Sherman Fire Department
STANDING DELEGATED ORDERS

Revised March 27, 2013

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

SAMalone MD

Page: A-01	Protocol Name: **Table of Contents**	
Page 1 of 3	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Section A: General	**Page Number**
Medical Director Approval / Duty Status	A-10
Geographical Area	A-20
Authority	A-30
Supplies and Equipment / Minimum Requirements	A-40
Approved Drug List	A-50
Controlled Substance Accountability	A-60
Reporting / Documentation Requirements	A-70
Do Not Resuscitate Orders (DNR)	A-80
On Scene Physician	A-85
Air Ambulance Transfer	A-90
Section B: Treatment Protocols – Adult	**Page Number**
Abuse / Sexual Assault	B-10
Amputation	B-20
Anaphylaxis / Allergic Reaction	B-30
Burns	B-40
Cardiogenic Shock	B-50
Cerebral Vascular Accident (CVA)	B-60
Chest Pain	B-70
Childbirth (Imminent Delivery)	B-80
Congestive Heart Failure	B-90
Dead-On-Scene	B-100
Diabetic Emergencies	B-110
Drowning (Near)	B-120
Envenomation / Spider or Snake Bite	B-130
Eye Injury	B-140
Fracture / Dislocation	B-150
Heat Related Emergencies	B-160
Hypertensive Crisis	B-170
Multi-Casualty Incidents	B-180
Nausea / Vomiting (Persistent)	B-190
Non-traumatic Shock / Unknown Emergency	B-200
Obstetrical Complications	B-210
Overdose / Poisoning	B-220
Pain Management	B-225
Psychiatric Emergencies	B-230
Respiratory Distress, COPD, Asthma	B-240
Seizures	B-250
Spinal / Neurological Shock (Head Injuries)	B-260
Transfer Ambulance Calls	B-270
Trauma	B-280
Unconscious / Unknown Etiology	B-290
Cardiac Dysrhythmias	
Asystole	B-300
Bradycardia / A-V Dissociation	B-310
Pulseless Electrical Activity / PEA / EMD	B-320
Paroxysmal Supraventricular Tachycardia / PSVT	B-330
Sustained Ventricular Tachycardia – Stable	B-340
Sustained Ventricular Tachycardia – Unstable	B-350
Ventricular Ectopy / PVCs	B-360
Ventricular Fibrillation/Pulseless V-Tach	B-370
Post-Resuscitative Management	B-380
Quick Reference Information	B-390

© Sharon A Malone, MD

Section C: Treatment Protocols – Pediatrics (≤12 yo)	Page Number
Abuse / Sexual Assault	C-10
Amputation	C-20
Anaphylaxis / Allergic Reaction	C-30
Burns	C-40
Dead-On-Scene	C-50
Diabetic Emergencies	C-60
Drowning (Near)	C-70
Envenomation / Spider or Snake Bite	C-80
Fracture / Dislocation	C-90
Heat Related Emergencies	C-100
Nausea / Vomiting (Persistent)	C-110
Non-traumatic Shock / Unknown Emergency	C-120
Overdose / Poisoning	C-130
Psychiatric Emergencies	C-140
Respiratory Distress	C-150
Seizures	C-160
Spinal / Neurological Shock (Head Injuries)	C-170
Trauma	C-180
Unconscious/Unknown	C-190
Cardiac Dysrhythmias	
Asystole / Pulseless Electrical Activity (P.E.A.)	C-200
Bradycardia / A-V Dissociation	C-210
Paroxysmal Supraventricular Tachycardia / PSVT	C-220
Sustained Ventricular Tachycardia – Stable	C-230
Sustained Ventricular Tachycardia – Unstable	C-240
Ventricular Ectopy / PVCs	C-250
Ventricular Fibrillation/ Pulseless V-Tach	C-260
Post-Resuscitative Management	C-270
Section D: Procedure Protocols	**Page Number**
A.E.D.	D-10
Airway Management	D-20
Bandaging	D-30
Cardiac Monitoring – 3 or 4 lead ECG/Cardiac 12 lead ECG	D-50/D-60
Cardioversion / Defibrillation	D-70
C.A.T.® Combat Action Tourniquet	D-75
Chest Needle Decompression	D-80
Combitube® Airway	D-90
Continuous Positive Airway Pressure (CPAP)	D-100
Drug Administration – Intramuscular (IM)/ Drug Administration – Intravenous (IV)	D-110
Drug Administration – Intravenous (IV)	D-120
Drug Administration – Subcutaneous / Intranasal	D-130/ D135
Intraosseous Therapy (IO)	D-160/ D-165
Intravenous Therapy (IV)	D-170
King Airway	D-175
Morgan Lenses	D-180
Nasal Intubation	D-190
Oral Intubation/ Rapid Sequence Intubation/PAI	D-200/ D-205
Oxygen Administration	D-210
Patient Examination	D-220
Quick Trach® Cricothyrotomy	D-230
Spinal Immobilization – Backboard / Kendricks Extrication Device	D-250
Splinting	D-260

© Sharon A Malone, MD

Section E: Drug List	Page Number
Adenosine (Adenocard)	E-20
Albuterol (Proventil)	E-30
Amiodarone OPTIONAL	E-35
Aspirin (ASA)	E-40
Atropine Sulfate	E-50
Calcium chloride 1 gm/10 mL **AmBus Only**	E-55
Captopril 25 mg tablet. **AmBus Only**	E-60
Dextrose 50% (D50)	E-65
Diazepam (Valium)	E-70
Diphenhydramine (Benadryl)	E-80
Dopamine (Intropin)	E-90
Enalaprilat (1.25 mg/1 mL) **AmBus Only**	E-95
Epinephrine	E-100
Ketamine (Kelar) OPTIONAL	E-110
Fentanyl (Sublimaze) OPTIONAL	E-115
Furosemide (Lasix)	E-120
Glucagon	E-130
Haloperidol (Haldol)	E-135
Ipratropium (Atrovent)	E-140
Labetalol	E-150
Lidocaine (Xylocaine)	E-160
Lorazepam (Ativan) OPTIONAL	E-170
Methylprednisolone (Solu-Medrol)	E-190
Metoclopramide (Reglan) OPTIONAL	E-200
Midazolam (Versed)	E-210
Morphine Sulfate	E-220
Naloxone (Narcan)	E-230
Nitroglycerin	E-240
Oral Glucose	E-245
Oxygen	E-250
Promethazine	E-260
Sodium Bicarbonate	E-280
Normal Saline (0.9% NaCl)	E-290
Succinylcholine	E-300
Tetracaine OPTIONAL	E-310
Tylenol	E-325
Vasopressin	E-330
Vecuronium (Norcuron)	E-335
Zofran	E-340

© Sharon A Malone, MD

Page: A-10	Protocol Name: **Medical Director Approval / Duty Status**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

The following standing delegated orders are authorizations for qualified personnel to provide prehospital healthcare. Use and delegation of these orders are subject to:

✓ Department personnel, acting in their official capacity while representing their department.

✓ These aforementioned personnel must be:
- Members or employees in active status as defined by department policies or by-laws.
- Certified or licensed by the Texas Department of State Health Services, holding at least one of the following certifications or licenses:
  1. ECA – Emergency Care Attendant
  2. EMT-B – Emergency Medical Technician – Basic
  3. EMT-I – Emergency Medical Technician – Intermediate
  4. EMT-P – Emergency Medical Technician – Paramedic
  5. LIC-P – Licensed Paramedic
- The credentials required above must be valid, active, and current.

Individuals meeting all criteria outlined above shall be classified as "On-Duty."

© Sharon A Malone, MD

Page: A-20	Protocol Name: **Geographical Area**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Use of these protocols are restricted to the following geographical areas:

- ✓ The use of these medical protocols is designated On-Duty Personnel of Sherman Fire Department within the State of Texas.
- ✓ However, these protocols are in effect and authorize Sherman Fire Department Personnel in any geographical area when officially requested to assist another EMS/Fire organization with a mutual aid situation, or backup 911 call.
- ✓ These protocols are in effect in any geographical area for which the need exists for emergency patient care as defined by these protocols, and while personnel are on-duty, as defined in Section A-10.

AmBus Patient Transfer of care:

Patients may be transferred into the care of a facility capable of providing the appropriate medical care.

Paramedic may consult with On-line medical control at the receiving hospital to determine the capabilities of that hospital and make destination decisions as necessary. Alternately, the sending physician or facility may be contacted to assist with any destination questions.

Not all patients must be transferred to the same facility. While on the AmBus, the patient remains in the care of Sherman Fire Department under the medical direction of Dr. Sharon Malone.

Patient care must be transferred at an equal or higher level of care. Patients being transferred to a nursing home must be received by a Registered Nurse.

If any question exist, consult the Medical Director: Sharon Malone, MD, LP 903-357-0436.

© Sharon A Malone, MD

Page: A-30	Protocol Name: **Authority**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

EMS personnel operating as "On-Duty," as defined herein, must only provide patient care at the level authorized and designated by the Medical Director. Each intervention authorized in these Standing Delegated Orders indicates the minimum requirements to perform the referenced intervention. Additionally, some standing orders may identify additional training or other requirements necessary to perform under the order.

Symbol — Minimum requirements to perform under referenced symbol

A **Emergency Care Attendant**

B **Emergency Medical Technician – Basic**
May administer Epi-Pen. May assist with patient prescribed Nitro.

* B2 **Emergency Medical Technician – Basic**
This designation requires special training in advanced airway management and IV placement, Finger Stick Glucose evaluation.

I **Emergency Medical Technician – Intermediate**

* I2 **Emergency Medical Technician – Intermediate**
This designation requires special training in advanced trauma / cardiac interventions.

P **Emergency Medical Technician – Paramedic / Licensed Paramedic**

* P3 **Emergency Medical Technician – Paramedic / Licensed Paramedic**
This designation requires special certification in RSI by medical director.

Interventions indicated with * require special written authorization by the Medical Director.

By default, Paramedics must perform under all symbols, except those with an *, which require INDIVIDUAL written authorization from the Medical Director.

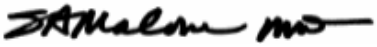
By default, EMT – Intermediates must perform under the **A** , **B** , and **I** orders.

By default, EMT – Basics must perform under the **A** , and **B** orders.

By default, ECAs must perform under the **A** orders.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Page: A-40	Protocol Name: **Supplies & Equipment**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

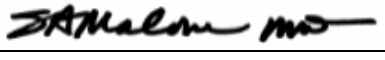
In addition to the supplies and equipment required by the Texas Department of State Health Services, the following list identifies the **minimum** supplies and equipment required on each ambulance:

Qty	Equipment & Supplies
	BLS
1	Protocol Book, Supply & Equipment List, and Drug List
1 ea	Oropharyngeal Airways (40,50,60,70,80,90,100,110 mm)
1 ea	Nasopharyngeal Airways (20,24,28,32 Fr)
1	Portable Suction Unit (with supplies necessary for normal operation)
1	Adult Bag Valve Mask
1	Child Bag Valve Mask
1	Infant Bag Valve Mask
2	Adult Non-rebreather Masks
1	Child Non-rebreather Masks
2	Nasal Cannulas
1	Infant Non-rebreather Masks
2	Portable Oxygen Cylinders (minimum size D)
2	Portable Oxygen Regulator
1	On-Board Oxygen Cylinder with Regulator (minimum size H)
2	Multi-Trauma Dressing
10	Sterile Gauze Pads
4	Occlusive Dressings
6	Kerlix Dressings
2	Rolls of Tape
2	Triangular Bandages
2	Sterile Burn Sheets
2	Adult C-Collars (adjustable size preferred)
2	Child C-Collars
2	Infant C-Collars
2	Long Spine Boards
3	Extremity Splints
2	Eye Protective Goggles – Medical Grade
2	Protective Medical Gowns – Medical Grade
2	Protective Face Masks – Medical Grade
1	Stethoscope
1	Adult and/or Large Adult Blood Pressure Cuff
1	Child Blood Pressure Cuff
1	Pen Light
2	Bandage Shears
1	Sealed Obstetrics Kits with Non-Porous Infant Insulator
1	Automatic External Defibrillator (NOT required on ALS ambulances)
1	Glucometer and 5 test strips
2	Multilevel Stretcher
10	Pair of Protective Non-Porous Gloves (sizes medium, & large)
1	Flashlight
1	Morgan Lenses OPTIONAL
2	Sheets
2	Sterile Gloves
2	Blankets
3	Emergency Warning Triangles
2	"No Smoking" Signs (one in cab and one in patient compartment)

Qty	Equipment & Supplies
1	Hand Disinfectant Wipes Dispenser
2	Puncture Resistant Sharps Containers
2	Red Biohazard Waste Bags
1	Fire Extinguisher (located in an obvious location)
4	Cold Packs
2	Sterile Water for irrigation
	ALS
1	Continuous Positive Airway Pressure Unit
2	Nebulizer
2	0.9% NaCl 10 mL flush for saline lock (required if saline locks used)
2	Saline Locks (optional)
2	Normal Saline (0.9% NaCl) 1000 mL IV Solution Bags
2	Micro-drip sets (60 gtts/mL)
2	Macro-drip sets (10 gtts/mL)
2	IV Catheters of sizes 14, 16, 18, 20, 22, 24 (2 of each size)
2	Tourniquets
2	Syringes of Sizes 1 cc, 3 cc, 10 cc, 30 cc (2 of each size)
2	Endotracheal Tubes of Sizes 2.5 – 9.0 (2 of each size)
1	Endotracheal tube Stylette
1	Laryngoscope Handle
1 ea	Laryngoscope Blade of Sizes 0-4 (Miller) & 1-4 (Macintosh)
1	McGill Forceps
1	Cardiac Monitor / Defibrillator Capable of Performing These Protocols
1	Quick-Combo Pads Adult
1	Quick-Combo Pads Pediatric
1	End Tidal CO2 Sensor
2	ECG Electrode Set
1	Combitube ® OPTIONAL
1	Combitube ® S.A. OPTIONAL
1	Quick Trach® Kit
2	Bougie Introducer
2	EZ-IO® Adult Needles
1	EZ-IO® Pediatric Needles
1	EZ-IO® Driver
1	VeinLight OPTIONAL
2	Nasal atomizers for nasal medication administration OPTIONAL
2 ea	King Airway (size 3,4,5)
1	C.A.T.® Combat Action Tourniquet OPTIONAL
1	Spare batteries for cardiac monitor/defibrillator/AED
2	"C" batteries for laryngoscope/flashlight
1	Spare battery for the glucometer.
1	Emergency Response Handbook

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Page: A-50	Protocol Name: **Approved Drug List**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

The following list identifies the type and minimum quantities of drugs to be stocked on each ambulance:

Qty	Drug
30 mg	Adenosine
10 mg	Albuterol
300 mg	Amiodarone OPTIONAL
648 mg	Aspirin (81 mg chewable tablets)
3 mg	Atropine Sulfate
1 gm	Calcium chloride (1 gm / 10 mL) **AmBus Only**
25 mg	Captopril (25 mg tablet) **AmBus Only**
25 gm	Dextrose 50%
10 mg	Diazepam (Valium)
50 mg	Diphenhydramine
1	Dopamine (400 mg / 250 mL)
1.25	Enalaprilat (1.25 mg/ 1 mL **OR** 1.25 mg / 2 mL) AmBus Only
2	Epinephrine 1:1,000 (1 mg / mL)
4	Epinephrine 1:10,000 (1mg / 10mL)
1	Epi-Pen© Adult (Not required on MICU or apparatus with Paramedic staff)
1	Epi-Pen© Junior (Not required on MICU or apparatus with Paramedic staff)
500 mg	Ketamine (100 mg/mL in 5 mL vial) OPTIONAL
300 mcg	Fentanyl (50 mcg / 2 mL) OPTIONAL
40 mg	Furosemide
1	Glucagon (1 mg powder / 1 mL dilute)
10 mg	Haldol (Haloperidol)
1 mg	Ipratropium
20 mg	Labetalol (20 mg / 2 mL vial)
1	Lidocaine HCl (1 g / 250 mL)
300 mg	Lidocaine HCl
4 mg	Lorazepam (Ativan) OPTIONAL
125 mg	Methylprednisolone (Solu-Medrol)
10 mg	Metoclopramide (Reglan) OPTIONAL
5 mg	Midazolam (Versed)
20 mg	Morphine Sulfate (5 mg / 10 mL vial)
4 mg	Naloxone (2 mg / 2 mL)
2 mg	Nitroglycerin Sublingual tablets or spray for minimum five doses
15 gm	Oral Glucose Gel
25 mg	Promethazine (25 mg/1mL) OPTIONAL
50 mEq	Sodium Bicarbonate (50 mEq/ 50 mL 50% solution of 8.4 %) OPTIONAL
2 each	Normal Saline (NaCl 0.9%) 1 L bags for IV therapy
200 mg	Succinylcholine (Anectine)
1	Tetracaine Ophthalmic anesthetic (0.5% Bottle / 15 mL) OPTIONAL
	Tylenol 500 mg tablets (4), Tylenol suppositories (325 mg) (4), Tylenol suspension (160mg/5 mL) (500 mg) OPTIONAL
40 units	Vasopressin (40 IU / 2 mL)
10 mg	Vecuronium (Norcuron) (10 mg/10mL)
8 mg	Zofran (ondansetron) 8 mg (2) Oral Disintegrating Tablets OR Ondansetron (2) 4 mg/2mL for IV

Drug Concentration Statement:
Periodically the aforementioned drugs may be supplied in concentrations or volumes other that those indicated. Regardless of the particular manner in which drugs are supplied, equivalent total amounts must be present. It is the paramedic's responsibility to ensure that the dosage administered to each patient corresponds with the applicable protocols set forth herein. Generic drugs and brand name drugs are interchangeable.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Page: A-60	Protocol Name: **Controlled Substance Accountability**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Controlled substances, such as Diazepam, Morphine, and Versed are the responsibility of each unit's medic in-charge. These drugs must be inventoried and accounted for every shift, and any use shall be well documented in the patient care record, stating the drug used, the reason for its use, the amount given, the amount wasted, and a witness to these events.

Every incoming in-charge medic shall properly verify the drug quantities on hand, and pursue any discrepancies with the appropriate personnel.

Documents similar to the following may be utilized for controlled substance accountability:

Controlled Substance Accountability Log

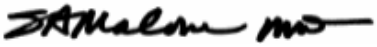
Date	Time	Drug	Amount On-Hand	Discrepancy	In-Charge Signature	Witness Signature
1-1-03	0545	Morphine	40 mg	0	Mr. I. Paramedic	Ms. W. Basic
1-1-03	0615	Morphine	35 mg	5 / see use log	Mr. I. Paramedic	Ms. W. Basic
1-1-03	1745	Morphine	35 mg	0	Ms. I. Medic	Mr. W. Intermediate

Controlled Substance Use Log

Date	Time	Drug	Amount Given	Amount Wasted	Run Incident #	In-Charge Signature	Witness Signature
1-1-03	0610	Morphine	2 mg	3 mg	2003-0001	I. Paramedic	W. Basic

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Page: A-70	Protocol Name: **Reporting / Documentation Requirements**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

For each patient encounter, documentation **MUST** be completed **immediately** following the encounter.

Your documentation will become a permanent record of the patient encounter event, and will serve as a legal document in the event of litigation. As such, the following items have been provided to serve as the minimum requirements for each patient encounter record. The following items must be including on each patient care report:

- Patient's Full Name
- Patient's Complete Address
- Patient's Contact Telephone Number
- Patient Encounter / Run Date
- Applicable Ambulance Times
    - Dispatched Time
    - Ambulance Enroute Time
    - Ambulance On-Scene Time
    - Depart Location Time
    - Arrive Hospital Time
    - Ambulance In Service Time
    - Ambulance Stage Time (when applicable)
    - Patient Encounter Time (when applicable)
- Ambulance / Unit Identifier
- Patient Pickup Location, Including Complete Address and Zip Code
- Patient Destination Location / Facility, Including Complete Address and Zip Code
- Patient's Complete SAMPLE
    - S – Signs & Symptoms
    - A – Allergies
    - M – Medications
    - P – Previous History
    - L – Last Meal
    - E – Events Leading Up To Acute Event
- Detailed Patient Examination Upon Contact & At Destination
- Chronological Event Sequence / Treatment Chronology
- Protective Equipment / Other State Reporting Information
- Glasgow Coma Score – Categorized
- APGAR – When Applicable (Childbirth)
- Full Crew Names, With Authoring Signature

In addition, in-charge medics are responsible for ensuring that all necessary information regarding HIPAA has been given to the patient, and a good faith effort must be made to obtain the patient's signature to acknowledge receipt of the information.

If the patient is a minor or has delegated their healthcare decision making to another individual, you must include the full name and contact information of the individual making the healthcare decisions.

If patients refuse transport to the hospital, you MUST obtain their signature (or responsible party's signature) on an approved Release from Liability form.

© Sharon A Malone, MD

Page: A-80	Protocol Name: **Do Not Resuscitate Orders (DNR)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Out of Hospital Do Not Resuscitate Orders (OOH DNR) should be honored under the following circumstances:

1. OOH DNR orders must be on the approved Texas Department of State Health Services OOH DNR form (sample shown below).
2. The aforementioned form must be appropriately signed and dated.
3. The aforementioned form must be intact and unaltered.
4. In the absence of the approved OOH DNR form, the following shall serve as a valid and enforceable OOH DNR order:

    a. An OOH DNR bracelet, meeting the following specifications:
        - The bracelet must be easily identifiable, intact, and unaltered.
        - The bracelet must have the word "Texas" or the shape of Texas with the word "STOP" imposed.
        - The bracelet must have the words "Do Not Resuscitate."
        - In lieu of the above requirements, the bracelet may simply state "Texas Do Not Resuscitate – OOH"
    b. An OOH DNR necklace, meeting the following specifications:
        - The necklace must be easily identifiable, intact, and unaltered.
        - The necklace must be inscribed with the words, "Texas Do Not Resuscitate – OOH."

5. OOH DNR orders must indicate the treatments to be withdrawn or withheld:
    a. Cardiopulmonary resuscitation;
    b. Advanced airway management;
    c. Artificial ventilation;
    d. Defibrillation; and
    e. Transcutaneous cardiac pacing.

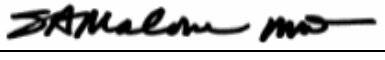
Under **NO** circumstances may an OOH DNR order be honored:

1. Under suspicious or unnatural circumstances.
2. If the patient is known by the healthcare providers (crew) to be pregnant.

If dispute about honoring an OOH DNR order exists, contact the Medical Director or on-line medical control physician.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort measures will be given as needed.

Person's full legal name _____ Date of birth _____ ☐ Male ☐ Female

A. Declaration of the adult person: I am competent and at least 18 years of age. **I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: ☐ legal guardian; ☐ agent in a Medical Power of Attorney; OR ☐ proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

☐ spouse, ☐ adult child, ☐ parent, OR ☐ nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

☐ seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR ☐ observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic # _____

E. Declaration on behalf of the minor person: I am the minor's: ☐ parent; ☐ legal guardian; OR ☐ managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. **I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Signature _____ Date _____

Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____

Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of _____. The above noted person personally appeared before me and signed the above noted declaration on this date: _____.

Signature & seal: _____ Notary's printed name: _____ *Notary Seal*

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Physician's signature _____ Date _____

Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. **I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.**

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____

Attending physician's signature _____ Second physician's signature _____

Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

SA Malone MD

Protocol: A-85	Protocol Name: **On Scene Physician**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Thank you for offering your service,

These certified Emergency Medical Professionals are operating under the authority of the Medical Director of Sherman Fire Department and are operating from approved treatment protocols. Interruption of patient care by you or any other physician is dependent upon your:

1. Identification as a Texas licensed MD or DO.
2. Agreement to accompany the patient to the hospital.
3. Agreement to remain with the patient in the emergency department until patient transfer to the physician at the ED is completed.
4. Agreement to assume all medical responsibility and liability for treatment at the scene and enroute to the hospital.

These emergency medical professionals may refuse orders given to them if any of the items below are true:

1. Treatment is contrary to approved protocols.
2. Treatment ordered is beyond their scope of training and certification.
3. Treatment ordered, in their estimation, may be detrimental to the patient.

SAMalone MD

Sharon Malone, MD, NREMT-P, FAAEM
Medical Director
Sherman Fire Department

Jeff J Jones
Fire Chief
Sherman Fire Department

I, _____, have demonstrated myself to the Sherman Fire Department as a physician licensed to practice medicine in the State of Texas. I understand that falsely representing myself as a physician is a violation of state law for which I can be prosecuted. I agree to assume all medical responsibility and liability for any and all care given under my control and supervision. I agree to remain with the patient until the receiving physician has accepted responsibility for the patient.

_____ Physician Printed name and TX license number

_____ Printed name of Sherman Fire Paramedic

_____ Signature of Physician Date Time

_____ Signature of Sherman Fire Paramedic

© Sharon A Malone, MD

	Sherman Fire Department Emergency Medical Services **STANDING DELEGATED ORDERS**	

Protocol: A-90	Protocol Name: **Air Ambulance Evacuation**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Air evacuation contact should reflect the closest responding helicopter in the interest of time and optimal patient care. The following criteria justify **but do not require** air evacuation for *adult patients.*

.

Indications

Air evacuation contact should reflect the closest responding helicopter in the interest of time and optimal patient care.

The following criteria justify **but do not require** air evacuation for *adult patients.*

- Multi-system blunt or penetrating trauma with unstable vital signs or any sign of shock.
- Penetrating injury to head, neck, chest, abdomen, or groin.
- Burns > 20% TBSA (2nd or 3rd degree) **OR** involving face, hands, feet or genitalia.
- Amputations or near amputation proximal to wrist or ankle.
- Paralysis or other signs of spinal cord injury.
- Open or suspected depressed skull fracture.
- Open or unstable pelvis fractures.
- Two or more proximal long bone fractures.
- Major multi-system trauma in patients> 55 years old.
- Head neck trauma with signs/symptoms of shock.
- MVA with death of an occupant in same vehicle.
- Patient extrication time greater than 20 minutes.
- Number of critically injured patients exceeds capabilities of local EMS agencies.
- Ambulance access to the scene, or away from the scene, is impeded by road conditions, weather conditions, or traffic.

The following criteria justify **but do not require** air evacuation for ***pediatric patients in addition to the above criteria.***

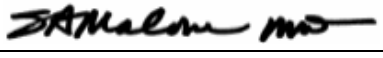
- Experienced or at risk for developing acute respiratory failure or respiratory arrest and not responsive to initial therapy.
- Invasive airway procedure with assisted ventilation.

When the estimated time of arrival of an Air Ambulance exceeds the normal transport time, transport to the nearest appropriate facility.

If any question exists, proceed to the closest appropriate facility to stabilize airway, breathing and circulation.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-10	Protocol Name: **Abuse / Sexual Assault**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Evaluate scene safety.
- ✓ Ensure Police or appropriate agency is notified and enroute.
- ✓ Mechanism of injury or abuse.
- ✓ Medications or allergies.

A Possible signs of abuse/assault:
- ✓ Child under 2 years of age with hot water burns or fractures.
- ✓ Mouth, facial, or genital injuries.
- ✓ Bilateral or symmetrical injuries.
- ✓ Injuries of different age (new and healing injuries).
- ✓ Poor nutrition, care, or hygiene.
- ✓ Delay in seeking treatment.
- ✓ Vague, inconsistent, or changing history.
- ✓ Child comatose, in shock, or in cardiac arrest.
- ✓ Abandoned elder or child, unable to care for self.

A If injured, refer to the appropriate protocol and treat related injuries.

A If abuse is suspected:
- ✓ Keep suspicions to yourself.
- ✓ Protect the patient.
- ✓ Convey impressions of abuse to law enforcement and hospital staff.
- ✓ Write a detailed, descriptive report. It will likely become a legal document.
- ✓ Do **NOT** make a diagnosis of abuse; simply describe findings in detail.

A If sexual abuse/assault is suspected:
- ✓ Take patient history from a medical standpoint.
- ✓ Act in a neutral, professional manner.
- ✓ Keep suspicions to yourself.
- ✓ Protect the patient.
- ✓ Convey impressions of abuse/assault to law enforcement and hospital staff.
- ✓ Write a detailed, descriptive report. It will likely become a legal document.
- ✓ The victim may prefer a medic of the same sex while enroute.
- ✓ Encourage victim **NOT** to change clothes or to bathe for preservation of evidence.
- ✓ If a struggle was involved, protect upper extremities with paper bags (Fig. 1)

A Transport to nearest, most appropriate facility.

A Contact receiving facility.

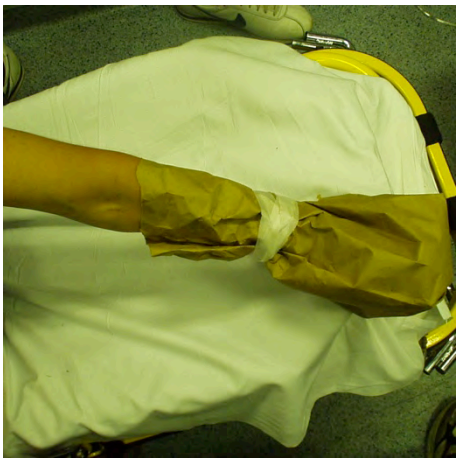


Figure 1: Paper bag covering hands.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-20	Protocol Name: **Amputations**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.
- ✓ Control life-threatening hemorrhage.
- ✓ If applicable, treat other life-threatening injuries.

