BLS PROTOCOLS
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1. DEFINITIONS

The following is a definition of frequently used terms:

- **EMT-B** - Person currently registered as an EMT-Basic by the Department of Health.
- **EMT-I** - Person currently registered as an EMT-Intermediate by the Department of Health.
- **EMT-P** - Person currently registered as an EMT-Paramedic by the Department of Health.

- **Standing orders** - Advanced life support interventions which may be undertaken before contacting on-line medical control.
- **Protocols** - Guidelines for prehospital patient care. Only the portion of the guidelines which are designated "standing orders" may be undertaken before contacting on-line medical control.
- **On-line medical control** - Medical direction of prehospital ALS activities by direct radio or telephone communications with an on-line medical control physician.
These "Southwest EMS Protocols and Standing Orders" are only to be used by personnel assigned to units which have been designated as a "Southwest EMS BLS Unit" by the system medical director and management. Routine advanced life support care is directed by the "SOUTHWEST EMS, INC. PROTOCOLS AND STANDING ORDERS."

Purpose

The primary purpose of these protocols is to serve as guidelines for out-of-hospital (prehospital and inter-hospital) care. Quality out-of-hospital care is the direct result of comprehensive education, accurate patient assessment, good judgment, and continuous quality improvement. All EMS personnel are expected to know the protocols and understand the reason for their use. EMS personnel should not perform any step or steps in a standing order or protocol if they have not been trained to perform the procedure or treatment in question.

Protocols and Standing Orders--Who May Use

These protocols may only be used by EMS personnel who are registered with Southwest EMS. EMS personnel who are authorized to operate under Southwest EMS may not utilize these standing orders outside of their work with the contracted agency or company unless such work is with another agency or company contracted with the system. All EMS personnel must adhere to the standards defined in these protocols, or face revocation of medical control if these standards are violated.

Off-duty personnel who are responding within Southwest EMS service area as part of a Rural Fire Department First Responder program are approved to perform skills within their scope of practice.
3. COMMUNICATION PROBLEMS

In the event an ambulance cannot contact medical control (i.e. mass casualty or radio/telephone problem), all protocols become standing orders. Likewise, in the event that a medical control physician cannot respond to the radio/telephone within two minutes of the call, all protocols are considered standing orders. An emergency department nurse at the medical control hospital may relay orders from the emergency physician in cases where it is impractical for him or her to come to the radio/telephone. It is not necessary to speak with a medical control physician concerning treatment modalities that are considered to be standing orders except if a question arises concerning the planned treatment.

In the event medical control cannot be contacted, and treatment protocols were carried out as standing orders, the record should be pulled for review by the medical director. Following review, the record will be signed by the medical record indicating retroactive approval.
4. GENERAL GUIDELINES FOR PROTOCOL USE

1. The patient history should not be obtained at the expense of the patient. Life-threatening problems detected during the primary assessment must be treated first.

2. Cardiac arrest due to trauma is not treated by medical cardiac arrest protocols. Trauma patients should be transported promptly with CPR, control of external hemorrhage, cervical spine immobilization, and other indicated procedures attempted en route.

3. Verbally repeat all orders received prior to their initiation.

4. If the patient's condition does not seem to fit a protocol or protocols, always contact medical control.

NEVER HESITATE TO CONTACT MEDCIAL CONTROL FOR ANY PROBLEM, QUESTION, OR FOR ADDITIONAL INFORMATION.
5. SCENE CONSIDERATIONS

Scene Times

A scene time of 20 minutes or less should be adhered to in all Emergency responses. Document reasons for all extended times on the patient care report.

Orders from Transferring/Receiving Physicians

During inter-hospital transport, medical crews will be asked to continue treatment initiated at the transferring hospital. These orders may be written or verbal. Verbal orders must be written by the medical crew and attached to the record. Ideally, the transferring physician should sign these orders. If, at any time the EMT questions orders from a referring or receiving physician, on-line medical control MUST be contacted. Likewise, anytime a transferring or receiving physician asks the EMT to carry out medical treatment for which they have not been trained, or which appears to be in conflict with established treatment protocols, on-line medical control MUST be contacted before initiating care.

Scene Responses/On-Scene Physicians

EMS personnel functioning under Southwest EMS may not accept orders from an on-scene physician. The exception is when a patient is being retrieved from the physician's office. Then, any care which differs significantly from protocol must be approved by the on-line medical control physician prior to initiation. If a controversy arises with an on-scene physician, place the on-scene physician in contact with the on-line medical control physician via cellular telephone or radio.

PASG / MAST Trousers

PASG / MAST trousers are no longer required by the medical director. However, individual stations can elect to carry and utilize the PASG / MAST as directed by On-line Medical Control. PASG / MAST trousers can also be utilized as an air splint.
6. RESUSCITATION CONSIDERATIONS

1. Do Not Resuscitate (DNR) orders should be honored when valid. If a patient’s family presents you with a DNR order written by the patient’s physician, the following procedures should be followed:
   - Contact medical control
   - Provide a brief synopsis of the situation. Be sure to include the diagnosis which resulted in the DNR order (i.e. cancer).
   - Provide a brief report of the patient's current status (vital signs, ECG tracing)
   - Confirm receipt of written DNR. Be sure to note issuing physician's name.
   - The medical control physician will determine whether to accept or deny the DNR order.

2. Resuscitation should not be attempted in the field in cases of:
   - Rigor mortis
   - Decapitation
   - Decomposition
   - Dependent lividity.
   - Obvious massive head or trunk trauma which is incompatible with life (provided the patient does not have vital signs.)

3. Consider the potential for organ donation. Patient's who have sustained mortal injuries may still warrant emergent care until a determination can be made whether the patient may be a potential organ or tissue donor.

4. The EMS/DNR Order form approved by the Arkansas Department of Health and Human Services executed properly allows emergency medical personnel to withhold or withdraw cardiopulmonary resuscitation from a particular patient in the event of cardiac or respiratory arrest.
   A. The form must be:
      - A document as approved by the Arkansas Board of Health or one created or used by a physician that is consistent with the current Arkansas EMS/DNR Rules and Regulations. The following requirements and provisions shall apply to any EMS/DNR Order form:
         1. Content of the Form – A valid EMS/DNR Order Form shall include the words "DNR" or "No Code," or similar language, the physician’s signature and the date.

         2. Copies of the EMS/DNR Order Form may be given to other providers or persons for information.
6. RESUSCITATION CONSIDERATIONS

3. Revocation of an EMS/DNR Order – An EMS/DNR Order may be revoked at any time or in any manner by the named patient or the patient’s attending physician or health care proxy.

