

SPEMS Protocol Changes
Emergency Care Attendant (ECA)
3/1/19 to 2/29/20

PROTOCOL CHANGES

- **Every Page**
 - Changed dates at bottom of each page
- **Cover Page**
 - Signature with March 1, 2019 date
 - Protocols will expire February 29, 2020
- **Page ii. Authorized Services**
 - New Page
 - Lists all services authorized to utilize SPEMS Protocols
 - Required by TDSHS
- **Page P-2 Table of Contents**
 - Page numbers adjusted for changes
 - Reflects addition of new Fever/Sepsis Algorithm on Page 15
- **Page P-19 Stroke/TIA (Suspected)**
 - New section
 - Discusses in more detail management of stroke/TIA patients
 - References performing the VAN assessment for all patients with positive CSS
 - To help determine if stroke is due to large vessel occlusion (LVO)
- **Page P-22 Transport to Freestanding Emergency Centers (FECs)**
 - New Section
 - Allows for transport of certain patient to approved FECs under for patients that meet certain criteria
 - Approved Lubbock FECs: Star ER and both Covenant HOPD locations
 - Approved Amarillo FECs: both ER Now locations
 - NO OTHER FECs are authorized by Protocols
 - Lists Indications and Contraindications for transport to these approved FECs
 - Provides guidance of timeframe and transport to appropriate facility
 - Flow chart included on page P-24
 - Lists addresses and contact phone numbers for each facility
 - ALL transports to FECs MUST be reviewed by a peer reviewer
- **Page P-37 Stroke/TIA Triage/Transport Decision Scheme**
 - Updated to reflect importance of determining “Last seen normal time”
 - References Large Vessel Occlusion and the VAN assessment
- **Page P-49 BLS Equipment**
 - Addition of 1- Thermometer (may be oral, tympanic, or skin monitoring)
 - Since monitoring of temperature is required with the new Fever/Sepsis Protocol, a thermometer is required
- **Page P-50 Signature Page**
 - Date changed to 3/1/2019
 - EMS Director MUST sign
- **Throughout Treatment Algorithms**
 - Changed the date on the bottom to read 03/01/2019
- **Page 15 Fever/Sepsis**
 - New Algorithm
 - Provides guidance for management of patients with sepsis
 - Lists criteria for both adult and pediatric Systemic Inflammatory Response Syndrome (SIRS)

- **Page 17 Heat Exposure**
 - Added “Obtain body temperature” to algorithm
- **Page 23 Stroke/TIA**
 - Indicates VAN Assessment (P-20) for patients with motor control deficit
 - Emphasizes limited scene time to 10 minutes or less
 - Emphasizes the need to obtain the “time of onset” or “last seen normal time”
 - Lists patient history and S/S that should increase suspicion of stroke/TIA (Box at bottom)
 - History of: CVA/TIA, Cardiac/vascular surgeries, DVT, Diabetes, HTN, CAD, A-Fib, Blood thinners
 - S/S: Altered mentation, Weakness/Paralysis, Visual changes, Sensory loss, Aphasia, Dysathria, Dysphagia, Syncope, Vertigo/Dizziness, Vomiting, Headache, SZ, Respiratory pattern changes, Hyper/Hypotension, Trouble walking/unsteady gait

PROTOCOL SUPPLEMENT CHANGES

- **Throughout Supplement**
 - Date of 3/1/2019 throughout
- **Page i Table of Contents**
 - Page numbers adjusted
- **Drug Index**
 - **Page S-12 Dextrose 10% (D10W)**
 - Removed references to D50W, D25W, and D12.5W)
 - Reflects changes from D50 to D10 for hypoglycemic patients where an IV is obtainable
 - Adult Dosage: Utilizing a 10 drop set (A-set), give wide open bolus, until patient becomes responsive. Once responsive, obtain BGL. If BGL \geq 90mg/dL, slow infusion to a TKO rate and monitor to maintain desired effect. May repeat X 1 if no improvement in LOC AND BGL remains $<$ 70mg/dL
 - Pediatric Dosage: Utilizing a 60 drop set (mini set), give wide open bolus, until patient becomes responsive. Once responsive, obtain BGL. If BGL \geq 90mg/dL, slow infusion to a TKO rate and monitor to maintain desired effect. May repeat X 1 if no improvement in LOC AND BGL remains $<$ 70mg/dL
 - Until current stocks of D50W (25G/50cc) are exhausted or expired, D10W can be achieved by utilizing a 250cc bag of NS and pre-filled D50W. 50cc should be withdrawn from the bag and the 50cc of D50W injected into the bag. This concentration must be well mixed (shaken) and D10W is achieved
- **Page S-18 Fentanyl**
 - Lowered pediatric dosages of Fentanyl to 2mcg/kg slow IV push to a max of 100mcg per single dose
- **Page S-21 through S-23 Ketamine**
 - Added usage to include pain management and sedation prior to electrical therapy under certain circumstances
 - For Pain Management, Ketamine can be used ONLY for patients with:
 - Extended extrication time ($>$ 10 minutes)
 - Severe non-cardiac pain rated at a 9 or 10 WITH noted signs/symptoms of severe pain such as elevated pulse rate, increased BP, obvious significant injury, etc.
 - Dosage is 0.5mg/kg IV or I/O to a maximum of 500mg
 - Given slow IV or IO push (Cannot be given IM for pain management)
 - Cannot be repeated without medical direction permission

- If Ketamine is administered, narcotics CANNOT be administered without contacting medical control for permission
 - If narcotics have been administered, Ketamine CANNOT be administered without contacting medical control for permission
 - Monitor waveform capnography if available
 - For sedation prior to electrical therapy (cardioversion or pacing), Ketamine can be used ONLY for conscious patients that are hypotensive (SBP < 90mmHg)
 - Versed is drug of choice unless hypotensive
 - Dosage is 0.5mg/kg IV or I/O to a maximum of 500mg
 - Given slow IV or IO push (Cannot be given IM for sedation prior to electrical therapy)
 - All uses of Ketamine must be reviewed by a peer reviewer
- **Adult Drug Charts**
 - Removed D50W and replaced with D10W
 - Added Ketamine to charts for pain management
 - Added Ketamine to charts for sedation prior to electrical therapy
- **Pediatric Drug Charts**
 - Adjusted Fentanyl for pain to reflect 2mcg/kg
 - Removed D50W, D25W, and D12.5W and replaced with D10W
 - Added Ketamine to charts for pain management
 - Added Ketamine to charts for sedation prior to cardioversion