

MD on Site

CHEST PAIN/PRESSURE

Guidelines are for Adult and Pediatric patients.....**Drugs doses are for the Adult population only**

Symptoms: patient may also present with dyspnea, left arm pain, jaw pain, lightheaded, stabbing back pain between the shoulder blades, etc.

Transport Category: **PRIORITY**

1. **Activate:** Emergency Response system and assure someone has brought essential equipment to the bedside.
2. **Oxygen:** Provide 2-4 LPM of O₂ by nasal canula; more if patient acutely short of breath by Non Re-breather @ 10-15 LPM and have patient sit or lay down on a bed/exam table
3. **Rapid H&P:**
 - a. Type of pain/pressure
 - b. Does it radiate
 - c. Duration
 - d. Dyspnea
 - e. Patient's color & appearance
 - f. Breath & heart sounds
 - g. Diaphoresis
 - h. Medications
 - i. Past events/relevant medical history
4. **Monitor//VS:** Obtain a set of vital signs and continuously monitor patient, be prepared to start CPR and use an AED
5. **Aspirin:** (**Adult Only**) If medication/drug box available have patient chew four 81mg baby aspirin or one 325 mg non coated aspirin while performing the history and physical exam, assuming no known allergy to aspirin exists
6. **IV:** Initiate IV and connect to normal saline and run as ordered by MD
7. **NITRO:** (**Adult Only**) Order, administer 0.4mg nitroglycerin sublingual for chest pain/pressure if BP is > 100mmhg and the patient is not tachycardic, bradycardic, or on any phosphodiesterase inhibitors, i.e. Viagra, Cialis, etc.
 - a. Repeat vital signs every five minutes and reassess for chest pain/discomfort
 - b. If patient continues to have chest pain repeat nitro tab sub lingual every 5 minutes up to a total of three
8. **12 Lead EKG:** (**Adult Only**) Obtain a 12-lead EKG if available and have someone make a copy to send with the emergency transport team or fax to the emergency department
 - a. With in UVA phone system, X-XXX
 - b. Outside UVA phone system XXX-XXXX

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Transport Category: **PRIORITY**

1. **ACTIVATE:** Immediately instruct someone to contact your emergency response system and bring an AED, (if no one is available you will need contact your emergency response system and get the AED)
2. **OXYGEN:** Provide 2-4 LPM of O₂ by nasal canula; more if patient acutely short of breath by Non Re-breather @ 10-15 LPM and have patient sit or lay down on a bed/exam table
3. **H&P:** Perform a rapid history and physical exam, i.e.
 - a. Type of pain/pressure
 - b. Does it radiate
 - c. Duration
 - d. Dyspnea
 - e. Patient's color & appearance
 - f. Breath & heart sounds
 - g. Diaphoresis
 - h. Medications
 - i. Past events relevant medical history
4. **VITAL SIGNS:** Obtain a set of vital signs while continuously monitoring the patient and provide comfort measures until your emergency response system arrives and assumes care
5. **ASPIRIN:** (**Adult Only**) Follow MD recommendation for aspirin-- have patient chew four 81mg baby aspirin or one 325 mg non coated aspirin while performing the history and physical exam, assuming no known allergy to aspirin exists
6. **VIGILANT:** Continually reassess and be prepared to start CPR and use the AED

MD on Site

Stroke

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Symptoms: patient may present with difficulty speaking, inability to lift or use left or right arm and/or numbness, facial droop to one side of the face, ALOC, visual changes, etc.

Transport Category: **Priority or Urgent** (if unable to protect airway)

1. **ACTIVATE:** Immediately instruct someone to contact your emergency response system, get the Monitor/code cart, and request the MD to the bedside, (if no one is available you will need contact your emergency response system and bring the code cart)
2. **TRANSFER:** If a stroke is suspected, the patient should be rapidly transferred to an emergency department
3. **OXYGEN:** Provide 2-4 LPM of O₂ by nasal canula; more if patient acutely short of breath by Non Re-breather @ 10-15 LPM and have patient sit or lay down on a bed/exam table
4. **H&P:** Perform a rapid history and physical exam and immediately use the Cincinnati stroke scale by utilizing the **Think F.A.S.T** algorithm and obtain a set of vital signs
 - a. **F**ace: ask the person to smile
 - i. Does one side of the face droop?
 - b. **A**rms: ask the person to hold both arms up evenly
 - ii. Does one arm drift downward
 - c. **S**peech: ask the person to repeat a simple sentence
 - iii. Are the words slurred or mixed up
 - d. **T**ime: if the person shows any of these signs or symptoms, document and immediately call your emergency response number if not already done
5. **VITAL SIGNS:** Obtain a set of vital signs while continuously monitoring the patient and provide comfort measures until your emergency response system arrives and assumes care
6. **CONSIDER GLUCOSE:** (**Adult Only**)
 - a. Treat if indicated by Glucose result and you have a drug box available with Dextrose, (D50)