4. Distribution of EMS/DNR Order Forms – EMS/DNR Forms shall be available to physicians through local Health Department offices, local hospitals, ambulance services, and to private physicians, on request.

B. Emergency personnel should look for this form in the following places (but not limited to):
   - The back of the door to the patient’s bedroom
   - The nightstand by the patient’s bed
   - The door to the refrigerator
   - The patient’s wallet

C. In the event of cardiac or respiratory arrest of a patient without a valid EMS/DNR Order, follow the appropriate medical procedures.

D. In order to provide comfort care or alleviate pain for a patient with a valid EMS/DNR Order, the following interventions may be provided, depending on the needs of the particular patient: Airway management (excluding intubation, advanced airway management or artificial ventilations)
   - Suction
   - Oxygen
   - Pain Medication
   - Control bleeding
   - Make patient comfortable
   - Be supportive to Family

E. The patient, attending physician, or the healthcare proxy may revoke the EMS/DNR Order at any time.

F. Document the presence of the EMS/DNR Order on the patient care report, and include a copy with the patient care report.

G. If there is a misunderstanding with the family or others present on scene or there are any concerns about the EMS/DNR Orders contact the attending physician or your medical control for guidance.

H. If there is any question about the validity of the EMS/DNR Order, **Resuscitate.**

I. There are many forms of Advanced Directives. For any type other than the EMS/DNR Order, the paramedic should contact patients attending physicians or medical control for guidance.
SOUTHWEST EMS, INC.
PROTOCOLS AND STANDING ORDERS

6. RESUSCITATION CONSIDERATIONS

STATE OF ARKANSAS
EMERGENCY MEDICAL SERVICES
DO NOT RESUSCITATE ORDER

Patient’s Full Name: ______________________________________________________

________________________________________________          __________________
Signature of Patient or Health Care Proxy or Legal Guardian          Date

ATTENDING PHYSICIAN’S ORDER

I, the undersigned, state that I am the physician for the patient named above.

I hereby direct any and all qualified Emergency Medical Services personnel,
commencing on the effective date noted below, to withhold cardiopulmonary
resuscitation (cardiac compression, endotracheal intubation and other advanced airway
management, artificial ventilation, defibrillation, administration of cardiac resuscitation
medications, and related procedures) from the patient in the event of the patient’s cardiac
or respiratory arrest. I further direct such personnel to provide to the patient other
medical interventions such as intravenous fluids, oxygen, or other therapies deemed
necessary to provide comfort care or alleviate pain.

________________________________________      ___________________________
Signature of Attending Physician                                 Physician’s Telephone number
(emergency #)

________________________________________      ___________________________
Physician’s Printed/Typed Name                                 Date Order Written
7. ROUTINE CARE

The following assessment is to be performed and information is to be obtained on all patients:

1. Always assure scene safety for yourself, your fellow rescuers, and your patient.

2. Primary survey:
   - **A** = Airway with cervical spine control if indicated
   - **B** = Breathing
   - **C** = Circulation with control of bleeding
     (These three are referred to as the "ABCs").
   - **D** = Disability Determination
     - **A** = alert and conscious
     - **V** = responsive to verbal stimuli
     - **P** = responsive to painful stimuli
     - **U** = unresponsive
     (These four are referred to by the acronym "AVPU").
   - **E** = Exposure

3. Secondary survey:
   - **A**. Obtain vital signs and perform objective head-to-toe assessment
   - **B**. Obtain history
     - Sex, age, and approximate weight
     - Chief complaint
     - Precipitating factors
     - Significant past medical history
     - Allergies
     - Current medications
   - **4.** Place monitoring equipment, if indicated.
     - Pulse oximetry
   - **5.** Apply appropriate protocol and standing order based on assessment.
   - **6.** Contact medical control as designated in protocol or for any problems or questions.
   - **7.** Position patient comfortably as indicated by condition or situation.
   - **8.** Reassure and calm patient. Loosen any restrictive clothing or remove as indicated.
   - **9.** Transport as soon as feasible.
8. HELICOPTER LANDING ZONES

GUIDELINES FOR ESTABLISHING A SAFE HELICOPTER LANDING ZONE:

1. Landing Zone Size and Composition.
   - The landing area selected should be approximately 80’ X 80’ during daytime and 100’ X 100’ at night.
   - An area with slope no more than 5 degrees, clear of people and vehicles with no obstructions should be considered.
   - Avoid rocks, gravel, or dry dirt areas. These types of areas should be wet down to minimize the risk of dust clouds or flying debris when the helicopter approaches.
   - Remember that wires and electric poles are difficult to see from the air.
   - Stumps and large rocks may be hidden in tall grass.

2. Marking the Landing Zone.
   - During daytime, use red or blue strobe lights of emergency vehicles to mark the area.
   - At night, emergency vehicle lights may be used as well as two vehicles placed with headlight beams forming an X in the landing area. The vehicles should be pointed into the wind as the pilot will usually approach and take off into the wind.
   - Turn off all non-essential lights to avoid reducing the pilot’s night vision quality.
   - Vehicles may be parked under wires to mark the hazard.
   - A spotlight may be used to mark electric poles at night.

3. Landing Zone Captain
   - A person should be selected to be in charge of the Landing Zone.
   - The LZ Captain is responsible for setting up the LZ properly
   - Maintain control over movement around the aircraft
   - Assigns a “tail-rotor guard”
   - Control radio communication between aircraft and all other personnel
   - Restrict public access to the LZ

4. Communication
   - The LZ captain should give a brief description of the LZ to the aircrew via radio. This should include location, size, obstructions, and the wind direction and speed.
   - Usually, if operating with VHF or UHF radio frequencies, the helicopter will be able to communicate on the radio frequency used in the area for Fire/EMS/Law Enforcement. The VHF frequency 155.340 is almost always monitored by the helicopter.
   - The aircrew will usually ask for patient information if available. This information should include a brief description of the patient’s injuries or medical condition and vital signs.
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PROTOCOLS AND STANDING ORDERS

8. HELICOPTER LANDING ZONES

5. Helicopter Arrival

- Safety should always come first!
- LZ personnel should provide security for the aircraft.
- No one should approach without an “OK” from the pilot. This is usually a “thumbs up” or flash of a landing light to communicate that it is safe to approach.
- Eye and Hearing protection should be worn.
- Hats should be removed and helmet chin straps should be buckled. Do not wear loose clothing.
- The “Tail-Rotor Guard” should watch the tail rotor and not let ANYONE near the tail rotor.
- Always approach the aircraft from the front or at a 45 degree angle.
- If the landing area has a slight slope, always approach from the down-slope side.
- The aircrew will ask for 3 to 4 people to assist in patient loading. Follow the instructions of the aircrew closely. The aircrew will secure the patient into the helicopter and close the doors.

