MEMORANDUM

TO: **Ontario Paramedics**

FROM: **Ontario Base Hospital Group Education Subcommittee (OBHG ESC)**

DATE: **May 26, 2025**

RE: **Advanced Life Support Patient Care Standards (ALS PCS) Version 5.4 Update — Impact on Clinical Practice and Educational Summary**

On June 2, 2025, version 5.4 of the ALS PCS will be put into force by the Ministry of Health (MOH). This communication memo will focus on the impact of the changes to clinical practice and patient care within the ALS PCS v.5.4 utilized by Ontario paramedics. It is the responsibility of the paramedic to ensure they have reviewed all aspects of the ALS PCS and medical directives in their entirety.

CONTENTS

PREAMBLE

Controlled Substances

This new section has been added to the Preamble and ensures provincial compliance pursuant to subsection 56(1) of the Controlled Drugs and Substances Act (CDSA). The section outlines how paramedics are required to count controlled substances, as well as the requirements for storage and transport of controlled substances.

CORE MEDICAL DIRECTIVES

PCP/ACP Advanced Airway and Tracheostomy Suctioning & Reinsertion

*previously named **PCP/ACP Endotracheal and Tracheostomy Suctioning & Reinsertion**

- This Medical Directive's name has been changed to include all advanced airways
- Indications have been edited to include SGA with gastric suction port
- Suctioning through the SGA gastric port (if available) has been added to the directive

INDICATIONS (REVISED)

Current (v5.4)	Previous (v5.3)
Patient with endotracheal, SGA (with gastric suction port) or tracheostomy tube. **AND** Airway obstruction or increased secretions.	Patient with endotracheal or tracheostomy tube. **AND** Airway obstruction or increased secretions.

CONDITIONS (NEW)

Suctioning through the SGA Gastric Port (if available)	
Age	N/A
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	Known or suspected gastric secretions or emesis following placement of SGA Persistent difficult ventilation despite other efforts to improve ventilation

PCP/ACP Advanced Airway and Tracheostomy Suctioning & Reinsertion (con't)

CONTRAINDICATIONS (NEW)

Suctioning through the SGA Gastric Port (if available)
N/A

TREATMENT (NEW) - PCP ONLY

Consider Suctioning through the SGA Gastric Port (if available)			
Age	< 1 year	≥ 1 to < 12 years	≥ 12 years
Dose	Suction at 60-100 mmHg	Suction at 100-120 mmHg	Suction at 100-150 mmHg
Max. single dose	Until fluid disappears or after 15 seconds of no fluid return		
Dosing interval	N/A		
Max. # of doses	N/A		

TREATMENT (NEW) - ACP ONLY

Consider Suctioning through the SGA Gastric Port (if available)			
Age	< 1 year	≥ 1 to < 12 years	≥ 12 years
Dose	Suction at 60-100 mmHg	Suction at 100-120 mmHg	Suction at 100-150 mmHg
Max. single dose	N/A		
Dosing interval	N/A		

CLINICAL CONSIDERATIONS (NEW)

Suctioning of SGA with gastric suction port:
When gastric secretions are not evident, consider other causes of difficult ventilation (e.g., improper device size, incorrect depth, lack of posterior/inferior pressure, or airway obstruction) prior to attempting SGA suctioning. Once fluid clears or if no fluid appears after 15 seconds, turn off suction.

PCP/ACP Medical Cardiac Arrest

- The treatment of Cardiopulmonary Resuscitation (CPR) has been removed from the ALS PCS as it is included in the BLS PCS, under the Cardiac Arrest Standard, in accordance with the current *Heart and Stroke Foundation of Canada Guidelines.* Paramedics are expected to perform CPR in the setting of cardiac arrest..
- The primary clinical considerations were edited to remove redundant items. This previous list is now encompassed in the phrase "known reversible cause of the arrest unable to be addressed".
- Double Sequential External Defibrillation (DSED) and Vector Change Defibrillation (VCD) have been added to the directive to reflect ILCOR's latest recommended treatment of refractory VF/pulseless VT. DSED will exist as an auxiliary component of the Medical Directive. In situations where one is not trained/authorized in DSED or where DSED is not available (i.e. less than 2 cardiac monitors on scene), VCD is to be utilized.
- The wording for lidocaine and amiodarone has been revised to eliminate redundancy. Treatment protocols remain unchanged.
- Revisions have been made to the conditions for AED or SAED defibrillation to eliminate redundancy.
- Medical TOR Contraindications have been edited to eliminate redundancy.
- Mandatory Patch Point has been restructured for clarification purposes.

