

# 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.

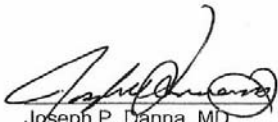
These orders are to be used in the following situations:

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.

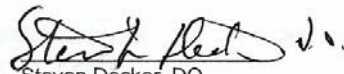
Due to geographic and regional considerations, some systems may include or exclude certain drugs as indicated.



Joseph P. Danna, MD  
Medical Director  
St. Mary's-Kankakee EMS System  
Provena St. Mary's Hospital



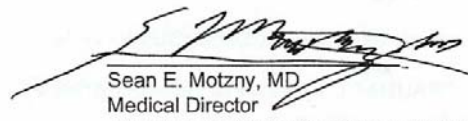
Bernard Heilicser, DO  
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Riverside EMS System  
Riverside Medical Center



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Advocate Christ Medical Center

REGION VII  
BLS STANDING MEDICAL ORDERS  
2008 REVISION SUMMARY

Only the following codes reflect changes. All other codes remain the same.

Code 1 Deleted line 4 under IMC (Evaluate cardiac rhythm if indicated)

Code 14- Changed to reflect same as ALS verbiage (regarding options related to transport times)

Code 22- Added Isolated burns

Code 39- Removed Box 8

Code 48- Added CPR 3 to 1 and accelerated transport

Code 50- Removed verbiage page 2 (maintain endotracheal tube)

Code 70- Changed line 4 (Follow AED instructions)

Code 72- Changed line 10 (Dispose of unit properly)  
Removed line 11 & 12

11/01/2008

# 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
2. RESPIRATORY DISTRESS
3. AIRWAY OBSTRUCTION
4. CARDIAC ARREST (SEE APPROPRIATE DYSRHYTHMIA)
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
21. A CRUSH INJURIES  
Revised 11/01/08  
Revised 11/1/06  
Revised 9/1/04
22. BURNS  
Effective 10/1/98 BLS

**CODE      TRAUMA PROTOCOLS - CONTINUED**

- 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. HYPERTENSIVE CRISIS
- 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

Revised 11/01/08  
Revised 11/01/06  
Revised 10/01/04  
Effective 10/01/98  
BLS

**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

Revised 11/01/08  
Revised 11/01/06  
Reviewed 10/01/04  
Effective 10/01/98 BLS

# 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).

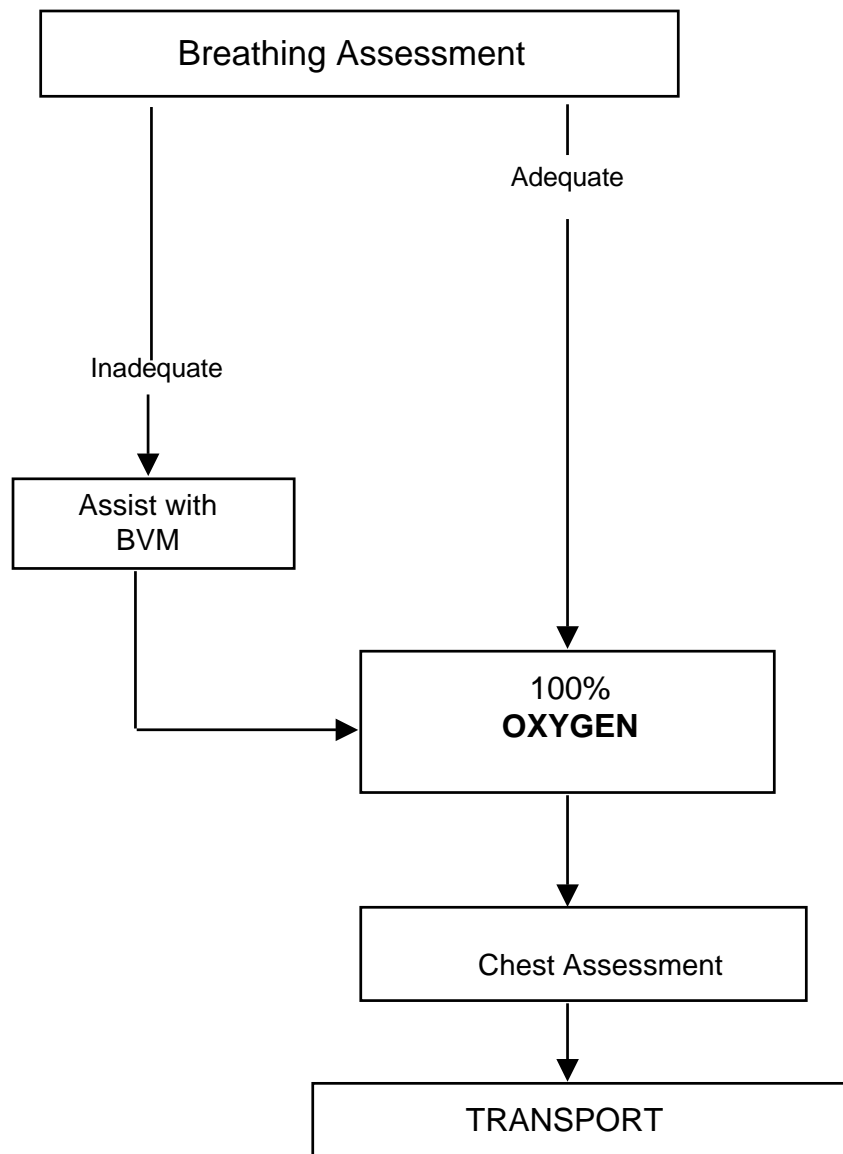
Refer to **CODE 1** and follow the steps under **GENERAL PATIENT ASSESSMENT** and **INITIAL MEDICAL CARE/ROUTINE CARDIAC CARE**.

