Tucson Medical Center

Base Hospital

TUCSON MEDICAL CENTER
BASE HOSPITAL ADMINISTRATIVE/STANDING INDEX

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ABDOMINAL PAIN ADMINISTRATIVE ORDER

Initiate Immediate Supportive Care:

- Oxygen to maintain O_2 sat ≥ 94%
- Complete primary and secondary survey as indicated
- Vital signs including FSBG and temperature as indicated
- ALS Cardiac Monitor

INCLUSION CRITERIA

Use administrative order on patients complaining of abdominal pain

EXCLUSION CRITERIA

This administrative order should not be used on patients who are:

- Pregnancy - follow ***OB/GYN SO***
- Meeting Level One or abdominal trauma - follow ***ALS/BLS Stabilization AO***

ORDERS

BLS Care

Stable: SBP >90 or HR <130

- Initiate IVNS/LR (if permitted)
- Transport in position of comfort with supportive measures as indicated

Unstable: SBP <90 or HR >130

- Follow stable orders
- To keep SBP> 90, bolus 20 ml/kg maximum, reassess hemodynamic and pulmonary status at 500 ml intervals

ALS Care

- Follow BLS orders
- If patient stable with complaints of nausea and/or vomiting, administer Ondansetron HCL IV/IM/PO
- **Adult size(>30 kg)**
  - Ondansetron 4 mg IV over 2-5 minutes, if no response, may repeat once after 15 minutes
  - If unable to obtain IV, give Ondansetron Orally Dissolving Tablet (ODT) 8mg PO, **Do NOT Repeat**
- **Pediatric size(<30kg)**
- Ondansetron 0.15 mg/kg IV/IO over 2-5 minutes, do **NOT** repeat dose
- If patient stable, may follow ***Pain Management AO***
- If patient unstable, and unable to start IV, use I/O for fluid bolus

If patient's condition deteriorates, call Medical Direction Authority
Consider transport to closest facility. Provide appropriate receiving facility notification.

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ALS STABILIZATION ADMINISTRATIVE ORDER

Initiate Immediate Supportive Care:
- O_2 to maintain sat > 94%
- Complete primary and secondary survey as indicated
- Cardiac monitor, vital signs including FSBG and temperature as indicated
- 12 Lead EKG as indicated

Airway maintenance, control and ventilation
- Follow Airway Management Protocol as needed
- Follow Medicated Facilitated Intubation Protocol if indicated, if patient condition worsens or unable to secure airway

  Midazolam (Versed) Dosing: IV/IO/IM
  - Age 14 years of age or older: 1-10 mg, may repeat to max of 20 mg
  - Age 9-14 years of age: 1-4 mg slow push, may repeat to max of 15 mg
  - Age 8 years of age or younger: 1-2 mg slow push, may repeat to max 10 mg
  - IM Dosing all ages: 0.2mg/kg IM, same max per age
- **CPAP Adult Sedation**: with **Dyspnea SO, follow Sedation Protocol**
- **Croup Management:** Epi 3mg 1:1,000 mixed in 3 ml NS via SVN along with **Dyspnea SO**

Emergency treatment of ACLS/PALS conditions
- Follow the appropriate ACLS/PALS algorithm
- Electrical therapy with pacing, defibrillation or cardioversion
- Use **Sedation Protocol** as needed
- I/O consider following lidocaine dosing sheet for pain control

Injury Triage Criteria
- Follow **Trauma Triage Protocol** as indicated
- ATLS/ABCDE-injury area
- Consider C-Spine precautions-follow -**SMR Protocol** documenting use
- Initiate IV/IO NS/LR TKO as appropriate-Bolus to maintain systolic BP ≥ 90
- Manage extremity injuries as appropriate
- If TBI suspected follow **EPIC Protocol** for Adult or Peds
- Needle Decompression per SAEMS protocol
- If unable to control bleeding, follow **External Hemorrhage Control Protocol and/or TQ AO**
- **Pain Management AO** as needed if stable
- Falls- evaluate, describe impact surface, height of fall
- Painful procedure follow the **Sedation Protocol**
- Physical Assault

Hypotension
- SBP ≤90, pulse≥120, increased respirations, pale, cool skin, diaphoresis, altered mental status, agitation, or restlessness, progression to profound hypotension
- NS/LR bolus 20 ml/kg maximum, reassess hemodynamic status and pulmonary status at 500 ml intervals
- Consider causes
- Initiate Dopamine drip (if heart rate ≤ 100) 2-20 mcg/kg/min titrate to SBP≥80 if time permits or follow **Push Dose Epi Protocol**

Unconscious/unresponsive patient unresponsive or responsive only to painful stimuli
- Manage airway as above
- Initial IV with NS/LR TKO
- Bolus 20 mL/kg k maximum, reassess hemodynamic status and pulmonary status at 500 mL intervals to maintain SBP ≥90
- Administer Naloxone IV/IO/IN/IM 0.5 mg-2.0 mg, titrate to effect
- FSBG≤70, give 1mL/kg of D10 and 100mg Thiamine (if available). May hold Thiamine if no history of alcohol abuse or malnourishment)
- If status improves after treating FSBG, follow **Hypoglycemia AO**
- If FSBG >400, follow **Hyperglycemia AO**

If patient's condition deteriorates, call Medical Direction Authority
Consider transport to closest facility
Provide appropriate receiving facility notification

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ALS/BLS GENERAL ADMINISTRATIVE

Initiate immediate supportive care:

- Oxygen to maintain O_2 sat ≥ 94%
- Complete primary and secondary survey as indicated
- Vital signs including FSBG and temperature as indicated

ALS	BLS
• General weakness • ≤ 3 months old with any symptoms of illness or injury • Fever- 55 years of age and older with Temp > 102 or above • Dizziness • Overdose • Lightheaded • Lacerations Hypertensive patient with no other medical issues *****Requires cardiac monitor*****	• Nose bleeds-minor with stable vital signs • Finger lacerations • Toe injuries • Cactus needles • Earache • Cough- low grade fever under 18 years of age • Cold symptoms • General minor complaints *****No cardiac monitor required*****

ORDERS

ALS

- IV NS/LR TKO as indicated
- If indicated- bolus 20 ml/kg maximum, reassess hemodynamic and pulmonary status at 500 ml intervals
- 12 ECG as indicated
- Febrile patient follow **Over-the-Counter Medication Protocol**

BLS

- Prepare for transport
- Basic supportive care as needed
- Febrile patient follow **Over-the-Counter Medication Protocol**

If patient's condition deteriorates call, Medical Direction Authority
Consider transport to closest facility
Provide appropriate receiving facility notification

Tucson Medical Center
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BEHAVIORAL EMERGENCY ADMINISTRATIVE ORDER

Initiate immediate supportive care:

- Oxygen to maintain O_2 sat ≥ 94%
- Vital signs including FSBG
- Cardiac Monitor as indicated
- Consider IV access
- Complete Primary and Secondary Survey as indicated

INCLUSION CRITERIA

- History of recent crisis, emotional trauma, bizarre or abrupt changes in behavior
- Suicidal Ideation/Homicidal Ideation
- Acute psychiatric complaint
- No identified acute medical needs related to any acute correctable medical problem ie hypoxia, hypoglycemia, hypercapnia

EXCLUSION CRITERIA

- Any acute medical needs that would better fit a different SO/AO

ORDERS

BLS Care

- Assess for immediate danger
- Protect yourself and others from danger
- Protect the patient from harming self and others
- Calm patient with reassuring voice and gestures
- Summon Law enforcement as needed
- If patient is violent or exhibiting behavior that is dangerous to self and others and the EMS provider can safely perform the following
  - Restrain all four extremities with either padded leather or soft restraints. Patient must remain in the supine position. Restraints must allow for quick release. Handcuffs are for law enforcement use only
  - If patient requires physical restraints, vitals must be monitored, documenting circulatory and hands Q15 minutes

