



CLINICAL PRACTICE GUIDELINES

CFR

CARDIAC FIRST
RESPONDER
- ADVANCED

2021 Edition (Updated June 2023)



PHECC Clinical Practice Guidelines

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Second Edition, 2004

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2nd Floor, Beech House, Millennium Park, Osberstown, Naas, Co Kildare, W91 TK7N, Ireland.

Phone: +353 (0)45 882042

Email: info@phecc.ie

Web: www.phecc.ie

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RESPONDER
- ADVANCED

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CLINICAL PRACTICE GUIDELINES

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This Handbook comprises the 2021 Edition Clinical Practice Guidelines (CPGs). These guidelines outline patient assessments and pre-hospital management for responders at:

RESPONDER LEVEL

- Cardiac First Responder
- First Aid Responder
- Emergency First Responder

REGISTERED PRACTITIONER

- Emergency Medical Technician
- Paramedic
- Advanced Paramedic



I am delighted that there are now 357 CPGs in total to guide integrated care across the six pre-hospital emergency care clinical levels. These CPGs ensure that responders and practitioners are practicing to best international standards and support PHECC's vision that people in Ireland receive excellent pre-hospital emergency care.

I would like to acknowledge the hard work and commitment the members of the Medical Advisory Committee have shown during the development of this publication, guided by Dr David Menzies (Chair). A special word of thanks goes to Dr Brian Power who retired in 2020 and has made an enormous contribution to the advancement of pre-hospital emergency care in Ireland. I want to acknowledge the PHECC Executive, for their continued support in researching and compiling these CPGs and paving the way for the future development of the pre-hospital emergency care continuum.

I recognise the contribution made by many responders and practitioners, whose feedback has assisted PHECC in the continual improvement and development of CPGs and welcome these guidelines as an important contribution to best practice in pre-hospital emergency care.

A handwritten signature in black ink that reads "Jacqueline Burke".

Dr Jacqueline Burke, Chairperson
Pre-Hospital Emergency Care Council

The process of developing CPGs has been long and detailed. The quality of the finished product is due to the painstaking work of many people, who through their expertise and review of the literature, ensured a world-class publication.

PROJECT TEAM

Mr Raymond Carney, Programme Manager, PHECC
Mr Ricky Ellis, Programme Manager, PHECC
Margaret Bracken, Aisling Ryan and Ashling Weldon

MEDICAL ADVISORY COMMITTEE (CPG 2021)

Dr David Menzies (Chair), Consultant in Emergency Medicine, Member of Council
Mr David Irwin (Vice Chair), Advanced Paramedic, Nominated by Chair
Professor Gerard Bury, Director, UCD Centre for Emergency Medical Science
Mr Ian Brennan, Advanced Paramedic, Operational Resource Manager, HSE NAS
Mr Hillery Collins, Paramedic, Vice Chairperson of Council
Dr Niamh Collins, Consultant in Emergency Medicine, Connolly Hospital, Blanchardstown
Mr Eoghan Connolly, Advanced Paramedic, representative from the Irish College of Paramedics
Dr Lisa Cunningham Guthrie, Registrar in Emergency Medicine, Nominated by Chair
Mr Mark Dixon, Advanced Paramedic, Paramedic Programme Lead, University of Limerick
Mr David Hennelly, Advanced Paramedic, Clinical Development Manager, HSE NAS
Mr Macartan Hughes, Chief Ambulance Officer – Education and Competency Assurance, HSE NAS
Dr Shane Knox, Assistant Chief Ambulance Officer - Education Manager, HSE NASC
Dr Stanley Koe, Consultant Paediatrician, CHI at Tallaght & Connolly Hospitals
Dr Mick Molloy, Consultant in Emergency Medicine, Wexford General Hospital
Mr Shane Mooney, Education and Competency Assurance Officer, HSE NAS
Dr Peter O'Connor, Medical Director, Dublin Fire Brigade
Professor Cathal O'Donnell, Clinical Director, HSE NAS
Mr Martin O'Reilly, District Officer, EMS Support, Dublin Fire Brigade
Dr Jason van der Velde, Clinical Lead, MEDICO Cork, Member of Council
Dr Philip Darcy, Consultant in Emergency Medicine, Connolly Hospital, Blanchardstown

EXTERNAL CONTRIBUTORS

PHECC would like to thank and acknowledge all of the experts who contributed to the creation of these Clinical Practice Guidelines.

MEDICATION FORMULARY REVIEW

Ms Regina Lee, MPSI

EXTERNAL CLINICAL REVIEW

Responder Niamh O'Leary & Michelle O Toole

Emergency Medical Technician: Gareth Elbell & Gavin Hoey

Paramedic: Eithne Scully & Andy O Toole

Advanced Paramedic: Terry Dore & Pete Thorpe

EXTERNAL QUALITY REVIEW

Dr Jack Collins

MEDICAL ADVISORY COMMITTEE (CPG 2023 Update)

Dr David Menzies (Chair), Consultant in Emergency Medicine, Member of Council

Associate Professor Tomás Barry, (Vice-Chair) Academic General Practitioner, member of Council

Mr Ian Brennan, Advanced Paramedic, JVOC representative

Mr Adrian Collins, Advanced Paramedic, NAS practitioner

Dr Niamh Collins, Consultant in Emergency Medicine; Medical Director, Dublin Fire Brigade

Mr David Irwin, Advanced Paramedic NAS; representative of PHECC practitioners

Mr Karl Kendellan, Advanced Paramedic, NAS; representative of PHECC practitioners

Mr John Mc Shane, Paramedic; representative of PHECC practitioners

Ms Laura O' Callaghan, Advanced Paramedic; representative of PHECC practitioners

Professor Cathal O'Donnell, Clinical Director, HSE NAS

Mr Martin O'Reilly, District Officer, EMS Support, Dublin Fire Brigade

Dr Nuala Quinn, Consultant in Paediatric Emergency Medicine CHI, nominated by IAEM

Dr Jason van der Velde, Clinical Lead, MEDICO Cork, Member of Council

Dr Alan Watts, Consultant in Emergency Medicine, nominated by IAEM

Welcome to the 2021 edition of the PHECC Clinical Practice Guidelines. This edition has been a long time in development and reflects the significant effort and contribution to the new CPGs by so many people.

As ever, a robust development and review process has been applied to the new and revised CPGs, including a detailed and comprehensive quality assurance process.

Pre-Hospital Care in Ireland has evolved significantly since the first editions of the CPGs. The suite of care the CPGs now enable is progressive and transformative across all levels of responder and practitioner.

The impact of Covid-19 has influenced these CPGs, both in posing challenges in continuing the regular Medical Advisory Committee meetings and discussions, while also giving rise to a specific suite of vaccination CPGs that enable PHECC practitioners to support the national Covid-19 vaccination programme.

For the first time, we have CPGs that enable practitioners to not convey patients to hospital as a matter of default. The non-conveyance CPGs are a step towards more alternative care pathways for our patients, in recognition that the traditional hospital-centric model for emergency care is not always appropriate or feasible. This suite of non-conveyance CPGs will be a key area for expansion and development in the next term of the Medical Advisory Committee.

Further developments include the designation of certain CPGs and elements of other CPGs as 'non-core'. This non-core element replaces the previous process of 'exemptions' accommodated for certain CPGs and recognises that not all Licenced CPG Providers need to implement every single CPG.

I would like to express my sincere thanks to all who contributed to this edition of the CPGs including the members of the Medical Advisory Committee, those who submitted queries for consideration, speciality groups and clinical programmes who provided expert external advice and feedback.

In particular, I would like to thank Dr Brian Power who retired from PHECC in 2020. Brian created the first edition of the PHECC CPGs and has managed the process of CPG development since then, including the majority of the development work for this suite of CPGs. Brian's contribution to the advancement of pre-hospital emergency care in Ireland has been significant and is the framework that supports responders and practitioners still. Since Brian's retirement, Ricky Ellis kindly and ably stepped into the gap, continuing to support MAC in the finalisation of the CPGs before handing over to Ray Carney, PHECC's new Clinical Programme Manager. Thank you both.

Finally, thanks to you, the responders and practitioners who implement these CPGs. I believe these CPGs will enable you to continue to provide expert compassionate pre-hospital care to patients every day of the year. PHECC greatly values your work and also your feedback.



Dr David Menzies, Chair Medical Advisory Committee



Clinical Practice Guidelines (CPGs) and the responder

CPGs are guidelines for best practice and are not intended as a substitute for good clinical judgment. Unusual patient presentations make it impossible to develop a CPG to match every possible clinical situation. The responder decides if a CPG should be applied based on patient assessment and the clinical impression. The responder must work in the best interest of the patient within the scope of practice for his/her clinical level. Consultation with fellow responders and/or practitioners in challenging clinical situations is strongly advised.

The CPGs herein may be implemented provided:

1. The responder maintains current certification as outlined in PHECC's Education & Training Standard.
2. The responder is authorised, by the organisation on whose behalf he/ she is acting, to implement the specific CPG.
3. The responder has received training on, and is competent in, the skills and medications specified in the CPG being utilised.

The medication dose specified on the relevant CPG shall be the definitive dose in relation to responder administration of medications. The onus rests on the responder to ensure that he/she is using the latest version of CPGs, which are available on the PHECC website www.phecc.ie

Definitions

| | |
|--------------------|--|
| Adult | A patient of 16 years or greater, unless specified on the CPG |
| Child | A patient between 1 and less than or equal to (\leq) 15 years old, unless specified on the CPG |
| Infant | A patient between 4 weeks and less than 1 year old, unless specified on the CPG |
| Neonate | A patient less than 4 weeks old, unless specified on the CPG |
| Paediatric patient | Any child, infant or neonate |

Completing an ACR/CFRR for each patient is paramount in the risk management process and users of the CPGs must commit to this process.

Minor injuries

Responders must adhere to their individual organisational protocols for treat and discharge/referral of patients with minor injuries.

The aim of pre-hospital emergency care is to provide a comprehensive and coordinated approach to patient care management, thus providing each patient with the most appropriate care in the most efficient time frame.

In Ireland today, the provision of emergency care comes from a range of disciplines and includes responders (Cardiac First Responders, First Aid Responders and Emergency First Responders) and practitioners (Emergency Medical Technicians, Paramedics, Advanced Paramedics, Nurses and Doctors) from the statutory, private, auxiliary and voluntary services.

CPGs set a consistent standard of clinical practice within the field of pre-hospital emergency care. By reinforcing the role of the responder, in the continuum of patient care, the chain of survival and the golden hour are supported in medical and traumatic emergencies respectively.

CPGs guide the responder in presenting to a practitioner a patient who has been supported in the very early phase of injury/illness and in whom the danger of deterioration has lessened by early appropriate clinical care interventions.

