

# Westchester Regional



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## ADVANCED LIFE SUPPORT STANDARD OPERATING PROCEDURES

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**ALS  
1.0**

**ADVANCED AIRWAY MANAGEMENT**

**DATE ISSUED:** May 2009

**UPDATES:**

1. Advanced Airway Management **(a)** includes, but is not limited to:
  - a. Endotracheal Intubation (ETT)
  - b. Laryngeal Mask Airway (LMA)
  - c. Multi-lumen Airway (i.e. Combitube™ )
  - d. Rapid Sequence Intubation (RSI) **(b)**
  - e. Foreign body removal with direct laryngoscopy and Magill's Forceps
  - f. Needle Cricothyrotomy
  - g. Tracheal Suctioning (including Meconimum aspiration)
  - h. Gastric Decompression (NG or OG)
  - i. Needle decompression for the treatment of a tension pneumothorax (refer to **SOP ALS - 1.1: Tension Pneumothorax**)
2. Providers must document **PRIMARY** confirmation of ETT placement using:
  - a. Quantitative Methods (Digital end-tidal CO<sub>2</sub> detectors, wave-form capnography)
  - b. Qualitative Methods (Colormetric end-tidal CO<sub>2</sub> detectors)
3. Providers must document **SECONDARY** confirmation of ETT placement using accepted clinical parameters and per ACLS guidelines.
4. If medication is used to facilitate intubation, whether or not it is successful, the patient's respiratory effort **MUST** be monitored with **CONTINUOUS WAVEFORM CAPNOGRAPHY**

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**NOTE**

- a. Procedures may only be performed consistent with the provider's level of training and certification..
- b. **RSI** may only be performed by a specially trained and credentialed paramedic working for an ALS agency that has received approval from the Westchester REMAC.



**ALS  
1.1**

## **TENSION PNEUMOTHORAX**

**DATE ISSUED:** May 2009

**UPDATES:**

1. Pleural decompression is indicated using large bore over the needle catheter, or other REMAC approved device, if:
  - a) If there is evidence of respiratory/cardiovascular compromise,

**AND**
  - b) Two (2) of the following:
    - Absent/decreased breath sounds on the affected side;
    - Tracheal deviation;
    - Subcutaneous emphysema.
2. Repeat procedure if signs and symptoms recur.



**ALS  
2.0**

**INTRAVENOUS ACCESS**

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UPDATES:

1. For patients who do not require a fluid challenge, it is acceptable to initiate IV access via a 0.9% normal saline lock or IV line set KVO (“keep vein open”) **(a)**.
2. For patients who require rapid volume replacement via IV, at least one (1) large bore IV line (18 gauge or larger) with 0.9% normal saline should be established.
3. Peripheral veins other than the external jugular (EJ) should be used as the primary access site. For adult patients ***IN EXTREMIS***, the EJ vein may be used as an alternate site if other sites are not accessible.
4. An FDA approved Tibial Intraosseous (IO) device may be used for adult patients ***in complete vascular collapse ONLY if other sites are not accessible***. Locations for placement are limited to: tibia, humerus, and medial malleolus.
5. Use of IO for administration of medications during cardiac arrest is preferred over ETT administration if a peripheral IV site is unavailable.
6. Blood drawing should be accomplished as indicated and possible **(b, c)**.

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**NOTE**

- a. KVO = 30 ml per hour
  - Mini or micro set (60 gtts) = 30 drops per minute
  - Macro set (10 – 15 gtts) = 5-8 drops per minute (depending on set)
- b. If required by the Service Medical Director, appropriate blood samples should be drawn before any medication administration, except in the case of cardiac arrest.
- c. If drawn, blood collection tubes must at a minimum be labeled with the patient’s name and date of birth.