6. Helicopter Departure

- Keep the departure path clear of vehicles and obstructions
- Remain 100 feet away from the aircraft
- Remain at the LZ for at least 5 minutes. In case of an emergency, the pilot may need the LZ for an emergency landing.
8. HELICOPTER LANDING ZONES

LANDING ZONE DIAGRAM

- If able, Spotlight poles
- Wires
- Vehicle Lights (Night)
- Level and clear
- No overhead wires or obstacles
- 80' (100' Night)

Touchdown Area

If Possible:
- Select LZ downwind from scene
- Advise of any known hazards

Pilot will normally approach over lowest obstacles and generally into the wind.
8. HELICOPTER LANDING ZONES

HELICOPTER DANGER ZONES
9. MEDICAL DIRECTOR APPROVAL

May 5, 2009

THESE BASIC LIFE SUPPORT PROTOCOLS HAVE BEEN APPROVED FOR USE BY SOUTHWEST EMS, INC AMBULANCE CREWS OPERATING ON BASIC OR INTERMEDIATE CERTIFIED AMBULANCE UNITS. CREWS MUST BE CERTIFIED OR LICENSED BY THE STATE DEPARTMENT OF HEALTH AS EMT-BASIC OR EMT-INTERMEDIATE OR EMT-PARAMEDIC. CREWS ARE DIRECTED TO CONTACT MEDICAL CONTROL FOR ORDERS FOR SITUATIONS THAT MAY NOT BE ADDRESSED IN THIS MANUAL. IN THE EVENT THAT MEDICAL CONTROL CANNOT BE REACHED, THE PROTOCOLS IN THIS MANUAL SHALL BECOME STANDING ORDERS.

DATE: __________________________

DR. DANNY SILVER
MEDICAL DIRECTOR AR #702
Transport decisions should be made with careful consideration for the patient’s choice of facility, the availability of tertiary care at that facility, the patient’s condition, and the coverage of the service area.

1. A complete patient assessment should be performed on every patient. Careful consideration should be made when choosing a destination facility. Vital Signs, mental status, and overall condition should be evaluated by the highest certified or licensed crewmember. If the patient’s condition is found to be unstable or critical, the patient should be transported to the closest facility as soon as possible.

2. Whenever possible, the patient should be transported to the facility of their choice. When the patient is unable to make a decision, and family is present, the family’s choice should be honored. If the patient is under direct physician care, the EMS crew should take the patient to the facility that the physician chooses.

3. When the patient or family makes a decision to transport a patient to a facility that does not have services available to properly treat the patient or provide tertiary care, they should be informed of this and encouraged to consider another facility.

4. A patient, family or patient physician may request transport to any hospital facility within 60 miles in an emergency situation.

5. When transporting a patient to a facility that is not the closest facility to the scene, coverage of the service area may not allow the ability to transport the patient to the farther hospital. If coverage is unavailable, the crew may elect to transport the patient to the closest facility.

6. If a patient refuses to accept treatment and transport to a facility within 60 miles, this refusal should be documented thoroughly on a patient refusal of treatment/transport form and signed by the patient. Every effort should be made to inform the patient of the risks involved with refusing treatment and/or transport so that they can make an informed decision.
SOUTHWEST EMS, INC.
PROTOCOLS AND STANDING ORDERS

1. AIRWAY OBSTRUCTION

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
   Choking, Inability to speak, Cough, Labored or absent respirations, Cyanosis,
   Loss of consciousness, Trauma to upper airway.

TREATMENT:

PARTIAL AIRWAY OBSTRUCTION:
1. Place Patient in position of comfort.
2. Oxygen @ 15 LPM via non-rebreather mask
3. Suction if necessary
   (as the Patient can tolerate without agitating the condition)

COMPLETE AIRWAY OBSTRUCTION:
1. If Patient is conscious, advise Patient that you will assist with abdominal
   thrusts to clear airway.
2. If airway is cleared, go to partial airway obstruction instructions.
3. If Patient is or becomes unconscious, place Patient in a supine position.
4. Open airway with head tilt/chin lift or jaw thrust if trauma is suspected.
5. Attempt to ventilate Patient. If unable to ventilate, reposition airway and
   reattempt to ventilate.
6. Administer 5 abdominal thrusts (chest thrusts for obese or pregnant Patients).
   Sweep mouth to clear airway and attempt to ventilate. Continue until airway
   obstruction is cleared.
7. When airway is cleared, place Patient in position of comfort and administer
   Oxygen @ 15 LPM via non-rebreather mask.
8. Airway management may be necessary using OPA or NPA and BVM
   ventilation with 15 LPM oxygen.
9. Suction as necessary to maintain a clear airway.
10. Monitor vital signs.
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PROTOCOLS AND STANDING ORDERS

2. ABDOMINAL PAIN

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS / SYMPTOMS:
  Nausea, Vomiting, Abdominal tenderness or guarding, Distention, Urinary discomfort, Diaphoresis, Pale skin color, Rectal bleeding, Fever, Pulsating mass.

TREATMENT:
  1. Nothing by mouth for Patient.
  2. Place Patient in position of comfort.
  3. Oxygen @ 15 LPM via non-rebreather if respirations are adequate.
  4. Assist ventilations, if necessary.
  5. Monitor vital signs.
  6. If Patient is hypotensive, refer to SHOCK PROTOCOL.
3. ABDOMINAL TRAUMA

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

LOOK FOR MECHANISM OF INJURY, TYPE, AND LOCATION OF INJURY

SIGNS / SYMPTOMS:
Abdominal pain, tenderness, distention, guarding, bruising, entrance / exit wounds, Punctures, evisceration, pelvic instability, respiratory distress, unconsciousness.

