



COUNTY OF ORANGE HEALTH CARE AGENCY

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TO: BASE HOSPITAL PHYSICIANS
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SADDLEBACK PARAMEDIC TRAINING PROGRAM
ORANGE COUNTY AMBULANCE SERVICE PROVIDERS

FROM: SAMUEL J. STRATTON, MD, MPH
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SUBJECT: CLARIFICATIONS OF 2011 UPDATE POLICIES AND MATERIALS

The following are questions that have been referred to Orange County EMS with the current 2011 Update:

Questions regarding Policy 310.30, Trauma Triage:

1. Can a patient who meets trauma criteria, if stable and only having apparent mild injury, be directed by a base hospital to the nearest receiving hospital?

Answer: Base contact is required for patients meeting trauma triage criteria. Destination of trauma patients is determined by the base hospital, so those who do not need the specialty services of a trauma center can be directed by a base hospital to a nearby receiving center if that PRC agrees with the base that they are capable of managing the case.

2. Should a patient with apparent alcohol intoxication and head injury from a ground level fall and GCS < 14 be considered a trauma patient?

Answer: As currently stated in policy, this patient meets trauma triage criterion. Base contact should be made and the base will determine appropriate triage destination.

3. Is a bicyclist thrown up onto the hood of a car after impact considered to meet trauma triage criteria?

Answer: Yes this patient should be considered to have met trauma triage criteria; such patients are at risk for chest or pelvic injuries or internal spleen or liver injury.

4. If a person meets trauma triage criteria and signs AMA for treatment or transport, should base contact be made?

Answer: Policy 330.65 in effect since 1993 requires base contact on any patient meeting base contact criteria who signs AMA (policy 330.65, IV., E).

5. Should a hanging victim, who is to be transported, be directed toward a PTRC or PRC?

Answer: For the majority of hangings encountered by EMS personnel, the primary medical issue is airway obstruction due to pressure on the upper airway, not cervical spine injury. Hanging victims should be transported to the nearest PRC under base hospital direction.

Questions regarding Policy 330.15, Advanced Life Support Treatment in Communications Failure or Without Base Hospital Contact:

1. The 24-hour requirement for submitting a 330.15 form may not be possible when assigned to an out-of-area strike team, but the slides for the Update emphasizes “No Exceptions”.

Answer: If deployed out-of –county, the 330.15 may be submitted upon return to Orange County.

Questions regarding intranasal (IN) midazolam (Versed®):

1. Can intranasal midazolam be given prior to emergency cardioversion?

Answer: IN midazolam (Versed®) is appropriate as a standing order to prepare for cardioversion. The dose should be the same as for IM administration, 10 mg IN for an adult. Guideline C-25 will be updated to reflect this change.

2. Can intranasal midazolam be administered to calm an agitated patient?

Answer: IN midazolam is not recommended for administration in agitated patients as they are unlikely to be cooperative to allow for safe administration of intranasal medications.

Questions regarding intranasal (IN) naloxone (Narcan®):

1. The slides used for the update are contradictory with one stating IN naloxone can be given for respiratory arrest and another stating it is contraindicated.

Answer: In respiratory arrest, BVM ventilation should take priority over using the upper airway to deliver naloxone. In respiratory arrest suspected of being complicated by narcotic overdose, a BVM should be immediately applied and naloxone administered intramuscularly or intravenously.

Questions regarding Zofran®

1. Is Zofran® a medication that can be given with the patient transported as ALS No-contact?

Answer: Zofran® can be administered as a standing order and a patient transported ALS No-contact. Revisions to Guideline I-40 are in process to clarify this issue.

2. If Zofran® is given after ALS No-contact administration of Morphine (for possible fracture) is this still an ALS No-contact call?

Answer: Yes, providing the patient continues to meet no contact criteria, the call may be managed as ALS No-contact. This will be reflected in an upcoming revision of Guideline I-40.

3. Can Zofran® be given prophylactically prior to administration of morphine or naloxone?

Answer: No, Zofran® is not recommended for prophylaxis of nausea and vomiting prior to administration of morphine or naloxone. Zofran should only be used as needed for nausea and vomiting to avoid potential side effects that could occur if the drug were administered without need. Morphine should be held if a patient reports they are not able to tolerate the drug.

4. Do Zofran® ODT tablets need to be placed under the tongue like nitroglycerine?

Answer: No, absorption is excellent anywhere within the mouth.

5. If a patient is given Zofran® and then decides to sign AMA for transport, is base contact required?

Answer: Refer to OCEMS Policy # 330.65 which defines field action and evaluation required for an AMA situation. While a patient given an ALS drug may sign out AMA after receiving the drug, ALS drugs should not be administered when the patient indicates they will refuse transport before receiving the medication.

6. Can Zofran® be given when a patient indicates they do not want to be transported?

Answer: In the hospice situation where Zofran® may be indicated and transport not considered, base contact should be made for management direction, otherwise ALS drugs should not be given without intent to transport.

7. Can Zofran® be administered to a trauma victim?

Answer: Yes, if indicated and stabilization and transport will not be delayed.

Question regarding Benadryl®:

1. Can Benadryl® be given IO (intraosseous)?

Answer: IO administration should be reserved for unstable patients and is not appropriate in an allergic reaction without signs of severe anaphylaxis. If indicated for management of severe anaphylaxis, Benadryl® can be administered IO in a 25 mg dose for adults or appropriate weight-based dose for children..

2. Is the maximum dose of Benadryl® 25 mg for all indications (Extrapyramidal reaction, allergic, anaphylaxis)?

Answer: The Benadryl® dose that should be used as a paramedic standing order / ALS-no contact dose is 25 mg for all indications. This is not a maximum dose as the base hospital can order additional doses.

Question regarding aspirin dosing:

1. If upon arrival to the scene of a patient with chest pain of suspected cardiac origin the patient reports having taken two 81 mg (“baby”) tablets of aspirin within the past four hours, should the paramedics administer another two 81 mg tablets to bring the total dose taken to 324 mg?

Answer: Yes, it is appropriate to administer the two additional 81 mg tablets.

Question regarding stroke patients:

1. Do suspected stroke full arrest patients need to go to SNRCs?

Answer: No, full arrest stroke victims should be transported to the nearest PRC.