



ACUTE CEREBROVASCULAR ACCIDENT (STROKE)

Adult

Pediatric

Stroke Alert Criteria

Stroke Alert: Any abnormal BE-FAST exam findings **AND** a Last Known Well Time (LKWT) < 24 hours

First assess for **any potential stroke** symptoms using **BE-FAST**:

Balance: patient performs bilateral finger-to-nose test and bilateral heel-to-shin test (while lying down):

- Normal: performs the 2 tests above normally
- Abnormal: failure of either exam, sudden onset loss of coordination or balance, trouble walking

Eyes: evaluate all 4 quadrants of the visual field:

- Normal: no visual changes from patient's baseline
- Abnormal: sudden change to vision, blurry, double vision or any loss of vision

Facial Droop: have the patient show their teeth or smile:

- Normal: both sides move equally
- Abnormal: 1 side of the face does not move equally

Arm Drift: patient closes both eyes and holds both arms straight out palms up for 10 seconds:

- Normal: both arms stay still or move the same
- Abnormal: 1 arm does not move, pronates, or drifts downward compared to the other

Speech: have the patient say, "You can't teach an old dog new tricks":

- Normal: correct words, no slurring
- Abnormal: slurred words, wrong words, or is unable to speak

Timing of the symptoms: Ask the last time they DID NOT have the current signs or symptoms

- **Stroke Alert if:** LKWT < 24 hours
 - LKWT: Time last known to be at baseline state of health, without present symptoms. NOT when symptoms were discovered.

Any abnormal BE-FAST findings AND LKWT < 24 hours: Complete and document LAMS score assessment:

- LAMS Score of 4 or 5: Consider triage direct Comprehensive Stroke Center (CSC) See Direction.
- LAMS score assessment not indicated if BE-FAST negative OR LKWT >24



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LAMS Score (≥ 4 indicates a high likelihood of Severe Stroke)	
Obvious asymmetry-unilateral weakness with any of the following motor exams:	
	Scoring
Facial Droop	Absent = 0 Points Present = 1 Point
Arm Weakness	Absent = 0 Points Drifts = 1 Point Falls Rapidly = 2 Points
Grips	Equal = 0 Points Weak = 1 Point No Grip = 2 Points
Adult	Pediatric
BLS	
Assess vital signs O ₂ , titrate SpO ₂ > 94%	
BLS Optional Scope	
Blood Glucose Check	
ALS	
Cardiac Monitor, Waveform EtCO ₂ , Vascular Access, 12-Lead ECG (do not delay transport for 12-Lead)	
Consider	
<ul style="list-style-type: none"> • If new onset altered state (GCS < 14) with unidentifiable etiology, consider acute stroke • Treat hypoglycemia if present • If not contraindicated, stroke victim with LAMS of 4 or 5 may still benefit from thrombolysis (TNK) when LKWT < 4 hours. See base direction section. <ul style="list-style-type: none"> ○ Contraindications to TNK: <ul style="list-style-type: none"> • Current anticoagulant therapy; not including ASA • History of stroke within the last 3 months • History of GI bleeding within the last 3 weeks • Any history of intracranial hemorrhage (ever) 	



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Direction

- Transport patient with head of bed at approximately 30 degrees (not supine)
- Bring patient's medications to hospital
- Bring family/caregiver. If unable, collect phone number of person who can provide history of events
 - Advise them to immediately answer phone calls from unknown numbers as it may be the treatment team
- Transport to the closest designated Stroke Receiving Center when:
 - LKWT is under 24 hours
 - Patient is BE-FAST positive
 - **LAMS 3 or lower transport to closest Stroke Receiving Center (any)**
 - **LAMS 4 or higher transport to closest Comprehensive Stroke Center (CSC) if:**
 - Travel time is less than 45 minutes
 - Stable airway
 - Systolic blood pressure above 90
- Contact the Stroke Receiving Center with a "**STROKE ALERT**" (preferably from the scene)
 - Include All of the following information:
 - Nature of the symptoms
 - LKWT
 - BE-FAST Stroke Assessment findings
 - LAMS Score- If LAMS of 4 or 5 give "**LAMS ALERT**"
 - Blood glucose
 - Vital signs
 - Treatment provided
- Contact the Base Hospital if there are treatment or transport questions
 - Perform destination consult for consideration of TNK when:
 - LAMS of 4 or 5 and LKWT between 3-4 hours, and
 - Transport to CSC will bypass a closer Stroke Receiving Center

BE-FAST and LAMS Scores MUST be documented in all PCRs



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ALTERED LEVEL OF CONSCIOUSNESS (ALOC)	
Adult	Pediatric
Indication	
Glasgow Coma Scale (GCS) is < 15 and etiology unclear	
BLS	
Assess vital signs Consider SMR for suspected trauma O ₂ , titrate SpO ₂ to ≥ 94% Assist ventilations as needed Temperature Suction as needed	
BLS Local Scope	
Blood Glucose Check	
Blood Sugar (BS) < 60 mg/dL or un-measurable	
Glucose Paste 1 tube by mouth (PO) <u>Or</u> Commercially prepared Glucose Solution , 1 bottle by mouth (PO) Do not administer if patient is unconscious, lethargic, or unable to drink fluids	
If mental status and respiratory effort are depressed and suspected opioid overdose	
Naloxone (Narcan) 2 mg IN <ul style="list-style-type: none"> • ½ dose per nare • May repeat x 1 • Max dose 4 mg <u>Or</u> Naloxone (Narcan) Preload IN <ul style="list-style-type: none"> • OK to give 4 mg dose as packaged 	
ALS	
Cardiac Monitor, Waveform EtCO ₂ , Vascular Access	