## **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

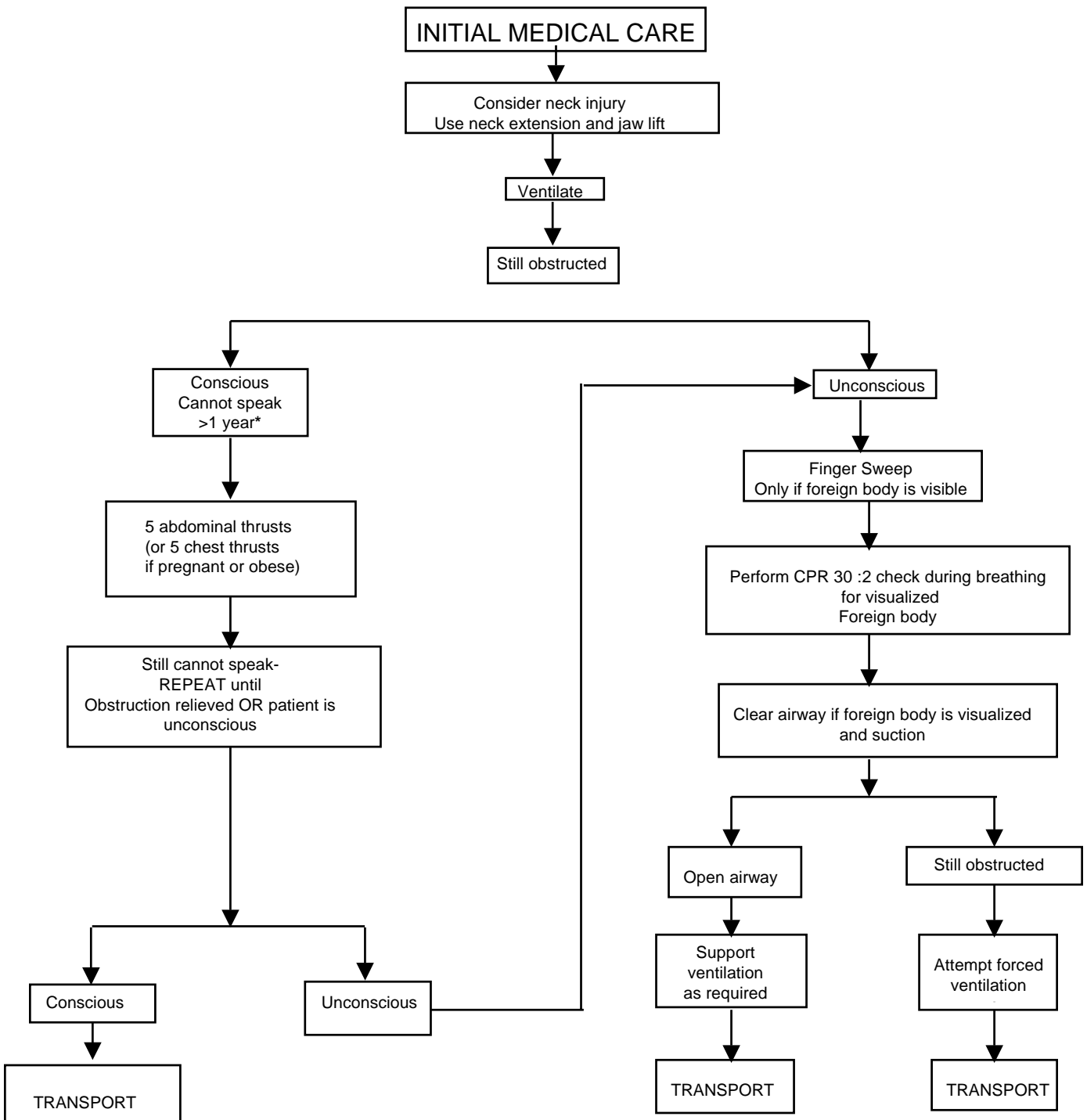
# Code 2

## RESPIRATORY DISTRESS



# Code 3

## AIRWAY OBSTRUCTION



\*<1 year

5 back blows followed by 5 chest thrusts

Reviewed 11/01/08

Revised 11/01/06

Reviewed 10/01/04

Effective 10/01/98

BLS

**Code 4**

**CARDIAC ARREST**

**(SEE APPROPRIATE  
DYSRHYTHMIA)**

# Code 5

**CARDIOGENIC SHOCK**

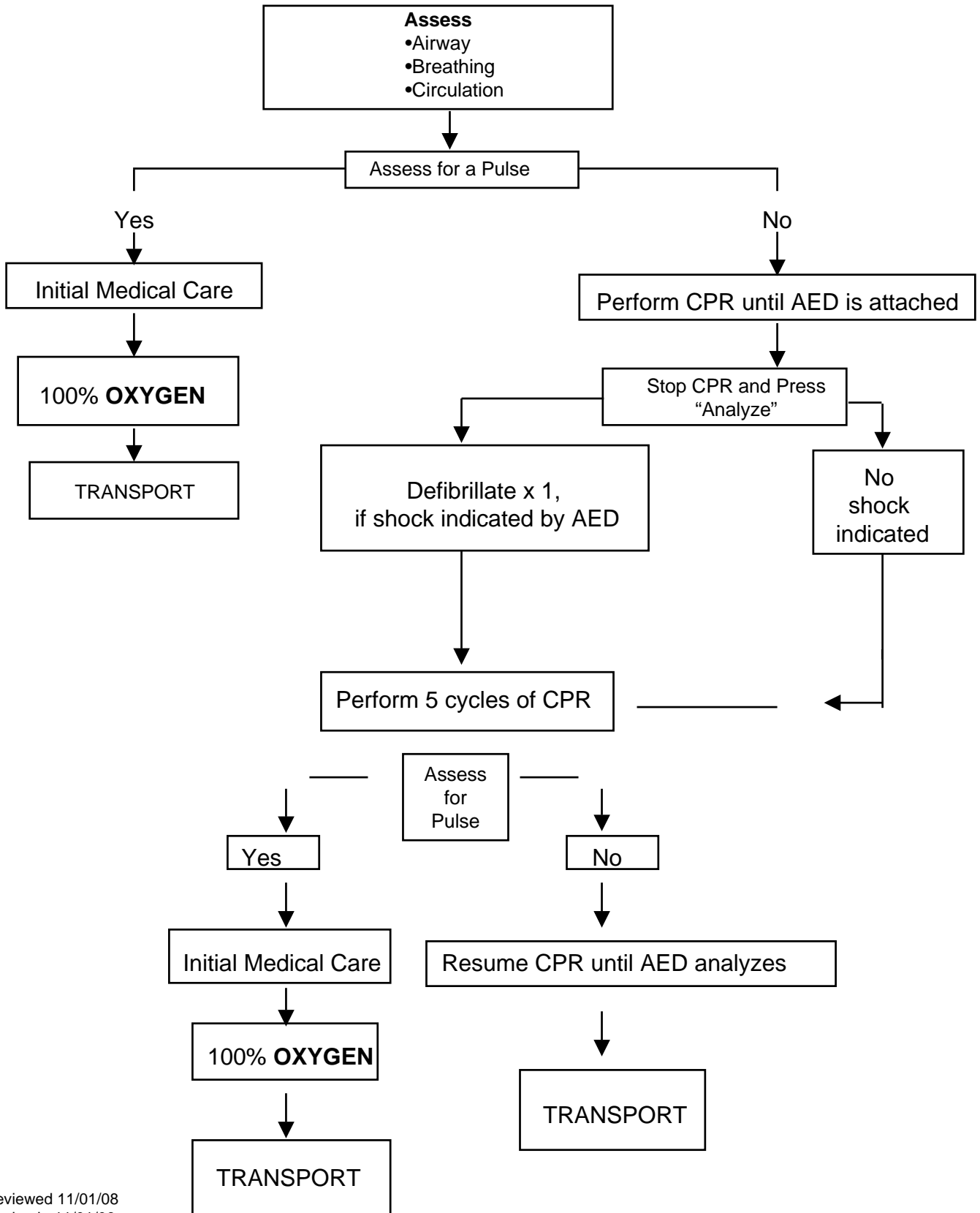
INITIAL MEDICAL CARE



**TRANSPORT**

# Code 6

## VENTRICULAR FIBRILLATION/ PULSELESS VENTRICULAR TACHYCARDIA



# Code 7

## TACHYCARDIAS (WITH PULSE)

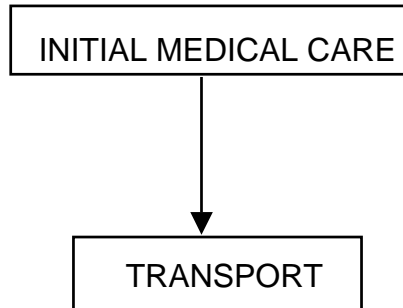
INITIAL MEDICAL CARE



TRANSPORT

# Code 8

## VENTRICULAR ECTOPY



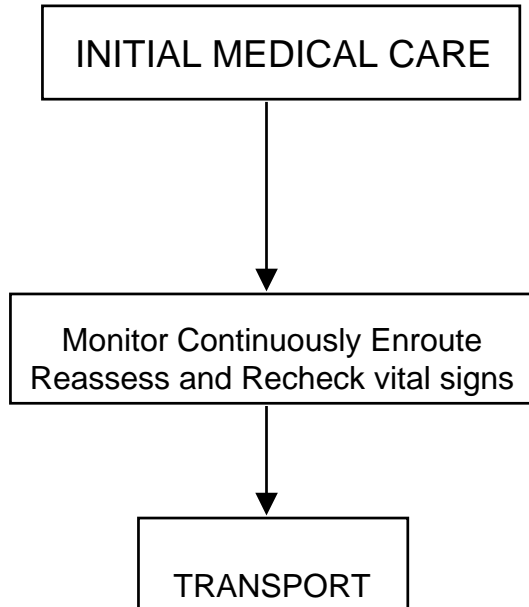
# Code 9

**PULSELESS ELECTRICAL ACTIVITY**

**SEE CODE 6**

# Code 10

## BRADYCARDIA (Pulse <60)



# Code 11

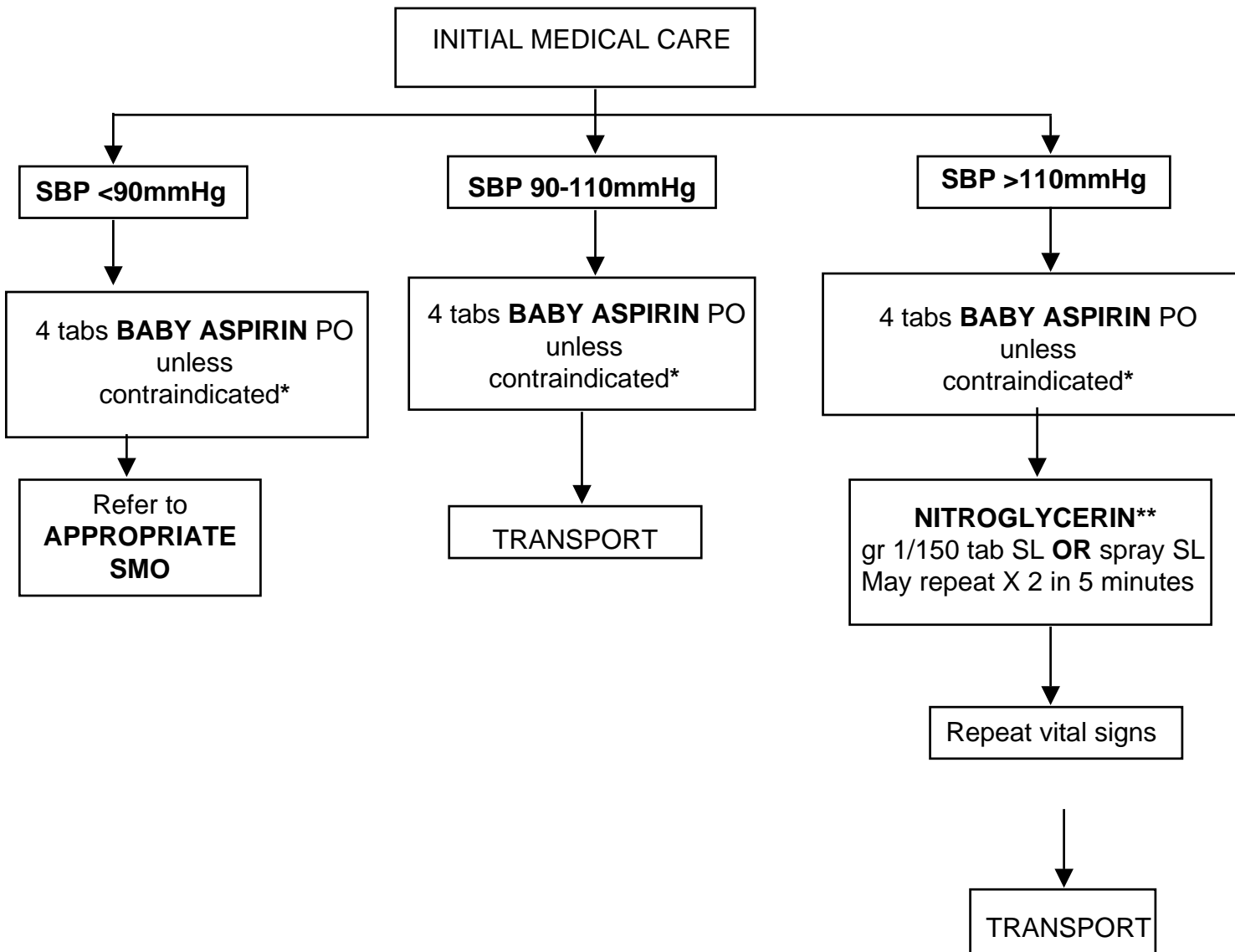
**ASYSTOLE**

**SEE CODE 6**

Reviewed 11/01/08  
Revised 11/01/06  
Reviewed 10/01/04  
Effective 10/01/98  
BLS

# Code 12

## SUSPECTED CARDIAC PATIENT



### **NOTE TO PREHOSPITAL PROVIDERS:**

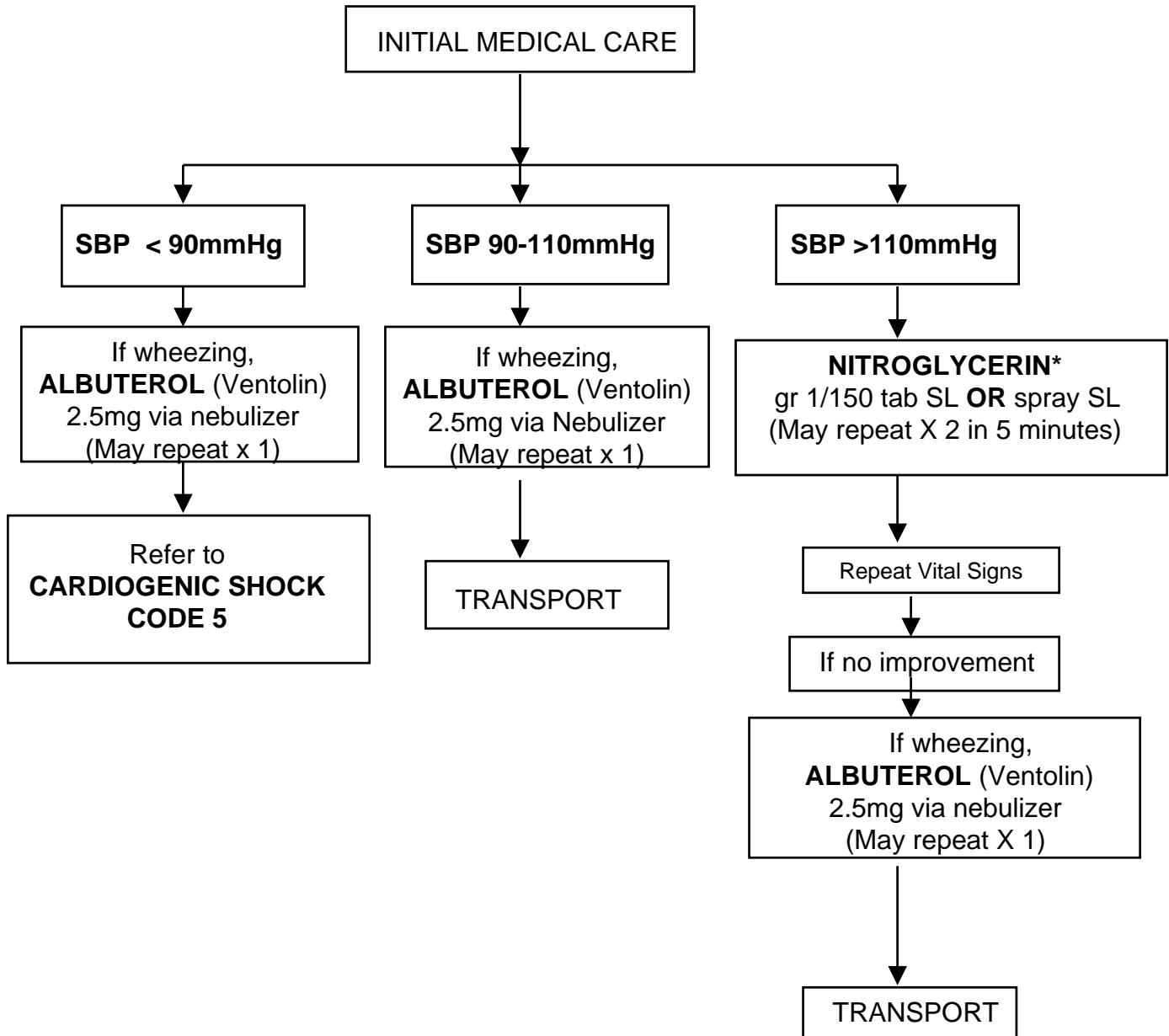
\*Contraindications to **ASPIRIN** would include **ASPIRIN** allergy & history of gastrointestinal bleeding.

\*\*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, Levetra, 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, Levetra, Cialis).

Reviewed 11/01/08  
Revised 11/01/06  
Revised 10/01/04  
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BLS

# **REGION 7**

## **STANDING MEDICAL ORDERS**

## **TRAUMA PROTOCOLS**

Reviewed 11/01/08

Reviewed 11/01/06

Reviewed 10/01/04

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 ⇄ 90 systolic (Peds <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.

- 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.

- Transmedialstinal 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.

- Blunt or penetrating trauma with unstable vital signs and/or:
  - ☆ Hemodynamic compromise as evidenced by:
    - Adult B/P <90 systolic
    - Peds B/P <80 systolic
  - ✂ Respiratory compromise as evidenced by:
    - respiratory rate <10 OR >29
  - ☒ Head injury with altered mentation as evidenced by a Glasgow Coma Score ⇄ 10.

- Anatomical Injury:
  - ① Penetrating injury of the head, neck, chest or abdomen.
  - ② Two or more body regions with potential life or limb threat.
  - ③ Combination trauma with ⇄ 20% TBSA.
  - ④ Amputation above the wrist or ankle.
  - ⑤ Limb paralysis and/or sensory deficit above the wrist or ankle.
  - ⑥ Flail chest.
  - ⑦ Two or more proximal long bone fractures.

### CATEGORY II

- Mechanism of Injury:
  - 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.

