2021 Patient Treatment Protocols
Effective January 1, 2021
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PREFACE
EMS Provider Scope of Practice

The Oregon Medical Board is responsible for the scope of practice of Emergency Medical Service Providers as well as the requirements and duties of these providers’ supervising physicians (EMS Medical Directors).

To view the complete Scope of Practice, see Oregon Administrative Rule (OAR) 847-035-0030.

Scope of Practice: Each EMS Provider can perform the procedures of each lower level certification plus those listed in their certification level.

Airway and Breathing

<table>
<thead>
<tr>
<th>Emergency Medical Responder</th>
<th>Emergency Medical Technician</th>
<th>Advanced EMT</th>
<th>EMT-Intermediate</th>
<th>Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>BVM</td>
<td>Supraglottic airway device</td>
<td></td>
<td></td>
<td>Cricothyrotomy</td>
</tr>
<tr>
<td>NPA</td>
<td>Tracheobronchial suctioning of ET tube</td>
<td></td>
<td></td>
<td>Endotracheal intubation</td>
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<tr>
<td>OPA</td>
<td>Ventilator</td>
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<tr>
<td>Pharyngeal suctioning</td>
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Pharmacological Intervention

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<th>Advanced EMT</th>
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<th>Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin for cardiac</td>
<td>Activated charcoal</td>
<td>Dextrose, hypertonic</td>
<td>Amiodarone</td>
<td>Administer medications authorized by protocol or physician's direct order</td>
</tr>
<tr>
<td>Epi by auto-injector for anaphylaxis</td>
<td>Epi by IM injection for anaphylaxis</td>
<td>Glucagon</td>
<td>Atropine</td>
<td></td>
</tr>
<tr>
<td>Naloxone via IN device or auto-injector</td>
<td>Nebulized albuterol and/or DuoNeb</td>
<td>IO lidocaine (anesthetic)</td>
<td>Diphenhydramine</td>
<td></td>
</tr>
<tr>
<td>Oral Glucose</td>
<td>Nitroglycerine (assist patient with own NTG)</td>
<td>Ipratropium</td>
<td>Epinephrine</td>
<td></td>
</tr>
<tr>
<td>Oxygen</td>
<td>Pralidoxime and Atropine by autoinjector for organophosphate agents</td>
<td>Isotonic IV solutions</td>
<td>Fentanyl</td>
<td></td>
</tr>
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<td></td>
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<td>Naloxone</td>
<td>Furosemide</td>
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<td>Nitroglycerine</td>
<td>Lidocaine</td>
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<td></td>
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<td>Nitrous oxide</td>
<td>Morphine</td>
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<td>Vasopressin</td>
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<td>Zofran</td>
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Medical/Cardiac Care

<table>
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<th>Emergency Medical Technician</th>
<th>Advanced EMT</th>
<th>EMT-Intermediate</th>
<th>Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• AED / SAED</td>
<td>• Blood glucose monitoring</td>
<td>• Blood draws</td>
<td>• EKG interpretation</td>
<td>• Access indwelling catheters and implanted central IV ports</td>
</tr>
<tr>
<td>• Hemorrhage Control</td>
<td></td>
<td>• Start IO’s in pediatrics and adults</td>
<td>• Manual defibrillation</td>
<td>• Cardioversion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Start IVs or saline locks</td>
<td>• Ora gastric tube</td>
<td>• Nasogastric tube</td>
</tr>
</tbody>
</table>

EMS Provider Nomenclature

The term “EMS Provider” has replaced the term “EMT” to describe all scope of practice levels. The term “EMT” now refers to the level formerly called “EMT-Basic.” Per Oregon Administrative Rules 333-265-0000 (Definitions) and Oregon Revised Statute Chapter 682 the terms have changed as follows:

<table>
<thead>
<tr>
<th>Old</th>
<th>New</th>
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</thead>
<tbody>
<tr>
<td>Did not exist</td>
<td>Advanced Emergency Medical Technician (AEMT or Advanced EMT)</td>
</tr>
<tr>
<td></td>
<td>• Is not used in these protocols</td>
</tr>
<tr>
<td>EMT</td>
<td>Emergency Medical Services Provider or EMS Provider</td>
</tr>
<tr>
<td>EMT-B</td>
<td>EMT or Emergency Medical Technician</td>
</tr>
<tr>
<td>EMT-I</td>
<td>Remains the same (or EMT-Intermediate)</td>
</tr>
<tr>
<td>EMT-P</td>
<td>Paramedic</td>
</tr>
<tr>
<td>First Responder</td>
<td>Emergency Medical Responder or EMR</td>
</tr>
</tbody>
</table>
Death in the Field

Purpose:
To define under what conditions treatment can be withheld or stopped.

