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**OHIO EMERGENCY MEDICAL SERVICES SOP’S**

**Introduction**

These Standing Orders and Protocols may be used by Emergency Medical and Fire Services personnel licensed by the State of Ohio Division of Emergency Medical Services to render appropriate care. All EMTs are to familiarize themselves with these SOPs. These Standing Orders and Protocols are applicable regardless of the final destination of the patient and/or their duty station.

No Firefighter EMT may function as such without successful completion by written documentation of competency in these Standing Orders and Protocols.

**Administrative Notes:**

1. These Standard Operating Procedures and Protocols are in addition to the minimum guidelines for patient care as outlined in the 1994 DOT EMT-Basic Curriculum. The Firefighter EMT-B and EMT-IV will assist ALS personnel as requested and/or as needed.

2. The Firefighter non-EMT will function under the current guidelines as stated in the AHA-BLS Healthcare Provider text. They shall also be responsible for other duties as assigned by the FF/EMT-B, EMT-IV or the FF/EMT-P.

3. When the Emergency Unit is out of quarters for any reason, the EMT-Paramedic will be in charge and will be responsible for all of the actions and or activities as it relates to the Emergency Unit. On the scene of an emergency, the EMT-Paramedic will be responsible for patient care. The EMT-Basic or EMT-IV will act within their scope of practice to any request for patient care or maintenance of the unit as directed by the EMT-Paramedic. Patient care is limited to acts within their scope of practice as defined by these SOPs.

4. It is the responsibility of the most qualified EMT-P caring for the patient to ensure transmission of all aspects of the patient assessment and care to the responding Emergency Unit or Medical Control.

5. When reporting a disposition to Medical control or the responding unit, provide the following minimum information:
   a. Patient’s age and chief complaint
   b. Is the patient stable or unstable (define), including complete V/S and LOC
   c. Interventions performed
   d. Provide other information as requested

6. For each and every call, the first directives are scene safety and body substance isolation precautions.

7. For any drug administration or procedures outside these Standing Orders and Protocols, the EMS Provider must receive authorization from Medical Control. Paramedics en-route to the scene are not authorized to issue medication orders.

8. The minimal equipment required for all patient calls:
   a. When the patient is in close proximity to the unit or 1st Responder Company: jump bag, cardiac monitor, and oxygen or other equipment as may be indicated by the nature of call
   b. When the patient is not in close proximity of the unit or 1st Responder Company: the above equipment, stretcher and any other equipment that may be needed as dictated by the nature of the call
9. The senior FF Paramedic riding on the Unit or Company has the ultimate responsibility to ensure that all records and reports are properly completed. The patient care report should accurately reflect the clinical activities undertaken. If there is a patient refusal or dismissal of service at the scene of the incident, the incident report should reflect the dismissal as well as the party or parties responsible for the request to terminate any and all evaluations and treatment.

10. Although the SOPs and Protocol procedures have a numerical order, it may be necessary to change the sequence order or even omit a procedure due to patient condition, the availability of assistance, or equipment. Document your reason for any deviations from protocol.

11. EMTs are expected to perform their duties in accordance with local, state and federal guidelines in accordance with the State of Ohio statutes and rules of Ohio Emergency Services. The EMT-P will work within their scope of practice dependent on available equipment.

12. Each patient care contact will be recorded on the EMS incident report form as completely and accurately as possible prior to leaving the station on the shift day in which the call was made. A complete copy of the patient out-of-hospital evaluation(s) and treatment(s) will be given to the emergency department personnel or staff prior to departing from the health care facility. This will ensure proper documentation of the continuity of care.

13. In potential crime scenes, any movement of the body, clothing, or immediate surroundings should be documented and the on scene law enforcement officer should be notified of such.

14. All patients should be transported to the most appropriate facility according to the patient or family request or to the facility that has the level of care commensurate with the patient’s condition. Certain medical emergencies may require transport to a facility with specialized capability.

15. Paramedics may transport the patient in a non-emergency status to the hospital. This should be based on the signs and symptoms of the patient, mechanism of injury or nature of illness.

16. The following refusal situations should be evaluated by a paramedic
   a. Hypoglycemic patients who have responded to treatment
   b. Any patient refusing transport who has a potentially serious illness or injury
   c. Patients age less than 4 years or greater than 70 years
   d. Chest pain any age or cause
   e. Drug overdose / intoxicated patients
   f. Potentially head injured patients
   g. Psychiatric Disorders

Clinical Notes:

1. A complete patient assessment, vital signs, treatments and continued patient evaluation are to be initiated immediately upon contact with patient and continued until patient care is transferred to a Higher Medical Authority. Refer to Patient Assessment Flow Chart on page 113.

2. The on-going assessment times are considered:

   **High Priority**
   Every 3-5 Minutes

   **Low Priority**
   Every 5-15 Minutes

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3. EMTs may give aspirin for chest pain and may assist patients with the following medications: Nitroglycerine, Epinephrine for Anaphylactic reaction (Epi-Pen), Albuterol or MDI. EMT-IV may administer Dextrose for hypoglycemia, Aspirin, Epinephrine for anaphylaxis, Sublingual Nitroglycerin, Benadryl, Narcan, and Glucagon.

4. If a glucometer reading of greater than 40 mg/dL and patient is asymptomatic, start an INT and administer oral glucose. If a glucometer reading is less than 80 mg/dL and patient is symptomatic, start an IV NS and administer 1 ampule of Dextrose. Reassess pt. every 5 min, repeat 1 amp PRN. **Note:** Any administration of Dextrose must be done through an IV line, not INTs. Normal Blood Sugar values are 80-120 mg/dL.

5. Blood Glucose and Stroke Screening will be performed on all patients with altered mental status.

6. Supportive care indicates any emotional and/or physical care including oxygen therapy, repositioning patient, comfort measures and patient family education.

7. Upon arrival at the receiving hospital, all treatment(s) initiated in the field will be continued until hospital personnel have assumed patient care.

8. The initial blood pressure MUST be taken manually. If subsequent blood pressures taken by machine vary more than 15 points diastolic, then a manual blood pressure will verify the machine reading.

**Clinical Notes – Airway:**

1. All Firefighter EMTs have standing orders for insertion of an approved airway device for patients meeting the indications.

2. Treat the patient, not the monitor.

3. Airway maintenance appropriate for the patient’s condition indicates any airway maneuver, adjunct, or insertions of tubes that provide a patent airway.

4. Pulse Oximetry should be utilized for all patients complaining of respiratory distress or chest pain (regardless of source).

5. Esophageal Intubation detectors and End Tidal CO$_2$ or capnography are MANDATORY for all intubation except double lumen airways. Reliability may be limited in patients less than 20 kg. Use other methods to assist in confirmation.

6. The use of cervical collars post intubation (double lumen or ET) is recommended to reduce the chance of accidental extubation. This is in addition to the tube securing devices currently in use.

**Clinical Notes – Cardio Vascular:**

1. In the adult cardiac arrest:
   a. CPR is most effective when done continuously, with minimum interruption
   b. All IV/IO drugs given are to be followed by a 10 cc NS bolus
   c. Elevate the extremity after bolus when given IV
d. Consider blind airway maneuvers (KING) whenever intubation takes longer than 30 seconds.

2. Defibrillation and Synchronized Cardioversion joules are based on the use of the current biphasic monitor.

3. If a change in cardiac rhythm occurs, provide all treatment and intervention as appropriate for the new rhythm.

4. In the case of cardiac arrest where venous access is not readily available, paramedics may use the EZ IO as initial access.

Clinical Notes – IV

1. Firefighter EMT-IVs and Paramedics have standing orders for precautionary IV and INTs. EMT-IVs have a standing order for the insertion of an IV or INT under the following guidelines.
   a. The patient must have some indication that they are unstable (See definitions, page 8)
   b. Limited to two attempts in one arm only. (Cannulation of legs or neck is not allowed).
   c. Drug administration will be followed by a minimum of 10cc of fluid to flush the catheter.
   d. Blood Glucose will be performed for all patients with altered mental status.
   e. IVs should not be attempted in an injured extremity.
   f. TKO (To Keep Open) indicates a flow rate of approximately 50 cc/hr
   g. IVs will not be started in arms with shunts.
   h. IVs appropriate for patients condition indicates; if patient is hypotensive, give a bolus of fluid, if patient’s BP is normal run IV TKO or convert to saline lock (INT).
   i. A Bolus of fluid is 20 cc/kg for all patients.

2. For external Jugular IVs attempted by paramedics, IV catheters should be 18 gauge or smaller diameter based on the patient.

3. Use of Pneumatic Anti-Shock Device (PASG):
   a. The chance of patient’s survival without the use of the PASG device should be evaluated prior to utilizing the PASG device. Orders must be received from Medical Control prior to inflation when used in the treatment of hypovolemia. The use of PASG should be considered if the systolic pressure falls to 50 mmHg.
   b. The use of the PASG as an air splint is based on the current DOT curriculum and may be used at the discretion of the EMT responsible for patient care.
   c. Other treatments will be based on mechanism of injury and signs and symptoms of the patient.

I have taken great care to make certain that doses of medications and schedules of treatment are compatible with generally accepted standards at the time of publication. Much effort has gone into the development, production, and proof reading of these Standard Operating Procedures and Protocols. Unfortunately, this process may allow errors to go unnoticed or treatments may change between the creation of these protocols and their ultimate use. Please do not hesitate to contact me if you discover any errors, typos, dosage, or medication errors.

I look forward to any questions, concerns, or comments regarding these protocols. I expect all EMS personnel to follow these guidelines, but also to utilize and exercise good judgment to provide the best care for all patients.
OHIO EMERGENCY MEDICAL SERVICES SOP’S

Definitions

1. Medical Director - the physician who has ultimate responsibility for the patient care aspects of the EMS system.

2. Unstable (symptomatic) - indicates that one or more of the following are present:
   a.) chest pain
   b.) dyspnea
   c.) hypotension (systolic B/P less than 90 mmHg in a 70 kg patient or greater)
   d.) signs and symptoms of congestive heart failure or pulmonary edema
   e.) signs and symptoms of a myocardial infarction
   f.) altered level of consciousness

3. Stable (asymptomatic) - indicates that the patient has no or very mild signs and symptoms associated with the current history of illness or trauma.

4. First Responder - The first person(s) or company to arrive at an emergency scene. If first on the scene responsible for immediately identifying and providing patient care to the level of their licensure and availability of equipment. Assist other personnel upon their arrival and ensure continuity of patient care. A first responder may include Firefighter Non-EMT, Firefighter EMT- Basics, Firefighter EMT- IV, and or Firefighter Paramedics.

5. Non-EMT - Personnel trained only in basic first aid and CPR. Are responsible for immediately identifying and providing patient care and assist other personnel upon their arrival and ensure continuity of patient care.

6. EMT- Basic - Personnel licensed by the Ohio Department of EMS and authorized by the Division Medical Director to provide basic emergency care according to the Standard of Care and these Standing Orders and Protocols.

7. EMT- IV - Personnel licensed by the Ohio Department of EMS and authorized by the Division Medical Director to provide limited advanced emergency care according to the Standard of Care and these Standing Orders and Protocols.

8. EMT-Paramedic - Personnel licensed by the Ohio Department of Health and authorized by the EMS Medical Director to provide basic and advanced emergency patient care according to EMS Standing Orders and Protocols.

9. Transfer of Care - Properly maintaining the continuity of care through appropriate verbal and or written communication of patient care aspects to an equal or higher appropriate medical authority.

10. Higher Medical Authority - any medical personnel that possesses a current medical license or certificate recognized by the State of Ohio with a higher level of medical training than the one possessed by EMS Personnel. (MD)

11. All EMTs are expected to perform their duties in accordance with local, state and federal guidelines.

12. Medical Control (transport) – the instructions and advice provided by a physician, and the orders by a physician that define the treatment of the patient; to access Medical Control, contact the Emergency Department physician on duty of the patient’s first choice. If the patient does not have a preference, the patient’s condition and or chief complaint may influence the choice of medical treatment facilities.
CARDIAC EMERGENCY

SOP # 101 Automatic External Defibrillator (AED)

Assessment
- Patient in Cardiopulmonary Arrest
- Basic Life Support in progress
- AED in use

Basic

1. If AED available, apply to patient and follow prompts.
2. 100% Oxygen and airway maintenance appropriate to patient’s condition. All CPR rates of compression are 100 per minute for all ages. Ventilation rates are 8-10/min with no pause in CPR for ventilations. Utilize King Airway at earliest possible time.
4. If AED is in use (defibrillating) prior to arrival, allow shocks to be completed, and then evaluate pulse:
   - If no pulse, continue to provide CPR and basic life support
   - If a pulse is present, evaluate respirations and provide supportive care appropriate for the patient’s condition.

5. EMT STOP Ø

EMT-IV

6. IV NS bolus (20 cc/kg), then TKO
7. EMT-IV STOP Ø

PARAMEDIC

8. Monitor patient and treat per SOP specific for the arrhythmia
9. PARAMEDIC STOP Ø

NOTE:

1. AED is contraindicated in the following situations:
   a. Patients less than 1 years of age and less than 10 kg (22 lbs).
   b. If the victim is in standing water, remove the victim from the water, and ensure that chest and surrounding area is dry.
   c. Trauma Cardiac Arrest.
2. Victims with implanted pacemakers, place pads 1 inch from device.
   a. If ICD/AICD is delivering shock to the patient allow 30 to 60 seconds for ICD/AICD to complete the treatment cycle before using the AED.
3. Transdermal medication patch at site of AED pads:
   - If a medication patch is in the location for an AED pad, remove the medication patch and wipe the area clean before attaching the AED electrode pad.
CARDIAC EMERGENCY

SOP # 103  Bradycardia

Assessment

Heart rate less than 60 beats per minute and symptomatic
Decreased / altered LOC
Chest pain / discomfort
CHF/ pulmonary edema
Head trauma
Dyspnea
Hypothermia, hypoglycemia, drug overdose
Signs of decreased perfusion
Rhythm may be sinus bradycardia, junctional, or heart block
Heart rates < 80/min for infant or <60/min for child

Basic

1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient’s condition.
   If the patient will not tolerate a NRB, apply Oxygen at 6 Lpm BNC.
2. Glucometer check
3. Supportive care
4. EMT STOP Ø

EMT-IV

5. INT or IV NS TKO
6. Administer Dextrose 50% if indicated
7. Cardiac monitor, assist with acquisition 12 lead EKG
8. Pulse Oximetry
9. EMT-IV STOP Ø

PARAMEDIC

10. 12 lead EKG, transmit if available
11. If patient is asymptomatic and heart rate is less than 60 beats per minute, transport and observe
12. Atropine 0.5 - 1.0 mg IV q 4 mins. up to 0.04 mg/kg or 3 mg if symptomatic
13. If PVC’s are present with bradycardia, do NOT administer Lidocaine.
    Adults –
    a. If systolic BP < 90 mmHg and heart rate <60/min
       i. If 2nd and 3rd degree blocks are present
          a. apply transcutaneous pacer pads (if available), administer Atropine 0.5mg IV
       b. If systolic BP < 90 mmHg and heart rate <60/min continues.
          i. Administer Atropine 0.5 mg up to 0.04 mg/kg (3 mg for adults)
       c. If systolic BP < 90 mmHg and heart rate <60/min continues
          i. contact Medical Control, and begin External Pacing per protocol
             ii consider Dopamine 2-20 mcg/kg/min
             iii continuous IV infusions to increase heart rate
14. Consider Glucagon 1-2mg IM/IV if unresponsive to Atropine, especially if taking Beta blockers
**Pediatric** –

a.  heart rates < 60/min for infant or <60/min for child
b.  signs of poor perfusion, respiratory distress, or hypotension
   i.  Yes – start chest compression, IV/IO
      a.  Epinephrine 1:10,000 0.01 mg/kg IV/IO q 4 min
      b.  Contact Medical Control
         1.  consider Dopamine 2-20mcg/kg/min as a continuous IV infusion to increase heart rate.
CARDIAC EMERGENCY

SOP # 104 Ischemic Chest Pain / Myocardial Infarction

Assessment

<table>
<thead>
<tr>
<th>Determination</th>
<th>P – placement of pain/discomfort (anything increase discomfort)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q – quality of pain</td>
</tr>
<tr>
<td></td>
<td>R – radiation of pain</td>
</tr>
<tr>
<td></td>
<td>S – severity of pain/discomfort (scale of 1-10)</td>
</tr>
<tr>
<td></td>
<td>T – time of pain/discomfort onset, type of pain</td>
</tr>
</tbody>
</table>

Determine quality, duration and radiation of pain.
Substernal Oppressive Chest Pain (crushing or squeezing)
Nausea and/or Vomiting
Shortness of breath
Cool, clammy skin
Palpitations
Anxiety or restlessness
Abnormal pulse rate or rhythm
History of Coronary Artery Disease or AMI
Currently taking cardiac medications
JVD
Distal pulse for equality/strength to assess for
Aneurysm
Diaphoresis, pallor, cyanosis
Breath sounds – congestion, rales, wheezing
Motor deficits

Basic

1. Oxygen at 2 – 6 Lpm BNC and airway maintenance appropriate to patient’s condition. If the patient is in severe respiratory distress, consider Oxygen 100% 12 – 15 Lpm NRB.
2. Glucometer check
3. Supportive care
4. If Systolic BP is >110 and the patient is symptomatic, assist patient with 1 nitroglycerine tablet or spray sublingually and reassess every 5 minutes. (Refer to the medication assist procedure # 10, page 5) Maximum of three doses.
5. Aspirin (nonenteric coated), 324 mg chewed then swallowed, if not self-dosed within last 24 hr
6. EMT STOP Ø

EMT-IV

7. INT or IV Normal Saline TKO
8. Administer Dextrose 50% if appropriate
9. Contact Medical Control to request orders for additional nitroglycerine in excess of three doses.

Note:
The maximum dosage of nitroglycerine is three. The total dosage is the total doses the patient has taken on their own combined with your subsequent dosages.
10. Cardiac Monitor, assist acquisition of 12 lead EKG
11. Oxygen Saturation
12. Aspirin (nonenteric coated), 324 mg chewed then swallowed, if not self-dosed within last 24 hr
13. Nitroglycerine – If patient is not Hypotensive (BP <100mmHg), administer one Nitroglycerine SL spray and apply 1” of Nitroglycerine to chest wall. Repeat Nitroglycerine spray once 5 minutes after initial spray and application of paste. Continue nitrate therapy until pain relieved or systolic BP <100mmHg.
14. EMT-IV STOP Ø
15. Obtain 12 lead EKG and transmit, if possible
16. Systolic BP is <100mgHg give 250 ml NS bolus (assess for signs of pulmonary congestion)
   a. If PVC’s >15/min – Lidocaine 1-1.5 mg/kg over 2 min, repeat to total of 3 mg/kg
17. If chest pain/discomfort continues:
    Continue Nitrate therapy
    Complete thrombolytic screening
    If chest pain greater than 5 on scale of 1-10, Morphine 2-4 mg q 10 minutes until pain is tolerated by
    patient
    Contact Medical Control
    Transport.
18. **PARAMEDIC STOP Ø**
CARDIAC EMERGENCY

SOP # 105 Chest Pain / NON Cardiac

Assessment

| Determine quality, duration and radiation of pain. | P – placement of pain/discomfort (anything increase discomfort) |
| Atypical Chest Pain | Q – quality of pain |
| NO Nausea and/or Vomiting | R – radiation of pain |
| NO Shortness of breath | S – severity of pain/discomfort (scale of 1-10) |
| NO Cool, clammy skin | T – time of pain/discomfort onset, type of pain |
| History of chest injury, persistent cough | |
| NO History of Coronary Artery Disease or AMI | |
| NOT Currently taking cardiac medications | |
| Distal pulse for equality/strength to assess for | |
| Aneurysm | |
| NO Diaphoresis, pallor, cyanosis | |
| Normal Breath sounds | |

Basic

1. Oxygen at 2 – 6 Lpm BNC and airway maintenance appropriate to patient’s condition. If the patient is in Severe respiratory distress, consider Oxygen 100%
2. Glucometer check
3. Supportive care
4. If Systolic BP is >110 and the patient is symptomatic, assist patient with 1 nitroglycerine tablet or spray sublingually and reassess every 5 minutes. (Refer to the medication assist procedure on # 10 on page 5) Maximum of three doses.
5. Aspirin (not to exceed 325 mg of chewable Aspirin) if patient has not self administered in last 12 hours.
6. EMT STOP Ø

EMT-IV

7. INT or IV Normal Saline TKO
8. Administer Dextrose 50% if appropriate
9. Contact Medical Control to request orders for additional nitroglycerine in excess of three doses.

Note:

The maximum dosage of nitroglycerine is three sublingual administrations, whether before or after your arrival.
10. Cardiac monitor, assist acquisition of 12 lead EKG
11. Oxygen saturation
12. Nitroglycerine – If patient is not Hypotensive (BP <100mmHg), administer one Nitroglycerine SL spray
13. EMT-IV STOP Ø

Paramedic

14. Obtain 12 lead EKG, transmit if available.
15. If no effect from Nitroglycerine, consider:

If chest pain greater the 5 on scale of 1-10, Morphine 2-4 mg q 10 minutes until pain is tolerated by patient
16. Contact Medical Control
17. Transport
18. PARAMEDIC STOP Ø

CAUTION: Patients with true cardiac disease may have subtle, atypical symptoms. Always err on the side of the patient safety

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CARDIAC EMERGENCY

SOP # 106  Pulseless Electrical Activity (P.E.A.)

**Assessment**

<table>
<thead>
<tr>
<th>Presence of electrical cardiac rhythm without palpable pulse</th>
</tr>
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<tbody>
<tr>
<td>Confirm rhythm with quick look paddles or electrodes in two leads</td>
</tr>
</tbody>
</table>

**Basic**

1. Utilized AED if available
2. Oxygen 100% and airway maintenance appropriate to the patient’s condition
3. CPR as indicated
4. Glucometer if time allows
5. **EMT STOP Ø**

**EMT-IV**

6. IV NS, bolus of fluid (20cc/kg)
7. Administer Dextrose 50% if appropriate
8. Cardiac Monitor
9. **EMT-IV STOP Ø**

**PARAMEDIC**

10. Epinephrine 1:10,000 1.0 mg IVP/IO *(peds Epinephrine 1:10,000 0.01 mg/kg IV/IO q 4 mins)*
11. If rate is below 60/min., administer Atropine 1 mg IVP/IO, repeat q 4 mins. (max. 0.04 mg/kg or 3 mg) *(not in peds)*

12. Search for underlying cause of arrest and provide the related therapy:
   a. hypoxia - ensure adequate ventilation
   b. hypovolemia - fluid administration /fluid challenge (adult 20cc/kg, peds 20cc/kg bolus)
   c. cardiac tamponade (adult up to 2 liter bolus *(peds 20cc/kg bolus)*
   d. tension pneumothorax - needle decompression
   e. KNOWN hyperkalemia - Sodium Bicarbonate 1 mEq/kg, may repeat @ 0.5 mEq/kg q 10 min *(peds 1 mEq/kg may repeat at 0.5 meq/kg q 10 min)* and CaCl 500mg IVP *(peds 20mg/kg)*
   f. KNOWN Acidosis or prolonged arrest: consider Sodium Bicarbonate 1-1.5 mEq/kg IV *(peds 0.5 meq/kg)*
   g. Drug overdose: Narcan 2 mg slow IVP *(peds 0.1 mg/kg slow IVP)*
   h. Hypothermia: initiate patient re-warming, avoid chest compressions if spontaneous circulation

13. Consider the use of: Dextrose 50% if blood glucose <80 mg/dL *(peds 2cc/kg D25)*
15. Consider External Cardiac Pacing per Protocol
16. PEA continues: Continue CPR, transport to appropriate facility.
17. **PARAMEDIC STOP Ø**
### CARDIAC EMERGENCY

#### SOP # 107 Premature Ventricular Contractions (PVC)

**Assessment**

- Any PVC in acute M.I. setting with associated chest pain
- Multi-focal PVCs
- Unifocal and >15/min
- Salvo's / couplets / runs of V-Tach (three or more PVCs in a row) and symptomatic
- PVCs occurring near the "T-wave"

**Basic**

1. Oxygen 100% and airway maintenance appropriate for the patient's condition.
2. Glucose check
3. Supportive care
4. **EMT STOP Ø**

**EMT-IV**

5. INT or IV NS TKO
6. Administer Dextrose 50% if appropriate
7. Cardiac Monitor, assist in acquisition of 12 Lead EKG
8. Oxygen Saturation
9. **EMT-IV STOP Ø**

**PARAMEDIC**

10. Obtain 12 lead EKG, transmit if available
11. If PVCs are present with heart rate >60/min
    
    Lidocaine 1.5mg/kg over 1 minute *(peds 1.0mg/kg)*, repeat up to 3 mg/kg
    
    a. if PVCs abolished, initiate Lidocaine drip @ 2-4 mg/min

**Note: Use ½ of initial dose for subsequent doses for patients > 70 yo or with history of hepatic disease**

12. **PARAMEDIC STOP Ø**

**Treatment - Protocol**

Consider Amiodarone 150-300 mg IV/IO if no response to Lidocaine
CARDIAC EMERGENCY

SOP # 108 Supraventricular Tachycardia (SVT)

Assessment

<table>
<thead>
<tr>
<th>Adult patients with heart rates in excess of 160 bpm <em>(peds rate &gt;220bpm)</em> (QRS width &lt;.12 sec [3 small block])</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients may exhibit symptoms of dyspnea, chest pain, radiating pain, altered mental status, hypotension (systolic BP &lt;90 mm/Hg)</td>
</tr>
</tbody>
</table>

**Basic**

1. Oxygen 100% and airway maintenance appropriate for the patient’s condition, pulse oximetry.
2. Glucose check
3. Supportive care
4. EMT STOP Ø

**EMT-IV**

5. INT or IV, NS TKO
6. Administer Dextrose 50% if appropriate
7. Cardiac Monitor, assist in acquisition of 12 Lead EKG
8. Oxygen Saturation

9. EMT-IV STOP Ø

**PARAMEDIC**

10. Obtain 12 lead EKG, transmit if available
11. Valsalva Maneuver for 10 seconds

Adenosine 6-12 mg rapid IV *(peds 0.1mg/kg 6 mg max)*, if no conversion 12 mg rapid IV *(peds 0.2mg/kg 12 mg max)*. If no conversion, repeat 12mg dose. Flush with 10cc NS after each dose

If rhythm does not convert to <150/min, or if patient is unstable or significantly symptomatic prepare for synchronized cardioversion.

a. Sedate as necessary:
   - Valium 2-5 mg IV *(peds 0.2 mg/kg IV)* or Versed 2-5 mg IV *(peds 0.1 mg/kg IV)*
   - and/or Morphine 2-4 mg IV *(peds 0.05- 0.2mg/kg)* Synchronized cardioversion @ 100j *(peds 0.5 j/kg, then 1j/kg)*, escalate energy to 200j , cardiovert until heart rate <150/min

b. If rhythm converts to rate <150/min: reassess for changes, maintain systolic BP >90mmHg, transport, and contact Medical Control.

