints to patient’s arms to prevent unplanned extubation

Reassess
- Vital Signs
- Adjust Rate and Depth of Ventilations as Needed
  - Goals – O2 Sat 94 to 99% and EtCO2 35 to 45
  - Consider Use of PEEP and PIP If Available
- Tube Placement after Each Patient Move

Administer paralytic
- If succinylcholine used as initial paralytic agent
  - Consider vecuronium 0.1mg/kg initial dose and maintain at 0.01 to 0.05mg/kg;
  - Or consider rocuronium 0.6 – 1.2 mg/kg initial dose and maintain at 0.1 – 0.2 mg/kg;
  - Or consider pancuronium 0.04 – 0.1 mg/kg
- If rocuronium used as initial paralytic agent
  - Consider rocuronium 0.6 – 1.2 mg/kg initial dose and maintain at 0.1 – 0.2 mg/kg;
  - Or consider vecuronium 0.1mg/kg initial dose and maintain at 0.01 to 0.05mg/kg;
  - Or consider pancuronium 0.04 – 0.1 mg/kg

Reassess and maintain
- Reassess vitals
- Titrate to maintain sedation **It is unethical to chemically paralyze a patient without sedation**
- Consider pain management See chart
- Consider bronchodilator medication for bronchospasms/exacerbation of COPD/anaphylaxis
- Re-dose non-depolarizing paralytic
### Approved Sedative/Induction Agents Chart

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Adult Dose <strong>DOSE FOR RSI</strong></th>
<th>Pediatric Dose <em>Maximum Dose Not To Exceed Adult Dose</em></th>
<th>Special Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benzodiazepine Class</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>5 to 10mg IV/IO</td>
<td>0.04 – 0.2 mg/kg IV./IO (6 Mo to 12 years)</td>
<td>Reversal Agent – Flumazenil (Romazicon) Use with caution as rapid reverse may lead to seizures especially in patient with history of seizures</td>
</tr>
<tr>
<td><strong>Carboxylated Imidazole Derivative Class – Most Preferred Alternative to Benzodiazepine Class for Adult Sedative/Induction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam (Ativan)</td>
<td>2.0 – 4.0 mg IV/IO</td>
<td>0.1 mg/kg to max of 4 mg May repeat ½ initial dose to maintain sedation</td>
<td></td>
</tr>
<tr>
<td>Midazolam (Versed) <strong>Most Preferred of this Class</strong></td>
<td>2.0mg – 6mg IV/IO/IM</td>
<td>0.2 to 0.3mg/kg (6 Mo and Older) May repeat ½ initial dose to maintain sedation</td>
<td></td>
</tr>
<tr>
<td><strong>NMDA Receptor Antagonist Class – Acceptable Alternative to Benzodiazepine Class for Adult and Pediatric Sedative/Induction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketamine</td>
<td>1.5 – 2 mg/kg IV/IO</td>
<td>For Patient's Over 6 Months Old 2.0 – 4.0 mg/kg IV/IO 0.25 – 0.5 mg/kg every 5 to 10 minutes to maintain sedation</td>
<td>To Prevent Hypersalivation Consider administration of Atropine 0.02 mg/kg with a minimal dose of 0.1 mg and a maximum of 0.5 mg for Pediatric 0.5mg Single Dose for Adults</td>
</tr>
<tr>
<td><strong>General Anesthesia/ Sedative/Hypnotic Class – Acceptable Alternative to Benzodiazepine Class</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Propofol</td>
<td>1 – 2 mg/kg IV/IO 0.05mg – 0.1mg/kg/min infusion to maintain sedation</td>
<td>1 – 2 mg/kg IV/IO 0.05 – 0.1mg/kg/min infusion to maintain sedation</td>
<td>May cause hypotension – Avoid in hypotensive patients or patients with a high risk of developing hypotension</td>
</tr>
<tr>
<td><strong>Barbiturate Class – Acceptable Alternative to Benzodiazepine Class When One of The Above Alternative Are Not Available</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methohexital (Brevital)</td>
<td>1 – 1.5 mg/kg IV/IO – 1% Solution 0.5 mg/kg every 4-7 minutes to maintain sedation</td>
<td>6.6 to 10 mg/kg IM 5% Solution 25mg/Kg Rectal 1% Solution Over 1 Month of Age Consider another agent to maintain sedation</td>
<td></td>
</tr>
<tr>
<td><strong>Phenothiazine Class – Least Desirable Alternative – Reserved To Incidents When No Other Alternative Are Available</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prochlorperazine (Compazine)</td>
<td>5 – 10mg IV/IO May Repeat Once</td>
<td>Not Approved</td>
<td>Use lowest possible dose to prevent extrapyramidal reactions For EPR consider Diphenhydramine (Benadryl) 12.5 to 25mg Peds 25 to 50mg Adults</td>
</tr>
<tr>
<td>Promethazine (Phenergan)</td>
<td>25 – 50mg IV/IO May Repeat Once</td>
<td>0.5 – 1.0 mg/kg to max of 25mg IV/IO Single Dose Only</td>
<td></td>
</tr>
</tbody>
</table>
### Approved Neuromuscular Blocking Agents Chart

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Generic (Brand Name)</th>
<th>Dosage (Paralytic)</th>
<th>Dosage (Defasciculating)</th>
<th>Onset</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depolarizing Class</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Succinylcholine (Anectine)</td>
<td>RSI: 1 to 2 mg/kg</td>
<td></td>
<td></td>
<td>30 to 60 seconds</td>
<td>4 to 6 minutes</td>
</tr>
<tr>
<td><strong>Non-Depolarizing Class</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vecuronium (Norcuron)</td>
<td>RSI: 0.1 mg/kg M: 0.01 – .05 mg/kg</td>
<td>0.01 mg/kg</td>
<td></td>
<td>2.5 to 5 minutes</td>
<td>25 – 40 minutes</td>
</tr>
<tr>
<td>Pancuronium (Pavulon)</td>
<td>RSI: 0.04 – 0.1 mg/kg M: 0.01 mg/kg</td>
<td></td>
<td></td>
<td>3 minutes</td>
<td>30 – 45 minutes</td>
</tr>
<tr>
<td>Rocuronium (Zemuron)</td>
<td>RSI: 0.6 – 1.2 mg/kg M: 0.1 – 0.2 mg/kg</td>
<td></td>
<td></td>
<td>1 – 3 minutes</td>
<td>30 minutes</td>
</tr>
</tbody>
</table>

**RSI** = Rapid Sequence Intubation  
**M** = Maintenance dose

### Approved Pain Management Chart for RSI

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Generic (Brand Name)</th>
<th>Adult Dose</th>
<th>Pediatric Dose</th>
<th>Special Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opioid Class</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td>2 – 4 mg IV/IO</td>
<td>0.05 – 0.2mg/kg IV/IO</td>
<td>Reversal Agent – Naloxone (Narcan)</td>
</tr>
<tr>
<td>Fentanyl</td>
<td></td>
<td>25 to 100 mcg IV/IO</td>
<td>1.0 – 2.0mcg/kg IV/IO</td>
<td></td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid)</td>
<td></td>
<td>0.2 – 0.6 mg IV/IO</td>
<td>0.03 to 0.08mg/kg IV/IO Over 6 Months</td>
<td></td>
</tr>
<tr>
<td>Nalbuphine (Nubain)</td>
<td></td>
<td>10 to 20mg IV/IO</td>
<td>0.05 to 0.1mg/kg IV/IO</td>
<td></td>
</tr>
<tr>
<td><strong>Opioid Class – Least Desirable Alternative – But Acceptable</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meperidine (Demerol)</td>
<td></td>
<td>50 – 100mg IV/IO/IM</td>
<td>1mg/kg IV/IO/IM</td>
<td>Reversal Agent – Naloxone (Narcan)</td>
</tr>
</tbody>
</table>
SEPSIS ALERT PROTOCOL (Revised 6/7/2019)