A. Resuscitation efforts may be withheld if:
   1. The patient has a “DNAR” order.
   2. The patient is pulseless and apneic in a mass casualty incident or multiple patient scene where the resources of the system are required for the stabilization of living patients.
   3. Decapitation.
   4. Rigor mortis in a warm environment.
   5. Decomposition.
   6. Skin discoloration in dependent body parts (dependent lividity).

B. Traumatic Cardiac Arrest
   1. A victim of trauma (blunt or penetrating) who has no vital signs at the scene may be declared dead. If opening the airway does not restore vital signs/signs of life, the patient should NOT be transported unless there are extenuating circumstances.
   2. A cardiac monitor may be beneficial in determining death in the field when you suspect a medical cause or hypovolemia:
      a. An organized rhythm may suggest profound hypovolemia and/or tension pneumothorax, and may respond to fluid resuscitation and/or needle decompression, respectively.
      b. VF should raise your index of suspicion for a medical event.
   3. At a trauma scene consider the circumstances surrounding the incident, including the possibility of cardiac arrhythmia, seizure, or hypoglycemia. When a medical event is suspected, treat as a medical event.
   4. If the patient deteriorates to no vital signs (i.e., no pulse/respiration), a cardiac monitor should be applied. A viable rhythm especially in patients with penetrating trauma may reflect hypovolemia or obstructive shock (tamponade, tension pneumothorax) and aggressive treatment should be continued.
   5. If a patient deteriorates to cardiac arrest during transport, perform CPR and notify the trauma facility.
C. Medical Cardiac Arrest
   1. If the initial EKG shows asystole or agonal rhythm confirmed in 6 leads with full gain, and the patient in the responder’s best judgment would not benefit from resuscitation:
      a. The PIC may determine death in the field; OR
      b. Begin BLS procedures, and contact OLMC with available patient history, current condition, and with a request for advice regarding discontinuing resuscitation.
   2. The PIC may determine the patient to be dead in the field if the patient persists in asystole (confirmed in 6 leads with full gain) after the airway is established, and the asystole protocol has been exhausted.
   3. Death in the field may be determined with EtCO₂ of < 10 in patients with PEA after 20 minutes of ACLS resuscitation. For patients with EtCO₂ > 10 either continue resuscitation or contact OLMC to stop resuscitation.
   4. Patients in VF should be treated and transported.

Notes and Precautions
A. ORS allows a layperson, EMT or paramedic to determine “Death in the Field.”
B. Consult OLMC with any doubt about the resuscitation potential of the patient.
C. A person who was pulseless or apneic and has received CPR and has been resuscitated is not precluded from later being a candidate for solid organ donation.
Dying and Death, POLST, and Do Not Attempt Resuscitation Orders

A. POLST ORDERS AND DECISION MAKING

1. In the pulseless and apneic patient who does not meet DEATH IN THE FIELD criteria, but is suspected to be a candidate for withholding resuscitation, begin CPR and contact OLMC.

2. A patient with decision-making capacity or the legally authorized representative has the right to direct his or her own medical care and can change or rescind previous directives.

3. EMS providers may honor a Do Not Attempt Resuscitation (DNAR) order signed by a physician, naturopathic physician, nurse practitioner, or physician assistant. DNAR orders apply only to the patient in cardiopulmonary arrest and do not indicate the types of treatment that a person not in arrest should receive. POLST was developed to convey orders in other circumstances.

