

SIGNA EMS MEDICAL PROTOCOLS

Approved by:  _____
Brett Monroe M.D.

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BLS

AIRWAY	Stock	BANDAGING AND SPLINTING	Stock
Bag-valve-mask (Adult,Child,Infant)	1ea	Backboard W/straps	1
Nasal cannula (adult)	2ea	Adhesive Strips	1bx
Non-rebreather mask (adult)	2ea	Cervical collar adjustable	2
Pediatric mask or non-rebreather	2ea	Cervical collar Pedi and Infant	2
O2 cylinder main (Secured)	1ea	KED or equivalent	1
O2 cylinder Portable	2ea	Extremity wire splints or equivalent	2
O2 cylinder wrench	1ea	Padded splints (Long & Short)	2ea
O2 regulator main & portable	1ea	Head bed or equivalent	2
Suction catheter 8 or 10, 14 or 16 french	2ea	Traction splint (Adult/Pedi combo)	1
Suction tip yaunker w/tubing	2ea	Self-adhering bandages (Kerlix or equivalent)	6
Portable suction	1ea	4X4 non-sterile sponges	20
Sharps container Mounted & Portable	1ea	4X4 sterile sponges	60
Veh. Mounted Suction	1ea	Trauma shears	2
Oropharyngeal Airway	1kt	Multi-trauma dressing	2
Nasal Airway	1kt	Burn sheets	4
		Triangle bandage	6
		Tape 1" & 2"	2rls
		CLINICAL SUPPLIES	
		Penlight	2
		Stretcher sheets, disposable	4
		Blanket, disposable Emergency	2
		B/P cuff (adult, large adult,child,infant)	1ea
		Spare Batty. For AED	1
		AED	1ea
		Pads for AED (Adult & Pedi)	1set ea
		Cot (secured to vehicle)	1
		Cold pack	4ea
		Glucometer	1ea
		Glucometer Batty.	1set
		Glucometer lancets	10ea
		Glucometer test strips	10ea
		Convenience bags or Emesis basins	2ea
		Isopropyl alcohol swabs	20ea
		OB Kit W/infant insulating device	2ea
		Pedi sizing/dosing tape or wheel	1ea
		Stethoscope	1
		Thermometer w/covers (not batt. Powered)	2&10 ea
		Stair Chair or equivalent	1
		Triage tags	6ea
		MEDICATIONS	
		Epi Pen and/or Sub Q Epi (Adult 0.30mg & Pedi 0.15mg)	1ea
		Insta Glucose (tube 15gm)	2
		O2 (2000 psi. per. cylinder)	2
		Stored in Compliance W/FDA Regulation	



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INTRODUCTION

OVERVIEW

From a broad perspective, Emergency Medical Services (EMS), including the vital pre-hospital phase, is an integral and essential part of our healthcare system. Sudden cardiac death and trauma have been identified as leading causes of mortality and morbidity in this country. Physician delegation of critical interventional tasks to qualified and well supervised pre-hospital emergency care providers has dramatically decreased the number of deaths and disability of the sick and injured.

Current statutes address the qualifications, responsibilities, authority, and accountability of physicians who provide medical direction to pre-hospital emergency care providers. Medical direction by a physician who delegates critical interventional healthcare tasks through treatment protocols or standing orders, and who is responsible for all aspects of the operation of an EMS system, is referred to as an off-line medical director. All advanced life support pre-hospital emergency care providers are required to have an off-line medical director. Fortunately, formalization of EMS systems and organization of EMS medical directors continues to grow and develop.

Immediate physician medical direction to a pre-hospital emergency care provider is referred to as on-line medical direction. All pre-hospital emergency care providers are required to identify, by a predetermined policy, a specific on-line medical direction source. A physician providing on-line medical direction assumes the medical and legal responsibility for the appropriateness of pre-hospital care provided under his direction of the EMS personnel.

The provision of off-line medical direction for pre-hospital emergency care providers continues to develop as qualified EMS physicians grow in number, in organization, and as the pre-hospital emergency care providers come into compliance with the current statutes.

PURPOSE

MEDICAL CONTROL protocols are intended to serve as guidelines for EMS personnel when providing pre-hospital care. They are not meant to substitute for sound medical judgment.

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DEFINITION

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MEDICAL DIRECTOR SYSTEM CERTIFICATION AND KEY TO PROTOCOLS

As described above, providers performing emergency medical care within the SIGNA EMS INC Clinical Practice System are required by the system and the DSHS to be certified to practice (“cleared”) by the Medical Director to perform at a specific level. When referring to the **Standard's of Medical Care (protocols)**, the terms: EMT-BASIC, may appear in each category of illness or injury. Whichever certification is held that is the section that needs to be followed.

EMT- BASIC (EMT-B):

This level refers to all providers who have been approved by the Medical Director to provide an ECA or EMT-B level of care. Providers must be trained or State certified at the EMT-Basic level. EMT's will follow *BASIC INTERVENTION* section in the protocol.

Authorized Skills:

Patient assessment
Oxygen administration
Bandaging / Splinting
Oropharyngeal airway
Bag-Valve-Mask device
Oropharyngeal suctioning
Blood Glucose Determination
EPI Pen Auto Injector Adult & Pedi

Spinal immobilization
AED application
CPR
Emergency childbirth
Occluded airway
Oral Glucose administration

**ADMINISTRATI
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PROTOCOL
S**

HAZMAT GUIDELINES

- A. EMS personnel should anticipate and be prepared for a potential HAZMAT incident anywhere at any time. Failure to recognize and to be prepared for these situations can endanger EMS personnel, other rescuers, and the patient.
- B. Each incident to which EMS personnel respond is unique. It is essential that EMS personnel identify areas of potential hazard in their community and be prepared to meet those hazards.
- C. The priority of EMS personnel should be to assure adequate personal protection. **EMS PERSONNEL SHOULD NOT ENTER THE SCENE IF UNTRAINED IN THE APPROPRIATE USE OF EQUIPMENT OR IF SUCH EQUIPMENT IS UNAVAILABLE.**
- D. Hazardous materials must be properly identified before any action can be taken to control an incident. Failure to properly identify a hazardous material(s) will only increase the hazard. Methods to recognize and identify hazardous materials include the use of labels, placards, shipping papers, and Material Safety Data Sheets (MSDS). EMS personnel can often gain important information from bystanders, location of incident, type of container, obvious characteristics, chemical name, manufacturer or trade name.
- E. Information resources include the following:
1. Emergency Response Guidebook
 2. The Chemical Transportation Emergency Center (CHEMTREC)
- F. Scene hazards may include toxic inhalation, skin contact, ingestion, or injection. With attention to airway and cervical spine precautions, initial decontamination should occur at the site of the incident. With injuries necessitating medical intervention, EMS personnel should wear protective clothing and/or respiratory protection and perform rapid decontamination. Only critical interventions should be performed in the immediate "hot" area.

25 After initial decontamination, the patient should be moved to a safe area where further assessment and support measures should be instituted.

FOR ASSISTANCE, CONTACT RESOURCES LISTED

- 1 CHEMTREC: 1-800-424-9300
- 2 "Emergency Response Guidebook"
- 3 Recommendation for transport method, including helicopter utilization
- 4 Destination and decontamination facilities

HOSPITAL COMMUNICATIONS

- A. Identify the unit, name and skill level of individual calling, and name and skill level of EMS attendant in charge. Note time of contact
- B. State the patient's priority status
- C. Await hospital personnel's acknowledgment and record contact name
- D. State the patient's age, gender, chief complaint, and/or mechanism of injury/Nature of Illness.
- E. State critical interventions performed
- F. State vital signs and physical exam
- G. State brief history to include S.A.M.P.L.E.
- H. State estimated time of arrival
- I. Provide additional history and/or information as requested

26 Sign-off

MASS CASUALTY GUIDELINES

- A. The highest level EMS personnel first on the scene should be the attendant in charge. The attendant in charge should initiate triage and direct subsequently arriving EMS personnel.

27 The scene should be surveyed noting any hazards or potential HAZMAT situation.

- C. After the number of injured is estimated, the EMS dispatch should be notified of the need for additional resources if necessary.

- D. If the incident involves ten or more seriously injured persons, a casualty collection point that is removed from the scene should be set up for patients awaiting transport by EMS units. Patients should be assigned to one of the following groups according to their acuity:

PRIORITY 1: immediately life-threatening (airway obstruction, flail chest, tension pneumo

PRIORITY III: non-urgent, minor

PRIORITY IV: unsalvageable or dead

- E. Patient transport should be according to their priority assignment.

GUIDELINES FOR HELICOPTER UTILIZATION

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GUIDELINES FOR HELICOPTER UTILIZATION
•1 Severely injured or ill patient located in a remote or off-road area not readily accessible to a ground EMS unit
•2 Severely injured or ill patient who requires a higher level of care than can be provided by the ground EMS unit
•3 Mass casualty situation when ground EMS resources are exhausted or •4 Exceeded
•5 Suspected severely injured patient with an anticipated prolonged (>20 minutes) vehicle extrication time
•6 Conditions which prohibit expedient ground transport to an appropriate •7 Facility
•8 Ground transport time > 20 minutes to a specialty center (i.e., trauma or burn centers) or appropriate medical facility for severely injured or ill patients
•9 NOTES: <ul style="list-style-type: none"> a. After the helicopter is en route to the scene, only the EMS attendant in-charge or the pilot has the authority to cancel the helicopter response.
28 In a situation appropriate for helicopter transport of a patient(s) with known or suspected HAZMAT involvement, inform the dispatcher to alert the helicopter transport team.

FACILITY DESTINATION

BURN CENTER GUIDELINES
•1 Burns > 10% total body surface area (BSA) in patients < 10 years or > 50 years of age
•2 Partial-thickness (PT) > 20% BSA in other age groups
•3 Full-thickness (FT) > 5% BSA in any age group
•4 PT and FT bums of the face, eyes, ears, hands, feet, genitalia, perineum, or involvement of skin overlying major joints
•5 Electrical bums, including lightning injury
•6 Significant chemical bums
•7 Inhalation injury
•8 Bum injury in patients with pre-existing illness that could complicate management, prolong recovery, or affect mortality
•9 Any bum patient with associated trauma that poses an increased risk of morbidity or mortality
•10 Bum injury in patients who will require special support

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FACILITY DESTINATION (continued)

TRAUMA CENTER GUIDELINES

VITAL SIGNS / LEVEL OF CONSCIOUSNESS	
•1 Glasgow Coma Scale < 14	Revised Trauma Score < 11
•2 Systolic BP < 90	Pediatric Trauma Score < 9
•3 Respiratory rate < 10 or > 29	
ANATOMY OF INJURY	
•1 Pelvic fracture	•2 Flail chest
•3 Limb paralysis	•4 Amputation prox. To wrist/ankle
•5 Two or > proximal long-bone fractures	•6 Trauma. + 10% burns or inhalation
•7 All penetrating injuries to head, neck,	•8 Torso, and extremities to elbow/knee
MECHANISM OF INJURY	
•1 Ejection from automobile * Falls > 20 feet	
•2 Death in same compartment * Roll over	
•3 Pedestrian thrown or run over * Extrication time > 20 minutes	
•4 Auto-pedestrian injury with significant (> 5 mph) impact	
•5 Motorcycle crash > 20 mph or with separation of rider and bike	
•6 High-speed auto impact: initial speed > 40 mph, major auto deformity, intrusion into passenger compartment > 12 inches	
RISK FACTORS	
•1 Age < 5 or > 55 years	
•2 Known cardiac disease; respiratory disease; or psychotics on medications	
•3 Diabetics on insulin; cirrhosis; malignancy; obesity; bleeding disorder	
WHEN IN DOUBT, TRANSPORT TO TRAUMA CENTER	

FACILITY DIVERSION

- A. When the resources of a hospital facility are compromised, the facility may request “diversion” status for any of the following reasons in order to assure prompt and appropriate routing of patients to the next closer appropriate facility:
1. Structural compromise in which the physical plant has been damaged or compromised in such a manner making further patient care untenable
 2. Exhaustion of facility and/or emergency resources such that the staffing, equipment or supplies necessary to continue the provision of emergency services either no longer exists or is significantly imperiled at the diverting facility
 3. The primary needs of a patient require specialized services not available at the diverting facility
 4. The diverting facility is participating in the activation of a coordinated regional or local disaster plan involving the triage of patients to various facilities by severity of injury
- B. When a facility requests diversion status, the following specific items should be documented:
1. date
 2. name of facility
 3. name of individual authorizing diversion
 4. rationale for diversion
 5. name and time notified with anticipated duration of diversion status
 6. verification times of facility status at four (4) hour intervals until diversion terminated
 7. time and name of individual terminating diversion status
- 29 Diversion status does not apply to patients with life-threatening conditions who require immediate definitive care at the closest appropriate facility.
- F. Diversion request based upon a patient’s financial status should not be honored.

