CONNECTICUT STATE BLS GUIDELINES

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GENERAL

MEDICAL

TRAUMA

ADDENDUM

Some segments of information are printed in bold or italicized. Interpret this information as follows:

Capitalized or Capitalized and bold: Special emphasis

Bold and Italicized: Pertaining to Medical Direction

Italicized: Additional information or special note

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Procedure #1

ASSESSMENT

Body substance isolation (BSI) precautions must be routinely taken to avoid skin and mucous membrane exposure to body fluids.

The evaluation of scene safety involves an assessment of the scene to ensure the well being of the EMT, the crew, the patient(s), and bystanders.

1. Scene Size-Up

    a. Take BSI precautions:

        - Includes eye protection, gloves, gown, and mask as needed
        - Wash hands after each patient contact

    b. Determine scene safety.

        - Evaluate responder's and patient's safety
        - Determine number of patients / resources needed

2. Initial Patient Assessment

    a.. Level of consciousness - categorize as below (AVPU):

        - Alert; recognize surroundings and responders
        - Responds to verbal stimulus
        - Responds to painful stimulus
        - Unresponsive

    b. Evaluate the situation e.g., chief complaint and why you were called. Consider the potential of C-spine involvement by mechanism, location and scope of injury. If there is potential spinal injury, stabilize before moving patient.

    c. Airway - determine that airway is unobstructed.

    d. Breathing - assure an open airway. Ventilate as needed.

    e. Circulation/Significant Bleeding - establish presence of pulses. Begin compressions as needed. Control bleeding as needed.

3. Vital Signs

a.. Evaluate Breathing

- Count respiratory rate.
- Observe if face, neck or chest muscles are used during respiration.
- Examine the mucosa of the mouth and lips for color (cyanosis).
- Observe for irregular respirations or a recognizable pattern.
- Breath sounds.

b. Evaluate Circulation

- Heart rate
- Skin color, temperature, moisture
- Skin **TURGOR**
- Capillary refill
- Blood pressure

c. Evaluate disability / deformity

- Pupils
- Neurological exam as appropriate

4. Recent History

Obtain the pertinent information relevant to this episode such as onset and duration of symptoms, characteristics of pain, and any associated symptoms. Then identify chronic conditions:

- O = Onset
- P = Provoking factors
- Q = Quality of pain
- R = Radiation
- S = Severity
- T = Time of onset

5. Obtain Past Medical History

a.. Obtain past medical history, including:

- S = Signs/Symptoms
- A = Allergies
- M = Medications currently used

- P = Past illnesses
- L = Last meal
- E = Events preceding

6. Detailed Physical Exam (time and critical care needs permitting)

A. Remove clothing as needed

B. Perform Detailed Physical Exam, including:

- D = Deformities
- C = Contusions
- A = Abrasions
- P = Punctures/Penetrations
- B = Burns
- T = Tenderness
- L = Lacerations
- S = Swelling

C. Locate and treat injuries/conditions according to the appropriate protocol without unnecessary delay in transport.

*Note: With **EVERY** patient, look for a Medical Alert tag*

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Procedure #2

OXYGEN

1. Flow Rates

   a. All patients in respiratory distress shall receive supplemental O_2 as follows:

      - 15 liters per minute (LPM)
      - 6 LPM by nasal cannula for patients who do *not* tolerate the nonrebreather mask

   b. Airway/O_2 adjuncts for the use of EMT-Bs include:

      - Oral (oropharyngeal) airways
      - Nasal (nasopharyngeal) airways
      - Pocket masks
      - Bag valve masks
      - Flow restricted oxygen-powered ventilation device
      - Nonrebreather mask
      - Nasal cannula

2. Assessment of need for supplemental O_2 should include the following:

      - Respiratory rate - between 8 & 24 times perminute
      - Respiratory quality
      - Color
      - **NATURE OF INJURY/MECHANISM OF INJURY**
      - Lung sounds
      - Pre-existing conditions
      - **MENTAL STATUS**
      - **CHEST PAIN**

3. Non-Breathing Patients and patients with respirations less than 8 or greater than 24 times per minute (preferred sequence):

      - Mouth to mask with supplemental oxygen
      - Bag valve mask used by two (2) persons
      - Flow restricted oxygen powered device
      - Bag valve mask used by one (1) person. *Only* as a last resort

- *Note: Either an oropharyngeal or nasopharyngeal airway should be used.*

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Procedure #3

ABDOMINAL PAIN

1. Perform initial assessment:

   a. Maintain airway, breathing and circulation.
   b. Provide oxygen according to Procedure #2.

2. Perform focused history and physical exam.

3. Take and record baseline vital signs.

4. Allow patient to seek position of comfort. Suggest knees flexed.

5. *Do not* administer anything by mouth.

6. Transport according to priority as defined by patient's condition. Need for Paramedic intercept will be determined by patient's condition and Medical Direction.

Note: Women should be assessed for obstetrical/gynecological emergencies.

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Procedure #4

ALLERGIC REACTION

Obtain orders from Medical Direction either on-line or off-line.

Always be prepared to initiate basic cardiac life support measures: CPR, SAED/AED and treat for shock (hypoperfusion).

1. Perform initial assessment:

    a. Maintain airway, breathing and circulation.
    b. Provide oxygen according to Procedure #2.

2. Perform focused history and physical exam:

    a. Patient has history of allergies.
    b. Substance patient was exposed to.
    c. How was patient exposed?
    d. Time of exposure.
    e. Take and record baseline vital signs.
    f. Determine if the patient has taken any medication in an attempt to relieve the current symptoms.

3. **Mild allergic reactions** with hives and itching but without signs of respiratory distress or hypoperfusion:

    a. Continue focused physical exam.
    b. Transport as soon as possible. Transport priority will be defined by patient's condition. Need for Paramedic intercept will be determined by patient's condition and Medical Direction.

4. **Severe Reactions:** Patient complains of itching, hives, with difficulty swallowing or difficulty breathing **WITH UPPER AIRWAY OBSTRUCTION WITH STRIDOR**. Wheezing may be audible without a stethoscope **OR MAY BE ABSENT**. Patient shows signs of shock (hypoperfusion).

    a. Place patient in position appropriate to condition (supine or sitting up).
    b. Transport as soon as possible. **FOR SEVERE REACTIONS TRANSPORT IMMEDIATELY. PARAMEDIC INTERCEPT SHOULD BE CALLED AS SOON AS POSSIBLE.**

c. Determine if patient has prescribed preloaded epinephrine available (refer to Addendum I).

For more information, refer to Addendum #1 - Epinephrine Auto Injector.

d. As per Medical Direction: Administer preloaded epinephrine auto injector

(1) Obtain patient's prescribed auto injector:

(a) Ensure auto injector is prescribed for the patient you are treating.

(b) Check expiration date of the auto injector.

(2) Remove safety cap from the auto injector.

(3) If time permits, swab the area to be injected with alcohol, if available.

(4) Place tip of auto injector against the patient's thigh.

(a) lateral portion of the thigh
(b) midway between the hip and knee.

(5) Push the injector firmly against the thigh until the injector activates.

(6) Hold the injector in place until the medication is injected, at least 10 seconds.

(7) Record activity and time.

(8) Dispose of injector in biohazard container.

e. Transport, reassessing patient's condition including airway, breathing, circulation, mental status and vital signs.

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Procedure #5

BEHAVIORAL EMERGENCIES

Behavioral emergencies are those situations where the patient exhibits behavior within a given circumstance that **IS INAPPROPRIATE OR MAY CONSTITUTE A SIGNIFICANT DANGER TO THE PATIENT'S HEALTH OR BYSTANDERS.**

1. Perform scene size-up.

2. If the patient **HAS THE POTENTIAL TO ACT IN AN** aggressive or combative manner, displays a weapon, **OR HAS POSSIBLE ACCESS TO A WEAPON** immediately summon police for assistance and EMS personnel **SHOULD WITHDRAW TO A SAFE AREA**.

3. When the situation is stabilized, perform initial assessment. Note that numerous medical conditions may mimic a behavioral emergency. Consider the following:

    - Low blood sugar (hypoglycemia)
    - Alcohol and/or drugs
    - Head trauma
    - Lack of oxygen (hypoxia)
    - CVA/Stroke

4. Perform initial assessment:

    a. If patient restraint is required, ensure police **AND ADEQUATE PERSONNEL ARE** present.
    b. Identify yourself, your role, and attempt to interview patient.
    c. Maintain at least three (3) feet from the patient.
    d. Be alert for changes in the patient's emotional status.
    fe Evaluate the patient for the possibility of self-destructive behavior and/or suicidal ideation.

5. Transport to closest, appropriate facility with law enforcement assistance, if necessary.

6. Contact receiving hospital with patient's condition and estimated time of arrival.

7. Perform ongoing assessment according to patient's behavior.

NOTE: Protect against false accusations:

1. Documentation of abnormal behavior exhibited by patient is very important.

2. Have witnesses in attendance, especially during transport, if possible.

3. Accusing EMT-Bs of sexual misconduct is common by emotionally disturbed patients. Have help: same sex attendant and third party witnesses.

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Procedure #6

CARDIAC ARREST

Non-Traumatic Arrest

1. a. Establish unresponsiveness.
   b. Establish and maintain airway.
   c. Call or verify dispatch of Paramedic.
   d. Attach SAED/AED.
   e. Initiate CPR.
   f. Follow local protocols for procedure to use SAED/AED.
   g. *Never activate SAED/AED in moving vehicle. Pull over and stop.*
   h. Contact receiving hospital.

