WIDE QRS COMPLEX TACHYCARDIA WITH A PULSE - ADULT/ADOLESCENT

ALS STANDING ORDERS:

1. Monitor cardiac rhythm and document with rhythm strip or 12-lead ECG.

   → If Automatic Implanted Cardiac Defibrillator (AICD) is in place and discharges ≥ 2 firings within 15 minutes, make Base Hospital contact for possible CVRC destination.

2. Pulse oximetry; if room air O_2 Saturation less than 95%:

   ▶ *High-flow oxygen by mask or nasal cannula at 6 l/min flow as tolerated.*

3. Assess hemodynamic stability of patient:

   Stable Wide Complex Tachycardia (Systolic BP > 90 mm Hg, appropriate mental status, minimal chest discomfort):

   - Monitor vital signs.
   - ALS escort to nearest ERC.

   Unstable Wide Complex Tachycardia (Systolic BP ≤ 90 mm Hg, altered LOC, chest pain, or signs of poor perfusion):

   ▶ Cardioversion : *100 J Biphasic or manufacturer's recommended cardioversion setting (do not delay for IV access if deteriorating);*

   → If cardioversion is unsuccessful:

   ▶ *Amiodarone 150 mg slow IV; allow to circulate for 2 minutes.*

   → If unstable Wide Complex tachycardia persists:

   ▶ Cardioversion: *At full voltage or manufacturer's recommended cardioversion setting.*

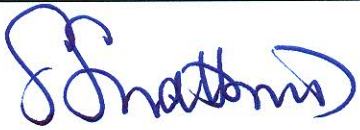
   → If Wide Complex tachycardia persists:

   ▶ Repeat *Amiodarone 150 mg slow IV*

   → After second dose of Amiodarone given and circulated 2 minutes, if Wide Complex Tachycardia persists:

   ▶ *Cardioversion: At full voltage or manufacturer's recommended cardioversion setting.*

   → ALS escort to nearest ERC or contact Base Hospital as needed.



TREATMENT GUIDELINES:

- Patients with stable wide complex tachycardia may present as syncope, weakness, chest pain, shortness of breath, or light-headedness. Patients with these symptoms should have cardiac monitoring with rhythm strip documented.

- Stable wide complex tachycardia (blood pressure present with minimal chest discomfort, alert and oriented, and minimal shortness of breath) is best transported without cardioversion or pharmacologic treatment.

- Amiodarone is associated with hypotension due to peripheral vasodilation and should be administered slowly to avoid profound drops in blood pressure.

ALS STANDING ORDERS:

1. For presentation of respiratory distress:

   Pulse oximetry, for oxygen saturation less than 95%:

   - ▶ *High-flow Oxygen by mask or nasal cannula 6 L/min flow rate (direct or blow-by) as tolerated*

2. In addition, if one of the following highlighted conditions exists, treat as indicated:

   Possible anaphylactic reaction with upper airway obstruction or respiratory distress, administer:

   - ▶ *Epinephrine 0.01 mg/kg IM (1 mg/mL preparation) (maximum dose 0.5 mg).*

   → *ALS escort to nearest appropriate ERC.*

   Wheezes, suspected asthma:

   - ▶ *Albuterol 6 mL (5 mg) continuous nebulization as tolerated.*
   - ▶ *CPAP, if proper mask size available, as tolerated and if not contraindicated (reference PR-120).*

   → *ALS escort to nearest appropriate ERC.*

   Croup-like Cough (recurrent "barking-type"):

   - ▶ *Normal saline 3 mL by continuous nebulization as tolerated.*

   If signs or symptoms of poor perfusion:

   - ▶ *Establish IV/IO access*
   - ▶ *Infuse 20 mL/kg normal saline (maximum 250 mL) IV/IO bolus and make BH contact. May repeat twice for total of three boluses as a standing order.*

   → *ALS escort to nearest appropriate ERC.*

3. Base Hospital Contact (CCERC base preferred) for any of above conditions if no response to therapy or status worsens.

RESPIRATORY DISTRESS – ADULT/ADOLESCENT

ALS STANDING ORDERS:

1. General:
   → Pulse oximetry, if oxygen saturation less than 95%, administer one of following based on tolerance or condition:

   ▶ *High-flow Oxygen by mask or nasal cannula at 6 l/min flow rate if tolerated*

   ▶ *If history of COPD, Oxygen by nasal cannula 2 liters/minute.*
   Do not withhold oxygen therapy for a COPD patient if severely hypoxic as manifested by struggling to breath and physical respiratory distress (O_2 Sat is unreliable to assess COPD distress in the acute field setting). Treat COPD patients with acute respiratory distress with O_2 and prepare to assist ventilation as needed.

   → Monitor cardiac rhythm.

2. In addition to the above, if one of the following conditions exists, treat as noted:

   Bilateral basilar rales, labored breathing (RR > 20/min) and suspected congestive heart failure or pulmonary edema:

   ▶ *If systolic BP ≥ 100 mm Hg, administer Nitroglycerine 0.4 mg SL, may repeat twice if BP remains ≥ 100 mm Hg.*
   OR,
   If systolic BP ≥ 150 mm Hg, administer Nitroglycerine 0.8 mg SL, may repeat twice if BP remains ≥ 150 mm Hg (if drops below 150 mm Hg, but remains above 100 mm Hg, continue with 0.4 mg SL dosing).

   ▶ *CPAP if available as tolerated and if not contraindicated (reference PR-120).*

   ▶ 12-lead ECG, if "Acute MI" indicated or a STEMI is suspected based on paramedic interpretation of 12-lead ECG contact Base Hospital for CVRC destination.

   → ALS escort to nearest appropriate ERC.

   Stridor (if suspected allergic reaction, refer to SO-M-15):

   ▶ Place in position of comfort and ALS escort to nearest appropriate ERC.

   Wheezes, suspected asthma or other forms of bronchospasm, including COPD:

   ▶ *Albuterol, Continuous nebulization of 6.0 mL (5 mg) concentration as tolerated.*

   ▶ *CPAP if available as tolerated and if not contraindicated (reference PR-120).*

   → ALS escort to nearest appropriate ERC.

3. If further orders required for patient stabilization, contact Base Hospital.