# ALS SMO Recert South Cook County EMS

April, 2014

# Code 1

- Scene Safety – Assure the safety of all responding personnel
- Care begins at the bedside!
- BSI precautions to help prevent exposure
- For Peds, have a tape or chart like the Broselow tape, available for dosing, sizing, etc.

# Code 1 (cont'd)

- AVPU – Alert, Verbal, Pain and Unresponsive for level of consciousness
- ABCDE – Airway, Breathing, Circulation, Disability and Exposure for initial patient care assessments.
- Glascow Coma Scale – when appropriate during the focused, secondary assessment.
- Contact hospital as soon as patient's condition permits.
- VS/assessments should be rechecked/reassessed at least every 15 minutes and documented with **TIMES**

# Zofran ODT (Ondansetron) Code 1

- Given as 4mg Orally Disintegrating Tablet X 1.
- Used to treat and/or prevent nausea in pts over 1 year of age.
- Zofran ODT (Orally Disintegrating Tablet) is a serotonin 5-$HT_3$ receptor blocker. It works by blocking a chemical thought to be a cause of nausea and vomiting in certain situations.

# Code 1 – Outline for Radio Report (when the patient's condition warrants.)

- 1. Name and vehicle number of provider
- 2. Requested destination, closest hospital and estimated time of arrival
- 3. Age, sex, and approximate weight of patient
- 4. Chief Complaint, to include symptoms and degree of distress
- 5. History of present illness/injury
- 6. Pertinent Medical History: AMPLE
- 7. Clinical condition: Survey and V/S
- 8. Treatment initiated and Response

# Code 3
# Airway Obstruction

- Code 3 only refers to patients that are over 1 year old.
- Finger sweep is used only if FB (foreign body) is visible.
- Use the laryngoscope and forceps and/or suction to visualize the airway.

# Code 5
# Cardiogenic Shock
# (Remember Rate/Rhythm/Pump)

- Without Dysrhythmia: Increase the output with fluids (200 ml increments) or Dopamine to help the pump.
- Dopamine dose of 5mcg/kg/min. (400mg in 250ml)

- With Dysrhythmia present:
- Find appropriate SMO to correct it.

# Code 5

## CARDIOGENIC SHOCK

INITIAL MEDICAL CARE

**SBP <90**
**WITHOUT DYSRHYTHMIA**

**TRANSPORT ASAP**

IV NS fluid challenge in
200ml increments up to 1000ml
(if lungs remain clear)
OR
until SBP >90

SBP >90

YES

Continue IMC
and Rapid
TRANSPORT

NO

Initiate **DOPAMINE** Drip
@ 5mcg/kg/min.
Titrate to maintain
SBP >90

Continue IMC and
Rapid TRANSPORT

**SBP <90**
**WITH**
**DYSRHYTHMIA**

**TREAT UNDERLYING**
**DYSRHYTHMIA**
**AND TRANSPORT ASAP**

**Dopamine Drip**:
400mg in 250ml D5W = 1.6mg/ml=1600mcg/ml
Dose = 5mcg/kg/min. to start
220 lbs. = 100kg x 5mcg/kg/min. = 500mcg/min. = 20microdrops/min. = 20ml/hr
132 lbs. = 60kg x 5mcg/kg/min. = 300mcg/min. = 12microdrops/min. = 12ml/hr

**NOTE TO PREHOSPITAL PROVIDERS**:
If patient is in (or develops respiratory distress) despite treatment, maintain airway and prepare to intubate.

Reviewed 10/01/11
Effective 05/01/98
ALS

# Code 6
# V-Fib/Pulseless V-tach

- Stress importance of high quality CPR with minimal interruptions.
- Only spend time on Advanced airway if unable to protect airway or effectively use BVM. Consider King tube
- CPR until defibrillator attached, CPR before and after defibrillation attempts, CPR throughout resuscitation.

# Code 6

## VENTRICULAR FIBRILLATION/ PULSELESS VENTRICULAR TACHYCARDIA

-ABCs
-Perform CPR until defibrillator attached
-VF/VT present on monitor

↓

Give 1 shock
Biphasic Device Specific (120-200J)
Monophasic 360J
Resume CPR Immediately

↓

Perform 5 cycles of CPR
Check Rhythm
Shockable rhythm?

← **Continue CPR – minimize any interruptions throughout resuscitation**
-Intubate if unable to BVM
-Consider King tube
-IV/IO NS without interrupting CPR

↓

Continue CPR while Defibrillator is charging
Biphasic device specific (120-200J) or Monophasic 360J
Resume CPR immediately after the shock
Epinephrine 1:10,000 1 mg IV/IO
Repeat every 3-5 minutes as long a rhythm persists

↓

Perform 5 cycles of CPR
Check rhythm
Shockable rhythm?

