**TAB 5 PEDIATRIC MEDICAL**

**EMERGENCY GUIDELINES**



# TAB 5 GUIDELINE 1 PEDIATRIC TABLES

|  |  |  |  |
| --- | --- | --- | --- |
| **Age** | **Pulse (beats/min)** | **Respirations** | **Blood Pressure**(SBP / DBP) |
| **Newborn** | **120 – 160** | **30 – 60** | **74 – 100 / 50 – 68** |
| **Infant** | **100 – 140** | **30 – 60** | **84 – 106 / 56 – 70** |
| **Toddler** | **80 – 130** | **24 – 40** | **98 – 106 / 50 – 70** |
| **Preschool** | **80 – 120** | **22 – 34** | **98 – 112 / 64 – 70** |
| **School age** | **60 – 100** | **18 – 30** | **104 – 124 / 64 – 80** |
| **Adolescent** | **50 – 90** | **12 – 18** | **118 – 132 / 70 – 82** |
|  |
| **Age** | **Estimated Weight** |
| **1** | **10 kg** |
| **3** | **15 kg** |
| **5** | **20 kg** |
| **7** | **25 kg** |
| **9** | **30 kg** |
|  |
| **AGE** | **ORAL AIRWAY** | **ENDOTRACHEAL****TUBE (uncuffed)** | **SUCTION CATHETER** |
| **Preemie** | **00** | **2.5 - 3.0** | **5 French** |
| **Newborn** | **0** | **3.0 - 3.5** | **6 French** |
| **6 Months** | **0-1** | **3.5** | **8 French** |
| **18 Months** | **1** | **4.0** | **8 French** |
| **3 Years** | **2** | **4.5** | **8 French** |
| **5 Years** | **2-3** | **5.0** | **10 French** |
| **8 Years** | **3** | **6.0 cuffed** | **10 French** |
| **Older** | **4** | **6.5 -7.0 cuffed** | **12 French** |

**TAB 5 GUIDELINE 2 ABDOMINAL PAIN**

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Age
* Past medical / surgical history
* Medications
* Onset
* Palliation / Provocation
* Quality (crampy, constant, sharp, dull, etc)
* Region / Radiation / Referred
* Severity (1-10)
* Time (duration / repetition)
* Fever
* Last meal eaten
* Last bowel movement
* Menstrual history (pregnancy)
 | **SIGNS / SYMPTOMS*** Pain (location / migration)
* Tenderness
* Nausea
* Vomiting
* Diarrhea
* Dysuria
* Constipation
* Vaginal bleeding / discharge
* Pregnancy

**ASSOCIATED SYMPTOMS:*** Fever, headache, weakness, malaise, myalgias, cough, headache, mental status changes, rash
 | **DIFFERENTIAL*** Pneumonia or Pulmonary embolus
* Liver (hepatitis, CHF)
* Peptic ulcer disease / Gastritis
* Gallbladder / Pancreatitis
* Myocardial infarction
* Kidney stone
* Abdominal aneurysm
* Appendicitis / Diverticulitis
* Bladder / Prostate disorder
* Pelvic (PID, Ectopic pregnancy, Ovarian

cyst)* Spleen enlargement
* Bowel obstruction
* Gastroenteritis (infectious)
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
| **Make NPO** |
|  |  |

**YES**

**Place Supine Position**

**Contact ALS Backup**

-Consider- **ResQGARD**

(wgt > 25 pounds)

**Hypotension / Signs of Dehydration**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**NO**

**Minim um Systolic BP by Age**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in years)**
* **y: 90 mmHg**

# TAB 5 GUIDELINE 3 ALLERGIC REACTION | ANAPHYLAXIS

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Onset and location
* Insect sting or bite
* Food allergy / exposure
* Medication history / allergy / exposure
* New clothing, soap, detergent
* Past history of reactions
* Past medical history
 | **SIGNS / SYMPTOMS*** Itching or hives
* Coughing / wheezing or respiratory

distress* Chest or throat constriction
* Difficulty swallowing
* Hypotension or shock
* Hypotension or shock / Edema
* Abdominal cramps
 | **DIFFERENTIAL*** Urticaria (rash only)
* Anaphylaxis (systemic effect)
* Shock (vascular effect)
* Angioedema (drug induced)
* Aspiration / Airway obstruction
* Vasovagal event
* Asthma
* CHF
 |

**Respiratory Distress / Shock**

**Consider ALS Backup**

**Universal Patient Care**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**Hives / Rash Only**

**No Respiratory Component**

**EpiPen (Jr) Auto-injector**

< 30 Kg (66 lbs) and > 15

Kg (33 lbs)

**Patient Not**

**Improved**

**Patient**

**Improved**

**Airway Managem ent**

**Pulse Oxim etry**

**Reassess Patient**

|  |
| --- |
| **Indications for Use of Epinephrine** |
| **Respiratory Compromise*** Airway occlusion
* Breathy difficulty or inadequate breathing with possible wheezing, stridor, or crowing
 | **Shock*** Absent or weak pulses
* Rapid heartbeat
* Decreased blood pressure [SBP < 70 + (2 x age) mmHg]
* Deteriorating mental status
 |
| **Minim um Systolic BP by Age** |
| * **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in years)**
* **y: 90 mmHg**
 |

|  |  |  |
| --- | --- | --- |
|  | **Albuterol**1.25 mg nebulized Wgt < 10 Kg |  |
|  |  |
|  | **Albuterol**2.5 mg nebulized |  |
|  |  |
|  | (May repeat x 2) |
|  |  |

# SPECIAL CONSIDERATIONS:

1. Patients with allergic reactions can deteriorate quickly. Airway is a prime concern.
2. Epinephrine (via Auto-Injector) should be administered for:

# Respiratory Compromise

* + 1. Airway occlusion
		2. Breathy difficulty or inadequate breathing with possible wheezing, stridor, or crowing

