

October 1, 2015 Standards Manual Changes

Document	Page	Change	Rationale	Practice Changes
Practice Guideline				
Ebola	1-14	Added monitored traveler as a high risk patient; notify Medical Examiner if high risk patient is deceased	Updated to meet state standards	Pre-identified monitored travelers to be considered for high risk evaluation; ME to be contacted for death of high risk patients
Medication List	1-28 – 1-30.03	Added two columns – administration guideline and indications for more specific instructions; added definitions for IV/IO Bolus and IV Push with administration rates; changed calcium carbonate to calcium gluconate 10% solution; changed lidocaine to a 2% solution to be used only for IO pain management; added dopamine drip chart as a reference	Provided more information for indications and administration of medications	Lidocaine 2% administered in conscious patients with IO; calcium gluconate replaces calcium carbonate
Spinal Movement Precautions	1-40.01	New algorithm provides more specific instructions for movement of high risk patients. “Padded backboard” verbiage replaced by “stretcher”.	Lots of confusion regarding current guideline and definition of a “padded backboard”. Stress movement of patient as a unit maintaining neutral alignment of the thoracic/lumbar/sacral spine	Stretcher to be used as “padded backboard”
Protocol				
Intraosseous Infusion	2-7.01	Moved from practice guideline to protocol section; added lidocaine for pain management in the conscious patient	IO infusion in conscious patients may be very painful; initial infusion of lidocaine assists in pain management	Possible administration of IO lidocaine in the conscious patient
Tachycardia With Pulses	2-14	Indication for cardioversion changed from unresponsive and hypotensive to altered LOC or hypotensive	Allows for earlier cardioversion in the unstable patient	Unstable patients may be cardioverted before going unresponsive
Skill				
Intravenous Push Medication	3-27.1	New skill	Slow IV push is the appropriate method of administration for some drugs: calcium gluconate, diphenhydramine, fentanyl, midazolam, ondansetron	Some drugs will be administered slow IV push

October 1, 2015 Standards Manual Changes

Defibrillation	3-33	ALS units to operate in manual mode with see through CPR; BLS units to operate in analyze/AED mode; rescue mode is not to be used	Rewritten to match CCC requirements and reduce preshock pauses	ALS units to operate in manual mode with see through CPR; BLS units to operate in analyze/AED mode; rescue mode is not to be used
Policy				
Transport Destination	4-29 – 4-30	Wheaton Franciscan – Franklin is now a STEMI/ROSC receiving hospital (but not a Stroke receiving hospital) Second page format also changed for clarity	Cath lab capabilities are open and ready to accommodate these patients Specialty services also listed by hospital	STEMI and ROSC patients may be transported to Wheaton Franciscan Franklin
To Be Deleted				
Intraosseous Infusion	1-24	Remove from manual	Replaced by Intraosseous Infusion medical protocol p. 2-7.01	Possible administration of IO lidocaine in the conscious patient
Spinal Immobilization	1-40	Remove from manual	Replaced by Spinal Movement Precautions p. 1-40.1	Providers will initiate SMP for potential spinal injuries

TABLE OF CONTENTS

October 1, 2015

Template	#-#		
Section 1 – Practice Guidelines	Page	Latest Revision #	Latest Update
12-lead ECG Acquisition	1-0.1	2	11/1/14
Advanced Airway Monitoring	1-1		7/1/11
Airway Management	1-2		7/1/11
Airway Obstruction	1-3		7/1/11
Altered Level of Consciousness	1-3.1		4/1/14
Aortic Rupture/Dissection	1-4		7/1/11
Apparent Life Threatening Event (ALTE)	1-5		7/1/11
Approved Abbreviations	1-6 – 1-7		7/1/11
Assessment Parameters	1-8		7/1/11
Cardiac Arrest	1-10	31	6/1/15
Cerebrovascular Accident/ Transient Ischemic Attack	1-11	7	11/1/14
Decontamination of Non-disposable Equipment	1-12		7/1/11
Do-Not-Resuscitate Orders	1-13		2/23/13
Ebola	1-14	1	10/1/15
Emergency Incident Rehabilitation	1-15		7/1/11
Gastrointestinal/Abdominal Complaints	1-16		7/1/11
Hanging	1-17		7/1/11
Heat Related Illness	1-18		7/1/11
Hemorrhage Control	1-19		7/1/11
History and Physical Examination	1-20		7/1/11
Hypertension	1-21		7/1/11
Hypothermia	1-22		2/15/12
Inhalation Injury	1-23		5/16/12
Left Ventricular Assist Devices	1-25	3	3/1/15
Mass Casualty Triage	1-26		7/1/11
Medication Administration	1-27		7/1/11
Medication List	1-28 – 1-30.03	28	10/1/15
Newborn Care and Assessment	1-30.1		2/23/13
Normal Vital Signs	1-31		7/1/11
Obstetrical/Gynecological Complaints	1-32		7/1/11
Oxygen Administration	1-33		7/1/11
Peripheral IV Lines	1-34		2/23/13
Poison/Overdose	1-35		7/1/11
Refusal of Medical Care and/or Transport	1-36		7/1/11
Removal of Conducted Energy Device Barbs	1-37		7/1/11

TABLE OF CONTENTS

October 1, 2015

Section 1 – Practice Guidelines	Page	Latest Revision #	Latest Update
Routine Medical Care for All Patients	1-38		7/1/11
S.A.L.T. Triage	1-39		7/1/11
Spinal Movement Precautions (SMP)	1-40.01	1	10/1/15
Submersion	1-40.1		2/15/12
Syncope	1-41		7/1/11
Tension Pneumothorax	1-42		7/1/11
Transfer of Care (Turndown)	1-43		7/1/11
Trauma Field Triage Guidelines	1-44		4/1/14
Universal Precautions	1-46		7/1/11
Section 2 - Medical Protocols	Page	Latest Revision #	Latest Update
Allergic Reaction	2-1	12	3/1/15
Angina/Acute Coronary Syndrome	2-3	24	4/1/14
Asthma/COPD	2-3.1	21	8/1/13
Asystole	2-4	23	6/1/15
Burns	2-4.1	11	3/1/15
Chemical Exposure	2-5		2/15/12
Congestive Heart Failure	2-5.1	21	8/1/13
Cyanide Poisoning	2-6		2/23/13
Hypo – Hyperglycemia	2-6.1	1	7/1/14
Hypotension/Shock	2-7		7/1/11
Intraosseous Infusion	2-7.01	10	10/1/15
Narcotic – Opiate Overdose	2-7.1	1	11/1/14
Bradycardia with Pulses	2-8	4	3/1/15
Nausea/Vomiting	2-8.1		8/1/13
Pain Management	2-9	5	11/1/14
Patient Restraint	2-10	9	6/1/15
Pulseless Electrical Activity	2-11		7/1/11
Seizure	2-13		2/23/13
Tachycardia with Pulses	2-14	1	10/1/15
Trauma	2-15		2/23/13
Ventricular Fibrillation or Pulseless Ventricular Tachycardia	2-16	23	8/1/13
Section 3 - Standards for Practical Skills	Page	Latest Revision #	Latest Update
Airway Skills:			
Bag-valve-mask Ventilation	3-2		6/01/06
Combitube Airway	3-3		12/11/02