↓

Continue CPR while Defibrillator is charging
Give 1 shock
Biphasic Device Specific (120-200J)
or Monophasic 360J
Resume CPR immediately after shock
Consider antiarrhythmics; give during CPR
Lidocaine 1.5mg/kg IV/IO first dose
May repeat 0.75 mg/kg IV/IO
Maximum 3mg/kg

Revised 10/01/11
Effective 05/01/98
ALS

# Code 7

## TACHYCARDIAS (WITH PULSE)

INITIAL MEDICAL CARE

**STABLE**
Rate >150
Patient is alert, without any signs of hypoperfusion*

- Narrow Complex
  - Valsalva Maneuvers
  - **ADENOSINE** (Adenocard) 6mg IVP
  - **ADENOSINE** (Adenocard) 12mg IVP
  - Continue IMC and TRANSPORT
- Wide Complex
  - Continue IMC and TRANSPORT

**UNSTABLE**
Rate >150 and signs of hypoperfusion*

If conscious, consider sedation with **MIDAZOLAM HYDROCHLORIDE** (Versed) 2.5mg slow IV

Synchronous Cardioversion**
Biphasic device specific (100-120J) or Monophasic 100-200J

If no response:
2nd dose
Biphasic escalate to maximum
Monophasic 360J

Contact Medical Control for further orders

**ACCELERATED TRANSPORT**

**NOTE TO PREHOSPITAL PROVIDERS:**

1. *Signs of hypoperfusion: severe CP, severe SOB, SBP < 90, diaphoresis, altered mental status.
2. **ADENOSINE** (Adenocard) should always be administered RAPIDLY IVP and immediately followed with a 10ml NS bolus. Antecubital vein is preferred site to administer **ADENOSINE** (Adenocard).
3. Always record rhythm strip and deliver to physician caring for patient.
4. Wide Complex = QRS > 0.12 sec. (3 small boxes)
   Narrow Complex = QRS < 0.12 sec.
5. Sinus Tachycardia should be treated appropriately.
6. If **MIDAZOLAM HYDROCHLORIDE** (Versed) is administered for sedation, the patient's oxygen saturation must be monitored via pulse oximetry.
7. **Do not delay synchronous cardioversion while awaiting IV access.

Reviewed 10/01/11
Effective 05/01/98
ALS

# Code 9 - PEA/Asystole

- Again, stress importance of high quality CPR with minimal interruptions.
- Only spend time on Advanced airway if unable to protect airway or effectively use BVM. Consider King tube
- Only administer **epinephrine** for PEA/Asystole situations.

  Atropine is no longer used for PEA/Asystole

  Not found to be helpful in PEA. The Pacemaker is not the issue, the cause of the heart not having sufficient mechanical force should be more of the focus here.

  Atropine still used as frontline for adult bradycardia. (Remember **Epinephrine** is the frontline for Peds Bradycardia) and

  still used for Organophosphate poisoning

# Code 9

## PULSELESS ELECTRICAL ACTIVITY/ASYSTOLE

PULSELESS ARREST
Perform CPR
Attach monitor/defibrillator

↓

Asystole/PEA

↓

Resume CPR immediately for 5 cycles
When IV available
Epinephrine 1:10,000 - 1 mg IV/IO
Repeat every 3 to 5 minutes

**Continue CPR – minimize any interruptions throughout resuscitation**
- -Intubate if unable to BVM
- -Consider King tube
- -IV/IO NS without interrupting CPR

↓

Perform 5 cycles of CPR

Check rhythm

Shockable rhythm?

**Not Shockable**

↓

Consider Treatment for possible causes

↓

TRANSPORT

**Shockable**

↓

Go to Code 6

Hypothermia ----------> Follow appropriate SMO
Hypovolemia ----------> Fluid challenge (200ml of current IV)
Tension Pneumothorax ----------> Pleural Decompression
Acidosis/Hypoxemia ----------> Ventilate with 100% **OXYGEN** (Check tube placement)
Pulmonary Embolism ----------> Rapid TRANSPORT with 100% **OXYGEN**

**AT DISCRETION OF A PHYSICIAN/ECRN:**
**SODIUM BICARBONATE** 1meq/kg IV/IO

Revised 10/01/11
Effective 05/01/98
ALS

# Code 10

## BRADYCARDIA (Pulse < 60)

INITIAL MEDICAL CARE

**UNSTABLE**
Signs of hypoperfusion*
OR
altered mental status

**ATROPINE** 0.5mg IV
every 3 to 5 minutes

Up to a total dose of
0.04mg/kg

Transcutaneous Pacemaker**
(if available) at rate=70 Increase MA until pulse
is present

While pacing, consider sedation with
**MIDAZOLAM HYDROCHLORIDE** (Versed)
2.5mg slow IV

Titrate **DOPAMINE** Drip
to maintain
SBP
90 - 105
and heart rate >60

**STABLE**
Patient is alert,
without any signs of
hypoperfusion*

Rapid TRANSPORT
Continue IMC
enroute.

**NOTE TO PREHOSPITAL PROVIDERS:**

1. *Signs of hypoperfusion include: severe chest pain, severe SOB, SBP <90, diaphoresis
2. If Transcutaneous Pacer not available, start **DOPAMINE** Drip. Begin @ 5mcg/kg/minute and titrate to patient response. Refer to **CARDIOGENIC SHOCK CODE 5** for **DOPAMINE** dosing chart.
3. **Do not delay Transcutaneous Pacer while awaiting IV access or for **ATROPINE** to take effect if patient is symptomatic.
4. If **MIDAZOLAM HYDROCHLORIDE** (Versed) is administered for sedation, the patient's oxygen saturation must be monitored via pulse oximetry.

Reviewed 10/01/11
Effective 05/01/98
ALS

# Code 11
# Induced Therapeutic Hypothermia

- Induced hypothermia for witnessed ROSC (return of spontaneous circulation) not related to trauma, hemorrhage, or infection.
- Pt should be intubated, have 12 lead (if available), be over 16 and not pregnant with initial temp above 93.2 F. If patient is not intubated, and a King airway is present, call medical control for further orders regarding cooling.
- Initiate cooling via ice packs and cold saline bolus of 30ml/kg up to 2L.

