

Arizona Emergency Medical Systems, Inc.

**RED BOOK
CHAPTER 3 - Part I**

Standing Orders for Paramedic

DISCLAIMER

This Manual sets forth procedures and protocols deemed by AEMS to be within the acceptable standard of medical care. It is specifically recognized that there are acceptable variations from these procedures and protocols, which may also satisfy the standard of care. Therefore, variations from these procedures and protocols are not necessarily deemed to be outside the standard of care. This manual does NOT define, limit, expand or otherwise purport to establish the legal standard of care.

RED BOOK

CHAPTER 3-Part 1

Standing Orders for Paramedics

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Developed by: Standing Orders Task Force

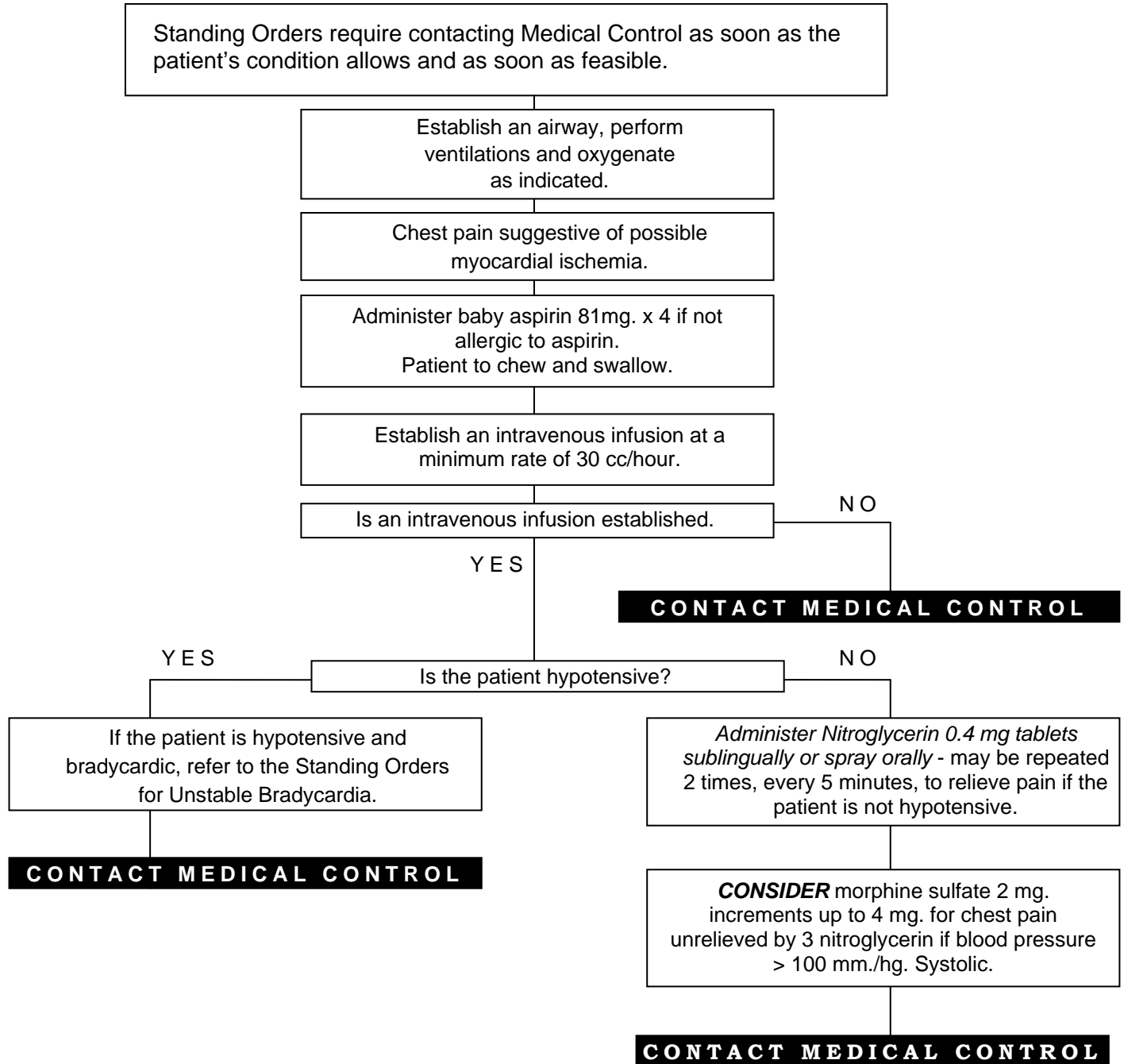
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STANDING ORDERS
FOR PARAMEDICS
Chart 1