2. **REFER TO ADDENDUM #2 FOR WITHHOLDING RESUSCITATION**

3. **IF STARTED,** resuscitation effort *must* be continued until relieved by hospital staff or other emergency provider except as follows:

   a. Exhaustion of team member(s).
   b. Directed to stop by on-line medical direction, on-scene paramedic, or on-scene, identified, licensed **PHYSICIAN** (with approval of medical direction).
   c. Patient is resuscitated.
   d. VALID DNR BRACELET AND TRANSFER FORM PRESENT.

4. Provide all quality assurance records from SAED/AED according to local medical direction policy.

Traumatic Arrest

1. a. Establish unresponsiveness.
   b. Establish *and maintain* airway. Provide cervical immobilization
   c. Initiate CPR.

   d. Transport as high priority. Transport should not be delayed awaiting arrival of Paramedic. Transport to the closest receiving hospital according to State Trauma Guidelines.

   e. Contact receiving hospital with patient condition and estimated time of arrival.

f. REFER TO ADDENDUM #2 FOR WITHHOLDING RESUSCITATION

2. Resuscitation effort *must* be continued until relieved by hospital staff or other emergency provider except as follows:

   a. Exhaustion of team member(s).
   b. Directed to stop by on-line medical direction, on-scene paramedic, or on-scene, identified, licensed **PHYSICIAN** (with approval of medical direction).
   c. Patient is resuscitated.

3. Provide all quality assurance records from SAED/AED according to local medical direction policy.

For further information, refer to Addendum #2 - State of Connecticut EMS Policy and Procedures, Reference #908, Guidelines for With-holding Resuscitation. and Addendum #3 - Do Not Resuscitate (DNR)

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Procedure #7

CHEST PAIN

Obtain orders from Medical Direction either on-line or off-line.

Always be prepared to initiate basic cardiac life support measures: CPR, SAED/AED.

1. Perform initial assessment:

    a. Maintain airway, breathing and circulation.
    b. Provide oxygen according to Procedure #2.

2. Perform focused history and physical exam.

    - Take and record baseline vital signs.

3. If the patient has a systolic blood pressure of less than 100 mmHg and/or an altered level of consciousness:

    a. Place patient in supine position if tolerated.
    b. Transport as soon as possible. Transport priority will be defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.
    c. Establish communication with emergency department.
    d. Relay chief complaint, patient history, vital signs and estimated time of arrival.

4. If the patient is alert and has a systolic blood pressure of 100 mmHg or greater:

    a. Place the patient in a position of comfort.
    b. Transport as soon as possible. Transport priority will be defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.

    c. If the patient has been prescribed nitroglycerin and has the nitroglycerin with them: ***Verify orders from Medical Direction either on-line or off-line. Relay the following:***

- ***Chief complaint***
- ***Patient history***
- ***Vital signs***
- ***If the patient has taken their medication prior to arrival of EMS and the medication expiration date***

IMPORTANT: MEDICAL DIRECTION NEEDS TO KNOW IF THE PATIENT IS TAKING **VIAGRA** *OR A SIMILAR PRODUCT***.**

d. Administer nitroglycerin per Medical Direction every three to five minutes, up to a maximum of three (3) doses: reassess vital signs and chest pain after each dose.

For further information, refer to Addendum #4 - Assisting the Patient With Prescribed Nitroglycerin

e. Document all times of administration.

5. GIVE ASPIRIN AS PER MEDICAL DIRECTION

FOR FURTHER INFORMATION, REFER TO ADDENDUM #5 - ASPIRIN

6. Perform ongoing assessment.

7. If the patient is alert with a systolic blood pressure of 100 mmHg or greater and does not have prescribed nitroglycerin:

   a. Place patient in position of comfort.
   b. Transport as soon as possible. Transport priority will be defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.
   c. Establish communication with emergency department.
   d. Relay chief complaint, patient history, vital signs and estimated time of arrival.
   e. Continue with elements of focused patient assessment.

8. Document.

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Procedure #8A

LABOR & DELIVERY

Full body substance isolation should be taken by EMT assisting

1. Perform initial assessment:

   a. Maintain airway, breathing and circulation.

   b. Provide supplemental oxygen according to Procedure #2.

2. Perform focused history and physical exam.

   Determine number of prior pregnancies and number of live births.

3. Take and record baseline vital signs.

4. Check for crowning of baby. If crowning present, prepare for emergency delivery. If limb or buttocks are presenting, see Special Considerations.

5. Arrange for paramedic intercept.

6. Perform delivery (consider contacting medical direction for guidance):

   a. Place sterile sheet under the patient's buttocks.

   B. NOTE ANY MECONIUM STAINING AND SUCTION MOUTH AND NARES

   c. Assist with the delivery of the baby.

   d. Check for the position of the umbilical cord around the baby's neck. Remove if present.

   e. Upon delivery, provide tactile stimulus to the baby in order to initiate respiratory effort.

   f. As pulsations cease, clamp, tie and cut the umbilical cord approximately four fingers width from the baby.

g. Note the time of delivery.

h. Determine APGAR score at 1 minute and 5 minutes post delivery.

i. Be prepared to provide the following:

- Supplemental oxygen
- Rescue breathing
- Chest compressions

j. Thoroughly dry the baby and maintain body warmth.

K. PLACE BABY ON MOTHER'S ABDOMEN.

7. Transport as soon as practical.

8. Monitor mother for the delivery of the placenta. DO NOT DELAY TRANSPORT awaiting the delivery of the placenta.

9. Perform ongoing assessment of mother and baby every 5 minutes.

Procedure #8B

OBSTETRIC AND GYNECOLOGICAL EMERGENCIES
SPECIAL CONSIDERATIONS

Complications of pregnancy may include ectopic pregnancy, hypertension in pregnancy (preeclampsia), seizures in pregnancy (eclampsia) and vaginal hemorrhage.

1. Perform initial assessment:
   a. Maintain airway, breathing and circulation.
   b. Provide supplemental oxygen according to procedure #2.
2. Perform focused history and physical exam.
   a. Determine number of prior pregnancies and number of live births.
3. Take and record baseline vital signs.
4. Transport according to priority as defined by patient's condition. Need for paramedic intercept will also be determined by patient's condition and Medical Direction.
5. Perform ongoing assessment every 5 minutes.

Contact Medical Direction for guidance and arrange for paramedic intercept:

1. If presenting fetal part is a limb, prevent further delivery by placing the patient in the trendelenburg position. *Transport immediately.*.
2. If presenting part is the placenta (placenta previa), vaginal hemorrhage should be treated by placing a trauma dressing over the vagina and place the patient in the trendelenburg position. *Transport immediately.*
3. If the presenting part is the buttocks or both-legs-first (breech) of the baby, *transport immediately*. Be ready to assist in delivery of the fetus. Place patient in trendelenburg position. Do not pull on the pelvis or legs of the baby. If torso delivers and head remains in vagina, place sterile glove in vagina with EMT's palm toward baby's face. With index finger and middle finger, form a "v" around baby's nose helping to push the vaginal wall away from baby's face. Transport in this manner as rapidly and safely as possible.

4. If prolapsed umbilical cord, place two gloved fingers in the vagina near the presenting cord in order to prevent the baby from crushing the cord. Wrap cord in sterile, moist towel. *Transport immediately*, continuing pressure to baby's head.

5. In cases of *trauma* in pregnancy, perform the following:

    a. Provide resuscitation if necessary.

    b. Provide oxygen according to Procedure #2.

    c. Be ready to suction.

    d. Transport as soon as possible in left lateral recumbent position unless a back or neck injury is suspected. If back or neck injury is suspected, secure patient to a longboard then tip board and patient to the left. Support with pillows or blankets.

    e. Provide emotional support.

Note:

Place all pregnant patients in the left lateral recumbent position if possible.

If pregnant patient is hypertensive (systolic greater that 150, diastolic greater than 100), be prepared to treat for grand mal seizure and arrange for paramedic intercept.

If pregnant patient has severe vaginal bleeding present, place trauma dressing over vagina. *Do not place anything in vagina.*

If pregnant patient is actively seizing, intercept with paramedic as soon as possible.

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Procedure #9

CVA / STROKE

Always be prepared to initiate basic cardiac life support measures: CPR, SAED/AED, and treat for shock (hypoperfusion).

1. Perform initial assessment:

    a. Maintain airway, breathing and circulation.
    b. Provide oxygen according to Procedure #2.
    c. Suction airway if necessary.

2. Perform focused history and physical exam.

    a. Attempt to identify time of onset for signs and symptoms for CVA/Stroke. **IF WITHIN THREE (3) HOURS, BRIEF SCENE TIME AND RAPID TRANSPORT TO HOSPITAL IS ESSENTIAL.**
    b. Early notification of receiving hospital for stroke alert per Medical Direction.
    c. Call receiving facility and relay the following:
        - Chief complaint
        - Level of consciousness
        - Vital signs
        - Patient's history
        - Time of onset of symptoms
        - Estimated time of arrival
    d. Determine Glasgow Coma Scale (see Addendum)

3. Transport priority will be defined by patient's condition. Need for paramedic intercept will be determined by patient's condition and Medical Direction.

4. Ongoing assessment will be performed according to patient's condition.

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Procedure #10

DIABETIC EMERGENCIES

Always be prepared to initiate basic cardiac life support measures: CPR, SAED/AED, and treat for shock (hypoperfusion).

1. Perform Initial Assessment:

    a. Maintain airway, breathing and circulation.
    b. Provide oxygen according to Procedure #2.

2. Perform focused history and physical exam:

    a. Patient has history of diabetes
    b. Patient takes medication for diabetes (insulin or oral med.)
    c. Patient took medication
    d. Patient's last oral intake

3. If the patient is unresponsive and/or unable to swallow and/or without an intact gag reflex:

    a. Begin immediate transport
    b. Call for ALS. Determine need for Paramedic Intercept per sponsor hospital guidelines.
    c. Establish communication with emergency department.
    d. Relay patient history, vital signs and estimated time of arrival.
    e. Determine Glasgow Coma Scale (see Addendum)

4. If patient is responsive, able to swallow **AND TAKE SAFELY BY MOUTH**, has an intact gag reflex and can protect own airway:

    a. Obtain orders from Medical Direction either on-line or off-line. ***Relay the following:***

        (1) Patient history
        (2) Vital signs
        (3) Any treatment provided

    b. When directed by Medical Direction, administer glucose orally.

c. Transport priority will be defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.