# Code 12
# Suspected Cardiac Patient

**Consider 12-Lead EKG for complaints of:**
(may be deferred if patient unstable)

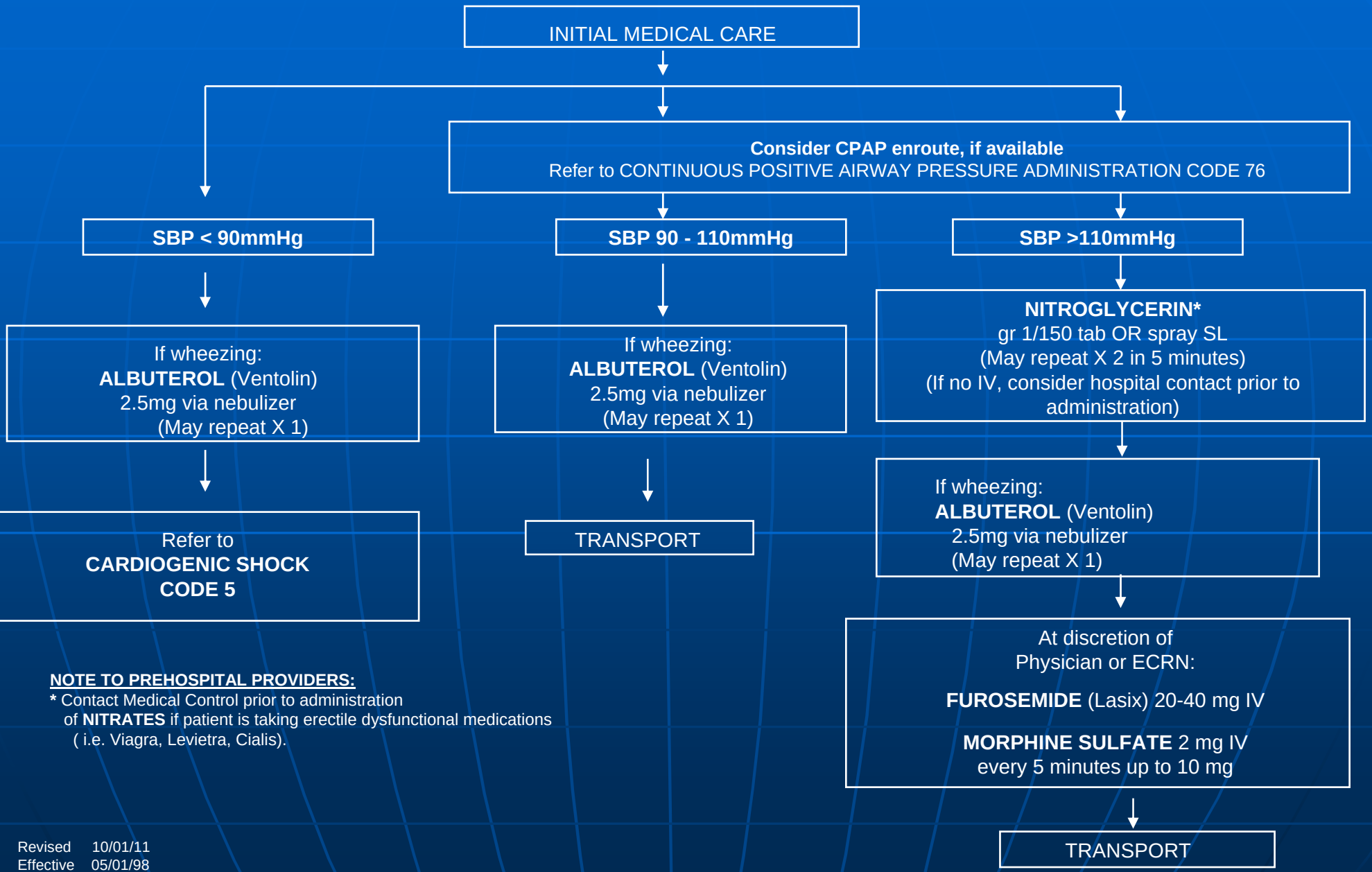
- Chest pain/Discomfort/Pressure
- Arm Pain (non-traumatic)
- Jaw Pain (non-traumatic)
- Upper back pain (non-traumatic)
- Unexplained diaphoresis
- Vomiting without fever or diarrhea
- Shortness of breath
- Dizziness/syncope
- Epigastric pain
- Fall in the elderly (unexplained)
- Weakness/Fatigue
- Bradycardia or Tachycardia

**All 12 leads should be performed prior to administration of NTG, if possible.**

If the patient has taken NTG prior to your arrival, notify Medical Control that NTG is already on board.

# Code 13

## PULMONARY EDEMA DUE TO HEART FAILURE




**NOTE TO PREHOSPITAL PROVIDERS:**

***** Contact Medical Control prior to administration of **NITRATES** if patient is taking erectile dysfunctional medications ( i.e. Viagra, Levietra, Cialis).

Revised 10/01/11
Effective 05/01/98
ALS

# Code 76

## CONTINUOUS POSITIVE AIRWAY PRESSURE ADMINISTRATION

- Observe body substance isolation at all times
- Oxygenate the patient with 15 liters via non-rebreather mask while setting up CPAP
- Connect fixed generator to portable oxygen regulator
- Open CPAP disposable package and attach patient corrugated tubing to bottom of generator and add filter to side of generator
- Attach other end of patient tubing to bottom of mask
- Attach 10cm isobaric peep valve to front of mask
- Connect head strap to top of one side of mask
- Turn oxygen tank on
- Encourage patient to place mask over mouth and nose, then firmly attach mask using final connection on side of mask
- When patient has been placed in the ambulance, “quick connect” generator to on-board oxygen
- Monitor patient’s level of consciousness and vital signs continuously. If patient develops decreased mental status or decreased blood pressure-**DISCONTINUE CPAP**.
- Continuous cardiac monitoring and pulse oximetry required

Note: If aerosol medication treatment is indicated, cut the patient’s corrugated tubing at first smooth part closest to the patient’s face. Place a “t” connector between the tubing and follow **ALBUTEROL** administration protocol.

