

Resources



NO

I DON'T KNOW

YES

I feel / I am



sick



in pain / hurt



dizzy



hot



cold



diarrhoea



vomit



constipated



headache



burnt



bleeding



broken



seizure / fit



allergic



need more information



call someone



What are you doing?



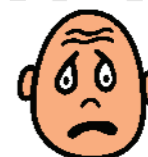
worried



sad / depressed



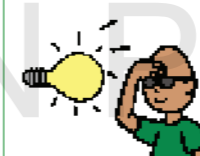
scared



too loud



too bright



homeless



that hurts



hungry



thirsty



no pain



1

slight pain



2

mild pain



3

moderate pain



4

moderate pain



5

moderate pain



6

severe pain



7

extreme pain



8

extreme pain



9

excruciating









10



SV0856

PARAMEDICS MIGHT...

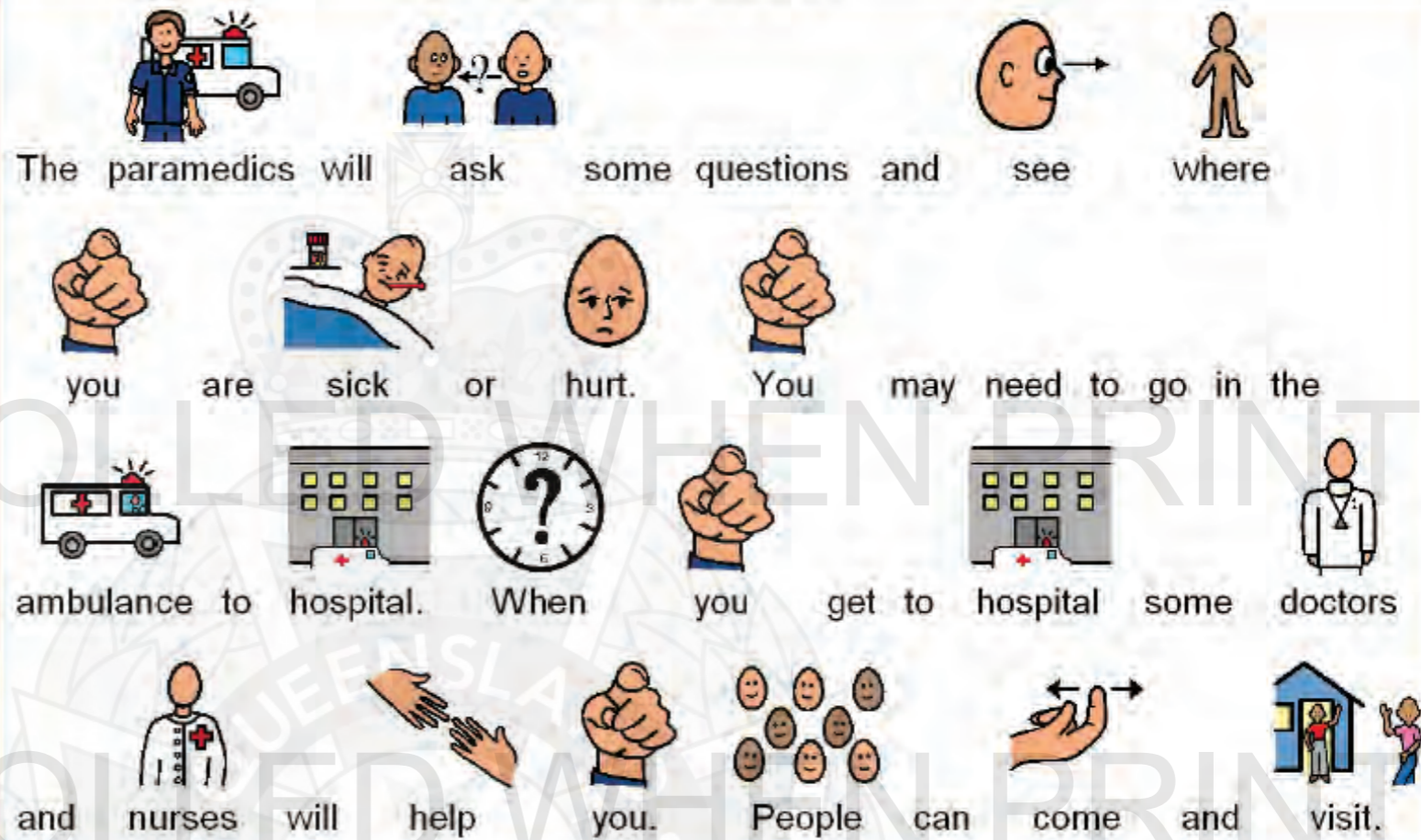
inhaler 	blood pressure 	take pulse 
take temperature 	oxygen 	stethoscope 
bandage 	medicine 	splint 
sling 	needle 	drip 

INTERACTION TIPS

1. ESTABLISH YES/NO
2. USE CALM VOICE
3. USE GESTURE & POINTING
4. REFER TO OBJECTS
5. USE FIRM TOUCH
6. SAY WHAT YOU'RE DOING
7. USE SHORT SENTENCES
8. SHOW ON YOURSELF OR SOMEONE ELSE FIRST

WHAT WILL HAPPEN?

The paramedics will ask some questions and see where you are sick or hurt. You may need to go in the ambulance to hospital. When you get to hospital some doctors and nurses will help you. People can come and visit.



please wait



please be still



please calm down



This communication board has been developed as a tool to enhance communication between Paramedics and patients. The development of this resource is a joint initiative between the **Department of Communities (Disability and Community Care Services)** and the **Queensland Ambulance Service**.



