Operational K9 10.0

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

These canine guidelines are reserved for use only on Operational K9s (OpK9) who are injured or become ill while on duty.
Ill or injured humans always take priority over canines.

Operational Canine Definition

According to SB 268, operational canine means a canine owned or used by a law enforcement department or agency and fire departments in the course of the department or agency's work, including a police canine, search and rescue canine, accelerant detection canine, comfort canine, or other canine that is in use by a county, municipal, or state law enforcement agency.

This law allows ambulances to transport operational canines to a veterinary care facility if the canine is ill or has been injured in the course of their official duties and no human needs transport or treatment.

These protocols do not apply to service canines as defined by the Americans with Disabilities Act (ADA) or to emotional support canines. Service dogs as defined by the ADA are canines specifically trained to do work or perform tasks directly related to the disability of an individual (i.e. guide dogs, medic alert dogs, etc). Emotional support canines are canines whose sole function is to provide comfort or emotional support; these canines do not qualify as service animals under the ADA.

Parameter	Normal Value
RR	10 - 40 breaths/minute
HR	60 - 80 bpm (up to 130 post exercise)
Capillary Refill	less than 2 sec.
Rectal Temp	100 -102.5 F (103-106 F post exercise)
LOC	Bright, alert, responsive (BAR)
BP	120/75 mmHg
Blood Glucose	70 - 120 mg/dL
SpO2	greater than 94%
EtCO2	35 - 45 mmHg

Intravenous & Intramuscular Therapies

10.1

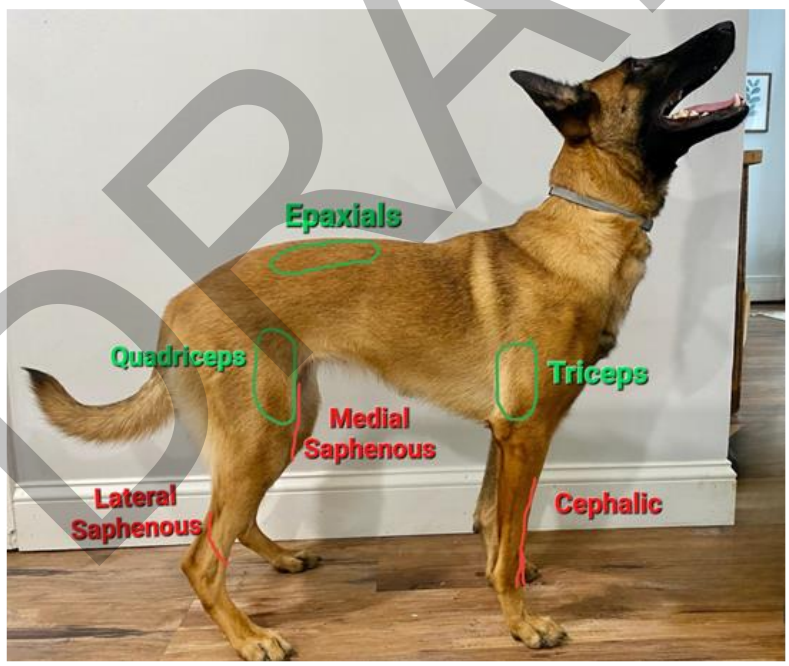
This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

Intravenous Access

- Peripheral intravenous catheters (20g and 18g preferred) placement and intravenous injections are most commonly performed in the cephalic or lateral saphenous veins, less commonly the medial saphenous.

Intramuscular Injections

- Intramuscular injections (needle size 22g, 20g or 18g preferred) are most commonly performed in the epaxials or quadriceps. The triceps can be used but is less common.



Operational K9 Anaphylaxis 10.2

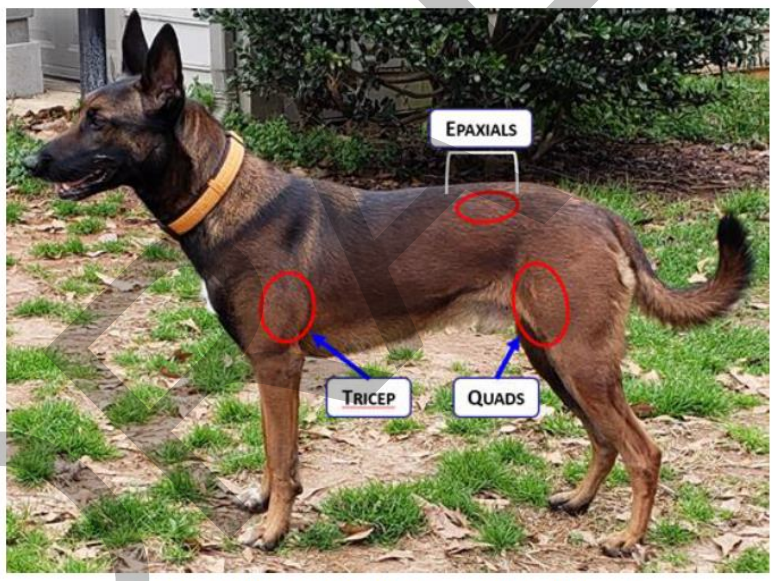
This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT/ADVANCED EMT/PARAMEDIC STANDING ORDERS

