REGION 7
Emergency Medical Services Systems

Advocate Christ Medical Center EMS System
Morris EMS System
Presence Saint Mary’s-Kankakee EMS System
Riverside EMS System
Silver Cross EMS System
South Cook County EMS System

EMERGENCY MEDICAL RESPONDER
Standing Medical Orders

REVISED: November 1st, 2016
Effective: January 1st, 2007
These orders are to be used as the prehospital treatment protocols. They are to be followed by all Emergency Medical Responder (EMR) members of the EMS System. We have incorporated evidence-based guidelines with historically proven practices to produce them. While it is impossible to address every possible variation of disease or traumatic injury, these protocols do provide a foundation for treating the vast majority of patients we encounter. Certainly our education, experience, and clinical judgment will assist us as we strive to provide the highest quality prehospital patient care. Deviations from these orders can be made only by the EMS Medical Director or designee.

These orders are to be used in the following situations:

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

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

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EMR
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PROTOCOL SYMBOL KEY

> greater than
>= greater than or equal to
< less than
<= less than or equal to
◇ enter from or exit to another protocol

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

**GENERAL PATIENT ASSESSMENT**

**Initial Assessment:**
1. Circulation (pulse) and hemorrhage control (if indicated)  
2. Airway - Establish and/or maintain an airway (cervical spine control, if indicated)  
3. Breathing - Assist ventilation as required  
4. Disability (Level of Consciousness)  
   • “Alert”  
   • “Verbal” - (responds to verbal stimuli)  
   • “Pain” - (responds to painful stimuli)  
   • “Unresponsive”  
5. Expose and examine (if indicated)

**Focused Assessment:**
1. Vital signs, and where applicable, Glasgow Coma Scoring parameters  
2. Systematic head - to - toe detailed assessment  
3. History of present illness/injury

**INITIAL MEDICAL CARE / ROUTINE CARDIAC CARE**

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

**NOTE:** In a combative or uncooperative patient, the requirement to initiate initial routine medical care, as written, may be altered or waived in favor of rapidly transporting the patient for definitive care. Document the patient's actions or behaviors which interfered with the performance of any assessments and/or interventions.
OUTLINE FOR RADIO REPORT (Transmit using as few words as possible)

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

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

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

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

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

NOTE: When contacting the receiving hospital with a CODE STEMI or CODE STROKE it is acceptable to use an abbreviated radio format announcing CODE STEMI or CODE STROKE when the patient’s condition and attention warrants.
Protocol 3

ADULT RESPIRATORY DISTRESS

Breathing Assessment

- Adequate

  Inadequate

  Consider assist with BVM

- Adequate

  Inadequate

  100% OXYGEN

Chest Assessment

TRANSPORT

For a pediatric patient refer to PEDIATRIC RESPIRATORY DISTRESS PROTOCOL #59

EMERGENCY MEDICAL RESPONDER
consider ILS/ALS mutual aid
**AIRWAY OBSTRUCTION**

**INITIAL MEDICAL CARE**

**Conscious**
- Cannot speak > 1 year *
  
  - 5 abdominal thrusts (or 5 chest thrusts if pregnant or obese)

  - Still cannot speak REPEAT until ... obstruction relieved or unconscious

  - Conscious
  - Unconscious

**TRANSPORT**

**For a Pediatric Patient:** * <1 year, 5 back blows followed by 5 chest thrusts

**Unconscious**

- Only if a foreign body is visible, remove object
  
  - Consider neck injury and use jaw thrust maneuver to open airway. Attempt to ventilate

  - If still obstructed and unconscious
  
  - Perform CPR 30 : 2

  - Every time you open the airway to give breaths (consider neck injury and use jaw thrust maneuver) if you see an object and it can be easily removed, remove the object.

  - Clear the airway if foreign body is visualized and suction

  - Open airway
  
  - Support Ventilation as needed

  - TRANSPORT

  - Still obstructed

  - Attempt forced ventilation

  - If unsuccessful

  - TRANSPORT

**EMERGENCY MEDICAL RESPONDER**

- consider ILS/ALS mutual aid

**Revised 12/01/16**

**EMR**
Protocol 5

PAIN CONTROL

Enter from protocol based on Specific Complaint

Assess Pain Severity

Use combination of Pain Scale, Circumstances, MOI, Injury or Illness severity

EMERGENCY MEDICAL RESPONDER consider ALS Mutual Aid

Allow for position of maximum comfort unless contraindicated

Monitor and Reassess

TRANSPORT

PAIN MEASUREMENT SCALE

0 NO HURT
1 HURTS LITTLE BIT
2 HURTS LITTLE MORE
3 HURTS EVEN MORE
4 WHOLE LOT
5 WHOLE LOT MORE
6 WHOLE LOT EVEN MORE
7 WHOLE LOT EVEN MORE
8 WHOLE LOT EVEN MORE
9 WORST
10 HURTS WORST

No pain Mild Moderate Severe Worst pain imaginable

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ADULT CARDIAC ARREST

Criteria for Death / No Resuscitation
- Decomposition
- Rigor Mortis
- Dependent Lividity
- Injury Incompatible with Life

Do not begin resuscitation
Refer to TRIPLE ZERO / DNR / CRITERIA FOR INITIATION OF CPR PROTOCOL #71

YES

CAB’s
- Begin Continuous CPR Compressions
  - Push Hard (> 2 inches)
  - Push Fast (100-120/min)
- Change Compressors every 2 minutes
  - (Limit changes/pulse checks < 5 seconds)

NO

AED (if available)

Shockable Rhythm

NO
- Continue CPR
  - 2 Minutes
  - Repeat and Reassess

YES
- Shock Delivery
  - Continue CPR
  - 2 Minutes
  - Repeat and Reassess

Support ventilation as needed
- Consider assist with BVM
- 100% OXYGEN

TRANSPORT

AT ANY TIME
- Return of Spontaneous Circulation
- Continue CAB monitoring and support

EMERGENCY MEDICAL RESPONDER
consider ILS/ALS mutual aid

For a pediatric patient refer to PEDIATRIC CARDIAC ARREST PROTOCOL #56

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ADULT CARDIOGENIC SHOCK

INITIAL MEDICAL CARE

NOTE TO PREHOSPITAL PROVIDERS:
If patient is in or develops respiratory distress despite treatment, Refer to ADULT RESPIRATORY DISTRESS PROTOCOL #3 as indicated

INITIATE RAPID TRANSPORT

For a pediatric patient refer to PEDIATRIC SHOCK PROTOCOL #61
Protocol 8

ADULT VENTRICULAR FIBRILLATION / PULSELESS VENTRICULAR TACHYCARDIA

Refer to

ADULT CARDIAC ARREST PROTOCOL #6

For a pediatric patient refer to PEDIATRIC CARDIAC ARREST PROTOCOL #56
INITIAL MEDICAL CARE

RAPID TRANSPORT

For a pediatric patient refer to PEDIATRIC TACHYCARDIA PROTOCOL #58
DO NOT TREAT ASYMPTOMATIC VENTRICULAR ECTOPY WITHOUT CONTACTING MEDICAL CONTROL
ADULT PULSELESS ELECTRICAL ACTIVITY (PEA) /ASYSTOLE

Refer to

ADULT CARDIAC ARREST PROTOCOL #6

For a pediatric patient refer to PEDIATRIC CARDIAC ARREST PROTOCOL #56
Protocol 12

ADULT BRADYCARDIA (PULSE < 60)

INITIAL MEDICAL CARE

Monitor continuously enroute. Reassess and recheck vital signs

Rapid TRANSPORT
Continue IMC enroute.

For a pediatric patient refer to PEDIATRIC BRADYCARDIA PROTOCOL #57

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Protocol 13

ADULT SUSPECTED CARDIAC PATIENT

1. INITIAL MEDICAL CARE

2. OXYGEN 15L NRB
   - Monitor continuously enroute.
   - Reassess and recheck vital signs

3. RAPID TRANSPORT
Protocol 14

ADULT PULMONARY EDEMA DUE TO HEART FAILURE

INITIAL MEDICAL CARE

OXYGEN 15L NRB

Monitor continuously enroute. Reassess and recheck vital signs

TRANSPORT

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Protocol 15

VENTRICULAR ASSIST DEVICES (VAD/LVAD)

INITIAL MEDICAL CARE

Treat non-VAD related conditions per usual protocol.
Transport to hospital where VAD was placed if at all possible.
Notify Medical Control

Signs or Symptoms of possible device malfunction or failure

YES

DURING TRANSPORT
determine type of device and assess any alarms
CALL VAD COORDINATOR
and DISCUSS PLAN WITH CAREGIVERS
Consider: change device batteries, reconnect cables

Continuous Flow Device
Auscultate chest for whirring mechanical pump sound.
Assess patient for hypoperfusion: altered mental status, pallor, diaphoresis
Consider CPR If no pump sound, no pulse or blood pressure, and signs of hypoperfusion

Pulsatile Flow Device
Measure pulse and blood pressure. If no pulse or blood pressure, providers should use the device’s HAND PUMP to maintain perfusion

Problem with Circulation, Perfusion, SYMPTOMATIC Dysrhythmia not at patient’s baseline, any other problems

NO

YES

Refer to appropriate protocol
Treat as per usual protocol, AND CALL VAD COORDINATOR and DISCUSS PLAN WITH CAREGIVERS
**Transport**
- Transport directly to the nearest Level I Trauma Center if transport time is less than 25 minutes.
- Transport to the nearest Level II Trauma Center if transport time is less than 30 minutes.
- Transport to the nearest Emergency Department if transport time is greater than 30 minutes.