A Evaluate present and past medical history:
- ✓ Time of amputation.
- ✓ Mechanism of injury / amputation.
- ✓ Care of severed limb or body part.
- ✓ Bleeding disorders.

A Consider oxygen to maintain SaO2 94-96%.

B Consider C.A.T.® Tourniquet if severe bleeding. Record time of placement.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Place severed limb or body part in moist sterile gauze, in a plastic bag, and then place the bag on ice.

A Cover amputated limb with moist sterile gauze, splint, and elevate.

A If partial amputation, dress with moist, sterile gauze, and splint in anatomical alignment.

P Consider
Morphine 2 - 5 mg IV every 5 minutes as needed for pain (max 20 mg)
OR
Fentanyl 50 – 100 mcg IV/IM/IN/IO every 5 minutes as needed for pain (maximum 300 mcg)
Consider antiemetic to control/prevent nausea.

A Transport. Consider facility with replantation capability if amputation is proximal to the wrist or ankle.

Contact receiving facility as soon as destination is determined to allow sufficient time to assemble their team.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-30	Protocol Name: **Anaphylaxis / Allergic Reactions**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Exposure to allergens.
- ✓ Check patient for medic alert bracelet, tag, or necklace.
- ✓ Prevent environmental, food, and medication allergies.

A Consider treatment if patient has:
- ✓ Dyspnea
- ✓ Hives
- ✓ Wheezing
- ✓ Altered Mental Status
- ✓ Decreased Perfusion.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

P For **minor allergic reactions**, or dystonic reactions:
- ✓ Consider Diphenhydramine 50 mg IM, or 25 mg IV

B For moderate to severe allergic reactions, consider
- ✓ Epi-Pen® Adult

P For **moderate to severe allergic reactions,** or if **hives are present**:
- ✓ Consider Epinephrine (1:1,000), 0.3 – 0.5 mg IM lateral thigh, or Epi-Pen® Adult*
- ✓ Consider Diphenhydramine 50 mg IM or 25 mg IV
- ✓ Consider Methylprednisolone 125 mg IV/IM

P If patient is **hypotensive** (MAP < 65 mmHg):
- ✓ Establish a Dopamine drip, 2 – 20 mcg/kg/min to maintain a MAP of 65 mmHg.

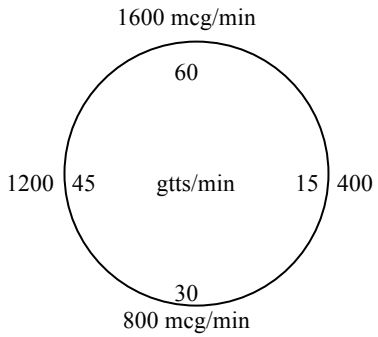
If patient remains hypotensive despite Dopamine drip at maximum dose, consider:
Epinephrine (1:10,000), 1 mg IV every 5-10 minutes to maintain a MAP of 65 mmHg.

A Transport.

A Contact receiving facility.

***Use cautiously in patients with coronary artery disease and consider lower dose.**

Dopamine Drip Clock
Using 1600 mcg/mL concentration
(800 mg in 500 mL bag 0.9% NaCl)



Do NOT administer epi if SBP > 120

Mean Arterial Pressure =

$$\frac{2 \times \text{Diastolic BP} + \text{Systolic BP}}{3}$$

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-40	Protocol Name: **Burns**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of burns (chemical, thermal, etc.)
- ✓ Medications and allergies.

A Consider treatment if patient has:
- ✓ Partial thickness (second degree) burns.
- ✓ Full thickness (third degree) burns.
- ✓ Burns involving hands, face, eyes, ears, feet, or genitalia.
- ✓ Burns associated with fractures or other trauma.
- ✓ Electrical burns.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 ml/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Place patient on dry sterile sheet. Cover burn with dry sterile dressing.

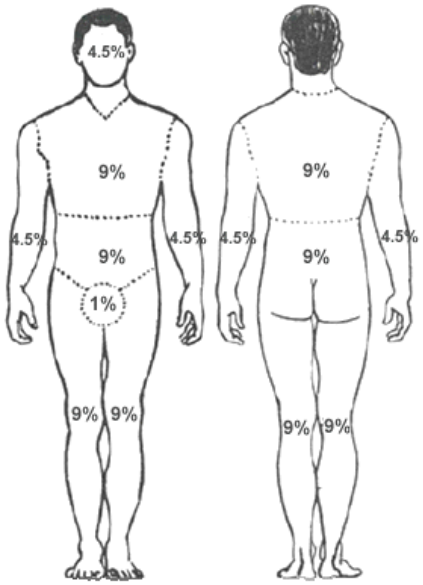


Figure 1: Adult Rule of Nines

P Consider
Morphine 2 – 5 mg IV/IO/IM/IN every 5 minutes as needed for pain (max 20 mg)
OR
Fentanyl 50 – 100 mcg IV/IM/IN/IO every 5 minutes as needed for pain (max 300 mcg)
Consider antiemetic.

A Ensure that other injuries are not overlooked, such as fractures, or lacerations.

A Transport to nearest, most appropriate facility.

A Consider transport to a burn center if one of the following is true:
- ✓ Partial thickness burns greater than 10% of total body surface area
- ✓ Burns that involve the face, hands, feet, genitalia, perineum, or major joints
- ✓ Circumferential burns
- ✓ Full thickness burns
- ✓ Electrical burns
- ✓ Chemical burns

Parkland Burn Formula
Fluid Requirements = TBSA burned(%) x Wt (kg) x 4mL.

Give 1/2 of total requirements in 1st 8 hours, then give 2nd half over next 16 hours.

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-50	Protocol Name: **Cardiogenic Shock**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Cardiac history.
- ✓ Medications and allergies.

A Consider treatment if patient is:
- ✓ Status post-arrest.
- ✓ Presenting with signs of myocardial infarction.
- ✓ Hypotensive (MAP < 65 mmHg) with signs of pulmonary edema.
- ✓ Altered level of consciousness.
- ✓ Showing possible compensatory diaphoresis and tachycardia.

A Consider airway management procedure.

A Administer 100% oxygen via NRB mask or BVM if necessary.

B Apply cardiac monitor, and obtain 12 lead ECG.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

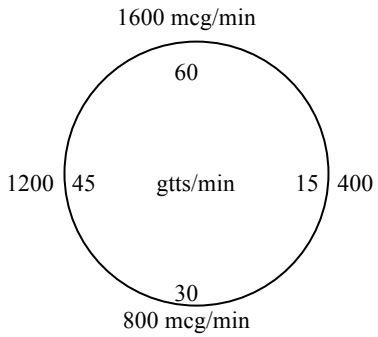
I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

P Administer a Dopamine drip, 2 – 20 mcg/kg/min, to maintain a MAP of 65 mmHg.

A Transport.

A Contact receiving facility.

Dopamine Drip Clock
Using 1600 mcg/mL concentration
(800 mg in 500 mL bag 0.9% NaCl)



Mean Arterial Pressure =

$$\frac{2 \times \text{Diastolic BP} + \text{Systolic BP}}{3}$$

NOTE: If any other form of shock is suspected, refer to the appropriate protocol.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-60	Protocol Name: **Cerebral Vascular Accident (CVA)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Hypertension.
- ✓ Head injury. Seizure at onset of symptoms.
- ✓ Previous cerebral vascular accident.
- ✓ Previous transient ischemic attacks.
- ✓ Medications and allergies.
- ✓ Last known normal mental status.

A Consider treatment if patient has:
- ✓ Altered level of consciousness.
- ✓ Neurological deficits, facial drooping, slurred speech, snoring respirations.
- ✓ Hypertension.

B Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

A Encourage a sitting position to reduce ICP, if applicable.

B Apply cardiac monitor, and obtain 12 lead ECG.

P Interpret ECG. Note if rhythm is regular or Atrial Fibrillation.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

B2 I Perform a blood glucose level test. If blood sugar level is < 60 mg/dL:
- ✓ Administer Dextrose 50%, 25 g, IV

P If hypertensive crisis is suspected (Systolic BP > 220 or Diastolic BP > 120):
- ✓ Consider Labetalol 10 – 20 mg IV.
  Do NOT drop blood pressure precipitously.

I If narcotic drugs are suspected:
- ✓ Consider Naloxone 0.2 to 2 mg IV/IN/IO/IM.

A Perform a secondary neurological examination, and protect paralyzed extremities.

A Transport.

B Contact receiving facility. If **acute stroke** notify receiving hospital of the LEGS score and note time and name of person taking report.

Texas Stroke Intervention
Pre-hospital Scale

Incident # _____ Name of EMS Agency _____
Last Known Normal: (LKN) Date/Time: _____
Next of Kin – Name _____ Phone (___)____-_____

LEGS Score (0-16)		Scoring Criteria
Leg Strength	Right	0 – No Drift 1 – Drift 2 - Some effort against gravity 3 – No effort against gravity 4 – No movement
	Left	0 – No Drift 1 – Drift 2 - Some effort against gravity 3 – No effort against gravity 4 – No movement
Eyes/Visual Fields		0 – No Visual Field Deficit 1 – Either the upper or lower visual field deficit 2 - Both upper and lower visual field deficit 3 – Blind in both eyes
Gaze		0 – No gaze paralysis 1 – Partial gaze paralysis 2 – Forced deviation to one side
Speech/Language		0 – Normal 1 – Mild loss of fluency or comprehension 2 - Incomprehensible 3 – Mute/Comatose
		Total Points

Perform Legs Scale and Record.
Report LEGS score to hospital.

Treatment window for acute stroke has increased to 4 ½ hours from Last Known Normal.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-70	Protocol Name: **Chest Pain**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Provocation.
- ✓ Quality of pain.
- ✓ Radiation of chest pain.
- ✓ Relieving Factors.
- ✓ Severity of pain.
- ✓ Time of the onset.
- ✓ Medications and allergies.

A Consider treatment if patient has:
- ✓ Any chest pain.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 12 lead ECG and print second copy for hospital.

P Interpret 12-lead EKG. Notify hospital AT ONCE if STEMI present

Notify hospital of **CODE STEMI** if present. Indicate leads in which ST segment elevation is present.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

B Administer Aspirin, 324 mg (chewed)*

*Do not administer aspirin if Patient has taken aspirin in the last six hours.

P Check blood pressure. If systolic pressure is > 100 mmHg:
- ✓ Administer Nitroglycerin 0.4 mg sublingual.

P Administer:
- ✓ Nitroglycerin 0.4 mg sublingual can be repeated every 5 minutes until a total of three doses have been administered.
- ✓ Administer Morphine 2 – 5 mg IV every 5 minutes, until pain resolved (max 20 mg).

Mean Arterial Pressure =

$$\frac{2 \times \text{Diastolic BP} + \text{Systolic BP}}{3}$$

P Exercise caution in Inferior/ Right/Posterior MI. These patients are dependent on preload.

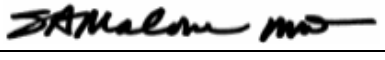
A Transport.

B Contact receiving facility. State **CODE STEMI** and indicate abnormal leads, and note time and name of person taking report.

NOTE: If the patient's MAP drops below 65 mmHg, and postural positioning is ineffective, refer to the Cardiogenic Shock protocol, B-50.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-80	Protocol Name: **Childbirth (Imminent Delivery)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Number of previous pregnancies.
- ✓ Number of previous deliveries.
- ✓ Spotting, cramping, vaginal discharges.
- ✓ Number of pads used.
- ✓ Time between contractions.

A Consider treatment if patient has:
- ✓ Crowning
- ✓ Contractions < 3 minutes apart.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Prepare for a sterile delivery.

A During delivery, prevent rapid birth.

A If head delivers, and membranes are intact, gently tear membranes to allow respirations.

A Suction infant's airway (mouth first) as soon as the head is delivered, and towel dry the newborn.

A Record the time of birth immediately upon delivery of the baby.

AFTER DELIVERY:

A Thoroughly dry the newborn. Maintain newborn position below level of mother.

B Clamp the umbilical cord at approximately 8 inches and 10 inches from the newborn.

B Cut the umbilical cord **between** the clamps.

B Perform APGAR score at 1 minute after birth, and 5 minutes after birth.

APGAR

	0	1	2
Activity	absent	flexion	active
Pulse	Absent	< 100	> 100
Grimace	None	grimace	active
Appearance	Pale gray/ blue	Normal except extrem	Pink
Respirations	Absent	Slow/ irreg	Good/ Reg

B Maintain infant's body temperature using a silver swaddler, or blanket.

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-90	Protocol Name: **Congestive Heart Failure**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Nocturnal dyspnea.
- ✓ Orthopnea.
- ✓ Water retention / dependent edema.
- ✓ Medication usage (Lasix, etc.)

A Consider treatment if patient has:
- ✓ Dyspnea, increasing upon lying down.
- ✓ Productive cough with pink frothy sputum.
- ✓ Peripheral edema.
- ✓ Rales on chest auscultation.
- ✓ Altered level of consciousness or unconscious.

B **Administer CPAP for CHF exacerbations**. First line therapy for CHF.

B Apply cardiac monitor, and obtain 12 lead ECG.

P Interpret ECG. If STEMI is present refer to **B-70**

B2 Establish saline lock.

P If MAP > 65 mmHg and cardiac cause suspected:
- ✓ Consider Nitroglycerin 0.4 mg sublingual every 5 minutes (up to three doses).

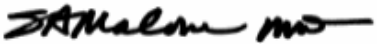
P If the patient has clear evidence of fluid overload:
Consider Furosemide 40 mg IV. Document the signs of fluid overload present.
Sepsis or hypovolemia is a contraindication to Lasix.

P Consider Albuterol with Ipratroprium by nebulization if the patient has wheezing or history of COPD/Asthma.

A Transport to the nearest appropriate facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-100	Protocol Name: **Dead On Scene**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Evaluate scene safety upon approach to the scene.

A Complete primary assessment.

A Evaluate present and past medical history (when appropriate).

A Initiate CPR if:
- ✓ Patient down time is less than 20 minutes.
- ✓ Down time cannot be reliably determined.
- ✓ Asystole cannot be verified in two leads.
- ✓ Hypothermia is present.
- ✓ Any doubt exists.

A Do not resuscitate if injuries are incompatible with life, as defined as **pulseless** and:
- ✓ Burns to entire body.
- ✓ Decapitation.
- ✓ Decomposition.
- ✓ Gunshot wound to the head.
- ✓ Hemicorporectomy.
- ✓ Mass casualty incidents where resources are needed to treat living critical patients.
- ✓ Open head trauma.
- ✓ Post-mortem lividity.
- ✓ Rigor mortis.
- ✓ Penetrating injuries to the chest or head with asystole verified in two leads.

A
If death is a result from vehicular or industrial accident:
- ✓ Do not move body unless it is necessary to resuscitate a living person, or if the body will be significantly destroyed by fire, explosion, etc.
- ✓ Cover body, if appropriate, or if directed by law enforcement personnel.
- ✓ Preserve the accident scene as best as possible.
- ✓ Keep spectators away from the immediate scene.
- ✓ Notify the dispatcher as soon as possible.
- ✓ Notify law enforcement.

A For deaths occurring at home, both naturally and homicide:
- ✓ Do not disturb anything.
- ✓ If scene is unstable, move to a position of safety.
- ✓ Notify the dispatcher as soon as possible.
- ✓ Document all findings and report to the first arriving officer any unusual or suspicious circumstances.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-110	Protocol Name: **Diabetic Emergencies**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Recent illness, chest pain, possibility of pregnancy.
- ✓ Last meal.
- ✓ Insulin type.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Altered level of consciousness.
- ✓ Blood sugar is abnormal. (BS < 60 mg/dL or > 300 mg/dL)

A Consider oxygen to maintain SaO2 94-96%.

B Whenever possible, delay intubation until patient has been treated.

Do NOT delay in administering glucagon if an IV is not immediately achievable.

B Apply cardiac monitor, and obtain 6-second ECG tracing or 12 lead ECG if available.

B2 Perform blood glucose level test.

If hypoglycemic: (blood glucose < 60 mg/dL)

B
B2
I
- ✓ Administer Oral Glucose if pt is conscious and able to swallow.
- ✓ Establish an IV, 0.9% NaCl, at 30 mL/hr.
- ✓ Administer 50% Dextrose 25 g IV

I If blood sugar level remains below 60 mg/dL:
- ✓ Administer additional 50% Dextrose 25 g IV

B2 If hyperglycemic: (blood glucose > 300 mg/dL)
- ✓ Establish an IV, 0.9% NaCl at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV. Repeat bolus if indicated.

P If hypoglycemic and IV attempts are unsuccessful:
- ✓ Administer Glucagon 1mg IM.

B2 Perform additional blood glucose level tests as needed.

A Transport.

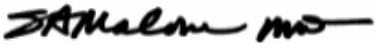
A Contact receiving facility.

If DKA is suspected:
Odor of acetone,
Tachycardia,
Protracted vomiting,
Altered mental status,
Signs of dehydration.

Paramedic treatment may include:
Administer bolus of NS (20 mL/kg).
Repeat fluid bolus if indicated by unresolved symptoms. Patient may be extremely intravascular fluid volume depleted.
Treat vomiting as indicated.
Notify facility of probable DKA

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Protocol: B-120	Protocol Name: **Drowning**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Evidence of trauma.
- ✓ Total downtime.
- ✓ Possibility of air embolism.
- ✓ Diving injury.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Unconscious.
- ✓ Altered level of consciousness.
- ✓ Known drowning (patient was resuscitated prior to arrival of EMS).

A Consider airway management procedure.

B Consider CPAP if the patient is breathing.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Keep patient warm and dry.

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-130	Protocol Name: **Envenomation / Spider or Snake Bite**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Type of bite, location of bite
- ✓ Time of bite or sting.
- ✓ Patient history of anaphylaxis.

A Consider treatment if:
- ✓ Sting or bite with obvious signs of envenomation.

Note: If signs and symptoms of an allergic reaction are noted, refer to Allergic Reaction protocol, B-30.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

P Consider pain control, nausea control if indicated.

A If a scorpion sting:
- ✓ Clean and dress injury.
- ✓ Apply a cold compress.
- ✓ Immobilize and splint the extremity whenever possible.

A If a spider or snake bite:
- ✓ Clean and dress injury.
- ✓ Immobilize and splint the extremity whenever possible.

Copperhead

A If a bee sting:
- ✓ Do not attempt to remove a remaining stinger unless visualized.
- ✓ If stinger removal is attempted, do not squeeze.
- ✓ Apply a cold compress to the sting area.

Cottonmouth

A Transport.

A Contact receiving facility.

Texas Coral Snake
Red on yellow, kill a fellow
Red on black, venom lack.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-140	Protocol Name: **Eye Injury**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of injury.
- ✓ If object is impaled: secure object, cover both eyes and transport.
- ✓ If IRREGULAR pupil, suspect open globe injury and do not put pressure on eye.

A Consider treatment if:
- ✓ The object is non-embedded and remains in the eye.
- ✓ Injury was caused by chemical or thermal burns.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B2 Administer 2 drops of 0.5% Tetracaine to the affected eye.

B If injury is due to chemical burn or non-impaled foreign body, consider irrigation.

B Assemble Morgan Lenses delivery set and attach to IV bag of Normal Saline.

B Insert Morgan Lens.
Initiate flow of fluids and irrigate with a total of 1 L 0.9% NaCl in affected eye.
Discontinue after one liter irrigation.

A Transport.

A Contact receiving facility.

Refer to D180 for Morgan Lens

If the pupil is **NOT ROUND** assume globe injury. Do not put pressure on the globe.

Cover the eye with a rigid shield and secure to the forehead and the cheek to prevent any pressure on the globe.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-150	Protocol Name: **Fracture / Dislocation**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of injury.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Suspected closed fracture / dislocation.
- ✓ Open fracture / dislocation.
- ✓ Pain and deformity.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Check for pulse distal and proximal to fracture or dislocation, and capillary refill.

A Immobilize the joint above and below the fracture or dislocation.

A Protect any exposed bone ends, and dress / bandage all open wounds prior to splinting.

A Splint in the position found. See splinting procedure.

B For closed, mid-shaft femur fractures, apply traction splint.

P For dislocations or severely angulated fractures associated with swelling, distal pulselessness, or paresthesia:
- ✓ Reposition the limb in anatomical alignment.
- ✓ Gently apply traction and counter-traction.
- ✓ Move limb to attempt to regain distal pulse.
- ✓ Attempt movement only once, and if unsuccessful, transport as soon as possible.

P Consider:
Morphine 2 – 5 mg IV/IO/IM/IN every 5 minutes as needed for pain (max 20 mg)
OR
Fentanyl 50 – 100 mcg IV/IM/IN/IO every 5 minutes as needed for pain (max 300 mcg)
Consider antiemetic as needed to control nausea.

A Transport

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-160	Protocol Name: **Heat Related Emergencies**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of heat related emergency.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Altered level of consciousness.
- ✓ Elevated temperature related to external environment.
- ✓ Moderate to severe abdominal cramps.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl 30 mL/hr.

I Bolus 0.9% NaCl 20 mL/kg IV. Repeat bolus if indicated.

P Consider treatment of muscle cramping:
Consider valium 2 - 10 mg IV/IM/IN/IO. Monitor blood pressure.

A Cool the patient with ice packs.

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-170	Protocol Name: **Hypertensive Crisis**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Cardiac history.
- ✓ Past cardiovascular accidents.
- ✓ Past transient ischemia attacks.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Systolic blood pressure above 220 and symptomatic.
- ✓ Diastolic blood pressure above 120 and symptomatic.
- ✓ Headache, nausea, dizziness, or blurred vision.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 12 lead ECG.

P Interpret 12 lead ECG.
- ✓ If **STEMI** is present, refer to **B-70.**

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr OR saline lock.

P Consider treatment if SBP > 220 or DBP > 120.
Consider Nitroglycerine 0.4 mg sublingual q 3 minutes. Max 5 doses.
OR
Consider Labetolol 10 – 20 mg IV/IO. Hold if HR < 60.
OR
If HR < 60, Consider enalaprilat 1.25 mg IV/IO.
OR
Consider captopril 25 mg PO if no contraindications.

Treatment for hypertension should be based on the patient's current condition and vital signs.

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: B-180	Protocol Name: **Multi-Casualty Incidents**	
Page 1 of 2	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.
- ✓ Evaluate scene safety.
- ✓ Number of patients.
- ✓ Is additional help or mutual-aid needed?
- ✓ Evaluate the severity of incident.
- ✓ Use personal protective equipment.

A Senior Medic arrives on scene, establishing Incident Command. The Incident Commander reports to dispatch:
- ✓ Type of incident.
- ✓ Approximate number of patients of each priority level.
- ✓ Any additional resources necessary.
- ✓ Unit staging instructions.
- ✓ Plan of action.
- ✓ If a multiple-agency response, establish a command post.

A The second medic becomes the triage officer and begins the START system, prioritizing the patients into universally recognized priority levels:
- ✓ **Immediate** (red)
  - o Respiratory rate above 30 / minute.
  - o Absent radial pulse.
  - o Delayed capillary refill.
  - o Altered mental status.
- ✓ **Delayed** (yellow)
  - o Injuries determined to be non-life-threatening.
- ✓ **Hold** (green)
  - o Also known as "walking wounded."
  - o Minor injuries that do not require stabilization.
- ✓ **Deceased** (black)
  - o Deceased patients.
  - o Live patients with obvious fatal or non-resuscitatable injuries.

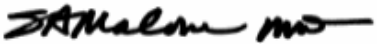
A Triage should last no more than 30 seconds per patient. Patients are triaged according to respirations, pulse, and mental status (RPM). Treatments by triage personnel are limited to:
- ✓ Open the airway.
- ✓ Control bleeding.
- ✓ Elevate the patient's legs.

The treatment team will provide additional patient care.

A Command staff should include:
- ✓ **Incident Command** – responsible for large scale decision making.
- ✓ **Safety Officer** – responsible for pro-active safety concerns.
- ✓ **Triage Officer** – responsible for triage process and personnel.
- ✓ **Liaison Officer** – coordination of multi-agency efforts.
- ✓ **Public Information Officer** – releases authorized information to the media.
- ✓ **Transportation Officer** – coordinates between Staging and Treatment officers to provide transportation of patients to the appropriate facilities.
- ✓ **Communication Officer** – informs hospitals of incoming patients.
- ✓ **Staging Officer** – supervises staging area, regulating resources and personnel.
- ✓ **Treatment Officer** – manages all patient treatment areas.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Protocol: B-180	Protocol Name: **Multi-Casualty Incidents**	
Page 2 of 2	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A S.T.A.R.T. Triage System shall be performed as follows:

- ✓ Check **R**espirations
  - If **no respirations**, open the airway. If still **no respirations**, patient considered **DECEASED.**
  - If **respirations above 30**, patient considered **IMMEDIATE**.
- ✓ Check **P**erfusion
  - If **no radial pulse**, or **delayed capillary refill**, patient should be considered **IMMEDIATE**.
- ✓ Check **M**ental Status
  - If patient **can NOT follow simple commands**, patient should be considered **IMMEDIATE**.
  - If patient **can follow simple commands**, patient should be considered **DELAYED**.

A Once primary triage is completed, the treatment officer shall:

- ✓ Request personnel from Staging Officer for patient treatment.
- ✓ Communicate with Staging Officer and Transportation Officer to transport patients to appropriate facilities.

A The Transportation Officer shall:

- ✓ Track and record the destination facilities for each patient.

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-190	Protocol Name: **Nausea / Vomiting**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ History of ulcers.
- ✓ Recent illness / infection.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ No altered level of consciousness.
- ✓ Nausea with active & persistent vomiting is present.

A Consider airway management procedure.

A Administer 100% oxygen via NRB mask or nasal cannula if unable to tolerate.

B Apply cardiac monitor, and obtain 12 lead ECG.

P Interpret ECG. If **STEMI** present refer to **B-70**.

B2 Perform a blood glucose level test.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

If blood sugar level is below 60 mg/dL:

P
- ✓ Administer 50% Dextrose, 25 g IV/IO

P Consider:

Zofran (ondansetron) 8 mg ODT/IV

OR

Metoclopramide 5 – 10 mg IV/IM/IO.

OR

Promethazine 6.25 – 25 mg IV/IM

May give Reglan after Zofran if Zofran is ineffective.

A Keep patient NPO.

I If signs of dehydration:
- ✓ Bolus 0.9% NaCl, 20 mL/kg.

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-200	Protocol Name: **Non-Traumatic Shock – Unknown Emergency**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ History of ulcers.
- ✓ Recent illness / infection.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Hypotension.
- ✓ Tachycardia.
- ✓ Pale, clammy skin.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 12 lead ECG.

P Interpret ECG. If **STEMI** present refer to **B-70**.

B2 Perform a blood glucose level test.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

If blood sugar level is below 60 mg/dL and the patient is symptomatic

P
- ✓ Administer 50% Dextrose, 25 g IV

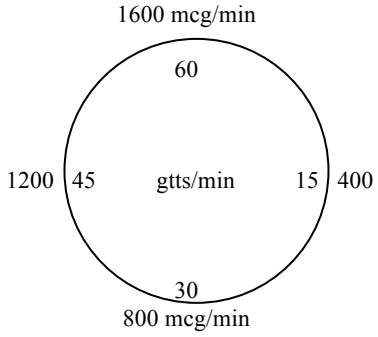
B2 If systolic blood pressure is below 90 mmHg, and the patient is symptomatic:
- ✓ Establish a second IV of 0.9% NaCl at 30 mL/hr.

P If the systolic blood pressure decreases with fluid therapy at any point:
- ✓ Initiate a Dopamine drip, 2 – 20 mcg/kg/min to maintain a MAP of 65 mmHg.

A Transport.

A Contact receiving facility.

Dopamine Drip Clock
Using 1600 mcg/mL concentration
(800 mg in 500 mL bag 0.9% NaCl)



Notes:
- **If any signs of injuries are present, refer to the Trauma protocol, B-280.**
- **If any patient is presenting with chest pains, arrhythmias, or symptoms of myocardial infarction, refer to the Cardiogenic Shock protocol, B-50.**
- **If patient is presenting with hypotension and bradycardia, refer to the neurogenic shock protocol, B-260.**

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: B-210	Protocol Name: **Obstetrical Complications**	
Page 1 of 3	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Number of previous pregnancies and deliveries.
- ✓ Previous complications.
- ✓ Number of pads used to control bleeding.
- ✓ Medications or allergies.

Post Partum Hemorrhage

A Consider treatment if:
- ✓ Massive post delivery bleeding.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Aggressively massage the uterine fundus.

A Transport.

A Contact receiving facility.

Third Trimester Bleeding, Abruptio Placenta, Placenta Previa, Ectopic Pregnancies

A Consider treatment if:
- ✓ Massive bleeding is noted.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

A Place the patient in the "shock" position.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Protocol: B-210	Protocol Name: **Obstetrical Complications**	
Page 2 of 3	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Prolapsed Cord

A Consider treatment if:
- ✓ The umbilical cord is the presenting part.

A Consider oxygen to maintain SaO2 94-96%.

A Immediately place the patient in the extreme Trendelenburg position, with hips elevated.

A If the umbilical cord is the presenting part:
- ✓ Place a sterile gloved hand in the birth canal, and gently keep the infant's head off the cord.
- ✓ Keep the cord moist with normal saline.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Transport.

