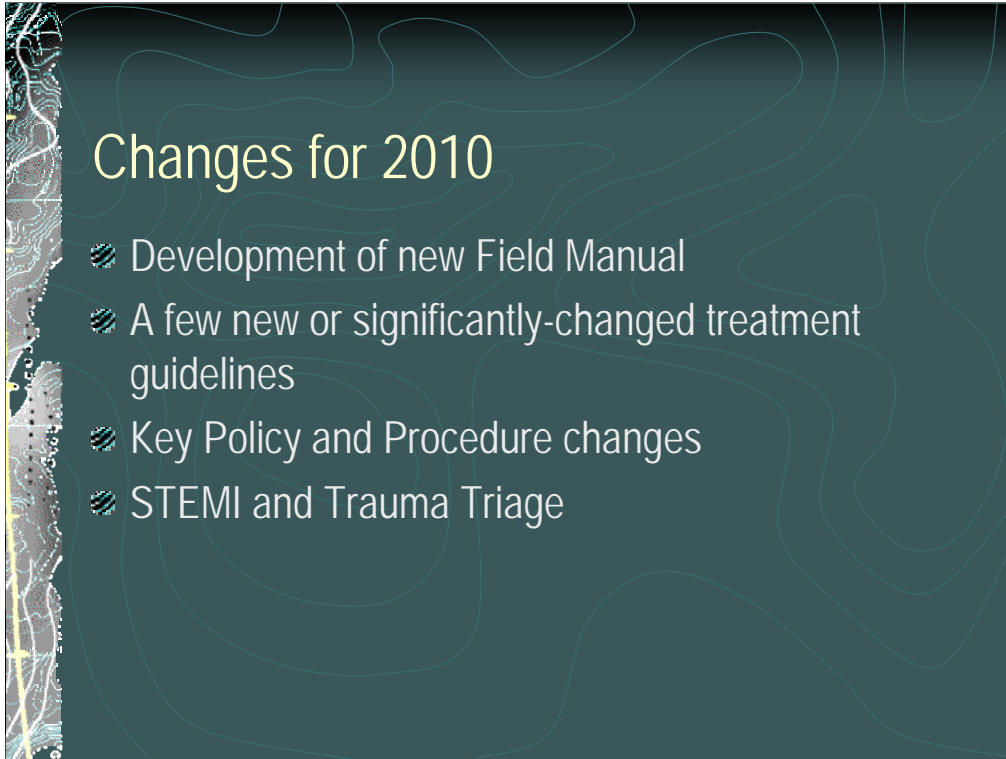


- Welcome to the Annual Contra Costa County EMS Update.
- The purpose of this update is to provide you with information and training on changes to Contra Costa prehospital care guidelines (PHCG) and (goldenrod) policy and procedures.
- Updated protocols, policies and guidelines go into effect January 1, 2010 and will be posted on [www.cccems.org](http://www.cccems.org) website at that time.
- If you have any questions after the presentation please contact your EMS provider agency educator or Contra Costa EMS.



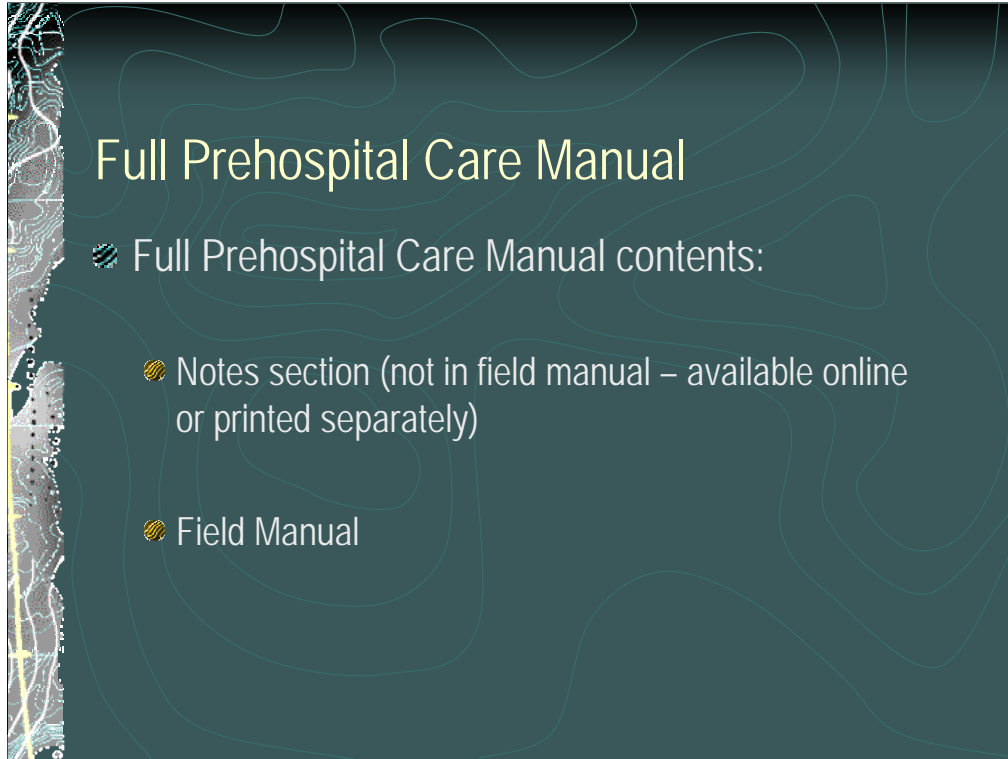
- There are many significant changes in the Prehospital Care Manual and in policies and procedures that will go into effect January 1.
- This presentation will go over many of the changes in great detail.
- Most patient treatment is unchanged but the format and content of our treatment guidelines have changed.
- In order to develop a pocket field manual information needed to be streamlined and duplication eliminated.
- Contra Costa EMS believes that the new format is more user-friendly and we will be looking for your comments and recommendations in the coming year to evaluate how effectively it meets your needs.

## New Field Manual

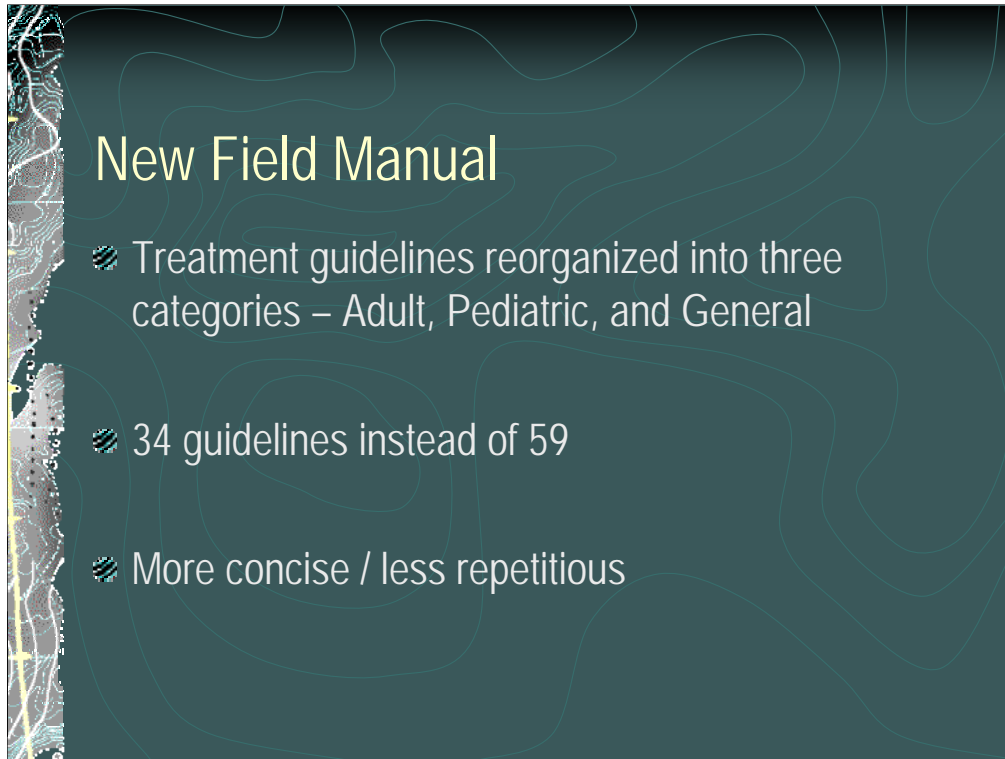
- Contains
  - Treatment Guidelines
  - Drug References
  - Summaries of Key Field Policies
  - Other Patient Care Reference Material



- The field manual is designed for a 4” X 6” format that truly should be pocket-sized.
- Compared to the field manuals that consisted of reductions of our full-sized pages, this should be more readable.
- In addition to all treatment guidelines, the manual has a number of reference documents, including summaries of key field policies.
- This is a new document for us, and we’re sure that in future years we can improve – we are certainly open to feedback on this.



- Not all the contents of our current prehospital care manual will be in the field manual.
- Reference material that is unlikely to be consulted in the field was not included in the field manual.
- However those resources will still be available in the 8 ½ X 11 format along with the contents of the field manual.
- The 8 ½ x 11 format will still be available to you and available on our website at [www.cccems.org](http://www.cccems.org)



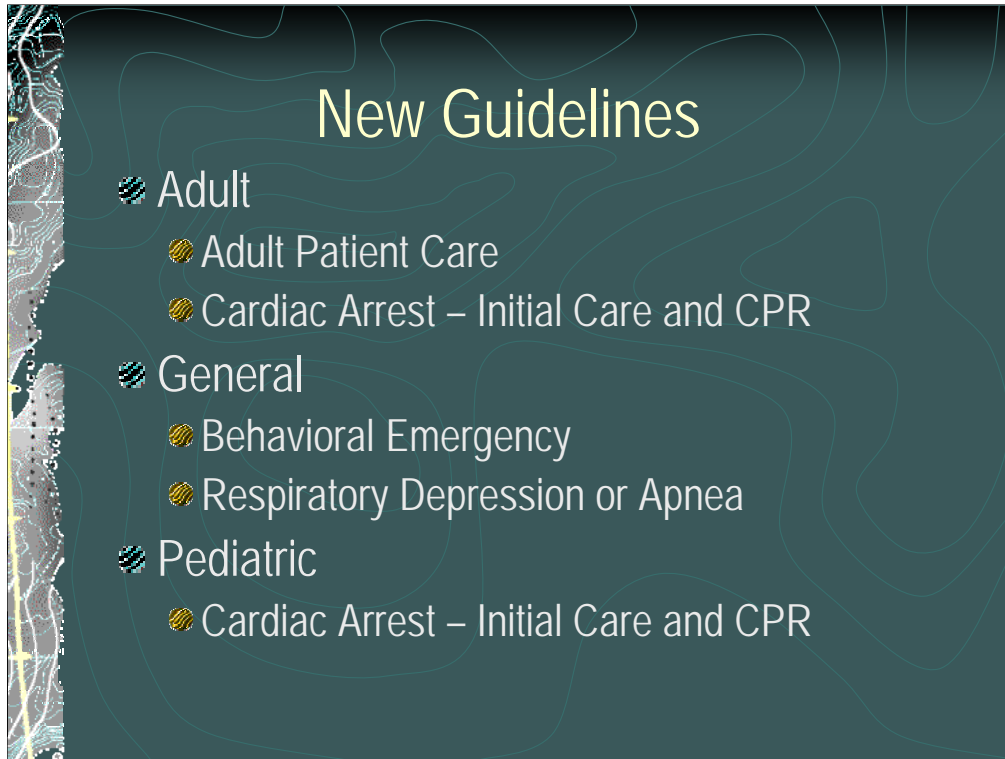
- We have reorganized from nine groups of guidelines down to three, adult, pediatric and general (many of which pertain to both adult and pediatric patients).
- When pediatric content is included in general guidelines, it is highlighted with a special icon (a star).
- In general, most guidelines have not changed significantly in terms of the treatments that are listed.
- The format has changed for all guidelines.

<b>A6 - ADULT</b>	<b>SYMPTOMATIC BRADYCARDIA</b>
<i>Heart rate less than 60 with signs or symptoms of poor perfusion (e.g., acute altered mental status, hypotension, other signs of shock).</i>	
<b>OXYGEN</b>	High flow. Be prepared to support ventilation as needed
<b>CARDIAC MONITOR</b>	
<b>12-LEAD ECG</b>	Consider pre- and post-treatment if condition permits
<b>IV</b>	TKO. If not promptly available, proceed to external cardiac pacing. Consider IO ACCESS if patient in extremis and unconscious or not responsive to painful stimuli.
<b>TRANSCUTANEOUS PACING</b>	Set rate at 80 Start at 10 mA, and increase in 10 mA increments until capture is achieved
Consider <b>SEDATION</b>	If pacing urgently needed, sedate after pacing initiated. <ul style="list-style-type: none"> <li>• <b>MIDAZOLAM</b> - initial dose 1 mg IV or IO, titrated in 1-2 mg increments (maximum dose 5 mg), and/or</li> <li>• <b>MORPHINE SULFATE</b> 1-5 mg IV or IO in 1 mg increments for pain relief if BP 90 systolic or greater</li> </ul>
Consider <b>ATROPINE</b>	<ul style="list-style-type: none"> <li>• 0.5 mg IV or IO if availability of pacing delayed or pacing ineffective.</li> <li>• Consider repeat 0.5 mg IV or IO every 3-5 minutes to maximum of 3 mg.</li> </ul> Use with caution in patients with suspected ongoing cardiac ischemia. Atropine should not be used in wide-QRS second- and third-degree blocks.
<b>TRANSPORT</b>	
Consider <b>FLUID BOLUS</b>	250-500 ml NS if clear lung sounds and no respiratory distress
Consider <b>DOPAMINE</b>	Begin infusion at 5 mcg/kg/min if not responsive to pacing or atropine (see table)

- Here is a sample of a treatment guideline.
- The key interventions are on the left-hand side and the details of care are on the right.
- All of the guidelines follow this format.

