Appendix B

Sample Protocols/Guidelines for EMT-Basic Monitoring Pulse Oximetry

GENERAL GUIDELINES

1. Scene size up and determine the mechanism of injury or nature of illness.

2. Initial assessment and treatment to include securing the airway and administering oxygen as indicated by clinical status and pulse oximetry.*

    A. OPA; NPA

    B. ETC; ET *

3. Suction secretions as indicated.

    A. Oropharynx

4. Administer oxygen as clinical status and pulse oximetry indicate.

    A. LOW FLOW: Nasal cannula 4-6 LPM. COPD patients should receive oxygen at 2 LPM unless clinical status and or pulse oximetry indicate otherwise.

    B. HIGH FLOW: Non-rebreathing mask at 10-15 LPM.

    C. Positive pressure ventilations with 15 LPM when indicated.

5. Assign and report a triage code.

6. Apply and monitor ECG as indicated.*

    A. Follow appropriate cardiac algorithms as indicated.

7. Obtain and document vital signs, LOC, history and physical examination. Document medications and bring unknown medications to the emergency room.

8. Consider intravenous infusion.*

A. Keep Vein Open (KVO 20-30 ml/hr) when volume expansion is not indicated. .

B. 250 ml fluid bolus when indicated by clinical status.

C. Wide Open (WO) with macro tubing for volume expansion, as indicated by clinical status.

9. Determine blood glucose level in suspected hypoglycemia. If glucometer reading is <45 mg/dl (<60 mg/dl if symptomatic), consider:

   A. Oral glucose 30 g SL or bucorally, for conscious, tolerant patient.

10. Consider the prehospital stroke evaluation if indicated.

CONTACT MEDICAL CONTROL WITH PATIENT INFORMATION AND FOR FURTHER ORDERS.

13. Transport patient to appropriate medical facility.

* C-spine precautions and full spinal immobilization are indicated whenever the mechanism of injury indicates the possibility of spinal injury.

* Endotracheal intubation with appropriate training

* ECG monitoring with appropriate training.

* Intravenous fluid administration with appropriate training.

* Intravenous fluid administration should be titrated to maintain adequate perfusion. When internal bleeding is suspected that cannot be controlled, increasing perfusion pressure may be detrimental.