



# **Westchester Regional**

## **EMT-INTERMEDIATE PROTOCOLS**

**2002**

## TABLE OF CONTENTS

<b><u>SECTION</u></b>	<b><u>PAGE</u></b>
<b>Introduction</b>	
EMT-Intermediate Program	3
Background To Protocols	3
Interpretation Of Protocols	3
Pediatric Patients	4
Medical Control	4
Updates And Changes	4
Protocol Exceptions	4
Record Keeping	5
Ambulance Diversion	5
Destination Decisions	5
Do Not Resuscitate Orders (DNR)	5
Transfer of Care	5
Inter-Facility Transfers	6
Medical Authority at the Scene	6
Communications	7
Communications Failure	7
Independent Operation of an EMT-I	7
EMT-I Operation Within an EMT-P Agency	7
ALS Complaint Procedures	8
ALS Disciplinary Procedures	9
Patients Who Refuse Care	10
Physician Release Form	11
<b>Protocol 1</b>	
Endotracheal Intubation (Adult and Pediatric)	12
<b>Protocol 2</b>	
Intravenous Therapy (Adult Trauma)	13
<b>Protocol 3</b>	
Intravenous / Intraosseous Therapy (Pediatric Trauma)	14
<b>Protocol 4</b>	
Intravenous Therapy (Adult Medical Patient)	15
<b>Protocol 5</b>	
Intravenous / Intraosseous Therapy (Pediatric Medical Patient)	16
<b>Appendix A</b>	
Equipment	17
Required Equipment List	18
Recommended Equipment List	19

## WESTCHESTER REGIONAL MEDICAL ADVISORY COMMITTEE EMT-INTERMEDIATE PROTOCOLS AND PROCEDURES

### EMT-INTERMEDIATE PROGRAM

The EMT-Intermediate program within the Westchester Region is designed for use only as an adjunct within an established EMT-P (Paramedic) system. Services providing EMT-Intermediate level services have agreed, in writing between the EMT-I service and the WREMSCO, to provide care within an established EMT-P (Paramedic) system and have so demonstrated such participation by providing written service procedures (EMT-I within existing EMT-P service) or mutual aid agreements between the EMT-I service and the EMT-P service (independent EMT-I services).

Since the EMT-I program is specifically designed to enhance an EMS system, but is focused in ALS capability, any EMS agency employing the EMT-Intermediate program agrees to utilize an EMT-P (Paramedic) two-tiered priority response according to the criteria established by the Westchester Regional EMS Council Medical Advisory Committee and in accordance with the criteria published in the New York State Department of Health EMS Program Statewide Basic Life Support Adult and Pediatric Protocols. It is suggested that EMT-I services utilize an automatic external defibrillator (AED).

### BACKGROUND TO PROTOCOLS

The protocol manual that follows was developed with guidance provided by emergency physicians, paramedics and administrative support personnel. Its basis is the previous EMT-I Protocol established by the Hudson Valley Regional Emergency Medical Services Council. These protocols represent the standard of care for provision of Advanced Life Support Service at the EMT-Intermediate level within the Westchester Region.

### INTERPRETATION OF PROTOCOLS

It is understood that the current New York State Basic Life Support Protocols issued by the New York State Department of Health are always to be initiated in conjunction with, and as an integral part of the Westchester Regional EMS EMT-Intermediate Protocols.

The EMT-Intermediate protocols contain Advanced Life Support procedures that may be initiated under standing orders as described herein.

Advanced Airway Management includes, but is not limited to: endotracheal intubation; laryngeal mask airway (LMA); Combitube<sup>TM</sup>; foreign body removal; tracheal suctioning.

Procedures may only be performed consistent with the provider's level of training and certification.

Providers must document confirmation of endotracheal tube placement with a combination of accepted clinical parameters, end-tidal CO<sub>2</sub> detectors, esophageal detector devices (EDD) and pulse oximetry, as per ACLS guidelines.

## PEDIATRIC PATIENTS

A pediatric patient is any patient who is less than fifteen (15) years old.

Advanced airway management in the pediatric patient should be considered only when basic life support airway management cannot maintain adequate ventilation and oxygen saturation.

Transportation of the pediatric patient should be considered earlier than in the care of the adult patient. Transport should be initiated prior to the institution of ALS procedures whenever possible.

## MEDICAL CONTROL

Advanced Life Support activity is **ALWAYS** under medical control, whether on-line or off-line.

