San Andreas Emergency Management

Emergency Medical Protocols Guide

SAN ANDREAS DEPARTMENT OF HEALTH
BUREAU OF EMERGENCY MEDICAL SERVICES

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Section 1.01.0

Purpose and Intent

The purpose of this document is to make an outline for all emergency responders to follow in any medical emergencies. These protocols are subject to change at any time by the State of San Andreas's Board of Emergency Medical Services Directors. All protocols are to be followed on a case-by-case basis. If you have any questions or concerns, please reach out to online medical control or a member of the San Andreas Health Network COC.

"Be it pledged as an Emergency Medical Technician, I will honor the physical and judicial laws of God and man. I will follow that regimen which, according to my ability and judgment, I consider for the benefit of patients and abstain from whatever is deleterious and mischievous, nor shall I suggest any such counsel."

This document intends to provide an outline of standardized care and procedures to be used by the first responders of the State of San Andreas so that the highest quality of treatment is provided to all citizens no matter status, race, sex, orientation, religion, or identity.

Signed by:
Joe P. 1500
Nick K. 1089
Mike L. 1100

Approved By HA: / /

Emergency Management Administration

Section 1.02.0
Patient Rights

1.02.1 Definition of a Patient

A patient is any person(s) who has requested or requires care/assistance from any first responder in any capacity.

1.02.2 Patient Bill of Rights

All patients have certain rights that at no time can be deviated from or broken; all patients have the right to the following:

- *Treatment of a medical condition(s) that will deteriorate if not provided proper care and support.*
- *Information regarding a diagnosis, planned course of treatment, prognosis, alternatives, and risk from the health care provider.*
- *Refuse treatment so long as they are in a mental capacity and state of mind to do so.*
- *Be treated with courtesy and respect, appreciation for their dignity, and respective privacy.*
- *Impartial access to medical treatment and/or accommodation, regardless of race, ethnicity, religion, handicap, or source of payment.*

In turn, all patients are expected to do the following:

- *Provide the healthcare provider with accurate and up-to-date information regarding their complaints and past medical history.*
- *Make sure that if they refuse medical care, their actions are those of their own.*

Section 1.03.0
Patient Refusal

1.03.1 Refusal of Medical Care / Transport

All patients maintain the right to refuse medical care or transportation so long that they are in the right mental capacity or state to do so. To determine this providers must do the following.:

- Make sure the patient is alert and oriented to their environment, some common questions that are asked are:
  - ***What is your name?***
  - ***Where are you right now?***
  - ***Do you know what day or time it is?***
  - ***Can you tell me what is happening right now?***
- The next step is to ensure they value their life and the lives of others. The patient must have the capacity to decide for themselves.

  Once all of the following has been established, you must fill out the patient refusal form and have the patient sign it accepting they understand the refusal terms.

1.03.2 Refusal of Medical Care / Transport - Patients in LEO Custody.

If a patient is in custody either by a State correctional facility or is detained by a Law Enforcement Officer, they may still refuse treatment or transport so long as the patient has the mental / decision-making capacity to do so. Due to the patient more than likely being in handcuffs or unable to sign, the Law Enforcement officer will sign for the patient. This will fall under involuntary consent. This however means that the LEO officer is charged with their care. As a result, the Law Enforcement officer can request that the patient be transported to the hospital for

further treatment and evaluation–the patient will not have the right to refuse.

Section 1.03.0
Patient Refusal

1.03.3 **Refusal of Medical Care / Transport - Minors**

A minor is defined as a person(s) who is under the age of 18 years and is not emancipated by a court ruling.

Minors do not reserve the right to make decisions regarding medical care for themselves. In cases where you are dealing with minors who wish to refuse medical care or transport, you must have a parent or legal guardian confirm the decision and sign the form on behalf of the patient. If there is not a parent or guardian available or cannot be contacted, the patient will be treated under implied consent. Follow all local protocols for treatment and transport–ensure every effort is made to contact the parent or legal guardian.

1.03.4 **Refusal of Medical Care - Advisements**

When a person(s) decides to refuse medical care or transport the medical provider must do the following:

- *Advise them of the risk associated with refusal of medical care.*
- *Advise them to seek care if the condition(s) persist, get worse, or if there is a new development.*
- *Advise them they can always contact Fire/EMS for re-evaluation and treatment.*
- *Have them sign the patient refusal form.*

1.03.5 **Refusal of Medical Care - Altered Patients**

In the case that you deem that the patient is unable to follow 1.03.4 to decide for themself, they will be considered altered. They will now be considered under implied consent and all medical treatments will continue as if they are of sound mind and oriented. It is then up to the provider of where the patient will be transported to seek proper medical attention.

1.03.5 **Refusal of Medical Care - Unconscious Patients**

An unconscious person(s) are unable to refuse care and will be treated under implied consent. This will continue until consciousness is regained and an unaltered status is confirmed for the patient to refuse.

Section 1.04.0
Patient Transportation

1.04.1 Transfer of Care and Transportation

It is the emergency responders' responsibility to make the best treatment plan for the patient's needs. This involves what treatments to perform, what facility to take the patient to, and who to hand them off to. You may never hand off a patient to a person whose care level is below yours. The patient is your responsibility until you hand them off to the appropriate certified medical caretaker.

As part of your patient transfer of care, you are to give the receiving facility a verbal report and get a signature on your patient care report.

Make sure to follow all response policies when transporting patients and take extra caution to ensure patient safety. It is recommended to call the facility ahead of time when transporting to notify them. The current response policies can be found here.

While in transport the following must take place if time allows:

- Call forward to the ER with patient details
- Perform a secondary assessment
- Continue treatment plan

For Staffed ERs hand patients off to ER staff

Non-staffed ERs utilize the hospital script.

Note: if you intend to treat a patient while en route to the ER, the patient must sit in one of the seats of the ambulance and not the stretcher.

Section 1.04.0
Patient Transportation

1.04.2 ER Care Levels

For your patient's best chance of survival make sure to transport them to an ER that has the resources capable of taking care of them. In San Andreas, there are 5 different levels of ERs.

Level I
The Trauma Center is a comprehensive regional resource that is a tertiary care facility central to the trauma system. A Level I Trauma Center is capable of providing total care for every aspect of injury – from prevention through rehabilitation.

Level II
A Level II Trauma Center can initiate definitive care for all injured patients.

Level III **Level III Trauma Center has demonstrated an ability to provide prompt assessment, resuscitation, surgery, intensive care, and stabilization of injured patients and emergency operations.**

Level IV
A Level IV Trauma Center has demonstrated an ability to provide advanced trauma life support before the transfer of patients to a higher-level trauma center. It provides evaluation, stabilization, and diagnostic capabilities for injured patients.