4. Physician Orders for Life-Sustaining Treatment (POLST):
   a. The POLST was developed to document and communicate patient treatment preferences across treatment settings. While these forms are most often used to limit care, they may also indicate that the patient wants everything medically appropriate done. Read the form carefully!
   b. When signed by a physician (MD or DO), naturopathic physician, nurse practitioner, or physician assistant, POLST is a medical order and EMS providers are directed to honor it in their Scope of Practice unless they have reason to doubt the validity of the orders or the patient with decision-making capacity requests change. If there are questions regarding the validity or enforceability of the health care instruction, begin BLS treatment and contact OLMC [OAR 847-035-030 (7)].
   c. If the POLST is not immediately available, a POLST form as documented in the Electronic POLST registry hosted at MRH (503-494-7333) may also be honored.
      • Section A: Applies only when patient is in cardiopulmonary arrest
      • Section B: Applies in all other circumstances
      • For a POLST form to be valid it must include:
        i. Patient’s name
        ii. Date signed (forms do not expire)
        iii. Health care professional’s signature (patient signature is optional)

5. The legally authorized representative may make decisions for the patient who is unable to make medical decisions. However, when in doubt or for unresolved conflict on the scene contact OLMC. The order is:
   a. A legal guardian
   b. A power of attorney for health care as designated by the patient on the Oregon advance directive
   c. Spouse or legal domestic partner
   d. Adult children
   e. Parent
6. **Death with Dignity**
   If a person who is terminally ill and appears to have ingested medication under the provisions of the Oregon Death with Dignity Act, the EMS provider should:
   a. Provide comfort care as indicated.
   b. Determine who called 9-1-1 and why (i.e., to control symptoms or because the person no longer wishes to end their life with medications).
   c. Establish the presence of DNAR orders and/or documentation that this was an action under the provisions of the Death with Dignity Act.
   d. Contact OLMC.
   e. Withhold resuscitation if: DNAR orders are present, and there is evidence that this is within the provisions of the Death with Dignity Act and OLMC agrees.

B. **PATIENTS ENROLLED IN HOSPICE AND DYING PATIENTS**
   1. Look for POLST forms (contact Registry if needed) and attempt to honor patient preferences. Always provide comfort measures.
   2. If patient is enrolled in hospice and the patient has not already done so, contact hospice if possible.
   3. EMS providers cannot take medical orders from a hospice nurse but their advice is often invaluable and may be followed with direction from OLMC.
   4. Treat dying persons with warmth and understanding. Do not avoid them. Allow them to discuss their situation, but do not push them to talk.
   5. Many dying people are not upset by discussions of death as long as you do not take away all of their hope.
   6. Touching a dying person is important. Use words like “death.” Do not use meaningless synonyms.
   7. Ask the person how you might help.
   9. Be aware of your own fears regarding death and admit when a dying person reminds you of a loved one. If a particular person is too disturbing, have other members of the responding team take over.
   10. Consider providing pain/symptom management and not transporting patient if they are Comfort Measures Only, the symptoms can be managed, and the patient and caregivers on scene do not want transport to the hospital. Consider OLMC contact for advice.

C. **CARE OF GRIEVING PERSONS**

**Resuscitation phase**
   1. As time allows give accurate and truthful updates about the patient’s prognosis. If available, assign one person to interact with and support family members.
   2. Consider gently removing children from the resuscitation area.
   3. Depending upon the emotional state of family members, consider allowing them to watch and/or participate in a limited and appropriate way.
4. If family or friends were doing CPR prior to your arrival, commend their efforts.
5. If family or friends are disruptive consider removing them or try assigning simple tasks, such as helping bring in the stretcher, telling other family about the event, and calling the doctor or minister.

**Once death is determined**

a. Treat the recently dead with respect.
b. Tell family and friends of the death honestly. Use the words “death” or “dead.” Avoid using euphemisms such as “passed away” or “gone.”
c. Avoid using past tense terms when speaking to survivors of the recently dead.
d. Allow family and friends to express their emotions. Listen to them if they want to talk but don’t push them.
e. Give factual information.
f. Genuine warmth and compassion will be more helpful than almost anything else for survivors. Don’t feel it necessary to say the “right” things. Listening often provides grieving people with the most comfort.

