

**Critical Care
Treatment
Guidelines**

WEST VIRGINIA
Department of

**Health &
Human
Resources**



BUREAU FOR PUBLIC HEALTH

Office of Emergency Medical Services



CCT Guidelines

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CCT Guidelines

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INITIAL TREATMENT / UNIVERSAL PATIENT CARE

- Utilize Appropriate BSI / Universal Precautions
- Obtain Transfer Information from Sending Facility
 - Bedside report information from sending facility
 - Review appropriate clinical and diagnostic data
 - (i.e. vital signs, EKG, labs)
 - Review and confirm all interventions intended to be continued during transport
 - (i.e. medications, procedures, interventions)
 - Review ventilator settings if possible

****NOTE – in the event a patient has a life sustaining medication, device, or other complication that is not directly addressed and approved by state guidelines or is not on state approved CCT Medication/Procedure List, the sending physician must provide an in-service and the crew must verbalize understanding of the medication / procedure, and that they are comfortable transporting the patient ***

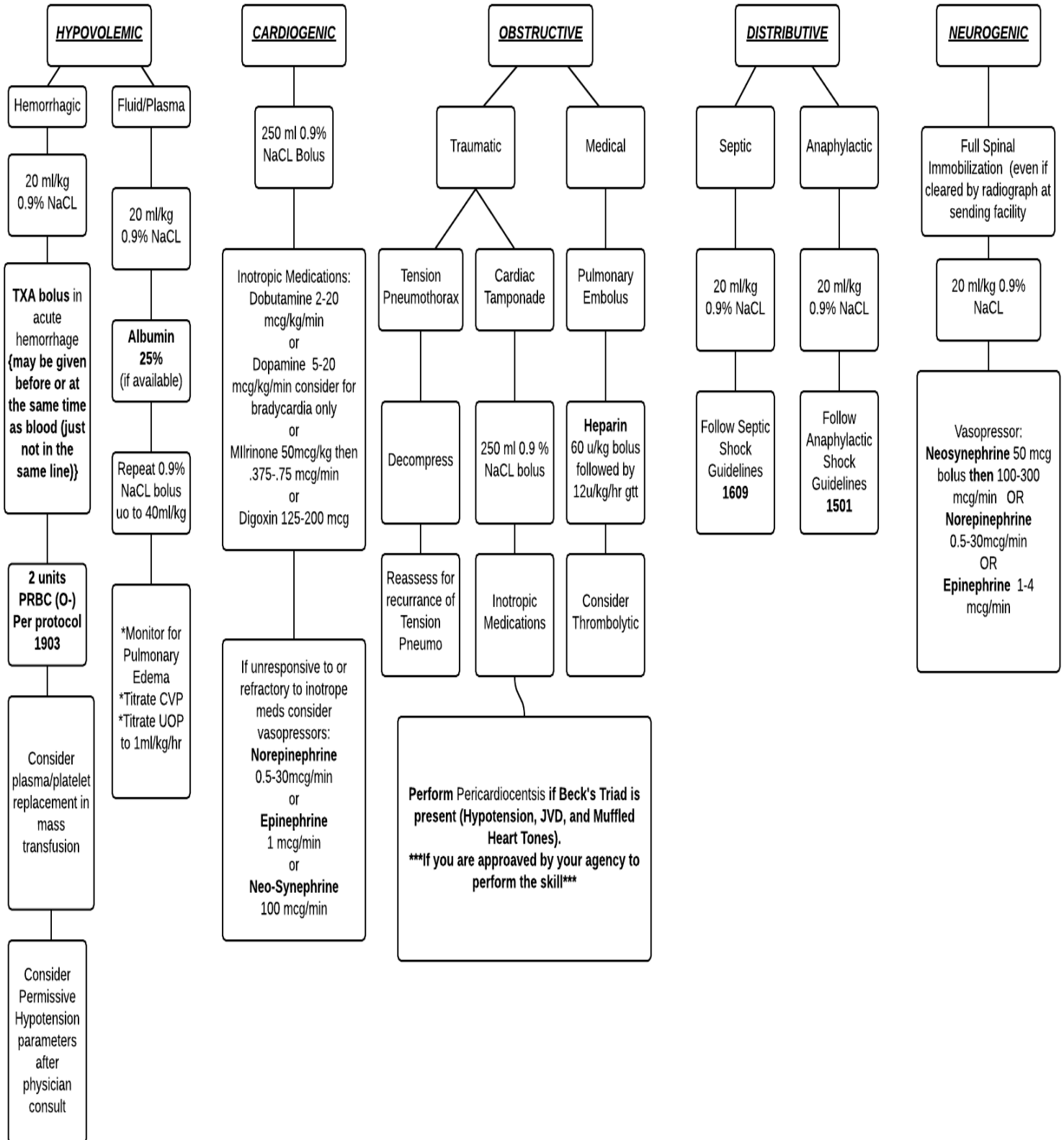
The transport medication / procedure should be documented with signatures from both the transferring physician and the crew and then attached to the patient's chart.

- In the event there is any change in initial transporting diagnosis, consider diverting from original destination to appropriate alternate destination (i.e. ER from direct admit, stable to unstable, non-STEMI to STEMI).

****NOTE – if the CCT crew needs medical direction, contact receiving physician, sending physician, agency CCT medical direction, and/or MCP****

- **Contact Medical Command or MCP:**
 - Any class 0 (Zero) transports
 - CCT Intercepts – if unable to arrange CCT transport initially, contact Medical Command to arrange CCT intercept between sending and receiving facility.
 - Significant patient deterioration that causes the patient to become hemodynamically unstable despite ongoing intervention

