Vermont Statewide
Emergency Medical Services Protocols
2023
Summary of Changes

Section 1: General Patient Care (and Preface)

Protocol	Area/Level	Change	Comments
Preface **Section 1: General Patient Care**			
Legend	VEFR	Add Vermont Emergency First Responder to Legend	New Color is Tan
EMR Routine Patient Care	EMR	Added Pulse Oximetry	Training completed
	EMR	New Link to Spinal Trauma and Assessment	Clarify Spinal Motion Restriction is approved, not Advanced Spinal Assessment
VEFR Routine Patient Care	VEFR	New section summarizing VEFR	
Routine Patient Care	All	Perform single question opioid screening test by asking: • In the past year, have you used substances or prescription medications for non-medical or recreational reason. • If the answer is **yes**, consider the patient an At-Risk Person. See the Naloxone Leave Behind Overdose Rescue Program	Use this single question opioid screening test to help identify patients with substance use disorder or opioid use disorder who would benefit from a naloxone leave behind overdose rescue kit and linkage to treatment if available.

Section 2: Medical Protocols

Protocol	Area/Level	Change	Comments
Section 2: Medical Protocols			
Abdominal Pain (Adult & Pediatric)	All	Combined adult and pediatric protocols into one.	Protocols similar enough it made sense to combine.
Allergic Reaction/Anaphylaxis- Adult	EMT	If signs and symptoms do not resolve in 5 minutes, may repeat epinephrine dose x 1. Contact **Medical Direction** for additional dosing.	Epinephrine may be a life-saving medication. This allows one repeat dose prior to contacting Medical Direction for additional doses.
	EMT	Ready-Check-Injection (RCI) instructions added as second page of protocol.	EMTs but be credentialed through RCI to administer epi via a syringe. This allows easier access to these guidelines.
	EMT	For bronchospasm, consider the administration of albuterol 2.5 mg via nebulizer. May repeat every 5 minutes for continued symptoms **OR** Ipratropium 0.5 mg and albuterol 2.5 mg via nebulizer (DuoNeb). May repeat every 5 minutes (maximum 3 doses). Contact **Medical Direction** for additional dosing.	Administration of nebulized albuterol and DuoNeb were moved from the AEMT to the EMT scope of practice.
	AEMT	Rapidly administer 0.9% NaCl up to 30 mL/kg bolus to maintain MAP ≥ _65 (systolic blood pressure ≥ _90 mmHg). See Shock Protocol	Clarified fluid administration to follow the shock protocol
	Paramedic	Consider push dose epinephrine (10 mcg/mL) for short transport times or as bridge to infusion	Added option for push dose epi as bridge to infusion

	Paramedic	Added a link to the Adult Drip Rate Reference Appendix for administration of epinephrine by infusion	Allows for quicker access to key drip rate information for epinephrine infusion.
	Red Flag	In anaphylaxis, epinephrine should not be delayed by taking the time to administer second-line medications such as albuterol or diphenhydramine.	Added albuterol to the list of meds that should not be given prior to epinephrine in anaphylaxis. Epinephrine is the priority.
Altered Mental Status - Adult	EMT	Remove 2nd, 3rd and 4th bullets. Replace with "Ensure a patent airway using appropriate positioning and adjuncts (OPA, NPA). Ensure adequate oxygenation (94 - 98%) and ventilation using supplemental oxygen and BVM when appropriate. If possible, elevate patient's head 30 degrees and prepare suction to avoid aspiration.	Improved language regarding airway management.
	EMT	If patient is violent or agitated, consider restraint.	Moved to EMT from Paramedic section.
	Paramedic	Changed last bullet to read "If hypotension persists, contact Medical Direction to consider vasopressors.	Clarifying language.