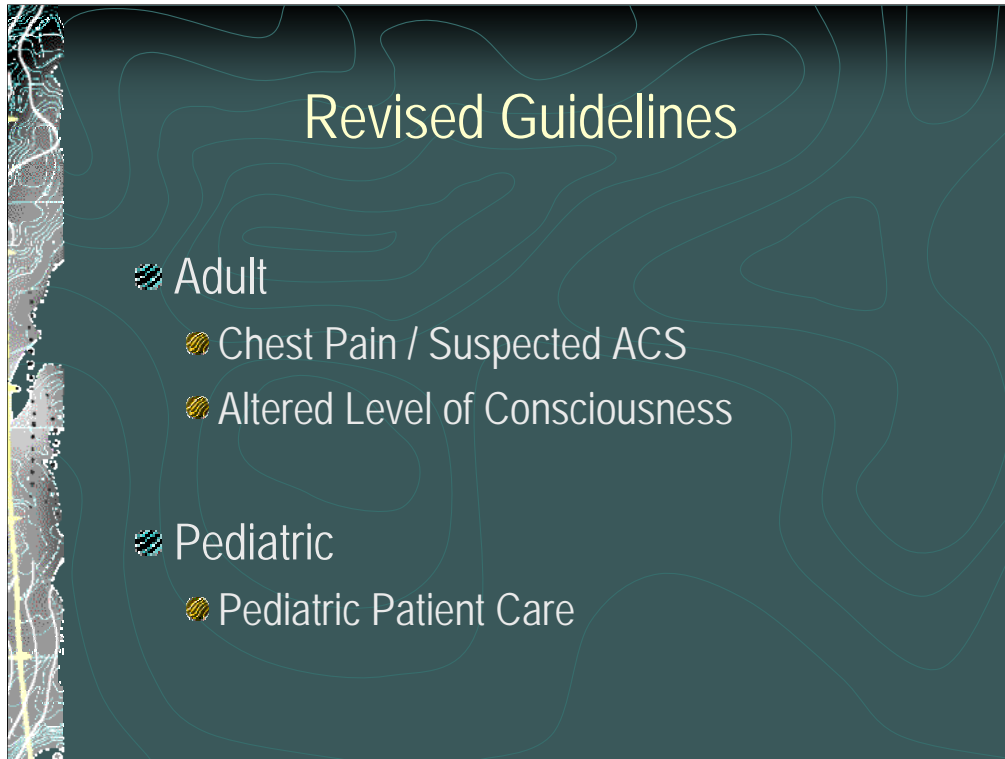
A1 ADULT	ADULT PATIENT CARE
<i>These basic concepts should be addressed for all adult patients (age 15 and over).</i>	
Scene Safety	
Body Substance Isolation	Use universal blood and body fluid precautions at all times.
Systematic Assessment	<ul style="list-style-type: none"> <li>• Assure open and adequate airway. Management of ABC's are priority.</li> <li>• Place patient in position of comfort unless condition mandates other position (e.g. shock, coma)</li> <li>• Consider spinal immobilization if history or possibility of traumatic injury exists</li> </ul>
Determine Primary Impression	<ul style="list-style-type: none"> <li>• Apply appropriate field treatment guideline(s)</li> <li>• Explain procedures to patient and family as appropriate</li> </ul>
Base Contact	<ul style="list-style-type: none"> <li>• Contact base hospital if any questions arise concerning treatment or if additional medication beyond dosages listed in treatment guidelines are considered.</li> <li>• Use SBAR to communicate with base</li> </ul>
Transport	<ul style="list-style-type: none"> <li>• Minimize scene time in critical trauma, STEMI, stroke, shock, and respiratory failure.</li> <li>• Transport patient medications or current list of patient medications to the hospital.</li> <li>• Give report to appropriate facility using SBAR</li> </ul>
Document	Document patient assessment and care in a timely manner

- One of the things we have done is to put some general guidelines in both an “Adult Patient Care” and “Pediatric Patient Care” guidelines that have some of the typical info that used to be in many of the guidelines – things like open airway, manage ABC’s, position of comfort.
- These items are not repeated in the other treatment guideline and it is assumed that all patient care should follow these general guidelines as well as the guideline specific to the patient’s needs/complaint.



- For 2010 we have a few new guidelines.
- These include Cardiac Arrest, Behavioral Emergency and Respiratory Depression or Apnea guidelines which we will review in detail.
- The new adult patient care guideline is self explanatory and straight-forward.







- We also have made some important changes to our Chest Pain / Suspected ACS guideline which will be discussed in greater detail.
- There are also changes in ALOC guideline that are the result of implementing the new guideline on respiratory depression or apnea.
- Our Pediatric Patient Care Guideline has also been revised to include the items that should be addressed on all calls, similar to the adult patient care guideline.

# Consolidated Guidelines

## “General” Guidelines (Adult and Pediatric)

- Allergy / Anaphylaxis
- Altered Level of Consciousness
- Burns
- Pain Management
- Poisoning / Overdose (Including Hazmat)
- Respiratory Distress
- Seizure
- Trauma (including Crush Injury)

The eight treatment guidelines listed are ones in which there have been consolidation of adult and pediatric care into one guideline. For the most part the only differences in the guidelines were related to drug dose – both doses are listed in the new format.

G14 GENERAL	SEIZURE / STATUS EPILEPTICUS
<ul style="list-style-type: none"> <li>• Tonic, clonic movements followed by a period of unconsciousness (post-ictal period).</li> <li>• A continuous or recurrent seizure is defined as seizure activity greater than 10 minutes or recurrent seizures without patient regaining consciousness.</li> </ul>	
OXYGEN	High flow. Be prepared to support ventilations
Protect patient	Do not forcibly restrain but protect from injuring self
CARDIAC MONITOR	
Consider IV	TKO
BLOOD GLUCOSE	Check and treat if indicated
Consider MIDAZOLAM IV	For continuous or recurrent seizures: Adult – initial dose 1 mg IV - titrate in 1-2 mg increments – max. dose 5 mg ★ Pediatric – titrate in 1 mg IV increments – up to 0.1 mg/kg – max. dose 5 mg
Consider MIDAZOLAM IM	If IV access unavailable: • Adult – 0.2 mg/kg IM - maximum dose 10 mg ★ Pediatric – 0.2 mg/kg IM - maximum dose 10 mg
MONITOR PATIENT	Carefully observe vital signs, respiratory status – support ventilations as needed
Related guidelines: Altered Level of Consciousness (G2), Respiratory Depression or Apnea (G12)	
<b>SAFETY WARNING:</b>	
	<ul style="list-style-type: none"> <li>• Use caution when treating with midazolam in pediatric patients previously treated by family or caretaker with rectal diazepam (Valium, Diastat) as a higher incidence of respiratory depression may occur.</li> <li>• Wait five (5) minutes after last rectal dose to determine effect and need for treatment. Consider using reduced dosage of midazolam.</li> </ul>
	

This shows one of the General guidelines for seizure – both adult and pediatric doses appear in the same guideline.

Note the star next to pediatric doses. All pediatric doses mentioned in the general guidelines have the star before them.

## Behavioral Emergency



- One of our most common calls
- Safety for crews and patient is critical
- Key Issues:
  - Must rule out medical causes of behavioral symptoms
    - (e.g., hypoxia, hypoglycemia, trauma)
  - Allows sedation with midazolam (after base contact) for chemical restraint when other techniques have not succeeded

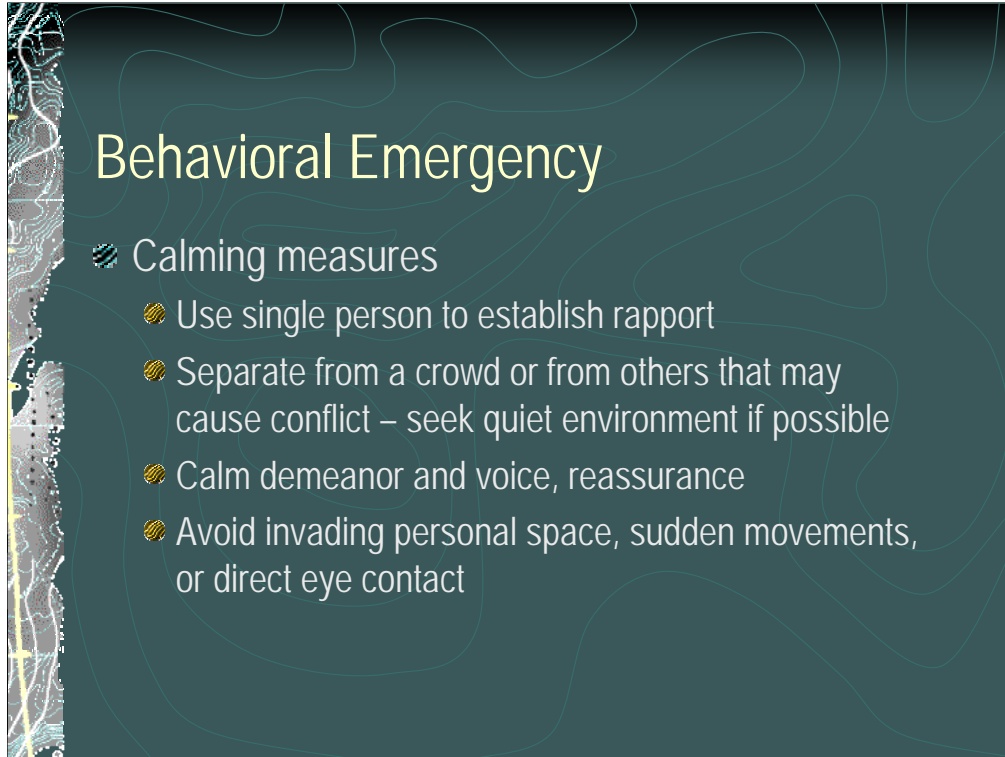
- It has been a long time coming but we have developed a guideline for behavioral emergencies.
- Somewhere between 10-15% of calls involve behavioral issues or mental health patients.
- Behavioral patients constitute a high volume high risk population in our EMS System.
- Changes in our policy reflect improved guidance for the protection of both our providers and the patient.

## Behavioral Emergency

- Non-pharmacologic approaches to deal with patients (de-escalation and physical restraint) **must** be used/attempted prior to use of midazolam
- Base contact is required




- Paramedics have always had the ability to call base for midazolam in behavioral emergency situations.
- That has not changed – the base still needs to be called.
- Currently we have been averaging around 4-5 calls for sedation for behavioral issues every year.
- We believe that there are more patients who may be in need of this treatment in order for everyone involved to be safe.
- But before using drugs, all the other de-escalation and restraint techniques need to be done or attempted.



- In the heat of the moment, there may be times where doing all of these things are difficult but what is clear is that in many situations, the behavior and actions of those taking care of these patients or others around them can either have a beneficial or detrimental effect.
- We want all personnel to do their best in these sometimes trying situations.
- If you need additional training on verbal de-escalation contact your EMS agency educator for the Fire EMS Consortium Training module on Behavioral Emergencies.

## Behavioral Emergency



- Scene safety is paramount
  - Be sure to utilize law enforcement when needed
  - Situational awareness is key
- **Monitor closely!**
  - Both if given sedation or not
- Document carefully and often
  - Mental status, respiratory status, CMSTP of extremities in restraint

- Safety issues are paramount for both you and the patient.
- The patients who are sedated need close monitoring – ECG and pulse ox monitoring, when they can be done, should be done.
- Assessment of CMSTP of extremities of patients in restraints should be done every 15 minutes.
- Careful observation needs to be backed up with careful documentation – these can be risky patients from a medicolegal standpoint.

## Midazolam for Chemical Restraint

### ● Dosage

- 5 mg IM (most instances)
- 1-5 mg IV in 1 mg increments only if patent IV already available (probably rare in these patients)
- Do not recommend repeat dosage
- Onset of effect may not be immediate – may be 15 minutes or greater in some cases

- Most of the time Midazolam will be given IM.
- If you could start and IV or keep one in, you probably wouldn't need the drug.
- The onset may be delayed and it is key that we don't add one layer of sedation over another and end up with respiratory compromise.
- For this reason, repeat dosage is not recommended.



## Midazolam for Chemical Restraint

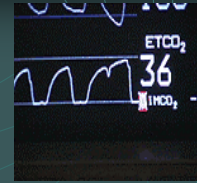
### ● Indication:

- When calming measures and physical restraint have not adequately addressed physically combative behavior (e.g. continue to struggle strenuously against restraints and may harm self or others)

### ● Should never be used to address verbal excesses of patients

- Chemical Restraint is not first line therapy and has significant risks associated with it.
- Documentation of the indication, base contact, patient monitoring and patient response is essential.

## Midazolam - Precautions



- Respiratory depression –
  - Place on monitor and pulse oximeter
  - Monitor depth and rate of respirations
  - Use non-invasive ETCO<sub>2</sub> if available to monitor
- Patient may have many other drugs on board so the potential for synergy between drugs needs to be respected

- Some agencies are adopting use of nasal cannula for monitoring end-tidal carbon dioxide.
- This can be particularly helpful in early detection of respiratory depression and also will give a respiratory rate for documentation.
- These patients may have other drugs on board and BLS management of airway may be needed if there is a temporary decrease in respiratory rate or depth.
- Always be prepared to support ventilation

A topographic map of a coastal region, showing landmasses, water bodies, and elevation contours. The map is oriented vertically on the left side of the slide.

## Cardiac Arrest – Initial Care & CPR

- Intent of guideline:
  - To reinforce importance of initial care in cardiac arrest
    - Uninterrupted CPR
    - Much less emphasis on advanced airway early (unless ResQPOD is used)
  - To encourage longer field resuscitation
    - Up to 30 minutes

- We have introduced a Cardiac Arrest – Initial Care guideline because many of the critical steps that save lives happen in the first few minutes.
- There is little evidence that medications, IV's, or intubation lead to better survival – it is CPR and defibrillation, and if CPR is not done well, defibrillation may not work.