The CPGs presume no intervention has been applied, nor medication administered, prior to the arrival of the responder. In the event of another practitioner or responder initiating care during an acute episode, the responder must be cognisant of interventions applied and medication doses already administered and act accordingly.

In this care continuum, the duty of care is shared among all responders/practitioners of whom each is accountable for his/her own actions. The most qualified responder/practitioner on the scene shall take the role of clinical lead. Explicit handover between responders/practitioners is essential and will eliminate confusion regarding the responsibility for care.

Classification of CPGs

The Taxonomy for Pre-Hospital Emergency Care CPGs has changed to a new method for configuring PHECC CPGs. There are now seventeen categories developed to group common themes and categories together.









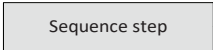

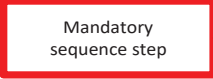

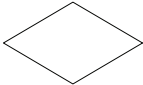
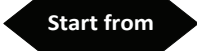
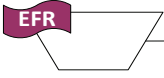

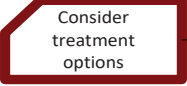



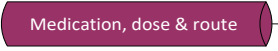

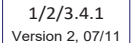

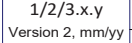
Basic Life Support – ILCOR 2020

Basic life support CPGs contained within this publication are in accordance with International Liaison Committee on Resuscitation (ILCOR) guidelines 2020.

| | |
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CODES EXPLANATION

CARDIAC FIRST RESPONDER - Advanced

| | | | |
|---|--|---|--|
|  | Cardiac First Responder (Level 1) for which the CPG pertains |  | First Aid Responder or lower clinical levels not permitted this route |
|  | First Aid Responder (Level 2) for which the CPG pertains |  | Ring ambulance control |
|  | Emergency First Responder (Level 3) for which the CPG pertains |  | Request an AED from local area |
|  | An EFR who has completed Basic Tactical Emergency Care training and has been privileged to operate in adverse conditions |  | An instruction box for information |
|  | A sequence (skill) to be performed |  | Special Instructions Which the Responder must follow |
|  | A mandatory sequence (skill) to be performed |  | A direction to go to a specific CPG following a decision process [Note: only go to the CPGs that pertain to your clinical level] |
|  | A Decision Process The Responder must follow one route |  | A clinical condition that may precipitate entry into the specific CPG |
|  | A skill or sequence that only pertains to EFR or higher clinical levels |  | Special Authorisation This authorises the Practitioner to perform an intervention under specified conditions |
|  | Given the clinical presentation consider the treatment option specified |  | Finding following clinical assessment, leading to treatment modalities |
|  | A medication which may be administered by a CFR or higher clinical level The medication name, dose and route is specified |  | Reassess the patient following intervention |
|  | A medication which may be administered by an EFR or higher clinical level The medication name, dose and route is specified |  | A Cyclical Process in which a number of sequence steps are completed |
|  | CPG numbering system 1/2/3 = clinical levels to which the CPG pertains x = section in CPG manual, y = CPG number in sequence, mm/yy = month/year CPG published |  | A Parallel Process in which a number of sequence steps are completed |
|  | | | |

Principles of general care (Responder)

Care principles are goals of care that apply to all patients. Scene safety, standard precautions, patient assessment, primary and secondary surveys, and the recording of interventions and medications on the Ambulatory Care Report (ACR) or the Cardiac First Response Report (CFRR), are consistent principles throughout the guidelines and reflect the practice of responders. Care principles are the foundations for risk management and the avoidance of error.

PHECC Care Principles

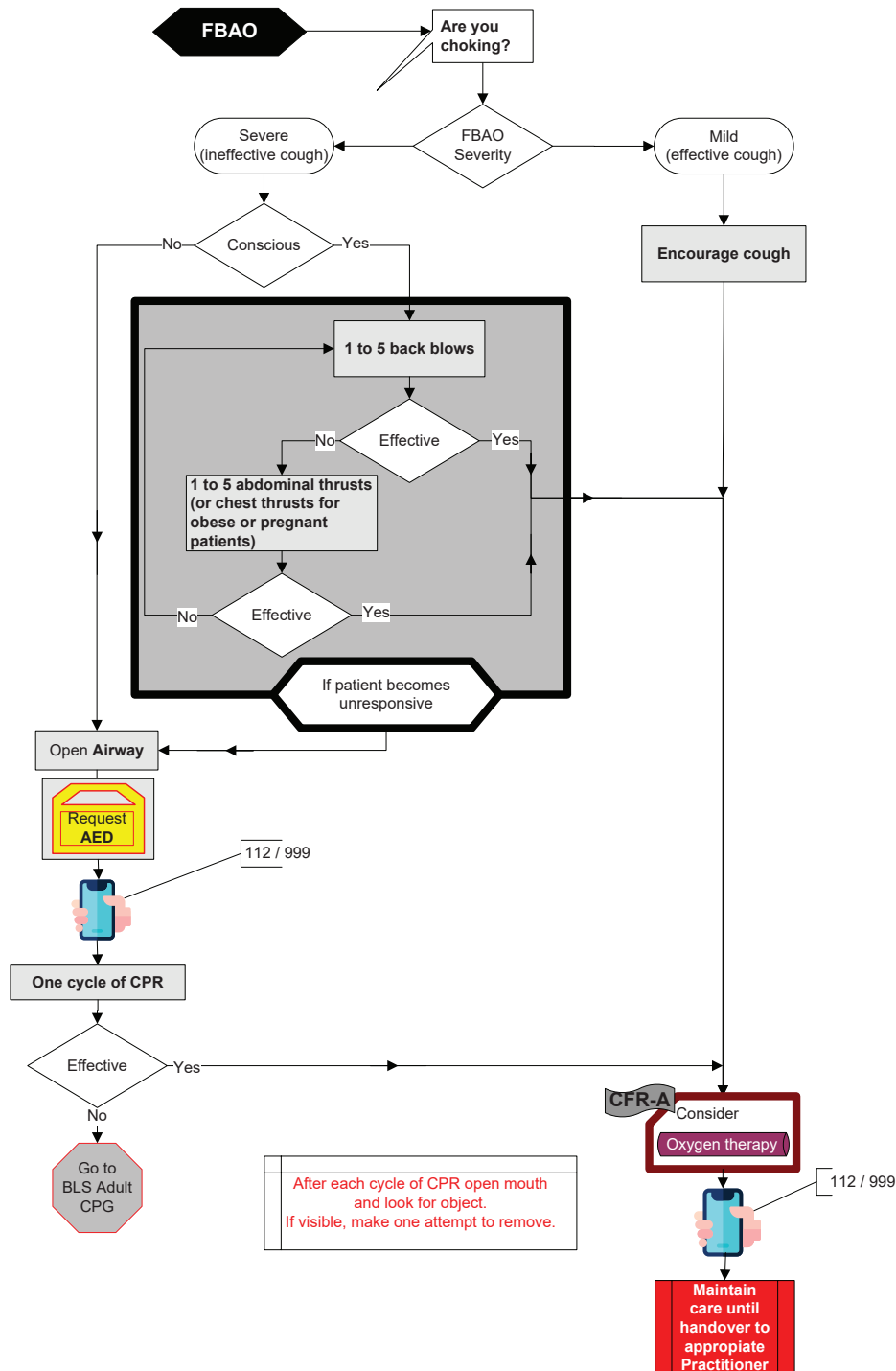
1. Ensure the safety of yourself, other emergency service personnel your patients and the public:
 - Review all pre-arrival information.
 - Consider all environmental factors and approach a scene only when it is safe to do so.
 - Identify potential and actual hazards and take the necessary precautions.
 - Liaise with other emergency services on scene.
 - Request assistance as required in a timely fashion, particularly for higher clinical levels.
 - Ensure the scene is as safe as is practicable.
 - Take standard infection control precautions.
 - 1.1 Ensure correct PPE is utilised in all situations and is compliant with latest guidance on standard, contact, droplet and airborne PPE. Place facemasks on patients when required. Handwashing and hand hygiene should be performed before and after all patient interactions. Utilise PPE checklists for correct donning and doffing procedures.
2. Call for help early:
 - Ring 112/999 using the RED card process, or
 - Obtain practitioner help on scene through pre-determined processes.
3. A person has capacity in respect to clinical decisions affecting themselves unless the contrary is shown (Assisted Decision-Making (Capacity) Act 2015).
4. Seek consent prior to initiating care:
 - Patients have the right to determine what happens to them and their bodies.
 - For patients presenting as P or U on the AVPU scale implied consent applies.
 - Patients may refuse assessment, care and/or transport.

Principles of General Care

1. Identify and manage life-threatening conditions:
 - Locate all patients. If the number of patients is greater than resources, ensure additional resources are sought.
 - Assess the patient's condition appropriately.
 - Prioritise and manage the immediate life-threatening conditions first.
 - Provide a situation report to Ambulance Control Centre (112/999) using the RED card process as soon as possible after arrival on scene.
2. Ensure adequate Airway, Breathing and Circulation:
 - Ensure airway is open.
 - Commence CPR if breathing is not present.
 - If the patient has abnormal work of breathing, ensure 112/999 is called early.
3. Control all external haemorrhage.
4. Identify the most important present condition and treat accordingly.
5. Place the patient in the appropriate position according to the presenting condition.
6. Ensure maintenance of normal body temperature (unless a CPG indicates otherwise).
7. Provide reassurance at all times.
8. Monitor and record patient's vital observations.
9. Maintain responsibility for patient care until handover to an appropriate responder/ practitioner.
10. Complete a patient care record following an interaction with a patient.
11. Identify the clinical lead, this should be the most qualified responder on scene.
12. Ambulances, medical rooms and equipment should be decontaminated as appropriate following an interaction with a patient.