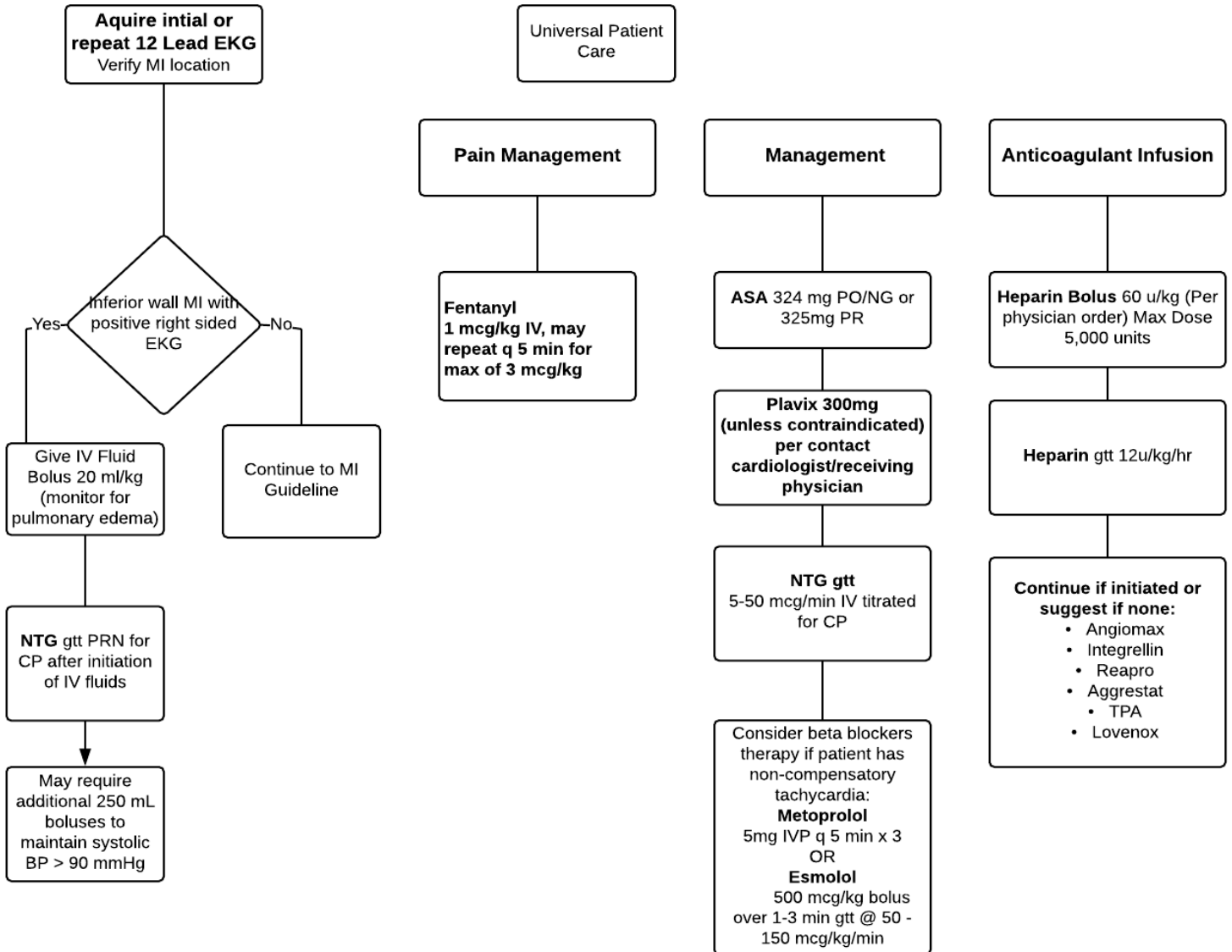
SHOCK



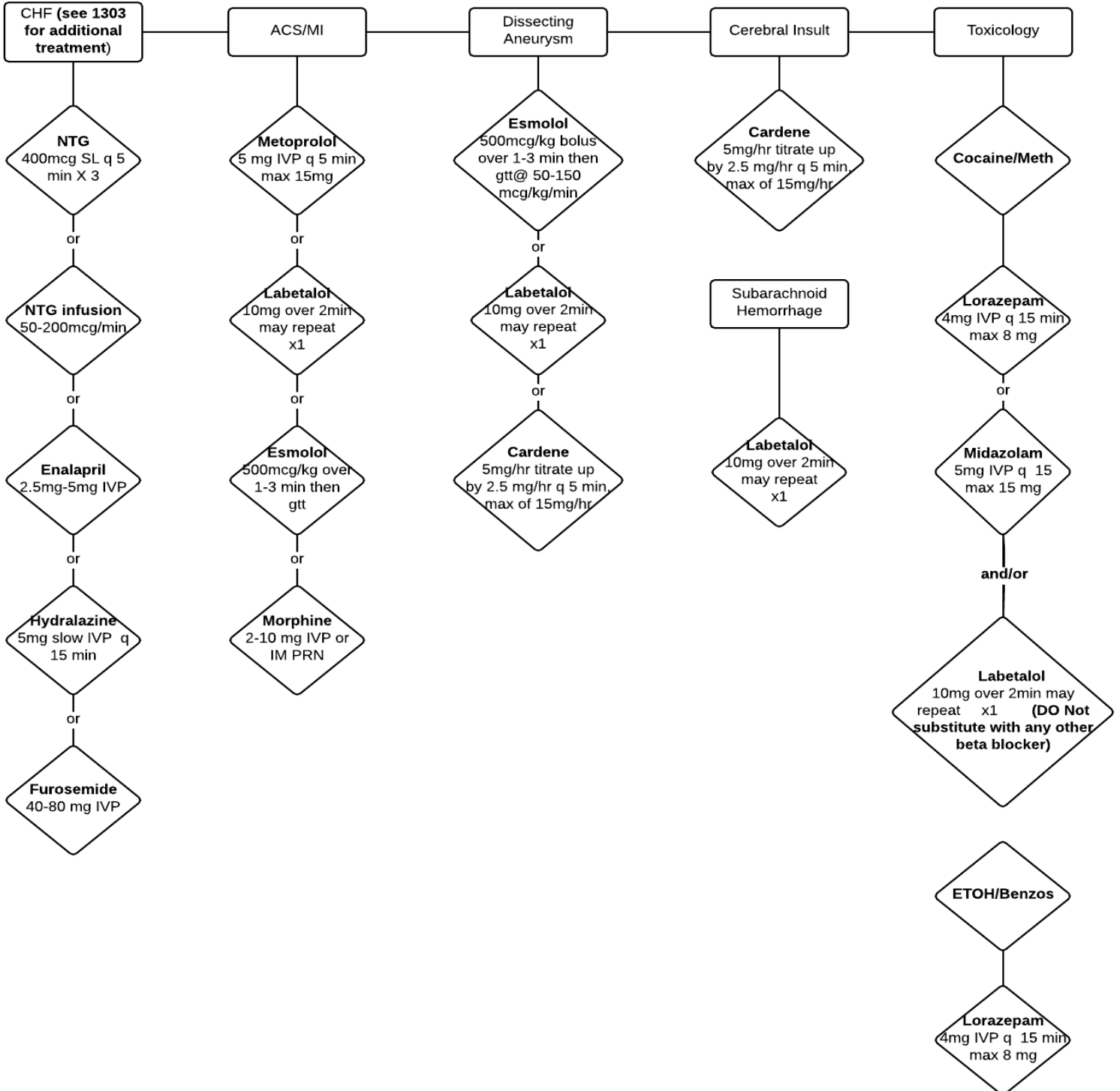
ACUTE MYOCARDIAL INFARCTION

AMI CCT