ETHICS OF RESUSCITATION

CONDITION INDICATIVE OF OBVIOUS DEATH	
•1 Decapitation	•2 Rigor mortis
•3 Dependent lividity	•4 Decomposition
•5 Severe head injury with exposed brain tissue	•6 Burned beyond recognition
•7 Multiple extremity amputations with no signs of life	•8 Underwater submersion of greater than two hours (cold water drowning excluded)

A. ADVANCED DIRECTIVES

30 DO NOT RESUSCITATE (DNR)

An order written by a physician limiting or withholding CPR in the event of arrest. Also described as "Do Not Attempt Resuscitation" (DNAR).

2. LIVING WILL

A legal document that is written by an individual to specify the kinds of medical treatment desired should the individual become physically or mentally unable to do so himself.

3. DURABLE POWER OF ATTORNEY

A legal document whereby an individual designates another individual (sometimes referred to as a "health-care proxy") to make health care decisions for that individual.

B. RESUSCITATION

1. In the absence of obvious conditions indicative of death, EMS personnel should institute resuscitative measures for individuals who suffer from an emergency medical condition.

31 Resuscitation should not be withheld on the basis of age, cost, preexisting mental or physical disability, or the circumstances surrounding the event.

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**ETHICS OF RESUSCITATION
(continued)**

- 32 Resuscitation with BLS measures should be continued until arrival at a hospital or until pre-hospital termination of resuscitation has been authorized by the authority of the on/off-line physician, OR his designee.

CONDITION / SITUATION
•1 Conditions indicative of obvious death
•2 Advanced directives for tissue donation
•3 Hospital DNR signed by patient
•4 Texas Out-Of-Hospital DNR order properly signed and executed
•5 Mass casualty incident where triage principles preclude CPR from being initiated on every victim
•6 SIDS victim with obvious signs of death
<u>AUTHORIZATION TO CEASE ALL RESUSCITATION MEASURES IS GRANTED BY STANDING ORDERS, IF IN THE OPINION OF THE ON-SCENE MEDIC IN CHARGE, AND THE ABOVE LISTED CONDITIONS/SITUATIONS EXIST.</u>

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OUT-OF-HOSPITAL DO NOT RESUSCITATE ORDERS

This protocol will address the handling of Out-of-Hospital Do Not Resuscitate Orders (DNR) for EMS Service Providers in accordance with the State of Texas Health and Safety Code, Title 8, Chapter 674, and the Texas Administrative Code, Title 25, Health Services, Part 1, Department of Health, Chapter 157 Emergency Medical Care, Section 157.25 Out-of-Hospital Do Not Resuscitate Orders,

Any Out-of-Hospital Do Not Resuscitate (DNR) orders encountered in the field by EMS Service Providers must be honored if at all possible.

IDENTIFICATION OF DNR PATIENTS

When any patient or patient representative presents a valid DNR order on the MH Standardized DNR form or legible copy that lists the designated procedures that are to be withdrawn or withhold it is the duty of the EMS personnel to honor the wishes of the patient.

Procedures that the patient may desire to be withdrawn or withhold shall be:

- Cardio-pulmonary resuscitation,
- Artificial ventilations

A patient may choose to wear a standardized DSHS Identification bracelet or necklace. This will serve the same function as a completed DNR order form.

DISPUTE RESOLUTION

In the event that a dispute arises as to the validity or authenticity of the DNR order, it will be the EMS service providers duty to begin resuscitative efforts on the patient and immediately begin efforts to contact the Medical Director or the hospital ER doctor on call for definitive orders as to whether to continue or discontinue efforts to resuscitate the patient.

DOCUMENTATION

In the event of a dispute over DNR orders, it is imperative that the EMS Service provider documents the reason for the dispute, the assessment of the patient's condition, and the justification for starting resuscitative efforts.

Records shall be maintained on every Incident In which a DNR order or DNR ID device is encountered, the number of times there is an on-site revocation or dispute and resuscitative efforts are begun, and the number of times there is a problem with the standardized form.

The documentation shall include:

- 1 An assessment of the patients physical condition
- 2 Whether an ID device or form was presented, and the Patient's ID number
- 3 Any problems related to the implementation of the DNR,
- 4 The name, address, and phone of the patient's personal physician,
- 5 The name, address, phone number, and relation to the patient of any witness used to identify patient

If the patient is transported to the hospital, alive or deceased, it is preferred that the original (or a legible copy A the DNR accompany the patient. A legible copy of the DNR is sufficient to honor the patent wishes if it displays the patient or patient representative signature, the attending physician's signature, and lift the specific resuscitative procedures to be withdrawn or withheld.

A copy of the DNR shall be kept with the responding EMS provider's patient report.

REPORTING

All EMS provider services shall report to DSHS the number of times personnel were presented with DNR orders, the number of times there was a problem and DNR orders could not be honored, and the number of times the problem involved the standardized form.

OUT OF STATE DNR ORDERS

EMS Services personnel may accept out of state DNR orders if there is no question as to their validity. Out of state bracelets, necklaces, or other Identification devices shall not be accepted. If there is any question as to the validity of the out of state DNR order, Medical Direction shall be contacted for further Instructions as how to handle the situation.

A complete patient assessment, description of patient physical condition that warrants the DNR orders, and as much information about the patient's personal physician as possible shall be relayed to the medical director or ER physician.

FAILURE TO HONOR DNR ORDERS

If the EMS provider personnel suspect any Indication of unnatural or suspicious circumstances they shall immediately begin resuscitative efforts until such time as directed by the medical director or hospital ER physician to cease their efforts.

PREGNANCY

EMS providers shall not withhold resuscitative efforts from anyone who is obviously or suspected to be pregnant

DNR FORM

A Standardized DSHS DNR form shall be used as the official form for withholding or withdrawing any resuscitative efforts.

PATIENT REFUSAL

PATIENT DEFINITION:

Patient: *an individual requesting or potentially needing medical evaluation or treatment*

The relationship between Provider and patient is established either by telephone, radio, or personal contact. This definition reflects more of an ethical principle than anything else. **In the case of a mass casualty incident everyone is a potential patient until proven otherwise.** This principle holds true for every incident, regardless of size or magnitude. It is every Provider's responsibility to make certain that all effected individuals are offered the opportunity for evaluation, treatment, and/or transport.

PATIENT CONFIDENTIALITY

All information obtained during the course of treating and transporting a patient is confidential.

Providers have an ethical responsibility to handle all information and documentation regarding a patient with a high degree of confidentiality. Patient information is only to be shared with those individuals who are part of the continuity of patient care. Patient records should not be routinely provided to law enforcement agencies or other non-medical public safety entities that are not part of the patient care continuum.

Once a patient record has been completed, it is considered a medical record and, therefore, is confidential. Every effort should be made to ensure that the record will not be left unattended, open for public view, or stored haphazardly in a way which will compromise the confidentiality of the patient and the record contents.

Similarly, it is our responsibility to not discuss patient care issues with anyone other than those medical professionals involved in that patient's care.

CONSENT TO MEDICAL TREATMENT

Consent for medical treatment is based upon the concept that every individual has the right to determine what is to be done with or to his/her own body. For consent to be legally valid, it must be informed. Except in emergency situations in which an individual has what appears to be a potentially life-threatening injury or illness, a person must be made aware of, and understand the risks of any procedures performed, medications administered, or the consequences of refusal of treatment and/or transportation. In addition, EMS must inform the patient of alternatives to evaluation, treatment and transport. In the case of a minor, consent should be obtained from a legally authorized representative who is usually a parent, but in some circumstances, may be another relative, or a legal guardian.

Anyone at least eighteen (18) years of age or older who is mentally competent may grant consent for treatment refuse transportation.

WHEN CONSENT IS NOT REQUIRED (implied Consent)

In life-threatening emergency situations, consent to treatment is not required. The law presumes that if the individual with a life –threatening injury or illness were conscious and able to communicate he/ she would consent to emergency treatment.

Consent For Emergency Care Is Not Required If the Individual

1. Is unable to communicate because of an injury, accident, illness, or unconsciousness. And;
2. Is suffering from what reasonably appears to be a life –threatening injury or illness.

In addition, consent to emergency treatment is not required for a minor (under age 18) who is suffering from what appears to be a life –threatening injury or illness and whose parents, managing or possessory conservator, * or guardian is not present.

WHEN MINOR MAY CONSENT TO TREATMENT

A minor may consent to his or her own medical, dental, psychological, and surgical treatment by a licensed physician or dentist in the following circumstances:

1. minor is on active duty with the Armed Services of the United States of America;
2. Is;
 - a. 16 years of age or older and resides separate and apart from his/her parents, managing conservator, * or guardian, with or without consent of parents, managing conservator, * or guardian, and regardless of duration of residence **and;**
 - b. Manages his/her own financial affairs, regardless of source of the income.
3. Consents to the diagnosis and treatment of an infectious, contagious, or communicable disease that is required by law or a rule to be reported by the physician or dentist to a local health officer or DSHS.
4. Unmarried and pregnant and consents to hospital, medical, or surgical treatment, other than abortion, related to pregnancy.
5. Consents to examination and treatment for drug or chemical addiction. Drug or chemical dependency, or any other condition directly related to drug of chemical use; **or;**
6. Unmarried, and has custody of the minor’s biological child and consents to medical, dental, psychological, or surgical treatment for the child.
7. Is legally married.
8. Minor has been legally emancipated by a court of law (minor should have court order as evidence).

- 33 *A managing conservator is an individual appointed by the court, usually during divorce proceedings, to have custody of a minor, to make decisions for the minor and to make a home for the minor. **A MANAGING CONSERVATOR IS RESPONSIBLE FOR CARING FOR THE MINOR.***

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Who Other Than a Parent May Give Legal Consent for Treatment of a Minor

The following persons may consent to medical treatment of a minor when the person having the right to consent as otherwise provided by law (typically a parent) cannot be contacted and that person has not given actual notice to the contrary.

- 1 A grandparent of the child.
- 2 An adult (over age 18) brother or sister of the child.
- 3 An adult (over age 18) aunt or uncle of the child.
- 4 An educational institution in which the child is enrolled that has received written authorization to consent from a person having the right to consent.
- 5 An adult who has actual care, control, and possession of a child under the jurisdiction of a juvenile court or committed by juvenile court to the care of an agency of the state or county, or;
- 6 A peace officer that has lawfully taken custody of minor, if the peace officer has reasonable grounds to believe the minor is in need of immediate medical treatment.

Incompetent Adult Patient:

A patient who has been declared legally incompetent by a court of law cannot consent to his or her treatment. The patient's court appointed guardian has the right to consent to, or refuse, treatment.

Additional Guidelines:

Any adult patient who is in possession of their faculties (i.e. conscious and alert to person, place, and time/date) **has the right to refuse any aspect of treatment** (such as drug therapy, spinal immobilization, etc.), even if that refusal could result in serious harm or death, but may still request and have the right to transportation by SIGNA EMS INC .. The patient should be made aware of the possible medical consequences of their refusal. In addition to refusing treatment for themselves, competent adults (age 18 and older), as determined by assessment and condition, have the right to refuse treatment and transportation of their children or anyone else for whom they are the legal guardians. Thorough documentation of the patient's refusal and the providers' efforts to persuade the patient to seek help are necessary and must be signed and witnessed.

