

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #1

**EPINEPHRINE AUTO-INJECTOR**

**Generic name:** epinephrine

**Trade Names:** Adrenalin®, Epi-Pen®, Epi-Pen Jr.®

**Mechanism of action:**

1. Epinephrine dilates the bronchioles
2. Constricts blood vessels
  - a. Shrinks swollen tissues
  - b. Increases blood pressure, heart rate and force of contraction

**Indications:**

1. The patient exhibits signs and symptoms of severe allergic reaction including respiratory distress, **WHEEZING** and signs and symptoms of shock (hypoperfusion).
2. The medication is prescribed for the patient.
3. Medical Control has authorized administration

**Contraindications:**

There are no contraindications when used in a life-threatening allergic reaction.

**Side Effects:**

1. increased heart rate **AND BLOOD PRESSURE**
2. pale skin
3. dizziness
4. chest pain
5. headache
6. nausea, vomiting
7. excitability, anxiousness

**Dosage:**

Adult: one adult auto-injector (0.3 mg)

Child/Infant: one child/infant auto-injector (0.15 mg)

**Administration:**

1. Confirm that the patient is exhibiting signs and symptoms of severe allergic reaction (anaphylaxis).
2. Confirm that the patient has a **LEGALLY** prescribed epinephrine auto-injector.
3. Ensure that the medication is not expired.
4. Ensure that the medication is not discolored (if visible).
5. Obtain the order to administer the medication (either off-line or on-line).
6. Remove the safety cap from the auto-injector.
7. Place the tip of the auto-injector against the lateral aspect of the patient's thigh, midway between the waist and knee.
8. Push the injector firmly against the thigh until the injector activates.
9. Hold the injector in place until the medication is injected.
10. Dispose of the injector in a biohazard container.
11. Reassess the patient's condition (second dose may be necessary).
12. Document administration.

**CONNECTICUT STATE BLS GUIDELINES**

Addendum #2

**REFERENCE #908**  
**EFFECTIVE MARCH 27, 1996**  
**GUIDELINES FOR WITHHOLDING RESUSCITATION**

NOTE: This guideline does not contain the new 1994 U.S. DOT EMT-Basic National Standard Curriculum terminology.

**Purpose:**

To provide specific instruction regarding the protocols used to withhold or withdraw resuscitation in the field.

**Introduction:**

Local emergency responders and EMS personnel in Connecticut who are trained in any of the National Standard curricula are instructed to follow the most recent national guidelines of the American Heart Association (Ref. *JAMA*, 268:16, October 28, 1992) for initiating CPR.

All clinically dead patients will receive all available resuscitative measures including cardiopulmonary resuscitation (CPR) unless contraindicated by one of the exceptions defined below. A clinically dead patient is defined as any unresponsive patient found without respirations and without a palpable carotid pulse.

The person who has the highest level of currently valid EMS certification, and who has direct voice communication for medical orders, and who is affiliated with an EMS organization present at the scene will be responsible for, and have the authority to direct, resuscitative activities.

In the event there is a personal physician present at the scene, who has an ongoing relationship with the patient, that physician may decide if resuscitation is to be initiated. In the event there is a Registered Nurse from a home health care or hospice agency present at the scene, who has an ongoing relationship with the patient, and who is operating under orders from the patient's private physician, that nurse (authorized nurse) may decide if resuscitation is to be initiated. If the physician or nurse decides resuscitation is to be initiated, usual Medical Control procedures will be followed.

**Procedure:**

The following conditions are the ONLY exceptions to initiating and maintaining resuscitative measures in the field on a clinically dead patient:

- I. Traumatic injury or body condition clearly indicating biological death (irreversible brain death), limited to:
  - a. Decapitation: the complete severing of the head from the remainder of the patient's body.
  - b. Decomposition or putrefaction: the skin is bloated or ruptured, with or without soft tissue sloughed off, or there is the odor of decaying flesh. The presence of at least one of these signs indicated death occurred at least 24 hours previously.
  - c. Transection of the torso: the body is completely cut across below the shoulders and above the hips through all major organs and vessels. The spinal column may or may not be severed.
  - d. Incineration: ninety percent of body surface area 3° burn as exhibited by ash rather than clothing and complete absence of body hair with charred skin.
  - e. Dependent lividity with rigor: when clothing is removed, there is a clear demarcation of pooled blood within the body, and major joints are immovable.