SV0856



FACT SHEETS



Wound care advice:
SUTURES



Wound care advice:
SKIN ADHESIVE



Wound care advice:
SKIN TEARS



Wound care advice:
GENERAL



Bereavement
Support Services



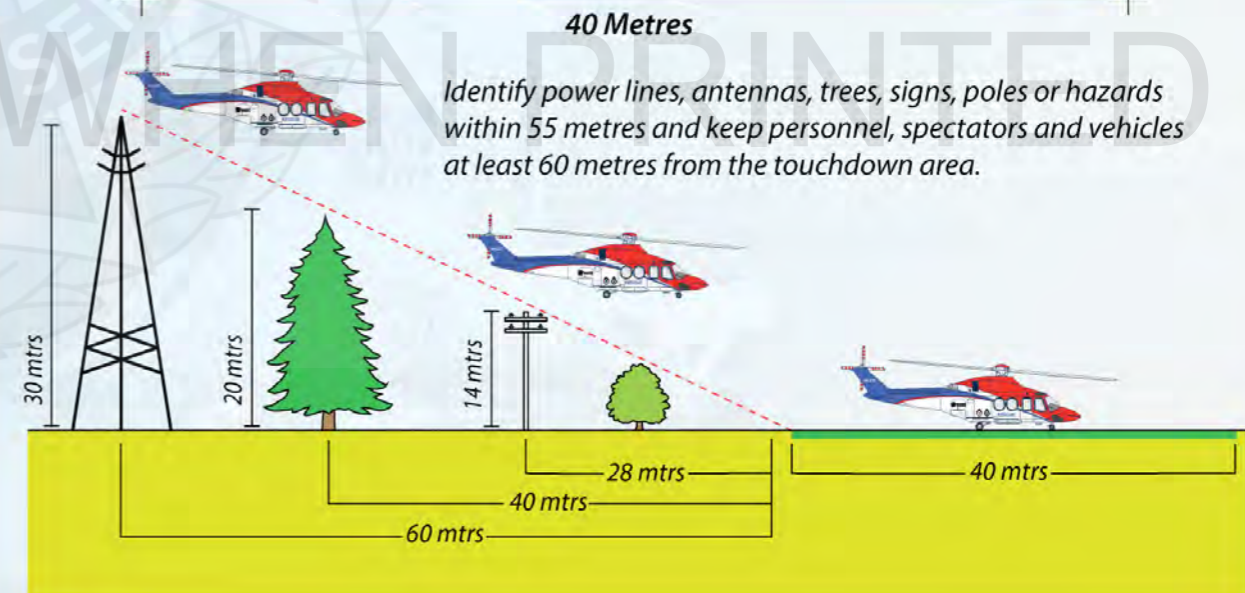
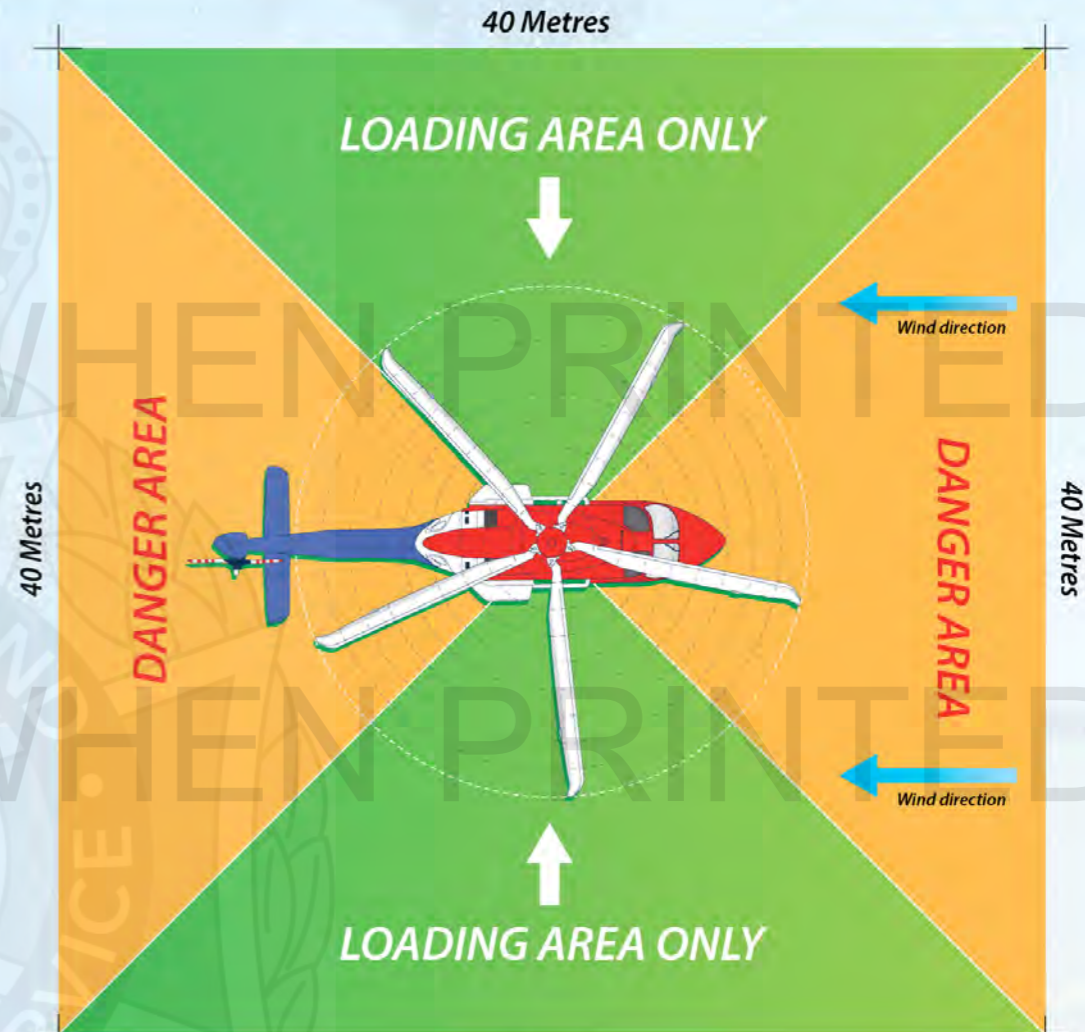
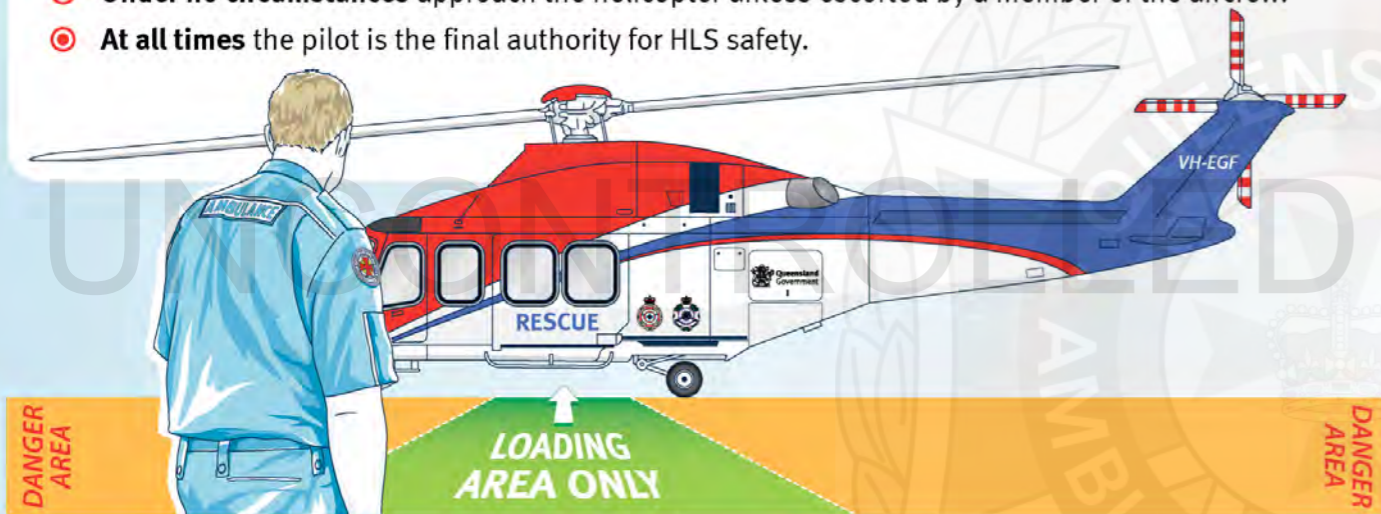
COVID-19



