

REGION 7

Emergency Medical Services Systems

Advocate Christ Medical Center EMS System

Morris EMS System

Provena Saint Mary's EMS System

Riverside EMS System

Silver Cross EMS System

South Cook County EMS System

BASIC LIFE SUPPORT Standing Medical Orders

REVISED: OCTOBER 1st, 2011

Effective: October 1st, 1998

REGION 7 EMERGENCY MEDICAL SERVICES SYSTEMS BASIC LIFE SUPPORT STANDING MEDICAL ORDERS

INTRODUCTION

These orders are to be used as the pre-hospital treatment protocols. They are to be followed by all Basic Life Support (BLS) members of the EMS System. Deviations from these orders can be made only by the Medical Director or designee.

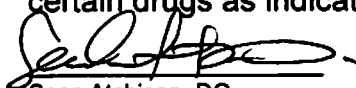
These orders are to be used in the following situations:

1. When the initiation of care begins before hospital communication is established.
2. In the event that communications cannot be established or communication is disrupted or lost between the responding intermediates and their directing hospital. Every effort should be made to contact the hospital over the MERCI radio, cellular phone or landline phone.
3. Until the patient arrives at the hospital and the patient's care has been transferred to the appropriate hospital personnel.
4. In disaster situations, when immediate action to preserve lives and limbs supersedes the need to communicate directly with the hospital.

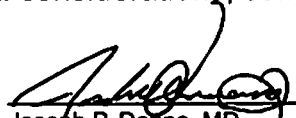
Never delay patient transport awaiting ALS/ILS backup if the ETA of the backup is greater than the ETA to the closest hospital.

All emergency patients must be transported to a hospital emergency department with inpatient facilities.

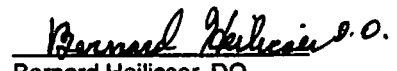
Due to geographic and regional considerations, some systems may include or exclude certain drugs as indicated.



Sean Atchison, DO
Medical Director
Morris EMS System
Morris Hospital



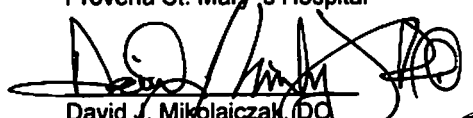
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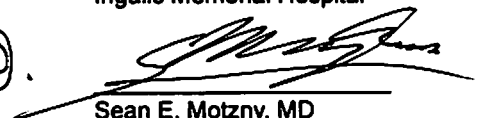
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REGION VII
BLS STANDING MEDICAL ORDERS
2011 REVISION SUMMARY

Only changed SMOs are listed below. If an SMO is not listed below, it was not changed.

- Code 2- Added reference to Failed Adult Airway for inadequate breathing
- Code 3- Deleted pediatrics (< 1 year) airway obstruction guidelines from the adult airway obstruction SMO.
- Code 4- Content from previous Code 6 Ventricular Fibrillation/Pulseless Ventricular Tachycardia moved here. While minimizing interruptions in CPR, consider King tube placement, if available.
- Code 6- Moved content to Code 4 Cardiac arrest
- Code 9- Refer to Code 4
- Code 11- Refer to Code 4
- Code 12- Added “Perform 12 Lead EKG and transmit, if available” and Added “Consider 12 Lead EKG for complaints of See list”
- Code 13- Consider CPAP enroute, if available, for patient’s with a BP >90
- Code 16- Page 1, added to #6: “For uncontrolled hemorrhage, consider use of a hemostatic agent, if available”
- Code 21- For uncontrolled hemorrhage, added “Consider use of a hemostatic agent, if available”
- Code 24- Added letter G: “Manually displace the uterus to the left side during CPR.
- Code 30- Added CPAP, if available, at the discretion of a Physician/ECRN.
- Code 32- Added consideration of Intranasal Glucagon
- Code 33- Added consideration of Intranasal Narcan and Intranasal Glucagon
- Code 34- Added consideration of Intranasal Narcan and Intranasal Glucagon
- Code 35- Added consideration of Intranasal Glucagon
- Code 38- Deleted Hypertensive Crisis Code;
Added “Suspected Stroke” Code
- Code 45- Deleted “involuntary pushing with contractions” and “contractions less than 2 minutes apart” from criteria to prepare for immediate delivery.
- Code 50- Format change

- Code 55- Terminology change, Consider “back slaps”, abdominal thrusts (age dependent)
- Code 56- Terminology change, Consider “back slaps”, abdominal thrusts (age dependent)
- Code 61- Simplified: “Do not induce vomiting”
- Code 65- Deleted #3 bullet point #3: Statement about child under the age of 10 being left unattended.
- Code 68- Added statement to “Maintain situational awareness and scene safety” first and foremost
- Code 73- Added procedure for Continuous Positive Airway Pressure Administration
- Code 74- Added procedure for Intranasal administration
- Code 75- Added code for Failed Adult Airway

REGION 7 STANDING MEDICAL ORDERS

I N D E X

CODE CARDIAC PROTOCOLS

1. INITIAL CARDIAC CARE/INITIAL MEDICAL CARE/ROUTINE CARDIAC CARE
 GENERAL PATIENT ASSESSMENT
- 1a. INITIAL CARDIAC CARE/INITIAL MEDICAL CARE/ROUTINE CARDIAC CARE
 GENERAL PATIENT ASSESSMENT/ABBREVIATED RADIO REPORT
2. RESPIRATORY DISTRESS
3. AIRWAY OBSTRUCTION
4. CARDIAC ARREST
5. CARDIOGENIC SHOCK
6. VENTRICULAR FIBRILLATION - PULSELESS VENTRICULAR TACHYCARDIA
7. TACHYCARDIAS (WITH PULSE)
8. VENTRICULAR ECTOPY
9. PULSELESS ELECTRICAL ACTIVITY
10. BRADYCARDIA (PULSE < 60)
11. ASYSTOLE
12. SUSPECTED CARDIAC PATIENT
13. PULMONARY EDEMA DUE TO HEART FAILURE

CODE TRAUMA PROTOCOLS

14. FIELD TRIAGE PROTOCOLS
15. REVISED TRAUMA SCORE/GLASGOW COMA SCALE
16. ROUTINE TRAUMA CARE: PRIMARY AND SECONDARY ASSESSMENT
17. HEMORRHAGIC SHOCK
18. SUSPECTED SPINAL CORD INJURY - SPINAL IMMOBILIZATION
19. HEAD TRAUMA/UNCONSCIOUS PATIENT
20. TRAUMATIC CARDIOPULMONARY ARREST
21. ISOLATED EXTREMITY INJURY AND/OR /AMPUTATED AVULSED PARTS
- 21a. CRUSH INJURIES

CODE TRAUMA PROTOCOLS - CONTINUED

- 22. BURNS
- 23. CHEST TRAUMA
- 24. TRAUMA IN PREGNANCY
- 25. INITIAL MANAGEMENT OF THE PEDIATRIC TRAUMA PATIENT
- 26. ACCELERATED TRANSPORT
- 27. PEDIATRIC TRAUMA
- 28. PEDIATRIC ASSESSMENT and TRAUMA SCORE
- 29. PEDIATRIC BURNS (Thermal, Electrical, Chemical)

CODE PROTOCOLS FOR MEDICAL EMERGENCIES

- 30. ACUTE ASTHMA/COPD WITH WHEEZING
- 31. ALLERGIC REACTION/ANAPHYLACTIC SHOCK
- 32. DIABETIC GLUCOSE EMERGENCIES
- 33. DRUG OVERDOSE/ALCOHOL RELATED EMERGENCIES/POISONING
- 34. COMA OF UNKNOWN ORIGIN (NO HISTORY OF TRAUMA)
- 35. SEIZURES/STATUS EPILEPTICUS
- 36. HEAT EMERGENCIES
- 37. COLD EMERGENCIES
- 38. SUSPECTED STROKE
- 39. HAZARDOUS MATERIALS - GENERAL
- 40. HAZARDOUS MATERIALS - EYE
- 41. HAZARDOUS MATERIALS - PESTICIDE/NERVE AGENT
- 42. HAZARDOUS MATERIALS - RADIATION
- 43. RENAL PROTOCOLS
- 44. DROWNING

CODE OBSTETRICAL/GYNECOLOGICAL PROTOCOLS

- 45. EMERGENCY CHILDBIRTH - LABOR & DELIVERY
- 46. OBSTETRICAL COMPLICATIONS
- 47. ABNORMAL DELIVERIES
- 48. RESUSCITATION AND CARE OF THE NEWBORN
- 49. MATERNAL CARE

CODE PEDIATRIC PROTOCOLS

- 50. PEDIATRIC INITIAL ASSESSMENT
- 51. PEDIATRIC CARDIAC ARREST
- 52. PEDIATRIC BRADYCARDIA
- 53. PEDIATRIC WIDE COMPLEX TACHYCARDIA
- 54. PEDIATRIC NARROW COMPLEX TACHYCARDIA
- 55. PEDIATRIC RESPIRATORY DISTRESS
- 56. PEDIATRIC RESPIRATORY ARREST
- 57. PEDIATRIC SHOCK
- 58. PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS
- 59. PEDIATRIC SEIZURES
- 60. PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS
- 61. PEDIATRIC TOXIC EXPOSURES/INGESTIONS
- 62. PEDIATRIC HEAT EMERGENCIES
- 63. PEDIATRIC COLD EMERGENCIES
- 64. PEDIATRIC DROWNING

CODE PROTOCOLS FOR SPECIAL SITUATIONS

- 65. SUSPECTED CHILD ABUSE AND NEGLECT
- 66. PSYCHOLOGICAL EMERGENCIES/DOMESTIC VIOLENCE/SPOUSAL ABUSE/
 GERIATRIC ABUSE/SEXUAL ASSAULT
- 67. TRIPLE 000/DNR/CRITERIA FOR INITIATION OF CPR
- 68. RESTRAINTS AND BEHAVIORIAL EMERGENCIES
- 69. REFUSALS OF CARE

CODE PROCEDURAL PROTOCOLS

- 70. DEFIBRILLATION-(Recommended Equipment for all BLS Providers)
- 71. MEDICATION ADMINISTRATION – NEBULIZED INHALATION
- 72. MEDICATION ADMINISTRATION – AUTO-INJECTOR PEN
- 73. CONTINUOUS POSITIVE AIRWAY PRESSURE ADMINISTRATION
- 74. INTRANASAL ADMINISTRATION
- 75. FAILED ADULT AIRWAY

REGION 7

STANDING MEDICAL ORDERS

CARDIAC PROTOCOLS

Code 1

INITIAL MEDICAL CARE ROUTINE CARDIAC CARE GENERAL PATIENT ASSESSMENT

1. Prehospital providers shall always assess the scene to assure the safety of all personnel.
2. Patient care and treatment begins at the "bedside."
3. Prehospital personnel shall take all reasonable precautions to prevent exposure to blood and/or body fluids of any patient. Use fluid repellent gowns, masks and goggles as situation dictates.

GENERAL PATIENT ASSESSMENT

1. Initial Assessment
 - A. Airway - Establish and/or maintain an airway (cervical spine control, if indicated)
 - B. Breathing - Assist ventilation as required
 - C. Circulation (pulse) and hemorrhage control (if indicated)
 - D. Disability (Level of Consciousness)
 1. "Alert"
 2. "Verbal" - (responds to verbal stimuli)
 3. "Pain" - (responds to painful stimuli)
 4. "Unresponsive"
 - E. Exposure and examine (if indicated)
2. Focused Assessment
 - A. Vital signs, and where applicable, Glasgow Coma Scoring parameters
 - B. Systematic head - to - toe detailed assessment
 - C. History of present illness/injury

INITIAL MEDICAL CARE/ROUTINE CARDIAC CARE

1. Reassure patient, provide comfort and loosen tight clothing.
2. Sit patient in semi-Fowler's or position of comfort (if applicable)
3. Obtain Pulse Oximeter value prior to oxygen delivery (if available)
Deliver OXYGEN 2-6 L/nasal cannula or 12-15L by mask, unless otherwise specified.
4. Contact hospital as soon as patient's condition permits. Transmit assessment information and await orders. If no radio contact can be established or patient's condition requires immediate treatment, refer to appropriate SMO and begin intervention immediately.
5. Recheck vitals and other pertinent signs at least every 15 minutes and record, noting times.
6. Transport to closest hospital. NOTE: By law, a physician must certify that the benefits outweigh the risk of transport to a facility other than the nearest hospital. If the patient refuses care or transport to the closest hospital, refer to policy and document signatures and situation.

NOTE: In a combative or uncooperative patient, the requirement to initiate initial routine medical care, as written, may be altered or waived in favor of rapidly transporting the patient for definitive care. Document the patient's actions or behaviors which interfered with the performance of any assessments and/or interventions.

OUTLINE FOR RADIO REPORT (Transmit using as few words as possible)

1. Name and vehicle number of provider
2. Requested destination, closest hospital, and estimated time of arrival
3. Age, sex, and approximate weight of patient
4. Chief Complaint, to include symptoms and degree of distress
5. History of present illness/injury
6. Pertinent Medical History:
 - Allergies
 - Medications
 - Past History of Current Illness
 - Last Meal
 - Events surrounding incident
7. Clinical condition:
Focused and detailed patient assessment findings
8. Treatment initiated and Response

Code 1a

**INITIAL MEDICAL CARE
ROUTINE CARDIAC CARE
GENERAL PATIENT ASSESSMENT
ABBREVIATED RADIO REPORT**

The use of an abbreviated report is optional. A full report may always be given at the discretion of the prehospital provider. A full report must always be given when vital signs are unstable, when any treatment has been initiated other than **OXYGEN** AND/OR establishment of an IV, OR when requesting transport to other than the closest hospital (by time).

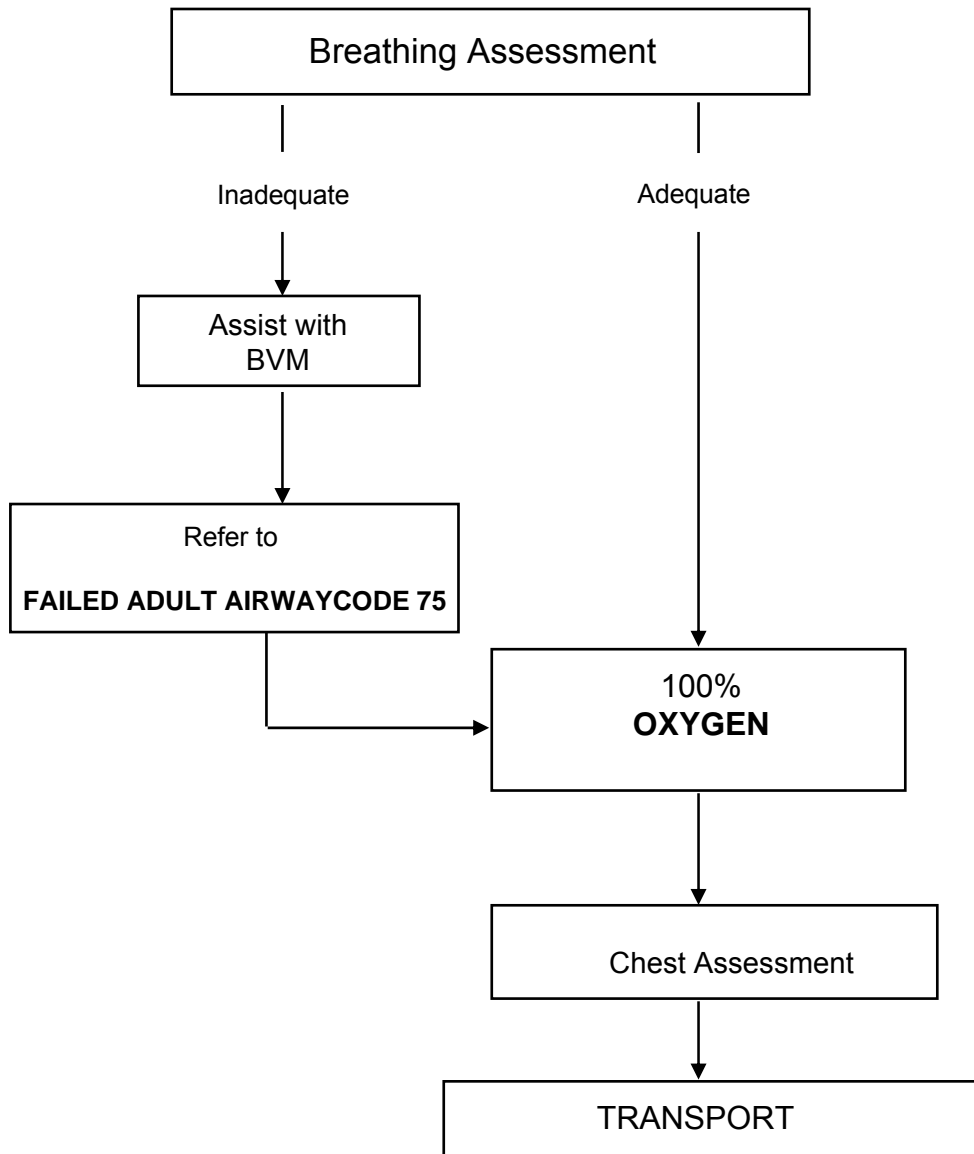
Refer to **CODE 1** and follow the steps under **GENERAL PATIENT ASSESSMENT** and **INITIAL MEDICAL CARE/ROUTINE CARDIAC CARE**.

OUTLINE FOR ABBREVIATED RADIO REPORT (Transmit using as few words as possible)

1. Name and vehicle number of provider
2. Requested destination, closest hospital, and estimated time of arrival
3. Age and sex
4. Chief Complaint, to include symptoms and degree of distress
5. Clinical condition:
 - Vital signs stable