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Adult	Pediatric																																				
ALS (cont.)																																					
BS < 60 mg/dL																																					
<p>Dextrose 10% 25 gm in NS 250 mL IV/IO</p> <ul style="list-style-type: none"> • Infuse wide open <p style="text-align: center;"><u>If no IV/IO</u></p> <p>Glucagon 1 mg IM/IN</p> <ul style="list-style-type: none"> • No repeat 	<p>Dextrose 10% in NS 250 mL IV (See <i>Infusion Chart</i>)</p> <ul style="list-style-type: none"> • Infuse wide open <p style="text-align: center;"><u>If no IV/IO</u></p> <p>Glucagon 0.5 mg IM/IN</p> <ul style="list-style-type: none"> • No repeat 																																				
	<table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th colspan="3" style="text-align: center;">Pediatric Dextrose 10% in 250 mL Infusion Chart</th> </tr> <tr> <th style="width: 33%;">AGE</th> <th style="width: 33%;">WEIGHT</th> <th style="width: 33%;">VOLUME D 10% 25 gm</th> </tr> </thead> <tbody> <tr><td>Preemie</td><td>2 kg</td><td>10 mL</td></tr> <tr><td>Newborn</td><td>3 kg</td><td>15 mL</td></tr> <tr><td>3 months</td><td>5 kg</td><td>25 mL</td></tr> <tr><td>6 months</td><td>7 kg</td><td>35 mL</td></tr> <tr><td>1 - 2 years</td><td>11 kg</td><td>55 mL</td></tr> <tr><td>3 - 4 years</td><td>15 kg</td><td>75 mL</td></tr> <tr><td>5 - 6 years</td><td>19 kg</td><td>95 mL</td></tr> <tr><td>7 - 8 years</td><td>24 kg</td><td>120 mL</td></tr> <tr><td>9 - 10 years</td><td>31 kg</td><td>155 mL</td></tr> <tr><td>11 - 15 years</td><td>40 kg</td><td>200 mL</td></tr> </tbody> </table>	Pediatric Dextrose 10% in 250 mL Infusion Chart			AGE	WEIGHT	VOLUME D 10% 25 gm	Preemie	2 kg	10 mL	Newborn	3 kg	15 mL	3 months	5 kg	25 mL	6 months	7 kg	35 mL	1 - 2 years	11 kg	55 mL	3 - 4 years	15 kg	75 mL	5 - 6 years	19 kg	95 mL	7 - 8 years	24 kg	120 mL	9 - 10 years	31 kg	155 mL	11 - 15 years	40 kg	200 mL
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Adult	Pediatric
ALS (cont.)	
If mental status and respiratory effort are depressed and suspected opioid overdose	
<p>Naloxone (Narcan) 0.4 mg increments IV/IO</p> <ul style="list-style-type: none"> • titrated to a respiratory rate \geq 12 and SpO₂ of 94% • May repeat to a max of 6 mg <p style="padding-left: 40px;"><u>If unable to obtain vascular access:</u></p> <p>Naloxone (Narcan) 2 mg IN</p> <ul style="list-style-type: none"> • ½ dose per nare • May repeat x 1 • Max dose 4 mg <p style="text-align: center;"><u>Or</u></p> <p>Naloxone (Narcan) Preload IN</p> <ul style="list-style-type: none"> • OK to give 4 mg dose as packaged <p style="padding-left: 40px;"><u>Following reversal of overdose</u></p> <p>See Opioid Withdrawal Protocol for treatment considerations</p>	<p>Naloxone (Narcan) 0.1 mg/kg IV/IO/IM</p> <ul style="list-style-type: none"> • May repeat x 2 every 2 - 3 minutes • Max single dose 2 mg <p style="text-align: center;"><u>Or</u></p> <p>Naloxone (Narcan) 0.1 mg/kg IN</p> <ul style="list-style-type: none"> • ½ dose per nare • May repeat x 1 • Max single dose 2 mg
Consider	
<ul style="list-style-type: none"> • Consider diabetic related complications (hypoglycemia/diabetic ketoacidosis) • Consider carbon monoxide toxicity • Consider 12-Lead ECG <p>AEIOU-TIPS*</p> <ul style="list-style-type: none"> • Alcohol • Epilepsy/Endocrine/Electrolytes/Exocrine • Insulin/Infection • Overdose/Oxygen deprivation • Uremia • Trauma/Temperature • Psychois/Porphyrin/Poison • Stroke/Shock/Sepsis/Space occupying lesion/Subarachnoid hemorrhage <p><i>*Refer to appropriate treatment protocol</i></p>	
Direction	
<ul style="list-style-type: none"> • Contact Base Hospital for additional treatment • Document COWS Score on all opioid reversals 	



TRAUMA PATIENT CARE	
Adult	Pediatric
Purpose	
<p>To identify trauma patients who are at the greatest risk for serious injury and determine the most appropriate destination.</p> <ul style="list-style-type: none"> • Trauma Centers improve outcomes for patients with significant traumatic injuries. Patients meeting Critical Trauma Criteria should be transported as soon as possible. On scene procedures should be limited to patient assessment, airway management, external hemorrhage control, and spinal motion restriction procedures. Additional interventions should take place en route with the exception of those incidents requiring prolonged extrication. 	
Physiological Criteria	
<ul style="list-style-type: none"> • All Patients <ul style="list-style-type: none"> ○ Unable to follow commands (motor GCS < 6) ○ RR < 10 or > 29 breaths/min ○ Respiratory distress or need for respiratory support ○ Room-air pulse oximetry < 90% • Age 0–9 years <ul style="list-style-type: none"> ○ SBP < 70 mm Hg + (2 x age in years) • Age 10–64 years <ul style="list-style-type: none"> ○ SBP < 90 mmHg or ○ HR > SBP • Age ≥ 65 years <ul style="list-style-type: none"> ○ SBP < 110 mmHg or ○ HR > SBP 	
Anatomical Criteria	
<ul style="list-style-type: none"> • Penetrating injury to head neck, torso, or extremities proximal to knee or elbow • Depressed or suspected open skull fracture • Chest wall instability or deformity or suspected flail chest • 2 or more proximal long bone fractures in an adult or 1 or more proximal long bone in patient < 14yrs. • Paralysis • Crushed, de-gloved, mangled extremity or pulseless extremity • Amputation proximal to wrist and ankle • Suspected Pelvic fracture 	



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Adult	Pediatric
Mechanism of Injury Criteria	
<ul style="list-style-type: none"> • High risk automobile crash <ul style="list-style-type: none"> ○ Intrusion into the passenger compartment (including roof): occupant side > 12 inches, any side > 18 inches ○ Death of occupant in the same compartment ○ Ejection from vehicle (partial or complete) ○ Child (age 0-9) unrestrained or in unsecured child safety seat ○ Vehicle telemetry data consistent with severe injury • Pedestrian/bicycle rider thrown, run over, or with significant impact falls from height greater than 10 feet (all ages) • Rider separated from transport vehicle with significant impact (e.g., motorcycle, ATV, horse, etc.) 	
Special Considerations	
<ul style="list-style-type: none"> • Patients 55 years or older • Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact • Anticoagulant use or bleeding disorder • Time sensitive extremity injury including tourniquet application • Suspicion of child abuse • End stage renal disease requiring dialysis • Pregnant patients > 20 weeks • Blunt trauma involving large livestock <p style="text-align: center;">Contact Base Hospital if there is any concern about appropriate destination.</p>	
BLS	
Open and position the airway Airway Adjuncts: OPA/NPA as needed to control the airway O ₂ , titrate SpO ₂ to ≥ 94% SMR if indicated Control external bleeding Prevent hypothermia Treat suspected shock	
ALS	
Cardiac Monitor, Waveform EtCO ₂ , Vascular Access	
<p style="text-align: center;"><u>SBP < 90 mmHg</u></p> <p>Fluid Bolus NS 250 mL IV/IO</p> <ul style="list-style-type: none"> • Titrate SBP ≥ 90 mmHg <p>Initiate second large bore IV</p>	<p style="text-align: center;"><u>If poor perfusion or suspected shock</u></p> <p>Fluid Bolus NS 20 mL/kg IV/IO</p> <ul style="list-style-type: none"> • Titrate to age appropriate SBP <p>Initiate second large bore IV</p>



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ALS (cont.)