**Focusing on survivors**

a. See to it that survivors have a support system present before you leave. Consider calling TIP through EMS Dispatch. Call friends, family, clergy, or neighbors to be with them. Respect the survivors’ wishes to be alone.
b. Explain the next steps to them after you have pronounced death. This will include the police coming to make reports, possibly the medical examiner, and the possible need for an autopsy.
c. Before moving or altering the body, contact the Medical Examiner’s office as soon as possible.
d. Allow family and friends to say their good-byes if possible.
e. A chaplain may be helpful in assisting with survivors. Call early, as chaplains do not have code-3 capabilities.
f. Help survivors make decisions such as which people should be called. If they ask you to make calls, try to comply. Mention the need to find a funeral home, if one has not been chosen. Clergy may also be helpful with this decision.

**C. DEATH OF A CHILD**

1. Do not accuse the parents of abuse or neglect, but note carefully the patient’s surroundings and the general physical condition of the child.
2. Do not be overly silent, which may imply guilt to the parents.
3. Ask the parents only necessary questions and do not judge or evaluate them. Do not tell them what they “should have” been doing before your arrival.
4. Remind parents to arrange for child care of other children.
5. Listen carefully to their statements and answer with accurate information.
6. If there is a police investigation, tell the parents that this is routine.
7. Successful management of child deaths requires supportive, compassionate, and tactful measures.
Medical Control for Drugs and Procedures

Policy:
If a patient receives a procedure or medication; is conscious (or regains consciousness); and refuses transport, every effort shall be made to encourage transport of the patient. If the patient persists in refusing transport, see the Non-Transport procedure.

These protocols contain Category A and B drugs and procedures. Before using any Category B drug or procedure you must contact OLMC. If the EMS Provider is unable to contact OLMC, Category B drugs or procedures should be administered as indicated in the protocol. If a Category B drug or procedure is used without OLMC contact, a written report must be sent to the Medical Director or Physician Supervisor. Continued attempts must be made to reach OLMC en route.

Category A:
Drug or procedure will be used at the EMS Provider’s discretion in accordance with the standing orders.

Drugs:
- Acetaminophen
- Activated Charcoal (ASA and APAP only)
- Adenosine (Adenocard®)
- Albuterol
- Albuterol (Hyperkalemia)
- Alprazolam (Xanax)
- Amiodarone
- Ammonia Inhalant
- Aspirin
- Atropine Sulfate
- Calcium Gluconate
- Dexamethasone (Decadron®)
- Dextrose 10%
- Dextrose 50%, IV
- Diphenhydramine (Benadryl®)
- Epinephrine
- Etomidate (Amidate®)
- Fentanyl (Sublimaze)
- Furosemide (Lasix®)
- Glucagon
- Glucose, Oral
- Haloperidol (Haldol®)
- Hydroxocobalamin (Cyanokit®)
- Ibuprofen
- Ipratropium (Atrovent®)
- IV Solutions
- Ketamine
- Ketorolac (Toradol®)
- Lidocaine (Xylocaine®)
- Magnesium Sulfate
- Midazolam (Versed®)
- Morphine
- Naloxone (Narcan®)
- Nitroglycerin
- Norepinephrine (Levophed®)
- Olanzapine (Zyprexa®)
- Ondansetron (Zofran®)
- Oxymetazoline hydrochloride (Afrin)
- Oxygen
- Pralidoxime (Protopam/2-PAM)
- Prochlorperazine (Compazine)
- Rocuronium Bromide
- Sodium Bicarbonate
- Sodium Thiosulfate
- Succinylcholine
- Sufentanil (Sufenta)
- Tranexamic Acid (TXA)
- Vasopressin
- Vecuronium Bromide (Norcuron®)
- Xylocaine, Viscous
- Ziprasidone (Geodon)
Category A:

**Procedures:**
- Chemical Patient Restraint
- Continuous Positive Airway Pressure (CPAP)
- End-Tidal CO₂ Monitoring
- Endotracheal Intubation
- i-gel
- Induced Hypothermia
- Intraosseous Infusion
- Intravenous Lines and IV Solutions (Management of)
- Intravenous Solutions (Control and Monitoring of)
- King LT-D/LTS-D Airway Device
- Left Ventricular Assist Device
- LUCAS
- Paralytic Intubation: Advanced Airway Training Required
- Physical Patient Restraint
- Self-Care Instructions
- Pelvic Wrap
- Selective Spinal Immobilization
- Sports Equipment Removal
- Surgical Cricothyrotomy
- Synchronous Cardioversion
  - A. Unstable VTachycardia, OR
  - B. SVT, unstable patient with BP less than 90 mmHg
- Taser Barb Removal
- Tension Pneumothorax Decompression
- Transcutaneous Pacing
- Video Laryngoscope

Category B:

Drug or procedure, not included in Category A, shall be initiated by request from EMS Provider to OLMC. Confirmation of dosage or procedure will be obtained directly from a Physician on Duty at OLMC.

**Drugs:**
- Activated Charcoal (All other ingestions < 2 hours old)
- Calcium Gluconate (Calcium Channel Blocker OD)
- Glucagon (Beta-blocker OD)
- Magnesium Sulfate (OB/GYN and asthma)
- Sodium Bicarbonate (Cyclic antidepressant OD)

**Procedures:**
- Automatic Implantable Cardio-Defibrillator Deactivation (AICD)
Required Multnomah County Medications

- Activated Charcoal: 25 grams
- Adenosine: 6 mg, 12 mg (3 mg/mL)
- Albuterol: 2.5 mg/3 mL
- Alprozolam (Xanax) 0.25 mg tablets
- Amiodarone: 150 mg/3 mL
- Aspirin: 81 mg tablets
- Atropine: 1 mg/10 mL
- Calcium Gluconate: 10% (100 mg/mL)
- Dexamethasone: 10 mg/mL
- Dextrose:
  - 10%, 250 mL (0.1 g/mL)
  - 50%, 50 mL (0.5 g/mL)
  - Oral, 24 gram
- Diphenhydramine: 50 mg/mL
- Epinephrine:
  - 1:1,000, 1 mg/mL
  - 1:10,000, 1 mg/10 mL
- Etomidate: 40 mg (2 mg/mL)
- *Fentanyl: 100 mcg/2 mL
- Furosemide: 40 mg/4 mL
- Glucagon: 1 mg/mL
- Haloperidol: 5 mg/mL
- Ipratropium: 0.5 mg/2.5 mL
- *Ketamine: 500 mg/10 mL
- *Ketorolac: 30 mg/mL
- Lidocaine:
  - 2%, 100 mg/5 mL
  - 2%, Viscous Jelly
- Magnesium Sulfate 50%: 1 g/2 mL
- *Midazolam: 10 mg/2 mL
- Naloxone: 2 mg/2 mL
- Nitroglycerin:
  - Tablets, 0.4 mg
  - IV Nitroglycerin 50 mg/10 mL
- Norepinephrine: by IV infusion pump only
- Olanzapine:
  - Tablets, 10 mg
- Ondansetron:
  - 4 mg/2 mL
  - Tablets, 4 mg
- Prochlorperazine (Compazine):
  - 10 mg/2 mL
- Rocuronium Bromide:
  - 10 mg/mL (5 mL, 10 mL)
  - [9-1-1 Responding Units Only]
- Sodium Bicarb: 50 mEq/50 mL
- Succinylcholine: 20 mg/mL
  - [9-1-1 Responding Units Only]
- *Sufentanil (Sufenta): 50 mcg/1 mL
- Tranexamic Acid (TXA): 1 gram/10 mL
- Vasopressin: 20 U/mL
- Vecuronium: 10 mg-powder (1 mg/mL)
  - [9-1-1 Responding Units Only]
- Ziprasidone: 20 mg/mL

Special Operations Medications

- 6% hetastarch in buffered electrolyte HET (Hextend®): 6% in 500 mL
- Pralidoxime (Protopam/2-PAM)
- Proparacaine Hydrochloride Ophthalmic Solution USP, 0.5%  

* Must be locked and counted at each shift change

NOTE:
Alternative formulations allowed with approval of EMS Medical Director.