*Note: In heart transplant patients and those on Tegretol, patients give ½ the normal dose of Adenosine.

12. PARAMEDIC STOP Ø

**NOTES:**

1. Adenosine is administered thru large a bore IV in the Antecubital Fossa.
2. Other vagal maneuvers may include asking the patient to hold their breath, trendelenburg position.
3. Carotid Sinus Pressure should be applied on the right if possible. If no effect, then try the left side. **NEVER** massage both sides at once.
4. Unstable SVT may be synchronized cardioverted immediately in frankly unstable patients prior to IV access. Assess the situation and make a good decision. Cardioversion hurts!
5. Significant symptoms include diaphoresis, hypotension, poor color or perfusion, mental status changes, chest pain >5/10
CARDIAC EMERGENCY

SOP # 109  Torsades de Pointe

Assessment

- Decreased / altered LOC
- Dyspnea
- Chest Pain / discomfort, suspected AMI
- Hypotension (systolic BP <90mmHg)
- CHF / Pulmonary edema
- Heart rate >160/min with QRS > .12 sec (3 small blocks) and twisting of points

**Basic**

1. Oxygen 100% and airway maintenance appropriate for the patient's condition, pulse oximetry
2. Glucose check
3. Supportive care
4. **EMT STOP Ø**

**EMT-IV**

5. INT or IV NS TKO
6. Administer Dextrose 50% if appropriate
7. Cardiac Monitor, assist in acquisition of 12 Lead EKG
8. Oxygen Saturation
9. **EMT-IV STOP Ø**

**PARAMEDIC**

10. Obtain 12 lead EKG, transmit if available.
11. Systolic BP
   a. If < 90mmHg – unstable / symptomatic
      i. prepare for cardioversion at 100j, escalate as needed.
      ii. sedation as necessary:
         Valium 2-5mg IV (peds 0.2mg/kg) OR Versed 2-5mg IV (peds 0.1mg/kg) and/or Morphine 2-4 mg (peds 0.05- 0.2mg/kg)
         if rhythm converts
         a. if rate <160/min – monitor for changes, transport, Magnesium Sulfate 1-2 g IVP over 2 minutes
         b. if rate >160/min – contact Medical Control, consider Amiodarone 150-300 mg IV/IO (peds 5mg/kg), transport
   b. If >90mmHg – stable / asymptomatic:
      i. Magnesium Sulfate 1-2 gram IVP over 2 min
      ii. did rhythm convert to rate <160/min
         a. if rate <160/min – monitor for changes, Magnesium sulfate may repeat 1-2 gram IVP over 2 minutes, transport
         b. if rate >160/min – contact Medical Control, consider Amiodarone 150-300 mg IV/IO (peds 5mg/kg), maintain systolic BP >90mmHg, transport

12. **PARAMEDIC STOP Ø**
CARDIAC EMERGENCY

SOP # 110  Ventricular Asystole

Assessment

<table>
<thead>
<tr>
<th>No pulse or respirations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirm cardiac rhythm with quick look paddles or electrodes</td>
</tr>
<tr>
<td>Record in two leads to confirm Asystole and to rule out fine V-Fib.</td>
</tr>
</tbody>
</table>

1. AED if available
2. CPR according to AHA guidelines for patient age.
3. Oxygen 100% and airway maintenance appropriate to the patients condition.
4. Glucose check
5. EMT STOP Ø

6. IV NS Bolus (20cc/kg bolus fluids).
7. Administer Dextrose 50% if appropriate
8. Cardiac Monitor
9. EMT-IV STOP Ø

10. Epinephrine 1:10,000 1 mg IO/IVP
11. Atropine 1.0 mg IO/IVP up to 0.04 mg/kg or 3 mg.(Adolescent max dose is 1 mg) (No atropine in pediatric asystolic arrests).
12. For prolonged resuscitation or known acidosis, consider: Sodium Bicarbonate 1 mEq/kg IV/IO followed by 0.5 mEq/kg q 10 min (peds-1 mEq/kg may repeat at 0.5 meq/kg q 10 min)
13. Consider:
   a. Defibrillation for possible fine ventricular fibrillation masquerading as asystole
   b. Consider discontinuing efforts if criteria is met under Discontinuation / Withholding of Life Support standing order.
14. PARAMEDIC STOP Ø

Reversible Causes

<table>
<thead>
<tr>
<th>Hypovolemia</th>
<th>Tablets (drug overdose)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoxia</td>
<td>Tamponade (cardiac)</td>
</tr>
<tr>
<td>Hydrogen ion (acidosis)</td>
<td>Tension pneumothorax</td>
</tr>
<tr>
<td>Hyperkalemia/Hypokalemia</td>
<td>Thrombosis - heart</td>
</tr>
<tr>
<td>Hypothermia</td>
<td>Thrombosis - lungs</td>
</tr>
</tbody>
</table>
CARDIAC EMERGENCY

SOP # 111 Ventricular Fibrillation / Pulseless Ventricular Tachycardia

Assessment

Ventricular Fibrillation, Ventricular Tachycardia
Pulseless, apneic

Confirm and record cardiac rhythm with quick look paddles or electrodes verified in 2 leads on monitor

**Basic**

1. AED if available
2. CPR (precordial thump if witnessed) according to AHA standards appropriate for patients age
3. Oxygen 100% and airway maintenance appropriate to the patients condition.
4. EMT STOP Ø

**EMT-IV**

5. IV NS TKO
6. Cardiac Monitor, defibrillate as defined below
7. EMT-IV STOP Ø

**PARAMEDIC**

8. Defibrillate @ 200,300,360 as escalating dose, if no change in rhythm perform two minutes of CPR and evaluate rhythm, if no change in rhythm, repeat defibrillation (escalate energy), perform two minutes of CPR and evaluate rhythm, if no change in rhythm, continue 5 cycles of CPR then defibrillation cycle. *(peds begin at 2 j/kg)*
9. Administer:
   a. Epinephrine 1:10,000 1 mg IVP/IO (only if no other option) q 4 mins *(peds Epinephrine 1:10,000 0.01 mg/kg IV/IO q 4 min)*
   b. Amiodarone 300 mg IV or IO, repeat after 5 min at 150 mg *(peds 5 mg/kg)*. May substitute Lidocaine 1.5mg/kg over 1 minute *(peds 1.0mg/kg)*, repeat up to 3 mg/kg and initiate Lidocaine drip @ 2-4 mg/min
   c. For prolonged resuscitation with known acidosis consider: Sodium Bicarbonate 1 mEq/kg IV/IO followed by 0.5 mEq/kg q 10 min *(peds-1 mEq/kg may repeat at 0.5 meq/kg q 10 min)*

10. PARAMEDIC STOP Ø

**Notes:**

Defibrillation should not be delayed for any reason other than rescuer or bystander safety. Prompt defibrillation is the major determinant of survival. Time on scene should be taken to aggressively treat ventricular fibrillation. Consider transport of patient after performing CPR/defibrillation cycles, securing the airway, obtaining IV/IO access, and administering two rounds of drugs. This will provide the best chance of return of a perfusing rhythm.
CARDIAC EMERGENCY

SOP # 112 Ventricular Tachycardia with a Pulse

Assessment
- Confirm and record cardiac rhythm with quick look paddles or electrodes in two leads
- Check for palpable carotid pulse
- Decreased / altered mental status
- Dyspnea
- Chest pain / discomfort, suspected AMI
- Hypotension (systolic BP < 90mmHg)
- CHF / pulmonary edema
- Heart rate > 150/min and QRS > .12 sec (3 small blocks)

**Basic**
1. Oxygen 100% and airway maintenance appropriate to the patient’s condition
2. Glucose check
3. Supportive care
4. EMT STOP Ø

**EMT-IV**
5. INT or IV NS TKO
6. Administer Dextrose 50% if appropriate
7. Cardiac Monitor, assist in acquisition of 12 Lead EKG
8. Oxygen Saturation
9. EMT-IV STOP Ø

**PARAMEDIC**
10. 12 Lead EKG, transmit if possible
11. IF RHYTHM POSSIBLY TORSADES de POINT – GO TO TORSADES de POINT PROTOCOL
12. If Systolic BP < 90mmHg, prepare for synchronized cardioversion.
   a. administer sedative as necessary – Valium 2-5mg IV (peds 0.2 mg/kg) OR Versed 2-5 mg IV (peds 0.1 mg/kg) and/or Morphine 2-4 mg (peds 0.05- 0.2 mg/kg, 2 mg max dose)
   b. synchronize cardiovert @ 100j, 120j, 150j, 200j, 200j until heart rate < 150/min (peds 0.5 j/kg then 1j/kg)
   c. If rhythm converts, monitor for changes, transport. If rhythm does not convert, administer Amiodarone 150 mg over 10 minutes (peds 5 mg/kg) or may substitute Lidocaine 1.5mg/kg over 1 minute (peds 1.0mg/kg), repeat up to 3 mg/kg, reattempt cardioversion at 200j, escalating to 360j per AHA standards (peds 2-4 j/kg).
   d. Contact Medical Control
13. If Systolic BP > 90mmHg – stable / asymptomatic.
   a. Have patient perform Valsalva maneuver for 10 sec and administer Amiodarone 150mg (peds 5 mg/kg) over 10 minutes
   b. If rhythm converts, monitor for changes, transport. If rhythm does not convert, administer Amiodarone 150 mg over 10 minutes (maximum is three 150mg doses) (peds three doses of 5 mg/kg). May substitute Lidocaine 1.5mg/kg over 1 minute (peds 1.0mg/kg), repeat up to 3 mg/kg and initiate Lidocaine drip @ 2-4 mg/min
14. PARAMEDIC STOP Ø
ADULT CARDIAC EMERGENCY

SOP #113  Post Resuscitation

Assessment

Completion of arrhythmia treatment

**Basic**

1. Oxygen 100% and airway maintenance appropriate to the patients condition
2. Supportive care
3. Check blood sugar, if low treat appropriately *(peds 2cc/kg D\(_{25}\)*)
4. **EMT STOP Ø**
5. **EMT-IV STOP Ø**

**EMT-IV**

5. IV NS TKO
6. Assess BP – if systolic <90 mmHg administer 250 ml NS bolus *(peds systolic BP 70 + 2 x age, 20cc/kg bolus)* repeat until BP >90 mmHg or appropriate for pediatric age
7. **EMT-IV STOP Ø**

**PARAMEDIC**

8. Medications:
   a. If anti-arrhythmic administered:
      i. Amiodarone – 300mg IV *(peds 5 mg/kg)*, if one dose given and arrhythmia persists, give second dose 150mg
      ii. If Lidocaine administered, start infusion of drip at 2-4 mg/min
9. **PARAMEDIC STOP Ø**

**Treatment – Protocol**

1. If patient does not tolerate ET tube, contact Medical Control for:
   Valium 2-10 mg *(peds 0.2 mg/kg)* or Versed 2-5 mg IV *(peds 0.1 mg/kg)* for patient sedation

**Consider the use of soft restraints if necessary for patient safety (to prevent extubation).**
ENVIRONMENTAL EMERGENCY

SOP # 201  Chemical Exposure

Special Note: Personnel safety is the highest priority. Do not handle the patient unless they have been decontaminated. All EMS Treatment should occur in the Support Zone after decontamination of the patient. Appropriate PPE will be utilized.

Assessment

<table>
<thead>
<tr>
<th>History of exposure to chemical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify substance and verify with documentation if possible</td>
</tr>
<tr>
<td>Material Safety Data Sheets (M.S.D.S.) if available</td>
</tr>
<tr>
<td>Stay within the appropriate zone for protection</td>
</tr>
<tr>
<td>History of exposure to chemical</td>
</tr>
<tr>
<td>Identify substance if possible</td>
</tr>
</tbody>
</table>

**BASIC** | **IV** | **PARAMEDIC**

1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient’s condition
2. Supportive care
3. IV NS TKO or INT PRN
4. Treatment - Standing Order
   - If Internal Exposure and Conscious:
     1. Treat as Drug Ingestion
     2. Contact Medical Control
   - If External Exposure:
     1. Remove victims clothing, jewelry, glasses, and contacts
     2. Decontaminate – EMS personnel must be wearing proper protective clothing prior to helping with the decontamination process.
   - Powder or like substance
     a. Brush off of patient
     b. Flush with copious amounts of water for at least 20 minutes, assess for hypothermia q 5 min
     c. Transport and continue flushing if necessary and if possible
   - Liquid substance
     a. Flush with copious amounts of water for at least 20 minutes, assess for hypothermia q 5 min
     b. Transport and continue flushing if necessary and if possible
   - If Inhalation:
     a. Reconsider Self Contained Breathing Apparatus
     b. Remove victim from source ensuring there is no danger to personnel
     c. Oxygen 100 % and airway maintenance appropriate to patients condition
   - If Ocular:
     a. Immediately flush eye with tap water or normal saline for 15 minutes
     b. Contact Medical Control

NOTE: Coordinate through the Haz Mat officer prior to transport
ENVIRONMENTAL EMERGENCY

SOP # 202 Drug Ingestion

Assessment

<table>
<thead>
<tr>
<th>History of drug ingestion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of consciousness (Alert, Verbal, Pain, or Unresponsive)</td>
</tr>
<tr>
<td>Neurologic status (LOC, pupils)</td>
</tr>
<tr>
<td>General appearance (sweating, dry or flushed skin, signs of trauma)</td>
</tr>
</tbody>
</table>

**Basic**

1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition
2. Ensure personnel protection from toxin and/or unruly patient
3. Glucose check
4. Supportive care

5. **EMT STOP Ø**

**EMT-IV PARAMEDIC**

6. IV NS TKO or INT PRN
7. Administer Dextrose 50% if appropriate
8. Cardiac Monitor
9. Oxygen Saturation
10. Treat Blood Sugar Level accordingly.
   a. ½ – 1 Amp D50 IV *(peds 2 cc/kg D25 IV)*
   b. If no IV/IO, then Glucagon 1-2 mg IM or IN *(peds 0.5-1 mg IM)*
11. Consider Valium 2 - 5 mg IV *(peds 0.2 mg/kg)* or Versed 2-5mg *(peds 0.1 mg/kg)* IVP or IN if patient is having seizures.
12. Narcan 2mg slow IVP or IN *(peds 0.1 mg/kg slow IVP or IN)* if narcotic use is suspected

13. **EMT-IV/PARAMEDIC STOP Ø**

**Notes:** Poison control may be contacted for INFORMATION ONLY. Treatment modalities are given within these protocols. Contact Medical Control.
ENVIRONMENTAL EMERGENCY

SOP # 203  Electrocution / Lightning Injuries

Assessment

- Presence of electrical wiring
- Entry / exit wounds

**Basic**

1. Oxygen and airway maintenance appropriate to the patients condition
2. Spinal immobilization if electrocution/lightning over 1,000 volts or suspicion of spinal injury
3. Control any gross hemorrhage and dress wounds
4. Supportive care
5. Treat burn per burn protocol
6. EMT STOP Ø

**EMT-IV PARAMEDIC**

7. IV LR if signs of shock 20cc/kg bolus of fluid *(peds 20cc/kg bolus)*
8. Cardiac Monitor
9. Oxygen saturation
10. Consider 2nd IV en route to hospital
11. EMT-IV/PARAMEDIC STOP Ø
ENVIRONMENTAL EMERGENCY

SOP # 204   Hyperthermia

Assessment

<table>
<thead>
<tr>
<th>History of exposure to warm temperature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually seen with increased exertion</td>
</tr>
<tr>
<td>Febrile</td>
</tr>
<tr>
<td>May have hot and dry or warm and moist skin</td>
</tr>
<tr>
<td>May be hypotensive</td>
</tr>
<tr>
<td>Determine history of therapeutic drug use (antipsychotics); history of substance abuse (cocaine, amphetamines, etc.)</td>
</tr>
<tr>
<td>Poor skin turgor</td>
</tr>
<tr>
<td>Signs of hypovolemic shock</td>
</tr>
<tr>
<td>History of infection or illness</td>
</tr>
<tr>
<td>Drug use</td>
</tr>
<tr>
<td>Dark urine – suggest muscle break-down and possible kidney damage</td>
</tr>
<tr>
<td>Tachycardia, hyperventilation, hypertension</td>
</tr>
<tr>
<td>Neurologic – light headedness, confusion to coma, seizures</td>
</tr>
</tbody>
</table>

**Basic**

1. Oxygen 100 % at 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition.
2. Remove clothing, apply wet linen or wet abdominal pads to groin and axillary areas.
   a.) Expose to circulating air.
   b.) DO NOT cool patient to the point of shivering
3. GENTLY massage extremities to prevent cold induced vasoconstriction
4. Move patient to protected environment (shade, AC, etc)
5. Glucose check
6. **EMT STOP Ø**

**EMT-IV PARAMEDIC**

7. IV NS or LR 20cc/kg bolus *(peds 20cc/kg bolus)*
   a. repeat second bolus of fluids if needed
   b. oral rehydration if patient able to maintain airway IV NS – rate proper for patient condition
8. Administer Dextrose 50% if appropriate
9. Cardiac monitor
10. Oxygen saturation
11. If hypoglycemic administer 1 amp D$_{50}$ *(peds 2 cc/kg D$_{25}$)*

**12. EMT-IV/PARAMEDIC STOP Ø**

**Remember:** Time is of the essence in decreasing the patient's body temperature.

**Note:** Hyperthermia may be caused by one of the following:
- Antipsychotic Medications and major tranquilizers: Phenothiazine (Thorazine®), Butyrophenones (Haldol®)
- Cyclic antidepressants such as: Elavil®, Norpramin®, Tofranil®
- Amphetamines
- Monoamine oxidase inhibitors such as: Nardil®, Marplan®
- Anticholinergic drug such as: Atropine, Cogentin, Scopolamine
- Illicit drug: Cocaine, PCP, LSD, Ecstasy (MDMA)
ENVIRONMENTAL EMERGENCY

SOP # 205 Hypothermia

Assessment

| History of exposure to cold temperature including duration |
| Drug/Alcohol use                                           |
| CNS depressants                                           |
| Examine for associated trauma                             |
| Immersion in cold water                                   |
| Predisposing medical condition                            |
| Signs – Vital signs, Bradycardia, Hypotension, Cold extremities, Neurologic (confusion, altered LOC, coma) |

**Basic**

1. Oxygen 100 % at 12 - 15 Lpm with BVM
2. Remove the patient from the cold environment
3. Remove wet clothing and cover with warm, dry blankets
4. Evaluate pulse for one full minute (Do not perform CPR until NO PULSE is confirmed)
5. Handle patient gently. (*slightest jolt may trigger V-Fib.*)
6. Do not allow patient to walk or exert themselves
7. Do not massage extremities
8. Glucose check
9. **EMT STOP Ø**

**EMT-IV PARAMEDIC**

10. IV NS @ 75 cc/hr warmed if possible *(peds 4 cc/kg/hr max 150cc/hr)*
11. Administer Dextrose 50% if appropriate
12. EKG monitor, No CPR if bradycardic rhythm exists
13. If blood glucose is <80 mg/dL and patient is symptomatic administer 1 amp of D50 *(peds 2cc/kg D25)*
14. If patient in coma, Narcan 2mg IVP or IN *(peds 0.1 mg/kg slow IVP/IN)* if Narcotics suspected
15. If body temperature >85 degrees F – follow normal arrest protocols
16. If body temperature <85 degrees F and patient in V-fib:
   a. defibrillate @ 100j, if no change begin CPR **defib at 2 min intervals, increase joules at each interval until 200j max** *(120j, 150j, 200j) *(peds 2 j/kg then 4 j/kg*
   b. withhold meds and further shocks until patient warmed to >85 degree F
   c. continue CPR
17. **EMT-IV/PARAMEDIC STOP Ø**

**NOTE:Ø**

If patient is alert and responding appropriately, rewarm actively:
- Heat Packs or warm water bottles to the groin, axillary and cervical areas

If the patient is unresponsive, rewarm passively:
- Increase the room temperature gradually, cover with blankets

The following are signs and symptoms found at varying body core temperature:

- 95 degrees – amnesia, poor judgment, hyperventilation, bradycardia, shivering
- 90 degrees – loss of coordination (drunken appearance), decreasing rate and depth of respirations, shivering ceases, bradycardia
- 85 degrees – decreased LOC, slow respirations, atrial fibrillation, decreased BP, decreased heart rate, ventricular irritability

Revised June, 2010

Effective: July, 2010
ENVIRONMENTAL EMERGENCY

SOP # 206  Near Drowning

Assessment

<table>
<thead>
<tr>
<th>History compatible with near drowning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspect hypothermia in &quot;cold water&quot; near drowning</td>
</tr>
<tr>
<td>Suspect cervical spine injury</td>
</tr>
</tbody>
</table>

### Basic

1. Oxygen 100% at 12-15 Lpm NRB and airway maintenance appropriate to patient's condition
   - The Heimlich Maneuver may be indicated for airway obstruction
   - Gastric decompression may be necessary to ensure adequate respirations or ventilations.
   - If necessary, ventilation’s may be started prior to patient’s removal from the water.
2. Remove patient from the water, clear airway while protecting the C-spine ASAP
3. If patient is unconscious and pulseless - Refer to the Cardiac Arrest protocol
4. If Hypothermic - Go to Hypothermia Protocol
5. Supportive care
6. EMT STOP Ø

### EMT-IV PARAMEDIC

7. INT or IV NS TKO, if hypotensive give 20cc/kg bolus of fluid (peds 20 cc/kg)
8. E.C.G. monitor and treatment specific for the arrhythmia
9. EMT-IV/PARAMEDIC STOP Ø

Note: Reinforce the need to transport and evaluation for all patients with a submersion incident.
Consider C-Spine immobilization.
ENVIRONMENTAL EMERGENCY

SOP # 207 Nerve Agent Exposure

Special Note: Personnel safety is the highest priority. Do Not handle the patient unless they have been decontaminated. All EMS Treatment should occur in the Support Zone after decontamination of the patient. Appropriate PPE will be utilized.

Assessment

| History of exposure
| Hyper-stimulation of muscarinic sites (smooth muscles, glands) and nicotinic sites (skeletal muscles, ganglions)
| Increased secretions – saliva, tears, runny nose, secretions in airways, secretions in GI Tract, sweating
| Pinpoint pupils
| Narrowing airway
| Nausea, vomiting, diarrhea
| Fasciculations, Flaccid paralysis, general weakness
| Tachycardia, hypertension
| Loss of consciousness, convulsions, apnea

1. Oxygen 100% and airway maintenance appropriate to the patients condition.
2. Depending on signs and symptoms administer Mark I antidote kit
   a) Mild – increased secretions, pinpoint pupils, general weakness
      i. Decontamination , supportive care
   b) Moderate – mild symptoms and respiratory distress
      i. 1 Mark I kit
      ii. May be repeated in 5 min prn
   c) Severe – unconsciousness, convulsions, apnea
      i. 3 Mark I kits
3. Keep patient warm
4. EMT STOP Ø

EMT-IV PARAMEDIC

5. IV NS TKO
6. EKG monitor
7. 10 mg Valium *(peds 0.2 mg/kg)* or 2-5mg Versed IV/IN for seizures *(peds 0.1 mg/kg)*
8. Oxygen saturation
9. EMT-IV/PARAMEDIC STOP Ø

Treatment - Protocol

Repeated doses of Atropine may be required after Mark I kits given

Note: This is for Mass-Casualty situations and is dependent on supplies available.