Revised 11/01/08  
Reviewed 06/24/08  
Reviewed 05/01/08  
Reviewed 06/01/06  
Reviewed 05/01/04  
Effective 05/01/98  
BLS

# 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
  - 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.

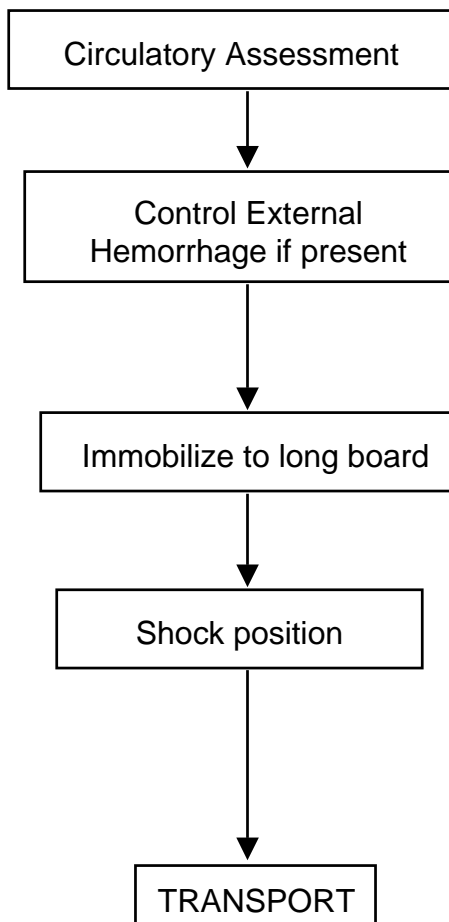
### OUTLINE FOR RADIO REPORT (transmit using as few words as possible)

1. Name and vehicle number of provider
2. Requested destination, closest hospital, and estimated time of arrival
3. Age, sex, and approximate weight of the 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 17

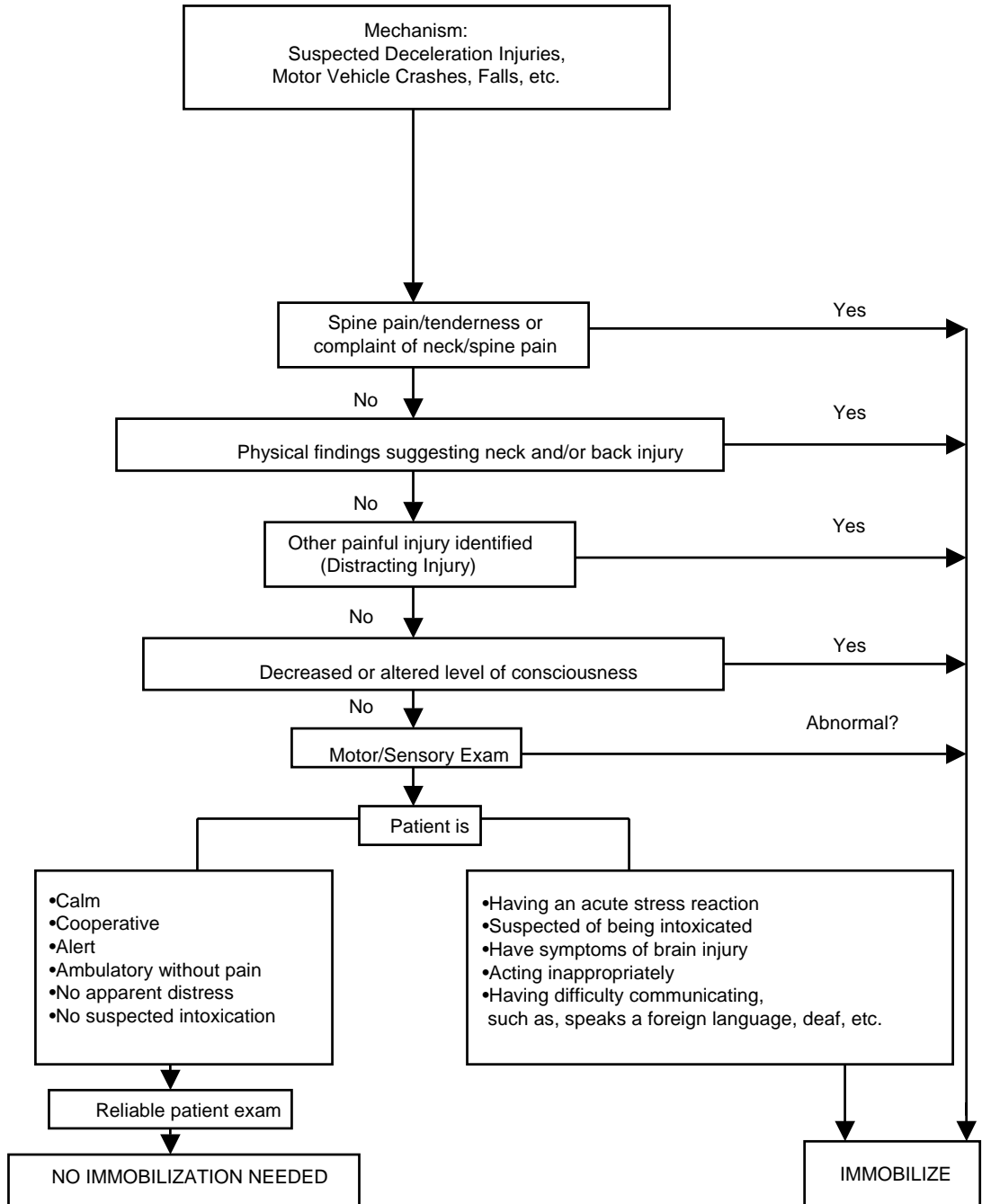
## HEMORRHAGIC SHOCK

ROUTINE TRAUMA CARE WITH 100% OXYGEN



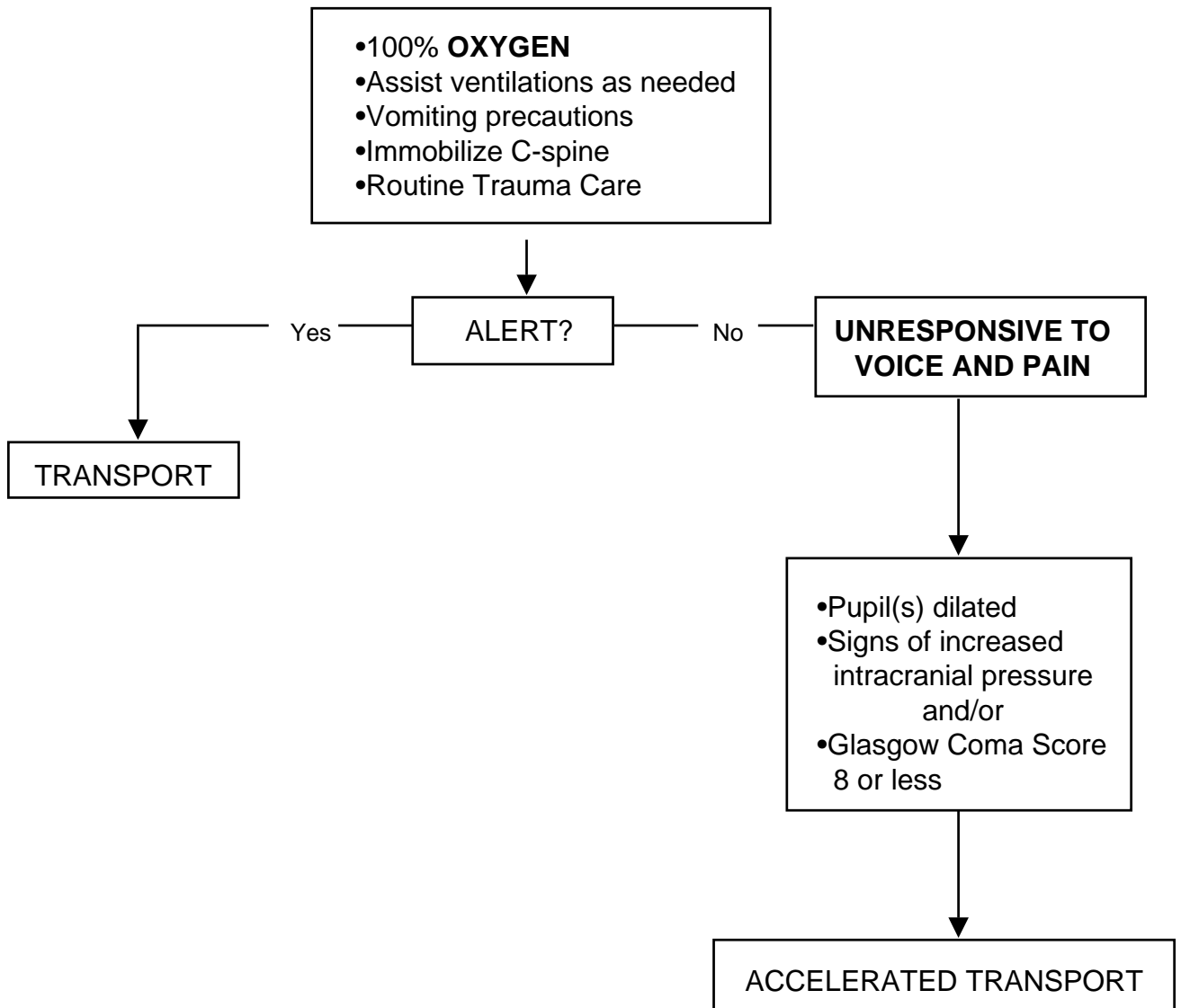
# Code 18

## SUSPECTED SPINAL CORD INJURY SPINAL IMMOBILIZATION



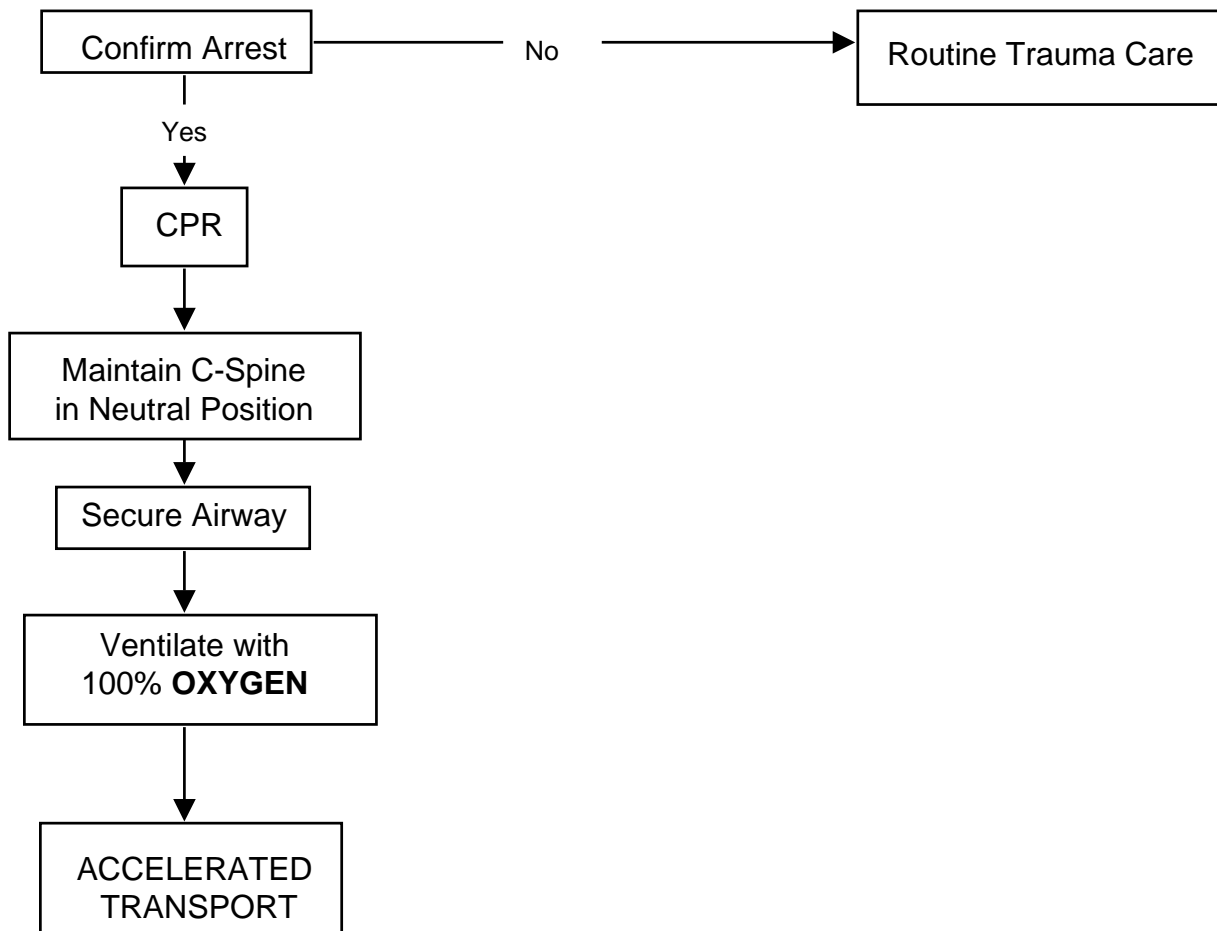
# Code 19

## 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**

- DO NOT use a tourniquet unless all else fails and the patient is hemorrhaging:
  - Note time of placement
  - Apply as close to 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**

