

Introduction

This Medical Operations Manual has been developed by the Miami-Dade Fire Rescue Protocol Advisory Committee and the Medical Director as part of the medical control program for the Miami-Dade Fire Rescue Department. Protocols describe emergency medical procedures that will be instituted by Department Emergency Medical Responders (EMR), EMT's, and Paramedics who have been certified by the State of Florida Department of Health and further approved by the Medical Director to utilize such protocols. The protocols have been designed as clinical guides, not as educational documents: Therefore, the therapeutic rationale behind the treatment protocols reflects the general principles of field care, and not a teaching document.

All information contained in this Medical Operations Manual and standard references collectively define the Standard of Care that will be provided by all uniformed personnel of the Miami-Dade Fire Rescue Department. Some patients may require treatment not specified in these protocols. The protocols should not be construed as prohibiting such flexibility. The EMR, EMT or Paramedic will use their judgment in administering treatment. The EMT or Paramedic may contact the Medical Control Physician (MCP) at any point to discuss treatment necessary to provide effective patient care.

The Medical Operations Manual (MOM) is divided into the following four sections:

- **Protocols:** This section contains treatment guidelines (the "when and why") developed by the Protocol Advisory Committee and approved by the Medical Director.
- **Procedures:** This section details specific procedures (the "how to") which will be followed by the appropriate department certified EMS personnel.
- **Medications:** This section provides a detailed description of indications, contraindications, side effects, adult and pediatric dose of every medication carried by Miami-Dade County Fire Rescue.
- **Appendix:** This section provides reference material such as approved abbreviations, symbols, Adult/Pediatric Trauma Alert Criteria, and the Glasgow Coma Score.

Each protocol and procedure delineates levels of care that will be provided by EMRs, EMT's and Paramedics. Basic Life Support tasks are outlined by the prefix BLS, Advanced Life Support tasks by the prefix ALS, and HAZMAT specific treatment by HTX. If tasks require Medical Control Physician approval, the prefix MCP is used. The protocol/procedure is written in an ascending order (1, 2, 3, etc.) with each step assuming that previous steps were done. Sub-steps (a, b, c, etc.) allow for treatment to be concurrent. Where applicable, each protocol indicates treatment specific for adults. Where necessary, specific pediatric protocols have been written and are designated by the (P) after the protocol number.

Initial Assessment

Protocol 1 is designed to provide personnel with a systematic approach to the evaluation and treatment of the medically ill or injured patient. This protocol is the foundation for all patient care. Additional protocols should be instituted as necessary. Judgment must be used in determining whether patients require ALS or BLS level of care. This protocol is frequently referred to by other protocols and procedures that may override it in recommending more specific therapy.

- A. [Scene Size-Up](#)
- B. [Primary Assessment](#)
- C. [Medical Patient Management](#)
- D. [Trauma Patient Management](#)
- E. [Secondary Assessment](#)

A. Scene Size-Up

EMR/BLS

1. Perform a Scene Assessment and determine:
 - a. Scene safety
 - b. Mechanism of injury (MOI) or nature of illness (NOI)
 - c. Number of patients
 - d. Severity of the patient(s)
 - e. Need for additional resources
2. Determine if patient meets any Alert Criteria, i.e. STEMI, STROKE, or TRAUMA, notify dispatch and receiving facility as soon as possible.
3. For ALL calls, be prepared to administer immediate life-saving interventions (defibrillation, airway management, etc.) upon INITIAL patient contact.
4. Determine the medical priority, treatment strategies and notify corresponding facility.

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B. Primary Assessment

This evaluation will be completed on every patient attended to by a responder. The purpose of the primary assessment is to identify and rapidly treat problems that are life threatening.

EMR/BLS

1. Airway

- a) Assure a patent airway and need for Spinal Motion Restriction [Protocol 40](#).
- b) If cervical or spinal injury is suspected, care must be taken not to move the head, but to maintain it in a neutral, in-line position as directed in Spinal Motion Restriction.

2. Breathing - patients should be observed for absence of or difficulty breathing and any spontaneous respiratory irregularities.