Pepper spray

Decon with H_2O, apply ice packs, discourage eye rubbing

Tazer Probes

Ask Law Enforcement to remove; if imbedded in face, neck or groin, transport for ED removal; do **NOT** remove

ALS Care

- ***Chemical Restraint Protocol*** as needed

Call Poison Control for suspected or verified Ingestions/overdose/exposures as needed
800-222-1222

Contact Medical Direction Authority:

- If the patient wishes to refuse
- If the EMS providers cannot safely restrain the patient
- If patient condition deteriorates

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BLS STABILIZATION ADMINISTRATIVE ORDER

Initiate Immediate Supportive Care:
- O_2 to maintain sat ≥ 94%
- Complete primary and secondary survey as indicated
- Cardiac monitor (non-interruptive) if available, vital signs including FSBG and temperature as indicated

Airway maintenance, control and ventilation
- Follow Airway Management Protocol

Dizzy or Lightheaded
- Treat BLS ABC
- Consider causes
- Start IV NS/LR at TKO (if permitted)

Injury Triage Criteria
- Follow ***Trauma Triage Protocol*** as indicated
- ABCDE-injury area
- Consider C-Spine precautions-follow ***SMR Protocol*** documenting use
- Initiate IV NS/LR TKO as appropriate-bolus to maintain systolic BP≥90
- Manage extremity injuries as appropriate
- If TBI suspected follow ***EPIC Protocol*** for Adult or Peds
- If unable to control bleeding, follow ***External Hemorrhage Control Protocol and/or Tourniquet AO***
- ***Pain Management AO*** *as needed if stable*
- Falls- evaluate, describe impact surface, height of fall
- Physical assault

Hypotension
- SBP ≤90, pulse ≥120, increased respirations, pale, cool skin, diaphoresis, altered mental status, agitation, or restlessness, progression to profound hypotension
- NS/LR bolus 20 mL/kg maximum, reassess hemodynamic status and pulmonary status at 500 ml intervals
- Consider causes

Unconscious/unresponsive patient unresponsive or responsive only to painful stimuli
- Manage airway as above
- Initial IV with NS/LR TKO
- Bolus 20 mL/kg maximum, reassess hemodynamic status and pulmonary status at 500 ml intervals to maintain SBP≥90
- If status improves after treating FSBG, follow ***Hypoglycemia AO***
- If suspected overdose-administer Naloxone per ***Naloxone Protocol***

Febrile patient follow ***Over-the-Counter Medication Protocol***

Anaphylaxis/Allergic Reaction/Urticaria
- Follow ***Dyspnea Anaphylaxis/Allergic Reaction SO***
- Follow ***Over-the-Counter Medication Protocol*** for diphenhydramine administration

Symptoms of dehydration and/or as indicated
- IV with NS/LR bolus 20 mL/kg maximum, reassess hemodynamic status and pulmonary status at 500 ml intervals (if permitted)

If patient's condition deteriorates call, Medical Direction Authority. Consider transport to closest facility.
Provide appropriate receiving facility notification

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BURN ADMINISTRATIVE ORDER

Initiate immediate supportive care as indicated:

- Oxygen to keep 0_2 Sat > 90%
- Cardiac Monitor

Inclusion

- Patients sustaining thermal burns
- Patients who are exposed to electrical current (AC or DC)
- Patients of all ages who have been the victim of a lightning strike

Exclusion

- Chemical and radiation burns

Orders

BLS Care:

- Stop the burning process:
  - Soak clothing and skin with water if smoldering
  - Remove clothing that is not stuck to the patient and remove jewelry
- Leave blisters intact
- Do not use ice
- Cover burns with a dry dressing or clean sheets.
- Evaluate for high risk burn injuries
- Keep patient warm.
- Estimate involved body surface area (BSA) using an appropriate burn estimation guide
- Establish IV access if authorized (If establishing IV avoid placement through burned skin)
- Start high flow oxygen with non-rebreather if
- inhalational injury suspected.

ALS Care

- Consider early aggressive airway management in patients at risk for inhalation injury
- Administer initial fluid bolus of 20 ml/kg
- Treat nausea/vomiting per Abdominal pain, nausea & vomiting SO
- Administer Pain medication for severe pain per Pain Management SO

High Risk Burns/ Burn Triage should be transported to the regional burn facility if meeting the following criteria:

Partial thickness burns:
- 10% total body surface area (TBSA)

Full thickness burn:
- 5% TBSA

Significant burns that involve the face, hands, feet genitalia, perineum or major joints

Electrical burns, including lightning injury

Inhalation injury

Significant burn injury in patients with pre-existing medical disorders that could complicate management, prolong recovery or affect mortality, such as: diabetes, cardiac disease, pulmonary disorders, pregnancy, cirrhosis, morbid obesity, immunosuppression, bleeding disorders

In outlying areas with a transport time of greater than 30 minutes to the regional burn facility, transport the patient to the closest facility or consider air transport directly to the closest burn facility.

Regional burn facility currently in SAEM S: Banner UMC-Tucson Campus

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CARDIAC ARREST ADMINISTRATIVE ORDER

Inclusion	Exclusion
• Out of hospital cardiac arrest	• Patients meeting SAEMS Dead on Scene SO • Age < 8-years-old

Initial Orders

- Initiate chest compressions with rate of 100-120 compressions per minute

Likely Cardiac Cause

Minimally Interrupted Cardiac Resuscitation (MICR) - first 8 minutes

- NRB mask, max flow 02 & NPA/OPA
- Perform 4 rounds of CPR
  - 200 compressions
  - Check rhythm (and pulse when indicated), defibrillate if indicated between rounds
  - Minimize interruptions

ALS

- Administer Epi 1mg IV/IO (as early as possible) to max total dose of 2mg with doses separated by 8 min.
- IF VF after first shock, administer Amiodarone 300mg IV/IO or lidocaine 1mg/kg IV/IO x 1
- If continued VF after THIRD shock administer Amiodarone, 150mg IV/IO or lidocaine 1mg/kg IV/IO x 1

Likely Non-cardiac Cause

ACLS

- Apply SAEMS Airway Management Protocol
- Perform CPR checking rhythm (and pulse when indicated), defibrillating if indicated every 2 minutes with ventilation rate of 10 breaths / minute

ALS

- Administer Epi 1mg IV/IO (as early as possible) to max total dose of 2 mg with doses separated by 8 min.*
- Consider ACLS H's & T's - treat per current ACLS guidelines*
- Avoid hyperthermia

BLS

- IF no shock indicated and patient meets Dead on Scene AO criteria for termination, no transport or further interventions are indicated.