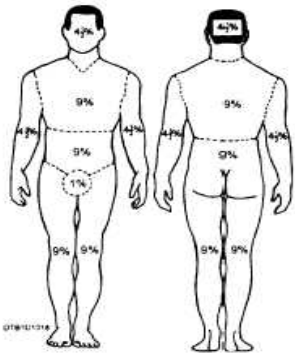
INITIAL MEDICAL CARE

TRANSPORT

Reviewed 11/01/08

Effective 11/01/06

BLS



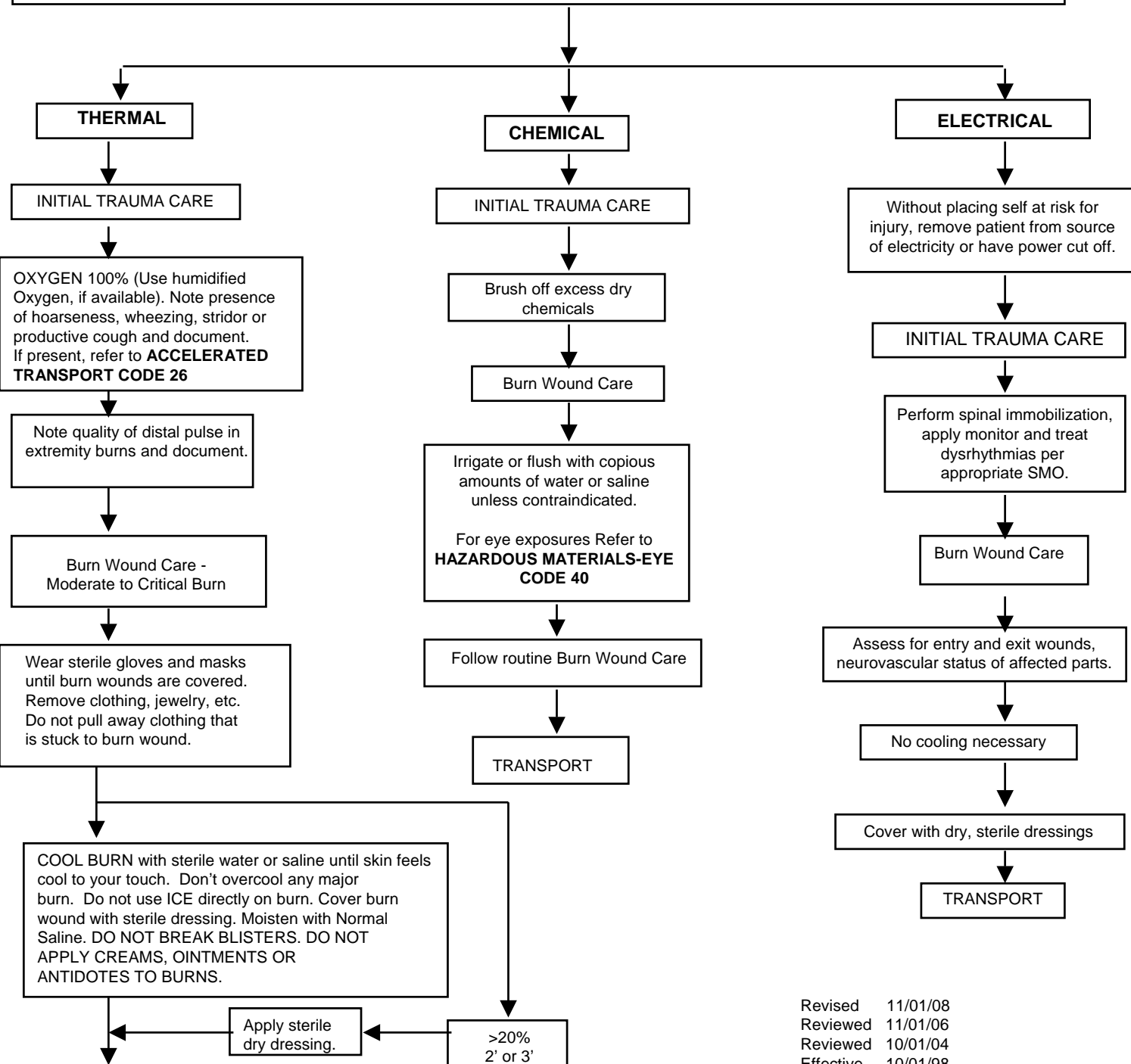
# Code 22

## 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.

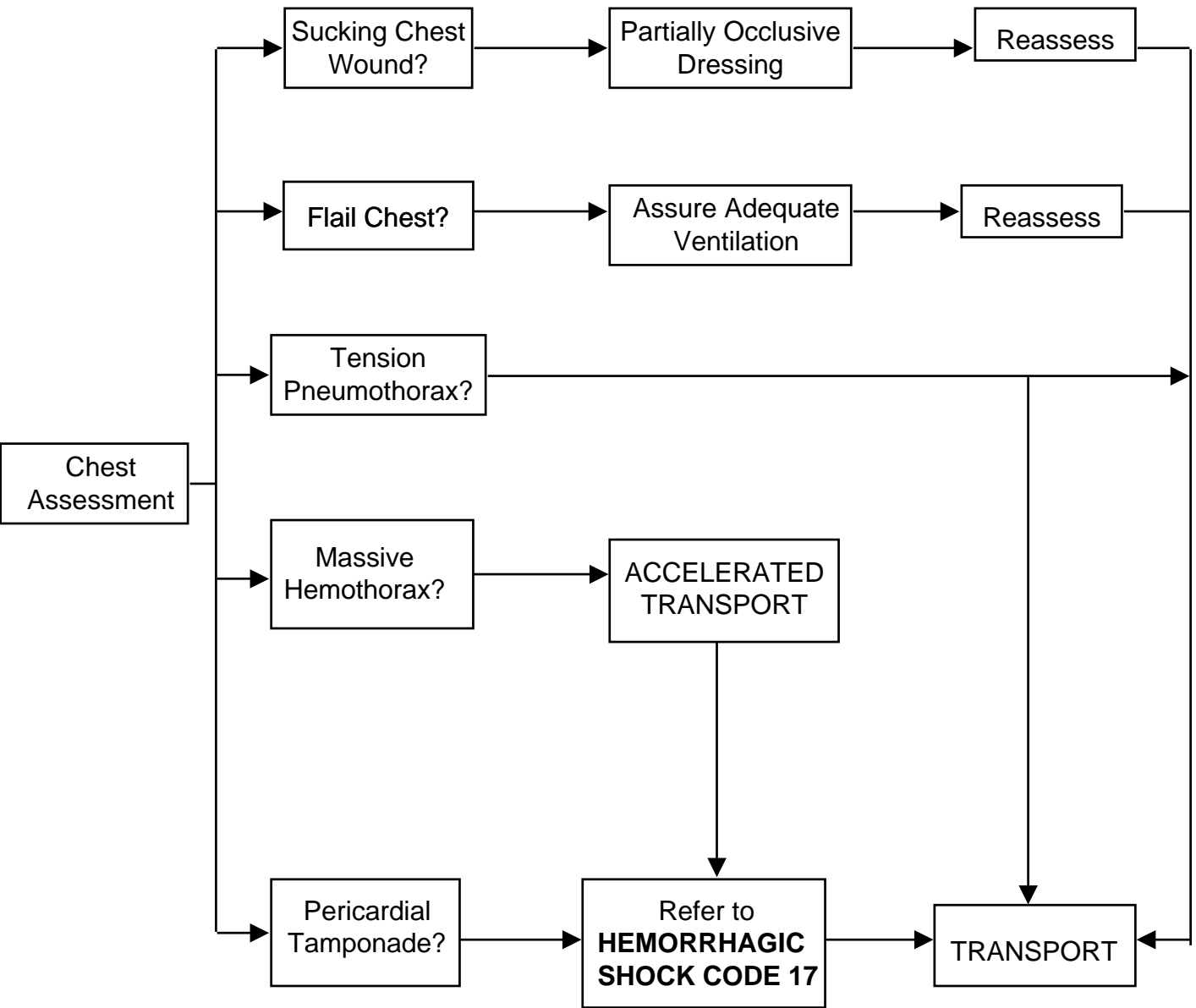


Revised 11/01/08  
 Reviewed 11/01/06  
 Reviewed 10/01/04  
 Effective 10/01/98  
 BLS

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.

# 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 11/01/08  
Reviewed 11/01/06  
Reviewed 10/01/04  
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.

# 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
<b>Pulse</b>	100-160	90 - 120	80 - 120	70 - 110	60 - 90	60 - 90
<b>Respirations</b>	30- 60	20 - 30	20 - 30	18 - 25	15 - 20	15 - 18
<b>Systolic Pressure</b>	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)

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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%

# Code 29

## PEDIATRIC BURNS (THERMAL, ELECTRICAL, CHEMICAL)

- 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 PEDS TRAUMA PT CODE 27**
- Assess percentage/depth of burn
- Remove constricting jewelry and clothes.

**No Respiratory Compromise**

**Respiratory Compromise**

Follow correct burn type path

**THERMAL BURNS**

**Superficial (1st degree)**

- Cool burned area with sterile 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

Support ventilation with BVM

Secure airway as appropriate

Refer to **PEDIATRIC RESPIRATORY DISTRESS CODE 55**

Support ABCs

- Observe
- Keep warm
- 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

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 Reviewed 11/01/06  
 Revised 10/01/04  
 Effective 10/01/98  
 BLS