If port is available for Albuterol administration, follow manufacturers guidelines.

# Code 21

## ISOLATED EXTREMITY INJURY AND/OR AMPUTATED AND AVULSED PARTS

INITIAL TRAUMA CARE
(ABCs always take priority over the severed part)

**Control bleeding with direct pressure and elevation**

For uncontrolled hemorrhage:

- Consider use of a hemostatic agent
- Use a tourniquet if needed
  - Note time of placement
  - Apply as close to the injury as possible
  - DO NOT release once applied

**NITROUS OXIDE** (optional)

- Wrap part in sterile gauze, sheet or towel.
- Place part in waterproof bag or container and seal.
- DO NOT immerse part in any solutions.
- Place this container in a second one filled with ice, cold water or cold pack.

Transport part to hospital with patient

TRANSPORT

**NOTE TO PREHOSPITAL PROVIDER:**
**MORPHINE SULFATE** 5-10mg slow IV in 5mg increments every 5 minutes as necessary for pain.

Reviewed 10/01/11
Effective 05/01/98
ALS

# Code 21
# ISOLATED EXTREMITY INJURY AND/OR AMPUTATED AND AVULSED PARTS

Stress the importance of bleeding control with the use of tourniquet, if needed. All ambulances should have a tourniquet on board. *Always:*

- Note time of placement
- Apply as close to the injury as possible
- DO NOT release once applied

# Code 21a

## Crush Injury

Suspected in extended extremity
and/or
Torso entrapment

Check for:
- Pain
- Paresthesia
- Paralysis
- Pallor
- Pulselessness

Not needed, but good indicators

INITIAL MEDICAL CARE

↓

AIRWAY AS NEEDED
Cardiac monitor as soon as possible
Morphine Sulfate 2mg increments IV/IM as needed for pain (do not administer if respiratory depression, bradycardia or hypotension SBP < 90)

↓

PRIOR TO RELEASE OF COMPRESSION, INITIATE
IV Normal Saline 1000ml bolus
Albuterol (Ventolin) 2.5mg via Nebulization

↓

If hyperkalemia suspected
and abnormal ECG rhythm - peaked T-wave or widened QRS → No → **Transport**
**YES ↓**
Sodium Bicarbonate 50 meq IV followed by 20ml Normal Saline flush
Calcium Chloride 1.0gm slow IV followed by 20ml Normal Saline flush

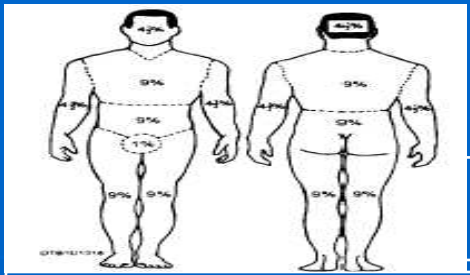
**TRANSPORT**

**NOTE TO PREHOSPITAL PROVIDERS:**
Consider hypoglycemia and need for 50% Dextrose IV.

Reviewed 10/01/11
Effective 06/01/06
ALS

# Code 22

# BURNS



Burn patients are often victims of multiple trauma.
Treatment of major traumatic injuries takes precedence over wound management.
**Isolated burn injury patients should be transferred to the closest available hospital**

## ASSESS

- Total body surface area: use rule of 9s or estimate using patient's palmar surface as 1%
- Depth of burn: partial or full thickness, consider exposure to products of combustion and treat as soon as possible.

## THERMAL

INITIAL TRAUMA CARE

OXYGEN 100% (Use humidified Oxygen, if available). Note presence of hoarseness, wheezing, stridor or productive cough and document.
If present, refer to **ACCELERATED TRANSPORT CODE 26**

Note quality of distal pulse in extremity burns and document.

Burn Wound Care - Moderate to Critical Burn

Wear sterile gloves and masks until burn wounds are covered. Remove clothing, jewelry, etc. Do not pull away clothing that is stuck to burn wound.

COOL BURN with sterile water or saline until skin feels cool to your touch. Don't overcool any major burn. Do not use ICE directly on burn. Cover burn wound with sterile dressing. Moisten with Normal Saline. DO NOT BREAK BLISTERS. DO NOT APPLY CREAMS, OINTMENTS OR ANTIDOTES TO BURNS.

Apply sterile dry dressing.

>20% 2° or 3°

Open sterile sheet on stretcher before placing patient for TRANSPORT.
Cover patient with dry, sterile sheets and blanket to maintain body temperature.

## CHEMICAL

INITIAL TRAUMA CARE

Brush off excess dry chemicals

Irrigate or flush with copious amounts of water or saline unless contraindicated.

For eye exposures Refer to **HAZARDOUS MATERIALS-EYE CODE 40**

Follow routine Burn Wound Care

TRANSPORT

## ELECTRICAL

Without placing self at risk for injury, remove patient from source of electricity or have power cut off.

INITIAL TRAUMA CARE

Perform spinal immobilization, apply monitor and treat dysrhythmias per appropriate SMO.