- Secure OpK9 see OpK9 Restraint Protocol.
- Allow OpK9 to assume position of comfort.
- Manage airway see Operation K9 Airway Management Protocol.
- Administer epinephrine via auto-injector:
  - Pediatric epinephrine autoinjector (EpiPen Jr) 0.15 mg IM for OpK9 < 25 kg,
  - Adult epinephrine autoinjector (EpiPen) 0.3 mg IM if OpK9 > 25 kg **OR**
- Administer epinephrine IM using Ready, Check and Inject:
  - If OpK9 < 25 kg, epinephrine (1 mg/mL) 0.15 mg (0.15 mL) IM*,
  - If OpK9 > 25 kg, epinephrine (1 mg/mL) 0.3 mg (0.3 mL)IM*.
- If signs and symptoms do not resolve may repeat in 5 minutes.

E/A/P

**EMTs must have completed the Ready, Check & Inject training.*



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PEARLS

In allergic reactions with progression to anaphylaxis, clinical signs are most often associated with the cardiovascular (CV) and gastrointestinal (GI) systems.

Respiratory signs may also develop, along with seizures and anxiousness, progressing to weakness and collapse.

Signs include:

- CV: tachycardia, weakness, weak pulses, mucous membrane color changes
- GI/GU: urinating, vomiting, and diarrhea that is often bloody
- Respiratory: increased respiratory effort, wheezes, and crackles

Operational K9 Hyperthermia 10.3

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

- OpK9s do not sweat. Their predominant cooling mechanism is by panting.
- The progression of heat injury in the Police K9 can be quite rapid and requires immediate intervention.
- Hyperthermia can be caused by environmental or exertional factors or a combination of the two.
- Avoid muzzles unless required for safety reasons; an open basket muzzle is the preferred muzzle in this case to allow for panting.

	Core Temp (F)*	Heart Rate	Mucous Membranes	LOC	Panting	Behavior Performance
Mild Heat Stress	Varies 105° - 106°	Fast, Strong	Moist/Pink	Alert	Heavily Controlled**	Excessive thrist, discomfort with physical activity, slightly decreased performance
Moderate Heat Exhaution	106° - 108°	Fast, Strong or Weak	Tachy or Dry Bright Red	Alert	Uncontrolled*** Failure to Salivate	Weakness, anxiety, unwillingness to work, acts tired, unresponsive to handler commands
Severe Heat Stroke	> 108°	Weak	Dry Pale	Altered	Maybe	Vomiting, diarrhea, ataxia, head tremors, seizures, blindness, abnormal pupil size

****Controlled panting:** the OpK9 can stop panting with an alcohol-soaked gauze is put in front of the nose or when the OpK9 becomes interested in or distracted by something (i.e. toy, reward, noxious stimulus, verbal command).
*****Uncontrolled panting:** the Op K9 cannot stop panting even when offered a treat or reward or when exposed to alcohol-soaked gauze or other noxious stimuli.

EMT STANDING ORDERS

E

Treatment for all stages of hyperthermia:

- Secure OpK9 see OpK9 Restraint Protocol.
- Remove OpK9 from the heat source and stop their work/exercise.
- Begin cooling.
- Monitor temperature (rectal or axillar) if equipped. Axillary temps are approximately 1 - 2 degrees F° less than rectal.
- Montor for changes in mention.

Mild (Heat Stress)

- Cool by bringing to a shaded or lightly air-conditioned area. If no A/C available use circulating fan to blow a light breeze by the OpK9.
- As feasible, remove muzzles, harnesses, tactical gear etc.
- Place on a cool surface to promote conductive cooling.
- Offer cool water and encouraging drinking.
- Monitor vital signs every 5 minutes; if able to measure temperature, discontinue cooling efforts when core temperature is 104°F or less.

Protocol Continues

10.3 Operational K9 Hyperthermia

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

Protocol Continued

EMT STANDING ORDERS

E

Moderate (Heat Exhaustion)

- Follow guidelines above to start active external cooling.
  - Use air conditioning or cooling fans, if available, to reduce core body temperature.
  - Avoid placing ice packs on the limbs as this causes vasoconstriction and slows the effects of conductive cooling and decreases heat loss ability.
  - Douse or spray body with water, soak hair to skin with cold water and use fans or A/C to cool further.
- Monitor vital signs every 5 minutes; if able to measure temperature, discontinue cooling efforts when core temperature is 104° F or less.
- Dry OpK9 off, place on a dry surface, if possible, and avoid direct application of air on from circulating fans or A/C.
- If able to monitor temperature and if body temperature drops below 100° F (rebound hypothermia) consider passive warming by covering with blankets.

Severe (Heat Stroke)

This is a life-threatening condition

- If able to monitor temperature, rapid cooling to a body temperature of 103.5° - 104° F.
  - Use water (do not submerge in ice bath).
  - Soaking the OpK9 to the skin with water. Soak the entire OpK9 as rapidly as possible through the hair, soaking the skin thoroughly and implement convective cooling with fans or A/C.
- If able to monitor temperature, when temperature reaches 104° F, remove from the bath/water, dry hair and continue to monitor temperature, watch for rebound hypothermia, as above.