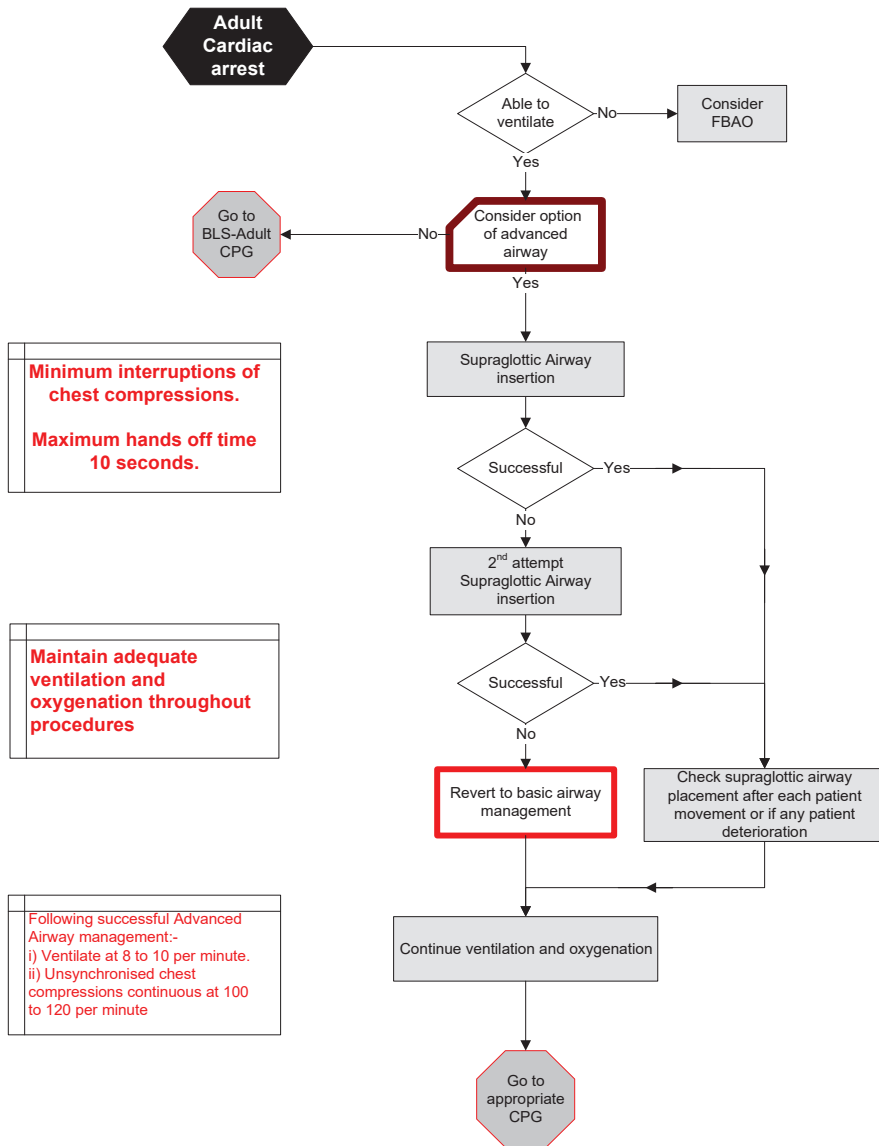
Foreign Body Airway Obstruction - Adult

1/2/3.2.1
Version 5, 04/2021



Advanced Airway Management – Adult

1/3.2.2T
Version 5, 12/2020



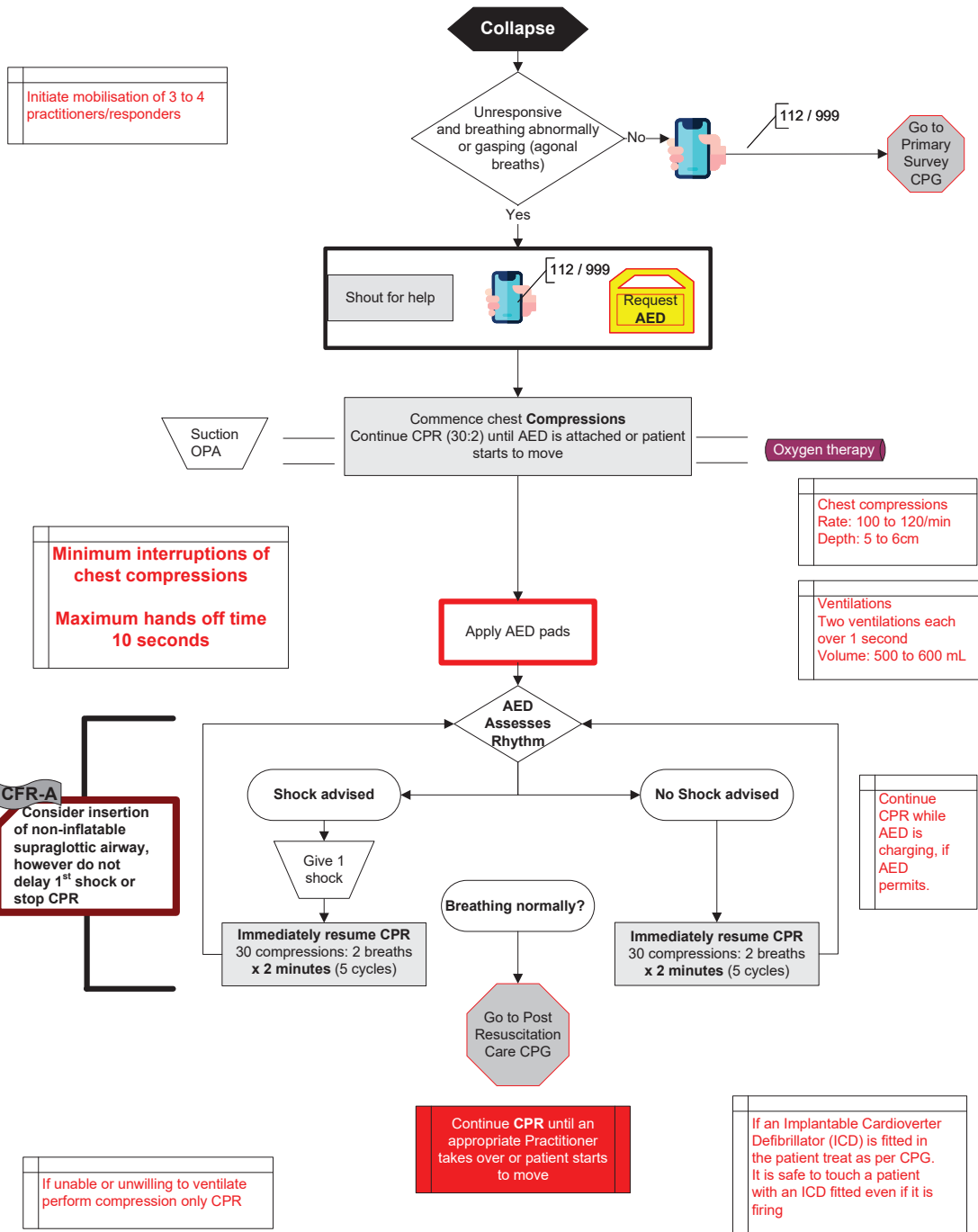
Minimum interruptions of chest compressions.
Maximum hands off time 10 seconds.

Maintain adequate ventilation and oxygenation throughout procedures

Following successful Advanced Airway management:-
i) Ventilate at 8 to 10 per minute.
ii) Unsynchronised chest compressions continuous at 100 to 120 per minute