\*Requires additional confirmation as found under "General Procedures", III, 2, a-f (pp3-4)
  
- II. Pronouncement of death at the scene, of a patient age 17 or older, by a licensed Connecticut physician or authorized registered nurse by:
  - a. On-line Medical Control physician orders withholding resuscitative measures, or
  - b. On-line Medical Control physician orders resuscitative measures to be stopped, or
  - c. Physician or authorized registered nurse at the scene in person, in consultation with the on-line Medical Control.

- III. A valid DNR bracelet is present, when it:
- a. Is on the wrist **OR ANKLE**, and
  - b. Is intact; it has not been cut or broken, and
  - d. Has the correct logo; stylized hand in "stop" position and words "EMS ALERT," and
  - d. Is the correct color--orange, and
  - e. Has an expiration date that has not elapsed.
- IV. At a mass casualty incident, if clinical death is determined prior to patient's arrival in the treatment area.

**General Procedures:**

- I. In cases of decapitation, decomposition, transection of the torso, or incineration, the condition of clinical death must be determined by noting the nature and extent of the condition of the body as defined above. No CPR need be performed and Medical Control need not be notified.
- II. In cases of dependent lividity with rigor, the condition of clinical death must be confirmed by observation of the following:
  - a. Reposition the airway and look, listen, and feel for at least 30 seconds for spontaneous respirations; respirations are absent.
  - b. Palpate the carotid pulse for at least 30 seconds; pulse is absent.
  - c. Auscultate with a stethoscope for lung sounds and visualize for chest movement for at least 30 seconds; lung sounds are absent.
  - d. Auscultate with a stethoscope for heart sounds for at least 30 seconds; heart sounds are absent.
  - e. Examine the pupils of both eyes with a light; both pupils are non-reactive.
  - f. Electrocardiographic monitoring by paramedic; finding of asystole OR a physician's order by radio to withhold resuscitation.

If any of the findings are different than those described above, clinical death is NOT confirmed and resuscitative measures must be immediately initiated.

- III. In all other patients age 17 years or older, not described above, the following will take place:
- a. If the field technician arrives at the scene of a clinically dead patient before a medical order not to start resuscitative measures had been given, resuscitation will be initiated while communication is established, assessment information is gathered, and a medical decision is being made, except in cases of decapitation, decomposition, transection of the torso, or incineration.
  - b. Medical control must be established early to reduce delay, as resuscitative measures cannot be withheld until ordered by the physician. The on-line Medical Control physician will be given information about early assessment, findings, and procedures initiated. The physician may then order withholding resuscitation before complete resuscitative efforts have been initiated
  - c. The on-line Medical Control physician may order that resuscitative measures underway by an EMT-Paramedic be stopped upon verification that no vital signs exist. Once an Advanced Cardiac Life Support resuscitative cycle has been completed, by an EMT-Paramedic on scene directing patient care, the patient will be assessed for absence of clinical response and the persistence of asystole. If these are present, contact may be made with an on-line Medical Control physician who may then order the EMT-Paramedic to stop resuscitative measures that are underway.
- IV. When a valid DNR bracelet is present, the Connecticut College of Emergency Physicians (CCEP) guidelines will be followed. Once a patient has been found not to be breathing, examination for a valid DNR bracelet will take place. If there is a valid bracelet, no mouth-to-mouth or other means of artificial respirations will be administered, and no external cardiac compressions will be initiated. If previously initiated, resuscitative measures will be **DISCONTINUED**.

- V. A complete documentation of the initial examination, findings and resulting procedures (if any) will be entered on the EMS patient care record.
- VI. If EMS personnel are delayed or precluded from making an appropriate physical examination by law or fire officials protecting the integrity of the scene, they shall so note on their patient care form. If subsequent access to the patient is allowed, then EMS personnel shall proceed according to this protocol. EMS personnel are required to provide documentation of the patient's physical condition only to the extent of the physical examination they performed.