Adult

Trauma patients with signs and symptoms of hemorrhagic shock meeting all of the following criteria:

- Blunt or penetrating trauma to the chest, abdomen, or pelvis
- Total time from Time of Injury to Trauma Center (ED) is > 30 minutes
- Within 3 hours of injury
- SBP < 90

TXA Bolus 2 gms SIVP

- No repeat

Fluid Bolus NS 250 mL IV/IO

- Repeat as needed to maintain SBP \geq 90

*** Place the approved neon green wristband on patient**

TXA Contraindications

- Active thromboembolic event (within the last 24 hours); i.e., active stroke, myocardial infarction, pulmonary embolism or DVT
- Hypersensitivity or anaphylactic reaction to TXA
- Traumatic arrest with > 5 minutes of CPR without return of vital signs
- Suspected traumatic brain injury
- Drowning or hanging victims
- Cervical cord injury with motor deficits

Consider

Consider advanced airway if GCS is \leq 8 and BLS airway is ineffective

- IV/IO access should be initiated en route
- Consider pain management
- **Pregnant patients** meeting criteria should be taken to a **Trauma Center** with **obstetric** services.
- Air ambulances should only be used when they offer a measurable advantage to ground transport and/or those in need of immediate procedures available to a Flight Nurse but outside the scope of practice of Paramedics.
- Patients with an uncontrolled airway may be considered for transport to the closest hospital.
- For trauma meeting burn criteria - refer to burn triage criteria
- This policy does not apply to Multi-Casualty Incidents

Direction

- If patient meets trauma triage criteria transport to a designated Trauma Receiving Center
- Contact the Trauma Center and advise them of a **“TRAUMA ALERT”** (preferably from the scene)
- If TXA administered advise the Trauma Hospital of **“TRAUMA ALERT TXA”**
- On scene time should be \leq 10 minutes
- Contact the Base Hospital for additional treatment or transport decisions
- When in doubt, transport to the closest Trauma Center



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CHILDBIRTH		
Adult		
BLS		
Assess vital signs O ₂ , titrate SpO ₂ to ≥ 94% Estimate blood loss		
Presenting Part		
Prolapsed Cord	Head	Breech or Footing
<ul style="list-style-type: none"> Protect cord Place mother in knee-chest position Insert gloved hand into vagina & gently push presenting part off the cord Cover the cord with wet saline dressing 	<ul style="list-style-type: none"> Allow delivery (note time) Provide warmth Assure open airway Evaluate for meconium and clear airway with bulb syringe Dry baby 	<ul style="list-style-type: none"> Protect cord Allow delivery to progress passively until baby's waist appears Rotate baby to face down position (do not pull) If head does not deliver in 3 minutes, insert gloved hand into vagina to create an air passage for infant As mother bears down, sweep the head out of the vagina
After the Delivery		
<ul style="list-style-type: none"> Dry and stimulate Provide warmth Insulate head Place newborn skin to skin with mother if possible APGAR at 1 minute Clamp and cut cord <ul style="list-style-type: none"> Delay clamping of the umbilical cord for 2 minutes for uncomplicated births not requiring resuscitation Double clamp cord, cut 6 inches from the baby between clamps APGAR at 5 minutes Vigorously massage fundus until firm 		
ALS		
Cardiac Monitor, Waveform EtCO ₂ , Vascular Access		
For Severe Post-Partum Hemorrhage: Tranexamic Acid (TXA) 1 gm/100 mL D5W or NS IV/IO <ul style="list-style-type: none"> Infused over 10 minutes 		



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Direction

- Transport to closest Receiving Hospital with obstetric services; do not wait for placenta delivery
- Transport mother and baby together whenever possible
- For complicated deliveries contact Base Hospital Physician early
- Contact Base Hospital for additional treatment

APGAR Score

	Sign/Score	0	1	2
A	Appearance	Blue/Pale	Peripheral Cyanosis	Pink
P	Pulse Rate	None	<100	>100
G	Grimace	None	Grimace	Cries
A	Activity	Limp	Some Motion	Active
R	Respiration	Absent	Slow/Irregular	Good, Strong Cry



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EXTERNAL HEMORRHAGE CONTROL	
Adult	Pediatric
BLS	
Apply direct pressure to bleeding wound Assess vital signs O ₂ , titrate SpO ₂ to ≥ 94% Estimate blood loss	
Significant bleeding where direct pressure is ineffective	
Apply Tourniquet at least 3 inches above the wound (not over joint, fracture, or penetration wound site) <ul style="list-style-type: none"> Tighten until the bleeding stops or distal pulses are affected or disappear Record the time applied directly on the tourniquet Cover wound with appropriate dressing/bandage <p style="text-align: center; margin-left: 40px;"><u>If bleeding continues or unable to apply a tourniquet</u></p> Pack the wound with a Hemostatic Agent <ul style="list-style-type: none"> Apply direct pressure over wound packing Apply a pressure dressing Once applied do not remove 	
Consider	
<ul style="list-style-type: none"> Hemostatic agents are most likely to be indicated for scalp, face, neck, axilla, groin, or buttocks. Hemostatic agents are NOT appropriate for minor bleeding, bleeding that can be controlled by direct pressure, or bleeding from open abdominal or chest wounds. If tourniquet was not applied by EMS check to ensure it is properly applied. To control hemorrhage, tourniquets must be applied very tightly and will cause significant pain to the alert patient. 	
ALS	
<u>If Moderate to Severe Pain see Pain Management Protocol</u>	
Direction	
<ul style="list-style-type: none"> Contact Base Hospital for additional treatment <p style="text-align: center; margin-left: 40px;"><u>For uncontrolled epistaxis or oral bleeding</u></p> TXA 1 gm Nebulized <ul style="list-style-type: none"> Base Hospital Orders Required 	



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PAIN MANAGEMENT	
Adult	Pediatric
BLS	
Mild Pain	
Assess Vital Signs O ₂ , titrate SpO ₂ to ≥ 94% Provide calming measures Treat underlying cause for pain: reposition, bandage, splint, elevation, traction, compression, and/or cold pack	
ALS	
Moderate to Severe Pain	
Cardiac Monitor, Consider Vascular Access	
<p>Acetaminophen 15 mg/kg IV Infusion</p> <ul style="list-style-type: none"> • Administer over 15 minutes • Total max dose 1,000 mg • No repeat <p>Fentanyl 50 mcg SIVP/IM</p> <ul style="list-style-type: none"> • IV - May repeat every 5 minutes • IM - May repeat every 10 minutes • Single max dose 50 mcg • Total max dose 200 mcg <p>Ketorolac 15 mg IV/IO or 30 mg IM</p> <ul style="list-style-type: none"> • No repeat <p>Ketamine (Ketalar) 0.3mg/kg in 100 mL NS IV Infusion</p> <ul style="list-style-type: none"> • Administer over 10 minutes • Single max dose 30 mg • May repeat x 1 after 20 minutes <p>* Ketamine may be administered in addition to Acetaminophen and Fentanyl for severe pain</p>	<p>Acetaminophen 15 mg/kg IV Infusion</p> <ul style="list-style-type: none"> • Use a length based pediatric resuscitation tape to determine weight for dosing • Administer over 15 minutes • Total max dose 1,000 mg • No repeat <p style="text-align: center; color: red;">Patients < 4 years – Base Physician contact required for Fentanyl</p> <p>Fentanyl 1 mcg/kg SIVP/IM</p> <ul style="list-style-type: none"> • IV - May repeat every 5 minutes • IM - May repeat every 10 minutes • Single max dose 50 mcg • Total max dose 200 mcg <p style="text-align: center;"><u>Or</u></p> <p>Fentanyl 1 mcg/kg IN</p> <ul style="list-style-type: none"> • ½ dose per nare • May repeat every 10 minutes • Single max dose 50 mcg • Total max dose 200 mcg <p>Ketorolac 0.5 mg/kg IV/IO or IM</p> <ul style="list-style-type: none"> • Single max dose 15 mg • No repeat