Credentials in Advanced Life Support will be authorized by the Westchester Regional Medical Advisory Committee.

Credentials in ALS will be required of all EMT-Intermediates and medical control physicians in order to practice Advanced Life Support in the Westchester Region.

## UPDATES AND CHANGES

Any recommendations or request for changes in the Westchester Regional EMT-Intermediate protocols should be referred to the Regional Medical Advisory Committee for review by the Protocol Committee.

There will be periodic reviews of the Regional ALS Protocols that may be updated annually with the New York State Emergency Medical Advisory Committee oversight/approval.

## PROTOCOL EXCEPTIONS

Should a situation arise which fails to conform to the Westchester Regional EMT-Intermediate Protocols, the EMT-I and on-line Medical Control Physician may agree upon an altered course of action. The physician should generate and document the order on the PCR/ALS Addendum. The EMT-I should question the on-line physician's order if the EMT-I does not understand what actions are requested or if the EMT-I feels those actions would be contrary to the patient's well being.

While acting in a setting which falls beyond the scope of the Westchester Regional EMT-Intermediate protocols, no EMT-I shall be faulted or suffer punitive action for following on-line physician orders; for refusing to follow an order which the EMT-I believes to increase the risk to the patient; or for refusing to perform a procedure which is beyond the EMT-I's training or expertise.

Whenever an action occurs outside of the Westchester Regional ALS protocols, the Medical Control Physician and the EMT-I shall each generate and forward a report of

the action to the Westchester Regional Medical Advisory Committee within 3 days of the deviation.

### RECORD KEEPING

The EMT-I will complete a pre-hospital care report (PCR) for every patient as soon as possible. The Medical Control Physician will sign the ALS PCR and/or the ALS Addendum, or other state approved form.

Copies of the PCR will be distributed to the agency completing the report, the Westchester Regional EMS office, and the receiving facility. The EMT-I will distribute all pertinent records other than the PCR to the receiving facility.

### AMBULANCE DIVERSION

Ambulance diversion is a hospital based decision and is not binding upon the ALS service. Compliance is a voluntary act that will be jointly decided by Medical Control and the senior EMT-I and Paramedic involved with the patient transport.

Diversion is not appropriate if the hospital on diversion is the nearest appropriate hospital and the patient's well-being may be compromised by a longer transport time.

### DESTINATION DECISIONS

Patients shall be transported to the nearest appropriate hospital. Medical Control must approve any anticipated deviation from this standard.

When patients are transported to a hospital not providing the medical control for the transport, the Medical Control physician will notify the receiving hospital of the transport and the patient treatment/status.

### DO NOT RESUSCITATE (DNR) ORDERS

Non-hospital DNR orders are allowed by Chapter 370 of the New York State Laws of 1991. Only the New York State Department of Health approved **NON-HOSPITAL DNR ORDER** or a New York State Department of Health approved bracelet may be honored.

A DNR order is **ONLY** an order not to perform resuscitation in the event of cardiac or pulmonary arrest. It does not infer that any other treatment is to be withheld. *Cardiopulmonary resuscitation* means measures to restore cardiac function or to support ventilation in the event of a cardiac or ventilatory arrest. *Cardiopulmonary resuscitation* shall not include measures to improve ventilation and cardiac functions in the absence of an arrest. **Hence all appropriate care in compliance with regional protocols is to be provided to patients who are NOT experiencing a cardiac or respiratory arrest, even if a valid DNR exists.**

## TRANSFER OF CARE

The EMT-I may transfer care of a patient to another provider as below:

1. To a similar or different level of service:
  - a) When the EMT-I at the scene recognizes that there is no indication for ALS intervention.
  - b) When ALS capabilities are exceeded and patient is triaged to other ALS or BLS services.
  - c) When transport is by a helicopter critical care team.
  - d) When a coroner or other appropriate agency takes custody.
2. To an appropriate receiving facility.

In each situation, the senior EMT-I, in concert with the Paramedic and Medical Control Physician will make the decision involved in transfer of care, and will document on the Pre-Hospital Care Report (PCR). In the event of communication failure the senior Paramedic will act in making the decision.

## INTER-FACILITY TRANSFERS

The Westchester Regional Medical Advisory Committee will not be responsible for providing medical control for inter-facility transfers.