CHEST PAIN OF PROBABLE CARDIAC ORIGIN

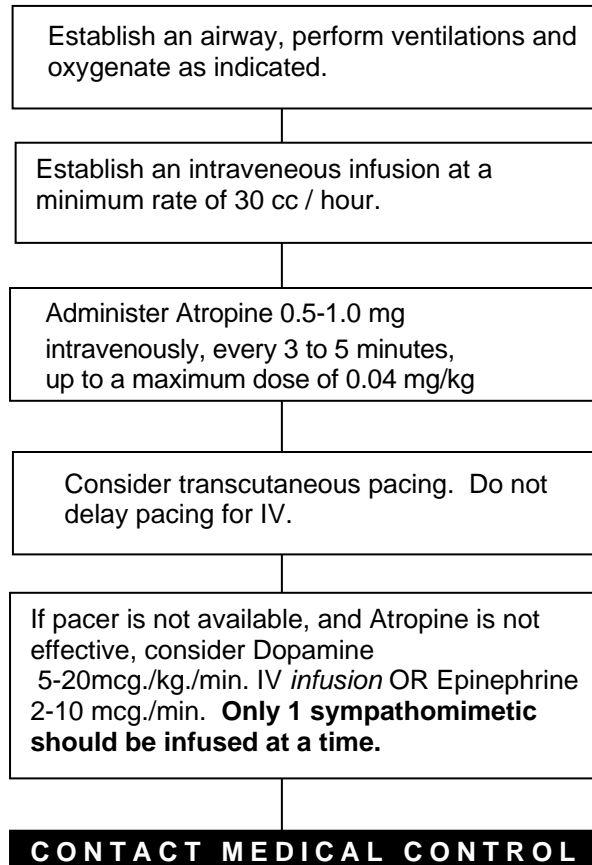


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STANDING ORDERS
FOR PARAMEDICS
Chart 2

UNSTABLE
BRADYCARDIA

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.



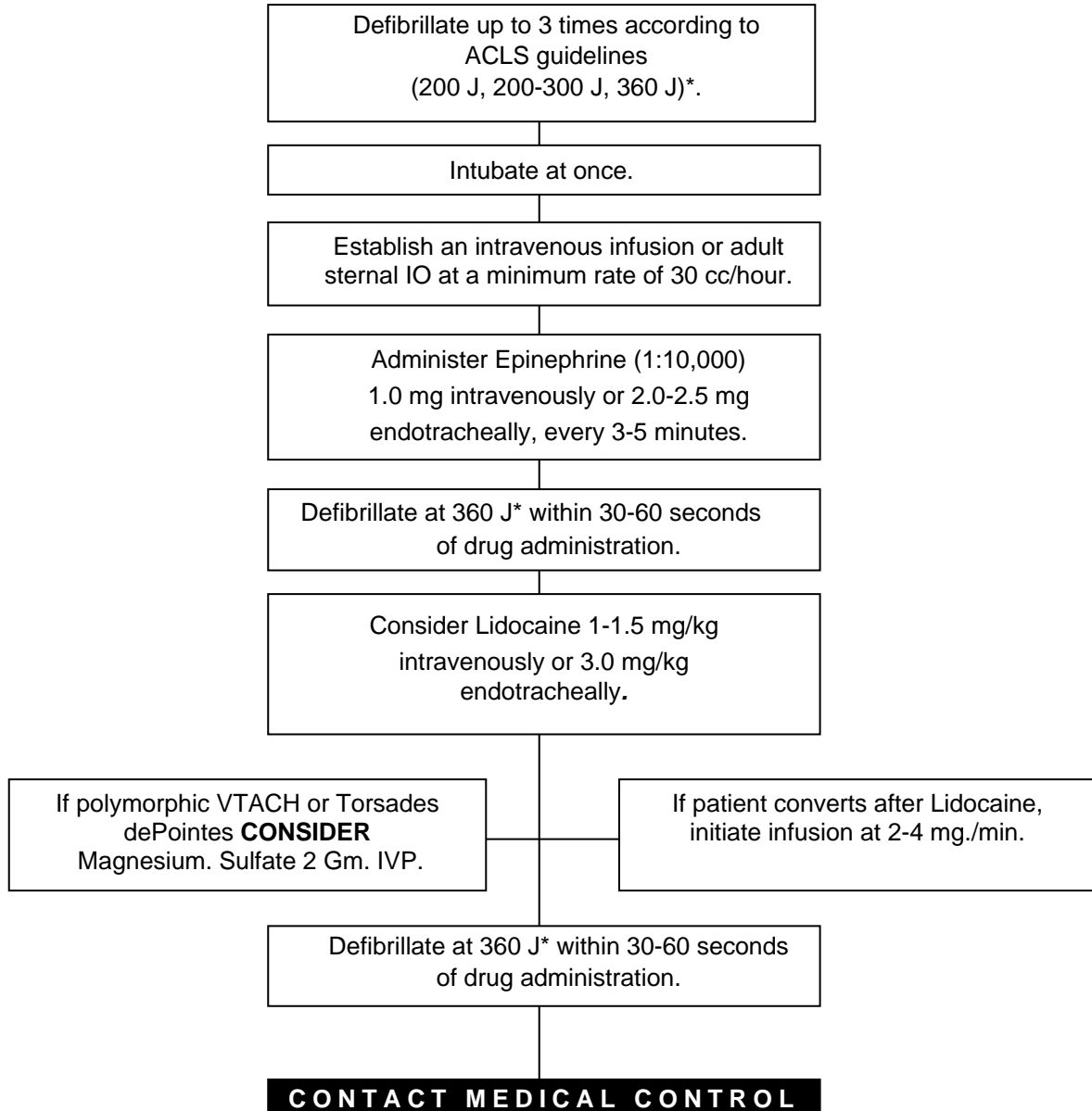
(Signs and symptoms of an unstable patient may include chest pain, shortness of breath, decreased level of consciousness, hypotension, shock, pulmonary edema, congestive heart failure, and acute myocardial infarction.)