Asthma/COPD/RAD – Adult	EMT	Removed special references to respiratory pandemic	Covered in separate protocol
	EMT	Removed (88-92% in COPD)	Too confusing, patients in respiratory distress more important to give adequate 02 and can tolerate for 911 transport times
	EMT	Removed reference to pandemic situation MDI use in both Adult and Pediatric Asthma protocols	Still true, but now will be found in the pandemic protocol
	EMR	Added pulse oximetry	Highlights use of pulse oximetry
	AEMT	Added, ETCO2 waveform capnography to monitor respiratory status.	Places emphasis on use of waveform capnography for these conditions
	AEMT	No Change but needs additional education	Education to increase appropriate use
Behavioral Emergencies	All	Full rewrite of protocol	See training module
	All	It may not be possible to transport all patients. Should it appear that the patient will not be transported, contact **Medical Direction**. If unable to transport patient, document circumstances clearly in the narrative. Include outreach to law enforcement, mobile crisis, and discussion with Medical Direction.	Added language to guide and cover EMS practitioners in the event a patient with SI refuses transport. Try all interventions first, including asking police and mobile crisis for help, if still unable to transport document as per the protocol.
	All	Added treatment categories for anxiety, resistant or aggressive behavior, and violent/combative behavior or delirium with agitation	Allows more focused treatment options based on patient presentation
	Paramedic	Added option for benzodiazepine for severe anxiety with Medical Direction approval in adult and pediatric patients	Provides for a lower dose of anxiety medications for patients not requiring restraint level dosing, right dose, right patient, right time. Consider PO option
	All	Delirium with Agitated Behavior	Reminder of change from excited delirium to new term – same disease
Brief Resolved Unexplained Event (BRUE)	All	Added glucose check, more detailed instructions for obtaining a history, and checking for non-accidental trauma	Please read though the new protocol
Diabetic Emergencies (Hyperglycemia) Adult & Pediatric	All	Combined adult and pediatric protocols	
	EMT	Obtain and transmit 12-lead ECG for patients ≥ 40	Obtain ECG in adults to assess for signs of associated hyper or hypokalemia
	EMT	Evaluate for possible sepsis and septic shock	Patients may have hyperglycemia due to underlying infection, including sepsis
	All	New Pearl: New onset DKA in pediatric patients commonly presents with nausea, vomiting, abdominal pain, and/or urinary frequency	
	All	New Pearl: If patient has continuous glucose monitor, EMS should confirm glucose measurement with own equipment	
Epistaxis/Nosebleed Adult & Pediatric	All	New Protocol	Please review
	Paramedic	Oxymetazolone, Phenylephrine 2 sprays into affected nostril adult,	Avoid in HTN, coronary artery disease, pregnant
Hyperkalemia	All	New Protocol	Please review

	Paramedic	Contact Medical Direction to consider administration of calcium gluconate or calcium chloride and sodium bicarbonate	Perform serial EKGs. Use constant cardiac monitoring with med admin
Hypothermia Adult & Pediatric	All	Established three sections: Alert, Responsive Patients/Localized Injury Altered Mental Status/Unresponsive Pulseless / Cardiac Arrest	Overall medicine is unchanged, but reorganization makes protocol easier to follow. Remember, you are not dead until you are warm and dead