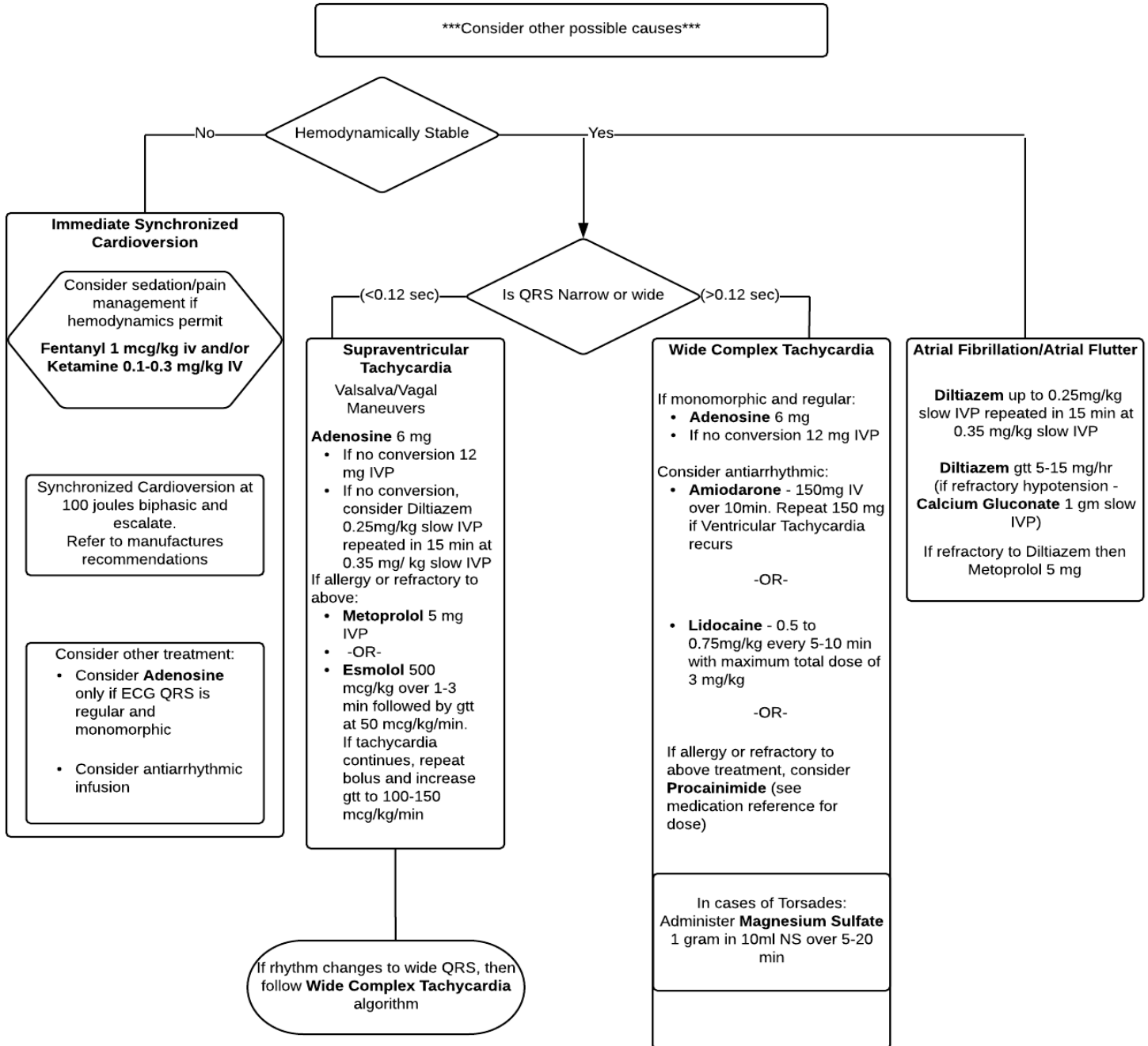
Universal Patient Care



HYPERTENSIVE EMERGENCIES

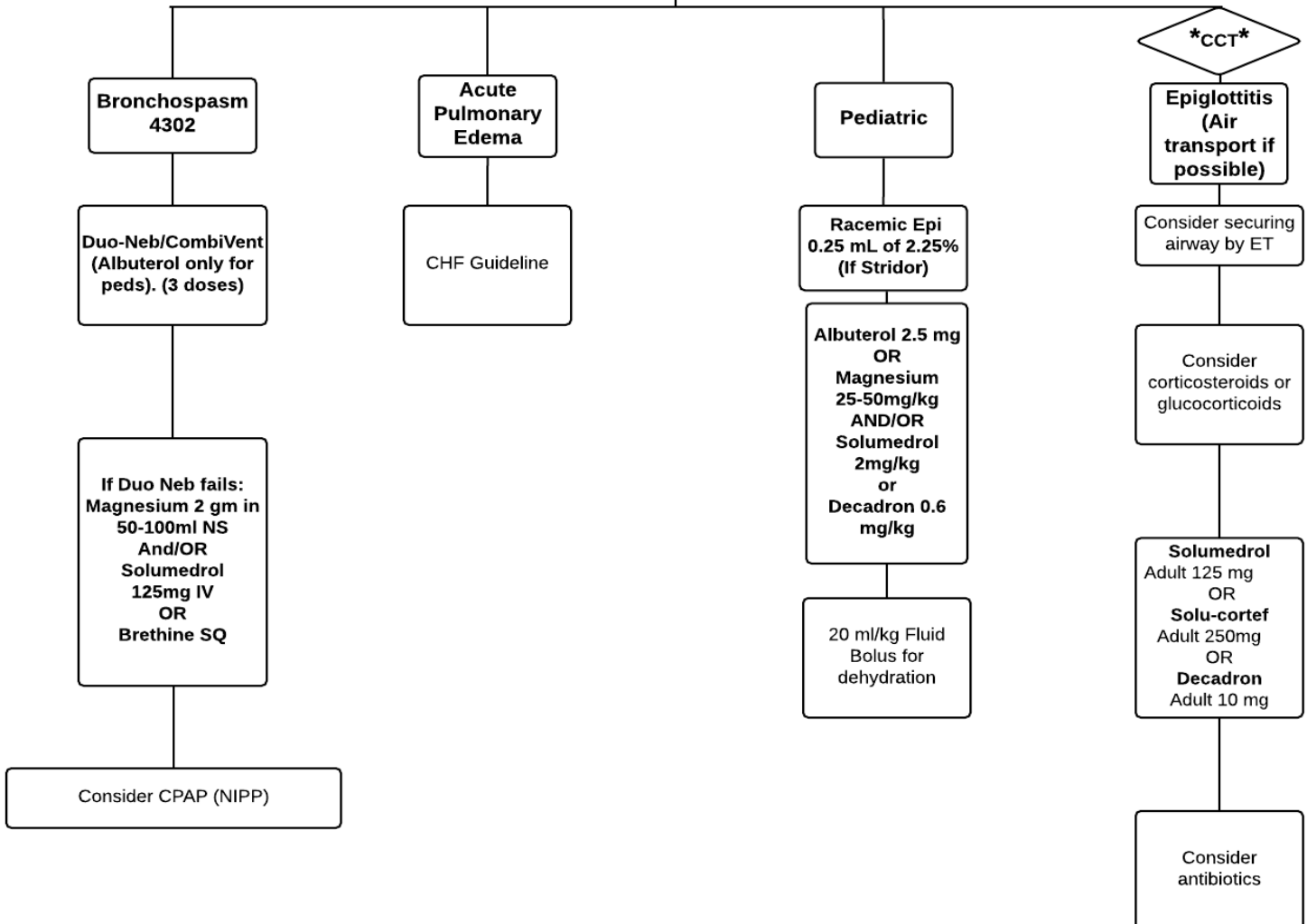


ADULT TACHYCARDIA