NO Response

If ROSC at ANY time:
Prepare for rapid transport per appropriate SAEMS Triage Protocol (CRC, Trauma , Peds, OB)

- If NO response, apply Dead On Scene AO
- Consider transport for a patient with: persistent VF, PEA with elevated $EtCO_2$ (> 20 mmHg), patients under age 18 years

ACLS Interventions

Hypoxia
- Airway management

Hydrogen Ion or acidosis
- 500cc fluid bolus
- Adjust $ETCO_2$ to 40

Hyperkalemia
- Administer Calcium Chloride 1gm IV/IO and Sodium Bicarbonate 50mEq IV/IO

Hypovolemia
- 500 ml fluid bolus

Hypoglycemia
- Dextrose

Hypothermia
- Hypothermia AO

Tension pneumothorax
- Needle decompression

Trauma
- Rapid transport

Toxins
- Beta
- TCA overdose, administer bicarb beta blocker or calcium channel blocker overdose; consider glucagon and cardiac pacing
- Opiate overdose; consider Narcan

Patient Destination: Patients should be transported per SAEMS Cardiac Receiving Center Triage Protocol
* if transitioning from MICR to ACLS give only a total of 2mg Epi

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CHEST PAIN ADMINISTRATIVE ORDER

Initiate immediate supportive care:

- Oxygen to maintain O_2 sat ≥ 94%
- Complete primary and secondary survey as indicated
- Vital signs including FSGB
- ALS cardiac monitor
- EMT cardiac monitor (non interruptive) if available

INCLUSION CRITERIA

Use this Administrative Order for patient's ≥25 years of age with these symptoms

- Dull aching or substernal/ epigastric pressure
- Possible radiation of pain/pressure to arm/neck/shoulder/jaw
- Associated diaphoresis/or shortness of breath
- Back pain or epigastric discomfort for women
- Past medical history of cardiac disease or angina
- Use on patients ≤25 years of age with hx of recent drug use

EXCLUSION CRITERIA

Administrative order should not be used on patients with these symptoms:

- Pulmonary edema- follow ***Dyspnea SO***
- ALS-Dysrhythmia's Specific- follow ***ALS Stabilization AO***

ORDERS

BLS Care

- Administer: Aspirin (4) 81mg chewable tablets or Aspirin 324 mg
- Initiate IV NS/LR TKO (if permitted)
- If SBP ≥ 110 give one* nitroglycerine 0.4 mg SL/spray or patient assist self-administration every 5 minutes X 3 or until pain relieved
- **Hold Nitroglycerin if SBP drops below 90mm Hg**
  - If SBP drops ≤90– place patient in Trendelenburg and give 250 ml fluid bolus, reassess hemodynamic and pulmonary status and repeat as needed
- **Use Nitroglycerin cautiously in patients with ST –segment elevation in leads II, III, and AVF (inferior MI).**

ALS Care

- Follow BLS orders
- Obtain 12-lead EKG and send to receiving facility if possible
- For nausea or vomiting administer Ondansetron:
  - Ondansetron 4 mg IV/IM over 2-5 minutes, if no response, may repeat once after 15 minutes
  - If unable to obtain IV, give Ondansetron Orally Dissolving Tablet (ODT) 8mg PO, **Do NOT Repeat**
- Morphine Sulfate 2-5mg IV/IM every 5 minutes to a maximum dose of 20 mg
- If patient allergic to Morphine
  Administer Fentanyl 25mcg-50mcg IV/IN/IM **slow IV push** over 2 minutes. May repeat every 5 minutes to a maximum dose of 200 mcg
- If at any point during medication administration, SBP≤90 drops follow above orders for fluid bolus and management

If patient's condition deteriorates, call Medical Direction Authority
Consider transport to closest facility. Provide appropriate receiving facility notification.

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DEAD ON SCENE ADMINISTRATIVE ORDER

INCLUSION
Pulseless and apneic

EXCLUSION
Hypothermia, lightning strikes

Does patient have condition incompatible with life?

- Decapitated
- Decomposed
- Rigor mortis
- Burned beyond recognition
- Extrusion of brain matter
- Removal of lower half of body
- Absent signs of life with VALID DNR

No

Yes

ASSESS CAUSE OF CARDIAC ARREST

Non-traumatic Cardiac Arrest

All the following criteria must be met for each category:

Un-witnessed arrest:

- Prolonged downtime (>30 min) is likely,
- PEA/Asystole or non-shockable rhythm noted on AED,
- and no pulse for 60 seconds.

OR

Witnessed Arrest:

- 20 minutes of resuscitation with PEA and $EtCO_2$ < 10 mmHg
- OR Asystole or non-shockable rhythm noted on AED.

Traumatic Cardiac Arrest

ORDERS

If airway obstruction or tension pneumothorax: Consider OPA/NPA and bilateral needle thoracostomy.

Penetrating Trauma

If continued pulseless

AND

Time to Level I

Trauma Center > 15 min

Blunt Trauma

If continued pulseless

ORDERS
May withdraw or withhold resuscitative efforts

Special Note:

If asked for a time of death please provide the TIME at which resuscitation was withheld/withdrawn

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Anaphylaxis/Allergic Reaction Administrative Order

Initiate Immediate Supportive Care:
- Oxygen to maintain O_2 sat ≥ 94%
- Complete primary and secondary survey as indicated
- Vital signs including FSBG and temperature as indicated

Unstable Allergic Reaction:

INCLUSION CRITERIA
• Signs of shock, severe respiratory distress or airway compromise

EXCLUSION CRITERIA
- Meets Stable Allergic Reaction Criteria

ORDERS

Unstable Allergic Reaction:
BLS Care
Administer Epinephrine via auto injector:
- Adult: weight >30kg
- Pediatric: weight <30kg

Administer Epi IM
Adult dose: 0.3-0.5ml (1ml=1mg), may repeat every 15 min, max 1mg
Peds dose: 0.01mg/kg (max dose 0.5mg), may repeat every 15 min, max 1mg.
- Consider early airway management per **Airway Management Protocol**
- Continue with orders outlined in Stable Allergic Reaction

ALS Care
- BLS Orders
- Epinephrine 0.01mg/kg IM to a max of 0.5mg. May repeat every 5 minutes for hypotension or airway edema.
  - 1mg/ml solution or may substitute age/weight appropriate epinephrine auto-injector

Stable Allergic Reaction:

INCLUSION CRITERIA
• Urticaria (Hives)
• Sense of dyspnea
• Sense of oropharyngeal swelling
• Sense of throat tightness

EXCLUSION CRITERIA
- Unstable vital signs, respiratory distress (Follow Unstable Allergic Reaction)

ORDERS

Stable Allergic Reaction
BLS Care if respiratory involvement
- Duoneb nebulized therapy every 15min, may repeat x 2, max of 3 doses
- *Albuterol nebulized therapy (if no Duoneb available)*
  - Single unit dose. May repeat Albuterol every five minutes to a max of three doses
- IV access and NS/LR if applicable
  - 20ml/kg to a max of 1000ml, reassess pulmonary after 500ml
- Diphenhydramine PO
  - **Dosage**
    - Adult (≥ 15 years old) 25-50 mg
    - Pediatric (≥ 6 months-14 years of age) 1 mg/kg (max 25mg)

ALS Care
- BLS Orders
- Diphenhydramine IV
  - 1mg/kg IV to a max of 50mg
- Methylprednisolone
  - 2mg/kg IV to a max of 125mg

Special Notes:
- If patient's condition deteriorates, call Medical Direction Authority
- Consider transport to closest facility. Provide appropriate receiving facility notification.

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ASTHMA/COPD ADMINISTRATIVE ORDER

Inclusion

History of respiratory disease (asthma, COPD), wheezing with increased work of breathing.

Exclusion

Anaphylaxis, bronchiolitis, croup, epiglottitis, CHF, drowning, bronchitis, pneumonia, trauma, foreign body aspiration

Initial BLS Care

- Duoneb nebulized therapy
  - May repeat Duo neb every 15 minutes to a max of three doses.

Initial ALS Care

- Duoneb nebulized therapy
  - May repeat Duoneb every 15 minutes to a max of three doses.
- IV access and NS/LR fluid bolus
  - 20ml/kg to a max of 1000ml
- Methylprednisolone
  - 2mg/kg IVP to a max of 125mg

Orders for Presumed Asthma and severe respiratory distress unresponsive to initial therapy:

ALS Care

- Epinephrine 0.01mg/kg to a max of 0.5mg - 1 mg/ml IM (preferred)* or may substitute age/ weight appropriate epinephrine auto-injector
- Magnesium Sulfate 40mg/kg to max of 2 grams IV
  - Dilute in 50cc bag of crystalloid and administer over 15-30 minutes

Orders for Presumed COPD and severe respiratory distress unresponsive to initial therapy:

BLS/ALS Care

- CPAP (if authorized for BLS provider)
  - Initiated per CPAP protocol
  - Limited to CPAP systems that allow administration of Albuterol and Ipratropium while CPAP is applied

If respiratory failure, support ventilation with BVM. Consider Airway Management Protocol.