# Shock

* + 1. Absent or weak pulses
		2. Rapid heartbeat
		3. Decreased blood pressure (SBP < 90 mmHg)
		4. Deteriorating mental status
1. Lethal edema may be localized to the tongue, uvula or other upper airway structures.
2. If severe reaction with signs | symptoms of shock and / or airway involvement and ALS not available, then administer Epipen Auto-injector for **weight > 30 Kg (66 lbs)**, otherwise use Epipen, Jr for weight **< 30 Kg (66 lbs) and > 15 Kg (33 lbs)**

# TAB 5 GUIDELINE 4 ALTERED MENTAL STATUS

|  |  |  |
| --- | --- | --- |
| **HISTORY*** < 16 years of age
* Known diabetic, medic alert tag
* Drugs, drug paraphernalia
* Report of illicit drug use or toxic ingestion
* Past medical history
* Medications
* History of trauma
 | **SIGNS / SYMPTOMS:*** Decreased mental status
* Change in baseline mental status
* Bizarre behavior
* Hypoglycemia
	+ Cool, diaphoretic skin
* Hyperglycemia
	+ Warm, dry skin
	+ Fruity breath
	+ Kussmaul respirations
	+ Signs of dehydration
 | **DIFFERENTIAL*** Head trauma
* CNS (stroke, tumor, seizure, infection)
* Cardiac (MI, CHF)
* Pulmonary (hypoxia)
* Infection
* Thyroid (hyper / hypo)
* Shock (septic, metabolic, traumatic)
* Diabetes (hyper / hypoglycemia
* Toxicologic / Electrolyte abnormality
* Acidosis / Alkalosis
* Environmental exposure
* Psychiatric disorder
 |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**Check Blood Glucose**

**Spinal Immobilization**

(if appropriate)

**Consider Airway**

**Management**

**Consider ALS Backup**

**NO**

**Oral Glucose**

0.5 Gm / Kg PO

(Mental Status?)

**YES**

**Release at Scene (RAS)**

Refusal of transport Adult (caregiver) present Blood sugar > 100

Patient has ability to eat meal

Patient with history of diabetes

No history of oral diabetic medications

**Minimum Systolic BP by Age**

|  |  |  |
| --- | --- | --- |
|  | **Consider Use of Restraints** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Cardiac Monitor / 12-Lead ECG** |  |
| **Perform procedure if able to transmit, do no delay care to obtain EKG** |
|  |  |

**Glucose 60 – Glucose > 250**

**Signs of Dehydration**

**Glucose < 60**

**Return to Baseline**

|  |
| --- |
| **Consider other causes:**ALTEHead injury Hypoxia Overdose Stroke |
|  |  |

**Universal Patient Care**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Document Treat and Release -or-****Transport to appropriate facility** |

**Consider Naloxone** 0.1 mg / Kg IN

(with respiratory depression)

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in years)**
* **y: 90 mmHg**

# TAB 5 GUIDELINE 5 BEHAVIORAL | EXCITED DELIRIUM

**Verbal techniques (reassurance, calm, establish rapport)**

**Check Blood Glucose**

**Rapid take-down w/ minimum**

**(4) EMS crew members**

**(If necessary)**

**Remove patient from stressful environm ent**

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in years)**
* **y: 90 mmHg**

**Minim um Systolic BP by Age**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose**0.5 Gm / Kg PO(Mental Status?) |  |

|  |  |  |
| --- | --- | --- |
|  | **12-Lead EKG** |  |
|  | **Monitor Respiratory status,****consider EtCO2** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** < 16 years of age or > 5 years of age
* Situational crisis
* Psychiatric illness / medications
* Injury to self or threats to others
* Medic alert tag
* Substance abuse / overdose
* Diabetes
 | **SIGNS / SYMPTOMS*** Anxiety, agitation, confusion
* Affect change, hallucinations
* Delusional thoughts, bizarre behavior
* Expression of suicidal / homicidal

thoughts* Poor concentration, easily distracted,

psychosis* Combative, violent
* Large pupils / light sensitivity
* Tachycardic / Hypertension
 | **DIFFERENTIAL*** See Altered Mental Status differential
* Hypoxia
* Alcohol intoxication
* Medication effect / overdose
* Withdrawal syndromes
* Depression
* Bipolar (manic-depressive)
* Schizophrenia, anxiety disorders, etc.
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

 **Glucose < 60**

|  |
| --- |
| Treat suspected medical or trauma problems per appropriate protocol **Altered Mental Status****Poisoning and Overdose****Head Trauma** |
|  |  |

|  |  |
| --- | --- |
|  | **Restraints*** **No transport in hobble or prone position.**
* **Do not inhibit**

**patient breathing, ventilations** |
| **Consider Restraints****(for patient / personnel safety)** |  |
|  |
|  |  |
| **Cardiac Monitor /** |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

# SPECIAL CONSIDERATIONS:

1. Excited delirium is an extreme disturbance of consciousness and mental status that occurs in individuals especially when under the influence of stimulants or anti-psychotic medications and it represents an acute **LIFE THREATENING MEDICAL EMERGENCY**
	1. Combination of delirium, psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent / bizarre behavior, insensitivity to pain, hyperthermia and increased strength. Potentially life-threatening and associated with use of physical control measures, including physical restraints and Tasers
		1. Need rapid take down, sedation by ALS providers, cooling measures and IV fluid replacement by ALS providers. These patients often suffer respiratory or cardiac arrest once subdued and should be closely monitored and transported by an ALS Unit to closest appropriate facility
	2. Most commonly seen in male subjects with a history of serious mental illness and/or acute or chronic drug abuse, particularly stimulant drugs such as cocaine, crack cocaine, methamphetamine, amphetamines or similar agents
	3. Alcohol withdrawal or head trauma may also contribute to the condition
2. Maintain objectivity during evaluation and treatment. Verbal aggression exhibited by patients can quickly escalate to physical violence. Always proceed with calm, reassuring directions for the patient. If a situation appears threatening, sufficient law enforcement presence may be necessary before patient restraint is attempted
	1. If needing to take the patient down, at minimum, utilize (4) ems crew members / police officers to secure each limb