Nausea/Vomiting Adult & Pediatric	EMT	Obtain and transmit 12-lead ECG, if available for patients ≥ 40	N/V can be a sign of acute coronary syndrome, so obtain ECG if >=40
	EMT	Isopropyl alcohol – Allow patient to inhale vapor from isopropyl alcohol wipe 3 times every 15 minutes as tolerated	An evidence-based 8intervention EMTs can offer the patient with N/V
	AEMT	Added an adult and pediatric section for fluid administration and moved the pediatric fluid bolus from Paramedic to AEMT	
	Paramedic	Clarified prochlorperazine and metoclopramide be given by slow IV push over 1-2 minutes	Use lower doses in elderly or smaller patients
	Paramedic	Prochlorperazine 5-10 mg slow IV push over 1-2 mins or 10 mg IM	Use lower doses in elderly or smaller patients
	Paramedic	Metoclopramide 5-10 mg slow IV push over 1-2 mins or 10 mg IM	Use lower doses in elderly or smaller patients
	Paramedic	Added option of Droperidol 0.625-1.25 mg slow IV push over 1-2 minutes or IM. Do not use in patients with known or suspected QT interval prolongation > 440 msec	Droperidol is a new (old, it has come back) medication useful as an antiemetic and for behavioral emergencies as it provides sedation. Do not use if QT prolongation > 440 msec
	Paramedic	Monitor ECG for arrhythmias or QT prolongation	
	Paramedic	If patient has prolonged QT may contact Medical Direction to consider benzodiazepine	Lorazepam 0.5-1 mg IV will often help nausea if unable to give other meds
	Paramedic	For akathisia or dystonic reactions administer diphenhydramine 25-50 mg slow IV push over 1-2 minutes or IM	
Nerve Agents/Organophosphate A&P	Paramedic	Added option for Paramedic administration of atropine and pralidoxime if autoinjectors are not available	Gives Paramedic more flexibility in an actual event
Normal Labor and Delivery	Paramedic	After completion of fetal deliveries: Oxytocin 10 Units IM	Update administration of oxytocin to any time after newborn is delivered.
Obstetrical Emergencies	Paramedic	After completion of fetal deliveries: Oxytocin 10 Units IM	
	Paramedic	Removed IV oxytocin	Just as effective IM and quicker
Pain Management Adult	AEMT	Added additional guidance on IV acetaminophen Acetaminophen 1000 mg IV over 10 minutes, if not given or taken PO	
	AEMT	Additional allowed uses for nitrous include uncomplicated back/flank pain or renal colic	
	Paramedic	Avoid ketorolac in hypotension	Kidneys poorly perfused in hypotension
Pain Management Pediatric	AEMT	Removed IV acetaminophen	Too many dosing errors
	Paramedic	Moved IV acetaminophen to Paramedic section Added instructions to remove excess volume from bottle prior to IV administration and dosing chart	Goal is to avoid dosing errors
	Paramedic	Added Contact Medical Direction for all ketamine administrations, both pain and behavioral dosing	Patient and EMS Personnel safety
Poisoning - Adult	EMT	See Naloxone Leave Behind Program 8.11 and consider screening, offering NLB kit and linkage to treatment	The opioid epidemic continues to be a high cause of fatality of Vermonters, screen patients for OUD, offer NLB rescue kits and arrange linkage to treatment when possible
Poisoning – Adult & Pedi	EMT	Consider restraints moved from AEMT to EMT	
Seizures – Adult & Pediatric	EMT	Removed reference to specific anti-seizure rescue medications and changed the language to read: "If anti-seizure rescue medications have been prescribed by the patient's physician and seizure	

		lasting > 5 minutes, may assist the patient or caregiver with administration by buccal/oral, rectal or intranasal route in accordance with physician's instructions."	