SPECIAL NOTE:

- In the management of patients with asthma, ETI should be used as a last resort.
- Following ETI, ventilate slowly (keep respiratory rate to 10/min or less) and with a low tidal volume (6cc/kg (ideal body weight)).

* *Administration of IV epinephrine can result in significant tachycardia / hypertension and complications such as heart attack & stroke.*

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CHF/VOLUME OVERLOAD ADMINISTRATIVE ORDER

Inclusion

History of volume overload (CHF, Renal Failure) with increased work of breathing or dyspnea.

Exclusion

Signs of infection (refer to Asthma/COPD AO), e.g., fever.

Orders for Normotensive (SBP>90) patients

BLS Care

- Initiate CPAP Protocol (If authorized)
- IV saline lock (if authorized)
- E+ CO_2 monitor, if applicable

ALS Care

- BLS Orders
- 12-lead ECG and continuous cardiac monitor
- Nitroglycerin
  - 0.4mg SL. Repeat every five minutes to a max of three doses.
  - Hold if SBP <90

Orders for Hypotensive (SBP<90) patients

BLS Care

- IV saline lock (if authorized)
- E+ CO_2 monitor, if applicable

ALS Care

- BLS Orders
- 12-lead ECG and continuous cardiac monitor
- Initiate CPAP Protocol with pressor support
- Dopamine (if heart rate <100)*
  - 2-20 mcg/kg/min titrate to SBP>80 to a max dose of 20 mcg/kg/min

Orders

If altered mental status or failure to respond to CPAP, support ventilation with BVM.

Consider Airway Management Protocol.

SPECIAL NOTE:

- Furosemide and Morphine are no longer considered appropriate first line prehospital interventions in the management of CHF/Volume overload in the prehospital setting. Should a provider feel that these interventions might be appropriate contact medical direction.

*Infusion of dopamine for patients with congestive heart failure and a heart rate greater than 100 decreases cardiac output and has been shown to increase mortality and morbidity.

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ETOH
ADMINISTRATIVE ORDER

Initiate immediate supportive care:
- Oxygen to maintain O_2 sat ≥ 94%
- Vital signs including FSBG
- Cardiac Monitor if indicated
- Consider IV access

INCLUSION CRITERIA

- ETOH consumption
- No other emergent medical need

ALL of the following must be present in ages 13 or greater:

- Glasgow coma score of 13 or greater
- Blood pressure: Systolic 100-180 Diastolic 60-100
- Pulse rate 60-120
- Respiratory Rate of 16-28
- Blood Glucose 70-400 adult

EXCLUSION CRITERIA

- Unconscious/unresponsive patient
- Requires any ALS treatment including EKG
- Pt falls under a more appropriate SO/AO

ORDERS

ALS/BLS Care

- Calm patient with reassuring voice and gestures
- Consider initiating IV NS/LR if permitted
- Consider bolus 20 ml/kg IV maximum. Reassess hemodynamic and pulmonary status at 500 ml intervals
- Utilize law enforcement assistance if necessary
- If patient is combative and/or a danger to themselves or EMS personnel and requires restraint, refer to ***Behavioral AO***
- Transport to the closest most appropriate facility

If patient's condition deteriorates, call Medical Direction Authority
Consider transport to the closest facility
Provide appropriate receiving facility notification

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EYE INJURY ADMINISTRATIVE ORDER

Initiate immediate supportive care:

- Oxygen to maintain O_2 sat ≥ 94%
- Vital signs
- Consider IV access

INCLUSION CRITERIA

- Blunt or penetrating trauma to the eye
- Chemical substance in the eye

ORDERS

PENETRATING EYE INJURY

BLS/ALS Care

- Follow SAEMS Trauma Triage Protocol
- Transport patient with head slightly elevated and BOTH eyes closed or loosely covered
- ***Pain Management AO*** as indicated
- **Presence of protruding foreign body**
  - DO NOT remove the foreign body
  - Stabilize foreign body

ORDERS

CORNEAL BURN/ABRASION OR CHEMICAL EXPOSURE

BLS Care

- Irrigate with Normal Saline for at least 20 minutes
- Continue irrigation en route to facility
- ***Pain Management AO*** as indicated

ALS Care

- Place Morgan Lens or other eye irrigation tool under eye lid and irrigate eyes with tap or water or NS.
  Refer to ***Morgan Lens Protocol***
- Discontinue when:
  - Patient cannot tolerate due to pain
  - 15 min of irrigation has been performed and eyes are no longer irritated

If patient's condition deteriorates, call Medical Direction Authority.

Consider transport to the closest facility.

Provide appropriate receiving facility notification.

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HYPERTHERMIA ADMINISTRATIVE ORDER

Initiate immediate supportive care:

- Oxygen to maintain O_2 sat ≥ 94%
- Vital signs including FSBG
- Cardiac Monitor, if available
- Consider IV access
- Move patient to cooler environment

INCLUSION CRITERIA

History of heat exposure:

- Heat Cramps: minor muscle cramps with normal temperature
- Heat Exhaustion: painful muscle cramps, nausea/vomiting, salt and water depletion leading to tachycardia, hypotension, elevated body temperature
- Heat Stroke: altered mental status, body temp typically >104°F, fainting or loss of consciousness, decreased sweating

ORDERS

ALS/BLS

- Passive cooling: Move patient to cool area and shield from sun or external heat source, loosen clothing, small sips of water if alert
- If temperature >104°F begin active cooling:
  - Remove clothing and continual misting the exposed skin with tepid water while fanning patient (most effective)
  - Apply ice packs to head, neck, groin, axilla
  - Stop active cooling if uncontrolled shivering develops, continue passive measures
- Establish IV/IO NS (If permitted)
  - 20mL/kg bolus, may repeat bolus once. Reassess hemodynamic and pulmonary status at 500ml intervals
- For seizures follow with treatment ***Seizure AO***
- For nausea or vomiting follow with treatment ***Nausea/Vomiting AO***
- Monitor for other complications:
  - AMI or heart failure
  - Weakness or paralysis
  - Electrolyte abnormalities may result in dysrhythmias; treat per ***ACLS guidelines***

If patient's condition deteriorates, call Medical Direction Authority

Consider Transport to closest facility

Provide appropriate receiving facility notification

Tucson Medical Center
Base Hospital

HYPO/HYPER-GLYCEMIA ADMINISTRATIVE ORDER

Initiate immediate supportive care:
- Secure & maintain airway
- Oxygen to keep O_2 sat >94%
- Complete primary and secondary survey as indicated
- Vital Signs including FSBG
- If FSBG ≥ 70 and ≤400, and patient is unconscious, follow ***Stabilization AO***

HYPOGLYCEMIA

For neonates with FSBG ≤40 mg/dl or for patients ≥ one month of age with a FSGB ≤70 mg/dl

ALS/BLS Care

(> 15 years of age)
- If alert and maintaining their airway, administer 1 to 2 tubes of oral glucose
- Initiate IV NS/LR at TKO (if permitted)
- Reassess FSBG

(> 1-14 years of age)
- If alert and maintaining their airway, administer 1 tube oral glucose
- Initiate IV NS/LR (if permitted)
- Reassess FSBG

ALS Care
- Initiate IV/IO NS/LR at TKO(saline lock not acceptable for administration)
- Reassess FSBG after each treatment
- **Dosage:**
  Dextrose 10% (D10) 1ml/kg, max 250 ml
  Flush IV with 10 ml NS/LR after D10 infusion
- May repeat dose to maintain FSBG ≥ 70