# If a patient suspected of excited delirium suffers cardiac arrest, consider a fluid bolus and sodium bicarbonate early

1. Patients requiring physical restraint should be placed in the lateral recumbent position when possible. Consider your own safety and limitations when physical restraint is required.
	1. Restrained patients should never be left unattended. Continue to evaluate effectiveness of restraints and any compromise that may be caused by the restraint process (i.e., airway, breathing, circulation)
	2. Positional asphyxia – very large ventilation volumes are needed to oxygenate and blow off carbon dioxide overload. They should never be left prone or face down in handcuffs and should never by “hog-tied”
2. Do not overlook the possibility of associated domestic violence or abuse

# TAB 5 GUIDELINE 6

**BRIEF RESOLVED UNEXPLAINED EVENT (BRUE)**

1. Specific information needed
	1. An episode in an infant or child less than (2) two years old which is frightening to the observer and is characterized by one or more of the following:
		1. Apnea (central or obstructive)
		2. Skin color change: cyanosis, erythema (redness), pallor, plethora (fluid overload)
		3. Marked change in muscle tone
		4. Choking or gagging not associated with feeding or a witnessed foreign body aspiration
		5. Seizure-like activity
2. Guideline
	1. Safe scene, universal precautions
	2. ABC (airway, breathing, circulation)
	3. Establish responsiveness (A.V.P.U)
	4. Check Vitals, Pulse Oximeter, Reassure patient
	5. Oxygen by cannula or NRB Mask to keep pulse ox greater than 92% (may have to assist ventilation)
	6. Contact on-line MEDICAL CONTROL and transport accordingly

# SPECIAL CONSIDERATIONS:

1. Most patients will appear stable and exhibit a normal physical examination. This episode may be a sign of an underlying serious illness or injury and further evaluation by medical staff is strongly recommended.
2. Provider must explain the potential risks of refusal to the caretaker on scene.
3. In the event that the legal guardian is not with the patient and transport is being refused, it is recommended that the legal guardian should be contacted
4. Always consider the possibility of abuse in these children

# TAB 5 GUIDELINE 7

**FOREIGN BODY AIRWAY OBSTRUCTION – CHILD**

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Events leading up to incident
* Trauma
* Aspiration
* Medication
* Allergic reaction
 | **SIGNS / SYMPTOMS*** Anxiety
* No air movement
* Clutching throat
* Unresponsive
* Sore throat, fever,
* “Hot potato” voice, drooling
 | **DIFFERENTIAL*** Foreign Body
* Infection
* Cancer
* Trauma
* Laryngeal or tracheal fracture
* Oropharyngeal laceration
 |

**Consider ALS Backup**

**Universal Patient Care**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**NO YES**

|  |  |  |
| --- | --- | --- |
|  | **Conscious** |  |
|  |  |

**NO**

**Chest Compressions**

**Unresponsive**

**Perform Abdominal Thrusts**

**Airway Obstruction Cleared**

**Attem pt breaths, if air does not enter retilt head and reattempt breaths**

**NO**

**Check airway / perform finger sweep if see object**

**PULSE YES**

**NO**

**Airway Obstruction Cleared**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

**Cardiac Arrest Guidelines**

|  |  |
| --- | --- |
| **Mild Airway Obstruction Signs** | **Severe Airway Obstruction Signs** |
| * Good air exchange
 | * Poor or no air exchange
 |
| * Responsive and can cough forcefully
 | * Weak, ineffective cough or no cough at all
 |
| * May wheeze between coughs
 | * High-pitched noise while inhaling or no noise at all
 |
|  | * Increased respiratory difficulty
 |
|  | * Possible cyanosis (turning blue)
 |
|  | * Unable to speak or move air
 |
|  | * Clutching the neck with the thumb and fingers
 |
|  | * Unresponsive
 |

# SPECIAL CONSIDERATIONS:

1. Use abdominal thrusts (the Heimlich maneuver) to relieve choking in children > 1 year of age. Give each individual thrust with the intent of relieving the obstruction. It may be necessary to repeat the thrust several times to clear the airway.
2. Choking victims initially may be responsive and then may become unresponsive. With a child choking victim who becomes unresponsive, open the airway, remove an object if you see it and begin CPR.
3. For a child victim, every time you open the airway to give breaths, open the victim’s mouth wide and look for the object. If you see an object, remove it with your fingers. If you do not see an object, keep doing CPR.
4. You can tell you have successfully removed an airway obstruction in the unresponsive victim if you:
	1. Feel air movement and see the chest rise when you give breaths
	2. See and remove a foreign body from the victim’s pharynx

# TAB 5 GUIDELINE 8

**Chest Compressions**

**Unresponsive**

|  |  |  |
| --- | --- | --- |
|  | **Conscious** |  |
|  |  |

**FOREIGN BODY AIRWAY OBSTRUCTION – INFANT**

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Events leading up to incident
* Trauma
* Aspiration
* Medication
* Allergic reaction
 | **SIGNS / SYMPTOMS*** Anxiety
* No air movement
* Unresponsive
* Fever,
* “Hot potato” voice, drooling
 | **DIFFERENTIAL*** Foreign Body
* Infection
* Trauma
* Laryngeal or tracheal fracture
* Oropharyngeal laceration
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**NO YES**

**Perform (5) Back blows /**

**(5) Chest Compression**

**Manuever**

**NO**

**PULSE YES**

**Attempt breaths, if air does not enter retilt head and reattempt breaths**

**Check airway / perform**

**finger sweep if see object**

**Airway Obstruction Cleared**

**NO**

**NO**

**Airway Obstruction Cleared**

**Cardiac Arrest Guidelines**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

|  |  |
| --- | --- |
| **Mild Airway Obstruction Signs** | **Severe Airway Obstruction Signs** |
| * Good air exchange
 | * Poor or no air exchange
 |
| * Responsive and can cough forcefully
 | * Weak, ineffective cough or no cough at all
 |
| * May wheeze between coughs
 | * High-pitched noise while inhaling or no noise at all
 |
|  | * Increased respiratory difficulty
 |
|  | * Possible cyanosis (turning blue)
 |
|  | * Unable to cry or move air
 |
|  | * Unresponsive
 |

# SPECIAL CONSIDERATIONS:

1. Clearing an object from an infant’s airway requires a combination of back slaps and chest thrusts.
2. Do not perform blind finger sweeps in infants and children because the foreign body may be pushed back into the airway, causing further obstruction or injury.
3. If the victim becomes unresponsive, you will stop giving back slaps and will begin CPR. Chest compressions give effective pressure in the chest and may be able to relieve the obstruction.