At a minimum, all providers should do the following when dealing with a patient who is conscious and able to communicate:

- 1 Obtain the patient's verbal consent prior to patient contact, evaluation, or treatment.
- 2 Assess the patient's ability to understand the medical condition and information communicated.
- 3 **Be courteous** to any patient who refuses an offer of evaluation, treatment, or transportation.
- 4 Evaluate the patient to determine the urgency of the condition.
- 5 Determine if the patient is capable of seeking assistance or taking actions for his or her own well being. **Refer to the "Restraint / Transport against Patient Will"**

Section for more guidelines when a patient's competency to refuse care and evaluation is in question.

- 6 If the patient refuses treatment and/or transportation, fully describe the potential consequences of their decision, and encourage them to immediately re-contact 911 if their condition worsens or further medical assistance is needed.

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PHYSICIANS AT THE SCENE

PHYSICIAN ON THE SCENE:

For situations in which a Texas Licensed Physician is at the scene of an EMS call the following procedures should be followed. In all cases, the pre-hospital provider is responsible for management of the patient and acts as an agent of the Medical Director unless the patient's physician is present (as in a physician's office) and assumes patient care responsibilities.

Private Physician On-Scene:

1. Conduct yourself in a professional manner and respectful attitude at all time. **The physician has certain professional and legal prerogatives as the senior medical officer on the scene.**
2. Advise the physician that you are operating under the Standard of Care protocols promulgated by the SIGNA EMS INC . Medical Director, and request that you be allowed to follow these orders as needed.
3. Follow any reasonable request of the physician. **Pre-hospital Providers shall not comply with orders which exceed their scope of practice or training.**
4. If the Pre-hospital Provider believes that the care rendered or requested by the private physician is inconsistent with quality patient care the Provider should contact On-Line Medical Control for guidance.

Intervener Physician On-Scene Wanting to Assume Patient Care:

1. A pre-hospital provider at an emergency scene should relinquish responsibility for patient management when the intervener physician has:
 - a. been properly identified (i.e., Medical ID card).
 - b. agreed to assume responsibility and;
 - c. agreed to fully document the intervention in a manner acceptable to EMS system.
2. The intervener physician should agree in advance to accompany the patient to the hospital if required or needed. However, in the event of a mass casualty incident or disaster patient care needs may require the intervener physician to remain at the scene.
3. The physician assuming responsibility must personally initiate any procedure or administer any medication not within the scope and / or training of the Pre-hospital Provider.
4. If the treatment at the emergency scene differs from existing EMS protocols and is contradictory to quality patient care, the Pre-hospital Provider retains the right to revert to existing EMS protocols for the continued management of the patient.
5. In cases of disagreement between an Intervener Physician and On-Line Medical Control, the Pre-hospital Provider will follow the orders of On-Line Medical Control.

Definitions:

Private physician: a physician who provides evidence of medical licensure in that state, has established a prior physician/patient relationship, wishes to take charge of a medical emergency, and is willing to accompany the patient to the hospital when so requested.

Intervener physician: A physician, who provides evidence of medical licensure, has not established a prior physician/patient relationship, wishes to take charge of a medical emergency, and is willing to accompany the patient to the hospital when so requested.

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PROFESSIONALISM

SIGNA EMS INC Prides itself on knowing that its employees help to maintain a nationally recognized professional system of quality pre-hospital care. **The following paragraphs were taken from Bledsoe's "Paramedic Emergency Care Second Edition," and established the foundation that all providers (volunteer or career) should strive for and maintain.**

"Professionalism describes the conduct or qualities that characterize a practitioner in a particular field or occupation. Health care professionals promote quality patient care and take pride in their profession. They earn the respect and confidence of team members by performing their duties to the best of their abilities and by exhibiting a high level of respect for their profession. Attaining professionalism is not easy. It requires an understanding of what distinguishes the professional from the non-professional. To develop this skill, keep the following points in mind."

"Professionals place the patient first; non-professionals place their egos first. Professionals practice their skills to the point of mastery, then keep practicing them to improve and remain sharp. Non-professionals do not believe their skills will fade and see no reason to constantly strive for improvement. Professionals understand the importance of response times; non-professionals get to an accident when it's convenient. Professionals take refresher courses seriously, because they know they have forgotten a lot and because they are eager for new information. Non-professionals believe they don't need training sessions and dislike being required to attend them. Professionals critically review their performance, always seeking a way to improve. Non-professionals look to protect themselves, to hide inadequacies, and to place blame on others. Professionals check out their equipment prior to the emergency response. Non-professionals hope that everything will work, supplies will be in place, batteries will be charged, and oxygen levels will be adequate."

"Maintaining professionalism requires effort. But, the result of that effort – the admiration and respect of one's peers- is the highest compliment a person can receive"

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ing a professional has nothing to do with pay of rank level of certification you hold. It is the goal that every member of our practice, from basic to medical director, constantly strives for to remain a comprehensive, clinically sophisticated, and compassionate EMS system. –Edward M. Racht, M.D. Medical Director Austin / Travis County EMS

UNIVERSAL PRECAUTIONS

Precautions to prevent transmission of infectious diseases are especially important in the emergency care setting where the risk of blood exposure is increased and the infection status of a patient is usually unknown. Universal blood and body fluid precautions should be consistently used for all patients to prevent skin and mucous membrane exposure.

1. Gloves should be worn for the following:
 - a. touching blood and body fluids, mucous membranes, or non-intact skin
 - b. handling items or surfaces soiled with blood or body fluids
2. Gloves should be changed after contact with each patient.
3. EMS personnel should wash hands immediately after removing gloves.
4. Masks, protective eye wear and gowns should be worn during procedures that are likely to generate droplets or splashes of blood or other body fluids.
5. EMS personnel should use mouthpieces, resuscitation bags, or other ventilation devices to avoid mouth-to-mouth contact.
6. These precautions will afford protection to pregnant EMS personnel and will minimize risk of perinatal transmission of infectious disease.
7. SIGNA EMS INC .. Personnel with an open lesion or weeping dermatitis should refrain from direct patient care and from handling patient care equipment.

GEOGRAPHICAL AREA DUTY STATUS

These protocols shall only be utilized under my direction in SIGNA EMS INC service area, mutual aid area and when on transfers.

DUTY STATUS

SIGNA EMS INC Personnel shall utilize these protocols under my medical direction only when acting in their official capacity when representing SIGNA EMS INC As defined in SIGNA EMS INC Standard Operating Procedures.

NON-EMS CERTIFIED PERSONNEL

Individuals who are employed by transferring facilities who are required to accompany a patient to another facility are not covered under SIGNA EMS INC Protocols. These individuals will be covered under the transferring facilities protocols.

HEMODIALYSIS PATIENTS SPECIAL CONSIDERATIONS FOR WITH AV FISTULAS AND GRAFTS

FISTULA: A small opening that is made in the side of an artery and vein. The two vessels are joined together at these openings under the skin. Because the pressure in the artery is much higher than the pressure in the vein, there is a rapid flow of blood from the-artery to the vein. The usual location for a fistula is near the wrist and as a result of the high blood flow, some of the veins in the forearm will become large, easily seen and felt. The flow through the dilated veins may be so forced that it-can be felt as a “buzz” whenever your hand is placed lightly on the arm.

GRAFT: many hemodialysis patients now have an artificial graft made of Dacron connecting an artery and a vein in the arm. The graft is buried under the skin in the forearm. Prolonged pressure over the- graft or above the graft will lead to clotting of the blood in the graft area.

- 1 Do not take blood pressures on extremities with fistula and/or grafts
- 2 Because of the higher pressure:
 - a. More pressure will be encountered when entering the fistula.
 - b. If the site becomes infiltrated or the attempt is unsuccessful, pressure must be applied to the site for a full five (5) minutes to achieve homeostasis.
- 3 Take the rest of vital signs
- 4 get the patient’s Weight before/or after treatment if allowed by the dialysis center

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CARDIAC EMERGENCIES GENERAL APPROACH TO CARDIAC EMERGENCIES CARDIAC ARREST

- A. ABC's
- B. If Pulseless and Apneic start CPR.
 - 34 Ventilations w/BVM with 100% O₂
- D. Apply AED, stop CPR while AED analyzes.
- E. If the Patient remains in Cardiac Arrest and the AED does not charge, continue CPR for one minute and re-analyze the patient
- F. Do Not perform CPR when the AED analyzes(all energy settings are per-set)

(This Protocol applies only to patients whose body weights exceeds 80lbs per AHA guidelines)

CHEST PAIN

Myocardial infarction is the irreversible cellular injury and necrosis of cardiac muscle caused by prolonged ischemia. It results from the marked reduction or absence of blood flow through one or more coronary arteries. In the vast majority of cases, there is rupture of an atherosclerotic plaque with secondary thrombosis and coronary artery spasm. Other less common mechanisms include coronary artery dissection, embolism, vasculitis, and cocaine-induced coronary artery spasm. The morbidity and mortality from acute MI can be significantly reduced if the patient receives prompt medical attention at the onset of symptoms, and, if indicated, undergoes coronary revascularization (thrombolytic therapy or angioplasty) as quickly as possible. The actual diagnosis of an acute MI is based on many factors, including history, risk factors, ECG findings, cardiac enzyme studies, and other diagnostic tools. Pre-hospital management of a potential acute MI is focused on maintaining ABCs, pain relief, rapid identification, rapid notification, and rapid transport to an appropriate ED.

BASIC INTERVENTION

1. Oxygen Non-Rebreather 15 lpm
2. Primary Survey
3. Obtain Vitals
4. Secondary Survey

ADULT MEDICAL PROTOCOLS

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ABDOMINAL EMERGENCIES

BASIC INTERVENTION

1. Perform primary and secondary survey.
2. Obtain history of present illness and past medical history.
3. Administer oxygen Non-Rebreather 15 lpm
4. Treat for shock if signs present.
5. Obtain and record vital signs

ABDOMINAL PAIN	
<p>Diffuse Pain Peritonitis Pancreatitis Sickle cell crisis Early appendicitis Aneurysm colitis Diverticulitis Intestinal obstruction</p>	<p>Upper Right Quadrant Hepatitis Gallbladder Kidney pain Intestinal obstruction Peptic ulcer Pancreatitis Myocardial pain</p>
<p>Lower Right Quadrant Appendicitis Ectopic pregnancy Inguinal hernia Ovarian problem Intestinal obstruction</p>	<p>Upper Left Quadrant Myocardial pain Gastritis Spleen Kidney pain Pancreatitis Intestinal obstruction</p>
<p>Lower Left Quadrant Ectopic pregnancy Appendicitis Ovarian problem Inguinal hernia Intestinal obstruction</p>	<p>NOTES: 1. ABDOMINAL PAIN IS DIFFICULT TO DIAGNOSE IN THE FIELD. 2. CONSIDER PREGNANCY IN ALL FEMALES OF CHILD-BEARING YEARS. 3. ECTOPIC PREGANCIES ARE A LIFE THREATING EMERGENCY. TRANSPORT ASAP IF SUSPECTED.</p>

Allergic Reaction-Anaphylaxis

Assessment

1. Usually a history of exposure to allergen, often oral ingestion.
2. May be from insect sting or drug ingestion. Penicillin is a very common allergen.
3. Patient usually has severe itching and hives, which is called a generalized urticarial reaction. (General body rash.)
4. May have stridor, facial edema, and swelling of the tongue.

Epinephrine

Generic Name: Epinephrine

Trade Name: Adrenalin®, Adult 0.3-5mg (USP, 1:1,000)®, and Pediatric 0.01mg/kg (USP, 1:1,000)

Mechanism of action:

1. Epinephrine dilates the bronchioles.
2. Constricts blood vessels.
3. Shrinks swollen tissues.
4. Increases blood pressure, heart rate, and force of contraction.