## Interruptions in CPR

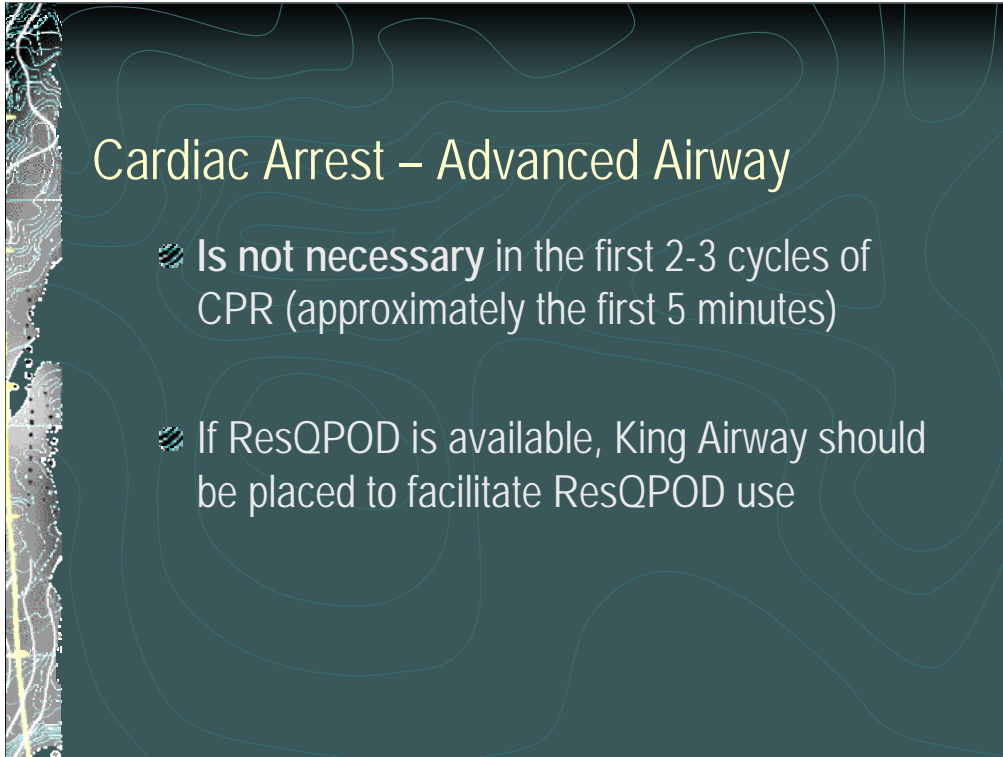


- Important to avoid
  - Blood pressure and flow created by CPR drops rapidly
- Optimally should never exceed 10 seconds
- Necessary during rhythm check and shock but not during charging of the defibrillator

•CPR “builds up a head of steam” and helps move blood through the vascular system, and this is felt to be a critical item to condition the heart to be able to resume beating in an organized fashion.

•When we stop CPR we lose that head of steam and it takes a long time to re-establish it.

•The new CPR guidelines scheduled to come out late in 2010 may actually further increase the compression/ventilation ratio to further emphasize the importance of compressions over ventilation.



- For patients who truly have sudden cardiac death, most have adequate oxygen levels at the time of arrest.
- That differs from those who may be arresting from a respiratory cause, drowning, trauma, and other causes.
- But in sudden cardiac arrest, there appears to be plenty of oxygen to sustain the body for several minutes – so the emphasis has turned away from maximizing oxygenation early in a cardiac arrest.
- Interruption of CPR to pass an endotracheal tube isn't a worthwhile tradeoff early in resuscitation.
- This is why we are not recommending any advanced airway in the first 2-3 cycles – unless ResQPOD is being used.




### ResQPOD Circulatory Enhancer

The ResQPOD is an **impedance threshold device (ITD)**. It selectively prevents inspiratory gases from entering the chest during the recoil (decompression) phase of CPR, which leads to...



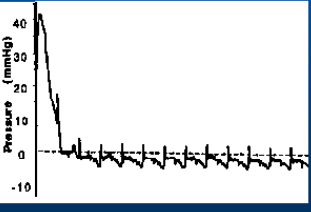
The ResQPOD is also called an impedance threshold device or ITD. It is currently being used in San Ramon and is an optional item to carry in Contra Costa, but several other agencies are planning to begin use of this in the near future. It keeps air from rushing back into the chest during chest recoil.



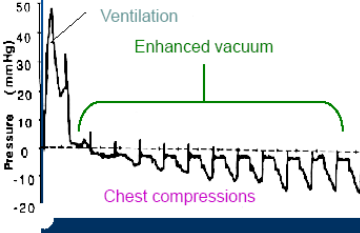
## ResQPOD Circulatory Enhancer

Greater vacuum (negative pressure) in the chest during chest compressions, which leads to...

**Conventional CPR**



**Conventional CPR w/ ResQPOD**




Ventilation

Enhanced vacuum

Chest compressions

That creates a larger negative pressure or vacuum in the chest as the chest expands but the air doesn't return.

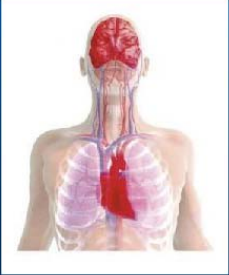



## ResQPOD Circulatory Enhancer

Greater venous return (preload) and coronary blood flow, which leads to...

Greater cardiac output on the next compression, which leads to...

Improved blood flow to vital organs.



This improves venous return, which leads to more blood being pumped during CPR and better flow to vital organs. Whether this device makes a difference in outcome is still being studied but many preliminary studies are promising.



## Cardiac Arrest and ResQPOD

- Impedance threshold device (ITD)
  - Can be done with a BLS airway but requires a continuous seal of the mask
  - Use with BLS airway not included in our treatment protocol



- The device can be used with a BVM, but it requires a continuous tight seal and it was decided that we will not use it with BLS airways at this point. So that is why we are recommending King Airway early – if we're going to use the ResQPOD we should use it as early as possible, and King airway allows rapid insertion without interruption of CPR.
- It can be used with an endotracheal tube as well.

A topographic map of a coastal region is visible on the left side of the slide, showing terrain contours and a coastline. The rest of the slide has a dark teal background with faint, light-colored wavy lines.

## Cardiac Arrest – Advanced Airway

- If endotracheal intubation done:
  - Position airway, visualize cords with CPR in progress
  - Stop compressions only to pass tube
- Eliminate gaps we now see in compressions
  - > 1 minute with airway management
  - > 30-45 secs waiting for defibrillator to charge

- We are recommending a change in the way we often do intubation – Currently we see many cases in which CPR is stopped while the airway is positioned, suctioning done, etc., and long gaps occur where CPR isn't done.
- Other EMS systems now only stop for tube passage and that is our goal – it may take some practice to get there.

## "Stay and Play" Resuscitation



- EMS has essentially the same tools the hospital has to treat cardiac arrest
- Transport
  - Interrupts compressions
  - Less than optimal compression depth
  - Possible injury to rescuers en route

• Cardiac Arrest is really an EMS disease – we are the ones who make the difference.

## Why "Stay and Play" Resuscitation

Survival is nil in sudden cardiac death patients when all of the following are present:

Unwitnessed arrest

AND

PEA or Asystole (non-shockable rhythms)


AND

No shock administered during resuscitation  
(rhythm does not change to v. fib or other shockable rhythm)

AND

No return of pulse during 20-30 minutes of concerted efforts

- Transport to the hospital adds essentially nothing in terms of patient outcome.
- We believe there are many patients in whom "scoop and run" ends up both compromising the resuscitation and ends up taking a patient who will have no chance of survival unnecessarily. Interruptions in CPR and performance of less-than-optimal CPR is bound to occur in many if not most patients who are transported.
- Crews are subjected to risks of a Code 3 transport, patients do no better, and ED care for the living is disrupted.



## "Stay and Play" Resuscitation

- Some patients will still be transported because of scene factors
  - e.g. scene safety, pediatric, public settings
  - Providing uninterrupted CPR as long as possible in field in these situations increases patient survival
- We are not requiring a full 30 minutes on all calls prior to cessation of efforts ("up to 30 minutes")
  - A shorter time period may be appropriate in some instances (e.g. obvious terminal illness without a DNR)

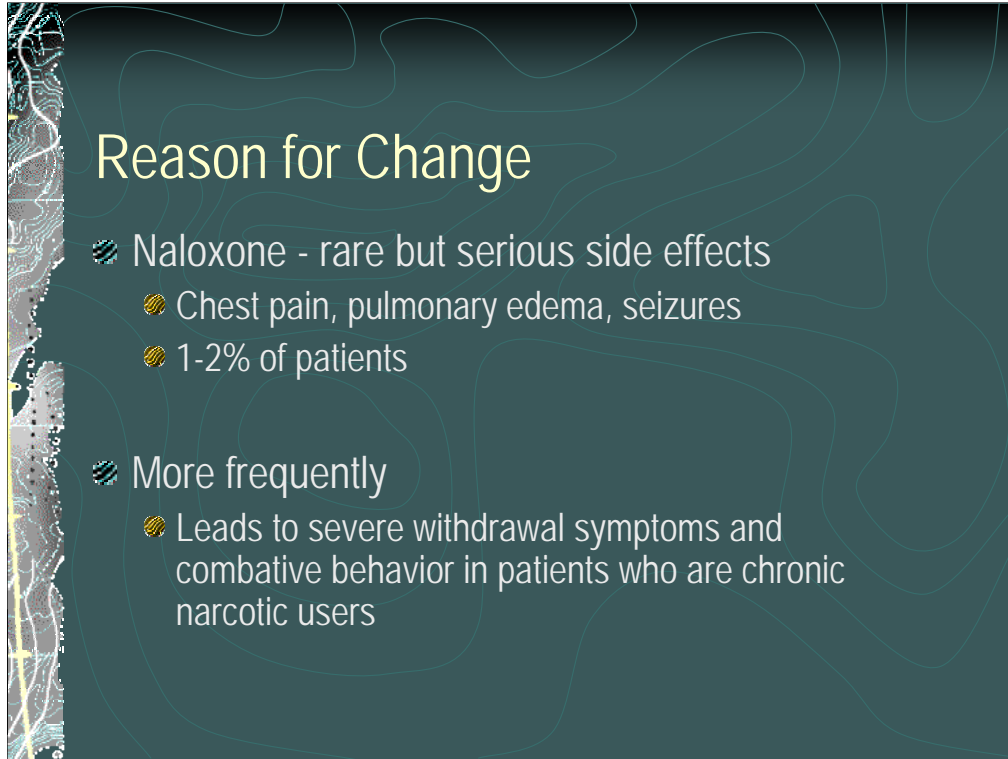
- We know that we will still transport some patients no matter what, and that is entirely okay.
- Patients who have multiple rhythm changes and yet may have not have consistent return of circulation are also persons that we will end up transporting in many situations.
- And we don't have to work on every patient for 30 minutes – some we know at the outset are not likely to respond and if good initial care and medications haven't helped, further care is probably not going to.

## Respiratory Depression or Apnea

- Naloxone has been removed from the Altered Level of Consciousness treatment guideline
- Naloxone use addressed in new guideline:
  - Respiratory Depression or Apnea



•One of the major changes for this upcoming year surrounds Naloxone.



- On occasion, we see problems after naloxone administration for both prehospital and hospital personnel – it happens often enough that we would not call it a rare occurrence.
- There are true safety considerations for staff as well as the patient.

A topographic map is visible on the left side of the slide, showing terrain contours and a road network. The map is partially obscured by the slide's content.

## Naloxone and Respiratory Depression

- Give naloxone only to patients who have suspected narcotic overdose and respiratory depression or apnea
  - Respiratory Depression is a rate less than 12
- EMS use has never been intended for patients who simply have ALOC

- The classic findings of narcotic overdose, aside from respiratory depression, include decreased level of consciousness and pinpoint pupils.
- Respiratory depression is what we are treating with naloxone, not the ALOC.





## Naloxone and Respiratory Depression

- Naloxone given ~500 times/year in CoCo
- Less than 25% have respiratory depression
- Should not be used for diagnostic purposes (to see if narcotics are the cause for ALOC)

• Given the potential risks of naloxone, it should not be given if there is no respiratory depression.



## Naloxone and Respiratory Depression

- We see increasing average age of patients given Naloxone – 1/3 of patients are age 60 or older
- Naloxone for heroin OD rare (~ 10-15% of cases)
- Prescription drug use and abuse are much more frequent causes for adverse narcotic effects

• We see increasing age and increasing incidence of adverse effects of prescription drugs – whether taken as directed or in an abusive manner.

• It is rarer now to see heroin OD's.

The background of the slide is a dark green topographic map with white contour lines. On the left side, there is a vertical strip showing a more detailed topographic map with yellow and white lines.

## Naloxone and Respiratory Depression

- Older patients
  - More prone to complex medical problems and cardiac disease
  - Naloxone may more often lead to severe adverse side effects in these patients.
- Management of agitation in a complex withdrawing and combative patient is undesirable

•So we definitely need to use much more caution when we're giving naloxone to older patients.

# Naloxone and ALOC

- Patients with ALOC who do not have respiratory depression should be closely monitored but don't need naloxone
  - Check Glucose
- Non-invasive end-tidal CO<sub>2</sub> may be the best way to monitor ventilation

- Some provider agencies have end-tidal carbon dioxide cannulas that can monitor respiratory rate and CO<sub>2</sub> levels – this may be a future way to better decide which patients are hypoventilating.
- Pulse oximetry is much slower to show changes in ventilation.



# Naloxone Administration

- We are introducing intranasal naloxone as another route for naloxone administration
- Purpose: To decrease potential for needle-related events from IV or IM use

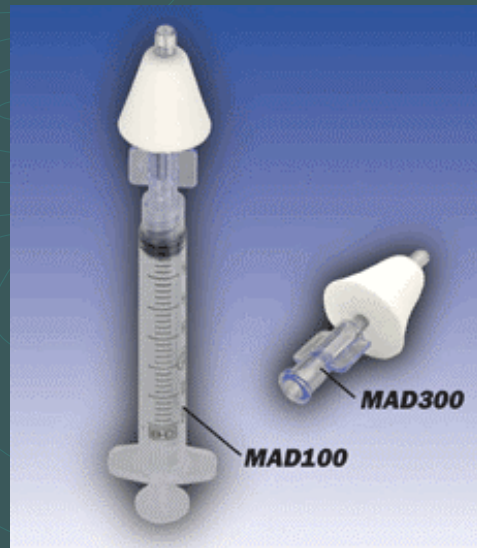
- Many other agencies have successfully implemented use of intranasal naloxone.
- This is being done in great part to enhance provider safety by avoidance of needles in many of these patients.

# Intranasal Naloxone

- Administered by a mucosal atomizer device (MAD)
- Well absorbed by nasal mucosa, rapid onset of action
- Effective in around 80-85% of cases so needle use on patient can be avoided

•The mucosal atomizer device is key to aerosolizing the medication so that it can be effectively absorbed.

## Mucosal Atomizer Device (MAD)



- This is the Mucosal Atomizer Device.

## Mucosal Atomizer Device (MAD)



This demonstrates the fine mist or atomization of the medication that allows for rapid uptake from the nasal mucosa. So it is an important part of the therapy. After drawing up 2 ml of naloxone, you will give 1 ml in each nostril. The little white flange blocks the nasal passage





- For now, we will not be using this device in pediatric patients (very few qualify for naloxone anyway) but this shows how the device is used.