PRIMARY CLINICAL CONSIDERATION(S) (REVISED) PCP ONLY

Current (v5.4)	**Previous (v5.3)**
In the following settings, consider very early transport after a minimum of one analysis (and defibrillation if indicated) once an egress plan is organized: 1. pregnancy presumed to be ≥ 20 weeks gestation (fundus at or above umbilicus, ensure manual displacement of uterus to left); 2. known reversible cause of the arrest unable to be addressed. For patients in refractory VF or pulseless VT, consider: 1. Double sequential external defibrillation (DSED) if authorized, OR 2. Vector change defibrillation (VCD) if DSED is unavailable or not authorized, AND 3. Transport following three (3) doses of DSED or VCD. Refractory VF or pulseless VT is defined for the purpose of this directive, as persistent VF or pulseless VT after 3 consecutive shocks.	In the following settings, consider very early transport after a minimum of one analysis (and defibrillation if indicated) once an egress plan is organized: 1. pregnancy presumed to be ≥ 20 weeks gestation (fundus above umbilicus, ensure manual displacement of uterus to left); 2. hypothermia; 3. airway obstruction; 4. non-opioid drug overdose/toxicology, or; 5. other known reversible cause of arrest not addressed. For patients in refractory VF or pulseless VT, transport of the patient should begin after the third consecutive shock. Refractory VF or pulseless VT is defined for the purpose of this directive, as persistent VF or pulseless VT after 3 consecutive shocks.

PCP/ACP Medical Cardiac Arrest (con't)

PRIMARY CLINICAL CONSIDERATION(S) (REVISED) – ACP ONLY

Current (v5.4)	Previous (v5.3)
In the following settings, consider very early transport after a minimum of one analysis (and defibrillation if indicated) once an egress plan is organized: 1. pregnancy presumed to be ≥ 20 weeks gestation (fundus at or above umbilicus, ensure manual displacement of uterus to left); 2. known reversible cause of the arrest unable to be addressed. For patients in refractory VF or pulseless VT, consider: 1. Double sequential external defibrillation (DSED) if authorized, OR 2. Vector change defibrillation (VCD) if DSED is unavailable or not authorized, AND 3. Transport following three (3) doses of DSED or VCD and three (3) rounds of epinephrine if they remain in VF or pulseless VT (or after 3rd consecutive defibrillation if no IV/IO/CVAD/ETT access). Refractory VF or pulseless VT is defined for the purpose of this directive, as persistent VF or pulseless VT after 3 consecutive shocks.	In the following settings, consider very early transport after a minimum of one analysis (and defibrillation if indicated) once an egress plan is organized: 1. pregnancy presumed to be ≥ 20 weeks gestation (fundus above umbilicus, ensure manual displacement of uterus to left); 2. hypothermia; 3. airway obstruction; 4. non-opioid drug overdose/toxicology, or; 5. other known reversible cause of arrest not addressed. For patients in refractory VF or pulseless VT, transport following 3 rounds of epinephrine (or after 3rd consecutive defibrillation if no IV/IO/CVAD/ETT access). Refractory VF or pulseless VT is defined for the purpose of this directive, as persistent VF or pulseless VT after 3 consecutive shocks.

CONDITIONS (REVISED)

AED or SAED Defibrillation		
	Current	**Previous**
Age	≥ 24 hours	≥ 24 hours
LOA	Altered	Altered
HR	N/A	N/A
RR	N/A	N/A
SBP	N/A	N/A
Other	Defibrillation indicated	Defibrillation indicated if not using manual defibrillation

PCP/ACP Medical Cardiac Arrest (con't)

CONDITIONS (NEW)

DSED or VCD	
Age	≥ 18 years
LOA	Altered
HR	N/A
RR	N/A
SBP	N/A
Other	Non-traumatic VF/pulseless VT of presumed cardiac origin Three consecutive standard shocks by Paramedics or Fire Services

CONDITIONS (REVISED) – ACP ONLY

Amiodarone		
	Current (v5.4)	**Previous (v5.3)**
Age	≥ 24 hours	≥ 24 hours
LOA	Altered	Altered
HR	N/A	N/A
RR	N/A	N/A
SBP	N/A	N/A
Other	VF OR pulseless VT	VF or pulseless VT as an equivalent to lidocaine