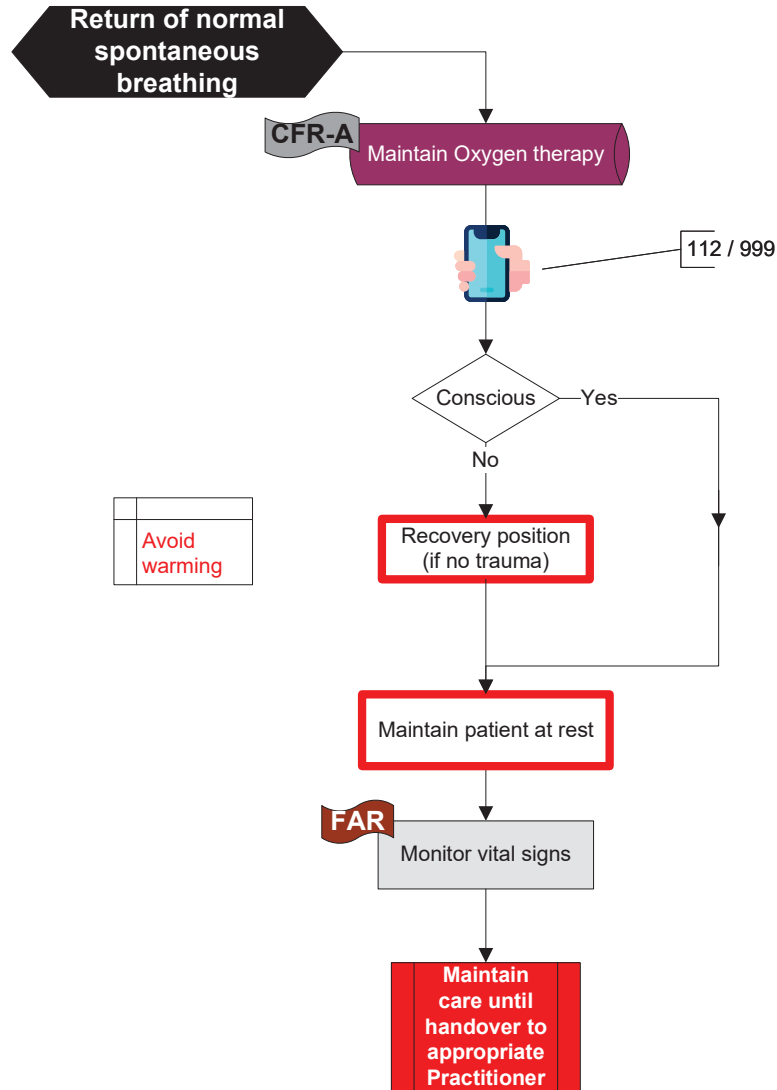
Basic Life Support – Adult

1/3.14.1
Version 6, 03/2021



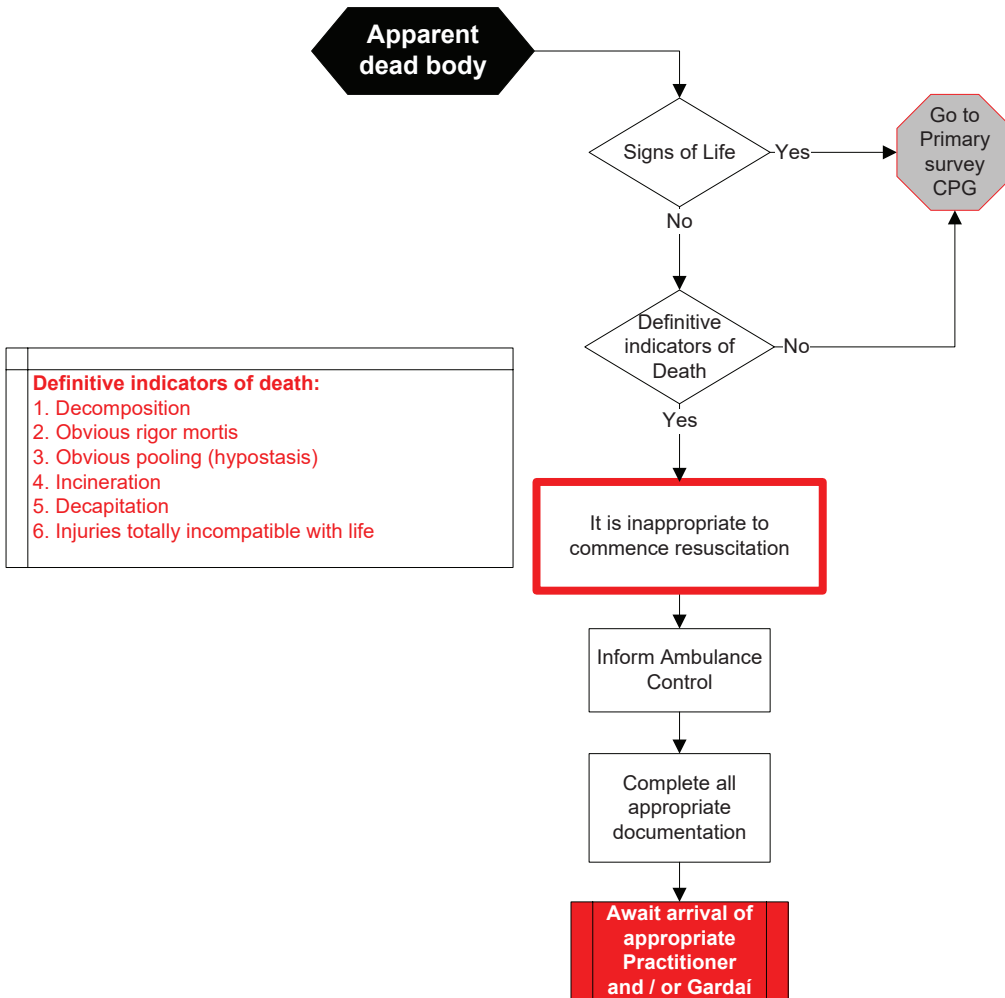
Post-Resuscitation Care – Adult

1/2/3.14.6
Version 5, 03/2021



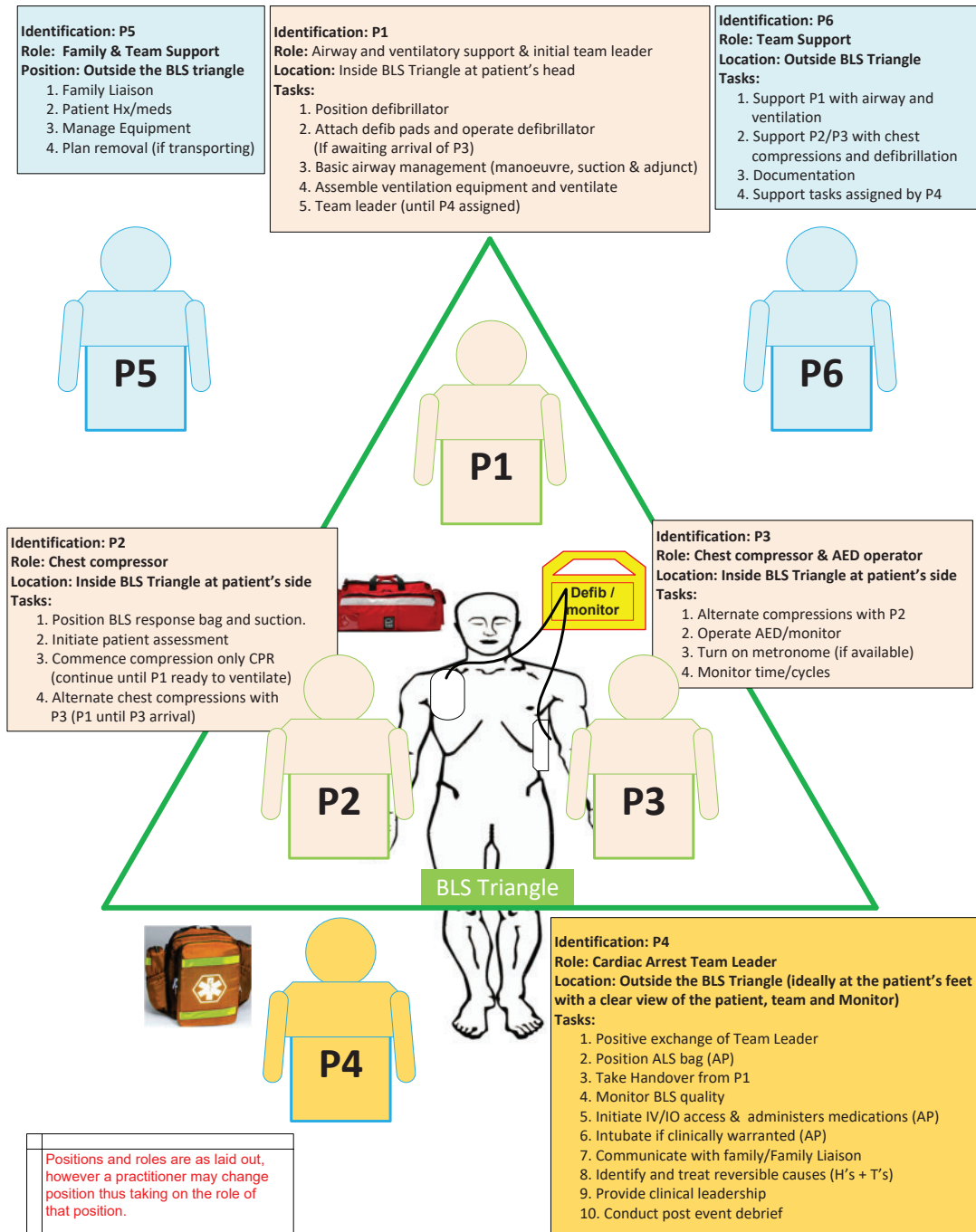
Recognition of Death – Resuscitation not Indicated

4.14.7
Version 2, 12/2020



Team Resuscitation

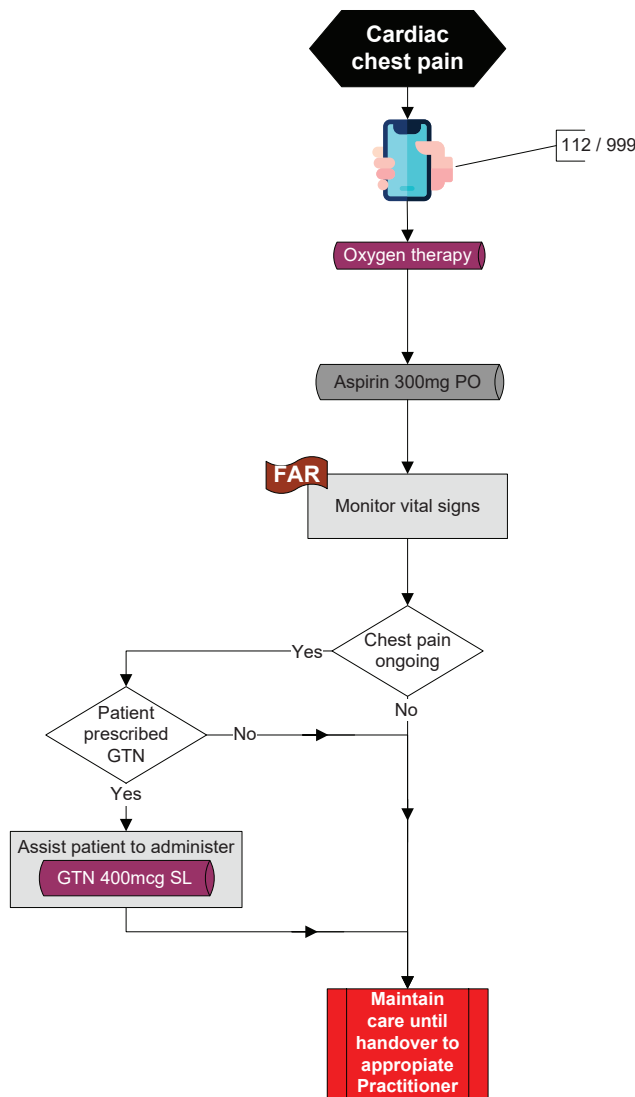
1/2/3.14.8
Version 2, 12/2020



If ALS are first on scene they perform BLS until sufficient BLS personnel are on scene

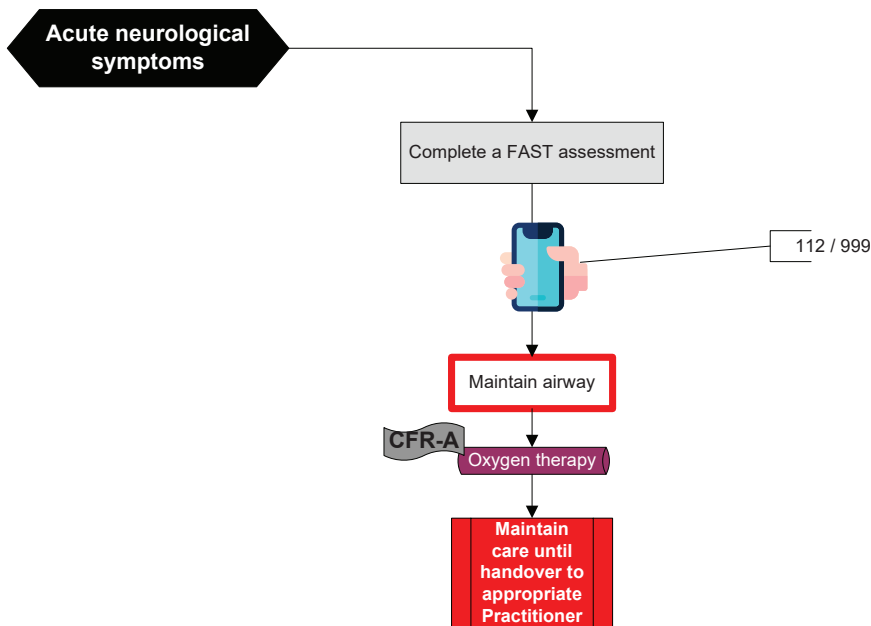
Cardiac Chest Pain – Acute Coronary Syndrome

