

2008 Protocol Errors/Typos & Frequently Asked Questions
(as of March 31, 2010)

- Brown 3 #15 it lists a, b, c, and c it should be a, b, c, and d
- Brown 3 the second #15 should be #16
- Blue 4 & 5 in the box; “epicatrium” should be spelled “epigastrium”
- Red 8 letter A #6 should be Amiodarone 150 mg with 50 ml D₅W (as in #5)
- Green 17 #5d reads “...if cannot be established...” and should read “...if IV cannot be ...”
- Yellow 15 title “OPHTHALMOLOGY” should be spelled “OPHTHALMOLOGY”
- Pink 4 11.a – Pediatric dosage of Midazolam (Versed) is incorrect. Corrected protocol is:

“11 a. Midazolam (Versed) 0.15 mg/kg to a maximum of 3mg or contact OLMC if repeat dosing is necessary.” (*Updated 11/25/09*)
- Pink 6 #3 reads “...normal sale...” and should read “...normal saline...”
- Pink 14 Lidocaine (last line of the chart) has been replaced with Amiodarone, so the lidocaine should have been deleted from this page; Amiodarone dosing for pulseless VT/VF is 5 mg/kg with a max. of 15 mg/kg/dose.
- Gray 1 Delete the word “original” from the first line of §II.C.2 of the *Do Not Resuscitate Guidelines* to resolve conflict with §II.E.
- Gray 8 title “MASS CASULTY...” should be spelled “...CASUALTY...”
- Gray 24 Lidocaine has been replaced with Amiodarone, so the lidocaine should have been deleted from this page
- Gray 25 same as above

FREQUENTLY ASKED QUESTIONS:

(comments/answers from Dr. Diaz – roundtable discussion at WMEMS conference 04/08)

- Red 8 In the Wide Complex Tachycardia protocol – OLMC is required for cardioversion of the middle column patient (BP less than 100), but is not required in column one (BP greater than 100) if the patient becomes “unstable at any time”
RESPONSE – OLMC is not required to cardiovert an unstable patient. However, it is recommended to contact OLMC to discuss premedication if necessary (especially given that a normal or close to normal mental status could potentially indicate a less urgent need for intervention).
- Red 13 #7 The phone icon appears next to transcutaneous pacing, but the only mention of OLMC is to say in the last line, “notify OLMC as soon as possible.”
RESPONSE – OLMC is not required in the decision to utilize pacing. However, it is recommended to contact OLMC to discuss premedication if necessary (especially given that a normal or close to normal mental status could potentially indicate a less urgent need for intervention).
- Green 17 #5b There is a phone icon close to Nitronox. Does that indicate OLMC is required?
RESPONSE – There is no need for OLMC in isolated trauma. Providers should Refer to the Fentanyl guidelines for further detail.
- Yellow 4 #5 For Cyclic Overdose, the phone icon is present but the protocol states only “contact OLMC if further direction is needed...”.
RESPONSE – It is unnecessary to contact OLMC for the initial assessment of Sodium Bicarbonate. OLMC would be necessary if further direction is needed.
- Pink 2 & 11 Pink 2 #9 Requires OLMC before 10 % Dextrose for Blood Glucose less than 80, but Pink 10 #9 (for the same patient) does not.
RESPONSE – This is an error. OLMC would be required for Critical Care/Paramedic only if a repeat dose is necessary.

Updates from 05/21/08:

- 1) Can an Amiodarone drip be piggybacked with a saline drip/line, or do you have to run a separate line?

Yes – you can piggyback the Amiodarone drip with a saline drip.

- 2) Green 19, #3 – in the Nausea/Vomiting protocol it says for ALS providers to establish a large bore IV and then contact OLMC for rate. Why the need to contact OLMC for rate when no where else in the protocols does it mention this need?

This was most likely an oversight in relation to N/V without volume depletion. However, at the top of the page it mentions that “treatment includes correction of volume depletion” and, if this is the case, it may be advisable to contact OLMC for rate.

- 3) Can we use nebulizer treatments with CPAP if we have the type of CPAP that has that in-line capability?