CONDITIONS (REVISED) – ACP ONLY

Lidocaine		
	Current (v5.4)	**Previous (v5.3)**
Age	≥ 24 hours	≥ 24 hours
LOA	Altered	Altered
HR	N/A	N/A
RR	N/A	N/A
SBP	N/A	N/A
Other	VF OR pulseless VT	VF or pulseless VT as an equivalent to amiodarone

CONTRAINDICATIONS (REVISED)

Medical TOR	
Current (v5.4)	**Previous (v5.3)**
Pregnancy presumed to be ≥ 20 weeks gestation. Suspected hypothermia. Airway obstruction. Non-opioid drug overdose/toxicology.	Known reversible cause of the arrest unable to be addressed. Pregnancy presumed to be ≥ 20 weeks gestation. Suspected hypothermia. Airway obstruction. Non-opioid drug overdose/toxicology.

PCP/ACP Medical Cardiac Arrest (con't)

TREATMENT (NEW)

Consider DSED (if authorized) or VCD (if DSED is not available or authorized)	
Age	≥ 18 years
Dose	1 DSED or VCD
Max. single dose	As per RBHP/manufacturer
Dosing interval	2 min
Max. # of doses	N/A

TREATMENT (REVISED) – ACP ONLY

Amiodarone	
Current (v5.4)	**Previous (v5.3)**
Consider amiodarone (if not using lidocaine)	Consider amiodarone

MANDATORY PROVINCIAL PATCH POINT (REVISED)

Current (v5.4)	Previous (v5.3)
Patch to consider Medical TOR (if applicable). Patch early to consider TOR if there are extenuating circumstances or where the paramedic considers ongoing resuscitation to be futile. If the patch fails, and/or, no ROSC after 20 minutes of resuscitation, initiate transport.	Patch to consider Medical TOR (if applicable). If the patch fails or if Medical TOR does not apply, transport to the closest appropriate hospital following ROSC or 20 minutes of resuscitation without ROSC. Patch early (e.g. following the 4th analysis) to consider TOR if there are extenuating circumstances; surrounding egress, prolonged transport or significant clinical limitations where the paramedic considers ongoing resuscitation to be futile.

CLINICAL CONSIDERATIONS (REVISED) – PCP ONLY

Current (v5.4)	Previous (v5.3)
The BHP might not authorize TOR even though the patient meets TOR rule. Factors may include: location of the patient, EtCO2, age, bystander witnessed, bystander CPR, transportation time, and unusual cause of cardiac arrest such as electrocution, hanging, and toxicology. DSED/VCD: The second defibrillator for Dual Sequential Defibrillation will be a paramedic service defibrillator or a fire service defibrillator (in order of preference and if agreed to by the fire service). If a second defibrillator is not available, Vector Change Defibrillation should be provided.	Consider regional base hospital advanced airway strategy (e.g. SGA Medical Directive) where more than OPA/NPA and BVM is required. There is no clear role for routine administration of naloxone in confirmed cardiac arrest. The BHP might not authorize TOR even though the patient meets TOR rule. Factors may include: location of the patients, EtCO2, age, bystander witnessed, bystander CPR, transportation time, and unusual cause of cardiac arrest such as electrocution, hanging, and toxicology. The BHP may authorize TOR even though the patient does not meet the TOR rule. Factors that may be taken into account include extenuating egress limitations, prolonged transport, caregiver wishes, existence of DNR confirmation form, and underlying end stage progressive illness.

PCP/ACP Medical Cardiac Arrest (con't)

