DETAINEE HOSPITAL GUANTANAMO BAY, CUBA Title: EMERGENCY MEDICAL TREATMENT SOP	SOP NO: 068 Page 1 of 25 Effective Date: May 2004
SCOPE: Detention Hospital, Delta Medical Clinic	

I. MISSION

To provide standardized emergent treatment to military and detainee personnel secondary to illness or injury.

II. OVERVIEW

Accident, injury or illness can occur at any time. By utilizing a standardized set of treatment principles and actions, the overall incidence of morbidity and mortality can be reduced. Also, by providing medical care utilizing protocols emergent treatment can be initiated in the absence of a medical officer and can be continued until a medical provider is contacted via phone or is present at the scene.

III. PROCEDURES

1) All nurses and corpsmen will receive training on protocol usage.

2) Once initial training is completed, shift nurses will be able approve corpsmen on protocol usage and medications specifically administered by hospital corps staff.

3) Newly arriving personnel must be approved on protocol usage prior to being assigned to an emergency response team (ERT).

4) Nurses and shift leaders will conduct ongoing protocol and medical refresher training.

5) Hospital corps staff will have this training annotated in their training record while at JTF GTMO.

6) Protocols are only in effect in the absence of a credentialed medical provider. Medical providers may modify, supercede or negate any protocol once the patient is under his or her care.

005124

ALTERED MENTAL STATUS

Common Causes:
- Alcohol
- Epilepsy
- Infection
- Overdose
- Uremia
- Trauma, Temperature
- Insulin (Hyper/Hypoglycemia)
- Psychogenic, Poison
- Shock, Stroke (CVA)

1) Assure ABC's

2) Provide supplemental O2 to maintain SpO2 > 92%

3) Obtain vascular access

4) If dehydration or hypoperfusion evident, go to **REHYDRATION/SHOCK PROTOCOL**

5) Obtain FSBS:

60-300 mg/dl: monitor
> 300 mg/dl: - give 250 ml NS fluid bolus(s) to maintain SBP > 90 mmHg
< 60 mg/dl: - give 1-2 tubes oral glucose if alert and able to maintain own airway (C)/(N)

- If unresponsive or unable to maintain own airway:
  - give ***Thiamine*** 100 mg IVP (N) if malnourished or pt is on hunger strike
  - ***D50W*** 25 grams IVP (N) or ***Glucagon*** 1mg IM (C)/(N) if IV not established

6) ***Naloxone*** 0.4-2mg IVP (N) titrated to effect for suspected narcotic overdose

7) If seizures evident, go to **SEIZURE PROTOCOL**

8) Consider ***Flumazenil*** for barbiturate overdose **

8) Continue to monitor, transport to clinic, and contact MO for medical oversight.

** Contact MO for guidance regarding risk for seizures and dosing amounts

005125

ALLERGIC/ANAPHYLACTIC REACTION

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) Obtain vascular access

4) ***Diphenhydramine*** 50mg IM (C) or 25-50mg IVP (N)

5) If hypotensive or respiratory distress evident:

- EKG monitor
- ***Epinephrine*** 1:1000 0.3mg SC (C)/(N) **
- ***Albuterol*** 2.5mg/5cc NS via HHN (C)/(N)
- 250 cc NS bolus(s) to maintain SBP > 90 mmHg
- ***Solumedrol*** 125mg IVP (N)

6) Continue to monitor, transport to clinic, and contact MO for medical oversight

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HHN= hand held nebulizer

** Use Epinephrine with caution in persons with known cardiac history or > 40y old

BURNS

1) Extinguish flames and ensure scene safety.

2) Go to **ADVANCED AIRWAY PROTOCOL** if inhalation injury present

3) Give supplemental O2 to keep SpO2 > 92%

4) Remove smoldering clothing and constricting jewelry

5) Evaluate burn extent using "Rule of Nines"

6) Attempt to remove offending agent:

- Dry chemical: Brush off. Irrigate for 20 min with H20
- Liquid chemical: Irrigate for 20 min with H20

7) Cover with burn sheets or dry, sterile dressing

8) Obtain vascular access

9) 250 ml NS bolus(s) to maintain SBP > 90 mmHg (Keep I/O total for burn formula calculation)

10) ***Morphine sulfate 2-4 mg IM*** (C) or IVP (N) q 5 min to a max of 10mg for pain control.