Pre-hospital Sepsis Alert Protocol

History
- Age (common in elderly and very young)
- Presence and duration of fever
- Previously documented infection or illness (UTI, pneumonia, meningitis, encephalitis, cellulitis, abscess, etc.)
- Recent surgery or invasive procedure
- Immunocompromised (transplant, HIV, diabetes, cancer)
- Bedridden or immobile patients
- Prosthetic or indwelling devices
- Immunization status
- Recent Hospitalization

Sign and Symptoms
- Warm, flushed, sweaty
- Chills/ Rigors
- Delayed cap refill
- Mental status changes
- Decreased urine output

Associated symptoms
- Myalgias, cough, chest pain, headache, dysuria, abdominal pain, rash

Other Possible Causes
- Cardiogenic shock
- Hypovolemic shock
- Dehydration
- Hyperthyroidism
- Medication/Drug interaction
- Non-septic infection
- Allergic reaction/anaphylaxis
- Toxicological emergency
- Heat stroke
- Stroke/Myocardial infarction

Routine Assessment and Care Protocol

Consider Appropriate PPE and for indicated infection control measures.

SEPSIS SCREEN:
Obvious or suspected source of infection AND any of these SIRS criteria:
- SBP < 90 mmHg
- Heart rate > 90/min
- Respiratory Rate > 20
- GCS < 15
- Temperature ≥ 100.4°F or < 96.0°F

If within scope of practice
- Normal saline bolus IV/IO
  - Adult: 500 mL
  - Repeat as needed, Max 2 L
  - Peds: 20 mL/kg
  - Repeat as needed, Max 80 mL/kg

Reassess SIRS criteria and re-examine after initial bolus. Repeat bolus as long as any SIRS criteria present, unless concern for fluid overload. (see pearls)

If BP < 90 or age appropriate hypotension after max bolus, begin Norepinephrine.

Adult: Norepinephrine IV/IO
  - (via infusion pump)
  - 1-10mcg/min
  - Titrated to SBP > 90
  - Peds: norepinephrine IV/IO
  - 0.05 - 2 mcg/kg/min
  - Titrated to age appropriate BP:
    - SBP ≥ 70 + 2X age

Monitor ETCO2. Is the ETCO2 < 28 on at least two consecutive measurements 5 minutes apart or positive SIRS criteria?

YES

SEPSIS ALERT
Notify receiving facility of possible sepsis.

Notify Destination per usual procedures or Contact Medical Control as needed

NO

PALS
- Early recognition of Sepsis allows for attentive care and early administration of antibiotics.
- Aggressive IV fluid therapy is the most important prehospital treatment for sepsis. Suspected septic patients should receive repeated fluid boluses while being checked frequency for sign of pulmonary edema, especially patients with known history of CHF or ESRD on dialysis. STOP fluid infusion in the setting of pulmonary edema.
- Septic patients are especially susceptible to traumatic lung injury and ARDS. If artificial ventilation is necessary avoid ventilating with excessive tidal volumes. If CPAP is utilized, airway pressure should be limited to 5cm H2O.
- Attempt to identify source of infection (skin, respiratory, etc.) and relay previous treatments and related history to ED.
- Elevated serum lactate levels are a useful marker of hypoperfusion in sepsis and often become elevated prior to the onset of hypotension. End tidal CO2 levels are correlated with lactate levels.
- Disseminated intravascular coagulation (DIC) is an ominous, late stage manifestation of sepsis characterized by frank, extensive bruising, bleeding from multiple sites and finally tissue death.
- Norepinephrine is preferred drug for septic shock. Alternative options may include: Epinephrine, Dopamine, Vasopressin.
TRACHEOSTOMY EMS PROTOCOLS (Revised 12/27/2017)

**General Principle:**

If ventilation adequate; O2 applied to tracheostomy via blow by.

Maintain open airway by placing patient in the “sniffing” position.

If vital signs have not improved after initial oxygen, re-evaluate oxygen delivery and adjust accordingly.

If not ventilating adequately: assist with BVM and 100% O2. Bag valve to trach, Bag-valve-mask to trach stoma, Bag-valve-mask to nose and mouth with occlusive dressing over trach stoma.

If pulse oximetry is used, adjust oxygen delivery devices to an oxygen saturation of 90% or above if possible.

<table>
<thead>
<tr>
<th>EMR</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scene Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BSI</strong></td>
<td>Safety First</td>
<td></td>
</tr>
<tr>
<td><strong>Level of Conscious</strong></td>
<td>Alert, verbal, pain, or unresponsive</td>
<td></td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td>In calm manner. <strong>DO NOT Excite/Scare the Child</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Airway</strong></td>
<td><strong>Trach Clear</strong></td>
<td><strong>Trach Obstructed</strong></td>
</tr>
<tr>
<td></td>
<td>Maintain airway. If necessary, assist patient/caregiver with suctioning trach as needed.</td>
<td>Assist patient/caregiver with suctioning trach up to 3 times. If unable to clear trach, remove it.</td>
</tr>
<tr>
<td><strong>Breathing</strong></td>
<td><strong>Administer oxygen</strong></td>
<td><strong>Administer oxygen</strong></td>
</tr>
<tr>
<td><strong>Consider</strong></td>
<td>Assisting patient/caregiver ventilations with Bag-valve-trach</td>
<td>Assisting ventilations with BVM. Place an occlusive dressing over stoma site.</td>
</tr>
<tr>
<td><strong>Circulation</strong></td>
<td><strong>Vital signs, skin color/temp</strong></td>
<td><strong>Vital signs, skin color/temp</strong></td>
</tr>
<tr>
<td><strong>Assess</strong></td>
<td>Conduct a Simple Patient Assessment</td>
<td>Conduct a Simple Patient Assessment</td>
</tr>
<tr>
<td><strong>EMT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td>Non-emergent transport if patient stable</td>
<td>Emergent</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Assess</td>
<td>Conduct Basic Patient Assessment</td>
<td>Conduct Basic Patient Assessment</td>
</tr>
<tr>
<td>Consider</td>
<td></td>
<td>Assist patient/caregiver with replacement of trach.</td>
</tr>
<tr>
<td>Consider</td>
<td>ALS Intercept</td>
<td>ALS Intercept</td>
</tr>
</tbody>
</table>

**EMT OPTIONS/ EMT -I**

| Consider          | If unable to replace trach, consider placing an ETT in trach stoma and provide bag-valve-ETT ventilations or insert an advanced airway and place an occlusive dressing over trach stoma. |

**IV**

| Consider          | Establish Peripheral IV Access. Do not delay transport. |
| Access            | Perform Advanced Physical Assessment |

**Access**

| IV                | IO Access in lieu of IV access |
| Cardiac Monitor   | Attach Cardiac Monitor, Interpret ECG |

**PARAMEDIC**

| Consider          | Rapid Sequence Intubation (RSI) *see RSI Protocol. Use occlusive dressing to cover stoma site. |
| Consider          | CPAP via trach |

| Consider          | CPAP |
WOUND CARE Tourniquet (Revised 3/22/2018)

Clinical Indications:

- Life-threatening extremity hemorrhage that cannot be controlled by any other means.
- Serious or life threatening extremity hemorrhage and tactical considerations prevent the use of standard hemorrhage control techniques.