**Special Procedures:**

- I. In all cases when there is any suspicion of an unnatural death, local police authorities will be notified. Removal of the body will be done only after the police officer authorizes this.
- II. A private physician at the scene who has an on-going relationship with the patient must produce identification showing the physician's name and the Connecticut license number (MD or DO). That physician may pronounce death on a clinically dead patient even if EMS personnel are present. The physician's pronouncement relieves the emergency personnel of the responsibility to begin or continue resuscitative measures. If the patient is not pronounced and the physician wishes to assume care of the patient, the physician must agree to assume responsibility for the patient's care and accompany the patient to the hospital in the ambulance if the patient is to be transferred to the hospital. The Medical Control hospital will be notified and the information will be documented on the EMS patient care form.
- III. A registered Nurse from a home health care or hospice agency at the scene, who has an ongoing relationship with the patient, and who is operating under orders from the patient's private physician and is authorized by law to pronounce death, may pronounce a clinically dead patient dead even if EMS personnel are present. The nurse's pronouncement relieves the emergency personnel of the responsibility to begin or continue resuscitative measures. The Medical Control hospital will be notified and the

information will be documented on the EMS patient care form.

**Disposition of Remains:**

- I. Disposition of dead bodies is not the responsibility of EMS personnel, but efforts must be taken to insure that there is a proper transfer of responsibility for scene security. However, to be helpful to family, police, and others, EMS personnel may assist those who are responsible.
- II. When a decision has been made to withhold or withdraw resuscitation, the body may be removed in one of the following ways:
  - a. When the body is in a secure environment (where it is protected from view by the public, from being disturbed or moved by unauthorized people) and police are not or should not be involved, the body may be removed by a funeral hearse. The attending physician should be notified if available and EMS personnel may leave. Example: a DNR patient at home.
  - b. When the body is in a secure environment and police are or should be involved, notify the police and the attending physician. If the attending physician is not available, the police may contact the office of the Chief Medical Examiner (203-679-3980 or 1-800-842-8820) for authorization to move the body by hearse, or the Medical Examiner may send a vehicle for the body. EMS personnel may leave. Example: an apparent overdose or injury at home.
  - c. When the body is not in a secure environment and police are not or should not be involved, contact Medical Control for permission to transport the body to the hospital morgue. Example: on the street with an unruly crowd of people.
  - d. When the body is not in a secure environment and police are or should be involved, notify the police and the attending physician. If the attending physician is not available, the police may contact the Office of the Chief Medical Examiner (203-679-3980 or 1-800-842-8820) for authorization to move the body by hearse, or the medical Examiner may elect to send a vehicle for

the body. EMS personnel may leave after turning the scene over to other appropriate authority. Example: on the street.

- III. The Office of the Chief Medical Examiner (860-679-3980 or 1-800-842-8820) must be notified of any death which may be subject to investigation by the Chief Medical Examiner (CG 19a-407), which includes almost all deaths which occur outside health care institutions. EMS personnel should determine that such notification has been made by the police, otherwise EMS personnel should make the notification **AND DOCUMENT ON THE PATIENT CARE RECORD.**
- IV. At other times the EMT feels the circumstances warrant, contact Medical Control for permission to transport the body to the hospital morgue.
- V. When Medical Control feels the circumstances warrant, Medical Control may request that the body be transported to the hospital morgue.

#### **Documentation:**

- I. A patient care record will be completed for each clinically dead patient who has resuscitation performed and for whom resuscitation was discontinued or was withheld. All Medical Control orders will be noted on the patient care record.
- II. In cases of decapitation, decomposition, transection of the torso, or incineration, when resuscitation was discontinued or not initiated, detailed findings consistent with these conditions will be entered on the patient care record.
- III. In cases of dependent lividity with rigor, when resuscitation was discontinued or not initiated, the following detail will be documented on the patient care record:
  - a. Breathing absent when airway was repositioned and assessed for at least 30 seconds.
  - b. Carotid pulse was absent upon palpation for at least 30 seconds.
  - c. There were no audible lung sounds after examining the patient's chest with a stethoscope for at least 30 seconds.

- d. There were no audible heart sounds after examining the patient's chest with a stethoscope for at least 30 seconds.
- e. The pupils of both eyes are non-reactive.
- f. A view of an EKG in at least two (2) leads, for at least 12 seconds, which shows asystole.

