WEST VIRGINIA DEPARTMENT OF
HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH
OFFICE OF EMERGENCY MEDICAL SERVICES

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Dear EMS Providers:

It has finally begun. After almost four years of discussion, debate, editing, rewriting, designing, downloading, importing, voting, and consensus building, the First Responder and EMT-B Statewide Protocols are now a reality. This first Statewide Document of Protocols ushers in a new era in cooperation in medical direction that is a landmark in the evolution and advancement of our State's EMS System.

Over the years, I have constantly been asked by providers, administrators, and medical directors, “Why are we all not using the same protocols throughout the state?” My answer has always been, “When the medical direction system determines it to be in the best interest of the patient, and when a process can be developed that insures continued local physician input into the protocol process.” That time has come.

After the State Critical Care Committee unanimously endorsed the development of statewide protocols at all levels, we chose to begin with the EMT-B protocols back in 1996 and then expanded to First Responder and the remaining EMT-B protocols. These two groups of protocols were approved in September 1998 by the State Critical Care Committee, and the tedious and difficult task began of placing them in the final graphic format which would be used for all state protocols thereafter. I believed it was very important for the protocols to have a distinct appearance that was simple, readable, and easily recognized as the “State” protocol. It was also important to have a consistent numbering system for these and future protocols. Please note the numbering system in the contents. Additionally, the logistics of distribution were important. These protocols are available in both hard copy and electronic format.

Please realize that in spite of the countless hours of proofreading and final preparation, the protocols will always remain a dynamic work in progress. I encourage everyone to provide feedback to your local and regional Medical Directors concerning these protocols and future protocols to be developed. Work has already begun on the Paramedic and Critical Care Transport protocols. By working together we can continue this monumental task which has now become a reality.

I would like to personally thank all of the Regional Medical Directors for their support and work on this project, and for their leadership in taking the first step toward statewide protocols. Special thanks must go to Jerry Kyle and the program work unit who have been a driving force in this effort, and to Jim Sowards and Joann Fleming for their tireless effort at rewriting and reformatting to produce as perfect a document as is humanly possible. Lastly and most importantly, I thank all those providers, program directors, and administrators for their unflattering persistence at repeatedly asking me, “Where are the Statewide Protocols???” To them and all of you I say, “Here they are!!”

William D. Ramsey, M.D.
State EMS Medical Director
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## EMT-Basic Treatment Protocols

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Breathing difficulty (often referred to as shortness of breath) can be caused by many different conditions including allergic reactions, pneumonia, chronic lung disease, or cardiac events. It should be considered a life threatening condition. Rapid response to relieve the respiratory distress is critical as a first step. An EMS provider transport service must be contacted for response to provide additional treatment and transfer to an appropriate facility.

A. Call for EMS transport, if not already activated.

B. Maintain airway:
   1. Administer oxygen 15 LPM via non-rebreathing mask.
   2. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.
   3. Be prepared to assist ventilations as needed, with oxygen via mouth to mask.

C. Position of comfort.

D. Monitor vital signs.

E. Transfer patient to the transporting provider.
Early access to the EMS system, CPR and defibrillation have been identified as vital to improving the chances of survival for the patient in cardiac arrest. Rapid access to advanced treatments by prehospital ALS personnel and hospital personnel is critical to the final patient stabilization. An EMS provider transport service must be contacted for response to provide additional treatment and transfer to an appropriate facility.

A. Call for EMS transport, if not already activated.

B. Confirm patient is pulseless and apneic.
   1. Open airway:
      a. Head tilt-chin lift.
      b. Jaw thrust if trauma suspected.
   2. Check breathing; if absent, give 2 breaths.
   3. Check carotid pulse:
      a. If present: Go to F.
      b. If absent: Continue to C.

C. Prepare and apply defibrillator:
   1. Attach monitor leads to electrodes.
   2. Apply electrodes to patient:
      a. Upper right anterior chest touching right border of the sternum.
      b. Lower left rib area in anterior axillary line.
   3. Turn defibrillator on - verify recording mechanism is on.
4. If any significant delay in completing the previous steps, perform CPR until defibrillator is available.

D. Initial Shocks:

1. Analyze rhythm - stop CPR, do not touch patient and stop all patient movement.

2. Initial shock:
   a. “Clear!”, assure that no one is touching the patient.
   b. Deliver shock.

3. Analyze rhythm - shock if needed.

4. Analyze rhythm - shock if needed.

5. Check pulse.

E. If no pulse:

1. Resume CPR for 1 minute.

2. Re-analyze rhythm and stop all patient movement.
   a. Repeat up to 3 additional shocks if needed.
   b. If no shock indicated, continue CPR.

F. If pulse present:

1. Check breathing.
   a. If rate and quality adequate, administer oxygen 15 LPM via non-rebreathing mask.
b. If none or inadequate, ventilate with oxygen via mouth to mask.

2. Check blood pressure.

3. Continuously monitor pulse.

G. Transfer patient to the transporting EMS provider.

**Special Notes:**

1. If after any rhythm analysis, **No Shock** is advised:
   a. Check pulse - CPR or monitor as appropriate.
   b. Check breathing - oxygenate or ventilate as appropriate.

2. If pulse returns at any time, provide appropriate care.
Patients with cardiac emergencies may present with many different signs and symptoms including chest pain and low blood pressure (hypotension).

A. Chest Pain:

Chest pain is a sign that can come from many causes. It should be considered a life threatening condition. An EMS provider transport service must be contacted for response to provide additional treatment and transfer to an appropriate facility.

1. Call for EMS transport, if not already activated.

2. Maintain airway:
   a. Administer oxygen 15 LPM via non-rebreathing mask.
   b. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.
   c. Be prepared to assist ventilations as needed, with oxygen via mouth to mask.


5. Monitor vital signs.

6. Transfer patient to the transporting EMS provider.
B. Hypotension:

Blood pressure (BP) less than 90 systolic: usually associated with chest pain and/or irregular heart beat, shortness of breath, and altered level of consciousness.

1. Call for EMS transport, if not already activated.

2. Maintain airway:
   a. Administer oxygen 15 LPM via non-rebreathing mask.
   b. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.
   c. Be prepared to assist ventilations as needed, with oxygen via mouth to mask.