Assessment:

1. ABC's with medical history and medication history and record. Vital signs and record.
2. May perform primary and secondary surveys.
3. High flow O₂ via non-rebreather mask at 15 LPM.
4. Perform focused history and physical exam. Determine if the patient is showing signs and symptoms of an acute allergic reaction.
5. Contact Medical Control or hospital as early as possible, rapid transport.
6. If the patient exhibits any of the following signs and/or symptoms; they should receive epinephrine.
 - A. Hypotension
 - B. Airway compromised such as:
 - i. Facial or oral edema
 - ii. Stridor
 - iii. Tongue/throat swelling
 - iv. Difficulty swallowing
 - v. Wheezing
7. Patients who are candidates for epinephrine should be evaluated for contraindications:
 - A. Relative contraindications (consider calling medical control or hospital but Epinephrine may be given on standing orders to patient with severe symptoms.)
 - i. Known history of heart disease.
 - ii. Use of patient's own EpiPen prior to EMS arrival.
 - iii. Pregnancy
 - B. Online medical control must be contacted prior to giving epinephrine for extremes of age :< 5 years of age or >55 years of age.
8. If patient needs criteria, administer epinephrine vials as follows:
9. Refer to Allergic Reactions and Respiratory Distress Protocols for detailed assessment.

Application:

1. Ask patient if they have any drug allergies.
2. Confirm medication, concentration, dose and clarity of liquid in vial
3. Tap ampule/vial to get medicine down from top, break top off ampule with gauze 2x2, place top in sharps container.
4. Adult draw up 0.3 ml of epinephrine 1mg/ml 1:1000, syringe approximately 1/3 full. Pediatric draw up 0.15 ml of epinephrine 1mg/ ml 1:1000, syringe.
5. Pointing syringe up, expel all air.
6. Inform patient they are going to receive an injection; side effects may include feeling shaky or heart racing.
7. Select an **Intramuscular Site** (Upper arm muscle, hip, and thigh) and cleanse area for subcutaneous injection.
8. Using one hand to tent skin, **insert needle at 90 degrees** into administration site and draw back checking for blood return. If there is blood return, select a different site, and insert needle, again check for blood return.
9. If no blood, administer 0.3 ml of epinephrine (1/3 of syringe) for adults, 0.15 ml of epinephrine for pediatric.
10. Remove needle and carefully re-cap using one-handed technique. Discard needle properly in sharps container if additional needles are available. If not, retain needle with syringe and remaining epinephrine as additional doses may be required. Discarded any remaining epinephrine not used.
11. Observe patient for improvement or disorientation of condition. Repeat exam and vitals after each dose.
12. Document procedure, vitals and response to treatment.
13. If an additional dose is required consult Allergic Reactions and Respiratory Distress Protocols.
14. If indicated by protocol, begin again from step 5.
15. Place sterile gauze over site and apply slight pressure.
16. Bandage site
17. Document the time, dosage and location of the medication administration
18. Re-assess the patients response to the medication:
 - a. Improvement:
 - i. Decreased effort to breath
 - ii. Decreased swelling in airway
 - b. No Change or worsening
 - i. Consult for additional dose of IM epinephrine

Anaphylactic Reaction:

1. Place the patient in a **modified Trendelenburg** position, if indicated. Use this position with caution in patients with COPD, CHF, or extreme obesity since this position may cause respiratory compromise.
2. Cryotherapy (Ice Packs) to affected area, if indicated.
3. ECA/Basic EMT: High flow O2 via non-rebreather mask at 15 LPM, Trendelenburg position if B/P less than 100 systolic, rapid transport.

Bea M.D. 10/26/2016

ALTERED MENTAL STATUS – NON TRAUMATI

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BASIC INTERVENTION

1. Perform primary and secondary surveys.
2. Obtain and record vital signs
3. Past history, especially of hypoxia, hypoglycemia, use of insulin, recent head trauma, hyperthermia, post ictal state or seizure history, drug intake, exposure to chemicals or fumes.
4. Administer oxygen by Nasal Cannula at 4 lpm
5. Protect the airway. May place patient in lateral recumbent position if C-spine injury is ruled out.
6. : Obtain Glucometer reading. If glucometer reading is less than 60 and patient has an intact gag reflex administer 15 grams of oral glucose

CHILD BIRTH

Most pregnancies progress in an orderly, normal fashion. Abnormalities during pregnancy affect both mother and child. Thus, care of the pregnant patient focuses on the evaluation and treatment of both the mother and in-utero child. Common emergencies encountered in the pre-hospital environment are bleeding, abnormal presentation of child, complicated deliveries, and abdominal pain. Rapid assessment and recognition of acute problems; including the possibility of having to support two or more lives with complications is the primary focus in the pre-hospital environment. It is impossible to address all potential illnesses and injuries in the pregnant patient in these standards.

BASIC INTERVENTION

1. If the obviously pregnant woman **greater than 20 weeks gestation** requires spinal immobilization, securely package her supine on long spine board and **tilt board** (with patient firmly secured to board) **15 degrees to the patient's left**.
2. Collect any aborted tissues and transport with patient.
3. Transport all non-traumatically injured patients greater than **20 weeks** gestation on their left side to prevent *supine hypotensive syndrome* (if patient can tolerate and is able to comply).

NORMAL UNCOMPLICATED BIRTH:

Uncomplicated pregnancy with appropriate prenatal care. No recent history of substance abuse.

1. Assess for amniotic sac rupture. If not yet ruptured, **DO NOT prematurely rupture membranes until complete delivery of the baby has been accomplished**. Once delivery has been accomplished and the membranes are still intact, carefully tear them open and immediately suction.
2. Place the mother in a comfortable position (supine) with legs drawn up at edge of bed (if still in house). Proper position may prevent shoulder impaction by baby.
3. Coach the mother to breathe deeply between contractions. Advise mother to "pant-breathe" with each contraction, and to relax between contractions.
4. Apply slight pressure to perineum as the head emerges. Gently assist its passage out of the birth canal. Do not allow an explosive delivery as vaginal tearing may result.
5. **Check for umbilical cord around neck (nuchal cord)**. If present, slip cord off over head. If cord is too tight to remove, **immediately clamp in two places and cut between clamps**.
6. As soon as the head is visible, instruct the mother to stop pushing, immediately suction first the mouth, then the nose, to remove fluid and mucous before the baby takes its first breath or the body is delivered. If meconium is present, and intubation equipment is unavailable, thoroughly attempt to suction the airway with a bulb syringe as much as possible.
7. Once you have suctioned, tell mother to resume pushing, supporting the infant's head as it rotates.
8. Deliver the anterior shoulder first, then the posterior shoulder. The body will soon follow.
9. Remember to keep the baby at the level of the vagina to prevent over or under transfusion of blood from the placenta. **Never "milk" the cord (milking causes destruction of blood cells)**.

(continued on next page)

10. Once pulsations cease in the cord, securely clamp (or tie) the umbilical cord (if not already done for **nuchal cord**). Place the first clamp approximately 7 inches from baby. Place the second clamp approximately 3 inches above the first. Carefully cut the umbilical cord **between** the clamps.
11. Allow the infant to nurse, if possible and infant is stable. This will help to promote uterine contractions (do not allow baby to nurse if multiple births are suspected!).
12. After birth the vagina should continue to ooze blood. *Do not pull on the umbilical cord* to expedite placental delivery. Eventually the cord will lengthen which indicates separation of the placenta from the uterine wall (usually within 20 minutes).
13. Following delivery inspect the mother's perineum and external vagina for tears. If any tears are present, apply direct pressure to control hemorrhage.
14. The placenta should then be delivered and transported with the mother for evaluation. Do not delay transport waiting for the placenta to deliver.

PROLAPSED UMBILICAL CORD I LIMB PRESENTATION:

1. **Do not** attempt to push cord or limb back in!
2. Insert two fingers of gloved hand into vagina to raise the presenting part of the fetus off of the cord. Simultaneously, check cord for pulsations in vagina, and push baby's head away to keep pressure off of cord (maintain this throughout transport).
3. Place mother in a **knee-chest position** (if possible). If mother unable to, comply, place in a trendelenburg position instead.
4. Continue to hold pressure off of cord. Keep cord moist with sterile saline.
5. Transport immediately with early notification to receiving ED.

BREECH BIRTH:

1. **Field delivery of a breech baby is best left to hospital personnel whenever possible**
Do not attempt breech delivery unless no other options exist or baby and/or mother is in distress.
2. **If delivery is imminent:** Position mother with buttocks at the edge of firm bed (if available). Ask her to hold her legs in a flexed position if possible.
3. As the infant delivers, do not pull on the legs, simply support them. Allow the entire body to be delivered with contractions only while you support the infant.
4. As the head passes the pubis, apply gentle upward traction until the mouth appears over the perineum.
5. If the head does not deliver and the baby begins to spontaneously breathe with its face pressed against the vaginal wall, place a gloved hand in the vagina with the palm toward infant's face.
6. Form a "V" with the index and middle finger on either side of the infant's nose, and push the vaginal wall away from the infant's face.
7. Maintain this position, and immediately transport with early notification to the receiving ED.

MULTIPLE BIRTHS:

1. Follow guidelines outlined for normal birth. Be aware that multiple births are generally smaller and may present with babies in multiple positions (i.e., normal, breech etc.).
2. Deliver first baby, clamp and cut cord as previously indicated. Deliver second (or additional) babies as previously indicated.
3. Be prepared to provide cardio –pulmonary support since multiple births generally produce much smaller and less developed babies, requiring more intensive care.
4. Do not begin fundal massage or allow the mother to breast feed until it is known for certain that all babies have been delivered.

SHOULDER DYSTOCIA:

(occurs when infant's shoulder is larger than its head)

1. Occurs most frequently with diabetic, obese mothers, and post mature pregnancies.
2. Do not pull on head. Have the mother drop her buttocks off the end of the bed.
3. Next, have her flex her thighs upward to facilitate delivery (McRobert's Position), and apply firm pressure with an open hand immediately above the symphysis pubis.
4. If delivery does not occur, immediately transport with early notification to the receiving ED, (maintain airway patency).

DEHYDRATION

BASIC INTERVENTION

1. Perform a primary and secondary assessment.
2. Obtain past and present medical history
3. Obtain vital signs
4. Administer oxygen by Nasal Cannula at 4 lpm

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DIABETIC / GLUCOSE EMERGENCIES

Sorting out the possibilities of disorders in glucose metabolism has been made much easier with the advent of the Glucometer. The old adage of “when in doubt give sugar” is no longer valid when a Glucometer is available. Diabetics may have abnormally high or low blood glucose leading to symptoms. The goal in managing diabetic conditions in the pre-hospital setting is glucose measurement, treatment of identified abnormalities, and search for precipitating causes.

BASIC INTERVENTION

1. ABCs

2. **Blood Glucose** level should be taken on all patients prior to and after glucose. (BGL range 60-100)

35 **Instant Glucose 15 grams** (1 tube) by mouth, if indicated, for the hypoglycemic patient who is able to swallow on their own and is capable of protecting their airway.