TREATMENT:
1. If spinal injury is suspected, take manual C-Spine control of Patient.
2. Insure Patient has an open airway free of blood, teeth, secretions, etc.
3. Respirations: if inadequate go to RESPIRATORY DISTRESS PROTOCOL.
4. Control bleeding with appropriate dressing and direct pressure.
   If evisceration is noted, cover exposed intestines with sterile dressing and wet with sterile saline.
5. Place Patient in supine position. If Patient is hypotensive, cover Patient with blankets and elevate feet, 8 to 12 inches.
6. Monitor vital signs.
4. ALTERED MENTAL STATUS INCLUDES DIABETIC AND SEIZURES

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS / SYMPTOMS:
- Sudden or bizarre behavior changes
- Decreased level of consciousness
- Fruity breath odor
- Convulsions, Post-ictal
- Cyanosis
- Abnormal respirations
- Medical alert tags
- Known Diabetic

TREATMENT:
1. Insure Patient safety.
3. Oxygen @ 15 LPM via non-rebreather if respirations are adequate.
   - If respirations are inadequate, go to RESPIRATORY DISTRESS PROTOCOL.
4. Monitor vital signs.
5. Place Patient in lateral recumbent position.
6. EMT-BASIC and above ONLY: for suspected diabetic, if Patient is responsive and can swallow, give Patient Oral glucose 15 gram tube or Orange juice.
8. If Patient is hypotensive, go to SHOCK PROTOCOL.
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PROTOCOLS AND STANDING ORDERS

5. ANAPHYLAXIS (ALLERGIC REACTION)

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS / SYMPTOMS:
   - Itching, Rash, Hives, Redness, Hoarseness, Laryngeal swelling, Difficulty breathing, Swelling at site of bite or sting, Abdominal pain, Vomiting, Weakness, Anxiety, Hives, Wheezing, Stridor.

TREATMENT:
   1. Insure Patient safety.
   2. Maintain an open airway for Patient. If necessary, use OPA or NPA to maintain airway.
   3. Oxygen @ 15 LPM via non-rebreather. If needed go to RESPIRATORY DISTRESS PROTOCOL.
   4. Place Patient in position of comfort. (Upright if in respiratory distress. Supine if shock is present.)
   5. Monitor vital signs frequently.
   6. **EMT-BASICS ONLY**: If Patient has a prescribed epinephrine auto-injector (Epipen), EMT-Basics may assist Patient with the administration of the medication.
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PROTOCOLS AND STANDING ORDERS

6. AMPUTATION

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNs AND SYMPTOMS:
Complete or partial amputation, Blood loss, Shock, Loss of or altered level of consciousness.

TREATMENT:
1. Insure Patient safety and take manual C-Spine control of Patient if C-Spine injury is suspected.
2. Maintain open airway and use OPA or NPA if necessary.
3. Oxygen @ 15 LPM via non-rebreather. If Patient is in respiratory distress, go to RESPIRATORY DISTRESS PROTOCOLS.
4. Control bleeding with the appropriate size dressing and apply direct pressure. DO NOT apply tourniquet to control bleeding.
5. Cover stump with saline-soaked sterile dressing, then cover with dry dressing and elevate.
6. Wrap severed part in moist sterile dressing and place in a watertight container, Place container in cooler with ice (do not use dry ice or freeze severed part.
7. Place Patient in supine position with legs elevated 8 – 12 inches.
8. Monitor vital signs.
9. If partial amputation, splint injured part in alignment with the extremity to ensure optimal blood flow.
7. BEHAVIORAL EMERGENCIES

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
Unusual behavior, Suicidal tendencies, Depression, Anxiety, Combativeness, Violent Tendencies, Altered Mental Status.

SUMMON LAW ENFORCEMENT BEFORE ENTERING.

TREATMENT:
1. Get Patient history and determine possible causes for behavioral problems.
2. Insure Patient safety.
3. If necessary, Oxygen @ 15 LPM via non-rebreather.
4. Place Patient in position of comfort.
5. Monitor vital signs.
8. BURNS

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
Reddened, Blistered, black or charred skin, Singed facial/ Nasal hair, Soot in airway, Hoarseness, Cough, Stridor, Wheezing, Respiratory Distress, Level of Consciousness.

SEVERITY OF BURN:
Determined by depth and location of burned body surface area (BSA) involved, age, and Health of Patient, associated injuries

MAJOR BURN:
1. Partial Thickness >25 % in adults and > 20 % in children and infants.
2. Full Thickness > 10 % BSA
3. All burns of Hands, Feet, Face, Ears and Genitals
4. Inhalation Burns
5. Electrical Burns
6. Burns complicated by fracture or other major trauma

MODERATE BURN:
1. Partial Thickness > 15 % to 25 % in adults and > 10 % to 20 % in children and infants.
2. Full Thickness < 10 % BSA

TREATMENT:
1. Safely Remove Patient to safety
2. Stop burning process. Remove burned clothing and constricting items such as rings, belts, bracelets, watches and necklaces.
3. Maintain Patient airway, OPA or NPA may be necessary to maintain airway.
4. Protect Patient’s C-Spine if trauma is suspected.
5. Oxygen @ 15 LPM via non-rebreather, if in respiratory distress, go to RESPIRATORY DISTRESS PROTOCOL.
6. Assess burned area and treat for shock as needed.
7. For small thermal burns(< 10% BSA), cover with sterile dressings and apply cool sterile water or saline to burned areas. For large thermal burns, and full thickness burns, cover with dry sterile dressings.
8. Leave blisters intact and DO NOT apply ointment to burned areas.
9. Monitor vital signs and keep Patient calm and warm.

SPECIAL CONSIDERATIONS:
1. Suspect airway injury in burns to face or sustained in a confined space.
2. Electrical or lightning burns/injury may cause respiratory and/or cardiac arrest.
SOUTHWEST EMS, INC.
PROTOCOLS AND STANDING ORDERS

9. CARDIAC ARREST

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
Unconscious, pulseless, and apneic. Pt’s skin may be cold and cyanotic.

TREATMENT:
1. Assess Patient to insure Patient is unresponsive, apneic and pulseless.
2. Move Patient to area on ground or floor with room to treat patient.
3. If available apply AED and shock Patient if indicated and according to proper AED sequence.
4. Open airway, insert OPA and ventilate Patient with 100% Oxygen and BVM, pocket mask or other barrier device.
5. Begin chest compressions and allow for ventilations checking every minute to reassess patient airway, breathing and pulse.
6. If possible determine events surrounding the Patient’s cardiac arrest
10. CHEMICAL EXPOSURE

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
   Redness, pain or irritation to skin or eyes, difficulty breathing, excessive tearing, burns, cough, wheezing, stridor, level of consciousness, seizures, associated trauma.

SPECIAL CONSIDERATIONS:
1. DO NOT attempt rescue in HAZ-MAT situations unless you have the required training and protective equipment necessary to attempt rescue.
2. During the flushing process, wear rubber or latex gloves and avoid splashing.

