

This packet contains proposed protocol changes discussed at the January 27, 2016 Protocol committee meeting.

Protocol	Item		
III.B	Max dose of Etomidate - max dose 40mg	Current dose not effective	<i>Same as Suffolk - NYC</i>
III.C	Add " or Proximal Humerus "		<i>Same as Suffolk - NYC</i>
III.F	Max dose of Etomidate - max dose 20mg	Current dose not effective	<i>NYC</i>
III.G	Standing order for CC Eliminate "Paramedic" line	Zofran Allow CC's to administer on standing orders	<i>Same as Suffolk</i>
III.I	Add Magnesium sulfate to Paramedic standing orders	Place below Steroids Change all references of Magnesium sulfate to 2g / 100ml over 10 minutes except for cardiac arrest	<i>Same as Suffolk</i>
III.K	Add Paramedic standing order NTG - repeat Q5 (max 3 doses) if SBP remains > 120		
III.N	Remove Vasopressin	AHA changes 2015	<i>No benefit</i>
III.O	Add " IN " to glucagon administration	Intra nasal administration	<i>Same as Suffolk - NYC</i>
III.O	Remove Vasopressin	AHA changes 2015	<i>No benefit</i>
III.P	ELIMINATE hypothermic procedures & nearest "hypothermia capable" hospital	AHA changes 2015	<i>No benefit potential complications</i>
III.Q	Magnesium-sulfate - Med control options standardized	Change Magnesium sulfate to 2g / 100ml over 10 minutes	<i>Same as Suffolk</i>
III.T	Add " IN " to glucagon administration	Intra nasal administration	<i>Same as Suffolk - NYC</i>
III.U	Magnesium-sulfate - Med control options standardized	Change Magnesium sulfate to 2g / 100ml over 10 minutes	<i>Same as Suffolk</i>
III.U	Add " IN " to glucagon administration	Intra nasal administration	<i>Same as Suffolk - NYC</i>
III.V	Add " IN " to glucagon administration	Intra nasal administration	<i>Same as Suffolk - NYC</i>
III.X	Add " IN " to glucagon administration	Intra nasal administration	<i>Same as Suffolk - NYC</i>
III.Y	Magnesium-sulfate - Med control options standardized	Change Magnesium sulfate to 2g / 100ml over 10 minutes	<i>Same as Suffolk</i>
P 01	Change " unless obstruction continues "	Do <u>not</u> replace ET tube once the airway has been cleared of thick meconium - unless obstruction continues. -	<i>AHA changes 2015</i>
P 01	Add note:	Use 3-lead ECG to verify heart rate	<i>AHA changes 2015</i>
P 08	Add " IN " to glucagon administration	Intra nasal administration	<i>Same as Suffolk - NYC</i>
P 09	Add " IN " to glucagon administration	Intra nasal administration	<i>Same as Suffolk - NYC</i>
P11	Change verbiage - Eliminate " if BLS measures not adequate "	To clarify statement	<i>AHA changes 2015</i>

19 Protocols effected. In addition the Adult & Pediatric Indexes, Appendix C - Medication List and Appendix D - Medication Formulary will be updated as appropriate.


Nassau Regional Emergency Medical Services

Paramedic ONLY	Medication Facilitated Intubation	Protocol III. B
		Approved: 10/30/13
		Effective: 4/01/14

Proposed Change

Standing Orders:

Paramedic only

- BLS Airway management
- Obtain vascular access as appropriate
- Cardiac monitor as appropriate
- Pre-oxygenate, position the patient appropriately
- Contact Medical Control for sedation medications.
- Post - Endotracheal intubation
 - monitor waveform capnography throughout transport.
 - use a colorimetric CO2 detector as a secondary device.
 - 2 attempts only - consider alternate airway device.