Establishing a Helicopter Landing Site (HLS)

'When in doubt, point it out'

- Identify an appropriate 40 x 40 metre HLS with a flat and firm surface.
- The HLS should be clear from all obstacles and debris (eg. powerlines, obscured trees stumps, livestock, bystanders and unsecured objects).
- Provide an accurate latitude and longitude to the relevant OpCen and obtain the correct aircraft frequency for ground to aircraft communications.
- Provide the OpCen/aircrew detailed information about the HLS, including any identified obstructions – *'when in doubt, point it out'*.
- All emergency services personnel must be wearing appropriate personal protective equipment (i.e. helmet, eye protection and hearing protection).
- Under no circumstances** approach the helicopter unless escorted by a member of the aircrew.
- At all times** the pilot is the final authority for HLS safety.





Manual Tasking Risk Assessments

Perform a clinical assessment prior to applying any Manual Tasking Strategies

Egress Test

Before attempting to walk a patient apply the Egress Test while the patient is still standing.

If the patient has any form of walking assist device (e.g. walking frame) allow them to use their device as they perform this test.

(The officer and patient do not move away from the the seated area until this test has been completed).

Do not walk patient if it is going to exacerbate their illness/injury.

- Demonstrate and then ask the patient to shift their weight from side to side – this reveals the patient’s balance and coordination.
- Demonstrate and then ask the patient to take a step forward with one foot and then return it and do the same with the other foot.
- When walking the patient allow some space between you and the patient so that you all can maintain a natural walking gait.
- **Single officer** – the officer should be positioned on the patient’s weakest side.

Key Points:

- Stay close to seated area.
- Be prepared to assist the patient from standing to sitting if they lose balance.
- Ensure space between the officer and the patient when walking to allow normal gait for all.



View corresponding video



Manual Tasking Risk Assessments

Perform a clinical assessment prior to applying any Manual Tasking Strategies

Patient Mobility Risk Assessment – Sitting Patient

Conducting a Patient Mobility Risk Assessment on a sitting patient establishes if the patient has the strength, balance and coordination to stand. It will also identify how much the patient will be able to assist you with their transfer. This will help you to determine the best technique to use, crew resource management requirements and any equipment you will require to perform the task and patient transfer safely.

It is unwise to try and stand a patient who can't weight bear reliably. These more dependent patients are likely to need another manual tasking method to transfer them safely, as they may not be able to assist much.

Check mobility and weight bearing status prior to standing or mobilising.

Assessing the patient's abilities prior to standing can prevent falls.

This technique can be done with 1 or 2 officers.

1. Leg Extension:

- Instruct the patient to lift one foot off the floor and, under control, straighten that leg until it is parallel to the ground and lower it under control – do not stand in front of the patient.
- Repeat the same test with the other leg.
- This demonstrates the patient's strength and control.

Key Points:

- Ensure the patient is able to do this movement in a controlled manner.

2. Seated Marching:

- Demonstrate and then instruct the patient to lift one foot then the other foot off the ground five times (marching on the spot). This gives you information about their leg strength, coordination and balance and hip flexors.

Key Points:

- Leg co-ordination.



Manual Tasking Risk Assessments

Perform a clinical assessment prior to applying any Manual Tasking Strategies

Patient Mobility Risk Assessment – Sitting Patient *(cont.)*

3. Partial stand:

- Instruct the patient to place their hands on the seat/handles of the chair, ensuring their feet are flat on the floor, and raise their buttocks slightly up off the chair. This tests trunk control and hip extensor strength, which is important for walking and standing.

Key Points:

- Hips elevated off chair.

4. Reaching outside base of support and balance:

- Holding your hand as a target, instruct the patient to lean forward, or to the side, to touch your hand. Be ready to steady them if they reach too far and lose their balance. Try to get them to move their trunk away from the support provided by the back of chair. This gives you information about the patient's trunk control and balance.