Glucagon administration: If unable to initiate IV
- **Adult Size (≤60 kg)**
  1 mg IM may repeat in 7-10 minutes
- **Pediatric Size (≤ 60 kg)**
  0.5 mg IM may repeat in 7-10 minutes

If patient **≥18 years,** condition improves and they do not wish further evaluation, no medical direction is required if all of the following are present:
- This was an acute hypoglycemic event and patient has regained a normal mental status
- Patient has history of Diabetes or Hypoglycemia
- Current FSBG is ≥ 70
- A responsible adult is present
- Further caloric intake is assured
- There are no clinical findings consistent with acute illness

HYPERGLYCEMIA

For patients > one month of age with a FSBG > 400

ALS/BLS Care

(> 8 years of age)
- Initiate IV/IO NS/LR
- Bolus 20 mL/kg maximum, reassess pulmonary status at 500 mL intervals
- Slow rate to TKO after fluid boluses
- Reassess FSBG

(< 8 years of age)
- Initiate IV NS/LR
- Bolus 20 ml/kg maximum, reassess pulmonary status once half of the bolus is infused
- Decrease rate to TKO
- Reassess FSBG

Special Note:

Dilute D50 (dextrose 50% containing 25 Grams of dextrose) to a 1:4 solution. To prepare, obtain a 250mL container of normal saline for IV use, waste 50mL and add 50mL of dextrose 50%. The resulting solution is dextrose 10% in normal saline or 10 Grams/100mL

If patient's condition deteriorates, call Medical Direction Authority
- Consider transport to closest facility
- Transport to closest pediatric care facility if condition permits
- If rural area, transport to closest facility
- Provide appropriate receiving facility

Tucson Medical Center
Base Hospital

HYPOTHERMIA ADMINISTRATIVE ORDER

Initiate Immediate Supportive Care

- Be gentle (rough handling of patient may precipitate arrhythmias)
- Secure and maintain airway
- Remove all wet garments (cut off to avoid jostling the patient)
- Move patient to warm/dry environment and protect from heat loss
- Oxygen to keep Sp O_2 > 94%
- Obtain vital signs including temperature and blood glucose
- Cardiac monitoring if available

Inclusion

Mild Hypothermia	Moderate Hypothermia	Severe Hypothermia
90 - 95 °F (32-35 °C)	82 - 90 °F (28-32 °C)	< 82°F (<28°C)
OR	OR	OR
Ataxia Slurred Speech Confusion Impaired judgment, Shivering	Bradycardia (afib/flutter) Hyporeflexia Decreased/absent shivering	Weak/absent pulse Hypotensive Unresponsive Fixed/dilated pupils, Pulmonary edema Ventricular dysrhythmia

Orders

Mild Hypothermia	Moderate Hypothermia	Severe Hypothermia
• 90 - 95 °F (32-35 °C) • Passive external rewarming	• 82 - 90 °F (28-32 °C) • Active external rewarming • Warm packs to groin, axillae, neck and trunk (avoid surface burns) • 20ml/kg NS bolus (warmed if possible)	• <82 °F (<28 °C) • Continue with moderate rewarming hypothermia tx guidelines. • Confirm pulse/rhythm every 3-5 minutes

Special Notes:

- Because field temperature measurement may be imprecise, the recognition of each stage is more important than exact categories.
- If resuscitative measures are indicated: Intubate only if patient is in V-fib or asystole, give IV medications as indicated (although generally ineffective), limit to one shock for VF/VT.

Tucson Medical Center
Base Hospital

NAUSEA/VOMITING ADMINISTRATIVE ORDER

Initiate immediate supportive care:

- Oxygen to keep O_2 sat ≥94%
- Complete primary and secondary survey as indicated
- Vital Signs including FSBG and temperature as indicate

INCLUSION CRITERIA

- Complaints of nausea and/or vomiting
- Diarrhea with either of the above

EXCLUSION CRITERIA

- None

ORDERS

BLS Care

- Establish IV NS/LR: If evidence of dehydration or hypo-perfusion to maintain adequate peripheral perfusion: (if permitted)
- Bolus 20 mL/kg maximum, reassess pulmonary status at 500 ml intervals

ALS Care

- Follow BLS orders
- Administer Ondansetron HCL IV/IM/PO
- **Adult size(>30 kg)**
  - Ondansetron 4 mg IV over 2-5 minutes, if no response, may repeat once after 15 minutes
  - If unable to obtain IV, give Ondansetron Orally Dissolving Tablet (ODT) 8mg PO
  - **Do NOT Repeat**
- **Pediatric size(<30kg)**
  - Ondansetron 0.15 mg/kg IV over 2-5 minutes
  - **Do NOT Repeat**

If patient's condition deteriorates, call Medical Direction Authority
Consider transport to closest facility.
Provide appropriate receiving facility notification.

Special Note:
Ondansetron in general is ineffective for motion sickness
Caution: avoid volume overload in geriatric patients

Tucson Medical Center
Base Hospital

OBGYN Vaginal Bleeding Administrative Order

Initiate immediate supportive care:

- Oxygen to maintain O_2 sat ≥ 94%
- Vital signs including FSBG
- Cardiac Monitor, as indicated
- Consider IV access

INCLUSION CRITERIA

- Vaginal Bleeding
  - Non-gestational
  - Gestational
  - Non-traumatic
  - Post-partum

EXCLUSION CRITERIA

- Contractions
- Traumatic Vaginal Bleeding
- Sexual Assault

ORDERS

BLS/ALS

Stable Vitals

- IV NS/LR at TKO
- If applicable, place products of conception in container and transport with patient
- ≥ 20 weeks place in left lateral recumbent position

Unstable Vitals: exhibiting shock symptoms including SBP ≤ 90, HR ≥ 110 or estimated blood loss ≥ 250 ml

- Shock position
  - ≥ 20 weeks: Left Lateral recumbent
  - ≤ 20 weeks or not pregnant: Trendelenburg
- High flow O2 via NRB, if pregnant
- Two large bore IV's, if permitted (16 or 18 gauge is preferred)
- NS/LR bolus of 20 ml/kg, reassess patient at 500 ml intervals

Is the patient experiencing Postpartum Hemorrhage?

Postpartum hemorrhage can occur up to 12 weeks after delivery

Yes

BLS Care

- Fundal massage

ALS Care

- Administer Pitocin 20 units in NS/LR 1000 ml wide open IV/IO

No

If patient condition deteriorates or no improvement, contact medical direction authority.

Transport to the most appropriate receiving facility or per **High Risk OB Triage Protocol**
Provide appropriate receiving facility notification

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Tucson Medical Center
Base Hospital

Presumed Pregnant with Contractions and/or SROM Administrative Order

Initiate immediate supportive care:

- Oxygen to maintain O_2 sat ≥ 94%
- Vital signs including FSBG
- Cardiac Monitor, as indicated
- Consider IV access

INCLUSION CRITERIA

- Known or suspected pregnancy (i.e. missed periods)
- Contractions or Signs of Labor
- Spontaneous Rupture of Membranes (SROM)
- Cord/Limb/Breech/Shoulder Presentation

ORDERS

BLS and ALS Care

- Place patient in left lateral recumbent position
- Large bore IV NS/LR (16 or 18 gauge) if permitted
- Initiate bolus 500 ml and reassess pt. If labor persists after assessment re-bolus with 500 ml
- Prepare for possible delivery

If delivery occurs:

- Suction mouth then each nostril with bulb syringe to clear airway
- Delayed Cord clamping: If possible, delay clamping and cord cutting for 1 minute after delivery as this also helps with resuscitation of the infant
- Assess infant and calculate APGAR score at one and five minutes post-delivery using table
- Perform Fundal massage on mother- Do not pull on umbilical cord
- Postpartum Bleeding- Refer to ***Vaginal Bleeding AO***