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ALS (cont.)

Contraindications

Acetaminophen

- Liver Disease or complications (e.g., Transplant)

Ketamine (Ketalar)

- $RR \leq 12$
- $SBP \leq 100$
- $GCS < 15$ or agitation

Ketorolac (Toradol)

- Active bleeding
- Age < 4 years old or > 75 years old
- Allergy to Non-Steroidal Anti-inflammatory agents (NSAIDs)
- Current Anticoagulation therapy, not including ASA
- Head Trauma
- History of peptic ulcer disease or GI bleeding
- History of kidney or liver disease or transplant
- Pregnancy

Fentanyl

- $SBP < \text{normal range for age}$
- $GCS < 15$

Direction

- Contact Base Hospital for additional pain management



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SEIZURE	
Adult	Pediatric
BLS	
Assess vital signs O ₂ , titrate SpO ₂ to \geq 94% Assist ventilations as needed Temperature Cooling measures if febrile	
BLS Local Scope	
Blood Glucose Check	
ALS	
Cardiac Monitor, Waveform EtCO ₂ , Vascular Access	
<p>For continuous or recurrent seizures without a lucid interval:</p> <p>Midazolam 5mg SIVP</p> <ul style="list-style-type: none"> May repeat once <p style="text-align: center;"><u>Or</u></p> <p>Midazolam 10 mg IM</p> <ul style="list-style-type: none"> No repeat 	<p>For continuous or recurrent seizures without a lucid interval:</p> <p>Midazolam 0.1 mg/kg SIVP</p> <ul style="list-style-type: none"> May repeat x 2 every 5 - 10 minutes Max single dose 2 mg Total max dose 4 mg <p><i>*Use a 1 mL syringe for Midazolam administration in pediatric patients</i></p> <p style="text-align: center;"><u>Or</u></p> <p>Midazolam 0.1 mg/kg IM</p> <ul style="list-style-type: none"> Max dose 4 mg No repeat
Direction	
<ul style="list-style-type: none"> Contact Base Hospital for additional treatment 	



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MEDICAL CARDIAC ARREST	
Adult	Pediatric
Primary Direction	
<ul style="list-style-type: none"> In the absence of factors requiring rapid transport (e.g., unsafe scene), all attempts should be made to perform resuscitative efforts on scene for a MINIMUM of 20 minutes or until ROSC is achieved Movement and transport of patients interrupts CPR and prevents adequate depth and rate of compressions. 	
BLS	
<p>Provide High Performance CPR (See HP-CPR quick reference guide):</p> <p>Continuous Chest Compressions rate of 100 - 120 per minute, allow for full chest recoil</p> <ul style="list-style-type: none"> Avoid interruptions. Do not interrupt CPR to administer medications or procedures Use metronome to ensure proper rate <p>Automated External Defibrillator (AED) Follow AED prompts, shock if indicated</p> <ul style="list-style-type: none"> Anterior posterior pad placement preferred Continue compressions while AED charges <p>Switch Compressors every 2 minutes</p> <ul style="list-style-type: none"> Reassess pulse every 2 minutes during compressor switch Do not exceed 10 seconds during pause <p style="text-align: center;"><u>Once compressions and AED are deployed</u></p> <p>Passive Oxygenation</p> <ul style="list-style-type: none"> OPA and bilateral NPAs Non-rebreather mask 15 LPM <p style="text-align: center;"><u>With adequate personnel (≥ 3) or after 8 minutes of resuscitation*</u></p> <p>Ventilate BVM with 100% Oxygen</p> <ul style="list-style-type: none"> 1 small volume ventilation on the up stroke of every 10th compression <p style="margin-left: 40px;"><i>* Consider earlier ventilations for pediatrics or if arrest has suspected respiratory cause</i></p>	
Compression depth 2" - 2.4"	Compression depth of at least 1/3 the diameter of the chest size
ALS	
<p style="text-align: center;">Cardiac Monitor, Defib Pads, Waveform EtCO₂, Metronome, IV Vascular Access, when possible, humeral IO is preferred over tibia IO if IV attempt(s) unsuccessful or not feasible, NG/OG Tube</p>	



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Adult	Pediatric
ALS (cont.)	
Ventricular Fibrillation (VF) Pulseless Ventricular Tachycardia (VT)	
<p>Manual Defibrillation on a 2-minute cycle</p> <ul style="list-style-type: none"> • Anterior posterior pad placement is preferred • Pre-charge the monitor at 1:45, continue compressions during charging • Minimize perishock pause to less than 5 seconds • Switch compressors during perishock pause 	
<p>Defibrillate using manufacturer recommended energy dose.</p> <ul style="list-style-type: none"> • If shocked prior to arrival, increase joules as appropriate • Anterior posterior pad placement preferred • Repeat every 2 minutes • Increase dose per manufacture recommendation <p>Epinephrine (1:10,000) 1 mg IV/IO</p> <ul style="list-style-type: none"> • Repeat every 3 - 5 minutes • No Max <p>Amiodarone 300 mg (first dose) SIVP/IO</p> <ul style="list-style-type: none"> • Repeat x1 in 3 - 5 minutes with 150 mg • Flush with NS 20 mL 	<p>Defibrillate at 2 J/kg</p> <ul style="list-style-type: none"> • Anterior posterior pad placement preferred • Repeat every 2 minutes at 4 J/kg <p>Epinephrine (1:10,000) 0.01 mg/kg IV/IO</p> <ul style="list-style-type: none"> • Repeat every 3 - 5 minutes <p>Amiodarone 5 mg/kg SIVP/IO</p> <ul style="list-style-type: none"> • Max single dose 300 mg • May repeat x 1 in 3 - 5 minutes
Asystole Pulseless Electrical Activity (PEA)	
<u>Address reversible causes based on applicable protocols</u>	
<p>Epinephrine (1:10,000) 1 mg IV/IO</p> <ul style="list-style-type: none"> • Repeat every 3 - 5 minutes • No Max 	<p>Epinephrine (1:10,000) 0.01 mg/kg IV/IO</p> <ul style="list-style-type: none"> • Repeat every 3 - 5 minutes • No Max
AIRWAY CONSIDERATIONS	
<ul style="list-style-type: none"> • A BLS airway is the preferred method of airway management during cardiac arrest unless advanced airway is indicated. • See Airway Management protocol for advanced airway management options 	



