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GENERAL INFORMATION**OVERVIEW****PURPOSE**

The purpose of this document is to provide 1) medical protocols regarding permissible and appropriate emergency medical services procedures which may be rendered by medics to a patient not in a hospital, and 2) communication protocols regarding which medical situations require direct voice communication between medics and a physician (or a nurse, or a paramedic, or a physician's assistant who is in direct communication with a physician) prior to those medics rendering specified emergency medical services procedures to a patient not in a hospital.

Authority:

The authority for implementing these protocols is found in O.C.G.A. 31-11-60.1(b) and (c), 31-11-50(b), and the Rules of the Department of Human Resources Public Health Chapter 290-5-30.

It is the responsibility of each medic to be familiar with the laws, rules and regulations and policies and adhere to them. Even an order by a physician does not justify procedures not in accordance with laws and rules and regulations.

Professional Judgment

Since each medical emergency must be dealt with on an individual basis and appropriate care determined accordingly, professional judgment is mandatory in determining treatment modalities within the parameters of these protocols.

Control of Patient Care at the Scene:

Control of patient care at the scene of an emergency shall be the responsibility of the individual in attendance most appropriately trained and knowledgeable in providing prehospital emergency stabilization and transport. When an ambulance arrives at the scene of a medical emergency, and contact is made with medical control by a medic, a physician/patient relationship is established between the patient and the physician providing medical control. The physician is responsible for the management of the patient and the medic acts as an agent of medical control unless a patient's physician is present.

When a physician other than the patient's physician on the scene of a medical emergency properly identifies himself and demonstrates his willingness to assume responsibility for patient management and documents his intervention by signing the emergency prehospital care report, the medic should place the intervening physician in communication with medical control. If there is disagreement between the intervening physician and the medical control physician, or if the intervening physician refuses to speak with medical control, the medic should continue to take orders from the medical control physician.

Reference: DHR Public Health Rule 290-5-30-.05(8)(i) Control of patient care at the scene.

ABBREVIATIONS

ABG	Arterial blood gases
AHA	American Heart Association
ALS	Advanced Life Support, includes Paramedic and CT certified procedures
ARC	American Red Cross
SAMPLE	Symptoms, Allergies, Medications, Past medical history, Last meal or ingestion, Events leading up to
AVPU	Response level: Alert, to verbal, to painful stimuli only, unresponsive
BLS	All other certified procedures
CRT	Capillary refill time
Cyanosis	Bluish discoloration of skin
D ₅ W	5% Dextrose in water
D ₅₀ W	50% Dextrose in water
BVM	Bag valve mask
Dyspnea	Difficulty breathing
ECG quick look	Using paddles to identify rhythm
ECG monitoring	Using electrodes to identify rhythm with continuous readout
ED	Emergency Department
ET	Endotracheal
GCS	Glasgow coma scale
GM	Gram
HX	History
KG	Kilogram
KVO	Keep vein open
L	Liter
LOC	Level of consciousness
LPM	Liters per minute
LR	Lactated Ringers
MAST	Military anti-shock trousers
MC	Medical Control
MEQ	Milliequivalent
MG	Milligram
ML	Milliliter
MOI	Mechanism of injury
NPO	Nothing by mouth
NRBM	Non-rebreathing mask
NOI	Nature of illness
NS	Normal saline
PE	Physical examination
PERRL	Pupils equal round and reactive to light
PPV	Positive pressure ventilation
PRN	As needed or necessary
PTLA	Pharyngeal tracheal lumen airway
Pulse Ox	Pulse Oximetry
RTS	Revised trauma score
Rapid Transport	Immediate transport with care rendered enroute
STAT	Immediately
Story Match	Described scenario doesn't coincide with injury or physical findings
Stridor	Harsh-high pitched inspiratory sound indicating possible (or probable) upper airway obstruction
Sublingual	Under tongue
Subq	Subcutaneous (beneath skin)
UG	Microgram

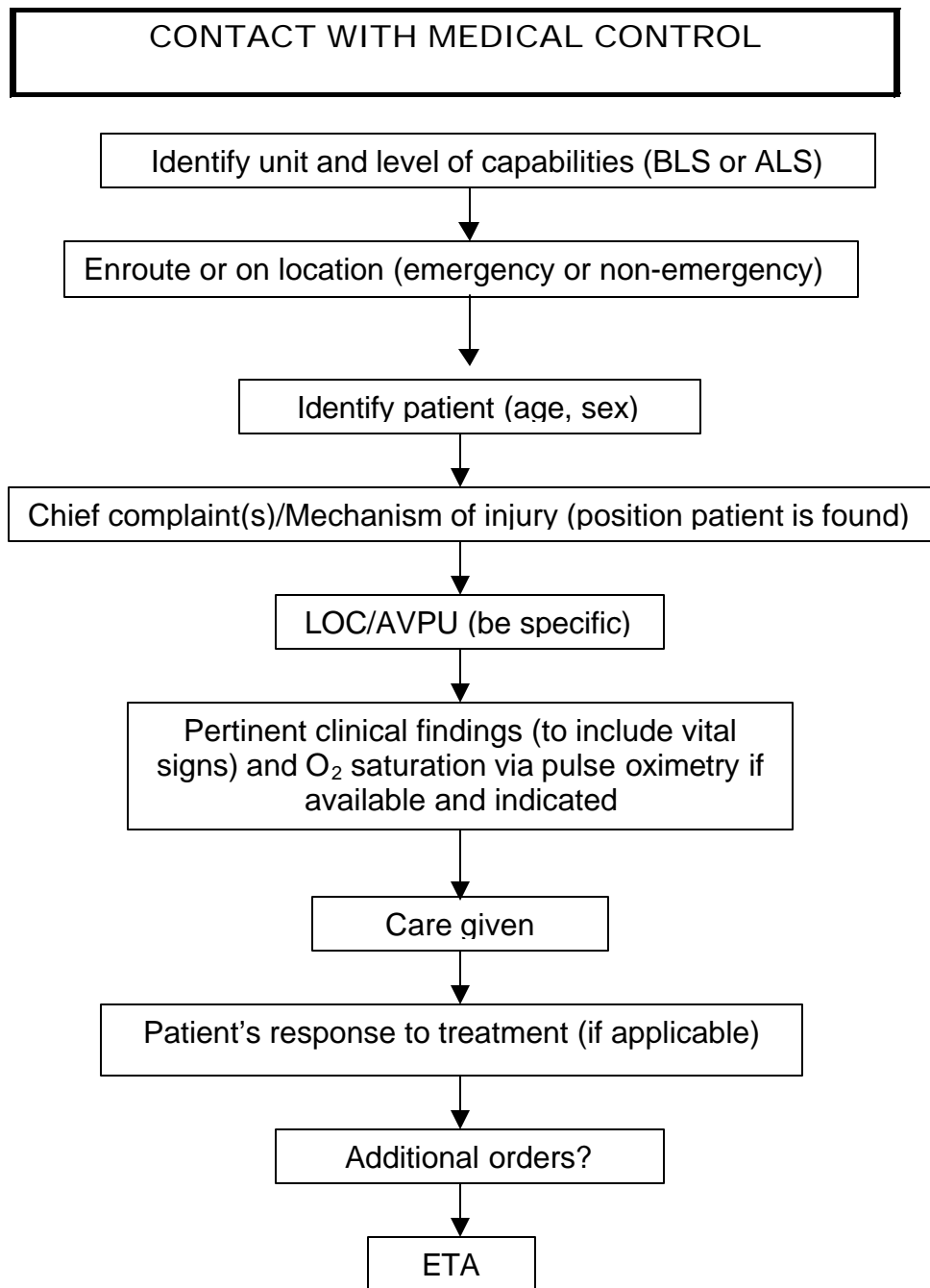
EMERGENCY DRUG KIT

DRUG DESCRIPTION	UNITS
ADENOSINE 3 mg/ml 2 ml vial	(5)
ALBUTEROL (PROVENTIL) NEB SALINE 3 ml	(3)
AMINOPHYLLINE 250 mg/10 ml vial	(2)
ATROPINE 1 mg/ 10 ml syringe	(6)
BRETYLIUM 500 mg/10 ml ampule	(4)
CALCIUM CHLORIDE 1 GM/10 ml vial	(2)
CATAPRES (Clonidine)	(1)
DEXAMETHASONE 4 mg/ml 5 ml vial	(1)
DEXTROSE 50 % syringe (25 GM/50 ml)	(2)
DIPHENHYDRAMINE 50 mg/1 ml syringe	(1)
DIAZEPAM 10 mg/2 ml syringe	(2)
DOPAMINE 400 mg/5 ml vial	(1)
EPINEPHRINE 1 mg/1 ml ampule (1:1000)	(2)
EPINEPHRINE 1 mg/10 ml syringe (1:10,000)	(6)
EPINEPHRINE 1 mg/ml 30 ml vial (1:1000)	(1)
FLUMAZENIL (ROMAZICON) 0.1 mg/ml 5 ml vial	(1)
FUROSEMIDE 40 mg/4 ml syringe	(2)
GLUCAGON 1 mg/1 ml syringe	(1)
LIDOCAINE 100 mg/5 ml syringe	(3)
LIDOCAINE 2 GM 500 ml premixed bag	(1)
MAGNESIUM SULFATE 5 GM/10 ml vial	(1)
MEPERIDINE HCL (DEMEROL) 50 mg/ml vial	(1)
NALOXONE 2 mg/2 ml ampule	(2)
NIFEDIPINE 10 mg capsule	(2)
NITROGLYCERINE 0.4 mg. Tablet 100 count bottle	(1)
OXYTOCIN 10 unit/1 ml ampule	(2)
PROCAINAMIDE 1 GM/10 ml vial	(1)
PROMETHAZINE 25 mg/1 ml ampule	(2)
SODIUM BICARBONATE 50 mEq/50 ml syringe	(2)
STERILE WATER for INJECTION 50 ml vial	(1)
THIAMINE 100 mg/1 ml vial	(1)
*TORADOL (Ketorolac) 60 mg/2 ml TUBEX syringe	(1)
VERAPAMIL 5 mg/2 ml ampule	(1)

* Caution in aspirin allergic patient

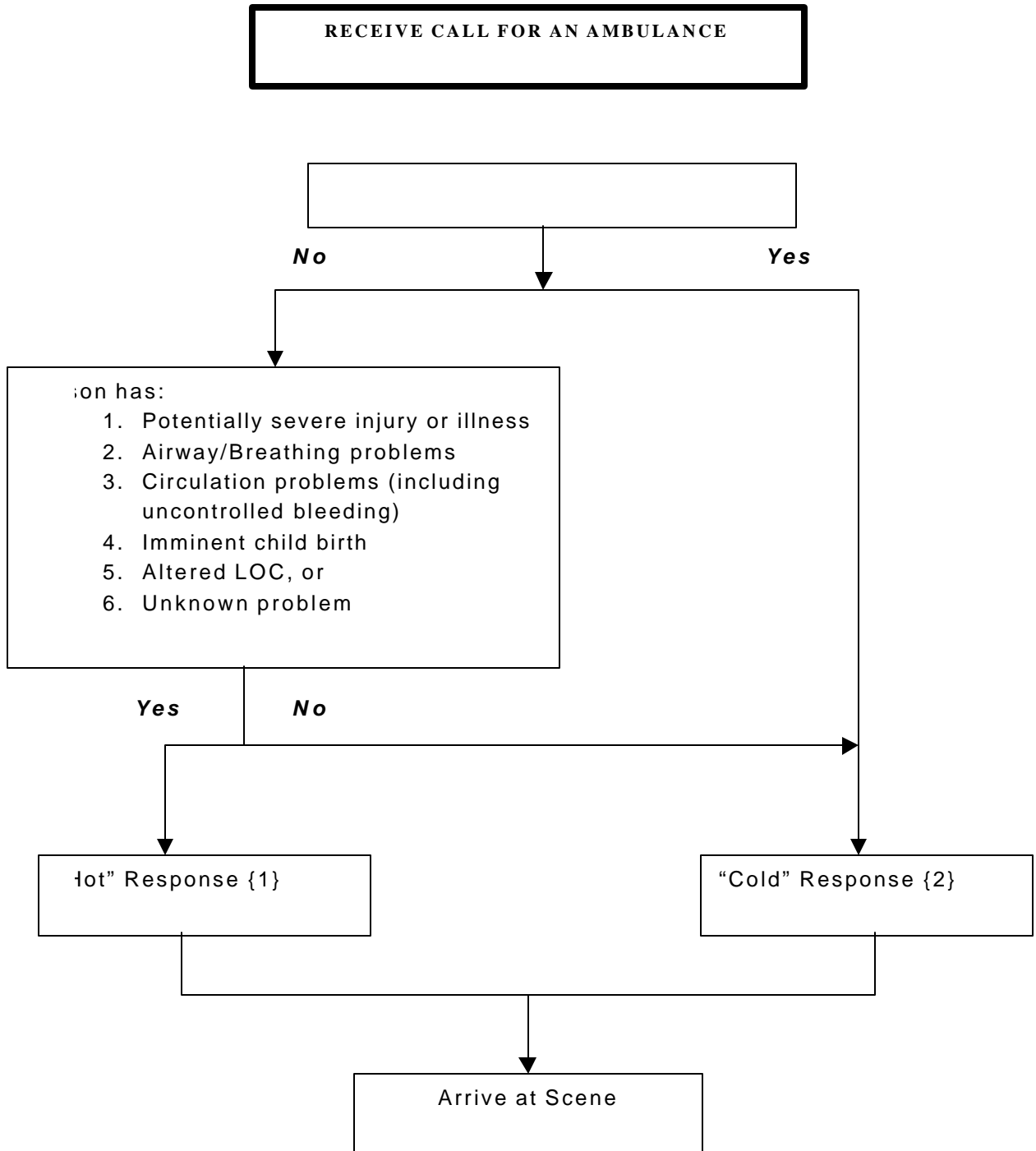
SAMPLE

Note: This is a sample drug list. Yours will be modified according to your needs and your medical director's approval This message will not appear on the final version of your protocol.



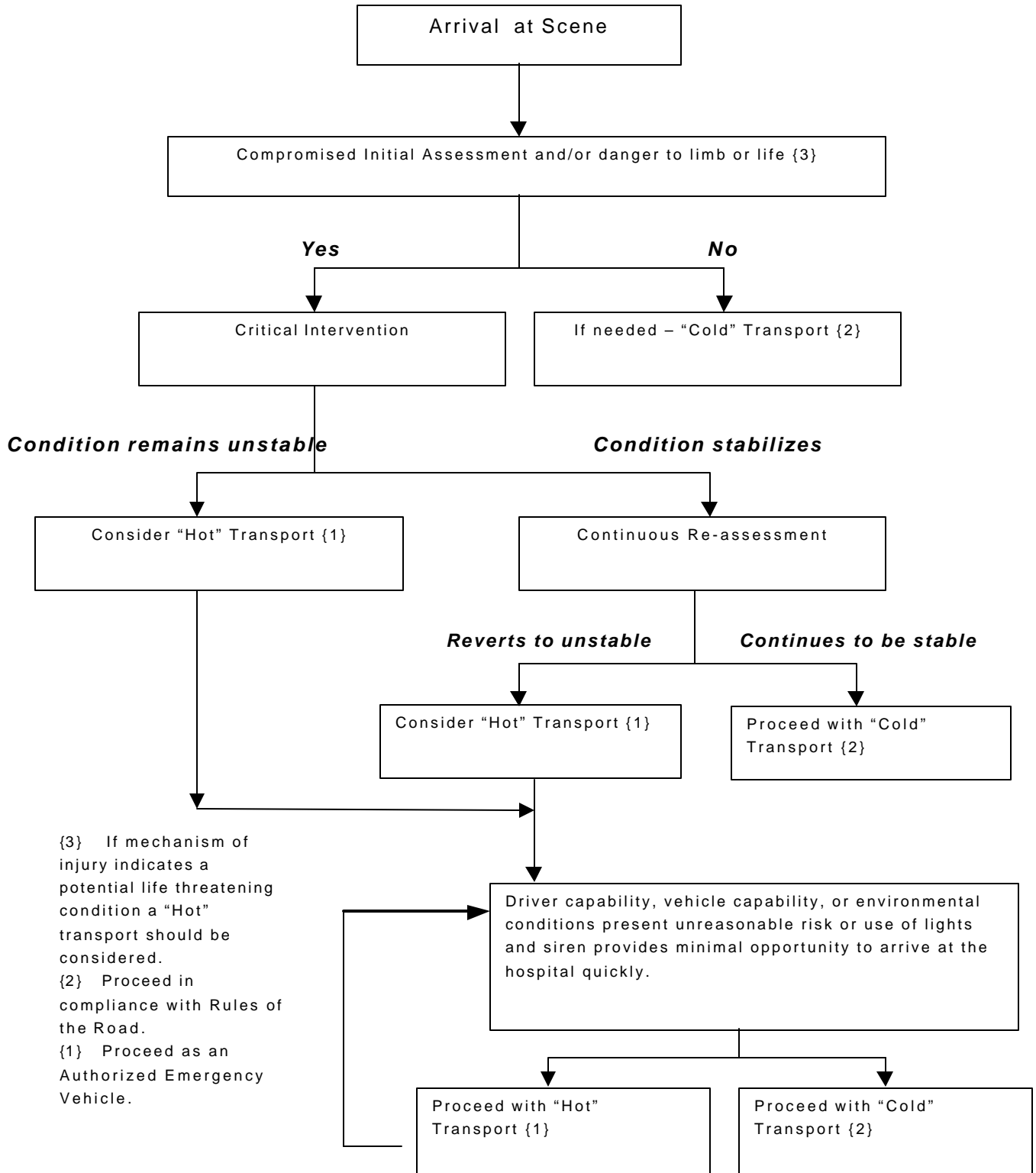
Patient's reports should be brief, concise, and to the point. They should only contain information that is pertinent to the chief complaint. Although signals and codes are used with individual services familiar with them, they should not be used in communicating with the hospital receiving facility.

This model demonstrates the manner in which patient's reports should be communicated to the receiving facility.



{1} *Proceed as an authorized emergency vehicle*
{2} *Proceed in compliance with Rules of the Road*
(Additional information en route to the patient will require re-assessment of run status)

POST PATIENT ASSESSMENT



emergency response is so urgent that we cannot respond in a safer manner so as to protect the lives of the public and ourselves. To do otherwise could compound an already urgent situation and result in additional emergency patients. The safety of individuals proceeding to the scene as well as the public through which they are traveling is of high priority.

The driver of any authorized emergency vehicle shall not be relieved from the duty to drive with due regard for the safety of all persons, nor shall it protect the driver from the consequences of his reckless disregard for the safety of others.

THE LAW

UNIFORM RULES OF THE ROAD

40-6-6. Authorized emergency vehicles.

(a) The driver of an authorized emergency vehicle, when responding to an emergency call, or when in the pursuit of an actual or suspected violator of the law, or when responding to but not upon returning from a fire alarm, may exercise the privileges set forth in this Code section.

(b) The driver of an authorized emergency vehicle may:

- (1) Park or stand, irrespective of the provisions of this chapter;*
- (2) Proceed past a red or stop signal or stop sign, but only after slowing down as may be necessary for safe operation;*
- (3) Exceed the maximum speed limits so long as he does not endanger life or property;*
- (4) Disregard regulations governing direction of movement or turning in specified directions.*

(c) The exceptions granted by this Code section to an authorized emergency vehicle shall apply only when such vehicle is making use of an audible signal and use of a flashing or revolving red light visible under normal atmospheric conditions from a distance of 500 feet to the front of such vehicle, except that a vehicle belonging to a federal, state, or local law enforcement agency and operated as such shall be making use of a flashing or revolving blue light with the same visibility to the front of the vehicle.

(d) The foregoing provisions shall not relieve the driver of an authorized emergency vehicle from the duty to drive with due regard for the safety of all persons.

DEFINITIONS

"Hot" Response - This type of response includes use of the ambulances warning lights and siren.

"Cold" Response - This type of response, while it may be deemed to be an emergency response, does not dictate the use of lights and siren by the ambulance service personnel. During a "cold" response the ambulance will be operated in compliance with the "Rules of the Road" and all traffic laws will be obeyed.

Emergency or Emergent - any circumstance calling for immediate action in which medical attention is indicated. 290-5-30-.02 (bb) Rules and Regulations for Ambulance Services.

Note: An emergency may require a "hot" or "cold" response.

Non-Emergency - means any circumstances in which a delayed action is appropriate and in which transport to a medical facility is indicated.

Note: Always requires a "cold" response.

GUIDING PRINCIPLES

The driver of the ambulance should be advised by the attending medic, as outlined by ambulance protocol, whether it is necessary to respond under "hot" conditions. If a question arises concerning the transport of any patient, medical control **shall** be contacted.

The driver should be advised by the attending medic if the patient's condition changes while in transport, and the method of operating as an authorized emergency vehicle can be altered as appropriate.

When operating a vehicle as "an authorized emergency vehicle", both the warning lights and audible signal must be in use. Operating a vehicle with only one of these warning devices in use does not satisfy the requirements of OCGA 40-6-6.

There are certain medical conditions that may require the rapid transport of the patient, but without the use of an audible warning device due to the patient's condition (i.e. acute MI, pre-eclampsia, etc.). In circumstances where lights only are used for transport, the driver should be advised that the vehicle **can not** proceed as "an authorized emergency vehicle" under the conditions set forth in OCGA 40-6-6. **The operator of the ambulance using lights only without the use of an audible warning device must proceed in complete compliance with the "Rules of the Road".**

Despite the existence of an emergency situation, there are times when it may be more appropriate to approach a scene or transport the patient to a medical facility silently or "cold". Similarly, there may be environmental conditions (i.e. traffic, weather, etc.) in which operating as an emergency vehicle or "hot" introduces unreasonable risk and/or disruption and provides minimal opportunity to arrive at the scene early. In any case, remember ambulance charges and third party payment rates do not correspond directly with the use of warning lights and siren.

When transporting a patient, either "hot" or "cold", the driver of the ambulance should be especially aware of the physical danger inherent and the operation of an emergency vehicle, and drive in a manner to minimize turbulence to passengers resulting from quick and/or sudden stops, acceleration, and turning movements.

Realizing all contingency cannot be considered and a hard and fast rule established, the practice of returning to a station or quarters "hot" for any reason other than an emergency is discouraged. Proper use of backup personnel and vehicles and the use of common sense should all but eliminate returning to station "hot".

PATIENT REFUSES TREATMENT

We recognize that patient refusals represent a difficult, almost impossible, medical – legal paradox. An appropriate policy must allow refusal of treatment by obviously lucid and rational individuals. However, we must be vigilant for those individuals who are incapacitated by means of substance abuse (i.e., drugs, and/or alcohol), medical condition (i.e., hypoglycemia), or trauma (i.e., head injury).

We recognize that, if a patient refuses and therefore is not given an appropriate screening evaluation/examination, it may be impossible to uncover incapacitation in seemingly “normal” appearing persons. This leaves open the possibility that a person needing treatment will refuse treatment.

The purpose of this policy is to provide a baseline for the EMS agency and its evaluators that recognizes the delicate balance between individual’s rights and appropriate EMS response.

Adult patients who are in full command of their mental faculties have the right to refuse treatment even when the refusal is imprudent by accepted medical standards. This only applies to patients who are mentally competent and capable of deciding for themselves. This is not the case with the patient who is neurologically depressed, mentally unstable (either chronically or acutely), or is gravely disabled, which means that he/she is unable to provide for the basic needs of life.