There is no contraindication for the use of a Mark I kit in the case of true nerve agent exposure.
ENVIRONMENTAL EMERGENCY

SOP # 208 Poisonous Snake Bite

Assessment

Protect yourself from the exposure of snakebite. Snakes can envenomate up to one hour after death. Determine type of snake if possible, time of bite, and changes in signs and symptoms since occurrence. If possible, transport the **DEAD** snake in a secure vessel with the victim for identification

- Parathesias (numbing or tingling of mouth, tongue, or other areas)
- Local pain
- Peculiar or metallic taste
- Chills, N & V, headache, dysphagia
- Hypotension
- Fever
- Local edema, blebs (blister or pustule jewel), discoloration
- Bite wound configuration

Basic

1. Remove rings and bracelets from patient
2. Oxygen 100% at 12 - 15 Lpm and airway maintenance appropriate to patient's condition
3. Immobilize affected area keeping extremities in neutral position
4. Mark progression of swelling at the time of initial assessment and q 5 minutes
5. Supportive care
6. EMT STOP Ø

EMT-IV PARAMEDIC

7. INT or IV NS TKO, if hypotensive 20 cc/kg (**peds 20 cc/kg**) (Ø)
8. Cardiac monitor
9. Oxygen saturation
10. EMT-IV/PARAMEDIC STOP Ø

Treatment - Protocol

Valium or Versed may be indicated if anxiety is overwhelming - Contact Medical Control prior to initiating therapy.

Note: DO NOT USE ice, tourniquets or constricting bands at the bite site or proximal to bite site, if already applied remove. Do NOT place IV in affected extremity if possible.
ENVIRONMENTAL EMERGENCY

SOP # 209  Radiation / Hazmat

Assessment

| Extent of chemical exposure (number of victims, skin vs. inhalation exposure) |
| Nature of exposure |
| Symptoms exhibited by patient |
| Neurologic status (LOC, pupil size) |
| General appearance (dry or sweaty skin, flushed, cyanotic, singed hair) |
| Associated injuries |
| Decontamination prior to treatment |

**Basic**

1. Oxygen and airway maintenance appropriate to the patient condition, pulse oximetry (keep sats >98%).
2. If eye exposure, irrigate
3. Treat associated injuries (LSB, limb immobilization, wound treatment)
4. Supportive Care
5. Treat burn per burn protocol
6. **EMT STOP Ø**

**EMT-IV PARAMEDIC**

7. INT or IV NS/LR, if hypotensive 20 cc/kg *(peds 20 cc/kg)*
8. EKG monitor
9. Oxygen saturation
10. **EMT-IV/PARAMEDIC STOP Ø**
MEDICAL EMERGENCY

SOP # 300  Medical Complaint Not Specified under other Protocols

Assessment

<table>
<thead>
<tr>
<th>Pertinent history to complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies / Medications taken or prescribed</td>
</tr>
<tr>
<td>Onset</td>
</tr>
<tr>
<td>Provocation</td>
</tr>
<tr>
<td>Quality of Pain / Discomfort</td>
</tr>
<tr>
<td>Relieved by</td>
</tr>
<tr>
<td>Signs and symptoms</td>
</tr>
<tr>
<td>Type of pain (sharp, dull, crushing,) and time of duration</td>
</tr>
</tbody>
</table>

**Basic**

1. Oxygen and airway maintenance appropriate for the patient’s condition
2. Patient positioning appropriate for condition
3. Glucose check as appropriate
4. Supportive care
5. **EMT STOP Ø**

**EMT-IV PARAMEDIC**

6. INT or IV NS TKO unless signs of shock, then 20 cc/kg fluid bolus
7. Cardiac monitor prn
8. 12 lead EKG as appropriate for history or if questionable
9. Oxygen saturation
10. **EMT-IV/PARAMEDIC STOP Ø**
OHIO EMERGENCY MEDICAL SERVICES SOP’S

MEDICAL EMERGENCY

SOP # 301  Abdominal Pain (non-traumatic)/Complaints/Nausea and Vomiting

Assessment

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of pain, onset, duration, location, character, radiation</td>
</tr>
<tr>
<td>Aggravating factors, last menstrual periods in females, vaginal bleeding in females</td>
</tr>
<tr>
<td>Recent trauma</td>
</tr>
<tr>
<td>History of abdominal surgery or problems</td>
</tr>
<tr>
<td>Blood in urine, vomitus, or stool</td>
</tr>
<tr>
<td>Nausea, Vomiting, diarrhea</td>
</tr>
<tr>
<td>Fever, diaphoresis, jaundice</td>
</tr>
<tr>
<td>Abdomen – tenderness, masses, rigidity, hernia, pregnancy, distension, guarding</td>
</tr>
</tbody>
</table>

**Basic**

1. Oxygen and airway maintenance appropriate to the patient’s condition
2. Allow patient to assume comfortable position or place patient supine, with legs elevated with flexion at hip and knees unless respiratory compromise or a procedure contraindicates
3. Supportive Care
4. EMT STOP Ø

**EMT-IV**

5. IV NS 20 cc/kg if signs of shock adult and (pediatric 20 cc/kg bolus)
6. EKG monitor
7. Oxygen saturation
8. EMT-IV STOP Ø

**PARAMEDIC**

9. Phenergan 6.25 – 25 mg Slow IV (peds 0.05 – 0.1 mg/Kg) or Odansetron (zofran) 2-4 mg (peds 0.05mg/kg) if intractable nausea and persistent vomiting and no signs of shock. Use lower dose initially especially in the elderly.
10. Consider second IV en route if patient continues to exhibit signs of shock
11. PARAMEDIC STOP Ø
MEDICAL EMERGENCY

SOP # 302       Acute Pulmonary Edema / CHF

Assessment
Focus Assessment on Airway, Breathing, and Circulation
Shortness of Breath
Cyanosis
Pedal Edema
Profuse Sweating, or Cool and Clammy Skin
Erect Posture
Distended Neck Veins (engorged, pulsating) - late sign
Bilateral Rales / Wheezes
Tachycardia (rapid pulse, >100bpm)
History of CHF or other heart disease, or Renal Dialysis
Lasix or Digoxin on medication list

1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient condition. If respiration is less than 10/min. or greater than 30/min., consider assisting breathing with BVM and 100% Oxygen.
2. Keep patient in upright seated position
3. If Systolic BP is >110 and the patient is symptomatic, assist patient with 1 nitroglycerine dose sublingually and reassess every 5 minutes. (Refer to the medication assist procedure). Maximum of three doses.
4. If the patient has Albuterol Inhalation Treatment prescribed, assist them with one treatment.

5. EMT STOP Ø

6. INT
7. If Systolic BP >90 mmHg
   a. Assess for crackles, wheezes, or rales, JVD, peripheral edema, cyanosis, diaphoresis, respiratory rate > 25/min or < 10/min then:
      i. One Nitroglycerine SL spray and apply 1” of Nitroglycerine to chest wall. Repeat Nitroglycerine spray once 5 minutes after initial spray. Discontinue therapy if systolic BP < 100mmHg;
      ii. Albuterol 2.5 mg/3 cc NS via Nebulizer q 5 min, to maximum of 3 doses;
8. If Systolic BP <90 mmHg
   a. Continue oxygen and initiate rapid transport, see hypotension protocol, contact Medical Control immediately

9. EMT-IV STOP Ø

10. If Systolic BP >90 mmHg
    Assess for crackles, wheezes, or rales, JVD, peripheral edema, cyanosis, diaphoresis, respiratory rate > 25/min or < 10/min then:
    Consider Lasix 40-80 mg IV, or Bumex 1.0 mg slow IVP.
    Consider Morphine Sulfate 2-4 mg IV

11. PARAMEDIC STOP Ø

Treatment - Protocol
Dopamine 400 mg/250cc D5W IV admix, begin @ 15 cc/hr (titrate) if patient is hypotensive and symptomatic. (Systolic pressure <90 mmHg)
MEDICAL EMERGENCY

SOP # 303 Anaphylactic Shock

**Assessment**
Contact with a known allergen or with substances that have a high potential for allergic reactions.
Sudden onset with rapid progression of symptoms.
Dyspnea, audible wheeze on confrontation, generalized wheeze on auscultation, decreased air exchange on auscultation.
Generalized urticaria, erythema, angioedema especially noticeable to face and neck.
Complaint of chest tightness or inability to take a deep breath.

**Basic**
1. Position of comfort, reassure
2. 100% Oxygen and airway maintenance appropriate for patient’s condition, pulse oximetry.
3. If patient has a prescribed Epinephrine for Anaphylaxis, assist patient with administration.
4. **EMT STOP Ø**

**EMT-IV PARAMEDIC**
5. IV NS or LR, large bore @ TKO – if hypotensive 20 cc/kg bolus (*peds 20 cc/kg bolus*)
6. EKG monitor
7. Oxygen saturation
8. Epinephrine 1:1000 0.3 – 0.5 mg IM (*peds Epinephrine 1:1000 0.01 mg/kg IM, max dose is 0.3 mg*)
9. Diphenhydramine (Benadryl) 25-50 mg IV or deep IM (*peds 1 mg/kg IVP.*)
10. Albuterol Inhalation Treatment if wheezing is present and persists post Epinephrine IM/IV.
11. Consider Glucagon 1-2mg IM/IV if unresponsive to Epinephrine, especially if taking Beta blockers.
12. **EMT-IV/ PARAMEDIC STOP Ø**
MEDICAL EMERGENCY

SOP # 304 Cerebrovascular Accident (CVA)

Assessment

- Altered level of consciousness (coma, stupor, confusion, seizures, delirium)
- Intense or unusually severe headache of sudden onset or any headache associated with decreased level of consciousness or neurological deficit unusual and severe neck or facial pain
- Aphasia/Dysphasia (unable to speak, incoherent speech or difficulty speaking)
- Facial weakness or asymmetry (Paralysis of the facial muscles, usually noted when the patient speaks or smiles); may be on the same side or opposite side from limb paralysis
- Incoordination, weakness, paralysis, or sensory loss of one or more limbs; usually involves one half of the body particularly the hand
- Ataxia (poor balance, clumsiness, or difficulty walking)
- Visual loss (monocular or binocular); may be a partial loss of visual field
- Intense vertigo, double vision, unilateral hearing loss, nausea, vomiting, photophobia, or phonophobia

Basic

1. Oxygen at 2 – 6 Lpm BNC and airway maintenance appropriate to patient's condition
2. Continually monitor airway due to decreased gag reflex and increased secretions.
3. Conduct a brief targeted history and physical exam. Establish time of onset. Include the Cincinnati Pre-hospital Stroke Scale. (Next Page)
4. Glucometer check, treat patient appropriately
5. Monitor airway due to decreased gag reflex and increased secretions (be prepared to intubate)
6. Maintain body heat, protect affected limbs from injury, anticipate seizures
7. Glucose check
8. If seizure present follow seizure protocol
9. If shock signs present follow shock protocol
10. EMT STOP Ø

EMT-IV

11. IV NS TKO (30 cc/hr) or INT
12. Administer Dextrose 50% if appropriate
13. Cardiac monitor
14. Oxygen saturation
15. If trauma suspected, spinal stabilization. Elevate head 30 degrees.
16. Narcan 2 mg IVP (peds 0.1 mg/kg slow IVP) if narcotics suspected
17. EMT-IV STOP Ø

PARAMEDIC

18. Complete Thrombolytic screening protocol
19. Complete Stroke assessment scale
20. If positive for CVA, recommend transport to stroke center
21. Blood Pressure should only be treated if SBP >220 or DBP >140, then give Nitro spray or SL q 5 min. Goal is reduce initial blood pressure by 15%
22. PARAMEDIC STOP Ø
REFERENCE

The Cincinnati Prehospital Stroke Scale

Facial droop (have patient show teeth or smile):
- Normal - both sides of the face move equally well.
- Abnormal - one side of the face does not move as well as the other side

Arm Drift (patient closes eyes and holds both arms out):
- Normal - both arms move the same or both arms do not move at all
  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 patient say “you can’t teach an old dog new tricks”):
- Normal - patient uses correct words with no slurring
- Abnormal - patient slurs word(s), uses inappropriate words, or is unable to speak

For evaluation of acute, non-comatose, non-traumatic neurologic complaint.

<table>
<thead>
<tr>
<th>Facial / Smile or Grimace</th>
<th>Normal - Both sides of the face move equally.</th>
<th>Abnormal - Left or Right side of face does not move as well.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have the patient show teeth or smile.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Arm Drift</th>
<th>Normal - Arms move equally or do not move.</th>
<th>Abnormal - Left or Right arm does not move or drifts down.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have the patient close both eyes and hold both arms straight out for 10 seconds.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Speech</th>
<th>Normal - Words stated correctly without slurring.</th>
<th>Abnormal - Patient slurs words or uses the wrong words, or is unable to speak.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have the patient repeat a simple phrase such as “It is sunny outside today”.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pre-Hospital Screen for Thrombolytic Therapy

Complete this report for all patients symptomatic for a Myocardial infarct or CVA. Report to the Emergency Department Physician/Nurse any positive findings. Document all findings in the PCR.

<table>
<thead>
<tr>
<th>Time of onset of symptoms: ____________________</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic BP &gt;240mmHg</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Diastolic BP &gt;110mmHg</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Right arm vs. Left arm Systolic BP difference &gt;15mmHg</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>History of recent brain/spinal cord surgery, CVA, or injury</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Recent trauma or surgery</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Bleeding disorder that causes the patient to bleed excessively</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Prolonged CPR (&gt;10 minutes)</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
<tr>
<td>Taking Coumadin, Aspirin, or other blood thinners</td>
<td>□ Yes</td>
<td>□ No</td>
</tr>
</tbody>
</table>
MEDICAL EMERGENCY

SOP # 305  Croup

Assessment

<table>
<thead>
<tr>
<th>History –</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viral infections resulting in inflammation of larynx, trachea</td>
</tr>
<tr>
<td>Seasonal – Late fall / early winter</td>
</tr>
<tr>
<td>Children under 6 yrs old with cold symptoms for 1-3 days</td>
</tr>
<tr>
<td>Hoarseness</td>
</tr>
<tr>
<td>Barking, Seal-like cough</td>
</tr>
<tr>
<td>Stridor, NOT wheezes</td>
</tr>
<tr>
<td>Low grade fever</td>
</tr>
<tr>
<td>No history of obstruction, foreign body, trauma</td>
</tr>
</tbody>
</table>

Basic

1. Oxygen and airway maintenance appropriate to the patients condition.
2. Allow patient to assume comfortable position or place patient supine.
3. Supportive care
4. EMT STOP Ø

EMT-IV

5. EMT-IV STOP Ø

PARAMEDIC

6. Nebulized Epinephrine 1:1.000
   a. 1mg diluted to 2.5 – 3 cc with saline flush, nebulized (mask or blow-by)
   b. May repeat up to 3 total doses.
   c. If the patient has significant distress, 3 ml (3mg) diluted with 2.5 to 3 cc saline flush may be administered as an initial aerosol.
7. Contact Medical Control for subsequent aerosols.
8. PARAMEDIC STOP Ø
MEDICAL EMERGENCY

SOP # 306 Family Violence

Assessment

- Fear of household member
- Reluctance to respond when questioned
- Unusual isolation, unhealthy, unsafe living environment
- Poor personal hygiene / inappropriate clothing
- Conflicting accounts of the incident
- History inconsistent with an injury or illness
- Indifferent or angry household member
- Household member refused to permit transport
- Household member prevents patient from interacting openly or privately
- Concern about minor issues but not major ones
- Household with previous violence
- Unexplained delay in seeking treatment

** Direct questions to ask when alone with patient and if time available.
  1. Has anyone at home ever hurt you?
  2. Has anyone at home touched you without your consent?
  3. Has anyone ever made you do things you didn’t want to?
  4. Has anyone taken things that were yours without asking?
  5. Has anyone scolded or threatened you?
  6. Are you afraid of anyone at home?

** Signs and Symptoms
  - Injury to soft tissue areas that are normally protected
  - Bruise or burn in the shape of an object
  - Bite marks
  - Rib fracture in the absence of major trauma
  - Multiple bruising in various stages of healing

Treatment - Standing Order

1. Patient care is first priority
2. If possible remove patient from situation and transport
3. Police assistance as needed
4. If sexual assault follow sexual assault protocol
5. Obtain information from patient and caregiver
6. Do not judge
MEDICAL EMERGENCY

SOP # 307  Hyperglycemia Associated with Diabetes

Assessment

- History of onset
- Altered level of consciousness
- Pulse: tachycardia, thready pulse
- Respirations (Kussmaul-Kien - air hunger)
- Hypotension
- Dry mucous membranes
- Skin may be cool (consider hypothermia)
- Ketone odor on breath (Acetone smell)
- Abdominal pain, nausea and vomiting
- History of polyuria, or polydipsia (excessive urination or thirst)
- Blood glucose determination

**Basic**

1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition. Suction airway as needed.
2. Glucometer check, treat accordingly
3. Supportive care
4. **EMT STOP Ø**

**EMT-IV PARAMEDIC**

5. IV NS TKO or INT. Consider 250-500cc NS bolus only in patients with signs of dehydration, vomiting, or DKA, *(peds 4 cc/kg/hr max 150cc/hr DO NOT bolus)*
6. EKG monitor
7. Oxygen saturation
8. If BS >250 mg/dL, start 10- 20cc/kg infusion of NS *(peds 4 cc/kg/hr max 150cc/hr DO NOT bolus)*, then reassess blood sugar
9. **EMT-IV/PARAMEDIC STOP Ø**
MEDICAL EMERGENCY

SOP # 308  Hypertensive Crisis

Assessment

Decreased / altered LOC
Headache, blurred vision, dizziness, weakness.
Elevated blood pressure (systolic and/or diastolic) \( \text{if systolic BP is greater than 220 mmHg and/or Diastolic BP is greater than 140 mmHg} \).
Dyspnea, peripheral or pulmonary edema.
Cardiac dysrhythmia, Neurological deficits

1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition
2. Position of comfort, elevation of head is preferred.
4. Glucose check
5. EMT STOP Ø

6. INT or IV NS TKO
7. Administer Dextrose 50% if appropriate
8. EMT-IV STOP Ø

9. Evaluate cardiac rhythm for dysrhythmia and treat appropriately with medical direction (contact Medical Control prior to initiation of anti-arrhythmic therapy)
10. If motor/neuro deficits present, go to stroke protocol
    a. If systolic BP is less than 220mm/Hg, contact Medical Control, monitor patient changes
    b. If systolic BP is greater than 220 mmHg and/or Diastolic BP is greater than 140 mmHg, Nitroglycerine one spray SL q 3-5 min until noted decrease in BP by 15%. May use nitro Paste 1 inch to chest wall, remove if BP drops 15% from the original reading.
11. Contact Medical Control and consider:
    a. Morphine 2-4 mg slow IVP
    b. Lasix 0.5 - 1 mg/kg if pulmonary edema present
12. PARAMEDIC STOP Ø
MEDICAL EMERGENCY

SOP # 309  Hypoglycemia

Assessment

<table>
<thead>
<tr>
<th>History of onset of event.</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Insulin excess (overdose, missed meal, exercise, vomiting, or diarrhea)</td>
</tr>
<tr>
<td>Confusion, agitation, headaches, or comatose</td>
</tr>
<tr>
<td>Pulse Rate (normal to tachycardia)</td>
</tr>
<tr>
<td>Respirations (shallow, slow)</td>
</tr>
<tr>
<td>Skin (sweaty, often cool)</td>
</tr>
<tr>
<td>Flaccid muscle tone</td>
</tr>
<tr>
<td>Grand Mal seizures</td>
</tr>
<tr>
<td>Fecal, urinary incontinence</td>
</tr>
</tbody>
</table>

**Basic**

1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition (snoring respirations is a sign of an INADEQUATE airway)
2. Glucose check
3. If patient is a known diabetic and is conscious with an intact gag reflex, administer one tube of Instant Glucose and reassess.
4. Supportive care

**EMT STOP Ø**

5. **EMT-IV Paramedic**

6. IV NS TKO
7. EKG monitor
8. Oxygen saturation
9. If patient is conscious and symptomatic, administer one tube instant glucose
   
   If blood sugar is less than 80 mg/dL and symptomatic: administer 25 grams of D50, *(peds 2cc/kg D25 IV/IO; if needed an admixture of D50% and Normal Saline can be obtained through mixing 1cc to 1cc for the treatment of symptomatic hypoglycemia in pediatric patients)*
   
   reassess blood sugar level q 15 min, administer 10 – 25 grams D50, prn
10. If unable to establish IV access, Glucagon 1-2mg IM or IN, *(peds - Glucagon 0.5-1 mg IM)*

**EMT-IV/Paramedic STOP Ø**
OHIO EMERGENCY MEDICAL SERVICES SOP’S

MEDICAL EMERGENCY

SOP # 310A  Medications At Schools

To provide authorization for the use of medications not commonly used by EMS and within the current SOPs.

Assessment

The patient must exhibit the signs and symptoms for which the medication is prescribed.

Basic IV

1. Oxygen and airway maintenance appropriate to the patients’ condition.
2. Other treatments will be in accordance with the EMS BLS / ALS SOPs.

PARAMEDIC

3. Necessary medication(s) administration as requested by school official(s):
   a. Schools must provide the medication(s) to be administered
   b. Schools must provide a written copy of the physician order and care plan for attachment to the patient care report
   c. This documentation by the patient’s primary physician should list the following:
      i. Name of the patient
      ii. Name of primary physician
      iii. Document must be signed by the primary physician
      iv. Contact phone number of the primary physician
      v. Name of medication(s)
      vi. Signs and symptoms for which the medication(s) is prescribed
      vii. Dosage of the medication(s)
      viii. Number of repeat doses of the medications(s)
      ix. Route(s) of administration(s)
      x. Potential side-effects of medication(s)

4. Medication(s) will only be administered if the patient meets the signs and symptoms for that medication.
5. Copies of the care plan and physician order must be attached to the patient care report.
6. If the medication(s) is not administered documentation must include those reasons for withholding
7. Whenever medication is administered under these circumstances transport is mandatory

Note: If you have any additional questions or concerns please contact medical control.
SOP #310 B Non Formulary Medications

To provide authorization for the use of medications not commonly used within the current guidelines. For Emergency Use Only.

Assessment

The patient must exhibit the signs and symptoms for which the medication is prescribed.

1. Oxygen and airway maintenance appropriate to the patients’ condition.
2. Other treatments will be in accordance with the BLS / ALS SOPs.

3. Necessary medication(s) administration as requested by caregiver(s):
   a. Caregiver must provide the medication(s) to be administered
   b. Caregiver must provide a written copy of the physician order and care plan for attachment to the patient care report
   c. This documentation by the patient’s primary physician should list the following:
      i. Name of the patient
      ii. Name of primary physician
      iii. Document must be signed by the primary physician
      iv. Contact phone number of the primary physician
      v. Name of medication(s)
      vi. Signs and symptoms for which the medication(s) is prescribed
      vii. Dosage of the medication(s)
      viii. Number of repeat doses of the medications(s)
      ix. Route(s) of administration(s)
      x. Potential side-effects of medication(s)

4. Medication(s) will only be administered if the patient meets the signs and symptoms for that medication.
5. Copies of the care plan and physician order must be attached to the patient care report.
6. If the medication(s) is not administered documentation must include those reasons for withholding
7. Whenever medication is administered under these circumstances, transport is mandatory

Note: If you have any additional questions or concerns please contact medical control.
# OHIO EMERGENCY MEDICAL SERVICES SOP’S

## MEDICAL EMERGENCY

### SOP # 311  Respiratory Distress (Asthma/COPD)

### Assessment

<table>
<thead>
<tr>
<th>Mild Attack</th>
<th>Slight increase in respiratory rate. Mild wheezes. Good skin color.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate Attack</td>
<td>Marked increase in respiratory rate. Wheezes easily heard. Accessory muscle breathing.</td>
</tr>
<tr>
<td>Severe Attack</td>
<td>Respiratory rate more than twice normal. Loud wheezes or so tight no wheezes are heard, patient anxious. Grey or ashen skin color.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hx</th>
<th>COPD, Emphysema, Asthma, or other restrictive lung disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Respiratory rate greater than 25 per minute or less than 10 per minute</td>
</tr>
<tr>
<td></td>
<td>Labored respiration, use of accessory muscles or tripoding</td>
</tr>
<tr>
<td></td>
<td>Breath Sounds: Bilaterally diminished, dry crackles, wheezing</td>
</tr>
<tr>
<td></td>
<td>Cyanosis/Diaphoresis</td>
</tr>
<tr>
<td></td>
<td>Use of short sentences</td>
</tr>
<tr>
<td></td>
<td>Unilateral breath sounds</td>
</tr>
</tbody>
</table>

### Basic

1. 100% Oxygen and airway maintenance appropriate for patients condition
2. If the patient has a prescribed Albuterol Inhalation treatment, assist the patient with 2.5mg/3ml NS and start the oxygen flow rate at 6 Lpm or until the appropriate mist is achieved.
3. If patient uses a MDI, assist patient with one dose.