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Adult	Pediatric
ALS (cont.)	
CONSIDERATION IN PREGNANCY ≥ 20 WEEKS GESTATION	
<ul style="list-style-type: none"> • Place patient 25° left lateral on backboard for CPR • IV/IO should be above the diaphragm • Pregnant patients are more prone to hypoxia so oxygenation and airway management should be prioritized • Consider early Advance Airway i-gel® or ET Intubation • Do not interrupt CPR to perform procedures • Prepare for early transport after 4 minutes of CPR 	
Termination of Resuscitation (TOR)	
<p><u>Consider TOR in the following conditions*, after a minimum of 20 minutes of resuscitation</u></p> <ul style="list-style-type: none"> • Patient remains pulseless with no signs of cellular metabolism or neurological activity (e.g., unreactive pupils, EtCO₂ < 10 mmHG, developing lividity) • Persistent asystole, wide complex PEA < 40 BPM, or ventricular fibrillation <p style="text-align: center;"><u>*Special Considerations</u></p> <ul style="list-style-type: none"> • Consider transport if patient has persistent narrow complex PEA > 100, or persistent V-Tach after 20 minutes of HP-CPR • Consider pediatric transport after 2 - 3 rounds of on scene ALS interventions IF the cause of the arrest is suspected to be airway related • If resuscitation is terminated at-scene, consider performing an Honor Pause. (see Grief Support Quick Reference for pediatric version) • Honor Pause <ul style="list-style-type: none"> ○ <i>“Let us take a moment to pause and honor this person. This is someone who was alive and now has passed away. They were someone’s friend and family member. Let us stand in silence to honor both this person and all the valiant efforts that were made on their behalf.”</i> 	
Direction	
<ul style="list-style-type: none"> • EMS personnel shall not transport expired patients by ambulance except in the rare occurrence that a patient expires during transport. In these situations, EMS personnel shall continue resuscitative efforts and proceed with transport to the closest receiving facility. • If resuscitative efforts are terminated, personnel shall confirm and document the patient’s cardiac rhythm in 2 separate ECG Leads and provide printed rhythm strips of at least 15 second duration. • Base Hospital Physician consultation should be obtained if EMS personnel have any patient care or scene safety concerns. • This policy does not apply to Mass Casualty Incidents. • Transmit Code Report via Physio Control Monitor – Required for all cardiac arrests 	



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: May 13, 2025

TRAUMATIC CARDIAC ARREST		
Adult	Pediatric	
Primary Direction		
<p>To provide guidelines for rapid, systematic patient assessment and intervention in the setting of traumatic cardiac arrest.</p> <ul style="list-style-type: none"> • Cardiac medications (i.e., Epinephrine, Amiodarone) have limited or no benefit in the setting of traumatic cardiac arrest. • Interventions take priority over chest compressions in agonal or pulseless conditions. <ul style="list-style-type: none"> ○ Airway management ○ Needle decompression ○ Hemorrhage control ○ Fluid resuscitation 		
BLS		
<p style="text-align: center;"><u>Blunt OR Penetrating traumatic arrest PRIOR to EMS arrival with no Signs of Life (SOL) (e.g., pulse, respirations, heart tones, reactive pupils, reaction to pain)</u></p> <ul style="list-style-type: none"> • Do Not Attempt Resuscitation <p style="text-align: center;"><u>Suspected medical cause – minor trauma not likely to be the cause of the arrest.</u></p> <ul style="list-style-type: none"> • Follow Medical Cardiac Arrest Protocol <p style="text-align: center;"><u>Blunt OR Penetrating traumatic arrest AFTER EMS arrival (e.g., absent or agonal pulse or respirations)</u></p> <ul style="list-style-type: none"> • Start CPR – Continuous Chest Compressions rate of 100 – 120 per minute, allow full chest recoil • Simultaneously treat reversible causes <ul style="list-style-type: none"> • Treatment of reversible causes may supersede CPR as needed • AED placement and analysis is not indicated • SMR precautions are secondary to resuscitation and controlling airway 		
External Bleeding	Airway Obstruction / Hypoxia	Penetrating Chest Trauma
<ul style="list-style-type: none"> • Control external bleeding <ul style="list-style-type: none"> ○ Hemostatic dressing, wound packing ○ Tourniquet 	<ul style="list-style-type: none"> • Clear airway – Suction • Ventilate BVM with 100% Oxygen • Basic or advanced airways as indicated 	<ul style="list-style-type: none"> • Apply chest seal with one-way valve



Yolo County Emergency Medical Services Agency

Protocols

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ALS

Blunt OR Penetrating traumatic arrest with Asystole or Wide Complex PEA < 40 BPM and no SOL

- **Do Not Attempt Resuscitation**
- **Terminate Resuscitation if already initiated**

Traumatic Arrest Not Meeting Above Criteria

- **Rapid Transport to Trauma Receiving Center**
- **Start CPR, Defibrillate if necessary**
- **Simultaneously treat reversible causes**
- **Do not administer epinephrine or amiodarone**

Hypovolemia	Hypoxia	Tension Pneumothorax
<ul style="list-style-type: none"> • Fluid Bolus NS 250 mL IV/IO <ul style="list-style-type: none"> ○ Repeat if no ROSC 	<ul style="list-style-type: none"> • Basic or advanced airways as indicated • Needle Cricothyroidotomy as indicated 	<ul style="list-style-type: none"> • Needle Thoracostomy (Chest Decompression) • Consider bilateral decompression in traumatic arrest due to chest trauma

Direction

- Contact the Trauma Center and advise them of a **“TRAUMA ALERT”** (preferably from the scene)
- If ROSC is achieved continue transport to the closest Trauma Receiving Center
- Contact Base Hospital for additional treatment or transport decisions
- Transmit Code Report via Physio Control Monitor – Required for all cardiac arrests



