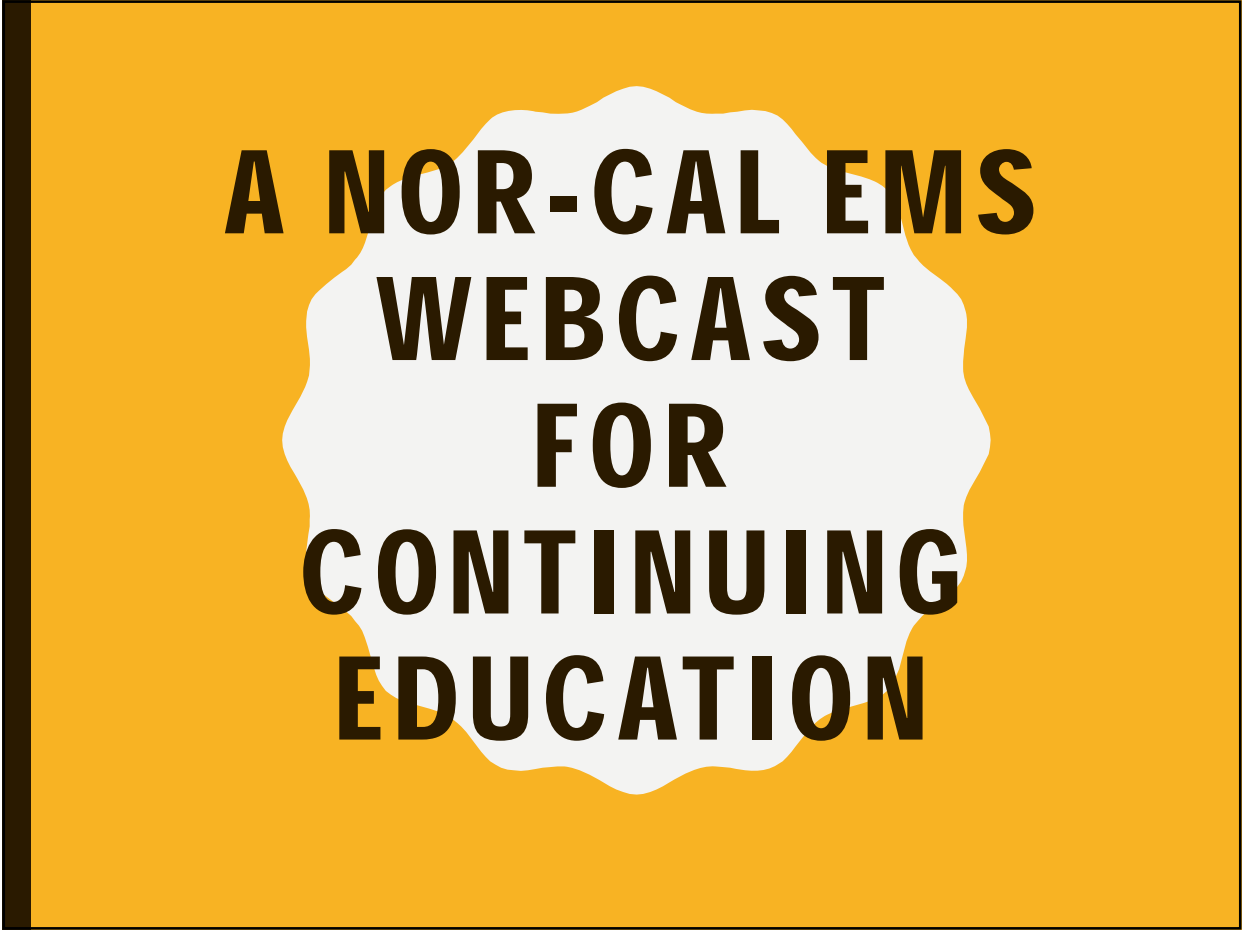


A Nor-Cal EMS Webcast
Nor-Cal EMS Medical Advisory Committee
Run Review January 2016

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A NOR-CAL EMS
WEBCAST
FOR
CONTINUING
EDUCATION

Presented by Eric Rudnick, MD, FACEP,
FAAEM, Medical Director for Nor-Cal EMS.
Recorded Live on January 12, 2016
by Engineer Bill Bogenreif

NOR-CAL EMS MEDICAL ADVISORY COMMITTEE RUN REVIEW JANUARY 12TH, 2016

Presented by:

Eric M. Rudnick, MD, FACEP, FAAEM

Medical Director for Northern California EMS

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CASE #1

- Chief Complaint: Chest Pain in 78 female
- Responded code three to a private residence for a female having chest pain.
- Arrived to find the patient sitting in a chair on the porch with fire personnel.
- Patient stated she has had multiple MI's and stated she last had a myocardial infarction 3 months ago.
- Patient stated she was sitting inside watch tv at 1345, when she experienced a sudden onset of light headedness and chest pain.
- Patient stated she self-administered baby aspirin and 3 nitroglycerin tablets however, had not experienced any relief from her chest pain.