Level V
A Level V Trauma Center provides initial evaluation, stabilization, and diagnostic capabilities and prepares patients for transfer to higher levels of care

1.04.2 ER Care Levels

LEVEL:	NAME:	POSTAL:	TRAUMA	PEDS	BURN	CARDIAC	HB CHAMBER	PSYCH	STROKE	ICU
I	Pillbox Hill MC	162	✔	✔	✔	✔	✔	✔	✔	I
II	Roxwood MC	1112	✔	✔		✔	✔		✔	II
III	Sandy Shores MC	822	✔	✔		✔	✔		✔	III
V	Paleto Bay Care Center	1022	DO NOT TRANSPORT							

Section 1.04.0
Patient Transportation

1.04.3 Utilization of Life Flight

Life Flight should be utilized if it can improve the chance of the patient surviving. Make sure to keep the following in mind.:

- *Obstructions*
- *Landing Zone*
- *2 or more fire department/ems personnel on the scene*
- *Time to get to the scene and the ER*
- *Weather conditions*

If conditions are met, clear a landing zone of approximately 100x100 feet for the helicopter to land or deploy a rescue basket. Stay in constant communication with the aircraft operator.

Alternatively, you can also rappel people up Into an aircraft if an LZ can not be cleared With appropriate certifications and training.

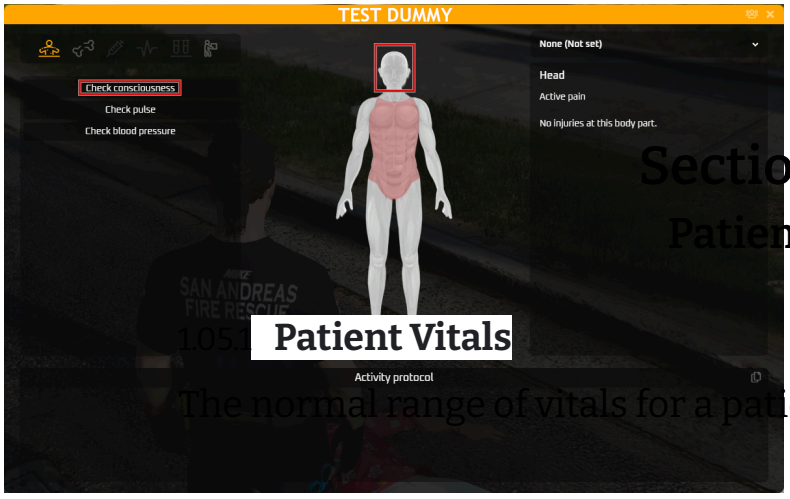


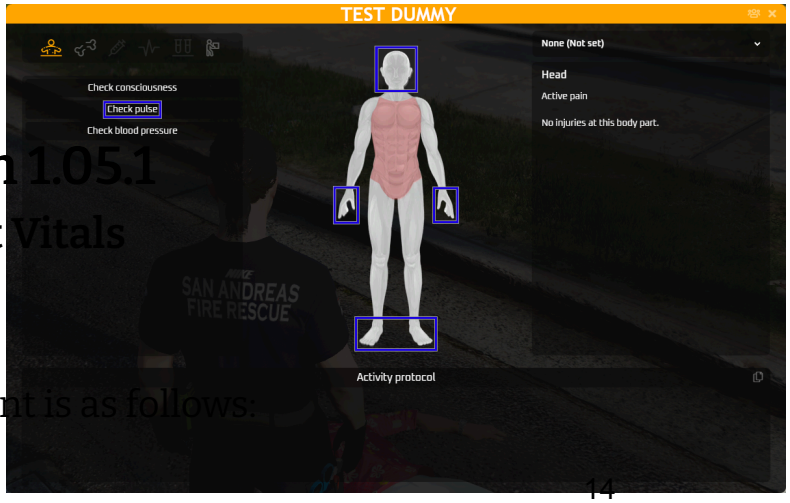
Section 1.05.0

Patient Assessment

To effectively and efficiently do a patient assessment do the following steps:

1. Make sure your scene is safe, and you have adequate resources for all patients.
2. Use the “H” Muscle to open the medical menu for **your** patient, if assessing **yourself** use the “Y” Muscle.
3. Do A full body Assessment of wounds.
4. The more severe the wounds the darker red they will appear.
5. Check to see if your patient is conscious.
   Medical Menu > Click on Head > Check Responsiveness
6. Check to see if your patient has a pulse.
   Medical Menu > Click anything but chest > Check Pulse
   - 6.1 If the Patient has no pulse follow protocol **3.01.01 Cardiac Life Support**
7. Check and treat any severe bleeding by **Protocol 2.01.01.**
8. Start Treating any Other Symptoms.
9. Perform a secondary assessment of wounds by **2.00.00**





Section 1.05.1

Patient Vitals

1.05.1 **Patient Vitals**

The normal range of vitals for a patient is as follows:

VITAL:	EXTREME LOW	LOW	NORMAL	HIGH	EXTREME HIGH
Pulse	0 - 20	21 - 40	60 BPM	150	250
BP Top	0 - 49	50 - 90	120	190	300
BP Bottom	0 - 59	60- 70	80	120	200
PATIENT PRESENTATION	CARDIAC ARREST	UNCONSCIOUS OR INJURED	The patient is doing well	INJURED	UNCONSCIOUS

If a patient's Vitals get too high they may go into cardiac arrest due to the strain on their body and low oxygenation to the brain.

1.05.2 **Patient ECG**

A normal sinus rhythm will look like the one below:



If there are any disruptions to the rhythm of the heart the patient can go into an arrest which is why it is imperative to find the cause of the arrhythmia and correct it.

Section 1.06.0
Patient Death

1.06.1 Patient Death

A patient's death can result from a multitude of issues, the most important thing to recognize is the signs of death and when to declare a patient deceased. It should also be noted that every death of a suspicious nature will be investigated so at that moment, it will become a crime scene.

1.06.2 Recognition of Death

If a patient presents with vitals or an injury incompatible with life (decapitation), bloating of the skin, severe decomposition, rigor mortis, fixed or dependent lividity, or is in a stage of decomposition they may be declared dead without a phone call to an ER physician.

1.06.3 Termination of Resuscitation

After 10 rounds of CPR or 10 minutes of resuscitation efforts if a pulse or shockable rhythm is not present the paramedic provider will load the patient and Emergently transport the patient to the closest most appropriate emergency room. No A-EMT or Paramedic will declare a patient in the field unless otherwise noted by the said patient and their decision to “Perma Kill” that said person.

1.06.4 Documentation and Reporting of a Death

Documentation of a death report is mandatory by the state of San Andreas. Make sure to include details of the death so that if an investigation does take place they have the needed information. If a death occurs in a suspicious circumstance, you must report it to the proper investigation agency.

Section 1.07.0
General Procedures

1.07.1 Responding to a crime scene

If a responder has to enter the scene of a crime or suspected crime, precautions should be taken to not contaminate the scene. Try to avoid displacing anything, leaving trails, or trash. Make sure to document every action that took place within the scene in your PCR. **You can never be denied access to a patient due to it being a crime scene unless the scene is currently not safe.**

1.07.2 Responding to a volatile or hazardous scene

If responding to a scene and it becomes hazardous or volatile, remove yourself, and if able, the patient immediately if they are not a threat. Call LEO and if needed request a TEMS activation from a COC member or a LEO supervisor. If unable to speak due to the circumstance, activating your panic button is always an option.