# TAB 5 GUIDELINE 9 HYPOTENSION (SHOCK)

**Oral Glucose**

0.5 Gm / Kg PO

(Mental Status?)

**Place Supine Position**

**Contact ALS Backup**

-Consider- **ResQGARD**

(wgt > 25 pounds)

**Minim um Systolic BP by Age**

|  |  |  |
| --- | --- | --- |
| **HISTORY*** < 16 years of age
* Blood loss
* Fluid loss Vomiting Diarrhea
* Infection
 | **SIGNS / SYMPTOMS*** Restlessness, confusion, weakness
* Dizziness
* Increased HR, rapid pulse
* Decreased BP
* Pale, cool, clammy skin
* Delayed capillary refill
 | **DIFFERENTIAL*** Trauma
* Infection
* Dehydration

Vomiting Diarrhea Fever* Congenital heart disease
* Medication or Toxin
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

 **YES**

**NO**

**Evidence or History of Trauma**

**Pediatric Trauma Guideline**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**Check Blood Glucose**

**Glucose < 60 Glucose > 60**

**YES**

**SBP < normal for age**

**NO**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in**

**years)**

* **y: 90 mmHg**

# TAB 5 GUIDELINE 10

**INFANT ABANDONMENT (OPERATION SAFE HAVEN)**

Dispatch may receive calls requesting evaluation of an infant **(< 30 days old)** who has been delivered by parent(s) to any fire or police station. (Pursuant to ORC 2152.3515 et. Seq., effective 03/24/2009 and local safety service entity agreement).

* EMS provider shall be dispatched to perform any evaluation or intervention necessary to protect the infant’s health or safety, and
* Transport the child to the closest appropriate hospital emergency department.

# Emergency Medical Services Workers Obligations to Whom a Child which is Less Than 30 Days Old is Delivered (ORC 2151.3515 et.seq. Effective 03/24/2009)

While acting in their official capacity an **EMS provider** (EMR, EMT, AEMT or Paramedic) on behalf of the Emergency Services Organization (as defined by 4765.01) that employs the worker or for which the worker provides services, **shall take possession** of a **child** who is seventy-two hours old or younger if that child’s **parent** has **voluntarily delivered** the child to that person without the parent expressing an intent to return for the child.

# Upon taking possession of the child, the Emergency Services Organization shall do all of the following:

1. Perform any act necessary to protect the child’s health or safety;
2. Notify EMS Dispatch that the child has been taken into possession;
3. When forms developed by the Ohio Department of Jobs and Family Service (ODJFS) are available designed to gather medical information concerning the child and the child’s parents, provide such to surrendering parent;
4. If available, offer written materials developed by ODJFS that describe services available to assist parents and newborns;
5. Only if the child appears to have a condition which reasonably indicates physical or mental abuse or neglect-attempt to identify and, if necessary, pursue the person who delivered the child;

# EMS Workers Shall Not:

1. Coerce or otherwise try to force the caregiver into revealing the identity of the child’s parents;
2. Pursue or follow the caregiver after the caregiver leaves the place at which the child was delivered;
3. Coerce or otherwise try to force the caregiver / parent not to desert the child;
4. Coerce or otherwise try to force the caregiver / parent to accept the medical information forms promulgated by the ODJFS;
5. Coerce or otherwise try to force caregiver / parent to accept materials promulgated by the ODJFS;

Items (1) and (2) above do not apply to a person who delivers or attempts to deliver a child who has suffered any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child.

# TAB 5 GUIDELINE 11

**Hypotension, Seizures, Ventricular dysrhythmias, or Mental status changes**

**Organophosphate / Nerve Agent**

**CO Poisoning**

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in**

**years)**

* **y: 90 mmHg**

**Minim um Systolic BP by Age**

**Altered Mental Status Blood Sugar < 60 mg / dl Respiratory Depression**

**Consider ALS Backup**

**Universal Patient Care**

**Appropriate Guideline**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose**0.5 Gm / Kg PO(Mental Status?) |  |
|  | **Naloxone** 0.1 mg / Kg IN (with respiratory depression) |  |

|  |  |  |
| --- | --- | --- |
|  | **NRB Mask @ 15 L O2** |  |
|  | **CPAP with PEEP @ 5 cm H2O** |  |

|  |  |  |
| --- | --- | --- |
|  | **Duodote** IM 1 – injectors (Age > 14 or > 40 Kg) |  |

**POISONING | OVERDOSE | TOXIC INGESTION**

|  |  |  |
| --- | --- | --- |
| **HISTORY*** < 16 years of age
* Ingestion or suspected ingestion of a

potentially toxic substance* Substance ingested, route, quantity
* Time of ingestion
* Reason (suicidal, accidental, criminal)
* Available medication in home
* Past medical history, medications
 | **SIGNS / SYMPTOMS*** Mental status changes
* Hypotension / Hypertension
* Decreased respiratory rate
* Tachycardia, dysrhythmias
* Seizures
 | **DIFFERENTIAL*** Tricyclic antidepressants (TCAs)
* Acetaminophen (Tylenol)
* Depressants
* Stimulants
* Anticholinergic
* Cardiac medications
* Solvents, alcohols, cleaning agents
* Insecticides (organophosphates)
 |