No – this was not the intent for the introduction of CPAP in the protocols and has not been approved by the MDPB at this time. CPAP is currently only mentioned in the Pulmonary Edema protocol (Blue 9/10), not in the Resp. Distress with Bronchospasm protocol (Blue 6/7).

Updates from 06/23/08 – questions posed to Dr. Diaz:

- 1) “In the chest pain protocol, is the first dose of Metoprolol a standing order? It states to call OLMC for repeat doses, but the phone appears to be next to both items.”

You would probably want to encourage a phone call first since this is new for all, but we had written as first dose standing order OK – but I would repeat the encouragement to call when using this since it is a new drug for all.

- 2) “In the Adult Seizure Protocol Gold 8. Do Paramedics need to call for an IM dose of Midazolam? There is no phone next to the dose of Midazolam, however there is a phone next to the option of calling for repeat IM administration of the drug.”

If breaking status epilepticus, then the first benzodiazepine dose is a standing order.

- 3) “The adult dose of Naloxone is 0.1 mg – 2 mg IV/IO titrated to effect, but the pediatric dose for patients greater than 20 kg is 2 mg IV/IO. Why are we automatically giving the pediatric patients the higher dose of Naloxone?”

There is no rebound effect at the pediatric age group – OK to give the higher dose.

- 4) “On Green 17 – the provider calls for permission to give Zofran; for N/V on Green 19 they don’t. Can providers use Zofran for N/V unrelated to narcotic administration?”

Ideally they should call at this point (Green 17), and, yes, they can use Zofran for N/V of any etiology.

Update from 08/06/08

Yellow 17 – clarification on the treatment steps listed at the bottom of the page

In Step 3 – the Cyanokit administration is for Critical Care/Paramedic level only
(per MDPB minutes from Nov. 2007)

Update 01/12/09

Brown 2 - #10

The following question has been asked to be addressed: “Was it the intent that the paramedic must be in the back of the ambulance on all cases where the EMT-I medication is administered without contacting OLMC?”

The paramedic must be in the ambulance, but does not have to be in the patient compartment.

Update 02/18/09

Red 1& 2 - #4 and #12

Regarding “chewable aspirin, 324 mg PO, if not contraindicated by allergy, bleeding/ anticoagulant history, or ulcer disease”.

Question 1: If the patient takes 81 mg ASA each day, we understand that giving 324 mg is ok, correct?

Yes, it is okay.

Question 2: If the patient takes PLAVIX, can we give the 324 mgs of aspirin?

Yes, it is okay.

Question 3: If the patient takes Coumadin, can we give the 324 mgs of aspirin?

Yes, it is okay, but the patient has probably been told by their doctor not to take aspirin – so if they fight you on it, don't force it.

Update 11/25/09

Pink 4 11.a – Pediatric dosage of Midazolam (Versed) is incorrect. Corrected protocol is - “11 a. Midazolam (Versed) 0.15 mg/kg to a maximum of 3mg or contact OLMC if repeat dosing is necessary.”

Update 3/31/10

Pink 14

Pediatric Asystole/pulseless arrest:

Remove:

Subsequent Doses

~~**IV, IO**, 0.1 mg/kg (1:1,000, 0.1ml/kg)~~

~~Repeat every 3—5 minutes~~

~~**IV, IO** doses as High as 0.2 mg/kg of 1:1,000 may be effective~~

Replace
with:

Subsequent Doses

IV, IO, 0.01 mg/kg (1:10,000, 0.1ml/kg)

Repeat every 3 – 5 minutes

Angiocath

Length for

Needle

Thoracostomy:

Although needle thoracostomy for presumed tension pneumothorax is a somewhat common procedure in Maine for critically ill EMS patients, its efficacy has never been demonstrated. Nonetheless, it has been clearly established that most angiocaths used for needle decompression are of insufficient length to penetrate the chest wall and reach the pleural space; this assures failure of the procedure. Therefore, angiocaths or equivalent devices used in needle decompression for adults should be a minimum length of 8 cm (3.25 inch).