1/2/3.3.1
Version 4, 03/2021



Stroke

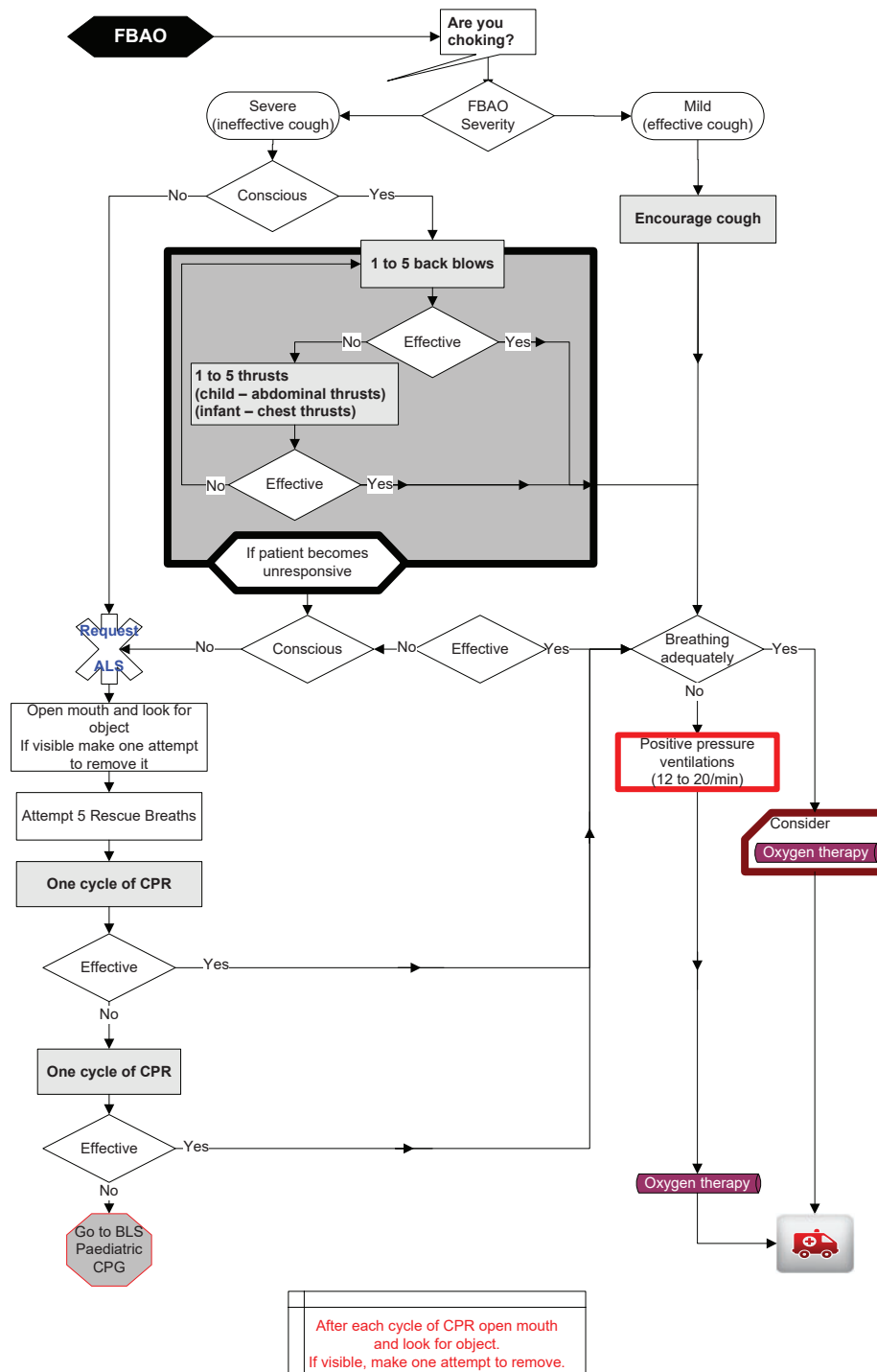
1/2/3.6.4
Version 3, 01/2021



- F – facial weakness**
Can the patient smile? Has their mouth or eye drooped? Which side?
- A – arm weakness**
Can the patient raise both arms and maintain for 5 seconds?
- S – speech problems**
Can the patient speak clearly and understand what you say?
- T – time to call 112 if FAST positive**

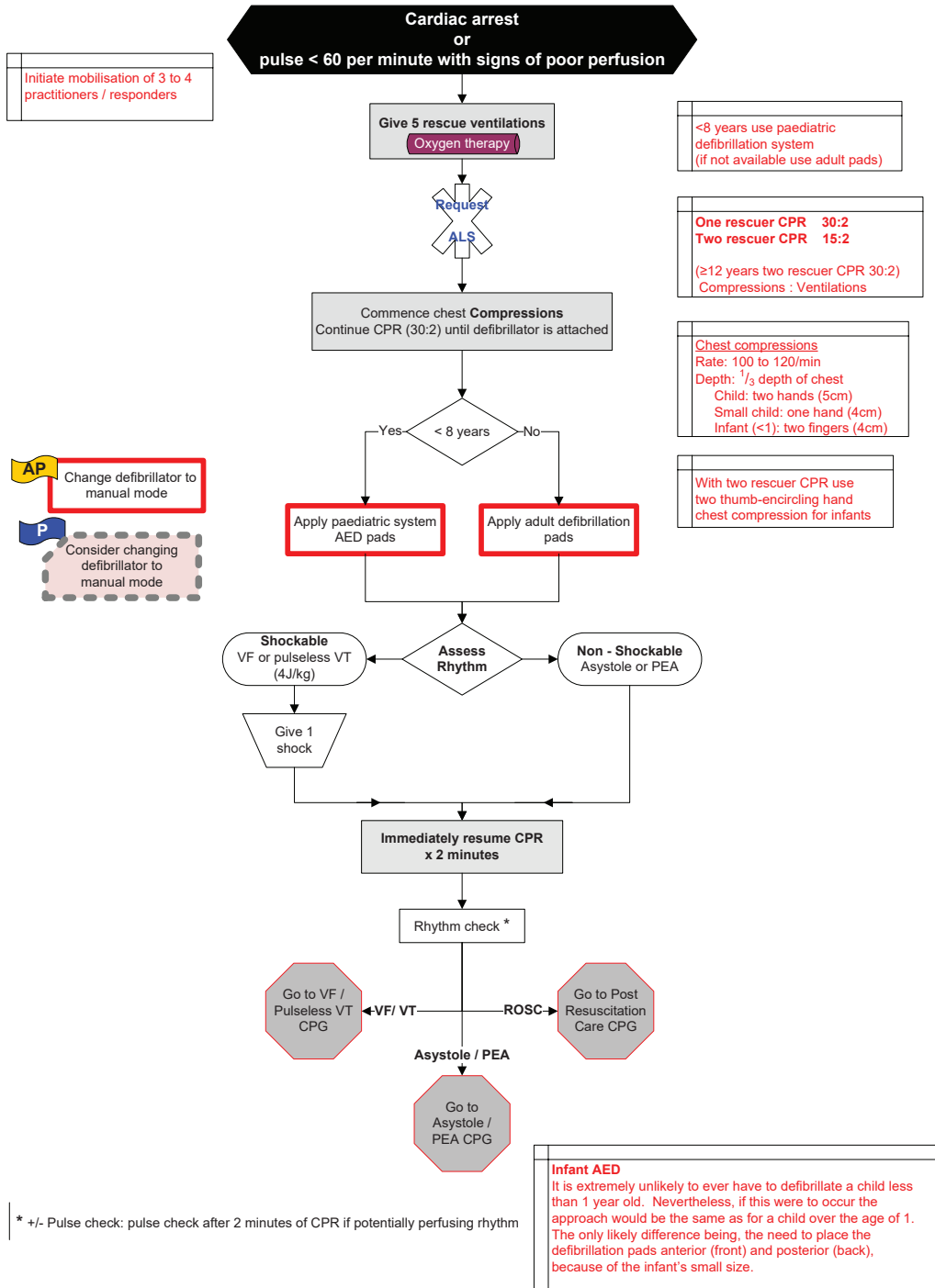
Foreign Body Airway Obstruction – Paediatric