Contraindications:

- Non-extremity hemorrhage
- Proximal extremity location where tourniquet application is not practical

Procedure:

- Place tourniquet proximal to wound
- Tighten per manufacturer instructions until hemorrhage stops and/or distal pulses in affected extremity disappear.
- Secure tourniquet per manufacturer instructions
- Note time of tourniquet application and communicate this to receiving care providers.
- Dress wounds per standard wound care protocol.

If one tourniquet is not sufficient or not functional to control hemorrhage, consider the application of a second tourniquet more proximal to the first.
ELECTRONIC CONTROL DEVICES (TASER) (Revised 12/7/2012)

Electronic Control Devices (Taser) is a device that uses an electrical shock to render an individual incapable for a short time to continue physical activity.

Electronic Control Devices may use probes that only have to be placed against the skin or devices in which probes are discharged and impaled into the skin.

ALL LEVELS
- Routine Assessment and Care

EMR
- Consider Oxygen
- Assess for trauma
  - Consider manual stabilization of head/neck
  - Consider manual stabilization of painful/deformed extremities
  - Care for open wounds
- For impaled probes in breast face/neck or genitals
  - Stabilize in place
- For impaled probes not in breast face/neck or genitals
  - Place finger on each side of probe
  - Pull probe straight outward
  - Control bleeding and bandage
- Consider ALS

EMR Options If Approved
- Consider spinal and/or extremity stabilization
- Initiate transport

EMT
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- Initiate transport

EMT Options and AEMT
- No additional guidance in absence of other signs and symptoms

EMT-I and Paramedic
- Consider cardiac monitoring

REQUESTS TO MEDICALLY CLEAR A PATIENT (Revised 12/7/2012)

The OOHECP may be approached by law enforcement to medically clear a patient so the officer may transport a patient to a facility other than a hospital.

The OOHECP may be approached at a sports event standby to medically clear a patient for return to play.

ALL LEVELS
- May not medically clear a patient
- When confronted with these situations the OOHECP
  - Should encourage the patient to seek evaluation at the hospital
  - Conduct an appropriate assessment and care
  - May obtain a refusal – See refusal guide lines
EMR TRANSPORT WITH PMD APPROVAL (Revised 12/7/2012)

The EMR may initiate transport of a patient. HOWEVER, for the EMR to transport the EMR and the Service must meet certain criteria prior to the call, AND must follow specific criteria during a call AND complete defined criteria after the call.

CRITERIA THAT MUST BE IN PLACE PRIOR TO THE CALL
- The individual EMR must have the appropriate training including at a minimum
  - Spinal stabilization devices
  - Extremity stabilization devices
  - Patient transport devices
- The individual EMR must have the approval of the PMD
- The service must have
  - The approval of the PMD
  - A recruitment and retention plan with a budget
  - An active schedule updated not less than monthly
  - An automatic aid plan
- **See Nebraska Rules and Regulations Title 172 NAC 11 and 12

CRITERIA AT THE TIME OF THE CALL
- An EMT or higher level responder does not respond to the call
- An EMT or higher level responder who responds to the call may NOT:
  - Delegate transport to an EMR;
  - Drive the ambulance during the transport leaving only an EMR in the patient compartment
- The automatic aid plan has been initiated and an EMT or higher level responder staffed unit has been dispatched
- The EMR intends to intercept with the EMT or higher level staffed service
- The EMR follows the protocol appropriate for the patient’s condition/situation
- The EMR will reassess patient including vital signs
  - Stable patients every 15 – 20 minutes
  - Unstable patients every 5 – 10 minutes
- The EMR will provide intercepting unit with a verbal and/or written report

CRITERIA AFTER COMPLETION OF THE CALL
- The EMR will complete a patient care report compliant with Nebraska Rules and Regulations Title 172 NAC 12
- The service must submit a report compliant with Nebraska Rules and Regulations Title 172 NAC 12
An EMS student enrolled in an approved training agency EMS course defined in titled 172 NAC 13 may perform the practices and procedures of the level of licensure for the EMS course the student is enrolled in.

**Student Status** means the status when the approved training agency releases the student to begin field clinical hours. Student status ends when the student is terminated from the course by the training agency (Examples; student fails, expelled, drops out, exceeds the time allowed for course completion) OR receives a Certificate of Completion from the training agency.

**Supervision of the EMS Student** means that a student must be supervised by a licensed OOECP at the same level or higher level of the course the EMS student is enrolled in.

**EMR Student Guidelines:**
EMR Students may under field supervision perform the Practices and Procedures of an EMR as defined in Title 172 NAC 11-009.01A.

**EMT Student Guidelines:**
EMT Students may under supervision perform the Practices and Procedures of an EMT as defined in Title 172 NAC 11-009.02A.

**AEMT Student Guidelines:**
AEMT Students may under supervision perform the Practices and Procedures of an AEMT as defined in Title 172 NAC 11-009.03A

**Paramedic Student Guidelines:**
Paramedic Students may under supervision perform the Practices and Procedures of a Paramedic as defined in Title 172 NAC 11-009.05A
Field Experience means a period of direct supervised experience when a student is mentored by a field supervisor while operating with an emergency medical service that responds to an emergency/medical request and proceeds from observation to providing care commensurate with the student's training.

Field Supervision means a period of direct supervision or indirect supervision of a temporary licensee by a field supervisor.

Field Supervisor means an individual who is a licensed OOHECP, with an unencumbered license and is the same or higher level of OOHECP as the temporary licensee or same or higher level as the student's course of study.

Direct Supervision means the field supervisor is present with the patient visually monitoring, providing verbal direction, and overseeing patient care that is being provided by a temporary licensee or student. The field supervisor must visually monitor the practices and procedures of the temporary licensee or student.

Indirect Supervision means the field supervisor is present at the scene and during transport. The field supervisor is located in proximity of the patient and must approve all practice and procedures being performed by the temporary licensee. The field supervisor does not need to witness the procedures as they are performed.

Temporary Licensed EMR:
The temporary licensed EMR must have direct supervision for 10 patient contacts. After 10 patient contacts this individual may have indirect supervision. The temporary licensed EMR may perform all the practices and procedures of an EMR defined in 11-009.01A. **See Temporary Licensee Examination Failure Supervision Below

A temporary licensed EMR DOES NOT qualify for EMR Transport.