### FIELD TRIAGE CATEGORY I

**Sustained hypotension** - B/P ≤ 90 systolic on two consecutive measurements five minutes apart. (For Peds hypotension see Peds VS below)

- Cavity penetration of the torso or neck

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

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

- Blunt or penetrating trauma with unstable vital signs and/or:
  - Hemodynamic compromise as evidenced by:
    - Adult B/P: ≤ 90 systolic
    - Peds: 0 – 5 mos of age: Sys BP < 60 mmHg
    - 6 mos – 5 yrs: Sys BP < 70 mmHg, HR < 70
    - > 6yrs: Sys BP < 80 mmHg, HR < 60
  - Respiratory compromise as evidenced by: respiratory rate <10 OR >29
  - Head injury with altered mentation as evidenced by a GCs ≤ 10.

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

**All patients who, in the judgment of the prehospital personnel, would benefit from the care derived at a Trauma Center- those conditions which may be considered for direct bypass to a Trauma Center may include:**
- Head Injury with persistent unconsciousness or focal signs such as seizures, posturing or the inability to respond to simple commands.
- Transmediastinal gunshot wounds
- Spinal cord injury with paralysis
- Maternal trauma with significant mechanism and/or obvious trauma at 20-32 weeks gestation.
- Pediatric trauma including blunt or penetrating head, chest or abdominal trauma.
A standard procedure for assessing revised trauma scores in the field is necessary so that the reliability of that revised trauma score is recognized by both field personnel and emergency department personnel.

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

1. Respiratory rate
2. Systolic blood pressure
3. Glasgow coma scale

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

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

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

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

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

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

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

The components necessary to calculate the Revised Trauma Score and Glasgow Coma Scale will be obtained by prehospital personnel. The actual calculation of these scores will be performed by Medical Control. These scores are to be obtained when the need for transport to a trauma center is questionable.
1. Prehospital providers shall always assess the scene to assure the safety of all personnel.
2. Patient care and treatment begins at the scene.
3. Prehospital personnel shall take all reasonable precautions to prevent exposure to blood
   and/or body fluids of any patient. Use fluid repellent gloves, gowns, masks and goggles, as situation dictates.

**PRIMARY PATIENT ASSESSMENT**

1. **ESTABLISH LEVEL OF RESPONSIVENESS**
   - Brief history: Any dyspnea or pain?
2. **IMMOBILIZE C-SPINE**
   - Manual immobilization initially
   - Rigid collar, Cervical Immobilization Device, and backboard as indicated prior to transport (Refer to CERVICAL SPINE INJURY PROTOCOL #20)
3. **CIRCULATION** (Refer to the ADULT HEMORRHAGIC SHOCK PROTOCOL #19 or the PEDIATRIC SHOCK PROTOCOL #60)
   - Life threatening hemorrhage - STOP THE BLEEDING.
     For uncontrolled hemorrhage, consider use of a hemostatic agent.
   - Peripheral pulses (weak, thready, absent)
   - Capillary refill (if delayed)
4. **CHECK THE NECK**
   - Carotid pulses
     If absent: CPR, minimize scene time (Refer to TRAUMATIC CARDIOPULMONARY ARREST PROTOCOL #22)
   - Tracheal deviation (Refer to CHEST TRAUMA PROTOCOL #28)
   - JVD (Refer to CHEST TRAUMA PROTOCOL #28)
5. **AIRWAY** (If obstructed Refer to AIRWAY OBSTRUCTION PROTOCOL #4)
   - Open or secure as needed
6. **BREATHING** (Refer to CHEST TRAUMA PROTOCOL #28 and either the ADULT RESPIRATORY DISTRESS PROTOCOL #3 or the PEDIATRIC RESPIRATORY DISTRESS PROTOCOL #59)
   - ASSIST VENTILATION AS REQUIRED
   - Inspect the chest
   - Palpate the chest
   - Auscultate the chest (including the heart)
7. **NEUROLOGIC DEFICIT** (Refer to HEAD TRAUMA / UNCONSCIOUS PATIENT PROTOCOL #21)
   - AVPU
   - Motor & Sensory
   - Pupils
SECONDARY PATIENT ASSESSMENT

1. Vital Signs
2. GCS scoring parameters
3. Systematic head to toe assessment
4. Medications
5. Allergies
6. Reassure patient, provide comfort and loosen tight clothing
7. Evaluate cardiac rhythm, if indicated. (All ALS patients do not necessarily require continuous ECG monitoring or transmission of a strip to the hospital.)
8. Contact hospital as soon as patient’s condition permits. Transmit assessment information and await orders.
   If no radio contact can be established or patient’s condition requires immediate treatment, refer to appropriate protocol and begin intervention immediately.
9. Recheck vitals and other pertinent signs and symptoms at least every 15 minutes and record, noting times.
   If unstable vital signs/sustained hypotension (SBP <90 on two separate readings 5 minutes apart), vital signs should be taken and recorded every 5 minutes.
10. All patients, who, in the judgment of prehospital personnel, would benefit from care derived from a Trauma Center, should be transported accordingly (Refer to FIELD TRIAGE PROTOCOLS #16).

If unable to ventilate, transport to nearest hospital.

NOTE TO PREHOSPITAL PROVIDERS:

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

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

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

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EMR
TRIUMA

Protocol 19

ADULT HEMORRHAGIC SHOCK

ROUTINE TRAUMA CARE WITH 100% OXYGEN

Circulatory Assessment

Control external hemorrhage if present
Consider use of a hemostatic agent
(if available)

Shock position

ACCELERATED TRANSPORT

For a pediatric patient refer to PEDIATRIC SHOCK PROTOCOL #61

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 Protocol 20

CERVICAL SPINE INJURY

Mechanism:
Suspected Deceleration Injuries,
Motor Vehicle Crashes, Falls, etc.

Spine pain/tenderness or
complaint of neck/spine pain

NO

Physical findings suggesting neck injury

NO

Other painful injury identified (distracting Injury)

NO

Decreased or altered level of consciousness

NO

Motor/Sensory Exam

Abnormal?

Patient is

• Calm
• Cooperative
• Alert
• Ambulatory without pain
• No apparent distress
• No suspected intoxication

Reliable patient exam

NO IMMobilIZATION NEEDED

• Having an acute stress reaction
• Suspected of being intoxicated
• Have symptoms of brain injury
• Acting inappropriately
• Having difficulty communicating, such as, speaks a foreign language, deaf, etc.

CERVICAL MMOBILIZATION

Revised 12/01/16
EMR
100% OXYGEN
• Assist ventilations as needed
• Vomiting precautions
• Immobilize C-spine
• Routine Trauma Care

ALERT?
YES
TRANSPORT

NO
UNRESPONSIVE TO VOICE AND PAIN

• Pupil(s) dilated
• Signs of increased intracranial pressure and/or
• Glasgow Coma Score 8 or less

EMERGENCY MEDICAL RESPONDER
Consider ALS Mutual Aid

ACCELERATED TRANSPORT

NOTE TO PREHOSPITAL PROVIDERS:
If unequal or fixed pupils and/or posturing, ventilate at 20 breaths/min.
Confirm Arrest

YES

CPR

Maintain C-Spine in neutral position

Secure airway

Ventilate with 100% OXYGEN

ACCELERATED TRANSPORT

NO

Routine Trauma Care
INITIAL TRAUMA CARE
(CABs always take priority over the severed part)

Control bleeding with direct pressure and elevation

For uncontrolled hemorrhage:
• Consider use of a hemostatic agent
• Use a tourniquet if needed
  • Note time of placement
  • Apply as close to the injury as possible
  • DO NOT release once applied

Refer to ADULT PAIN CONTROL PROTOCOL #5

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

Transport part to hospital with patient

TRANSPORT
TRAUMA

Protocol 24

ADULT CRUSH INJURY

Suspected in extended entrapment of extremity and/or torso

EMERGENCY MEDICAL RESPONDER
STRONGLY CONSIDER ALS MUTUAL AID (if available)

Check for:
- Pain
- Paresthesia
- Paralysis
- Pallor
- Pulselessness

Not needed but good indicators

INITIAL MEDICAL CARE

TRANSPORT
Suspension trauma is a term used to describe the condition where a person is trapped in an upright position while using a safety harness for fall protection.