Medical Control Options: (if available)

- If the patient is conscious prior to performing endotracheal intubation, contact medical control for prehospital sedation (if available)
 - Diazepam (Valium) 5-10 mg IV/IO (*if hemodynamically stable*)
repeat dose may be given as necessary (*max total dose 20 mg*)
or
 - Midazolam (Versed) 1-5 mg IV/IO/IN
repeat dose may be given as necessary (*max total dose 5 mg*)
or
 - Lorazepam (Ativan) 2-4 mg IV/IO/IN
repeat dose may be given as necessary (*max total dose 4 mg*)
or
 - Etomidate (Amidate) 0.3 mg/kg rapid IV/IO push (*max dose 40mg*)
After intubation,
 - Diazepam (Valium) 5mg IV/IO for continued sedation.

Nassau Regional Emergency Medical Services



Critical Care & Paramedic	Vascular Access / Fluid & Medication Management	Protocol III. C
		Approved: 10/30/13
		Effective: 4/01/14

Proposed Change

Standing Orders:

- **Saline lock** or KVO I.V. line with normal saline may be used.
- Patients that require rapid volume IV drip, at least one (1) large bore IV line with normal saline should be established.
- Peripheral veins should be used as a primary site. The **external jugular vein (EJ)** may be used *in extremis* for adult patients if no other site is accessible.
- An **intraosseous (IO)** device may be used for patients in complete vascular collapse via Proximal Tibia or Proximal Humerus. Drug administration via this route utilizes doses identical to those used for IV administration.
- In the absence of intravenous access, **intranasal (IN)** with an appropriate atomizer device may be used if available.
The **only** drugs approved for this route are Naloxone (Narcan), Lorazepam (Ativan), Midazolam (Versed) and Fentanyl.

(this is the preferred route for violent patients, seizures, or if provider safety is compromised)

Nassau Regional Emergency Medical Services



Critical Care & Paramedic	Procedural Sedation	Protocol III. F
		Approved: 10/30/13
		Effective: 4/01/14

Proposed Change

Conscious patients requiring synchronized cardioversion or pacing

Standing Orders:

- Airway management
- Vascular access
- Cardiac monitor

Medical Control Options: (if available)

- Diazepam (Valium) 5-10 mg IV/IO
- Midazolam (Versed) 1-5 mg IV/IO/IN
- Lorazepam (Ativan) 2-4 mg IV/IO/IN
- Morphine sulfate 2-10 mg (0.1 mg/kg) IV/IO
- Etomidate (Amidate) 0.15 mg/kg IV/IO (max 20mg total)
- Fentanyl 1mcg/kg IV/IO//IN (max 100 mcg)

If nausea or vomiting:

- Ondansetron (Zofran) 4 mg IV/IO over 2 minutes *or* 4 mg ODT

Nassau Regional Emergency Medical Services



Critical Care & Paramedic	Severe Nausea / Vomiting	Protocol III. G
		Approved: 10/30/13
		Effective: 4/01/14

Proposed Change

Adult patients with persistent vomiting or severe nausea

Consider and treat any underlying cause (i.e. poisoning, Myocardial ischemia, etc.)

Standing Orders:

- Airway management
- Vascular access
- Cardiac monitor
- Ondansetron (Zofran) 4 mg IV/IO over 2 minutes *or* 4 mg ODT, *(may be repeated)*

Medical Control Options:

- Ondansetron (Zofran) 4 mg IV/IO over 2 minutes *or* 4 mg ODT


Nassau Regional Emergency Medical Services

Critical Care & Paramedic	Asthma / Bronchospasm	Protocol III. I
		Approved: 10/30/13
		Effective: 4/01/14

Proposed Change

Standing Orders:

- Airway management
- Vascular access as appropriate
- Cardiac monitor as appropriate
- Albuterol ^{0.083%} 2.5 mg and Ipratropium (Atrovent) ^{0.02%} 500 mcg via Nebulizer
- Repeat Albuterol 2.5 mg via Nebulizer
- CPAP/ BIPAP (if available)

Paramedic _____

For severe presentation:

- Epinephrine 1:1000 0.3 mg IM/SQ
- Dexamethasone 12 mg IV/IO/IM
- or*
- Methylprednisolone 125 mg IV/IO/IM
- Magnesium sulfate 2 gm in 100 ml IV/IO - (*over 10 minutes*)