3. Position with head elevated, no more than 15 degrees.

4. Monitor vital signs.

5. Transfer patient to the transporting EMS provider.
This protocol is for patients with diabetes who present with confusion, unusual behavior or unconsciousness. An EMS provider transport service must be contacted for response to provide additional treatment and transfer to an appropriate facility.

A. Call for EMS transport, if not already activated.

B. Maintain airway:
   1. Administer oxygen 15 LPM via non-rebreathing mask.
   2. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.
   3. Be prepared to assist ventilations as needed, with oxygen via mouth to mask.

C. Monitor vital signs.

D. If patient has a mildly altered level of consciousness but is able to drink liquids without aspirating, give orange juice or a solution that contains sugar.

E. Transfer patient to the transporting EMS provider.
Gathering accurate information regarding the nature of the substance(s) ingested is an important part of the prehospital care for toxic ingestion. For the vast majority of toxic ingestion, no specific antidotes are available. An EMS provider transport service must be contacted for response to provide additional treatment and transfer to an appropriate facility.

A. Call for EMS transport, if not already activated.

B. Maintain airway:
   1. Administer oxygen 15 LPM via non-rebreathing mask.
   2. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.
   3. Be prepared to assist ventilations as needed, with oxygen via mouth to mask.

C. Monitor vital signs.

D. Determine the substance ingested:
   1. What.
   2. When.
   3. How much.
   4. Over what period of time.

E. Contact Medical Command - do not give anything orally unless ordered by Medical Command.

F. If patient is unconscious:
   1. Position on left side.
   2. Watch for vomiting and shock.

G. Transfer patient to the transporting EMS provider.
Shock is a complex syndrome wherein there is insufficient blood flow to supply oxygen and nutrients to the body. Shock may be a result of several mechanisms, including internal or external bleeding or fluid loss from burns, vomiting, diarrhea, dehydration, severe infection and other non-traumatic causes. An EMS provider transport service must be contacted for response to provide additional treatment and transfer to an appropriate facility.

A. Call for EMS transport, if not already activated.

B. Maintain airway:
   1. Insert oral or nasopharyngeal airway as needed.
   2. Administer oxygen 15 LPM via non-rebreathing mask.
   3. Assist ventilations with oxygen via mouth to mask.

C. Control external bleeding.

D. Prevent heat loss.

E. Monitor vital signs.

F. Immobilize as appropriate.

G. Elevate lower extremities.

H. Transfer patient to the transporting EMS provider.
In the severely injured patient, time is of the essence. However, caution must be exercised in stabilizing the cervical spine while executing a rapid extrication. Initial assessment should be performed on the scene. All other procedures must be performed en route to an appropriate facility. An EMS provider transport service must be contacted for response to provide additional treatment and transfer to an appropriate facility.

A. Call for EMS transport, if not already activated.

B. Maintain airway:
   1. Stabilize c-spine and open airway using jaw thrust technique.
   2. Insert oral or nasopharyngeal airway as needed.

C. Breathing:
   1. If adequate, administer oxygen 15 LPM via non-rebreathing mask.
   2. If inadequate, ventilate with oxygen via mouth to mask.

D. Circulation:
   1. Control bleeding.
   2. Assess perfusion status. (Note skin color, temperature, and capillary refill.)

E. Treatment:
   1. Immobilize patient on long spine board with cervical collar.
   2. Monitor vital signs.

F. Transfer patient to the transporting EMS provider.

Special Note:

If full traumatic cardiac arrest, the Protocol #102 (Cardiac Arrest-Adult) should also be used.
EMT-Basic
Treatment Protocols
Allergic reactions are characterized by varying degrees of respiratory distress, wheezing, hypotension, hives, and chest pain. Common causes of allergic reactions are bee stings, insect bites, medications, foods, fumes or chemicals. Symptoms will vary with each patient, therefore, treatment must be tailored to each individual case. This can be a life threatening situation.

A. Maintain airway:
   1. Administer oxygen 15 LPM via non-rebreathing mask.
   2. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.
   3. Assist ventilations with 100% oxygen as needed.

B. Monitor vital signs.

C. If wheezing, respiratory distress and/or shock is present:
   1. Determine if patient has prescribed epinephrine auto-injector (epi-pen) available, if so:
   2. Has patient taken dose recently?
   3. Contact Medical Command.
   4. Assure it is the correct patient/medication/dose/expiration date (if liquid is visible, assure clarity).
      a. Administer pre-loaded injection*, if ordered by Medical Command.
      b. Reassess patient.
   5. Request ALS Backup.

D. Transport, continue treatment en route.

*See auto-injector procedural protocol.
Special Note:

1. Epinephrine should be used with caution in patients greater than 65 years of age or with history of hypertension or cardiac disease.

2. If the patient only has hives and no respiratory distress or shock, the epinephrine may not need to be given. The patient should be monitored for signs of respiratory distress or shock.
A. Maintain airway:
   1. Administer oxygen 15 LPM via non-rebreathing mask.
   2. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.
   3. Be prepared to assist ventilations as needed, with 100% oxygen.

B. Position of comfort.

C. Monitor vital signs.

D. Determine if patient has prescribed inhaler, if so:
   1. Has patient taken dose recently?
   2. Assure correct patient/medication/dose/expiration date.
   3. Contact Medical Command.
      a. Shake inhaler and test spray.
      b. If ordered by Medical Command, administer 1 dose or assist patient to administer dose.
      c. Wait approximately 1 minute and administer second dose.
      d. Reassess patient.

E. Request ALS backup.

F. Transport, continue treatment en route.
Special Note:

1. A very small percentage of COPD patients are on hypoxic drive and high concentrations of oxygen may result in depressed respirations. It is important to continuously monitor the patient’s respiratory rate and adjust oxygen rate or assist respirations as directed by Medical Command.

2. If respiratory distress appears to be caused from an acute allergic reaction, go to protocol #301 (Allergic Reaction).
Prior to arrival at a confirmed or suspected cardiac arrest, call for ALS backup.

A. Confirm patient is pulseless and apneic.
   1. Open airway:
      a. Head tilt-chin lift.
      b. Jaw thrust if trauma suspected.
   2. Check breathing; if absent, give 2 breaths.
   3. Check carotid pulse:
      a. If present: Go to E.
      b. If absent: Continue to B.

B. Prepare and apply defibrillator:
   1. Attach monitor leads to electrodes.
   2. Apply electrodes to patient.
      a. Upper right anterior chest touching right border of the sternum.
      b. Lower left rib area in anterior axillary line.
   3. Turn defibrillator on - verify recording mechanism is on.
   4. If any significant delay in completing the previous steps, perform CPR until defibrillator is available.