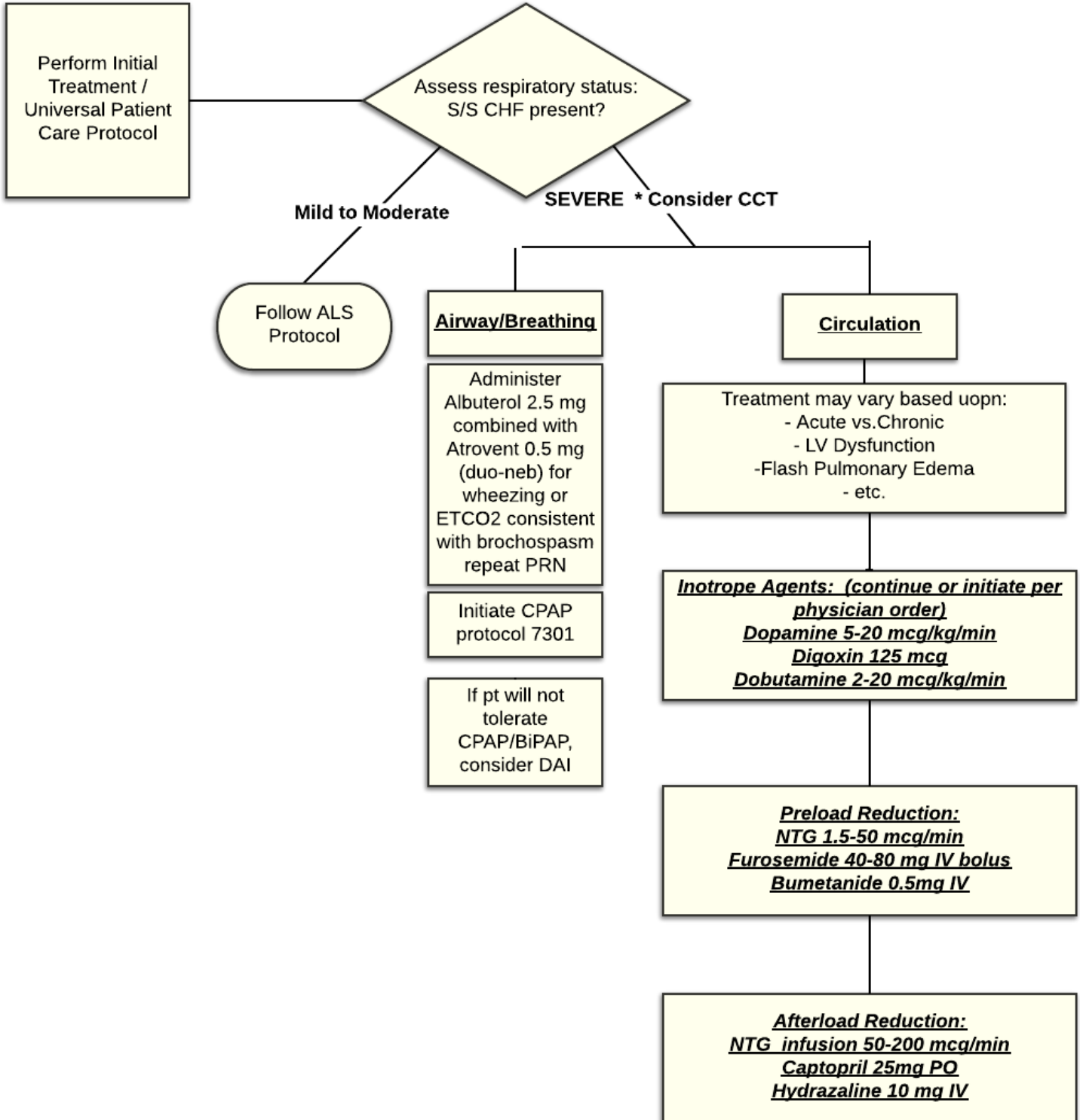


RESPIRATORY DISTRESS

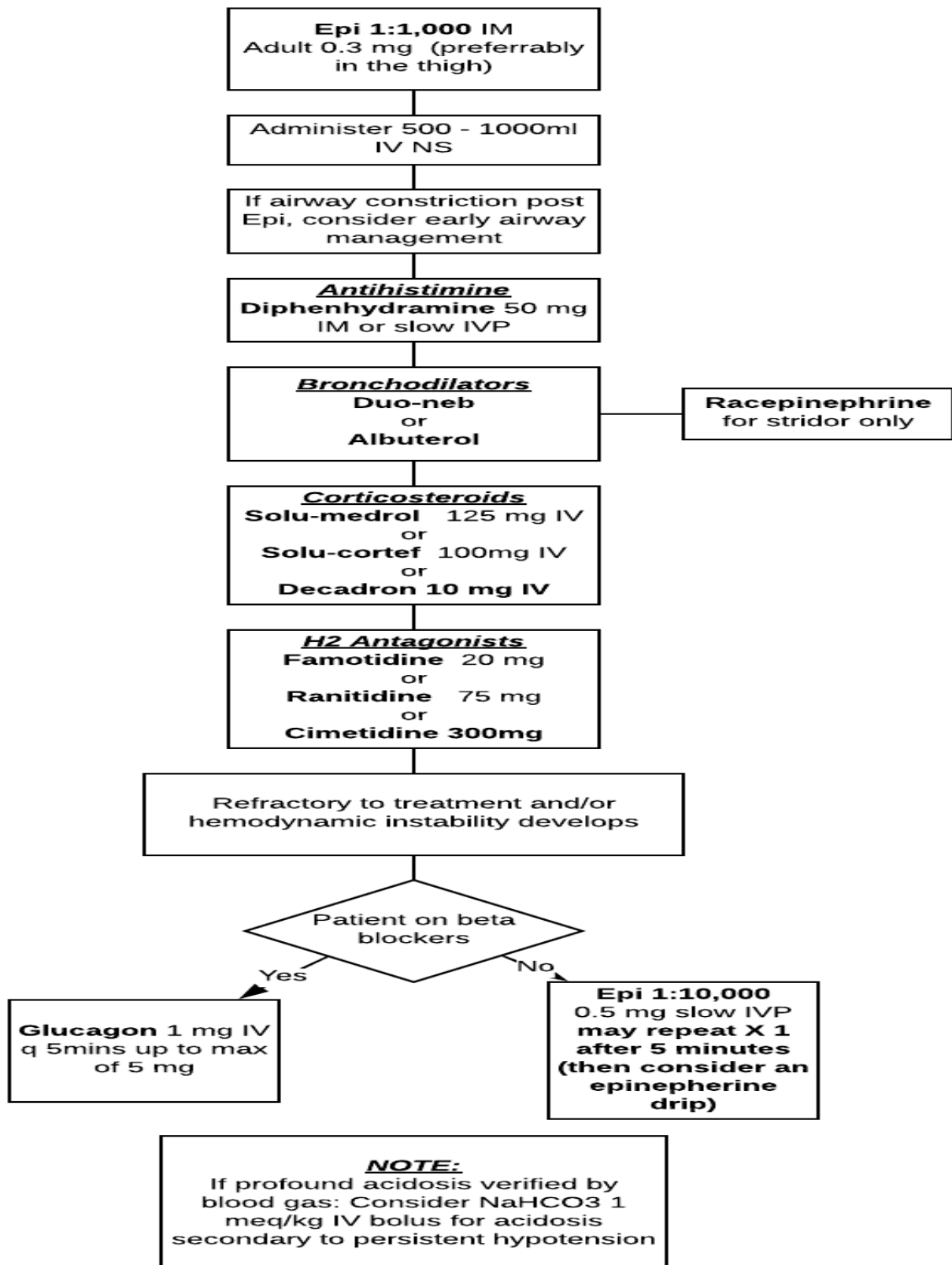
Initial Treatment/Universal Patient Care Guideline