TABLE OF CONTENTS

October 1, 2015

Section 3 - Standards for Practical Skills	Page	Latest Revision #	Latest Update
Airway Skills:			
Combitube Removal	3-4		12/11/02
Confirmation of Intubation	3-4.1		9/24/03
Continuous Positive Airway Pressure (CPAP)	3-4.2		8/1/13
Endotracheal Intubation	3-5		10/14/09
Endotracheal Extubation	3-6		2/16/11
Gastric Tube Placement	3-7	3	3/1/15
King LT-D Airway	3-7.1		10/15/08
King LT-D Airway Removal	3-7.2		10/15/08
Nasopharyngeal Airway Insertion	3-8		6/01/06
Nasotracheal Intubation	3-9		10/15/08
Oral Airway Insertion	3-10		6/01/06
Pocket Mask Ventilation	3-13		6/01/06
Removal of Airway Obstruction	3-14		5/21/08
Suctioning	3-15		5/21/08
Tracheostomy Care	3-17		5/21/08
IV Skills:			
	Page	Latest Revision #	Latest Update
Blood Draw for Analysis	3-18		5/10/00
Capped IV Lines	3-19		5/10/00
Central Indwelling IV Lines	3-20		6/1/05
Intraosseous Infusion	3-21	5	11/1/14
Jugular Vein Access	3-22		5/10/00
Peripheral IV Access	3-23		5/10/00
Medication Administration:			
	Page	Latest Revision #	Latest Update
Endotracheal Administration of Medication	3-24		6/1/05
Intramuscular Administration of Medication	3-25		2/17/10
Intranasal Administration of Medication	3-25.1		2/17/10
Intravenous Bolus Administration of Medication	3-26		5/10/00
Intravenous Drip Administration of Medication	3-27		2/14/01
Intravenous Push Medication	3-27.1		10/1/15
Medication Preparation for Administration	3-28		2/16/11
Nebulized Administration of Medication	3-29		5/21/08
Oral Administration of Medication	3-29.1		12/6/00
Oxygen Administration	3-29.2		5/10/00
Rectal Administration of Medication	3-30		5/21/08
Subcutaneous Administration of Medication	3-31		2/16/11

TABLE OF CONTENTS

October 1, 2015

Section 3 - Standards for Practical Skills	Page	Latest Revision#	Latest Update
ECG Skills:			
4-Lead Electrocardiogram	3-31.1	3	8/1/13
12-Lead Electrocardiogram	3-32	9	11/1/14
Defibrillation	3-33	8	10/1/15
ECG Transmission	3-33.01	2	8/1/13
ECG Upload Process	3-33.02		8/1/13
Infrared Data Upload for ZOLL AED Pro or AED Plus	3-33.1		10/10/07
Serial Cable Data Upload for ZOLL M-Series	3-33.2		10/10/07
Synchronized Cardioversion	3-34	6	8/1/13
Transcutaneous Pacing	3-34.1		11/1/13
Splinting & Trauma Care:			
Board Splint	3-35		5/10/00
Headbed II Immobilizer	3-36	3	7/1/14
Hemorrhage Control & Bandaging	3-37		5/10/00
Kendrick Extrication Device	3-38		2/15/12
Kendrick-Type Traction Device	3-38.1		5/21/08
Log Roll to Long Board - Prone Patient	3-39	3	7/1/14
Log Roll to Long Board - Supine Patient	3-40	3	7/1/14
Pelvic Sling	3-40.1		7/1/11
Pro Splints	3-41		5/10/00
Rigid Board Splint for Joint Injury	3-42		5/10/00
Scoop Stretcher - Movement of Supine Patient	3-43		5/10/00
Sling and Swathe	3-44		10/15/08
Spinal Stabilization	3-45	3	7/1/14
Traction Splinting	3-46		9/24/03
Tourniquet Application	3-46.1		2/17/10
Vacuum Splints	3-47		5/16/12
Miscellaneous Skills:			
Cardiopulmonary Resuscitation	3-48.1	6	6/1/15
Esophageal Probe Placement for Core Temp Measurement	3-48.2		10/17/12
Foreign Material in Eye	3-49		5/10/00
Labor/Delivery - Non-Vertex Presentation	3-50		2/23/13
Labor/Delivery - Vertex Presentation	3-51		2/23/13
Needle Thoracostomy	3-52		10/14/09
Pericardiocentesis	3-54		5/21/08
Miscellaneous Skills:			
Pneumatic Anti-Shock Garment	3-56		5/12/04
Radio Communication	3-57		6/01/06

TABLE OF CONTENTS

October 1, 2015

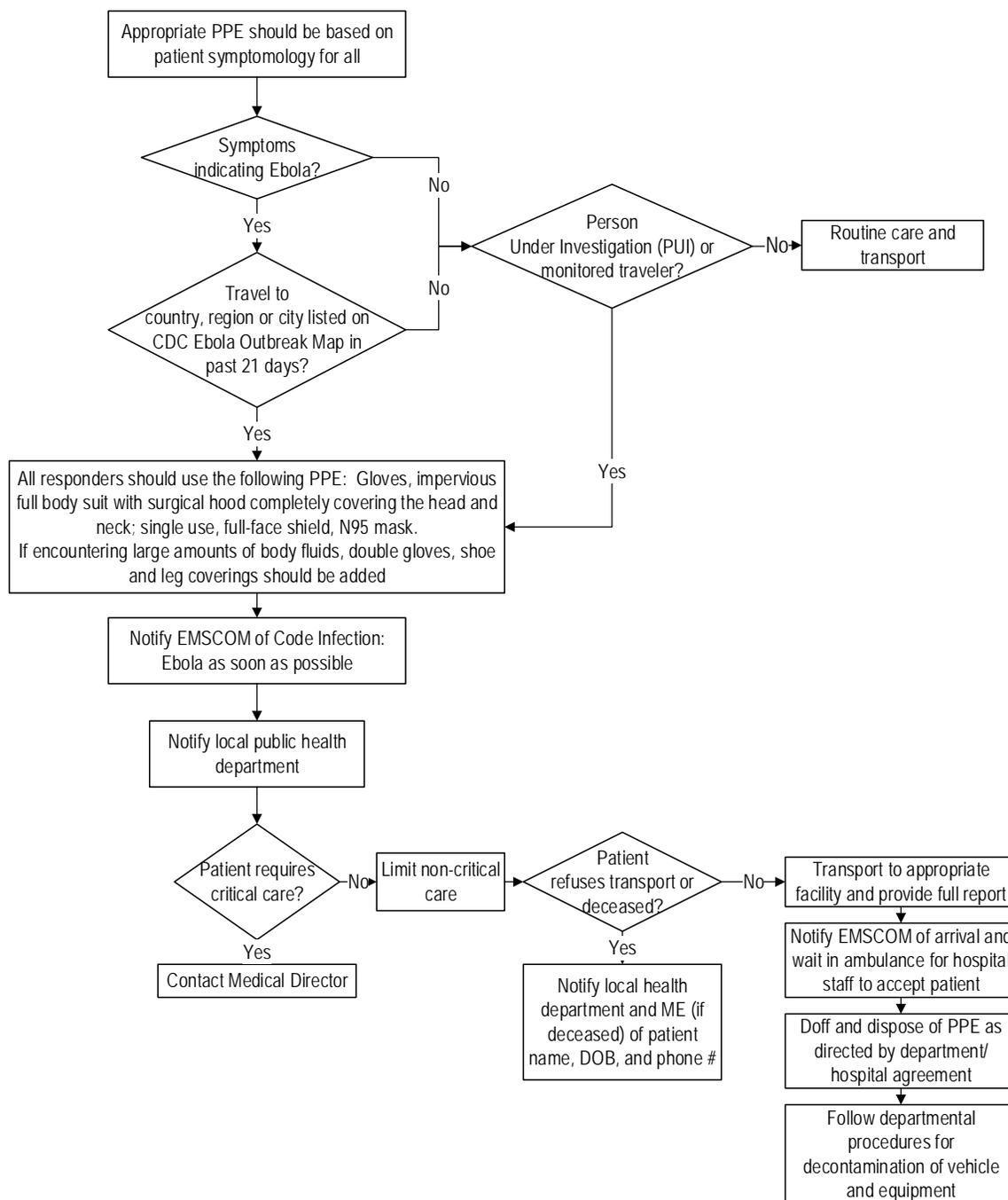
Section 3 - Standards for Practical Skills	Page	Latest Revision#	Latest Update
Miscellaneous Skills:			
Radio Report Elements to Base/Receiving Hospital	3-57.1		2/06/06
Val Salva Maneuver	3-59		5/10/00
Patient Assessment Skills:	Page		Latest Update
Blood Glucose Monitoring Using Precision Xtra [®] Monitor	3-60		5/21/08
Blood Pressure Measurement	3-61		5/21/08
Blood Pressure Monitoring - Non-Invasive	3-62		5/21/08
End Tidal Carbon Dioxide (EtCO ₂) Monitoring	3-64	2	8/1/13
Level of Consciousness Assessment	3-64.1		10/15/08
Orthostatic Blood Pressure Measurement	3-66		5/21/08
Pain Assessment	3-67	1	11/1/14
Physical Assessment	3-68		5/21/08
Pulse Oximetry	3-69		5/21/08
Temperature Measurement	3-70		3/1/15
Section 4 - Operational Policies	Page	Latest Revision #	Latest Update
Administration of Medication	4-1		2/16/11
Alerts – Code STEMI / Code Stroke / Code Infection	4-1.2 – 4-1.3	1	3/1/15
EMS Communications Notification	4-2		2/11/09
Benchmarks	4-2.01		1/1/11
Conducted Energy Devices Patients	4-2.02		5/21/08
Controlled Substance Documentation & Inspection	4-2.1	6	6/1/15
Controlled Substance Mgt. by Area of Responsibility	4-2.2		2/16/11
Deviation from ALS Evaluation (Load & Go)	4-3.1		12/6/00
Documentation	4-4 - 4-7.02		5/16/12
EMS Continuing Education Requirements	4-7.1 – 4-7.3		6/01/06
Electrocardiographic Monitoring	4-8		2/13/08
Equipment/Supplies	4-9		5/10/00
Equipment Failure/Exchange	4-10		6/1/05
Exceptions to Standard, Protocol, Skill, Policy Mandates	4-10.01		2/13/08
HEMS – Wisconsin Policy	4-10.02 – 4-10.03	3	3/1/15
Interfacility Transports	4-10.2	5	8/1/13
Management of Deceased Patients	4-10.3 – 4-10.4	1	7/1/14
Medication Errors	4-11		5/10/00
Narrative Documentation Guidelines for the PCR	4-11.1		5/16/12
New Product Evaluation	4-12		6/01/06

