April 4th, 2019

RE: BREMS Competency Review

As of April 1, 2019, the OMD Committee has made changes to the skills review process:

Skills Review – Competency Style Format

- Name change: The review will now be referred to as "Competency Review".
- The BREMS Competency Review will now consist of Procedures from the BREMS Protocol book for each department or locality to review internally
- No PowerPoint will be created to show with the review
- 3-4 procedures per year will be sent out each year
- In an attempt to be less repetitive, all procedures will be done on a rotating basis will be made. Some may be reviewed more frequently with OMD and CQI Review

Training Events

- This format can be flexible to the needs of your organization
- A department or locality can use the previous quarterly scheduling if preferred
- Training may also be done on shift or as part of an existing training program within an organization
- The carbon copy forms should still be maintained as in previous years
- BREMS Staff will also be willing to help at scheduled trainings, business meetings, or other events if requested by a department

Feedback

- Please let us know how the new format fits the needs of your organization
- The goal is to meet the needs of each agency, but to ensure we still provide high quality patient care

Thank you for your attention to this matter. And as always, feel free to contact us here at the BREMS office with questions anytime. (434) 947-5934

Thank you,
BREMS Staff on behalf of Regional OMD Dr. Marilyn McLeod and OMD Committee Physicians

Gastric Tube Insertion

Indications:

- For adults only.
- To decompress gastric distention in the patient with advanced airway placement.

Contraindications:

- Patient not intubated.
- Nasal insertion not to be attempted.

I	Intermediate	I
P	Paramedic	P

- *See * notation regarding AEMT use below*

Procedure:

1. Assemble equipment - OG tube, 50 ml syringe, tape, emesis basin, gloves, saline for irrigation, stethoscope, suction, lubricant.
2. Observe universal precautions.
3. Measure the tube from the patient's mouth, around the earlobe to the umbilicus; mark the correct tube length.
4. Insert lubricated tube into the mouth.
5. Pass the tube to the predetermined length. Do not force the tube if resistance is encountered. If unable to insert tube to predetermined measurement, the tube may be in the trachea or curled in the patient's throat.
6. Check the placement by aspirating gastric contents. If there is no return place a stethoscope over the epigastric region and auscultate while injecting 20-30 ml of air into the tube.
7. Tape the tube in place and connect to low suction as indicated.
8. Document the procedure, size of tube, tube placement check and patient response.

**Advanced-EMT/Intermediate/Paramedic level providers may use gastric tube insertion in conjunction with supraglottic airways when needed. Proper training prior to use is required.*

Childbirth- Uncomplicated Delivery

Contact receiving facility to notify of delivery

Observe head crowning

Follow ***Universal Patient Care*** Protocol

- Prepare mother for delivery
- Set up equipment and administer oxygen as necessary

Delivery of head:
Firm, gentle pressure with flat of hand to slow expulsion.
Allow head to rotate normally, check for cord around neck, wipe face free of debris.
Suction mouth and nose with bulb syringe, only if meconium is present. Do not aggressively suction the infant.

Delivery of body:
Place one palm over each ear. With next contraction, gently move head downward until upper shoulder appears. Then gently lift up on the lower shoulder.
Support the head and neck with one hand and buttocks with the other.
Document all times (delivery, contraction frequency, and length).

Newborn and cord:
Keep newborn at level of vaginal opening. Keep warm and dry. After 10 seconds, clamp cord in two places with sterile equipment at least 6-8 inches from newborn.
Cut between clamps. Do not pull on the cord to deliver the placenta. If the placenta delivers, place it in the bag provided in the OB kit. Take the placenta to the hospital with the patient.

