



EMS Protocols

Universal

- 4 Airway
- 6 Breathing (Hypoxia)
- 8 Circulation (Shock)
- 10 Hypertension
- 12 Bradycardia
- 14 Tachycardia
- 16 Fever
- 18 Hyperkalemia
- 20 Pain
- 22 Nausea/Vomiting

Medical

- 24 Medical CODE
- 26 Medical ROSC
- 28 Chest Pain
- 30 Dyspnea (SOB)
- 32 Allergic Reaction
- 34 Abdominal Pain
- 36 Altered LOC/Syncope
- 38 Diabetic
- 40 Overdose / Tox
- 42 Seizure
- 44 Stroke
- 46 Psychiatric
- 48 Pregnancy / Delivery
- 50 Neonate

Trauma

- 52 Trauma CODE
- 54 Trauma ROSC
- 56 Major Trauma
- 58 Bleeding
- 60 Immobilization
- 62 Head Injury
- 64 Trunk Injury
- 66 Extremity Injury
- 68 Crush Injury
- 70 Cold / Heat
- 72 Burns
- 74 Inhalation
- 76 Sting / Bite
- 78 Epistaxis

Misc

- 1 How To Use
- 79 Procedures
- 89 Deliver Baby
- 90 Policies
- 94 Termination
- 97 Refusals
- 98 Destination Triage

A Peds Dosing

B Index

Welcome to the EMS Protocols 2019!

- Think of this like a **tool box**, not a **cookbook**.
- You should **use several protocols** at the same time on every call.
- You may use any intervention marked for your level or lower.

Basic procedures are assumed for every call.

- Don't forget: scene safe, BSI, ABC's, call for **ALS**, notify the ED, etc.
- Every patient should have a full assessment including vitals.
- Ask about medical allergies and pregnancy before giving meds.

Call for on-line **Medical Direction** at any time for advice on:

- Any questions, problems, or if uncertain for any reason.
- Getting permission to **deviate** from these protocols.
- If unable to contact, remember: **Get the patient to the hospital.**

Protocols mean you **can**, but not always that you **should**.

- Use only enough to stabilize and/or improve. Don't follow blindly.
- Skip anything unnecessary. Not every box needs to be completed.
- The listed **order suggests importance**, but is not absolute.

Severity is a **subjective judgment** that requires thought.

- Not all decisions are black and white. Use this text as a guide.
- **Reassess and restart** protocols as needed during a call.
- Use good clinical sense to decide what takes precedence.

Presume routine things when appropriate, like:

- SpO₂, EKG, EtCO₂, glucometer, phlebotomy, etc.
- Regular layperson first aid treatments like splinting and band-aids.
- Note: protocols may also include reminders (like "12-Lead").

Pediatric considerations are **included** in every protocol.

- Patients 13 y/o and over (13 +) are generally treated as **adults**.
- Children (1-12) and Infants (< 1) are considered **peds**.
- Refer to Appendix A or other approved source for peds dosing.

References are included. This text is not comprehensive.

- Medication names may appear as **brand** or **generic** (or both).
- Always consider child or elder abuse. EMS are mandated reporters.

Please e-mail corrections to: western@vaems.org

EMS Protocols 2019

Protocols, Procedures, Policies and Medications
of the Western VA EMS Medical Direction Committee

Editors: Drs. Ekey, LePera, and Stanley



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WVEMS Council
1944 Peters Creek Rd.
Roanoke, VA 24017

Phone: 540-562-3482
Web: www.western.vaems.org
Email: western@vaems.org

Protocol Flow and Intervention Symbols

Indications

Use
Judgment

Don't
Forget

Important
Note

Concept
• And Details

WARNING

Basic Life Support (**BLS**)

EMR

E

EMT

A

AEMT

Advanced Life Support (**ALS**)

I

Intermediate

P

Paramedic

Also called: Choking, Suction, Oral Airway, BIAD

Imperatives

- Maintain the simplest effective airway. **Escalate only as needed.**
- If BIAD fails, **try again with a different size.**
 - Most common failure of a BIAD is inappropriate size.
- Use several techniques to confirm airway:
 - Physical exam: lung sounds, skin color, etc.
 - Rising SpO₂
 - Appropriate EtCO₂: capnography or capnometry
- Be prepared to escalate airway if signs of **Poor Perfusion.**

Poor Perfusion

- Suspect if **several** of these:
 - **Altered Mental Status**
 - Skin Pale, Cool, Diaphoretic
 - Tachycardia, Hypotension
 - Dyspnea, Tachypnea

Notes

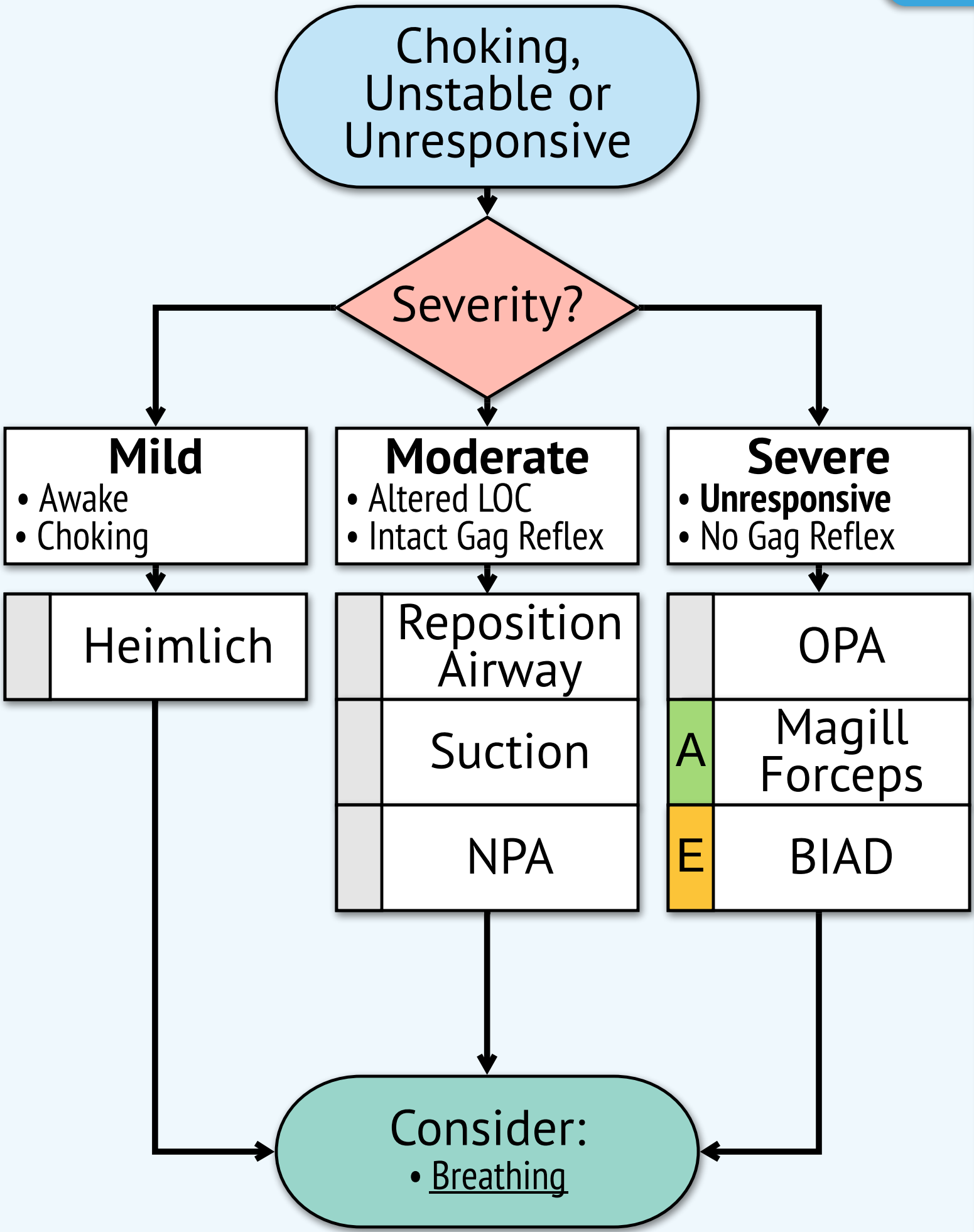
- If BIAD accommodates an OG-Tube, consider placing an OG-Tube.
- Secure BIAD well. Use tape or manufactured holding device.
 - May place c-collar (even without trauma) to help stabilize.
- Reposition with: Head Tilt / Chin Lift (med) or Jaw Thrust (trauma)
- Endotracheal intubation is not included in this protocol.

Pediatrics

- Suspect an airway obstruction. Use back blows if indicated.
- Do not use blind finger sweeps.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
 - Brady Emergency Care 12th Ed: Chapter 8



Also called: Oxygenation, O₂, Pneumothorax (PTX), PE

Imperatives

- Dyspnea with **penetrating trauma** is a **severe** problem.
 - Apply a chest seal to any penetrating injury to neck or trunk.
 - Do not wait for hypoxia to develop.
- Spontaneous or traumatic **PTX** can be a **severe** problem.
 - Needle Decompress for Hypotension or persistent hypoxia.
- CPAP requires a patient that is awake and compliant.
 - Contraindicated with vomiting, hypotension or altered LOC.
- BVM: Use two providers and two handed technique if able.
 - Maintain EtCO₂ 35-45 mmHg. Avoid hyperventilation.
 - During CPR: alternate **30 : 2** until BIAD placed.

BVM Rate

- Adult / Peds: **Q 6 sec** (10/min)

Notes

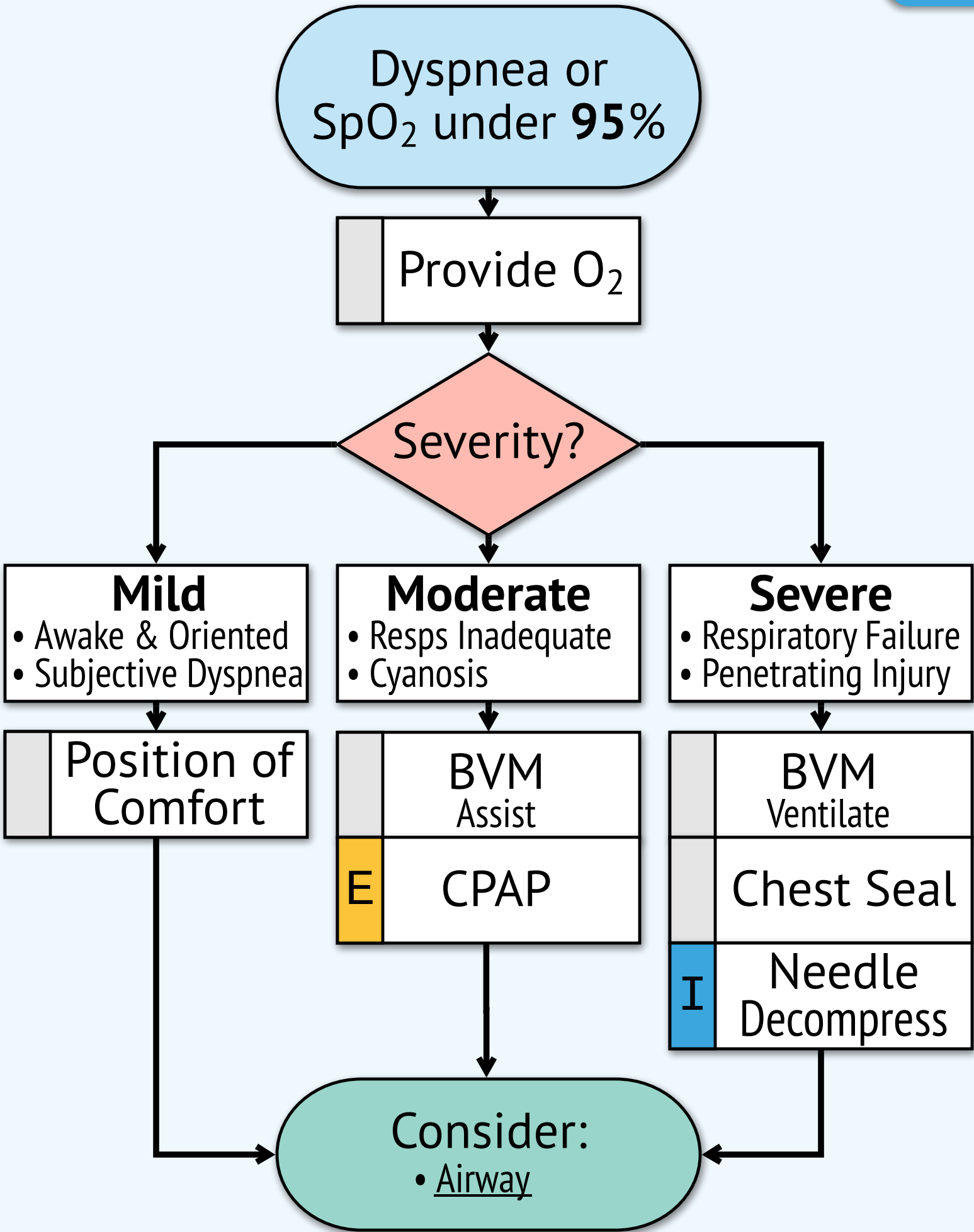
- Provide O₂ at appropriate doses. Titrate for effect.
 - Nasal Cannula (NC): 1 - 6 L/min
 - Non-Rebreather (NRB): 10 - 15 L/min
- Consider **reducing** supplemental O₂ if SpO₂ rises above 98%.
 - Hyperoxia can make some conditions worse.
- If SpO₂ unavailable or machine fails: use good clinical judgment.

Pediatrics

- Refer to Neonate for any peds **under 1 month** (< 31 days) old.
- Use caution to prevent barotrauma from BVM.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
 - Brady Emergency Care 12th Ed: Chapter 9



Also called: Hypotension

Imperatives

- Consider underlying causes:
 - Bradycardia, Tachycardia
 - Cardiac, Anaphylaxis
 - Diabetic, Overdose
 - Major Trauma, Exposure

Poor Perfusion

- Suspect if **several** of these:
 - **Altered Mental Status**
 - Skin Pale, Cool, Diaphoretic
 - Tachycardia, Hypotension
 - Dyspnea, Tachypnea

Medications

- **NS Bolus** (saline 0.9%): indicated for **poor perfusion**.
 - May call **Medical Control** for more fluids after initial boluses.
- **Epi Drip** (epinephrine): Mix and use as follows:
 - Add 1 mg Epi into a 1,000 mL bag of NS (1 mcg/mL).
 - Adults (13+): Use a macro drip (10 or 15 per mL) set.
 - Peds (0-12): Use a micro drip (60 per mL) set.
 - Start at 1 drop per second and **titrate as needed**.
- **Dopamine**: Most useful for medical causes refractory to Epi.
 - May titrate **up to 4x starting dose** if needed.

Notes

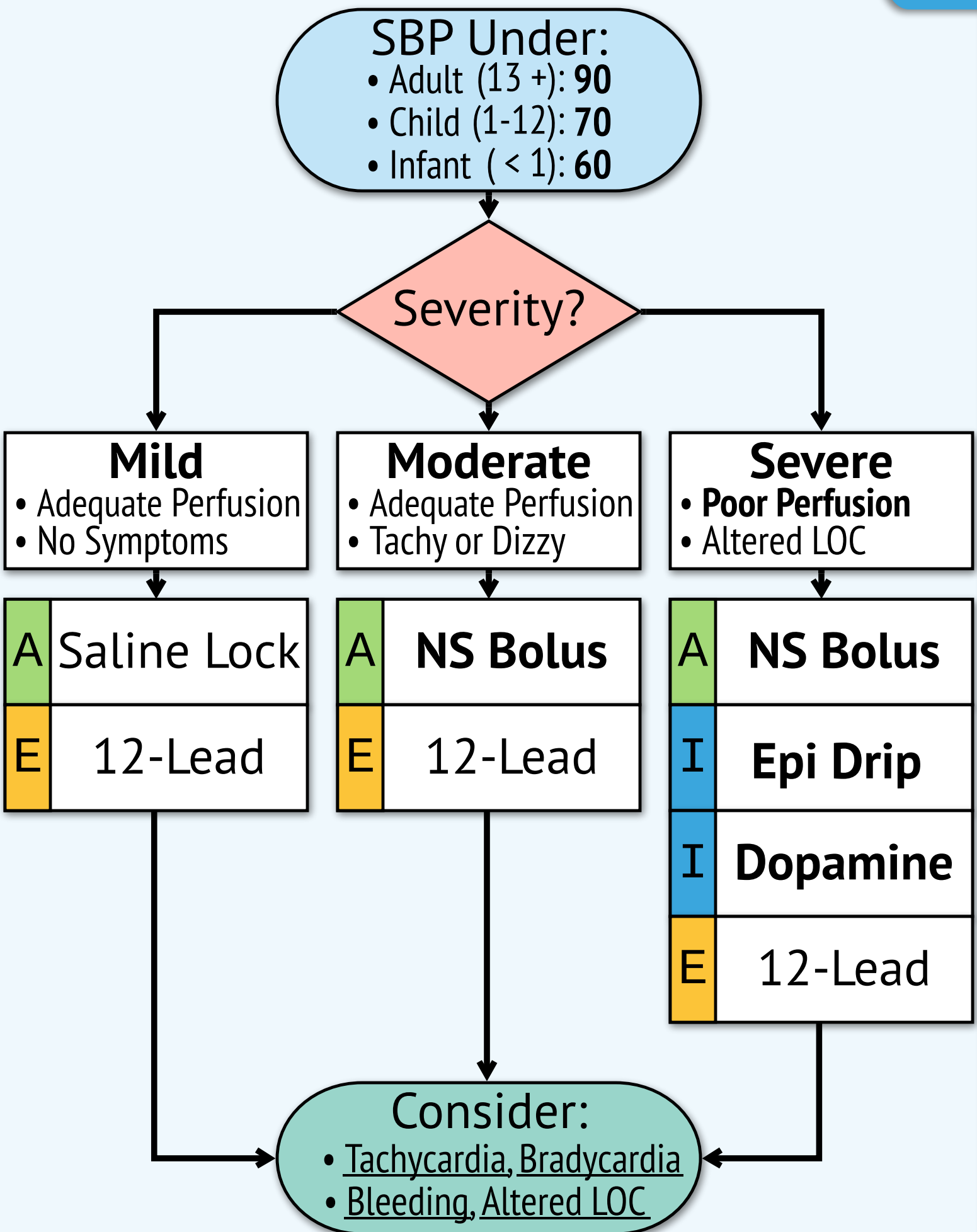
- Give fluids and reassess. Start pressors if poor response.
- Recheck lung sounds before and after fluid administration.

Pediatrics

- The majority of peds decompensation is airway related.
- Fluids are important for hypotension. Pressors are a last resort.
- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape Vitals: emedicine.medscape.com/article/2172054
 - Brady Emergency Care 12th Ed: Chapters 18, 20, 27

**NS Bolus: 1,000 mL**

IV/IO x2

Epi Drip: 1 gtt/s

IV/IO Titrated Drip

Dopamine: 5 mcg/kg/min

IV/IO Titrated Drip

**Adult
Doses**

Also called: HTN, Elevated BP, Malignant Hypertension

Imperatives

- Confirm elevated SBP with two reliable blood pressures.
- HTN is a frequent reaction to Pain and acute stress.
 - Investigate and **treat pain** and underlying causes first.
 - **Inappropriate** use of anti-HTN meds can **cause harm**.

Medications

- **Labetalol**: Aim for 20% reduction in SBP. Do not exceed 25%.
 - Contraindicated if SBP under 190 mmHg.
 - Call **Medical Control** if SBP remains elevated after two doses.
 - Try lower dose first, then double if second dose needed.

Notes

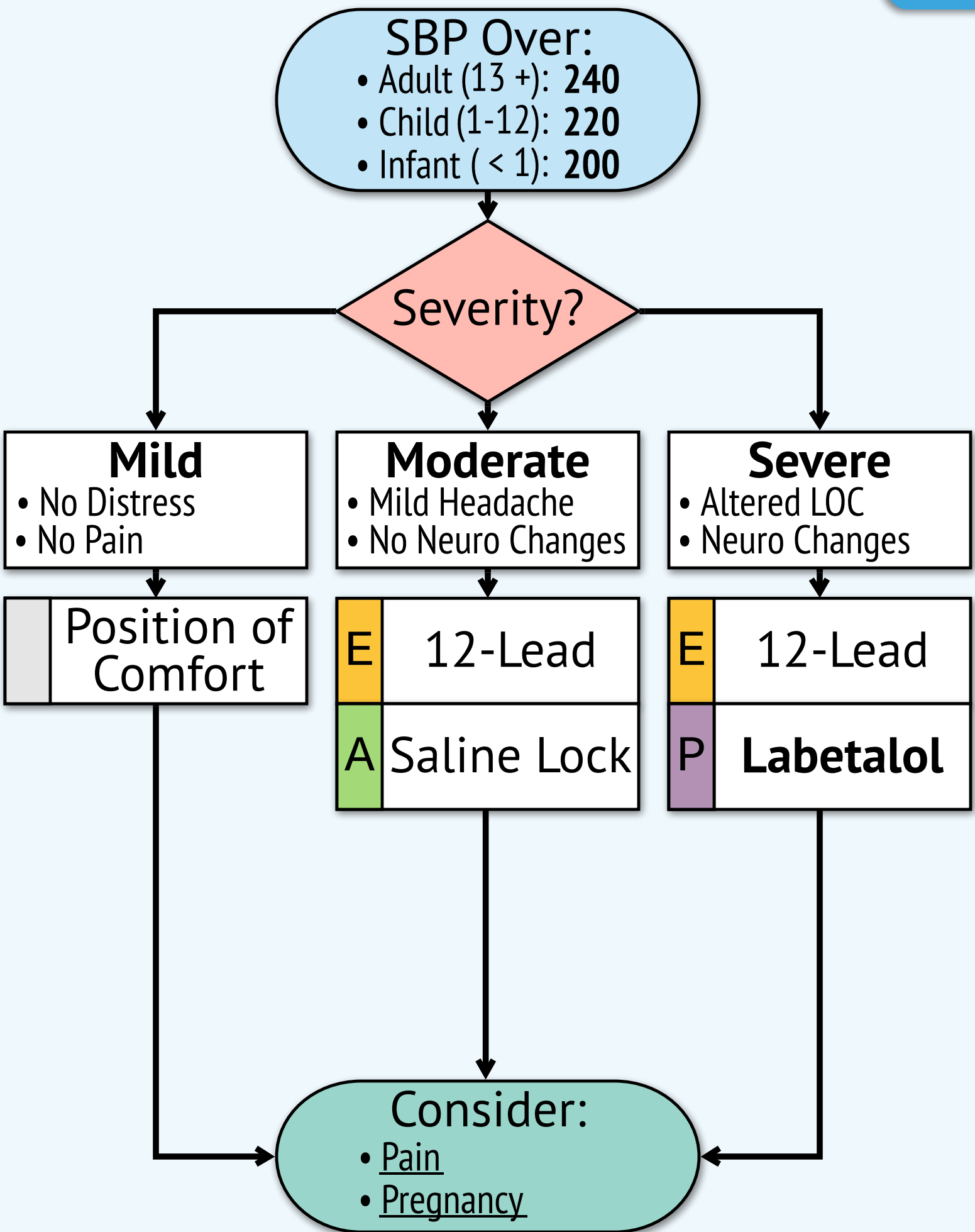
- **Severe neurologic changes** include:
 - Obvious weakness, paralysis, seizure, etc.
 - Severe headache and vomiting
 - Vision **loss** (not simple flashes or double vision)

Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape Vitals: emedicine.medscape.com/article/2172054
- Medscape Peds HTN: emedicine.medscape.com/article/889877
- NIH NHLBI: www.nhlbi.nih.gov/files/docs/resources/heart/hbp_ped.pdf
 - Brady Emergency Care 12th Ed: Chapter 12, 20



Labetalol: 10 ► 20 mg IV/IO Q 10 min x2

Adult

Also called: Slow Heart Rate, Heart Block

Imperatives

- Slow, wide complex bradycardia may be due to Hyperkalemia.
- Consider Overdose if clinically suspected.
 - Several common meds can produce bradycardia.

Poor Perfusion

- Suspect if **several** of these:
 - **Altered Mental Status**
 - Skin Pale, Cool, Diaphoretic
 - Hypotension
 - Dyspnea, Tachypnea

Medications

- **Atropine**: may not be effective (but is also not harmful) for:
 - 3° Heart Block, Heart Transplant
- **Epi** (epinephrine): Preferred agent over **Atropine** in peds.
 - Use Epi (brady) dosing from Appendix A.

Notes

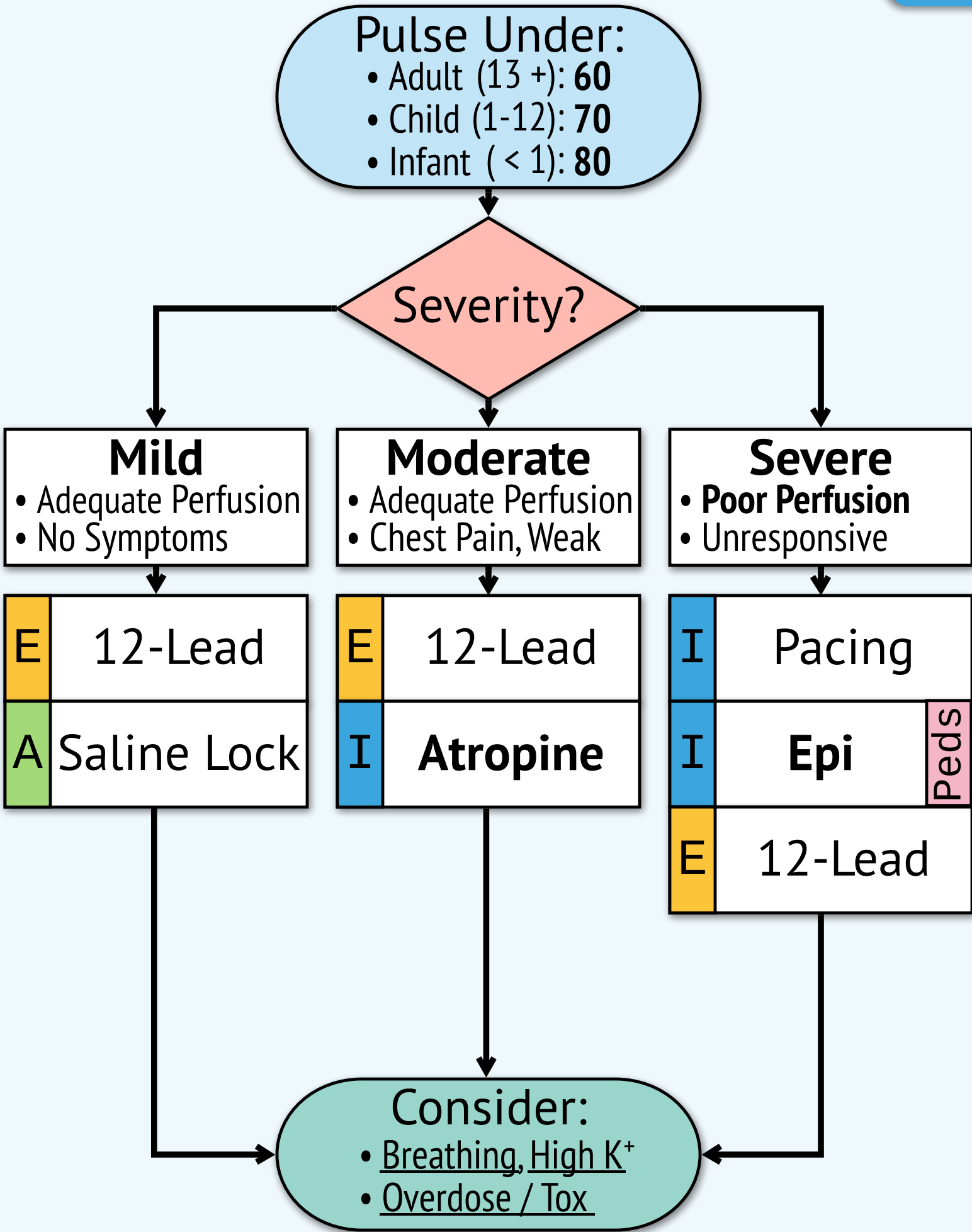
- Pacing: Start at **80 bpm / 80 mA**. Escalate mA as needed.
 - Alternate: follow manufacturer's or OMD's dosing guideline.

Pediatrics

- Refer to Neonate for any peds **under 1 month** (< 31 days) old.
- Frequently a Breathing problem: don't forget O₂.
- Even a single pill of some meds can cause severe bradycardia.
 - Consider opiate, Ca²⁺ or β blocker Overdose.
- Consider effects of maternal medication in breast milk.
- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape Vitals: emedicine.medscape.com/article/2172054
 - Brady Emergency Care 12th Ed: Chapter 20



Atropine: 0.5 mg	IV/IO Q 5 min x3	Adult
Epi: see Appendix A	IV/IO Q 5 min	

Also called: Sinus Tach, SVT, A-Fib, A-Flutter, RVR, V-Tach

Imperatives

- Must distinguish a simple tachycardia from a critical arrhythmia.
- **Simple tachycardias** (like Sinus Tach) occur for many reasons.
 - Reactive causes like: Shock, Pain, Fever or Bleeding, etc.
 - Hidden causes like: OD / Tox, Psychiatric or Anaphylaxis, etc.
 - Cardiac causes like: A-Flutter or A-Fib w/ RVR, etc.
 - Treat the cause. Avoid anti-arrhythmics or cardioversion.
- **Critical arrhythmias** (like SVT or V-Tach w/ pulse) are much faster.
 - A fast pulse is not always critical. Judgment is necessary.
 - ALS: Vagal Maneuvers may be attempted.

Critical Arrhythmia

- Suspect if pulse over:
 - Adult (13 +): **150**
 - Child (1-12): **180**
 - Infant (< 1): **220**

Poor Perfusion

- Suspect if **several** of these:
 - **Altered Mental Status**
 - Skin Pale, Cool, Diaphoretic
 - Tachycardia, Hypotension
 - Dyspnea, Tachypnea

Medications

- **Adenosine**: Give rapid IV push. Escalate for second dose.
- **Amiodarone**: Give over 10 min IV drip.

Notes

- Cardioversion: Enable **SYNC**. Start at **50 J**. Escalate as needed.
 - Alternate: follow manufacturer's or OMD's dosing guideline.

Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape Vitals: emedicine.medscape.com/article/2172054
 - Brady Emergency Care 12th Ed: Chapter 14

Pulse Over:

- Adult (13 +): **100**
- Child (1-12): **130**
- Infant (< 1): **160**

Severity?

Mild

- Adequate Perfusion
- Simple Tachycardia

E 12-Lead

A NS Bolus

Moderate

- Adequate Perfusion
- **Critical** Arrhythmia

E 12-Lead

A NS Bolus

I **Adenosine**
If QRS ≤ 120ms

I **Amiodarone**
If QRS > 120ms

Severe

- **Poor Perfusion**
- **Critical** Arrhythmia

I Cardioversion

E 12-Lead

I **Magnesium**
If Torsades

A NS Bolus

Consider:

- Circulation, Pain
- Fever, Bleeding

NS Bolus: 1,000 mL IV/IO x1

Adenosine: 6 ► 12 mg IV/IO Q 5 min x2

Amiodarone: 150 mg IV/IO over 10 min

Magnesium: 2 g IV/IO x1

**Adult
Doses**

Also called: Sepsis, Toxic Infection, Flu

Imperatives

- Use an appropriate mask for any cough or respiratory disease.
- Fever is a response to an infection.
 - Hyperthermia caused by environment or drugs is different.
 - Fever medications are contraindicated in Hyperthermia.
- Aggressive EMS fluid for sepsis without Shock is unnecessary.

Medications

- **Tylenol** (acetaminophen): contraindicated with liver disease
- **Ibuprofen** (Motrin): contraindicated with GI bleeding or ulcers

Poor Perfusion

- Suspect if **several** of these:
 - **Altered Mental Status**
 - Skin Pale, Cool, Diaphoretic
 - Tachycardia, Hypotension
 - Dyspnea, Tachypnea

Notes

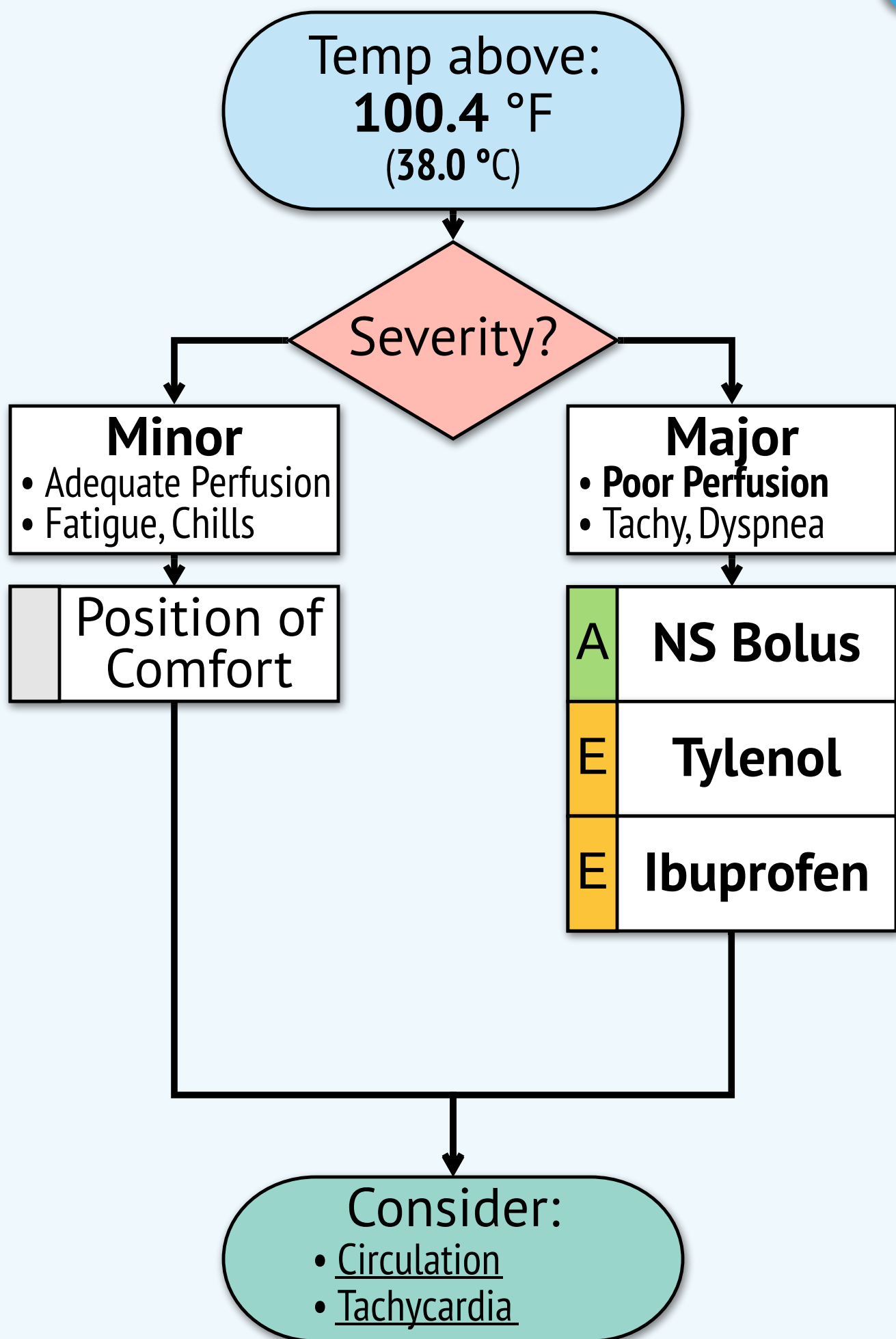
- Temporal thermometers are inaccurate on sweaty skin.
- Oral thermometers are inaccurate after PO fluids or while talking.

Pediatrics

- Peds under 5 y/o may have a Seizure caused by fever.
 - It is usually self limiting and does not require intervention.
 - Consider intervention if longer than 5 min or Seizure reoccurs.
- Breaking tablets in half is appropriate. Do not break capsules.
- Withhold medications if unable to provide accurate dose.
- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape Vitals: emedicine.medscape.com/article/2172054
 - Brady Emergency Care 12th Ed: Chapter 14



Tylenol: 500 mg	PO	Q 15 min x2	Adult Doses
Ibuprofen: 400 mg	PO	Q 15 min x2	
NS Bolus: 1,000 mL	IV/IO	x1	

Also called: Renal Failure, High K⁺, Elevated Potassium

Imperatives

- Be aggressive with treatment if there are EKG changes.
 - Elevated potassium can be very dangerous.
- Don't delay transport to wait for EKG interpretation.

K⁺ EKG Changes

- From minor to life threat:
 - Peaked T-waves
 - Long PRI / Loss of P-wave
 - Wide QRS (Over 120 ms)
 - Slow V-Tach (Sine Wave)

Medications

- **Albuterol** (Ventolin): May give without an EKG if hyperkalemic.
- **NS Bolus** (saline 0.9%): Aggressive fluids help dilute potassium.
 - Consider aggressive fluids even without Hypotension.
- **Calcium**: Avoid if the patient is taking digoxin (Lanoxin).
 - Do not mix with **Bicarbonate**. Flush line between meds.

Notes

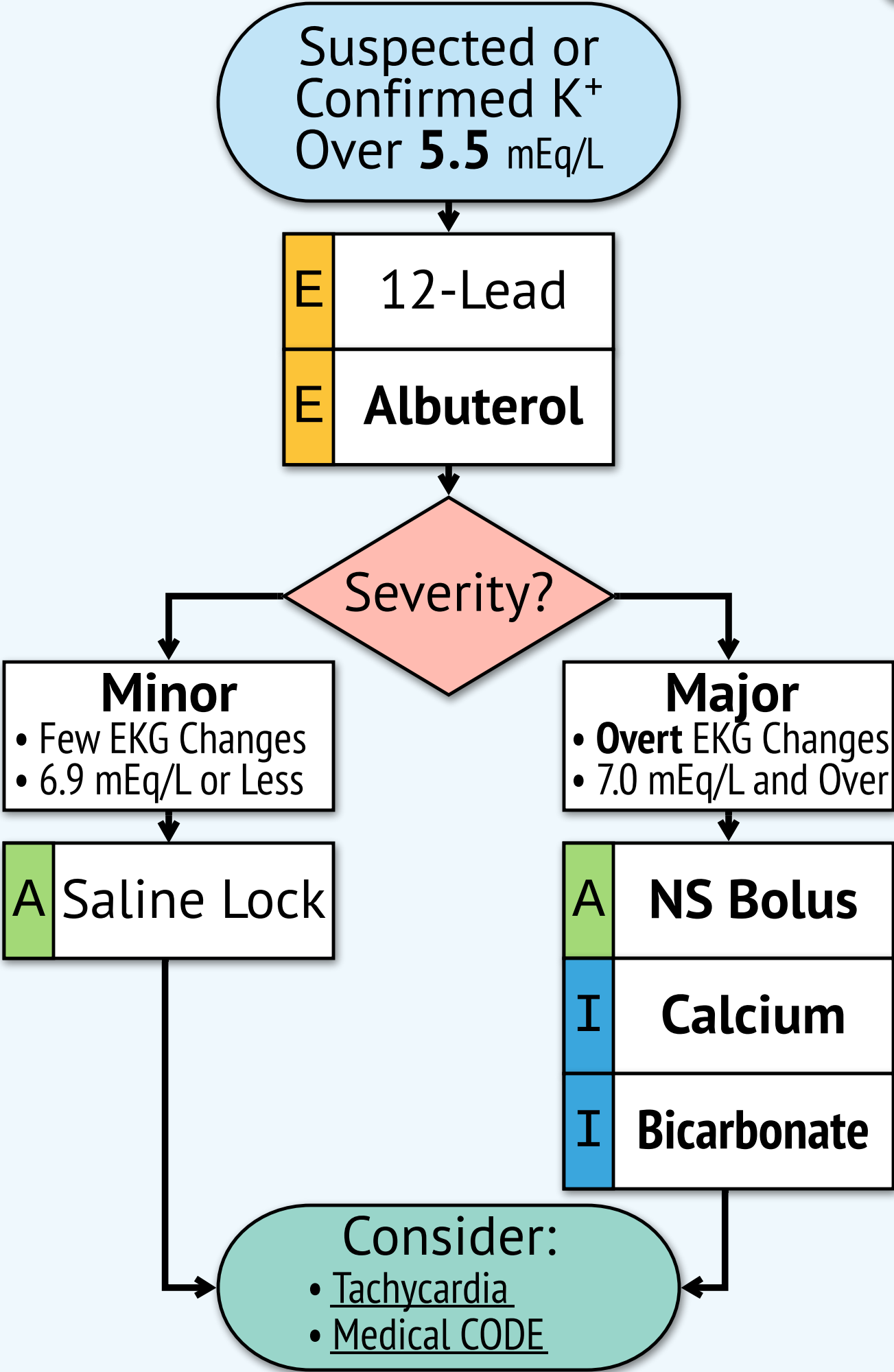
- Consider hyperkalemia in a **dialysis** or renal failure patient.
 - If called to a dialysis center, inquire about the last K⁺ level.
 - Avoid starting an IV in the same extremity as dialysis access.
- Consider hyperkalemia during Crush or suspension injury.

Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape Hyperkalemia: emedicine.medscape.com/article/240903
 - Brady Emergency Care 12th Ed: Chapter 26



Albuterol: 10 mg	NEB	(4 Nebes) x1	Adult Doses
NS Bolus: 1,000 mL	IV/IO	x2	
Calcium: 1 g	IV/IO	x1	
Bicarbonate: 50 mEq	IV/IO	x1	

Also called: Backache, Toothache, Migraine, Fibromyalgia

Imperatives

- EMS pain control is indicated for recent injury or sudden pain:
 - Major Trauma, Obvious Fractures
 - Sudden Abdominal or Chest Pain
- PO pain meds are of limited use during short transports.
 - Consider **deferring** PO meds for mild/moderate pain to the ED.

Medications

- **Tylenol** (acetaminophen): contraindicated with liver disease
- **Ibuprofen** (Motrin): contraindicated with GI bleeding or ulcers
- **Fentanyl**: contraindicated for subacute or chronic pain like:
 - Toothache, Headache (Migraine), Sciatica, Fibromyalgia, etc.
- **Ketamine**: contraindicated for subacute or chronic pain like:
 - Toothache, Headache (Migraine), Sciatica, Fibromyalgia, etc.

Notes

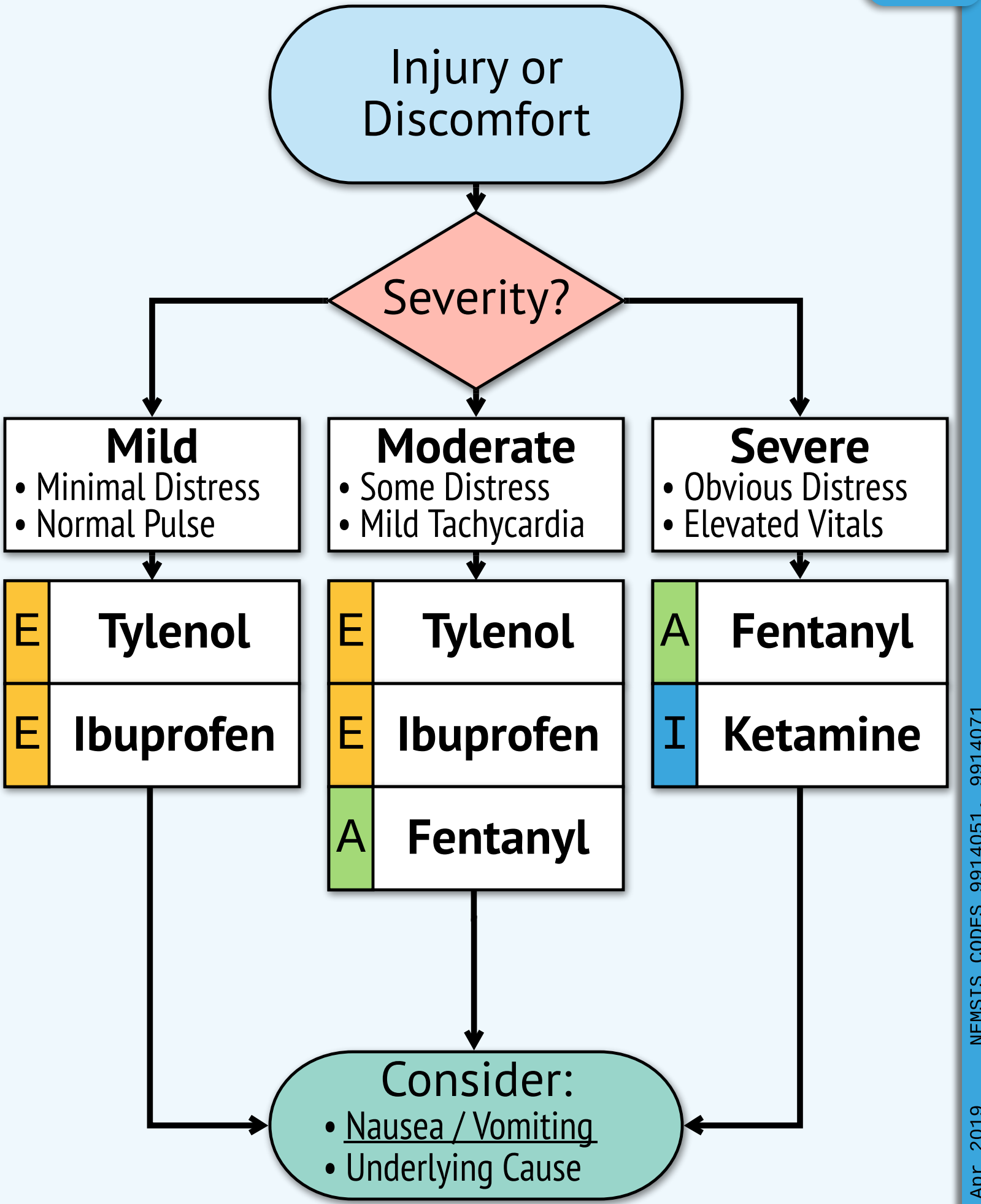
- Pain is subjective. Clinical judgment is required.
 - It is appropriate to try another med if the first is ineffective.
 - Changes in pain scale are more useful than absolute numbers.

Pediatrics

- Breaking tablets in half is appropriate. Do not break capsules.
- Withhold medications if unable to provide accurate dose.
- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape Pain: emedicine.medscape.com/article/310834
 - Brady Emergency Care 12th Ed: Chapters 28, 30, 32



Tylenol: 500 mg	PO	Q 15 min x2
Ibuprofen: 400 mg	PO	Q 15 min x2
Fentanyl: 50 mcg	IV/IO, IM/IN	Q 5 min x4
Ketamine: 20 mg	IV/IO, IM/IN	Q 5 min x2

Adult
Doses

Also called: Throwing Up

Imperatives

- It is appropriate to **pre-treat for nausea** even before symptoms.
 - Consider before any intervention that may cause nausea.
 - Especially if vomiting would cause serious complications.

Medications

- **Zofran** (Ondansetron): contraindicated in OD and Pregnancy

Notes

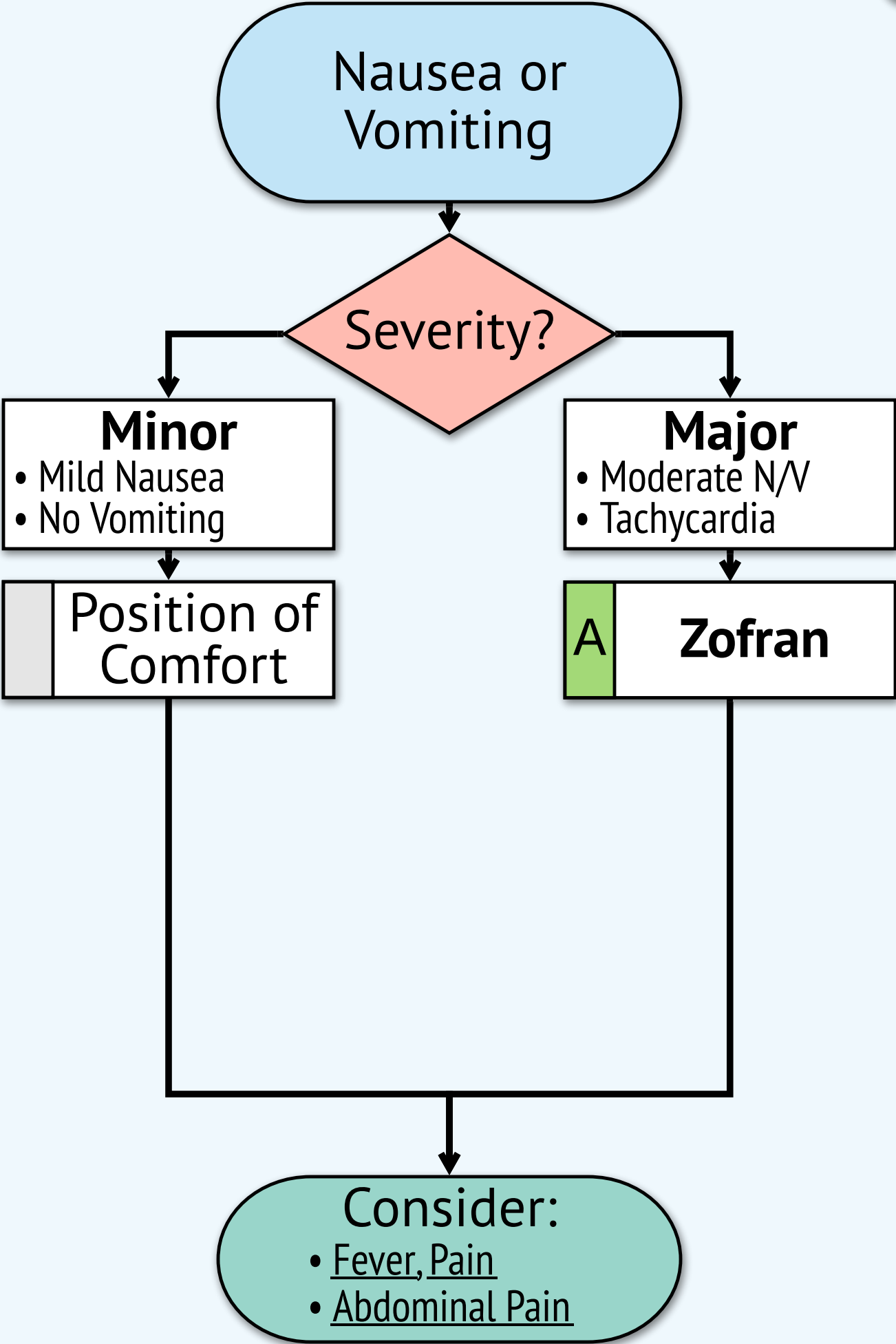
- Consider an atypical Cardiac cause in diabetics and the elderly.

Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape Vomiting: emedicine.medscape.com/article/933135
 - Brady Emergency Care 12th Ed: Chapters 21, 23, 24



Zofran: 4 mg	IV/IO, IM/IN	Q 5 min x2	Adult
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Also called: Cardiac Arrest, CPR, VT/VF, PEA, Asystole

Imperatives

- Start compressions in place.
 - Transport ASAP if ROSC.
 - Transport ASAP if **peds, pregnant** or any other **Special Case**.
- BLS: Get ALS ASAP. Transport ASAP if witnessed or after any shock.
- ALS: Try for **30 min**. If no ROSC:
 - Call for Termination

Compressions

- Adult/Peds: **120** /min
- OPA/NPA: **30:2** w/ BVM
- BIAD: **Continuous**

Obvious Death

- Pooling Lividity or
- Rigor Mortis or
- Body Decomposition

Medications

- If no response to initial therapy, consider **adjunct medications**:

I	Amiodarone: 300 ► 150 mg	IO x2	Persistent VT/VF
I	Bicarbonate: 50 mEq	IO x1	Persistent VT/VF
I	Calcium: 1 g	IO x1	Persistent VT/VF
I	Magnesium: 2 g	IO x1	Torsades

Notes

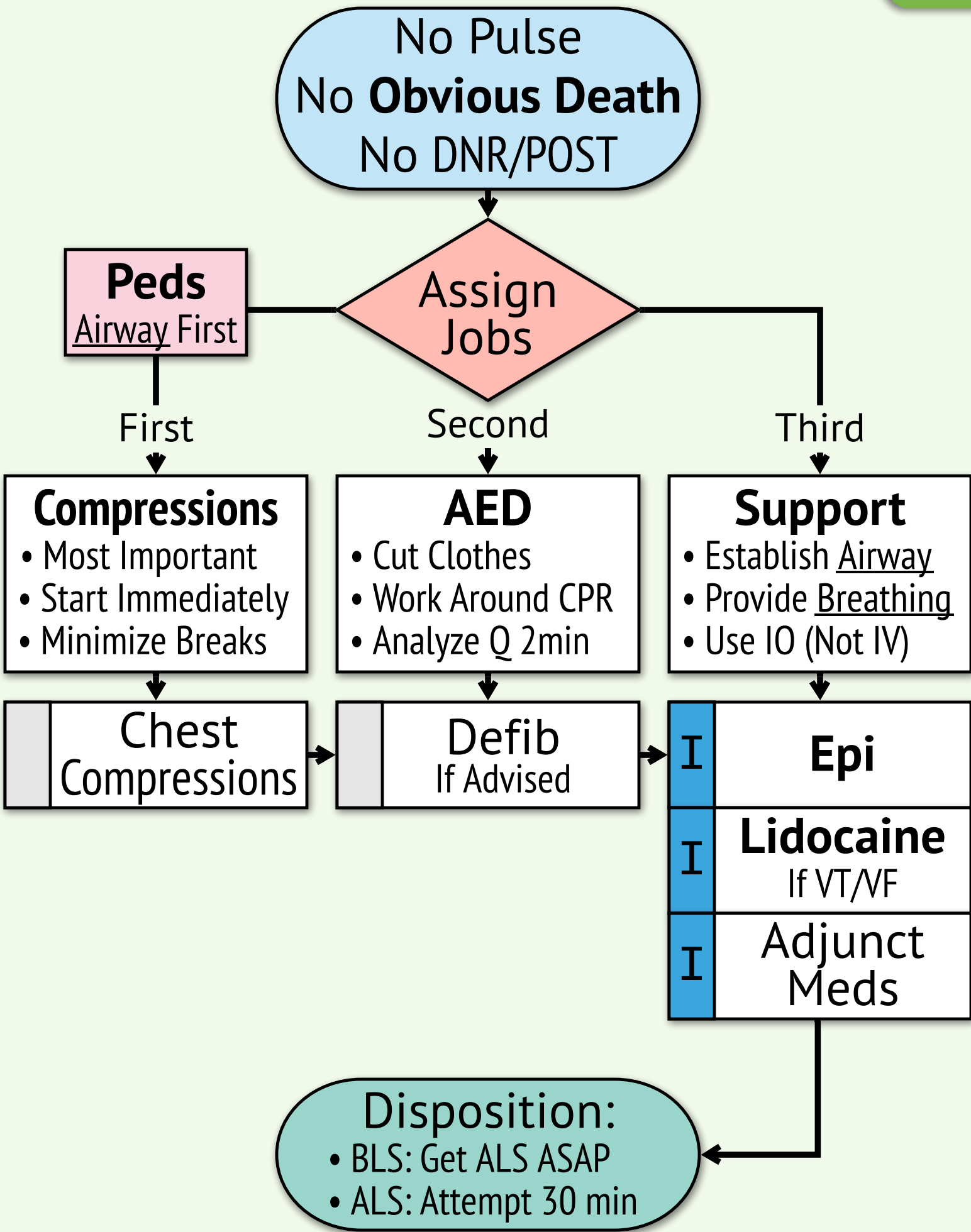
- Use caution with **compressions** and **defib** in a moving vehicle.
- EtCO₂ can help identify ROSC and guide termination decision.
- A well run CODE should operate like a **pit crew**. Focus on your job.

Pediatrics

- Use 15:2 compression ratio for dual rescuer BLS resuscitation.
- Refer to Neonate for any peds **under 1 month** (< 31 days) old.
- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape CPR: emedicine.medscape.com/article/1344081
- Brady Emergency Care 12th Ed: Chapter 20



Epi: 1 mg	IO	Q 5 min	Adult Doses
Lidocaine: 100 mg	IO	Q 5 min x3	
Epi: 0.01 mg/kg	IO	Q 5 min	Peds Doses
Lidocaine: 1 mg/kg	IO	Q 5 min x3	

Also called: Return of Pulse, Post-Resuscitation Care

Imperatives

- Most important aspect is to prioritize emergent transport.
 - **Get the patient to the hospital.**
 - Move with purpose, but don't sacrifice patient stability.
- Second most important is to treat Hypotension.
 - Be aggressive with fluids and pressors to treat Circulation.
- Avoid hyperventilation. It can cause Hypotension and repeat arrest.

Medications

- **Ketamine:** Indicated for biting on BIAD or obvious discomfort.

Notes

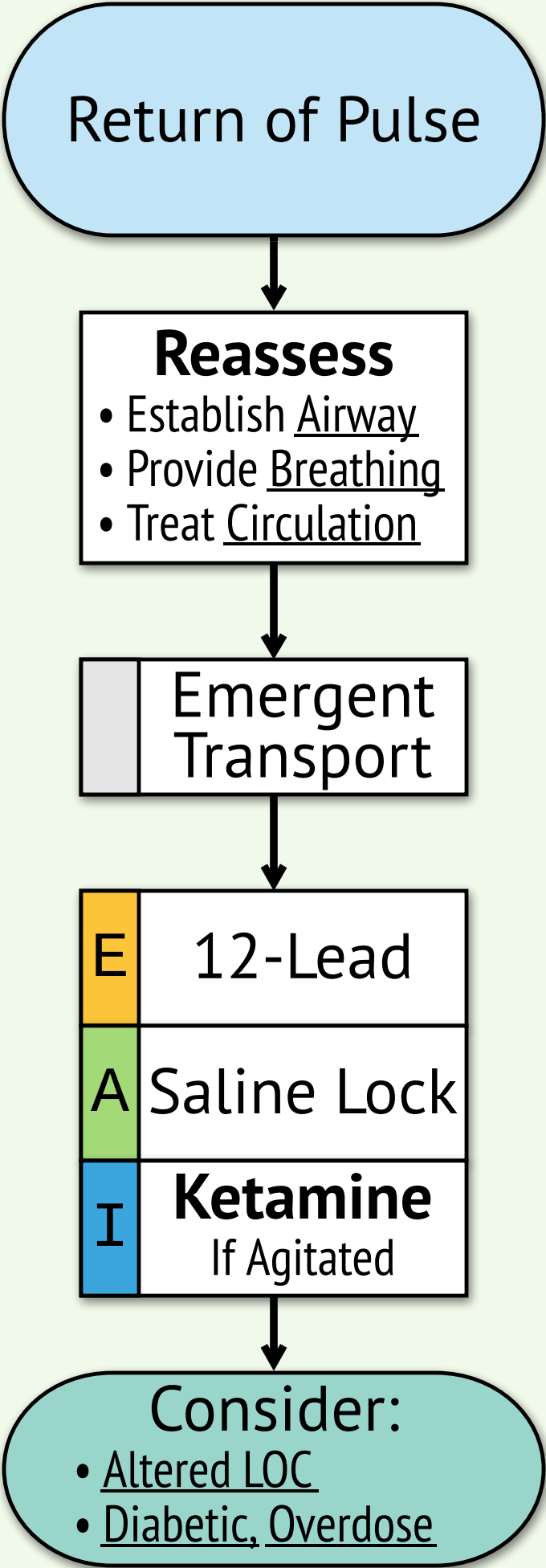
- EtCO₂ can help identify ROSC.
- Therapeutic hypothermia is not included in this protocol.
 - This is also known as targeted temperature management.

Pediatrics

- Arrhythmias are common after ROSC, but are usually self-limited.
- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape ROSC: www.medscape.com/viewarticle/762373
- Brady Emergency Care 12th Ed: Chapter 20



Ketamine: 20 mg	IV/IO	Q 5 min x2	Adult
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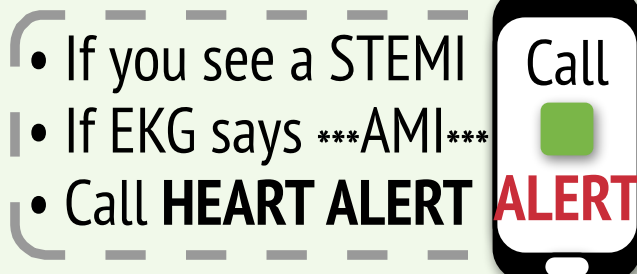
Also called: Heart Attack, Acute MI, Cardiac, Chest Discomfort

Imperatives

- This protocol is for suspected **cardiac** (ACS) emergencies only.
 - For pain resulting from chest trauma, refer to Trunk Injury.
 - For palpitations refer to Tachycardia or Bradycardia.
- Place **defib pads** on all patients with identified STEMI.