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3. **OXYGEN:** Provide 2-4 LPM of O₂ by nasal canula; more if patient acutely short of breath by Non Re-breather @ 10-15 LPM and have patient sit or lay down on a bed/exam table
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 - iii. Are the words slurred or mixed up
 - d. **T**ime: if the person shows any of these signs or symptoms, document and immediately call your emergency response number if not already done

VITAL SIGNS: Obtain a set of vital signs while continuously monitoring the patient and provide comfort measures until your emergency response system arrives and assumes care

5. **CONSIDER GLUCOSE:** (**Adult Only**)
 - b. Check glucose.
 - c. IF MD ON SITE: Treat if indicated by Glucose result and you have a drug box available with Dextrose (D50)

MD on Site

DIFFICULTY BREATHING/SHORTNESS OF BREATH

Guidelines are for Adult and Pediatric patients.....**Drugs doses are for the Adult population only**

Symptoms: patient presents with signs/symptoms and or complaint of difficulty breathing, pale, diaphoretic, audible breath sounds, wheezing, increased work of breathing, accessory muscle use, etc.

Transport Category: Priority to Urgent (Extreme SOB or work of breathing)

1. **ACTIVATE:** Immediately instruct someone to contact your emergency response system, get the Monitor/code cart, and request the MD to the bedside, (if no one is available you will need contact your emergency response system and bring the code cart)
2. **OXYGEN:** Provide 2-4 LPM of O₂ by nasal canula; more if patient acutely short of breath by Non Re-breather @ 10-15 LPM and have patient sit or lay down on a bed/exam table
3. **Perform:** a rapid history and physical exam, i.e.
 - a. Questioning if the individual has any pain or pressure associated with their SOB
 - b. What does it feel like
 - c. how long has it been going on
 - d. Color
 - e. Listen to breath & heart sounds
 - f. diaphoresis
 - g. medications
 - h. past events/relevant medical history
4. **Obtain:** a set of vital signs and continuously monitor patient, be prepared to start CPR and use an AED

The Following interventions/treatments are recommended when a MD is at the bedside

5. **Initiate:** an IV while performing #4
6. **Prepare:** to administer medications per MD order and if a drug box available, i.e.
 - a. CHF (**Adult Only**)
 - i. Lasix
 - ii. Nitro sub-lingual
 - b. Asthma
 - i. Albuterol neb
 - ii. Atrovent neb
 - iii. Solu-Medrol - I.V.

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 - b. What does it feel like
 - c. how long has it been going on
 - d. Color
 - e. Listen to breath & heart sounds
 - f. diaphoresis
 - g. medications
 - h. past events/relevant medical history
4. **Obtain:** a set of vital signs and continuously monitor patient, be prepared to start CPR and use an AED

MD on Site

Hypoglycemia

Guidelines are for Adult and Pediatric patients.....**Drugs doses are for the Adult population only**

Symptoms: Patient may present with ALOC, pale, cool clammy skin, dizziness, lightheaded, etc.

Transport Category: **Priority to Urgent** (ALOC or Unresponsive)

1. **Activate:** Immediately instruct someone to contact your emergency response system, get the Monitor/code cart, and request the MD to the bedside, (if no one is available you will need contact you emergency response system and bring the code cart)
2. **Oxygen:** Provide 2-4 LPM of O₂ by nasal canula; more if patient acutely short of breath by Non Re-breather @ 10-15 LPM and have patient sit or lay down on a bed/exam table
3. **Perform:** a rapid history and physical exam, i.e.
 - a. how long has it been going on
 - b. Color
 - c. diaphoresis
 - d. medications
 - e. past events/relevant medical history
 - f. mental status
4. **Obtain:** a set of vital signs and continuously monitor patient, Obtain a finger stick blood glucose

