

SKILL	INDICATION	ALS STANDING ORDER	CONTRAINDICATION	COMMENTS
Bougie	Assist with intubation	Yes	Unable to visualize the cords	No blind intubations. May use bougie if agency approved and trained annually Optional inventory
Carboxyhemoglobin monitor	Suspected or known carbon monoxide exposure	Yes	None	Consider transport to facility with hyperbaric chamber for suspected carbon monoxide poisoning in the unconscious or pregnant patient.
Cardioversion: synchronized	Unstable VT Unconscious SVT	Yes	<b>Pediatric:</b> If defibrillator unable to deliver <5 J or biphasic equivalent	In addition to NTG patches, remove chest transdermal medication patches prior to cardioversion.
	Unconscious Atrial fibrillation/flutter and HR >180	After x3 BHO		
	Unstable, conscious SVT (BHO) Unstable, conscious Atrial Fibrillation/Flutter HR ≥180(BHPO)	No		
CPAP	Age ≥ 15 years Respiratory Distress: CHF, COPD, asthma, pneumonia or drowning. Moderate to severe respiratory distress. Retractions/accessory muscle use <b>AND</b> <ul style="list-style-type: none"> <li>• RR ≥25/min</li> <li><b>OR</b></li> <li>• SpO<sub>2</sub> &lt;94%</li> </ul>	Yes	Unconscious CPR BP <90 mmHg Vomiting Age<15 Possible pneumothorax Facial trauma Unable to maintain airway	CPAP may be used only in patients alert enough to follow direction and cooperate with the assistance. Non-verbal patients with poor head/neck tone may be too obtunded for CPAP. BVM assisted ventilation is the appropriate alternative.  CPAP should be used cautiously for patients with ?COPD or pulmonary fibrosis, start low and titrate pressure.
Defibrillation	VT (pulseless) VF	Yes	None	In addition to NTG patches, remove chest transdermal medication patches prior to defibrillation.
Dermal Medication	When route indicated.	Yes*	Profound shock CPR Pediatric	Avoid application to areas that may be used for cardioversion.

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EKG monitoring	Any situation where potential for cardiac dysrhythmia.	Yes	None	Apply monitor before moving patient with chest pain, syncope, or in arrest. Document findings on PPR and leave strip with patient.
12 lead EKG	Chest pain and/or Signs and symptoms suggestive of myocardial infarction.  Suspected hyperkalemia and $\geq 72$ hours since last dialysis.  ROSC after cardiac arrest  To identify a rhythm.	Yes	None	Report: ***Acute MI*** or ***Acute MI Suspected*** Bundle Branch Block (LBBB, RBBB). Poor quality EKG, artifact, paced rhythm, atrial fibrillation or atrial flutter for exclusion from STEMI assessment.  Repeat the 12-lead EKG only if the original EKG interpretation is NOT ***ACUTE MI SUSPECTED***, and patient's condition worsens. Do not delay transport to repeat. Document findings on the PPR and leave EKG with patient.
End tidal CO <sub>2</sub> Detection Device (Qualitative)	All intubated patients <15kgs - unless quantitative end tidal CO <sub>2</sub> available for patient <15kgs.	Yes	None	Monitor continuously after ET / ETAD/ Perilaryngeal Airway Adjunct insertion
End tidal CO <sub>2</sub> Detection Device – Capnography (Quantitative)	All intubated patients Respiratory distress Trauma	Yes	None	Monitor continuously after ET / ETAD/ Perilaryngeal Airway Adjunct insertion Use early in cardiac arrest
Esophageal Detection Device-aspiration based	Patients intubated with ETT or ETAD	Yes	Patient <20 kg Laryngeal/Tracheal Airway (King Airway)	Repeat as needed to reconfirm placement. May use for both ET/ETAD (Port 2) Optional
External Cardiac Pacemaker	Unstable narrow complex bradycardia with a pulse refractory to Atropine 1 mg Unstable wide complex bradycardia (BP <90 AND chest pain, dyspnea or altered LOC	Yes	None	Document rate setting, milliamps and capture  External pacing on standing orders should begin with minimum rate set at 60/min. Energy output should be dialed up until capture occurs, usually between 50 and 100mA. The mA should then be increased a small amount, usually about 20%, for ongoing pacing.

