

**SECTION: G-1**

**TITLE: Foundations of Patient Care**

**REVISED: October 15, 2014**

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**Ada County/City Emergency Services System Standing Written Orders (SWOs)**

**A. Foundation:** These SWOs are the result of the combination of nationally recognized guidelines, local medical practice, and input from the medical directors and the Standards of Care Committee (SOCC). Sources include but are not limited to:

- Basic Life Support (CPR), Advanced Cardiac Life Support (ACLS and ACLS-EP) and associated branch courses
- Pediatric Advanced Life Support (PALS)
- Emergency Pediatric Care (EPC)
- Neonatal Resuscitation Program (NRP, NALS)
- Advanced Medical Life Support (AMLS)
- Basic Trauma Life Support (BTLS), Pre-Hospital Trauma Life Support (PHTLS) and associated branch courses, and
- Advanced Burn Life Support (ABLS)

EMS personnel are encouraged to use the guidance and algorithms of these courses to supplement SWOs. If contradiction occurs, these SWOs will supersede any other algorithm. Alternative courses of action may be utilized, when appropriate, following standard medical control, deviation, and documentation guidelines.

Special Emergency Response Team (SERT) providers face unusual situations often outside the depth of these guidelines, having roles that border on law enforcement functions, or require procedures beyond the scope of normal EMS providers. These special situations may be covered in separate protocols and policies which will supplement this document.

- B.** While this document cannot cover every possible variation of disease or injury encountered in the field, it should provide a foundation for the acute care of the majority of patients seen.
- C.** Each and every protocol should be considered to have, as its first directive, a mandate to maintain universal blood and body fluid precautions/isolation.
- D.** Newer defibrillators using biphasic technology require lower energy doses and self-regulate the appropriate electrical energy. When not specified, or when a different device (than normally used), or if device deployment changes after publication of the SWOs, all protocols assume energy levels as set by the manufacturer recommendations for the device.

- E. Unless specifically addressed in these protocols, a provider's scope of practice is assumed to include lower levels. For example, a paramedic level guideline is assumed to include the EMT scope as well.
- F. **Trauma, Cardiac and Stroke patients:** All patients shall be stabilized and transported as rapidly and efficiently as possible. When treating patients who may benefit from specific interventional therapy (surgery, thrombolytic, catheterization lab) a goal of less than ten minutes on-scene time is desirable (within the bounds of providing quality patient care).
- G. **EARLY NOTIFICATION OF RECEIVING FACILITY IS ESSENTIAL IN SIGNIFICANT CASES**
- H. **General treatment:** All patients shall receive the following general supportive care as appropriate within the scope of practice and sound clinical judgment of the provider:

**Airway control**

- Positioning/suctioning
- Oral or nasopharyngeal airways
- Combi-tube, King LTS (or other adopted advanced airway)
- Endotracheal intubation (oral, nasal, RSI, digital)
- Cricothyrotomy (needle, surgical, and similar devices)
- Use of pharmacological agents to facilitate airway control
- Use of difficult airway devices, such as the Endotracheal Tube Introducer (a.k.a. the Gum Bougie) to facilitate airway control

**Ventilatory support**

- Supplemental oxygen by appropriate means
- Bag-valve mask using a traditional face mask, intra-oral mask (IOM) , or similar device
- Bag-valve ETT
- Monitoring of pulse oximetry and end tidal CO<sub>2</sub>
- CPAP and BiPAP devices when available
- Deep tracheal suctioning
- Use of a mechanical ventilator

**Circulatory support**

- CPR and components of CPR
- Use of devices to support circulation, including mechanical CPR devices (such as the LUCAS™2, or other devices) and CPR adjuncts (such as the ResQPod, ITD, and similar devices) as training and availability allow
- Basic bleeding control, up to and including use of tourniquets

## **Naso- and oro-gastric tube placement**

**Spinal immobilization:** Selective immobilization using cervical collars, KEDs (or similar devices), spine boards (or similar devices), and improvised devices. This includes screening for appropriate immobilization.

**Splinting:** Using pillows, cardboard splints, vacuum splints, traction devices and other improvised devices as appropriate and available.

## **Vascular access**

- Single or multiple lumens
- Peripheral or intraosseous access, including pre-established lines
- Normal saline and saline lock as appropriate
- Use and maintenance of other crystalloid solutions and pre-established vascular access, including PICC lines, Hickman catheters, hemodialysis lines, and other routes of vascular access (as provider training and comfort level allows)
- While ILS providers are often limited in the number of IV attempts and fluid administration by this document, ILS providers may exceed those guidelines when functioning under the general direction of the Paramedic in charge of the patient. Likewise, Paramedics are limited by sound clinical judgment rather than an arbitrary number of “attempts” at vascular access

**EKG/Electrical therapy:** Defibrillation/cardioversion/pacing, including AEDs and manual devices. EKG and 12-lead monitoring.

- Patients in which EKG monitoring has been initiated for any reason will be considered ALS patients; these patients shall be attended by a Paramedic at all times.

## **Needle thoracostomy (chest decompression)**

## **Blood glucose monitoring**

**Monitoring and titration of medication drips,** including medications on pumps when appropriate and training allows.

## **Monitoring of blood product infusions**

**Physical restraints as required for patient and provider safety. This does not imply that EMS providers assume law enforcement functions.**

**ALS providers may decrease the dosage or prolong the administration intervals of any medication with sedative properties when doing so would decrease adverse effects and still likely obtain the clinical goal.**

Protocol

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