### EMT-IV

5. INT or IV NS TKO
6. Cardiac Monitor, assist in acquisition of 12 Lead EKG if appropriate
7. Oxygen Saturation
8. Albuterol Inhalation Treatment 2.5 mg/3 mL NS q 5-15 minutes *(peds 2.5 mg / 3ml NS q 5-15 min)*
9. If poor response, consider Atrovent 500mcg (2.5cc) nebulized. May mix with other beta agonists *(not for use in patients less than 12)*
10. In severe cases, consider Epinephrine as dosed below.

### Paramedic

12. EKG monitor (consider 12 lead, transmit if available)
13. Epinephrine 1:1000, 0.3 – 0.5 mg IM *(peds Epinephrine 1:1000 0.01 mg/kg IM, max dose is 0.3 mg)*
14. PARAMEDIC STOP  Ø
MEDICAL EMERGENCY

SOP # 312  Seizures

Assessment

Seizure (onset, duration, type, post-seizure, level of consciousness)
Medical (diabetes, headaches, drugs, alcohol, seizure history)
Physical (seizure activity, level of consciousness, incontinence, head and mouth trauma, vital signs)
Trauma (head injury or hypoxia secondary to trauma)

**Basic**

1. Oxygen 100 % at 12 - 15 Lpm and airway maintenance appropriate to patient's condition
2. Protect patient from injury during active seizures.
3. Glucometer check, treat patient appropriately
4. If patient is actively seizing, consider therapy if:
   a. Unstable ABC’s exist, patient has been actively seizing for 5 or more minutes, patient has underlying disease or condition that will be adversely affected if seizures continue (trauma, COPD, pregnancy, severely hypertensive).

5. **EMT STOP Ø**

**EMT-IV PARAMEDIC**

6. IV NS TKO or INT
7. Administer Dextrose 50% if appropriate
8. C-spine precaution if appropriate.
9. If febrile, cool as per hyperthermia protocol and monitor
10. EKG monitor – treat dysrhythmia per protocols
11. If no IV available and blood glucose levels are <80 mg/dl, Glucagon 1-2 mg IM or IN (**peds 0.5 – 1 mg IM**)  
   12. Adults – if actively seizing – Valium SLOW IVP 2 – 5 mg or Versed 2-5 mg IV may repeat if seizure continues. If narcotic overdose, Narcan 2 mg IV/IO/IN
   13. **Peds:**
      a. **Valium 0.2 mg/kg IV/IO or Versed 0.1 mg/kg IV/IO/IN**
      b. **Valium 0.5 mg/kg rectal**
      c. **If seizure persists for 4 minutes repeat medication once**
      d. **If seizure recurs repeat medication**
      e. **Narcan 0.1 mg/kg up to 2 mg, titrated to effect if narcotic use is suspected**

14. **PARAMEDIC STOP Ø**

Specifically evaluate for: active bleeding, trauma, eye deviation, pupil equality, mouth or tongue bleeding, Urinary or fecal incontinence, lack of arm or leg movement or tone.
OHIO EMERGENCY MEDICAL SERVICES SOP’S

MEDICAL EMERGENCY

SOP # 313 Sexual Assault

Assessment

Traumatic injuries

BASIC IV PARAMEDIC

1. Oxygen 100% and airway maintenance appropriate to patient's condition
2. Be calm, caring and sensitive toward patient
3. DO NOT make unnecessary physical contact with patient
4. Have witness the same sex as the victim present at all time if possible
5. Wrap plastic sheet around victim if possible
6. DO NOT inspect genitals unless evidence of uncontrolled hemorrhage, trauma or severe pain is present
7. DO NOT allow patient to shower or douche
8. Collect patients clothing involved when possible
   a. place clothing in plastic sheet or separate plastic/paper bags with ID labels and found location
   b. leave all sheets placed in plastic/paper bag with patient at facility
   c. notify staff of clothing samples
9. Transport patient to appropriate facility for treatment and examination
MEDICAL EMERGENCY

SOP # 314  Sickle Cell Anemia

Assessment

<table>
<thead>
<tr>
<th>History of Sickle Cell Anemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signs of infection</td>
</tr>
<tr>
<td>Hypoxia</td>
</tr>
<tr>
<td>Dehydration</td>
</tr>
<tr>
<td>Painful joint</td>
</tr>
<tr>
<td>Limited movement of joints</td>
</tr>
</tbody>
</table>

### Basic

1. Oxygen 100% and airway maintenance appropriate to patient's condition
2. Supportive care
3. **EMT STOP Ø**

### EMT-IV

4. IV NS bolus 20 cc/kg *(peds 20 cc/kg bolus)*
5. EKG monitor
6. Oxygen saturation  (Keep oxygen sats >95%)
7. **EMT-IV STOP Ø**

### Paramedic

8. If pain persists – Morphine 2 mg increments q 10 min up to 6 mg *(peds .2 mg/kg Maximum dose 3 mg)*
9. **PARAMEDIC STOP Ø**

**NOTE:**
Use caution in administering narcotic to a patient with SpO₂ <95%

**ALL PATIENTS WHO RECEIVE NARCOTIC MEDICATION MUST BE TRANSPORTED FOR FURTHER EVALUATION**
MEDICAL EMERGENCY

SOP # 315  Unconscious / Unresponsive / Altered Mental Status

Assessment

Unconscious or unresponsive with vital signs
Any patient not responding appropriately to verbal or painful stimulus
Altered level of consciousness with vital signs
Assess for head trauma
Assess for Hypo / Hyperthermia, hemiparesis, and fever, OD, Hypoglycemia
Peds – less commonly associated with intussusception (fold of one intestine into another), intracranial catastrophe, metabolic disorder

1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition
2. Glucose check
3. Assess for underlying causes: head trauma, hypovolemia, hypothermia, hemiparesis, and fever and treat accordingly.
4. **EMT STOP Ø**

**Basic**

5. IV NS TKO or INT
6. EKG monitor
7. Oxygen saturation
8. Administer Narcan 2mg slow IVP/IN *(peds <5 yo – 0.1 mg/kg up to 2 mg IV, >5 y/o – 2 mg IV)*
9. If hypoglycemia and unable to maintain airway, and CVA is not suspected and history of diabetes:
   a. 12.5 – 25 grams D50 IVP *(Peds 2 cc/kg D25 IV/IO)* through IV with Fluids.
   b. If no IV access Glucagon 1-2 mg IM/IN, *(peds if no IV access Glucagon 0.5-1 mg IM/IN)*
10. Contact Medical Control for further orders
11. **EMT-IV/PARAMEDIC STOP Ø**
MEDICAL EMERGENCY

SOP # 316  SYNCOPE

Assessment

<table>
<thead>
<tr>
<th>Loss of consciousness with recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lightheadedness, dizziness</td>
</tr>
<tr>
<td>Palpitations, slow or rapid pulse, irregular pulse</td>
</tr>
<tr>
<td>Decreased blood pressure</td>
</tr>
</tbody>
</table>

**Basic**

1. Oxygen at 2-6Lpm and airway maintenance appropriate to patient’s condition
2. Glucose Check
3. Supportive Care
4. EMT STOP Ø

**EMT-IV**

5. INT or IV NS TKO – if hypotensive 20 cc/kg bolus (*peds 20 cc/kg bolus*)
6. Administer Dextrose 50% if appropriate
7. EKG monitor
8. Oxygen saturation
9. EMT-IV STOP Ø

**PARAMEDIC**

10. 12-Lead EKG, treat any cardiac dysrhythmia per appropriate protocol
11. Assess neuro status; if abnormal refer to appropriate protocol
12. PARAMEDIC STOP Ø
SHOCK / TRAUMA

Air Ambulance Transport

SOP # 401 Air Ambulance Transport

In the absence of an on-scene FF/Paramedic or EMS Lieutenant, the most qualified FF/EMT-Basic or EMT - IV shall have the responsibility of determining the need for an air ambulance transport. DO NOT call for air ambulance transport if the patient is in traumatic cardiopulmonary arrest. Request for an Air Ambulance must be thru the Incident Commander.

A scene flight by air ambulance MAY be indicated IF:

- The Level I trauma patient’s condition warrants immediate and extreme action and the extrication and/or transport time is greater than 30 minutes and if patient is not in trauma full arrest.
- Transport time is defined as the length of time beginning when the emergency unit would leave the scene transporting until time of arrival at the trauma center.

The on-scene FF/EMT-Paramedic or EMS Lieutenant shall have the authority to disregard the response of an air ambulance through the Incident Commander.

Additional Criteria:
- Multi-system blunt or penetrating trauma with unstable vital signs
- Greater than 25% TBSA burns
- Paralysis or spinal injury
- Amputation proximal to wrist or ankle
- Flail or crushed chest

Situational Criteria:
- High energy mechanisms
- Prolonged entrapment
- Multiple casualty incident

Patients will be categorized according to the current Ohio Trauma Destination Determinates.

DO NOT call for air ambulance transport if patient is in traumatic cardiopulmonary arrest. If the patient has no vital signs, they are a trauma full-arrest.
The FF/PM in charge of the patient shall have the authority through the Incident Commander to disregard the response of the air ambulance.
The FF/PM will coordinate with the Incident Commander to insure the helicopter receives patient information and landing zone location.

Note:
Medical responsibility will be assumed by the medical flight crew personnel upon arrival at the scene.
Note: Limitations of the helicopter:
  a. adults who have a tractions splint applied
  b. patients over 6’ 3”
  c. patients who exceed 350 lbs
  d. any splint or device that exceeds the boundary of the long spine board
OHIO EMERGENCY MEDICAL SERVICES SOP’S

SHOCK/TRAUMA

SOP # 402 Abdominal / Pelvic Trauma

Assessment

Abdominal / retroperitoneal abrasions/contusions
Penetrating injuries
Hypotension
Abdominal evisceration(s)
Abdominal pain on palpation
Hematuria, bloody stool
Altered bowel sounds
Vomiting blood
History of abdominal injury/trauma
Suspected injury secondary to mechanism of trauma

Basic

1. Oxygen 100% and airway maintenance appropriate for the patient’s condition
2. C-Spine stabilization
3. Stop any life threatening hemorrhaging
4. Systolic BP or peds normal for age:
   a. If systolic BP >90mmHg place patient supine with legs elevated and flexed at knees and hips if no C-Spine, contact Medical Control
5. Patient pregnant:
   a. If patient is not past 1st trimester: place patient supine with legs elevated and flexed at knees and hips if no C-Spine, contact Medical Control
   b. If patient is past 1st trimester: place patient in left lateral recumbent position
6. Penetrating object:
   a. If no penetrating object: place patient supine with legs elevated and flexed at knees and hips if no C-Spine, contact Medical Control
   b. If penetrating object present: stabilize object(s)
7. Evisceration:
   a. If present: place patient supine with legs elevated and flexed at knees and hips if no C-Spine, contact Medical Control, cover evisceration(s) with saline soaked trauma dressing
8. Supportive care
9. EMT STOP Ø

EMT-IV PARAMEDIC

10. IV NS/LR TKO
    a. If systolic BP <90mm/Hg, IVNS/LR 20cc/kg bolus (peds 20 cc/kg bolus) target SBP is 90 - 110mmHg in adult trauma patients
11. EKG monitor
12. Oxygen saturation
13. EMT-IV/PARAMEDIC STOP Ø
SHOCK / TRAUMA

SOP # 403  Avulsed Teeth- Standing Order

Assessment

<table>
<thead>
<tr>
<th>Avulsed teeth may be handled in much the same manner as small parts; i.e. rinse in normal saline (do not rub or scrub) and place in moistened gauze, but there is no need to cool with ice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not cool tooth with ice.</td>
</tr>
</tbody>
</table>

### Basic EMT-IV

1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient condition.
2. C-spine stabilization.
3. Treat other associated injuries.
4. Pay attention to the airway, bleeding and avulsed teeth may cause airway obstruction.
5. Supportive care
6. Avulsed teeth may be handled in much the same manner as small body parts; i.e. rinse in normal saline (do not rub or scrub) and place in moistened gauze, but there is no need to cool with ice.

### EMT & EMT-IV STOP Ø

### Paramedic

8. Re-implantation is recommended if possible at the scene as this creates maximum possibility of reattachment as minutes count. The follow guidelines pertain to re-implantation at the scene:

   a. Applicable only for permanent teeth (i.e., with patients over 6.5 years of age)
   b. Applicable when only one or two teeth are cleanly avulsed and the entire root is present
   c. Applicable only to anterior teeth (front 6, upper and lower)
   d. The patient must be conscious
   e. Should be attempted with the first 30 mins. (The sooner performed, the greater success rate.)
   f. Do not force re-implantation. Gentle insertion is all that is necessary. Slight incorrect positioning can be corrected later.

9. If re-implantation is not feasible and the patient is a fully conscious adult, then the best procedure is to place the tooth in the mouth, either under the tongue or in the buccal vestibule. This is not recommended for children.

### Paramedic STOP Ø
SHOCK / TRAUMA

SOP # 404  Cardiogenic Shock

Assessment
Frequently associated with tachy/brady dysrhythmia, acute MI, or blunt chest trauma
Neck vein distention in sitting position
Moist sounding lungs (rales, rhonchi)
Peripheral edema (if chronic heart failure)
Determine if cardiac dysrhythmia exists
Consider tension pneumothorax
Consider cardiac tamponade
Increased heart rate
Decreased BP
Altered LOC

Basic
1. Semi-Fowlers or position of comfort
2. Oxygen 100% and airway maintenance appropriate to patient's condition, pulse oximetry
3. EMT STOP Ø

EMT-IV PARAMEDIC
4. IV NS or LR if hypotensive give 20cc/kg bolus (peds 20 cc/kg bolus)
5. Evaluate cardiac rhythm and treat appropriately
6. Oxygen saturation
7. PARAMEDIC STOP Ø

Treatment – Paramedic Only

Contact Medical Control, consider:
Dopamine 400 mg / 250 cc D5W IV admix, begin 2-20ug/kg/min (peds 2-20 ug/kg/min)
SHOCK/TRAUMA

SOP # 405  Eye Trauma

Assessment

<table>
<thead>
<tr>
<th>Impaled object</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inability to open eye(s)</td>
</tr>
<tr>
<td>Swollen, edematous eye(s)</td>
</tr>
<tr>
<td>Photophobia</td>
</tr>
<tr>
<td>Visual defects, loss of vision</td>
</tr>
<tr>
<td>Redness</td>
</tr>
</tbody>
</table>

Treatment – Standing Order

1. Oxygen and airway maintenance appropriate for the patient’s condition.

2. C-Spine stabilization if needed

3. If thermal or chemical:
   a. flush eye(s) with NS or water for 15 min
   b. cover both eyes
   c. transport

4. Penetration:
   a. stabilize
   b. cover unaffected eye
   c. Transport

5. Blunt trauma
   a. Cover both eyes
   b. Transport

6. Is loss of vision present:
   a. No – contact Medical Control
   b. Yes – if loss of vision was sudden, painless and non-traumatic, consider Retinal Artery Occlusion:
      Contact medical control and:
      (1) apply cardiac monitor and assess for changes
      (2) apply vigorous pressure using heel of hand to affected eye for 3-5 seconds, then release (patient may perform this procedure and may be repeated as necessary)
SHOCK / TRAUMA

SOP # 406  Hypovolemic Shock

Assessment

Blood loss due to penetrating injuries to torso or other major vessel
Fracture of femur or pelvis
G.I. bleeding, vaginal bleeding, or ruptured ectopic pregnancy
Dehydration caused by vomiting, diarrhea, inadequate fluid intake, excessive fluid loss due to fever,
uncontrolled diabetes, or burns
Pulse may be greater than 120 beats per minute
Blood pressure may be less than 90 mm Hg systolic
Orthostatic (Tilt) changes in vital signs (consider possible spinal injury) pulse increase of 20 beats per
minute, B/P decrease of 10 mm Hg systolic
Severe shock (hypovolemia) is defined as decreased level of consciousness, absent radial pulse, capillary
refill greater than 2 seconds, no palpable blood pressure

Basic

1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient’s condition.
2. Consider spinal stabilization and hemorrhage control
3. Control gross hemorrhage.
4. Trendelenburg patient if no suspected spinal injury

EMT STOP  Ø

EMT-IV

6. IV NS bolus (20cc/kg)
7. EKG monitor
8. Oxygen saturation
9. EMT-IV STOP  Ø

PARAMEDIC

10. IV NS or LR x 2 large bore titrated to restore patients vital signs (in patients with ongoing blood loss
maintain patient's systolic blood pressure 90 – 110mmHg).

Pediatrics –
   a. IV/IO NS 20 cc/kg bolus
   b. Reassess patient
   c. Repeat fluid bolus 20 cc/kg if no improvement
   d. Place a second IV as needed
   e. Maintain temperature >97 degrees
11. Contact Medical Control, consider:

   Adult & Peds - Dopamine 2-20 ug/kg/min

12. PARAMEDIC STOP  Ø

Note: Cervical spine immobilization is not necessary in patients suffering penetrating trauma (stab or gun
shot wound) below the nipple line AND no evidence of spinal or head injury. Do not delay transport of
patients meeting this criteria for immobilization.
SHOCK / TRAUMA

SOP # 407 Major Thermal Burn

Major Burn:
- Greater than 20 % BSA, partial thickness surface involvement
- Greater than 10% BSA, full thickness burn
- Full thickness burns of the head, face, feet, or perineum
- Inhalation burns or electrical burns
- Burns complicated by fractures or other significant injury
- Elderly, pediatric, or compromised patients

Assessment

- Remove clothing from affected parts
- DO NOT pull material out of the burn site: Cut around it.
- Look for burns of the nares, oropharyngeal mucosa, face or neck
- Listen for abnormal breath sounds
- Note if burn occurred in closed space
- Determine extent of injury (including associated injuries)
- Cardiac monitor for all major burn patients
- Respiratory Distress
- ETOH / drug use
- Associated injuries / trauma
- Hypotension
- Past medical history

Basic

1. Stop the burn process with tepid water or normal saline solution and remove any smoldering clothing.
2. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition.
   a. Edema may cause patient's airway to close almost instantly without warning signs.
   b. Be prepared to Assist ventilation with BVM
3. Monitor all vital signs and continue reassessment with emphasis on the respiratory rate, peripheral pulses (circulation) and level of consciousness.
4. Remove any jewelry
5. Cover burned area with dry sterile dressing or burn sheet. Attempt to keep blisters intact.
6. DO NOT use Water-jel or any other commercially manufactured burn products. DO NOT remove if applied prior to arrival.
7. Monitor to prevent hypothermia
8. Stabilize all associated injuries (e.g. chest, potential spine injury, fractures, dislocations, etc.)
9. EMT STOP Ø

EMT-IV PARAMEDIC

10. INT or IV NS, if hypotensive 20 cc/kg (peds 20 cc/kg)
11. EKG monitor
12. Oxygen saturation
13. For major burns, Morphine 2-4 mg (contact medical control in multi-system trauma/pregnancy), transport (all additional doses must be approved by Medical Control)
14. If extremity injured, cover open fractures/lacerations/injuries with sterile dressing, splint fractures prn, avoid unnecessary movement, transport
15. EMT-IV/PARAMEDIC STOP Ø

Revised June, 2010

Effective: July, 2010
Administer IV fluids using the following guide:
- 500 mL per hour for patients over 15 years old
- 250 mL per hour for patients 5 - 15 years old
- 150 mL per hour for patients under 5 years old

Excessive or overly aggressive amounts of fluid administration may increase third-spacing shock.
SHOCK/TRAUMA

SOP # 408  Musculoskeletal Trauma

Assessment

<table>
<thead>
<tr>
<th>Hypotension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past medical history</td>
</tr>
<tr>
<td>Deformity, swelling, tenderness, crepitus, open or closed fractures</td>
</tr>
<tr>
<td>Hemorrhaging, lacerations, ecchymosis, instability</td>
</tr>
<tr>
<td>Decreased function, pulses</td>
</tr>
<tr>
<td>Loss of sensation of distal extremities</td>
</tr>
<tr>
<td>ETOH/drug use</td>
</tr>
</tbody>
</table>

**Basic**

1. Oxygen 100% and airway maintenance appropriate for the patient’s condition
2. C-Spine stabilization prn
3. Stop any life threatening hemorrhaging
4. Consider applying MAST as splint
5. Splint prn, stabilize penetrating objects
6. EMT STOP Ø

**EMT-IV**

7. INT or IV, LR TKO, if hypotensive 20 cc/kg **(peds 20 cc/kg)**
8. EKG monitor
9. Oxygen saturation
10. EMT-IV STOP Ø

**PARAMEDIC**

11. Trauma: **Isolated extremity trauma only**
   a. If systolic BP >90mmHg or peds normal range for age, consider Morphine 2-4mg IV **(peds .03-.05 mg/kg IV/IO)**
      Cover open fractures/lacerations, check distal motor/sensory/pulse pre/post splinting, avoid unnecessary movement
   b. If systolic BP <90mmHg, IV NS/LR 20cc/kg **(peds 20 cc/kg)**
      If patient pregnant: Isolated extremity trauma only
      (a) If past 1st trimester contact and systolic BP >90mmHg contact Medical Control.
      (b) If systolic BP <90mmHg place patient in left lateral recumbent position, IV NS/LR 20cc/kg

12. PARAMEDIC STOP Ø

**Note:** Cervical spine immobilization is not necessary in patients suffering penetrating trauma (stab or gun shot wound) below the nipple line AND no evidence of spinal or head injury. Do not delay transport of patients meeting this criteria for immobilization.
SHOCK / TRAUMA

SOP # 409  Multi-System Trauma

1. Initiate in-line C-spine stabilization while simultaneously evaluating and controlling the patients ABC’s. Incorporate the Mechanism of Injury into the patient care scheme.
2. Control any hemorrhage and simultaneously provide: Oxygen 100% at 12-15 Lpm NRB and airway maintenance appropriate to patient’s condition.
3. Secure patient to LSB.
4. **EMT STOP Ø**
5. INT or IV NS, if hypotensive 20 cc/kg *(peds 20 cc/kg)*
6. EKG monitor
7. Oxygen saturation
8. **EMT-IV/PARAMEDIC STOP Ø**

**Note:** Cervical spine immobilization is not necessary in patients suffering penetrating trauma (stab or gun shot wound) below the nipple line **AND** no evidence of spinal or head injury. Do not delay transport of patients meeting this criteria for immobilization.
SHOCK/TRAUMA

SOP # 410 Neurogenic Shock

Assessment
Associated with spinal cord injuries, closed head injuries and overdoses
Signs of hypovolemic shock without pale diaphoretic skin (warm shock)

**Basic**
1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient’s condition.
2. Establish and maintain C-spine stabilization.
3. Hemorrhage control.
4. Supportive care
5. EMT STOP Ø

**EMT-IV**
6. INT or IV NS, if hypotensive 20 cc/kg (*peds 20 cc/kg*)
7. EKG monitor
8. Oxygen saturation
9. EMT-IV STOP Ø

**PARAMEDIC**
10. Contact Medical Control to consider:
    Adult & Pediatric – Dopamine at 2-20 ug/kg/min

Special Note: Consider occult bleeding and treat as Hypovolemic Shock Protocol.