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: April 30, 2025

MENTAL HEALTH CRISIS RESPONSE TRIAGE	
Adult	Pediatric
Purpose	
<ul style="list-style-type: none"> To identify individuals experiencing a mental health crisis and connect them to a Yolo County-approved Mental Health Crisis response resource, which may meet their needs better than transport to an Emergency Department (ED). 	
BLS	
Assess vital signs Temperature Provide reassurance and de-escalation	
BLS Local Scope	
Blood Glucose Check if known or suspected history of Diabetes	
Provider Impression of Behavioral/Psychiatric Crisis	
Suspect new onset mental health condition:	If “NO” continue
Medical condition that poses a risk of harm without further EMS evaluation, treatment, or transport:	If “NO” continue
Abnormal Vital Signs: <ul style="list-style-type: none"> Temperature: > 38.0° C (100.4° F), or signs and symptoms of fever HR: < 50 or > 120 bpm (sustained) BP: < 100 systolic or > 200 mmHg (2 consecutive readings) RR: < 8 or > 22 breaths/min SpO₂: < 94% room air Blood Sugar (BS) < 60 mg/dL or > 200 mg/dL 	If “NO” continue
Mental Status: <ul style="list-style-type: none"> Cannot answer name, month/year, and location Does not have decisional capacity as defined in Patient Refusal of Treatment/Transport policy 	
Risky Presentation: <ul style="list-style-type: none"> Possible OD/Ingestion Eating disorder Possibility for alcohol withdrawals (DT’s) Ill appearing Any obvious life-threatening injuries 	If “NO” continue
If ALL categories are answered with “NO”	
<ul style="list-style-type: none"> The patient should be offered a referral to Mobile Mental Health Crisis response as an alternative to treatment and transport by EMS. If ANY categories are answered with “YES,” then the patient shall be treated and transported by EMS according to YEMSA policy. 	



Yolo County Emergency Medical Services Agency

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Direction

- All patients referred to a Mental Health Crisis response must be informed that they are being referred to a non-medical provider and that they are agreeing to forgo further medical evaluation, treatment, and transport by EMS.
- EMS providers should request Mental Health Crisis response on the radio channel assigned to the local jurisdiction. EMS providers should be prepared to contact the Mental Health Crisis response team by telephone if requested.
- EMS providers must provide for a handoff of the patient to a County-approved Mental Health Crisis Responder, either in-person or by phone (if agreed to by the Mental Health Crisis response team).
- Patient assessment and triage criteria must be documented in the ePCR, and the patient must complete the Release at Scene (RAS) documentation prior to the EMS provider terminating the patient-provider relationship.
- Patients referred to a Mobile Mental Health Crisis response may still be transported by non-EMS resources to appropriate facilities, including an ED, as needed for medical clearance.
- If at any time there is a concern about the patient's eligibility for referral, the patient should be evaluated by ALS, and the Base Hospital should be contacted as needed.



Yolo County Emergency Medical Services Agency

Protocols

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INGESTION - OVERDOSE - POISONING	
Adult	Pediatric
BLS	
Consider calling Poison Control Assess vital signs O ₂ , titrate SpO ₂ ≥ 94% Assist ventilations as needed Suction as needed	
BLS Local Scope	
Blood Glucose Check	
If mental status and respiratory effort are depressed and suspected opioid overdose	
Naloxone (Narcan) 2 mg IN <ul style="list-style-type: none"> ½ dose per nare May repeat x 1 Max dose 4 mg <p style="text-align: center;"><u>Or</u></p> Naloxone (Narcan) Preload IN <ul style="list-style-type: none"> OK to give 4 mg dose as packaged 	
ALS	
Cardiac Monitor, Waveform EtCO ₂ , Vascular Access	
If mental status and respiratory effort are depressed and suspected opioid overdose	
Naloxone (Narcan) 0.4 mg increments IV/IO <ul style="list-style-type: none"> titrated to a respiratory rate ≥ 12 and SpO₂ of 94% May repeat to a max of 6 mg <p style="margin-left: 20px;"><u>If unable to obtain vascular access:</u></p> Naloxone (Narcan) 2 mg IN <ul style="list-style-type: none"> ½ dose per nare May repeat x 1 Max dose 4 mg <p style="text-align: center;"><u>Or</u></p> Naloxone (Narcan) Preload IN <ul style="list-style-type: none"> OK to give 4 mg dose as packaged 	Naloxone (Narcan) 0.1 mg/kg IV/IO/IM <ul style="list-style-type: none"> May repeat x 2 every 2 - 3 minutes Max single dose 2 mg <p style="text-align: center;"><u>Or</u></p> Naloxone (Narcan) 0.1 mg/kg IN <ul style="list-style-type: none"> ½ dose per nare May repeat x 1 Max single dose 2 mg



Yolo County Emergency Medical Services Agency

Protocols

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Adult	Pediatric
ALS (cont.)	
<u>Following reversal of overdose</u>	
<p>See Opioid Withdrawal Protocol for treatment considerations</p>	
Beta Blockers	Beta Blockers
<p>Glucagon 1 mg IV/IO</p> <ul style="list-style-type: none"> ○ Given over 1 minute ○ No repeat <p style="text-align: center;"><u>Or</u></p> <p>Glucagon 1 mg IM</p> <ul style="list-style-type: none"> ○ No repeat <p style="text-align: center;"><u>If no response to Glucagon</u></p> <p>Atropine 1.0 mg IV/IO</p> <ul style="list-style-type: none"> ○ May repeat every 5 minutes ○ Max 3 mg <p style="text-align: center;">If SBP < 90 and HR < 50</p> <p>PUSH DOSE Epinephrine (1:100,000) 1 mL</p> <ul style="list-style-type: none"> • <u>Every 1-5 minutes</u> • Until SBP > 90 <p>Consider TCP</p>	<p>Glucagon 0.1 mg/kg IV/IO/IM</p>
Tricyclic Antidepressants	Tricyclic Antidepressants
<p style="text-align: center;"><u>If any of following are present</u></p> <ul style="list-style-type: none"> • SBP < 90 mmHg • QRS > 0.12 seconds • Seizures <p>Sodium Bicarbonate 1 mEq/kg IV/IO</p> <ul style="list-style-type: none"> • No repeat 	<p style="text-align: center;"><u>With tachycardia and signs of QRS widening</u></p> <p>Sodium Bicarbonate 1 mEq/kg IV/IO</p> <ul style="list-style-type: none"> • May repeat every 10 minutes at ½ the initial dose with persistent wide QRS



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Adult	Pediatric
ALS <i>(cont.)</i>	
Organophosphate or Carbamate Pesticides	Organophosphate or Carbamate Pesticides
See NERVE AGENT TREATMENT Protocol	See NERVE AGENT TREATMENT Protocol
Direction	
<ul style="list-style-type: none">• Contact Base Hospital for additional treatment• Document COWS score on all opioid reversals	<ul style="list-style-type: none">• Overdose/poisoning in the pediatric population is dynamic and requires rapid transport• Contact Base Hospital for additional treatment



Yolo County Emergency Medical Services Agency

Protocols

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NERVE AGENT TREATMENT

Direction

- Antidote medications in this treatment protocol are available in prepositioned CHEMPACKs available for exposure to Nerve Agents (chemical warfare) and Organophosphates (commercial pesticides).
- An Incident Commander may request CHEMPACK deployment according to the Yolo County CHEMPACK plan. Request through the Yolo Emergency Communications Agency (YECA), or directly from the MHOAC when:
 - Suspected of confirmed symptomatic exposure to nerve agents or organophosphates
 - Antidotes are medically needed to save human life
- Auto-injectors of atropine and pralidoxime may be administered by EMR, PSFA and EMTs who have been trained by a YEMSA approved Optional Skills training program.
- Auto-injectors are NOT to be used in children under 40 kg.
- Auto-injectors may be self-administered by first responders for self-rescue following symptomatic exposure