Temporary Licensed EMT:
The temporary licensed EMT must have direct supervision for 20 patient contacts. After 20 patient contacts this individual may have indirect supervision. The temporary licensed EMT may perform all the practices and procedures of an EMT defined in 11-009.02A. **See Temporary Licensee Examination Failure Supervision Below

Temporary Licensed AEMT:
The temporary licensed AEMT must have direct supervision for 40 patient contacts. After 40 patient contacts this individual may have indirect supervision. The temporary licensed AEMT may perform all the practices and procedures of an AEMT as defined in 11-009.03A. **See Temporary Licensee Examination Failure Supervision Below

Temporary Licensed Paramedic:
The temporary licensed Paramedic must have direct supervision for 70 patient contacts. After 70 patient contacts this individual may have indirect supervision. The temporary licensed AEMT may perform all the practices and procedures of a Paramedic as defined in 11-009.05A. **See Temporary Licensee Examination Failure Supervision Below

Temporary Licensee Examination Failure Supervision:
Any temporary licensee who fails the licensure examination must have direct supervision for all patient contacts until the licensee has successfully completed the examination process.
EXTRA PAIR OF HANDS CONCEPT (Revised 12/7/2012)

The Nebraska Board of Emergency Medical Services issued this guideline for out-of-hospital emergency care providers (OOHECP) when using assistive personnel as their “extra-pair of hands”. The purpose of this guideline is to give direction to the OOHECP when he/she deems it necessary to request assistance from other individuals in rendering emergency care.

An assistive person means a firefighter, law enforcement officer, ambulance driver or any other available person who is requested to provide assistance in an emergency and who is not licensed/certified as an OOHECP or other health care provider.

When such assistance is needed an OOHECP may use this extra pair of hands if the:
• Assistive person is physically present and in the same proximity or visual field as the OOHECP;
• OOHECP instructs and directs the activity that the assistive person is to perform;
• Ultimate responsibility for assessment, care, and treatment remains with the OOHECP;
• Activity provided by the assistive person does not require such person to exercise knowledge of the nature or to the degree required to initiate, modify or discontinue the emergency care; and
• Activity provided by the assistive person does not require such person to assess the condition of the patient.

Examples of activities an assistive person may perform include but are not limited to:
• Assisting with lifting a patient;
• Holding an IV bag;
• Spiking an IV bag;
• Assist with CPR;
• Applying pressure to a wound;
• Placing straps on transport boards and cots;
• Pumping up a vacuum splint-air splints;
• Assisting with log rolling;
• Holding emesis basin; and
• Obtaining equipment.

When an OOHECP uses an “extra pair of hands”, he/she must remember:
• The OOHECP is accountable for the emergency treatment provided;
• The OOHECP cannot delegate to the assistive person the performance of any skills that requires EMS certification;
• The ultimate responsibility for identification of emergency care must remain with the OOHECP; and
• No task may be given to an assistive person that will cause injury or harm to the patient.

EMR and EMT Assisting AEMT, EMT-I or Paramedic

A licensed EMR or EMT may assist the AEMT, EMT-I or Paramedic with patient care and perform care within the practices and procedures of the EMR or EMT including any PMD authorized additional skills.

The EMR and EMT may assist the AEMT, EMT-I or Paramedic under direction with:
• Spiking an IV Bag;
• Retrieving medications, and other ALS supplies from box/bags/cabinets;
• Witness the waste of controlled medications; and
• The ultimate responsibility any assisted procedure remains with the AEMT, EMT-I or Paramedic
**INTER-FACILITY TRANSPORTS (Revised 12/7/2012)**

**ALL LEVELS**
- Routine assessment and care adult or pediatric

**EMR**
- May Assist the EMT, AEMT, EMT-I, or Paramedic during inter-facility transport

**EMR Options if Approved**
- EMR may transport from a nursing home to hospital in emergent situations
- EMR may not transport
  - Hospital to hospital
  - Hospital to nursing home or patient residence
  - Nursing home to nursing home

**EMT**
- Obtain patient report from sending facility staff and confirm the following:
  - Reason for transport and destination facility
  - Any patient orders for care during transport
  - Patient orders do not exceed the OOHECP’s scope of practice
- Consider Oxygen and adjust delivery device and LPM flow to achieve 94% or better O2 saturation
- May monitor but not establish
  - Urinary catheters
  - Gastric tubes
- Provide monitoring as appropriate to level of licensure and patient conditions
  - Consider vitals
    - Once for baseline at initiation of transport
    - Every 30 to 60 minutes for stable patients
    - Every 5 to 15 minutes for unstable patients
    - Once at or near the end of transport
- **See appropriate protocol for patients that develop additional complaint or have changes**

**EMT Options if Approved and AEMT**
- Monitor IV at ordered rate

**EMT-I**
- Consider cardiac monitoring

**Paramedic**
- Consider anti-emetic
- Monitor and adjust ventilator settings as needed
- Administer ordered medications by ordered route unless contraindicated
- Monitor and adjust medication infusions as needed examples (not all inclusive)
  - Adjust nitroglycerin infusion to maintain chest pain/pressure control AND blood pressure
  - Adjust vasopressor agents to maintain blood pressure
  - Generally anti-coagulants/anti-platelets will not need adjustment
- Monitor and re-dose sedation, pain management, and paralytic agents
- Administer and/or monitor blood/blood products
RESTRAINT (Revised 12/7/2012)

EMR
- Non-combative patients
  - Calm and reassure patient
  - Give clear explanations and directions
- Combative patients
  - Contact law enforcement
  - Consider physically restraining patient
    - Supine
    - Physically restrain one arm above head
      - If injury or limited range of motion restrain arm at patient’s side
    - Physically restrain second arm at side
    - Physically restrain each leg just above knee
    - Consider use of commercially available spit hood

EMR Options, EMT, AEMT and Paramedic
- Combative patients
  - Restrain patient
    - Supine on to transport or stabilization device
    - Use self-adhering bandage or commercial restraint device
      - Restrain one arm above head
        - If injury or limited range of motion restrain arm at patient’s side
      - Restrain second arm at side
    - Restrain with a minimum of three straps
      - One across upper chest
      - One across waist
      - One across lower thigh just above knees
    - Consider use of commercially available spit hood
  - Handcuffs are only to be applied by law enforcement and generally should be avoided

ALL LEVELS – DO NOT
- Restrain patient prone
- “Hog tie” patient and place prone
- Place gauze or tape over or in mouth
- “Sandwich” patient between stabilization devices
TRIAGE (Revised 12/27/2017)

START TRIAGE (Revised 12/7/2012)

The START Triage method is the adopted triage method for multiple patient incidents.

Triage Colors:
- Green /Minor – Walking type wounded requiring little or no care
- Yellow/Delayed – Unable to ambulate and require care
- Red/Immediate – Unable to ambulate and require immediate care
- Black – Patient without a pulse or injuries incompatible with life
The START Triage method is the adopted triage method for multiple patient incidents.