HISTORY:
1. Type and amount of chemical.
2. Victim immersed in chemical.
3. Chemical danger to rescuer.
4. Duration of exposure.
5. Time of and since exposure.

TREATMENT:
1. **NOTIFY HAZMAT IF CHEMICAL IS A DANGER TO RESCUERS AND OTHERS, OR IF IT IS UNKNOWN WHAT TYPE OF CHEMICAL IS PRESENT.**
2. Insure safety of rescuers and remove Patient from exposure to chemical.
3. Decontaminate patient as necessary to get chemical off of Patient.
4. Maintain patient airway. If necessary, use OPA or NPA to maintain airway.
5. If respiratory distress or respiratory and / or cardiac arrest exists, go to appropriate protocol and continue treatment of patient.
6. Oxygen @ 15 LPM via non-rebreather.
7. Treat any injury or trauma noted.
8. Monitor vital signs and contact responding ambulance.
9. For most chemicals irrigate affected areas with copious amounts of water. DO NOT flush dry chemicals known to be reactive to water.
10. Treat for shock per SHOCK PROTOCOL
10. CHEMICAL EXPOSURE

SPECIAL TREATMENTS:

**EYE BURNS:**

1. **IMMEDIATELY** flush eyes and surrounding areas with copious amounts of water for at least 15 minutes; irrigate well under eyelids.
2. Remove victim’s contact lenses if present.
3. Continue flushing eyes with water for following amount of time:
   A. ACID BURNS: at least 5 minutes
   B. ALKALI BURNS: at least 10 minutes
   C. UNKNOWN CAUSTIC: at least 20 minutes.
4. After flushing, cover both eyes with moistened eye pads; continue irrigation especially if patient complains of burning or irritation.

**DRY LIME:**

1. Brush dry lime from patient’s skin, hair, clothing and remove jewelry/clothing.
2. Flush with water after above and only with large quantities of water.

**CARBOLIC ACID (PHENOL)**

1. This chemical is not water-soluble; if available, an alcohol product should be used for initial wash of unbroken skin; follow with long, steady water flush.
2. If alcohol is not available flush with water at scene.

**SULFURIC ACID/SODIUM METALS:**

1. These chemicals produce heat when mixed with water and may explode; **DO NOT** use water unless a hose or shower is available. (Brush off metallic sodium first).
2. For mild burns, after initial flush, wash burn area with mild, soapy water.

**HYDROFLOURIC ACID:**

1. Burns may be delayed for hours depending on concentration and duration of exposure. All exposed Patients should be treated even if asymptomatic.
2. If available, apply baking soda solution first, and then flood with water.
3. After initial washing, apply calcium gluconate gel or magnesium oxide paste, if available.
10. CHEMICAL EXPOSURE

WHITE OR YELLOW PHOSPHORUS:
1. Phosphorus burns on contact with moist air.
2. Burns may be smoking and continued injury may occur.
3. Rescuers must avoid direct skin contact with phosphorus. Brush off all non-adherent material. **DO NOT** apply ointments.
4. After thorough irrigation with water, the burned area should be immersed in water, if possible, to stop the burning process.

SPECIAL CONSIDERATIONS:
1. **DO NOT** attempt rescue in HAZ-MAT situations unless you have the required training and protective equipment necessary to attempt rescue.
2. During the flushing process, wear rubber or latex gloves and avoid splashing
11. CHEST PAIN

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
Chest pain: pressure, heaviness or tightness, Difficulty breathing, Pain radiating to a jaw, neck, back or arms, Nausea, Vomiting, Sweating.
Sharp Chest Pain: shooting, stabbing, moving from one side of the chest to the other, cough, abnormal breath sounds.

DETERMINE LOCATION, TYPE, RADIATION, ONSET AND DURATION OF CHEST PAIN AND IDENTIFY ANY PAIN RELIEVING FACTORS OR MEDICATIONS.

TREATMENT:
1. Maintain Patient airway, use OPA or NPA if necessary.
2. Oxygen @ 15 LPM via non-rebreather.
3. Place Patient in position of comfort.
4. If Patient is in respiratory distress, go to RESPIRATORY DISTRESS PROTOCOL.
5. Monitor vital signs.
6. If available, have AED by Patient.
7. Treat per SHOCK PROTOCOL if Patient is hypotensive.
8. EMT-BASICS AND ABOVE ONLY: Assist Patient with administration of Nitroglycerin if:
   a. BP > 100mmHg systolic
   b. Patient is able to swallow.
   c. Nitro is prescribed to Patient and Patient has not already taken 3 doses.
   d. Follow prescribed instructions.
12. CHEST TRAUMA

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
   Pain, Tenderness, Bruising, Open wound, Uneven chest wall movement, 
   Difficulty breathing, Abnormal respiratory rate/pattern, Cyanosis, change in 
   mental status.

DETERMINE MECHANISM OF INJURY AND PROBABLE TIME OF INJURY.

TREATMENT:
   1. If scene is safe, take and maintain C-Spine control. 
   2. Maintain open airway, use OPA or NPA if necessary to maintain open airway. 
   3. Oxygen @ 15 LPM via non-rebreather. Assist ventilations with BVM if necessary. 
   4. Control bleeding and bandage with sterile dressing. 
   5. Treat chest injury according to type of injury. 
   6. If respiratory distress or arrest develops, go to RESPIRATORY DISTRESS PROTOCOL. 
   7. Stabilize any impaled object. 
   8. Place Patient in position of comfort or maintain C-Spine stabilization. 
   9. Monitor vital signs. 
  10. Assess neurologic status.

SPECIFIC TREATMENT:
   PENETRATING INJURIES
   1. Locate entrance/exit wounds. 
   2. Apply direct pressure with 4 x 4, ABD pad or trauma dressing to control bleeding. 
   3. Cover open chest wounds with occlusive dressing to allow air to escape but not enter. Tape on three sides and leave fourth side untapped. 
   4. Assess and monitor breath sounds.

FLAIL SEGMENT
   1. Apply bulky dressing to flail segment and secure upon exhalation. 
   2. Monitor Patient’s respiratory status.
13. CVA (STROKE)

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY.

SIGN AND SYMPTOMS:
Sudden change in level of consciousness or mental status, Weakness or numbness to one side of the Patient’s body, Facial drooping, Slurred or abnormal speech, Headache, Loss of Motor control to one extremity or one side of the body, Incontinence.

DETERMINE EXACT TIME OF ONSET OF SYMPTOMS IF POSSIBLE.