Check for:
- Pain
- Paresthesia
- Paralysis
- Pallor
- Pulselessness

Not needed but good indicators

INITIAL MEDICAL CARE

W-position
AIRWAY AS NEEDED
Do NOT allow the patient to lie flat or stand up

Provide oxygen at 100% for all patients

Manually stabilize the C-Spine via all possible means (KED), but do not lie the patient flat

FULLY CONSCIOUS and MOBILE:
Place patient in a safe position which is, sitting upright with the legs bent at the waist (‘W-position’) for 30 minutes

TRANSPORT

Transport patient, in sitting position, to nearest hospital unless in arrest

Revised 12/01/16
Certain situations require treatment within minutes.

These situations occur when a problem is discovered in the primary survey that cannot be rapidly resolved by field intervention.

Only airway and cervical spinal immobilization should be managed prior to transport.

Further efforts at stabilization should be performed enroute and should not delay transport.

If circumstances demand hospital care for patient stability, rapid transport is indicated.

Each case will be unique and compelling reasons must be documented.

Notify the receiving hospital of the situation so that preparations can be made.

Primary resuscitative measures must be initiated.

Establish contact with Medical Control as soon as possible.
Burn patients are often victims of multiple trauma. Treatment of major traumatic injuries takes precedence over wound management. Isolated burn injury patients should be transferred to the closest available hospital.

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

**THERMAL**
- Initial Trauma Care
  - Oxygen 100% Use humidified Oxygen, (if available). Note presence of hoarseness, wheezing, stridor or productive cough and document. If present, refer to ACCELERATED TRANSPORT PROTOCOL #26.
  - Note quality of distal pulse in extremity burns and document.
  - Burn Wound Care - Moderate to Critical Burn
    - Wear sterile gloves and mask until burn wounds are covered. Remove clothing, jewelry, etc. Do not pull away clothing that is stuck to burn wound.
    - Cover burn wound with sterile dressing. DO NOT BREAK BLISTERS. DO NOT APPLY CREAMS, OINTMENTS OR ANTIDOTES TO BURNS.
    - Open sterile sheet on stretcher before placing patient for TRANSPORT. Cover patient with dry, sterile sheets and blanket to maintain body temperature.

**CHEMICAL**
- Initial Trauma Care
  - Brush off excess dry chemicals
  - Irrigate or flush with copious amounts of water or saline unless contraindicated.
  - For eye exposures Refer to HAZARDOUS MATERIALS-EYE PROTOCOL #44
  - Follow routine Burn Wound Care
    - TRANSPORT

**ELECTRICAL**
- Initial Trauma Care
  - Without placing self at risk for injury, remove patient from source of electricity or have power cut off.
  - Immobilization (as indicated) Refer to CERVICAL SPINE INJURY PROTOCOL #23
  - Apply monitor and treat dysrhythmias per appropriate protocol.
  - Burn Wound Care
    - Assess for entry and exit wounds and neurovascular status of affected parts.
    - No cooling necessary
    - Cover with dry, sterile dressings
    - TRANSPORT

For a pediatric patient refer to PEDIATRIC BURNS PROTOCOL #33.
Chest Assessment

- Sucking Chest Wound?
  - Partially Occlusive Dressing
    - Reassess

- Flail Chest?
  - Assure Adequate Ventilation
    - Reassess

- Tension Pneumothorax?

  - Massive Hemothorax?
    - ACCELERATED TRANSPORT

  - Pericardial Tamponade?
    - Refer to ADULT HEMORRHAGIC SHOCK PROTOCOL #19

TRANSPORT
Principles of Management

Routine Trauma Care

Check externally for uterine contractions

Check externally for vaginal bleeding

Unless spinal injury is suspected, transport the patient on her left side to minimize uterine compression of the inferior vena cava

If a patient with suspected spinal injury becomes hypotensive while supine on backboard, elevate right side of backboard to relieve pressure on vena cava from uterus

Manually displace the uterus to the left side during CPR
Protocol 30
INITIAL MANAGEMENT OF THE PEDIATRIC TRAUMA PATIENT

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

Refer to HEAD TRAUMA / UNCONSCIOUS PATIENT PROTOCOL #21 as indicated

ventilation, respiratory effort

Adequate
Control hemorrhage
Pulse oximetry
Reassess perfusion

ventilation, respiratory effort
Inadequate

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

Normal perfusion
Hypoperfusion

Splint/immobilize fracture(s) as indicated

- Support CABs
- Keep warm
- Observe
- TRANSPORT

Refer to PEDIATRIC SHOCK PROTOCOL #61 OR PEDIATRIC CARDIAC ARREST PROTOCOL #56 as indicated

NOTE TO PREHOSPITAL PROVIDERS:
* Refer to PEDIATRIC ASSESSMENT AND TRAUMA SCORE PROTOCOL #35

Revised 12/01/16
EMR
Routine Trauma Care

1. Circulation
   1. Note variation of normal values

2. Airway
   - Keep suction available
   - Cervical spine immobilization

3. Breathing
   1. Note changes in ventilation rates by age
   2. 100% OXYGEN
   3. Assist ventilations as needed

Treatment of suspected child abuse or neglect:
(Refer to SUSPECTED CHILD ABUSE AND NEGLECT PROTOCOL #69)

1. Treat obvious injuries

2. If parents refuse to let you transport the child after treatment:
   1. Remain at the scene
   2. Call for police assistance
   3. Request that the officer place the child under protective custody
   4. Assist with transport

3. You are required by law to report your suspicions to the Department of Children and Family Services (DCFS). Also, document and report your suspicions to the ED physician and/or charge nurse.

4. Carefully document history, physical findings and environmental surroundings on patient care report.
Indicators of hypoperfusion:
- Respiratory difficulty
- Cyanosis despite oxygen administration
- Truncal pallor/cyanosis and coolness
- Hypotension (ominous sign)
- Bradycardia (late sign)
- Weak, thready, or absent peripheral pulses
- Decreasing consciousness
- No palpable blood pressure

Pediatric vital signs:

<table>
<thead>
<tr>
<th>Component</th>
<th>Newborn</th>
<th>1 year</th>
<th>3 years</th>
<th>6 years</th>
<th>10 years</th>
<th>15 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse</td>
<td>100-160</td>
<td>90 - 120</td>
<td>80 - 120</td>
<td>70 - 110</td>
<td>60 - 90</td>
<td>60 - 90</td>
</tr>
<tr>
<td>Respiration</td>
<td>30- 60</td>
<td>20 - 30</td>
<td>20 - 30</td>
<td>18 - 25</td>
<td>15 - 20</td>
<td>15 - 18</td>
</tr>
<tr>
<td>Systolic BP</td>
<td>50- 90</td>
<td>80 - 100</td>
<td>80 - 110</td>
<td>80 - 110</td>
<td>90 - 120</td>
<td>100 - 130</td>
</tr>
</tbody>
</table>

Pediatric Trauma Score*:

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

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

TOTAL POINTS
(Total points range from -6 to +12)
Protocol 33

PEDiatric BURNS: THERMAL, ELECTRICAL, CHEMICAL

- Assess scene safety, wear BSI, remove patient to safety
- Assess CABs
- Administer 100% OXYGEN
- Complete initial assessment assessing for:
  - wheezing
  - retractions
  - stridor
  - diminished respirations or apnea
  - tachypnea
  - grunting
  - decreasing consciousness
- Refer to INITIAL MANAGEMENT OF THE PEDIATRIC TRAUMA PATIENT PROTOCOL #30
- Assess percentage/depth of burn
- Remove constricting jewelry and clothes.

**Estimating % of Body Surface Area**

<table>
<thead>
<tr>
<th>Body Area</th>
<th>Age in Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-1</td>
</tr>
<tr>
<td>Head</td>
<td>19%</td>
</tr>
<tr>
<td>Neck</td>
<td>2%</td>
</tr>
<tr>
<td>Chest or Back</td>
<td>13%</td>
</tr>
<tr>
<td>(each)</td>
<td></td>
</tr>
<tr>
<td>Buttock (each)</td>
<td>2.5%</td>
</tr>
<tr>
<td>Genitalia</td>
<td>1%</td>
</tr>
<tr>
<td>Upper Arm (each)</td>
<td>4%</td>
</tr>
<tr>
<td>Lower Arm (each)</td>
<td>3%</td>
</tr>
<tr>
<td>Hand (each)</td>
<td>2.5%</td>
</tr>
<tr>
<td>Thigh (each)</td>
<td>5.5%</td>
</tr>
<tr>
<td>Lower leg (each)</td>
<td>5%</td>
</tr>
<tr>
<td>Foot (each)</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

**THERMAL BURNS**

- Superficial (1st degree)
  - Cover burn wound with dry sterile dressing.

- Partial or Full thickness (2nd or 3rd degree)
  - Wear sterile gloves/mask while burn areas are exposed
  - Cover burn wound with DRY sterile dressings
  - Replace patient on clean sheet on stretcher and cover patient with dry clean sheets and blanket to maintain body temperature.