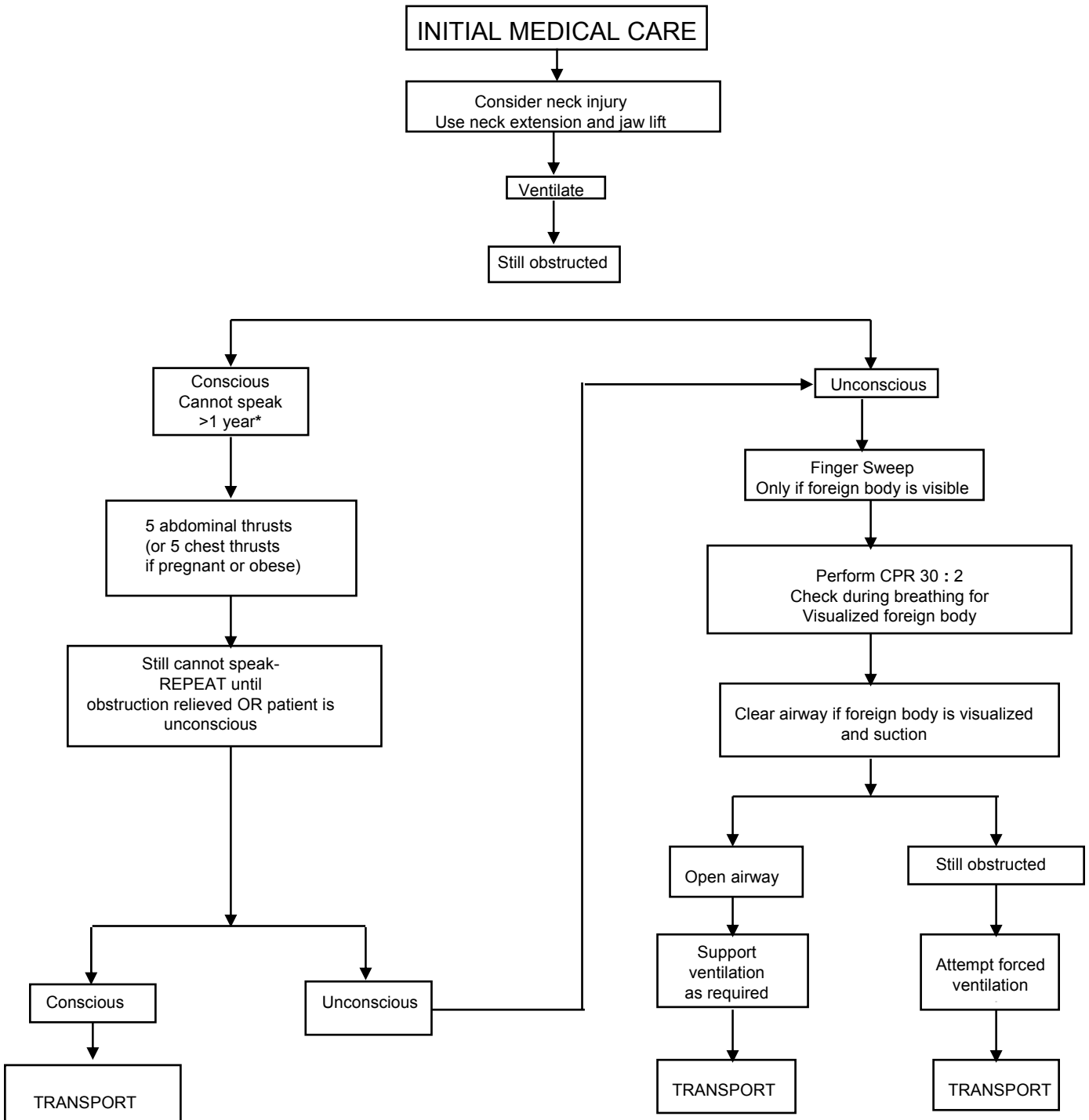
Code 2

RESPIRATORY DISTRESS



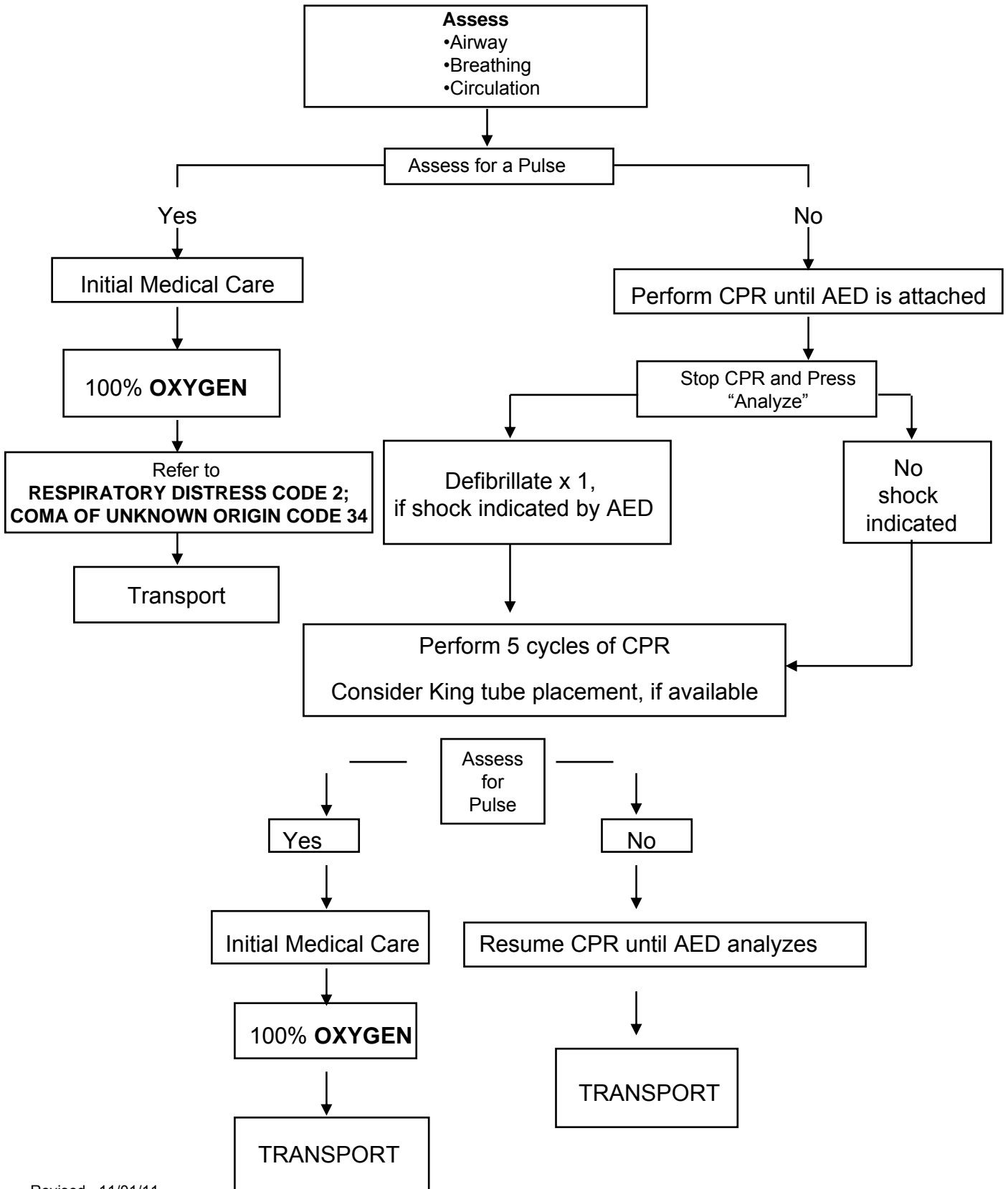
Code 3

AIRWAY OBSTRUCTION



Code 4

CARDIAC ARREST



Code 5

CARDIOGENIC SHOCK

INITIAL MEDICAL CARE



TRANSPORT

Code 6

**VENTRICULAR FIBRILLATION/
PULSELESS VENTRICULAR TACHYCARDIA**

**REFER TO CODE 4
CARDIAC ARREST**

Code 7

TACHYCARDIAS (WITH PULSE)

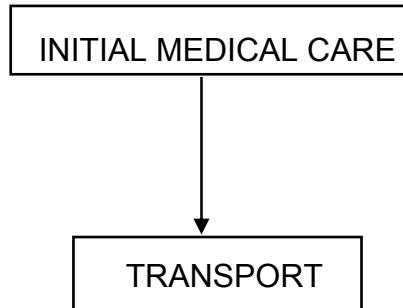
INITIAL MEDICAL CARE



TRANSPORT

Code 8

VENTRICULAR ECTOPY



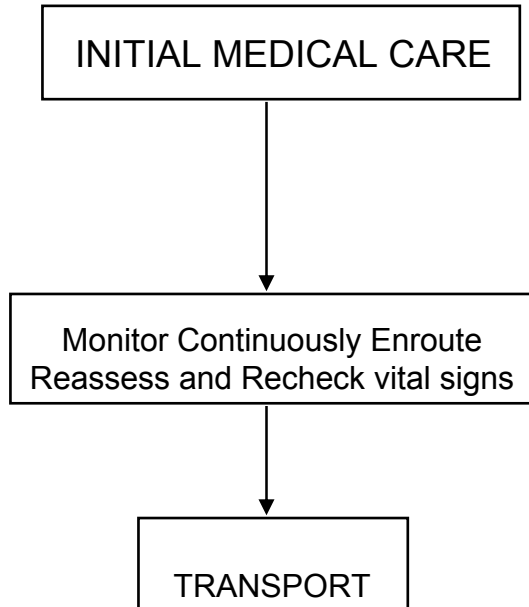
Code 9

PULSELESS ELECTRICAL ACTIVITY

SEE CODE 4

Code 10

BRADYCARDIA (Pulse <60)



Code 11

ASYSTOLE

SEE CODE 4

Code 12

SUSPECTED CARDIAC PATIENT

INITIAL MEDICAL CARE
Perform 12 Lead EKG and Transmit, if available

SBP <90mmHg

4 tabs **BABY ASPIRIN** PO
unless
contraindicated*

Refer to
**APPROPRIATE
SMO**

SBP 90-110mmHg

4 tabs **BABY ASPIRIN** PO
unless
contraindicated*

TRANSPORT

SBP >110mmHg

4 tabs **BABY ASPIRIN** PO
unless
contraindicated*

NITROGLYCERIN**
gr 1/150 tab SL **OR** spray SL
May repeat X 2 in 5 minutes

Repeat vital signs

TRANSPORT

Consider 12-Lead EKG for complaints of:

(may be deferred if patient unstable)

- Chest pain/Discomfort/Pressure
- Arm Pain (non-traumatic)
- Jaw Pain (non-traumatic)
- Upper back pain (non-traumatic)
- Unexplained diaphoresis
- Vomiting without fever or diarrhea
- Shortness of breath
- Dizziness/syncope
- Epigastric pain
- Fall in the elderly (unexplained)
- Weakness/Fatigue
- Bradycardia or Tachycardia

NOTE TO PREHOSPITAL PROVIDERS:

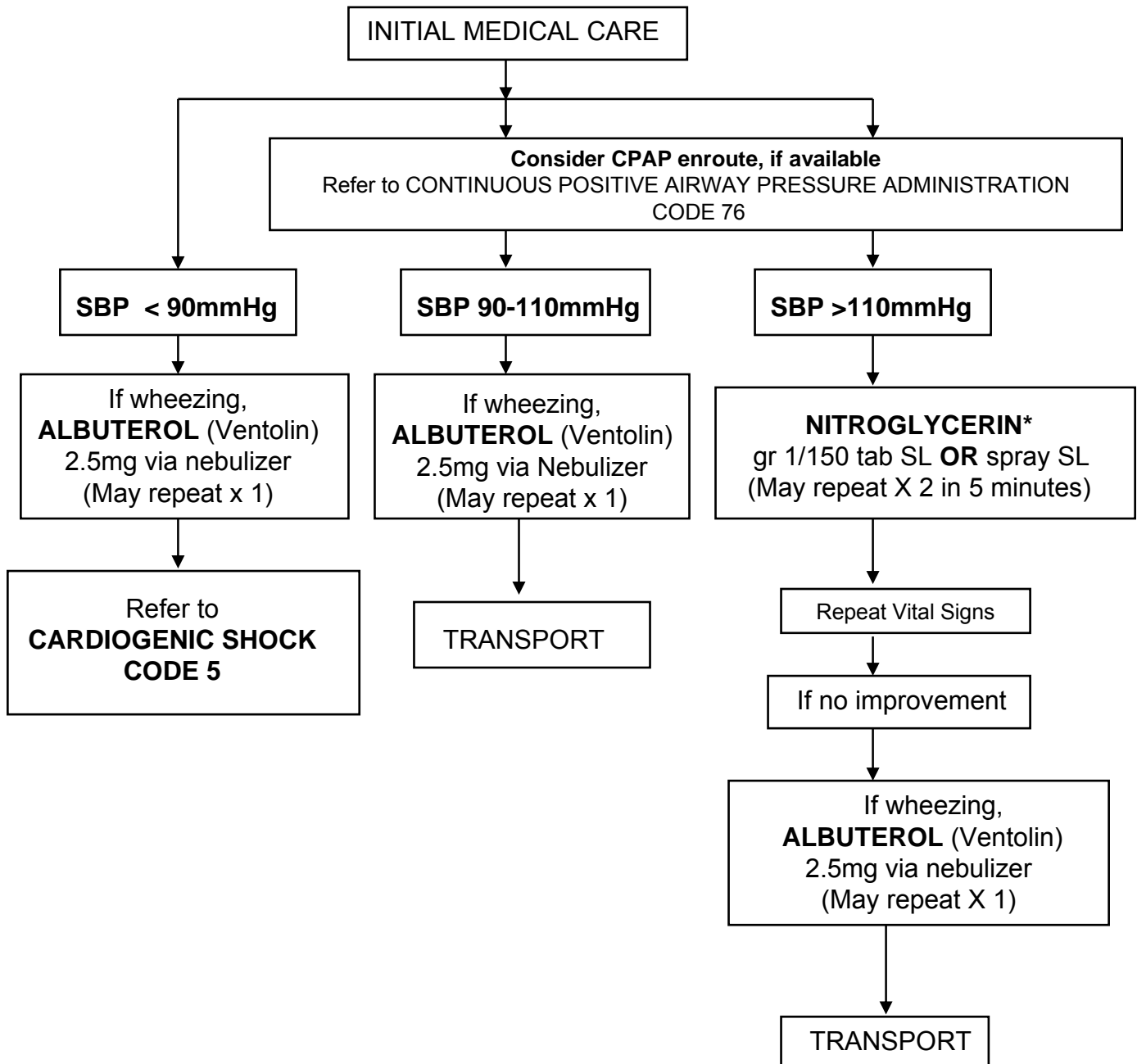
*Contraindications to **ASPIRIN** would include **ASPIRIN** allergy & history of gastrointestinal bleeding.

**Contact Medical control: may assist with self administration of patient's prescription
NITROGLYCERIN gr 1/150 tab SL **OR** spray SL.

Contact Medical Control prior to administration of **NITRATES if patient is taking erectile dysfunctional medications
(i.e. Viagra, Levitra, Cialis).

Code 13

PULMONARY EDEMA DUE TO HEART FAILURE



NOTE TO PREHOSPITAL PROVIDER:

*Contact Medical Control: May assist with the self administration of patient's prescription **NITROGLYCERIN** gr 1/150 tab SL OR spray SL.

*Contact Medical Control prior to administration of **NITRATES** if patient is taking erectile dysfunctional medication (i.e. Viagra, Levietra, Cialis).

Revised 11/01/11
Effective 10/01/98
BLS

REGION 7

STANDING MEDICAL ORDERS

TRAUMA PROTOCOLS

Reviewed 11/01/11
Effective 10/01/98

BLS

Code 14

FIELD TRIAGE PROTOCOLS

- Transport directly to the nearest Level I Trauma Center if transport time is less than 25 minutes.
- Transport to the nearest Level II Trauma Center if transport time is less than 30 minutes.
- Transport to the nearest Emergency Department if transport time is greater than 30 minutes

FIELD TRIAGE CATEGORY I

Sustained hypotension - B/P \leq 90 systolic (Peds \leq 80 systolic) on two consecutive measurements five minutes apart.

■ Cavity penetration of the torso or neck

→ MANDATORY NOTIFICATION OF THE TRAUMA SURGEON FROM THE FIELD (done by the Trauma Center).

→ PATIENTS BEING BYPASSED TO A TRAUMA CENTER MUST BE ADEQUATELY VENTILATED (ET TUBE OR BVM) AND HAVE CERVICAL IMMOBILIZATION AS INDICATED. OTHERWISE, THE PATIENT SHOULD BE TRANSPORTED TO THE CLOSEST COMPREHENSIVE EMERGENCY DEPARTMENT.

■ Blunt or penetrating trauma with unstable vital signs and/or:

- Hemodynamic compromise as evidenced by:
Adult B/P \leq 90 systolic
Peds B/P \leq 80 systolic
- Respiratory compromise as evidenced by:
respiratory rate $<$ 10 OR $>$ 29
- Head injury with altered mentation as evidenced by a Glasgow Coma Score \leq 10.

CATEGORY II

Mechanism of Injury:

- Anatomical Injury:
 - Penetrating injury of the head, neck, chest or abdomen.
 - Two or more body regions with potential life or limb threat.
 - Combination trauma with \geq 20% TBSA.
 - Amputation above the wrist or ankle.
 - Limb paralysis and/or sensory deficit above the wrist or ankle.
 - Flail chest.
 - Two or more proximal long bone fractures.
- All patients who, *in the judgement of the prehospital personnel*, would benefit from the care derived at a Trauma Center- those conditions which may be considered for direct bypass to a Trauma Center may include:
 - Head Injury with persistent unconsciousness or focal signs such as seizures, posturing or the inability to respond to simple commands.
 - Transmediastinal gunshot wounds
 - Spinal cord injury with paralysis
 - Maternal trauma with significant mechanism and/or obvious trauma at 20-32 weeks gestation.
 - Pediatric trauma including blunt or penetrating head, chest or abdominal trauma.

- Ejection from a motor vehicle.
- Death in the same passenger compartment.
- Falls $>$ 20 feet.
- Falls $>$ three times the body length of a child.
- Maternal trauma $>$ 24 weeks.

Code 15

REVISED TRAUMA SCORE/GLASGOW COMA SCALE

A standard procedure for assessing revised trauma scores in the field is necessary so that the reliability of that revised trauma score is recognized by both field personnel and emergency department personnel.

The patient is scored by assessing the following vital functions and computing a score - the **REVISED TRAUMA SCORE**.

- A. Respiratory rate
- B. Systolic blood pressure
- C. Glasgow coma scale

For the Glasgow Coma Scale, the examiner determines the best response the patient can make to a set of standardized stimuli.

- I. Eye opening:
The examiner determines the minimum stimulus that evokes opening of one or both eyes.
 - a. (4 points) SPONTANEOUS
 - b. (3 points) VOICE
 - c. (2 points) PAIN
 - d. (1 point) NONE

Note: If the patient cannot open the eyes because of bandages, edema or direct trauma, please note and document in the patient's record.

- II. Best Verbal Response:
The examiner determines the BEST response after arousal:
 - a. (5 points) ORIENTED
 - b. (4 points) CONFUSED
 - c. (3 points) INAPPROPRIATE WORDS
 - d. (2 points) INCOMPREHENSIBLE SOUNDS
 - e. (1 point) NO VERBAL RESPONSE

Note: If the patient is intubated, dysphasic or has maxillofacial injuries which may preclude a verbal response, the examiners assessment should be documented in the patient's record.

- III. Best Motor Response:
The examiner determines the BEST movement from either arm in response to stimulus.
 - a. (6 points) OBEYS SIMPLE COMMANDS
 - b. (5 points) LOCALIZES PAIN
 - c. (4 points) FLEXION WITHDRAWAL
 - d. (3 points) ABNORMAL FLEXION
 - e. (2 points) ABNORMAL EXTENSION
 - f. (1 points) NO MOTOR RESPONSE

Note: If the patient has suspected or known spinal cord injury, this neurologic deficit should be noted in the patient's record.

The components necessary to calculate the Revised Trauma Score and Glasgow Coma Scale will be obtained by prehospital personnel. The actual calculation of these scores will be performed by medical control. These scores are to be obtained when the need for transport to a trauma center is questionable.

ROUTINE TRAUMA CARE

1. Prehospital providers shall always assess the scene to assure the safety of all personnel.
2. Patient care and treatment begins at the scene.
3. Prehospital personnel shall take all reasonable precautions to prevent exposure to blood and/or body fluids of any patient. Use fluid repellent gloves, gowns, masks and goggles, as situation dictates.
4. For pediatric Dosing, utilize a length based Pediatric Tape or Chart.

PRIMARY PATIENT ASSESSMENT

1. ESTABLISH LEVEL OF RESPONSIVENESS
 - Brief history: Any dyspnea or pain?
2. IMMOBILIZE C-SPINE
 - Manual immobilization initially
 - Rigid collar, Cervical Immobilization Device, and backboard prior to transport
(Refer to **SUSPECTED SPINAL CORD INJURY/SPINAL IMMOBILIZATION CODE 18**)
3. AIRWAY (Refer to **OBSTRUCTED AIRWAY CODE 3**)
 - Open or secure as needed
4. CHECK THE NECK
 - Carotid pulses
If absent: CPR, Accelerated transport (Refer to **TRAUMATIC CARDIOPULMONARY ARREST CODE 20**)
 - Tracheal deviation (Refer to **CHEST TRAUMA CODE 23**)
 - Jugular vein distention (Refer to **CHEST TRAUMA CODE 23**)
5. BREATHING (Refer to **CHEST TRAUMA CODE 23** and **RESPIRATORY DISTRESS CODE 2**)
 - ASSIST VENTILATION AS REQUIRED
 - Inspect the chest
 - Palpate the chest
 - Auscultate the chest (including the heart)
6. CIRCULATION (Refer to **HEMORRHAGIC SHOCK CODE 17**)
 - Life threatening hemorrhage - STOP THE BLEEDING
For uncontrolled hemorrhage, consider use of a hemostatic agent, if available.
 - Peripheral pulses (weak, thready, absent)
 - Capillary refill (if delayed)
7. NEUROLOGIC DEFICIT (Refer to **HEAD TRAUMA/UNCONSCIOUS PATIENT CODE 19**)
 - AVPU
 - Motor & Sensory
 - Pupils

ROUTINE TRAUMA CARE

SECONDARY PATIENT ASSESSMENT

1. Vital Signs
2. GCS scoring parameters
3. Systematic head to toe assessment
4. Medications
5. Allergies
6. Reassure patient, provide comfort and loosen tight clothing
7. Contact hospital as soon as patient's condition permits. Transmit assessment information and await orders. If no contact can be established or patient's condition requires immediate treatment, refer to appropriate SMO and begin intervention immediately.
8. Recheck vitals and other pertinent signs at least every 15 minutes and record, noting times. If unstable vital signs/sustained hypotension (SBP <90 on two separate readings 5 minutes apart), vital signs should be taken and recorded every 5 minutes.
9. All patients, who, in the judgment of prehospital personnel, would benefit from care derived from a Trauma Center, should be transported accordingly (Refer to **FIELD TRIAGE PROTOCOLS CODE 14**). If no patent airway, transport to nearest hospital.

NOTE TO PREHOSPITAL PROVIDERS:

In a combative or uncooperative patient, the requirement to initiate initial routine trauma care, as written, may be altered or waived in favor of rapidly transporting the patient for definitive care. Document the patient's actions or behaviors which interfered with the performance of any assessments and/or interventions.