Burn Wound Care

Assess for entry and exit wounds, neurovascular status of affected parts

No cooling necessary

Cover with dry, sterile dressings

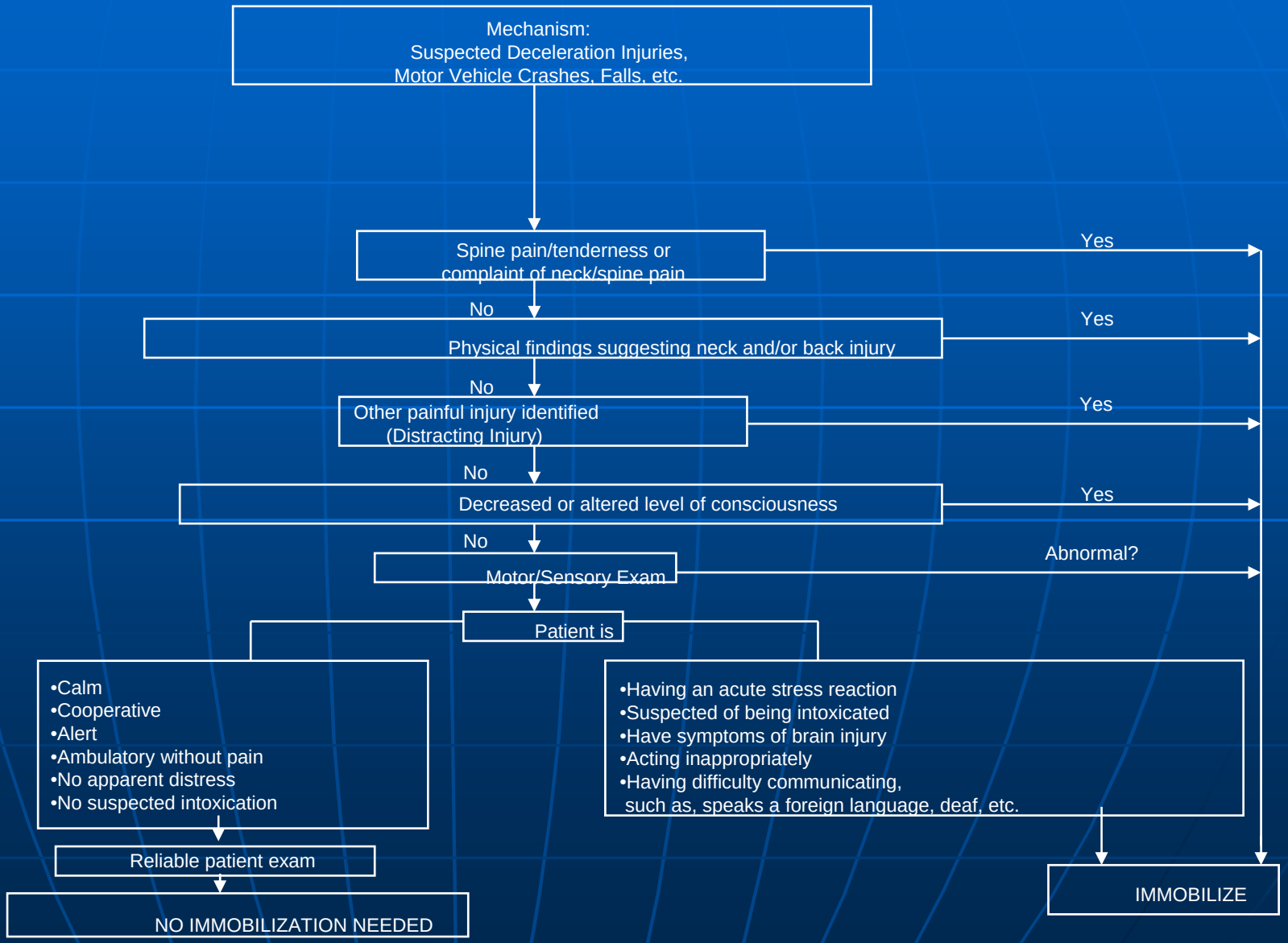
TRANSPORT

**NOTE TO PREHOSPITAL PROVIDER:**
FOR ALL TYPES OF BURNS:
**MORPHINE SULFATE** 5-10mg IVP in 5mg increments every 5 minutes as necessary for pain.
- Do not administer until shock has been controlled.
- DO NOT GIVE IM.
- **NITROUS OXIDE Inhalation** (optional)

Revised 10/01/11
Effective 05/01/98
ALS

# Code 18

## SUSPECTED SPINAL CORD INJURY
## SPINAL IMMOBILIZATION




Reviewed 10/01/11
Effective 05/01/98
ALS

# Code 30
# Acute Asthma/COPD with Wheezing

**TRANSPORT IMMEDIATELY**

**DO ALL TREATMENT ENROUTE**

**CPAP should be considered, at the discretion of the Physician/ECRN, when available and as appropriate.**

# Code 32, 33, 34 (Diabetes, Overdose & Coma)
# Addition of Intranasal Med

- Narcan and Glucagon may be given intranasally.
- Mix and draw med and dose as normal.
- Replace needle with a MAD (medication atomization device) tip.
- Place in nostril till cone seals.
- Administer half the dose.
- Repeat in other nostril for second half of the dose.

