Connecticut
Statewide EMERGENCY MEDICAL SERVICES Protocols

Initial Roll Out Education Aid
2016

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Goal

To establish a standard format for the roll-out of 2016 Statewide Emergency Medical Services Protocols

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Objectives

- **At the end of the presentation the participant will:**
  - Recognize the benefit of unified, evidence-based EMS protocols
  - Differentiate between foundational, required protocol and sponsor hospital approved “add-on” protocols.

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Objectives

- **At the end of the presentation the participant will:**
  - Distinguish between previous regional guideline allowable practice and new evidence-based protocols
  - Collaborate with other providers to roll-out new protocols in a timely manner.

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Protocols Background

- “Living Document” developed and drafted by the Statewide Protocols Committee of CEMSMAC. May be edited and updated at any time.

- Formally reviewed, edited and released every two years.

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Protocols Background

- Protocols are as evidence-based as current literature will allow (February 2016)
- Protocols establish the standard of EMS patient care for all levels of EMS provider.

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Protocols Background

- Protocols address MINIMUM/FLOOR competencies that everyone will be able to demonstrate at BOTH BLS and ALS levels

- Sponsor Hospitals may chose not to authorize specific meds or procedures but may not add or substitute anything not already written in the protocols.

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Review Process

- Protocols are formally reviewed, edited and released every two years by CEMSMAC
- Approved by CEMSMAC, CEMSAB and Commissioner
- Subcommittee with diverse EMS representation will review and recommend changes

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Protocol Changes

- Individual Sponsor hospitals may petition CEMSMAC and the commissioner for approval of local variations in scope of practice and treatment protocols.

- The Commissioner shall notify each sponsor hospital, EMS organization and EMS personnel of approved statewide EMS protocols no later than 10 days after the effective date of such protocols.

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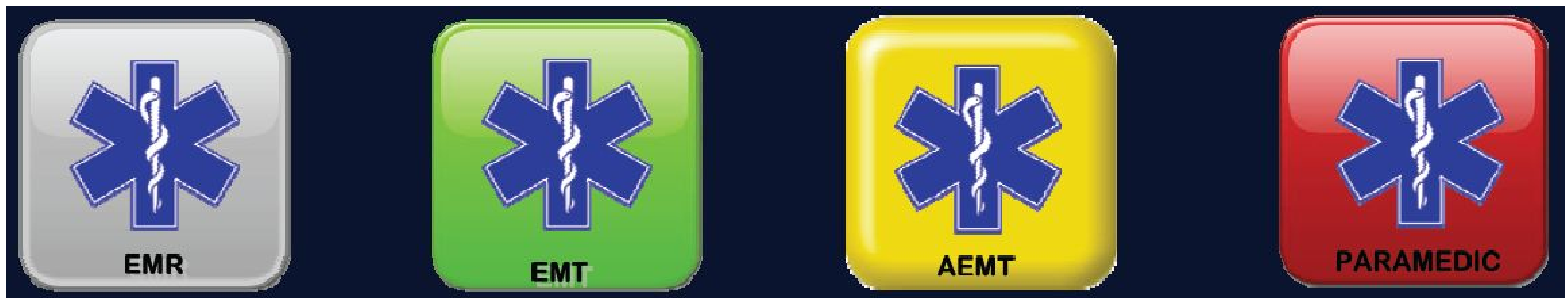
Protocol Format

- Color coded within each protocol by provider level
- EMR routine patient care is separately addressed in section 1.1
- Pediatric protocols generally integrated - not a separate section
- Procedures listed at the end



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Symbols used in Text

Legend	Definition
	Emergency Medical Responder (EMR)
	Emergency Medical Technician (EMT)
	Advanced Emergency Medical Technician (AEMT)
	Paramedic
	CAUTION – Red Flag topic
	Telephone Direct Medical Oversight
	Pediatric

Blue underline – text formatted as a hyperlink

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Hyperlinks

- In the electronic version of the protocols, clicking on a blue protocol title or page reference in the table of contents will take you to that page.