- Refer to PEDIATRIC SHOCK PROTOCOL #61 as indicated

**ELECTRICAL BURNS**

- Immobilize as indicated
- Identify and document any entrance and exit wounds
- Assess neurovascular status of the affected part
- Cover wounds with dry sterile dressings
- Support CABs
  - Observe
  - Keep warm
  - TRANSPORT

**CHEMICAL BURNS**

- Refer to PEDIATRIC TOXIC EXPOSURE/INGESTIONS PROTOCOL #65
- If powdered chemical, brush away excess
- Remove clothing if possible
- Rapid visual acuity
- If eye involvement, irrigate with saline or sterile water continuously.

DO NOT CONTAMINATE THE UNINJURED EYE WITH IRRIGATION

- Irrigate area with copious amounts of sterile water or saline ASAP and during transport

**SPECIAL CONSIDERATIONS:**

- Assess for potential child abuse and refer to SUSPECTED CHILD ABUSE AND NEGLECT PROTOCOL #69
- Keep the child warm and protect from hypothermia.
- Pulse oximetry

---

**Estimated Body Surface Area**

- Head and neck (21%)
- Abdomen (13%)
- Back (13%)
- Buttocks (5%)
- Each leg (13.5%)
- Genital area (1%)
INITIAL MEDICAL CARE

TRANSPORT IMMEDIATELY
DO ALL TREATMENT ENROUTE

OXYGEN at 2-6l/min
If severe respiratory distress or cyanosis is present then administer OXYGEN at 15L NRB

Continue
RAPID TRANSPORT

For a pediatric patient refer to PEDIATRIC RESPIRATORY DISTRESS PROTOCOL #59
INITIAL MEDICAL CARE

If swelling is increasing rapidly, apply a tourniquet proximal to injection site or insect bite.

Ventilate with **100% OXYGEN** as necessary

Maintain airway

RAPID TRANSPORT

For a pediatric patient refer to **PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS PROTOCOL #62**
Obtain blood glucose level reading, (if available)

If patient is awake and gag reflex intact, administer small amounts of **ORAL GLUCOSE PO**

**TRANSPORT**
Protocol 37

ADULT DRUG OVERDOSE
ALCOHOL RELATED EMERGENCIES
POISONING

INITIAL MEDICAL CARE

Obtain Blood Glucose Reading, (if available)

If suspected narcotic or synthetic narcotic overdose and respiratory rate <12
Consider NALOXONE (Narcan) (if available) 2mg IN

If altered level of consciousness and cause unknown
OR if blood sugar level <60:

Administer small amounts of ORAL GLUCOSE PO
(if patient’s gag reflex is intact)

TRANSPORT
Protocol 38

ADULT COMA OF UNKNOWN ORIGIN (NO HISTORY OF TRAUMA)

INITIAL MEDICAL CARE

Assess level of consciousness using Glasgow Coma Scale

Obtain Blood Glucose Reading

If blood sugar level <60
  Administer small amounts of ORAL GLUCOSE PO (if patient’s gag reflex is intact)

If respiratory rate <12
  Consider NALOXONE (Narcan) (if available) 2mg IN

Monitor neuro status, vital signs, ECG and transport patient secured to backboard.
  Protect airway - be prepared to suction if no gag reflex present.

RAPID TRANSPORT
INITIAL MEDICAL CARE

Protect patient from injury
Protect patient airway

Obtain Blood Glucose Reading
If blood sugar level <60
Administer small amounts of **ORAL GLUCOSE PO**
if patient’s gag reflex is intact

EMERGENCY MEDICAL RESPONDER
consider ALS Mutual Aid

TRANSPORT

For a pediatric patient refer to **PEDIATRIC SEIZURES PROTOCOL #63**
INITIAL MEDICAL CARE

HEAT CRAMPS OR TETANY
- Allow for oral intake of water or electrolyte replacement fluids
- Move patient to a cool environment, do not massage cramped muscles

HEAT STROKE
- Move patient to a cool environment
- Place patient in semi-reclining position with head elevated. Take seizure precautions.
- Increase OXYGEN to 100%
- Initiate rapid cooling:
  1. Remove as much clothing as possible.
  2. Cool packs to lateral chest wall, groin, axilla, carotid arteries, temples, and behind knees and/or sponge with cool water or cover with wet sheet and fan the body.

HEAT EXHAUSTION OR SYNCOPE
- Move patient to a cool environment
- Place in supine position with feet elevated
- Remove as much clothing as possible to facilitate cooling

TRANSPORT

For a pediatric patient refer to PEDIATRIC HEAT EMERGENCIES PROTOCOL #66
**Systemic Hypothermia**

Mild/Moderate 93.2 - 86 F (34-30 C)
- Conscious
- OR
- Altered sensorium with shivering

Rewarm patient:
- Place patient in a warm environment.
- Remove wet clothing.
- Apply hot packs wrapped in towels to axilla, groin, neck, thorax.
- Wrap patient in blankets.

**Severe Hypothermia**

86 F or less (<30 C):
- HANDLE PATIENT VERY GENTLY TO AVOID PRECIPITATING V-FIB.
- Patient may appear uncoordinated with poor muscle control, or stiff simulating rigor mortis.
- There will be NO SHIVERING.
- Level of consciousness may be confused, lethargic and/or withdrawn
- Coma

**Frostbite**

Move patient to a warm environment as soon as possible

- Handle skin like a burn
- Protect with light sterile dressings
- Do not let skin rub on skin (between fingers or toes).

Cover patient and prevent re-exposure.

**TRANSPORT**

**OXYGEN 12-15 L/mask**

**OXYGEN 100% enroute**

Do not hyperventilate

---

**NOTE TO PREHOSPITAL PROVIDERS:**
Assess pulse for 30-45 seconds before beginning CPR.
Begin CPR only if pulseless and not breathing.
Apply AED (if available). May attempt defibrillation x 1

For a pediatric patient refer to **PEDIATRIC COLD EMERGENCIES PROTOCOL #67**
**Cincinnati Prehospital Stroke Scale**

**Facial Droop** (Have the patient show teeth or smile)
- Normal – Both sides of face move equally well
- Abnormal – One side of face does not move as well as the other side

**Arm Drift** (Patient closes eyes and holds both arms straight out for 10 seconds)
- Normal – Both arms move the same or both arms do not move at all (other findings, such as pronator grip, may be helpful)
- Abnormal – One arm does not move or one arm drifts down compared with the other

**Speech** (Have the patient say, “You can’t teach an old dog new tricks.”)
- Normal – Patient uses correct words with no slurring
- Abnormal – Patient slurs words, uses inappropriate words, or is unable to speak
PROTECT YOURSELF FIRST:
ALL PERSONNEL SHOULD BE APPROPRIATELY TRAINED AND
HAVE PROTECTIVE CLOTHING AS INDICATED

Identify substance, if possible
Contact local HazMat unit*

Isolate

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

Maintain Airway. Administer OXYGEN 12-15L/min. by mask.
Assist ventilations with BVM, if indicated, using 100% OXYGEN.

Treat per appropriate protocol:
SHOCK
CARDIAC DYSRHYTHMIAS
PULMONARY EDEMA
SEIZURES
BURNS (CHEMICAL)
UNCONSCIOUSNESS
ASTHMA/COPD WITH WHEEZING
FROSTBITE

Refer to HAZARDOUS MATERIALS EYE PROTOCOL #44 for eye exposures

Treat specific poisons with antidotes per Medical Control

TRANSPORT

NOTE TO PREHOSPITAL PROVIDERS:
*Consult Hazardous Materials Injuries, A Handbook for Prehospital Care,
The North American ERG, MSDS sheet or similar text.
Indication: Suspected or actual HazMat eye exposure
(Refer to HAZARDOUS MATERIALS GENERAL PROTOCOL #43 as needed)

- Identify substance
- Decontamination
- Initial Medical Care

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

Establish Medical Control contact ASAP
Eye irrigation with NORMAL SALINE may be instituted prior to contact.
Irrigate at “wide-open” rate, using IV tubing attached to 1000ml NORMAL SALINE

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

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

Signs & Symptoms:
- Bradycardia leading to heart block
- Chest tightness and wheezing due to bronchospasm
- Increased salivation, sweating and tearing
- Increased urination
- Abdominal cramps with nausea and vomiting
- Constricted pupils
- Weakness, muscle tremors/twitching/cramps
- Seizures, coma, shock, respiratory arrest

- Identify substance
- Decontamination
- Initial Medical Care

Establish Medical Control contact ASAP

If patient is seizing, Refer to
ADULT SEIZURES PROTOCOL #42
or
PEDIATRIC SEIZURES PROTOCOL #68
as indicated

TRANSPORT
PROTECT YOURSELF FIRST:
Keep each rescuer’s exposure time to a minimum.
(Female paramedics who are pregnant or may
be pregnant should stay out of the radiation area).