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

CHEST PAIN

1) Assure ABC's

2) If having difficulty breathing, go to **DIFFICULTY BREATHING PROTOCOL**

3) Give O2 2-4 lpm via NC or as needed to keep SpO2 . 92%

4) 3-lead EKG monitor

5) Obtain IV access and draw "Rainbow" lab panel

6) *ASA* 324 mg PO (C)/(N) X (2) doses. (Chew first dose, swallow second dose)

7) NS 250 ml bolus(s) to maintain SBP > 90 mmHg **

8) *Nitroglycerin* 0.4 mg SL (C)/(N) q 5 min up to a max of three doses *

9) 12 Lead EKG

10) *Morphine sulphate* 2-4 mg IVP (N) q 5 min (max 10 mg) titrated for pain relief

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

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* Check blood pressure in between nitroglycerin doses. Withhold nitroglycerin if SBP < 90mmHg

** If evidence of right ventricular failure (hypotension, JVD, pitting edema), withhold nitroglycerin and morphine. Contact MO ASAP for medical oversight.

005128

DEHYDRATION

1) Assure ABC's

2) Vital signs with Tilts. (A decrease in 10 pts for B/P or increase of the HR of 20 points means pt is tilt positive) You may just follow HR and response vice complete set of tilts.

3) Draw CBC, and Chem 7 to be sent stat, if detainee does not respond to 2 liters of IV fluids. May D/C labs if detainee is tilt negative. There is no need for IVF.

4) Two liter bolus of NS or LR.

5) Finger stick. If blood glucose is less than 60 then start second IV line and infuse D5W @ 200cc / hr for total of 400cc and Thiamine 100mg IM/IVPB and call MO.

6) Pulse ox. If pulse ox is less than 95% administer O2 and call MO if hadn't done so already.

7) May D/C to block if re-tilt is negative. You may re-tilt after first IV bag.

8) If re-tilt positive, call MO if hadn't done so already.

9) Please call MO for any concerns or questions.

C05129

DIFFICULTY BREATHING

1) Assure ABC's

2) If respiratory failure is imminent, got to **ADVANCED AIRWAY PROTOCOL**

3) Provide supplemental O2 to keep SpO2 > 92%

4) If anaphylaxis is present, got to **ALLERGY/ANAPHYLAXIS PROTOCOL**

5) If rales present or history of cardiac/MI:

- EKG monitor
- Obtain vascular access with "Rainbow" blood draw
- *Nitroglycerin 0.4* mg SL (C)/(N) q 5 min X 3 doses
- *Lasix* 0.5-1 mg/kg IVP (N)
- *Albuterol* 2.5 mg/ 5cc NS via HHN if active wheezing present

If history of COPD, asthma, wheezes or diminished breath sounds:

- *Albuterol* 2.5 mg/5 cc NS via HHN (C)/(N)

If no improvement:

- *Albuterol* 2.5 mg/5cc NS/ *Atrovent* 0.5mg/5cc NS via HHN (C)/(N)
- Obtain vascular access
- *Solumedrol* 125 mg IVP (N)
- Repeat *Albuterol* 2.5 mg/5cc NS via HHN (C)/(N)

6) Continue to monitor, transport to clinic, and contact MO for medical oversight

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HHN= Hand Held Nebulizer

005130

Mild Sx's: Extremity pain, itching

Serious Sx: Visual disturbances
Ear pain, vertigo
Focal weakness
Vision difficulty
Speech difficulty
Numbness, tingling
Mental status changes
Seizure
Cardiac arrest

DIVING MEDICAL DISORDERS

1) Assure ABC's

2) Obtain diving history:

- depth of dive
- total diving time (time leaving surface until time reaching surface= total dive time)
- time spent at bottom
- ascent time
- type of mixture (air, NITROX, helium/oxygen mixture, etc.)
- any complications during dive

3) NRB 10-15 lpm O2

4) Obtain IV access

5) Transport supine on spine board to NH GTMO for eval

Important Numbers:

Dive Locker: [redacted]

Dive Supervisor:

005131

NOV00289

ELECTRICAL/LIGHTNING INJURIES

1) Ensure scene safety

2) Assure ABC's

3) Consider spinal immobilization

4) If cardiac arrest or bradycardia present, refer to appropriate protocol

5) 3-lead EKG monitor

6) Obtain vascular access with "Rainbow" lab draw

7) 250 ml NS bolus(s) to maintain SBP > 90 mmHg

8) 12-Lead EKG

9) If burn injury present, go to **BURN PROTOCOL**

10) Continue to monitor, transport to clinic, and contact MO for medical oversight