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #3

**DO NOT RESUSCITATE (DNR)**

If there is a DNR bracelet or DNR Transfer Form and there are signs of life:

**Contact Medical Direction** before introducing any invasive procedures or therapies.

If there are no signs of life: DO NOT start CPR

**DNR Bracelet**

A DNR bracelet shall be the only valid indication recognized by EMS providers that a DNR order exists for patients outside a healthcare institution, other than those patients received by an EMS provider directly from a healthcare institution.

A valid DNR bracelet shall:

- a. be the correct color - *orange*
- b. have the correct logo
- c. be affixed to the patient's wrist or ankle
- d. display the patient's name and attending physician's name
- e. not have been cut or broken at any time.

**DNR Transfer Form**

- a. To transmit a DNR order during transport by an EMS provider between healthcare institutions, the DNR order shall be documented on the DNR transfer form.
- b. The DNR transfer form shall be signed by a licensed physician or a registered nurse and shall be recognized as such and followed by EMS providers.
- c. The DNR remains in place during transport as well as to the point of admission to the receiving facility.

**Revocation of the DNR**

- a. The patient or "authorized representative" may verbally tell a certified EMT they wish to alter their DNR status.
- b. This statement must be entered on the prehospital care report.
- c. Any witnesses present should support this statement.

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #4

**ASSISTING THE PATIENT WITH PRESCRIBED  
NITROGLYCERIN**

**Generic Name:** Nitroglycerin

**Trade Names:** Nitrostat®, Nitrobid®, Nitrolingual Spray®

**Mechanism of Action:**

1. Causes relaxation of the smooth muscle of blood vessel walls
2. Relaxation of the blood vessels causes pooling of blood in dependent portions of the body due to gravity. This reduces the amount of blood returning to the heart, decreasing the heart's workload.

**Indications:**

1. The patient is having chest pain
2. The patient has **LEGALLY** been prescribed nitroglycerin
3. Authorization to administer is obtained from Medical Direction (off-line or on-line)

**Contraindications:**

1. The patient has hypotension or blood pressure below 100 mm/Hg systolic
2. The patient has a head injury
3. The patient has taken the maximum recommended dose
4. Medical Direction does not give permission
5. The patient is an infant or child

*IMPORTANT: MEDICAL DIRECTION NEEDS TO KNOW IF THE PATIENT IS TAKING **VIAGRA**.*

**Side Effects:**

1. Headache
2. Hypotension
3. Dizziness, weakness
4. Flushing, feeling of warmth

**Dosage:**

The dosage is one tablet or spray under the tongue (sublingual). This may be repeated in 3 to 5 minutes (maximum of three doses) if:

1. Patient continues to have chest pain.
2. **CHECKING THE BLOOD PRESSURE AFTER EACH DOSE AND** the blood pressure remains above 100 mm/Hg systolic.
3. Medical Direction is obtained.

**Administration:**

1. Confirm that the patient is having chest pain.
2. Confirm that the patient has physician prescribed nitroglycerin.
3. Ensure that the nitroglycerin is not expired.
4. Determine if the patient has already taken any doses.
5. Assess blood pressure (above 100 mm/Hg systolic).
6. Obtain order from Medical Direction

*Tablet Administration:*

- a. Apply gloves (nitroglycerin can be absorbed through the skin).
- b. Ask the patient to raise his/her tongue.
- c. Pour one tablet into the bottle cap.
- d. Hand the medication to the patient for self-administration or place the tablet under the patient's tongue.
- d. Instruct the patient to keep his/her mouth closed and not to swallow until the tablet is dissolved and absorbed.

*Spray Administration:*

- a. Ask the patient to raise his/her tongue.
- b. Hand the medication to the patient for self-administration or spray the medication under the patient's tongue.
- c. Instruct the patient to keep his/her mouth closed and not to swallow until the medication is dissolved and absorbed.
7. Reassess the patient's condition.
8. Document administration.