## MEDICAL AUTHORITY AT SCENE

Advanced Life Support personnel may not relinquish medical control to any person at the scene. Only a Medical Control Physician may relinquish medical control, and only to an identified physician at the scene. The Medical Control physician may allow the EMT-I to follow orders from the physician at the scene, providing such orders are included within the established Westchester Regional EMT-Intermediate Protocols. Orders given by the on scene physician that are not within established WREMAC protocols require:

1. That the on scene physician implements the order.
2. That the physician utilizes his/her own drugs and equipment.
3. That the physician accompany patient to hospital.

The physician who accepts medical control will complete and sign the "Physician Release Form" on page 11.

If the physician at the scene who accepts medical control wishes to relinquish medical control, the EMT-I will communicate with the Westchester Regional Medical Control physician who will resume medical control.

The Westchester Regional Medical Control physician may re-establish medical control at any time.

**COMMUNICATIONS**

The EMT-I may contact Medical Control at any time. The EMT-I is not required to contact medical control for ALS procedures performed when an EMT-P will be assuming patient care prior to arrival at the receiving hospital. In these cases it is understood that the EMT-P will be required to make medical control contact. The EMT-I must contact Medical Control upon completion of standing orders or within 20 minutes of arrival on scene, whichever comes first, if the patient care will not be turned over to an EMT-P prior to arrival at the receiving hospital.

The EMT-I will contact medical control whenever there is a patient who requires ALS services but refuses transport or treatment.

**COMMUNICATION FAILURE**

In the situation where voice contact with medical control cannot be established by radio/telephone/cellular apparatus or telemetry, the EMT-I will complete appropriate standing orders and initiate transport.

Continued attempts should be made to establish voice contact. Attempts should be made to establish voice contact with any available Westchester Regional Medical Control facility.

Pre-hospital care reports (PCR) must document attempts to contact medical control, and the reasons for communication failure.

**INDEPENDENT OPERATION OF AN EMT-I**

Although the EMT-I program is designed to function as a component of an EMT-P response, it is understood that there may be occasions whereby the EMT-I may function independently of the EMT-P while rendering ALS care. The situations whereby the EMT-I will be allowed to function independently are:

- 1. There are no EMT-P units available.
- 2. While operating at a multiple casualty incident, the EMT-P triages an ALS patient to the EMT-I for transport to the receiving hospital.

In these cases, the EMT-I agency shall mark these calls specifically for Quality Improvement and Medical Director review to determine appropriateness of care and to review the circumstances under which the EMT-I operated independently.

**EMT-I OPERATION WITHIN AN EMT-P AGENCY**

- 1. EMT-I must be part of an EMT-P response team, and cannot respond in the place of an EMT-P.
- 3. While operating at a multiple casualty incident, the EMT-P may triage an ALS patient to the EMT-I for transport to the receiving hospital.

## ALS COMPLAINT PROCEDURES

In order to handle complaints concerning participating organizations, or individual participants such as Paramedics, Nurses and Physicians involved in pre-hospital ALS, the following procedure is established.

Complaints can be made by a patient, the public, participating organizations or individual participants, including Westchester Regional EMS staff members. All complaints should be written, signed and delivered to the Westchester Regional EMS Executive Director.

Appropriate grounds for complaints include:

1. Practicing without proper NYS certification or WREMAC authorization
2. Deviation from Westchester Regional EMT-I Protocols, including interim updates from the WREMAC (protocols, procedures, medications schedule, policies)
3. Unprofessional conduct (ie. disrespect towards patients, families or fellow providers, intoxication while on duty, breaking patient confidentiality)
4. Immoral or indecent behavior
5. Unauthorized possession, fraud or misappropriation of property
6. Falsification of records
7. Insubordination

Complaints will be handled by the following process:

1. Written, signed complaint delivered to the WREMS Executive Director.
2. WREMS Executive Director confers with the named party privately, if possible, and notifies the named organization, Paramedic, Nurse or Physician of the complaint by certified mail.
3. The WREMS Executive Director sends written notification of the alleged infraction to the Regional Medical Director and the party's supervisor at his/her field agency or institution.
4. WREMS Executive Director may choose any of the following options:
  - a. Decide complaint unwarranted, and report it to the Evaluation Committee.
  - b. Issue written warning, and report it to the Evaluation Committee.
  - c. If a serious Infraction, the Executive Director may confer immediately with the Regional Medical Director and Evaluation Committee Chairperson, then hold a meeting of same with the named party and one representative of his/her institution.