Triage Colors:
- Green / Minor – Walking type wounded requiring little or no care
- Yellow / Delayed – Unable to ambulate and require care
- Red / Immediate – Unable to ambulate and require immediate care
- Black – Patient without a pulse or injuries incompatible with life
Medication Formulary (Revised 6/7/2019)
<table>
<thead>
<tr>
<th>Class</th>
<th>Medication Name</th>
<th>Other Name</th>
<th>Antidote</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>Special Information</th>
<th>Pediatric Dose</th>
<th>Route(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesic</td>
<td>Fentanyl</td>
<td>Naloxone</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>25 to 100 mcg</td>
<td>1.0 to 2.0 mcg/kg</td>
<td>IV/IO/IM/MAD</td>
</tr>
<tr>
<td></td>
<td>Hydromorphone</td>
<td>Dilaudid</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>0.2 to 0.6 mg</td>
<td>ONLY 0.01 mcg/kg</td>
<td>IV/IO/IM/MAD</td>
</tr>
<tr>
<td></td>
<td>Morphine</td>
<td>Naloxone</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>2 – 4 mg May Repeat</td>
<td>0.05 to 0.2 mcg/kg May Repeat</td>
<td>IV/IO/IM/MAD</td>
</tr>
<tr>
<td></td>
<td>Nalbuphine</td>
<td>Nubain</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>10 to 20 mg</td>
<td>0.05 to 0.1 mcg/kg</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Stadol</td>
<td>Naloxone</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>0.5 to 2 mg</td>
<td>Not Approved Under Age 18</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Ketorolac</td>
<td>Toradol</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>15 to 30 mg</td>
<td>0.5 mg/kg</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Adenosine</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>6 mg May Repeat at 12 mg</td>
<td>0.1 mg/kg May Repeat at 0.2 mg/kg</td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td>Amiodarone</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>150 mg - Stable Wide Complex Tach</td>
<td>EMT-I May Not Give for Stable Wide Complex Tach</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Amiodarone Infusion</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>1 mg/min Infusion</td>
<td>Seek Medical Control /PMD Consult</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Metoprolol</td>
<td>Lopressor</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>0.25 mg/kg Over 2 Minutes May Repeat Once After 15 Minutes 0.35 mg/kg Over 2 Minutes - Consult Medical Control, PMD, Or Transport Orders for Infusion</td>
<td>Not Approved</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Lidocaine 2%</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>1 to 1.5 mg/kg - V-Fib /V-Tach May Repeat at 1/2 Initial Dose to Max 3mg/kg</td>
<td>1.0 mg/kg - V-Fib /V-Tach May Repeat at 1/2 Initial Dose to Max 3mg/kg</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Lidocaine 2%</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>1 to 4 mg/min Infusion</td>
<td>20 - 50 mcg/min Infusion</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Metoprolol</td>
<td>Lopressor</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>5 mg IV. May be repeated every 5 minutes for a total of three (3) doses.</td>
<td>Not approved</td>
<td>IV</td>
</tr>
<tr>
<td>Class</td>
<td>Medication Name</td>
<td>Other Name</td>
<td>Antidote</td>
<td>EMR</td>
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</tr>
<tr>
<td><strong>Antidote</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Atropine -</td>
<td>2-Pam</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>X</td>
<td>Mark I</td>
<td>Mild Symptoms – One Each</td>
</tr>
<tr>
<td>Pralidoxime</td>
<td>Pralidoxime</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Moderate Symptoms – Two Each</td>
</tr>
<tr>
<td></td>
<td>Separate Auto</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Severe Symptoms – Three Each</td>
</tr>
<tr>
<td></td>
<td>Injectors</td>
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<tr>
<td></td>
<td>Atropine -</td>
<td>2-Pam</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>X</td>
<td>DouDote Kit</td>
<td>Mild Symptoms – One</td>
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<tr>
<td></td>
<td>Pralidoxime</td>
<td>DouDote</td>
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<td>Moderate Symptoms – Two</td>
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<td>Auto-Injector</td>
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<td></td>
<td>Severe Symptoms – Three</td>
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</tr>
</tbody>
</table>

**Procainamide Infusion**
- X
- 20 - 50 mg/min to Maximum of 17mg/kg STOP If QRS Widens >50%
- Seek Medical Control / PMD Consult
- IV/IO

**Sotalol**
- X
- 1.5mg/kg IV/IO over 5 minutes
- Not Approved
- IV/IO

**Verapamil**
- X
- 2.5 to 5 mg over 2 minutes - Consult Medical Control, PMD, Or Transport Orders for Infusion
- Not Approved
- IV/IO

**Naloxone**
- Narcan
- X X X X X
- If symptoms of narcotic overdose reoccur after initial response to Naloxone, re-administer dose
- 0.4 to 4 mg Max Dose 4 mg
- May repeat dose for recurrence of opioid overdose symptoms as needed
- 0.1 mg/kg
- May repeat dose for recurrence of opioid overdose symptoms as needed
- MAD/auto injector only EMR & EMT
- IV/IO/MAD AEMT and above

**Pralidoxime**
- 2-Pam
- X
- 600 to 1200 mg Over 5 Minutes OR as an Infusion Over 15-30 Minutes
- 20-50 mg/kg Max 1200mg Over 15 to 30 Minutes After 15 Minutes May Consider 10 – 20 mg/kg/hr infusion
- IV/IO
<table>
<thead>
<tr>
<th>Class</th>
<th>Medication Name</th>
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<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>Paramedic</th>
<th>Special Information</th>
<th>Adult Dose</th>
<th>Pediatric Dose</th>
<th>Maximum Dose Not to Exceed Adult Dose</th>
<th>Route(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-Emetic</td>
<td>Hydroxocobalamin</td>
<td>Cyanokit</td>
<td>Cyanokit</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>5g in 200mL NS over 15 minutes</td>
<td>Physician Order Only</td>
<td>IV/IO</td>
<td></td>
<td></td>
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<tr>
<td>Anti-Emetic</td>
<td>Dolasetron</td>
<td>Anzemet</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.5 mg May Repeat</td>
<td>Not Approved</td>
<td>IV/IO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Emetic</td>
<td>Ondansetron</td>
<td>Zofran</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 to 8 mg May Repeat</td>
<td>Under 40kg 0.1 mg/kg</td>
<td>IV/IO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Emetic - Sedative</td>
<td>Prochlorperazine</td>
<td>Compazine</td>
<td>X</td>
<td>Anti-Emetic</td>
<td>5 mg – Nausea – May Repeat Once</td>
<td>12.5 to 25 mg May Repeat Once</td>
<td>Not Approved</td>
<td>IV/IO **Use With Caution in Patient's with Suspected AMI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Emetic - Sedative</td>
<td>Promethazine</td>
<td>Phenergan</td>
<td>X</td>
<td>Least Desirable Class For Sedation</td>
<td>5 mg – Sedative – May Repeat Once Reserved to Incidents When No Other Alternative is Available</td>
<td>25 mg – Sedative – May Repeat Once Reserved to Incidents When No Other Alternative is Available</td>
<td>Not Approved</td>
<td>IV/IO **Use With Caution in Patient's with Suspected AMI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antihistamine</td>
<td>Diphenhydramine</td>
<td>Benadryl</td>
<td>X X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>25 to 50 mg</td>
<td>1 to 2 mg/kg</td>
<td>IV/IO/IM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Hypertensive</td>
<td>Trandate</td>
<td>Labetalol</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10-20 mg slow IV push (over 2 minutes)</td>
<td>Bolus Dose of 0.2 to 1 mg/kg (over 2 minutes)</td>
<td>IV (Continuous infusion must be administered by mechanical infusion pump)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Hypertensive</td>
<td>Apresoline</td>
<td>Hydralazine</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5 mg IV. May repeat 5-10 mg IV every 20 minutes to a total dose of 40 mg.</td>
<td>Not Approved</td>
<td>IV/IO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Nebraska EMS Medication Formulary Sorted By Class