In situations of a mentally competent adult refusal, the following steps should be taken:

1. Explain in comprehensible terms the need for treatment and the consequences to the patient of declining treatment, (i.e., you may die; you may never walk again, etc.). Explain to the patient what treatment is to be done per protocol (such as Oxygen, IV’s, and backboard, etc.). Also, explain to the patient what treatment may be done at the hospital such as x-rays, EKG, blood test and physician evaluation.
2. Sometimes other steps can help in getting a patient’s acceptance of treatment:
 - A. Removing a patient from the public or embarrassing scene.
 - B. Involving family members or friends as needed or requesting that the patient be allowed to respond to questions privately.
3. If the patient still declines care, meticulously document what you advised the patient (i.e., you may die, you may never walk again, etc.) and all indications of the patient’s alertness, full orientation and capacity to repeat back the explanation given. Have the patient do this in front of another person, preferably in the presence of a police officer or ambulance crew personnel and document the results of that request and the name of the person who witnessed the event of the refusal.
4. If the patient should deteriorate or lapse into unconsciousness, the pre-hospital provider may render any treatment deemed appropriate.

Note: Whenever possible contact medical control for cases in which patient refuses treatment/transport.

DESTINATION OF PREHOSPITAL PATIENTS

The patient shall be transported by the ambulance service to the hospital of his/her choice providing that the hospital chosen is within reasonable distance of the patient's location and is capable of meeting the patient's immediate needs. The ambulance service medical director has established reasonable distances for rendition of prehospital emergency care for _____ EMS. (See below) In the event of exigent circumstances on-line medical control may override the established reasonable distances.

If the patient's choice of hospital is not within a reasonable distance, medical control will determine the closest hospital capable of meeting the patient's immediate needs.

If the patient's choice of hospital is within a reasonable distance but medical control (or the medic, if the medic is unable to communicate with medical control) determines that 1) the patient's condition is too critical to risk excessive time necessary to reach the hospital chosen and a nearer hospital is capable of meeting the patient's immediate needs, or 2) the hospital chosen is unable to meet the patient's immediate needs, or 3) the hospital chosen by the patient has notified the medic that it is unable to receive the patient, THEN medical control and/or the medic should make a reasonable effort to convince the patient that a hospital other than the one chosen is more capable of meeting the patient's immediate needs. If the patient continues to insist on being transported to the hospital he/she has chosen then the patient shall be transported to that hospital.

If the patient does not, cannot, or will not express a choice of hospitals, the ambulance service shall transport the patient to the nearest hospital believed capable of meeting the patient's immediate medical needs without regard to other factors, (e.g., patient's ability to pay, hospital charges, county or city limits, etc.).

Reference: DHR Public Health Rule 290-5-30-.05(8)(k) Destination of Prehospital Patients.

Reasonable Distances for rendition of prehospital emergency care for _____ EMS.

Reasonable distances have been determined based on the patient's medical or:

- (1) Trauma related emergency
- (2) Resources at the local and surrounding facilities
- (3) Geographic location of the various facilities
- (4) Ambulance service resources
- (5) Obligation to provide emergency services in the assigned ambulance zone
- (6) Availability of mutual aid

With due consideration of normal workloads and/or extraordinary circumstances at the time of the request for service (i.e. medics, ambulances, and resources of intended receiving facility).

_____ shall be within reasonable distance for rendition of prehospital emergency care.

Continued

Use the following criteria to help determine if air transportation is needed:

GENERAL

- Land transport time greater than 30 minutes for critically ill/injured patient whose condition is likely to worsen in transport and air transport will significantly reduce that time.

TRAUMA

Physiologic Status

Glasgow Coma Scale <14
Systolic blood pressure <90
Respiratory rate <10 or >29
Revised Trauma Score <11

Anatomy of Injury

All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
Flail chest
Combination trauma with burns
Two or more proximal long-bone fractures
Pelvic fractures
Open and depressed skull fracture
Paralysis of extremities, new onset
Amputation or near amputation, excluding digits
Major burns >10 of body surface of face, hands, feet or perineum, or burns with significant respiratory involvement or major electrical or chemical burns

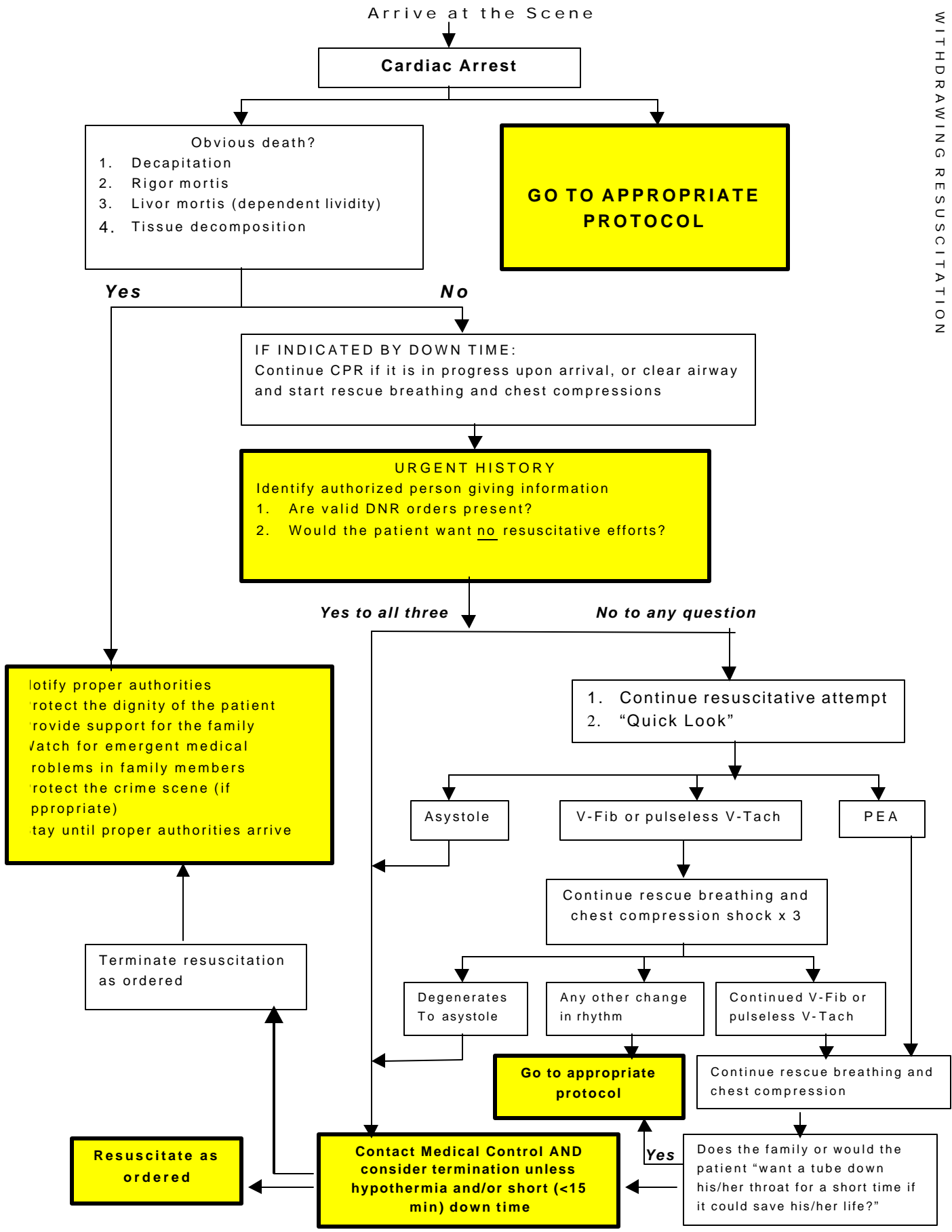
Mechanism of Injury

Ejection from automobile
Death in same passenger compartment
Extrication time >20 minutes
Falls >20 feet
Rollover
High-speed auto crash: Initial speed >40 mph
 Major auto deformity >20 inches
 Intrusion into passenger compartment >12 inches
Auto-pedestrian/auto-bicycle injury with significant (>5 mph) impact
Pedestrian thrown or run over
Motorcycle crash >20 mph or with separation of rider from bike

OTHER FACTORS

Age <5 or >55
Cardiac disease, respiratory disease
Insulin-dependent diabetes, cirrhosis, or morbid obesity
Pregnancy
Immunosuppressed patients
Patient with bleeding disorder or patient on anticoagulants

PATIENT AND SITUATION IS DIFFERENT AND VARIATIONS FROM THESE GUIDELINES MAY BE NECESSARY. DECISIONS FOR TRANSPORT BY HELICOPTER SHOULD NOT REPLACE DECISIONS BASED ON SOUND MEDICAL JUDGMENT. TRANSPORT TO LOCAL FACILITY FOR STABILIZATION AND TRANSFER TO TERTIARY CARE IN CRITICAL SITUATIONS WHERE AIR TRANSPORT IS NOT FEASIBLE.



General Comments

1. Emergency medical services provide rapid evaluation and treatment of potentially life-threatening illnesses and injuries in the out of hospital environment. The first obligation is to the patient(s) in distress. The receipt of a 911 call establishes an implied contract to perform a patient assessment and give appropriate treatment.
2. Patient assessment should always occur promptly and without delay. NEVER withhold or put off patient assessment to take time to read a document. Vital moments in a patient's life may be spent in such an effort. In the absence of a valid DNR, requests by family members to withhold assessment and lifesaving treatment should be set aside initially except in the setting of a patient who is obviously dead.
3. EMS personnel are not trained in making legal opinions and should not attempt to decide if DNR orders or living wills are valid or not while on the scene of a patient in distress. Instead, verbal communication from (1) the patient, (2) the immediate family (authorized person), or (3) medical personnel specifically assigned to and familiar with the patient should be used to make decision.
4. CPR can be stopped in the field in the proper settings. (OCGA 31-39-4). Patients experiencing asystole in the field almost always die. Even if they respond initially, almost no studies show survival of any of these patients to hospital discharge.
 - REMEMBER: Patients experiencing hypothermia may present in asystole. Patients must be warm (95°) before they are pronounced dead. The exception is in the obviously dead patient.
 - REMEMBER: Patients NEVER resuscitate beyond the point they were when they arrested. The terminally ill cancer patient will still have terminal cancer when resuscitated.
 - REMEMBER: Patients with chronic terminal illnesses that have been doing well will OFTEN have many more years of quality life when resuscitated.
5. Patients that have died or for whom it is later determined did NOT want intubation (or the individuals who legally may substitute their judgment for them did NOT want intubation) can be extubated in the emergency department. Endotracheal extubation should not be performed in the field.
6. Since each DNR situation must be dealt with on an individual basis and appropriate care and decision-making determined accordingly, professional judgment is mandatory in determining treatment modalities within the parameters of this protocol.
7. Emergency medical providers must always remember the primary goal of this profession: Render aid and comfort to the suffering. The application of this protocol in no way diminishes this responsibility. All patients whether they are dying, are near death, or have some other clinical problem deserve the provider's utmost compassion and concern.

Withholding of Resuscitation

1. It is proper that resuscitation should not be attempted on certain patients. Any victim meeting one or more of the criteria of "obvious death" should have resuscitative attempts withheld. You must be familiar with the signs of obvious death. A patient who is in rigor mortis, has dependent lividity (pooling of blood due to gravity), has decomposition, or has experienced decapitation or obviously fatal trauma should have resuscitation withheld. If there is EVER any doubt, attempt resuscitation.
2. "Down time", while not a nebulous concept, is fraught with too many variables to permit a specific period of time being used in this protocol to determine whether or not to withhold resuscitation. The medic must exercise professional judgment in determining if "down time", say, 15-minutes in a particular set of circumstances, would clearly indicate withholding resuscitation. If there is any doubt the medic will initiate a resuscitative attempt and proceed to URGENT HISTORY.
3. Living Will - In recognition of the dignity and privacy which patients have a right to expect, the Georgia General Assembly allows a competent adult person to make a written directive, known as a living will, instructing his physician and others to withhold or withdraw life-sustaining procedures in the event of a terminal condition, a persistent coma, or persistent vegetative state. SEE OCGA 31-32. Each medic should be familiar with this statute which includes a sample living will and goes into the execution and revocation of a living will, including the immunity of participants from liability.
 - REMEMBER: If you elect to ignore a living will and resuscitate the patient, you are protected from liability.
 - REMEMBER: If you elect to follow a living will's instructions, you are protected from liability.
4. DNR Order - This is an order in writing by the attending physician using the term "do not resuscitate", "DNR", "order not to resuscitate", "no code", or substantially similar language in the patient's chart. This constitutes a legally sufficient order and authorizes a physician, health care professional, emergency medical technician, cardiac technician, or paramedic to withhold or withdraw cardiopulmonary resuscitation whether or not the patient is receiving treatment from or is a resident of a health care facility. SEE OCGA 31-39. Each medic should be familiar with this statute.

Urgent History

1. Obtain the urgent history only after the appropriate medical measures have been initiated. The resuscitation measures should not be interrupted while the urgent history is obtained.
2. Determine the most legitimate person present from whom the history should be taken, for example the spouse, next of kin, and so on. This is the "authorized person". Know what durable power of attorney for health care means.
3. Determine the following:
 - a. Is there a terminal illness involved?
 - b. Is there an advance treatment directive such as a living will or DNR order?
 - c. Did the patient express to an authorized person any desires regarding resuscitative measures, e.g. proxy directive through durable power of attorney for health care? If so, what?
4. REMEMBER: Just because a living will exists does NOT mean that the patient wants NO resuscitative effort. Even a terminal cancer patient would likely want to have an airway suctioned, oxygen given, and proper aid and comfort administered.

Endotracheal Intubation

1. The field patient who is experiencing an arrest state should be evaluated where possible to determine if the patient may or may not have wanted to be intubated. This should not delay the medic's efforts to do so if, in the judgment of the medic, that intubation is the proper course to follow.
2. The unresponsive field patient in asystole, PEA, or in ventricular fibrillation or unstable tachycardia refractory to initial care needs to be intubated. If the patient's family or authorized medical agent states that they and/or the patient did not wish to have endotracheal intubation even for a short period, this wish should be followed. When in doubt, intubate. The tube can always be removed in the emergency department.

Medical Control

Generally speaking medical control should always be contacted prior to withholding or withdrawing resuscitative efforts.

Revised 05/01/01

Approved by J. Pat O'Neal, M.D.

Medical Director, Office of Emergency Medical Services

DEATH SCENE

The Cardiac Arrest Protocol is to be initiated on all patients except under the following situations:

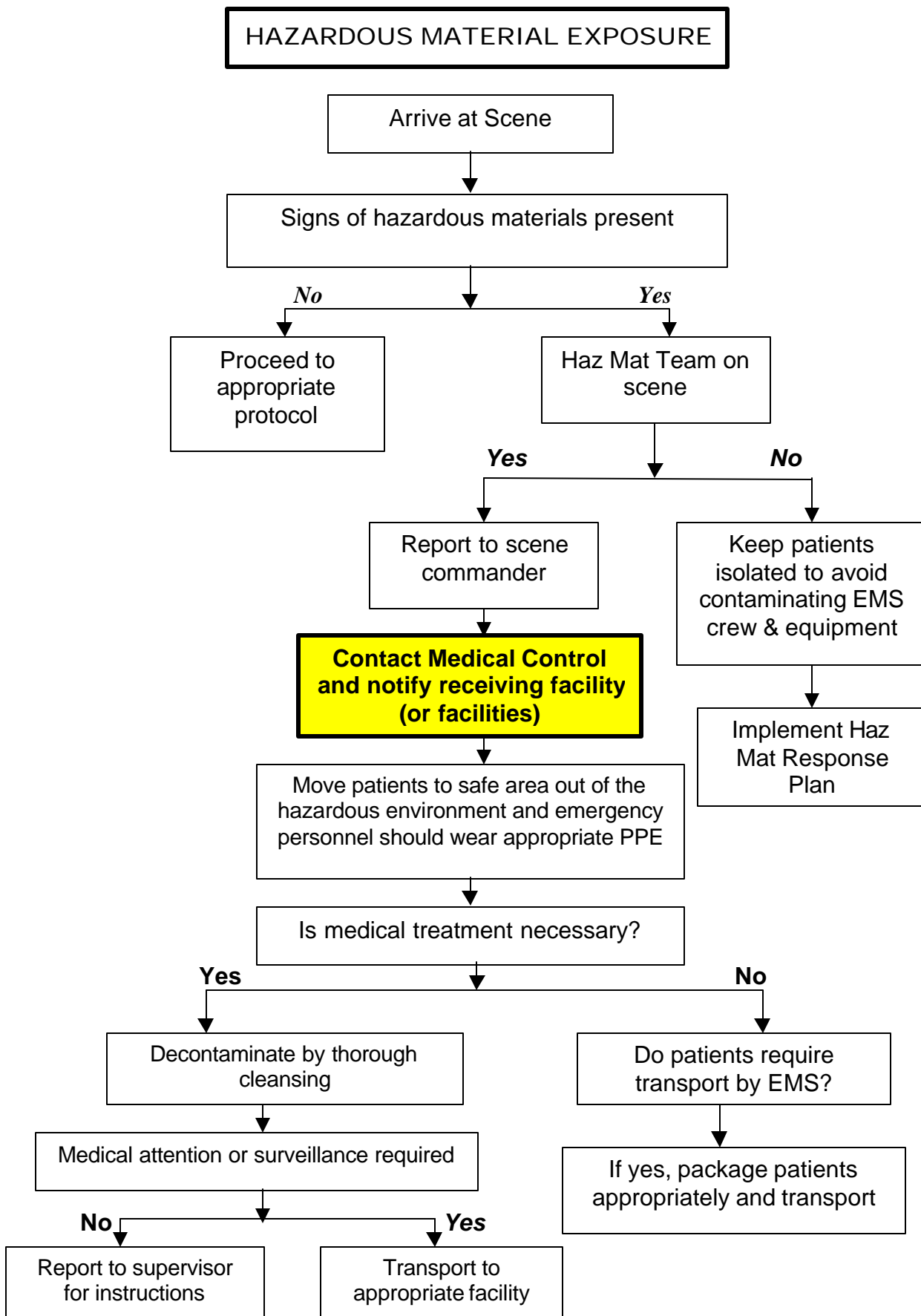
1. The patient is displaying obvious and accepted signs of irreversible death such as rigor mortis, dependent lividity, decapitation, decomposition, or incineration.
2. Blunt trauma victims who have no respirations, no pulse, show asystole confirmed in 2 leads on the cardiac monitor and have obvious signs of trauma.
3. A Georgia Licensed Physician, Medical Examiner, Coroner or other person legally authorized in Georgia to pronounce death.
4. The physician (patient's physician, medical director, or Emergency Room physician) states to at least two (2) EMS personnel, (Paramedics and/or EMTs), that resuscitation is not to be attempted on this patient and the physician agrees to accept responsibility for pronouncing the patient dead.
5. The patient's family has a "Do Not Resuscitate" Order present on the scene that has been signed by a Licensed Physician.

The Paramedic's/EMTs responsibility is to the patient.

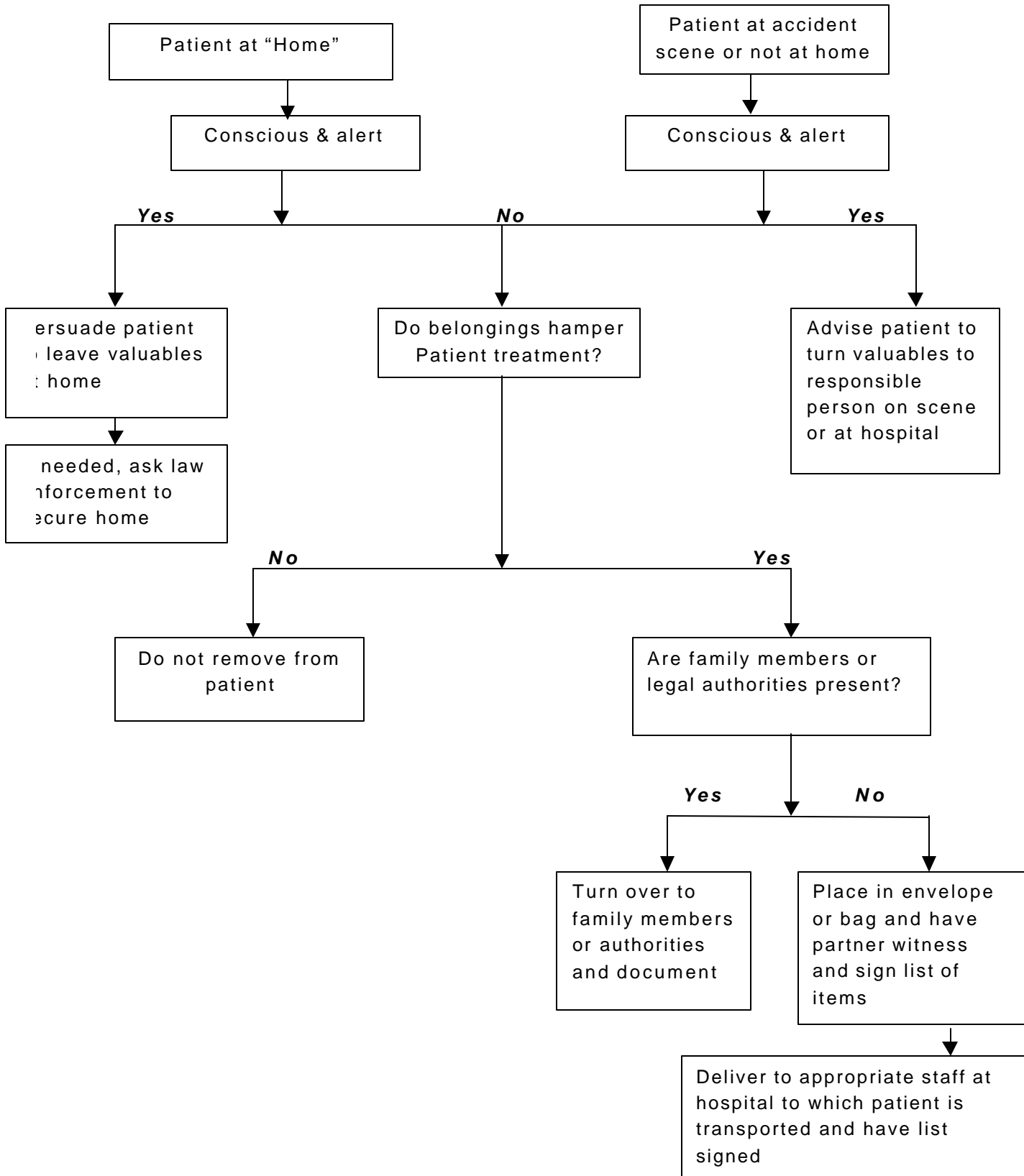
1. Neither the family nor Law Enforcement Officers have the right to refuse resuscitation attempts for the patient.
2. The Paramedic/EMT is responsible for the medical judgment as to whether a patient is obviously dead or dismembered.
3. Document absence of vital signs and attach the EKG strip to the EMS record.

In possible crime cases, do not remove or cut clothing, remove penetrating objects, or cut through penetrating holes in clothing unless absolutely necessary for patient evaluation/care.

If the Paramedic/EMT has any doubt as to how to handle a situation, notify medical control and give an assessment of the situation.



HANDLING PATIENT'S PERSONAL PROPERTY



GENERAL STATEMENT

A medic's first responsibility is to treat the patient. Handling a patient's valuables or personal property is secondary to proper prehospital emergency care. However, special attention needs to be paid to how a patient's personal property is handled by the medic (when handling it cannot be avoided) to minimize potential problems for the medic and the EMS later on. In "load-and-go" situations, do not waste time handling patient's valuables.

