SPEMS Protocol Changes
EMT-Intermediate
2007-2008

- **Every Page**
    - Changed dates at bottom of each page
- **Cover Page**
    - Signature with October 1, 2007 date
- **Page P-2: Table of Contents**
    - Added lines to make it easier to find page numbers
- **Page P-4**
    - Addition of 3rd paragraph (from top) that reads: “It is the responsibility of the individuals’ EMS Service Provider to keep records of individual EMS certifications, immunization records, protocol exams, case review participation, skills exams and any specialized training required by the medical director i.e.: SQ injections. These records are subject to examination at anytime, by the SPEMS Medical Director or his/her designate.
    - #3: Added “A copy of the protocol exam must be forwarded to the SPEMS office.”
    - #4: Added about Case Reviews: “Two of which are recommended by the end of the first half of the year and the remaining two by the end of the second half of the year”
    - #5: Added “by the 10th of each month” in regards to transmission of run data to SPEMS
- **Page P-9 and P-10 Definitions**
    - Definitions are now in alphabetical order
- **Page P-9 Appropriate Level of Care**
    - Added the paragraph “Following a complete assessment of the patient, the EMT-Intermediate should treat the patient at the EMT-Intermediate protocol level unless impractical or unobtainable. In that event, the EMT-Intermediate may treat the patient at the EMT-Basic protocol level. An example of this might be: A very close (< 3 minutes) proximity to the receiving hospital where initiating ALS treatment would not affect patient care. Another example: **Oral Glucose** could be administered as oppose to IV **Dextrose** 50%, in the event that an IV is unobtainable. The EMT-Intermediate should document these occurrences and justifications in the report narrative. **All incidences mentioned above must be peer reviewed.**
- **Page P-11 through P-14 Treatment Procedures**
    - Now in alphabetical order
    - Moved “Treatment for Shock” and “Treatment for Snakebites” into this section
- **Page P-11 through P-13 Intraosseous Infusion Adult and Pediatric**
    - Add administration of Lidocaine 1mg/kg SIVP to a max of 50mg if there are no contraindications (drug allergies, bradycardia, etc)
    - Added “Appropriate training and testing must be documented prior to administration of Lidocaine”
- **Page P-13 Intraosseous Infusion Pediatric**
    - Defined pediatric bradycardia
        - Newborn to 1 year <100bpm
        - 1year to 4 yoa <90bpm
        - 5 yoa and older <60bpm

- **Page P-13 IV Therapy**
    - Added “IV fluids should be infused at 20cc/kg over 10 minutes and may be repeated once in all pediatric arrest situations”
- **Page P-15 Pre-Hospital Medications and Intravenous Fluids**
    - Added Lidocaine and Benadryl
- **Page P-16 through P-17 Decision Making in CPR**
    - Brought current to comply with Texas Administrative Code and Texas Health Code
    - #9: “Out-of-Hospital DNR Order forms executed in another state or devices authorized by another state as describe in the Do Not Resuscitate Section. (Refer to the Do Not Resuscitate Section)”
    - #11: Changed number of family members from 2 to 1 that can request that resuscitative measures be withheld. (Note: Medical Direction must still be contacted)
    - Under section that states “Once initiated, BLS shall continue until one of the following occurs:
        - Added #5: “A legitimate TDSHS Out of Hospital DNR is presented to ambulance personnel. (Refer to the Do Not Resuscitate Section)”
        - Added #6: “A legitimate Out-of-Hospital DNR Order forms executed in another state is presented to ambulance personnel. (Refer to the Do Not Resuscitate Section)”
    - Addition of statement “EXCEPT AS DESCRIBED ABOVE, UNDER NO CICUMSTANCES WILL THE DECISION TO TERMINATE RESUSCITATION BE MADE BY A NON-PHYSICIAN”
- **Page P-18 through P-21 Do Not Resuscitate Orders**
    - New Section
    - Brought current to comply with Texas Administrative Code and Texas Health Code
    - **THIS SECTION SHOULD BE READ AND UNDERSTOOD THOROUGHLY**
    - Summary of this section:
        - ONLY the TDSHS OOH DNR or other state (other than Texas) issued DNR may be accepted
            - A written DNR by a physician is NOT acceptable by EMS personnel
        - OOH DNR applies to out-of-hospital settings including ERs, Nursing Homes, Physician’s offices, clinics, dialysis centers, private residences, etc.
        - OOH DNR applies only AFTER the cessation of spontaneous respirations or circulation