TABLE OF CONTENTS

October 1, 2015

Section 4 - Operational Policies	Page	Latest Revision #	Latest Update
On-scene Physicians	4-13	5	3/1/15
Out-of-Balance Controlled Substances	4-13.1		5/16/07
Outside Student Participation	4-14, 4-15		2/11/09
Patient Transfer of Care	4-15.01		2/11/09
Potential Crime Scenes	4-15.1		12/6/00
Practice Privilege Change	4-15.11 – 4-15.13	3	3/1/15
Practice Status and Privileges	4-15.2 – 4- 16.01	6	8/1/13
Protective Custody	4-16.02		3/1/15
Required Evaluation by a Milwaukee County ALS Unit	4-16.1 - 4-16.2	10	11/1/14
Response, Treatment and Transport	4-17		7/1/11
Routine Operations	4-24		2/16/11
Safe Place for Newborns	4-24.1		9/11/02
Scope of Practice	4-24.2 – 4-24.5	7	3/1/15
Standards of Practice: Roles and Responsibilities	4-25 - 4-28		2/16/11
Transport Destination	4-29 – 4-29.1	41	10/1/15
Uniforms	4-32		5/10/00
Vaccine Administration	4-33		7/1/11
Section 5 - Medical Standards for Special Operations	Page	Latest Revision #	Latest Update
Special Operation Teams	5-1		10/14/09
TEMS - Care of the Patient in the Tactical Setting	5-2 – 5-3		10/14/09
TEMS – Documentation	5-4		10/14/09
TEMS – Hemostatic Agents	5-4.1		5/16/12
TEMS – Operations Security and Medical Intelligence	5-5		10/14/09
TEMS – Routine Tactical Medical Care for All Patients	5-6		10/14/09
TEMS – Terminology	5-7		10/14/09
TEMS – Tourniquet Application	5-8		10/14/09
TEMS – Use of Tourniquets	5-9		10/14/09
Section 6 - Research Protocols	Page	Latest Revision #	Latest Update
Amiodarone Lidocaine Placebo Study	6-3	1	8/1/13
Prehospital Tranexamic Acid (TXA) Use	6-4		11/1/14

History:	Signs/Symptoms:	Working Assessment:
Travel to country, region or city listed on the CDC Ebola Outbreak Map within the last 21 days Exposure/contact with known Ebola Patient Currently being monitored as a Person Under Investigation (PUI) by the CDC, state or local health authority	Fever Headache Diarrhea Nausea/Vomiting Abdominal pain Unexplained bleeding or bruising	Ebola



Note:

Link to CDC Ebola Outbreak Map: <http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html>

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MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
MEDICATION LIST

Approved by: M. Riccardo Colella, DO, MPH, FACEP
Page 1 of 6

POLICY:

- All medications will be administered and documented as outlined in system policy.
- Concentrations and packaging of medications may change depending on availability; adjust volume administered to ensure proper dosing.
- IV/IO bolus should be administered over 10 seconds.
- Slow IV push should be administered over 1 – 2 minutes.
-

MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Adenosine 12 mg in 4 mL Prefilled syringe	12 mg	1 st dose - 0.1 mg/kg 2 nd dose - 0.2 mg/kg Max dose 12 mg	Rapid IV/IO	Continuous ECG Attempt to record conversion	Narrow complex tachycardia	Heart block Heart transplant Resuscitated PNB
Albuterol/ Ipratropium (Ventolin/ Atrovent) 2.5 mg albuterol / 0.5 mg ipratropium in 3 mL unit dose	5 mg albuterol /1 mg ipratropium in 3 mL, Max dose 15 mg albuterol/ 3 mg ipratropium	2.5 mg albuterol / 0.5mg ipratropium in 3 mL Max dose 7.5 mg albuterol/ 1.5 mg ipratropium	Nebulized; Do not dilute	Patients with cardiac history over the age of 60 will have ECG monitoring during administration Heart rate Change in respiratory status	Respiratory distress	Heart rate >180
Amiodarone (Cordarone) 150 mg in 3 mL Carpject	300 mg	5mg/kg	IV/IO bolus	ECG changes Blood pressure	Cardiac arrest	2 nd or 3 rd degree AV block, Bradycardia Not to be administered via ETT
	150 mg add to 100 mL D5W	5mg/kg add to 100 mL D5W, Max dose 300 mg	IV/IO drip, run over 10 minutes		Wide complex tachycardia	
Aspirin 81 mg Chewable tablet	324 mg - 4 tablets	N/A	Chew and swallow	N/A	Angina / acute coronary syndrome	Allergy

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MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
MEDICATION LIST

Approved by: M. Riccardo Colella, DO, MPH, FACEP
Page 2 of 6

MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Atropine 1mg in 10 mL Prefilled	0.5 - 1 mg Minimum dose 0.1 mg Max dose 0.04 mg/kg	0.02 mg/kg Minimum dose 0.1 mg Max dose 1 mg	IV/IO	Heart rate before and after administration; BP within 5 minutes of administration; ECG changes	Bradycardia	Tachycardia
	2 mg	0.4 mg/kg	ET			
	2 - 5 mg	0.5 mg/kg	IV/IO			
Calcium Gluconate 1g in 10mL Single dose vial	3 g Max dose 3g	60 mg/kg Max dose 3000mg	IV/IO Push over 2-5 minutes	ECG changes Watch carefully for infiltration Bradycardia	Suspected hyper- kalemia in cardiac arrest; As directed by medical control	Ventricular fibrillation Ventricular tachycardia
D5 in Water 100 mL bag	Used to dilute amiodarone, sodium bicarbonate	Used to dilute dextrose and sodium bicarbonate		Monitor for infiltration Monitor pediatric blood glucose levels		None
Dextrose 25 g in 50 mL Prefilled	25 g	500 mg/kg (1 ml/kg) to a max of 25 g/dose	IV bolus or swallowed <i>IO in cardiac arrest</i> Dilute 1:1 with D5W for patient < 100 lbs (45 kg)	Changes in level of consciousness Repeat blood sugar determination Watch carefully for infiltration	Hypoglycemia	If hypoglycemic, no Contraindications