In Georgia case law *Bricks v. Metro Ambulance Service, Inc., et.al.* 70517,177 Ga. App. 62 (1985) the court ruled that an ambulance service is a common carrier under Georgia law and therefore it owes duty to passengers not only to protect their lives and persons from insult and injury but to also protect their personal effects from loss. The common carrier (ambulance service) is liable for willful and wanton acts of its own servants in its employment, so proper handling of a patient's valuables is very important.

Proper procedure under this protocol is determined by location of the patient (at home, accident scene, etc.), whether family members or friends of the patient are present, whether law enforcement personnel are present and several other factors. **Every situation cannot be described here, but the following is to serve as a guideline.**

Patient's personal property could include but not be limited to: glasses, dentures, wallets, money, watches, jewelry, expensive clothing, medications, keys.

PATIENT AT HOME OR A RESIDENCE

Advise and encourage the patient to leave all unnecessary personal items and valuables at home or with a family member or friend.

A patient's medication in most cases would need to go to the hospital either with the patient or be carried by a family member. If it is necessary for the medic to handle these medications they should be treated like any other patient valuables.

Do not remove a watch, jewelry, or wallet from a patient unless it is necessary to treat the patient, e.g. start an I.V.

If it is necessary to do so tell the patient you are removing the item. Then try to give it to the patient if conscious and alert or to a family member if present and document this on the ambulance trip report. If possible have another medic or law enforcement officer witness what you did with the patient's personal property.

If the patient insists on taking personal items with him, the patient must be alert enough to keep possession of the items.

If you are uncomfortable about the security of the premises you are leaving, notify law enforcement.

PATIENT AT ACCIDENT SCENE OR NOT AT HOME

If the patient is conscious encourage the patient to give personal property and valuables to a responsible person of his choice. If you have to remove any item from the patient (e.g. watch, jewelry, etc.) to treat the patient, return the items to the patient, and if possible, have someone witness this and document it on the trip report.

If law enforcement presents you with a patient's personal items, request that they (law enforcement) present the items to the patient (if conscious and alert) or to the patient's family, or present them to the hospital staff.

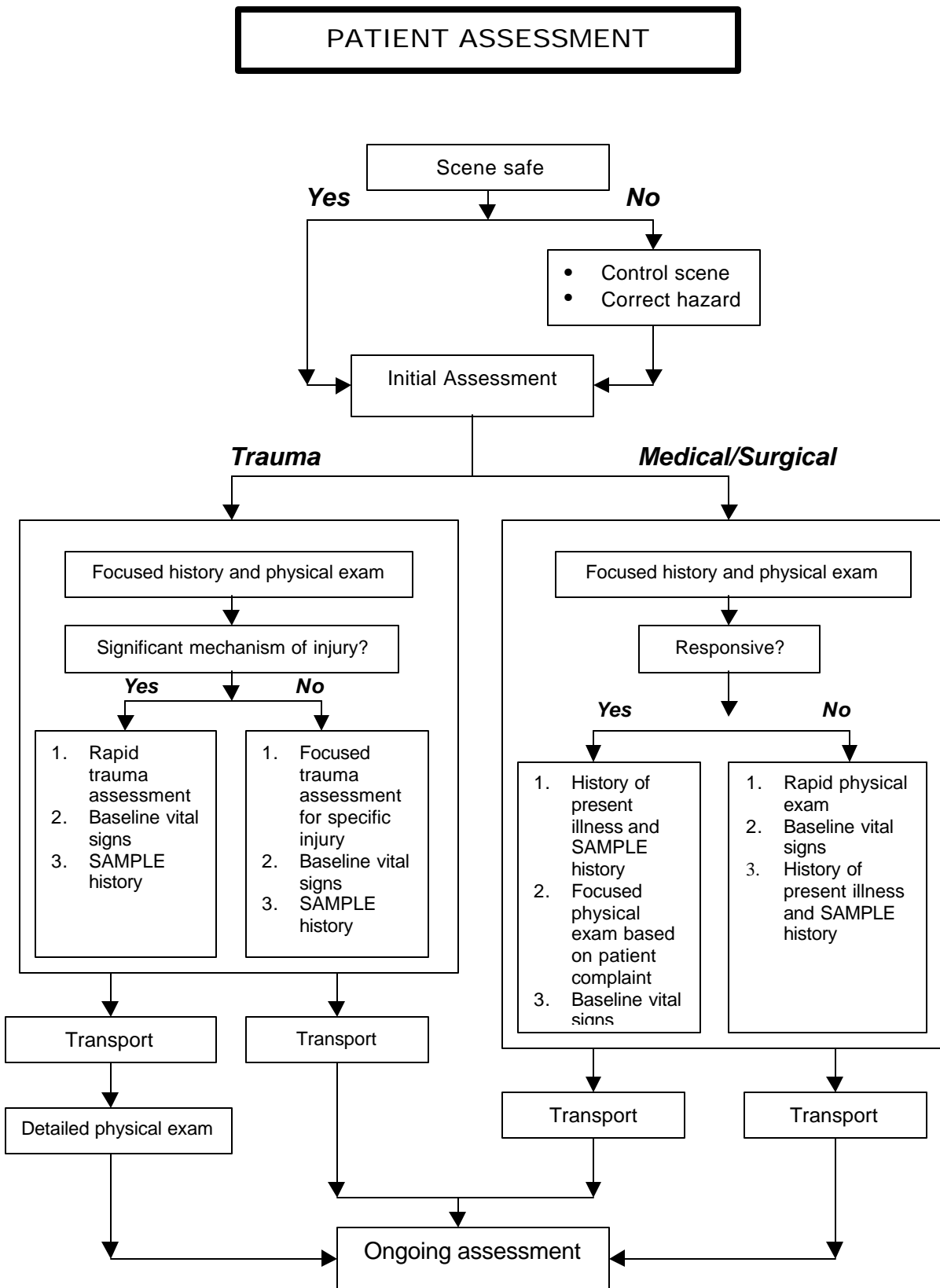
If personal items or valuables are handled by first responders or bystanders before they were presented to you, document this on the trip report.

If personal items or valuables are destroyed in order to gain access to the patient, this should be documented and the items kept.

If patient is disoriented or unconscious give the patient's personal items to a family member or law enforcement officer if possible. Document any incident involving valuables on the trip report and obtain signature from the person receiving valuables. If family or law enforcement are unavailable, transport valuables with patient.

TAKING CHARGE OF PATIENT'S PERSONAL ITEMS

When the medic finds himself in possession of a patient's personal items and valuables, he/she should carefully document what he/she did with the items. Place the items in a container provided for that purpose – zip lock bags for small items and plastic garbage bags for larger items. Make a list of the items placed in each bag and place the list on the bag or in the bag. Medications should be listed separately. Currency should be listed by amount. Have your partner or law enforcement officer verify (sign) the list of items included in the bag. When you



ALTERED LEVEL OF CONSCIOUSNESS (LOC)

Unknown Cause

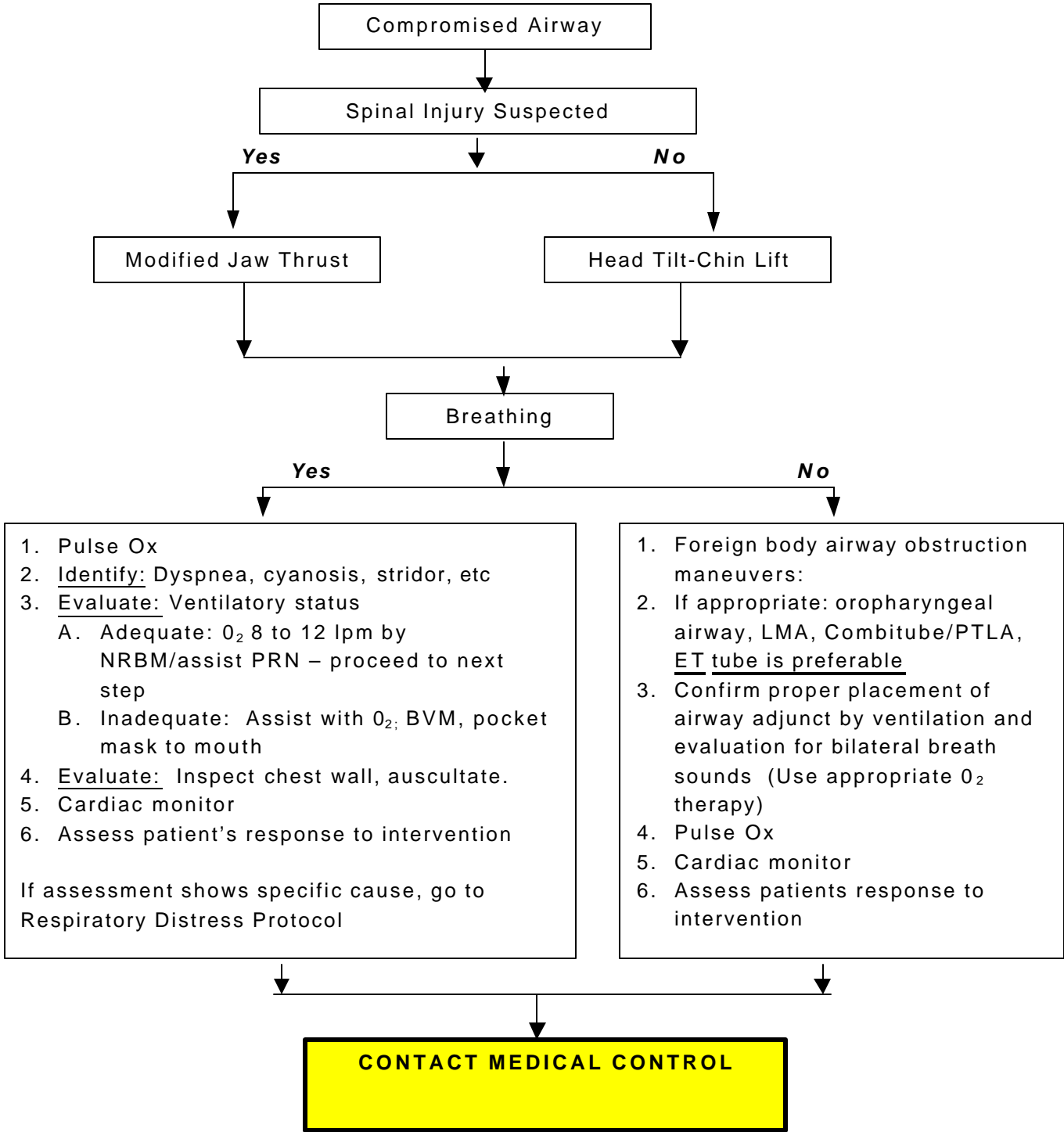
Known Cause

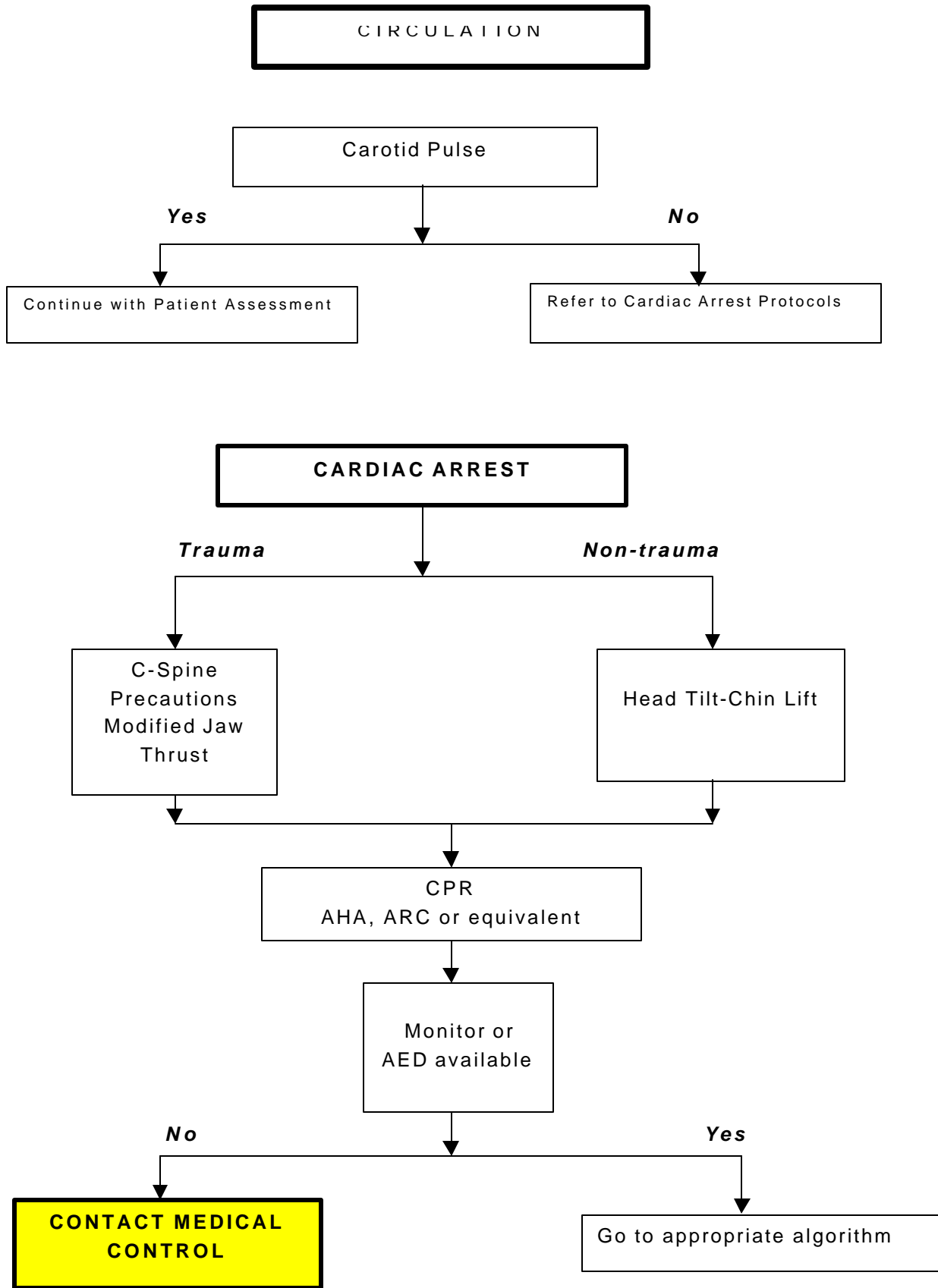
1. Appropriate airway management and O₂ therapy with appropriate C-spine control
 2. Pulse Ox
 3. Finger stick glucose test
 4. Cardiac monitor
 5. Appropriate IV therapy
- Contact Medical Control/orders may include the following:**
6. Narcan 2.0 mg titrated to patient's respirations
 7. D50_w 25-50 GM if hypoglycemic blood
 8. glucose < _____*
 9. Thiamine 100 mg IV (for suspected malnourished patient)

- Refer to appropriate protocol tab:
- Cardiac
 - Stroke
 - Diabetic Management
 - Drugs
 - Hypoxia
 - Seizures
 - Trauma
 - Labor - Eclampsia

* Medical Director to determine this value

AIRWAY - BREATHING





CHEST PAIN

CARDIAC

NON-CARDIAC

**Refer to
specific
protocol**

1. Pulse Ox
2. Initial Assessment/Resuscitation
3. Assure Airway, O₂ 10 to 15 lpm by NRBM/assist PRN
4. Cardiac monitor
5. Detailed Assessment , History: S.A.M.P.L.E., PE
Vital signs (to include pulse rate, rhythm and quality) q 5 minutes. Neck, chest, heart, abdomen, skin, extremities, back
6. IV NS KVO
7. Administer two chewable baby aspirins (162 mg) or one 81 mg if patient is on home regimen

CONTACT MEDICAL CONTROL/orders may include the following:

8. •† NTG – (1/150 gr or spray) x q 5 min PRN x 3
 - Assessment for thrombolytic therapy
 - Anti-dysrhythmics (see appropriate dysrhythmia protocol)
 - Morphine 2 to 10 mg slow IV titrated to pain relief

Transport in position of comfort

SUSPECTED MI

1. Pulse Ox
2. Oxygen
3. Cardiac Monitor
4. IV NS KVO or INT
5. Vital signs
6. Administer two chewable baby aspirins (162 mg.) or one 81 mg, if pt on home regimen.

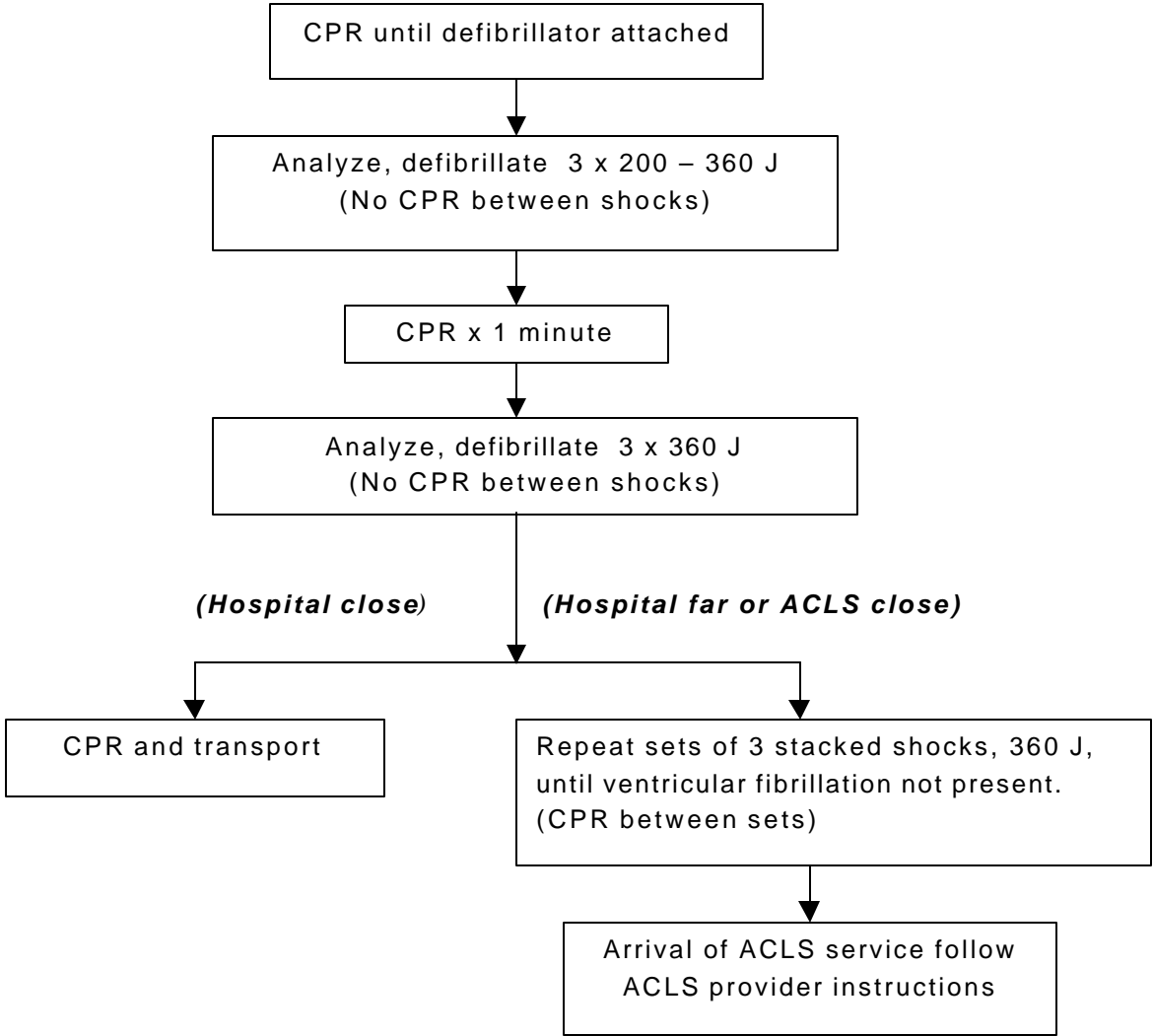
CONTACT MEDICAL CONTROL/orders may include the following:

- † Nitroglycerin
- Pain relief with narcotics
- Expeditious transport to emergency department
- Prehospital screening for *thrombolytic* therapy*
- 12-lead ECG, analysis, transmission to emergency department *
- Initiation of *thrombolytic* therapy*

*When available capability

† Be sure that the patient has not taken Viagra prior to administering NitroGlycerin or other vasodilatory agent and that all vital signs are adequate.

AUTOMATED EXTERNAL DEFIBRILLATOR



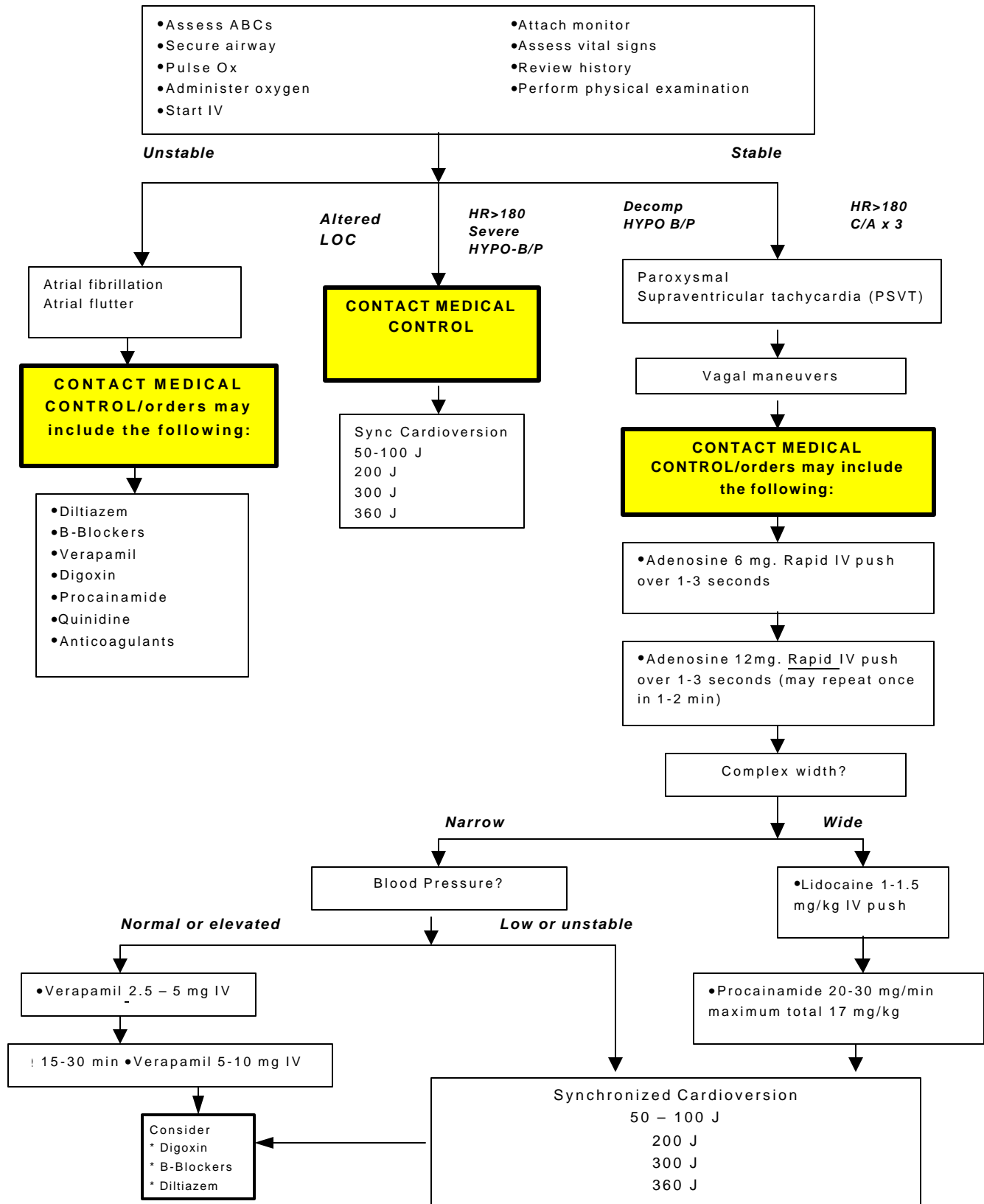
FREQUENT PVC'S OR MULTIFOCAL
PVC'S

Initial assessment
Pulse Ox
Assure airway/O₂ 10 to 15 lpm by NRBM/assist PRN. Check pulse rate, rhythm and quality. (Assessment – slow/normal/fast rate: regular rhythm; changing quality)
Check pulse (rate/rhythm/quality) and level of consciousness (A.V.P.U.) q 5 minutes. ECG quick look and connect to monitor
V NS KVO

CONTACT MEDICAL CONTROL/orders may include the following:

Lidocaine initial bolus 1-1.5 mg/kg IV or for ET tube use double IV dose. Repeat ½ initial bolus q 5 to 10 minutes PRN until maximum dose of 3 mg/kg given
Lidocaine drip of 2 – 4 mg/minute (Premixed drip or one 2 GM ampule in 500 ml D₅W equals 4 mg/ml) starts at 30 microdrops/minute, titrate to effect within the stated dose range

**PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA
(PSVT)**



VENTRICULAR TACHYCARDIA

- Assess ABCs
 - Secure airway
 - Administer oxygen
 - Start IV
 - Attach monitor, pulse ox, and automatic sphygmomanometer*
 - Assess vital signs
 - Review history
 - Perform physical examination
 - 12-lead ECG*
- *Available capability

If ventricular rate > 150 beats/min. and the patient presents as unstable with diminished LOC:

- Prepare for immediate cardioversion
- May give brief trial of medications based on arrhythmia
- Immediate cardioversion is seldom needed for heart rates < 150 beats/min

Wide complex tachycardia

Ventricular tachycardia

CONTACT MEDICAL CONTROL/orders may include the following:

Wide-complex tachycardia of uncertain type

•**Lidocaine** 1-1.5 mg/kg IV push

Every 5-10 min.
-**Lidocaine**
0.5 – 0.75 mg/kg IV push, maximum total 3 mg/kg

-**Adenosine** 6 mg, rapid IV push over 1-3 seconds

•**Adenosine** 12 mg, rapid IV push over 1-3 sec. (may repeat once in 1-2 min.)