5. Ongoing assessment will be performed every 5 minutes.

6. Document patient's condition after administering glucose.

For further information, refer to Addendum #6 - Oral Glucose

Procedure #11

ENVIRONMENTAL EMERGENCIES

Systemic Hypothermia

1. Perform initial assessment:
    a. Maintain airway, breathing and circulation:

       Do not presume death in the unresponsive, non-breathing, pulseless patient with suspected hypothermia.
    b. Provide oxygen and assist ventilations according to Procedure #2.
    c. Assess circulation for up to 30 seconds as the rate may be extremely slow. **IF THERE IS A PULSE, DO NOT PERFORM CHEST COMPRESSIONS.**
    d. Perform chest compressions if indicated.
    e. Transport as soon as possible. Transport priority will be defined by patient's condition. Need for Paramedic intercept will be determined by patient's condition and Direction.
    f. Apply SAED/AED if shock is advised, delivering up to a maximum of 3 shocks.
    g. Remove any wet clothing and warm patient by completely wrapping in blanket, including underneath.
2. Perform focused history and physical exam.
3. Take and record baseline vital signs.
4. Perform ongoing assessment every 5 minutes.

Localized Hypothermia (Frostbite)

1. Perform initial assessment:
    a. Maintain airway, breathing and circulation.
    b. Provide oxygen according to Procedure #2.
2. Perform focused history and physical exam:
    a. Take and record baseline vital signs.
    b. Remove all coverings from injured parts. Protect injured areas from pressure, trauma and friction. *Do not* rub. *Do not* break blisters.
    c. *Do not* allow patient to ambulate if a limb has started to thaw.
    d. *Do not* allow the limb to thaw if there is a chance that the limb may refreeze before evacuation is complete.

e. Keep the patient warm with blankets.
f. Transport as soon as possible. Need for Paramedic intercept will be determined by patient's condition and Medical Direction.
g. Establish communication with receiving facility, providing all patient information, including approximate ambient temperature and estimated arrival time.
h. Ongoing assessment every 5 minutes.

NOTE: Handle all hypothermia patients with care. Rough handling may precipitate ventricular fibrillation.

Hyperthermia

1. Perform initial assessment:

   a. Maintain airway, breathing and circulation.
   b. Provide oxygen according to Procedure #2.
   c. Remove from source of heat.

2. Perform focused history and physical exam:

   a. Take and record baseline vital signs. Note skin moisture, temperature and color.
   b. Transport as soon as possible. Transport priority will be defined by patient's condition. Need for Paramedic intercept will be determined by patient's condition and Medical Direction. **BRING ALL PATIENT MEDICATIONS.**
   c. Ongoing assessment every 5 minutes.
   d. Apply cool packs to neck, groin and armpits and keep the skin wet by applying water by sponge or wet towels.
   e. Fan aggressively.

NOTE: Not all heat emergencies are environmental in nature. The patient may have febrile or neurological etiology. High body temperature may cause seizure, particularly in infants.

Procedure #12

OBSTRUCTED AIRWAY

Responsive Patient:

1. Perform initial assessment:

    a. If patient can not speak but is coughing, encourage a strong and forceful cough.

    b. When patient is no longer producing an effective cough and cannot speak, perform the Heimlich maneuver.

    c. Continue Heimlich maneuver until obstruction is removed or patient becomes unconscious.

2. If obstruction is removed, check patient for breathing:

    a. Maintain airway, breathing and circulation.
    b. Provide oxygen according to Procedure #2.

3. If patient becomes unresponsive and airway remains obstructed, perform Heimlich maneuver (abdominal thrusts) with patient supine.

4. Perform focused history and physical exam.

5. Take and record baseline vital signs.

6. Transport according to priority as defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.

Unresponsive/Unwitnessed Patient:

1. Determine responsiveness.

2. Determine breathing:

    a. If no breathing, give initial breaths.
    b. If breaths do not enter, reposition the victim's head and reattempt breaths.

c. If breaths still do not enter, perform Heimlich maneuver (abdominal thrusts).
d. Attempt to ventilate.
e. If unsuccessful, repeat the sequence until the obstruction is relieved.

3. If obstruction is removed, check patient for breathing:

    a. Maintain airway, breathing and circulation.
    b. Provide oxygen according to Procedure #2.

4. Perform focused history and physical exam.

5. Obtain baseline vital signs.

6. Transport according to priority as defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.

SEE PEDIATRIC GUIDELINES FOR INFANT AIRWAY MANAGEMENT

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Procedure #13

OVERDOSE/POISONING

CONNECTICUT POISON CONTROL CENTER: 1-800-343-2722

Always be prepared to initiate basic cardiac life support measures: CPR, SAED/AED, and treat for shock (hypoperfusion).

Principle: Treat the patient, not the poison. Contact Poison Control Center rather than relying solely on label instructions. Bring all containers, bottles and labels of poison agents to the receiving facility. If exposure is to a *hazardous material*, follow protocol established by the incident command structure.

1. Perform Initial Assessment:
   a. Maintain airway, breathing and circulation.
   b. Provide oxygen according to Procedure #2.
   c. Determine Glasgow Coma Scale (see Addendum).
2. Perform focused history and physical exam.
3. Evaluate the mechanism of the poisoning/overdose.
   a. If the patient has orally **ingested** poison and/or shows signs and symptoms of drug overdose:
      (1) Support ventilations as needed.
      (2) Transport according to priority as defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.
      (3) ***Contact Medical Direction and relay the following:***
         - ***Patient history***
         - ***Vital signs***
         - ***Substance ingested (if known)***
         - ***Time of ingestion***
         - ***Amount ingested***
         - ***Patient mental status• Gag reflex status - can the patient protect their own airway***

(4) **IF PATIENT IS AWAKE WITH GAG REFLEX,*when directed by Medical Direction, administer activated charcoal.***

(a) Usual adult dose: 25-50 grams

(b) Usual infant/child dose: 12.5 - 25 grams

5. Reassess patient status enroute. Update medical control if needed.

For more information, refer to Addendum #7 Activated Charcoal

b. If the patient **inhaled** a drug or poison:

(1) Ensure the patient is removed from the substance source.
(2) Administer oxygen according to protocol and support ventilations as needed.
(3) Transport according to priority as defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.
(4) Establish communication with emergency department.
(5) Relay patient's history, vital signs and estimated time of arrival.

c. If the patient **injected** drugs or poison:

(1) Ensure the patient is removed from the substance source.
(2) Administer oxygen according to protocol and support ventilations as needed.
(3) Transport according to priority as defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.
(4) Establish communication with emergency department.
(5) Relay patient's history, vital signs and estimated time of arrival.

d. If the patient has been exposed to a poison that is **absorbed**:

(1) Ensure the patient is removed from the substance source.

(2) Carefully remove the patient's contaminated clothing to avoid further exposure to the patient and EMT.

(3) Remove the contaminant **AS COMPLETELY AS POSSIBLE PRIOR TO TRANSPORT**:

(a) If substance is *powder or solid* on the skin, brush off, irrigate with clean water or saline for at least 20 minutes. Begin irrigation immediately. Do not delay transport. Continue irrigation enroute to receiving facility.

(b) If substance is a *liquid* on the skin, irrigate with clean water or saline for at least 20 minutes. Begin irrigation immediately. Do not delay transport. Continue irrigation enroute to receiving facility.

(c) If substance is *in the eye,* irrigate with clean water or saline, flowing away from the midline, for at least 20 minutes. Begin irrigation immediately. Do not delay transport. Continue irrigation enroute to receiving facility.

(4) Transport according to priority as defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction. **MEDICAL DIRECTION IS TO DETERMINE DESTINATION HOSPITAL.**

(5) Establish communication with emergency department.

(6) Relay patient's history, vitals signs and estimated time of arrival.

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Procedure #14

RESPIRATORY EMERGENCIES

Always be prepared to initiate basic cardiac life support measures: CPR, SAED/AED or assist ventilations

Acute respiratory distress with a history of Asthma and Chronic Obstructive Pulmonary Disease (COPD), including Emphysema and Chronic Bronchitis.

1. Perform initial assessment.
   a. Maintain airway, breathing and circulation.
   b. Provide oxygen according to Procedure #2.

2. Perform focused history and physical exam.
   - Take and record baseline vital signs.

3. Determine if patient has received any medication in an attempt to relieve the current symptoms.

4. Determine if patient has a prescribed inhaler.

5. Transport as soon as possible. Transport priority will be defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.

6. Place patient in a position of comfort.

7. **FOLLOW *orders from Medical Direction either on-line or off-line.***

8. ***As per Medical Direction: Administer BETA AGONIST metered dose inhaler.***

9. ***Repeat as per Medical Direction.***

10. Reassess patient's condition including airway, breathing, circulation, mental status and vital signs.

For more information, refer to Addendum, #8 - Assisting the Patient With a Prescribed Inhaler

Procedure #15

SEIZURES

Always be prepared to initiate basic cardiac life support measures: CPR, SAED/AED, and treat for shock (hypoperfusion).

Seizures can have many causes.