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STANDING ORDERS
FOR PARAMEDICS
Chart 3

CARDIOPULMONARY ARREST - VENTRICULAR FIBRILLATION AND PULSELESS VENTRICULAR TACHYCARDIA

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.



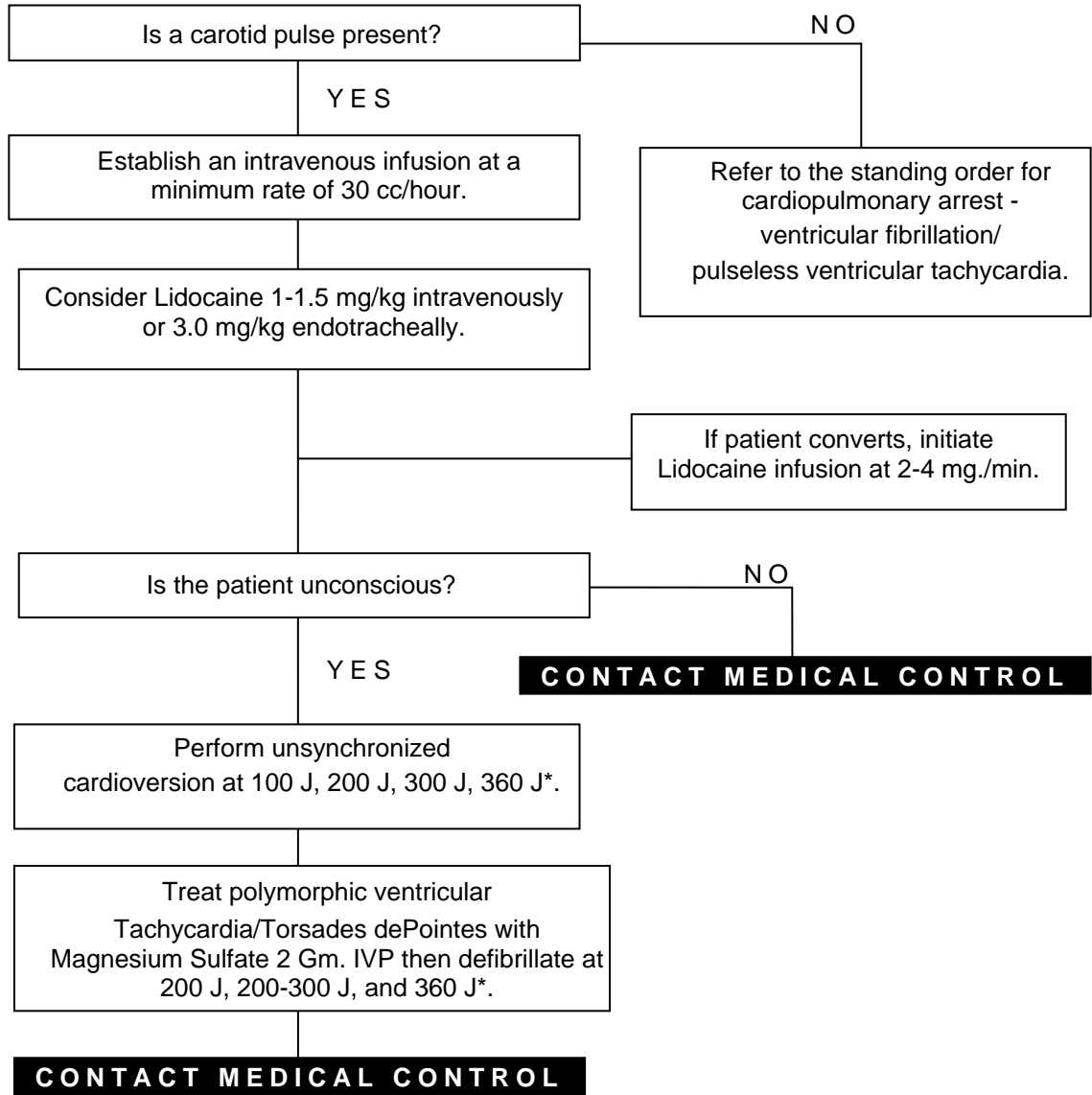
*Or biphasic equivalent.