A Contact receiving facility.

Eclamptic with Seizures

A Consider treatment if:
- ✓ Patient is actively seizing.
- ✓ Patient is presenting with pre-eclamptic signs / symptoms.

A Consider Airway Management procedures.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

P If patient is actively seizing, see seizure protocol **B-250**

A Transport quickly.

A Contact receiving hospital.

© Sharon A Malone, MD

Breech Delivery

A Consider treatment if:
- ✓ History of breech presentation.
- ✓ Presentation of child's buttocks or both feet.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A If possible, allow the buttocks and trunk to deliver, giving support only.

A Place the patient in the knee-to-chest position, and assist the delivery of the baby's head.

A If delivery of the baby's head is delayed:
- ✓ Insert a sterile gloved hand into birth canal and create an airway for the infant.
- ✓ Make a "V" shape with hand and maintain the infant's airway.
- ✓ Attempt to push the vaginal wall away from the infant's mouth.

A Transport and contact receiving facility.

Limb Presentation, Amniotic Sac Presentation

A Consider treatment if:
- ✓ Presentation of one foot.
- ✓ Presentation of one or both arms.
- ✓ Empty amniotic sac present (can determine by transluminating with pen light).

A Consider oxygen to maintain SaO2 94-96%.

A Immediately place the patient in extreme Trendelenburg position, with hips elevated.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Transport and contact receiving facility.

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-220	Protocol Name: **Overdose / Poisoning**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Name of substance taken.
- ✓ Amount of substance taken.
- ✓ Time at which substance was taken.
- ✓ Gather all pill bottles at scene to transport with the patient.

A Consider treatment if:
- ✓ Decreased level of consciousness.
- ✓ Unresponsive or unconscious.
- ✓ History of narcotic / opiate abuse.
- ✓ History of cyanide poisoning, phenothiazine reaction, or envenomation.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 12 lead ECG if patient condition allows.

B2 Perform a blood glucose level test.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

If blood sugar level is below 60 mg/dL:

P
- ✓ Administer 50% Dextrose 25 g IV/IO

I If narcotic involvement is suspected and if respirations are compromised:
- ✓ Consider Naloxone 0.2 to 2 mg IV /IO / IN (IV may repeat up to 2 times).
- ✓ Titrate Naloxone to respiratory improvement only.

P If suspected organophosphate poisoning, and symptomatic patient (bradycardia, salivation, lacrimation, etc.):
- ✓ Consider Atropine 2 mg IV/IO every 10 minutes as needed to relieve symptoms.

A Contact Poison Control – **1-800-222-1222**, and consider instructions.

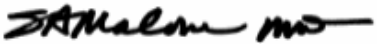
A Transport.

A Contact receiving facility.

Bath salts exposure causes severe paranoia and the patient can be extremely violent. Treatment for severe psychosis in this case is benzodiazepine:
Versed 2 – 5 mg IM/IN
OR
Ativan 2 – 4 mg IM/IN
Rescuer safety first.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-225	Protocol Name: **Pain / Anxiety Management**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Location of pain, radiation of pain.
- ✓ Onset and current level of pain.
- ✓ History of previous similar pain.
- ✓ Current medical problems and medications.
- ✓ Level of consciousness and/or alertness.
- ✓ DO NOT medicate lethargic patients.
- ✓ DO NOT medicate hypotensive patients.

A Consider treatment if:
- Severe pain.
- Severe anxiety.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 12 lead ECG.

P Interpret ECG. If **STEMI** refer to Chest Pain **B-70**.

B2 Perform a blood glucose level test.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

If blood sugar level is below 60 mg/dL:

P ✓ Administer 50% Dextrose 25 g IV

P Consider treatment for pain:
Morphine 2 – 5 mg IV/IM/IN/IO q 5 minutes for pain. Maximum 20 mg.
OR
Fentanyl 50 – 100 mcg IV/IM/IN/IO q 5 minutes for pain. Maximum 300 mcg.

Maximum IN volume
1 mL per nostril.

P Consider treatment for severe anxiety:
Valium 2 – 5 mg IV/IM/IN/IO. Maximum 10 mg.
OR
Versed 0.5 to 1 mg IV/IM/IO/IN. Maximum 5 mg.
OR
Ativan 2 – 4 mg IV/IM/IO/IN. Maximum 4 mg.

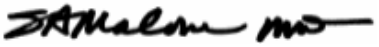
P Consider treatment for nausea as indicated.

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-230	Protocol Name: **Psychiatric Emergencies**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.
- ✓ Attempt to have law enforcement on scene prior to patient contact.

A Evaluate present and past medical history:
- ✓ Diagnosed disease or disorder.
- ✓ Precipitating events.
- ✓ Recreational drug use.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Any injuries.
- ✓ Possible drug overdose (refer to appropriate protocol).
- ✓ Stated or alluded suicidal or homicidal ideation.

A Identify yourself and attempt to develop a rapport with the patient.

A Be calm and reassuring while attempting to obtain information from the patient.

A Act in a neutral, professional manner. Do not respond to anger. Instead, use tact and firmness, and attempt to gain control of the situation.

A Use all resources necessary to safely care for the patient.

P **If physical restraints are ineffective** or patient is presenting with aggressive, agitated behavior:
Consider Haldol 5 – 10 mg IM. Consider lower dose in patients older than 65 years.
OR
Consider Valium 2 – 10 mg IM/IV/IN. Maximum 10 mg.
OR
Consider Ativan 2 – 4 mg IV/IM/IN. Maximum 4 mg.

Parkinson's Dementia or Alzheimer' Dementia should NOT be treated with Haldol.

Consider Valium or Ativan in elderly patients with dementia.

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-240	Protocol Name: **Respiratory Distress, COPD, Asthma**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Previous home breathing treatments, including home oxygen.
- ✓ Past cardiac history.
- ✓ Past respiratory problems.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Tachypneic, dyspnea, increased work of breathing., wheezing.
- ✓ Diaphoretic, tachycardic, pale.
- ✓ Use of accessory muscles during inspiration.
- ✓ Unable to speak.
- ✓ Prolonged forced exhalation.

B Consider CPAP and institute early in severe dyspnea.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 12 lead ECG.

P Interpret ECG.

A If applicable, encourage the patient to a sitting or upright position to aid their respiratory effort.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

B Administer Albuterol 2.5 mg in 3 mL NaCl, via nebulizer.

P Consider both Albuterol and Ipratropium together as nebulized treatment
- ✓ Consider Methylprednisolone (Solu-Medrol) 125 mg IV/IM.

B Repeat the albuterol as needed to improve breathing.
Do not repeat the Ipratropium.

A If no improvement, or patient has decreased level of consciousness or loses consciousness:
- ✓ Perform airway management procedure and assist ventilations with BVM.

P If **severe** bronchoconstriction and NO evidence of acute MI on ECG:
- ✓ Consider Epinephrine (1:1,000), 0.3 – 0.5 mL IM.

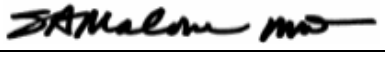
Do not give epinephrine if SBP > 120.

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-250	Protocol Name: **Seizures**	
Page 1 of 2	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Previous head injury.
- ✓ Pregnancy or epilepsy.
- ✓ Fever.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Patient is actively seizing.
- ✓ Patient is in post-ictal state, characterized by lethargy, altered mental status, etc.

B Consider airway management procedure including nasopharyngeal airway.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

P If patient is actively seizing administer benzodiazepine:

Valium (diazepam) 2 - 10 mg IV/IO or Intranasal titrated to seizure activity.
OR
Versed (midazolam) 1 - 5 mg IV/ IO / or Intranasal, titrated to seizure activity.

If still seizing in 15 minutes may repeat either . Be prepared to manage airway and support the blood pressure.

B2 Perform blood glucose level test.

If blood sugar level is below 60 mg/dL:
I Administer Dextrose 50%, 25 g IV

I If narcotic involvement is suspected:
Consider naloxone, 0.2 to 2 mg, IV/IM/IO/IN.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A If the patient is febrile:
Cool patient with water or cool packs.

P If suspected dystonic reaction:
Consider Diphenhydramine 25 - 50 mg IV//IO/IM.

A Transport.

A Contact receiving facility.

Valium (Diazepam) Administration:

Weight:	Dosage:
40 kg	5 mg
50 kg	5 mg
60 kg	10 mg
70 kg	10 mg
≥ 80 kg	10 mg

Versed (Midazolam) Administration:

Weight:	Dosage:
40 kg	2 mg
50 kg	2.5 mg
60 kg	3 mg
70 kg	4 mg
≥ 80 kg	5 mg

Versed is much more sedating.
Consider if Valium ineffective.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: B-250	Protocol Name: **Seizures**	
Page 2 of 2	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

If the patient is Post-Ictal upon arrival:

A Consider airway management procedure including nasopharyngeal airway.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Perform blood glucose level test.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

I If blood sugar level is below 60 mg/dL:
- ✓ Administer Dextrose 50%, 25 g IV/IO

I If narcotic involvement is suspected:
- ✓ Consider Naloxone, 0.2 to 2 mg, IV/IO/IN/IM

A Transport.

A Contact receiving facility.

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-260	Protocol Name: **Spinal / Neurological Shock (Head Injuries)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of injury.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Neurological deficit, with obvious head injury.
- ✓ Hemodynamically unstable.

If the patient is conscious and alert:

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

A Immobilize and secure patient to spinal immobilization device. If patient has suspected head injury, elevate head of the backboard approximately 30 degrees.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

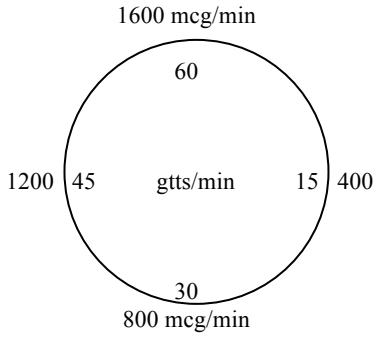
I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

P If patient has signs of isolated spinal cord injury (hypotension and bradycardia): Start Dopamine drip, 2 – 20 mcg/kg/min titrated to maintain a MAP of 65 mmHg.

A Transport to closest appropriate facility.

A Contact receiving facility.

Dopamine Drip Clock
Using 1600 mcg/mL concentration
(800 mg in 500 mL bag 0.9% NaCl)



© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-270	Protocol Name: **Transfer Ambulance Calls**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A For transfer ambulance responses:

- ✓ Follow appropriate protocols for any injury or illness.
- ✓ If patient has written orders from a physician, the physician's orders may be followed during transport. If any doubt, contact medical director.
- ✓ If patient is on a ventilator a respiratory therapist from the transferring hospital must accompany the patient. Paramedic may maintain simple transfer ventilator.
- ✓ If the patient is on IV drips which are outside the scope of these orders a Registered Nurse from the transferring hospital must accompany patient unless the Paramedic on duty has training in the medications.
- ✓ If patient's condition worsens or changes out of the scope of the transferring physician's written orders, contact medical director OR medical control at receiving hospital for further orders. Document information in the patient record.

A Monitor vital signs according to patient's condition.

P Monitor all interventions, including:

- ✓ Oxygen therapy, SaO2.
- ✓ IV therapy.
- ✓ ECG monitoring.
- ✓ Artificial ventilation therapy.
- ✓ Any other interventions or care necessary.

A Document any changes in the patient's condition while enroute.

A Report all appropriate information to receiving facility.

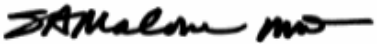
A Transport.

A Contact receiving facility.

If the Paramedic has any concern about the patient's safety during transport, contact Medical Director 903-357-0436.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-280	Protocol Name: **Trauma**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of injury.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Systolic blood pressure is below 100 mmHg, with signs and symptoms of shock.
- ✓ Suspected blunt / penetrating chest or abdominal trauma associated with signs and symptoms of shock.

A Consider airway management procedure. Spinal precautions must be observed.

A Consider oxygen to maintain SaO2 94-96%.

A Consider BTLS transport criteria.

A Perform Spinal Immobilization procedure.

A Perform rapid secondary survey.

B Apply cardiac monitor and obtain a 6-second ECG strip.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

B2 Establish a second IV while enroute to receiving facility or while awaiting extrication or aeromedical transport. Continue to monitor vital signs every 3 – 5 minutes.

A Transport.

A Contact receiving facility.

Note: If tension pneumothorax is suspected, consider chest needle decompression.
Consider C.A.T.® Tourniquet if severe bleeding is present.

A **Consider rapid transport to a trauma facility if:**
- ✓ **Blunt / penetrating trauma with signs and symptoms of shock.**
- ✓ **Head / neck trauma with signs and symptoms of shock.**
- ✓ **High-velocity impact.**
- ✓ **Rapid acceleration / deceleration.**
- ✓ **Motor vehicle accidents with death of an occupant in the same vehicle.**

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-290	Protocol Name: **Unconscious / Unknown Emergency**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Recreational drug use.
- ✓ Cardiac history.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Unconscious with unknown etiology.

A Consider airway management procedure. Spinal precautions if any evidence of trauma.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 12 lead ECG.

P Interpret ECG. If abnormal, refer to appropriate Standing Delegated Order.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.
- ✓ Obtain blood glucose level.

If blood glucose level is below 60 mg/dL:
P Administer 50% Dextrose, 25 g, IV/IO

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

I If narcotic involvement is suspected:
- ✓ Consider Naloxone 0.2 to 2 mg, IV / IO / IM / IN.

B2 If no response is noted in 3 – 5 minutes:
- ✓ Perform a second blood glucose level test in the opposite arm.

If blood sugar level remains below 60 mg/dL:
I
- ✓ Administer a second dose of 50% Dextrose, 25 g, IV/IO

A Transport.

A Contact receiving facility.

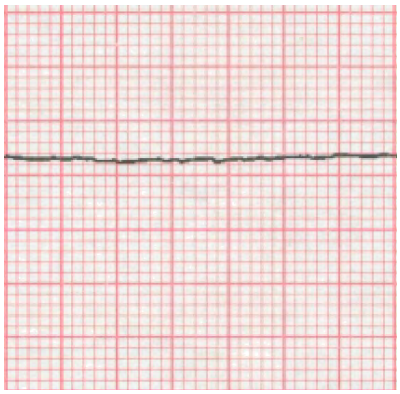
© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

SA Malone MD

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-300	Protocol Name: **Asystole**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



A Complete primary assessment.
- ✓ Initiate aggressive CPR with BVM and 100% oxygen.

A Evaluate present and past medical history:
- ✓ Previous heart attacks, cardiac history, etc.
- ✓ Current down time.

B P B Apply cardiac monitor (quick-look) and obtain a 6-second ECG strip:
- ✓ Confirm asystole in leads I and II, or II and III.
- ✓ Attach monitor with leads or Quick Combo ® pads.

A If unclear or uncertain, treat as Ventricular Fibrillation, **protocol B-370**.

P Administer 100% oxygen via BVM and initiate intubation procedures.

B2 Establish an IV, 0.9% NaCl at 30 mL/hr.

P If IV unsuccessful in three attempts or 90 seconds establish IO access.

Any IV medication can be given IO.

P Administer vasopressor:
- ✓ Epinephrine (1:10,000), 1 mg IV. Repeat every 3 – 5 minutes.

OR
- ✓ Vasopressin 40 units IV to replace first two doses of epinephrine.

P Consider Calcium Chloride/ Sodium Bicarb in renal failure patients with possible hyperkalemia or if calcium channel blocker overdose is known.

P Reassess effectiveness of CPR, ET tube placement, IV placement.

B2 I Perform blood glucose level test. If blood glucose level is below 60 mg/dL:
- ✓ Administer 50% Dextrose, 25 g, IV

A Consider and treat other possible causes:
- ✓ Hypoxia.
- ✓ Hyperkalemia.
- ✓ Hypokalemia.
- ✓ Hypothermia.
- ✓ Acidosis.
- ✓ Drug overdose.

Consider contacting Medical Control for discontinuation of efforts if there is no patient response after 15 minutes of ACLS CPR.

A Transport.

A Contact receiving facility.

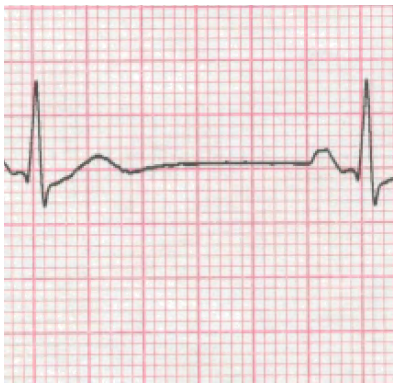
***For Post Resuscitative Management, refer to B-380**

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-310	Protocol Name: **Bradycardia / A-V Dissociation**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Chest pain, dyspnea.
- ✓ Syncope.
- ✓ Pacemaker.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Heart rate below 60 BPM with hypotension or congestive heart failure.
- ✓ Heart rate below 60 BPM with chest pain, or
- ✓ Heart rate below 60 BPM with altered level of consciousness.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor and obtain 12 lead ECG.

P Interpret ECG. Do not delay pacing for second degree Mobitz or third degree block.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

P Sinus bradycardia: may consider Atropine 0.5 mg IV. May repeat once.
Heart block requires immediate pacing.

P Second degree Mobitz block requires pacing.

P Complete heart block requires immediate pacing.

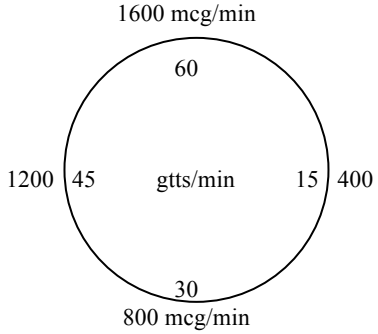
P If no improvement is noted after pharmacological therapy and patient is symptomatic:
- ✓ Begin external pacing.
- ✓ Set pacing rate at 80 BPM, and press start.
- ✓ Increase the current in 10 mA increments until mechanical and electrical capture is noted. Check for pulse matching electrical capture.
- ✓ Consider Valium 2- 5 mg IV/IM for anxiety. Hold if SBP < 100.

P If the patient's MAP is below 65 mmHg after successful pacing:
- ✓ Dopamine 2 – 10 mcg/kg/min, titrated to maintain a MAP of 65 mmHg.

A Transport.

A Contact receiving facility.

Dopamine Drip Clock
Using 1600 mcg/mL concentration
(800 mg in 500 mL bag 0.9% NaCl)



In second and third degree heart block, atropine can cause fatal ventricular dysrhythmia.

If pacing is not effective, begin dopamine as above.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-320	Protocol Name: **Pulseless Electrical Activity (PEA)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.
- ✓ Initiate aggressive CPR with BVM and 100% oxygen.

A Evaluate present and past medical history:
- ✓ Downtime.
- ✓ Previous myocardial infarction and cardiac history.
- ✓ If trauma related, maintain spinal immobilization.
- ✓ Medications and allergies.

A Initiate and continue high quality CPR without interruption.

B Apply cardiac monitor and obtain a 6-second ECG strip.

P Establish an IV/IO, 0.9% NaCl at 30 mL/hr.

I Bolus 0.9% NaCl 20 mL/kg IV.

P Administer vasopressor:
- ✓ Epinephrine 1:10,000, 1 mg IV, and repeat every 3 – 5 minutes.

OR
- ✓ Vasopressin 40 units IV to replace first two doses of epinephrine.

P Treat for possible causes:
- ✓ Myocardial infarction.
- ✓ Acidosis: Consider Sodium Bicarbonate 1 mEq/kg.
- ✓ Tension pneumothorax: Perform chest needle decompression.
- ✓ Cardiac tamponade: Transport immediately to a trauma facility.
- ✓ Hypovolemia: Perform fluid challenge (20 mL/kg of NaCl IV)
- ✓ Hyperkalemia: Administer Sodium Bicarbonate 50 mEq.
- ✓ Hypothermia: Continue CPR while warming patient.
- ✓ Hypoxia: Confirm tube placement, and consider possible causes.
- ✓ Cardiogenic / Neurogenic Shock: Refer to appropriate protocol.

A Transport.

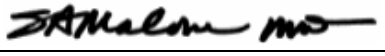
A Contact receiving facility.

Note: If the patient regains a pulse and exhibiting signs and symptoms of cardiogenic shock, refer to the Post Resuscitative Management protocol, B-380.

***For Post Resuscitative Management, refer to B-380**

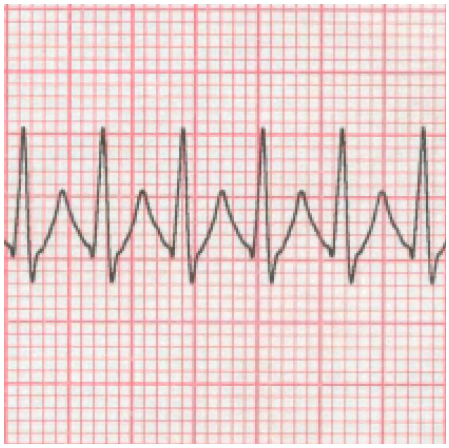
© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-330	Protocol Name: **Paroxysmal Supraventricular Tachycardia / PSVT**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Cardiac history.
- ✓ Heart rate above 150 BPM.
- ✓ Present chest pain or dyspnea.
- ✓ Level of consciousness.
- ✓ Congestive heart failure or pulmonary edema.
- ✓ Shock.
- ✓ Medications and allergies.

B Consider treatment if:
- ✓ Heart rate above 150 BPM and ECG reveals narrow-complex QRS.
- ✓ Severe chest pain.
- ✓ Congestive heart failure.
- ✓ Altered level of consciousness.
- ✓ Hypotension or shock.

B Apply cardiac monitor and obtain a 6-second ECG strip or 12 lead ECG if time permits.

A Consider oxygen to maintain SaO2 94-96%.

B Consider vagal maneuvers while establishing IV.

B2 Establish an IV in the antecubital fossa, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

P Administer Adenosine 6 mg rapid IV/IO (over 1 - 2 seconds).

P If no effect in 2 minutes, repeat Adenosine 12 mg, rapid IV/IO (over 1 - 2 seconds).

P If no effect in 2 minutes, repeat an additional Adenosine 12 mg, rapid IV/IO (over 1 - 2 seconds)

P If the patient is unstable do not delay Cardioversion
Consider Valium 2 – 5 mg IV/IM/IO if patient conscious and SBP > 100.
- ✓ Perform synchronized cardioversion at 50 J (monophasic) or 75 J (biphasic). If unsuccessful:
- ✓ Perform synchronized cardioversion at 100 J (monophasic) or 100 J (biphasic). If unsuccessful:
- ✓ Perform synchronized cardioversion at 200 J (monophasic) or 150 J (biphasic). If unsuccessful:
- ✓ Perform synchronized cardioversion at 360 J (monophasic) or 200 J (biphasic).

A Transport.

A Contact receiving hospital.

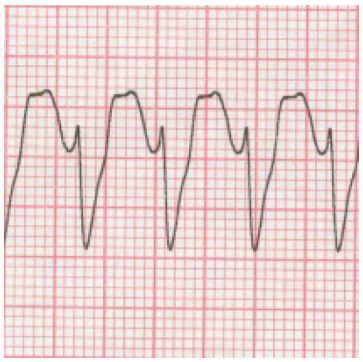
Note: If IV access is delayed, synchronized cardioversion may be performed prior to administration of adenosine. If patient becomes pulseless, immediately turn SYNC off and treat according to the appropriate protocol.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-340	Protocol Name: **Sustained Ventricular Tachycardia - Stable**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Cardiac history.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Ventricular tachycardia is confirmed.

B Apply cardiac monitor and obtain a 6-second ECG strip.
P If time permits and patient remains stable, confirm dysrhythmia with 12-lead ECG.

A Consider oxygen to maintain SaO2 94-96%.

P Confirm rhythm and presence of pulse. **If patient is pulseless, treat according to Ventricular Fibrillation protocol, B-370.**

P Establish an IV/IO, 0.9% NaCl, at 30 mL/hr.

P Consider Lidocaine 1 - 1.5 mg/kg IV After 5 minutes, if ventricular tachycardia is not resolved, administer an additional dose of Lidocaine, 0.75 - 1 mg/kg IV.
OR
Amiodarone 150 mg IV/IO over 10 minutes. May repeat in 10 minutes if not resolved.

P Initiate a Lidocaine drip at 2 - 4 mg / min if the patient converts with Lidocaine.
I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

P If ventricular tachycardia is not resolved after medication and Patient Symptomatic:
Consider Valium 2 – 5 mg IV/IM/IO if patient conscious and SBP > 100.
- ✓ Perform **synchronized** cardioversion at 50 J (monophasic or biphasic)

If unsuccessful,
- ✓ Perform **synchronized** cardioversion at 100 J (monophasic) or 120 J (biphasic).

If unsuccessful,
- ✓ Perform **synchronized** cardioversion at 200 J (monophasic) or 150 J (biphasic).

If unsuccessful,
- ✓ Perform **synchronized** cardioversion at 360 J (monophasic) or 200 J (biphasic).
- ✓ Manage the airway as necessary, and administer 100% oxygen.

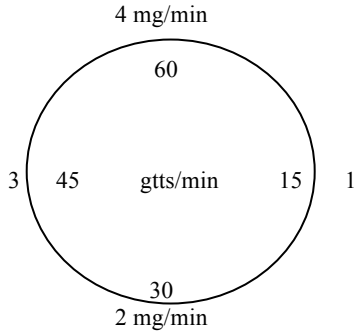
A Transport.

A Contact receiving facility.

Note: If at anytime, the patient converts to ventricular fibrillation, or becomes pulseless, immediately turn the synchronized mode off and refer to the Vfib/pulseless Vtach B-370.

Note: If at anytime, the patient becomes unstable, refer to the Ventricular Tachycardia – Unstable B-350.

Lidocaine Drip Clock:
4 mg/mL concentration
(2 gm in 500 mL bag 0.9% NaCl)

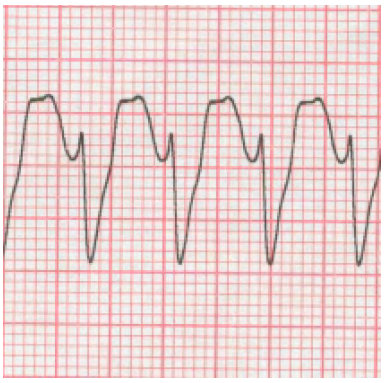


© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-350	Protocol Name: **Sustained Ventricular Tachycardia - Unstable**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Cardiac history.
- ✓ Medications and allergies.

A Consider treatment if ventricular tachycardia is confirmed, and:
- ✓ Hypotensive (systolic blood pressure below 90 mmHg).
- ✓ Chest pain.
- ✓ Congestive heart failure.
- ✓ Acute myocardial infarction.
- ✓ Pulmonary edema.
- ✓ Decreased level of consciousness.

B Apply cardiac monitor and obtain a 6-second ECG strip or 12 lead ECG.

P Interpret 12 lead ECG.

A Consider oxygen to maintain SaO2 94-96%.

P Confirm rhythm and presence of pulse.
If patient is pulseless, treat as Ventricular Fibrillation (B-370).

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

P
- ✓ Perform **synchronized** cardioversion at 100 J (monophasic or biphasic). If unsuccessful,
- ✓ Perform **synchronized** cardioversion at 200 J (monophasic) or 120 J (biphasic). If unsuccessful,
- ✓ Perform **synchronized** cardioversion at 300 J (monophasic) or 150 J (biphasic). If unsuccessful,
- ✓ Perform **synchronized** cardioversion at 360 J (monophasic) or 200 J (biphasic).

Manufacturer recommended energy levels may be given.

P Manage patient airway.

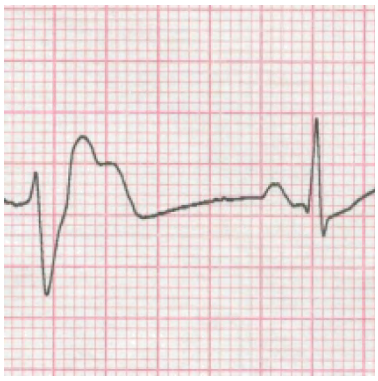
A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: B-360	Protocol Name: **Ventricular Ectopy / PVCs**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Cardiac history.
- ✓ Present chest pain or dyspnea.
- ✓ Medications and allergies.

P Consider treatment if one or more of the following conditions exist:
- ✓ Ectopy in a patient with active chest pain.
- ✓ Malignant PVCs (R-on-T phenomenon).
- ✓ Multiple PVCs (greater than 6 / minute).
- ✓ Couplets or short bursts of ventricular tachycardia.
- ✓ Multifocal PVCs.

Note: If heart rate is below 60 BPM, refer to the Bradycardia protocol, B-310.

B Apply cardiac monitor and obtain a 6-second ECG strip.

P If time permits and patient remains stable, confirm dysrhythmia with 12-lead ECG.

P If multifocal PVC's and the patient is symptomatic consider Lidocaine 1 mg/kg IV to a maximum of 100 mg IV.
Do NOT administer Lidocaine if second or third degree heart block is present.

A Consider oxygen to maintain SaO2 94-96%.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Transport.

A Contact receiving facility.