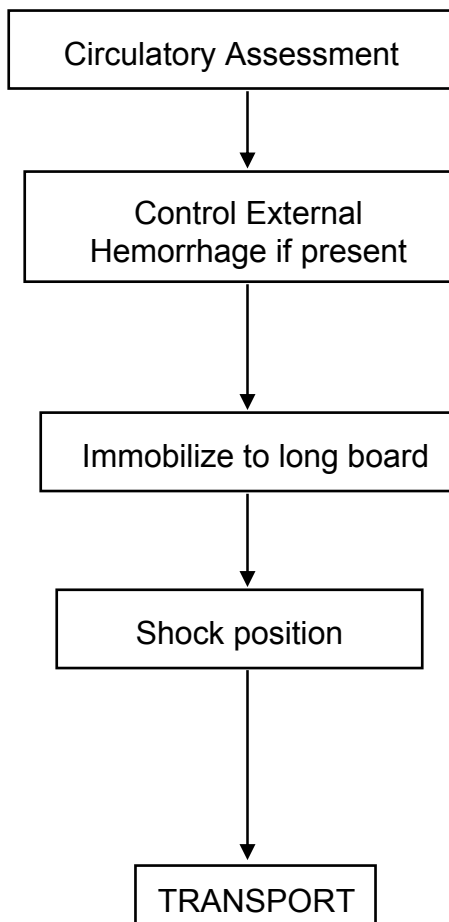
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6. Pertinent Medical History
 - Allergies
 - Medications
 - Past History of Current Illness
 - Last Meal
 - Events surrounding incident
7. Clinical condition:
Focused and detailed patient assessment findings
8. Treatment initiated and Response

Code 17

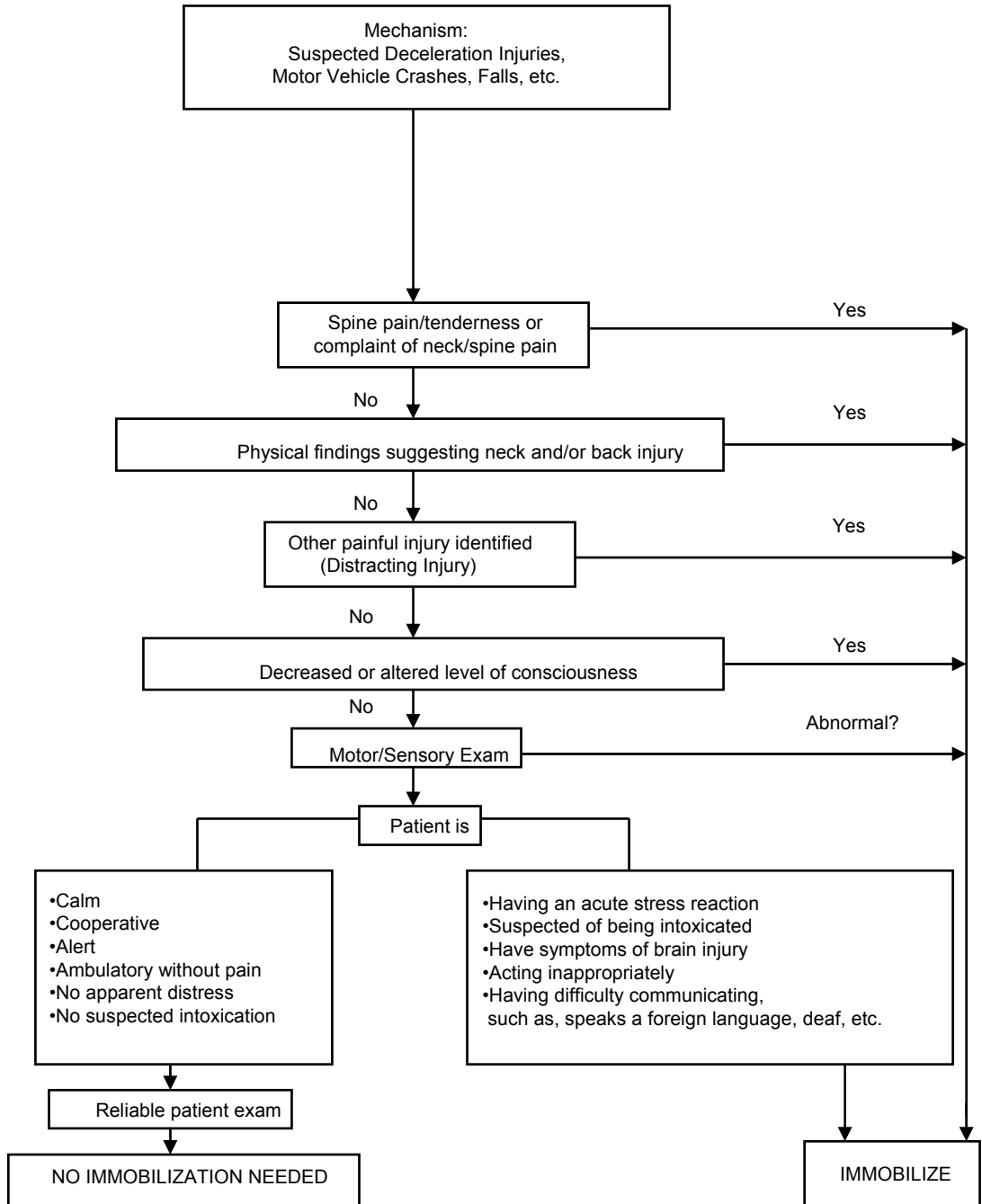
HEMORRHAGIC SHOCK

ROUTINE TRAUMA CARE WITH 100% OXYGEN



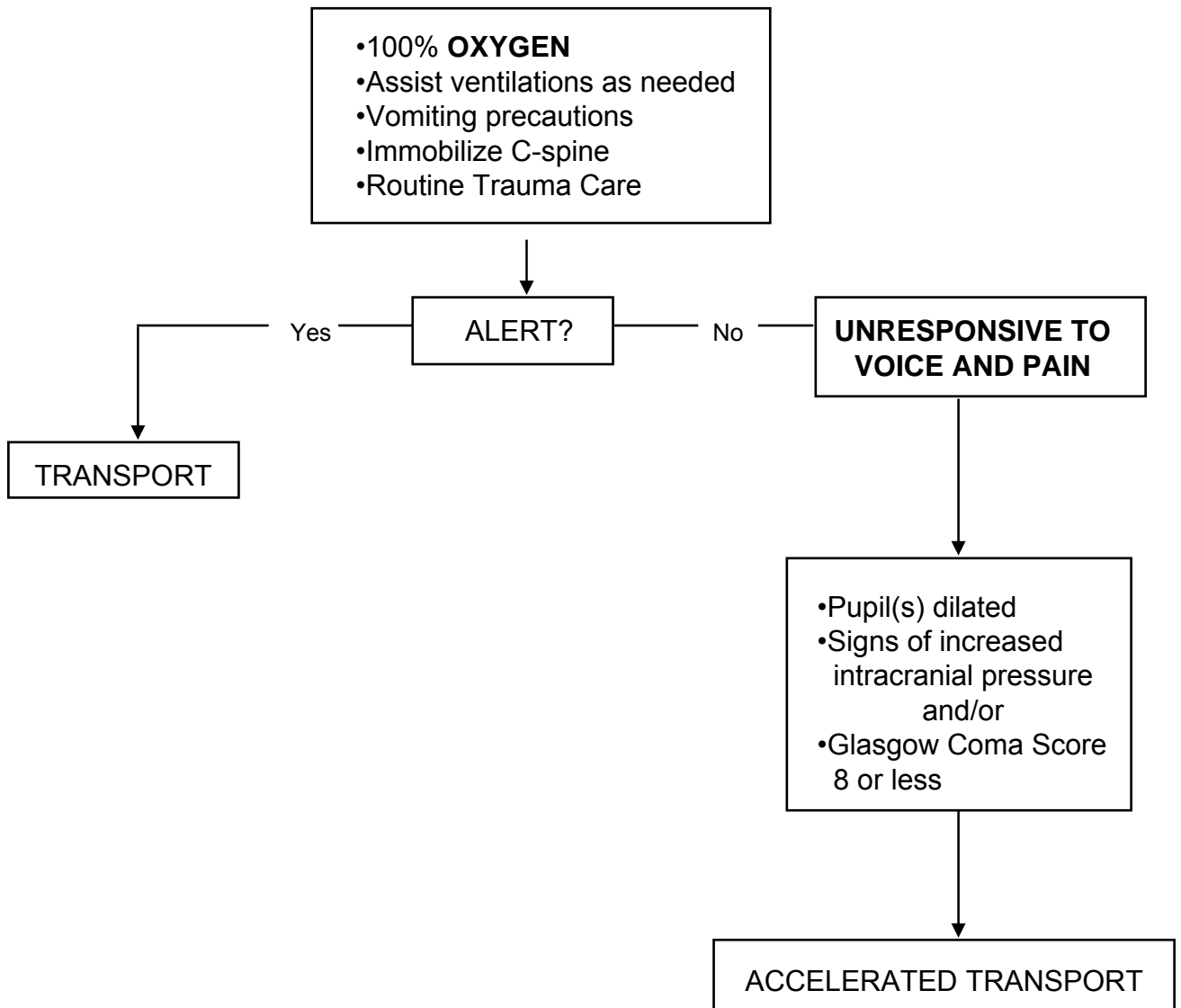
Code 18

SUSPECTED SPINAL CORD INJURY SPINAL IMMOBILIZATION



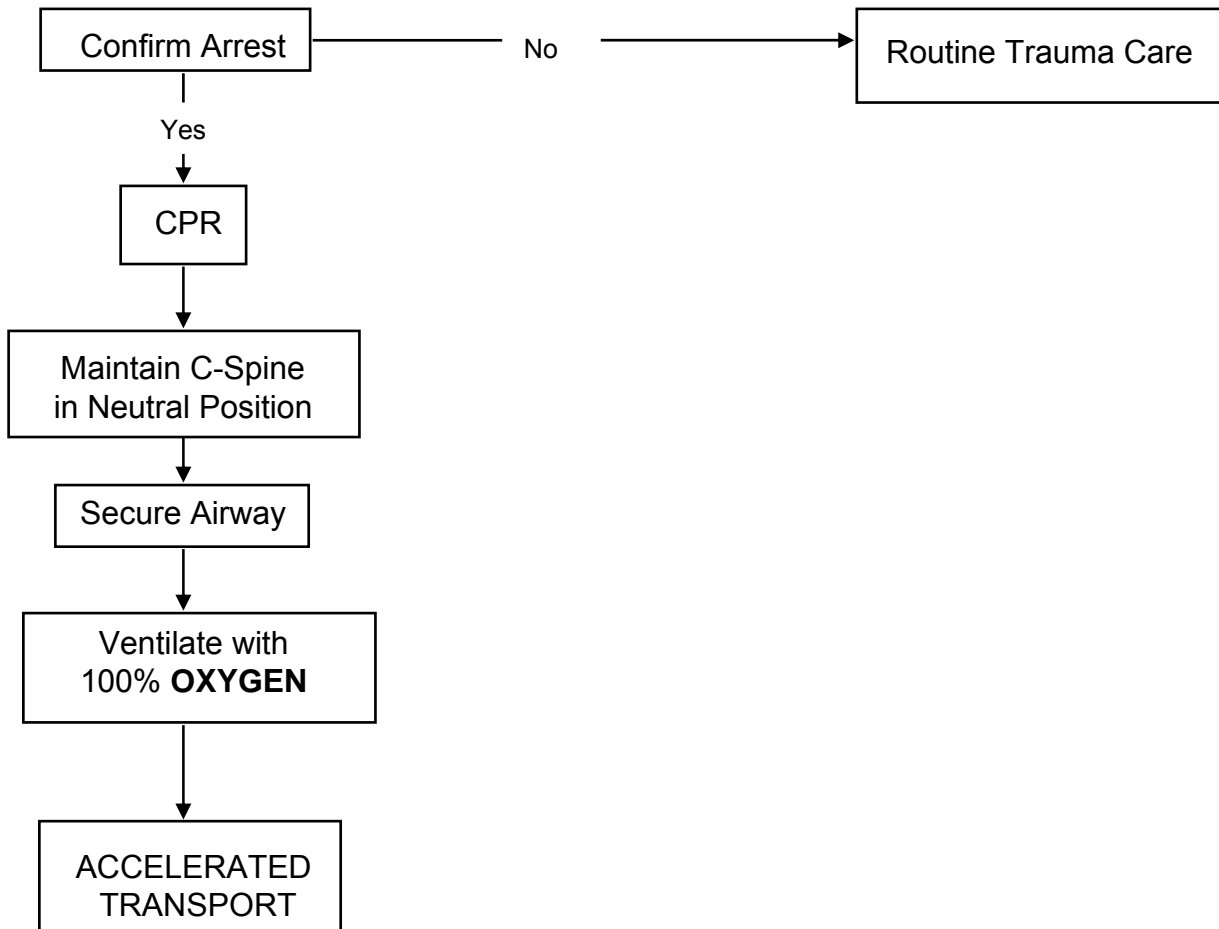
Code 19

HEAD TRAUMA/UNCONSCIOUS PATIENT



Code 20

TRAUMATIC CARDIOPULMONARY ARREST



Code 21

ISOLATED EXTREMITY INJURY AND/OR AMPUTATED AND AVULSED PARTS

INITIAL TRAUMA CARE
(ABCs always take priority over the severed part)

Control bleeding with direct pressure and elevation

For uncontrolled hemorrhage:

- Consider use of a hemostatic agent, if available
- Use a tourniquet if needed
 - Note time of placement
 - Apply as close to the injury as possible
 - DO NOT release once applied

- Wrap part in sterile gauze, sheet or towel.
- Place part in waterproof bag or container and seal.
- DO NOT immerse part in any solutions.
- Place this container in a second one filled with ice, cold water or cold pack.

Transport part to hospital with patient

TRANSPORT

Code 21a

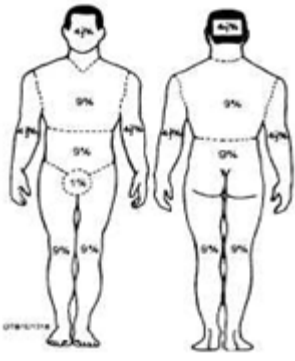
Crush Injury

Suspected in extended extremity
and/or
Torso entrapment

**STRONGLY CONSIDER ALS
INTERVENTIONS IF
AVAILABLE**

INITIAL MEDICAL CARE

TRANSPORT



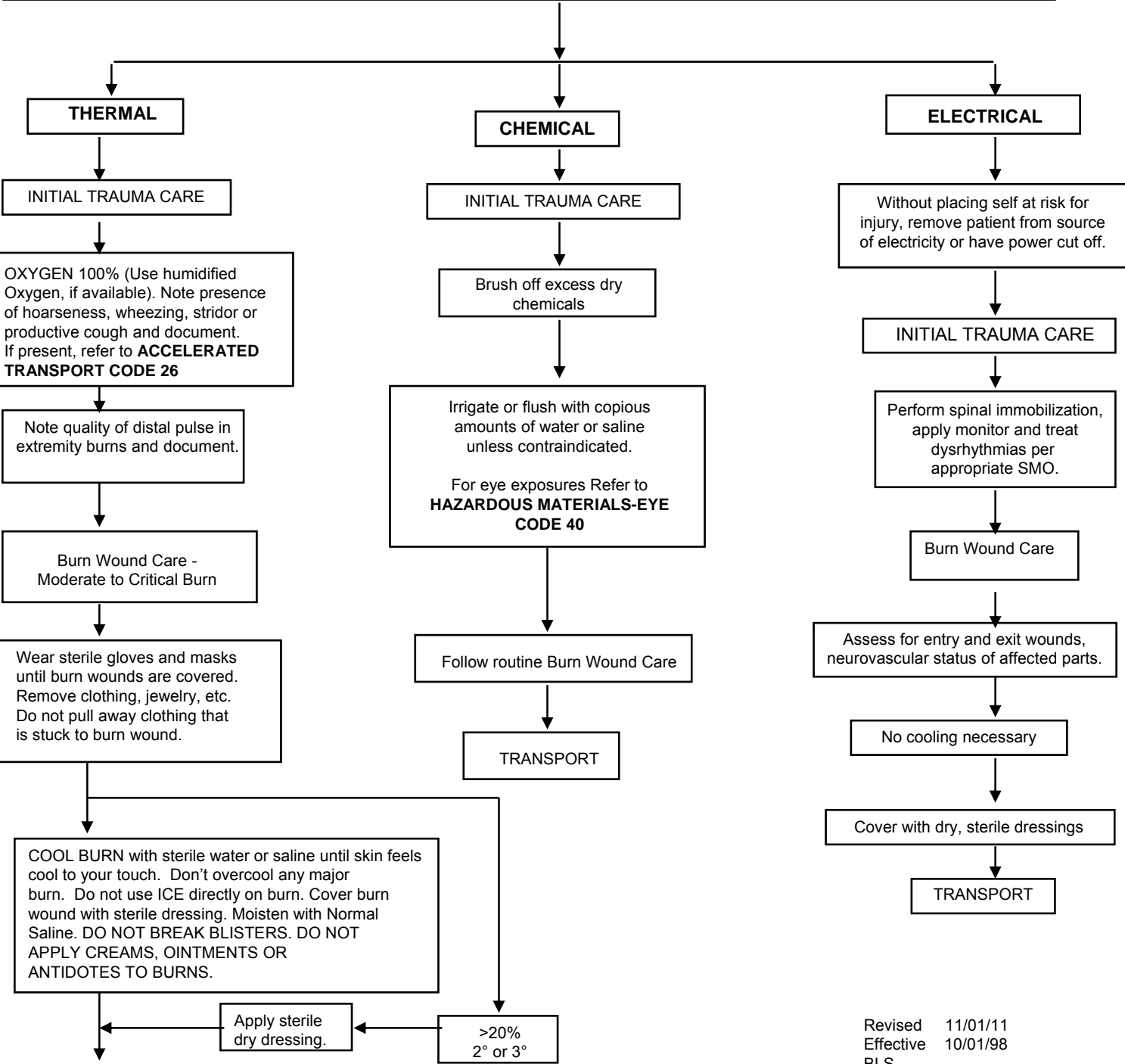
Code 22

BURNS

Burn patients are often victims of multiple trauma.
 Treatment of major traumatic injuries takes precedence over wound management.
Isolated burn injury patients should be transferred to the closest available hospital

ASSESS

- Total body surface area: use rule of 9s or estimate using patient's palmar surface as 1%
- Depth of burn: partial or full thickness, consider exposure to products of combustion and treat as soon as possible.

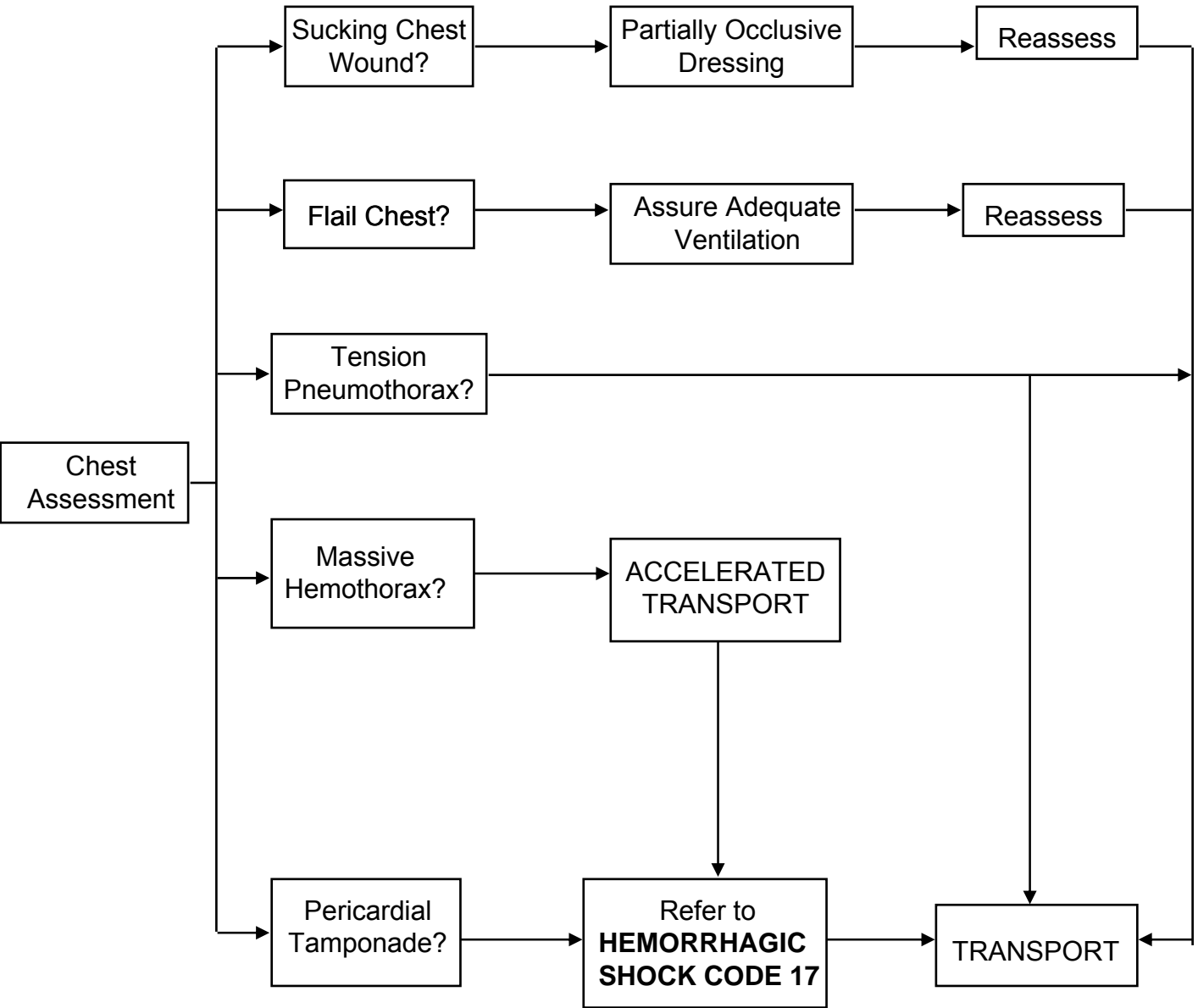


Revised 11/01/11
 Effective 10/01/98
 BLS

Open sterile sheet on stretcher before placing patient for TRANSPORT. Cover patient with dry, sterile sheets and blanket to maintain body temperature.

Code 23

CHEST TRAUMA



Code 24

TRAUMA IN PREGNANCY

Principles of Management

- A. Routine Trauma Care
- B. Check externally for uterine contractions.
- C. Check externally for vaginal bleeding.
- D. Unless spinal injury is suspected, transport on the left side to minimize uterine compression of the inferior vena cava.
- E. If a patient with suspected spinal injury becomes hypotensive while supine on backboard, elevate right side of backboard to relieve pressure on vena cava from uterus.
- F. Manually displace the uterus to the left side during CPR.

Code 25

INITIAL MANAGEMENT OF THE PEDIATRIC TRAUMA PATIENT

- Assess ABCs
- Administer 100% **OXYGEN**
- Immobilize spine as indicated
- Complete initial assessment, including *Pediatric Trauma Score**
- Keep warm

Refer to
HEAD TRAUMA CODE 19
as indicated

Ventilation, respiratory effort adequate

Inadequate ventilation, respiratory effort

Control hemorrhage

- Jaw thrust
- Relieve upper airway obstruction as indicated
- Assist ventilation with BVM as indicated
- Secure airway as appropriate

- Pulse oximetry, if available
- Reassess perfusion

Normal perfusion

Hypoperfusion*

Splint/immobilize fracture(s) as indicated

Refer to
PEDIATRIC SHOCK CODE 57
OR
PEDIATRIC CARDIAC ARREST CODE 51
as indicated

- Support ABCs
- Keep warm
 - Observe
 - TRANSPORT

Reviewed 11/01/11
Effective 10/01/98
BLS

NOTE TO PREHOSPITAL PROVIDERS:

*Refer to **PEDIATRIC ASSESSMENT AND TRAUMA SCORE CODE 28.**

Code 26

ACCELERATED TRANSPORT

Certain situations require treatment within minutes. These situations occur when a problem is discovered in the primary survey that cannot be rapidly resolved by field intervention. Only airway and spinal immobilization should be managed prior to transport. Further efforts at stabilization should be performed enroute and should not delay transport.