Consider the following cause in adult patients:

a. Head injury
b. CVA/Stroke
c. Epilepsy
d. Hypoglycemia
e. Hypoxia
f. Poisonings/Overdose

Consider the following cause in children:

a. Febrile seizures (high fever)
b. Any of above adult causes

1. Perform initial assessment:

    a. Maintain airway, breathing and circulation.
    b. Provide oxygen according to Procedure #2.
    c. Protect the patient from injury. (Bite sticks are contraindicated.)
    d. Determine Glasgow Coma Scale (see Addendum #9).
    e. Transport priority will be defined by patient's condition. Need for Paramedic intercept will be determined by patient's condition and Medical Direction.

2. Perform focused history and physical exam.

3. Perform ongoing assessment every 5 minutes.

Procedure #16

UNRESPONSIVE
WITH UNKNOWN CAUSE

Prepare to treat respiratory and/or cardiac arrest or seizures. Prepare to handle combative, disoriented patient.

1. Perform initial assessment:

    a. Maintain airway, breathing and circulation

    b. Provide oxygen according to Procedure #2.

    c. With any evidence or suspicion of trauma, immobilize patient using the Spinal Cord Injury Procedure #20.

    d. Determine Glasgow Coma Scale (see Addendum #9).

2. Transport according to priority as defined by patient's condition. Paramedic intercept **SHOULD BE CALLED AS SOON AS POSSIBLE.**

3. Perform focused history and physical exam:

    a. *Do not* administering any medications by mouth
    b. Pay special attention to the presence of medical identification devices (such as necklace, wrist or ankle bracelet, wallet cards)

4. Treat any injuries accordingly.

5. Take and record baseline vital signs.

CONNECTICUT STATE BLS GUIDELINES

Procedure #17

AMPUTATIONS

1. Perform initial assessment:

   a. Maintain airway, breathing and circulation.
   b. Provide oxygen according to Procedure #2.

2. Perform focused history and physical exam.

3. Treatment of Amputations

   a. **Stump**

      (1) Control any active bleeding **WITH DIRECT PRESSURE AND PRESSURE POINTS**.

      (2) If there is no active bleeding, apply a sterile dressing.

      (3) A tourniquet SHOULD NOT BE applied unless the above methods have failed to control bleeding.

   b. **Amputated Part**

      (1) Wrap the amputated part in a sterile dressing.

      (2) Wrap or bag the amputated part in plastic and keep cool.

      (3) Transport the amputated part with the patient.

      (4) Do not complete partial amputations.

      (5) Immobilize to prevent further injury.

4. Transport as soon as possible. Transport priority will be defined by patient's condition. Need for Paramedic intercept will be determined by patient's condition and Medical Direction.

CONNECTICUT STATE BLS GUIDELINES

Procedure #18

BURNS

1. Stop the burning process and remove the patient from the source of injury.

2. Perform initial assessment:

   a. Maintain airway, breathing and circulation.
   b. Provide oxygen according to Procedure #2.
   c. Transport priority will be defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.

3. Perform focused history and physical exam.

   - Obtain and record baseline vitals.

4. Determine cause of burn:

   If **thermal burn:**

   a. Remove involved clothing which is not adhering to the patient.
   b. Remove jewelry and other constricting items.
   c. Apply dry sterile burn dressings to the affected areas.

   If **chemical burn:**

   a. Remove clothing which is not adhering to the patient.
   b. Remove jewelry and other constricting items.
   c. Remove the chemical in a manner appropriate to the substance:
      (1) If the substance is a dry powder, brush it off.
      (2) If the substance is an alkali, irrigate the area with water or saline throughout the period of prehospital care.
      (3) If the substance is an acid, irrigate the area with water or saline for at least 10-15 minutes or until the patient's pain is relieved.

   d. If the chemical is in the eye, remove any dry material and irrigate using an eye irrigation set throughout the period of prehospital care.
   e. Apply dry sterile burn dressings to the affected areas. Cool water or saline is of value to reduce pain and the burning process if applied within 15 minutes of the burn. This should not be applied to more than 10 percent of the body surface area at one time.

If **electrical burn:**

a. Remove the patient from the electrical source only if the EMT is trained to do so without incurring further risk to the rescuer and/or patient.
b. Monitor vitals and be prepared to use SAED.
c. Remove the clothing which is not adhering to the patient and any other constricting items such as jewelry.
d. Examine patient for both entrance and exit woulds.
e. Apply **only** dry sterile burn dressings to the affected areas. **Do not** apply water or saline to electrical burns.

5. Evaluate injuries:

a. Evaluate the patient for any major injuries and provide appropriate care.
b. If there is evidence and/or suspicion of an inhalation injury (cyanosis and/or singed hairs and/or sooty sputum):
   (1) Support ventilations as needed.
   (2) Keep patient sitting up if tolerated.
   (3) Cover patient to prevent loss of body heat.
   (4) Transport according to priority as defined by patient's condition.
c. Evaluate the degree of burns and the percent of body surface burns utilizing the rule of nines. If greater than 20% partial thickness or full thickness burns, ***rapid*** **transport is advised. *Consider contacting Medical Direction for selection of destination hospital.***
d. Identify and document location and extent of exit burns.
e. Ongoing assessment every 5 minutes.

CONNECTICUT STATE BLS GUIDELINES

Procedure #19

HEAD INJURY

Always be prepared to initiate basic cardiac life support measures: CPR, SAED/AED, and treat for shock (hypoperfusion).

1. Perform initial assessment:

    a. Stabilize head and neck.
    b. Maintain airway, breathing and circulation.
    c. Provide oxygen according to Procedure #2.
    d. Obtain baseline vital signs.
    e. Determine Glasgow Coma Scale (see Addendum #9)

2. Transport priority will be defined by patient's condition. Need for paramedic intercept will be determined by patient's condition and Medical Direction. This may be especially necessary in the event of airway compromise and/or seizures.

3. Immobilize with cervical collar, long backboard and sufficient straps to provide complete stabilization.

4. Perform focused history and physical exam:

    Take special note of ears, nose and mouth for CSF,
    eyes for pupilary reaction, JVD, and tracheal deviation.

5. Treat any open wounds. Avoid pressure on open head wounds.

6. Perform ongoing assessment including level of consciousness using Glasgow Coma Scale.

7. Consider transport to a Level I or II trauma center depending on Glascow Coma Scale, mechanism of injury and patient condition per State Trauma Regulations (see Addendum #10).

8. Treat other injuries as indicated.

9. Perform ongoing assessment every 5 minutes.

Procedure #20

MULTI-SYSTEM TRAUMA

Transport priority should be at the highest level as in-hospital stabilization is essential to patient outcome.

1. Perform initial assessment:

    a. Maintain airway with C-spine precautions.
    b. Provide oxygen according to Procedure #2.
    c. Treat major bleeding. If signs and symptoms of hypoperfusion (shock) are present, treat patient accordingly. Use PASG according to Medical Direction (see Addendum #11).

2. Perform rapid trauma assessment:

    a. Transport immediately with patient supine on backboard with cervical immobilization. Destination shall be selected according to State Trauma Regulations. Need for Paramedic intercept will be determined by patient's condition and Medical Direction.
    b. Obtain baseline vital signs.

3. Perform focused history and physical exam.

4. Provide treatment for other injuries.

5. Establish communication with receiving facility providing all patient information including Glasgow Coma Score (see Addendum), estimated time of arrival, and mechanism of injury.

CONNECTICUT STATE BLS GUIDELINES

Procedure #21

MUSCULOSKELETAL INJURIES

If multiple trauma is suspected, treat the patient according to the Multi-System Trauma Procedure #20. If a fracture of the spine is suspected, treat the patient according to the Spinal Cord Injury Procedure #23.

1. Perform initial assessment:

    a. Maintain airway, breathing and circulation.
    b. Provide oxygen according to Procedure #2.

2. Perform focused history and physical exam:

    a. Evaluate the neurovascular status of the distal portion of the affected extremity, including sensation, capillary refill, movement and distal pulse.
    b. Apply sterile dressing to any open wound(s).
    c. If an extremity injury is present or suspected because of mechanism of injury (MOI), immobilize both the joint above and below the injury. If there is severe angulation or neurovascular impairment, align with gentle traction and splint.

        (1) If an injury to the femur is present, utilize traction splinting techniques.
        (2) If an injury to the hip is present, utilize appropriate immobilization techniques, such as a long backboard.
        (3) Evaluate **AND DOCUMENT** neurovascular status before and after manipulation.

3. Transport priority will be defined by patient's condition. Need for Paramedic intercept will be determined by patient's condition and Medical Direction. Determine patient destination according to State Trauma Regulations (see Addendum #10).

4. Perform ongoing assessment according to the condition of the patient.

CONNECTICUT STATE BLS GUIDELINES

Procedure #22

SEXUAL ASSAULT

1. Perform initial assessment:
   a. Maintain airway, breathing and circulation.
   b. Provide oxygen according to Procedure #2.
2. Perform focused history and physical exam.
3. Reassure the patient and provide emotional support.
4. Treat other injuries as indicated.
5. Transport according to priority as defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.
6. Perform ongoing assessment during transport as needed.

NOTE:

1. Ensure scene safety and preserve evidence in cooperation with law enforcement. If law enforcement personnel are not at the scene, police are to be notified.
2. Ask the patient to delay bathing, douching or changing clothes prior to hospital evaluation.
3. This is a highly emotional and volatile situation. Be sure your findings and treatment are clearly documented on the written prehospital care report.
4. Crew members of the same sex may relate better with the patient in time of emotional crisis.

Procedure #23

SPINAL CORD/NECK INJURY

If multi-system trauma is suspected, treat the patient according to the Multi-System Trauma Procedure #20.

1. If airway, breathing and circulation are present:

   a. Establish and maintain airway. *Do not move the patient's neck.*

   b. Provide oxygen according to Procedure #2.

   c. Prevent aspiration by suctioning secretions as necessary. If the patient vomits, log roll on one side as a unit.

   d. Secure patient on long spineboard using cervical collar, head rolls, and sufficient strapping to prevent patient from lateral movement.