*NOTE: Nitroglycerin has a half-life of 15 minutes*

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #5

**ASPIRIN**

**Generic Name:** Aspirin

**Trade Names:** Acetylsalicylic acid®, Bayer®, Aspirin, Anacin®, Ecotrin®, Bufferin®, and many more

**Mechanism of Action:**

1. Inhibits platelet aggregation thereby decreases blood clotting time
2. Anti-inflammatory effects
3. Reduces fever
4. Analgesic effects

**Indications:**

Cardiac chest pain to decrease incidence of heart attack

**Contraindications:**

1. Active gastrointestinal bleeding, ulcer disease
2. Hypersensitivity/allergy to aspirin
3. Patient is less than 13 years of age

**Side Effects:**

1. Gastric irritation
2. Nausea, vomiting
3. Abdominal pain
4. Gastrointestinal bleeding
5. Peptic ulcer formation
6. Ringing in ears

**Dosage:**

Adult: One dose (two chewable baby aspirin) - 162 mg **or 342 mg**

**Administration:**

1. Confirm that the patient is having chest pain suggestive of a myocardial **ISCHEMIA**.

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #6

**ORAL GLUCOSE**

**Generic Name:** oral glucose

**Trade Names:** Glutose®, Insta-glucose®

**Mechanism of action:**

Increases the blood sugar level

**Indications:**

Patients with all of the following are candidates for administration:

1. altered mental status
2. history of diabetes controlled by medication
3. ability to swallow

**Contraindications:**

1. The patient is unresponsive
2. The patient is unable to swallow (no gag reflex)
3. Medical Direction does not give permission

**Side Effects:**

1. Oral glucose causes no side effects when given properly
2. A patient with no gag reflex may aspirate it

**Dose:**

Oral glucose is a gel and is packaged in a toothpaste-type tube.

**Administration:**

1. Obtain an order from Medical Direction (off-line or on-line).
2. Squeeze oral glucose on a tongue depressor and place it between the patient's cheek and gum.
3. Reassess the patient's condition.
4. Document administration.

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #7

**ACTIVATED CHARCOAL**

**Generic Name:** activated charcoal

**Trade Names:** SuperChar®, InstChar®, Actidose®, LiquidChar®

**Mechanism of Action:**

Binds with certain poisons in the gastrointestinal tract and prevents them from being absorbed into the body

**Indications:**

Patients who have ingested certain poisons

**Contraindications:**

1. Patients who are unresponsive or have an altered mental status
2. Patients who have ingested acids (rust removers, phenol, battery acid) or alkalis (ammonia, household bleach, drain cleaner)
3. Patient is unable to swallow (no gag reflex)
4. Medical Direction does not give permission

**Side Effects:**

1. black stools, constipation
2. abdominal cramping
3. vomiting

**Dosage:**

Adults:	25 - 50 grams
Infant/Child	12.5 - 25 grams

**Administration:**

1. Confirm that the patient has ingested a poison.
2. Obtain an order from Medical Direction (off-line or on-line).
3. Shake the charcoal container thoroughly.
4. If the patient takes a long time to drink the mixture, the charcoal will settle and will need to be shaken or stirred again.
5. Reassess the patient's condition.
6. Document administration.

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #8

**ASSISTING THE PATIENT WITH A PRESCRIBED INHALER****Generic name (trade names):**

Albuterol (Proventil®, Ventolin®)  
Isoetharine (Bronkosol®, Bronkometer®)  
Metaproterenol (Metaprel®, Alupent®)

**Mechanism of action:**

1. Relaxes bronchial smooth muscle
2. Relieves bronchospasm
3. Reduces airway resistance

**Indications:**

1. The patient exhibits signs and symptoms of respiratory distress
2. Authorization from Medical Control is obtained (off-line or on-line)

**Contraindications:**

1. rapid heart rates
2. use with caution in patients with high blood pressure, chest pain

**Side Effects:**

1. increased pulse rate
2. tremors
3. nervousness
4. nausea, heartburn

**Dosage:**

The patient should take 1 to 2 inhalations. Dose may be repeated in 15 minutes.

**Administration:**

1. Confirm that the patient is having difficulty breathing.
2. Confirm that the patient has a **LEGALLY** prescribed handheld inhaler.
3. Ensure that the inhaler has a current expiration date.
4. Determine if the patient has already taken any doses.
5. Obtain an order from Medical Direction (off-line or on-line).