<table>
<thead>
<tr>
<th>Class</th>
<th>Medication Name</th>
<th>Other Name</th>
<th>Antidote</th>
<th>EMR</th>
<th>AEMT</th>
<th>Paramedic</th>
<th>Special Information</th>
<th>Adult Dose</th>
<th>Pediatric Dose</th>
<th>Route(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ant-Psych</td>
<td>Cardene</td>
<td>Nicardipine</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>2.5 mg/hr IV continuous infusion.</td>
<td>2.5 mg/hr IV continuous infusion.</td>
<td>Efficacy in patients under age 18 has not been established. IV (Continuous infusion must be administered by mechanical infusion pump)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Haloperidol</td>
<td>Haldol</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>2.5 to 5 mg</td>
<td>Not Approved</td>
<td>IV/IO/IM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diazepam</td>
<td>Valium</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>2 to 4 mg Seizure May Repeat</td>
<td>0.04 to 0.2 mg/kg Seizures May Repeat</td>
<td>IV/IO/Rectal **Pediatric Dose are for Ages 6 Months and Older</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lorazepam</td>
<td>Ativan</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>2 to 4 mg Seizures May Repeat</td>
<td>0.05 to 1mg/kg Seizures May Repeat</td>
<td>IV/IO/MAD **Pediatric Dose are for Ages 6 Months and Older</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Midazolam</td>
<td>Versed</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>2 to 4 mg Seizures May Repeat</td>
<td>0.1mg/kg - seizures May repeat 0.1 mg/kg</td>
<td>IV/IO/IM/MAD **Pediatric Dose are for Ages 6 Months and Older</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Albuterol</td>
<td>Proventil</td>
<td></td>
<td>*</td>
<td>X</td>
<td>X</td>
<td>Preferred Agent for RSI Sedation</td>
<td>Preferred Agent for RSI Sedation</td>
<td></td>
<td>Nebulized</td>
</tr>
</tbody>
</table>
# Nebraska EMS Medication Formulary Sorted By Class