# Code 35

## SEIZURES/STATUS EPILEPTICUS*

INITIAL MEDICAL CARE

↓

•Protect patient from injury
•Protect patient airway

↓

Obtain Blood Glucose Reading
If <60
OR signs and symptoms of Insulin Shock or Hypoglycemia
**DEXTROSE** 50ml of 50% IVP
**OR**
**GLUCAGON** 1mg IM/IN
(If IV not able to be established)

↓

If seizure activity > 2 - 3 minutes,

**MIDAZOLAM HYDROCHLORIDE** (Versed) 2.5 mg IV (may repeat X 1 in 5 minutes)

If no IV, may administer **MIDAZOLAM HYDROCHLORIDE** (Versed) 2.5 mg IM (may repeat X 1 in 5 minutes)

↓

TRANSPORT

***** Refer to **PEDIATRIC SEIZURES CODE 59,** as indicated

Reviewed 10/01/11
Effective 05/01/98
ALS

# Code 33*

## DRUG OVERDOSE
## ALCOHOL RELATED EMERGENCIES/POISONING

INITIAL MEDICAL CARE

↓

Obtain Blood Glucose Reading

↓

If suspected narcotic or synthetic narcotic overdose and respiratory rate <12
Administer **NALOXONE** (Narcan) 2mg IV/IM/IN
(Consider restraints prior to administration.)
May be repeated every 5 minutes as necessary, up to 6mg.

↓

If blood sugar
level <60:
**DEXTROSE** 50% 50ml IVP
**OR**
**GLUCAGON** 1mg IM/IN
(If IV not able to be established)

↓

TRANSPORT

**NOTE TO PREHOSPITAL PROVIDERS:**
***Refer to **PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS CODE 60,** as needed

## SUSPECTED TRICYCLIC ANTIDEPRESSANT OVERDOSE**

INITIAL MEDICAL CARE

↓

**SODIUM BICARBONATE** 1meq/kg IVP. If hypotensive,
altered level of consciousness, or dysrhythmias are present,
Consider additional doses of **SODIUM BICARBONATE**, if symptoms persist

↓

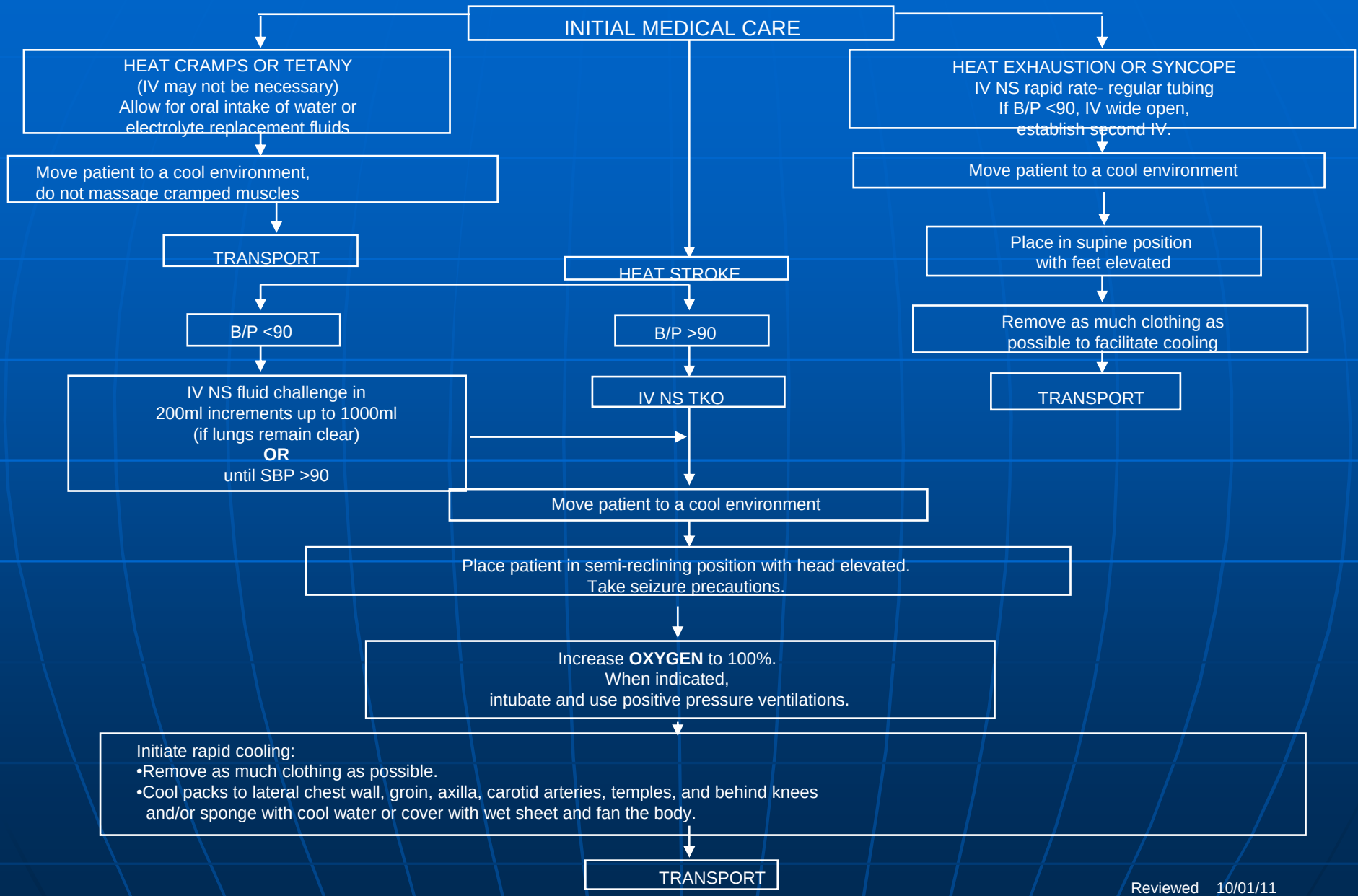
TRANSPORT

Revised 10/01/11
Effective 05/01/98
ALS

****TRICYCLIC ANTIDEPRESSANTS INCLUDE:**
**AMITRIPTYLINE, AMOXAPINE, ASCENDIN, DESIPRAMINE, DESYREL, ELAVIL, ENDEP, IMIPRAMINE, LUDIOMIL, NORPARAMINE, PAMELOR, SINEQUAN, TRIAVIL, TOFRANIL**, and others