6. Shake the inhaler vigorously several times.
7. Have the patient exhale.
8. Have the patient put his/her lips around the opening of the inhaler.
9. Have the patient depress the handheld inhaler as he/she begins to inhale deeply.
10. Instruct the patient to hold his/her breath for as long as it is comfortably possible so that the medication can be absorbed.
11. If the patient has a spacer device it should be used.
12. Reassess the patient's condition.
13. Document administration.

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #9

**GLASGOW COMA SCALE**

The Glasgow Coma Scale will result in a total score from 3 to 15:

## CHILD/ADULT

## INFANT

Eye opening:

4	Spontaneous	4	Spontaneous
3	To voice	3	To speech
2	To pain	2	To pain
1	None	1	No response

Best Verbal Response:

5	Oriented	5	Coos, babbles
4	Confused	4	Irritable cries
3	Inappropriate words	3	Cries to pain
2	Incomprehensible	2	Moans, grunts
1	No response	1	No response

Motor Response:

6	Obeys commands	6	Obeys commands
5	<b>LOCALIZES</b> pain	5	<b>LOCALIZES</b> from pain
4	Withdraws from pain	4	Withdraws from pain
3	Flexion (decorticate)	3	Flexion (decorticate)
2	Extension (decerebrate)	2	Extension (decerebrate)
1	No response	1	No response

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #10

**TRAUMA REGULATIONS****Field Triage Protocols**

- (a) The following field triage protocol shall provide criteria to categorize trauma patients and determine destination hospitals with resources appropriate to meet the patient's needs:
1. Assess the physiologic signs. Trauma patients with any of the following physiologic signs shall be taken to a Level I or Level II trauma facility:
    - a. Glasgow Coma Scale of twelve (12) or less; or
    - b. systolic blood pressure of less than ninety (90) mm/Hg; or
    - c. respiratory rate of less than ten (10) or more than twenty-nine (29) breaths per minute.
  2. Assess the anatomy of the injury. Trauma patients with any of the following injuries shall be taken to a Level I or Level II trauma facility:
    - a. gunshot wound to chest, head, neck, abdomen, or groin;
    - b. third degree burns covering more than fifteen (15) per cent of the body, or third degree burns of face, or airway involvement;
    - c. evidence of spinal cord injury;
    - d. amputation, other than digits; or
    - e. two (2) or more obvious proximal long bone fractures.
  3. Assess the mechanism of injury and other factors and, if any of the following is present, determination of destination hospital shall be in accordance with medical direction:
    - a. Mechanisms of injury:
      - (1) falls from over twenty (20) feet;
      - (2) apparent high speed impact;
      - (3) ejection of patient from vehicle;
      - (4) death of same car occupant;
      - (5) pedestrian hit by car going faster than twenty (20) MPH;

- (6) rollover, or
  - (7) significant vehicle deformity - especially steering wheel
- b. Other factors:
- (1) age less than five (5) or greater than fifty-five (55) years;
  - (2) known cardiac or respiratory disease;
  - (3) penetrating injury to thorax, abdomen, neck, or groin other than gunshot wounds.
4. Severely injured patients less than thirteen (13) years of age should be taken to a Level I or II facility with pediatric resources including a pediatric ICU.
  5. When transport to a Level I or II trauma facility is indicated but the ground transport time to that hospital is judged to be greater than twenty (20) minutes, determination of destination hospital shall be in accordance with local medical direction.
  6. If, despite, therapy, the trauma patient's carotid or femoral pulses can not be palpated, airway cannot be managed, or external bleeding is uncontrollable, determination of destination hospital shall be in accordance with local medical direction.
  7. When in doubt regarding determination of destination hospital, contact medical direction.
- (b) All EMS providers transporting trauma patients to hospitals shall provide receiving hospitals with a completed OEMS approved patient care form prior to departing from the hospital. A patient care form shall be completed for each trauma patient at the scene who is not transported and shall be forwarded to OEMS **AND SPONSOR HOSPITAL**.
- (c) Beginning October 1, 1995, all hospitals and EMS providers shall follow the field triage protocols.

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #11

**DOCUMENTATION**

1. Documentation of all patient contacts shall be performed for all emergency responses, transfers, patient refusals and stand-bys.
2. Documentation of patient care shall be done immediately upon completion of patient care, and/or transfer of care.
3. A patient care record shall be left at the receiving health care facility. Report may be faxed to the receiving facility if necessary.

