

# Vermont Statewide Emergency Medical Services Protocols 2025 Summary of Changes

Protocol	Area/Level	Change	Comments
<b>Preface</b> <b>Section 1: General Patient Care</b>		<p>Added - Medical Direction: EMS medical direction refers to the guidance and oversight provided by a licensed physician to Emergency Medical Services (EMS) personnel in the delivery of prehospital care. This direction is crucial to ensure that EMS practitioners deliver appropriate and effective treatment to patients in the field. Medical direction is typically outlined in a protocol book, which serves as a comprehensive reference guide for EMS practitioners.</p> <p>Online medical direction involves real-time communication between EMS personnel and a designated medical director using telecommunication technologies. This allows for immediate consultation and guidance on patient care decisions, especially in situations where time is critical.</p> <p>Offline medical direction, on the other hand, involves predetermined protocols and standing orders provided by the medical director. These protocols are established based on best practices and evidence-based medicine, allowing EMS providers to initiate certain treatments without direct real-time communication with a physician.</p> <p>In cases where an EMS agency is transporting a patient across district lines, it is important to note that medical direction may shift to the medical director at the receiving hospital once the transport destination is chosen that is not the local facility. This ensures continuity of care and allows the receiving hospital's medical director to provide guidance and oversight during the transport and upon arrival. Local DMA restrictions will remain in place for the transporting ambulance.</p> <p>The protocol book serves as a valuable tool for EMS personnel, containing a detailed set of guidelines, procedures, and protocols approved by the medical director. It provides a standardized approach to patient care, ensuring consistency and adherence to established medical practices. Both online and offline medical direction contribute to the overall quality and safety of prehospital care provided by EMS agencies.</p>	<p>New Medical Direction section in preface</p>
Legend	VEFR	Added Vermont Emergency First Responder (VEFR) and Emergency Medical Responder (EMR) to Legend	New color VEFR is Tan New color EMR is Gray
VEFR Routine Patient Care	VEFR	Added two bullets under Other Skills Section: *VEFR may not complete a VT EMS Refusal Form. *VEFR may not cancel an ambulance unless no patient is present or found	Clarifies that VEFRs cannot do a patient refusal or cancel an ambulance (unless there is no patient)

EMR Routine Patient Care	EMR	EMR may cancel an ambulance only when no patient is present or found.	Same clarification as for VEFR on canceling an ambulance
	EMR	Nasopharyngeal airway	Added to EMR scope of practice
Routine Patient Care	All		
Extended Care Guidelines	All		

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<b>Section 2: Medical Protocols</b>			
Abdominal Pain (Adult & Pediatric)			
Adrenal Insufficiency			
Allergic Reaction/Anaphylaxis- Adult			
Allergic Reaction/Anaphylaxis - Pedi	EMT - All	For anaphylaxis, administer: (anterolateral thigh preferred administration site) o Epinephrine Autoinjector: ▪ Patients < 25 kg: Pediatric epinephrine autoinjector 0.15 mg IM ▪ Patients > 25 kg: Adult epinephrine autoinjector 0.3 mg IM, OR o Epinephrine (1 mg/mL): ▪ Patient < 25 kg: Administer 0.15 mg (0.15 mL) IM ▪ Patient > 25kg: Administer 0.3 mg (0.3 mL) IM ▪ Contact Medical Direction for additional dosing	Pediatric anaphylaxis epinephrine dosing has been simplified. All practitioner levels may use the EMT dosing so as to avoid having to calculate weight-based dosing which is error prone
	AEMT	Removed weight based dosing of epinephrine	See EMT dosing schedule above
