CT STATEWIDE EMS PROTOCOLS v2017.2 REVISION SUMMARY

protocol or page #	Title	Comments/Justification for Change	Change made
GLOBAL UPDATE TO ALL AFFECTED PROTOCOLS		Normal Saline should be consistent throughout (either 0.9% Sodium Chloride or Normal Saline)	Changed throughout to "normal saline".
NEW ADDITION TO ALL PROTOCOLS			Added "ToC" icon to all pages that hyperlinks back to corresponding location in Table of Contents.
GLOBAL UPDATE TO ALL AFFECTED PROTOCOLS		FDA, ISMP (Institute for Safe Medication Practices) and the USP (United States Pharmacopeia) collaborate on drug labeling and drug safety issues. As of May 2016, the USP no longer allows ratio expressions of single entity drug products (e.g. 1:1000 Epi). They have directed that Epi 1:1000 injection will only be displayed as 1 mg/ml , and 1:10,000 will only be displayed as 0.1 mg/ml.	Revised Epinephrine to read 1 mg/ml (1:1,000) and Epinephrine 0.1 mg/ml (1:10,000) to ensure consistency and assist in the transition period.
GLOBAL UPDATE TO ALL AFFECTED PROTOCOLS		Add 'if available' to glucose reading for EMT/AEMT	Added 'if available' to glucose reading for EMT/AEMT sections for the applicable protocols.
GLOBAL UPDATE TO ALL AFFECTED PROTOCOLS			IO and IV are interchangeable. Added IO to all protocol routes as IV.
3	Table of Contents	Need to add page numbers to table of contents	page numbers added
7	Preface	There has been a good deal of question about the floor/ceiling issue that it may be best to get rid of all together - simply describe it as it is...we now have a single set of statewide protocols, there are options within the protocols that are sponsor hospital dependent.	Removed the sentence, " This document creates a desire for uniform practice in the State of Connecticut. Although there are options within the Protocols…"
9	Revision and Update Procedure	on page 1 "every two years" review is stated but on page 8, "annual review" is stated.	Changed verbiage to every two years.
9	Revision and Update Procedure	The phrase regarding review timeline of emergecny change requests states the review will be "in an expedited manner and the decision made conveyed to the petitioner in 5 business days" doesn't create a logical timeline.	Revised to delineate 5 business days from receipt of ct statewide protocol subcommittee Chair.
1.0	1.0 - Routine Patient Care	Revise Infant RR (Supraglotic) to 18-20 breaths per minute.	corrected.
1.0	Routine Patient Care	Requirement for sending the patient care report to the receiving hospital.	added as a bullet point.
2.0	2.0 - Abdominal Pain	Consistent with AHA guidelines/Mission Lifeline data, Remove 'consider' and require 12 lead for all patients > 30 years of age with epigastric pain / heartburn.	Removed "consider" .

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protocol or page #	Title	Comments/Justification for Change	Change made
2.0	2.0 - Abdominal Pain	Address guidance for and in setting of pain in pregnancy or labor with the following: Pregnant patients experiencing moderate to severe pain may receive opioid analgesics if indicated. This includes patients in active labor. Care should be taken to avoid excessive dosing and maternal sedation since maternal hypoventilation and resultant hypoxia may be harmful to the fetus. Fentanyl may be preferred in active labor due to its short half life and lower pain should not induce dependence in the fetus and is unlikely to be directly harmful. Closely monitor any patient receiving opioids for sedation. Be certain to accurately and effectively communicate information regarding EMS opioid administration to receiving medical staff.	Added to PEARL in PAIN MANAGEMENT Protocol: Be cautious with pregnancy, or have the potential for hemodynamic compromise. If available, Fentanyl is the preferred Analgesia in this patient population (pregnancy). Additionally, add hyperlink to Pain Management protocol (Obstetrics - 2.5) Added to PEARLS: 1) Pregnant patients, including those in active labor, may receive opiates if indicated. 2) Care should be taken to avoid maternal hypoventilation as resultant hypoxia may be harmful to the fetus. 3) Closely monitor any patient receiving opioids for sedation. 4) Be certain to accurately and effectively communicate information regarding EMS opioid administration to receiving medical staff.
2.0	2.0 - Abdominal Pain	Under AEMT the protocol states “if pt is hypotensive consider fluid per shock - non-traumatic protocol 2.20”. The suggestion is to change the verbiage to “if the patient is hypotensive, treat according to Non-Traumatic Shock Protocol”. This would also standardize similar references to other protocols.	Changed verbiage to “if the patient is hypotensive, treat according to Non-Traumatic Shock Protocol
2.2P	2.2P - Allergic reaction	Pediatric Vasopressor Dosing - Pedi Anaphylaxis 2.2P has epi drip as 0.1-2 mcg/kg/min with max of 10 mcg/min. Pedi Septic Shock 2.19P and Pedi Post resus care 3.4 both have epi drip as 0.1-1 mcg/kg/min with no max dose. Is it intended for anaphylaxis to have a higher per kg dose? If so, why a max cap on the dose for anaphylaxis but not the other shock states?	Revised to Epi at 0.1-2 mcg/kg/min, start low and titrate to effect. No maximum dosage.
2.3	2.3 - ALTE	ALTE will need revision to BRUE (Brief Resolved Unexplained Event)	Updated, providing both terms (ALTE and BRUE) with the acronym spelled out (Brief Resolved Unexplained Event) during the transition.
2.4P	2.4P Asthma / Bronchiolitis	Continue with nebulized racemic epinephrine	Added verbiage Consider nebulized racemic Epinephrine, 0.5 ml of 2.25% (11.25mg) OR nebulized Epinephrine, 5 mg of 1 mg/mL (1:1000).
2.4P	2.4P Asthma / Bronchiolitis	Add bullets to PEARLS	Made technical change.