1.07.3 Triage

- Green Tag Patients are defined as patients who are stable and unlikely to decompensate and able to self-ambulate.
- Yellow Tag Patients are patients who are currently stable but have the potential to decompensate and usually are unable to self-ambulate.
- Red Tag Patients are patients who are unstable and need immediate attention from an emergency room.
- Code Blue Patients are any patients in cardiac arrest. Once ROSC is obtained you should wait approximately 5 minutes to stabilize and then transport to the nearest most appropriate facility.
- Black Tag is any patient who is declared deceased on the scene.

Section 1.07.0
Procedures

1.07.4 Chest Pain

Any patient who has a chief complaint of chest pain or discomfort should be placed on a 12-lead EKG and an IV attempted to be started. Always obtain a second 12-lead EKG strip.

1.07.5 Code Yellow Patients

Any Person(s) who has been triaged as a code yellow or higher is required to have an IV established.

1.07.6 PCR's

All personnel are required to file a PCR report for every person they encounter failure to do this can and will result in an investigation for negligence and can result in suspension–or possible termination–of license.

All PCRs will be reviewed by a member of the CoC if a report is not satisfactory all persons will be issued a 5-day Grace period to fix the report. Failure to fix the report may result in disciplinary action.

1.07.7 Patient Transportation

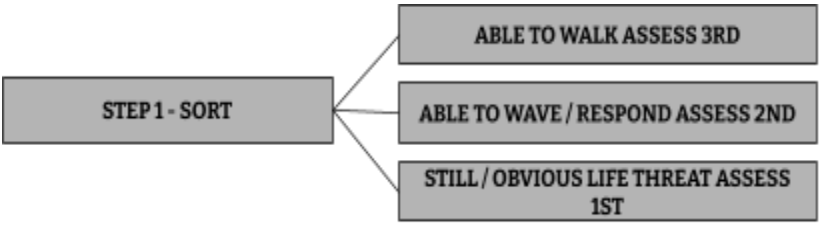
All personnel are required to take a patient to an ER that is staffed by medical professionals based on their medical needs. Failure to do so is considered patient abandonment.

Section 1.08.0
Mass Casualty Incidents (MCI's)

1.08.1 MCI Definition

An MCI is defined as an incident that requires more resources than are readily available to respond. This can be from a man-made or natural disaster.

1.08.2 MCI Steps



Section 1.09.0
Logistics

1.09.1 Care Levels

The San Andreas Health Network is an Intermediate Life Support Service (ILS), with all providers having a minimum of an AEMT certification. Providers are expected to be able to handle critical patients and provide intermediate cardiac care until the patient is either transported to a care facility or until an ALS provider can take over.

AEMT - An Intermediate Life Support person(s) with the ability to start IVs and do limited cardiac monitoring and medication administrations.

Paramedic - Advanced Life Support person(s) with the ability to perform many procedures and do advanced cardiac monitoring support measures.

Hospital Staff - Staff trained to provide high-quality advanced care in the clinical settings, this includes nurses and doctors.

A	ADVANCED EMERGENCY MEDICAL TECHNICIAN
P	PARAMEDIC
ED	EMERGENCY DEPARTMENT STAFF

1.09.2 Care Levels Apparatus

Every Apparatus is assigned a care level based on what resources are available only a level 1 apparatus can transport a patient(s).

Level 1: Has ALS and ACLS equipment on board along with staffing that is needed to provide the care needed in nearly any medical situation along with resources needed to transport patients over long distances.
Examples: Ambulance's, Aircare, Eagle

Level 2: Has ALS and ACLS equipment and staff to provide prompt quality care but is not able to transport patients.
Examples: Fly Cars

Level 3: Has ALS equipment and staff to provide prompt quality care but is not able to transport patients or provide in-depth cardiac life support.
Examples: Engine, Tech Rescue, Heavy Rescue, Squad

Level 4: Has BLS equipment to provide prompt care but is not able to transport patients or provide in-depth
Examples: Mobile Medic, Crab, LEO Vehicles

Section 2.01.0
Wound Care / Treatment

2.01.1 Wound Types

Abrasions - Caused by friction against a rough surface, normally caused by falling.

Bandaging Protocol:
Level 1 - Field Dressings
Level 2 - Elastic Bandage
Level 3 - Quick Clot & Field Dressing
Level 4 - Tourniquet

Treatment Protocols:
If BP is Low Administer Saline (Blood)
Fentanyl For Pain
REQUEST ALS FOR STITCHES IF NEEDED

Avulsions - Forceful removal of a body structure from a force.

Bandaging Protocol:
Level 1 - Field Dressings & Quikclot
Level 2 - Quick Clot & Field Dressing
Level 3 - Quick Clot & Field Dressing
Level 4 - Tourniquet

Treatment Protocols:
If BP is Low Administer Saline (Blood)
Fentanyl For Pain
REQUEST ALS FOR STITCHES IF NEEDED

Contusions - Forceful trauma that damages internal structures.

Bandaging Protocol:
Level 1 - Field Dressings
Level 2 - Elastic Bandage
Level 3 - Quick Clot & Field Dressing
Level 4 - Tourniquet

Treatment Protocols:
If BP is Low Administer Saline (Blood)
Fentanyl For Pain
REQUEST ALS FOR STITCHES IF NEEDED

Crush - Wounds where the skin has split and tearing of underlying structures has occurred.

Bandaging Protocol:
Level 1 - Field Dressings
Level 2 - Elastic Bandage
Level 3 - Quick Clot & Field Dressing
Level 4 - Tourniquet

Treatment Protocols:
If BP is Low Administer Saline (Blood)
Fentanyl For Pain
REQUEST ALS FOR STITCHES IF NEEDED

Section 2.01.0
Wound Care / Treatment

2.01.1 Wound Types

Cuts - Slicing wounds that produce even edges.

Bandaging Protocol:
Level 1 - Field & Elastic Dressings
Level 2 - Quick Clot
Level 3 - Quick Clot & Packaging Bandages
Level 4 - Tourniquet

Treatment Protocols:
If BP is Low Administer Saline (Blood)
Fentanyl For Pain
REQUEST ALS FOR STITCHES IF NEEDED

Lacerations - Wounds that produce ragged edges.

Bandaging Protocol:
Level 1 - Elastic Bandages
Level 2 - Quick Clot & Elastic Bandages
Level 3 - Quick Clot & Packaging Bandages
Level 4 - Tourniquet

Treatment Protocols:
If BP is Low Administer Saline (Blood)
Fentanyl For Pain
REQUEST ALS FOR STITCHES IF NEEDED

Velocity Wounds - Wounds caused by objects normally small at high speeds,

Bandaging Protocol:
Level 1 - Elastic Bandages
Level 2 - Quick Clot & Elastic Bandages
Level 3 - Quick Clot & Packaging Bandages
Level 4 - Tourniquet

Treatment Protocols:
If BP is Low Administer Saline (Blood)
Fentanyl For Pain
REQUEST ALS FOR STITCHES IF NEEDED

Puncture Wounds - Deep narrow wounds produced by sharp objects.