	Paramedic		Removed PO diphenhydramine, not good for anaphylaxis, IV/IM/IO remain
Altered Mental Status - Adult			
Altered Mental Status - Pedi			
Asthma/COPD/RAD – Adult	EMT	For patients who do not respond to treatments, or for impending respiratory failure, continue nebulizers and consider CPAP up to a maximum of 10 – 15 cm H2O pressure support.	CPAP moved from AEMT to EMT level – Adults Only
	Paramedic	Clarified magnesium 2 g in 50 mL of D5W or NaCl, not 50-100 mL	
Asthma/Bronchiolitis/RAD/Croup - Pedi	AEMT	For patients who do not respond to treatments, or for impending respiratory failure, consider: (anterolateral thigh preferred administration site) o Epinephrine Autoinjector: ▪ Patients < 25 kg: Pediatric epinephrine autoinjector 0.15 mg IM ▪ Patients > 25 kg: Adult epinephrine autoinjector 0.3 mg IM, OR o Epinephrine (1 mg/mL): ▪ Patient < 25 kg: Administer 0.15 mg (0.15 mL) IM ▪ Patient > 25kg: Administer 0.3 mg (0.3 mL) IM	Changed epinephrine to simplified fixed doses
Behavioral Emergencies	All	Major Updates to Protocol – Please Review Entirety Temporary vs Protective Custody	Reformatted and new information, RASS, C-SSRS, Changed the phone number to 988. Cleaned up graphics. Added resources for first responders.
Brief Resolved Unexplained Event (BRUE)			
Diabetic Emergencies (Hyperglycemia) Adult & Pediatric			
Diabetic Hypoglycemia - Adult			
Diabetic Hypoglycemia - Pediatric			
Epistaxis/Nosebleed Adult & Pediatric			
Exertional Heat Stroke	All	If Tmax is at or above 40 C (104F), initiate immediate rapid cooling to a temperature less than 40C even it means a delay in transport	This line was changed to read “even if it means a delay in transport” instead of the old version which said “within 30

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			minutes of collapse”. The change was made to clarify that if you have access to a cold water immersion, it is more important to cool the patient immediately on scene, even if it means a delay in transport. If no cold-water immersion is available, continue the other cooling techniques & transport
	All	5.c. If whole-body cold water immersion is not feasible, utilize ice packs, fans, cold water dousing or shower. Rotating ice water towels covering as much of the body surface area as possible should be considered a minimum cooling modality enroute.”	Clarified that if whole-body cold water emersion is not available, other cooling means are better than nothing and should be utilized. Added the “if not feasible” part of the sentence
Hyperkalemia and Renal Failure		1 mEq/Kg sodium bicarbonate (maximum dose 50 mEq) IV/IO over 5 minutes	Clarified sodium bicarbonate dose as mEq/Kg vs 50 mEq for all patients, with a max of 50mEq which will be the most common dose
Hyperthermia (Environmental) A&P			
Hypothermia (Environmental ) A&P			
Nausea/Vomiting Adult & Pediatric			
Nerve Agents/Organophosphate Adult			
Nerve Agents/Organophosphate Pedi			
Newborn Resuscitation	Paramedic	If bag valve mask ventilation is inadequate or chest compressions are indicated, intubate the infant using a cuffed 3.0 mm to 4.0 mm endotracheal tube.	Clarified use of a CUFFED endotracheal tube
Normal Labor and Delivery	AEMT	After completion of fetal delivery(s), consider oxytocin 10 Units IM .	Moved oxytocin to AEMT Level.
Obstetrical Emergencies	AEMT	After completion of fetal delivery(s), consider oxytocin 10 Units IM .	Moved oxytocin to AEMT Level.
	Paramedic	Clarified TXA is mixed in 50-100 mL 0.9% NaCl	
	Paramedic	Consider benzodiazepine for seizures not responding to magnesium (See Seizures – 2.22A).	Added consider benzo for seizure not responding to magnesium in eclampsia – Caution respiratory depression.
Pain Management Adult	EMT	In not contraindicated, consider : Ibuprofen 600 mg PO, no repeat.	Added ibuprofen po for EMT in pain mgt section.