CLINICAL CONSIDERATIONS (REVISED) – ACP ONLY

Current (v5.4)	Previous (v5.3)
The IV/IO/CVAD routes of medication administration are preferred over the ETT route. However, ETT administration may be used if the IV/IO/CVAD routes are delayed (e.g. ≥ 5 min). The BHP might not authorize TOR even though the patient meets TOR rule. Factors may include: location of the patients, EtCO2, age, bystander witnessed, bystander CPR, transportation time, and unusual cause of cardiac arrest such as electrocution, hanging, and toxicology. DSED/VCD: The second defibrillator for Dual Sequential Defibrillation will be a paramedic service defibrillator or a fire service defibrillator (in order of preference and if agreed to by the fire service). If a second defibrillator is not available, Vector Change Defibrillation should be provided.	Consider regional base hospital program advanced airway strategy where more than OPA/NPA and BVM is required. There is no clear role for routine administration of naloxone in confirmed cardiac arrest. The IV/IO/CVAD routes of medication administration are preferred over the ETT route. However, ETT administration may be used if the IV/IO/CVAD routes are delayed (e.g. ≥ 5 min). The BHP might not authorize TOR even though the patient meets TOR rule. Factors may include: location of the patients, EtCO2, age, bystander witnessed, bystander CPR, transportation time, and unusual cause of cardiac arrest such as electrocution, hanging, and toxicology. The BHP may authorize TOR even though the patient does not meet the TOR rule. Factors that may be taken into account include extenuating egress limitations, prolonged transport, caregiver wishes, existence of DNR confirmation form, and underlying end stage progressive illness.

PCP/ACP Analgesia

- SBP parameters changed to N/A for both ketorolac and fentaNYL. Note that morphine still has a SBP requirement of normotension.
- ACP only - Ketamine has been added as a treatment option. To avoid side effects, Ketamine should be administered as a slow push over 2 to 3 minutes. Similar to fentaNYL and morphine, Ketamine requires a patch, but for all patients less than 18 years of age.
- ACP only – Clinical considerations have been edited to clarify the sequential administration of narcotics and ketamine.
- While the drug monograph states ketamine should be administered IV/IM, the OBHG MAC has approved it to be administered off-label via the intranasal route.

CONDITIONS (REVISED)

Ketorolac		
	Current (v5.4)	**Previous (v5.3)**
Age	≥ 12 years	≥ 12 years
LOA	Unaltered	Unaltered
HR	N/A	N/A
RR	N/A	N/A
SBP	N/A	Normotension
Other	N/A	N/A

CONDITIONS (REVISED) – ACP ONLY

FentaNYL		
	Current (v5.4)	**Previous (v5.3)**
Age	≥ 1 years	≥ 1 years
LOA	Unaltered	Unaltered
HR	N/A	N/A
RR	N/A	N/A
SBP	N/A	Normotension
Other	N/A	N/A

CONDITIONS (NEW) – ACP ONLY

Ketamine	
Age	≥ 1 year
LOA	Unaltered
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

PCP/ACP Analgesia (con't)

CONTRAINDICATIONS (NEW) – ACP ONLY

Ketamine
Allergy or sensitivity to ketamine
Treatment of headache
Treatment of chronic pain
Suspected Ischemic chest pain
Active labour

TREATMENT (NEW) – ACP ONLY

Consider ketamine				
Age	≥ 1 year to < 18 years		≥ 18 years	
Route	IV	IN	IV	IN
Dose	0.25 mg/kg	1 mg/kg	0.25 mg/kg	1 mg/kg
Max. single dose	10 mg	30 mg	20 mg	75 mg
Dosing interval	15 min		15 min	
Max. # of doses	2		2	

CLINICAL CONSIDERATIONS (REVISED) – ACP ONLY

Current (v5.4)	**Previous (v5.3)**
Administration of morphine or fentaNYL and ketamine must be sequential, not co-administered. The dosing interval must be no earlier than the most recently administered medication dosing interval. When higher doses of morphine (5-10 mg) or fentaNYL (50-75 mcg) are given intravenously, consider administering medication in small aliquots q 3 minutes until desired effect or max. single dose is reached to avoid nausea and vomiting.	Whenever possible, consider co-administration of acetaminophen and ibuprofen. Suspected renal colic patients should routinely be considered for NSAIDs, either ibuprofen or ketorolac, and morphine or fentaNYL. Exercise caution when using narcotics in opioid naïve patients and patients ≥ 65 years old as they may be more sensitive to dosages. When higher doses of morphine (5-10 mg) or fentaNYL (50-75 mcg) are given intravenously, consider administering medication in small aliquots q 3 minutes until desired effect or max. single dose is reached to avoid nausea and vomiting. FentaNYL should not be used in combination with morphine unless authorized by BHP. The maximum volume of fentaNYL that may be administered IN is 1 mL per nare.