**PATIENT REFUSAL - MINORS**

## Definition of Minor:

Under Connecticut General Statutes (CGS), a minor is defined as a person under the age of eighteen (18). As a minor, these individuals are not authorized to make decisions regarding medical treatment. As EMS providers, we are authorized to treat minor patients under the doctrine of **'Implied Consent'**, meaning that if the patient were able to authorize treatment, they would wish to receive such treatment.

In some cases, a minor may be **'Emancipated'** (reference CGS Section 46-b-150-a-e. Minors are granted emancipation by the court system and, as such, are deemed by the courts to be responsible for their own actions and decisions. If the patient is an emancipated minor, they possess the legal capacity to refuse medical care, providing the other conditions are met.

## Legal Capacity:

*Minors do not have the legal capacity to refuse medical care except in the case of an **'Emancipated Minor'** (refer to Glossary). The decision to make medical care available rests with the EMS provider under Implied Consent. Therefore, to assure that the best interests of the patients are properly served, all minors who suffer injury or illness should be transported to a medical facility. Once at the receiving facility, the facility will make attempts to reach the*

patient's legal guardian in order to determine the medical treatment wishes of the guardian as they pertain to the minor.

#### On-Scene Considerations:

In the event an EMS provider responds to an emergency scene and is presented with a minor patient who has any physical signs or symptoms of injury or illness, transport the patient to an appropriate receiving facility. If a guardian is present (i.e., parent) they may make the decision regarding the treatment and transport of the minor. If the guardian refuses care and/or transport, it is the guardian who signs the refusal form as the responsible party.

#### Guardians Refusing Care for a Sick or Injured Minor:

There may be times when the guardian refuses medical care and/or transportation even when the minor has serious illness or injury. The reasons may be religious or economic. However, if the on-scene EMS providers believe that the patient may suffer grave medical consequences if left on-scene, consult a Medical Control Physician for advice. If the physician agrees that further medical evaluation is necessary, request police assistance to facilitate transport.

**CONNECTICUT STATE BLS GUIDELINES**

## Addendum #12

**PNEUMATIC ANTISHOCK GARMENTS (PASG/MAST)**

Currently, the clinical use of the PASG is controversial. The following represent groups of settings in which the use of this device is considered either:

- A. Acceptable and useful
- B. Possibly helpful, or
- C. Not indicated and possibly harmful.

The age and size of the patient, environmental factors, location, and distance from the hospital and the patient's comorbidities may modify the potential benefit or harm. The use, therefore, must be congruent with current on-line and off-line Medical Direction.

- A. Acceptable and useful:
  - 1. Hypotension due to:
    - a. Ruptured abdominal aorta aneurysm
    - b. Suspected pelvic fracture
    - c. Unstable anaphylaxis
    - d. Uncontrolled lower extremity hemorrhage
    - e. Other severe trauma
- B. Possibly helpful:
  - 1. Hypotension due to:
    - a. Penetrating abdominal injury (not an impaled object)
    - b. Gynecological hemorrhage
    - c. Ruptured ectopic pregnancy
    - d. Sepsis and unstable anaphylaxis
    - e. Uncontrolled urologic hemorrhage
    - f. Others as indicated by Medical Direction
- C. Not indicated and possibly harmful:
  - 1. CPR adjunct
  - 2. Thoracic injury
  - 3. Pulmonary edema
  - 4. Abdominal evisceration or impaled object
  - 5. Acute myocardial infarction

6. Cardiogenic shock
  7. Cardiac tamponade
  8. Pregnancy beyond first trimester
- D. Technical considerations in use of PASG where decision has been made to use the device. Application and inflation must not unnecessarily delay transport to the hospital, and when the location of the emergency scene is less than 10 minutes from the hospital, the patient should probably be transported directly without the application of the PASG:
1. Begin rapid transport to the closest medical facility. During transport, inflate the abdominal section to 80 mmHg for adults. Sections may be inflated simultaneously. For patients weighing less than 50 kilograms (110 pounds), inflate leg sections to 60 mmHg followed by inflating the abdominal section to 60 mmHg. Sections may be inflated simultaneously.
  2. Reassess patient.
  3. Contact Medical Direction and advise of patient's condition.