Connecticut Statewide Protocols 2016 – Table of Contents

(Alphabetical order by section) Page

Section 3 – Cardiac Emergencies

Acute Coronary Syndrome – Adult 3.0
Bradycardia – Adult 3.1A
Bradycardia – Pediatric 3.1P
Cardiac Arrest – Adult 3.2A
Cardiac Arrest – Team Focused CPR 3.2A
Cardiac Arrest – Pediatric 3.2P
Congestive Heart Failure (Pulmonary Edema) 3.3
Post Resuscitative Care 3.4
Tachycardia – Adult 3.5A
Tachycardia – Pediatric 3.5P

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Local Protocol Options

- Many protocols have several treatment options to choose from.
  - Options usually related to Advanced EMT or Paramedic level practice

- Local medical control will determine which options in the protocols will be available to their sponsored services.

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Table of Contents

Protocols divided into the following Sections:

- Section 1 – General Patient Care
- Section 2 – Medical Protocols
- Section 3 – Cardiac Emergencies
- Section 4 – Traumatic Emergencies
- Section 5 – Airway Protocols & Procedures
- Section 6 – Other Procedures
- Section 7 – Hazmat & MCI
- Appendices

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1.0 Routine Patient Care

- Provides a framework for all EMS patient encounters
- Outlines basic response and assessment expectations
- Directs the provider to identify and follow the correct protocol based on initial assessment findings
- Gives guidance for transport decision making

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1.1 EMR Routine Patient Care

- Establishes EMR scope of practice within larger body of protocols
- Provides a framework for patient assessment and care by EMRs
- Directs the provider to identify and follow the correct protocol based on initial assessment findings

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1.2 Exception Protocol

- Identifies the Statewide Patient Care protocols as the accepted standard for patient care.
- Recognizes that there may be very limited instances when no protocol fits the patient being cared for.
- Provides guidance on when and how a provider may act outside of protocol in these very limited situations.

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3.2 Cardiac Arrest

- Focus on uninterrupted 2 minute cycles of CPR and addition of AED early if indicated
- Ventilations / oxygenation determined by presumed origin of arrest
- **Passive insufflation** for cardiac etiology only.
- **BVM ventilation** – may be used for all etiologies. 1 breath every 10 chest compressions.

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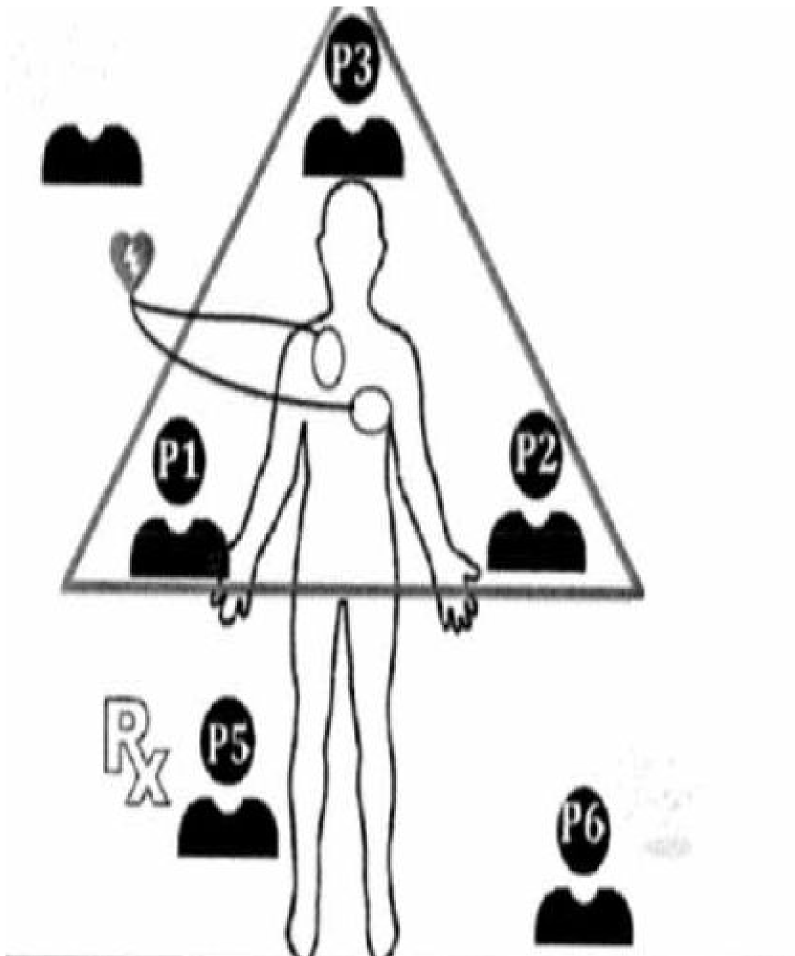
3.2A Team Focused CPR - Adult