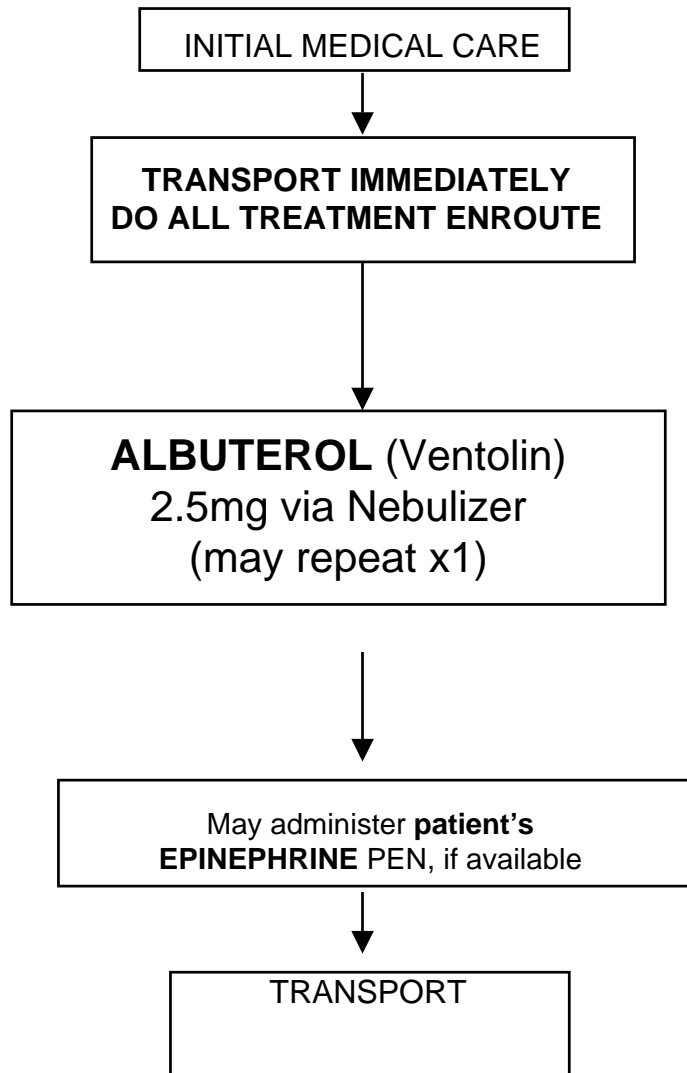
**REGION 7**

**STANDING MEDICAL ORDERS**

**PROTOCOLS FOR  
MEDICAL EMERGENCIES**

# Code 30

## ACUTE ASTHMA/COPD WITH WHEEZING

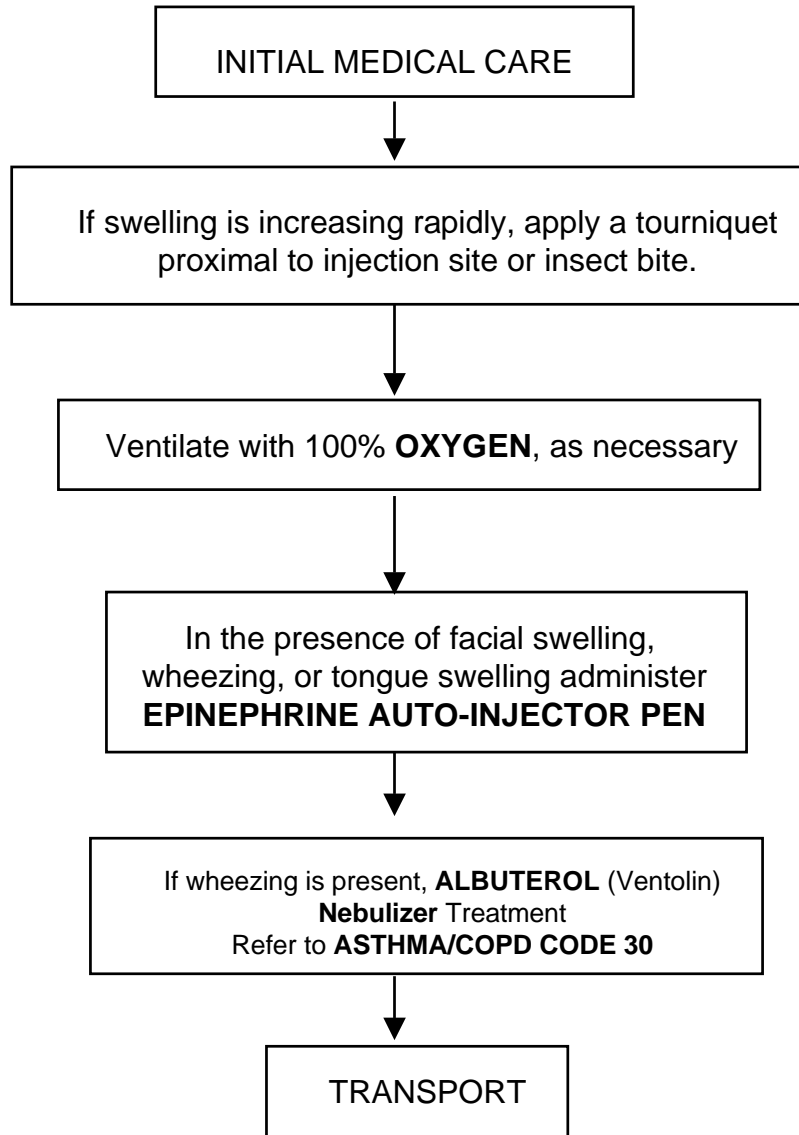


### NOTE TO PREHOSPITAL PROVIDERS:

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

# 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 sugar level reading, if available

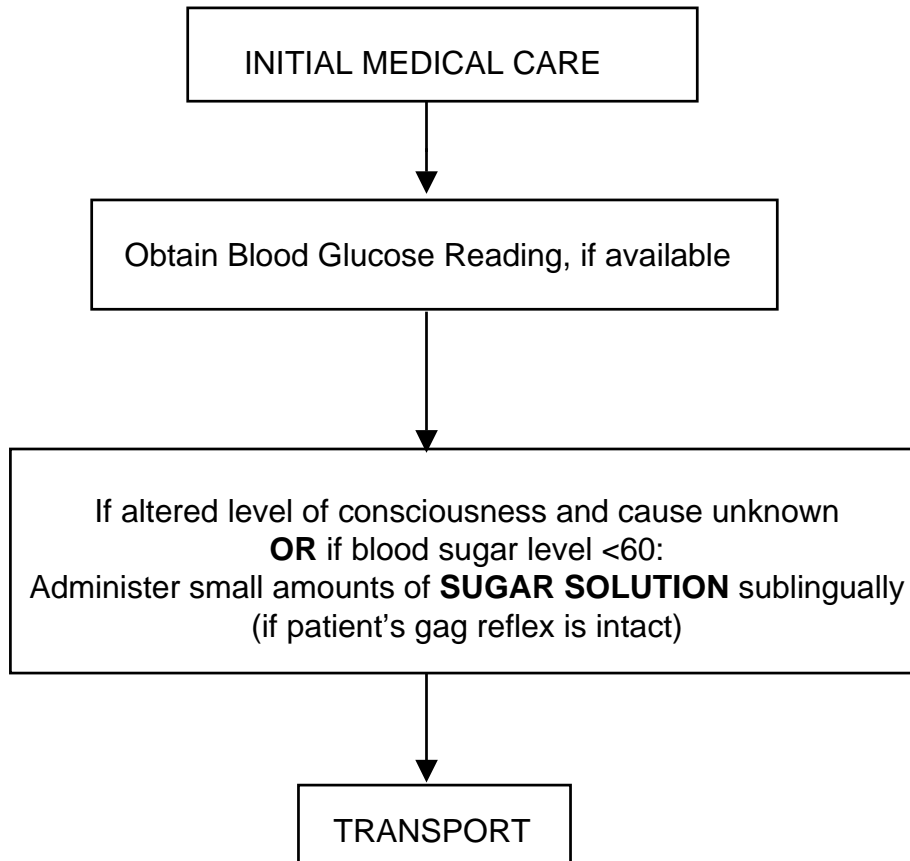
If patient is awake and gag reflex intact, administer small amounts of **SUGAR SOLUTION** sublingually

TRANSPORT

Reviewed 11/01/08  
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Reviewed 10/01/04  
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BLS

# Code 33\*

## DRUG OVERDOSE ALCOHOL RELATED EMERGENCIES/POISONING



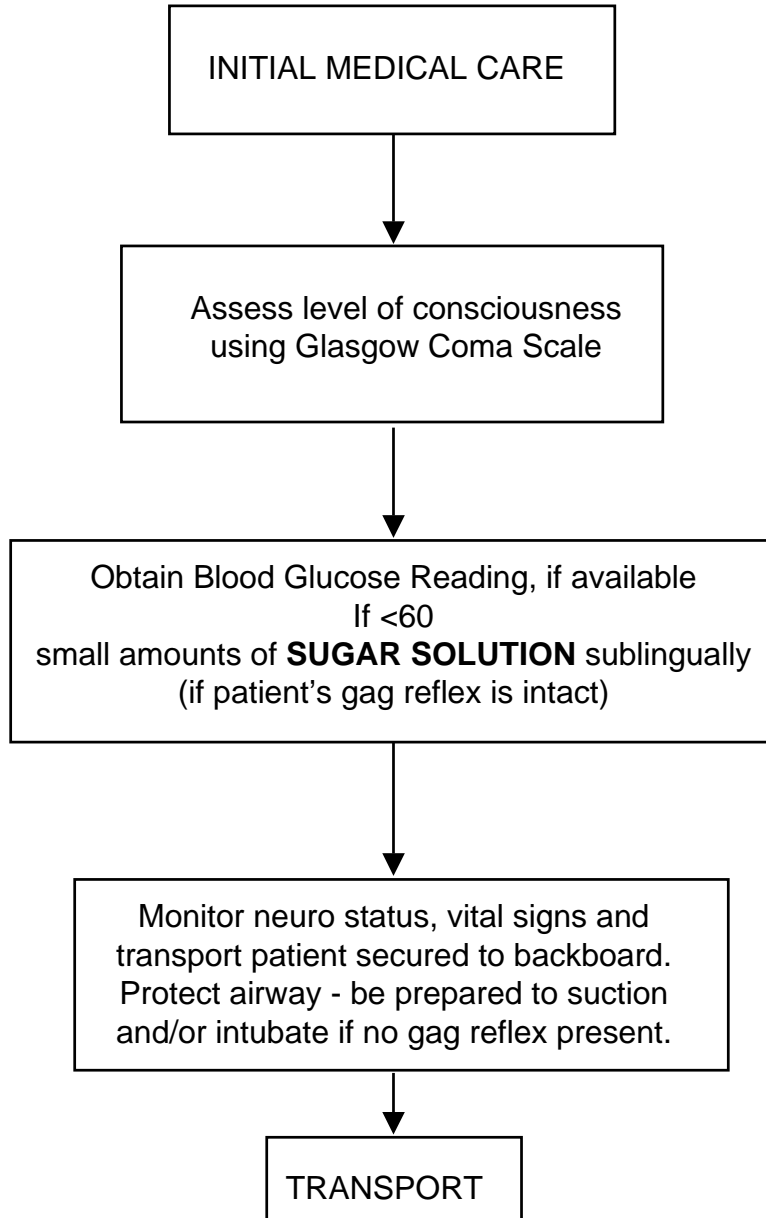
### NOTE TO PREHOSPITAL PROVIDERS:

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

Reviewed 11/01/08  
Reviewed 11/01/06  
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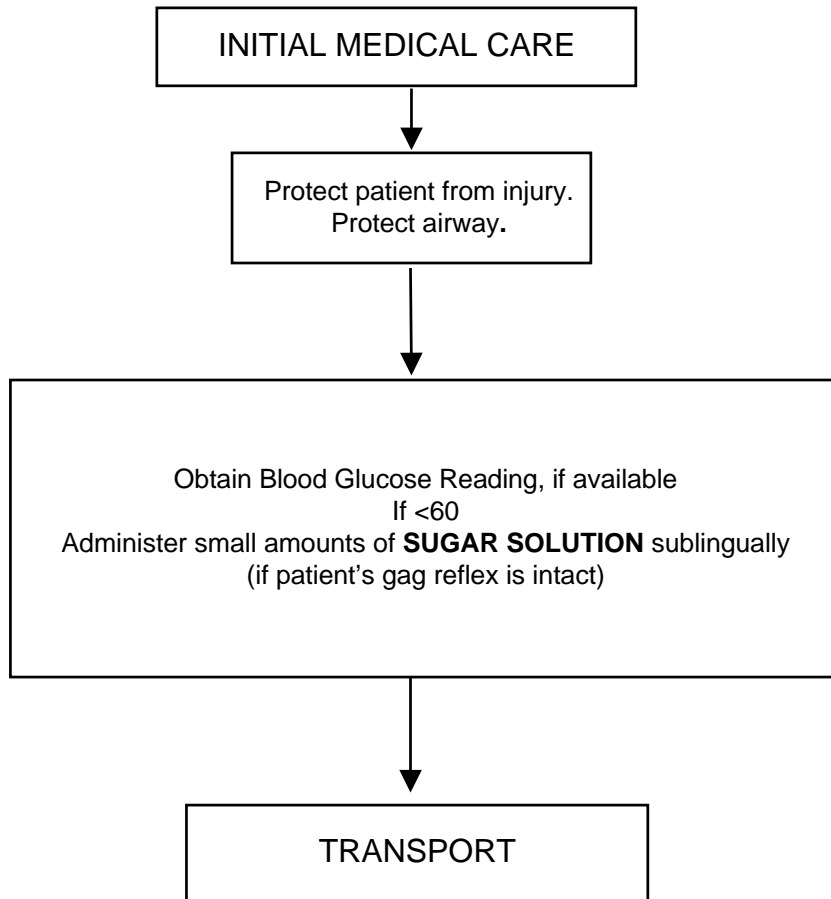
# Code 34