C. Initial shocks:
   1. Analyze rhythm - stop CPR, do not touch patient, stop all vehicle and/or patient movement.
2. Initial shock:
   a. “Clear!”, assure that no one is touching patient.
   b. Deliver shock.

3. Analyze rhythm - shock if needed.

4. Analyze rhythm - shock if needed.

5. Check pulse.

D. If no pulse:
   1. Resume CPR for 1 minute.
   2. Re-analyze rhythm, stop all vehicle and/or patient movement.
      a. Repeat up to 3 additional shocks if needed.
      b. If no shock indicated, continue CPR and prepare to transport.

E. If pulse present:
   1. Check breathing:
      a. If rate and quality adequate, administer oxygen 15 LPM via non-rebreathing mask.
      b. If none or inadequate, ventilate with 100% oxygen.
   2. Check blood pressure.
   3. Continuously monitor pulse.
F. Transport:

1. Request ALS backup, if not previously requested.

2. If pulse present:
   a. Insert oral or nasopharyngeal airway as tolerated.
   b. Oxygenation or ventilation as appropriate.
   c. Transport.
   d. Monitor vital signs continuously.
   e. Contact Medical Command.

3. If no pulse present:
   a. Insert oral airway.
   b. Ventilate with 100% oxygen.
   c. Continue CPR.
   d. Transport continuing CPR and oxygenation en route.
   e. Re-analyze rhythm after patient is loaded but prior to departing - repeat up to 3 additional shocks if needed.
   f. Contact Medical Command.
   g. Transport.
   h. Per Medical Command, reanalyze rhythm as needed (will require stopping vehicle).
Special Note:

1. If after any rhythm analysis, **No Shock** is advised:
   a. Check pulse - CPR or monitor as appropriate.
   b. Check breathing - oxygenate or ventilate as appropriate.

2. If pulse returns at any time, provide appropriate care.

3. If shock is indicated on re-analysis en-route:
   a. Deliver 1 shock.
   b. Contact **Medical Command**.
A. Chest pain
   1. Maintain airway:
      a. Administer oxygen 15 LPM via non-rebreathing mask.
      b. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.
      c. Be prepared to assist ventilations as needed.
   2. Position of comfort.
   4. Monitor vital signs.
   5. If patient has any one of the following, then administer four (4) 81 mg chewable baby aspirin unless the patient has an allergy to aspirin:
      a. Male over 25 years or female over 35 years complaining of substernal chest pain, pressure, or discomfort of greater than 15 minutes duration.
      b. Any patient with chest pain and a history of previous MI with recurrence of “similar” symptoms. After administering aspirin, contact Medical Command.
   6. Determine if patient has been prescribed nitroglycerin (NTG), if so:
      a. Has the patient taken NTG recently?
      b. Assure it is the correct patient/medication/dose/expiration date.
      c. Contact Medical Command.
      d. If blood pressure above 100 systolic:
Cardiac Emergencies

i. Administer 1 dose of NTG, if ordered by Medical Command.

ii. Reassess vitals and chest pain.

iii. **If no relief**, may repeat every 3 - 5 minutes as ordered by Medical Command.

e. **Do not administer NTG if blood pressure is less than 100 systolic.**

7. Request ALS backup.

8. Transport, continue treatment en route.

B. Hypotension

BP is less than 90 systolic: usually associated with chest pain and/or irregular heartbeat, S.O.B., and altered level of consciousness (**No** NTG within past 30 minutes).

1. Maintain airway:
   
   a. Administer oxygen 15 LPM via non-rebreathing mask.

   b. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.

   c. Be prepared to assist ventilations as needed, with 100% oxygen.

2. Position with head elevated, no more than 15 degrees.

3. Monitor vital signs.

4. **Do not administer nitroglycerin** (NTG).

5. Contact **Medical Command**.

   This is a true life threatening emergency.

7. Transport, continue treatment en route.

Special note: If patient has respiratory distress with fluid in lungs with crackling or bubbly lung sounds and frothy sputum and respirations are inadequate, assist ventilations with 100% oxygen, positive pressure, even if patient is conscious.
This protocol is for patients with diabetes who present with confusion, unusual behavior or unconsciousness.

A. Maintain airway:
   1. Administer oxygen 15 LPM via non-rebreathing mask.
   2. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.
   3. Be prepared to assist ventilations as needed, with 100% oxygen.

B. Monitor vital signs.

C. Request ALS backup.

D. If gag reflex is present, administer oral glucose:
   1. Administer between cheek and gum or
   2. Smear on inside of cheek with tongue depressor.
   3. If no improvement, may repeat in five minutes.

E. Transport, continue treatment en route.

F. Contact Medical Command and advise that glucose was given.

G. If patient’s mental status has returned to normal, consider canceling ALS backup with approval of Medical Command.
A. Maintain airway:
   1. Administer oxygen 15 LPM via non-rebreathing mask.
   2. If patient cannot tolerate mask, administer oxygen 6 LPM via nasal cannula.
   3. Be prepared to assist ventilations as needed, with 100% oxygen.

B. Monitor vital signs.

C. Determine the substance ingested:
   1. What.
   2. When.
   3. How much.
   4. Over what period of time.

D. Do not give anything orally unless directed by Medical Command.

E. Contact Medical Command.

F. If patient is unconscious, request ALS backup and go to H below.
   If patient is conscious continue to G.

G. Determine patient’s approximate weight. If ordered by Medical Command, orally administer Activated Charcoal Suspension. Dosage* as ordered by Medical Command.

* Special Note: The usual dose of activated charcoal is 1 gram per kilogram. There are 2.2 pounds per kilogram.

H. Position patient on left side, watch for vomiting and shock, treat as needed.

I. Transport, continue treatment en route.
Shock is a complex syndrome wherein there is insufficient blood flow to supply oxygen and nutrients to the body. Shock may be a result of several mechanisms, including internal or external bleeding or fluid loss from burns, vomiting, diarrhea, dehydration, severe infection and other non-traumatic causes.

A. Maintain airway:
   1. Insert oral or nasopharyngeal airway as needed.
   2. Administer oxygen 15 LPM via non-rebreathing mask.
   3. Assist ventilations with 100% oxygen as needed.