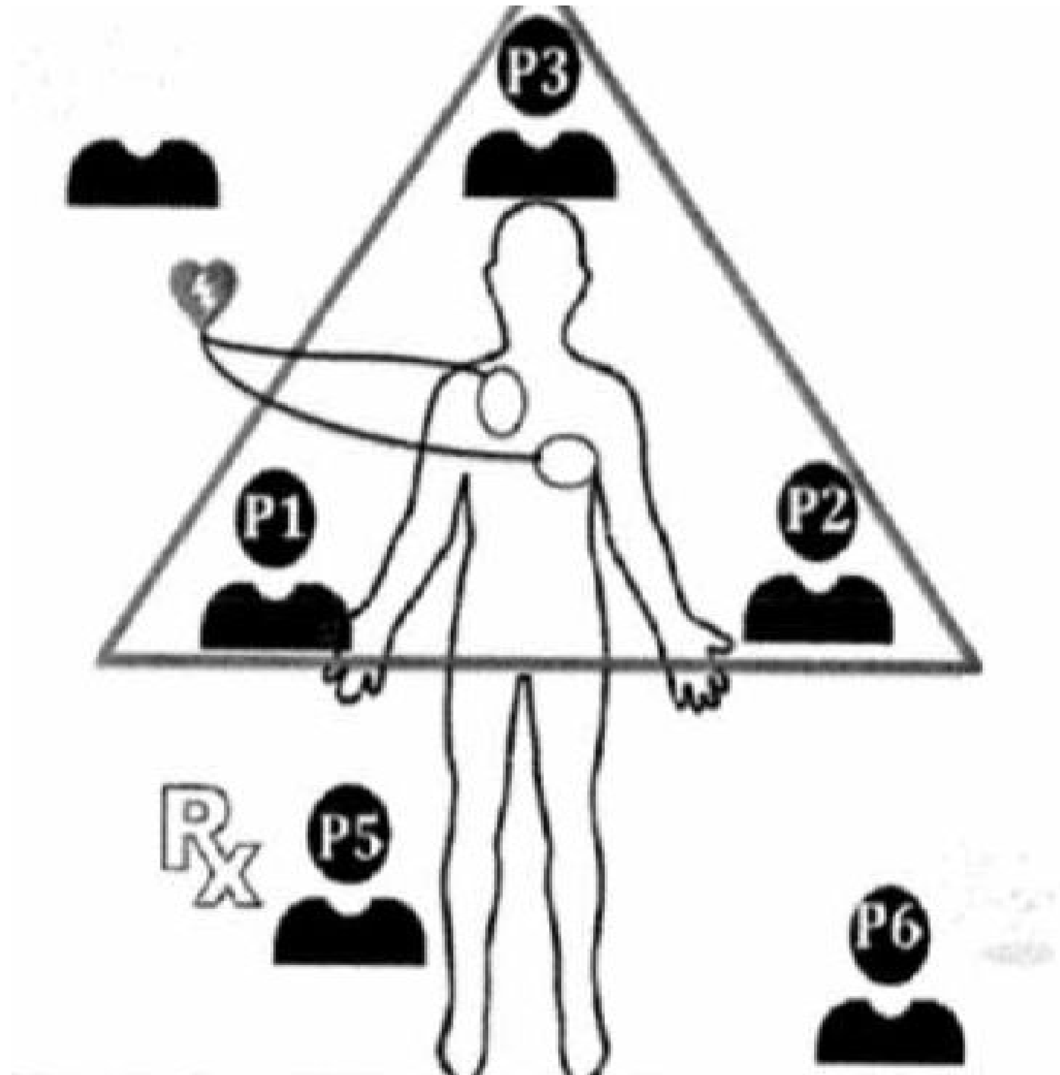
- Use of "pit crew" approach recommended.
- Training should include teamwork simulations, predefined roles.
- Several models available to follow.