•3. *May be repeated once, at same dose, if no response in 15 minutes. Check Glucose level*

HYPOTHERMIA

BASIC INTERVENTION

1. Perform primary and secondary survey.
2. Obtain history of present illness and past medical history.
3. Administer oxygen by Nasal Cannula at 4 lpm.
4. Obtain and record vital signs
5. Move to a warm environment.
6. Handle patient gently
7. Keep patient supine
8. If respirations less than 12 / minute – BVM assist at 18 – 20 breaths a minute.
9. Gentle external warming

HEAT EXHAUSTION

BASIC INTERVENTION

1. Remove the patient from warm environment.
2. Begin external cooling measures. (i.e. cold packs)
3. Primary survey
4. Obtain Vitals
5. Secondary survey

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HEAT STROKE

BASIC INTERVENTION

1. Remove patient from warm environment.
2. Lay patient supine with feet elevated.
3. Begin external cooling measures.(i.e. cold packs)
4. Primary survey
5. Obtain vitals
6. Secondary survey

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HYPERTENSIVE CRISIS

BASIC INTERVENTION

1. ABC's
2. Primary and secondary survey
3. Vital Signs
4. Oxygen Non-Rebreather 15 lpm.

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HYPERVENTILATION

BASIC INTERVENTION

1. Perform primary and secondary survey.
2. Obtain history of present illness and past medical history.
3. Administer oxygen via Nasal Cannula (less than 2 LPM)
4. Obtain and record vital signs
5. Provide psychological support

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HYPOTENSION

BASIC INTERVENTION

1. Perform primary and secondary assessment
2. Oxygen therapy Nasal Cannula 3 lpm
3. Obtain and record vital signs

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OVERDOSE/POISONING

BASIC INTERVENTION

1. Perform a primary and secondary survey.
2. Obtain history of present illness and past medical history.
 - a. Type and amount of agent involved (bring to ED if possible).
 - b. Method of exposure.
 - c. Time of exposure.
 - d. Reason for exposure.
 - e. Action taken by bystanders.
3. Administer oxygen by Non-Rebreather 15 lpm. Providing ventilatory assistance if necessary per Bag Valve Mask with 25 liters supplement oxygen.
4. Perform additional examination for:
 - a. Smell of substance around mouth.
 - b. Burns or contamination of the mouth or nose.
 - c. Skin color.
5. if external contamination:
 - a. Remove clothing and jewelry that has been exposed
 - b. Brush solid chemicals from skin surface
 - c. Decontaminate patient with copious amounts of water or normal saline
 - d. For eye injury, irrigate with normal saline 1 liter per eye, keeping fluid from nasal margin of the eye.
6. If patient has known internal contamination:
7. Contact Poison Control
8. If ingestion less than 30 minutes ago, if conscious and if not contraindicated:
 - a. If comatose, prevent aspiration, control airway, suction as needed.
 - b. If the patient aspirates, save aspirated contents for hospital analysis

Note:

Contraindications: petroleum distillates or medicines that may cause CNS depression. If in doubt contact medical control.

PULMONARY EDEMA

Applications:

Shortness of breath WITH evidence of pulmonary edema (auscultated findings, history, etc.) and cardiac history

WITH systolic BP of greater than 100mm Hg

Treatment:

EMT-B

CABC's
O2-15 L/min Non-rebreather
V/S

RESPIRATORY DISTRESS – NON CARDIA

C

BASIC INTERVENTION

1. Primary and secondary survey.
2. Obtain history of present illness and past medical history
 - a. Exposure to allergens
 - b. Past history of COPD
 - c. Exposure to noxious chemicals
 - d. Medication usage
3. Administer oxygen Non-Rebreather 15 lpm.
4. Obtain and register all vital signs.

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SEIZURE S

BASIC INTERVENTION

1. Perform primary and secondary surveys.
2. Obtain history of present illness and past medical history.
 - a. Prior seizure
 - b. Recent or past head trauma, CVA or aneurysm
 - c. Drug/ETOH use
 - d. Pregnancy/toxemia
 - e. Fever
 - f. Insulin dependent diabetes
 - g. Poisoning
 - h. Medic alert badge
3. If patient has suspected recent head trauma, immobilize the neck and cervical spine
4. Administer oxygen by Non-Rebreather at 15 lpm.
5. If patient < 2 years old and febrile – Uncover patient
6. Obtain Blood Glucose Level

STROKE (CVA)

BASIC INTERVENTION

1. Primary and secondary survey.
2. Obtain history of present illness and past medical history.
 - a. Past cardiac disease or hypertension
 - b. Head trauma
 - c. Diabetes
 - d. Previous CVAs
 - e. Recent syncope, visual disturbances, changes in behavior
 - f. Time of onset and duration of present episode
 - g. Medication usage
3. Perform neurologic exam:
 - a. Response to verbal stimuli
 - b. Motor and sensory functions of extremities
 - c. Pupillary responses
4. Administer oxygen by Non-Rebreather at 15 lpm.
5. Obtain Blood Glucose Level

PSYCHIATRIC EMERGENCIES

Psychiatric emergencies require careful assessment. It is important to maintain a professional demeanor with the necessary degree of authority in one's voice. In all cases, substance-induced disorders (intoxication, withdrawals, etc.), organic causes (cerebral lesions etc.), endocrine emergencies (hypoglycemia and hyperglycemia, etc.), and hypoxia must be ruled out before a patient's condition is provisionally diagnosed as psychiatric. Remember that these patients are often agitated, suicidal, and may be under the influence of alcohol or drugs. This creates a particularly hazardous situation for Pre-hospital Providers.

BASIC INTERVENTION

1. Scene safety.
2. Physical restraints as needed for patient and provider protection (must clearly document need – see a. "Restraint / Transport Against Will")
3. Blood glucose assessment (rule out hypoglycemia). Refer to "Diabetic / Glucose Emergencies."

PEDIATRIC EMERGENCIES

Cardiac Arrest

1. Assess scene safety/ensure BSI
2. Assess ABC's
3. If there is an indication, apply c-spine immobilization
4. Remove pt. from water, if the pt. is in or near water

If Apneic and Pulseless:

2. Initiate CPR
3. Administer o₂ via BVM w/supplemental o₂ 15lpm
4. Test BGL
5. Apply pulse oximetry (if available)

After 2 min. of CPR stop and check ABC's, if pt. continues to be apneic and pulseless apply AED w/pedi pads

1. Turn on AED
2. Attach Pedi AED pads to bare dry skin
3. Stop CPR and press analyze button and stand clear of pt.
4. If there is no shock advised-check ABC's and continue CPR analyze w/AED every 2 min.
5. If shock is advised-ensure all is clear of the pt. and press shock button. After shock recheck ABC's. If pt. remains pulseless continue CPR for 2 min. then reanalyze AED.

If return of Pulse:

Continue w/rescue breathing using BVM/supplemental o₂ 15lpm monitor B/P pulse rate.

If return of Pulse and Respirations:

Keep pt. warm, monitor VS-Pulse, B/P Respirations

(This protocol applies to Pediatrics to 8 years of age)

PEDIATRIC MEDICAL – UNSPECIFIC

BASIC INTERVENTION

1. ABCs
2. Apply AED w/Pedi Pads (if unconscious, assist with breathing w/BVM)
3. Obtain present and past medical history
4. Obtain vital signs.
5. Administer oxygen by Pedi Non-Rebreather at 10 lpm.
6. Check for Medic Alert Tag.
7. If Signs & Symptoms of allergic reaction administer Epi pen 0.15mg (pedi)

PEDIATRIC TRAUMA

BASIC INTERVENTION

1. Perform primary and secondary assessment.
2. Protect the cervical spine, immobilize if needed.
3. Stop all life threatening bleeding
4. Administer oxygen by Pedi Non-Rebreather at 10 lpm. (assist respirations with BVM if needed.)
5. Obtain vital signs.
6. Begin transport if patient is considered "urgent" or "critical"

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ADULT TRAUMA PROTOCOLS

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AMPUTATIONS

BASIC TREATMENT

**** SCENE SAFETY ****

1. Perform primary and secondary survey.
2. Control hemorrhage with direct pressure.
3. Obtain history of present injury and past medical history
 - a. Time of amputation
 - b. Mechanism of amputation
 - c. Bystander care of severed part
 - d. Medication usage
4. Treat other urgent injuries.
5. Administer oxygen by Non-Rebreather at 15 lpm.
6. Treat for hemorrhagic shock if necessary.
7. Cover amputated part with sterile gauze. Moisten with saline irrigation. Next, cover with dry dressings, then splint, and then elevate.
8. Place severed part in sterile gauze.
9. If partial amputation, dress with moist gauze, splint in alignment with extremities to ensure optimum blood flow. Avoid torsion when handling amputated part.
10. If amputated extremity and profuse bleeding cannot be controlled by: direct pressure, elevation, and pressure dressing, or pressure point, contact medical control for possible application of a tourniquet.
11. Provide emotional support.
12. Transport to facility capable of re-attachment.

BURN S

BASIC INTERVENTION

1. Perform primary and secondary surveys.
2. Obtain history of present injury and past medical history
 - a. Cause of burn (chemical, thermal, electrical, etc.)
 - b. Length of exposure
 - c. Length of time in enclosed compartment
 - d. Type of material burning
 - e. Past history of smoking, CV problems, COPD
 - f. Bystander treatment
3. Administer oxygen by Non-Rebreather at 15 lpm.
4. Suction as needed
5. C-Spine immobilization if not cleared.
6. Cover affected areas with dry sterile dressings/sheets. If chemical exposure begin decontamination with saline.
7. Treat associated fractures, lacerations, or other injuries.

HEAD INJURY – ISOLATED

BASIC INTERVENTION

1. Perform primary and secondary survey
2. Oxygen by Non-Rebreather at 15 lpm.
3. Cervical spine immobilization unless cleared.
4. Monitor vital signs
5. Transport in supine or 30 degree elevation of the head, if not contraindicated. Tilt the b-board if c-spine immobile.

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DROWNING / NEAR DROWNING

Drowning is the fourth most common cause of trauma related death in the United States. It can occur anywhere from a residential bathroom to area lakes. Of these incidents 75% are associated with alcohol consumption. Near Drowning is defined as a submersion accident with recovery of vital signs and survival greater than 24 hours post incident. The primary mechanism of death in drowning is hypoxia and suffocation due to lack of oxygen or atelectasis of lung tissue. Concomitant factors of trauma from surface impacts, spinal cord injuries, orthopedic, and tissue injuries are common. Patient survival is based largely on early access, aggressive airway management and resuscitation intervention.

BASIC INTERVENTION

1. Remove from water if so trained, and it is safe to do so.
2. Spinal immobilization, protecting C-spine if mechanism suggests trauma.
3. If patient is in cardiopulmonary arrest, refer to appropriate cardiac arrest Standard.
4. Provide and maintain patient warmth. Remove wet clothing.

GENERAL TRAUMA

BASIC INTERVENTION

1. Perform primary and secondary survey
2. Obtain history of present illness and past medical history.
 - a. Mechanism of injury
 - b. Vehicle speed
 - c. Seat belt use
 - d. Integrity of vehicle compartment
 - e. Ballistics information
3. Maintain airway and immobilize the cervical spine.
4. Treat life-threatening injuries.
5. Monitor the vital signs every 5-10 minutes, more frequently if patient unstable
6. Administer oxygen by Non-Rebreather at 15 lpm.
7. Treat if:
 - f. Systolic blood pressure less than 100 mm Hg and signs and symptoms of shock exist
 - g. Suspected blunt/penetrating chest or abdominal trauma associated with signs and symptoms of shock.
 - h. There are suspected fractures of the femur or pelvis.

SPINAL TRAUMA

Spinal trauma, if not recognized and properly managed in the field, can result in significant life-long injury and impairment. Any patient who has sustained an injury indicative of spinal loading or stretching, significant injury above the clavicles, significant blunt trauma to the torso, a head injury resulting in an altered level of consciousness, or a major fall must be suspected of suffering a potential spinal cord injury and should be immobilized in a neutral in-line position (unless contraindicated). **The patient's ability to walk should not be a factor in determining whether a patient needs to be treated for potential spinal injury.** According to PHTILS,

almost 20% of patients who required surgical repair of unstable spine injuries were found "walking around" at the accident scene by EMS personnel.

BASIC INTERVENTION

- Spinal immobilization prior to moving.
 - ABC
 - C-Collar
 - Head Immobilizer
 - Back Board

Patient should be strap with 3 straps.

SKILLS

AIRWAY ADJUNCTS

The most common obstruction to an open airway is the tongue. Airway adjuncts – devices that aid in maintaining an open airway – should be used early in the treatment of the unresponsive patient and continued throughout the pre-hospital care. The two most common airway adjuncts use are the oropharyngeal airway and the nasopharyngeal airway.

Oropharyngeal Airway (OPA):

An oropharyngeal airway is a curved device that can be inserted in to the patient's mouth. The OPA has a flange that rests against the patient's lips. The rest of the OPA holds the tongue as it curves back to the pharynx.

Guidelines for Using Airway Adjuncts:

- 1 The OPA is an airway adjunct for all unresponsive patients **without** an intact gag reflex.
- 2 Always open the patient's airway manually (jaw thrust if trauma) before using either device.
- 3 If inserting an OPA, take care not to obstruct the airway by pushing the tongue further into the pharynx; do not continue to insert either device if the patient begins to gag.
- 4 When an airway adjunct is in place you must **continually monitor the patient's airway** and be prepared to remove the device if the patient's gag reflexes returns.
- 5 Always use appropriate infection control practices when inserting or removing an airway.