ADVANCED EMT/PARAMEDIC STANDING ORDERS

A/P

- IV enroute.
- If shock present, administer 20 mL/kg fluid bolus (lactated ringers preferred).

NOTE: No single core temperature value defines heat-related illness for all OpK9s in all circumstances. Well - conditioned, acclimated OpK9 may reach peak core temperatures as high 106° - 108° F while working, yet display no behavioral or clinical signs of heat stress. Base clinical assessment on presence and progression of clinical signs over core temperature.

Operational K9 Nerve Agent/ Organophosphate Exposure

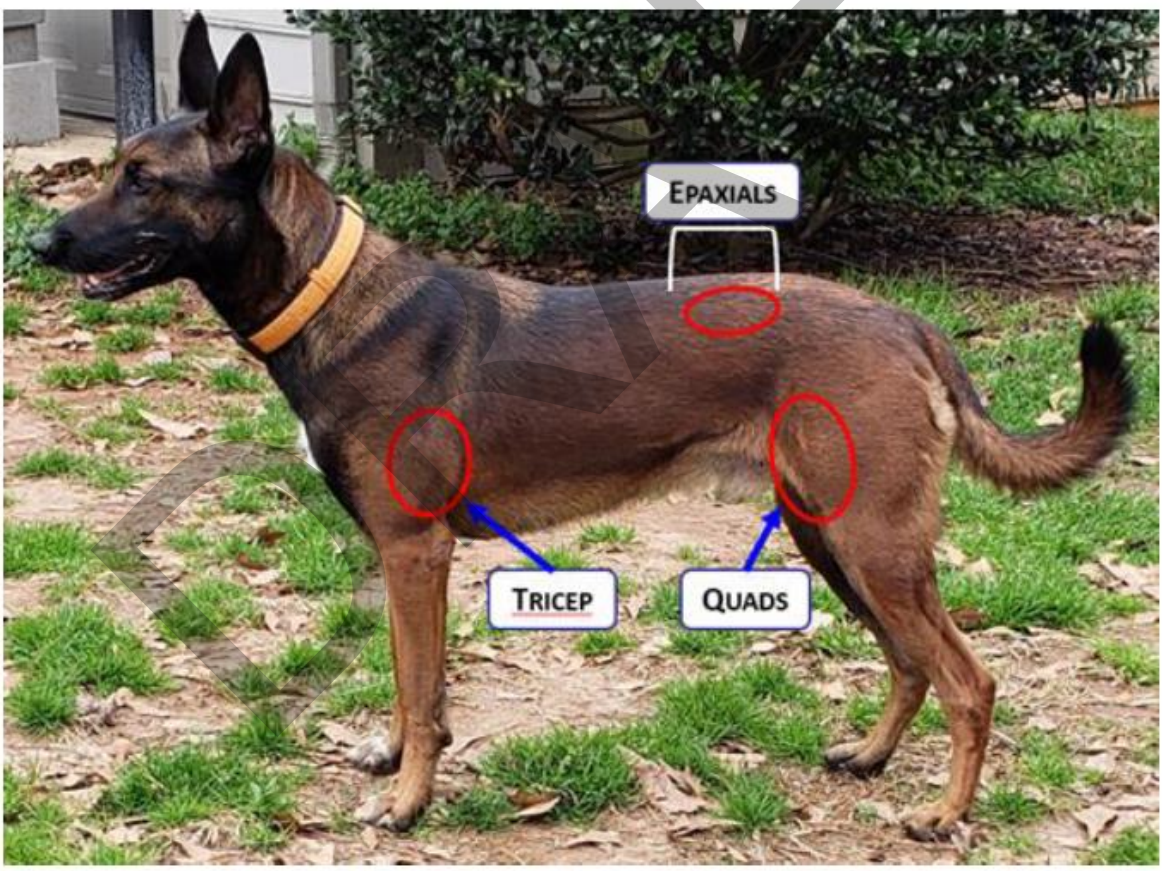
10.4

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT/ADVANCED EMT/PARAMEDIC STANDING ORDERS

E/A/P

- Secure OpK9 see OpK9 Restraint Protocol.
- Assess for SLUDGEM [Salivation, Lacrimation, Urination, Defecation, Gastric upset, Emesis, Muscle twitching/Miosis (constricted pupils) and KILLER Bs (Bradycardia, Bronchorrhea, Bronchospasm).
- Remove from contaminated area and consider decontamination as needed.
- Manage airway as appropriate; see OpK9 Airway Management Protocol.
- Vigorous suctioning may be necessary.
- Administer atropine/pralidoxime auto-injectors:
  - 18 – 27 kg (40 – 60 pounds): 2 atropine/pralidoxime auto-injectors.
  - 32 – 36 kg (70 – 80 pounds): 3 atropine/pralidoxime auto-injectors.
  - ≥ 41 kg (90 pounds): 4 atropine/pralidoxime auto-injectors.