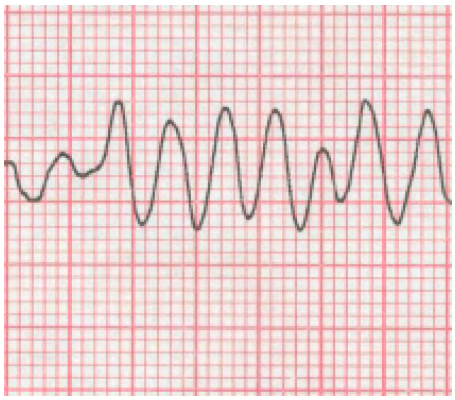
Note: If at any point, the rhythm deteriorates into ventricular fibrillation, refer to the Ventricular Fibrillation B-370.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-370	Protocol Name: **Ventricular Fibrillation / Pulseless V-Tach**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



P If patient is being monitored, and deteriorates into ventricular fibrillation or if downtime ≤ 4 minutes:
Defibrillate at 360 J (monophasic) or 200 J (biphasic).

P If patient is not being monitored:
Begin aggressive CPR at 30:2 (push hard, push fast).
After 5 cycles of CPR, defibrillate at 360 J (monophasic) or 200 J (biphasic).

A Immediately resume CPR and give 5 cycles of 30:2.

A During CPR, ventilate patient with 100% oxygen via BVM at 8 – 10 breaths/min.

B2 During CPR, establish IV access, 0.9% NaCl at 30 mL/hr.
P Establish IO.

P After 5 cycles of CPR, check rhythm. If no change, defibrillate at 360 J (monophasic) or 200 J (biphasic).

A Immediately resume aggressive CPR and give another 5 cycles of 30:2

P Administer Epinephrine (1:10,000), 1 mg IV/IO every 3 – 5 minutes.
OR
Vasopressin 40 units IV / IO (which replaces two doses of Epinephrine).

P Consider Calcium Chloride for wide-complex tachycardia in renal patients.

A If an advanced airway is in place:
Ventilate with 100% oxygen at 8 – 10 breaths/min. (Every 6 seconds).
Give continuous chest compressions without pausing for ventilations.

P If no change in rhythm, defibrillate at 360 J (monophasic) or 200 J (biphasic).

A Immediately resume aggressive CPR.

P Consider:
Lidocaine 1 - 1.5 mg/kg IV/IO. Up to two additional doses of Lidocaine 0.75 mg/kg IV must be administered every five minutes if ventricular fibrillation is not resolved, for a maximum dose of 3.0 mg/kg.
OR
Amiodarone 300 mg IV/IO. May repeat 150 mg.

P After 15 minutes of CPR, consider Sodium Bicarbonate, 1 mEq/kg IV/IO.

P Continue defibrillation at 360 J (monophasic) or 200 J (biphasic) every 3 – 5 minutes. Check for a change in the rhythm before each defibrillation.

A Rapid Transport. Contact receiving facility.
***For Post Resuscitative Management, refer to B-380**

If the recommended energy of the defibrillator differs from this protocol, paramedic may follow the manufacturer recommendation for energy settings.

Note: If at any point, the patient converts into any other rhythm, proceed to the appropriate protocol.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: B-380	Protocol Name: **Post Resuscitative Management**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date:

B Assess ABC's

I If hypotensive, bolus 20 mL/kg NS IV/IO.

P Continue airway management, or secure airway and ventilate appropriately.
Monitor SaO2. Maintain > 94%.
Ventilate 8 – 10 times per minute. Do not over ventilate.
Monitor ETCO2 and maintain 35 – 45 mm Hg.

B Obtain 12 lead ECG. Paramedic to interpret.

P If STEMI is present notify receiving facility. Transport immediately.

P Consider cooling the patient **IF** the patient can be transported to a facility that will continue treatment.

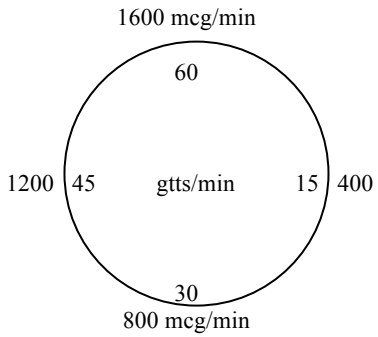
P If dysrhythmia persists, consider treatment. See appropriate dysrhythmia protocol.

P If hypotensive despite fluid bolus, consider dopamine.
Dopamine 2 – 20 mcg/kg/minute. Titrate for SBP > 100.

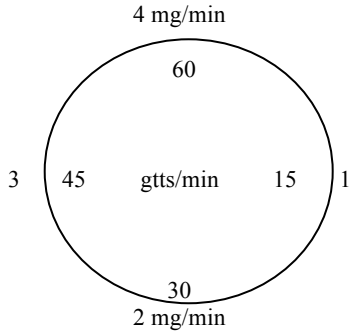
B Transport immediately.

Note:
If patient is hemodynamically unstable, refer to Cardiogenic Shock protocol, B-50.
If patient develops ventricular ectopy, refer to Ventricular Ectopy protocol, B-360.

Dopamine Drip Clock
Using 1600 mcg/mL concentration
(800 mg in 500 mL bag 0.9% NaCl)



Lidocaine Drip Clock:
4 mg/mL concentration
(2 gm in 500 mL bag 0.9% NaCl)



© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Quick Reference B390

Glasgow Coma Scale

EYE OPENING

4	Spontaneous
3	To Speech
2	To Pain
1	None

BEST MOTOR RESPONSE

6	Obeys Commands
5	Localizes Pain
4	Withdraws From Pain
3	Flexion Posture
2	Extensor Response at Elbows
1	None

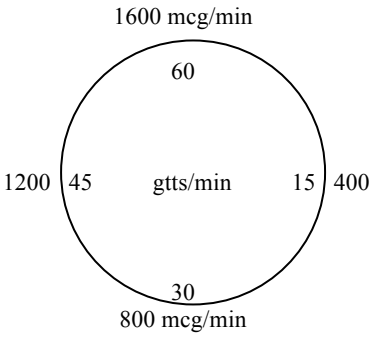
VERBAL RESPONSE

5	Oriented Conversation
4	Confused Conversation
3	Inappropriate Words
2	Incomprehensible Sounds
1	None

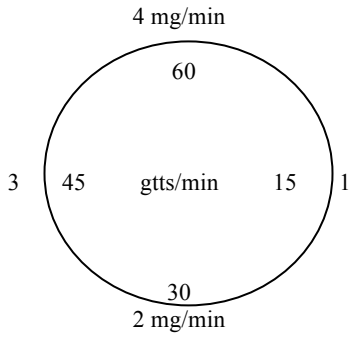
Dopamine Infusion Guidelines
Using 60 gtts/mL set and
1600 mcg/mL concentration

To administer 10 mcg/kg/min:	
30 kg	12 gtts/min
40 kg	15 gtts/min
50 kg	19 gtts/min
60 kg	23 gtts/min
70 kg	27 gtts/min
80 kg	30 gtts/min
90 kg	34 gtts/min
100 kg	38 gtts/min
110 kg	41 gtts/min
120 kg	45 gtts/min
130 kg	49 gtts/min
140 kg	53 gtts/min
150 kg	56 gtts/min

Dopamine Drip Clock
Using 1600 mcg/mL concentration
(800 mg in 500 mL bag 0.9% NaCl)



Lidocaine Drip Clock:
4 mg/mL concentration
(2 gm in 500 mL bag 0.9% NaCl)



© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: C-10	Protocol Name: **Pediatric Abuse / Assault**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Evaluate scene safety.
- ✓ Ensure Law Enforcement is notified and enroute.
- ✓ Mechanism of assault or abuse.
- ✓ Medications or allergies.

A Possible signs of abuse/assault:
- ✓ Child under 2 years of age with hot water burns or fractures.
- ✓ Mouth, facial, or genital injuries.
- ✓ Bilateral or symmetrical injuries.
- ✓ Injuries of different age (new and healing injuries).
- ✓ Poor nutrition, care, or hygiene.
- ✓ Delay in seeking treatment.
- ✓ Vague, inconsistent, or changing history.
- ✓ Child comatose, in shock, or in cardiac arrest.
- ✓ Abandoned elder or child, unable to care for self.

A If injured, refer to the appropriate protocol and treat related injuries.

A If abuse is suspected:
- ✓ Keep suspicions to yourself.
- ✓ Protect the patient.
- ✓ Convey impressions of abuse to law enforcement and hospital staff.
- ✓ Write a detailed, descriptive report. It will likely become a legal document.
- ✓ Do **NOT** make a diagnosis of abuse; simply describe findings in detail.

A If sexual assault is suspected:
- ✓ Take patient history from a medical standpoint.
- ✓ Act in a neutral, professional manner.
- ✓ Keep suspicions to yourself.
- ✓ Protect the patient.
- ✓ Convey impressions of assault/abuse to law enforcement and hospital staff.
- ✓ Write a detailed, descriptive report. It will likely become a legal document.
- ✓ The victim may prefer a medic of the same sex while enroute.
- ✓ Encourage victim **NOT** to change clothes or to bathe for preservation of evidence.
- ✓ If a struggle was involved, protect upper extremities with paper bags (Fig. 1)

A Transport to nearest, most appropriate facility.

A Contact receiving facility.

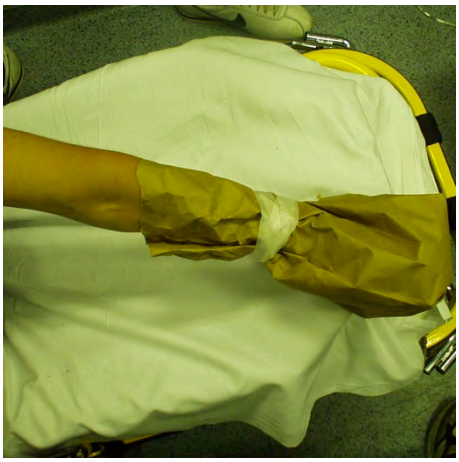


Figure 1: Paper bag covering hands.

© Sharon A Malone, MD

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-20	Protocol Name: **Pediatric Amputations**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.
- ✓ Control life-threatening hemorrhage.
- ✓ If applicable, treat other life-threatening injuries.

A Evaluate present and past medical history:
- ✓ Time of amputation.
- ✓ Mechanism of injury / amputation.
- ✓ Care of severed limb or body part.
- ✓ Bleeding disorders.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Place severed limb or body part in moist sterile gauze, in a plastic bag, and then place the bag on ice.

A Cover amputated limb with moist sterile gauze, splint, and elevate.

A If partial amputation, dress with moist, sterile gauze, and splint in anatomical alignment.

P Consider:
Morphine 0.1 mg/kg IV every 5 minutes as needed for pain (max 5mg)
OR
Fentanyl 1 – 2 mcg/kg IV/IM/IN/IO. Maximum of 100 mcg.
Consider Antiemetic as needed for nausea/vomiting.

Mean Arterial Pressure =

$$\frac{2 \times \text{Diastolic BP} + \text{Systolic BP}}{3}$$

A Transport.

A Contact receiving facility.

May use Weight/Length tape to determine medication dose if applicable.

To convert to kilograms:
Weight in pounds divided by 2, then subtract 10%

Example: weight 70 pounds. Divide by 2 = 35
Subtract 10 % = 31.5 kg (can round to 32 kg)

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-30	Protocol Name: **Pediatric Anaphylaxis / Allergic Reaction**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Exposure to allergens.
- ✓ Check patient for medic alert bracelet, tag, or necklace.
- ✓ Prevent environmental, food, and medication allergies.

A Consider treatment if patient has:
- ✓ Dyspnea
- ✓ Hives
- ✓ Wheezing
- ✓ Altered Mental Status
- ✓ Decreased Perfusion.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

P For **moderate allergic reactions**, dystonic reactions, or **if hives are present**:
- ✓ Consider Diphenhydramine 1 mg/kg IV/IM

I If hypotensive bolus 0.9% NaCl 20 mL/kg.

B If severe allergic reaction, consider
- ✓ Epi-Pen® JR

P For **severe allergic reactions**:
- ✓ For patients ages 8-12:
  - ✓ Administer Epinephrine (1:1,000), 0.2 mg **IM** or Epi-Pen® JR
  - ✓ Consider Diphenhydramine 1 mg/kg IV/IM/IO
  - ✓ Consider solumedrol 2 mg/kg IV/IM/IO
- ✓ For patients under the age of 8:
  - ✓ Administer Epinephrine (1:1,000), 0.1 mg **IM** or Epi-Pen® JR
  - ✓ Consider Diphenhydramine 1 mg/kg IV/IM
  - ✓ Consider solumedrol 2 mg/kg IV/IO/IM

P If patient is **hypotensive** (MAP < 65 mmHg):
- ✓ Establish a Dopamine drip, 2 – 20 mcg/kg/min to maintain a MAP of 65 mmHg.

A Transport.

A Contact receiving facility.

Dopamine Infusion Guidelines for Pediatrics using a 60 gtt/mL set at 280 mcg/mL concentration

To administer ~10 mcg/kg/min:	
2 kg	5 gtts/min
5 kg	10 gtts/min
7 kg	15 gtts/min
10 kg	20 gtts/min
12 kg	25 gtts/min
15 kg	30 gtts/min
17 kg	35 gtts/min
20 kg	40 gtts/min
23 kg	50 gtts/min
25 kg	55 gtts/min
≥ 30 kg	see adult guidelines

To make a concentration of 280 mcg/mL, withdraw 15 mL of Dopamine Pre-mix (1600 mcg/mL) and insert it into a buretrol set. Then fill the buretrol set with 85 mL of 0.9% NaCl which brings the total fluid level to 100 mL.

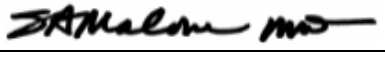
Mean Arterial Pressure =

$$\frac{2 \times \text{Diastolic BP} + \text{Systolic BP}}{3}$$

Administer epi in lateral thigh.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-40	Protocol Name: **Pediatric Burns**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of burns (chemical, thermal, etc.)
- ✓ Medications and allergies.

A Consider treatment if patient has:
- ✓ Partial thickness (second degree) burns.
- ✓ Full thickness (third degree) burns.
- ✓ Burns involving hands, face, eyes, ears, feet, or genitalia.
- ✓ Burns associated with fractures or other trauma.
- ✓ Electrical burns.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If patient is hypotensive bolus 20 mL/kg 0.9% NaCl.

A Place patient on dry sterile sheet.

A Cover burns with dry sterile dressings.

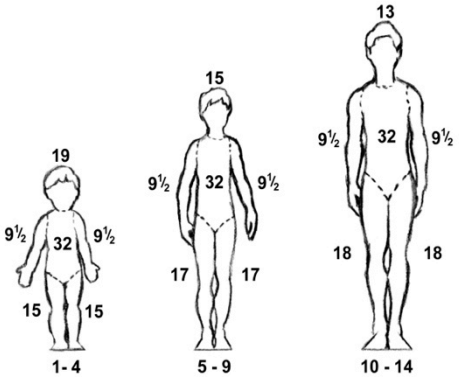


Figure 1: Pediatric Rule of Nines

P Consider:
Morphine 0.1 mg/kg IV/IM/IN/IO every 5 minutes as needed for pain. (Max 5mg).
OR
Fentanyl 1 – 2 mcg/kg IV/IM/IN/IO every 5 minutes for pain. (Max 100 mcg.)
Consider antiemetic for nausea/vomiting.

Maximum volume of morphine is one mL in each nostril. Do not exceed that volume.

A Ensure that other injuries are not overlooked, such as fractures, or lacerations.

A Transport to nearest, most appropriate facility.

A Contact receiving facility.

May use Weight/Length tape to determine medication dose if applicable.

To convert to kilograms:
Weight in pounds divided by 2, then subtract 10%

Example: weight 70 pounds. Divide by 2 = 35
Subtract 10 % = 31.5 kg (can round to 32 kg)

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-50	Protocol Name: **Pediatric Dead-On-Scene**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Evaluate scene safety upon approach to the scene.

A Complete primary assessment.

A Evaluate present and past medical history (when appropriate).

A Initiate CPR if:
- ✓ Patient down time is less than 20 minutes.
- ✓ Down time cannot be reliably determined.
- ✓ Asystole cannot be verified in two leads.
- ✓ Hypothermia is present.
- ✓ Any doubt exists.

A Do not resuscitate if injuries are incompatible with life, as defined as **pulseless** and:
- ✓ Burns to entire body.
- ✓ Decapitation.
- ✓ Decomposition.
- ✓ Gunshot wound to the head.
- ✓ Hemicorporectomy.
- ✓ Mass casualty incidents where resources are needed to treat living critical patients.
- ✓ Open head trauma.
- ✓ Post-mortem lividity.
- ✓ Rigor mortis.

P
- ✓ Penetrating injuries to the chest or head with asystole verified in two leads.

A If death is a result from vehicular or industrial accident:
- ✓ Do not move body unless it is necessary to resuscitate a living person, or if the body will be significantly destroyed by fire, explosion, etc.
- ✓ Cover body, if appropriate, or if directed by law enforcement personnel.
- ✓ Preserve the accident scene as best as possible.
- ✓ Keep spectators away from the immediate scene.
- ✓ Notify the dispatcher as soon as possible.
- ✓ Notify law enforcement.

A For deaths occurring at home, both naturally and homicide:
- ✓ Do not disturb anything.
- ✓ If scene is unstable, move to a position of safety.
- ✓ Notify the dispatcher as soon as possible.
- ✓ Document all findings and report to the first arriving officer any unusual or suspicious circumstances.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-60	Protocol Name: **Pediatric Diabetic Emergencies**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Last meal.
- ✓ Insulin type.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Altered level of consciousness.
- ✓ Blood sugar is abnormal. (blood glucose < 60 mg/dL or > 300 mg/dL)

A Consider oxygen to maintain SaO2 94-96%.

B Whenever possible, delay intubation until patient has been treated.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Perform blood glucose level test.

If hypoglycemic: (blood glucose < 60 mg/dL)

B
B2
I
- ✓ Administer Oral Glucose if patient is conscious and can swallow
- ✓ Establish an IV, 0.9% NaCl, at 30 mL/hr.
- ✓ Administer 25% Dextrose 2 mL/kg IV *

I If blood sugar level remains below 60 mg/dL:
- ✓ Administer additional 25% Dextrose 2 mL/kg IV *

B2 If hyperglycemic: (blood glucose > 300 mg/dL)
- ✓ Establish an IV, 0.9% NaCl at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 ml/kg IV.

B2 Perform additional blood glucose level tests as needed.

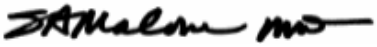
A Transport.

A Contact receiving facility.

* 25% Dextrose is made by diluting 50% Dextrose with an equal volume (1:1 solution) Normal Saline.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Protocol: C-70	Protocol Name: **Pediatric Drowning**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Evidence of trauma.
- ✓ Total downtime.
- ✓ Possibility of air embolism.
- ✓ Diving injury.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Unconscious.
- ✓ Altered level of consciousness.
- ✓ Known drowning (patient was resuscitated prior to arrival of EMS).

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr

I If hypotensive bolus 0.9% NaCl 20 ml/kg IV.

A Keep patient warm.

A Rapid transport.

A Contact receiving facility.

© Sharon A Malone, MD

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-80	Protocol Name: **Pediatric Envenomation / Spider or Snake Bite**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Type of bite.
- ✓ Location of injury.
- ✓ Time of bite or sting.

A Consider treatment if:
- ✓ Sting or bite.

Note: If signs and symptoms of an allergic reaction are noted, refer to Allergic Reaction protocol, C-30.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG.

A If a Black Widow spider bite:
- ✓ Apply a cold compress to the bite area.

A If a Snake Bite:
- ✓ Immobilize extremity.
- ✓ Do not apply cold compress.
- ✓ Identify the source of the bite if possible but do not delay transport.

A If a scorpion bite:
- ✓ Apply cold compress to bite area.

A If a Bee sting:
- ✓ Do not attempt to remove a remaining stinger.
- ✓ Apply a cold compress to the sting area.

P Consider:
Morphine 0.1 mg/kg IV/IM/IN/IO every 5 minutes as needed for pain. (Max 5 mg.)
OR
Fentanyl 1 – 2 mcg/kg IV/IM/IN/IO every 5 minutes for pain. (Max 100 mcg.)
Consider antiemetic.

A Transport.

A Contact receiving facility.

Cottonmouth

Copperhead

Texas Coral Snake

Red on yellow, kill a fellow,
Red on black, venom lack.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-90	Protocol Name: **Pediatric Fracture / Dislocation**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of injury.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Suspected closed fracture / dislocation.
- ✓ Open fracture / dislocation.
- ✓ Pain and deformity.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive, bolus 0.9% NaCl 20 mL/kg.

A Check for pulse distal and proximal to fracture or dislocation, and capillary refill.

A Immobilize the joint above and below the fracture or dislocation.

A Protect any exposed bone ends, and dress / bandage all open wounds prior to splinting.

A Splint in the position found. See splinting procedure.

A For closed, mid-shaft femur fractures, apply traction splint.

P Consider:
Morphine 0.1 mg/kg IV/IM/IO/IN every 5 minutes for pain. (Max 5 mg).
OR
Fentanyl 1 – 2 mcg/kg IV/IM/IN/IO every 5 minutes for pain. (Max 100 mcg.)
Consider antiemetic.

P For dislocations or severely angulated fractures associated with swelling, distal pulselessness, or paresthesia:
- ✓ Reposition the limb in anatomical alignment.
- ✓ Gently apply traction and counter-traction.
- ✓ Move limb to attempt to regain distal pulse.
- ✓ Attempt movement only once, and if unsuccessful, transport as soon as possible.

A Transport.

A Contact receiving facility.

Use Weight/Length tape for medication dose if applicable.
To convert to kilograms:
Weight in pounds divided by 2, then subtract 10%

Example: weight 70 pounds. Divide by 2 = 35
Subtract 10 % = 31.5 kg (can round to 32 kg)

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: C-100	Protocol Name: Pediatric **Heat Related Emergencies**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of heat related emergency.
- ✓ Medications or allergies.

P Consider treatment if:
- ✓ Altered level of consciousness.
- ✓ Elevated temperature related to external environment.
- ✓ Moderate to severe abdominal cramps.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG.

B2 Establish an IV, 0.9% NaCl at 30 mL/hr.

I Bolus 0.9% NaCl 20 ml/kg IV. Repeat bolus if indicated.

A Cool the patient.

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-110	Protocol Name: **Pediatric Nausea / Vomiting**	
Page 1 of 1	Effective Date: January 26, 2004	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Recent illness / infection.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ No altered level of consciousness.
- ✓ Nausea with active & persistent vomiting is present.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

B2 Perform a blood glucose level test.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If blood sugar level is below 60 mg/dL:
Administer 25% Dextrose 2 mL/kg * IV / IO

P Consider
Zofran (ondansetron) Oral Disintegrating Tablet:
2 mg ODT age 2 – 4 years.
4 mg ODT if > 4 years old to age 11
8 mg ODT if > 11 years old
OR
Zofran (ondansetron) 0.15 mg/kg IV/IM/IO for Age > 2 months. (Max 4 mg.)
OR
Reglan (metoclopramide) 0.1 mg/kg IV/IM/IO Age > 3 months. (Max 5 mg.)

A Keep patient NPO.

I If signs of dehydration (dry mucous membranes, anuria, poor skin turgor):
- ✓ Bolus 0.9% NaCl 20 mL/kg. May repeat bolus if indicated.

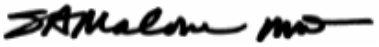
A Transport.

A Contact receiving facility.

* 25% Dextrose is made by diluting 50% Dextrose with an equal volume (1:1 solution) Normal Saline.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-120	Protocol Name: **Pediatric Non-Traumatic Shock - Unknown Etiology**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ History of ulcers.
- ✓ Recent illness / infection.
- ✓ Medications or allergies.

P Consider treatment if:
- ✓ Hypotension.
- ✓ Tachycardia.
- ✓ Pale, clammy skin.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 12 lead ECG.

P Interpret ECG.

B2 Perform a blood glucose level test.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

P If unable to establish IV after 2 attempts or 60 seconds, establish IO.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

I If blood sugar level is below 60 mg/dL and the patient is symptomatic:
- ✓ Administer 25% Dextrose 2 mL/kg *

B2 If systolic blood pressure is below 70 mmHg, and the patient is symptomatic:
- ✓ Establish a second IV of 0.9% NaCl at 30 mL/hr.

P If the systolic blood pressure decreases with fluid therapy at any point:
- ✓ Initiate a Dopamine drip, 2 – 20 mcg/kg/min to maintain a MAP of 65 mmHg.

A Transport.

A Contact receiving facility.

* 25% Dextrose is made by diluting 50% Dextrose with an equal volume (1:1 solution) Normal Saline.

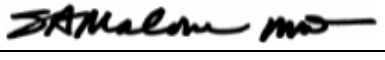
Dopamine Infusion Guidelines for Pediatrics using a 60 gtt/mL set at 280 mcg/mL concentration**

To administer ~10 mcg/kg/min:	
2 kg	5 gtts/min
5 kg	10 gtts/min
7 kg	15 gtts/min
10 kg	20 gtts/min
12 kg	25 gtts/min
15 kg	30 gtts/min
17 kg	35 gtts/min
20 kg	40 gtts/min
23 kg	50 gtts/min
25 kg	55 gtts/min
≥ 30 kg	see adult guidelines

**To make a concentration of 280 mcg/mL, withdraw 15 mL of Dopamine Pre-mix (1600 mcg/mL) and insert it into a buretrol set. Then fill the buretrol set with 85 mL of 0.9% NaCl which brings the total fluid level to 100 mL.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-130	Protocol Name: **Pediatric Overdose / Poisoning**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Name of substance taken.
- ✓ Amount of substance taken.
- ✓ Time at which substance was taken.

Bring all bottles and containers of possible ingestants with the patient.

Do not delay transport.

A Consider treatment if:
- ✓ Decreased level of consciousness.
- ✓ Unresponsive or unconscious.
- ✓ History of narcotic / opiate abuse.
- ✓ History of cyanide poisoning, phenothiazine reaction, or envenomation.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG.

B2 Perform a blood glucose level test.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

I If blood sugar level is below 60 mg/dL:
- ✓ Administer 25% Dextrose 2 mL/kg *

I If narcotic involvement is suspected:
- ✓ Consider Naloxone 0.2 - 2 mg slow IV if pt > 4 yo or > 20 kg (max dose 2 mg).
- ✓ Consider Naloxone 0.1 mg/kg if pt is < 5 yo or < 20 kg (max dose 2 mg).
- ✓ May administer Intranasal for first 2 mg. Total IN volume only 1 mL/nostril.

Titrate Naloxone for respiratory depression.

P If suspected dystonic reaction:
- ✓ Consider Diphenhydramine 1 mg/kg IV/IM

P If suspected organophosphate poisoning, and symptomatic patient (bradycardia, salivation, lacrimation, etc.):
- ✓ Consider Atropine 0.05 mg/kg IV/IO.
- ✓ Minimum single dose is 0.1 mg.
- ✓ Maximum dose is 1 mg IV.

Atropine in dose of less than 0.1 mg can cause paradoxical bradycardia.

A Contact Poison Control – **1-800-222-1222**, and follow instructions.

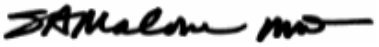
A Transport.

A Contact receiving facility.

* 25% Dextrose is made by diluting 50% Dextrose with an equal volume (1:1 solution) Normal Saline.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Protocol: C-140	Protocol Name: **Pediatric Psychiatric Emergencies**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.
- ✓ Attempt to have law enforcement on scene prior to patient contact.

A Evaluate present and past medical history:
- ✓ Diagnosed disease or disorder.
- ✓ Precipitating events.
- ✓ Recreational drug use.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Any injuries.
- ✓ Possible drug overdose (refer to appropriate protocol).
- ✓ Stated or alluded suicidal or homicidal ideation.

A Identify yourself and attempt to develop a rapport with the patient and parent or caregiver.

A Be calm and reassuring while attempting to obtain information from the patient or parent.

A Act in a neutral, professional manner. Do not respond to anger. Instead, use tact and firmness, and attempt to gain control of the situation.

P Consider Valium (diazepam) 0.05 – 0.1 mg/kg IV/IM/IO/IN. Max 10 mg.
- ✓ Monitor for hypotension or decreased respiratory effort.
- ✓ Maximum of 5 mg.

A Use all resources necessary to safely care for the patient.

Note: Always consider the rescuer's safety first!

A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-150	Protocol Name: **Pediatric Respiratory Distress**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Previous home breathing treatments.
- ✓ Past cardiac history.
- ✓ Past respiratory problems.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Tachypnea, dyspnea, wheezing.
- ✓ Diaphoretic, tachycardic, pale.
- ✓ Use of accessory muscles during inspiration.
- ✓ Unable to speak.
- ✓ Prolonged forced exhalation.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing.

A If applicable, encourage the patient to a sitting or upright position to aid their respiratory effort.

B Administer Albuterol 2.5 mg in 3 mL NaCl, via nebulizer mask at 6 lpm

A Reassess patient's respiratory efforts and vital signs.

A If treatment is successful, add 3 – 5 cc NaCl to nebulizer for humidified oxygen.

B Repeat the albuterol as needed to improve the breathing.

B If no improvement, or patient has decreased level of consciousness or loses consciousness:
- ✓ Perform airway management procedure and assist ventilations with BVM.

P If severe bronchoconstriction and severe respiratory distress despite albuterol nebs:
- ✓ Consider Epinephrine (1:1,000), 0.1mg IM (Max 0.3 mg)

B2 If patient condition does not improve, establish an IV, 0.9% NaCl, at 30 mL/hr.