## COMA OF UNKNOWN ORIGIN (NO HISTORY OF TRAUMA)



# Code 35

## \*SEIZURES/STATUS EPILEPTICUS

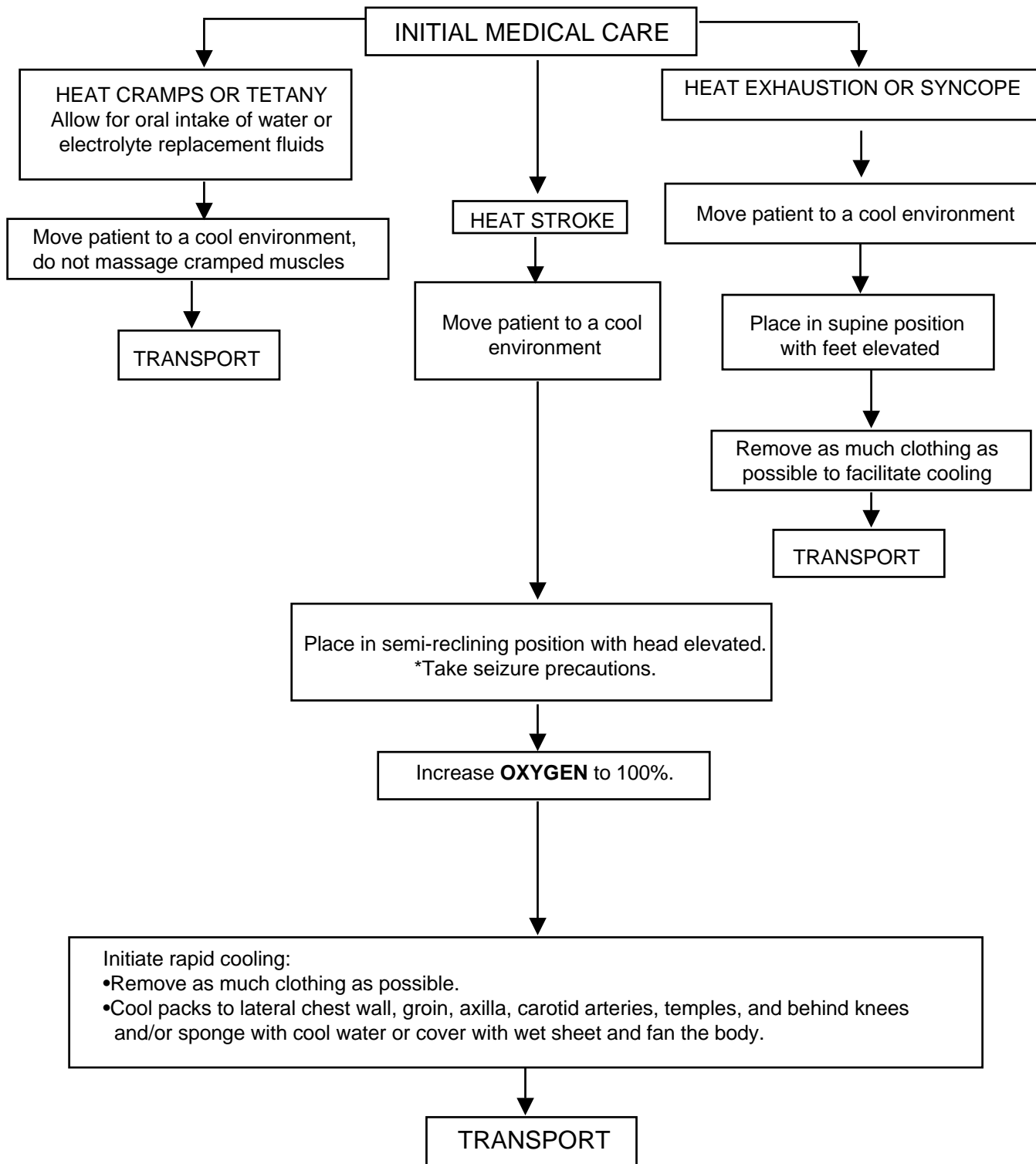


\* Refer to **PEDIATRIC SEIZURES CODE 59**, as needed

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BLS

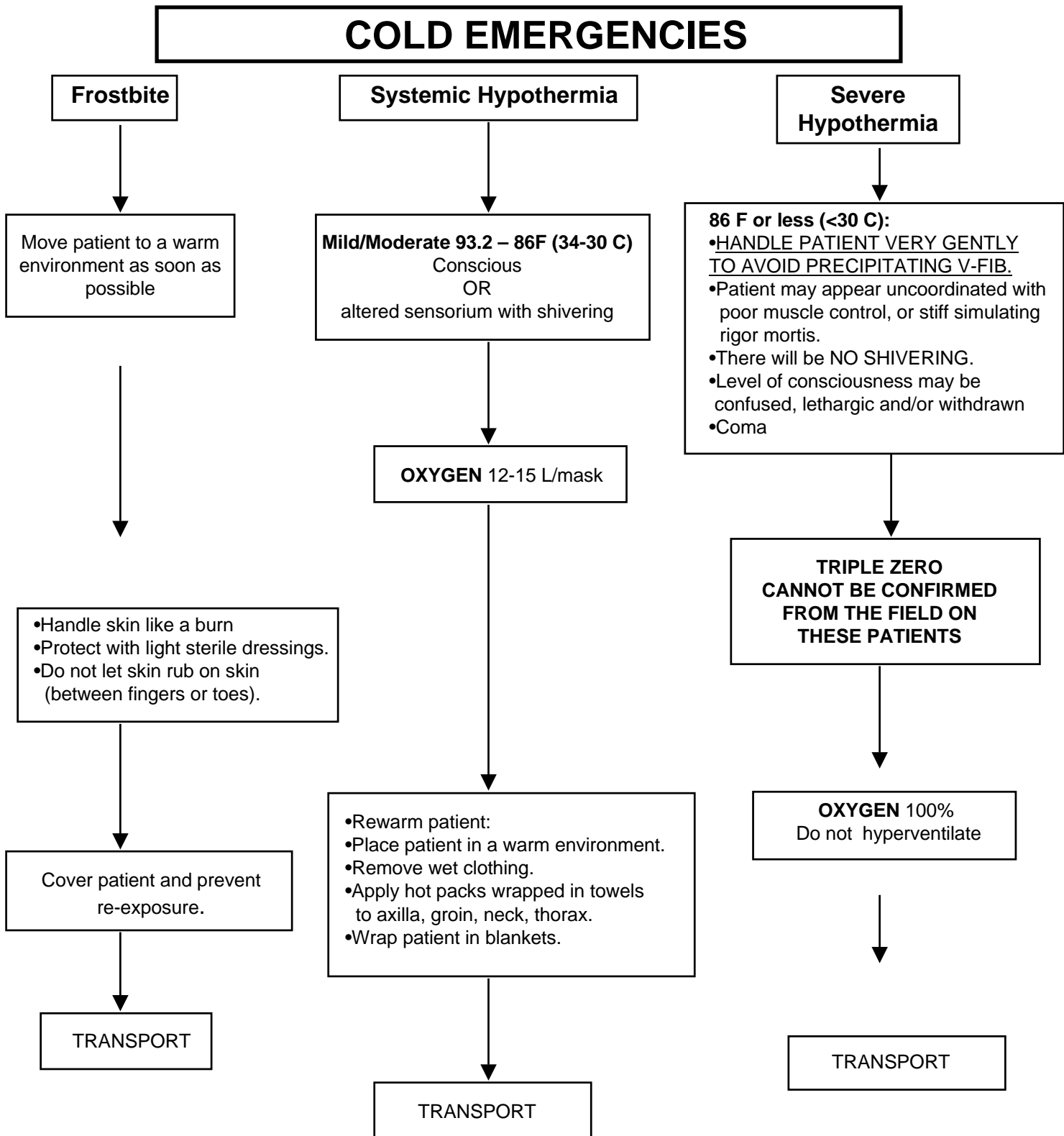
# Code 36

## 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

## HYPERTENSIVE CRISIS

Diastolic B/P > 130 mmHg  
**AND**  
neurologic changes:  
(i.e., headache, confusion, seizures, visual disturbances, lethargy)

INITIAL MEDICAL CARE

TRANSPORT

# 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 the local HazMat Unit

Isolate

Brush off solid substances, remove contaminated clothing and decontaminate as indicated  
The decontaminate 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

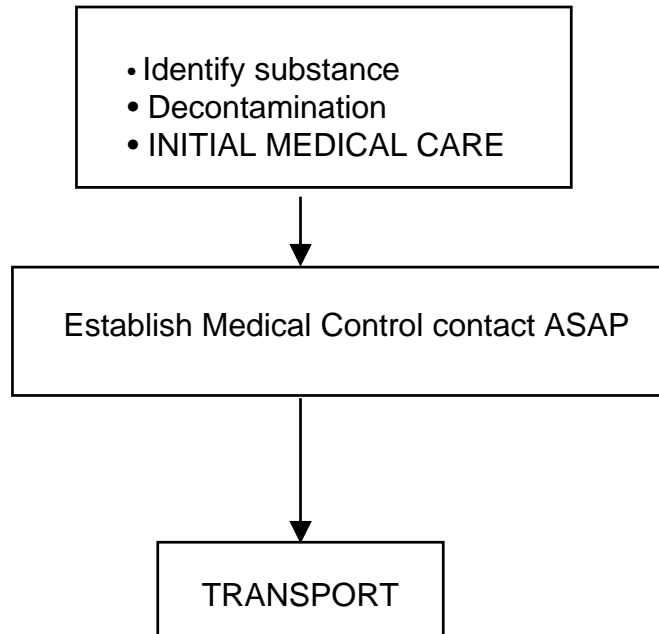
## HAZARDOUS MATERIALS PESTICIDE/NERVE AGENT

**Indications:**

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

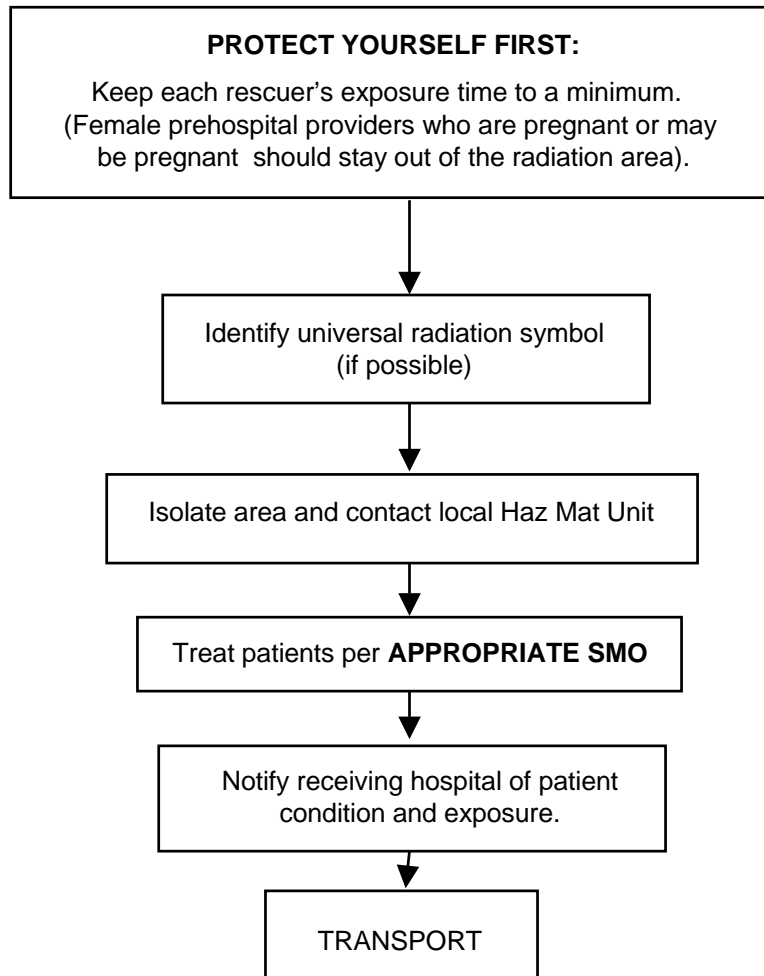
**Signs & Symptoms:**

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

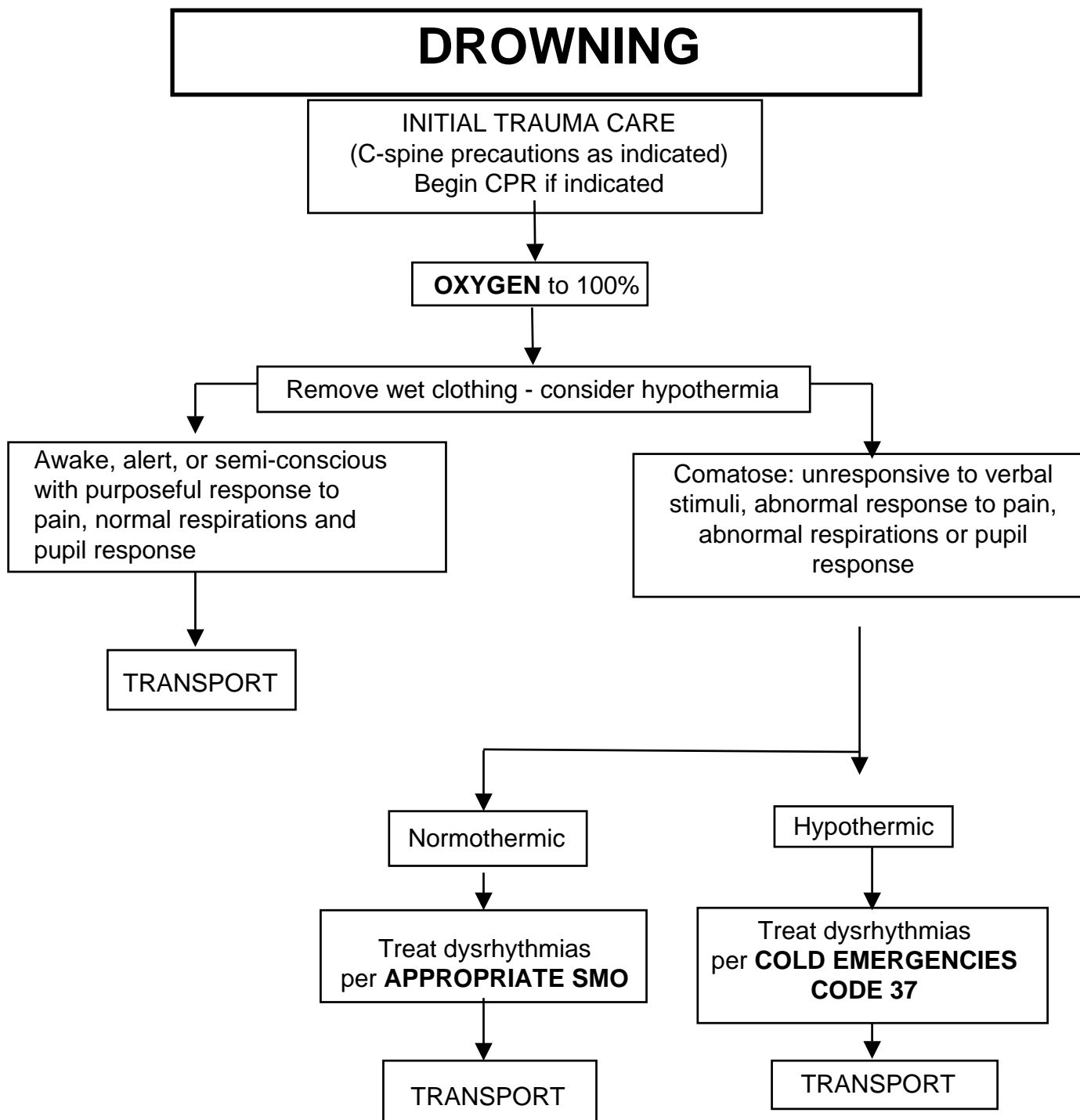
In the event of cardiac arrest, follow the **APPROPRIATE SMO**.

### 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
- Involuntarily pushing with contractions
- Contractions less than 2 minutes apart.

**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**

Reviewed 11/01/08  
Revised 11/01/06  
Reviewed 10/01/04  
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