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Revision: 28

MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
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Approved by: M. Riccardo Colella, DO, MPH, FACEP
Page 3 of 6

MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Diphenhydramine (Benadryl) 50 mg in 1 mL, 25 mg pills	25 – 50 mg	1 mg/kg Max dose 25 mg	IV/IO Push, IM, oral	Changes in level of consciousness	Anaphylaxis	Presence of a self-administered CNS depressant
Dopamine 200 mg in 250 mL Premixed IV	2 – 20 mcg/kg/min	2 – 20 mcg/kg/min	IV/IO drip	ECG changes Headache Watch carefully for infiltration	Hypotension	Hypovolemic shock Ventricular fibrillation, Ventricular tachycardia or PVCs
DuoDote Kit Atropine 2.1 mg/0.7 mL Pralidoxine 600 mg/2 mL Autoinjector	Atropine – 2 mg IM Pralidoxine – 600 mg IM	N/A	IM autoinjectors	Change in symptoms Change in level of consciousness	Chemical exposure	Mild symptoms with no miosis
Epinephrine 1:1000 – 1 mg in 1 mL vial	0.3 mg (greater than 30 kg) or adult autoinjector	0.15 mg (less than 30 kg) or pediatric autoinjector	IM, or autoinjector (Vastus lateralis preferred site)	Breath sounds and vital signs within 5 minutes of administration Effect on heart rate ECG changes	Anaphylaxis	No absolute contraindications in a life-threatening situation Use caution when administering to patient with hypertension or coronary artery disease
	0.5 - 1 mg 2 mg	0.01 mg/kg 0.1 mg/kg	IV/IO ET		Cardiac arrest	
Epinephrine 1:10,000 1 mg in 10 mL Prefilled	0.1 mg/kg	0.01 mg/kg Max dose 1 mg	IV/IO	Breath sounds and vital signs within 5 minutes of administration Effect on heart rate ECG changes	Refractory anaphylaxis	No absolute contraindications in a life-threatening situation Use caution when administering to patient with hypertension or coronary artery disease
	0.5 – 1mg	IV/IO – 0.01mg/kg Max dose 1 mg	IV/IO		Cardiac arrest	
	2 mg ET	0.1 mg/kg Max dose 1 mg	ET		Cardiac arrest	

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MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
MEDICATION LIST

Approved by: M. Riccardo Colella, DO, MPH, FACEP
Page 4 of 6

MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Fentanyl 100 mcg/ 2 mL Carpject/tubex	1 mcg/kg Max single dose 100 mcg	0.5 – 1mcg/kg Max single dose 50 mcg	IV/IO Push IM, IN	Change in pain level Changes in respiratory rate and effort	Pain management	Respiratory depression GCS < 14 Hypotension
Glucagon 1 mg with 1 mL diluting solution	1 mg	1 mg	IM, IN	Level of consciousness Repeat blood glucose determination	Hypoglycemia	Known hypersensitivity Known pheochromocytoma
Glucose (oral) 15 g in 37.5 g Gel tube	15g	15g	Swallowed	Level of consciousness	Hypoglycemia	Lack of gag reflex Patient unable to swallow
Hydroxocobalamin (CYANOKIT®) (1) 5 g vial Reconstitute with 200 mL saline or D5W	5 g IV/IO drip	70 mg/kg Max dose 5 g	IV/IO drip infused wide open over 15 minutes	Blood pressure Nausea Headache Site reactions Rash	Cyanide poisoning	None
Ketamine 500 mg in 5 mL Vial	1 mg/kg; max dose 100 mg ----- 3 mg/kg max dose 300 mg	1 mg/kg IV; max dose 100 mg ----- 3 mg/kg max dose 300 mg	IV; dilute 1:1 with NS ----- IM; do not dilute	Heart rate and rhythm Blood pressure Level of consciousness / hallucinations Excessive salivation Respiratory rate	Excited delirium; Immediate threat of harm to self or others	Hydrocephalus Allergy
Lidocaine (Xylocaine) 20 mg/mL in 5 ml vial	1 mg/kg Max dose 40 mg	1mg/kg Max dose mg	IO Push	ECG changes	Pain management in conscious patients with IO insertion	Heart block Junctional arrhythmia Brady arrhythmia

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MEDICATION LIST

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Page 5 of 6

MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Midazolam (Versed) 5 mg in 5 mL vial	1 - 4 mg Max dose 4 mg	0.1mg/kg Max dose 2 mg	IV/IO Push, IN, rectal	Changes in respiratory rate and effort Changes in level of consciousness and seizure activity	Seizure Chemical restraint	Hypotension Presence of a self-administered CNS depressant
	10 mg Max dose 10 mg	0.25 mg/kg Max 5 mg	IM			
Naloxone (Narcan) 2 mg in 2 mL Prefilled	0.5 mg	0.1 mg/kg Max single dose 0.5 mg	IV/IO bolus, ET, IM, IN	Change in level of consciousness	Narcotic overdose	Allergy
Nitroglycerin Metered spray canister – 0.4 mg/spray	0.4 mg	N/A	Sublingual metered spray	Blood pressure prior to and after administration Headache	Angina / acute coronary syndrome/ CHF	Hypotension Use of Viagra-like medication (phosphodiesterase inhibitor) within last 72 hours
Normal Saline 1000 mL, 250mL bags, 2mL carpject	As needed for volume replacement or to administer medications	20 mL/kg	fluid bolus	Label date and time set up assembled Document mL of fluid infused Blood pressure Monitor for infiltration Attempt to keep warm in extreme cold	Fluid replacement	Discard after 24 hours or if no longer sterile
Ondansetron (Zofran) 4 mg oral dissolving tablets	Over 30 kg: 8 mg	15 – 30 kg: 4 mg	oral dissolving tablet	Headache Dizziness Dysarthria	Nausea/ vomiting	Prolonged QT complex: Male: greater than 450 ms Female: greater than 470 ms
Ondansetron 2 mg/mL in 2 mL vial	0.1 mg/kg–max 4 mg	0.1 mg/kg - max 4 mg	IV/IO Push	Headache Dizziness Dysarthria	Nausea/ vomiting	Prolonged QT complex: Male: greater than 450 ms Female: greater than 470 ms

Initiated: 9/92
Reviewed/revised: 10/1/15
Revision: 28

**MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
MEDICATION LIST**

Approved by: M. Riccardo Collella, DO, MPH, FACEP
Page 6 of 6

MEDICATION	USUAL ADULT DOSE	USUAL PEDS DOSE	ADMINISTRATION GUIDELINE	MONITOR, REPORT, DOCUMENT	INDICATIONS	CONTRAINDICATIONS
Sodium Bicarbonate 50 mEq in 50 mL Prefilled	0.5 - 1 mEq/kg	1 mEq/kg	IV/IO Bolus; dilute for infants 5 kg and less 1:1 with D5W	Change in level of consciousness ECG changes if given for tricyclic OD	Acidosis; Tricyclic OD	Do not mix with epinephrine or dopamine

Dopamine Drip Rate Chart – based on standard premixed solution of 200 mg/250 mL, using microdrip tubing (60 gtt/min/mL)