A topographic map of a coastal region, showing landmasses, water bodies, and contour lines, serving as a background for the slide.

## Intranasal Naloxone

- **Indications:** Respiratory depression or apnea in adult patients with suspected narcotic overdose
- In some specific situations, other routes of administration are preferred

- We are using this in adult patients only as little data exists on pediatric use.
- Those specific situations will be discussed next.

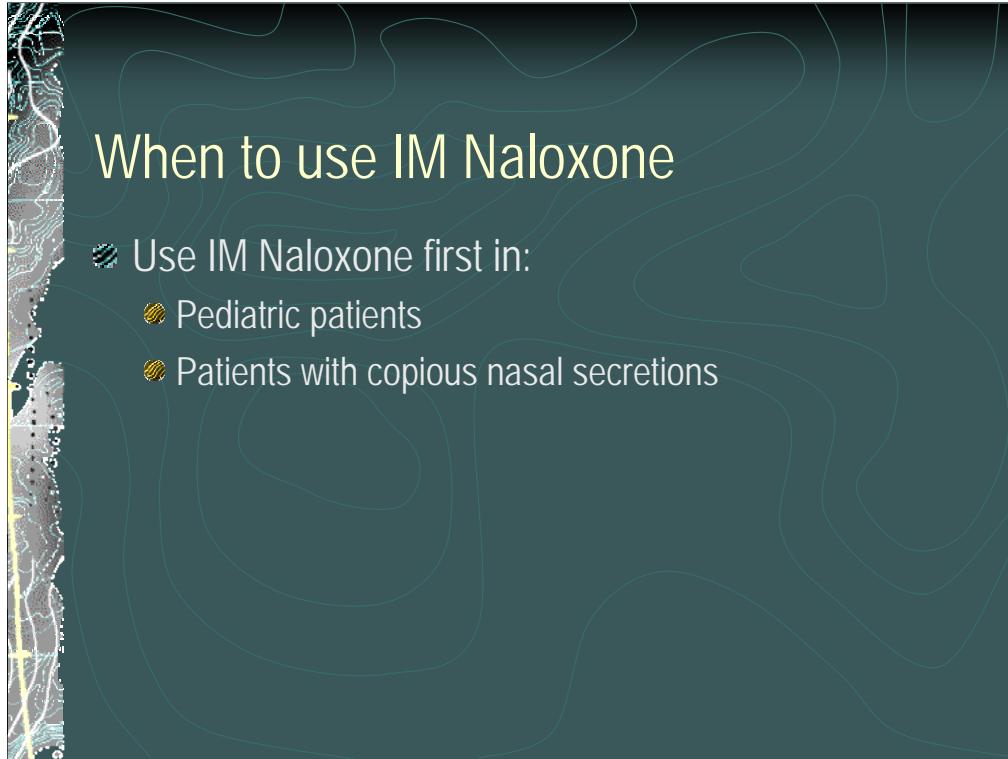
## Intranasal Naloxone

### Contraindications:

- Respiratory rate 12 or above
- Age < 15
- Patients in shock
- Patients who have copious nasal secretions

### Relative Contraindication:

- Patients with long-term use of narcotics for terminal illness or chronic pain (IV titration preferable)



## When to use IM Naloxone

- Use IM Naloxone first in:
  - Pediatric patients
  - Patients with copious nasal secretions

•IM Naloxone is an effective intervention in these circumstances. It is nearly as effective as the IV route in many studies and because the medication's peak absorption is a little more delayed, it may cause less adverse effects as well.

## When to use IV Naloxone

Use IV naloxone first:

- If patient in shock
  - If patient merits titration of diluted naloxone
  - If patient already has IV for other reasons
- IM is the preferable backup route for patients in shock (not EJ or IO!)

- Respiratory depression is manageable with BLS airway.
- Always titrate IV doses to avoid unintended consequences of acute withdrawal in at risk patients.

## Naloxone

- Most patients will respond to intranasal dose – should see effects within a few minutes
  - Can be supported with BVM if needed
- If IN or IM dosing does not improve respiratory rate, IV dose should be given if narcotics suspected

- Approach to Naloxone administration should be stair stepped.
- If IN or IM dose does not work then IV should be considered.
- Some patients may require higher doses or repeat doses, and of course some patients with respiratory depression will not respond because narcotics turn out not be involved in the situation.



## Advanced Airway and Naloxone

- Intubation is contraindicated in suspected narcotic overdose
- When patient is apneic and pulse and BP are normal, suspect narcotics
  - Administer naloxone before moving to advanced airway

•In the last few years we have had several patients who presented with respiratory arrest or markedly decreased respiratory rate, yet had remarkably normal blood pressure and pulse rates.

•Intubation was done or attempted on several of these, and later naloxone was given and addressed the problem.

•That combination of relatively normal pulse and blood pressure may be a clue to potential narcotic overdose in some cases.

## Naloxone Dosage / Route

- Adult Dosage
  - 2 mg intranasally (IN) – 1 mg each nostril
  - 1-2 mg IM
  - 1-2 mg IV or diluted IV when indicated
- Pediatric dose – 0.1 mg/kg IM or IV (can repeat)

- So there are a variety of ways that naloxone can be given.
- Repeat doses may be needed in some cases.



## Titration of Diluted Naloxone

- 1:10 dilution with saline
- Give 1 ml (0.1 mg) slowly IV:
  - Terminal patients on long-term narcotics
  - New Indication – Patients who are known to have long-term use of narcotics for chronic pain
  - Check for fentanyl patches and remove if present

- The intent here is that patients who have been on long term treatment with narcotics, whether for terminal disease or chronic pain, should have reversal done slowly.
- These are patients who will likely have acute withdrawal and are at higher risk of complications.

## Naloxone – Parting Comments

- Patients with ALOC due to narcotics don't need reversal if no respiratory depression
  - Dangerous for patient and caregivers
- Treatment with naloxone will now be a little more complex but should lead to enhanced patient and rescuer safety

• Acute withdrawal has even more dangerous consequences for the patient and those caring for them.

• **Remember: First, do no harm!**



## Changes to Chest Pain / ACS

- Field Treatment Guideline will now direct performance of ECG with V4R lead when inferior MI is noted
  - To detect Right Ventricular MI (RVMI)
  - RVMI Treatment is radically different

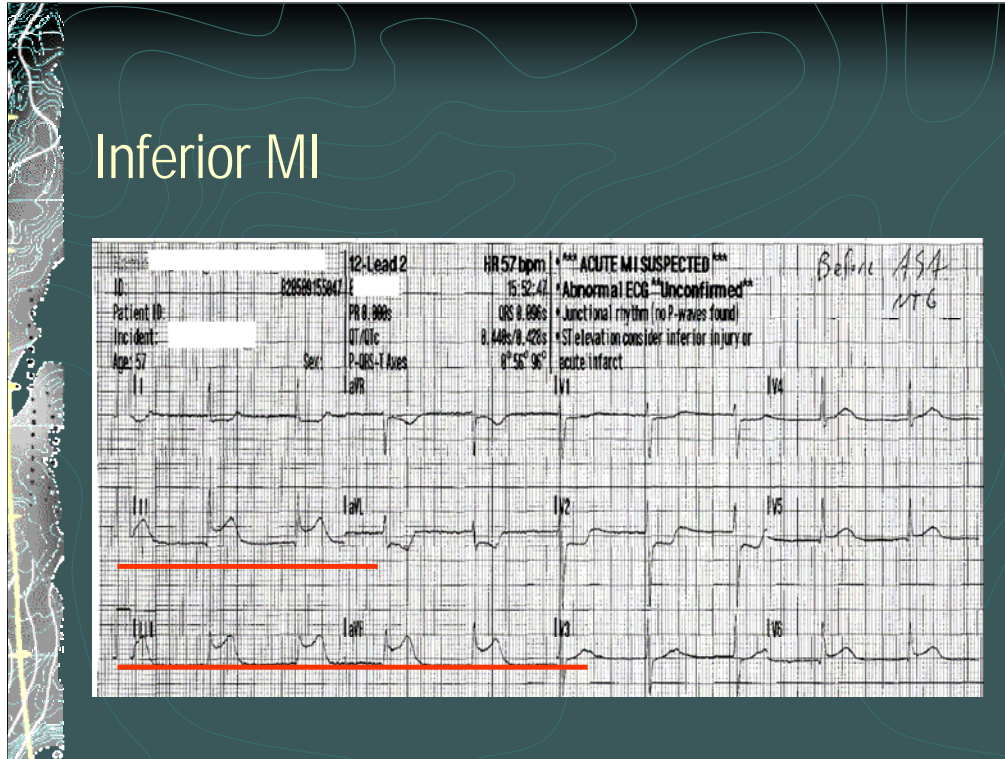
- Previously we have treated chest pain patients with MI in a similar fashion no matter what type of MI they have.
- With the 12-lead, we can detect right ventricular MI, which has a significantly different treatment approach.



## Inferior MI Findings

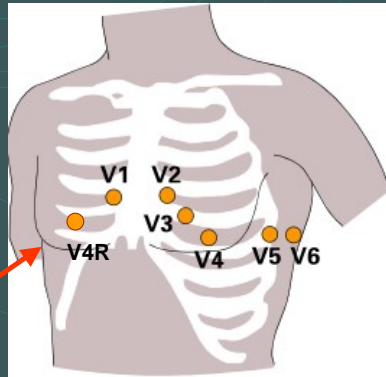
- ST-elevation in II, III, and aVF
- \*\*\*Acute MI\*\*\* message

## Inferior MI



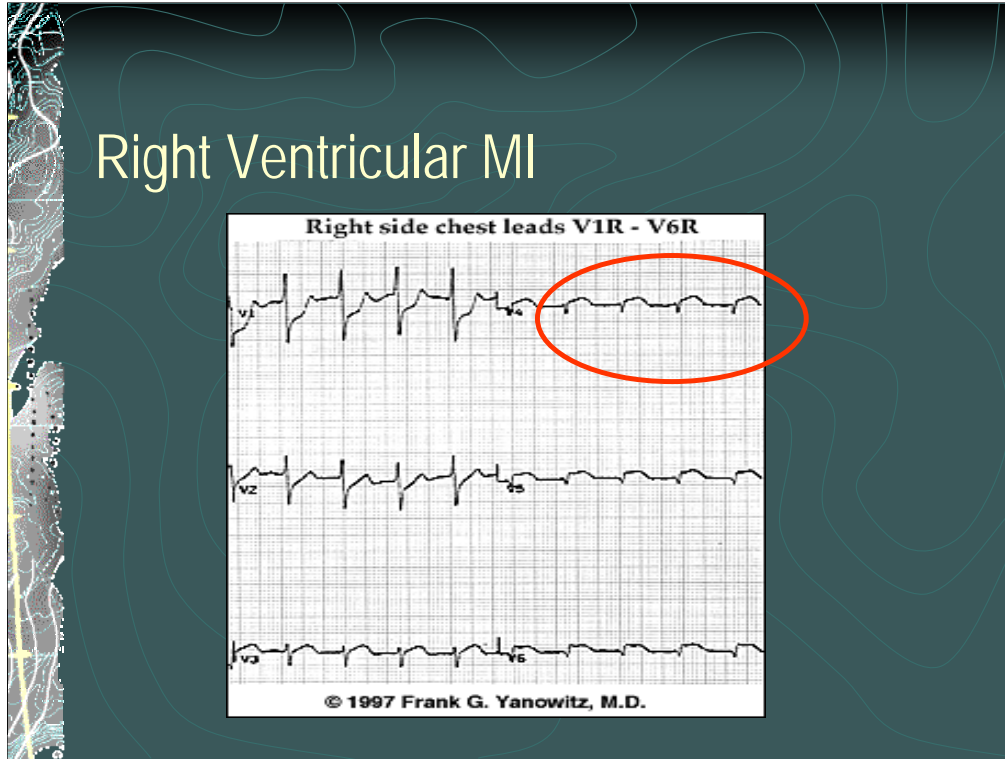
- When you see a classic pattern of II, III, and aVF, think possible right ventricular MI.
- Do V4R in these cases.

## V4R Placement



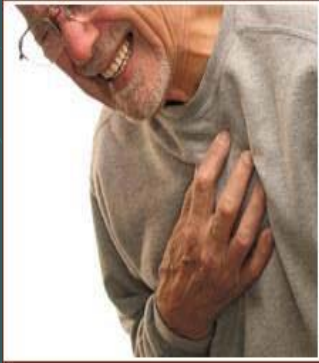
- V4R is simply the mirror image of V4, at the midclavicular line in the 5<sup>th</sup> interspace.
- After the initial ECG, move V4 to the right side and repeat.
- It's very important to label the ECG readout and note your findings in the PCR.
- The computerized readout may well not be entirely accurate on the ECG with V4R because it assumes typical lead placement – but you already know that it is a STEMI and you simply are looking for the right ventricular involvement.

## Right Ventricular MI



- This is actually an entire right-sided ECG V1R through V6R.
- We really only need V4R to diagnose right-sided MI and here you see ST elevation in V4 through V6, indicating a right-sided MI.

## Physiologic Consequences of RVMI



- Disrupts the circulation to the right ventricle
  - Decreases circulation of blood to the lungs
  - Decreases left ventricular filling so that hypotension may occur



## Treatment in RVMI



- DO NOT GIVE NTG or MORPHINE!
  - May cause severe hypotension if not already present because of further preload reduction
- If hypotensive, patients with clear lungs should receive fluid boluses

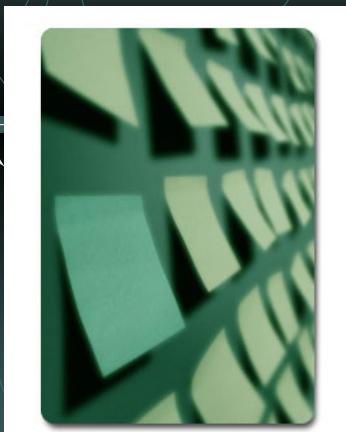
- Right Ventricular MI is a condition that supports the notion of performing the 12-lead **before** considering use of NTG.
- The patient's BP may be adequate initially, yet drop when NTG is given.
- While both NTG and MS are important to provide comfort to most patients, we don't have a good option for pain relief with RVMI at this point. Rapid movement to the hospital and cath lab will get them their relief.