If circumstances demand hospital care for patient stability, rapid transport is indicated. Each case will be unique and compelling reasons must be documented. Notify the receiving hospital of the situation so that preparations can be made. Primary resuscitative measures must be initiated. Establish contact with medical control as soon as possible.

Code 27

PEDIATRIC TRAUMA

I. Routine Trauma Care

- A. Airway - Keep suction available
 - C-Spine immobilization
- B. Breathing
 - 1. Note changes in ventilation rates by age
 - 2. 100% **OXYGEN**
 - 3. Assist ventilations as needed
- C. Circulation
 - 1. Note variation of normal values

II. Treatment of Suspected Battered or Abused Child

(Refer to **SUSPECTED CHILD ABUSE AND NEGLECT CODE 65**):

- A. Treat obvious injuries
- B. If parents refuse to let you transport the child after treatment:
 - 1. Remain at the scene
 - 2. Call for police assistance
 - 3. Request that the officer place the child under protective custody
 - 4. Assist with transport
- C. You are required by law to report your suspicions to the Department of Children and Family Services (DCFS). Also, document and report your suspicions to the ED physician and/or charge nurse.
- D. Carefully document history, physical findings and environmental surroundings on patient care report.

Code 28

PEDIATRIC ASSESSMENT AND TRAUMA SCORE

Indicators of hypoperfusion:

- Respiratory difficulty
- Cyanosis despite oxygen administration
- Truncal pallor/cyanosis and coolness
- Hypotension (ominous sign)
- Bradycardia (late sign)
- Weak, thready, or absent peripheral pulses
- Decreasing consciousness
- No palpable blood pressure

Pediatric vital signs:

	Newborn	1 year	3 years	6 years	10 years	15 years
Pulse	100-160	90 - 120	80 - 120	70 - 110	60 - 90	60 - 90
Respirations	30- 60	20 - 30	20 - 30	18 - 25	15 - 20	15 - 18
Systolic Pressure	50- 90	80 - 100	80 - 110	80 - 110	90 - 120	100 - 130

Pediatric Trauma Score*:

Component	+2	+1	-1
Weight	>20 kg	10-20 kg	<10 kg
Airway	Normal	Maintainable	Unmaintainable
CNS	Awake	Obtunded	Coma
Systolic BP or **Pulse Palpable	>90mmHg At Wrist	90-50mm Hg At Groin	<50 mmHg or No Pulse Palpable
Open Wound	None	Minor	Major
Skeletal Injury	None	Closed Fx	Open/Multiple Fx

**If proper size BP cuff is unavailable, BP may alternatively be assigned by determining pulse palpable point.

TOTAL POINTS _____
(Total points range from -6 to +12)

Code 29

PEDIATRIC BURNS THERMAL, ELECTRICAL, CHEMICAL

ESTIMATING % OF BODY SURFACE AREA

Body Area	Age in Years			
	0-1	1-4	4-9	10-15
Head	19%	17%	13%	10%
Neck	2%	2%	2%	2%
Chest or Back (each)	13%	13%	13%	13%
Buttock (each)	2.5%	2.5%	2.5%	2.5%
Genitalia	1%	1%	1%	1%
Upper Arm (each)	4%	4%	4%	4%
Lower Arm (each)	3%	3%	3%	3%
Hand (each)	2.5%	2.5%	2.5%	2.5%
Thigh (each)	5.5%	6.5%	8.5%	8.5%
Lower leg (each)	5%	5%	5%	6%
Foot (each)	3.5%	3.5%	3.5%	3.5%

•Assess scene safety. As indicated:

- Remove patient to safety
- Appropriate body substance isolation

•Assess ABCs

•Administer 100% OXYGEN

•Complete initial assessment. Assess for:

- wheezing
- retractions
- stridor
- diminished respirations or apnea
- tachypnea
- grunting
- decreasing consciousness

•Refer to **INITIAL MGMT OF THE PEDI TRAUMA PT CODE 25**

•Assess percentage/depth of burn

•Remove constricting jewelry and clothes.

Respiratory Compromise

- Support ventilation with BVM
- Secure airway as appropriate
- Refer to **PEDIATRIC RESPIRATORY DISTRESS CODE 55**

Follow correct burn type path

No Respiratory Compromise

THERMAL BURNS

Superficial (1st degree)

- Cool burned area with water or saline until cool to your touch
- If <20% body surface involved, apply sterile saline soaked dressings. DO NOT OVER COOL major burns or apply ice directly to burned areas.

Partial or Full thickness (2nd or 3rd degree)

- Wear sterile gloves/mask while burn areas exposed
- Cover burn wound with DRY sterile dressings
- Place patient on clean sheet on stretcher and cover patient with dry clean sheets and blanket to maintain body temperature.
- Refer to **PEDIATRIC SHOCK CODE 57** as indicated.

ELECTRICAL BURNS

- Immobilize as indicated
- Apply AED if available and assess for dysrhythmias. Treat according to appropriate protocol
- Identify and document any entrance and exit wounds
- Assess neurovascular status of affected part
- Cover wounds with dry sterile dressings

CHEMICAL BURNS

- Refer to **PEDIATRIC TOXIC EXPOSURE/INGESTIONS CODE 61**
- If powdered chemical, brush away excess
- Remove clothing if possible
- Rapid visual acuity
- If eye involvement, irrigate with saline or sterile water continuously. **DO NOT CONTAMINATE THE UNINJURED EYE WITH EYE IRRIGATION**
- Irrigate area with copious amounts of sterile water or saline ASAP and during transport

SPECIAL CONSIDERATIONS:

- Assess for potential child abuse and follow appropriate reporting mechanism
- Keep the child warm and protect from hypothermia. Be cautious with cool dressings.
- Pulse oximetry, if available

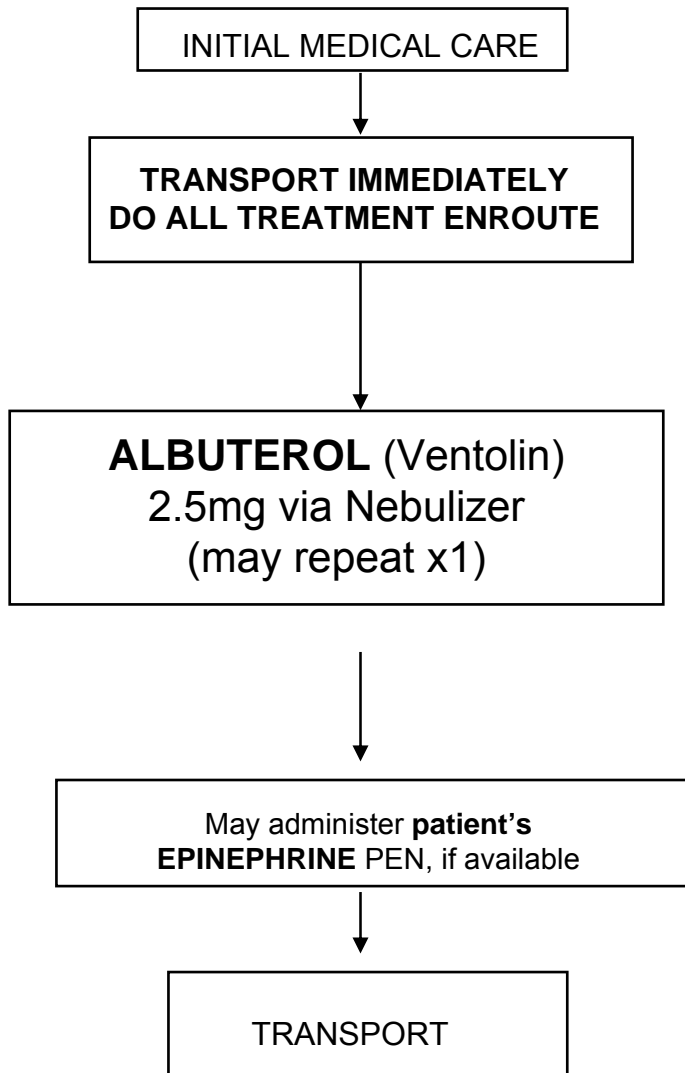
REGION 7

STANDING MEDICAL ORDERS

**PROTOCOLS FOR
MEDICAL EMERGENCIES**

Code 30

ACUTE ASTHMA/COPD WITH WHEEZING



NOTE TO PREHOSPITAL PROVIDERS:

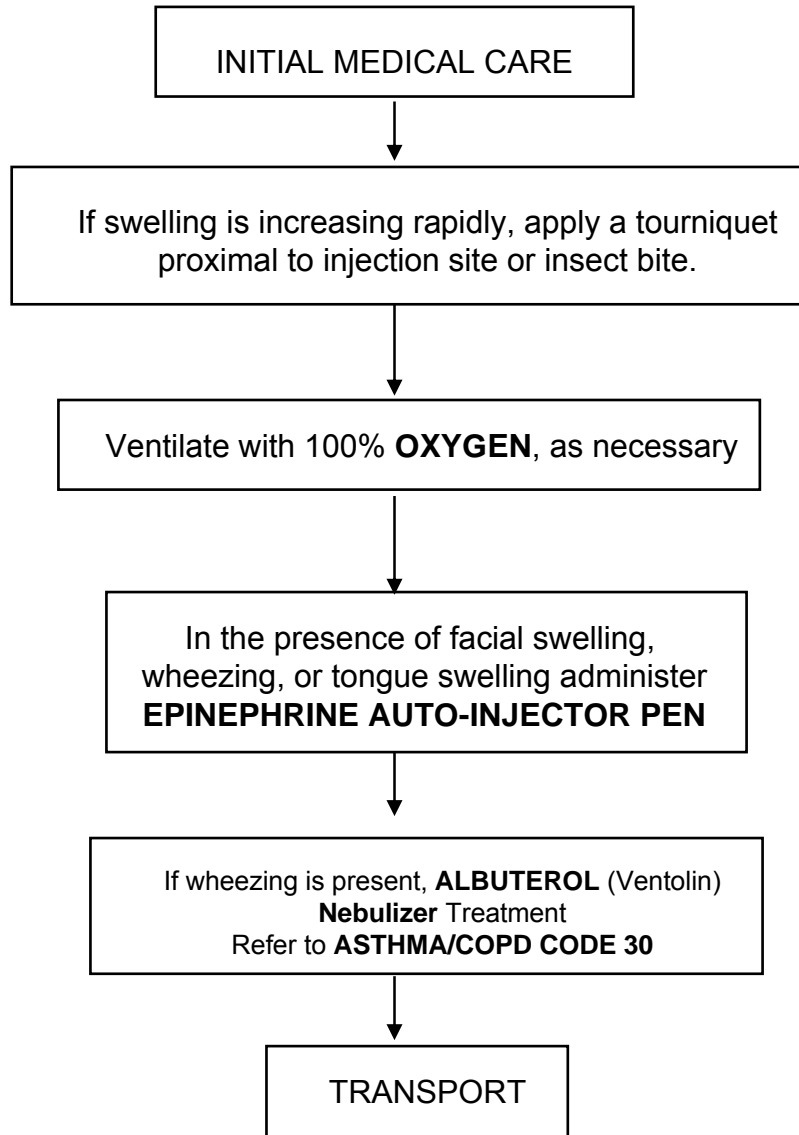
•**OXYGEN @ 2 - 6L/min.** If severe respiratory distress or cyanosis, 15L via NRB mask.

AT THE DISCRETION OF A PHYSICIAN/ECRN:

1. CPAP if available

Code 31

ALLERGIC REACTION ANAPHYLACTIC SHOCK



Code 32

DIABETIC/GLUCOSE EMERGENCIES

INITIAL MEDICAL CARE
(Include history of time last medication taken and whether or not patient has eaten.)

Obtain blood glucose reading, if available

Blood sugar level < 60 or signs & symptoms of Insulin Shock or Hypoglycemia

If patient is awake and gag reflex intact,
administer small amounts of **SUGAR SOLUTION** sublingually

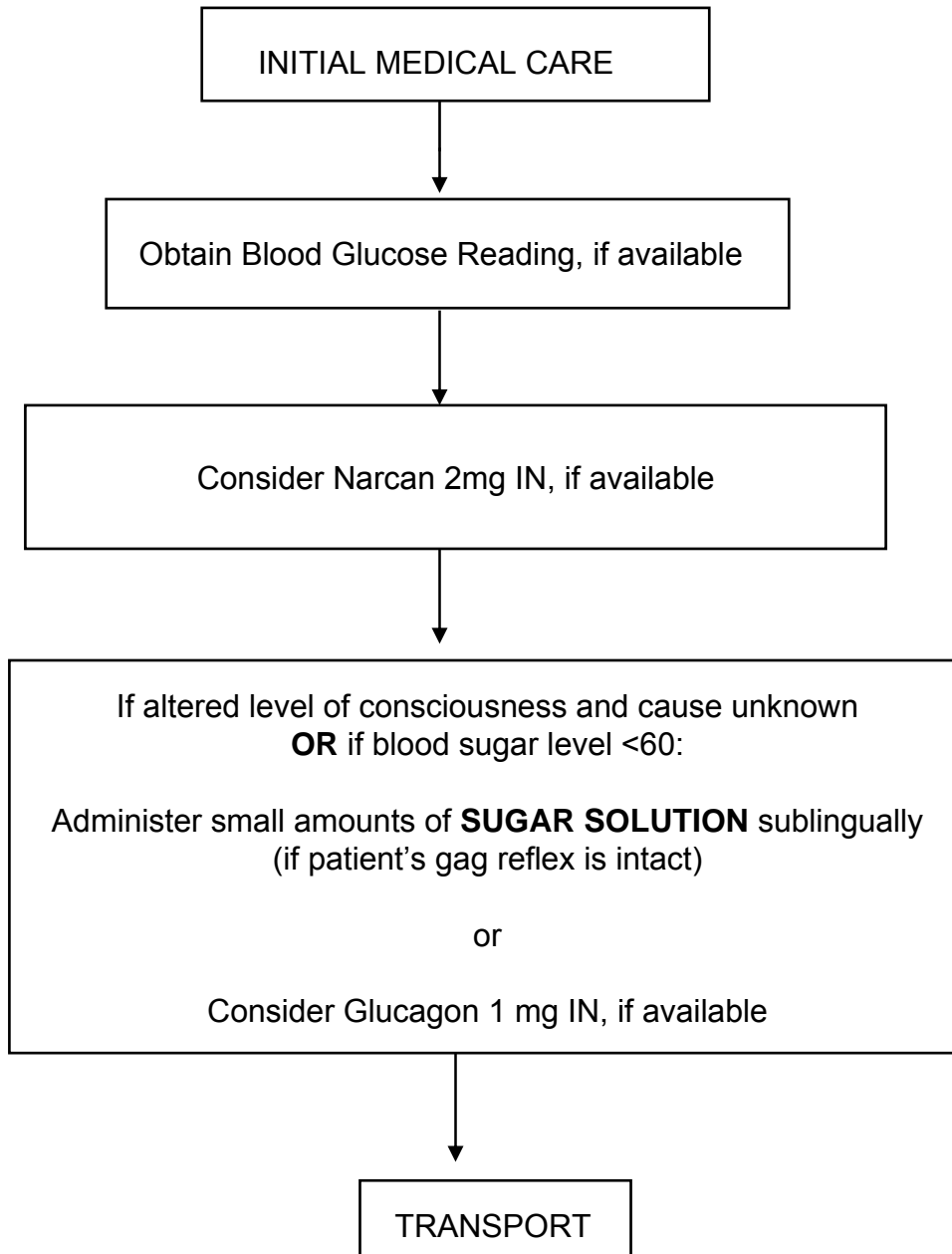
or

Consider Glucagon 1 mg IN, if available

TRANSPORT

Code 33*

DRUG OVERDOSE ALCOHOL RELATED EMERGENCIES/POISONING



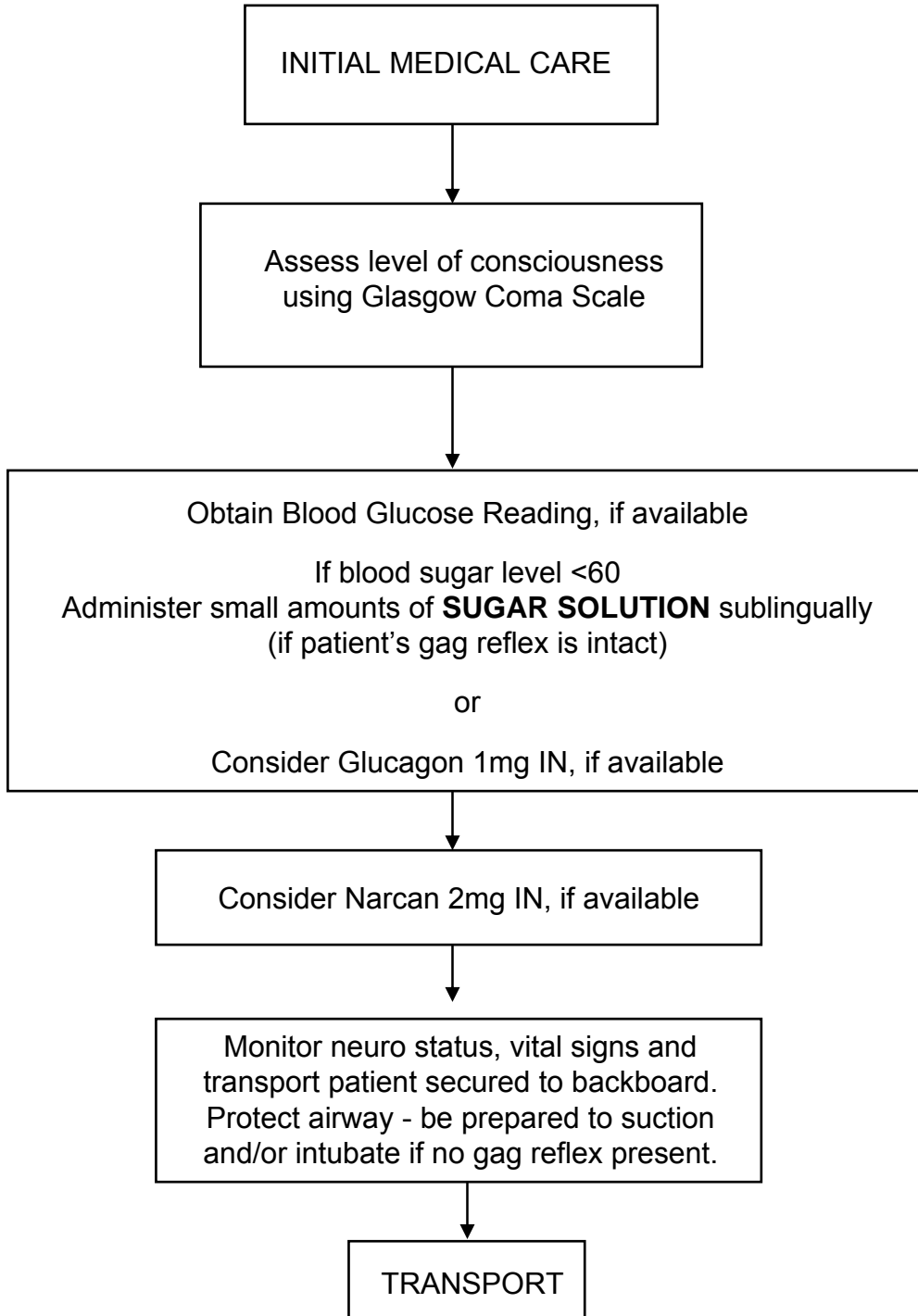
NOTE TO PREHOSPITAL PROVIDERS:

*Refer to **PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS CODE 60**, as needed

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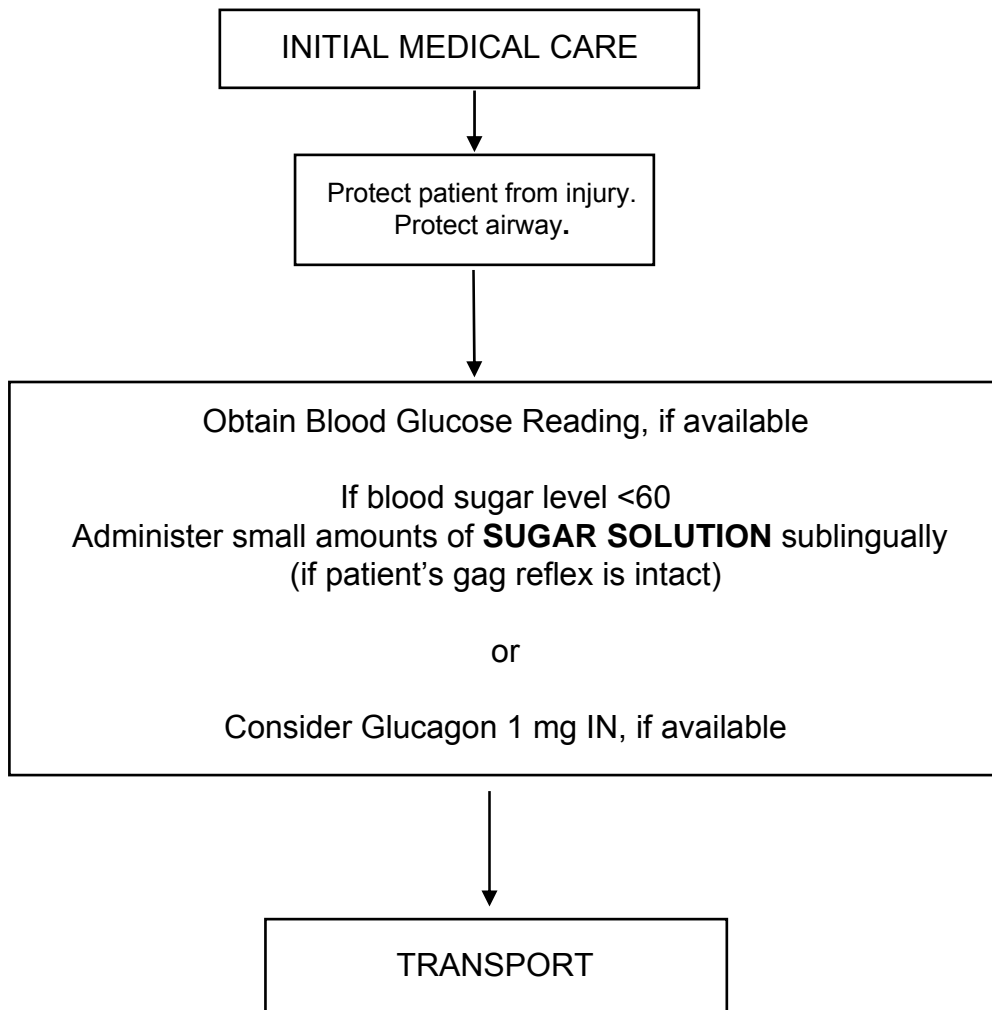
Code 34