Identify universal radiation symbol
(if possible)

Isolate area and contact local Haz Mat unit

Treat patients per appropriate protocol

Notify receiving hospital
of patient’s condition and exposure.

TRANSPORT
PROTECT YOURSELF AND OTHER PROVIDERS FIRST

Maintain patent airway and assess CAB’s often

INITIAL MEDICAL CARE

PATIENT PRESENTING WITH:
- Altered mental status/Coma
- Headache/Confusion/Disorientation
- Dyspnea/Chest tightness/Nausea/Emesis
- Pupil dilation/Seizure
- Abnormal vital signs

Apply OXYGEN 10-15 L/min by NRM

Continual patient assessment

Transport and contact Medical Control as soon as possible

*Remember Pulse Ox can be incorrect in cases of increased carboxyhemoglobin. Do not rely on SpO2 for guidance of patient care. Apply Rad57 (if available) for CO level and provide OXYGEN 10-15 L/minute to any patient with respiratory symptoms.

Revised 12/01/16
EMR
In the event of cardiac arrest, follow the appropriate protocol.

Cardiac Arrest in a Dialysis Patient

In the event of cardiac arrest, follow the appropriate protocol.

Pulmonary Edema in a Dialysis Patient

Give high flow **OXYGEN** via a non-rebreather mask if possible.

Place patient in upright position.

Refer to **ADULT PULMONARY EDEMA DUE TO HEART FAILURE PROTOCOL #14**

Do not take blood in arm with Fistula or graft.
Protocol 49
ADULT DROWNING

INITIAL TRAUMA CARE
C-spine precautions as indicated
Begin CPR if indicated

OXYGEN to 100%

Remove wet clothing - consider hypothermia

Awake, alert, or semi-conscious
with purposeful response to
pain, normal respirations and
pupil response

TRANSPORT

Normothermic

Treat dysrhythmias
refer to appropriate
protocol

TRANSPORT

Comatose: unresponsive to
verbal stimuli, abnormal
response to pain, abnormal
respirations or pupil response

Hypothermic

Treat dysrhythmias
refer to ADULT
COLD EMERGENCIES
PROTOCOL #41

TRANSPORT

NOTE TO PREHOSPITAL PROVIDERS:
After 90 minutes of documented submersion time, the receiving hospital should be contacted for concurrence
of no resuscitative efforts on recovery of the patient.
The Dive Team will at this time go from rescue to recovery mode.

For a pediatric patient refer to PEDIATRIC DROWNING PROTOCOL #68
Obtain history and determine if there is adequate time to transport.
- # of pregnancies
- # of live births
- Due date
- How far apart are contractions
- Duration of contractions
- Length of previous labors - in hours
- Bag of water intact or time since membrane rupture
- High risk concerns - Drug use, multiple births, amniotic fluid color

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

PREPARE FOR DELIVERY IF bulging perineum or crowning IS PRESENT

DO NOT ATTEMPT TO RESTRAIN OR DELAY DELIVERY

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

Cord around neck

Delivery

Normal presentation

- Control delivery of head so it does not emerge too quickly.
- Support infant's head as it emerges and protect perineum with gentle hand pressure.
- Tear amniotic membrane if it is still intact and visible outside vagina. When infant's head delivered, suction and maintain airway.
- As shoulders emerge, guide head and neck downward to deliver anterior shoulder.
- Support and lift head and neck slightly to deliver posterior shoulder. Remainder of infant's delivery should occur with passive participation.
- Maintain a firm hold on the baby.
- Refer to RESUSCITATION AND CARE OF THE NEWBORN PROTOCOL #53

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

Administer post-partum care - Refer to MATERNAL CARE PROTOCOL #57

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

TRANSPORT IMMEDIATELY

100% OXYGEN, place mother on LEFT side

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

TRANSPORT

PRE-ECLAMPSIA OR TOXEMIA

TRANSPORT IMMEDIATELY

OXYGEN 12-15 L/mask

INITIAL MEDICAL CARE:
Gentle handling

Place mother on LEFT side

Minimal CNS stimulation - do not check pupillary light reflex

Seizure precautions

If seizures occur: Increase OXYGEN to 100% and Refer to ADULT SEIZURES/STATUS EPILEPTICUS PROTOCOL #39
Protocol 52
ABNORMAL DELIVERIES

**PROLAPSED CORD**

1. TRANSPORT IMMEDIATELY
2. INITIAL MEDICAL CARE: Increase **OXYGEN** to 100%
3. Elevate mother's hips
4. Place gloved hand in vagina between pubic bone and presenting part with cord between fingers and exert counter pressure against presenting part
5. Keep exposed cord moist and warm
6. Keep hand in position while enroute

**BREECH BIRTH**

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

Revised 12/01/16
Infant Care

Begin Infant Prehospital Care Report

Document time of delivery

Is meconium present?

NO

Is infant limp?

YES

Clear airway with bulb syringe

YES

Able to ventilate?

NO

Attempt to ventilate with BVM

ACCELERATED TRANSPORT

NO

Obtain one minute APGAR SCORE

- Wait for cord pulsations to stop.
- Clamp cord 6-8 inches from infant's body.
- Cut between clamps with sterile knife or scissors.

Dry baby, wrap in chux or blanket to maintain body heat.
- Utilize an infant hat, (if available).
- If in cold environment, wrap aluminum foil or silver swaddler around blanket to insulate.
- If placenta has delivered, it may be used as a heat source.
- Place placenta in plastic bag and wrap infant and placenta in blanket insulated with foil.

Place infant on side, preferably head lower than trunk, suction as needed.
- IF INFANT IS CYANOTIC, BUT BREATHING SPONTANEOUSLY, place adult face mask next to infant's face & administer OXYGEN at 6L/minute.

Obtain five minute APGAR SCORE and document on report form.

Place ID tags on mother and infant.

TRANSPORT

Apgar Score (evaluate at 1 AND 5 minutes postpartum)

<table>
<thead>
<tr>
<th>SIGN</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appearance (Skin Color)</strong></td>
<td>Blue, pale</td>
<td>Body pink extremities blue</td>
<td>Completely Pink</td>
</tr>
<tr>
<td><strong>Pulse rate (HR)</strong></td>
<td>Absent</td>
<td>Below 100</td>
<td>Above 100</td>
</tr>
<tr>
<td><strong>Grimace</strong></td>
<td>No Response</td>
<td>Grimaces</td>
<td>Cries</td>
</tr>
<tr>
<td><strong>Activity</strong></td>
<td>Limp</td>
<td>Some flexion of extremities</td>
<td>Active Motion</td>
</tr>
<tr>
<td><strong>Respiratory (Effort)</strong></td>
<td>Absent</td>
<td>Slow and Irregular</td>
<td>Strong Cry</td>
</tr>
</tbody>
</table>

Revised 12/01/16
TRANSPORT IMMEDIATELY

Allow the placenta to deliver on its own, but **DO NOT** delay transport waiting for it. (It should deliver within 20 - 30 minutes.)

**DO NOT** pull on cord to facilitate delivery. If delivered, collect placenta in a plastic bag and bring to hospital.

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

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

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

2. GENERAL APPROACH TO THE STABLE/CONSCIOUS PEDIATRIC PATIENT
   Assessments and interventions must be tailored to each child in terms of age, size and development.
   - Smile if appropriate to the situation.
   - Keep voice at an even quiet tone, don't yell.
   - Speak slowly, use simple, age appropriate terms.
   - Use toys or penlight as distracters; make a game of assessment.
   - Keep small children with their caregiver(s);
   - Kneel down to the level of the child if possible.
   - Be cautious in use of touch. In the stable child, make as many observations as possible before touching (and potentially upsetting) the child.
   - Adolescents may need to be interviewed without their caregivers present if accurate information is to be obtained regarding drug use, alcohol use, last menstrual period, sexual activity, child abuse.

While walking up to the patient, observe/inspect the following:
   - General appearance, age appropriate behavior.
   - Malnourished appearance? Is child looking around, responding with curiosity or fear, playing, sucking on a pacifier or bottle, quiet, eyes open but not moving much or uninterested in environment?
   - Obvious respiratory distress or extreme pain.
   - Position of the child. Are the head, neck or arms being held in a position suggestive of spinal injury? Is the patient sitting up or in tripod position?
   - Level of consciousness, i.e., awake vs asleep or unresponsive.
   - Muscle tone: good vs limp.
   - Movement: spontaneous, purposeful, symmetrical.
   - Color: pink, pale, flushed, cyanotic, mottled.
   - Obvious injuries, bleeding, bruising, impaled objects or gross deformities.
   - Determine weight - Use length/weight tape to determine kilos for medication administration.
   - A length/weight based tape will be utilized to determine medication dosing.