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STANDING ORDERS
FOR PARAMEDICS
Chart 4

UNSTABLE VENTRICULAR TACHYCARDIA OR WIDE COMPLEX TACHYCARDIA OF UNCERTAIN ORIGIN

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.



(Signs and symptoms of an unstable patient may include chest pain, shortness of breath, decreased level of consciousness, hypotension, shock, pulmonary edema, congestive heart failure, and acute myocardial infarction.)

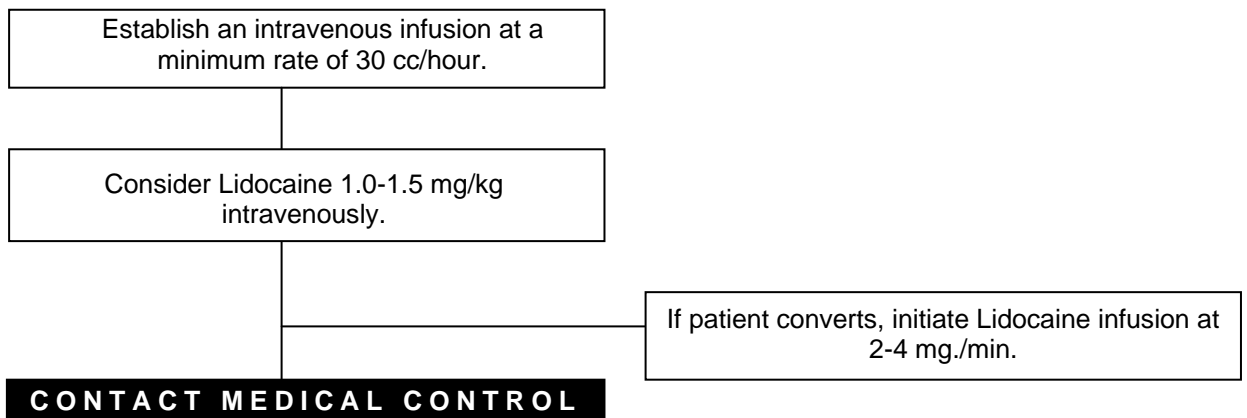
*Or biphasic equivalent.

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STANDING ORDERS
FOR PARAMEDICS
Chart 5

STABLE VENTRICULAR TACHYCARDIA OR WIDE COMPLEX TACHYCARDIA OF UNCERTAIN ORIGIN

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.



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CARDIOPULMONARY ARREST – ASYSTOLE

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.

Establish an airway, perform ventilations and oxygenate as indicated.

Confirm asystole in 2 or more leads.

Establish an intravenous infusion or adult sternal IO at minimum rate of 30 cc /hour.

Consider possible causes:

- | | |
|----------------------------|--------------------------------------|
| 1. Hypovolemia | 6. "Tablets" (Drug OD, Accidents) |
| 2. Hypoxia | 7. Tamponade, cardiac |
| 3. Hydrogen Ion – Acidosis | 8. Tension Pneumothorax |
| 4. Hyper-/Hypokalemia | 9. Thrombosis, coronary (ACS) |
| 5. Hypothermia | 10. Thrombosis, pulmonary (embolism) |

Consider immediate transcutaneous pacing (TCP).

Administer Epinephrine (1:10,000)
1.0 mg intravenously or 2.0-2.5 mg
endotracheally, repeat every 3-5 minutes.

Administer Atropine 1.0 mg intravenously
or 2.0-2.5 mg endotracheally, repeat every
3-5 minutes up to maximum dose
of 3.0 mg.

CONTACT MEDICAL CONTROL

CARDIOPULMONARY ARREST - PULSELESS ELECTRICAL ACTIVITY

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.

Establish an airway, perform ventilations and oxygenate as indicated.

Establish an intravenous infusion or adult sternal IO at a minimum rate of 30 cc/hour.

Consider possible causes:

- | | |
|----------------------------|--------------------------------------|
| 1. Hypovolemia | 6. "Tablets" (Drug OD, Accidents) |
| 2. Hypoxia | 7. Tamponade, cardiac |
| 3. Hydrogen Ion – Acidosis | 8. Tension Pneumothorax |
| 4. Hyper-/Hypokalemia | 9. Thrombosis, coronary (ACS) |
| 5. Hypothermia | 10. Thrombosis, pulmonary (embolism) |

Consider volume infusion of 300-500 cc fluid with frequent reassessment. May repeat as indicated.