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2.5	2.5 - Behavioral Emergencies	First bullet under Excited/ Agitated Delirium in E/A section hyperlinks to Hyperthermia protocol 2.10. Hyperthermia protocol is actually 2.8.	Corrected link.
2.7	2.7 Hyperglycemia - Adult & Pediatric	Move Nausea Protocol hyperlink to A/P	Removed from EMT section to AEMT/Paramedic section.
2.9A	2.9A - Hypoglycemia	Standing order for additional dose of d10%	Added standing order to Repeat D 10% dosage x 1, with verbiage for Providers to contact Direct Medical Oversight for patients requesting refusals (as this is a high risk refusal). Also added to PEARLS (Providers are encouraged to administer additional dosages while transporting to the Emergency Department).
2.11	2.11- Nausea/Vomiting Adult & Pediatric	Also, allow metoclopramide 10mg IM as an option (Region 3 MAC endorsed 9/13/16). The suggestions were due to the delay in onset of action of ondansetron, which is 10-20 min when given IV, and for patients who are refractory to the other antiemetics (eg already administered or take at home and not working).	Revised Metoclopramide dosage to 5-10 Mg. IM / IV
2.12A	2.12A - Nerve Agents Organophosphate Poisoning	Is midazolam / lorazepam dosing too low?	Added bullet to end of protocol hyperlinking to Seizure protocol if actively seizing.
2.12A	2.12A - Nerve Agents Organophosphate Poisoning	Change Atropine to escalating dose (double every 5 minutes until out of atropine or bronchorrhea ceases). Literature supports this measure.	Added PEARL, if Atropine toxicity is observed, cease administation and treat as appropriate. Also changed Atropine dosing to: Atropine 2 mg IV; double the dose and repeat every 5 minutes (i.e. 4mg, then 8mg, etc.) until out of atropine or bronchorrhea ceases.
2.15	2.15 OB Emergencies	Under Pre-Eclampsia/Eclampsia, under paramedic standing orders, the protocol states “magnesium sulfate, 4 grams IV bolus….”. The recommendation is to specify that the 4gm magnesium sulfate IV is to be diluted in a minimum of 100mL NS	Added magnesium sulfate to be diluted in a minimum of 100mL NS under pre-eclampsia/eclampsia section.
2.16A	2.16A - Pain Management	Add 'to max total of 30 Mg.' for Ketamine	Added 'to max total of 30 Mg.' for Ketamine dosing.
2.16A	2.16A - Pain Management Adult	1st attempt tactile stimulation, add dose of naloxone for iatrogenic overdose. 1st attempt tactile stimulation. insert PEARL to consider diluting in syringe or bag to facilitate titration (beg with 0.4 mg and titrate up PRN)	Added to section: 1st attempt tactile stimulation. Revised Antidote dosage to 0.04 Mg IV and titrate up to 2.0 Mg until able to maintain oxygenation. Inserted PEARL to consider diluting in syringe or bag to facilitate titration.