PCP/ACP Nausea and Vomiting

- The addition of IM and IV administration routes for ondansetron has been included when the formulation is available and the paramedic is authorized to administer it via these routes.
- DimenhyDRINATE can now be administered to patients ≥ 65 years old when ondansetron is unavailable. If ondansetron is unavailable, an initial reduced dose of 25 mg of dimenhyDRINATE can be administered to this patient population if the benefits outweigh the risks. Risks of administering dimenhyDRINATE to elderly patients include sedation, precipitated delirium, and interactions with other anticholinergic/sedating medications. These can all negatively impact the patient's ability to be properly assessed and diagnosed.
- Clinical considerations have been simplified to address the use of multiple antiemetic agents.

TREATMENT (REVISED)

Ondansetron		
	Current (v5.4)	**Previous (v5.3)**
Weight	≥ 25 kg	≥ 25 kg
Route	PO/ IV*/IM*	PO
Dose	4 mg	4 mg
Max. single dose	4 mg	4 mg
Dosing interval	N/A	N/A
Max. # of doses	1	1

*IV/IM (if formulation is available and authorized)

TREATMENT (REVISED)

DimenhyDRINATE				
	Current (v5.4)		**Previous (v5.3)**	
Weight	≥ 25 kg to < 50 kg	≥ 50 kg	≥ 25 kg to < 50 kg	≥ 50 kg
Route	IV/IM	IV/IM	IV/IM	IV/IM
Dose	25 mg	**25 mg or 50 mg	25 mg	50 mg
Max. single dose	25 mg	50 mg	25 mg	50 mg
Dosing interval	N/A	30 min	N/A	N/A
Max. # of dose	1	2	1	1
Max. Cumulative dose	N/A	50 mg	-	–

**If ondansetron is unavailable, assess the risks and benefits to patients≥65 years old for dimenhyDRINATE administration. This may include an initial reduced dose of 25 mg.

PCP/ACP Nausea and Vomiting (con't)

CLINICAL CONSIDERATIONS (REVISED) - PCP ONLY

Current (v5.4)	Previous (v5.3)
IV administration of dimenhyDRINATE and ondansetron applies only to PCPs authorized for PCP Autonomous IV. Prior to IV administration, dilute dimenhyDRINATE (concentration of 50 mg/1 ml) 1:9 with Normal Saline or D5W. If administered IM do not dilute. If a patient has received an antiemetic and has no relief of their nausea & vomiting symptoms after 30 minutes, the alternative antiemetic may be considered.	IV administration of dimenhyDRINATE applies only to PCPs authorized for PCP Autonomous IV. Prior to IV administration, dilute dimenhyDRINATE (concentration of 50 mg/1 ml) 1:9 with Normal Saline or D5W. If administered IM do not dilute. If a patient has received Ondansetron and has no relief of their nausea & vomiting symptoms after 30 minutes, dimenhyDRINATE may be considered (or vise versa). DimenhyDRINATE can be used in patients ≥ 65 if ondansetron is not unavailable.

CLINICAL CONSIDERATIONS (REVISED) - ACP ONLY

Current (v5.4)	Previous (v5.3)
Prior to IV administration, dilute dimenhyDRINATE (concentration of 50 mg/1 ml) 1:9 with Normal Saline or D5W. If administered IM do not dilute. If a patient has received an antiemetic and has no relief of their nausea & vomiting symptoms after 30 minutes, the alternative antiemetic may be considered.	Prior to IV administration, dilute dimenhyDRINATE (concentration of 50 mg/1 ml) 1:9 with Normal Saline or D5W. If administered IM do not dilute. If a patient has received Ondansetron and has no relief of their nausea & vomiting symptoms after 30 minutes, dimenhyDRINATE may be considered (or vise versa). DimenhyDRINATE can be used in patients ≥ 65 if ondansetron is not unavailable.

AUXILIARY MEDICAL DIRECTIVES

PCP/ACP Traumatic Hemorrhage Medical Directive *NEW*

- This Medical Directive allows the administration of Tranexamic Acid (TXA) for suspected hemorrhage.
- Pelvic binding, previously mentioned in earlier continuing medical education sessions, will remain in the BLS PCS and will not be incorporated into this Medical Directive.
- If TXA must be given IM, administer it in 5 ml (500 mg) volumes in each vastus lateralis.
- While the drug monograph for TXA states it should be administered IV, OBHG MAC has approved it to be administered off-label via the intramuscular route.

INDICATIONS (NEW)

Suspected hemorrhage due to trauma. **AND** Hemodynamic instability.