Key Points:

- Trunk must move away from the support of the chair.
- Aim to slightly lift one side of buttocks off the seat.
- Demonstrates the ability to move from their centre of gravity (core) and back in a controlled coordinated manner.



View corresponding video



Manual Tasking Risk Assessments

Perform a clinical assessment prior to applying any Manual Tasking Strategies

Patient Mobility Risk Assessment – Supine Patient

Conducting a Patient Mobility Risk Assessment establishes how much the patient is able to assist you prior to attempting to move or transfer the patient. This assists you to determine the best technique to use, crew resource management and any equipment you will require to perform the task safely.

It is unwise to try and stand a patient who can't weight bear or try to sit someone up if they have poor strength and trunk control. The more dependent patients need another method to transfer them safely.

These assessments also provide information about the patient's cognitive ability, understanding (including hearing) and willingness to cooperate.

This technique can be done with 1 or 2 officers.

Straight Leg Raise:

- Hold one hand above the patient's foot (approximately 30 cm) and ask them to raise their leg up until their toes touch your hand and then lower their leg to the ground.
- These movements need to be done in a controlled manner.
- Repeat with other leg.
- This provides you with information about the patient's leg and core strength. It also provides information on coordination.

Bridging:

- Ask the patient to bend their knees and place their feet flat on the floor/bed.
- Ask the patient to lift their hips up off the floor/bed. They are able to use their hands if they need to.
- This provides you with information about their trunk control and hip extensor strength, which is important for walking and standing.

Trunk Control:

- Holding your hand as a target, instruct the patient to reach across to touch your hand.
Ensure they move their trunk up and away from the support provided by the floor/bed by raising their shoulder when reaching.
- This provides you with information about the patient's trunk control and balance.

Head Control:

- Instruct the patient to lift their head up off the floor or pillow and touch their chin to their chest. There is no need to do this test if the patient has already demonstrated this movement while in your presence.
- This provides you with information about head control and whether the patient will require head support during transfers.
- This is essential for sitting a patient to ensure they have head control.



View corresponding video

Brisbane Emergency Departments located in Private Hospitals

Northern suburbs

- **Brisbane Northside Emergency** (Chermside)
- **Wesley Emergency** (Auchenflower)
- **St Andrew's Emergency** (Spring Hill)

Southern suburbs

- **Mater Emergency** (South Brisbane)
- **Greenslopes Emergency** (Greenslopes)

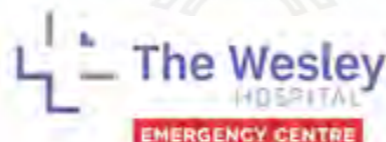
General information

- All of these facilities have high level care with **Coronary care** and **Intensive care** as well as a wide range of specialties.
- All of these facilities have an **out-of-pocket cost that is separate from Medicare**.
Health Insurance does not cover visits as they are outpatient facilities.

Information for patients

- At your request, paramedics will take you to one of the facilities listed above.
However, you are responsible for any out-of-pocket expenses.
- If you have concerns regarding costs, pre-arrival advice is available by phoning the facility. Paramedics can connect you through to any of these facilities via telephone.

This advice has
been prepared by
the ED Director Group



Gold Coast Emergency Departments

located in Private Hospitals

Northern Gold Coast

- **Pindara Private Hospital** (*Benowa*)
- **Gold Coast Private Hospital** (*Southport*)

Southern Gold Coast

- **John Flynn Private Hospital** (*Tugun*)

General information

- All these facilities have a high level of care with **Coronary care** and **Intensive care** as well as a wide range of specialities.
- All these facilities have an **out-of-pocket cost that is separate from Medicare**.
Health insurance does not cover visits as they are outpatient facilities.

Information for patients

- At your request, paramedics will take you to one of the facilities listed above.
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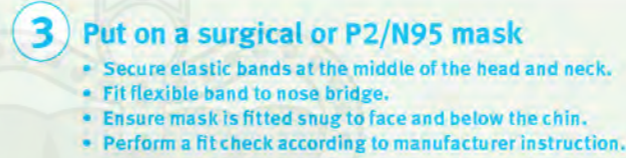
 **Pindara
Private Hospital**
Part of Ramsay Health Care
Ph: 0755 889 000

 **Gold Coast**
PRIVATE HOSPITAL
Ph: 0755 300 800

 **John Flynn
Private Hospital**
Part of Ramsay Health Care
Ph: 0755 989 001

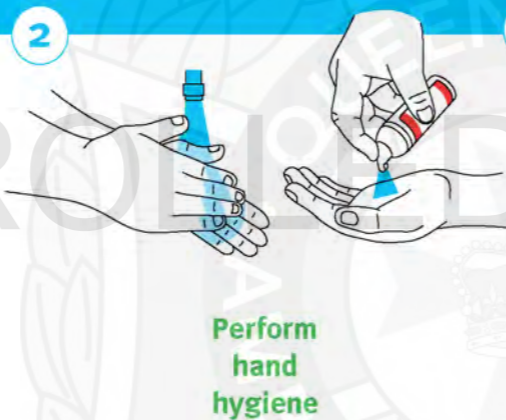
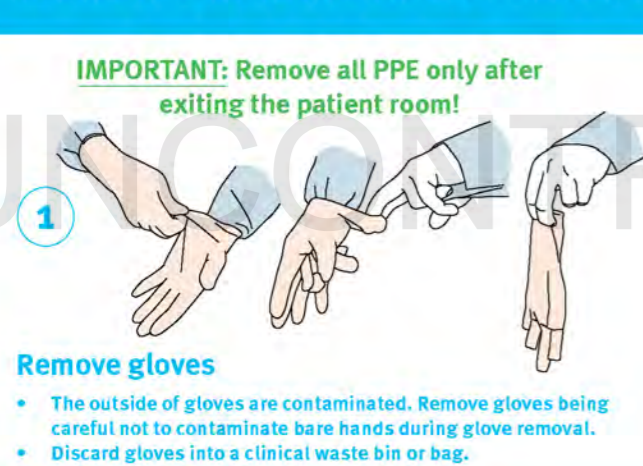
CORRECT PROCESS FOR DONNING PPE

IMPORTANT: Maintain standard precautions when donning and doffing PPE; when caring for suspected or confirmed cases of COVID-19



CORRECT PROCESS FOR DOFFING PPE

IMPORTANT: Remove all PPE only after exiting the patient room!