P If respiratory arrest occurs and IV access is unobtainable after 2 attempts or 60 seconds, establish IO access, 0.9% NaCl, at 30 mL/hr, bolus 20 mL/kg if patient is hypotensive.

A Transport.

A Contact receiving facility.

Figure 1: Pediatric NRB

Figure 2: Albuterol Treatment

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-160	Protocol Name: **Pediatric Seizures**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Previous head injury.
- ✓ Fever.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Patient is actively seizing.
- ✓ Patient is in post-ictal state, characterized by lethargy, altered mental status, etc.

A Consider airway management procedure including nasopharyngeal airway.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

P If patient is actively seizing: Administer:
- ✓ Valium (diazepam) 0.1 – 0.2 mg/kg IV/IM/IO/IN Max 10 mg.

OR
- ✓ Versed (midazolam) 0.05 – 0.1 mg/kg IV/IM/IO/IN if valium ineffective. Max 5 mg.

May use **Weight/Length Tape** for weight and drug dosages.

B2 Perform blood glucose level test.

I If blood sugar level is below 60 mg/dL:
Administer 25% Dextrose 2 mL/kg IV or IO *

* 25% Dextrose is made by diluting 50% Dextrose with an equal volume (1:1 solution) of Normal Saline.

P If narcotic involvement is suspected:
Consider Naloxone 0.2 - 2 mg IV/IO/IM/IN for pt > 4 yo or > 20 kg (max dose 2 mg).
Consider Naloxone 0.1 mg/kg IV/IO/IM/IN for pt is < 5 yo or < 20 kg (max dose 2 mg).

May administer Intranasal for first 2 mg.
Total IN volume only 1 mL/nostril.

P If the patient is febrile:
Consider Tylenol rectally (if available) and cool patient.

Tylenol 15 mg/kg (Optional)

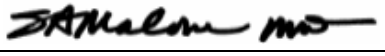
P If suspected dystonic reaction:
Consider Diphenhydramine 1 mg/kg IV/IM (max 50 mg).

A Rapid Transport to closest facility.
A Contact receiving facility.

Weight Length Tape	Weight	Diazepam IV
Gray	**3-4-5 kg**	**0.6 - 0.8 - 1 mg**
Pink	**6-7 kg**	**1.3 mg**
Red	**8-9 kg**	**1.7 mg**
Purple	**10-11 kg**	**2 mg**
Yellow	**12-14 kg**	**2.6 mg**
White	**15-18 kg**	**3.3 mg**
Blue	**19-22 kg**	**4.2 mg**
Orange	**24-28 kg**	**5.3 mg**
Green	**30-36 kg**	**6.6 mg**

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Protocol: C-170	Protocol Name: **Pediatric Spinal / Neurological Shock (Head Injuries)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of injury.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Neurological deficit, with obvious head injury.
- ✓ Hemodynamically unstable.

If the patient is conscious and alert:

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG if available.

A Immobilize and secure patient to spinal immobilization device. If patient has suspected head injury, elevate head of the backboard approximately 30 degrees.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg.

P If patient has signs of isolated spinal cord injury (hypotension and bradycardia): Start Dopamine drip, 2 – 20 mcg/kg/min titrated to maintain a MAP of 65 mmHg.

A Transport.

A Contact receiving facility.

Mean Arterial Pressure =

$$\frac{2 \times \text{Diastolic BP} + \text{Systolic BP}}{3}$$

Dopamine Infusion Guidelines for Pediatrics using a 60 gtt/mL set at 280 mcg/mL concentration

To administer ~10 mcg/kg/min:

2 kg	5 gtts/min
5 kg	10 gtts/min
7 kg	15 gtts/min
10 kg	20 gtts/min
12 kg	25 gtts/min
15 kg	30 gtts/min
17 kg	35 gtts/min
20 kg	40 gtts/min
23 kg	50 gtts/min
25 kg	55 gtts/min
≥ 30 kg	see adult guidelines

To make a concentration of 280 mcg/mL, withdraw 15 mL of Dopamine Pre-mix (1600 mcg/mL) and insert it into a buretrol set. Then fill the buretrol set with 85 mL of 0.9% NaCl which brings the total fluid level to 100 mL.

© Sharon A Malone, MD

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-180	Protocol Name: **Pediatric Trauma**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Mechanism of injury.
- ✓ Medications or allergies.

P Consider treatment if:
- ✓ Systolic blood pressure is below 80 mmHg, with signs and symptoms of shock.
- ✓ Suspected blunt / penetrating chest or abdominal trauma associated with signs and symptoms of shock.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

A Consider BTLS transport criteria.

A Perform Motion Restriction /spinal immobilization procedure.

A Perform rapid secondary survey.

B Apply cardiac monitor and obtain a 6-second ECG strip.

P Establish an IV/IO, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

B2 Establish a second IV while enroute to receiving facility or while awaiting extrication or aeromedical transport. Continue to monitor vital signs every 3 – 5 minutes.

A Transport.

A Contact receiving facility.

P **Note: If tension pneumothorax is suspected, consider chest needle decompression.**

P **Consider rapid transport to a trauma facility if:**
- ✓ **Blunt / penetrating trauma with signs and symptoms of shock.**
- ✓ **Head / neck trauma with signs and symptoms of shock.**
- ✓ **High-velocity impact.**
- ✓ **Rapid acceleration / deceleration.**
- ✓ **Motor vehicle accidents with death of an occupant in the same vehicle.**

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-190	Protocol Name: **Pediatric Unconscious / Unknown Emergency**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Recreational drug use.
- ✓ Cardiac history.
- ✓ Medications or allergies.

A Consider treatment if:
- ✓ Unconscious with unknown etiology.

A Consider trauma and immobilize the patient appropriately if indicated.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor, and obtain 3 lead 6-second ECG tracing, or 12 lead ECG if available.

B2 Perform blood glucose level test.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV/IO

I If blood glucose level is below 60 mg/dL:
- ✓ Administer 25% Dextrose 2 mL/kg *

I If narcotic involvement is suspected:
- ✓ Consider Naloxone 0.2 - 2 mg IV/IO /IN if pt > 4 yo or > 20 kg (max 4 mg).
- ✓ Consider Naloxone 0.1 mg/kg IV/IO /IN if pt is < 5 yo or < 20 kg (max 2 mg).
- ✓ May administer Intranasal for first 2 mg. Total IN volume only 1 mL/nostril.

B2 If no response is noted in 3 – 5 minutes:
- ✓ Perform a second blood glucose level test in the opposite arm.

I If blood glucose level remains below 60 mg/dL:
- ✓ Administer a second dose of 25 % Dextrose 2 mL/ kg.

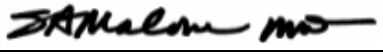
A Transport.

A Contact receiving facility.

* 25% Dextrose is made by diluting 50% Dextrose with an equal volume (1:1 solution) of Normal Saline for injection.

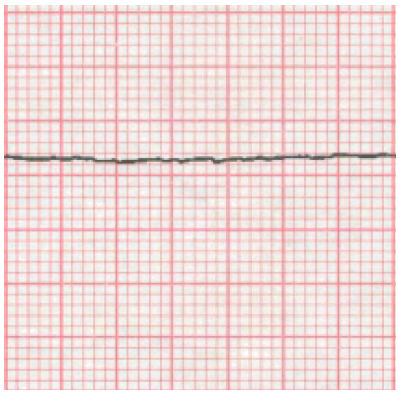
© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-200	Protocol Name: **Pediatric Asystole / Pulseless Electrical Activity (P.E.A.)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



A Complete primary assessment.
- ✓ Initiate aggressive CPR with BVM and 100% oxygen.

A Evaluate present and past medical history:
- ✓ Congenital disorders.
- ✓ Current down time.

B P Apply cardiac monitor (quick-look) and obtain a 6-second ECG strip:
- ✓ Confirm asystole in leads I and II, or II and III.
- ✓ Attach monitor with leads or Quick Combo ® pads.

A If unclear or uncertain, treat as **Ventricular Fibrillation, protocol C-260**.

A Resume CPR immediately – minimize interruptions in chest compression.

A Administer 100% oxygen via BVM.

I If blood glucose less than 60 mg/dL administer D25 1 mg/kg IV/IO *

P Establish IO access.

P Consider advanced airway management as indicated if BVM is not effective.

P Administer Epinephrine (1:10,000), 0.01 mg/kg (0.1 mL/kg) IV/IO, max 1 mg. Repeat every 3 – 5 minutes.

P Reassess effectiveness of CPR, ET placement, IV placement.

B2 Perform blood glucose evaluation.

I If blood glucose remains below 60, repeat the dose of D25*

B Consider and treat other possible causes:
- ✓ Hypoxia.
- ✓ Hyperkalemia.
- ✓ Hypovolemia.
- ✓ Hypothermia.
- ✓ Acidosis.
- ✓ Drug overdose.

A Rapid Transport.

A Contact receiving facility.

* 25% Dextrose is made by diluting 50% Dextrose with an equal volume (1:1 solution) Normal Saline.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-210	Protocol Name: **Pediatric Bradycardia**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Congenital disorders.
- ✓ Syncope.
- ✓ Pacemaker.
- ✓ Medications and allergies.

A Consider oxygen to maintain SaO2 94-96%.

B Apply cardiac monitor and obtain a 6-second ECG strip or 12 lead ECG.

P Establish an IV/IO, 0.9% NaCl, at 30 mL/hr.

I Consider bolus 0.9% NaCl 20 mL/kg IV/IO.

A If HR < 60/min despite oxygenation and ventilation, perform CPR.

P Administer Epinephrine 0.01 mg/kg IV/IO (1:10,000). Repeat every 3 – 5 minutes.*

P If bradycardia present and patient is symptomatic:
- ✓ Consider Atropine 0.02 mg/kg IV/IO.
- ✓ May repeat once.
- ✓ Minimum single dose 0.1 mg, and maximum single dose is 0.5 mg.

P If no improvement is noted after pharmacological therapy and patient is still symptomatic:
- ✓ Begin external pacing.
- ✓ Set pacing rate at 100 BPM, and press start.
- ✓ Increase the current in 5 mA increments until mechanical and electrical capture is noted.

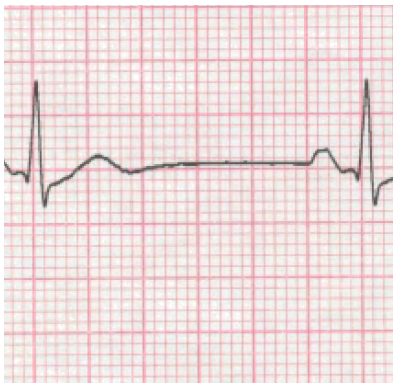
P If the patient's MAP is below 65 mmHg:
- ✓ Infuse Dopamine 2 – 20 mcg/kg/min, titrated to maintain a MAP of 65 mmHg.

A Transport.

A Contact receiving facility.

May use Weight/Length tape for drug dosages.

Heart block in symptomatic patient requires immediate pacing.



Dopamine Infusion Guidelines for Pediatrics using a 60 gtt/mL set at 280 mcg/mL concentration***

To administer ~10 mcg/kg/min:	
2 kg	5 gtts/min
5 kg	10 gtts/min
7 kg	15 gtts/min
10 kg	20 gtts/min
12 kg	25 gtts/min
15 kg	30 gtts/min
17 kg	35 gtts/min
20 kg	40 gtts/min
23 kg	50 gtts/min
25 kg	55 gtts/min
≥ 30 kg	see adult guidelines

***To make a concentration of 280 mcg/mL, withdraw 15 mL of Dopamine Pre-mix (1600 mcg/mL) and insert it into a buretrol set. Then fill the buretrol set with 85 mL of 0.9% NaCl which brings the total fluid level to 100 mL.

Mean Arterial Pressure =

$$\frac{2 \times \text{Diastolic BP} + \text{Systolic BP}}{3}$$

© Sharon A Malone, MD

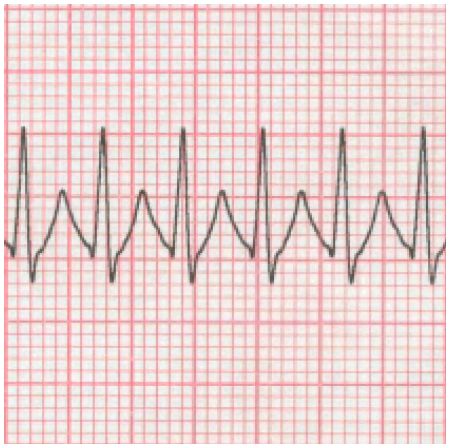
Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-220	Protocol Name: **Pediatric Paroxysmal Supraventricular Tachycardia / PSVT**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Congenital disorders.
- ✓ Heart rate above > 220 BPM in infants & > 180 BPM in children.
- ✓ Present chest pain or dyspnea.
- ✓ Level of consciousness.
- ✓ Shock.
- ✓ Medications and allergies.



A Consider treatment if:
- ✓ Heart rate above 220 BPM.
- ✓ Severe chest pain.
- ✓ Altered level of consciousness.
- ✓ Hypotension or shock.

B Apply cardiac monitor and obtain a 6-second ECG strip.

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

A Consider vagal maneuvers

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

P Administer Adenosine 0.1 mg/kg rapid IV (over 1 - 2 seconds). Max first dose 6 mg.

P If no effect in 2 minutes, Adenosine 0.2 mg/kg, rapid IV (over 1 - 2 seconds). Maximum second dose 12 mg.

P Reassess hemodynamic stability. If patient is hemodynamically unstable:
- ✓ If patient is conscious, consider with Valium 0.1 mg/kg IV (Max 5 mg).
- ✓ Perform synchronized cardioversion at 0.5 J/kg. If unsuccessful:
- ✓ Perform synchronized cardioversion at 1 J/kg. If unsuccessful:
- ✓ Perform synchronized cardioversion at 2 J/kg.

A Transport.

A Contact receiving facility.

Note: If IV access is delayed, synchronized cardioversion may be performed prior to administration of adenosine. If patient becomes pulseless, immediately turn SYNC off and treat according to the appropriate protocol.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

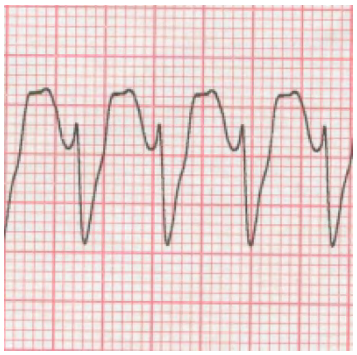
Protocol: C-230	Protocol Name: **Pediatric Sustained Ventricular Tachycardia (Stable)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Cardiac history.
- ✓ Medications and allergies.

A Consider treatment if:
- ✓ Ventricular tachycardia is confirmed.

B Apply cardiac monitor and obtain a 6-second ECG strip or 12 lead ECG.



A Consider oxygen to maintain SaO2 94-96%.

P Confirm rhythm and presence of pulse. **If patient is pulseless, treat according to Ventricular Fibrillation protocol, C-260.**

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

P Consider Lidocaine 1 mg/kg IV/IO. (Max 100mg) After 5 minutes, if ventricular tachycardia is not resolved, consider an additional dose of Lidocaine, 1 mg/kg IV/IO. Max 100 mg.

P After 5 minutes, if ventricular tachycardia is not resolved, one additional dose may be given of Lidocaine, 1 mg/kg IV, maximum dose of 3.0 mg/kg.

P Consider Lidocaine drip at 20 – 50 mcg/kg/min if the bolus was effective.

P If ventricular tachycardia is not resolved after pharmacologic therapy:
- ✓ Consider Valium 0.1 mg/kg IV (Max 5 mg) if SBP normal for age.
- ✓ Perform **synchronized** cardioversion at 0.5 J/kg. If unsuccessful,
- ✓ Perform **synchronized** cardioversion at 1 J/kg. If unsuccessful,
- ✓ Perform **synchronized** cardioversion at 2 J/kg. If unsuccessful,
- ✓ Manage airway appropriately and administer 100% oxygen.

A Rapid Transport.

A Contact receiving facility.

Note: If at anytime, the patient converts to ventricular fibrillation, or becomes pulseless, immediately turn the synchronized mode off and refer to the appropriate protocol.

Note: If at anytime, the patient becomes unstable, refer to the Ventricular Tachycardia – Unstable protocol, C-240.

Lidocaine Infusion Guidelines for Pediatrics using 60 gtts/mL set and 900 mcg/mL concentration*

To administer 30 mcg/kg/min:	
3 kg	6 gtts/min
5 kg	10 gtts/min
8 kg	16 gtts/min
10 kg	20 gtts/min
13 kg	26 gtts/min
15 kg	30 gtts/min
18 kg	36 gtts/min
20 kg	40 gtts/min
23 kg	46 gtts/min
25 kg	50 gtts/min
28 kg	56 gtts/min
30 kg	60 gtts/min

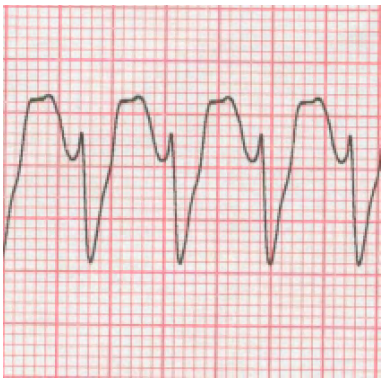
*To make 900 mcg/mL concentration, mix 90 mg (4.5 mL of 20 mg/mL) of Lidocaine into 100 mL NS.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-240	Protocol Name: **Pediatric Sustained Ventricular Tachycardia - Unstable**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Cardiac history.
- ✓ Medications and allergies.

A Consider treatment if ventricular tachycardia is confirmed, and:
- ✓ Hypotension (systolic blood pressure below 90 mmHg).
- ✓ Chest pain.
- ✓ Respiratory distress.
- ✓ Pulmonary edema.
- ✓ Decreased level of consciousness.

A Consider oxygen to maintain SaO2 94-96%.

P Confirm rhythm and presence of pulse.
If patient is pulseless, treat as Ventricular Fibrillation C-260.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV/IO.

P
- ✓ Perform **synchronized** cardioversion at 0.5 J/kg. If unsuccessful,
- ✓ Perform **synchronized** cardioversion at 1 J/kg. If unsuccessful,
- ✓ Perform **synchronized** cardioversion at 2 J/kg.

B2 Manage airway and administer 100% oxygen.

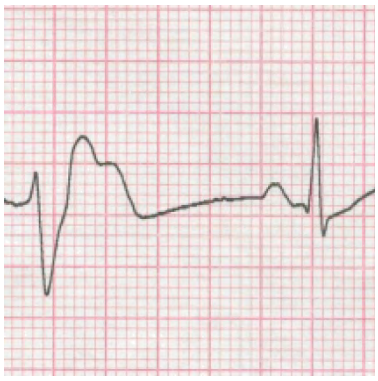
A Transport.

A Contact receiving facility.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: C-250	Protocol Name: **Pediatric Ventricular Ectopy / PVCs**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



A Complete primary assessment.

A Evaluate present and past medical history:
- ✓ Cardiac history.
- ✓ Present chest pain or dyspnea.
- ✓ Medications and allergies.

P Consider treatment if one or more of the following conditions exist:
- ✓ Ectopy in a patient with active chest pain.
- ✓ Malignant PVCs (R-on-T phenomenon).
- ✓ Couplets or short bursts of ventricular tachycardia.
- ✓ Multifocal PVCs.

Note: If heart rate is below 80 BPM, refer to the Bradycardia protocol, C-210.

B Apply cardiac monitor and obtain a 6-second ECG strip.
- ✓ Perform 12-lead if time permits

A Consider airway management procedure.

A Consider oxygen to maintain SaO2 94-96%.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

I If hypotensive bolus 0.9% NaCl 20 mL/kg IV.

A Transport.

A Contact receiving facility.

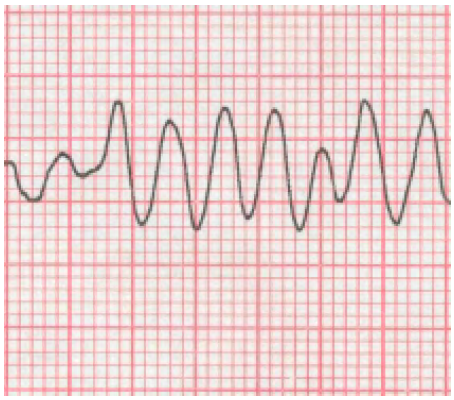
Note: If at any point, the rhythm deteriorates into ventricular fibrillation, refer to the Ventricular Fibrillation protocol, C-260.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-260	Protocol Name: **Pediatric Ventricular Fibrillation / Pulseless V-Tach**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014



P If patient is being monitored, and deteriorates into ventricular fibrillation:
- ✓ Defibrillate at 2 J/kg

P If patient is not being monitored and found pulseless:
- ✓ Immediately begin aggressive CPR (1 person 30:2 or 2 person 15:2).
- ✓ After 5 cycles of CPR, check rhythm. If unchanged,
- ✓ Defibrillate at 2 J/kg.

A Give 5 cycles of CPR. Do NOT interrupt compressions for greater than 10 seconds.

P During CPR, establish an IV/IO, 0.9% NaCl, at 30 mL/hr.

P Consider IO access early.
Bolus 0.9% NaCl 20 mL/kg IV/IO.

A If there is a change in rhythm, check pulse and refer to the appropriate protocol.

P If no change in the rhythm, defibrillate at 4 J/kg.

A Immediately continue CPR for another 5 cycles.

B2 Begin airway management procedure.*

P Administer Epinephrine, (1:10,000), 0.01 mg/kg max 1 mg IV/IO. Repeat every 3 – 5 minutes.

A After 5 cycles of CPR, check rhythm. If rhythm is not shockable, refer to the appropriate protocol.

P If no change in rhythm, defibrillate at 4 J/kg

A Resume CPR immediately. Do not allow interruptions of compressions for more than 10 seconds.

P Administer Lidocaine 1 mg/kg IV/IO.
Defibrillate after circulating. May repeat lidocaine 1 mg/kg IV/IO to a maximum dose of 3.0 mg/kg.
OR
Amiodarone 5 mg/kg IV/IO. May repeat twice.

P Continue defibrillation at 4 J/kg every 3 – 5 minutes. Check for a change in the rhythm BEFORE each defibrillation.

A Transport pediatric arrest immediately.

A Contact receiving facility.

Note: If at any point, the patient converts into any other rhythm, proceed to the appropriate protocol.

*Once an advance airway is inserted, "cycles" of CPR are not required. Give continuous compression at 100 beats/min and ventilations at 10 - 12 breaths/min.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: C-270	Protocol Name: **Pediatric Post Resuscitative Management**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A Repeat assessment.

A Continue oxygen to maintain SaO2 96-98%.

B Apply cardiac monitor, and obtain 6-second ECG tracing, or 12 lead ECG.

B2 Establish an IV, 0.9% NaCl, at 30 mL/hr.

P Consider Lidocaine drip at 20 to 50 mcg/kg per minute if bolus was effective.

Lidocaine Infusion Guidelines for Pediatrics using 60 gtts/mL set and 900 mcg/mL concentration*

To administer 30 mcg/kg/min:	
3 kg	6 gtts/min
5 kg	10 gtts/min
8 kg	16 gtts/min
10 kg	20 gtts/min
13 kg	26 gtts/min
15 kg	30 gtts/min
18 kg	36 gtts/min
20 kg	40 gtts/min
23 kg	46 gtts/min
25 kg	50 gtts/min
28 kg	56 gtts/min
30 kg	60 gtts/min

*To make 900 mcg/mL concentration, mix 90 mg (4.5 mL of 20 mg/mL) of Lidocaine into 100 mL 0.9% NaCl.

P If hemodynamically unstable:
- ✓ Begin Dopamine infusion at 2 – 20 mcg/kg/min IV/IO.

A Constantly monitor the patient, remaining prepared to defibrillate if necessary.

A Transport.

A Contact receiving facility.

Note:
If patient develops ventricular ectopy, refer to Ventricular Ectopy protocol, C-250.

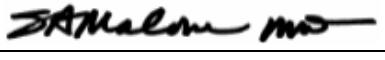
Dopamine Infusion Guidelines for Pediatrics using a 60 gtt/mL set at 280 mcg/mL concentration**

To administer ~10 mcg/kg/min:	
2 kg	5 gtts/min
5 kg	10 gtts/min
7 kg	15 gtts/min
10 kg	20 gtts/min
12 kg	25 gtts/min
15 kg	30 gtts/min
17 kg	35 gtts/min
20 kg	40 gtts/min
23 kg	50 gtts/min
25 kg	55 gtts/min
≥ 30 kg	see adult guidelines

**To make a concentration of 280 mcg/mL, withdraw 15 mL of Dopamine Pre-mix (1600 mcg/mL) and insert it into a buretrol set. Then fill the buretrol set with 85 mL of 0.9% NaCl which brings the total fluid level to 100 mL.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013



Pediatric Quick Reference

Glasgow Coma Scale

EYE OPENING

4	Spontaneous
3	To Speech
2	To Pain
1	None

BEST MOTOR RESPONSE

6	Infant moves purposefully
5	Infant withdraws from touch
4	Infant withdraws from pain
3	Decorticate response
2	Decerebrate response
1	None

VERBAL RESPONSE

5	Infant coos or babbles
4	Infant is irritable and continually cries
3	Infant cries to pain
2	Infant moans to pain
1	None

Quick Calculations

Weight in kg: (2 x age in years) + 8 (+/- 5)
Systolic BP: (2 x age in years) + 80 (+/- 10)
Tube Size: (age in years / 4) + 4
Tube Depth: (age in years / 2) + 12

Pediatric Vital Signs by Age

Age	HR	BP	RR
0-3 mo	120-160	65/45	30-60
3-12 mo	90-140	90/50	24-40
1 – 4 yr	80-100	100/60	22-34
4 – 12 yr	75-100	105/65	18-30
>12 yr	60-90	120/70	12-16

APGAR Scale

	SCORE	0	1	2
A	*Activity*	Absent	Arms / Legs Flexed	Active Movement
P	*Pulse*	Absent	Below 100 bpm	Above 100 bpm
G	*Grimace*	No Response	Grimace	Sneezes, Coughs, Pulls Away
A	*Appearance*	Blue-gray, Pale	Normal, Except Extremities	Normal, Entire Body
R	*Respiration*	Absent	Slow, Irregular	Good, Crying

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Procedure: D-10	Procedure: **Automated External Defibrillation (AED)**	
Page 1 of 1	Effective: September 1, 2012	Expiration:

A The use of Automated External Defibrillators (AEDs) is limited to pulseless patients.

A 1. Verify pulselessness and begin CPR while preparing equipment.

A 2. Connect AED pads as indicated on manufacturer's instructions.
Some pads may have illustrated directions on the pads.
If directions are unclear, attach pads as illustrated to the right:
APEX: left midaxillary line
STERNUM: right anterior thorax, below the clavicle

A 3. Turn AED power ON and press **ADVISORY** (LifePak 12) or turn selector switch to **DEFIB** (Zoll).

A 4. Stop CPR, stand clear, and press **ANALYZE**.

A 5. If shock is advised, have all personnel and bystanders stand clear and press **SHOCK**.

A 6. If shock is not advised, continue CPR for 5 cycles, and return to step 4.

A 7. a) If shock was delivered and your AED reanalyzes:
Continue to steps 6-8 until three shocks have been delivered (2000 Guidelines).
b) If shock was delivered and your AED does not reanalyze:
Immediately resume CPR and check pulse after 5 cycles of CPR (2005 Guidelines).

A 8. Check for a pulse. If the patient remains pulseless, continue CPR.

A 9. After every 5 cycles of CPR, return to step 4.

A 10. If patient regains pulse, continue to assist respirations with a BVM as needed.

A 11. If patient regains adequate spontaneous respirations, administer oxygen.

Figure 1: Correct AED pad placement.

Figure 2: Physiocontrol LifePak12 panel.

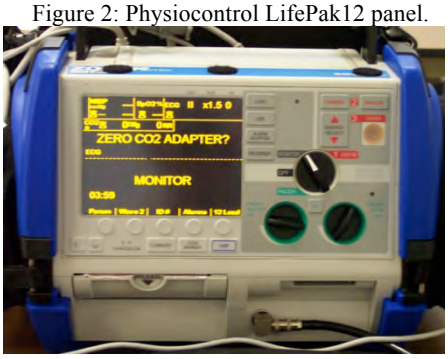


Figure 3: Zoll M Series

Be familiar with your AED! Know if it is capable of defibrillating pediatrics and if it is current on the new AHA 2005 Guidelines. It is also good to know if your AED delivers monophasic or biphasic waveforms.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Procedure: D-20	Procedure: **Airway Management**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indications
Apnea
Hypoxia
Prolonged capillary refill despite oxygen administration via NRM at 15 lpm.
Inadequate SpO2 despite oxygen administration via NRM at 15 lpm.
Inadequate respiratory rate.

A 1. Tilt head to open airway. On trauma patients, use the jaw thrust method.

A 2. Attach Bag Valve Mask (BVM) to oxygen at 25 lpm.

A 3. Using your hand, form a tight seal between the mask and patient's face.

A 4. Squeeze bag to ventilate:
Adults: approximately 10 ventilations per minute
Pediatrics: approximately 20 ventilations per minute

A 5. As soon as available, insert an appropriately sized oropharyngeal airway (OPA).