# Code 36

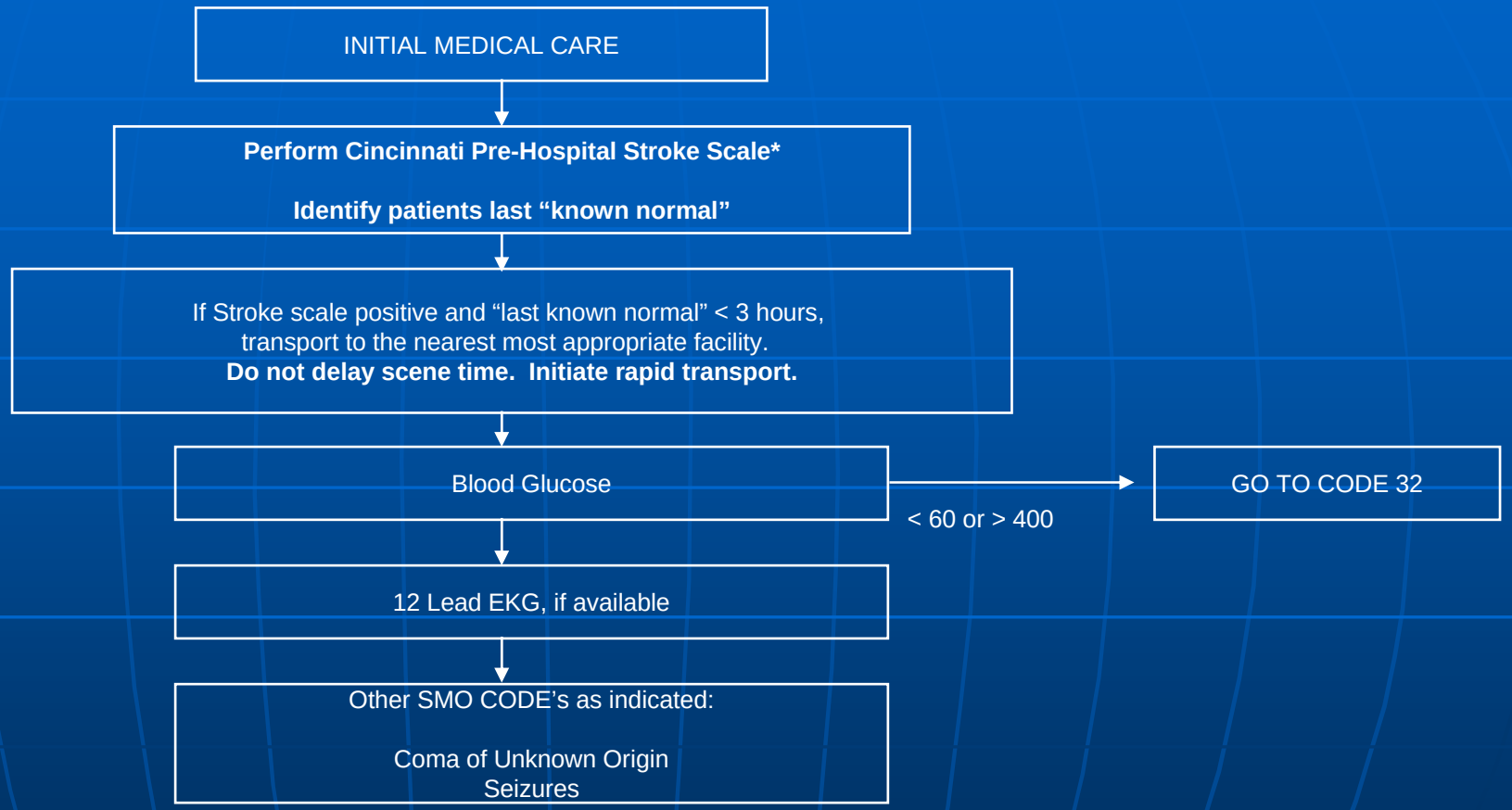
## HEAT EMERGENCIES




Reviewed 10/01/11
Effective 05/01/98
ALS

# Code 38

## SUSPECTED STROKE




***Cincinnati Prehospital Stroke Scale**

Facial Droop (Have the patient show teeth or smile)
- •Normal – Both sides of face move equally well
- •Abnormal – One side of face does not move as well as the other side

Arm Drift (Patient closes eyes and holds both arms straight out for 10 seconds)
- •Normal – Both arms move the same or both arms do not move at all (other findings, such as pronator grip, may be helpful)
- •Abnormal – One arm does not move or one arm drifts down compared with the other

Speech (Have the patient say, "You can't teach an old dog new tricks.")
- •Normal – Patient uses correct words with no slurring

Revised 10/1/11
Effective 05/01/10
ALS

# Code 47

# ABNORMAL DELIVERIES

## PROLAPSED CORD

TRANSPORT IMMEDIATELY

↓

INITIAL MEDICAL CARE:
Increase **OXYGEN** to 100%

↓

Elevate mother's hips

↓

Place gloved hand in vagina between pubic bone and presenting part
with cord between fingers and exert counterpressure against presenting part

↓

Keep exposed cord
moist and warm

↓

Keep hand in position while enroute

---

## BREECH BIRTH

- Accelerated transport indicated with care enroute
- NEVER ATTEMPT TO PULL THE BABY FROM THE VAGINA BY THE LEGS OR TRUNK.
- As soon as legs are delivered, support baby's body, wrapped in towel.
- After shoulders are delivered, gently elevate trunk and legs to aid in delivery of head (if face down). Head should deliver in 30 seconds. IF NOT, reach two gloved fingers into the vagina to locate infant's mouth. Press vaginal wall away from baby's mouth to form an airway and apply gentle pressure to mother's mid upper abdomen. Maintain this position until delivery or arrival at the hospital.