Bandaging Protocol:
Level 1 - Packaging Bandages
Level 2 - Quick Clot & Packaging Bandages
Level 3 - Quick Clot & Elastic Bandages
Level 4 - Tourniquet

Treatment Protocols:
If BP is Low Administer Saline (Blood)
Fentanyl For Pain
REQUEST ALS FOR STITCHES IF NEEDED

Section 2.02.0
Field Stitching

PARAMEDIC

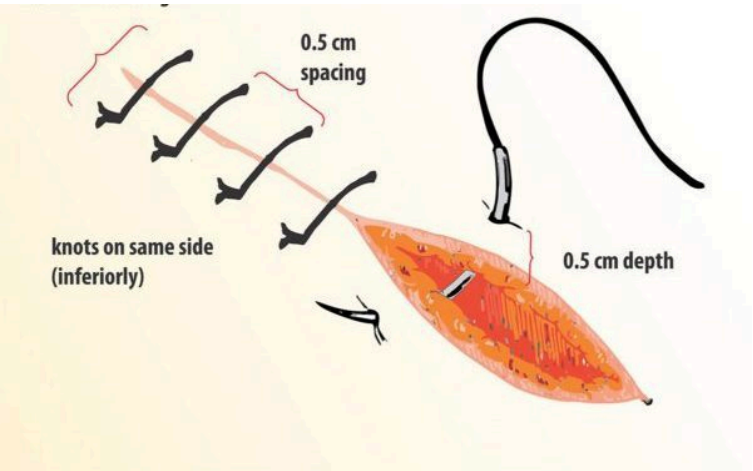
2.02.1 Field Stitching Requirements

To perform field stitches the following requirements must be met:

- ☐ A Sterile Area to Perform Procedure
- ☐ A need for the stitches
- ☐ No Active ER within 2 miles
- ☐ A partner to help with the procedure

2.02.2 Field Stitching Procedure

1. Gather materials
   - Surgery Kit
   - Gloves & Mask
   - Field Dressing
   - 500 mL Saline (Blood)
   - 2 Doses Fentanyl
2. Start Patient on 500 mL Saline at 5 mL / Min
3. Administer 1 dose of fentanyl and reevaluate pain in 5 min if needed administer 2nd dose
4. Control all Bleeding
5. Thread needle and use stitching technique to close wound
6. Cover wound with field dressing monitor vitals and transport to ER
7. Document on PCR



Section 2.03.0
Shock Care

2.03.1 Shock

Shock is a word used to describe the body's state of being after suffering an injury. There are two major types of shock that the provider needs to look out for:

Compensated - The body is attempting to compensate for the damage done to the body this can cause some noticeable changes,

Looks Like: Elevated Pulse, BP, Cold, Cool, Clammy Skin

Decompensated - The body is no longer able to keep up with the demand due to the injury and is giving up organ failure will start to set in.

Looks Like: Blood Pressure and pulse Drops, Patient becomes altered or unresponsive.

2.03.2 Shock Treatment

The shock treatment is the same for either stage, however, with decompensated shock time is life.

Start of Fluids and manage Heart Rate and Blood Pressure

Do:	Don't:
Give Saline (Blood)	Give Morphine (Tanks Blood Pressure pulse)
EPI as a last resort	Give any food, due to surgery
Control Bleeding and wounds	
Start on an ECG if not done	
Transport rapidly	
Request ALS if not on scene.	

Section 2.04.0
Blood Loss Measures

2.04.1 Bleeding Classifications

The amount of blood loss will affect how the person feels. Keep in mind a normal person has 5 Liters of blood in their body. (6 Liters is standard for the script)

CLASS	AMOUNT OF BLOOD LOSS	SYMPTOMS
I	0.1 - 0.8 Liters	**NO NOTICEABLE, EXTERNAL HEMORRHAGE**
II	0.9 - 1.7 Liters	**"LOST SOME BLOOD" WARNING, WEAKNESS**
III	1.8 - 2.3 Liters	**"LOST A LOT OF BLOOD" WARNING, WEAKNESS**
IV	2.4 - 2.9 Liters	**"LOST A LARGE AMOUNT OF BLOOD" WARNING, UNCONSCIOUSNESS**
V	3 or More Liters	**"LOST A FATAL AMOUNT OF BLOOD" WARNING, UNCONSCIOUSNESS, DEATH**

2.04.2 Fluid Intervention Protocol

CLASS	Blood Loss	Fluid Intervention	Considerations
I	0.1 - 0.8 Liters	**250 mL**	**None**
II	0.9 - 1.7 Liters	**250 - 500 mL**	**None**
III	1.8 - 2.3 Liters	**500 - 750 mL**	**No Morphine, Bilateral IV's**
IV	2.4 - 2.9 Liters	**750 - 1000 mL**	**No Morphine, ER Notification**
V	3 or More Liters	**1000 mL**	**No Morphine, ER Notification**

If a patient has a blood pressure that is below 90/50 mmHg consider administering fluids in more than one limb to raise the blood pressure faster.

Note do not exceed the recommended fluid limits or the patient will have a hypertensive emergency.

Section 2.05.0
Traumatic Pain Management

ADVANCED MEDICAL TECHNICIAN

2.05.1 Traumatic Pain Management

If a trauma patient is in severe pain (Over a 7 rating), the practitioner should consider the following.
- Is there trauma? - What are their vitals? - Are their wounds controlled?

Fentanyl Indications:
For extreme pain with abnormally high vitals
Pulse: 222 Lower Blood Pressure: 200/100 Lower

Notes: Fentanyl takes approximately 15 Seconds after administration to take effect and is most effective after 30 seconds

Side Effects: Will raise pulse and blood pressure by 35 marks.

Instruction, administer 1 dose and reevaluate vitals after 30 seconds if pulse is 190 + do not administer again. A maximum of 4 doses may be administered. For additional doses contact the medical control

PARAMEDIC

Morphine Indications:
For extreme pain with abnormally high vitals
Pulse: 155 + Blood Pressure: 150/90

Notes: Morphine takes approximately 15 Seconds after administration to take effect and is most effective after 30 seconds

Side Effects: Will lower pulse and blood pressure by 35 marks. May cause susceptibility to future injuries.

Instruction, administer 1 dose and reevaluate vitals after 30 seconds if the pulse is under 120 do not administer again. A maximum of 2 doses may be administered.
Suspected Overdose: For suspected overdoses administer 1 dose of epinephrine

Section 2.06.0
ER Trauma Care

EMERGENCY DEPARTMENT STAFF

2.06.1 Traumatic Pain Management

Stage I:
If prehospital pain treatment has not been successful administer subsequent doses of fentanyl until vitals reach the following:
Pulse: 155 +
Blood Pressure: 150/90 +

Stage II:
Reevaluate pain after each dosage of fentanyl. If pain persists, start on a 500 mL saline (blood) transfusion, administer a dosage of morphine, and evaluate vitals.