A 6. Have suction prepared and readily available, in case the patient vomits.

A 7. Watch for chest rise with each ventilation.

8. Prepare for intubation:
B Combitube®/King Airway.
P Endotracheal Intubation.

P3 9. Consider rapid sequence intubation procedure.

Figure 1: Apply tight seal around mouth.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-30	Procedure: **Bandaging**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indications
Avulsions
Abrasions
Burns
Lacerations
Penetrations

A 1. Control active bleeding by applying sterile gauze, pressure, and elevating.

A 2. If actively bleeding and gauze becomes saturated, apply additional gauze.

A 3. Clean affected area with normal saline or sterile water.

A 4. Apply a sterile dressing and loosely secure.

A 5. If an object is impaled, do not remove the object. Instead, secure it in place.

A 6. If an extremity is involved, check distal pulse, motor capabilities, and sensation.

© Sharon A Malone, MD

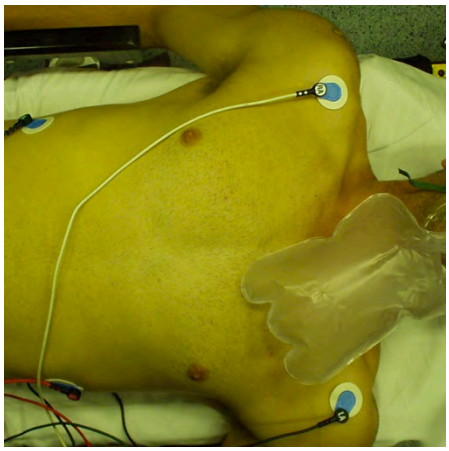
Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Procedure: D-50	Procedure: **Cardiac Monitoring – 3 lead / 4 lead ECG**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indications

All patients requiring ambulance transportation, with few exceptions as follows:

- Psychiatric emergencies, not involving alcohol or drug use.
- Sexual assault, not involving hemodynamic instability.
- Routine transfer calls, not requiring continuous cardiac monitoring.



B 1. Whenever possible, always protect patient's privacy.

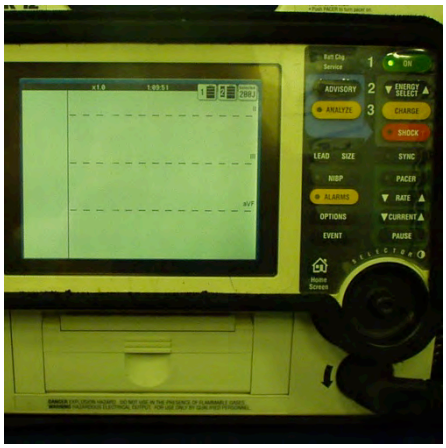
B 2. Attach electrodes as shown in the diagram:

White	right arm / shoulder
Black	left arm / left shoulder
Red	left leg / left midaxillary rib border
Green	right leg / right midaxillary rib border

B 3. Connect electrode cable.

B 4. Turn monitor ON.

B 5. Print two six (6) second ECG strips.



P 6. Interpret ECG.

B 7. Upon arrival at destination, surrender ECG as supporting documentation.

B 8. Retain a copy of the printed ECG strip for your documentation.

© Sharon A Malone, MD

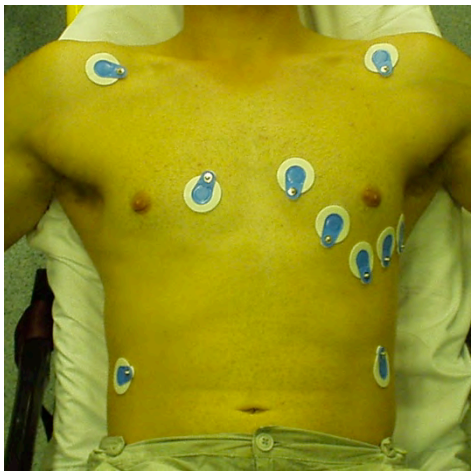
Approved By:
Version 13.2
March 20, 2013

SA Malone MD

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Procedure: D-60	Procedure: **Cardiac Monitoring – 12 Lead ECG**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indications
Chest Pain
Thorax Pain
Arm Pain: Cause Unknown
Abdominal Pain / Epigastric Pain
Cardiac Dysrhythmias
Acute Pulmonary Edema

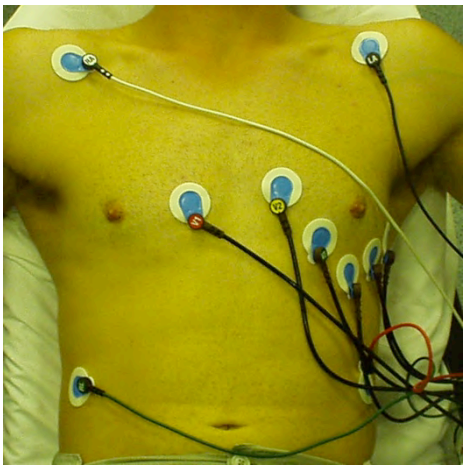


B 1. Whenever possible, always protect the patient's privacy.

B 2. Attach limb leads, as with routine ECG monitoring.

B 3. Attach precordial electrodes, as shown to the right.

V1	4th intercostal space, 1 cm to the right of the sternum
V2	4th intercostal space, 1 cm to the left of the sternum
V3	between V2 and V4
V4	5th intercostals space, midclavicular line
V5	between V4 and V6
V6	6th intercostals space, midaxillary line



B 4. Attach electrode cable to monitor.

B 5. Press 12 LEAD button or the equivalent.

B 6. If required, enter the patient's age.

B 7. Stand clear and ask the patient to avoid speaking and movement.

B 8. Print two copies of the 12 lead ECG.

B 9. Retain one copy for documentation, and surrender one copy to the destination provider.

P2 10. Cover the automated interpretation, and interpret the ECG.

P2 11. Compare your interpretation to the automated interpretation.

Special Note
Interpretation of 12 lead ECGs requires special training, diligence, and routine study and review. Treatment decisions based on 12 lead ECGs can only be performed by qualified individuals that have obtained and met all necessary requirements. Nonetheless, lack of training must not prevent performing a 12 lead ECG, as it may be an imperative tool in overall patient management by the receiving healthcare provider.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-70	Procedure: **Cardioversion / Defibrillation**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indications
Ventricular Fibrillation
Pulseless Ventricular Tachycardia
Ventricular Tachycardia – Unstable
Paroxysmal Supraventricular Tachycardia – Unstable

P 1. Apply paddles/combo pads as indicated in photograph to the right.

P 2. Charge paddles/pads to protocol indicated joule setting.

P 3. Ensure that you, the crew, and bystanders are not making physical contact with patient.

P 4. Announce your intention to shock the patient.

P 5. Again, verify that no one is contacting the patient.

P 6. Press both paddle discharge button to deliver shock or press shock button when using hands free combo pads.

P 7. Except as otherwise indicated, you should recheck pulse before each shock.

P 8. If underlying dysrhythmia changes after shock, treat according to the new rhythm.

P 9. Return to referring treatment protocol.

Note
When cardioverting a dysrhythmia with a pulse, remember to press the SYNC button.
If additional cardioversion attempts are required, recheck to ensure that SYNC is on.

© Sharon A Malone, MD

Procedure: D-75	Procedure: **C.A.T.® Tourniquet**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

The C-A-T® is Delivered in its One-Handed Configuration

This is the recommended carrying configuration

1 Insert the Wounded Extremity

Through the loop of the Self-Adhering Band

2 Pull the Self-Adhering Band Tight

And securely fasten the band back on itself

3 Adhere the Band Around the Arm

Do not adhere the band past the Windlass Clip™

4 Twist the Windlass Rod™

Until bright red bleeding has stopped

5 Lock the Rod With the Windlass Clip™

Bleeding is controlled

For added security and **always before moving a patient**, secure the Windlass Rod™ with the Windlass Strap™. Fo small extremities, also secure the Self-Adhering Band under the Windlass Strap™.

6 Adhere the Band Over the Rod

For small extremities, continue adhering the band around the extremity and over the Windlass Rod™

7 Secure the Rod and Band With the Strap

Adhering it to the opposite hook on the Windlass Clip™.

The C-A-T® is ready for transport

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

SAMalone MD

Procedure: D-80	Procedure: **Chest Needle Decompression**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indications
Tension Pneumothorax
Hyperresonance on auscultation of affected side
Tracheal deviation opposite of affected side
Pulseless Electrical Activity / Shock

NOTE: Incidence of tension pneumothorax is highest in tall, thin males.

P 1. As always, use universal precautions.

P 2. Attach a 14-16 gauge catheter over needle to a 10-20 cc syringe.

P 3. Locate the 2nd intercostal space, midclavicular line.

P 4. Clean needle insertion site. Betadine is preferred for cleaning the insertion site.

P 5. Pull skin tight, keeping two fingertips in the 2nd intercostal space.

P 6. Insert the needle on the superior margin of the 3rd rib.

P 7. While inserting needle, maintain negative pressure in the syringe.

P 8. You will feel a slight pop as the needle passes through the intercostals muscles.

P 9. When back pressure on the syringe decreases, and the syringe feels freely with air: Withdraw the needle, leaving the catheter in place.

P 10. Allow trapped air to escape.

P 11. Secure catheter in place. Cover with dressing taped down on **three** sides.

P 12. Continue according to your treatment protocols.

© Sharon A Malone, MD

Procedure: D-90	Procedure: **Combitube® and Combitube® S.A.**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indications

Failed Intubation (1 attempt unsuccessful)
Anticipated difficult airway or patient entrapment
No ALS Provider (EMT-I / EMT-P / LIC-P) Available and:
- Respiratory Arrest
- Cardiac Arrest

Note: Do not delay CPR and AED in cardiac arrest.

Contraindications

Patients under 4 feet tall
Responsive patients with intact gag reflex
Patients with known esophageal disease
Patients who have ingested caustic substances
Foreign body airway obstructions
Patients with a stoma (tracheostomy)

B 1. Select appropriate tube:
- Combitube® - Patients 5 feet tall or over.
- Combitube® S.A. – Patients 4.5 feet tall to 5.5 feet tall.

B 2. Ventilate the patient with a bag valve mask and verify patency of the airway.

B 3. Have suction prepared, in case of vomiting.

B 4. Insert tube until the printed lines are aligned with the patient's teeth.

B 5. If tube does not insert, withdraw the tube, ventilate, and reattempt.

B 6. Inflate the blue pilot balloon, designated No. 1, as follows:
- Combitube® - 100 ml of air
- Combitube® S.A. – 85 ml of air

B 7. Inflate the white pilot balloon, designated No. 2, as follows:
- Combitube® - 15 ml of air
- Combitube® S.A. – 12 ml of air

B 8. Attach the BVM to the longest tube (blue tube) and begin ventilation.

B 9. Auscultate lung sounds and gastric sounds.

B 10. If lung sounds are present, and gastric sounds absent, continue ventilation.

B 11. If gastric sounds are present, without lung sounds:
Attach BVM to the shorter (clear) tube, and reattempt steps 9-10.
If still unable to hear breath sounds, deflate cuffs, withdraw tube, and reattempt.

B 12. Combitube® or Combitube® S.A. should only be attempted twice.
If persistently unsuccessful, ventilate using Airway Management procedure.

B 13. If Combitube® is in place, and patient awakens or begins vomiting:
- Deflate cuffs
- Withdraw tube
- Prepare to suction

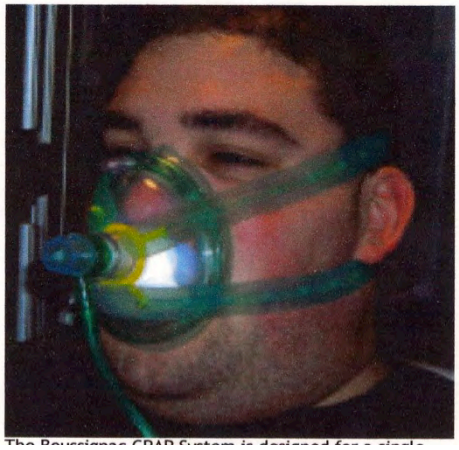
© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-100	Procedure: **Continuous Positive Airway Pressure Device**: **Disposable Unit**	
Page 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indication
Respiratory distress secondary to CHF or COPD exacerbation

Signs & Symptoms
Dyspnea and Tachypnea
Chest Pain, Tachycardia, Hypertension
Anxiety, Restlessness, Altered Level of Conscious
Peripheral Edema, JVD, Rales, Wheezes



B 1. Always use universal precautions.

B 2. Have patient sit in Fowler's position.

B 3. Assist patient in holding mask to face as the flow of oxygen begins

B 4. Attach CPAP mask to oxygen capable of 10 – 25 L/min flow rate

B 5. Connect tubing to CPAP unit and face mask. Begin to seat mask to patient's face and obtain secure seal. Attach straps around head to secure mask.

B 6. Begin with oxygen at 10 L/min which gives CPAP of 2.5 – 3 cm H_2O.

B 7. Titrate flow rate for patient comfort and respiratory rate.

B 8. Oxygen flow rate of 15 L/min gives 4.5 – 5 cm H_2O.

B 9. Oxygen flow rate of 20 L/min gives 7 – 8 cm H_2O.

B 10. Oxygen flow rate of 25 L/min gives 8.5 – 10 cm H_2O

B 11. Adjust CPAP unit as needed to improve the patient's respiratory distress .
- ✓ If CPAP is not effective after five minutes at initial setting, increase oxygen flow to increase CPAP.
- ✓ Maximum level of 10 cm H_2O is obtained at 25 L/minute flow rate.

B 11. Reassess the patient for hemodynamic stability.

B 12. Continuously monitor patient throughout transport.

B 13. Return to appropriate treatment protocol.

P 14. Albuterol and or Atrovent can be nebulized through the Boussignac.

25 L/minute flow rate will deplete a full D cylinder in 14 minutes.

25 L/ minute flow rate will deplete a full E cylinder in 23 minutes.

If the Boussignac unit is used, the oxygen tank for the ambulance must be assessed before another run is made to assure adequate oxygen on board.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-110	Procedure: **Drug Administration – Intramuscular**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indication
Indications per referring treatment protocol.

P 1. Always use universal precautions.

P 2. Select ordered medication, and inspect the medication for the following:

Tampering
Color & Clarity
Expiration Date

P 3. Attach a 20 – 22 gauge needle (1") to a syringe, and draw up appropriate dose.

P 4. Always inquire about medication allergies.

P 5. Clean the injection site with alcohol or betadine.

P 6. Insert the needle at a 90° angle with the skin.

P 7. Aspirate for blood return.

P 8. If no blood return is present, inject the medication.

P 9. Remove the needle, and dispose in an appropriate container.

P 10. Apply a bandage.

P 11. Document the time of injection.

P 12. Monitor the patient for possible medication reaction.

P 13. Return to appropriate treatment protocol.

Figure 1: Clean injection site.

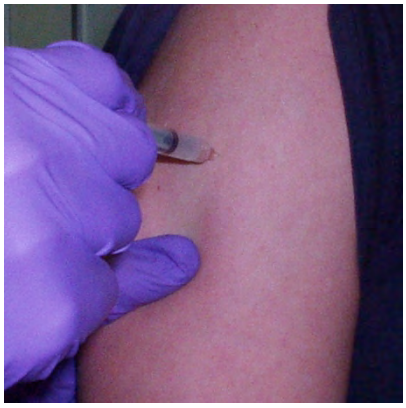


Figure 2: Aspirate prior to injecting.

Figure 3: Inject medication.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-120	Procedure: **Drug Administration – Intravenous (IV)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Indication
Indications per referring treatment protocol.

I 1. Always use universal precautions.

I 2. Select ordered medication, and inspect the medication for the following:

Tampering
Color & Clarity
Expiration Date

I 3. Attach a 20 – 22 gauge needle (1") to a syringe, and draw up appropriate dose.

I 4. Select IV tubing port closest to IV catheter.

I 5. Clean the port with alcohol.

I 6. Inspect IV site to ensure that there is no infiltration or erythema.

I 7. Check ordered medication again.

I 8. Crimp IV tubing above the tubing port.

I 9. Inject the ordered medication quantity.

I 10. Inject a 10 – 20 cc normal saline flush, if ordered in treatment protocol.

I 11. Release crimp on IV tubing and inspect drip chamber for continued patency.

I 12. Document time of medication administration, and monitor patient.

I 13. Document medication, time, and quantity on your medical record.

I 14. Return to referring treatment protocol.

Figure 1: Clean the injection site.

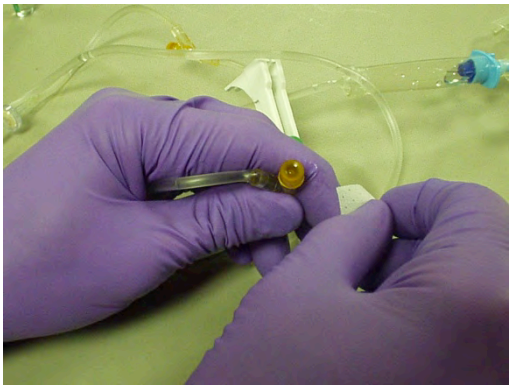


Figure 2: Crimp the tubing above the port.

Figure 3: Inject the medication, and flush if necessary.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-130	Procedure: **Drug Administration – Subcutaneous Injection**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indication
Indications per referring treatment protocol.

P 1. Always use universal precautions.

P 2. Select ordered medication, and inspect the medication for the following:

Tampering
Color & Clarity
Expiration Date

P 3. Attach a 20 – 25 gauge needle (3/4") to a syringe, and draw up appropriate dose.

P 4. Always inquire about medication allergies.

P 5. Clean the injection site with alcohol or betadine.

P 6. Insert the needle at a 45° angle with the skin.

P 7. Aspirate for blood return.

P 8. If no blood return is present, inject the medication.

P 9. Remove the needle, and dispose in an appropriate container.

P 10. Apply a bandage.

P 11. Document the time of injection.

P 12. Monitor the patient for possible medication reaction.

P 13. Return to appropriate treatment protocol.

Figure 1: Clean injection site.

Figure 2: Aspirate prior to injecting.

Figure 3: Inject medication.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-135	Procedure: **Drug Administration – Intranasal Atomization**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indication
Indications per referring treatment protocol.

P 1. Always use universal precautions.
Always inquire about medication allergies.

P 2. Select ordered medication, and inspect the medication for the following:

Tampering
Color & Clarity
Expiration Date

P 3. Attach an 18 – 25 gauge needle (3/4") to a 3 mL syringe, and draw up appropriate dose.
Expel all air from syringe.

P 5. Remove needle and place in sharps protected container

P 6. Attach the atomizer nozzle to the syringe.

P 7. Place the atomizer to the nostril and inject 1 mL per nostril.
Brisk injection is required to atomize the volume correctly.
If another mL of drug needs to be atomized repeat procedure in second nostril

P 8. Dispose of atomizer and syringe in appropriate container.

P 11. Document the time/route/volume of drug delivery.

P 12. Monitor the patient for possible medication reaction.

P 13. Return to appropriate treatment protocol.

Figure 1: Brisk delivery for proper atomization of drug

Maximum volume for intranasal delivery is one milliliter per nostril.

© Sharon A Malone, MD

Procedure: D-140	Procedure: **EpiPen ® Auto-Injector**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indication
Indications per referring treatment protocol.

B 1. Always use universal precautions.

B 2. Select correct EpiPen ®, and inspect the medication for the following:

Tampering
Color & Clarity
Expiration Date

B 3. Locate the injection site on the anterolateral thigh.

B 4. Always inquire about medication allergies.

B 5. Clean the injection site with alcohol or betadine.

B 6. Press the auto-injector firmly at a 90° angle with the skin.

B 7. A pop will be felt when the medication has been administered.

B 8. Remove the needle, and dispose in an appropriate container.

B 9. Apply a bandage.

B 10. Document the time of injection.

B 11. Monitor the patient for possible medication reaction.

B 12. Return to appropriate treatment protocol.

Epi-Pen auto injector NOT required on ALS ambulances

Figure 1: Locate injection site.

Figure 2: Clean injection site.

Figure 3: Press firmly at 90° until a pop is felt.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-165	Procedure: **EZ-IO® Intraosseous Infusion Therapy**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Indications

Cardiac and/or respiratory arrest.
Unstable patient requiring immediate fluids or medications
After two (2) unsuccessful attempts at peripheral venous access, or if access is delayed by 60 seconds.

Contraindications

Fracture in bone selected for IO, Infection at the insertion site, excessive tissue at site.
Joint surgery in the bone selected (look for overlying surgical scar)

Equipment

- EZ IO AD® or PD® needle set with EZ connect and wristband
- Towel roll, gauze, tape to stabilize after insertion
- Alcohol wipes.
- 10 mL syringe.
- IV set up, including IV solution and tubing.
- Cardiac Lidocaine (preservative free) for conscious patients

P

1. Prepare insertion site with aseptic technique
2. Prepare EZ IO® driver and appropriate needle set
3. Prepare the EZ-Connect® by flushing with saline
4. Stabilize the site and insert the needle
5. Stabilize the hub and remove the driver
6. Remove stylette from the needle set while stabilizing the hub
7. Place stylette in the shuttle or sharps container
8. Confirm placement
9. Attach the primed EZ-Connect®
10. If conscious and NOT in heart block, give Lidocaine:
    Pediatric dose is 0.5 mg/kg of 2% preservative free Lidocaine
    Adult dose is 40 mg of 2% preservative free Lidocaine
11. Connect syringe to the EZ-Connect® and flush with the correct bolus
    Pedi flush 5 ml normal saline as a bolus
    Adult flush 10 ml of normal saline as a bolus
12. Attach Normal Saline and deliver indicated fluid bolus and any other medications indicated per standing delegated orders. Deliver fluids with pressure bag or pressure cuff on 0.9% NaCl bag, or syringe bolus as indicated
13. Dress site and secure EZ-Connect tubing. Apply wristband indicating time and date the IO was established
14. Monitor EZ IO® site and patient condition
15. Remove catheter within 24 hours

Fig 1 Pediatric IO

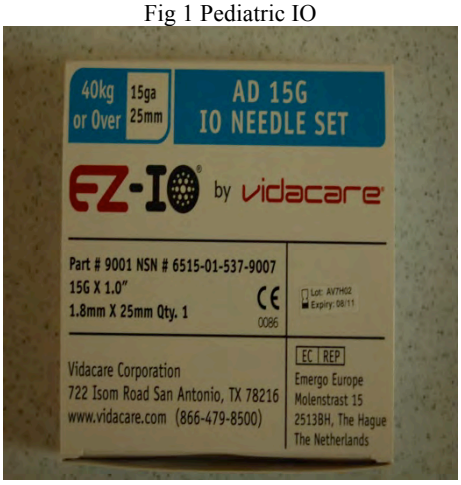


Fig 2 Adult IO

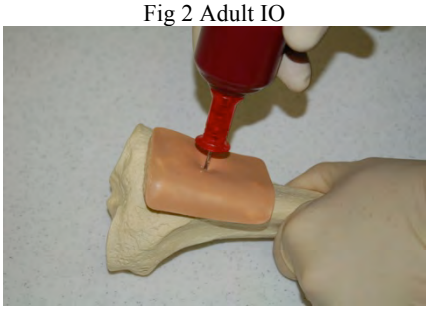


Fig 3 Proximal Tibia Site

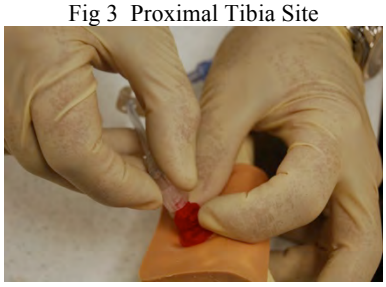


Fig 4 Connect EZ-Connect®

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Procedure: D-170	Procedure: **IV Therapy**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Indication
Indications per referring treatment standing delegated orders.

B2 1. Always use universal precautions.

B2 2. Select ordered IV solution, and inspect the solution for the following:

Tampering
Color & Clarity
Expiration Date

B2 3. Spike IV bag with drip set, or metered chamber for pediatric IV therapy.

B2 4. Flush IV tubing, removing all air / air bubbles.

B2 5. Select an appropriate IV site, preferably the hand or arm.

B2 6. Clean the IV site with alcohol or betadine.

B2 7. Apply a venous constricting band above the proposed site.

B2 8. Insert the IV catheter, bevel up, into the vein, at a 45° angle.

B2 9. Once blood return is obtained ("flash"), level the needle off and advance the catheter.

B2 10. Consider blood draw procedure.

B2 11. Connect IV tubing and evaluate for adequate flow.

B2 12. Inspect IV site for erythema or infiltration.

B2 13. Secure IV catheter and tubing, using tape or Veniguard® (preferable).

B2 14. Document the IV time, solution, drip set, location, and rate.

B2 15. Return to referring treatment protocol.

B2 may initiate IV therapy once trained and certified by Education Officer or Training Officer and approved by Medical Director.

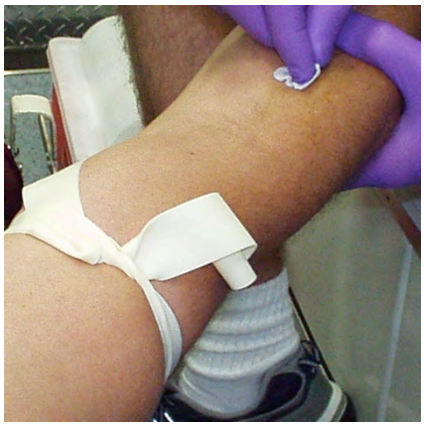


Figure 1: Clean injection site.

Figure 2: Insert the needle.

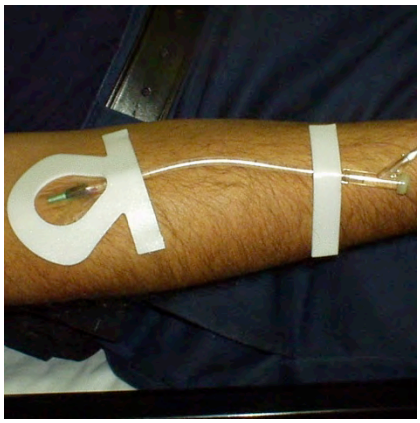


Figure 3: Secure IV in place.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

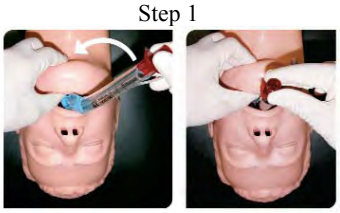
Procedure: D-175	Procedure: **King Airway**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Indications
Airway control.

B **STEP 1:** Hold the KING LT(S)-D at the connector with dominant hand. With non-dominant hand, hold mouth open and apply chin lift, unless contraindicated by C-spine precautions or patient position. Using a lateral approach, introduce tip into corner of mouth.

Step 1

STEP 2: Advance the tip behind the base of the tongue while rotating tube back to midline so that the blue orientation line faces the chin of the patient.


Step 2

STEP 3: Without exerting excessive force, advance tube until base of connector is aligned with teeth or gums.

Step 3

STEP 4: Inflate cuffs to 60 cm H2O or to "just seal" volume. Typical inflation volumes are as follows:

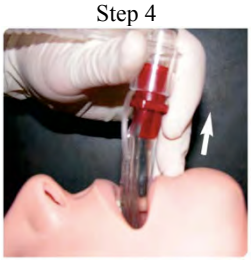
KING LT-D: Size #2, 25-35 ml; Size #2.5, 30-40 ml; Size #3, 45-60 ml; Size #4, 60-80 ml; Size #5, 70-90 ml.

KING LTS-D: Size #3, 40-55 ml; Size #4, 50-70 ml; Size #5, 60-80 ml.

Step 4

STEP 5: Attach the breathing circuit/resuscitator bag to the KING LT(S)-D. While gently bagging the patient to assess ventilation, withdraw the KING LT(S)-D until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).

STEP 6: If necessary, add additional volume to cuffs to maximize seal of the airway.


Step 5

STEP 7: When utilizing the KING LTS-D's gastric access lumen: Lubricate gastric tube (up to an 18 Fr) prior to inserting into KLTSD's gastric access lumen.

Step 7

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-180	Procedure: **Morgan Lenses**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Indications
Treatment for thermal and chemical burns and removal of non-embedded objects.

B Step 1: Instill topical ocular anesthetic, if available. (Note: The irrigating solution will soothe the eye and the Morgan Lens will provide additional relief by separating the lid from the cornea so that an anesthetic is not essential)

B Step 2: Attach Morgan Lens Delivery Set, IV, or syringe using solution and rate of choice; start flow so the Morgan Lens floats on the fluid (it does not rest on the cornea).

B Step 3: Have patient look down, insert lens under upper lid. Have patient look up, retract lower lid and drop lens in place.

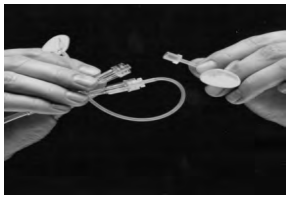
B Step 4: Release the lower lid over lens and adjust flow. Tape tubing to patient's forehead to prevent accidental lens removal. Absorb outflow. **DO NOT RUN DRY**.

If removal is indicated, continue to step 5.

B Step 5: Continue flow, have patient look up, retract lower lid - hold position.

