

Southeast Arizona EMS Region

Standing Order Training Module

Unconscious/Unresponsive

January 2005

PURPOSE

This SAEMS Standing Order Training Module has been developed to serve as a template for EMS provider training. The intent is to provide consistent and concise information to all providers practicing within the SAEMS Region. The content of the Training Module has been developed by the Protocol Development and Review Committee, and includes the specific Standing Order, resource and reference material, and instructions for completing the Training Module to obtain continuing education credit. One hour of SAEMS continuing education credit may be issued following successful completion of the module.

OBJECTIVES: Upon completion of this learning module the participant will be able to:

1. Discuss the role of medical direction related to the use of Standing Orders.
2. List three benefits of Standing Orders.
3. Outline inclusion and exclusion criteria for this Standing Order.
4. Describe the communication process between the field and the receiving facility when a Standing Order is implemented.
5. List the elements of the dispatch radio relay.
6. List two reasons for direct facility (on-line) contact following implementation of a Standing Order.

INSTRUCTIONS:

1. Read the accompanying information, Standing Order, and any additional reference material as necessary.
2. Complete the attached Posttest by _____, and return with self addressed envelope to:

3. A SAEMS CE Form will be issued to providers scoring greater than ____% on the Posttest.
4. Please contact _____ for questions, suggestions, concerns.

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Resource Material

OVERVIEW

The EMS system in Tucson has traditionally operated under direct medical control, requiring early radio contact with a base hospital physician on all prehospital encounters. The concept of Standing Orders developed as a natural evolution of a busy EMS system. SAEMS implemented Standing Orders in 1998, with the intent of reducing the amount of time required for radio contact while maintaining or improving the level of patient care provided in the community. The regional Base Hospital Medical Directors approved each Standing Order and granted authority for providers to assess and treat select patients *without* on-line medical direction. The potential benefits of a Standing Order (off-line) system include a shorter on-scene time, more appropriate treatment decisions, more time to interact with the patient, and broader consistency in care.

Providers practicing in the SAEMS region are governed not only by their Scope of Practice, but also by Protocols, Minimum Treatment Standards, and Standing Orders. There are a number of SAEMS *Administrative* Protocols outlining responsibilities for such things as approved documentation abbreviations, infectious disease exposure notification, and select patient triage parameters. The *Advanced Training* Protocols list those skills requiring additional training and medical director approval; for example, automatic transport ventilators and central line insertion.

Minimum Treatment Standards are an algorithmic flow of basic standards of care for various patient care situations. They outline, at a minimum, the assessment and treatment considerations for BLS and ALS providers, and are available should communication attempts for on-line medical direction fail.

Standing Orders differ from Protocols and Minimum Treatment Standards in that there is no required contact with a medical direction authority for orders. The physician orders are outlined on each Standing Order document. They are the legal equivalent of a radio transmitted, on-line order from a medical direction authority. For this reason, they do not allow for any deviation: orders must be followed sequentially and precisely. They are not guidelines or suggested interventions.

DEFINITIONS

- **Protocols** - Guidelines for prehospital care ranging from administrative to procedural.
- **Minimum Treatment Standards** – Algorithm for minimum standard of care guidelines for patient care situations.
- **Standing Orders** – Specific interventions which may be undertaken in lieu of contacting on-line medical direction.
- **On-Line Medical Direction** - Medical direction of prehospital activities by direct radio or telephonic communications with a medical direction authority.
- **Medical Direction Authority** – An administrative medical director or an on-line medical direction physician.
- **MEDS (dispatch) Communication Relay** – Essential information relayed from the field to the receiving facility via dispatch regarding a Standing Order patient.

DOCUMENTATION

Quality prehospital care can be achieved following adequate education and training, accurate patient assessment, skilled procedure intervention, use of good judgment, and continuous quality improvement. Documentation is essential to validate quality care. Reports should allow others to understand and follow the providers' decision-making process, particularly when Standing Orders are implemented, as the prehospital care report will often be the sole document describing the call.

There are key components to the written report when Standing Orders are utilized. Thorough documentation of an adequate assessment is essential. Reference to inclusion and exclusion criteria is recommended, with attention also paid to pertinent negatives. It should be clear why the particular Standing Order was chosen. Implementation and response to interventions is also a critical part of the prehospital report. Independent, off-line practice often requires additional responsibility on the part of the provider when it comes to judgment and documentation.

COMMUNICATION

All standing orders require the following information be provided to dispatch and relayed to the receiving facility: specific standing order used, age, sex, and ETA. Additional information may be required as follows:

- | | |
|---|--|
| 1. Acute Anaphylaxis/Stable Allergic Reaction | Stable/Unstable |
| 2. Acute Pulmonary Edema | |
| 3. Asthma/COPD | |
| 4. Cardiac Arrest | |
| 5. Chest Pain | 12-Lead sent? |
| 6. Dead on Scene | No hospital relay |
| 7. Hypoglycemia | |
| 8. Minor Medical | Chief complaint ("Sick Person" not acceptable) |
| 9. Motor Vehicle Crash | No hospital relay |
| 10. Pain Management | Chief complaint (mechanism of injury) |
| 11. Seizures | BLS or ALS |
| 12. Stroke/TIA | Symptom onset, patient weight |
| 13. Unconscious/Unresponsive | |

There is no need for a dual patch on standing order patients going to a non-medical direction authority facility (VA, HCH, or UPH), as the physician orders are already provided. Receiving facilities must be familiar with each standing order to best anticipate and prepare for the patient's arrival. Standing Orders are not intended for use during interfacility transfers, nor are they appropriate for use on pregnant patients. Check with your medical direction authority for recommendations regarding the use of Standing Orders during scene transfers greater than 30 minutes. Also check with your medical direction authority for a list of those Standing Orders approved for *your* use.