If the patient overdoses on morphine or that the patient becomes hypotensive or bradycardiac, administer 1 dose of epinephrine and allow 30 sec to react. If the patient does not react, administer 1 subsequent dose of epinephrine.

Stage III:
If pain is still present, start a patient on general anesthesia by administering 250 mg propofol. Wait 50 Seconds for the drug to take effect. Then grab an emergency revive kit and administer it to the patient, allow the anesthesia to wear off, and reexamine the patient. Keep the patient under observation for 24 hours then if there are no complications you may discharge the patient.

Anesthesia Time Delay: 50 Seconds
Anesthesia Effective time: 200 Seconds
Notes: There is no current reversal for anesthesia.

((If the patient still has an altered walking pattern, reset it in the /emoteui menu.)

Section 2.06.0
ER Trauma Care

EMERGENCY DEPARTMENT STAFF

2.06.2 Traumatic Wound Management

Stage I:
If prehospital pain treatment has not been successful continue to bandage all wounds and reassess if stitching is needed.

Stage II:
If stitching is required, start on a 250 ML saline infusion if not done already and administer one round of fentanyl if not done already. Then promptly follow Protocol 2.02.0 Field Stitching

Stage III:
If bleeding does not subside with stitches or the patient still has wounds that have not cleared try to bandage again.

For contusions that do not go away give a round of fentanyl and additional fluids until the patient's pulse and blood pressure are or are higher than normal limits.

Once completed, administer x1 dose of morphine in the affected area.

For suspected overdose give epi.

Stage IV:
After all actions have been taken and if wounds are still present apply a tourniquet to the affected area if applicable then put the patient under general anesthesia by administering 250 mg propofol. Wait 50 Seconds for the drug to take effect. Then grab an emergency revive kit and administer it to the patient, allow the anesthesia to wear off, and reexamine the patient. Keep the patient under observation for 24 hours then if there are no complications you may discharge the patient.

Anesthesia Time Delay: 50 Seconds
Anesthesia Effective time: 200 Seconds
Notes: There is no current reversal for anesthesia.

Section 2.07.0
C-Spinal Precautions

2.07.1 C-Spinal Precautions

If one of the following C-Spinal Precautions should be put in place,

- Fall from 30 or, more feet
- MVA with speeds over 45 mph
- Head neck or back pain
- Spinal deformity
- Unknown Trauma
- Drowning / Water Rescue

To take these precautions you will have to place the patient in a C-Collar then whenever you move the patient move them onto a backboard or basket.

2.07.1 C-Spinal Precautions Seated Positions

If you have a patient in a seated position apply a KED then remove them from the vehicle and onto a backboard if able.

Section 3.01.0
Cardiac Life Support

3.01.1 Advanced Cardiac Life Support

Required Resources:

- 1 - 3 Rescuers
- X10 Epinephrine Doses
- X2 500 mL Saline (Blood)
- Defibrillator
- X5 Fentanyl Doses
- Lifepak Monitor
- X 2 Morphine Doses

Step 1: Either manually take a pulse or apply an ECG (Do not take a pulse while CPR is being performed you will get a false positive.

Step 2: If there is still a pulse present do one of the following:
- If over 30 BPM Give a dose of fentanyl and start on 500 mL of saline (Blood)
- If the pulse is under 30, administer a dose of epinephrine.
- Treat wounds with no need for CPR

Step 3: Apply an ECG if not done and Start CPR
- If there is more than one provider switch who does CPR after every round (Make sure all providers have needed medications on hand)

Step 4: After every round of CPR recheck ECG
- If there is a return of electrical activity, give epi rapidly. **(If present you will have 6 seconds)**

Step 5: If there is no electrical activity Shock the Patient with a defibrillator
- If there is a return of electrical activity, give epi rapidly. **(If present you will have 6 seconds)**

Step 6: If there is no electrical activity administer 1 round of epi and repeat steps 3 - 6

Note:
*1 If there is still active bleeding, have someone work to patch wounds while CPR is being done if it does not intervene.

*2 If fluids are administered and there is no pulse the fluids will not enter the body.

Section 3.01.0
Cardiac Life Support

EMERGENCY DEPARTMENT STAFF

3.01.2 ER Cardiac Life Support

Required Resources:

- 1 - 3 Rescuers
- X10 Epinephrine Doses
- X2 500 mL Saline (Blood)
- Defibrillator
- X5 Fentanyl Doses
- Emergency Revive Kit
- Lifepak Monitor
- X 2 Morphine Doses

Stage I: Follow **Protocol 3.01.01** once attempts are considered futile move to section 2

Stage II: Ignore this section if the patient wishes to be declared dead or if wounds are realistically unable to be resuscitated.
After all actions have been taken and if there are no cardiac rhythms put the patient under general anesthesia by administering 250 mg propofol. Wait 50 Seconds for the drug to take effect.
Then grab an emergency revive kit and administer it to the patient, allow the anesthesia to wear off, and reexamine the patient. Keep the patient under observation for 24 hours then if there are no complications you may discharge the patient.

Anesthesia Time Delay: 50 Seconds
Anesthesia Effective time: 200 Seconds
Notes: There is no current reversal for anesthesia.

3.01.3 ER Cardiac Life Support

If the patient does not wish to be revived, administer 150 mg of Propofol and administer a lethal dose of epinephrine / Morphine. Once done mark the patient as a black tag and declare death.

Section 3.02.0
Cardiac Procedures

ADVANCED MEDICAL TECHNICIAN

3.02.1 ROSC Procedures

If ROSC is achieved the following should be done.

1. Support Pulse and blood pressure with fentanyl and IV fluids
2. Patch all wounds
3. Transport to the nearest Cardiac Center

3.02.2 Low Pulse Procedures

Moderate Bradycardia (> 35 bpm):
Administer 1 dose of fentanyl and reexamine after 30 seconds.
Reevaluate vitals, and administer subsequent doses up to 4 doses. For any additional doses contact medical control.

Severe Bradycardia (< 35 bpm):
Administer 1 dose of epinephrine and reexamine after 30 seconds.
Reevaluate vitals, and administer subsequent doses up to 2 doses. For any additional doses contact medical control.