Complicated Childbirth

Cord Around Neck

- Loosen Cord
- If too tight- apply two clamps, cutting between clamps

Prolapsed Cord

- Transport mother with hips elevated and knees to chest
- Insert gloved finger to relieve pressure on cord
- Assess pulsations
- DO NOT pull on cord
- Protect exposed cord

Limb/Breech/Shoulder Presentation

- Do not encourage mother to push
- Support but do not pull presenting parts
- Insert gloved finger to relieve pressure on cord if needed

If patient condition deteriorates or no improvement- contact medical direction authority

Transport to the most appropriate receiving facility or per ***High Risk OB Triage Protocol***
Provide appropriate receiving facility notification

APGAR Scoring (SIGN)	0	1	2
Appearance	Blue or Pale	Body Pink, Extremities Blue	Completely Pink
Heart Rate (BPM)	Absent	≤100	>100
Grimace (reaction to catheter in nares)	No Response	Grimace	Cough or Sneeze
Muscle Tone	Limp	Some Flexion	Active Motion
Respiratory Rate	Absent	Slow/Irregular	Good, Crying

Tucson Medical Center
Base Hospital

Eclamptic Seizure Administrative Order

Initiate immediate supportive care:

- Oxygen to maintain O_2 sat ≥ 94%
- Vital signs including FSBG
- Cardiac Monitor, as indicated
- Consider IV access

INCLUSION CRITERIA

- Known/suspected pregnancy with gestational age of 20 weeks or greater
- Postpartum up to 12 weeks from delivery
- New onset seizure and known seizure disorder

EXCLUSION CRITERIA

- Known/suspected pregnancy with gestational age less than 20 weeks

ORDERS

BLS Care

- Place patient in left lateral recumbent position
- High-flow oxygen via NRB
- Initiate IV NS/LR at TKO if permitted

ALS Care

- Follow BLS orders
- Give Midazolam 10 mg IM
- Administer Magnesium Sulfate 5 gram bolus in 250 mL IV/IO over 15 minutes
  - Hold of SBP ≤ 90 mmhg
  - Monitor of respiratory depression

↓

If seizure does not terminate or patient condition deteriorates or no improvement, contact Medical Direction Authority

↓

Transport to the most appropriate receiving facility or per
High Risk OB Triage Protocol
Provide appropriate receiving facility notification

Tucson Medical Center
Base Hospital

PAIN MANAGEMENT ADMINISTRATIVE ORDER

Initiate immediate supportive care:
- Oxygen to maintain O_2 sat ≥ 94%
- Vital signs including FSBG
- Cardiac Monitor
- Consider IV access

INCLUSION CRITERIA

- Acute extremity injuries to include but not limited to hip, pelvic, and shoulder
- Acute back pain
- Burns ≤ 10% BSA
- Eye injuries
- Acute flank Pain
- Snake Bites-stable
- Abdomen pain-stable

EXCLUSION CRITERIA

- Decreased mental status
- Pregnancy

ORDERS

BLS Care
Determine pain score assessment using standard pain scale
- 3 months of age-4 years: Observational scale (FLACC)
- 4-12 years: Face pain scale
- ≥ 12 years: Numeric Rating Scale

Initiate IV NS/LR TKO (if permitted)
Analgesic (if no nausea, vomiting, abdomen pain)
Acetaminophen (oral liquid, rectal suppository or tablet/capsule) **ONE TIME DOSE**
- Adult (≥ 15 years) up to 650 mg PO
- Pediatric (6-14 years) 10 mg/kg PO or PR
- Pediatric (≤ 6 years) rectal:
  - ≤10 kg-120 mg suppository
  - 10-20 kg-160 mg suppository
  - ≥ 20 kg 325 mg suppository

Ibuprofen (oral, liquid or tablet/capsule) **ONE TIME DOSE**
- ≥ 6 months of age (maximum dose 600 mg)
  - Adult (≥ 15 years) 200-600 mg PO
  - Pediatric (≥ 6 months-14 years)
    - 5 mg/kg

ALS Care
Follow BLS Treatment
Cardiac Monitor
Ondansetron IV/IM/IO for nausea or vomiting
- Adult size (≥30 kg)
  - Ondansetron 4 mg IV over 2-5 minutes, may repeat once after 15 minutes
  - If unable to obtain IV, give Ondansetron 8mg PO Orally Dissolving Tablet (ODT), Do NOT Repeat
- Pediatric size(≤30kg)
  - Ondansetron 0.15 mg/kg IV over 2-5 minutes, do NOT repeat dose

Morphine Sulfate IV/IO/IM
- Adult size (≥30kg) 2-5 mg q5 max dose of 20mg
- Pediatric size (≤30kg) 0.1mg/kg in increments of 1-2mg

Fentanyl IV/IN/IM/IO
- Adult: (≥ 15 years) 25-50 mcg SLOW, over 2 minutes, max individual dose of 50 mcg. If no response, may repeat every 5 minutes to a max total dose of 200mcg
  - Intranasal dosing max 1ml per nostril
- Pediatric: (2 years-14 years) 1mcg/kg SLOW (given over 2-5minutes) Not to exceed 50 mcg, every one hour as needed
  - Intranasal dosing = ½ of dose per nostril

Do not continue dosing unless SBP ≥90mmHg, patient remains alert, respiratory rate and effort remain normal

If patient's condition deteriorates, call Medical Direction Authority
Consider transport to closest facility. Provide appropriate receiving facility notification.

Tucson Medical Center
Base Hospital

PEDIATRIC CARDIAC ARREST ADMINISTRATIVE ORDER

Initiate immediate supportive care

- Obtain vital signs
- Oxygen to keep SpO_2 > 94%
- Cardiac monitor (if available)
- Use the Broselow or Handtevy to determine weight/dose

Inclusion	Exclusion
• Pulseless and apneic with age < 8-years-old	• Age > 8-years-old

Orders

- Begin chest compressions and ventilations
  - C - Start CPR - Compression rate 100-120 per minute
  - A - Establish airway with OPA/NPA
  - B - Ventilate with BVM @ 100% high flow 02 (15:2 or 10 breaths per minute)
- Attach monitor or AED Pads
- Establish IV/IO access and administer epinephrine as soon as possible.
- Epi 0.01 mg/kg (1 mg/IO mL) max 1 mg.

If VF/VT

ALS Care:

- Begin chest compressions and ventilations
  - C - Start CPR - Compression rate 100-120 per minute
  - A - Establish airway with OPA/NPA
  - B - Ventilate with BVM @ 100% high flow 02 (15:2 or 10 breaths per minute)
- Attach monitor or AED Pads
- Establish IV/IO access and administer epinephrine as soon as possible.
- Epi 0.0lmg/kg (1 mg/lOmL) max 1 mg

Continue CPR for All Rhythms

BLS Care:

- Continue cycles of chest compressions and ventilations (synchronous or asynchronous)
- Analyze rhythm and pulse check every 2 minutes.

ALS Care

- Administer epinephrine every 3-5 minutes.

ALS Drug Dose

- Defibrillation: 2 J/kg --> 4 J/kg --> 6 J/kg --> 10 J/kg (Max 200J)
- Epinephrine (1 mg/l0mL) 0.01 mg/kg IV/IO (max dose 1 mg)
- Amiodarone 5 mg/kg IV/IO. Max dose 300 mg
  - May repeat x 1 in 10 minutes at 2.5 mg/kg 1/10. Max dose for repeat is 150 mg
  - Follow amiodarone doses with NS flush
- Lidocaine lmg/kg (max dose 100 mg) IV/IO
  - May repeat x 1 at 0.5 mg/kg (max dose 50 mg)

For T orders:

- Magnesium Sulfate 25-50 mg/kg IV/IO

Focused CPR on scene is preferred for a minimum of 20 minutes or until ROSC achieved.