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2.16A	2.16A - Pain Management	Number in blue margin does not match protocol number	made technical change.
2.16A	2.16A - Pain Management Adult	Add guidance regarding indications for pain management, documentation when / why withholding;	Added to Paramedic standing orders section: After appropriate BLS intervention, if patient still reports pain ≥4/10, the paramedic should offer/discuss analgesic administration with patient regardless of vital signs or patient affect. When appropriate, analgesia should be offered prior to movement or procedures likely to worsen pain. If analgesia is withheld for moderate to severe pain, the reasons/decision-making should be documented.
2.16P	2.16P - Pain Management	Antiemetic use for pediatric patients receiving narcotics	Pediatric dosing of Ondansetron added via addition of Nausea/Vomitting protocol hyperlink.
2.17A	2.17 A - Poisoning / Substance Abuse / Overdose	Add sedation, hydration, cooling for sympathomimetic / stimulant OD	Added: to treat hyperthermia/dehydration, see Hyperthermia Protocol 2.8.
2.17A	2.17A Poisoning/Substance Abuse/Overdose	Add tinnitus to s/sx of aspirin Overdose	Tinnitus added to s/sx of Aspirin Overdose.
2.17A	2.17A Poisoning/Substance Abuse/Overdose	Revise the statewide protocols to allow for the dose of IN naloxone to be 2-4mg. This takes into consideration the potential for having to treat a fentanyl/fentanyl derivative and the increasing presence of and desire to carry the newer Narcan IN setup which only comes in a 4mg preparation at this point. There is some science regarding bioavailability that makes the 4mg dose more palatable to me. Also, anecdotally, the NASEMSO medical directors have not seen the expected over vigorous wake-up/withdrawal and many are using the Narcan device widely.	***PREVIOUSLY RELEASED*** - Revised dosage for EMT/AEMT/Paramedic to 2-4 Mg IN.
2.17P	2.17 P - Poisoning / Substance Abuse / Overdose	Add sedation, hydration, cooling for sympathomimetic / stimulant OD	Added: to treat hyperthermia/dehydration, see Hyperthermia Protocol 2.8.
2.17P	2.17P - Poisoning/Substance Abuse/Overdose	AEMT can give Naloxone IM/IV to pedi patient but only via IN to adults.	Added verbiage relative to those operating under the 2007 Scope of Practice.

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protocol or page #	Title	Comments/Justification for Change	Change made
2.17P	2.17P - Poisoning/Substance Abuse/Overdose	Add tinnitus to s/sx of aspirin Overdose	Tinnitus added to s/sx of Aspirin Overdose.
2.17P	2.17P - Poisoning/Substance Abuse/Overdose		Under Suspected Simpathomimetic/Anticholinergic/Stimulant modified Midazolam dosing max from “max 5mg” to “max 2mg”. Also modified administration intervals for both midazolam and lorazepam from “repeat once in 10 minutes” to “repeat once in 5 minutes”.
2.17P	2.17P - Poisoning/Substance Abuse/Overdose	Revise Naloxone dosage to 4 Mg - Maximum dosage per application. Approved for both Pediatric and Adult, however should not be used for neonatal population (may need PEARL for neonatal population). Also need clear up benzodiazepine dosing - add hyperlink to seizure protocol.	Added to PEARLS: consider alternative treatments when multiple doses are administered, including airway management, and Airway management should remain paramount. Added “/Anticholinergic” to “Suspected Sympathomimetic/Stimulant” bullet; Added bullet below the benzodiazepines in “suspected sympathomimetic” to address cooling/hydration: Treat hyperthermia/dehydration, see Hyperthermia Protocol 2.8 A&P AND added below hyperthermia/dehydration bullet: Treat seizures per Seizure Protocol 2.18.
2.18A	2.18A - Seizures	Change IM Midazolam dosing to 5 Mg if 39 kg or less	Added"(≤39kg)"to midazolam dosage. Based upon Rampart study.
2.18A	2.18 A - Seizures	specify lorazepam 2 Mg for 39 kg and under and 4 mg for > 39 Kg	Added"(≤39kg)"to lorazepam dosage. Based upon Rampart study.
2.18A	2.18A - Seizures	Add 'if available' to glucose reading for EMT/AEMT	Added 'if available' to glucose reading for EMT/AEMT sections for the applicable protocols.
2.18A	2.18A - Seizures	If midazolam is unavailable, the Provider may administer lorazepam IM route. Will also need to update the 'Pearls' to remove the verbiage surrounding IM lorazepam.	Added IM route to lorazepam (with note) and removed lorazepam from 6th PEARL
2.18A	2.18A - Seizures	Consistency with Pediatric - repeat admin intervals for IM Midazolam (q 5 or 10 mins).	Revised IM midazolam administration intervals to every 5 minutes for consistency throughout.
2.18P	2.18P - Seizures	Consistency with Adult - repeat admin intervals for IM Midazolam (q 5 or 10 mins).	Revised IM midazolam administration intervals to every 5 minutes for consistency throughout.
2.19A	2.19A - Septic Shock	Add guidance on norepinephrine titration	Added "titrate dosage in increments of 1-4 mcg/min every 3-5 minutes".
2.19P	2.19P - Septic Shock	Pedi septic shock 2.19P has “pediatric” following the heading of “standing orders” for the EMT and AEMT sections but “Adult” in the paramedic section.	Corrected.