**NEVER HESITATE TO CONTACT MEDICAL
DIRECTION FOR ANY PROBLEM, QUESTION,
OR CHANGE IN STATUS!**

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Post Test

Name: _____ Date: _____

1. Which of the following is not indicated in the initial supportive care for the Unconscious/Unresponsive Standing Order?
 - a) Oxygen to keep O2 saturation above 90%
 - b) Finger stick blood sugar
 - c) Cervical spine immobilization
 - d) Cardiac monitor

2. Upon arrival, you find a 68 year old male lying supine on the grass near his house. Neighbors state he may have been working on the roof. Assessment reveals a response only to painful stimuli and a respiratory rate of 30. You notice an abrasion to the occipital scalp. In discussing the possible implementation of the Unconscious/Unresponsive Standing Order, you opt for direct contact with the medical direction authority because:
 - a) The patient's age excludes him as a candidate
 - b) The patient's respiratory rate excludes him as a candidate
 - c) The bystanders are intoxicated
 - d) The possibility of trauma excludes him as a candidate

3. The Unconscious/Unresponsive Standing Order should be implemented for patients with these symptoms:
 - a) Age less than 21, history of drug use, cardiac dysrhythmias, FSBS less than 20
 - b) Age greater than 16, no cardiac dysrhythmias, absence of trauma, history of drug use
 - c) Age greater than 16, unequal pupils, slurred speech, recent head trauma
 - d) Recent head trauma, history of drug use, FSBS greater than 60

4. You respond to the McDonald's restroom for an unconscious female with evidence of IV drug use. Following implementation of the Unconscious/Unresponsive Standing Order, you obtain a FSBS reading of 42. Your next course of action would be:
 - a) Terminate the use of the Unconscious/Unresponsive Standing Order and begin implementation of the Hypoglycemia Standing Order
 - b) Continue with the Unconscious/Unresponsive Standing Order and administer 100mg Thiamine and one amp of D50
 - c) Continue with the Unconscious/Unresponsive Standing Order and titrate dextrose to effect
 - d) Terminate the use of the Unconscious/Unresponsive Standing Order and contact your medical direction authority for orders

5. In treating the patient in question # 4 you initiate an IV and begin titrating Narcan. What *gradual* effects are you attempting to achieve?
 - a) Reversal of hypotension
 - b) Reversal of respiratory depression
 - c) Reversal of depressed mentation
 - d) All of the above

6. After administering Thiamine, Dextrose, and 2 mg of Narcan to the patient in question # 4, her condition remains unchanged. She begins to vomit and you are concerned about protecting the airway. You should:
 - a) Turn, suction and intubate
 - b) Relay to dispatch a change in the patient's condition
 - c) Suction, intubate and then give more Narcan
 - d) None of the above

7. If two IV attempts have been unsuccessful your next course of action would be to:
 - a) Continue transporting to the closest facility
 - b) Administer 0.2 mg per kg sublingual Narcan
 - c) Administer 0.5 to 2 mg subcutaneous Narcan
 - d) Administer 0.5 to 2 mg rectal Narcan

8. The theory behind Thiamine administration prior to Dextrose administration is that it:
 - a) Should be administered first as it is a negatively charged ion
 - b) Is more rapidly administered IV as it consists of less volume than Dextrose
 - c) Avoids the consequences of Wernicke's Encephalopathy
 - d) Avoids the complications of Korsakoff's Syndrome

9. Consider intubation in the Unconscious/Unresponsive Standing Order patient if they:
 - a) Have a respiratory rate less than 8
 - b) Are unable to protect their airway
 - c) Have a Glasgow Coma Score less than 8
 - d) All of the above

10. Communication relay regarding the Unconscious/Unconscious Standing Order patient should include:
 - a) Patient age, sex, history, GCS
 - b) Standing order, age, sex, ETA, transporting unit
 - c) Nationality, ETOH use, age, GCS
 - d) Standing order, age, history, ETA, transporting unit

Bibliography

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2. Krafur J: What to do when EMS protocols don't fit. *National Association of Emergency Physicians Newsletter*. 2000; 9:3. 2-3.
3. Trauma Team EMS PROTOCOLS
[HTTP://WWW.SSGFX.COM/CP2020/MEDTECH/PROCEDURES/PROTOCOLS.HTM](http://www.ssgfx.com/CP2020/MEDTECH/PROCEDURES/PROTOCOLS.HTM)
Prehospital Medical Protocols & Standing Orders Bryan E. Bledsoe, DO, FACEP.
4. Azzara A, *PreHospital Providers' Guide to Medication*. W.B. Saunders, Philadelphia, PA, 2000.
5. Bledsoe B, Porter R, Shade B, *Paramedic Emergency Care*. 2nd Ed. Prentice hall, Englewood Cliffs, NJ, 1994

Unconscious/Unresponsive Pitfalls & Pearls

- This standing order is developed for use on patients experiencing a narcotic or other drug/toxin overdose. It is **NOT** intended for patients unconscious/unresponsive following a possible neurologic insult or trauma.
- Narcan is administered in incremental doses “to effect”. Ideally, the desired effect is a reversal of respiratory depression, hypotension, and an improvement in mentation to the point where the patient can protect their airway. An initial, full 2.0 mg dose of Narcan may result in an uncooperative, combative patient in narcotic withdrawal.
- Medical direction contact is required for Narcan doses exceeding 2.0 mg.