Note: If patient converts with lidocaine therapy, initiate lidocaine drip at 2-4 mg/min. If patient converts with bretylium, initiate bretylium drip at 1-2 mg/min

•**Procainamide** 20-30 mg/min, maximum total 17 mg/kg

•**Bretylium** 5-10 mg/kg over 8-10 min, maximum total 35 mg/kg over 24 hours

Ventricular Tachycardia (VT)

•**Lidocaine** 1-1.5 mg/kg IV

Every 5-10 min.
-**Lidocaine** 0.5 – 0.75 mg/kg IV push, maximum total 3 mg/kg

•**Procainamide** 20 – 30 mg/min. Maximum total 17 mg/kg

•**Bretylium** 5-10 mg/kg over 8-10 min, maximum total 35 mg/kg over 24 hours

Synchronized cardioversion

**VENTRICULAR FIBRILLATION - WIDE QRS COMPLEX TACHYCARDIA
WITHOUT PULSE
(VENTRICULAR TACHYCARDIA)**

- ABCs
- Perform CPR until defibrillator attached
- Pulse Ox
- VF/VT present on defibrillator

Defibrillate up to 3 times if needed for persistent VF/VT (200J, 200-300J, 360J)

Rhythm after the first 3 shocks?



- Continue CPR
- Intubate at once
- IV NS

- Epinephrine 1 mg IV push – repeat every 3-5 min

Defibrillate 360J after 30-60 seconds of CPR

Lidocaine 1.5 mg/kg IV push q 3-5 min.

Defibrillate 360J after 30-60 seconds of CPR

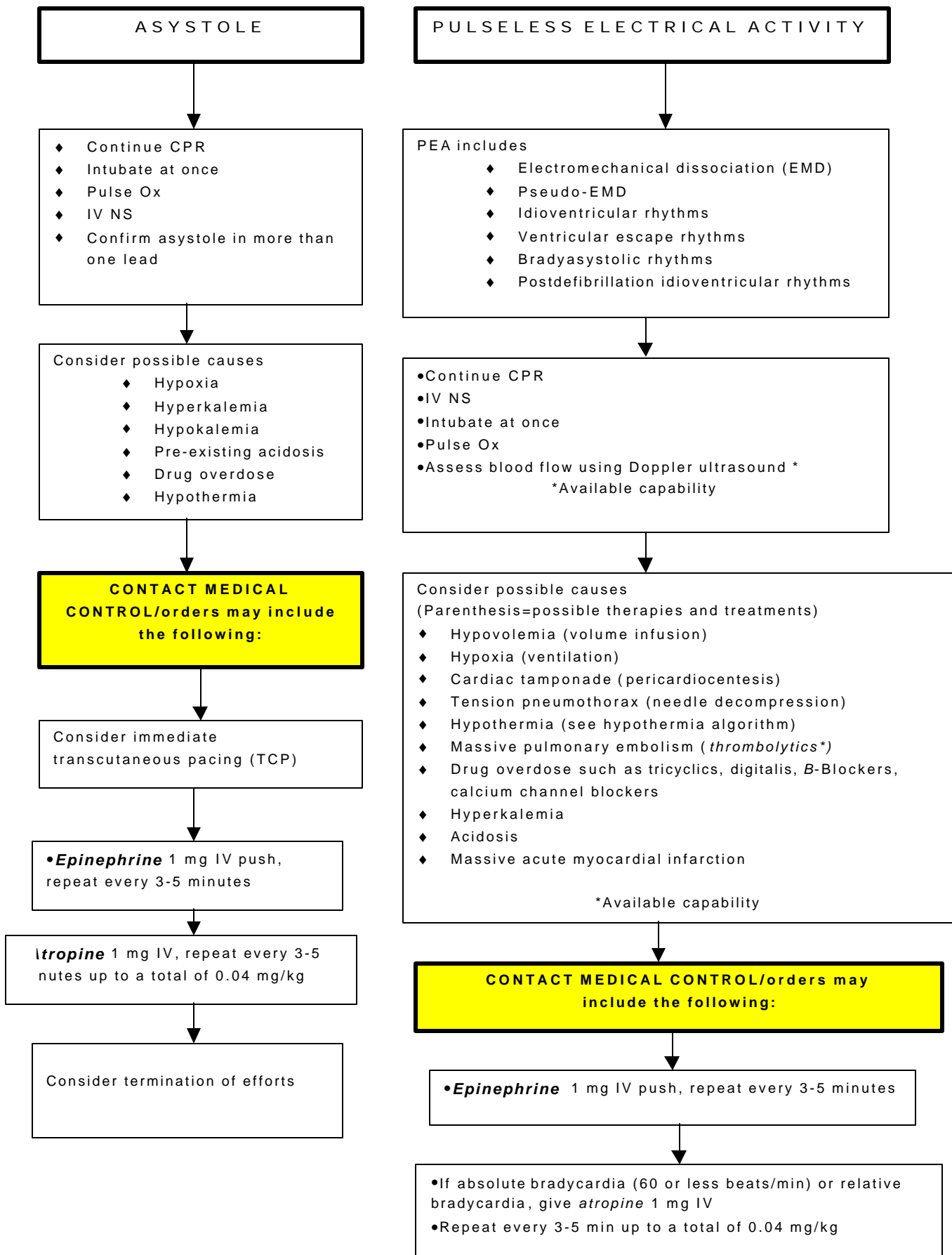
- Assess vital signs
- Support airway
- Support breathing

CONTACT MEDICAL CONTROL/orders may include the following:

- Administer medications of probable benefit in persistent or recurrent VF/VT
- Bretylum 5 mg/kg IV push (repeat 10 mg/kg in 5 min.)
- Magnesium sulfate 1-2 GM IV
- Procainamide 30 mg/min (max.17 mg/kg.)
- Consider Sodium Bicarbonate

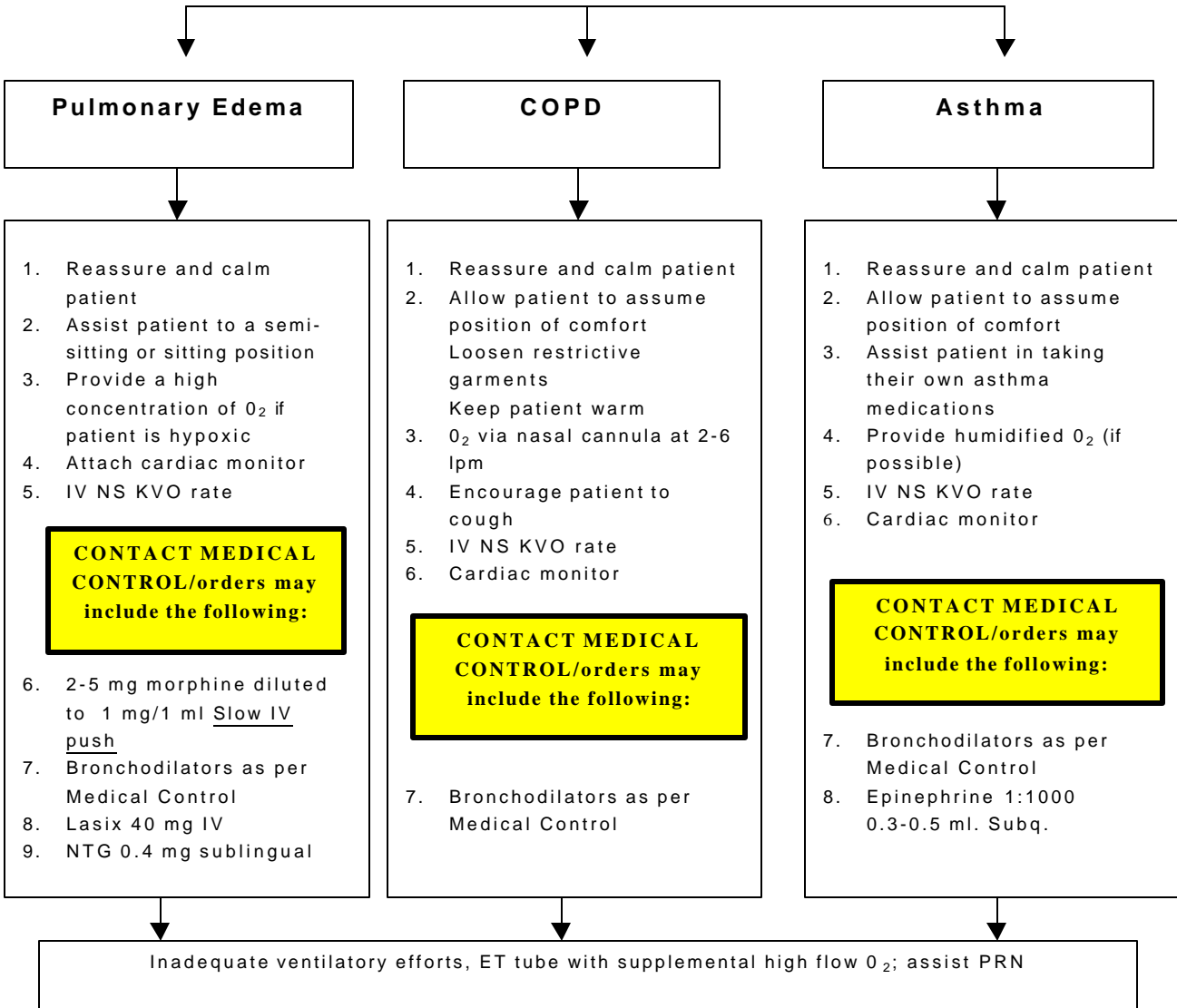
- Defibrillate 360J, 30-60 sec. After each dose of medication
- Pattern should be drug-shock, drug-shock

Provide medications appropriate for blood pressure, heart rate, and rhythm



**RESPIRATORY DISTRESS
(NON-TRAUMA)**

1. Initial Assessment
 - A. Pulse Ox
 - B. Assure airway; O₂ 10 to 15 lpm by NRbm/assist PRN except known COPD, then start 2-6 lpm via nasal cannula and increase as required; be prepared to ventilate
2. Detailed assessment
3. *If patient is coughing, must have mask on when coming to ED



* Consider active TB

SEIZURES

Active

Yes

No

1. Initial Assessment
 - A. Pulse Ox
 - B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN
2. Protect from injury
3. Check LOC by A.V.P.U.; pupils by P.E.R.R.L.
4. Fingertick glucose, draw blood samples
5. IV NS at KVO rate

CONTACT MEDICAL CONTROL prior to detailed survey/ orders may include the following:

6. D₅₀W 25-50 GM; 100 mg. Thiamine IV if fingerstick shows hypoglycemia; blood sugar < * _____
7. Valium 2.5-5 mg. IV slowly over 1-2 minutes. Titrated to resolve seizure activity

1. Initial Assessment/Resuscitation
 - A. Pulse Ox
 - B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN (Watch for emesis)
2. Check LOC by A.V.P.U.; pupils by P.E.R.R.L.
3. Detailed Assessment
4. Fingertick glucose, draw blood samples
5. IV NS at KVO rate

CONTACT MEDICAL CONTROL/orders may include the following:

6. 100 mg Thiamine if suspected malnourished patient or Hx of alcohol abuse
7. * D₅₀W 25-50 GM, if fingerstick shows hypoglycemia; blood sugar < * _____

**Medical Director to determine glucose level*

Hypoglycemia

Initial Assessment/Resuscitation

- A. Pulse Ox
- B. Assure airway; O₂ 10 to 15 lpm by NRBM, assist PRN

Detailed assessment

Fingerstick glucose

Patient conscious – sugar PO

Patient unconscious: IV NS at KVO rate *draw blood samples*

Cardiac Monitor

CONTACT MEDICAL CONTROL/orders may include the following:

- 1. 100 mg. Thiamine IV for suspected malnourished patient or Hx of alcohol abuse
- 3. D₅₀W 25-50 GM if blood sugar <-----*
- 4. Glucagon 1-2 mg IM if IV access cannot be achieved (and/or) patient is combative

Hyperglycemia

1. Initial Assessment

- A. Pulse Ox
- B. Assure airway; O₂ 10 to 15 lpm by NRBM, assist PRN

2. Detailed assessment

3. Fingerstick glucose

4. IV NS at 200 cc/hr

5. Cardiac monitor

CONTACT MEDICAL CONTROL

***Medical Director to determine glucose level**

ABDOMINAL DISTRESS
(NON-TRAUMA)

(NON-TRAUMA)

Initial Assessment

- a. Pulse Ox
- b. Assure airway, O₂ 10 to 15 lpm by NRBM/assist PRN
- c. Manage shock appropriately

Detailed Assessment

- a. Consider cause: GI/GU, cardiac, aneurysm, GYN/pregnancy, insect bite/sting, poisoning/overdose, other

Save/note significant emesis/other drainage

IV NS

Draw blood samples

Cardiac monitor

Keep patient NPO

CONTACT MEDICAL CONTROL

DEHYDRATION

. Initial Assessment

- A. Pulse Ox
- B. Assist airway O₂ 10 to 15 lpm NRBM/assist PRN
- C. Manage shock appropriately

!. Detailed assessment

CONTACT MEDICAL CONTROL

- . IV NS at rate determined by Medical Control. Draw blood samples

OB GYN/LABOR

1. Initial Assessment
 - A. Pulse Ox (for both if possible)
 - B. Assure airway ;O₂ 10 to 15 lpm by NRBM/assist PRN
 - C. Blow by O₂ for baby
2. Detailed Assessment
 - A. Determine: Frequency of contractions, rupture of membranes. PE: Crowning, presenting part
 - B. Hx. A.M.P.L.E., (complications present or past pregnancy, due date, number of pregnancies, number of deliveries, multi gestations, physician)
3. Cardiac monitor

Imminent Birth

Non-Imminent Birth

CONTACT MEDICAL CONTROL

Transport

Normal Delivery

Breech

Heavy Bleeding

Presenting Part

1. Control head, then body until delivery completed, keep head below level of body; check for presence of cord around neck and gently remove as indicated
 2. Suction baby's airway, mouth first, then nostrils as soon as head delivers
 3. Assess baby's APGAR score and record time of birth, keep baby warm
 4. Double cross-clamp umbilical cord approximately 3 inches from infant – divide between clamps
 5. Allow placenta to deliver spontaneously. DO NOT PULL CORD. Save all tissue. Do not wait in field for placenta to deliver
 6. Massage fundus (top of uterus) to control bleeding
 7. IV NS KVO
- CONTACT MEDICAL CONTROL/orders may include the following:**
8. Pitocin 3-10 units IM
Pitocin 10-20 units per liter NS, rate per Medical control, monitor B/P closely
 9. Monitor mother's vital signs

1. Allow infant to deliver to waist while supporting body
 2. Flex body to allow head to deliver
 3. If head does not deliver in 3 minutes, insert gloved hand to create an airway
 4. Suction with bulb syringe PRN
- STAT Transport
- CONTACT MEDICAL CONTROL**

- Heavy bleeding shock:
- IV NS shock volume 14 -16 gauge x 2 at wide-open rate
- STAT Transport
- CONTACT MEDICAL CONTROL**

1. Position mother on back with head below level of pelvis; coach (pant, don't bear down)
 2. Use gloved hand with gentle firm pressure on baby
- CONTACT MEDICAL CONTROL/orders may include the following**
- Consider sedation
- STAT transport

These procedures should be done enroute.

VAGINAL BLEEDING

Initial Assessment/Resuscitation:

- A. Pulse Ox
- B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN
- C. Manage shock appropriately

Detailed Assessment

- A. Consider cause: Pregnancy/spontaneous abortion, trauma, abnormal menstrual flow
 - B. Hx: A.M.P.L.E.
 - C. PE: Skin, cardiac, abdomen, Gyn
- IV NS 2 large bore IV's if shock is present
Cardiac monitor

CONTACT MEDICAL CONTROL/orders may include the following:

MAST

PRE-ECLAMPSIA (TOXEMIA)

. Initial Assessment/Resuscitation:

- A. Pulse Ox
- B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN
- . Protect patient from injury

. Detailed Assessment

- A. History: A.M.P.L.E. (pre-eclampsia, seizure activity)
- B. PE: Skin, pulmonary, cardiac, neurological

- . Monitor vital signs q 5 minutes
- . Keep patient calm and quiet; anticipate seizures
- . Cardiac monitor
- . IV NS

CONTACT MEDICAL CONTROL/orders may include the following:

- . Magnesium Sulfate 2-4 GM of 10% solution IV slowly
- . Valium 5 mg, IV slowly over 1-2 minutes

Expedient transport (as gently as possible; no flashing lights, no siren – may precipitate seizures)

CHEST TRAUMA

Unstable trauma patients: follow unstable trauma guidelines first, then refer to specific treatment protocols

1. Initial Assessment/Resuscitation:
 - A. Pulse Ox
 - B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN
 - C. Evaluate/manage compromised or absent breathing
2. Control hemorrhage (if not possible – load and go)
3. IV NS KVO - manage shock appropriately
4. Cardiac monitor

Open chest wall Wound

Flail Chest

Tension Pneumo/Hemothorax

1. Use non-porous material, seal on three sides ONLY which allows air to escape from the pleural space (With respiratory distress)
2. Assist ventilation by most appropriate method, ET intubation preferable if tolerated, transport
3. Cardiac monitor

1. Splint, assist ventilation by most appropriate method – ET tube if tolerated
2. Transport
3. Cardiac monitor

1. Hot transport
 2. ET Intubation
 3. Cardiac monitor
- CONTACT MEDICAL CONTROL** orders may include the following:
4. Possible pleural needle decompression

CONTACT MEDICAL CONTROL

Detailed Assessment

On scene time should not exceed 10 minutes, unless necessary for extrication

1. Appropriate airway management with Pulse Ox and O₂ therapy with C-spine immobilization
2. Control blood loss and immobilize to long backboard. (If on scene time limit will not be exceeded, apply appropriate splints)
3. Advise receiving hospital of patient status and treatment, GCS, RTS immediately, according to Communication Protocol; Request additional orders if necessary
4. While en route, two large bore IV's of NS wide open through a blood or trauma set, if time permits. Transportation will not be delayed to allow for IV's, but if scene time is delayed for some other reason such as entrapment, IV's should be started on scene
5. Blood may be drawn (if time permits)

CONTACT MEDICAL CONTROL/additional orders may be requested or ordered

Special Note: CRT is usually a reliable, general indicator of shock (may be affected by body and weather temperature)

Pulse location is usually a good indicator of blood pressure

Present radials – 90 systolic

Present carotids – 60 systolic

Cold IV fluids should be warmed if possible

T R A U M A

Unstable Trauma Patients: Follow Unstable Trauma Guidelines first, then refer to specific treatment protocols

HEAD

1. Initial Assessment/Resuscitation: Spinal precautions*
 - A. Pulse Ox
 - B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN
 - C. Establishment of effective ventilation is imperative
 - D. Adjuncts/BVM, hyperventilation usually indicated
 - E. ET tube may be indicated to obtain strong and effective ventilations
2. Manage shock appropriately
3. Detailed Assessment
4. C-collar
5. Fingertick glucose
6. IV NS at KVO
Draw blood samples
7. Cardiac monitor

CONTACT MEDICAL CONTROL

8. Transport to closest appropriate hospital

ABDOMINAL

1. Initial Assessment/Resuscitation:
 - A. Pulse Ox
 - B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN
2. Manage shock appropriately
3. Detailed Assessment
4. Cover open wounds – LR soaked dressings
5. Pelvic injury
6. Spinal immobilization PRN
7. IV NS
8. Cardiac monitor
9. Transport to closest appropriate hospital

CONTACT MEDICAL CONTROL

AMPUTATED PARTS

1. Initial Assessment/Resuscitation
2. Manage shock appropriately
3. Detailed Assessment
 - A. Length of time of amputation
4. Short transport (local) – wrap part in clean/sterile towel/sheet
5. Prolonged transport
 - A. Wash in LR
 - B. Wrap in sterile gauze with damp LR
 - C. Wrap in sterile towel with damp LR
 - D. Place in plastic bag
 - E. Place bag on crushed ice or ice pack for transport

NEVER freeze part
NEVER allow direct contact with ice
NEVER float part in solution
NEVER use antiseptics or other solutions on part
6. Incomplete amputation – Splint in position/control hemorrhage
7. Cardiac monitor
8. Transport to closest appropriate hospital