	EMT	Contraindication of ibuprofen: Hypersensitivity to ibuprofen; cerebrovascular bleeding or other bleeding disorders, active gastric bleeding; administration of a medication containing ibuprofen within last 6 hours.	Added Red Flag for Ibuprofen
	Paramedic	For mild or moderate pain, consider ketorolac 15 mg IV or 30 mg IM (no repeat).	Removed need to call medical direction for ketorolac, check with your DMA for any local restrictions
Pain Management Pediatric			
Poisoning - Adult		To reduce post overdose agitation: * Fix hypoxia first through rescue breathing * Utilize only enough naloxone to restore ventilations, titrate to effect when possible * Allow 3 to 5 minutes between naloxone doses * Provide therapeutic environment (reduce number of people/uniforms in room upon awakening)	Added pearl to improve care of overdose patients in the post-overdose phase
Poisoning – Pediatric			
Seizures - Adult	EMT	Obtain and transmit 12-lead ECG, if available.	Added ECG to EMT section in seizure
	Paramedic	Clarified seizure medication orders based on if vascular access (IV or IO) is present or absent.	If vascular access is absent, use Midazolam IM (preferred) or IN. If vascular access is present IV medications are preferred over IM/IN.
	Pearls	If no vascular access is present, the preferred initial dose of benzodiazepine is midazolam IM/intranasal. After initial dose, establish an IV in case additional medication doses are needed. If an IV is already established, administer benzodiazepine IV.	Updated pearl to reflect above guidance on presence or absence of vascular access and seizure medications
Seizure - Pediatric			

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Sepsis – Adult			
Sepsis - Pediatric			
Shock - Adult			
Shock - Pediatric	Paramedic	Norepinephrine infusion 0.1 – 2 mcg/kg/min titrated to effect ( <b>max dose 30 mcg/min</b> ), OR, Epinephrine 0.1 – 1 mcg/kg/min titrated to effect ( <b>max dose 10 mcg/min</b> )	Added max dose for norepinephrine and max dose for epinephrine in pediatric patients
Smoke Inhalation	EMT	Consider CPAP for respiratory distress (Continuous Positive Airway Pressure (CPAP) – 5.4). Adults Only.	CPAP moved from AEMT to EMT level for ADULTS ONLY
Stroke - Adult	All		JoinTriage App may be used to calculate a score, JOIN app is no longer available for destination determination
	All	Stroke Alert should be called within 10 minutes of recognition.	Added to protocol and New Red Flag
		<p>Posterior Circulation Stroke (PCS): Unlike anterior strokes, PCS often evades detection with standard stroke screens like CPSS and FAST-ED. Key signs include sudden visual disturbances, loss of balance or coordination, dizziness, or nausea and vomiting.</p> <p>Balance: Perform bilateral finger-to-nose and heel-to-shin tests to assess sudden loss of balance, coordination issues, or trouble walking.</p> <p>Eyes: Assess trouble seeing out of one or both eyes or sudden double vision by evaluating 4 quadrants of the visual field, having the patient locate your index finger in each quadrant. For patients with concerning PCS symptoms and negative stroke screens, contact Medical Direction to consider a stroke alert.</p>	<p>Updated the pearls on Posterior Circulation Stroke to include more detailed instructions on assessing Balance and Eyes. The stroke screening exam may include all of the following:</p> <p>B – Balance E – Eyes F – Facial Droop A – Arm Drift S – Speech T – Time last known well.</p> <p>Local stroke plans may opt to include BE-FAST vs FAST for stroke screening</p>
	All	If your local stroke plan utilizes BEFAST, See BEFAST Appendix A.8	Added a hyperlink to the BEFAST protocol for those Districts/Agencies that under their local stroke plan will be using BEFAST vs. FAST for initial Stroke assessment.