**Other**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

**SPECIAL CONSIDERATIONS:**

1. General:
	1. Improve the care of patients with poisonings, and environmental/biochemical terrorism exposures in the pre-hospital setting. Provide for the most timely and appropriate level of care to the patient, including the decision to transport or treat on the scene
	2. If no immediate life threat or need for transport is identified, EMS personnel may conference the patient/caller with the Poison Center Specialist at the **Poison Control Center at 800-222-1222**.
		1. The Poison Center Specialist at the State Poison Center will evaluate the exposure and make recommendations regarding the need for on-site treatment and/or hospital transport in a timely manner
		2. If the patient is determined to need EMS transport, the poison control center Specialist will contact the receiving hospital and provide information regarding the poisoning, including treatment recommendations. EMS may contact medical control for further instructions or to discuss transport options.
		3. If the patient is determined not to require EMS transport, personnel will give the phone number of the patient/caller to the Poison Control Center Specialist. The Specialist will initiate a minimum of one follow-up call to the patient/caller to determine the status of patient.
		4. Minimal information that should be obtained from the patient for the state poison center includes:

|  |  |
| --- | --- |
| Name and age of patient | Substance(s) involved |
| Time of exposure | Any treatment given |
| Signs and symptoms |  |

* + 1. Minimal information which should be provided to the State Poison Center for mass poisonings, including biochemical terrorism and HazMat, includes:

|  |  |
| --- | --- |
| Substance(s) involved | Time exposure |
| Signs and symptoms | Any treatment given |

* 1. Do not induce vomiting for

|  |  |  |
| --- | --- | --- |
| * Hydrocarbons
 |  | * Strong Acids  Strong Base Iodides
 |
| * Silver Nitrate
1. Do not neutralize acids w
2. Product labels and home
 |  | * Strychnine  Who are not alert ith alkali or Do not neutralize alkali with acids

kits may be misleading and dangerous |

1. All empty containers of ingested material should accompany patient to the hospital
2. Do not rely on patient history of ingestion, especially in suicide attempts
3. Overdose / Ingestion concerns:
	1. **Acetaminophen** – Initial presentation normal or nausea/vomiting. If not detected and treated, will cause irreversible liver failure
	2. **Anticholinergic** – increased HR, increased temperature, dilated pupils, mental status changes
	3. **Cardiac Meds** – dysrhythmias and mental status changes
	4. **Depressants** – decreased HR, decreased BP, decreased temperature, decreased respirations, non-specific pupils
	5. **Insecticides** – increased or decreased HR, increased secretions, nausea, vomiting, diarrhea, pinpoint pupils
	6. **Solvents** – nausea, vomiting, and mental status changes
	7. **Stimulants** – increased HR increased BP, increased temperature, dilated pupils, and seizures
	8. **Tricyclics** – 4 major areas of toxicity: seizures; dysrhythmias; hypotension; decreased mental status or coma; rapid progression from alert mental status to death

|  |  |
| --- | --- |
| **Condition** | **Treatment** |
| Carbon Monoxide | * Carbon monoxide is produced from a variety of sources such as vehicles, gasoline engines, camp stoves, lanterns, burning charcoal and wood, gas ranges, heating systems and poorly vented chimneys. Structural fires are another common source of CO exposure.
* Normal Carbon Monoxide Levels
	+ 1 – 2 %
* Factors which may reduce the reliability of carbon monoxide readings:
	+ Poor peripheral circulation (hypovolemia, hypotension, hypothermia).
	+ Excessive sensor motion.
	+ Fingernail polish (may be removed with finger nail polish remover).
	+ Irregular heart rhythms (atrial fibrillation, SVT, etc.).
	+ Jaundice**.**
 |

|  |  |
| --- | --- |
|  | * **Consider transport to hospital with hyperbaric chamber for potential hyper oxygen therapy. Consult with On-Line Medical Control for**

**diversion approval.** |
| Cyanide | * Any smoke inhalation victim with mental status changes should also be treated for Cyanide Poisoning if medication is available, or if known exposure to Cyanide. Any patient or firefighter that goes into cardiac arrest after exposure to smoke from a fire.
* Present history: when last well, progression of present state, prior symptoms such as increase in respirations, convulsions, coma.
* Check for bottles and read ingredient label. If patient is in an industrial setting, ask if they use Cyanide.
* Principal manifestations of poisoning with these compounds are rapid respirations, blood pressure fall, convulsions and coma; may also cause lightheadedness, vomiting, flushing, headache, drowsiness, hypotension, rapid pulse and unconsciousness.
* Check for odor of “BITTER ALMONDS”.
 |
| Hydrofluoric Acid | * EMT should continue the therapy initiated by previous EMS providers in

regards to dermal or inhalation therapy of Calcium Gluconate. |
| Nerve Agent Exposure / Organophosphate Poisoning | * Mild symptoms:
	+ 1 Duodote
* Moderate: Unable to ambulate but still conscious
	+ 1 Duodote
* Severe: Unconscious / seizures
	+ 3 Duodote

**Do not administer more than three (3) DuoDote Auto-Injectors or three (3) Mark 1 Kits** unless definitive medical care is available. The limit of 3 doses is specific to the pralidoxime component of the DuoDote and Mark 1 Kit. **If necessary, additional doses of atropine can be administered if the 3 doses of****DuoDote or Mark 1 Kit injections do not produce an adequate response.** |

# TAB 5 GUIDELINE 12 POISONING | OVERDOSE | OPIATE

**Minim um Systolic BP by Age**

|  |  |  |
| --- | --- | --- |
| **HISTORY*** What type of ingestion
* When did ingestion occur
* How Much
* Reason for ingestion
* Actions of bystanders
* Previous psychiatric disorders
* Diseases / Medications: ie depressants
* Medical alert tags
 | **SIGNS / SYMPTOMS*** Increased salivation
* Soot or burns in mouth
* Irritation of the eyes
* Sweating and skin burns
* Decreased respiratory rate
* Lung findings (ie edema)
* Delayed capillary refill
* Tachycardia / Arrhythmias
* Seizures
 | **ENVIRONMENT*** Acetaminophen
* Anticholinergic
* Aspirin
* Cardiac medications
* Insecticides (organophosphates)
* Solvents, alcohols, cleaning agents
* Stimulants
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
| **Exposure control**(PPE = Non-Porous Gloves / EyeProtection / N95 Mask / Gown) |
| **Ensure crew safety Avoid evidence tampering** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**Respiratory Rate < 12**