11. PARAMEDIC STOP Ø
SHOCK / TRAUMA

SOP # 411 Septic Shock

Assessment

<table>
<thead>
<tr>
<th>Hot &amp; dry or cool &amp; clammy skin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor capillary refill</td>
</tr>
<tr>
<td>Tachycardia / Hypotension</td>
</tr>
<tr>
<td>Potential for underlying infection</td>
</tr>
</tbody>
</table>

**Basic**

1. Oxygen at 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient’s condition.
2. Consider spinal stabilization appropriate to patient’s condition.
3. Obtain and record an oral or axillary temperature if possible.
4. Glucose check
5. Maintain body temperature above 97 degrees F
6. **EMT STOP Ø**

**EMT-IV**

7. INT or IV NS, if hypotensive 20 cc/kg *(pediatrics 20 cc/kg)*
8. Administer Dextrose 50% if appropriate
9. EKG monitor
10. Oxygen saturation
11. **EMT-IV STOP Ø**

**PARAMEDIC**

12. If no improvement after two boluses of IV fluids, contact Medical Control and consider Dopamine 2-20ug/kg/min *(pediatrics 2-20 ug/kg/min)*

13. **PARAMEDIC STOP Ø**

**Note:** Ensure Body Substance Isolation precautions.
SHOCK/TRAUMA

SOP # 412  Soft tissue / Crush Injuries

Assessment

| Hypotension  |
| Past medical history |
| Deformity, swelling, tenderness, crepitus, open or closed fractures |
| Hemorrhaging, lacerations, ecchymosis, instability |
| Decreased function, pulses |
| Loss of sensation of distal extremities |
| ETOH/drug use |

**Basic**

1. Oxygen 100% and airway maintenance appropriate for the patient’s condition
2. C-Spine stabilization prn.
3. Stop any life threatening hemorrhaging
4. Consider applying MAST as a splint
5. Other splints prn, stabilize penetrating objects
6. EMT STOP Ø

**EMT-IV**

7. INT or IV, NS/LR, if hypotensive 20 cc/kg *(peds 20 cc/kg)*
8. EKG monitor
9. Oxygen saturation
10. EMT-IV STOP Ø

**PARAMEDIC**

11. Trauma: *Isolated extremity trauma only*
   
   a. If systolic BP >90mmHg or peds normal range for age, Consider Morphine 2-4mg IV *(peds .03-.05 mg/kg IV/IO)*
      Cover open fractures/lacerations, check distal motor/sensory/pulse pre/post splinting, avoid unnecessary movement
   
   b. If systolic BP <90mmHg, IV NS/LR 20cc/kg *(peds 20 cc/kg)*
      If patient pregnant: Isolated extremity trauma only
      (a) If past 1st trimester contact and systolic BP >90mmHg contact Medical Control.
      (b) If systolic BP <90mmHg place patient in left lateral recumbent position, IV NS/LR 20cc/kg
12. PARAMEDIC STOP Ø

Note: Cervical spine immobilization is not necessary in patients suffering penetrating trauma (stab or gun shot wound) below the nipple line AND no evidence of spinal or head injury. Do not delay transport of patients meeting this criteria for immobilization.
**SHOCK/TRAUMA**

**SOP # 413  Spinal Cord Injuries**

**Assessment**
- Hypotension without actual volume loss
- Warm/flushed skin despite hypotension
- Paralysis
- Loss of reflexes
- Posturing
- Priapism
- Diaphragmatic breathing

---

**Basic**

1. Oxygen 100% and airway maintenance appropriate for the patient’s condition
2. C-Spine stabilization
3. Control hemorrhaging
4. Consider **mild** hyperventilation (20-24 bpm) if suspected intracranial injury
5. **EMT STOP   Ø**

---

**EMT-IV**

6. IV fluid NS/LR if hypotensive bolus 20 cc/kg (repeat bolus once if needed)
7. EKG monitor
8. Oxygen saturation
9. **EMT-IV STOP   Ø**

---

**PARAMEDIC**

10. Contact Medical Control
    Consider Dopamine 2-20 ug/kg/min then titrated
11. **PARAMEDIC STOP   Ø**
SHOCK/TRAUMA

SOP # 414  Traumatic Cardiac Arrest

Assessment
Cardiac arrest secondary to trauma

**Basic**
1. Oxygen 100% and airway maintenance appropriate for the patient’s condition
2. CPR
3. Treat cardiac rhythms per specific protocols
4. EMT STOP Ø

**EMT-IV**
5. IV NS/LR give 20cc/kg bolus
6. EKG monitor
7. Oxygen saturation
8. EMT-IV STOP Ø

**Paramedic**
9. Treat cardiac rhythms per specific protocols
10. If suspected pneumothorax perform needle chest decompression
11. PARAMEDIC STOP Ø
SHOCK / TRAUMA

SOP # 415  Tension Pneumothorax

Patient must meet AT LEAST THREE of the below assessment findings to qualify for this standing order, otherwise, contact Medical Control.

Assessment

- Acute Respiratory Distress, Cyanosis
- Unilaterally decreased breath sounds or absent breath sounds
- Hyper-Resonance of chest unilaterally
- Jugular Vein Distention
- Subcutaneous Emphysema
- Acute Traumatic chest injury, ecchymosis or obvious rib fractures
- History of COPD or other chronic lung disease which predisposes patient to spontaneous pneumothorax
- Hypotension
- Tracheal Deviation away from the affected side
- Arrhythmia
- Oxygen saturation - <90%

Basic

1. Oxygen 100% 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition.
2. Perform frequent evaluation of the breath sounds and blood pressure.
3. Consider institution of the multiple trauma protocol, if indicated. Remember this order may be indicated for the medical patient as well.
4. Follow the trauma treatment priority reference as needed. (On page 115).
5. If the traumatic tension pneumothorax is secondary to a sucking chest wound, apply an occlusive dressing and treat appropriately.
6. Stop any life threatening hemorrhaging
7. EMT STOP Ø

EMT-IV

8. IV NS/LR, if hypotensive 20 cc/kg (peds 20 cc/kg)
9. EKG monitor
10. Oxygen saturation
11. EMT-IV STOP Ø

PARAMEDIC

12. If tension pneumothorax suspected, perform needle decompression:
13. PARAMEDIC STOP Ø
SHOCK/TRAUMA

SOP # 416  Traumatic Amputation(s)

Assessment

<table>
<thead>
<tr>
<th>Hypotension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past medical history</td>
</tr>
<tr>
<td>Deformity, swelling, tenderness, crepitis, open or closed fractures</td>
</tr>
<tr>
<td>Hemorrhaging, lacerations, ecchymosis, instability</td>
</tr>
<tr>
<td>Decreased function, pulses</td>
</tr>
<tr>
<td>Loss of sensation of distal extremities</td>
</tr>
<tr>
<td>ETOH/drug use</td>
</tr>
</tbody>
</table>

1. Oxygen 100% and airway maintenance appropriate for the patient’s condition
2. C-Spine stabilization prn.
3. Stop any life threatening hemorrhaging
4. Consider applying MAST as a splint
5. Other splints prn
6. Amputated part: If recovered rinse with NS, wrap in moist dressing, place in plastic bag, and transport with patient.

7. EMT STOP Ø

EMT-IV

8. INT or IV, NS/LR, if hypotensive 20 cc/kg (peds 20 cc/kg)
9. EKG monitor
10. Oxygen saturation
11. EMT-IV STOP Ø

PARAMEDIC

12. Amputation
   a. If systolic BP >90 mmHg or peds normal range for age, consider giving Morphine 2-4mg IV (peds .03-.05 mg/kg IV/IO).
   b. Cover open fractures/lacerations, check distal motor/sensory/pulse pre/post splinting, avoid unnecessary movement.
13. PARAMEDIC STOP Ø
APGAR scoring

<table>
<thead>
<tr>
<th>Clinical Sign</th>
<th>0 Points</th>
<th>1 Point</th>
<th>2 Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Blue/Pale</td>
<td>Body Pink</td>
<td>Completely Pink</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extremities Blue</td>
<td></td>
</tr>
<tr>
<td>Pulse</td>
<td>Absent</td>
<td>Below 100/minute</td>
<td>Above 100/minute</td>
</tr>
<tr>
<td>Grimace</td>
<td>No response</td>
<td>Grimace</td>
<td>Cries</td>
</tr>
<tr>
<td>Activity</td>
<td>Limp</td>
<td>Some flexion of extremities</td>
<td>Action Motion</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Absent</td>
<td>Slow/Irregular</td>
<td>Good strong cry</td>
</tr>
</tbody>
</table>

The APGAR Score should be calculated after birth of the infant. The five (5) clinical signs are evaluated according to the scoring system detailed above. Each sign is assigned points to be totaled. A total score of 10 indicates that the infant is in the best possible condition. A score of 4 to 6 indicates moderate depression and a need for resuscitative measures.

**DO NOT delay resuscitation efforts to obtain APGAR score.** Obtain APGAR at 1 and 5 minute after delivery.
OBSTETRICAL EMERGENCIES

SOP # 500  Obstetrical / Gynecological Complaints (non-delivery or gynecological only)

Assessment

<table>
<thead>
<tr>
<th>Patient Para &amp; Gravida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term of pregnancy in weeks, EDC, Multiple births expected or history</td>
</tr>
<tr>
<td>Vaginal bleeding (how long and approximate amount)</td>
</tr>
<tr>
<td>Possible miscarriage / products of conception</td>
</tr>
<tr>
<td>Pre-natal medications, problems, and care</td>
</tr>
<tr>
<td>Last menstrual cycle</td>
</tr>
<tr>
<td>Any trauma prior to onset?</td>
</tr>
<tr>
<td>Lower extremity edema</td>
</tr>
</tbody>
</table>

**Basic**

1. Oxygen and airway maintenance appropriate for the patient’s condition
2. Patient positioning appropriate for condition
3. Glucose check
4. Control hemorrhage as appropriate
5. **EMT STOP Ø**

**EMT-IV PARAMEDIC**

10. INT or IV NS TKO unless signs of shock, then 20 cc/kg fluid bolus
11. EKG monitor prn
12. Oxygen saturation
13. **EMT-IV/PARAMEDIC STOP Ø**
OBSTETRICAL EMERGENCIES

SOP # 501 Normal Delivery

Assessment

<table>
<thead>
<tr>
<th>Patient Para &amp; Gravida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term of pregnancy in weeks, EDC</td>
</tr>
<tr>
<td>Vaginal bleeding</td>
</tr>
<tr>
<td>Pre-natal medications, problems, and care</td>
</tr>
<tr>
<td>Membrane ruptured</td>
</tr>
<tr>
<td>Lower extremity edema</td>
</tr>
</tbody>
</table>

**Mother:**

1. Oxygen 100% and airway maintenance appropriate for the patient’s condition
2. Check mother for crowning
3. Use gentle pressure to control delivery. When head delivers, suction airway and check for cord around neck.
4. After delivery, keep mother and infant on same level, clamp cord @ 8 and 10 inches from the baby and cut between clamps.
5. Dry infant and wrap to keep warm. Maintain airway
6. Check APGAR at 1 and 5 minutes post-delivery.
7. DO NOT allow mother to nurse until both have been evaluated in the Emergency Department.
8. Allow placenta to deliver
   - massage uterine fundus (lower abdomen)
   - observe and treat signs of shock with increased delivery of oxygen and IV fluids
   - be alert to the possibility of multiple births
9. Re-evaluate vaginal bleeding

**Infant:**

1. Protect against explosive delivery
2. When head delivers suction airway (mouth first then nose) & check for cord around neck
3. After delivery clamp cord @ 8 and 10 inches from baby and cut between clamps
4. Dry infant and wrap to keep warm (silver swaddler). Maintain airway, suction PRN
5. Oxygen 100% and airway maintenance appropriate to patient's condition
6. Check APGAR Score at 1 and 5 minutes after delivery
7. DO NOT allow infant to nurse until both have been evaluated in the Emergency Department
8. Re-evaluate cord for bleeding, if bleeding, add additional clamp and re-evaluate

**EMT STOP Ø**

**EMT-IV PARAMEDIC**

10. INT or IV LR TKO if patient in active labor defined as regular contractions q 3 - 5 mins. with 30 - 60 second duration.
11. EKG monitor prn
12. Oxygen saturation

**13. PARAMEDIC STOP Ø**
Note: Considerations

1. The greatest risks to the newborn infant are airway obstruction and hypothermia. Keep the infant warm (silver swaddler), dry, covered, and the infant’s airway maintained with a bulb syringe. Always remember to squeeze the bulb prior to insertion into the infant's mouth or nose.

2. The greatest risk to the mother is post-partum hemorrhage. Watch closely for signs of hypovolemic shock and excessive vaginal bleeding.

3. Spontaneous or induced abortions may result in copious vaginal bleeding. Reassure the mother, elevate legs, treat for shock, and transport.

4. Record a blood pressure and the presence or absence of edema in every pregnant woman you examine, regardless of chief complaint.

**NOTE: Complete patient care reports on BOTH mother and child.**
OBSTETRICAL EMERGENCIES

SOP # 502 Abruptio Placenta

Assessment

Multiparity
Maternal hypertension
Trauma
Drug Use
Increased Maternal age
History
Vaginal bleeding with no increase in pain
No bleeding with low abdominal pain

Basic

1. Oxygen 100% and airway maintenance appropriate to the patients condition
2. Position patient in left lateral recumbent position
3. EMT STOP Ø

EMT-IV PARAMEDIC

4. IV NS TKO, if hypotensive 20 cc/kg (peds 20 cc/kg)
5. EKG monitor
6. Oxygen saturation
7. EMT-IV/PARAMEDIC STOP Ø
OBSTETRICAL EMERGENCIES

SOP # 503  Amniotic Sac Presentation

Assessment

- Amniotic Sac visible
- Membrane not broken
- Fetus may or may not be visible
- Pre-natal medications, problems, and care
- Usually Third Trimester
- Applies to greater than 20 weeks gestation
- Abdominal pain
- Indications of immediate delivery

1. Oxygen 100% and airway maintenance appropriate to the patients condition
2. Place patient in position of comfort
3. Amniotic Sac
   - if no fetus visible, cover presenting part with moist, sterile dressing
   - if head of the fetus has delivered, tear sac with fingers and continue steps for delivery
4. Contact medical control ASAP
5. **EMT STOP Ø**

6. IV NS TKO, if hypotensive 20 cc/kg *(peds 20 cc/kg)*
7. EKG monitor
8. Oxygen saturation
9. **EMT-IV/PARAMEDIC STOP Ø**
OBSTETRICAL EMERGENCIES

SOP # 504  Breech or Limb Presentation

Assessment

Patient Para & Gravida
Term of pregnancy in weeks, EDC
Vaginal bleeding
Pre-natal medications, problems, and care
Water broken
Buttock, arm or leg presentation

**Breech Presentation - Treatment - Standing Order** – All EMT’s
1. Oxygen 100% at 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition
2. Allow the delivery to progress spontaneously - DO NOT PULL!
3. Support the infant's body as it delivers
4. If the head delivers spontaneously, deliver the infant as noted in 'Normal Delivery'
5. If the head does not deliver within 3 minutes, insert a gloved hand into the vagina to create an airway for the infant
6. DO NOT remove your hand until relieved by a Higher Medical Authority.

**Limb Presentation - Treatment - Standing Order** – All EMT’s
7. Oxygen 100% 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition
8. Position the mother in a supine position with head lowered and pelvis elevated

9. EMT STOP Ø

**EMT-IV PARAMEDIC**
10. IV NS TKO, if hypotensive 20 cc/kg *(peds 20 cc/kg)*
11. EKG monitor
12. Oxygen saturation
13. Transport ASAP
14. EMT-IV/PARAMEDIC STOP Ø
OBSTETRICAL EMERGENCIES

SOP # 505 Meconium Stain

Assessment

<table>
<thead>
<tr>
<th>Patient Para &amp; Gravida</th>
<th>Term of pregnancy in weeks, EDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal bleeding</td>
<td>Pre-natal medications, problems, and care</td>
</tr>
<tr>
<td>Membrane Ruptured</td>
<td>Amniotic fluid that is greenish or brownish-yellow</td>
</tr>
<tr>
<td>Fecal material expelled with the amniotic fluid</td>
<td></td>
</tr>
</tbody>
</table>

**Basic**

1. Do not stimulate respiratory effort before suctioning the oropharynx
2. Suction the **mouth then the nose** (using a meconium aspirator) while simultaneously providing Oxygen 100% by blow-by method and while maintaining the airway appropriate to the patient’s condition
3. Obtain an APGAR score after airway treatment priorities. Score at one minute after delivery and at five minutes after delivery. (Time permitting)
4. Repeat initial assessment and complete vital signs until patient care is transferred to the appropriate ER staff

**EMT STOP Ø**

**EMT-IV/PARAMEDIC**

6. IV NS TKO, if hypotensive 20 cc/kg *(peds 20 cc/kg)*
7. EKG monitor
8. Oxygen saturation

**EMT-IV/PARAMEDIC STOP Ø**
OBSTETRICAL EMERGENCIES

SOP # 506 Placenta Previa

Assessment

Painless bleeding which may occur as spotting or recurrent hemorrhage
Bright red vaginal bleeding usually after 7th month
History
Multiparity
Increased maternal age
Recent sexual intercourse or vaginal exam
Patient Para & Gravida
Term of pregnancy in weeks
Pre-natal medications, problems, and care
History of bed rest
Placenta protruding through vagina

Basic

1. Oxygen 100% and airway maintenance appropriate to the patients condition
2. Position of comfort
3. EMT STOP Ø

EMT-IV PARAMEDIC

4. IV NS TKO, if hypotensive 20 cc/kg (peds 20 cc/kg)
5. EKG monitor
6. Oxygen Saturation
7. EMT-IV/PARAMEDIC STOP Ø

Note: Any painless bleeding in the last trimester should be considered Placenta Previa until proven otherwise. If there are signs of eminent delivery membrane rupture is indicated followed by delivery of the baby. The diagnosis of eminent delivery depends on the visual presence of the baby’s body part through the membrane.
OBSTETRICAL EMERGENCIES

SOP # 507  Prolapsed Umbilical Cord

Assessment
Cord emerges from the uterus ahead of the baby
With each uterine contraction the cord is compressed between the presenting part and the pelvis
Pulse on exposed cord may or may not be palpable
Patient Para & Gravida
Term of pregnancy in weeks, EDC
Vaginal bleeding
Pre-natal medications, problems, and care
Membrane ruptured

Basic
1. Palpate pulses in the cord.
2. Oxygen 100% and airway maintenance appropriate to patient's condition.
3. Position the mother with hips elevated.
   a. Knee to chest
   b. Hips elevated as much as possible on pillows
4. Instruct mother to pant with each contraction, which will prevent her from bearing down.
5. Check for a pulse in the cord
   a. If no pulse - Insert a gloved hand into the vagina and gently push the infant's head off of the cord.
      While pressure is maintained on the head cover the exposed cord with a sterile dressing moistened in saline. Transport immediately and DO NOT remove your hand until relieved by hospital staff.
   b. If pulse present – cover exposed cord with moist dressing
6. Contact Medical Control as soon as possible if time and patient condition allows.
7. EMT STOP Ø

EMT-IV PARAMEDIC
8. IV NS TKO, if hypotensive 20 cc/kg (peds 20 cc/kg)
9. EKG monitor
10. Oxygen saturation
11. EMT-IV/PARAMEDIC STOP Ø
OBSTETRICAL EMERGENCIES

SOP # 508 Pre-eclampsia and Eclampsia

Assessment

<table>
<thead>
<tr>
<th>Patient Para &amp; Gravida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term of pregnancy in weeks, EDC</td>
</tr>
<tr>
<td>Vaginal bleeding</td>
</tr>
<tr>
<td>Pre-natal medications, problems, and care</td>
</tr>
<tr>
<td>Membrane Ruptured</td>
</tr>
<tr>
<td>Usually begins after the twentieth week of pregnancy</td>
</tr>
<tr>
<td>Most often affects women during their first pregnancy</td>
</tr>
<tr>
<td>May have a history of chronic hypertension and/or diabetes</td>
</tr>
<tr>
<td>May experience hypertension and edema</td>
</tr>
<tr>
<td>May experience headaches, blurred vision, and abdominal pain</td>
</tr>
<tr>
<td>May experience seizures which indicates a progression from pre-eclampsia to eclampsia</td>
</tr>
</tbody>
</table>

1. Oxygen 100% 12 - 15 Lpm NRB and airway maintenance appropriate to patient's condition.
2. Place patient in left lateral recumbent position
3. Check glucose levels
4. **EMT STOP Ø**

5. IV NS TKO, if hypotensive 20 cc/kg (**peds 20 cc/kg**)  **EMT-IV STOP Ø**
6. EKG monitor
7. Oxygen saturation
8. **EMT-IV STOP Ø**

9. Valium 5 mg slow IV PRN or Versed 2-5 mg IVP if generalized seizure activity.
10. Contact Medical Control and consider:
    - Magnesium Sulfate 1-2 grams IV slowly
11. **PARAMEDIC STOP Ø**

**Note:** Record a blood pressure and the presence or absence of edema in every pregnant woman you examine no matter what the chief complaint.
MISCELLANEOUS

SOP # 601 Discontinuation / Withholding of Life Support

Once life support has been initiated in the field, Non ALS personnel CAN NOT discontinue resuscitative measures unless directed to do so by the on-scene physician, FF/EMT-Paramedic or presented with a valid Physician Orders for Scope of Treatment (POST).

Withholding Resuscitation - Standing Orders
1. If there is no CPR in progress, CPR may be withheld if one or more of the conditions are met:
   a. Obviously dead patients with dependent lividity, rigor mortis, or massive trauma: (i.e., evacuation of the cranial vault, crushed chest, crushed head, etc).
   b. Obviously dead patients with tissue decomposition.
   c. Patients without vital signs who cannot be accessed for treatment due to entrapment for prolonged time.(12 - 15 minutes or greater)
   d. Severe blunt trauma with absence of B/P, pulse, respiratory effort, neurologic response and pupillary response
   e. When presented a valid POST order or a copy as approved by the Ohio Department of Health. DNR and POST orders not on the official state form can be accepted if it is documented in a medical record such as a nursing chart, hospice care, or home nursing
   f. Instructed to do so by the Paramedic on the scene.

Discontinuing Life Support
Once life support has been initiated in the field, in order to discontinue life support, the following conditions must be met:
1. Asystole is present on the EKG monitor in two leads and
2. The patient had fixed, dilated pupils prior to the administration of Atropine, and
3. There is absence of pulse, respirations, and neurological reflexes and at least one of the following conditions are met:
   a. Endotracheal intubations has been confirmed, the patient has been well ventilated with 100% oxygen and multiple (at least three) administrations of Epinephrine and Atropine have not been effective in generating an EKG complex.
   b. Transcutaneous pacing, if available, has not been effective in generating a complex.
   c. Obvious signs of death in the absence of hypothermia, cold water drowning, lighting strikes or induced coma.
   d. the FF/Paramedic can document lack of C.P.R. for at least 10 minutes, or
   e. prolonged resuscitation in the field without hope for survival, or
   f. massive trauma such as evacuation of cranial vault, etc., or
   g. severe blunt trauma with absence of vital signs and pupillary response, or
   h. end-tidal CO$_2$ less than 20 while performing effective CPR

Upon termination in the field any tubes, needles and IV lines will be left in place (IV lines to be tied off and cut with catheter left in place).

Note:
Personnel shall give careful consideration when utilizing this standing order. Conditions such as; overdose, electrical shock, hypothermia, and hypoglycemia may mimic some of the above signs and symptoms.

All deaths must be confirmed by a Paramedic

Revised June, 2010 79 Effective: July, 2010
MISCELLANEOUS

SOP # 602  FIELD DETERMINATION OF DEATH

Assessment

<table>
<thead>
<tr>
<th>Pulseless, non-breathing with definitive signs of death:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rigor Mortis</td>
</tr>
<tr>
<td>Dependent lividity</td>
</tr>
<tr>
<td>Decomposition of body tissue</td>
</tr>
<tr>
<td>Devastating, un-survivable injury</td>
</tr>
<tr>
<td>Decapitation</td>
</tr>
<tr>
<td>Incineration</td>
</tr>
<tr>
<td>Separation of vital internal organ from the body or total destruction of organs</td>
</tr>
<tr>
<td>Gunshot wound to the head that crosses the midline (entrance and exit)</td>
</tr>
</tbody>
</table>

If patient is pulseless, non-breathing without definitive signs of death:
   Must receive resuscitation unless a properly executed DNR or POST form is present

Treatment-Standing Order

DNR orders:
   If family member or caregiver can produce a properly executed DNR or POST order, resuscitation can be withheld.
   Treat patients with known DNR orders appropriately, just do not initiate CPR if they develop cardiovascular or respiratory arrest.
   When there is any doubt about what to do, begin resuscitative efforts with all skill available

Resuscitation has been initiated prior to EMS arrival:
   Anytime CPR or an attempt at resuscitation has been initiated by anyone at the scene, resuscitative efforts will be continued until:
      1. A physician directs the team to stop (either on line or on-scene)
      2. It is determined the patient meets the criteria for “definitive signs” of death.
      3. A properly executed DNR or POST form is presented.
MISCELLANEOUS

SOP # 603     Mandatory EKG

EKGs will be mandatory under the following conditions:

A. Patients
   1. Complaining of chest pain regardless of source (trauma or illness)
   2. In cardiac arrest with or without CPR in progress
   3. That are non-viable (other than those exhibiting body decomposition, dependent lividity, or rigor mortis, decapitation)

B. EKGs will have the following information printed on the recording:
   1. Name or report number
   2. Age (if possible)
   3. Unit number and date

C. EKGs will be taped to the appropriate form on all four sides

Note: EMT-B and EMT-IV may assist Paramedic with 12 Lead EKG.
MISCELLANEOUS

SOP # 604 Patient Refusal of Care – Patient Non-Transport Situations

Assessment

<table>
<thead>
<tr>
<th>Determine presence of injury or illness and desire for transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify the person who made the EMS call</td>
</tr>
<tr>
<td>Reason for refusal</td>
</tr>
</tbody>
</table>

Standing Orders

1. Perform and document mini-mental status exam to confirm competency to refuse care.
2. Confirm and document the absence of intoxicating substance or injury
3. Confirm patient is of legal age of majority, or emancipated minor.
5. Document pertinent past history.
6. Perform vital signs and problem directed exam.