COMA OF UNKNOWN ORIGIN (NO HISTORY OF TRAUMA)



Code 35

*SEIZURES/STATUS EPILEPTICUS

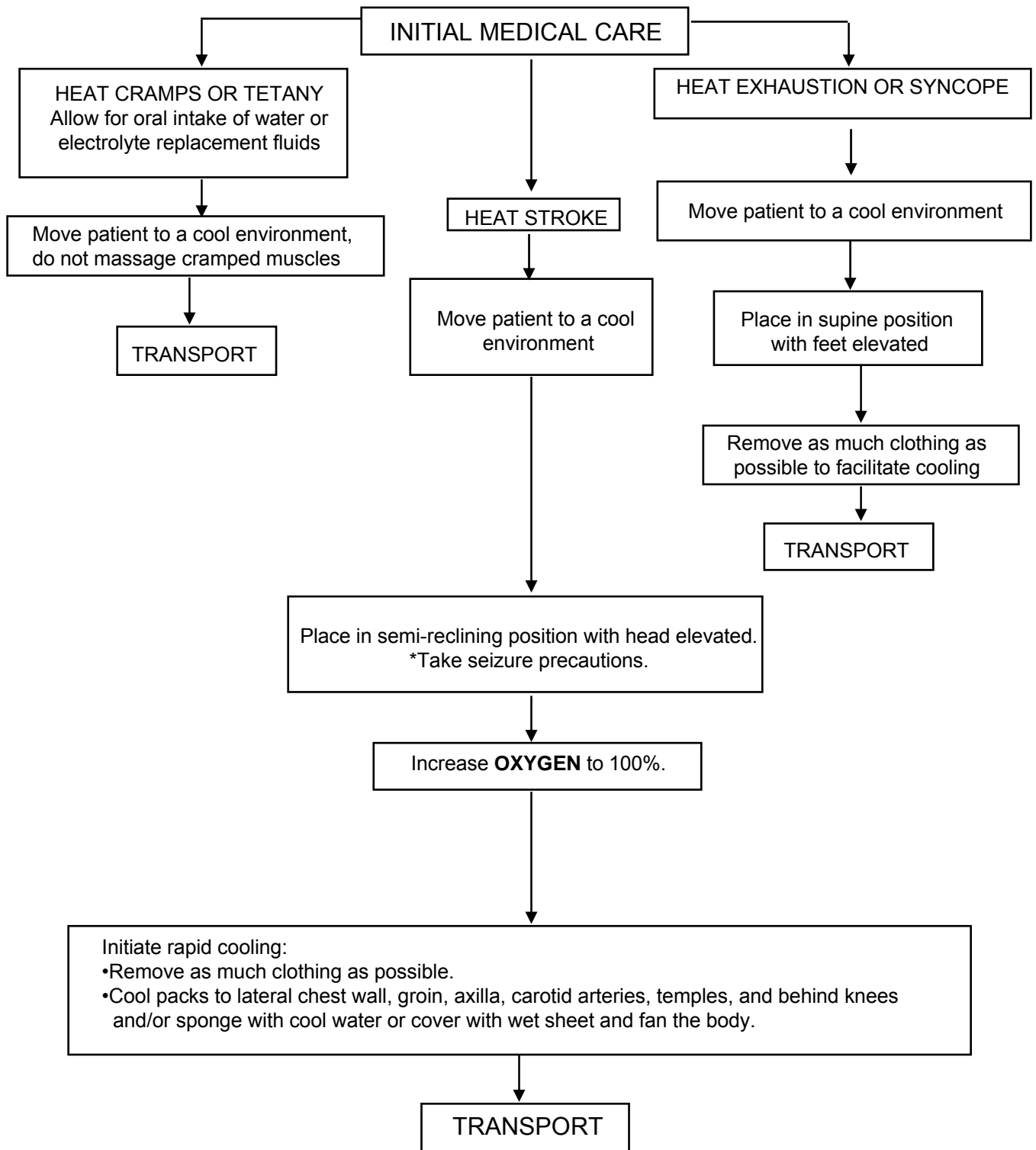


* Refer to **PEDIATRIC SEIZURES CODE 59**, as needed

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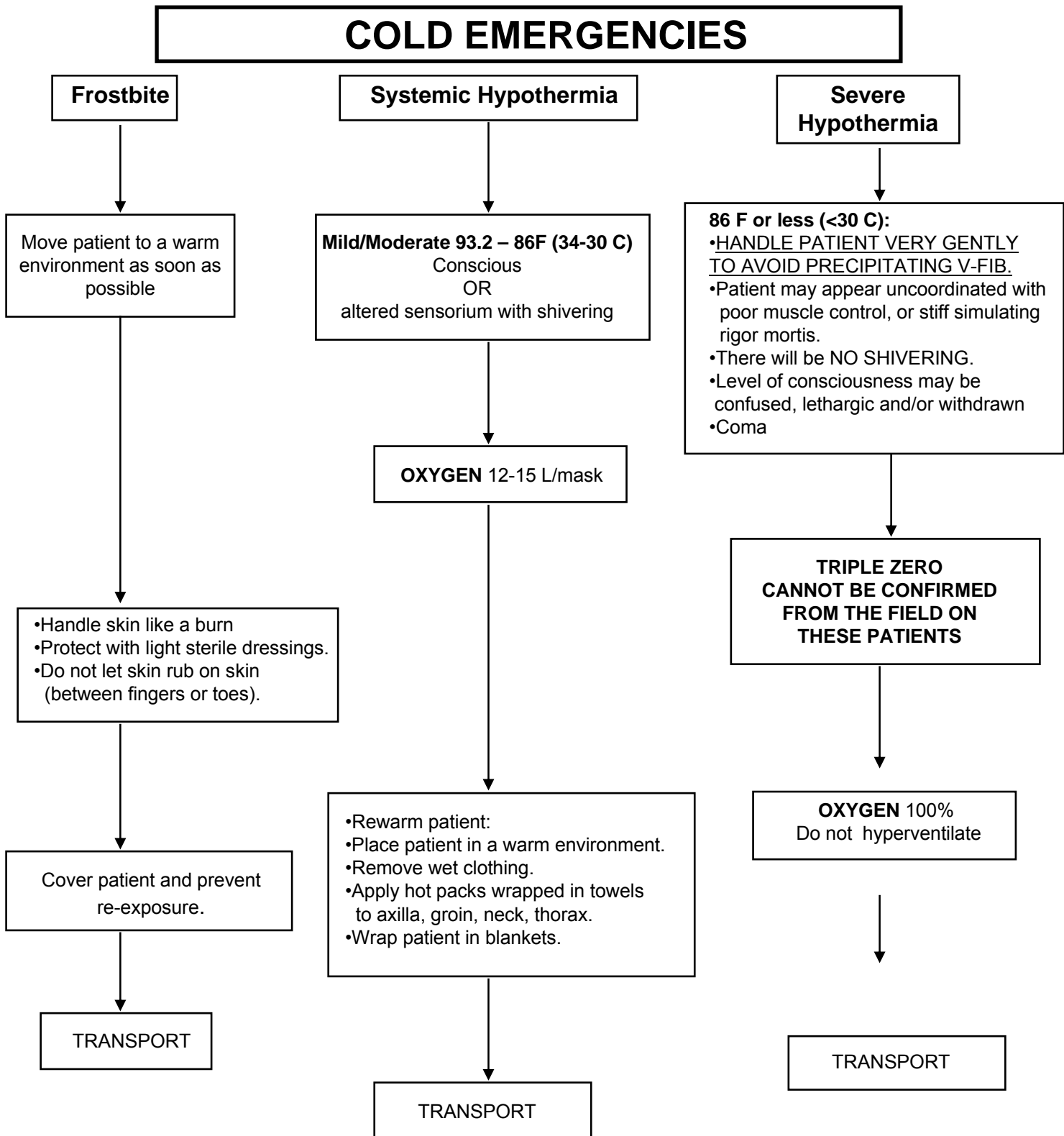
Code 36

HEAT EMERGENCIES



Code 37

COLD EMERGENCIES

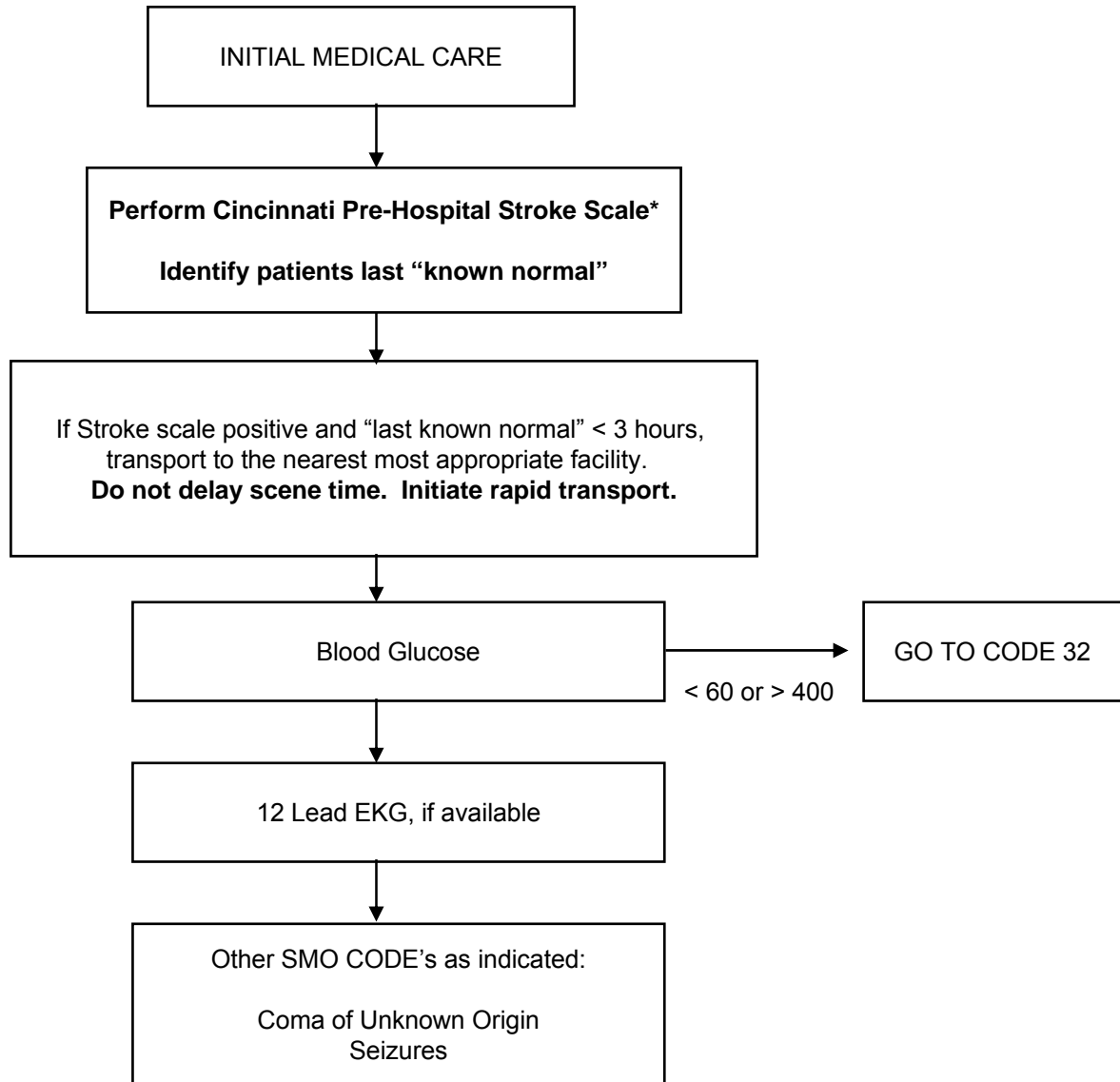


NOTE TO PREHOSPITAL PROVIDERS:

- Assess pulse for 30-45 seconds before beginning CPR.
- Begin CPR only if pulseless and not breathing.
- Apply AED if available. May attempt defibrillation X 1.

Code 38

SUSPECTED STROKE



***Cincinnati Prehospital Stroke Scale**

Facial Droop (Have the patient show teeth or smile)

- Normal – Both sides of face move equally well
- Abnormal – One side of face does not move as well as the other side

Arm Drift (Patient closes eyes and holds both arms straight out for 10 seconds)

- Normal – Both arms move the same or both arms do not move at all (other findings, such as pronator grip, may be helpful)
- Abnormal – One arm does not move or one arm drifts down compared with the other

Speech (Have the patient say, “You can’t teach an old dog new tricks.”)

- Normal – Patient uses correct words with no slurring
- Abnormal – Patient slurs words, uses inappropriate words, or is unable to speak

Code 39

HAZARDOUS MATERIALS GENERAL

PROTECT YOURSELF FIRST:
ALL PERSONNEL SHOULD BE APPROPRIATELY TRAINED AND
HAVE PROTECTIVE CLOTHING AS INDICATED

Identify substance, if possible
Contact local HazMat Unit *

Isolate

Brush off solid substances, remove contaminated clothing and decontaminate as indicated
The decontaminant should be contained

Maintain Airway.
Administer **OXYGEN** 12-15 L/min. by mask
Assist ventilations with BVM, if needed.

Treat per SMO:
Shock
Cardiac dysrhythmias
Pulmonary edema
Seizures
Burns (Chemical)
Unconsciousness
Asthma/COPD with Wheezing
Frostbite

Refer to **HAZARDOUS MATERIALS EYE CODE 40**, for eye exposures

Treat specific poisons with antidotes per Medical Control

TRANSPORT

NOTE TO PREHOSPITAL PROVIDERS:

*Consult "Hazardous Materials Injuries,
A Handbook for Prehospital Care",
The North American ERG, MSDS sheet or similar text.

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BLS

Code 40

HAZARDOUS MATERIALS EYE

EYE IRRIGATION

Indication: Suspected or actual HazMat eye exposure
(Refer to **HAZARDOUS MATERIALS GENERAL CODE 39** as needed)

- Identify substance
- Decontamination
- Initial Medical Care

- Establish Medical Control contact ASAP -
- Eye irrigation with Normal Saline may be instituted prior to contact.

Confirm that contact lenses are not present, or remove if present.

Volume to be used is 1000ml Normal Saline per eye, minimum.
For suspected or actual alkali exposure, continue irrigation until advised by Medical Control to stop.

TRANSPORT

Code 41

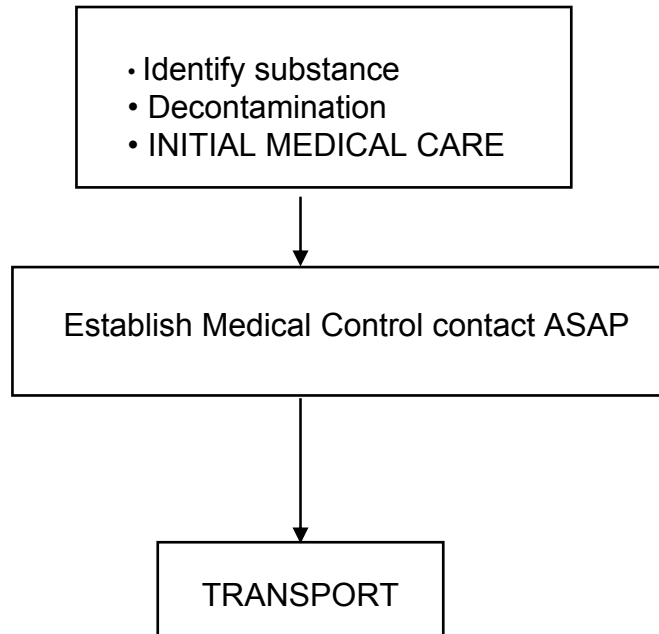
HAZARDOUS MATERIALS PESTICIDE/NERVE AGENT

Indications:

Poisoning with anticholinesterase agents (e.g., chemicals or pesticides of the organophosphate class)

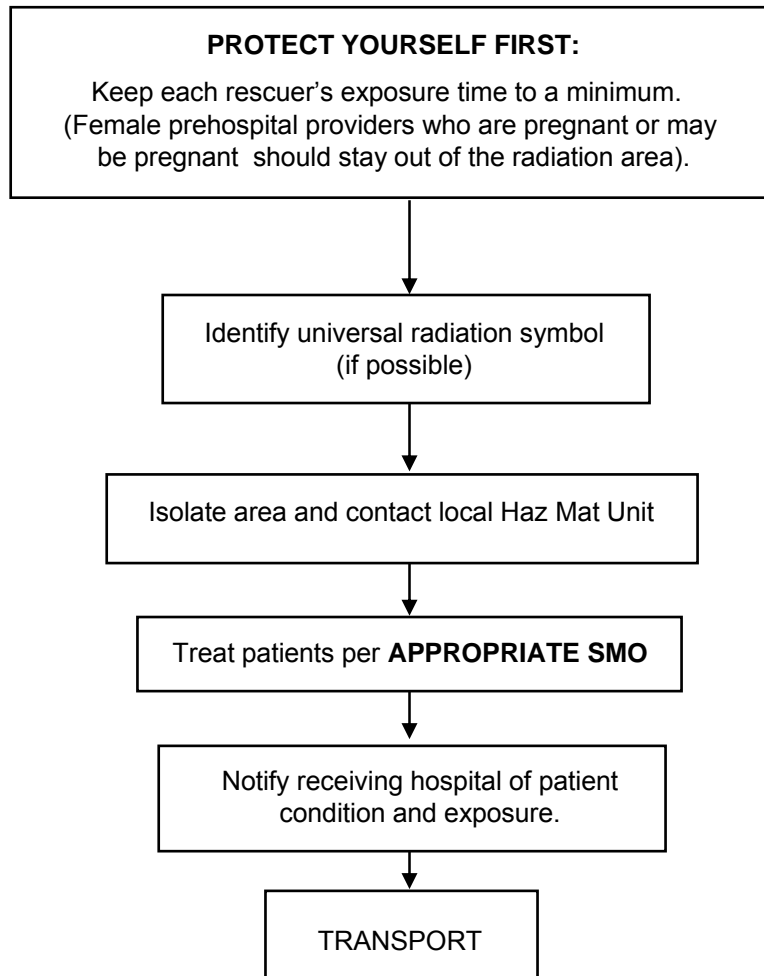
Signs & Symptoms:

Bradycardia
Chest tightness and wheezing due to bronchospasm
Increased salivation, sweating and tearing
Increased urination
Abdominal cramps with nausea and vomiting
Constricted pupils
Weakness, muscle tremors/twitching/cramps
Seizures, coma, shock, respiratory arrest



Code 42

HAZARDOUS MATERIALS RADIATION



Code 43

RENAL PROTOCOLS

Do not take blood pressure in arm with fistula or graft.