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PEARLS:

- Transport canine with all windows of ambulance open.
- Decontaminate entire ambulance after canine transport.
- All providers who contacted the canine require decontamination.

Operational K9 Opioids Overdose

10.5

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT STANDING ORDERS

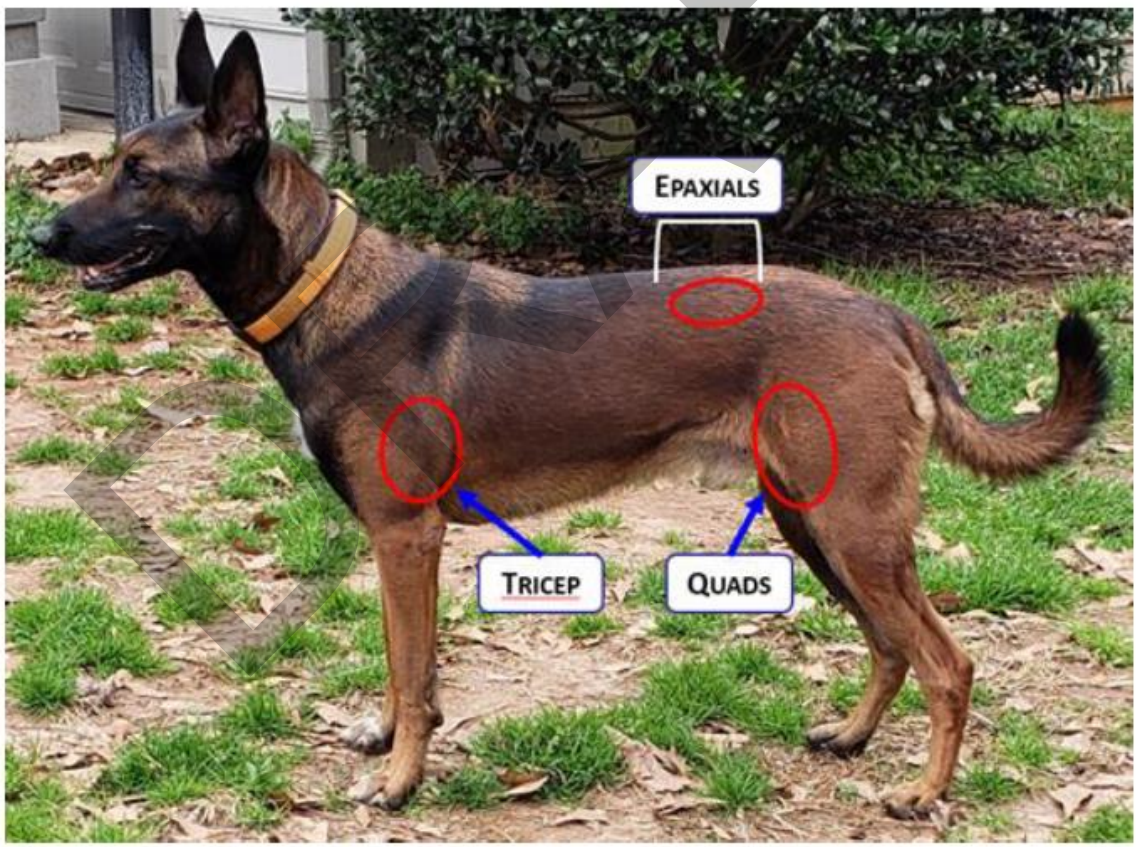
E

- Manage airway as appropriate; see OpK9 Airway Management Protocol.
- Consider securing canine with muzzle in anticipation of reversal of opioid.
- For suspect opioid overdose administer:
  - Naloxone 2 – 4 mg IN, may repeat every 2 – 5 minutes **OR**
  - Naloxone 2 – 4 mg IM via auto – injector, many repeat every 2 – 5 minutes.

ADVANCED EMT/PARAMEDIC STANDING ORDERS

A/P

- Establish IV.
- Alternative route for Naloxone 2 - 4 mg IV, may repeat every 2 – 5 minutes.
- If hypotensive, administer 20 mL/kg (lactated ringers preferred).



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PEARLS:

- Common signs of opioid overdose include: excessive sedation, bradycardia, mydriasis, and hypothermia.

Operational K9 CO/CN Exposure/Smoke Inhalation

10.6

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT STANDING ORDERS

E

- Secure canine, see OpK9 Restraint Protocol.
- Manage airway as appropriate; see OpK9 Airway Management Protocol.
- Administer high-flow oxygen.

ADVANCED EMT & PARAMEDIC STANDING ORDER

A/P

- Establish IV.
- If hypotensive, administer 20 mL/kg (lactated ringers preferred).

Operational K9 Cardiac Arrest ROSC & Post - Resuscitation Care

10.7

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT STANDING ORDERS

E

- Place canine in lateral recumbency for narrow chested dogs and in dorsal recumbency for barrel/round-chested dogs.
- Initiate chest compressions.