BAG VALVE MASK (BVM)

PROCEDURES

1. Select the appropriately sized mask.
2. Connect the oxygen tubing to the BVM device and adjust the flow of oxygen.
3. Assure that the patient's airway is patent and secured.
4. Apply the mask to the patient's face ensuring a tight seal.
5. Ventilate the patient.
6. The adequacy of ventilation is assessed by observing the patient's chest movement.
 - 25 The patient should be ventilated in this manner once every 5 seconds.

GLUCOMETE R

(Blood Glucose Assessment)

The Glucometer Elite blood glucose testing process is based on an electrode sensor technology. Capillary action at the end of the test strip draws a small amount of blood into the reaction chamber and a reading is displayed 30 to 60 seconds after insertion into the machine. No timing, wiping, or blotting is required. If done properly, the glucose level can be determined to within 10% of clinical laboratory values.

1. Open foil packet, carefully peeling back to the line on the foil package. Expose the meter end of test strip.
2. Hold the test end of the test strip between the foil and insert the test strip into the meter.
3. A beep sound and a full display should appear, followed by the function number (F#) and the previous test result. Make sure that the F# of the foil package corresponds with display reading, if the F# on the foil packet and meter does not match, do not use (will get erroneous readings).
4. Remove the foil from the test strip. **Proceed immediately (within 3 minutes) to the next step or device will shut itself off.**
5. Cleanse the skin with alcohol and allow to completely dry before puncturing the skin. Obtain a blood sample using an approved lancing device. Press the fingertip to form a small drop of blood. **In neonates and infants, a heel stick is the preferred location to obtain a blood sample (avoid excessive pressure on heel when using lancet device).**
6. Touch and hold the test end (tip) of the test strip to the drop of blood. Blood should be automatically drawn into the test strip and a “beep” heard. Ensure that a full sample is drawn into the test strip or an erroneous reading may result.
7. When using the top-load (newest) model, test results will appear after 30 seconds.
8. When using the side-load (older) model, test results will appear after 59 seconds.

NOTE:

Side-loading Glucometer Elite blood glucose range is 40 – 500 mg/dL

If **Lo** appears in the display, the blood glucose value may be **below 40 mg/Dl**

If **Hi** appears, the value may be **above 500 mg/Dl**.

Top-loading Glucometer Elite blood glucose range is 20 – 600 mg/dL

If **Lo** appears in the display, the blood glucose value may be **below 20 mg/Dl**

If **Hi** appears, the value may be **above 600 mg/Dl**.

Readings should be confirmed on any patient in which the clinical presentation does not support blood glucose findings.

INDICATION:

Any patient with an altered mental status.

Patients who have metabolic or endocrine disorders, and present with non-specific complaints. Bradycardia (after airway control) or hypothermia in any infant.

OXYGEN ADMINISTRATION

INDICATIONS		
<ol style="list-style-type: none"> 1. Any suspected cardiopulmonary emergency 2. Complaints of shortness of breath or respiratory difficulty 3. Suspected ischemic chest pain 4. Traumatic injuries 5. Syncope 6. Signs of stroke 7. Altered mental status 		
CONSIDERATIONS		
26 Closely observe a patient dependent on hypoxic respiratory drive (i.e., sema)		
ADMINISTRATION CHART		
METHOD	FLOW RATE	% O ₂ DELIVERED
Room air		21%
Mouth to mouth		16%
Nasal cannula	1 Lpm	24%
	2 Lpm	28%
	3 Lpm	32%
	4 Lpm	36%
	5 Lpm	40%
	6 Lpm	44%
Non-Rebreather Mask	8-15 Lpm	80-90%
BVM with reservoir	25 Lpm	90%

AUTOMATIC EXTERNAL DEFIBRILLATION

ASSESSMENT:

1. ABC's

- A. Oxygen therapy and Airway Management (BVM w/supplement o2 15lpm)
- B. CPR
- C. Apply AED, turn on and stand clear while analyzing
- D. If AED charges, states to defibrillate ensure all is clear and push button
- E. If no shock recheck ABC's no pulse start CPR for 2 min.
- F. Reanalyze, if AED charges, defibrillate

Continue steps A-F until:

AED does not charge

Relieved by other equally equipped and trained personnel

At any time the patient remains in cardiac arrest, but the AED does not charge, continue CPR for two min. and re-analyze.

Do not perform CPR when the AED analyzes.

All energy settings are pre-set.

SPINAL IMMOBILIZATION

INDICATIONS

1. Blunt trauma to thorax
 2. Head trauma
 3. Penetrating trauma at or near the spine
 4. Axial spine trauma
 5. Significant deceleration injury
-
1. Obtain manual control of the cervical spine. This must be done as soon as possible and must be maintained until the head is completely secured via the adjuncts described below.
 2. Select and place a semi-rigid cervical collar as per manufacture's instructions. If necessary and clinically appropriate an alternate adjunct device such as towel rolls or trauma dressing may be substituted for a commercial cervical collar.
 3. Assess the patient's pulse, motor and sensory function in all four extremities.
 4. Using the procedures specified in the BTLIS guidelines, move the patient onto a long spine board.
 5. Position the patient in the spine position on the board. Patients with special needs such as elderly with Kyphosus or patients with specific injuries to the back, may be immobilized in other positions so long as these alternative positions are clinically appropriate and achieve effective spinal immobilization.
 6. Secure the patient's legs, pelvis and chest to the long spine board. The patient should be secured as follows:
 - a. One strap across patient's legs, just below the knees.
 - b. One strap across the patient's pelvis.
 - c. One strap across the patient's chest, just below the nipple line.
 7. Additional straps may be added if the medic so chooses.
 8. Immobilize the patient's head to the long spine board.
 9. The patient's head should be secured as follows:
 - a. Place head bed on backboard at the patient's head.
 - b. Place tape across the top of the patient's forehead, attaching the tape to the board.
 - c. Place tape across the cervical collar, attaching the tape to the board.
 10. Reassess the patient's pulse, motor and sensory function in all four extremities.

PATIENT ASSESSMENT

ENVIRONMENT

1. Recognize environment hazards, overviews and scene.
2. Identify number of patients. Initiate a triage system, if appropriate.
3. Recognize mechanism of injury or chief complaint, position of patient.
4. Identify yourself, determine level of consciousness.
5. Call for back-up; initiate communication.
6. Asks for primary complaint.

PRIMARY SURVEY

7. **Airway:** open, check for adequacy, note and correct potential problems, provide for c-spine stabilization.
8. **Breathing:** respiratory noises and effort, skin color, behavior. Note and correct potential problems.
9. **Circulation:** note presence, location and quality of pulse.
10. **Responsive:** note initial level.
11. **Shock:** watch for cool, clammy, pale skin, thirst, agitation.
12. Check tracheal position and neck vein distention.
13. Check for major chest trauma.
14. Check for major bleeding.
15. NOTE: Should take 30 seconds or less for assessment. Neck immobilization should be completed following this if appropriate.

SECONDARY SURVEY

16. **Neck:**
 - a. evaluate for trauma and immobilize if appropriate.
17. **Head and Face:**
 - b. Palpate for deformities, asymmetry, blood and pain.
 - c. Recheck airway for potential compromise dentures, loose or avulsed teeth, proper occlusion.
18. **Eyes:**
 - d. pupils (equal or unequal, responsiveness to light), foreign bodies, contact lenses, lacerations, blurred or lost vision.
19. **Nose:**
 - e. deformity, bleeding, discharge.
20. **Ears:**
 - f. bleeding, discharge.
21. **Neck:**
 - g. Recheck for deformity or tenderness if not already immobilized.
 - h. Note wounds, neck vein distention, use of neck muscles for respiration, altered voice and medical alert tags.
 - i. Apply cervical collar if exam suggests this is appropriate.

22. **Chest:**
- j. Observe breathing for symmetry, effort, noises with respirations, evidence of air leaks or flail segment.
 - k. Inspect for wounds, bruising, anteriorly and posteriorly.
 - l. Palpate for tenderness, wounds, fractures, unequal rise of chest and crepitus.
 - m. Have patient take deep breath: recheck wounds, symmetry of breathing.
23. **Abdomen:**
- n. Inspect for wounds, bruising.
 - o. Palpate for tenderness, rigidity.
 - p. "AMPLE" History
 - q. Medication
 - r. Previous illness
 - s. Last meal
 - t. Event preceding incident
24. **Pelvis:**
- u. Palpate and compress for tenderness, instability.
25. **Shoulders/Upper Extremities:**
- v. Palpate symmetrically for wounds, fractures, and tenderness.
 - w. Check for distal pulses, color, medical alert tags.
 - x. Check for sensation.
 - y. Check for weakness (have patient squeeze your hands if not obvious fracture present).
 - z. If exam normal, gently move arms to check overall function.
26. **Lower Extremities:**
- aa. Palpate symmetrically for wounds, fractures, tenderness.
 - bb. Check for distal pulses, color.
 - cc. Check for sensation.
 - dd. Check for weakness (have patient push feet against your hands if no obvious fracture present).
 - ee. If exam is normal, gently move legs to recheck overall function.
27. **Back:**
- ff. Inspect the palpate for wounds, fractures and tenderness, when moving patient as a unit onto a long backboard.
 - gg. Recheck for motor or sensory deficits as appropriate.

NOTE:

Should take 1-2 minutes to complete. Should be systematic, though exact order may vary. Do not interrupt for treatment unless ABC deterioration noted. Auscultate abdomen or chest if appropriate. Obtain quantitative vital signs after secondary survey unless patient shows signs of shock.

VITAL SIGNS

- 28. Obtain first quantitative set of vital signs within 5 minutes (pulse, blood pressure, respiratory rate).
- 29. Repeat according to patient's condition. At least one more set prior to transport or enroute.

SPECIAL NOTES

1. Do not let gathering of information distract you from management of threatening problems.
2. Appropriate questioning can provide valuable information while establishing your authority.
3. History is commonly obtained while performing secondary survey. Assistant is often used gathering information from patient by bystanders.
4. DO NOT FORGET TO USE BYSTANDERS to confirm information obtained from patient and to provide facts when patient cannot. History from the scene is invaluable; you are the only one who can obtain this.
5. Over-the-counter medications (including aspirin) and birth control pills are frequently overlooked by patient and rescuer.
6. Consider medical causes for trauma, particularly in single person accidents.
7. Patients are people in need. They ask for your kindness, and consideration. Your interaction with them demands professionalism and confidentiality.

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PATIENT POSITIONING

Trendelenburg Position:

The most common position for the patient in shock is supine; with his/her legs raised approximately 12 inches. This position helps to promote increased venous return to the heart and brain. However, this position also exacerbates respiratory distress and is generally reserved for those patients in which respiratory compromise is not a factor.

Modified Trendelenburg:

Patients with respiratory distress or disease (i.e., CHF, COPD, extreme obesity) should be placed in a Modified Trendelenburg this position maintains elevation of the head and upper torso, while simultaneously elevating the feet 10-12 inches to increase venous return.

Fowler's Position:

An upright, sitting position is generally preferred for patients with respiratory distress without hemodynamic compromise.

McRobert's Position:

The mother's thighs are hyperflexed, bringing her knees "to her chest." This position is limited to complicated deliveries in which shoulder dystocia is present.

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1 RESTRAINT / TRANSPORT AGAINST PATIENT WILL

An EMS System has an obligation to treat and transport certain patients who may be suffering from an illness or injury that impairs their ability to make an informed decision. These patients will often refuse treatment or transport to a medical facility. In circumstances where an acute illness or injury impairs a patient's ability to make an informed decision AND the patient is in need of medical treatment or evaluation to prevent further significant illness or injury, the patient shall be transported to an ED for further evaluation. There are certain circumstances where a patient's condition or behavior poses an immediate threat to the health and safety of themselves or others around them. In these circumstances, the patient should be safely and humanely restrained and continuously monitored during restraint. **Patient restraint and transport against will should never be taken lightly.** Every individual has a legal and moral right to refuse medical treatment, even if that refusal results in potential harm. It is our responsibility to make sure the patient is making an informed decision and that the patient causes no harm to themselves or others as a result of their behavior.