	Paramedic	Midazolam 10 mg IM (preferred if no IV access established)	Clarified midazolam IM is preferred if no IV access already established, faster
Seizure - Pediatric	AEMT	If febrile >= 98 C (100.4F) Consider acetaminophen 15mg/kg PO (max 1,000 mg) See Pediatric Color-Coded Appendix for dosing	
Sepsis – Adult & Pediatric	All	Changed name from Septic Shock to Sepsis	Avoids confusion with shock protocols
Stroke - Adult	All	Added Pearl about Posterior Circulation Stroke. Changed Pictogram at top of Page 3 to read "if feasible, transport to Endovascular Center, per your local stroke plan.	Stroke plans vary based on geography in VT. REMINDER – Obtain and share FAST-ED Scores, divert to thombectomy center when appropriate, may use app
	All	If stroke screening is positive, determine the probability of patient having a Large Vessel Occlusion (LVO) stroke by calculating a FAST-ED score	Clarified that patients who first get a positive stroke screen, then need a FAST-ED score to assess for LVO
Syncope – Adult & Pediatric	All	New protocol	Please review
Section 3: Cardiac Protocols			
Acute Coronary Syndrome	EMT	Administer aspirin 324 mg PO (chewable). If patient has taken a partial dose within the last hour, administer additional aspirin dose to equal 324 mg. If more than one hour since the patient took any dose of aspirin, administer 324 mg aspirin (chewable).	More detailed guidelines for aspirin administration
Bradycardia Adult Bradycardia Pediatric	Paramedic	Changed from: "For symptomatic calcium channel blocker overdose or hyperkalemia/renal failure, consider:" to "For symptomatic calcium channel blocker overdose, hyperkalemia/renal failure, or wide-complex bradycardia, consider:" Added wide-complex bradycardia as an indication for administration of calcium gluconate/chloride and noted that in patients with a pulse calcium gluconate is the preferred agent. Adult dose is mixed in 50 mL NS or D5W to be administered over 10 mins. Pediatric dose is given over 10 mins. Both may be repeated in 10 minutes.	Wide-complex bradycardia may be a sign of hyperkalemia/renal failure. Calcium gluconate should be used in patients with a pulse, calcium chloride is preferred in arrest situations. Administer slowly over 10 mins if a non-arrest situation.
	Paramedic	Updated atropine dose from 0.5 to 1 mg every 3-5 mg to a total of 3 mg to be consistent with AHA	
	Paramedic	Ketamine 0.25 mg/kg every 15 minutes prn analgesia	Added ketamine to Adult Bradycardia as an option for analgesia during transcutaneous pacing
	Pearls	Hyperkalemia should be suspected in dialysis or renal failure patients with ECG changes such as tall, peaked T-waves, loss of p waves, QRS widening and bradycardia. When pushed too quickly, glucagon can cause nausea and vomiting.	New Pearls
Cardiac Arrest - Adult	All	Top diagram, first blue box, reworked. Now "OPA/NPA - 100% O2. BVM (preferred) or passive ventilation with NRB a 15 lpm. No advanced airway."	BVM is preferred. In resource limited settings may consider passive ventilation. If you can ventilate with BVM, it is better
	All	Ventilation / Oxygenation options: BVM ventilation (preferred) 1 breath every 10 chest compressions without interrupting compressions; **OR** If resource-limited, apply high flow oxygen via non-rebreather mask (NRB) for passive ventilation.	BVM is preferred. In resource limited settings may consider passive ventilation. If you can ventilate with BVM, it is better
	All	Top diagram, third blue box now reads: "Continue protocol. If applicable discontinue passive ventilation and start BVM ventilation. Consider advanced airway. Transport/TOR as indicated."	Language clarification. Continue 2-minute cycles until decision to transport or terminate

	EMT	[New Bullet] Assess for treatable causes: hypoxia, overdose/poisoning, hypothermia, hypovolemia and hypoglycemia. Treat per protocol if possible and notify incoming ALS units.	
	AEMT	Top diagram, second blue box Removed 3 mg limit for cardiac epinephrine. Administer epinephrine 1 mg (0.1mg/mL) IV/IO; repeat every other cycle:	Using AHA guidelines 1 mg every 3-5 minutes which works out to every other cycle when using HP-CPR.
	AEMT	Top diagram, second blue box, drop reference to 1:10,000 epi. Packaging has now changed to 0.1mg/mL across the board. "Changed to read: "Epinephrine 1 mg (0.1 mg/mL) IV/IO every other cycle"	1:10,000 epi is no longer shown on the package, the cardiac epinephrine is referred to as epinephrine (0.1mg/mL)
	AEMT	4th bullet: Removed max dose of epinephrine. Changed to read: "Administer epinephrine 1 mg (0.1mg/mL) IV/IO; repeat every other cycle: For shockable rhythms: Administer epinephrine after first 2-minute cycle. For non-shockable rhythms: Administer epinephrine as soon as possible."	Using AHA guidelines 1 mg every 3-5 minutes which works out to every other cycle when using HP-CPR. Focus on early epinephrine.