B. Control external bleeding.

C. Prevent heat loss.

D. Request ALS backup.

E. Monitor vital signs.

F. Immobilize as appropriate (i.e. trauma).

G. Elevate lower extremities.

H. Begin immediate transport if possible.

I. Apply MAST.

J. Contact Medical Command.

K. If hypotensive (BP < 90 systolic) and ordered by Medical Command, inflate MAST.

L. Transport, continue treatment en route, contact Medical Command.

M. Request ALS backup, if not already done.
Special Note: If an unstable pelvic fracture is suspected, then MAST may be applied and all three compartments inflated only until slight pressure creates a dimple that remains. This is to act as a splint only.
In the severely injured patient, time is of the essence. However, caution must be exercised in stabilizing the cervical spine while executing a rapid extrication. Initial assessment should be performed on the scene. All other procedures must be performed en route to an appropriate facility.

A. Maintain airway:
   1. Stabilize c-spine with jaw thrust.
   2. Insert oral or nasopharyngeal airway as needed.

B. Breathing:
   1. If adequate, administer oxygen 15 LPM via non-rebreathing mask.
   2. If inadequate, ventilate with 100% oxygen via bag-valve-mask.

C. Circulation:
   1. Control bleeding.
   2. Assess perfusion status. (Note skin color, temperature, and capillary refill.)

D. Limit on scene time:
   1. Not entrapped - 10 minutes or less.
   2. Entrapped - within 5 minutes of extrication.

E. Request ALS backup and/or aeromedical transport.

F. Treatment:
   1. Immobilize patient on long spine board.
   2. Transport, continue treatment en route.
3. Apply MAST.

4. Monitor vital signs.

5. Contact Medical Command.

6. If hypotensive (BP < 90 systolic) and ordered by Medical Command, inflate MAST.

7. Request ALS backup, if not already called.

Special Note: If full traumatic cardiac arrest, then Protocol #303 (Cardiac Arrest) should also be used.
A. Conscious:

1. Able to talk or cough:
   a. Reassure victim.
   b. Encourage coughing.
   c. Administer oxygen 15 LPM via non-rebreathing mask.
   d. Transport, continue treatment en route.

2. Unable to talk or cough or weak, ineffective cough:
   a. Deliver repeated abdominal thrusts until obstruction relieved or victim becomes unconscious.
   b. Chest thrusts are preferred in advanced pregnancy and marked obesity.
   c. Immediate transport, continue treatment en route.
   d. Request ALS backup.

B. Unconscious:

1. Open airway.
2. Attempt ventilation.
3. Reposition airway, attempt ventilation.
4. Deliver 5 abdominal thrusts.
5. Finger sweep for foreign body.
6. Repeat abdominal thrusts and finger sweep.

7. If still obstructed, immediate transport - continue steps 3 - 5 en route.

8. Request ALS backup.
Reptile/Insect

General symptoms include swelling and redness around the site, fever, weakness, vomiting, and restlessness. Hypotension and seizures may also occur. Field treatment is mostly supportive in nature.

A. Keep patient calm.

B. Remove all jewelry and clothing on affected extremity.

C. Clean site with sterile water and saline.

D. Immobilize bite area, do not elevate.

E. May use cool compresses on site, do not use ice.

F. Monitor vital signs.

G. Transport, continue treatment en route.

H. If systemic symptoms present, then request ALS backup and treat as per appropriate protocol: i.e. Allergic Reaction - Protocol #301; Breathing Difficulty - Protocol #302, etc.
A. **Hypothermia:**

Generalized body cooling with core (rectal) temperature of 95°F (35°C) or less. All suspected hypothermia patients are candidates for resuscitation unless obvious signs of death are present (i.e. skin sloughing, severe lividity, mortal trauma, etc.)

1. **Moderate Hypothermia**

   Rectal temperature above 90°F with uncontrollable shivering, pale, cold skin:
   
   a. Place patient in warm environment.
   
   b. Remove all wet clothing.
   
   c. Insulate core (head, neck, trunk) with warm blankets or other insulating material.
   
   d. Administer oxygen 15 LPM via non-rebreathing mask - warmed if possible.
   
   e. Monitor vital signs and temperature.
   
   f. Rapid, smooth transport, continue treatment en route.
   
   g. Apply heat packs to neck, chest, and abdominal areas.
   
   h. Contact *Medical Command*.
   
   i. Consider air transport to trauma facility per MCP.
2. **Severe Hypothermia:**

Rectal temperature below 90°F, unconscious, may have inaudible heart sounds, unobtainable blood pressure, non-reactive pupils, weak/absent pulses:

a. Place in warm environment.

b. Handle very gently - cut away wet clothes.

c. Insulate core (head, neck, trunk) with warm blankets or other insulating material.

d. Manually maintain airway - no oral or nasopharyngeal airways:

i. If breathing adequate - administer oxygen 15 LPM via non-rebreathing mask - warmed if possible.

ii. If breathing inadequate - assist with 100% oxygen as needed - do not hyperventilate.

iii. Monitor vital signs and temperature.

iv. If cardiac arrest, administer CPR in 10° head down position.

v. Smooth rapid transport, continue treatment en route.

vi. Consider air transport to trauma facility per MCP.

3. **Localized cold injuries (frostbite):**

Usually extremities and exposed areas (ears, nose, face).

a. Remove from cold environment and protect from further injury.

b. Administer oxygen 15 LPM via non-rebreathing mask - warmed if possible.
c. Remove wet or restrictive clothing and jewelry.

d. Cover with dry dressings.

e. **Do not:**

i. Rub or massage area.

ii. Break blisters.

iii. Apply direct heat.

iv. Allow patient to walk on or use affected area.

v. Re-expose to cold.

f. Transport, continue treatment en route.

g. Contact **Medical Command.**
A. Skin normal to cool and moist:
   1. Remove from hot environment.
   2. Administer oxygen 15 LPM via non-rebreathing mask.
   3. Loosen or remove clothing.
   5. Place supine with legs elevated.
   6. Monitor vital signs.
   7. If responsive - give small amounts of water to drink at frequent intervals.
   8. If unresponsive - transport on left side and contact Medical Command.