2. Perform focused history and physical exam:

   Be alert for onset of shock and treat accordingly.

3. Evaluate patient's neurological status, including Glasgow Coma Scale (see Addendum #9).

4. Evaluate and treat any major injuries.

5. Transport according to priority as defined by patient's condition and State Trauma Regulations (see Addendum #10). Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.

6. Perform ongoing assessment every 5 minutes.

Procedure #24A

CANCELED EN ROUTE

In the event an EMS response is canceled while the EMS unit is en route to the call, the ambulance crew should complete an approved Prehospital Care Report (PCR) detailing the following information:

Date of Service

Time of:

Call
Dispatch
Activation
Cancellation
Available

Incident Location

Incident Type

MVA, Medical, Medical Alarm, Well-Being Check, etc.

Identity of 'Canceler'

By Name or Agency

By documenting the response to the call and subsequent cancellation, the agency will be able to reference the specific details of the incident in the event that a patient later is discovered, or the call is brought into question for any reason.

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Procedure #24B

NO PATIENT ON-SCENE

In the event an EMS response is initiated and after arrival of the ambulance it has been determined that there is no patient on-scene, the ambulance crew should complete an approved Pre-hospital Care Report (PCR) detailing the following information:

Date of Service

Time of:
- Call
- Dispatch
- Activation
- Cancellation
- Available

Incident Location

Incident Type
- MVA, Medical, Medical Alarm, Well-Being Check, etc.

Narrative of On-Scene Conditions
- What was found on-scene, who provided information, etc.

Names and Service Numbers of Responding EMS Personnel

Support Services On-Scene
- Police, Fire, Visiting Nurse, etc.

Signature of Person(s) Completing Report

By thoroughly documenting the scene findings, the agency will be able to reference the specific details of the incident in the event that a patient later is discovered, or the call is brought into question for any reason.

Procedure #24C

PATIENT ON-SCENE WITHOUT COMPLAINT

The EMS provider must follow good medical judgment in these situations. A typical scenario would be the EMS response to an MVA and on arrival, they find a patient without medical complaint.

A **RECORD FOR TRANSPORT** may not be needed if:

- there is no mechanism of injury
- the patient is without complaint and **IS ASSESSED**
- the patient does not have any **APPARENT** injuries
- **THOROUGH DOCUMENTATION OF PATIENT CONDITION MUST BE DONE**

A refusal form should be signed if:

- there is a mechanism of injury
- in the judgment of the EMS provider the patient should be medically evaluated.
- **PATIENT'S FAMILY INITIATED CALL FOR EMS.**

Every attempt should be made to convince the patient to allow ambulance transportation to a local medical facility. Should the patient refuse this offer of transport, a full refusal PCR should be completed following the format described in Procedure #24D.

See Accompanying Algorithm (Page 45)

CONNECTICUT STATE BLS GUIDELINES

Procedure #24D

PATIENT REFUSAL - ADULT

Determining the Reason for Refusing Care:

When faced with a patient refusing medical care, the EMS provider can help the patient make an appropriate decision by employing the following techniques:

a. Be willing to take the necessary time to gain the patient's undivided attention. In some cases, it may be necessary to utilize an interpreter if the patient is unable to understand the EMS provider due to a language barrier.

b. Ensure that the assessment of the patient's emotional, intellectual and physical status is performed to determine if the patient comprehends the information the provider needs to convey (risks, consequences, alternatives, etc.).

c. After completing a thorough assessment, communicate your findings in clear, concise language. Avoid vague ambiguous wording such as, "Well, if you feel worse..."

d. Employ the use of friends and/or family members to assist in convincing the patient to seek immediate medical attention.

e. Attempt to determine the underlying reason for the patient's apprehension regarding ambulance transport. Many patients may be concerned over seemingly minor issues such as financial requirements, care of family or pets, or embarrassment.

If, in your opinion, the patient is in need of immediate medical attention and the patient is still refusing medical care, establish contact with a *Medical Control Physician* via telephone or C-Med. Explain the situation to the physician and seek advice. In some cases, it may be advisable to allow the on-line physician to speak directly with the patient in an effort to convince the patient of the need for further medical evaluation.

Finally, if in spite of your best efforts, the patient still refuses transport, you can help minimize the potential risk of legal consequences by utilizing the following criteria:

a. Offer transportation at least *three* (3) times.

b. Fully explain the *potential medical consequences* of refusing care to the patient (and to a family member if possible).

c. Ask the patient *direct questions*, such as, "What did I just tell you to do if the bleeding starts again?"

d. Advise the patient (and family if present) of *alternative treatment resources* , i.e., private physician, transportation by private vehicle, recall of 9-1-1, etc.

Documentation:

You should document the following on your PCR or refusal form:

Patient Demographics

Name
Address
Date of Birth
Phone Number

Physical Evaluation

Initial assessment and SAMPLE history (see Procedure #1)

Special Notation of the Following

Any potential use of alcohol, drugs or chemical substances
Head trauma
Functional or Organic Mental Syndrome
Normal vs abnormal vital signs
Significant or suspicion of significant illness or injury

Patient Recommendations

What consequences were explained to the patient, *up to and including* death. Who the consequences were explained to

Once completed, the PCR or refusal form form should be *signed by the patient* and *a witness* (Police Officer, Family Member, or other 'third party'). The witness should not be the EMS provider, as it may represent a '*your word vs their word*' legal opportunity. Provide the patient with a copy of the PCR or refusal form and ask him to explain, in his own words, the possible consequences of not receiving immediate medical treatment. In the event the patient refuses care and refuses to sign the PCR, document this fact and have the witness attest to the refusal to sign.

For further information and Patient Refusal - Minors, see Addendum #11

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Procedure #25

HAZARDOUS MATERIALS INCIDENT

1. When EMS personnel have been dispatched to a potential hazardous materials incident, they should try and approach the scene from upwind and uphill.

2. Stop your vehicle at least 1,000 feet or more and/or a safe designated area from the incident and use binoculars to assess the scene.

3. If a fire unit has not been dispatched, notify your dispatcher. *Do not* enter the danger area of contamination until authorized by Fire Department Incident Commander.

4. Look for any identifying markings or markers on involved vehicle(s).

5. Attempt to identify all potential victims.

7. Arrange a safety zone and staging area.

8. All patients should be removed by those rescuers trained in decontamination procedures, **AND DECONTAMINATION AT THE SCENE SHOULD BE DONE AS MUCH AS POSSIBLE.**

9. Follow protocols for initial patient assessment, oxygen administration, triage (if necessary).

10. Contact medical control to identify receiving facility (including type of exposure, patient history, type of hazardous material).

11. Contact receiving emergency department with patient history, type of hazardous material and estimated arrival at facility.

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Procedure #26

PEDIATRIC

Medical Pediatric Emergencies

Examples of medical pediatric emergencies may include poisoning, seizures, child abuse, fever/febrile seizures, anaphylactic reactions, near drowning, epiglottitis and croup.

1. Perform initial assessment.

    a. Maintain airway, breathing and circulation.
    b. Provide oxygen according to Procedure #2.

2. Perform focused history and physical exam.

3. Take and record baseline vital signs:

    a. If epiglottitis or croup are suspected, transport sitting straight upright to assist with clearing of respiratory secretions. **DO NOT ATTEMPT TO EXAMINE UPPER AIRWAY OR OTHERWISE AGGRAVATE THE PATIENT.**

    b. If child abuse is suspected, note general appearance of the scene. Report all findings and suspicions to the emergency department upon arrival. Objectively document all observations on written prehospital care report.

4. Transport according to priority as defined by patient's condition. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.

Pediatric Trauma*

1. Perform initial assessment:

    a. Maintain airway with C-Spine precautions.

    b. Provide oxygen according to Procedure #2.

c. Treat major bleeding.

d. Transport immediately.

e. Transport according to Trauma Regulations. Need for Paramedic intercept will also be determined by patient's condition and Medical Direction.

*Consider near drowning trauma.

2. Perform focused history and physical exam.

3. Obtain baseline vital signs.

4. Provide treatment for other injuries.

CONNECTICUT STATE BLS GUIDELINES

Procedure #27

SHOCK (HYPOPERFUSION)

1. Perform initial assessment:

   a. Maintain airway, breathing and circulation.
   b. Provide oxygen according to procedure.
   c. control major bleeding.
   d. Perform focused history and physical exam.
   e. Obtain and record baseline vital signs.

2. *Do not delay transport* to perform a physical exam if the patient presents with hypoperfusion or a systolic blood pressure of less than 100 with tachycardia. Focused history and physical exam may be performed enroute.

3. Transport using an appropriate immobilization device.

4. Elevate lower extremities unless contraindicated.

5. Transport priority will be defined by patient's condition. **PARAMEDIC INTERCEPT SHOULD BE CALLED AS SOON AS POSSIBLE.**

6. Treat all injuries accordingly.

7. Perform ongoing assessment every 5 minutes.

Procedure #28

TRIAGE / MULTIPLE CASUALTY INCIDENT (MCI)

An incident is considered a multiple casualty incident when there are more victims than rescue resources. Rescue resources include personnel, equipment and modes of transportation of the injured victims.

1. Perform initial scene size up:

    a. Identify any scene hazards.
    b. Make estimation of total number of patients **(ACTUAL AND POTENTIAL)**.
    c. Identify what resources will be needed (i.e., fire department, extra police, hazardous material cleanup, air ambulance).
    d. Notify C-Med to initiate notification plan for surrounding hospitals and ambulance services.