 **YES NO**

|  |  |  |
| --- | --- | --- |
|  | **Check Blood Glucose** |  |

**Glucose < 60**

**Altered Mental Status Presumed Opiate Overdose Respiratory Rate < 8**

**Appropriate Guideline**

**Position of patient comfort**

|  |  |  |
| --- | --- | --- |
|  | **Apply Pulse Ox** |  |
| **Administer Oxygen for Saturation < 94%** |
| **Airway Managem ent** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose**0.5 Gm / Kg PO(Mental Status?) |  |

**Naloxone** 0.1 mg / Kg IN (administer max dose 0.5 mg / dose every 1 – minutes)

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |
| **Decontaminate Ambulance and****Equipment after Transport** |

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in**

**years)**

* **y: 90 mmHg**

# SPECIAL CONSIDERATIONS:

1. The main focus for treatment is to ensure proper respiratory and oxygen saturation status. The goal is “**NOT TO WAKE”** the patient up. Naloxone administration should be at no more than

0.5 mg aliquots every 1 – 2 minutes. While naloxone is being administered ensure that proper ventilation is being performed with bag-valve mask and oxygen

1. All suspected patients with opiate overdose should be handled using non-porous type gloves (nitrile style, non-latex) and eye protection. Consider wearing N-95 mask and gowns for any patient that has visible powder on body, or if there is visible powder in patient care area
2. Vehicle and Equipment Decontamination
	1. Any concern for opiate contamination within the vehicle or on the equipment should be cleaned using N95 mask with non-porous type gloves (nitrile style, non-latex) and eye protection
	2. Spill Clean Up Instructions
		1. Wear appropriate PPE
		2. Add one teaspoon full of powder OxiClean™ to 500 mL water
		3. Shake gently until all powder is in solution
		4. Completely cover spill with spray
		5. Within 15 minutes, scrub with a paper towel until dry (solution evaporates over time and this decreases the effectiveness of decontamination)
		6. All PPE (except goggles) and paper towels must be disposed of in a biohazardous waste bin

# TAB 5 GUIDELINE 13 PSYCHIATRIC PATIENT

**Patient Agitated / Aggressive**

**Remove patient from stressful environment**

**Consider ALS Back-Up**

**Universal Patient Care**

**Behavioral | Excited Delirium Guideline**

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Situational crisis
* Psychiatric illness / medications
* Injury to self or threats to others
* Medic alert tag
* Substance abuse / overdose
* Diabetes
 | **SIGNS / SYMPTOMS*** Anxiety, agitation, confusion
* Affect change, hallucinations
* Delusional thoughts, bizarre behavior
* Expression of suicidal / homicidal

thoughts* Poor concentration, easily distracted,

psychosis* Combative, violent
 | **DIFFERENTIAL*** See Altered Mental Status differential
* Hypoxia
* Alcohol intoxication
* Medication effect / overdose
* Withdrawal syndromes
* Depression
* Bipolar (manic-depressive)
* Schizophrenia, anxiety disorders, etc.
 |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

**NO**

**Patient having anxiety attack**

**NO**

**YES**

**Verbal techniques**

**(reassurance, calm, establish rapport)**

**Patient Depressed / Suicidal / Homicidal**

**Consider Mental Health**

**Hold (Pink Slip)**

**Rapid take-down w/ minimum**

**(4) EMS crew members (If necessary)**

**Consider Use of Restraints**

**(for patient / personnel safety)**

**Glucose < 60**

**Restraints**

* **No transport in hobble or prone position.**
* **Do not inhibit**

**patient breathing,**

**ventilations**

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose**0.5 Gm / Kg PO (Mental Status?) |  |

|  |  |  |
| --- | --- | --- |
|  | **Check Blood Glucose** |  |
|  |  |

**Minim um Systolic BP by Age**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in years)**
* **y: 90 mmHg**

# TAB 5 GUIDELINE 14 RESPIRATORY DISTRESS

**Wheezing**

**Age < 18 months with 1st wheeze**

**Pulse Oxim etry**

**Position of**

**patient comfort**

**Minimum Systolic BP by Age**

**Severe symptoms**

* Hypoxia despite O2
* Severe retractions
* Cyanosis
* Altered LOC

**Severe symptoms**

* Stridor at rest
* Severe retractions
* Cyanosis
* Altered LOC

**Albuterol** 2.5 mg nebulized (May repeat x 2)

Wgt > 10 Kg

**Respiratory Insufficiency**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** < 16 years of age
* Time of onset
* Possibility of foreign body
* Medical history
* Medications
* Fever or respiratory infection
* Other sick siblings
* History of trauma
 | **SIGNS / SYMPTOMS*** Wheezing or stridor
* Respiratory retractions
* Increased heart rate
* Altered level of consciousness
* Anxious appearance
 | **DIFFERENTIAL*** Asthma
* Aspiration
* Foreign body
* Infection
	+ Pneumonia
	+ Croup
	+ Epiglottitis
* Congenital heart disease
* Medication or toxin
* Trauma
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

YES NO

**Airway Managem ent**

|  |
| --- |
| **Wheezing****Age > 18 months or history of wheeze** |
|  |  |

**Stridor / Croup**

|  |  |  |
| --- | --- | --- |
|  | **Albuterol** 1.25 mg nebulized Wgt < 10 Kg**Albuterol** 2.5 mg nebulized(May repeat x 2) |  |
|  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in years)**
* **y: 90 mmHg**