3. INITIAL ASSESSMENT
   Circulation
   - Heart rate - compare to normal rate for age and situation.
   - Central/truncal pulses (brachial, femoral, carotid) - strong, weak or absent.
   - Distal/peripheral pulses - present/absent, thready, weak, strong.
   - Color - pink, pale, flushed cyanotic, mottled.
   - Skin temperature - hot, warm, cool.
   - Blood pressure - compare to normal for age of child. Must use appropriate sized cuff.
   - Hydration - anterior fontanel in infants, mucous membranes, skin turgor, crying tears, urine output history.
Airway Access/Maintenance with Cervical Spine Control
• Maintainable with assistance: positioning.
• Maintainable with adjuncts: oral airway, nasal airway.
• Maintainable with endotracheal tube.
• Listen for any audible airway noises, i.e., stridor, snoring, gurgling, wheezing.
• Patency: suction secretions as necessary.

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

Disability - Brief Neuro Examination
• Assess Responsiveness
  A Alert
  V Responds to verbal stimuli
  P Responds to painful stimuli
  U Unresponsive
• Assess pupils
• Assess for transient numbness/tingling.

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

4. FOCUSED HISTORY/PHYSICAL ASSESSMENT

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

Responsive Medical Patients
• Perform rapid assessment based on chief complaint. A full review of systems may not be necessary. If chief complaint is vague, examine all systems.
Unresponsive Medical Patients
• Perform rapid assessment: CABs, quick head-to-toe exam.
• Emergency care based on signs and symptoms, initial impressions and standard operating procedures.

Trauma patient with NO significant mechanism of injury.
• Focused assessment is based on patient complaint.

Trauma patient WITH significant mechanism of injury.
• Perform rapid assessment of all body systems.

5. DETAILED ASSESSMENT

Performed to detect non-life-threatening conditions and to provide care for those conditions/injuries. Usually performed enroute. May be performed on scene if transport is delayed.
• Inspect and palpate each of the major body systems for the following:
  • Deformities
  • Contusions
  • Abrasions
  • Penetrations/punctures
  • Burns
  • Tenderness
  • Lacerations
  • Swelling/edema
  • Instability
  • Crepitus
  • Auscultation of breath and heart sounds as well as blood pressure readings may be required in the field.

6. ONGOING ASSESSMENT

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

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

• Be familiar with CSHN in your service community and with both the child as well as their anticipated emergency care needs.
• Refer to child’s emergency care plan formulated by their medical providers, (if available). Understanding the child’s baseline will assist in determining the significance of altered physical findings. Parents/caregivers are the best source of information on: medications, baseline vitals, functional level/normal mentation, likely medical complications, equipment operation and troubleshooting, emergency procedures.
• Regardless of underlying condition, assess in a systematic and thorough manner. Use parents/caregivers/home health nurses as medical resources.
• Be prepared for differences in airway anatomy, physical development, cognitive development and possibly existing surgical alterations or mechanical adjuncts. Common home therapies include: respiratory support (oxygen, apnea monitors, pulse oximeters, tracheostomies, mechanical ventilators), nutrition therapy (nasogastric or gastrostomy feeding tubes), intravenous therapy (central venous catheters), urinary catheterization or dialysis (continuous ambulatory peritoneal dialysis), biotelemetry, ostomy care, orthotic devices, communication or mobility devices, or hospice care.
• Communicate with the child in an age appropriate manner. Maintain communication with and remain sensitive to the parents/caregivers and the child.
• The most common emergency encountered with these patients is respiratory related and so familiarity with respiratory emergency interventions/adjuncts/treatment is appropriate.
Protocol 56

PEDIATRIC CARDIAC ARREST

- Establish unresponsiveness
- Position airway
- Determine breathlessness
- Ventilate with BVM 100% OXYGEN
- Determine pulselessness
- Initiate compressions, and continue as indicated
- Maintain airway
- AED (if available) Use as soon as available for a sudden witnessed collapse

---

**Less than 1 year of age**

- Continue CPR
- Give 5 cycles of CPR (15:2)
- Support CABs
  - Complete initial assessment
  - Observe
  - Keep warm

**Greater than 1 year of age**

- Continue CPR
- Give 5 cycles of CPR (15:2)
- until AED (if available) is attached

- NARCAN at 0.1mg/kg IN
  - Max single dose 2mg

---

NOTE TO PREHOSPITAL PROVIDERS:
In patients ages 1-8 use pediatric defibrillation pads (if available)
Perform chest compressions if despite oxygen and ventilation, heart rate <60/min with hypoperfusion. Continue compressions as indicated.

Support CABs
Observe
Keep warm
RAPID TRANSPORT

Severe cardiorespiratory compromise

• Secure airway as appropriate
• Support ventilation with BVM as indicated
• Pulse oximetry

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

Improved cardiac status

Continued severe cardiac compromise

Refer to PEDIATRIC CARDIAC ARREST PROTOCOL #56

NOTE TO PREHOSPITAL PROVIDERS:
1. Hypoglycemia has been known to cause bradycardia in infants.
2. Refer to PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS PROTOCOL #64
3. Special conditions may apply in the presence of severe hypothermia.
4. Refer to PEDIATRIC COLD EMERGENCIES PROTOCOL #67 as needed.
NOTE TO PREHOSPITAL PROVIDERS:

Vagal maneuvers may precipitate asystole and therefore should be employed with caution and only when authorized by Medical Control.

Refer to PEDIATRIC SHOCK PROTOCOL #66 if patient has signs of severe cardiorespiratory compromise:
- Respiratory distress
- Truncal cyanosis and coolness
- Weak thready, or absent peripheral pulses
- Hypotension/no palpable blood pressure
- Decreasing consciousness
Avoid any agitation
Position of comfort
Assess tolerance of OXYGEN administration

Assess CABs
Administer 100% OXYGEN
Complete initial assessment
Assess for:

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

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

Support CABs
Observe
Keep warm
TRANSPORT

Obstruction Relieved
Patient can talk

Obstruction Unrelieved
Patient can’t talk

Relieve Upper Airway Obstruction
- Reposition airway
- Consider back blows & abdominal thrusts (age dependent)

Refer to PEDIATRIC RESPIRATORY ARREST PROTOCOL #65 as indicated

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EMR
Refer to PEDIATRIC RESPIRATORY DISTRESS PROTOCOL #59

- Assess Airway
  - Perform airway maneuver, maintaining in-line C-spine stabilization.
    - jaw thrust or chin lift/head tilt
    - suction
    - oropharyngeal airway
  - C-spine immobilization as indicated

Breathing resumed

Refer to PEDIATRIC RESPIRATORY DISTRESS PROTOCOL #59

- Administer 100% OXYGEN
- Support ventilation with BVM as indicated
- Secure airway as appropriate
- Per Medical Control, consider blood glucose test and administration of: ORAL GLUCOSE PO (if patient’s gag reflex is intact) AND NALOXONE (Narcan) at 0.1mg/kg IN for suspected narcotic exposure.

Chest Rise Adequate

- Not Breathing
  - Administer 100% OXYGEN
  - Support ventilation with BVM
  - Age appropriate rate

Chest Rise Inadequate

Hypoperfusion**

- Refer to PEDIATRIC SHOCK PROTOCOL #61 or PEDIATRIC CARDIAC ARREST PROTOCOL #61

Normal Perfusion**

- Support CABs
  - Complete initial assessment
  - Pulse oximetry (if available)
  - Observe
  - Keep warm
  - TRANSPORT

Relieve Upper Airway Obstruction

- Reposition airway
- Consider back slaps & chest/abdominal thrusts (age dependent)

NOTE TO PREHOSPITAL PROVIDERS:
Respiratory arrest may be a presenting sign of a toxic ingestion or metabolic disorder.

**Refer to PEDIATRIC ASSESSMENT AND TRAUMA SCORE PROTOCOL #32
PEDIATRIC
Protocol 61
PEDIATRIC SHOCK

**Pediatric Shock Vital Signs:**
- 0 – 5 mos of age: Sys BP < 60 mmHg
- 6 mos – 5 yrs: Sys BP < 70 mmHg, HR < 70
- ≥ 6 yrs: Sys BP < 80 mmHg, HR < 60

**INITIAL MEDICAL CARE**

100% **OXYGEN**
Assist ventilation with BVM if indicated
Complete initial assessment
Transport in Supine position

**Support CABs**
Pulse oximetry
Observe
Keep warm
**TRANSPORT**
NOTE TO PREHOSPITAL PROVIDERS:
*Simple hives do not require any additional field treatment.
Support CABs
Observe
Keep warm
TRANSPORT

• Test blood glucose
• Pulse oximetry
• Protect from injury
• Vomiting and aspiration precautions

Seizure Activity

NO

YES

Glucose >60

Support CABs
Observe
Keep warm
TRANSPORT

Glucose ≤60 or unknown

Consider ORAL GLUCOSE to gums if gag reflex intact

NOTE TO PREHOSPITAL PROVIDERS:
Refer to PEDIATRIC RESPIRATORY ARREST PROTOCOL #65 as indicated
For suspected ACUTE narcotic exposure consider NALOXONE (Narcan) at 0.1mg/kg IN