2. Establish liaison with fire department officer who has the responsibility as Incident Commander.

3. Follow local multiple casualty incident plan as per local protocol.

CONNECTICUT STATE BLS GUIDELINES

Addendum #1

EPINEPHRINE AUTO-INJECTOR

Generic name: epinephrine

Trade Names: Adrenalin®, Epi-Pen®, Epi-Pen Jr.®

Mechanism of action:

1. Epinephrine dilates the bronchioles
2. Constricts blood vessels
   a. Shrinks swollen tissues
   b. Increases blood pressure, heart rate and force of contraction

Indications:

1. The patient exhibits signs and symptoms of severe allergic reaction including respiratory distress, **WHEEZING** and signs and symptoms of shock (hypoperfusion).
2. The medication is prescribed for the patient.
3. Medical Control has authorized administration

Contraindications:

There are no contraindications when used in a life-threatening allergic reaction.

Side Effects:

1. increased heart rate **AND BLOOD PRESSURE**
2. pale skin
3. dizziness
4. chest pain
5. headache
6. nausea, vomiting
7. excitability, anxiousness

Dosage:

Adult: one adult auto-injector (0.3 mg)
Child/Infant: one child/infant auto-injector (0.15 mg)

Administration:

1. Confirm that the patient is exhibiting signs and symptoms of severe allergic reaction (anaphylaxis).
2. Confirm that the patient has a **LEGALLY** perscribed epinephrine auto-injector.
3. Ensure that the medication is not expired.
4. Ensure that the medication is not discolored (if visible).
5. Obtain the order to administer the medication (either off-line or on-line).
6. Remove the safety cap from the auto-injector.
7. Place the tip of the auto-injector against the lateral aspect of the patient's thigh, midway between the waist and knee.
8. Push the injector firmly against the thigh until the injector activates.
9. Hold the injector in place until the medication is injected.
10. Dispose of the injector in a biohazard container.
11. Reassess the patient's condition (second dose may be necessary).
12. Document administration.

CONNECTICUT STATE BLS GUIDELINES

Addendum #2

REFERENCE #908
EFFECTIVE MARCH 27, 1996

GUIDELINES FOR WITHHOLDING RESUSCITATION

NOTE: This guideline does not contain the new 1994 U.S. DOT EMT-Basic National Standard Curriculum terminology.

Purpose:

To provide specific instruction regarding the protocols used to withhold or withdraw resuscitation in the field.

Introduction:

Local emergency responders and EMS personnel in Connecticut who are trained in any of the National Standard curricula are instructed to follow the most recent national guidelines of the American Heart Association (Ref. JAMA, 268:16, October 28, 1992) for initiating CPR.

All clinically dead patients will receive all available resuscitative measures including cardiopulmonary resuscitation (CPR) unless contraindicated by one of the exceptions defined below. A clinically dead patient is defined as any unresponsive patient found without respirations and without a palpable carotid pulse.

The person who has the highest level of currently valid EMS certification, and who has direct voice communication for medical orders, and who is affiliated with an EMS organization present at the scene will be responsible for, and have the authority to direct, resuscitative activities.

In the event there is a personal physician present at the scene, who has an ongoing relationship with the patient, that physician may decide if resuscitation is to be initiated. In the event there is a Registered Nurse from a home health care or hospice agency present at the scene, who has an ongoing relationship with the patient, and who is operating under orders from the patient's private physician, that nurse (authorized nurse) may decide if resuscitation is to be initiated. If the physician or nurse decides resuscitation is to be initiated, usual Medical Control procedures will be followed.

Procedure:

The following conditions are the ONLY exceptions to initiating and maintaining resuscitative measures in the field on a clinically dead patient:

I. Traumatic injury or body condition clearly indicating biological death (irreversible brain death), limited to:

   a. Decapitation: the complete severing of the head from the remainder of the patient's body.

   b. Decomposition or putrefaction: the skin is bloated or ruptured, with or without soft tissue sloughed off, or there is the odor of decaying flesh. The presence of at least one of these signs indicated death occurred at least 24 hours previously.

   c. Transection of the torso: the body is completely cut across below the shoulders and above the hips through all major organs and vessels. The spinal column may or may not be severed.

   d. Incineration: ninety percent of body surface area 3 burn as exhibited by ash rather than clothing and complete absence of body hair with charred skin.

   e. Dependent lividity with rigor: when clothing is removed, there is a clear demarcation of pooled blood within the body, and major joints are immovable.

      *Requires additional confirmation as found under "General Procedures", III,2,a-f(pp3-4)

II. Pronouncement of death at the scene, of a patient age 17 or older, by a licensed Connecticut physician or authorized registered nurse by:

   a. On-line Medical Control physician orders withholding resuscitative measures, or

   b. On-line Medical Control physician orders resuscitative measures to be stopped, or

   c. Physician or authorized registered nurse at the scene in person, in consultation with the on-line Medical Control.

III. A valid DNR bracelet is present, when it:

   a. Is on the wrist **OR ANKLE**, and

b. Is intact; it has not been cut or broken, and

c. Has the correct logo; stylized hand in "stop" position and words "EMS ALERT," and

d. Is the correct color--orange, and

e. Has an expiration date which has not elapsed.

IV. At a mass casualty incident, if clinical death is determined prior to patient's arrival in the treatment area.

General Procedures:

I. In cases of decapitation, decomposition, transection of the torso, or incineration, the condition of clinical death must be determined by noting the nature and extent of the condition of the body as defined above. No CPR need be performed and Medical Control need not be notified.

II. In cases of dependent lividity with rigor, the condition of clinical death must be confirmed by observation of the following:

a. Reposition the airway and look, listen, and feel for at least 30 seconds for spontaneous respirations; respirations are absent.

b. Palpate the carotid pulse for at least 30 seconds; pulse is absent.

c. Auscultate with a stethoscope for lung sounds and visualize for chest movement for at least 30 seconds; lung sounds are absent.

d. Auscultate with a stethoscope for heart sounds for at least 30 seconds; heart sounds are absent.

e. Examine the pupils of both eyes with a light; both pupils are non-reactive.

f. Electrocardiographic monitoring by paramedic; finding of asystole OR a physician's order by radio to withhold resuscitation.

If any of the findings are different than those described above, clinical death is NOT confirmed and resuscitative measures must be immediately initiated.

III. In all other patients age 17 years or older, not described above, the following will take place:

a. If the field technician arrives at the scene of a clinically dead patient before a medical order not to start resuscitative measures had been given, resuscitation will be initiated while communication is established, assessment information is gathered, and a medical decision is being made, except in cases of decapitation, decomposition, transection of the torso, or incineration.

b. Medical control must be established early to reduce delay as resuscitative measures cannot be withheld until ordered by the physician. The on-line Medical Control physician will be given information about early assessment, findings, and procedures initiated. The physician may then order withholding resuscitation before complete resuscitative efforts have been initiated

c. The on-line Medical Control physician may order that resuscitative measures underway by an EMT-Paramedic be stopped upon verification that no vital signs exist. Once an Advanced Cardiac Life Support resuscitative cycle has been completed, by an EMT-Paramedic on scene directing patient care, the patient will be assessed for absence of clinical response and

the persistence of asystole. If these are present, contact may be made with an on-line Medical Control physician who may then order the EMT-Paramedic to stop resuscitative measures that are underway.

IV. When a valid DNR bracelet is present, the Connecticut College of Emergency Physicians (CCEP) guidelines will be followed. Once a patient has been found not to be breathing, examination for a valid DNR bracelet will take place. If there is a valid bracelet, no mouth-to-mouth or other means of artificial respirations will be administered, and no external cardiac compressions will be initiated. If previously initiated, resuscitative measures will be **DISCONTINUED**.

V. A complete documentation of the initial examination, findings and resulting procedures (if any) will be entered on the EMS patient care record. (See page 7.)

VI. If EMS personnel are delayed or precluded from making an appropriate physical examination by law or fire officials protecting the integrity of the scene, they shall so note on their patient care form. If subsequent access to the patient is allowed, then EMS personnel shall proceed according to this protocol. EMS personnel

are required to provide documentation of the patient's physical condition only to the extent of the physical examination they performed.

Special Procedures:

I. In all cases when there is any suspicion of an unnatural death, local police authorities will be notified. Removal of the body will be done only after the police officer authorizes this.

II. A private physician at the scene who has an on-going relationship with the patient must produce identification showing the physician's name and the Connecticut license number (MD or DO). That physician may pronounce death on a clinically dead patient even if EMS personnel are present. The physician's pronouncement relieves the emergency personnel of the responsibility to begin or

continue resuscitative measures. If the patient is not pronounced and the physician wishes to assume care of the patient, the physician must agree to assume responsibility for the patient's care and accompany the patient to the hospital in the ambulance if the patient is to be transferred
to the hospital. The Medical Control hospital will be notified and the information will be documented on the EMS patient care form.

III. A registered Nurse from a home health care or hospice agency at the scene, who has an ongoing relationship with the patient, and who is operating under orders from the patient's private physician and is authorized by law to pronounce death, may pronounce a clinically dead patient dead even if EMS personnel are present. The nurse's pronouncement relieves the emergency personnel of the responsibility to begin or continue resuscitative measures. The Medical Control hospital will be notified and the information will be documented on the EMS patient care form.

Disposition of Remains:

I. Disposition of dead bodies is not the responsibility of EMS personnel, but efforts must be taken to insure that there is a proper transfer of responsibility for scene security. However, to be helpful to family, police, and others, EMS personnel may assist those who are responsible.