Medical Control Options:

- Albuterol 2.5 mg via Nebulizer
- Ipratropium (Atrovent) 500 mcg via Nebulizer
- Epinephrine 1:1000 0.3 IM/SQ
- Magnesium sulfate 2 gm in 100 ml IV/IO - (*over 10 minutes*)
- CPAP/ BIPAP (if available)
- Dexamethasone 12 mg IV/IO/IM
- Methylprednisolone 125 mg IV/IO/IM

Nassau Regional Emergency Medical Services



Critical Care
& Paramedic

Acute Pulmonary Edema

Protocol III. K

Approved: 10/30/13

Effective: 4/01/14

Standing Orders:

- Airway management
- Vascular access
- Cardiac monitor / 12 lead ECG
- Nitroglycerin 0.4 mg SL *or* SL spray
 - If Systolic B/P is ≥ 120 or ≥ 100 with IV access*
- CPAP/ BIPAP (if available)

Paramedic

- Nitroglycerin 0.4 mg SL *or* SL spray - Repeat q 5 minutes (max 3 doses)
 - If Systolic B/P remains ≥ 120*

Medical Control Options:

- Nitroglycerin 0.4 mg SL *or* SL spray
- Furosemide 40-100 mg IV/IO
- Dopamine drip 5-20 mcg/kg/min IV/IO (*titrated to effect*)
- Norepinephrine (Levophed) 2-4 mcg/min- initial dose IV/IO (*max 30 mcg/min*)
 - large vein if possible
- CPAP/ BIPAP (if available)

NOTE: Patients who have used medications for erectile dysfunction within the last 72 hours should not be given Nitroglycerin unless otherwise directed by Medical control.


Nassau Regional Emergency Medical Services

Critical Care & Paramedic	Acute Coronary Syndrome / Chest Pain	Protocol III. M
		Approved: 10/30/13
		Effective: 4/01/14

Proposed Change

Standing Orders:

- Airway management
- Vascular access
- Aspirin 325 mg. (chewed)
- Cardiac monitor / 12 lead ECG *
- Nitroglycerin 0.4 mg SL *or* SL spray - (If SBP \geq 120 or \geq 100 with IV)*
Caution with inferior wall MI's

Medical Control Options:

- Transport to nearest PCI capable hospital *
- Aspirin 325 mg (chewed)
- Nitroglycerin 0.4 mg SL *or* SL spray
- Morphine Sulfate 2-10 mg IV/IO
- Fentanyl 1mcg/kg IV/IO/IM/IN (*max 100 mcg*)
- Fluid challenge
- Dopamine drip 5-20 mcg/kg/min IV/IO (*titrated*) - *for hypotension*
- Norepinephrine (Levophed) (2-4 mcg/min- initial dose) IV/IO (*max 30 mcg/min*) - large vein if possible

*** NOTES:**

Medical Control Physician will make the determination to divert to PCI center based on transmitted 12-lead. If transmission is NOT possible, advise Physician of machine interpretation or field interpretation.

Patients who have used medications for erectile dysfunction within the last 72 hours should not be given Nitroglycerin unless otherwise directed by Medical control.

Nassau Regional Emergency Medical Services



Critical Care & Paramedic	Cardiac Arrest - VF / Pulseless VT	Protocol III. N
		Approved: 10/30/13
		Effective: 4/01/14

Standing Orders:

- CPR *per AHA guidelines* - limit interruptions in chest compressions*
- If NO CPR in progress - perform 2 minutes - check pulse /rhythm
- Defibrillate (*max joules*) - repeat every 2 minutes if no rhythm change
- Establish IV/IO access - without CPR interruption ($\geq 18g$ if possible)
- Epinephrine 1:10,000 1 mg IV/IO - repeat every 3-5 minutes
May use Vasopressin 40 units IV/IO (1st or 2nd dose) - if available
- Airway management - including waveform capnography (*keep ETCO₂ >10*)
- Cardiac monitor
- Amiodarone 300 mg IV/IO

Contact medical control

Medical Control Options:

- Epinephrine 1:10,000 1 mg IV/IO
- Defibrillate (*max joules*)
- Amiodarone 150 mg IV/IO (2nd dose)
- Magnesium sulfate 1-2 gm IV/IO
- Sodium bicarbonate 1 mEq/kg IV/IO
- Calcium chloride 1 gm IV/IO

*NOTE: CPR should not be paused for procedures or to administer medications.
Continue CPR while defibrillator charges. If possible - rotate chest compressors q 2 min.
All medications should be followed by a normal saline flush.*

Consider & treat underlying causes if possible:

*Hypoxia, Hypovolemia, Hypothermia, Hyper / Hypokalemia, Hydrogen Ion (acidosis)
Trauma, Tension pneumothorax, Tamponade, Toxin/Overdose, Thrombosis/Embolus*

Nassau Regional Emergency Medical Services



Critical Care & Paramedic	Cardiac Arrest - Asystole / PEA	Protocol III. O
		Approved: 10/30/13
		Effective: 4/01/14

Standing Orders:

- CPR *per AHA guidelines* - limit interruptions in chest compressions*
- If NO CPR in progress - perform 2 minutes - *check pulse /rhythm*
- Establish IV/IO access - without CPR interruption ($\geq 18g$ if possible)
- Epinephrine 1:10,000 1 mg IV/IO - **repeat every 3-5 minutes**
May use Vasopressin 40 units IV/IO (1st or 2nd dose) if available
- Airway management - including waveform capnography (*keep ETCO₂ >10*)
- Cardiac monitor

Paramedic

- Needle decompression - *for suspected tension pneumothorax*

Contact Medical Control

Medical Control Options:

- Epinephrine 1:10,000 1 mg IV/IO
- Fluid challenge
- Naloxone (Narcan) 2.0 mg IV/IO/IN
- Dextrose (D50) 25gm IV/IO bolus (*if blood glucose ≤ 60 mg/dl*)
- Sodium bicarbonate 1 mEq/kg IV/IO
- Calcium chloride 1 gm IV/IO
- Glucagon 1mg IV/IO/ **IN**
- Needle decompression - *for suspected tension pneumothorax*
- Termination of resuscitation.

Any of the above orders may be repeated as per Physician's discretion

NOTE: CPR should not be paused for procedures or to administer medications.
Continue CPR while defibrillator charges. If possible - rotate chest compressors q 2 min.
All medications should be followed by a normal saline flush.

Consider & treat underlying causes if possible:

Hypoxia, Hypovolemia, Hypothermia, Hyper / Hypokalemia, Hydrogen Ion (acidosis)
Trauma, Tension pneumothorax, Tamponade, Toxin/Overdose, Thrombosis/Embolus

Nassau Regional Emergency Medical Services



Proposed Change

Critical Care & Paramedic	Post Resuscitation (Return of circulation (ROSC))	Protocol III. P
		Approved: 10/30/13
		Effective: 4/01/14

Standing Orders:

- Airway management including waveform capnography (*EtCO₂ 35-45*)
- If hypoperfusion persists - *see Hypoperfusion /shock protocol*
- Treat other medical/trauma conditions as appropriate
- Maintain a waveform capnography value of 35 - 45 mmHg
- Perform 12-lead ECG - evaluate for STEMI criteria
- ~~If patient is Comatose/Unresponsive initiate hypothermic procedures (if available)~~
 - ~~Use \geq 18g device (IV/IO)~~
 - ~~Start rapid infusion of ice cold (4 Celsius) normal saline via IV/IO to a total of 30ml/kg (max total = 2 liters) (use pressure infusion sleeve)~~
- Contact medical control for transport to nearest **PCI** /~~Hypothermia~~ capable hospital.