B. Skin hot, dry or moist:
   1. Remove from hot environment.
   2. Remove clothing.
   3. Administer oxygen 15 LPM via non-rebreathing mask.
   4. Active cooling - do not overcool:
      a. Cool compresses/packs to neck, groin, armpits.
      b. Wet skin with water on sponge or towels.
   5. Monitor vital signs.
### Environmental Emergencies
#### Heat Exposure

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<tr>
<td>6.</td>
<td>Transport, continue treatment en route.</td>
</tr>
<tr>
<td>7.</td>
<td>Request ALS backup.</td>
</tr>
<tr>
<td>8.</td>
<td>Contact <strong>Medical Command</strong>.</td>
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</tbody>
</table>
A. Drowning/Near Drowning (70°F or greater water temperature):

All near drowning victims need evaluation in a medical facility.

1. Conscious:
   b. Administer oxygen 15 LPM via non-rebreathing mask.
   c. Transport with full spinal immobilization - continue treatment en route.

2. Unconscious:
      i. Suction as needed.
      ii. Insert oral or nasopharyngeal airway as needed.
      iii. Assist ventilations with 100% oxygen as needed.
      iv. If no spontaneous respirations or pulse - administer CPR and follow Cardiac Arrest Protocol #303.

   b. Transport with full spinal immobilization - continue treatment en route.
   c. Request ALS backup.

B. Cold Water Drowning/Near Drowning (less than 70°F water temperature):

1. Maintain airway - stabilize cervical spine.
2. Handle very gently - cut away all wet clothes.
3. Insulate core from cold.
4. Monitor vital signs and temperature.

5. Oxygen:
   a. If breathing adequate - administer oxygen 15 LPM via non-rebreathing mask.
   b. If inadequate or not breathing, assist with 100% oxygen - do not hyperventilate.

6. If no pulse present after 1 minute of checking, administer CPR in 10° head down position, and follow Cardiac Arrest Protocol #303.

7. Smooth, rapid transport with full spinal immobilization.

8. Request ALS backup.

9. Consider aeromedical transport to trauma facility per MCP.
The primary step in burn care is stopping the burning process by removing the victim from the source and removing all clothing, jewelry etc. Assess for respiratory involvement (facial burns, singed facial hair, swollen, sooty or reddened mucous membranes); assume such if patient was in confined space and/or unconscious. Assess for other injuries. Treat in accordance with the extent and severity of the burn.

A. Minor (no critical areas involved):

1. Criteria:
   a. Superficial and partial-thickness burns less than 18% of adult body surface.
   b. Superficial and partial-thickness burns less than 9% of child body surface.
   c. Full-thickness burns less than 2% of body surface.

2. Treatment:
   a. Remove all clothing and/or jewelry.
   b. Cover with clean dressing.
   c. Consider application of cool/moist compress.
   d. Transport, continue treatment en route.

B. Major:

1. Criteria:
   a. All burns of face, neck, hands, feet and genitalia.
   b. All suspected or positive airway involvement.
c. All electrical burns.
d. Any burns greater than 18% of adult’s body surface.
e. Any burns greater than 9% of child’s body surface.
f. Full thickness burns greater than 2% of the body surface.
g. Circumferential burns, especially of the chest and abdomen.
h. Associated injuries and/or underlying medical problems.

2. Treatment:
   a. Maintain airway - stabilize spine as appropriate.
      i. Administer oxygen 15 LPM via non-rebreathing mask.
      ii. Assist ventilation with 100% oxygen as needed.
   b. Remove all clothing and/or jewelry.
   c. Cover with clean dry dressings.
   d. Maintain body heat.
   e. Transport, continue treatment en route.
   f. Contact Medical Command.
   g. Consider ALS backup and/or aeromedical transport to burn center for extensive and/or severe burns.
A. Avoid self contamination by using protective clothing and gloves.

B. Remove the chemical.

C. If dry - brush off the excess.

D. Remove all clothing and/or jewelry.

E. Flush with large amounts of water. (Precaution: certain substances such as heavy metals may cause further burning if flushed with water.) If in doubt about flushing, contact Medical Command for direction.

F. Contact Medical Command.

G. After adequate decontamination at scene, transport and treat en route per Medical Command.

H. Consider ALS backup.
A. Insure victim is not in contact with electrical source - don’t become a victim yourself.

B. Maintain airway - stabilize cervical spine.
   1. Insert oral or nasopharyngeal airway if needed.
   2. Administer oxygen 15 LPM via non-rebreathing mask.
   3. Assist ventilations as needed.

C. Monitor vital signs.

D. If in cardiac arrest, follow appropriate protocol (#303 - Cardiac Arrest).

E. Request ALS backup.

F. Contact Medical Command.

G. Transport with full spinal immobilization - continue treatment en route.

H. Consider aeromedical transport directly to a burn center, as per Medical Command.
A. Total Amputations:

1. Dress remaining part of limb:
   a. Wrap sterile compress dressing, just tight enough to control bleeding.
   b. Do not place clamps on arteries or veins.
   c. If bleeding remains excessive, apply a tourniquet just proximal to the amputation.

2. Care for severed part:
   a. Wrap part in sterile gauze slightly dampened with sterile normal saline.
   b. Place wrapped part in clean plastic bag or waterproof container.
   c. Place water in container large enough to hold severed part.
   d. Add just enough ice to keep the water cold during transport.
   e. Immerse bag containing the severed part into the cold water.

B. Partial amputations:

1. Dress injury with a sterile compress dressing tight enough to control bleeding.
2. If bleeding remains excessive, apply a tourniquet just proximal to the amputation.
3. Splint injured area.
4. Apply ice indirectly to injury site.
C. Transportation:

1. Transport patient and severed part to the nearest appropriate facility.
2. Provide other care per appropriate protocols.
3. Contact Medical Command.
4. Consider aeromedical transport to reimplantation facility per MCP.
Soft Tissue Injuries
Closed/Open Injuries

A. Closed injuries:
   1. Immobilize as appropriate.
   2. Apply cool compress to site.
   3. Transport, continue treatment en route.

B. Open injuries:
   1. Expose wound if hidden beneath clothing.
   2. Control bleeding.
      a. Direct pressure.
      b. Elevation.
      c. Pressure point.
   3. Prevent further contamination.
   4. Apply dressing and bandage securely.
   5. Treat for shock.
   6. Immobilize as appropriate.
   7. Transport, continue treatment en route.
A. Penetrating trauma to globe:
   1. Observe for bleeding and leakage of iris material or clear fluid.
   2. Do not palpitate globe or apply any pressure to the eye.
   3. Shield injured eye.
   4. Stabilize impaled objects in place.
   5. Patch the non-injured eye.
   6. Avoid unnecessary movement. Advise patient not to cough, sneeze or move.
   7. Transport, continue treatment en route.
   8. Contact Medical Command.