CONTACT MEDICAL CONTROL

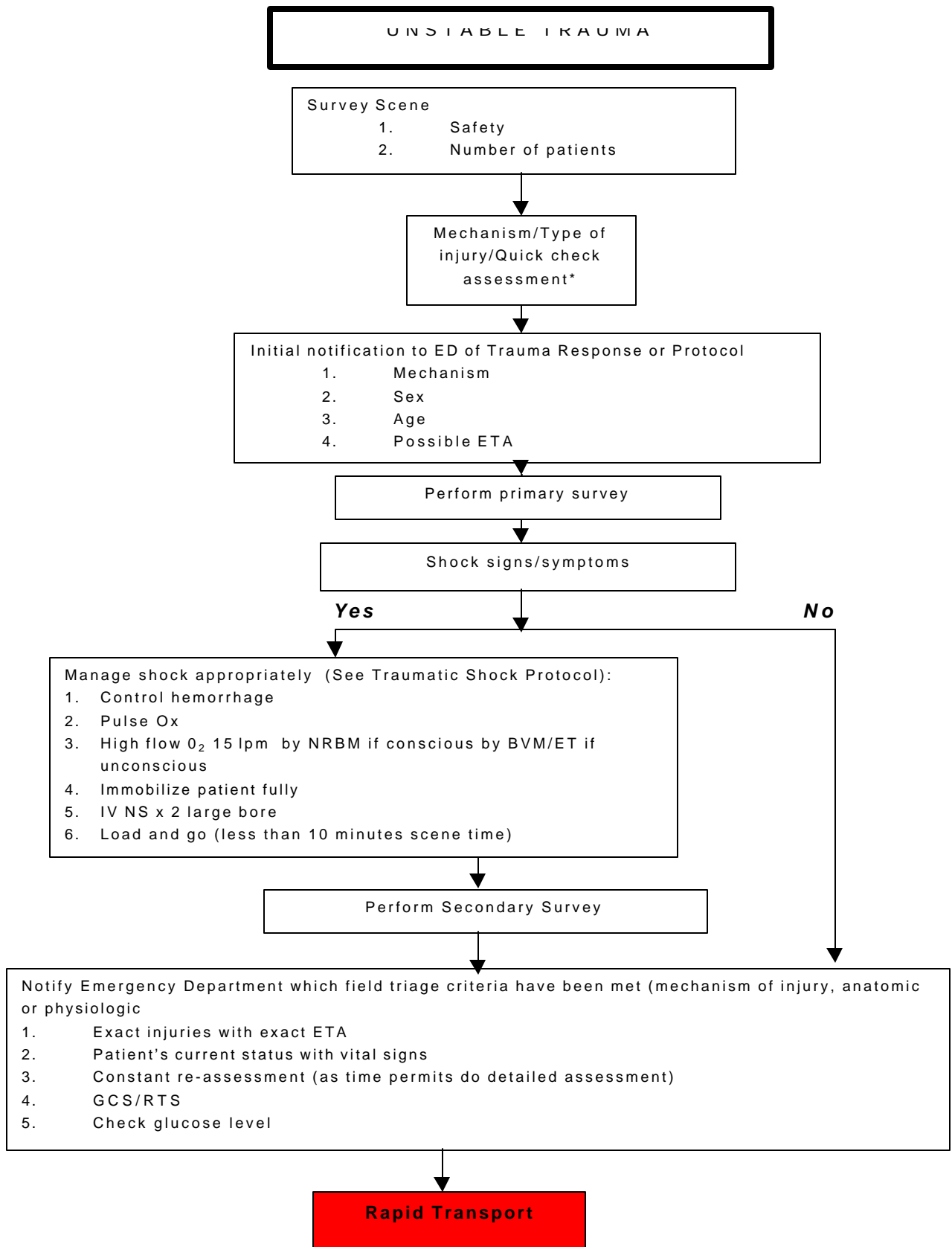
EXTREMITY

1. Initial Assessment/Resuscitation
 - A. Pulse Ox
 - B. Assure airway; O₂ 8 to 12 lpm by NRBM/assist PRN
2. Manage shock appropriately
3. Detailed Assessment
4. Splint fractures as extremity lies; check distal neuro/vascular status
5. Open fractures – dry dressing
Amputation – dressing, see “Amputated Parts”
6. Pelvis
7. IV LR or NS
8. Cardiac Monitor

CONTACT MEDICAL CONTROL/orders may include the following:

9. Angulations with no distal pulse – traction for realignment. Check neuro/vascular status, splint, check neuro/vascular status
10. Transport to closest appropriate hospital

**On all trauma patients, report GCS/RTS to receiving hospital

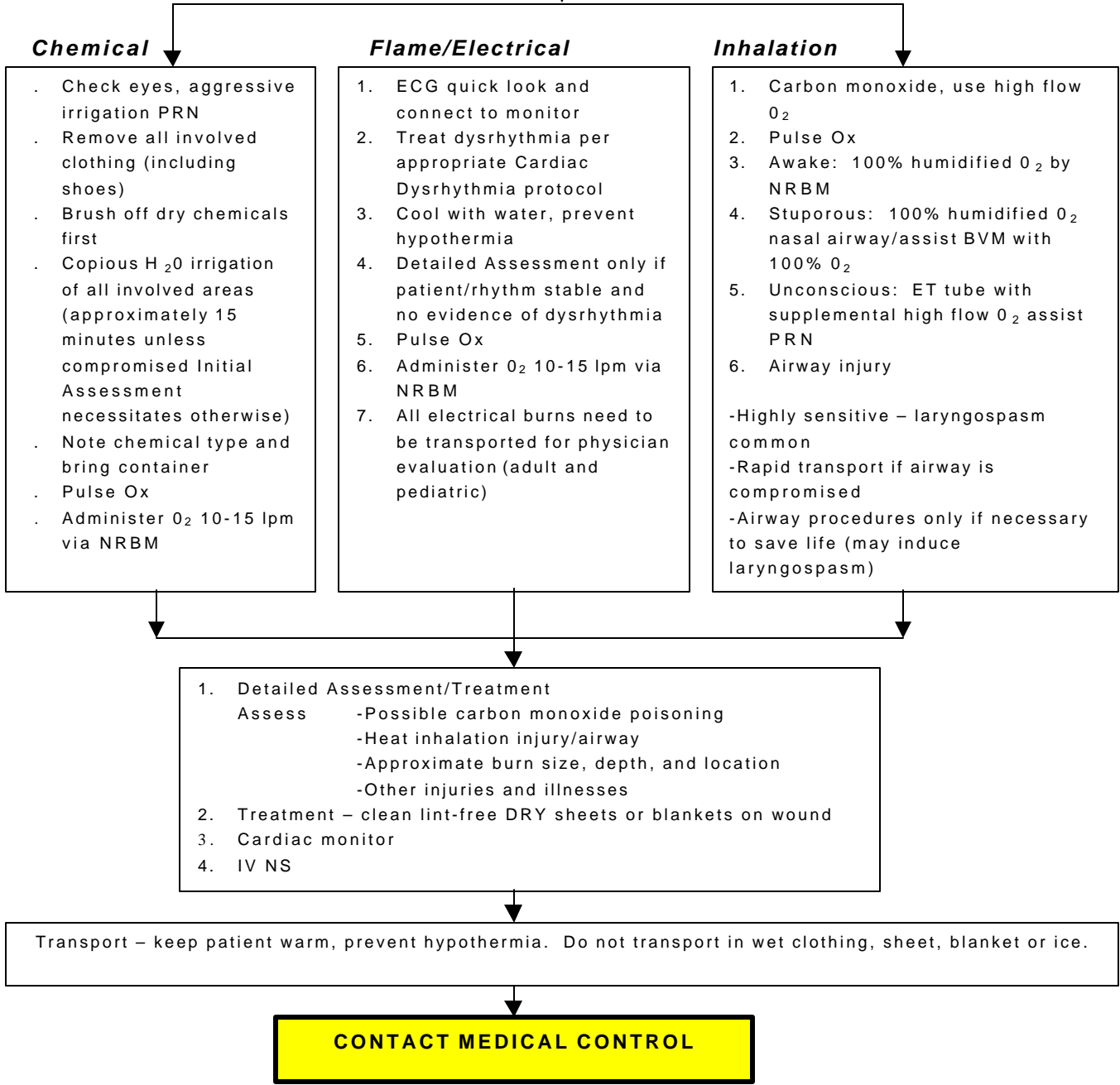


**Quick Check Assessment - ABC's, location of injury or injuries*

BURNS

Remove from burning process if possible (only if properly trained)

Initial Assessment



See Analgesic Protocol for pain management

ANAPHYLAXIS

Initial Assessment/Resuscitation:

- A. Pulse Ox
- B. Assure airway/O₂ 10 to 15 lpm by NRBM/assist PRN
- C. Watch for anaphylaxis/shock and treat per protocol if indicated

Detailed Assessment

- A. Identify cause: insect, etc. (bring) – length of time since sting

Keep patient at rest, NPO

Ice pack to wound intermittently (cool wound, do not freeze)

Vital signs q 5 minutes

Cardiac monitor

IV NS KVO – large bore IV's

Benadryl 25 – 50 mg IM

CONTACT MEDICAL CONTROL

- 1. Epinephrine 0.3 – 0.5 ml. of 1:1000 subq if systemic allergic reaction without shock
- 2. Transport STAT, start IV NS large bore enroute
- 3. Monitor ECG. Monitor and follow Airway Protocol PRN

CONTACT MEDICAL CONTROL as soon as anaphylaxis is identified. STAT orders may include the following:

- 4. 1 ml of 1:10,000 solution Epinephrine, IV titrate to effect (relief of airway compromise, reduction of bronchospasms, adequate circulation) monitoring B/P
- 5. Benadryl 25-50 mg slow IV push or deep IM

POISONING

Initial Assessment/Resuscitation

- A. Pulse Ox
- B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN
- C. ECG quick look and connect to monitor

Detailed Assessment

Eye and skin decontamination: Copious H₂O flush (if appropriate)

CONTACT MEDICAL CONTROL/orders may include the following:

Gastric emptying:

Not indicated for comatose/stuporous patient, caustics (acid or alkali), petroleum products, phenothiazines

Bring container of poison to ED

IV as ordered

CONTACT GEORGIA POISON CENTER 1-800-282-5846

ORGANOPHOSPHATE/CARBAMATE POISONING

Scene Safety
1. Personal protection
2. Decontamination

Initial Assessment/Resuscitation:
1. Pulse Ox
2. Assure airway; O₂ 10 – 15 lpm by NRB/assist or intubate PRN
3. Suction PRN
4. Cardiac Monitor watch for dysrhythmias
5. IV NS KVO
6. Obtain history

Detailed assessment

CONTACT MEDICAL CONTROL/orders may include the following:

Atropine 2 mg IV every 1 to 15 minutes as required to induce; tachycardia, flushing, and decreased secretions

Diazepam 2 – 5 mg for seizures

Activated charcoal

CONTACT GEORGIA POISON CENTER 1-800-282-5846

SNAKEBITES

Assure scene safety/location of snake

Obtain information: Confirm bite marks by visualization, determine type, size, length of snake, measure initial width between bite marks, time lapsed since bite occurred

Initial Assessment/Resuscitation PRN:
Assure airway/manage appropriately

Keep patient at rest, NPO

Immobilize area bitten (leaving wound exposed) Do not place in ice or cold pack on bite site

RAPID TRANSPORT

Probable envenomation by poisonous snakebite or unknown type of snake

Pulse Ox

Manage airway appropriately with O₂ therapy/assist PRN

Vital signs q 5 minutes

Cardiac monitor

IV NS at KVO rate

Immobilize involved extremity and lower below level of heart

CONTACT MEDICAL CONTROL IMMEDIATELY

No envenomation or non-poisonous snakebite

Vital signs/reassess q 5 minutes

CONTACT MEDICAL CONTROL

- ◆ No bandage or dressing is recommended over bite unless it is bleeding profusely.
- ◆ Have snake identified or brought to the hospital by qualified personnel other than your unit.
- ◆ Absolutely no ice or constrictive type bands.

NEAR DROWNING

1. Initial Assessment with stabilization of neck and spine (prior to removal from the water)
 - A. Pulse Ox
 - B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN
 - C. Intubate if needed with C-spine control
2. Remove wet cold garment/prevent hypothermia
3. Connect to ECG monitor
4. Monitor and follow Airway/Breathing/Circulation Protocols PRN
5. IV NS

CONTACT MEDICAL CONTROL: Include length of time submerged and drowning particulars and the type of water i.e. salty-fresh/orders may include the following:

6. Treat Dysrhythmia per appropriate Cardiac Dysrhythmia Protocol

HYPOTHERMIA

- Actions for all patients
1. Remove wet garments
 2. Protect against heat loss and wind chill
 3. Maintain horizontal position
 4. Avoid rough movement and excessive activity
 5. Monitor core temperature
 6. Monitor cardiac rhythm

Pulse/Breathing Present

Pulse/Breathing Absent

Assess responsiveness, breathing, and Pulse Ox

1. Assure airway. O₂ 10 to 15 lpm by NRBM/assist PRN (warmed)
 2. IV NS (warmed)
- CONTACT MEDICAL CONTROL**

1. Start CPR
2. Defibrillate VF/VT up to a total of 3 shocks (200J, 300J, 360J)
3. Intubate
4. Ventilate with warm, humid oxygen (42°C-46°C) (108°-114°F)
5. IV NS
6. Infuse warm normal saline (43°C) (109°F)

What is core temperature?
If accurate core temp is available – proceed. If no core temperature is available, contact medical control.

<30°C (86°F)

>30°C (86°F)

1. Continue CPR
 2. Withhold IV Medications
 3. Limit shocks for VF/VT to 3 maximum
 4. Transport to hospital
- CONTACT MEDICAL CONTROL**

1. Continue CPR
- CONTACT MEDICAL CONTROL/orders may include the following:**
2. Give IV medications as indicated
 3. Repeat defibrillation for VF/VT as core temperature rises

Resuscitation efforts should not be abandoned until core temperature approaches normal

HYPERHERMIA

HYPERHERMIA

Heat Cramps

Initial Assessment
A. Pulse Ox
B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN

Detailed Assessment

Aggressive cooling

Cardiac Monitor

Oral fluids

CONTACT MEDICAL CONTROL

Heat Exhaustion

1. Initial Assessment
A. Pulse Ox
B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN

2. ECG quick look and connect to monitor

3. Remove patient from heat, place in supine position

4. Detailed Assessment

5. Actively cool patient: loosen/remove clothing, tepid water skin irrigation, fan, wet towels

6. Monitor vital signs q 5 to 10 minutes

7. Consider **CAUTIOUS** oral replacement

CONTACT MEDICAL CONTROL

8. IV NS KVO

Heat Stroke

1. Initial Assessment
A. Pulse Ox
B. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN

2. ECG quick look and connect to monitor

3. Remove patient from heat; place in supine position

4. Detailed Assessment

5. Actively cool patient: Loosen/remove clothes, tepid water skin irrigations, fan, wet towels. (Consider iced water soaked towels over trunk extremities, axilla & groin)

6. Monitor vital signs q 5-10 minutes

7. IV NS KVO

CONTACT MEDICAL CONTROL

8. Rapid transport

GENERAL OVERDOSE

Initial Assessment

1. Pulse Ox
2. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN
3. Cardiac Monitor
4. IV NS KVO
5. Appropriate blood samples
6. Narcan 2 mg IV
7. D₅₀W 50 ml if comatose; otherwise administer dextrostix

Detailed Assessment

CONTACT MEDICAL CONTROL/orders may include the following:

gastric emptying is NOT indicated for comatose/stuporous patient, caustics (acid or alkali), petroleum products, phenothiazine

CONTACT GEORGIA POISON CENTER 1-800-282-5846

BENZODIAZEPINE OVERDOSE

Scene Safety

- Initial Assessment
1. Pulse Ox
 2. Assure airway; O₂ 10 to 15 lpm by NRBM/assist or Intubate PRN
 3. Cardiac Monitor
 4. IV NS KVO or rate given by medical control
 5. Obtain history
- Detailed Assessment

CONTACT MEDICAL CONTROL

CONTACT GEORGIA POISON CENTER 1-800-282-5846

NARCOTIC OVERDOSE

Scene Safety (law enforcement on scene)

Initial Assessment/Resuscitation:

1. Pulse Ox
2. Assure airway; O₂ 10 to 15 lpm by NRBM/assist PRN or intubation if indicated
3. Cardiac Monitor
4. Obtain history
5. Detailed Assessment
6. Dextrostix

IV NS KVO

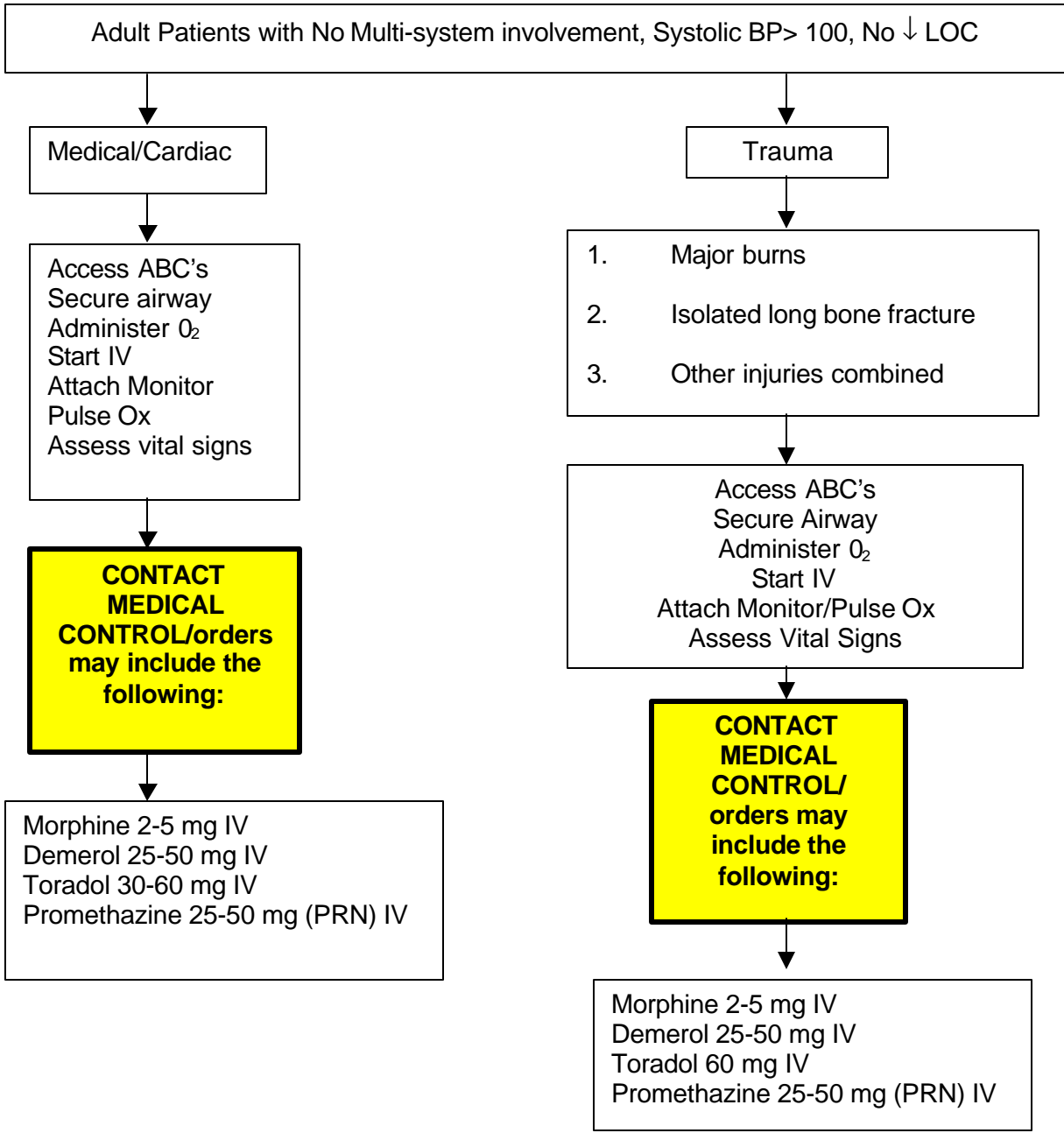
CONTACT MEDICAL CONTROL/orders may include the following

Naloxone titrated to effect

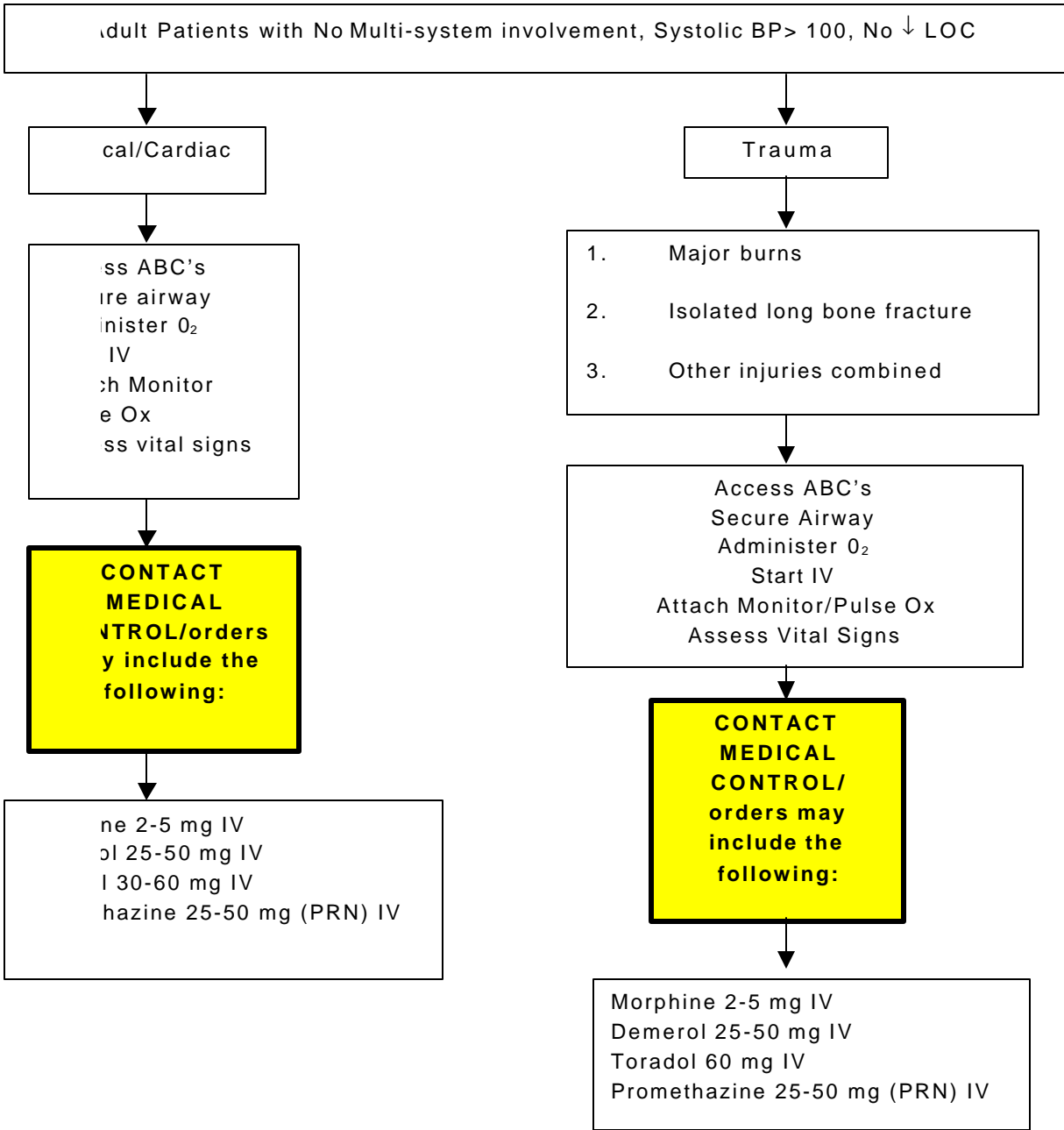
Restrain PRN (after receiving order from Medical Control or law enforcement)

CONTACT GEORGIA POISON CENTER 1-800-282-5846

ANALGESIC PAIN MANAGEMENT



**ANALGESIC
PAIN MANAGEMENT**



PSYCHOLOGICAL

Careful Assessment

No apparent danger to self or others

Danger to self or others

Apparent emergency life threatening danger to patient, medics or others

Obtain consent from:

1. Patient
2. Police
3. Court Order
4. Medical Control

Have police on scene

If by court order have officer of court accompany ambulance

Use verbal communications that are firm and clear but not abusive

CONTACT MEDICAL CONTROL for orders

CONTACT MEDICAL CONTROL for orders

1. Have adequate help to restrain safely
2. Have certified law officer on location
3. Restrain with individualized effort/with as much dignity as possible
4. Place on stretcher and secure with patient in prone position with appropriate straps
5. Medical and treatment reassessment to be continual

1. Have certified law officer on scene
2. Necessary restraints may be immediately applied

CONTACT MEDICAL CONTROL as soon as possible

3. Medical and treatment reassessment to be continual
4. Document carefully the reason for immediate restraint and obtain authorizing physician's signature upon arrival to ED

Restraints

No

Yes

transport monitor

Restrain with individualized effort and do so with dignity

INTRODUCTION TO PEDIATRIC GUIDELINES

The Need for Standardized Protocols

Our emergency medical services system is founded on the principle of delegated practice. Medical oversight establishes a certain standard of emergency patient care, which is then carried out by pre-hospital providers in the field.