ADULT STANDARDISED DILUTIONS

Drug	Indication	Route	Stock Drug	Diluent	Final Volume	Syringe Size	Final concentration per 1mL
Adrenaline [Epinephrine] <i>(1 mg/1 mL = 1:1000)</i> <i>(1 mg/10 mL = 1:10 000)</i> <i>*Please be aware of multiple presentations of adrenaline injections*</i>	Cardiac arrest	IV/IO	1 mg/1 mL (1:1000)	N/A	1 mL	3 mL	1 mg/1 mL
	Anaphylaxis (or severe allergic reaction) Bronchospasm (severe life-threatening)	IM	1 mg/1 mL (1:1000)	N/A	1 mL	3 mL <i>VanishPoint®</i>	1 mg/1 mL
		IV/IO	1 mg/1 mL (1:1000)	9 mL NS	10 mL	10 mL	100 microg/1 mL
		IV/IO	1 mg/10 mL (1:10 000)	N/A	10mL	10mL	100 microg/ 1 mL
		IV/IO Infusion	3 mg/3 mL (1:1000)	47 mL NS	50 mL	50 mL	60 microg/1 mL
	Shock (unresponsive to adequate fluid resuscitation)	IV/IO	1 mg/1 mL (1:1000)	9 mL NS	10 mL	10 mL	100 microg/1 mL
		IV/IO	1mg /10 mL (1:10 000)	N/A	10 mL	10 mL	100 microg/1 mL
		IV/IO Infusion	3 mg/3 mL (1:1000)	47 mL NS	50 mL	50 mL	60 microg/1 mL
	Bradycardia (unresponsive to atropine)	IV/IO	1 mg/1 mL (1:1000)	9 mL NS	10 mL	10 mL	100 microg/1 mL
IV/IO		1mg/10 mL (1:10 000)	N/A	10mL	10 mL	100 microg/ 1mL	
Amiodarone <i>(150 mg/3 mL)</i>	Cardiac arrest (refractory VF or pulseless)	IV/IO	300 mg/6 mL	N/A	6 mL	10 mL	300 mg/6 mL
	Sustained conscious VT (haemodynamically stable)	IV Infusion	300 mg/6 mL	44 mL D5W	50 mL	50 mL	6 mg/1 mL
Atropine <i>(1.2 mg/1 mL)</i>	Bradycardia	IM	1.2 mg/1 mL	N/A	1 mL	3 mL <i>VanishPoint®</i>	1.2 mg/1 mL
	Envenomation						
	Hypersalivation	IV/IO	1.2mg/1 mL	N/A	1 mL	3mL	
	Organophosphate toxicity	IV Infusion	Required dose	NS up to 50 mL	50 mL	50 mL	N/A
Benztropine <i>(2 mg/2 mL)</i>	Acute Dystonic reaction	IM	2 mg/2 mL	N/A	2 mL	3 mL <i>VanishPoint®</i>	1 mg/1 mL
		IV	2 mg/2 mL	N/A	2 mL	3 mL	
Box Jellyfish Antivenom <i>(20 000 units/1.5-4 mL)</i>	Box Jellyfish Envenomation	IM	60 000 units	N/A	4.5-12 mL	3 mL <i>VanishPoint®</i> <small>(max. 2mL at each injection site x number required to deliver dose)</small>	N/A
	Box Jellyfish Envenomation in cardiac arrest	IV	20 000 units	N/A	1.5-4 mL	10 mL	N/A
Calcium Gluconate <i>(2.2 mmol/10 mL)</i>	Hyperkalaemia Calcium channel blocker toxicity Hypotension (secondary to Mg Infusion administration)	IV/IO	2.2 mmol/10mL	N/A	10 mL	10 mL	0.22 mmol/1 mL
Calcium Gluconate <i>(4.4 mmol/25 mL)</i>	PRBC (HARU only)	IV/IO	4.4 mmol/25mL	N/A	25 mL	PFS	N/A
Ceftriaxone <i>(1 g powder)</i>	Suspected meningococcal septicaemia	IM (2 x separate doses)	2 g	2 x 2.4 mL WFI/Lignocaine 1%	2 x 3 mL	2 x 3 mL <i>VanishPoint®</i>	333 mg/1 mL
		IV/IO	2 g	18.8 mL WFI	20 mL	30 mL <i>Springfusor®</i>	100 mg/1 mL
Droperidol <i>(10mg/2mL)</i>	Acute Behavioural Disturbance	IM	10 mg/2 mL	NA	2 mL	3 mL <i>VanishPoint®</i>	5 mg/1 mL
		IV	10 mg/2 mL		2 mL	3 mL	

D5W = Glucose 5%
NS = Normal saline/sodium chloride 0.9%
WFI = Water for Injection
PFS = Pre-filled syringe