The Following interventions/treatments are recommended when a MD is at the bedside

5. **Initiate:** an IV while performing #4
6. **Prepare:** to administer Dextrose I.V. per MD order and if a drug box available

If no IV available, prepare to administer Glucagon 1mg IM per MD order and if a drug box available

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3. **Perform:** a rapid history and physical exam, i.e.
 - g. how long has it been going on
 - h. Color
 - i. diaphoresis
 - j. medications
 - k. past events/relevant medical history
 - l. mental status
4. **Obtain:** a set of vital signs and continuously monitor patient, Obtain a finger stick blood glucose

RN, LPN, or non-MD Only

Allergic Reaction

Guidelines are for Adult and Pediatric patients.....**Drugs doses are for the Adult population only**

Symptoms: patient presents with itching, hives, SOB, wheezing, facial swelling, tongue/throat swelling, cool, pale, weakness/dizziness, etc

Transport Category: **Priority to Urgent** (ALOC, Extreme SOB, Hypotension, etc.)

1. **Activate:** Immediately instruct someone to contact your emergency response system, get the Monitor/code cart, and request the MD to the bedside, (if no one is available you will need contact you emergency response system and bring the code cart)
2. **Oxygen:** Provide 2-4 LPM of O₂ by nasal canula; more if patient acutely short of breath by Non Re-breather @ 10-15 LPM and have patient sit or lay down on a bed/exam table
3. **Perform:** a rapid history and physical exam, i.e.
 - a. Identify substance causing the reaction
 - b. Color
 - c. diaphoresis
 - d. medications
 - e. past events/relevant medical history
4. **Obtain:** a set of vital signs and continuously monitor patient for signs of shock and or respiratory arrest and prepare to assist with respirations as needed

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Allergic Reaction

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3. **Perform:** a rapid history and physical exam, i.e.
 - f. Identify substance causing the reaction
 - g. Color
 - h. diaphoresis
 - i. medications
 - j. past events/relevant medical history
4. **Obtain:** a set of vital signs and continuously monitor patient for signs of shock and or respiratory arrest and prepare to assist with respirations as needed

The Following interventions/treatments are recommended when a MD is at the bedside

5. **Initiate:** an IV while performing #4 and attached normal saline
6. **Immediately:** (**Adult Only**) prepare to give medications per MD order

a. Epinephrine (1:1000) 0.3mg-Sq/Im	b. Fluids
c. Albuterol (for wheezing, etc.)	d. Benadryl 25mg IV (50mg IM if no IV)
e. Solu-Medrol 125mg IV	f. Monitor Patient Continuously
g. Have ETT Transport Patient to Emergency Department for continued Evaluation	

(Refer to Local Medical Direction for Pediatric Medications)

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Seizures

Guidelines are for Adult and Pediatric patients.....**Drugs doses are for the Adult population only**

Symptoms: patient presents with generalized seizure activity

Transport Category: **Priority to Urgent** (Airway compromise, Status Epilepticus)

1. **Activate:** Immediately instruct someone to contact your emergency response system, get the Monitor/code cart, and request the MD to the bedside, (if no one is available you will need contact you emergency response system and bring the code cart)
2. **Protect:** patient, **DO NOT** attempt restrain the patient
3. **Monitor:** airway and provide suction if available
4. **Oxygen:** Provide 2-4 LPM of O₂ by nasal canula; more if patient acutely short of breath by Non Re-breather @ 10-15 LPM
5. **Perform:** a rapid history and physical exam, i.e.
 - a. History of seizures if family member or other individual able to provide information
 - b. Monitor airway
 - c. Color
 - d. diaphoresis
 - e. medications
 - f. past events/relevant medical history
6. **Obtain:** a set of vital signs and continuously monitor patient for signs of shock and or respiratory arrest and prepare to assist with respirations as needed

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5. **Perform:** a rapid history and physical exam, i.e.
 - g. History of seizures if family member or other individual able to provide information
 - h. Monitor airway
 - i. Color
 - j. diaphoresis
 - k. medications
 - l. past events/relevant medical history
6. **Obtain:** a set of vital signs and continuously monitor patient for signs of shock and or respiratory arrest and prepare to assist with respirations as needed