Medications

- **Aspirin**: contraindicated with GI bleeding or peds.
 - Have patient chew 4x 81mg (baby) Aspirin.
- **Nitro** (nitroglycerin): May cause Hypotension.
 - Contraindicated if Hypotensive or inferior STEMI.
 - Contraindicated if recent (36 h) use of Viagra, Cialis, or Levitra.
 - **EMT**: May assist pt with their own **Nitro** if appropriate.



Notes

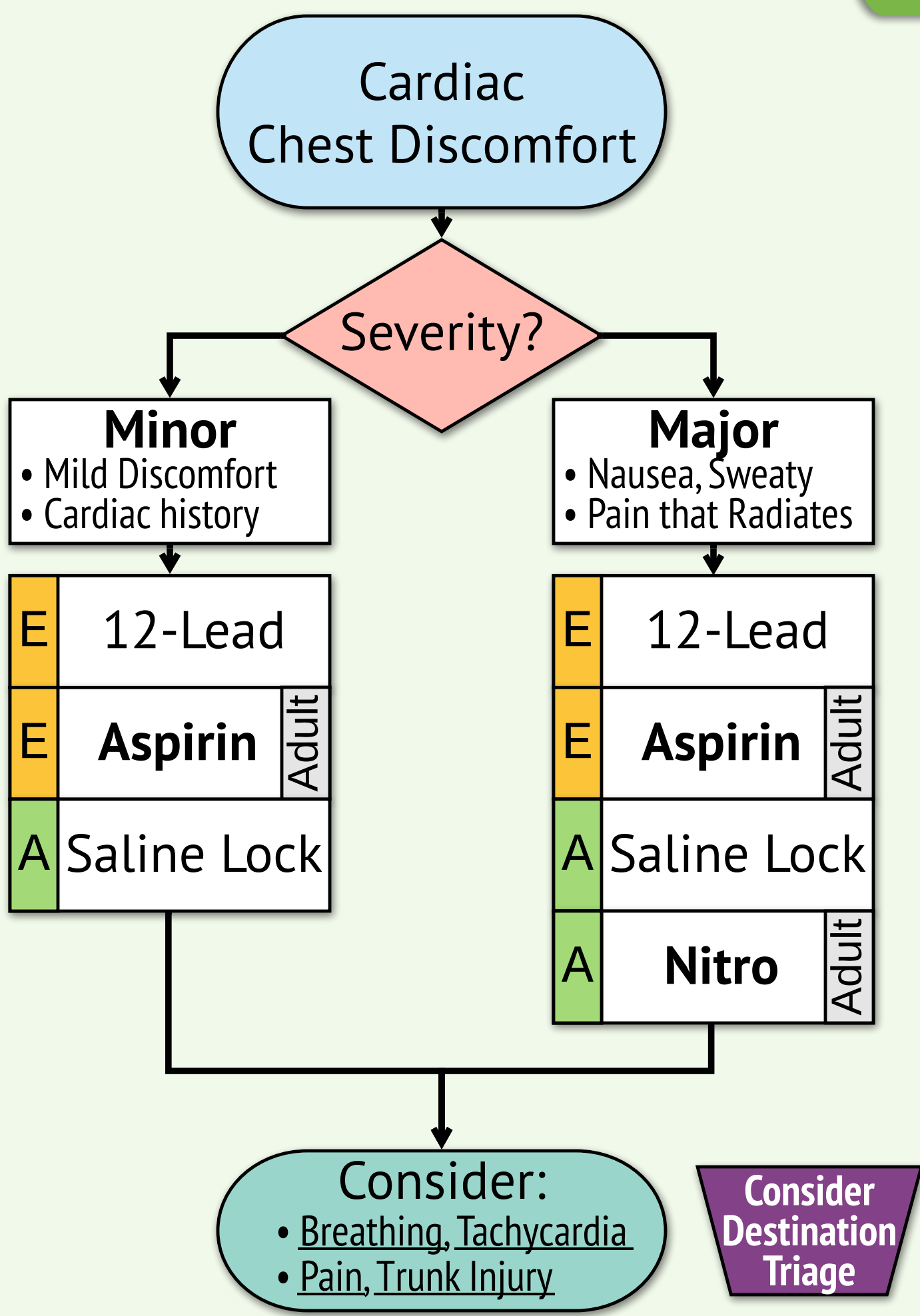
- Consider an atypical cardiac presentation in **diabetics and elderly**.
 - Actual chest pain is not always present.
 - Patients may have chest "discomfort" or be weak or sweaty.
 - Ask about: nausea, SOB, abd pain, altered LOC, cardiac hx, etc.

Pediatrics

- Cardiac pain is unlikely in peds. Consider other causes.
- **Aspirin** and **Nitro** are contraindicated in peds chest pain.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape ACS: emedicine.medscape.com/article/1910735
 - Brady Emergency Care 12th Ed: Chapter 20



Aspirin: 4x 81 mg	PO	x1	Adult Doses
Nitro: 0.4 mg	SL	Q 5 min x3	

Also called: Wheezing, Asthma, COPD, CHF, Respiratory Distress

Imperatives

- Breathing (O₂ and CPAP) should take precedence over meds.
- SpO₂ and EtCO₂ should be used extensively for dyspnea.

Medications

- **Decadron** (dexamethasone): May give PO.
 - May mix the IV solution with juice, or drink straight.
- **Nitro** (nitroglycerin): May cause Hypotension.
 - Contraindicated if Hypotensive or Inferior STEMI.
 - Contraindicated if recent (36 h) use of Viagra, Cialis, or Levitra.

Notes

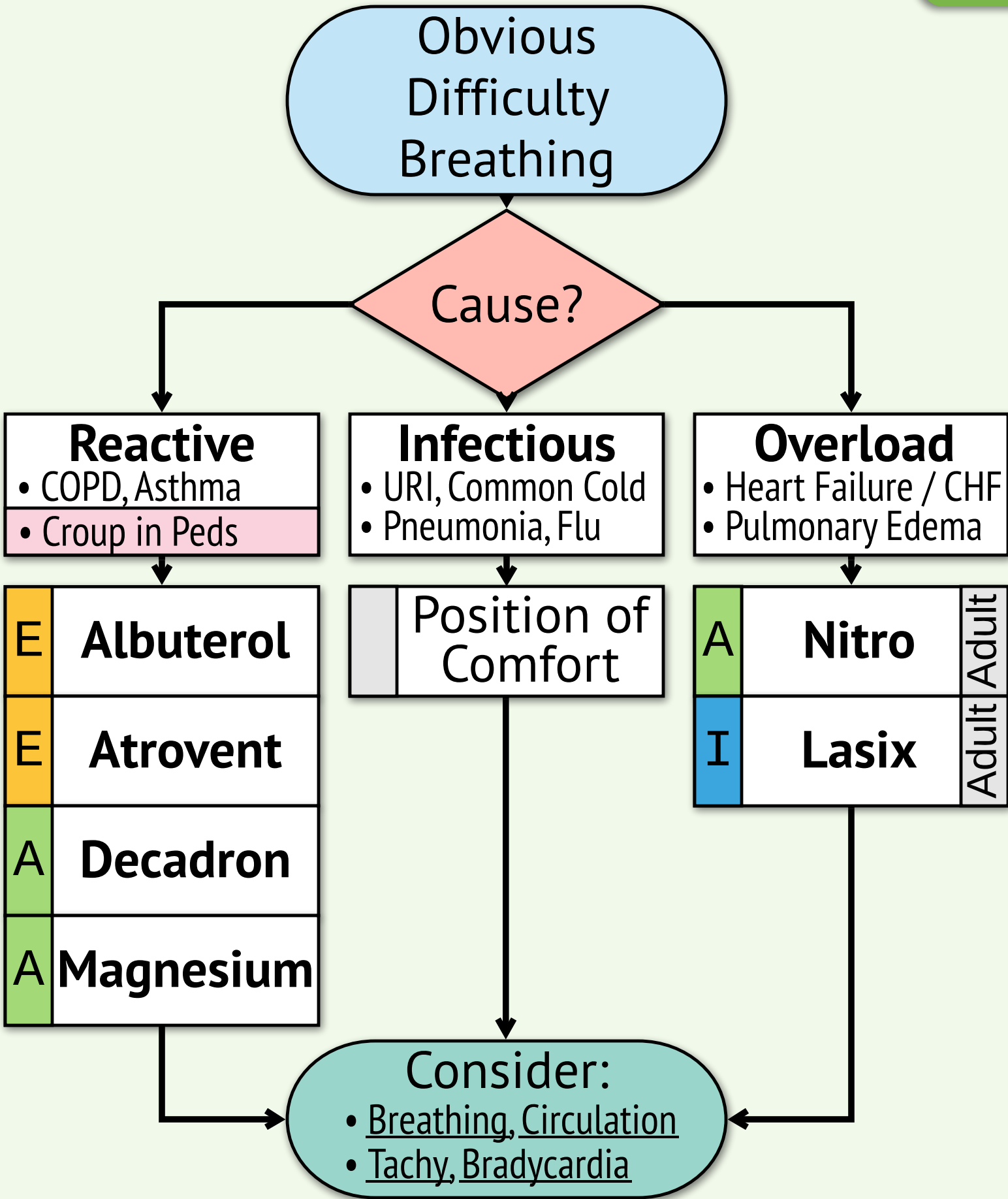
- Consider an atypical Cardiac cause in diabetics and the elderly.
- Anxiety can also cause dyspnea and hyperventilation.
 - Consider simple reassurance for obvious benign anxiety.

Pediatrics

- Defer aggressive evaluation if any concern for **epiglottitis**.
 - Agitation will make it much worse.
 - Epiglottitis is unlikely in fully vaccinated patients.
- **Croup** is a viral infection that should be treated as reactive.
- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape COPD: emedicine.medscape.com/article/297664
- Medscape Asthma: emedicine.medscape.com/article/296301
- Medscape CHF: emedicine.medscape.com/article/163062
- Medscape Croup: emedicine.medscape.com/article/962972
 - Brady Emergency Care 12th Ed: Chapter 19



Albuterol: 2.5 mg	NEB	Q 5 min x4	Adult Doses
Atrovent: 0.5 mg	NEB	Q 5 min x2	
Decadron: 8 mg	PO, IV/IO	x1	
Magnesium: 2 g	IV/IO	x1	
Nitro: 0.4 mg	SL	Q 5 min x3	
Lasix: 40 mg	IV/IO	x1	

Also called: Rash, Hives, Itching, Anaphylaxis, Angioedema

Imperatives

- Massive lip and tongue swelling may be **Angioedema**.
 - Angioedema can be an immediate life threatening condition.
 - It is not technically an allergy, but is treated similarly.

Medications

- **Epi** (epinephrine): Treat life threatening reactions aggressively.
 - Use for any Airway, Breathing or Circulation emergency.
 - **EMT**: Only use auto-injector or color coded admin system.
 - **AEMT** and above: May use any available source.
 - Common side effects: chest discomfort, palpitations, shaking
 - Be cautious in patients over 50 y/o or with chest pain.
- **Albuterol** (Ventolin): Use for dyspnea or wheezing.
 - Unlikely to help with rash or itching. May cause palpitations.
- **Decadron** (dexamethasone)
- **Benadryl** (diphenhydramine)
 - **EMT**: Only use PO.
 - **AEMT** and above: May use PO or IV/IO.

Poor Perfusion

- Suspect if **several** of these:
 - **Altered Mental Status**
 - Skin Pale, Cool, Diaphoretic
 - Tachycardia, Hypotension
 - Dyspnea, Tachypnea

Notes

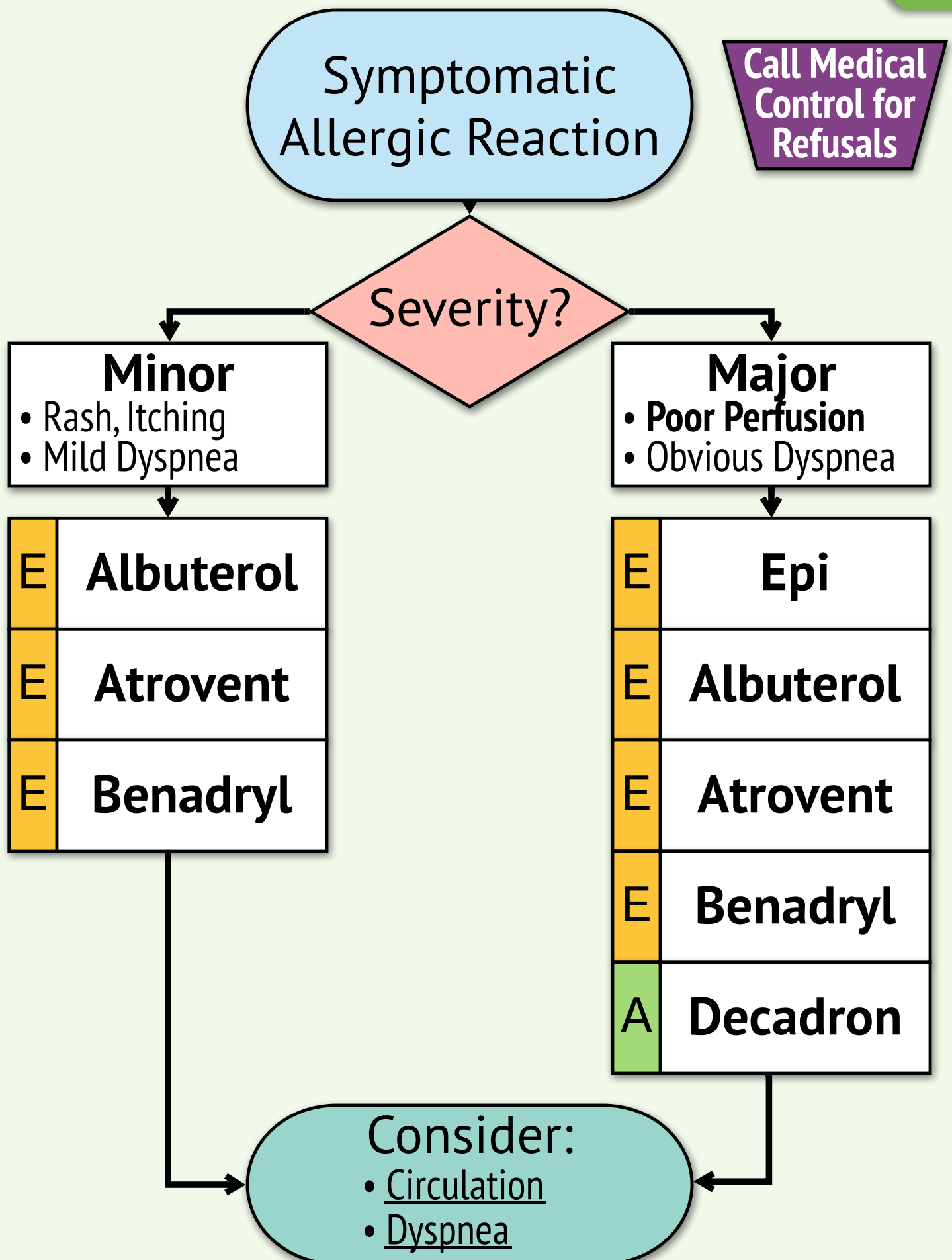
- Rapid onset of symptoms indicates a more severe reaction.
- Severe reactions may include N/V and abdominal pain.

Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape Allergy: emedicine.medscape.com/article/137362
- Medscape Anaphylaxis: emedicine.medscape.com/article/135065
 - Brady Emergency Care 12th Ed: Chapter 22



Albuterol: 2.5 mg	NEB	Q 5 min x4	Adult Doses
Atrovent: 0.5 mg	NEB	Q 5 min x2	
Benadryl: 25 mg	PO, IV/IO	x1	
Epi: 0.3 mg	auto, IM	Q 5 min x3	
Decadron: 8 mg	IV/IO	x1	

Also called: Stomach (Belly) Pain, Heartburn, GERD, Acid Reflux

Imperatives

- Investigate and treat underlying cause.
- This protocol is for **medical** causes of abdominal pain.
 - For traumatic abdominal pain, refer to Trunk Injury.
- Inquire about Pregnancy and consider complications.
- Prepare for Hypotension if suspected:
 - **AAA**: Mid-line "pulsatile mass" in the elderly
 - **GI Bleeding**: Black stool (melena) or "coffee ground" emesis
- Avoid PO meds with severe abdominal pain.

Notes

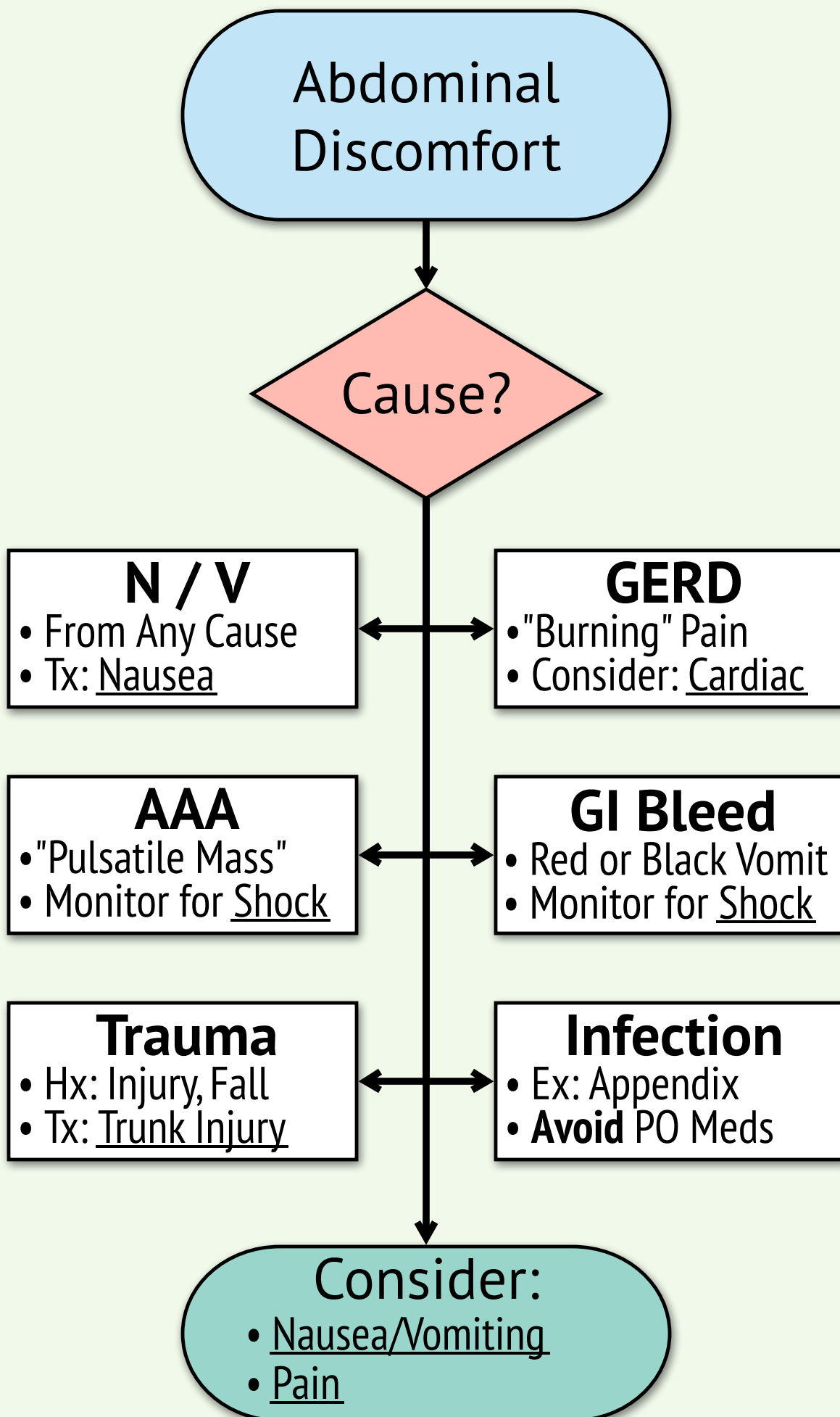
- Consider an atypical Cardiac cause in diabetics and the elderly.

Pediatrics

- Simple constipation is a common cause in peds.
 - It does not require aggressive EMS intervention.

References

- Medscape Abd Pain: emedicine.medscape.com/article/776663
- Brady Emergency Care 12th Ed: Chapter 24



Also called: Fainting, Collapse, Unresponsive "but breathing"

Imperatives

- Altered LOC and syncope are complex problems.
 - Most important step is to consider and search for the cause.
 - Investigate the scene and take a careful history.
- Unstable patients should be treated aggressively.
 - Be prepared for a Medical CODE.
- Alcohol and drugs can mask other causes of altered LOC.
 - Don't assume Intoxication is the only problem.
- Syncope may be caused by or result in trauma.
 - Maintain a high index of suspicion.

Notes

- Consider an atypical Cardiac cause in diabetics and the elderly.

Pediatrics

- Most causes of transient syncope are benign.
- Prolonged altered LOC indicates potentially serious pathology.
- Syncope during exertion can be a true cardiac emergency.

References

- Medscape Syncope: emedicine.medscape.com/article/811669
- Medscape Delirium: emedicine.medscape.com/article/793247
- Medscape Hypoglycemia: emedicine.medscape.com/article/122122
- Brady Emergency Care 12th Ed: Chapter 21

Confused or
Unresponsive
(but breathing)

	Glucometer
E	12-Lead
A	Saline Lock

Cause?

Diabetic

- Hx: Diabetes
- Abnormal Glucose

Psychiatric

- Suicidal, Homicidal
- Delusions, Psychosis

Overdose/Tox

- Hx: Ingestion/Exposure
- Obvious Drugs/EtOH

Injury

- Head Injury, Bleeding
- Cold / Heat Exposure

Seizure

- Hx: Epilepsy
- Shaking, Confused

Fever

- Hx: Illness or Sepsis
- Skin hot

Stroke

- Facial Droop, Weakness
- Slurred Speech

Cardiac

- Bradycardia, Tachycardia
- Shock, Chest Pain

Also called: Hypoglycemia, Hyperglycemia, Blood Sugar/Glucose

Imperatives

- EMS intervention is not required for mild asymptomatic patients.
- Consider a concurrent Cardiac emergency in the elderly.

Medications

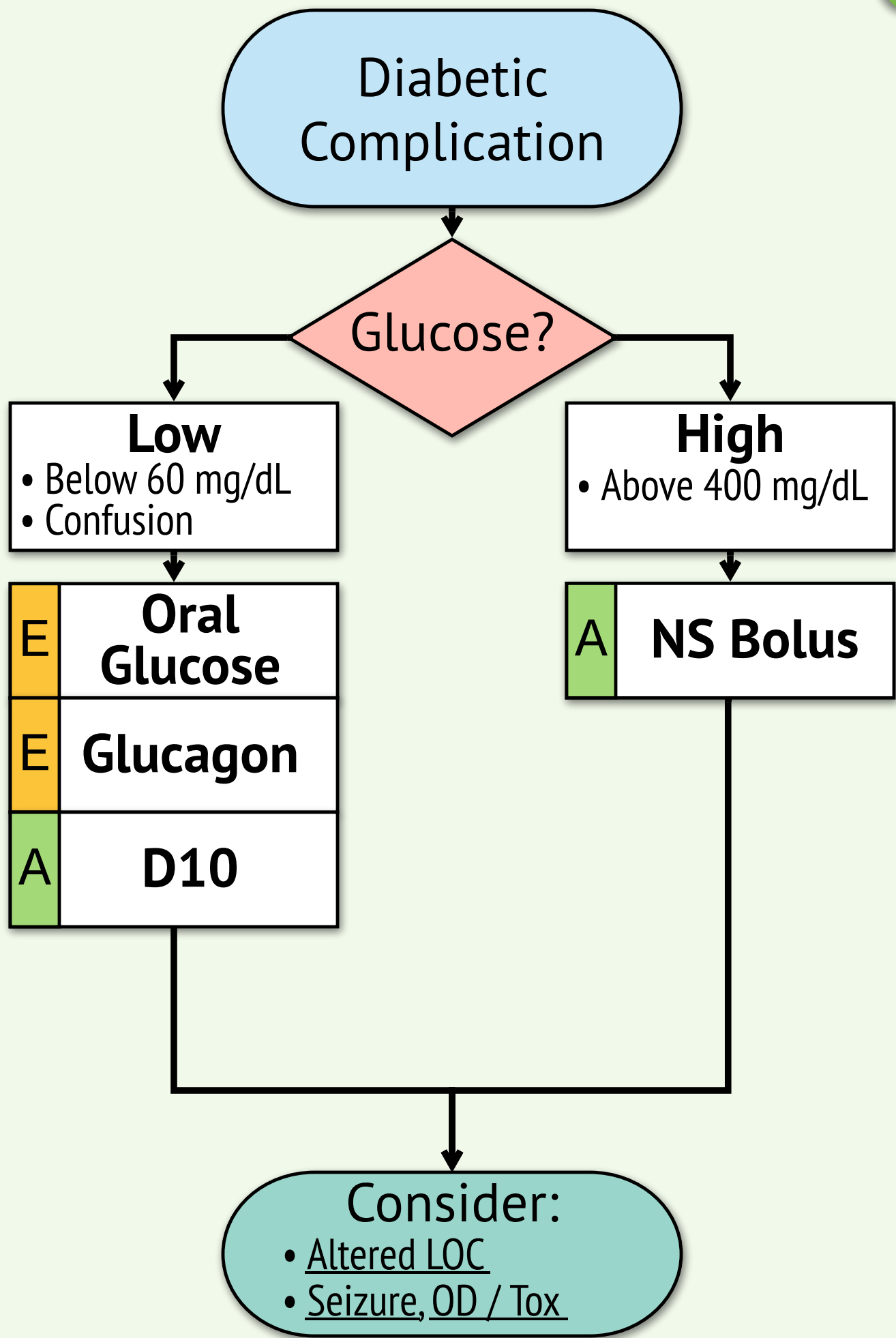
- **Oral Glucose:** Contraindicated if patient cannot swallow.
 - Consider regular food as an alternative if available.
 - Prioritize food and drinks with simple sugar.
 - Also provide complex carbs/protein (peanut butter sandwich).
- **Glucagon:** Use caution, patient improvement is only temporary.
 - Must provide additional glucose after administration.
 - Give PO replacement if able and be prepared to give D10.
 - Call **Medical Control** for all refusals after **Glucagon**.
 - **EMT:** Only use IN route for administration.
 - **AEMT** and above: May also give intramuscular (IM).
- **D10:** May attempt without glucometer if hypoglycemia likely.
 - Recheck glucose prior to repeat dosing.

Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape Hypoglycemia: emedicine.medscape.com/article/122122
 - Brady Emergency Care 12th Ed: Chapter 21



Oral Glucose: 15 g	PO	Q 5 min x3	Adult Doses
Glucagon: 1 mg	IM/IN	x1	
D10: 100 mL	IV/IO	Q 5 min x3	
NS Bolus: 1,000 mL	IV/IO	x1	

Also called: Drunk, Intoxication, Poisoning, Ingestion

Imperatives

- Collect a detailed history and SDS (Safety Data Sheet) if able:
 - Substance, quantity and time of ingestion or exposure
- Monitor Airway closely with all **caustic ingestions**.
- Not all ingestions require a specific antidote or intervention.
 - Stable patients may be monitored and transported.
 - Supportive care is sufficient for **Alcohol** (ethanol) intoxication.

Medications

- **Narcan** (naloxone): Should only be used to treat Hypoxia.
 - **EMT**: May provide premeasured intranasal doses only.
 - **AEMT**: Titrate for breathing. Avoid rapid reversal.
 - Call **Medical Control** for any refusal after **Narcan**.
- **Atropine**: Massive doses may be required for organophosphates.
- **Calcium**: Avoid if the patient is taking digoxin (Lanoxin).

Notes

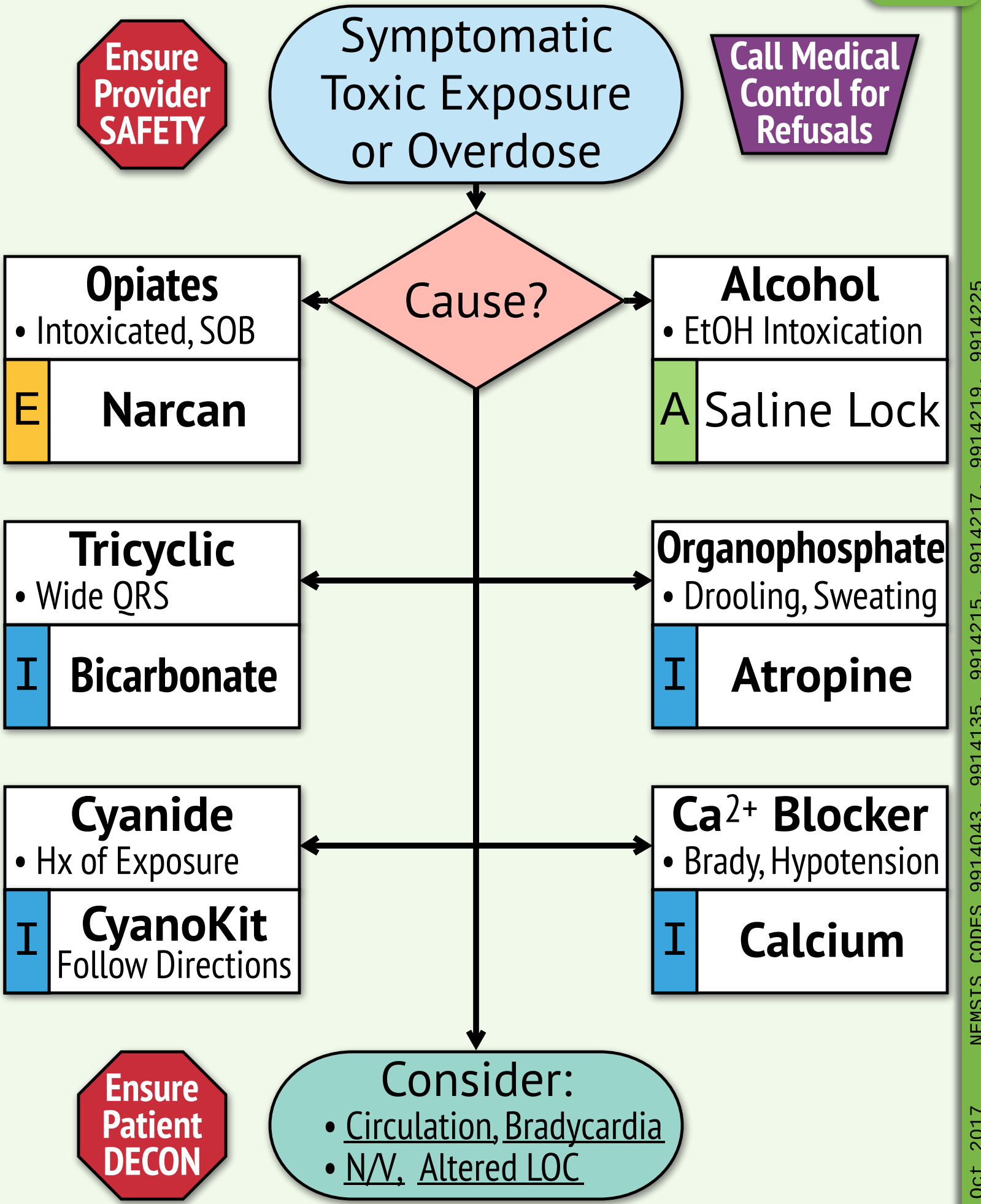
- If substance is known, consider **Poison Control**: 800-222-1222.
- This protocol includes chemical **ingestions** and organophosphates.
 - For most **gas** exposures, refer to Inhalation.
 - For other **skin** exposures refer to Burns.