4/5.13.5
Version 4, 03/2021



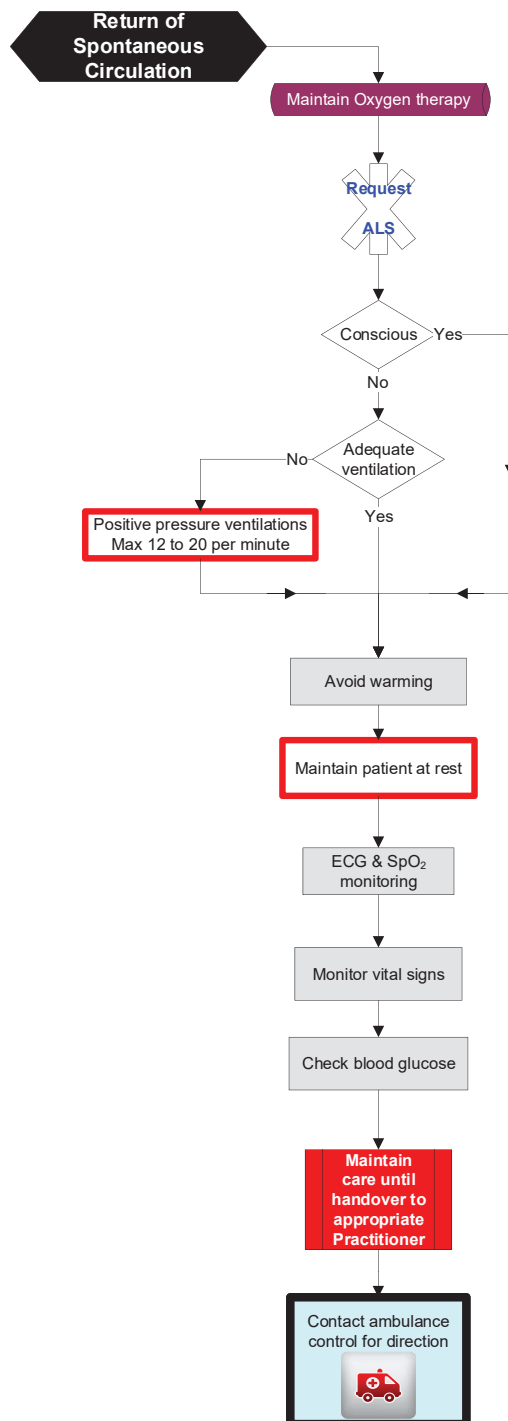
Basic Life Support – Paediatric

4/5/6.13.22
Version 4, 03/2021



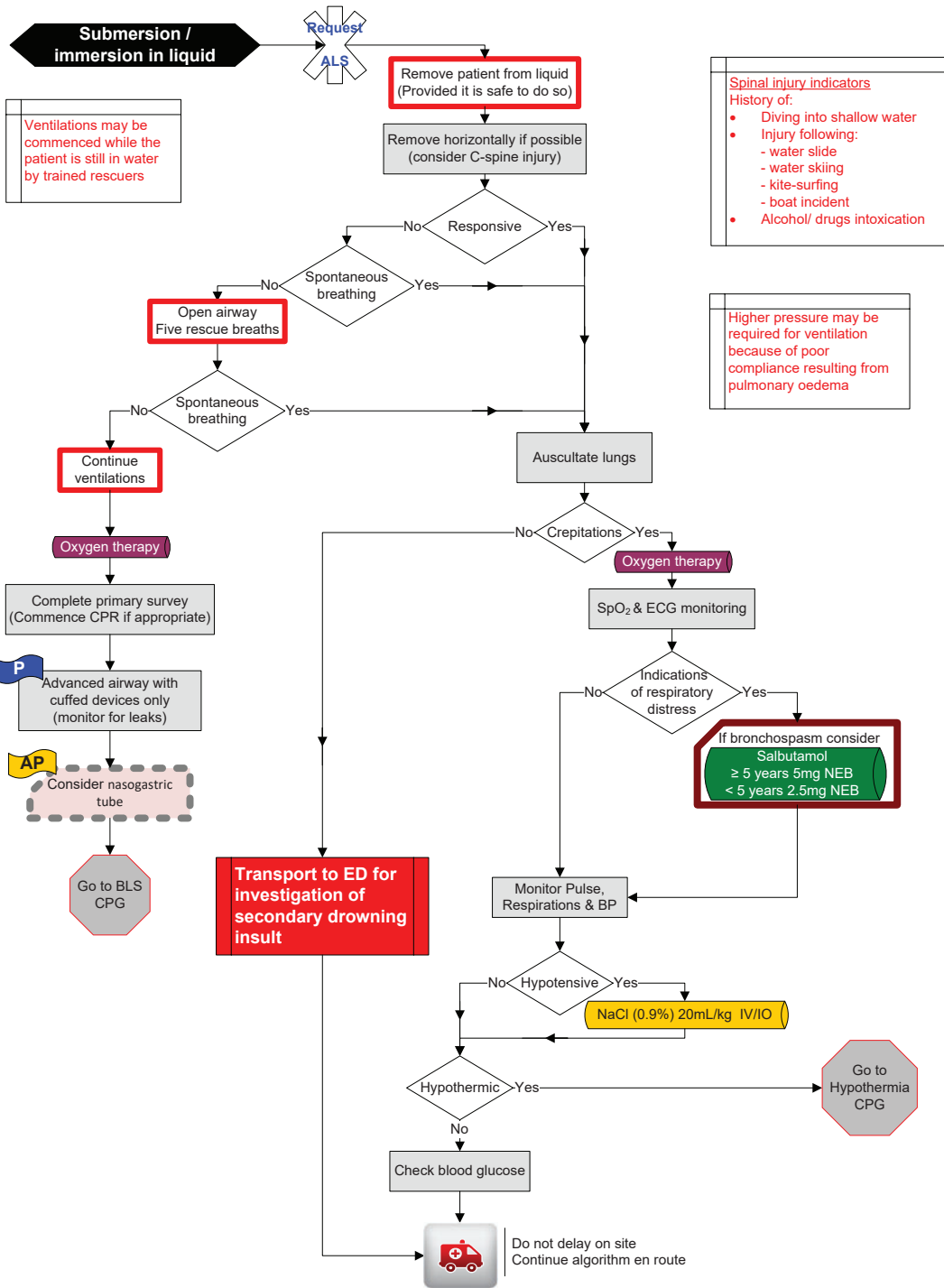
Post-Resuscitation Care – Paediatric

4.13.26
Version 4, 04/2021



Submersion/ Immersion Incident

4/5/6.8.9
Version 3, 03/2021



Medication Formulary for Cardiac First Responders - Advanced

The Medication Formulary is published by the Pre-Hospital Emergency Care Council (PHECC) to support Cardiac First Responders to be competent in the use of medications permitted under Clinical Practice Guidelines (CPGs).

The Medication Formulary is recommended by the Medical Advisory Committee (MAC) prior to publication by Council.

The medications herein may be administered provided:

1. The Cardiac First Responder complies with the CPGs published by PHECC.
2. The Cardiac First responder is privileged by the organisation on whose behalf he/she is acting, to administer the medications.
3. The Cardiac First Responder has received training on, and is competent in, the administration of the medication.

The context for administration of the medications listed here is outlined in the CPGs. Every effort has been made to ensure accuracy of the medication doses herein. The dose specified on the relevant CPG shall be the definitive dose in relation to Cardiac First Responder administration of medications. The principle of titrating the dose to the desired effect shall be applied.

The onus rests on the Cardiac First Responder to ensure that he/she is using the latest versions of CPGs which are available on the PHECC website www.phecc.ie

The route of administration should be as specified by the CPG.

Pregnancy caution:

Medications should be administered in pregnancy only if the expected benefit to the mother is thought to be greater than the risk to the foetus, and all medications should be avoided if possible during the first trimester.

Responders therefore should avoid using medications in early pregnancy unless absolutely essential, and where possible, medical oversight should be sought prior to administration.

This edition contains 2 medications for Cardiac First Responders Advanced

Please visit www.phecc.ie for the latest edition/version

Changes to Monographs

1. Class and Description headings have merged to one Classification heading in line with BNF drug descriptors
2. Long term side effects have been removed unless essential
3. Pharmacology/Action has been removed unless essential information

| ASPIRIN | | |
|------------------------|---|--|
| Heading | Add | Delete |
| Classification | Merge Class and Description to Classification: Antithrombotic – Antiplatelet Drug which reduces clot formation. | Class. Description. |
| Description | | Anti-inflammatory agent and an inhibitor of platelet function. Useful agent in the treatment of various thromboembolic diseases such as acute myocardial infarction. |
| Pharmacology/ Action | | Antithrombotic: Inhibits the formation of thromboxane A ₂ , which stimulates platelet aggregation and artery constriction. This reduces clot/thrombus formation in an MI. |
| Long term side-effects | | Generally mild and infrequent but incidence of gastro-intestinal irritation with slight asymptomatic blood loss, increased bleeding time, bronchospasm and skin reaction in hypersensitive patients. |

| OXYGEN | | |
|------------------------|---|--|
| Heading | Add | Delete |
| Clinical Level | | |
| Classification | Merged Class and description. | Class. Description. |
| Pharmacology/Action | | Pharmacology/Action Oxygenation of tissue/organs. |
| Additional Information | Caution with emollients containing paraffin e.g. lip balms & moisturisers – may lead to skin burns. | |

Clinical Level:



| MEDICATION | ASPIRIN |
|------------------------|--|
| Classification | Antithrombotic – Antiplatelet Drug which reduces clot formation. |
| Presentation | 300 mg dispersible tablet. 300 mg Enteric Coated (EC) tablet. |
| Administration | Orally (PO) - dispersed in water, or to be chewed if not dispersible form. (CPG: 5/6.3.1, 4.3.1, 1/2/3.3.1). |
| Indications | Cardiac chest pain or suspected myocardial infarction. Management of unstable angina and non ST-segment elevation myocardial infarction (NSTEMI). Management of ST-segment elevation myocardial infarction (STEMI). |
| Contra-Indications | Active symptomatic gastrointestinal (GI) ulcer/ Bleeding disorder (e.g. haemophilia)/ Known severe adverse reaction/ Patients < 16 years old (risk of Reye's Syndrome). |
| Usual Dosages | <i>Adult:</i> 300 mg Tablet. <i>Paediatric:</i> <i>Contraindicated.</i> |
| Side effects | Epigastric pain and discomfort/ Bronchospasm/ Gastrointestinal haemorrhage/ Increased bleeding times/ skin reactions in hypersensitive patients. |
| Additional information | Aspirin 300 mg is indicated for cardiac chest pain, regardless if patient is on an anti-coagulant or is already on Aspirin. If the patient has swallowed Aspirin EC (enteric coated) preparation without chewing, the patient should be regarded as not having taken any Aspirin; administer 300 mg PO. |

Clinical Level:



| MEDICATION | OXYGEN |
|------------------------|---|
| Classification | Gas. |
| Presentation | <p><i>Medical gas:</i> D, E or F cylinders, coloured black with white shoulders. (Please note: By 2025, all cylinders will be completely white with OXYGEN in black). <i>CD cylinder:</i> White cylinder.</p> |
| Administration | <p><i>Inhalation via:</i> High concentration reservoir (non-rebreather) mask/ Simple face mask/ Venturi mask/ Tracheostomy mask/ Nasal cannulae/ CPAP device/ Bag Valve Mask. (CPG: Oxygen is used extensively throughout the CPGs).</p> |
| Indications | <p>Absent / Inadequate ventilation following an acute medical or traumatic event. SpO₂ < 94% adults and < 96% paediatrics. SpO₂ < 92% for patients with acute exacerbation of COPD. SpO₂ < 90% for patients with acute onset of Pulmonary Oedema.</p> |
| Contra-Indications | Bleomycin lung injury. |
| Usual Dosages | <p>Adult: Cardiac and respiratory arrest or sickle cell crisis; 100%. Life threats identified during primary survey; 100% until a reliable SpO₂ measurement obtained then titrate O₂ to achieve SpO₂ of 94% - 98%. For patients with acute exacerbation of COPD, administer O₂ titrate to achieve SpO₂ 92% or as specified on COPD Oxygen Alert Card. All other acute medical and trauma titrate O₂ to achieve SpO₂ 94% - 98%.</p> <p>Paediatric: Cardiac and respiratory arrest or sickle cell crisis; 100%. Life threats identified during primary survey; 100% until a reliable SpO₂ measurement obtained then titrate O₂ to achieve SpO₂ of 96% - 98%. Neonatal resuscitation (< 4 weeks) consider supplemental O₂ (≤ 30%). All other acute medical and trauma titrate O₂ to achieve SpO₂ of 96% - 98%.</p> |
| Side effects | Prolonged use of O ₂ with chronic COPD patients may lead to reduction in ventilation stimulus. |
| Additional information | <p>Caution with emollients containing paraffin e.g. lip balms & moisturisers – may lead to skin burns. A written record must be made of what oxygen therapy is given to every patient. Documentation recording oximetry measurements should state whether the patient is breathing air or a specified dose of supplemental Oxygen. Consider humidifier if oxygen therapy for paediatric patients is > 30 minutes duration. Caution with paraquat poisoning, administer Oxygen if SpO₂ < 92%. Avoid naked flames, powerful oxidising agent.</p> |

New Medications and Skills for 2021

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|---|-------|-------|-----|-----|-----|---|----|
| Activated Charcoal PO* | | | | | ✓ | ✓ | ✓ |
| Adrenaline nebulised | | | | | | ✓ | ✓ |
| Dexamethasone PO | | | | | | ✓ | ✓ |
| Lidocaine IO | | | | | | | ✓ |
| Ketamine IM* | | | | | | | ✓ |
| Uterine massage | | | | | ✓ | ✓ | ✓ |
| Tourniquet application | | | | | ✓ | ✓ | ✓ |
| Pressure points | | | | | ✓ | ✓ | ✓ |
| Ketone measurement* | | | | | ✓ | ✓ | ✓ |
| Tracheostomy management | | | | | ✓ | ✓ | ✓ |
| Malpresentations in labour | | | | | | ✓ | ✓ |
| Shoulder Dystocia management | | | | | | ✓ | ✓ |
| Posterior ECG in ACS | | | | | | ✓ | ✓ |
| Intubation of Stoma | | | | | | | ✓ |
| Nasogastric Tube insertion* | | | | | | | ✓ |
| Procedural Sedation* | | | | | | | ✓ |
| Richmond Agitation-Sedation Scale (RASS)* | | | | | | | ✓ |

New Medications and Skills for June 2023 update for CPG 2021

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|--------------------|-------|-------|-----|-----|-----|---|----|
| Trauma Triage Tool | | | | | ✓ | ✓ | ✓ |
| Non-conveyance | | | | | | ✓ | ✓ |

Care management including the administration of medications as per level of training and division on the PHECC Register and Responder levels.