The Regional Medical Director, in conjunction with the Executive Director and

Chairman of the Evaluation Committee, may suspend the named party pending meeting with the named party.

All Medical Control Hospitals will be notified in writing of the party's suspension and only the WREMS Executive Director will notify the Hospital in writing when the party has been reinstated.

The WREMS ALS Evaluation Committee will review, at their next scheduled meeting, complaints processed through steps 4 a-c above.

In cases where it is the consensus of opinion of the WREMS ALS Evaluation Committee that no follow-up action is warranted, the Chairman of the Evaluation Committee, or the Regional Medical Director, shall communicate that opinion in writing, to the complaint, the named party, and the named party's supervisor at his/her field agency or institution.

When the complaint is judged meritorious of further investigation, the Chairman of the Evaluation Committee shall appoint a Board of Inquiry that will meet within 30 days with the named party and a representative of his or her agency or institution and report back to the Evaluation committee.

### **ALS DISCIPLINARY PROCEDURES**

The Board of Inquiry shall consist of one permanent member of the Regional MAC and two members of the Evaluation Committee. No member of the field unit or institution involved in the complaint shall be appointed to the Board of Inquiry. The Board of Inquiry's report shall become the basis for a consensus recommendation to the Regional MAC, from the Evaluation Committee.

The Regional MAC may conduct any subsequent investigations and/or hearings deemed warranted and shall issue a decision in the matter within 30 days of receipt of the consensus recommendation of the Evaluation Committee.

The decision shall then be transmitted by certified mail to the complainant, the named party, and the named party's supervisor. The decision of the Regional MAC shall be considered binding and final.

Disciplinary options include, but are not limited to:

1. Probation with supervision.
2. Suspension for a specified time period.
3. Revocation of privileges to participate in the WREMS System.

A record of each complaint and the completion of the appropriate disciplinary steps shall be kept by the WREMS staff.

Appeals by the complainant or the named party should be directed to the Westchester Regional EMS Council.

**PATIENTS WHO REFUSE CARE**

Patients have a right to accept or refuse treatment or transport. That right may be infringed upon only if the patient or responsible guardian/proxy does not have the capacity to make the decision to accept or refuse the service. When a patient or guardian/proxy refuses treatment or transport:

1. Attempt to gain understanding of rationale for refusal; include family whenever possible.
2. Evaluate mental status and capacity for decision-making in the specific situation.
3. Communicate with Medical Control if ALS is indicated.
4. Request a police agency if necessary.
5. Document the following on the Pre-Hospital Care Report (PCR):
  - a. Findings (e.g. history, physical, mental status, etc.)
  - b. Patient's stated reason for refusal of treatment or transport .
  - c. Risks explained to patient or guardian/proxy.
  - d. Recommendations for follow up.
  - e. Signatures of patient or guardian/proxy and witness.
  - f. Name of police agency, officer's names and badge numbers if available.

**PHYSICIAN RELEASE FORM**

AMBULANCE/RESCUE SQUAD \_\_\_\_\_

RUN # \_\_\_\_\_ PCR # \_\_\_\_ -- \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**WARNING:** THE SIGNING OF THIS DOCUMENT CONSTITUTES THE ASSUMPTION OF LEGAL LIABILITY BY THE SIGNER WHOSE SIGNATURE FOR THE CARE AND TREATMENT OF THE PATIENT NAMED BELOW.

The physician whose signature appears below, by subscribing this instrument acknowledges that:

1. He/she is aware that the ambulance or rescue squad, named above, called to attend the below named patient, is operating under the coordination of the Westchester Regional EMS Council (hereinafter referred to as WREMSCO).
2. That the WREMSCO supplies coordination for Basic and Advanced Life Support Systems in this geographical area.
3. That there is available to the ambulance or rescue squad, named above, a communications system capable of eliciting advice and instruction for the care and treatment of this patient by Regional Medical Advisory Committee Certified Physicians under a system of protocols and procedures subscribed to by physicians in the geographical area served by WREMSCO.
4. That the undersigned physician assumes full responsibility for the care and treatment of the patient named below and by his/her signature agrees to hereby forever release and discharge WREMSCO, its agents, servants or employees and the attending ambulance or rescue unit and its/their agents, servants or employees from any cause of action whatsoever, including but not limited to, any action ever as a defendant in a lawsuit brought by the patient or his/her heirs, executors, administrators or assigns against said WREMSCO and/or the ambulance or rescue squad named above, by reason of the care and treatment tendered to said patient under the orders of said undersigned physician.