Administer Epinephrine (1:10,000)
1.0 mg intravenously or 2.0-2.5 mg
endotracheally, repeat every 3-5 minutes.

If bradycardic, see Unstable Bradycardia
Standing Order.

CONTACT MEDICAL CONTROL

ALTERED LEVEL OF CONSCIOUSNESS¹ (ADULT) NON-TRAUMA

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.

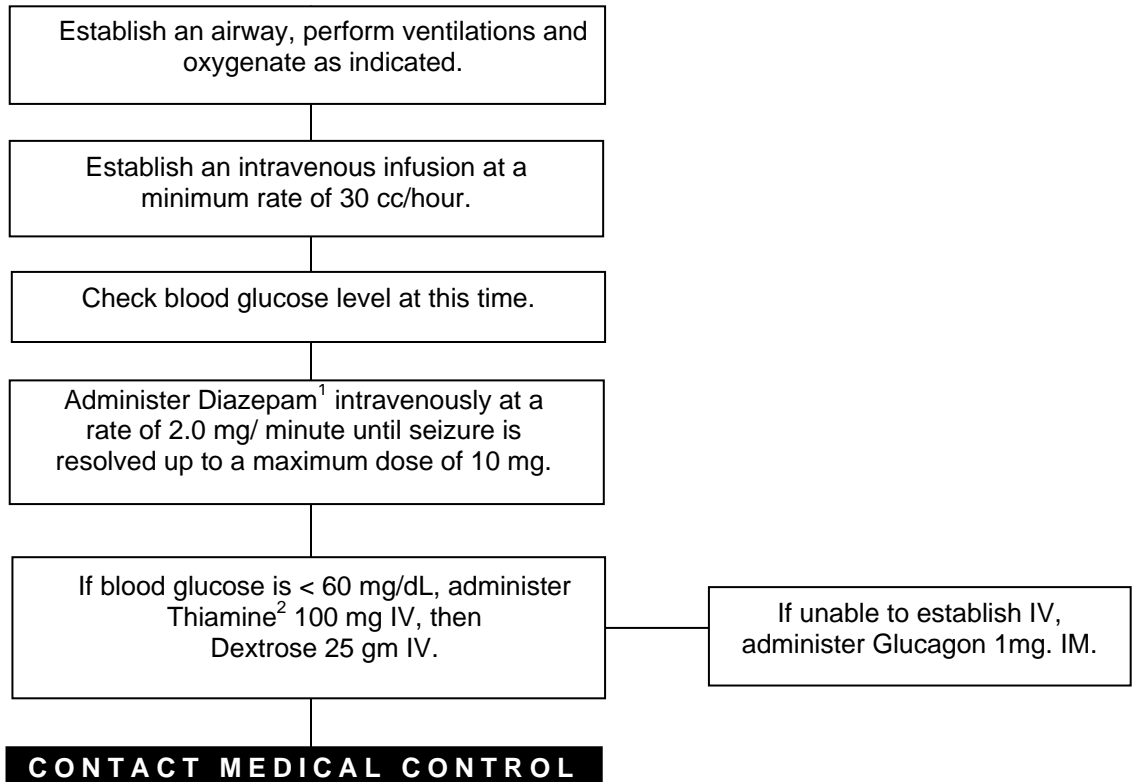


¹There are many different causes of an altered level of consciousness, many of which are life threatening and include CVA, hypoglycemia, cardiac dysrhythmias, etc.,. Some patients are not A&O x 4 as a normal baseline. Check with family, bystanders, friends, etc.,.

²If no history of alcoholism, malnutrition, or cachexia is present, Thiamine may be withheld.

SEIZURES (ADULT)

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.