Reviewed 10/01/11
Effective 05/01/98
ALS

# Code 68

## RESTRAINTS AND BEHAVIORAL EMERGENCIES

**Maintain situational awareness and scene safety.** Introduce yourself to the patient, and attempt to gain their confidence in a non-threatening manner. If the patient refuses assistance, attempt to determine their mental status. This includes determining their orientation and the presence of anything that could produce an altered mental status, such as drug/alcohol intoxication or withdrawal, trauma (head injury), hypoxia, hypotension, hypoglycemia, stroke, infections, psychological emergencies (i.e. homicidal, suicidal, psychosis, etc.) or dementia (i.e. acute or chronic organic brain syndromes).

↓

No

↓

If the mental status is judged to be abnormal, prehospital personnel must carry out treatment and transport in the patient's best interest.

↓

In any form of intervention, prehospital personnel must ALWAYS CONSIDER THEIR OWN SAFETY FIRST!

↓

1. Again attempt to verbally reassure the patient and seek their willing cooperation.
2. If it is necessary to physically restrain a patient, perform all the following:
   - A. Prepare all the necessary equipment.
   - B. Use police and /or fire personnel if needed. If available, have one person assigned to each extremity and one to hold equipment.
   - C. Apply the restraints as loosely as possible to maintain a safe situation, but prevent neurovascular compromise and undue patient discomfort. Apply restraints over clothing when possible.
   - D. Never place restraints over a patient's chest or on the abdomen of a pregnant patient.
   - E. Perform routine and specific medical care as indicated by the patient's condition. Routinely document the neurovascular status of the patient's extremities distal to the restraints.
   - F. Notify the receiving hospital of the situation, and request security assistance upon arrival.
   - G. Continue to attempt to verbally reassure the patient and seek their cooperation. Inform the patient's family of the reasons for the use of restraints.
   - H. Thoroughly document the situation including the reasons for using restraints and how they were applied.
   - I. At no time will towels, washcloths or other devices be placed over the mouth and/or nose of a restrained patient for any reason.
   - J. Never restrain a patient in the prone position.
   - K. For reasons of medical safety, any patient who is under police hold and requires handcuffs, must have a police officer accompany the patient in the back of the ambulance while enroute to the hospital or provide the transporting EMS personnel with keys to the handcuffs.

Reviewed 10/01/11
Effective 05/01/98
ALS

**NOTE TO PREHOSPITAL PROVIDERS:**
Once restrained, continue to be conscious of the patient's airway and other medical needs.

# Code 73
# Intraosseous
# Needle insertion
# (Adult)

**Contraindications:**

- Infection at the site of insertion
- Fracture of the bone at the site of insertion
- Excessive tissue preventing identification of landmarks
- Previous significant orthopedic procedures
- Previous IO insertion attempt at this site within the last 24 hours

**Approved Sites:** Proximal tibia or proximal humerous

Reviewed 10/01/11
Effective 05/01/10
ALS

# Code 24

## TRAUMA IN PREGNANCY

**Principles of Management**

A. Routine Trauma Care

B. Increased IV volume is needed. Establish IV. If total transport time is less than 30 minutes, no IV should be attempted unless it will not delay transport to the nearest Trauma Center

C. Check externally for uterine contractions.

D. Check externally for vaginal bleeding.

E. Unless spinal injury is suspected, transport the patient on her left side to minimize uterine compression of the inferior vena cava.

F. If a patient with suspected spinal injury becomes hypotensive while supine on backboard, elevate right side of backboard to relieve pressure on vena cava from uterus.

G. Manually displace the uterus to the left side during CPR.

Reviewed 10/01/11
Effective 05/01/98
ALS

# Code 86
# Concealed/Carry Firearm

**PATIENT CARE**

- All legal efforts should be utilized to avoid having to transport the weapon to the Emergency Department. However, if the Patient's condition requires immediate transportation , then transportation should not be delayed unless there is an imminent life threat to the providers. If the patient is stable, and Police are in route, transportation may be delayed to relinquish the weapon to the Police Officer.

**SAFETY**

- Scene safety remains the top priority for EMS responders. If the EMS responders feel that there is a valid life threat to themselves, then retreat to a safe zone is indicated. Stage in a safe location to be able to reenter the scene when secured by Law Enforcement.
- When you must transport the weapon, it ***must*** be secured to prevent accidental discharge.

**NOTIFICATION TO THE EMERGENCY DEPARTMENT**

- When transporting the weapon on the Ambulance, the provider will contact the Emergency Department early. The report needs to contain the verbiage "***I have a CODE 86***".This informs the Emergency Department that there is a secured weapon on the ambulance and will require someone from the Hospital to take custody of the weapon upon arrival.

**TRANSFERRING THE WEAPON AT THE HOSPITAL**

- Upon arrival, relinquish the weapon to the Hospital's designee as soon as possible. Do not leave the weapon unattended at any time.