Signs & Symptoms

DUMBBELS:

- **D**iarrhea
- **U**rination
- **M**iosis (pupil constricted) / Muscle Weakness
- **B**ronchospasm / Bronchorrhea (secretions)
- **B**radycardia
- **E**mesis
- **L**acrimation
- **S**alivation / sweating

SLUDGE:

- **S**alivation
- **L**acrimation
- **U**rination
- **D**efecation
- **G**astrointestinal Pain & Gas
- **E**mesis

or

Mild/Moderate Exposure

- Localized sweating
- Muscle Fasciculations (continuous twitching)
- Nausea
- Vomiting
- Abdominal Cramps
- Weakness
- Mild Dyspnea
- Pinpoint Pupils
- Unexplained Runny Nose

Severe Exposure

- Excessive Salivation
- Unconsciousness
- Seizures
- Severe difficulty breathing
- Apnea
- Flaccid Paralysis



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BLS	
Decontamination Remove all clothing Blot off the agent Flush area with large amounts of water Assess vital signs O ₂ , titrate SpO ₂ to ≥ 94% Suction and assist ventilations as needed	
Mild/Moderate Exposure	Severe Exposure
Patient > 40 kg (88 lbs)	
1 - 2 auto-injectors Atropine 2-4 mg IM 1 auto-injector Pralidoxime 600 mg IM	3 auto-injectors Atropine 6 mg IM 1 - 2 auto-injector Pralidoxime 600 - 1800 mg IM <ul style="list-style-type: none"> • 1 for small adult/frail/elderly
ALS	
Cardiac Monitor, Waveform EtCO ₂ , Vascular Access BLS protocols for > 40 kg, as supplies are available	
Mild/Moderate Exposure	Severe Exposure
Patient > 40 kg (88 lbs)	
<p style="text-align: center;">If auto-injector not available</p> Atropine 2 - 4 mg IV/IO <ul style="list-style-type: none"> • repeat every 5 - 10 minutes 2 mg IV/IO <p style="text-align: center;">Any <u>seizure</u> activity</p> Midazolam 5 mg SIVP <ul style="list-style-type: none"> • May repeat once <p style="text-align: center;">or</p> Midazolam 10 mg IM <ul style="list-style-type: none"> • No repeat 	<p style="text-align: center;">If auto-injector not available</p> Atropine 6 mg IV/IO <ul style="list-style-type: none"> • repeat every 5 - 10 minutes 2 mg IV/IO <p style="text-align: center;">Any <u>Severe Exposure</u></p> Midazolam 5 mg SIVP <ul style="list-style-type: none"> • May repeat once <p style="text-align: center;">or</p> Midazolam 10 mg IM <ul style="list-style-type: none"> • No repeat
Fluid Bolus NS 250 mL IV/IO <ul style="list-style-type: none"> • Repeat as needed to maintain SBP ≥ 90 	



Yolo County Emergency Medical Services Agency

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ALS (cont.)	
Patient < 40 kg (88 lbs)	
<p>Atropine 0.05 mg/kg IV/IO</p> <ul style="list-style-type: none"> Repeat every 5 - 10 minutes as needed Max single dose 1 mg 	<p>Atropine 0.1 mg/kg IV/IO</p> <ul style="list-style-type: none"> Repeat every 5 - 10 minutes Max single dose 2 mg <p style="text-align: center;">Seizures</p> <p>Midazolam 0.1 mg/kg SIVP/IM</p> <ul style="list-style-type: none"> May repeat IV x 2 once every 5 – 10 minutes No repeat IM Max single dose 2 mg Total max dose 4 mg
Consider	
<ul style="list-style-type: none"> Repeat IV/IO Atropine until decreased respiratory secretions, improved breathing or ventilation compliance. Antidote medications are to be given for symptomatic exposure, not prophylactically Antidote medications in CHEMPACK are part of a federal shelf-life extension program (SLEP) that monitors and tests long-term potency. EXPIRED CHEMPACK medications CAN be used Treatment Protocol is to be used in conjunction with the YEMSA Hazardous Material or Weapons of Mass Destruction protocol and department Hazardous Material response plans Hot (exclusion) zone treatment should be limited to use of IM Auto-injectors for Severe Exposures 	



Yolo County Emergency Medical Services Agency

Quick References

Revised Date: May 1, 2025

GRIEF SUPPORT

Purpose

The intent of this policy is to provide grief support to the families of deceased individuals who are not transported from the field. Field personnel should identify the need for grief support as soon as possible, especially for an unexpected death or if considering discontinuation of CPR in the field.

Responsibilities

- Assist the family in dealing with the death or anticipated death of the patient.
- If resuscitation is in progress, communicate with the family what you are doing and explain to them the next steps based on patients' response to treatment.
- There are many different religious beliefs regarding death, respect these beliefs and do everything you can to accommodate the family and their wishes.
- Once death has been determined:
 - Contact all appropriate agencies (Police, Coroner)
 - Assist with the notification of clergy, if requested
 - Provide support until additional resources arrive

Grief Support Guidelines

Breaking the News

- Physically join the family
- Remove your gloves
- Introduce yourself and your role
- Clearly state that you have news about the deceased (use the patients name)
- Clearly state the events leading to the death. *"We found your (relation) not breathing and without a heartbeat. We did everything we could but your (relation's) condition was so severe we were unable to revive them. I am very sorry to tell you that your (relation) has died."*
- Avoid using euphemisms like "passed away" or "no longer with us"
- Avoid medical terminology
- Give the family time to react; don't leave
- Consider Honor Pause for patient- see below for wording

Grief Support Skills

- Ask the family if there is someone they would like you to contact
- Give them permission to cry
- Tolerate silence
- Touching is okay if they request a hug or reach out
- Ask if they have any questions
- Verify their understanding
- Offer them an opportunity to view the deceased
- You cannot fix grief, but you can give it an honest and safe place to exist



Yolo County Emergency Medical Services Agency

Quick References

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Grief Support Guidelines (cont.)

Tell the Family What Happens Next

- The coroner or mortuary must be notified
- The police will be coming to assist
- Tell them you will need to collect some information about the deceased

Knowing When to Leave

- Verify they have support on scene
- Tell them it is time for you to go and ask *"Is there anything else I can do?"*
- Give them a number where they can reach you or your supervisor
- Offer your condolences, shake hands, or touch if appropriate

Useful Phrases

- I can't imagine how difficult this is for you.
- I know this is very painful for you.
- I'm so sorry for your loss.
- It must be hard to accept.
- It's harder than most people think.
- You must have been very close to him/her.
- How can I help?
- Most people who go through this react just as you are.

Keys to Success: Understanding, Caring, Empathy, Support, & Advocacy.