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EMR
Protocol 64

PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS

- Assess CABs
- Immobilize spine as indicated
- Administer 100% OXYGEN
- Support ventilation with BVM as indicated
- Complete initial assessment
- Test blood glucose
- Consider other causes of altered mentation and refer to indicated protocol(s).
- Pulse Oximetry
- Seizure Precautions

Glucose >60 mg/dl

Glucose ≤60 mg/dl or unknown

Consider ORAL GLUCOSE to gums if gag reflex intact

Reassess Respiratory Effort

Adequate Respiratory Effort

Support CABs
Observe
Keep warm
TRANSPORT

Inadequate Respiratory Effort

*NALOXONE (Narcan) at 0.1mg/kg IN if respiratory rate <12
Max single dose 2mg

Altered level of consciousness

Improved level of consciousness

NOTE TO PREHOSPITAL PROVIDERS:
*NALOXONE (Narcan) should be used only for suspected ACUTE narcotic exposure.
Assess scene safety as indicated:
  
  - Appropriate body substance isolation
  - Refer to appropriate HAZMAT PROTOCOL #43-47
  - Stop exposure
  
Assess CABs
Secure airway as appropriate
Support ventilation with BVM as indicated
Administer 100% OXYGEN
Pulse oximetry
Complete initial assessment

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

EXPOSURE TO OR INGESTION OF NARCOTICS OR UNKNOWN SUBSTANCES
For altered level of consciousness consider:
• NALOXONE (Narcan) at 0.1mg/kg IN if respiratory rate <12. Max single dose 2 mg
• If seizures occur, refer to PEDIATRIC SEIZURES PROTOCOL #63 as indicated
• DO NOT INDUCE VOMITING.

POTENTIAL EXPOSURES
• Burning overstuffed furniture = Cyanide
• Old burning buildings = Lead fumes and Carbon monoxide
• Pepto-Bismol = Aspirin
• Pesticides = Organophosphates & Carbamates
• Common poisonous plants: Diefenbachia, Foxglove, Holly leaves and berries, Lilly of the Valley, Nightshade, Philodendron, Rhubarb leaves, and Tobacco

• Smells:
  - Almond = Cyanide
  - Fruit = Alcohol
  - Garlic = Arsenic, parathion, DMSO
  - Mothballs = Camphor
  - Natural gas = Carbon monoxide
  - Rotten eggs = Hydrogen sulfide
  - Silver polish = Cyanide
  - Stove gas = Think CO (CO and methane are odorless)
  - Wintergreen = Methyl salicylate

NOTE TO PREHOSPITAL PROVIDERS:
1. Anticipate vomiting, respiratory arrest, seizure, dysrhythmias and refer to indicated protocol(s).
2. Do not induce vomiting.
**Initiate cooling**
Refer to PEDIATRIC SEIZURES PROTOCOL #63 as indicated

**Assess scene for environmental risks**
- Place in a cool environment
- Remove clothing as appropriate

**Assess CABs**
**Administer 100% OXYGEN**
**Complete initial assessment. Assess for:**
- Hot, dry, flushed or ashen skin
- Tachycardia
- Tachypnea
- Diaphoresis
- Decreasing consciousness
- Profound weakness and fatigue
- Vomiting, diarrhea
- Hypoperfusion
- Muscle cramps

**NOTE TO PREHOSPITAL PROVIDERS:**

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

*Refer to PEDIATRIC ASSESSMENT AND TRAUMA SCORE PROTOCOL #32*
**Frostbite**
- Move patient to a warm environment as soon as possible
- Handle skin like a burn
- Protect with light sterile dressings.
- Do not let skin rub on skin (between fingers or toes).
- Cover patient and prevent re-exposure.

**Systemic Hypothermia**
- **Mild/Moderate**
  - 86-93.2°F (30-34°C):
    - Conscious
    - Handle patient very gently to avoid precipitating V-FIB.
    - Patient may appear uncoordinated with poor muscle control, or stiff simulating rigor mortis.
    - There will be NO SHIVERING.
    - Level of consciousness may be confused, lethargic and/or withdrawn
  - **OXYGEN** 12-15 L/mask

**Severe Hypothermia**
- 86°F or less (<30°C):
  - Handle patient very gently to avoid precipitating V-FIB.
  - Patient may appear uncoordinated with poor muscle control, or stiff simulating rigor mortis.
  - There will be NO SHIVERING.
  - Level of consciousness may be confused, lethargic and/or withdrawn
  - Coma

**Rewarm patient:**
- Place patient in a warm environment.
- Remove wet clothing.
- Apply hot packs wrapped in towels to axilla, groin, neck, thorax.
- Wrap patient in blankets.

**Transport**

---

*NOTE TO PREHOSPITAL PROVIDERS:*

Assess pulse for 30-45 seconds before beginning CPR.
Begin CPR only if pulseless and not breathing.
Apply AED (if available). May attempt defibrillation x 1.
Refer to PEDIATRIC CARDIAC ARREST PROTOCOL #56

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EMR
Protocol 68

PEDIATRIC DROWNING

- Assess airway, ventilation, and respiratory effort
- Assess for hypothermia:
  Refer to PEDIATRIC COLD EMERGENCIES PROTOCOL #67

Adequate ventilation and respiratory effort
- Administer 100% OXYGEN
- Immobilize spine as indicated

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

Reassess airway patency
  patent
  obstructed

- Inadequate ventilation and respiratory effort

Pulse Oximetry

Refer to
- PEDIATRIC SEIZURES PROTOCOL #63
  OR APPROPRIATE
  PEDIATRIC DYSRHYTHMIA PROTOCOLS #56-58

Support CABs
  Observe
  Keep warm
TRANSPORT

Refer to
- PEDIATRIC RESPIRATORY ARREST PROTOCOL #60
  OR
  PEDIATRIC CARDIAC ARREST PROTOCOL #56
  as indicated

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EMR
Regardless of extent of injuries.

Treat obvious injuries.

Refer to PEDIATRIC TRAUMA PROTOCOL #34

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

TRANSPORT
Regardless of extent of injuries.

Transport agreed upon by parent/caregiver

Support CABs
Observe
TRANSPORT
Document all findings

Transport refused by parent/caregiver

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

Report Suspicions to ED physician, ED charge nurse AND DCFS (1-800-25-ABUSE)
(1-800-252-2873)
NOTE TO PREHOSPITAL PERSONNEL:

1. You are required by law to report your suspicions.

2. Suspect battered or abused child if any of the following is found:
   - A discrepancy exists between history of injury and physical exam.
   - Caregiver provides a changing or inconsistent history.
   - There is a prolonged interval between injury and the seeking of medical help.
   - Child has a history of repeated trauma.
   - Caregiver responds inappropriately or does not comply with medical advice.
   - Suspicious injuries are present, such as:
     - Injuries of soft tissue areas, including the face, neck and abdomen
     - Injuries of body areas that are normally shielded, including the back and chest
     - Fractures of long bones in children under 3 years of age
     - Old scars, or injuries in different stages of healing
     - Bizarre injuries, such as bites, cigarette burns, rope marks, imprint of belt or other object
     - Trauma of genital or perianal areas
     - Sharply demarcated burns in unusual areas
     - Scalds that suggest child was dipped into hot water

3. The following are some common forms of neglect:
   - Environment is dangerous to the child (e.g. weapons within reach, playing near open windows without screen/guards, perilously unsanitary conditions, etc.).
   - Caretaker has not provided, or refuses to permit medical treatment of child’s acute or chronic life-threatening illness, or of chronic illness, or fails to seek necessary and timely medical care for child.
   - Abandonment
   - Caretaker appears to be incapacitated (e.g. extreme drug/alcohol intoxication, disabling psychiatric symptoms, prostrating illness) and cannot meet child’s care requirements.
   - Child appears inadequately fed (e.g. seriously underweight, emaciated, or dehydrated) inadequately clothed, or inadequately sheltered.
   - Child is found to be intoxicated or under the influence of an illicit substance(s).
1. PURPOSE/DEFINITION

Given the magnitude of the problems of abuse and violence in our society, early detection of domestic violence victims, appropriate legal and social service referrals and the delivery of timely medical care are essential. Domestic violence is a pattern of coercive behavior engaged in by someone who is or who was in an intimate or family relationship with the recipient. These behaviors may include: repeated battering, psychological abuse, sexual assault or social isolation such as restricted access to money, friends, transportation, health care or employment. Typically, the victims are female, but it must be recognized that males can be victims of abuses as well.

