

Protocol Changes for Statewide Treatment Protocols, Version 10.01  
Effective March 1, 2012

<b>Protocol or Appendix</b>	<b>Change</b>	<b>Reason</b>
Introduction	Guidelines for care and care delivery specified, and language updated and streamlined.	Clarification, continued streamlining and update
1.2	50j and 100 j removed from energy lists in ALS-P Standing orders and from medical control	AHA guideline
1-1.11;2.1-2.6; 3.1-3.4; 3.7-.16; 4.1-4.10; 5.1-5.3; and 5.5-5.13	Where it states “provide advanced airway management if indicated” add “perform capnography if available”	Reinforce capnography as standard that will be mandatory in 1/1/2013
1.2; 1.3; 1.4; 1.9; 1.11; 3.8; 3.9	Diazepam IN as standing order	Accepted method of giving drug, had only been permitted under MC option
1.2; 1.3; and 1.9	Remove diltiazem drips	Eliminates chance of improper drip dosing, since field units do not use metered IV pumps
1.2; 1.3; 1.4; 1.5; 1.9; 1.11; 3.7; 3.14; 4.2 5.9 and 5.13	Fentanyl 1 mcg/kg. to max. 150 mcg. slow IV push, If no IV access, Fentanyl 1mcg/kg. to max. 150 mcg nasally. REMINDER: this is a weight based medication. This is a one time dose option: For additional doses contact medical control.	Dose and administration clarification for Fentanyl administration under Paramedic Procedures The Reminder add to medical control sections
1.4	Removed “rate determined by physician” from ALS-P medical control orders-2b	
1.4; 1.6; 3.2; 3.5; 3.10; 4.7 and 5.8	Dopamine infusion dose 2 mcg/kg to 20 mcg/kg per minute.	Standardized, changed ug/kg to mcg/kg
1.4; 1.6 and 3.2	Epinephrine drip dosing standardized to 1-10 mcg/min no longer using ug/min. flow rate guideline added, added information to the Epinephrine drug reference	Standardized dosing
1.6	Mandating therapeutic hypothermia do not delay transport. hyperlinked to Appendix V. a. mandating therapeutic hypothermia, without causing delay in transport b. Title of 1.6 changed to Post-Cardiac Arrest Care/Return of Spontaneous Circulation (ROSC) c. Dopamine dose changes to 2-20 mcg under Paramedic procedure e. Epinephrine drip added as a MCO also under ALS-P medical control options 2-3 <sup>rd</sup> bullet Amiodarone added the following wording “bolus as ordered follow by”	Standard of care

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1.7	Removed PVC protocol 1.7	No longer used, PVCs are only treated when associated with conditions treated with other protocols. Eliminates chance of accidentally giving toxic meds for inadequate reason
3.7	Metoprolol dosing added 2.5 to 5 mg slow IV push over 2 minutes Under MCO 2d.	Standardize dosing
3.13	Basic and Intermediate intranasal Naloxone, in accordance with approval by the service's affiliate hospital medical director	Increases access of Naloxone to opiate overdose patients (supports DPH/Bureau of Substance Abuse initiative under which nasal Naloxone is being provided by trained laypersons).
3.14	Added IM/SC/IO to morphine routes under standing orders and medical control	Accepted method of giving drug
3.14 and 5.13	Ondansetron IM as standing order	Accepted method of giving drug
5.1; 5.2; 5.3 and 5.5	Epinephrine drip dosing standardized to mcg/kg/min -no longer using ug/kg/min.	Standardized dosing
5.1	Lidocaine 2%, 1mg/kg IV or IO has been deleted also in ALS-standing orders removed the words "12 lead ECG"	Not required as MCO, not a standard of care
5.3	Naloxone administration via the ETT deleted	Not an effective route for administration
5.7	Dextrose and Naloxone doses added to the MCO also Removed the word "additional" from in front of Naloxone in the ALS-P medical control options	Eliminates the need to refer to the previous protocol
5.9	Midazolam doses: 6 mo-5yrs 0.05-0.1 mg/kg IV or nasal to a maximum dose of 5 mg. 6-12 years 0.1 mg/kg IV or nasal to a maximum of 5 mg. Maximum dose of Midazolam changed to 5 mg in 6-12 years dosing	Standardized dosing-weight based.
5.10	Maximum dose of Midazolam changed to 5 mg in 6-12 years dosing	Standardized dosing

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5.13	Added IO to morphine route medical control	Accepted method of giving drug
Appendix A	Make morphine an optional medication rather than required (fentanyl is already required)	Allows services to reduce the amount of controlled substances carried
Regarding Epinephrine Drug Reference	removed “if given ET...” from special considerations	Not a standard method of administration
Appendix B	Add MOLST to Comfort Care/DNR Verification Order Appendix and elsewhere as indicated.	Based on positive results of pilot project, and in accordance with statute, statewide implementation in this advance in end of life care across the health care continuum.
Appendix I	Albuterol advisory date was updated to the 4/9/10 memo date also Added c under BLS condition-it reads: c. Intranasal Naloxone (Service Option), with approval of service’s Affiliate Hospital Medical Director	Recent date  Increases access of Naloxone to opiate overdose patients
Appendix K	Appendix K protocol-process simplified for submitting change requests. -Deadline for submission of proposed changes to chair of MSC is fixed as October 1 of the preceding year. -Protocol changes to be implemented by the department shall be issued no later than February 1 of each year, with implementation no later than March 15 by EMS services unless the department specifies a longer window of issue or implementation	Simplifies process
Appendix N	-Clarify appropriate staffing during IFT transport; clarify training for IFTs to explicitly require refresher training every 2 years and whenever new equipment or medication is approved for use on IFT calls; -In Part 2 General Protocols, language added to clarify capnography use in accordance with 1/1/2013 implementation deadline.	Clarification to minimize confusion on these points
Appendix R	Adopted the AHA’s Fibrinolytic checklist	Current AHA recommendation

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Appendix V	Formalize therapeutic hypothermia protocol as Appendix V	Establishes a consistent standard for care
Appendix W	Add new Special Considerations Protocol	Guidelines for treating patients with special considerations – first category, included in this version, is for patients with Ventricular Assist Devices (VADs).