# SPECIAL CONSIDERATIONS:

1. Do not force a child into a position. They will protect their airway by their body position.
2. Upper airway obstruction and stridor are usually due to croup, viral disease with inflammation, edema, or narrowing of the larynx, trachea or bronchioles. Croup usually affects infants and toddlers (< 2 years of age). Most children with croup present with a history of cold-type symptoms followed by the development of a barking or “seal” cough, stridor and various levels of respiratory distress. Many times, accompanied by a low-grade fever, the symptoms of croup often worsen during the night-time hours. The severity of symptoms will vary widely among patients.
3. Wheezing is the hallmark of lower airway obstruction. Decreased unequal or absent breath sounds also can occur. The respiratory rate is generally rapid (although when expiration becomes prolonged, the rate may fall). Bronchiolitis, asthma, and foreign body obstruction should be strongly considered. Bronchiolitis is a lower airway obstruction from viral illness with wheezing in the toddler or infant under the age of 2 years. Asthma or foreign body inhalation can also cause similar symptoms. Bronchiolitis may not respond to Albuterol due to lower airway swelling from the infection
4. With respiratory distress of sudden onset, think of foreign body airway aspiration. The mouth is a major sensory organ for children. The EMS provider must anticipate infants and children placing a multitude of obstructive hazards in their airway.
5. Epiglottitis typically affects children > 2 years of age. It is bacterial, with fever, rapid onset, possible stridor, patient wants to sit up to keep airway open, and drooling is common. Airway manipulation and patient agitation may lead to total airway obstruction and worsening of the patient’s condition.
6. If children with croup, Epiglottitis or laryngeal edema present in respiratory arrest, it is usually due to exhaustion or airway obstruction. Ventilation by bag-valve mask may be difficult due to airway edema. Epiglottitis and croup can become total airway obstructions very quickly.

# TAB 5 GUIDELINE 15 SEIZURE

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Age
* Fever
* Prior history of seizures
* Seizure medications
* Reported seizure activity
* History of recent head trauma
* Congenital abnormality
 | **SIGNS / SYMPTOMS*** Observed seizure activity
* Altered mental status
* Hot, dry skin or elevated body temperature
* Sleepiness
* Incontinence
* Evidence of trauma
* Unconsciousness
 | **DIFFERENTIAL*** Infection / Fever
* Head trauma
* Medication or toxin
* Hypoxia or respiratory failure
* Electrolyte abnormality (Na, Ca, Mg)
* Drugs, medications, non-compliance
* Hyperthermia / Hypoglycemia
* Metabolic abnormality / acidosis
* Tumor
 |

|  |
| --- |
| **Universal Patient Care** |
| **Consider ALS Backup** |
|  |  |

Glucose < 60

**Febrile**

Tympanic temperature measurement

**Minimum Systolic BP by Age**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Consider Spinal Immobilization** |
|  | **Airway Management** |  |
|  | **Check Blood Glucose** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose**0.5 Gm / Kg PO (Mental Status?) |  |

NO

YES

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in**

**years)**

* **y: 90 mmHg**

|  |
| --- |
| **Cooling Measures** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Cardiac Monitor /****12-Lead EKG** |  |
|  |  |

NO YES

**Contact ALS Backup**

**Active Seizure**

|  |
| --- |
| **Focused History / Physical Exam** |
| Evidence of shock or trauma ? |
| **Appropriate Guideline** |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

# SPECIAL CONSIDERATIONS:

1. If actively seizing patient is encountered, move hazardous material away from the patient. Protect the patient’s head from injury. Remember to always immediately check for pulses after seizure activity stops.
2. Trauma to the tongue during seizure activity is unlikely to cause serious problems. Attempt to force anything into the patient’s airway may cause complete obstruction.
3. If febrile, remove clothing and sponge with room temperature water. Do not delay transport for cooling measures. Removal of clothing may be all that is necessary.
4. Unlike the adult with a diagnosis of Epilepsy, a child who has had a seizure usually requires transport. Do not be falsely reassured by a child who appears to return to normal status quickly.
5. Seizures in children may not always present tonic-clonic (generalized) in nature. Unusual gaze/eye movement, unresponsiveness, or localized twitching may be the only clue. Parents or caregivers are usually very sensitive to the abnormality and potential seriousness of the child’s presentation.
6. The diagnosis of “febrile seizures” can be difficult to make in the field. Other causes must be excluded. Temperature measurements (tympanic thermometer) should be acquired with suspicion of fever.
7. **Status epilepticus** is defined as two or more successive seizures without a period of consciousness or recovery. This is a true emergency requiring rapid airway control, treatment, and transport. **Grand Mal seizures (generalized)** are associated with loss of consciousness, incontinence, and tongue trauma**. Focal seizures (petit mal)** effect only a part of the body and are not usually associated with a loss of consciousness. **Jacksonian seizures** are seizures that start as a focal seizure and become generalized.
8. If evidence or suspicion of trauma, full c-spine immobilization is required.

# TAB 5 GUIDELINE 16 SUSPECTED ABUSE | NEGLECT

**To Be Transported to**

**Trauma Center**

**Minim um Systolic BP by Age**

|  |
| --- |
| **Universal Patient Care** |
| **Ensure scene safety and offender is not****near the victim** |
|  |  |

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |
| --- |
| **Consider Spinal Immobilization** |
|  | **Airway Managem ent** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Events leading up to call
* Has individual gone to the bathroom,

showered* History of trauma
 | **SIGNS / SYMPTOMS*** Bruising to extremities
* Vaginal injury
* Withdrawal from caregiver / EMS provder
 | **DIFFERENTIAL*** Sexual abuse
* Neglect
* Traumatic injuries
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Provide appropriate emergency medical treatment for all injuries found** |  |  |
|  | **Be calm and assuring with****sensitivity toward the patient** |  |
|  | **DO NOT make unnecessary****physical contact with the patient** |  |
|  |  |
|  |

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in**

**years)**

* **y: 90 mmHg**

**Assess for signs of neglect**

**Assess for physical abuse**

**Assess for psychological**

**characteristics of abuse**

**Make Patient NPO**

**Concern to Physical Abuse**

**Don t allow patient to change**

**clothes or wash**

**Discourage patient going to bathroom**

**Make Patient NPO**

**Concern to Sexual Abuse**

|  |  |  |
| --- | --- | --- |
|  | **Document careful physical exam and any comments made by victim , family, bystanders** |  |
|  |  |

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility,****severely injured patients should be****transported to trauma center** |
| **Report suspected case of child abuse, neglect or exploitation to Children Services (855-642-4453)** |

