County of Santa Cruz

HEALTH SERVICES AGENCY

POST OFFICE BOX 962, 1080 EMELINE AVENUE SANTA CRUZ, CA 95061-0962
(831) 454-4120 FAX: (831) 454-4272 TDD: (831) 454-4123

EMERGENCY MEDICAL
SERVICES PROGRAM

Policy No. 5300
April 1, 2012

Emergency Medical Services Program

Approved

_____

Medical Director

Subject: NEEDLE THOROCOSTOMY

A. This procedure is indicated for the patient who is *in extremis* and has clinical signs of a tension pneumo-thorax.

B. Patient must have sufficient anatomical landmarks to identify structures needed to perform procedure.

C. Base Station contact is not required prior to procedure. Base Station contact shall be made, as soon as possible, after the procedure is performed.

D. Paramedics are only authorized to establish needle thorocostomy using the anterior, midclavicular approach. Lateral chest wall needle thorocostomy is prohibited.

E. All patients with needle thoracostomy are considered *in extremis* and will be transported to the closest receiving hospital.