The Following interventions/treatments are recommended when a MD is at the bedside

7. **Initiate:** an IV while performing #5
 - a. If available check the patient's Glucose(**Adult Only**)
 - b. Treat if indicated by Glucose result and you have a drug box available with Dextrose, (D50) (**Adult Only**)

RN, LPN, or non-MD Only

Trauma

Guidelines are for Adult and Pediatric patients.....**Drugs doses are for the Adult population only**

Symptoms: Can include, head, neck, extremity as a result of a fall, assault or other circumstances. (If the injury is severe or you suspect the individual has head or c-spine injury perform the following)

Transport Category: **Priority to Urgent** (Airway compromise, C-Spine injury suspected)

1. **Activate:** Immediately instruct someone to contact your emergency response system and request the MD to the patients side, (if no one is available you will need contact you emergency response system and bring the code cart)
2. **Protect:** the patient and prepare to immobilize the injury.
 - a. For extremities
 - i. Assess patient's pulse, motor, and sensation distal to the injury
 - ii. Immobilize the joint above and below the injury by using a
 1. splint
 2. Magazine
 3. Etc
 - iii. Secures the entire extremity using
 1. Gauze
 2. ace wrap
 3. etc
 - iv. Positions the hand/foot in position of function
 - v. Reassesses pulse, motor, and sensation after immobilization
 - b. If you suspect head or c-spine trauma
 - vi. Have patient lie as still as possible
 - vii. Do Not perform c-spine control unless specifically trained in this procedure
3. **Oxygen:** If patient is having difficulty breathing; provide O2 by nasal canula, more if patient acutely short of breath by Non Re-breather @ 10-15 LPM

Trauma Continued

4. **Control:** any bleeding by applying pressure to the wound
5. **Perform:** a rapid history and physical exam, i.e.
 - a. Monitor airway
 - b. Determine the cause of the event
 - c. Is the patient diaphoretic
 - d. Medications
 - e. Last oral intake
 - f. Past events/relevant medical history
6. **Obtain:** a set of vital signs and continuously monitor patient for signs of shock and or respiratory arrest

MD On Site Trauma

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 - xiii. Have patient lie as still as possible
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3. **Oxygen:** If patient is having difficulty breathing; provide O2 by nasal canula, more if patient acutely short of breath by Non Re-breather @ 10-15 LPM

Trauma Continued

4. **Control:** any bleeding by applying pressure to the wound
5. **Perform:** a rapid history and physical exam, i.e.
 - g. Monitor airway
 - h. Determine the cause of the event
 - i. Is the patient diaphoretic
 - j. Medications
 - k. Last oral intake
 - l. Past events/relevant medical history
6. **Obtain:** a set of vital signs and continuously monitor patient for signs of shock and or respiratory arrest

The Following interventions/treatments are recommended when a MD is at the bedside

7. Initiate an IV while performing #5 if indicated
 - b. Significant bleeding
 - c. Angulated extremity
 - d. ALOC
 - e. Hypotension
 - f. Respiratory distress

RN, LPN, or non-MD Only

Hypotension/Shock

Guidelines are for Adult and Pediatric patients.....**Drugs doses are for the Adult population only**

Symptoms: Patient who presents with signs of shock may include; Pallor, Diaphoresis, Cool and clammy skin, ALOC, Low blood pressure

- a. Low blood pressure in the absence of the above signs and symptoms does not by itself signify hypotension

Transport Category: **Priority to Urgent** (ALOC, Extreme SOB, Hypoperfusion)

1. **Activate:** Immediately instruct someone to contact your emergency response system and request the MD to the patients side, (if no one is available you will need contact you emergency response system and bring the code cart)
2. **Oxygen:** If patient is having difficulty breathing; provide O2 by nasal canula, more if patient acutely short of breath by Non Re-breather @ 10-15 LPM
3. **Protect:** Have the patient lie down on a bed and raise their legs
 - a. If patient has significant rales, or history of moderate / severe CHF then DO NOT lie flat
4. **Perform:** a rapid history and physical exam
5. **Obtain:** a set of vital signs and continuously monitor patient for signs of worsening shock and or respiratory compromise
 - a. Monitor airway
 - b. Determine the cause of the event
 - c. Is the patient diaphoretic
 - d. Medications
 - e. Last oral intake
 - f. Past events/relevant medical history
 - g. If patient develops respiratory compromise; elevate head slightly