## Prognosis of RVMI

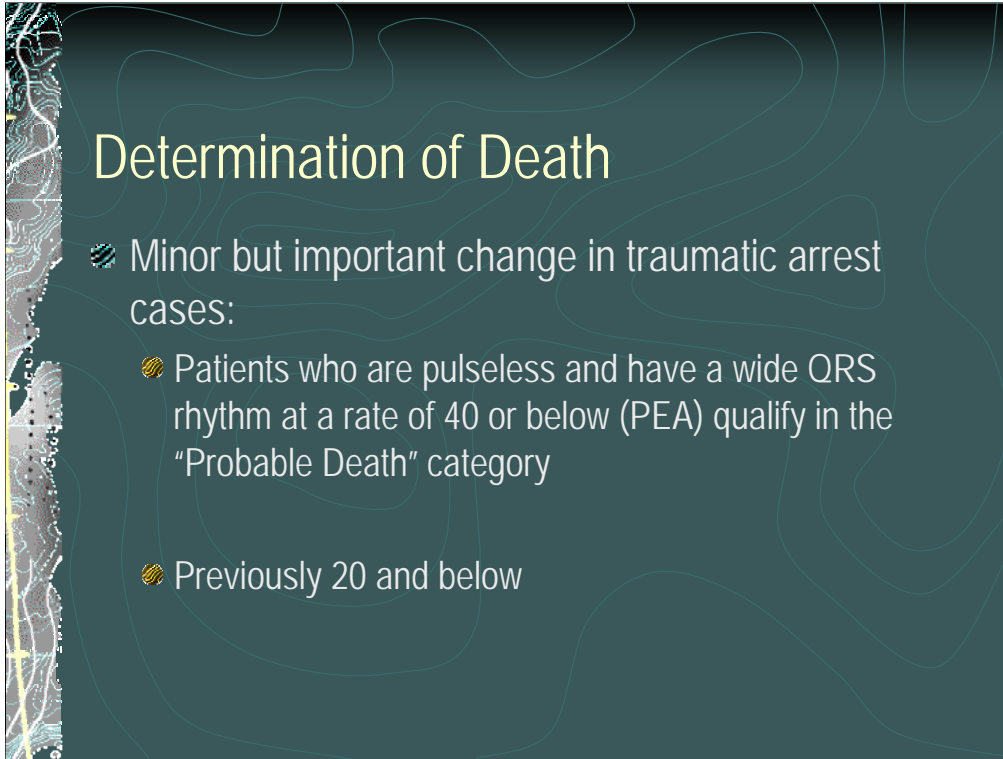


- These patients may be very ill at onset
- If they recover from the initial episode, they do very well

# Contra Costa Emergency Medical Services



Policy &  
Procedure  
Changes

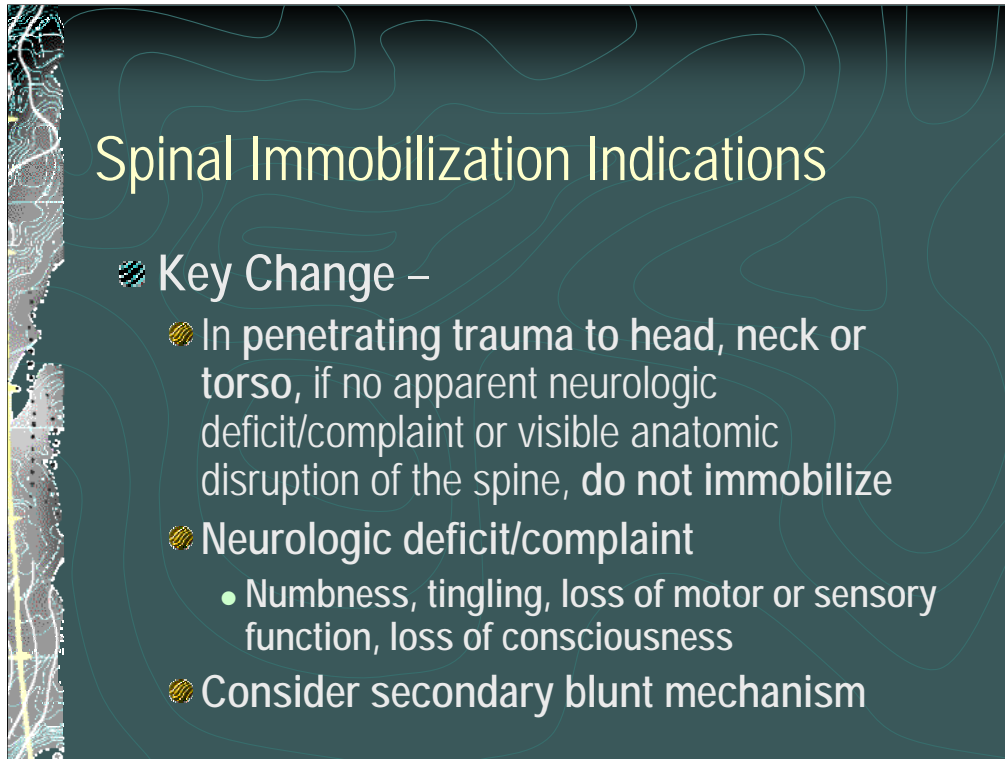


- We have made this change because no patients survive once their heart beat begins to slow with trauma and shock.
- The previous cutoff rate of 20 was not useful because many patients tend to have rates in the 30's, then rapidly go to zero, so few patients qualified and they were often transported when there was no chance of recovery.
- The new policy also will not require a "wide, bizarre rhythm" – just a widened QRS. Narrow complex QRS with bradycardia still merits resuscitation if encountered as this could potentially represent vagal tone.

## Spinal Immobilization

- Changes reflects new PHTLS version with algorithm
- In the field manual, we summarize the concepts in a chart





- Spinal immobilization in penetrating chest trauma with patients who are short of breath is counterproductive – and any management of airway is much more complex when patient is on a board with a collar

- If the injury is not to the head, neck or torso, immobilization is not necessary for penetrating injury.

- If the patient has neurologic complaints or deficits, as listed, immobilize. If there is loss of consciousness, immobilize.

- Always consider whether there could be a secondary injury from a blunt mechanism – a fall, car crash, etc.

## Spinal Immobilization Algorithm

### Key Questions for blunt trauma:

1. Is there ALOC? If yes, immobilize
2. If no ALOC, is there spinal pain or tenderness, neurologic deficit or complaint (e.g. bilateral paralysis, partial paralysis, numbness, weakness, tingling, priapism) or anatomic deformity of spine?  
If yes, immobilize

•Spinal immobilization in blunt trauma is not significantly different with the new PHTLS version though things are slightly reorganized.

•There are a few key questions to ask:



## Spinal Immobilization Algorithm

3. If no ALOC, spinal pain/tenderness, neuro deficits or anatomic deformity, is there a **concerning mechanism of injury**?
  - If yes, consider factors that may hinder good assessment such as:
    - Presence of alcohol or drugs
    - Distracting painful injury
    - Inability to communicate

**If any of these exist – immobilize**



## Spinal Immobilization Algorithm

4. If there is doubt, immobilize! Use clinical judgment!





•I want to mention some definitions that help clarify the guideline -

## Spinal Immobilization - Definitions

### Concerning mechanisms of blunt injury:

- Mechanisms that may produce a violent impact to head, neck, torso, or pelvis
- Sudden deceleration or acceleration or lateral bending forces to neck or torso
- Any fall, particularly in elderly
- Ejection from powered devices (motorized or not, including bicycles, horses)
- Shallow-water diving accident

This is not an exclusive list – other mechanisms may also be encountered and judgment is required

•Review the definition.

•If you have questions contact your EMS agency educator.

## Spinal Immobilization - Definitions

### ● Distracting Injury:

● Injury that impairs patient's ability to appreciate other injuries. Examples:

- Long bone fractures
- Large laceration, degloving injury or crush injury
- Large burns
- Other injuries that may cause functional impairment of judgment

•Review the definition.

•If you have questions contact your EMS agency educator.

## Spinal Immobilization - Definitions

- Inability to communicate (examples):
  - Speech or hearing impaired
  - Developmentally delayed
  - Psychiatric illness impairing speech or communication
  - Young children
  - Language barrier

•Review the definition.

•If you have questions contact your EMS agency educator.

INDICATIONS FOR SPINAL IMMOBILIZATION	
Penetrating Injury (Trauma to head, neck or torso)	<ul style="list-style-type: none"> <li>• Presence of neurologic complaint or deficit – paralysis, weakness, numbness, tingling, priapism or neurogenic shock, loss of consciousness</li> <li>• Anatomic deformity of spine</li> </ul>
Blunt Injury (Regardless of mechanism)	<ul style="list-style-type: none"> <li>• Altered level of consciousness (GCS &lt; 15)</li> <li>• Presence of spinal pain or tenderness</li> <li>• Anatomic deformity of spine</li> <li>• Presence of neurologic complaint or deficit – paralysis, weakness, numbness, tingling, priapism or neurogenic shock</li> </ul>
Blunt Injury (When mechanism of injury is concerning)	<ul style="list-style-type: none"> <li>• Presence of alcohol or drugs or acute stress reaction / anxiety</li> <li>• Distracting injury (e.g. long bone fracture, large laceration, crush or degloving injury, large burns)</li> <li>• Inability to communicate (e.g. speech or hearing impaired, language gap, small children, developmental or psychiatric conditions)</li> </ul>
<p><i>Concerning mechanisms of injury</i> include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Violent impact to head, neck, torso, or pelvis (e.g. assault, entrapment in structural collapse)</li> <li>• Sudden acceleration, deceleration or lateral bending forces to neck or torso (e.g., moderate- to high-speed MVC, pedestrian struck, explosion)</li> <li>• Falls (especially in elderly patients)</li> <li>• Ejection from motorized or other transportation device (e.g. scooter, skateboard, bicycle, motor vehicle, motorcycle, recreational vehicle, or horse)</li> <li>• Victims of shallow-water diving incident</li> </ul>	
<b>*** USE CLINICAL JUDGMENT – IF IN DOUBT, IMMOBILIZE ***</b>	

- This is how the indications are listed in the field manual.
- Basically this is the algorithm from PHTLS boiled down to fit on the page.

## Vascular Access Matrix

- Lists indications and contraindications for vascular access
- Lists various types of vascular access and situations under which they are appropriate



•EMS is introducing a vascular access matrix to support appropriate vascular access decision making in the field.

## Vascular Access Matrix

### Key issues:

- Not every patient requires a prehospital IV
- Antecubital IV's are indicated when rapid IV bolus drugs needed (e.g. adenosine, in arrest)
- EJ and IO routes **contraindicated** in stable patients

•Vascular access is an invasive procedure with indications and risks. An IV should be started if there is a need to administer IV medications or IV fluids, or if there is an anticipated need to give medications or fluids.

•Patients should receive vascular access appropriate to their condition



## Vascular Access

- Key issues (continued):
  - IV access in critical trauma should not delay scene time – do en route to hospital or helispot
  - In other time critical situations (e.g. stroke, STEMI, or pulmonary edema) undue delay on scene is not appropriate
  - If only a potential need is identified, no more than two attempts should be made

•Vascular access should never delay scene time in trauma or other critical situations.



## External Jugular Venous Access

- Why have a procedure outlined?
  - EJ is a more invasive technique with higher risk than peripheral IV
- Defines situations where indicated:
  - Emergent need for fluid or IV med and no peripheral access is available, AND
  - No alternative route is available (IM or IN) for the drug, AND
  - The patient does not merit IO


- Despite the advent of the IO, we still see a fair number of EJ's being used and we still see inappropriate use.
- A procedure has been added to the prehospital care manual to define the limited role EJ should play.



## External Jugular Venous Access

- Patient must be in Trendelenburg (preferred) or supine position – should never be done in a sitting patient. If patient can't lie down, EJ should not be done.
- Stable patients should not have EJ attempts

•If you cannot perform the procedure under safe conditions and no other options exist, the priority should be to get the patient to definitive care.

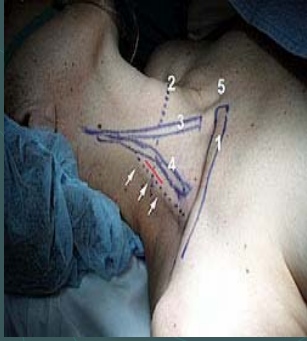


## External Jugular Venous Access

- While EJ is a peripheral IV, it has potential complications:
  - Air embolism
  - Hematoma requiring compression of neck
    - Patients with suspected coagulopathy such as patient with liver disease or on Coumadin may be at higher risk
  - Extravasation, infection, thrombosis

•External Jugular Access is considered invasive and has well known risks associated with it.

# External Jugular Venous Access



## Why limit indications for EJ?

- Some cases are done incorrectly (patient sitting)
- Some cases are done inappropriately
  - Patient could have received Naloxone IM or Glucagon IM
- Use in cardiac arrest problematic since success rate is much lower and it interrupts CPR

- Patient safety is really the priority and trumps all other considerations.

## External Jugular Venous Access

- Since IO introduced, EJ uses down by 70%
- Success rate for EJ just over 50%
- Of those which are done:
  - 25% appear appropriate
  - 50% done when glucagon or naloxone could have been given or non-emergent situations encountered
  - 25% done in arrest when IO is appropriate

- Intraosseous access has markedly decreased EJ use.
- The success rates have been low all along.
- For arrest patients, it makes little sense to use an EJ with this success rate when IO is available – if the patient has no legs, that is a possibility but that is very rarely encountered.
- The biggest issues are that there are alternatives to EJ when the patient has ALOC from hypoglycemia or narcotic and those should be used first. It's also important to remember that hypoglycemia does not kill in a few minutes – you need to let glucagon work for 15 minutes and recheck levels.
- If the patients aren't coming around, get them ready for transport.

# Contra Costa Emergency Medical Services

## QI Topics



- Contra Costa has an active program of Quality Improvement
- Every year we have the opportunity of enhancing our protocols, education and policies based on evidence of what works and what does not work in our system.
- This year we have several areas of focus for quality efforts.

A topographic map showing terrain contours in shades of green and brown, serving as a background for the slide content.

## Trauma Triage

- No changes to high-risk criteria
- Minor change in call-in criteria list:
  - Children and elderly (65 & up) struck by automobile
  - Also have rearranged policy slightly to reinforce that elderly patients with less forceful mechanisms should be considered for call-in

•Our trauma triage policy has changed based on our study of the data and looking at best practices in trauma triage.