High-flow 02 with BVM ventilation 1 breath every 10 chest compressions during recoil and without interrupting compressions. Avoid respiratory rate greater than 10 per minute in cardiac arrest.

- Compression at a ratio of 30:2.
  - Compression rate of 100 - 120 compressions/minute.
  - Depth of 1/2 -1/3 of chest width.
  - End-tidal of > 15 mmHg indicates good compressions.
- Continue 2-minute cycles of chest compressions with pulse checks.
- If ROSC occurs, see OpK9 Post-Resuscitation Care Protocol.
- If no ROSC in 20 minutes and ALS-trained K9 care clinician not on scene, terminate resuscitation.

ADVANCED EMT STANDING ORDERS

A

- Establish IV without interrupting chest compressions.
- Secure airway, see OpK9 Airway Management Protocol
- If ROSC is achieved and shock or hypotension present:
  - Administer 10 – 20 mL/kg fluid bolus (lactated ringers preferred), repeat within 15 – 30 minutes, as needed, up to 2 times in order to achieve palpable femoral pulse and improved mentation.

PARAMEDIC STANDING ORDERS

P

- Epinephrine 0.01 mg/kg of 1mg/10mL IV/IO every 3 - 5 minutes.

Ventricular Tachycardia/Ventricular Fibrillation

- Amiodarone 5 mg/kg IV/IO **OR**
- Lidocaine 2 mg/kg IV/IO.

Asystole/PEA

- Atropine 0.04 mg/kg IV push at the initiation of CPR, re-dose every other 2 - minute cycle of compressions.

Consider Causes

- Suspected hypovolemia: 20 mL/kg fluid bolus.
- Suspected hypoxia: high-flow oxygen and manage airway see OpK9 Airway Management Protocol
- Suspected pneumothorax: perform bilateral needle decompressions, see OpK9 Chest Trauma Protocol.

		Weight (kg)	25	30	35	40	45	50
		Weight (lb)	50	60	70	80	90	100
	Drug	Dose	mL	mL	mL	mL	mL	mL
Arrest	Epi 1mg/10mL every other BLS cycle	0.01 mg/kg	2.5	3	3.5	4	4.5	5
	Atropine (0.54 mg/mL)	0.04 mg/kg	1.9	2.2	2.6	3	3.3	3.7
Anti-Arrhyth	Amiodarone (50 mg/mL)	5 mg/kg	2.5	3	3.5	4	4.5	5
	Lidocaine (20 mg/mL)	2 mg/kg	2.5	3	3.5	4	4.5	5
Reversal	Naloxone (0.4 mg/mL)	0.04 mg/kg	2.5	3	3.5	4	4.5	5

Operational K9 Burns 10.8

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT STANDING ORDERS

E

- Remove collar/harness/vest/botties, etc. Avoid pulling away any gear that is melted in the skin/coat.
- Manage airway as appropriate see OpK9 Airway Management Protocol.
- Give highest priority to airway problems and major bleeding.
- Burns < 15% TBSA, consider cooling with cool water (sterile/saline, if available).
- Cover burns with dry sterile dressing/sheets.
- Prevent heat loss/hypothermia.
- If suspect CO/CN poisoning see OpK9 CO/CN Exposure/Smoke Inhalation Protocol.

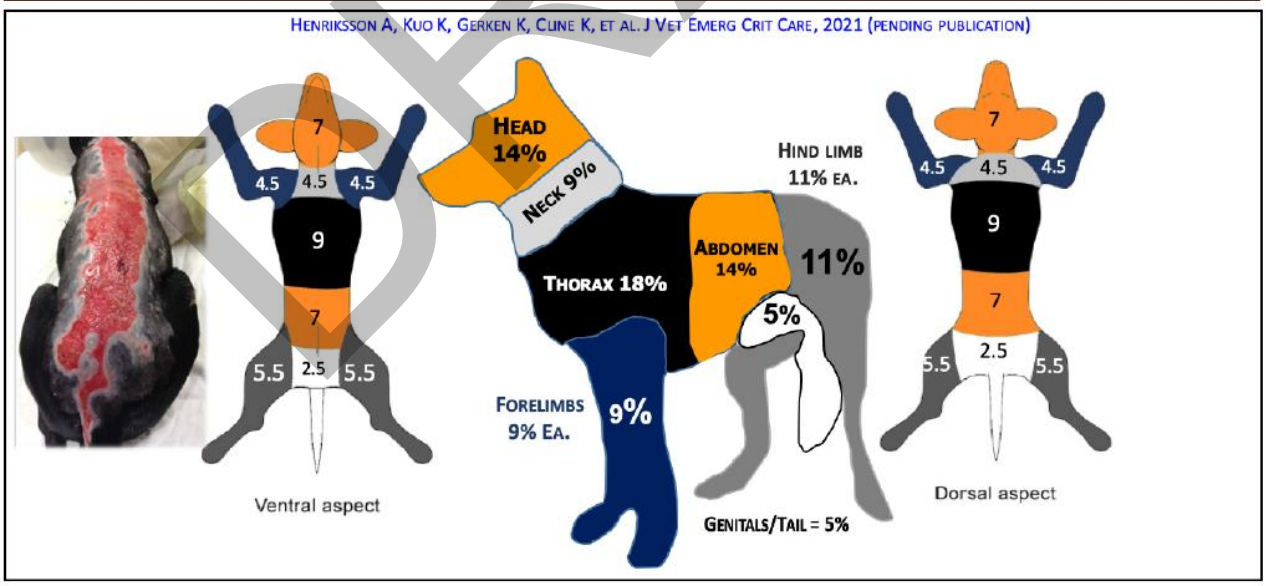
ADVANCED EMT/PARAMEDIC STANDING ORDERS

A/P

- IV enroute.
- If shock present, administer 20 mL/kg (lactated ringers preferred).