**WARNING:** THIS IS AN ASUMPTION OF LEGAL RESPONSIBILTY FOR CARE OF THIS PATIENT AND AN INDEMNIFICATION TO AND RELEASE OF WREMS AND ATTENDING AMBULANCE/RESCUE SQUAD.

IN WITNESS WHEREOF, I have hereunto set my hand and seal

This \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
(Signature)

PHYSICIAN:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

PATIENT:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



**PROTOCOL 1**  
**Endotracheal Intubation**  
(Adult and Pediatric)

**REQUEST EMT-P RESPONSE**  
**DO NOT DELAY TRANSPORT**

1. Basic Life Support airway management procedures are initiated.
2. Endotracheal Intubation is indicated under any of the following conditions:
  - A. Respiratory arrest or imminent respiratory arrest
  - B. Obstructed or suspected obstructed airway
  - C. Facial/Respiratory Burns (unconscious patient)
  - D. Respiratory distress with associated ventilatory failure
  - E. Major trauma or head trauma, associated with decreased level of consciousness or unconscious.
  - F. Any unconscious or unresponsive patient when an adequate BLS airway cannot be maintained.
3. Endotracheal Intubation on scene shall not exceed 3 attempts prior to initiating transport. After transport is initiated, additional Endotracheal Intubation attempts may be made.

**ENDOTRACHEAL INTUBATION OR LARYNGOSCOPE IS NOT  
ATTEMPTED IN ANY PEDIATRIC PATIENT SUSPECTED OF  
HAVING CROUP OR EPIGLOTTITIS UNLESS THE AIRWAY  
BECOMES OBSTRUCTED AND ADEQUATE VENTILATION  
CANNOT BE MAINTAINED.**

**PROTOCOL 2**  
**Intravenous Therapy**  
(Adult Trauma)

**REQUEST EMT-P RESPONSE**  
**DO NOT DELAY TRANSPORT**

Intravenous therapy may be established in any adult patient who meets the criteria of TRAUMA as established in the NYSDOH BLS PROTOCOLS and who is determined to be **potentially unstable, unstable or critical**. These include:

- Amputation
- Bleeding
- Burns
- Fractures/Dislocations
- Adult Major Trauma / Traumatic Arrest
- Suspected Head or Spinal Injury

1. Basic Life Support trauma management protocols are initiated.

**DO NOT DELAY TRANSPORT TO INITIATE I.V. THERAPY.**

2. An Intravenous Infusion is established with Normal Saline using a large bore I.V. Catheter.

A. If hemodynamically stable, the I.V. rate is set at KVO. If hypovolemic shock is suspected, the I.V. is run wide open to maintain adequate hemodynamic status.

B. If hypovolemic shock is suspected, a second large bore I.V. is established, run wide open.

**PROTOCOL 3**  
**Intravenous / Intraosseous Therapy**  
(Pediatric Trauma)

**REQUEST EMT-P RESPONSE**  
**DO NOT DELAY TRANSPORT**

Intravenous / intraosseous therapy may be established in any pediatric patient who meets the criteria of TRAUMA as established in the NYSDOH BLS PROTOCOLS and who is determined to be **potentially unstable, unstable or critical**. These include:

- Amputation
- Bleeding
- Burns
- Fractures/Dislocations
- Pediatric Major Trauma / Traumatic Arrest
- Suspected Head or Spinal Injury

1. Basic Life Support trauma management protocols are initiated.

**DO NOT DELAY TRANSPORT TO INITIATE I.V./I.O. THERAPY.**

2. An intravenous infusion is established with Normal Saline using a large bore I.V. catheter. If unable to establish an I.V. infusion after three attempts, I.O. access is attempted, but limited to one tibial site.

A. If hemodynamically stable, I.V. rates are set at KVO.

B. If hypovolemic shock, a fluid bolus, 20 cc/kg of Normal Saline, is administered. Repeat bolus in 10 minutes if shock persists.