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Glucose Monitoring	Hypoglycemia (suspected)	Yes	None	Repeat BS not indicated en route if patient is improving. Repeat BS must be done if patient left on scene and initial was abnormal. (AMA/Release)
Hemostatic Gauze	Life-threatening hemorrhage when tourniquet cannot be used or to supplement tourniquet.	Yes	Bleeding controlled with direct pressure with standard gauze.	Should be applied with minimum 3 minutes of direct pressure.
Intranasal: IN	When IN route indicated	Yes*	None	Volumes over 1ml per nostril are likely too large and may result in runoff out of the nostril.
Injection: IM	When IM route indicated	Yes*	None	Usual site: Deltoid in patients greater than or equal to 3 years of age. (Maximum of 1ml volume).  Vastus lateralis patients less than 3 years of age. (Maximum of 3ml volume).
Injection: IV	When IV route indicated	Yes*	None	
Intubation-ET/Stomal	Apnea or ineffective respirations for unconscious adult patient or decreasing LOC.  If unable to adequately ventilate via BVM the unconscious pediatric patient who is apneic or has ineffective respirations.  Newborn deliveries if HR<60 after 30 seconds of ventilation and if unable to adequately ventilate via BVM.  To replace ETAD/Perilaryngeal if: <ul style="list-style-type: none"> <li>• ventilations inadequate OR</li> <li>• need ET suction</li> </ul>	Yes	? Opioid OD prior to Narcan  Able to adequately ventilate the pediatric patient via BVM  Gag reflex	3 attempts per patient <u>SO</u> Additional attempts <i>BHPO</i> Attempt=attempt to pass ET (not including visualizations and suctioning). Document and report <b>LEADSD</b> Reconfirm and report EtCO <sub>2</sub> and lung sounds after each pt movement and at turnover Extubation <u>SO</u> if placement issue, otherwise per <b>BHO</b> . ET Depth Pediatrics: Age in years plus 10. If intubated patient is to be moved apply c-collar prior to moving.

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Intubation: Perilaryngeal airway adjunct  (ETAD/Combitube. Laryngeal- Tracheal/King Airway)	Apnea or ineffective respirations for unconscious patient or decreasing LOC.	Yes	Gag reflex present Patient <4' tall ? Opioid OD prior to Narcan Ingestion of caustic substances Hx esophageal disease Laryngectomy/Stoma	Extubate <u>SQ</u> if placement issue, otherwise per BHO  <u>King Airway:</u> Use Size 3 (yellow) for patients 4' – 5' tall Use Size 4 (red) for patients 5' – 6' tall Use Size 5 (purple) for patients >6' tall  <u>ETAD:</u> Use Small Adult size tube in all patients under 6' Report and document ventilation port number if ETAD.  Document and report <b>LEADSD</b> . Reconfirm and report EtCO <sub>2</sub> and lung sounds after each patient movement and at turnover. If intubated patient is to be moved apply c-collar prior to moving.
Length Based Resuscitation Tape (LBRT)	Determination of length for calculation of pediatric drug dosages and equipment sizes.	Yes	None	Base dosage calculation on length of child, if weight unknown. Refer to pediatric chart for dosages (P-117). Children >37 kg. use adult medication dosages regardless of age or height.
Magill Forceps	Airway obstruction from foreign body with decreasing LOC/unconscious	Yes	None	
Nasogastric / Orogastric tube	Gastric distention interfering w/ ventilations	Yes	Severe facial trauma Known esophageal disease	If NG tube needed in a patient with a King Airway, insertion should be via the suction port, if available.
Nebulizer, oxygen powered	Respiratory distress with: • Bronchospasm • Wheezing • Croup-like cough • Stridor	Yes*	None	Flow rate 4- 6 L/min. via mouthpiece; 6-10 L/min. via mask/ET.

