



Prehospital Care Bundles

The MLREMS Prehospital Care Bundles have been created to provide a simple framework to help EMS providers identify the most critical elements when caring for a patient. These bundles do not replace protocol, but are designed to assist quality assurance and performance evaluations as we work collectively to optimize the delivery of prehospital medicine. As the science and evidence changes, so will these care bundles.

The New York State Collaborative Protocols and the MLREMS Care Bundles are intended to improve patient care by prehospital providers. They reflect current evidence and the consensus of content matter experts. The Collaborative Protocols and the MLREMS Care Bundles are intended to provide principles and direction for the management of patients that are sufficiently flexible to accommodate the complexity of care in the prehospital environment. No Protocol or Care Bundle can be written to cover every situation that a provider may encounter, nor are they substitutes for the judgement and experience of the provider. Providers are expected to utilize their best clinical judgement to deliver care and procedures according to what is reasonable and prudent for specific situations. However, it is expected that any deviations from protocol shall be documented along with the rationale for such deviation.

**NO PROTOCOL OR CARE BUNDLE IS A SUBSTITUTE FOR
SOUND CLINICAL JUDGEMENT.**



Post-Intubation Management

Care Bundle

Post-Intubation Management

Metric	Goal
Elevate Head of Bed	Head of bed at 30 degrees
Capnography	Monitoring and ventilation with EtCO ₂ target of 35-45 mmHg
Analgesia	Administered if required per protocol
Sedation	Administered if required per protocol
Orogastric Tube	Placed unless contraindicated

Theory/Evidence

Elevate Head of Bed

- In the absence of the need for spinal motion restriction, an intubated patient should have the head of the bed elevated to 30 degrees. This position will prevent the risk of aspiration, and in cases of suspected intracranial hemorrhage, will help manage intracranial pressure.

Capnography

- Applied to the endotracheal tube to confirm correct placement; ventilating to a target of 35-45 mmHg to ensure adequate ventilation and reduce risk of hyperventilation.

Analgesia

- If evidence of pain or discomfort, analgesia should be the first line intervention, re-dosed per protocol, and continually reassessed to ensure adequate analgesia.

Sedation

- If evidence of inadequate analgesia despite proper dosing, and if evidence of movement or ventilator dyssynchrony that impedes effective ventilation, sedation should be administered, re-dosed per protocol, and continually reassessed to optimize ventilation.

Orogastric Tube

- Placed to provide gastric decompression, enhance lung compliance, and decrease the risk of aspiration pneumonia provided there are no contraindications.