BODY SURFACE AREA IN K9S – "K9 RULE OF 9'S"

HENRIKSSON A, KUO K, GERKEN K, CLINE K, ET AL. J VET EMERG CRIT CARE, 2021 (PENDING PUBLICATION)



Operational K9 Chest Trauma 10.9

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT STANDING ORDERS

E

- Manage airway as appropriate see OpK9 Airway Management Protocol.

Impaled Object

- Secure in place with bulky dressing.

Open Chest Wounds

- Cover with vented or non-vented occlusive dressing.
- If shock present, consider tension pneumothorax and burp/vent the chest seal.

Flail Segment with paradoxical movement and respiratory distress

- Consider positive pressure ventilations.

ADVANCED EMT STANDING ORDERS

A

- IV enroute.
- If shock present, administer 20 mL/kg (lactated ringers preferred).

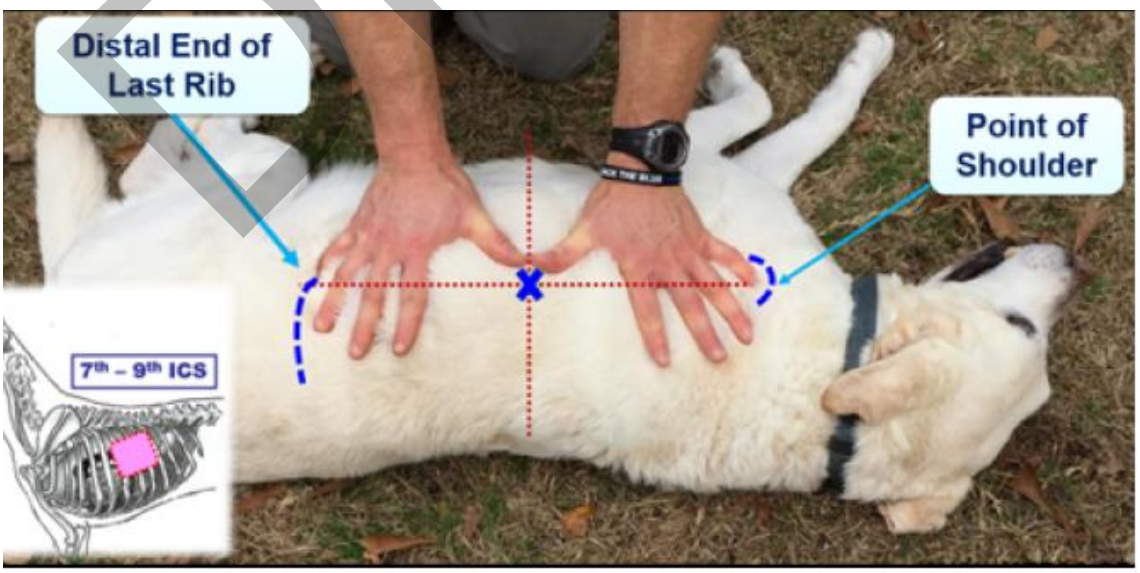
PARAMEDIC STANDING ORDER

P

- For presumed tension pneumothorax, perform chest decompression using 14 - 18 gauge or other approved decompression device.

Landmark:

- 7^{th} – 9^{th} intercostal space (canines have 13 ribs) OR
- Midpoint between shoulder and last rib/widest point on rib cage.
  - Go over tope (cranial) aspect of rib.
  - Aspirate and consider decompressing the other side of the chest as well.
  - Remember the canine mediastinum is fenestrated.
  - DO NOT leave decompression catheters(s) in place.



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Operational K9 Hemorrhage Control

10.10

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT STANDING ORDERS

E

- Ascertain all sites of bleeding and control with direct pressure
- Extremity: apply an elastic wrap/pressure bandage, or Stretch Wrap and Tuck Tourniquet (SWAT-T).

Commercially made windlass tourniquets are not effective on canines due to the tapered shape of their extremities.

- For deep wounds in junctional areas or areas containing large muscle bellies (neck, thigh, shoulder/triceps area) control bleeding by applying hemostatic agent and packing the agent in the wound and applying/maintaining pressure over the agent for a minimum of 5 minutes.
- Check for ongoing bleeding. If bleeding has stopped, apply appropriate pressure bandage over the top of the dressing; if bleeding continues, reapply manual pressure for a minimum of 5 minutes.
- If bleeding continues, remove the initial hemostatic agent and repeat with a new hemostatic agent. Remember, for these agents to have maximum effectiveness, they must be packed inside the wound as close to the bleeding source as possible.
- Treat for shock, if indicated, see OpK9 Shock Protocol.
- Manage airway as appropriate, see OpK9 Airway Management Protocol.

