

CHANGES IN 4TH EDITION EMT-INTERMEDIATE PROTOCOLS UPDATE JUNE 25, 2008

1. Updated Table of Contents
 - Safe Transportation of Pediatric Patients added to Section 6
 - Helicopter protocols added to Section 7
 - Request to be taken to a hospital on diversion added to Section 10
2. Section II, Patient Rights
 - Updated #5
 - The protocol has been rewritten to emphasize that a patient who is conscious and alert has the right to be taken to the hospital of his/her choice, even if the hospital is on diversion.
3. Section 3.2
 - Updated section on Medical Direction Hospitals
 - It has been added that if a service's off-line medical director has a medical control physician identification (MCPI) number and is board certified in emergency medicine or is current in ATLS and ACLS, he/she may give on-line medical direction (OLMD) for the service.
4. Section 3.4
 - Updated lists of Category A and B medications
5. Updated 4.7 Burns
 - It has been added that cyanide poisoning can cause dyspnea and cerebral anoxia the same as carbon monoxide. Also added indications for entering a burn patient into the trauma system and transporting directly to a ready burn center. Also added that the pulse oximeter is unreliable in cyanide poisoning and if a patient is suffering from smoke inhalation the EMT should give 100% oxygen.
6. Updated 4.9 Cardiac Symptoms/Acute Coronary Syndrome
 - Added that if equipment is available to record and transmit a 12-lead ECG, the EMT is required to do so (provided the hospital has the ability to receive). If the hospital lacks the equipment to receive the 12-lead ECG, the EMT is to run the ECG and deliver it to the hospital with the patient.
7. Updated 4.20 Hypoglycemia
 - We have had multiple complaints from medical direction physicians about hypoglycemic patients being drilled with an intraosseous needle in order to give D50W (often without even trying to start an IV). We added a note that IO is not indicated for hypoglycemia except in extreme circumstances and use of IO for this would be reviewed in each case. Our new electronic patient care report allows us to monitor use of such procedures on a daily basis.
8. Updated 4.28 Stroke
 - The giving of aspirin to every patient with stroke symptoms was part of the original stroke protocol in the mid 90s at the suggestion of Dr. Gomez when he was head of the UAB Stroke service. This has always been controversial because of the possibility of increased intracranial bleeding if the patient was having a hemorrhagic stroke. There was also the danger of aspiration of the aspirin if the stroke had affected the patient's ability to swallow. We now have national guidelines for emergency stroke care. The 2007 stroke association guidelines

suggest keeping patients NPO until their swallowing can be adequately tested. The guidelines also recommend aspirin only for ischemic stroke and then it can be given any time within 48 hours. The change is to remove the prehospital use of aspirin for patients with stroke symptoms and to keep the patient NPO.

9. Updated 5.2 Aspirin
The use of aspirin for patients with stroke symptoms has been deleted.
10. Updated 6.1 Endotracheal Intubation
This protocol has been rewritten to correct errors (such as esophageal disease being a contraindication for ET intubation), to add use of the bougie for difficult adult intubations, and to add a procedure for use of nasotracheal intubation (not indicated for services that can perform RSI). It stresses that either qualitative or quantitative CO₂ monitoring must be done. We also added that pediatric patients very rarely need endotracheal intubation and are usually better ventilated by bag-mask.
11. Updated 6.3 Intraosseous Infusion
We have had multiple complaints from medical direction physicians about inappropriate use of the intraosseous route of drug administration since the IO drill became available. For this reason we changed the procedure to CAT B except for:
 1. Cardiac arrest or shock with altered mental status in children
 2. Cardiac arrest or shock with BP <90 in adults.We also changed the protocols to reflect indications, contraindications, and precautions of the procedure rather than listing specific details of performing the procedure (which vary depending on the device used). Also changed the wording to make it clear that the proximal tibia is the only acceptable site for IO (except for the sternum if using the FAST-1).
12. Added new protocol 6.10 Safe Transport of Pediatric Patients.
13. Added new protocol 7.9 Early Activation of Helicopter EMS.
14. Added new protocol 7.10 Guidelines for Helicopter Transport of Trauma System Patients.
15. Added new protocol 7.11 Guidelines for Helicopter Utilization for Scene Response Other than Trauma System.
16. Updated 8.5 Trauma System Protocol.
17. Updated 9.2 Hemostatic Agents by adding WoundStat.
18. Updated 9.4 Continuous Positive Airway Pressure Devices by adding O₂-RESQ single use system by Pulmodyne.
19. Added 10.3 Request to be Taken to a Hospital on Diversion (Optional form)