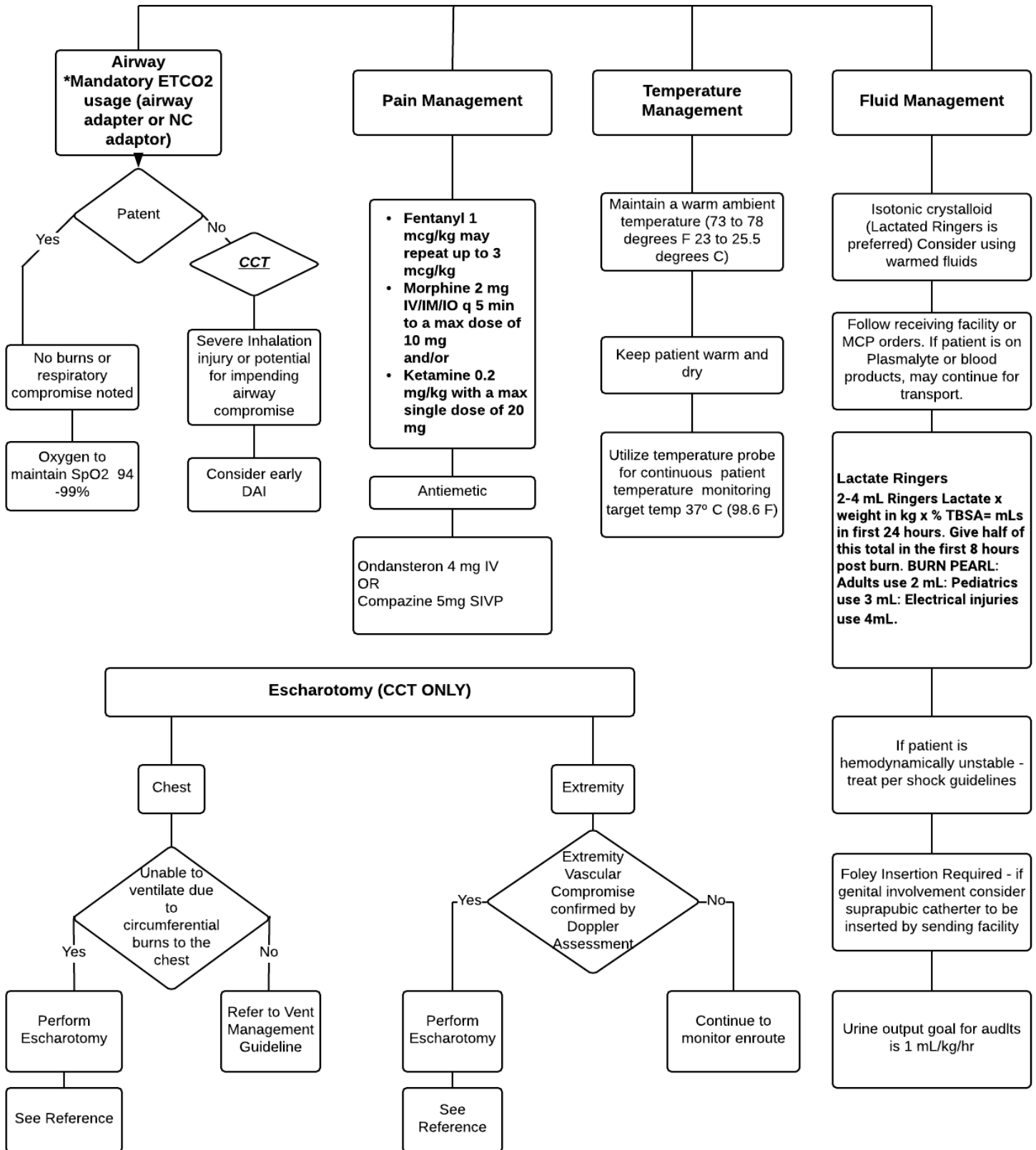
PULMONARY EDEMA / CHF



ANAPHYLAXIS

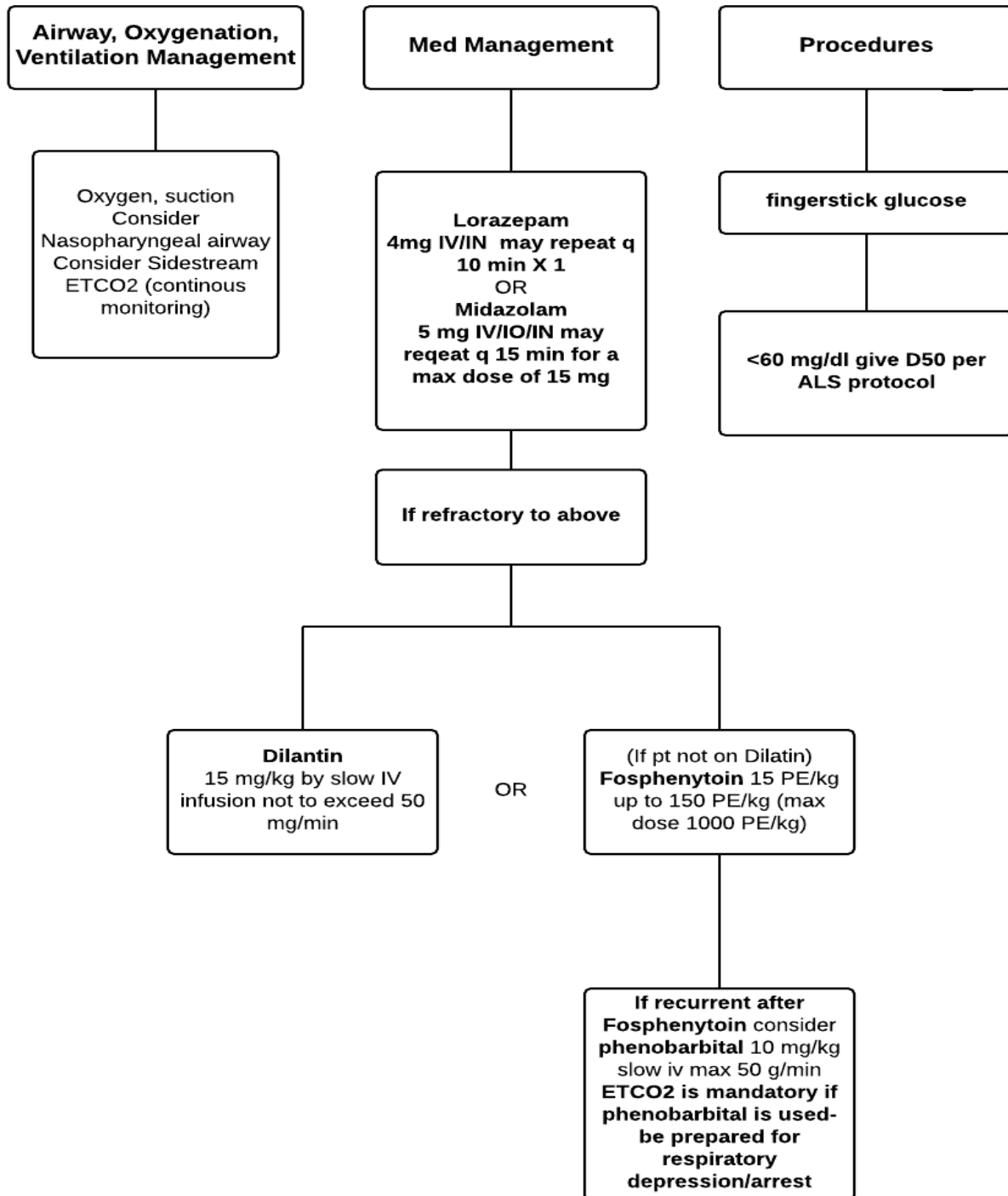


BURNS



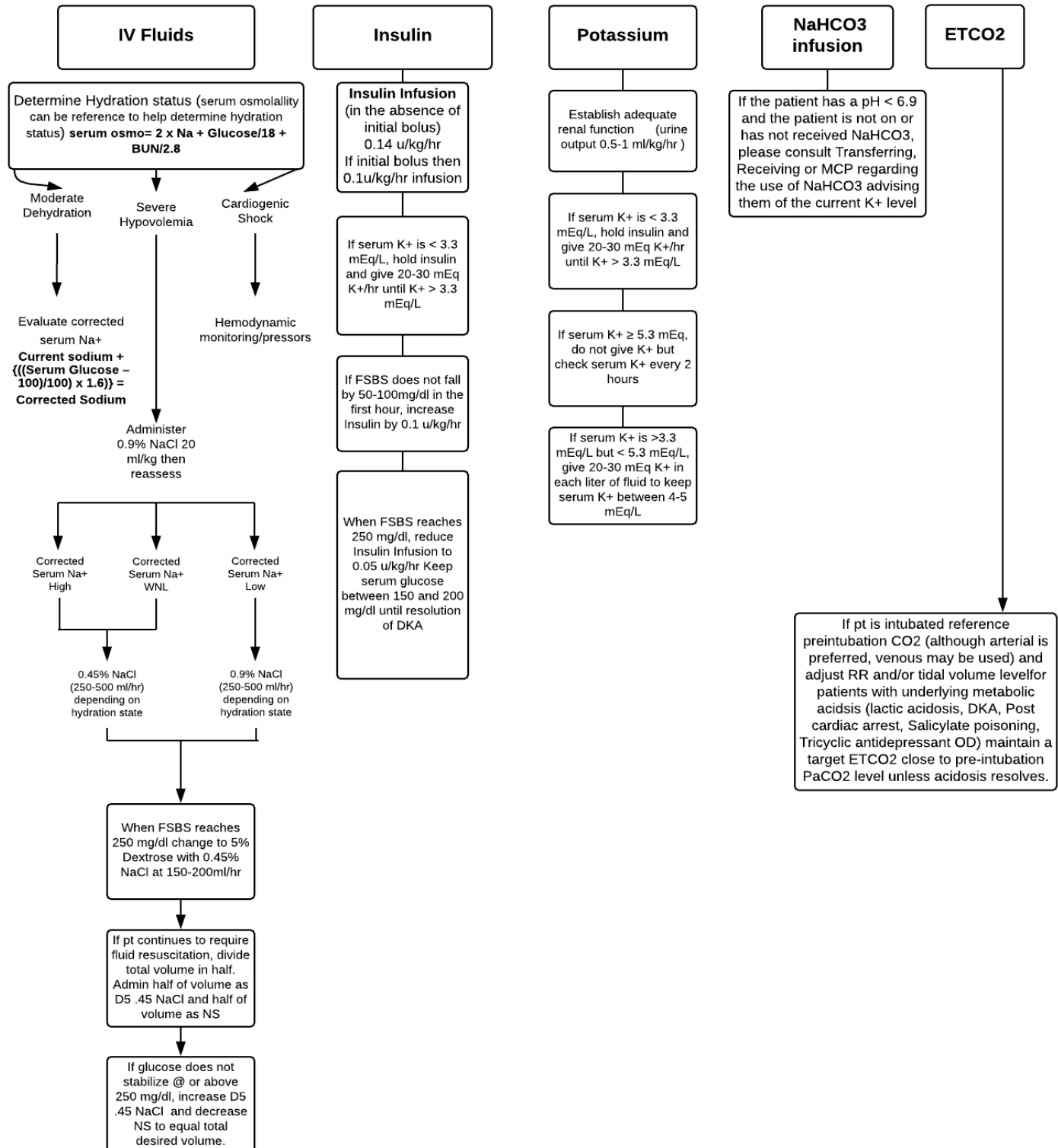
SEIZURES

Seizure (prolonged or recurrent not related to eclampsia)