Syncope – Adult & Pediatric			
<b>Section 3: Cardiac Protocols</b>			
Acute Coronary Syndrome			Review of oxygen and ASA administration
Bradycardia Adult Bradycardia Pediatric			
Cardiac Arrest - Adult	ALL	Pulse Check/Analysis	Added “Pulse Check” along with Analysis on the infographic to reinforce that both a pulse check and rhythm analysis should occur between compression cycles
	All		Remove hypoglycemia from CPR checklist, not one of the H’s or T’s
	EMT	If hypothermic arrest (Hypothermia (Environmental) Adult & Pediatric – 2.13).	Added reference to hypothermia protocol if hypothermic arrest
	AEMT	Establish IV/IO access (IV preferred when possible; use IO if IV access cannot be established promptly.	Clarified that IV is the preferred access for cardiac arrest when possible. If IV access cannot be established promptly, use IO access
	Paramedic	Changing pad placement from anterior-apex to anterior-posterior, or vice versa.	For refractory VF/VT – added vice versa to recognize initial pad placement may have been anterior posterior.
	Paramedic	If second manual defibrillator is available consider Double Sequential Defibrillation Procedure 6.1	Due to new evidence-based research we have added Double Sequential Defibrillation back into the protocol as an option to consider

Cardiac Arrest - Pediatric	All	Pulse Check/Analysis	Added "Pulse Check" along with Analysis on the infographic to reinforce that both a pulse check and rhythm analysis should occur between compression cycles
	EMT	If hypothermic arrest (Hypothermia (Environmental) Adult & Pediatric – 2.13).	Added reference to hypothermia protocol if hypothermic arrest
	AEMT	Establish IV/IO access (IV preferred when possible; use IO if IV access cannot be established promptly).	Clarified that IV is the preferred access for cardiac arrest when possible. If IV access cannot be established promptly, use IO access
Congestive Heart Failure - Adult	EMT	Consider Continuous Positive Airway Pressure (CPAP) – ADULT ONLY with maximum 10 – 15 cm H2O pressure support (Continuous Positive Airway Pressure (CPAP) - 5.4). Consider CPAP for patient with moderate to severe respiratory distress concurrent with the following signs and symptoms: <ul style="list-style-type: none"> <li>▪ Oxygen saturation &lt; 94%</li> <li>▪ Respiratory rate &gt; 25/minute</li> <li>▪ Retractions or accessory muscle use</li> <li>• SBP must be ≥ 100 mmHg (MAP ≥ 65) to utilize CPAP</li> <li>• Call for Paramedic intercept, if available. If not available, call for AEMT intercept.</li> </ul>	CPAP moved from AEMT to EMT level Adults Only
Post-Resuscitative Care - Adult			
Post-Resuscitative Care - Pediatric			
Tachycardia - Adult	Paramedic	Lidocaine (considered second-line therapy) 1 – 1.5 mg/kg IV. May repeat once in 5 minutes to maximum of 3 mg/kg. If successful, consider a maintenance infusion of 1 – 4 mg/minute.	Added lidocaine (considered second-line therapy) per AHA into Tachycardia protocol for Regular Monomorphic Wide Complex Tachycardia
Tachycardia - Pediatric			
Team-Focused CPR	All	<b>Reversible Causes</b> Hypovolemia Hypoxia Hydrogen Ions (acidosis) Hypothermia Hyper/hypokalemia Tablets/toxins Tamponade Tension pneumothorax Thrombosis (MI) Thrombosis (PE)	Removed hypoglycemia and trauma from list of Reversible Causes of cardiac arrest
<b>Section 4: Trauma Protocols</b>			
Burns/Electrocution/Lightning Adult and Pediatric			
Drowning/Submersion Injuries	EMT	If water temperature is estimated to be less than 6 degrees C (43 degrees F) and submerged: If water temperature is estimated to be greater than 6 degrees C (43 degrees F) and submerged:	Reformatted for clarity
	EMT	Consider CPAP for respiratory distress (Continuous Positive Airway Pressure (CPAP) – 5.4). Adults Only.	CPAP moved from AEMT to EMT level for Adults Only
Eye Injuries			
Hemorrhage Control	All		Reformat of hemorrhage protocol to include tourniquet. TXA moved to Traumatic Emergencies protocol
Musculoskeletal Injuries			