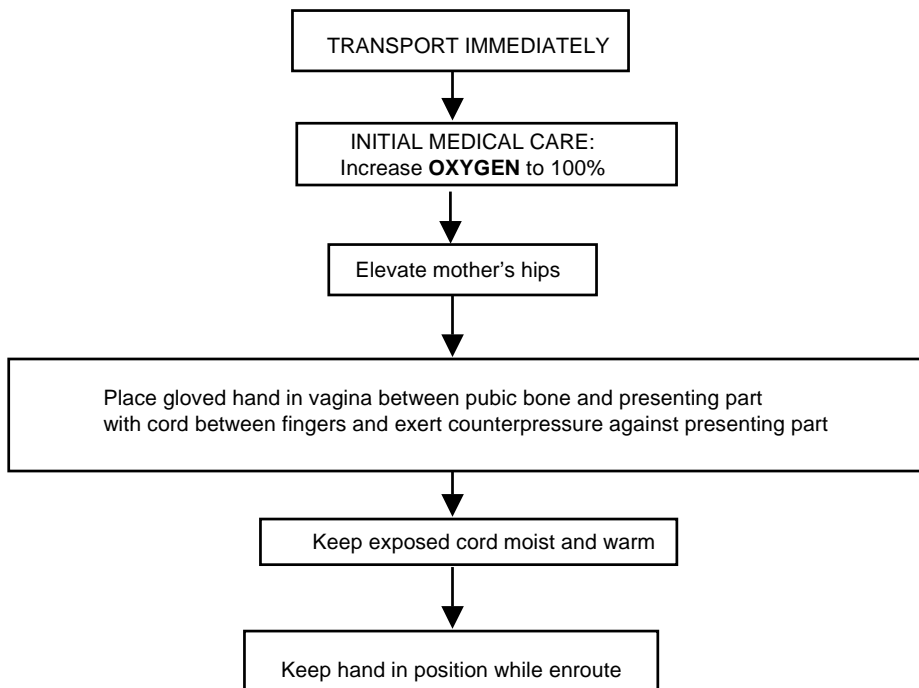
Seizure precautions

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

# Code 47

## ABNORMAL DELIVERIES

### PROLAPSED CORD

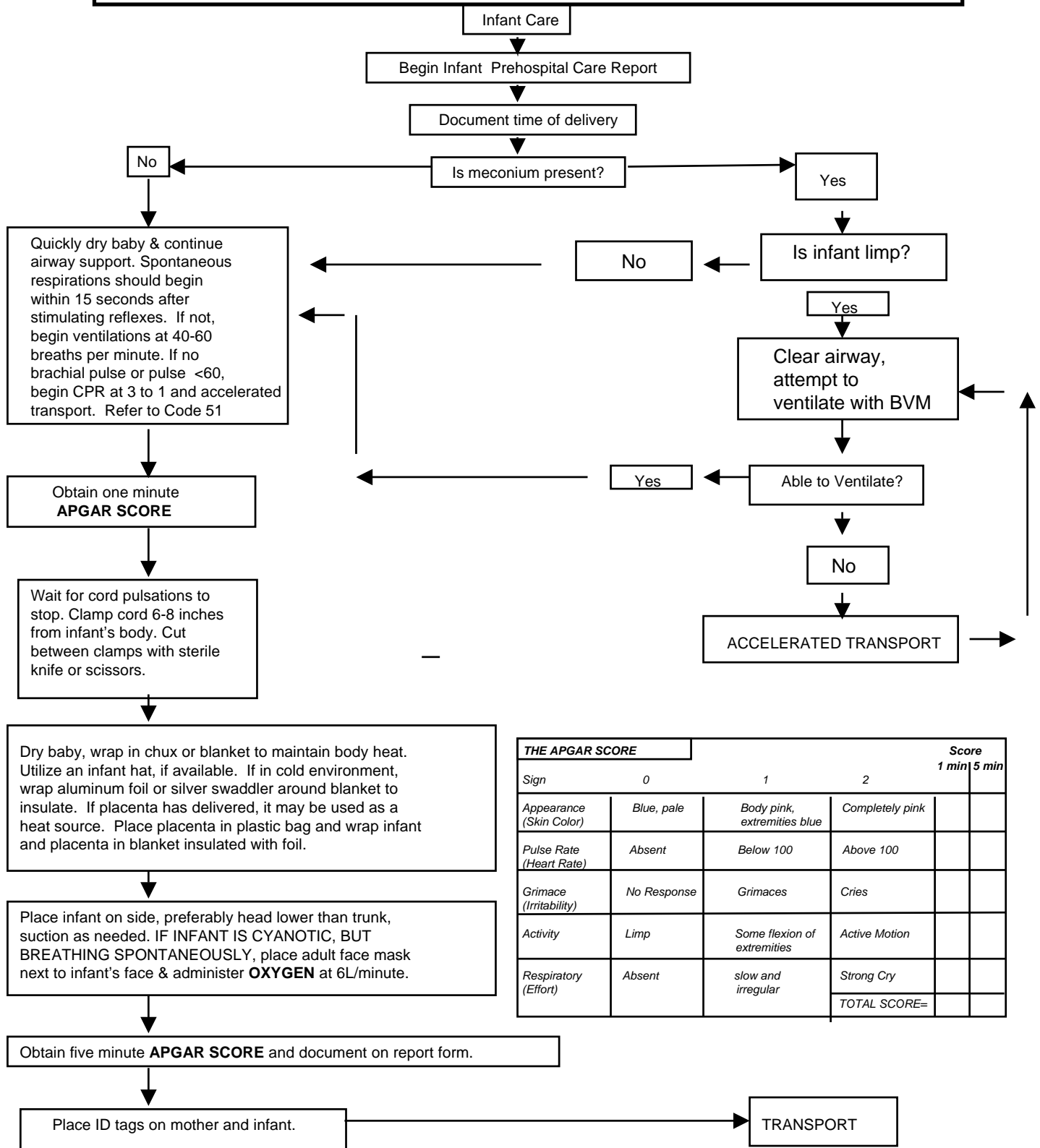


### BREECH BIRTH

- 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, LMP, 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.

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**PEDIATRIC INITIAL ASSESSMENT**

- \* 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

**PEDIATRIC INITIAL ASSESSMENT**

- 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
- \* Lacerations
- \* Swelling/edema
- \* Tenderness
- \* 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 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.

Reviewed 11/01/08  
Revised 11/01/06  
Revised 10/01/04  
Effective 10/01/98  
BLS

# 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**

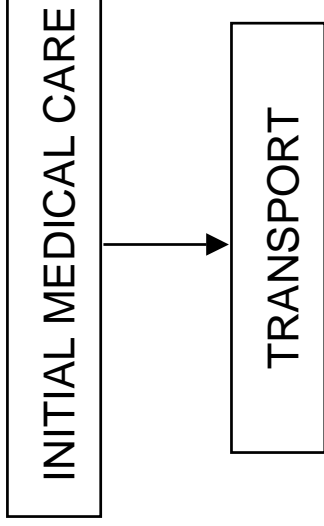
Refer to **PEDIATRIC CARDIAC ARREST CODE 51**

**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 blows, abdominal thrusts (age dependent)

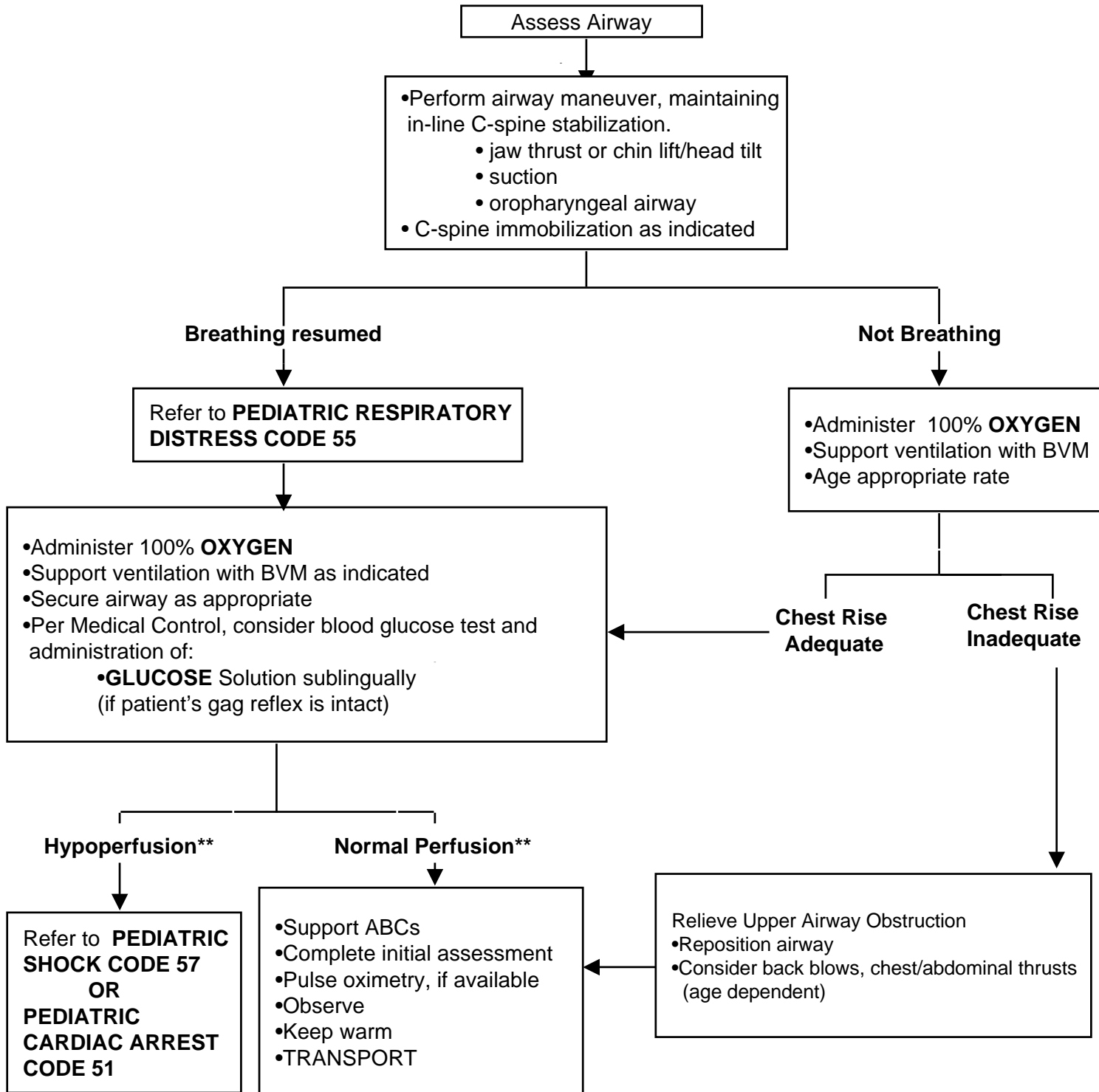
Relieved

Un-Relieved

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

# Code 56

## PEDIATRIC RESPIRATORY ARREST



### NOTE TO PREHOSPITAL PROVIDERS:

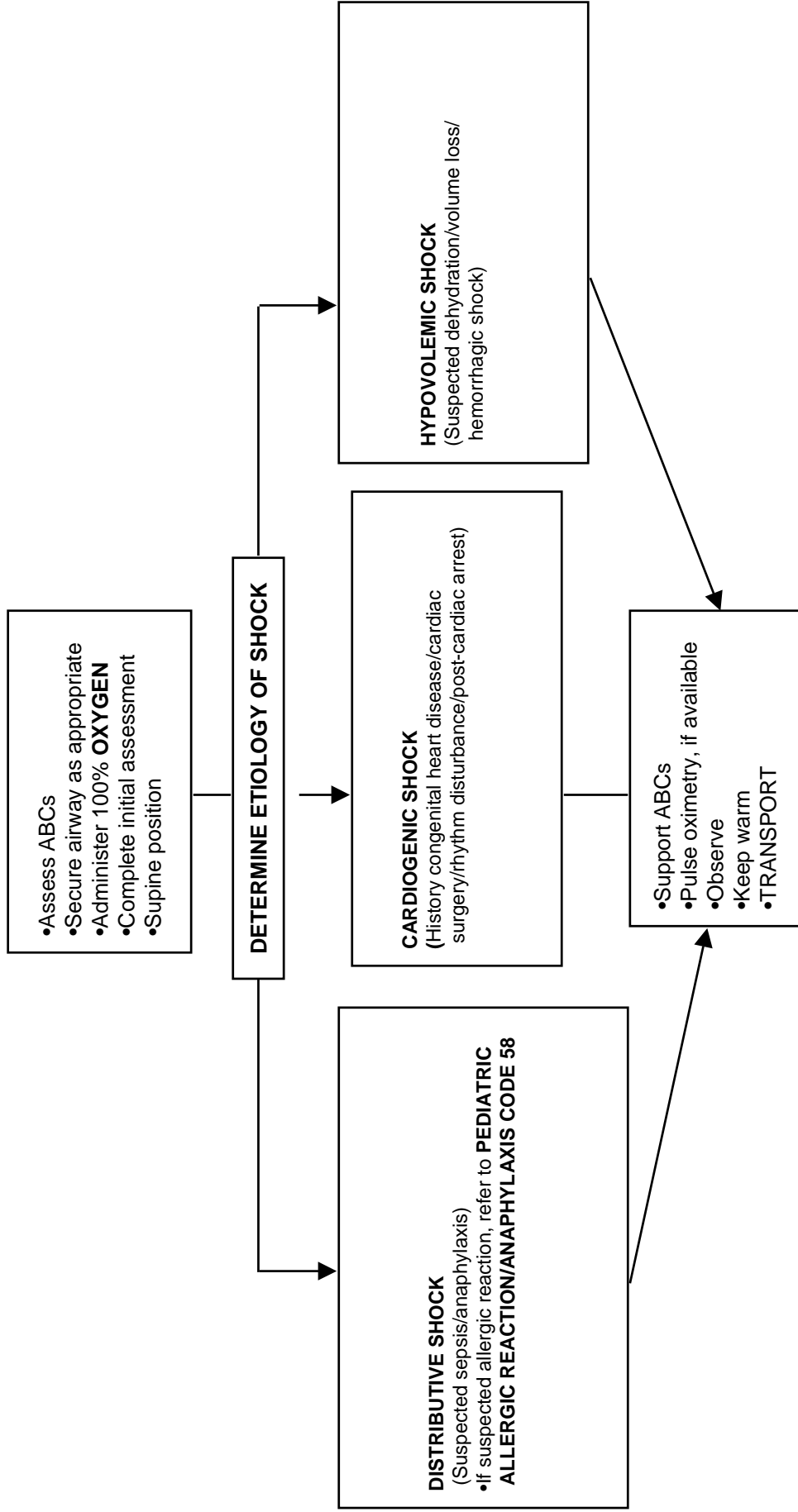
•Respiratory arrest may be a presenting sign of a toxic ingestion or metabolic disorder.

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

\*\*See **PEDIATRIC ASSESSMENT AND TRAUMA SCORE CODE 28**

Reviewed 11/01/08  
Reviewed 11/01/06  
Reviewed 10/01/04  
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BLS

# PEDIATRIC SHOCK



# Code 58

## PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS

- Assess ABCs
- Secure airway as indicated
- Support ventilation with BVM as indicated
- Administer 100% **OXYGEN**
- Complete initial assessment

**Local Reaction**

**Respiratory Distress**

Apply ice/cold pack to site\*

In the presence of facial swelling, wheezing, or tongue swelling administer  
**PEDIATRIC EPINEPHRINE  
AUTO-INJECTOR PEN**

- Reassess
- Pulse oximetry, if available
- Nebulized ALBUTEROL (Ventolin) 2.5mg for wheezing.