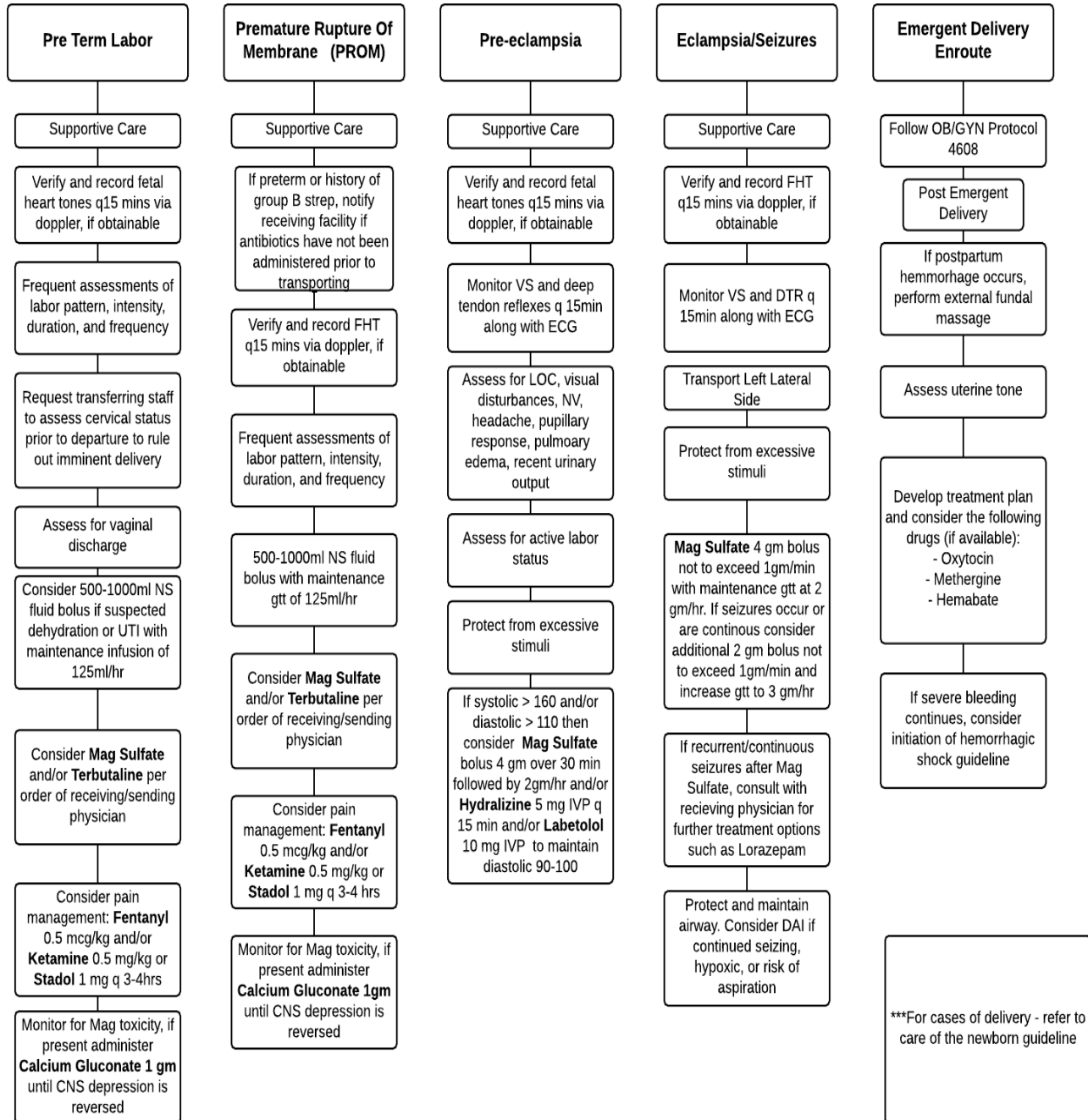
ADULT DKA

Complete Initial evaluation. Ensure labs are <30 mins old or repeat labs and request staff call results to transport crew. Check capillary glucose and serum/urine ketones to confirm hyperglycemia and ketonemia/ketonuria. Start IV fluids: 1.0 L of 0.9% NaCl per hour. Monitor ETCO₂ on all patients and repeat glucose checks every 30 mins. If transport time is >2 hours, consider aeromedical transport.

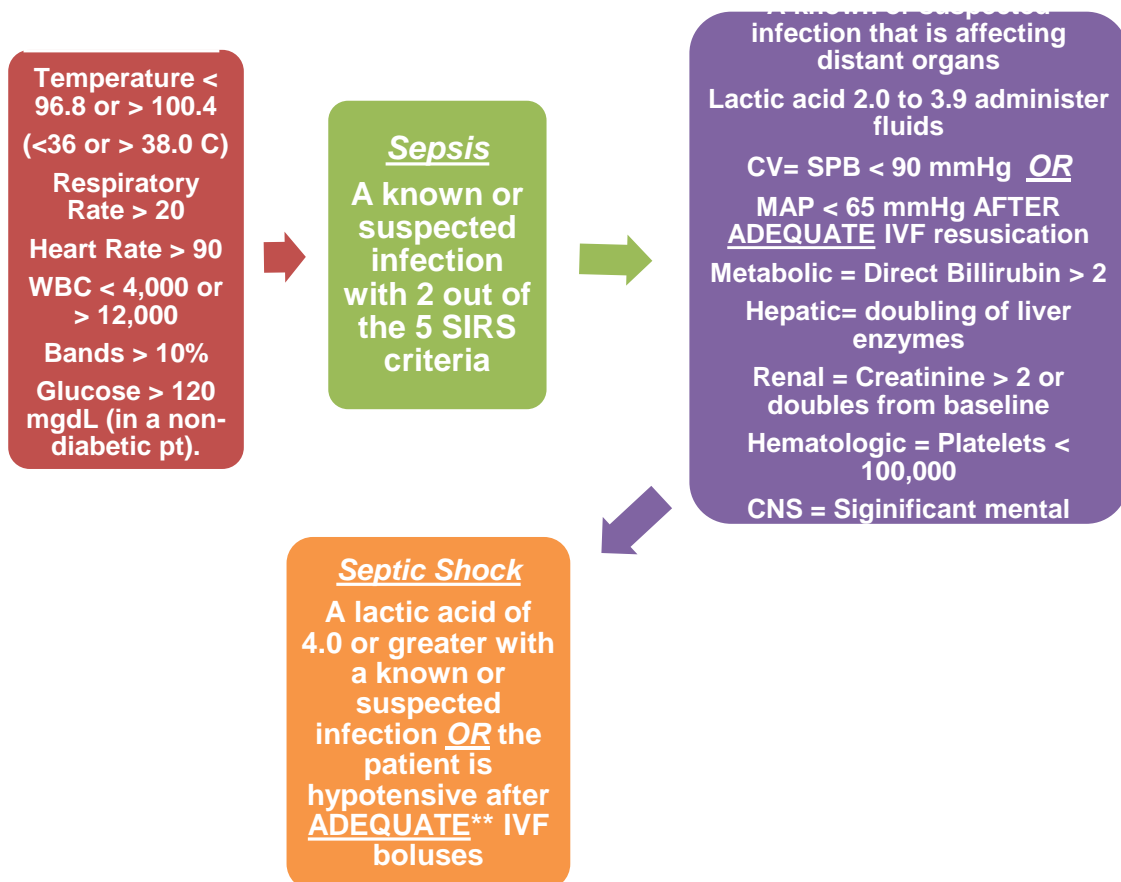


OBSTETRIC EMERGENCIES

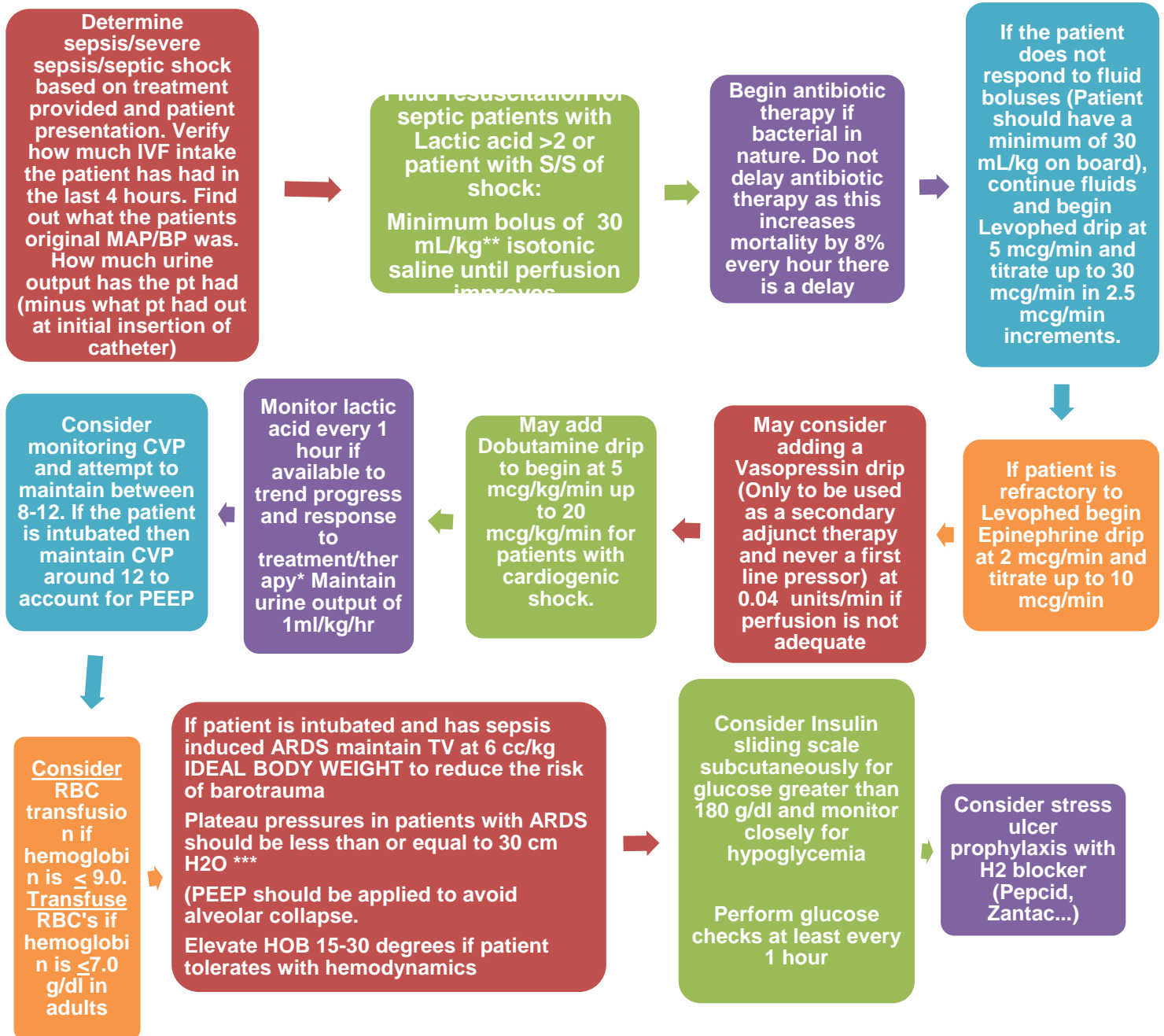
Prior to transport, obtain orders from receiving/sending for typical anticipated complications