Pre-Hospital Responders and Practitioners shall only provide care management including medication administration for which they have received specific training. Practitioners must be privileged by a Licensed CPG Provider to administer specific medications and perform specific clinical interventions.

Paramedic authorisation for IV continuation

Practitioners should note that PHECC registered paramedics are authorised to continue an established IV infusion in the absence of an advanced paramedic or doctor during transportation.

| | |
|---------------|--|
| √ | Authorised under PHECC CPGs |
| URMPIO | Authorised under PHECC CPGs under registered medical practitioner's instructions only |
| APO | Authorised under PHECC CPGs to assist practitioners only (when applied to EMT to assist paramedic or higher clinical levels) |
| √ SA | Authorised subject to special authorisation as per CPG |
| BTEC | Authorised subject to Basic Tactical Emergency Care rules |
| * | Non-core specified element or action |
| √ * | Non-core specified element or action for identified clinical level |

MEDICATIONS

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|----------------------------------|-------|-------|-----|------|-----|------|----|
| Aspirin PO | √ | √ | √ | √ | √ | √ | √ |
| Oxygen INH | | √ | | √ | √ | √ | √ |
| Glucose gel buccal | | | | √ | √ | √ | √ |
| Glyceryl Trinitrate SL | | | | √ SA | √ | √ | √ |
| Adrenaline (1:1000) autoinjector | | | | √ SA | √ | √ | √ |
| Salbutamol MDI | | | | √ SA | √ | √ | √ |
| Activated Charcoal PO* | | | | | √ | √ | √ |
| Adrenaline (1:1000) IM | | | | | √ | √ | √ |
| Chlorphenamine PO/IM | | | | | √ | √ | √ |
| Glucagon IM | | | | | √ | √ | √ |
| Ibuprofen PO | | | | | √ | √ | √ |
| Methoxyflurane INH | | | | | √ | √ | √ |
| Naloxone IN | | | | | √ | √ | √ |
| Nitrous Oxide and Oxygen INH | | | | | √ | √ | √ |
| Paracetamol PO | | | | | √ | √ | √ |
| Salbutamol nebulised | | | | | √ | √ | √ |
| Adrenaline nebulised | | | | | | √ | √ |
| Clopidogrel PO | | | | | | √ | √ |
| Cyclizine IM | | | | | | √ | √ |
| Dexamethasone PO | | | | | | √ | √ |
| Glucose 5% IV | | | | | | √ SA | √ |
| Glucose 10% IV | | | | | | √ SA | √ |
| Hydrocortisone IM | | | | | | √ | √ |
| Ipratropium Bromide nebulised | | | | | | √ | √ |
| Midazolam buccal/IM/IN | | | | | | √ | √ |
| Naloxone IM/SC | | | | | | √ | √ |
| Ondansetron IM | | | | | | √ | √ |
| Oxytocin IM | | | | | | √ | √ |
| Paracetamol PR | | | | | | √ | √ |

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|------------------------------|-------|-------|-----|-----|-----|------|----|
| Ticagrelor PO | | | | | | √ | √ |
| Sodium Chloride 0.9% IV/IO | | | | | | √ SA | √ |
| Adenosine IV | | | | | | | √ |
| Adrenaline (1:10,000) IV/IO | | | | | | | √ |
| Adrenaline (1:100,000) IV/IO | | | | | | | √ |
| Amiodarone IV/IO | | | | | | | √ |
| Atropine IV/IO | | | | | | | √ |
| Ceftriaxone IV/IO/IM | | | | | | | √ |
| Chlorphenamine IV | | | | | | | √ |
| Cyclizine IV | | | | | | | √ |
| Diazepam IV/PR | | | | | | | √ |
| Fentanyl IN/IM/IV | | | | | | | √ |
| Furosemide IV | | | | | | | √ |
| Glycopyrronium Bromide SC* | | | | | | | √ |
| Haloperidol PO/SC* | | | | | | | √ |
| Hydrocortisone IV | | | | | | | √ |
| Hyoscine Butylbromide SC* | | | | | | | √ |
| Ketamine IV/IM* | | | | | | | √ |
| Lidocaine IV/IO | | | | | | | √ |
| Lorazepam PO | | | | | | | √ |
| Magnesium Sulphate IV | | | | | | | √ |
| Midazolam IV | | | | | | | √ |
| Morphine IV/PO/IM | | | | | | | √ |
| Naloxone IV/IO | | | | | | | √ |
| Ondansetron IV | | | | | | | √ |
| Paracetamol IV/PR | | | | | | | √ |
| Sodium Bicarbonate IV/IO | | | | | | | √ |
| Tranexamic Acid IV | | | | | | | √ |

AIRWAY & BREATHING MANAGEMENT

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|--------------------------------------|-------|-------|-----|------|------|---|----|
| FBAO management | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Head tilt chin lift | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pocket mask | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Recovery position | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Non-rebreather mask | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Oropharyngeal airway | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Oral suctioning | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Venturi mask | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Bag Valve Mask | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Jaw thrust | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Nasal cannula | | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Supraglottic airway adult (uncuffed) | | ✓ | | | ✓ | ✓ | ✓ |
| Oxygen humidification | | | | ✓ | ✓ | ✓ | ✓ |
| Nasopharyngeal airway | | | | BTEC | BTEC | ✓ | ✓ |
| Supraglottic airway adult (cuffed) | | | | | ✓ SA | ✓ | ✓ |
| Tracheostomy management | | | | | ✓ | ✓ | ✓ |
| Continuous Positive Airway Pressure | | | | | | ✓ | ✓ |
| Non-Invasive ventilation device | | | | | | ✓ | ✓ |
| Supraglottic airway paediatric | | | | | | ✓ | ✓ |
| Endotracheal intubation | | | | | | | ✓ |
| Intubation of stoma | | | | | | | ✓ |
| Laryngoscopy / Magill forceps | | | | | | | ✓ |
| Needle cricothyrotomy | | | | | | | ✓ |
| Needle thoracocentesis | | | | | | | ✓ |

CARDIAC

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|---|-------|-------|-----|-----|------|-----|----|
| AED adult & paediatric | √ | √ | √ | √ | √ | √ | √ |
| CPR adult, child & infant | √ | √ | √ | √ | √ | √ | √ |
| Recognise death and resuscitation not indicated | √ | √ | √ | √ | √ | √ | √ |
| Neonate resuscitation | | | | | √ | √ | √ |
| ECG monitoring | | | | | √ | √ | √ |
| CPR mechanical assist device* | | | | | √ | √ | √ |
| Cease resuscitation - adult | | | | | √ SA | √ | √ |
| 12 lead ECG | | | | | | √ | √ |
| Manual defibrillation | | | | | | √ * | √ |
| Right sided ECG in ACS | | | | | | √ | √ |
| Posterior ECG in ACS | | | | | | √ | √ |

HAEMORRHAGE CONTROL

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|------------------------|-------|-------|-----|-------|------|-----|-----|
| Direct pressure | | | √ | √ | √ | √ | √ |
| Nose bleed | | | √ | √ | √ | √ | √ |
| Haemostatic agent | | | | BTEC* | √ * | √ | √ |
| Tourniquet application | | | | BTEC | √ | √ | √ |
| Pressure points | | | | | √ | √ | √ |
| Wound closure clips | | | | | BTEC | √ * | √ * |
| Nasal pack | | | | | | √ | √ |

MEDICATION ADMINISTRATION

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|---------------------------------|-------|-------|-----|------|-----|---|----|
| Oral | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Buccal | | | | ✓ | ✓ | ✓ | ✓ |
| Metered dose inhaler | | | | ✓ SA | ✓ | ✓ | ✓ |
| Sublingual | | | | ✓ SA | ✓ | ✓ | ✓ |
| Intramuscular injection | | | | | ✓ | ✓ | ✓ |
| Intranasal | | | | | ✓ | ✓ | ✓ |
| Nebuliser | | | | | ✓ | ✓ | ✓ |
| Subcutaneous injection | | | | | ✓ | ✓ | ✓ |
| Infusion maintenance | | | | | | ✓ | ✓ |
| Per rectum | | | | | | ✓ | ✓ |
| Infusion calculations | | | | | | | ✓ |
| Intraosseous injection/infusion | | | | | | | ✓ |
| Intravenous injection/infusion | | | | | | | ✓ |

TRAUMA

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|--|-------|-------|-----|------|-----|---|----|
| Burns care | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Application of a sling | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Soft tissue injury | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hot packs for active rewarming (hypothermia) | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Active Spinal Motion Restriction | | | | ✓ | ✓ | ✓ | ✓ |
| Cervical collar application | | | | ✓ | ✓ | ✓ | ✓ |
| Helmet stabilisation/removal | | | | ✓ | ✓ | ✓ | ✓ |
| Splinting device application to upper limb | | | | ✓ | ✓ | ✓ | ✓ |
| Splinting device application to lower limb | | | | ✓ | ✓ | ✓ | ✓ |
| Log roll | | | | APO | ✓ | ✓ | ✓ |
| Move patient with a carrying sheet | | | | APO | ✓ | ✓ | ✓ |
| Extrication using a long board | | | | ✓ SA | ✓ | ✓ | ✓ |
| Rapid Extraction | | | | ✓ SA | ✓ | ✓ | ✓ |
| Secure and move a patient with an extrication device | | | | ✓ SA | ✓ | ✓ | ✓ |
| Move a patient with a split device (Orthopaedic stretcher) | | | | ✓ SA | ✓ | ✓ | ✓ |
| Passive Spinal Motion Restriction | | | | | | ✓ | ✓ |
| Pelvic Splinting device | | | | BTEC | ✓ | ✓ | ✓ |
| Move and secure patient into a vacuum mattress | | | | BTEC | ✓ | ✓ | ✓ |
| Move and secure a patient to a paediatric board | | | | | ✓ | ✓ | ✓ |
| Traction splint application | | | | | APO | ✓ | ✓ |
| Lateral dislocation of patella – reduction | | | | | | ✓ | ✓ |
| Taser gun barb removal | | | | | | ✓ | ✓ |