- Our local data along with evidence in trauma and prehospital studies shows that occult head injury is a big problem.
- In particular, elderly patients with falls do not have a violent mechanism and may not present with prominent symptoms, but our index of suspicion needs to be higher in these cases.
- Alcohol is a confounding factor in assault cases – rarely in the elderly.
- We believe we can do better in this important high risk population.
- Of all the seriously injured patients that go to hospitals other than the trauma center, 75% , or around 3 calls per month, go there without any triage call being made, whereas around 25% or around one case per month is missed after the triage call is missed.

## Head Injuries



- Potential important factors to consider when making judgment about call-in:
  - Presence of anticoagulants (Coumadin, Aspirin, Plavix)
  - Higher-risk symptoms like vomiting, combative behavior
  - Any alteration in known baseline CNS function of elderly patients

- The trauma center cannot take every elderly patient with a fall, and some with a variety of these important factors will not come to the trauma center.
- But there is no chance they will in many cases unless a call is made citing a concern.



## Missed Injuries

- Take-home messages
  - Take ground level falls seriously in the elderly
  - Alcohol is not a “protective” factor in trauma – if you assume it is the cause for ALOC you may get burned
  - Make base contact if you have any concerns
    - 75% of our misses are in patients without base contact
    - 25% have base contact

- Simply making base contact, of course, is not enough – you need to effectively communicate.
- SBAR is the best practice communication tool for all field and base communication. If you have questions about SBAR contact your EMS training coordinator.

## STEMI System Improvement

- STEMI System has been very successful in lowering door-to-intervention times at STEMI Centers – median time is < 60 minutes
- 89% of patients get intervention within 90 minutes of initial field ECG showing STEMI



- Our STEMI system started in September of 2008 and has been incredibly successful in lowering door-to-intervention times (so-called door to balloon or D2B or Door-to PCI are terms you will hear).
- Almost 90% get intervention within 90 minutes of the initial field ECG showing STEMI, and that performance is well above what has been seen around the country.
- So those are things to be very proud of with regard to the system.

# STEMI System Improvement

## ● Area for Improvement

- False positive STEMI activations from the field
- False activations in around 30% of cases



- Our primary quality improvement focus for STEMI is the reduction of false positives.
- What's a false positive?
- Basically it is a patient who is triaged to a STEMI Center who does not have a STEMI.
- This is most likely due to problems with the ECG and not patient factors.



## False STEMI Activations

### Reasons

- Well-done ECG is read by computer as a STEMI when it is not (50-55%)
- ECG with significant artifact has reading of \*\*\* Acute MI\*\*\* (40%)
- Activation by EMS personnel when ECG does not say \*\*\* Acute MI\*\*\* (5-10%).

•Here is what we know from our experience with false positives since our STEMI System began.

## Computer Misreads (No Artifact)

- Rapid heart rates
- Tachyarrhythmias
- Unrecognized paced rhythm
- Widened QRS (not enough for LBBB but enough to fool computer)



- All of these items will cause ST elevation, often quite diffusely, that is not ischemic in nature.

# Recognizing Machine Generated Misreads

## ● How to Decrease Misreads

- Look for pattern of infarct – if not present potentially a computer misread
- ECG Transmission – Trial planned



- The 12 lead interpretation of the ECG is not perfect and it takes a combination of prehospital provider recognition and the 12 lead device to come up with a reliable 12 lead.



## Recognizing Misreads

- Patterns of infarct
  - Inferior MI - II, III, aVF
  - Anterior MI - V1-V4
    - Called Septal MI V1-V2
  - Lateral infarct - I, aVL, V5-V6
    - Associated with either inferior or anterior MI
- No focal pattern of infarct increases the chance that ECG is false positive

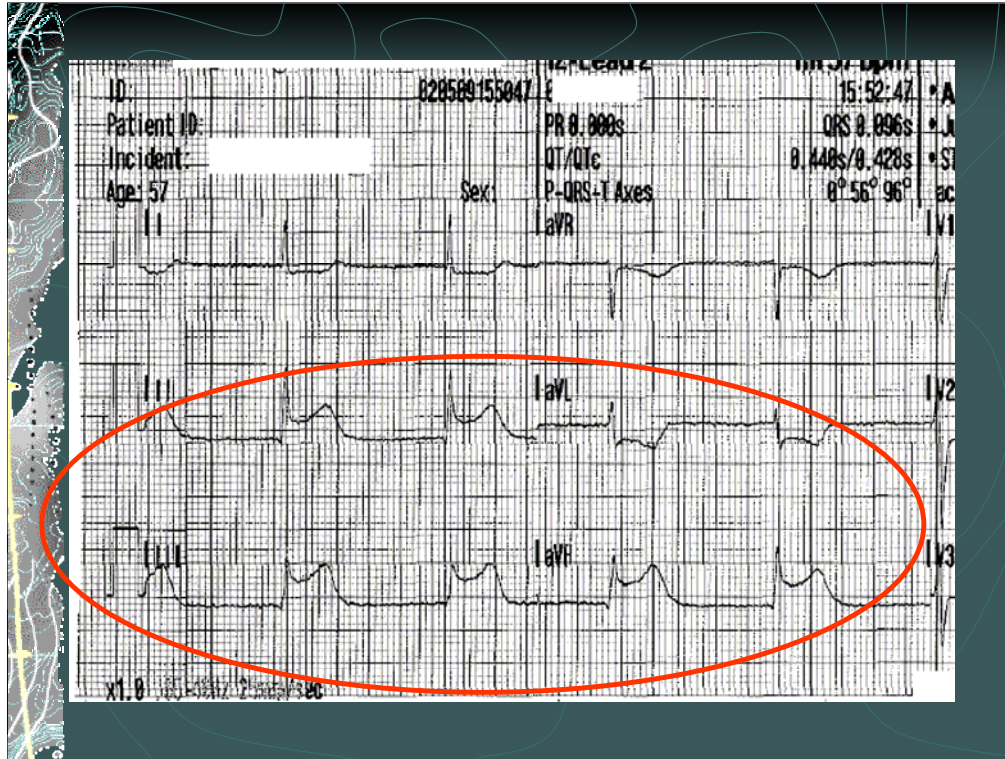
•Understanding patterns of infarct can help you identify when the ECG device is being fooled.

### LOCALIZING SITE OF INFARCT

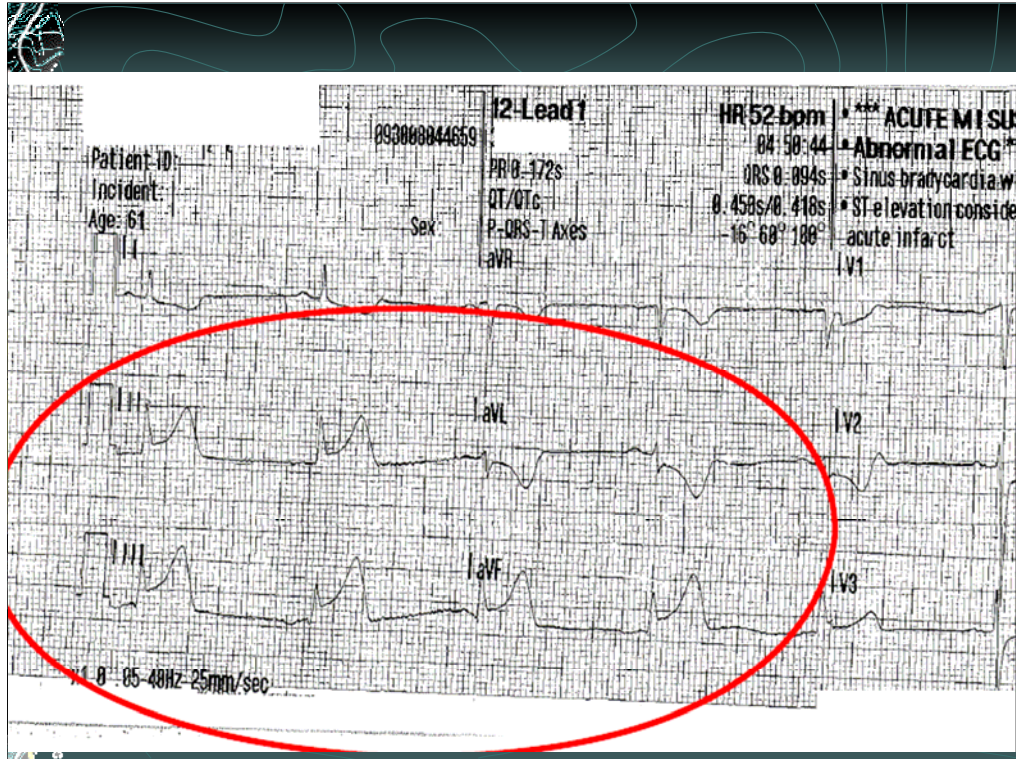
- Localization of an infarct pattern adds to the accuracy of ECG interpretation.
- A STEMI will have 1 mm or more ST-segment elevation in two or more contiguous leads (which means findings noted in the same anatomical location of the infarct).
  - Contiguous leads for inferior infarction include II, III, and aVF
  - Contiguous leads for anterior infarction include V1-V4 (V1-V2 elevation also called septal infarction)
  - Contiguous leads for lateral myocardial infarction include Leads I, aVL, V5, and V6
  - Lateral MI findings may be in addition to anterior or inferior MI patterns (anterolateral or inferolateral)
- In patients with an inferior infarct pattern (Leads II, III, aVF), a separate ECG with V4R should be obtained.
- A 1 mm ST-segment elevation in V4R when inferior infarction noted indicates right ventricular infarct

I – LATERAL or ANTERIOR	aVR	V1 – SEPTAL or ANTERIOR	V4 – ANTERIOR (V4R – RVMI)
II - INFERIOR	aVL – LATERAL or ANTERIOR	V2 – SEPTAL or ANTERIOR	V5 – LATERAL
III – INFERIOR	aVF - INFERIOR	V3 – ANTERIOR	V6 – LATERAL

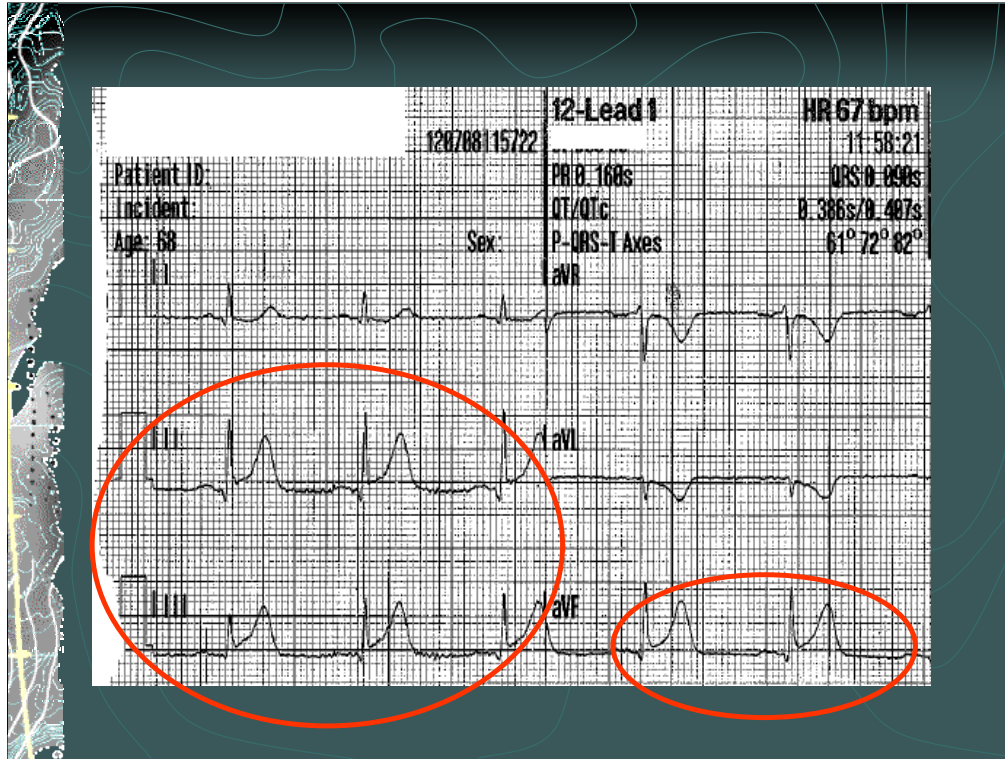
- In the field care manual – we have added a section on localizing infarct patterns as a reference.
- Some have seen the clear plastic overlays that some manufacturers have for the same purpose.



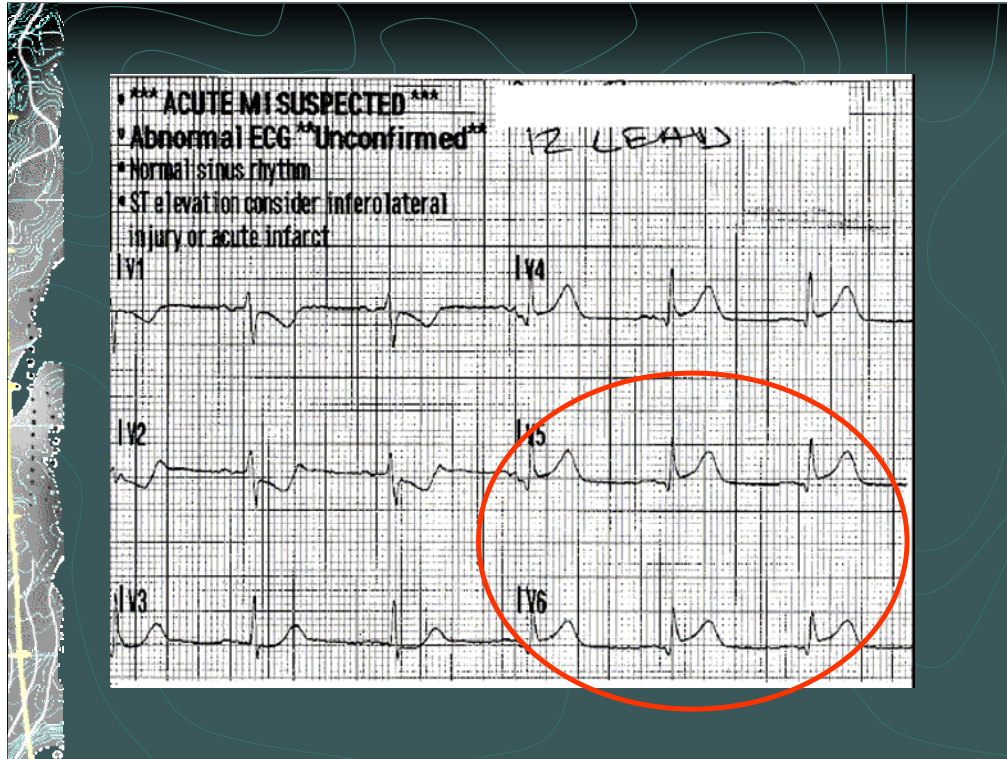
- Here's a good example of an Inferior MI. You can clearly see ST elevation in II, III, and aVF.
- This is the most common pattern we see in terms of MI.
- Turns out this patient also has a junctional rhythm, not uncommon with increased vagal tone in inferior MI (bradycardia also).