Spinal Trauma and Assessment			
Tranexamic Acid (TXA)			Protocol retired, mention of TXA moved to Traumatic Emergencies Protocol and OB Emergencies
Trauma Triage and Transport Decision	All	If feasible, and transport time ≤ 60 minutes, consider transport to a Level 1 Trauma Center	Increased diversion window from 50 to 60 minutes

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Traumatic Brain Injury			
Traumatic Cardiac Arrest	All	Initiate Resuscitation Efforts and Transport Immediately	Added the word, "Immediately" to the flow sheet at the top of the protocol to clarify that traumatic arrests should be transported as soon as possible with no delay in care if possible. Procedures should be performed en-route. The number one thing these patients need beyond interventions that can be performed in the field is access to a Trauma Surgeon and OR. Do NOT work traumatic cardiac arrests on scene for 20 minutes and then call for TOR, this approach is for medical arrests.
Trauma Triage and Transport Decision	All	If feasible, and transport time ≤ 60 minutes, consider transport directly to closest Level I Trauma Center	Increased transport time window to 60 minutes from 50 minutes
Traumatic Emergencies	Paramedic	Consider tranexamic acid (TXA) (must have approval of District Medical Advisor): o Mix 1 gram of TXA in 50 - 100 ml of 0.9% NaCl; infuse over approximately 10 minutes IV or IO o Notify receiving facility of TXA administration prior to arriving	Moved TXA here, no change in the dosing instructions
<b>Section 5: Airway Protocols &amp; Procedures</b>			
Airway Management	All	Patient positioning can significantly impact respiratory mechanics. Patients with severe bronchospasm should be left in the position of comfort (perhaps tripod) whenever possible. Elevating the head or padding (shoulders, occiput) can assist with opening airway and respiratory mechanics. This can both improve the ability to ventilate and limit aspiration	Added information on position patient to help with airway management
	All	OPA/NPA: Oropharyngeal airways (OPA) or nasopharyngeal airways (NPA) can be placed if needed to maintain a patent airway and make BVM ventilation more effective i. OPA are used for patients without gag reflex ii. NPA are used for patients with gag reflex. Note NPAs are relatively but not absolutely contraindicated in trauma, use clinical judgement.	Added information on OPA/NPA, specifically that NPA has relative but not absolute contraindications for use in trauma, clinical judgement must be utilized.
Airway Management Adult	EMT	For adults in severe respiratory distress secondary to pulmonary edema, COPD, asthma, pneumonia, near drowning or undifferentiated respiratory distress, consider use of CPAP	CPAP moved from AEMT to EMT level for Adult Patients Only
Airway Management Pediatric	EMT	For apnea or hypoventilation and decreased level of consciousness with possible opioid overdose, administer naloxone. (Poisoning/Substance Abuse/Overdose – 2.21P)	Added bullet
BIPAP	Paramedic	Consider administering anxiolytic, contact <b>Medical Direction</b> : Midazolam 2.5 mg IV/intranasal, may repeat once in 5 minutes, <b>OR</b> 5 mg IM may repeat once in 10 minutes, <b>OR</b> Lorazepam 0.5 – 1 mg IV, may repeat once in 5 minutes, <b>OR</b> 1 – 2 mg IM, may repeat once in 10 minutes, <b>OR</b> Diazepam 5 mg IV (may repeat once in 5 minutes)	Aligned anxiolytic orders with CPAP
CPAP	EMT	MOVED CPAP TO EMT LEVEL for Adults	SEE FULL TRAINING MODULE, Added to Scope of Practice Appendic
Orotracheal Intubation	Paramedic	Post-Intubation Care	Separated adult and pedi dose sections
Percutaneous Cricothyrotomy	Paramedic	Adult and Pediatric	Clarified adult and pediatric. Also added to the Scope of Practice Appendix

Supraglottic Airway		Post Tube Placement Care	Separated adult and pedi dose sections Also Note: Double Lumen Devices (e.g., Combitube) are no longer approved & have been removed from protocol.