Pediatrics

- Even a single pill of some adult meds can cause severe symptoms.
 - Be prepared to treat Shock if overdose is suspected.
 - Ingested **nicotine** (cigarettes or vape fluid) can be fatal.
- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape Opioids: emedicine.medscape.com/article/815784
- Medscape Tricyclics: emedicine.medscape.com/article/819204
- Medscape Organophosphate: emedicine.medscape.com/article/167726
 - Brady Emergency Care 12th Ed: Chapter 23



Narcan: 0.4 - 4 mg	IV/IO, IN	Q 5 min x2	Adult Doses
Bicarbonate: 50 mEq	IV/IO	x1	
Atropine: 0.5 mg	IV/IO	Q 2 min	
Calcium: 1 g	IV/IO	x1	

Also called: Epilepsy, Eclampsia, Febrile Seizure, Withdrawal

Imperatives

- Active convulsions with Altered LOC should be treated promptly.
 - Meds are contraindicated without active convulsions.
- Non-specific shaking with normal LOC may not need intervention.
- Non-epileptic **pseudoseizures** do not require EMS intervention.
 - Consider other causes such as Psychiatric or OD / Tox.
- Aggressively treat seizures due to alcohol or benzo withdrawal.

Medications

- **Versed** (midazolam): Only appropriate during active convulsions.
- **Magnesium**: May cause Hypotension and Dyspnea.
 - Useful for seizures in **late pregnancy** (20 weeks & over).
 - Do not provide in early pregnancy. Eclampsia is unlikely.

Notes

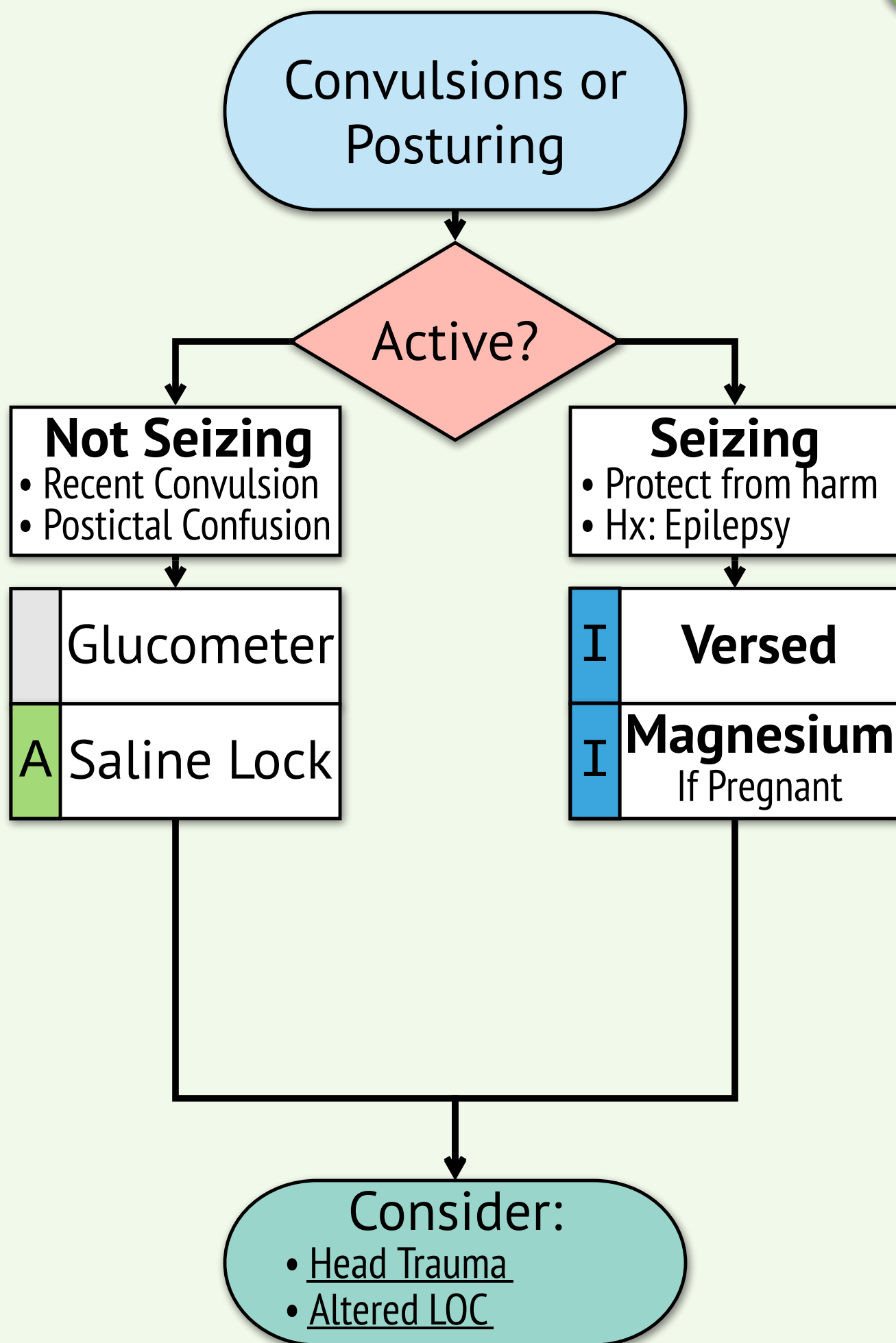
- Obtain details of patient's **seizure meds** if immediately available.
- Seizures can come in groups, be prepared to treat another seizure.
- Confusion after seizure is common and may last over 30 min.
 - Transient stroke-like paralysis is also possible but is not a CVA.

Pediatrics

- Peds under 5 y/o may have a seizure caused by Fever.
 - It is usually self limiting and does not require intervention.
 - Consider medication if longer than 5 min or seizure reoccurs.
 - Aggressively treat any peds seizure not associated with Fever.
- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape Seizure: emedicine.medscape.com/article/1184846
- Brady Emergency Care 12th Ed: Chapter 21



Versed: 2.5 mg IV/IO, IM/IN Q 2 min x4

Magnesium: 2 g IV/IO x1

**Adult
Doses**

Also called: CVA, TIA, Mini Stroke

Imperatives

- Stroke treatment is time sensitive.
- **Time Last Normal** is not necessarily when symptoms started.
 - If noticed upon waking up: last normal is before bed.
 - If altered LOC: last normal is when someone saw them normal.
- Stroke Questionnaires:
 - The **Cincinnati Stroke** FAST is appropriate for EMS screening.
 - Consider additional screening if able (Stroke VAN or NIHSS).

Cincinnati Stroke

- Facial Droop?
- Arm Drift?
- Slurred Speech?
- Time Last Normal?

Stroke VAN

- Vision - Partial / Total Loss?
- Aphasia - Trouble Speaking?
- Neglect - Ignoring One Side?

- If you suspect a CVA
- If Last Normal < 6h
- Call **STROKE ALERT**



Notes

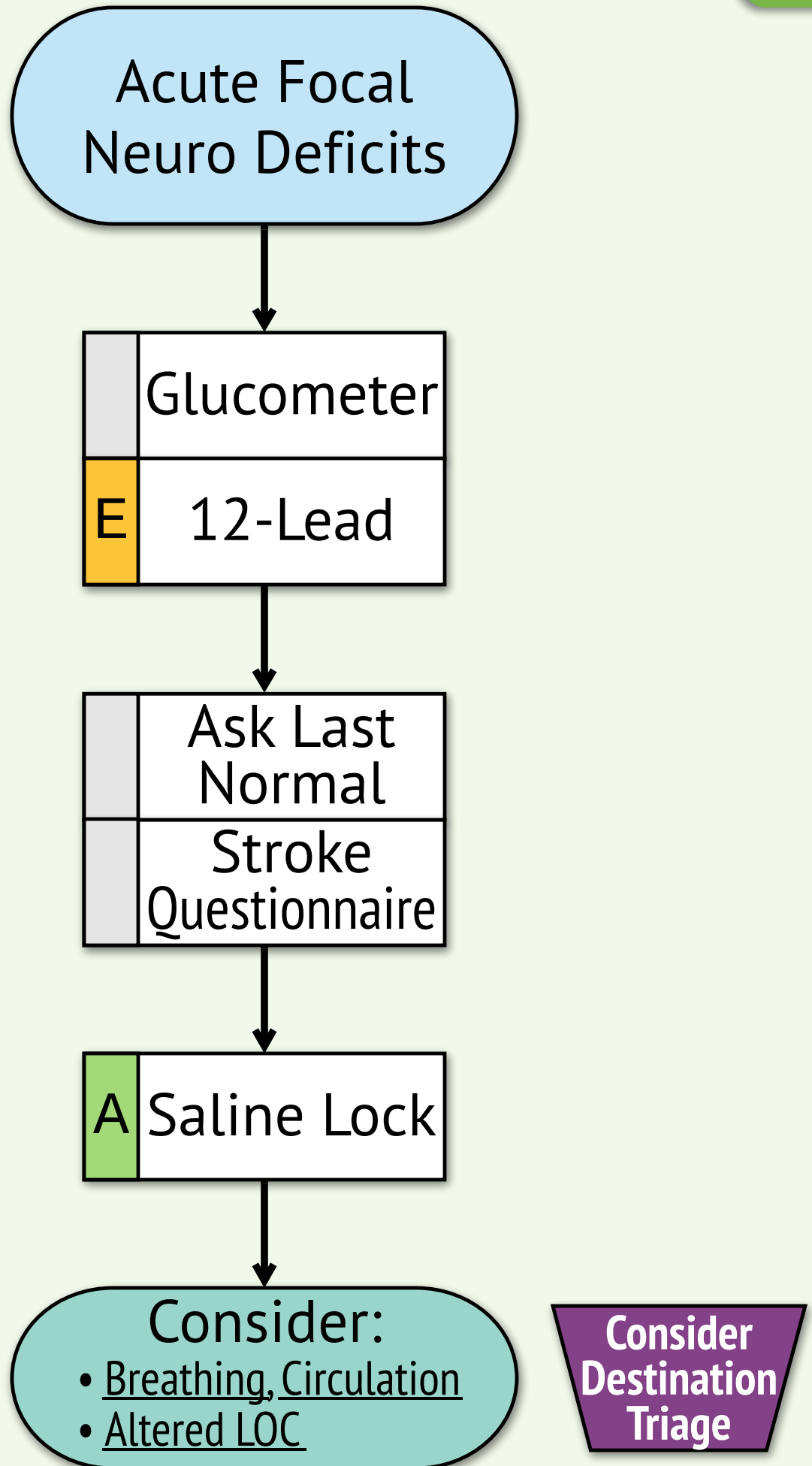
- Most thrombolytic therapy must occur **within 6 hours**.
 - Vascular intervention may be possible out to 24 hours.
- Encourage family or guardian to accompany patient.
 - There are important decisions to be made quickly at the ED.
 - Record phone number for family or guardian if possible.

Pediatrics

- Stroke is unlikely in peds. Consider other causes of Altered LOC.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- Medscape Stroke: emedicine.medscape.com/article/1916852
 - Brady Emergency Care 12th Ed: Chapter 21



Also called: Restraint, Suicidal, Behavioral, Dementia, Delirium

Imperatives

- **Do not assume** psychosis. Evaluate and treat for other causes.
- Psychiatric patients may not have the capacity to Refuse.
 - Involve Police and call **Medical Control** for any psych refusal.
- Use of any restraint presents significant medical (and legal) risk.
 - Use **only to ensure safety** of patient and providers.
 - Use only when risk of harm is greater than risk of restraint.
 - Elderly or frail patients are unlikely to need restraint.
 - Restraint should be a **last resort**.
- Physical restraint should only be used in conjunction with Police.
 - **Ask for Police** help if the patient is physically combative.
 - Monitor closely for Airway or Breathing complications.

Medications

- **Versed** (midazolam): May start with half dose when given IV.
- **Haldol** (haloperidol): Requires transport and **ALS** monitoring.

Notes

- Consider calling **Medical Control** for repeat dosing.
- SI / HI: Suicidal or Homicidal Ideation
 - Thoughts or acts of hurting themselves or other people.

Pediatrics

- Consider calling **Medical Control** prior to restraining peds.
- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape Suicide: emedicine.medscape.com/article/2013085
- Medscape Aggression: emedicine.medscape.com/article/288689
 - Brady Emergency Care 12th Ed: Chapter 25

Ensure
Provider
SAFETY

Overt Psychosis
or SI / HI

Call Medical
Control for
Refusals

Severity?

Mild
• Mostly Calm
• Mostly Agreeable

Moderate
• Moderate Agitation
• Will Listen to You

Severe
• Agitated Delirium
• Fighting, Irrational

Position of
Comfort

I **Versed**

Call Police

I **Versed**

I **Haldol**

Consider:
• Circulation (shock)
• Altered LOC

Versed: 5 mg	IV/IO, IM/IN	x1
Haldol: 5 mg	IM	x1

Adult
Doses

Also called: Contractions, Pre / Eclampsia, Post-Partum care

Imperatives

- This protocol applies to **late pregnancy** (20 weeks & over).
 - Uterus palpable **above the umbilicus** suggests late pregnancy.
 - There are no specific EMS interventions for early pregnancy.
- Any SBP reading above 140 mmHg may be **preeclampsia**.
 - Prioritize transport. Call **Medical Control** for any refusal.
- Aggressively treat any Seizure as **eclampsia**.
- Any **maternal trauma** after 20 weeks should be transported.
 - Fetus may have injury that is not immediately obvious.
 - Even minor trauma (simple falls, etc) can cause fetal harm.
- **Prioritize transport for any complications** with delivery.
 - **Reduce cord** if found around the neck.
- **Manage Complications** during transport:
 - Failed Delivery / Shoulder Dystocia: transport knees to chest
 - Prolapsed Cord: fingers in vagina to remove pressure on cord
 - Breech: support presenting part, do not pull on part

Notes

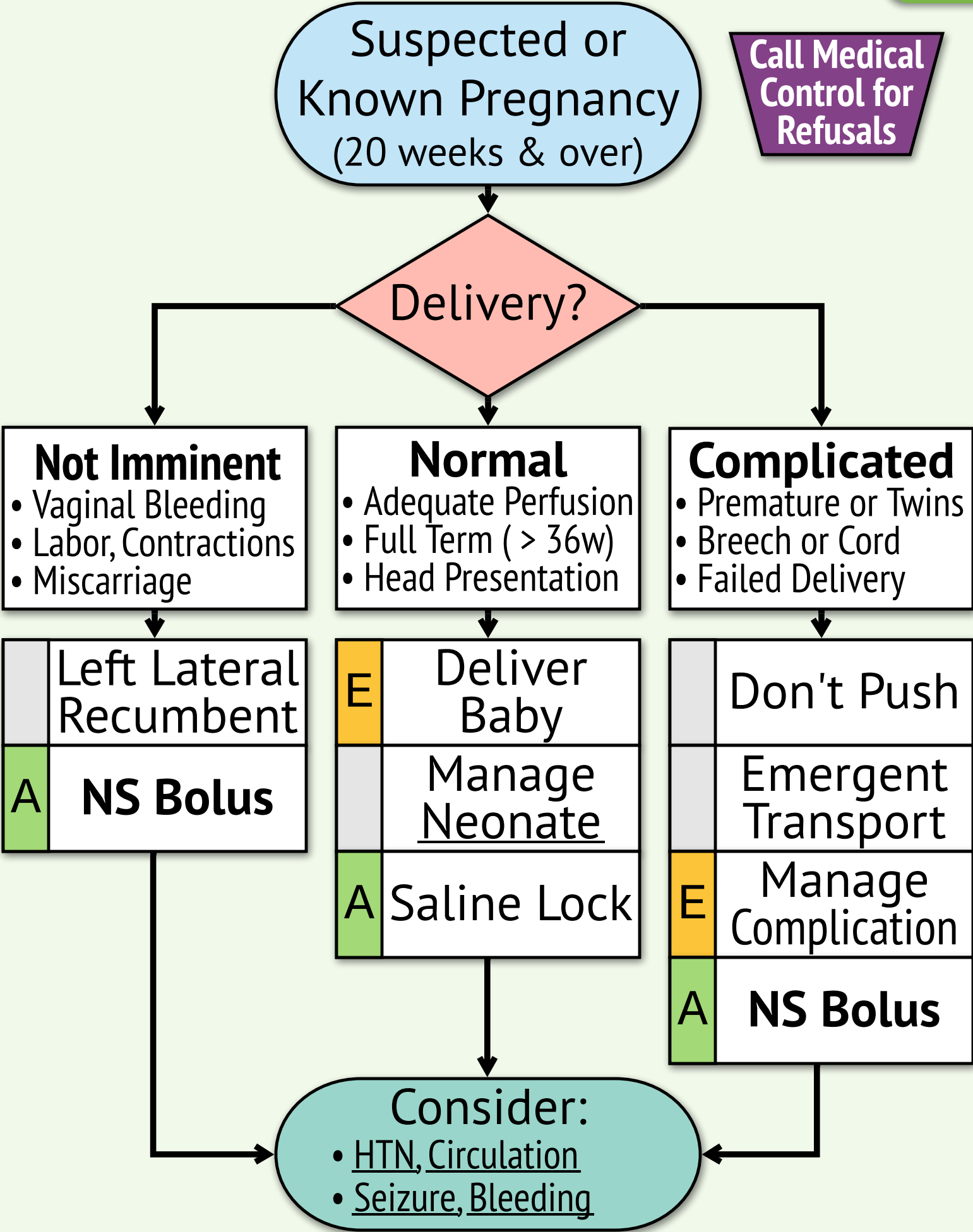
- Remember not all medications are safe in pregnancy.
 - Call **Medical Control** if any question.
- **Fundal massage** is important to help stop post-partum bleeding.
- May attempt **home delivery** if uncomplicated and imminent.
 - Crowning and urge to push suggest delivery is imminent.
- Attempt to have a **chaperone** present for any genital evaluation.

Pediatrics

- Refer to Neonate for management of the newborn baby.

References

- Medscape Delivery: emedicine.medscape.com/article/260036
- Medscape Eclampsia: emedicine.medscape.com/article/253960
 - Brady Emergency Care 12th Ed: Chapter 34



NS Bolus: 1,000 mL IV/IO x1 **Adult**

Also called: Newborn, Baby Resuscitation

Imperatives

- Most respond to stimulation.
 - Suction mouth then nose.
 - Clamp & cut cord.
 - Dry off. Keep warm.
 - Use **BVM** if any distress.
- Other less common causes of newborn distress include:
 - Pneumothorax, Hypoglycemia, Shock

Compressions

- Neonate: **120** /min
- OPA/NPA: **3:1** w/ BVM
- BIAD: **Continuous**

BVM Rate

- Neonate: **Q 2 sec** (30/min)

APGAR

	2	1	0
• Appearance	pink	blue	gray
• Pulse	100+	99-1	0
• Grimace	good	poor	none
• Activity	kicks	weak	limp
• Respiration	cry	gasp	0

Notes

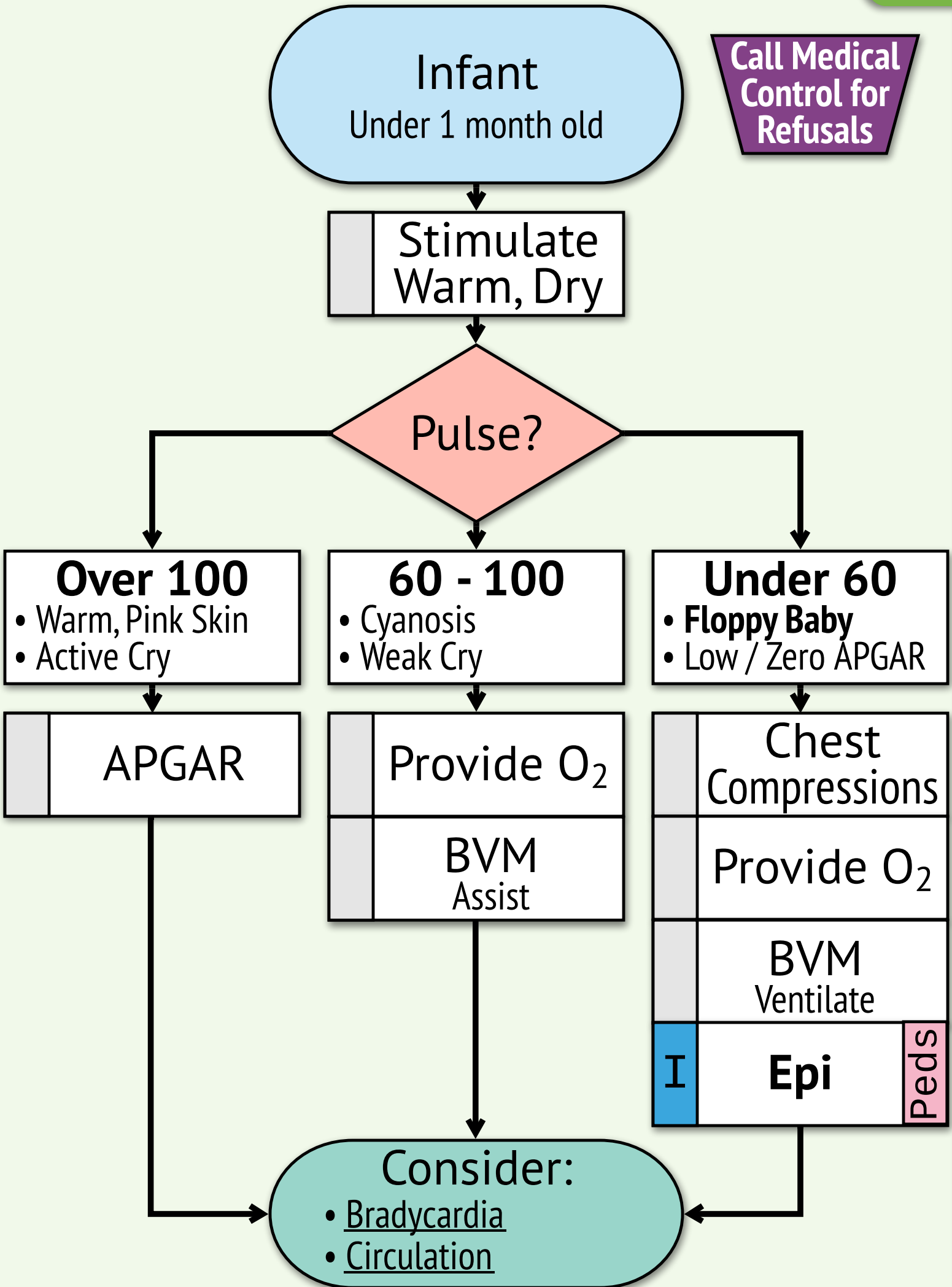
- Document 1 and 5 minute APGAR scores.
 - Add total points from each of the five categories.
- Use mom and baby ID bands if available.
- Meconium suction is not included in this protocol.
- Avoid high flow oxygen into a newborn's eyes.

Adults

- This protocol is for infants under 1 mo. It does not apply to adults.

References

- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape Delivery: emedicine.medscape.com/article/260036
- Medscape Neonate: emedicine.medscape.com/article/977002
 - Brady Emergency Care 12th Ed: Chapter 34



Epi: 0.5 mL (of 1 mg / 10 mL) IV/IO Q 5 min **Peds**

Also called: Traumatic Arrest

Imperatives

- Place **tourniquets** if needed.
 - Hemostasis is critical.
- Try bilateral **decompression**.
 - Hidden pneumothorax may cause traumatic arrest.
- This protocol applies to cardiac arrest caused by **severe trauma**.
 - Refer to Medical CODE for arrest with only incidental injuries.
- Definitive treatment for traumatic arrest is the operating room.
 - Prioritize compression, tourniquets and **transport ASAP**.

Compressions

- Adult/Peds: **120** /min
- OPA/NPA: **30:2** w/ BVM
- BIAD: **Continuous**

- If Major Trauma
- If active CPR
- Call **FIELD ALERT**



Mortal Injuries

- Decapitation or Exposed Brain
- Destruction of Trunk or Organs
- Burned Beyond Recognition
- Massive Blunt Force, Explosion
- Over 30 min Since Arrest

Medications

- **NS Bolus** (saline 0.9%): Appropriate use in trauma is critical.
 - Be aggressive with fluid for Hypotension or **poor perfusion**.
 - Avoid aggressive fluids once SBP above **90** mmHg.

Notes

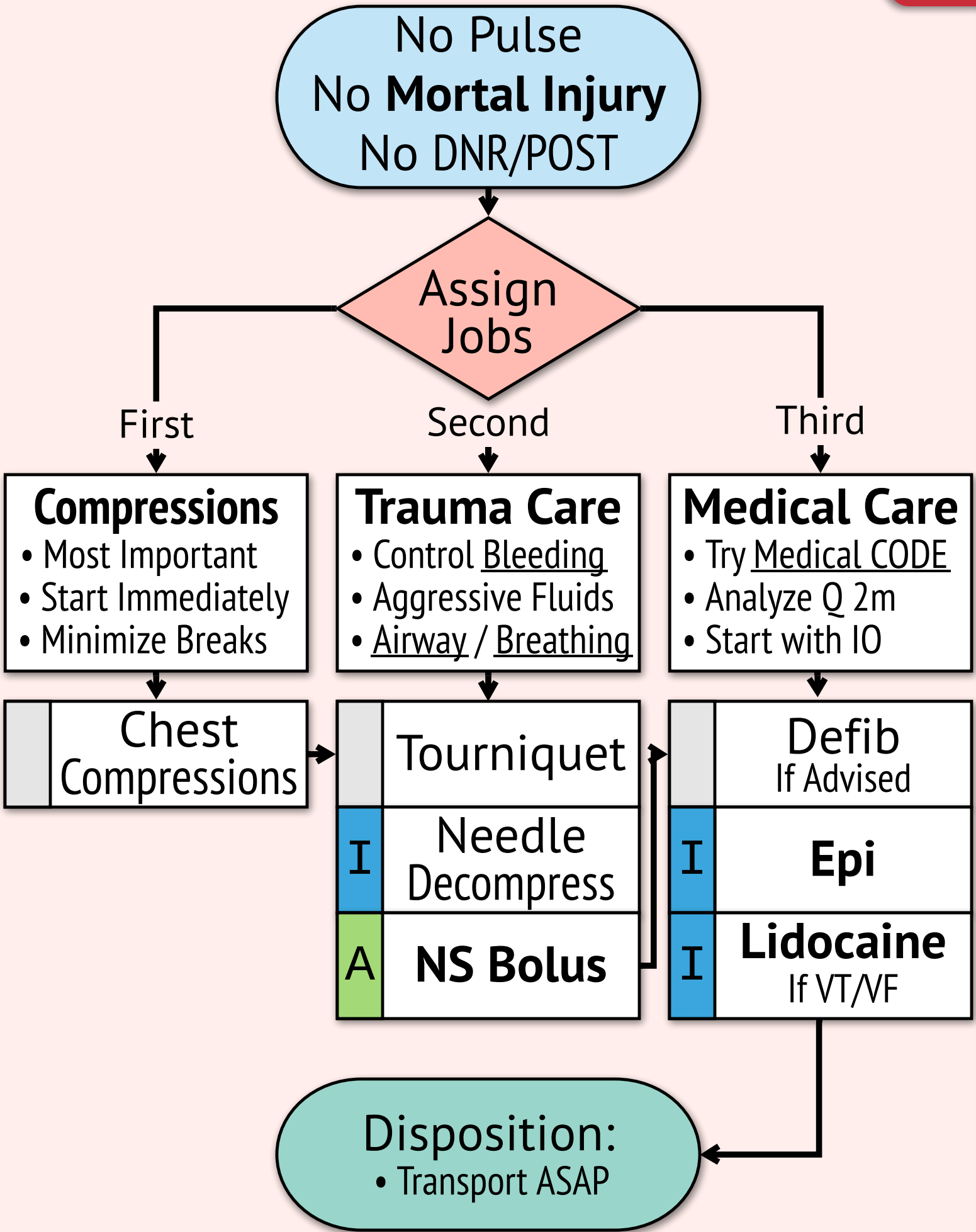
- Use caution with **compressions** and **defib** in a moving vehicle.
- EtCO₂ can help identify ROSC and guide termination decision.
- A well run CODE should operate like a **pit crew**. Focus on your job.

Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- ATLS: www.ncbi.nlm.nih.gov/pubmed/23609291
- NAEMSP: doi.org/10.3109/10903127.2012.755586
- Brady Emergency Care 12th Ed: Chapter 32



NS Bolus: 1,000 mL	IV/IO	x2	Adult Doses
Epi: 1 mg	IV/IO	Q 5 min	
Lidocaine: 100 mg	IV/IO	Q 5 min x3	

Also called: Return of Pulse / Post-Resuscitation after Trauma

Imperatives

- Most important aspect is to prioritize emergent transport.
 - **Get the patient to the hospital.**
- Reassess and repeat Needle Decompression as needed.
 - Repeat immediately if decompensation after initial success.
- Reassess and apply additional Tourniquets as needed.
 - Pack and apply pressure for trunk bleeding.
- Consider a concurrent medical cause preceding the trauma.