<table>
<thead>
<tr>
<th>Class</th>
<th>Medication Name</th>
<th>Other Name</th>
<th>Antidote</th>
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<th>EMR</th>
<th>AEMT</th>
<th>EMT-</th>
<th>Special Information</th>
<th>Adult Dose</th>
<th>Pediatric Dose</th>
<th>Route(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronchodilator</td>
<td>Albuterol For Hyperkalemia</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>For Hyperkalemia Confirmed By Diagnostic 3 lead or 12 lead with Tall Spiked T waves 15mg (6 ea. Unit Dose) Nebulized</td>
<td>3mg -0.5mg Unit Dose May Repeat</td>
<td>3mg -0.5mg Unit Dose May Repeat</td>
<td>Nebulized</td>
</tr>
<tr>
<td></td>
<td>Albuterol/ Ipratropium</td>
<td>DuoNeb</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>3mg -0.5mg Unit Dose</td>
<td>3mg -0.5mg Unit Dose</td>
<td>Nebulized</td>
</tr>
<tr>
<td></td>
<td>Ipratropium</td>
<td>Atovent</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Alternate for Racemic Epinephrine</td>
<td>0.5mg Unit Dose</td>
<td>125 to 250 mcg 1/4 to 1/2 Unit Dose</td>
<td>Nebulized</td>
</tr>
<tr>
<td></td>
<td>Epinephrine 1:1000 Nebulized</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>3 to 5mg Diluted in 1 to 3 ML NS</td>
<td>0.5 to 1.5mg in 1 to 3 ML NS</td>
<td>Nebulized</td>
</tr>
<tr>
<td></td>
<td>Metaproterenol 5%</td>
<td>Alupent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10 to 15mg in 3 ml NS</td>
<td>0 to 20kg – 0.25mg in 3 ml NS</td>
<td>Nebulized</td>
</tr>
<tr>
<td></td>
<td>Epinephrine - Racemic Epinephrine 2.5%</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>Consider As A First Line Agent For Pediatric RSV and Croup</td>
<td>0.5 to 0.75ml in 3 ml NS</td>
<td>0 to 20kg – 0.25mg in 3 ml NS</td>
<td>Nebulized</td>
</tr>
<tr>
<td></td>
<td>Terbutaline</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.25 mg</td>
<td>0.005 to 0.01mg/kg</td>
<td>SubQ</td>
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<tr>
<td></td>
<td>Aminophylline</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>Second Line Therapy For Exacerbations of COPD</td>
<td>5mg/kg added to 50 to 250 NS infused over 20 to 30 minutes</td>
<td>Not Approved</td>
<td>IV/IO</td>
</tr>
<tr>
<td>Diuretic</td>
<td>Furosemide</td>
<td>Lasix</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20 to 80 mg</td>
<td>Physician Order Only</td>
<td>IV/IO Slowly</td>
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<tr>
<td>Class</td>
<td>Medication Name</td>
<td>Other Name</td>
<td>Antidote</td>
<td>EMR</td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-</td>
<td>Paramedic</td>
<td>Special Information</td>
<td>Adult Dose</td>
<td>Pediatric Dose</td>
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<td>--------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Electrolyte</td>
<td>Calcium Chloride</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>X</td>
<td>Known Calcium Channel Blocker Overdose 5ml (500mg) over 2-5 Mins Avoid In Mixed Ods OR Situations Where Calcium Channel Blocker OD Can Not be Confirmed</td>
<td>Physician Order Only</td>
<td>IV/IO</td>
</tr>
<tr>
<td>Electrolyte</td>
<td>Calcium Gluconate</td>
<td>10%</td>
<td></td>
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<td>X</td>
<td>Known Calcium Channel Blocker Overdose 15ml over 2-5 Mins Avoid In Mixed Ods OR Situations Where Calcium Channel Blocker OD Can Not be Confirmed</td>
<td>Physician Order Only</td>
<td>IV/IO</td>
</tr>
<tr>
<td>Electrolyte</td>
<td>Magnesium Sulfate</td>
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<td></td>
<td></td>
<td>X</td>
<td>Torsades 1 to 2 Grams</td>
<td>Physician Order Only</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Sodium Bicarb</td>
<td>4.2%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>X</td>
<td>See Sodium Bicarb 8.4% Age 8 and Under 1mEq/kg 4.2%</td>
<td>IV/IO</td>
<td></td>
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<tr>
<td></td>
<td>Sodium Bicarb</td>
<td>8.4%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>X</td>
<td>50 mEq 8.4% Over Age 8 1mEq/kg 8.4%</td>
<td>IV/IO</td>
<td></td>
</tr>
<tr>
<td>Glucoconoid</td>
<td>Dexamethasone</td>
<td></td>
<td></td>
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<td></td>
<td>X</td>
<td>0.6 mg/kg Max Dose: 10 mg</td>
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<td>IV/IO</td>
</tr>
</tbody>
</table>
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<th>Pediatric Dose</th>
<th>Route(s)</th>
</tr>
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<tbody>
<tr>
<td>Glucose Agent</td>
<td>Dextrose 10%</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>125-250 ml</td>
<td>Infant to 8 years – 5 ml/kg to max of 6 grams</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Dextrose 12.5%</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>100-200 ml</td>
<td>Age 0 to Puberty – 4ml/kg max 6 Grams</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Dextrose 25%</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>50-100 ml</td>
<td>Age 1 to Puberty – 2ml/kg Max 6 grams Age 8 to Onset Puberty 1ml/kg to Max 25 grams</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Dextrose 50%</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>25-50 ml</td>
<td>IV/IO</td>
<td></td>
</tr>
<tr>
<td>Oxygen</td>
<td>Glucagon</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>1 mg</td>
<td>Under 25 kg – 0.5 mg 25kg and Over – 1 mg SubQ/IM/MAD</td>
<td>SubQ/IM/MAD</td>
</tr>
<tr>
<td></td>
<td>Oxygen – All Devices</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>As required Per Device / Patient Needs</td>
<td>As required Per Device /Patient Needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxygen – BVM</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>10 – 15 LPM</td>
<td>10 – 15 LPM</td>
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<tr>
<td></td>
<td>Oxygen – Nasal Cannula</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>1 to 6 LPM</td>
<td>1/4 to 6 LPM</td>
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</tr>
<tr>
<td></td>
<td>Oxygen – Non-Rebreather</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>10 to 15 LPM</td>
<td>10 to 15 LPM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oxygen – Venturi</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>Flow By % Required Per Patient</td>
<td>Flow By % Required Per Patient</td>
<td></td>
</tr>
<tr>
<td>Depolarizing</td>
<td>Succinycholine</td>
<td>Anectine</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RSI: 1 to 2 mg/kg Once Only</td>
<td>RSI: 1 to 2 mg/kg Once Only</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Pancuronium</td>
<td>Pavulon</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RSI: 0.04 to 0.1 mg/kg Maintain: 0.01 mg/kg</td>
<td>RSI: 0.04 to 0.1 mg/kg Maintain: 0.01 mg/kg</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Rocuronium</td>
<td>Zemuron</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RSI: 0.6 to 1.2 mg/kg Maintain: 0.1 to 0.2 mg/kg</td>
<td>RSI: 0.6 to 1.2 mg/kg Maintain: 0.1 to 0.2 mg/kg</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Vecuronium</td>
<td>Norcuron</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>RSI: 0.1 mg/kg Maintain: 0.01 to 0.05 mg/kg</td>
<td>RSI: 0.1 mg/kg Maintain: 0.01 to 0.05 mg/kg</td>
<td>IV/IO</td>
</tr>
<tr>
<td>Sedative</td>
<td>Etomidate</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Induction: 0.3 mg/kg Maintain: 0.1 to 0.15 mg/kg</td>
<td>Induction: 0.3 mg/kg Maintain: 0.1 to 0.15 mg/kg</td>
<td>IV/IO</td>
</tr>
<tr>
<td>Class</td>
<td>Medication Name</td>
<td>Other Name</td>
<td>Antidote</td>
<td>EMR</td>
<td>EMT</td>
<td>AEMT</td>
<td>EMF-1</td>
<td>Paramedic</td>
<td>Special Information</td>
<td>Adult Dose</td>
<td>Pediatric Dose</td>
</tr>
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<td>-------</td>
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</tr>
<tr>
<td></td>
<td>Ketamine</td>
<td>Ketalar</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.5 to 2 mg/kg sedation and induction</td>
<td>Age 6 months and older 2 to 4 mg/kg IV/IO for sedation and induction</td>
<td>IV/IO/IM</td>
</tr>
<tr>
<td></td>
<td>Methohexital</td>
<td>Brevital</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 to 1.5 mg/kg IV/IO of 1% Solution Induction 0.5mg/kg every 4 to 7 Mins to Maintain Sedation</td>
<td>Age 1 Month and Older 25mg/kg Rectal (1% Solution) 6.6 to 10 mg/kg IM (5% Solution) **Approved for RSI and NOT for Pain Mgt And Sedation Consider Another Agent to Maintain Sedation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Propofol</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 to 2 mg/kg IV/IO Induction</td>
<td>0.05 to 0.1 mg/kg/min Infusion to maintain Sedation Must Be On a Pump</td>
<td>**Approved for RSI and NOT for Pain Mgt And Sedation</td>
</tr>
<tr>
<td>Steroid</td>
<td>Methylprednisolone</td>
<td>Solu-Medrol</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>125 to 250mg</td>
<td>2 mg/kg to Max of 125Mg</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Decadron</td>
<td>Dexamethasone</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.6 mg/kg Max Dose: 10 mg</td>
<td>IV/IO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Epinephrine - 0.15mg Auto-Injector</td>
<td>EpiPen Jr</td>
<td>* * X X X</td>
<td>Adults Use 0.30 mg Epinephrine Auto Injector</td>
<td>30 kg and Under Use 0.15 mg Epinephrine Auto Injector</td>
<td>SubQ</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Epinephrine - 0.3mg Auto-Injector</td>
<td>EpiPen</td>
<td>* * X X X</td>
<td>Adults Use 0.30 mg Epinephrine Auto Injector</td>
<td>Over 30 Kg Use 0.30 mg Epinephrine Auto Injector</td>
<td>SubQ</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Epinephrine 1:10,000</td>
<td></td>
<td>X X</td>
<td>1 mg Cardiac Arrest</td>
<td>0.01 mg/kg Cardiac Arrest</td>
<td>IV/IO and ET in Cardiac Arrest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Epinephrine 1:1000</td>
<td></td>
<td>X X X X</td>
<td>0.3 mg</td>
<td>0.01 mg/kg</td>
<td>IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Class</td>
<td>Medication Name</td>
<td>Other Name</td>
<td>Antidote</td>
<td>EMR</td>
<td>EMT</td>
<td>AEMT</td>
<td>EM-I</td>
<td>Paramedic</td>
<td>Special Information</td>
<td>Adult Dose</td>
<td>Pediatric Dose</td>
</tr>
<tr>
<td>-------</td>
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<td></td>
<td></td>
<td></td>
<td>0.4 mg Every 5 mins for Chest Pain. Total dose 3 for EMT, AEMT, and EM-I.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vasodilator</td>
<td>Nitroglycerin</td>
<td>* X X X X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Paramedics may give additional doses 0.4 mg every 5 mins for Chest Pain. Paramedics may give additional doses for CHF in distress with systolic BP 180 and greater – 3 each 0.4 mg*, 140 to 180 – 2 each .04 mg*, 100 to 140 – 1 each 0.4 mg* (Must have IV/IO Access). Nitroglycerin may be mixed in D5W or NS begin nitroglycerin drip at 5 mcg/min. Increase drip by 5 mcg/min at 5 min intervals if chest pain persists and systolic BP remains above 100mmHg.</td>
<td>Not Approved</td>
<td>SL IV/IO Paramedic Only</td>
</tr>
<tr>
<td>Vasoressor</td>
<td>Dobutamine</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 to 20 mcg/kg/min</td>
<td>2 to 20 mcg/kg/min</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Dopamine</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 to 20 mcg/kg/min</td>
<td>2 to 20 mcg/kg/min</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Norepinephrine</td>
<td>Levophed</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8-12 mcg/min IV. Maintenance infusion of 2-20 mcg/min to obtain adequate perfusion, usual dose 2-4 mcg/min. Maximum 30 mcg/min</td>
<td>0.1-2 mcg/kg/min IV.</td>
<td>IV (Continuous infusion must be administered by mechanical infusion pump)</td>
</tr>
<tr>
<td>Vitamin</td>
<td>Thiamine</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100 mg IV/IO</td>
<td>100 mg For Adolescent Patient with Gastric Bypass or Gastric Banding And Trauma – Otherwise by Physician Order</td>
<td>IV/IO</td>
</tr>
<tr>
<td></td>
<td>Aspirin</td>
<td>* X X X X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4 Each – 81mg Chewed and Swallowed</td>
<td>Not Approved</td>
<td>PO</td>
</tr>
</tbody>
</table>
### Nebraska EMS Medication Formulary Sorted By Class