The term medical oversight encompasses both direct and indirect facets of medical control. Direct medical control is the on-line guidance provided by designated physicians to pre-hospital providers during emergency calls. Indirect medical control consists of training programs, patient care protocols, and quality assurance measures that are initiated by local, regional, state, and agency medical directors or advisory boards. Throughout this document, the term *Medical Control* represents all forms of medical oversight as applied by the state, region or agency. To make a delegated system work, medical direction must ensure that all pre-hospital providers are equipped to meet appropriate standards of patient care. This requires education and training, treatment protocols to guide rescuers' actions in the field, and support from qualified on-line medical control physicians as needed. The responsibilities of medical control include authorizing an accepted scope of practice for EMTs and Paramedics; verifying that pre-hospital providers have received the necessary training to render field care swiftly and skillfully; and developing and approving protocols that delineate the proper steps in patient management.

Protocols represent an important element in furthering the quality of patient care. While they cannot replace sound clinical judgement, they facilitate rapid and effective treatment. They serve to standardize management actions so that, pre-hospital providers will know how to proceed in a given patient presentation. They also provide an unambiguous gauge by which adherence to EMS practice standards may be measured.

Putting the Protocols to Use

EMS systems provide services under widely varying conditions. Current protocols therefore differ between agencies. The protocols developed and presented in this document provide a basis for medical direction to create or refine existing protocols to meet local, regional and state needs. In this manner, the protocols set forth a standardized approach to pediatric treatment that can be employed by a wide variety of EMS providers. The following legend has been established to differentiate between on-line medical control and off-line medical control:



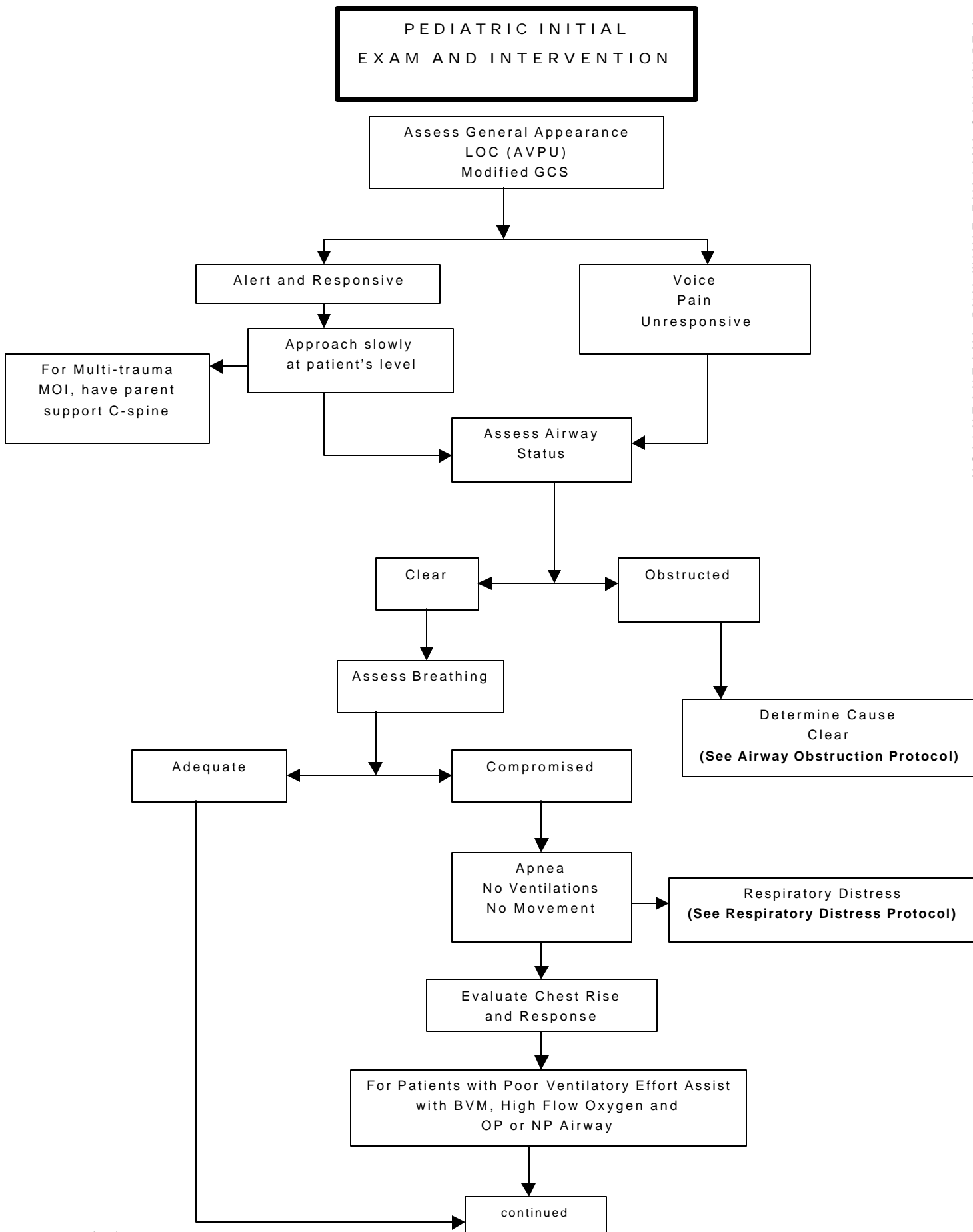
Interventions that are considered standing orders, requiring no consultation with on-line medical control.

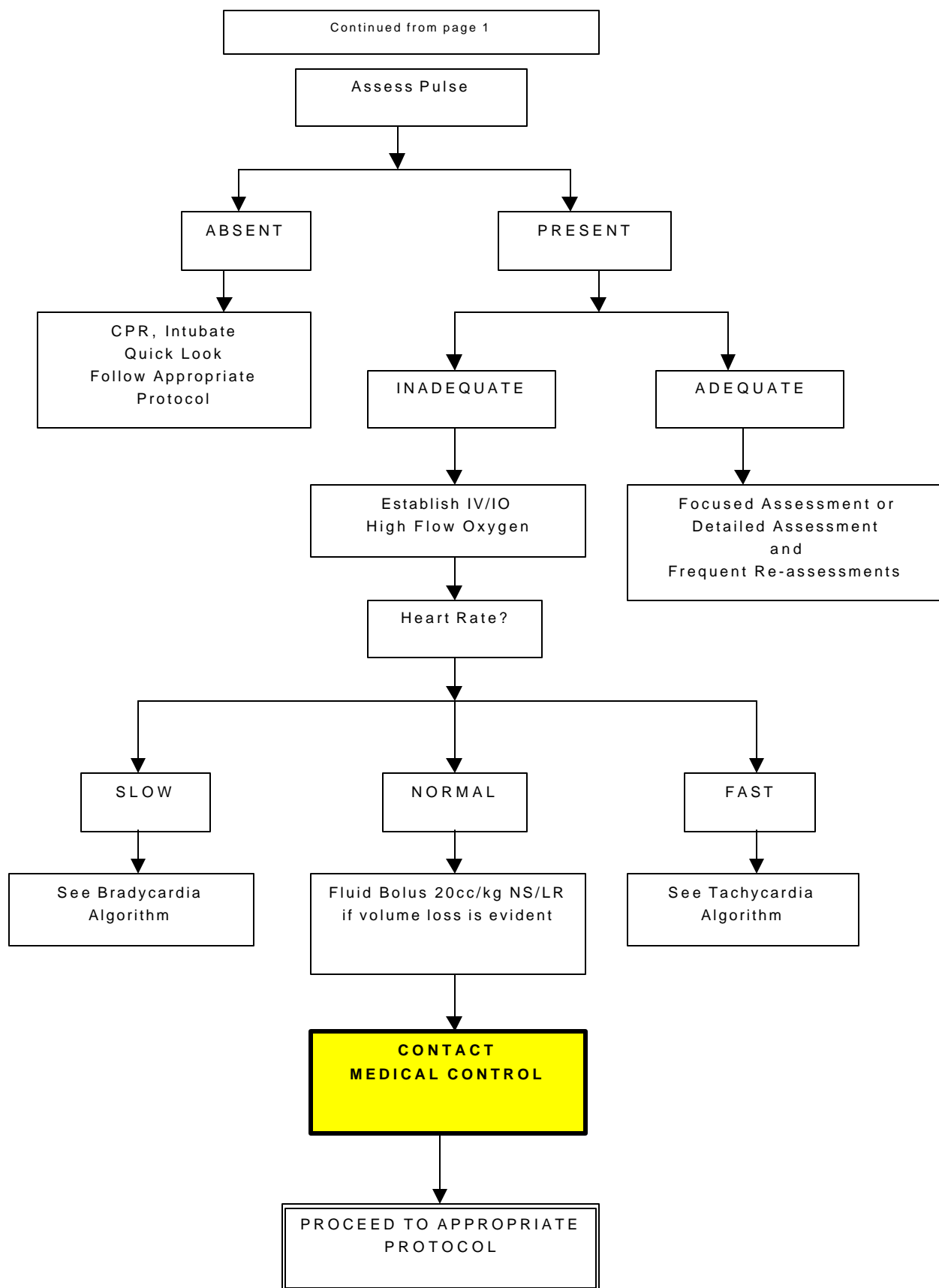


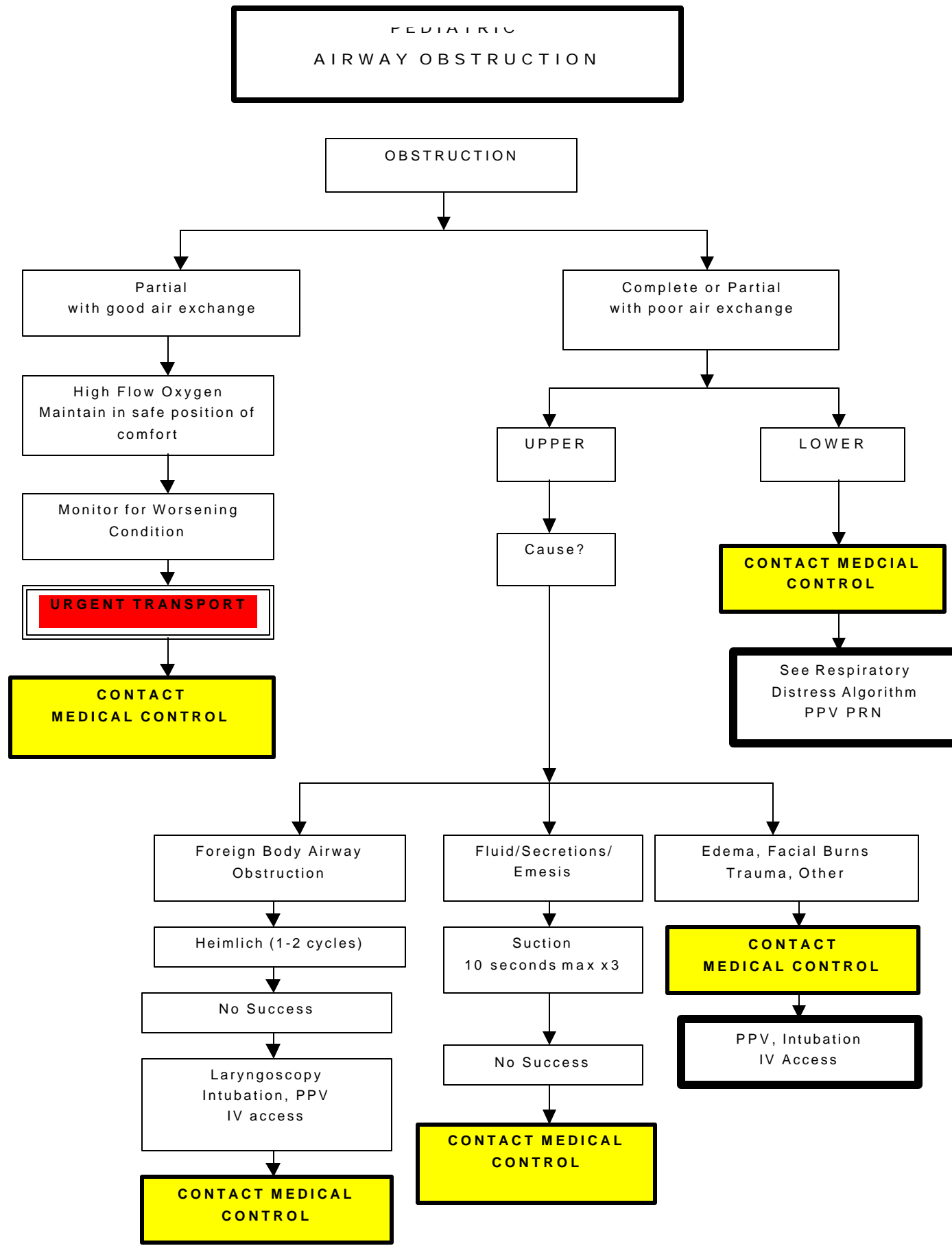
Interventions that are considered medical control options, to be carried out only after obtaining approval from an on-line physician.

Because of the highly individual determination, these protocols do not designate the aspects of practice for any specific EMS provider. In deciding which interventions should be on-line versus off-line medical direction, EMS providers and local medical direction should consider critical time factors. For certain lifesaving interventions, taking the time to consult an on-line medical control physician before initiating the action could have a detrimental effect on patient survival. Critical factors include:

- Any measure needed to establish or maintain airway patency, including advanced airway procedures
- Treatment for respiratory distress, failure or arrest
- Defibrillation or cardioversion for cardiopulmonary failure or arrest
- Treatment for shock
- Treatment for prolonged seizures
- Treatment for anaphylaxis







PEDIATRIC CARDIAC ARREST

PEDIATRIC
CARDIAC ARREST

Unresponsive
Apneic
Pulseless

**DO NOT DELAY
DEFIBRILLATION FOR
VF OR PULSELESS VT**

CPR with BVM
High Flow Oxygen
Quick Look/monitor
Intubate

Pulseless Electrical Activity

Asystole

**Ventricular Fibrillation or
Pulseless Ventricular
Tachycardia**

Attempt IV/IO

Attempt IV/IO

Defibrillate 2J/kg
Repeat 4J/kg PRN x2 in
succession
Continue CPR
If rhythm unchanged

Epinephrine
Initial Dose
1:10,000 IV/IO
0.01mg/kg (0.1cc/kg)
OR
1:1000 ET
0.1mg/kg (0.1cc/kg)

Epinephrine
Initial Dose
1:10,000 IV/IO
0.01mg/kg (0.1cc/kg)
OR
1:1000 ET
0.1mg/kg (0.1cc/kg)

Attempt IV/IO

CONTACT MEDICAL CONTROL

Repeat Epinephrine 1:1000
IV/IO/ET 0.1mg/kg
(0.1cc/kg)

Epinephrine
Initial Dose
1:10,000 IV/IO
0.01mg/kg (0.1cc/kg)
OR
1:1000 ET
0.1mg/kg (0.1cc/kg)

IV Fluids
Needle aspiration of chest
Sodium Bicarbonate
Warming devices
(See Airway Obstruction)

CONTACT MEDICAL CONTROL

Defibrillate 4J/kg after each
subsequent medication

Repeat Epinephrine 1:1000 IV/IO/ET
0.1mg/kg (0.1cc/kg) q 3-5 minutes

Repeat Epinephrine 1:1000
IV/IO/ET 0.1mg/kg
(0.1cc/kg) q 3-5 minutes

Lidocaine 1mg/kg

NOTE: Continual re-assessment of
rhythm and status is necessary. Any
change sends you back to the Initial
Exam.

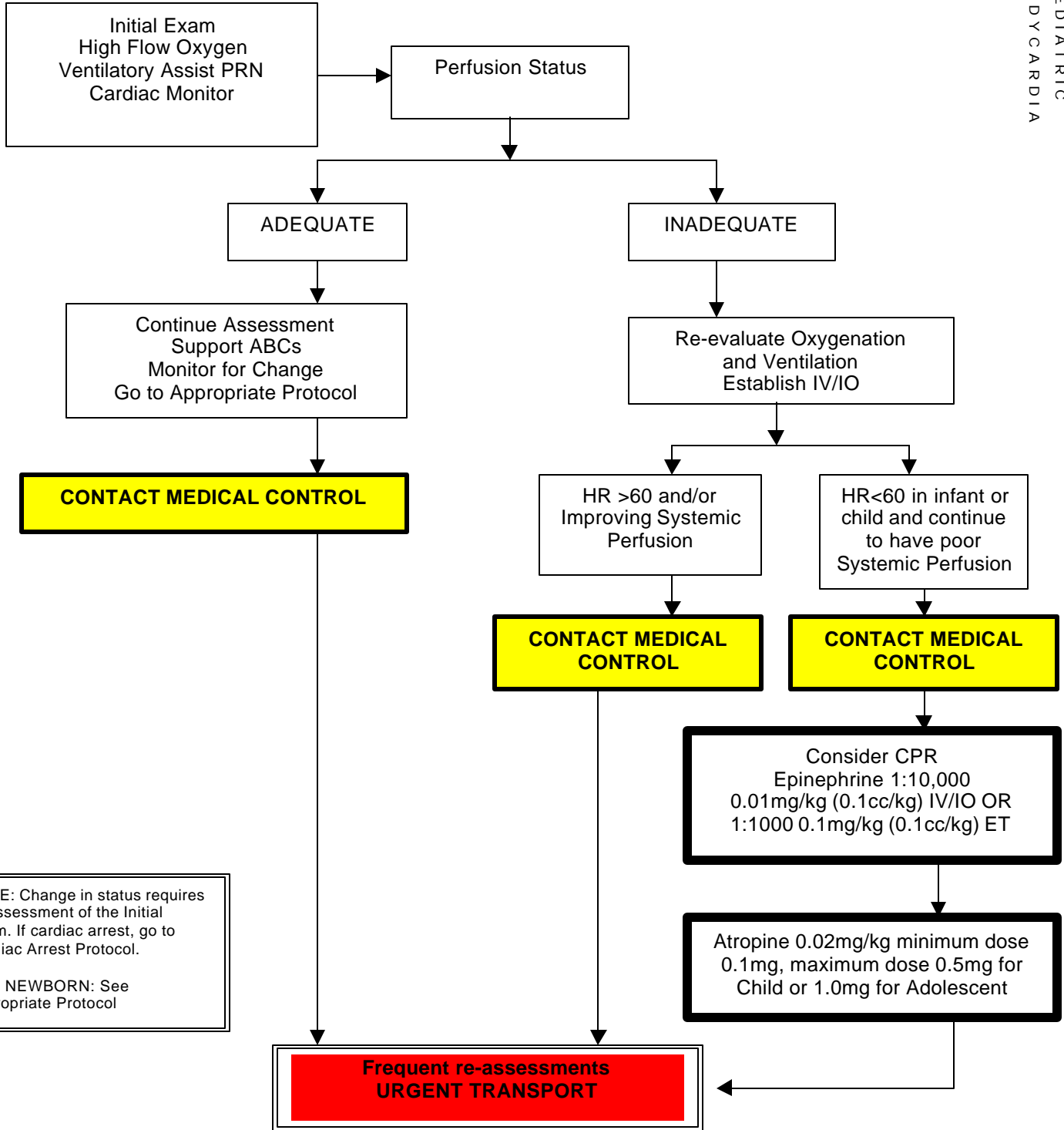
Defibrillate 4J/kg
Repeat Epinephrine 1:1000
IV/IO/ET 0.1mg/kg (0.1cc/kg)
q 3-5 minutes

EMERGENT TRANSPORT

CONTACT MEDICAL CONTROL

PEDIATRIC BRADYCARDIA

PEDIATRIC
BRADYCARDIA



NOTE: Change in status requires re-assessment of the Initial Exam. If cardiac arrest, go to Cardiac Arrest Protocol.

FOR NEWBORN: See Appropriate Protocol

TACHYCARDIA/SHOCK/HYPOTENSION

Initial Exam
High Flow Oxygen
Pulse Ox
Ventilatory Assist PRN
Pulse Present & Rapid

Perfusion Status

ADEQUATE

Detailed Exam

CONTACT MEDICAL CONTROL

Frequent re-assessments and URGENT TRANSPORT

INADEQUATE

Establish IV/IO
NS/RL 20cc/kg

Volume loss?
Trauma?
Infection?