Consider

Crime scenes or traumatic events will require additional considerations:

- Move family away from the scene before informing them of the patient's condition.
- Family notifications at a crime scene should be done with law enforcement.
- If they were injured or involved, consider their injuries before informing.
- If transporting a survivor contact the hospital to have grief counselors available when you arrive.

Honor Pause

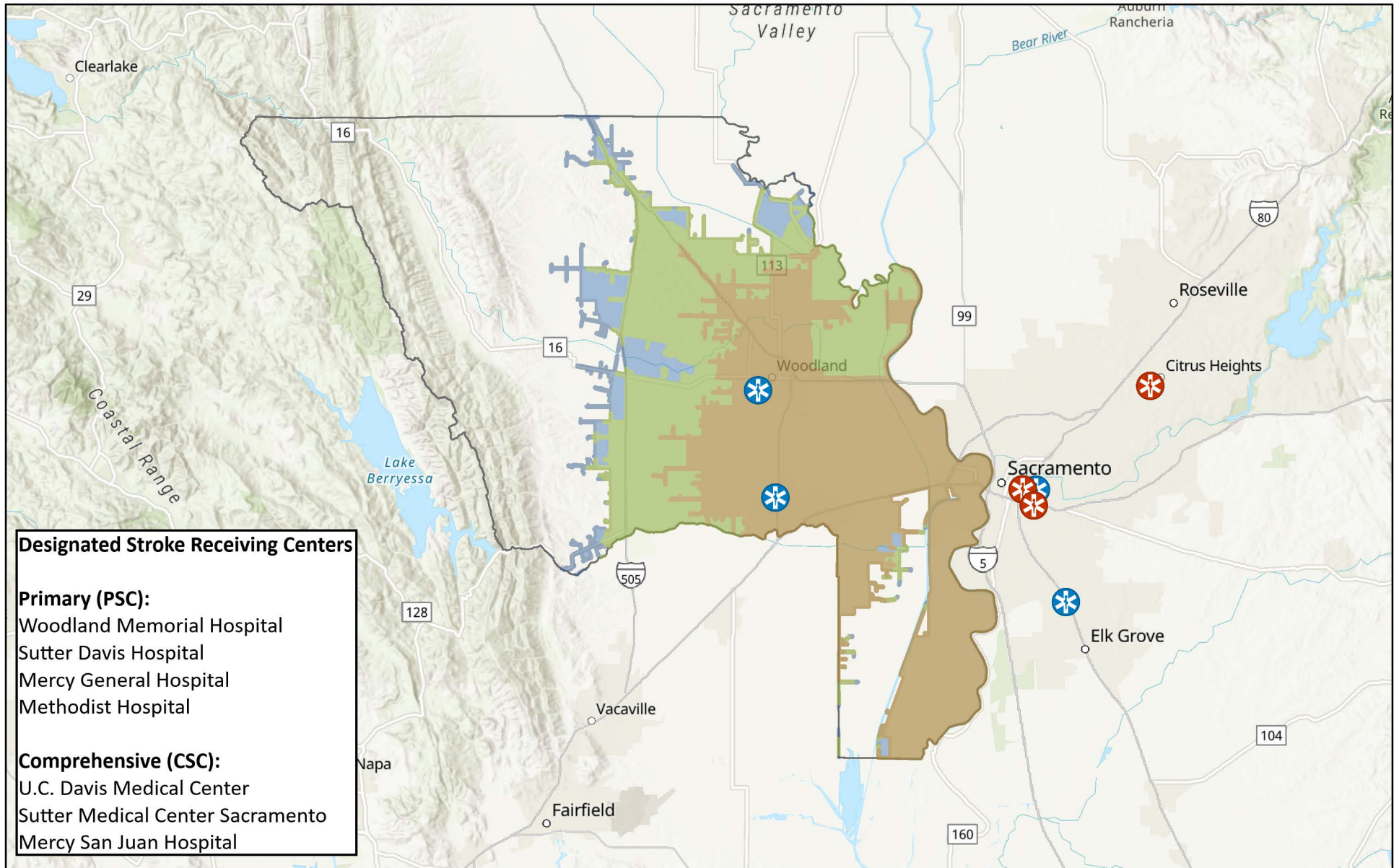
Adults:

"Let us take a moment to pause and honor this person. This is someone who was alive and now has passed away. They were someone's friend and family member. Let us stand in silence to honor both this person and all the valiant efforts that were made on their behalf."

Pediatrics:

"Let us take a moment to pause and honor this child. This child was alive and now has passed away. They have a family who loves them. Although they are small, they have made a large impact on life. Let us stand in silence to honor both this child and all the valiant efforts that were made on their behalf."

Yolo County Designated Stroke Receiving Centers








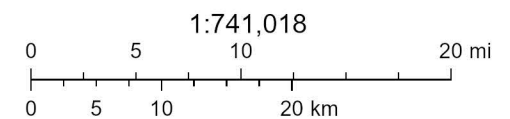
Designated Stroke Receiving Centers

Primary (PSC):
 Woodland Memorial Hospital
 Sutter Davis Hospital
 Mercy General Hospital
 Methodist Hospital

Comprehensive (CSC):
 U.C. Davis Medical Center
 Sutter Medical Center Sacramento
 Mercy San Juan Hospital

Effective Date: June 16, 2025

-  Comprehensive Stroke Center (CSC)
-  Primary Stroke Center (PSC)
-  Estimated 45 min to CSC at 3 pm
-  Estimated 45 min to CSC no traffic
-  Estimated 45 min to CSC at 5 pm



Sources: Esri, TomTom, Garmin, FAO, NOAA, USGS, © OpenStreetMap contributors, and the GIS User Community, Esri, USGS



Yolo County Emergency Medical Services Agency

Quick Reference

Revised Date: May 1, 2025

Medication Profile

Tranexamic Acid (TXA)

Class:

Antifibrinolytic agent, antihemophilic agent, hemostatic agent, lysine analog

Action:

TXA inhibits fibrin clots from being dissolved or degraded in the body by plasmin.

Onset: Immediate

Peak: Immediate

Duration: Unknown

Indications:

Trauma patients with signs and symptoms of hemorrhagic shock meeting all of the following criteria:

- Blunt or penetrating trauma to the chest, abdomen, or pelvis
- Time of incident to trauma center > 30-minutes
- Within 3 hours of injury
- SBP < 90
- Post Partum Hemorrhage within 3-hours of childbirth
- Uncontrolled epistaxis or oral bleeding

Contraindications:

Active thromboembolic event (within the last 24 hours); i.e., active stroke, myocardial infarction, pulmonary embolism or DVT.

Hypersensitivity/allergy

Traumatic arrest with > 5-minutes of CPR without return of vital signs

Suspected traumatic brain injury

Drowning or hanging victims

Cervical cord injury with motor deficits

Side Effects:

CNS: Dizziness

GI: Nausea, vomiting

CV: Thromboembolic events

Notes:

This document is not a substitute for Protocols and Procedures.

Effective Date: June 16, 2025

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