HYPERTHERMIA

1) Assure ABC's

2) If respiratory failure is imminent, go to **ADVANCED AIRWAY PROTOCOL**

3) Remove from environment

4) Provide supplemental O2 to maintain SpO2 > 92%

5) If altered LOC or rectal temp > 104 F:

- FSBS (if less than 60 mg/dl, got to **ALTERED MENTAL STATUS PROTOCOL**)
- obtain vascular access with "Rainbow" blood draw
- Infuse 2 L IV NS bolus (C)/(N)
- Aggressive cooling measures (ice to arm pits and groin, water and direct wind from fan, etc.)
- Discontinue aggressive cooling measures when core temp reaches 101 degrees F

Heat Exhaustion

- Place in air-conditioned environment
- Infuse 2L IV NS bolus (C)/(N)

Heat Cramps:

- Encourage PO intake
- Educate need for increase fluid requirements while operating in hot environment

6) 250ml NS bolus(s) to maintain SBP > 90 mmHg

7) Continue to monitor, transport to clinic, and contact MO for medical oversight

005133

NAUSEA AND VOMITING

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) If dehydration or hypoperfusion evident, go to **REHYDRATION/SHOCK PROTOCOL**

4) Obtain vascular access as needed

5) If active nausea and vomiting present:

- ***Phenergan*** 25mg IM (C)/(N) or 12.5-25mg IVP (N)

or

- ***Zofran*** 4mg IVP (N)

6) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

005134

POISONING/OVERDOSE

1) Assure ABC's

2) Obtain history:
- type and amount of poison
- route (ingested, inhaled, injected or through skin surface contamination)
- time poisoned
- has patient vomited? When?
- history of drug or ETOH usage?
- PMH

3) In unresponsive or altered mental status, got to **ALTERED MENTAL STATUS PROTOCOL**

4) If seizing, got to **SEIZURE PROTOCOL**

5) If anaphylaxis or allergic reaction suspected, go to **ANAPHYLAXIS/ALLERGIC REACTION PROTOCOL**

6) If inhaled poison:
- expose to fresh air/remove from environment
- administer 100% O2 via NRB

7) If skin surface contaminated:

Dry Chemical
- brush off particles
- irrigate with H2O for 20 min

Liquid Chemical
- irrigate area with H2O for 20 min

8) Ingested poison (non acid, alkali, or other caustic substance):
- if acid, alkali or other caustic substance, proceed to step 9
- if < 30 min after poison ingestion, give 1 gram/kg Activated Charcoal PO (if tolerated)
- place NG tube if unable to tolerate PO
- if > 30 min since ingestion, monitor and proceed to step 9

9) Contact Poison Control Center or obtain MSDS sheets as needed

005135

10) Continue to monitor, transport to clinic, contact MO ASAP for medical oversight

SEIZURE

1) Assure ABC's

2) Protect patient from injury

3) If respiratory failure is imminent, proceed to **ADVANCED AIRWAY PROTOCOL**

4) Obtain FSBS. If less than 60 mg/dl, go to **ALTERED MENTAL STATUS PROTOCOL**

5) If patient is actively seizing > 10 min:

- obtain vascular access
- ***Diazepam*** 2-10mg IVP (N) ** or ***Lorazepam*** 2-5 mg IVP (N) **

6) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

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** If unable to obtain IV access, may administer Diazepam via rectum

GENERAL TRAUMA PROTOCOL

1) Assure scene safety

2) Perform primary assessment:

A
- ensure open airway with c-spine control
- if respiratory failure imminent, go to ADVANCED AIRWAY PROTOCOL

B
- IAPP and ensure adequate respiratory function
- provide supplemental O2 to keep SpO2 > 92%
- if S/S of tension pneumothorax evident, perform needle thoracentesis

C
- stop all life-threatening hemorrhage
- perform "blood sweep"

D
- AVPU or GCS
- ongoing mental status checks

E
- expose all suspected injury areas
- prevent hypothermia and shock from excessive exposure

F
- full set of vital signs (including SpO2 and pain assessment)
- EBL to determine blood loss