Medications

- **Ketamine:** Indicated for biting on BIAD or obvious discomfort.

Poor Perfusion

- Suspect if **several** of these:
 - **Altered Mental Status**
 - Skin Pale, Cool, Diaphoretic
 - Tachycardia, Hypotension
 - Dyspnea, Tachypnea

- If Major Trauma
- If Unstable Vitals
- Call **FIELD ALERT**



Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- ATLS: www.ncbi.nlm.nih.gov/pubmed/23609291
 - Brady Emergency Care 12th Ed: Chapter 32

Return of Pulse

Reassess

- Establish Airway
- Provide Breathing
- Treat Circulation

	Emergent Transport
--	--------------------

	Tourniquet
--	------------

I	Needle Decompress
---	-------------------

E	12-Lead
---	---------

A	Saline Lock
---	-------------

I	Ketamine If Agitated
---	--------------------------------

Consider:

- Bleeding, Shock
- Medical ROSC

Consider Destination Triage

Ketamine: 20 mg	IV/IO	Q 5 min x2	Adult
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Also called: Multisystem Trauma, Explosion / Blast Injury

Imperatives

- Rapid transport is **critical** for massive life threatening injury.
 - **Get the patient to the hospital.**
 - Delay transport only to address major threats to life.
 - Secondary survey and treatment can occur during transport.
- It is appropriate to start with rapid manual immobilization only.
 - May delay placing the c-collar and LBB to the secondary survey.
 - You should delay extremity splinting to the secondary survey.

Medications

- **NS Bolus** (saline 0.9%): Appropriate use in trauma is critical.
 - Be aggressive with fluid for Hypotension or **poor perfusion**.
 - Avoid aggressive fluids once SBP above **90** mmHg.

Poor Perfusion

- Suspect if **several** of these:
 - **Altered Mental Status**
 - Skin Pale, Cool, Diaphoretic
 - Tachycardia, Hypotension
 - Dyspnea, Tachypnea

- If Major Trauma
- If Unstable Vitals
- Call **FIELD ALERT**



Notes

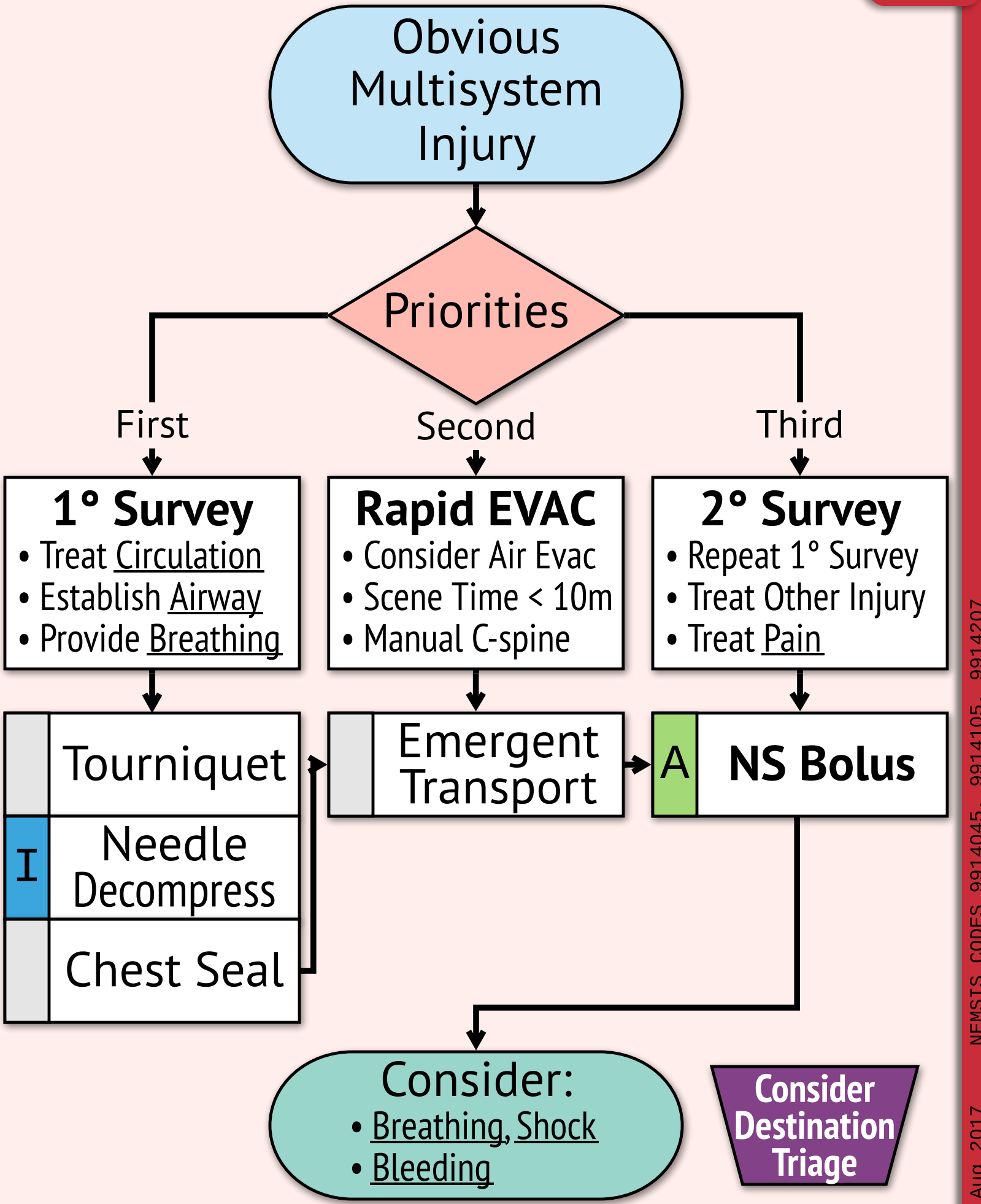
- Do not remove **impaled** objects. Splint object in position found.
- **Mechanism** is an important indicator of injury severity.

Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape Polytrauma: emedicine.medscape.com/article/1270888
- Brady Emergency Care 12th Ed: Chapter 32



NS Bolus: 1,000 mL IV/IO x2 Adult

Also called: Hemorrhage Control, Tourniquet

Imperatives

- Advance to tourniquet rapidly for major arm / leg bleeding.
 - Write the time of tourniquet application on the patient.
- Avoid packing or tourniquets for:
 - Unstable, depressed or open skull fractures
 - Bleeding from body cavities: vagina, rectum, ear, mouth, etc.
 - Deep chest or abdominal injury
- For **non-traumatic bleeding**:
 - Prioritize transport.

- If Major Mechanism
- If Major Intervention
- Call **FIELD ALERT**



Poor Perfusion

- Suspect if **several** of these:
 - **Altered Mental Status**
 - Skin Pale, Cool, Diaphoretic
 - Tachycardia, Hypotension
 - Dyspnea, Tachypnea

Medications

- **TXA** (tranexamic acid): Appropriate for all major bleeding.
 - Avoid if injury greater than 3 hours old or known DVT/PE.

Notes

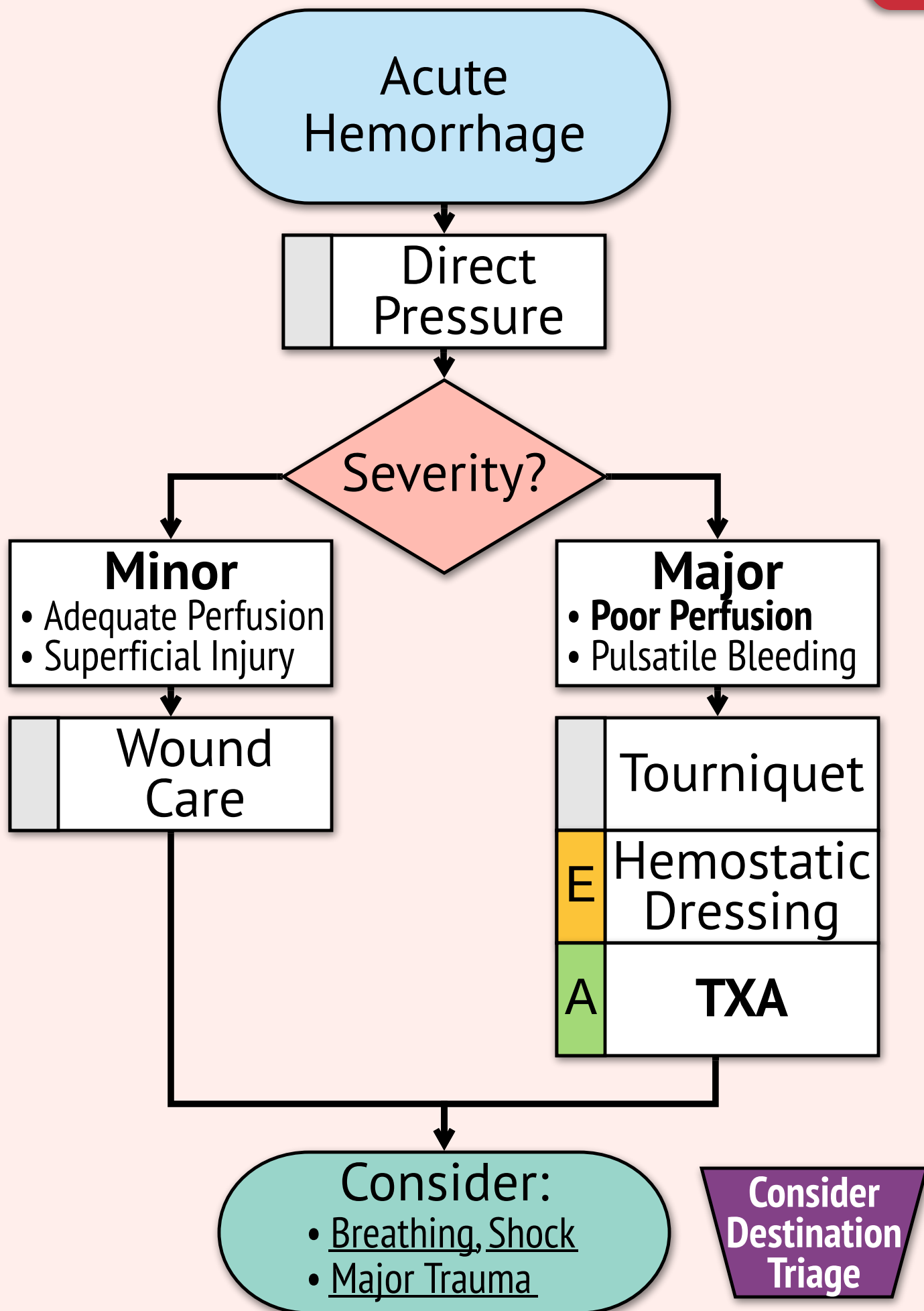
- Consider removing bystander dressings to investigate severity.
- **Lacerations** benefit from repair within the first few hours.
- Bandage wounds after bleeding is controlled.

Pediatrics

- Hypotension is a late sign of Shock in peds.
- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- ATLS: www.ncbi.nlm.nih.gov/pubmed/23609291
- Stop the Bleed: stopthebleedingcoalition.org
 - Brady Emergency Care 12th Ed: Chapter 27



TXA: 1 g	IV/IO	over 10 min	Adult
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Also called: Spinal Motion Restriction (SMR), C-spine, Backboard

Imperatives

- While backboards have historically been used to attempt spinal immobilization, SMR may also be achieved by use of a scoop stretcher, vacuum splint, **ambulance cot**, or other similar device to which a patient is safely secured. †
- A long spine board, a scoop stretcher, or a vacuum mattress is recommended to assist with **patient transfers** in order to minimize flexion, extension, or rotation of the possibly injured spine. †
- There is no role for SMR in penetrating trauma. †
- SMR requires **supine positioning** and a **c-collar**.
- Awake, compliant patients may be safely secured with seat belts.

Notes

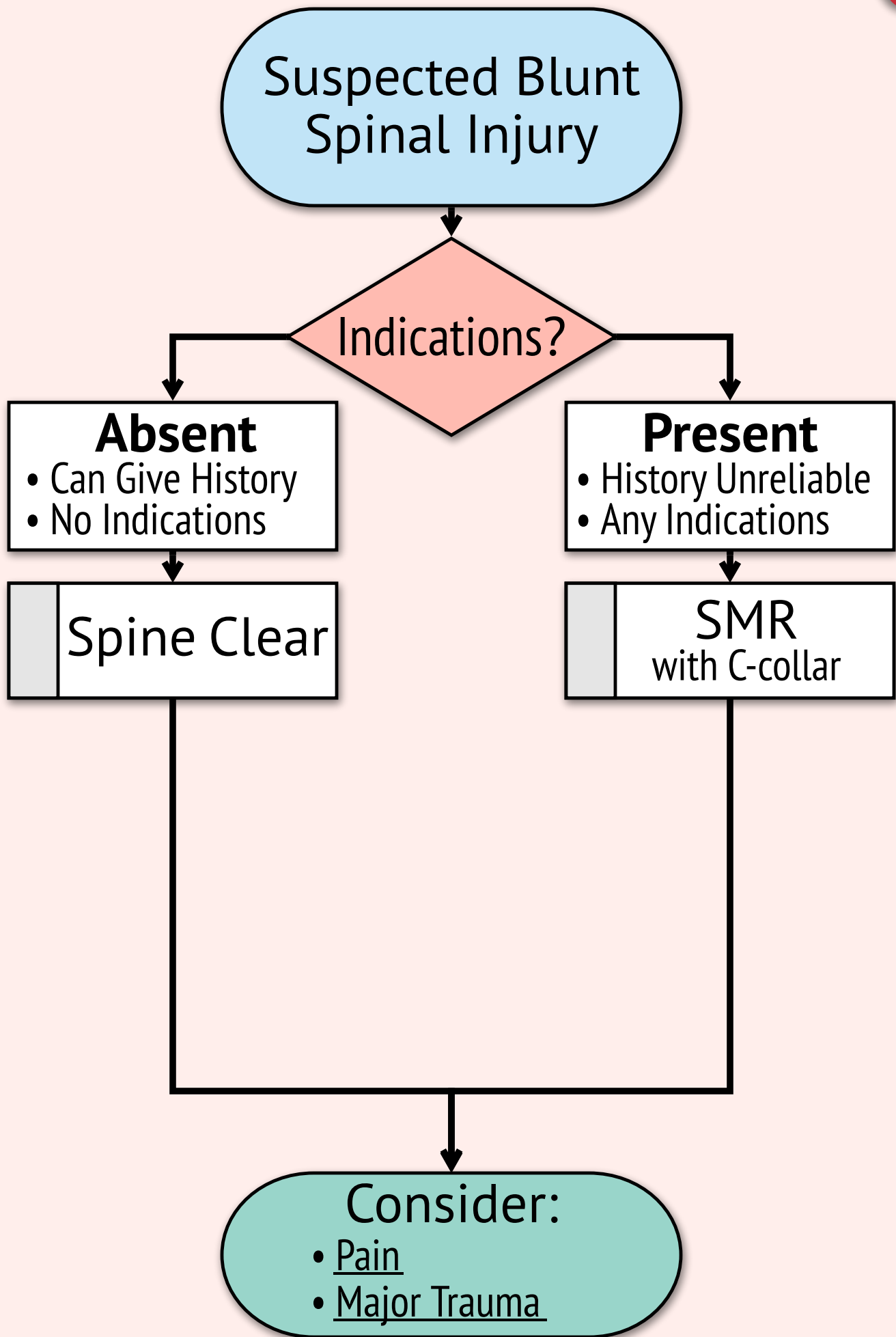
- **Spine Tenderness or Deformity** includes any:
 - Mid-line neck or back pain, tenderness, step off etc.
- **Neuro Deficits** include any new symptoms of neurologic injury:
 - Unconscious greater than 1 min, or seizure
 - Paralysis, weakness, numbness, or vision changes
 - Shooting 'electric' pain or tingling in any extremity
- **Altered LOC from Baseline** includes any change in mentation:
 - GCS less than baseline, new confusion
- **Acute Intoxication** includes any alteration in mentation due to:
 - Alcohol, medications or illegal drugs
- **Distracting Injury or Mechanism** may include:
 - Airway trauma, obvious SOB, major bleeding, unstable vitals
 - Fall > 10 ft, flail chest, unstable pelvis, 2° or 3° Burn > 10%
 - Major fracture, crushed, mangled or amputated extremity
 - High risk MVC: ejection, roll over, death in vehicle, struck by car

Pediatrics

- Any child that cannot provide a reliable history should have SMR.

References

- ACS-COT, ACEP, NAEMSP 2018 SMR in Trauma - Joint Statement †
- Brady Emergency Care 12th Ed: Chapter 31



Indications

- Spine Tenderness
- Spine Deformity
- Neuro Deficits
- Altered LOC from Baseline
- Acutely Intoxicated
- Distracting Injury or Mechanism

Also called: Concussion, Face / Neck / Eye / Mouth Trauma

Imperatives

- Transport emergently if sudden changes in LOC.
- Hyperventilate to EtCO₂ of 30-35mmHg if signs of herniation:
 - Obvious HTN with profound bradycardia
 - Altered LOC with unequal pupils or posturing
- Do not remove **impaled** objects. Splint object in position found.
- Wrap amputated parts in saline gauze and place in sealed bag.
 - Transport on ice if available. Record time placed on ice.
- **Lacerations** benefit from repair within the first few hours.
- **Mechanism** predicts severity.

- If Major Mechanism
- If Major Intervention
- Call **FIELD ALERT**



Notes

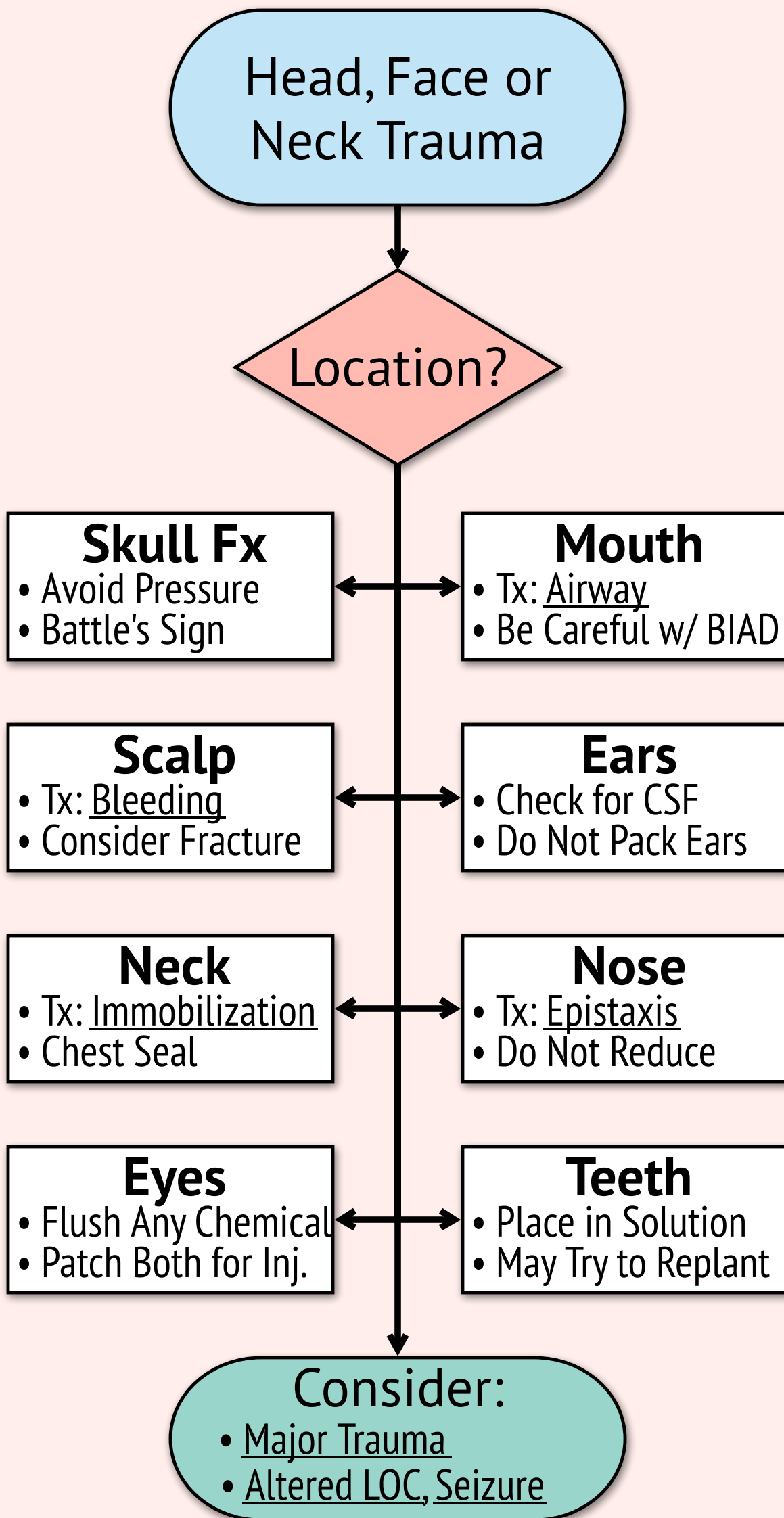
- **Skull Fx:** May cause bruising behind ears or around both eyes.
- **Scalp:** Lacerations may bleed aggressively. Direct pressure if no fx.
- **Neck:** All penetrations should have a chest seal.
- **Eye:** Contamination benefits from copious flushing (NS or water).
 - Patch both eyes for any penetrating injury.
- **Mouth:** Monitor Airway. May skip BIAD if obvious complications.
- **Ear:** Check any discharge for CSF by dropping on white paper.
 - A yellow / clear halo suggests CSF leak from skull fracture.
- **Nose:** Do not attempt to reduce. Treat for Epistaxis.
- **Teeth:** Transport avulsions in Hank's solution or NS.
 - Attempt replantation only in uncomplicated & isolated injury.
- **Concussion:** Usually does not require EMS intervention.

Pediatrics

- Do not attempt replantation for primary (baby) teeth.
- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape Head Injury: emedicine.medscape.com/article/1163653
- Brady Emergency Care 12th Ed: Chapter 31



Also called: Thoracic / Abdominal Injury, Evisceration

Imperatives

- Do not remove **impaled** objects. Splint object in position found.
- **Lacerations** benefit from repair within the first few hours.
- **Mechanism** is an important indicator of injury severity.

- If Major Mechanism
- If Major Intervention
- Call **FIELD ALERT**



Notes

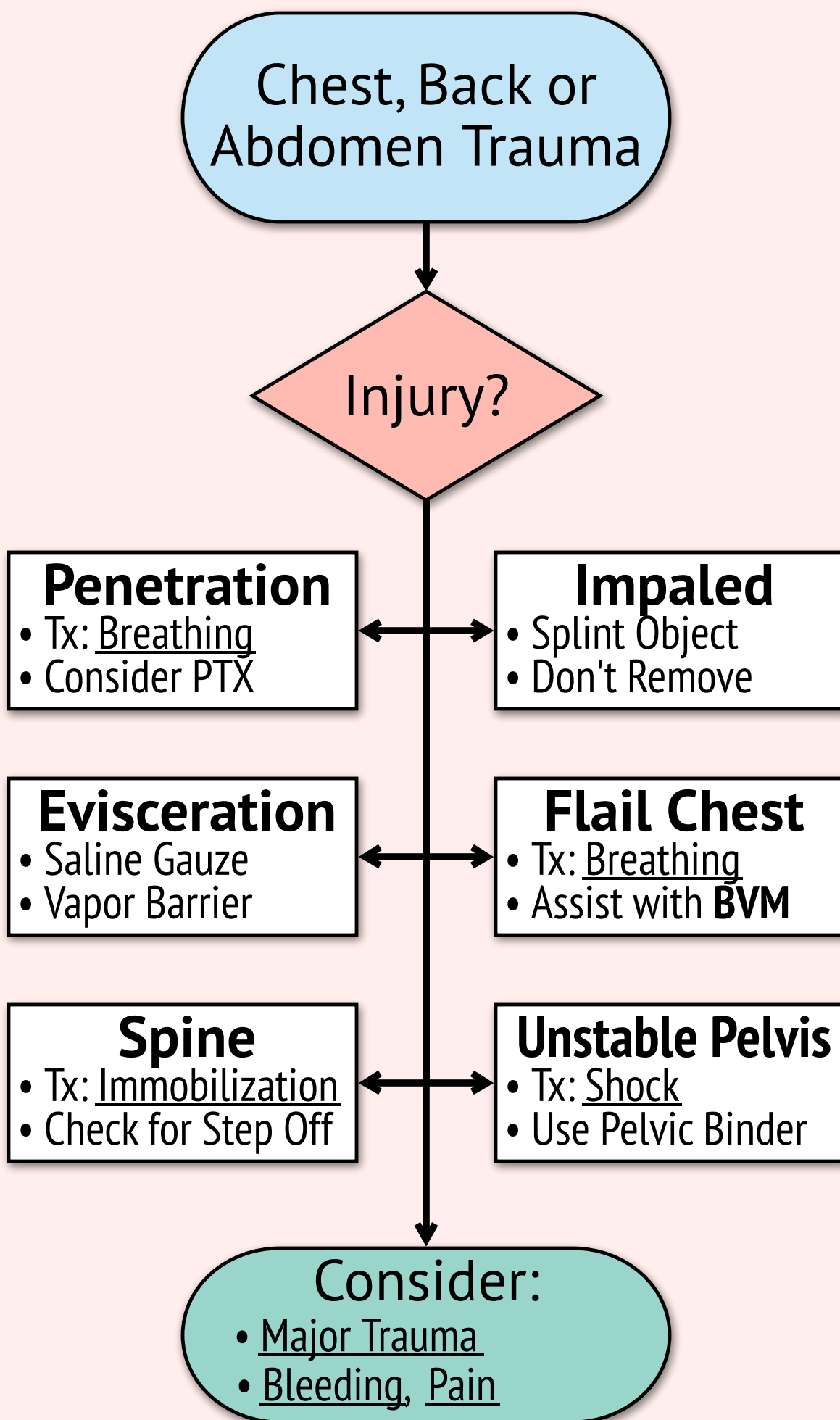
- **Penetration:** All penetrations should have a chest seal.
- **Evisceration:** Cover with saline gauze and vapor barrier.
- **Spine:** Monitor for Neuro Deficits and treat Immobilization.
- **Impaled:** Cut object free of wreckage. Do not remove from patient.
- **Flail Chest:** Monitor for Pneumothorax. Use BVM for Dyspnea.
- **Unstable Pelvis:** Assess with compression once. Use **Pelvic Binder**.

Pediatrics

- Trunk injury is more likely in peds struck by a car.

References

- Medscape Blunt Chest: emedicine.medscape.com/article/428723
- Medscape Penetrating Abd: emedicine.medscape.com/article/1270717
- Brady Emergency Care 12th Ed: Chapter 29



Also called: Amputation, Long Bone Fx, Splinting, Sprain/ Strain

Imperatives

- **Pulseless extremities** and **amputations** are true emergencies.
 - Record time of injury. Transport ASAP.
 - Wrap amputated parts in saline gauze and place in sealed bag.
 - Place bag on ice if available. Record time placed on ice.
- Remove adjacent and distal jewelry if able.
- Record peripheral neurovascular status before and after splinting.
- Consider a Traction Splint for **femur fractures** when appropriate.
 - Massive internal bleeding is possible with femur or hip fx.

- If Major Mechanism
- If Major Intervention
- Call **FIELD ALERT**



Notes

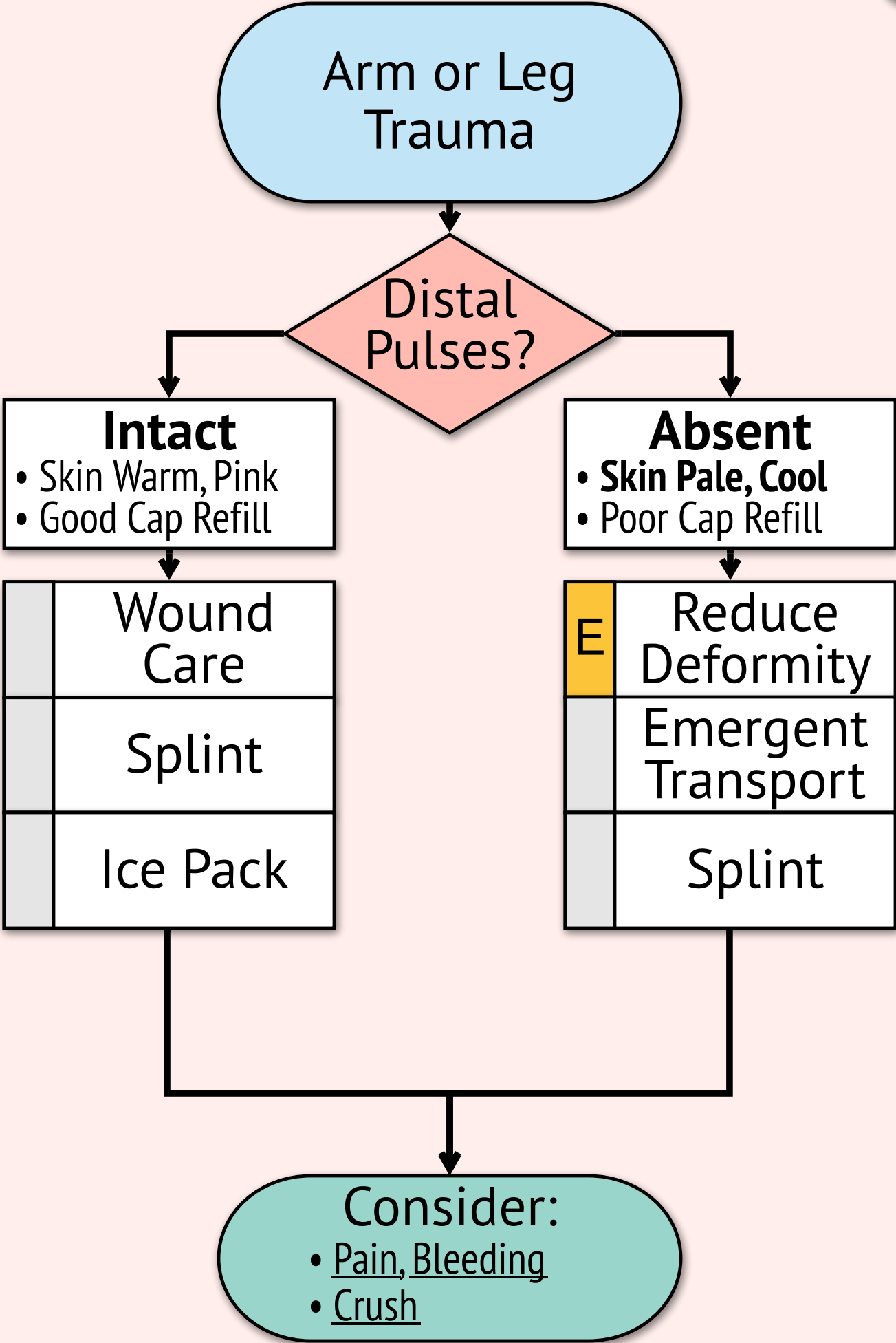
- **Lacerations** benefit from repair within the first few hours.
- **Mechanism** is an important indicator of injury severity.