	Paramedic	Follow AHA ACLS guidelines unless otherwise specified in these protocols.	Clarifying language.
	Paramedic	Removed reference to double sequential defibrillation	Double Sequential Defib deleted based on negative endorsement by AHA
	Paramedic	Removed Magill Forceps bullet	This is included in airway section
	Paramedic	Amiodarone 300 mg IV/IO, repeat dose 150 mg	Per AHA guidelines
	Paramedic	Calcium chloride listed before calcium gluconate	CaCl is preferred in cardiac arrest
Cardiac Arrest - Pediatric	AEMT	Removed reference to 1:10,000 epi as in adult	
	All	In shaded blue box, changed continuous chest compressions/BVM ventilation rate to 5:1 interposed asynchronously from 10:1	This gives the proper ventilation rate per updated AHA guidelines
	AEMT	Once an advanced airway is in place, perform continuous chest compressions with one ventilation every 5 compressions interposed asynchronously.	
	Paramedic	Amiodarone 5mg/kg (maximum 300 mg) IV/IO. May repeat up to 2 times for refractory VF/VT; **OR** Lidocaine 1 mg/kg IV/IO (maximum dose 100 mg).	Removed maintenance infusion for lidocaine to match AHA guidelines
	Paramedic	**For Asystole or Pulseless Electrical Activity (PEA):** Administer epinephrine as soon as possible:	For asystole or PEA arrest give epinephrine as soon as possible
Congestive Heart Failure - Adult	Paramedic	In the AEMT section it notes that SL Nitro is a standing order for Paramedics.	AEMTS contact medical direction Paramedics standing order
Post-Resuscitative Care - Adult	AEMT	If advanced airway is present, start ventilations at 10 breaths/min. Titrate ventilation rate to waveform capnography of 35 to 45 mmHg.	Match AHA guidelines
	Pearl	Monitor for recurrent cardiac arrest or seizures	Recurrent arrest or seizures can occur
Post-Resuscitative Care - Pediatric	Pearl	Monitor for recurrent cardiac arrest or seizures	
Tachycardia - Adult	Paramedic	(May dilute adenosine with 20mL of 0.9% normal saline and give as rapid IVP)	Added adenosine dosing administration option, pre-mixed with NS vs flush
	Paramedic	Changed magnesium dosing from 2 g mixed in 10 mL of D5W or NS to 50 mL over 10 mins. **Polymorphic Ventricular Tachycardia/Torsades de Pointes:** If pulse present, consider magnesium sulfate 2 gm IV/IO diluted in 50 mL D5W or 0.9% NaCl over 10 minutes.	Easier to give 50 mL over 10 mins than. 10 mL
	Paramedic	Added procainamide to wide complex tachycardia	Please review new protocol in detail, this is a new medication for Paramedic
	Paramedic	Avoid Procainamide in patients who are currently on Dofetilide (Tikosyn) or Soltalol (Betapace) as administration of procainamide may further prolong the QT interval and lead to torsades de pointes	New Red flag bullet
Tachycardia - Pediatric	Paramedic	Changed mag to be mixed in 10 mL D5W or NS	
Team-Focused CPR	All	Moved to be part of Cardiac Arrest Protocol	
Double Sequential Defibrillation	Paramedic	Removed from protocol	"Usefulness of double sequential defibrillation for refractory shockable rhythm has not been established. It is

			premature for double sequential defibrillation to be incorporated into routine clinical practice given the lack of evidence" (p. 24 of adult basic and advanced life support). Evidence is that changing vectors is more valuable, which is achieved by the prior protocol bullet to consider changing pad placement. Most monitor manufacturers also do not support use of double sequential defib with their devices due to risk of irreparable damage.