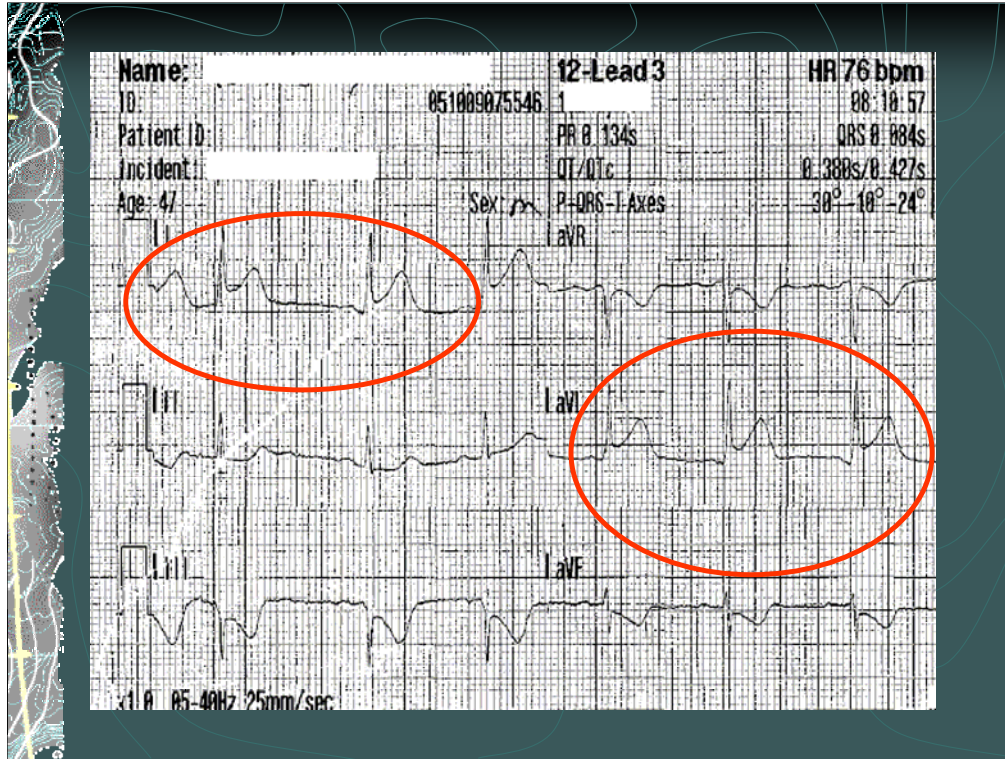
- Another example of clear ST elevation in II, III, and aVF



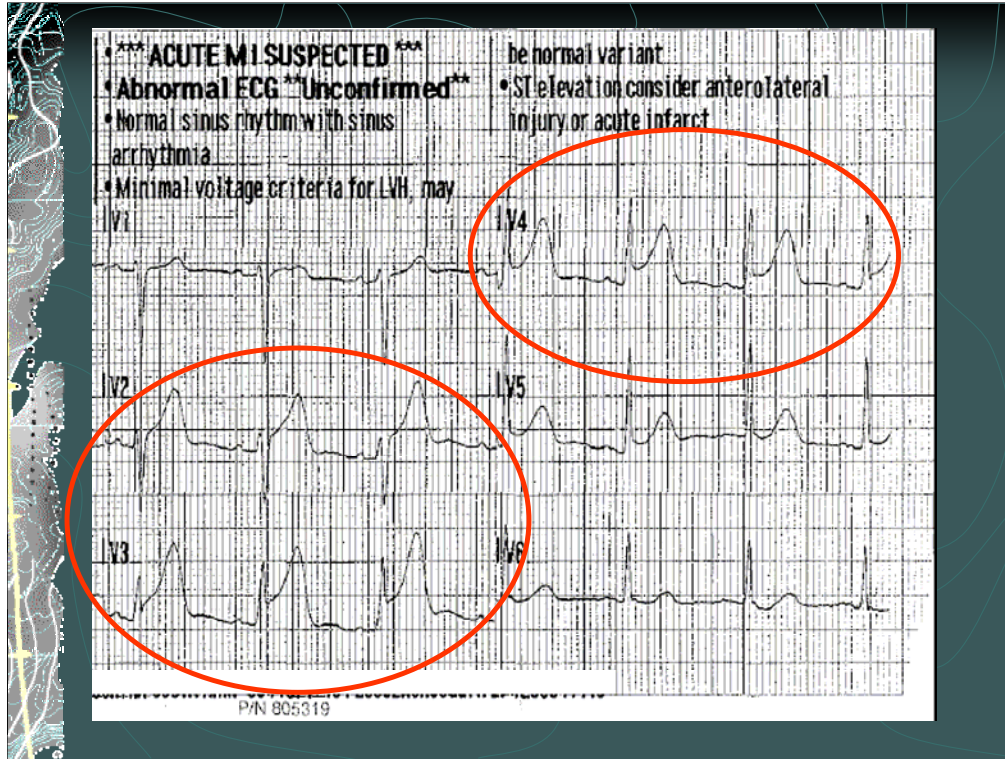
•Here's another one with II, III, and aVF elevated – inferior MI pattern.



- And here is the other half of that same ECG showing elevation in V5 and V6 consistent with lateral infarct as well as inferior.

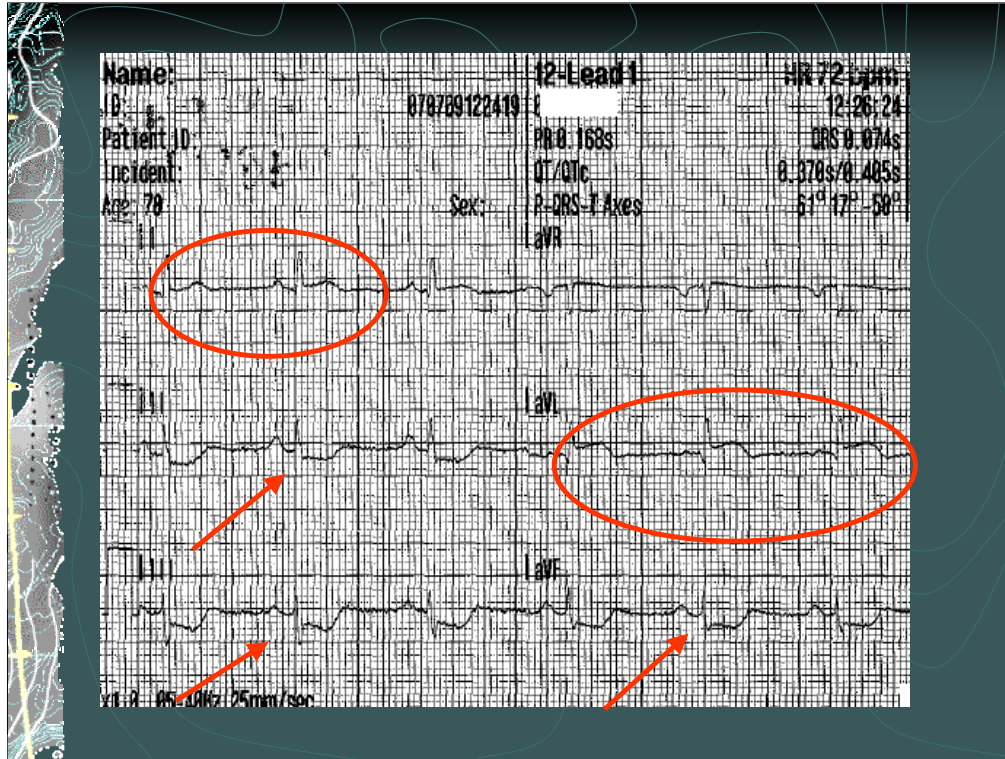


- Perhaps a little hard to see but this is the left side of an ECG with an anterolateral MI.
- There is marked ST elevation in leads I and aVL.

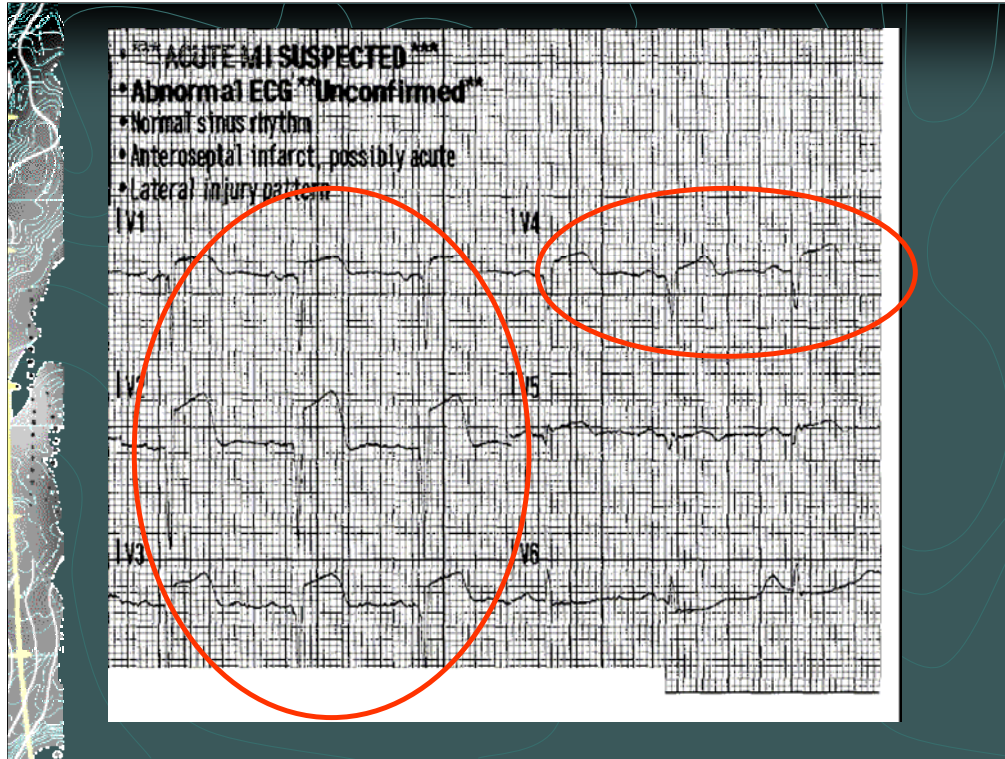


- Here is the other side of the same ECG showing anterolateral MI.
- Note the ST elevation in V2-V4.






- Here is the left-hand side of another anterior MI – the ST changes are perhaps a bit subtle in Lead I and more obvious in aVL.
- The arrows denote marked ST depression in II, III, and aVF which are reciprocal changes that are often seen.




•Here is the right side of the same ECG – tombstones in V1-V4. This is a big-time anterior infarct in progress. This tracing is a little difficult to see on this slide but hopefully you can pick up the changes.



## Recognizing Artifact

- Motion artifact which falsely elevates ST segments can lead to false \*\*\*Acute MI\*\*\* readings
  - Especially a problem with leads II and III
  - Also a problem with V1-V3

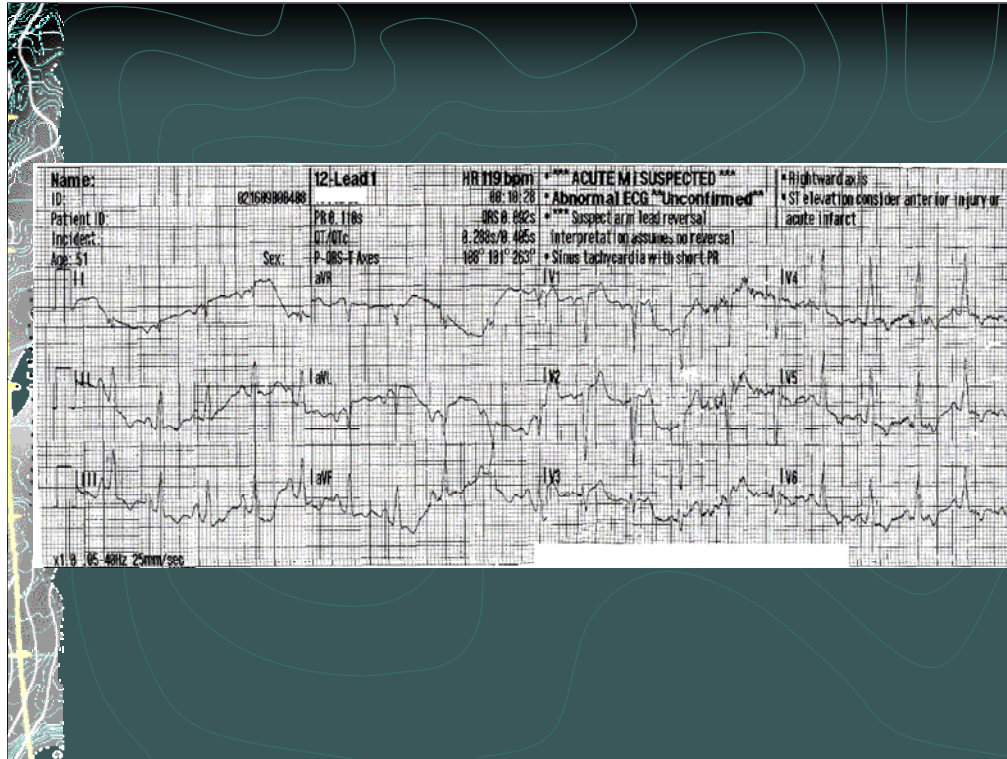
- Artifact is the most common reason for false positives and needs to be eliminated.
- Don't let the excitement of getting a ECG positive for STEMI off the device sidetrack you to this common problem