ADVANCED EMT/PARAMEDIC STANDING ORDERS – ADULT & PEDIATRIC

A/P

- IV enroute.
- Administer 20 mL/kg fluid bolus (LR preferred), repeat every 15 - 30 min to achieve palpable femoral pulse and improved mentation, with typical maximum volume of 500 – 600 mL; maximum total dose 60 mL/kg.

Operational K9 Hemorrhagic Shock 10.11

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT STANDING ORDERS

E

If history of illness or mechanism of injury consistent with signs/symptoms of shock (elevated pulse, elevated respiratory rate, pale mucous membranes, altered LOC, or lowered BP) transport as soon and as efficiently as possible.

- Control bleeding, refer to Hemorrhage protocol, see OpK9 Hemorrhage Control Protocol.
- Manage airway as appropriate; see OpK9 Airway Management Protocol.

ADVANCED EMT/PARAMEDIC STANDING ORDERS

A/P

- IV enroute.
- Administer 20 mL/kg fluid bolus (LR preferred), repeat every 15 - 30 min to achieve palpable femoral pulse and improved mentation, with typical maximum volume of 500 – 600 mL; maximum total dose 60 mL/kg.

Stage of Shock	Heart Rate	Capillary Refill	Mucous Membranes	Mentation	Pulse Quality	Systolic BP
Normal (at rest)	< 120	< 2 sec	Pink	Bright Alert	Strong	> 90
Acute Compensatory	> 120	< 1 sec	Red	Alert	Fair	> 90
Early Decompensatory	> 140	> 2 sec	Pale	Depressed	Weak	< 90
Terminal/ Irreversible	< 80	Absent	Pale	Stupor Comatose	Absent	Low

Operational K9 Restraint 10.12

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT/ADVANCED EMT/PARAMEDIC STANDING ORDERS

The goal is to *safely* provide the canine's initial medical evaluation, treatment and transport to definitive care. Injured and ill canines may pose an unintentional threat to clinicians, therefore it is imperative that the canine be secured prior to medical evaluation. This is best done by the canine's handler. It is preferable that the handler stay with their canine throughout all phases of care, evacuation, and transport unless they, themselves, are injured or required for threat neutralization. If the primary handler is not available, attempt to locate another handler or person that is familiar with handling OpK9s to secure and stay with the injured canine.

All injured canines should be muzzled before handling.

E/A/P

The following are relative contraindications to muzzling:

- Unconsciousness.
- Upper airway obstruction.
- Vomiting.
- Severe facial trauma
- Heat-related injury (need to allow evaporative cooling via panting). If these canines need to be muzzled, a Cage or Basket-type muzzle is preferred.

Muzzling:

- The type of muzzle used depends on the size of the canine, available material, type of injury and desired canine access.
- The canine should be restrained in a position of comfort, which may include sitting or standing. Do not restrain the canine in such a manner that its ability to breathe or pant is impeded.
- Slide the appropriately-sized muzzle over the canine's snout from the rostral (anterior) to caudal (posterior) aspect. Be sure that the lower jaw is captured in the muzzle and not free.
- Be sure to frequently check the security of the muzzle and make sure that it is not impeding the canine's ability to breathe.

It is important that the clinician be adequately trained to restrain the OpK9 in order to safely apply a muzzle. A stressed canine may not only bite the EMS clinician or others, but may bite its handler as well.**

Muzzle Type	Required Material	Suggested Use
Cage or Basket	Manufactured cage/basket muzzle (Preferably made out of rubber)	"'All-purpose "'Preferred muzzle: allows for open-mouth breathing "'Suggested if oxygen delivery is indicated
Fabric	Manufactured, pre-sized muzzle	All - purpose
Quick Muzzle	Any available, broad-width (greater than 1-2 inches) tape, leash, webbing, gauze, etc.	...use only if fabric or cage/ basket muzzle is unavailable "'Narrow tape/gauze etc. can cause injury

Operational K9 Airway Management 10.13

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMT/ADVANCED EMT STANDING ORDERS

E/A

- Place the canine in the sternal (prone) position.
- Open airway.
- Tilt head and slightly extend the neck.
- If foreign body suspected, see OpK9 Airway Obstruction Protocol
- Provide oxygen to maintain SpO_2 > 94%*.
- Provide oxygen via BVM (with canine mask) with goal respiratory rate of 10 - 12 breaths/minute. Pediatric or Adult BVMs can be used, targeting goal tidal volume on seeing chest rise.
  - If positive pressure ventilations are not required, supplemental oxygen may be administered by holding a NRB near the nose, taping oxygen tubing to the muzzle or holding a canine mask near the nose (without tight seal).