          EXCEPT: Airway obstruction

          Suspicious Circumstances

          Suicide, homicide, or other unnatural causes of death

          Pregnant patients

          Patient or guardian state desire not to follow DNR
        - Interventions to be withheld are:
            - CPR

        - Advanced Airways (Intubation and Combi-Tube)
        - Artificial ventilation (does not pertain to assisting ventilations on a breathing patient)
        - Defibrillation (includes AED)
        - Transcutaneous cardiac pacing
    - If uncertain, err on side of resuscitation until status can be clarified
    - The OOH DNR device (form, bracelet, or necklace) should be left attached to and transported with the patient
    - Out-of-state DNR may be honored if no reason to question the authenticity of the order or device exists
  - Includes a copy of the TDSHS DNR form (Front and Back)
- **Page P-25 Transportation Guidelines**
  - Addition of #6: "During interfacility transfers SPEMS personnel should operate under the orders of the transferring physician, except were State statute or regulation dictate otherwise such as a physician written DNR. An attempt should be made to contact the transferring or receiving physician to dictate treatment if a decrease in the patient's condition occurs or at the onset of new complications which need to be immediately addressed. If contact is not possible, SPEMS personnel are authorized to operate under the existing SPEMS protocols. Personnel may also contact Medical Control at anytime. Include in your verbal as well as written report any changes in patient condition, orders received or treatment provided. Interfacility transfers include but are not limited to: Hospital to Hospital, Hospital to Specialized care centers and Hospitals to extended care facilities"
- **Page P-29 and P-30 Guidelines for Trauma Team Activation**
  - Multiple changes
  - Updated to meet current guidelines
- **Page P-34 No Transport Codes**
  - Addition of statement "**ALL CALLS REQUIRE A WRITTEN REPORT. ALL N-3, N-4, N-5, N-6, AND N-8 CALLS REQUIRE A FULL REPORT (A SPEMS RUN FORM WILL BE A 5 PAGE REPORT). ALL N-3, N-4, AND N-5 CALLS REQUIRE THAT THE SERVICE DIRECTOR OR (DESIGNEE) REVIEW THE WRITTEN REPORT."**
- **Page P-38 through P-40 Equipment List**
  - Added Lidocaine and Benadryl
  - Medical Director Signature
  - **Service Director must also sign**

- **Throughout Algorithms**
  - Divided into Sections with divider pages
    - Trauma emergencies
    - Respiratory emergencies
    - Cardiovascular emergencies
    - Other Medical emergencies
  - Algorithms in alphabetical order in each section
  - Changed dates on bottom of pages
- **Page 1 Burns**
  - Addition of charts for rule of 9's

- **Page 7 Cardiac Arrest**
    - Added pediatric fluid challenge in box that states “Pediatric: Infuse 20cc/kg over 10 minutes. May repeat once.”
- **Page 11 Allergic Reaction**
    - Addition of box that states “Request Paramedic Backup for all pt’s with bee stings that have shortness of breath or BP < 90mmHg”
    - Added Benadryl
        - For patients with BP>90 with adequate perfusion
- **Page 12 Cold Exposure**
    - Changed estimated temperature to <86 degrees to conform with ACLS
    - Removed the box that stated “do not perform more than one defibrillation”
    - Added Fluid Bolus Box for Cardiac Arrest
- **Page 13 Decreased Level of Consciousness**
    - Addition of Cincinnati Stroke Scale
        - Pass or fail scale
        - Should be reported to hospital and documented in narrative
    - Addition of box that states “**To prevent florid withdrawal in patients on chronic or high dose narcotics administer Narcan in increments of 0.1mg every 2-3 minutes until clinical effect noted”