3) Secure airway using ADVANCED AIRWAY PROTOCOL if needed

4) Obtain venous access and infuse NS via bolus(s) to maintain SBP > 90 mmHg

5) Perform secondary assessment and treat all associated injuries

6) ***Morphine sulfate*** 2-5mg IM (C)/(N) or 2-5mg IV (N) PRN for pain (maximum 10mg) titrated to effect

7) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

CARDIAC ARREST PROTOCOL FOR NON-ACLS PROVIDERS

AUTOMATED EXTERNAL DEFIBRILLATION (AED) FOR NON-ACLS PERSONNEL

1) Establish pulselessness
2) Contact Delta Clinic or Detention Hospital and call "Code Blue"
3) Start CPR utilizing BVM and 100% O2.
4) Turn AED on
5) Attach electrodes
6) Analyze rhythm

If shock indicated:
- give (3) "stacked shocks"
- continue CPR for (1) minute
- maintain airway control utilizing **ADVANCED AIRWAY PROTOCOL** and establish IV access
- ***Epinephrine*** 1:10,000 1mg IVP (N) or 2.5 mg ETT (N) q 3-5 min
- analyze rhythm
- give (3) "stacked shocks" if needed
- continue CPR for (1) minute
- ***Lidocaine*** 1-1.5 mg/kg IVP (N) or 2-3 mg ETT (N) to a maximum of 3 mg/kg
- analyze rhythm
- give (3) "stacked shocks" if needed
- continue CPR, monitoring and delivering drug, shock, drug, shock, etc.

If no shock indicated:
- continue CPR
- maintain airway control and establish IV access
- ***Epinephrine*** 1:10,000 1mg IVP (N) or 2.5mg ETT (N) q 3-5 min
- continue CPR
- ***Atropine*** 1mg IVP (N) or 2mg ETT (N) q 5min (max of 3mg)

- continue CPR, monitoring with AED and proceed to "If shock indicated" if shock

7) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

8) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight.

005139

NOV00297

EMERGENCY CARDIAC CARE PROTCOLS FOR ACLS PROVIDERS

ASYSTOLE

Possible Causes
- Myocardial Infarction
- Acidosis
- Tension Pneumothorax
- Hyperkalemia/Hypokalemia
- Hyothermia
- Hypoxia
- Cardiac Tamponade
- Emboli
- Drug Overdose

1) Establish unresponsiveness

2) Begin CPR with BVM and 100% O2

3) 3-lead EKG monitor

4) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**

5) Obtain vascular access

6) ***Epinephrine*** 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5min

7) Continue CPR

8) ***Atropine*** 1mg IVP or 2mg ETT (C)/(N) q 3-5 min (max 3 mg)

9) Continue CPR

10) If spontaneous return of pulse, go to **POST RESUSCITATION PROTOCOL**

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

005141

BRADYCARDIA

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) EKG monitor

4) If 2nd degree Type II or 3rd degree Heart Block present with signs of hypoperfusion, consider early transcutaneous pacing (TCP)

5) Obtain vascular access

6) *Atropine* 0.5-1mg IVP (N) titrated to effect (maximum 3mg)

7) If patient fails to respond to atropine, consider transcutaneous pacing (TCP)

8) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

PULSELESS ELECTRICAL ACTIVITY (PEA)

Possible Causes
- Myocardial Infarction
- Acidosis
- Tension Pneumothorax
- Hyperkalemia/Hypokalemia
- Hyothermia
- Hypoxia
- Cardiac Tamponade
- Emboli
- Drug Overdose

1) Establish pulselessness

2) Begin CPR with BVM and 100% O2

3) Maintain airway utilizing **ADVANCED AIRWAY PROTOCOL**

4) Obtain vascular access

5) ***Epinephrine*** 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5 min

6) Continue CPR

7) ***Atropine*** 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5 min (maximum 3mg) **

8) Continue CPR

9) Rule out causes of PEA and treat according to appropriate protocol

10) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

11) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

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** Give atropine for electrical heart rate < 60 bpm

TACHYCARDIA- NARROW COMPLEX

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) 3-lead EKG monitor

4) If pulse > 150 bpm with signs of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *
   - if pulseless got to appropriate protocol

5) Obtain vascular access

6) 12 Lead EKG

7) If pulse > 150 bpm and without signs of hypoperfusion, attempt vagal maneuver **

8) If signs of deteriorating mental status or hypoperfusion present
   - synchronized cardioversion (100J, 200J, 300J, 360J) ***
   - if pulseless go to appropriate protocol

9) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

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* May start at 50J for Atrial Flutter

** Vagal maneuvers should not be attempted on the following:
   - history of transient ischemic attack (TIA)/ cerebral vascular accident (CVA)
   - previous neck surgery
   - neck cancer
   - history of aortic stenosis
   - known carotid artery blockage

*** If possible, provide sedation with analgesia:
   - *Versed* 1-2mg IVP (N)
   - *Morphine Sulfate* 2-4mg IVP (N)

005144

NOV00302

TACHYCARDIA- WIDE COMPLEX

1) Assure ABC's

2) Provide supplemental O2 to keep SpO2 > 92%

3) 3-lead EKG monitor

4) If pulse > 150 bpm with signs of altered mental status or hypoperfusion:
   - synchronized cardioversion (100J, 200J, 300J, 360J) *

5) Obtain vascular access

6) 12 Lead EKG

7) ***Lidocaine*** 1-1.5 mg/kg slow IVP (N) over 2 min **

8) If rhythm does not spontaneously convert to sinus within 10 min:

   - ***Lidocaine*** 0.5-0.75 mg/kg slow IVP (N) over 2 min **

9) If patient becomes pulseless, go to **VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA PROTCOL**

10) If patient develops sign of altered mental status or hypoperfusion:
    - synchronized cardioversion (100J, 200J, 300J, 360J) *

11) If patient converts to sinus rhythm, start ***Lidocaine*** drip 2-4 mg/min

☐ Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

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* If possible, provide sedation with analgesia:
  - ***Versed*** 1-2mg IVP (N)
  - ***Morphine Sulfate*** 2-4mg IVP (N)

** Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

005145

NOV00303

VENTRICULAR FIBRILLATION/PULSELESS VENTRICULAR TACHYCARDIA

1) Establish pulselessness

2) Contact Delta Clinic or Detention Hospital and call "Code Blue"

3) EKG monitor

4) Defibrillate at 200J, 300J, 360J

5) CPR with BVM and 100% O2

6) Maintain airway utilizing ADVANCED AIRWAY PROTOCOL

7) Obtain venous access

8) ***Epinephrine*** 1:10,000 1mg IVP (N) or 2mg ETT (C)/(N) q 3-5min

9) Continue CPR

10) Defibrillate at 360J

11) ***Lidocaine*** 1-1.5mg/kg IVP (N) or 3mg/kg ETT (C)/(N) •

12) Continue CPR

13) Defibrillate at 360J

14) ***Lidocaine*** 1.5mg/kg IVP (N) or 3mg/kg ETT (C)/(N) • (maximum 3mg/kg)

15) Continue CPR

16) Defibrillate 360J

16) Continue "drug-shock" sequence with defibrillation every 30-60 seconds after drug administration

17) If spontaneous return of pulse, got to **POST RESUSCITATION PROTOCOL**

18) Continue to monitor, transport to clinic, and call MO ASAP for medical oversight

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• Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

005146

NOV00304

POST RESUSCITTATION

1) Assure ABC's

2) Assess heart rate:
   - if heart rate < 60 bpm, got to **BRADYCARDIA PROTOCOL**
   - if heart rate > 150, go to **NARROW or WIDE TACHYCARDIA PROTOCOL**

3) If patient is hypotensive and lung sounds are clear:
   - give 250ml NS bolus(s) to maintain SBP > 90 mmHg
   - consider ***Dopamine*** 5-10 mcg/kg/min to maintain SBP > 90 mmHg if unresponsive to fluid bolus(s)

4) If patient V-FIB or V-TACH during resuscitation:
   - give ***Lidocaine*** 1.5 mg/kg slow IVP (N) over 2 minutes (if not previously given) *
   - start ***Lidocaine*** drip at 2-4 mg/min

5) Continue to monitor, transport to clinic, and contact MO ASAP for medical oversight

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* Give ½ dose in patients with impaired liver function, left ventricular dysfunction or > 70 yo

STANDARD OPERATING PROCEDURES
Detention Hospital
Guantanamo Bay, Cuba

REVIEWED AND APPROVED BY:

_____ _____
Officer In Charge Date

IMPLEMENTED BY:

_____ _____
Director for Administration Date

_____ _____
Senior Enlisted Advisor Date

ANNUAL REVIEW LOG:

By:_____ Date:_____
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SOP NO:_____ Date:_____

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