Pediatrics

- Consider Child Abuse for injuries that do not match the history.

References

- Medscape Fracture Care: emedicine.medscape.com/article/1270717
- Medscape Vascular Trauma: emedicine.medscape.com/article/462752
- Brady Emergency Care 12th Ed: Chapter 29



Also called: Entrapment, Harness Hang

Imperatives

- Aggressively treat major crush injury as soon as possible.
 - An initial 12-Lead is not necessary before treatment.
 - Do not wait for EKG changes to initiate treatment.
 - Start during extrication if safe and prudent.
 - May **delay extrication briefly** if rapid treatment is available.
- Remove distal jewelry if able.

Medications

- **NS Bolus** (saline 0.9%): Aggressive fluids help dilute potassium.
 - Consider aggressive fluids even without Hypotension.
- **Calcium**: Avoid if the patient is taking digoxin (Lanoxin).
 - Do not mix with **Bicarbonate**. Flush line between meds.

- If Major Mechanism
- If Major Intervention
- Call **FIELD ALERT**



K⁺ EKG Changes

- From minor to life threat:
 - Peaked T-waves
 - Long PRI / Loss of P-wave
 - Wide QRS (Over 120 ms)
 - Slow V-Tach (Sine Wave)

Notes

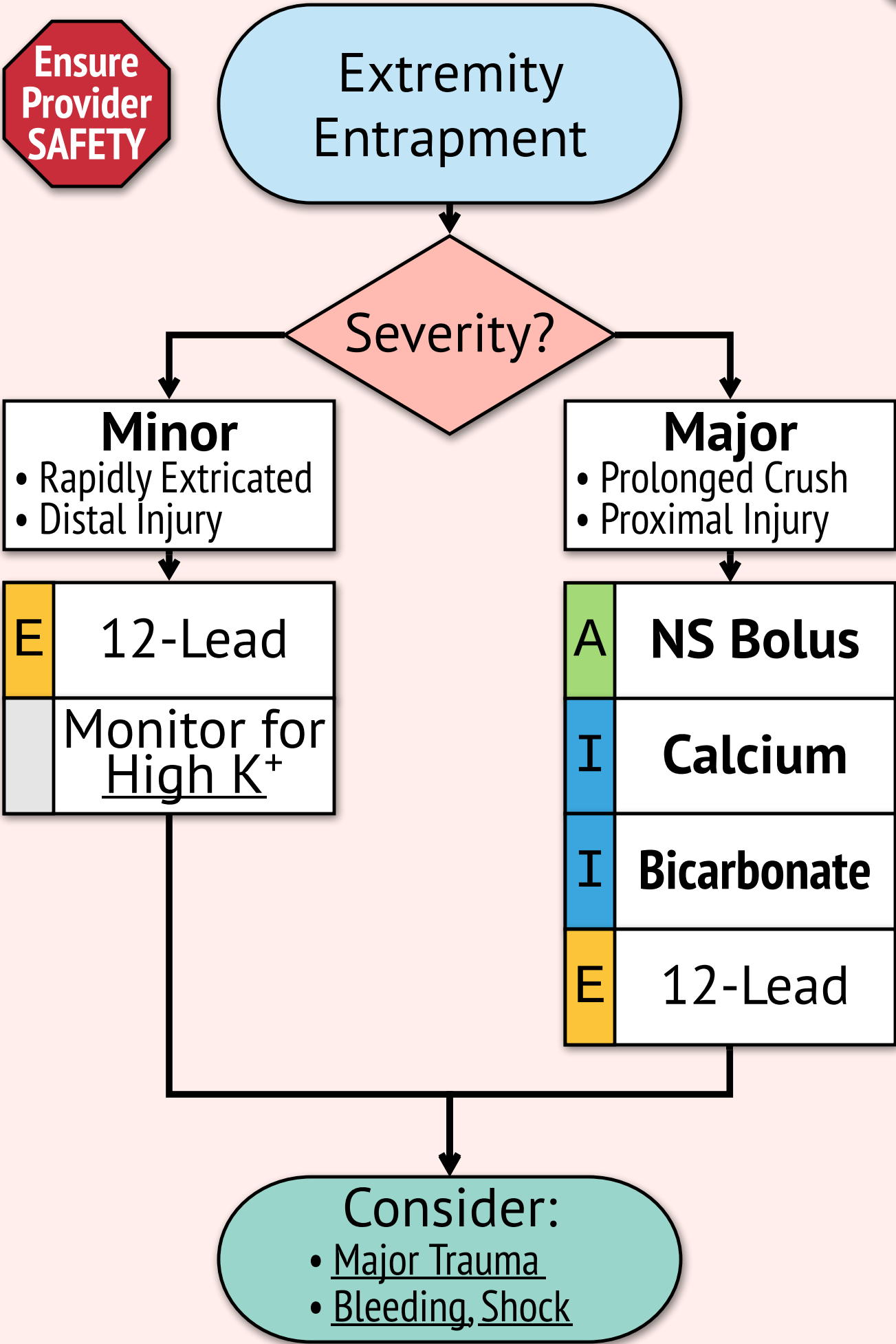
- Meds are unnecessary for isolated crush injury of hands or feet.
- Trapped patients may become hypothermic even in warm climate.

Pediatrics

- May exhibit symptoms quicker than adults.
- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape Rhabdo: emedicine.medscape.com/article/1007814
- Brady Emergency Care 12th Ed: Chapter 28



NS Bolus: 1,000 mL	IV/IO	x2	Adult Doses
Calcium: 1 g	IV/IO	x1	
Bicarbonate: 50 mEq	IV/IO	x1	

Also called: Hypo/ Hyperthermia, Frost Nip/ Bite, Heat Stroke

Imperatives

- **Resuscitation** of major **hypothermia** is a special case:
 - Most important intervention is **active rewarming**.
 - Check carefully for pulse. If present, it will be **very** faint.
 - Only **defib once**. Only give **ACLS meds once**. Avoid pacing.
 - Call **Medical Control** before termination of resuscitation.
 - Resume normal Medical CODE above **86 °F (30 °C)**.
- **Confusion** is the hallmark of major **hyperthermic** emergencies.
 - Patients with a normal LOC respond well to passive cooling.
- **Hyperthermia** is **not** the same as Fever.
 - Meds for Fever **worsen hyperthermia** and are contraindicated.
- **Passive techniques** include clothing and environment changes.

Notes

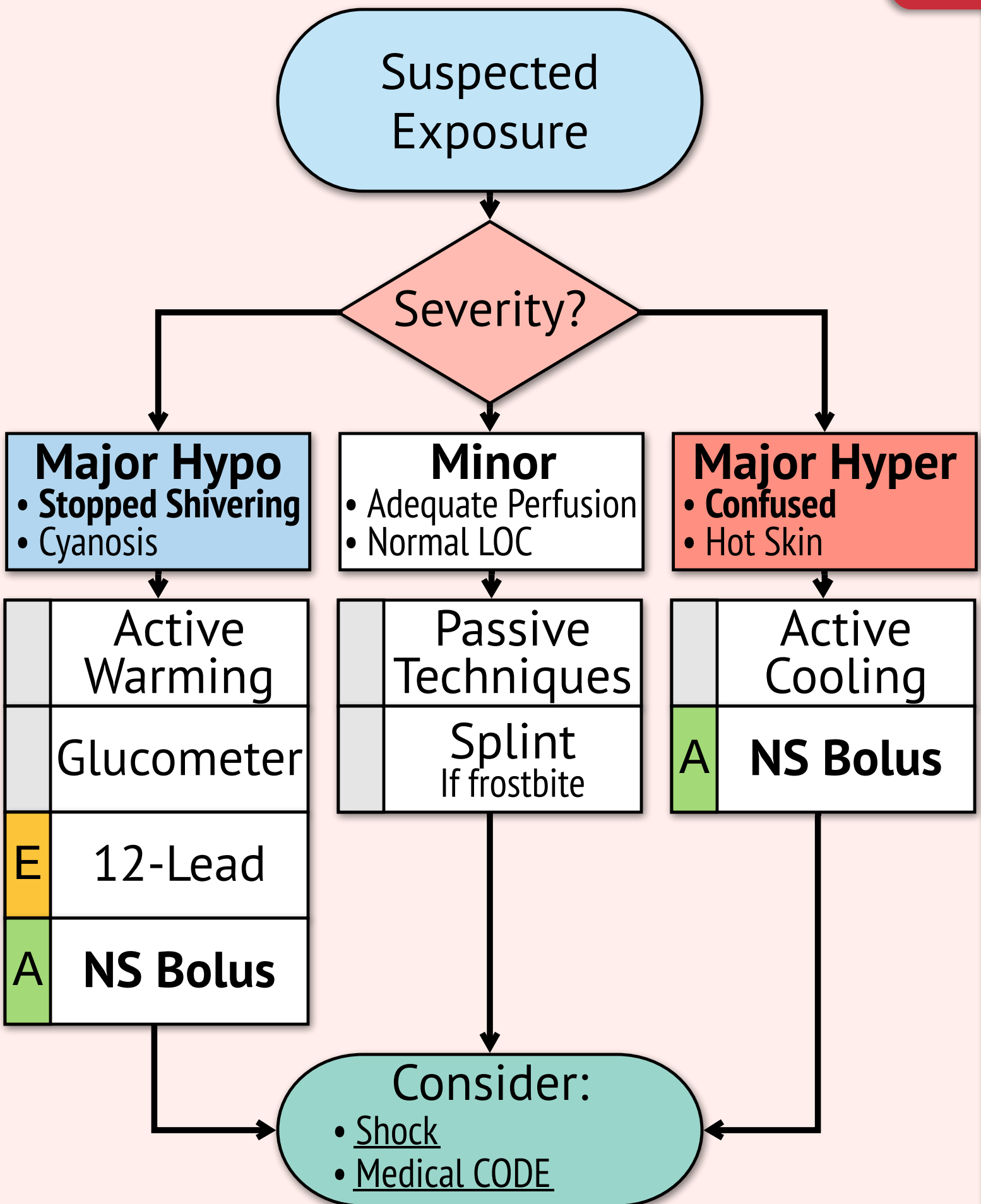
- Special thermometers or core temp monitors may be helpful.
 - Major **hypothermia** is likely below: **86 °F (30 °C)**.
 - Major **hyperthermia** is likely above: **106 °F (41 °C)**.
- Excessive movement of **hypothermic** patients can cause V-Fib.
- Delay active rewarming if unable to maintain (prolonged evac).
- Drugs may also cause **hyperthermia**. The treatment is the same.
- Peds and the elderly will decompensate faster.
- Try to pad heat or ice packs. Do not place directly against the skin.

Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape Hypothermia: emedicine.medscape.com/article/770542
- Medscape Heat Stroke: emedicine.medscape.com/article/166320
 - Brady Emergency Care 12th Ed: Chapter 33

**Active Warming**

- Remove Wet Clothes
- Heat Packs (kit) to Groin/ Pits
- Warmed IV Fluids

Active Cooling

- Fan and Misting
- Ice Packs to Groin / Armpits
- Chilled IV Fluids

NS Bolus: 1,000 mL IV/IO x2**Adult**

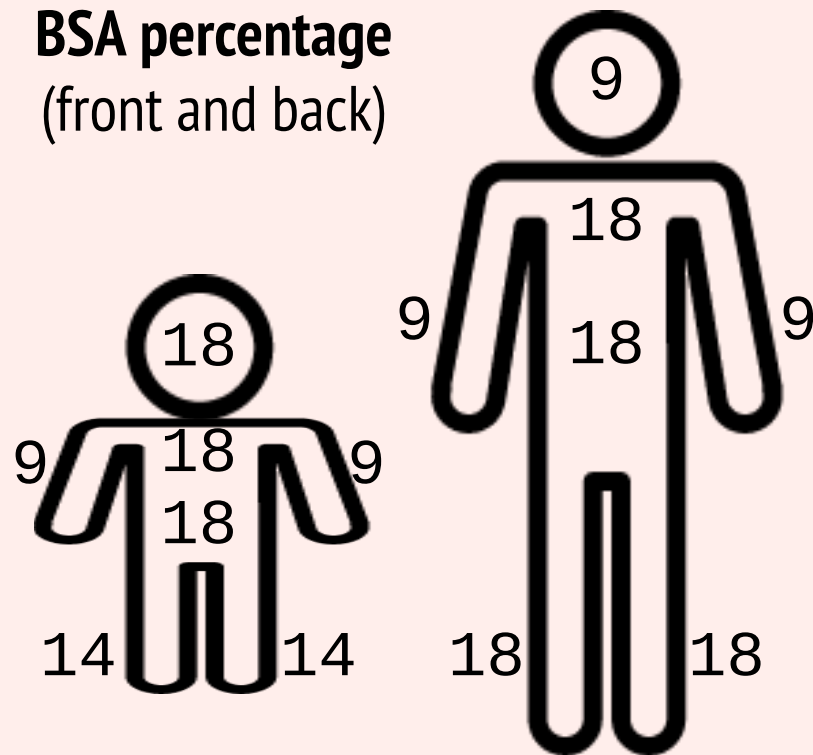
Also called: Haz Mat, Heat / Chemical / Electric Burn, Sunburn

Imperatives

- Monitor Airway closely with any facial, nasal or oral burns.
- Remove adjacent and distal jewelry if able.
- Be aggressive with fluids for **major burns**.
 - Be prepared for Hypothermia. Avoid ice.
- **ALS** should monitor EKG in electrical burns.

BSA percentage
(front and back)

- If Major Mechanism
- If Major Intervention
- Call **FIELD ALERT**



Notes

- Rule of 9's can estimate BSA in adults.
 - Patient's palm (without fingers) is about 1% BSA.
 - Consider only partial and full thickness when calculating BSA.
- This protocol includes most exposures on **skin**.
 - For most **gas** exposures, refer to Inhalation.
 - For chemical **ingestions** or organophosphates, refer to OD/Tox.
- If substance is known, consider Poison Control: 800-222-1222.
- This does not include **radiation** exposure. Call **Medical Control**.

Pediatrics

- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape Burns: emedicine.medscape.com/article/1278244
- Brady Emergency Care 12th Ed: Chapter 28

Ensure
Provider
SAFETY

Heat, Chemical, or
Electric Injury

Stop The
Burning

Severity?

Minor
• Superficial
• Less than 5% BSA

Position
of Comfort

Major
• Deep or Blistering
• Face or Genitals

	Burn Dressing
A	NS Bolus

Ensure
Patient
DECON

Consider:
• Breathing, Shock
• Pain, OD/Tox

Consider
Destination
Triage

NS Bolus: 1,000 mL	IV/IO x2	Adult
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Also called: Smoke Inhalation, Carbon Monoxide, Toxic Gas

Imperatives

- Monitor Airway closely with any facial, nasal or oral burns.
- Provide high flow oxygen for any carbon monoxide (CO) exposure.
 - Symptoms may include: headache, confusion, red skin, N/V.
 - SpO₂ may read false normal. (CO can fool the SpO₂ monitor.)
 - Oxygen is critical for pregnant females exposed to CO.
- Even non-toxic gases can produce Hypoxia and dyspnea.

Notes

- SpCO monitors are available and work like SpO₂ monitors.
 - Normal: less than 3% (may be up to 6% in heavy smokers)
 - Exposure: 3% - 10%
 - Toxic: above 10%
- This protocol includes most **gas** exposures.
 - For most **skin** exposures refer to Burns.
 - For chemical **ingestions** or organophosphates, refer to OD/Tox.
- If substance is known, consider Poison Control: 800-222-1222.

Pediatrics

- May exhibit symptoms quicker than adults.

References

- ACLS: circ.ahajournals.org/content/132/18_suppl_2
- PALS: circ.ahajournals.org/content/132/18_suppl_2/S526
- Medscape CO: emedicine.medscape.com/article/2085044
 - Brady Emergency Care 12th Ed: Chapter 31



Toxic or Anoxic
Gas Exposure

Remove
from Harm

Assess for:

- Airway, Breathing
- Burns

Provide O₂



Consider:

- Shock
- Bleeding

Also called: Animal/ Snake/ Spider/ Tick Bite, Bee/ Wasp Sting

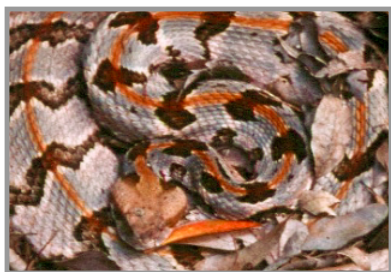
Imperatives

- **Don't bring** animals, snakes or bugs with you to the ED.
- Remove distal jewelry if able.
- Venous tourniquets and wound suction are not indicated.
- Serious or deep bites (especially human and cat) need antibiotics.
- Inquire about the rabies status of any domestic animal.
- Consider ice for animal bites and insect stings.
 - Avoid ice for snake bites.

Notes

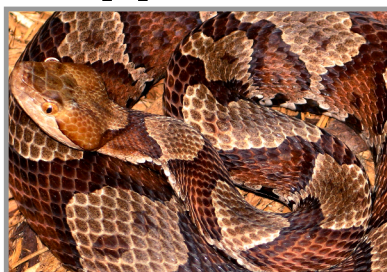
- Police can assist with animal control.
- Tick bites do not usually require EMS intervention.
- This protocol does not apply to marine stings or bites.
- Venomous bites in VA: Rattlesnake, Copperhead, Black Widow
- Use caution around all dangerous animals.
 - Do not risk provider safety to catch or photograph.

Rattlesnake



Timber_Rattlesnake

Copperhead



PHIL 8129

Black Widow



Redback_back_view

Pediatrics

- Watch for first time Anaphylaxis.

References

- Medscape Snakebite: emedicine.medscape.com/article/168828
- Medscape Widow Spider: emedicine.medscape.com/article/772196
- Wikimedia Commons © BY-SA 3.0: commons.wikimedia.org/w/index.php
- Brady Emergency Care 12th Ed: Chapter 33



Animal or Insect Trauma

Assess for:

- Allergic Reaction
- Bleeding

	Splint
	Stinger Removal

Consider:

- Pain
- Underlying Injury

Also called: Nose Bleed

Imperatives

- Have the patient lean forward slightly.
- Have patient squeeze the soft part of their nose together firmly.

Medications

- **Afrin** (oxymetazoline): contraindicated with chest pain

Notes

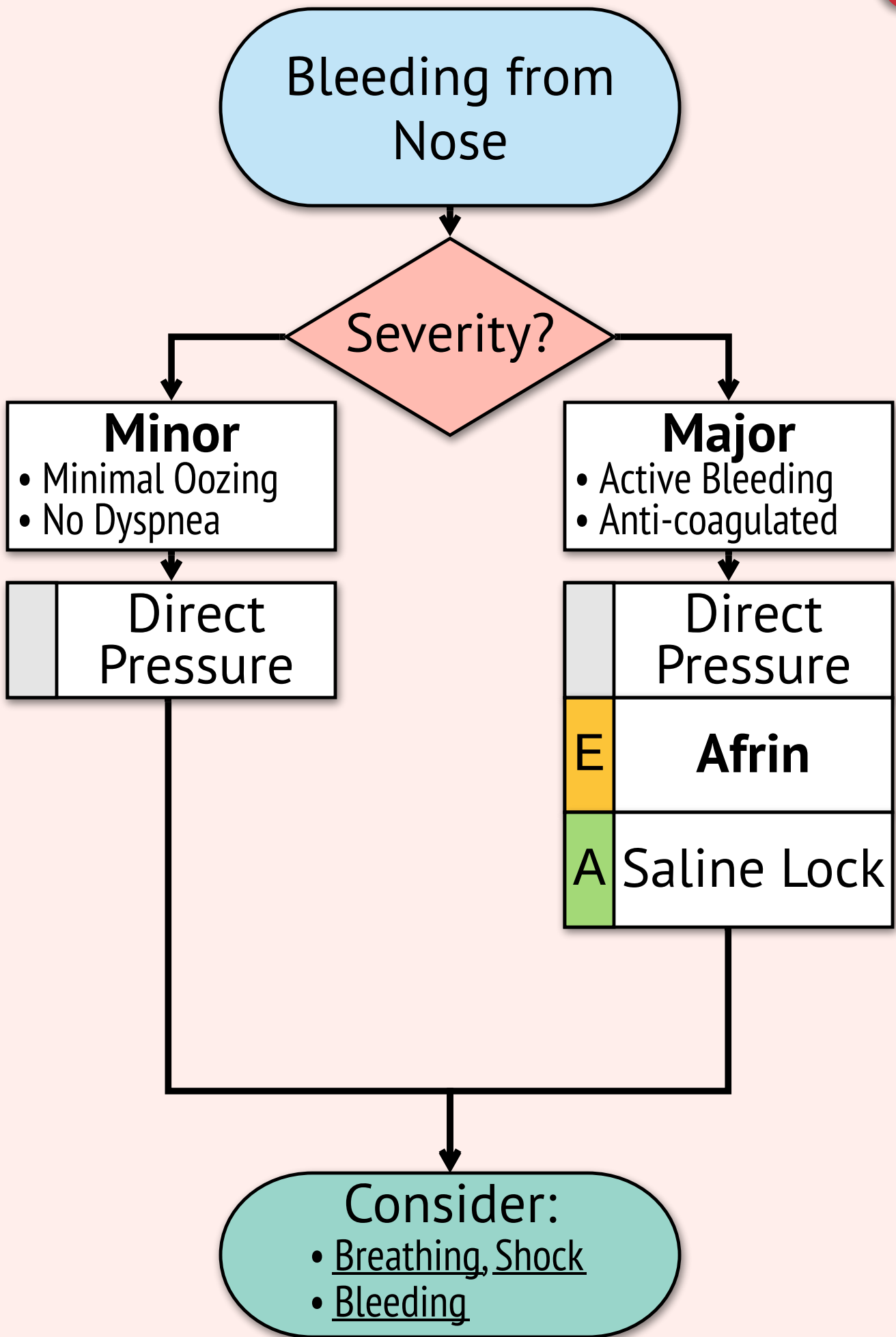
- It is very difficult to quantify the amount of blood loss.
- Check pharynx for possible posterior bleeding.
- Not all nose bleeds are traumatic. The treatment is the same.
- Ask about anti-coagulation medications such as:
 - Aspirin
 - Coumadin (warfarin)
 - Plavix (clopidogrel)
 - Xarelto (rivaroxaban)
 - Effient (prasugrel)
 - Pradaxa (dabigatran)
 - Brilinta (ticagrelor)
 - Lovenox (enoxaparin)

Pediatrics

- Nose bleeds are usually from minor trauma (nose picking).
- Refer to Appendix A or other approved source for peds dosing.

References

- Medscape Epistaxis: emedicine.medscape.com/article/764719
- Brady Emergency Care 12th Ed: Chapter 27



Afrin: 1 spray	IN	Q 5 min x3	Adult
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Page 80

General

A	Saline Lock
	Glucometer
E	12-Lead

Page 81

Airway

	Heimlich
	Suction
A	Magill Forceps

Page 82

Breathing

	BVM
E	CPAP

Page 83

Resuscitation

	Chest Compressions
A	I O
	Defib

Page 84

Adjuncts

	NPA
	OPA
E	OG-Tube

Page 85

Advanced Adjuncts

E	BIAD
I	Needle Decompress

Page 88

Cardiac

I	Pacing
I	Cardioversion

Page 86

Bleeding

	Wound Care
	Tourniquet
E	Hemostatic Packing

Page 87

Injury

	SMR with C-collar
E	Reduce Deformity
	Splint
	Stinger Removal

Page 89

Obstetrics

E	Deliver Baby
E	Manage Complication

A Saline Lock

1. Investigate for good site.
 - AC and wrist are common sites.
 - Try to avoid legs, forehead and jugular unless necessary.
 - Advance rapidly to IO in emergencies. Start with IO in a CODE.
 2. Clean site well. Apply a venous tourniquet.
 3. Perform venipuncture with appropriate size cath.
 4. Confirm placement with flash of blood. (Draw labs if available.)
 5. Attach lock and flush with saline. Secure well with tape.
- NOTE: It is almost always inappropriate for EMS to access an established indwelling central line (such as dialysis or PICC line).
- EMS may consider using established lines in a CODE only.

Glucometer

1. Prepare glucometer and test strip.
2. Identify and clean site.
 - The patient may have a preference.
3. Pierce skin with lancet to obtain blood sample.
 - May alternatively obtain blood from an IV attempt.
4. Place blood in/on reagent strip per manufacturer's instructions.

E 12-Lead

1. Enter patient info into monitor.
 2. Prepare chest and place electrodes.
 3. Instruct pt to **lay still**. Press button on monitor to acquire 12-lead.
 4. Acquire EKG while not moving. Try to **minimize artifact**.
 5. Transmit EKG to ED. Contact receiving hospital to confirm.
- BLS: May read machine interpretation. ALS: May interpret directly.

Heimlich

1. Help patient **cough if able**.
2. Attempt thrusts only if choking:
 - Adult: Abdominal thrusts (Use chest thrusts if obese/preg.)
 - Child: Abdominal thrusts
 - Infant: 5 back blows then 5 chest thrusts
3. Keep going until choking relieved or pt becomes unresponsive.
 - **Begin CPR if unresponsive.**
4. Remove any foreign bodies from mouth before ventilation.
 - Do not perform blind finger sweeps.

Suction

1. Awake pts may suction themselves.
2. Prepare suction device with tip:
 - Oropharynx: **hard tip** (Yankauer)
 - BIAD, Trach tube: **soft cath** (French)
3. Insert tip with suction off and/or vent hole uncovered.
 - May use 2-3ml saline to loosen secretions.
4. Cover vent hole and apply suction as tip is withdrawn.

A

Magill
Forceps

1. Prepare appropriate laryngoscope:
 - Average adults use **Mac #3**.
2. Visualize posterior pharynx with laryngoscope in left hand.
3. Use Magill Forceps to remove any identified foreign bodies.
 - Consider using suction.
4. Secure airway with BIAD if needed.

1. Prepare appropriately sized BVM.
 - Connect to high-flow oxygen.
 - Extend O₂ reservoir if equipped.
2. Maintain adequate mask seal. Dual rescuers is preferred.
 - Single Rescuer: Use E - C clamp technique.
 - Dual Rescuers: Use two handed technique.
3. Ventilate with slow deliberate squeezing of bag.
 - Assist with natural rate if adequate.
 - Provide additional breaths if natural rate is inadequate.

BVM

1. Explain procedure to pt.
 - Consider an NPA.
 2. Start the flow of oxygen to the mask. Set PEEP at 7.5 cm H₂O.
 3. Place the mask over patient's nose and mouth.
 4. Ensure adequate seal by adjusting placement and straps.
 5. Provide encouragement. Monitor closely for complications.
 - Remove promptly if vomiting or unresponsive.
- BLS: Maintain PEEP at 7.5 cm H₂O. ALS: May titrate PEEP.

E

CPAP

Chest Compressions

1. Confirm no pulse and not breathing.
 2. Place hands on chest:
 - Adult: Two hands with fingers interlaced over center of chest
 - Child: One hand over center of chest
 - Infant: Two hands circling chest using thumbs
 3. Push hard and fast. Compress about $\frac{1}{3}$ the depth of the chest.
 4. **Minimize interruption.** Compressions are the most important.
 5. Switch personnel every 2 min or sooner if needed.
- NOTE: Consider placing a mechanical device after the first 2 min.

A	I O
---	-----

1. Prepare IO device and select site.
 - Consider pre-treating for Pain.
2. Insert IO following manufacturer's recommended procedure.
3. Secure well with bulky dressing or other device.
4. Consider admin of **Lidocaine** to adults for local discomfort.

Lidocaine: 10 mg IO Q 5 min x3 PRN pain	Adult
--	--------------

5. Consider using a pressure bag to increase fluid rates if needed.

Defib

1. Cut clothes to expose chest.
 - Consider shaving excessive hair.
 - Remove any medication patches. Wipe off residue.
 2. Apply defibrillator pads. Avoid implanted devices or catheters.
 3. When indicated, stop compressions and analyze cardiac rhythm.
 - BLS: Use AED "analyze" function. ALS: May interpret directly.
 4. If shock indicated: charge defibrillator while continuing CPR.
 - Follow manufacturer's or OMD's dosing guideline.
 - Refer to Appendix A or other approved source for peds dosing.
 5. **Assertively state "CLEAR!"** Visually confirm everyone is clear.
 6. Defibrillate by pressing the **SHOCK** button.
 - Restart compressions immediately.
- ALS: Consider **dual sequential** defibrillation for persistent VT/VF:
- Attach two separate defibrillators. Do not overlap pads.
 - Defibrillate **at the same time** using both machines.

1. Measure appropriate NPA size:
 - Tip of nose to angle of jaw
2. Apply water-soluble lube to NPA.
3. Insert NPA into nare with bevel toward septum.
 - Start on larger nare. Rotate slowly if resistance is felt.
4. If unsuccessful: try more lube, smaller size and/or other side.
 - Minor **nose bleeding is common**.

NPA

1. Measure appropriate OPA size:
 - Corner of mouth to angle of jaw
2. Insert OPA into mouth slowly. May use tongue blade to assist.
 - Insert with tip to **nose for adults** and tip to **toes for peds**.
3. Rotate into place. Remove promptly if any gagging.

OPA

1. Measure appropriate tube depth:
 - Tip of nose to the stomach
2. Only place a prehospital OG-tube with an appropriate airway.
3. Lubricate the OG-tube.
4. Place into airway device per manufacturer's recommendation.
5. Advance the tube gently until the appropriate depth is reached.
6. Confirm placement and then secure the tube.
 - Inject air. Listen for bubbles in the stomach.
 - Attempt to aspirate gastric contents.
7. Continue to decompress the stomach of air and/or food.
 - Use low suction or manually aspirate with large tip syringe.