Tachycardia

CONTACT MEDICAL CONTROL

CONTACT MEDICAL CONTROL

NARROW COMPLEX
Rate >230 INFANT or >200 CHILD
Vagal Maneuvers
Adenosine 50-100mcg/kg
RAPID IVP ONLY

WIDE COMPLEX
Rate >120
Lidocaine 1mg/kg IV/IO/ET

Cardioversion
0.5J/kg

Cardioversion
0.5J/kg

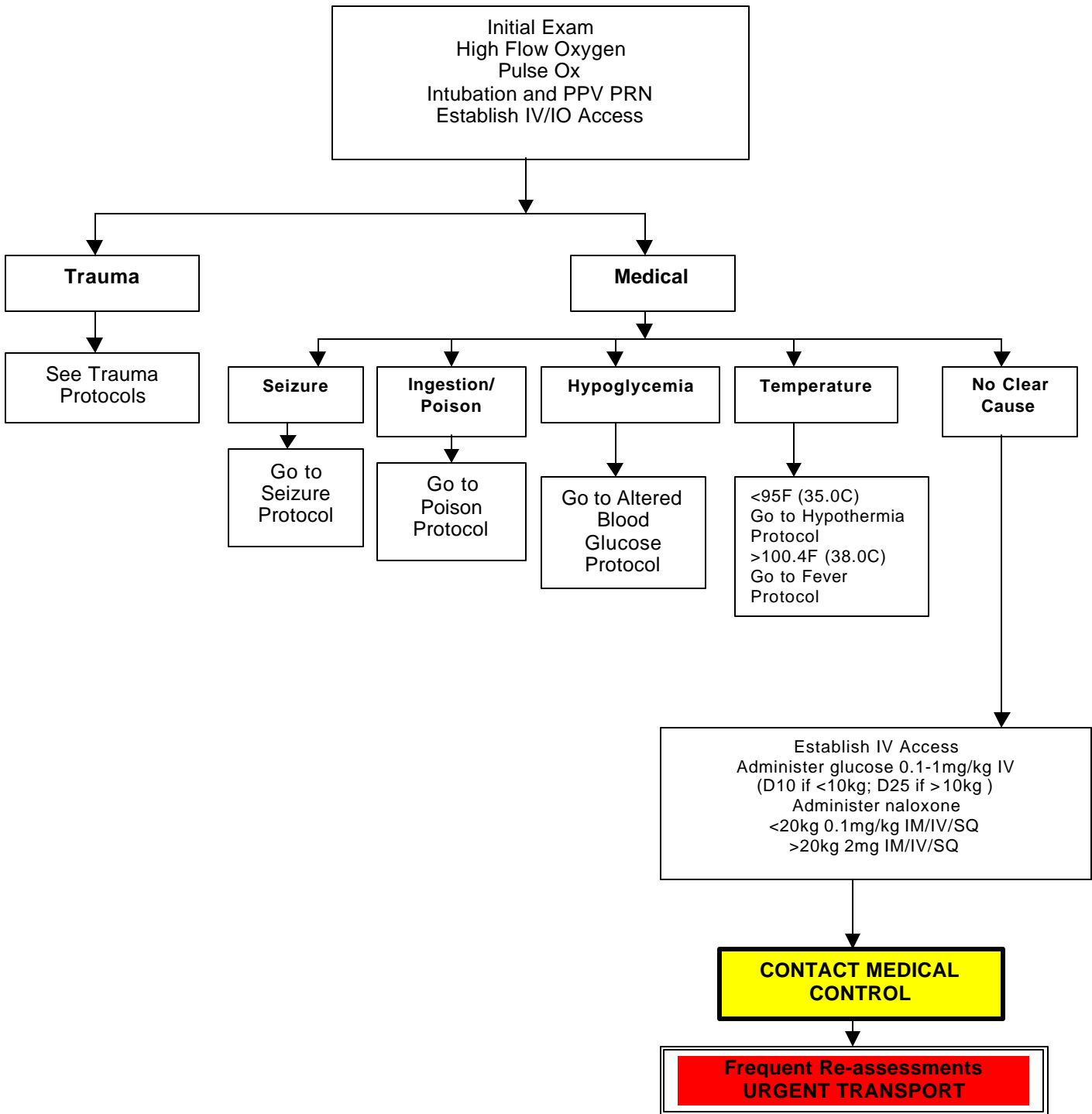
Frequent Re-assessments URGENT TRANSPORT

NOTE: Sedation may be ordered in the awake/alert patient prior to cardioversion.

Change in status requires re-assessment of the Initial Exam. If cardiac arrest, go to Cardiac Arrest Protocol.

PEDIATRIC ALTERED LOC

PEDIATRIC
ALTERED LEVEL OF CONSCIOUSNESS

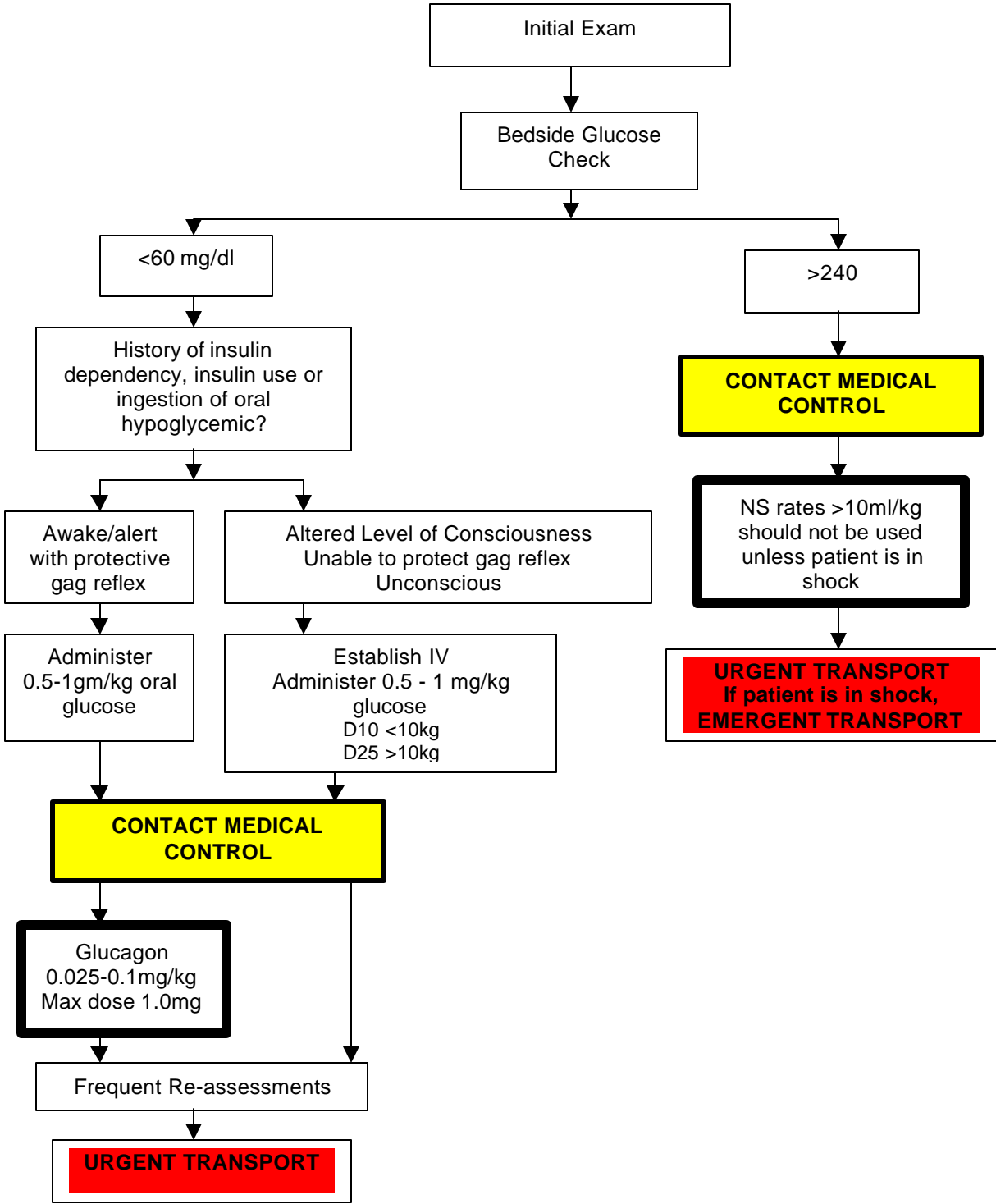


Revised 05/01/01

Approved by J. Pat O'Neal, M.D.

Medical Director, Office of Emergency Medical Services

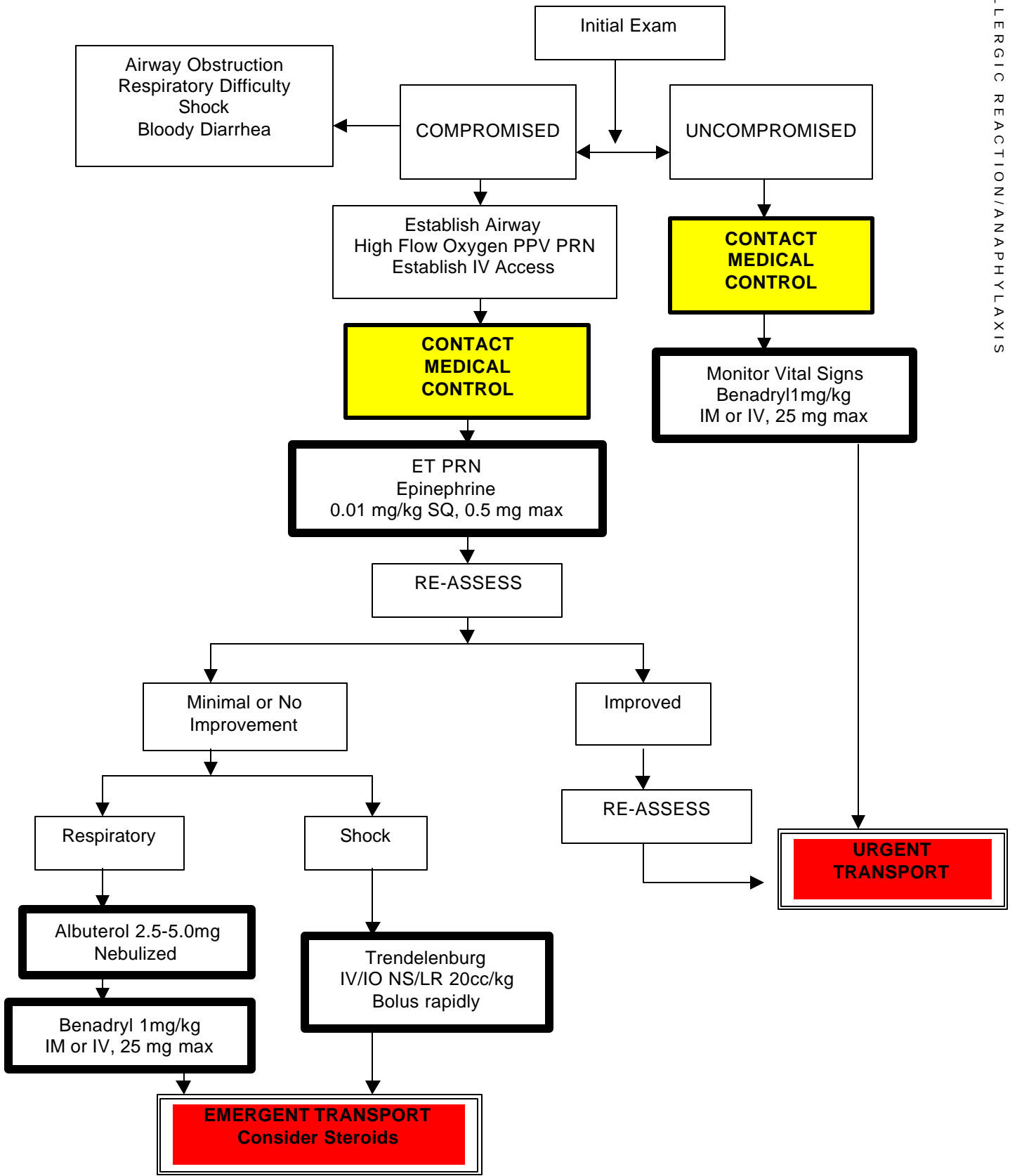
PEDIATRIC ALTERED BLOOD GLUCOSE

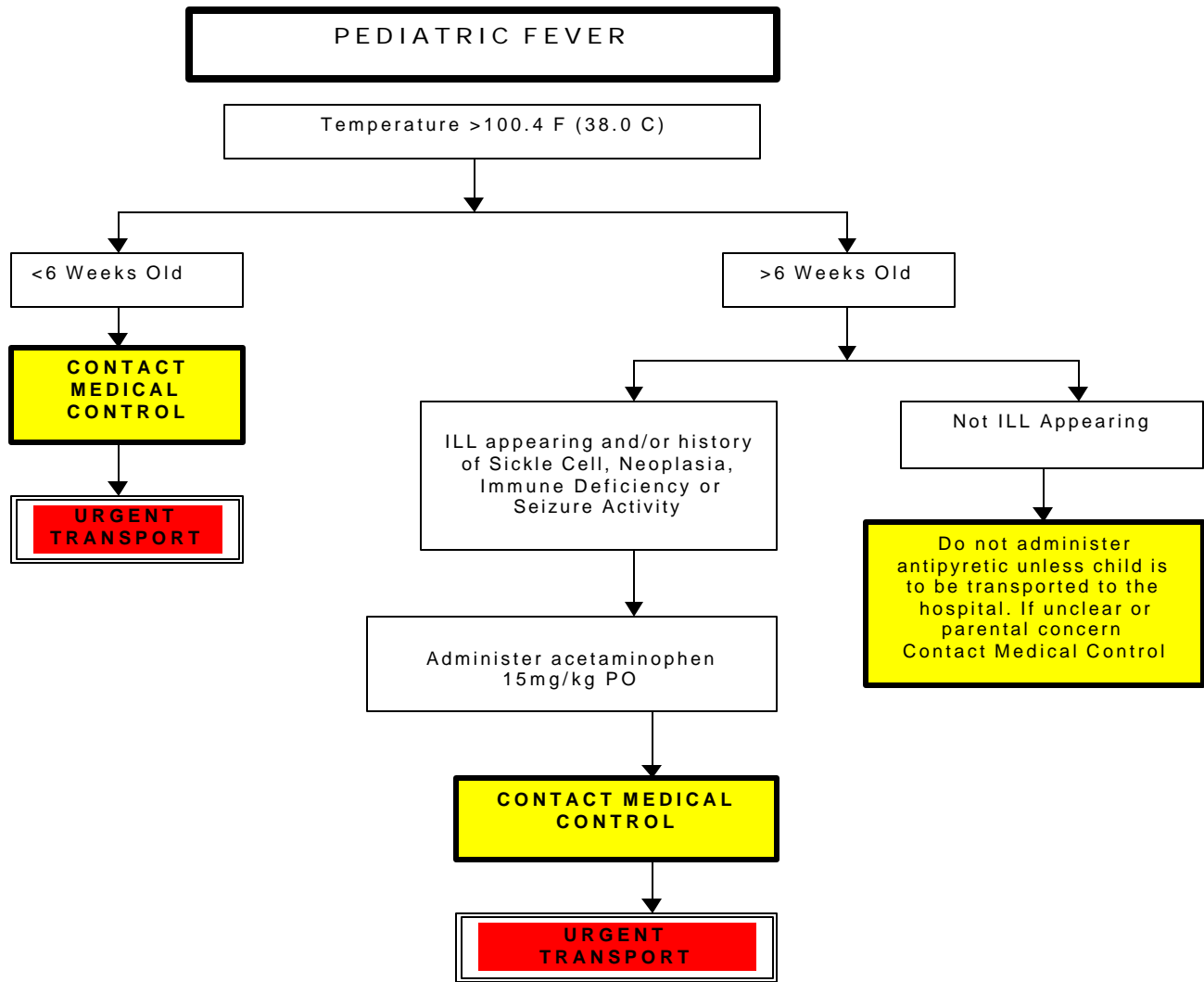


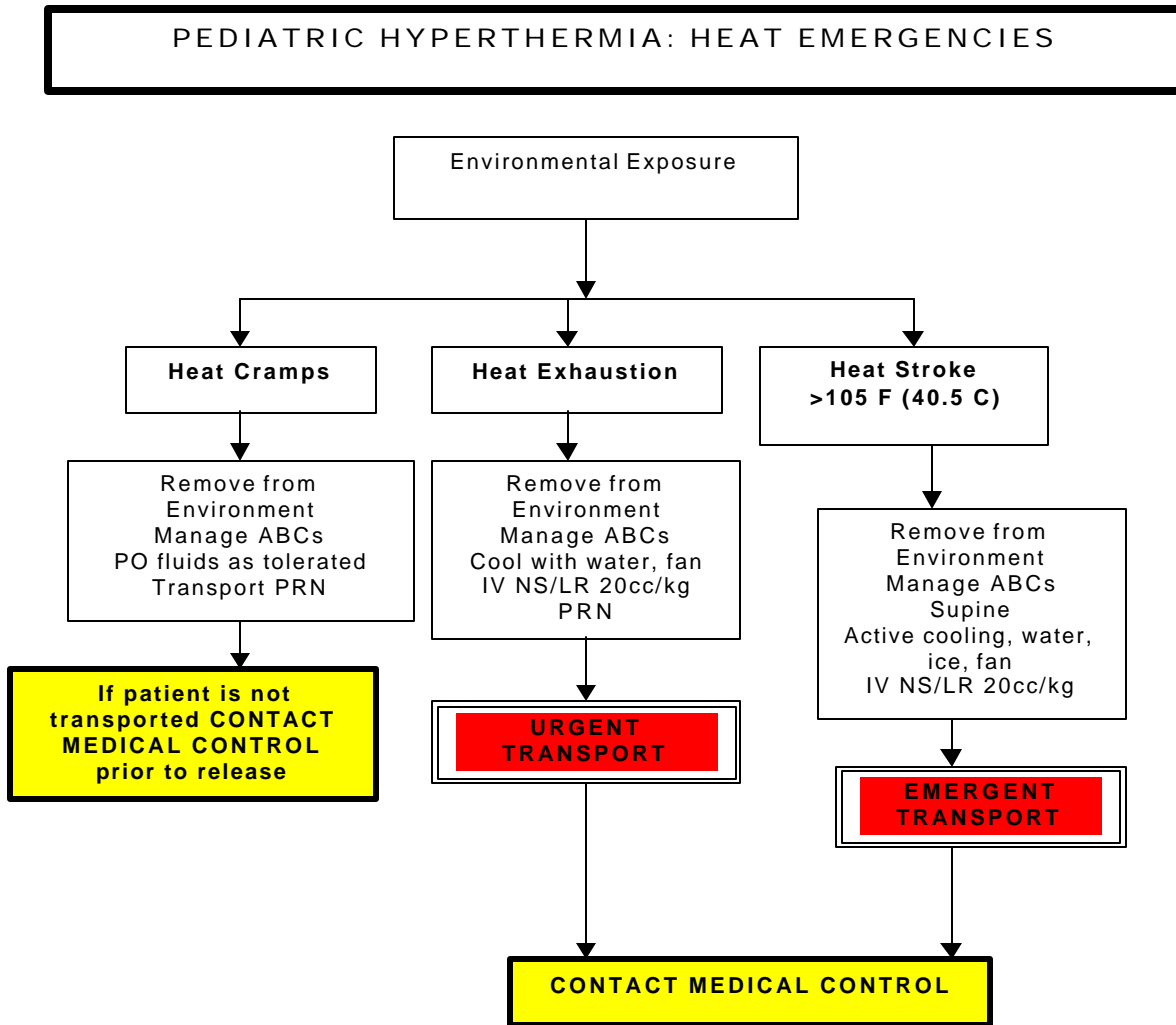
NOTE: Draw a pre-glucose blood sample in children without a history of previous glucose problems.

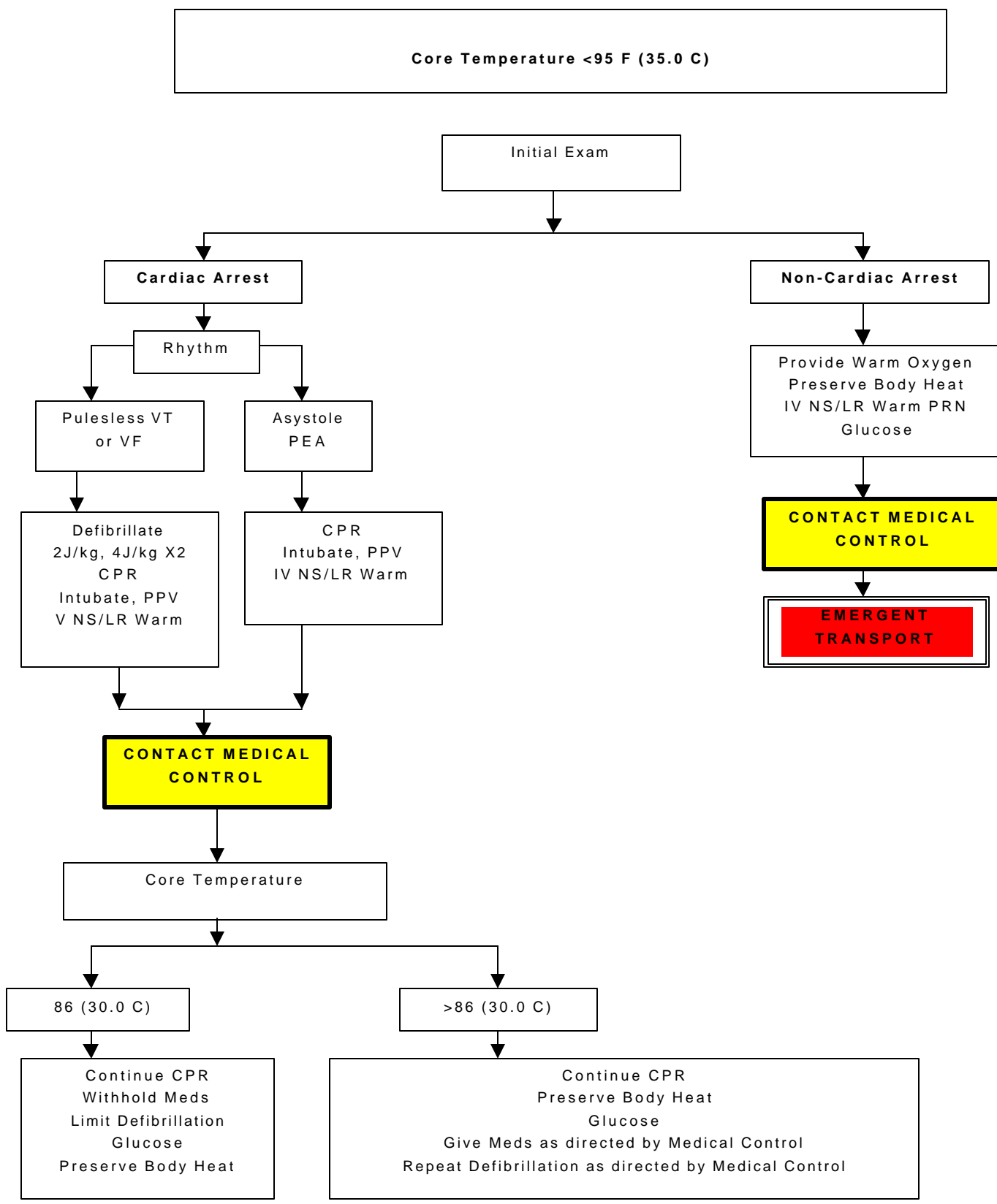
PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS

PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS

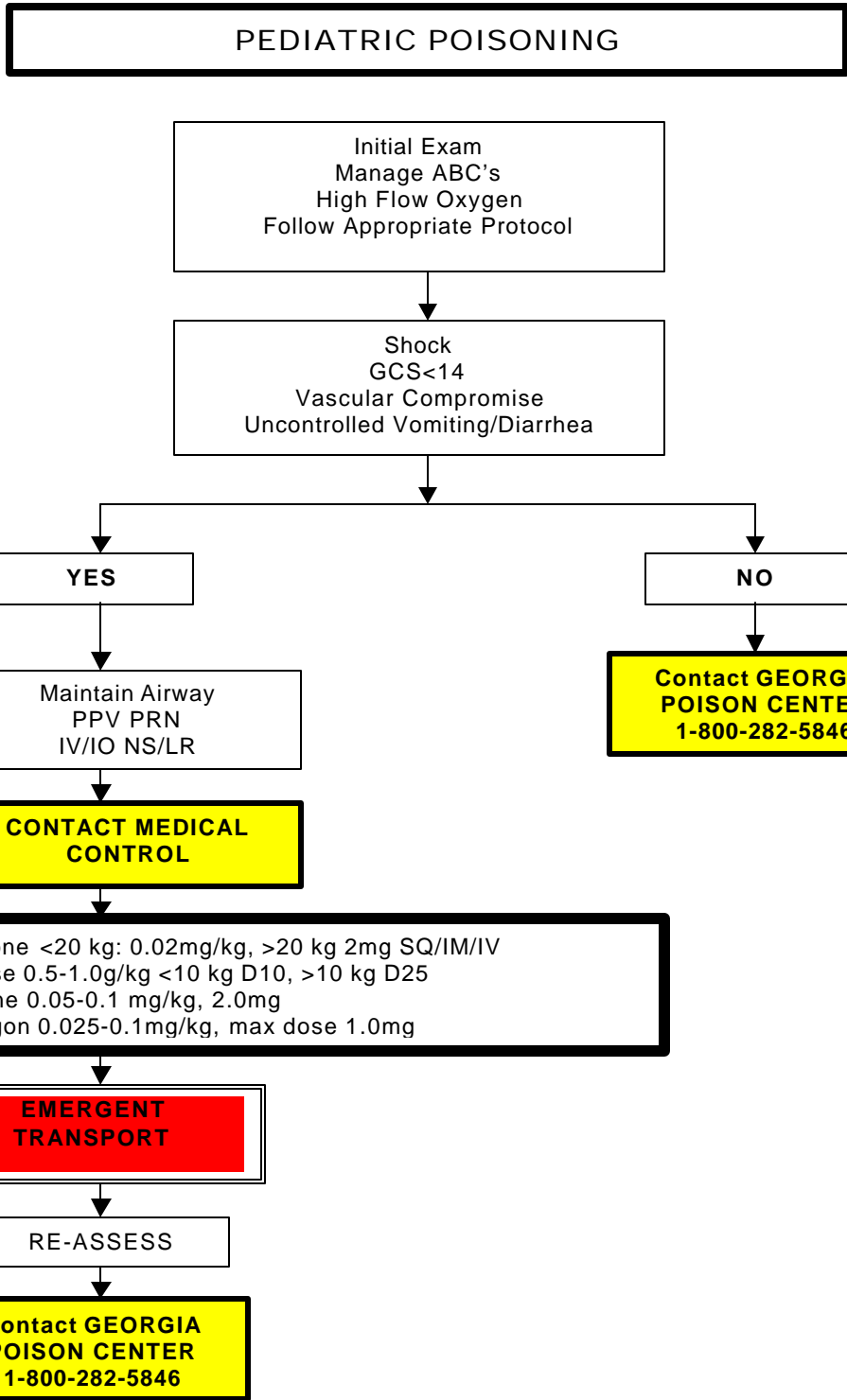


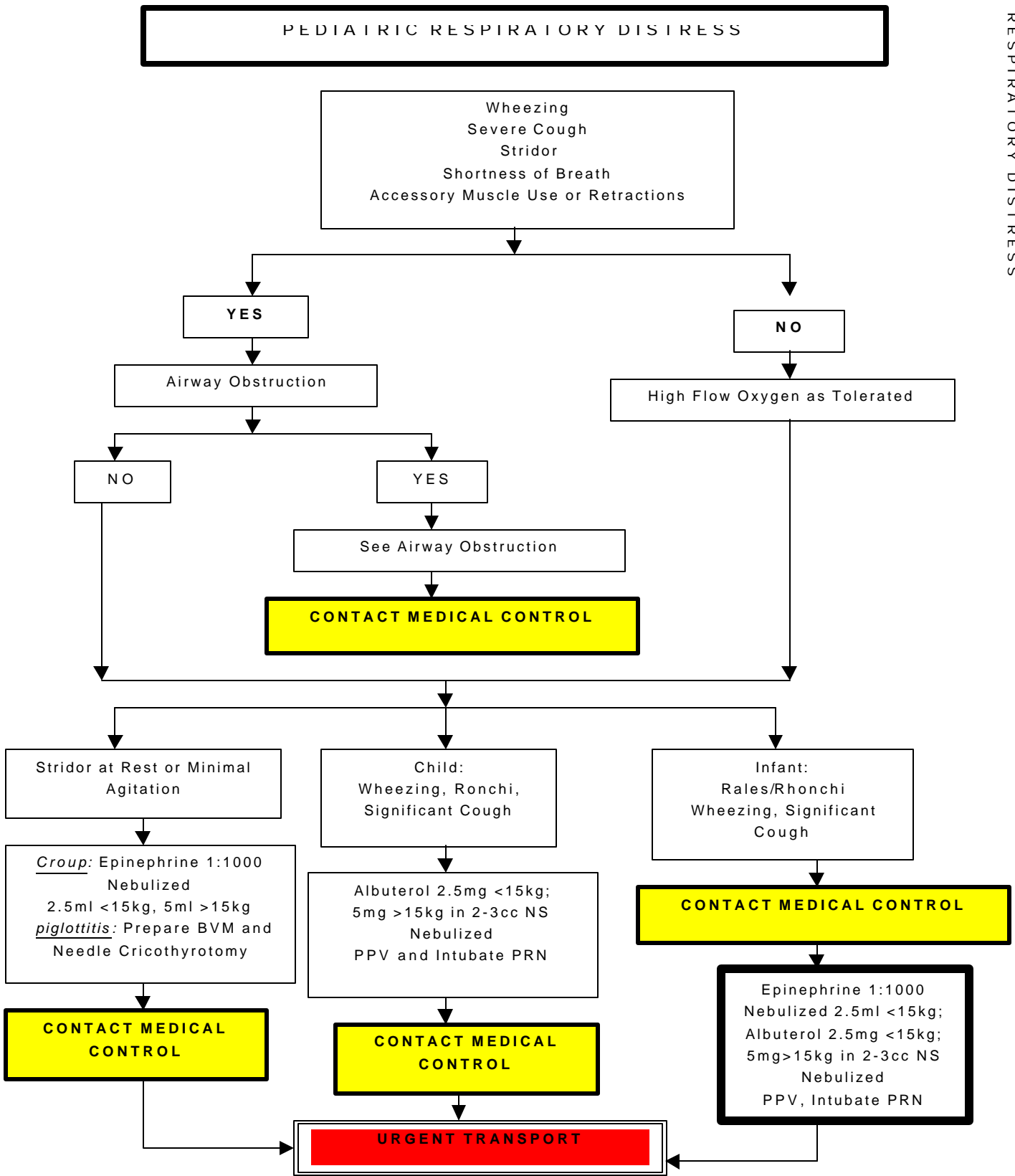


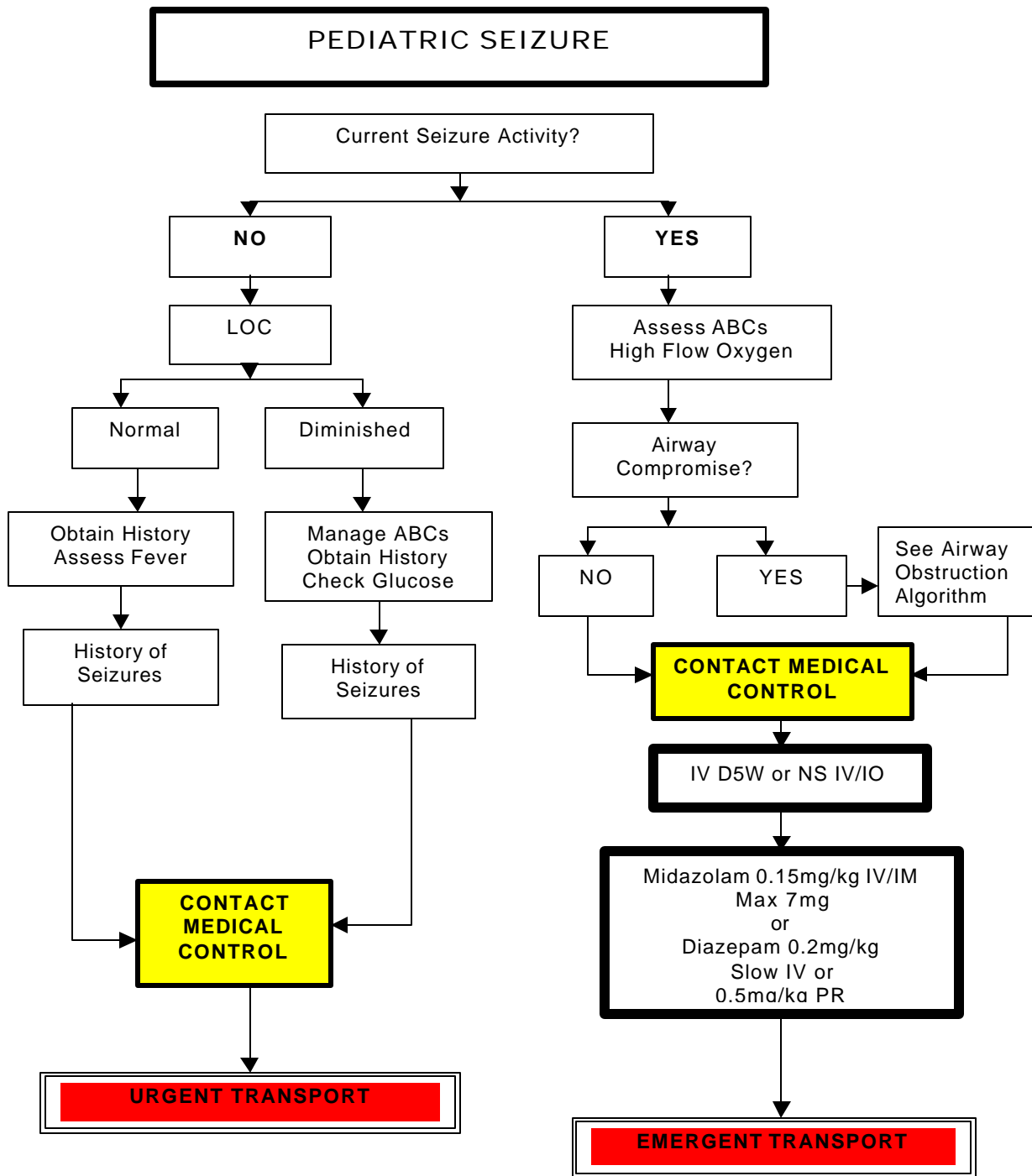


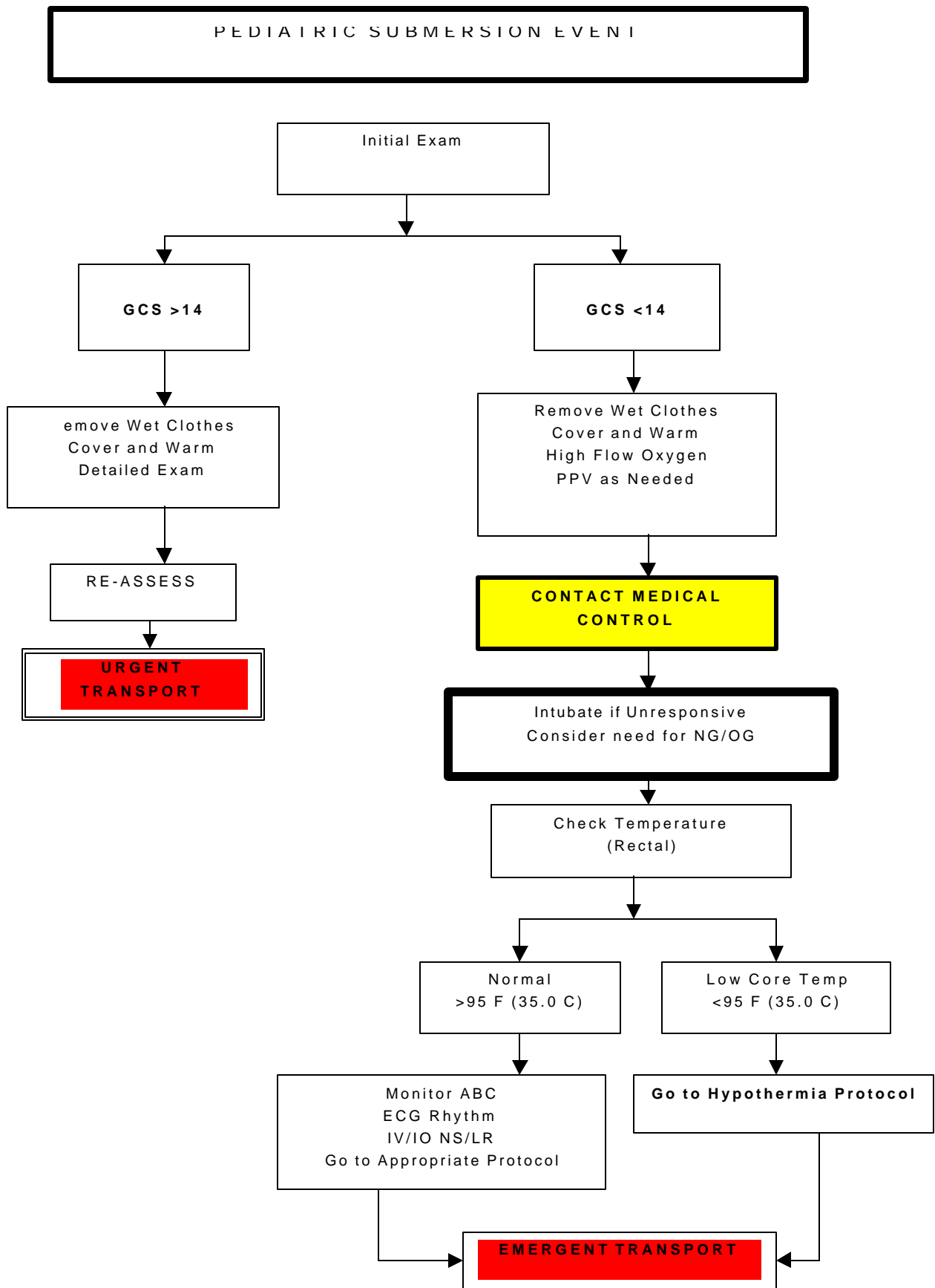


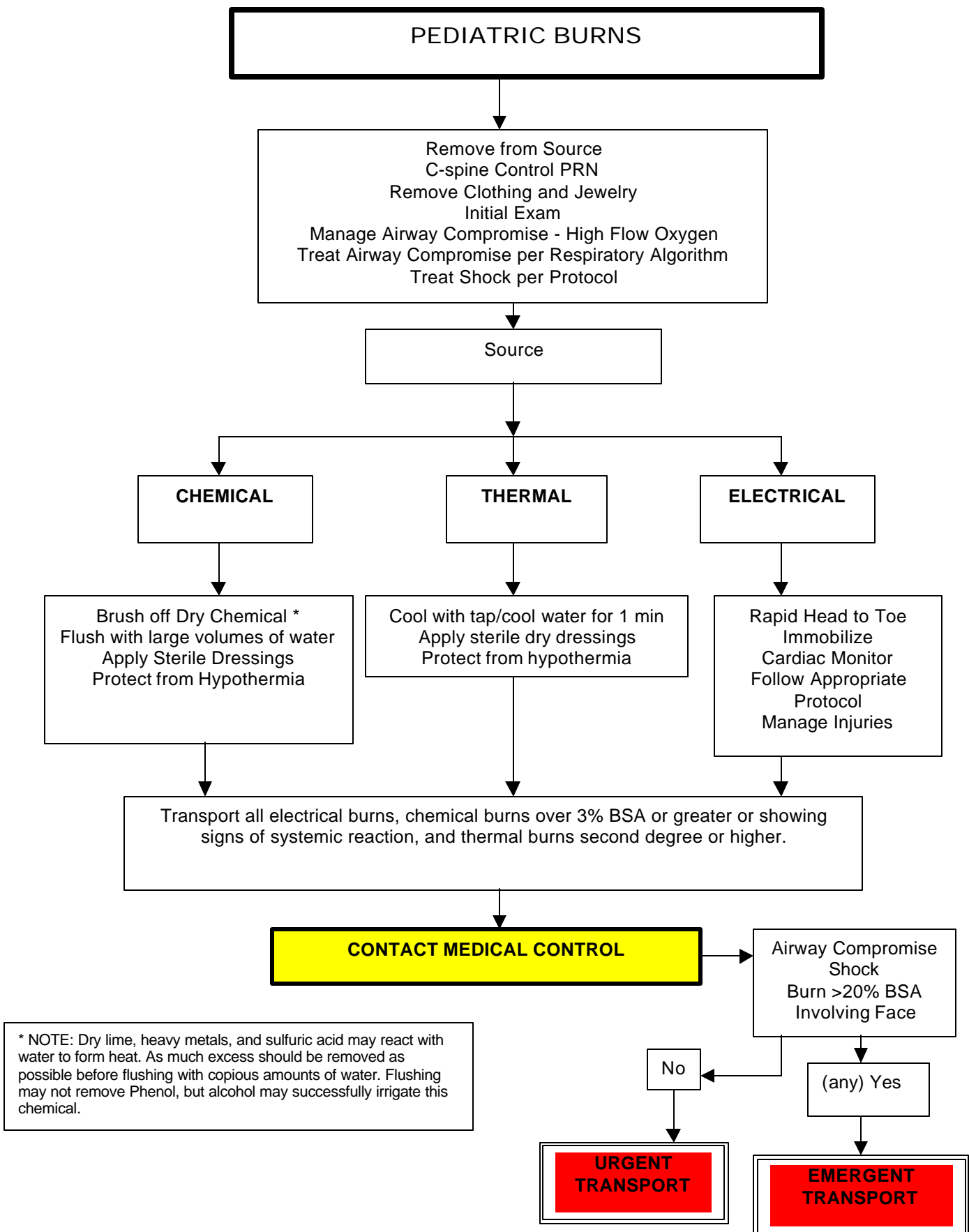
NOTE: Resuscitation efforts should continue until core temperature approaches normal.











PENETRATING INJURY

Scene Evaluation
MOI
Initial Exam

Maintain
ABC's

Control Bleeding
Dress serious Open Injuries
Chest and Neck – Occlusive Dressing

Detailed Assessment

DOES ANY OF THE FOLLOWING EXIST:

- Glasgow Coma Scale (modified for pre-verbal children) <14
- Systolic blood pressure <90
- Respiratory rate <10 or in distress
- Pediatric Trauma Score <8
- Need for any airway adjunct
- Need for fluid resuscitation to support heart rate, peripheral perfusion and/or central pulses
- Cardiac arrest or CPR performed prior to arrival
- Penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee
- Open/sucking chest wound
- Combination trauma with burns
- Two or more proximal long bone fractures
- Pelvic fractures
- Open and depressed skull fracture
- Spinal injury with paralysis or any neurologic deficit
- Amputation proximal to wrist and ankle

Yes

**CONTACT MEDICAL CONTROL /
CONTACT PEDIATRIC TRAUMA CENTER**

Flow Oxygen, PPV/ET PRN, IV/IO Access, Limited Fluid
scitation, Supine, Legs Elevated if in shock

EMERGENCY TRANSPORT

No

SEE NEXT
PAGE

continued from previous page

Head injury with any loss or alteration of consciousness
Spinal injury with risk of paralysis or neurologic deficit
Blunt chest trauma with contusion or tenderness, or with potential for hemo- or pneumothorax
Blunt abdominal trauma with contusion, tenderness or distention
De-gloving injury of extremity or laceration > 7 cm
Penetrating wound involving joint and/or significant vascular injury
Ejection from automobile
Death in same passenger compartment
Extrication time >20 minutes
Falls >20 feet
Rollover
High speed auto crash: Initial speed >40 mph
Major auto deformity >20 inches
Intrusion into passenger compartment >12 inches
Auto-pedestrian/auto-bicycle injury with significant impact >20 mph
Pedestrian thrown or run over
Motorcycle crash >20 mph or with separation of rider from bike

YES

**CONTACT MEDICAL CONTROL/CONTACT
PEDIATRIC TRAUMA CENTER**

High Flow Oxygen, IV Access, Limited Fluid
Resuscitation

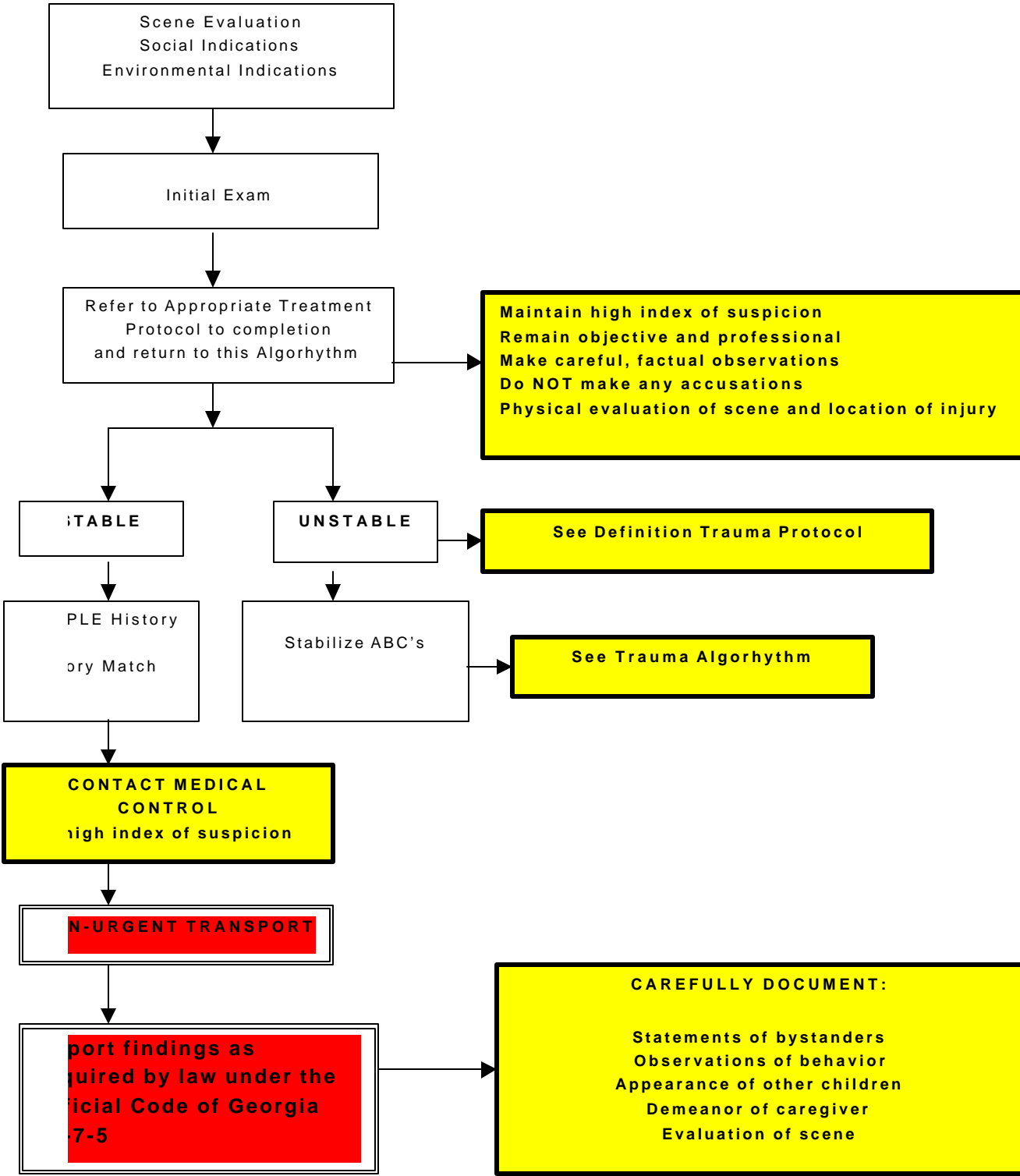
NO

Dress Wounds
RE-ASSESS

**CONTACT MEDICAL
CONTROL**

URGENT TRANSPORT

**PEDIATRIC TRAUMA:
SUSPECTED CHILD ABUSE**



PEDIATRIC TRAUMA:
SUSPECTED CHILD ABUSE