<table>
<thead>
<tr>
<th>Class</th>
<th>Medication Name</th>
<th>Other Name</th>
<th>Antidote</th>
<th>Paramedic</th>
<th>EMT</th>
<th>AEMT</th>
<th>EMR</th>
<th>Special Information</th>
<th>Adult Dose</th>
<th>Pediatric Dose</th>
<th>Route(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain/Fever Reducer</td>
<td>Motrin</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>400 mg PO q4-6h prn</td>
<td>&lt;6 mo-11:</td>
<td>PO</td>
<td>PO</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Max: 2400 mg/day</td>
<td>Dose: 5-10 mg/kg PO q6-8h prn; Max: 40 mg/kg/day</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>12 and older:</td>
<td>Dose: 400 mg PO q4-6h prn; Max: 2400 mg/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acetaminophen</td>
<td>Tylenol</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>325-1000 mg PO q 4-6 hr prn] Max: 1 g/4h and 4 g/day from all sources</td>
<td>Neopantes:</td>
<td>PO</td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dose: 10-15 mg/kg PO q 6-8 hr prn; Max: 60 mg/kg/day from all sources</td>
<td>Infants/Children:</td>
<td>Dose: 10-15 mg/kg PO q 4-6 hr prn; Max: 75 mg/kg/day up to 1 g/4h and 4 g/day from all sources</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>12 and older:</td>
<td>Dose: 325-650 mg PO q 4-6 hr prn; Max: 1 g/4h and 4 g/day from all sources</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acetaminophen</td>
<td>Tylenol</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>Indicated for mild-to-moderate pain and moderate-to-severe pain with adjunctive opioid analgesics; also indicated for reduction of fever injectable solution 10mg/mL</td>
<td>&lt;50 kg:</td>
<td>PO</td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12.5 mg/kg IV q 4 hr OR 15 mg/kg IV q 6 hr; not to exceed 750 mg/dose or 3.75 g/day</td>
<td>Infuse IV over at least 15 minutes (also see Administration)</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>≥50 kg: 650 mg IV q 4 hr OR 1000 mg IV q 6 hr; not to exceed 4 g/day</td>
<td>2-12 years:</td>
<td>12.5 mg/kg IV q4hr OR 15 mg/kg IV q8hr; not to exceed 75 mg/kg/day</td>
<td>IV</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>≥13 years</td>
<td>50 kg: 12.5 mg/kg IV q 4 hr OR 15 mg/kg IV q 6 hr; not to exceed 750 mg/dose or 3.75 g/day</td>
<td>INFANTS/CHILDREN:</td>
<td>Dose: 325-650 mg PO q 4-6 hr prn; Max: 1 g/4h and 4 g/day from all sources</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>&lt;50 kg: 12.5 mg/kg IV q 4 hr OR 15 mg/kg IV q 6 hr; not to exceed 750 mg/dose or 3.75 g/day</td>
<td>≥50 kg:</td>
<td>INFANTS/CHILDREN:</td>
<td>INFANTS/CHILDREN:</td>
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<td></td>
<td></td>
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<td>75 mg for Patients &gt;75</td>
<td>NOT APPROVED</td>
<td>PO</td>
<td>PO</td>
</tr>
</tbody>
</table>

* Special Situations And/or Additional Training and PMD Approval Required
Recent Updates:

<table>
<thead>
<tr>
<th>Protocol Updated</th>
<th>Date Updated</th>
<th>Brief Description</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>IM Injection Epi for EMT</td>
<td>6/7/2019</td>
<td>Added max and repeat dosing</td>
<td>62, 119, 157</td>
</tr>
<tr>
<td>Naloxone</td>
<td>6/7/2019</td>
<td>Added</td>
<td>161</td>
</tr>
<tr>
<td>Decadron</td>
<td>6/7/2019</td>
<td>Added</td>
<td></td>
</tr>
<tr>
<td>Over the counter analgesics for pain or fever</td>
<td>6/7/2019</td>
<td>Added for EMT and AEMT Tylenol 165 Ibuprofen 162</td>
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<tr>
<td>Sepsis Alert Protocol</td>
<td>6/7/2019</td>
<td>Added</td>
<td>141-143</td>
</tr>
<tr>
<td>Pain Management</td>
<td>6/7/2019</td>
<td>Updated Protocol w/ Ibuprofen and Tylenol</td>
<td>131</td>
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<tr>
<td>Medication Formulary – Ibuprofen / Motrin</td>
<td>6/7/2019</td>
<td>Added</td>
<td>163</td>
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<tr>
<td>Medication Formulary – Tylenol</td>
<td>6/7/2019</td>
<td>Added</td>
<td>165</td>
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<tr>
<td>Medication Formulary – Tylenol IV</td>
<td>6/7/2019</td>
<td>Added</td>
<td>165</td>
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<tr>
<td>Wound Care Tourniquet</td>
<td>3/22/2018</td>
<td>Deleted section calling for tourniquet removal after 45 min</td>
<td>142</td>
</tr>
<tr>
<td>Hemostatic Agents</td>
<td>3/22/2018</td>
<td>Hemostatic agents: ability to use with PMD approval and direction</td>
<td>18, 68, 69, 70, 75, 93, 125, 129</td>
</tr>
<tr>
<td>Zofran and Fetanyl Removed - AEMT</td>
<td>3/22/2018</td>
<td>See Below: Note removed due to further evaluation of State Rules and Regulations that prohibit this</td>
<td></td>
</tr>
<tr>
<td>Zofran – Added use by AEMT Throughout Protocols NOTE: Currentl not available for use for EMT Intermediates</td>
<td>12/27/2017</td>
<td>23, 38, 48, 49, 50, 51, 62, 64, 68, 69, 72, 73, 74, 75, 76, 77, 78, 80, 96, 109, 110, 119, 123, 124, 125, 126, 127, 128, 129, 132</td>
<td></td>
</tr>
<tr>
<td>Fentanyl – Added use by AEMT throughout Protocols NOTE: Currently not available for use for EMT Intermediates</td>
<td>12/27/2017</td>
<td>23, 38, 51, 68, 69, 72, 73, 74, 76, 77, 78, 80, 96, 123, 124, 125, 126, 127, 129, 132</td>
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<tr>
<td>Medication Formulary – Dextrose</td>
<td>12/27/2017</td>
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<td>159</td>
</tr>
<tr>
<td>Medication Formulary – Apresoline / Hydralazine</td>
<td>12/27/2017</td>
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<tr>
<td>Complications During Pregnancy</td>
<td>12/27/2017</td>
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<tr>
<td>Hypoglycemia – Adult</td>
<td>12/27/2017</td>
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<td>Hypoglycemia – Pediatric</td>
<td>12/27/2017</td>
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<td>46</td>
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<tr>
<td>Medication Formulary – Trandate / labetalol</td>
<td>12/27/2017</td>
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<tr>
<td>Medication Formulary – Cardene/nicardipine</td>
<td>12/27/2017</td>
<td></td>
<td>156</td>
</tr>
<tr>
<td>Medication Formulary – Levophed/norepinephrine</td>
<td>12/27/2017</td>
<td></td>
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<td></td>
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<td>163</td>
</tr>
</tbody>
</table>
### Nebraska EMS Model Protocols

| Added IM as route of administration Midazolam | 12/27/2017 | 157 |
| Corrected Ketamine Dose | 12/27/2017 | 160 |
| Triage – Added SALT Triage | 12/27/2017 | 152 |
| Added Tourniquet Protocol | 12/27/2017 | 142 |
| Added Tracheostomy Protocol | 12/27/2017 | 140 |
| Updated Stroke Protocol | 12/27/2017 | 42 |