Cardiac Arrest in a Dialysis Patient

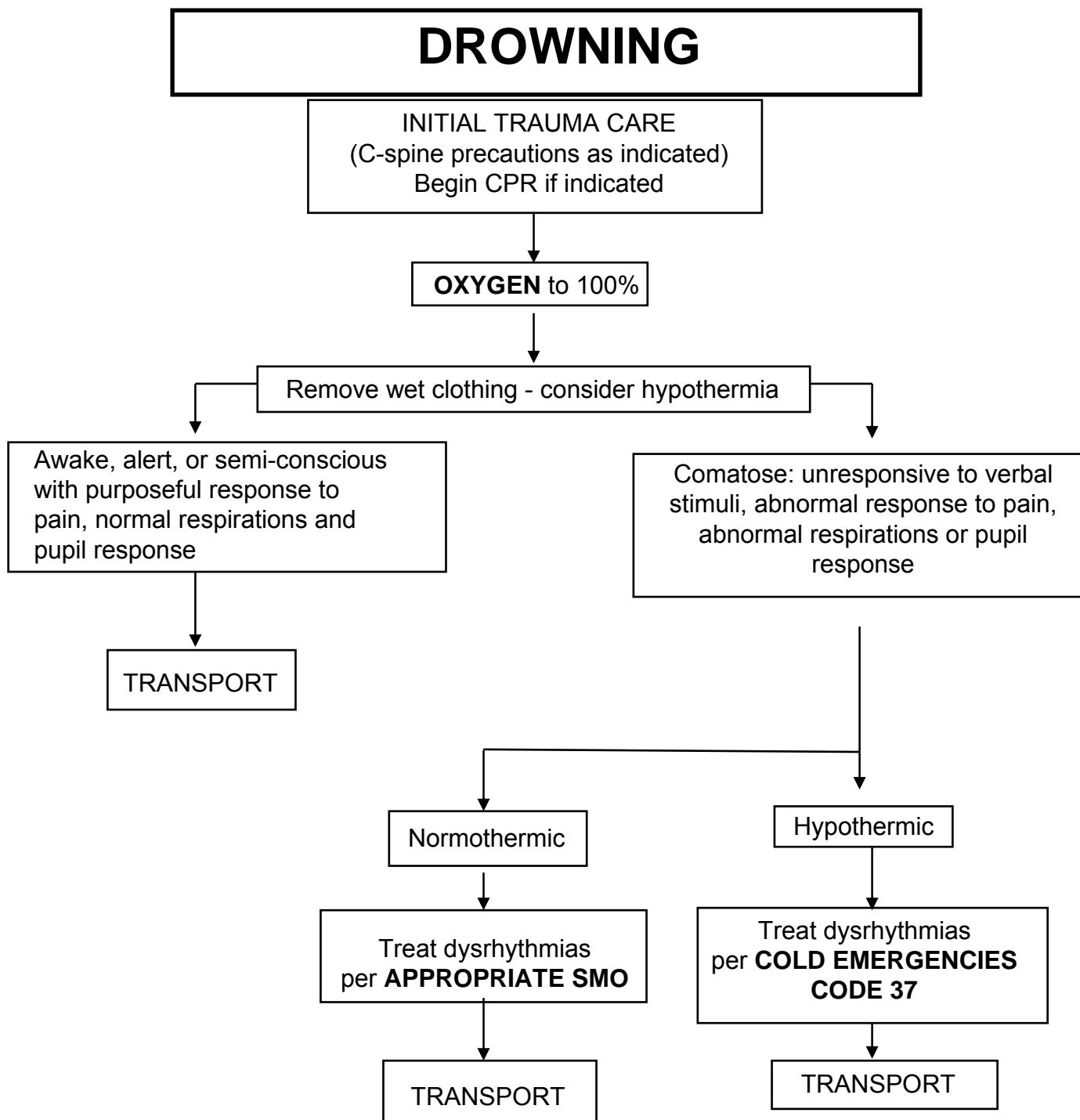
In the event of cardiac arrest, follow the **APPROPRIATE SMO**.

Pulmonary Edema in a Dialysis Patient

Give high flow **OXYGEN** via a non-rebreather mask if possible. Place patient in upright position. Refer to **PULMONARY EDEMA DUE TO HEART FAILURE CODE 13**.

Code 44

DROWNING



NOTE TO PREHOSPITAL PROVIDERS:

After 90 minutes of documented submersion time, the receiving hospital should be contacted for concurrence of no resuscitative efforts on recovery of the patient.

The Dive Team will at this time go from rescue to recovery mode.

REGION 7

STANDING MEDICAL ORDERS

**OBSTETRIC/GYNECOLOGICAL
PROTOCOLS**

Code 45

EMERGENCY CHILDBIRTH LABOR AND DELIVERY

Obtain history and determine if there is adequate time to transport.
of pregnancies
of live births
Due date
How far apart are contractions
Duration of contractions
Length of previous labors - in hours
Bag of waters intact or time since membrane rupture
High risk concerns - Drug use, multiple births, amniotic fluid color

If mother is hyperventilating encourage slow deep breaths.
Administer **OXYGEN** 12-15L/mask

PREPARE FOR DELIVERY IF ANY OF THE FOLLOWING ARE PRESENT:

- Bulging perineum
- Crowning

DO NOT ATTEMPT TO RESTRAIN OR DELAY DELIVERY

Place mother in a supine position, put on sterile gloves,
open OB pack and drape mother's abdomen and perineum.

Cord around neck

Delivery

Normal presentation

In unable to loosen and remove
cord from around infant's neck,
clamp x2 and cut between
clamps.

Control delivery of head so it does not emerge too quickly. Support infant's head as it emerges and protect perineum with gentle hand pressure. Tear amniotic membrane if it is still intact and visible outside vagina. When infant's head delivered, suction and maintain airway. As shoulders emerge, guide head and neck downward to deliver anterior shoulder. Support and lift head and neck slightly to deliver posterior shoulder. Remainder of infant's deliver should occur with passive participation. Maintain a firm hold on the baby.
Refer to RESUSCITATION AND CARE OF THE NEWBORN CODE 48

Wrap in blanket and position on side or back with constant airway monitoring

Administer post-partum care - Refer to **MATERNAL CARE CODE 49**

TRANSPORT

Revised 11/01/11
Effective 10/01/98
BLS

Code 46

OBSTETRICAL COMPLICATIONS

THIRD TRIMESTER BLEEDING - 6-9 MONTHS (Placenta Previa, Abruption Placenta, Trauma)

TRANSPORT IMMEDIATELY

100% **OXYGEN**, place mother on LEFT side

Note type and amount of bleeding and/or discharge. Do NOT place gloved hand in vagina to check for bleeding. Palpate uterus externally for tonicity

TRANSPORT

PRE-ECLAMPSIA OR TOXEMIA

TRANSPORT IMMEDIATELY

OXYGEN 12-15 L/mask

INITIAL MEDICAL CARE:
Gentle handling

Place mother on LEFT side

Minimal CNS stimulation - do not check pupillary light reflex

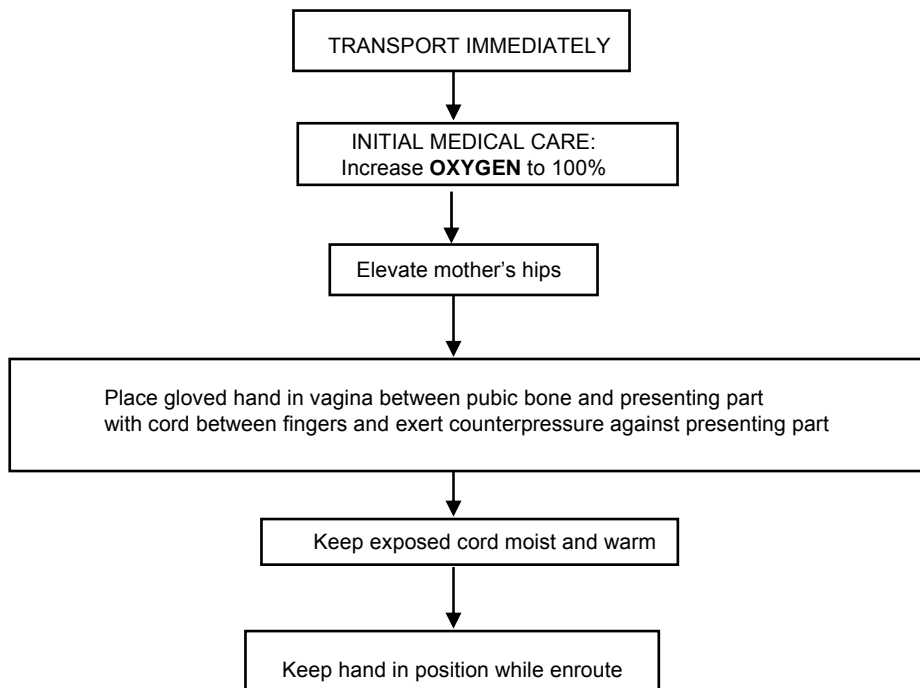
Seizure precautions

If seizures occur, increase **OXYGEN** to 100%

Code 47

ABNORMAL DELIVERIES

PROLAPSED CORD

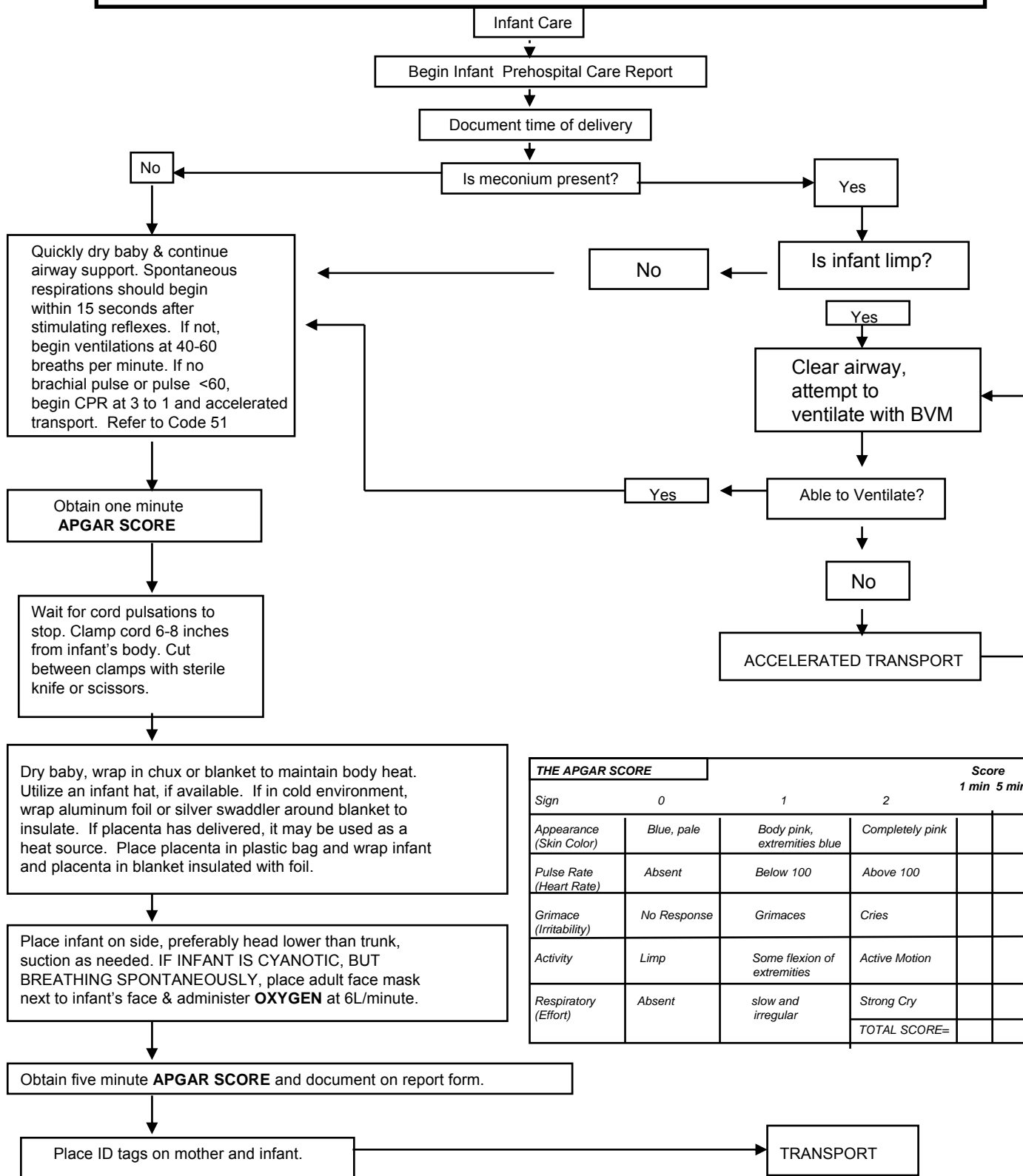


BREECH BIRTH

- Accelerated TRANSPORT indicated with care enroute
- NEVER ATTEMPT TO PULL THE BABY FROM THE VAGINA BY THE LEGS OR TRUNK.
- As soon as legs are delivered, support baby's body, wrapped in towel.
- After shoulders are delivered, gently elevate trunk and legs to aid in delivery of head (if face down). Head should deliver in 30 seconds. IF NOT, reach two gloved fingers into the vagina to locate infant's mouth. Press vaginal wall away from baby's mouth to form an airway and apply gentle pressure to mother's mid upper abdomen. Maintain this position until delivery or arrival at the hospital.

Code 48

RESUSCITATION AND CARE OF THE NEWBORN



THE APGAR SCORE				Score	
Sign	0	1	2	1 min	5 min
Appearance (Skin Color)	Blue, pale	Body pink, extremities blue	Completely pink		
Pulse Rate (Heart Rate)	Absent	Below 100	Above 100		
Grimace (Irritability)	No Response	Grimaces	Cries		
Activity	Limp	Some flexion of extremities	Active Motion		
Respiratory (Effort)	Absent	slow and irregular	Strong Cry		
			TOTAL SCORE=		

Code 49

MATERNAL CARE

TRANSPORT IMMEDIATELY

Allow the placenta to deliver on its own - **DO NOT** delay transport waiting for it.
(It should deliver within 20 - 30 minutes.)
DO NOT pull on cord to facilitate delivery. If delivered, collect placenta in a plastic bag and bring to hospital.

If the perineum is torn and bleeding, apply direct pressure with a sterile dressing or sanitary pad.

Observe for profuse bleeding (>500ml).
If present, massage uterus.

Mother may be encouraged to breastfeed to stimulate uterine contraction.

REGION 7

STANDING MEDICAL ORDERS

PEDIATRIC PROTOCOLS

PEDIATRIC INITIAL ASSESSMENT

I. SCENE SIZE UP

- *Identify possible hazards.
- *Assure safety for patient and responder.
- *Observe for mechanism of injury/nature of illness.
- *Note anything suspicious at the scene, i.e., medications, household chemicals, other ill family members.
- *Assess any discrepancies between the history and the patient presentation, i.e., infant fell on hardwood floor - however floor is carpeted.
- *Initiate appropriate body substance isolation (BSI) precautions
- *Determination of number of patients.

II. GENERAL APPROACH TO THE STABLE/CONSCIOUS PEDIATRIC PATIENT

- A. Assessments and interventions must be tailored to each child in terms of age, size and development.
- * Smile if appropriate to the situation.
 - * Keep voice at even quiet tone, don't yell.
 - * Speak slowly, use simple, age appropriate terms.
 - * Use toys or penlight as distracters; make a game of assessment.
 - * Keep small children with their caregiver(s);
 - * Kneel down to the level of the child if possible.
 - * Be cautious in use of touch. In the stable child, make as many observations as possible before touching (and potentially upsetting) the child.
 - * Adolescents may need to be interviewed without their caregivers present if accurate information is to be obtained regarding drug use, alcohol use, LNMP, sexual activity, child abuse.
- B. While walking up to the patient, observe/inspect the following:
- * General appearance, age appropriate behavior.
 - * Malnourished appearance? Is child looking around, responding with curiosity or fear, playing, sucking on a pacifier or bottle, quiet, eyes open but not moving much or uninterested in environment?
 - * Obvious respiratory distress or extreme pain.
 - * Position of the child. Are the head, neck or arms being held in a position suggestive of spinal injury? Is the patient sitting up or tripodding?
 - * Level of consciousness, i.e., awake vs asleep or unresponsive.
 - * Muscle tone: good vs limp.
 - * Movement: spontaneous, purposeful, symmetrical.
 - * Color: pink, pale, flushed, cyanotic, mottled.
 - * Obvious injuries, bleeding, bruising, impaled objects or gross deformities.
 - * Determine weight – ask child or caretakers or use length/weight tape.

III. INITIAL ASSESSMENT

A. Airway Access/Maintenance with Cervical Spine Control

- * Maintainable with assistance: positioning.
- * Maintainable with adjuncts: oral airway, nasal airway.
- * Listen for any audible airway noises, i.e., stridor, snoring, gurgling, wheezing.
- * Patency: suction secretions as necessary.

B. Breathing

- * Rate and rhythm of respirations. Compare to normal rate for age and situation.
- * Chest expansion - symmetrical.
- * Breath sounds - compare both sides and listen for sounds (present, absent, normal, abnormal).
- * Positioning - sniffing position, tripod positions.
- * Work of breathing - retractions, nasal flaring, accessory muscle use, head bobbing, grunting.

C. Circulation

- * Heart rate - compare to normal rate for age and situation.
- * Central/truncal pulses (brachial, femoral, carotid) - strong, weak or absent.
- * Distal/peripheral pulses - present/absent, thready, weak, strong.
- * Color - pink, pale, flushed cyanotic, mottled.
- * Skin temperature - hot, warm, cool.
- * Blood pressure - compare to normal for age of child. Must use appropriate sized cuff.
- * Hydration status - anterior fontanel in infants, mucous membranes, skin turgor, crying tears, urine output history.

D. Disability - Brief Neuro Examination

- * Assess Responsiveness
 - A Alert
 - V Responds to verbal stimuli
 - P Responds to painful stimuli
 - U Unresponsive
- * Assess pupils
- * Assess for transient numbness/tingling.

E. Expose and Examine

- * Expose the patient as appropriate based on age and severity of illness.
- * Initiate measures to prevent heat loss and keep the child from becoming hypothermic.

IV. FOCUSED HISTORY/PHYSICAL ASSESSMENT

A. Tailor assessment to the needs of the patient. Rapidly examine areas specific to the chief complaint.

- * S Signs & Symptoms as they relate to the chief complaint.
- * A Allergies to medications, foods, environmental
- * M Medications: prescribed, over-the-counter, compliance with prescribed dosing regimen, time, date and amount of last dose
- * P Past Pertinent Medical History
 - Pertinent medical or surgical problems
 - Preexisting diseases/chronic illness
 - Previous hospitalizations
 - Currently under medical care
 - For infants, obtain a neonatal history (gestation, prematurity, congenital anomalies, was infant discharged home at the same time as the mother)
- * L Last oral intake of liquid/food ingested.
- * E Events surrounding current problem
 - Onset, duration and precipitating factors
 - Associated factors such as toxic inhalants, drugs, alcohol
 - Injury scenario and mechanism of injury
 - Treatment given by caregiver

B. Responsive Medical Patients

* Perform rapid assessment based on chief complaint. A full review of systems may not be necessary. If chief complaint is vague, examine all system.

C. Unresponsive Medical Patients

* Perform rapid assessment: ABCs, quick head-to-toe exam.
* Emergency care based on signs and symptoms, initial impressions and standard operating procedures.

D. Trauma patient with NO significant mechanism of injury.

* Focused assessment is based on patient complaint.

E. Trauma patient WITH significant mechanism of injury

* Perform rapid assessment of all body systems.

V. DETAILED ASSESSMENT

A. Performed to detect non-life-threatening conditions and to provide care for those conditions/injuries. Usually performed enroute. May be performed on scene if transport is delayed.

* Inspect and palpate each of the major body systems for the following:

- * Deformities
- * Contusions
- * Abrasions
- * Penetrations/punctures
- * Burns
- * Tenderness
- * Lacerations
- * Swelling/edema
- * Instability
- * Crepitus

* Auscultation of breath and heart sounds as well as blood pressure readings may be required in the field.

VI. ONGOING ASSESSMENT

To effectively maintain awareness of changes in the patient's condition, repeated assessments are essential and should be performed at least every 5 minutes on the unstable patient, and at least every 15 minutes on the stable patient.

VII. CONSIDERATIONS FOR CHILDREN WITH SPECIAL HEALTHCARE NEEDS (CSHN)

- * Be familiar with CSHN in your service community and with both the child as well as their anticipated emergency care needs.
- * Refer to child's emergency care plan formulated by their medical providers, if available. Understanding the child's baseline will assist in determining the significance of altered physical findings. Parents/caregivers are the best source of information on: medications, baseline vitals, functional level/normal mentation, likely medical complications, equipment operation and troubleshooting, emergency procedures.
- * Regardless of underlying condition, assess in a systematic and thorough manner. Use parents/caregivers/home health nurses as medical resources.
- * Be prepared for differences in airway anatomy, physical development, cognitive development and possibly existing surgical alterations or mechanical adjuncts. Common home therapies include: respiratory support (oxygen, apnea monitors, pulse oximeters, tracheostomies, mechanical ventilators), nutrition therapy (nasogastric or gastrostomy feeding tubes), intravenous therapy (central venous catheters), urinary catheterization or dialysis (continuous ambulatory peritoneal dialysis), biotelemetry, ostomy care, orthotic devices, communication or mobility devices, or hospice care.
- * Communicate with the child in an age appropriate manner. Maintain communication with and remain sensitive to the parents/caregivers and the child.
- * The most common emergency encountered with these patients is respiratory related and so familiarity with respiratory emergency interventions/adjuncts/treatment is appropriate.

Code 51

PEDIATRIC CARDIAC ARREST

- Establish unresponsiveness
- Position airway
- Determine breathlessness
- Ventilate with BVM/100% **OXYGEN**
- Determine pulselessness
- Initiate compressions and continue as indicated
- Maintain airway

PERFORM CPR

Less than 1 Year of Age

Greater than 1 Year of Age

Continue CPR (15 : 2)
Give 5 cycles of CPR between each assessment

Perform CPR (15 : 2) while AED is attached
Give total of 5 cycles of CPR

RAPID TRANSPORT

Use AED as soon as available
for sudden witnessed collapse

RAPID TRANSPORT

NOTE TO PREHOSPITAL PROVIDERS:

- In patients ages 1-8 use pediatric defibrillation pads, if available.

Code 52

PEDIATRIC BRADYCARDIA

- Assess ABCs
- Administer 100% **OXYGEN**
- Complete initial assessment. Assess for:
 - Respiratory difficulty
 - Cyanosis despite **OXYGEN** administration
 - Truncal cyanosis and coolness
 - Hypotension
 - No palpable blood pressure
 - Weak thready, absent peripheral pulses
 - Decreasing consciousness

No cardiorespiratory compromise

Severe cardiorespiratory compromise

- Support ABCs
- Observe
 - Keep warm
 - TRANSPORT

- Secure airway as appropriate
- Support ventilation with BVM
- Pulse oximetry, if available

Perform chest compressions if despite oxygen and ventilation, heart rate <60/min. with hypoperfusion. Continue compressions as indicated.