B. Ultraviolet light exposure, (i.e., arc welder or sun lamp burns):
   1. Symptoms may be delayed 3 to 10 hours after exposure.
   2. Place cool compresses lightly over both eye lids.
   3. Transport, continue treatment en route.
   4. Contact Medical Command.

C. Sudden, painless loss of vision:
   1. May be due to central retinal artery occlusion, stroke or other embolic event.
2. Administer oxygen 6 LPM via nasal cannula.

3. Transport supine, continue treatment en route.

4. Contact Medical Command.
The goal of BLS treatment is to prevent further deterioration (until definitive care can be provided) by combining appropriate treatment, minimal on scene time, and smooth, rapid transport to an appropriate facility.

A. Conscious:
   1. Maintain airway - stabilize cervical spine.
   2. Administer oxygen 15 LPM via non-rebreathing mask.
   3. Monitor vital signs.
   4. Transport with complete spinal immobilization, continue treatment en route.
   5. Contact Medical Command.

B. Decreased level of consciousness/unconsciousness:
   1. Maintain airway - stabilize cervical spine.
   2. Insert oral or nasopharyngeal airway as tolerated.
   3. Assist ventilations with 100% oxygen at a rate of 24 per minute.
   4. Request ALS backup.
   5. Transport with complete spinal immobilization, continue treatment en route.
   6. Consider aeromedical transport.
   7. Contact Medical Command.
Most seizures are self-limiting and require no specific treatment other than insuring an airway and protecting the patient.

A. Active seizing:
   1. Turn patient to left side if no spinal injury suspected.
   2. Protect from injury, however, do not attempt to restrain seizure activity.
   3. Loosen restrictive clothing.

B. After seizure:
   1. Maintain airway.
      a. Place on left side for airway drainage.
      b. Suction as needed.
      c. Administer oxygen 15 LPM via non-rebreathing mask.
      d. Assist ventilations with 100% oxygen if needed.
   2. Monitor vital signs.
   3. Transport, continue treatment en route.
   4. Request ALS backup if active seizures last more than 3 minutes or patient does not regain consciousness between seizures.
Neurological Emergencies
Spinal Injuries

A. Suspect injury based on mechanism and/or signs and symptoms:
   1. Falls.
   2. Motor vehicle crashes.
   3. Diving/water related incidents.
   4. Penetrating injuries to head, neck, or torso.
   5. Head injuries.
   6. Neck or back pain.
   7. Sensory loss or parasthesia.
   8. Muscular weakness or paralysis.

B. Stabilize cervical spine in neutral position.

C. Assess and treat priority injuries as needed.

D. Assess neck - apply appropriate size rigid cervical collar.

E. If weakness and/or paralysis of extremities evident, administer oxygen 15 LPM via non-rebreathing mask.

F. Immobilize as appropriate for situation.
   1. “KED/XP-1” type device for stable, seated patients.
   2. Long backboard device if patient is accessible.
   3. If patient is in immediate danger or unstable, execute rapid extrication.
## Neurological Emergencies
### Spinal Injuries

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<tr>
<td><strong>G.</strong></td>
<td>Secure to long backboard using head immobilizer and straps or cravats.</td>
</tr>
<tr>
<td><strong>H.</strong></td>
<td>Reassess sensory and motor function.</td>
</tr>
<tr>
<td><strong>I.</strong></td>
<td>If pregnant, tilt entire backboard to left.</td>
</tr>
<tr>
<td><strong>J.</strong></td>
<td>Transport, continue treatment en route.</td>
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</tbody>
</table>
Neurological Emergencies
Stroke

A. Maintain airway:
   1. Administer oxygen 2 LPM via nasal cannula.
   2. If respiratory distress is present:
      a. Insert oral or nasopharyngeal airway as needed.
      b. Administer oxygen 15 LPM via non-rebreathing mask.
      c. Assist ventilations with 100% oxygen as needed.

B. Assess for speech disturbances, facial weakness or paralysis, extremity weakness or paralysis.

C. Monitor vital signs.

D. Contact Medical Command.

E. Consider ALS backup if airway is compromised or patient is unconscious.

F. Transport on left side with head elevated - continue treatment en route.
A. General guidelines:

1. Perform initial assessment.
   a. Manage priority areas (i.e., ABC's, shock, life threatening injuries).
   b. Musculoskeletal injuries are rarely first priority.
   c. Treat all painful, swollen or deformed (PSD) areas as fractures.

2. Determine patient priority status.
   a. Stable patients - splint before transporting.
   b. Unstable patients - immobilize completely on long spine board - load and go.

3. Use bandaging, dressing and splinting device(s) appropriate to the injury.
   a. Visualize injured areas - remove clothing and jewelry.
   b. Check motor, sensory and circulation (MSC) before and after immobilization.
   c. Cover open wounds with dressings prior to immobilization.
   d. Realign PSD extremity if no distal pulse or if required to allow immobilization.
   e. Splint joints above and below PSD site.

B. Pelvic Injuries:

These carry a high risk for serious internal bleeding:

1. Immobilize patient on long board device.
2. Administer oxygen 15 LPM via non-rebreathing mask.

3. If BP less than 90 systolic, contact Medical Command. Apply and inflate MAST per MCP only.

4. Transport, continue treatment en route.

5. MAST may be used as a splint if not inflated beyond 30 mm/Hg.

6. Request ALS backup if hypotensive or tachycardic.

C. Extremity injuries:

1. Support injury site:
   a. Attempt to straighten severely angulated extremities by applying gentle, steady axial traction. **Stop if any resistance is met.**
   b. Splint joint injuries, especially knee and elbow, in position found.

2. Apply appropriate splinting device:
   a. Use traction splint for displaced fractures of the femur.
   b. If appropriate, apply and inflate MAST to 30 mm/Hg only to splint lower extremity fractures.

3. Immobilize one joint above and below site, or if joint injury, the bone above and below site.

4. Elevate extremity.

5. Apply cold pack to site.

6. Transport, continue treatment en route.
A. Approach all apparent behavioral patients carefully and professionally. Assure scene safety.

