
**OFFICE OF THE
PROVINCIAL MEDICAL DIRECTOR**
MEDICAL OVERSIGHT QUARTERLY UPDATE
APRIL 2004

1.0 REVISED POLICIES, PROTOCOLS, PROCEDURES AND MEDICATIONS

Please note: With this quarterly update, I have included a listing of all revised/updated policies, protocols, etc (attached). Please update your manual accordingly.

- 1.1 Policy 6120.03: Trip Destination (Attached)**
Policy 6120.03 A: Trip Destination for Trauma Patients (Attached)
- 1.1.1 To follow up on the last memo, patients with Major Trauma Triage Criteria should be taken to a Trauma Centre, either District or Tertiary, if you are within a 30 minute radius (including extrication time). If you are not within a 30 minute radius (extrication plus travel time) to a District or Tertiary Trauma Centre please contact the **AMT On Line Medical Oversight Physician (OLMOP)** via Dispatch. You, along with the OLMOP and the AMT Dispatcher will make a decision as to the destination and/or launch of AMT.
- 1.2 Policy 6125.02: Physical Restraints (Released 2/5/04)**
Procedure 6618.02: Restraints (Attached)
- 1.2.1 Upon review of this policy and procedure please note ACPs should now use Midazolam or Valium plus/minus (+/-) Haldol to control patients suspected of having agitated delirium secondary to cocaine who are physically restrained, in order to avoid hyperkalemia and rhabdomyolysis.
- 1.3 Policy 6129.06: Ground Transfer of Patients-Medical Responsibilities (Attached)**
-Medical Staff Not Accompanying
- 1.3.1 Section 4.4 now states that **all levels of paramedics** may transfer patients with KCI added to the IV solution as well as may transfer patients receiving antibiotics. This is pending completion of the inservices..
- 1.4 Policy 6134.03 Chronic Obstructive Pulmonary Disease Patients (Attached)**
Policy 6135.03 Patients on Home Oxygen (Attached)
Protocol 6229.02 Suspected Cardiac Origin (Attached)
Protocol 6280.03 Asthma (Attached)
Protocol 6281.03 COPD (Attached)
Protocol 6282.05 Pulmonary Edema (CHF) (Attached)
Protocol 6283.02 Respiratory Distress NYD (Attached)
Protocol 6284.02 SOB (Stoma/Trach) (Attached)

1.4.1 Please review these policies regarding oxygen use and the use of (O₂) saturations as a

comfortable just on a stretcher however placing them on a backboard makes sense when you consider that they have to be moved from the ambulance stretcher to the hospital stretcher and then moved over to an x-ray table. Perhaps patients who are to be transported a short distance by ambulance could be placed on a backboard while patients who are to be transported a long distance such as inter-facility transfers could be placed on the stretcher? This might make a good subject for a research project?

2.4 Gravol in Patients with severe headaches, nausea and vomiting.

2.4.1 Gravol should not be used in these instances as they may make the patient drowsy and interfere with on going neurological assessments.

2.5 Endotracheal tube intubation verified and not verified.

2.5.1 Please remember - upon arrival at hospital with any patient you have intubated, have the physician or the RT sign off on the PCR in the area provided.

2.6 Hypothermia for post cardiac arrest patients.

2.6.1 Protocol 6311.01: Post Cardiac Arrest - ROSC (Released 02/05/04)

2.6.1.1 Based on the results of two (2) very good studies it would appear that survival to hospital discharge is improved when patients who survive to hospital admission have hypothermia induced for at least 24 hours. In keeping with this, please review the Protocol 6311.01: Post Cardiac Arrest - ROSC. Essentially for patients who have not recovered consciousness but have a palpable pulse and a blood pressure, you should attempt to keep them cool by exposing them to the air. No attempt to re-warm them should be made.

2.7 Energy setting for defibrillation in young children.

2.7.1 The American Heart Association has recently changed its guidelines enabling paramedics to defibrillate children younger than eight (8) years of age with AEDs at regular energy settings (200,300, 360). This has been endorsed by the National Association of EMS Physicians. Therefore all paramedics, not able (by registration level) to perform manual defibrillation, may now use the LP12, in its automatic mode to defibrillate children younger than eight (8) years of age. **Please refer to the above Protocol 6259.04: Pediatric VF/Pulseless VT (shock advised).**

2.8 NOBIs in Group Homes

2.8.1 Please be aware that staff in group homes have no medical training and are not able to sign consent or refusal for patients in their care. If you are leaving a patient in a group home, after consultation with the group home worker and the On Line Medical Oversight Physician, please complete a Refusal Form documenting the instructions, advice and patient condition when you left. This is to ensure/provide documentation for reference for any other crew which may attend the patient later. Do not ask the group home worker to sign this.