II. When a decision has been made to withhold or withdraw resuscitation, the body may be removed in one of the following ways:

a. When the body is in a secure environment (where it is protected from view by the public, from being disturbed or moved by unauthorized people) and police are not or should not be involved, the body may be removed by a funeral hearse. The attending physician should be notified if available and EMS personnel may leave. Example: a DNR patient at home.

b. When the body is in a secure environment and police are or should be involved, notify the police and the attending physician. If the attending physician is not available, the police may contact the office of the Chief Medical Examiner (203-679-3980 or 1-800-842-8820)
for authorization to move the body by hearse, or the Medical Examiner may send a vehicle for the body. EMS personnel may leave. Example: an apparent overdose or injury at home.

c. When the body is not in a secure environment and police are not or should not be involved, contact Medical Control for permission to transport the body to the hospital morgue. Example: on the street with an unruly crowd of people.

d. When the body is not in a secure environment and police are or should be involved, notify the police and the attending physician. If the attending physician is not available, the police may contact the Office of the Chief Medical Examiner (203-679-3980 or 1-800-842-8820) for authorization to move the body by hearse, or the medical Examiner may elect to send a vehicle for the body. EMS personnel may leave after turning the scene over to other appropriate authority. Example: on the street.

III. The Office of the Chief Medical Examiner (860-679-3980 or 1-800-842-8820) must be notified of any death which may be subject to investigation by the Chief Medical Examiner (CG 19a-407), which includes almost all deaths which occur outside health care institutions. EMS personnel should determine that such notification has been made by the police, otherwise EMS personnel should make the notification **AND DOCUMENMT ON THE PATIENT CARE RECORD**.

IV. At other times the EMT feels the circumstances warrant, contact Medical Control for permission to transport the body to the hospital morgue.

V. When Medical Control feels the circumstances warrant, Medical Control may request that the body be transported to the hospital morgue.

Documentation:

I. A patient care record will be completed for each clinically dead patient who has resuscitation performed and for whom resuscitation was discontinued or was withheld. All Medical Control orders will be noted on the patient care record.

II. In cases of decapitation, decomposition, transection of the torso, or incineration, when resuscitation was discontinued or not initiated, detailed findings consistent with these conditions will be entered on the patient care record.

III. In cases of dependent lividity with rigor, when resuscitation was discontinued or not initiated, the following detail will be documented on the patient care record:

a. Breathing absent when airway was repositioned and assessed for at least 30 seconds.

b. Carotid pulse was absent upon palpation for at least 30 seconds.

c. There were no audible lung sounds after examining the patient's chest with a stethoscope for at least 30 seconds.

d. There were no audible heart sounds after examining the patient's chest with a stethoscope for at least 30 seconds.

e. The pupils of both eyes are non-reactive.

f. A view of an EKG in at least two (2) leads, for at least 12 seconds, which shows asystole.

CONNECTICUT STATE BLS GUIDELINES

Addendum #3

DO NOT RESUSCITATE (DNR)

If there is a DNR bracelet or DNR Transfer Form and there *are* signs of life:

Contact Medical Direction

before introducing any invasive procedures or therapies.

If there *are no* signs of life:

DO NOT start CPR

DNR Bracelet

A DNR bracelet shall be the only valid indication recognized by EMS providers that a DNR order exists for patients outside a healthcare institution, other than those patients received by an EMS provider directly from a healthcare institution.

A valid DNR bracelet shall:

a. be the correct color - *orange*
b. have the correct logo
c. be affixed to the patient's wrist or ankle
d. display the patient's name and attending physician's name
e. not have been cut or broken at any time.

DNR Transfer Form

a. To transmit a DNR order during transport by an EMS provider between healthcare institutions, the DNR order shall be documented on the DNR transfer form.

b. The DNR transfer form shall be signed by a licensed physician or a registered nurse and shall be recognized as such and followed by EMS providers.

c. The DNR remains in place during transport as well as to the point of admission to the receiving facility.

Revocation of the DNR

a. The patient or "authorized representative" may verbally tell a certified EMT they wish to alter their DNR status.

b. This statement must be entered on the prehospital care report.

c. This statement should be supported by any witnesses present.

CONNECTICUT STATE BLS GUIDELINES

Addendum #4

ASSISTING THE PATIENT WITH PRESCRIBED NITROGLYCERIN

Generic Name: Nitroglycerin

Trade Names: Nitrostat®, Nitrobid®, Nitrolingual Spray®

Mechanism of Action:

1. Causes relaxation of the smooth muscle of blood vessel walls
2. Relaxation of the blood vessels causes pooling of blood in dependent portions of the body due to gravity. this reduces the amount of blood returning to the heart, decreasing the heart's workload.

Indications:

1. The patient is having chest pain
2. The patient has **LEGALLY** prescribed nitroglycerin
3. Authorization to administer is obtained from Medical Direction (off-line or on-line)

Contraindications:

1. The patient has hypotension or blood pressure below 100 mm/Hg systolic
2. The patient has a head injury
3. The patient has taken the maximum recommended dose
4. Medical Direction does not give permission
5. The patient is an infant or child

IMPORTANT: MEDICAL DIRECTION NEEDS TO KNOW IF THE PATIENT IS TAKING **VIAGRA.**

Side Effects:

1. Headache
2. Hypotension
3. Dizziness, weakness
4. Flushing, feeling of warmth

Dosage:

The dosage is one tablet or spray under the tongue (sublingual). This may be repeated in 3 to 5 minutes (maximum of three doses) if:

1. Patient continues to have chest pain.
2. **CHECKING THE BLOOD PRESSURE AFTER EACH DOSE AND** the blood pressure remains above 100 mm/Hg systolic.
3. Medical Direction is obtained.

Administration:

1. Confirm that the patient is having chest pain.
2. Confirm that the patient has physician prescribed nitroglycerin.
3. Ensure that the nitroglycerin is not expired.
4. Determine if the patient has already taken any doses.
5. Assess blood pressure (above 100 mm/Hg systolic).
6. Obtain order from Medical Direction

   Tablet Administration:

   a. Apply gloves (nitroglycerin can be absorbed through the skin).
   b. Ask the patient to raise his/her tongue.
   c. Pour one tablet into the bottle cap.
   d. Hand the medication to the patient for self-administration or place the tablet under the patient's tongue.
   e. Instruct the patient to keep his/her mouth closed and not to swallow until the tablet is dissolved and absorbed.

   Spray Administration:

   a. Ask the patient to raise his/her tongue.
   b. Hand the medication to the patient for self-administration or spray the medication under the patient's tongue.
   c. Instruct the patient to keep his/her mouth closed and not to swallow until the medication is dissolved and absorbed.
7. Reassess the patient's condition.
8. Document administration.

NOTE: Nitroglycerin has a half-life of 15 minutes

CONNECTICUT STATE BLS GUIDELINES

Addendum #5

ASPIRIN

Generic Name: Aspirin

Trade Names: Acetylsalicylic acid®, Bayer®, Aspirin, Anacin®, Ecotrin®, Bufferin®, and many more

Mechanism of Action:

1. Inhibits platelet aggregation thereby decreases blood clotting time
2. Anti-inflammatory effects
3. Reduces fever
4. Analgesic effects

Indications:

Cardiac chest pain to decrease incidence of heart attack

Contraindications:

1. Active gastrointestinal bleeding, ulcer disease
2. Hypersensitivity/allergy to aspirin
3. Patient is less than 13 years of age

Side Effects:

1. Gastric irritation
2. Nausea, vomiting
3. Abdominal pain
4. Gastrointestinal bleeding
5. Peptic ulcer formation
6. Ringing in ears

Dosage:

Adult: One dose (two chewable baby aspirin) - 162 mg **or 342 mg**

Administration:

1. Confirm that the patient is having chest pain suggestive of a myocardial **ISCHEMIA**.

2. Follow guidelines regarding the administration of Nitroglycerin.
3. Obtain an order from Medical Direction (off-line or on-line)
4. 4.Establish that the patient's mental state is awake and alert.
5. Establish that the patient does not have an allergy to Aspirin **OR OTHER CONTRAINDICATIONS**.
6. Pour tablet(s) into bottle cap.
7. Hand medication to the patient to place in mouth.
8. Instruct patient to swallow or chew tablet(s).
9. Reassess the patient's condition.
10. Document time of administration.

CONNECTICUT STATE BLS GUIDELINES

Addendum #6

ORAL GLUCOSE

Generic Name: oral glucose

Trade Names: Glutose®, Insta-glucose®

Mechanism of action:

Increases the blood sugar level

Indications:

Patients with all of the following are candidates for administration:

1. altered mental status
2. history of diabetes controlled by medication
3. ability to swallow

Contraindications:

1. The patient is unresponsive
2. The patient is unable to swallow (no gag reflex)
3. Medical Direction does not give permission

Side Effects:

1. Oral glucose causes no side effects when given properly
2. It may be aspirated by a patient with no gag reflex

Dose:

Oral glucose is a gel and is packaged in a toothpaste-type tube.

Administration:

1. Obtain an order from Medical Direction (off-line or on-line).
2. Squeeze oral glucose on a tongue depressor and place it between the patient's cheek and gum.
3. Reassess the patient's condition.
4. Document administration.

CONNECTICUT STATE BLS GUIDELINES

Addendum #7

ACTIVATED CHARCOAL

Generic Name: activated charcoal

Trade Names: SuperChar®, InstChar®, Actidose®, LiquidChar®

Mechanism of Action:

Binds with certain poisons in the gastroinsestinal tract and prevents them from being absorbed into the body

Indications:

Patients who have ingested certain poisons

Contraindications:

1. Patients who are unresponsive or have an altered mental status
2. Patients who have ingested acids (rust removers, phenol, battery acid) or alkalis (ammonia, household bleach, drain cleaner)
3. Patient is unable to swallow (no gag reflex)
4. Medical Direction does not give permission

Side Effects:

1. black stools, constipation
2. abdominal cramping
3. vomiting

Dosage:

Adults: 25 - 50 grams
Infant/Child 12.5 - 25 grams

Administration:

1. Confirm that the patient has ingested a poison.
2. Obtain an order from Medical Direction (off-line or on-line).
3. Shake the charcoal container thoroughly.
4. If the patient takes a long time to drink the mixture, the charcoal will settle and will need to be shaken or stirred again.
5. Reassess the patient's condition.
6. Document administration.