The following may not refuse transport:

1. Patients with impaired judgment
2. Minors (if not 18 years of age or older or emancipated)
3. All minors must have refusal from parent or guardian, not older sibling or other relative
4. Do not release minor on the scene without parent/guardian consent

Reasons for Non-Transport

1. Minor illness or injury and acceptable alternative transportation available.

MINI-MENTAL STATUS EXAM

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Orientation to time – time of day, day, week, month year</td>
<td>5 Pts max</td>
</tr>
<tr>
<td>2. Orientation to place – building, street, city, state, country</td>
<td>5 Pts max</td>
</tr>
<tr>
<td>3. Say “boy, dog, ball” and have them repeat it</td>
<td>3 Pts max</td>
</tr>
<tr>
<td>4. Ask the patient to spell would backward, or do serial 3s backward from 20</td>
<td>5 Pts max</td>
</tr>
<tr>
<td>5. Without repeating the words, ask them to repeat the previous 3 words (boy, dog, ball)</td>
<td>3 Pts max</td>
</tr>
<tr>
<td>6. Ask the patient to do the following after you have completed the request “stick out your tongue and touch your right hand to your left ear”</td>
<td>3 Pts max</td>
</tr>
<tr>
<td>7. Ask the patient to identify your pen and watch.</td>
<td>2 Pts max</td>
</tr>
<tr>
<td>8. Ask the patient to read the following sentence and then does as it says “shut your eyes”</td>
<td>1 Pt</td>
</tr>
<tr>
<td>9. Ask the patient to write a sentence.</td>
<td>1 Pt</td>
</tr>
<tr>
<td>10. Ask the patient to draw two overlapping pentagons (show them an example)</td>
<td>1 Pt</td>
</tr>
</tbody>
</table>

A score of 21 or better is considered mentally competent by most psychiatrists for a patient to make reasonable decisions.
MISCELLANEOUS

SOP # 605  Physical Restraint:

**BASIC**  **IV**  **PARAMEDIC**

All Patients:
1. Safety of fire department personnel is the main priority in any situation where a patient exhibits aggressive or combative behaviors and needs to be restrained.
2. Use the minimum amount of force and restraint necessary to safely accomplish patient care and transportation with regard to the patient’s dignity. Avoid unnecessary force.
3. Assure that adequate personnel are present and that police assistance has arrived, if available, before attempts to restrain patient.
4. Plan your approach and activities before restraining the patient.
5. Have one fire department person talk to and reassure the patient throughout the restraining procedure.
6. Approach with a minimum of four persons, one assigned to each limb, all to act at the same time.
7. Initial take down may best be accomplished leaving the patient in the prone position. After restraint, the patient should be placed in a supine position.
8. Call for additional help if patient continues to struggle against restraint.
9. Restrain all 4 extremities with patient supine on stretcher.
10. Use soft restraints to prevent the patient from injuring him or herself or others.
11. A police officer or other law enforcement personnel shall always accompany a patient in the ambulance if the patient has been restrained.
12. Do not place restraints in a manner that may interfere with evaluation and treatment of the patient or in any way that may compromise patient’s respiratory effort.
13. Evaluate circulation to the extremities frequently.
14. Thoroughly document reasons for restraining the patient, the restraint method used, and results of frequent reassessment.
15. Initial “take down” may be done in a prone position to decrease the patient’s visual field and stimulation, and the ability to bite, punch, and kick. After the individual is controlled, he/she shall be restrained to the stretcher or other transport device in the supine position.
16. **DO NOT** restrain patient in a hobbled, hog-tied, or prone position.
17. **DO NOT** sandwich patient between devices, such as long boards or Reeve’s stretchers, for transport. Devices like backboards should be padded appropriately.
18. A stretcher strap that fits snugly just above the knees is effective in decreasing the patient’s ability to kick.
19. Padded or leather wrist or ankle straps are appropriate. Handcuffs and plastic ties are not considered soft restraints.
20. Never apply restraints near the patient’s neck or apply restraints or pressure in a fashion that restricts the patient’s respiratory effort.
21. Never cover a patient’s mouth or nose except with a surgical mask or a NRB mask with high flow oxygen. A NRB mask with high flow oxygen may be used to prevent spitting in a patient that also may have hypoxia or another medical condition causing his/her agitation, but a NRB mask should never be used to prevent spitting without also administering high flow oxygen through the mask.
Performance Parameters
1. Verbal techniques include:
   a. Direct empathetic and calm voice.
   b. Present clear limits and options.
   c. Respect personal space.
   d. Avoid direct eye contact.
   e. Non-confrontational posture.
2. There is a risk of serious complications or death if patient continues to struggle violently against restraints. Chemical restraint by sedation by ALS personnel may be indicated in some dangerous, agitated patients.

3. INT or IV NS/LR, if hypotensive 20cc/kg (peds 20cc/kg)
4. EMT-IV STOP Ø

5. a. Valium: 2 – 5 mg IV only, repeat once
   b. Versed: 2-5 mg IV or IM or IN , may repeat once
   c. Additional doses must be authorized by Medical Control
6. EMT-Paramedic STOP Ø

Possible Medical Control Orders: Medical Control may order restraint and transport of a patient against his/her will.

Documentation:
A Review for documentation of frequent reassessment of vital signs, cardiopulmonary status, and neurovascular status of restrained extremities, reason for restraint and method used. Benchmark of documenting of these items is at least every 15 minutes.
MISCELLANEOUS

SOP # 606  Physician On-Scene

**BASIC**  **IV**  **PARAMEDIC**

If private physician intervenes by phone the EMT-Basic / IV shall:

Request the physician contact Medical Control and relay any orders through them.

**NO ORDERS** will be taken over the phone from the private physician.

**Standing Order:**

1. No one will be recognized as a physician without proof of license. This must be in the form of a wallet card or visual personal recognition. **NO ORDERS** will be accepted until proof of license is verified.

2. Consider need for Law Enforcement if any difficulty with person occurs.

3. The EMT shall:
   a. Inform the physician that they must contact Medical/Trauma Control.
   b. Inform Medical/Trauma Control of the presence of a physician on the scene.

4. Medical/Trauma Control may:
   a. Speak to the physician to determine qualifications
   b. Request the EMT/Paramedic to verify licensure of the physician.
   c. Relinquish total responsibility for the patient to the on-scene physician.

5. Physician (intervening) may:
   a. Assist the EMT and allow you to operate under EMS standing orders and protocols. Offer assistance by allowing the EMT to remain under Medical/Trauma Control; or
   b. Request to talk to Medical/Trauma Control to offer advice and assistance; or,
   c. Take total responsibility for the care given by the EMT if okay with Medical/Trauma Control, then physically accompany the patient to the Emergency Department where responsibility is assumed by the receiving physician; and shall,
   d. Sign for all instructions given to the EMT
   e. Contact should be made with Medical/Trauma Control if this happens.

6. If private physician intervenes by phone or in person the EMT shall:
   a. Inform the physician that the EMT must contact Medical/Trauma Control.
   b. Request the physician contact Medical Control and relay any orders through them.
   c. **NO ORDERS** should be taken over the phone from the private physician. At no time should any order be taken over the telephone except from Medical/Trauma control.
MISCELLANEOUS

SOP # 607  By-standers on the Scene

**BASIC IV PARAMEDIC**

**Standing Order**

By-stander participation – You may use them at your discretion. However, YOU will be responsible for their actions and treatment. Remember, YOU are responsible for the patient. If any by-stander is uncooperatively trying to take over direction of patient care, have law enforcement remove the person for “Obstruction of Emergency Services”.

MISCELLANEOUS

SOP # 608  Procedure for Deviation from Standing Orders

**BASIC IV PARAMEDIC**

NEVER simply disregard a standing order or protocol.

These Standing Orders have been established so that EMTs and Paramedics may provide the best care possible for our patients. Most of our patients will be covered by a single Standing Order. However, some patients may have signs and symptoms of illness and/or injury that are covered by more than one Standing Order or, in rare cases, following a Standing Order may not be in the best interest of the patient. In these cases you must be aware that combining Standing Orders may lead to medication errors, overdose, and medication incompatibility. You are expected to use your judgment and to always make decisions that are in the best interest of the patient.

If you use more than one standing order when treating your patient, you must document your reasoning in the NARRATIVE SECTION of the Patient Care Report.

If in your judgment, following a standing order is not in the best interest of the patient, CONTACT MEDICAL CONTROL, regarding your treatment. Document the rationale for deviation, and the name of the physician giving the order.
MISCELLANEOUS

SOP # 609 Spinal Immobilization

Spinal Immobilization Protocol

If the patient presents with a mechanism which could cause spinal injury ANY of the following criteria, complete Spinal Immobilization (C-spine, and back, using C-collar, head blocks, backboard, and straps) should occur.

1. Any fall from standing or sitting with evidence of injury above the clavicles
2. Fall from a height (above ground level)
3. Any MVC crash (except a low speed mechanism such as a simple rear end MVC, without rollover or ejection and minimal to no vehicular damage)
4. Any type trauma where victim was thrown or struck at high speed (e.g. pedestrian accident or explosion)
5. Any lightning or high voltage electrical injury
6. Any axial load type injury as might be sustained while swimming/diving or an acute submersion event, where diving may have been involved
7. Penetrating trauma to the thorax when bullet track may involve spine OR

Any unknown or possible mechanism of injury when the history from the patient or bystanders does not exclude the possibility of a spine injury

- History of Loss of Consciousness
- Disoriented or Altered LOC
- Suspected Use of Drugs or Alcohol
- Symptoms of Neck or Back pain or Midline Cervical Tenderness
- Focal Neurological Deficit such as Extremity Weakness or Numbness Even if resolved
- Painful distracting injury that could mask Cervical pain or injury
- Pain with active Range of Motion of Patient’s neck

If ALL the above documentation negative, spinal immobilization is NOT required.

MISCELLANEOUS

Revised June, 2010

Effective: July, 2010
SOP # 610   Stretcher Transport

The following conditions require patients to be transported by stretcher or stair chair. Other patients may be transported ambulatory unless their condition warrants stretcher use.

1. Pregnant greater than 20 weeks
2. Possible cardiac chest pain
3. Shortness of breath
4. Asthma
5. Chronic Obstructive Pulmonary Disease
6. Stroke
7. Patients requiring spinal immobilization
8. Penetrating trauma to the torso, neck, or head
9. Lower extremity, pelvis trauma
10. Low back trauma
11. Unconscious, unresponsive patients
12. Seizures within past hour or actively seizing
13. Generalized weakness
14. Patients unable to ambulate secondary to pain or weakness
15. Altered level of consciousness, except psychiatric patients
16. Psychiatry patients requiring restraint

MISCELLANEOUS

SOP # 611   Terminally Ill Patients

Standing Order

1. Maintain a calm environment and avoid performing measures beyond basic life support.
2. Elicit as much information from persons present who are familiar with the patient's condition as possible.
3. Obtain and document the name and telephone number of the patient's physician if possible.
4. Maintain BLS procedures and contact Medical Control as soon as possible. Provide full information on the patient's present condition, history, and the name of the patient's physician and telephone number.
5. Medical Control will direct management of the call.
6. Acceptable DNR/POST forms (original or copy):
   - State approved forms
   - Signed order in patients medical records: nursing home, hospice, or home care
** If DNR/POST form is used to withhold or terminate resuscitation efforts, a copy must be attached to the PCR.
OHIO EMERGENCY MEDICAL SERVICES SOP’S

MISCELLANEOUS

SOP # 612  “Excited Delirium” / Taser Use

Assessment

| Changes in LOC | Ongoing disorientation | Agitation | Hallucination | Hyperthermia | Seizure | Chest pain or difficulty breathing | Significant injury from fall or takedown |

1. 100% Oxygen and airway maintenance appropriate to patient’s condition
2. Glucose check
3. Supportive care
4. EMT STOP Ø

5. IV LR or NS, bolus (20cc/kg)
6. Administer Dextrose 50% if appropriate
7. EKG monitor
8. Oxygen saturation
9. EMT-IV STOP Ø

10. Valium 2-10 mg slow IVP PRN or Versed 2-5 mg IVP/IN if generalized seizure activity
11. PARAMEDIC STOP Ø

Note:
All persons subjected to use of the device should be medically evaluated and monitored regularly. Darts should be treated as biohazard, and not be removed in the field except by trained personnel. Darts to eyes, mouth, face, neck, and genitals or near indwelling medical devices or lines should not be removed in the field.
SOP # 613   Neonatal Resuscitation

Assessment

Newborn with respiratory or circulatory distress

**Basic**

1. Dry and place in face-up head down position
2. Keep infant level with mother until cord is clamped
3. Suction airway
4. Respirations.
   a. If spontaneous:
      1. complete clamping cord and cut between clamps
      2. cover infant head
      3. wrap and keep warm
      4. provide oxygen
      5. transport without delay
   b. if no respirations:
      1. stimulate respirations: rub back, snap bottom of feet gently , if no change or respirations become depressed (<20bpm)
         (a) re-suction airway
         (b) high flow oxygen if no change ventilate with BVM at 30/min
         (c) clamp cord and cut between clamps, transport immediately
5. Pulse:
   a. If pulse rate is less than 60 perform CPR at rate of 120 compressions/min, transport
      i. Continue chest compressions.

**EMT-IV**

7. INT or IV NS, if hypotensive bolus 20 cc/kg
8. EKG monitor
9. Oxygen Saturation
10. **EMT-IV STOP Ø**

**PARAMEDIC**

11. The dose of epinephrine is 0.01 mg/kg IV/IO (0.1 cc/kg of 1:10,000) given q 4 minutes and repeated every 4 minutes until heart rate is above 60 / minute.
12. If pulse rate is >60 keep warm, ventilate with BVM if necessary, transport
13. **PARAMEDIC STOP Ø**
PROCEDURE

CHEST DECOMPRESSION

1. Cleanse skin on affected side using aseptic technique
2. Using a 14 or 16 gauge 2¼” angiocath, insert between the 2nd/3rd mid-clavicular or 4th/5th mid-axillary spaces
3. Advance needle until “pop” is felt while the needle is entering the pleural space
4. Advance catheter until hub contacts skin
5. Cover catheter hub with Asherman Chest Seal or equivalent (ensure one way valve effect)
6. Reassess patient or breath-sound changes
7. If signs of tension reoccur check chest seal, consider repeating chest decompression per above steps
8. Contact Medical Control
9. Transport

*Use the same procedure for pediatric patients: use 18 or 20 gauge angiocath*
PROCEDURE Vascular Access

1. The preferred site for an IV is the hand followed by the forearm and antecubital and is dependent on the patient’s condition and treatment modality.

2. EMT-IV STOP Ø

3. In the event that an IV cannot be established, and the IV is considered critical for the care of the patient, other peripheral sites may be used, i.e. external jugular, feet, legs.

4. External Jugular Veins should never be the first line attempted unless the patient has no limbs for the initial attempts. INTs SHOULD NOT be used in External Jugular access.

5. The intraosseous site may be used in patients in whom IV access cannot be established within 2 attempts or 90 seconds when IV access is critical. (REFER TO THE EZ IO PROCEDURE)

Intravenous Fluid Administration

Any patient having a condition that requires an IV or INT may receive it if the EMT-IV or Paramedic deems it necessary. Weigh the transport time against the time it would take to start an IV and make a good decision.

**Trauma:**

Minimize on scene time. IVs are to be started while en route to the hospital unless the patient is pinned in vehicle or a prolonged scene time is unavoidable.

IV Lactated Ringers or Normal Saline may be used for trauma patients. The rate is based on patient condition and shall be to maintain the patient's systolic blood pressure 80 - 100 mmHg.

**Medical:**

INT or IV Normal Saline for chest pain, cardiac arrest or other medical conditions requiring possible IV access. If IV access is all that is needed, the INT is preferred.
Medication administration in a certain subgroup of patients can be a very difficult endeavor. For example, an actively seizing or medically restrained patient may make attempting to establish an IV almost impossible which can delay effective drug administration. Moreover, the paramedic or other member of the medical team may be more likely to suffer a needle-stick injury while caring for these patients.

In order to improve prehospital care and to reduce the risks of accidental needle-stick, the use of the Mucosal Atomizer Device (MAD) is authorized in certain patients. The MAD allows certain IV medications to be administered into the nose. The device creates a medication mist which lands on the mucosal surfaces and is absorbed directly into the bloodstream.

**Indications:**

Emergent need for medication administration and IV access unobtainable or presents high risk of needlestick injury due to patient condition.

- Seizures / Behavioral Control: Midazolam (Versed) may be given intranasally until IV access is available.
- Altered Mental Status from Suspected Narcotic Overdose: Naloxone (Narcan) may be given intranasally until IV access is available.
- Symptomatic Hypoglycemia (Blood sugar less than 80mg/dl): Glucagon may be given intranasally until IV access is available.

Medications administered via the IN route require a higher concentration of drug in a smaller volume of fluid than typically used in the IV route. In general, no more than 1 milliliter of volume can be administered during a single administration event.

**Contraindications:**

- Bleeding from the nose or excessive nasal discharge
- Mucosal Destruction

**Technique:**

- Draw proper dosage (see below)
- Expel air from syringe
- Attach the MAD device via LuerLock Device
- *Briskly* compress the syringe plunger

**Complications:**

- *Gently* pushing the plunger will not result in atomization
- Fluid may escape from the nares
- IntraNasal Dosing is less effective than IV dosing (Slower onset, incomplete absorption)
- Current patient use of nasal vasoconstrictors (Neosynephrine/ Cocaine) will significantly reduce the effectiveness of IN medications. Absorption is delayed, peak drug level is reduced, and time of drug onset is delayed.
**Midazolam**

<table>
<thead>
<tr>
<th>Patient age (yr)</th>
<th>Weight (kg)</th>
<th>IN Midazolam volume in ml (assuming 5mg/ml concentration)</th>
<th>Midazolam volume dose (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonate</td>
<td>3</td>
<td>0.12 ml 0.6 mg</td>
<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>6</td>
<td>0.24 ml 1.2 mg</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>10</td>
<td>0.40 ml 2.0 mg</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>14</td>
<td>0.56 ml 2.8 mg</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>16</td>
<td>0.64 ml 3.2 mg</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>18</td>
<td>0.72 ml 3.6 mg</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>20</td>
<td>0.80 ml 4.0 mg</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>22</td>
<td>0.88 ml 4.4 mg</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>24</td>
<td>0.96 ml 4.8 mg</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>26</td>
<td>1.04 ml 5.2 mg</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>28</td>
<td>1.12 ml 5.6 mg</td>
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<tr>
<td>10</td>
<td>30</td>
<td>1.20 ml 6.0 mg</td>
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<tr>
<td>11</td>
<td>32</td>
<td>1.28 ml 6.4 mg</td>
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<tr>
<td>12</td>
<td>34</td>
<td>1.36 ml 6.8 mg</td>
<td></td>
</tr>
<tr>
<td>Small teenager</td>
<td>40</td>
<td>1.60 ml 8.0 mg</td>
<td></td>
</tr>
<tr>
<td>Adult or full grown teenager</td>
<td>50 or more</td>
<td>2.0 ml 10.0 mg</td>
<td></td>
</tr>
</tbody>
</table>

**Precautions:**
- Midazolam may cause hypoventilation and potential respiratory depression/arrest. Have equipment and help readily available to manage the airway when administering this medication.
- If hypotension develops after the administration of midazolam, administer a 20ml/kg bolus of normal saline.

**Naloxone**

**Adult**
- Naloxone 0.4 mg every 5 minutes until the respiratory rate improves and the patient can maintain a pulse oximetry reading of 96% OR until 2 mg has been given.
- Split dose equally between each nostril

**Pediatric**
- Naloxone 0.1 mg/kg until the respiratory rate improves and the patient can maintain a pulse oximetry reading of 96% OR until 2 mg has been given.
- Split dose equally between each nostril

**Glucagon**

Intranasal lyophilized Glucagon may be given to Hypoglycemic adults in the same dose as IM or IV routes. The dose should be split evenly between each nostril.
PROCEDURE

EZ IO

Indications:

1. Intravenous fluid or medications needed AND
2. Peripheral IV cannot be established in 2 attempts or 90 seconds AND the patient exhibits one or more of the following:
   - Altered mental status (GCS of 8 or less)
   - Respiratory compromise (SaO2 of 80% or less following appropriate oxygen therapy, and/or respiratory rate <10 or >40/min)
   - Hemodynamically unstable (Systolic BP <90)
3. IV access is preferred, however, IO may be considered prior to peripheral IV attempts in the following situations:
   - Cardiac Arrest (Medical or Trauma)
   - Profound hypovolemia with altered mental status

Contraindications:

1. Fracture of the tibia or femur (for tibia insertion) – consider alternate tibia
2. Fracture of the humerus (for humeral head insertion) – consider alternate humerus
3. Previous orthopedic procedures (ex.: IO within previous 24 hrs, knee replacement, shoulder replacement)
4. Infection at insertion site
5. Significant edema
6. Excessive tissue at insertion site
7. Inability to locate landmarks

Considerations:

1. Flow Rates: Due to the anatomy of the IO space you will note flow rates to be slower than those achieved with IV access.
   - Ensure the administration of 10 ml rapid bolus with syringe.
   - Use a pressure bag or pump for fluid challenge
2. Pain: Insertion of the IO device in conscious patients causes mild to moderate discomfort and is usually no more painful than a large bore IV. However, fluid infusion into the IO space is very painful and the following measures should be taken for conscious patients:
   - Prior to IO bolus or flush on a conscious adult patient, SLOWLY administer 20 – 50 mg of 2% Lidocaine.
   - Prior to IO bolus or flush on a conscious pediatric patient, SLOWLY administer 0.5mg/kg 2% Lidocaine
Adult Patient: Defined as a patient weighing 40kg or greater
The adult (blue cap) needle set shall be used for adult patients

Primary Insertion Site: Tibial Plateau
- If IO access is warranted the tibia shall be the insertion site of choice if possible

Alternate Insertion Site: Humeral Head or Medial Malleolus (adult pt. only)
- If IO access is not available via the tibia insertion site due to contraindications or inability to access the site due to patient entrapment and vascular access is imperative the IO may be placed in the humeral head or medial malleolus

Do Not attempt insertion medial to the Intertubecular Groove or the Lesser Tubercle

Pediatric Patient: Defined as a patient weighing 3 – 39kg
- The pediatric needle set (pink cap) shall be used for pediatric patients
- Use the length based assessment tape to determine pediatric weight
- The only approved site for pediatric IO insertion is the tibial plateau

Standing Order: The EZ IO may be used if the Indications are met and no Contraindications exist.

Precautions:
1. The EZ IO is not intended for prophylactic use
2. The EZ IO infusion system requires specific training prior to use

Proper identification of the insertion site is crucial.

Landmarks: Tibial Plateau
There are three important anatomical landmarks – the Patella, the Tibial Tuberosity (if present) and the Flat Aspect of the Medial Tibia.

Important: The tibial tuberosity is often difficult or impossible to palpate on very young patients! The traditional approach for IO insertions in small patients - where the tibial tuberosity cannot be palpated - is to identify the insertion site - “TWO FINGER WIDTHS BELOW THE PATELLA and then medial along the flat aspect of the TIBIA.”

The traditional approach to IO insertion in slightly larger patients - where the tuberosity can be appreciated - generally suggests “One finger width distal to the tibial tuberosity along the flat aspect of the medial tibia.”
The EZ-IO should be inserted two finger widths below the patella (kneecap) and one finger medial (toward the inside) to the tibial tuberosity.

For the morbidly obese patient – consider rotating the foot to the mid-line position (foot straight up and down). With the knee slightly flexed, lift the foot off of the surface allowing the lower leg to “hang” dependant. This maneuver may improve your ability to visualize and access the tibial insertion site.
Landmarks: Humerus

Place the patient in a supine position.

Expose the shoulder and place the patient’s arm against the patient’s body.

Rest the elbow on the stretcher with the forearm on the abdomen. Palpate and identify the mid shaft humerus and continue palpating toward the humeral head. As you near the shoulder you will note a small protrusion. This is the base of the greater tuberele insertion site. With the opposite hand “pinch” the anterior and inferior aspects or the humeral head confirming the identification of the greater tuberlce. This will ensure that you have identified the midline of the humerus itself. The insertion site is approximately two finger widths inferior to the coracoid process and the acromion.

Landmarks: Medial Malleolus

The insertion site is two finger widths proximal to the Medial Malleolus and positioned midline on the medial shaft.