PARAMEDIC

3.02.2 High Pulse / Blood Pressure Procedures

Tachycardia / Hypertension (145 + or 160/120):

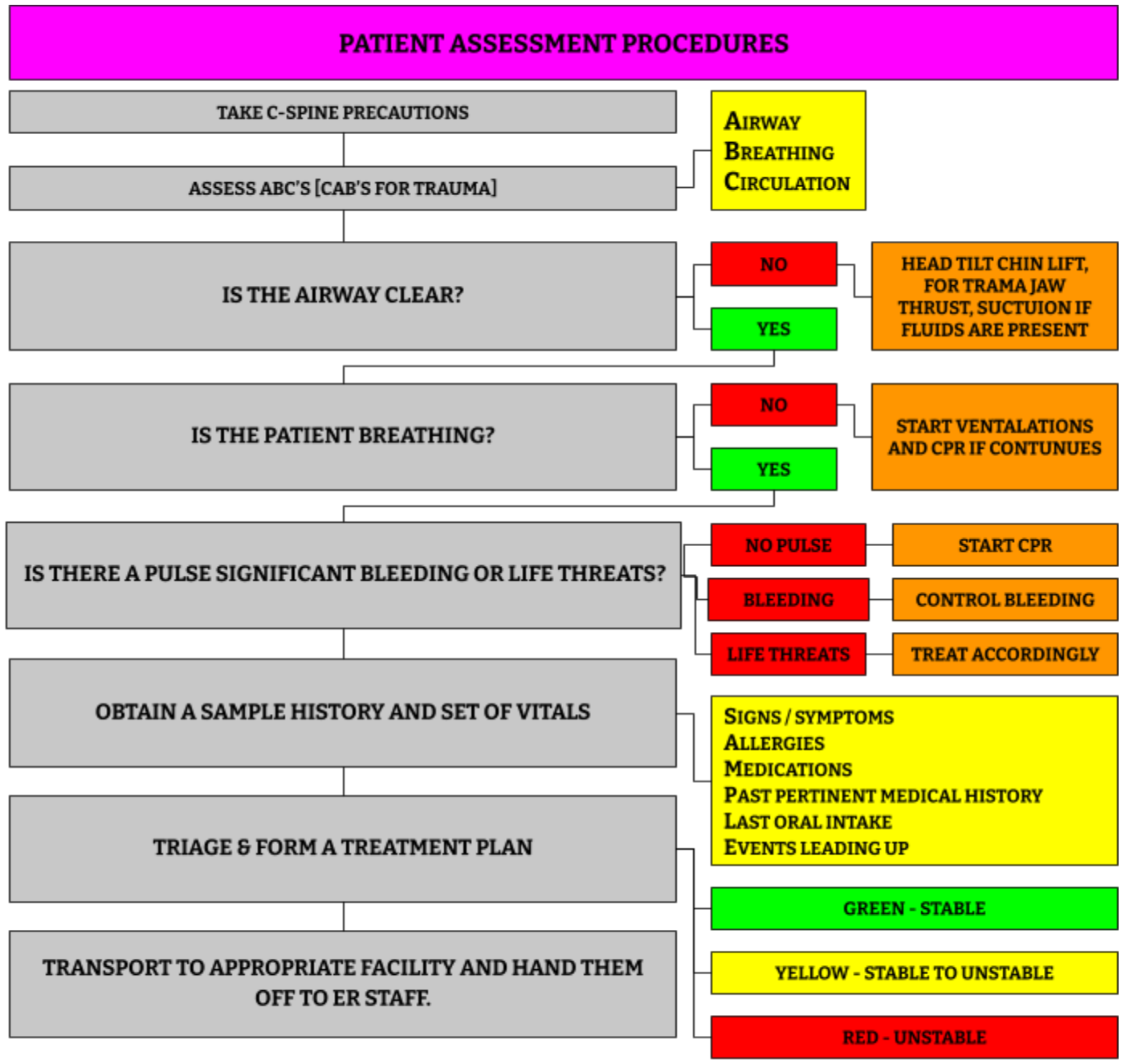
- Start the patient on an ECG and evaluate cardiac status
- If ILS, request an ALS Provider if none is present then transport to the emergency department and prepare cardiac measures.
- Prepare morphine and administer wait 30 seconds for the medication to take effect.
- If needed, administer a 2nd dose of morphine (Pulse must be 155+ BP: 155/125).

For suspected overdose if the pulse is over 60 administer fentanyl.
For suspected overdose if the pulse is under 60 administer epinephrine.

Section 4.01.0
Medical Care Procedures

ADVANCED MEDICAL TECHNICIAN

4.01.1 Medical Assessment



Section 4.02.0
Environmental Emergencies

4.02.1 Dehydration

Signs/symptoms:
Moderate: Weakness, Fatigue, Headache, Cramps
Severe: Seizure, Loss Of Consciousness

Treatment:
Moderate Dehydration:
All SAFD apparatuses carry water that can be dispensed to people who need it.

Severe Dehydration:
Start IV fluid resuscitation and transport to the emergency department. Treat symptoms.

4.02.2 Hunger

Signs/symptoms:
Moderate: Weakness, Fatigue, Headache, Cramps
Severe: Seizure, Loss Of Consciousness

Treatment:
Moderate Hunger:
SAFD apparatuses do not carry food; you may however give them a "food voucher" so that they can get food.

Severe Hunger:
Start on IV fluid resuscitation and transport to the emergency department. Treat symptoms.

Do not give water or food to any code yellow or higher patients as they will more than likely need to go into surgery.

Section 4.03.0
Behavioral Emergencies

ADVANCED MEDICAL TECHNICIAN

4.03.1 Delirium

Overview:
Delirium is a serious change in mental abilities. It results in confused thinking and a lack of awareness of someone's surroundings.

4.03.2 Hallucinations

Overview:
Where a patient may hear, see, smell, taste, or feel things that appear to be real but only exist in their mind.

4.03.3 Panic Attack

Overview:
A panic attack is a brief episode of intense anxiety, which causes the physical sensations of fear. These can include a racing heartbeat, shortness of breath, dizziness, trembling, and muscle tension.

4.03.4 Treatment

1. **Use calming measures [Square breathing, NRM that has little O2 flow.]**
2. **Remove from environmental stressors**

4.03.5 Violent Patients

If a patient becomes violent or has the potential to become violent, request ALS and LEO presence restrain the patient, and sedate them.

PARAMEDIC

4.03.6 Sedation

Administer Proponol based on transport time. Keep in mind that the medication takes 50 seconds to take effect.

