

**Medical Directors' Disaster Working Group**  
**January 17, 2008**

**DRAFT Altered Protocols**

These State of Texas Disaster Protocols are to be used by medical personnel in the field (EMT's, paramedics, nurses, physicians, etc) who are caring for patients that are directly affected by the disaster for which these altered-standard-of-care protocols are being implemented. These protocols are to be used only by medical personnel who are deployed under the State's disaster plan. These protocols are to be used in conjunction with each acting medic's protocols that are already set forth by his or her medical director from his or her home service.

The following altered protocols should replace a medic's regular protocols only in the medical emergencies denoted, and only when one or more of the following apply:

- 1) The patient is not within a reasonable transport time to his or her destination
- 2) The equipment available is not adequate to support the prolonged treatment or resuscitation of the patient in question and still maintain an adequate reserve of necessary equipment to support the other patients under the medic's care
- 3) The personnel available to care for the patient(s) are not adequate to support a prolonged treatment or resuscitation
- 4) An alternate transport vehicle (local ambulance or helicopter) is not available to intercept the patient within a reasonable amount of time.

**CARDIAC ARREST**

(A long conversation about altered cardiac arrest protocols ensued. Some in the group felt that the protocol in the first set of GETAC Disaster Task Force Recommendations was adequate. Others felt that patients in cardiac arrest should receive one shock [if indicated] and then BLS care only.)

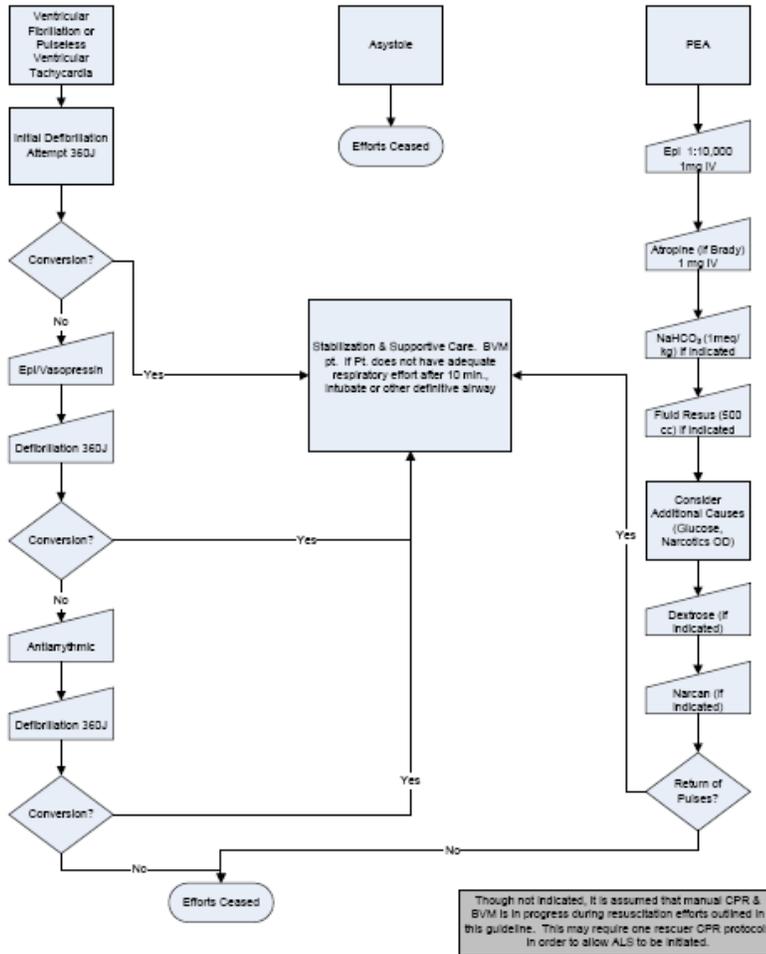
See next page for original GETAC Disaster Task Force recommended altered protocol.

**GETAC Disaster/Emergency  
Preparedness  
Task Force**

**Attachment 2**

**Modified Cardiac Arrest Resuscitation Guidelines  
For Evacuation Scenarios**

Draft Version 2



Modified May 22<sup>nd</sup>, 2007

## **RESPIRATORY ARREST**

### **RESPIRATORY DISTRESS / HYPOXIA**

It is recognized that a patient may require supplemental oxygen chronically, or for an acute respiratory event. If a patient brings his or her own oxygen supply, that oxygen supply should be used for that patient until depleted, but it is recognized that there may not be further oxygen available for chronic or acute treatment of a respiratory emergency. If this is the case, medical personnel are to use room air for bagging patients or providing nebulizer therapy if necessary.

### **ASTHMA/COPD**

The group discussed the possibility of the State providing battery powered nebulizers on ALS buses.

### **CHEST PAIN**

AED's with 3-lead capability will be available to medics on ALS buses, but the group had a lengthy discussion on whether a medic should obtain a 12-lead EKG on a patient with chest pain, as there would not be no way to adequately treat a STEMI in an evacuation or MCI situation.

The group agreed that chest pain patients should be treated with:

- 1) Aspirin if available and not contraindicated in the patient
- 2) Nitroglycerin SL if available and the patient has an adequate blood pressure
- 3) IV fluids if available and the patient is hypotensive
- 4) Oxygen if available