ADULT STANDARDISED DILUTIONS

Drug	Indication	Route	Stock Drug	Diluent	Final Volume	Syringe Size	Final concentration per 1mL
Enoxaparin (60 mg/0.6 mL) (100 mg/1 mL)	STEMI	IV	60 mg	N/A	0.6 mL	PFS	100 mg/1 mL
			100 mg	N/A	1 mL		100 mg/1 mL
Fentanyl (100 mcg/2 mL)	Pain Autonomic dysreflexia	IV	100 microg/2 mL	8 mL NS	10 mL	10 mL	10 microg/1 mL
		IM	100 microg/2 mL	N/A	2 mL	3 mL VanishPoint®	50 microg/1 mL
			100 microg/2 mL		2 mL		
	Sedation	IV/IO	100 microg/2 mL	8 mL	10 mL	10 mL	10 microg/1 mL
	Induction for RSI	IV/IO	100 microg/2 mL	N/A	2 mL	3 mL	50 microg/1 mL
Glucagon (1 mg powder)	Hypoglycaemia Refractory Anaphylaxis	IM	1 mg	1 mL WFI	1 mL	3 mL VanishPoint®	1 mg/1 mL
		IV	1 mg		1 mL		
Heparin (5000 units/5 mL)	STEMI Critical care patients requiring anticoagulation (during interfacility transport)	IV	5000 units	N/A	5 mL	10 mL	1000 units/1 mL
		IV infusion	25 000 units/25 mL	25 mL NS	50 mL	50 mL	500 units/1 mL
Human Fibrinogen (RiaSTAP® 1g powder)	Suspected Traumatic Haemorrhage	IV infusion	1 g	50 mL WFI	1 g/50 mL	50 mL	20 mg/1 mL
Hydrocortisone (100 mg powder)	Asthma COPD Adrenal Insufficiency Allergy/anaphylaxis	IM	100 mg	2 mL (contained within vial)	2 mL	3 mL VanishPoint®	50 mg/1 mL
		IV	100 mg		2 mL		
Hydroxocobalamin (5 g - CYANOKIT®)	Life threatening cyanide toxicity	IV Infusion	5 g	2 x 100 mL NS bags	200 mL	2 x 100mL NS bags	25 mg/1 mL
Ketamine (200 mg/2 mL)	Severe Pain Induction for RSI	IV/IO	200 mg/2 mL	18 mL NS/WFI	20 mL	20 mL	10 mg/1 mL
	Acute Behavioural Disturbance	IM	200 mg/2 mL	N/A	2 mL	3 mL VanishPoint®	100 mg/1 mL
Levetiracetam (500 mg/5 mL)	Convulsive Status Epilepticus continuing > 20 mins post first midazolam dose	IV Infusion	500mg/5mL	1 x 100 mL NS bag	100 mL	1 x 100mL NS bag	Required dose in 100mL
		IV/IO Infusion	500mg/5mL	NS up to 50mL (in each syringe)	2 x 50 mL	2 x 50mL Syringe	Required dose divided between 2 x 50mL syringes
Lidocaine 1% (50 mg/5 mL)	Pain associated with IO	IO	60 mg/6 mL	N/A	6 mL	10 mL	10 mg/1 mL
	Local anaesthesia	SubCut	50 mg/5 mL	N/A	5 mL	10 mL	10 mg/1 mL
	Reconstitute ceftriaxone (for IM injection; see ceftriaxone)	IM	24 mg/2.4mL per 1g Ceftriaxone vial	N/A	2.4 mL	3 mL VanishPoint®	10 mg/1 mL
Magnesium Sulphate (10 mmol/5 mL)	Eclampsia	IV/IO	20 mmol/10 mL	10 mL NS	20 mL	30 mL Springfusor®	1 mmol/1 mL
	Irukandji syndrome (with intractable pain) Box Jellyfish envenomation (unresponsive to antivenom)	IV/IO	10 mmol/5 mL	15 mL NS	20 mL	30 mL Springfusor®	0.5 mmol/1 mL
	Asthma (Severe life-threatening requiring adrenaline)						
	Torsades de Pointes	IV/IO	10 mmol/5 mL	5 mL	10 mL	30 mL Springfusor®	1 mmol/1 mL

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PFS = Pre-filled syringe

ADULT STANDARDISED DILUTIONS

Drug	Indication	Route	Stock Drug	Diluent	Final Volume	Syringe Size	Final concentration per 1mL
Metaraminol (3 mg/6 mL)	Hypotension	IV/IO	3 mg/6mL	N/A	6 mL	10 mL	0.5 mg/1 mL
Midazolam (5 mg/1 mL)	Seizures Sedation	IV/IO	5 mg/1 mL	4 mL NS	5 mL	10 mL	1 mg/1 mL
		IM	5 mg/1 mL	N/A	1 mL	3 mL VanishPoint®	5 mg/1 mL
		NAS	5 mg/1 mL		1 mL	3 mL	
	Acute Behavioural Disturbance	IM	5 mg/1 mL	N/A	1 mL	3 mL VanishPoint®	5 mg/1 mL
		IV	5 mg/1 mL	N/A	1 mL	3 mL	
Morphine (10 mg/1 mL)	Pain	IV/IO	10 mg/1 mL	9 mL NS	10 mL	10 mL	1 mg/1 mL
	Sedation Autonomic dysreflexia	IM	10 mg/1 mL	N/A	1 mL	3 mL VanishPoint®	10 mg/1 mL
Naloxone (400 mcg/1 mL)	Respiratory depression	IM	400 microg/1 mL	N/A	1 mL	3 mL VanishPoint® <small>(max. 2mL at each injection site x number required to deliver dose)</small>	400 microg/1 mL
		IV	400 microg/1 mL	7 mL NS	8 mL	10 mL	50 microg/1 mL
Ondansetron 4mg dose (4 mg/2 mL)	Nausea and vomiting	IM	4 mg/2 mL	N/A	2 mL	3 mL VanishPoint®	2 mg/1 mL
		IV	4 mg/2 mL		2 mL	3 mL	
Ondansetron 8mg dose (4mg/2mL)	Nausea and Vomiting	IM (2 x separate doses)	4 mg/2 mL	N/A - use 2 x 4 mg/2 mL ampoules to achieve dose	2 x 2 mL	2 x 3 mL VanishPoint®	2mg / 1mL
		IV	4 mg/ 2mL		4 mL	5 mL	2 mg/ 1 mL
Oxytocin (10 units/1 mL)	Third stage of labour/ Prevention of PPH	IM	10 units/1 mL	N/A	1 mL	3 mL VanishPoint®	10 units/1 mL
	Management of PPH	IV	10 units/1 mL	9 mL NS	10 mL	10 mL	1 unit/1 mL
		IV INF	10 units/1 mL	19 mL NS	20 mL	20 mL	0.5 units/1 mL
Propofol (200 mg/20 mL)	Induction of Anaesthesia Sedation	IV	200 mg/20 mL	N/A	20 mL	20 mL	10 mg/1 mL
Rocuronium (50 mg/5 mL)	Facilitate paralysis Maintain paralysis	IV	50 mg/5 mL	N/A	5 mL	5 mL	10 mg/1 mL
Sodium bicarbonate (8.4% in 100 mL)	Cardiac Arrest TCA Poisoning Sodium Channel Blockade Hyperkalaemia	IV/IO	100 mL	N/A	100 mL	2 x 50mL syringe	(Equivalent to) 1 mmol/1 mL
Tenecteplase (50 mg powder)	STEMI	IV	50 mg	10 mL WFI PFS	10 mL	10 mL PFS	5 mg/1 mL
Tranexamic Acid (1 g/10 mL)	Traumatic injuries Management of uncontrolled PPH	IV/IO	1 g/10 mL	N/A	10 mL	10 mL	100 mg/1 mL
		IV Infusion	1 g/10 mL	100 mL	110 mL	100mL NS bag	~9.1 mg/1 mL
		IO Infusion	1 g/10 mL	N/A	10 mL	10 mL 30 mL Springfusor®	100 mg/1 mL