Medical Control Options:

- Hospital diversion
- Dopamine drip 5-20 mcg/kg/min IV/IO
- Norepinephrine (Levophed) (2-4 mcg/min- initial dose) IV/IO (*max 30 mcg/min*) - *large vein if possible*
- Midazolam (Versed) 1-5 mg IV/IO - *for shivering*
- Diazepam (Valium) 5 mg IV/IO
- Fentanyl 1mcg/kg IV/IO (*max 100 mcg*)



Proposed Change

Critical Care & Paramedic	Wide Complex Tachycardia - with Pulse	Protocol III. Q
		Approved: 10/30/13
		Effective: 4/01/14

treat only if symptomatic

Standing Orders:

- Airway management
- Vascular access
- Cardiac monitor / 12 lead ECG

(Paramedic)

-
- Synchronized cardioversion 50-360 j - if unstable (*consider procedural sedation*)
 - Amiodarone 150 mg (in 100ml D₅W) IV/IO - *over 10 min.*
 - Fluid challenge - as appropriate

Medical Control Options:

- Amiodarone 150 mg (in 100ml D₅W) IV/IO - *over 10 min..*
- Magnesium sulfate 2 gm in 100 ml IV/IO - (*over 10 minutes*)
- Synchronized cardioversion 50-360 j - (*consider procedural sedation*)
- Fluid challenge
- Sodium bicarbonate 1 mEq/kg IV/IO
- Calcium chloride 1 gm IV/IO

Nassau Regional Emergency Medical Services



Proposed Change

Critical Care & Paramedic	Altered Mental Status	Protocol III. T
		Approved: 10/30/13
		Effective: 4/01/14

Standing Orders:

- Airway management - including waveform capnography
- Vascular access as appropriate
- Cardiac monitor as appropriate
- Naloxone (Narcan) 0.4 mg - 2.0 mg (titrated) IV/IO/IM/IN
if signs/history of narcotic use with respiratory depression. (give prior to dextrose if OD is suspected)
May repeat x 2
- Assess blood glucose - treat if ≤ 60 mg/dl
- Oral glucose, juice, etc. - *if patient is alert enough to swallow with intact gag reflex*
- Dextrose (D50) 25 gm IV/IO
- Glucagon 1 mg IM / IN (if no IV access)

Medical Control Options:

- Dextrose (D50) 25 gm IV/IO
- Naloxone (Narcan) 0.4 - 2.0 IV/IO/IM/IN
- Glucagon 1 mg IM / IN

Nassau Regional Emergency Medical Services



Critical Care & Paramedic	Seizures / Status Epilepticus	Protocol III. U
		Approved: 10/30/13
		Effective: 4/01/14

Proposed Change

Standing Orders:

- Airway management - including waveform capnography
- Vascular access as appropriate
- Cardiac monitor as appropriate
- Assess blood glucose - treat if ≤ 60 mg/dl
- Dextrose (D50) 25 gm IV/IO
- Glucagon 1 mg IM / IN (if no IV access)

- Diazepam (Valium) 5 mg IV/IO/IM/PR
or
- Midazolam (Versed) 1-5 mg IV/IO/IM/IN
or
- Lorazepam (Ativan) 2-4 mg IV/IO/IM

Medical Control Options:

- Diazepam (Valium) 5 mg IV/IO/IM/PR
- Midazolam (Versed) 1-5 mg IV/IO/IM/IN
- Lorazepam (Ativan) 2-4 mg IV/IO/IM
- Dextrose (D50) 25 gm IV/IO
- Glucagon 1 mg IM / IN (if no IV access)
- Magnesium sulfate 2 gm in 100 ml IV/IO - (over 10 minutes)- if eclampsia

Nassau Regional Emergency Medical Services



Proposed change

Critical Care & Paramedic	Stroke / Transient Ischemic Attack	Protocol III. V
		Approved: 10/30/13
		Effective: 4/01/14

Standing Orders:

- Airway management - including waveform capnography
- Vascular access as appropriate
- Cardiac monitor as appropriate
- Assess blood glucose - treat if ≤ 60 mg/dl
- Dextrose (D50) 25 gm IV/IO
- Glucagon 1 mg IM / **IN** (if no IV access)
- Cincinnati stroke assessment
- Obtain the "time of onset" of symptoms
- Transport to a "stroke center" hospital with notification

Medical Control Options:

- Dextrose (D50) 25 gm IV/IO
- Glucagon 1 mg IM / **IN** (if no IV access)
- Hospital diversion / stroke team activation

Nassau Regional Emergency Medical Services



Critical Care & Paramedic	Obstetric / Pregnancy Related	Protocol III. Y
		Approved: 10/30/13
		Effective: 4/01/14

Proposed Change

Standing Orders:

- BLS childbirth management
- Airway management - including capnography - Oxygen 100% via NRB
- Vascular access (\geq 18g device)
- Contact medical control for diversion to "obstetric" receiving hospital.
- Rapid transport - Do not delay on scene

Postpartum hemorrhage

- IV Bolus - 1 liter Normal saline
- Massage fundus firmly & consider allowing infant to nurse

Placenta previa or Placenta abruption

- IV bolus - 1 liter Normal saline - if hypotensive

Eclampsia (Seizures) or

Pre-eclampsia (SBP \geq 160 / DBP \geq 110 and/or severe headache, visual disturbances,) (acute pulmonary edema, upper abdominal tenderness)

- Transport carefully - with lights dimmed.
- Contact Medical control for Magnesium sulfate or Diazepam order.

Medical Control Options:

- Magnesium sulfate 2 gm in 100 ml IV/IO - (over 10 minutes) - for seizures - May repeat
- Diazepam (Valium) 5 mg IV/ IM - for refractory seizures
- Fluid challenge - hypotension / bleeding
- Hospital diversion to "obstetric" receiving hospital

Nassau Regional Emergency Medical Services



Pediatric ALS Protocols

NEWBORN RESUSCITATION

Protocol P1

Approved: 10/30/13

Effective: 4/01/14

Suction immediately after birth ONLY if there is an obvious obstruction to spontaneous breathing or positive-pressure ventilation is necessary.

Standing Orders

- BLS Newborn Resuscitation procedures.
- If newborn is depressed and meconium staining is present, delay drying and stimulation. Suction airway before taking other resuscitative measures.
- Begin Newborn Resuscitation procedures only after the airway has been cleared of thick meconium, as follows:
 - Perform endotracheal intubation and directly suction the endotracheal tube via a meconium aspirator/adaptor while slowly withdrawing the endotracheal tube.
Note: Do not exceed 100-mmHg suction vacuum
 - Repeat this procedure until little or no meconium is acquired or until the heart rate indicates resuscitation must begin immediately.
 - Do not replace the endotracheal tube once the airway has been cleared of thick meconium **unless obstruction continues.**

For all newborns requiring resuscitation once BLS Newborn Resuscitation procedures have begun:

During transport, or if transport is delayed:

- If the newborn appears to be in respiratory distress and the heart rate is below **120** BPM, administer oxygen in as high a concentration as possible.
- If the newborn appears to be in respiratory distress and the heart rate is below **100** BPM, ventilate via BVM or mouth-to-mask with oxygen attached.
- If the newborn appears to be in respiratory distress and the heart rate is below **60** BPM, ventilate via BVM or mouth to mask, **begin CPR**, administer:
- Epinephrine 1:10,000 0.01 mg/kg via IV / IO

Note: It is recommended to use 3-lead ECG to verify heart rate

MEDICAL CONTROL OPTIONS

- Repeat Epinephrine every 3-5 minutes
- Endotracheal Intubation
- Epinephrine 1:1000 0.1 mg/kg via Endotracheal tube
- Check for Blood Glucose < 60 mg/dl
- IV / IO infusion of Normal Saline (0.9% NaCl) 10 ml/kg.
Reassess & document after each bolus. Attempt IV or IO only once each.

Nassau Regional Emergency Medical Services



Pediatric ALS Protocols

PEDIATRIC ALTERED MENTAL STATUS

Protocol P8

Approved: 10/30/13

Effective: 4/01/14

Proposed Change

For pediatric patients in coma, with evolving neurological deficit, or with altered mental status of unknown etiology:

NOTE: MAINTENANCE OF NORMAL RESPIRATORY AND CIRCULATORY FUNCTION IS ALWAYS THE FIRST PRIORITY. PATIENTS WITH ALTERED MENTAL STATUS DUE TO RESPIRATORY FAILURE OR ARREST, OBSTRUCTED AIRWAY, SHOCK, TRAUMA, NEAR DROWNING OR OTHER ANOXIC INJURY SHOULD BE TREATED UNDER OTHER PROTOCOLS.