CASE #1

- 78 yo female CC chest pain. Patient stated her chest pain today mimics the chest pain she experienced during the last MI.
- Patient stated the pain is sharp and in the center of her chest, substernally.
- Patient stated the pain radiates through her chest to the middle of her shoulder blades in her back and stated the pain is 8 out of 10.
- Patient stated nothing alleviates or worsens the pain.
- Patient denied recent illness, denied recent medication changes, denied recent trauma, denied HA, denied visual disturbance, denied dizziness, denied weakness, denied numbness or tingling in extremities.
- Denied SOB, denied abdomen pain, denied pain upon palpation of sternum and ribs, denied neck pain, denied increase in pain upon inspiration and expiration, denied vomiting and diarrhea, and stated she felt slightly nauseated and light headed.

CASE #1

- Upon assessment: HEENT: clear, trachea midline, neg JVD, neg use accessory muscles, equal chest rise and fall, adequate tidal volume.
- Lungs clear in all fields, ABD SNT, Pelvis stable, neg incontinence, posterior clear, CSM's intact in all extremities, and neg pedal edema.

CASE #1

- Initial set of vitals taken by fire personnel. Oxygen therapy administration initiated by fire personnel PTA.
- Continuation of oxygen therapy continued throughout patient contact.
- Assessment and 12 lead.
- Patient able to stand and transfer with minimal assistance from chair on porch to main stretcher without incident.
- Patient secured to main stretcher and placed into LSV without incident.

CASE #1

- 12 lead transmitted to hospital.
- Vitals, ASA administration, first nitroglycerin administration, IV access established, and transported patient code three to ED.
- 12 lead obtained.
- Second set of vitals and administration of nitroglycerin.
- Base contact made without questions or orders.
- Vitals and 12 lead obtained.
- Third nitroglycerin administered.
- Vitals and 12 lead obtained.

CASE #1

- Arrived at ED and signature obtained.
- Transfer patient to facility gurney from main stretcher via draw sheet without incident.
- Transfer of care to ED RN.
- Patient's medications left at bedside with patient.
- No further patient contact.

CASE #1

- Medication Allergies: Vicodin
- Medications: Levothyroxine, Metoprolol, Isorbide, Nitro Bid, Amiodarone, Provasatin
- PMH: HTN, Myocardial infarction, Dysrhythmia, Hypothyroidism, Hypercholesterolemia, Anemia

CASE #1

- 13:56 Mental Status: Oriented person, place, time, events
- Neuro: normal
- Skin: warm, capillary nail bed less than 2 seconds
- 13:56 Chest: normal, clear and equal breath sounds, chest pain/pressure (non-reproducible), pain radiating to neck/back/arms

CASE #1

- 13:56 BP 176/88 HR 76 RR18 SpO2 98 GCS 15 Pain 8
- 14:03 BP 182/88 HR 80 RR 18
- 14:18 BP 190/P HR 70 RR 18
- 14:25 BP 164/78 HR 60 RR 18 SpO2 99 low O2
- 14:33 BP 161/78 HR 67 RR 18
- 14:35 BP 160/76 HR 80 RR 18 SpO2 100 low O2 Pain 5