DSW = Glucose 5%
NS = Normal saline/sodium chloride 0.9%
WFI = Water for Injection
PFS = Pre-filled syringe

PAEDIATRIC STANDARDISED DILUTIONS

Drug	Indication	Route	Stock Drug	Diluent	Final Volume	Syringe Size	Final concentration per 1 mL
Adrenaline [Epinephrine] (1 mg/1 mL = 1:1000) (1 mg/10 mL = 1:10 000) *Please be aware of multiple presentations of adrenaline injections*	Cardiac arrest	IV/IO	1 mg/1 mL (1:1000)	Dilution 1: 9 mL NS	10 mL	10 mL	100 microg/1 mL (1:10 000)
				Dilution 2: 1 mL of dilution 1 + 9 mL NS	10 mL	10 mL	10 microg/1 mL (1:100 000)
		IV/IO	1 mg/10 mL (1:10 000)	1 mL of ampoule + 9 mL NS	10mL	10mL	10microg/ 1 mL (1:100 000)
	Anaphylaxis (or severe allergic reaction)	IM	1 mg/1 mL (1:1000)	N/A	1 mL	1 mL <i>VanishPoint</i> ®	1 mg/1 mL
	Bronchospasm (severe life-threatening)	IV/IO INF	3 mg/3 mL (1:1000)	47 mL NS	50 mL	50 mL	60 microg/1 mL
	Shock (unresponsive to adequate fluid resuscitation)	IV/IO INF	3 mg/3 mL (1:1000)	47 mL NS	50 mL	50 mL	60 microg/1 mL
	Bradycardia (unresponsive to atropine)	IV/IO	1 mg/1 mL (1:1000)	Dilution 1: 9 mL NS	10 mL	10 mL	100 microg/1 mL (1:10 000)
Dilution 2: 1 mL of dilution 1 + 9 mL NS				10 mL	10 mL	10 microg/1 mL (1:100 000)	
IV/IO		1 mg/10 mL (1:10 000)	1mL of ampoule + 9mL of NS	10mL	10mL	10 microg/ 1 mL (1:100 000)	
Amiodarone (150 mg/3 mL)	Cardiac arrest (refractory VF or pulseless VT)	IV/IO	150 mg/3mL	12 mL D5W	15 mL	20 mL	10 mg/1 mL
Atropine (1.2 mg/1 mL)	Bradycardia	IV/IO	1.2 mg/1 mL	11 mL NS	12 mL	10 mL	100 microg/1 mL
	Envenomation Organophosphate toxicity Hypersalivation	IM	1.2 mg/1 mL	N/A	1 mL	3 mL <i>VanishPoint</i> ®	1.2 mg/1 mL
Benztropine (2 mg/2 mL)	Acute Dystonic reaction	IV	2 mg/2 mL	8 mL NS	10 mL	10 mL	200 microg/1 mL
		IM	2 mg/2 mL	N/A	2 mL	3 mL <i>Vanishpoint</i> ®	1 mg/1 mL
Box Jellyfish Antivenom (20 000 units/1.5-4 mL)	Box Jellyfish Envenomation	IM	60 000 units	N/A	4.5-12 mL	3 mL <i>VanishPoint</i> ® (max. 2mL at each injection site x number required to deliver dose)	N/A
	Box Jellyfish Envenomation in cardiac arrest	IV	20 000 units	N/A	1.5-4 mL	10 mL	N/A
Calcium Gluconate (2.2 mmol/10 mL)	Hyperkalaemia Calcium channel blocker toxicity Hypotension (secondary to Mg Infusion administration)	IV/IO	2.2 mmol/10 mL	N/A	10 mL	10 mL	0.22 mmol/1 mL

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 NS = Normal saline/sodium chloride 0.9%
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PAEDIATRIC STANDARDISED DILUTIONS