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2.19P	2.19P - Septic Shock	Pediatric Vasopressor Dosing - Pedi Anaphylaxis 2.2P has epi drip as 0.1-2 mcg/kg/min with max of 10 mcg/min. Pedi Septic Shock 2.19P and Pedi Post resus care 3.4 both have epi drip as 0.1-1 mcg/kg/min with no max dose. Is it intended for anaphylaxis to have a higher per kg dose? If so, why a max cap on the dose for anaphylaxis but not the other shock states?	Epi at 0.1-2 mcg/kg/min, start low and titrate to effect. No maximum dosage.
2.19P	2.19P - Septic Shock	Norepi dosing as “0.05 – 0.1 mcg/kg/min titrated to effect to maximum dose 2 mcg/kg/min” Maximum dose is greater than is listed for the titration range.	Revise to 0.1-2.0 Mcg / kg/min). Also add Norepinephrine to color coded pediatric dosing. Also add (30 mcg / minute as maximum (consistent with adult protocol)).
2.19P	2.19P - Septic Shock Pediatric	Pediatric Vasopressor Dosing - Pedi Anaphylaxis 2.2P has epi drip as 0.1-2 mcg/kg/min with max of 10 mcg/min. Pedi Septic Shock 2.19P and Pedi Post resus care 3.4 both have epi drip as 0.1-1 mcg/kg/min with no max dose. Is it intended for anaphylaxis to have a higher per kg dose? If so, why a max cap on the dose for anaphylaxis but not the other shock states?	Epi at 0.1-2 mcg/kg/min, start low and titrate to effect. No maximum dosage.
2.21A	2.21A - Smoke Inhalation Adult		Added consideration of nebulized Epinephrine (5 mg 1 Mg/mL Epinephrine) for Stridor at rest
2.21P	2.21A - Smoke Inhalation Pediatric		Added consideration of nebulized Epinephrine (5 mg 1 Mg/mL Epinephrine) for Stridor at rest
2.22	2.22 - Stroke	Consider adding vascular access (2) for AEMT / Paramedic - consistent with current best practices	Added Consider adding vascular access for AEMT/Paramedic standing orders section.
2.22	2.22 - Stroke	Revise local plan verbiage to 'Please refer to your local Stroke agreement plan.' and remove 'This pain intentionally left blank…"	Changed verbiage to Please refer to your local stroke agreement plan.
3.0A	3.0 - ACS	Add reference to N/V protocol.	Added hyperlink to Nausea/Vomiting protocol.
3.0A	3.0 - ACS	add STEMI scene time goal of <15 mins.	Added "STEMI scene time goal of <15 minutes" to PEARL.
3.0A	3.0 - ACS	Add 'Early notification of the receiving facility, preferably from the bedside, has been shown to significantly improve patient outcomefor STEMI patients' to first PEARL regarding transmission. Consistent with current Mission Lifeline goals.	Added 'Early notification of the receiving facility, preferably from the bedside, has been shown to significantly improve patient outcome for STEMI patients' to first PEARL regarding transmission.