E

OG-Tube

E

BIAD

1. Prepare appropriately sized device:
 - Apply water-soluble lube.
 - Average adults use an **iGel #4 (green)**, or a **King #4 (red)**.
2. Pull jaw and tongue forward, or use jaw thrust.
3. Insert BIAD into pharynx slightly rotated to either side.
 - Rotate back to mid-line while advancing.
 - Rock BIAD gently to seat in airway.
4. **If balloon(s)** present: inflate per manufacturer's instruction.
5. **If dual lumen**: attempt alternate port if poor ventilation.
6. Confirm placement. Secure well with tape or other device.
 - Use auscultation, capnometry, EtCO₂ and SpO₂ if available.
7. If BIAD fails, **try again with a different size**.
 - Most common failure of a BIAD is inappropriate size.

I

Needle
Decompress

1. Identify side and clean best site:
 - 2nd intercostal mid-clavicular
 - Backup site: 4th intercostal mid-axillary
2. Insert large (12- or 14- gauge) IV needle into the skin at 90°
 - Preferably use a needle specifically made for decompression.
 - Go just over the top of the rib to minimize bleeding.
3. Advance until a "pop" is felt and/or you hear a hiss of air.
 - Hold needle in place, advance cath only the rest of the way.
4. Remove the needle, leaving the plastic cath in place.
5. Cover the cath with a chest seal.
6. Vent chest seal or repeat decompression if dyspnea returns.

Wound Care

1. Apply direct pressure for bleeding.
 - Consider tourniquet or packing.
2. If bleeding is easily controlled, irrigate contaminated wounds.
 - Consider pre-treatment of Pain.
3. Cover wounds with sterile gauze and apply appropriate dressing.
 - Monitor and document distal pulse, movement and sensation.
4. Cover burns with sterile burn dressing.
5. Apply a chest seal (occlusive) to any neck or trunk penetration.

Tourniquet

1. Apply direct pressure.
2. Confirm massive limb bleeding.
2. Apply tourniquet proximal to bleed per manufacturer instruction.
3. Tighten until bleeding is controlled. Secure windlass in place.
 - Consider placing second tourniquet if bleeding continues.
4. Record time on tourniquet or directly on the patient's skin.

E Hemostatic Packing

1. Apply direct pressure.
2. Consider treatment of Pain.
3. If massive bleeding from a limb, consider a tourniquet first.
4. If bleeding continues, wipe gross blood and clot out of wound.
5. Insert packing inch by inch as deep as possible into wound.
 - Avoid rapidly stuffing a large wad. Pack deep and deliberately.
 - Insert as much packing into the wound as possible.
6. Reapply direct pressure on top of packing.

SMR

with C-collar

1. Provide manual cervical SMR.
2. Prepare appropriately sized c-collar.
 - Apply c-collar while maintaining manual cervical SMR.
3. Use adjuncts to minimize all spinal motion while transferring.
 - Such as: backboard, scoop stretcher, vacuum mattress, etc.
4. Once on the cot, adjuncts may be removed if appropriate.
 - Prolonged transport on a backboard is potentially harmful.
 - Awake, compliant patients can be safely secured with seat belts.
 - Up to 30° of head elevation may be used to maintain an airway.
5. Manual cervical SMR may be released if the patient will hold still.
 - Otherwise: secure the head to an appropriate adjunct.

NOTE: Some patients (due to size, age or anatomy) will not be appropriate for standard equipment. Never force a patient into a non-neutral position. Use alternate techniques or manual SMR.

Splint

1. Provide manual immobilization.
2. Remove or cut clothing if able.
3. Check and document distal pulse, movement and sensation.
4. Select appropriate splint and secure above and below injury.
5. Recheck and document distal pulse, movement and sensation.
 - Reapply or remove splint if any decline in distal function.

NOTE: Consider traction splint for isolated femur fracture.

E

Reduce Deformity

1. Confirm no pulse distal to injury.
2. Explain procedure to patient.
 - Consider pre-treating for Pain if time and condition allow.
3. Manually reduce injury and splint in anatomic neutral position.
4. Recheck and document distal pulse, movement and sensation.

Stinger Removal

1. Inspect wound for stinger.
2. If visualized, scrape stinger away.
 - Use tool with firm edge, like a credit card.

I Pacing

1. Place defib pads and 12-Lead.
 - Consider pre-treating for Pain.
2. Place monitor in "pacing" mode.
 - Select initial rate and energy of **80 bpm** for adults.
 - Refer to Appendix A or other approved source for peds rate.
 - Select initial energy of **80 mA** for all patients.
 - Alternate: follow manufacturer's or OMD's dosing guideline.
3. Slowly increase mA output until electrical capture is noted.
 - Note pacer spikes on EKG screen.
4. Once electrical capture is noted, check for mechanical capture.
 - Pulse should correspond to electrical activity on EKG screen.
5. Continue to increase mA output if no mechanical capture.
6. Maintain a balance between pt comfort and medical necessity.
 - Treat Pain aggressively if patient condition allows.
 - Consider reducing energy if appropriate.

I Cardioversion

1. Place defib pads and 12-Lead.
 - Consider pre-treating for Pain.
2. Enable **SYNC** mode and charge to **50 J** for adults.
 - Alternate: follow manufacturer's or OMD's dosing guideline.
 - Refer to Appendix A or other approved source for peds dosing.
3. **Assertively state "CLEAR!"** Visually confirm everyone is clear.
4. Cardiovert by **pressing and holding** the **SHOCK** button.
 - There may be a noticeable delay before energy is delivered.
5. Reassess patient and rhythm. Escalate and repeat as needed.
 - Follow manufacturer's or OMD's escalation guideline.
 - Refer to Appendix A or other approved source for peds dosing.

E**Deliver Baby**

1. **Expose patient.** Have a chaperone.
 - Visually inspect vaginal area.
2. Identify presenting part. Prioritize **transport if not crowning.**
 - If any problems, manage complications and transport ASAP.
3. **Deliver Head.** Suction mouth, then nose with bulb suction.
4. **Check for cord around neck.** Slip over head if found.
5. **Deliver shoulders.** Deliver top shoulder first.
 - May flex mom's legs to chest to assist.
 - May press on mom's lower abdomen to assist.
7. Deliver body. Caution: **neonates are slippery.**
8. **Clamp and cut cord.**
 - Clamp about 2 in. away from the baby. Cut between clamps.
9. Manage Neonate. (Stimulate, warm, clean, dry.)
10. Massage mother's lower abdomen (fundal massage).
 - This should help stop post-partum bleeding.
11. Prepare for delivery of the placenta. Do not pull on the cord.
 - Take the placenta to the hospital with mom and baby.

E**Manage Complication**

1. **Prioritize emergent transport.**
2. **Tell mom: Do Not Push.**
2. Continue standard care. Treat: Breathing, Pain, etc.
 - EMS can do very little for: preemies, twins, or breech birth.
3. Try to help during transport.
 - Failed Delivery / Shoulder Dystocia: transport knees to chest
 - Prolapsed Cord: fingers in vagina to remove pressure on cord
 - Breech: support presenting part, do not pull on part

Page 91 - Medications

- Drug Box

Page 92 - Abuse

- Patient Abuse and Neglect
- Infant Abandonment

Page 93 - Bystanders, Physician Orders

- Verification of On Scene Personnel
- Physician Orders

Page 94 - Termination

- Withholding Resuscitation
- Termination of Resuscitation

Page 95 - LVADs

- Left Ventricular Assist Devices

Page 96 - Standbys, Police

- EMS Standbys
- Scene Rehab
- Law Enforcement Assistance

Page 97 - Refusals

- Patient Refusals
- Who is a Patient

Page 98 - Destination

- Destination Triage Plan: STEMI, CVA, Trauma

Page 99 - Deceased Subjects, MCI

- Deceased Subjects
- Mass Casualty

Drug Box

- Agencies participating in the regional drug box exchange program shall follow the procedures below regarding the use and exchange of boxes at regional hospitals.
- EMS provider breaks seal and places seal in top tray of drug box. There will be a new/unused GREEN seal in both the box, and another in the narcotics box, and must be saved for resealing the opened box(es) after use.
- EMS provider documents medications used on the patient care report and the WVEMS/BREMS Regional Pharmacy Administration Record Physician Order Form. A physician's signature shall be obtained when a provider obtains online orders for medications (including DEA number in any and all cases where online orders for narcotics are used). Boxes will be returned to the Emergency Department, if the signature of the physician or nurse is not legible and/or there is not a DEA number when needed and the regional council will be notified. Enter the RESEAL serial number(s) on the WVEMS/BREMS Regional Pharmacy Administration Record Physician Order Form. Except under extenuating circumstances the drug box should only be used on one patient and exchanged after use.
- EMS provider and E.D. nurse, physician, pharmacist or pharmacy technician and/or other person as authorized, check used box to account for narcotics. Both assure that all trash and used needles have been removed from the box. The old seal should be left in the box and forwarded to the pharmacy. The nurse, physician, or authorized person will sign the appropriate space indicating that all narcotics have been accounted for. After everything is accounted for, the AIC shall take the green reseal(s) provided in the drug box/narcotics box, and seal the box(es).
- E.D. nurse, physician, pharmacist or pharmacy technician or authorized person issues a new box to the EMS provider, both complete the "Drug Box Exchange Log". The seal on the new box is not to be broken until needed on the scene of an emergency. Boxes on which seals have been broken must be returned to the E.D. or Pharmacy for exchange. If the facility requires a copy of a PPCR or patient reporting printout with an explanation of why the seal was broken this must accompany the box.
- Pharmacy will fill the box in accordance with the contents used from the box schematic. The pharmacy checks the box to assure all contents are present and in-date. The box is sealed with a numbered seal provided by the EMS Council. A hospital sticker indicating the date of the first drug to expire is to be placed on the outside of the box.
- If a box is returned to the pharmacy with dirty needles or excessive litter and debris, the box will be held out of service and the EMS Council notified. The Council will in turn notify the agency and/or personnel responsible and they will be required to report to the hospital to correct the situation. Repeated occurrences by the same provider/agency may result in suspension or revocation of drug box privileges.
- Refilled boxes are returned to the E.D. or stored in the pharmacy for distribution. Each hospital is responsible to assure that the boxes are properly secured against tampering while at the hospital.
- If an EMS provider opens a box and finds one or more medications missing he/she shall document such on the PPCR or patient reporting software and the EMS provider shall notify the EMS Council in writing of the discrepancy; noting the box number and seal number in the report. If the missing drug is a narcotic refer to item # 11. As long as the missing medication is not a narcotic, the box may be returned to service by the hospital pharmacy after restocking the box.
- No item for item exchange may be made in the E.D. The box must be returned to the pharmacy to be checked, restocked, and resealed.
- When narcotics are used on a call, the ALS technician will bring the unused portion to the E.D. The nurse, physician, or authorized person checking the box will record the amount remaining on the patient care report and the WVEMS/BREMS Regional Pharmacy Administration Record Physician Order Form, and sign his/her name. The authorized person signing and the ALS technician will then properly dispose and accounting for the narcotic according to hospital policy.
- In the event that medications are missing from the box the following steps must be followed:
 - A. If the seal is found to be broken during a routine drug inspection:
 1. Avoid handling the box.
 2. Contact local law enforcement. (NARCOTICS ONLY)
 3. Contact the agency Chief or Captain
 4. Contact the Western Virginia EMS Council
 5. Complete and file a drug diversion form with the Office of EMS (see 12 VAC 5-31-520, D of the Virginia EMS Rules and Regulations)
 6. Have drug box inspection forms ready for police, EMS Council, and Office of EMS personnel.
 - B. If the seal is on the box and medications are missing while performing patient care or after arriving at the hospital:
 1. Continue patient care, you may continue to utilize the contents of the box.
 2. If the medication needed is not present consider requesting another unit to meet en route, DO NOT DELAY TRANSPORT.
 3. Upon arrival at the hospital notify the E.D. Nursing Supervisor of the problem.
 4. Follow the procedures listed in 11-A.
 5. The box must be secured in the hospital and may be released only after being notified by the EMS Council.
 - C. In all cases you will be asked to write a report stating the events surrounding the incident. It should include the box number, seal number, witnesses and a description of what occurred.
 - D. Depending on the individual circumstances, the Operational Medical Director of the agency or the Regional Medical Director may suspend the agency's authorization to administer drugs in the pre-hospital setting pending the outcome of a formal investigation by law enforcement or the Office of EMS, and may require implementation of additional security measures at the agency's expense.

Patient Abuse and Neglect

- Abuse in this policy is considered any physical, sexual and / or mental injury of any child, domestic partner, senior citizen, or incapacitated adult by another person through action or neglect. Abuse may be at the hand of a partner, parent, caregiver, spouse, neighbor, or adult child of the patient. The recognition, appropriate reporting, and referral of abuse is a critical step to improving patient safety, providing quality health care, and preventing further abuse. This also ensures EMS compliance as “Mandatory Reporters” under the Code of Virginia.
- **Be aware** of the potential for abuse in all patients. In any case where abuse is suspected, first protect the patient and the EMS team from harm. Collect as much information as possible and preserve physical evidence if able. Signs of abuse may include:
 - **Physical:** injuries that are inconsistent with the reported mechanism, injuries in different stages of healing, defensive injuries (ex. to forearms), or injuries during pregnancy
 - **Psychological:** excessive passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, behavioral disorders, substance abuse, or non-compliance
 - **Neglect:** inappropriate level of clothing for weather, inadequate hygiene, inattentive caregiver, or malnutrition
- **Immediately report** any suspicious findings to both the receiving hospital (if transported) and social services:
For children contact Child Protective Services at (800) 552-7096.
For adults contact Adult Protective Services at (888) 832-3858.
For domestic violence offer police intervention and provide the patient with the National Hotline, 1-800-799-SAFE.

Infant Abandonment

- The Code of Virginia (§18.2-371.1 B.2) allows a new parent to surrender their newborn to a hospital or EMS agency under certain circumstances. EMS providers should accept without hesitation, assess and transport any infant surrendered to them.

Verification of on scene personnel

- The delivery of prehospital care at the scene of an emergency is the responsibility of the **responding EMS resources**. Occasionally, bystanders may be crucial to providing or assisting with treatment. Bystanders can be considered when the immediate needs outweigh the EMS resources available, or if a bystander can provide a unique resource. EMS should never authorize or perform any intervention outside their scope **or comfort level**.
- Bystanders may have a unique understanding of a **specialized medical device** or condition. EMS should consider the advice of patients or bystanders, such as caretakers managing a vent at home, or a patient with an LVAD, etc. EMS must call **Medical Control** for any orders to deviate from routine EMS care.
- **BLS procedures** are frequently taught as a component of common first aid. Appropriate bystanders may assist with common first aid when EMS resources are insufficient. EMS must direct bystanders and maintain overall responsibility.
- **ALS interventions** are only appropriate by responding ALS resources. A formal mutual aid agreement or authorization by **Medical Control** must exist prior to delivery of ALS interventions. EMS has no authority to enable non-EMS medical personnel (RN, NP, PA, CRNA, RT, etc.) to perform ALS interventions.

Physician Orders

- Physicians represent a unique resource. EMS may follow written or verbal orders from a patient's established physician. EMS may also follow **appropriate** verbal orders from a physician bystander on scene. EMS should only consider orders outside these protocols **if the physician bystander accompanies EMS** to the hospital. Call **Medical Control** if there is any conflict.

Withholding Resuscitation

- Resuscitation is not appropriate if efforts are futile or against the patient's explicit wishes. **Withhold resuscitation if any signs of obvious death, mortal injury, or if the patient has a DNR / POST.**
- EMS should attempt to validate any DNR / POST with family or health care workers. Begin resuscitation and call **Medical Control** if there is any question. EMS may stop resuscitation once verified.

Termination of Resuscitation

- Transportation during resuscitation is not optimal and exposes EMS crews to significant risk. This policy balances the risk of emergent transport against the benefit of prolonged resuscitation.

- **Prioritize transport for any special case.** If attempting resuscitation, these special cases may benefit from resources not available in the field. Prioritize compressions and AED and transport ASAP.

- **ALS** should resuscitate on scene for non-special cases. **Call Medical Control if no ROSC within 30 min.**

- **BLS** should try to turn over care to ALS (or the hospital) within 15 min. **Prioritize transport if a hospital is within 15 min.** Extended BLS resuscitation beyond 15 min may still be successful if the arrest is witnessed by EMS or if any shock is ever advised by the AED. **Prioritize transport for any witnessed or shocked arrest regardless of time to the hospital.** Call **Medical Control** if not witnessed, and not shocked, and no ALS after 15 min.

Special Cases

- Suspected Traumatic Cause
- Pediatric or Pregnant Patients
- Hypothermia or Drowning
- Lightning or Electric Shock
- Overdose or Poisoning

ALS Termination

- Not a Special Case
- No ROSC within 30 min

BLS Termination

- Not a Special Case
- Not witnessed by EMS
- Never shocked by AED
- No ALS within 15 min
- No ROSC within 15 min

LVAD (left ventricular assist device)

- LVAD patients can quickly become very complicated.
 - Their life literally depends on an external pump they wear.
 - **When in doubt, follow regular protocols.**
- All LVAD patients will have an assigned "**LVAD center.**"
 - The patient should have the emergency phone number.
 - EMS may try to **contact the LVAD center** with any problems.
 - Call **Medical Control** to verify any recommendations.
- Diagnosing LVAD problems is complex.
 - **Do not unplug anything.**
 - Consider the advice of the patient and any trained bystanders.
 - Some LVADs may provide voice prompts for troubleshooting.
 - Call **Medical Control** to verify any recommendations.
- Patients who are alive and well **may not have a palpable pulse.**
 - It may be impossible to palpate or auscultate a blood pressure.
 - Do not start CPR on patients who are obviously alive and well.
- An LVAD makes diagnosis of cardiac arrest difficult.
 - Look for other signs of life and listen for the LVAD pump noise.
 - Chest compressions may harm an LVAD.
 - Consider the advice of trained bystanders or the LVAD center.
 - Call **Medical Control ASAP for any unconscious LVAD** patient.
- **Bring all LVAD supplies** and information to the ED with you.
 - Bring batteries and cords.
 - Bring paperwork and contact information.
- Consider destination triage in consultation with **Medical Control.**

EMS Standbys

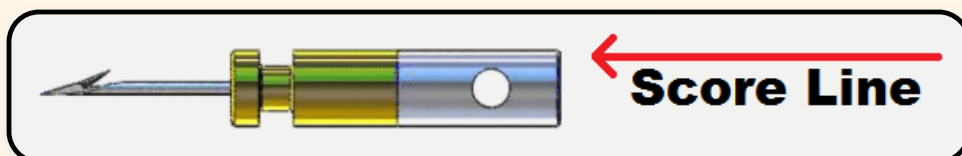
- EMS may be utilized to standby at a scene without a specific pt.
- EMS should complete a full report for any patients or treatments.
 - Consider simple interventions such as PO pain meds and ice.
 - Document a refusal if any patient declines transport.

Scene Rehab

- EMS may provide rehab for large scenes like structure fires, etc.
 - This may include abbreviated screening and / or treatment.
 - Rehab is only applicable to fellow responders.
- EMS should coordinate all activity with incident command.
- Standard rehab includes a specific area dedicated to medical ops.
 - Rehab generally involves checking vital signs and simple exam.
 - Provide PO fluids and food. Monitor until back to baseline.
 - An abbreviated record may be substituted for a full report.
 - Incident command will dictate who may return after rehab.

Law Enforcement

- EMS may also be called to evaluate a patient in custody.
 - Always offer transport. EMS can never recommend a refusal.
 - EMS can provide treatment, but cannot "clear" a patient.
 - Officers may elect to decline transport, but should sign a refusal.
 - Officers should accompany any patient in custody.
 - Call **Medical Control** if there is any conflict.
- EMS may remove CEW (**Taser™**) probes as part of wound care.
 - EMS should document a full report.
 - Officers may sign a refusal for a person under their arrest.
 - Probes are small straight barbs. Stretch skin tight and pull out.
 - The barb is in-line with the score mark on the probe.



Patient Refusals

- Refusals represent a unique medical risk. EMS should complete a formal refusal with **at least one witness signature** for any patient who declines any intervention and/or transport.
- EMS should encourage treatment and transport for every patient.
 - EMS may not refuse transport if requested.
- All patients who wish to refuse must be **eligible** to make their own decisions. Eligible patients include:
 - Adults (18 y/o and older)
 - Minors who are married, divorced or emancipated
- The Code of Virginia (§54.1-2969 G) allows **pregnant minors** to direct treatment **only relating to the delivery of their baby**.
- The responsible party (parent, guardian, etc.) may refuse for a patient who is not eligible to refuse on their own.
- All patients or guardians who wish to refuse must also demonstrate **capacity**. This requires them to be awake, oriented, and able to demonstrate understanding of the potential risks associated with their refusal.
 - Patients with altered LOC lack capacity and cannot refuse.
 - Suicidal patients lack capacity and cannot refuse.
- Call **Medical Control** and enlist police help for any patient who attempts to refuse, but should not be allowed to do so.

Who is a Patient?

- Any person for whom EMS is specifically summoned should be considered a patient. Every patient should have a full report completed with a transport or a refusal documented.
- Not every person on scene of an emergency needs to be considered a patient. EMS is not obligated to document a refusal for a person who declines EMS assessment, **and** is acting normally without obvious distress, **and** for whom EMS was not specifically summoned.
 - A refusal should be documented if there is any doubt.

Destination Triage Plan

- Some specific conditions benefit from prehospital triage to a more appropriate destination. Consider increasing transport time **no more than 30 minutes** to reach a more capable facility if any of the following emergency conditions are identified.
- The decision to pass a less capable facility and therefore increase transport time should include consideration of **air transport**, the stability of the patient and system resources at the time. Call **Medical Control** if there is any doubt or conflict.



Acute STEMI with chest pain

- Pts should have an appropriate presentation (chest pain, etc.) and an EKG identified as *** **ACUTE MI** *** by automated analysis.
- ALS may manually identify EKG changes of 1 mm or more of ST segment elevation in 2 or more anatomically contiguous leads.
- Appropriate WEMS heart hospitals (with emergent PCI) include:
 - **Carilion Roanoke, Lewis Gale Salem** and **Danville Regional**

Acute (large vessel) CVA

- Pts should have a definite **time last normal under 6 hrs** and at least one positive finding on a **Cincinnati Stroke** (FAST) exam.
- Pts must also have at least one positive finding on a **VAN** exam.
- Appropriate WEMS stroke hospitals (PSC or CSC) include:
 - **Carilion Roanoke Memorial** and **Lewis Gale Salem**

Major or Unstable Trauma

- Pts should meet trauma triage guidelines with **major injury** and/or major mechanism.
- Appropriate WEMS trauma hospitals (Level I or II) include:
 - **Carilion Roanoke Memorial**

Deceased Subjects

- EMS may occasionally encounter a deceased subject.
 - Maintain respect for the deceased and their family.
 - Always involve the police. Always write a full report.
- If resuscitation was **not attempted**:
 - Consider all deceased subjects as a potential crime scene.
 - Limit EMS ingress/egress and coordinate with the police.
 - Police may request EMS to confirm death.
- If resuscitation **was attempted** and subsequently terminated:
 - **Medical Control** should already be involved.
 - Do not remove any pads, leads, invasive lines or tubes.
 - EMS may disconnect hardware such as EKG wires and BVM.
 - Defer to the direction of the police or Medical Examiner.
- In some situations the **police may release the body**.
 - EMS should not transport the deceased to the ED.
 - EMS may offer courtesy transport to a funeral home.
 - EMS may remove lines, tubes, etc if the body is released.
 - Courtesy transport is not required. Defer to agency policy.
 - Inform **Medical Control** of any courtesy transports.
- EMS may confirm death in several ways including:
 - Lack of pulse, respirations or response.
 - Asystole in at least two cardiac leads with gain at max.
 - Obvious Death or Mortal Injury.

Mass Casualty

- **Call for more help. Begin a standardized MCI triage system.**
 - Several systems are described, such as START and JumpSTART.
- Do the most good for the most people until adequate help arrives.
 - Consider utilizing any available resources, such as bystanders.
 - Prioritize life-saving interventions.
 - Triage and prioritizing care during an MCI is not abandonment.

GRAY

Resuscitation

Defib: 10 ► 20 J
Epi (code): 0.04 mg
Lidocaine: 4 mg

Common

NS Bolus: 100 mL
Afrin: <do not use>
Albuterol: 0.625 mg
Atrovent: 0.25mg
Benadryl: 5 mg
D10: 25 mL
Decadron: 2 mg
Epi (allergy): 0.04 mg
Epi (neb): 0.25 mL
Fentanyl: 5 mcg
Glucose: 3.25 g
Ibuprofen: 40 mg
Ketamine (pain): <do not use>
Narcan: 0.4 mg
Tylenol: 64 mg
Zofran: <do not use>

Misc

IV Cath: 24 g
King Airway: Clear (0)
iGel Airway: Pink (1)
Pacing Rate: 120 bpm
Cardioversion: 5 ► 10 J

Less Common

Adenosine: 0.4 ► 0.8 mg
Amiodarone: <do not use>
Atropine: 0.1 mg
Bicarbonate: 4 mEq
Calcium: 100 mg
Dopamine: 20 mcg/min
Epi (brady): 0.004 mg
Glucagon: 0.5 mg
Haldol: <do not use>
Ketamine (rosc): <do not use>
Labetalol: 2.5 ► 5 mg
Magnesium: 0.25 g
TXA: 50 mg
Versed: 0.25 mg

0 - 5 kg

0 - 12 lbs

- Refer to the adult dosing for route and frequency.
- Emergent peds dosing by its nature cannot be an exact science.
 - Weight based dosing is best. Match actual weight if available.
 - Length based tape is second best. These are Broselow™ colors.
 - Age ranges are least accurate, but are better than guessing wt.

PINK

Resuscitation

Defib: 15 ► 30 J
Epi (code): 0.06 mg
Lidocaine: 6 mg

Common

NS Bolus: 120 mL
Afrin: <do not use>
Albuterol: 0.625 mg
Atrovent: 0.25mg
Benadryl: 5 mg
D10: 25 mL
Decadron: 3 mg
Epi (allergy): 0.06 mg
Epi (neb): 0.25 mL
Fentanyl: 10 mcg
Glucose: 3.25 g
Ibuprofen: 60 mg
Ketamine (pain): 1.5 mg
Narcan: 0.4 mg
Tylenol: 96 mg
Zofran: 0.5 mg

Misc

IV Cath: 24 g
King Airway: White (1)
iGel Airway: Blue (1.5)
Pacing Rate: 110 bpm
Cardioversion: 7 ► 15 J

Less Common

Adenosine: 0.6 ► 1.2 mg
Amiodarone: 30 mg
Atropine: 0.1 mg
Bicarbonate: 6 mEq
Calcium: 150 mg
Dopamine: 30 mcg/min
Epi (brady): 0.006 mg
Glucagon: 0.5 mg
Haldol: <do not use>
Ketamine (rosc): 1.5 mg
Labetalol: 2.5 ► 5 mg
Magnesium: 0.25 g
TXA: 50 mg
Versed: 0.5 mg

6 - 7 kg

13 - 16 lbs

- Refer to the adult dosing for route and frequency.
- Emergent peds dosing by its nature cannot be an exact science.
 - Weight based dosing is best. Match actual weight if available.
 - Length based tape is second best. These are Broselow™ colors.
 - Age ranges are least accurate, but are better than guessing wt.

RED

Resuscitation

Defib: 15 ► 30 J
Epi (code): 0.08 mg
Lidocaine: 8 mg

Common

NS Bolus: 160 mL
Afrin: *<do not use>*
Albuterol: 1.25 mg
Atrovent: 0.25mg
Benadryl: 5 mg
D10: 25 mL
Decadron: 4 mg
Epi (allergy): 0.08 mg
Epi (neb): 0.25 mL
Fentanyl: 10 mcg
Glucose: 3.25 g
Ibuprofen: 80 mg
Ketamine (pain): 2 mg
Narcan: 0.8 mg
Tylenol: 128 mg
Zofran: 0.5 mg

Misc

IV Cath: 24 g
King Airway: White (1)
iGel Airway: Blue (1.5)
Pacing Rate: 100 bpm
Cardioversion: 7 ► 15 J

Less Common

Adenosine: 0.8 ► 1.6 mg
Amiodarone: 40 mg
Atropine: 0.2 mg
Bicarbonate: 8 mEq
Calcium: 150 mg
Dopamine: 40 mcg/min
Epi (brady): 0.008 mg
Glucagon: 0.5 mg
Haldol: *<do not use>*
Ketamine (rosc): 2 mg
Labetalol: 2.5 ► 5 mg
Magnesium: 0.25 g
TXA: 50 mg
Versed: 0.5 mg

8 - 9 kg

17 - 20 lbs

- Refer to the adult dosing for route and frequency.
- Emergent peds dosing by its nature cannot be an exact science.
 - Weight based dosing is best. Match actual weight if available.
 - Length based tape is second best. These are Broselow™ colors.
 - Age ranges are least accurate, but are better than guessing wt.

PURPLE

Resuscitation

Defib: 20 ► 40 J
Epi (code): 0.1 mg
Lidocaine: 10 mg

Common

NS Bolus: 200 mL
Afrin: <do not use>
Albuterol: 1.25 mg
Atrovent: 0.25mg
Benadryl: 10 mg
D10: 50 mL
Decadron: 5 mg
Epi (allergy): 0.1 mg
Epi (neb): 0.5 mL
Fentanyl: 10 mcg
Glucose: 7.5 g
Ibuprofen: 100 mg
Ketamine (pain): 2 mg
Narcan: 0.8 mg
Tylenol: 160 mg
Zofran: 1 mg

Misc

IV Cath: 22 g
King Airway: White (1)
iGel Airway: Blue (1.5)
Pacing Rate: 100 bpm
Cardioversion: 10 ► 20 J

Less Common

Adenosine: 1 ► 2 mg
Amiodarone: 50 mg
Atropine: 0.2 mg
Bicarbonate: 10 mEq
Calcium: 200 mg
Dopamine: 50 mcg/min
Epi (brady): 0.01 mg
Glucagon: 0.5 mg
Haldol: <do not use>
Ketamine (rosc): 2 mg
Labetalol: 2.5 ► 5 mg
Magnesium: 0.5 g
TXA: 100 mg
Versed: 0.75 mg

10 - 11 kg

21 - 25 lbs

- Refer to the adult dosing for route and frequency.
- Emergent peds dosing by its nature cannot be an exact science.
 - Weight based dosing is best. Match actual weight if available.
 - Length based tape is second best. These are Broselow™ colors.
 - Age ranges are least accurate, but are better than guessing wt.