Consider Air Medical Transport for transports over 30 minutes. Transport Per Critical Pediatric Decision Scheme Protocol

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Tucson Medical Center
Base Hospital

PEDIATRIC RESPIRATORY DISTRESS ADMINISTRATIVE ORDER

Wheezing < 2 years old (Bronchiolitis and Croup)

Initiate immediate supportive care

- Oxygen to maintain O_2 sat ≥ 94%
- Complete primary and secondary survey as indicated
- Vital signs including FSBG and temperature as indicated
- ALS Cardiac Monitor if applicable

Inclusion

- Child < 2 years old with wheezing or diffuse rhonchi.

Exclusion

- Suspected anaphylaxis,
- Epiglottitis
- Foreign body aspiration
- Submersion/drowning

BLS Care

BLS Care:

- Suction the nose and/or mouth (via bulb, Yankauer or catheter) if excessive secretions are present.
- Supplemental oxygen: escalate from nasal cannula to face mask to non-rebreather mask as needed in order to maintain normal oxygenation.
- BVM ventilation for children with respiratory failure

Duoneb nebulized therapy

- Single unit dose. May repeat every 15 minutes to a max of three doses.

Airway support with LMH only if above measures fail.

ALS Care

Duoneb nebulized therapy

- Single unit dose. May repeat every 15 minutes to a max of three doses.
- IV should only be placed for clinical concerns of severe dehydration requiring immediate treatment or for administration of IV medications.
- For severe respiratory distress, if suctioning and oxygen fail to result in clinical improvement, administer

If croup is suspected use this treatment first.

Epinephrine:

1 mg/mL, 3 mg (3 mL in 3 mL NS) nebulized.

Intubation or LMH only if above measures fail

Consider Air Medical Transport for transports over 30 minutes. Transport Per Critical Pediatric Decision

Tucson Medical Center
Base Hospital

PATIENT REFUSAL TRANSPORT FOR 17 YEARS AND YOUNGER ADMINSITRATIVE ORDER

Initial patient assessment as indicated to include, but not limited to:

- Vital signs including FSBG
- Appropriate body system assessment

INCLUSION CRITERIA

- A patient who agrees to have a medical evaluation and wishes to refuse treatment or transport
- Patient must be ≤ 17 years of age
- Minor with consent from parent/legal guardian

EXCLUSION CRITERIA

- Patients 18 years and Older (Follow ***Patient Refusal for 18 years and Older AO***)

ORDERS

Legal Guardian or Parent is on Scene AND meets all criteria required in Refusal for ≥ 18 yr and older AO:

- May refuse medical care for minor
- Ensure the guardian or parent verbalizes an understanding of the nature of the problem, the potential consequences of non-transport, and formulates plan for future needs

Patient does NOT meet ALL criteria listed

- **Call medical direction authority**

ORDERS

Legal Guardian or Parent NOT on Scene

- **Patient cannot refuse**
- **MUST call medical direction;** whom can speak with guardian or parent on phone via EMS. Only then can refusal be accepted
- Guardian or Parent is alert and oriented to person, place time and event.
- Guardian or parent is not impaired by drugs or alcohol
- Ensure the guardian or parent verbalizes an understanding of the nature of the problem, the potential consequences of non-transport, and formulates plan for future needs

Contact Medical Direction and Law Enforcement if:

- Life threatening conditions exist
- Possible abuse situation

Tucson Medical Center
Base Hospital

PATIENT REFUSAL TRANSPORT FOR 18 YEARS OR OLDER ADMINISTRATIVE ORDER

Initial patient assessment as indicated to include, but not limited to:

- Vital signs including FSBG
- Appropriate body system assessment

INCLUSION CRITERIA

- A patient who agrees to have a medical evaluation and wishes to refuse treatment or transport
- Patient must be ≥ 18 years of age
- Emancipated minor
  - Must have identifier on Drivers' License or ID card

EXCLUSION CRITERIA

- Patients 17 years of age and under

Patient must meet <u>all</u> of the following criteria:

- Demonstrate mental capacity to refuse treatment or transport
- Alert and oriented to person, place, time and event, OR at their baseline mental status per witness on scene
- Does not appear impaired by drugs or alcohol
- Does not demonstrate or verbalize a danger to self or others
- No evidence of neurological injury
- No evidence of hemodynamic instability (hypoxia, hypo or hypertension)
- No symptomatic hypoglycemia
- Ability to verbalize an understanding of the risks of refusing transport up to and including permanent disability, worsening condition, or death
- Assumes complete responsibility for the decision not to be transported

ORDERS

Patient meets all above criteria:

- May refuse medical care
- Ensure the patient verbalizes an understanding of the nature of the problem, the potential consequences of non-transport, and formulates plan for future needs
- **Obtain orthostatic VSS for complaints related to altered mental status, cardiac, hyperthermia, or syncope**

ORDERS

Patient does NOT meet ALL above criteria

- **Call medical direction authority**
- **Obtain orthostatic VSS for complaints related to altered mental status, cardiac, hyperthermia, or syncope**

CONSIDERATIONS

Include the following in patient documentation:

- Who called 911? Why was 911 called?
- What treatments have been suggested? What could happen if treatments are not completed?
- Why patient wishes to refuse
- What is patients plan if symptoms return or worsen?

Tucson Medical Center
Base Hospital

SEIZURE ADMINISTRATIVE ORDER

Initiate immediate supportive care:
- Oxygen to maintain O_2 sat ≥ 94%
- Vital signs including FSBG
- Cardiac Monitor, if available
- Consider IV access

INCLUSION CRITERIA

- Seizure activity
- Postictal mental status

EXCLUSION CRITERIA

- Pregnant > 20 weeks gestation, follow ***OBGYN AO***

ORDERS

BLS Care
- If patient actively seizing
  - Call for ALS Transport (if possible)
  - IV NS/LR TKO (if permitted)

BLS Transport
- **Single seizure with:**
  - **Known seizure disorder**
  - **Hemodynamically stable an returned to baseline metal status**

ALS Care
- If patient actively seizing administer Midazolam IM first
  - ***≤ 12 kg:*** administer 0.2mg/kg IM
  - **13-40 kg:** administer 5 mg IM
  - **40 kg:** administer 10 mg IM

If IV access already established, give half (½) the above IM dose
- IV/IO at TKO
- If unable to start IV/IO, may be given Intranasal (IN) with mucosal atomizer device (1ml per nare)

Continued seizure 5-10 minutes after initial medication or Midazolam **NOT** available or **NOT** given. Administer **one additional dose** of a single medication.
(Listed in order of preference of use)

Midazolam:
- IM/IN-repeat full dose
- IV/IO-repeat at half the initial dose

Lorazepam: IV/IO
- *≤ 12kg: 0.05-0.1 mg/kg*
- *13-40 kg: 2 mg*
- *40 kg and all adults: 4mg*

Diazepam: *IV/IO*
- 0.2 mg-0.3 mg/kg (max of 5 mg)

If received rectal Diazepam prior to arrival, half the above dose

Special Note:
Suspected febrile seizures in pediatric patients, remove clothing and blankets to help cool patient off.

If patient's condition deteriorates, call Medical Direction Authority.
Consider transport to closest facility.
Provide appropriate receiving facility notification.