Section 4: Trauma Protocols			
Burns/Electrocution/Lightning Adult and Pediatric	AEMT	Establish IV/IO access. Establish a large bore IV through unburned skin, if possible. IVs may be placed through burned skin if that is the only option. IOs may be placed through burned skin so long as underlying bone is not compromised. Burns greater than 20% Total Body Surface Area (TBSA) should have 2 large bore IV/IOs established) · Administer warmed LR (preferred, if available) or 0.9% NaCl intravenous fluids as below: Transport time less than one hour: Prior to calculating TBSA burned, the initial fluid rates for patients with visibly large burns are based on patient age: · Adults and children 14 years and older: 500ml LR per hour · 6-13 years old: 250ml LR per hour · 5 years old and younger: 125ml LR per hour Transport time greater than one hour: · Perform secondary survey to determine: o Patient's weight in kg o Percent TBSA second and third-degree burns. · Adjust fluid rates for patients with 20% and greater TBSA burns (TBSA is based only on second and third-degree burns. First degree burns are not used in TBSA calculations) as follows: • Adult Thermal and chemical burns: • 2 ml LR x patient's weight in kg x % TBSA (2nd & 3rd degree burns), with half of the 24-hr total (in mLs) infused over the first 8 hrs.	Burn fluid rate adjustments have been updated in ABLS. This recommendation changed from 4ml 20 2mL per kg as the higher volume was resulting in excessive edema formation and over-resuscitation.
Crush/Suspension Injury A&P	EMT	Added hyperlink to new hyperkalemia protocol	
	EMT	Acquire and transmit 12-lead ECG if available. If extrication is prolonged, obtain multiple ECGs.	Added bullet to obtain and transmit ECG and serial ECGs if suspect hyperkalemia
	AEMT	Clarified adult and pediatric fluid bolus orders	Separated into adult and pediatric sections
	Paramedic	Clarified adult and pediatric orders	Separated into adult and pediatric sections
	Paramedic	Updated calcium gluconate and calcium chloride to be mixed in 50 mL of NS or D5W and infused slowly over 10 mins	See hyperkalemia protocol
	Paramedic	Secondary to initial bolus, consider sodium bicarbonate infusion (**Paramedic**):o 150 mEq in 1000 mL D5W at a rate of 250 mL/hr or 4 mL/min (**Adult**).	Clarified sodium bicarb infusion is only mixed in D5W, not NS. Adult dose
Eye Injuries	E/A	An anti-emetic is strongly recommended for penetrating or blunt eye trauma. Refer to N/V protocol.	Consider administration of antiemetics to prevent increases in intraocular pressure due to nausea and vomiting in penetrating and blunt trauma to the eye

	EMT	Moved pain reference to EMT section	
Hemorrhage Control	All	New Protocol	Combines TXA and Tourniquet
Musculoskeletal Injuries	All	Moved pain bullet to EMT	Cleaned up / streamlined language
	Paramedic	For Patella dislocation, contact Medical Direction to consider reduction by exerting medially directed pressure on lateral patellla while extending knee (VT approved training required). Consider pain control prior to procedure.	Added patella reduction for Paramedics with medical direction
Spinal Trauma and Assessment	All	New Protocol	Combined Spinal Motion Restriction and Spinal Assessment into one protocol and moved all to the trauma section
Tranexamic Acid (TXA)	Paramedic	Deleted. Now integrated into Hemorrhage & OB Emergencies Protocols	
Traumatic Brain Injury	All		No significant change, however, please review as more education and emphasis on this protocol is to follow
Traumatic Cardiac Arrest	AEMT	Administer epinephrine per Cardiac Arrest Protocol	Per AHA epinephrine does have a role in traumatic arrest and has been added back into this protocol
	Paramedic	Administer epinephrine per Cardiac Arrest Protocol	Per AHA epinephrine does have a role in traumatic arrest and has been added back into this protocol
Trauma Triage and Transport Decision	All	New Trauma Triage guidelines from ASC-COT Injury Patterns Mental Status & Vital Signs Mechanism of Injury EMS Judgement The protocol has been moved to the Trauma Section from Medical Policies	Same general process but new categories stress injury patterns first (as this is what has been found to be primarily utilized by EMS in decision making, then mental status and vital signs, then mechanism of injury and EMS judgement