CONDITIONS (NEW)

Tranexamic Acid (TXA)	
Age	≥ 16 years
LOA	N/A
HR	N/A
RR	N/A
SBP	N/A
Other	HR ≥ 110 bpm or hypotension

CONTRAINDICATIONS (NEW)

Tranexamic Acid (TXA)
Allergy or sensitivity to TXA. Greater than 3 hours from the time of injury to drug administration **OR** unknown time of injury. Isolated head injury.

TREATMENT (NEW)

Consider tranexamic acid (TXA)	
Route	IV, IM
Initial dose	1000 mg
Max. single dose	1000 mg
Dosing interval	N/A
Max. # of doses	1

PCP/ACP Traumatic Hemorrhage Medical Directive (con't)

CLINICAL CONSIDERATIONS (NEW) - PCP ONLY

Current (v5.4)
TXA should not delay transport and should not be prioritized over the management of other reversible causes. IV administration of TXA applies only to PCPs authorized for PCP Autonomous IV. Tranexamic Acid solution for injection should be administered intravenously by slow injection over a period of at least 5 minutes, as rapid administration can cause hypotension.

CLINICAL CONSIDERATIONS (NEW) - ACP ONLY

Current (v5.4)
TXA should not delay transport and should not be prioritized over the management of other reversible causes. Tranexamic Acid solution for injection should be administered intravenously by slow injection over a period of at least 5 minutes, as rapid administration can cause hypotension.

PCP Tachydysrhythmia Medical Directive *NEW*

INDICATIONS (NEW)

Symptomatic Tachydysrhythmia

CONDITIONS (NEW)

Valsalva Maneuver	
Age	≥ 18 years
LOA	Unaltered
HR	≥ 150 bpm
RR	N/A
SBP	Normotension
Other	Narrow complex and regular rhythm

CONTRAINDICATIONS (NEW)

Valsalva Maneuver
Sinus tachycardia or atrial fibrillation or atrial flutter.

TREATMENT (NEW)

Consider Rhythm determination (confirm regularity).

Consider 12-lead ECG acquisition and interpretation to confirm QRS width (if this won't delay therapy).

Consider valsalva maneuver

- Perform a maximum of 2 attempts lasting 10 to 20 seconds duration each.

PCP Tachydysrhythmia Medical Directive (con't)

TREAT AND DISCHARGE (if authorized) (NEW)

The patient must meet all of the following criteria:

- the patient is ≥ 18 AND < 65 years old;
- patient must have a prior history of SVT;
- the patient presented with narrow complex and regular rhythm Supraventricular Tachycardia (SVT);
- the patient must have only had a single SVT episode in the past 24 hours;
- the patient has returned to normal sinus rhythm (NSR) either spontaneously or with a valsalva maneuver and is now asymptomatic;
- the patient has returned to their normal level of consciousness;
- a complete set of vital signs are within expected normal ranges with a HR <100bpm and the patient remains in NSR for at least 15 minutes post conversion;

AND

- the patient is not pregnant;
- the SVT must not be related to alcohol or substance abuse or withdrawal, and;
- the patient has no fever or preceding illness.

In addition to the above criteria, if all of the following requirements have been met, the patient can be discharged by paramedics:

- a responsible adult agrees to remain with the patient for the next 4 hours;
- all of the patient or substitute decision makers questions were answered and a care plan was developed;
- the patient or substitute decision maker has been advised to follow up with their primary health care team or provider;
- clear instructions to call 911 were provided should symptoms redevelop;
- patient or substitute decision maker has the ability to access 911 should symptoms redevelop, and;
- patient or substitute decision maker consents to the discharge.

CLINICAL CONSIDERATIONS (Treat and Discharge) (NEW)

Patch to BHP for consultation if you are unclear if the patient meets all of the discharge criteria.

PCP/ACP Lateral Patellar Dislocation *NEW*

INDICATIONS (NEW)

Patient with suspected lateral patellar dislocation

CONDITIONS (NEW)

Patellar Reduction	
Age	≥ 10 years to ≤ 50 years
LOA	Unaltered
HR	N/A
RR	N/A
SBP	N/A
Other	N/A

CONTRAINDICATIONS (NEW)

Patellar Reduction
High velocity trauma Direct knee trauma

TREATMENT (NEW)

Consider Patellar Reduction
With the patient in a seated or lying position, gently extend the knee while lifting up on the patella and placing medial pressure to the edge of the patella. The maximum number of attempts for Patellar Reduction per patient is 2.