- a) Record the rate, rhythm and quality of respirations
- b) Note the effort of breathing:
 - i. Depth and effort?
 - ii. Use of accessory muscles?
 - iii. Symmetrical chest movements?
- c) If breathing is abnormal, ensure the patency of the airway.
 - i. Listen for abnormal sounds (wheezing, rales, rhonchi, pleural rub, lack of breath sounds, etc.)
 - ii. Evaluate for trauma (penetrating wounds, bruises, rib fractures, etc.)

3. Circulation

- a) Record the patient's palpable pulse rate and location
- b) Assess for obvious life threatening external blood loss (active bleeds should be managed immediately)
- c) Evaluate the patient's skin and perfusion
 - Peripheral pulses present (radial, pedal)
 - Capillary refill time
 - Skin color, temperature, and moisture

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4. Neurological Exam

- a) Level of consciousness;
 - Is patient oriented to person, place and time?
 - Determine the Glasgow Coma Score [Appendix 5](#) and [Appendix 6](#)
 - Is a FAST-ED stroke assessment needed?
 - F: Is the face symmetrical?
 - A: Assess motor function and sensation
 - S: Check for abnormal speech, proper words, and/or slurring
 - T: Determine time of onset
- b) Assess the patient's pupil size, equality and their reaction to light
- c) If the patient is conscious, do all extremities move equally?
- d) Assess patient for any pain [Protocol 18](#)

C. Medical Patient Management

EMR/BLS

1. Airway Management [Protocol 7](#), [Protocol 8](#) and [Procedure 49](#).
2. Assess the need for administration of Oxygen [Procedure 1](#). Obtain and document pulse oximetry and capnography as needed.
3. Perform a blood glucose check via finger stick as indicated in [Procedure 19](#).
4. Administer Narcan (Naloxone) for significant respiratory depression due to suspected opiate overdose [Protocol 15](#).
5. Assist with patient prescribed medication administration such as:
 - a. Nitroglycerin for chest pain [Medication 27](#)
 - b. Inhalers (Ventolin, Proventil, etc.) for difficulty breathing.
 - c. Oral glucose for conscious diabetics.
 - d. Epi Pen for acute anaphylaxis.

ALS

6. Perform advanced airway management, as indicated. [Protocol 7](#) and [Protocol 8](#).
7. Cardiac evaluation and EKG monitoring [Protocol 10](#).
8. Establish vascular access as indicated [Procedure 13](#) and [Procedure 14](#).

MCP

9. Guidance for treatment not defined in these protocols.

D. Trauma Patient Management**EMR/BLS**

1. Airway Management with C-spine control [Protocol 7](#) and [Protocol 40](#).
2. Administer Oxygen [Procedure 1](#).
3. Control obvious hemorrhage.
4. Bandage and splint.
5. Backboard and package the patient [Protocol 40](#).
6. Obtain and document a pulse oximetry reading.
7. If the patient is in shock (i.e., a systolic blood pressure < 90 mmHg) place patient in Trendelenburg position - in absence of airway or breathing compromise).
8. Establish Trauma Center contact, if indicated [Appendix 3](#).

ALS

8. Advanced airway management, as indicated.
9. Advanced interventions as needed.
10. Establish intravenous access if indicated [Procedure 13](#).
11. EKG monitoring if situation allows [Protocol 10](#).

MCP

12. Guidance for treatment not defined in these protocols.

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E. Secondary Assessment

These procedures can be carried out simultaneously along with the primary assessment and treatment when resources permit. This assessment is a more thorough evaluation of the patient.

EMR/BLS

1. Identify a chief complaint.
2. Document vital signs. A second set of vitals will be obtained and documented for the following patients:
 - a. Patients transported by MDFR.
 - b. Patients transferred to an ambulance/BLS unit.
 - c. Patients who refuse treatment/transport against medical advice. (The second set of vitals should be obtained just prior to release.)
 - d. Unstable patients as indicated in other protocols.
3. Document estimated weight whenever a medication is administered and/or anytime a patient is transported by MDFR.
4. Document a pertinent medical history:
 - S: Signs and symptoms.
 - A: Allergies
 - M: Medications
 - P: Past medical history
 - L: Last oral intake
 - E: Events leading to the call for help
5. Complete and document a head-to-toe survey. Utilize the patient's complaint to guide your assessment.

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