Tucson Medical Center
Base Hospital

SEPSIS ADMINISTRATIVE ORDER

Initiate immediate supportive care:
- Oxygen to maintain O_2 sat ≥94% (COPD HX >92%)
- Vital signs including FSBG
- Cardiac Monitor, if available
- Consider IV access

Inclusion CRITERIA

- Presumed Source of infection: lungs, skin, urine, abdomen, CNS
- VS Criteria:
  - Temp >100.9 or <96.8, HR >90, RR >20

Exclusion CRITERIA

- Hospice or Comfort Care

ORDERS

BLS Care
- Establish IV NS/LR (if permitted)
- 30ml/kg bolus x1 @ 100mL/min
- Reassess hemodynamic and pulmonary status frequently
- Notify Facility of "Sepsis Alert"

ALS Care
- Follow BLS care
- IV
- Capnography (if available)
- Obtain 12 lead ECG

Please consider the following orders for patients with:
- Cardiogenic Shock-hypotension w/ suspected pulmonary edema
  - Give NS/LR 250mL bolus at a time
- Currently receiving treatment for Congestive Heart Failure/ESRD
  - Reevaluate
  - Give up to 15mL/KG to keep SBP >90
- ***OTC Protocol:*** for antipyretic use for fever
- ***Hypoglycemic AO:*** abnormal blood glucose
- ***ACLS/PALS:*** cardiac dysrhythmias

Septic Shock Adult

Initial treatment of septic shock involves maximizing perfusion **with IVF boluses**, not vasopressors. If fluid challenge fails to restore adequate blood pressure or if hypotension is life threatening during fluid resuscitation, consider vasopressors.
- 18G x 2, or IO (Humeral if possible)
- **Push-Dose Epi** follow protocol; Limit dose to 0.5mL if evidence of STEMI

Special Notes
- **Concern for Organ Dysfunction if:**
  - SBP <90
  - New onset AMS
  - New O2 requirement
  - Cap Refill >3 sec
  - Decreased Urine Output
  - FSBG >140 in nondiabetic
  - Jaundice w/o cirrhosis or ETOH HX
- When in service area where Paramedic is available, arrange an ALS intercept, but do not delay transport
- Patients predisposed to shock: Immunocompromised (chemotherapy, acquired immunodeficiency), adrenal insufficiency, transplant pts, elderly, infants
- If patient's condition deteriorates, call Medical Direction Authority
- Consider Transport to closest facility
- Provide appropriate receiving facility notification

Pediatrics
- **USE OF BROSELOW TAPE or HANDTEVY METHOD IS REQUIRED.** Bolus maximum 60 ml/kg total (until vital signs/perfusion normal or rales or hepatomegaly on exam)

Exception: volume-sensitive conditions, 10 ml/kg increments, Neonates (0-28 days), congenital heart disease, chronic lung disease
- Call medical direction for orders

Tucson Medical Center
Base Hospital

SEXUAL ASSAULT ADMINISTRATIVE ORDER

Initiate immediate supportive care as indicated:

- Oxygen to keep 0_2 Sat > 90%
- Cardiac Monitor
- Position of comfort
- Notify Law Enforcement; they will determine the need for a forensic exam

INCLUSION

Use standing order on patients with a report of a sexual assault (SA) or concern for a possible sexual assault.

EXCLUSION

Standing order should not be used on patients meeting SAEMS Trauma Triage Decision Scheme.

Patient/guardian wishes to refuse

If patient is 18 or older, provide with contact information for

SARS Advocate

(520) 349-8221

If patient is under18, release to law enforcement.

Patient meets criteria for standing order

ORDERS

- Transport to the closest emergency department
- Reassure patient, provide emotional support
- Treat injuries as appropriate
- Consider same sex attendant
- Document patient demeanor and statements related to the assault.
- Discourage use of restroom or cleansing
- Do not discard first voided urine; place on ice if possible.
- Place any clothing in a clean paper bag
- Human bites - do not clean. Cover with a dry dressing.

Special Note:

Currently in **SAEMS**, TMC has SA Forensic Exam capability and can fully process these patients.

Tucson Medical Center
Base Hospital

SNAKEBITE
ADMINISTRATIVE ORDER

Initiate immediate supportive care as indicated:

- Obtain vital signs.
- Oxygen to keep SpO_2 > 94%
- Cardiac monitor (if available)

Inclusion	Exclusion
• Symptomatic or Asymptomatic Snake Bite	

Orders

BLS Care:

- Initiate IV in unaffected extremity (if authorized).
- Follow Dyspnea/Anaphylaxis/Allergic Reaction 5.0 if indicated.

ALS Care

- If SBP < 90 administer 20 ml/kg bolus of NS, may repeat as needed and reassess patient after each bolus
- Follow Pain Management 5 .0 or if indicated to treat pain from local reaction.

- Note estimated time bite occurred
- Prepare for immediate transport, do not delay until onset of symptoms Remove all watches, rings, jewelry, etc. (including shoes) from fill extremities
- Immobilize affected extremity in an extended position and watch for constriction due to swelling
- Elevate limb to the level of the heart
- Perform neurovascular checks and mark the edge of any discoloration or swelling and write the time on the line, if possible
- Monitor every 15 minutes
- Do NOT wrap extremity or place any constricting bands, ice or tourniquets. No suction or cut to the bite
- Consider contacting receiving facility to confirm availability of antivenin.

Contact Medical Direction for:

Deterioration in patient condition

Management of a tourniquet placed prior to EMS arrival.

Non-native/exotic snakebites.

Tucson Medical Center
Base Hospital

STROKE ADMINISTRATIVE ORDER

Initiate immediate supportive care:
- Keep O_2 sat >94%)
- Finger Stick Blood glucose
- Cardiac Monitor

INCLUSION CRITERIA

Signs and symptoms of suspected stroke:
- Facial droop
- Unequal grips or arm drift
- Unilateral numbness/weakness
- Slurred speech
- Sudden loss of vision
- Ataxia: acute changes in coordination (arms, legs or gait)

Last Known at baseline neurologic status <24 hours

EXCLUSION CRITERIA

- Age <18 years
- Shock and/or respiratory distress
- Evidence of a traumatic injury
- Symptom onset >24 hours
- Cardiac dysrhythmia where resuscitative measure might be needed
- Unconscious/Unresponsive
- Drug or alcohol intoxication

If patient does not meet inclusion criteria or meets any exclusion criteria, or wishes to refuse transport, transport to closest facility and/or contact Medical Direction Authority

ORDERS

- Establish and relay "STROKE ALERT" with time last seen normal
- Initiate proximal IV: 20 gauge or larger with NS/LR TKO
- 12 lead ECG
- Finger stick Blood Glucose- Treat per ***Hypoglycemia AO*** if indicated
- ***Seizure AO*** if indicated

Symptom onset less than 4 hours

- Transport to nearest Acute Stroke Ready, Primary or Comprehensive Stroke Center.
- In outlying areas with a transport interval of greater than 30 minutes to a primary or comprehensive stroke center, transport patient to closest facility or consider air transport to primary or comprehensive stroke center

VAN Negative

Symptom onset greater than 4 hours

- Assess for unilateral motor weakness for 10 seconds. If unilateral weakness is present, perform VAN** screening
- **If VAN positive, consider transport of patient to nearest Comprehensive Stroke Center or designated Thrombectomy Ready Center**

**Special Notes: Evaluate stroke severity using VAN scale to assess for Large Vessel Occlusion (LVO). First assess for unilateral motor weakness. If unilateral motor weakness present, assess for visual disturbance, aphasia and neglect
- Visual disturbance (Field cut, double vision or blind vision)
- Aphasia (Inability to speak or understand)
- Neglect (Gaze to one side or ignoring one side)

If patient has any unilateral motor weakness present PLUS any one of the above, this is likely a large vessel occlusion

Acute Stroke Ready Hospitals: CQCH-Bisbee, CQCH- Douglas
Primary Stroke Centers: NWMC, OVH, TMC, SJH, SMH, BUMCT
Comprehensive Stroke Centers: TMC and BUMCT
Designated Thrombectomy Ready: N/A