Improved cardiac status

Continued severe cardiac compromise

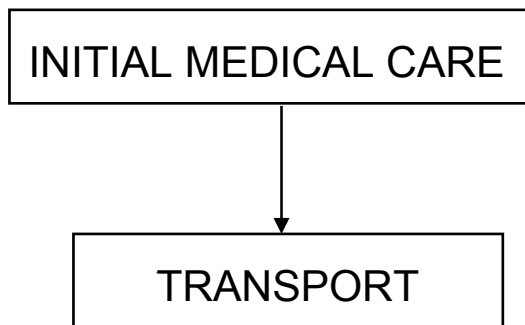
Refer to **PEDIATRIC CARDIAC ARREST CODE 51**

NOTE TO PREHOSPITAL PROVIDERS:

- Hypoglycemia has been known to cause bradycardia in infants.
- Special conditions may apply in the presence of severe hypothermia. Refer to **PEDIATRIC COLD EMERGENCIES CODE 63**, as needed

Code 53 and Code 54

PEDIATRIC NARROW AND WIDE COMPLEX TACHYCARDIA



Code 55

PEDIATRIC RESPIRATORY DISTRESS

- Assess ABCs
- Administer 100% **OXYGEN**
- Complete initial assessment Assess for:

Reactive Airway Disease

- wheezing
- grunting
- retractions
- tachypnea
- diminished respirations
- decreased breath sounds
- tachycardia/bradycardia
- decreasing consciousness

Partial Airway Obstruction

- suspected foreign body, obstruction or epiglottitis
- stridor
- choking
- drooling
- hoarseness
- retractions
- tripod position

Reactive (Lower) Airway Disease

Partial (Upper) Airway Obstruction

- Position of comfort
- Nebulized ALBUTEROL (Ventolin) 2.5mg
- Pulse Oximetry, if available

- Avoid any agitation
- Position of comfort
- Assess tolerance of **OXYGEN** administration
- Consider Nebulized ALBUTEROL (Ventolin) 2.5mg

Obstruction Relieved

“Patient can talk”

Obstruction Unrelieved

“Patient can not talk”

- Support ABCs
- Observe
- Keep warm
- TRANSPORT

- Relieve Upper Airway Obstruction
- Reposition airway
- Consider back slaps, abdominal thrusts (age dependent)

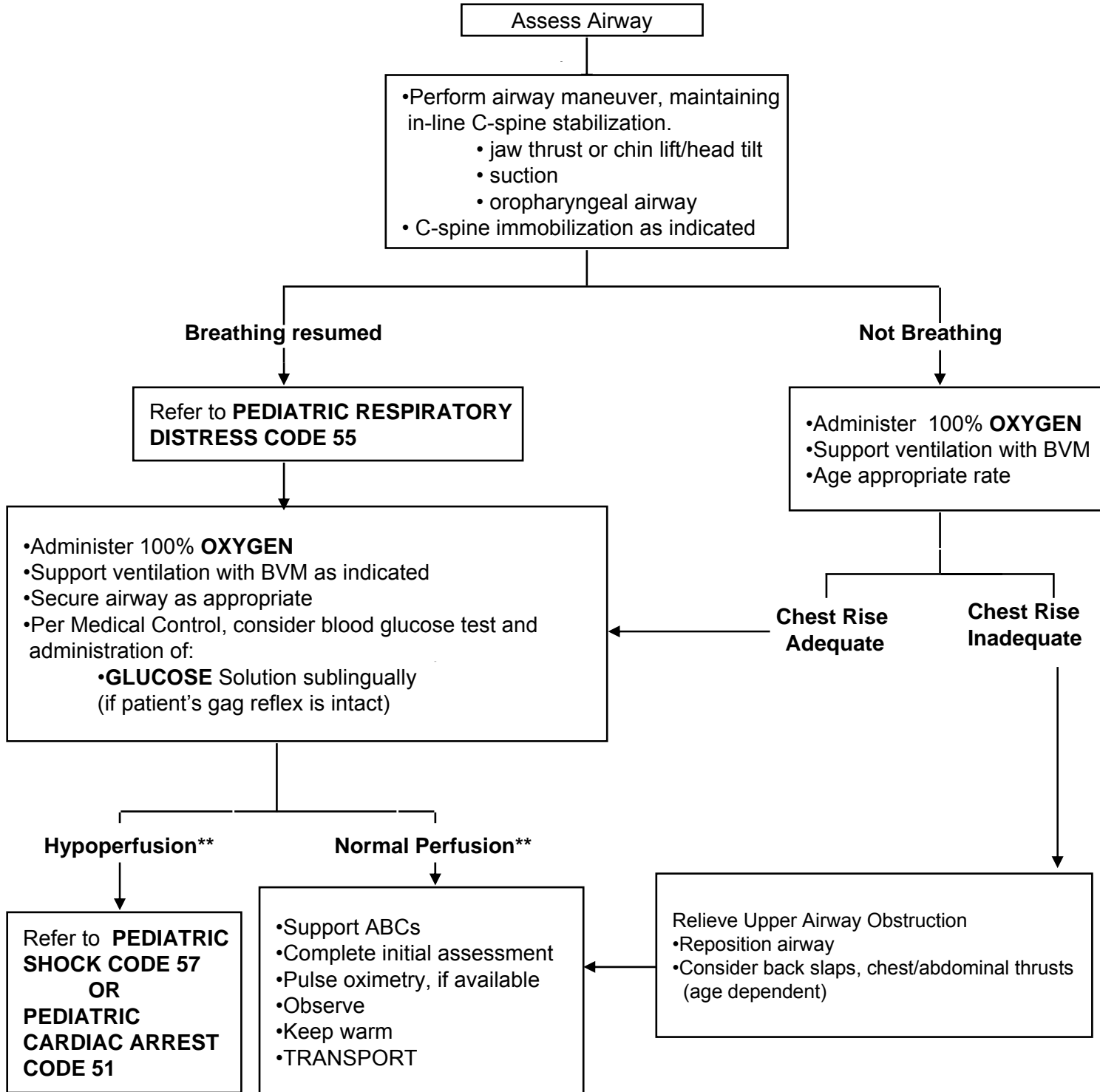
Relieved

Un-Relieved

Refer to **PEDIATRIC RESPIRATORY ARREST CODE 56** as needed

Code 56

PEDIATRIC RESPIRATORY ARREST



NOTE TO PREHOSPITAL PROVIDERS:

•Respiratory arrest may be a presenting sign of a toxic ingestion or metabolic disorder.

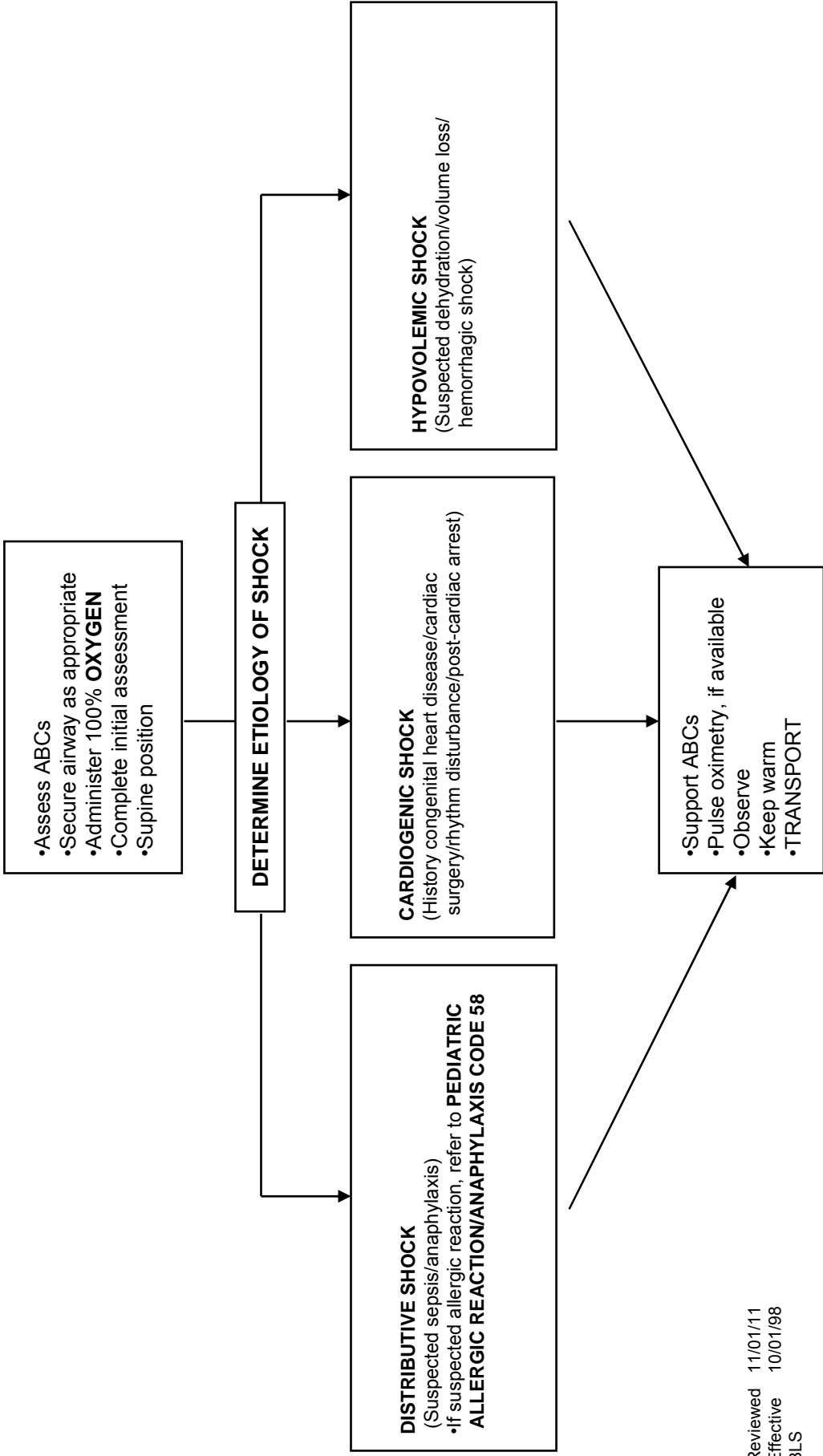
•Consider **GLUCOSE** per Medical Control if patient's gag reflex is intact.

See **PEDIATRIC ASSESSMENT AND TRAUMA SCORE CODE 28

Revised 11/01/11
Effective 10/01/98
BLS

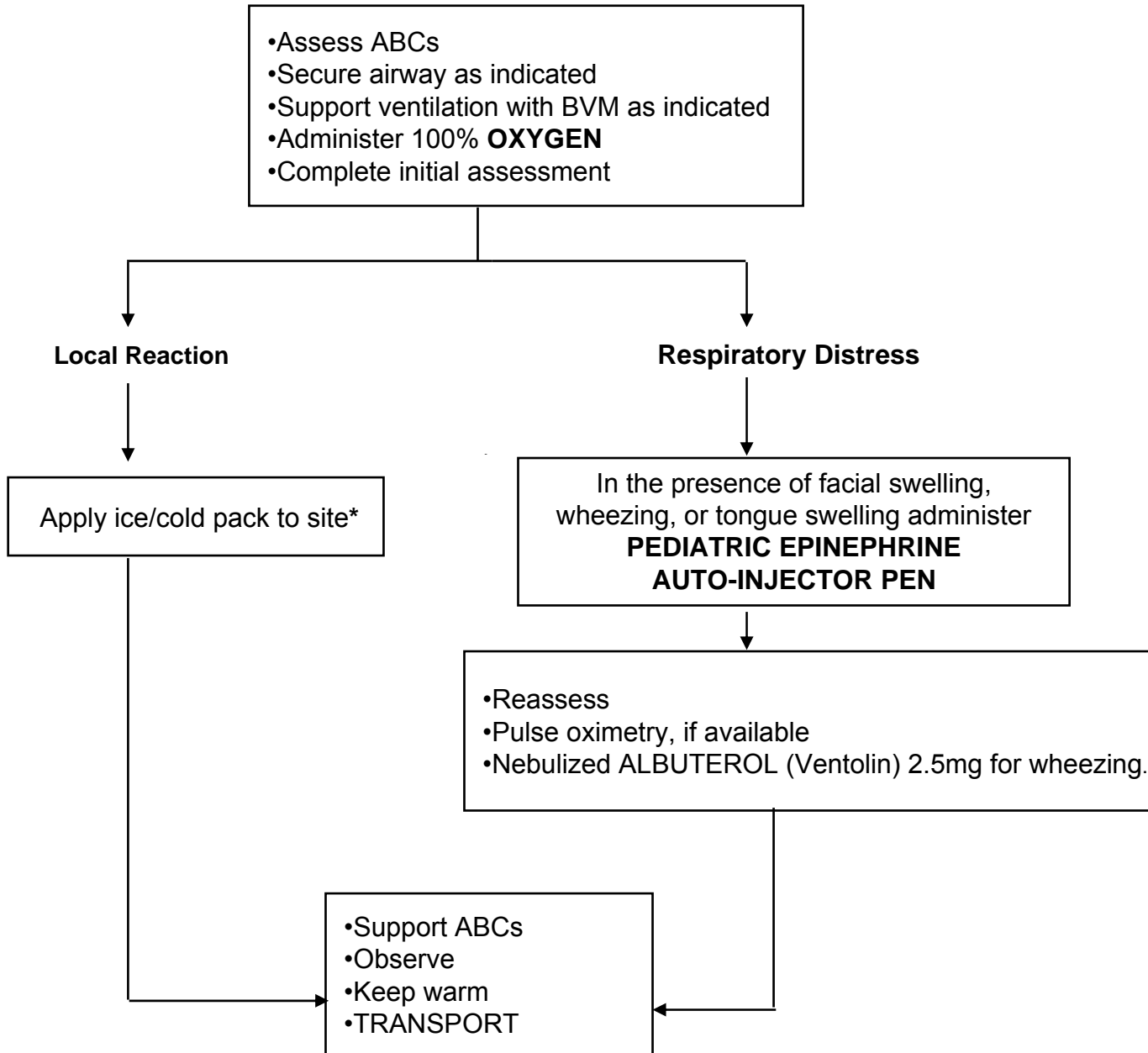
Code 57

PEDIATRIC SHOCK



Code 58

PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS



NOTE TO PREHOSPITAL PROVIDERS:

*Simple hives do not require any additional field treatment

Reviewed 11/01/11
Effective 10/01/98
BLS

Code 59

PEDIATRIC SEIZURES



NOTE TO PREHOSPITAL PROVIDERS:

Refer to **PEDIATRIC RESPIRATORY ARREST CODE 56** as indicated

Code 60

PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS

- Assess ABCs
- Immobilize spine as indicated
- Administer 100% **OXYGEN**
- Support ventilation with BVM as indicated
- Complete initial assessment
- Test blood glucose, if available
- Consider other causes of altered mentation and refer to indicated protocol(s).

Glucose >60 mg/dl

Glucose ≤60 mg/dl OR unknown

Consider **GLUCOSE SOLUTION** to gums
if gag reflex intact.

Reassess respiratory effort

Altered level of
consciousness

Improved level of
consciousness

Inadequate
respiratory effort

Adequate
respiratory effort

Secure airway as appropriate

- Support ABCs
- Observe
- Keep warm
- TRANSPORT

PEDIATRIC TOXIC EXPOSURES/INGESTIONS

- Assess scene safety as indicated:
 - Appropriate body substance isolation
 - Refer to appropriate **HAZMAT CODE**
 - Stop exposure
- Assess ABCs
- Secure airway as appropriate
 - Support ventilation with BVM as indicated
- Administer 100% **OXYGEN**
- Pulse oximetry, if available
- Complete initial assessment



- Initial interventions per Medical Control as indicated for identified exposure
- Support ABCs
- Observe
- Bring container(s) of drug or substance to the ED
- TRANSPORT

NOTE TO PREHOSPITAL PROVIDERS:

- Anticipate vomiting, respiratory arrest, seizure, dysrhythmias and refer to indicated protocols.
- Do not induce vomiting.

PEDIATRIC TOXIC EXPOSURE/INGESTION

EXPOSURE TO OR INGESTION OF NARCOTICS OR UNKNOWN SUBSTANCES

•DO NOT INDUCE VOMITING.

POTENTIAL EXPOSURES

- Burning overstuffed furniture = Cyanide
- Old burning buildings = Lead fumes and Carbon monoxide
- Pepto-bismol = Aspirin
- Pesticides = Organophosphates & Carbamates
- Common poisonous plants:
 - Dieffenbachia
 - Foxglove
 - Holly leaves and berries
 - Lilly of the Valley
 - Nightshade
 - Philodendron
 - Rhubarb leaves
 - Tobacco
- Smells:
 - Almond = Cyanide
 - Fruit = Alcohol
 - Garlic = Arsenic, parathion, DMSO
 - Mothballs = Camphor
 - Natural gas = Carbon monoxide
 - Rotten eggs = Hydrogen sulfide
 - Silver polish = Cyanide
 - Stove gas = Think CO (CO and methane are odorless)
 - Wintergreen = Methyl salicylate

Code 62

PEDIATRIC HEAT EMERGENCIES

- Assess ABCs
- Administer 100% OXYGEN
- Complete initial assessment. Assess for:
 - Hot, dry, flushed or ashen skin
 - Tachycardia
 - Tachypnea
 - Diaphoresis
 - Decreasing consciousness
- Assess scene for environmental risks
 - Place in a cool environment
 - Remove clothing as appropriate
- Profound weakness and fatigue
- Vomiting, diarrhea
- Hypoperfusion
- Muscle cramps

Normal Level of Consciousness
& Diaphoresis

Systolic BP \geq 100

- Give cool liquids PO

Hypoperfusion*
or Presence of
Nausea/Vomiting

Decreased Consciousness,
Dry Skin

- Secure airway as appropriate
- Support ventilation with BVM

- ** Initiate cooling
- Pulse oximetry, if available
- Refer to **PEDIATRIC SEIZURES CODE 59** as needed

- Support ABCs
- Observe
- TRANSPORT

**NOTE TO PREHOSPITAL PROVIDERS:

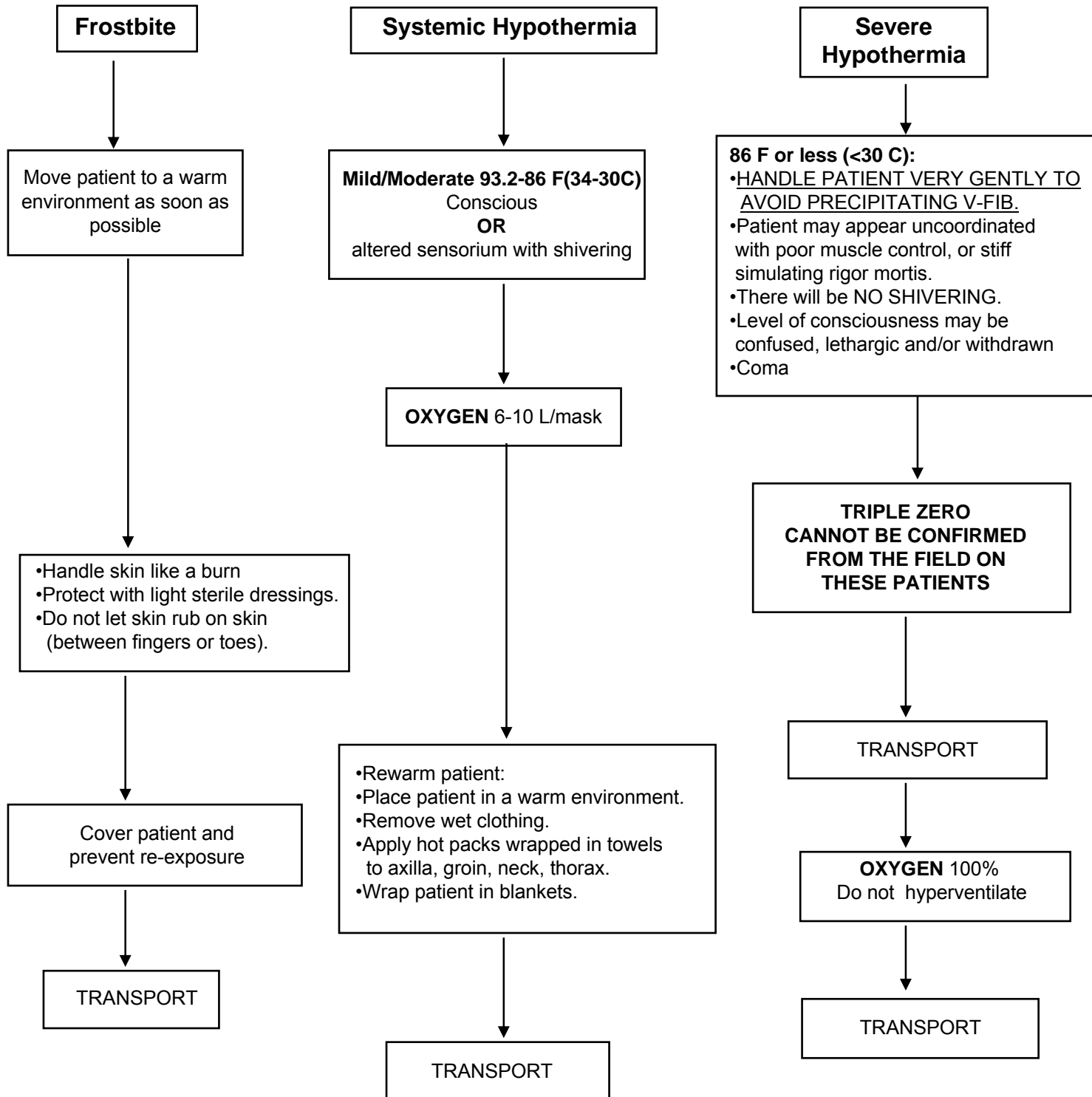
Cooling Techniques

- Apply cool pack to head, neck, armpits, groin, behind knees and to lateral chest.
- Tepid water per sponge/spray
- Manually fan body to evaporate and cool
- **Stop cooling if shivering occurs.**

*Refer to **PEDIATRIC ASSESSMENT AND TRAUMA SCORE CODE 28**

Code 63

PEDIATRIC COLD EMERGENCIES



NOTE TO PREHOSPITAL PROVIDERS:

Assess pulse for 30-45 seconds before beginning CPR.