B Step 6: Slide lens out; terminate flow.

Step 1


Step 2

Step 3

Step 4

Step 5

Step 6

* The instructions and pictures were reproduced with permission from MorTan, Inc.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-190	Procedure: **Nasotracheal Intubation**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indications
As per endotracheal intubation, but for patients with an intact gag reflex.

Contraindications
Midface trauma.

I 1. Always use universal precautions, including gloves and goggles.

I 2. Ventilate the patient with a BVM.

I 3. Assemble necessary equipment. You will need:
- Appropriately sized endotracheal tube with stylette
- Water soluble lubricant
- Syringe, 10 cc
- Suction device with catheter
- Securing Tape

I 4. Advance tube in the larger nostril, in an anterior to posterior direction.

I 5. As the tube approaches the larynx, listen for breath sounds and observe for misting.

I 6. Insert the tube into the trachea on inhalation.

I 7. Be prepared to suction, if the patient begins to vomit.

I 8. Inflate the tube with 10 ml of air.

I 9. Auscultate bilateral lung fields and epigastrium to ensure proper tube placement.

I 10. Intubation attempt should take no more than 20 seconds.

I 11. If intubation attempt is unsuccessful, repeat steps 3 – 11.

I 12. If two attempts fail, and patient's condition is unchanged perform basic airway management.

I 13. Treat according to referring protocol, and frequently recheck tube placement.

Figure 1: Ventilate with BVM.

Figure 2: Secure Tube with Tape.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Procedure: D-200	Procedure: **Oral Intubation**	
Page 1 of 1	Effective: September 1, 2012	Expiration: August 31, 2014

Indications

Apnea
Hypoxia:
Prolonged capillary refill despite oxygen administration via NRM at 15 lpm.
Inadequate SpO2 despite oxygen administration via NRM at 15 lpm.
Inadequate respiratory rate.
Glasgow Coma Scale Score = or < 8 (Refer to Glasgow Score on Quick Reference B390)

I 1. Always use universal precautions, including gloves and goggles.

I 2. Ventilate the patient with a BVM.

I 3. Assemble necessary equipment. You will need:
- Appropriately sized endotracheal tube with stylette
- Water soluble lubricant
- Laryngoscope with appropriately sized blade
- Suction device with catheter
- Endotracheal tube securing device, or tape

I 4. Insert the laryngoscope blade, sweeping the tongue from right to left.

I 5. Blade dependent, rest the laryngoscope blade in the appropriate resting spot.

I 6. Be prepared to suction, if the patient begins to vomit.

I 7. Cricoid pressure may be useful, and can help prevent aspiration.

I 8. Lift the laryngoscope, without using the teeth as a fulcrum.

I 9. Visualize the vocal cords, and pass the endotracheal tube into the trachea.

I 10. If tube is cuffed, inflate the tube with approximately 10 mL of air.

I 11. Auscultate bilateral lung fields and epigastrium to ensure proper tube placement.*

I 12. Intubation attempt should take no more than 30 seconds.

I 13. If intubation attempt is unsuccessful, repeat steps 2 – 13.

I 14. If three attempts fail, and patient's condition is unchanged, attempt Combitube.

I 15. Treat according to referring protocol, and frequently recheck tube placement.

* Use of capnography can assist in verification of tube placement, and with effectiveness of cardiopulmonary resuscitation.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

SA Malone MD

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Procedure: D-205	Procedure: **Rapid Sequence Intubation/ Pharmacologically Assisted Intubation**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Indications:
Airway control in patients with airway compromise, or GCS 8 or less who cannot otherwise be intubated.
Procedure can be performed as PAI with elimination of succinylcholine if patient condition permits.

Contraindications:
Airway obstruction above vocal cords.

P3 1. Pre-oxygenate the patient with a BVM and high flow oxygen.
Place nasal cannula on patient and continue 2 L/minute while performing the procedure. Record SaO2.

P3 2. Assemble all necessary supplies including suction, and rescue adjuncts (King Airway or Combitube/QuickTrach).

P3 3. Prepare the medications and **label** for administration.
- ✓ Versed 0.05 mg/kg. Max 5 mg IV/IO for amnesia.
- ✓ Ketamine 2 mg/kg IV/IO. For sedation.
- ✓ Fentanyl 1-2 mcg/kg Max 300 mcg IV/IO **OR** morphine 10 mg IV/IO for analgesia.
- ✓ Succinylcholine 1.5 - 2 mg/kg Max 200 mg IV/IO for paralysis.
- ✓ Vecuronium 0.1 mg/kg IV/IO (Max 10 mg) to be given after the airway is secured for 30-45 minutes of paralysis.

Contraindication to succinylcholine:
1. 20 % or greater TBSA burn that is more than 48 hours old.
2. Known hyperkalemia.

P3 If Head Injury is present administer: Lidocaine 1.5 mg/ kg IV/IO prior to intubation or RSI.

P3 Begin RSI Procedure.
1. Preoxygenate. If head injury present administer lidocaine wait 60 seconds.
2. Administer Versed, Fentanyl (OR morphine) and Ketamine.
3. Administer Succinylcholine.
4. Wait 60 – 90 seconds for paralysis to occur. Fasciculations will occur. Fasiculations are not seizures.
5. Using laryngoscope, expose the vocal cords and pass the endotracheal tube.
6. Verify: Equal bilateral breath sounds, absence of borborygmi sounds over gastrum, end tidal CO2 by capnography.
7. Secure the ET tube and record depth of placement. Consider c-collar to reduce tube migration after intubation.
8. Monitor and record both SaO2 and ETCO2 continuously. Record the capnography strip.

P3 Administer vecuronium for paralysis once airway is secured.

P3 Administer Versed and either fentanyl or morphine to treat pain and anxiety after intubation in appropriate doses.
If SBP < 100, administer NS bolus 500 to 1000 mL IV/IO.

Be prepared with alternate airway (Combitube/ King Airway/Surgical Airway).

If intubation is possible without the paralytic, succinylcholine may be withheld. Vecuronium should be given once intubation has been verified.
DO NOT INTUBATE THE PATIENT WITHOUT ADMINISTERING VERSED.

Continue with referring protocol.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-210	Procedure: **Oxygen Administration**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Indications
Nearly all patients requiring ambulance transport require oxygen!
See referring treatment protocol for indication.

A 1. Patients in respiratory distress require 100% O2 by NRB or BVM.

A 2. If a patient is unable to tolerate the NRM or is vomiting, use a nasal cannula at 4 lpm.

A 3. Record pulse oximetry readings on room air, and on oxygen.

A 4. If oxygen must be discontinued, remove the mask prior to turning off the oxygen.

A 5. All patients on oxygen should receive continuous pulse oximetry.

Continuous pulse oximetry.

SPECIAL NOTE:
Oxygen supports combustion. Do not operate around open flames or fire.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-220	Procedure: **Patient Examination**	
Page 1 of 2	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Indications:
All patients evaluated or transported by emergency medical services.

A **Scene Size-Up:**
- Scene safety.
- Personal protective equipment.
- Mechanism of illness or injury.
- Number of patients.
- Additional resources.

A **Initial Assessment:**
- General impression of the patient: What do you see?
- Evaluate airway.
- Check patient's breathing.
- Assess circulation.
- Control any bleeding.

A **Initial Interventions:**
- Manual neutral spinal alignment.
- Oxygen.
- CPR.

A **Transport Priority:**
- High – significant trauma, unresponsive or critical medical call, chest pain, dyspnea, etc.
- Low – any non-life threatening illness or injury.

A **Focused Physical Exam: (minor trauma)**
- Examine injured area. Check distal and proximal to injury for further injury and to evaluate its severity.

A **Rapid Trauma Survey: (unconscious medical or trauma)**
- Very rapid evaluation of injuries. Head-to-toe check for DCAPBTLS.
- Listen for breath sounds, palpate the abdomen.
- Should take no longer than 60 seconds.

A **Baseline vital signs:**
- Blood pressure, pulse, respirations, pulse oximeter.

A **SAMPLE History:**
- Signs / symptoms of illness or injury.
- Allergies to medications or foods.
- Medications taken daily.
- Past medical history.
- Last oral intake / Last menstrual period.
- Events leading up to illness or injury.

A **Additional Interventions:**
- C-collar, backboard, intravenous therapy, ECG monitor, drug administration, etc.

Figure 1: Listening for breath sounds.

Figure 2: Palpate the abdomen.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Procedure: D-220	Procedure: **Patient Examination**	
Page 2 of 2	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

A **Detailed Physical Examination:**
- Head-to-toe evaluation of patient. This is similar to the rapid trauma survey; however it should be more thorough.
- Check eyes, ears, nose, throat, abdomen, etc.

A **Radio / Telephone Report:**
- Report all incoming patients to the receiving hospital, if possible.
- Report the patient's age, sex, chief complaint, significant findings, interventions, changes while enroute, and E.T.A. to receiving facility.

A **Ongoing Assessment:**
- Monitor vital signs and interventions every 5 minutes.
- Check interventions such as:
  - IV therapy.
  - Oxygen therapy.
  - ECG monitor reading.
  - All other interventions.
- Report findings or change in patient's condition to receiving facility.

© Sharon A Malone, MD

Procedure: D-230	Procedure: **Quick Trach®**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Indication

Airway control in patients with maxillofacial trauma with upper airway obstruction.
When endotracheal intubation and Combitube® fail.
Immediate relief in upper airway obstruction.

P 1. Preoxygenate the patient with a BVM and high flow oxygen.

P 2. As with intubation, have all necessary supplies ready, including suction.

P 3. Preoxygenate the patient with a BVM if possible.

P 4. Locate the cricothyroid membrane, between the cricoid & thyroid cartilages.

P 5. Clean the proposed procedure area with alcohol or betadine (preferred).

P 6. Inspect Quick Trach® kit for all required components.

P 7. If spinal injury is unlikely, or no mechanism of spinal injury exists:
Support the patient's neck with a towel roll, if available.

P 8. Insert the Quick Trach® needle through cricothyroid membrane at 45° angle to skin.
The needle should point towards the patient's feet.

P 9. The needle should be inserted to the white plastic stopper.

P 10. Once you get free air return in the syringe, stabilize the hub and remove syringe.

P 11. Detach the white plastic stopper and advance remaining portion of hub.

P 12. Secure hub with the strap provided. Fasten loosely around the patient's neck.

P 13. Continue with referring protocol.

© Sharon A Malone, MD

Procedure: D-250	Procedure: **Spinal Immobilization**	
Page 1 of 3	Effective: September 1, 2012	Expiration: August 31, 2014

Indications
All Trauma (not isolated to a single extremity)
Neck Injury
Back Injury
Falls & Suspected Falls
Diving & Water Accidents

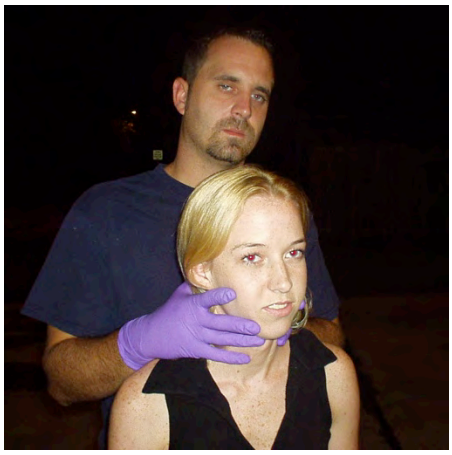


Figure 1: Manual C-Spine Immobilization

A 1. Always use universal precautions, including gloves.

A 2. In all cases, immobilize the patient's cervical spine first, prior to proceeding.

A 3. Select the appropriate spinal immobilization technique, as follows:

If the patient is standing or ambulatory, use the standing immobilization technique.
If the patient is prone, supine, or recumbent, use the conventional technique.
If the patient is sitting without serious signs/, use the KED technique.
If the patient is sitting with serious signs, use the rapid extrication technique.

A **Standing Immobilization Technique:**

1. Instruct the patient to stand still, and eliminate movement.
2. Have an additional rescuer position a spine board behind & against the patient.
3. Each rescuer should immobilize the patient's cervical spine with one hand.
4. The rescuer's other hand should firmly grip the board, under the patient's axilla.
5. Correct hand placement and positioning is demonstrated in Figure 3.
6. Without assistance from the patient, lower the spine board to the ground.
7. Secure the patient to the board, as you would with the conventional technique.

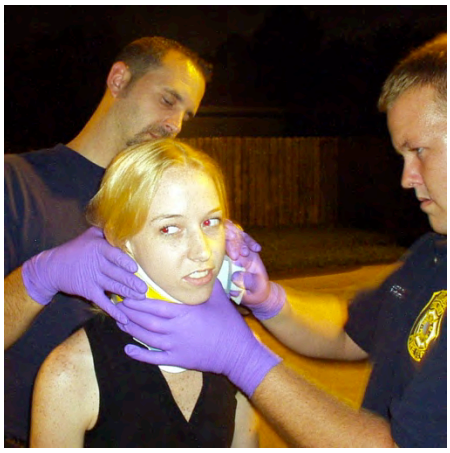


Figure 2: Correct C-Collar Application

A **Conventional Technique:**

1. Instruct the patient to eliminate movement.
2. If the patient is supine, log roll the patient, without spinal manipulation.
3. Inspect the patient's back for later reporting and documentation.
4. Position a long spine board behind the patient's back.
5. Log roll the patient onto the long spine board.
6. Secure the patient to the board using tape or webbing, in the following order:

   1st, secure the chest and pelvis to the board.
   2nd, secure the thighs and legs to the board.
   3rd, secure the patient's head to the board using towel rolls, blocks, or other commercially available devices.

Figure 3: Standing Immobilization Technique

A **KED Technique:**

1. Instruct the patient to eliminate movement.
2. Apply the KED, according to manufacturer's directions:
3. Place the KED behind the patient's back, and fasten straps as follows:
   middle strap, bottom strap, leg straps, top strap
4. Place KED pad behind the patient's head, to fill in the gap.
5. Strap or tape head in place, without manipulating the spine.
5. Using the handles, position the patient on a long spine board.
6. Release the leg straps.
7. Secure the patient to the long spine board, as in the conventional technique.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

A **Rapid Extrication Technique:**

1. If patient is conscious, instruct patient to elimination movement.
2. Place long spine board underneath the patient's buttocks.
3. Without manipulating the spine, rotate patient, torso first, onto board.
4. Maintain cervical spine control throughout movement.
5. Slide patient into normal position on long spine board.
6. Secure patient to the long spine board, as in the conventional technique.

A **All Methods:**

1. Once cervical spine immobilization has been initiated, you must not release.
2. Upon securing head and c-collar to spine board with tape, you may release.
3. Do not ever use spine boards that are cracked or broken.

Figure 4: Lowering patient to the ground.

Figure 5: Maintaining C-Spine Control.

Figure 6: Securing Patient to Spine Board

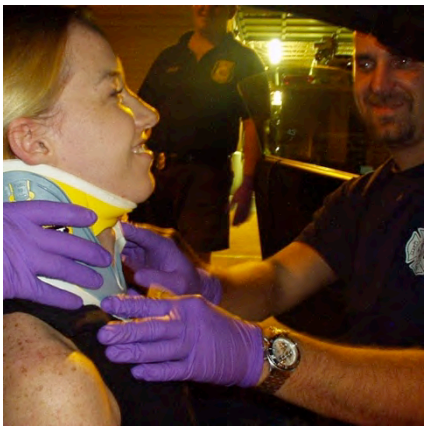


Figure 7: Rapid Extrication Technique

Figure 8: Rapid Extrication from Vehicle

Figure 9: Correctly Immobilized Patient

Protocol: D-260	Protocol Name: **Splinting**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Indications
Known or suspected fractures

A 1. As always, use universal precautions, including gloves.

A 2. Have one rescuer stabilize the injured extremity with both hands.

A 3. Check pulse, motor, and sensation distal to the injury site.

A 4. Apply a rigid splint, preferably a Sam® splint to the injured extremity.

A 5. Secure extremity to splint, using roll bandages.

A 6. Once secured, recheck distal pulse, motor, and sensation.

A 7. Return to appropriate treatment protocol.

Figure 1: Immobilizing Suspected Fracture

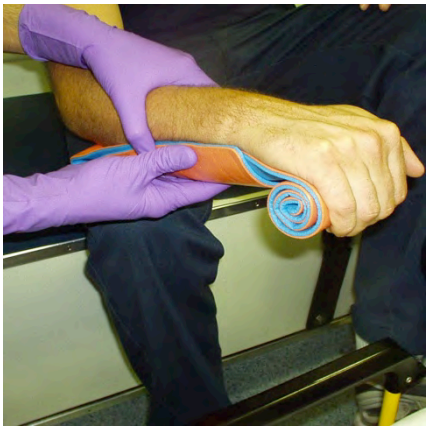


Figure 2: Applying splint.

Note:
On open fractures, cover bone ends with moist sterile dressings, and loosely bandage the open wound, prior to securing the extremity to the splint

Figure 3: Checking distal PMS

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-20	Protocol Name: **Adenosine (Adenocard)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Adenocard slows the electrical conduction through the AV node and can interrupt re-entry pathways through the AV node. Adenocard is antagonized by methylxanthines such as caffeine and theophylline and potentiated by blockers such as dipyridamole (persantine). Adenocard is not blocked by Atropine.

Indications

For patients presenting with paroxysmal supraventricular tachycardia (P.S.V.T.).

Contraindications

Second or third degree AV block and sick sinus syndrome (except in patients with functioning artificial pacemaker), patients with a known hypersensitivity to the drug. Patients with atrial fibrillation can experience serious second or third degree heart block.

Precautions

Patients who develop a second or third degree AV block after administration of one dose of Adenocard should not be given any additional doses. Adenosine may also produce facial flushing, headaches, shortness of breath, dyspnea, lightheadedness, vertigo, or nausea.

Dosage

Adult: 6 mg rapid IV push over 1 – 2 seconds. If no response, two additional doses of 12 mg rapid IV push over 1 – 2 seconds. Each dose must be followed by 10 – 20 cc 0.9% NaCl flush.
Pediatric: 0.1 mg/kg rapid IV push over 1 -2 seconds (max initial dose of 6 mg). If no response, the dose may be doubled (0.2 mg/kg; max second dose: 12 mg).

Route

Intravenous push only at the most proximal site, preferably the antecubital fossa. Can be given IO.

How Supplied

6 mg in a pre-loaded syringe or 6 mg in a single dose vial.

Do not administer adenosine to patients with an irregular rhythm, or patients with history of atrial fibrillation.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-30	Protocol Name: **Albuterol (Proventil)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

A selective beta-2 adrenergic bronchodilator which causes bronchial smooth muscle relaxation. Beta 2 stimulation may result in slight cardiovascular and central nervous system stimulation.

Indications

For the relief of bronchoconstriction or bronchospasm in patients with reversible obstructive airway diseases (asthma, or COPD).

Contraindications

Use with caution in patients who have stimulant inhalers for self-treatment or patients being treated with monoamine oxidase inhibitors or tricyclic antidepressants since the action of Albuterol can be potentiated by these drugs. Also use caution with patients with a history of cardiac disease, hypertension, or diabetes.

Precautions

May cause an increase in heart rate, blood pressure, or arrhythmias. Central nervous system effects may include tremors, headaches, or nervousness. Rare instances of paradoxical bronchospasm have been reported.

Dosage

1 unit, 2.5 mg per 3 mL, 0.083%.

Route

Nebulized at 6 – 10 liters/minute of oxygen.

- **Adults:** 6 lpm
- **Pediatric:** 10 lpm

How Supplied

2.5 mg in a 3 mL single-dose vial.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: E-35	Protocol Name: **Amiodarone (Cordarone)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
A very potent antiarrhythmic indicated for serious ventricular and supraventricular dysrhythmias.

Indications
Life threatening ventricular arrhythmia.

Contraindications
Contraindicated in cardiogenic shock and with marked sinus bradycardia or 2nd/3rd degree heart block if no pacemaker. Do not administer to neonate (under 30 days of age).

Precautions
Hypotension.

Dosage
Adults: 150 mg IV/IO over 10 minutes, may repeat once. Cardiac arrest 300 mg IV/IO.
Pediatric: 5 mg/kg IV/IO up to 150 mg in cardiac arrest.

Route
IV, IO.

How Supplied
150 mg/ 3 mL vial.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-40	Protocol Name: **Aspirin (Children's Chewable)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Aspirin is a thromboxane A-2 inhibitor, effective in reducing or arresting further platelet adhesion in cases where blood clots are the cause of an acute condition.

Indications
To reduce the mortality rate in patients with acute coronary syndromes.

Contraindications
Children under the age of 18 years, pregnant women in their third trimester, allergies to aspirin, patients with asthma, stomach problems such as ulcers, and patients with blood clotting diseases.

Precautions
May cause increased bleeding and stomach irritation.

Dosage
4 tablets: four 81 mg tablets chewed.

Route
Oral only.

How Supplied
81 mg chewable tablets.

*Administration of aspirin should be avoided if the patient self-administered aspirin in the 6 hours prior to arrival.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-50	Protocol Name: **Atropine Sulfate**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
An anticholinergic, Atropine Sulfate inhibits acetylcholine at the parasympathetic neuroeffector junction, blocking vagal effects on the SA node, enhancing conduction through the AV node, which speeds the heart rate.

Indications
Symptomatic bradycardia, bradyarrhythmias (junctional or escape rhythm), organophosphate poisoning.

Contraindications
None in the prehospital setting.

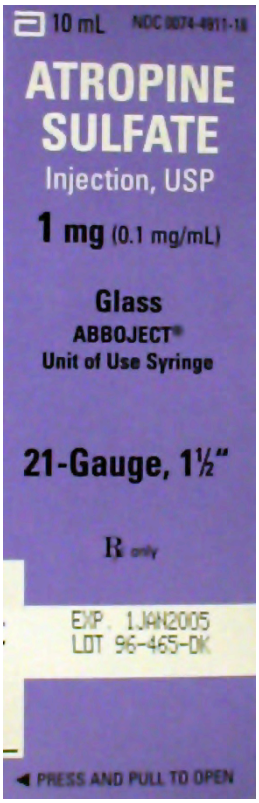
Precautions
Except in organophosphate poisoning, do not exceed 0.04 mg/kg. If the heart rate fails to increase, external transcutaneous pacing is indicated.

Dosage
Adults: For bradyarrhythmias, 0.5 mg IV or IO every 5 minutes up to a maximum dose of 0.04 mg/kg. For organophosphate poisoning, 2 mg IV or 1 mg IM is indicated.

Pediatrics: For bradycardia, 0.02 mg/kg IV or IO with a **minimum dose of 0.1 mg** and maximum dose of 1 mg. For organophosphate poisoning, 0.05 mg IV q 10 minutes prn. For RSI, 0.01 mg/kg in children < 10 yo to prevent reflex bradycardia.

Route
IV/IO

How Supplied
1 mg in a 10 mL preload syringe (0.1 mg/mL)



© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: E-55	Protocol Name: **Calcium Chloride AmBus Only**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Calcium chloride increases cardiac contractility and acts as a positive inotrope.

Indications
Evidence of hyperkalemia such as wide-complex tachycardia. Cardiac arrest in dialysis patient. Respiratory distress due to magnesium administration. Calcium channel blocker overdose.

Contraindications
Do NOT administer by intramuscular or subcutaneous. Caution in patients taking digoxin.

Precautions
Monitor IV site for extravasation.

Dosage
Adults: 1 gram IV (10 mL of a 10% solution for IV injection).

Route
Intravenous, intraosseous.

How Supplied
100 mg per mL in 10 mL vial as a 10% solution.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: E-60	Protocol Name: **Captopril (Capoten) AmBus Only**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Calcium channel blocker that is used to treat hypertension.

Indications
Hypertension without evidence of acute Stroke signs.

Contraindications
Acute ischemic stroke. Lowering the blood pressure more than 30% of the initial blood pressure will make the stroke WORSE.

Precautions
Hypotension.

Dosage
Adults: 25 mg orally.

Route
Oral, sublingual.

How Supplied
25 mg tablet.

Do NOT administer captopril to a patient with possible stroke.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-65	Protocol Name: **Dextrose 50%**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Dextrose 50% elevates the blood glucose level for patients experiencing low blood sugar.

Indications
Blood glucose level test below 60 mg/dL.

Contraindications
Blood glucose levels of greater than 80.

Precautions
Monitor IV site for extravasation, as Dextrose 50% has a marked sclerosing effect on veins and is harmful if injected into the interstitial tissues.

Dosage
Adults: 25 g of 50% Dextrose solution (50 mL) IV
Pediatrics: 25% Dextrose 2 mL/kg*

Route
IV/IO

How Supplied
50 mL preloaded syringe.

* 25% Dextrose is made by diluting 50% Dextrose with an equal volume (1:1 solution) Normal Saline.

Do not withhold dextrose from any patient with blood glucose of 60 or less.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-70	Protocol Name: **Diazepam (Valium)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Depresses the central nervous system at the limbic and subcortical levels of the brain. As an anticonvulsant suppresses the spread of seizure activity produced by epileptogenic foci in the cortex, thalamus, and limbic structures.

Indications

Status epilepticus and acute severe anxiety.

Contraindications

Patients under the influence of a sedative or alcohol, or hypotensive.

Precautions

Reduce dosage for patients over 65 years of age. May cause hypotension, confusion, stupor, cardiac arrest, or dizziness. Caution should be taken with patients that have consumed alcohol as Diazepam is well known to cause respiratory depression in these patients.

Dosage

Adults: 2-5 mg. slow IV/IM/IO/IN for patients in status epilepticus or acute anxiety.

Pediatrics: 0.1 to 0.2 mg/kg slow IV/IM/IO/IN to maximum of 6 mg, or 0.4 mg/kg rectal with maximum dose of 10 mg titrated to seizure activity in pediatrics.

Route

IV/IM/IO/IN.

How Supplied

10 mg preload syringe or ample.

May carry as vial or ampule .

Weight Length Tape	Weight	Diazepam IV
Gray	**3-4-5 kg**	**0.6 -0.8 - 1 mg**
Pink	**6-7 kg**	**1.3 mg**
Red	**8-9 kg**	**1.7 mg**
Purple	**10-11 kg**	**2 mg**
Yellow	**12-14 kg**	**2.5 mg**
White	**15-18 kg**	**3 mg**
Blue	**19-22 kg**	**4 mg**
Orange	**24-28 kg**	**5 mg**
Green	**30-36 kg**	**6 mg**

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-80	Protocol Name: **Diphenhydramine (Benadryl)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Competes with histamine for receptor sites on effector cells. Prevents but does not reverse histamine-mediated response, particularly histamine's effects on the smooth muscles of the bronchial tubes, gastrointestinal tract, uterus, and blood vessels. Structurally related to local anesthetics diphenhydramine provides local anesthesia by preventing initiation and transmission of nerve impulses. It also suppresses the cough reflex by a direct effect in the medulla of the brain.

Indications

Anaphylaxis, atopic reactions, phenothiazine reactions, dystonic reactions.

Contraindications

Acute asthmatic, narrow angle glaucoma, and prostastic hypertophy.

Precautions

May cause headaches, tachycardia, narrow angle glaucoma, and hypertrophy.

Dosage

Adults: 25 mg IV or 50 mg IM for atopic reactions, anaphylaxis and dystonic reactions; 50 mg IV/IM for phenothiazine reactions.

Pediatrics: 1 mg/kg IV/IM/IO for anaphylaxis and atopic reactions; 2 mg/kg IV/IM for phenothiazine reactions (max 50 mg).

Route

IV/IM/IO.

How Supplied

50 mg /mL in vial

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-90	Protocol Name: **Dopamine (Intropin)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Dopamine acts primarily on B1 receptors exerting a positive inotropic effect on the heart in the treatment of hypotension associated with cardiogenic shock. Dopamine does not cause an increase in the myocardial oxygen demand as much as isoproterenol and does not cause an increase in myocardial oxygen demand as much as isoproterenol and does not have the same powerful chronotropic effect. Dopamine, when used in therapeutic dosages, will maintain blood flow the renal and mesenteric vessels. For these reasons, Dopamine is the most commonly used vasopressor, because usually it will increase the systolic blood pressure and the pulse pressure.

Indications

Dopamine is indicated in the treatment of acute hypotension due to cardiac shock.

Contraindications

Hypotension due to hypovolemia, patients with pheochromocytoma.

Precautions

Do not administer in the presence of tachyarrhythmias or ventricular fibrillation

Dosage

Adults & **Pediatrics**: 2-20 mcg/kg/min IV drip, titrated to maintain a MAP > 65 mmHg.

Route

IV/IO.

How Supplied

Premixed IV solution formulation (400 mg / 250 mL).

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-95	Protocol Name: **Enalaprilat OPTIONAL ON MICU**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Enalaprilat is the active metabolite of enalapril. It is an ACE Inhibitor. It lowers the peripheral vascular resistance, decreases afterload, decreases wedge pressure, and increases the cardiac output. There is no significant effect on the heart rate, and can be given to hypertensive patients with heart rate of 55 or greater.

Indications

Blood pressure control without decreasing the heart rate.

Contraindications

Hypotension due to hypovolemia.

Precautions

Renal failure patients.

Dosage

Adults: 1.25 mg IV q 6 hours.

Route

IV/IO.