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4. **Perform:** a rapid history and physical exam
5. **Obtain:** a set of vital signs and continuously monitor patient for signs of worsening shock and or respiratory compromise
 - h. Monitor airway
 - i. Determine the cause of the event
 - j. Is the patient diaphoretic
 - k. Medications
 - l. Last oral intake
 - m. Past events/relevant medical history
 - n. If patient develops respiratory compromise; elevate head slightly

The Following interventions/treatments are recommended when a MD is at the bedside

6. Initiate an IV while performing #5 if indicated and provide fluid as directed by the MD

MD Ambulatory Care Guidelines

Medical Transport Categories

<p>CATEGORY 1 Emergent</p>	<p><u>Life Threatening:</u></p> <ul style="list-style-type: none"> • Cardiac and/or Respiratory arrest • Imminent Arrest • Altered Mental Status • Seizure <p><u>Response:</u></p> <ul style="list-style-type: none"> • Immediate with NO Delays • Any Delay initiates immediate secondary/mutual aid response <p><u>Destination:</u></p> <ul style="list-style-type: none"> • Emergency Department Only
<p>CATEGORY 2 Priority</p>	<p><u>Serious Condition:</u></p> <ul style="list-style-type: none"> • Shortness of Breath • Chest Pain • Hypotension • Or any other serious change in patient's condition <p><u>Response:</u></p> <ul style="list-style-type: none"> • 15 Minute on site response time • > 15 Minutes on site arrival initiates a secondary/mutual aid response <p><u>Destination:</u></p> <ul style="list-style-type: none"> • Emergency Department Only
<p>CATEGORY 3 Routine</p>	<p><u>Un-planned Transport:</u></p> <ul style="list-style-type: none"> • Decision to admit patient • Further evaluation required in Emergency Department <ul style="list-style-type: none"> ▪ Non-Emergency or Non-Urgent criteria <p><u>Response:</u></p> <ul style="list-style-type: none"> • >15 minute and/or delayed response will not impact patient outcome • >120 minute response initiates a secondary/mutual aid response <p><u>Destination:</u></p> <ul style="list-style-type: none"> • Emergency Department, admission, or patient care unit
<p>CATEGORY 4 Scheduled</p>	<p><u>Scheduled Transport:</u></p> <ul style="list-style-type: none"> • Pre-arranged patient transport • Excludes the patient with a deteriorating condition <p><u>Response:</u></p> <ul style="list-style-type: none"> • Should be within a 30 minute projected window of time • Delays will not impact patients status <p><u>Destination:</u></p> <ul style="list-style-type: none"> • Open

RN Ambulatory Care Guidelines

Medical Transport Categories

<p>CATEGORY 1 Emergent</p>	<p><u>Life Threatening:</u></p> <ul style="list-style-type: none"> • Cardiac and/or Respiratory arrest • Imminent Arrest • Altered Mental Status • Seizure <p><u>Response:</u></p> <ul style="list-style-type: none"> • Immediate with NO Delays • Any Delay initiates immediate secondary/mutual aid response <p><u>Destination:</u></p> <ul style="list-style-type: none"> • Emergency Department Only
<p>CATEGORY 2 Priority</p>	<p><u>Serious Condition:</u></p> <ul style="list-style-type: none"> • Shortness of Breath • Chest Pain • Hypotension • Or any other serious change in patient's condition <p><u>Response:</u></p> <ul style="list-style-type: none"> • 15 Minute on site response time • > 15 Minutes on site arrival initiates a secondary/mutual aid response <p><u>Destination:</u></p> <ul style="list-style-type: none"> • Emergency Department Only
<p>CATEGORY 3 Routine</p>	<p><u>Un-planned Transport:</u></p> <ul style="list-style-type: none"> • Decision to admit patient • Further evaluation required in Emergency Department <ul style="list-style-type: none"> ▪ Non-Emergency or Non-Urgent criteria <p><u>Response:</u></p> <ul style="list-style-type: none"> • >15 minute and/or delayed response will not impact patient outcome • >120 minute response initiates a secondary/mutual aid response <p><u>Destination:</u></p> <ul style="list-style-type: none"> • Emergency Department, admission, or patient care unit
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