Formula: Amount to give (mcg) X weight (kg) X drip factor ÷ amount on hand (mcg/mL)

Example: Start a dopamine drip at 7.5 mcg on a patient who weighs 176 lbs, using standard premixed dopamine (200 mg/250 mL or 800 mcg/mL)

$$\frac{7.5 \text{ mcg} \times 80 \text{ kg} \times 60 \text{ gtt/min/mL}}{800 \text{ mcg/mL}} = \frac{36000}{800} = 45 \text{ gtt/min}$$

	lbs: 99	110	121	132	143	154	165	176	187	198	209	220
	kg: 45	50	55	60	65	70	75	80	85	90	95	100
Dose: 1 mcg/kg/min	4	4	4	5	5	5	6	6	6	7	7	8
2.5	8	9	10	11	12	13	14	15	16	17	18	19
5	17	19	21	23	24	26	28	30	32	34	36	38
7.5	25	28	31	34	37	39	42	45	48	51	53	56
10	34	38	41	45	49	53	56	60	64	68	71	75
15	51	56	62	68	73	79	84	90	96	101	107	113
20	68	75	83	90	98	105	113	120	128	135	143	150
25	84	94	103	113	122	131	141	150	159	169	178	189
30	101	113	124	135	146	158	169	180	191	203	214	225
35	118	131	144	158	171	184	197	210	223	236	249	263
40	135	150	165	180	195	210	225	240	255	270	285	300
45	152	169	186	203	219	236	253	270	287	304	321	338
50	169	188	206	225	244	263	281	300	319	338	356	375

Initiated: 7/1/14
Reviewed/revised: 10/1/15
Revision: 1

**MILWAUKEE COUNTY EMS
PRACTICE GUIDELINE
SPINAL MOVEMENT PRECAUTIONS**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 1 of 1

Definitions:

Spinal Movement Precautions (SMP): An effort to minimize unnecessary movement of the spine through a keen assessment, attention to maintaining a neutral, anatomic position of the spine and the use of adjuncts such as cervical collar, well-padded long backboard, scoop stretcher, or a flat ambulance stretcher (which essentially is a padded backboard); the goal of SMP is to minimize the risk of **spinal cord injury (SCI)** from an unstable fracture and reduce the need for and harm of using a backboard when possible.

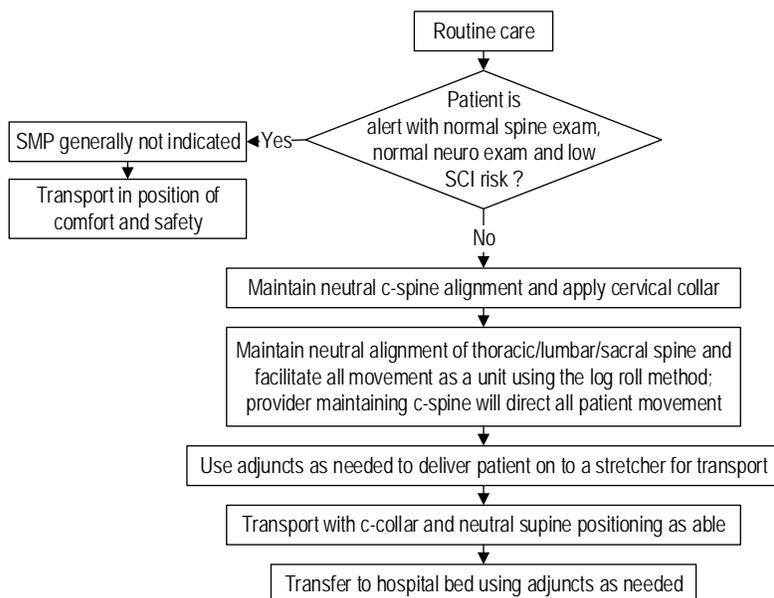
Alert patient: GCS 15, cooperative, clearly communicates, not distracted by pain, injury or circumstance and can focus on your instructions and exam; not intoxicated.

Normal spine exam: No midline bone pain or anatomic deformity ("step-off") and can subsequently passively rotate head 45 degrees to the left and right. An abnormal exam implies pain in the midline of the spine, palpable anatomic deformity of the spine, or an inability to passively rotate head 45 degrees to the left and right.

Normal Neurologic exam: Symmetrical hand squeeze, wrist extension, dorsiflexion, plantar flexion, gross sensation, NO numbness/weakness or priapism.

Low SCI Risk (Mechanism or Patient): EMS judgment of very low speed impact (e.g. minor MVC or ground level fall). Alert patients age 3 to 65 with no neurologic findings or no spine pain based on EMS judgment; ambulatory patients at scene; blunt trauma patients not meeting Level I or II trauma center evaluation criteria.

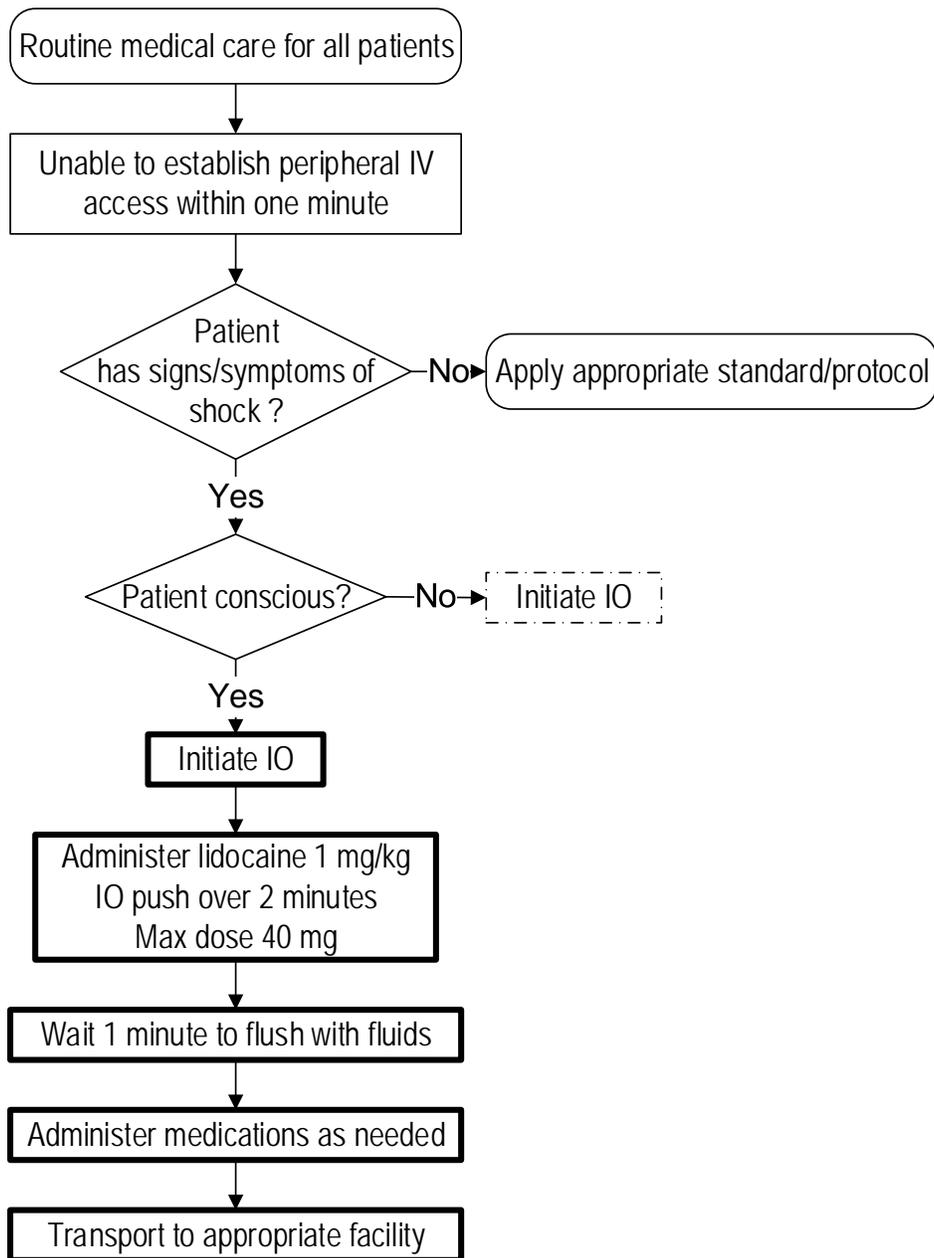
High SCI Risk (Mechanism or Patient): Blunt trauma meeting trauma transfer criteria for a Level I or II trauma center; penetrating trauma ONLY if an abnormal spine or neurologic exam AND transport not delayed by applying SMP (penetrating trauma to neck or torso alone does not make the patient high risk); age less than 3 or greater than 65 may be considered high risk when considering other major trauma factors.