Standing Orders

- Assess respiratory and circulatory status.
- Begin BLS Altered Mental Status procedures.
- IV of Normal Saline (0.9% NaCl) KVO, or a saline lock. Attempt IV only once.

Perform a glucometer test for blood sugar level. If less than 60 mg/dL administer dextrose or glucagon and continue to monitor as needed after administration.

- Dextrose **D10** IV / IO - (0.5 gm/kg)

OR

- Glucagon 0.1 mg/kg IM / **IN** (if no IV established).

MEDICAL CONTROL OPTIONS:

- Repeat any of the above orders.
- IO infusion of Normal Saline (0.9% NaCl).
- Naloxone 0.1mg/kg IV / IO / IM / IN - *if there is no change in mental status*
- Transport to a Pediatric specialty receiving facility

Nassau Regional Emergency Medical Services



Proposed Change

Pediatric ALS Protocols	PEDIATRIC STATUS EPILEPTICUS	Protocol P9
		Approved: 10/30/13
		Effective: 4/01/14

For pediatric patients in Status Epilepticus:

Standing Orders

- Begin BLS Seizures procedure - cardiac monitor, pulse oximetry, waveform capnography.

Perform a glucometer test for blood sugar level. If ≤ 60 mg/dL:

- IV / IO infusion of Normal Saline (0.9% NaCl) KVO
- Dextrose **D10** IV / IO - (0.5 gm/kg)

OR

- Glucagon 0.1 mg/kg IM / IN (if no IV established).

Paramedic

If patient is still seizing or blood sugar is normal:

- Midazolam 0.2 mg/kg IM / IN (max. 5 mg) *Note: IN route is preferred*

If seizures persist - contact Medical control of options.

MEDICAL CONTROL OPTIONS:

- IO infusion of Normal Saline (0.9% NaCl).
- Midazolam 0.2 mg/kg IM / IN (max. 5 mg) - *Note: IN route is preferred*
- Lorazepam 0.05 mg/kg IV/ IN/ IO (*slowly over 2 minutes*)
Repeat doses may be given if seizures persist
- Diazepam 0.1 mg/kg IV/ IO (*slowly over 2 minutes*)
Repeat doses may be given if seizures persist

If NO IV / IO:

- Repeat Midazolam 0.2 mg/kg IM / IN (max. 5 mg)
- Diazepam 0.1 mg/kg per rectum

NOTE: DO NOT ADMINISTER DIAZEPAM or MIDAZOLAM IF THE SEIZURES HAVE STOPPED.

FLUSH IV LINE BETWEEN GLUCOSE AND DIAZEPAM or MIDAZOLAM

Nassau Regional Emergency Medical Services



Pediatric ALS Protocols	PEDIATRIC TRAUMATIC CARDIAC ARREST	Protocol P11
	Reviewed: 6/2/15	Approved: 10/30/13
		Effective: 4/01/14

Proposed Change

Standing Orders:

- Initiate BLS stabilization procedures
- Perform Airway management — if BLS measures not adequate (use caution with possible C-spine injury)
- **Begin rapid transport**
- Establish IV or IO access, administer bolus Normal Saline (0.9% NaCl)
(no more than 60 cc/Kg unless ordered by Medical Control)
- Monitor ECG
- If continued signs of inadequate perfusion persist repeat second IV bolus of up to 60cc/Kg

Medical Control Options:

- Continue Normal Saline (0.9% NaCl) IV Drip beyond 60 cc/Kg
- Hospital Diversion
- Epinephrine 1:10,000 0.01 mg/kg IV/IO

Paramedic - If a tension pneumothorax is suspected consider orders to perform needle decompression, using an 18-20 gauge catheter