TREATMENT:
1. Control C-Spine if trauma is suspected.
2. Maintain open airway, use OPA or NPA if necessary. Assist ventilations if needed and go to RESPIRATORY DISTRESS PROTOCOL.
3. Oxygen @ 15 LPM via non-rebreather.
4. Place Patient in position of comfort.
5. Assess neurologic status.
6. Monitor vital signs. Take BP in both arms if possible.
14. DROWNING

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY.

SIGNS AND SYMPTOMS:
   Level of consciousness, Apnea, Pulselessness, Dyspnea, Head or neck trauma, Cyanosis, Pallor, Cold skin.

IF SAFE, REMOVE VICTIM FROM WATER

TREATMENT:
1. Maintain C-Spine stabilization if trauma is suspected.
2. Maintain open airway, suction and clear any obstruction. Use OPA or NPA if necessary. Assist ventilation with BVM as needed.
3. Oxygen @ 15 LPM via non-rebreather.
4. Monitor vital signs.
5. If Patient is breathing adequately, turn on side in rescue position.
6. Keep Patient covered and as warm as possible.
7. If Patient is unresponsive, apneic and pulseless, initiate CPR
15. EXTREMITY INJURY

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY.

SIGNS AND SYMPTOMS:
- Pain or tenderness to injured location, deformity, crepitus, limited or lack of movement of extremity, discoloration, open wound, bleeding, swelling, loss of sensation, trauma.

DETERMINE MECHANISM OF INJURY

TREATMENT
1. Check Patient for responsiveness, airway, breathing and circulation.
2. Take C-Spine control of patient if spinal trauma is suspected.
3. Stabilize the injured extremity and note any deformity, discoloration, swelling or open wound.
4. If patient is hypotensive, treat per SHOCK PROTOCOL.
5. If Patient has difficulty breathing, give Oxygen @ 15 LPM via non-rebreather and monitor.
6. If Patient has isolated extremity fracture:
   a. Check for distal pulses, motor function, and sensation before immobilization.
   b. Apply sterile dressings to open wounds.
   c. Splint as appropriate, supporting extremity while splinting.
   d. Elevate extremity.
   e. Recheck distal pulses, motor function and sensation after splinting.
   f. Apply cold pack or ice pack wrapped in towel or washcloth if available.
   g. Monitor circulation.
7. Avoid unnecessary movement of fracture site.
16. FACIAL AND NECK TRAUMA

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
   Tenderness, Swelling, Bleeding, Bruising, Respiratory Difficulty, Laceration, Vomit, Blood, Teeth or debris in mouth, Crepitus, Hoarseness, Eye injury.

DETERMINE MECHANISM OF INJURY

TREATMENT:
1. If necessary, use jaw thrust to open airway while maintaining C-Spine control.
2. Remove teeth/debris from mouth, suction if needed.
3. Use OPA if tolerated to maintain open airway. NO NPA.
4. Support breathing with Oxygen @ 15 LPM via non-rebreather or if Patient is in respiratory distress, treat per RESPIRATORY DISTRESS PROTOCOL.
5. Control any bleeding with direct pressure and sterile dressings. Bandage with sterile dressings.
6. Apply appropriate sized cervical collar to Patient, and if available, secure Patient to long spine board if spinal trauma is suspected.
7. Assess neurologic status.
8. Monitor vital signs.
9. Cover both eyes if one or both are injured
17. HEAT ILLNESSES

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
- Skin: warm or cool, pale or flushed, moist or dry;
- Difficulty breathing;
- Altered mental status;
- Seizures;
- Nausea/vomiting;
- Headache;
- Chills or sweats;
- Weakness;
- Muscle Cramps;
- Thirst;
- Visual disturbances.

REMOVE PATIENT FROM HOT ENVIRONMENT TO A COOL PLACE.

TREATMENT:
1. Airway Management.
2. Oxygen @ 15 LPM via non-rebreather, if Patient has difficulty breathing or has altered mental status.
3. Remove Patient’s clothing to cool, cool with cold packs @ inguinal, neck and axillary areas. Use air conditioning to cool.
4. Monitor vital signs.
5. Do not cool Patient to the point that Patient becomes hypothermic.

HEAT STROKE IS A TRUE EMERGENCY CHARACTERIZED BY ALTERED LEVEL OF CONSCIOUSNESS
18. HEAD TRAUMA

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
Altered mental status, Visual disturbances, Nausea/vomiting, Contusions, Abrasions, Numbness, tingling or loss of sensation in extremities, Paralysis, Alteration of pupil size, Symmetry or reactivity, Lacerations, Tenderness, Neurologic deficit, Combative.

DETERMINE MECHANISM OF INJURY IF POSSIBLE.

TREATMENT:
1. Maintain C-Spine control of Patient
2. Maintain airway, use modified jaw-thrust if needed to open airway. OPA may be used to keep airway open if tolerated. **NO NPA.**
3. Support Patient breathing as needed. Oxygen @ 15 LPM via non-rebreather. If in respiratory distress or apneic treat per RESPIRATORY DISTRESS PROTOCOL.
4. Apply appropriate sized cervical collar and if available, immobilize Patient using a long spine board securing patient with straps and head immobilizer.
5. Monitor neurologic status.
6. Monitor vital signs.
7. Elevate head of Patient 30 degrees.
8. Treat life-threatening injuries and control bleeding.
9. Check for cerebrospinal fluid in ears, bleeding from nose, ears or mouth.
10. Be prepared to roll spine board and suction if Patient begins to vomit.
11. Monitor changes in respiratory pattern
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PROTOCOLS AND STANDING ORDERS

19. HEMORRHAGE CONTROL

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY.

SIGNS AND SYMPTOMS:
Lacerations, Punctures, Gunshot wounds, Tears, Amputations, Avulsions

DETERMINE MECHANISM OF INJURY, TYPE OF INJURY, LOCATION OF BLEEDING AND ESTIMATED AMOUNT OF BLOOD LOSS.

TREATMENT:
1. Assure Patient airway and adequate respirations.
2. Oxygen @ 15 LPM via non-rebreather.
3. Control bleeding with direct pressure and sterile dressing.
4. Elevate if bleeding is from extremity.
5. Use pressure points if needed to control bleeding.
6. Bandage wounds with sterile dressing.
7. Keep Patient calm and place in supine position with feet elevated, if Patient is in shock.
8. Monitor vital signs.
9. If dressing becomes blood-soaked, place another sterile dressing over first dressing. **DO NOT** remove the dressing that became blood-soaked. **DO NOT** remove impaled objects. Secure in place.
20. HYPERTENSION

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
  Headache, Altered level of consciousness or mental status, Visual disturbances,
  Nosebleed, Chest pain, Shortness of breath.