SEPSIS

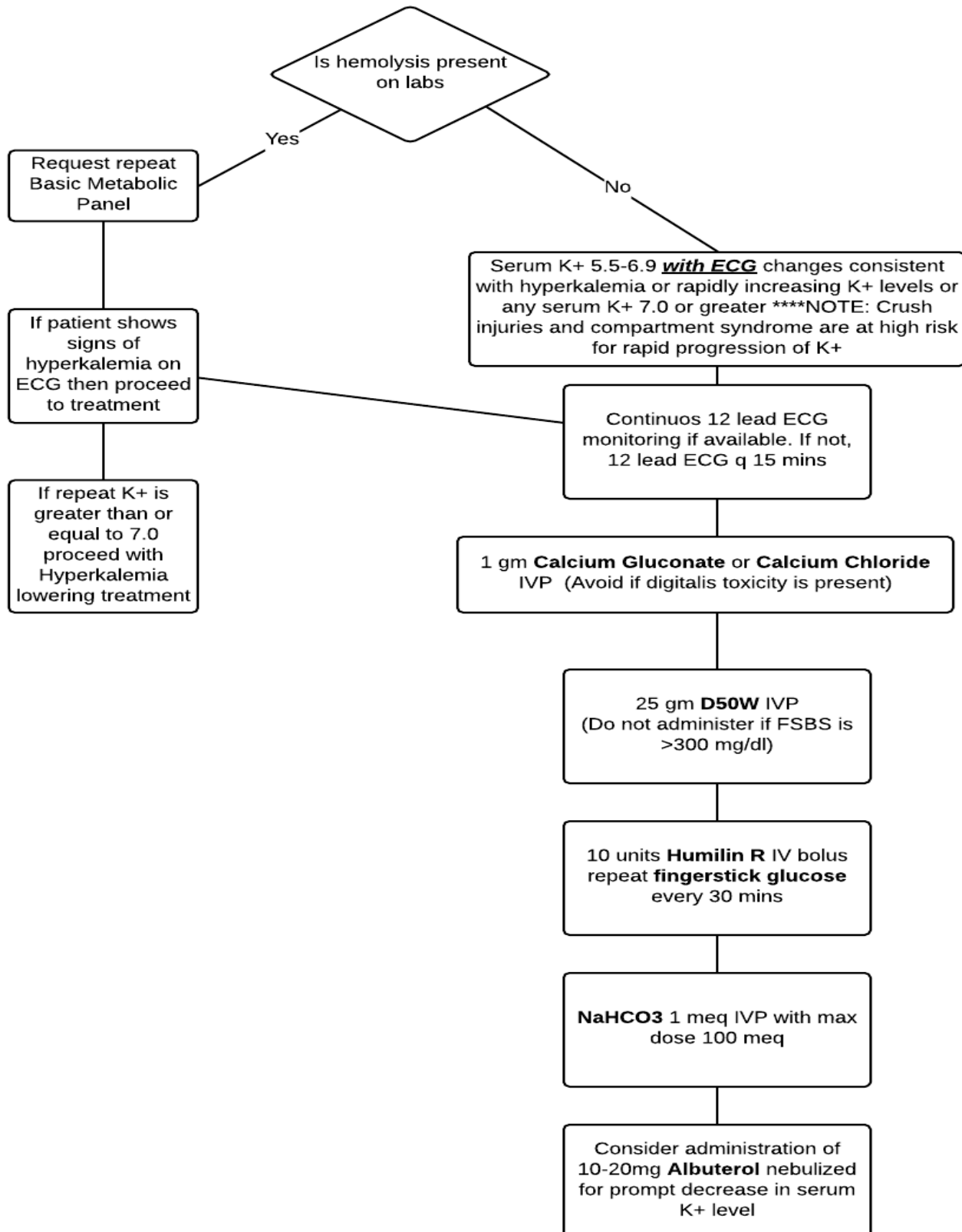


SEPSIS



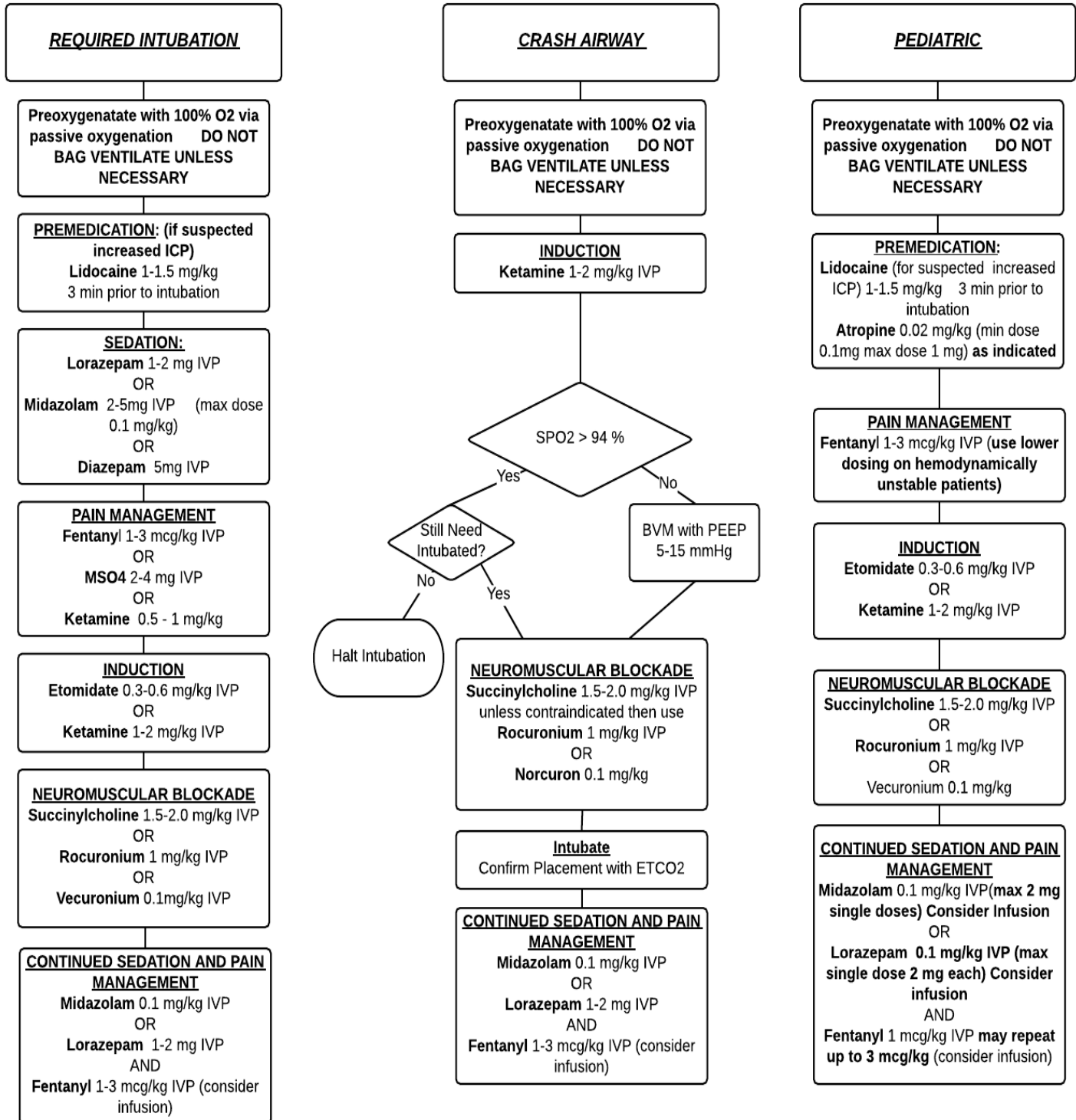
*Monitor urine output and record every 1 hour. Attempt to maintain urine output at 1 mL/kg/hr
 ** IVF boluses may be repeated after reaching the recommended 30-40 mL/kg as long as the boluses are effective as evidenced by: decreased HR, increased BP and or MAP, increased urine output, improved LOC—without development of Rales/Crackles or other contraindicated side effects of too much volume resuscitation. 30mL/kg of IVF should be achieved within 3 hours.
 ***May substitute peak airway pressure if plateau pressure is unavailable. Peak airway pressure should not exceed 40 cmH₂O → if it does then change to pressure control ventilation.