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3.0A	3.0 A - ACS	Revise local plan verbiage to 'Please refer to your local STEMI agreement plan. Allows reference to local Sponsor Hospital/Regional plans within restraints of the document.	Changed verbiage to read Please refer to your local STEMI agreement plan.
3.0	3.0 - ACS - Adult	Activate Catheterization lab vs. "STEMI Alert"	Changed verbiage from Notify receiving facility of a 'STEMI Alert to Initiate local process for catheterization lab activation ('STEMI Alert').
3.0	3.0 - ACS - Adult	Replace Aspiring to Aspirin	Corrected.
3.0	3.0 - ACS - Adult	Heading of “If operating under 2007 scope of practice” is in bold face type on all other protocols where applicable.	Corrected.
3.1A	3.1A - Bradycardia	norepi in bradycardia , as it has no effect on heart rate -can we move it off and leave it in shock?	Removed Norepinephrine from protocol.
3.1A	3.1A - Bradycardia	Despite checking multiple resources (including AHA and Chief of Pharmacy at ECHN) I cannot find bradycardia as indication for administering Norepinephrine (unlike Dopamine).	Removed Norepinephrine from protocol.
3.2A	3.2A - Cardiac Arrest - Adult	Move 'Consider advanced airway only if airway patency cannot be maintained using basic maneuvers and adjuncts to AEMT.	Removed 'Consider Advanced Airway…' from EMT Protocol
3.4	3.4 - Post resuscitative care adult & pediatric	Pediatric Vasopressor Dosing - Pedi Anaphylaxis 2.2P has epi drip as 0.1-2 mcg/kg/min with max of 10 mcg/min. Pedi Septic Shock 2.19P and Pedi Post resus care 3.4 both have epi drip as 0.1-1 mcg/kg/min with no max dose. Is it intended for anaphylaxis to have a higher per kg dose? If so, why a max cap on the dose for anaphylaxis but not the other shock states?	Changed to Epi at 0.1-2 mcg/kg/min, start low and titrate to effect. No maximum dosage.
3.4	3.4 - Post resuscitative care adult & pediatric	Norepi dosing as “0.05 – 0.1 mcg/kg/min titrated to effect to maximum dose 2 mcg/kg/min” Maximum dose is greater than is listed for the titration range.	Revised to 0.1-2.0 Mcg / kg/min. Also added Norepinephrine to color coded pediatric dosing. Also added (30 mcg / minute as maximum (consistent with adult protocol)).
3.4	3.4 - Post resuscitative care adult & pediatric	Pediatric Vasopressor Dosing - Pedi post resus care 3.4 has norepi dose as 0.1-2 mcg/kg/min with no max. Why the very different dose ranges for pedi sepsis vs post resus care?	Revised to 0.1-2.0 Mcg / kg/min. Also added Norepinephrine to color coded pediatric dosing. Also added (30 mcg / minute as maximum (consistent with adult protocol)).

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3.4	3.4 - Post resuscitative care adult & pediatric	Pediatric Vasopressor Dosing - Pedi Anaphylaxis 2.2P has epi drip as 0.1-2 mcg/kg/min with max of 10 mcg/min. Pedi Septic Shock 2.19P and Pedi Post resus care 3.4 both have epi drip as 0.1-1 mcg/kg/min with no max dose. Is it intended for anaphylaxis to have a higher per kg dose? If so, why a max cap on the dose for anaphylaxis but not the other shock states?	Changed to Epi at 0.1-2 mcg/kg/min, start low and titrate to effect. No maximum dosage.
3.5A	3.5A - Tachycardia	Remove 3rd Adenosine dose (Consistent with current AHA guidelines/reference)	Removed 3rd Adenosine dose.
3.5A	3.5A - Tachycardia - Adult	Add 'Avoid Beta Blockers in patients with COPD / Asthma history"	Added under the 'Red Flag' portion
3.5A	3.5A - Tachycardia - Adult	The patient is already prescribed a calcium channel blocker administered diltiazem 0.25 mg per kilogram IV.	Added the nomenclature of '...if not currently on heart rate controlled agent' to Diltiazem
4.0A	4.0A - Burns	Use of Epinephrine - inhalation for upper airway inhalation burns	Added "stridor at rest" to list of clinical indicators that would direct provider to Airway Management 5.1
4.0A	4.0A - Burns	continue use of calcium gluconate for hydrofluoric acid burns/exposure. (evidence of CT manufacturing plants use large amounts of HF)	Added language: For Suspected or verified Hydrofluoric acid Skin Exposure a) Apply gauze soaked with 2.5% calcium gluconate gel to effected sites if available. b) Change dressing and apply new gauze soaked with 2.5% calcium gluconate gel to effected sites every 2 minutes as needed for ongoing pain c) Use caution in disposing of used gauze as it may contain trace amounts of HF
4.0A	4.0A - Burns	Under A-EMT, The Parkland Burn Formula only takes into account Second Degree (partial thickness) and greater in calculating resuscitation fluid volume – not clearly indicated in protocol. Should read…..If patient has sustained partial thickness second degree burn or full thickness third-degree burn greater than 20%.	In EMT portion, changed first degree to superficial. No additional actions required as the EMT section states specifically superficial should not be included in the TBSA.
4.0P	4.0P - Burns	Use of Epinephrine - inhalation for upper airway inhalation burns.	Added "stridor at rest" to list of clinical indicators that would direct provider to Airway Management 5.1