2. DOMESTIC VIOLENCE INDICATORS

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

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

Other factors include:

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

Physical injuries commonly associated with domestic violence:

- Central injuries, specifically to the face, head, neck, chest, breasts, abdomen, or genital areas.
- Contusions, lacerations, abrasions, stab wounds, burns, human bites, fractures (particularly of the nose and orbits) and spiral wrist fractures
- Complaints of acute or chronic pain without tissue injury
- Signs of sexual assault
- Injuries of vaginal bleeding during pregnancy, spontaneous or threatened miscarriage
- Direct impact of domestic violence on pregnancy may include:
  - Abdominal trauma leading to abruption, pre-term labor, and delivery
  - Fetal fracture
  - Ruptured maternal liver, spleen, uterus
  - Antepartum hemorrhage
  - Exacerbation of chronic illness
- Multiple injuries in different stages of healing
3. APPROACHES FOR INTERVIEWING THE PATIENT
The goals of the physical examination are to identify injuries requiring further medical intervention and to make observations and collect evidence that may corroborate the patient’s report of abuse. A thorough physical examination is essential to uncover hidden injuries or compensated trauma. If the patient reports sexual assault, the DOMESTIC VIOLENCE/SPOUSAL ABUSE/GERIATRIC ABUSE/SEXUAL ASSAULT PROTOCOL #75 should be followed:

- Always interview the patient in a private place, away from anyone accompanying them to the ED. Questioning the patient in front of the batterer may place the patient and any children in danger.
- You may be the first person or professional to acknowledge the abuse. It is important that you convey your concerns about what has happened to the patient to the Emergency Physician and Nurse.
- When interviewing, do not ask the patients if they were battered or abused (many battered persons do not consider themselves in this light). Instead you can ask the patient:
  - “Have you had a fight with someone?”
  - “Did anyone hurt you?”
  - “Many times we have seen these types of injuries in patients who are hurt by someone else, did someone hurt you?”
  - “I am concerned that someone may be hurting you or scaring you, can you tell me what happened?”
- Most battered persons feel very shamed and humiliated about what has happened to them. It is important to acknowledge that you understand how difficult it is to talk about what has happened.
- Many battered persons will minimize the abuse or blame themselves for what happened. It is important that you repeatedly reinforce that no one deserves to be hurt no matter what they may or may not have done.
- Questions/attitude Not to Ask/Express:
  - What keeps you with a person like that?
  - Do you get something out of the violence?
  - What did you do at the moment that caused them to hit you?
  - What could you have done to avoid or defuse the situation?

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

Report Suspicions of Geriatric (Elder) Abuse or Neglect to ED physician, ED charge nurse AND the 24-hour Adult Protective Services Hotline 1-866-800-1409

Revised 12/01/16
EMR
Personnel, whether operating at a Basic, Intermediate, or Advance Life Support levels, are required to immediately initiate CPR whenever clinical signs of death exist.

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

1. Triple Zero: Signs of Explicit Biological Death Exists

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

   A. The field unit will notify the hospital over telemetry, “We have a TRIPLE ZERO.” This indicates that they have a patient who is pulseless, non-breathing, and exhibits one or more of the following long-term indications of death:
      • Profound dependent lividity
      • Rigor mortis without profound hypothermia
      • Patient who has suffered decapitation
      • Skin deterioration or decomposition
      • Mummification or dehydration, especially in infants
      • Putrefaction

   B. Transmit a rhythm strip via telemetry, and give the appropriate hospital the known patient history. (Rhythm strip may be omitted for b through f.)

   C. The hospital will confirm the Triple Zero and will give orders to transport providing it is not a county medical examiner’s case.

   D. The confirmation of a Triple Zero is not to be construed as a pronouncement of death.

   E. Transport of Triple Zero - Situations may arise where prolonged delays resulting from dispensations of obviously dead patients would tie up an ALS vehicle for unreasonable lengths of time. If the paramedics encounter a patient whom they confirm to be a Triple Zero over telemetry, they may transfer responsibility for transportation of that patient to another ambulance service, either BLS, ILS or ALS, the appropriate police department, or an agency who is reasonably appropriate for the circumstance, who may transport the patient to a hospital to have death pronounced by an individual legally authorized to do so.

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

   ❖ Except in the conditions listed above, CPR is to be initiated immediately and continued until one (1) of the following occurs:
      1. Effective spontaneous circulation and ventilation have been restored.
      2. Resuscitation efforts have been transferred to other persons of at least equal skill, training and experience.
      3. The rescuers are exhausted and physically unable to continue resuscitation.
      4. A direct order from on-line Medical Control is given to discontinue CPR.

   ❖ A system hospital is to be contacted over telemetry in ALL cases of cardiac arrest, whether or not the patient has signs of clinical death, meets the criteria for Triple Zero (Biological Death) or has a “Do Not Resuscitate” order. In cases where the patient’s status is unclear and the appropriateness of CONTINUED CPR is questioned, paramedics should call the appropriate system hospital AFTER initiation of CPR.
Maintain situational awareness and scene safety. Introduce yourself to the patient, and attempt to gain their confidence in a non-threatening manner. If the patient refuses assistance, attempt to determine their mental status. This includes determining their orientation and the presence of anything that could produce an altered mental status, such as drug/alcohol intoxication or withdrawal, trauma (head injury), hypoxia, hypotension, hypoglycemia, stroke, infections, psychological emergencies (i.e. homicidal, suicidal, psychosis, etc.) or dementia (i.e. acute or chronic organic brain syndromes).

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

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

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

NOTE TO PREHOSPITAL PROVIDERS:
Once restrained, continue to be conscious of the patient’s airway and other medical needs.
1. **Document situation in all cases of refusal and contact Medical Control as per System Policy.**
2. Initiate documentation on a refusal form.
3. **If multiple patients**, may use Multiple Release Form.
4. The narrative portion of the patient care report for refusals of care must include:
   - Evidence of decision making capacity such as:
     - the patient is alert, oriented and understands and answers questions appropriately
   - A physical assessment
   - The specific potential consequences told to the patient of not receiving medical care/evaluation
   - The alternatives to care (contacting private physician immediately, etc.)
   - Signature of patient, legal guardian or Durable Power of Attorney for Healthcare
     - a spouse is not a legal guardian unless appointed by the Court
5. If a patient wishes to refuse treatment and **will not sign the refusal form**, document the situation on the prehospital patient care report.
6. All personnel who witness the event should sign the prehospital patient care report.

Contact Medical Control with any questions.
PROCEDURES

Protocol 74

INTRANASAL ADMINISTRATION

- Observe body substance isolation at all times
- Assess ABC’s and support ventilation as needed
- Inspect medication
  - Identify concentration
  - Inspect for contamination
  - Check expiration date

- For suspected Opiate overdose
  - Remove the medication atomization device (MAD) tip from the syringe
  - Draw up **NALOXONE** (Narcan) 2ml (1mg/ml) and replace the MAD Intranasal Atomizer tip
    (OR place the MAD tip on a luer-lock prefilled syringe)
  - Tilt the patients head back, if possible
  - Place atomizer in the nare opening and advance it until the cone tip is sealed against the opening.
  - Depress the plunger and administer 1ml briskly in each nostril
  - Remove the device
  - Monitor the patient for desirable and undesirable effects
  - Continue to support respirations as needed

- For hypoglycemia (blood sugar < 60) and altered level of consciousness
  - Reconstitute **GLUCAGON** 1mg in 1ml sterile water
  - Remove the medication atomization device (MAD) tip from the syringe
  - Draw up the reconstituted **GLUCAGON** (1mg/ml) and replace the MAD Intranasal Atomizer to syringe
  - Tilt the patient’s head back, if possible
  - Place atomizer in the nare opening and advance it until the cone tip is sealed against the opening.
  - Depress the plunger and administer 0.5 ml briskly in each nostril
  - Remove the device
  - Continue to monitor closely for desirable and undesirable effects
• Place the patient in a safe environment, away from pooled water and metal surfaces.

• In patients 1-8 years of age, use pediatric defibrillation pads, if available.

• Apply AED electrode pads to patient chest or appropriate conductive medium to chest.

• AED may need to be turned off to follow 2006 SMO guidelines (software updates pending).
PATIENT CARE

All legal efforts should be utilized to avoid having to transport the weapon to the Emergency Department. However, if the patient’s condition requires immediate transportation, then transportation should not be delayed unless there is an imminent life threat to the providers. If the patient is stable, and law enforcement is in route, transportation may be delayed to relinquish the weapon to the Police Officer.

SAFETY

Scene safety remains the top priority for EMS responders. If the EMS responders feel that there is a valid life threat to themselves, then retreat to a safe zone is indicated. Stage in a safe location to be able to re-enter the scene when secured by law enforcement.

When you must transport the weapon, it must be secured to prevent accidental discharge.

NOTIFICATION TO THE EMERGENCY DEPARTMENT

When transporting the weapon on the Ambulance, the provider will contact the Emergency Department early. The radio report needs to contain the verbiage “I have a firearm on board” to inform the emergency department that there is a secured weapon on the ambulance and will require someone from the hospital to take custody of the weapon upon arrival.

TRANSFERRING THE WEAPON AT THE HOSPITAL

Upon arrival, relinquish the weapon to the Hospital’s designee as soon as possible. Do not leave the weapon unattended at any time.
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Revised 12/01/16
EMR