HYPERKALEMIA

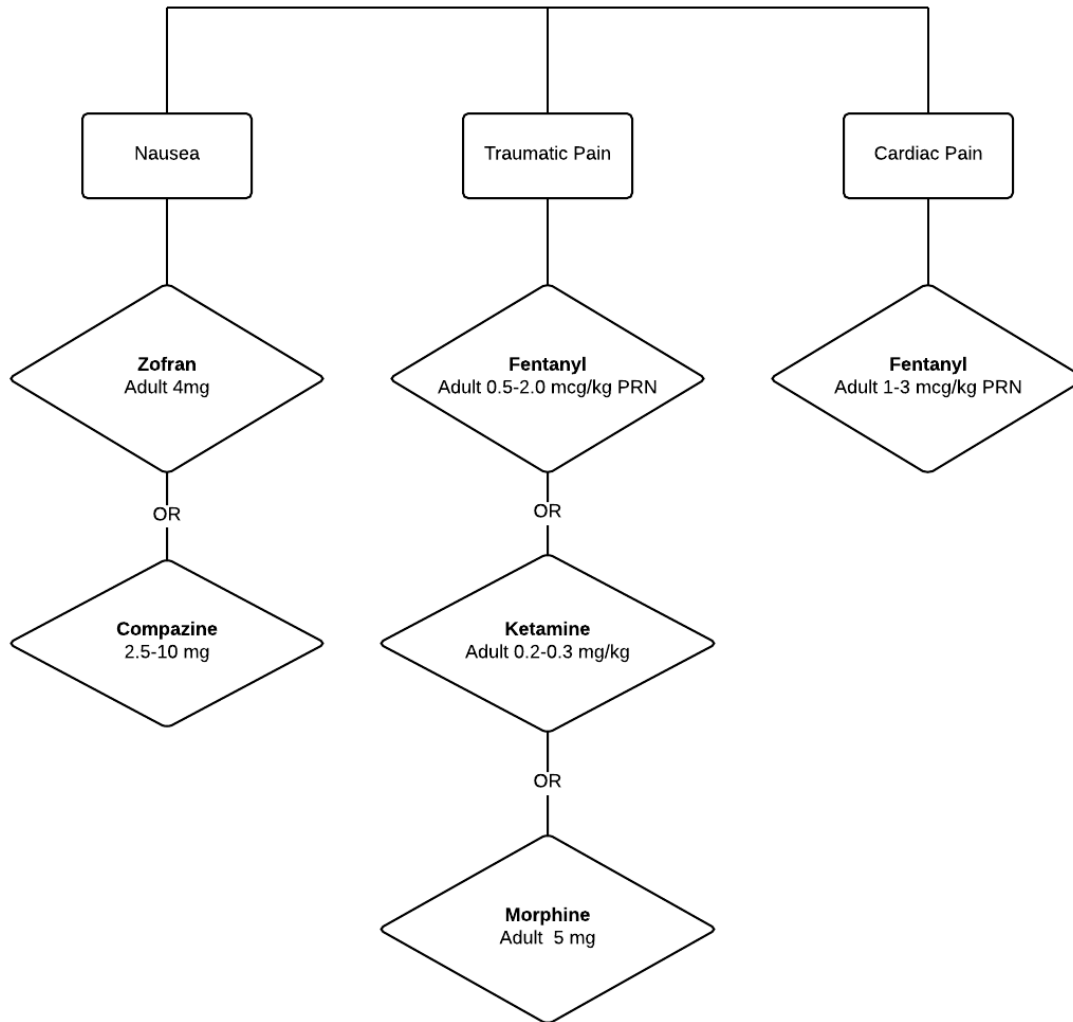


ADVANCED AIRWAY MANAGEMENT - DAI

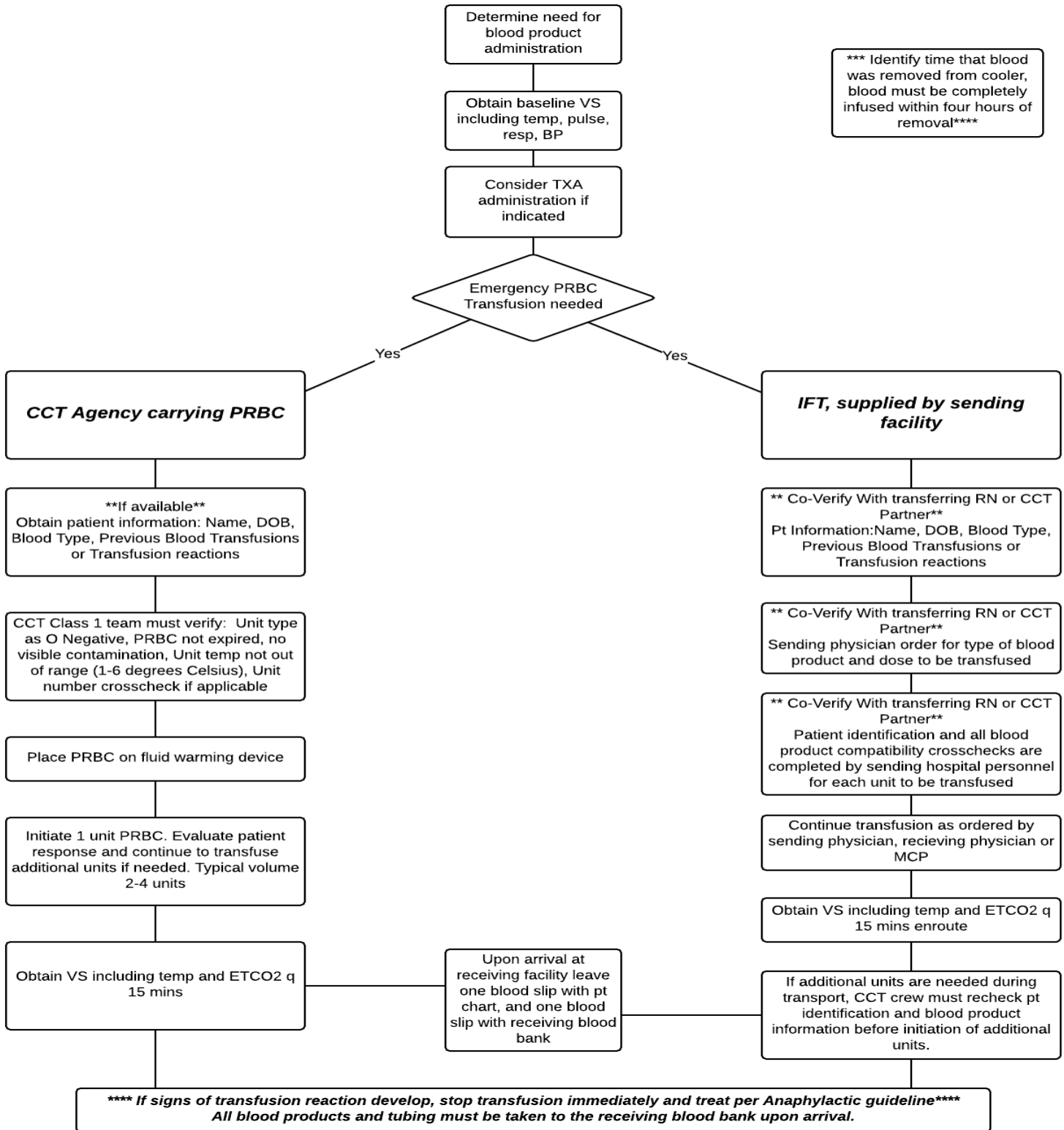
LEMON Assessment
Back up Devices Available



PATIENT COMFORT



BLOOD PRODUCT ADMINISTRATION



SEDATION AND RESTRAINT