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4.0P	4.0P - Burns	continue use of calcium gluconate for hydrofluoric acid burns/exposure. (evidence of CT manufacturing plants use large amounts of HF)	Added language: For Suspected or verified Hydrofluoric acid Skin Exposure a) Apply gauze soaked with 2.5% calcium gluconate gel to effected sites if available. b) Change dressing and apply new gauze soaked with 2.5% calcium gluconate gel to effected sites every 2 minutes as needed for ongoing pain c) Use caution in disposing of used gauze as it may contain trace amounts of HF
4.0P	4.0P - Burns	Under A-EMT, The Parkland Burn Formula only takes into account Second Degree (partial thickness) and greater in calculating resuscitation fluid volume – not clearly indicated in protocol. Should read…..If patient has sustained partial thickness second degree burn or full thickness third-degree burn greater than 20%.	In EMT portion, change first degree to superficial. No additional actions required as the EMT section states specifically superficial should not be included in the TBSA.
4.2	4.2 - Eye and Dental Injuries Adult & Pediatric	Add direction on volume of fluid to irrigate for chemical burns 2 L per eye as wide open as pt will tolerate; add guidance that warm fluids is better tolerated.	Added to the second bullet - 'Large volume, up to 2 Liters of preferably warm Normal Saline'.
4.7	4.7 - Traumatic Brain Injury A/P	IM option is not listed in the TBI protocol. “IN” a typo and supposed to be “IM"	corrected.
4.7	4.7 - TBI	Lorazepam IN discussed in Protocol 4.7, and IM in 6.14 - desire for consistency in route of administration	Changed to be consistently IM.
5.1A	5.1A - Airway Management Adult		Added consideration of nebulized Epinephrine (5 mg 1 Mg/mL Epinephrine) for Stridor at rest.
5.1A	5.1A - Airway Management	Need to place hyperlink direct to Ventilator Protocol.	Added hyperlinked bullet below the RSI Protocol (just prior to "If feasible…")
5.1P	5.1P - Airway Management Pediatric		Added consideration of nebulized Epinephrine (5 mg 1 Mg/mL Epinephrine) for Stridor at rest.
5.5	5.5 - Nasotracheal Intubation	Verbiage for Fentanyl should read OR as opposed to AND	Added heading that states 'Consider Analgesia and Sedation (general statement and not specific medications) Ketamine placed under sedation portion. (1-2 Mg/Kg - need to confirm medication doses)
5.6	5.6 - Orotracheal Intubation	Verbiage for Fentanyl should read OR as opposed to AND	Added heading that states 'Consider Analgesia and Sedation (general statement and not specific medications) Ketamine placed under sedation portion (1-2 Mg/Kg - need to confirm medication doses)
5.8A	5.8 - RSI	Continue RSI for pediatric patients	Changed RSI protocol to remove 'Adult Only'