B. Complete initial assessment.

C. Complete focused history and physical exam if possible.

D. Attempt to calm the patient and bystanders.

E. Do not appear threatening or authoritative.

F. Consider transporting to a facility with an advanced psychiatric unit that is capable of dealing with your patient per Medical Command.

G. Treat any existing trauma and/or medical problems per appropriate protocol.
A. Temperature control

Whether an infant is full-term or premature, avoid “cold stress”:

1. Dry infant quickly.
2. Keep infant as warm as possible at all times - cover head and body with a dry blanket.
3. Turn ambulance heater on high to reduce radiant heat loss.
4. If radiant heat is not available, keep infant in skin-to-skin contact with mother’s body and cover both with warm blankets.
5. Maintain axillary (under the arm) temperature at 97°F. Check temperature every 15 minutes during transport.

B. Airway and breathing:

1. Gently suction mouth and nose with bulb syringe. Continue suctioning intermittently, lay infant on side with the head 2-3 inches lower than the legs.
2. Infant breathing:
   a. Stimulation of infant may be necessary.
   b. Cyanotic:
      i. If respirations and pulse are adequate, administer 100% oxygen via “blow-by”.
      ii. If respirations or pulse are not adequate, ventilate with 100% oxygen via bag mask for 30-60 seconds and reassess.
      iii. If still cyanotic, continue to ventilate at 30-40 times per minute.
3. Infant not breathing: ventilate with infant bag mask, 100% oxygen at a rate of 30 - 40 per minute. Reassess every 30 seconds.

C. Circulation:
1. Normal neonatal heart rate is more than 120 beats per minute.
2. If pulse is less than 100 but adequate breathing (30 times per minute):
   a. Provide 100% oxygen via “blow-by”, reassess every 30 seconds.
   b. If pulse is rising, continue oxygen until pulse is 120.
3. CPR should be started if heart rate drops below 60 beats per minute.

D. Transportation:
1. Assure infant remains warm.
2. Maintain airway and oxygenation.
3. Perform basic cardiac life support (CPR) if needed.
4. Transport to nearest appropriate facility per Medical Command direction.
When assessing pregnant patients, determine history of the pregnancy, including: due date, number of previous pregnancies, number of living children, problems with this and/or prior pregnancies.

A. Vaginal bleeding:
   1. Attempt to determine amount of bleeding.
   2. Administer oxygen 15 LPM via non-rebreathing mask.
   3. Monitor vital signs.
   4. Transport head down, buttocks raised, continue treatment en route.
   5. Place sanitary napkin over vaginal opening, don’t attempt to stop bleeding. Save sanitary napkins for physician exam.
   6. Request ALS backup.

B. Delivery:
   1. Normal:
      a. Determine timing and duration of contractions.
      b. Transport on the left side.
      c. If delivery is imminent, proceed at scene:
         i. Prevent “explosive” delivery by supporting head/perineum.
         ii. Suction baby’s mouth and nose as soon as head is delivered.
         iii. Check for cord around neck.
         iv. Hold and support infant during delivery.
v. Dry infant quickly, cover head, place in skin-to-skin contact with mother, keep both warm.

vi. When cord ceases pulsating, clamp at 7 and 10 inches from navel, cut cord between clamps.

vii. Transport, continue treatment en route per Medical Command.

2. Breech birth:
   a. Allow spontaneous delivery with support of presenting part and perineum until legs and trunk delivered. Then assist head gently.
   b. If head not delivered within 4 minutes, insert one gloved hand into the vagina to form a “V” airway around the infant’s nose and mouth.
   c. Administer oxygen 15 LPM via non-rebreathing mask on mother.
   d. Rapid transport, continue treatment en route.

3. Prolapsed cord or limb presentation:
   a. Rapid transport to appropriate facility, continue treatment en route.
   b. Contact Medical Command.
   c. Administer oxygen 15 LPM via non-rebreathing mask on mother.
   d. Place mother in head down, buttocks raised position.
   e. Insert gloved hand into vagina to push presenting part of baby off the cord to insure continued circulation through the cord. Continue until relieved at the hospital.
   f. Cover the exposed cord with wet sterile towel and a dry sterile towel over that to protect it.
A. Conscious infant/incomplete obstruction:
   1. Deliver 5 back blows.
   2. Deliver 5 chest thrusts.
   3. Repeat sequence of back blows and chest thrusts.
   4. Administer oxygen via “blow-by”.
   5. Transport, continue treatment en route.

B. Unconscious infant/complete obstruction:
   1. Deliver 5 back blows.
   2. Deliver 5 chest thrusts.
   3. Lift tongue and jaw, remove foreign body if seen.
   4. Attempt to ventilate.
   5. If still obstructed, repeat steps 1 - 4.
   6. If still obstructed, immediate transport, continue treatment en route.
   7. Request ALS backup.

C. Conscious child:
   1. Deliver 5 abdominal thrusts.
   2. Check for foreign body expulsion.
   3. Repeat sequence until airway is clear.
D. Unconscious child:

1. Deliver 5 abdominal thrusts.
2. Lift tongue and jaw, remove foreign body if seen.
3. Attempt to ventilate.
4. If still obstructed, repeat steps 1 - 3.
5. If still obstructed, immediate transport, continue treatment en route.
6. Request ALS backup.
Consider causes such as hypoglycemia, poisoning, head injury, hypoxia, and shock.

A. Maintain airway:
   1. Maintain c-spine immobilization if trauma suspected.
   2. Insert oral or nasopharyngeal airway as appropriate.
   3. Suction as needed.

B. Oxygen:
   1. Administer 15 LPM via non-rebreathing mask.
   2. Be prepared to assist ventilations with 100% oxygen as needed.

C. Transport, continue treatment en route.

D. If diabetic history, consider oral glucose per MCP.

E. If patient remains or becomes unconscious, call for ALS backup.
# Pediatric Emergencies

## Bradycardia

A. Maintain airway.

B. Oxygen:
   1. Administer 15 LPM via non-rebreathing mask if tolerated.
   2. Deliver “blow-by” oxygen if mask is not tolerated.

