Advisory 17-05 Updated Policies

To: All MLREMS Paramedic Providers, ALS Chiefs, and Agency Leadership

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Regional Medical Director

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Please find the attached MLREMS Policies and forward them to your staff as applicable.

Conducted Energy Weapons: The Collaborative Protocols do not include a protocol for the removal of barbs from Conducted Energy Weapons. The previous MLREMS Protocol has been converted to a regional policy so providers may continue the practice of barb removal and release to law enforcement under the circumstances stated.

Continuity of Therapy for Oxygen Dependent Patients: The need for this regional policy was recognized following this year's windstorm and establishes guidelines that may assist agencies and providers during utility or supply interruptions to meet patient's needs for oxygen therapy without requiring transport to an emergency department.

Mass Gathering Intravenous Hydration: Locally, several Agency Medical Directors have used similar protocols at mass gathering events. This policy allows for uniformity and will aid agencies in planning and executing efficient care at mass gatherings. Please note the express authorization of the Agency Medical Director is required for the use of the policy prior to and specific to each individual mass gathering event.

Please feel free to contact the Regional Program Agency with questions. These policies are also available online here.

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CONDUCTED ENERGY WEAPONS

PURPOSE

EMS providers may be called by law enforcement agencies to assess patients either when conducted energy weapon deployment is anticipated or after conducted energy weapons have been deployed.

Conducted Energy Weapons [also referred to as Electronic Control Devices, Conducted Energy Devices (CED), etc.] are used by law enforcement as an alternative to ballistic devices and other physical force in order to gain compliance with a non-cooperative person. These devices send an electrical charge of up to 50,000 volts per pulse with 12 to 20 pulses per second up to five seconds per cycle. The electrical current is about 2.1-3.5 milliamps. The delivered energy is between 0.7 to 1.76 joules. The number of discharges and the duration of discharges can, in some cases, be controlled by the operator. The discharge can either be through probes fired from the device with a range of up to 35 feet or with a contact discharge where the device is held against the subject. Either method will work through clothing. Either method uses electricity to cause the skeletal muscles between the probes to contract and release, rapidly preventing voluntary control of the affected muscles. The barbs that contact the patient have an end that is similar to a fishhook and may imbed as much as 1.5 cm

The device may cause a brief altered mental status, but subjects regain normal mentation and muscle control almost immediately, although some subjects may take up to a minute to recover.

POLICY

1. Assure patient is not a danger to providers, and if necessary, appropriately restrained.

2. Assess patient and treat per appropriate protocol. The device does not cause sustained altered mental status. Any altered level of consciousness must be assessed and treated in accordance with the appropriate protocol (i.e. Excited Delirium, Hypoglycemia, Trauma, etc).

3. Assess the patient for high-risk criteria. Most patients who have been exposed to a CED will be in police custody and treatment decisions should be a cooperative venture. Presence of one or more of the following risk factors should prompt an ALS evaluation and transport to an Emergency Department is encouraged:

    - Sustained altered mental status
    - Extended physical struggle including multiple discharges or cycles
    - Known cardiac history including pacemaker/implantable defibrillator
    - Known seizure disorder
    - Pregnancy
    - Known or suspected drug use/misuse/abuse

4. Do NOT remove probe if implanted in patient’s genitals, eye, or other sensitive area.

5. To remove the probe, stabilize the soft tissue around the probe. With a gloved hand, remove the probe by pulling firmly outward. If there is resistance when removing the probe, leave the probe in place and transport to the Emergency Department. Clean the area with an alcohol or betadine prep and dress appropriately.

CONTINUITY OF THERAPY FOR OXYGEN DEPENDENT PATIENTS

PURPOSE

To establish a standard approach to providing oxygen to patients on chronic home oxygen therapy during interruptions in the patient's own source of oxygen that could occur with supply exhaustion, equipment malfunction, or power loss.

POLICY

An EMT or Paramedic may administer oxygen to a patient without the need for transport to an Emergency Department, provided:

The patient is on chronic home oxygen therapy;

AND

The patient requests EMS to provide oxygen therapy as a result of supply exhaustion, equipment malfunction, or power loss;

AND

The patient has no other complaints and does not wish to be transported to the hospital.

If the above criteria are met:

1. Perform routine history and physical exam.

2. Provide oxygen at the patient's prescribed home oxygen rate.

3. Any patient on home oxygen with symptoms other than dyspnea or mild hypoxia that is explained by the absence of home oxygen and rapidly corrects with oxygen administration at their prescribed dose must be transported to the Emergency Department.

4. Assist the patient with locating a source of oxygen to meet their home need.

    a. Once the patient has re-established their own oxygen source, obtain an informed refusal of transport.

    b. If the patient is unable to re-establish their own oxygen source (eg power failure, home displacement, etc), the patient may be moved to a location in which they can receive oxygen therapy (community center, public safety building, etc). Once moved to that location, obtain an informed refusal of transport.

MASS GATHERING INTRAVENOUS HYDRATION

PURPOSE

To establish a standard approach to providing intravenous hydration to participants or attendees of a sporting or mass gathering event (marathon, festival, etc).

POLICY

A paramedic, with the express authorization of its Medical Director for the event in which this policy will be used and who (or their designee) is available for telephone consultation during the event, may provide intravenous hydration and obtain a refusal of transport provided the:

The patient is between 15 and 65 years of age;

AND

The patient presents with presumed dehydration/heat exhaustion in patients with no signs of heat stroke, altered mental status, or other medical condition;

AND

The patient has no significant co morbidity (e.g. no reduced heart function, CHF, or other comorbidity that might mean less tolerant of fluids);

If the above criteria are met:

1. Perform routine history and physical exam.

2. Administer 1000ml NS IV and provide concurrent oral hydration and cooling.

3. Reassess the patient's response to intravenous and oral hydration.

4. Following IV fluid administration, a paramedic may release the patient after obtaining documented refusal of transport, has removed the IV, and the patient has been instructed to continue oral rehydration and cooling if the following conditions are met:

   The patient exhibits no pulse sign or symptom of orthostasis (pulse sign is greater than 20 increase when standing; symptomatic orthostasis is dizzy or lightheaded upon standing)

   AND

   The patient's vital signs are within normal limits (HR 60-100, RR 8-20, SBP 90-140, SaO2 >94%)

   AND

   The patient is tolerating PO fluids

AND

The patient has no complaints and does not want transport to the ED

5. The agency Medical Director (or designee) must be contacted for any intravenous fluids beyond one liter, if the paramedic believes the patient would benefit from further field treatment in lieu of transport, or with any concerns regarding the patient's presentation or response.

6. All other care is to be provided consistent with regional protocols.