PATIENT ASSESSMENT

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|--|-------|-------|-----|------|-----|---|----|
| Assess responsiveness | √ | √ | √ | √ | √ | √ | √ |
| Check breathing | √ | √ | √ | √ | √ | √ | √ |
| FAST assessment | √ | √ | √ | √ | √ | √ | √ |
| Capillary refill | | | √ | √ | √ | √ | √ |
| AVPU | | | √ | √ | √ | √ | √ |
| Pulse check | | | √ | √ | √ | √ | √ |
| Breathing / pulse rate | | √ SA | √ | √ | √ | √ | √ |
| Primary survey | | | √ | √ | √ | √ | √ |
| SAMPLE history | | | √ | √ | √ | √ | √ |
| Secondary survey | | | √ | √ | √ | √ | √ |
| CSM assessment | | | | √ | √ | √ | √ |
| Rule of Nines | | | | √ | √ | √ | √ |
| Assess pupils | | | | √ | √ | √ | √ |
| Blood pressure | | | | √ SA | √ | √ | √ |
| Pulse oximetry | | | | √ | √ | √ | √ |
| Capacity evaluation | | | | | √ | √ | √ |
| Chest auscultation | | | | | √ | √ | √ |
| Glucometry | | | | | √ | √ | √ |
| Ketone measurement* | | | | | √ | √ | √ |
| Paediatric Assessment Triangle | | | | | √ | √ | √ |
| Pain assessment | | | | | √ | √ | √ |
| Patient Clinical Status | | | | | √ | √ | √ |
| Temperature | | | | | √ | √ | √ |
| Triage sieve | | | | | √ | √ | √ |
| Trauma Triage Tool | | | | | √ | √ | √ |
| Capnography | | | | | | √ | √ |
| Glasgow Coma Scale (GCS) | | | | | | √ | √ |
| Peak expiratory flow | | | | | | √ | √ |
| Pre-hospital Early Warning Score | | | | | | √ | √ |
| Treat and referral | | | | | | √ | √ |
| Triage sort | | | | | | √ | √ |
| Richmond Agitation-Sedation Scale (RASS) * | | | | | | | √ |

OTHER

| CLINICAL LEVEL | CFR-C | CFR-A | FAR | EFR | EMT | P | AP |
|------------------------------------|-------|-------|-----|-----|-----|---|----|
| Use of Red Card | √ | √ | √ | √ | √ | √ | √ |
| Assist normal delivery of a baby | | | | APO | √ | √ | √ |
| De-escalation and breakaway skills | | | | | √ | √ | √ |
| ASHICE radio report | | | | | √ | √ | √ |
| IMIST-AMBO handover | | | | | √ | √ | √ |
| Uterine massage | | | | | √ | √ | √ |
| Broselow tape | | | | | | √ | √ |
| Malpresentations in labour | | | | | | √ | √ |
| Non-conveyance | | | | | | √ | √ |
| Shoulder Dystocia management | | | | | | √ | √ |
| Umbilical cord complications | | | | | | √ | √ |
| Verification of Death | | | | | | √ | √ |
| Intraosseous cannulation | | | | | | | √ |
| Intravenous cannulation | | | | | | | √ |
| Nasogastric tube insertion* | | | | | | | √ |
| Procedural Sedation* | | | | | | | √ |
| Urinary catheterisation* | | | | | | | √ |

CRITICAL INCIDENT STRESS MANAGEMENT (CISM)

Your Psychological Well-Being

It is extremely important for your psychological well-being that you do not expect to save every critically ill or injured patient that you treat. For a patient who is not in hospital, whether they survive a cardiac arrest or multiple traumas depends on a number of factors including any other medical condition the patient has. Your aim should be to perform your interventions well and to administer the appropriate medications within your scope of practice. However, sometimes you may encounter a situation which is highly stressful for you, giving rise to Critical Incident Stress (CIS). A critical incident is an incident or event which may overwhelm or threaten to overwhelm our normal coping responses. As a result of this we can experience CIS.

When can I be adversely affected by a critical incident? Listed below are some common ways in which people react to incidents like this:

- Feeling of distress or sadness
- Strong feeling of anger
- Feeling of disillusionment
- Feeling of guilt
- Feeling of apprehension/anxiety/fear of:
 - Losing control/breaking down or
 - Something similar happening again
 - Not having done all I think I could have done
- Avoidance of the scene of incident/trauma
- Bad dreams, nightmares or startling easily
- Distressing memories or 'flashbacks' of the incident
- Feeling 'on edge', irritable, angry, under threat/pressure
- Feeling emotionally fragile or emotionally numb
- Feeling cut off from your family or close friends – "I can't talk to them" or "I don't want to upset them"
- Feeling of needing to control everything

Some Do's and Don'ts

- **DO express your emotions:**
 - Talk about what happened
 - Talk about how you feel and how the event has impacted you
 - Be kind to yourself and to others.
- **DO** talk about what has happened as often as you need
- **DO** find opportunities to review the experience **DO** discuss what happened with colleagues **DO** ask friends and colleagues for support
- **DO** listen sympathetically if a colleague wants to talk
- **DO** advise colleagues about receiving appropriate help
- **DO** keep to daily routines
- **DO** drive more carefully
- **DO** be more careful around the home
- **DON'T** use alcohol, nicotine or drugs to hide your feelings **DON'T** simply stay away from work – seek help and support **DON'T** allow anger and irritability to mask your feelings **DON'T** bottle up feelings
- **DON'T** be afraid to ask for help
- **DON'T** think your feelings are a sign of weakness

When things get tough, pro-actively minding yourself is crucial. Control the things you can control. Get more sleep than you think you need. Eat fresh, healthy foods at regular times and avoid snacks. Get outdoor exercise at least three times a week. Have a meaningful conversation with someone you like at least once a day. Resolve what makes you sad or angry or otherwise let it go. Be kind.

Everyone may have these feelings. Experience has shown that they may vary in intensity according to circumstance. Nature heals through allowing these feelings to come out. This will not lead to loss of control but stopping these feelings may lead to other and possibly more complicated problems.

When to find help?

1. If you feel you cannot cope with your reactions or feelings.
2. If your stress reactions do not lessen in the two or three weeks following the event.
3. If you continue to have nightmares and poor sleep.
4. If you have no-one with whom to share your feelings when you want to do so.
5. If your relationships seem to be suffering badly, or sexual problems develop.
6. If you become clumsy or accident prone.
7. If, in order to cope after the event, you smoke, drink or take more medication, or other drugs.
8. If your work performance suffers.
9. If you are tired all the time.
10. If things get on top of you and you feel like giving up.
11. If you take it out on your family.
12. If your health deteriorates.

Experiencing signs of excessive stress?

If the range of physical, emotional and behavioural signs and symptoms already mentioned do not reduce over time (for example after two weeks), it is important that you seek support and help.

Where to find help?

Your own licensed CPGs provider will have a CISM support network or system.

We recommend that you contact them for help and advice (i.e. your peer support worker/ coordinator/staff support officer).

- For a self-help guide, please go to www.cismnetworkireland.ie
- The NAS CISM and CISM Network published a booklet called 'Critical Incident Stress Management for Emergency Personnel'.
- It can be purchased by emailing: info@cismnetworkireland.ie
- Consult your own GP or see a health professional who specialises in traumatic stress.
- In partnership with NAS CISM Committee, PHECC developed an eLearning CISM Stress Awareness Training (SAT) module. It can be accessed by the following personnel:
 - PHECC registered practitioners at all levels
 - National Ambulance Service-linked community first responders
 - NAS non-PHECC registered personnel
- Under the direction of CISM Network, bespoke CISM SAT modules are developed by Network member organisations.

Responder Level Updates

Several broad changes have been applied in the 2021 version:

- The Care Principles have been updated.
- The classification of CPGs has changed to up to seventeen categories, developed to group common themes and categories together.
- The Occupational First Aid (OFA) level has been removed from the CPGs.
- The term 'Registered' has been removed from references to registered healthcare professionals, for example Registered Medical Practitioner (RMP) will now appear as Medical Practitioner (MP).
- The 'ring ambulance control' symbol, along with other symbols, is modernised throughout the CPGs and the telephone number is standardised to '112/999'.
- References to published source literature no longer appear on CPGs but are available from PHECC on request.
- The description of dose of medications less than one milligram is now described in micrograms, for example GTN 0.4mg SL is now GTN 400 mcg SL.
- The age descriptor has been removed from the title of paediatric CPGs.

No CPGs have been added or deleted in 2021 Edition

Updated CFR CPGs from 2021 version

To support upskilling of the 2021 CPGs, the CPGs that have content changes are outlined below.

| CPGs | The principal differences are |
|--|---|
| CPG 1/2.2.1 Foreign Body Airway Obstruction – Adult | Deleted Elements pertaining to EFR level |
| CPG 1/2.3.1 Cardiac Chest Pain – Acute Coronary Syndrome | Deleted Elements pertaining to EFR level Instruction box 'If registered healthcare professional, and pulse oximetry available, titrate oxygen to maintain SpO2 Adult: 94% to 98%' |

| CPGs | The principal differences are |
|---|--|
| CPG 1/2.6.4 Stroke | <p>Deleted</p> <p>Elements pertaining to EFR level</p> <p>Instruction box 'If registered healthcare professional, and pulse oximetry available, titrate oxygen to maintain SpO2 Adult: 94% to 98%'</p> |
| CPG 1/2.8.9 Submersion Incident | <p>Deleted</p> <p>Elements pertaining to EFR level</p> <p>Instruction box 'Higher pressure may be required for ventilation because of poor compliance resulting from pulmonary oedema'</p> <p>Added</p> <p>Instruction box 'Ensure chest rise when providing ventilations'</p> |
| CPG 1/2.13.5 Foreign Body Airway Obstruction – Paediatric | <p>Added</p> <p>Sequence step 'Request AED'</p> <p>Instruction box 'If visible, make one attempt to remove' replaces 'If visible attempt once to remove it'</p> |
| CPG 1/2.13.22 Basic Life Support – Paediatric | <p>Added</p> <p>Decision process 'Unresponsive and breathing abnormally or gasping (agonal breaths)' replaces 'Unresponsive and breathing abnormally or gasping'</p> |
| CPG 1/2.14.1 Basic Life Support – Adult | <p>Decision process 'Unresponsive and breathing abnormally or gasping (agonal breaths)' replaces 'Unresponsive and breathing abnormally or gasping'</p> <p>Instruction Box 'Ventilations - Two ventilations each over 1 second'</p> |
| CPG 1/2.14.6 Post-Resuscitation Care | <p>Deleted</p> <p>Elements pertaining to EFR level</p> <p>Instruction box 'If registered healthcare professional, and pulse oximetry available, titrate oxygen to maintain SpO2 Adult: 94% to 98% Paediatric: 96% to 98%'</p> |



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2nd Floor, Beech House, Millennium Park, Osberstown, Naas, Co. Kildare W91 TK7N

☎ 045 882042 ✉ info@phecc.ie

www.phecc.ie