TREATMENT:
  1. Maintain open airway and use OPA or NPA if needed.
  2. Oxygen @ 15 LPM via non-rebreather. If in respiratory distress, treat per
     RESPIRATORY DISTRESS PROTOCOL.
  3. Place Patient in recovery position or in supine position.
  4. Monitor vital signs. Check BP in both arms.
21. HYPOTHERMIA

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY.

SIGNS AND SYMPTOMS:
Skin cool to touch, Extremity pain, Frostbite, Shivering

REMOVE PATIENT FROM COLD AND TO WARM ENVIRONMENT.

TREATMENT;
1. Open and maintain Patient airway, use OPA or NPA as needed.
2. Oxygen @ 15 LPM via non-rebreather. If difficulty breathing or apneic, treat per RESPIRATORY DISTRESS PROTOCOL.
3. Remove wet clothing. Cover Patient with blankets and place hot packs at axilla, neck and groin.
4. Start CPR and treat per CARDIAC ARREST PROTOCOL, if Patient is unresponsive, apneic and pulseless.
5. Monitor vital signs.
6. Assess neurologic status.
22. MULTIPLE TRAUMA

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY.

SIGNS AND SYMPTOMS:
   Tenderness, Swelling, Guarding, Lacerations, Deformity, Crepitus, Pain, Sweating, Pallor, Altered level of consciousness, Entrance/Exit wounds, Difficulty breathing, Bruising, Abrasions, JVD, Tracheal deviation.

DETERMINE MECHANISM AND TYPE OF INJURIES

TREATMENT:
   1. Take C-Spine control of Patient and open airway with modified jaw-thrust and use OPA if needed.
   2. Clear airway of blood, teeth or debris. Suction if needed.
   3. Oxygen @ 15 LPM via non-rebreather. If patient has difficulty breathing, treat per RESPIRATORY DISTRESS PROTOCOL.
   4. Control bleeding with direct pressure and sterile dressing. Bandage with sterile dressing.
   5. Apply appropriate size cervical collar and immobilize Patient with long spine board. Secure Patient with straps and head immobilizer.
   6. Monitor vital signs.
   7. Assess neurologic status.
   8. Splint any fractures to extremity if time permits.
   9. Assess for shock, elevate foot of spine board 8 to 12 inches if hypotensive and if no head injury.
TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY.

HISTORY:
1. Time of birth.
2. Type of delivery (breech, head first, …)
3. Any health problems experienced by mother.

STABILIZATION:
1. Dry face (newborns have a strong “diving reflex”—wet face causes bradycardia).
2. Tactile stimulation—suction mouth, then nose with bulb syringe.
3. If good respirations and heart rate, wrap newborn in blanket and place next to mother and keep baby warm.
4. Record 1 and 5 minute APGAR scores.

<table>
<thead>
<tr>
<th>APGAR SCORE</th>
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<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Blue, Pale</td>
<td>Body Pink, Ext. Blue</td>
<td>Pink</td>
</tr>
<tr>
<td>Pulse</td>
<td>absent</td>
<td>&lt; 100</td>
<td>&gt; 100</td>
</tr>
<tr>
<td>Grimace (reflexes)</td>
<td>Absent</td>
<td>grimaces</td>
<td>Cough or sneeze</td>
</tr>
<tr>
<td>Activity(muscle tone)</td>
<td>Limp</td>
<td>Some flexion</td>
<td>Active</td>
</tr>
<tr>
<td>Respirations</td>
<td>Absent</td>
<td>&lt; 30</td>
<td>30-50, strong cry</td>
</tr>
</tbody>
</table>

DEPRESSED RESPIRATIONS AND/OR HEART RATE:
Initial treatment of infants with slow respirations, with or without bradycardia, is blow-by Oxygen. If the infant remains bradycardic and bradypneic, most respond to BVM and Oxygen. If respirations absent, and the infant remains bradycardic, continue BVM ventilations and begin chest compressions.
TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

HISTORY AND SIGNS:
Last menstrual period, Pregnant or not, Pregnancies/viable deliveries, Bleeding, Contractions, Discharge, Ruptured membranes.

TREATMENT:
1. Place Patient on their left side.
2. Oxygen @ 15 LPM via non-rebreather. Use RESPIRATORY DISTRESS PROTOCOL if any difficulty breathing develops.
3. If Patient has significant vaginal bleeding, treat per SHOCK PROTOCOL.
4. If baby is crowning, assist delivery. Suction baby’s mouth then nose with bulb syringe. Check APGAR @ 1 and 5 minutes. Clamp cord in two places 6-8 inches apart and 8-10 inches from the mother. If newborn is in distress, treat per NEONATAL RESUSCITATION PROTOCOL. Dry infant, wrap in clean or sterile blanket and give to mother. Allow placenta to deliver naturally and place in plastic bag for transport by ambulance. If excessive bleeding noted, treat per SHOCK PROTOCOL and massage uterus.
5. **For prolapsed cord presentation:**
   Place mother in trendelenburg and knee-chest position.
   Check for pulses in the cord. If necessary, hold pressure on the infant’s head to relieve any pressure on the cord.
   Keep the cord moist with sterile saline.
6. **For foot/leg presentation:**
   Support the presenting part.
   Place the mother in trendelenburg and knee-chest position.
7. **For cord around the neck:**
   Unwrap the cord from around the neck and deliver normally
TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY.

PRESENTATION:
1. Children are not just little adults. They get sick and just like adults, but usually for different reasons. Children also compensate far longer than adults, but can deteriorate far quicker than adults.
2. Children are easily frightened. Use a calm voice, decoys, appropriate wording and all your patience.

VITAL SIGNS:
1. All children over 3 should have their blood pressure taken as part of routine vital signs.
2. Pulse, respiratory rate and effort, and temperature (when indicated) are indicated in all age groups as appropriate.
3. How a child looks and acts can indicate how sick a child is.
4. Urinary output can be gauged by wet diapers per day in the younger age groups.

BLS per AHA guidelines.
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26. PEDIATRIC RESPIRATORY DISTRESS

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY.

CARDIAC ARREST IN CHILDREN USUALLY OCCURS SECONDARY TO RESPIRATORY ARREST. MONITOR AND TREAT BREATHING DIFFICULTY IN CHILDREN QUICKLY.

SIGNS AND SYMPTOMS:
- Retractions, Labored breathing, Poor skin color/tone, Tachypnea, Tachycardia, Noisy breath sounds.