Surgical Cricothyrotomy	Paramedic	PARAMEDIC STANDING ORDERS – ADULT & PEDIATRIC (8 YEARS AND OLDER)	Added clarifying language for this protocol to be adult and pediatric 8 yrs and older
	Paramedic	INDICATIONS • Failure to maintain airway (including oxygenation, ventilation and protection) through other less invasive means. • Patient 8 years or older with palpable landmarks.	Added INDICATIONS section
High Flow Nasal Cannula Adult & Peds	Paramedic	HFNC may also be used for adult patients. Clarified that Paramedics may use HFNC, CCPs if the patient is Complex	Clarified under indications that HFNC may be use in adult patients. Updated Scope of practice document. Added to Protocol book
<b>Section 6: Medical Procedures</b>			
Children with Special Healthcare Needs	All	New protocol	Please review full protocol
Double Sequential Defibrillation	Paramedic	Indication: Refractory Ventricular Fibrillation/Tachycardia after 3 unsuccessful shocks and a second manual defibrillator is available	Secondary to evidence-based review this protocol has been reinstated
ECG Acquisition	All	Removed: EMRs, EMTs and AEMTs may not apply 3/4 lead ECG to patient except under direct observation/request of an on-scene Paramedic.	Confusing: This is not part of ECG acquisition
	All	<i>Agencies are strongly encouraged to develop the capability to transmit ECGs to receiving hospitals.</i>	Removed from protocol, by now all agencies should be doing this, but does not need to be a sentence in the protocol. Agencies are still strongly encouraged to do so.
Intraosseous Access	AEMT and Paramedic	CONTRAINDICATIONS • Fracture of bone or trauma to selected site • Active soft tissue infection at insertion site • Previous attempt at the same bone within 48 hours • Inability to identify landmarks • Prosthetic bone or joint at insertion site (suspect if surgical scar)	Updated list of contraindications for IO access
	AEMT and Paramedic	In cardiac arrest, IV preferred when possible; use IO if IV access cannot be established promptly.	Clarified that IV is preferred in cardiac arrest, but if unable to establish IV promptly, use IO access
	AEMT and Paramedic	Pearl: Use caution for distal femur IO placement. Excess soft tissue may cause insufficient needle length. Insure at least one black line is visible on the needle after bone contact prior to drilling.	Added pearl to clarify that distal femur IO cannot be used if there is too much soft tissue and the needle is not long enough.