PEARLS*

- Pulse oximetry is most reliable in unconscious, sedated, or anesthetized canines.
- Finger probes used for people do not work well in canines.
- If possible, obtain and use a flat ear probe attachment. Place the probe on the tongue or non-pigmented portion of the lip.
- In conscious dogs, use the ear pinna, lip fold, inguinal skin fold or prepuce/vulva; although not optimal for oximetry, these alternate sites generally yield reliable results inmost instances.
- Alternatively, a neonatal or disposable pulse oximetry adhesive sensor attached to the base of the canine's tail provides an alternative and very reliable site.

PARAMEDIC STANDING ORDERS

P

If unable to ventilate with basic airway maneuvers, proceed with intubation (only if canine is unconscious).

Prepare

- Suction.
- Light source (flashlight/headlamp/laryngoscope).
- ET tube ready with lubricant, bougie and syringe.
- Measure ETT from incisor to thoracic inlet (typical ETT size is 9-11mm).
- Tube-securing device ready (umbilical tape, roll gauze).
- Continuous end-tidal CO_2 monitor ready, if available.

Position

- Sternal/prone position.
- Assistant to help open mouth.
- Second rescuer may use gauze/leash and place behind upper canines to hold mouth/airway open.

Protocol Continues

10.13 Operational K9 Airway Management

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

Protocol Continued

PARAMEDIC STANDING ORDERS

P

Pass the Tube

- Pull tongue straight out and over mandible.
- Visualize vocal cords.
- Directly visualize ETT passing through cords to pre-measured depth.
- Inflate cuff.

Check Tube Placement

- Breath sounds/chest rise.
- End-tidal $C0_2$, if available (35 - 45 mmHg).

Secure ETI

- Consider using a mouth-gag to keep mouth open and prevent damage to the ETT. This can be achieved with a 1 – 2 wide inch roll of tape. Do not force mouth open beyond 1 – 2 inches for any significant length of time as it can cause damage to TMJ, muscles and nerves and result in altered maxillary blood flow.
- Titrate oxygen to maintain $Sp0_2$ ~94%.

Operational K9 Airway Obstruction 10.14

This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

EMR/EMT/ADVANCED EMT/PARAMEDIC STANDING ORDERS

Clinical signs of airway obstruction include the following:

- Gagging.
- Pawing at the mouth.
- Excessive drooling.
- Frequent swallowing motions.
- Extension of the head and neck.
- Tripod position.
- Reluctance to lie down.
- Cyanosis (late sign).

Similar to a person who can speak clearly without any respiratory distress, consider a canine that is barking, growling, or whining without any clinical signs of respiratory distress to have a patent airway.

E/A/P

1. Allow for position of comfort (sit or stand, sternal helps with gravity).
2. Secure canine with leash/rope.
3. Avoid putting hands in canine's mouth (serious injury to clinician can occur).
4. Attempt Heimlich maneuver (avoid if sharp object involved).
   - "Bear hug" or lay canine on side and place fist just below sternum or behind ribs.
   - Five (5) quick and upward abdominal thrusts followed by airway check.
   - If not successful, repeat 1 – 2 times.
5. Palpate throat/trachea - you may be able to dislodge a supraglottic foreign body cephalad out of the pharynx.
   - Palpate the object at the supraglottic region (ventral mandible).
   - From caudal aspect of object, squeeze/push cranially.
     - Two-handed with both thumbs, or
     - Single-handed with thumb and index or middle finger.

Protocol Continues

10.14 Operational K9 Airway Obstruction

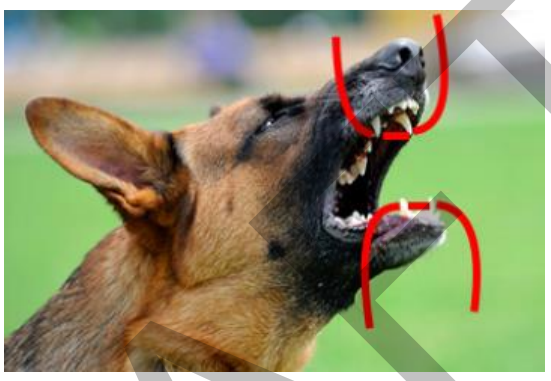
This prerequisite protocol is only to be used by EMS Units and their affiliated providers who are authorized by the NH Bureau of EMS.

Protocol Continued

EMR/EMT/ADVANCED EMT/PARAMEDIC STANDING ORDERS

6. In an unconscious canine, open the airway by extending the head and neck, and pull the tongue forward. A second rescuer may use gauze/leash looped behind upper canine teeth to keep the mouth open. You may use a second length of gauze/leash for the lower jaw as well.

E/A/P



7. In an unconscious canine, if the obstruction is:
   - VISIBLE: attempt to manually remove; do not push foreign body further back in airway.
   - NOT VISIBLE: do not attempt a blind finger sweep due to risk of pushing the foreign body further down the airway.
8. If object is not removed and canine collapses, provide chest compressions and mouth-to-snout or BVM (with a canine mask). If unable to get chest rise, see OpK9 Airway Management Protocol and/or OpK9 Cardiac Arrest Protocol.