1. Determine scene safety. Attempts to physically restrain a patient should be made (when possible) with law enforcement assistance.
2. Determine that a potentially harmful condition exists (if the condition is immediately life-threatening, the patient should be treated and transported as soon as safely possible).
3. Determine patients competency to make an informed decision using the following:
 - *Is the patient alert? Oriented times (person, place, and time)?*
 - *Does the patient understand his / illness or injury and the potential for adverse outcome?*
 - *Can the patient describe his / her condition to you?*
 - *Does the patient understand consequences (including death) of not treating his / her illness or injury?*
 - *Does the patient understand the alternatives to Immediate care by EMS?*
 - *Does the patient have any physical findings suggestive of impaired physiology that could affect decision making? Hypotension, hypothermia, hypoxia, head Injury, alcohol / drug intoxication, evidence of CVA, systems of psychiatric decompensation*
4. If, based on Provider assessment, the patient is not capable of making an informed decision (because of abnormalities defined above) and the patient has a potentially harmful illness or injury, the patient should be extensively counseled regarding the need for medical care. If the patient STILL refuses further care / evaluation, or is harm to (him / her) self or others, the patient should be physically restrained by EMS personnel (with law enforcement assistance, if available).
5. PHYSICAL RESTRAINTS should be safe & humane. At NO TIME should a patient be struck or managed in such a way as to impose pain. Restrain in a position of comfort and safety.
6. Thoroughly document (on the PCR) the reason for restraint the mental status exam, options attempted, and method of restraint (no exceptions).
7. Patients should be monitored every 5-10 minutes during either, restraint period and findings documented on PCR. Never leave a patient alone after any form of restraint.

GENERAL REFERENCE

TRAUMA SCORE

ADULT REVISED TRAUMA SCORE			
SCORE	GCS	RESP. RATE	SYSTOLIC BP
0	0-3	0	0
1	4-5	1-5	1-49
2	6-8	6-9	50-75
3	9-12	>29	76-89
4	13-15	10-29	>89

RTS = GCS SCORE + RESPIRATORY RATE SCORE + SYSTOLIC SCORE

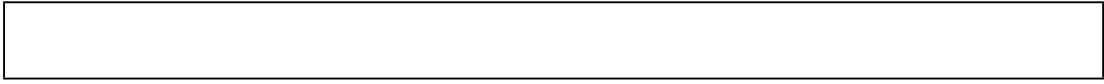
PEDIATRIC TRAUMA SCORE			
ASSESSMENT	SCORE		
	2	1	0
Weight	>20 kg	10-20 kg	<10 kg
Airway	Normal	Oral or Nasal	Advanced
Systolic	>90	50-90	<50
LOC	Awake	Altered Mental Status	Comatose
Open Wound	None	Minor	Major or Penetrating
Fracture	None	Minor	Open or Multiple

PTS = SUM OF ASSESSMENT SCORES

ADULT GLASCOW COMA SCALE

EYE RESPONSE	BEST VERBAL RESPONSE	BEST MOTOR RESPONSE
1. No response	1. No reponse	1. No Response
2. To pain	2. Incomprehensible	2. Extension
3. To Voice	3. Inappropriate	3. Abnormal flexion
4. Spontaneously	4. Disoriented	4. Abnormal withdrawal
		5. Localizes Pain
		6. Obeys
GLASCOW COMA SCORE = E + V + M		

MODIFIED GLASCOW COMA SCALE FOR INFANTS / CHILDREN			
REPNSE	CHILD	INFANT	SCORE
Eye opening	Spontaneous	Spontaneous	4
	To voice	To voice	3
	To Pain	To Pain	2
Verbal Response	No response	No response	1
	Oriented, appropriate	Coos and babbles	5
	Confused	Irritable cries	4
	Inappropriate words	Cries to pain	3
	Incomprehensible words or sounds	Moans to pain	2
Motor response	No response	No Response	1
	Obeys commands	Moves spontaneously and purposefully	6
	Localizes to pain	Withdraws to touch	5
	Flexion response to pain	Flexion response to pain	4
	Extension response to pain	Extension response to pain	3
	No response	No response	1



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CLASSIFICATION OF BURNS

CLASSIFICATION OF BURNS			
DEPTH	CAUSE	SURFACE	SENSATION
First degree	Sun, flash, hot liquid	Red, dry, absence of blisters	Painful
Second Degree (partial thickness) Third	Sun, flash, hot liquid, flame	Red / mottles, swelling, Blisters	Painful
Degree (full thickness)	Flame, Hot liquid object, electric	Pale, white, dry, charred, or leathery	Painless

RULES OF NINE

“RULES OF NINE”			
Adult		Child / Infant	
Region	% TBS	Region	% TBS
Hand /neck	9 %	Head / neck	18 %
Thorax	18 % front 18 % back	Thorax / perineum	18 % front 18 % back
Arm	9 % right 9 % left	Arm	9 % right 9 % left
Leg	18 % right 18 % left	Leg	18 % right 18 % left
Perineum	1 %		
Palm of hand = 1 % TBS			

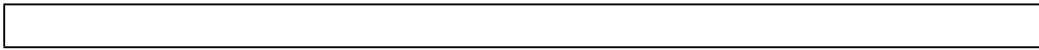
APGAR SCORE

Evaluate the infant with this scale at 1 minute and 5 minute after complete birth.

Parameter	0	1	2
Heart Rate	Absent	< 100 / Minute	> 100 / Minute
Respiratory effort	Absent	Slow, irregular	Good, crying
Muscle tone	Limp	Some flexion	Active motion
Response to irritation	None	Grimace	Withdraws, cries
Color	Blue / Pale	Cyanotic peripherally	Totally pink

NOTES:

1. A respiratory rate of 60-90 is normal in the first few hours of life.
2. Apgar Scores are assessed at 1 minute and at 5 minutes of age:
 - a. < 3 predicts poor neurologic outcome
 - b. If the 5-minute score is < 7, additional scores should be obtained every 5 minutes for a total of 20 minutes.
 - c. The Apgar Score should not be used to determine the need for resuscitation. Resuscitative efforts should be initiated promptly and should not be delayed while the score is obtained.



**NORMAL VITAL SIGNS FOR
PEDIATRIC
PATIENT BY WEIGHT AND
AGE**

Age	Heart Rate	Systolic BP	Respiratory Rate	Weight (kg)
Newborn	100-160	50-70	30-60	3
1-6 weeks	100-160	70-95	30-60	4
6 months	90-120	80-100	24-40	7
1 years	90-120	80-100	20-30	10
3 years	80-120	80-110	18-25	20
10 years	60-90	90-120	15-20	30

DOCUMENTATIO N STANDARD S

AIRWAY

:

Look, listen and feel for air exchange. Document abnormal findings:

A partial airway obstruction due to:

- 1 secretions,
- 2 the tongue,
- 3 blood,
- 4 mucous or edema,
- 5 complete-airway obstruction,
- 6 any trauma induced deformity affecting breathing,
- 7 tracheal deviation.

BREATHING:

Record:

- 1 rate
- 2 depth
- 3 exertion,
- 4 symmetrical chest movements.
- 5 skin and mucous membrane -color,
- 6 breath sounds,
- 7 history -of respiratory-infection in pediatric- patients-with stridor

Abnormal findings:

- 1 Absent respirations
- 2 Absent breath sounds
- 3 Nasal flaring
- 4 Tracheal tugging
- 5 Retraction of intercostal muscles
- 6 Excessive use of diaphragm, neck and/or abdominal muscles
- 7 Cyanosis-(central-or peripheral)
- 8 Irregular or abnormal respiratory patterns (Cheyne-Stokes, central neurogenic hyperventilation (CNH), apneustic, cluster or biots, ataxic, Kussmaul), snoring, Rhonchi, rales, wheezing, stridor
- 9 Asymmetrical or paradoxical chest wall movement Shallow respirations
- 10 Tachypnea, bradypnea

CIRCULATION:

Record:

- 1 Pulse rate, rhythm and quality
- 2 Blood pressure,
- 3 Skin color,
- 4 Temperature,
- 5 Peripheral pulses,
- 6 Status of neck veins,
- 7 Level of consciousness,

Abnormal findings:

- 1 Pulselessness,
- 2 Unresponsiveness,
- 3 Hypotension,
- 4 Hypertension,
- 5 Tachydysrhythmias,
- 6 Bradydysrhythmias or other dysrhythmias with the presence of any hemodynamic compromise. Jugular venous distention

HEMORRHAGE:

Record:

- 1 Size and location of wounds,
- 2 Mechanism of injury,
- 3 Amount of bleeding (arterial or venous),
- 4 Orthostatic; vital signs as required,
- 5 Neurovascular status, distal to- injury

Abnormal findings:

- 1 Bleeding uncontrolled by direct pressure,
- 2 Tachycardia
- 3 Hypotension
- 4 Pallor with cold clammy skin
- 5 Multiple bleeding sites
- 6 Possible intrathoracic
- 7 Intraabdominal, or intracranial bleeding as evidenced-by signs and symptoms

LEVEL OF CONSCIOUSNESS:

Record:

Use the A-V-P-U scale

A = Alert

V = Responds to verbal stimuli

P = Responds to painful stimuli

U = Unresponsive

CHEST PAIN:

Record:

- A-Airway
- B-Breathing
- C-Circulation
- P-Provokes,
- Q-Quality,
- R-Radiation,
- S-Severity,
- T-Time

Abnormal findings:

- Diaphoresis
- Syncope,
- Hypotension,
- Dysrhythmias,
- Dyspnea,
- Jugular venous distension,
- Rales,
- Rhonchi,
- VAmzes,
- Cyanosis,
- Ectopy,
- Peripheral edema

CHEST TRAUMA:

Record:

- A-Airway
- B-Breathing
- C-Circulation
- P-Provokes
- Q-Quality
- R-Radiation
- S-Severity
- T-Time for pain,
- Chest-excursion and symmetry, - signs of bleeding or shock,
- Wounds,
- Tracheal position
- Heart sounds Breath sounds

Abnormal findings:

- Abdominal distension,
- Guarding or rigidity
- Evisceration
- Hypotension with tachydysrhythmias,
- Hematuria,
- Hematemesis
- Penetrating injuries with or without hemorrhage.

ABDOMINAL TRAUMA:

Record:

- A-Airway
- B-Breathing
- C-Circulation,
- P-Provokes,
- Q-Quality,
- R-Radiation,
- S-Severity,
- T-Time for Pain
- Location of penetrating wounds,
- contusions,
- Ecchymosis,
- tenderness,
- signs of bleeding and shock

Abnormal findings:

- Abdominal distension,
- guarding or rigidity,
- Evisceration,
- Hypotension with tachycardia,
- Hematuria, Hematemesis,
- Penetrating injuries with or without hemorrhage.

HEAD AND NECK TRAUMA:

Record:

A-Airway,
B-Breathing
C-Circulation,

Immobilization of the spine,

Location of lacerations contusions

Neurological vital signs:

1. Pupils – size and response
2. Extraocular movement
3. Motor response (document stimulus-and-response)
4. Respiratory effort
5. Level of consciousness
6. Peripheral sensation

Abnormal findings:

Unresponsiveness or decreasing level of consciousness
Drainage of blood or fluid from the nose or ears,
Paralysis
Paresthias,
Airway injury,
Respiratory insufficiency,
Hypotension,
Unequal pupils,
Dilated, constricted, or unresponsive pupils,
Incomplete extraocular movement,
Decorticate or decerbrate posturing,
Asymmetrical motor response,
Abnormal respiratory patterns,
Battles signs,
Raccoon eyes,
History of loss of-consciousness,

EXTREMITIES/BACK/PELVIC INJURIES:

Record:

- A-Airway
- B-Breathing C-
Circulation
- Range of Motion
Including pelvic rock,
Distal pulses, sensory, and motor function before and after
splinting,

Abnormal findings:

- Shortening of limbs
- Deformities
- Ecchymosis
- Bleeding
- Crepitus
- Loss of or decreased distal pulses, sensation, or motor function
- Decreased range of motion
- Localized edema

BURNS:

Record:

A-Airway

B-Breathing

C-Circulation

Type of burn and causative agents,

Time of burn,

Degree and percent body surface area (BSA) involved,

Injury environment,

Level of consciousness.