Procedure:

Inserting the EZ IO

1. Determine that the EZ IO is indicated
2. Ensure that no contraindications are present.
3. Locate the proper insertion site.
4. Clean the insertion site with alcohol.
5. Prepare the EZ IO driver and needle set.
6. Stabilize the leg (or arm).
7. Position the driver at the insertion site with the needle at a 90 degree angle to the surface of the bone.
8. Power the needle set through the skin until you feel the tip of the needle set encounter the bone. Apply firm steady pressure on the driver and power through the cortex of the bone. Stop when the needle flange touches the skin or a sudden resistance is felt. Stop on the POP. This indicates entry into the bone marrow cavity.
9. Grasp the hub firmly with one hand and remove the driver from the needle set.
10. While continuing to hold the hub firmly, rotate the stylet counter clockwise and remove it from the needle set. Dispose of the stylet properly in a sharps container.
11. Confirm proper placement of the EZ IO catheter tip:
   a. The catheter stands straight up at a 90 degree angle and is firmly seated in the tibia.
   b. Blood is sometimes visible at the tip of the stylet
   c. Aspiration of a small amount of marrow with a syringe.
12. Attach a primed extension set to the hub and flush the IO space with 10 cc of Normal Saline.

   **NO FLUSH – NO FLOW**

13. If the patient is conscious, administer Lidocaine 2% 20-50 mg slowly PRIOR to the initial bolus.
14. Initiate the infusion per standing orders. Use of a pressure infuser or blood pressure cuff is recommended to maintain adequate flow rates.
15. Apply the wrist band and a dressing.
PROCEDURE

INDUCED HYPOTHERMIA FOLLOWING ROSC
The goal is to begin cooling the patient who meets criteria as soon as possible. You may initiate resuscitation with cold saline as your IVF of choice if the patient appears to be a candidate for IH. Therefore, if you have cold saline available when the first IV is started, begin cold fluids immediately. If IV access is already established, change to Cold saline when ROSC is achieved. If ROSC is not achieved, proceed as you would with any nonresponsive cardiac arrest, and document that cold saline was initiated. This will assist the medical examiner in determining times of death. Complete the remainder of the protocol.

PARAMEDIC

Criteria for Induced Hypothermia
- Age Greater than 18
- Return Of Spontaneous Circulation (regardless of blood pressure) following cardiac arrest (all non-traumatic causes)
- Patient remains comatose (GCS<8 and/or no purposeful responses to pain)
- Intubated or needs airway management (King Airway is acceptable)
- Systolic Blood Pressure can be maintained at 90 mm/Hg spontaneously or with fluids and pressors.

Patient Exclusion Criteria:
- Pregnant female with obviously gravid uterus
- Systolic Blood Pressure cannot be maintained at 90 mmHg or greater spontaneously or with fluids and pressors
- Coagulopathy or thrombocytopenia.

PROCEDURE
1. Patient meets criteria for Induced Hypothermia?
   If No, proceed to Post-Resuscitation protocol
   If Yes, Is the ET Tube placed?
   If No, proceed with Intubation. King Airway is acceptable.
   (Once airway is controlled, follow remaining steps)
2. Perform Neuro Exam to confirm meets criteria
3. Expose patient – Apply ice packs to Axilla, Neck, and Groin
4. Administer Cold Saline bolus (IV/IO) 20-30 mL/kg to max of 2 liters
5. Administer Versed 0.15 mg/kg to max 10 mg, if needed to control agitation or shivering.
6. If necessary, Administer Dopamine 10-20 mcg/kg/min for MAP 90-100

SPECIAL NOTES
- If patient meets other criteria for induced hypothermia and is not intubated, then intubate according to protocol before inducing cooling. If unable to intubate, use of King Airway is acceptable.
- When exposing patient for purpose of cooling, undergarments may remain in place. Be mindful of your environment and take steps to preserve the patient’s modesty.
- Do not delay transport for the purpose of cooling.
- Reassess airway frequently and with every patient move.
- Patients develop metabolic alkalosis with cooling. Do not hyperventilate.
- If there is loss of ROSC after cooling is initiated please document on PCR, discontinue cooling, and proceed with appropriate resuscitation protocol.
- Transport patient to Hypothermia capable center. Do NOT initiate this protocol if there are no receiving hospitals capable of continuing IH.
PROCEDURE

EXTERNAL TRANSCUTANEOUS CARDIAC PACING

Non-invasive cardiac pacing, also referred to as external or transcutaneous pacing, involves the temporary application of externally applied electrodes to deliver an adjustable electrical impulse directly across an intact chest wall for the purpose of rhythmically stimulating the myocardium to increase the mechanical heart rate.

Indications:
(1) It is indicated for the treatment of hemodynamically compromised patients in settings where cardiac output is compromised due either to the complete failure of cardiac rhythm or to an insufficient rate of the patient's intrinsic pacemaker.
(2) Bradycardia with a systolic BP of less than 80 mmHg with shocklike signs or symptoms.
(3) Patients who experience provider-witnessed cardiopulmonary arrest and who present with asystole, or patients whose EKG converts to asystole while the EKG is being monitored.
(4) Prompt application of the transcutaneous cardiac pacemaker is appropriate prior to the administration of epinephrine and atropine when a patient converts to asystole as a primary rhythm during EKG monitoring by a EMT-P.
(5) Pediatric patients (40 kg or less) with profound symptomatic bradycardia unresponsive to optimal airway management, oxygenation, epinephrine, and atropine.

NOTE: Medical consultation is required for pacing pediatric patients.

Contraindications:
(1) Non-witnessed cardiopulmonary arrest with asystole
(2) Patient not meeting blood pressure criteria

Technique:
Start at a pacemaker heart rate of 70 beats per minute and the milliamperes (m.a.) as low as possible and gradual increase m.a. until palpable pulse confirmed capture or 200 m.a.

POTENTIAL ADVERSE EFFECTS/COMPLICATIONS
Patients may experience mild to moderate discomfort.
   If patient is conscious and has adequate blood pressure consider:
       Morphine 1-2 mg/min IVP/IO
       And/or
       Diazepam 2.5-10 mg slow IV/IO or Versed 2-4 mg IV/IO

Musculoskeletal twitching in upper torso may occur during pacing.

PRECAUTIONS
When properly applied, chest compressions can be performed directly over the insulated electrodes while the pacer is operating

DO NOT USE EXTERNAL PACING ON A HYPOTHERMIC PATIENT.
PROCEDURE

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)

Continuous Positive Airway Pressure has been shown to rapidly improve vital signs, gas exchange, reduce the work of breathing, decrease the sense of dyspnea, and decrease the need for endotracheal intubation in patients who suffer from shortness of breath from asthma, COPD, pulmonary edema, CO poisoning, Near Drowning, CHF, and pneumonia. In patients with CHF, CPAP improves hemodynamics by reducing left ventricular preload and afterload.

2. INDICATIONS
   A. Any patient who is in respiratory distress for reasons other than trauma or pneumothorax, and;
      1) Are awake and able to follow commands
      2) Are over 12 years old and is able to fit the CPAP mask
      3) Have the ability to maintain an open airway
      4) Has a systolic blood pressure above 90 mmHg
      5) Uses accessory muscles during respirations
      6) Sign and Symptoms consistent with asthma, COPD, pulmonary edema, CHF, or pneumonia
   B. AND who exhibit two or more of the following:
      1) A respiratory rate greater than 25 breaths per minute
      2) Pulse Oximetry of less than 94% at any time
      3) Use of accessory muscles during respirations

3. CONTRAINDICATIONS
   1) Patient is in respiratory arrest/apneic
   2) Patient is suspected of having a pneumothorax or has suffered trauma to the chest
   3) Patient has a tracheostomy
   4) Patient is actively vomiting or has upper GI bleeding
   5) Patient has decreased cardiac output, obtundation and questionable ability to protect airway (e.g. stroke, obtundation etc.), penetrating chest trauma gastric distention severe facial injury, uncontrolled vomiting and hypotension secondary to hypovolemia.

PRECAUTIONS:
Use care if patient:
   A. Has impaired mental status and is not able to cooperate with the procedure
   B. Had failed at past attempts at noninvasive ventilation
   C. Has active upper GI bleeding or history of recent gastric surgery
   D. Complains of nausea or vomiting
   E. Has inadequate respiratory effort
   F. Has excessive secretions
   G. Has a facial deformity that prevents the use of CPAP

4. PROCEDURE
   A. EXPLAIN THE PROCEDURE TO THE PATIENT
      1) Ensure adequate oxygen supply to ventilation device
      2) Place the patient on continuous pulse oximetry
      3) Place the patient on cardiac monitor and record rhythm strips with vital signs
      4) Place the delivery device over the mouth and nose
5) Secure the mask with provided straps or other provided devices. Be sure to Select a sealing face mask and ensure that the mask fits comfortably, seals the bridge of the nose, and fully covers the nose and mouth.

6) Use 5 cm H₂O of PEEP to start, may increase to 7.5 cm H₂O. Higher levels of pressure are rarely needed and associated with more complications.

7) Check for air leaks

8) Monitor and document the patient’s respiratory response to treatment

9) Check and document vital signs every 5 minutes.

10) Administer appropriate medication as certified (continuous nebulized Albuterol for COPD/Asthma and repeated administration of nitroglycerin spray or tablets for CHF)

11) Continue to coach patient to keep mask in place and readjust as needed

12) Contact medical control to advise them of CPAP initiation

13) If respiratory status deteriorates, remove device and consider intermittent positive pressure ventilation via BVM and/or placement of non-visualized airway or endotracheal intubation.

5. REMOVAL PROCEDURE

1) CPAP therapy needs to be continuous and should not be removed unless the patient can not tolerate the mask or experiences respiratory arrest or begins to vomit.

2) Intermittent positive pressure ventilation with a Bag-Valve-Mask, placement of a non-visualized airway and/or endotracheal intubation should be considered if the patient is removed from CPAP therapy.

6. SPECIAL NOTES

1) Do not remove CPAP until hospital therapy is ready to be placed on patient.

2) Watch patient for gastric distention that can result in vomiting.

3) Procedure may be performed on patient with Do Not Resuscitate Order.

4) Due to changes in preload and afterload of the heart during CPAP therapy, a complete set of vital signs must be obtained every 5 minutes.
REFERENCE

Consent Issues

<table>
<thead>
<tr>
<th>BASIC</th>
<th>IV</th>
<th>PARAMEDIC</th>
</tr>
</thead>
</table>

• Minors are defined in Ohio as being less than eighteen (18) years old. Law does not allow a minor to accept or refuse treatment.

• Exceptions
  ~ A minor who is married
  ~ A minor not living in the parent’s home may be legally considered an “emancipated minor.”
  ~ Active duty military personnel
Patient Assessment Flow Chart

**BASIC**
- Scene Size Up
- BSI
  - Safe Scene / Hazards
  - Determine N.O.I. / M.O.I
  - Number of Patients / Additional Help
  - Consider C-Spine
- Initial Assessment
  - General Impression
  - Introduction
  - Determine Chief Complaint
  - Determine Level of Consciousness (AVPU)
  - Provide Immediate Life Threatening Interventions
  - Prioritize

**IV**

**PARAMEDIC**

**TRAUMA**
- **High Priority**
  - Rapid Trauma Assessment
  - Vitals
  - S.A.M.P.L.E.
  - Interventions
  - Transport
- **Low Priority**
  - Assess Area of CC
  - (Focused History)
  - S.A.M.P.L.E.
  - Vitals
  - Interventions
  - Transport

**MEDICAL**
- **Low Priority**
  - Assess Area of CC
  - (Focused History)
  - History of Illness
  - S.A.M.P.L.E.
  - O.P.Q.R.S.T.
  - Vitals
  - Interventions
  - Transport
- **High Priority**
  - Rapid Medical Assessment
  - S.A.M.P.L.E.
  - O.P.Q.R.S.T.
  - Vitals
  - Interventions
  - Transport

**Transport**
- Treat Secondary Injuries as Priority Allows

**Detailed Exam if High Priority Trauma**
- Repeat RTA + HEENT
- DCRP/BTLS
- Vitals

**Detailed Exam if Low Priority Trauma**
- Reassess area of CC
- Vitals

**Ongoing Assessment**
- Repeat Initial Assessment
- Repeat Vital Signs
- Check Interventions

Added to BLS SOP's Sept 2005
PEDIATRIC SHOCK / TRAUMA

Pediatric Points to Remember-

<table>
<thead>
<tr>
<th>BASIC</th>
<th>IV</th>
<th>PARAMEDIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. An infant is less than one year old.</td>
<td></td>
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</tr>
<tr>
<td>2. A child is from one to eight years old.</td>
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</tr>
<tr>
<td>3. Remember that few pediatric arrests are primary cardiac events. Most stem from respiratory (airway) problems, dehydration/metabolic, or hypothermia. Ensure that a child that arrests or is pending arrest is well oxygenated, well hydrated and warm.</td>
<td></td>
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<tr>
<td>4. Prognosis is extremely poor for a child that arrests.</td>
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<tr>
<td>5. Treat children aggressively before they arrest.</td>
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<td></td>
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<tr>
<td>6. When in doubt contact Medical Control</td>
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<tr>
<td>7. The use of a length based assessment tape is <strong>required</strong> for all pediatric patients as a guide for medications and equipment sizes.</td>
<td></td>
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</tr>
<tr>
<td>8. Treat children aggressively before they arrest.</td>
<td></td>
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<tr>
<td>9. Remember that with children the Intraosseous drug route is quick to establish and may be easier than gaining IV access.</td>
<td></td>
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<tr>
<td>10. When administering medications through the endotracheal tube:</td>
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<tr>
<td>- the medication should be diluted with normal saline to a volume of 3 - 5 mL and instilled into the endotracheal tube.</td>
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</tr>
<tr>
<td>- alternatively, the medication may be delivered beyond the tip of the endotracheal tube by instillation through a suction catheter followed by a 3 - 5 mL flush of normal saline.</td>
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<td></td>
</tr>
<tr>
<td>- following endotracheal medication administration, several positive-pressure breaths (hyperventilation with BVM) must be provided.</td>
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</tr>
<tr>
<td>- medications administered via IV should be followed by at least 5 mL NS bolus and extremity elevated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Children may be effectively ventilated using a BVM. This is the preferred method of ventilation in respiratory or cardiac arrest.</td>
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</table>

If in doubt always contact Medical Control.
### Pediatric Trauma Score

#### Component

<table>
<thead>
<tr>
<th>Component</th>
<th>+ 2 points</th>
<th>+ 1 point</th>
<th>- 1 point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size</td>
<td>Greater than 20 kg</td>
<td>10-20 Kg</td>
<td>Less than 10 kg</td>
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<tr>
<td>Airway</td>
<td>Normal</td>
<td>Oral/Nasal Airway</td>
<td>Unmaintainable/Intubated</td>
</tr>
<tr>
<td>Systolic B/P</td>
<td>Greater than 90 mm Hg</td>
<td>50-90 mm Hg</td>
<td>Less than 50 mm Hg</td>
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<tr>
<td>CNS</td>
<td>Awake</td>
<td>Obtunded/LOC</td>
<td>Coma</td>
</tr>
<tr>
<td>Open Wound</td>
<td>None</td>
<td>Minor</td>
<td>Major/Penetrating</td>
</tr>
<tr>
<td>Skeletal</td>
<td>None</td>
<td>Closed Fractures</td>
<td>Open/Multiple Fractures</td>
</tr>
</tbody>
</table>

Total Point Values from Physical Presentation or Injury
Trauma Score _____________ Sum of Points
REFERENCE Pulse Oximetry

EMT-IV PARAMEDIC

A. Pulse Oximetry – Assessment

Pulse Oximetry is not without limits and must NOT be used to supersede other assessments.

The Firefighter Paramedic shall treat the patient and NOT the pulse oximeter’s display. The patient’s other key signs and symptoms must be assessed and evaluated so that the oximeter’s readings are interpreted within the context of the patient’s overall condition.

The percentage of oxygen saturation measured by an oximeter only reflects the supplied pulmonary oxygenation and is not an indicator or measure of cellular oxygenation. Furthermore, it is useful both in the assessment of the patient and as an adjunct for evaluating the effectiveness of the airway management, ventilation, and oxygen enrichment provided.

Oxygen saturation pressure (SpO2) is a different measurement than the partial pressure of oxygen (PaO2) which is commonly measured by laboratory blood gas analysis.

Pulse Oximetry should be deferred until more urgent assessment and care priorities have first been resolved.

Pulse oximetry is a diagnostic tool that, along with the patient’s vital signs, chief complaint, mental status, and other considerations, may assist us in determining the patient’s respiratory status.

The pulse rate determined by the pulse oximeter is not an accurate indicator of the patient’s pulse rate.

Falsely low readings may occur in the following:
   a. patients with cold extremities or hypothermic patients
   b. patients with hemoglobin abnormalities
   c. patients without a pulse
   d. hypovolemic patients
   e. hypotensive patients

Falsely normal or high oxygen saturation readings may occur in the following patients:
   a. anemic patients, carbon monoxide poisoning
   b. cyanide toxicity which is being treated with the antidote
   c. very bright lighting (direct sunlight or nearby strong lamp)

Other factors affecting accurate readings:
   a. patient movement
   b. action of vasopressor drug
   c. peripheral vascular disease
   d. elevated bilirubin levels
   e. abnormal hemoglobin values
   f. IV diagnostic die has been administered in the last 24 hours
B. Pulse Oximetry Values

1. Normal
   a. 96 - 100%
   b. Treatment - non-rebreather mask (12-15 Lpm) or nasal cannula (4-6 Lpm) if patient can not tolerate a mask and based on patient’s’ chief complaint

2. Mild Hypoxia
   a. 91 – 95%
   b. immediate need to increase the FiO2
   c. Treatment - non-rebreather mask, 12 – 15 Lpm

3. Moderate Hypoxia
   a. 86 – 90%
   b. immediate need to increase the FiO2
   c. consider possible loss of airway patency
   d. Treatment - non-rebreather mask, 12 – 15 Lpm, consider airway adjunct and bag-valve-mask @ 15 Lpm, on assist

4. Severe Hypoxia
   a. \( \leq 85\% \)
   b. Treatment - assist ventilations with adjunct and bag-valve-mask @ 15 Lpm, call Medical Control for order to intubate.
OHIO EMERGENCY MEDICAL SERVICES SOP’S

REFERENCE

Quality Improvement Documentation Criteria

Documentation on all patients must include the following and any other information pertinent to patient care:

- OPQRST and SAMPLE are the acronyms for the United States DOT EMS and Paramedic patient assessment curriculum.

  O - Circumstances surrounding the onset of complaint
  P - What provoked (or provokes) the complaint?
  Q - Describe the quality (sharp, burning, stabbing etc.) of the complaint?
  R - Where does the pain radiate?
  S - Describe the severity of the pain on a 1-10 scale 1(minimal) – 10 (maximum)
  T - Time of onset?

All patients transported by EMS should have at least two sets of vital signs assessed and documented. Initial set of vitals will include blood pressure (systolic/diastolic), pulse rate, respiratory rate, pulse oximetry and blood glucose if indicated, and the time they were assessed must be recorded.

- All medications taken by the patient should be listed on the report. If medications are taken to ER document in narrative who the medications were left with.

- When documenting the presumed presence of alcohol that is based solely upon breath odor, do so in the following manner: “Patients breath has the odor that is commonly associated with the consumption of alcohol.”

ABDOMINAL PAIN/PROBLEMS

1. Location of pain
2. Distension
3. Tenderness / Radiation
4. Nausea / Vomiting / Diarrhea
5. Urinary complaints
6. LMP if applicable
7. Vaginal bleeding / discharge if applicable
8. Treatment / reassessments
9. Report given and Signature of RN

ALCOHOL INTOXICATION

1. Patients breath has odor of ETOH
2. Patient admits to drinking (type, amount, time frame)
3. Speech (normal, slurred)
4. Gait (normal, unsteady)
5. Any obvious injuries noted
6. Blood glucose level
7. Level of consciousness
8. Treatment / reassessments
9. Report given and Signature of RN

ALTERED MENTAL STATUS

1. OPQRST, Sample as appropriate
2. ETOH / Substance use
3. Any obvious injuries noted
4. Blood glucose level
5. Normal mental status
6. EKG and strip attached
7. Treatment / reassessments
8. Report given and Signature of RN

ASSAULT / FIGHT

1. OPQRST, Sample as appropriate
2. Method of assault
3. Any obvious injuries or pain
4. Loss of consciousness How long
5. Treatment / reassessments
6. Report given and Signature of RN
OHIO EMERGENCY MEDICAL SERVICES SOP’S

AIRWAY OBSTRUCTION
1. Can patient speak / forcibly cough
2. Is patient moving air
3. Inspiratory stridor
4. What caused obstruction
5. Duration of obstruction
6. Treatment / reassessments
7. Report given and Signature of RN

ALLERGIC REACTION
1. Cause of reaction
2. Dyspnea
3. Facial / airway edema
4. Chest Pain
5. Rash / itching
6. Urticaria / hives
7. Treatment / reassessments
8. Report given and Signature of RN

ANIMAL BITE / STING
1. Type of animal or insect
2. Location of bite(s) / sting
3. Edema at site
4. Rabies / immunization status of animal if appropriate
5. Treatment / reassessments
6. Report given and Signature of RN

ATRAUMATIC GI BLEED
1. Nausea, vomiting, diarrhea, constipation
2. Active bleeding
3. Bloody emesis / stool
4. Color of emesis / stool
5. Abdominal pain, location and quality
6. Treatment / reassessments
7. Report given and Signature of RN

BURN
1. Burn source (flame, chemical, electricity)
2. Environment (enclosed, outside)
3. Entrance / exit wounds if appropriate
4. Burn surface area and thickness
5. Facial, oral, nasal area singed
6. Chest pain / dyspnea
7. Treatment / reassessments
8. Report given and Signature of RN

CARDIAC ARREST
1. Events prior to onset
2. Description / location of patient on arrival
3. Estimated down time
4. Treatment / reassessments
5. Report given and Signature of RN

CHEST PAIN
1. OPQRST and Sample as appropriate
2. Factors relieving or increasing pain
3. Dyspnea, cough
4. Nausea, vomiting
5. Diaphoresis
6. Aspirin within past 12 hours
7. Treatments / reassessments
8. Report given and Signature of RN

CHF / PULMONARY EDEMA / SOB
1. Chest pain
2. Dyspnea
3. Nausea, vomiting
4. Diaphoresis
5. JVD / lower extremity edema
6. Treatment / reassessments
7. Report given and Signature of RN

DEATH
1. Last time patient seen or talked to
2. Position / location of body
3. Any movement of body made by EMS
4. Any injuries noted
5. Dependant lividity / rigor mortis
6. EKG strip in two leads attached
7. Released to

DIABETIC
1. OPQRST and Sample as appropriate
2. Nausea / vomiting / recent illness
3. Pre/Post treatment of blood glucose level
4. Treatment / reassessments
5. Report given and Signature of RN

ANIMAL BITE / STING
1. Type of animal or insect
2. Location of bite(s) / sting
3. Edema at site
4. Rabies / immunization status of animal if appropriate
5. Treatment / reassessments
6. Report given and Signature of RN

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1. Nausea, vomiting, diarrhea, constipation
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4. Color of emesis / stool
5. Abdominal pain, location and quality
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8. Report given and Signature of RN

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3. Any movement of body made by EMS
4. Any injuries noted
5. Dependant lividity / rigor mortis
6. EKG strip in two leads attached
7. Released to

DIABETIC
1. OPQRST and Sample as appropriate
2. Nausea / vomiting / recent illness
3. Pre/Post treatment of blood glucose level
4. Treatment / reassessments
5. Report given and Signature of RN
OHIO EMERGENCY MEDICAL SERVICES SOP’S

HYPERTENSION
1. Chest pain / dyspnea
2. Nausea / vomiting
3. Headache / mental status
4. Neuro Assessment
5. Treatments / reassessments
6. Report given and Signature of RN

HYPER / HYPO THERMIA
1. Approximate ambient air temperature
2. Estimate exposure time
3. Type of environment (inside, outside, wet)
4. Loss of consciousness
5. Fluid intake
6. Skin turgor / condition
7. ETOH / substance abuse
8. Treatments / reassessments
9. Report given and Signature of RN

INHALATION INJURY (TOXIC GAS/SMOKE)
1. Type of gas
2. Duration of exposure
3. Area of exposure (enclosed room)
4. Heated environment
5. Burns / singing (oral, nasal, facial area)
6. Treatments / reassessments
7. Report given and Signature of RN

POISONING / DRUG INGESTION
1. Name of substance
2. Amount
3. Route of intake
4. How long ago
5. Vomiting since ingestion as appropriate
6. Intentional vs. Unintentional
7. ETOH / substance use
8. Oral mucosa burns if appropriate
9. Treatments / reassessments
10. Report given and Signature of RN