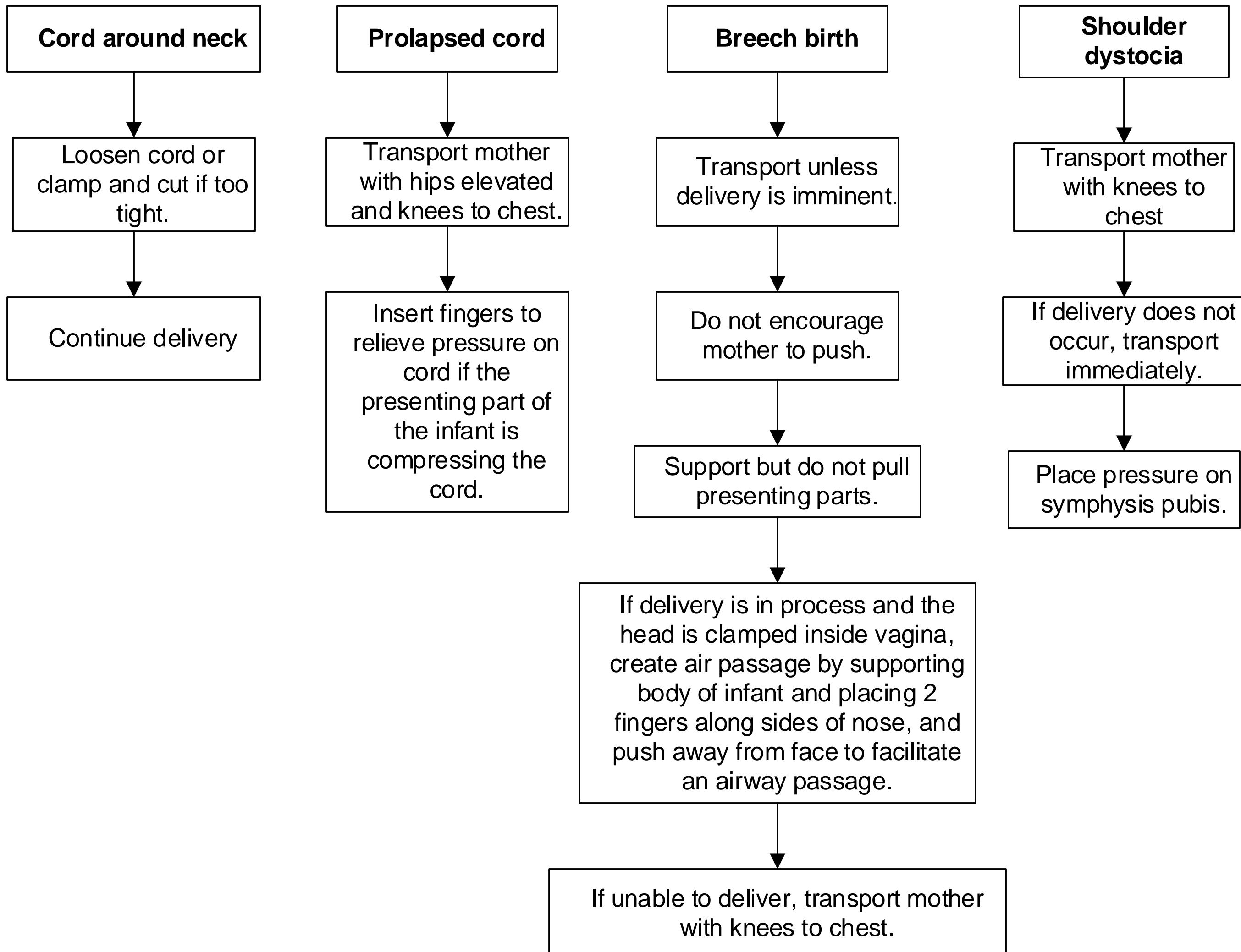
EMT	EMT	EMT
A	Advanced EMT	A
I	Intermediate	I
P	Paramedic	P

KEY POINTS/CONSIDERATIONS

Patients going to Lynchburg area hospitals:

- Patients who are > 20 weeks are to be transported to Virginia Baptist. If the patient is < 20 weeks the patient is to be transported to Lynchburg General.
- All trauma patients, regardless of stage of pregnancy, are to be transported to Lynchburg General.
- After delivery, massaging the uterus (lower abdomen) will promote uterine contractions and help to control post-partum bleeding.
- Some perineal bleeding is normal with any childbirth. Large quantities of blood or free bleeding are abnormal.
- If delivery becomes imminent, prepare to deliver and protect mother's privacy if possible (stop the ambulance and prepare for delivery).

Childbirth- Abnormal Birth Emergencies



Contact Medical Control for further consideration.