TREATMENT:
1. Maintain open airway and assist breathing with appropriate size BVM if needed.
2. Oxygen @ 15 LPM via method tolerated by child (blow-by, pediatric mask).
3. Monitor vital signs.
4. Place in position of comfort (mother’s lap if necessary) and/or possible or position necessary to maintain open airway.

SPECIAL SITUATIONS:
1. CROUP-sounds like a percolator, dog or seal. Symptoms worsen at night. Place in cool environment, administer humidified Oxygen if available.
2. ASTHMA-EMT-Basics only may assist Patient with prescribed inhaler if available.
3. EPIGLOTITIS-MEDICAL EMERGENCY-This child looks sick and drools. Keep Patient calm. Administer humidified Oxygen if tolerated.
4. FOREIGN BODY OBSTRUCTION- Attempt to clear airway per AHA guidelines, monitor and administer Oxygen.
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PROTOCOLS AND STANDING ORDERS

27. POISONING/OVERDOSE

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
Mouth or throat pain, Eye irritation/burning, Dyspnea, Sleepiness,
Nausea/Vomiting, Abdominal Pain, Dysphasia, Diarrhea, Headache, Itching,
Cough, Chest pain, Cyanosis, Rash, Diaphoresis, Increased salivation, Difficulty
breathing, Altered level of consciousness/mental status.

TRY TO DETERMINE THE AGENT USED IN OVERDOSE/POISONING.

Poison Control Phone #: 1-800-222-1222
www.AAPCC.org

TREATMENT:
1. Maintain open airway, use OPA or NPA if needed. Assess neurologic status.
2. Assess breathing, Administer oxygen @ 15 LPM via non-rebreather. If
   Patient is having difficulty breathing, treat per RESPIRATORY DISTRESS
   PROTOCOL.
3. Monitor vital signs and neurologic status.
4. Prepare for a combative/uncooperative Patient (restrain if necessary, contact
   law enforcement if necessary).
5. Place Patient on left side in recovery position if unconscious.
6. Have suction available and ready to use.
28. RESPIRATORY DISTRESS

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
   Chest pain (location, quality, position), Cough, Sputum-color, Numbness/tingling in extremities, Fever, Chills, Sore throat, Hoarseness, Dyspnea, Dysphagia, Cyanosis, Peripheral edema, Hives, Evidence of facial, neck or head trauma, Drooling, Nasal flaring, Stridor, Rales, Wheezing, Rhonci, Neck vein distension, Abnormal or absent breath sounds, Level of consciousness, Restlessness, Slurred speech, Inability to speak.

TREATMENT:
1. Maintain open airway, use OPA or NPA if needed. Assist ventilations if breathing is inadequate. Use modified jaw-thrust to open airway if trauma is suspected.
2. Oxygen @ 15 LPM via non-rebreather. If breathing is inadequate or absent, ventilate Patient with BVM and 100% Oxygen.
3. Place Patient in position of comfort or supine if ventilation assistance required.
4. Monitor vital signs and level of consciousness.

If allergic reaction is suspected to be cause of respiratory distress, treat per ANAPHYLAXIS PROTOCOL
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PROTOCOLS AND STANDING ORDERS

29. SHOCK

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
   Thirst, Unconsciousness, Dyspnea, Chest/abdominal pain, Itching,
   Peripheral/facial edema, Fever, Chills, Nausea/vomiting, Tachycardia, Systolic
   BP <90 mmHg, Cool, Clammy (hypovolemic, cardiogenic), Flushed, warm
   (neurogenic, septic, Anaphylactic), Slow capillary refill, Altered mental status,
   Restlessness, Associated Trauma or Bleeding.

TREATMENT:
   1. Maintain open airway use OPA or NPA if needed. Assist ventilations as
      needed.
   2. Oxygen @ 15 LPM via non-rebreather. Treat breathing difficulty per
      RESPIRATORY DISTRESS PROTOCL.
   3. Control bleeding with sterile dressing and direct pressure.
   4. Control C-Spine if spinal trauma suspected.
   5. Place Patient in supine position with feet elevated 8-10 inches.
   7. Monitor vital signs and assess neurologic status.

TREAT THE PATIENT, NOT THE PATIENT’S BLOOD PRESSURE.
30. SNAKE BITE

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY.

SIGNS AND SYMPTOMS:
- Diaphoresis, Chills, Headache, Numbness/tingling, Local pain, Nausea/vomiting,
- Peculiar or metallic taste, Hypotension, Fever, Bite-wound location, Size, 1 or 2
  fangs or entire jaw imprint, Local edema, Discoloration.

Protect Patient from further injury from snake. Capture snake, if possible, for transport to
hospital by ambulance for identification (if it can be done safely).

TREATMENT:
1. Maintain open airway, assist as needed. Oxygen @ 15 LPM via non-rebreather.
2. Remove constricting clothing/items.
3. Immobilize the bitten part at or slightly below heart level.
4. Keep Patient warm.
5. Monitor vital signs and assess mental status.
6. Keep Patient calm and bitten part still to minimize venom absorption.
7. Cleanse bite with soap and water.
8. **DO NOT** use ice on the bite.
31. SPINAL TRAUMA

TAKE BSI PRECAUTIONS AND ASSURE SCENE SAFETY

SIGNS AND SYMPTOMS:
   Neck or back pain, Sensory loss, Numbness/tingling, Muscle weakness, Paralysis, 
   Respiratory distress, Incontinence, Priapism, Tenderness, Deformity, Associated
   Trauma.

Determine mechanism of injury and move Patient as little as possible.

TREATMENT:
   1. Stabilize C-Spine and maintain in-line stabilization. 
   2. Maintain open airway using jaw-thrust. Use OPA or NPA if needed. 
   3. Oxygen @ 15 LPM via non-rebreather. If in respiratory distress or arrest, 
      treat per RESPIRATORY DISTRESS PROTOCOL. 
   4. Control bleeding with direct pressure and sterile dressing. Bandage with 
      sterile dressing. 
   5. Immobilize Patient as follows: apply appropriate size cervical collar, logroll 
      Patient onto long spine board, and secure Patient with straps at chest, waist 
      and knees. Immobilize Patient’s head with head immobilizer and straps. 
      Assess sensory, motor and circulation before and after immobilizing Patient. 
   6. Monitor vital signs and assess mental status. 
   7. If hypotensive, treat per SHOCK PROTOCOL. 
   8. Be prepared to roll spine board if Patient vomits.