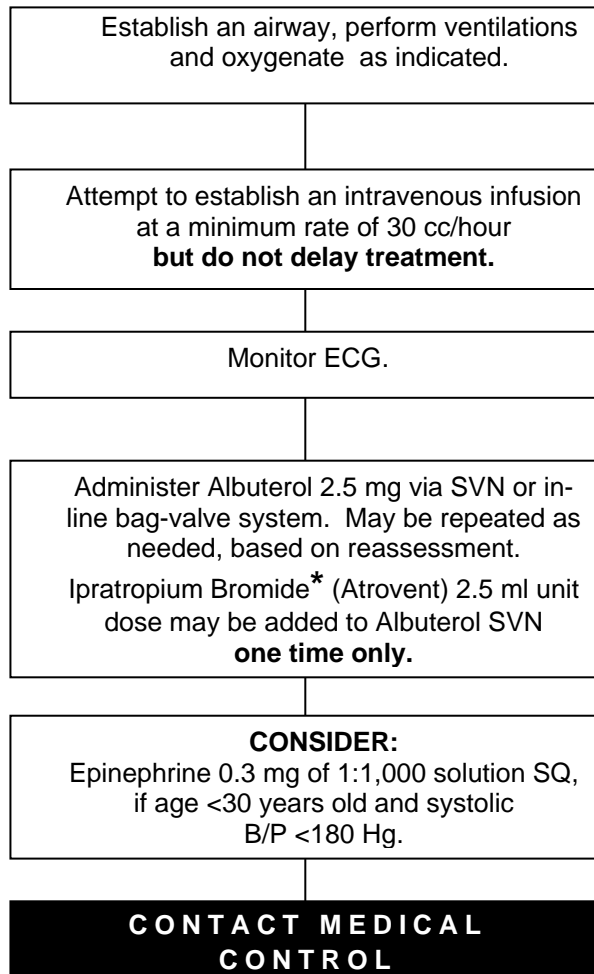


¹Diazepam administration applies to prolonged, repetitive, or status epilepticus seizures.

²If no history of alcoholism, malnutrition, or cachexia is present, Thiamine may be withheld.

BRONCHOSPASM

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.



*Ipratropium Bromide (Atrovent) is contraindicated in patients with allergies to peanuts and soy.

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ACUTE ALLERGIC REACTION / ANAPHYLAXIS

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.

Establish an airway, perform ventilations and oxygenate as indicated.

Establish an intravenous infusion at a minimum rate of 30 cc/hr. However, if unable to establish do not delay treatment.

Monitor ECG and treat dysrhythmias following the appropriate standing order.

Anaphylactic Shock

Acute Allergic Reaction

Administer Epinephrine - 0.3 mg (0.3cc) of 1:1,000 solution (subcutaneously).

Administer Diphenhydramine HCl (Benadryl) 50 mg IM or slow IV push.

Consider:
Albuterol 2.5 mg in 3.0 cc NS by nebulizer for respiratory distress.

Consider:
Epinephrine IV Infusion 2-10 mcg/min.

CONTACT MEDICAL CONTROL

Administer Diphenhydramine HCl (Benadryl) 50 mg IM or slow IV push

Administer Epinephrine - 0.3 mg (0.3cc) of 1:1,000 solution (subcutaneously), if age <30 years old AND systolic B/P <180mm Hg.

Consider:
Albuterol 2.5 mg in 3.0 cc NS by nebulizer for respiratory distress.