PREGNANCY / OB DELIVERY
Separate report required for mother and each delivery
Non-Delivery
1. Abdominal pain, contractions (duration & frequency)
2. Gravida / Para / Abortion
3. Length of gestation / estimated due date
4. Edema (pedal) / BP / Headache / Visual disturbance
5. Vaginal bleeding / discharge If yes describe
6. Treatments / reassessments
7. Report given and Signature of RN
8. Time since last fetal movement

Delivery
1. Multiple fetuses
2. Mucous plug presented
3. Membranes ruptured / if yes is amniotic fluid clear
4. Crowning as appropriate

SEIZURES
1. OPQRST and Sample as appropriate
2. Obvious injuries (mouth, head, tongue)
3. Duration and number of events
4. Incontinence
5. Level of Consciousness (postictal)
6. Treatments / reassessments
7. Report given and Signature of RN

STROKE / CVA / TIA
1. OPQRST and Sample as appropriate
2. Onset and duration of symptoms
3. Headache / vision disturbances
4. Thrombolytic screening and stroke screen
5. Treatments / reassessments
6. Report given and Signature of RN

Revised June, 2010 110 Effective: July, 2010
NEONATE
1. Time of birth
2. Thoroughly dried and warmed
3. Oral and nasal suctioning
4. Meconium present
5. APGAR at 1 and 5 minutes
6. General appearance
7. Treatments / reassessments
8. Report given and Signature of RN

SYNCOPE/FAINTING / WEAKNESS
1. OPQRST and Sample as appropriate
2. Injuries, chest pain, dyspnea, nausea
3. Vertigo / postural / TILT changes
4. New or changed medications
5. Last meal
6. Blood glucose level
7. EKG
8. ETOH / Substance use
9. Treatments / reassessments
10. Report given and Signature of RN

TRAUMA
1. OPQRST and Sample as appropriate
2. Description of event
3. Weapon (size, caliber, depth of penetration) if applicable
4. Description of damage, estimated speed, airbag deployment as applicable
5. Patient protection as applicable
6. Level of or Loss of consciousness
7. Obvious Injuries and area of pain
8. Palpation / assessment of injured areas
9. Disability (PMS/SMC intact)
10. Treatments / reassessments
11. Report given and Signature of RN

REFUSALS
Documentation of:
1. Competency
2. MMSE
3. Lack of Trauma
4. Situation
5. Ability to make good decisions
6. Safety of patient is assured by caretakers, family, etc.
S.T.A.R.T. Triage

Ref: S.T.A.R.T. Triage

**BASIC**

- **Respirations Present**
  - **NO**
    - Reposition Head
    - Re-check breathing
  - **YES**
    - >30/min
    - <30/min check perfusion

**IV**

- Perfusion (Radial Pulse)
  - **Absent**
    - Red Tag
  - **Present**
    - Check Mental Status

**PARAMEDIC**

- Mental Status
  - **Delayed in following commands**
    - Yellow Tag
  - **Cannot follow commands**
    - Red Tag

**Tagging System**

- **Black** – Deceased
- **Red** – Transport ASAP
- **Yellow** – Delayed Transport
- **Green** – Last Transported

Revised: June, 2010
Effective: July, 2010
### Trauma Assessment / Destination Guidelines

#### BASIC IV PARAMEDIC

- Perform primary and secondary survey
- Treat any life threatening injuries / illness
- Obtain vital signs
- Determine mechanism of injury
- Obtain past medical history

#### Is transport to Trauma Center >30 minutes

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| Initiate transport to closest appropriate facility. Notify Medical Control of decision | TRANSPORT TO LEVEL 1 TRAUMA CENTER IF:
  - GCS is <13 and/or
  - Systolic BP is <90mmHg
  - Respiratory rate <10 or >30 |
| Transport to trauma center may exceed 30 minutes If dictated by local Medical Control or trauma control | TRANSPORT TO LEVEL 1 TRAUMA CENTER IF:
  - Penetrating injury proximal to elbow or knee
  - Flail chest, penetrating chest or abdominal injury
  - Combination trauma with burns of >15% BSA, or to face and/or airway
  - Limb paralysis
  - Amputation proximal to wrist or ankle
  - Patient ejection from vehicle
  - Death of passenger in same vehicle
  - Extrication time >20 min with above trauma |
| Medical Control will have final jurisdiction over destination, excluding:
  - Any patient of legal majority (age 18 or over), the parent or legal guardian of a minor patient or an emancipated minor shall have the right to request transport to a specific facility with the county of origin. | CONTACT TRAUMA CONTROL TO CONSIDER TRANSPORT TO LEVEL I, II, III TRAUMA CENTER IF:
  - High speed auto accident with suspected injury
  - Velocity change of >20 mph
  - Passenger compartment intrusion of >12”
  - Auto vs. pedestrian injury with >5 mph impact
  - Motorcycle accident >20 mph or with separation of rider and motorcycle
  - Bicycle accident with significant impact |
| Transport of the patient to the requested destination shall not constitute neglect of duty imposed by law on all EMS personnel if the person making the decision has been informed that Ohio has a trauma system, which would in their circumstance transport them to another facility. | CONTACT TRAUMA CONTROL TO CONSIDER TRANSPORT TO LEVEL I, II, III TRAUMA CENTER IF:
  - Patient age >55 years
  - Know cardiac, respiratory disease or psychosis on medication
  - Insulin dependent diabetic, cirrhosis, malignancy, obesity or coagulopathy |
| If the patient’s condition deteriorates during transport, such that their life/health are considered in serious jeopardy if the requested/planned destination is pursued, AND if Medical Control deems transport to a higher level trauma center is necessary, the patient may be transported to the appropriate facility. | |

Revised June, 2010 113 Effective: July, 2010
Trauma Treatment Priorities

1. If multiple patients, initiate the S.T.A.R.T. and Multiple Casualty Incident System
2. Oxygen 100% and airway maintenance appropriate for the patient’s condition
3. Consider, if available, PASG. Treat for shock appropriate to patients condition
4. Certain situations require rapid transport. Non-lifesaving procedures such as splinting and bandaging must not delay transport. Contact the responding emergency unit when any of the following exist:
   a. Airway obstructions that cannot be quickly relieved by mechanical methods such as suction, or jaw-thrust maneuver
   b. Traumatic cardiopulmonary arrest
   c. Large open chest wound (sucking chest wound)
   d. Large flail chest
   e. Tension pneumothorax
   f. Major blunt chest trauma
   g. Shock
   h. Head injury with unconsciousness, unequal pupils, or decreasing level of consciousness
   i. Tender abdomen
   j. Unstable pelvis
   k. Bilateral femur fractures
**REFERENCE TRAUMA SCORE**

<table>
<thead>
<tr>
<th>Revised Trauma Score</th>
<th>Basic</th>
<th>IV</th>
<th>Paramedic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RESPIRATORY RATE</strong></td>
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<tr>
<td>10-24/min</td>
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<tr>
<td>24-35/min</td>
<td>24</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>&gt;36/min</td>
<td>&gt;36</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1-9/min</td>
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<td></td>
</tr>
<tr>
<td>None</td>
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<tr>
<td><strong>RESPIRATORY EXPANSION</strong></td>
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<td>Normal</td>
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<tr>
<td>&gt;90 mmHg</td>
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<td>No Pulse</td>
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<tr>
<td><strong>Capillary Refill</strong></td>
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<td>2</td>
<td></td>
</tr>
<tr>
<td>Delayed</td>
<td>Delayed</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Points to add to the RTS based on the GCS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-15</td>
<td>14-15</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>11-13</td>
<td>11-13</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>8-12</td>
<td>8-12</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>5-7</td>
<td>5-7</td>
<td>2</td>
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</tr>
<tr>
<td>3-4</td>
<td>3-4</td>
<td>1</td>
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</tr>
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</table>

**Glasgow Coma Scale**

<table>
<thead>
<tr>
<th>Eye Opening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous</td>
</tr>
<tr>
<td>Opening to voice</td>
</tr>
<tr>
<td>Response to pain</td>
</tr>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Verbal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oriented</td>
</tr>
<tr>
<td>Verbal confused</td>
</tr>
<tr>
<td>Inappropriate words</td>
</tr>
<tr>
<td>Incomprehensible sounds</td>
</tr>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Motor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obey command</td>
</tr>
<tr>
<td>Localizes pain</td>
</tr>
<tr>
<td>Withdraws (pain)</td>
</tr>
<tr>
<td>Flexion</td>
</tr>
<tr>
<td>Extension</td>
</tr>
<tr>
<td>None</td>
</tr>
</tbody>
</table>
Pediatric Trauma Score of 8 or less: Refer to Destination Determinates see Pediatric Shock / Trauma Protocol.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transport to Level I Pediatric Trauma Center Advise Medical Control</td>
<td>Assess anatomy of injury</td>
</tr>
<tr>
<td>Penetrating injury proximal to elbow, and knee, including head and neck</td>
<td></td>
</tr>
<tr>
<td>Flail chest</td>
<td></td>
</tr>
<tr>
<td>Traumatic Respiratory Arrest</td>
<td></td>
</tr>
<tr>
<td>Pelvic fracture with shock</td>
<td></td>
</tr>
<tr>
<td>Amputation proximal to wrist &amp; ankle</td>
<td></td>
</tr>
<tr>
<td>Combination trauma with burns of 15% BSA, or to the face or airway</td>
<td></td>
</tr>
<tr>
<td>2 or more proximal long bone fractures</td>
<td></td>
</tr>
<tr>
<td>Limb paralysis</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Medical Control for consideration of transfer to Level I or II Pediatric Trauma Center. If Medical Control is unavailable, then transport to highest level Trauma Center</td>
<td>Assess anatomy of injury</td>
</tr>
<tr>
<td>Evidence of High Impact</td>
<td>Re-evaluate with Medical Control</td>
</tr>
<tr>
<td>Ejection from automobile</td>
<td></td>
</tr>
<tr>
<td>Death of vehicle occupant (particular if unrestrained)</td>
<td></td>
</tr>
<tr>
<td>Fall greater than 20 feet</td>
<td></td>
</tr>
<tr>
<td>Velocity change greater than 20 mph</td>
<td></td>
</tr>
<tr>
<td>Passenger intrusion greater than 12 inches</td>
<td></td>
</tr>
<tr>
<td>Pedestrian impact (significant) 5-20 + MPH</td>
<td></td>
</tr>
<tr>
<td>Motorcycle accident greater than 20 MPH or with separation of rider and bike</td>
<td></td>
</tr>
<tr>
<td>Bicycle accident with significant impact</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Medical Control for consideration of transfer to Level I or II Pediatric Trauma Center. If Medical Control is unavailable, then transport to highest level Trauma Center</td>
<td></td>
</tr>
</tbody>
</table>
### Reference: Pediatric

#### Basic

<table>
<thead>
<tr>
<th>Age</th>
<th>Weight (kg)</th>
<th>Normal Diastolic BP</th>
<th>Normal Systolic BP</th>
<th>Heart Rate Per Minute</th>
<th>Respiratory Rate Per Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>3.5</td>
<td>56 - 70</td>
<td>66 - 90</td>
<td>110 – 160</td>
<td>30 - 60</td>
</tr>
<tr>
<td>6 mos</td>
<td>7.0</td>
<td>56 - 70</td>
<td>70 - 104</td>
<td>100 – 140</td>
<td>30 - 50</td>
</tr>
<tr>
<td>1 yr</td>
<td>10.0</td>
<td>56 - 76</td>
<td>80 - 104</td>
<td>100 – 140</td>
<td>24 - 34</td>
</tr>
<tr>
<td>2 yr(s)</td>
<td>13.0</td>
<td>56 - 76</td>
<td>80 - 104</td>
<td>90 – 110</td>
<td>20 - 30</td>
</tr>
<tr>
<td>3 yr(s)</td>
<td>15.0</td>
<td>56 - 76</td>
<td>80 - 104</td>
<td>90 – 110</td>
<td>20 - 30</td>
</tr>
<tr>
<td>4 yr(s)</td>
<td>17.0</td>
<td>56 - 76</td>
<td>90 - 110</td>
<td>80 – 110</td>
<td>20 - 30</td>
</tr>
<tr>
<td>5 yr(s)</td>
<td>19.0</td>
<td>56 - 76</td>
<td>90 - 110</td>
<td>80 – 110</td>
<td>20 - 30</td>
</tr>
<tr>
<td>6 yr(s)</td>
<td>23.0</td>
<td>56 - 76</td>
<td>90 - 110</td>
<td>70 – 100</td>
<td>16 - 30</td>
</tr>
<tr>
<td>7 yr(s)</td>
<td>25.0</td>
<td>56 - 76</td>
<td>90 - 110</td>
<td>70 – 100</td>
<td>16 - 30</td>
</tr>
<tr>
<td>8 yr(s)</td>
<td>28.0</td>
<td>60 - 76</td>
<td>90 - 110</td>
<td>70 – 100</td>
<td>16 - 30</td>
</tr>
<tr>
<td>9-10 yr(s)</td>
<td>30.0</td>
<td>64 - 76</td>
<td>90 - 114</td>
<td>70 – 90</td>
<td>10 - 20</td>
</tr>
<tr>
<td>11-12 yr(s)</td>
<td>37.0</td>
<td>64 - 80</td>
<td>90 - 120</td>
<td>70 – 90</td>
<td>10 - 20</td>
</tr>
<tr>
<td>13-15 yr(s)</td>
<td>50.0</td>
<td>64 - 80</td>
<td>110 - 124</td>
<td>60 – 80</td>
<td>10 - 20</td>
</tr>
<tr>
<td>16-18 yr(s)</td>
<td>65.0</td>
<td>64 - 90</td>
<td>110 - 134</td>
<td>60 – 80</td>
<td>10 - 20</td>
</tr>
</tbody>
</table>

\[
\text{Size ETT} = \frac{16 + \text{(age in years)}}{4}
\]

#### IV

#### Paramedic

### Reference: Pediatric

#### Basic

<table>
<thead>
<tr>
<th>Age and Weight - Related Pediatric Equipment Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C-collars</strong></td>
</tr>
<tr>
<td>Premature 3 kg</td>
</tr>
<tr>
<td>Small</td>
</tr>
<tr>
<td><strong>O2 Masks</strong></td>
</tr>
<tr>
<td>Premature or Newborn</td>
</tr>
<tr>
<td><strong>BVM</strong></td>
</tr>
<tr>
<td>Infant</td>
</tr>
<tr>
<td><strong>Laryngoscopes</strong></td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td><strong>ET Tubes</strong></td>
</tr>
<tr>
<td>2.5 - 3.0</td>
</tr>
<tr>
<td><strong>Suction Catheters</strong></td>
</tr>
<tr>
<td>6 - 8 Fr</td>
</tr>
<tr>
<td><strong>Oral Airways</strong></td>
</tr>
<tr>
<td>Infant</td>
</tr>
<tr>
<td><strong>IV Equipment</strong></td>
</tr>
<tr>
<td><strong>BP Cuffs</strong></td>
</tr>
<tr>
<td>Newborn</td>
</tr>
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</table>

Revised June, 2010

117

Effective: July, 2010
## Reference Medication Dosage

<table>
<thead>
<tr>
<th>Drug:</th>
<th>Trade Names</th>
<th>Dosage:</th>
</tr>
</thead>
</table>
| Adenocard     | Adenosine                          | 1<sup>st</sup> dose - 6mg rapid IVP with flush. 2<sup>nd</sup> dose – 12mg rapid IVP with flush. Infant: 0.1mg/kg max dose 6mg, 2<sup>nd</sup> dose 0.2mg/kg max dose 12mg.  
|               |                                    | **Pediatric** – 1<sup>st</sup> dose 0.1mg/kg max dose 6mg, 2<sup>nd</sup> dose 0.2mg/kg max dose 12mg. |
| Albuterol Sulfate | Proventil, Ventolin, Albuterol Sulfate | Aerosol Nebulization: 2.5mg in 3cc NS q 5 min if heart rate is <150.  
|               |                                    | Peds- Aerosol Nebulization: 2.5mg in 3cc normal saline q 5 min if heart rate <200. |
| Amiodarone    | Cardarone                          | 300mg then 150mg.  
|               |                                    | **Pediatrics** 5mg/kg. |
| Aspirin       | Aspirin                            | 162-324 mg Chewed and then swallowed. Peds—NO Pediatric Dosing. |
| Atropine Sulfate | Atropine                           | 1mg IVP q 4 min max dose 0.04mg/kg.  
|               |                                    | **Pediatrics 0.02mg/kg q 4 min max dose 0.04 mg/kg**. |
| Calcium Chloride |                                  | 500 mg IVP.  
|               |                                    | Peds-20mg/Kg. |
| Dextrose 50%  | D<sub>50</sub>, D<sub>50</sub>W    | ½ -1 Amp (12.5-25 gram) IVP.  
|               |                                    | No Peds Dosing. |
| Dextrose 25%  | D<sub>25</sub>, D<sub>25</sub>W    | 2cc/kg (D<sub>50</sub> mixed 50/50 with Normal Saline). |
| Diazepam      | Valium                             | 2-10 mg slow IVP, titrated to effect.  
|               |                                    | **Pediatrics 0.2mg/kg slow IVP, titrated to effect or 0.5 mg/kg rectal**. |
| Dopamine      |                                    | 2-20 mcg/kg/min.  
|               |                                    | Peds 2-20mcg/kg/min. |
**Drug: Diphenhydramine**  
**Trade Names:** Benadryl  
**Dosage:** 25-50mg IM or slow IVP  
*Peds 1mg/kg*

**Drug: Epinephrine**  
**Trade Names:** Adrenaline  
**Dosage:**  
- Cardiac Arrest 0.5-1mg of 1:10,000 solution IVP q 4 min  
- Anaphylaxis 0.3 – 0.5mg of 1:1000 solution IM  
*Peds*  
- Cardiac Arrest: Epinephrine 1:10,000 0.01 mg/kg IV/IO q 5 min  
- Anaphylaxis: Epinephrine 1:1000 0.01 mg/kg IM, max dose is 0.3 mg  
- Croup: Nebulized Epinephrine 1:1000 diluted to 2,5-3 cc saline flush may repeat up to 3 doses.

**Drug: Furosemide**  
**Trade Names:** Lasix  
**Dosage:**  
- In CHF: 40-80mg IVP slow  
- In Hypertensive Crisis: 0.5-1.0 mg/kg if pulmonary edema is present.

**Drug: Glucagon**  
**Trade Names:** Glucagen  
**Dosage:** 1-2mg IM / IN  
*Peds 0.5-1mg IM*

**Drug: Lidocaine**  
**Trade Names:** Xylocaine  
**Dosage:** 1-1.5mg/kg max dose 3mg/kg  
*Peds-1.0 mg/kg*

**Drug: Lidocaine Drip**  
**Trade Names:** Xylocaine  
**Dosage:** 2-4mg/min  
*Peds 2-4 mg/min*

**Drug: Magnesium Sulfate**  
**Trade Names:**  
**Dosage:**  
- Torsades only – 1-2gm IVP over 2 min  
- Pre-eclampsia or Eclampsia: 2-4 g slow IVP over 2 min/g  
- Drip – 4g in 250ccD5W (16mg/ml) run at 30-60gtts/min

**Drug: Midazolam HCL**  
**Trade Names:** Versed  
**Dosage:** 2-5 mg IV or IM  
*Peds 0.2mg/kg*

**Drug: Morphine**  
**Trade Names:** Morphine Sulfate, MS Contin, MSIR  
**Dosage:** 2-4 mg IVP see standing orders for repeat doses  
*Peds- sedation dose- 0.05- 0.2mg/kg  
- Pain management- 0.03-.05mg/kg IV/IO*
### Nitroglycerin
- **Dosage:** Oral 0.4 mg SL or spray q 5 min for pain  
  Transdermal – 1” on chest wall  
  NTG Therapy --1 spray sl and apply 1” paste repeat SL spray once after 5 min.  
  Continue therapy until pain is relieved or systolic b/p <100 mmHg

### Naloxone
- **Dosage:** 2 mg slow IVP or IN  
  Peds 0.1mg/kg slow IVP or IN

### Promethazine
- **Dosage:** 6.25-25 mg slow IVP  
  Peds-0.05-0.1mg/kg

### Procainamide
- **Dosage:** 50-100mg slow IVP  
  15mg/kg slow IVP

### Sodium Bicarbonate
- **Dosage:** 1 mEq/kg I.V/IO followed by 0.5 mEq/kg q 10 min  
  (peds-1 mEq/kg may repeat at 0.5 mEq/kg q 10 min)

### Methylprednisolone
- **Dosage:** 62.5 or 125 mg  
  Peds- contact medical control

### Defibrillation
- **Adult:** 200,300,360 as escalating dose  
  Peds – 2j/kg then 4j/kg

### Cardioversion
- **Adults:** refer to specific SOP  
  Peds-0.5j/kg then 1j/kg
### Lidocaine

2 gram medication / 500 mL D5W = 4 mg/mL (always use 60 gtt. set)

- 1 mg / min = 15 gtt / min
- 2 mg / min = 30 gtt / min
- 3 mg / min = 45 gtt / min
- 4 mg / min = 60 gtt / min

### Procainamide

- For maintenance infusion only. Refer to Specific Standing Order for Initial Dose.

2 gram medication / 500 mL D5W = 4 mg/mL or 1 gm / 250cc D5W (always use 60 gtt. set)

- 1 mg / min = 15 gtt / min
- 2 mg / min = 30 gtt / min
- 3 mg / min = 45 gtt / min
- 4 mg / min = 60 gtt / min

### Magnesium Sulfate

4g in 250ccD5W (16mg/ml) run at 30-60gtts/min

### Dopamine

400mg / 250cc D5W or 800mg/500cc D5W = 1600 ug/mL (always use 60 gtt/set)

- 50 kg patient = 110 lbs
- 2.5 ug/kg/min = 5gtt/min
- 5 ug/kg/min = 12gtt/min
- 10 ug/kg/min = 19gtt/min
- 20 ug/kg/min = 38gtt/min

- 100 kg patient = 220 lbs
- Ped dose 2-20ug/kg/min

- 70 kg patient = 154 lbs
- 2.5 ug/kg/min = 7 gtt/min
- 5 ug/kg/min = 13 gtt/min
- 10 ug/kg/min = 27 gtt/min
- 20 ug/kg/min = 53 gtt/min
OHIO EMERGENCY MEDICAL SERVICES SOP’S

REFERENCE
Common Medical Abbreviations

a = before
AED = automated external defibrillator
AOX3 = alert, and oriented to person, place, and time
abd. = abdomen
Ab. = abortion
ac = antecubital
AF = atrial fibrillation
ARDS = Adult Respiratory Distress Syndrome
AT = atrial tachycardia
AV = atrioventricular
b.i.d. = twice a day
BSA = body surface area
BS = blood sugar and/or breath sounds
c = with
CC or C/C = chief complaint
CHF = congestive heart failure
CNS = central nervous system
c/o = complains of
CO = carbon monoxide
CO² = carbon dioxide
D/C = discontinue
DM = diabetes mellitus
DT’s = delirium tremens
DVT = deep venous thrombosis
Dx = diagnosis
EKG – EKG = electrocardiogram
EDC = estimated date of confinement
EJ = external jugular
ENT = ear, nose and throat
ETOH = alcohol by definition is any chemical compound containing the Hydrox1 group OH. ETOH is the abbreviation of Ethanol (grain alcohol)
fl = fluid
fx = fracture
GB = gall bladder
Gm – g = gram
g. = grain
GSW = gun shot wound
gtt. = drop
GU = genitourinary
GYN = gynecologic
h, hr. = hour
H/A = headache
Hg = mercury
H & P = history and physical
Hx = history
ICP = intracranial pressure
JVD = jugular venous distention
KVO = keep vein open
LAC = laceration
LBBB = left bundle branch block
MAEW = moves all extremities well
NaCl = sodium chloride
NAD = no apparent distress/no acute distress
NPO = nothing by mouth
NKA = no known allergies
OD = overdose
O.D. = right eye
O.S. = left eye
PERL = pupils equal and reactive to light
PID = pelvic inflammatory disease
p.o. = by mouth
1° = primary, first degree
PTA = prior to arrival
pt. = patient
q = every
q.h. = every hour
q.i.d. = four times a day
RBBB = right bundle branch block
R/O = rule out
ROM = range of motion
Rx = take, treatment
s = without
S/S = signs and symptoms
TIA = transient ischemic attack
t.i.d. = three times a day
V.S. = vital signs
y.o. = years old
AUTHORIZATION FOR STANDING ORDERS

These Emergency Medical Services (EMS) Standing Orders and Protocols (revision project completed April, 2010) are hereby adopted. They are to be initiated by EMS personnel within their scope of licensure whenever a patient presents with injury or illness covered by the protocols. Where indicated to contact Medical Control, the EMS Provider should receive voice orders from Medical Control before proceeding. Other orders may be obtained from Medical Control when the situation is not covered by the protocols or as becomes necessary as deemed by the Firefighter EMT-Paramedic.

Effective date of these SOPs: ________________

Joe Holley, MD, FACEP
Medical Director