Abnormal findings:

Facial burns

Singed eyebrows,

Carbonaceous sputum

POISONING:

Record:

- A-Airway
- B-Breathing
- C-Circulation,
- Level of consciousness
- What was taken?
- How much was taken,
- History of psychiatric problems,
- Pupillary responses,,
- Other physical signs and symptoms,
- Patient environment,
- Antidote or emesis

ANAPHYLAXIS/ALLERGIC REACTION:

Record:

A-Airway

B-Breathing

C-Circulation,

History of exposure to allergen,

Presence or absence of cutaneous symptoms,

, *and* breath sounds

Abnormal *findings*:

Rash,

Wheals or wheeps,

Respiratory distress,

Edema

OB/GYN EMERGENCIES:

Record:

- A-Airway
- B-Breathing
- C-Circulation
- Last-menstrual period (LMP) or EDC,
- G-Number of pregnancies,
- T-term (deliveries-36+ weeks),
- P-Number of deliveries,

A-Abortions (deliveries -occurring spontaneously and otherwise less than 20 weeks).

- L-live (five children now),
- History of problems with *pregnancy*,
- Onset of labor,
- Frequency of contractions,
- Rupture of membranes,
- Presenting part (if crowning),

Abnormal findings:

- Presenting part if-other than-head,
- Any vaginal bleeding in pregnancy,
- Meconium- staining with delivery,
- Hypertension with peripheral edema,

SEIZURES:

Record:

A-Airway

B-Breathing

C-Circulation

Level of consciousness

Description of seizures including number of and duration of each

Any history of seizures -or head injury,

Presence of postictal state,

Incontinence,

Current medications,

PSYCHIATRIC DISORDERS:

Record:

A-Airway

B-Breathing

C-Circulation

Description of patient behavior,

History of psychiatric problems,

Any use of psychotropic medications,

Does-patient present a-threat to self and/or others.

DO NOT COPY

CRITICAL INDICATION / SECONDARY SCENE S

Refusal of transport:

Record:

- Vital signs,
- Mental status,
- Patient injuries,
- Obtain signature of patient on appropriate form(s),
- Obtain witness signature of family member(s) and/or law enforcement officials present,
- Document any warnings or advice given to patient,

Dead on the Scene:

Record:

- Notification of medical-control,
- Notification of local justice of-the peace and/or law enforcement officials,

Need for law enforcement:

Record:

- Description of patient behavior,
- Who requested law enforcement (PD, EMS, patient, etc?)

Medication error/Adverse reaction to medication administered:

Record:

- Vital signs-before and after incident
- Any changes in patient condition
- Notification of medical control
- Any orders from medical control,

Complete incident report-and document completion of the incident report on your response record.

Procedure error/Deviation from Protocol not ordered by Medical Control:

Record:

- Vital signs before and after incident,
- Any changes in patient condition,
- Reason for deviation,
- Notification of medical control,

Any orders from medical control,

ATTENDING PHYSICIAN STATEMENT: I am the attending physician of the above-named person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Complete incident report and document completion of the incident- report on your response record.

Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Equipment malfunction.

Record:
Attending physician's signature _____ Date _____ Printed name _____ Lic# _____
Signature of second physician _____ Date _____ Printed name _____ Lic# _____
Type of equipment, Type of malfunction, _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.
Person's signature _____ Guardian/Agent/Proxy/Relative signature _____
Attending physician's signature _____
Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____
Notification-of medical control as indicated.

This document or a copy thereof must accompany the person during his/her medical transport.

OUT-OF-HOSPITAL DO-NOT-RESUSCITATE (OOH-DNR) ORDER TEXAS DEPARTMENT OF STATE HEALTH SERVICES

This document becomes effective immediately on the date of execution for health care professionals acting in out-of-hospital settings. It remains in effect until the person is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort care will be given as needed.

Person's full legal name _____ Date of birth _____ Male Female

A. Declaration of the adult person: I am competent and at least 18 years of age. I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Person's signature _____ Date _____ Printed name _____

B. Declaration by legal guardian, agent or proxy on behalf of the adult person who is incompetent or otherwise incapable of communication:

I am the: legal guardian; agent in a Medical Power of Attorney; OR proxy in a directive to physicians of the above-noted person who is incompetent or otherwise mentally or physically incapable of communication.

Based upon the known desires of the person, or a determination of the best interest of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature _____ Date _____ Printed name _____

C. Declaration by a qualified relative of the adult person who is incompetent or otherwise incapable of communication: I am the above-noted person's:

spouse, adult child, parent, OR nearest living relative, and I am qualified to make this treatment decision under Health and Safety Code §166.088.

To my knowledge the adult person is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent or proxy. Based upon the known desires of the person or a determination of the best interests of the person, I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature _____ Date _____ Printed name _____

D. Declaration by physician based on directive to physicians by a person now incompetent or nonwritten communication to the physician by a competent person: I am the above-noted person's attending physician and have:

seen evidence of his/her previously issued directive to physicians by the adult, now incompetent; OR observed his/her issuance before two witnesses of an OOH-DNR in a nonwritten manner.

I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____

E. Declaration on behalf of the minor person: I am the minor's: parent; legal guardian; OR managing conservator.

A physician has diagnosed the minor as suffering from a terminal or irreversible condition. I direct that none of the following resuscitation measures be initiated or continued for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Signature _____ Date _____
Printed name _____

TWO WITNESSES: (See qualifications on backside.) We have witnessed the above-noted competent adult person or authorized declarant making his/her signature above and, if applicable, the above-noted adult person making an OOH-DNR by nonwritten communication to the attending physician.

Witness 1 signature _____ Date _____ Printed name _____
Witness 2 signature _____ Date _____ Printed name _____

Notary in the State of Texas and County of _____ The above noted person personally appeared before me and signed the above noted declaration on this date: _____

Signature & seal: _____ Notary's printed name: _____ Notary Seal

[Note: Notary cannot acknowledge the witnessing of the person making an OOH-DNR order in a nonwritten manner]

PHYSICIAN'S STATEMENT: I am the attending physician of the above-noted person and have noted the existence of this order in the person's medical records. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Physician's signature _____ Date _____
Printed name _____ License # _____

F. Directive by two physicians on behalf of the adult, who is incompetent or unable to communicate and without guardian, agent, proxy or relative: The person's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgment, considered ineffective or are otherwise not in the best interests of the person. I direct health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue for the person: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation.

Attending physician's signature _____ Date _____ Printed name _____ Lic# _____
Signature of second physician _____ Date _____ Printed name _____ Lic# _____

Physician's electronic or digital signature must meet criteria listed in Health and Safety Code §166.082(c).

All persons who have signed above must sign below, acknowledging that this document has been properly completed.

Person's signature _____ Guardian/Agent/Proxy/Relative signature _____
Attending physician's signature _____ Second physician's signature _____
Witness 1 signature _____ Witness 2 signature _____ Notary's signature _____

This document or a copy thereof must accompany the person during his/her medical transport.

INSTRUCTIONS FOR ISSUING AN OOH-DNR ORDER

PURPOSE: The Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order on reverse side complies with Health and Safety Code (HSC), Chapter 166 for use by qualified persons or their authorized representatives to direct health care professionals to forgo resuscitation attempts and to permit the person to have a natural death with peace and dignity. This Order does NOT affect the provision of other emergency care, including comfort care.

APPLICABILITY: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments.

IMPLEMENTATION: A competent adult person, at least 18 years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:

Section A - If an adult person is competent and at least 18 years of age, he/she will sign and date the Order in Section A.

Section B - If an adult person is incompetent or otherwise mentally or physically incapable of communication and has either a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, the guardian, agent, or proxy may execute the OOH-DNR Order by signing and dating it in Section B. **Section C** - If the adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, or proxy, then a qualified relative may execute the OOH-DNR Order by signing and dating it in Section C.

Section D - If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D.

Section E - If the person is a **minor** (less than 18 years of age), **who has been diagnosed by a physician as suffering from a terminal or irreversible condition**, then the minor's parents, legal guardian, or managing conservator may execute the OOH-DNR Order by signing and dating it in Section E.

Section F - If an adult person is incompetent or otherwise mentally or physically incapable of communication and does not have a guardian, agent, proxy, or available qualified relative to act on his/her behalf, then the attending physician may execute the OOH-DNR Order by signing and dating it in Section F with concurrence of a second physician (signing it in Section F) who is not involved in the treatment of the person or who is not a representative of the ethics or medical committee of the health care facility in which the person is a patient.

In addition, the OOH-DNR Order must be signed and dated by two competent adult witnesses, who have witnessed either the competent adult person making his/her signature in section A, or authorized declarant making his/her signature in either sections B, C, or E, and if applicable, have witnessed a competent adult person making an OOH-DNR Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. Optionally, a competent adult person or authorized declarant may sign the OOH-DNR Order in the presence of a notary public. However, a notary cannot acknowledge witnessing the issuance of an OOH-DNR in a nonwritten manner, which must be observed and only can be acknowledged by two qualified witnesses.

Witness or notary signatures are not required when two physicians execute the OOH-DNR Order in section F. The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

REVOCACTION: An OOH-DNR Order may be revoked at ANY time by the person, person's authorized representative, or physician who executed the order. Revocation can be by verbal communication to responding health care professionals, destruction of the OOH-DNR Order, or removal of all OOH-DNR identification devices from the person.

AUTOMATIC REVOCACTION: An OOH-DNR Order is automatically revoked for a person known to be pregnant or in the case of unnatural or suspicious circumstances.

DEFINITIONS

Attending Physician: A physician, selected by or assigned to a person, with primary responsibility for the person's treatment and care and is licensed by the Texas Medical Board, or is properly credentialed and holds a commission in the uniformed services of the United States and is serving on active duty in this state. [HSC §166.002(12)].

Health Care Professional: Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. [HSC §166.081(5)]

Qualified Relative: A person meeting requirements of HSC §166.088. It states that an adult relative may execute an OOH-DNR Order on behalf of an adult person who has not executed or issued an OOH-DNR Order and is incompetent or otherwise mentally or physically incapable of communication and is without a legal guardian, agent in a medical power of attorney, or proxy in a directive to physicians, and the relative is available from one of the categories in the following priority: 1) person's spouse; 2) person's reasonably available adult children; 3) the person's parents; or, 4) the person's nearest living relative. Such qualified relative may execute an OOH-DNR Order on such described person's behalf.

Qualified Witnesses: Both witnesses must be competent adults, who have witnessed the competent adult person making his/her signature in section A, or person's authorized representatives making his/her signature in either Sections B, C, or E on the OOH-DNR Order, or if applicable, have witnessed the competent adult person making an OOH-DNR by nonwritten communication to the attending physician, who signs in Section D. Optionally, a competent adult person, guardian, agent, proxy, or qualified relative may sign the OOH-DNR Order in the presence of a notary instead of two qualified witnesses. Witness or notary signatures are not required when two physicians execute the order by signing Section F. One of the witnesses must meet the qualifications in HSC §166.003(2), which requires that at least one of the witnesses not: (1) be designated by the person to make a treatment decision; (2) be related to the person by blood or marriage; (3) be entitled to any part of the person's estate after the person's death either under a will or by law; (4) have a claim at the time of the issuance of the OOH-DNR against any part of the person's estate after the person's death; or, (5) be the attending physician; (6) be an employee of the attending physician or (7) an employee of a health care facility in which the person is a patient if the employee is providing direct patient care to the patient or is an officer, director, partner, or business office employee of the health care facility or any parent organization of the health care facility.

Report problems with this form to the Texas Department of State Health Services (DSHS) or order OOH-DNR Order/forms or identification devices at (512) 834-6700.

Declarant's, Witness', Notary's, or Physician's electronic or digital signature must meet criteria outlined in HSC §166.011