C. Assist ventilations with 100% oxygen via bag valve mask as needed. **Do not wait for child to stop breathing, intervene early!**

D. Transport, continue treatment en route.

E. Request ALS backup.

F. If patient condition continues to deteriorate and/or becomes symptomatic, consider CPR **per MCP**:
   1. If the heart rate is 60 or less.
   2. If the heart rate is 80 or less with adequate airway management.
Cardiac arrest in infants and children is usually a result of a depressed respiratory function resulting in decreased cardiac function. Cardiac arrest can be prevented if respiratory failure, shock and/or cardiac failure are quickly recognized and aggressively treated.

A. Establish pulselessness.

B. Open airway:
   1. Head tilt-chin lift.
   2. Jaw thrust if trauma is suspected.

C. Check breathing: if absent, give 2 breaths.

D. Check pulse, if absent begin compressions.

E. Insert oral airway.

F. Ventilate with 100% oxygen via bag valve mask.

G. Transport, continue treatment en route.

H. Contact Medical Command.

I. Request ALS backup - do not delay transport, meet en route.
Caused by vomiting, diarrhea, poor fluid intake, diabetes, and bleeding.

A. Administer oxygen 15 LPM via non-rebreathing mask.

B. Treat for shock.

C. Transport, continue treatment en route.

D. If decreased level of consciousness, request ALS backup.
Fever is defined as a core temperature above 101.3°F (38°C):

A. Maintain airway - be alert for seizure.

B. Check temperature.

C. Cooling - **do not overcool**.
   1. Passive - remove clothing.
   2. Active - wet towel with tepid water and apply to trunk/head.
   3. **Do not submerge in water, use ice, or rubbing alcohol!**

D. Transport, continue treatment en route.
In all cases, manage airway, breathing and circulation first!

A. Ingested:
   1. Determine substance, amount, and time of ingestion.
   2. Contact Medical Command.
   3. Consider Activated Charcoal, 1 gm/kg per MCP.
   4. Transport, continue treatment en route.

B. Absorbed:
   1. Remove clothing.
   2. Brush any residue off skin.
   3. Decontaminate skin by flushing with water if appropriate.
   4. Transport, continue treatment en route.

C. Inhaled:
   1. Administer oxygen 15 LPM via non-rebreathing mask.
   2. Assist ventilations with 100% oxygen if needed.
   3. Transport, continue treatment en route.
A. Maintain airway - Position of comfort for patient.

B. Oxygen:
   1. Administer oxygen 15 LPM via non-rebreathing mask if tolerated.
   2. Blow-by oxygen if mask is not tolerated.
   3. Assist ventilations with 100% oxygen as needed.

C. Transport, continue treatment en route.

D. If an inhaler is prescribed for patient, administer per MCP.

E. Consider ALS backup.
A. Maintain airway:
   1. Suction as needed.
   2. Administer oxygen 15 LPM via non-rebreathing mask.

B. Position on left side - protect from injury.

C. If seizure is caused by fever, remove excess clothing.

D. If seizure is prolonged or no period of consciousness between seizures:
   1. Transport, continue treatment en route.
   2. Request ALS backup.
A. Maintain airway.

B. Administer oxygen 15 LPM via non-rebreathing mask.

C. Keep warm, elevate legs.

D. Transport, continue treatment en route.

E. If trauma:
   1. Control bleeding.
   2. Immobilize as appropriate.

F. If respirations deteriorate:
   1. Insert oral or nasopharyngeal airway.
   2. Assist ventilations with 100% oxygen.

G. If due to allergic reaction: assist with epi-pen injection if prescribed for patient per MCP.

H. Request ALS backup.
The unexpected, sudden death of a seemingly normal, healthy infant that occurs during sleep with no physical evidence of disease.

A. Begin resuscitation immediately unless rigor mortis, severe lividity, or early tissue breakdown is evident. If any doubt, resuscitate.

B. Note the position and condition of the victim and the surroundings.

C. Use extreme tact and professionalism. Do not let emotions or prejudices interfere with carrying out appropriate patient care or family support.
   1. Do not make judgements concerning the situation.
   2. Do not add to the parent’s sense of guilt or helplessness.
   3. Remember, people react differently to stressful situations.

D. If resuscitation is begun:
   1. Transport, continue treatment en route.
   2. Request ALS backup.
## A. Complete a thorough physical exam.

## B. Provide appropriate emergency medical treatment for all injuries found.

## C. Obtain history from all available sources, including the child, parents/caretaker, and other witnesses.

## D. Use extreme tact and professionalism. Do not let emotions or prejudices interfere with carrying out appropriate patient care.

## E. Sexual abuse:

1. Discourage patient from going to the bathroom.

2. Don’t allow patient to change clothes or wash.

3. Give nothing by mouth.

## F. Transport, continue treatment en route.

## G. Upon arrival at receiving facility, inform staff of findings and/or suspicion. Document your findings thoroughly on the Prehospital Care Record Form.
Guidelines for Normal Pediatric Vital Signs:

<table>
<thead>
<tr>
<th>Group/Age</th>
<th>Pulse Rate</th>
<th>Respiration</th>
<th>Systolic BP</th>
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<tbody>
<tr>
<td>Newborn 1 - 6 wks.</td>
<td>100 - 160</td>
<td>30 - 60</td>
<td>70 - 95</td>
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<tr>
<td>Infants 0 - 6 mo.</td>
<td>90 - 120</td>
<td>25 - 40</td>
<td>80 - 100</td>
</tr>
<tr>
<td>Toddlers 1 - 3</td>
<td>80 - 120</td>
<td>20 - 30</td>
<td>80 - 100</td>
</tr>
<tr>
<td>Preschoolers 3-6</td>
<td>70 - 120</td>
<td>18 - 30</td>
<td>80 - 110</td>
</tr>
<tr>
<td>Schoolagers 6 - 12</td>
<td>70 - 90</td>
<td>18 - 20</td>
<td>90 - 120</td>
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</tbody>
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For use of this protocol, the patient must have a current Glasgow Coma Scale total of 12 or less.

A. Maintain airway:
   1. Insert oral or nasopharyngeal airway as needed.
   2. Administer oxygen 15 LPM via non-rebreathing mask.
   3. Assist ventilations with 100% oxygen as needed.

B. Continue assessment and monitor vital signs.

C. Transport on left side, continue treatment en route.

D. Contact Medical Command.

E. Request ALS backup.

F. If gag reflex present and no signs of stroke, consider oral glucose per MCP:
   1. Administer between cheek and gum.
   2. Smear on inside of cheek with tongue depressor.
   3. Monitor during transport for respiratory depression, seizures, emesis, treat as needed.