Drug	Indication	Route	Stock Drug	Diluent	Final Volume	Syringe Size	Final concentration per 1 mL
Calcium Gluconate (4.4 mmol/25 mL)	PRBC (HARU only)	IV/IO	4.4 mmol/25mL	N/A	Varies based on dose required	PFS	N/A
Ceftriaxone (1 g powder)	Suspected meningococcal septicaemia	IM	1 g	2.4 mL WFI or Lignocaine 1%	3 mL	3 mL VanishPoint®	333 mg/1 mL
		IV/IO	<u>Less than 20kg:</u> (approx. younger than 4 yrs) 1 g	9.4 mL WFI	10 mL	10 mL	100 mg/1 mL
		IV/IO	<u>Greater than 20kg:</u> (approx. older than 4 yrs) 2 g	18.8 mL WFI	20 mL	20 mL	100 mg/1 mL
Droperidol (10 mg/2 mL)	Acute Behavioural Disturbance	IM	10 mg/2 mL	N/A	2 mL	3 mL VanishPoint®	5 mg/1 mL
		IV	10 mg/2 mL	8 mL NS	10 mL	10 mL	1 mg/1 mL
Fentanyl (100 microg/2 mL)	Pain Sedation	IM	100 microg/2 mL	N/A	2 mL	3 mL VanishPoint®	50 microg/1 mL
		IV/IO	100 microg/2 mL	8 mL NS	10 mL	10 mL	10 microg/1 mL
		NAS	100 microg/2 mL	N/A	2 mL	1 mL/3 mL	50 microg/1 mL
	Induction for RSI (on Clinical Consult & Advice ONLY)	IV/IO	100 microg	8 mL NS	10 mL	10 mL	10 microg/1 mL
Glucagon (1 mg powder)	Symptomatic Hypoglycaemia Refractory Anaphylaxis (with persistent hypotension/shock)	IM/IV	1 mg	1 mL WFI	1mL	1 mL (VanishPoint® for IM)	1 mg/1 mL
Hydrocortisone (100 mg powder)	Asthma COPD	IV	100 mg	2 mL (contained within vial)	2 mL	3 mL	50 mg/1 mL
	Adrenal Insufficiency Allergy/anaphylaxis	IM	100 mg		2 mL	3 mL VanishPoint®	

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PAEDIATRIC STANDARDISED DILUTIONS

Drug	Indication	Route	Stock Drug	Diluent	Final Volume	Syringe Size	Final concentration per 1 mL
Ketamine (200 mg/2 mL)	Severe Pain	IV (2 dilutions required)	200 mg/2 mL	Dilution 1: 18 mL NS/WFI	Dilution 1: 20 mL	20 mL	Dilution 1: 10 mg/1 mL
				Dilution 2: 2 mL of dilution 1 + 18 mL NS	Dilution 2: 20 mL	20 mL	Final Concentration: 1 mg/1 mL
	Induction of Anaesthesia	IV/IO	200 mg/2 mL	18 mL NS	20 mL	20 mL	10 mg/1 mL
	Acute Behavioural Disturbance (12-15 yrs old; on Clinical Consult & Advice ONLY)	IM	200 mg/2 mL	N/A	2 mL	1 mL/3 mL VanishPoint®	100 mg/1 mL
Levetiracetam (500 mg/5 mL)	Convulsive Status Epilepticus continuing >20 mins post first midazolam administration	IV/IO	500 mg/5 mL	Equal volume to dose of NS (to a total minimum of 10 mL)	Minimum of 10 mL total	50 mL	Varies based on dose required
Lidocaine 1% (50 mg/5 mL)	Pain associated with IO	IO	60 mg/6 mL	N/A	6 mL	10 mL	10 mg/1 mL
	Local Anaesthesia	SubCut	50 mg/5 mL	N/A	5 mL	10 mL	10 mg/1 mL
	Reconstitute Ceftriaxone (for IM injection; see ceftriaxone)	IM	24 mg/2.4mL per 1g Ceftriaxone vial	N/A	2.4 mL	3 mL VanishPoint®	10 mg/1 mL
Magnesium Sulphate (10 mmol/5 mL)	Box Jellyfish envenomation (unresponsive to antivenom; IO for this indication on Clinical Consult & Advice ONLY) Irukandji Syndrome (with intractable pain; IO for this indication on Clinical Consult & Advice ONLY)	IV/IO	10 mmol/5 mL	0.1 mmol/kg dose (rounded up to nearest 0.5 mmol) + NS up to 15 mL	15 mL	30 mL Springfusor®	0.1 mmol/kg/15 mL
	Torsades de Pointes Asthma (Severe life-threatening requiring adrenaline)	IV/IO	10 mmol/5 mL	0.1 mmol/kg dose (rounded up to nearest 0.5 mmol) + NS up to 10 mL	10 mL	30 mL Springfusor®	0.1 mmol/kg/10 mL
Midazolam (5 mg/1 mL)	Seizures	IM	5 mg/1 mL	N/A	1 mL	1 mL VanishPoint®	5 mg/1 mL
	Acute Behavioural Disturbance Sedation	IV/IO	5 mg/1 mL	4 mL NS	5 mL	10 mL	1 mg/1 mL

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PAEDIATRIC STANDARDISED DILUTIONS

Drug	Indication	Route	Stock Drug	Diluent	Final Volume	Syringe Size	Final concentration per 1 mL
Morphine (10 mg/1 mL)	Pain Sedation	IM	10 mg/1 mL	N/A	1 mL	1 mL/3 mL VanishPoint®	10 mg/1 mL
	Pain Autonomic dysreflexia	IV/IO	10 mg/1 mL	9 mL NS	10 mL	10 mL	1 mg/1 mL
Naloxone (400 microg/1 mL)	Respiratory depression	IM	400 microg/1 mL	N/A	1 mL	3 mL	400 microg/1 mL
Ondansetron (4 mg/2 mL)	Nausea and vomiting	IM	4 mg/2 mL	N/A	2 mL	3 mL	2 mg/1 mL
		IV	4 mg/2 mL	6 mL NS	8 mL	10 mL	0.5 mg/1 mL
Propofol (200 mg/20 mL)	Induction of Anaesthesia <i>(on Clinical Consult & Advice ONLY)</i>	IV	200 mg/20 mL	N/A	20 mL	20 mL	10 mg/1 mL
Rocuronium (50 mg/5 mL)	Facilitate paralysis Maintain paralysis <i>(on Clinical Consult & Advice ONLY)</i>	IV	50 mg/5 mL	N/A	5 mL	10 mL	10 mg/1 mL
Sodium bicarbonate (8.4% in 100 mL)	Cardiac Arrest Crush syndrome Hyperkalaemia	IV/IO	100 mL	N/A	100 mL	50 mL	(Equivalent to) 1 mmol/1 mL
Tranexamic Acid (1 g/10 mL)	Traumatic injuries <i>(on Clinical Consult & Advice ONLY)</i>	IV/IO	On consult Draw up required dose (15 mg/kg)	Dilute to 10 mL NS	10 mL	10 mL	N/A

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