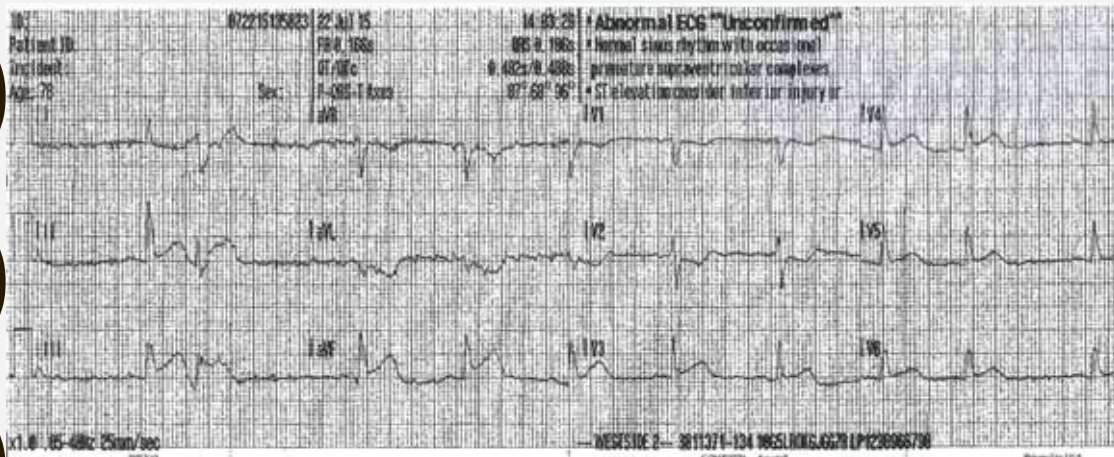
CASE #1

- 14:03 12 lead NSR, STEMI
- 14:09 12 lead NSR, STEMI
- 14:30 12 lead Atrial Flutter, STEMI
- 14:36 12 lead Atrial Flutter, STEMI

CASE #1

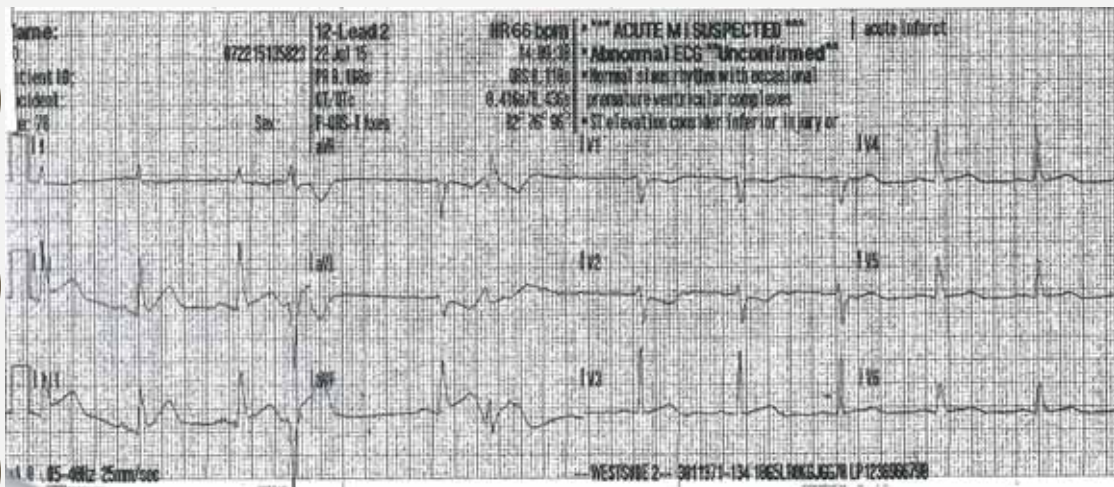
- 13:55 Oxygen by nasal cannula 2 lpm, unchanged
- 14:05 ASA, unchanged
- 14:06 NTG, Improved
- 14:19 NTG, Improved
- 14:31 NTG, Improved

CASE #1



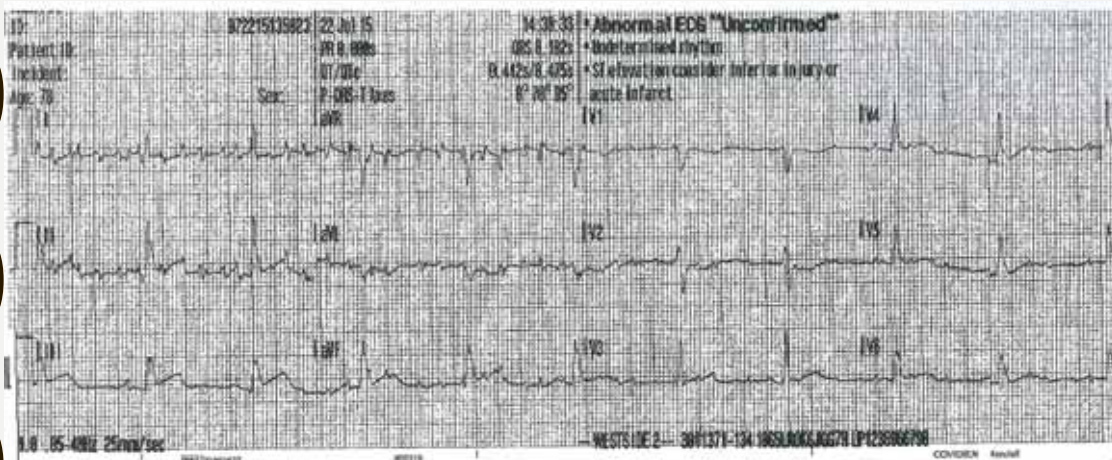
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CASE #1