CONNECTICUT STATE BLS GUIDELINES

Addendum #8

ASSISTING THE PATIENT WITH A PRESCRIBED INHALER

Generic name (trade names):

Albuterol (Proventil®, Ventolin®)
Isoetharine (Bronkosol®, Bronkometer®)
Metaproterenol (Metaprel®, Alupent®)

Mechanism of action:

1. Relaxes bronchial smooth muscle
2. Relieves bronchospasm
3. Reduces airway resistance

Indications:

1. The patient exhibits signs and symptoms of respiratory distress
2. Authorization from Medical Control is obtained (off-line or on-line)

Contraindications:

1. rapid heart rates
2. use with caution in patients with high blood pressure, chest pain

Side Effects:

1. increased pulse rate
2. tremors
3. nervousness
4. nausea, heartburn

Dosage:

The patient should take 1 to 2 inhalations. Dose may be repeated in 15 minutes.

Administration:

1. Confirm that the patient is having difficulty breathing.
2. Confirm that the patient has a **LEGALLY** prescribed handheld inhaler.
3. Ensure that the inhaler has a current expiration date.
4. Determine if the patient has already taken any doses.
5. Obtain an order from Medical Direction (off-line or on-line).
6. Shake the inhaler vigorously several times.
7. Have the patient exhale.
8. Have the patient put his/her lips around the opening of the inhaler.

9. Have the patient depress the handheld inhaler as he/she begins to inhale deeply.
10. Instruct the patient to hold his/her breath for as long as it is comfortably possible so that the medication can be absorbed.
11. If the patient has a spacer device it should be used.
12. Reassess the patient's condition.
13. Document administration.

CONNECTICUT STATE BLS GUIDELINES

Addendum #9

GLASGOW COMA SCALE

The Glasgow Coma Scale will result in a total score from 3 to 15:

CHILD/ADULT		INFANT	
	<u>Eye opening</u>:		
4	Spontaneous	4	Spontaneous
3	To voice	3	To speech
2	To pain	2	To pain
1	None	1	No response
	<u>Best Verbal Response</u>:		
5	Oriented	5	Coos, babbles
4	Confused	4	Irritable cries
3	Inappropriate words	3	Cries to pain
2	Incomprehensible	2	Moans, grunts
1	No response	1	No response
	<u>Motor Response</u>:		
6	Obeys commands	6	Obeys commands
5	**LOCALIZES** pain	5	**LOCALIZES** from pain
4	Withdraws from pain	4	Withdraws from pain
3	Flexion (decorticate)	3	Flexion (decorticate)
2	Extension (decerebrate)	2	Extension (decerebrate)
1	No response	1	No response

Addendum #10

TRAUMA REGULATIONS

Field Triage Protocols

(a) The following field triage protocol shall provide criteria to categorize trauma patients and determine destination hospitals with resources appropriate to meet the patient's needs:

1. Assess the physiologic signs. Trauma patients with any of the following physiologic signs shall be taken to a Level I or Level II trauma facility:

   a. Glasgow Coma Scale of twelve (12) or less; or
   b. systolic blood pressure of less than ninety (90) mm/ Hg; or
   c. respiratory rate of less than ten (10) or more than twenty-nine (29) breaths per minute.

2. Assess the anatomy of the injury. Trauma patients with any of the following injuries shall be taken to a Level I or Level II trauma facility:

   a. gunshot would to chest, head, neck, abdomen, or groin;
   b. third degree burns covering more than fifteen (15) per cent of the body, or third degree burns of face, or airway involvement;
   c. evidence of spinal cord injury;
   d. amputation, other than digits; or
   e. two (2) or more obvious proximal long bone fractures.

3. Assess the mechanism of injury and other factors and, if any of the following is present, determination of destination hospital shall be in accordance with medical direction:

   a. Mechanisms of injury:

      (1) falls from over twenty (20) feet;
      (2) apparent high speed impact;
      (3) ejection of patient from vehicle;
      (4) death of same car occupant;
      (5) pedestrian hit by car going faster than twenty (20) MPH;

(6) rollover, or
(7) significant vehicle deformity - especially steering wheel

b. Other factors:

(1) age less than five (5) or greater than fifty-five (55) years;
(2) known cardiac or respiratory disease;
(3) penetrating injury to thorax, abdomen, neck, or groin other than gunshot wounds.

4. Severely injured patients less than thirteen (13) years of age should be taken to a Level I or II facility with pediatric resources including a pediatric ICU.

5. When transport to a Level I or II trauma facility is indicated but the ground transport time to that hospital is judged to be greater than twenty (20) minutes, determination of destination hospital shall be in accordance with local medical direction.

6. If, despite, therapy, the trauma patient's carotid or femoral pulses can not be palpated, airway cannot be managed, or external bleeding is uncontrollable, determination of destination hospital shall be in accordance with local medical direction.

7. When in doubt regarding determination of destination hospital, contact medical direction.

(b) All EMS providers transporting trauma patients to hospitals shall provide receiving hospitals with a completed OEMS approved patient care form prior to departing from the hospital. A patient care form shall be completed for each trauma patient at the scene who is not transported and shall be forwarded to OEMS **AND SPONSOR HOSPITAL.**

(c) Beginning October 1, 1995, all hospitals and EMS providers shall follow the field triage protocols.

CONNECTICUT STATE BLS GUIDELINES

Addendum #11

DOCUMENTATION

1. Documentation of all patient contacts shall be performed for all emergency responses, transfers, patient refusals and stand-bys.

2. Documentation of patient care shall be done immediately upon completion of patient care, and/or transfer of care.

3. A patient care record shall be left at the receiving health care facility. Report may be faxed to the receiving facility if necessary.

PATIENT REFUSAL - MINORS

Definition of Minor:

Under Connecticut General Statutes (CGS), a minor is defined as a person under the age of eighteen (18). As a minor, these individuals are not authorized to make decisions regarding medical treatment. As EMS providers, we are authorized to treat minor patients under the doctrine of ***'Implied Consent'***, meaning that if the patient were able to authorize treatment, they would wish to receive such treatment.

In some cases, a minor may be ***'Emancipated'*** (refererence CGS Section 46-b-150-a-e. Minors are granted emancipation by the court system and, as such, are deemed by the courts to be responsible for their own actions and decisions. If the patient is an emancipated minor, they possess the legal capacity to refuse medical care, providing the other conditions are met.

Legal Capacity:

M*inors do not have the legal capacity to refuse medical care except in the case of an* ***'Emancipated Minor'*** (refer to Glossary). The decision to make medical care available rests with the EMS provider under Implied Consent. Therefore, to assure that the best interests of the patients are properly served, all minors who suffer injury or illness should be transported to a medical facility. Once at the receiving facility, the facility will make attempts to reach the patient's legal guardian in order to

determine the medical treatment wishes of the guardian as they pertain to the minor.

On-Scene Considerations:

In the event an EMS provider responds to an emergency scene and is presented with a minor patient who has any physical signs or symptoms of injury or illness, transport the patient to an appropriate receiving facility. If a guardian is present (i.e., parent) they may make the decision regarding the treatment and transport of the minor. If the guardian refuses care and/or transport, it is the guardian who signs the refusal form as the responsible party.

Guardians Refusing Care for a Sick or Injured Minor:

There may be times when the guardian refuses medical care and/or transportation even when the minor has serious illness or injury. The reasons may be religious or economic. However, if the on-scene EMS providers believe that the patient may suffer grave medical consequences if left on-scene, consult a Medical Control Physician for advice. If the physician agrees that further medical evaluation is necessary, request police assistance to facilitate transport.

CONNECTICUT STATE BLS GUIDELINES

Addendum #12

PNEUMATIC ANTISHOCK GARMENTS (PASG/MAST)

Currently, the clinical use of the PASG is controversial. The following represent groups of settings in which the use of this device is considered either:

A. Acceptable and useful
B. Possibly helpful, or
C. Not indicated and possibly harmful.

The potential benefit or harm may be modified by the age and size of the patient, environmental factors, location, and distance from the hospital and the patient's comorbitities. The use, therefore, must be congruent with current on-line and off-line Medical Direction.

A. Acceptable and useful:

1. Hypotension due to:

    a. Ruptured abdominal aorta aneurysm
    b. Suspected pelvic fracture
    c. Unstable anaphylaxis
    d. Uncontrolled lower extremity hemorrhage
    e. Other severe trauma

B. Possibly helpful:

1. Hypotension due to:

    a. Penetrating abdominal injury (not an impaled object)
    b. Gynecological hemorrhage
    c. Ruptured ectopic pregnancy
    d. Sepsis and unstable anaphylaxis
    e. Uncontrolled urologic hemorrhage
    f. Others as indicated by Medical Direction

C. Not indicated and possibly harmful:

1. CPR adjunct
2. Thoracic injury
3. Pulmonary edema

4. Abdominal evisceration or impaled object
5. Acute myocardial infarction
6. Cardiogenic shock
7. Cardiac tamponade
8. Pregnancy beyond first trimester

D. Technical considerations in use of PASG where decision has been made to use the device. Application and inflation must not unnecessarily delay transport to the hospital, and when the location of the emergency scene is less than 10 minutes from the hospital, the patient should probably be transported directly without the application of the PASG:

1. Begin rapid transport to the closest medical facility. During transport, inflate the abdominal section to 80 mmHg for adults. Sections may be inflated simultaneously. For patients weighing less than 50 kilograms (110 pounds), inflate leg sections to 60 mmHg followed by inflating the abdominal section to 60 mmHg. Sections may be inflated simultaneously.

2. Reassess patient.

3. Contact Medical Direction and advise of patient's condition.