How Supplied

1.25 mg / 1 mL OR 1.25 mg / 2 mL vial or syringe.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-100	Protocol Name: **Epinephrine**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Epinephrine 1:1,000 is the drug of choice for bronchoconstriction accompanying asthma, and bronchoconstriction that accompanies anaphylaxis. Epinephrine 1:10,000 is the most commonly used drug in cardiac arrest.

Indications

Anaphylaxis, bronchial asthma, cardiac arrest (asystole, ventricular fibrillation, pulseless electrical activity, and pulseless ventricular tachycardia).

Contraindications

There are no contraindications in the cardiac arrest situation.

Precautions

Protect the solution from light. May be deactivated by alkaline solutions, such as sodium bicarbonate. **Use caution in patients with cardiovascular disease or hypertension.** Continuously monitor patient for EKG or vital sign changes. May cause palpitations, anxiety, nausea, and headaches.

Dosage

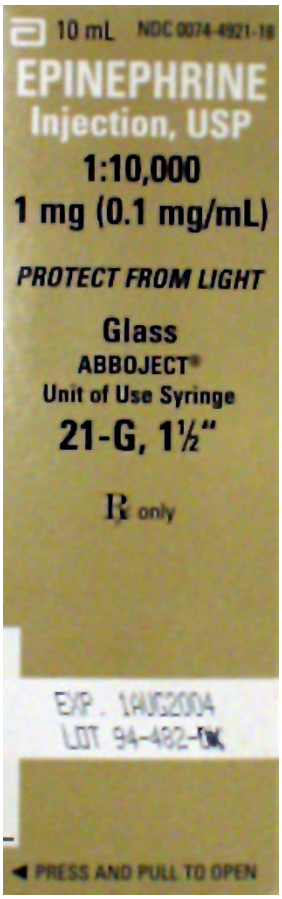
(1:1,000) Adults: 0.3 – 0.5 mg IM, or Adult EpiPen®. **Pediatrics**: For patients 8 – 12 years old, 0.2 mg IM, EpiPen Jr.®. For patients under 8 years old, 0.1 mg IM, or EpiPen Jr.®
(1:10,000) Adults: 1 mg IV/IO. **Pediatrics**: 0.1 – 0.2 mg/kg IV/IO. every 5 minutes.

Route

(1:1,000) Intramuscular into lateral thigh.
(1:10,000) Intravenous, Intraosseous.

How Supplied

(1:1,000) 1 mg in a 1 mL ampule (1 mg/mL), or pre-filled Epi-Pen®.
(1:10,000) 1 mg in a 10 mL preloaded syringe. (0.1 mg/mL)



NOTE: Epi Pen™ is not required on ALS ambulances.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-110	Protocol Name: **Ketamine (Kelar) (P 3 Certified Paramedics Only)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Ketamine is a dissociative anesthetic. It provides potent analgesia, amnesia, and sedation. Ketamine binds to NMDA receptors causing a disconnect between the limbic system and the thalamoneocortical tract, that results in a trance-like state. It binds to opoid receptors (mu, delta, and kappa) delivering potent analgesia. Ketamine also binds to aminergic receptors producing nausea, as well as muscarinic receptors producing increased salivation and lacrimation.

Indications

RSI procedure.

Contraindications

Known allergy to ketamine.

Precautions

Store below 40 °C (104 °F), preferably between 15 and 30 °C (59 and 86 °F), unless otherwise specified by manufacturer. Protect from freezing.

Dosage

2 mg/kg IV/IO.

Route

IV or IO

How Supplied

100 mg/mL in 5 mL vial.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-115	Protocol Name: **Fentanyl (Sublimaze)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Fentanyl is a powerful synthetic opoid agonist.

Indications
Severe pain.

Contraindications
Allergy to fentanyl.

Precautions
May cause life-threatening respiratory depression. May cause drowsiness and/or sedation, which may be enhanced by alcohol & other CNS depressants.

Dosage
Adults: 50 – 100 micrograms IV/IO/IM. Maximum dose 300 micrograms.
Pediatrics: (over 1 year old) 1 - 2 mcg/kg IV/IO/IM. Max 100 micrograms.

Route
IV/IO/IM/IN

How Supplied
50 mcg/ mL.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: E-120	Protocol Name: **Furosemide (Lasix)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Inhibits reabsorption of sodium and chloride in the ascending loop of Henle, which causes exertion of sodium and water. It is useful in the treatment of pulmonary edema and congestive heart failure. The effects are usually seen in about 5 minutes.

Indications
Pulmonary edema, congestive heart failure (CHF).

Contraindications
Sulfa allergy. Pregnancy, anuria, hypokalemia, or electrolyte imbalance.

Precautions
Protect furosemide from light. Electrolyte depletion, namely potassium, may occur.

Dosage
Adults: 40 mg IV.

Route
IV/IO.

How Supplied
20 or 40 mg vial

Begin CHF therapy with CPAP.

Consider Lasix if there are
Definite signs of including peripheral edema, jugular venous distention.

Contraindicated in sepsis or hypovolemia.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-130	Protocol Name: **Glucagon**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
a polypeptide hormone identical to human glucagon that increases blood glucose by stimulating the release of glycogen from the liver.

Indications
Symptomatic hypoglycemia (blood glucose < 60 mg/dL) in cases which IV access is unobtainable.

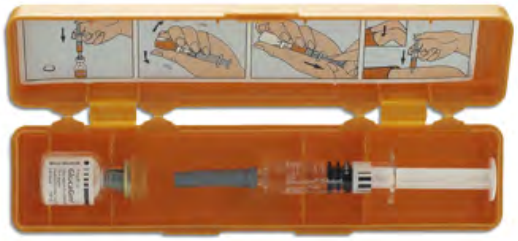
Contraindications
Pheochromocytoma

Precautions
Glucagon is effective in treating hypoglycemia only if sufficient liver glycogen is present; because liver glycogen availability is necessary to treat patients with hypoglycemia, glucagon has virtually no effects on patients in states of starvation or adrenal insufficiency.

Dosage
1 mg

Route
Intramuscular

How Supplied
1 unit (1 mg) white powder in 1 ml of diluting solution (1 mg/ml).



In cases where IV access is delayed, do not delay glucagon.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: E-135	Protocol Name: **Haldol (haloperidol)***	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Haldol is an antipsychotic which is an dopamine D2 receptor antagonist.

Indications
Haldol is indicated in the management of manifestations of acute and chronic psychosis, including schizophrenia and manic states.

Contraindications
CNS depression (including coma), neuroleptic malignant syndrome (NMS), poorly controlled seizure disorder, Parkinson's Disorder.

Precautions
Pregnancy class C. Avoid in breastfeeding.. Avoid in Parkinson's Disorder.
Consider reducing the dose in patients >65 years of age and adult patients less than 50 kg.

Dosage
5mg to 10 mg

Route
IM.

How Supplied
5 mg / 1 mL for injection.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-140	Protocol Name: **Ipratropium Bromide (Atrovent)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
An anticholinergic drug that inhibits the interaction of acetylcholine at the smooth muscle receptors, causing bronchodilation.

Indications
Bronchospasm in those with COPD

Contraindications
Do not use for children under 12 years old, glaucoma, prostatic hypertrophy, and bladder-neck obstruction.

Precautions
May cause anxiety, dizziness, headache, nervousness, dry mouth, and blurred vision.

Dosage
Adults: 0.5 mg via nebulizer. Can be given with albuterol.

Route
Nebulized mist.

How Supplied
0.5 mg in a 2.5 mL vial.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

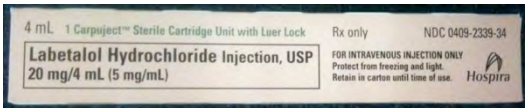
Protocol: E-150	Protocol Name: **Labetalol**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Labetalol lowers blood pressure without significantly altering cardiac output or heart rate. It reduces blood pressure by dilating both arterial and venous vessels.

Indications

Labetalol is indicated for hypertensive emergencies (SBP > 220, DBP > 120). Due to its combined alpha- and beta-blocking activity, labetalol is useful in treating hypertension caused by pheochromocytoma and hypertensive emergencies.



Contraindications

Reduced ventricular function (CHF, MI), peripheral vascular insufficiency, bradycardia or AV node conduction problems.

Precautions

May cause orthostatic hypotension, bradycardia, or CNS depression.

Dosage

Adults: 10 - 20 mg IV/IO over 2 minutes.

Route

Intravenous, intraosseous.

How Supplied

20 mg in 4 mL prefilled syringe.

During times of manufacturer distribution problems, labetolol may be available in different volume or packaging. Although prefilled syringes are preferred, labetolol may be carried in currently available packaging. Care must be taken to use only the doses of the labetolol as directed in the standing delegated orders.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-160	Protocol Name: **Lidocaine (Xylocaine)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Possibly the most frequently used antiarrhythmic agent in the prehospital setting. It is effective in suppressing ventricular ectopy, ventricular tachycardia and in some cases the ventricular fibrillation threshold is increased in acute myocardial infarction (AMI).

Indications

The treatment of ventricular tachycardia and ventricular fibrillation and the prevention of the recurrence of both dysrhythmias.

Contraindications

2nd degree type II and 3rd degree AV blocks. Bradycardia and sinus arrest.

Precautions

May cause myocardial and circulatory depression, drowsiness, disorientation, hearing loss, paraesthesia, agitation, focal and grand mal seizures. The dosage should be reduced to half for patients with hepatic dysfunction, hypovolemia, and over 70 years of age.

Dosage

Adults: 1.5 mg/kg IV initial dose, 0.75 mg/kg IV every 5 minutes in ventricular tachycardia (max dose 3 mg/kg). 2-4 mg/min. in a continuous infusion after conversion.

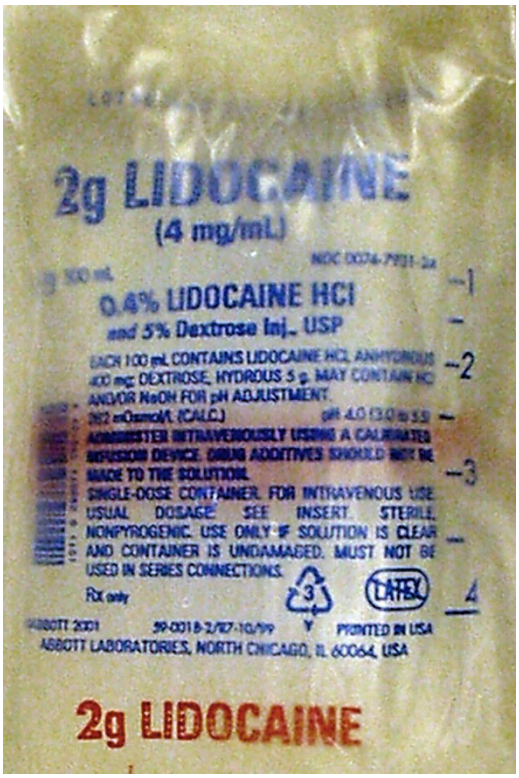
Pediatrics: 1mg/kg up to 3 mg/kg. 20-50 mcg/kg/min. in a continuous infusion.

Route

IV/IO

How Supplied

100 mg in a 5 ml preload syringe (20 mg/ml), and premix IV drip solution of 4 mg/mL.



Concentrations may vary due to drug shortages and availability. The Paramedic must be diligent in providing the patient the correct dose.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-170	Protocol Name: **Lorazepam (Ativan)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Benzodiazepine.

Indications
Seizure, acute anxiety associated with pain, acute psychosis.

Contraindications
Allergy to lorazepam, hypotension (SBP < 90). Pregnancy Class D. Excreted in breast milk.

Precautions
Respiratory depression. Be prepared to manage airway. Hypotension.

Dosage
Adults: 2 – 4 mg Q 4 hours. Titrate to effect with attention to respiratory depression.
Pediatrics: 0.05-0.1 mg/kg IV over 2-5 minutes. May repeat 0.05 mg/kg x 1 in 10-15 minutes/kg if still seizing. Do NOT exceed 4 mg in single dose.

Route
IV / IO / IM / IN

How Supplied
2mg /mL vial

Weight	Lorazepam IV
3-5 kg	0.15 to 0.25 mg
6-7 kg	0.35 mg
8-9 kg	0.45 mg
10-11 kg	0.55 mg
12-14 kg	0.7 mg
15-18 kg	0.9 mg
19-22 kg	1.1 mg
24-28 kg	1.4 mg

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-190	Protocol Name: **Methylprednisolone (Solu-Medrol)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Methylprednisolone is a synthetic steroid that suppresses acute and chronic inflammation. In addition, it potentiates vascular smooth muscle relaxation by beta-adrenergic agonists and may alter airway hyperactivity.

Indications

Anaphylaxis / Allergic Reactions, Refractory Asthma, or COPD.

Contraindications

Hypersensitivity to the drug and head injury.

Precautions

Use cautiously in pregnant females and patients who are immunosuppressed.

Dosage

Adults: 125 mg IV for respiratory distress or anaphylaxis.

Pediatrics: 2 mg/kg for respiratory distress or anaphylaxis.

Route

IV/IM/IO

How Supplied

125 mg in a 2 mL single-dose vial

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-200	Protocol Name: **Metoclopramide (Reglan)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Reglan is an antiemetic. It is a dopamine antagonist that raises the threshold of activity in the chemoreceptor trigger zone. It also promotes peristalsis increasing gut motility.

Indications

Treatment of nausea and vomiting in children and adults.

Contraindications

Hypersensitivity to Reglan, mechanical bowel obstruction.

Precautions

May cause dystonic reaction, dizziness, drowsiness

Dosage

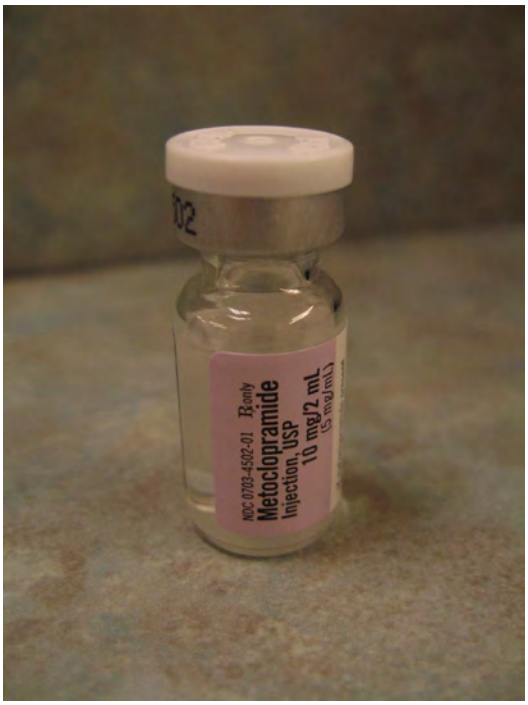
Adults: 5 – 10 mg IV/IM/IO
Pediatrics: 0.1 – 0.2 mg/kg/dose IV/IM/IO for age > 3 months

Route

IV/IM/IO

How Supplied

5 mg/ml in 2 mL vial



© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-210	Protocol Name: **Midazolam (Versed)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Midazolam is a short acting benzodiazepine.

Indications
Seizure activity and acute psychotic agitation.

Contraindications
Neonates , sensitivity to benzodiazepines and Myasthenia Gravis.

Precautions
Patients who are pregnant or hypotensive.

Dosage
Adult: 1-5 mg IV/IM/IO/IN. Must monitor for sedation, respiratory depression, hypotension.

Pediatrics Greater than 3 months: 0.05 mg/kg IV/IM/IO/IN.

Intranasal dosage will be the same as the IV dosage. One mL per nostril maximum volume.

Route
Intravenous, Intramuscular, Intraosseous, or Intranasal.

How Supplied
5 mg / 1 ml carpuject or vial

Monitor patient closely for respiratory depression and be prepared to support ABC's.

Weight/Length Tape	Weight	Midazolam IV
Gray	3-5 kg	0.15 to 0.025 mg
Pink	6-7 kg	0.35 mg
Red	8-9 kg	0.45 mg
Purple	10-11 kg	0.55 mg
Yellow	12-14 kg	0.7 mg
White	15-18 kg	0.9 mg
Blue	19-22 kg	1.1 mg
Orange	24-28 kg	1.4 mg
Green	30-36 kg	1.8 mg

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-220	Protocol Name: **Morphine Sulfate (MS)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Morphine is a potent narcotic analgesic, relieving pain and anxiety in pain patients.

Indications

Chest pains, obvious fracture with severe pain, and burns.

Contraindications

Bradycardia, hypotension, decreased respiratory effort, elevated intracranial pressure, head injuries.

Precautions

Hypotension in acute inferior MI. May cause respiratory depression, especially when used in patients with alcohol intoxication.

Dosage

Adults: 2 – 5 mg IV/IM/IO/IN titrated to pain control every 5 minutes; max of 20 mg.

Pediatrics: 0.05 – 0.1 mg/kg IV/IM/IO/IN every 5 minutes as needed for pain; maximum 5 mg.

Route

IV / IO / IM / IN

Maximum volume for IN is one milliliter per nostril.

How Supplied

10 mg in a 1 mL vial or ampule or carpuject.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-230	Protocol Name: **Naloxone (Narcan)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Displaces previously administered narcotic analgesics from their receptors.

Indications
Known or suspected narcotic-induced respiratory depression. Patients unconscious with unknown etiology.

Contraindications
None in the prehospital setting.

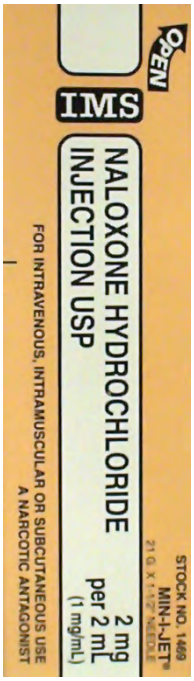
Precautions
Use cautiously in known narcotic overdoses, as patient may become violent after administration.

Dosage
Adults: 0.2 to 2 mg IV/IM/IO/IN, as need for respiratory depression (may repeat twice). Titrate to improved respirations, not full reversal or opoid effects.

Pediatrics: Pts > 4 yo or 20 kg, 0.2 to 1 mg IV/IM/IO/IN. Pts < 5 yo or < 20 kg, 0.1 mg/kg max 1 mg IV/IM/IO/IN.

Route
IV/ IM / IO / IN
Maximum volume for IN is one milliliter per nostril.

How Supplied
2 mg in a preloaded syringe.



Naloxone therapy should be titrated to respiratory effort, not complete reversal of narcotic effects.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-240	Protocol Name: **Nitroglycerin**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Reduces cardiac oxygen demand by decreasing left ventricular end-diastolic pressure (pre-load) and systemic vascular resistance (after-load). Also increases blood flow through collateral coronary vessels.

Indications
Relief of pain associated with angina pectoris, mild hypertension.

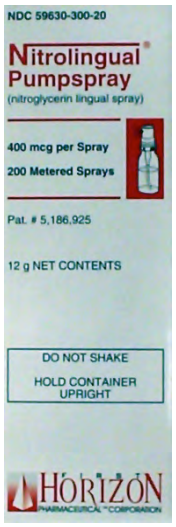
Contraindications
Hypersensitivity to nitrites, head trauma, cerebral hemorrhage, severe anemia, hypotension, and pediatrics. Patients taking medications for erectile dysfunction.

Precautions
May cause nausea, vomiting, orthostatic hypotension, reflex tachycardia, headache, and weakness.

Dosage
Adult: 0.4 mg sublingual. May repeat every 5 minutes, to a maximum of three total doses. HTN protocol has maximum of three doses. Do not give nitro if acute Stroke suspected.

Route
Sublingual (sublingual) either tablet or spray

How Supplied
0.4 mg metered dose spray bottle or tablets for sublingual administration.



Tablets and spray of 0.4 mg dose are considered equivalent.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: E-245	Protocol Name: **Oral Glucose**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Oral glucose gel increases the blood glucose by oral absorption.

Indications
Hypoglycemia.

Contraindications
Unconscious or unable to control airway.

Precautions
Altered level of consciousness.

Dosage
15 grams in 1.3 ounces, administer one tube.
May repeat if no improvement in 15 minutes.

Route
Oral

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-250	Protocol Name: **Oxygen**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Oxygen increases perfusion by providing the patient with a higher percentage of oxygen than in the atmospheric air.

Indications
Hypoxemia, chest pain, hypotension, trauma, acutely ill patients, suspected carbon monoxide poisoning.

Contraindications
There are no contraindications to oxygen therapy.

Precautions
Caution should be used with COPD patients who breathe due to hypoxia. The administration of oxygen should not be withheld; however, be prepared to assist ventilations.

Dosage
Nasal cannula 2 – 6 liters, 15 liters per minute via non-rebreather mask, via BVM, or blow-by method.

Route
Inhaled.

Do not withhold oxygen therapy to patients with known COPD. Monitor closely for decreased respiratory drive and reduce oxygen therapy if this occurs.

AHA recommends oxygen saturation to be maintained between 94- 98% in patients with acute MI.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-260	Protocol Name: **Promethazine (Phenergan) Variance Protocol**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description

Promethazine is an anti-emetic, reducing or eliminating common signs / symptoms of gastrointestinal illness, such as nausea and vomiting.

Indications

Nausea / Vomiting

Contraindications

This medication must not be used in trauma patients, possible CVAs, those with an altered level of consciousness, those suspected or known to have ingested toxins or medications in excess of recommended quantities (overdose) or in **pediatrics ≤ 2 years of age**. Also, do not use this medication to treat nausea associated with heart problems / chest pain.

Precautions

This medication may cause drowsiness, and has been known to cause acute dystonic reactions (restlessness, muscle spasms of neck, jaw and back, oculogyric crisis). Be prepared for these reactions, and if necessary, attempt reversal with diphenhydramine (see overdose / poisoning / allergic reaction protocols). Use cautiously in pediatrics > 2 years of age and < 12 years of age.

Dosage

Adults: 6.25 mg - 25 mg.
Pediatrics: 0.1 mg/kg (max 12.5 mg). Age over 8.

Route

Intravenous or intramuscular.

How Supplied

25 mg in a 1 mL ampule or vial.*

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-280	Protocol Name: **Sodium Bicarbonate**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Restores buffering capacity of the body. Also neutralizes excess acid in the cardiac arrest / apnea setting.

Indications
Metabolic acidosis, hyperkalemia, prolonged ACLS CPR, Tricyclic Antidepressant overdose, wide QRS bradycardia in dialysis patient with possible hyperkalemia.

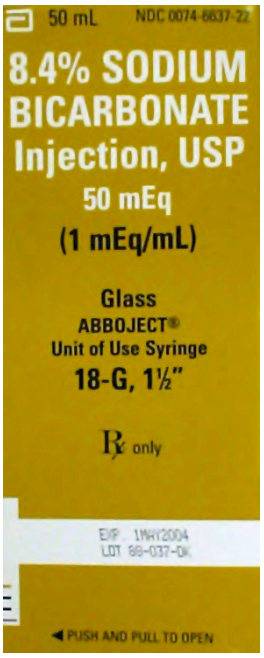
Contraindications
Hypokalemia, alkalotic states.

Precautions
Use cautiously on patients who have pulmonary insufficiency, congestive heart failure (CHF), and in infants.

Dosage
Adults: 1 mEq/kg IV/IO 8.4% solution.

Route
IV / IO.

How Supplied
50 mEq in a 50% solution of 8.4% (1 mEq/mL)



© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: E-290	Protocol Name: **Sodium Chloride 0.9% (NS)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
A crystalloid that is used for extracellular fluid replacement. Its electrolyte solutions are osmotically equivalent to blood, and can cause increased circulating volume by remaining in the vascular system.

Indications
Used for fluid and electrolyte replacement in shock and dehydration.

Contraindications
Use cautiously on patients with suspected congestive heart failure or isolated head trauma.

Precautions
On pediatric patients, must be administered through metering chamber to prevent high volume fluid administration.

Dosage
According to patient's needs and as per protocol.

Route
IV / IO, can be used for eye irrigation.

How Supplied
1 L bags.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-300	Protocol Name: **Succinylcholine (Anectine) (P 3 Certified Paramedics Only)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Succinylcholine is a depolarizing neuromuscular blocking drug that provides immediate paralytic effect to skeletal muscles and diaphragm.

Indications
Prior to rapid sequence intubation by depolarizing muscle membranes.

Contraindications
Penetrating eye injuries, glaucoma, skeletal myopathies, history of malignant hyperthermia, Duchenne's muscular dystrophy. Do not use repeated doses.

Precautions
Use caution as succinylcholine immediately arrests respirations. Have BVM and cricothyroidotomy supplies available.

Dosage
Adults: 1.5 – 2 mg/kg IV/IO Max 200 mg.

Route
Intravenous, intraosseous.

How Supplied
200 mg / 2 mL vial

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: E-310	Protocol Name: **Tetracaine (Optional)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Stabilizes membranes of conjunctiva and corneal pain fibers to inhibit depolarization and perception of pain.

Indications
To be used as a local anesthetic in isolated eye injuries to facilitate treatment with morgan lens and irrigation.

Contraindications
In patients with known hypersensitivity to tetracaine, procaine (Novocain) or chloroprocaine (Nesacaine).

Precautions
The patient may experience a transient stinging or burning in the eye.

Dosage
2 drops of 0.5% solution

Route
Ocular

How Supplied
0.5% ophthalmic solution in 15 mL bottle

Tetracaine

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-325	Protocol Name: **Tylenol (acetaminophen) OPTIONAL**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Used to reduce body temperature.

Indications
Fever

Contraindications
Allergic to tylenol. Altered mental status. Do not give orally if any airway distress or concern over surgical etiology.

Precautions
Be sure patient has not had full therapeutic dose in the last four (4) hours.

Dosage
15 mg per kilogram up to 1 gram.

Route
Rectal suppository or oral suspension. Tablets in adults may be given with 20 mL water.

How Supplied
325 mg suppository, 500 mg tablets for adults, suspension for pediatrics.

Weight/Length Tape	Weight	Tylenol
Gray	**3-5 kg**	**75 mg**
Pink	**6-7 kg**	**105 mg**
Red	**8-9 kg**	**135 mg**
Purple	**10-11 kg**	**165 mg**
Yellow	**12-14 kg**	**210 mg**
White	**15-18 kg**	**270 mg**
Blue	**19-22 kg**	**330 mg**
Orange	**24-28 kg**	**420 mg**
Green	**30-36 kg**	**540 mg**

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-330	Protocol Name: **Vasopressin**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Improves perfusion of heart, brain and kidneys during cardiac arrest resuscitation by means of vasoconstriction.

Indications
Asystole, PEA, Ventricular Fibrillation

Contraindications
None in this setting

Precautions
Due to its long half-life, only one dose is to be administered. Ten minutes after administration, begin Epinephrine administration if Asystole/PEA/V-Fib is not resolved.

Dosage
40 IU IV/IO

Route
Intravenous, Intraosseous.

How Supplied
40 IU in a 2 mL vial or 20 IU in 1 mL vial.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Protocol: E-335	Protocol Name: **Vecuronium Bromide (Norcuron) (P3 Certified Paramedics only)**	
Page 1 of 1	Effective Date: June 1, 2010	Expiration Date: August 31, 2014

Description

Vecuronium bromide is a non-depolarizing agent used to cause skeletal muscle paralysis. It is used to assist in endotracheal intubation and improve patient compliance in mechanical ventilation.

Indications

To provide skeletal muscle relaxation to facilitate endotracheal intubation.

Contraindications

Patients with a known sensitivity to Vecuronium.

Precautions

The patient will lose the ability to breathe! **You must be able to establish a patent airway!**

Dosage

0.1 mg/kg IV or IO

Route

IV or IO

How Supplied

10 mg Vecuronium bromide in 10 mL vial

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Sherman Fire Department
Emergency Medical Services
STANDING DELEGATED ORDERS

Protocol: E-340	Protocol Name: **Zofran (ondansetron)**	
Page 1 of 1	Effective Date: September 1, 2012	Expiration Date: August 31, 2014

Description
Zofran is an antiemetic that works on the 5 HT receptor.

Indications
Nausea and vomiting.

Contraindications
Allergy to Zofran.

Precautions
Lethargic patient if the PO preparation is given.

Dosage
Adults: 4 to 8 mg ODT, OR 4 – 8 mg IV/IM/IO of Zofran for IV administration

Pediatrics: Age 2 to 4 years 2 mg ODT or 2 mg IV/IM
Age over 4 : 4 mg ODT or IV/IM
Age over 11: 8 mg ODT or IV/IM

Route
Oral disintegrating tablet placed on or under the tongue.
IV/IM injectable.

How Supplied
8 mg ODT (Oral Disintegrating Tablet)
Tablet may be cut in half or quartered for pediatric dosing.
4 mg / 2 mL IV/IM/IO for IV administration.

Either the generic or trade preparation may be carried.

© Sharon A Malone, MD

Approved By:
Version 13.2
March 20, 2013

Useful Information
Revised May 29, 2013

Medical Director:

Sharon Malone, MD, LP (903) 357-0436

Call at ANY time (903) 357-0436

Backup: On-Line Medical Control at destination hospital

TMC: (903) 416-2183
WNJ: (903) 870-4122
Medical Center of McKinney (972) 540-4950
Red River Regional (903) 640-7334

Madill Memorial (580) 795-0310
Denton Presby (940) 387-0049
Denton Regional (940) 384-3500
North Texas MC Gainesville (940) 665-7672

Poison Control Number: 1-800-222-1222

Please send any comments, concerns, suggestions to:
Sharon Malone, MD at docmalone@me.com

© Sharon A Malone, MD