YELLOW

Resuscitation

Defib: 25 ► 50 J
Epi (code): 0.12 mg
Lidocaine: 12 mg

Common

NS Bolus: 250 mL
Afrin: *<do not use>*
Albuterol: 1.25 mg
Atrovent: 0.25mg
Benadryl: 10 mg
D10: 50 mL
Decadron: 6 mg
Epi (allergy): 0.12 mg
Epi (neb): 0.5 mL
Fentanyl: 20 mcg
Glucose: 7.5 g
Ibuprofen: 120 mg
Ketamine (pain): 3 mg
Narcan: 1.2 mg
Tylenol: 192 mg
Zofran: 1 mg

Misc

IV Cath: 22 g
King Airway: Green (2)
iGel Airway: Grey (2)
Pacing Rate: 100 bpm
Cardioversion: 12 ► 25 J

Less Common

Adenosine: 1.2 ► 2.4 mg
Amiodarone: 60 mg
Atropine: 0.3 mg
Bicarbonate: 12 mEq
Calcium: 250 mg
Dopamine: 60 mcg/min
Epi (brady): 0.012 mg
Glucagon: 0.5 mg
Haldol: *<do not use>*
Ketamine (rosc): 3 mg
Labetalol: 5 ► 10 mg
Magnesium: 0.5 g
TXA: 100 mg
Versed: 1 mg

12 - 14 kg

26 - 31 lbs

- Refer to the adult dosing for route and frequency.
- Emergent peds dosing by its nature cannot be an exact science.
 - Weight based dosing is best. Match actual weight if available.
 - Length based tape is second best. These are Broselow™ colors.
 - Age ranges are least accurate, but are better than guessing wt.

WHITE

Resuscitation

Defib: 30 ► 60 J
Epi (code): 0.15 mg
Lidocaine: 15 mg

Common

NS Bolus: 300 mL
Afrin: <do not use>
Albuterol: 2.5 mg
Atrovent: 0.25mg
Benadryl: 15 mg
D10: 50 mL
Decadron: 8 mg
Epi (allergy): 0.15 mg
Epi (neb): 0.5 mL
Fentanyl: 20 mcg
Glucose: 7.5 g
Ibuprofen: 160 mg
Ketamine (pain): 4 mg
Narcan: 1.6 mg
Tylenol: 256 mg
Zofran: 1 mg

15 - 18 kg

Misc

IV Cath: 22 g
King Airway: Green (2)
iGel Airway: Grey (2)
Pacing Rate: 100 bpm
Cardioversion: 15 ► 30 J

Less Common

Adenosine: 1.5 ► 3 mg
Amiodarone: 80 mg
Atropine: 0.3 mg
Bicarbonate: 15 mEq
Calcium: 300 mg
Dopamine: 80 mcg/min
Epi (brady): 0.015 mg
Glucagon: 0.5 mg
Haldol: <do not use>
Ketamine (rosc): 4 mg
Labetalol: 5 ► 10 mg
Magnesium: 0.5 g
TXA: 100 mg
Versed: 1.25 mg

32 - 40 lbs

- Refer to the adult dosing for route and frequency.
- Emergent peds dosing by its nature cannot be an exact science.
 - Weight based dosing is best. Match actual weight if available.
 - Length based tape is second best. These are Broselow™ colors.
 - Age ranges are least accurate, but are better than guessing wt.

BLUE

Resuscitation

Defib: 40 ► 80 J
Epi (code): 0.2 mg
Lidocaine: 20 mg

Common

NS Bolus: 400 mL
Afrin: *<do not use>*
Albuterol: 2.5 mg
Atrovent: 0.25mg
Benadryl: 20 mg
D10: 100 mL
Decadron: 10 mg
Epi (allergy): 0.15 mg
Epi (neb): 0.5 mL
Fentanyl: 30 mcg
Glucose: 15 g
Ibuprofen: 200 mg
Ketamine (pain): 5 mg
Narcan: 2 mg
Tylenol: 320 mg
Zofran: 2 mg

Misc

IV Cath: 20 g
King Airway: Green (2)
iGel Airway: Grey (2)
Pacing Rate: 90 bpm
Cardioversion: 20 ► 40 J

Less Common

Adenosine: 2 ► 4 mg
Amiodarone: 100 mg
Atropine: 0.4 mg
Bicarbonate: 20 mEq
Calcium: 400 mg
Dopamine: 100 mcg/min
Epi (brady): 0.02 mg
Glucagon: 0.5 mg
Haldol: *<do not use>*
Ketamine (rosc): 5 mg
Labetalol: 5 ► 10 mg
Magnesium: 1 g
TXA: 200 mg
Versed: 1.5 mg

19 - 23 kg

41 - 51 lbs

- Refer to the adult dosing for route and frequency.
- Emergent peds dosing by its nature cannot be an exact science.
 - Weight based dosing is best. Match actual weight if available.
 - Length based tape is second best. These are Broselow™ colors.
 - Age ranges are least accurate, but are better than guessing wt.

ORANGE

Resuscitation

Defib: 50 ► 100 J
Epi (code): 0.25 mg
Lidocaine: 25 mg

Common

NS Bolus: 500 mL
Afrin: 1 spray
Albuterol: 2.5 mg
Atrovent: 0.5mg
Benadryl: 25 mg
D10: 100 mL
Decadron: 10 mg
Epi (allergy): 0.15 mg
Epi (neb): 0.5 mL
Fentanyl: 30 mcg
Glucose: 15 g
Ibuprofen: 260 mg
Ketamine (pain): 6 mg
Narcan: 2 mg
Tylenol: 320 mg
Zofran: 2 mg

Misc

IV Cath: 20 g
King Airway: Orange (2.5)
iGel Airway: White (2.5)
Pacing Rate: 90 bpm
Cardioversion: 25 ► 50 J

Less Common

Adenosine: 2.5 ► 5 mg
Amiodarone: 125 mg
Atropine: 0.5 mg
Bicarbonate: 25 mEq
Calcium: 500 mg
Dopamine: 125 mcg/min
Epi (brady): 0.025 mg
Glucagon: 1 mg
Haldol: 1.25 mg
Ketamine (rosc): 6 mg
Labetalol: 5 ► 10 mg
Magnesium: 1 g
TXA: 200 mg
Versed: 2 mg

24 - 29 kg

52 - 64 lbs

- Refer to the adult dosing for route and frequency.
- Emergent peds dosing by its nature cannot be an exact science.
 - Weight based dosing is best. Match actual weight if available.
 - Length based tape is second best. These are Broselow™ colors.
 - Age ranges are least accurate, but are better than guessing wt.

GREEN

Resuscitation

Defib: 60 ► 120 J
Epi (code): 0.3 mg
Lidocaine: 30 mg

Common

NS Bolus: 600 mL
Afrin: 1 spray
Albuterol: 2.5 mg
Atrovent: 0.5mg
Benadryl: 25 mg
D10: 100 mL
Decadron: 10 mg
Epi (allergy): 0.3 mg
Epi (neb): 0.5 mL
Fentanyl: 40 mcg
Glucose: 15 g
Ibuprofen: 300 mg
Ketamine (pain): 8 mg
Narcan: 2 mg
Tylenol: 320 mg
Zofran: 2 mg

Misc

IV Cath: 18 g
King Airway: Orange (2.5)
iGel Airway: White (2.5)
Pacing Rate: 90 bpm
Cardioversion: 30 ► 60 J

Less Common

Adenosine: 3 ► 6 mg
Amiodarone: 150 mg
Atropine: 0.5 mg
Bicarbonate: 30 mEq
Calcium: 600 mg
Dopamine: 150 mcg/min
Epi (brady): 0.03 mg
Glucagon: 1 mg
Haldol: 2.5 mg
Ketamine (rosc): 8 mg
Labetalol: 5 ► 10 mg
Magnesium: 1 g
TXA: 300 mg
Versed: 2.5 mg

30 - 36 kg

65 - 80 lbs

- Refer to the adult dosing for route and frequency.
- Emergent peds dosing by its nature cannot be an exact science.
 - Weight based dosing is best. Match actual weight if available.
 - Length based tape is second best. These are Broselow™ colors.
 - Age ranges are least accurate, but are better than guessing wt.

##	
9's (rule of) <i>in:</i>	
Burns	72
12-Lead	80

A	
A-Fib / A-Flutter <i>in:</i>	
Tachycardia	14
AAA (Abd Aneurysm) <i>in:</i>	
Abdominal Pain	34
Abandonment <i>in:</i>	
Infant Abandonment	92
Abdominal Pain	34
Abdominal Trauma <i>in:</i>	
Trunk Injury	64
Abuse and Neglect	92
Acetaminophen <i>see:</i> Tylenol	
Acid Reflux <i>in:</i>	
Abdominal Pain	34
Adenocard <i>see:</i> Adenosine	
Adenosine <i>for:</i>	
Tachycardia	14
Advil <i>see:</i> Ibuprofen	
Afrin <i>for:</i>	
Epistaxis	78
Agitated Delirium <i>in:</i>	
Psychiatric	46
Airway	4
Albuterol <i>in:</i>	
Hyperkalemia	18
Dyspnea	30
Allergic Reaction	32
Alcohol Intoxication <i>in:</i>	
Overdose / Tox	40
Allergic Reaction	32
ALS (Advanced Life Support) <i>in:</i>	
How To Use	2
Altered LOC / Syncope	36
Amiodarone <i>for:</i>	
Tachycardia	14
Medical CODE	24
Amputation <i>in:</i>	
Extremity Injury	66
Anaphylaxis <i>in:</i>	
Allergic Reaction	32
Angioedema <i>in:</i>	
Allergic Reaction	32
Arrest <i>in:</i>	
Medical CODE	24
Police	96
Arrhythmia <i>in:</i>	
Bradycardia	12
Tachycardia	14
Aspirin <i>for:</i>	
Chest Pain	28
Asthma <i>in:</i>	
Dyspnea	30
Asystole <i>in:</i>	
Medical CODE	24
Atropine <i>for:</i>	
Bradycardia	12
Overdose / Tox	40
Atrovent <i>for:</i>	
Dyspnea	30
Allergic Reaction	32
Avulsion (teeth) <i>in:</i>	
Head Injury	62

B	
B-blocker <i>see:</i> Labetalol	
B-blocker Overdose <i>in:</i>	
Overdose / Tox	40
Baby <i>in:</i>	
Pregnancy / Delivery	48
Neonate	50
Backache <i>in:</i>	
Pain	20
Backboard <i>in:</i>	
Immobilization	60
Behavioral Emergency <i>in:</i>	
Psychiatric	46
Benadryl <i>for:</i>	
Allergic Reaction	32
Benzodiazapine <i>see:</i> Versed	
BIAD <i>in:</i>	
Airway	4
BIAD	85
Bicarbonate <i>for:</i>	
Hyperkalemia	18
Medical CODE	24
Overdose / Tox	40
Crush Injury	68
Bite / Sting	76
Blast Injury <i>in:</i>	
Major Trauma	56
Bleeding	58
Blood Glucose / Sugar <i>in:</i>	
Diabetic	38
Glucometer	80
BLS (Basic Life Support) <i>in:</i>	
How To Use	2
Bolus <i>see:</i> NS Bolus	
Bradycardia	12
Breech Birth <i>in:</i>	
Pregnancy / Delivery	48
Deliver Baby	89
Manage Complication	89
Breathing	6
Burns	72
BVM <i>in:</i>	
Breathing	6
BVM	82
Bystanders <i>in:</i>	
On Scene Personnel	93

C	
C-Collar / C-Spine <i>in:</i>	
Immobilization	60
C-Collar	87
Ca-blocker Overdose <i>in:</i>	
Overdose / Tox	40
Calcium <i>for:</i>	
Hyperkalemia	18
Medical CODE	24
Overdose / Tox	40
Crush Injury	68
Calcium Carbonate <i>see:</i> Calcium	
Calcium Gluconate <i>see:</i> Calcium	
Capnography <i>in:</i>	
Breathing	6
Capnometry <i>in:</i>	
Airway	4
Carbon Dioxide (EtCO2) <i>in:</i>	
Breathing	6
Carbon Monoxide (CO) <i>in:</i>	
Inhalation	74

Cardiac Arrest <i>in:</i>	
Medical CODE	24
Cardiac Arrhythmia <i>in:</i>	
Tachycardia	14
Cardioversion	88
Chemical Burn <i>in:</i>	
Burns	72
Chest Compressions	83
Chest Pain	28
Chest Trauma <i>in:</i>	
Trunk Injury	64
CHF <i>in:</i>	
Dyspnea	30
Chest Seal <i>in:</i>	
Breathing	6
Major Trauma	56
Needle Decompress	85
Wound Care	86
Choking <i>in:</i>	
Airway	4
Heimlich	81
Chronic Pain <i>in:</i>	
Pain	20
Cincinnati Stroke Scale <i>in:</i>	
Stroke	44
Circulation (Shock)	8
CODE <i>in:</i>	
Medical CODE	24
Trauma CODE	52
COPD <i>in:</i>	
Dyspnea	30
Collapse <i>in:</i>	
Medical CODE	24
Altered LOC / Syncope	32
Cold <i>in:</i>	
Cold / Heat	70
Combitube <i>in:</i>	
Airway	4
BIAD	85
Compressions <i>in:</i>	
Medical CODE	24
Trauma CODE	52
Chest Compressions	83
Concussion <i>in:</i>	
Head Injury	62
Contractions <i>in:</i>	
Pregnancy / Delivery	48
Convulsion <i>in:</i>	
Seizure	42
Cooling <i>in:</i>	
Medical CODE	24
Cough <i>in:</i>	
Dyspnea	30
CPAP <i>in:</i>	
Breathing	6
CPAP	82
CPR <i>in:</i>	
Medical CODE	24
Trauma CODE	52
Chest Compressions	83
Croup <i>in:</i>	
Dyspnea	30
Crush Injury	68
CVA <i>in:</i>	
Stroke	44
Cyanide Exposure <i>in:</i>	
Overdose / Tox	40
Cyanosis <i>in:</i>	
Dyspnea	30

D

D10 for:	
Diabetic	38
Death in:	
Medical CODE	24
Termination	94
Deceased Subject	99
Decadron for:	
Dyspnea	30
Allergic Reaction	32
Deceased Subject	99
Decompression (needle) in:	
Breathing	6
Needle Decompress	85
Defibrillation in:	
Medical CODE	24
Trauma CODE	52
Defib	83
Deficits (Neuro) in:	
HTN	10
Stroke	44
Immobilization	60
Trunk Injury	64
Deformity (reduction) in:	
Extremity Injury	66
Reduce Deformity	87
Delirium / Dementia in:	
Psychiatric	46
Delivery in:	
Pregnancy / Delivery	48
Deliver Baby	89
Dental in:	
Pain	20
Head Injury	62
Destination Triage	98
Dextrose see: D10	
Diabetic	38
Dialysis in:	
Hyperkalemia	18
Saline Lock	80
Diaphoresis in:	
Circulation (Shock)	8
Diphenhydramine see Benadryl	
Direct Pressure in:	
Bleeding	58
Difficulty Breathing (DIB) in:	
Breathing	6
Dyspnea	30
DNR in:	
Withhold Resuscitation	94
Dopamine for:	
Circulation (Shock)	8
Dosing in:	
Peds Dosing	A
Dressing in:	
Wound Care	86
Drug Box	91
Drunk in:	
Overdose / Tox	40
Dyspnea	30

E

Ear Trauma in:	
Head Injury	62
ECG / EKG in:	
12-Lead	80
Eclampsia in:	
Seizure	42
Pregnancy / Delivery	48

Ejection in:	
Major Trauma	56
Immobilization	60
EKG / ECG in:	
12-Lead	80
Electric Burn in:	
Burns	72
End Tidal CO2 (EtCO2) in:	
Breathing	6
Entrapment in:	
Crush Injury	68
Environmental in:	
Allergic Reaction	32
Cold / Heat	70
Sting / Bite	76
Epilepsy in:	
Seizure	42
Epiglottitis in:	
Dyspnea	30
Epinephrine (Epi) for:	
Circulation (Shock)	8
Bradycardia	12
Medical CODE	24
Allergic Reaction	32
Neonate	50
Trauma CODE	52
Epi-Pen, Epi-Pen Jr. for:	
Allergic Reaction	32
Epistaxis	78
Ethanol Intoxication in:	
Overdose / Tox	40
Evisceration in:	
Trunk Injury	64
Explosion Injury in:	
Major Trauma	56
Exposure in:	
Cold / Heat	70
External Jugular in:	
Saline Lock	80
Extremity Injury	66
Eye Trauma in:	
Head Injury	62

F

Facial Trauma in:	
Head Injury	62
Failed Airway in:	
Airway	4
Fainting in:	
Altered LOC / Syncope	36
Fatigue in:	
Rehab	96
FAST Stroke Scale in:	
Stroke	44
Febrile Seizure in:	
Fever	16
Seizure	42
Fentanyl for:	
Pain	20
Fever	16
Fibromyalgia in:	
Pain	20
Flail Chest Segment in:	
Trunk Injury	64
Fracture in:	
Immobilization	60
Head Injury	62
Trunk Injury	64
Extremity Injury	66

Frostbite / Frostnip in:	
Cold / Heat	70
Flu in:	
Fever	16

G

Gas Exposure in:	
Inhalation	74
Gastric Tube (G-tube)	84
GERD in:	
Abdominal Pain	34
Glucagon for:	
Diabetic	38
Glucometer	80
Glucose for:	
Altered LOC / Syncope	36
Diabetic	38
Gun Shot Wound (GSW) in:	
Breathing	6
Immobilization	60
Head Injury	62
Trunk Injury	64

H

Haldol for:	
Psychiatric	46
Harness Hang Syndrome in:	
Crush Injury	68
Head Injury	62
Headache in:	
Hypertension	10
Pain	20
Heartburn in:	
Abdominal Pain	34
Heart Attack in:	
Chest Pain	28
Heart Block in:	
Bradycardia	12
Heart Failure in:	
Dyspnea	30
Heat in:	
Fever	16
Cold / Heat	70
Heat Exhaustion / Stroke in:	
Cold / Heat	70
Heimlich	81
Hemorrhage in:	
Bleeding	58
Hemostatic Packing	86
Hives in:	
Allergic Reaction	32
Hyperglycemia in:	
Diabetic	38
Hyperkalemia	18
Hypertension	10
Hyperthermia in:	
Fever	16
Cold / Heat	70
Hypoglycemia in:	
Diabetic	38
Hypotension in:	
Circulation (Shock)	8
Hypothermia in:	
Medical CODE	24
Cold / Heat	70
Hypoxia in:	
Breathing	6
Dyspnea	30

I

Ibuprofen <i>for:</i>	
Fever	16
Pain	20
Ice <i>in:</i>	
Extremity Injury	66
Cold / Heat	70
iGel (airway) <i>in:</i>	
Airway	4
BIAD	85
Immobilization	60
Impaled Object <i>in:</i>	
Major Trauma	56
Head Injury	62
Trunk Injury	64
Infant <i>in:</i>	
Pregnancy / Delivery	48
Neonate	50
Abandonment	92
Infection <i>in:</i>	
Fever	16
Influenza <i>in:</i>	
Fever	16
Ingestion <i>in:</i>	
Overdose / Tox	40
Inhalation	74
Intraosseus (IO)	83
Intravenous (IV) <i>in:</i>	
Saline Lock	80
Insulin Reaction <i>in:</i>	
Diabetic	38
Intubation <i>in:</i>	
Airway	4
Intoxication <i>in:</i>	
Overdose / Tox	40
Ipratropium Brom. <i>see</i> Atrovent	
Itching <i>in:</i>	
Allergic Reaction	32

J**K**

King (airway) <i>in:</i>	
Airway	4
BIAD	85
Ketamine <i>for:</i>	
Pain	20
Medical ROSC	26
Trauma ROSC	54

L

Labetalol <i>for:</i>	
HTN	10
Laceration <i>in:</i>	
Bleeding	58
Wound Care	86
Lasix <i>for:</i>	
Dyspnea	30
Length Based Tape <i>in:</i>	
Peds Dosing	A
Level of Consciousness(LOC) <i>in:</i>	
Altered LOC / Syncope	36
Lidocaine <i>for:</i>	
Medical CODE	24
Trauma CODE	52
Lividity <i>in:</i>	
Medical CODE	24
Termination	94

Loss of Consciousness <i>in:</i>	
Altered LOC / Syncope	36
LVAD	95

M

Magill Forceps	81
Magnesium <i>for:</i>	
Tachycardia	14
Medical CODE	24
Dyspnea	30
Seizure	42
Major Trauma	56
Malignant HTN <i>in:</i>	
Hypertension	10
Manage Complication (baby)	89
Mass Casualty	99
Medical CODE	24
Medical Control <i>in:</i>	
How To Use	1
Medical ROSC	26
Medications <i>in:</i>	
Drug Box	91
Peds Dosing	A
Mental Disorder <i>in:</i>	
Psychiatric	46
Midazolam <i>see:</i> Versed	
Migraine <i>in:</i>	
Pain	20
Miscarriage <i>in:</i>	
Pregnancy / Delivery	48
Monitor (cardiac) <i>in:</i>	
12-Lead	80
Mortal Injury <i>in:</i>	
Trauma CODE	52
Deceased Subjects	99
Motrin <i>see:</i> Ibuprofen	
Mouth Trauma <i>in:</i>	
Head Injury	62
Multisystem Trauma <i>in:</i>	
Major Trauma	56
Myocardial Infarction (MI) <i>in:</i>	
Chest Pain	28

N

Narcan <i>for:</i>	
Overdose / Tox	40
Naloxone <i>see:</i> Narcan	
Nasopharyngeal Airway	84
Nausea / Vomiting	22
Nebulizer <i>in:</i>	
Dyspnea	30
Neck Trauma <i>in:</i>	
Immobilization	60
Head injury	62
Needle Decompression <i>in:</i>	
Breathing	6
Needle Decompress	85
Neglect <i>in:</i>	
Stroke	44
Abuse and Neglect	92
Neonate	50
Neuro Deficits <i>in:</i>	
HTN	10
Stroke	44
Immobilization	60
Trunk Injury	64
Newborn <i>in:</i>	
Neonate	50
Nitro <i>for:</i>	
Chest Pain	28
Dyspnea	30

Normodyne <i>see:</i> Labetalol	
Nose Bleed <i>in:</i>	
Head Injury	62
Epistaxis	78
NS Bolus <i>for:</i>	
Circulation (Shock)	8
Tachycardia	14
Fever	16
Hyperkalemia	18
Diabetic	38
Pregnancy / Delivery	48
Trauma CODE	52
Major Trauma	56
Crush Injury	68
Cold / Heat	70
Burns	72

O

Obvious Death <i>in:</i>	
Medical CODE	24
Deceased Subjects	99
Occlusive Dressing <i>in:</i>	
Breathing	6
Major Trauma	56
Needle Decompress	85
Wound Care	86
On Scene Personnel	93
Ondansetron <i>see:</i> Zofran	
Opiates <i>see:</i> Fentanyl <i>in:</i>	
Pain	20
Overdose / Tox	40
Oral Glucose <i>see:</i> Glucose	
Organophosphate Exposure <i>in:</i>	
Overdose / Tox	40
Oropharyngeal Airway	84
Overdose / Tox	40
Oxygen (O2) <i>in:</i>	
Breathing	6
Inhalation	74
Oxymetazoline <i>see:</i> Afrin	

P

Pacerone <i>see:</i> Amiodarone	
Pacing	88
Pain	20
Palpitations <i>in:</i>	
Tachycardia	14
Patient <i>in:</i>	
How To Use	1
Refusal	97
PEA <i>in:</i>	
Medical CODE	24
Pediatrics <i>in:</i>	
How To Use	1
Peds Dosing	A
Pelvic Trauma <i>in:</i>	
Trunk Injury	64
Penetrating Trauma <i>in:</i>	
Breathing	6
Immobilization	60
Head Injury	62
Trunk Injury	64
Physician Orders	93
PICC lines <i>in:</i>	
Saline Lock	80
Pleural Decompression <i>in:</i>	
Breathing	6
Needle Decompress	85
Pneumonia <i>in:</i>	
Dyspnea	30

Pneumothorax <i>in</i> :	
Breathing	6
Needle Decompress	85
Poisoning <i>in</i> :	
Overdose/Tox	40
Police <i>in</i> :	
Psychiatric	46
Police Assist	96
Poor Perfusion <i>in</i> :	
Airway	4
Circulation (Shock)	8
Bradycardia	12
Tachycardia	14
Fever	16
Allergic Reaction	32
Major Trauma	56
Bleeding	58
POST <i>in</i> :	
Withhold Resuscitation	94
Post-Partum Care <i>in</i> :	
Pregnancy / Delivery	48
Post-Resuscitation Care <i>in</i> :	
Medial ROSC	24
Trauma ROSC	52
Potassium Elevation <i>in</i> :	
Hyperkalemia	18
Preeclampsia <i>in</i> :	
Seizure	42
Pregnancy / Delivery	48
Pregnancy / Delivery	48
Pressors <i>in</i> :	
Circulation (Shock)	8
ProAir / Proventil <i>see</i> : Albuterol	
Prolapsed Cord <i>in</i> :	
Pregnancy / Delivery	48
Pseudoseizure <i>in</i> :	
Seizure	42
Psychiatric	46
PTX <i>in</i> :	
Breathing	6
Needle Decompress	85
Pulmonary Edema <i>in</i> :	
Dyspnea	30
Pulmonary Embolism (PE) <i>in</i> :	
Breathing	6
Pulseless Electrical Activity <i>in</i> :	
Medical CODE	24

Q

R

Rash <i>in</i> :	
Allergic Reaction	32
Reduce Deformity	87
Refusals	97
Rehab	96
Renal Failure <i>in</i> :	
Hyperkalemia	18
Restraint <i>in</i> :	
Psychiatric	46
Resuscitation <i>in</i> :	
Medical CODE	24
Trauma CODE	52
Rigor Mortis <i>in</i> :	
Medical CODE	24
Termination	94
ROSC <i>in</i> :	
Medical ROSC	26
Trauma ROSC	54
Rule of 9's <i>in</i> :	
Burns	72

S

Saline <i>see</i> : NS Bolus	
Saline Lock	80
Seizure	42
Sepsis <i>in</i> :	
Fever	16
Shock (Circulation)	8
Shortness of Breath (SOB) <i>in</i> :	
Dyspnea	30
Skull Trauma <i>in</i> :	
Head Injury	62
Smoke Inhalation <i>in</i> :	
Inhalation	74
Sodium Bicarb <i>see</i> Bicarbonate	
Spinal Clearance <i>in</i> :	
Immobilization	60
Spinal Precautions <i>in</i> :	
Immobilization	60
Splint	87
Sprain / Strain <i>in</i> :	
Extremity Injury	66
Splint	87
ST Elevation MI (STEMI) <i>in</i> :	
Chest Pain	28
Stabbing Injury <i>in</i> :	
Breathing	6
Immobilization	60
Head Injury	62
Trunk Injury	64
Standby	96
Sting / Bite	76
Stinger Removal	87
Stomach Pain <i>in</i> :	
Abdominal Pain	34
Stroke	44
Suction	81
Suicidal <i>in</i> :	
Psychiatric	46
Sunburn <i>in</i> :	
Burns	72
SVT <i>in</i> :	
Tachycardia	14
Syncope / Altered LOC	36

T

Tachycardia	14
Teeth <i>in</i> :	
Pain	20
Head Injury	62
Tension Pneumothorax <i>in</i> :	
Breathing	6
Needle Decompress	85
Termination	94
Therapeutic Hypothermia <i>in</i> :	
Medical CODE	24
Thermometer <i>in</i> :	
Fever	16
Cold / Heat	70
TIA <i>in</i> :	
Stroke	44
Toothache <i>in</i> :	
Pain	20
Head Injury	62
Tourniquets <i>in</i> :	
Trauma CODE	52
Major Trauma	56
Bleeding	58
Tourniquet	86
Tox / Overdose	40
Tranexamic Acid <i>see</i> : TXA	

Transport <i>in</i> :	
How To Use	1
Destination Triage	98
Trauma CODE	52
Trauma ROSC	54
Triage <i>in</i> :	
Mass Casualty	99
Destination Triage	98
Tricyclic Overdose <i>in</i> :	
Overdose / Tox	40
Trunk Injury	64
Twins <i>in</i> :	
Pregnancy / Delivery	48
TXA for :	
Bleeding	58
Tylenol for :	
Fever	16
Pain	20

U

Umbilical Cord <i>in</i> :	
Pregnancy / Delivery	48
Unresponsive <i>in</i> :	
Medical CODE	24
Altered LOC / Syncope	32

V

V-Fib <i>in</i> :	
Medical CODE	24
V-Tach <i>in</i> :	
Tachycardia	14
Medical CODE	24
VAN Stroke Scale <i>in</i> :	
Stroke	44
Versed for :	
Seizure	42
Psychiatric	46
Ventolin <i>see</i> : Albuterol	
Vision Changes <i>in</i> :	
Hypertension	10
Head Injury	62
Vomiting / Nausea	22

W

Warming <i>in</i> :	
Cold / Heat	70
Weakness <i>in</i> :	
Altered LOC / Syncope	32
Wheezing <i>in</i> :	
Dyspnea	30
Allergic Reaction	32
Withdrawal <i>in</i> :	
Overdose / Tox	40
Seizure	42
Withhold Resuscitation	94
Wound Care	86
Wound Packing <i>in</i> :	
Hemostatic Packing	86

X

Xylocaine <i>see</i> : Lidocaine	
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Y

Z

Zofran for :	
Nausea / Vomiting	22



EMS Protocols 2019

Protocols, Procedures, Policies and Medications
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- VA OEMS Procedure Scope 2019
- VA OEMS Formulary Scope 2019
- WVEMS Protocols 2015
- NEMSIS 3.4.0 2015

Physician Reviewers:

- Dr. C. Bernier
 - Dr. B. Ekey
 - Dr. C. Lane
 - Dr. A. LePera
 - Dr. J. Mark
 - Dr. H. Rose-Inman
 - Dr. M. Saccocci
 - Dr. E. Stanley
- Et al.

With assistance from:

- Chris Christensen
 - Cathy Cockrell
 - John Cook
 - Gene Dalton
 - Mike Garnett
 - Rob Logan
 - BVRS Members
- Et al.

WVEMS Council
1944 Peters Creek Rd.
Roanoke, VA 24017

Phone: 540-562-3482
Web: www.western.vaems.org
Email: western@vaems.org