Thoracic and Abdominal Injuries	AEMT	Moved fluids for traumatic asphyxia from Paramedic to AEMT section	
Section 5: Airway Protocols & Procedures			
Airway Management	All	Added use of disposable bacteriostatic filter for BVM	Use when available, infection control
	All	**SALAD** (**S**uction **A**ssisted **L**aryngoscopy and **A**irway **D**econtamination) Procedure: Utilize for difficult airway with liquid contaminants present in adult.	Suction airway: for significantly contaminated airways, consider utilizing a **s**uction **a**ssisted **l**aryngeal **a**irway **d**econtamination (**SALAD**) technique
Airway Management Adult	Paramedic	The appropriate method of airway management should be determined based on patient condition. If basic procedures are deemed inappropriate or have proven to be inadequate, then more advanced methods should be used.	Clarifying language
	Paramedic	Consider Bilevel Positive Airway Pressure (BiPAP) Procedure	Added option of BiPAP to Paramedic if available, trained and credentialed
		If unable to establish an airway or ventilate, consider cricothyrotomy (Percutaneous Cricothyrotomy Procedure 5.8 or Surgical Cricothyrotomy Procedure 5.11).	New bullet
Airway Management Pediatric	Pearls	Updated Pearls	
BiPAP	Paramedic	New Protocol	Optional equipment if an agency wants to use must train/credential personnel
CPAP	Paramedic	Med Direction for Benzo discuss	
Orotracheal Intubation	Paramedic	Assess for difficult airway. Have fallback plan and equipment ready (reinforced by a checklist). Utilize a modified **L-E-M-O-N** mnemonic; **L**ook externally, **E**valuate airway anatomy, **M**allampati (minimal use in prehospital environment), **O**bstruction or **O**besity, **N**eck mobility. Perform **HEAVEN** assessment - (**H**) hypoxia, (**E**) extremes of size, (**A**) anatomic disruption, obstruction, (**V**) vomiting, blood, secretions, (**E**) exsanguination, (**N**) neck mobility.	Added LEMON, HEAVEN and SALAD to protocol and other instructions for difficult airway, please review

		Positioning goal of patient's ear canal level with the sternal notch. Use ramping of patients as necessary. Consider first pass Bougie/Flex Guide approach with predicted difficult airways. If a difficult airway with liquid contaminants is present in the adult; consider the **SALAD** (**S**uction **A**ssisted **L**aryngoscopy and **A**irway **D**econtamination) procedure for oral decontamination using a wide bore suction catheter (such as DuCanto Catheter) as a tongue depressor/lifter followed by laryngoscope blade insertion. Insert Bougie through catheter to facilitate ETT placement as needed. For pediatric inflate just enough to obtain seal	
Percutaneous Cricothyrotomy	Paramedic	New Red Flag: *Devices may be utilized on patients of any age for which they are designed, and appropriate sizes are available. *If anatomical landmarks cannot be identified the procedure should not be performed.	Follow manufacturer's instructions. Must have appropriately sized device. Generally, not indicated for age < 1
Surgical Cricothyrotomy	Paramedic	7. Securing device or tape	
Section 6: Medical Procedures			
Intraosseous Access	AEMT and Paramedic	Added option of distal femur site In cardiac arrest: Adults: Proximal humeral/distal femur preferred over anterior tibial site Pediatrics: Distal femur preferred over anterior tibial site Assess needle for correct size, listing in general based on size of patient, generally:	More stable and higher success rate than anterior tibial. While proximal humeral is likely best in cardiac arrest, distal femur also has good blood supply and may be considered in cardiac arrest as may be easier operationally. Distal femur is preferred site for cardiac arrest in pediatrics. Do not use proximal humeral site in pediatric patients. Is not developed until age 9 or so. Needle size is 45 or 25 mm depending on patient size. Generally, 45 mm adult, 25 mm pediatric. Do not use the pink 15 mm size for distal femur, generally too small.