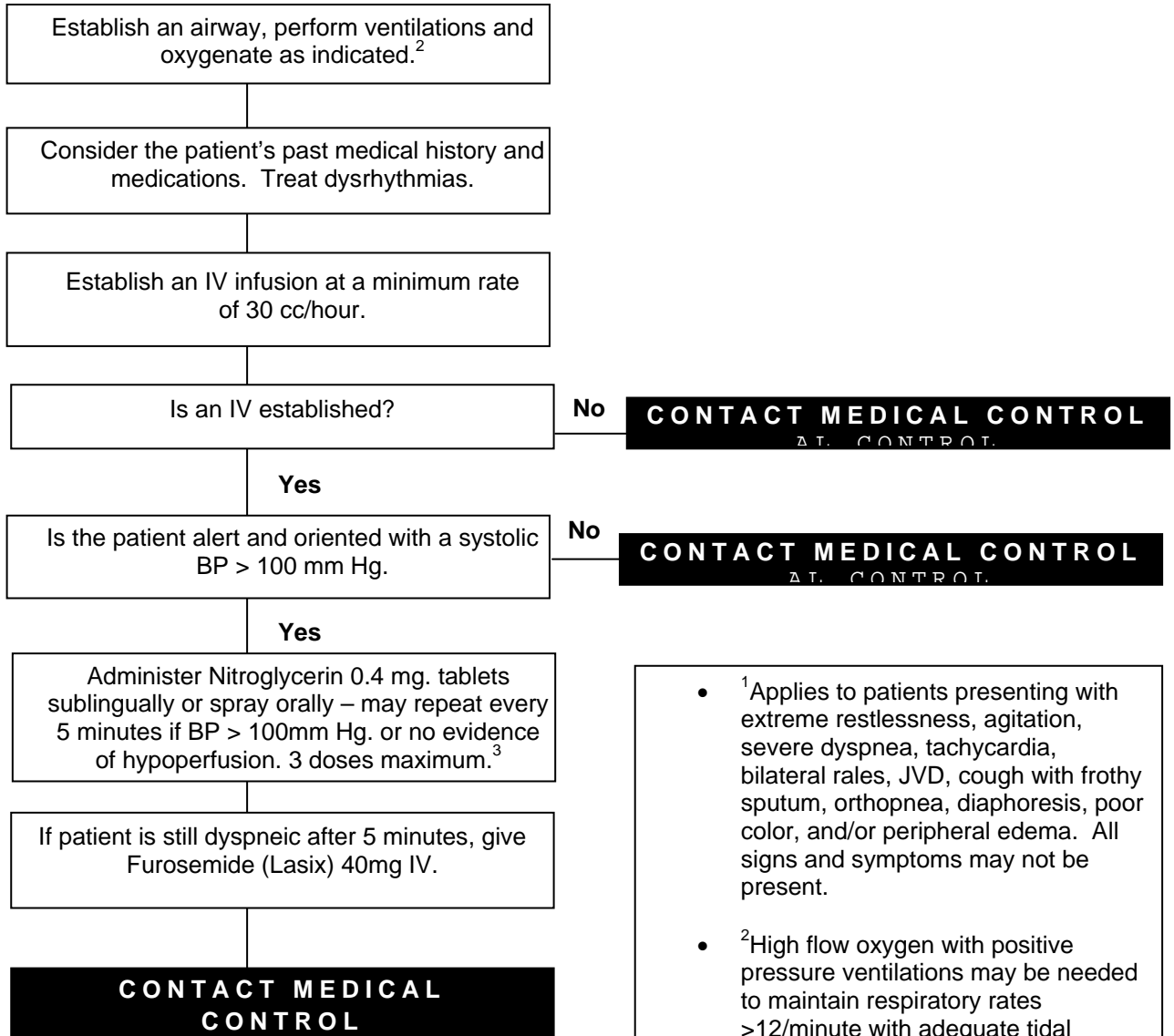
CONTACT MEDICAL CONTROL

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STANDING ORDERS
FOR PARAMEDICS
Chart 10C

RESPIRATORY ARREST OR INSUFFICIENCY - PULMONARY EDEMA¹

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.



- ¹Applies to patients presenting with extreme restlessness, agitation, severe dyspnea, tachycardia, bilateral rales, JVD, cough with frothy sputum, orthopnea, diaphoresis, poor color, and/or peripheral edema. All signs and symptoms may not be present.
- ²High flow oxygen with positive pressure ventilations may be needed to maintain respiratory rates >12/minute with adequate tidal volume.
- ³Obtain vital signs and lung auscultation before and after administration of each medication.

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STANDING ORDERS
FOR PARAMEDICS
Chart 11

TRAUMA OR HYPOVOLEMIC SHOCK

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.

Establish an airway with spinal immobilization, if indicated. Perform ventilations, oxygenate, and intubate as indicated.

Do Not Delay Transport

Manage prioritized injuries enroute to the appropriate emergency care facility.

Establish 2 intravenous infusions with large bore catheters. (A recommendation of 18 gauge or larger catheter.) Maintain tissue perfusion as indicated.

CONTACT MEDICAL CONTROL
AL CONTROL

Consider use of an anti-shock garment (PASG), if available.

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HEAD INJURY OR UNCONSCIOUS PATIENT (ADULT)

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.

Initiate and maintain spinal immobilization procedures. Establish an airway, ventilate, oxygenate and intubate as indicated. Elevate the head of backboard 10 to 15 degrees.

Ventilate with 100% oxygen to maintain a rate of 12-20/min.

Do Not Delay Transport

Manage prioritized injuries enroute to the appropriate emergency care facility.

Establish an intravenous infusion at a minimum rate of 30 cc/hour

If the patient is hypotensive, establish 2 intravenous infusions with large bore catheters. (A recommendation of 18 gauge or larger catheter.)