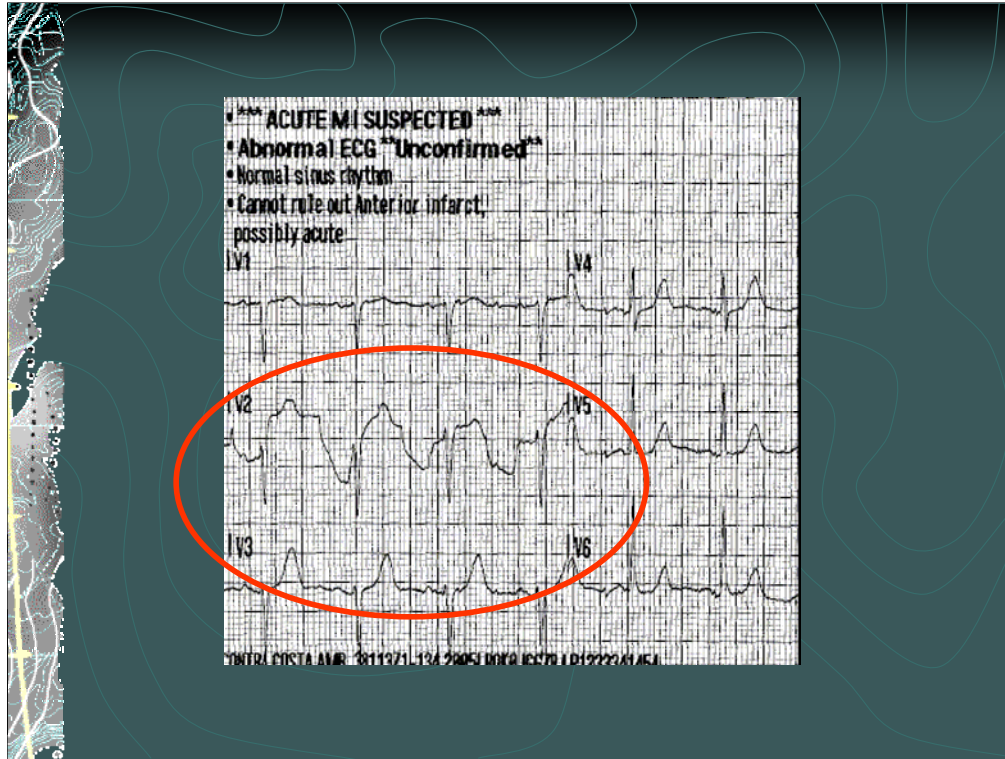
## Recognizing Artifact

- Look at all 12 leads
- There should be a steady baseline in every lead
- Usually at least 2-3 complexes in each lead
  - These complexes should look nearly identical (except if PVC or aberrant conduction)
  - If they don't look identical suspect motion artifact

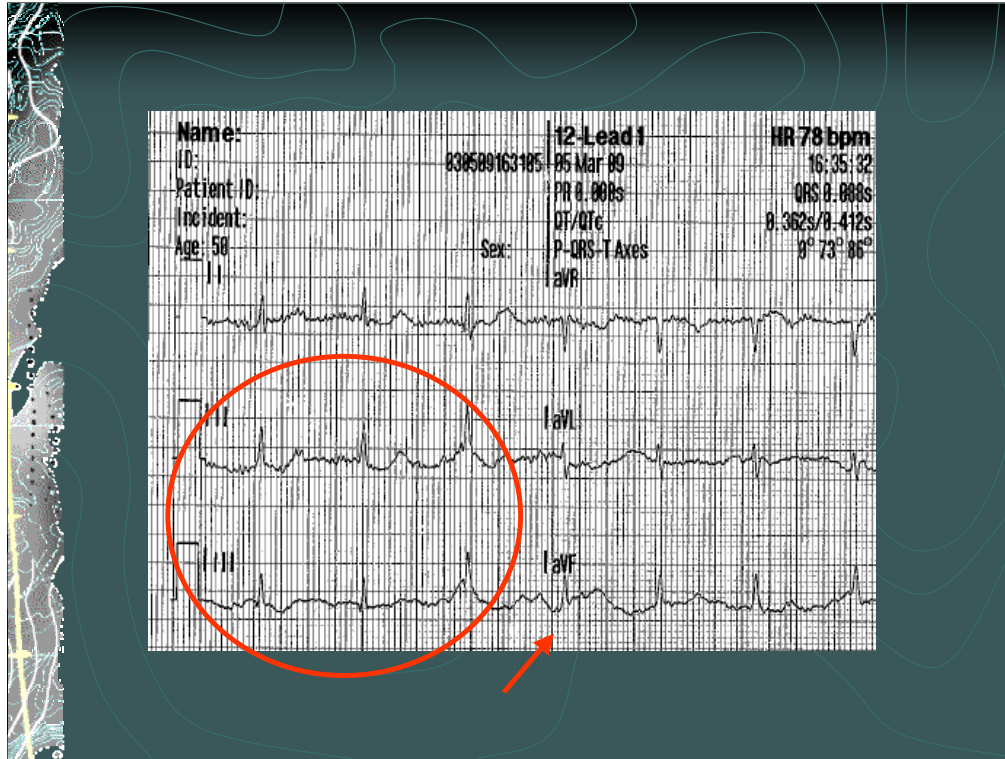
- There are many things you can look at to assure you have minimal artifact.



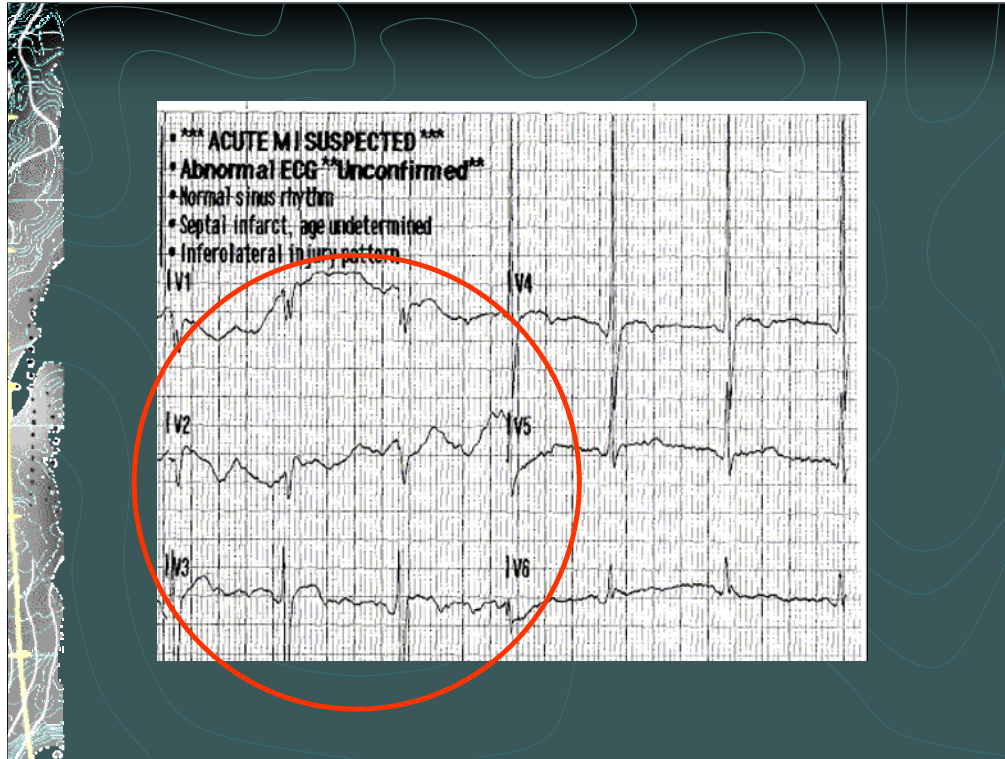
- This ECG has obvious artifact yet this patient was a STEMI activation (repeat ECG at hospital negative).



- This patient had a normal ECG on initial reading, then a second tracing was taken that said “Acute MI”.
- Each of the 4 complexes in V2 look very different while all the others in all 11 leads look similar.
- This is undoubtedly a lead contact issue. This ECG should be disregarded and repeated.

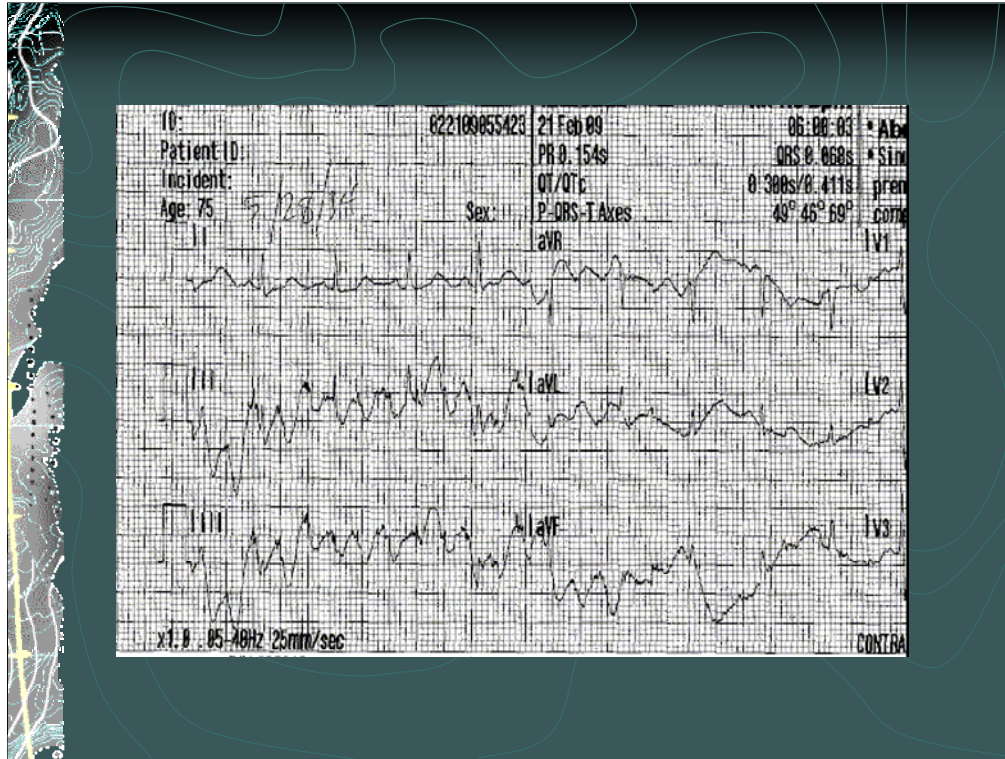


- This led to a false activation.
- The complexes in II and III are changing with each beat.
- aVF looks to have ST elevation in one complex and not in others.
- This is relatively subtle, but there just is no clear pattern of ischemia and there is artifact.




- The computer calls this a septal infarct and inferolateral injury pattern.
- There's no way that this could be considered an acceptable ECG given the artifact seen, and it should have been repeated.
- Again, it led to a false activation.





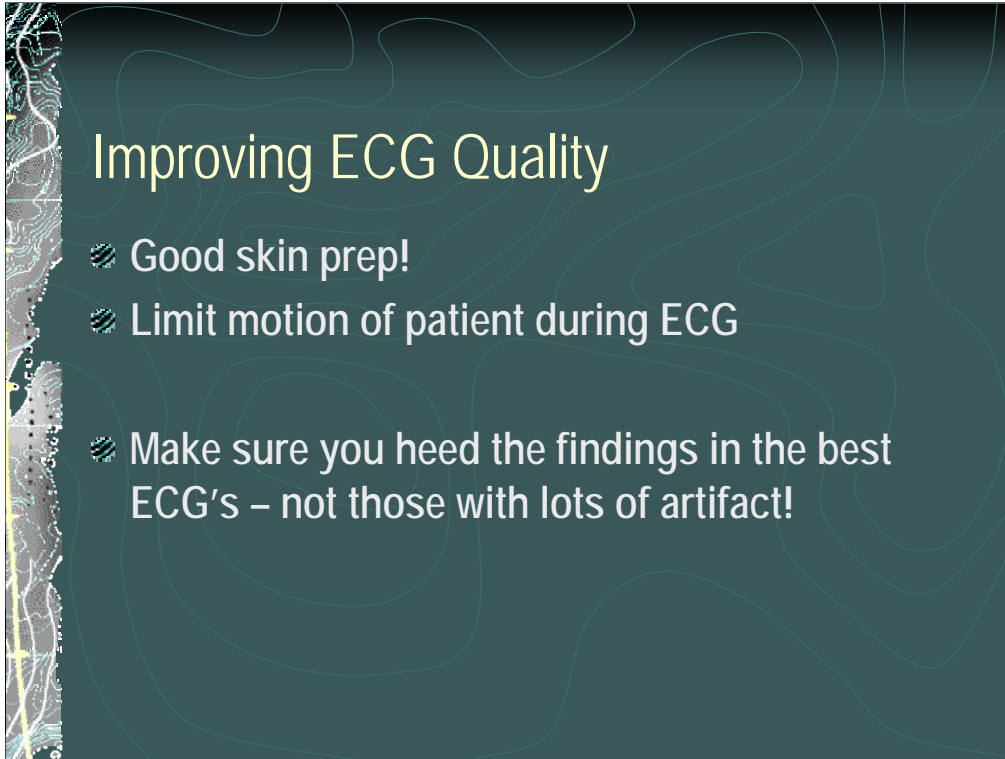
- Here's another that ended up with a false activation.
- These kind of false positives are easily avoided if you look at the 12 lead complexes themselves.
- Lead I looks pretty good, but just about all of the others are undecipherable.
- These are the kind that would make my hair fall out if I had any.



## STEMI Activation

- Just having \*\*\* Acute MI\*\*\* on ECG isn't enough to activate a STEMI Alert
- Activate only if ECG is reasonably free of artifact in all 12 leads
- Let hospital know if:
  - Patient has pacer
  - Suboptimal tracings
  - Focal pattern of infarct seen or not seen

Look at all 12 leads, make sure you have a good tracing, and look for that focal pattern of infarct.



## Improving ECG Quality

- Good skin prep!
- Limit motion of patient during ECG
- Make sure you heed the findings in the best ECG's – not those with lots of artifact!

- These are simple but effective ways of reducing artifact.

# Questions?



- This training will be made available on the EMS website at [www.cccems.org](http://www.cccems.org)
- A Self Study module is also planned so this can be a reference to you at anytime
- See your EMS Educator if you have further questions on any of this material or contact Contra Costa EMS.