Begin CPR only if pulseless and not breathing.

Apply AED if available. May attempt defibrillation X 1.

Refer to **PEDIATRIC CARDIAC ARREST CODE 51**

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Code 64

PEDIATRIC DROWNING

- Assess airway, ventilation, and respiratory effort
- Assess for hypothermia:
Refer to **PEDIATRIC COLD EMERGENCIES CODE 63**

Adequate Ventilation and Respiratory Effort

- Administer 100% **OXYGEN**
- Immobilize spine as indicated

- Complete initial assessment
- Remove wet clothing
- Warm. Place heat packs to axilla and groin, taking care to avoid direct skin contact.

- Pulse Oximetry, if available
- Refer to:
PEDIATRIC SEIZURES CODE 59
OR
APPROPRIATE PEDIATRIC DYSRHYTHMIA CODE
as needed.

- Support ABCs
- Keep warm
- Observe
- TRANSPORT

Inadequate Ventilation and Respiratory Effort

- Perform airway maneuver, maintaining in-line C-spine stabilization:
 - Jaw thrust
 - Suction
- Relieve upper airway obstruction as indicated
- Support ventilation with BVM and 100% **OXYGEN**
- Spinal immobilization if indicated

Reassess Airway Patency

Patent

Obstructed

- Refer to:
PEDIATRIC RESPIRATORY ARREST CODE 56
OR
PEDIATRIC CARDIAC ARREST CODE 51
as needed

REGION 7

STANDING MEDICAL ORDERS

**PROTOCOLS FOR
SPECIAL SITUATIONS**

SUSPECTED CHILD ABUSE AND NEGLECT

- Assess ABCs
- Complete initial assessment

Treat obvious injuries. Refer to **PEDIATRIC TRAUMA CODE 27**

Note:

- Environmental surroundings
- Child's interaction with parents
- Physical assessment findings
- Discrepancies in child and parent history and injuries

TRANSPORT, regardless of extent of injuries.

**Transport Agreed Upon
By Parent/Caregiver**

- Support ABC's
- Observe
- TRANSPORT
- Document all findings

**Transport Refused
By Parent/Caregiver**

- Assess scene safety
- If possible, remain at site
- Call police/Medical Control and request protective custody
- Do not confront caregivers

**Report Suspicions to ED physician, ED charge nurse AND DCFS (1-800-25-ABUSE)
(1-800-252-2873)**

SUSPECTED CHILD ABUSE AND NEGLECT**NOTE TO PREHOSPITAL PERSONNEL:**

1. You are required by law to report your suspicions.
2. Suspect battered or abused child if any of the following is found:
 - A discrepancy exists between history of injury and physical exam.
 - Caregiver provides a changing or inconsistent history.
 - There is a prolonged interval between injury and the seeking of medical help.
 - Child has a history of repeated trauma.
 - Caregiver responds inappropriately or does not comply with medical advice.
 - Suspicious injuries are present, such as:
 - Injuries of soft tissue areas, including the face, neck and abdomen
 - Injuries of body areas that are normally shielded, including the back and chest
 - Fractures of long bones in children under 3 years of age
 - Old scars, or injuries in different stages of healing
 - Bizarre injuries, such as bites, cigarette burns, rope marks, imprint of belt or other object
 - Trauma of genital or perianal areas
 - Sharply demarcated burns in unusual areas
 - Scalds that suggest child was dipped into hot water
3. The following are some common forms of neglect:
 - Environment is dangerous to the child (e.g. weapons within reach, playing near open windows without screen/guards, perilously unsanitary conditions, etc.).
 - Caretaker has not provided, or refuses to permit medical treatment of child's acute or chronic life-threatening illness, or of chronic illness, or fails to seek necessary and timely medical care for child.
 - Abandonment
 - Caretaker appears to be incapacitated (e.g. extreme drug/alcohol intoxication, disabling psychiatric symptoms, prostrating illness) and cannot meet child's care requirements.
 - Child appears inadequately fed (e.g. seriously underweight, emaciated, or dehydrated) inadequately clothed, or inadequately sheltered.
 - Child is found to be intoxicated or under the influence of an illicit substance(s).

PSYCHOLOGICAL EMERGENCIES

DOMESTIC VIOLENCE
SPOUSAL ABUSE
GERIATRIC ABUSE
SEXUAL ASSAULT

I. PURPOSE/DEFINITION

Given the magnitude of the problems of abuse and violence in our society, early detection of domestic violence victims, appropriate legal and social service referrals and the delivery of timely medical care are essential.

Domestic violence is a pattern of coercive behavior engaged in by someone who is or who was in an intimate or family relationship with the recipient. These behaviors may include: repeated battering, psychological abuse, sexual assault or social isolation such as restricted access to money, friends, transportation, health care or employment. Typically, the victims are female, but it must be recognized that males can be victims of abuses as well.

II. DOMESTIC VIOLENCE INDICATORS

While sometimes the specific history of abuse is offered, many times the victim of abuse, (either out of fear or because of the coercive nature of the relationship or out of desire to protect the abuser) will not volunteer a true history but instead ascribe injuries to another cause. Therefore, an appropriate review must be undertaken with respect to patients presenting with injuries:

- That do not seem to correspond with the explanation offered.
- That are of varying ages.
- That have the contour of objects commonly used to inflict injury (hand, belt, rope, chain, teeth, cigarette).
- During pregnancy.

Other factors include:

- Partner accompanies patient and answers all questions directed to patient.
- Patient reluctant to speak in front of partner.
- Denial or minimalization of injury by partner or patient.
- Intensive, irrational jealousy or possessiveness expressed by partner.

Physical injuries commonly associated with domestic violence:

- Central injuries, specifically to the face, head, neck, chest, breasts, abdomen, or genital areas.
- Contusions, lacerations, abrasions, stab wounds, burns, human bites, fractures (particularly of the nose and orbits) and spiral wrist fractures
- Complaints of acute or chronic pain without tissue injury
- Signs of sexual assault
- Injuries of vaginal bleeding during pregnancy, spontaneous or threatened miscarriage
- Direct impact of domestic violence on pregnancy may include:

- Abdominal trauma leading to abruption, pre-term labor, and delivery
- Fetal fracture
- Ruptured maternal liver, spleen, uterus
- Antepartum hemorrhage
- Exacerbation of chronic illness

* Multiple injuries in different stages of healing

III. APPROACHES FOR INTERVIEWING THE PATIENT

The goals of the physical examination are to identify injuries requiring further medical intervention and to make observations and collect evidence that may corroborate the patient's report of abuse. A thorough physical examination is essential to uncover hidden injuries or compensated trauma. If the patient reports sexual assault, the sexual assault protocol should be followed:

- * Always interview the patient in a private place, away from anyone accompanying them to the ED. Questioning the patient in front of the batterer may place the patient and any children in danger.
- * You may be the first person or professional to acknowledge the abuse. It is important that you convey your concerns about what has happened to the patient to the Emergency Physician and Nurse.
- * When interviewing, do not ask the patients if they were battered or abused (many battered persons do not consider themselves in this light). Instead you can ask the patient:

“Have you had a fight with someone?”

“Did anyone hurt you?”

“Many times we have seen these types of injuries in patients who are hurt by someone else, did someone hurt you?”

“I am concerned that someone may be hurting you or scaring you, can you tell me what happened?”

- * Most battered persons feel very shamed and humiliated about what has happened to them. It is important to acknowledge that you understand how difficult it is to talk about what has happened.
- * Many battered persons will minimize the abuse or blame themselves for what happened. It is important that you repeatedly reinforce that no one deserves to be hurt no matter what they may or may not have done.
- * Questions/attitude **Not** to Ask/Express:
 - What keeps you with a person like that?
 - Do you get something out of the violence?
 - What did you do at the moment that caused them to hit you?
 - What could you have done to avoid or defuse the situation?

IV. PRACTICE

- * Treat obvious injuries; transport.
- * Report your suspicion and supporting findings to the Emergency Department Physician and on the prehospital report form.
- * Document the name of the physician and/or nurse to whom you reported your suspicion on the prehospital report form.
- * If the patient refuses transport, make appropriate referral and document on run sheet.
- * Document your findings on the prehospital report form:
 - Presenting condition
 - Any suspicious indicators
 - Any suspicious commentary made by the patient on interviewing the patient.
 - Physical exam including any evidence of abuse.
 - Treatment rendered

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**Report Suspicions of Geriatric abuse to ED physician, ED charge nurse AND
THE DEPARTMENT ON AGING (1-800-252-8966)**

Code 67

TRIPLE ZERO/DNR/CRITERIA FOR INITIATION CPR

Personnel, whether operating at a Basic, Intermediate, or Advance Life Support levels, are required to immediately initiate CPR whenever clinical signs of death exist.

THERE ARE ONLY TWO (2) EXCEPTIONS TO THIS REQUIREMENT:

A. Triple Zero: Signs of Explicit Biological Death Exists

The use of the term "Triple Zero" helps to alleviate the possibility of hysteria from family and/or bystanders due to any radio communications they may overhear and clearly alerts the hospital telemetry personnel to the likelihood of the patient arriving DOA.

1. The field unit will notify the hospital, "We have a TRIPLE ZERO." This indicates that they have a patient who is pulseless, non-breathing, and exhibits one or more of the following long-term indications of death:
 - a. Profound dependent lividity
 - b. Rigor mortis without profound hypothermia
 - c. Patient who has suffered decapitation
 - d. Skin deterioration or decomposition
 - e. Mummification or dehydration, especially in infants
 - f. Putrefaction
2. The hospital will give orders to transport providing it is not a county medical examiner's case.
3. The documentation of a Triple Zero is not to be construed as a pronouncement of death.
4. Transport of Triple Zero - Situations may arise where prolonged delays resulting from dispensations of obviously dead patients would tie up a vehicle for unreasonable lengths of time. If the prehospital providers encounter a patient whom they document to be a Triple Zero over, they may transfer responsibility for transportation of that patient to another ambulance service, either ALS, ILS or BLS, the appropriate police department, or an agency who is appropriate for the circumstance, who may transport the patient to a hospital to have death pronounced by an individual legally authorized to do so.

B. DNR (Do Not Resuscitate) - See System Policy

C. Except in the conditions listed above, CPR is to be initiated immediately and continued until one (1) of the following occurs:

1. Effective spontaneous circulation and ventilation have been restored.
2. Resuscitation efforts have been transferred to other persons of at least equal skill, training and experience.
3. The rescuers are exhausted and physically unable to continue resuscitation.
4. A direct order from on-line medical control is given to discontinue CPR.

D. A system hospital is to be contacted in ALL cases of cardiac arrest, whether or not the patient has signs of clinical death, meets the criteria for Triple Zero (Biological Death) or has a "Do Not Resuscitate" order.

In cases where the patient's status is unclear and the appropriateness of CONTINUED CPR is questioned, prehospital providers should call the appropriate system hospital AFTER initiation of CPR.

Code 68

RESTRAINTS AND BEHAVIORAL EMERGENCIES

Maintain situational awareness and scene safety. Introduce yourself to the patient and attempt to gain their confidence in a non-threatening manner. If the patient refuses assistance, attempt to determine their mental status. This includes determining their orientation and the presence of anything that could produce an altered mental status, such as drug/alcohol intoxication or withdrawal, trauma (head injury), hypoxia, hypotension, hypoglycemia, stroke, infections, psychological emergencies (i.e. homicidal, suicidal, psychosis, etc.) or dementia (i.e. acute or chronic organic brain syndromes).

No

If the mental status is judged to be abnormal, prehospital personnel must carry out treatment and transport in the patient's best interest.

In any form of intervention, prehospital personnel must **ALWAYS CONSIDER THEIR OWN SAFETY FIRST!**

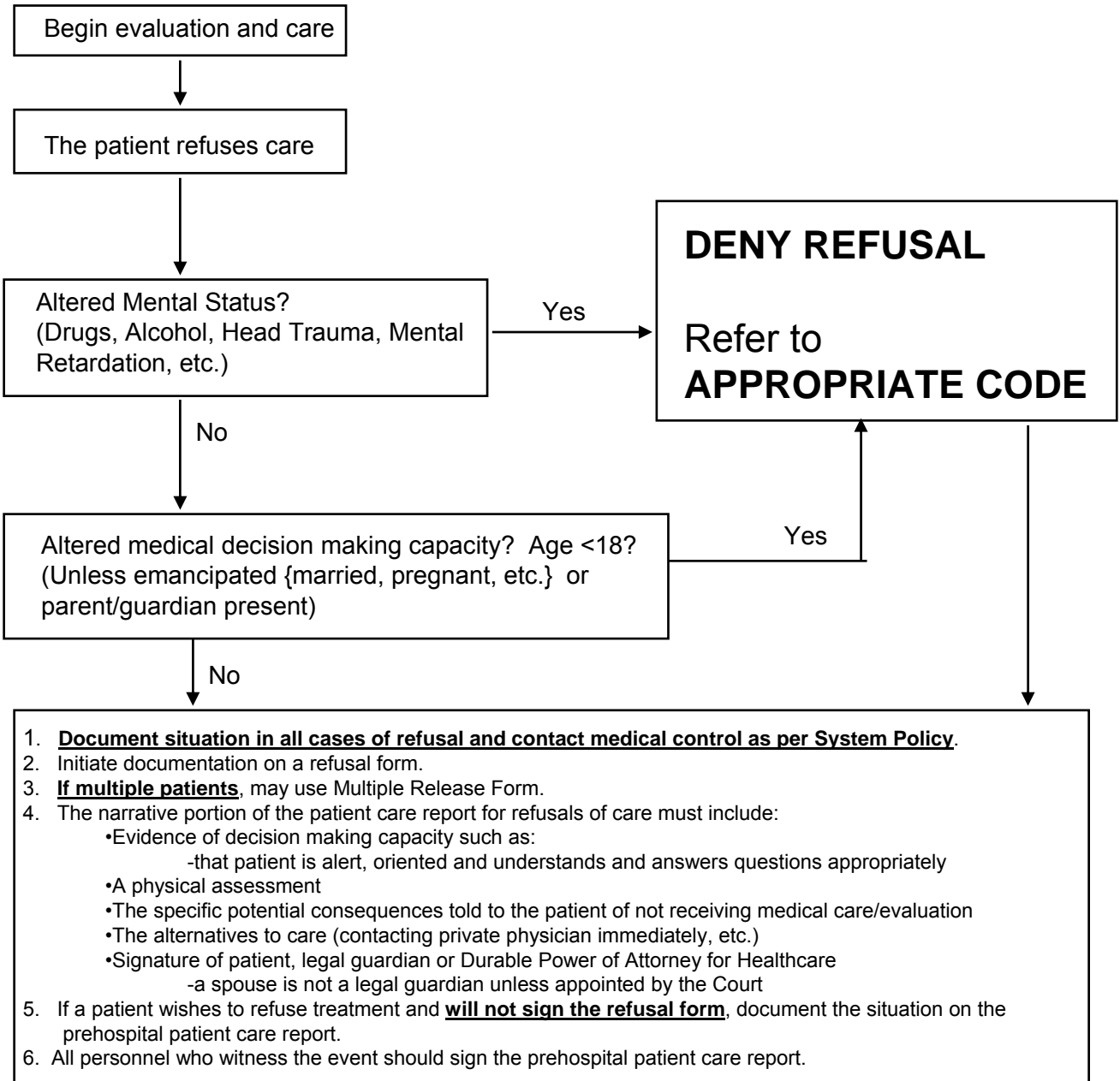
1. Again attempt to verbally reassure the patient and seek their willing cooperation.
2. If it is necessary to physically restrain a patient, perform all the following:
 - A. Prepare all the necessary equipment.
 - B. Use police and /or fire personnel if needed. If available, have one person assigned to each extremity and one to hold equipment.
 - C. Apply the restraints as loosely as possible to maintain a safe situation, but prevent neurovascular compromise and undue patient discomfort. Apply restraints over clothing when possible.
 - D. Never place restraints over a patient's chest or on the abdomen of a pregnant patient.
 - E. Perform routine and specific medical care as indicated by the patient's condition. Routinely document the neurovascular status of the patient's extremities distal to the restraints.
 - F. Notify the receiving hospital of the situation, and request security assistance upon arrival.
 - G. Continue to attempt to verbally reassure the patient and seek their cooperation. Inform the patient's family of the reasons for the use of restraints.
 - H. Thoroughly document the situation including the reasons for using restraints and how they were applied.
 - I. At no time will towels, washcloths or other devices be placed over the mouth and/or nose of a restrained patient for any reason.
 - J. Never restrain a patient in the prone position.
 - K. For reasons of medical safety, any patient who is under police hold and requires handcuffs, must have a police officer accompany the patient in the back of the ambulance while enroute to the hospital or provide the transporting EMS personnel with keys to the handcuffs.

NOTE TO PREHOSPITAL PROVIDERS:

Once restrained, continue to be conscious of the patient's airway and other medical needs.

Code 69

REFUSALS OF CARE



Contact Medical Control with any questions.

REGION 7

STANDING MEDICAL ORDERS

PROCEDURAL PROTOCOLS

Code 70

DEFIBRILLATION

- Place the patient in a safe environment, away from pooled water and metal surfaces.
- In patients 1-8 years of age, use pediatric defibrillation pads, if available.
- Apply AED electrode pads to patient chest or appropriate conductive medium to chest.
- Follow AED instructions.

Code 71

MEDICATION ADMINISTRATION - NEBULIZED INHALATION

- Observe body substance isolation precautions
- Confirm patient is not allergic to medication
- Explain procedure to patient
- Take baseline vital signs and peak flow measurement
- Check medication
 - Identify concentration
 - Inspect for contamination
 - Check expiration date
- Assemble nebulizer device
- Dispense proper dose of medication and saline
- Connect device to oxygen at 6-12 L/min
- Position patient in sitting position
- Have patient breathe through mouthpiece of nebulizer
- Observe patient for medication effects and repeat peak flow measurement
- Reassess vital signs after medication administration and document on prehospital patient care report

Code 72

AUTO-INJECTOR PEN

- Grasp auto-injector pen, with the black tip pointing downward
- Form a fist around the auto-injector pen (black tip down).
- With the other hand, pull off the gray activation cap.
- Hold the black tip near the patients outer thigh.
- Swing and jab firmly into the outer thigh so the auto-injector pen is at a 90 degree angle to the thigh.
- Hold firmly in the thigh for several seconds.
- Remove auto-injector pen, massage injection area for several seconds.
- Check the black tip:
 - If needle is exposed, you have given the dose
 - If not, repeat the above steps.
- Note: Most of the liquid (about 90%) stays in the auto-injector pen and cannot be reused.
- Dispose of unit properly

Code 73

CONTINUOUS POSITIVE AIRWAY PRESSURE ADMINISTRATION

- Observe body substance isolation at all times
- Oxygenate the patient with 15 liters via non-rebreather mask while setting up CPAP
- Connect fixed generator to portable oxygen regulator
- Open CPAP disposable package and attach patient corrugated tubing to bottom of generator and add filter to side of generator
- Attach other end of patient tubing to bottom of mask
- Attach 10cm isobaric peep valve to front of mask
- Connect head strap to top of one side of mask
- Turn oxygen tank on
- Encourage patient to place mask over mouth and nose, then firmly attach mask using final connection on side of mask
- When patient has been placed in the ambulance, “quick connect” generator to on-board oxygen
- Monitor patient’s level of consciousness and vital signs continuously. If patient develops decreased mental status or decreased blood pressure-**DISCONTINUE CPAP**.
- Continuous cardiac monitoring and pulse oximetry required

Note: If aerosol medication treatment is indicated, cut the patient’s corrugated tubing at first smooth part closest to the patient’s face. Place a “t” connector between the tubing and follow **ALBUTEROL** administration protocol.

If port is available for Albuterol administration, follow manufacturers guidelines.

Code 74

INTRANASAL ADMINISTRATION

- Observe body substance isolation at all times
- Assess ABC's and support ventilation as needed
- Inspect medication
 - Identify concentration
 - Inspect for contamination
 - Check expiration date
- For suspected Opiate overdose,
 - Remove the medication atomization device (MAD) tip from the syringe
 - Draw up **NALOXONE** (Narcan) 2ml (1mg/ml) and replace the MAD Intranasal Atomizer tip (OR place the MAD tip on a luer-lock prefilled syringe)
 - Tilt the patients head back, if possible
 - Place atomizer in the nare opening and advance it until the cone tip is sealed against the opening.
 - Depress the plunger and administer 1ml briskly in each nostril
 - Remove the device
 - Monitor the patient for desirable and undesirable effects
 - Continue to support respirations as needed
- For hypoglycemia (blood sugar < 60) and altered level of consciousness when an IV is not able to be established,
 - Reconstitute **GLUCAGON** 1mg in 1ml sterile water
 - Remove the medication atomization device (MAD) tip from the syringe
 - Draw up the reconstituted GLUCAGON (1mg/ml) and replace the MAD Intranasal Atomizer to syringe
 - Tilt the patient's head back, if possible
 - Place atomizer in the nare opening and advance it until the cone tip is sealed against the opening.
 - Depress the plunger and administer 0.5 ml briskly in each nostril
 - Remove the device
 - Continue to monitor closely for desirable and undesirable effects

Code 75

FAILED ADULT AIRWAY