2.9 Special Patient Program

- 2.9.1 This program, which has been developing for the last couple of years, involves approximately 27 children and young adults mainly in the Metro area. Special patients have extremely complicated medical problems that our own protocols, if applied, may actually harm. As a result, each of these patients have their own protocols which they either carry with them or are with their care giver (copy of Special Patient Card attached). For those of you who are unaware of this program or would like more information, please e-mail me at cainej@gov.ns.ca.

2.10 IV Fluid during Arrest

- 2.10.1 I recently reviewed the amount of fluid being given during arrests. The average amount of fluid given to a patient in VF was 900ccs. The average amount given a patient in PEA was 790ccs and asystole 900ccs. Please be cognizant of the amount of fluid you are giving. Patients that recover will often have decreased cardiac function and are prone to going into pulmonary edema if given a lot of fluid during the arrest. If patients have a pulse with CPR it is very unlikely that hypovolemia is the cause of PEA.

2.11 CTAS

- 2.11.1 Last summer a medical student conducted a study looking at the use of pre-hospital criteria to determine if any could be used to identify which patients truly needed transport to hospital. One of the criteria was the CTAS score. Unfortunately the CTAS score was missing in 47% of 121 patients. Please fill in the CTAS score according to the severity you find the patient in when you first attend him/her. When calling the Emergency Department, please use the CTAS score the patient has at the time you are radioing in.

3.0 RESEARCH

3.1 CPAP

- 3.1.1 This study continues in Metro and has recently expanded so that patients enrolled in this study can now be taken to Dartmouth General Hospital. To date approximately 30 patients have been enrolled.

3.2 WEST Study

- 3.2.1 This study is also continuing in the Central Region. To date we have enrolled approximately 40 patients, including 15 pre-hospital. 102 patients have been enrolled across Canada. Our aim is to enroll 300 patients country wide and the numbers should increase now that Vancouver and Montreal have joined Edmonton and ourselves. Please see Jay Walker's excellent monthly CDs for more information about WEST.

3.3 *The Use of Canadian C-Spine Role by Paramedics*

3.3.1 We are still waiting to get Research and Ethics Board approval for this study.

4.0 *Suggested Reading*

4.1 I am attaching two (2) abstracts that I hope you will find interesting. The first is out of San Diego and involves the use of RSI and its complications. The second comes from more data published from the CAPTIM study in France which suggests that pre-hospital thrombolysis is a better initial re-perfusion therapy than transfer for PCI in patients presenting with STEMI within two (2) hours of symptom onset.

REVISIONS/ADDITIONS

MEDICAL POLICY/PROTOCOL/PROCEDURES/MEDICATIONS MANUAL

The attached have been revised/added for update of your manual:

POLICIES

- 6120.03: Trip Destination
- 6120.03 A: Trip Destination for Trauma Patients
- 6129.06: Ground Transfer of Patients-Medical Responsibilities
-Medical Staff Not Accompanying
- 6134.03 Chronic Obstructive Pulmonary Disease Patients
- 6135.03 Patients on Home Oxygen

PROTOCOLS

- 6223.02: VF/Pulseless VT (shock advised)
- 6225.02: Tachycardia Overview
- 6229.02 Suspected Cardiac Origin
- 6242.03: Abdominal Pain/Flank Pain
- 6259.04: Pediatric VF/Pulseless VT (shock advised)
- 6266.02: Pediatric Stridor
- 6278.02 Violent/Agitated
- 6280.03 Asthma
- 6281.03 COPD
- 6282.05 Pulmonary Edema (CHF)
- 6283.02 Respiratory Distress NYD
- 6284.02 SOB (Stoma/Trach)

PROCEDURES

- 6613.02: Emergency Synchronized Cardioversion
- 6618.02: Restraints

MEDICATIONS

- 6972.02: Racemic Epinephrine

The “Revisions” section at the end of each Policy/Procedure/Medication provides you with a detailed explanation of changes.

I also attach a revised Table of Contents for each section.

If you have any questions, or if you notice any discrepancies, please contact Sharon Oulton at 424-1729 or oultosm@gov.ns.ca.