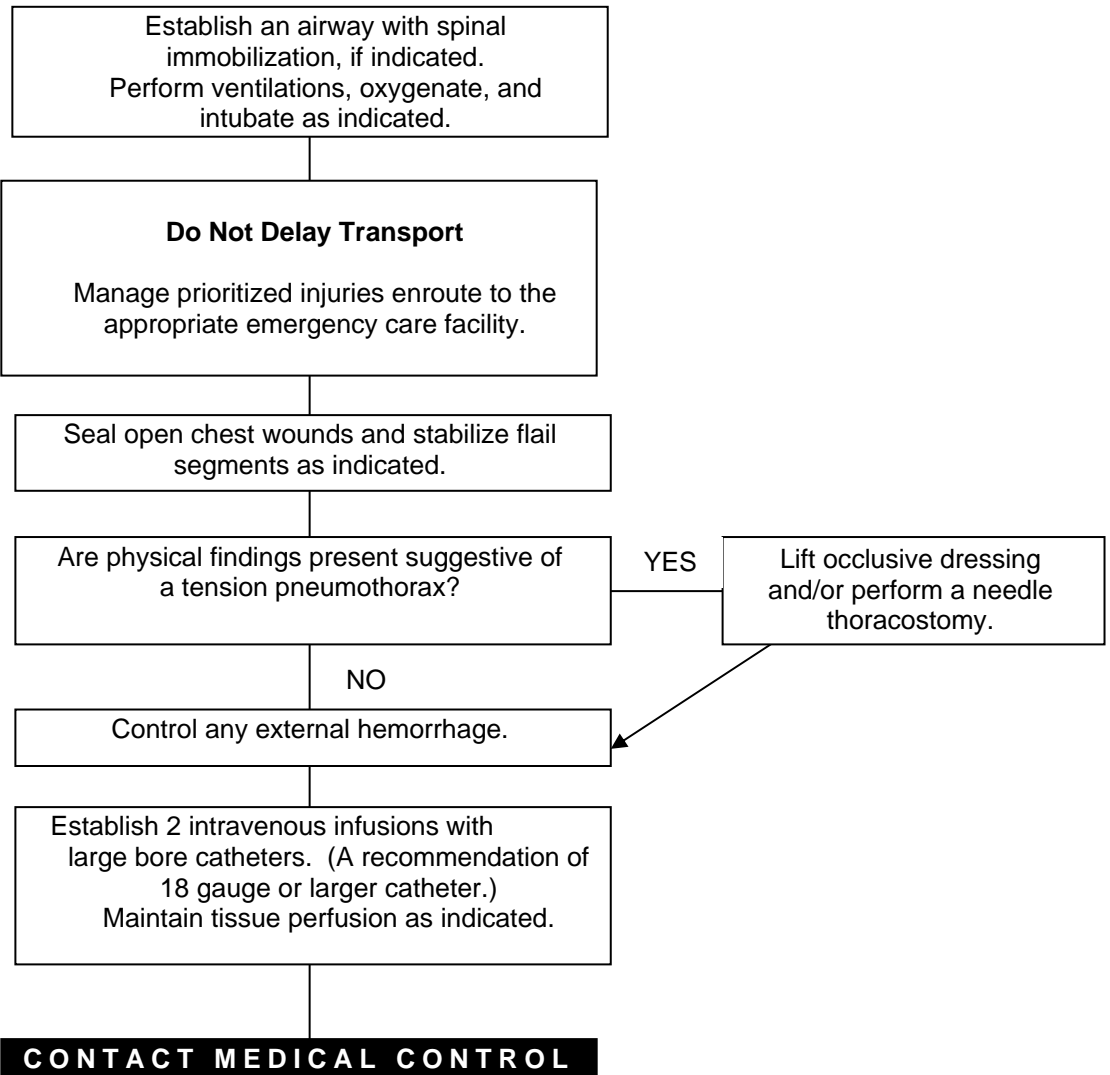
Maintain tissue perfusion as indicated.

CONTACT MEDICAL CONTROL

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CHEST TRAUMA

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.

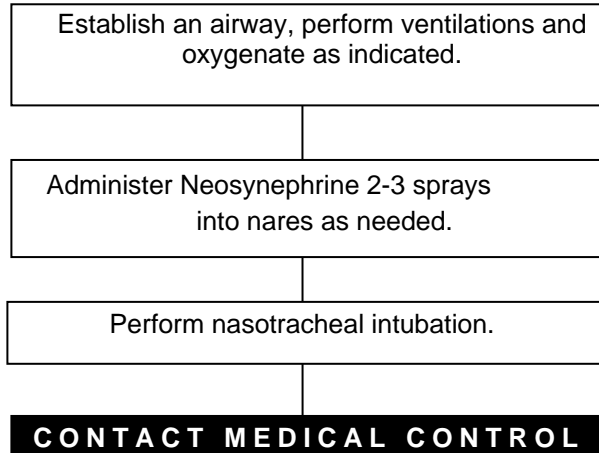


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STANDING ORDERS
FOR PARAMEDICS
Chart 14

NASOTRACHEAL INTUBATION

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.



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STANDING ORDERS
FOR PARAMEDICS
Chart 15

PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA (PSVT)

Standing Orders require contacting Medical Control as soon as the patient's condition allows and as soon as feasible.

Establish an airway, perform ventilations and oxygenate as indicated.

Establish an intravenous infusion at a minimum rate of 30 cc/hour.

If the patient is stable, perform Valsalva's maneuver.

CONTACT MEDICAL CONTROL
If unable to contact, continue with Standing Order.

STABLE BUT SYMPTOMATIC
signs and symptoms (i.e., angina, mild shortness of breath, low blood pressure, decreased level of consciousness).

Administer Adenosine 6 mg. rapid intravenous push, over 1-3 seconds, followed by a 20 cc normal saline fluid

If PSVT continues, administer Adenosine 12 mg. rapid intravenous push, over 1-3 seconds, followed by a 20 normal saline fluid bolus.
May repeat 1 time.

CONTACT MEDICAL CONTROL

UNSTABLE
signs and symptoms related to tachycardia (i.e., shock, pulmonary edema, unconsciousness).

If conscious, consider sedation with Valium 2.0-10.0 mg intravenously.

Perform synchronized cardioversion at 100 J, 200 J, 300 J, 360 J*.

CONTACT MEDICAL CONTROL

*Or biphasic equivalent.

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