NOTES:

- Do not strap or tape patient's head to the cot.
- It is mandatory to document the initial neurologic exam and upon each patient transfer (e.g. on to backboard/scoop/stretcher, prior to movement onto hospital bed and once transfer to hospital bed occurs). A simple one-line statement such as "patient's neurologic exam remained unchanged throughout all transfers" would suffice.
- Ideally, the backboard or scoop stretcher would be used as an adjunct if multiple extrication steps are needed in order to move a patient to a stretcher. Ambulatory patients or those patients with minor spine pain seated in a vehicle or at the scene may be gently assisted directly to an ambulance stretcher brought directly to them to minimize movement. EMS will make every effort to minimize movement to the spine in this process. A "short board" or K.E.D may be used as an extrication tool. It does not provide benefit and should not be used when implementing spinal movement precautions.
- Pediatrics age 3 to 8 that otherwise fit the low risk criteria may not require SMP based on the EMS provider's judgment.
- Hospital inter-facility transfers should not require a backboard although they will often require SMP; careful coordinated movement from hospital to ambulance stretcher using a scoop stretcher or slide board should suffice; ambulance stretcher straps should be secured.

1 st Responder
BLS
ILS
ALS



Notes:

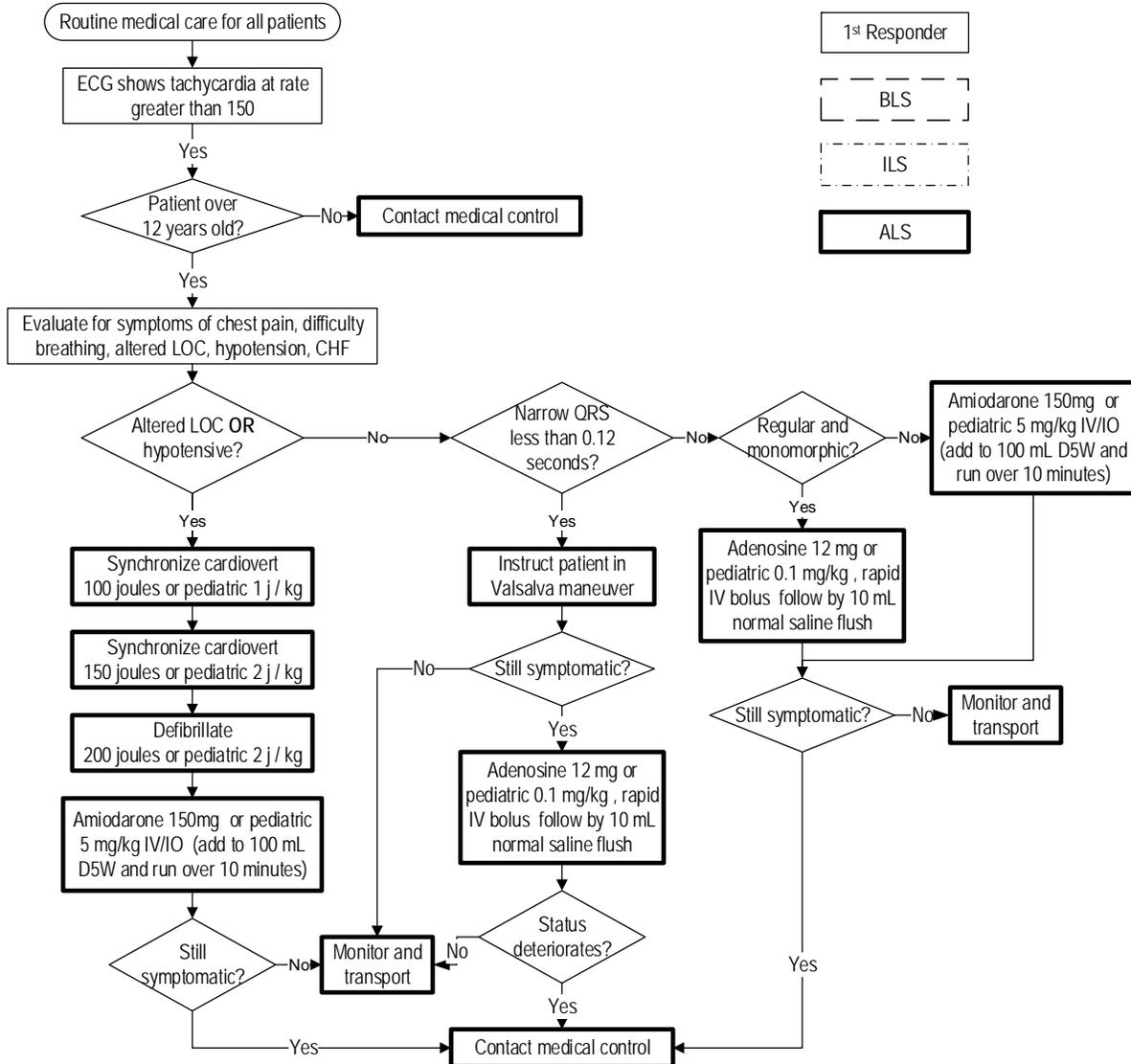
- Inability to locate an appropriate vein site is equivalent to an attempt. It is not necessary to actually penetrate the skin with a needle *for this protocol only*.
- Contraindications to the use of the intraosseous route are major extremity trauma (fractured femur/tibia or evidence of internal/external thigh hemorrhage), and area of infection over the proposed insertion site (infected skin, abscess, etc.).

Initiated: 5/22/98
 Revised: 10/1/15
 Revision: 8

**MILWAUKEE COUNTY EMS
 MEDICAL PROTOCOL
 TACHYCARDIA WITH PULSES**

Approve: M. Riccardo Colella, DO, MPH, FACEP
 WI EMS Approval Date: 6/22/11
 Page 1 of 1

History	Signs/Symptoms	Working Assessment
Arrhythmia History of palpitations or "racing heart" AICD MI CHF History of stimulant ingestion	Systolic blood pressure <90 Altered LOC, dizziness Chest pain Shortness of breath Diaphoresis Palpitations ECG shows tachycardia greater than 150/min	Tachycardia



NOTES:

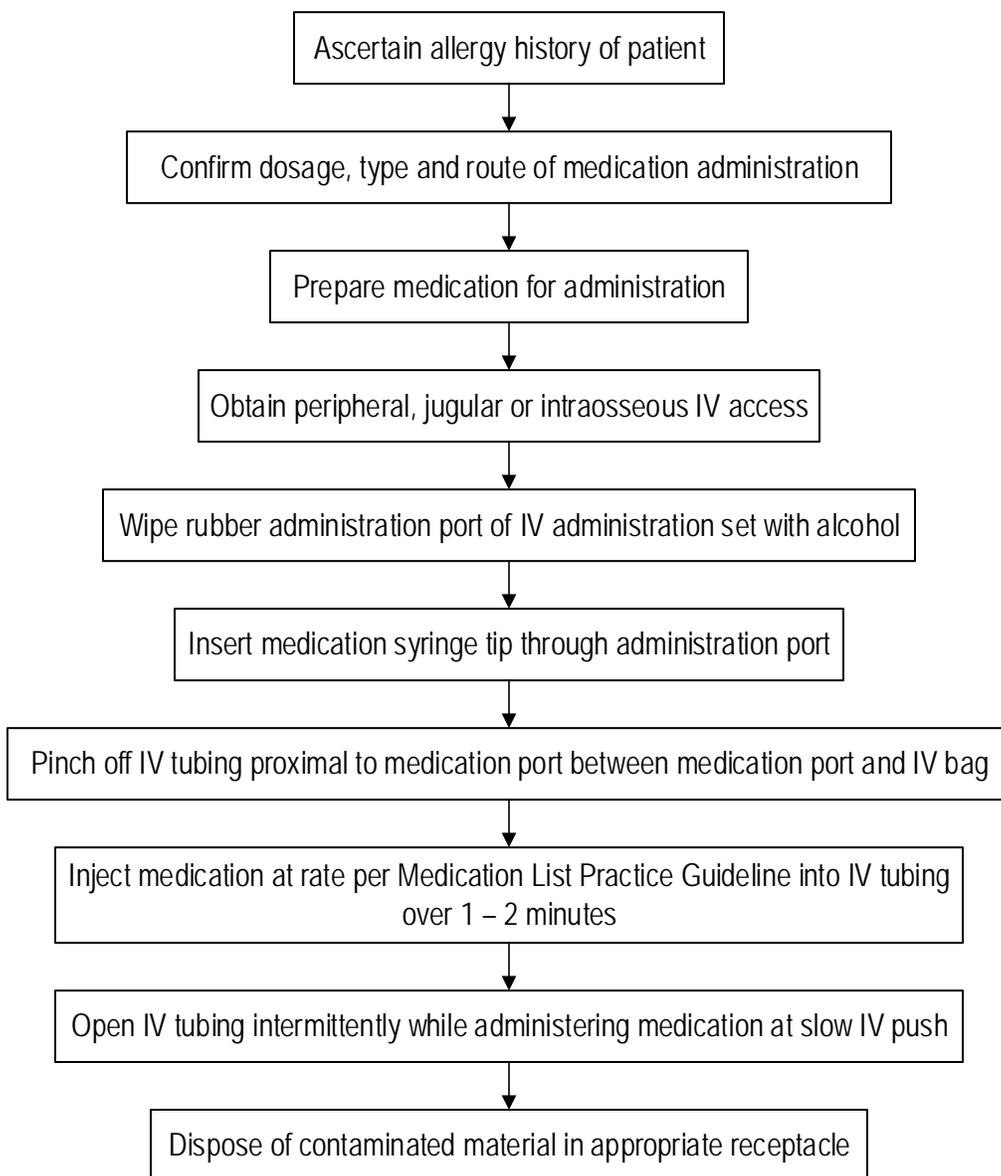
- Contraindications to adenosine are: heart block, heart transplant, resuscitated cardiac arrest; patients taking theophylline products, Tegretol (carbamazepine, which increases the degree of heart blocks caused by adenosine) or Persantine (dipyridamole, which potentiates the effects of adenosine).
- Because of its short half-life, adenosine must be administered rapid IV bolus followed by a 10 cc normal saline flush
- After administration of adenosine, patient may have a disorganized ECG or brief period of asystole prior to conversion to sinus rhythm. Patients have reported feelings of "impending doom" during this period.
- Adenosine is not effective on atrial fibrillation.
- Carotid massage is not to be performed in the Milwaukee County EMS System.

Initial: 9/92
 Revised: 10/1/15
 Revision: 3

MILWAUKEE COUNTY EMS
 PRACTICAL SKILL
 INTRAVENOUS PUSH
 MEDICATION

Approved: M. Riccardo Colella, DO, MPH, FACEP
 Page 1 of 1

Purpose: To deliver medication directly into the blood stream for slower distribution to the rest of the body, preventing adverse reactions		Indications: Patients with IV access who need medication with higher probability of adverse reaction due to rapid administration	
Advantages: Delivers medication slowly to the circulatory system for distribution throughout the body	Disadvantages: Must have IV access	Complications: Irritation to the vein by medication injected Extravasation of medication into subQ tissue if IV infiltrates	Contraindications: Infiltration of IV line Injury to the venous system proximal to the injection site