Section 5.01.0
Formulary

5.01.1 Epinephrine

ADVANCED EMERGENCY MEDICAL TECHNICIAN					
INDICATION	**MAX DOSE**	**EFFECT(S)**	**TIME IN BODY**	**TIME TILL MAX EFFECT**	**CONTRAINDICATION**
LOW BP / PULSE / CARDIAC ARREST	10 UNITS	INCREASE HR & BP 10 - 50 MARKS	2 MIN	10 SECONDS	HR110 + BP 120/80 +

5.01.2 Fentanyl

ADVANCED EMERGENCY MEDICAL TECHNICIAN					
INDICATION	**MAX DOSE**	**EFFECT(S)**	**TIME IN BODY**	**TIME TILL MAX EFFECT**	**CONTRAINDICATION**
PAIN LOW BP LOW PULSE	4 UNITS	INCREASE HR & BP 5 - 10 MARKS Decreases Pain Levels	30 MIN	30 SECONDS	HR120 + BP 120/80 +
NARCOTIC LOG REQUIRED: LOT NUMBER 01					

5.01.3 Morphine

PARAMEDIC					
INDICATION	**MAX DOSE**	**EFFECT(S)**	**TIME IN BODY**	**TIME TILL MAX EFFECT**	**CONTRAINDICATION**
PAIN HIGH HP HIGH PULSE	4 UNITS	DECREASES HR & BP 10 - 35 MARKS Decreases Pain Levels	30 MIN	30 SECONDS	HR120 + BP 120/80 +
NARCOTIC LOG REQUIRED: LOT NUMBER 02					

Section 5.01.0
Formulary

5.01.4 Blood (Saline)

ADVANCED EMERGENCY MEDICAL TECHNICIAN			
INDICATION	**DOSE**	**EFFECT(S)**	**CONTRAINDICATION**
LOW BP	100 - 1000 mL	Raises Blood Pressure	BP 200/100 +

5.01.5 Propofol

PARAMEDIC					
INDICATION	**MAX DOSE**	**EFFECT(S)**	**TIME IN BODY**	**TIME TILL MAX EFFECT**	**CONTRAINDICATION**
PSYCHOSIS EMERGENCY ANESTHESIA	100 - 250 mL	SEDATION / ANESTHESIA	1 SEC PER mL MINUS 50 mL	50 Seconds	NOT NEEDED
NARCOTIC LOG REQUIRED: LOT NUMBER 03					

Section 6.01.0
Medical Directives

6.01.2 Patient Care Reports

All members of SAHN are expected to fill out a Patient Care Report or PCR. According to the law if an action/administration is not included in your report it did not happen and thus the provider and service can be held liable.

All PCR Narratives should include the following:

- **All care provided with reasoning**
- **All medications given with narcotic logs if applicable**
- **Findings on scene**
- **Field Diagnosis / Findings**
- **Continuation of care**

OUTLINE EXAMPLE OF A PCR:

PATIENT CARE REPORTS NARRATIVE	
IMPORTANT QUESTIONS: WHAT DID YOU SEE? WHO DID YOU SEE? HOW DID YOU SEE THEM? WHERE DID YOU SEE THEM? WHY WERE YOU CALLED? WHAT DID YOUR FINDINGS INDICATE / WHAT IS YOUR DIAGNOSIS? WHAT DID YOU DO TO HELP THE PATIENT?	SUBJECTIVE INFORMATION: INFORMATION FROM YOUR VIEW POINT OBJECTIVE INFORMATION: INFORMATION THAT IS FACTUAL AND NON INFLUENCED ASSESSMENT INFORMATION: WHAT YOU ASSESSED, VITALS, DIAGNOSIS PLAN INFORMATION: WHAT YOU DID
- KEEP OPINIONS OUT OF REPORTS, DON'T USE "I, WE, YOU'S" - USE PLAIN LANGUAGE AND APPROVED ABBREVIATIONS - KEEP IN MIND THAT VITALS ARE RECORDED IN THE VITAL SECTION	

6.01.2 Patient Care Reports - Medication Administration

All medications are to be logged by SAHN personnel when administered however if a narcotic is given a narcotic log must be present on a PCR any missing narcotics will launch an IA investigation into crews.

Section 6.01.0
Medical Directives

6.01.3 Patient Care Reports - Narcotic Logs

Below is an example of a medication log and a narcotic logs. With narcotic logs a "Lot Number" is required; this is simply the medication code followed by the day of the month and hour minute.

MEDICATION DOCUMENTATION PROCESS			
MAKE SURE TO DOCUMENT THE FOLLOWING WHEN ADMINISTERING MEDICATIONS			
NON-NARCOTIC DRUGS		NARCOTIC DRUGS	
MEDICATION: DOSAGE: TIME: INDICATION: PROVIDER:	EXAMPLE MEDICATION: ATROPINE SULFATE DOSAGE: 1 MG TIME: 16:00 ZULU INDICATION: BRADYCARDIA PROVIDER: TOBY R.	MEDICATION: DOSAGE: TIME: INDICATION: PROVIDER: BADGE NUMBER: LOT NUMBER:	EXAMPLE MEDICATION: FENTANYL DOSAGE: 1 UNIT ROUTE: IN TIME: 16:16 ZULU INDICATION: SEVERE PAIN PROVIDER: TOBY R. BADGE NUMBER: 9080 LOT NUMBER: 01141616
LOT NUMBERS			
NUMBER CODE - DAY, HH:MM			
EXAMPLE PROPOFOL GIVEN AT 17:25 ZULU ON 07/04/2023 LOT NUMBER: 03041725			

MEDICATION CODES:
01 - FENTANYL
02 - MORPHINE
03 - PROPOFOL

FOR MULTIPLE OF THE SAME MEDICATIONS GIVEN AT THE SAME TIME JUST ADD TO THE NUMBER OF UNITS GIVEN

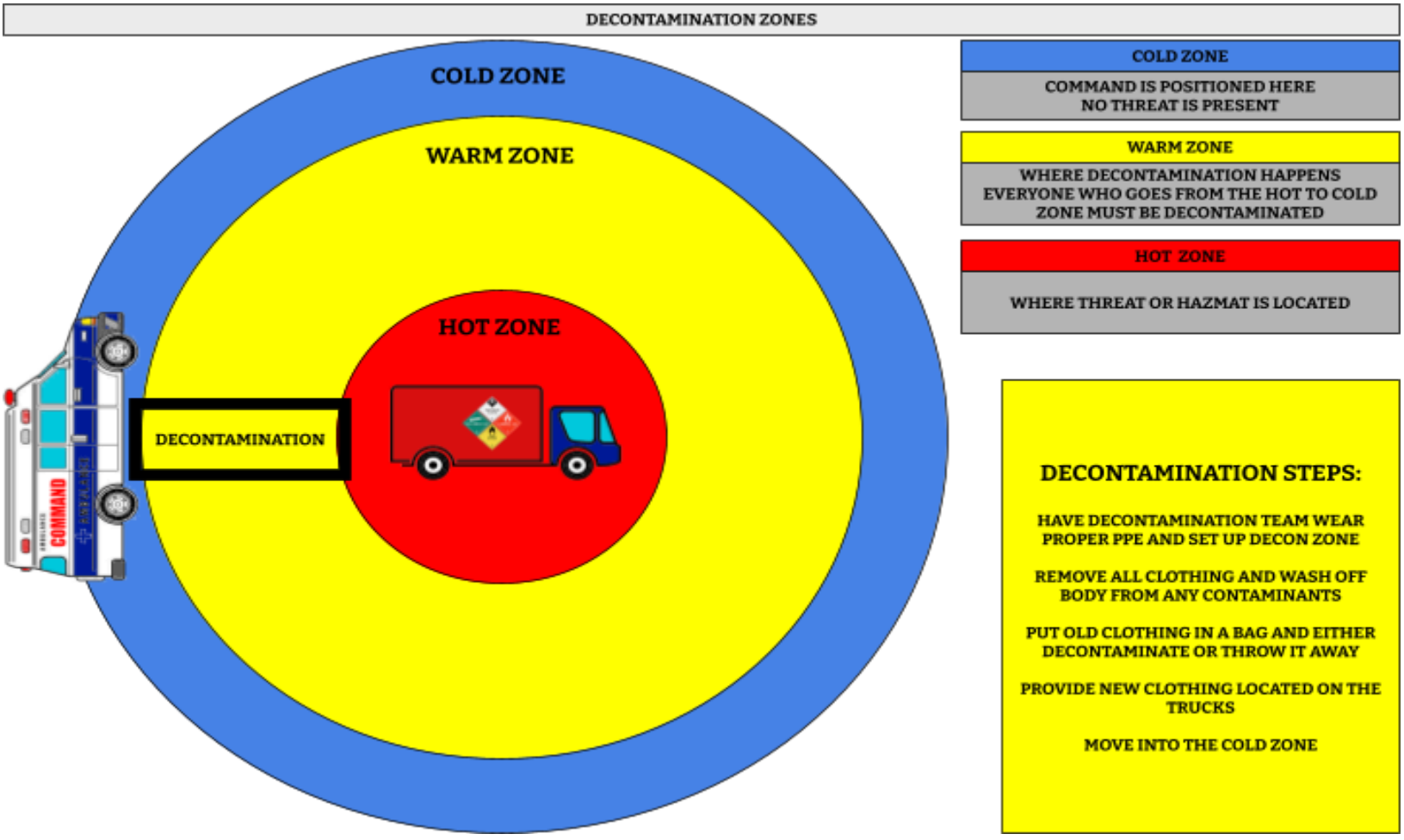
Outline:
MEDICATION:
DOSAGE:
TIME:
INDICATION:
PROVIDER:

BADGE NUMBER:
LOT NUMBER:

Section 6.02.0
Medical Directives

6.02.1 Decontamination areas

On all scenes where a hazardous material is present, HAZMAT is to be requested and decontamination zones are to be established.



In the event that a HAZMAT officer is not able to respond the Medical / Safety officer should establish a decontamination zone using available resources.

For any hazardous spills contact CHEMEX.
Number: 000-867-5309
EMAIL: CHEMEX@SA.GOV

Section 6.02.0
Medical Directive

6.02.2 Personal Protective Equipment

All SAHN personnel are to use the appropriate PPE at the appropriate time in accordance with training.

PPE CLASSES
LEVEL A
SEALED CHEMEX SUIT WITH AIR REGULATION
LEVEL B
FULL BODY CHEM SUIT WITH SCBA
LEVEL C
PARTICLE MASK WITH CHEM SUIT
LEVEL D
STANDARD WORK CLOTHING



6.02.3 Rehabilitation

All SAHN personnel are required to get rehabilitated if they have been inside of a building that has had a gas or fire exposure. This will be carried out by the designated medical / safety officer or their lesion.

Rehab will consist of the following:

- **Assessment for injuries**
- **Assessment of vitals**
- **A quick body scan of injuries**

- **Hydration checks**

Section 6.03.0
Medical Directive

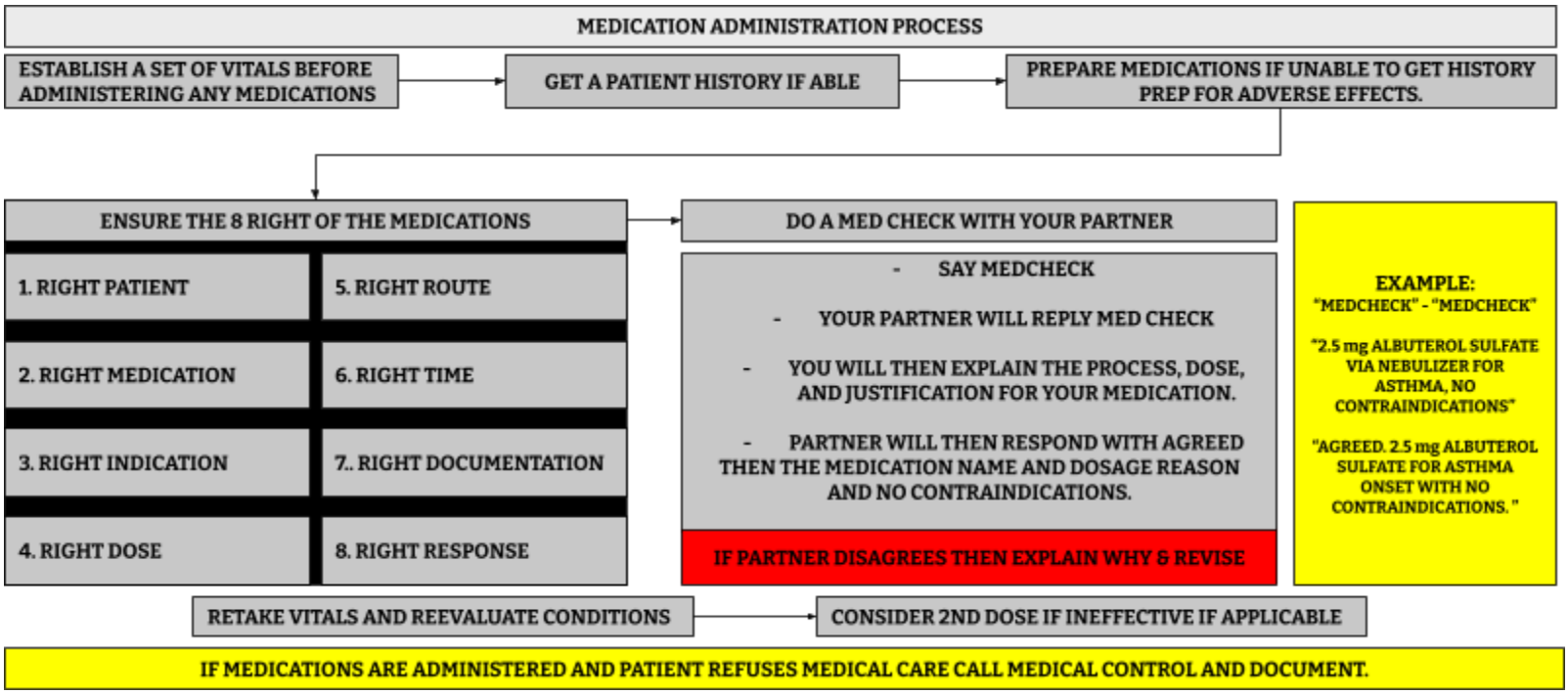
6.03.1 Medication Checks

If you are administering medication it is always good to do a quick medication check if you have a partner to cover your bases and provide good quality care.

First, go through the 5 rights with yourself.

Next, prepare the medication and prepare for any adverse reactions.

Next do a med-check with your partner then administer the medication.



CHANGE LOG		
NAME	**DATE**	**CHANGE**