Table 1 – Update analysis post 2006 publication of the UK Ambulance Service Clinical Practice Guidelines (2006)[1]

Guideline	Update / Rationale for new guidance
Clopidogrel	**New guidance – Published August 2008:** o Two major trials have reported, results both supporting extension of the use of clopidogrel to the STEMI end of the acute coronary syndrome spectrum. The 2007 update of the American College of Cardiology/American Heart Association STEMI guidelines, and the guidance on acute coronary syndromes published by the Scottish Intercollegiate Guidelines Network (SIGN)5 last year also recommend clopidogrel (although the SIGN guideline remit is restricted to in-hospital, rather than pre-hospital care). o Many Cardiac Networks are now recommending addition of clopidogrel to the pre-hospital treatment of STEMI patients, and the Joint Royal Colleges Ambulance Liaison Committee Cardiac Sub-Committee also recommended that clopidogrel be added to the prehospital treatment to bring ambulance practice in line with hospital practice (clopidogrel is increasingly being given on arrival in the emergency department). A small number of ambulance services are providing clopidogrel with the agreement of local Cardiac Networks.The clopidogrel drug protocol is now finalised. Based on current best evidence and expert consensus, the Joint Royal Colleges Ambulance Liaison Committee Guideline Development Group are recommending, for patients with ST segment elevation myocardial infarction aged 75 years or less: **(a)** 300mg of clopidogrel orally for patients who are receiving, or where it is anticipated that patents will receive, thrombolysis **(b)** 600mg of clopidogrel orally where it is anticipated that patients will undergo primary percutaneous coronary intervention.
Midazolam	**New guidance – Published April 2009:** o The current management options, if patients are still convulsing ten minutes after the carer has administered Midazolam, are either to cannulate and administer intravenous Diazepam or to administer to rectal diazepam. Both options entail time delays and it would be preferable to administer a second dose of Midazolam. o However, the Misuse of Drugs Act does not permit paramedics or technicians to be in possession of Midazolam, although it is permissible for a paramedic or technician to administer a patient's own prescribed medication, if they are competent to administer medication via the designated route and are familiar with the indications, actions and side effects of the medication. o This guidance is designed to provide information on the buccal or intranasal administration of the patients' own prescribed Midazolam when a grand-mal convulsion continues ten minutes after a carer has administered a first dose of Midazolam. Information on the presentation, indications, actions, administration, side effects, and Patient Specific Directions are also provided.
Pelvic Trauma	**New guidance – Published April 2009:** o Pelvic fracture should be considered based upon mechanism of injury. o The majority of pelvic fractures are stable pubic ramus or acetablar fractures o Any patient with hypotension and potentially relevant mechanism of injury **MUST** be considered to have a **TIME CRITICAL** pelvic injury. o 'Springing' or distraction of the pelvis must not be undertaken. o Pelvic stabilisation should be implemented as soon as is practicable whilst still on scene. o Consider appropriate pain management.

[1] All changes to the updated guidelines are highlighted in grey on the guidelines.

Sickle Cell Crisis	**Changes following guideline update – Published April 2009:** o the phrase sickle cell disease has replaced sickle cell anaemia throughout the guideline o expansion of the paragraph on sickled cells o expansion of conditions that may precede a crisis to include mental stress o removal of references to 'acute coronary chest syndrome' o inclusion of a definition of Acute Chest Syndrome o expansion of the signs and symptoms to include long bones, pyrexia, headache and priapism o re-wording of the of the paragraph on individualised patient plans o new supplemental oxygen guidance in line with the British Thoracic Society Guidelines 2008 o 12-lead ECG undertaken for patients with chest pain not routinely o increased emphasise on pain management – preference for oral or subcutaneous administration.
Oxygen	**Changes following guideline update – Published April 2009:** o The 2009 update of the JRCALC oxygen clinical practice guideline is based on O'Driscoll BR, Howard LS, Davison AG, on behalf of the British Thoracic Society. BTS guideline for emergency oxygen use in adult patients. Thorax 2008;63(Suppl_6):vi1-68. http://www.ncbi.nlm.nih.gov/pubmed/18838559 o This update includes significant changes in practice for some conditions in ADULTS e.g. stroke or myocardial infarction. o Administration of supplemental oxygen is based on target saturation range. o Initial dosage i.e. flow rate is determined by condition. o Conditions are grouped together into four main categories of illness and or injury: critical illness, serious illness, and COPD and other conditions requiring controlled or low-dose oxygen and conditions requiring no supplemental oxygen unless patients are hypoxaemic. o Target saturations for each of the four categories are set out in four tables together with other relevant guidance including the initial dose and method of administration. o In some instances there is a choice of administrative device e.g. simple face mask to nasal cannulae to allow for maximum flexibility. o An algorithm has been developed to support implementation of this guidance.
Stroke and transient ischaemic attack	**Changes following guideline update – Published August 2009:** o The stroke and transient ischaemic attack guideline has been updated to take account of the recent update of the 'diagnosis and initial management of acute stroke and transient ischaemic attack' guideline by the National Institute for Health and Clinical Excellence and the Department of Health's National Stroke Strategy. o Although, there are no significant changes to the assessment and management of patients suffering a stroke or transient ischaemic attack, there are changes in tone to reflect the importance of this topic nationally and recognition of the need to reduce unnecessary delay including: • Upgrading the FAST test to the 'time critical features' section. • De-emphasising some non-essential interventions such as the 12 lead ECG and intravenous access, which should be considered en-route if indicated. • Amending the oxygen therapy guidance in line with the BTS guideline for emergency oxygen use in adult patients. Thorax 2008;63(Suppl_6):vi1-68. http://www.ncbi.nlm.nih.gov/pubmed/18838559.