KEY POINTS/CONSIDERATIONS

Patients going to Lynchburg area hospitals:

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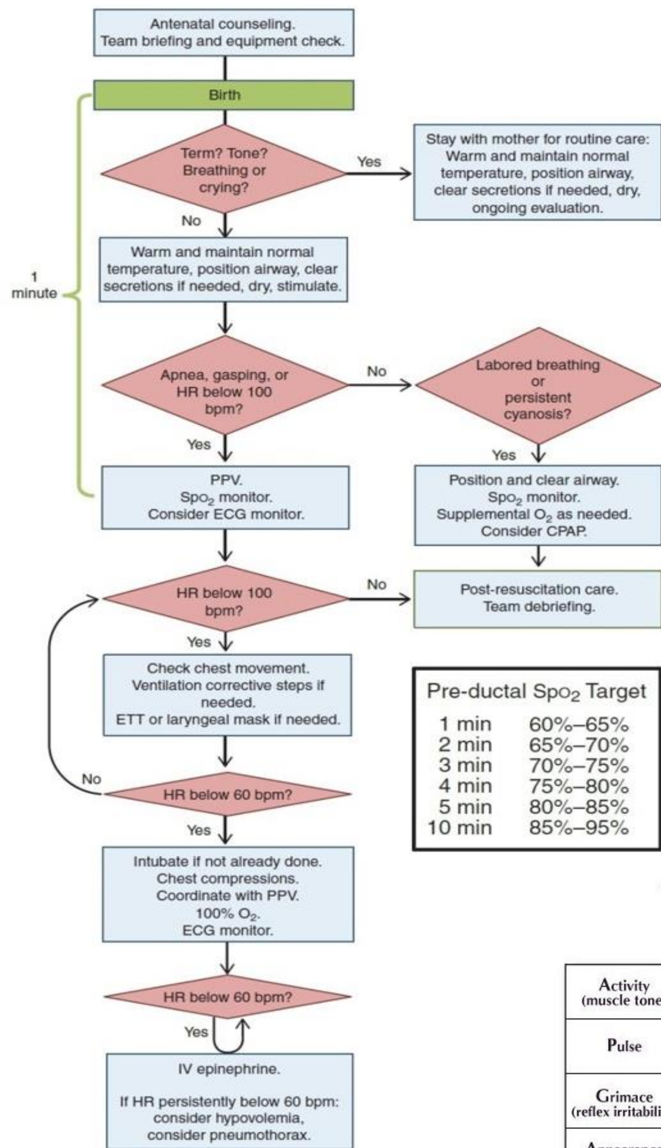
- All trauma patients, regardless of stage of pregnancy, are to be transported to Lynchburg General.

Childbirth - Care of the Newborn



EMT	EMT	EMT
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APGAR SCORING SYSTEM

	0 Points	1 Point	2 Points	Points totaled
Activity (muscle tone)	Absent	Arms and legs flexed	Active movement	
Pulse	Absent	Below 100 bpm	Over 100 bpm	
Grimace (reflex irritability)	Flaccid	Some flexion of Extremities	Active motion (sneeze, cough, pull away)	
Appearance (skin color)	Blue, pale	Body pink, Extremities blue	Completely pink	
Respiration	Absent	Slow, irregular	Vigorous cry	

Severely depressed	0-3
Moderately depressed	4-6
Excellent condition	7-10

KEY POINTS/CONSIDERATIONS

- **Temperature**: Keep the infant warm & dry. Allow skin to skin contact with the parent.
- **Airway**: Provide O2 as needed. (See permissible pre-ductal chart above.)
- **Suction**: Only as needed; if meconium is present, suction until mucosa is clear
- **Breathing**: Stimulate the baby to cry by tapping its feet or buttocks; DO NOT stimulate if meconium is present.
- **Circulation**: Asses heart rate and color
- If the infant's heart rate is <100bpm, but >60bpm, begin positive pressure ventilation via BVM. Please note that when providing PPV, only small "puffs" of the BVM are necessary. Do not over ventilate the infant.
- If the infant's heart rate is near or <60bpm, initiate chest compressions at a 3:1 ratio - (3 compressions; 1 ventilation). A 2-thumb technique is recommended.
- **APGAR**: Assign APGAR scoring at 1 minute after birth, and then again at 5 minutes after birth.

**Reference – Neonatal Resuscitation Program, 7th edition update, June, 2016*