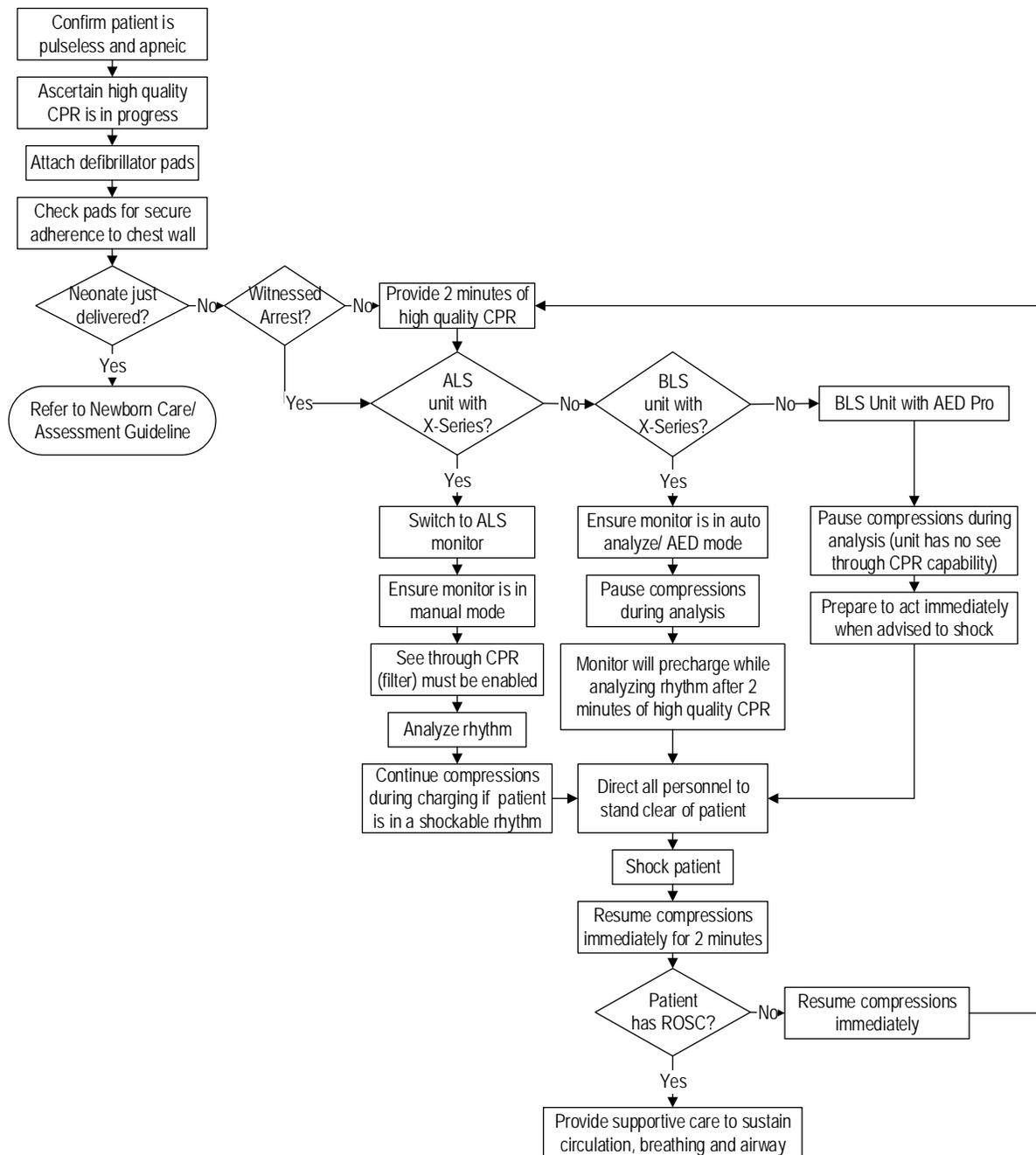


Initial: 9/92
Reviewed/ revised: 10/1/15
Revision: 8

**MILWAUKEE COUNTY EMS
PRACTICAL SKILL
DEFIBRILLATION**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 1 of 1

Purpose: To simultaneously depolarize the myocardial cells to terminate ventricular fibrillation or ventricular tachycardia		Indications: Patient presents pulseless and apneic in ventricular fibrillation or ventricular tachycardia	
Advantages: Termination of VF or VT in the pulseless, apneic patient	Disadvantages: Electrical current causes some injury to myocardium	Complications: Poor interface between chest wall and pads can cause burns	Contraindications: Any patient with pulses Valid DNR orders Conditions incompatible with life



NOTES:

- Rescue mode is not to be used on the X-Series
- Do not apply defibrillator pads over a pacemaker or automatic implanted cardiac defibrillator (AICD).
- Remove Nitropatch or Nitropaste before attaching defibrillator pads.
- Do not defibrillate when conditions exist for electrical conductivity (wet environment, etc.).

Initiated: 12/10/82
Reviewed/Revised: 10/1/15
Revision: 41

**MILWAUKEE COUNTY EMS
OPERATIONAL POLICY
TRANSPORT DESTINATION**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Page 1 of 2

POLICY: Patients are to be transported to the closest, most appropriate, open receiving hospital, taking into consideration:

- Patient's medical condition;
- Patient's request;
- Location of regular care, primary medical doctor and/or medical records;
- Insurance/HMO.

Patients in need of specialty care should be transported to the closest appropriate receiving facility, based on the following information:

Medical Emergencies :		
Aurora: Grafton Sinai St. Luke's – Milwaukee St. Luke's – South Shore West Allis Memorial/Women's Pavilion Children's Hospital and Health System Children's Hospital of Wisconsin	Columbia St. Mary's (CSM): Milwaukee Ozaukee Froedtert Health: Community Memorial Froedtert ProHealth Care: Waukesha Memorial	Wheaton Franciscan Healthcare (WFH): All Saints (Racine) Elmbrook Memorial Franklin St. Francis St. Joseph The Wisconsin Heart Hospital Zablocki VA Medical Center (VA)
Patient Assessment:	Specialty Hospital:	
STEMI (Acute MI per pre-hospital ECG) ROSC	Transport to closest hospital, regardless of diversion status – Aurora Grafton; St. Luke's Milwaukee; Children's Hospital of Wisconsin; CSM-Milwaukee; CSM-Ozaukee; Community Memorial, Froedtert Hospital, Waukesha Memorial; All Saints, Elmbrook Memorial, St. Francis, St. Joseph, Wheaton Franklin, WI Heart Hospital. If patient is stable and requests transport to medical home, transport to closest STEMI/ROSC hospital within medical system.	
Stroke Center – Last Known Well (LKW) less than 8 hours	Transport to closest hospital, regardless of diversion status – Aurora Grafton; Aurora Sinai; St. Luke's Milwaukee; West Allis Memorial; St. Luke's South Shore; Children's Hospital of Wisconsin; CSM-Milwaukee; CSM-Ozaukee; Community Memorial, Froedtert Hospital, Waukesha Memorial; Elmbrook Memorial; St. Francis; St. Joseph. If patient is stable and requests transport to medical home, transport to closest stroke hospital within medical system.	
Need for Trauma Center evaluation Burns and/or possible CO poisoning WITH major/multiple trauma	Children's Hospital of Wisconsin Froedtert Hospital	
Possible CO poisoning with altered mental status, WITHOUT burns/major trauma	Transport to the closest: St. Luke's - Milwaukee	
Significant burns (thermal, chemical or electrical) <i>with or without</i> possible CO poisoning WITHOUT major trauma	CSM - Milwaukee	
Other hyperbaric (air embolism, decompression disease, bends, SCUBA)	Transport to the closest: St. Luke's - Milwaukee	
Major pediatric illness/injury	Children's Hospital of Wisconsin	
Pediatric burns (Age <12)	Children's Hospital of Wisconsin	
Unstable newborns	Transport to the closest Neonatal Intensive Care Unit: Children's Hospital of Wisconsin	St. Joseph CSM - Milwaukee All Saints - Racine
Sexual assault - WITHOUT co-existing life threatening condition	Adults (age 18 and over): Aurora Sinai West Allis Memorial Emergency Department	Children (under age 18): Children's Hospital of Wisconsin
OB patients in labor	1. Facility where patient received their prenatal care is preferred. Hospitals never close to women in labor. <i>For gestational age less than 20 weeks, patient will be evaluated in ED.</i> 2. For imminent delivery, transport to the closest open hospital: Aurora Grafton; Aurora Sinai; West Allis Memorial; CSM-Milwaukee; CSM-Ozaukee; Community Memorial, Froedtert Hospital, Waukesha Memorial; All Saints; Elmbrook Memorial; St. Francis; St. Joseph; WI Heart Hospital	
Psychiatric Emergencies: Medical clearance needed No medical clearance needed/patient is at high risk for harm to self or others, and/or is behaviorally disruptive (should be placed on Emergency Detention) No medical clearance needed/patient is at low risk for harm to self or others (police involvement not required)	Closest Emergency Department Psychiatric Crisis Service of Milwaukee County Behavioral Health Division (PCS) 1. If patient is seen in the Milwaukee County Behavioral Health system (MCBHD), transport to the Psychiatric Crisis Service (PCS) center on a voluntary basis 2. If not a patient of MCBHD, transport to closest ED for mental health evaluation	
Infection Alert: Ebola Ebola Virus Disease (EVD)	Wheaton Franciscan Healthcare - transport to St. Joseph for stable patients requesting a Wheaton Franciscan hospital All other hospital systems – transport to the closest appropriate hospital	

- NOTES:**
- No routine transport to a closed hospital under any circumstances.
 - Hospitals providing specialty services never close to their specialty.
 - *WI Trac* will post transport instructions for extenuating circumstances

<i>Designation by Hospital</i>							
<i>Hospital</i>	<i>Stroke</i>	<i>STEMI/ ROSC</i>	<i>Trauma</i>	<i>Burn</i>	<i>Unstable Newborn</i>	<i>Hyperbaric</i>	<i>Sexual Assault</i>
Aurora Grafton	Primary						
Aurora Sinai	Primary						Over 18 years
Aurora St. Luke's (Main)	Comprehensive					CO without burns	
Aurora St. Luke's – South Shore	Primary						
Aurora West Allis	Primary						Over 18 years
Children's Hospital of Wisconsin	Primary		Under 18 years	Under 12 years			Under 18 years
Columbia St. Mary's - Milwaukee	Primary			12 years & over			
Columbia St. Mary's – Ozaukee	Primary						
Froedtert Community Memorial	Primary						
Froedtert Hospital	Comprehensive		18 years & over				
Waukesha Memorial	Primary						
Wheaton Franciscan All Saints (Racine)							
Wheaton Franciscan Elmbrook Memorial	Primary						
Wheaton Franciscan Franklin							
Wheaton Franciscan St. Francis	Primary						
Wheaton Franciscan St. Joseph	Primary						
Wheaton Franciscan Wisconsin Heart Hospital							

Note:

White box = hospital open to specialty service	Gray box = hospital does not offer specialty service; no transport
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