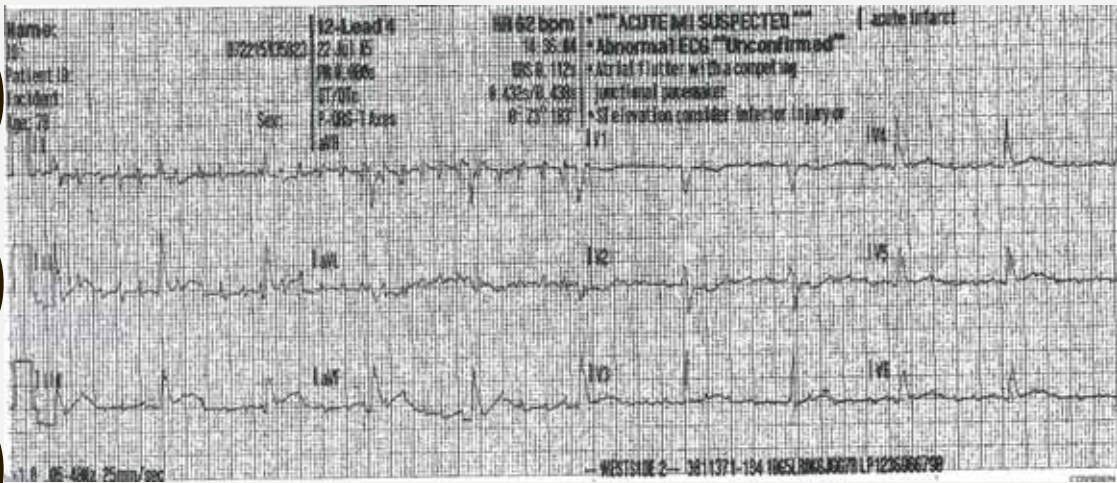
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CASE #1



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CASE #1



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CASE #1

- Documentation?
- Quality of care delivered?
- Other issues and concerns?
- Care appropriate?
- Overall impression?
- Protocol changes required?
- Teaching/Take home points

CASE #2

- Chief Complaint: ALOC in a 8 yo female
- Dispatched code three to a private business for a patient experiencing possible s/s consistent with an unspecified illness/injury.
- Arrived to find an 8 yo female patient (~31 kg) lying supine (bed) with both patient's parents and Fire personnel in attendance.
- Patient's parents are Spanish speaking only and as such, a translator is utilized during assessment.
- The patient's parents state the following: the patient has no specific medical history, is subsequently not prescribed any medications, and has no known drug allergies.

CASE #2

- They state that the patient was “acting fine all day” and that she had just consumed pizza and soda for dinner.
- They state that immediately following dinner she began to complain of a headache and then suddenly vomited several times (no abnormalities observed regarding vomitus – food particulate).
- They state that the patient became minimally responsive and that she has become progressively worse during the transport team’s response.
- They deny anything like this ever occurring before as well as any recent trauma, illness, or changes to the patient’s medications.

CASE #2

- They deny the patient having any access to any ETOH or drugs (illicit or prescribed) and state that no one else in their family has experienced any obvious/acute anomalies.
- Fire personnel state that they contacted the patient and found her to be markedly obtunded and minimally responsive to painful stimuli.
- Fire personnel state that they did not provide the patient with any interventions but did measure her vital signs.

CASE #2

- C/C Altered level of consciousness.
- The patient is contacted lying supine (bed).
- She is minimally responsive to painful stimuli but is observed to be ventilating/oxygenating adequately.
- As such, no information can be directly from the patient.

CASE #2

- Airway remains open/patent, breathing remains adequate /non-labored with symmetric chest rise and fall observed and no obvious/acute circulatory deficits are observed at present time.
- Patient remains 2-1-5 for a total GCS 8 (initial), pupils remain PERRLA left-upward deviation of gaze observed, and skin remains pink-warm-moist.
- HEENT remains negative for any obvious/acute anomalies, no JVD is appreciated, and trachea remains midline.
- Chest wall remains intact with lung sounds significant for rhonchi and equal bilaterally.

CASE #2

- Abdomen remains soft/non-tender, pelvis remains stable, and no incontinence is observed.
- Posterior remains negative for any obvious/acute anomalies, CSM markedly reduced in all extremities movement is observed to be absent throughout.

CASE #2

- Patient is moved to stretcher and is transferred into the rear of ambulance without incident.
- Supplemental oxygen therapy is administered via NC (3 liters/minute) and hemodynamic monitoring is initiated (both continuing for duration of transport).
- Cardiac monitoring defibrillation pads are applied to the patient's bare chest.
- IV is successfully established in the patient's left AC (20 gauge) ;corresponding to 1000 ml NS at TKO.