**PROTOCOL 4**  
**Intravenous Therapy**  
**(Adult Medical Patient)**

**REQUEST EMT-P RESPONSE**  
**DO NOT DELAY TRANSPORT**

Intravenous therapy may be established in any adult medical patient who meets the following criteria:

- Altered Mental Status
- Unconscious / Unresponsive
- Cardiopulmonary Arrest
- Allergic Reaction / Anaphylaxis
- Cardiac Related Problem
- Respiratory Distress
- Seizures
- Hypovolemia / Dehydration

1. Basic Life Support protocols are initiated.

**DO NOT DELAY TRANSPORT TO INITIATE I.V. THERAPY.**

2. An intravenous infusion is established with Normal Saline at a KVO rate.
- A. If patient exhibits signs of hypotension (with no signs of pulmonary edema), a fluid bolus of 250 cc is administered. Bolus may be repeated up to a total of 1000 cc of normal saline.

**MEDICAL CONTROL OPTION**

Additional fluid bolus of Normal Saline above the 1000 cc limit under standing orders.

If unable to contact Medical Control, the EMT-I may contact the responding EMT-P for orders to administer an additional bolus of Normal Saline.

**PROTOCOL 5**  
**Intravenous / Intraosseous Therapy**  
(Pediatric Medical Patient)

**REQUEST EMT-P RESPONSE**  
**DO NOT DELAY TRANSPORT**

Intravenous therapy may be established in any pediatric medical patient who meets the following criteria:

- Altered Mental Status
- Unconscious / Unresponsive
- Cardiopulmonary Arrest
- Allergic Reaction / Anaphylaxis
- Cardiac Related Problem
- Respiratory Distress
- Seizures
- Hypovolemia / Dehydration

1. Basic Life Support trauma protocols are initiated.

**DO NOT DELAY TRANSPORT TO INITIATE I.V. THERAPY.**

2. An intravenous infusion is established with Normal Saline. If unable to establish an I.V. infusion after three attempts, I.O. access is attempted, but limited to one tibial site.
  - A. If hypovolemic shock, a fluid bolus, 20cc/kg of Normal Saline, is administered. Repeat bolus in 10 minutes if shock persists.

# APPENDIX A



## REQUIRED EQUIPMENT

<u>ITEM</u>	<u>QUANTITY</u>
Automatic External Defibrillator (with associated equipment)	1
Endotracheal Tube, 2.5 Uncuffed	2
Endotracheal Tube, 3.0 Uncuffed	2
Endotracheal Tube, 3.5 Uncuffed	2
Endotracheal Tube, 4.0 Uncuffed	2
Endotracheal Tube, 4.5 Uncuffed	2
Endotracheal Tube, 5.0	2
Endotracheal Tube, 6.0	2
Endotracheal Tube, 7.0	2
Endotracheal Tube, 8.0	2
End-Tidal CO <sub>2</sub> Detector (Qualitative/Colormetric or Quantitative/Digital), Adult	1
End-Tidal CO <sub>2</sub> Detector (Qualitative/Colormetric or Quantitative/Digital), Pediatric	1
Esophageal Detection Device (Syringe or Bulb Type)	1
Intubation Stylet, Adult	2
Intubation Stylet, Pediatric	2
IV Administration Set, Macro-drip	2
IV Administration Set, Micro-drip	4
IV Catheter, 14G	3
IV Catheter, 16G	3
IV Catheter, 18G	3
IV Catheter, 20G	3
IV Catheter, 22G	3
IV Catheter, 24G	3
Laryngoscope Batteries, Spare	1 set
Laryngoscope Blades, Macintosh	4 Assort Sizes
Laryngoscope Blades, Miller/Wisconsin	4 Assort Sizes
Laryngoscope Handle, Large	1
Laryngoscope Handle, Small	1
Lubricant, Water Soluble	6 packets
Magill Forceps, Adult	1
Magill Forceps, Pediatric	1
Meconium Aspirator	1
Needle, Intraosseous	2
Normal Saline (.9%) IV Fluid 1000 ml bag	2 bags
Normal Saline (.9%) IV Fluid 250 ml bag	4 bags
Phlebotomy Tourniquet	2
Pulse Oximeter (with Adult and Pediatric Sensors)	1
Syringe, 10 cc (for ET and IO Sets)	2

**RECOMMENDED EQUIPMENT LIST**

<b><u>ITEM</u></b>	<b><u>QUANTITY</u></b>
Blood Tube Barrel - Luer Adapter (i.e. Vacutainer™ Type)	4
Blood Tube Barrel (i.e. Vacutainer™ Type)	2
Blood Tubes (Amount and Type Determined by Agency)	2 sets
Combitube™	1
Laryngeal Mask Airways (Assorted sizes)	1 set
Laryngoscope Bulbs, Spare (Large)	2
Laryngoscope Bulbs, Spare (Small)	2