**Stabbing Choking Electrocution Burn**

# SPECIAL CONSIDERATIONS:

1. Reporting concern of abuse, neglect or exploitation
	1. Per Ohio Revised Codes (ORC) 2151.421 and 5101.61 EMS and Fire personnel are **REQUIRED** to report abuse, neglect or exploitation of adult (elderly) or child (under the age of 18)
	2. Report suspected child abuse, neglect or exploitation to Ohio’s Public Children Service Agencies for your respective county or free hotline at 855-642-4453
	3. Report suspected elderly abuse, neglect or exploitation to Ohio’s Adult Protective Services for your respective county or free hotline at 855-644-6277
2. If possible, have a witness the same gender as the victim present at all times
3. Wrap a plastic sheet around the victim if possible
4. DO NOT inspect genitals unless evidence of uncontrolled hemorrhage, trauma, or severe pain is present
5. DO NOT allow patient to shower or douche
6. Collect patient’s clothing when possible
	1. Place clothing in plastic sheet or separate plastic/paper bags with ID labels and found location
	2. Leave all sheets placed in plastic/paper bag with patient at facility
	3. Notify all staff of clothing samples

# TAB 5 GUIDELINE 17 VOMITING AND DIARRHEA

**Make NPO**

**Consider ALS Backup**

**Universal Patient Care**

|  |
| --- |
| **LEGEND** |
|  | **EMR** |  |
|  | **EMT** |  |
|  | **A-EMT** |  |
|  | **EMT-P** |  |
|  | **MC Order** |  |

|  |  |  |
| --- | --- | --- |
| **HISTORY*** Age < 16
* Time of last meal
* Last bowel movement/emesis
* Improvement or worsening with food or activity
* Duration of problem
* Other sick contacts
* Past medical history
* Medications
* Menstrual history (pregnancy)
* Travel history
* Bloody emesis / diarrhea
 | **SIGNS / SYMPTOMS*** Pain
* Character of pain
* Distention
* Constipation
* Diarrhea
* Anorexia
* Radiation

**Associated symptoms:****(Helpful to localize source)**Fever, headache, blurred vision, weakness, malaise, cough, headache, dysuria, mental status changes, rash | **DIFFERENTIAL*** CNS
* Myocardial infarction
* Drugs (NSAID's, antibiotics, narcotics,

chemotherapy)* GI or renal disorders
* Diabetic ketoacidosis
* Gynecologic disease
* Infections (pneumonia, influenza)
* Electrolyte abnormalities
* food or toxin induced
* Medication or substance abuse
* Pregnancy
* Psychological
 |

**Place Supine Position Contact ALS Backup**

**Hypotension**

* **< 1 mo: 60 mmHg**
* **1 mo to 10 y: 70 + (2 × age in**

**years)**

* **y: 90 mmHg**

|  |  |  |
| --- | --- | --- |
|  | **Contact Medical Control** |  |
| **Transport to appropriate facility** |

**SPECIAL CONSIDERATIONS:**

**Glucose < 60**

**Check Blood Glucose**

**Minimum Systolic BP by Age**

|  |  |  |
| --- | --- | --- |
|  | **Oral Glucose**0.5 Gm / Kg PO(Mental Status?) |  |

1. Complete assessment and physical exam including evaluation of mental status, skin, HEENT, neck, heart, lungs, abdomen, back, extremities and neuro.
2. Frequent re-assessments are needed to monitor vascular status.

# TAB 5 GUIDELINE 18

**CHILDREN WITH SPECIAL HEALTHCARE NEEDS**

1. EMS providers are encouraged to know which children in a given area have special needs and to keep a logbook for potential problems related to these children.
	* This will allow for easier reference and treatment for the patient.
2. Parents and caretakers are usually trained in emergency management and can be of assistance to EMS personnel. Listen carefully to the caregiver and follow his / her guidance regarding the child’s treatment.
3. Treat the ABC’s first. Treat the child, not the equipment. If the emergency is due to an equipment malfunction, manage the child appropriately using your own equipment.
4. Children formerly cared for in hospitals or chronic care facilities are often cared for in homes by parents or other caretakers. These children may have self-limiting or chronic diseases.
	* There are multitudes of underlying medical conditions that may categorize children as having special needs.
	* Many are often unstable and may frequently involve the EMS system for evaluation, stabilization, and transport.
	* Special needs children include technology-assisted children such as those with tracheostomy tubes with or without assisted ventilation, children with gastrostomy tubes, and children with indwelling central lines. The most serious complications are related to tracheostomy problems.
5. Children with Special Healthcare Needs (CSHCN) have many allergies.
	* Children with spina bifida are often allergic to latex. Before treating a patient, ask the caregivers if the children are allergic to latex or have any other allergies. Stock latex-free equipment. (Some regularly used equipment that contains latex includes gloves, oxygen masks, IV tubing BVM, blood pressure cuff, IV catheters, etc.)
6. Children with chronic illnesses often have different physical development from well children.
	* Their baseline vital signs may differ from normal standards. Ask the caregiver if the child normally has abnormal vital signs. (i.e. a fast heart rate or a low pulse oximeter reading)
	* The size and developmental level may be different from age-based norms and length based tapes used to calculate drug dosages.
7. Some CSHCN may have sensory deficits (i.e. they may be hearing impaired or blind) yet may have age-appropriate cognitive abilities. Follow the caregivers’ lead in talking to and comforting a child during treatment and transport. Do not assume that a CSHCN is developmentally delayed.
8. When moving a special needs child, a slow careful transfer with two or more people is preferable. Do not try to straighten or unnecessarily manipulate contracted extremities as it may cause injury or pain to the child. Certain medical conditions will require special care. Again, consult the child’s caregiver.
9. Caregivers of CSHCN often carry “go bags” or diaper bags that contain supplies to use with the child’s medical technologies and additional equipment such as extra tracheostomy tubes, adapters for feeding tubes, suction catheters, etc. Before leaving the scene, ask the caregivers if they have a “go bag” and carry it with you.
10. Caregivers may also carry a brief medical information form or card. The child may be enrolled in a medical alert program whereby emergency personnel can get quick access to the child’s medical history. Ask the caregivers if they have an emergency information form or some other form of medical information for their child.
11. Caregivers of CSHCN often prefer that their child be transported to the hospital where the child is regularly followed or the “home” hospital. When making the decision as to where to transport a CSHCN, take into account: local protocols, the child’s condition, capabilities of the local hospital, caregivers’ request, ability to transport to certain locations.