Restraints	Paramedic	**Management of Resistant or Aggressive Behavior** (Resisting necessary treatment/ interventions, goal is alert and calm): Contact Medical Direction to consider: Option 1 – Droperidol 5mg IM/IV Option 2 – Midazolam 5mg IM/IN, or 2.5 mg IV, OR Lorazepam 2 mg IM, or 1 mg IV, OR Diazepam 2.5 mg IV Option 3 - Combination of a benzodiazepine and Haloperidol: Midazolam 5 mg IM, OR Lorazepam 2 mg IM, AND Haloperidol, 5 mg IM, (may combine with benzodiazepine in one syringe) Contact **Medical Direction** if additional dosing is needed **Management of Violent/Combative Behavior, OR Delirium with Agitated Behavior:** (Immediate danger to self/others) Target goal is safe and compliant. **Contact Medical Direction** and consider one of the following treatment options: Option 1 - Ketamine 4 mg/kg IM injection only (preferred agent, use 100 mg/mL	Added treatment categories: Resistant or Aggressive Behavior and Violent/Combative Behavior or Delirium with Agitation. Added options for treatment with droperidol. Review new protocol. There are also pediatric orders for the violent/combative patient. All restraint medications require contact medical direction.

		concentration, maximum dose 500 mg); may repeat 100 mg IM dose in 5 – 10 minutes for continued agitation Option 2 - Droperidol 10 mg IM Option 3 - Combination of a benzodiazepine and Haloperidol: Midazolam 5 mg IM, OR Lorazepam 2 mg IM, AND Haloperidol, 5 mg IM, (may combine with benzodiazepine in one syringe) Contact **Medical Direction** if additional dosing is needed.	
Section 7: Prerequisite Protocols			
Interfacility Transfers	All	Major update released last spring	Please review in detail
Section 8: Medical Policies			
Hospice	Pearl	Though patients in hospice have decided not to pursue further treatment for their underlying condition, these patients can and do still require transport by EMS for acute problems unrelated to their underlying condition and should be treated according to local and state protocols, as well as the patient's hospice plan.	Clarifying language
	AEMT	Ondansetron	Split out AEMT from EMT for nausea
Naloxone Leave Behind	All	Perform single question opioid screening test by asking: • In the past year, have you used substances or prescription medications for non-medical or recreational reason. • If the answer is **yes**, consider the patient an At-Risk Person	Added single question screening test for OUD here and in Routine Patient Care. At-Risk persons should then be offered a naloxone starter pack and other available harm reduction resources such as linkage to treatment.
		NALOXONE LEAVE BEHIND KIT CONTENTS Naloxone spray, instruction on harm reduction and how to access treatment, and other available harm reduction resources.	Provide instructions on linkage to care if available in your EMS District
		Naloxone Leave Behind Kits may be given to both transported and non-transported patients.	Clarify NBL kit can be given to both transported and non-transported patients
Refusal of Care	All	Clarified refusal form. The last gray box is applicable only to patients that lack capacity or is a pediatric patient. Box added for patient that refuses to sign	For normal adults with full capacity, use the N/A box in this field
	All	Offer a naloxone leave behind kit if an "At-Risk" patient or patient with recent OD who is refusing transport	Added to protocol instructions to leave naloxone leave behind kit for "At-Risk" patients, or patients with recent OD who are refusing transport
	All	Naloxone leave-behind kit offered if "At-Risk" patient	Added check box on leave behind form to leave naloxone leave behind kit for "At-Risk" patients
Strangulation	All	Moved to Trauma Section	
Trauma Triage and Transport Decision	All	2022 Update – Move to Trauma Section	Review
Lift Assist Protocol	All	New Protocol	Review
DNR/COLST	All	Updated COLST Form	
Termination of Resuscitation	All	Consider early transport if unable to ventilate	