Restraints	All	MAJOR UPDATE TO RESTRAINTS PROTOCOL	PLEASE REVIEW FULL MODULE/PROTOCOL
	E/A	Ensure that there are sufficient personnel available to physically restrain the patient safely. Initially restrain all 4 extremities.	Clarified that if the decision is made to apply restraints, all 4 extremities should initially be restrained
	Paramedic	Increased diazepam dose from 2.5 to 5 mg	
	Paramedic	PARAMEDIC STANDING ORDERS – PEDIATRIC (15 years of age or younger, regardless of patient's weight).	Clarified for restraints a pediatric patient is age 15 years of age or younger regardless of weight
Tourniquet & Hemostatic Agent	All	Protocol Deleted	Combined with Hemorrhage Control and protocol in Trauma Section
<b>Section 7: Prerequisite Protocols</b>			
Interfacility Transfers	EMT	CPAP Adults Only	CPAP moved from AEMT to EMT level for Adults Only
	AEMT	- Cardiac monitoring should be used <i>only</i> for detecting cardiac arrest arrhythmias and must	Clarified when an AEMT can utilize cardiac monitoring

		<p>be correlated with physical assessment findings, such as the absence of palpable pulses.</p> <ul style="list-style-type: none"> <li>- If cardiac monitoring is needed for suspected or anticipated arrhythmias that are <i>not</i> related to cardiac arrest, the patient is <i>not</i> appropriate for transport by an AEMT.</li> </ul>	
	Paramedic	For massive hemorrhage, administer 1 gm calcium chloride or 2 gm calcium gluconate after the first 2 units of blood products. Repeat dosing after each additional 4 units of blood products	Administer calcium for transferring patients who are receiving blood projects. Added to Paramedic level and scope of practice chart
	Paramedic	HFNC	Added HFNC to protocol and to Paramedic IFT scope chart
	Paramedic	Continuation of Potassium containing maintenance fluids, 0.9% NaCl plus 20 mEq potassium, or Lactated Ringers plus 20 mEq potassium	
	Critical Care Paramedic	HFNC in complex pt	Added HFNC in complex patient to protocol and to IFT scope chart
Point of Care Ultrasound	Paramedic		New protocol. Must have DMA approval, training and credentialing. See Point of Care Ultrasound Resource Kit
<b>Section 8: Medical Policies</b>			
Communications Failure		In the event of a communication failure due to equipment malfunction, lack of cell phone or radio service, or inability to reach Medical Direction despite reasonable attempts appropriate to the urgency of the situation, the following procedures will apply:	Clarified definition of communication failure
Consent for Treatment of a Minor	All	When a parent or legal guardian is not reasonably available, another adult family member or other authorized representative having custody of the minor may refuse care.	Clarified
Hospice	Paramedic	Note: Administration of hospice medications does not necessarily require transport to the Emergency Department.	Clarified transport to ED is not required if medications are given, goal remains to follow hospice plan
Naloxone Leave Behind	All		Please REVIEW this protocol in detail, including the single question screening tool
	All	Patients with an implantable Ventricular Assist Device (VAD) should not be pronounced dead at the scene unless there are obvious factors of death (See Resuscitation Initiation & Termination 8.17). Due to the unique nature of VADs, there are specific protocols to follow, as these patients may have signs of life that are not immediately apparent.	
Pediatric Transportation	All	MOTHER AND NEWBORN TRANSPORT • It is not acceptable, under any circumstances, to transport a pediatric patient in the arms of an adult. • Secure and transport mother on the cot. • If mother and newborn are both stable and a commercial device is available to fasten newborn to mom, follow manufacturer's guidelines. • If mother and/or newborn are not stable or a commercial device is not available, best practice is to request two ambulances, transporting each in their own ambulance. • If a second ambulance is not available, transport stable newborn secured to the rear-facing provider seat/captain's chair using a size-appropriate child restraint system. Infant should be facing the rear of the ambulance. Enter a convertible safety seat with a forward-facing belt path or an integrated child restraint system certified by the manufacturer to meet	Added Mother and Newborn Transport guidelines



		FMVSS No. 213 may be used to secure the infant. Do NOT use a rear-facing only safety seat in the rear-facing provider seat/captain's chair as this is dangerous and may lead to significant injuries. Special attention should be paid to the high risk of hypothermia in newborns.	
Police Custody	All		Clarified Temporary, Protective and Police Custody
Refusal of Care	All	When a parent or legal guardian is not reasonably available, another adult family member or other authorized representative having custody of the minor may refuse care.	Clarified
Safe Response & Transport Guidelines	All		Added follow manufacturers instructions for use of belts and other devices
Strangulation	All		
Lift Assist Protocol	All		
DNR/COLST	All		
Implantable Ventricular Assist Device (VAD)	All	Patients with an implantable Ventricular Assist Device (VAD) should not be pronounced dead at the scene unless there are obvious factors of death (See Resuscitation Initiation & Termination 8.17)	