- Support ABCs
- Observe
- Keep warm
- TRANSPORT

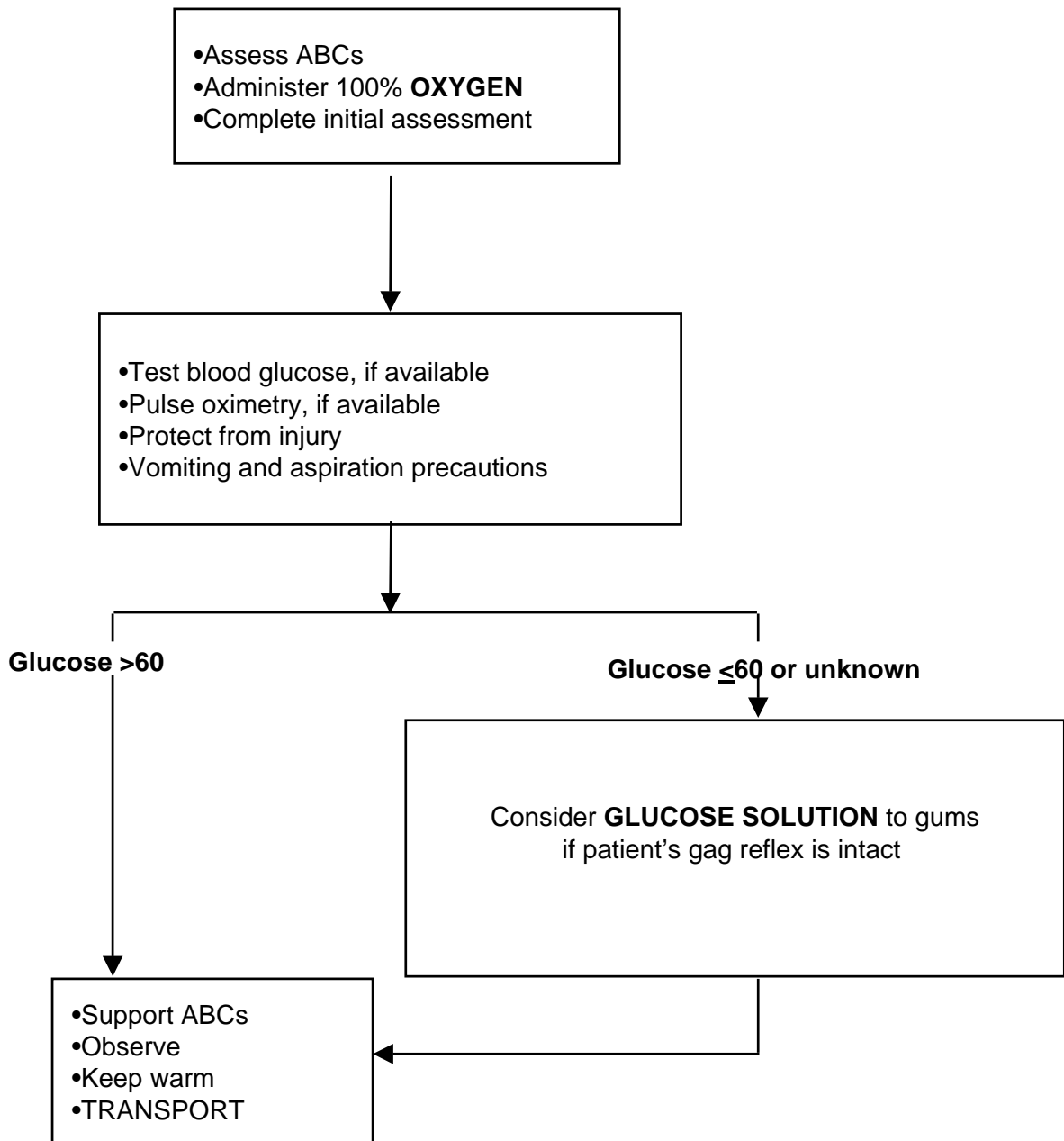
### NOTE TO PREHOSPITAL PROVIDERS:

\*Simple hives do not require any additional field treatment

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# 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, especially in cases where caustic substance ingestion is suspected.

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## PEDIATRIC TOXIC EXPOSURE/INGESTION

### EXPOSURE TO OR INGESTION OF NARCOTICS OR UNKNOWN SUBSTANCES

- DO NOT INDUCE VOMITING, ESPECIALLY IN CASES WHERE CAUSTIC SUBSTANCE INGESTION IS SUSPECTED.

### 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 cool environment
  - remove clothing as appropriate
- Profound weakness and fatigue
- Vomiting, diarrhea
- Hypoperfusion
- Muscle cramps

### Normal Level of Consciousness and 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

### 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.**

- Support ABCs
- Observe
- TRANSPORT

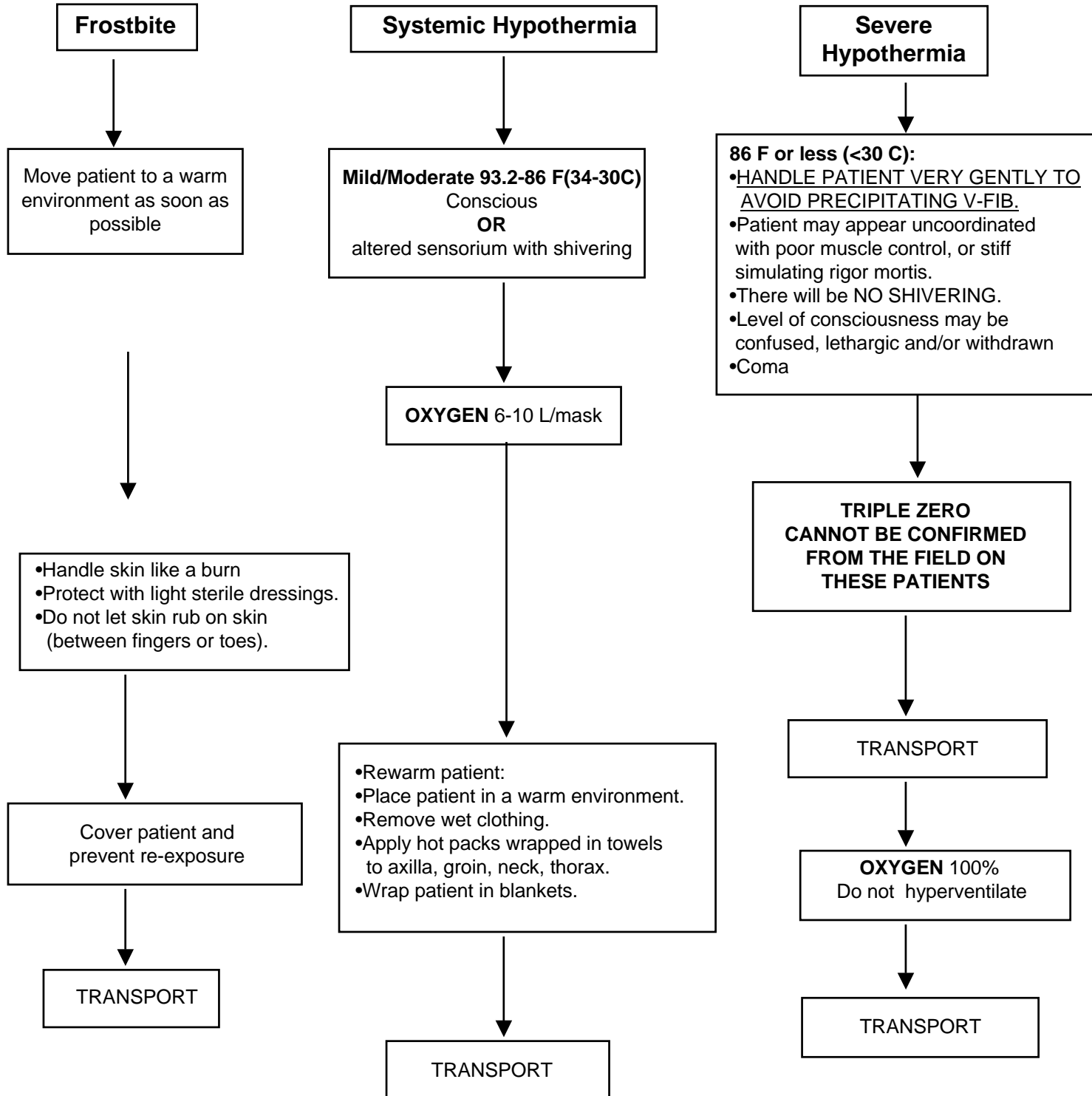
- Initiate cooling
- Pulse oximetry if available
- Refer to **PEDIATRIC SEIZURES CODE 59** as needed

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

Reviewed 11/01/08  
Reviewed 11/01/06  
Reviewed 10/01/04  
Effective 10/01/98  
BLS

# 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**

Reviewed 11/01/08  
Revised 11/01/06  
Reviewed 10/01/04  
Effective 10/01/98  
BLS

# 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

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Revised 11/01/06  
Reviewed 10/01/04  
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**REGION 7**

**STANDING MEDICAL ORDERS**

**PROTOCOLS FOR  
SPECIAL SITUATIONS**

Reviewed 11/01/08

Reviewed 11/01/06

Revised 10/01/04

Effective 10/01/98

BLS

## 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.
  - Child under the age of 10 has been left unattended or unsupervised. (Although in some situations children under 10 years of age may be left alone without endangerment, EMS personnel cannot make such determinations.) All instances should be reported for DCFS investigation.
  - 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).

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BLS

## 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:

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BLS

- 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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 BLS

**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

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.

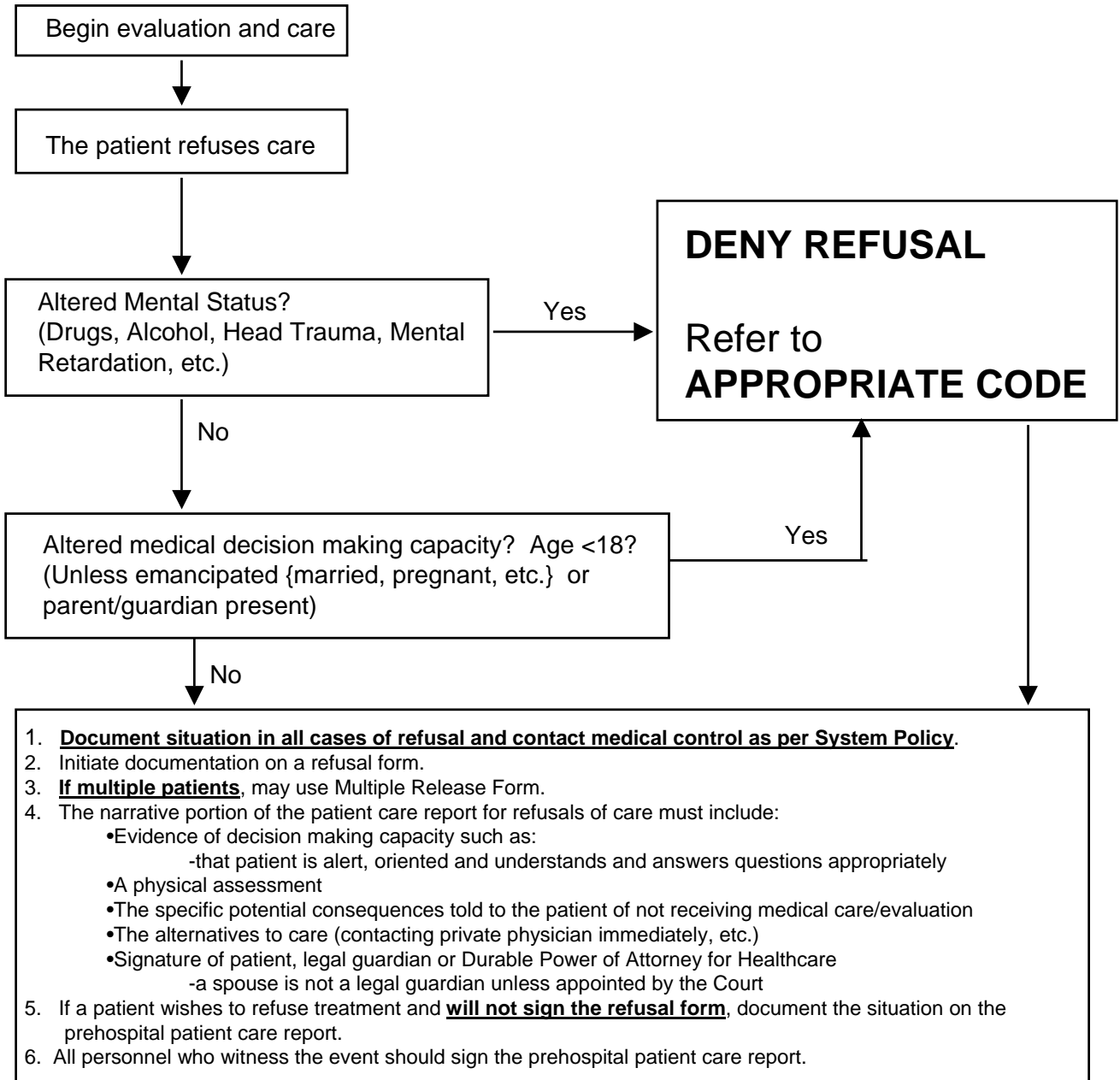
Reviewed 11/01/08  
Reviewed 11/01/06  
Reviewed 10/01/04  
Effective 10/01/98  
BLS

### **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.

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Reviewed 11/01/06  
Reviewed 10/01/04  
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BLS

# **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