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5.8P	5.8P - RSI Pediatric	NEW	NEW
5.12	5.12 - Tracheostomy Care	In the EMT/AEMT section, add that they should suction any VISIBLE mucus plugs to help clear the airway, but NOT suction deep into the tracheostomy itself.	Added to EMT/AEMT section: suction any VISIBLE mucus plugs to help clear the airway, but NOT suction deep into the tracheostomy itself.
6.5	6.5 - Consent for Treatment of a Minor	Add criteria for implied consent 'when emergency treatment is reasonably believed to be necessary'.	Added implied consent section: when emergency treatment is reasonably believed to be necessary.
6.12	6.12 - Refusal of Care	Recommend adding reporting suspected child abuse to DCF and local police, not just local police.	Added to #9 of procedure section to contact DCF. Added consider contacting local law enforcement if immediate harm to life or limb is suspected.
6.12	6.12 - Refusal of Care	Direct Providers to call DMO for high risk refusals. Insert additional detail regarding competence / capacity exam and documenting same.	Added to criteria list: The patient is able to demonstrate clear thought process and understanding of risk of refusals. Documentation shall include the competence assessment and risk / benefit understanding by the patient.
6.12	6.12 - Refusal of Care	Recommend adding Pediatric considerations (<12 months) recommending the child is completely exposed to look for any bruising, intra-oral injury or other signs of abuse, regardless of chief complaint.	Added to procedure section: for patients <12months, during assessment examine for any bruising, intra-oral injury or other signs of abuse.
6.12	6.12 - Refusal of Care	Insert criteria for post dextrose administration.	Added to #1 of examples of high risk refusals list: 'History of Insulin Dependent Diabetes, Return to normal mental status, pretreatment glucose <80 mg/dL, post treatment glucose > 80 mg/dL, tolerates food by mouth, no other complicating factors or comorbid factors, follow up with primary care physician, no use of sulfonylureas, normal vital signs.
6.12	6.12 - Refusal of Care	patients that were tased added to list of high risk refusals.	Added to the list of examples of high-risk refusals: Patients that have been tased.
6.14	6.14 - Restraints	Lorazepam IN discussed in Protocol 4.7, and IM in 6.14 - desire for consistency in route of administration.	Changed to be consistently IM.
6.15	6.15 - Resuscitation Initiation and Termination	Revise bullets to letters. (a-d in section I and e-f in Section II)	Made technical correction.
6.15	6.15 - Resuscitation Initiation and Termination	Are E-F for EMR level providers as well? Clarificatrion should be provided to clarify that this is for EMT, AEMT, and Paramedic level only.	Added to Procedure for determination of death section: above EMR level.

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6.16	6.16 - Tasers	Contact Direct Medical Oversight for patients requesting Refusal of medical attention.	Added to procedure section: Contact Direct Medical Oversight for patients requesting Refusal of medical attention
6.17	6.17 - Tourniquet application	The third pearl in the list says, "transport patients directly to a level I or level I trauma center…" should say "level I or level II".	Made technical correction.
155	Adult Medication Reference	alter the statewide protocols to allow for the dose of IN naloxone to be 2-4mg. This takes into consideration the potential for having to treat a fentanyl/fentanyl derivative and the increasing presence of and desire to carry the newer Narcan IN setup which only comes in a 4mg preparation at this point. There is some science regarding bioavailability that makes the 4mg dose more palatable to me. Also, anecdotally, the NASEMSO medical directors have not seen the expected over vigorous wake-up/withdrawal and many are using the Narcan device widely. I would like to see this get reviewed at next month's meeting so we can include it with the first bolus of changes. I will make sure any support is in for the discussion.	***PREVIOUSLY RELEASED*** - Revised dosage for EMT/AEMT/Paramedic to 2-4 Mg IN.
155	Adult Medication Reference	Norepinephrine is Alpha adrenergic not adronergic.	Corrected.
155	Adult Medication Reference	Calcium Chloride - 1gm IV/IO over 5 minutes, ensure IV potency and do not exceed 1 ml per minute". Our services carry 1gm/10ml, so to give 10ml over 5 minutes would require 2ml per minute, which contradicts the protocol.	Revised to '5-10 minutes but not to exceed 1 mL per minute'.
155	Adult Medication Reference	Nitroglycerin - CHF - Revise SBP to 100 mmHg - consistency with the CHF protocol.	Made technical change.
168	Pediatric Color Coded Medication Reference		Added Norepinephrine dosing to all weight categories.
168	Pediatric Color Coded Medication Reference	Revise Tretracaine to Tetracaine	Corrected.
172	Scope of Practice Reference	Cardiac Management – Application of 12 Lead - Should be Triangle instead of Star for EMT & AEMT levels	Made technical change.
171	Scope of Practice Reference	Does not include cricothyrotomy	Surgical and Percutaneous Cric added to the Scope of Practice Reference.

CT STATEWIDE EMS PROTOCOLS v2017.2 REVISION SUMMARY

protocol or page #	Title	Comments/Justification for Change	Change made
171	Scope of Practice Reference	Nasopharyngeal airways should include EMR. NPAs for EMRs – The scope of practice matrix at the end excludes EMRs from inserting NPAs. I have services asking if they should discontinue buying them. Was this intended to be removed or a typo?	Corrected to include EMR level.