WADING RIVER FIRE DISTRICT BOARD OF FIRE COMMISSIONERS

6.4a EMS Scenarios for Clearing Process

******Provider will have 2 credentialed EMTs to Assist with Patient Care******

1. Cardiac Arrest

   52 y/o male witnessed arrest by wife. Pt found supine of floor of living room at home. CPR being performed by family member. Compressions initiated by family approx. 1 minute after arrest. EMS assessment finds patient pulseless and apneic. VFib on the monitor. Hx of HTN and Hyperlipidemia. No drug allergies. Goal is to have provider run the Vfib/Pulseless vtac protocol correctly which will lead to ROSC after at least a proper placement of advanced airway, IV/IO or EJ, one round of epinephrine, one round of amio and at least 2 shocks. When ROSC is achieved, provider will be expected to manage the patient under the Shock/Hypoperfusion protocol. It will be expected that the provider will continue to monitor the post arrest patient and will administer both IV fluid and Norepinephrine to patient with proper doses. A 12 lead must be acquired on the post arrest patient as well. If the providers is unable to manage the arrest patient, ROSC will not be achieved and the patient will go into asystole. It will be expected that the provider continue to run the call under the asystole/PEA protocol.

2. Cardiac Dysrhytmia

   VTac – 74 y/o female found unresponsive on floor with vtac on monitor at a rate of 220bpm. BP 64/36. RR 10/min. SPO2 91%. Patient has hx of MI, HTN, and Type 2 DM. Allergies limited to PCN. It will be expected that the provider manages the patient by identifying the proper cardiac rhythm and performs cardioversion of patient at proper joule setting. Patient will be cardioverted twice in order to convert cardiac rhythm to NSR.

   Symptomatic Bradycardia – 68 y/o male c/o 8/10 sternal chest pain with radiation to left shoulder and mild dyspnea. Vital are HR 38/regular. BP 76/40. RR 20/slightly labored. SPO2 94%. Monitor shows sinus brady. 12 lead shows no signs of MI. Provider is expected to control rate by administering atropine as per protocol. If successful, rhythm will change to NSR at rate of 84 with patient becoming normotensive. Chest pain and SOB will also be resolved.

SVT – 29 y/o female c/o palpitations. No significant medical hx. No allergies. EKS shows SVT at rate of 186bpm. BP 96/68. RR 20/regular. SPO2 97%. Provider is expected to manage SVT by administering adenosine. Rhythm will convert to NSR if second dose of adenosine is properly administered IVP

Rapid Afib – 91 y/o female found unresponsive at home. Hx of afib, MI, HTN and mild dementia. No drug allergies. EKG shows rapid afib at rate of 180. BP 68/38. RR 16/shallow. SPO2 91% Provider is expected to perform cardioversion at proper joule setting. After 2 successful cardioversion attempts rhythm converts to afib at rate of 60bpm.

3. Acute MI

58 y/o male c/o 10/10 chest pain and SOB. Cardiac Rhythm is Sinus Brady at rate of 54bpm. 12 lead shows inferior/lateral wall ST elevations. BP 104/60. RR 26/labored. SPO2 87% RA. Increases to 96% with supplemental O2. Hx of HTN and hyperlipidemia. No allergies. Patient must be managed by acquiring 12 lead and transmitting. ASA at proper dose. IV/IO/EJ must be established. Looking for provider to withhold NTG due to BP/inferior wall pattern. Transport to a PCI center is expected. Possible medical control request for pain management after consult about 12 lead.

67 y/o female c/o pain to left shoulder blade, 8/10 scale with nausea and vomiting. 12 lead shows sinus rhythm with PVCs with ST elevations in V1 and V2 consistent with septal wall MI. HR is 88bpm. BP 168/104. RR 16/regular. Patient must me managed with O2, 12 lead, ASA, IV/IO/EJ and NTG. Medical control must be contacted for transport decision and analgesia can be requested during consult. Medical Hx of HTN, Hyperthyroidism and Type 1 DM.

4. Difficulty Breathing

74 y/o female c/o SOB. Hx of CHF, MI, COPD and HTN. HR/104bpm Sinus Tach. BP 194/116. RR 30/shallow and labored. SPO2 81% RA. Does not respond well to O2 via NRB. SPO2 only increases to 84% without relief. Lung sounds show rales and diffuse wheezes bilat with diminished sounds at bases. Pedal edema is present. Patient must me managed with CPAP and NTG. No drug allergies.

5. Major Trauma

29 y/o male found lying in roadway after being struck by vehicle while jogging. Patient presents with unresponsiveness (GCS of 3), head trauma and tension pneumothorax on left side. Patient also has left obvious femur fracture and unstable pelvic fx. HR 140bpm Sinus Tach, RR 38/min shallow and labored. Lung Sounds on left are absent and clear on Right. SPO2 78%. BP 64/30. No significant gross bleeding. Patient must be managed as per Suffolk county trauma protocols

as well as transported to Level One trauma center as per CDC trauma triage guidelines. Needle decompression and fluid challenges are a must or patient will expire.

6. Pediatric medical scenario

7 y/o female c/o severe SOB and dizziness. Patient has allergy to peanuts and was eating Halloween candy when she became symptomatic. Patients presents with HR of 160 bpm Sinus Tach. RR 30/min shallow and labored. BP 68/36. SPO2 84%. Audible stridor can be heard. Lung sounds present with inspiratory and expiratory wheezes. Skin is warm and flushed with raise urticarial. Patient weighs 60lbs. Patient must be managed with Epinephrine, diphenhydramine and combi vent inhalation meds.