CASE #2

- BG is successful obtained during IV establishment.
- A second IV is attempted in the patient's right AC (20 gauge).
- ED MICN successfully contacted via cell phone for patient report.
- Consultation with the on duty ED physician is requested with the ED physician agreeing with the appropriateness of continuing to reassess/support the patient while transporting code three to hospital.
- He verifies the appropriateness of not initiating positive pressure ventilations.

CASE #2

- Transport is initiated with the patient's level of consciousness fluctuating during transport (brief periods of lucidity observed).
- Reassessment continues for the duration of the transport.
- Patient is transported code three to hospital and is transferred into the care of ED RN/MD without incident.
- Patient's belonging are left at the ED in both the care of both the patient and the parent's receiving RN/MD.
- No further contact.

CASE #2

- NKDA
- Medications: none
- PMH: none

CASE #2

- 00:50 Mental status: normal for patient, oriented person place, time, event
- Neuro: normal Eye R reactive Eye L reactive
- Head/face: normal
- Neck: normal
- Chest/Lungs: Normal chest assessment, normal clear and equal bilaterally
- Heart: normal

CASE #2

- LUQ/LLQ/RUQ/RLQ: normal, soft, non-tender
- GU: normal
- Cervical: normal
- Thoracic normal
- Lumbar: normal
- Extremities: RU/RL/LU/LL: normal

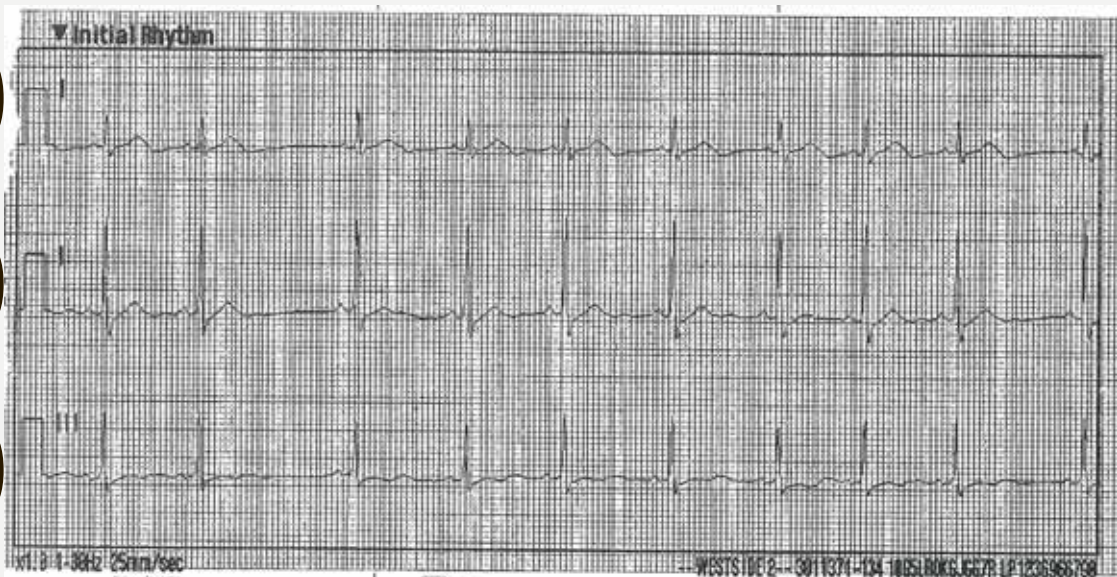
CASE #2

- 00:57 BP 106/54 HR 65 RR 14 SpO2 98% room air GCS 6
- 01:05 BP 108/48 HR 68 RR 14 SpO2 100% low O2 GCS 6
- 01:06 BP 110/52 HR 78 RR 14
- 00:58 cardiac monitor
- 01:05 venous access extremity successful
- 01:08 venous access extremity not successful
- 00:59 oxygen by nasal cannula

CASE #2

- Documentation?
- Quality of care delivered?
- Other issues and concerns?
- Care appropriate?
- Overall impression?
- Protocol changes required?
- Teaching/Take home points

CASE #3



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CASE #3

- Documentation?
- Quality of care delivered?
- Other issues and concerns?
- Care appropriate?
- Overall impression?
- Protocol changes required?
- Teaching/Take home points

CASE #4

- Documentation?
- Quality of care delivered?
- Other issues and concerns?
- Care appropriate?
- Overall impression?
- Protocol changes required?
- Teaching/Take home points