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Needle Thoracostomy	Severe respiratory distress with unilateral, diminished breath sounds and systolic BP <90 in intubated or positive pressure ventilated patients.  Pediatric: severe respiratory distress with unilateral diminished breath sounds AND BP <70 + (2 x age) in intubated or positive pressure ventilated patients.	Yes	None	Use 14g, 3.25 inch IV catheter  Insert into 2nd/3rd ICS in mid-clavicular line on the involved side. (Preferred) <b>OR</b> Insert catheter into anterior axillary line 4th/5th ICS on involved side  Tape catheter securely to chest wall and leave open to air.
Prehospital Pain Scale	All patients with a traumatic or pain-associated chief complaint	Yes	None	Assess for presence of pain and intensity.
Prehospital Stroke Scale	All adult patients with suspected Stroke/CVA	Yes	None	Assess facial droop, arm drift, & speech. Bring witness, or obtain contact number, to help hospital personnel establish time of onset.
Pulse Oximetry	Assess oxygenation	Yes	None	Obtain room air saturation if possible, prior to O <sub>2</sub> administration.
Re-Alignment of Fracture	Grossly angulated long bone fracture	Yes	None	Use unidirectional traction. Check for distal pulses prior to realignment and every 15" thereafter. <b>BHO</b> in long bone fractures with neurovascular compromise.
Removal of Impaled Object	Compromised ventilation of patient with impaled object in face/cheek or neck.	Yes	None	

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Spinal Stabilization	Spinal pain of ?trauma MOI suggests ?potential spinal injury Acute neurological deficit Penetrating trauma with neurological deficit.	Yes	None	Pregnant patients (>6mo) tilt 30 degree left lateral decubitus.  Optional if no neuro deficit <b>AND all of the following are present and documented:</b> <u>Adult Patient (&lt;65 years of age)</u> 1. awake, oriented to person, place & time 2. no drug/ETOH influence 3. no pain/tenderness of neck or back upon palpation 4. no significant competing, distracting pain 5. cooperative 6. no language barrier  <u>Pediatric Patient</u> N=no altered LOC E=evidence of obvious injury absent C=complete spontaneous ROM without pain K=kinematic (mechanism) negative  Children restrained in car seat may be immobilized and extricated in the car seat. If patient condition allows and immobilization is secure the child may remain in the car safety seat for transport.
Tourniquet	Severely injured extremity when direct pressure or pressure dressing fails to control life-threatening hemorrhage.	Yes	None	Direct pressure failure not required prior to tourniquet application in mass casualty.  Tourniquet must be tight enough to occlude arterial flow.
Valsalva Maneuver	SVT	Yes	None	Most effective with adequate BP D/C after 5-10 sec if no conversion

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<b>VASCULAR ACCESS</b>				
External jugular	When unable to establish other peripheral IV and IV is needed for definitive therapy <b>ONLY</b> .	Yes	None	
Extremity	Whenever IV line is needed or anticipated for definitive therapy.	Yes BHPO if other than upper extremities or external jugular	None	Lower extremities remain SO in the pediatric patient.
Indwelling Devices	Primary access site for patients with indwelling catheters if needed for definitive therapy.	Yes	Devices without external port	Clean site for minimum of 15 seconds prior to accessing. Infuse at a rate to support continuous flow and prevent backflow into IV line. Needleless systems may require adaptor. Examples include Groshong, Hickman, PICC lines.
Intraosseous	Fluid/medication administration in <b>acute status</b> patient when needed for definitive therapy and unable to establish venous access.  Pediatric patient: unconscious.	Yes	Tibial fracture Vascular Disruption Prior attempt to place in target bone	Splint extremity. Observe carefully for signs of extravasation. Do not infuse into fracture site. Neonate < 28 days old <b>BHO</b> (<1 cm in depth).  In conscious adult patient slowly infuse Lidocaine 2% (preservative free) 40mg IO prior to fluid administration.
Percutaneous Dialysis Catheter Access(e.g. Vascath)	Unable to establish other peripheral IV and <b>IV needed for immediate definitive therapy ONLY</b> and no other medication delivery route available	No	None	Vas Cath contains concentrated dose of Heparin which must be aspirated <b>PRIOR</b> to infusion. Infuse at a rate to support continuous flow and prevent backflow into IV line. Needleless systems may require adaptor. Annual training required.
Shunt/graft - AV (Dialysis)	Unable to establish other peripheral IV and <b>IV is needed for immediate definitive therapy ONLY</b> and no other medication delivery route available.	No	None	Prior to access, check site for bruits and thrills. Access fistula on venous side (weaker thrill). Inflate BP cuff around IV bag to just above patient's systolic BP to maintain flow of IV. If unsuccessful, hold direct pressure over site for 10" to stop bleeding. Do not apply pressure dressing.

\* When medication by that route is a SO.

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