Pit Crew CPR



- Position 1
  - Compressor 1
- Position 2
  - Compressor 2
- Position 3
  - Airway
- Position 4
  - Team Leader (outside triangle)
- Position 5
  - Vascular / meds
- Position 6
  - Code Commander

Pit Crew CPR



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6.1 Abuse and Neglect – Child, Elder, Incapacitated Adults

- According to CT laws, any and all cases of suspected abuse, neglect, or exploitation of children or the elderly must be reported.
- This applies even in cases when the patient is not transported.
- Protocol provides direction on how and when to report.

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6.2 Air Medical Transport

- Protocol provides guidance for determining the need and appropriateness of Air Medical Transport
- Of note:
    - AMT is not indicated for patients in cardiac arrest.
    - Transfers from ground ambulance to air-ambulance at a hospital heliport - no transfer of care to the hospital is implied or should be assumed by hospital personnel, unless specifically requested by EMS providers.

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6.4 Communications Failures

- Protocol provides guidance on how to handle communication failure with Direct Medical Oversight due to equipment malfunction or incident location.
- Of Note:
  - Providers acting under this protocol will provide a written notification pertaining to the communication failure describing the circumstances of the communication failure and the actions taken, to the agency's medical director or hospital EMS coordinator within 48 hours.

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7.1 Mass/ Multiple Casualty Triage

- Defines a Mass Casualty vs. Multi-Casualty Incident according to the FEMA definition.
- Identifies expectations for command structure, communication, triage.

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Appendix – Scope of Practice

ADULT Scope of Practice

Airway Management	EMR	EMT	AEMT	PARAMEDIC
BVM	x	x	x	x
Chest Tube Maintenance				x
Cleared, Opened, Heimlich	x	x	x	x
Combitube			x	x
CPAP		Δ	Δ	x
Endotracheal Intubation				x
Endotracheal Suctioning			x	x
KING LT-D			x	x
Laryngeal Mask Airway			x	x
Nasogastric Tube				x
Nasopharyngeal Airway		x	x	x
Nasotracheal Intubation				x
Nebulizer Treatment			*	x
Needle Decompression				x
Oral Suctioning	x	x	x	x
Oropharyngeal Airway	x	x	x	x
Oxygen Administration	x	x	x	x
Pulse Oximetry		x	x	x
Rapid Sequence Intubation				Δ
Tracheostomy Maintenance				x
Ventilator Operation				x

Specific skills are broken down by provider level

There are 3 sections to this appendix:

1. Adult Scope of Practice
2. Pediatric Scope of Practice
3. Adult & Pediatric Scope of Practice

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Acknowledgement

Special thanks to those who have provided input into this training program:

- Douglas Gallo, MD
- Richard Kamin, MD
- Connecticut EMS Advisory Board members

And especially:

The Connecticut EMS Advisory Board, Education and Training Committee for putting it all together.

A Few New Changes

Removal of Taser barbs is allowed

Narcan may be redosed after 3-5 minutes

EPI Pen slight change in wording

MDI = not just Albuterol; 4-6 puffs q5 min

CHF = assist with patients Nitro q5 min as long as systolic BP > 100mmHg

BGL for EMT’s = pathway is forthcoming

Worth Mentioning

VNS Magnets - not obligated to use, only if comfortable

Insulin Pump - best if family or others familiar with the unit can assist

Diastat - language may change with future version to specify “if properly trained in administration...may assist.”